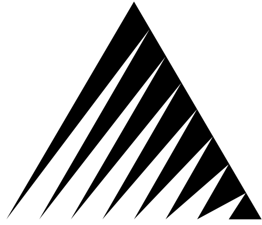

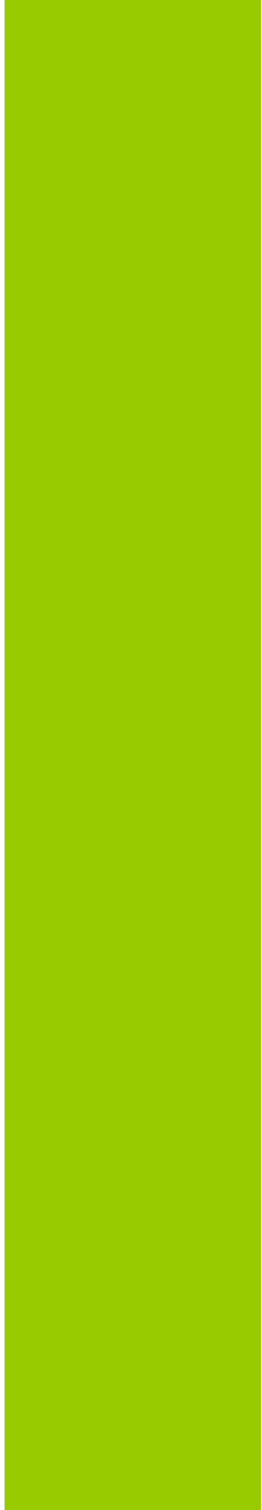

BUILDING A SOLID FOUNDATION FOR HEALTH:

A Report on Public Health System Development

Minnesota Department of Health
January 2009

Commissioner's Office
625 Robert Street North
PO Box 64975
St. Paul, MN 55164-0975
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Protecting, maintaining and improving the health of all Minnesotans

January 2009

Dear Colleague:

We are pleased to share with you *Building a Solid Foundation for Health: A Report on Public Health System Development for 2009*. The report was prepared to comply with Minnesota Statutes Chapter 62Q.33, which requires a biennial report on local public health system development.

We hope you find this report to be a clear and informative description of issues facing the public health system in Minnesota. The report outlines several areas that are currently being addressed, as well as changes that are needed to have an effective and efficient public health infrastructure to keep all Minnesotans healthy.

Today's public health system is operating in a rapidly changing environment. Meeting the challenges presented by those changes and the need to leverage better services to communities is both daunting and exciting. Working together, we can meet these challenges and ensure that Minnesota has a strong public health foundation for the twenty-first century.

If you have any questions, please contact Debra Burns at 651-201-3873.

Sincerely,

Sanne Magnan

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As requested by Minnesota statute 3.197:
This report cost approximately **$2,500** to prepare, including staff time, printing, and mailing expenses.
Upon request, this report will be made available in an alternative format, such as large print, Braille or cassette tape.

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Executive Summary

The responsibility for protecting and promoting the health of the public in Minnesota is shared among state and local governments. Minnesota's local public health system, known as Community Health Services (CHS), is designed to assure that the public's health and safety are protected while providing the flexibility local governments need to identify and address local priorities. The CHS system consists of 53 community health boards (CHB). Each CHB is comprised of one or more local health departments (e.g., city or county health department). A statutory advisory body called the State Community Health Services Advisory Committee (or SCHSAC) consisting of one representative of each of the 53 CHBs comes together regularly with the commissioner of health and key Minnesota Department of Health (MDH) staff to develop shared goals, clarify roles and work to build a consensus on issues affecting the state and local public health system.

The visionary goal for Minnesota's state and local public health system, developed by SCHSAC is, *"A strong and dynamic partnership of governments fully equipped to meet the changing needs of the public's health."*

A long history of working together, engaged local elected officials, well-qualified staff, and shared expectations favor collective progress. Yet several factors threaten further advancements, including:

- Reliance on multiple, categorical funding streams with time-consuming administrative requirements;
- Frequent and difficult-to-fill vacancies in the local public health workforce;
- Inconsistent capacity between some large and small jurisdictions;
- Difficulties using, managing and sharing information; and
- Emerging, large scale budgetary pressures that will require new and innovative strategies to preserve the strong foundation for public health protection and prevention that Minnesota's population currently enjoys.

Nonetheless, members of a 2008 SCHSAC strategic planning work group recognized opportunity amidst these challenges. They pointed out that the economic crisis will force people to think in new ways; may increase willingness to change; and will provide opportunities for improvement. An attitude of opportunity seeking by policymakers will serve Minnesotans well during these challenging times.

Actions are needed to enhance agility, and assure a resilient, sustainable and successful public health system into the future. These actions should be directed toward:

- Clear roles and effective communication about state and local public health responsibilities to protect and improve health;

- Sufficient, stable and flexible funding;
- Streamlined administrative processes;
- A ready and capable workforce from border to border;
- Supportive, effective, and efficient governing and organizational structures;
- Performance management and a culture of quality improvement; and
- Modernized public health information systems.

This report describes key aspects of the Minnesota's state and local public health system, and examines this set of strategic issues.

Introduction

This report was prepared to comply with Minnesota Statutes Chapter 62Q.33, which requires the commissioner of health to submit a biennial report to the legislature on local public health system development. This report describes Minnesota's public health infrastructure and examines several pivotal - or *strategic* - issues currently facing our local public health system. The issues presented here build upon those identified in the 2008-2013 strategic plan of the State Community Health Services Advisory Committee (a statutorily established advisory group of the commissioner of health that is comprised of one representative from each community health board). The report also reflects on-going dialogue within the public health system, between state and local governments, and with community partners regarding the current fiscal challenges and the need to seek new and innovative ways to fulfill government responsibilities for protecting and promoting the public's health.

