BUILDING A SOLID FOUNDATION FOR HEALTH:

A Report on Public Health System Development

Minnesota Department of Health
February 1999

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 12, 1999

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 local public health system development.

I hope you will find this report to be a clear and informative description of issues facing the local public health system in Minnesota. The report outlines the financial and structural changes causing us to take a serious look at the future roles of public health professionals, and summarizes a plan of action that the Minnesota Department of Health will undertake over the next two years to strengthen the public health infrastructure in Minnesota.

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 with fewer dollars is both daunting and exciting. Working together, we can meet these challenges and ensure that Minnesota has a strong public health infrastructure as we move into the twenty-first century.

Sincerely,

Jan K. Malcolm
Commissioner

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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 local public health system development. It incorporates the discussion and recommendations of two advisory groups to the Commissioner of Health during 1998: the State Community Health Services Advisory Committee (SCHSAC)[1] and the Minnesota Health Improvement Partnership (MHIP)[2], as well as many conversations with local public health agency administrators and staff.

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. 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.

The 1990s: A Decade of Change

The public health system, both in Minnesota and nationally, continues to be under stress as new demands are placed on it and as funding streams continue to shift. The additional demands include new health threats such as emerging diseases and violence, which require additional resources; the demands of a rapidly changing health system, which requires additional efforts to develop new ways of working with managed care organizations and other entities to achieve public health goals; and changing demographics which present an increased need to implement public health programs among diverse sectors of the population with language and other cultural differences. At the same time these new demands are facing the public health system, local public health agencies are experiencing financial stress.

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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 49 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.

Although these issues exist at both the state and local levels, this report is focused on local needs and issues, pursuant to state statute.

Priority Issues for the New Millennium

Several areas of challenge facing the local public health system will provide a particular focus for work during the upcoming biennium. Those issues include financing; developing updated health information systems; monitoring organizational capacity and performance; ensuring state and local coordination; and strengthening collaborative relationships.

Financing issues

Foremost among the priority issues is addressing the financial stresses that local government public health agencies are experiencing. Reasons for financial stresses include:

- Pressure on local revenues
- Decline in Medical Assistance revenues for family health activities
- Reliance on state and federal categorical grants
- Fragmented funding for public health
- Increased requirements for Medicare certification

The compounded effect of these factors is such that the local governmental public health system continues to experience financial stress, especially in some parts of the state. Counties that have other economic stresses are experiencing this to the greatest extent, as are counties that have invested heavily in providing services to individuals and families. This occurs because they have relied heavily on payment sources such as MA, which is declining; because there are fewer other providers to carry out such services; and because they lack staff devoted specifically to population-based activities. These areas experience the greatest difficulty in expanding their focus from delivery of individual and family services to core public health functions. In general, these challenges tend to be more acute for sparsely populated counties.

In recognition of critical local public health needs, the Minnesota Legislature provided five million dollars in 1997 to assist local governments providing basic public health functions in their communities. That funding has proven extremely valuable to local public health agencies. However, critical needs still remain. While some communities are holding their own, others report a state of near crisis in meeting the public health demands placed upon them with the resources available.

Updating public health information systems

To function effectively in an increasingly complex world, state and local government public health agencies must update their information systems. For example, in the event of a bioterrorist attack, the public health system must be able to rapidly respond to medical emergencies, environmental threats, and subsequent physical and mental health issues. No less important are information needs related to ongoing monitoring of communicable diseases.

Monitoring effectiveness

Like business, government at all levels is moving toward quality improvement and greater accountability. Measures of public health system performance are needed to monitor effectiveness. To move forward in this area, the SCHSAC has recommended that indicators of organizational capacity to support the public health infrastructure be identified, and that voluntary performance measures be developed.

State and local coordination

Strong state-local coordination must be maintained despite decreasing resources for locally-based state liaisons; expanding responsibilities and size of the MDH; and increasingly complex public health issues.

Strengthening collaborative relationships

In this era of change, public health agencies, health plans, providers and others interested in improving the public's health are developing new ways of working together to improve health and healthcare and meet shared health improvement goals. These opportunities are both exciting and daunting.

Plan of Action

Following is a plan of action by which the MDH will work to address important public health system challenges. It identifies a long term direction and highlights efforts currently underway and continuing/expanding in the next year. These actions were developed with the advice of the SCHSAC and the MHIP. Staff of local Community Health Boards were also contacted to provide input to this report. The action steps are consistent with the objectives in Goal 16, of the *Healthy Minnesotans Public Health Goals*, which is focused on strengthening the state and local government public health infrastructure.

1. **Ensure stable, adequate financing for the local public health system.**

   As discussed earlier, stable financing is critical and is at risk. In particular, some parts of the state are facing challenges to maintaining an adequate infrastructure for public health. Action steps include the following:

   - Advocate for broad-based state funding for the local government public health system. Such funding should be administered in accordance with the Local Public Health Act but be sufficient to provide an adequate base for areas of the state currently experiencing the greatest challenges to maintain an adequate public health infrastructure.

   - Streamline the grants processes by utilizing broad-based formula funding mechanisms whenever possible. When not possible, work internally to consolidate or simplify the application processes. A state-local work group has been formed and has begun meeting

to address these concerns. Implement proposed changes to the Maternal and Child Health Grant formula, if passed by the legislature.

- Work with other state agencies and the federal government to identify ways to more effectively utilize other state and federal funds to support local public health.

2. Improve organizational capacity and performance.

Strengthening the public health infrastructure requires more than additional financial resources. This includes both informing and educating local elected officials and others about government's public health responsibilities and working to improve other components of the local and state infrastructure, such as workforce capacity and efforts to engage the community. Work done by the SCHSAC Governance and Accreditation groups in the past year provides a good framework for next steps to identify areas for improvement and to actually improve performance of state and local public health. Action steps include the following:

- Develop, test and use tools to assess and improve organizational capacity.

- Develop and implement performance indicators in selected program areas.

- Continue to support the Community Health Services planning process as the key means to identify and address locally identified health concerns.

3. Improve information systems and technology to better address critical public health questions.

As described in the report, timely, accurate information is critical to protecting and improving the public's health. The MDH and local public health agencies have laid the groundwork for a coordinated information system. Action steps include the following:[3]

- 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.

[3] These are partially contingent on receiving a legislative appropriation and/or federal funding.

4. Strengthen state and local coordination.

Maintaining a coordinated state and local public health system is crucial to achieving public health goals. MDH budget reductions, changes in the size and scope of state and local public health agencies, and increased complexity of public health issues pose challenges to effective coordination. A concerted effort is needed to improve coordination at both levels, including developing greater clarity of expectations and roles. Action steps include the following:

- With the SCHSAC, identify "behavioral indicators" of state and local agencies for partnership.

- Organize state technical support and communication to effectively respond to local concerns. This could take a number of forms, from having staff assigned to district offices, as has occurred until recently, to identifying central office-based contact people to serve as a channel for communication with the rest of the MDH.

5. Expand partnerships with others to improve the public's health.

Everyone is encouraged to participate in improving the health of the state. Achieving Minnesota's goals and objectives will require the combined efforts of state and local public health agencies, health care providers, businesses, community-based organizations, health plans, educational institutions, faith communities, all levels of government, as well as families and individuals. Additional efforts are needed to elicit the involvement of broad segments of the community. Action steps include the following:

- 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.

A Report on Public Health Systems Development

I. 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 local public health system development. It incorporates the discussion and recommendations of two advisory groups to the Commissioner of Health during 1998: the State Community Health Services Advisory Committee[1] and the Minnesota Health Improvement Partnership[2], as well as many conversations with local public health agency administrators and staff.

The report takes a close look at issues facing local government public health agencies. Stable and adequate financing is foremost among the issues that must be addressed to successfully navigate a rapidly changing environment. Other challenges include ensuring that the public health information systems are updated to provide efficient public health services to Minnesotans; developing measures of public health system performance to monitor effectiveness; strengthening state and local coordination during a time of decreasing resources for locally-based state liaisons; and developing new and strengthened collaborative relationships with private and nonprofit sector organizations to leverage the resources of many entities to achieve shared health improvement goals. The report also presents recommendations and action steps to address those challenges.

