State Community Health Services Advisory Committee

Accountability Review Process Work Group Report

January 2007

Community and Family Health Division
Office of Public Health Practice
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January 22, 2007

Dianne M. Mandernach, Commissioner
Minnesota Department of Health
Post Office Box 64975
St. Paul, MN 55164-0975

Dear Commissioner Mandernach:

I am pleased to present to you the final report of the Accountability Review Process Work Group of the State Community Health Services Advisory Committee (SCHSAC). The SCHSAC approved the report at its December 15, 2006 meeting.

The Work Group was charged with addressing accountability issues outlined in the 2003 Local Public Health Act. This report summarizes issues discussed by the Work Group; describes the roles state and local entities will play in implementing the accountability provisions; presents a recommended accountability review process; and makes recommendation for implementation and future work.

The Work Group developed an accountability review process that focuses on quality improvement, strengthens the local public health system, and builds upon the local-state partnership. The Work Group is confident that the accountability review process will lead to quality improvement in local public health and improved health for all Minnesotans. We hope you will accept this report.

Sincerely,

Gary Sorenson, Chair
State Community Health Services Advisory Committee
4610 United States Avenue
Storden, MN 56174

Protecting, maintaining and improving the health of all Minnesotans

January 31, 2007

Gary Sorenson, Chair
Accountability Review Process Work Group
State Community Health Services Advisory Committee
4610 United States Avenue
Storden, MN 56174

Dear Chair Sorenson:

Thank you for sending me the final report of the Accountability Review Process Work Group of the State Community Health Services Advisory Committee (SCHSAC). The accountability review process developed by the Work Group addresses the accountability issues laid out in the work group charge and operationalizes the provisions of the Local Public Health Act of 2003. I believe that the recommendations and roles identified in this report build upon the strong local-state partnership and focus on quality improvement.

I applaud the Work Group for its ability to discuss and reach consensus on many complex issues involved in developing the accountability review process. I look forward to working with you and the SCHSAC, as we jointly implement the process and work towards continuous quality improvement to promote and protect the health of all Minnesotans.

Sincerely,

Dianne M. Mandernach
Commissioner
Post Office Box 64975
St. Paul, MN 55164-0975

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Accountability Review Process Work Group

WORK GROUP CHARGE

Review Minnesota Statute 145A.131 Subdivision 3. (Accountability) and make recommendations to operationalize the provisions of the law that allow the commissioner of health to withhold Local Public Health Act funding under certain circumstances.

WORK GROUP MEMBERSHIP

Gary Sorenson, Chair, Cottonwood-Jackson Community Health Board
Ann Bajari, Meeker-McLeod-Sibley Community Health Board
Bonnie Engen, Clearwater County Nursing Service
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Debra Burns, Community and Family Health Division
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Marie Margitan, Community and Family Health Division

EXECUTIVE SUMMARY

INTRODUCTION

The Accountability Review Process Work Group (here forward, "the Work Group") was charged with addressing accountability issues as outlined in the 2003 Local Public Health Act. The law gives the commissioner of health authority to withhold funds when "progress" is not occurring and provides a broad outline of an accountability review process.

SUMMARY OF WORK GROUP DISCUSSIONS

The Work Group developed *Guiding Principles* which focused on quality improvement and building off the strengths of the local-state partnership. Those principles guided the work and laid the foundation for the accountability review process.

Many issues related to accountability and the accountability review process were addressed by the Work Group including funding and accountability; roles of state and local entities; reporting levels; enhanced technical assistance; and monitoring.

FRAMEWORK FOR THE ACCOUNTABILITY REVIEW PROCESS

The Work Group developed an accountability review process with three levels in addition to a probation period and an appeals mechanism.

Level 1 Review

Level 1 Review is a basic compliance review that will be done annually. It is very similar to the review done in the past. Factors that will be considered during Level 1 include:

- ✓ Are community health priorities for each area of public health responsibility on file within the 5-year cycle?
- ✓ Is a current action plan on file that addresses the essential local public health activities and community health issues?
- ✓ Were performance measures and financial, staffing, and statistical reporting completed accurately with minimal follow-up (e.g. clarifying telephone call)?
- ✓ Were Local Public Health Act Funding Assurances and Agreements submitted?
- ✓ Were other legal requirements of the Local Public Health Act met (i.e., the 75 percent required match for state portion and 50 percent for Title V portion, CHS administration, medical consultant, community health board requirements)?
- ✓ Are the key indicators from the performance measures met, if not:
    - Can concerns/issues be easily explained/addressed with minimal follow-up (e.g., telephone call to clarify)?
    - Are there extenuating circumstances (e.g., staffing shortages, funding mix, and resources)?
    - Are issues/concerns being addressed (e.g., the action plan describes improvements that will be made)?

If all items on the checklist have been satisfied, the community health board/local public health department has successfully completed the accountability review process.

If not, the community health board/local public health department moves to Level 2.

Level 2 Review

Factors that will be considered during Level 2 review include the following:

- ✓ Are steps being taken to address concerns identified in Level 1 review (e.g., the action plan describes improvements that will be made)?
- ✓ Is enhanced technical assistance being utilized by the community health board/local public health department?

If steps taken to address issues and technical assistance is provided and accepted, continued monitoring will take place to ensure that progress in addressing the issues is ongoing.

If this is not the case, the community health board/local public health department moves to Level 3.

Level 3 Review

Factors to be considered during a Level 3 review include the following:

- ✓ Did the community health board/local public health department develop a correction plan?
- ✓ Is the community health board/local public health department following through on activities in the correction plan?
- ✓ Is enhanced technical assistance being utilized by the local public health department?
- ✓ Is performance improving over time?
- ✓ Have issues of concern been successfully addressed?

If the answer to each question on the checklist is "yes", the Minnesota Department of Health will continue monitoring and offering technical assistance.

If not, the commissioner will provide formal written notification of specific action that must be taken within the next twelve months (one-year probation) to maintain eligibility for the local public health grant.

Probation Period

Factors to be considered during the 12-month probation period include:

- ✓ Did the community health board/local public health department develop a correction plan?
- ✓ Is the community health board/local public health department following through on activities in the correction plan?
- ✓ Is enhanced technical assistance being utilized by the local public health department?

- ✓ Is performance improving over time?
- ✓ Have issues of concern been successfully addressed?

At the end of the 12-month probation period, the commissioner determines whether to distribute funds based on corrective actions taken during the 12-month period.

RECOMMENDATIONS

These recommendations address issues of purpose, structure and implementation of the accountability review process. The Work Group recommends that:

1. The accountability review process outlined in this report should be adopted as a way to ensure accountability, while at the same time maintaining a strong focus on, and incentives for, quality improvement.

2. The accountability review process should be implemented following the submission of reporting data in March 2008.

3. The Minnesota Department of Health should continue to provide technical assistance to all community health boards/local public health departments.

4. The Minnesota Department of Health should offer technical assistance to meet the changing needs of community health boards/local public health departments.

5. The Minnesota Department of Health, in partnership with the State Community Health Services Advisory Committee, and other partners, should work to identify the amount of funding needed to perform essential local public health activities throughout the state.

6. The accountability review process and other components of the quality improvement system developed following the 2003 statutory changes should be reexamined in 2010 by the Minnesota Department of Health and the State Community Health Services Advisory Committee

7. The current practice of allowing multi-county community health boards to report as one entity or as individual counties within the community health board should continue. However, the performance measures and the financial, staffing, and statistical report must be reported in the same manner.

8. The State Community Health Services Advisory Committee and the Minnesota Department of Health should stay apprised of the national discussion on accreditation of local public health departments and ensure that Minnesota's quality improvement process positions local public health departments for voluntary accreditation, if a national accreditation program is developed.

9. The 2008 Assurances and Agreements and the CHS Administration Handbook should be updated to reflect the six areas of public health responsibility, the essential local public health activities, the new planning components, the performance measures, and the accountability review process.

INTRODUCTION

The Accountability Review Process Work Group (here forward, "the Work Group") was charged with addressing accountability issues as outlined in the 2003 Local Public Health Act. The Local Public Health Act, MS 145A.131, subdivision 3, states that "community health boards accepting local public health grants must document progress toward the statewide outcomes... to maintain eligibility to receive the local public health grant." The law also gives the commissioner of health authority to withhold funds when "progress" is not occurring and provides a broad outline of an accountability review process.

The Work Group began by clarifying specific terms and concepts from the accountability provisions of the Local Public Health Act. Those concepts included:

- the definition of "documenting progress";
- whether "maintaining" at the same level from year to year can be considered "progress";
- how intermediate outcomes relate to progress; and
- whether local public health departments do a "self assessment" of essential local public health activities, or the commissioner determines whether they are being met[1].

Other concepts needing clarification included:

- what is meant by "effort put forth" by community health boards; and
- what "other factors" the commissioner might require to make her/his determination.

This report summarizes issues discussed by the Work Group; describes the roles that state and local entities play in implementing the accountability provisions; presents a recommended accountability review process; and makes recommendations for implementation and future work.

BACKGROUND

The Minnesota public health system is a partnership between state and local governments. The Community Health Services Act of 1976 formalized this partnership. Throughout the years of working together, efforts to build quality and competence have been a mutual focus. Most activities centered on strengthening the local community health assessment and planning processes along with program-specific topics. Then in 2001, a local-state work group of the State Community Health Services Advisory Committee (SCHSAC) developed a long-range strategic plan for the statewide public health system. Three points emerged from that work:

1. All parts of the state should be served by a public health department that meets state statutory requirements.
2. Locally governed public health is preferable to services provided entirely by the state.
3. Some form of minimum standards and statewide uniformity in public health functions would greatly simplify efforts to describe the system- and its benefits- to the legislature, locally elected officials, and citizens[2].

[1] State Community Health Services Advisory Committee. Assuring Essential Local Public Health Activities Throughout the State Work Group. Final Report. Minnesota Department of Health. Community and Family Health Division. Office of Public Health Practice. January 2005.

[2] State Community Health Services Advisory Committee. Strategic Planning Work Group. Final Report. Minnesota Department of Health. Community and Family Health Division. Office of Public Health Practice. September 2003.

The recommendations of that work group led to significant changes to the Local Public Health Act in 2003. Several SCHSAC work groups have subsequently recommended changes to the local public health system framework to be in accordance with the new provisions in statute. Since 2003, the following activities have occurred.