Background: Minnesota's Public Health System

Minnesota has a strong foundation for a state and local public health partnership, which is established by state statute. The Community Health Services Act was first enacted in 1976 and was revised and replaced with the Local Public Health Act (Chapter 145A) in 1987. The Local Public Health Act was again revised in 2003 to modernize the public health system and streamline funding sources.

Responsibility for protecting and promoting the health of the public in Minnesota is shared among state and local governments. Minnesota's local public health system, known as Community Health Services (CHS), is designed to assure that the public's health and safety are protected while providing the flexibility local governments need to identify and address local priorities. The CHS system consists of 53 community health boards (CHB). Each CHB is comprised of one or more local health departments (e.g., city or county health department).

As noted in the box below, the responsibilities of the public health system are broad and foundational to the well-being of the public.

Six Areas of Public Health Responsibility

1. Assure an adequate public health infrastructure.
2. Promote healthy communities and healthy behaviors.
3. Prevent the spread of infectious disease.
4. Protect against environmental health hazards.
5. Prepare for and respond to disasters, and assist communities in recovery.
6. Assure the quality and accessibility of health services.

In 2003 and 2004, state and local public health partners collaboratively developed a set of basic activities (referred to as "essential local public health activities") that people in Minnesota should expect to receive from their local health department no matter where in the state they live. (See Appendix A for a complete list.) The six areas of public health responsibility and the essential local public health activities provide the framework for local public health in Minnesota.

Recent System Accomplishments

Following, is a brief list of actions taken by local health departments to accomplish the essential local public health activities (as reported in the Planning and Performance Measurement Reporting System for the year 2007).

- 97% of local health departments (LHDs) **provided vaccinations to children**. LHDs provide an important safety net for vaccinations for underserved populations.

- 41% of LHDs **provided direct observed therapy** (DOT) to patients with Tuberculosis (TB). They monitored a total of 369 clients. Given the recent outbreaks of TB in several counties, the number of clients monitored is expected to be higher for 2008.

- LHDs **investigated** 1,166 **public health nuisances**; of these 540 were confirmed. The top three public health nuisance complaints were garbage houses, mold and improper sewage disposal. LHD data shows that vacant properties are becoming an increasing concern.

- 100% of LHDs **promoted healthy communities** by addressing injury prevention, child growth and development, nutrition, and preventing unintended pregnancy.

- 100% of LHDs i**mproved their emergency response capabilities** through planning exercises, and by responding to public health issues in actual local emergencies - including the 35W bridge collapse, mass vaccination clinics for Hepatitis A and influenza, the Elbridge pipeline explosion, the Ham Lake Fire, blizzards, floods, and water supply contamination.

- 100% of LHDs helped **implement the Freedom to Breathe Act** smoke-free workplace requirements by providing training, materials and support to local business affected by the ban.

- Over 90% of LHDs worked to **improve the cultural competency of services** they offer. Improving cultural competency in public health and healthcare settings is an important strategy for eliminating health disparities. Actions taken include, using more interpreters, translating materials, hiring more diverse staff and conducting staff trainings.

- In 2006 (the most recent year data is available) there were 80 confirmed foodborne outbreaks in Minnesota, and nearly 1,300 confirmed cases of foodborne illness. LHDs assisted the MDH in **responding to foodborne outbreaks**, and worked to improve safe food handling practices in their communities.

Recent System Improvements

In recent years Minnesota's public health system has taken many steps to promote internal accountability and improve its own performance. State and local partners have had numerous accomplishments, including:

- Developed essential local public health activities;
- Implemented a revised community assessment and planning process;
- Delineated enhanced accountability review process to implement statutory requirements;
- Implemented a web-based local public health reporting system (called the "planning and performance measurement reporting system" or PPMRS); and
- Implemented statewide effort to integrate continuous quality improvement into public health practice.

Strategic Issues for Minnesota's Public Health System

In 2008, the State Community Health Services Advisory Committee (SCHSAC) built upon these achievements in its new, five-year strategic plan, which was inspired by this goal:

> ***The public health system in Minnesota is a strong and dynamic partnership of governments fully equipped to address the changing needs of the public's health.***

While it is evident that Minnesota has a strong and active public health system, it is also clear that the system faces multiple threats, as well as many opportunities for improvement.

Challenges and Opportunities

Current challenges faced by Minnesota's local public health system include:

- Reliance on multiple, categorical funding streams with time-consuming administrative requirements;
- Frequent and difficult-to-fill vacancies in the local public health workforce;
- Inconsistent capacity between some large and small jurisdictions;
- Difficulties using, managing and sharing information; and
- Emerging, large scale budgetary pressures that will require new and innovative strategies to preserve the strong foundation for public health protection and prevention that Minnesota's population currently enjoys

Yet, members of a 2008 SCHSAC Strategic Planning work group pointed out that the current economic crisis will force people to think in new ways, increase willingness to change, and provide opportunities for improvement. Similarly commissioner of health, Sanne Magnan, MD, PhD, recently posed the following challenge and questions to Minnesota Department of Health (MDH) staff regarding the projected state budget deficit:

> *"I want to ask that we be open to the opportunities ahead of us. What is possible in these hard times that would not have been do-able previously? How can we use this environment to focus attention on the important messages of public health and prevention?"*

Her questions are also very relevant for Minnesota's local public health system. Consider the following "opportunities" identified by local elected officials and local public health leaders during the recent SCHSAC strategic plan development process.