This is the third report to address public health system development issues. Many of the issues facing the public health system in 1995 and 1997, when the first two system development reports were published, remain as important concerns. However, it is now possible to look back and describe progress that has been made toward the issues described in earlier reports. Section III provides a brief description of that progress.

[1] The State Community Health Advisory Committee is advisory to the Commissioner of Health on issues relating to local public health. Its 49 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

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.

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. The statewide *Healthy Minnesotans Public Health Improvement Goals* were recently published as a call to action, and also a reminder that we all share the benefits of and the responsibility for a healthy society.

Within the eighteen *Healthy Minnesotans* goals, three themes emerge as critical priorities for assuring a healthy future for all Minnesota residents. The three critical priority areas of opportunity for improving the health of all Minnesotans include assuring a foundation for health protection; eliminating disparities in health status; and increasing years of healthy life. All organizations are urged to consider carefully how they can address the three priority areas when looking at the goals and objectives.

This report focuses on the first of those three priorities, assuring a strong foundation for health protection. The foundation for health protection in Minnesota begins with the state and local public health system.

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.

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

- 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, we expect that public health workers will watch out for the health of our communities. These responsibilities are often called the "core functions" of public health (see Appendix A for more information).

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.

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.

B. What is an Infrastructure?

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 that 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.

The public health infrastructure is most visible in times of crisis–when disease outbreaks threaten community health, or during natural or human-made disasters–and forms the foundation for Minnesota's efforts to protect, maintain and improve health. In Minnesota, a viable system has been in place for many years, supported by federal, state, and local funds. It is critical to maintain this strong system as Minnesota considers ways to reshape its health delivery system and address emerging health problems.

C. How is Minnesota's Public Health Infrastructure Organized?

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 (CHBs) (see Appendix B for map) 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 49 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. In addition to guiding community health improvement efforts, CHS plans are also used in the development of the statewide *Healthy Minnesotans* goals referenced earlier.

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.

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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.

III. The 1990s: A Decade of Change

In recent years, many changes have occurred which challenge the ability of local governments to protect the public's health. The 1990s' have been a decade of rapid change for the entire health system. The Minnesota Legislature passed a series of laws which sought aggressive reforms in Minnesota's health care system. Market forces have continued the rapid evolution of the health system during the mid to late 1990s. These changes in the broader health system have had an impact on the public health system. Foremost are changes in the financial structure which has long supported the public health system.

In the past few years, as managed care has been expanded to include citizens on publicly financed programs such as MA, state policy has restricted MA reimbursements to "medically necessary" services to individuals. As a result, the funding for some local public health departments has declined, particularly for services to children and families. While the result may be more medical care for high-risk families, this transition also threatens the ability of the public health system to fulfill its basic responsibilities to protect and improve the health of all Minnesotans.

These shifts in funding came during a time that additional demands were being placed on the public health system. Examples include:

- *Emerging threats to health posed by new diseases.* For example, drug-resistant tuberculosis and new contaminants to our food supply brought about by the global food market are health hazards that did not exist a decade ago.

- *Societal problems with consequences that affect our health,* such as violence. Such problems can be approached by using public health principles such as epidemiology, prevention and mobilizing communities.

- *Need for greater public-private coordination.* Changing demographics, a changing marketplace, and resulting cost-consciousness are stimulating health providers and health plans to look outside their institutional walls to improve the health of those they serve. Efforts of these groups to consider prevention and reach out to the entire population lead them to the local public health system.

Combined, all of these factors have stressed the capacity of the local public health system over much of the 1990s.

System Development Issues

In 1995, the first system development report identified key issues that must be addressed to allow the local public health system to adapt to the changing environment. The four key issues are:

- Stable and adequate funding, so that the changes taking place in the health care system do not erode the ability of local governments to provide needed public health services in the community.

- Joint planning to strengthen relationships with managed care organizations and other providers to achieve public health goals.

- Better coordination of services and assuring quality in an increasingly complex health care system.

- Building "capacity" to perform the core public health functions, particularly in the area of assessment.

Progress has been made in all four of these areas. The 1997 Legislature recognized the financing shifts and new demands and the potential threat they posed to local government's ability to protect the public's health. In response, they appropriated $5 million annually to be used to support local government core public health functions.

The additional funding has enabled local government to begin to move beyond delivery of individual services to increased population-based assessment, improved collaboration with health plans and community organizations, and toward addressing targeted populations such as communities of color. Local health departments, especially in the seven-county metropolitan area, have enhanced technology in order to improve their assessment capability. Many areas of greater Minnesota have formed public health cooperatives in order to better collaborate with health plans on locally identified public health goals. Many have begun to address health problems of special populations by hiring interpreters and developing culturally sensitive programs. (For a summary of how the funds have been used, see Appendix A). These activities are critical if the public health system is to respond to current challenges.

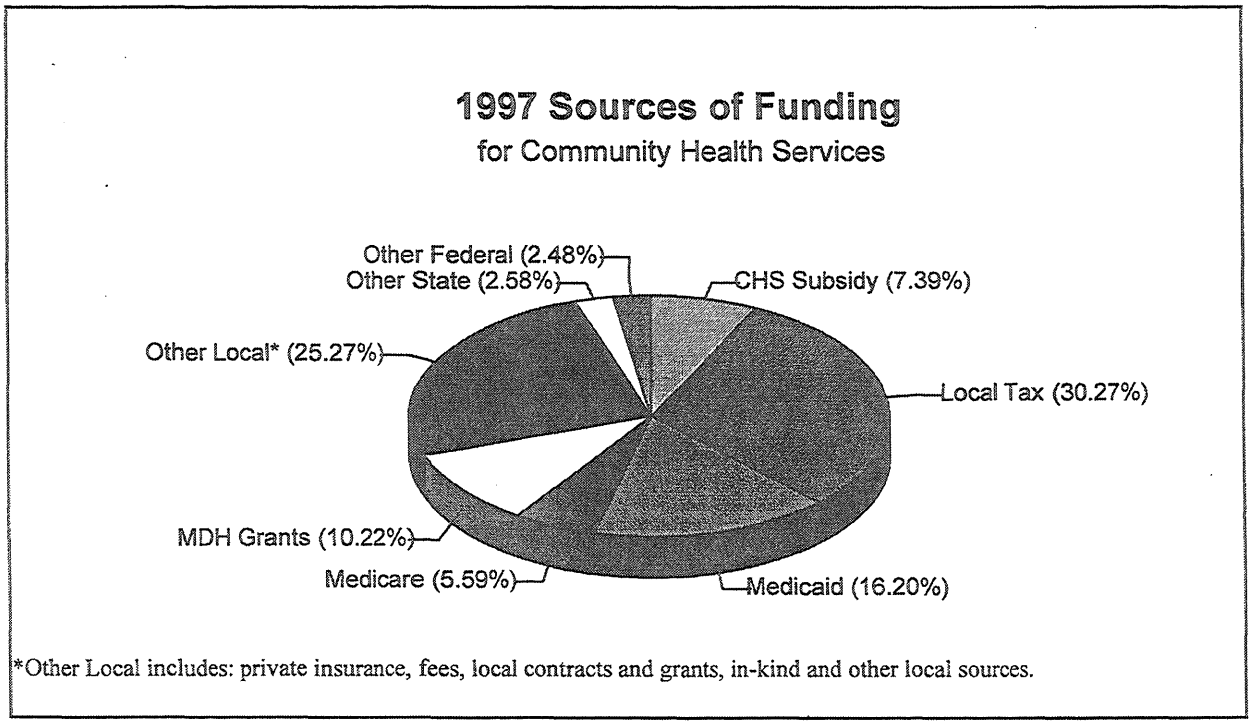
The system development report published in 1997 identified specific action steps that the MDH should take to address key system development issues and support the transition and adaptation of the local public health system. Those action steps are listed in Appendix C, along with a short synopsis of progress which has been made in each of those areas over the past two years.

