Foundational Public Health Services (FPHS) Workgroup

August 1, 2019 – Meeting Summary

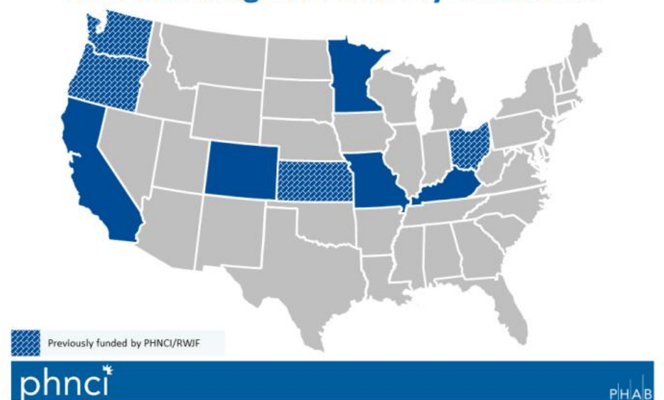
> "The charge for the FPHS Workgroup is getting you to provide critical feedback on how do we in Missouri visualize this [FPHS model] and describe it, because visualizing it is half of the advocacy work that is going to happen, but the other part is on the economic analysis – what would it cost us to have an infrastructure that fulfills the model you describe."
>
> -Dr. Eric Armbrecht

Learning from Other States

Missouri needs an FPHS model to create a consistent expectation of the fundamental public health programs and services that must be available in every county in order for Missouri to have a functional public health system. The model will facilitate a cost analysis for the foundational public health capabilities and areas defined in the new Missouri FPHS model.

#HealthierMO Project Manager, Casey Parnell, summarized lessons learned from other states participating in the PHNCI Learning Community.

She explained that while most have created their own FPHS model, based on the original RESOLVE model, which has now been revised as the new national PHNCI model, there have been very few true deviations. Most are aligning with the PHNCI model, developed by public health professionals from across the nation.



Nine states are participating in the PHNCI Learning Community. Some states are centralized, with transformation efforts led by and/or mandated by state legislation. Others are de-centralized, like Missouri, with transformation efforts led by an agency other than the state health department.

Kansas, Ohio and Kentucky are most similar to Missouri in structure, but only Missouri is using a grassroots approach. Following are key updates from the other states.

Washington:
10 years into their project, further along than any other state; currently doing reassessment work; hired a communications consultant for branding, consistent language and a strong website; identified legislative champions and achieved funding increases through legislation; doing cross-jurisdictional shared services pilot projects

Oregon:
State mandated work; capacity and cost assessment simultaneously done in one year by contracted consultant; built in accountability measures; incentivizing adoption of FPHS model – requires cross-sector collaboration

Minnesota:
On about the same timeline as Missouri; very thoughtful communication strategies; use "strengthening the public health system" rather than "transformation"; meet with state health commissioner on a regular basis

Ohio:
Just finished costing data analysis; came up with $33.54/per person/year to deliver FPHS; mandatory PHAB accreditation for LPHAs; trained peer leaders across the state

Kentucky:
Transformation prompted by public health retirement system running out of money; changed "services" to "responsibilities"; looking not at cost of individual program or service delivery, but at cost of providing one FTE; determined a minimum of 3 FTEs required to delivery FPHS at a cost of $109,000 each; developed a costing analysis based on this approach with additional FTE allocated for each additional 15,000 population in a jurisdiction

Kansas:
Similar to Missouri in local public health system structure; very rural; explored legal obstacles to transformation; developed a local implementation plan and roadmap; rural pilot project with peer counties and cross-jurisdictional resource sharing

Colorado:
Holds regular "open office" conference line for stakeholders to call in and ask questions about transformation; made changes to their state board of health rules rather than attempt legislative changes; similarly focused on transparency and stakeholder engagement

Casey provided the following takeaways from the recent Learning Community meeting:

- Transformation is a long-term process with no end point (continuous quality improvement).
- None of the states deviated significantly from the national FPHS model.
- Cross-jurisdictional and resource sharing are a must, happening in every state so far.
- Cost assessments done so far have had similar results, making data comparable.
- Some states have had success changing legislation and increasing funding for public health.
- When implementing the FPHS model, consider human resources policies.

Review FPHS Model Sketches

Dr. Armbrecht presented the workgroup with two rough sketches of FPHS models built on feedback and input on surveys. They are intended to be different, rough sketches to solicit workgroup feedback.

