

FPHS Deep Dive - Homework

DISCUSSION GUIDE OVERVIEW

Introduction: What is Foundational

Foundational public health services (FPHS) are those services which should be provided at a uniform level statewide. FPHS includes the services that:

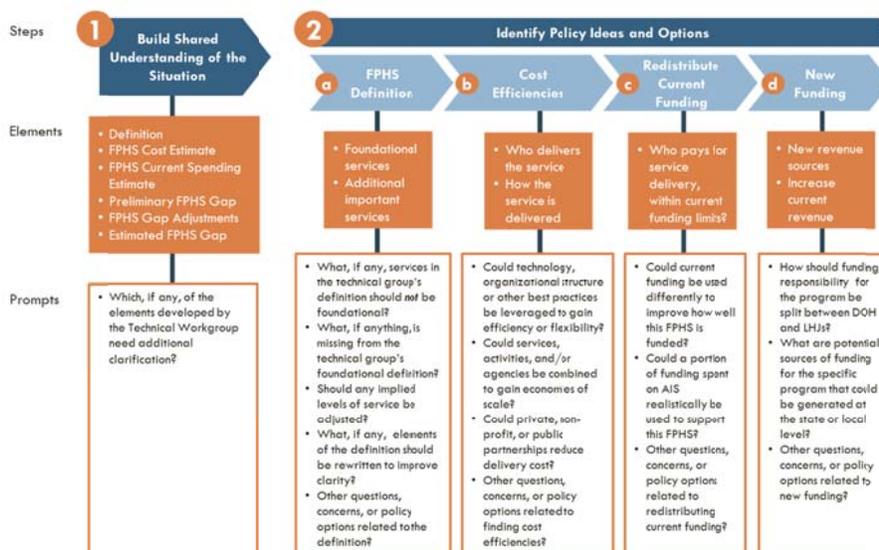
- Must be present everywhere in order to serve anywhere
- Should be available to everyone, everywhere
- Should be provided by the public sector
- Are a solid foundation on which additional important services (AIS) can be added community by community

Over the last two years, the Technical Workgroup has worked to develop definitions for FPHS and costs based on those definitions. For more detail on the Technical Workgroup’s approach to defining the difference between foundational services and additional important services, please see the document titled *How FPHS Definitions Were Developed* from your Meeting 2 materials packet. For additional information on the estimates, please see the document titled *Summary of Technical Workgroup Findings and Approach* from the same packet.

Objective and Process

To better understand the current situation, the Policy Workgroup will work through FPHS specifics, one program at a time. This discussion guide is designed to help Policy Workgroup members understand the definitions and estimates that the Technical Workgroup has developed for each program, and identify policy ideas and options for further analysis.

Policy Workgroup members will work through the process described in the diagram below. A full-sized version of this diagram is included in the meeting materials packet from Meeting 2.



INSTRUCTIONS: Please read through Step One of each program and write your answers to the questions at the end of each program section in Step Two. As the Policy Workgroup, the focus of your effort should be in Step Two of the process for program discussion. Write your comments, questions, and ideas directly into the Word Document. When you are finished, please email your responses to Simana Dimitrova at Simana.Dimitrova@DOH.WA.GOV. The deadline for homework is **June 11, 2014**.

MATERNAL/CHILD/INFANT HEALTH

STEP 1: UNDERSTAND THE SITUATION

Definition

The **foundational definition** of Maternal/Child/Infant Health includes:

1. Provide timely, statewide, and locally relevant and accurate information to the state and community on emerging and on-going maternal child health trends taking into account the important of Adverse Childhood Experiences (ACEs) and health disparities.
2. Assure mandated newborn screening done by the state public health lab to test every infant born in Washington to detect and prevent the developmental impairments and life-threatening illnesses associated with congenital disorders that are specified by the State Board of Health
3. Identify, disseminate, and promote emerging and evidence-based information about early interventions in the prenatal and early childhood period that optimize lifelong health and social-emotional development.
4. Identify local maternal and child health community assets; using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and advocate and seek funding for high priority policy initiatives.
5. Coordinate and integrate other categorically funded maternal, child, and family health programs and services.

Examples of **Additional Important Services** include:

1. Assure access and/or coordination of Women, Infants and Children Supplemental Nutrition Services (WIC) that adhere to the USDA Nutrition Services Standards (including current categorical federal funding).
2. Assure access and/or coordination of maternity support and nurse family partnership services (including services currently funded by third party payers including Medicaid).
3. Family planning services (including current state and federal categorical funding).
4. Child Death Review.
5. Outreach, linkage and system development for children with special needs.

The estimates on the following page show that the vast majority of current spending on maternal/child/infant health is categorized as AIS, based on the current definitions. Similar to communicable disease control, a lot of the decisions around what was foundational or not came down to determining (a) what needed to be provided **everywhere** and (b) what components deal with **population-based** services, rather than individual interventions.

Most of the programmatic elements around interventions in this program were categorized as AIS based on these screens. The foundational definition describes a very core set of services that are not geared toward direct interventions.

Cost Estimate and Current Spending Estimate

Please read through the foundational definition elements and make note of any questions you have for the Technical Workgroup or concerns you have regarding the estimates for Maternal/Child/Infant Health.

Exhibit 1: Maternal/Child/Infant Health Cost Estimate and Current Spending Estimate for LHJs (2013 \$)

