BUILDING A SOLID FOUNDATION FOR HEALTH:

A Report on Public Health System Development

Minnesota Department of Health

January 2011

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MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

January 2011

Dear Colleague:

We are pleased to share with you *Building a Solid Foundation for Health: A Report on Public Health System Development*. 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 21st century.

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

Sincerely,

Jeanne Danaher, J.D.
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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 between state and local governments. Minnesota's local public health system, known as Community Health Services (CHS), is designed to ensure 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 52 community health boards (CHBs). Each CHB is comprised of one or more local health departments (e.g., a city or county health department). A statutory advisory body called the State Community Health Services Advisory Committee (SCHSAC), consisting of one representative of each of the 52 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. However, it is clear that the system faces both multiple challenges and many opportunities for improvement. Actions toward the following strategic issues are needed to enhance agility, and assure a resilient, sustainable and successful public health system into the future:

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

The public health system has made progress in addressing those strategic issues, as described in this report. However, there is still significant work to be done. In February 2011, SCHSAC will adopt a work plan for the year, which will to continue to address many of these issues. 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 Block Grant, the CHS system will continue to make progress in realizing the single, unifying vision:

All Minnesotans have the opportunity to achieve optimum health.

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. The following describes Minnesota's public health infrastructure and examines several pivotal — or *strategic* — issues currently facing our local public health system. Those issues were identified in a 2008 strategic plan of the State Community Health Services Advisory Committee (SCHSAC), and have been the focus of joint work since then. SCHSAC is a statutorily defined advisory group to the commissioner of health that is comprised of one representative from each local health jurisdiction (community health board) in Minnesota. Also reflected in this document is the ongoing dialogue regarding the current 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 Minnesota Statutes Chapter 145A, referred to as the Local Public Health Act.

Responsibility for protecting and promoting the health of the public in Minnesota is shared between state and local governments. Minnesota's local public health system, known as Community Health Services (CHS), is designed to ensure 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 52 community health boards (CHBs). Each CHB is comprised of one or more local health departments (e.g., a city or county health department).

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

Public Health Responsibilities

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.

The Minnesota Department of Health (MDH) and CHBs play complementary roles in carrying out the above responsibilities.

Recent Local Public Health System Accomplishments

A brief summary of local public health accomplishments follows, as reported in the Planning and Performance Measurement Reporting System (PPMRS) for the year 2009.

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

- 82 percent of LHDs **provided direct observed therapy** (DOT) to patients with Tuberculosis (TB). They monitored a total of 1925 clients. This number is significantly higher than recent years due to the recent outbreaks of TB in several counties.
- LHDs **investigated 912 public health nuisances** and confirmed 502 nuisances. The top three public health nuisance complaints were mold, garbage houses, and accumulation of rubbish or junk. LHD data shows that vacant properties continue to pose a public health concern.
- 100 percent of LHDs **promoted healthy communities** by addressing child growth and development and conducting pregnancy and birth programs and activities.
- 100 percent of LHDs **improved their emergency response capabilities** through planning exercises, and by responding to public health issues in actual local emergencies — including mass vaccination clinics for H1N1 influenza outbreak, floods, blizzards, and fires.
- Over 89 percent 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 training and education, working with specific cultural/racial groups to build relationships, using more interpreters, translating materials, and hiring more diverse staff.
- 100 percent of LHDs and 82 percent of tribal governments **implemented community interventions** focused on reducing tobacco use and exposure and reduce obesity through policy, systems, and environmental changes, through the Statewide Health Improvement Program (SHIP).

Recent Public Health System Improvements

In recent years, Minnesota's public health system has taken many steps to promote internal accountability and improve its own performance, including those listed below:

- Identified structural challenges and developed tools for counties considering restructuring options.
- Evaluated the statutorily required community health assessment and planning process as a step toward quality improvements.
- Developed a vision for public health performance management in Minnesota and encouraged the use of the national standards as the foundation for a shared commitment to quality improvement.
- Implemented an innovative initiative, SHIP, using policy, systems, and environmental strategies to prevent chronic disease. This process included compilation of key interventions and supporting materials, defined evaluation and data collection processes, a technical assistance plan, effective tools for communication.
- Identified objectives and key indicators for measuring of local public health departments' outcomes statewide.
- Continued to implement a statewide effort to integrate continuous quality improvement into public health practice.
- Developed a Practice-based Research Network (PBRN) and brought together public health practitioners, researchers, and elected officials to conduct research to improve public health policy, systems, and outcomes in Minnesota.

