Transforming Public Health Systems: Stories for 21st Century States, PART II

phnci

Introduction

Transforming. Modernizing. Improving. Evolving. No single word can precisely define the movement underway to transform the public health system into one that can efficiently and effectively meet the health challenges of the 21st century.

With a grant from the Robert Wood Johnson Foundation, three states – Ohio, Oregon and Washington – are participating in a learning community supported by the Public Health National Center for Innovations (PHNCI). Our ultimate goal? To test and implement the systems transformations required to ensure that all residents have equitable access to public health.

A New Model for Public Health

Transforming Public Health Systems: Stories from 21st Century States, Part II, chronicles the progress of three states toward building a new model for public health built on implementing a minimum package of foundational public health services that "must be available everywhere for the system to work anywhere." Over the past year, the states' collective successes have included: targeting legislators, educating policy-makers, engaging non-traditional partners, telling real-life public health stories, building bridges with clinical medicine, developing assessment tools, identifying opportunities for implementing cross-jurisdictional sharing, and taking on the role of chief health strategists in their communities in order to prevent death, disease and disability.

The following stories capture highlights of the work underway in Ohio, Oregon and Washington as they move closer to their goal of building a 21st century public health system.

Ohio

Public Health Leads the Way in Ohio's Journey to Health Transformation

As the summer of 2016 was winding down, Ohio's public health leaders were gearing up for new challenges. The Health Policy Institute of Ohio had just released the new state health assessment, and it signaled an urgent need to improve the health and well-being of Ohio's residents.

> *The report noted that Ohio – on several national scorecards – ranked in the bottom quartile of states for a range of health indicators. Even more troubling, Ohio's performance on population health outcomes had steadily declined relative to other states, falling from 27th to 39th over a 25-year period.*

Ohio also has significant health disparities by race, income and geography, and spends more on health care than most other states," said the Health Policy Institute of Ohio report, which went on to highlight some of the many opportunities available to public health workers on the journey to improving health outcomes.

For Ohio's public health leaders, the journey is not new, having embarked on it when post-recession reductions in state, federal and local funding, combined with a host of other political and financial pressures, first signaled that the state's public health landscape was changing. By 2016 they were fully immersed in adapting and adopting new tools, building new relationships, and reflecting on their emerging identity in working to best serve their communities. National initiatives like the U.S. Department of Health and Human Services' Public Health 3.0, the Centers for Disease Control and Prevention's HI-5 and the Robert Wood Johnson Foundation's Culture of Health framework heralded these forces of change.

The Association of Ohio Health Commissioners (AOHC) had set the ball in motion in 2011 when they launched the landmark Public Health Futures Project to develop a new model for Ohio's local governmental public health system. Their findings, published in Public Health Futures: Considerations for a New Framework for Local Public Health in Ohio, spotlighted the wide array of activities that Ohio's public health agencies perform at the local level, with very limited resources.

The report contained recommendations that continue to steer the dialogue for transforming local public health in Ohio into an appropriately structured and funded system for the future. The recommendations include identifying and assessing potential models of collaboration and consolidation and articulating rules, policies, and standards that positively influence the future of local public health, including statutory mandates and financial incentives, national public health department accreditation standards, and policy changes catalyzing the convergence of health care and public health prevention.

> *The most groundbreaking recommendation was that all Ohioans, regardless of where they live, should have access to a "minimum package" of foundational public health services (FPHS) that should be used to guide future changes in funding, governance, capacity building and quality improvement.*

These recommendations were built on studies contained in a 2012 Institute of Medicine (IOM) report, for the Public's Health: Investing in a Healthier Future. In that national report, an IOM committee presented the minimum package concept as a way to define a basic set of public health services that must be made available by health departments in all jurisdictions and for which costs can be estimated.