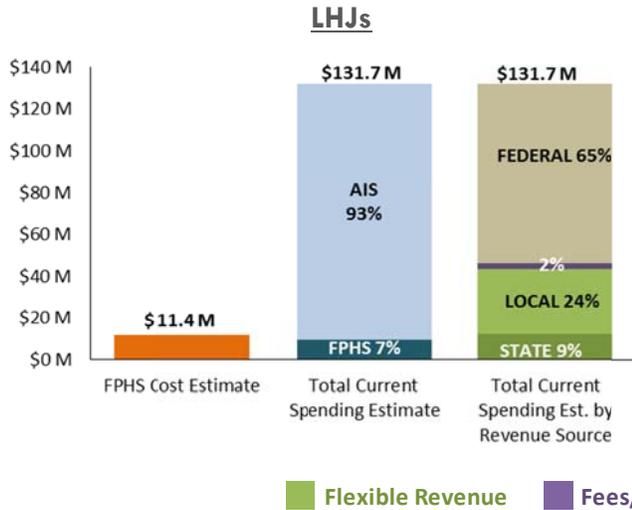
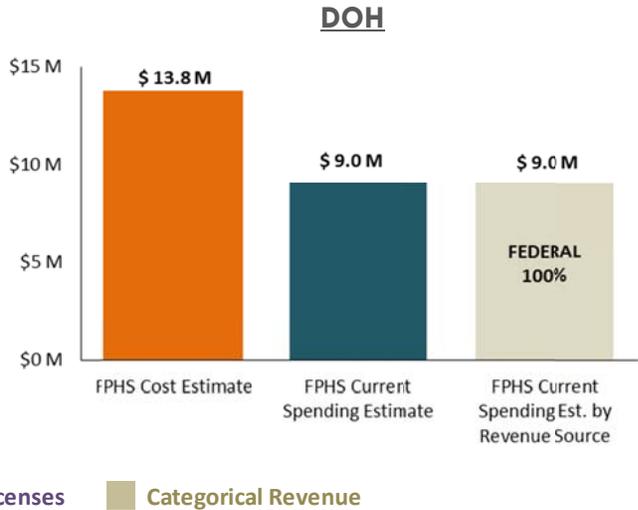


Exhibit 2: Maternal/Child/Infant Health Cost Estimate and Current Spending Estimate for DOH (2013 \$)



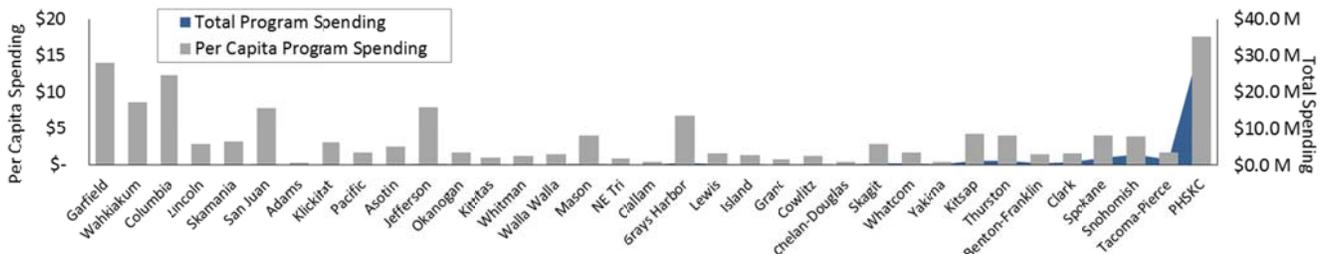
Program Information for LHJs

- The model-generated FPHS Cost Estimate for this program is \$11.4 million.
- LHJs currently spend about \$131.7 million on **all** maternal/child/infant health activities.
 - Of this \$131.7 million, 7% of this activity is currently defined as foundational.
- Spending on all maternal/child/infant health activities came from a variety of sources. Federal categorical dollars make up the majority of funding (65%), following by local flexible funding (24%), and state flexible funding (9%).

Program Information for DOH

- The FPHS Cost Estimate for this program is about \$13.8 million for DOH.
- DOH currently spends about \$9.0 million on this program.
- DOH funding for maternal/child/infant health is wholly from federal revenues (100%).

Exhibit 3: Current Total & Per Capita Spending by LHJ for all Maternal/Child/Infant Health services



- Current levels of per capita spending on this program vary widely across LHJs. It is important to remember there are these differences between jurisdictions when developing policy ideas and options

Estimated FPHS Gap

Exhibit 4: Estimated FPHS Gap for Maternal/Child/Infant Health

Program	Service Delivery	(1)	-	(2)	=	(3)	+		(4)	=	(5)
		FPHS Cost Estimate		FPHS Current Spending Estimate		Preliminary FPHS Gap	FPHS Gap Adjustments		(a) Exclude LHJ Spending Above Estimates	(b) Exclude Uncertain Revenue	Estimated FPHS Gap
Maternal/ Child/ Family Health	DOH	\$ 13.8 M		\$ 9.0 M		\$ 4.7 M			-	\$ 0.0 M	\$ 4.7 M
	LHJs	\$ 11.4 M		\$ 9.4 M		\$ 2.0 M			\$ 2.0 M	\$ 2.1 M	\$ 6.0 M
Total Statewide		\$ 25.2 M		\$ 18.5 M		\$ 6.7 M			\$ 2.0 M	\$ 2.1 M	\$ 10.8 M

- (1) **FPHS Cost Estimate.** The estimated cost to provide foundational maternal/child/infant health services is \$25.2 M per year. About 55% (or \$13.8 M) would be spent by DOH, and about 45% (or \$11.4 M) would be spent by LHJs.
- (2) **FPHS Current Spending Estimate.** Annual current spending on foundational maternal/child/infant public health services is about \$18.5 M. About 49% (or \$9.0 M) is spent by DOH, and about 51% (or \$9.4 M) is spent by the LHJs.
- (4) **FPHS Gap Adjustments.** There were two types of adjustments made to develop the Estimated FPHS Gap:
 - a. **Exclude LHJ Spending Above Estimates.** About \$2.0 million of current spending was excluded, because it was being spent at LHJs where the FPHS Current Spending Estimate for this program was higher than the FPHS Cost Estimate for this program. Since this spending above the estimate cannot be necessarily used to offset gaps at other LHJs or in other programs, these amounts were excluded when estimating the Gap.
 - b. **Exclude Uncertain Revenues.** About \$2.1 million of current spending was excluded. The excluded amount included federal funding, which the Technical Workgroup considered too uncertain to support foundational maternal/child/infant public health activities.
- (5) **Estimated FPHS Gap.** This column shows the estimated amount needed, in addition to current spending, to support provision of foundational environmental public health services (as defined) statewide. The Estimated FPHS Gap is \$10.8 M for this program. For DOH, the Estimated FPHS Gap is about \$4.7 M. For LHJs, it is about \$6.0 M.

For additional detail on the methodology used for these estimates, please refer to the document titled *Summary of Technical Workgroup Findings and Approach* from your Meeting 2 materials packet.

STEP 2: IDENTIFY POLICY IDEAS AND OPTIONS

In order to assure appropriate funding for foundational Maternal/Child/Infant Health, the policy group must evaluate structural changes and funding options. Please brainstorm questions, concerns, and policy ideas using the questions below.