Opportunities for the CHS System: ***identified by SCHSAC, summer 2008***

- The economic crisis will force people to think in new ways. This also makes people more willing to change, which can provide opportunities for improvement—whether it is reshaping the public health system or change at an individual level such as increasing physical activity or quitting smoking.
- Community partners have a vested interest in public health outcomes. With fewer resources available, more groups are more likely to work together.
- There are increasingly large numbers of diverse populations in Minnesota, which compels us to seek ways to improve our cultural competence and provides opportunities to expand and improve the workforce.
- The current emphasis on healthcare transformation has led to renewed interest in cost-saving prevention activities (SHIP).
- The push toward electronic health records (ELR) shines a light on the current deficiencies and gaps in our technical capacity, but also provides opportunity for investment, improvement and streamlining of services.

The SCHSAC strategic plan is a blueprint for the future of Minnesota's public health system, and is a core resource for this report. The remainder of this document will describe seven broad strategic issues currently facing Minnesota's public health system, and explore the related challenges, and opportunities.

Strategic Issues for Minnesota's Public Health System:

- Clear roles and effective communication about state and local health public health responsibilities to protect and improve health;
- Sufficient, stable and flexible funding;
- Streamlined administrative requirements;
- A ready and capable workforce;
- Supportive, effective, and efficient governance and organizational structures;
- Modernized public health information systems; and
- Performance management and a culture of quality.

Strategic Issue 1: Clear roles and effective communication about state and local responsibilities to protect and promote health

The public generally understands the functions of a fire department, police department, or a school district. They understand that those services have important effects on their quality of life. Surveys indicate that the public values clean water, safe food, and swift, accurate responses to dangerous events such as disease outbreaks and disasters. Yet, most people have an incomplete understanding of the role that state and local health departments play in addressing those and other issues. Historically, this lack of awareness can lead to a scarcity of "champions" for public health resources, since policy makers work to meet the needs identified by the public.

The scarcity of public health champions may be due to several factors, including the following:

- Significant variations in the structure, function, and services of local health departments may result in a "lack of identity". Because Minnesota's local public health system has a high degree of local flexibility (something generally viewed as a positive attribute) there isn't a commonly understood image of a local health department.

- Although a few public health activities are highly visible, most are not.

  Many times the highly visible activities are individual services performed to address unmet community needs (e.g., providing home care) or to meet a population-based goal (e.g., vaccinating individuals to prevent disease in the population). However, when public health efforts are successful, they prevent events, diseases, or injuries from occurring and, are therefore, relatively unknown.

- In addition to focusing on prevention, public health responsibilities are primarily population-based, which is a difficult concept to explain and understand.

  A population-based approach is very different in its goals than a patient or client-based approach, which seeks to address individual needs. Characteristics of population-based programs, policies, and practice include:

  - A foundation on community need, which is determined through a systematic assessment of the health status of the whole population and community input;
  - Consideration of all members of a population that have the same risks, concerns, or characteristics;
  - Consideration of the broad determinants of health;
  - A strong prevention component; and
  - Reliance on all levels of intervention – interventions focused on whole communities, individuals, families, and on systems.

Over the last decade, local public health departments have greatly expanded their population-based focus. This expansion is based on sound scientific evidence, and is required by many important sources of local, state and federal funding.

The decision (by the Governor and the 2008 Minnesota Legislature) to provide funds for local health departments and tribes to use on policy, systems and environmentally-based obesity and tobacco prevention efforts, is an acknowledgement of the importance of investment in public health prevention activities as a strategy for promoting health and reducing health care costs. It is a vote of confidence in the value of good public health practice, and in the ability of local health departments to create change in their communities and in the state.

Minnesota's s public health system should build on that success and continue communicating with policymakers, partners and the public. It is likely that a deeper appreciation of public health services by the public, and an understanding of the population-based approach employed by public health, would help to mobilize attention and action to address the strategic issues outlined in this report.

Strategic Issue 2: Sufficient, stable and flexible funding

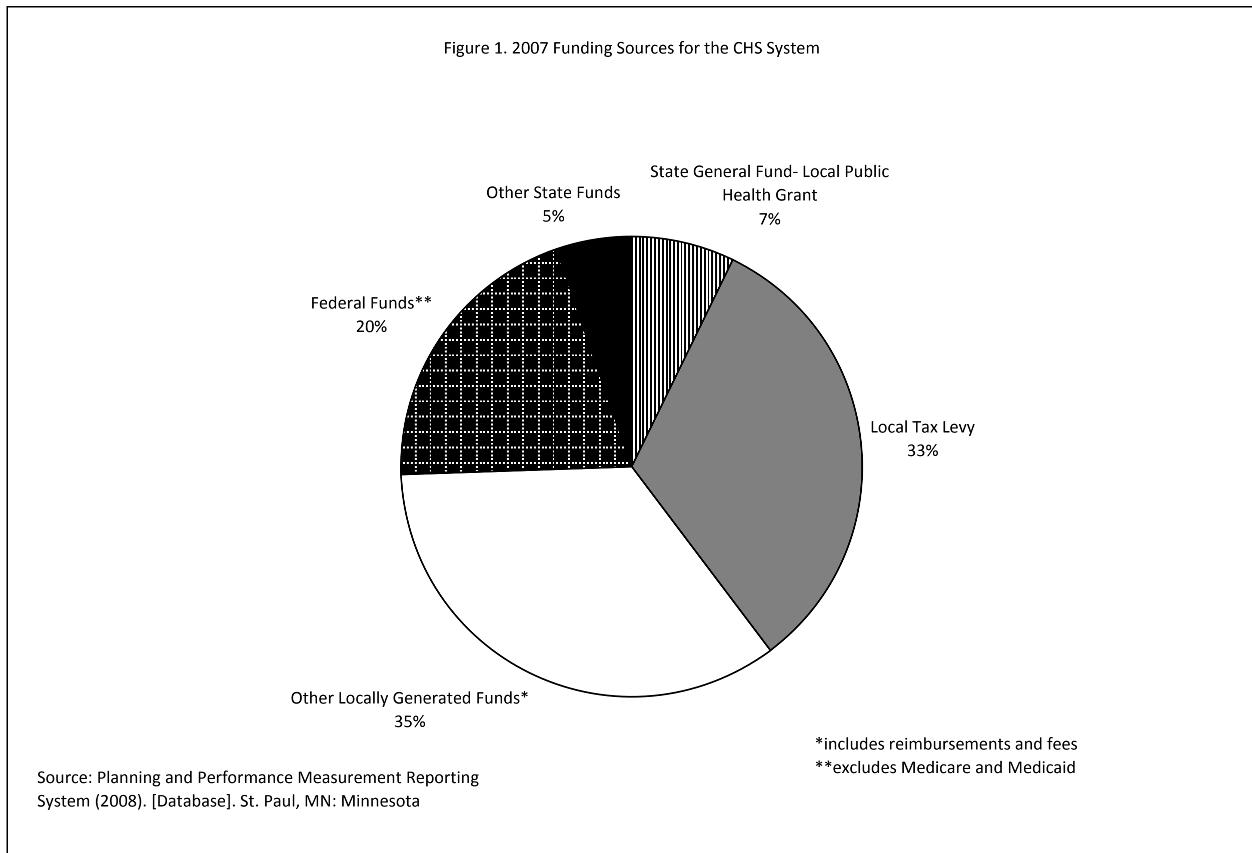
Minnesota's funding system for local public health services has been shaped by years of incremental decisions, many of which were tied to specific programs or resources. This has resulted in a complex combination of local, state, and federal funding sources; varied distribution formulas; and categorical restrictions that may or may not align with local need. There are few sources of relatively flexible funding available to meet community needs. Time-limited competitive grants have proliferated, thereby adding layers of complexity to an already fragmented funding structure for local public health activities. The current mix of funding sources and parameters delivers inconsistent support across jurisdictions.