- The six areas of public health responsibility have been delineated.
- A set of "essential local public health activities" has been established, which reflects what Minnesotans in all parts of the state should be able to expect from their local public health department (See Appendix A).
- The local community assessment and planning process was revised to incorporate an assessment of capacity to perform essential local public health activities and planning for improvement.
- Performance measures related to essential local public health activities were developed, and are reported annually via the local public health planning and performance measurement reporting system (LPH PPMRS).

As SCHSAC, its work groups, and the Minnesota Department of Health worked on the local public health system re-design, **quality improvement** was a common thread woven throughout. In making recommendations on how to implement the commissioner's enhanced responsibilities related to accountability, the Work Group continued that theme by developing recommendations that would promote quality improvement in local public health.

MINNESOTA'S LOCAL PUBLIC HEALTH QUALITY IMPROVEMENT SYSTEM

Minnesota's local public health improvement process includes a number of interconnected components (see Table 1). Understanding these components provides context for the accountability review process. Key components are described below. Detailed information on each component can be found in Appendix B.

Capacity Assessment and Priority Setting

The capacity assessment is a self-examination of a local public health department's human, organizational, informational, and fiscal resources. It looks at a local public health department's ability to carry out essential local public health activities in each of the six areas of public health responsibility. Priority setting helps local public health departments to focus resources on essential local public health activities that will have the greatest positive impact.

Planning to Improve Performance of the Essential Local Public Health Activities

After local public health departments have identified priority areas for improvement, they plan how to improve the performance of essential local public health activities which describes the following:

- Aspects of one or more essential local public health activities that need improvement, including goals and objectives.
- The resources that will be invested to make the needed improvement.

- The actions that will be taken to improve essential local public heath activities.
- The measures/indicators that will be used to determine success.

Performance Measures

The performance measures make up a set of information used to document progress towards achieving statewide outcomes. Both process measures and intermediate outcomes related to essential local public health activities are included in the report. Local public health departments complete and submit the performance measures report annually to the Minnesota Department of Health.

<table>
<tr><th colspan="11">Table 1. Minnesota's Local Public Health Quality Improvement System</th></tr>
<tr><td>Goals</td><td colspan="5">Healthy People 2010</td><td colspan="5">Healthy Minnesotans Goals</td></tr>
<tr><td>Standards</td><td colspan="4">National Accreditation Standards (future)</td><td colspan="3">Areas of Public Health Responsibility</td><td colspan="3">Essential Local Public Health Activities (ELAs)</td></tr>
<tr><td>Community Health Assessment and Action Planning (CHAAP)</td><td colspan="5">Activities to Improve Community Health Issues
✓ Community assessment and priority-setting
✓ Planning to address community health issues</td><td colspan="5">Activities to Improve Performance of Essential Local Public Health Activities
✓ Capacity assessment and priority-setting
✓ Planning to improve performance of Essential Local Public Health Activities</td></tr>
<tr><td>Measures</td><td colspan="2">Inputs</td><td colspan="2">Outputs</td><td colspan="2">Process Measures</td><td colspan="2">Intermediate Outcomes</td><td colspan="2">Statewide Outcomes</td></tr>
<tr><td>Performance & Accountability</td><td colspan="10">Local Public Health Planning & Performance Measurement Reporting System (LPH PPMRS)
Accountability Review Process</td></tr>
</table>

SUMMARY OF ACCOUNTABILITY REVIEW PROCESS WORK GROUP DISCUSSIONS

The Work Group was convened in July 2005. At the first meeting, a philosophical consensus began to emerge around the importance of shaping the accountability review process in a way that incorporates incentives to encourage and reward quality improvement. The Work Group developed guiding principles that directed their work and laid the foundation of the accountability review process.

Guiding Principles

The Work Group set forward the following six guiding principles to govern its efforts.

1. *The accountability review process provides a positive opportunity to strengthen Minnesota's public health infrastructure.* Because sanctions are available, this process could be viewed in a negative way. However, the Work Group chooses to view it as a positive opportunity to strengthen local public health capacity. The foundation of this opportunity is the existence of a long standing and positive working relationship between state and local public health in Minnesota.

2. *The accountability review process is consistent but also retains flexibility to evolve as the public health needs of Minnesotans change and evolve*. Consistency is needed when applying standards. This creates fairness and establishes expectations for local public health departments and the Minnesota Department of Health. However, flexibility is needed to address local priorities, emerging public health issues, workforce and funding shortages, and other uncontrollable events.

3. *The accountability review process promotes continuous quality improvement*. The Work Group understands the importance of developing a process that creates incentives for quality improvement. The process should not "punish" departments for an honest reflection of strengths and weaknesses.

4. *In setting forth an accountability review process, the Work Group accepts the possibility that some local public health departments might fail to meet the standards*. While this is a daunting thought, this mindset is necessary to avoid setting the level of accountability at the "lowest common denominator."

5. *The process includes an element of rehabilitation.* The accountability review process that is developed should keep the primary goal in mind, improving system performance. Therefore, rehabilitation—providing opportunities for struggling local public health departments to succeed—must be incorporated into the conceptual framework.

6. *Implementation of the accountability review process must not weaken the strong state and local partnership for public health.* Local and state public health departments have unique, but complementary roles that depend upon a strong partnership. This strong spirit of partnership has been a hallmark of the system for the past thirty years, characterized by cooperation, mutual problem solving, clear communication and respect. SCHSAC has summarized these characteristics in *Three Simple Rules of the Community Health Services Partnership*: seek first to understand; make expectations explicit; and think about the part and the whole. The changes to the Local Public Health Act in 2003 added a new dimension of performance improvement and accountability with the intent of strengthening the local public health system. However, giving the commissioner of health the responsibility to withhold funding based on performance introduced an element of authority that was not present before. This change must not detract from the partnership or it will weaken Minnesota's public health system.

Issues

The Work Group discussed a number of issues that are pertinent to accountability and the accountability review process. The following is a summary of those discussions.

Local public health funding sources and changes over time

As context for a discussion of the relationship between funding and accountability, the Work Group reviewed a statewide analysis of the last 30 years of local public health funding. Five themes that emerged from the analysis were seen as pertinent to their work (see Appendix C for the complete analysis).

1. Eligible local match has remained relatively stable over time and has consistently provided a majority of funding.
2. The composition of eligible local match has fluctuated over time, with local tax levy proportions decreasing and Medicaid reimbursement increasing.
3. Over time, the Community Health Services subsidy (now referred to as the Local Public Health Act funding) has declined as a proportion of total expenditures from 20 percent in 1979 to 7 percent in 2004.
4. Other state and federal funds as a proportion of total expenditures increased in the last three decades.
5. Flexible funding as a proportion of total expenditures has decreased.

Relationship between funding and accountability review process

The accountability provision of the Local Public Health Act is part of a complex relationship between funding of community health boards/local public health departments and their ability to perform essential local public health activities. The relationship is complicated by the fact that local public health departments are funded differently throughout the state; however, each community health board does receive the Local Public Health Act funding and must provide a 75 percent match for the state general fund portion and a 50 percent match for the Title V portion.

Based on the Work Group members' extensive experience as local public health administrators, directors and local elected officials, there was general agreement that the Local Public Health Act funding and required match are not sufficient to fulfill all of essential local public health activities. Even taking into account all funding received by local public health, the Work Group felt that there is not enough money currently in the system to fulfill all of local public health activities. However, the amount needed to fulfill essential local public health activities is currently unknown.

This leads to the question-how; or to what extent-can local public health departments be held accountable for performing essential local public health activities?

The answer to this question is in the wording of the accountability provisions of the Local Public Health Act, which indicates that community health boards must "document progress" towards the statewide outcomes (see Appendix D). Therefore, the basis of the accountability review process is to "make progress" with the funds available, which can be done by engaging in a meaningful quality improvement process that identifies where improvement is needed, or desired, and by developing and implementing action plans to achieve improvements.

Progress and effort put forth

In addition to specifying that community health boards must document *progress* towards the statewide outcomes, the Local Public Health Act states that the commissioner shall consider *effort put forth*. In order to build on the intent of the law, the Work Group developed an operational definition for both *progress* and *effort put forth*. The following summarizes the working definitions of each term.

Progress

- Positive movement or change towards goals and outcomes related to improving population health or strengthening organizational capacity of local public health departments. Examples include improving immunization levels; increasing the skills of the public health workforce; and working to decrease community acceptance of secondhand smoke.
- Moving forward after a problem has been identified, and successfully implementing a plan for improvement.

Effort put forth

- *Effort put forth* can be measured by looking at such factors as meeting statutory requirements, improving on previous performance, addressing core functions and essential activities of public health, and responding to community change.
- The effectiveness of the *effort put forth* is as important as the amount of *effort put forth*.
- Asking for and accepting help demonstrate that effort is being put forth.

Both terms (*progress* and *effort put forth*) take in to account extenuating factors, such as workforce shortages and natural disasters. In addition, both support a commitment to quality improvement for local public health departments while allowing for flexibility and accountability.

Key indicators

The Work Group identified a subset of the performance measures to serve as “key indicators,” in measuring the *progress* and *effort put forth* by local public health departments. The Work Group suggested that not meeting a key indicator is a signal that follow-up is needed by the Minnesota Department of Health. At times, the follow-up would simply involve a clarifying phone call, while other times it would involve technical assistance to resolve the issue.

The Work Group reviewed the results from the 2005 performances measures pilot test, focusing on the key indicators. The results showed the usefulness of having the key indicators to serve as markers in the accountability review process. (For a complete list of the key indicators go to Appendix E)

Roles related to the accountability review process

State and local public health have separate yet key roles that are incorporated into the accountability review process. Because the structure and operations of community health boards and local public health departments differ around the state, there is likely to be variability in exactly how these roles are fulfilled. However, some broadly applicable roles for the Minnesota Department of Health, community health boards, and local public health are described below.

Community Health Board

> The governance responsibility for a local public health department lies with the community health board. The community health board has the responsibility to approve key public health priorities, activities, and programs. As the governing body, the community health board chair currently receives official correspondence regarding the Local Public Health Act funding. Therefore, in the event that there are significant issues to be resolved around the requirement to *document progress* towards the statewide outcomes, the community health board chair will be notified and invited to meet with the Minnesota Department of Health and other local representatives.