1. As discussed in Meeting #2, some policy workgroup members felt that ACEs and other services related to mental health and informed trauma were missing from the definition of Chronic Disease and Injury Prevention.
 - a. Do the sub-definitions of Maternal/Child/Infant Health, address your concerns about including ACEs and related services in the foundational definition?
 - b. If not, what sub-definition would you add to either Chronic Disease and Injury Prevention or to Maternal/Child/Infant Health?
2. What, if any, AIS does your local community provide in Maternal/Child/Infant Health (not necessarily included in the examples of AIS) that you think should be provided at the same level statewide, and therefore considered foundational?
3. What, if any, services are not included in the Maternal/Child/Infant Health definition of FPHS that the governmental public health network in your community has to provide because of mandates or local priorities?
4. Current FPHS definitions apply to only LHJ and DOH services. At the last Policy Workgroup meeting, it was acknowledged that tribal service delivery should be incorporated and that many other state and local agencies also work on public health issues.
 - a. What, if any, services that would fall in this program area are *not* currently provided by tribal public health, DOH or LHJs and should be performed by governmental public health? Please describe the service or program and how you think it should be provided.
5. What big issues in Maternal/Child/Infant Health are not being addressed by the governmental public health system and should be provided statewide as a foundational program? Please describe the service or program and how you think it should be provided.
6. The Estimated FPHS Gap for Maternal/Child/Infant Health is \$10.8 million. Given your experience in this program area, do you think the FPHS Cost Estimate, FPHS Current Spending Estimate, or Estimated FPHS Gap are overestimated or underestimated? Why?
7. Do you have any ideas about how we could deliver Maternal/Child/Infant Health services at a lower cost by changing who delivers the service or how service delivery is shared?
8. Do you have any ideas about how we could redistribute current funding or find new funding for the services included in the Maternal/Child/Infant Health program definition?
9. Any other comments, questions, ideas, or concerns?

VITAL RECORDS

STEP 1: UNDERSTAND THE SITUATION

Definition

Please read through the elements of the foundational definition and the examples of additional important services, and make note if any of the services need clarification.

The **foundational definition** of Vital Records includes:

1. In compliance with state law and in concert with national, state, and local groups, assure a system of vital records
2. Provide certified birth and death certificates in compliance with state law and rule.

Examples of **Additional Important Services** include:

There are currently no AIS activities being performed by LHJs or DOH within Vital Records. All current activities are considered foundational.

Cost Estimate and Current Spending Estimate

Please read through the foundational definition elements and make note of any questions you have for the Technical Workgroup or concerns you have regarding the estimates for Vital Records.

Exhibit 5: Vital Records Cost Estimate and Current Spending Estimate for LHJs (2013 \$)

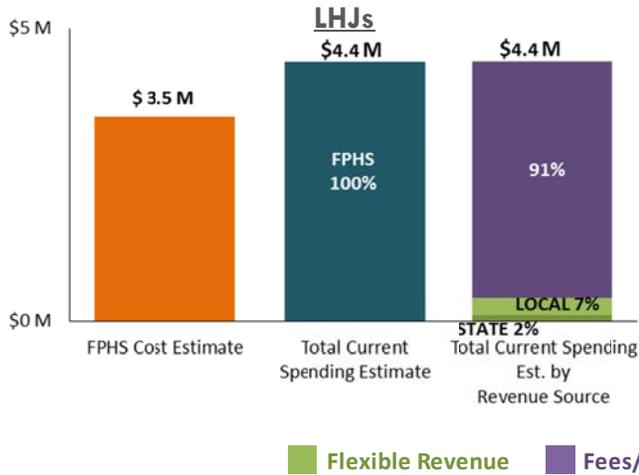
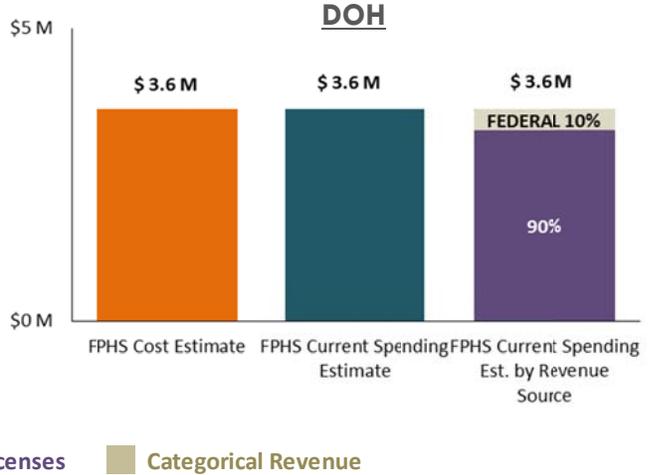


Exhibit 6: Vital Records Cost Estimate and Current Spending Estimated for DOH (2013 \$)



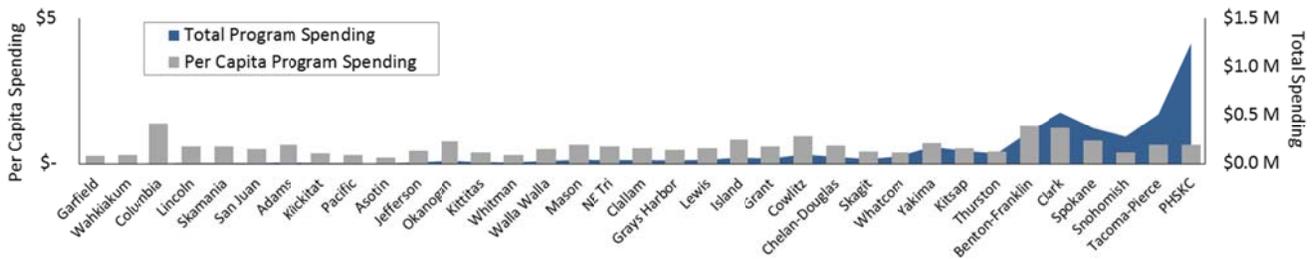
Program Information for LHJs

- The model-generated FPHS Cost Estimate for this program is \$3.5 million.
- LHJs currently spend about \$4.4 million on **all** vital records activities.
 - The entire \$4.4 million currently spent is considered to be on foundational services.
- The majority of spending on all vital records activities was from fees and licenses (91%). Another 7% comes from local flex funding and 2% from state flex funding.