Current Expenditures

Each year, local health departments submit expenditure data to the MDH. Total expenditures for all local health departments for the year 2007 (the most recent data available) were approximately $302 million.

As shown in Figure 1, *Local Tax Levy* was the largest funding source in 2007, accounting for nearly one-third of all funding. The *State General Fund- Local Public Health Act Grant* accounted for seven percent of all funding that year.

Figure 1. 2007 Funding Sources for the CHS System



Source: Planning and Performance Measurement Reporting System (2008). [Database]. St. Paul, MN: Minnesota

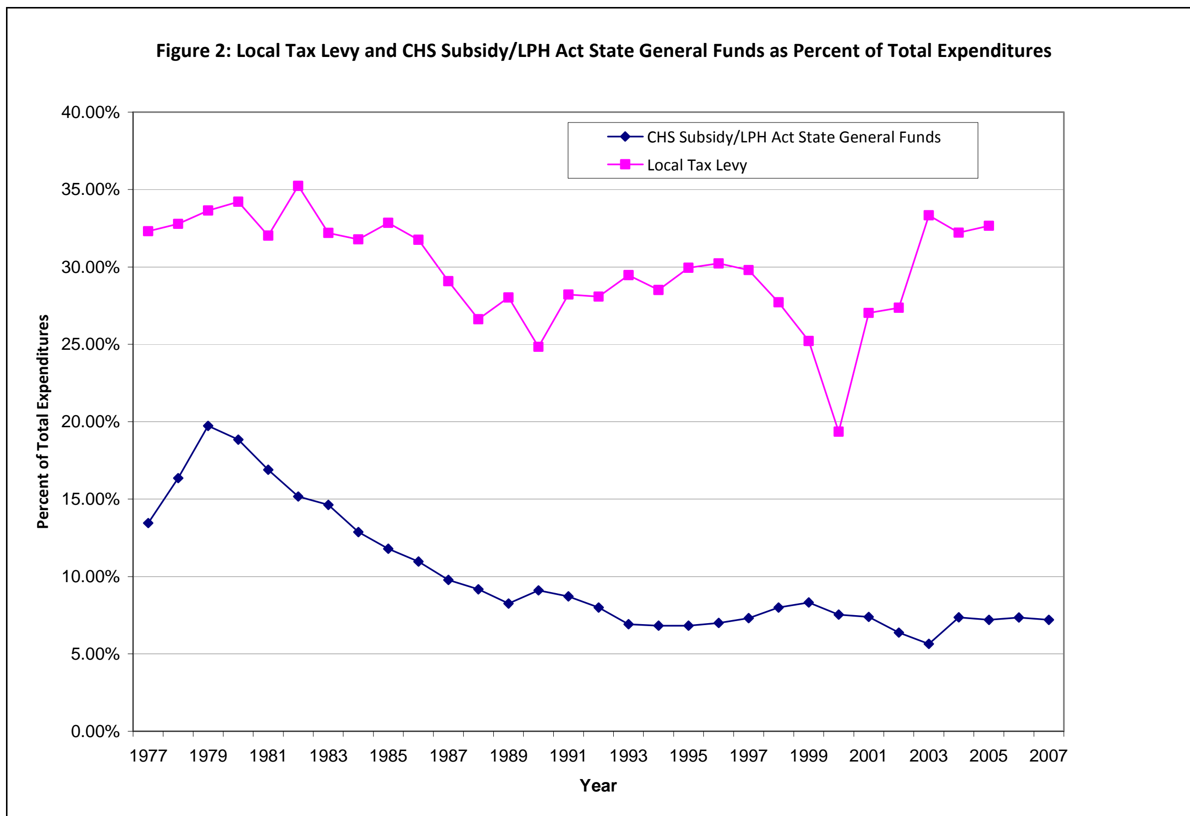
Other notable findings related to local public health expenditures in 2007 include:

- Almost two-thirds of total funding for the CHS system came from locally-generated funds, which include reimbursements and fees for services, local tax levy, and other local funds.