IV. Demands Facing the Public Health System in the New Millennium

Although much progress has been made, much remains to be done. The local public health system faces demands in several areas, including stable and adequate financing, coordinated information systems, clarifying state-local partnership (coordination), and expanding partnership with others. These areas of particular focus for the upcoming biennium are described below.

A. Financing the Local Public Health System

The CHS subsidy–which includes the core function funding provided by the legislature in 1997–is now at $19 million and comprises less than 10 percent of all funding for local public health. However, it is an important centerpiece of the total picture because it is stable over time and is flexible enough to be used for locally identified health problems. The following table and chart show sources of funds for community health services.



*Other Local includes: private insurance, fees, local contracts and grants, in-kind and other local sources.

Although the 1997 core functions funding has better enabled Minnesota's local public health system to meet its responsibilities, the system continues to experience considerable stress. In some areas of the state in particular, the threat to the local infrastructure is even more severe than in 1997. Financial pressures are related to local tax levy, changes in Medical Assistance and Medicare, and categorical grant programs. While there are some common trends, the effect of these pressures is felt differently in different parts of the state. The following is an analysis of reasons the system continues to experience this financial stress.

1. **Local funding support for public health remains crucial. Local support is under pressure, especially in counties experiencing economic hardship.**

   Local revenues are a significant source of support for local public health activity. Under the Local Public Health Act, CHBs are required to provide a dollar-for-dollar match to the CHS subsidy. In fact, many local public health departments contribute far more than the match required under the law. Local support for CHS from all sources comprises 77 percent of total local public health expenditures. (Eligible local support includes local tax levy, Medicare, Medical Assistance, Veteran's Assistance, private insurance, individual fees, local contracts and grants, and other local match.)

   Local tax levy. In particular, local tax levy is a significant source of funding for community health services. Local tax levy comprises 30 percent of support for local public health statewide ($65 million in 1997). Local tax levy is important because it is flexible, relatively stable over time, and is a good indicator of local commitment for public health.

Table 1. 1997 Sources of Funding for Community Health Services

Source of Funding	Amount	Percent	Counties/Cities
ELIGIBLE LOCAL			
Local			
County & Municipal Tax	$65,057,661	29.9	85
Private Insurance	$8,711,467	4.0	78
Individual Fees	$25,961,795	12.0	89
Local Contracts & Grants	$16,720,859	7.7	83
In-Kind	$861,913	0.4	16
Other*	$2,442,774	1.1	51
Subtotal	$119,756,469	55.1	
Federal			
Medicare	$12,018,584	5.5	78
Medicaid	$34,831,207	16.0	85
Veterans Administration	$475,259	0.2	72
Subtotal	$47,325,050	21.7	
TOTAL (includes in-kind)	$167,081,519	76.8	
Other Sources of Funding			
State Grants			
CHS**	$15,882,165	7.3	91
Special Project Grants***	$21,976,542	10.1	90
Other State	$7,040,431	3.3	88
(includes vaccine)			
TOTAL	$44,899,138	20.7	
Federal Grants			
TOTAL	$5,340,003	2.5	20
TOTAL ALL SOURCES *(includes in-kind)*	**$217,320,660**	**100.0**	

* Includes inspection and licensing fees and miscellaneous funds.

** Reflects expenditures for CHS in 1997. The 1997 legislative appropriation for the CHS subsidy was $14,112,000, and Community Health Boards reported $683,599 in carry-over funds from the 1996 CHS Subsidy.

*** Includes MCH expenditures of $7,254,585, WIC expenditures of $8,516,787, as well as Family Planning Special Project Grants, Native American, Nonsmoking, and other smaller grants.

Statewide, local tax levy has remained strong, increasing by 9 percent from 1996 to 1997. A few counties have increased their local match by as much as 23 percent over the past year. However, over half the counties and cities in the CHS system reported less local tax levy for public health in 1997 than in 1996. Preliminary analysis shows that smaller counties (under 3,000) tended to provide less local tax levy.

"Our costs for out-of home placements have risen 250% in the past eight years. These costs are impossible to effectively budget for as sentencing is determined by judges in the juvenile courts. High expenditures in this area, combined with levy limits, means that we have less county tax dollars for public health programs." Kandiyohi County Commissioner

County government faces increasing pressures due to demands in other government programs, such as requirements for new correctional facilities or out-of-home placements. In addition, some parts of the state are facing economic pressure in all areas of government as a result of declining property values, scarce populations, and declining farm prices. Such pressures are likely to continue and make it difficult for counties to continue to support public health with local tax levies. Finally, levy limits reduce the amount available for public health activities even if the county is financially able, and the board willing, to support such activities. Counties that are currently at their levy limit are not able to increase local tax levy support for public health unless they reduce this support in other county departments.

In Polk county, local tax support for public health is threatened due in part to falling agricultural property values.

2. Medical Assistance revenues for family health activities continue to decline.

Medical Assistance (MA) has also been an important funding source for local public health, comprising 16 percent of local public health revenues statewide in 1997. MA has been used to support the essential public health services (e.g., public health nursing staff to coordinate community activities, assist in Individual Education Plans for disabled children, participate in family service collaboratives.) In addition, it has provided funding for a base of staff support available to respond to outbreaks and disasters such as the January meningitis outbreak in Duluth or the tornados in Comfrey and St. Peter last summer.

The decline in MA revenue identified in the 1997 System Development Report continues. In 1997, MA payments for family health activities decreased by 23 percent, a decline from $3.4 million to $2.6 million statewide. This decrease was due primarily to MA being used for medically necessary services, which are not usually provided by public health.

MA constitutes an even greater amount of the funding for home health care services provided by public health agencies, approximately $35 million statewide in 1997. While MA revenues for home health care increase slightly, many agencies anticipate a dramatic decline in revenue as they take on broader public health responsibilities and leave provision, and the subsequent revenue collected, from home health care to private providers. In some areas this has already begun. While this change may "free" local public health staff to focus on population-based public health strategies, it also means that less revenue is available to support the foundation (infrastructure) for local public health.

Freeborn County experienced a decline of over $4,000–from $9,200 to $3,900–in MA revenues for family health activities from 1996 to 1997. Chisago County experienced a 50% decline in MA revenues for family health activities from 1997 to 1998. Wadena County anticipates one-third less revenue from MA from 1997 to 1998 for maternal and child health activities and Child and Teen Checkup services. In the year 2000, they expect to lose over $300,000 in MA revenue.

As in the case of pressures on local tax levies, these pressures are felt most strongly in greater Minnesota. Many smaller counties have been heavily reliant on MA to serve elderly, disabled, and families because there have been few other providers in those areas. Many such areas also have an aging population who have a greater need for public health services. In some counties, MA comprises up to 30 percent of the public health department's budget. In one county in southeastern Minnesota, for example, staff estimates that revenues for home health care declined from $20,800 in 1996 to $11, 500 in 1997, due in large part to home health care services being provided by private providers rather than the local public health department.

3. **Increased reliance on state and federal categorical grants is fostering an unstable funding base.**

State and federal categorical grants administered by the MDH and other state agencies are an important source of revenue for local public health. In 1997, such grants comprised almost 10 percent of the total funding for CHBs, more than the CHS subsidy. Such grants can be a valuable way for local public health departments to fund locally identified priorities if they are stable, relatively broad-based, and consistent with locally identified needs. They are helpful in enhancing an adequately funded infrastructure and provide support for specific health problems. The Maternal and Child Health (MCH) Special Projects block grant, for example, is stable from year to year, distributed under a needs-based formula, and broad enough to address a range of issues related to family health.