Strategic Issues for Minnesota's Public Health System

In 2008, SCHSAC created a 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 challenges, as well as many opportunities for improvement.

The SCHSAC strategic plan is one tool for mapping out the future of Minnesota's public health system, and remains a core resource for this report. The rest of this document will describe seven broad strategic issues currently facing Minnesota's public health system, and will explore the related challenges and opportunities as well as progress to date. The numbering of these strategic issues does not represent the order of their importance.

Strategic Issues for Minnesota's Public Health System:

- Clear roles and effective communication about state and local public health responsibilities to protect and promote health;
- Sufficient, stable and flexible funding;
- Streamlined administrative requirements;
- Ensuring a ready and capable workforce from border to border;
- 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. Members of the public understand that those services have important effects on their quality of life. Surveys indicate that the public also 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, local and tribal health departments play in addressing those and other issues. Historically, this lack of awareness of the role of public health can lead to a scarcity of "champions" for public health resources, since policymakers work to meet the needs identified by the public.

State, territorial, local and tribal health departments across the county have participated in the development of a set of national standards and measures for public health along with a voluntary national accreditation program. The purpose of the standards, measures and accreditation program is to improve and protect the health of the public by advancing the quality and performance of public health departments. For a summary of the national standards, please see Appendix A on page 20.

This movement has resulted in a national consensus around the role of public health, and sets standards for its practice. These standards provide a consistent framework to describe what the public can expect from their health department, and may have the following benefits in articulating state and local responsibilities to protect and promote health:

- The standards and measures represent a national consensus on the core functions and essential services of local and state public health departments and largely reflect current practice in Minnesota.
- Achieving the national standards will improve local and state public health performance, and improving performance will ultimately improve public health outcomes.
- The process of assessing capacity to meet the national standards provides valuable, measurable feedback to health departments on their strengths and areas for improvement.
- The recognition of excellence brought on by meeting the national standards can positively impact staff morale and enhance the visibility of the health departments.
- Becoming "accredited" can result in increased credibility for health departments among funders, governing bodies, and the public, as well as demonstrate accountability for resources.

Communicating with the public about the role of public health is an issue that is partially being addressed through the Statewide Health Improvement Program (SHIP). Through SHIP, all CHBs and nine tribal governments have received funds to implement evidence-based policy, systems, and environmental change strategies designed to create sustainable, population-based changes in tobacco use and exposure, and in obesity. This program has focused on a participatory and collaborative approach by involving the communities in the entire process, specifically through SHIP Community Leadership Teams, SHIP Local Partnership Teams, and other partnerships and coalitions. The successes of SHIP have been published widely in the media, including in more than 80 newspapers statewide, with additional coverage via radio, television, online, organizational newsletters, and more. This media coverage increases public awareness and knowledge of public health efforts to provide healthier foods in schools and neighborhoods, make it easier to bike and walk to work or school, and reduce smoking and exposure to second-hand smoke.

Strategic Issue 2: Sufficient, stable and flexible funding

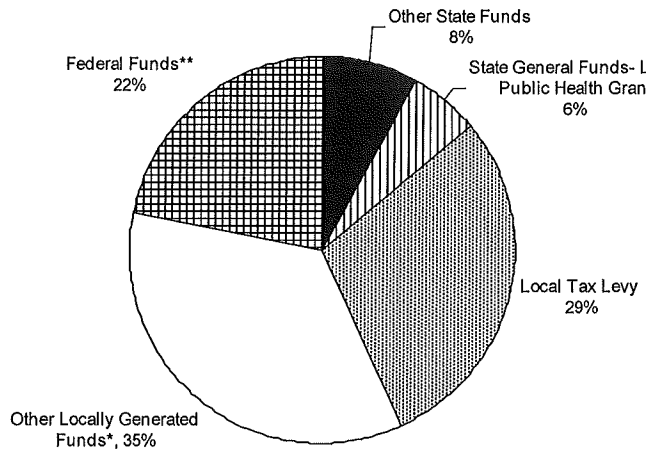
Minnesota's funding system for local public health services has been shaped by years of incremental decisions, many of which were tied to specific programs or resources. This has resulted in a complex combination of local, state, and federal funding sources; varied distribution formulas; and categorical 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

LHDs submit annual financial data to MDH. In 2009 (the most recent data available), LHDs reported total expenditures of approximately $298 million.