- Altogether, state funds accounted for 13 percent of total funding, whereas federal funds (other than reimbursements through Medicare and Medicaid) accounted for 20 percent of total funding.

Flexible Funding

Local tax levy and the Local Public Health Act State General Funds are the two sources of flexible funding for local health departments. Flexible funding sources are very important, as many critical public health responsibilities are not funded by any particular categorical grant and are not services that are eligible for reimbursements or fees. Examples include foodborne illness outbreaks, public health nuisance investigations, the sharing of local infectious disease data with area health care providers, and most health promotion and prevention activities.



As shown in Figure 2, Local Public Health Act State General Funds have decreased as a percentage of total expenditures over time, while local tax levy has fluctuated, generally between 25 percent and 35 percent. Other points related to financing of the local public health system include:

- Flexible funding as a percentage of individual local health department expenditures in 2007 ranged from a low of five percent to a high of 47 percent.

- In a majority of local health departments, less flexible funding such as categorical grants, reimbursements, and fees for specific services made up 75 percent or more of their funding in 2007, while flexible funding sources represented less than 25 percent.

- A cost model developed by University of Minnesota researchers during 2008 as part of an ongoing Robert Wood Johnson Executive Nurse Leadership project estimated a gap of approximately $32 million ($5.28 per person per year) between the amount of funding currently in the local public health system and the funding needed to carry out the essential local public health activities.

Strategic Issue 3: Streamlined administrative requirements

Streamlined and simplified administrative requirements are a longstanding request from CHBs to MDH. In 2000, a SCHSAC workgroup examined how to maximize efficiency and flexibility in MDH grants to CHBs while assuring that all administrative requirements are met, and MDH has the information that it needs to demonstrate accountability to state and federal governments. Work group findings included the following:

- Funding for the CHS system is fragmented;

- Fragmented funding has resulted in increasing amounts of time devoted to administration of programs rather than on actual program activities;

- Each grant program has its own application, program development and reporting requirements. These requirements come from numerous sources including federal or state legislation, federal or state agency interpretation of legislation, federal and state grant management policies and local agency policies; and

- Traditional accountabilities for grants have been based on detailed financial and program reporting rather than performance measures or outcomes.

Recommendations were made for ways to address those issues. Since 2000, several of the recommendations have been achieved and progress has been made on others. For example:

- Six grants were consolidated into a local public health block grant (Local Public Health Act State General Funds);

- Statewide outcomes for the above funding were developed by the Commissioner in consultation with SCHSAC and the Maternal and Child Health Advisory Committee;

- A master grant contract was developed that incorporates all grants provided from MDH to a CHB;

- An online reporting system (the PPMRS) was developed and reporting for several grants is being incorporated into that system; and

- Communication related to grants is increasingly electronic.

Advancements have been made. Nevertheless, as resources tighten it is essential that administrative requirements are kept to those necessary to achieve accountability and demonstrate progress towards outcomes. Ongoing dialogue through SCHSAC will aid the state and local public health system in identifying ways to continue forward movement in addressing these issues.

Strategic Issue 4: Ensuring a ready and capable workforce

Workforce issues continue to be of major concern to local public health in Minnesota. The CHS system needs an adequate supply of *suitably educated* public health professionals that *reflect the populations served* and are *appropriately distributed* throughout the state.

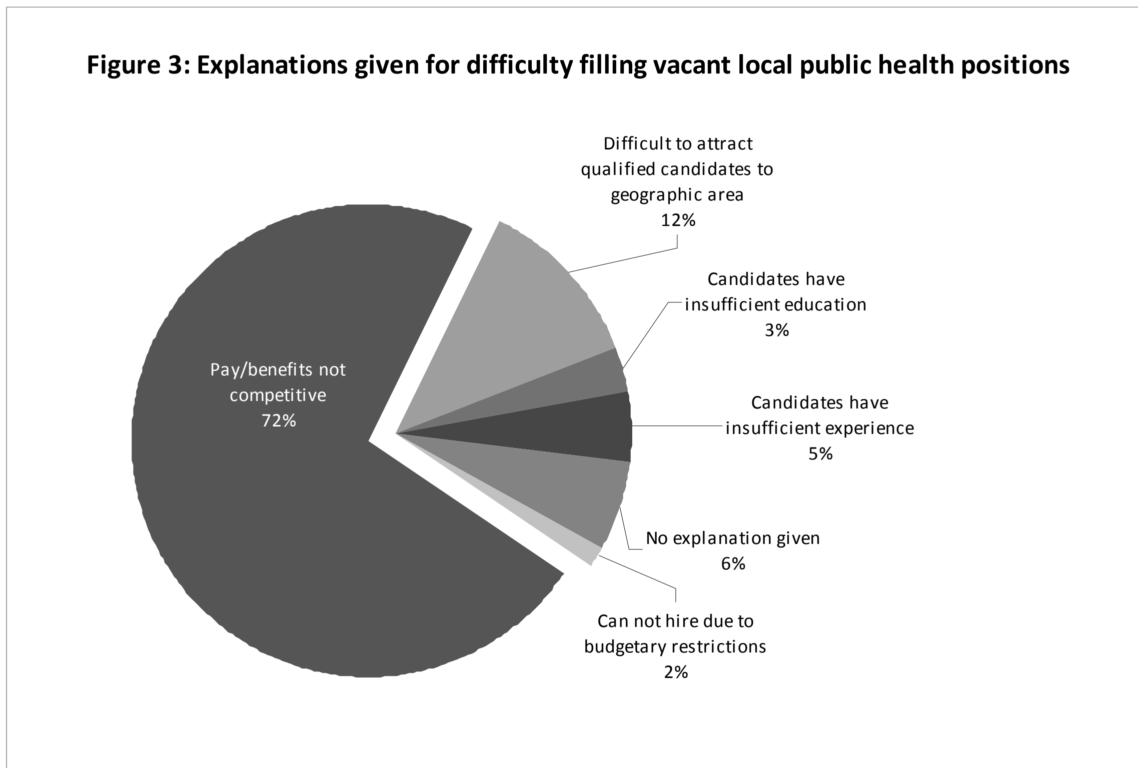
Data reported to MDH for 2007 provides information on vacancies in the CHS system:

- Approximately half of local health departments reported difficulty filling a vacancy last year. More than one quarter reported difficulty filling two or more positions. A vacancy was defined as *difficult to fill* if it was open for six or more months.