However, such grants tend more and more to be used to support core public health activities in an effort to meet increasing demands of the system and supplement flagging revenues from

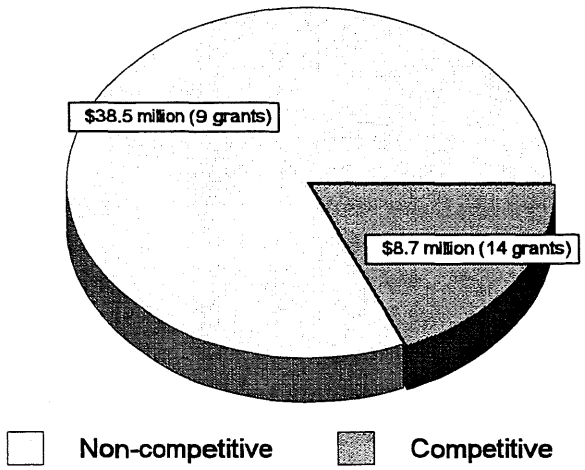
other sources. Many such grants are small, narrowly focused and require extensive time to apply for and report on. Even more important, they do not provide a stable source of revenue to support local government's core public health functions.

"Using narrow categorical grants to support core functions is like trying to fit a square peg in a round hole. Such grants should be the trimming on the Christmas tree, not the basic support for public health." CHS administrator in Northeastern Minnesota

Although such grants have received increased attention in recent years, they do not make up a larger *proportion* of total local public health spending than in the past (10.1 percent of total expenditures in 1997, the same percentage as in 1996). CHBs receive more funds from non-competitive (e.g., formula) grants than from competitive grants (see Pie Chart below). However, it appears that the number of smaller, competitive grants have increased while broader, formula-based grants have decreased. In 1998, there were 14 competitive grants available to CHBs compared with 10 such grants in 1996. Several broad-based formula grants were reduced in the past year, including the MCH special project grant and the Immunization Action Plan grant. This "withering" of broad-based funding sources means that local health departments must cut staff and reduce services or spend more administrative time applying for smaller grants for related programs.

For example, a Planned Parenthood outreach clinic, serving several counties within Quin CHB, was forced to close due to reductions in the MCH special project grant. This means county residents must travel up to 80 miles to receive subsidized family planning services.

1998 MDH Grants to Community Health Boards*



*Includes CHS Subsidy

4. **Funding for public health activities is fragmented among state departments.**

   In addition, funding for public health activities occurs through other state agencies but is administered through local organizations other than CHBs, such as the family service collaboratives. Public health agencies are often involved in these collaboratives and can then apply for funds through the collaboratives. Local public health departments add much value to such efforts because of their focus on prevention, their knowledge of the community, and their population-based approach. However, their involvement in such activities takes staff time for which there is no reimbursement source. While many local health departments do receive funds from these other sources, the funds are not stable from year to year.

5. **Increased requirements to retain Medicare certification divert attention away from engaging communities and addressing population-based activities.**

   Increased Medicare requirements divert time away from other essential public health activities. For example, Medicare is soon expected to implement rules to collect information on outcome assessment. One local public health nursing director estimates these will require an additional 30 minutes every 60 days for each home health visit to reassess families. These rules also apply to clients funded through other payment sources, such as Medicaid. Thus, if a local health department wants to continue to receive MA revenue, it must meet these requirements for all clients. According to one CHS administrator, this draws time from engaging the community and targeted home visiting as staff are spending additional time on these home visits and the subsequent paperwork. It also means the agency cannot cover its costs to provide such home-based services.

The compounded effect of these factors is as follows:

- The local governmental public health system continues to experience financial stress, especially in some parts of the state.

- Counties that have other economic stresses are experiencing this to the greatest extent.

- Counties that have invested heavily in providing services to individuals and families are most affected. This occurs because they have relied heavily on payment sources such as MA, which is declining; because there are fewer other providers to carry out such services; and because they lack staff devoted specifically to population-based activities. These areas experience the greatest difficulty in making the transition from delivery of individual and family services to core public health functions. In general, these challenges tend to be more acute for sparsely populated counties.

B. Updated, Coordinated 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. These strategic themes provide a focus to help state and local governments achieve their public health mission.

To address these goals, certain information is critical. This information consists of three questions:

1) How healthy are Minnesotans?
2) What public health strategies work?
3) What public health activities are we currently undertaking?

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.

To address these concerns, an integrated state-local information system is needed. 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 are critically aware of the need to upgrade information systems. In an information resource management planning session and in individual conversations with local staff in preparing this report, many spoke to 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 CHBs recognize the need to better coordinate data and share information both within the MDH and between state and local government.

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.

C. Measure and Improve Performance

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 MCH 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.

D. State and Local Coordination

An effective working relationship between state and local governments is at the heart of Minnesota's public health system. This system is voluntary, and is based on a shared mission, and responsibilities. The Local Public Health Act states that, "the commissioner must assist community health boards in the development, administration and implementation of community

health services."[7] The MDH fulfills that requirement in a number of ways. One of the most visible and concrete forms of assistance has been through regionally-based state staff.

Since early in this century, the MDH has had regional consultants available to local public health agencies. While most of these consultants were technical advisors (specialists in particular program areas), some played the critical role of general consultant, or "liaison" between the MDH and local agencies. Until recently, agencies had two generalist consultants available in most of the seven district offices of the MDH–a District Representative who provided advice on governance and financial matters, and a Public Health Nurse Consultant who provided guidance on overall agency planning and program development, as well as specific consultation on public health nursing.

However, in the past decade, most of these positions have been eliminated as part of state budget reductions. With budget cuts in the 1990s, the consultant functions of the District Representative positions were eliminated, followed more recently by cuts in PHN Consultant positions and a restructuring of the remaining positions.

The most recent reductions in regional staffing, along with several other factors, has precipitated an examination of how state and local public health agencies can work together to fulfill public health responsibilities in the current environment. Other relevant factors include the maturing of the 20-year-old CHS system; the expanded responsibilities and size of the MDH; and the increasing complexity of public health issues to be addressed. Moreover, there are numerous issues that affect local public health ability to perform their duties, especially in the area of assurance (e.g., elderly and disabled), in which MDH has minimal authority to influence. Local public health agencies have raised several issues for joint discussion including sharing information about the MDH budget and legislative priorities; two-way communication mechanisms; the organizational structure of the MDH; interagency cooperation; and roles for the SCHSAC. These discussions are underway, and are expected to result in a clear articulation of Minnesota's state-local system of public health in which each party understands and is accountable for their respective responsibilities to promote and protect the public's health.

E. Expanding Relationships

The current opportunities for strengthening partnerships and focusing on population-wide public health approaches are both exciting and daunting. Protecting the public health in Minnesota has long depended on a strong partnership between state and local health departments. Effective public health practice has also required teamwork among governmental units, such as education social services; and others in the community, such as businesses and consumers.

In this era of change, as successful collaborative efforts are beginning to occur between the public and private health care sectors in Minnesota; public health agencies, health plans, providers, and others interested in improving the public's health are developing new ways of working together to improve health and health care.

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[7] Minnesota Statutes Chapter 145A.

Legislation that passed in 1994 and mandated Collaboration Plans created new and more formalized opportunities for dialogue between public health agencies and the private system of health care. A Collaboration Plan is a document that every state licensed managed care organization is required to file with the MDH every two years. 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 plan is to be developed in collaboration with local public health units, appropriate Regional Coordinating Boards and other community organizations providing health services within the same service area. 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.

In 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, they 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.

Together, public, private and nonprofit sectors should 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. 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.

V. Plan of Action

This report has laid out the critical importance of the public health system in achieving goals for a healthy Minnesota. It has also described some of the challenges currently facing the local public health system as well as actions that have been taken to date to address these challenges. Following is a plan of action by which the MDH will work to address important local public health system challenges. It identifies a long term direction and highlights efforts currently underway and continuing/expanding in the next year. These actions were developed with the advice of the SCHSAC and the MHIP. Individual staff of CHBs were also contacted to provide input to this report. The action steps are consistent with the objectives in Goal 16, of the *Healthy Minnesotans Public Health Goals*, which is focused on strengthening the state and local government public health infrastructure (see Appendix D).

