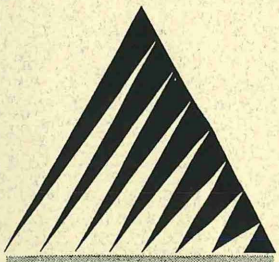

BUILDING A SOLID FOUNDATION FOR HEALTH:

A Report on Public Health System Development

MINNESOTA MDH DEPARTMENT OF HEALTH

Minnesota Department of Health
February 2001

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Dear Colleague:

I am 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 public health system development.

I hope you will find this report to be a clear and informative description of issues facing the public health system in Minnesota. The report outlines several strategic directions for public health which must be addressed to ensure the health of Minnesota residents. It also summarized a plan of action that the Minnesota Department of Health will undertake over the next two years to strengthen the public health system's capacity to address those issues.

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.

Sincerely,

Dan K. Malcolm, Commissioner
P.O. Box 64882
St. Paul, Minnesota 55164-0882

BUILDING A SOLID FOUNDATION FOR HEALTH:

A Report on Public Health System Development

February 2001

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EXECUTIVE SUMMARY

INTRODUCTION

This report was prepared to comply with Minnesota Statutes Chapter 62Q.33 which requires the Commissioner of Health to submit to the Legislature a biennial report on public health system development. It incorporates the discussion and recommendations of advisory groups to the Commissioner of Health during 2000, such as the State Community Health Services Advisory Committee (SCHSAC)[1] and the Minnesota Health Improvement Partnership (MHIP)[2]. It also reflects many conversations with local public health staff, and dialogue with community groups.

PUBLIC HEALTH IN MINNESOTA

Protecting the health of the public is a fundamental responsibility of government. Much as we expect to have police to watch out for our public safety, we expect that public health workers will watch out for the health of our communities. "The preservation of the public health is one of the duties devolving upon the state as a sovereign power and cannot be successfully controverted or delegated. In fact, among all the objects to be secured by government laws, none is more important than the preservation of the public health."[3]

State and local government public health agencies improve the lives of Minnesota residents by:

- Preventing epidemics and the spread of communicable diseases.
- Protecting us against environmental hazards in our water and soil.
- Preventing injury and violence.
- Encouraging healthful behaviors that reduce other health costs.
- Responding to disasters.
- Providing essential services to at-risk populations who are not served by the medical care system.

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[1] The State Community Health Advisory Committee is advisory to the Commissioner of Health on issues relating to local public health. Its 50 members represent each of the Community Health Boards in the state.

[2] The Minnesota Health Improvement Partnership was established in 1996 to advise the Commissioner on system development issues that cross the boundaries of public, private and non-profit sectors, with a broad-based membership from each of those sectors.

[3] Schulte V. Fitch, N.W. 717, 1925.

Creating a healthy society is a responsibility that is shared by all residents. While governments are vested with specific health protection and promotion responsibilities, it is what we do collectively, as individuals, communities and organizations that moves us towards a healthier future.

Efforts to strengthen public health in Minnesota have two main focal points. First, the governmental public health system must strengthen its ability to carry out core governmental public health functions and make measurable progress on reaching public health goals. This means responding to increased demands due to demographic changes, new health threats, and accountability for outcomes. State and local government share efforts to strengthen the public health system. Many of these efforts occur through the State Community Health Services Advisory Committee (SCHSAC), a 50-member committee representing all community health boards in Minnesota.

The second major public health system development activity in recent years has been to build and expand partnerships with organizations and agencies outside of the governmental public health system that play a role in improving the public's health. Much of that work has been done in collaboration with the Minnesota Health Improvement Partnership (MHIP) and is part of Minnesota's Turning Point Project funded by the Robert Wood Johnson Foundation.

The expected outcomes of these combined efforts are:

- A strong infrastructure of governmental public health at the state and local levels;
- Expanded network of public health partnerships; and
- Improved services and health outcomes for all Minnesotans with particular attention to those experiencing health disparities.

STRATEGIC DIRECTIONS FOR PUBLIC HEALTH

A key responsibility of the public health system is to watch for trends in health status and health threats. The *Healthy Minnesotans Public Health Improvement Goals 2004* identify a wide range of statewide efforts to improve health. In addition, local public health departments (known in Minnesota as "community health boards") identify and address local public health problems and strengths through a community health planning process, conducted every four years. These locally identified health problems and strengths inform and influence statewide efforts. Several important health issues facing Minnesota will provide a particular focus for work by the public health system during the upcoming biennium. These issues include: eliminating disparities in health status, improving readiness to respond to emerging health threats, assisting communities to raise healthy youth; and preparing for the next wave of health reform. The four issues, or "strategic directions" are complex issues with complex solutions. To make meaningful progress on these (and other) issues it will be important to emphasize two key areas: 1) engaging many people and many organizations around the state in solutions to these issues; and 2) with our partners, developing mutual accountability for progress.

Eliminate Disparities in Health Status. Even though Minnesota ranks very high nationally in overall health status, those high marks start to plummet when the data are examined more closely. American Indians, populations of color, and foreign-born populations, among others, simply do not enjoy the same level of health as other Minnesotans.

Barriers to improved health for populations of color and others often go beyond problems with access. Poverty, language, culture and other factors can make it harder for people to get prevention information and treatment. Disparities exist in data collection, policy and program funding. Environmental conditions also have an impact on health.

Minnesota's public health system will work together with communities most adversely affected by health disparities to close these and other health gaps and assure that all Minnesotans experience health parity.

Improve Readiness to Respond to Emerging Health Threats. As new diseases appear and former diseases reappear in new populations, as terrorists threaten to use biological weapons, and as governments struggle with limited resources, concern has grown about the ability of state and local public health agencies to respond quickly and effectively to large-scale emergencies and multiple outbreaks.

The list of threats to the public's health is growing. Drug-resistant bacterial infections, rising rates of tuberculosis and other infectious diseases in foreign-born populations, growth in the potential for food-borne illnesses, and bioterrorism all present new challenges. Public health agencies also are called upon to respond to public health needs created by disasters such as floods, tornadoes and spills of hazardous materials. Many local public health agencies are working hard to meet day-to-day needs while preparing to cope with large-scale public health emergencies.

To improve public health readiness, the public health system will work to: 1) formalize and strengthen our partnerships with many groups, including emergency responders; 2) improve coordination of emergency response, in particular to reach high-risk populations; 3) strengthen our capacity to detect emerging health hazards and develop and introduce technologies to address them; and 4) improve on systems for rapid notification and response with our state, local, and federal partners.

Support Communities to Raise Healthy Youth. Healthy youth are critical resources for the future. They must learn the skills needed to take their place in the workforce and lead self-sufficient lives. Good health is a necessary foundation for learning. To be good learners, children first need to have their health concerns addressed, and they also need to have safe and healthy school and community environments. Supportive communities are critical to raising healthy youth.

The most devastating behaviors affecting youth health include alcohol and other drug use, behaviors resulting in unintentional and intentional injuries, tobacco use, unhealthy sexual behaviors, poor nutrition, and physical inactivity. Recent years have seen a steady increase in these behaviors among youth, with alarming implications for their health now and in the future. At the same time, we recognize the strengths of youth and the power of building on the strength of youth, their families and communities in countering health risks.

Young people do not make their choices in a vacuum. Strategies for addressing youth behavior –and encouraging healthy choices for a lifetime –require understanding and involving the communities in which they are raised. Parents, teachers, community leaders and other youth mentors all play an important role in the lives of the children in their communities. Community norms and socioeconomic conditions are significant factors influencing youth behavior. And young people themselves must be engaged in the development of strategies intended to give them the best possible chance at a healthy life.

Minnesota's historic tobacco settlement and legislation setting up the Tobacco Prevention and Local Public Health Endowment will help us build ongoing efforts to help young people make healthier choices.

Key issues for Minnesota's public health system in creating the conditions that lead to the development of healthy youth include: cultivating partnerships for youth health (including youth); engaging the public in issues that affect youth health; improving technical assistance to local partners to strengthen the community approach to youth health; ensuring that preventive health services for adolescents are available and utilized; and ensuring safe and healthy schools.

Prepare Minnesota for the Next Stage of Health Reform. Today's health system is inordinately complex, understood by too few and pulled in opposite directions by the conflicting expectations of various stakeholders. Despite the high cost of health care, there are still too many uninsured Minnesotans, including more than 70,000 children. The uninsured either go without care and compromise their health, or they get care in the most uneconomical ways, which are ultimately paid for by insured citizens and taxpayers.

This rising tide of health care issues has led us into new conversations about health system reform. Public health must be a clear and compelling voice in these discussions. To influence the debates we need a clear view of what we want out of our health system, and consensus about how to get it. The system needs to be refocused on value: actually producing better health, not just producing more and costlier services. Individuals need to be encouraged to take more responsibility for their own health, by providing them with an environment that gives them more control over their health and health care while holding them accountable for the choices they control.

This new stage of health system reform has an emphasis about 1) developing tools for healthy, empowered, responsible individuals; 2) reinvigorating efforts in health quality improvement,

3) expanding health insurance coverage for children, and 4) improving health care financing policies.

Critical Factors in Addressing the Priority Issues. The four issues described above are complex, with multiple facets and multiple solutions. To make meaningful progress on these (and other) issues the public health system must emphasize two key areas: 1) engaging many people and many organizations around the state in solutions to these issues; and 2) with our many partners, be mutually accountable for our progress.

Bring the Community Together on Public Health Goals. Public health is a collective concern. No single agency, government or otherwise, can address all the social, economic, and behavioral issues that affect health. Government can, however, act as the catalyst to engage the community in the search for solutions to health issues. Minnesota did just that with the development of its Public Health Improvement Goals. These 18 goals, with objectives targeted to 2004, were developed collaboratively with leaders from 26 statewide public and private organizations.

The public health improvement goals cover areas ranging from birth outcomes to violence prevention; from adolescent health to workplace safety; from childhood development to the many issues arising from the "graying" of the population. The breadth of the goals, and the depth of the partnerships created in that process, has given us the impetus to continue forging stronger connections with citizens, local public health agencies, other government entities, health care providers, the business community, health plans, community organizations, and more. Engaging communities effectively is a real, yet critically important, challenge. The public health system will continue efforts to increase its capacity to engage the public in health issues, and will work to provide coordinated resources for others attempting to do the same.

Hold Ourselves and Others Accountable for Results. The concept of accountability is vital to the strength of government efforts. Being accountable means using resources wisely and well. The information for knowing if we are "doing the right things" may come in a variety of ways, including citizen feedback, stakeholder discussions, focus groups and opinion surveys, and statistical data and research.

It is important that public health activities around the state lead to measurable improvements in health status and healthy behavior. Prevention is undeniably hard to measure, and the factors that affect health are numerous and complex. Recognizing the importance and high cost of replicating research and evaluation, it is essential to utilize existing research and best practices in public health activities.

It is essential that continued efforts be made to better evaluate our own and others' performance through a variety of means, with an emphasis on improving health outcomes. Minnesota will work in conjunction with efforts at the local, state and national levels to develop tools and guidelines for enhanced accountability in public health. The public health

system will continue to protect consumers by monitoring and responding to disease trends, environmental conditions, and health care quality. Accountability requires effective communication, and thus we will work in close interaction with our many partners to make Minnesota a place where every person can be healthy.

PLAN OF ACTION

The steps listed below represent ways that MDH will work over the next two years to strengthen the public health system's capacity to address the strategic direction for public health issues. Each of these ten operates across several of the Strategic Directions. While the action plan is not exclusive to MDH, nor to the local public health system, it will require close partnership between state and local government.