Community Health Services Administrator

> The community health services administrator (here forward known as the "CHS administrator") is responsible for the administration of the Local Public Health Act in the geographic area that the community health board serves. CHS administrators are responsible for ensuring timely and accurate reporting to the Minnesota Department of Health, as well as the development and submission of action plans. Questions or concerns that the Minnesota Department of Health has about reporting information or progress towards quality improvement will be directed first to the CHS administrator. If a meeting were requested to discuss issues related to accountability, the CHS administrator would likely coordinate local participation.

Public Health Director/Supervisor/Public Health Nursing Director

> Local public health departments typically have a position (public health director, public health supervisor, or public health nursing director) with assigned leadership and supervisory responsibilities. Due to the differing structures of local public health departments throughout the state, a number of different titles are used to designate the lead public health staff person. Additionally, because of differing structures this person may or may not complete the performance measures but would have responsibility for developing and implementing the action plan for the local public health department. In some cases, this person will also be the CHS administrator.

County Boards and/or City Councils

> County boards and/or city councils have the ultimate responsibility to ensure there is a system established to fulfill the requirements of the Local Public Health Act. County boards and/or city councils can also review and sign off on the action plan and other reporting data. The reasons for this are twofold. First, they are responsible for the

activities and allocation of resources for their jurisdiction. Second, sharing these materials can serve as an educational tool to increase understanding of public health and essential local public health activities and the accountability review process.

Commissioner of Health

The general duties of the commissioner include an overall responsibility for the "development and maintenance of an organized system of programs and services for protecting, maintaining and improving the health of the citizens" (MN Stat. 144.05 subd. 1), as well as a responsibility to "coordinate and integrate local, state and federal programs and services affecting the public's health" (MN Stat. 144.05 subd. 1[f]) .

As described earlier in this report, the commissioner also has specific statutory responsibilities that are set forth in the Local Public Health Act, of which one is to set in place accountabilities for funding awarded to community health boards through the Act. The commissioner, in turn, is responsible to the Legislature and the federal government for state and federal funds provided to the Minnesota Department of Health, including those distributed to community health boards and other entities through grants.

Minnesota Department of Health's Functions related to the Accountability Review Process

Technical Assistance

Technical assistance provided by the Minnesota Department of Health to community health boards/local public health departments has been both a cornerstone of the partnership with local public health and a component of quality improvement for public health in Minnesota. Provisions for providing technical assistance have been in statute since the passage of the Community Healthy Services Act in 1976.

Minnesota Statute 145A.12 states:

> The commissioner must assist community health boards in the development, administration, and implementation of community health services. This assistance may consist of, but is not limited to:
>
> 1. informational resources, consultation, and training to help community health boards plan, develop, integrate, provide and evaluate community health services; and
> 2. administrative and program guidelines and standards, developed with the advice of the state community health advisory committee.

The Office of Public Health Practice has primary responsibility for providing technical assistance around the Local Public Health Act. Technical assistance includes such activities as training, the development of guidelines, and staffing SCHSAC work groups. Regional public health nurse consultants provide group and one-on-one consultation for general public health practice issues, facilitation of regional meetings, and guidance regarding local public health issues. They also play a key role in maintaining a strong relationship between local public health and the Minnesota Department of Health.

Other staff from the Minnesota Department of Health provides specialized programmatic technical assistance. This programmatic assistance includes such areas as epidemiology, environmental health, WIC, Minnesota Children with Special Health Needs, home visiting to families with children, and public health preparedness.

Enhanced Technical Assistance

The accountability provisions added to the Local Public Health Act in 2003 specifically charge the commissioner with providing assistance to underperforming community health boards. As seen in Minnesota Statute 145A. 131 Subdivision 3, “the commissioner shall provide administrative and program support to assist the community health board in taking the actions recommended in written notification” of “not documenting progress toward the selected statewide outcomes.”

The Local Public Health Act requires that the commissioner provide administrative and program support to assist a community health board that has failed to document progress towards selected statewide outcomes. The Work Group defined this as “enhanced technical assistance” to differentiate it from the ongoing technical assistance routinely provided. The Minnesota Department of Health will offer enhanced technical assistance when there are concerns about performance. The enhanced technical assistance will support local public health in the development and implementation of a correction plan. Local public health may also seek enhanced technical assistance from other organizations including other local public health departments and the Local Public Health Association.

Monitoring

Previously, the Minnesota Department of Health conducted an annual review to ensure that community health boards met the legal provisions of the Local Public Health Act, and that timely and accurate financial, staffing, and statistical data were submitted. The 2003 Local Public Health Act placed additional monitoring responsibilities on the commissioner to determine if community health boards are putting forth effort and making progress towards the statewide outcomes.

In this expanded function, the Minnesota Department of Health will monitor community health boards at several levels. The basic review contains most aspects of the compliance review that has been in place for many years, and adds a review of the performance measures, including a review of key indicators.

At subsequent levels of review, additional components include:

- notifying appropriate local officials throughout the accountability review process and meeting to discuss concerns; and
- developing a correction plan with follow-up to ensure successful implementation of that plan.

Community Health Board Reporting

One reporting issue pertains primarily to multi-county community health boards and the four city community health boards. Multi-county community health boards function differently around the state, which affects how the information is reported to the Minnesota Department of Health (i.e. is the reporting for an entire community health board or individual county). While the Local Public Health Act clearly states that *accountability* lies with the community health board, the current practice is to allow multi-county community health boards to choose how to submit data (as one entity or as separate counties). The choice of local reporting applies to the performance measures, the financial, staffing, and statistical report and the action plan.

The Work Group discussed the following factors to consider when developing a recommendation regarding local reporting.

- The usefulness of the data to community health boards, counties and cities, and the Minnesota Department of Health.
- The need to assure an accurate reflection of the relationship between the community health board and the local public health department.
- The need to provide enough detail in the reports that promote quality improvement within all entities making up the community health board.
- The need to document the availability and distribution of services and programs in all entities making up the community health board.
- The desire to avoid masking disparities and issues by aggregating data into one report from all entities of a community health board.
- The desire to support the community health board model that was put into place by the Minnesota Legislature in 1976.

Sanctions

The Local Public Health Act gives the commissioner of health the authority to withhold funds. It specifically states, "the commissioner may determine not to distribute funds to the community health board… for the next fiscal year." Sanctions can only be applied if the community health board is not documenting progress toward the statewide outcomes and has not taken the specific actions recommended by the commissioner.

The focus of the accountability review process is not to apply sanctions but to strengthen local public health through quality improvement. Sanctions are a last resort only after enhanced technical assistance and ongoing monitoring are unsuccessful in helping the local public health department to make progress towards fulfilling essential local public health activities.

Appeals

The accountability provisions of the Local Public Health Act state that a community health board may appeal the commissioner's decision to withhold funding. The Administrative Procedure Act outlines the procedure by which appeals can be made to an Administrative Law Judge. That procedure assures due process and allows for a hearing before an impartial party. The Minnesota Department of Health master grant contract for community health boards contains the following language:

If Grantee is dissatisfied with the decision of the State's Authorized Representative, Grantee's sole and exclusive remedy is an administrative hearing before an administrative law judge under the contested case procedures of the Minnesota Administrative Procedure Act (Chapter 14 of the Minnesota Statutes).

FRAMEWORK FOR THE ACCOUNTABILITY REVIEW PROCESS

The Work Group incorporated components of the local public health improvement process and all of the guiding principles to develop a recommended accountability review process. They also considered the legislative concepts of documenting *progress* and *effort put forth*. The resulting recommended process has three levels in addition to a probation period and an appeals mechanism. Technical assistance from the Minnesota Department of Health is an integral part of the accountability review process.

Level 1 Review

Level 1 is similar to the general compliance review, which has taken place in the past. After due dates for reporting and other documentation have passed, files are reviewed to ensure all documents have been submitted. Factors that will be considered during Level 1 include:

- ✓ Are the community health priorities for each area of public health responsibility on file within the 5-year cycle?
- ✓ Is a current action plan on file that addresses the essential local public health activities and community health issues?
- ✓ Were performance measures and financial, staffing, and statistical reporting completed accurately with minimal follow-up (e.g. clarifying telephone call)?
- ✓ Were Local Public Health Act Funding Assurances and Agreements submitted?
- ✓ Were other legal requirements of the Local Public Health Act met (i.e., the 75 percent required match for state portion and 50 percent for Title V portion, CHS administration, medical consultant, community health board requirements)?
- ✓ Are the key indicators from the performance measures met, if not:
    - Can concerns/issues be easily explained/addressed with minimal follow-up (e.g., telephone call to clarify)?
    - Are there extenuating circumstances (e.g., staffing shortages, funding mix, and resources)?
    - Are issues/concerns being addressed (e.g., the action plan describes improvements that will be made)?

If **YES** to all, a letter will be sent to the community health board chair acknowledging the successful completion of the accountability review process. The letter is carbon copied to the CHS Administrator and the lead public health staff person.

If **NO** to any, the community health board chair, CHS administrator, and the lead public health staff person receive a letter, including a timeline, noting areas that need follow up with additional Minnesota Department of Health monitoring. The community health board/local public health department moves to Level 2.

Level 2 Review

In Level 2, community health board/local public health departments will be offered enhanced technical assistance to address the issues/concerns identified in Level 1. Factors that will be considered during Level 2 review include the following:

- ✓ Are steps being taken to address concerns identified in Level 1 review (e.g., the action plan describes improvements that will be made)?
- ✓ Is enhanced technical assistance being utilized by the community health board/local public health department?

If **YES** to all, a letter is sent to the community health board chair encouraging the need to continue to make progress in areas of issues/concerns, carbon copied to the CHS administrator and the lead public health staff person. The letter will include a timeline of activities and deadlines. Continued monitoring will take place to ensure that progress in addressing the issues is ongoing, or whether the problems are resolved.

If **NO** to any, a letter is sent to the community health board chair and carbon copied to the CHS administrator and lead public health staff person stating a need for a meeting. The community health board/local public health department moves to Level 3.

Level 3 Review

The Minnesota Department of Health representatives meet with the CHS administrator, lead public health staff person, and appropriate local elected officials and community members to develop a formal **correction plan**. This plan must include a timeline. Again, enhanced technical assistance offered based on needs identified in the correction plan. Factors to be considered during a Level 3 review include the following:

- ✓ Did the community health board/local public health department develop a correction plan?
- ✓ Is the community health board/local public health department following through on activities in the correction plan?
- ✓ Is enhanced technical assistance being utilized by the local public health department?
- ✓ Is performance improving over time?
- ✓ Have issues of concern been successfully addressed?