- These vacancies spanned many types of public health worker, but over three quarters were for nursing positions.

- For each position that was difficult to fill, respondents were asked to identify a primary reason for the hiring difficulty. For the vast majority of difficult vacancies (73%), respondents cited non-competitive pay and benefits as the primary issue. For an additional 12% of vacancies, respondents suggested it had been difficult to attract candidates to the geographic area.

Because data for 2008 are not yet available, it is not clear in what way the current national economic downturn has affected the issues noted above.



A landmark study released by the Center for Studying Health System Change reinforces on-going conversations and observations within the CHS system. Their findings suggest that:

- Shortages are likely to persist and to worsen given aggressive competition from the private sector and overall scarcity of key health professionals.
- Skill deficits are less apparent than worker shortages but may more directly affect the quality of public health services.
- Investment in the training and retention of existing workers is critical.
- Relationships with academic public health programs have value and promise, but require more focused attention to be mutually rewarding.
- Changing of the guard to the next generation of public health workers and leaders presents key opportunities if adequately anticipated and planned.

Although current data regarding education and experience of staff hired by local health departments are not available at a statewide level, it is known that many local staff lack public health experience and/or formal public health training when they are hired. Workforce training remains an issue for local health departments and also for MDH (which assists in providing public health orientation and training to the local public health workforce).

Strategic Issue 5: Supportive, effective and efficient governance and organizational structures

Minnesota's local governments carry out their public health activities through a variety of legal and organizational arrangements. County boards can organize to fulfill their public health requirements under one of three governance structures: as a board of health, as a community health board, or as a human services board.

A *board of health* is the governance structure outlined in MS 145A.03 through 145A.08. It only pertains to a county or counties that choose NOT to qualify to receive the local public health grant as described in MS 145A.131 and other funding awarded to CHBs.

Two governance structures are acceptable to receive Local Public Health Act funds:

- A community health board (CHB), as described in MS 145A.09.

- A human services board (HSB), as defined in MS 402. If a county or counties establishes an HSB, then the powers and duties of the CHB *must* be assigned to the HSB.

The CHB structure encourages multi-county community health boards, in which groups of counties have joined together to seek the efficiencies that can come with a larger population base. Currently 59 counties in Minnesota are cooperating in one of the 21 multi-county CHBS All counties and four cities in Minnesota currently qualify to receive monies from the Local Public Health Act and other funding awarded to CHBs. For an outline of organizational structures statewide, see Appendix C.

Within these governance structures, counties and cities have varying organizational structures for their public health functions. The majority are comprised of stand-alone public health departments. Some have combined public health with other departments such as social services, veterans' services, and corrections. A few have opted to contract out public health services to a local hospital (Appendix C).

As the population, the workforce, resources, and key leadership change, local elected officials periodically examine different options for governance or organizational structure. Given the current environment of significant resource constraints and the desire to look for innovative ways to carry out government services, it is very likely that more local governments will examine these issues.

Currently, there are few resources available for elected officials to use when considering different public health models and weighing the advantages and disadvantages of each approach. One resource that compares system fundamentals - such as the mission, focus of action, issues addressed, and strategic approaches - of public health, social services, and hospitals/health care systems is included in Appendix D.

There is also a lack of resources regarding characteristics of an effective local health department. However, there is progress in that direction through the development of standards and performance measures for state and local health departments.

In early 2009, the newly formed Public Health Accreditation Board – *the national organization overseeing implementation of voluntary national accreditation for public health departments* - will release a set of national standards and performance measures to establish uniform expectations for the practice of public health throughout the United States. The emerging national public health accreditation program will likely have significant implications for Minnesota's public health system and should be considered in relationship to governance and organization of local public health. Although the accreditation system is voluntary, many suspect that future federal funding opportunities may be affected by a health department's accreditation status.

The SCHSAC strategic plan recommends joint work, between state and local partners, to examine issues of governance and organizational structure and accreditation; and to develop discussion resources in 2009. The work on governance and organizational structures will be particularly timely, given the current search for improved ways to deliver governmental services. Moreover, while the full implication of accreditation will only emerge over time, seizing the opportunity to begin to examine how this common set of standards can be used to strengthen public health practice in Minnesota is critical.

Strategic Issue 6: Modernize public health information systems

State and local health departments in Minnesota have a long history of collecting data, conducting evaluations and applying findings to improve public health. Indeed, using data to identify patterns of disease, injury, or death and to target programs and resources to those most affected by a condition are at the very core of public health practice. New technologies and information systems have the potential to allow the public health system to improve both efficiency and effectiveness of public health endeavors.

Several projects to modernize public health information systems are currently under development. Two examples include the Minnesota Electronic Disease Surveillance System, and the Environmental Knowledge Management Project. Those and other system improvements have great potential, but still require considerable, ongoing work.

Despite the good progress being made in those individual projects, significant gaps exist in the capabilities of the public health system to collect and exchange data—both within the public health system (between local health departments and MDH) and within the broader health care system (public health and health care systems). This is due to several factors:

- Lack of a commitment to a shared vision and lack of a strategic action plan for modernizing public health information systems statewide.