1. Implement Workforce Development Activities to Address Health Disparities

2. Expand the Capacity of Minnesota Communities to Take Leadership on Disparity Issues

3. Implement Recommendations of the Social Conditions and Health Action Team (e.g., Health Impact Assessment)

4. Improve the Public Health System's Capacity to Respond to Emerging Health Threats

5. Cultivate Partnerships for Youth/Engage the Public in Issues That Affect Youth Health

6. Strengthen MDH Capacity to Provide Support and Technical Assistance to Community Health Boards

7. Strengthen Public Health Strategies for Mental Health

8. Increase Capacity of MDH and Local Agencies to Engage Communities

9. Begin Renewed Efforts to Reform the Health System

10. Continue to Maintain and Strengthen the State-local Public Health Infrastructure

A REPORT ON

PUBLIC HEALTH SYSTEM DEVELOPMENT

I. 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 public health system development. It incorporates the discussion and recommendations of advisory groups to the Commissioner of Health during 2000, including the State Community Health Services Advisory Committee[1] and the Minnesota Health Improvement Partnership.[2] It also incorporates conversations with many local public health staff and dialogue with community groups.

In addition to describing Minnesota's public health infrastructure, this report takes a close look at several important issues facing the public health system. These issues have been identified as strategic opportunities for the public health system and its partners to take action which will result in meaningful improvements in the public's health. One such challenge is eliminating the disparities in health status that exist in Minnesota. Others include improving public health system readiness to respond to emerging health threats; supporting communities to raise healthy youth; and ensuring that the next wave of health reform has public health at the center. Addressing these priority issues will require us to effectively engage the community in the search for solutions to public health problems and develop appropriate accountabilities and information systems.

This is the fourth report to address public health system development issues. Many of the issues identified in those earlier reports remain as important concerns. However, it is now possible to look back and describe progress that has been made in those areas. Appendix A provides a brief description of progress on the plan of action set forth in the last report.

[1] The State Community Health Advisory Committee is advisory to the Commissioner of Health on issues relating to local public health. Its 50 members represent each of the Community Health Boards in the state.

[2] The Minnesota Health Improvement Partnership was established in 1996 to advise the Commissioner on system development issues that cross the boundaries of public, private and non-profit sectors, with a broad-based membership from each of those sectors.

II. PUBLIC HEALTH IN MINNESOTA

The public health system in Minnesota consists of a strong state and local government system at its core, complemented by partnerships with the many organizations and entities that play a role in improving health. These components are described in more detail below.

A. Government's Responsibility for Public Health

Protecting the public's health is so basic, and the consequences of *not* protecting the public's health are so serious, that both the state and federal constitution contain provisions to ensure this protection. The Supreme Court has repeatedly found that protection of the public's health is a duty that falls on government: "The preservation of the public health is one of the duties devolving upon the state as a sovereign power and cannot be successfully controverted or delegated. In fact, among all the objects to be secured by government laws, none is more important than the preservation of the public health."[3]

State and local government public health agencies improve the lives of Minnesota citizens by:

- Preventing epidemics and the spread of communicable diseases.
- Protecting us against environmental hazards in our water and soil.
- Preventing injury and violence.
- Encouraging healthful behaviors that reduce other health costs.
- Responding to disasters.
- Providing essential services to at-risk populations who are not served by the medical care system.

Governmental public health agencies ensure safe drinking water, safe food, clean air, adequate immunizations, and provide necessary support to young families, the disabled, and the elderly. Moreover, as government entities, public health agencies also have unique responsibilities and an established structure for collecting and analyzing data on births, deaths, and the health status of the population, including monitoring of disease and injury. Much as we expect to have police to watch out for our public safety, public health workers have a responsibility to watch out for the health of our communities. These responsibilities are often called the "core functions" of public health.

To fulfill their duties, government public health agencies have been granted specific authorities for the enforcement of health and sanitary codes relating to housing, water, health care facilities, food, and plumbing; to enforce disease control laws in a variety of situations; and to enforce minimum standards in the delivery of health care services.

[3] Schulte V. Fitch, N.W. 717, 1925.

The responsibility of government for the health and well-being of the public applies by definition to all citizens, not just a select few. This approach to public health is referred to as "population-based." Population-based strategies emphasize health promotion and prevention of health problems and may be directed at individuals, communities, or systems, depending upon how the problem may best be addressed.

In order for government to carry out its public health responsibilities, an effective system must be in place at both the state and local levels. This system is commonly referred to as the public health infrastructure. Difficult though it might be to visualize, the public health infrastructure is integral to the day-to-day functioning of a community. It is like roads, bridges, water systems, and other types of essential government services and structure which citizens may take for granted, but expect to exist. It requires that the necessary legal authorities, trained public health workforce, equipment and other resources are present in sufficient amounts to address public health issues that arise in a community or state.

Minnesota's State and Local Government Partnership. Minnesota is unique among states for having a public health system that is a partnership of shared responsibility between state and local governments. This system allows state and local government to coordinate resources to address public health needs.

The Commissioner of Health is responsible for "developing and maintaining an organized system of programs and services for protecting, maintaining and improving the health of the citizens".[4] Minnesota Department of Health program areas include disease prevention and control, family health, community health, environmental health, public health laboratory services, health care policy, and regulation.

The Local Public Health Act lays out the vision for the strong local public health system that exists in Minnesota today.[5] This law calls on local government to "develop an integrated system of community health services" by "extending health services into the community."

"Community Health Boards" are established and supported by local government and made possible by state funding provided through the state community health services (CHS) subsidy.[6] To be eligible for the CHS subsidy, each of the 50 CHBs develops a four-year community health plan to address locally-determined public health problems. By law, the CHS plans must address the six program areas of disease prevention and control; emergency medical services; environmental health; family health; health promotion; and home health care.

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[4] Minnesota Statutes Chapter 144.05, subd.1.

[5] Minnesota Statutes Chapter 145A.

[6] A CHB is a county or group of counties, or city eligible to receive the CHS subsidy. In this document, the terms CHB and "local public health department or agency" may be used interchangeably.

This state and local public health system recognizes the differing needs of communities around the state, provides the flexibility to address specific needs yet establishes expectations for local government for public health. It allows sharing of technical expertise, data and resources between state and local government and promotes direct and timely communication between state and local agencies. The CHS system has resulted in an effective state and local partnership that does not rely on mandates for cooperation, but upon shared goals and a strong desire to work together to improve the lives of all Minnesotans.

B. Effective Partnerships With Others

Creating a healthy society is a responsibility that is shared by all residents. While governments are vested with specific health protection and promotion responsibilities, no one person, family, business, organization or government agency has the resources to bring about the changes needed for a healthy public. It is what we do collectively, in our communities, and personally that will move us as individuals and as a state towards a healthier future.

Many organizations have a role in improving the public's health. To focus broad community attention and inspire action toward addressing health problems, public health agencies at the national, state, and local levels work with their communities to create shared goals to guide health improvement efforts. At the local level, each Community Health Board conducts a community assessment and develops a Community Health Services Plan every four years. At the state level, the *Healthy Minnesotans Public Health Improvement Goals* were published in 1998 as a statewide agenda for health. The *Healthy Minnesotans* goals represent a statewide call to action, and also a reminder that we all share the benefits of and the responsibility for a healthy society.

In 1996, the Commissioner of Health convened a broad-based group, the Minnesota Health Improvement Partnership (MHIP), representing many of the types of organizations that play a role in improving the public's health. One of the major responsibilities of this group was to work with MDH in developing the *Healthy Minnesotans* goals. During the course of developing the *Healthy Minnesotans* goals, the MHIP recognized a need to set realistic expectations about what could be accomplished in the short term and at the same time set a longer term course for the future. Their long-term recommendations lay the groundwork for stronger partnerships, and improvements and actions to address public health issues.

For example, MHIP identified the need for additional efforts to elicit the involvement of broad segments of the community in public health improvement goals. Healthcare systems and physicians are critical to the achievement of many, if not most, of the health improvement goals set forth in *Healthy Minnesotans*, and the need for these systems to work in coordination is becoming more widely articulated and accepted. Furthermore, the MHIP recommended that voluntary and nonprofit organizations, the educational system, the health care industry, and the business sector should be actively involved in discussions of prevention and public health goals, in a way that is sensitive to the differing interests and capacities of those entities. During the 1990s, a particular emphasis was placed on developing relationships with managed care organizations. Legislation that passed in 1994 created new and more formalized

opportunities for dialogue between public health agencies and the private system of health care through the development of collaboration plans. The Collaboration Plan's purpose is to describe the actions that the Health Maintenance Organizations or Community Integrated Service Networks have taken and those it intends to take to contribute to achieving public health goals for its service areas. The Collaboration Plans are to be developed on the same timeline as the CHS plans, and provide an opportunity to undertake joint planning to meet locally and regionally identified needs. The *Healthy Minnesotans Public Health Improvement Goals* and *Strategies for Public Health* provide a broad framework for those efforts.

Recently, representatives from MDH, local public health, and health plans have discussed ways that this legislation could be strengthened and streamlined. New language has been drafted for consideration by the Legislature in 2001.

Strengthening Minnesota's Public Health System. Although Minnesota currently has a strong public health system, many issues remain to be addressed. Efforts to strengthen Minnesota's public health system have two main focal points. First, the governmental public health system must strengthen its ability to carry out core governmental public health functions and fulfill its responsibilities under state law. This includes responding to increased demands on the system due to demographic changes and new health threats. State and local government share efforts to strengthen the public health system. Much of these efforts occur through the State Community Health Services Advisory Committee (SCHSAC), a 50-member committee representing all community health boards in Minnesota.

The second major emphasis involves broadening the public health focus beyond government to explicitly include the many other organizations that work to improve the public's health. Much of that work in recent years has been done in collaboration with the Minnesota Health Improvement Partnership and is part of Minnesota's Turning Point Project, which is funded by the Robert Wood Johnson Foundation.

Over time, the expected outcomes of these combined efforts to strengthen public health in Minnesota are:

- A strong infrastructure of governmental public health;
- Expanded network of public health partnerships; and
- Improved services and health outcomes for Minnesotans particularly those experiencing health disparities.

III. STRATEGIC DIRECTIONS FOR PUBLIC HEALTH

A key responsibility of the public health system is to watch for trends in health status and health threats. The *Healthy Minnesotans Public Health Improvement Goals* identify a wide range of statewide efforts to improve health. In addition, community health boards identify and address local public health problems and strengths through a community health planning process, conducted every four years. These locally identified health problems inform and influence statewide efforts. Several strategic issues have been identified as critical to addressing our goal of ensuring a vital and healthy Minnesota. These issues represent significant areas of opportunity, and will be the target of focused efforts during the upcoming biennium. They are: eliminating disparities in health status; improving capacity to respond to emerging health threats; supporting communities to create healthy youth; and ensuring that the next wave of health reforms have public health at the center. Health Commissioner Jan Malcolm refers to these issues as "strategic directions" for public health over the next few years. To make progress on these issues is will be critical to engage communities in working to achieve public health goals; and to develop appropriate accountabilities and information systems. It is essential that Minnesota's public health system has the capacity to address these issues.

A. Eliminate Disparities in Health Status

Even though Minnesota ranks very high nationally in overall health status, those high marks start to plummet when the data are examined more closely. American Indians, populations of color, and foreign-born populations, among others, simply do not enjoy the same level of health as other Minnesotans. We have some of the widest gaps in health status between the white and non-white populations of any state. Although 'eliminate disparities' is a bold statement, it is essential that we work to close these and other health gaps and assure that all Minnesotans experience health parity.