As shown in Figure 1, almost two thirds of total funding for the CHS system (64 percent) came from locally-generated funds, which include reimbursements and fees for services, local tax levy, and other local sources. Altogether, state funds accounted for 14 percent of total funding, and federal funds (other than reimbursements through Medicare and Medicaid) accounted for 22 percent of the total. The state general funds comprising the Local Public Health Block Grant accounted for six percent of all funding in 2009, however these proportions are locally quite variable.

Figure 1. 2009 Funding Sources for the CHS System



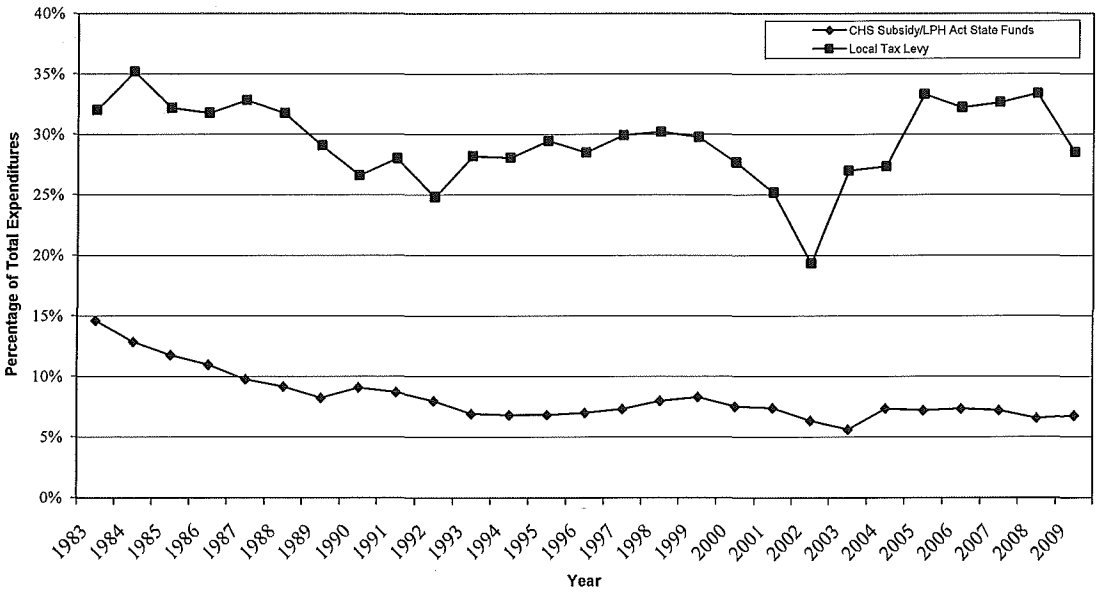
Source: Planning and Performance Measurement Reporting System (2010). [Database]. St. Paul, MN: Minnesota

*includes reimbursements and fees
**excludes Medicare and Medicaid

Flexible Funding

Local tax levy and the Local Public Health Block Grant are the two sources of flexible funding for LHDs. 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. It should be noted that higher levels of locally sourced funding are predictive of increased performance of a local health department.

Figure 2. Local Tax Levy and CHS Subsidy/LPH Act State General Funds as a Percent of Total Expenditures



As shown in Figure 2, the Local Public Health Block Grant has decreased as a percentage of total expenditures over time, while local tax levy has fluctuated, generally between 25 percent and 35 percent. When considering the financing of the local public health system, the following is also important to note:

- Since 2004, Local Public Health Block Grant funds have comprised only six to seven percent of total expenditures.
- 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 essential local public health activities.
- Flexible funding for individual LHDs ranges from 3 percent to 87 percent with a median of 28 percent.

Strategic Issue 3: Streamlined administrative requirements

The Master Grant Contract (MGC) for CHBs and annual online reporting via PPMRS, along with other tools, continue to serve local public health and have helped to streamline administrative requirements. Nevertheless, as resources tighten it is essential that administrative requirements are kept only to those necessary to achieve accountability and demonstrate progress towards system outcomes.

While the PPMRS is not yet the "one stop reporting shop" that local public health has requested, additional reporting modules are incorporated each year, and the time is ripe to take the system to the next level.

On July 1, 2011, the Minnesota Accounting and Procurement System (MAPS) will be replaced by the Statewide Integrated Financial Tools (SWIFT) system. SWIFT will integrate administrative functions among all state agencies, including financial, procurement, reporting, and the current State HR/payroll system. The SWIFT Project team is working closely with state agencies to implement the new system. With its robust grants database and user-friendly application templates it is anticipated that when fully implemented, SWIFT will reduce the administrative burden for both local public health grantees and MDH.