- Lack of agreement on shared data standards for secure information exchange.

- Lack of standard specifications for county/city information systems. At the county/city level, individual counties have invested in multiple, different data management systems (e.g., to share data, report activities, track expenditures, and enable data exchange); and

- Individually revamping or creating information systems from scratch. This is very costly, and often has limited success. Resources have been very limited and often require short term spending instead of use over several years needed for most information systems.

A legislative mandate (Section 62J.495 Minnesota statutes) states that all health care providers and hospitals must have an interoperable electronic health record (EHR) system by 2015. This mandate applies to public health as a provider of care and an exchange partner of electronic information. Through the Minnesota e-Health Initiative, and with the help of MDH loans and grants many rural and small clinics are modernizing their systems and have made significant progress in meeting that mandate. However, much work remains to be done within the local public health system.

What is needed is a commitment by state and local leaders to use a systems approach to modernizing the public health system statewide. This includes a commitment to:

- Using a collaborative approach to define the standards for information system specifications statewide, which avoids the costly approach of individually developed systems, and leverages the work of others.

- Identifying standards for information exchanges between state partners and community partners.

- A statewide action plan for implementing systems in phases over several years.

- Identification of resources to support the effort.

- Support the workforce by adopting and using the new CDC informatics competencies. Efforts are needed to improve the knowledge and skills of the public health workforce. The emerging field of public health informatics uses new knowledge and skills in order to improve the practice of public health through better use of data for decision making.

- Establish state and local governance effort. For several years a state and local partnership called the Minnesota Public Health Information Network (or MN PHIN) worked to create a roadmap for modernizing public health information systems. However, resources have not been available recently to move that work forward.

This is a time of great opportunity to leverage new and exciting technology to improve public health practice and the health of Minnesota communities. To realize that potential, the State and local public health system must work better together and increase the capacity of those who work in public health to effectively turn data into useful information and, wisdom and ultimately into healthier communities.

Strategic Issue 7: Performance management and a culture of quality

Flexibility, accountability, and attention to outcome measures are essential components of public health practice. In Minnesota, local health department services are based on an assessment of local needs and operate within a broad framework of statewide guidelines with a minimum of state mandates. Because of the local control and significant local investment of resources, the type and level of local health department services provided by community health boards has varied throughout the state.

As noted earlier in this report, over the past several years, the state and local public health partnership has worked to put into place systems and resources designed to improve the performance and accountability of the CHS system. Combined, they make up a comprehensive quality improvement system. Components of this QI system include the following:

- The essential local public health activities were developed to assure that all Minnesotans receive at least a core set of public health services, and to simplify efforts to describe the system and its benefits.

- A new resource and toolkit (the Community Health Assessment and Action Planning – "CHAAP") was created to facilitate the local planning and assessment processes carried out routinely at the local level.

- An online reporting system was created (the local public health Planning and Performance Measurement Reporting System – "PPMRS") to assess progress in meeting the Essential Local Public Health Activities and to inform decision making.

- The annual review process, which assures the accountability of agencies that receive Local Public Health Act General Funds, was streamlined and strengthened.

Efforts to systematically apply methods and tools of quality improvement (QI) are underway in the CHS system. For example, a current statewide collaborative of more than 40 CHBs is taking a structured approach to integrating QI into practice.

All of these advances in local needs assessment, performance improvement, accountability and quality will help position Minnesota health departments to put into place ongoing systems to assure that public health activities are efficient and streamlined. They will help in looking at program effectiveness and in preparing for a voluntary accreditation program that is scheduled to roll-out nationally in 2011. Ultimately, they will also help move the system toward outcome-based performance management and a culture of quality.

Conclusion

Minnesota's state and local public health system, the CHS system, is unique and well positioned to promote and protect the public's health. Yet, a strong, sustainable and successful system depends on many inter-related factors.

Through the leadership of SCHSAC, with the help of local partners and MDH staff, a series of recommended actions or "next steps" have been developed to begin to address the strategic issues described in this report. In February 2009, the SCHSAC will adopt a work plan for the year to begin to address many of these issues. (For the complete list of "next steps" see Appendix E.)

With continued support from state lawmakers and the people of Minnesota, and with the stable, flexible and non-categorical funding provided by the Local Public Health Act Grant, the CHS system will continue to make progress in realizing the single, unifying vision that:

> ***"All Minnesotans have the opportunity to achieve optimum health".***

Appendix A: 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.

Appendix B: Local Public Health Governance Structures

Governance Structures 2008

Single county, city, or county/city Community Health Board (CHB): minimum 30,000 population; the county board assumes the duties of the CHB OR appoints a CHB. (24 CHBs)		
Anoka Bloomington Carver Chisago Douglas Edina	Freeborn Goodhue Hennepin Kandiyohi Minneapolis Mower Olmsted	Otter Tail Polk Ramsey/St. Paul Rice Richfield Sherburne Washington Winona
Multi-county CHB: joint powers; minimum 30,000 population; the county boards appoint representatives to the CHB. (20 CHBs)		
Aitkin-Itasca-Koochiching Beltrami-Clearwater-Hubbard-Lake of the Woods Big Stone-Chippewa-Lac Qui Parle-Swift-Yellow Medicine Brown-Nicollet Carlton-Cook-Lake-St. Louis	Clay-Wilkin Cottonwood-Jackson Dodge-Steele Fillmore -Houston Grant-Pope-Stevens-Traverse Isanti-Mille Lacs Kanabec-Pine Morrison -Todd-Wadena	Kittson-Marshall-Pennington-Red Lake-Roseau Le Sueur-Waseca Lincoln-Lyon-Murray-Pipestone Mahnomen-Norman Meeker-McLeod-Sibley Nobles-Rock Redwood-Renville
Single county Human Services Board (HSB): no minimum population required; assumes the duties of the CHB. (8 HSBs)		
Becker Benton Blue Earth	Crow Wing Cass Dakota Scott	StearnsWabasha Watonwan Wright
Multiple-county HSB: no minimum population required; assumes the duties of the CHB. (1 HSB)		
Faribault-Martin		