> *Disparity Definition - For these purposes "disparity" is defined as: significant differences in health status that are evident among certain populations in the state of Minnesota characterized by race and ethnicity, national origin, socio-economic status, age, gender, disability status, geographic location, sexual orientation and age.*

In Minnesota, our most dramatic disparities are evident among American Indians and minorities. Examples of health disparities that exist in Minnesota include:

- The infant mortality rates in the African American and American Indian populations are two to four times higher than for the white population;

- The rate of diabetes for American Indians in Minnesota and Wisconsin is 600 percent higher than whites;

- African American males between the ages of 15 and 25years old are 25 times more likely to die as a result of firearms than whites of the same age;

- Adults from populations of color are more likely to be under immunized than their white counterparts; and

- Foreign-born individuals with TB in Minnesota are more than twice as likely as U.S. – born cases to have drug-resistant TB.

This sampling of statistics clearly illustrates the critical need to address the health disparities – particularly among minorities and American Indians that exist in Minnesota.

Key Issues in Eliminating Disparities. In developing plans to eliminate health disparities in Minnesota during the past year a number of important issues have been identified which must be addressed in order to move ahead. These issues are summarized below.

Utilize Community Leadership and Assets. Leadership of health improvement efforts must be rooted in the community. Those affected by health disparities must be active participants in the selection or priorities and in the development of solutions. Despite the adversity faced by many immigrants and refugees, American Indians, people of color, and persons with low incomes, there are numerous opportunities to build on community assets. These include: community-based programs and entities; community-run businesses, schools, health care services, and centers that engage their constituents; skilled individuals with non-traditional training but real community connections.

Build Relationships. Public health agencies at the state and local level need to build and expand partnerships with communities most adversely affected by health disparities. Dialogue with community groups has emphasized the importance of avoiding "one size fits all" programs and services imposed by funding organizations outside the community. They have also emphasized the urgency of addressing the disparities that exist in Minnesota; the need for representation and diversity among those in decisionmaking positions power; and the absolute necessity of involving those affected by disparities in developing approaches to resolving the disparities. Moreover, members of the community have asked for support from the public health system in collecting the data needed to effectively articulate the problems/issues that they know exist from their own experience, and identify the actual level of the problem. Developing close working relationships will be necessary to understand diverse perspectives, and to develop effective interventions.

Building and Fully Utilizing a Representative Workforce. The striking gaps and disparities in health status are paralleled by the significant under-representation of populations of color in health-related occupations. Increasing the racial and ethnic diversity of the health workforce is an important structural change that will improve

the extent to which racial and ethnic minorities receive culturally appropriate health care and public health services.

Increasing the representation of populations of color in the public health workforce is necessary but not sufficient. Staff who are representative of disparity and diversity interests across the MDH have shared their perspectives on past, current and future barriers and opportunities. These conversations have revealed ways in which the MDH work environment supports and impedes our ability to achieve success in reducing disparities. These perspectives provide valuable insight into what can be done within MDH and similar organizations to strengthen workforce diversity.

Addressing Underlying Social Conditions. Health is a product of individual factors (genes, health practices and coping skills) and collective conditions (the environment, the health care system). Many of the factors that affect the health of Minnesotans lie beyond illness treatment and beyond the current health care system. The social and economic environment, physical environment, health practices and coping skills, biology and health care services are inter-related and are widely regarded to determine health status. (See Appendix B)

Research findings in fields ranging from medicine and epidemiology to economics, political science, history and sociology, have transformed our understanding of the connection between health status and the social and economic environment. Factors such as housing, income, education, culture, community connectedness and equal opportunity affect health in fundamental and lasting ways.

Numerous studies have directed specific attention toward racial/ethnic and socioeconomic health disparities, and suggest that several underlying, inter-related factors explain much of the difference in health. These factors include income, education, race, stress, opportunity, and discrimination. A report prepared by the Minnesota Health Improvement Partnership Social Conditions and Health Action Team report summarizes that research as follows:

- Income is a major determinant of health status. People with higher income generally enjoy better health and longer lives than people with a lower income. The rich are healthier than the middle class, who are in turn, healthier than the poor. This is true for people of all racial and ethnic backgrounds.

- People of color and American Indians do not experience worse health simply because they are more likely to have a lower income (although this is an important factor). *At every level of income*, the health of people of color is consistently worse than that of their white peers.

- Discrimination and racism play a crucial role in explaining health status and health disparities through factors such as restricted socioeconomic opportunities and mobility, limited access to and bias in medical care, and residential segregation (which can limit access to social goods and services), and chronic stress.

- It is essential to address these and other aspects of the social and economic environment in order to eliminate disparities. Efforts to improve access to culturally competent health care and promote healthy choices are important but not sufficient in isolation from broader efforts to address racial/ethnic and socioeconomic disadvantage.

- Broader efforts focused at social and economic opportunity promise not only to alleviate health disparities, but also to improve the health of the whole community.

These finding challenge and encourage us to broaden health improvement efforts to reflect the full range of the determinants of health, with renewed attention to social and economic factors.

Current Efforts. Many efforts are underway in MDH, and in Minnesota communities, to address health disparities. These range from the minority health assessment grants from MDH to 11 Community Health Boards, to the Minnesota Health Status Report on populations of color, to the American Indian Infant Mortality Reduction Project. Much more needs to be done to coordinate efforts across communities and governmental organizations. In addition, MDH and local government must improve their ability to actively engage communities and citizens in finding solutions to disparities. Recognizing the strengths of American Indians and minority communities in being able to build on success through adequate support and resources is essential.

What Will Success Look Like?

- Significant improvement in health realized among those in communities experiencing the greatest disparity in health status.
- External activities and internal policies and programs of state and local public health agencies will reflect prioritization of eliminating health disparities and promoting healthy diversity.
- Health disparity data are identified, collected, analyzed and communicated in ways that generate health benefits for those experiencing substantial health disparities. Minnesota has a strong, culturally-representative public health workforce.

B. Improve Readiness to Respond to Emerging Health Threats

The public health system is increasingly being asked to anticipate and address new and emerging health issues. New or antibiotic resistant infectious disease threats, and the re-emergence of familiar diseases that were once thought to be effectively controlled, are among these issues. For example, food borne diseases, while not new, are increasingly being recognized as an important public health problem. Clandestine drug labs that manufacture methamphetamine have created health, environmental, and law enforcement problems of crisis proportions in other states. Toxins in school buildings have posed health threats in children. The public health system is asked to find ways to address health implications of a wide variety of potential crises and emergencies—including natural disasters, environmental releases of toxic substances, major disease outbreaks and acts of terrorism. And as our state's

population continues to diversify, we are increasingly being asked to assess and respond to health issues that face our newest citizens.

Key Issues in Improving Readiness to Respond to Health Threats. In no other area of public health is it more crucial to have a strong infrastructure—a skilled and prepared workforce, effective information systems, and ability to mobilize community organizations. This foundation—the public health infrastructure—must be strengthened to respond to emerging health threats at both the state and local levels. Strengthening the infrastructure involves several components:

- Forming new partnerships and improving collaboration between/among state and local organizations.
- Detecting and monitoring emerging issues.
- Increasing capacity to respond to emerging health threats.
- Strengthening intervention capacity.

Partnerships and Improved Collaboration. Readiness to respond to emerging health threats requires a complex collaboration of federal, state and local government and also private organizations. At the state level, MDH has been working with many primary partners to assure a system is in place for any public health threat. Depending on the issue, additional federal, state or community partners may be needed. Many relationships are informal and on an as-needed basis. The increasing awareness of the need for coordinated planning and communication highlights opportunities to formalize relationships and coordination.

The public health system must continue to collaborate with federal, state and local government and private organizations and, depending upon the issue, add federal, state or community partners. Efforts should be made to increase statewide awareness of the need for coordinated planning and communication. Local public health agencies should use the handbook to connect with emergency management officials in their communities.

Detecting and Monitoring of Emerging Issues. For the public health system to effectively detect and monitor emerging health threats, it must have sufficient capacity in several key areas. First, it must have the capacity to collect and analyze data on specific health behaviors, diseases, drug resistance, health effects, or exposures in the population. Second, it must have sufficient laboratory capacity to conduct surveillance for detection and identification of infectious agents, hazardous chemicals and radioactive substances. Finally, it must have sufficient epidemiological and toxicological expertise to interpret data on disease, disability and exposure to biological organisms and chemical agents in order to develop effective prevention and control programs.

Emerging Threat Response Capacity Issues. Emerging threat response capacity refers to the ability to effectively *respond* to threats to the public's health once they are detected. Inherent in this capacity is staffing capacity for planning, coordination, management and response; and data management and communication infrastructure to support a rapid exchange of information with partners.

Issues Related to Emergency Public Health Intervention Capacity. Emergency public health *intervention* capacity refers to the legal authorities needed to take the extraordinary steps that might be needed to protect the public's health during a terrorism event, large scale disease outbreak or other public health threat; as well as the ongoing training, planning, exercises, and evaluation of response systems to assure the systems are continually modified to reflect changes in resources, expertise and threats.

Current Efforts. Some efforts have begun to address these issues. First, state and local government have worked together to identify roles and activities needed to address infectious diseases. A 1997 work group of the SCHSAC developed a framework of activities for disease prevention and control common to all local health departments and MDH. While not all local health departments are able to perform all activities, all CHBs have begun to work with MDH to determine their current capacity and set benchmarks for improvement. Second, the SCHSAC also worked with MDH and emergency management at the state and local levels to develop a handbook to assist local health departments to prepare for public health emergencies. Following the completion of this work, a state-local work group developed a template for developing a disaster and emergency response plan. Local health departments have begun to develop such plans, which may be included as an annex to the county disaster plan. Third, efforts to improve communication with many organizations have expanded due to development of a Health Alert Network. This network, funded by a grant from the CDC, provides for internet access to all local health departments. This network will be used to communicate about public health disasters and other health threats.

Other efforts involve coordination among many state level organizations. For example, MDH has worked with the Department of Emergency management to prepare a legislative report on Minnesota's capacity to prepare for public health emergencies, especially bioterrorism attacks.

What Will Success Look Like?

- Emergency planning and response are effectively coordinated with the Department of Public Safety, the Department of Emergency Management and other partners.
- Rapid and effective responses are made to emergency health threats.
- Surveillance and assessment systems are comprehensive and effective.

C. Support Communities to Raise Healthy Youth

Healthy youth are critical resources for the future. Youth must learn the skills needed to take their place in the workforce and lead self-sufficient lives. Good health is a necessary foundation for learning. To be good learners, children first need to have their health concerns addressed, and they also need to have safe and healthy school and community environments. Supportive communities are critical to raising healthy youth.

Each stage of development is influenced by the social context in which our youths live, work and/or attend school. Different strategies are required to reach older youth and children. For example, as young people move into and through adolescence, they are bombarded with messages encouraging them to engage in risky behaviors. They develop a strong sense of

needing to belong, to fit in. It is critical that we consider the decisions our youth face in the context of their social environment, beginning in the years before adolescence.

Key Issues in Supporting Communities to Raise Healthy Youth. Research and experience have taught many lessons about what must be in place to raise healthy youth. Key issues include the following:

Build Partnerships Within the Community. The tremendous success the Minneapolis Schools have had with their "Healthy Learner Board" – a partnership of the school district, health experts, business and community leaders, and parents – illustrates the importance of developing effective partnerships to raise healthy youth. That group established ambitious goals, and demonstrated that, by working together, they could produce amazing results. For example, one very significant outcome of the project was a dramatic improvement in immunization rates for school-age children – from 67 percent to 98 percent.

Ensure a Safe and Healthy School Environment. More than a million children attend school in Minnesota. They bring with them an increasingly diverse set of health needs – serious concerns like asthma, diabetes, obesity, depression and other mental health conditions. During any given week of the school year, Minnesota's young people will spend at least a third of their time in the school setting. Often, that will mean spending time in a school building where they are exposed to hazards like mold, dust, and air pollutants. These environmental hazards place children at risk for serious health problems. Moreover, the introduction of new vaccines, and new combinations of old vaccines, has made it much more difficult for parents, health care providers, childcare providers and school health officials to keep accurate records of each child's immunization status.