Liked:

- connectedness/overlap of activities
- language easy to understand
- more detail
- access is first category listed
- vulnerable population (population-specific needs were called out)
- additional services tailored to each community (liked the wording – it's like the icing on the cake)

Disliked:

- health equity as a lens (different based on personal bias, opens door for inconsistency)
- injury prevention and chronic disease should not go together
- vital records is missing (NOTE: under Organizational Administrative Competencies)
- "local"
- population vs vulnerable

Liked:

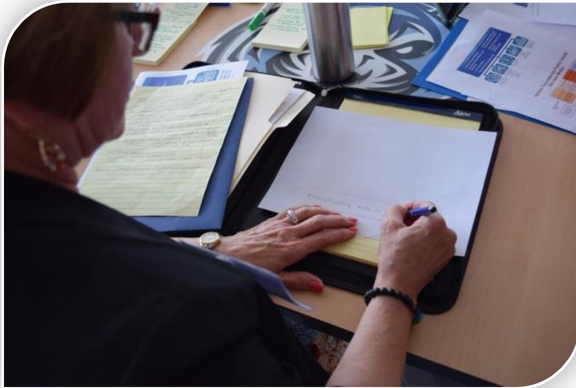
- whether or not the word "health equity" is used, liked it as a foundation rather than a wrap-around lens
- title specifying "governmental public health"
- wording "responsive" and "programs"
- inclusion of "behavioral health"
- "access to medical and behavioral health"

Disliked:

- "health equity" (buzzword hard to articulate)
- PH doesn't deliver behavioral health
- categories too high level and broad
- things missing (MCH)
- groupings
- separation communicates silos
- "access" doesn't convey "assure and linkage"
- vulnerable pop should be better defined

FPHS Key Components

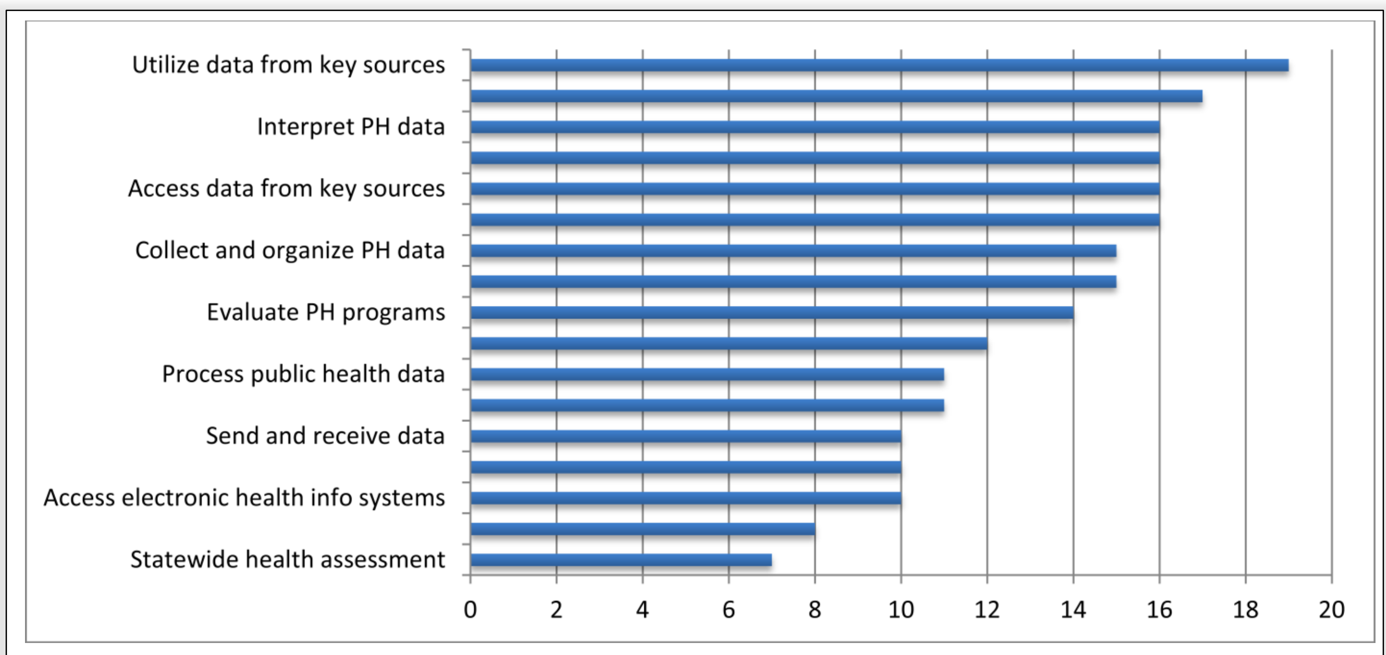
Dr. Armbrecht then asked each member of the workgroup to draw a draft model that contained at least three key components they felt were most important to include in Missouri's model.



