

State Community Health Services Advisory Committee

SCHSAC Strategic Plan 2009-2013



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SCHSAC Strategic Plan 2009-2013

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Executive Summary

Together, Minnesota’s state and local public health departments periodically pause to review progress in maintaining and strengthening the statewide governmental public health system (sometimes referred to as the public health “infrastructure”). They re-affirm a shared vision that guides the state-local partnership, and jointly develop goals and strategies to address ongoing and emerging public health issues and challenges.

The 2008 SCHSAC Strategic Planning Work Group was asked to answer two key questions: “*What do you want to accomplish in the next three to five years?*” and, “*What do you want the system/organization to look like in the next three to five years?*” Their charge was to (1) develop a long-range strategic plan to define and address the infrastructure needs of the statewide CHS system in order to improve the health of the public; and (2) recommend activities that the MDH, Community Health Boards (CHBs), and SCHSAC should undertake to implement the plan.

Infrastructure denotes the systems, competencies, relationships, and resources that enable performance of public health’s core functions and essential services in every community. Categories include human, organizational, informational, and fiscal resources.

Shared Vision

The shared vision statement is: “*All Minnesotans have the opportunity to achieve optimum health*”, with a visionary goal specific to the governmental public health system: “*The public health system in Minnesota is a strong and dynamic partnership of governments fully equipped to address the changing needs of the public’s health*”.

The visionary goal includes four key elements:

- 1) **A Partnership of Governments.** This partnership includes the relationship between the MDH and local public health jurisdictions including city, county and multi-county community health boards. It also embraces a broader partnership of other government entities, comprised of city and county departments, Minnesota’s 11 sovereign tribal governments and federal agencies such as the Indian Health Service and the Centers for Disease Control and Prevention.
- 2) **Strong.** This partnership will build upon the strengths of its established, long, and rich history. Strong public health partnerships are those in which all members: share a common understanding of the public health principles that provide direction and the ethical framework for decision-making; maintain meaningful, multi-directional communication with all other members; engage in effective community coalition-building; develop relationships with potential partners; and sustain a true commitment to reflecting on and continually strengthening member relationships.
- 3) **Dynamic.** Dynamic public health partnerships will be resilient – able to quickly adapt to rapid change and to involve other entities as issues require. This flexibility will require all

The vision also stresses the importance of working with many partners.

partners to know their communities well and to be able to creatively and effectively identify, organize, maximize, and deploy community resources – including people – as needed.

- 4) Fully Equipped. In order to meet the current and emerging challenges to promoting health and preventing disease, public health partners in Minnesota must have the information, tools, and technology needed to monitor and track health status and disease outbreaks; a professional and culturally-competent workforce that is qualified and prepared to address emerging public health challenges; and stable and sufficient funding to finance their work.

This visionary goal focuses on the governmental partnership. However, because public health issues are complex, and authorities and expertise do not always reside within the scope of governmental public health practice, **the visionary goal also stresses the importance of working with non-governmental public health partners.**

The work group identified four public health systems goals (listed below). These goals and strategies (described later) can be incorporated into SCHSAC’s annual work plan during the next five years.

Goals

Goal 1: *The statewide public health system is prepared, strong, and sustainable and receives stable, adequate, and flexible funding*

In Minnesota, the state and local health departments are responsible for promoting and protecting health, preventing epidemics and the spread of disease, responding to disasters, and protecting against environmental hazards. A prepared, strong, and sustainable public health system from border to border is necessary to carry out these responsibilities.

Several characteristics of the public health system in Minnesota have fostered effective public health practice to date. This includes the early development of broad-based statutory authority for governmental public health, local financial commitment to public health and a history of high standards for the state and local health departments’ workforce. Factors and issues for future attention include articulating concepts of population-based practice, maintaining an appropriate balance between flexibility and standardization; ensuring a ready and capable workforce and stable, adequate and flexible funding; identifying governance, organizational and other characteristics that contribute to strong and effective local health departments; and a continued emphasis on performance management and a culture of quality.

Goal 2: *The state and local governmental public health partnership is dynamic, resilient, and nimble*

State and local governmental public health officials share a long and rich history marked with significant accomplishments in working cooperatively to improve the public’s health. Hallmarks of Minnesota’s state-local partnership include:

- Engaged decision-makers at the state, county, and city levels,
- Commitment to collaborative leadership and approaches to problem solving, and
- Respectful participation in dialogue about tough issues.

Despite its maturity, the partnership is not static and requires nurturing and ongoing attention. Because the State Community Health Services Advisory Committee, or SCHSAC, is a primary mechanism for maintaining the state and local partnership, ongoing efforts to enhance the operations of SCHSAC and improve information flow from SCHSAC back to communities are important to consider.

Goal 3: *Public health information (i.e., data) is leveraged to create the foundation for decision making*

Public health practitioners can often add depth to policy discussions because they collect accurate and timely data that can show the relative importance of perceived problems. Historically, scientific expertise has been the foundation of credible public health information and it should continue to be the hallmark of public health policy advice. Changing the health profile of the population is dependent on the ability to identify and monitor trends for the major factors that give shape to that profile. It is also critical that the public health workforce continue to interpret, analyze, and “translate” the information in understandable terms for partners and the public. Continued efforts to strengthen public health information systems, data sources and professional skills will enhance contributions to decision-making and ultimately translate into healthier communities.

Goal 4: *The public, including policymakers, sees public health initiatives as cost-effective means to addressing today’s health issues and preventing tomorrow’s problems*

Surveys indicate that the public values clean water, safe food, and swift, accurate responses to dangerous and stressful events such as disease outbreaks and natural or manmade disasters. However, many Minnesotans, including local and state policy makers, do not understand that state and local health departments play a key role in those functions. Nor do they understand the related costs of delivering such services. Concerns about the cost of health care provide an opportunity to discuss the cost saving benefits of primary prevention.