Engage Youth in the Development of Strategies. It is critical that young people be engaged in the development of strategies. "Preachy" public health messages have limited success with youth. New strategies are being employed with various activities throughout the country that give a voice to youth in reaching others. This model is built on the "peer education" programs that have sprung up across the land in the past few decades.

Develop Mentors. The impact of adults in the lives of youth cannot be underestimated. Parents, teachers, mentors, and adult role models affect resilience factors and can increase the chance for successful outcomes. As youth move through this critical phase of life, the role of adults shifts from primarily teachers to mentors who help in the process of decision making and moving toward independence.

Better Coordination of Data on Health Outcomes for Youth. Efforts are needed to collect data that are useful and will help achieve the desired outcomes. "What do we already have and what is missing? " Early steps in this direction have lead to the establishment of the interagency children's data "port" - www.mnkids.org. Through

this single site statewide and local vital record and program-specific data on children across the state can be accessed.

Coordination of the Concepts and Efforts to Improve Youth Health With Those Addressing the Social Conditions that Affect Health Status and Disparities in Health Status. Within these areas discussions are focusing on community-determined activities and outcomes - both quantitative and qualitative. It is critical that we work to recognize earlier markers of needs in children, youth, and families, and more universally available ways for families and communities to have contact with resources and strategies to support and promote healthy environments and behaviors, ideally before risk behaviors begin.

Ensuring the Availability and Utilization of Preventive Health Services for Adolescent. Providing health insurance to younger Minnesota children continues to be a priority public health issue. However, less often discussed is the role that the health care system plays with respect to adolescents, in identifying risks and protective factors that relate to an adolescent's health, and in providing preventive health services to that age group.

Addressing Mental Health Issues. Addressing mental health issues is critical to raising healthy youth. A community based public health approach to mental health is needed in Minnesota, which includes increased coordination of existing and future prevention activities in state agencies and in local communities; working with local public health agencies and other community-based partners to develop and implement best practices for prevention; and promoting greater public awareness and acceptance of mental health concerns. Suicide, which is the second leading cause of death for 10 – to 34 year-olds, provides one important example of a mental health issue that could benefit from a public health approach.

Current Efforts. In 1999, the Minnesota legislature created the Tobacco Prevention and Local Public Health Endowment. While efforts have been underway for several years to address the many behaviors with potentially negative consequences to short and long term health of youth, these additional resources create a unique opportunity to rethink the public health infrastructure for addressing youth health. In 1999 and 2000, a SCHSAC Youth Risk Endowment work group developed a framework to improve youth health. Both this group and the Tobacco Endowment Advisors' group developed principles and methods to administer funds available through the endowment and evaluate success of new efforts. There has been considerable work done in the past year to begin to implement the local public health endowments to address youth risk behaviors. This has been accomplished with limited new resources at the state level and modest resources to community health boards and other community organizations. Technical assistance and evaluation efforts are currently being organized among current staff; however, lack of dedicated remains a concern to carry out this substantial leadership responsibility. During 2000, the Minnesota Health Improvement Partnership Adolescent Health Services Action Team developed recommendations intended to begin the process of developing a statewide consensus on a standard set of comprehensive

clinical preventive health services for Minnesota adolescents and to provide a short term infusion of funds into a stressed financing system.

What Will Success Look Like?

- Community approach to youth health is strengthened, with youth in a leadership role.
- Youth issues are addressed in the context of community norms and social conditions as well as youth behavior.
- Objectives in the Healthy Minnesotans Public Health Improvement Goals, Maternal and Child Health Performance Measures, and Minnesota Student Survey indicators are achieved.

D. Preparing for the Next Wave of Health Reform

Health care is again high on the public agenda as medical care costs begin to rise steeply after a few years of stability. While the economy is good and Minnesotans are relatively healthy and well-insured, many forces are combining that may change this picture. Some of these forces are:

- An older, more diverse population.
- The resulting shift in health care and health care costs to chronic diseases, mental illness, and lifestyle behaviors.
- Resource and access disparities between the metro area and greater Minnesota.
- More high tech, expensive medical treatments and pharmaceuticals.
- Increased utilization of medical services.

With little or no change in public policy, the following is the likely scenario for our health system:

- Investments in population health status—the public's health—will continue to be overshadowed by more acute and growing health problems.
- The number of uninsured will continue to grow.
- Workforce shortages will increase.
- The gap between haves and have-nots will grow and health disparities among populations will grow.

In the early1990s, Minnesota had an ambitious strategy for health reform. This strategy was based on many policies intended to influence health care costs, quality, and access. The Minnesota Health Care Commission, comprised of consumers, employers, health care providers, health plan companies, labor unions, and state government, provided advice and direction to the legislature on health reform. Among the major initiatives were: MinnesotaCare, an expanded insurance coverage for low-income enrollees; small employer market reforms; growth limits established to keep health care affordable (although these were eventually repealed); the Pre-paid Medical Assistance Program, which allows health maintenance organizations to provide care for medical assistance enrollees; and initiatives to strengthen the rural health care system, such as subsidies and transition grants for rural hospitals; the Minnesota Health Data Institute was established to create a public-private

partnership to plan and administer data initiatives, and Regional Coordinating Boards, created to address local cost containment issues, became an avenue to address other local health-related issues (later eliminated).

In Minnesota as in the nation, health care reform discussions did not originally include discussions of public health. However, the health care reform movement stimulated discussions, in SCHSAC and other forums, about the public health system's contributions to a reformed health system. These discussions resulted in several legislative initiatives and many more recommendations about how the public health system should contribute to health reform.

The public health system learned a considerable amount about the role of public health in health reform from experiences in the 1990s. The most valuable of these lessons are the following:

- **Protecting the health of the public is a fundamental responsibility of government.** Government has a legal obligation to protect the health of the public. In order to fulfill its authority and responsibility to protect the public's health, there needs to be a solid governmental foundation for health—a public health infrastructure.

- **The public health system cannot do it alone.** As described in the *Healthy Minnesotans 2004 Public Health Improvement Goals,* government has the basic responsibility for protecting the health of the public, but acknowledges that no one person, family, business, organization or governmental agency has the resources to bring about the changes needed. It is what we do collectively, in our communities, and personally that will move us as individuals and as a state toward a healthier future.

- **Public health efforts must be evidence-based.** Our experience has led us to greater rigor, design and deliver of programs. Using research and evidence-based science leads us to effectively achieve our goals.

- **Coverage does not equal access**. Although changes were made to increase health care coverage for individuals (e.g., Minnesota Care and small group market reforms), the issue of access to health care, over and above insurance coverage, has not been resolved.

- **Large increases in spending in health technology, health care and health insurance coverage may only result in incremental improvements in health status.** There is no evidence to suggest that the more we spend on health care the more we will reap greater improvements in health status. In fact, evidence worldwide demonstrates that countries spending far less per capita than the U.S. have greater health status overall.

- **It is difficult to assess overall improvements in health because of the many and various indicators used to measure health.** The U.S. Department of Health and

Human Services has outlined ten leading health indicators to assess health. These measures are useful; however, they may indicate good health in some areas and poor in other areas.

These lessons should be kept in mind as new initiatives are proposed to address highly visible issues related to health care costs. Many policy changes resulted from these discussions. Among significant changes were: a $5 million annual appropriation from the state legislature for governmental core function activities; statutory authority for the commissioner to establish public health goals and the creation of the Healthy Minnesotans public health goals document; collaboration plans to require health plans to work with local public health agencies; and tobacco endowments to local government to coordinate community efforts at youth tobacco use prevention.

Key Issues in Preparing for the Next Wave of Health Reform. SCHSAC formed a Health Reform 2000 work group to review past work and identify next steps for the local public health system. This group identified several issues related to government's responsibility for the public's health. These issues confirm and expand on findings in the 1999 system development report. See part three of this report for progress in many of these areas.

Lack of Understanding About the Local Governmental Role in Protecting the Public's Health. Although all levels of government share in the responsibility for the public's health, there is often a lack of understanding by other areas of government about the authority and responsibility of local government in protecting the health of its citizens.

Lack of Federal, State and Local Governmental Coordination. There is a lack of coordination among government entities which is often demonstrated through a shift of problem or administrative burden to another area of government that lacks the resources needed to adequately address it.

Insufficient Accountability for Public Dollars Spent on the Public's Health. We have not made those who spend public dollars accountable for its use primarily because we lack appropriate indicators to measure the effectiveness of both the public health system and the private sector that implement programs with public dollars.

Difficulty Assessing Health Status. It is difficult to assess how healthy Minnesotans are, what public health efforts work, and even what public health activities are currently occurring due to lack of baseline data, difficulty accessing data, and uncoordinated data systems.

Changing Demographics and Needs of Our Population. Minnesota's population is changing through our aging population, the settlement of migrant workers, and immigration from Asia, Africa, and Eastern Europe. This change adds to the difficulty for the public health system in understanding and addressing community need.

Growing Health Workforce Shortages. Parts of Minnesota currently lack qualified health care and public health personnel, due to retiring older workers and an exodus of younger workers from small communities. With the increasingly diverse population, there is a need to hire culturally diverse or sensitive staff and/or provider training for existing staff.

Fragmented Funding. Although CHBs receive a $19 million annual CHS subsidy from the state, this subsidy represents an average of only eight percent of local public health departments' budgets statewide. CHBs rely on state and federal categorical grants for many activities which often results in unstable and fragmented funding.

Increasing Financial Pressures. Privatizing public programs, such as Medicaid and Medicare, have reduced the resources available to local public health departments. In addition, there is increasing pressure on local tax levy and fee revenues, particularly for smaller counties, and a continual struggle to determine what agency and what tax pays for what services.

Lack of Coordination with Other Organizations. The governmental responsibility for assurance is often difficult because of the fragmented decision-making among providers, payers and insurers and the public health system.

Lack of Priority for Health Promotion and Prevention Activities. As seen in the previous section, health behaviors may influence health status by approximately 50 percent, yet our funding for health promotion and prevention activities that can impact behaviors do not reflect this.

Current Efforts. In addition to SCHSAC's work on public health roles in health reform, several forums have been created to address health reform concerns. First and most visible, a Governor's Health Policy Council identified many issues and developed a vision for a health system for the next 50 years. This group has identified four major components: helping people to be healthy through coverage and prevention expansion, controlling health and costs and helping make an emphasis on outcomes, and shoring-up the health care infrastructure. In addition, there is a strong interest in encouraging consumers to better participate in health reform issues in order to get public input to difficult choices that need to be made.

What Will Success Look Like?

- A strong emphasis within health reform on public health and prevention.
- A health system that is simplified and sustainable.
- Data collection efforts are improved and focused on meaningful measures.
- Policies for public financing of health care are explicit.

E. Bring the Community Together on Public Health Goals

As illustrated in the earlier section on healthy youth development, public health is a collective concern. No single agency, government or otherwise, can address all the social, economic,

and behavioral issues that affect health. Government can, however, act as the catalyst to engage the community in the search for solutions to health issues. Minnesota did just that with the development of its *Public Health Improvement Goals.* As noted earlier in this report, these 18 goals, with objectives targeted to 2004, were developed collaboratively with the Minnesota Health Improvement Partnership, which consisted of leaders from 26 statewide public and private organizations.

To move forward on the goals, the Minnesota Department of Health and local public health agencies must forge new and stronger connections with citizens, other government entities, health care providers, the business community, health plans, community organizations, and more. Achieving progress on the goals will help to increase years of healthy life for all Minnesotans.