Based on the workgroup's rough drawings and the feedback they provided earlier on the two original sketched models, Dr. Armbrecht created a new draft model to present during the afternoon session.

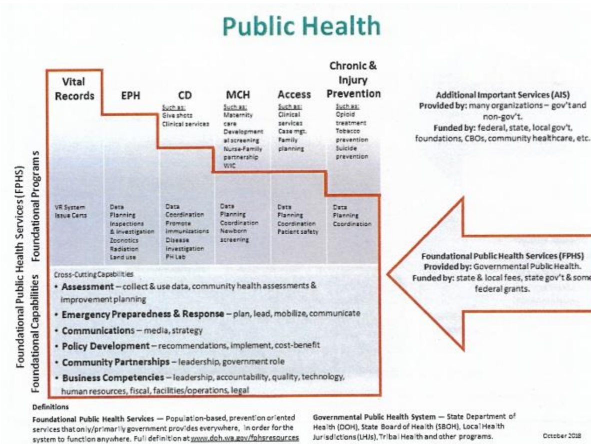
FPHS Survey and Models Comparison

Initiative evaluator, Dr. Todd Daniel, presented outcomes from the survey FPHS Workgroup members completed in July. The survey asked them to identify "truly necessary" components under each FPHS capability and area in the national FPHS model that must be provided by every local public health agency in order to have a functional public health system in Missouri. Dr. Daniel used Pareto charts to display survey results, but expressed the desire to have a larger data set, as only 19 surveys were usable.



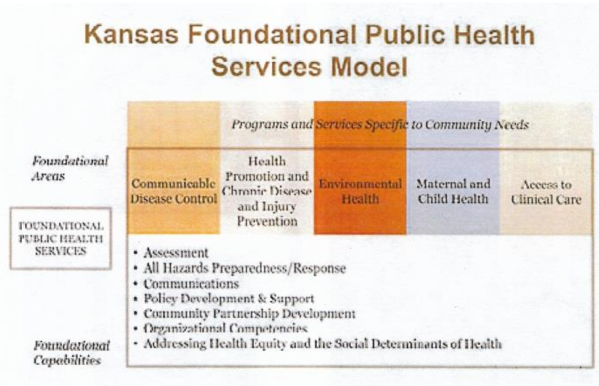
Dr. Daniel showed the workgroup models developed by other states and compared them to the original RESOLVE model and the current PHNCI national model.

Washington:
- Informed development of the original RESOLVE model

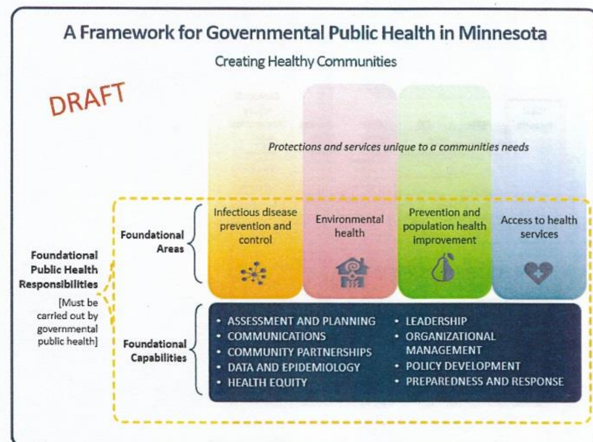


Oregon:
- Capabilities match original 7 in RESOLVE model
- Combined MCH and Family Health into Prevention and Health Promotion
- Added Health Equity and Cultural Responsiveness

Kansas:
- Only state to keep the original RESOLVE look
- Added Health Equity and Social Determinants of Health
- Order of categories is different from RESOLVE