Along with the recommendation, the Ohio Public Health Futures Committee advised that all local health departments should have access to the skills and resources, or "foundational capabilities," that are necessary to effectively support the activities required to deliver the minimum package of core services. The Ohio committee adopted the recommendation and a team of Ohio public health leaders soon began to define a "minimum package" of foundational public health services, or those services that, as described by the state of Washington's work, "must be available everywhere for the system to work anywhere."

At the time, Ohio was one of three states – along with Oregon and Washington – working on the foundational public health services model. In 2016, the three states were selected by the Robert Wood Johnson Foundation to receive grants for implementing the systems transformations required to provide the foundational public health services and ensure health equity. Working with the Public Health National Center for Innovations (PHNCI), Ohio is part of a first-of-its-kind learning community convened by PHNCI, which is working to identify, implement and spread innovations in public health practice to help meet the health challenges of the 21st century in communities nationwide.

As a grantee state, Ohio's efforts are being led by the Ohio Public Health Partnership (OPHP), a consortium that includes the Association of Ohio Health Commissioners, the Ohio Environmental Health Association, Ohio Public Health Association, Ohio Association of Boards of Health, and the Society for Public Health Education Ohio Chapter. Over the past year, and with input from scores of public health leaders across the state, Ohio's work to increase the opportunity for better health outcomes through incentivized performance improvement has moved forward in a number of important areas, including the development of a standardized method for collecting cost information for implementing the foundational public health services; exploring a pathway to national accreditation for small health departments; and identifying opportunities, barriers, and solutions for implementing cross-jurisdictional sharing in Ohio, especially for smaller health departments.

Additionally, to help build a bridge between clinical medicine and public health to improve community health, OPHP members have continued to strategize the various ways in which local health departments and hospitals in their respective counties can synchronize their community health assessment processes by 2020, which is a new state legislative requirement.

Moreover, OPHP's work over the past year also includes efforts to modify a new costing tool, said Beth E. Bickford, MS, RN, CAE, Executive Director of the Association of Ohio Health Commissioners. The tool was developed by a team of researchers at the University of Kentucky to capture local public health investment in accordance with the foundational public health services, Bickford said, and to identify both actual expenses and desired investment to meet community need. The tool is currently being finalized in preparation for the next step, which calls for using it in a pilot test with 10 to 12 local health districts.

"With the pilot test, we want to ensure that all services are in the right buckets as far as assigning them to foundational public health services," Bickford said. "We're hoping that this work can transform and serve as the foundation of the annual financial information that all local health departments in Ohio are required to submit to the Ohio Department of Health. If we get to the end of this project and have done everything right, then we will have an annual financial report for every Ohio health district that is based on the foundational public health services, down to the capability or the capacity that we are interested in looking at."

A New Way of Doing Business

Ohio's work is also advancing on the shared services front. For the first time since 2011, OPHP's Shared Services Workgroup resurveyed local health departments about shared service arrangements, with an additional piece about knowledge and utilization of the foundational public health services. The findings are currently being analyzed by the Center for Sharing Public Health Services in Topeka, Kansas.

"There is so much sharing already occurring between health districts that are near each other, or even in the same region, but not necessarily contiguous," Bickford said. "They might not necessarily share a border but are close by to one another."

The initial analysis will determine if there are areas that are conducive to sharing capacity when needs aren't driven by geography, Bickford said, adding, "Where you can still help each other, assist each other, contract with each other for services, but you don't necessarily have to be right next to each other."

> *Terry Allan, MPH, Health Commissioner at Cuyahoga County Board of Health, suggested there might be opportunities for shared-service arrangements in which multiple health departments in several counties could come together to share services around, for instance, epidemiologic capacity, or to share services around quality improvement or health improvement planning.*

"It's a new way of doing business," Allan said. "Finding a way to make it economically feasible to gain an asset that all the parties can benefit from is the goal."

In addition, the Small Health Districts Workgroup has been collaborating with the Shared Services Workgroup to explore the needs of small local health departments. The two groups worked together to issue the shared services survey and will be focusing on the survey results from smaller jurisdictions to see how capacity and need might be aligned going forward. More than half of Ohio's local health departments have populations of fewer than 50,000 people.