If **YES** to all, the Minnesota Department of Health continues monitoring and offering technical assistance. A letter is sent to the community health board chair stating the necessity of continuing to make progress in areas of issues/concerns. The letter is carbon copied to the CHS administrator and the lead public health staff person.

If **NO** to any, the commissioner provides formal written notification to community health board chair, which is carbon copied to CHS administrator and to the lead public health staff person; it recommends specific action that must be taken within the next twelve months (one-year probation) to maintain eligibility for the local public health grant.

Probation Period

The probation period begins with written notification from the commissioner specifying actions that must be taken to maintain funding. Factors to be considered during the probation period include:

- ✓ Did the community health board/local public health department develop a correction plan?
- ✓ Is the community health board/local public health department following through on activities in the correction plan?
- ✓ Is enhanced technical assistance being utilized by the local public health department?
- ✓ Is performance improving over time?
- ✓ Have issues of concern been successfully addressed?

The commissioner determines whether to distribute funds based on corrective actions taken during the 12-month period.

If the commissioner **determines to distribute funds** for the next fiscal year, ongoing enhanced technical assistance and monitoring will be continued until the community health board/local public health department has returned to functioning at Level 1.

If the commissioner **determines not to distribute funds** for the next fiscal year, the community health board/local public health department may appeal.

RECOMMENDATIONS

These recommendations address issues of purpose, structure and implementation of the accountability review process. The Work Group recommends that:

10. *The accountability review process outlined in this report should be adopted as a way to ensure accountability, while at the same time maintaining a strong focus on, and incentives for, quality improvement.* The Work Group views the proposed process as striking the appropriate balance between accountability and quality improvement. The process contains a component of rehabilitation, which is consistent with the guiding principles. The fact that the process was developed by a SCHSAC work group reinforces the strong partnership and thirty-year history of jointly developed policies and guidelines.

11. *The accountability review process should be implemented following the submission of reporting data in March 2008*. The initial five-year cycle following the 2003 changes to the Local Public Health Act has been viewed as a time to develop and pilot test the various components of the retooled system. Implementing the provisions in 2008 allows time for local public health departments to assess their capacity to perform essential local public health activities and develop an action plan, while still allowing for review/evaluation of the process during the initial five-year cycle.

12. *The Minnesota Department of Health should continue to provide technical assistance to all community health boards/local public health departments*. Ongoing technical assistance must

remain available to all local public health departments. The enhanced technical assistance is for those in Levels 2 and 3 and the probation period.

13. *The Minnesota Department of Health should offer technical assistance to meet the changing needs of community health boards/local public health departments.* New public health issues arise with relative frequency. It will be important for the Minnesota Department of Health staff to provide technical assistance in new and emerging areas to support local efforts.

14. *The Minnesota Department of Health, in partnership with the State Community Health Services Advisory Committee, and other partners, should work to identify the amount of funding needed to perform essential local public health activities throughout the state*. Without such an estimate, it is difficult to determine what the "gap" is between current capacity and the goal of local public health departments statewide fully performing essential local public health activities.

15. *The accountability review process and other components of the quality improvement system developed following the 2003 statutory changes should be reexamined in 2010 by the Minnesota Department of Health and the State Community Health Services Advisory Committee.* It will be important to gain experience in implementing the various components of the re-tooled local public health system, including the accountability review process. These components/processes should be viewed as works in progress and reviewed periodically to incorporate modifications and improvements as needed.

16. *The current practice of allowing multi-county community health boards to report as one entity or as individual counties within the community health board should continue. However, the performance measures and the financial, staffing, and statistical report must be reported in the same manner*. Allowing the decision on how to report to be made at the local level provides flexibility to accommodate the different ways community health boards work.

17. *The State Community Health Services Advisory Committee and the Minnesota Department of Health should stay apprised of the national discussion on accreditation of local public health departments and ensure that Minnesota's quality improvement process positions local public health departments for voluntary accreditation, if a national accreditation program is developed*. The development of Minnesota's essential local public health activities and performance measures was based on national work, including the National Association of County and City Health Officials (NACCHO) operational definition of a local public health department. The National Performance Standards and other state performance measures and accreditation programs were also reviewed and relevant elements were incorporated. Every effort has been made to ensure that local public health departments are well positioned to participate in any future voluntary accreditation programs. This proactive stance should be continued.

18. *The 2008 Assurances and Agreements and the CHS Administration Handbook should be updated to reflect the six areas of public health responsibility, the essential local public health activities, the new planning components, the performance measures, and the accountability review process.* This will take that work to the next level, incorporating it into the general practices of local public health.

APPENDIX A:
ESSENTIAL LOCAL PUBLIC HEALTH ACTIVITIES

Essential Local Public Health Activities

Assure An Adequate Local Public Health Infrastructure

IN1. Maintain a local governance structure for public health, consistent with state statutes.

IN2. Assess and monitor community health needs and assets on an ongoing basis for each of the 6 areas of public health responsibility in this framework.

IN3. Identify community health and prevention priorities every five years with input from community members and key partners, including communities of color, tribal representatives and special populations, ensuring that community wisdom and cultural diversity are used to understand and interpret qualitative and quantitative information.

IN4. Every five years, develop an action plan with evaluation measures and recommended policy options to address essential local activities and local priorities.

IN5. Convene community members and key community partners, including communities of color, tribal representatives and people with special needs to build community collaborations, determine roles, identify and leverage community assets/resources and participate in research that benefits the community, as resources allow.

IN6. Advocate for policy changes needed to improve the health of populations and individuals.

IN7. Lead or participate in efforts to foster healthy physical, economic, and social environments (e.g., participate in community improvement and development decisions).

IN8. Provide annual information to MDH to evaluate progress toward statewide outcomes and local priorities, and to meet federal reporting requirements.

IN9. Meet personnel requirements for the CHS Administrator and the Medical Consultant.

IN10. Designate, recruit, train and retain local public health staff so that every local agency has appropriate expertise in each of the 6 areas of public health responsibility.

IN11. Recruit local public health staff that culturally and ethnically reflect the community served.

Promote Healthy Communities and Healthy Behaviors

HC1. Engage the community on an on-going basis to promote healthy communities and behaviors through activities including but not limited to (a) assessment, prioritization and developing action plans, (b) coalition building, (c) community readiness, (d) empowerment, and (e) decision making.

HC2. Based on community assessment, resources, and capacity, develop action plans to promote healthy communities, healthy behaviors (e.g., physical activity, nutrition, tobacco, alcohol and other drug use, unintentional pregnancy, HIV/AIDS/STD), mental health, maternal and child health, and the prevention of injury and violence.

HC3. Conduct evidence-based, culturally sensitive programs, and disseminate information on services and resources to promote healthy communities and healthy behaviors (e.g., physical activity, nutrition, tobacco, alcohol and other drug use, unintentional pregnancy, HIV/AIDS/STD), mental health, maternal and child health, and the prevention of injury and violence.

HC4. Inform and educate different audiences, e.g., general public, providers and policy leaders, about healthy communities and population health status.

HC5. Support the development and enforcement of policies, and encourage cultural norms that promote healthy communities.

HC6. Participate in decisions about community improvement and development to promote healthy communities and healthy behaviors.

HC7. Promote the optimum quality of life, e.g., healthy growth, development, aging, and management of chronic diseases across the lifespan.

HC8. Identify and address the needs of vulnerable populations e.g., high-risk pregnant women, mothers, children, frail elderly, persons with mental illness and people experiencing health disparities.

Prevent the Spread of Infectious Disease

ID1. Work with providers and other community partners to facilitate infectious disease reporting and address problems with compliance.

ID2. Assess immunization levels and practice standards, and promote/provide age appropriate immunization delivery.

ID3. Assess infectious disease risks in jurisdiction, apprise community of risks and assure appropriate interventions.

ID4. Based on surveillance data, develop strategies and plans to detect and respond to infectious disease problems and outbreaks within jurisdiction/region.

ID5. Assist and/or conduct infectious disease investigations with MDH.

ID6. When surveillance detects an imminent threat of infectious disease outbreak or epidemic, implement appropriate local disease control programs, including but not limited to mass treatment clinics, mass immunizations clinics, and isolation and quarantine.

Protect Against Environmental Health Hazards

EH1. Provide the general public and policy leaders with information on health risk, health status, and environmental health needs in the community as well as information on policies and programs regarding environmental health threats to humans.

EH2. Identify the federal, state, tribal or local agencies with regulatory authority and bring people together to address compliance with public health standards.

EH3. Develop public health nuisance policies and plans, and assure enforcement of public health nuisance requirements.

EH4. Monitor the community for significant and emerging environmental health threats, and develop strategies to address these threats.

Prepare For and Respond To Disasters, and Assist Communities in Recovery

EP1. Provide leadership for public health preparedness activities in the community by developing relationships with community partners and tribal governments at the local, regional, and state levels.

EP2. Conduct or participate ongoing assessments to identify potential public health hazards and the capacity to respond.

EP3. Develop, exercise and periodically review comprehensive plans for all threats to the public's health.

EP4. Participate in surveillance and monitoring activities to detect patterns of unusual events; implement appropriate actions.

EP5. Participate in an all hazard response and recovery.

EP6. Develop and maintain a system of public health workforce readiness, deployment and response.

EP7. Develop and implement a system to provide timely, accurate and appropriate information in a variety of languages for elected officials and the public, the media, and community partners, including tribal governments in the event of all types of public health emergencies.

Assure the Quality and Accessibility of Health Services

HS1. Identify gaps in the quality and accessibility of health care services.

HS2. Based on the on-going community assessment, inform and educate the public and providers on issues related to the quality and accessibility of health care services in the community.

HS3. Lead efforts to establish and/or increase access to personal health services, including culturally competent preventive and health promotion services, as identified in the planning process.

HS4. Promote activities to identify and link people to needed services.