The quest to simplify grant administration process for both grantees and MDH continues, and will be the focus of concentrated efforts in 2011. Minnesota recently received federal funding through the Centers for Disease Prevention and Control (CDC) Public Health Improvement Initiative which will allow for concerted efforts in this area.

Strategic Issue 4: Ensuring a ready and capable workforce from border to border?

Workforce issues continue to be a major concern of 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. In addition, there is a need for accelerated preparation of strong, local leadership that can navigate the challenging public health work and assist in building strong and successful health departments in Minnesota.

A landmark study released by the Center for Studying Health System Change reinforces ongoing conversations and observations within the CHS system in Minnesota. The Center's findings suggest that:

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

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).

PPMRS data reported to MDH for 2009 provides information on vacancies in the local public health system, which has shown a shift from previous years' data due, in part, to the economic downturn:

- Local health departments reporting "difficult to fill" vacancies have dropped from approximately 50 percent to 30 percent. (A vacancy was defined as "difficult to fill" if it was open for six or more months.)
- For each position that was "difficult to fill", respondents were asked to identify a primary reason for the hiring difficulty. Previously, the vast majority of respondents (73 percent) cited non-competitive pay and benefits as the primary reason to categorize vacancies as "difficult to fill". The 2009 data indicates that this number has decreased, and LHDs currently report budgetary restrictions as the main reason why vacancies were "difficult to fill".

As indicated in the previous data from the Center for Studying Health System Change, preparing a strong workforce is a key focus in public health with special concern for leadership. A 2010 MDH Practice Based Research Network (PBRN) survey of CHS administrators, public health directors and some health and human service directors, asked questions on retirement predictions.

Based on those results, which projected 43 percent of leaders retiring within five years, the state and local public health system needs to increase its focus on planning for turnover and continuity. The following are examples of work that has been done or is in progress in response:

- Clarification of leadership roles: A SCHSAC work group has concluded that it is critical to have clearly defined and appropriate roles, responsibilities, and authorities that "endure" transitions.
- Succession planning: This SCHSAC work group also cited succession planning for leadership as an area to address. MDH PPMRS data for 2009 indicates that 66 percent of reporting entities had undertaken activities to assure leadership succession in their department, with some examples being robust and long-term. Follow-up work is being conducted by MDH public health nurse consultants.
- Leadership development and technical assistance: MDH public health nurse consultants have provided considerable assistance to new leaders, including day to day consultation and mentoring, redesign of the leader orientation process (including an MDH and local leader mentoring system in collaboration with LPHA), development of MDH Leader Orientation beginning in 2010, and collaboration with the University of Minnesota on a Leadership Academy.
- Leadership networking and collaboration: The Emerging Leaders Network of Minnesota (ELN) was held each year between 2003 and 2010. This leadership development program aimed to increase the diversity among public health leaders, build leadership networks, and enhance the skills and build confidence of public health leaders in collaborative leadership. It occupied a unique niche in that it focused on collaborative leadership skills for public health professionals who represent a cross-section of organizations, public, private, and nonprofit. Though the program has ended, ELN alumni will continue their input and involvement in Minnesota's public health system and related activities.

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 organizational and governance structures. County boards must organize to fulfill their public health requirements as either a CHB under Minnesota Statutes Chapter 145A, or as a human services board under Minnesota Statutes Chapter 402. While these governance options have slightly different leadership and administration requirements, both are eligible to receive Local Public Health Block Grant funding, and both are responsible for ensuring that the requirements of the Local Public Health Act (Minnesota Statutes Chapter 145A) are met within the jurisdiction.

The CHB structure encourages and incentivizes multi-county arrangements, in which groups of counties join together to seek the efficiencies that often come with serving a larger population base. Currently 57 counties in Minnesota are cooperating in one of the 21 multi-county CHBs. All 87 counties and four metropolitan cities currently qualify to receive monies from the Local Public Health Block Grant and other funding awarded to CHBs.

Within these governance structures, counties implement various organizational structures to carry out their public health functions. The majority of counties (approximately 2/3) are comprised of stand-alone public health departments. Additionally, nearly 1/3 of counties are organized with social services and public health as part of a human services agency. A few other counties have combined public health with other departments, including veterans affairs, corrections, environmental services, and land planning.