What Do We Mean by Bring the Community Together on Public Health Goals?"

This issue is essentially about leadership– both community leadership and about a new model of government leadership. By promoting health as a shared responsibility, the MDH is encouraging a new model of government leadership in health, characterized by:

- Citizen leadership.
- State and local government agencies that are willing and able to effectively support and guide citizen-led initiatives.
- Cooperation between the public, private, and nonprofit sectors.

This new model of government leadership can be used to develop a shared understanding of health information such as epidemiologic, behavioral, and intervention data, as well as a shared understanding of community norms and values related to health. This model can also be used to prioritize the use of limited resources.

Together, public, private and nonprofit sectors need to look for ways to identify and work jointly on areas of common concern. The goals, objectives and strategies identified in *Healthy Minnesotans* can provide a unifying framework and common agenda to work more closely together.

Local government is a critical link in fostering greater citizen leadership in community health. Local governments, organized under the state's local public health act, can be catalysts for engaging citizens in deciding health priorities and mobilizing resources throughout their communities A mechanism for community input into local goals already exists as part of the Community Health Services planning process. This process should be supported and strengthened as a way to increase community support and participation in improved community health. State and local public health agencies should work to develop tools to support and strengthen these efforts as a way to increase community support and participation in improved community health.

Key Issues in Bringing Communities Together Around Public Health Goals. Despite some successes, there are numerous barriers to fully integrating this approach into public health practice.

Categorical Funding. Specifies programs for which those funds may be used, which may not be the highest priority problem in a community.

Time and Resource Intensity. Engaging communities in the search for solutions to health problems is time consuming. Local public health agencies report stress in identifying the resources needed to engage in community mobilization efforts. At the MDH, staffs have suggested the need for this approach to be fully embraced and supported by all levels of management.

Balancing Autonomy with Accountability. This approach requires giving up power to communities to make decisions. However, MDH and Community Health Boards are accountable to Congress, the Minnesota Legislature and the citizenry for appropriate use of resources. A balance must be established between community autonomy and accountability.

Defining Community. We know that we need to build community capacity, but the definition of community is not always simple. People do not become part of a "community" by virtue of having the characteristics of a specific population. Community requires interaction, and therefore generally requires proximity. Community also is about shared beliefs, purpose, and principles. For example, some neighborhoods (proximity) become communities; while some do not (no shared purpose). Many individuals in our society live in relative isolation. Others are members of multiple communities: neighborhood, work, culture, and faith.

Current Efforts. Numerous program areas within MDH and public health agencies actively engage communities in their work. An informal group within MDH has met to identify ways that staff involved in community engagement can support each other and local public health agencies, and share resources and information. As a result, a community engagement web site is being developed by which information and resources can be shared. The website will contain sample documents, resources, tip sheets, informational materials on community engagement and web links.

What Will Success Look Like?

- Improved public and MDH awareness of the public health goals.
- Active community involvement in public health issues/goals.
- MDH programs aligned to public health improvement goals.
- Increased state and local capacity for community engagement.
- Affected communities are engaged in the search for solution to health issues.

F. Accountability and Information Systems

In order for state and local government to successfully carry out their shared mission to lead efforts to protect, maintain and promote the health of the public, good information is needed. Good information resource management can help reach the overarching goals stated in the public health goals: to increase years of healthy life, to reduce disparities in the health status of populations, and to maintain and strengthen the public health infrastructure. Moreover, assuring the accountability of the health care system is a key function of public health agencies. While once a leader, Minnesota now lags far behind other states in making data on the health system publicly available, analyzing trends, and providing feedback to improve health quality and enable sound decision making.

Accountability in the Public Health System. Like business, government at all levels is moving toward quality improvement and greater accountability. The federal government, in conjunction with several public health organizations, has developed several performance measurement tools to identify benchmarks for effective performance. One example is the national Maternal Child Health performance measures. The Centers for Disease Control has recently completed a draft of indicators of performance for local health departments that may be used as a tool to address performance in each of the essential public health services. This is seen as the possible precursor for a national accreditation program.

Minnesota's public health system has taken several steps toward identifying ways to improve performance in the local public health system. In 1998, a companion document to the *Healthy Minnesotans* document, *A Compendium of Strategies for Public Health*, was published. This document provides a resource for effective strategies for public health activities. In addition, the MDH has developed evidence-based practice standards for several areas of public health, including violence prevention. Also in 1998, two work groups of the SCHSAC addressed the issue of improved performance. The SCHSAC Governance Work Group concluded that, in order for government to fulfill its responsibilities, a solid foundation, or infrastructure was needed at both the state and local levels. The work group recommended more work be done to identify indicators of organizational capacity to support this infrastructure. Another SCHSAC work group reviewed national efforts to accredit local health departments. This group concluded that accreditation was not the best way to improve performance in Minnesota at this time. However, they recommended that the MDH and CHBs work together to develop and implement voluntary performance measures.

Minnesota's public health system has been based in large part on the voluntary cooperation between state and local government. Establishment of required performance measures, and particularly an accreditation process, would represent a major departure from this approach unless agreed upon by state and local government. Jointly assessing organizational capacity and performance and developing plans for improvement is a first step to targeting resources effectively.

Two examples illustrate the importance of good information systems. The first example is that of a bioterrorist attack. In such an event, the public health system must be able to rapidly

respond to medical emergencies, environmental threats, and subsequent physical and mental health issues. In order to do this, local, state, and federal public agencies must be able to share information in a timely and coordinated fashion.

The second example relates to ongoing monitoring of communicable disease. An essential public health activity is to monitor and investigate health problems, including communicable disease. In this case, it is important for state and local government to be able to share information on population-based efforts to control disease; number of individuals immunized, and target areas where the risk is greatest. In order to do this, information systems must be compatible, be able to share information in a timely fashion, and be coordinated to eliminate duplication. In addition, information systems must also be designed to access information from other state agencies and private health care providers.

Key Issues in Public Health Information Systems

Designing an Integrated State-local Information System. An integrated state and local public health information system would help state and local government work together as partners to monitor progress toward health outcomes. The MDH and local public health representatives have identified key components of an effective information resources management system as:

- Strengthen the ability of users to make informed decisions and set priorities.
- Provide users with full access to public health information within the limits of the law.
- Integrate and or/coordinate information needs and systems so that information is collected and disseminated in an effective and efficient manner.
- Improve collaboration between federal, state, and local agencies.

Local public health staff and county commissioners are critically aware of the need to upgrade information systems. Many of them have expressed repeated concerns about the financial drain of creating, upgrading, and supporting information systems at a time when resources are also stressed. At the same time, both the MDH and community health boards recognize the need to better coordinate data and share information both within the MDH and between state and local government.

Accountability for Health Quality and Outcomes. Vital, healthy communities require a supportive, affordable, high quality health system. Ultimately, it will be individual decision-making and consideration of options that will reduce health care costs and improve health quality. The health system of the future will increasingly on individuals using unbiased information on cost, quality and access to guide their choices. In the health marketplace today, individuals routinely make choices about health care services, but often they make these choices without information that enables them to know which providers, hospitals, health plans, treatments or drugs consistently create the best results.

Although U.S. citizens have access to some of the most advanced medical treatments in the world, the U.S. ranks far from the top when it comes to the overall health of our citizens. Variations in the quality of health care have serious implications for the effectiveness and cost of our system.

Key Issues in Health Care Accountability

Consumer Empowerment. Enabling consumers to use health care cost and quality information to guide their choices by identifying consumer needs and developing useful, accessible public information.

Monitoring and Reporting. Increasing the accountability of the health care system by monitoring and publicly reporting comparative measures of care delivery and health outcomes.

Assuring Quality. Assuring quality of health care and health improvement by measuring results and prioritizing health services and programs that make a difference in health status.

Current Efforts. The MDH and local public health departments currently lack the resources to address these critical issues. However, within the past year the MDH worked with the SCHSAC to develop a plan for information resource management for state and local public health. This work resulted in a MDH legislative initiative to provide for an integrated state-local information system to be used to address the three critical questions discussed above. While this legislative initiative was not successful, progress has been made on local health department internet connectivity through the health alert network grant and on the improving assessment information through the county health profiles. The Population Health Assessment Work Group (PHAWG) has undertaken projects to assess quality of health services and outcomes in several key areas, including tobacco and diabetes.

IV. PLAN OF ACTION

Previous sections have described Minnesota's public health system roles in achieving goals for a healthy Minnesota. They have also described the critical need to engage communities and partner organizations in working with state and local government toward improved health. Additionally, several priorities have been identified which provide significant opportunities to improve health over the next few years. For each of those priority areas, key issues were identified which must be addressed in order to move forward. This section describes actions that the MDH will take over the next two years to strengthen the public health system's capacity to address those issues. Each component of the plan operates across several of the MDH Strategic Directions. While the action plan is not exclusive to MDH, nor to the local public health system, it will require close partnership between state and local government.

1. Implement workforce development activities to address health disparities

Build capacity and affirm role of public health staff in eliminating health disparities (achieving parity). To begin to meaningfully address disparities in health status requires that state and local public health agencies begin to think about their work in different ways. Over the next two years MDH will work with local public health agencies to organize public health resources in the state to better address health disparities. Specific strategies include creating mentoring opportunities, workshops and other educational opportunities.

Increase the diversity of the public health workforce. Another important step in eliminating health disparities is attracting and retaining a diverse workforce. This process requires that MDH and local public health agencies establish and adhere to practices to recruit, retain, and promote personnel who reflect the cultural and ethnic diversity of the communities served. Strategies include creating an environment where all employees feel welcome, accepted and valued; creating diverse applicant pools of qualified people; increasing the future pool of qualified applicants; ensuring that applicants of color are given full consideration in the hiring process; retaining people of color in the workforce. MDH will continue to support the proposed Public Health Fellowship program at the University of Minnesota School of Public Health, which seeks to recruit and support students of color in obtaining public health degrees.

Increase cultural competency of the public health workforce. Issues of cultural competency are also key. Several activities that are underway at MDH should continue over the next two years. The Office of Minority Health is developing a cultural competency curriculum. Additionally, the MDH Section of Public Health Nursing has incorporated cultural competency into the Public Health Nursing for the 21st Century initiative. The section will continue to work to integrate cultural competency as a core skill in the practice of public health nursing. The MDH Office

of Workforce Diversity has offered a series of opportunities for MDH staff to learn about diverse populations.

2. Expand the capacity of Minnesota communities to take leadership on disparity issues

SCHSAC/MHIP workgroup and pilot project. SCHSAC and MHIP (in collaboration with the Minority Health Advisory Committee, MCH Advisory Task Force and Rural Health Advisory Committee) will convene a group charged with identifying opportunities, as well as barriers and solutions, to more broadly implement health improvement programs that use principles of community-development and participatory research and evaluation, to address health disparities.

Eliminating disparities initiative. A legislative initiative on Eliminating Health Disparities has been proposed, which, if implemented, will greatly expand the capacity of Minnesota communities to deal with health disparities, as well as begin to address some of the workforce development issues described above. The initiative has the following components: 1) a partnership with tribal governments and racial and ethnic communities to reduce disparities in one or more of the following areas: infant mortality; breast and cervical cancer screening; cardiovascular disease; diabetes; HIV/AIDS/STDs; immunizations; and violence and injury prevention; 2) establishment of a Health Disparities Advisory Council charged with providing recommendations to the commissioner on the most effective strategies to eliminate disparities; 3) provision of timely, culturally sensitive health care to Minnesota's refugee and immigrant populations to reduce prolonged infectiousness and drug-resistant disease; and 4) resources to attract and retain a more diverse public health workforce and create culturally and linguistically appropriate public health communications.

