

The 21st Century (21C) states participated in many in-depth conversations during their convening in June 2022, which produced several key learnings that may be of interest to others looking to transform their public health systems. The first set of learnings outline the processes and activities related to assessing and costing Foundational Public Health Services, data modernization, implementing transformation models and frameworks, and sharing services and resources. The second set of learnings focus on specific aspects of the Foundational Capabilities and the public health workforce, and the last set of learnings include ways states can use products and tools developed by the Public Health Accreditation Board (PHAB) and the Public Health National Center for Innovations in their efforts.

**Assessing and Costing Foundational Public Health Services (FPHS)**

A key component for states to accomplish implementation of the FPHS across their public health systems is assessing the current capacity and cost to deliver capabilities and programs that no jurisdiction should be without. This assessment estimates the gap between current spending and capacity, which states can use to determine what would be needed for full implementation systemwide. Several 21C states have embarked on an assessment process that has resulted in real impact, with a few examples below.

<b>Brief Overview of State Process</b>	<b>Awesome Advice</b>
<p>Washington used their state-specific FPHS definitions to assess the current implementation level and to estimate the cost to fully implement FPHS systemwide. The state used BERK Consulting to develop, design, deploy, and analyze the assessment, which revealed a \$225 million annual gap in FPHS provision.</p>	<ul style="list-style-type: none"> <li>- The assessment can be completed in a short amount of time (Washington’s process took 3-4 months), but aiming for at least 6 months to a year to complete is ideal for meaningful participation.</li> <li>- Technical assistance on the assessment tool and FPHS definitions, as well as office hours and peer sharing, helped local health departments understand how to report their data.</li> <li>- A dedicated staff person at a local health department is needed to assist with completing the assessment and navigate challenges. Ideally that person would have a public health background (preferably at the masters level) and have experience at the local level with program evaluation and FPHS.</li> <li>- Local health departments could partner with a school of public health to assist with completing the assessment.</li> </ul>
<p>Ohio requires local health departments to complete Annual Financial Reports (AFRs) that outline actual expenditures, and the state transformed the AFR spreadsheet to capture FPHS activities and then calculate a per capita cost for every foundational capability. The AFRs now provide an estimate on how a local health department is meeting a capability and use actual data to calculate gaps and needs.</p>	<ul style="list-style-type: none"> <li>- It is important to do any definition work upfront in order to explain what full implementation means and looks like. It is also important to be transparent about the formulas used in the AFR spreadsheet, which can be unlocked for public view.</li> <li>- The assessment should not be done in under a year, and states should spend a lot of time training local health departments and on communications to get buy in.</li> <li>- The process highlighted the importance of partnerships as it would not have happened without locals, state organizations, and the state working together. For example, a feedback loop for local health departments was built into the process in order to adapt the tool as needed.</li> </ul>

	<ul style="list-style-type: none"> <li>– Consider using an out of state independent reviewer to bolster accountability and credibility to the process.</li> </ul>
<p>Kentucky developed a costing tool based on the work of Glen Mays at the University of Kentucky that looked at actual costs spent in local health departments (e.g., hours worked, materials bought, etc.). The state used its existing budgeting system with actual cost data to bring cost centers together and align them with FPHS. Kentucky’s model/formula revealed that 3 FTEs per every 5,000 people are needed to implement FPHS.</p>	<ul style="list-style-type: none"> <li>– Consider how to incorporate or adapt existing costing models into the process and ensure those align well with FPHS.</li> </ul>

### Data Modernization

To serve communities equitably, public health systems need access to modern, real-time, hyperlocal data and tools, and to center community and people in driving decisions. These are critical in understanding the needs of the people, making data-driven decisions that address community priorities, and transforming public health infrastructure.

21C states acknowledge this work requires expertise in data interpretation and technical aspects of sharing data, like how to work with multiple systems that may not easily integrate. For example, some states are using consultants or have Chief Data Officers on board (although this position may be specific to a larger umbrella agency). States also note the need to better communicate about their data modernization strategies and about any activities that are already occurring. Additionally, states need standard definitions of data and data sharing – they know what isn’t working and can easily determine what is needed from data systems if a common language and understanding exists within the system.

States recognize that there are many data systems that are separate from one another and have various access levels across the system. There are opportunities to understand what the influences on decision making power can be to better connect systems. States also need techniques and language to communicate better between IT and public health personnel, as well as the policymakers and the public. Lastly, privacy is a big concern since public health collects a lot of data and it is not always easy to deidentify it or translate it into a useable form. It is important to build or rebuild relationships with health systems to share data.