Ohio's efforts to improve health outcomes and reduce disparities received a much-needed boost in June from Ohio lawmakers, who approved a two-year budget bill that included a doubling of the state subsidy for accredited health departments. Ohio is currently the only state in the nation where national accreditation through the Public Health Accreditation Board is mandated and codified. Among the pathways recommended for accreditation, local health departments may choose to pursue accreditation on their own, or several local health jurisdictions may form a single operating unit, sometimes referred to as a Council of Governments (COG).

Local health jurisdictions may also choose to merge if the agencies and their communities determine it makes sense for them. The funding that is allocated in the new budget provides -- for the first time since the mandate went into effect – money for accredited health departments, thereby rewarding health districts that are accredited by doubling their state subsidy from 17 cents up to 34 cents.

"Within the past year, the state health department has begun to approach this as a way they can help health districts become accredited through some specific pots of funding," Bickford said. "It's a positive approach, rewarding health districts who are accredited by doubling their state subsidy. While this increased funding opportunity trailed the legislative mandate by a few years, the new philosophy represents an important incentive for local health departments."

Health districts that are working toward their accreditation mandate are also eligible to receive the funds. But as the clock continues to tick toward their first deadline, which is that every health district in Ohio must apply to PHAB for accreditation by July 2018, public health leaders recognize that they are facing a significant level of work and responsibility.

> *The recently passed budget also sets aside $3.5 million to help health districts that choose to merge. The funds can be used to cover accreditation fees, accreditation coordinators, or any kind of accreditation-related work or technical assistance.*

While the funding is very flexible for covering the costs associated with mergers, public health leaders agree that there are limited situations currently in Ohio where conversations about mergers are taking place. These new relationships take time to mature, they say, and as such it is unlikely that these funds will be fully expended solely for that purpose.

"We know those resources can be perishable from the legislative standpoint," Allan added. "We are hoping there will be some flexibility in the utilization of those dollars. We know that there is a range of needs in this sphere, and a broader view on how to best utilize these funds is essential. This flexible approach will help to advance public health practice and also further incentivize accreditation."

A portion of the budget's $3.5 million is earmarked to provide a one-time allocation of $12,000 per local health department to support their activities toward aligning their community health assessments with local hospitals and hospital systems. To maintain their nonprofit designations, an Internal Revenue Service requirement enacted through the Affordable Care Act requires nonprofit hospital systems in the United States to conduct health status assessments every three years.

Ohio codified a similar requirement for local health departments to conduct a community health assessment every three years. However, PHAB requires that a health department have a community health assessment every five years, which means some of Ohio's health departments are currently out of sync with the three-year requirement and are still on the five-year cycle. The statutory language requires that local health departments, by 2020, align at the county level with hospital systems on a three-year cycle.

While the requirement presents challenges on several fronts, Allan believes the prospect is very important and supports the convergence of clinical medicine with public health.

"It has been said that clinical medicine and public health were separated at birth and that we're amidst a reunification process," Allan said.

> *"The statutory language helps to facilitate and encourage health departments and hospitals to work together in new ways. It's a lot of work to do the assessments, but the big idea in all of this is to get hospital systems and public health working together, and we are in full support of that. We think it is long overdue."*

Oregon

In Oregon, Public Health Transformation Brings New Ways of Doing Business

Blessed with a diverse landscape of forests, mountains, meadows, farms, and beaches, Oregon is often associated with images of healthy communities built around active lifestyles. Yet despite an abundance of natural and human resources, health inequities based on factors such as race, income, geographic location, and education persist across Oregon's population, preventing the state from achieving its goal of ensuring the basic protections that are critical to the health of everyone in Oregon. Adding to the challenges, a litany of funding woes has long hampered Oregon's ability to keep pace with a rapidly changing world and achieve a population-wide focus on prevention and wellness.