Demands of a changing health system continue to require that the local public health system carry out their core governmental functions of assessment, policy development, and assurance. This involves providing basic health protection from disease outbreaks and disasters and actively engaging the community in addressing health problems. While considerable strides have been made in this direction, the effort needs to continue and be more focused. The following is the MDH's plan of action to assist the local system in this effort:

1. **Ensure stable, adequate financing for the local public health system.**

   As discussed earlier, stable financing is critical and is at risk. In particular, some parts of the state are facing challenges to maintaining an adequate infrastructure for local public health. It should be noted that the MDH has similar infrastructure and resource needs which are not addressed in this report. Action steps to ensure stable funding for local public health include the following:

   - Advocate for stable, broad-based state funding for the local government public health system. Such funding should be administered in accordance with the Local Public Health Act, but be sufficient to provide an adequate base for areas of the state currently experiencing the greatest challenges to maintain an adequate public health infrastructure.

   - Streamline the grants processes by utilizing broad-based formula funding mechanisms whenever possible. When not possible, work internally to consolidate or simplify the application processes. A state-local work group has been formed and has begun meeting to address these concerns. Implement proposed changes to the MCH grant formula, if passed by the legislature.

   - Work with other state agencies and the federal government to identify ways to more effectively utilize other state and federal funds to support local public health.

2. **Improve organizational capacity and performance.**

Strengthening the public health infrastructure requires more than additional financial resources. This includes both informing and educating local elected officials and others about government's public health responsibilities and working to improve other components of the local and state infrastructure, such as workforce capacity and efforts to engage the community. Work done by the SCHSAC Governance and Accreditation groups in the past year provides a good framework for next steps to identify areas for improvement and to actually improve performance of state and local public health. Action steps include the following:

- Develop, test and use tools to assess and improve organizational capacity.
- Develop and implement performance indicators in selected program areas.
- Continue to support the CHS planning process as the key means to identify and address locally identified health concerns.

3. **Improve information systems and technology to better address critical public health questions.**

As described in the report, timely, accurate information is critical to protecting and improving the public's health. The MDH and local public health agencies have laid the groundwork on a framework for a coordinated information system. Action steps include the following:[8]

- 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.

4. **Strengthen state and local coordination.**

Maintaining a coordinated state and local public health system is crucial to achieving public health goals. MDH budget reductions, changes in the size and scope of state and local public health agencies, and increased complexity of public health problems pose challenges to effective coordination. A concerted effort is needed to improve coordination at both levels, including developing greater clarity of expectations and roles. Action steps include the following:

[8] These are partially contingent on receiving a legislative appropriation and/or federal funding.

- With the SCHSAC, identify "behavioral indicators" of state and local agencies for partnership.

- Organize state technical support and communication to effectively respond to local concerns. This could take a number of forms, from having staff assigned to district offices, as has occurred until recently, to identifying central office-based contact people to serve as a channel for communication with the rest of the MDH.

5. Expand partnerships with others to improve the public's health.

Everyone is encouraged to participate in improving the health of the state. Achieving Minnesota's goals and objectives will require the combined efforts of state and local public health agencies, health care providers, businesses, community-based organizations, health plans, educational institutions, faith communities, all levels of government, as well as families and individuals. Additional efforts are needed to elicit the involvement of broad segments of the community. Action steps include the following:

- 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.

Appendix A

Core Public Health Functions Funding

Core Public Health Functions Funding
Plan for the 1997 Legislative Appropriation

Introduction

The 1997 Legislature appropriated $10 million for each biennium for local government core public health functions. These funds have been added to the base of the community health services (CHS) subsidy to improve local government's ability to perform core functions in a changing health system. In accordance with the provisions of the Local Public Health Act, funds were allocated on a per capita basis (approximately $1.07 per capita), and a dollar-for-dollar local match was required. The funds were allocated based on recognition of three factors:

1. Emerging threats to the health system, including emerging infectious diseases and increasingly diverse populations.
2. Increased need to collaborate with managed care and other community organizations on public health goals.
3. Reduced revenues due to Medical Assistance (MA) funds being redirected to pay for medical care for low income individuals.

The funds appropriated by the 1997 Legislature were made available to community health boards (CHBs) on July 1, 1997[9]. Because CHS plan updates were not due to the Department until October 31, 1997, the Minnesota Department of Health (MDH) asked that CHBs submit a brief summary of how they intended to use the funds for the first six-month time period. Review of these summaries indicates that:

- CHBs are using the funds to address the three areas described above;
- there is a strong emphasis on coordinating activities with health plans, private health care providers, and community organizations and within geographic regions (across county boundaries);
- many CHBs are using some funds for targeted efforts to reach special needs populations, such as refugee populations or high-risk children and families; and
- funds are being used to increase the assessment and surveillance roles of public health, through immunization registries, community surveys, or computer software.

Additional information on the ongoing use of core functions funds was included in the 1998-99 CHS plan updates. The MDH will use this information to design administrative and program support to assist CHBs in carrying out core functions activities and to communicate with the Legislature and other organizations about how local government carries out its public health responsibilities.

[9] The 1996 Legislature had previously appropriated $1.5 million for core functions which was distributed to the 22 counties that were participating in PMAP as of July 1, 1996.

Description of Proposed Core Functions Activities

Community Health Board	Activities to be Supported with Core Functions Dollars
Aitkin-Itasca-Koochiching	Staff support for alcohol/tobacco use prevention efforts in schools; participation in NE MN Public Health Cooperative; MCH home visiting; implementation of teen pregnancy prevention plan.
Anoka	Violence prevention (coordination and education); staff support in family health to replace lost MA revenues; staff support for planning and evaluation.
Beltrami-Clearwater-Hubbard-Lake of the Woods (North Country)	Continuation of Communities Caring for Children regional program for integrated outreach and information and referral for pregnant women and children birth-5 years of age. The project emphasizes improved prenatal care, immunization rates, and number of children receiving well child checkups.
Becker-Mahnomen-Norman (Multi-County)	Continuation of Communities Caring for Children (see Beltrami above).
Benton-Sherburne	Replace lost MA revenues for public health staff support and computer hardware and software, web page development, and computer training.
Big Stone-Chippewa-Lac Qui Parle-Swift-Yellow Medicine	Prenatal pilot; collaboration through Prairie Health Alliance and Minnesota Rural Health Cooperative, collaboration on immunization systems; PMAP and county-based purchasing implementation; redesign reporting system.
Blue Earth	Replace lost MA revenues for family health activities; planning for Region 9 immunization registry.
Brown-Nicollet	Analysis of health care market for county-based purchasing and PMAP; participation in community collaborative efforts for healthy youths, adolescents, chemical and other health promotion; collaboration on adult day care; work on regional health profile.
Carlton-Cook-Lake-St. Louis	Teen pregnancy prevention in schools; family and children's collaborative involvement; study of impact of home visiting on families; Moose Lake Community Partnership; Northeastern Minnesota Public Health Cooperative.
Carver	Family Health Specialist position for Healthy Family violence prevention; data collection, hardware and software for Team Crash EMS project.
Cass-Todd-Wadena-Morrison	Prenatal care; universal home visiting; immunization tracking, registry development, and collaboration with providers; DP&C activities for uninsured; staff inservice for disease surveillance, assessment, outcome evaluation; youth tobacco prevention; development of county-based purchasing.

Chisago	Initiate PMAP implementation; evaluation and planning for transitioning of home health care activities; preventive health education materials for elementary school children and for county employees; education at women's health clinics in collaboration with Fairview clinic (to offset reductions in breast and cervical cancer grant).
Clay-Wilkin	Newborn assessment, community assessment and assurance through collaborative efforts.
Cottonwood-Jackson	Immunizations, chemical health promotion; prenatal and postpartum care; co-location of MCH staff to medical clinic; injury assessment and farm injury prevention; family violence prevention; and mental health assessment.
Crow Wing	ACCLAIM software to track immunizations; healthy communities participation; smoking prevention/cessation for pregnant women; subsidizing MCH and WIC; coordination on injury prevention; public health nuisance; participation in county-based purchasing/PMAP discussion and Community Health Assessment and Improvement Task Force.
Dakota	Update and integrate health data systems; participation in development of Metro immunization registry; continuation of performance measurement efforts; development of Dakota Healthy Families Initiative home visiting project.
Dodge-Steele	Enhancement of WIC, MCH and Health Promotion programs to offset reduced MA funding; expansion of work in reemerging disease, violence prevention.
Douglas	Community assessment, staff development on core functions, and expansion of health promotion activities
Faribault-Martin	Healthy Families home visiting for violence prevention for newborns.
Fillmore-Houston	Increase work with high-risk families; expansion injury prevention for farm families and infants; increase coordination with private providers on immunizations, family planning, and health promotion; explore PMAP and county-based purchasing options.
Freeborn	Family services collaborative activities; county-based purchasing development; SE MN domestic violence prevention project, and lactation friendly workplace project.
Goodhue-Wabasha	Infectious disease outbreak plan; pilot hand washing project in industrial sites; collaboration with managed care organizations; collaboration on priority areas in CHS plan; regional collaboration on domestic violence.
Grant-Pope-Stevens-Traverse (Mid-State)	Cancer and cardiovascular disease risk reduction coalition w/schools, hospitals, physicians, extension education; assessment of current community policy regarding tobacco use; involvement in family service and children's mental health collaboratives.