To see the complete framework with statutory references and examples of the kinds of programs that fit in each activity, please see http://www.health.state.mn.us/divs/chs/framework.html

APPENDIX B:
MINNESOTA'S LOCAL PUBLIC HEALTH QUALITY IMPROVEMENT SYSTEM

<table>
<tr><th colspan="6">Minnesota's Local Public Health Quality Improvement System</th></tr>
<tr><td>Goals</td><td colspan="2">Healthy People 2010</td><td colspan="3">Healthy Minnesotans Goals</td></tr>
<tr><td>Standards</td><td colspan="2">National Accreditation Standards (future)</td><td colspan="2">Areas of Public Health Responsibility</td><td>Essential Local Public Health Activities (ELAs)</td></tr>
<tr><td>Community Health Assessment and Action Planning (CHAAP)</td><td colspan="2">Activities to Improve Community Health Issues
✓ Community assessment and priority-setting
✓ Planning to address community health issues</td><td colspan="3">Activities to Improve Performance of Essential Local Public Health Activities
✓ Capacity assessment and priority-setting
✓ Planning to improve performance of Essential Local Public Health Activities</td></tr>
<tr><td>Measures</td><td>Inputs</td><td>Outputs</td><td>Process Measures</td><td>Intermediate Outcomes</td><td>Statewide Outcomes</td></tr>
<tr><td>Performance & Accountability</td><td colspan="5">Local Public Health Planning & Performance Measurement Reporting System (LPH PPMRS)
Accountability Review Process</td></tr>
</table>

Goals

Healthy People 2010, released by the United States Department of Health and Human Services, provides a framework for prevention for the Nation. It is a set of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.

The *Healthy Minnesotans Public Health Improvement Goals* initiative is an evolving partnership which seeks to engage diverse segments of the community in working with the state and local government public health system to set agreed-upon goals and priorities; identify effective strategies to address these goals; clarify the complementary roles that each entity can play; and mobilize communities to work collectively to improve health.

Standards

A *national accreditation program* is being developed. Currently, the National Association of County and City Health Officials (NACCHO) and the Association of State and Territorial Health Officials (ASTHO) are coordinating this initiative. Building on the experience of professionals at every level of public health practice, the *Exploring Accreditation* project will make recommendations regarding how a voluntary national accreditation program for state and local health departments could be established and whether to move forward on a collaborative basis with implementation.

The six *areas of public health responsibility* (Table 1) each have a set of essential local public health activities needed to address that responsibility. These were created by the assuring essential local public health activities throughout the state work group.

Table 1. Area of Public Health Responsibility
Assure An Adequate Local Public Health Infrastructure
Promote Healthy Communities and Healthy Behaviors
Prevent the Spread of Infectious Disease
Protect Against Environmental Health Hazards
Prepare For and Respond To Disasters, and Assist Communities in Recovery
Assure the Quality and Accessibility of Health Services

The *essential local public health activities* are each grouped into one of the six areas of public health responsibility. Minnesotans should expect these activities from their local health departments no matter where they live. The essential local public health activities provide a consistent framework for describing local public health to state and local policy makers and the public. Created by the assuring essential local public health activities throughout the state work group, the 40 essential local public health activities are the foundation for ongoing measurement, accountability, and quality improvement (See Appendix F for essential local public health activities).

Community Health Assessment and Action Planning (CHAAP)

The *community health assessment and action planning* (CHAAP) process is based on the former Community Health Services (CHS) planning process. It contains activities to improve community health issues and to improve performance of the essential local public health activities. For more information on CHAAP, go to www.health.state.mn.us/trailhead/index.html.

Measures

Inputs are resources dedicated to or consumed by the program. This includes money, staff time, facilities, equipment, laws, regulations, and funders' requirements.

Outputs are the direct product of program activities. Examples include the number of brochures distributed, doses of vaccines delivered, percentage of births enrolled in a registry, and program outcomes.

Process measures describe the implementation of the essential local public health activities.

Intermediate outcomes describe the impact or result of implementing the essential local public health activities. These are often short-term results or outcomes.

Statewide outcomes are goals for improving the public's health as well as improving Minnesota's public health infrastructure. Local health departments work towards achieving the 32 statewide outcomes by performing the essential local public health activities. The process measures and intermediate outcomes connect the essential local public health activities and statewide outcomes by describing how implementing the essential local public health activities leads to short-or-intermediate results that eventually lead to achieving the statewide outcomes.

Performance and Accountability

The *local public health planning and performance measurement reporting system (LPH PPMRS)* describes key aspects of Minnesota's local public health system including activities, outcomes, funding, and staffing. It provides consistent and accurate information for ongoing evaluation, decision-making, and technical assistance to improve public health activities. It also meets the reporting requirements of Minnesota's Local Public Health Act and provides accountability for state and federal funds. The performance measures and financial, staffing, and statistical report are part of this system.

The accountability review process addresses the accountability issues as outlined in the 2003 Local Public Health Act. The act states "community health boards accepting local public health grants must document progress towards the statewide outcomes… to maintain eligibility to receive the local public health grant." The accountability review process promotes continuous quality improvement, offers an element of rehabilitation, and provides a positive opportunity to strengthen Minnesota's public health infrastructure.

APPENDIX C:
ANALYSIS OF FUNDING FOR MINNESOTA'S COMMUNITY HEALTH SERVICES SYSTEM

Analysis of Funding for Minnesota's Community Health Services System: A Working Paper of the Accountability Review Process Work Group

Community Health Services System Funding Mix

Before the historic changes of 1976, funding for local health departments was inconsistent and fragmented. It consisted of state dollars, given to implement specific programs, and local tax dollars, which addressed local needs. In 1976, the Community Health Services (CHS) Act created a system whereby state dollars in combination with local match[3] supported programs based on locally determined needs and priorities.

> *"Historically, public health programs at the community level have been financed primarily from local funds. The Act recognizes the significant responsibility of state government to encourage and facilitate the establishment and expansion of activities for the promotion and protection of human health through organized community efforts. The impetus provided by state financing is expected to result in the organization of local health boards throughout the state"* (excerpted from a memo from Warren R. Lawson, M.D. Commissioner to Health to Local Government Officials dated October 22, 1976).

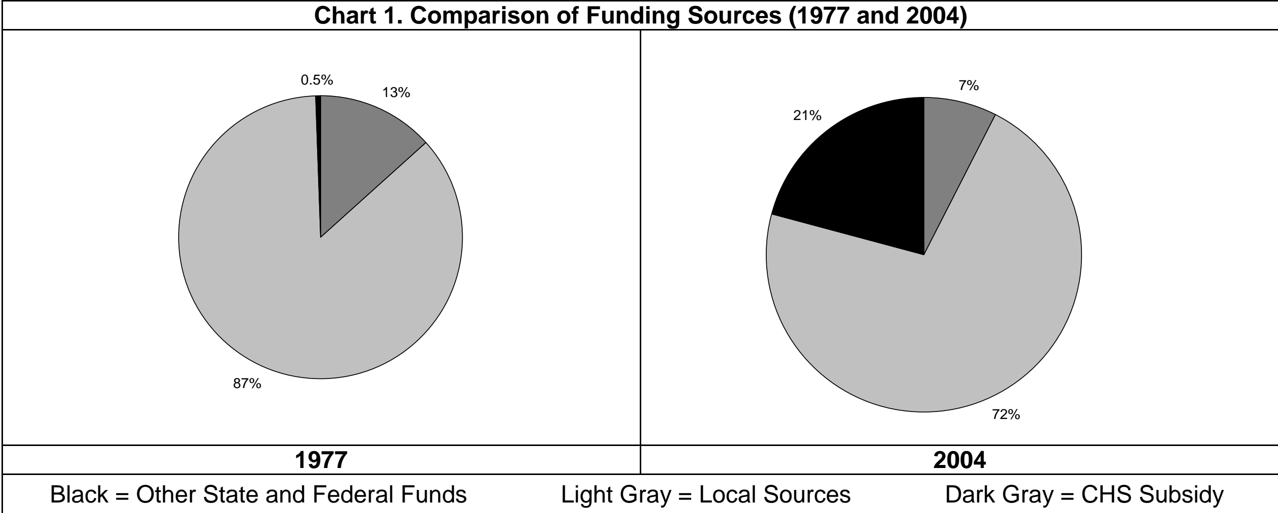
While the CHS subsidy supported local health department programs, it also provided an incentive to form a more efficient infrastructure. Because of the law, over 2,000 local boards of health combined to create community health boards. In 2006, there are 53 community health boards in Minnesota; this includes 91 county and city local health departments. Together, the CHS subsidy and required 75 percent match from locally generated funds provide ongoing financial support for local health departments.

In reviewing financial data submitted to the Minnesota Department of Health from local public health departments over the last 28 years, several CHS system funding trends can be identified.

1. Eligible local match has remained relatively stable over time and has consistently provided a majority of funding.

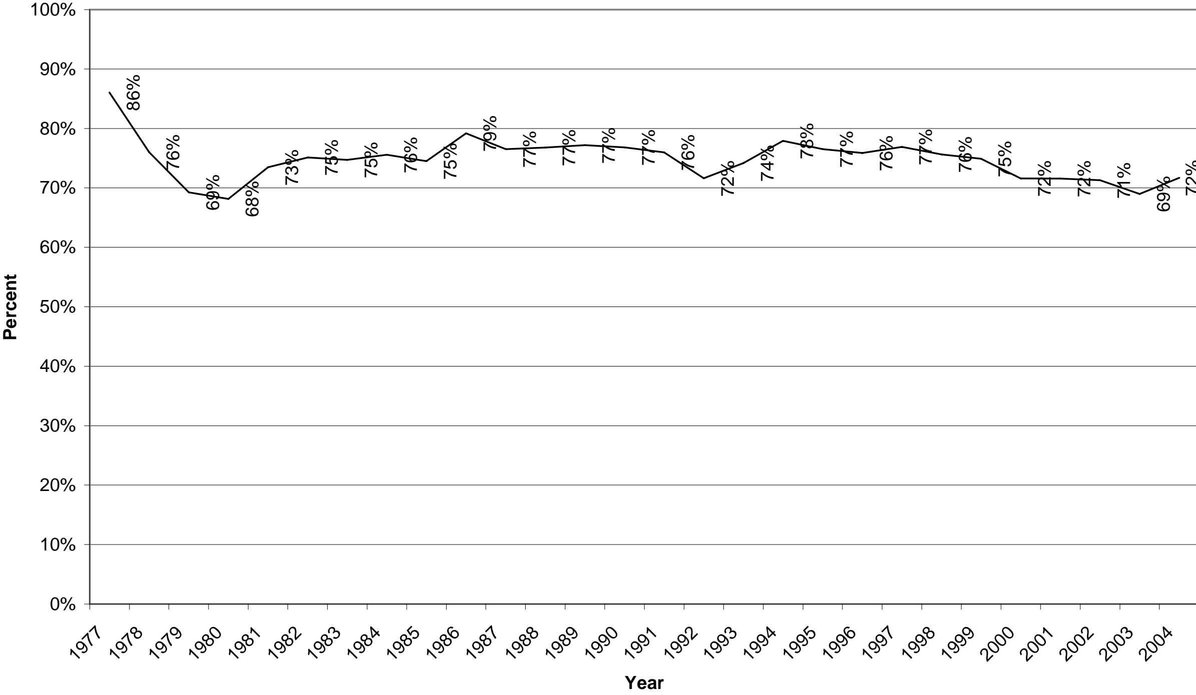
As noted in the 1976 memo from Commissioner Lawson (see box), locally generated funds made up a majority of expenditures when the CHS Act was passed. This remains true today. As highlighted in Chart 1, 86 percent of total expenditures in 1977 were from eligible local match. The remaining funding came from the CHS subsidy (13 percent) and other state and federal funds (0.5 percent). In 2004, 72 percent of total expenditures was eligible local match, 7 percent was the CHS subsidy (now the state portion of the Local Public Health Act funding), and 21 percent was other state and federal sources.