To effectively and efficiently meet the needs of their communities, Oregon's public health leaders have worked in earnest for the past four years to transform and modernize the state's public health system. In July 2015, public health leaders celebrated a landmark victory when the Oregon legislature passed House Bill 3100, ushering in a new model for public health in Oregon and setting the state on a path aimed at modernizing its public health system.

"House Bill 3100 said modernization was now the law of the land in Oregon; it said, 'this is where you're going, money or no money,'" explained Charlie Fautin, RN, MPH, Deputy Director and Health Administrator at Benton County Health Department in Corvallis, Oregon.

Remarkably, House Bill 3100 essentially signed into law all of the recommendations made by a task force that for nine months had been studying the future of public health services in Oregon.

> *Most importantly, the House Bill 3100 adopted the task force's recommendation that a core package of foundational public health services be available to everyone in the state, wherever they live.*

The law stated that no health department could be without these services, which must be present in every community in order to efficiently and effectively protect everyone. The framework for this basic set of capabilities and programs, known as "foundational public health services," had originally been set forth in an Institute of Medicine report titled For the Public's Health: Investing in a Healthier Future.

Cara Biddlecom, MPH, Director of Policy and Partnerships at Oregon Health Authority, which is the formal name of Oregon's state health department, is among those working to implement the state's long-term plan for modernizing the public health system. By working collaboratively with the Oregon Coalition of Local Health Officials and state and local public health practitioners, each foundational capability and program has been defined down to a detailed level for state and local public health authorities. The Oregon Health Authority Public Health Division published the definitions in 2015 in the 162-page Public Health Modernization Manual. The manual defines each foundational capability and program as they apply specifically to state and local public health departments, which in turn are working closely with community members and partners to implement them.

Having adopted the foundational public health services as a roadmap for rebuilding and modernizing Oregon's public health system, the Oregon Health Authority in 2016 worked with an outside consultant to assess the degree to which all 34 local health departments and the state health department were providing the foundational capabilities and programs, and what resources were needed to fully implement them. The results of the assessment were published in the Public Health Modernization Assessment Report. Upon the report's release in 2016, the Oregon Health Authority, the Public Health Advisory Board, and local public health leaders began working closely to understand the findings and come up with a way to prioritize the work moving forward.

"We realized we can't address every priority at once, but we knew we could immediately start addressing some of the issues and expand that over time," Biddlecom said.

The assessment's findings came as a wake-up call for public health leaders who had been working with state and local health departments to implement the foundational capabilities and programs.

> *"As part of that assessment, we found that in over one-third of communities in our state, public health services are limited or minimal," Biddlecom said. "We also found gaps in services, and those gaps vary greatly, both across program areas as well as across sizes of health departments."*

The findings showed no clear patterns across the public health system of where gaps existed, with large gaps detected in all areas of the foundational public health services model and across all local public health departments, as well as the state health department. Equally alarming, the gaps appeared to be largest in the areas of health equity and cultural responsiveness. "As such, current implementation of public health modernization can be described as a 'patchwork quilt,'" the report said. In addition, the report found that there were no foundational programs or capabilities that were "substantially implemented universally across all public health authorities."

State and local health department leaders used the assessment's findings to create Oregon's initial Statewide Public Health Modernization Plan, which was published in early 2017 as required by HB 3100. According to Oregon Health Authority Policy Analyst Sara Beaudrault, MPH, the plan includes a "roadmap" made up of three overarching and equally important strategies that must be addressed if public health modernization is to be scaled up over the next six to ten years. One of the strategies is to build capacity around the foundational capabilities within public health departments and the public health workforce.

> *"In other words, health departments will work to build their capacity to form meaningful community partnerships, build their capacity around collecting population health data – using that data to drive decision-making – and build their capacity to work with communities that are experiencing disparities," Beaudrault said.*

The second of the three overarching strategies calls on the public health system to change how it works with other sectors – in other words to form new and different relationships with sectors such as health care and education so that they can build some shared responsibility for health priorities that they have in common.