Appendix C: Local Public Health Organizational Structures

Organizational Structures 2008

Counties/cities with a local health department: (61 counties, 5 cities)		
Big Stone-Chippewa-Lac Qui Parle-Swift-Yellow Medicine* Bloomington Brown Carver Cass Clay Cottonwood-Jackson* Crow Wing Dodge-Steele* Douglas Edina Fillmore Freeborn Goodhue Hennepin Houston	Isanti Kandiyohi Koochiching Le Sueur Lincoln-Lyon-Murray-Pipestone* Mahnomen-Norman* Marshall Meeker McLeod Mille Lacs Minneapolis Mower Nicollet Nobles-Rock* Pope Olmsted	Otter Tail Pennington-Red Lake* Polk Ramsey/St. Paul Redwood Renville Rice Richfield Sherburne Sibley Stevens-Traverse-Grant* Todd Wadena Waseca Washington Wilkin Winona **Multi-county LHD*
Counties with a human services agency that includes public health: (21 counties)		
Aitkin Anoka Becker** Beltrami Benton** Blue Earth** Carlton	Chisago Cook Dakota** Faribault-Martin** Itasca Kanabec Lake Morrison	Pine St. Louis Scott** Stearns** Wabasha** Watonwan** Wright** ***Under a Human Services Board*
Counties with a hospital contract for public health activities: (5 counties)		
Clearwater Hubbard	Kittson Lake of the Woods	Roseau

Appendix D: Comparison of Public Health, Social Services and Hospitals

	Public Health	Social Services	Hospitals
Mission	To protect, promote, and maintain the health of all citizens at the community level.	To help people meet their basic needs by providing or administering health care coverage, economic assistance, and a variety of services.	To meet the medical needs of individuals.
Focus of Action	Populations – all citizens within a jurisdiction; the environment; communities; systems	Children, people with disabilities and older Minnesotans.	Individuals who use the hospital/clinic services
Types of Issues Addressed	Chronic disease prevention and health promotion; communicable disease prevention and control; bioterrorism and emergency preparedness; environmental health; family health; assuring access to health care	Child protection, child support enforcement, child welfare services; publicly-funded health care programs; services for people who are mentally ill, chemically dependent or have physical or developmental disabilities.	Acute health care services Outpatient clinical services
Strategic Approach	Prevention, especially primary prevention	Crisis intervention and treatment	Treatment of acute and chronic medical conditions
Authority	State delegated; governmental *Sources: MDH Website and CHS Mission	State delegated; governmental *Source: DHS Website	County delegated; contractual *Sources: various

Appendix E: Next Steps from the SCHSAC Strategic Planning Process, 2008

Minnesota's state and local public health system is unique and well-positioned to promote and protect population health. A strong, sustainable and successful system depends on many inter-related factors. SCHSAC recommends several steps to realize the potential of the system.

Next steps to communicate the value of investments in public health activities

Create materials intended to build awareness of public health and the state/local public health partnership among elected officials and community members. Materials should emphasize the benefits of public health in many ways (e.g., cost savings, lives saved, and peace of mind).

Create more opportunities for interaction and dialogue among state and local public health leaders and local elected officials (e.g., city council members and county commissioners).

Sufficient, stable and flexible funding

Examine data from PPMRS, the Cost Model Project for Local Health Departments and other available data to better understand the cost to provide all Essential local public health activities statewide and the implications for Minnesota.

Develop a long range strategy to secure stable sources of funding that balance flexibility with accountability, and close the gap between funds available and funds needed.

A ready and capable workforce from border to border

Identify specific actions that the state-local partnership will take to:

Assure a sufficient workforce, with particular attention to retention, succession planning and leadership development.

Identify specific actions that the state-local partnership will take to assure a ready and capable workforce that has skills needed for a population health approach and reflects the racial and ethnic diversity of Minnesota residents.

Supportive governing and organizational structures

Identify and evaluate characteristics of different structural models that contribute to a strong local health department.

Examine the impact of the voluntary national accreditation program on local health departments with varying sizes and structures.

Examine the potential impact that size and structure may have on the ability of local health departments to readily and successfully apply for accreditation.

Review the intent of the Community Health Services Act of 1976. Explore the extent to which various organizational models align that the intent of that legislation.

Performance management and a culture of quality improvement

Continue to strengthen planning, measurement and accountability systems to improve Minnesota's public health system, and the health of Minnesotans.

Provide training/technical assistance and create incentives to help state and local partners more fully integrate the principles and techniques of quality improvement into routine practice of public health.

Examine the national performance standards and measures upon release in 2009.

Identify opportunities to align Minnesota's existing quality improvement processes with the uniform national standards and accreditation procedures to be articulated by the Public Health Accreditation Board. Avoid duplication and create efficiencies to the extent possible.

Convene a workgroup of the State Community Health Services Advisory Committee (SCHSAC) as a focal point for discussion and preparation for state and local accreditation. Make recommendations to maximize the likelihood that health departments in Minnesota that choose to pursue accreditation, can do so successfully and with as little burden as possible.

Public health information systems

Build awareness of the implications of interoperable data systems for public health practice and improvement.

Promote informatics competency in the public health workforce.

Encourage a common set of expectations for integration and interoperability (e.g., public health terminology, data standards, and quality control measures).

Strengthen PPMRS and CHAAP as data sources for decision making.