The local public health system finds itself in a time of significant transition, considering Minnesota's changing demographics, the pending retirement of many in governmental leadership positions, and unprecedented budget shortfalls. Local elected officials are increasingly looking for different ways to do business, including making changes to their public health governance and organizational structures. To illustrate this, a recent survey (Spring 2010) of top local health officials in Minnesota found that nearly 30 percent of local jurisdictions had either considered or were in the process of making changes to their structures within the past year.

It has been previously noted that few resources have been available for elected officials to use when considering different public health organizational and governance structure models, but significant progress has been made in this strategic issue area over the past two years. In July 2009 a SCHSAC work group was convened to investigate the increase in organizational and governance structure changes at the local level. Later, the work group's scope was broadened to encompass a discussion about the foundations underpinning the local public health system and to update the blueprint for strong and successful local health departments. This work group met from July 2009 to November 2010, and included statewide representation and a significant number of local elected officials. In addition to a final report and recommendations (including recommendations for strengthening governance within the local public health system), several key products and tools were developed by this work group.

One tool released in December 2009, "A Discussion Guide for Exploring Public Health Governance and Structure Change," has been widely used by public health leaders and locally

elected officials throughout the state in the past year. As an example, two west-central Minnesota CHBs used the guide to explore the feasibility of merging into one larger CHB. The directors of those CHBs report that the discussion guide helped officials from the five counties comprising the two CHBs to answer the question: "Will our residents be better served by a single CHB?" In the end, they decided that a single CHB would be more efficient and effective, and made the decision to merge.

Additionally, in 2009 it was reported that there is a lack of information on the characteristics of effective LHDs. To address this gap, the SCHSAC work group and Minnesota's PBRN conducted a survey of top local health officials in Minnesota during 2010. This survey has provided a wealth of information about the public health system in Minnesota, much of which is still being analyzed.

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 utilizing 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 and enhanced 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; examples include the Minnesota Electronic Disease Surveillance System (MEDSS), the Minnesota Immunization Information Collaborative (MIIC), the Laboratory Information System, and in particular, health information exchange (HIE) activities in both health care and public health systems. These and other system improvements have great potential, but still require considerable, ongoing work.

Because of the Minnesota state mandate that electronic health records be in place by 2015, and the federal Health Information Technology for Economic and Clinical Health (HITECH) and Affordable Care Act, there is a significant commitment to advancing the effective use of information technology in the health care setting. However, few resources have focused on the public health side of the continuum. The public health information collection and exchange system in Minnesota is falling seriously behind in the efforts to establish statewide HIE capability and create an ingrained and functional decision support system. MDH's strategic planning around these issues has ignited recognition that a convergence of the state's 300+ disparate data systems is needed to monitor overall progress toward achieving improved health outcomes and identify areas for improvement in the provision of public health services.

Significant gaps exist in the capabilities of the public health system to collect and exchange data — both within the public health system (between LHDs and MDH) and within the broader health care system (between 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.

Building a strong HIE infrastructure is foundational in improving the quality, effectiveness, and efficiency of health care and public health services, consumer safety, and ultimately, individual and population health outcomes. By facilitating ready access to the necessary information, individuals and communities are able to make the best possible health-related decisions. Just as information must "follow the patient" and be used meaningfully to support the provision of appropriate, consumer-centered care, so must aggregated information about individuals and the environments in which they live be available to inform decisions that will impact the health of Minnesota's entire population, as well as that of disparate groups within the state's population.

MDH has committed some of its limited state resources to infrastructure improvements, and resources from the CDC's National Public Health Improvement Initiative have been allocated to augment those state resources. However, those resources are targeted at developing and improving MDH's systems, planning for local public health system improvements, and establishing standards. Federal and state mandates and resources have motivated the private health care sector to convert to interoperable electronic health record (EHR) systems by 2015, and with the help of MDH loans and grants, many rural and small clinics are modernizing their systems. However, work remains to be done within the local public health system. Resources, similar to those received by the private health care sector, must be identified to augment the very limited internal resources available for the local public health system.