"With most of our population health issues here in Oregon, it is really important that the health care system is addressing those, but it's equally important that public health is there with our complementary ways of addressing those problems," Beaudrault said. "If we can work together, we'll get some collective action and see some real improvements in those areas."

The third and final overarching strategy contained in the initial statewide Public Health Modernization Plan is to ensure that public health is accountable and "really demonstrating results" from a modern public health system in ways that it hasn't done before, Beaudrault said.

"So, it calls on us to be continually evaluating our work, to understand where we're making progress, and if we are not making progress to be able to change course so that we're meeting our goals," Beaudrault added.

Talking the Talk

The winter of 2017 found Oregon's public health community immersed in a series of 10 regional "Aligning Innovative Models for Health Improvements (AIMHI)" meetings across the state. Unprecedented in their scope and mission, the AIMHI meetings brought together public health leaders and stakeholders from many different sectors to talk about building a public health system for the future and explore the potential for regional implementation opportunities.

Organized by the Oregon Coalition of Local Health Officials (CLHO) and supported by a grant from the Robert Wood Johnson Foundation, the meetings were attended by county commissioners and representatives from a range of sectors, including health care, equity coalitions, child care, senior care, education, and transportation. At each of the 10 meetings around the state, presenters sought participants' advice on how to promote a public health system for the future "in a way that would appeal to and would grab the attention of people that weren't public health wonks," said Fautin, who is CLHO's current chair. "We were really trying to get their take on how to communicate this whole concept of a modernized 21st century public health system in a compelling and clear way."

The ten regional meetings also served as opportunities to equip participants with the communications tools they would need to "talk the talk" about modernization with legislators at the upcoming 2017 legislative session, so that when they interacted with the legislators they would pitch modernization as well, Fautin explained.

"The intent was to have these folks interact with legislators before they actually went into session, and CLHO worked really hard on that," Fautin said. "It was a very successful strategy because this was a long session (January to June 2017) and all the budget work comes last in the state legislative session. So it gave us a good opportunity to provide this background and rally those forces in time for the legislature."

Despite the prep work, the 2017 legislative session turned out to be "a bit of a roller coaster," Fautin said. "Given Oregon's fiscal situation, it seemed a long shot to get anything, but we ended up with $5 million.

The concept we kept hearing from the legislators was: If you are talking about modernization you are explicitly saying that this is a new, different, and innovative way to practice public health, and that's what we're going to be looking for.'"

The heat was on, but the legislature ultimately showed its support and commitment to public health by unanimously passing House Bill 2310. Signed into law in August 2017, the bill makes minor changes to the implementation of public health modernization, such as establishing accountability metrics for state and local public health to track their progress, and adding a Tribal member or Tribal representative to the Public Health Advisory Board. The $5 million legislative investment for the 2017-19 biennium will be used to support communicable disease control efforts at a regional level across the state, with an emphasis on reducing communicable disease-related health disparities.

To meet the accountability metrics requirement, the Public Health Advisory Board has established a set of eight public health accountability metrics tied to the foundational programs. The measurement areas selected include tobacco, opioid-related overdose deaths, childhood immunizations, sexually transmitted infections, effective contraceptive use, oral health, active transportation, and drinking water standards. The metrics will be used to measure the progress of their work toward improving population health and modernizing the public health system.

"Now it's up to us," Fautin said. "We only have $5 million to go statewide and two years is not much time to move the needle on anything in public health, but we now have the mechanisms for measuring and we'll need something to be able to take back to them. We are looking at this as an 18-to-20 month push to see what we can do with this little bit of money in a focused way within these regions around the state to make a demonstrable difference. It's a challenge."

But the "inertia has started," said Fautin, who is grateful for the additional boost provided to CLHO from the Robert Wood Johnson Foundation (RWJF). In 2016, RWJF selected Oregon as one of three states to receive a grant for implementing the systems transformations required to provide the foundational public health services and ensure health equity. Working with the PHNCI, Oregon joins Ohio and Washington in a first-of-its-kind learning community convened by PHNCI, which is working to identify, implement and spread innovations in public health practice to help meet the health challenges of the 21st century in communities nationwide.