Program Information for DOH

- The FPHS Cost Estimate for this program is about \$3.6 million for DOH.
- DOH currently spends about \$3.6 million on this program, including both FPHS and additional important services.
- The majority of funding (90%) comes from licenses and fees, and about 10% of funding comes from federal categorical funding.

Exhibit 7: Current Total & Per Capita Spending by LHJ for all Vital Records



- With very few exceptions, per capita spending on vital records is less than a dollar per capita across each of the State's 35 LHJs.

Estimated FPHS Gap

Exhibit 8: Estimated FPHS Gap for Vital Records

Program	Service Delivery	(1)	-	(2)	=	(3)	+		(4)	=	(5)
		FPHS Cost Estimate		FPHS Current Spending Estimate		Preliminary FPHS Gap	FPHS Gap Adjustments		(a) Exclude LHJ Spending Above Estimates	(b) Exclude Uncertain Revenue	Estimated FPHS Gap
Vital Records	DOH	\$ 3.6 M		\$ 3.6 M		\$ 0.0 M			-	\$ 0.0 M	\$ 0.0 M
	LHJs	\$ 3.5 M		\$ 4.4 M		(\$ 0.9 M)			\$ 1.2 M	\$ 0.0 M	\$ 0.3 M
Total Statewide		\$ 7.1 M		\$ 8.0 M		(\$ 0.9 M)			\$ 1.2 M	\$ 0.0 M	\$ 0.3 M

- (1) **FPHS Cost Estimate.** The estimated cost to provide foundational vital records is \$7.1 M per year. About 51% (or \$3.6 M) would be spent by DOH, and about 49% (or \$3.5 M) would be spent by LHJs.
- (2) **FPHS Current Spending Estimate.** Annual current spending on foundational vital records is about \$8.0 M. About 45% (or \$3.6 M) is spent by DOH, and about 55% (or \$4.4 M) is spent by the LHJs.
- (4) **FPHS Gap Adjustments.** There were two types of adjustments made to develop the Estimated FPHS Gap:
 - a. **Exclude LHJ Spending Above Estimates.** About \$1.2 million of current spending was excluded, because it was being spent at LHJs where the FPHS Current Spending Estimate for this program was higher than the FPHS Cost Estimate for this program. Since this spending above the estimate cannot be necessarily used to offset gaps at other LHJs or in other programs, these amounts were excluded when estimating the Gap.
 - b. **Exclude Uncertain Revenues.** No revenues were excluded from supporting this program.
- (5) **Estimated FPHS Gap.** This column shows the estimated amount needed, in addition to current spending, to support provision of foundational vital records (as defined) statewide. The Estimated FPHS Gap for LHJs is about \$0.3 M for this program. There is no Estimated FPHS Gap for DOH.

For additional detail on the methodology used for these estimates, please refer to the document titled *Summary of Technical Workgroup Findings and Approach* from your Meeting 2 materials packet.

STEP 2: IDENTIFY POLICY IDEAS AND OPTIONS

In order to assure appropriate funding for foundational Vital Records, the policy group must evaluate structural changes and funding options. Please brainstorm questions, concerns, and policy ideas using the questions below.

1. What, if any, AIS does your local community provide in Vital Records (not necessarily included in the examples of AIS) that you think should be provided at the same level statewide?
2. What, if any, services are not included in the Vital Records definition of FPHS that the governmental public health network in your community has to provide because of mandates or local priorities?
3. Current FPHS definitions apply to only LHJ and DOH services. At the last Policy Workgroup meeting, it was acknowledged that tribal service delivery should be incorporated and that many other state and local agencies also work on public health issues.
 - a. What, if any, services that would fall in Vital Records are *not* currently provided by tribal public health, DOH or LHJs and should be performed by governmental public health? Please describe the service or program and how you think it should be provided.
4. What big issues in Vital Records are not being addressed by the governmental public health system and should be provided statewide as a foundational program? Please describe the service or program and how you think it should be provided.
5. The Estimated FPHS Gap for Vital Records is \$0.3 million. Given your experience in this program area, do you think the FPHS Cost Estimate, FPHS Current Spending Estimate, or Estimated FPHS Gap are overestimated or underestimated? Why?
6. Do you have any ideas about how we could deliver Vital Records services at a lower cost by changing who delivers the service or how service delivery is shared?
7. Do you have any ideas about how we could redistribute current funding or find new funding for the services included the Vital Records program definition?
8. Any other comments, questions, ideas, or concerns?

ACCESS/LINKAGE WITH CLINICAL HEALTH CARE

Notes about this program

As you complete the homework for this program, please note that this is a uniquely challenging program to analyze due to its emerging nature as well as some specific data limitations:

The role of public health in this program is changing. The access/linkage with clinical health care program is the main area of intersection between the governmental public health network and the health care system. Because of the many changes occurring in health care due to implementation of the Affordable Care Act (ACA), the role of public health in this program is actively changing. Given these changes, there is a lot of uncertainty about how this program should be defined going forward.

The definition and estimates that appear on the following pages are based on the Technical Workgroup's best understanding of this area when data collection and analysis was conducted last year. The Technical Workgroup is planning to revisit the definition and the estimates of cost and spending in concert with a subcommittee on ACA that DOH has organized. The subcommittee is providing an overarching review of how ACA will impact public health provision. The work of this subcommittee will be aligned with Technical Workgroup revisions and communicated to the Policy Workgroup as it is completed.

Current spending data for LHJs is not available. The State Auditor's Office Budget Accounting and Reporting System (BARS) does not have specific expenditure codes that capture activities within access/linkage with clinical health care. Because of this limitation, this program was ill-suited to BARS analysis, and we do not have a FPHS Current Spending Estimate for this program. Actual current expenditures are likely spread throughout the current spending estimates for all other programs in this study.

STEP 1: UNDERSTAND THE SITUATION

Definition

Please read through the elements of the foundational definition and the examples of additional important services, and make note if any of the services need clarification.