[3] For purposes of the CHS Act, eligible local match includes local tax levy, Medicaid, fees, local contracts and grants, private insurance, Medicare, other local sources, in-kind, and Veterans Administration.



Eligible local match has fluctuated only slightly throughout the years (Chart 2). It has been above 80 percent of total expenditures just once, in 1977. Since then it has dropped below 70 percent three times (1979, 1980, and 2003). In recent years, the eligible local match, as a proportion of total expenditures, has remained between 69 and 72 percent. The mean (average) and median (middle value) are both 75 percent.

Chart 2. Eligible Local Match as Percent of Total Local Public Health Expenditures (1977-2004)



2. The composition of eligible local match has fluctuated over time, with local tax levy proportions decreasing and Medicaid reimbursement increasing[4].

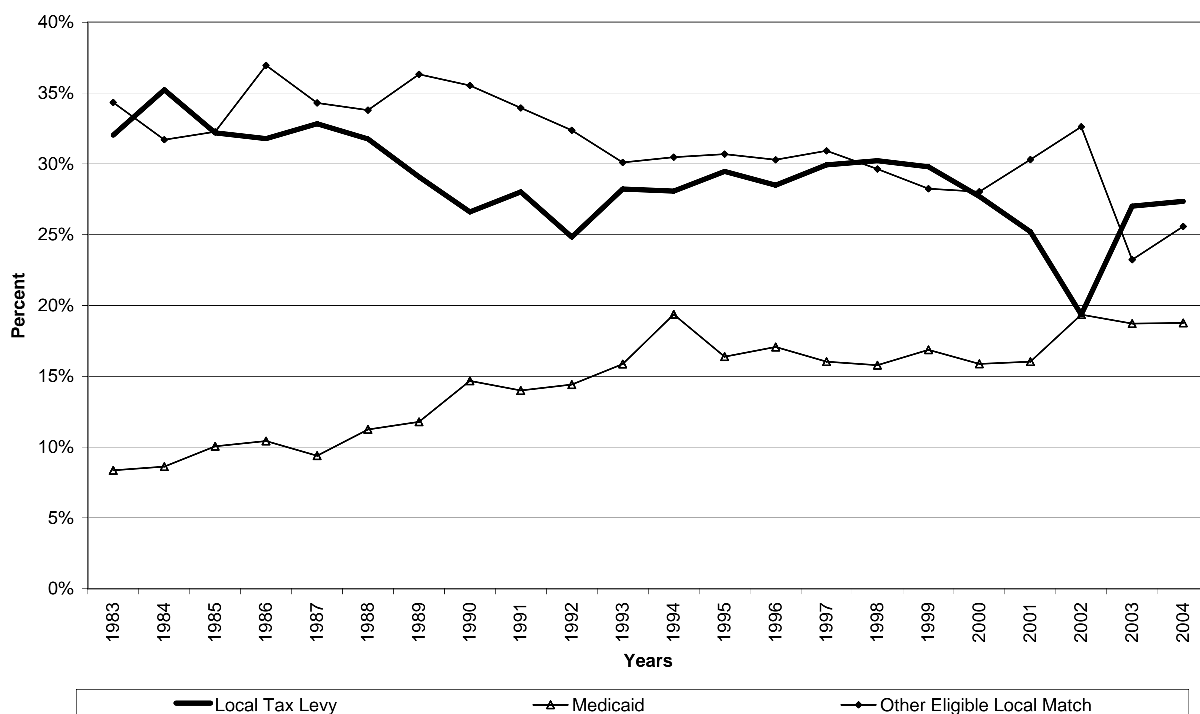
Eligible local match includes local tax levy, Medicaid, fees, local contracts and grants, private insurance, Medicare, other local sources, in-kind, and Veterans Administration. Throughout the years only local tax levy and Medicaid have been consistently tracked. Therefore, for analysis purposes, all other sources of eligible local match were placed into "other eligible local match" (Chart 3).

Local tax levy, the largest individual source of expenditures, as a percent of total expenditures has slightly declined. It has ranged from 35 to 25 percent, with one extreme outlier in 2002, at 19 percent. In 1979, local tax was 32 percent of total expenditures; in 2004, it was 27 percent. The mean (average) and median (middle value) was 30 percent.

Medicaid, the second largest individual source of expenditures, has been tracked since 1983. In 1983, it was eight percent of total expenditures ($6 million); today it is 19 percent of total expenditures ($53 million). The mean (average) was 14.5 percent and median (middle value) was 16 percent.

A majority of other eligible local match appeared to be fees, private insurance, and Medicare. Other eligible local match and local tax levy proportions have gradually decreased as Medicaid has increased.

Chart 3. Local Tax Levy, Medicaid, and Other Eligible Local Match as a Percent of Total Local Public Health Expenditures (1983-2004)



[4] In 2002, there were significant cuts to local government aid, which may account for the significant decrease in local tax levy allocated to local health departments.

3. Over time, the CHS subsidy has declined as a proportion of total expenditures.

In 1979, the CHS subsidy was at its highest proportion of total expenditures, 20 percent (Chart 4). For the next ten years, the subsidy as a proportion of total expenditures decreased. The last 15 years, 1989-2004, the subsidy has been between six and nine percent of total expenditures. The mean (average) was ten percent and the median (middle value) was nine percent.

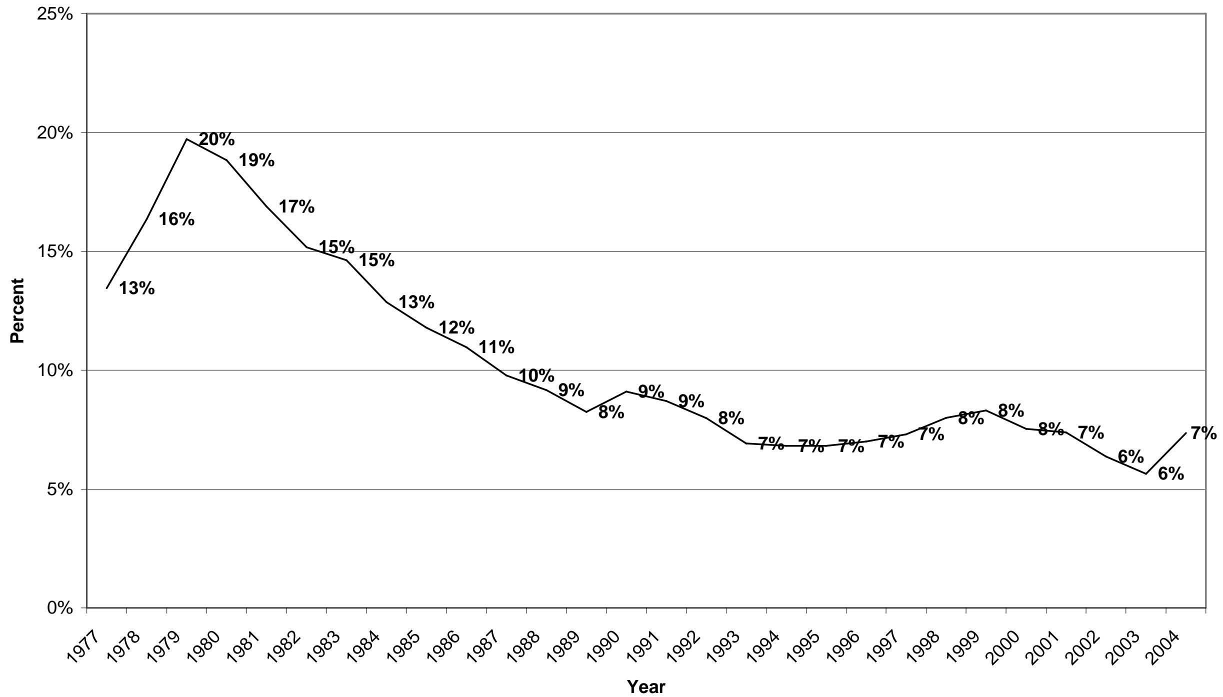
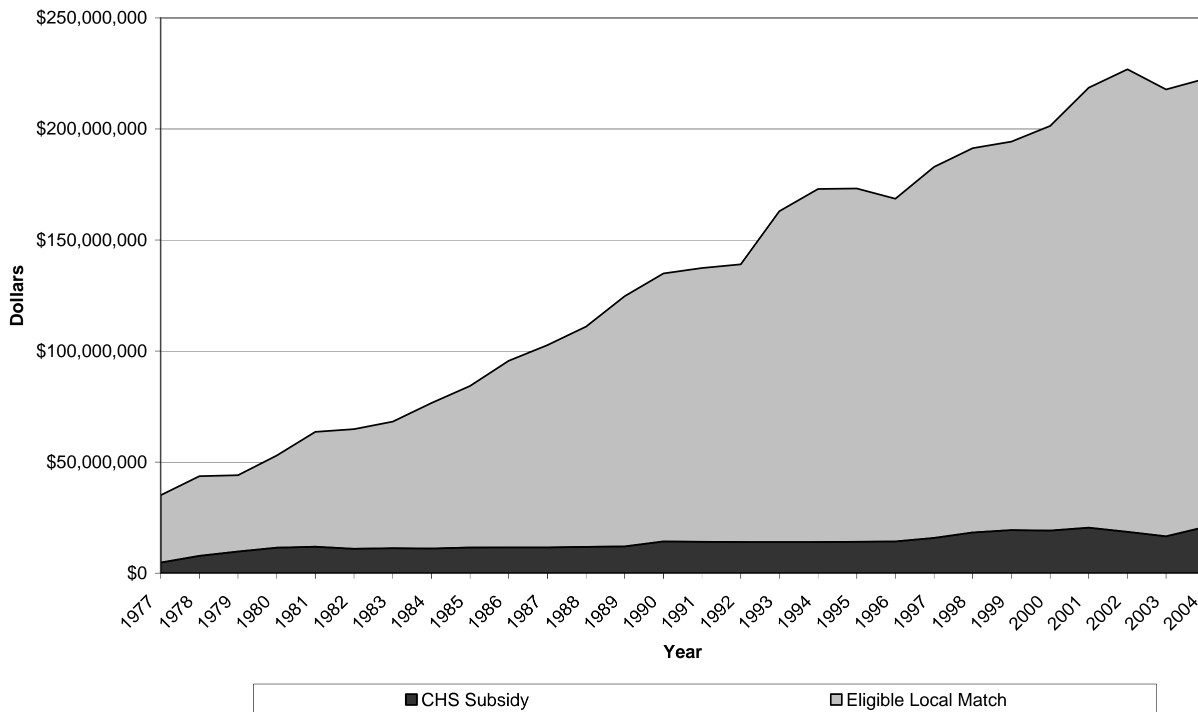


