

PUBLIC HEALTH IMPROVEMENT PARTNERSHIP

PUBLIC HEALTH FUNDING SUBGROUP

PURPOSE

The Agenda for Change (A4C) Subgroup on Public Health Funding was established to assist the A4C Workgroup in developing a long-term strategy for predictable and appropriate levels of financing as outlined in the October 2010 Agenda for Change white paper.

The purpose of the subgroup on Public Health Funding is to define the core capacities, activities, and services that should comprise the core of public health services that is to be available statewide and funded by state and local flexible funds. In addition, working with a consultant, the cost to deliver those core services should be identified. The costing work will exclude programs that are supported by fees – since these already have a funding source

MEMBERSHIP

Co-Chairs: Barry Kling and Gregg Grunenfelder

DOH Members: Maryanne Guichard, Jennifer Tebaldi

LHJ Members: Regina Delahunt, David Fleming/Dennis Worsham, Tim McDonald, Torney Smith

Staff: Marie Flake

TASKS

The Public Health Funding Subgroup will:

1. Build on the work and thinking done and shared by both Barry Kling and David Fleming.
2. Define what core capacities, activities, and services comprise the core of public health (or essential benefits package) that is to be available statewide and funded by state and local flexible funds (as opposed to categorical funds from any source).
The list will not indicate who or how the services should be delivered statewide, but rather identify the services that should be available statewide.
3. Identify which services are currently supported by fees or could be supported by fees. These services will be part of the conceptual model and list of core of public health (or essential benefits package), but will not be included in the cost model.
4. Oversee the work of a contractor who will be charged with:
 - a. Meeting with the workgroup to discuss the conceptual framework and the capacities, activities, and services that comprise the core of public health; pose questions to the workgroup in order to create enough specificity and clarity to be able to cost these services; propose and discuss concepts to be incorporated into a cost model; and receive guidance on how to develop the cost model
 - b. Developing and presenting to the workgroup a cost model that is scalable for different population sizes, addition / elimination of various services, or changes in the amount of service (and maybe different geographic areas, population health status, etc); receive input from the workgroup; make revisions as needed; return to the workgroup.

- c. Costing the core public health services (or essential benefits package) for a representative population size
- d. Write up the description of the model and the costing of the core public health services such that the work can be replicated with alterations in different variables and shared with the public health community, elected officials, and researchers.

TIMELINE

The A4C Subgroup on Public Health Funding will begin work in March 2012 and complete the tasks below by July 30, 2012. The work period for the contractor is expected to be approximately March 15 through June 30, 2012.

PROCESS

Workgroup conference calls every two weeks, initially.

Work Plan / Discussion Steps

1. Conceptual model
 - a. Review Fleming diagram and variations of it
 - b. Settle on a working draft
2. Core Public Health Services (table) –
 - a. Review Barry Kling’s paper “A Proposal for Sustainable Basic Local Public Health in Washington State, Version 4, December 2011” and the “Core Public Health Services Table – Discussion Paper 01-27-12”
 - b. Review other materials as identified (PHEPR Capabilities, other???)
 - c. Review Core Public Health Services
 - d. Add Pre-ambule to provide context – describe the scope of services displayed on the table and the purpose – identification and prioritization of services that comprise “core of public health” or the essential benefit package that is to be available statewide and funded via “base” funding that is derived from state and local flexible funds. Include language like – the table / model is agnostic about who should provide these services and how. Just that they comprise the core or essential benefits package that should be available to all and funded by state and local flexible funding.
 - e. Services – add more services (i.e. DOH EMS/Trauma)
 - f. Relabel the “cross-cutting / other” section as “Fundamental Capabilities” and add more rows and begin fleshing these out
 - g. Scoring Criteria –
 - How to balance biggest bang for the buck (populationbased score is biased toward large scale affect) vs. big impact for a few marginalized people? How does this relate to the principles of equity?
 - Add ROI?
 - Remove “mandated”?
 - Other criteria? (what else is on the DOH matrix?)

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- h. Remove funding column, since this table will not deal with funding. The purpose of the table is to illustrate the “ball park” of public health services, identify Tier 1 or “core” services with enough specificity to be able to cost them.

3. Vet core public health services with public health colleagues?

4. Specificity in order to be able to cost the work

- a. Involve contractor in discussions early on. Let them challenge the group with questions on each service – do you mean this or that? How much of this or that?, etc....since the contractor will be the one that has to figure out the cost. Discuss with the contractor concepts to be incorporated into the cost model; review previous PHIP cost model work with the contractor - discuss strengths and weaknesses. Give guidance on how to develop the cost model.

5. Review / receive presentation from the contractor on the cost model and provide critique.

6. Review final cost model and cost of public health services work; provide critique.

7. Receive final product, discuss, develop and implement a communication plan.

February 2012