The **foundational definition** of Access/Linkage with Clinical Health Care includes:

1. Provide timely, statewide, and locally relevant and accurate information to the state and community on the clinical health care system.
2. Improve patient safety through inspection and licensing of health care facilities and licensing, monitoring, and discipline of health care providers.
3. In concert with national and statewide groups and local providers of health care, identify health care assets, develop prioritized plans for increasing access to health homes and quality health care, and advocate and seek funding for high priority policy initiatives.
4. Provide state-level health system planning
5. Coordinate and integrate other categorically-funded clinical health care programs and services.

Examples of **Additional Important Services** include:

1. Clinical services to vulnerable populations that follow established clinical practice guidelines and are delivered in a timely manner, including integrated medical and behavioral care, sexual health, oral health, adolescent health services, immunizations, and travel health services (including services funded by third party payers, including Medicaid).

2. Quality, accessible, and timely jail health services in accordance with standards set by the National Commission on Correctional Health Care that include medical, mental health, chemical dependency, dental, nursing, pharmacy, and release planning services.
3. Emergency medical services including basic life support (BLS) and advanced life support (ALS) response by certified EMTs and paramedics to residents in need of emergency medical services (including current locally funded levy services).
4. Public health laboratory testing that meets certification standards of Washington Department of Health's Office of Laboratory Quality Assurance and the federal Clinical Laboratory Improvement Amendments to assure accurate, reliable, and prompt reporting of test results (including services funded by third party payers including Medicaid) for personal health (i.e., primary diagnostic testing).
5. Refugee health screening that follows CDC's Refugee Health Guidelines and is delivered within 90 days of arrival in the US, in accordance with the Office for Refugee Resettlement (including current categorical federal funding).
6. Monitoring and reporting of indices of measures of quality and cost of health care.
7. Death investigations and authorization to dispose of human remains that meet National Association of Medical Examination accreditation standards.

Cost Estimate and Current Spending Estimate

Please read through the foundational definition elements and make note of any questions you have for the Technical Workgroup or concerns you have regarding the estimates for Access/Linkage with Clinical Health Care.

Exhibit 9: Access/Linkage Cost Estimate and Current Spending Estimate for LHJs (2013 \$)

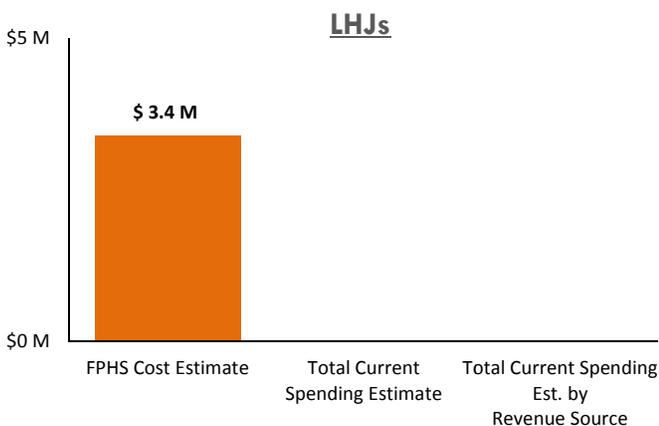
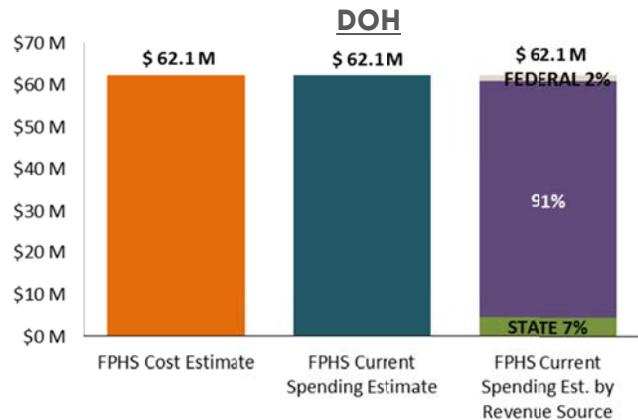


Exhibit 10: Access/Linkage Cost Estimate and Current Spending Estimate for DOH (2013 \$)



■ Flexible Revenue
 ■ Fees/Licenses
 ■ Categorical Revenue

Program Information for LHJs

- The FPFS Cost Estimate for this program is about \$3.4 million for LHJs.
- Given the limitations in BARS data categories, we do not have estimates for current spending on access/linkage with clinical health care for LHJs.
- What is being currently spent is like spread among other categories and captured in the FPFS Current Spending Estimates for other programs.

Program Information for DOH

- The FPFS Cost Estimate and FPFS Current Spending Estimate for this program are the same, at about \$62.1 million for DOH.
- The majority of funding (91%) comes from fees and licenses, and about 7% of funding comes from state flexible revenue. Another 2% comes from federal categorical funds.

Estimated FPHS Gap

Exhibit 11: Estimated FPHS Gap for Access/Linkage with Clinical Health Care

Program	Service Delivery	(1)	-	(2)	=	(3)	+	(4)		=	(5)	
		FPHS Cost Estimate		FPHS Current Spending Estimate		Preliminary FPHS Gap		FPHS Gap Adjustments	(a) Exclude LHJ Spending Above Estimates	(b) Exclude Uncertain Revenue	Estimated FPHS Gap	
Access/Linkage to	DOH	\$ 62.1 M		\$ 62.1 M		\$ 0.0 M			-	\$ 0.0 M		\$ 0.0 M
Clinical Health Care ⁶	LHJs	\$ 3.4 M		\$ 0.0 M		\$ 3.4 M			\$ 0.0 M	\$ 0.0 M		\$ 3.4 M
Total Statewide		\$ 65.6 M		\$ 62.1 M		\$ 3.4 M			\$ 0.0 M	\$ 0.0 M		\$ 3.4 M

(1) **FPHS Cost Estimate.** The estimated cost to provide foundational access/linkage with clinical health care is \$65.6 M per year. About 95% (or \$62.1 M) would be spent by DOH, and about 5% (or \$3.4 M) would be spent by LHJs.

(2) **FPHS Current Spending Estimate.** Annual current spending on foundational access/linkage with clinical health care by DOH is about \$62.1 M. Due to limitations in BARS data categories, we do not have an estimate of current spending for LHJs for this program.

Since there is no specific BARS categories that capture current spending on this program for LHJs, any current spending that is occurring in this area must be captured in other BARS categories. Therefore, these expenditures are likely spread throughout the current spending estimates for all other programs in this study.