Chart 5 contrasts the CHS subsidy and the eligible local match. In 1977, the eligible local match was six times more than the CHS subsidy. By 2004 the eligible local match was almost ten times more that the CHS subsidy.

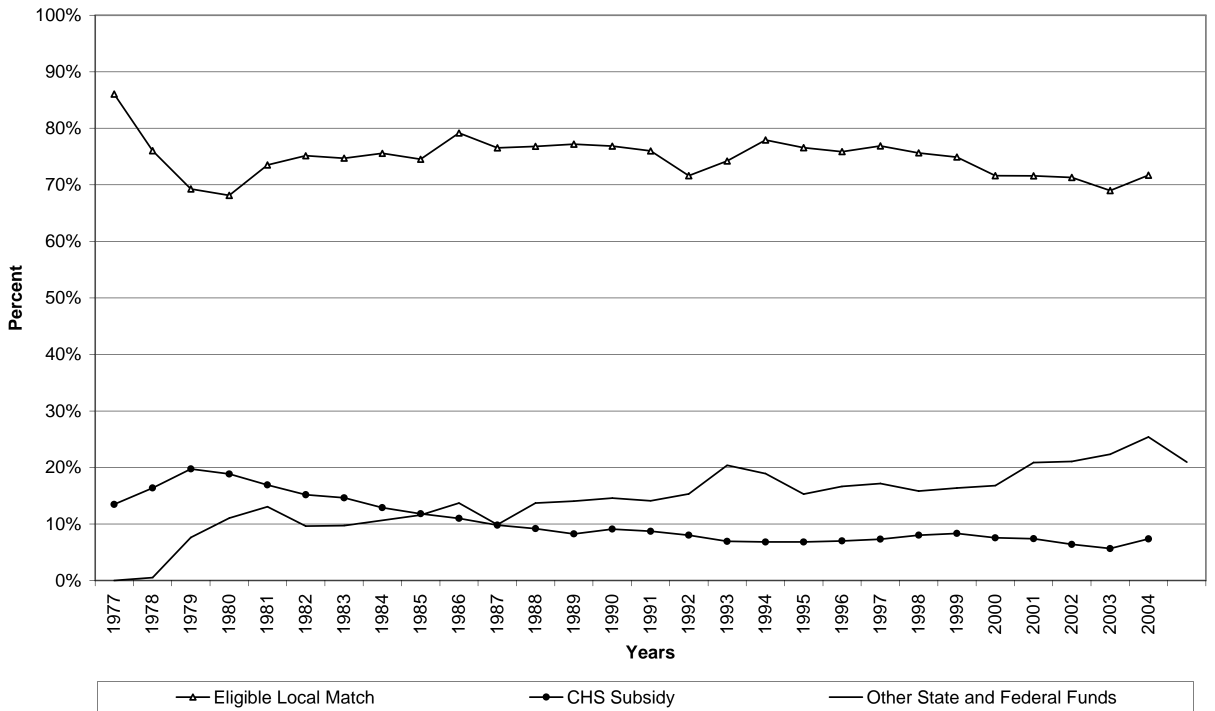


4. Other state and federal funds as a proportion of total expenditures increased in the last three decades.

In 1977, 0.5 percent or $173,710 total expenditures were other state and federal funds (Chart 6). In 2004, 20.9 percent or $59 million of total expenditures were other state and federal funds, largely categorical grants. The other state and federal funds category has been larger than the CHS subsidy since 1985. This increase is likely due at least in part to a shift towards categorical grants at both the federal and state levels. The decreases in the proportions of CHS subsidy and eligible local match were partly a result of increase in other state and federal funds (Chart 7).

Chart 6. Other State and Federal Funds as a Percent of Total Local Public Health Expenditures (1977-2004)

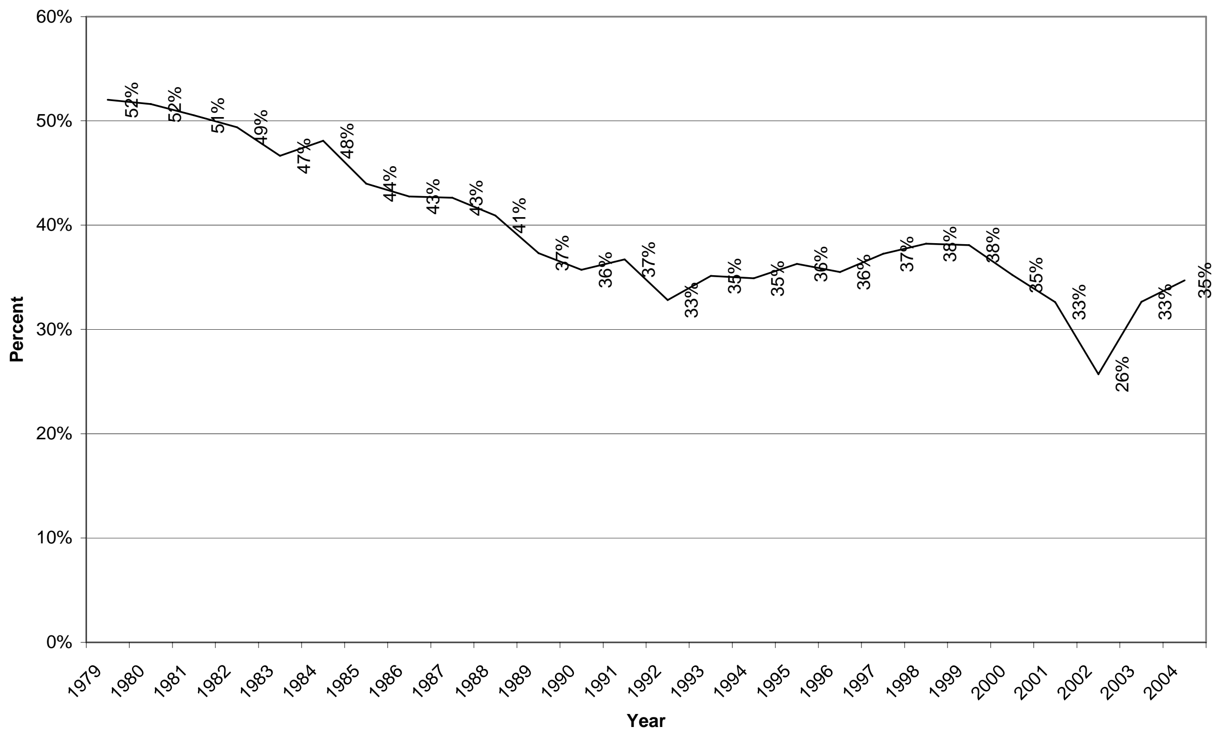
Chart 7. Funding Sources as a Percent of Total Local Public Health Expenditures (Eligible Local Match, CHS Subsidy, Other State and Federal Funds; 1977-2004)



5. Flexible funding as a proportion of total expenditures has decreased.

The CHS subsidy and local tax levy are “flexible funding,” as these two funding sources are not associated with contracts, categorical grants, or reimbursements. The proportion of this type of funding has decreased from 52 percent in 1979 to 36 percent in 2004 (Chart 8). This is significant because it represents fewer funds used at the discretion of local health departments.

Chart 8. Flexible Funding as a Percent of Total Local Public Health Expenditures (1979-2004)



Discussion Points

The work group discussed funding in relation to the essential local public health activities and accountability for performing the essential local public health activities. The following are points from these discussions.

- The funding of local health departments is increasingly complex. Funding for local health departments come from local, state, and federal sources. These sources vary over time; as one funding stream decreases local health department’s dependency on the other funding streams increases. Local health departments have become very adept at filling gaps and leveraging all possible resources. This has resulted in an increasingly complex mix of funding streams. For example, it is common for a small local health department to have 15 or more funding sources or for a single program to have more than one funding source (see example). The administrative aspects of local health departments have grown increasingly time-consuming, as each grant or funding source can require its own budget, reporting, requirements, grant writing, and work plans.

Example of Complex Funding Sources for Single Program
Child Passenger Safety Program, Sherburne County Public Health Department

In 2005, the Child Passenger Safety Program in Sherburne County was supported by ten funding sources. Three health plans contracted with the public health department to provide education. Two of these health plans contracted to distribute car seats. More car seats were obtained through a grant from the Department of Public Safety and through funds from the Ford Foundation. More education was funded through a grant from National Safe Kids. Client donations and training fees also funded the program. In addition, staff time (not covered by any of the other sources) was paid for through local tax dollars.

- State and local health departments agree that the essential local public health activities should be available to all Minnesotans no matter where in the state they live. In the words of a previous SCHSAC work group, "the essential local public health activities are the basic, indispensable, and necessary activities that all local public health departments in Minnesota do to protect and promote the health of all Minnesotans." This is a shared vision from the work of the *Assuring Essential Local Public Health Activities Throughout the State Work Group.*

- There is a general agreement that current funding levels are not sufficient for all local health departments to perform all essential local public health activities. However, the work group acknowledges that funding is not the only factor influencing local health departments' performance of the essential local public health activities. Local health departments may be very effective in fulfilling the essential local public health activities despite having fewer resources. Workforce, leadership, skill sets, working environment, community support and collaboration, and support from local elected officials all play important roles in a health department's effectiveness.