Hennepin	Development of Immulink immunization registry; increase assessment of child health; child abuse prevention through home visits for assessment, intervention, and evaluation; coordination of violence prevention activities; assessment of alcohol availability, and compliance checks for sale of alcohol to minors; and dissemination of findings.
Hennepin (Bloomington)	PHN visits for high risk families and those in unsafe housing conditions; monitor and follow-up on reportable diseases; youth health promotion initiatives; development of a public health database.
Hennepin (Edina)	Public health nuisance abatement due to deteriorated housing; improved assessment tools.
Hennepin (Richfield)	Coordinate with Bloomington CHB in immunization registry development; supporting health promotion for adolescents and families; health promotion in the areas of chemical health, STD/HIV prevention, teen pregnancy, violence prevention, and vulnerable seniors; and "Neighbors Helping Neighbors" volunteer program.
Hennepin (Minneapolis)	Conduct 2 youth access to tobacco studies; contribute to Immulink immunization registry development; child health survey to assess health status of children by community; violence prevention efforts in conjunction w/Hennepin, Bloomington, Richfield, and Edina.
Isanti-Mille Lacs	Public health nuisance control investigation and education; update and expand health promotion resource materials; tobacco awareness, day care for special needs children; PMAP implementation.
Kanabec-Pine	Alcohol, tobacco and other drug abuse prevention; teenage pregnancy prevention; collaborate with Search Institute project for youth asset-building; parenting education; health promotion staff; immunization action plan staff and clinic expenses.
Kandiyohi	Increased activity in disease prevention and control communicable disease reporting, registry implementation; MCH special project and home visiting coordination, health promotion education programming.
Kittson-Marshall-Pennington-Red Lake-Rosseau (Quin)	Continuation of Communities Caring for Children project (see Beltrami above), EMS educational efforts.
LeSueur-Waseca	Will spend remainder of 1997 planning for ongoing use of funds and carry over funds to 1998; possible activities to include staff training, immunization registry development; breast/cervical cancer screening program.
Lincoln-Lyon-Murray-Pipestone	Immunization registry development; parent and teen sexuality education; promotion of prostate cancer screening; food safety education; lead poisoning education; incorporating alcohol, tobacco and other drug abuse prevention education into home visits; home visits for family violence prevention; educational presentations on gambling addiction.

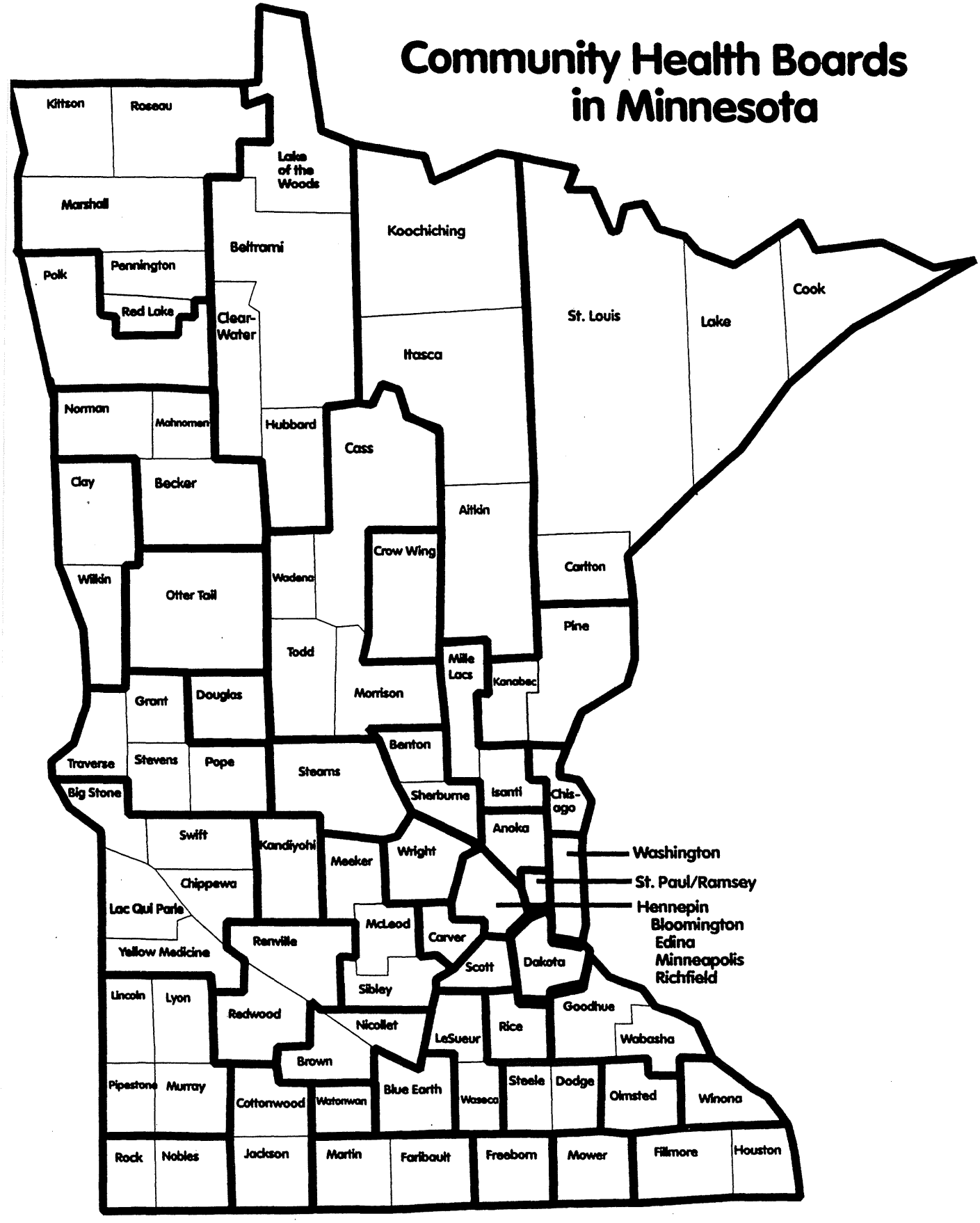
Meeker-McLeod-Sibley	Improve information systems, including software and Internet access; CHS administration and coordination efforts; offset reductions in MA to support early intervention parenting activities.
Mower	Health promotion efforts to reduce chronic disease and unintended injury; violence prevention through improved parenting and early intervention; immunization registry, refugee health; communicable disease investigation; participate in development of PMAP and county-based purchasing.
Nobles-Rock	Increase PHN staff time to address: alcohol, tobacco, and other drug use efforts; chronic disease prevention; unintended pregnancy prevention; violence prevention; injury prevention; capital improvements in Worthington office.
Olmsted	Offset loss of MA funds to support family health services; strengthen assessment capacity to collect data; coordinate assessment w/health and social services organizations; and improve presentation of community health data; augment health promotion efforts, including Healthy Behaviors project, Save Our Children tobacco use prevention initiative, and Multi cultural Health Care Alliance.
Otter Tail	Staffing for consultation on lactation; staffing to address refugee health issues; software programs to track core functions activities.
Polk	Support continuation of Communities Caring for Children project (see Beltrami above).
Redwood-Renville	Working with New Pioneer and other health plans to meet public health goals; working with local government on county-based purchasing; coordination of care for special needs populations such as TB in migrant farm workers, high risk parents, and frail elderly.
Rice	Staffing for: county wide infectious disease work group; Faribault area Stop Teen Access to Tobacco Coalition; support for child abuse and neglect prevention activities; child health promotion activities with individuals and community groups; cardiovascular disease prevention.
Saint Paul-Ramsey	Implement Saint Paul-Ramsey joint powers agreement; promote positive parenting and healthy growth and development for children with special needs; participation in metro wide immunization registry development.
Scott	Software and hardware to track health outcomes in collaboration with other local health departments and health plans; participate in development of county-based purchasing.
Stearns	Test disease prevention and control common activities framework; disease surveillance network; childhood injury prevention projects; research tobacco use prevention efforts in Stearns County and implement ordinances as necessary; expand home visiting efforts for high-risk families.