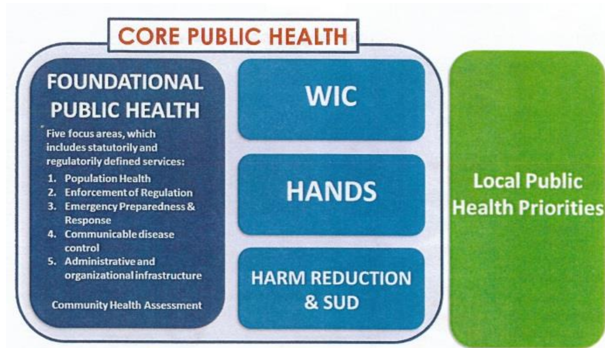


Minnesota:
- Deviates from national model the most
- Collapsed 5 areas into 4
- Combined Chronic Disease and MCH into Prevention and Population Health Improvement
- Added Health Equity
- Removed Accountability and Performance Management
- Split Organizational and Leadership Management
- Changed Surveillance Assessment to Data Epidemiology
- Changed All Hazards to Preparedness Response



Colorado:
- Nearly identical to PHNCI national model
- Removed Accountability/Performance Management
- Added Health Equity and Social Determinants of Health

Kentucky:
- Handed down from state mandate, not a true FPHS model



National Model Development Outcomes

- The **only true addition** has been Health Equity and Social Determinants of Health.
- The **only real subtraction** has been Accountability/Performance Management.
- The **most common change** has been collapsing 5 categories into 4 by combining MCH and Chronic Disease.

"If the workgroup makes a true change to the Missouri model, such as adding "vulnerable population," they will need to further identify the abilities that define that piece of the model and a way to attach costs to that. Vulnerable populations could be a separate foundational capability or a program area or an integrated piece woven into all areas."

-Dr. Todd Daniel

"Maternal Child Health (MCH) is a unique population. There is support for why it was separated out in the original model. Other populations are already being addressed through the outcomes. If we truly address MCH, chronic disease isn't going to be such an issue."

-Martha Smith

"There is a similar nature between serving vulnerable populations and health equity as a tool towards achieving equitable health outcomes. Health equity cuts across areas of responsibility."

-Jonathan Garoutte

Refining the Missouri Model

Dr. Armbrecht presented a draft model based on the workgroup's sketches and feedback on the two original sketches. He emphasized this was not a final version, but a starting point for discussion.

He explained his methodology in developing this version of the Missouri model.

- Based on the earlier conversation around health equity having a different lens for each individual, Dr. Armbrecht left a specific mention of health equity out of the model. He explained if it was spelled out, it would need an individual cost associated with it. However, it can still be integrated throughout the model.
- He kept the overlapping of the four primary areas to show how programmatic work is connected.
- He grouped all programmatic areas under four main categories.
- Safety includes injury prevention, emergency response and other public health programs.
- Since chronic disease is more about health promotion and prevention than managing chronic disease, he identified the group title Prevention and Promotion. This group would also include MCH, since that is the majority of the work done with the MCH population.
- The draft model attempts to incorporate special populations under Local Responsive Services and Programs, without calling out individual population groups.
- The term "vulnerable populations" was dropped completely, in order to not perpetuate the perception that public health serves only the poor, and emphasize the truth that public health is for everyone.

- Linkages to Medical, Behavioral and Community Resources primarily support the most vulnerable who need assistance getting linkage to resources.
- Linkages to Medical, Behavioral and Community Resources are depicted as wrap-around services. "Community" is included to capture areas like transportation and housing that play a definite role in health outcomes.
- For the sake of simplicity, the capabilities listed in the national PHNCI model are just grouped here under Operations and Management Capabilities. These will be defined further by the evaluation team as they identify measurements to demonstrate the level of function.

The group discussed the model and with only a couple of minor suggestions, all agreed it captured their ideas well and included all of the core components they felt were important.

Next Steps

Casey shared a proposed timeline for next steps in the FPHS model development. In August a more stylized version of the new model will be shared with local public health administrators at regional meetings, to collect their feedback. Casey emphasized the need for widespread input since #HealthierMO is a grassroots initiative that must be guided by local public health agencies and their public health system partners.

Aug 2019	Share the draft model out with other public health stakeholders for feedback
Sep 2019	FPHS Workgroup meets again to refine model based on stakeholder feedback
Oct 2019	Model shared with #HealthierMO Executive Committee for review and approval
Nov 2019	Model shared out publicly with stakeholders across Missouri
Early 2020	FPHS Workgroup reconvenes to strategize an implementation proposal

Casey asked FPHS Workgroup members to attend the feedback meeting in their region to show support for the process of developing the model and answer questions from their peers.

This meeting summary and more information on Foundational Public Health Services will be available at http://healthiermo.org/fphs.html.