(4) **FPHS Gap Adjustments.** No current spending was excluded for this program.

(5) **Estimated FPHS Gap.** This column shows the estimated amount needed, in addition to current spending, to support provision of foundational access/linkage with clinical health care (as defined) statewide. The table indicates there is no estimated FPHS Gap for DOH. While this may have been true when these estimates were originally developed, changes in the dynamics of health care delivery and implementation of the ACA require re-evaluation of original assumptions and estimates for both DOH and LHJs. The Technical Workgroup is continuing to refine both the definition and the estimates, and the Policy Workgroup will be kept up to date on any changes in this program.

The Estimated FPHS Gap shown for LHJs is \$3.4 million. The description of this gap, however, is slightly different from what the Gap means for other programs. As noted above, current spending on this program is likely captured throughout other programs, since there are no BARS categories directly related to access/linkage with clinical health care.

If the categories that include this spending are flagged as foundational within other programs, then the current spending is in the total FPHS Current Spending Estimate for all programs, it's just not broken out for this program. In this case, the Estimated FPHS Gap listed in those programs is slightly underestimated, while the Estimated FPHS Gap for access/linkage with clinical health care is being overestimated. However, the total Estimated FPHS Gap would still be reasonable.

However, if the current spending on access/linkage with clinical health care is not being captured within other foundational programs, then the Estimated FPHS Gap is slightly overestimated overall, and the "Gap" identified for access/linkage with clinical health care would support new and emerging activities in this area.

For additional detail on the methodology used for these estimates, please refer to the document titled *Summary of Technical Workgroup Findings and Approach* from your Meeting 2 materials packet.

STEP 2: IDENTIFY POLICY IDEAS AND OPTIONS

In order to assure appropriate funding for foundational Access/Linkage with Clinical Health Care, the policy group must evaluate structural changes and funding options. Please brainstorm questions, concerns, and policy ideas using the questions below.

Given the data limitations and changing nature of this program, we understand it may be challenging to answer the homework questions in this area. If you have questions about how this program is related to ACA or the ongoing processes of the Technical Workgroup, please note them here. Providing your key questions, concerns, and ideas about this program now will ensure that they can be addressed in the concurrent work being done in this area.

1. The role of DOH, tribal health, LHJs, and partners under ACA is emerging.
 - a. What, if any, programs do you anticipate implementing or have already begun to implement as a result of ACA that you think should be considered foundational and provided statewide?
 - b. What types of services are going to be most significantly affected by ACA?
 - i. Are there existing services that will experience increased demand?
 - ii. Will it result in new services for governmental public health to provide?
2. What, if any, services are not included in the Access/Linkage definition of FPHS that the governmental public health network in your community has to provide because of mandates or local priorities?
3. What, if any, services that the governmental public health network in your community has to provide, either because of mandates or local priorities, are not included in the Access/Linkage definition of FPHS?
4. Current FPHS definitions apply to only LHJ and DOH services. At the last Policy Workgroup meeting, it was acknowledged that tribal service delivery should be incorporated and that many other state and local agencies also work on public health issues.
 - a. What, if any, services that would fall into Access/Linkage are *not* currently provided by tribal public health, DOH or LHJs and should be performed by governmental public health? Please describe the service or program and how you think it should be provided.
5. What big issues in Access/Linkage are not being addressed by the governmental public health system and should be provided statewide as a foundational program? Please describe the service or program and how you think it should be provided.
6. The Estimated FPHS Gap for Access/Linkage with Clinical Health Care is \$3.4 million. Given your experience in this program area, do you think the FPHS Cost Estimate, FPHS Current Spending Estimate, or Estimated FPHS Gap are overestimated or underestimated? Why?
7. Do you have any ideas about how we could deliver Access/Linkage services at a lower cost or meet increasing demands more efficiently by changing who delivers the service or how service delivery is shared?
8. Do you have any ideas about how we could redistribute current funding or find new funding for the services included in the Access/Linkage program definition?
9. Any other comments, questions, ideas, or concerns?

FOUNDATIONAL CAPABILITIES

In the FPHS framework, Foundational Capabilities are defined as cross-cutting capabilities that support all of the Foundational Programs you have reviewed. These Capabilities ensure that an organization has the basic building blocks necessary to support the effective operation of Foundational Programs and AIS.

There are six elements of Foundational Capabilities:

- Assessment
- Emergency preparedness
- Communications
- Policy development and support
- Community partnership development
- Business competencies

During the Technical Workgroup process, each element was analyzed separately. Cost sample data was collected for each, and the FPHS Cost Estimate was developed element by element. This process reflects the fact that there is a significant portion of public health activities and services included in these six elements, and addressing them in the aggregate may not reflect how they are provided by organizations.

The Foundational Capabilities are grouped together and presented below, because current spending information from LHJs (from BARS) was not available for each individual element. Therefore, the FPHS Current Spending Estimate and Estimated FPHS Gap for Foundational Capabilities combines all six elements together.

When reviewing this homework, please consider the foundational definition for each element of the Capabilities carefully, as the sub-elements of the definition underlie the Technical Workgroup's analysis and drive the aggregate numbers presented below.

STEP 1: UNDERSTAND THE SITUATION

Definition

The **foundational definition** of Capabilities includes:

1. **Assessment (Surveillance and Epidemiology)**

- a. Ability to collect sufficient statewide data to develop and maintain electronic information systems to guide public health planning and decision making at the state and local level. Foundational data includes Behavioral Risk Factor Surveillance Survey (BRFSS), Healthy Youth Survey (HYS), and vital statistics and foundational information systems include PHIMS, PHRED, CHARS, and CHAT.
- b. Ability to access, analyze, and use data from eight specific information sources, including (1) U.S. Census data, (2) vital statistics, (3) notifiable condition data, (4) certain clinical administrative data sets including hospital discharge, (5) BRFSS, (6) HYS, (7) basic community and environmental health indicators, and (8) local and state chart of accounts.
- c. Ability to prioritize and respond to data requests and to translate data into information and reports that are valid, statistically accurate, and readable to the intended audiences.
- d. Ability to conduct a basic community and statewide health assessment and identify health priorities arising from that assessment, including analysis of health disparities.