Washington	Carry over funds to 1998, to be used to fund community assessment projects, such as: access to care for uninsured; localized BRFS survey; upgrade of existing computer programs and development of new data bases; participation in the metro immunization registry project; and violence prevention activities.
Watonwan	Work w/local clinics to increase immunization rates; teen pregnancy prevention; home visiting through family service collaborative; participate in Salundando Salud (greeting health grant) to help Chicano/Latino/Mexican population access health services in Watonwan County.
Winona	Community assessment to assure services to vulnerable and high risk populations; medical translator services; continue Immunization Action Plan; cancer prevention activities; development of county-based purchasing (set-aside).
Wright	Co-location of PHN services with schools to coordinate outreach; health education in the schools; traffic safety collaborative project; PMAP implementation.

Appendix B

Map of the Community Health Boards

Community Health Boards in Minnesota



Appendix C

Progress on 1997 Action Plan

Appendix C

Progress on 1997 Action Plan

1. **Administer $6 million in core function funds, if available, in accordance with the CHS subsidy administrative requirements.**

   As indicated above, the legislature appropriated $5 million core functions funding. No funds were appropriated to the MDH for administrative and program support. Funds are administered to CHBs in accordance with the CHS subsidy distribution formula. A summary of activities for which these funds are being used is included in Appendix A. The MDH furnished technical support in using these funds through the CHS division's Public Health Nursing Section, which provided consultation to local agencies and developed educational modules to assist in transitioning staff into core function activities. Additional technical support was offered through individual consultation and written materials, and video conference sessions were provided through the Immunization Action Plan grant program, the Healthy Communities program, and other MDH program areas. MDH staff also assisted local staff in administering these funds through the existing CHS plan, budget and reporting system.

2. **Develop and utilize a vision and principles to guide administration of categorical grants to community health boards.**

   The MDH developed this vision and principles in 1997. It has been used as a guide for grant programs such as the state tobacco free communities grant. The MDH is currently meeting with local public health representatives to identify changes that may be made to streamline the grants process in other grant programs.

3. **Create an organized structure to undertake statewide discussions of public health goals and other population health issues and projects that cross the boundaries between the state and local public health system, managed care organizations and other health care providers, counties, regional coordinating boards, educational institutions, state agencies, and other organizations.**

   The Commissioner of Health formed the Minnesota Health Improvement Partnership in 1997, a broad-based advisory group with a charge reflecting the language above. The MHIP met quarterly through December 1998, working closely with the MDH in developing goals and strategies for health improvement efforts on the part of the public, private and non-profit sectors. Planning is now underway to consider next steps for the MHIP.

4. **Examine existing population health assessment methodologies and develop a long-term vision for population health assessment in Minnesota.**

   The Commissioner of Health convened the Population Health Assessment Workgroup in 1997. This group has since formed two sub-groups, one devoted to developing a long term

vision for population health assessment, the other developing pilot projects in four topic areas which will broaden the scope of assessment in those areas by identifying and incorporating additional measures to provide a more complete picture.

5. **Develop the 1998 Minnesota Public Health Goals and action steps to serve as a unifying framework for public, private and not-for-profit organizations' efforts to improve health.**

   New statewide goals, the *Healthy Minnesotan Public Health Improvement Goals*, were published in October 1998. These goals are based on a vision of "Healthy People in Healthy Communities– a Shared Responsibility". A set of fundamental principles and values has been developed to guide the development of the *Healthy Minnesotans* initiative. Eighteen goals were developed, and three priority areas of opportunity were presented to focus efforts of public, private, and nonprofit groups.

6. **Work proactively to identify, compile, and disseminate strategies to address major health issues.**

   Part I of *Strategies for Public Health: A Compendium of Ideas, Experience and Research from Minnesota's Public Health Professionals* was published in fall 1998. Part II will be published in February 1999. These strategies can be used by local public health agencies in the development of their community health plans, by health plans in the development of their collaboration plans and priorities for action, by schools and businesses in their work with communities as well as to grassroots and other kinds of organizations.

7. **Actively work to support the development of collaboration plans and collaborative relationships among health plans, providers, RCBs, and state and local public health agencies.**

   Following the submission of the last collaboration plans in October 1997, MDH representatives met with each managed care organization to provide feedback obtained through the review process, and to solicit input on the collaboration planning process. The guidelines for collaboration planning were revised, based on those meetings and other input, and will be distributed in January 1999. MDH staff regularly attend meetings of the regional public health/managed care collaboratives that exist in many parts of the state.

8. **Provide assistance to communities to identify community health services and activities needed to assure access to these services.**

   A work group of the SCHSAC, the Public Health/Hospital Coordination Work Group, was formed in 1997 to address concerns related to public health and health care access. This work group presented a draft report to the SCHSAC; however, the SCHSAC agreed that more work needed to be done on local public health governance issues before the SCHSAC could act on the report. The SCHSAC spent much of 1998 addressing the issue of governance and completed a policy paper addressing governance issues. The report of the

public health/hospital coordination work group will be brought back the SCHSAC for action in January of 1999. In the meantime, the MDH staff have consulted with CHBs who contract with hospitals or are considering such organizational structures to make sure that they are aware of their governance and core public health responsibilities and identify ways to improve operations.

9. **Continue to assess the infrastructure needs of the state and local public health system, and work to address those needs.**

   As indicated in earlier sections of this report, the MDH and local public health departments worked together to develop a plan to address information resource management issues in 1998. This culminated in a proposed legislative initiative for information resource management. Changing roles have been addressed through consultation by MDH staff to local agencies, including development of core essential modules to be used by local health departments for staff development. A six-part audio and video-conference, *Taking Charge of Change*, was used to assist local staff in identifying roles and responsibilities in relation to health plans, providers, and community organizations. The MDH also sponsored training on adapting to change for state staff who work with local public health agencies. A 1998 SCHSAC work group addressed roles of health plans and local public health departments in establishing public health goals to be included in the Prepaid Medical Assistance Program contracts.

10. **Coordinate technical support that is delivered from the MDH to local public health agencies to ensure that support meets local needs and is efficient and effective.**

    Several examples of coordinated agency-wide technical support efforts during the past two years include the review of the CHS plan updates, the development of the *Strategies for Public Health* document, the Center for Health Promotion's Capacity Building for Health Education effort. In addition, the MDH has developed an intranet calendar to aid in coordinating scheduling of workshops and so forth for local public health agencies. Coordination remains a significant issue to be further addressed within the MDH.

11. **Provide ongoing technical assistance and consultation at the local community level to support service coordination efforts.**

    Several activities have taken place over the past several years to support service coordination at the community level. The Disease Prevention and Control Common Activities provide a template for activities that state and local public health agencies, providers, and others in the community should undertake with respect to disease prevention and control. The *Strategies for Public Health* document provides suggested roles, and can also serve as a tool for community coordination. Finally, the CHS planning process can be a tool for community coordination to the extent that it becomes more of a community plan (rather than exclusively an agency plan) and to the extent that it is coordinated with the collaboration planning process that managed care organizations undertake.

Appendix D

Goal 16

Healthy Minnesotans Public Health Improvement Goals

GOAL 16 Ensure an effective state and local government public health system.