#### Awesome Advice

- Create an overarching message that outlines what public health needs data systems to do, what people in leadership positions need to know, what strategies exist or need to be developed, who are the decision makers and where do they sit in the process, who can join discussions, and who communicates all of this work internally and externally.
- Put legal and data sharing agreements into place as early as possible to help alleviate any issues down the line.
- Determine how to make data processes more transparent throughout the system and to the public.
- Think about how to harness joint purchasing power across the system.
- Look at successful data modernization projects in other countries.

### Implementing Transformation Models and Frameworks

Many 21C states—including those that have been doing this work for years, as well as those who are newer to this work—are using the national FPHS model or adapting it for their state system (e.g., California, Indiana, Kansas, Kentucky, Missouri, North Carolina, Ohio, Washington, and Wisconsin). These states have found FPHS useful to define their public

health system both broadly and narrowly to capture the governmental entities that provide foundational service systemwide, determine where resources/services can be shared across the system, and train the workforce on how to deliver foundational services. Additionally, even before the national FPHS framework was updated to include equity, several state-specific models incorporated health equity, social determinants of health, and performance improvement.

**Words of Wisdom**

“It is critical to have leadership involved from the start to advocate for system change.”

“COVID-19 helped us identify why the foundational capabilities are so important.”

A couple 21C states are using other frameworks for their transformation efforts, including the 10 Essential Public Health Services (10 EPHS), PHAB Accreditation, Public Health 3.0, and Public Health Forward. These states noted PHAB accreditation connects the 10 EPHS and the FPHS frameworks, therefore, going through the accreditation process inherently supports both models.

**Words of Wisdom**

“Communication is needed to convey that the various frameworks align and connect with one another and help a system move toward transformation. It is also needed to outline ‘who does what’ and ‘who should do what’ within the system.”

Other 21C states are just beginning their transformation journeys and are still deciding which direction to take.

- States are assessing readiness to undertake transformation activities and how they can learn from those with years of experience, especially coming out of the COVID-19 pandemic.
- States are determining how public health infrastructure is being built, supported, or improved, and how to strengthen relationships between health departments.
- States are focusing on and utilizing previous initiatives on workforce training, health and racial equity, and performance improvement to start transformation activities.
- States are considering how public health is assured in their systems and how best to communicate about that assurance.

**Words of Wisdom**

“States should define the problem first before selecting a model and identify what is foundational in their system.”

**Sharing Services and Resources**

21C states described that sharing services and resources looks very different among states and there is no one right way to share. However, states agreed that sharing arrangements must be developed by those involved and adding value to the process is important to success. States are very interested to incentivize service and resource sharing that leads to formal changes, but they need to learn more in order to do more.

**Foundational Capabilities**

The Foundational Capabilities are the cross-cutting skills and capacities needed to support the public health infrastructure of basic public health protections, programs, and activities key to ensuring community health, wellbeing and achieving equitable outcomes.

**Community Partnership Development**

There is a range of questions emerging in terms of community engagement, and state systems are looking for strategies to move from input to community voice, to shared power, and to ceded power:

- What are strategies to bring in community voices without “talking inside baseball” or tokenizing?
- Are states looking for community voice or more diversity at the table? (Both are important but not actually the same thing.)
- How do states get engagement at the table focused on transforming the public health system?
- How can states bring previous partners back to the table to collaborate again on other issues?
- How do we enhance 2-way communication skills to listen better and consider what other people can bring to the table and what they actually need?
- Health departments are not seen as a trusted partner and community voice is often lost when states miss action at the local level.
- Healthcare and public health are often conflated, and it is hard to get the community to understand why public health should matter to them.
- Public health authority has been weakened or stripped during the COVID-19 pandemic.

21C states are thinking about the future and how to sustain relationships as the public health landscape changes. They noted an important focus in the next 5-10 years is how to build up the workforce in areas where there won't be pipelines for expertise, but where workers are passionate about their communities, which is a skill that is more valuable. Also, community health workers might be a missing component to community partnership development and states could figure out how to better utilize them in these capability activities.