> *"We have so much appreciation for the backing of RWJF and PHNCI," Fautin said. "It adds so much validation and legitimacy to what we are doing here to say that these nationally recognized organizations are coming to Oregon and supporting us.*

We have legislators now who never thought about public health before, but who now know something about it and understand the importance of public health," Fautin said. "That was a huge step, hearing the words 'public health'" and the word 'modernization' out of the mouths of legislators who really never cared about public health before."

Washington

Washington's Public Health Leaders Take the Next Steps Toward Building a 21st Century Public Health System

In December 2016, while many Washingtonians were getting ready for the holiday season, the state's public health leaders were rushing to meet an important deadline. The state legislature, in a nod to the financial challenges faced by the public health system and the impact of those challenges on the system's ability to deliver essential public health services, had directed the state health department and local public health jurisdictions to submit, no later than mid-December, a plan for rebuilding, modernizing and funding a 21st century public health system.

Two weeks before Christmas, public health leaders submitted their plan to the state's lawmakers. The 48-page Plan to Rebuild and Modernize Washington's Public Health System explained not only the problem, but also proposed a solution that had been developed during five years of collaborative work. "Protecting the public's health is one of the state's fundamental responsibilities," the plan said. "However, the public health system has become woefully inadequate and is now unable to meet its basic responsibilities to protect the health and safety of people in Washington State." The solution, it said, could be found in a "limited statewide set of core public health services, called 'Foundational Public Health Services' (FPHS), that government is responsible for providing."

The issue of inadequate funding of Washington's public health system had been building for years. Even before the 2008 recession, funding had been gradually reduced year after year, or had remained flat, while inflation occurred, and efforts to prevent diseases had sharply declined across the state as public health funding had eroded.

"The burden to fund public health has been pushed down continually by the state to the locals, but the locals can't do it, especially in Washington State where our commissioners don't have the authority to raise our property taxes by more than 1 percent per year, and so property tax, which is the main income source for counties, has been significantly decreasing for the last 16 years now," said Chris Bischoff, MSML, RS/REHS, Environmental Health Manager at Cowlitz County Health and Human Services in Longview, Wash., and President of the Washington State Association of Local Public Health Officials (WSALPHO). "Even if the commissioners vote for that annual 1 percent, it is still falling well below inflation. This has been a negative death spiral. They are cutting not just health, they are cutting everything. They don't have a choice and it is getting kind of brutal."

Starting in 2009, state and local public health practitioners began to collaborate formally in search of a solution that would yield a long-term strategy for predictable and appropriate funding for the state's public health system. In 2012, a work group made up of state and local governmental public health experts was formed to develop a long-term strategy to ensure the effectiveness and sustainability of the governmental public health system. Building on the work of an Institute of Medicine report titled For the Public's Health: Investing in a Healthier Future, the workgroup identified a "minimum package of services" needed everywhere to support population health anywhere. The workgroup went on to develop the Foundational Public Health Services (FPHS) model as a viable framework for Washington's governmental public health system.

The FPHS framework includes both cross-cutting foundational capabilities and programs needed everywhere in order for the system to work anywhere. In addition to defining the FPHS, the workgroup set out to determine the total cost to the governmental public health system just to implement them. To advise them on the funding and implementation issues, a policy workgroup reviewed their work and published their recommendations in a report titled Foundational Public Health Services: A New Vision for Washington State. The report recommended adopting the FPHS framework and definitions, and called for the establishment of a dedicated account for FPHS funds.

Speaking With One, Unified Voice

Building on the work accomplished over the past several years by the technical and policy workgroups, the FPHS Steering Committee in 2016 turned its attention to preparing for the 2017 legislative session. The session would be an opportunity for public health leaders to have a formal and public dialogue with the legislature about the FPHS framework, and to test their support by asking for a down payment, with the plan to return to the legislature in 2019 with a full-fledged proposal that would provide support for a sustainable foundational public health system for the entire state. To prepare the legislature for the upcoming dialogue, WSALPHO and its partners launched the "Public Health is Essential" campaign with the goal of promoting local public health and the FPHS to the general public and policymakers.