3. Implement Recommendations of the Social Conditions and Health Action Team

The Social Conditions and Health Action Team, which is a sub-group of the Minnesota Health Improvement Partnership, has worked over the past year to examine the social determinants of health such as income, race and racism, working conditions, community connectedness, living conditions, and education. Over the next two years, MDH will work with local public health agencies and MHIP partners to implement recommendations developed by the group. Specifically, MDH will:

- Develop and pilot tools for health impact assessment in Minnesota. Health Impact Assessment is an emerging approach to policy development and program planning designed to assure that new initiatives contribute toward meeting public health improvement goals or at least do not hamper achievement of those goals.

- Publish and disseminate research briefs articulating the linkages to health, and summarize evidence-based and promising approaches within each area.

- Disseminate and champion the findings of the Action Team to public, private and non-profit organizations working to improve health in Minnesota.

- Take this work to the next stage by continuing to convene a multi-sector group to advance progress toward the next set of objectives for the Healthy Minnesotans goal related to social determinants (Goal 18).

4. Improve the public health system's capacity to respond to emerging health threats

Achieving this will involves many short and long-term action steps. The most immediate include:

Improve state and local health department's ability to respond to public health emergencies and natural disasters in partnership with other state and local organizations and the federal government. First, MDH will participate with the Department of Emergency Management to complete a legislative report on Minnesota's capacity to prepare for public health emergencies. Second, MDH will assist all local health departments to complete an emergency operations plan for public health. This plan may serve as, or be used as background for, a public health annex to the county's emergency response plan. Completion of these plans will involve: dissemination of a disaster/emergency response template completed by a state-local workgroup in 2000; a videoconference training available to all local public health/environmental health staff and county emergency operations directors; and technical assistance as needed.

Improve MDH, local health departments, and medical facilities ability to communicate about public health threats, using electronic surveillance and communications tools. Establishing an electronic network for communicable disease surveillance that provides reporting from clinics, hospitals, and laboratories, uses common standards for integrated data management, improves data analysis by adding geographic information system capability for mapping disease, and assures secure electronic-based access to data and summary information.

Complete the rollout of the Health Alert Network for communication with local public health agencies and identify additional partners who also need to be linked electronically or by other means.

Assess and Improve Local Health Department's Capacity to Fulfill the Common Activities for Disease Prevention and Control. This framework, developed by MDH and SCHSAC in 1998, identifies roles and activities for MDH and local agencies in infectious disease control. The Disease Prevention and Control

Division will meet with all CHBs over the next two years to discuss their current ability to carry out the common activities and develop plans to increase their capacity.

In addition, the MDH will explore longer-range steps to improve the public health systems ability to respond to emerging health threats. These may include exploring way to increase legal authorities to protect the publics health; improving laboratory capacity; increasing training for technical and scientific staff in epidemiology and toxicology; and developing capacity to evaluate and monitor the burden of respiratory and gastrointestinal disease. Close collaboration with other partners, such as the University of Minnesota, will be required.

A legislative initiative has been proposed to help the state's public health system prepare for emerging health threats such as antibiotic-resistant diseases, bioterrorism, emerging infectious diseases, and exposure to health threats from clandestine drug labs. It provides funding to monitor for emerging health threats and to ensure that the state's public health system is able to respond quickly and effectively. Activities proposed include sophisticated lab services that can "fingerprint" disease organisms; information systems to improve the reporting of diseases to MDH; and prevention programs and plans for large-scale public health disasters.

5. Cultivate partnerships for youth/engage the public in issues that affect youth health

Healthy Kids Learn initiative. Governor Ventura has proposed the creation of a Healthy Kids Learn Endowment, using funds from the state's Tobacco Settlement Fund. The proposed program would set a clear goal, adopting scientifically established "best practices" for achieving that goal, making a commitment to work through ongoing community partnerships, and making use of effective evaluation methods. This program would apply the same model used by the Healthy Learner Board Project. As state-level Healthy Kids Learn Steering Committee would be charged with developing multi-faceted plans to address some of the most pressing problems facing our states school children, such as asthma, autism and immunization. If passed, this initiative will serve to cultivate partnerships for youth health.

Adolescent health services. The Adolescent Health Services Action Team of the Minnesota Health Improvement Partnership presented recommendations for a preventive health services package for adolescents, for financing adolescent preventive health services; and or establishing and using a set of standardized codes and a common statement of benefits consistent with the minor consent law that will protect confidentiality through billing procedures; and for the training, education and recruitment of providers. During the next two years, MDH will work with MHIP partners to implement key recommendations in the above mentioned areas.

6. Strengthen MDH capacity to provide support and technical assistance to Community Health Boards

State legislation (145A.12) specifies that the Commissioner of Health must assist community health boards in the development, administration and implementation of community health services. During the next two years, staff in the CHS division will work to:

- Provide consultation, materials and training that will help community health boards assess, plan for and address the needs of their communities, with special emphasis on community engagement and on identifying health disparities.

- Develop a plan for targeted technical support to community health boards based on areas for improvement identified in the CDC performance measurement field test.

- Identify areas in which MDH has no capacity to provide program support and identify other resources that can be utilized for such support.

- Periodically survey CHS agencies for their administrative and program support needs to identify those needs and document whether they are being met.

- Evaluate the provision of the administrative and technical support provided to community health boards by MDH. See Appendix C for the Administrative and Program Support Plan developed by MDH.

7. Strengthen public health strategies for mental health

Mental health is an underdeveloped and under funded part of health. In the past year, MDH published a comprehensive set of strategies on suicide prevention. More recently, a state government interagency task force called Toward Better Mental Health was formed. This task force encourages the various agencies with mental heath programs to develop a more comprehensive plan for how their programs fit together.

During the next two years, MDH will continue these efforts, as well as broadening efforts to destigmatize mental illness. The public health community needs to work to create conditions in which people can achieve optimal mental health, which means breaking out of the illness mind set, and embracing health improvement as the goal; promoting positive, healthy behaviors; continuing to make appropriate services accessible and acceptable; and creating and environment that supports getting help.

A Suicide Prevention Initiative has been initiated for consideration by the Minnesota Legislature. This initiative would strengthen the capacity of state and local public health agencies to work with communities to address suicide prevention.

8. Increase capacity of MDH and local agencies to engage communities

Engaging communities effectively is a real challenge. However, it is increasingly evident that this is a very important part of any effort to improve health. This issue will become even more important as we begin to address health disparities. Local public health agencies and others have requested consultation and training from MDH in these areas.

Some programs in MDH, as well as many community-based organizations, have experienced great success in effectively engaging communities in health issues. MDH will inventory existing projects, and assess the resources available within the agency and within local public health agencies that can be shared to take full advantage of the expertise and experience that exists within the system. Effective strategies and tools will be shared across the agency and with local public health agencies through the development of resource directories including web-based formats. The Human Resources Division has periodically offered training opportunities in this area. Those sessions could be repeated and, if resources are available, expanded to include local public health via video-conferencing. In particular, the idea of engaging citizens in governing their public institutions will be explored. This work will also be incorporated into technical assistance and training for the CHS planning process for 2004.

9. Begin renewed efforts to reform the health system

- While this is a huge undertaking, progress in each of the Strategic Directions will lead to improvements in the health system. For example, focusing on prevention, as is beginning in the tobacco and youth endowment activities, will reap rewards in terms of future health costs. Steps taken to strengthen the public health infrastructure will help improve the population's health status. MDH has worked with a Governor's health policy council to identify a vision for the health system for the next 50 years. Priorities identified by this group were addressed in several proposals included in the Governor's budget. Four items designed to address these goals that are included in MDH's portion of the Governor's budget are:

  Form a Center for Health Quality. This initiative establishes the Minnesota Center for Health Quality, which will integrate, coordinate, and focus health assessment and quality activities in the state in order to achieve measurable health improvement for Minnesotans.

  Expand workforce development. Health worker shortages exist in many Minnesota communities and across many occupations. The first part of this initiative ($1.6 million/year) would expand state educational loan forgiveness programs, proven effective in attracting and retaining necessary health providers in rural communities, by adding 247 additional placements per year. A second proposed solution, community/regional health workforce grants program ($600K/year) would allow

communities or regions to identify and implement local strategies to meet their workforce needs, including strategies designed to attract and retain members of minority communities in the health workforce. Locally based strategies to address health worker shortages would be identified and implemented in at least 15 communities or regions of the state (e.g., targeted training partnerships, new scholarship programs, targeted recruitment, and/or retention efforts, etc.) within the next 1-5 years.

Strengthen the health care safety net. This initiative requests an appropriation to support community clinics; hospitals with excess charity care burdens, and rural hospital capital improvements.

Begin health plan regulatory reform. This initiative is designed to increase health plan flexibility and choices, make regulation consistent across all managed care plans, and consolidate all regulatory authority at the Department of Commerce.

In addition, the considerable emphasis on prevention in the proposed budget illustrates, for many policymakers, a new view of how to improve health. It will be important for MDH to continue dialog with community health boards, through SCHSAC, to ensure that local perspectives such as those identified by the SCHSAC health reform work group, are addressed.

10. Continue to maintain and strengthen the state-local public health infrastructure

The 1999 System Development Report spoke extensively to the need for a stable state and local public health infrastructure. This infrastructure is defined as the workforce, community organizing capacity, and information systems needed to respond to health threats and promote and improve health. As they share authority and responsibility to protect the health of Minnesota's citizens, Community Health Boards efforts are critical to carrying out the MDH strategic directions. To contribute, a strong local public health infrastructure is needed. Appendix A contains an update on the activities proposed in the 1999 report to improve the governmental public health system. Many of these are ongoing activities that will be continued in the next two years. For example:

Continue efforts to increase stable and adequate financing for the local system. A 2000 SCHSAC work group identified short and long-term actions to streamline grants to local Health departments. Some of their recommendations were included in MDH legislative proposals. Additional internal work will continue on administratively streamlining the application and reporting process. MDH staff will be exploring with DHS ways in which LHDs can receive medical assistance reimbursement for public health nursing activities without Medicare Certification, and assisting interested LHDs in making decisions on whether to pursue this payment method. the Department will monitor the effect that property tax reform, if enacted, will have on financing for local public health activities.

Build on opportunities to improve information systems and track health outcomes. Although the 1999 legislative proposal for a public health information system was not funded, several efforts to improve information systems have begun (e.g., HAN, NEDDS), and the enhanced county health status reports. As new information and reporting systems are developed, MDH will move toward more outcome-focused monitoring and evaluation efforts. Behavior change indicators such as those used in the tobacco prevention grants, and data collection methods such as those to be developed by the NEDDS grant, will provide building blocks for integrated data collection systems that are focused on health outcomes. The Center for Health Quality, if funded, could provide a way to coordinate local public health data collection and focus on indicators and outcomes.

Improve organizational capacity and performance. Develop technical assistance (APS) and quality improvement plans based on the findings of that CDC national public health performance measurement standards field test. In addition, continue to build capacity of local public health departments around disparities, emerging health threats, youth, and high priority areas. The grant from the Board of Government Innovation and Cooperation to evaluate the SCHSAC process and structure will provide an analysis by which to improve SCHSAC's functioning and use it as a model of state-local cooperation.

APPENDICES

APPENDIX A:
Progress Report on 1999
Systems Development Report Plan of Action

APPENDIX B:
Determinants of Health

APPENDIX C:
Administrative Program Support Plan

APPENDIX A:

Progress Report on 1999 SDR Plan of Action

The 1999 System Development Report laid out the critical importance of the public health system in achieving goals for a healthy Minnesota. It also described some of the challenges currently facing the local public health system as well as a plan of action by which the MDH planned to work to address important local public health system challenges. A short report on progress is presented below:

Ensure Stable Adequate Financing for the Public Health System

- Advocate for broad-based funding for the local system.
- Streamline grants process.
- Work w/other state agencies and feds to utilize other funds to support local public health.