**Awesome Advice**

- There are no shortcuts to building trust – it takes time, repeated conversations, commitment to keeping your word, showing up, following through, and understanding needs.
- Recognize and compensate community members for their contributions.
- Remain a facilitator and convenor but acknowledge this is work the community is building.
- Consider network mapping or relationship mapping to track connections and conversations.
- Require communities that are underrepresented be members of boards and commissions.
- Opportunity to pool resources to advance transformation activities. For example, states can gather resources to do community-based participatory operationalizing like what was done during COVID-19 response (e.g., vaccines, care coordination, etc.).
- Opportunity to lobby transformation efforts through private partners, like state public health associations, medical providers, larger health groups, and the like. This allows states to not self-advocate for themselves and rely on partner endorsements.

**Equity**

There are several success stories from 21C states incorporating equity into their transformation efforts. States have infused equity at the organizational and community levels, and have equity resourced through staff (like an equity coordinator) and training centers (like regional public health training centers, who want to be helpful and connected to this work and could address unmet needs if partnering with health departments).

However, there is a challenge around where to start and options for language when the word “equity” is not an accepted term in some areas, which can turn stakeholders away from conversations about it. It is important to create a narrative without the buzzwords – most people can get behind the concept but not the word “equity.” One example from a public health department was that they shifted from Diversity, Equity, and Inclusion language to innovation, access, and belonging, as well as incorporating the concept of improving health and wellbeing for everyone.

**Awesome Advice**

- Ensure staff look like the communities they serve and understand a community's norms and values.
- Create equity statements to articulate and model the organizational commitment to equity.
- Understand when to label something as equity or possibly something else that would resonate better – messaging and words are important.

- Be transparent around public health decision making.

### Public Health Workforce

Workforce issues have persisted since well before the pandemic – baby boomers are retiring, institutional knowledge is being lost, and the public health landscape has been changing. There is a challenge among 21C states assessing what workforce they lack and how to bring in new talent when necessary. They note “right sizing” is important as it allows certain types of staff to help with sustainability through service sharing (e.g., states shared epidemiology capacity during H1N1). Additionally, competition is not limited to public health – health departments need to balance recovering and still being a place where people want to work that doesn’t feel negative. Some states are considering how to make compensation a whole package, not just a salary, as well as to standardized pay scales and make them more attractive to attract candidates.

21C states note the need for strong connections to universities within states to grow the workforce and to revise curricula that meets the needs and ensures the ongoing training of the future workforce. States are using the core competencies as a starting point in workforce development and to institutionalize shared competencies around certain areas, like social determinants of health. States are also exploring competencies to non-credentialed individuals who have community expertise where hiring in rural areas is difficult (e.g., community health workers could be utilized within health departments or outsourced to other organizations). These positions can expand the workforce greatly but need to have trust – obstacle of smaller health departments feeling like they are being taken over or that intentions are not genuine. Strong partnerships among the state, locals, and community members are important. People that come to the table must commit to the process and have to be willing to engage in hard conversations and not leave that until later – need to be willing to address red flags, concerns, politics, and personal things it in the moment.

21C states (both decentralized and centralized) shared that having regional positions are tremendously valuable, especially:

- Accreditation coordinators
- Communications specialists
- Community health workers
- Disease intervention specialists
- Emergency preparedness planners
- Epidemiologists
- Health equity coordinators
- Human resource professionals
- Infectious disease specialists
- Nurses/public health nurses
- Tobacco prevention coordinators

### PHAB Products and Tools

PHAB offers a variety of products and tools that may serve states in the transformation efforts.

- The **Readiness Assessment** is a way for health departments to assess their readiness for PHAB programs. This includes a focus on the Foundational Capabilities and provides valuable feedback directly from PHAB. 21C states feel this assessment is very useful to establish a baseline to determine which program fits best with the health department.
- The **Staffing Up: Governmental Public Health Workforce Calculator** will be designed to reflect the total number of full-time equivalents (FTE) a health department needs to provide the FPHS in their community. 21C states note state associations of health officials might be great broker to market this tool to local health departments and encourage them to use it.

- A **capacity and costing assessment tool** is currently being developed that state-wide health department systems can use to determine their level of current implementation of Foundational Capabilities and Foundational Areas and their associated costs. The assessment tool identifies the needed expertise and capacity to fully achieve improved organizational systems and processes to deliver the FPHS. More details on the FPHS Capacity and Costing Assessment Tool will be shared in the coming months. 21C states note there will be other useful applications of the data collected, like a salary survey and to help local health departments answer questions they have about themselves.