2. **Emergency Preparedness (All Hazards)**

- a. Ability to develop and rehearse response strategies and plans, in accordance with national and state guidelines, to address natural or manmade disasters and emergencies, including special

protection of vulnerable populations.

- b. Ability to lead the Emergency Support Function 8 – Public Health & Medical for the county, region, jurisdiction, and state.
- c. Ability to activate the emergency response personnel in the event of a public health crisis; coordinate with federal, state, and county emergency managers and other first responders; and operate within, and as necessary lead, the incident management system.
- d. Promote community preparedness by communicating with the public in advance of an emergency, steps that can be taken before, during, or after a disaster.

3. Communication

- a. Ability to maintain ongoing relations with local and statewide media including ability to write a press release, conduct a press conference, and use electronic communication tools to interact with the media.
- b. Ability to develop and implement a communication strategy, in accordance with Public Health Accreditation Board Standards, to increase visibility of a specific public health issue and communicate risk. This includes the ability to provide information on health risks, healthy behaviors, and disease prevention in culturally and linguistically appropriate formats for the various communities served, including use of electronic communication tools.

4. Policy Development and Support

- a. Ability to develop basic public health policy recommendations that are evidence-based and legally feasible.
- b. Ability to work with partners and policy makers to enact policies that are evidence-based.
- c. Ability to utilize cost benefit information to develop an efficient and cost-effective action plan to respond to the priorities identified in a community and statewide health assessment, including identification of best and emerging practices, and those that respond to health inequities.

5. Community Partnership Development

- a. Ability to create and maintain relations with important partners, including health-related national, statewide, and community-based organizations; community groups or organizations representing populations experiencing health disparities; key private businesses and health care organizations; and key federal, tribal, state, and local government agencies and leaders.
- b. Ability to strategically select and articulate governmental public health roles in programmatic and policy activities and coordinate with these partners.

6. Business Competencies

- a. Leadership. Ability to lead internal and external stakeholders to consensus and action planning (adaptive leadership) and to serve as the public face of governmental public health in the community.
- b. Accountability and Quality Assurance Services. Ability to uphold business standards and accountability in accordance with federal, state, and local laws and policies and to assure compliance with national and Public Health Accreditation Board Standards.
- c. Quality Improvement. Ability to continuously improve processes, including plan-do-study-act cycles.
- d. Information Technology Services. Ability to maintain and access electronic health information to support the public health agency operations and analyze health data. Ability to support, maintain,

and use communication technology.

- e. Human Resources Services. Ability to develop and maintain a competent workforce, including recruitment, retention, and succession planning functions; training; and performance review and accountability.
- f. Fiscal Management, Contract, and Procurement Services. Ability to comply with federal, state, and local standards and policies.
- g. Facilities and Operations. Ability to procure, maintain, and manage safe facilities and efficient operations.
- h. Legal Services and Analysis. Ability to access and appropriately use legal services in planning and implementing public health initiatives.

Augmented Foundational Capabilities

Instead of identifying specific examples of Additional Important Services within Capabilities, the Technical Workgroup identified a list of potential ways that jurisdictions can augment the base level of capabilities identified in the foundational definition and provide an additional level of service in these areas.

- A. Ability to conduct public health practice applied research and evaluation, including data collection, data analysis, policy research, and evaluation services that meet standards for peer-reviewed publications
- B. Ability to identify and promote policy change opportunities in non-health sectors including the use of analytic tools to assess the health impact of these policies
- C. Ability to develop and implement social marketing campaigns, including social media communication platforms
- D. Ability to collaborate in training and service with community education programs and schools of public health
- E. Ability to develop effective interventions, in partnership with community members, to reduce and eliminate health disparities
- F. Ability to compete for grant funding from government organizations, philanthropic organizations, health system partners, and corporate foundations

Cost Estimate and Current Spending Estimate

Please read through the foundational definition elements and make note of any questions you have for the Technical Workgroup or concerns you have regarding the estimates for Foundational Capabilities.

Exhibit 12: Capabilities Cost Estimate and Current Spending Estimate for LHJs (2013 \$)

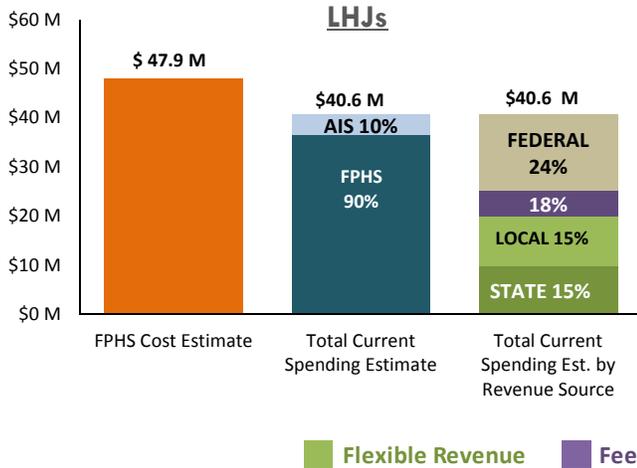
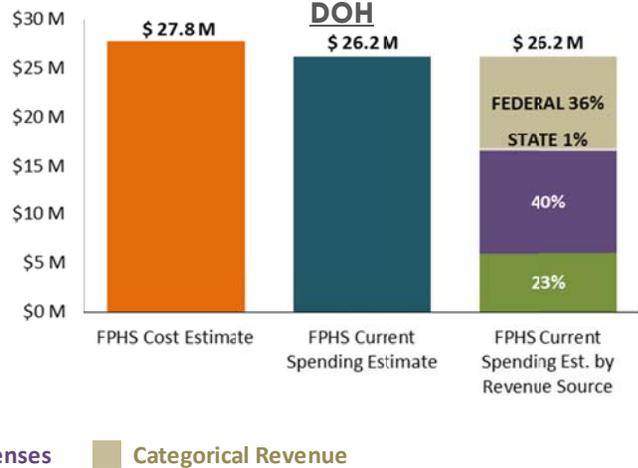


Exhibit 13: Capabilities Cost Estimate and Current Spending Estimate for DOH (2013 \$)