Materials created for the campaign highlighted the work governmental public health does around communicable disease, which is one of the core FPHS areas.

"Local health jurisdictions contributed local stories on outbreaks they were experiencing, such as mumps and TB, and the cost to control these outbreaks," said WSALPHO Managing Director Jaime Bodden, MPH, MSW. "Some local health jurisdictions also held town hall meetings."

Keeping with the campaign's branding goals, the "Public Health is Essential" tag line became a familiar one around the state. A variety of media platforms, including radio, TV, newspaper and social media, trumpeted the campaign's message about how the public health system is essential to the well-being and safety of communities, and the importance of "core services" that the state should financially support so that every Washingtonian could have equal access to public health programs and services.

In addition, health officials shared real stories about local public health in action, newspaper editors penned editorials about the importance of the FPHS, and health officers and administrators authored dozens of op-eds. The messages resonated well with the community, and as hoped reached the ears of legislators, many of whom had little or no previous knowledge of local public health or FPHS.

"The campaign was really good about honing in on that message," Bischoff said. "The groundwork that was laid in advance was 'What does it mean to have a foundational service? What are the things that every health department should do?' And I think that was very important for the legislature because the first question they were going to ask was 'What are you talking about?' And with the FPHS work that has been done and with the groundwork that has been laid we had things we could point to and say: 'These things. These are what must be done. These are the bare minimum.'"

Another campaign goal – preparing the 35 local health jurisdictions to communicate the message directly to their local legislators – was more difficult because of the vast differences in the sizes of their counties and various related resources and priorities. However, armed with templates, talking points and some coaching from campaign organizers, all of the local health jurisdiction spokespersons – from the 2.1 million population Seattle and King County to Garfield County, which has a population of 2,600, spoke with one voice about foundational public health in Washington State.

The campaign and related advocacy efforts paid off. The 2017-2019 biennium budget that passed on June 30, 2017 included a $12 million allocation to the FPHS. Of that, $2 million was allocated to the state to improve and build capacity within the state health department, and $10 million was allocated to local health jurisdictions to be used for improving local capacity around communicable disease control, with an emphasis on shared services.

Looking ahead, the FPHS Technical Workgroup will be working with various WSALPHO Committees to obtain input into the FPHS Operational Definitions, which will form the Operational Definitions Manual that will be used in a statewide FPHS Assessment to benchmark the current capacity for providing FPHS and spending on FPHS statewide, said Marie Flake, who works on special projects at the Washington State Department of Health in Olympia, Wash.

> *"Information from the FPHS Assessment will inform our approach, work plan, strategy and legislative engagement going forward," Flake said.*

The Manual and Assessment are slated to be completed by the fall of 2018, with a final report ready for the 2019 legislative session, which will be the next budget session for Washington.

Flake is pleased that Washington State has been selected by the Robert Wood Johnson Foundation as one of three states to receive a grant for implementing the systems transformations required to provide the foundational public health services and ensure health equity. Working with PHNCI, Washington joins Ohio and Oregon in a first-of-its-kind learning community convened by the Alexandria, Virginia-based PHNCI, which is working to identify, implement and spread innovations in public health practice to help meet the health challenges of the 21st century in communities nationwide.

Stronger Together

On a recent Wednesday afternoon in early September, Jeff Ketchel, MA, RS, Interim Administrator at Snohomish County Health District in Everett, Wash., had just returned from having lunch with some local mayors. Much of the talk around the lunch table had focused on public health's inconsistent response to the opioid epidemic. Ketchel used the opportunity to familiarize the mayors with the idea of local health departments taking on the role of chief health strategist for their communities.