- The ELAs will not be redefined from year to year. However, funding sources and the amount of funding available for the essential local public health activities vary from year to year.

- There is agreement that the state funding and required eligible local match should be used to support the essential local public health activities. A previous SCHSAC workgroup recommended, "Performing the essential local public health activities must be the first priority of the Local Public Health Act funding and required local match." The work group also stated, "The cost of providing the public health services is shared by federal, state, and local governments. Therefore, a variety of funding sources will contribute to paying for the essential local activities."

- There currently is limited methodology to determine the funding level needed to fulfill the essential local public health activities or what funding mix is appropriate. It is assumed that funding for the ELAs may be different for every local health department due to local circumstances and community need.

- There is not a consensus on how the essential local public health activities should be funded (i.e., what share local, state, and federal government each should pay).

APPENDIX D:
STATEWIDE OUTCOMES

Statewide Outcomes for the Local Public Health Act

Assure an Adequate Local Public Health Infrastructure

1. Increase the number of Community Health Boards that assess health disparities and the social conditions that underlie health and address them in their action plans.

2. Increase the number of Community Health Boards that perform 100% of the essential local public health activities.

3. Increase the number of Community Health Boards that have designated staff with knowledge and experience in:

    - Maternal and child health/family health
    - Public health administration and management
    - Infectious diseases
    - Health promotion
    - Environmental health
    - Emergency preparedness
    - Risk communications

Promote Healthy Communities and Healthy Behaviors

4. Decrease the percentage of adults ages 18 and older who are overweight or obese.

5. Increase the percentage of adults ages 18 and older who are physically active.

6. Increase the percentage of youth in 9th grade who are physically active.

7. Decrease the percentage of children ages 2-5 who are overweight.

8. Decrease the percentage of adults ages 18 and older who smoke cigarettes.

9. Decrease the percentage of youth in 9th grade who smoke cigarettes.

10. Decrease the percentage of adults ages 18 and older who binge drink.

11. Decrease the percentage of youth in 9th grade who use alcohol.

12. Decrease the percentage of youth in 9th grade who use marijuana.

13. Decrease the rate of births/pregnancies to adolescents ages 15-17.

14. Decrease the rate of suicides.

15. Decrease the rate of hospital-treated self-inflicted injuries.

16. Increase the screening for mental health needs for adolescents, children with special health needs, and pregnant and postpartum women.

17. Decrease the rate of very low birth weight infants among all live births.

18. Increase the percentage of children ages 0-3 who are screened for developmental and social –emotional issues every 4-6 months.

19. Decrease the rate of persons killed and injured in motor vehicle crashes.

20. Decrease the rate of hospital admissions for falls in persons aged 65 and older.

21. Decrease the rate of maltreatment and sexual assault of children ages 0-17.

Prevent the Spread of Infectious Disease

22. Decrease the spread of active tuberculosis (TB) disease.

23. Increase the number of vulnerable adults immunized for influenza.

24. Increase the percentage of 2-year olds that have been age appropriately immunized.

25. Decrease the incidence of Chlamydia.

26. Decrease the incidence of HIV infection.

Protect Against Environmental Health Hazards

27. Increase the percent of public health nuisances that were abated.

28. Decrease the average number of foodborne illness risk factors per establishment.

29. Increase the number of CHBs that assessed the status of drinking water quality.

Prepare for and Respond to Disasters, and Assist Communities in Recovery

30. Increase the number of Community Health Boards that have a local public health department emergency operations plan that is exercised and updated annually.

Assure the Quality and Accessibility of Health Services

31. Increase the participation rate of Medical Assistance and MinnesotaCare enrolled children aged 0 to 21 in the Child and Teen Check-Up Program.

32. Increase the number of pregnant women receiving early and adequate prenatal care.

33. Increase the percentage of families of children with special health care needs ages 0-18 that partner in decision-making at all levels and are satisfied with services they receive.

34. Increase the percentage of children with special health care needs ages 0-18 whose families report that community-based service systems are organized for easy use.

35. Increase the number of clients who are enrolled in health insurance programs.

APPENDIX E:
KEY INDICATORS

2006 Key Indicators

Assure An Adequate Local Public Health Infrastructure

1) The CHB has reviewed, signed and returned the assurances and agreements document provided by the MDH.

   ○ Yes
   ○ No

2) The composition of the CHB meets the requirements required by MS 145A.03, subd. 4.

   ○ Yes
   ○ No

3) The CHB met at least twice during the past year as required by MS 145A.03, subd. 5.

   ○ Yes
   ○ No

4) The CHB has in place written procedures for transacting business and has kept a public record of its transactions, findings, and determinations as required by MS 145A.03, subd. 5.

   ○ Yes
   ○ No

5a) The CHB has appointed an agent as required by MS 145A.04, subd. 2.

   ○ Yes
   ○ No

5b) The agent's name, title and address are:

   Name:
   Title:
   Address:
   Phone:
   Email:

6) Check all that apply:

   □ The CHB serves a population of more than 30,000
   □ The CHB serves three or more contiguous counties
   □ The Human Services Board has assumed the powers and duties of a CHB
   □ The CHB met statute requirement when formed

7) The CHB has a CHS Administrator who meets the requirements of Minnesota Rule 4736.0110 (note: these requirements pertain to CHS Administrators who were appointed after March 21, 1994).

   ○ Yes
   ○ No
   ○ CHS Administrator was appointed before March 21, 1994

8) The CHB has a medical consultant in accordance with MS 145A.10, subd 3.

   ○ Yes
   ○ No

9) The public health department or CHB designated staff with knowledge and experience in the following areas to serve as contact(s) to the MDH:

   Public Health Administration and Management
   Health Promotion
   Infectious Diseases
   Environmental Health
   Emergency Preparedness
   Risk Communications
   Maternal and Child Health/Family Health

10) List the year that the community health assessment and the action plan were updated in each of the six areas of public health responsibility. If the community health assessment was updated all at once (not by each area of public health responsibility), enter the year (199X or 200X) it was updated in each row.

Areas of Public Health Responsibility	Year Community Health Assessment Was Last Updated	Year Action Plan Was Last Updated
Assure an adequate local public health infrastructure		
Promote healthy communities and healthy behaviors		
Prevent the spread of infectious disease		
Protect against environmental health hazards		
Prepare for and respond to disasters, and assist communities in recovery		
Assure the quality and accessibility of health services		

20a) The public health department has trained, designated staff to provide risk communication to the public about real or perceived public health concerns.

- ○ Yes
- ○ No

20b) If yes to 20a, how many trained staff? [text box 10 characters or less]

23) Administrator/Director and management staff reviewed the Culturally and Linguistically Appropriate Services (CLAS) standards.

- ○ Yes
- ○ No

Promote Healthy Communities and Healthy Behaviors

The local public health department does something in this area of public health responsibility.

Prevent the Spread of Infectious Disease

1) The public health department monitored and analyzed **infectious disease** risk, occurrence, and reporting to identify disease trends and reporting gaps.

- ○ Yes. If yes, describe the disease trends and reporting gaps you identified. (This question refers to the results of your analyses, not what you did to determine the trends or gaps.) Describe:
- ○ No. If no, check why not [check one]:
  - o Do not have staff capacity
  - o Do not have timely data
  - o Do not have jurisdiction specific data
  - o Another entity (e.g., district epidemiologist, another county) performs this function for our jurisdiction
  - o Other. Explain:

2) The public health department monitored and analyzed **immunization** data and practices to identify immunization trends and practice gaps.

- ○ Yes. If yes, describe the immunization trends and practice gaps you identified. (This question refers to the results of your analyses, not what you did to determine the trends or gaps.) Describe:
- ○ No. If no, check why not [check one]:
  - o Do not have staff capacity
  - o Do not have timely data
  - o Do not have jurisdiction specific data
  - o Another entity (e.g., district epidemiologist, another county) performs this function for our jurisdiction
  - o Other. Explain:

3) The public health department provided infectious disease and immunization information and education to **local providers** on pertinent topics.

○ Yes
○ No. If no, explain:

12) The public health department provided or contracted for directly observed therapy (DOT).
○ Yes
○ No, performed by another entity
○ No, no TB cases
○ No, TB case(s) or physicians refused DOT
○ No, agency does not provide DOT

14) The public health department identified, located, evaluated, and monitored contacts of infectious TB cases based on MDH/CDC standards.
○ Yes
○ No, performed by another entity
○ No, no infectious TB cases

Protect Against Environmental Health Hazards

34) The public health department has written policies and procedures for implementing the removal and abatement of public health nuisances specified in Minn. Stat. 145A.04 Subd. 8 and 145A.03 Subd. 17.
○ Yes
○ No

Prepare for and Respond to Disaster and Assist Communities in Recovery

1) The public health department kept primary contact information updated with the MDH.

○ Yes
○ No

2) The public health department updated the public health contact information in the local jurisdiction's Emergency Operations Plan (EOP).

○ Yes
○ No

6) The public health department has trained appropriate staff in the National Incident Management System (NIMS).

○ Yes
○ No

8) The public health department tested the notification and deployment system.

○ Yes
○ No

10) The public health department has an emergency response plan that includes how the public health department will communicate with the media and public.

○ Yes
○ No

Assure the Quality and Accessibility of Health Services

1) In the most recent community assessment, the public health department identified gaps in health care services or barriers to health care access in the following areas [**check all that apply**]:

□ Transportation
□ Lack of insurance (including, uninsured, underinsured, and uninsurable)
□ Income
□ Basic life needs (issues related to poverty, i.e., food, clothing, shelter)
□ Cultural competency of providers

<u>Lack of providers:</u>

□ Mental health providers (e.g., psychologists, psychiatrists)
□ Chemical health providers
□ Dental providers
□ Primary care providers
□ Specialists
□ Nurses

<u>Lack of services:</u>

□ Dental services
□ Family planning/sexual transmitted infections (STI) services
□ Emergency medical services (EMS)/urgent care services
□ Mental health services
□ Chemical health services
□ Supportive home services (e.g., respite care, adult day care, home care, chore services, foster care)
□ Jail/correctional health services
□ Nursing home services/assisted living services

<u>Other not listed:</u>

□ Other. Specify: [text box 5 words or less]

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