Protecting the health of the public is a fundamental responsibility of government. State and local public health agencies in Minnesota are assigned specific duties and authorities to fulfill governmental responsibilities for public health.

Minnesota carries out this responsibility through a unique partnership between state and local government. The state commissioner of health is statutorily responsible for developing and maintaining an organized system of services for protecting, maintaining and improving the health of the public. The state health department shares the responsibility for protecting the public's health with 49 Community Health Boards, composed of single-county, multi-county, and four city health departments. The legal authority for local public health is contained in Minnesota Statutes Chapter 145A, the Local Public Health Act. Under this law, counties may form community health boards if they meet certain organizational, planning and population requirements. In addition, counties have responsibilities under law as boards of health, regardless of whether they participate in community health services (CHS). The MDH supports the CHS system with funding, technical support and ongoing communications. Together, state and local government forms Minnesota's governmental public health system.

Government is responsible for certain core functions of public health. These core functions are assessment, policy development, and assurance. They have always been critical responsibilities of all levels of governmental public health departments. However, changes in the health system in recent years have made it even more important to articulate government's unique contributions to protecting the public's health and to act on those responsibilities as one part of a coordinated health system. In the first half of this decade, therefore, state and local public health in Minnesota defined the core governmental functions and identified a range of activities to be performed in carrying out these core functions.

The core functions framework has been used at the national level to identify government's responsibilities for public health. Within these three core functions, the federal government has identified 10 essential services to further define government's contributions. These essential services are:

- Monitor health status to identify and solve community health problems;
- Diagnose and investigate health problems and health hazards in the community;
- Inform, educate and empower people about health issues;
- Mobilize community partnerships and action to identify and solve health problems;
- Develop policies and plans that support individual and community health efforts;

- Enforce laws and regulations that protect health and ensure safety;
- Link people to needed personal health services and ensure the provision of health care when otherwise unavailable;
- Assure a competent public health and personal health care workforce;
- Evaluate effectiveness, accessibility and quality of personal and population-based health services; and
- Research for new insights and innovative solutions to health problems.

Although Minnesota has become accustomed to the core functions framework, the essential services framework (Figure 16.1) is also important because it is used in the federal Healthy People 2010 objectives for the nation. In addition, performance measures are being developed around the essential services which may be tied to federal funding for state and local government. The essential services shown in Figure 16.1 represent a list of activities that describe the core functions in terms more readily understandable to some people.

Figure 16.1

This chapter includes this topic area:

State and Local Government Public Health System

Why Is This Issue Important To Minnesotans?

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.

As discussed in the introduction of this chapter, this infrastructure forms the foundation for Minnesota's efforts to protect, maintain and improve health. The term infrastructure refers to the legal authority, policy, organizational structure (financing, workforce and information systems), community support, and research base necessary to carry out public health activities effectively.

In Minnesota, a viable system has been in place for many years, supported by federal, state and local funds. It is critical to maintain this strong system as Minnesota considers ways to reshape its health delivery systems and address emerging health problems.

The public health objectives described on the following pages emphasize the need to:

- Define indicators of a strong infrastructure;
- Identify elements of the system which require further development; and
- Devise and carry out plans for improvement.

What Minnesota Populations Are Affected?

Government has the responsibility to protect and maintain the health of all residents. In addition, all Minnesotans benefit from a healthy society.

Is Minnesota Gaining Or Losing Ground?

Minnesota's public health system is unique in the nation for its partnership between state and local public health. Coordinated development of public health goals, a common mission, coordinated policy development, standardized assessment and planning guidelines, and effective communication have all enhanced the ability of state and local government to fulfill its public health mission.

Although the current system is strong, several emerging issues threaten the ability of state and local government to protect the public's health with current resources. At the state level, stagnant funding to support infrastructure activities threatens to erode the state's ability to develop good information systems, respond to disasters, maintain laboratory support, and provide technical support. At the local level, Medical Assistance and Medicaid funds, which have helped to support the public health infrastructure, are being redirected to pay for medically necessary care. In some areas of the state, changing demographics are resulting in changes to the economy, which weakens the tax base and fee structure to support local public health. Changing local economies also affect the ability of the public health system to maintain a qualified workforce that is prepared to address emerging public health problems and respond to outbreaks and disasters. Increased emphasis on surveillance and outcome measurement requires adequate and coordinated information systems.

What Are the Data Highlights?

In order to target resources and technical support better, an assessment of organizational capacity of the MDH and local health departments is needed. During 1998, state and local government will undertake activities that will provide better data to accomplish the objectives identified in this goal.

Moreover, efforts will be taken to expand and improve the public health information infrastructure. The public health information infrastructure consists of systems that are used to store, track, collect and communicate public health information. These systems need to be enhanced to provide: better integration between systems from different public health programs; a focus on the collection of information to meet our public health goals; better access to those who need this information; and all enhancements needed to reflect data privacy and security concerns.

What Are The Potential Benefits Of Reaching This Objective?

A strong public health infrastructure will better enable Minnesota to achieve its overarching priorities of increasing healthy years of life and reducing disparities in health status. Achieving the objectives outlined below will ensure that public health protection is available in all areas of the state.

Where Can You Go For Additional Information?

Refer to Appendix A.

OBJECTIVES: ByThe Year 2004 ...

Legal Authorities/Governance

16.1 The MDH and each Community Health Board in Minnesota will have appropriate legal authorities to accomplish the essential public health services. (The term Community Health Board, or CHB, refers to the legal structure for organizing local public health in Minnesota. When used here, CHB includes all 87 counties and 4 cities that comprise the local public health system.)

16.2 Minnesota's federal-state-local partnership for public health will be clearly articulated, and all partners will understand their responsibilities and will hold each other accountable for their respective responsibilities to promote and protect the public's health.

Organizational Competencies

16.3 The MDH and the Community Health Boards will jointly identify both the organizational capacity needed to perform essential public health services in Minnesota and the indicators needed to assess organizational capacity.

Policy Development/Planning

16.4 The community health planning process will be continuously improved, will be based on a comprehensive community assessment of needs and resources and broad public participation, and will include local public health goals, interventions, budgets and evaluation plans.

16.5 Every four years, the MDH will develop and publish a set of statewide public health goals and strategies based on the community health planning process and broad public participation.

Surveillance/Research and Information Systems

16.6 The MDH and the Community Health Boards, in partnership with health care research institutions, higher educational institutions and others will identify priority public health surveillance, information, research, and evaluation needs and will develop plans to address them.

16.7 The MDH and the Community Health Boards will expand and improve the public health information infrastructure.

16.8 The MDH and all Community Health Boards will have the staff, training, hardware, software and Internet connections needed to carry out surveillance, assessment, interventions and research necessary to protect and promote the public's health.

16.9 The MDH and Community Health Board information systems will provide a means to collect information about indicators to assess their performance of essential public health services.

16.10 The MDH and each Community Health Board will be able to access knowledge-based information through easily accessible sources such as the MDH library and the Worldwide Web.

16.11 The MDH website will provide information about the department and its programs, as well as professional information of particular interest and value to the Community Health Boards.

Workforce

16.12 The MDH and each Community Health Board will have a culturally competent workforce that has the capacity to accomplish essential services.

16.13 The MDH and each Community Health Board will effectively use distance learning techniques and any associated technology to further the development of public health professional skills and abilities.

Emergency Response

16.14 The MDH and each Community Health Board will have, or participate in the development of, a response plan for disease outbreaks and natural and human-made disasters.

16.15 The MDH and each Community Health Board will efficiently and effectively fulfill government public health responsibilities to respond to disease outbreaks as well as natural and human-made disasters.

Public Health Laboratory

16.16 The MDH laboratory will establish working partnerships with local public and private laboratories that will enhance population-based clinical and environmental laboratory testing, staff development, and implementation of improved methods.

Financing

16.17 The MDH and Community Health Boards will have stable and adequate resources (both financial and personnel) to fulfill government's responsibilities to protect and promote the public's health.

Assurance

16.18 The MDH and each Community Health Board will fulfill government's responsibilities to assure that health care services meet community needs.