Work is underway through a SCHSAC work group to look at improving the interoperability and integration of local public health information systems. However, there continues to be a need for 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.
- Developing a statewide action plan for implementing systems in phases over several years.
- Identifying resources to support the effort.
- Supporting 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.
- Establishing a state and local governance effort. For several years a state and local partnership called the Minnesota Public Health Information Network (or MN PHIN)

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 together (interoperation and integration) 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

Over the last several years, the state and local public health partnership has worked to establish systems and resources designed to improve the performance and accountability of the state and local public health system. Minnesota has been laying the foundation for building a comprehensive performance management system by implementing the following activities:

- Three-quarters of local public health agencies in the state have participated in at least one of three quality improvement collaboratives. Projects have focused on issues such as increasing access to physical activity and healthy foods, preventing tobacco use and exposure, reducing wait times in WIC clinics, improving immunization rates, and increasing public health leadership competencies.
- Staff at MDH have implemented 20 Lean/Kaizen events to improve the efficiency and effectiveness of various processes. These events have addressed issues such as timely issuance of birth and death certificates, referral of infants to appropriate services for genetic and hearing disorders, laboratory supplies purchasing, and agreements for data use and sharing across the department.
- State and local public health staff have been trained in the use of quality improvement methods and tools that have been used to improve the implementation of community health interventions and for use with the community health needs assessment and planning process.
- As capacity in quality improvement methods and tools has increased, the focus of training has expanded to quality improvement leadership, creating a culture of quality, quality planning, and integrating quality improvement into agency operations through performance management systems.

The national standards and measures outlined in the public health accreditation program (as described in Strategic Issue 1) provide a new framework for managing the work of public health agencies and improving the quality of services provided. Minnesota has been actively involved in the development and refinement of the standards. This work led to the understanding that accreditation is one component of a performance management system that is focused on continuous improvement of public health practice; other pieces of this system include comprehensive assessment and planning, annual performance measurement and reporting, and accountability to requirements of the Local Public Health Act.

During the past year, a SCHSAC work group explored the implications of the national standards and the voluntary accreditation program for the Minnesota public health system. The work group affirmed the value of the national standards and measures for improving public health

performance and made recommendations to guide performance improvement efforts for state and local public health in Minnesota.

In 2010, MDH was awarded a cooperative agreement through the Public Health Improvement Initiative of the CDC. This funding will support MDH's efforts to build, implement, and institutionalize performance management capacity throughout the Minnesota public health system. This will be done in partnership with local public health partners and other key stakeholders.

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. However, 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 have been developed to begin to address the strategic issues described in this report. Many of these actions and next steps have already been accomplished, as is noted in this report, but significant work remains. In February 2011, SCHSAC will adopt a work plan for the year which will to continue to address many of these issues.

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 toward realizing the single, unifying vision of public health in Minnesota:

All Minnesotans have the opportunity to achieve optimum health.

Appendix A

Domains of the National Standards for State and Local Public Health Departments

Administrative Capacity and Governance

- Provide Infrastructure for Public Health Services
- Provide Financial Management Systems
- Define Public Health Authority
- Provide Orientation / Information for the Governing Entity

Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community

- Collect and Maintain Population Health Data
- Analyze Public Health Data
- Use Data for Public Health Action

Domain 2: Investigate health problems and environmental public health hazards to protect the community

- Investigate Health Problems and Environmental Public Health Hazards
- Contain/Mitigate Health Problems and Environmental Public Health Hazards
- Maintain Provision for Epidemiological, Laboratory, and Support Response Capacity
- Maintain Policies for Communication

Domain 3: Inform and educate about public health issues and functions

- Provide Prevention and Wellness Policies, Programs, Processes, and Interventions
- Communicate Information on Public Health Issues and Functions

Domain 4: Engage with the community to identify and address health problems

- Engage the Public Health System and the Community in Identifying and Addressing Health Problems
- Engage the Community to Promote Policies to Improve the Public's Health

Domain 5: Develop public health policies and plans

- Establish, Promote, and Maintain Public Health Policies
- Develop and Implement a Strategic Plan
- Conduct a Community Health Improvement Planning Process
- Conduct a State Health Improvement Planning Process

Domain 6: Enforce public health laws and regulations

- Maintain Up-to-Date Laws
- Educate About Public Health Laws
- Conduct Enforcement Activities

Domain 7: Promote strategies to improve access to healthcare services

- Assess Healthcare Capacity and Access to Healthcare Services
- Implement Strategies to Improve Access to Healthcare Services

Domain 8: Maintain a competent public health workforce

- Maintain a Qualified and Competent Public Health Workforce

Domain 9: Evaluate and continuously improve processes, programs, and interventions

- Evaluate the Effectiveness of Public Health Processes, Programs, and Interventions
- Implement Quality Improvement

Domain 10: Contribute to and apply the evidence base of public health

- Identify and Use Evidence-Based and Promising Practices; Promote Understanding and Use of Research