The community chief health strategist concept was originally put forward in a 2014 RESOLVE report, The High Achieving Governmental Health Department in 2020 as the Community Chief Health Strategist. In light of the nation's changing health landscape, the report called on governmental public health leaders to take on the role of chief health strategist in their communities and to acquire new skills and tasks in order to prevent death, disease, and disability; address emerging threats to health, security, and equity; and eliminate the social and structural injustices that result in health disparities.

"When I talk about the modernization of the public health system, that report and the seven ideas it presents is one of my favorite guidance documents for the future of local public health," said Ketchel, a former WSALPHO president and current co-chair of WSALPHO's Legislative Committee, as well as a member of the FPHS Steering Committee.

> *"If we are going to really be chief health strategists, then we need to find ways to prevent and respond to things that we don't necessarily have categorical funding for or even statutory authority or jurisdictional authority for. We need to do whatever we need to do to prevent premature death, illness or injury in our communities."*

Ketchel also sees cross-jurisdictional sharing as another important avenue toward achieving public health system transformation in Washington. Of the $12 million awarded to the state for FPHS, $1 million, or $500,000 a year for two years, will go to pilot some shared-service demonstration projects. Sharing services is another way that the governmental public health system can be more effective with their funds, while still providing the core FPHS to the public. It is not a new concept, but one that has room for expansion.

The idea of local public health sharing services is a topic of great interest to Ketchel. As a former administrator of Grant County Health District – a rural community in Moses Lake, Wash. – Ketchel often shared different services with neighbor Barry Kling, administrator and director of Environmental Health at nearby Chelan-Douglas Health District in East Wenatchee, Wash. The arrangement worked well for both health districts, Ketchel said. For example, Kling's health district delivered "a lot of emergency preparedness services," which Ketchel's health jurisdiction enjoyed, and in return Ketchel's health district delivered "a lot of healthy community and chronic disease prevention-type services, so that was a good relationship," said Ketchel, whose work with WSALPHO has since given him the opportunity to dive deeper into the subject. Looking at some different public health programs, Ketchel said he was curious to learn why some programs worked well as "shared" and other programs did not.

"We came up with a shared service theory," Ketchel said. "The first part of it has to do with specialization. If you're in a smaller county and something novel happens, you have a short amount of time to ramp up and respond to that outbreak or situation, and chances are you are not going to have the in-house expertise to handle it. But if you had guaranteed access to different specialists who are perhaps located in another jurisdiction that had a responsibility to provide specialized services to you and to your neighbors, you wouldn't have to spend the time to ramp up. In fact, you could respond very quickly, knowing that specialized expertise was at your fingertips."

The shared-service scenario could be around zoonotic diseases, Ketchel said, or it could be around different kinds of data analysis, assessment or reporting; or it could be around policy development, such as a vaping or tobacco-free space ordinance. Services that would not work well in a shared scenario include sharing services that are labor intensive, Ketchel said, or sharing services with counties that are geographically very large, which might require too much travel time, or sharing services around situations where relationships are necessary, such as when local relationships with community leaders and elected officials are necessary in order to get an ordinance passed.

The next step, he said, is to look at the 55 different FPHS and determine which ones would work best at being delivered cross-jurisdictionally and which ones ought to be located within each local health jurisdiction "so that all 55 of these services are guaranteed to be delivered to every Washingtonian in accordance with the original vision," he said.

Over the next six months, Ketchel is looking forward to seeing what types of pilot projects will be selected for a shared services demonstration project. WSALPHO and the state health department are currently working to lay out a process for selecting projects that will represent the diverse range of local health jurisdictions in Washington – from large urban to small rural -- and focusing on communicable disease. A report to the legislature at the end of 2017 will provide a brief overview of these projects, including what the anticipated impact and measured outcomes will be. A final report on the demonstration projects, as well as the impact of FPHS funding, will be provided to the legislature at the end of 2018.

"Even though the pot of money for these projects is small, people are willing to experiment with expanding shared services," Ketchel said. "So I'm excited about this willingness to take a risk in Washington State and try something new."