Action:

The *1999 System Development Report* strongly advocated for stable, adequate funding for the local government public health infrastructure. Several steps were taken toward this goal in the past two years. In 2000, Governor Ventura proposed creating a local public health endowment with part of the tobacco settlement proceeds. Originally, this funding would be administered in accordance with the CHS subsidy provisions. While this proposal did not become law, the legislature did create a local public health endowment for CHBs to address youth risk behavior. This endowment, when fully funded, will provide approximately $5 million annually to CHBs on a statewide formula basis. This funding, and the flexible way in which it was made available, will help ensure stable resources to address six different youth risk behaviors. Additional funding provided through tobacco endowments provides opportunities for CHBs to work with schools, law enforcement, and local community organizations to prevent youth tobacco use.

Several attempts to streamline grant funding for CHBs occurred. For example, the Department sought, albeit unsuccessfully, an increase to the MCH formula block grant to address risk of high-risk families. Funds provided by a federal bioterrorism grant provided each county/CHB with funds to establish a Health Alert Network. MDH worked with a group of other state departments on a SAFE (state agencies fostering effectiveness) grants group to identify ways to streamline administration of grants throughout state government. In addition, SCHSAC formed a state-local work group in 2000 on to identify short and long term strategies to streamline the grants process. Some recommendations are expected to be reflected in the Department's 2001 legislative initiatives. While none of these activities in and of itself is a full solution, they each represent a growing awareness of MDH and other state agencies of the administrative burden and unstable funding base created by over reliance on competitive and narrowly categorical grants.

Improve Organizational Capacity and Performance

- Develop, test, and use tools to assess and improve organizational capacity.
- Develop and implement performance indicators in selected areas.
- Continue to support CHS planning process.

Action:

Minnesota was one of three states to participate in a field test of the CDC National Public Health Performance Measurement standards project. The MDH and 66 counties/cities participated in the field test. Results are expected to be available at the end of December. This tool will help yield valuable information about each agency's assessment of capacity to perform the essential public health services and should guide MDH providing technical support.

Performance indicators were developed to measure Minnesota's progress toward reducing the rate of tobacco use by 30 percent by 2004. This is an excellent "test case" to develop indicators of performance in one health risk area.

MDH had a 1999 legislative initiative to create a public health information system to improve information systems and track progress toward meeting health goals. The information system would have provided funding for internet connectivity to all local health departments; assistance with improved assessment methods, and creation of a data warehouse to facilitate more coordinated reporting of local and state activities. This proposal was not funded; however, some of the goals of the project have been realized through other means. For example, the HAN funding has allowed all counties to be internet connected, and continued efforts will improve the "people ware" skills to respond to electronic communication. The county health profiles are being enhanced and made available in a more user-friendly way on-line. The NEDDS project will provide for more real time and coordinated reporting of communicable diseases.

In the area of technology-assisted communication, much progress has been made. MDH and local health departments are now using distance-learning techniques more extensively than two years ago. Use of videoconferencing has now become a standard mode of communication and greatly helps link greater Minnesota and the metro area. Web sites have been developed in MDH and by many local health departments. For example, the CHS division web site has been remodeled to provide better access to local agencies, better navigating, and link to local health departments. The PHN section has an electronic newsletter which provides full access to the Section's activities. Projects such as the Nursing Practice for the 21st century are taught via' extensive use of satellite presentations in several states.

While much progress has been made, much more work is needed, especially to streamline reporting and better track outcomes resulting from public health efforts.

Improve Information Systems and Technology to Better Address Critical Public Health Questions

- Implement MDH/local information resource management plan, if funded by the legislature.

- Re-engineer communication systems to adapt to new technologies. This includes enhanced web sites, redesigning and systematizing communications from one-way, written form to e-mail, and developing capability to electronically share data.

- Expand on and effectively utilize distance-learning techniques, such as video conferencing, satellite offerings, and interactive education programs.

Strengthen State and Local Coordination

- Identify indicators of successful partnership.

- Organize state technical support and communications.

A SCHSAC work group described the state-local public health partnership as a "complex system" that is "massively entangled". In other words, there is no quick fix to making such an arrangement work well. The group identified rules to guide the SCHSAC and state-local interactions, which have been used successfully to this point. The MDH strategic directions have provided a common framework for communicating about the Department's priorities. Communication has also improved through methods such as in-person feedback on the CHS plans, videoconferences, and meetings to discuss ways to improve communication. In addition, MDH has moved some staff (e.g., new tobacco staff) to the district offices, providing more hands-on technical support than in the past. However, there has yet been no organized department-wide plan for coordinating communication between MDH and CHBs.

Expand Partnerships with Others to Improve the Public's Health

- Continue to use the *Healthy Minnesotans Public Health Improvement Goals* and *Strategies for Public Health* to foster local and state public health leadership in collaborative efforts to improve health.

- Promote the local community health services planning process as a way to engender active community involvement in the development of local public health priorities and coordination of local resources.

- Inspire and engage additional voluntary efforts to achieve state and local public health goals, particularly on the part of physicians and business representatives. One important aspect to explore relates to incentives for involvement on the part of these groups.

Actions:

Commissioner Malcolm reconvened the Minnesota Health Improvement Partnership in spring 1999. MDH provided staff support to Minnesota Health Improvement Partnership, a 40 plus member committee of public, private and nonprofit partners that works with the Commissioner of Health to develop coordinated public, private and non-profit efforts to improve the health of Minnesota residents. This was accomplished through four full partnership meetings, 12 meetings of two Action Teams and numerous smaller group meetings with partners. In 2000, MHIP addressed issues related to Adolescent Health Services, and the Social and Economic Determinants of Health. Staff participated in over 30 key partner events and other activities (meetings, conferences) to publicize the Health Minnesotans goals as a common framework for efforts to improve health, and to share the work of the Minnesota Health Improvement Partnership. A quarterly *Healthy Minnesotans Update* was produced and disseminated to over 2000 interested parties.

MDH staff provided consultation to managed care organizations and systems of health care to make a population perspective part of their culture. Staff also participated in regional collaboration meetings between the public and private sectors and provides linkages between regional collaboration groups, and worked with representatives of managed care organizations and local public health to develop a consensus on revisions to Minnesota's Collaboration Plan Law.

APPENDIX B:

The Determinants of Health

Health is a product of individual factors (genes, health practices and coping skills) and collective conditions (the environment, the health care system). Many of the factors that affect the health of Minnesotans lie beyond illness treatment and beyond the current health care system. The following five inter-related factors are widely regarded to determine health status:

Social and Economic Environment: Aspects of families, neighborhoods and communities that shape everyday experiences, including individual and community socioeconomic factors; social support and connectedness, employment and working conditions; living conditions; and culture. The social and economic environment of a community is created by the individual and collective actions of its members.
Physical Environment: The safety, quality and sustainability of the environment, which provides basic necessities such as food, water, air, and sunshine; materials for shelter, clothing and industry; and opportunities for recreation.
Health Practices and Coping Skills: Individual health promoting and health-compromising behaviors and the ways in which people cope with stress.
Biology: Genetic makeup, family history, and physical and mental health problems acquired during life (aging, diet, physical activity, smoking and drug use, stress, injury, and infections affect one's biology over the lifecycle).
Health Care Services: Access to and quality of health services to promote health and prevent and treat disease and other threats to health.

Research findings in fields ranging from medicine and epidemiology to economics, political science, history and sociology, have transformed our understanding of the connection between health status and the social and economic environment, yet these factors have not been a major focus of the health community in the past. Our vision for a future health system should reflect this expanded view.

Social and Economic Determinants of Health

Individual and Community Socioeconomic Factors. Population groups that experience the worst health status are also those that have the highest poverty rates and least education. Higher socioeconomic position (a reflection of income, education, occupation and prestige) is directly related to lower levels of disease and death. This relationship holds for almost all causes of death, and is not explained by differences in health behavior or access to medical care. Community-level socioeconomic factors also affect health, even when controlling for individual and household income.

Disease and death rates are higher in communities (metropolitan areas, states and countries) that have a greater gap in income and wealth between rich and poor. Among developed countries, it is not the richest societies that have the best health, but those with the smallest income differences. For example, economic inequality explains much of the variability across states in the rates of death from heart disease and cancer. A 1 percent increase in inequality has been associated with an excess mortality of 22 deaths per 100,000 people.

Social Support and Connectedness. Dozens of national and international studies have documented the adverse health effects of isolation, as well as the health benefits of social support and social cohesion (a "sense of community"). People are healthiest when they feel safe, supported, and connected to others i their families, neighborhoods and communities. More cohesive communities (e.g., those characterized by greater civic participation, trust, respect, and concern for the well being of others) have lower rates c violence and death. Discrimination is a major contributor to poor health through isolation, mistrust, an experience of daily hassles and chronic stress.

Employment and Working Conditions. Generally people are healthier when they have a job, because of the adverse financial and psychological consequences of unemployment. Yet not all jobs can protect physical and mental health. Experience of job insecurity can be as detrimental as unemployment. Peop are healthiest when they believe that their job is secure, the work they do is important and valued, the workplace is safe and there are opportunities for decision-making and influence. For example, having low control over one's work is strongly related to increased risk of low back pain, absenteeism, and cardiovascular disease, independent of psychological characteristics. Jobs with high demand and low control carry special risk.

Living Conditions. To assure health and quality of life, people need convenient access to affordable options for housing, nutritious foods, and transportation.

- Compared to middle class neighborhoods, grocery stores in low-income neighborhoods have poorer quality foods at higher prices. Good nutrition is essential for health. A mother's nutritior state during pregnancy affects her child's health during infancy through adulthood. Inadequate nutrition during childhood can slow growth, limit intellectual development, and impair immune function.

- Housing is essential for health. Availability of housing is related to both quantity, quality and affordability. Some of the most complete data on the health affects of housing are available for children. Educational outcomes, nutrition, and growth are compromised in children whose families are homeless or paying a disproportionate share (>35 percent) of income on rent. Children living in substandard housing conditions are at increased risk of asthma, lead poisoning and burns.

- The lack of convenient transportation increases social isolation and interferes with the ability to meet basic needs (purchasing food, accessing health care, maintaining employment). Community transportation patterns have major implications for health through social, environmental and economic impacts. Cycling, walking, and the use of public transport can promote health in four ways: (1 increased physical activity,

(2 reduced motor vehicle fatalities, (3 increased social contact, and (4 reduced air pollution.

Culture. Spiritual beliefs, religious practices, family and social structures, mass media, and other factors collectively shape the beliefs, norms, values, behaviors and social institutions of a community.

- Spiritual beliefs and religious commitment affect health behaviors and health status. Strength of faith and religious commitment are related to physical and mental health indicators such as immune function, experience of depression, blood pressure level, and life expectancy.

- Exposure to media violence is related to more frequent aggressive behavior among adolescents. Children purchase the most heavily advertised brands of tobacco and are three times more affected by tobacco advertising than adults.

APPENDIX C:

Administrative Program Support Plan

State legislation (145A.12) specifies that the Commissioner of Health must assist community health boards in the development, administration and implementation of community health services. This assistance may consist of but is not limited to:

- Informational resources, consultation, and training to help community health board plan, develop, integrate, provide and evaluate community health services.

- Administrative and program guidelines, developed with the advice of SCHSAC.

A subsequent rule-making process has determined that the Commissioner of Health will review the community health plans to coordinate statewide administrative and program support; and that the Commissioner of Health will provide statewide administrative and program support to community health boards to:

- Identify and, if possible, fill unmet needs for local program support.