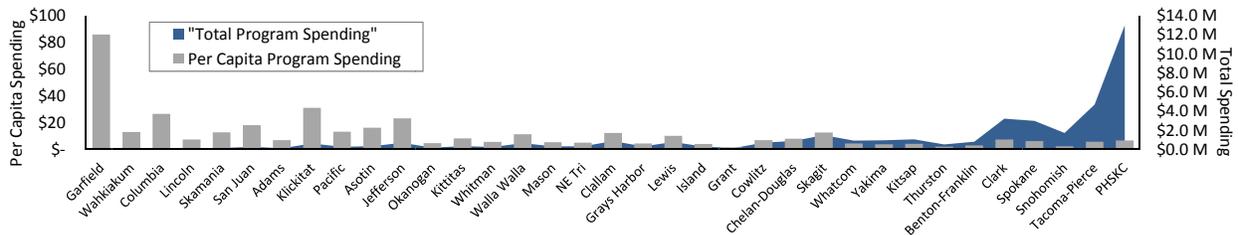
Program Information for LHJs

- The model-generated FPHS Cost Estimate for capabilities is \$47.9 million.
- LHJs currently spend about \$40.6 million on **all** capabilities.
 - About 90% of this spending, or \$36.3 million, is considered to be on foundational services.
- Capabilities are funded by a variety of sources, including federal categorical revenues (24%), fees and licenses (18%), local flexible funding (15%) and state flexible funding (15%).

Program Information for DOH

- The FPHS Cost Estimate for foundational services is about \$27.8 million for DOH.
- DOH currently spends about \$26.2 million on this program, including both FPHS and additional important services.
- Funding is a mix of licenses and fees (40%), federal categorical funding (36%), and state flexible revenue (23%). State categorical revenue makes up less than 1%.

Exhibit 14: Current Total & Per Capita Spending by LHJ for all Foundational Capabilities



- Current levels of per capita spending on this program vary widely across LHJs. It is important to remember there are these differences between jurisdictions when developing policy ideas and options

Estimated FPHS Gap

Exhibit 15: Estimated FPHS Gap for Foundational Capabilities

Program	Service Delivery	(1)	-	(2)	=	(3)	+		(4)	=	(5)
		FPHS Cost Estimate		FPHS Current Spending Estimate		Preliminary FPHS Gap	FPHS Gap Adjustments		(a) Exclude LHJ Spending Above Estimates	(b) Exclude Uncertain Revenue	Estimated FPHS Gap
Foundational	DOH	\$ 27.8 M		\$ 26.2 M		\$ 1.6 M			-	\$ 0.0 M	\$ 1.6 M
Capabilities	LHJs	\$ 47.9 M		\$ 36.3 M		\$ 11.6 M			\$ 1.6 M	\$ 1.9 M	\$ 15.1 M
Total Statewide		\$ 75.7 M		\$ 62.5 M		\$ 13.2 M			\$ 1.6 M	\$ 1.9 M	\$ 16.7 M

- (1) **FPHS Cost Estimate.** The estimated cost to provide foundational capabilities is \$75.7 M per year. About 37% (or \$27.8 M) would be spent by DOH, and about 63% (or \$47.9 M) would be spent by LHJs.
- (2) **FPHS Current Spending Estimate.** Annual current spending on foundational capabilities is about \$62.5 M. About 42% (or \$26.2 M) is spent by DOH, and about 58% (or \$36.3 M) is spent by the LHJs.
- (4) **FPHS Gap Adjustments.** There were two types of adjustments made to develop the Estimated FPHS Gap:
 - a. **Exclude LHJ Spending Above Estimates.** About \$1.6 million of current spending was excluded, because it was being spent at LHJs where the FPHS Current Spending Estimate for this area was higher than the FPHS Cost Estimate for this area. Since this spending above the estimate cannot be necessarily used to offset gaps at other LHJs or in other programs, these amounts were excluded when estimating the Gap.
 - b. **Exclude Uncertain Revenues.** About \$1.9 million of current spending was excluded for this program. The excluded amount was funded from federal sources, which the Technical Workgroup considered too uncertain to support foundational capabilities.
- (6) **Estimated FPHS Gap.** This column shows the estimated amount needed, in addition to current spending, to support provision of foundational capabilities (as defined) statewide. The Estimated FPHS Gap is \$16.7 M for this program. For DOH, the Estimated FPHS Gap is about \$1.6 M. For LHJs, it is about \$15.1 M.

For additional detail on the methodology used for these estimates, please refer to the document titled *Summary of Technical Workgroup Findings and Approach* from your Meeting 2 materials packet.

STEP 2: IDENTIFY POLICY IDEAS AND OPTIONS

In order to assure appropriate funding for Foundational Capabilities, the policy group must evaluate structural changes and funding options. Please brainstorm questions, concerns, and policy ideas using the questions below.

1. Are there services in the definition of Capabilities that should be shifted to specific programs?
2. “Provide timely, statewide, and locally relevant and accurate information to the state and community” and “Coordinate and integrate other categorically funded” are sub-definitions used in every foundational program except for Vital Records. Do you think these actions should be moved into Capabilities or kept in each program?
3. What, if any, services are not included in the Capabilities definition of FPHS that the governmental public health network in your community has to provide because of mandates or local priorities?
4. What, if any, services does the governmental public health network in your community have to provide, either because of mandates or local priorities, are not included in the Capabilities definition of FPHS?
5. Current FPHS definitions apply to only LHJ and DOH services. At the last Policy Workgroup meeting, it was acknowledged that tribal service delivery should be incorporated and that many other state and local agencies also work on public health issues.
 - a. What, if any, services that would fall into Capabilities are *not* currently provided by tribal public health, DOH or LHJs and should be performed by governmental public health? Please describe the service or program and how you think it should be provided.
6. What big issues in Capabilities are not being addressed by the governmental public health system and should be provided statewide as a foundational program? Please describe the service or program and how you think it should be provided.
7. The Estimated FPHS Gap for Foundational Capabilities is \$16.7 million. Given your experience in this program area, do you think the FPHS Cost Estimate, FPHS Current Spending Estimate, or Estimated FPHS Gap are overestimated or underestimated? Why?
8. Do you have any ideas about how we could deliver Capabilities services at a lower cost by changing who delivers the service or how service delivery is shared?
9. Do you have any ideas about how we could redistribute current funding or find new funding for the services included in the Capabilities definition?
10. Any other comments, questions, ideas, or concerns?