- Coordinate or combine related activities for maximum effectiveness at the least expense of time and funds.

- Provide a positive and supportive response to local community health planning and program development.

- With the advice of SCHSAC and other bodies, make informed decisions and develop healthy public policies.

- Provide leadership to the statewide community health services system.

This is an outline for coordinating MDH's responses to the requests for administrative and program support in the 2000-2003 Community Health Services (CHS) Plans. It briefly summarizes what has been done so far with regard to the 2000-2003 CHS planning cycle including what was learned from reviewing the plans. It then briefly describes the most commonly identified Administrative and Program Support needs and proposed methods that either are being or can be implemented by MDH to respond to those needs.

What Has Been Done So Far:

- MDH provided assistance and support during the CHS planning process.

- MDH produced and disseminated new materials to support the planning process (e.g., public health goals and strategies, CHS planning guidelines, collaboration plan guidelines); conducted regional trainings on the planning process; provided one-on-one assistance to agencies; asked local public health agencies what kind of feedback they wanted on their plans and how they wanted to receive that feedback.

- The 2000-2003 CHS Plans have been reviewed by MDH staff.

- The requests from the plans for administrative and program support have been compiled by category of public health and by infrastructure needs; shared with MDH staff, who have been encouraged to use them in their planning for providing TA to local public health, and shared with local public health.

- Regional meetings were held to provide statewide and regional feedback on the 2000-2003 CHS Plans.

- A summary of MDH's review of the plans and of the regional meetings has been prepared and shared with MDH staff and with local public health staff.

What Was Learned from the 2000-2003 CHS Plans and Regional Meetings?

The regional meetings were well attended with nearly every county in the state represented. After reviewing the CHS Plans and meeting regionally with local public health staff, certain themes related to needed administrative and program support surfaced. They and potential responses by MDH are described below.

APS Needs: Better Back-and-Forth Communication

- There could be a more effective and frequent mechanism for local public health agencies to communicate to MDH their needs for technical assistance.

- It is important for MDH to be clear with local agencies about what it can and cannot provide.

- State-local dialogue is valued. Based on suggestions from local public health, the CHS Plan Review Regional Meetings were designed to be informal and to facilitate discussion and sharing among all participants. According to the evaluations of the meetings: in-person sharing, interaction, and structured dialogue are worthwhile, relevant and time well spent, and tend to increase mutual understanding. MDH and local staff learned from each other and came away with a better understanding of issues and difficulties from each other's point of view.

APS Response from MDH:

Activities that have been or are being implemented by MDH:

- Provide an accurate, up-to-date, easy to use contact list of MDH staff that is accessible by specific program or topic area (requested by local public health).

- Encourage, expand and support (both within MDH and among local public health) the use of the Mailbag and the Mailbag calendar to communicate about the provision of administrative and program support.

- Participate in regional LPHA meetings as appropriate.

Proposed activities that could be implemented by MDH:

- Promote to MDH staff ways that they can utilize in their work the lists of TA requests from the 2000-2003 CHS Plans.

- Help MDH staff to communicate to local public health that their work is in part a response to the requests for technical assistance in the 2000-2003 CHS Plans.

- Assess and be clear about what APS needs MDH can realistically provide (requested by local public health).

- Identify those areas in which MDH has no capacity to provide administrative assistance and support and identify other resources that can be utilized for such support. Let local public health and MDH staff know what those other resources are (requested by local public health).

- Plan and conduct periodic in-person forums for open dialogue, discussion and sharing between MDH and local public health (requested by local public health).

APS Need: Fine-tune the CHS Planning Process

Most found the CHS Planning Guidelines to be helpful in their planning process and few wanted a new set of guidelines to be developed. Nevertheless, suggestions were made for fine-tuning them. Those suggestions and issues related to the planning process itself included:

- Simplify the guidelines and the planning process, and make them more meaningful, clear and relevant. Suggestions for doing this include:

    - Provide more assessment data, and put it all in one place (e.g., a web site) so that it can be easily downloaded.

- Provide examples of "good" process objectives, measurable outcomes, evaluation measures for people to use and/or adapt.

- Provide a common set of indicators that is consistent with other sets of indicators (e.g., *Healthy People 2010, Minnesota Milestones, Healthy Minnesotans,*).

- Provide copies of tools that other agencies use to collect data, involve community members, prioritize problems.

- Update the *Strategies for Public Health.*

- Place the guidelines, tools, reporting forms on the web.

- As the assessment and planning process becomes more involved and complex, many Administrators and Directors struggle with balancing it with the daily workload of the agency.

- The process of providing grants to CHS agencies should be based on the CHS Plans.

- Timing is an issue. It would be helpful if the CHS Plan was due BEFORE the MCH Plan and other major grants. This way, those grants could be based on the CHS Plan, and staff would not have to be writing all of them concurrently.

- The planning process is a core function of public health and should be an ongoing process vs something that is done every four years.

APS Response from MDH:

Activities that have been or are being implemented by MDH:

- Provide support, help, training, consultation and/or referrals for:

  - Leadership, public health advocacy, state and local policy development.
  - Community assessment and planning.
  - Data collection/analysis, developing measurable outcomes.
  - Involving communities, coalition building.

- Regional planning and program development, emerging issues, working across boundaries (agency, program).

- While providing consultation and technical assistance, refer local staff to appropriate strategies.

- Connect the administrative concerns and issues of CHS Administrators and PHN Director with the work of the SCHSAC Streamlining Grants Administration Work Group and the MDH Grant Managers Group.

- Put CHS planning tools (guidelines, strategies, goals) and all reporting forms (CHS, MCH, WIC) on the web (requested by local public health).

Proposed activities that could be implemented by MDH:

- Work with local public health to improve the CHS assessment and planning process including (requested by local public health):

  - Simplify and/or re-organize the CHS planning guidelines.
  - Disseminate the planning guidelines and tools earlier.
  - Provide training on and/or support for the planning guidelines on an ongoing basis to reinforce the utilization of the assessment and planning process as one that is a continuous process rather than one that occurs every four years.
  - Identify examples of "good elements" of CHS Plans to share.

- Update the Strategies document (requested by local public health).

- Facilitate sharing among local public health agencies (e.g., via Tool Time or perhaps something like a "CHS Planning Fair") of their Plans, methods of and tools for developing their Plans, balancing the work of the Plans with other work that needs to be done, so that agencies can learn from each other (requested by local public health).

APS Need: Build on Community Partnerships and Involvement

Recognizing that public health cannot do its work alone, the kinds and numbers of partnerships needed to accomplish its work at both the state and local levels are expanding. Along with this expansion, comes the expectation within the community that public health be involved, especially as a neutral convener, facilitator and/or community mobilizer. More and more of the work of public health is becoming that of nurturing and maintaining partnerships rather than delivering services and programs. This is perceived by local public health as a "good new" / " bad news" thing:

- The "good news" is that with increased community involvement comes more ownership by the community of public health goals— they are seen as community goals. This in turn gives public health more visibility in the community, which results in public health staff becoming increasingly involved in community issues and in additional and new partnerships.

- The "bad news" is that this process highlights issues of work overload and the need for workforce development.

APS Response from MDH:

Activities that have been or are being implemented by MDH:

- Put tools and related links for community engagement on the web (requested by local public health).

- Provide management and leadership development through the coordination of education and training programs with colleges, universities, the MDH Office of Rural Health and Primary Care and other entities.

- Provide technical assistance regarding population-based practice for local public health staff.

- Coordinate and organize support, help, training, consultation and/or referrals as needed and/or requested.

- Provide support on administrative and management issues upon request.

Proposed activities that could be implemented by MDH:

- Highlight local successes as resources for others. For example, creative ways of involving community members include an agency that has two youth on its CHS Advisory Committee, and another agency that is basing its involvement with a small community within its county boundaries on the issues that are most relevant to that community rather than the county as a whole (requested by local public health).

- Provide technical assistance regarding population-based practice for Community Health Boards.

- Provide support and technical assistance to CHS Administrators and PHN Directors as they work with their Boards to understand the value of and time required in involving community members in achieving public health goals.

APS Need: Use of Technology

More and more local public health is utilizing technology in its work, including the assessment and planning process. E-mail and the internet are often used to request and receive data, tables, and help from MDH and other sources. This is an important infrastructure issue that is a joint responsibility between state and local public health and that is reflected in the Minnesota Health Improvement Goal 16 ("Ensure an effective state and local governmental public health system.") as well as in Healthy People 2010.

APS Response from MDH:

Activities that have been or are being implemented by MDH:

- The CDC Health Alert Network grant has:
  - Allowed every county to acquire computers, software and training ("people ware") to become hooked up to the internet and to have e-mail capacity. Eventually, each county will be hooked up to each other as well as to MDH.
  - Supported every county in becoming electronically connected to many community partners for the purposes of rapid communication and notification of public health threats and distribution of web-based resources.
  - Encourage every county to put their plan on the web.
  - Put grant applications on line.
  - Use e-mail lists to distribute information to Community Health Boards.

Proposed activities that could be implemented by MDH:

- For the next CHS planning cycle, provide the CHS Planning Guidelines electronically and require that the CHS Plans be submitted electronically (requested by local public health).
- Put the CHS Plans on the web, or if plans are on county web pages, have links to those pages (requested by local public health).
- Help local agencies advocate for room in the county capital budgets for their technical updates and upgrades.

APS Need: Advocacy for a Sustained, Strong and Vibrant Public Health System

Local agencies clearly need adequate, stable and ongoing funding that supports a viable public health infrastructure in Minnesota. This calls into play leadership at both the state and local levels; effective advocacy for and communication about public health; an assessment of the strengths and weaknesses of the state and local public health infrastructure; increased collaboration and decreased duplication of policies, funding and reporting requirements among state agencies; and recruitment and retention of adequately prepared public health staff.

APS Response from MDH:

Activities that have been or are being implemented by MDH:

- Work with the MDH Public Information Office to advocate publicly when appropriate.
- Work with the workforce development activities within MDH to identify ways to address workforce needs.
- Develop and disseminate materials that can be used to educate new county commissioners about public health and their role in advocating for public health in their counties.
- To the extent possible, share with the Local Public Health Association legislative issues and potential initiatives.

Proposed activities that could be implemented by MDH:

- Work with policy makers and state and local leaders to actively fund, build and support the statewide infrastructure for public health (requested by local public health).
- Work with other state agencies to better coordinate funding, programs, communication and decrease duplication (requested by local public health).

System Development Work Within MDH That Can Increase Our Proficiency in Providing Relevant and Effective Administrative and Program Support to Local Public Health Agencies:

Activities that have been or are being implemented by MDH:

- Encourage MDH staff to contact local agencies after their program-specific review of the 2000-2003 CHS Plans and to offer their feedback on the plans and to build relationships with local staff.
- Provide consultation with MDH staff to help them be more responsive to the program specific TA requests in the CHS Plans.
- Of the TA requests that were organized by infrastructure needs, identify those that are related to ongoing or existing work within the agency, and connect them with this work.

Proposed activities that could be implemented by MDH:

- Meet with MDH staff (attending section/unit/program staff meetings) and ask them how best to respond to the TA requests in the CHS Plans.

- Hold a series of brown bag pizza meetings for MDH staff who work with local public health agencies and who have interests and/or expertise in issues that cut across topic areas, e.g., community participation/mobilization, evaluation, communication, social marketing, workforce development, grants. The purpose of these meetings will be to: get to know each other; to look for similarities and gaps in what we do and how we do it, and to better coordinate our efforts to provide technical assistance in these areas to local public health agencies.

- Evaluate the provision of TA/help/support by MDH to determine if it is working, helpful, and/or relevant, so that MDH can make ongoing informed TA plans and decisions.