Public health professionals should continue to find ways to inform partners, the public, and policymakers about the value of a strong public health system. Messages about the roles of state and local health departments must be crafted and delivered in a way that the intended audience hears, understands, and is able to take action.

Introduction

SCHSAC Strategic Plan

Together, Minnesota's state and local public health departments periodically pause to review progress in maintaining and strengthening the statewide governmental public health system. They re-affirm a shared vision that guides the state-local partnership, and jointly develop goals and strategies to address ongoing and emerging public health issues and challenges.

Minnesota has a strong foundation for local public health and for a state and local public health partnership, both of which were created by and continue to be supported by state statute. The Community Health Services (CHS) Act was enacted in 1976 and recodified and replaced with the Local Public Health Act, (Chapter 145A) in 1987. The Local Public Health Act was revised again in 2003.

Many changes have occurred in Minnesota since 1976 when the CHS system was developed. The state's population continues to grow and become more diverse, public health issues and problems remain complicated, and state and local governments are more complex. Peoples' expectations of government continue to change. Since 1976, the Minnesota Department of Health (MDH) has seen an increase in responsibilities, constituency and advocacy groups, and funding sources. Community health boards (CHBs) and local health departments (LHDs) have also seen growth in their local responsibilities, issues, and relationships. Some LHDs struggle to fulfill local public health responsibilities. In addition, some issues that existed in 1976 continue today, including gaps in capacity between metropolitan and greater Minnesota LHDs.

Background and Process

State Community Health Services Advisory Committee (SCHSAC) typically undertakes a strategic planning process every five to ten years. In 1993 and 2003, the processes were extensive and involved significant data collection activities. The 1993 strategic planning process focused on health reform efforts and served as the basis for several SCHSAC annual work plans. In 2003, the strategic plan integrated the SCHSAC's efforts into one comprehensive statement of future direction for the public health system. The 2003 strategic plan also served as a basis for the SCHSAC annual work plans from 2003 through 2008 and included significant system-wide infrastructure development.

The 2003 SCHSAC Strategic Planning Team was asked to answer two key questions: "*What do you want to accomplish in the next three to five years?*" and, "*What do you want the system/organization to look like in the next three to five years?*" Their charge was to: (1) develop a long-range strategic plan to define and address the statewide CHS system infrastructure needs in order to improve the health of the public; (2) recommend activities that the MDH, CHBs, and SCHSAC should undertake to implement the plan; and (3) periodically revisit the strategic plan to determine progress made.

Many of the recommendations in the 2003 Strategic Plan have been completed. Six areas of public health responsibility and the essential local public health activities were articulated, a revised community assessment and planning process was put into place, enhancements to accountability systems were implemented, and local health departments began submitting information to MDH through the local public health planning and performance measurement system (PPMRS). Additionally, the strategic plan laid the groundwork for stimulated work that is currently underway to identify the costs of providing public health services and gaps in current funding.

In 2008, work on the current Strategic Plan was initiated.. After reviewing the 2003 SCHSAC Strategic Plan, the SCHSAC Executive Committee agreed the plan’s vision and goals continued to be relevant and that an “update” rather than development of a brand new vision, goals, etc. would be sufficient to help direct SCHSAC’s work for the next three to five years. A Work Group was charged with updating the strategic plan. The same two key questions that were used in 2003 guided the update: *What do you want to accomplish in the next three to five years?*” and, *“What do you want the system/organization to look like in the next three to five years?”* These questions were discussed by the SCHSAC Executive Committee, by the full SCHSAC, and by the Work Group.

SCHSAC Strategic Plan Update Work Group Charge and Membership

Charge

A SCHSAC Strategic Planning Work Group will:

- Review and update the 2003 SCHSAC Strategic Plan.
- Identify additional topics and issues that should be included in the Plan.

Membership:

Cheri Lewer, Chair
CHS Administrator
Le Sueur-Waseca CHB

David Benson
Nobles County Commissioner
Nobles-Rock CHB

Ben Brunsvold
Clay County Commissioner
Clay-Wilkin CHB

Bonnie Engen
CHS Administrator
North Country CHB

Lowell Johnson
CHS Administrator
Washington CHB

Susan Morris
Isanti County Commissioner
Isanti-Mille Lacs CHB

Julie Myhre
CHS Administrator
Carlton-Cook-Lake-St. Louis CHB

Joyce Mueller
Public Health Nurse Manager
Crow Wing CHB

DeeAnn Pettyjohn
CHS Administrator
Dodge-Steele CHB

Ann Stehn
CHS Administrator
Kandiyohi CHB

Sandy Tubbs
CHS Administrator
Douglas CHB

Marcia Ward
Winona County Commissioner
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MDH Representatives

Patricia Adams
Craig Acomb
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Maggie Diebel
Kristen Ehresmann
Mary Manning

MDH Staff

Mickey Scullard
Gail Gentling
Debra Burns

SCHSAC Strategic Plan for 2009-2013

Overview

Minnesota is recognized as a national leader for its state and local public health partnership. Due in large part to the strength and resilience of the partnership, public health in Minnesota continues to achieve great successes. Gains in improving the public's health are not limited, however, to the public sector. Public health encompasses both governmental efforts – local public health jurisdictions, the state department of health – as well as broad collaborations with Minnesota's 11 American Indian tribes, community-based organizations, health maintenance organizations and health plans, health care providers, institutes of higher education and schools, faith organizations, communities, and individuals. As governments realize increasing financial pressures, this broad collaboration is expected to grow in its importance and influence.

The 2009-2013 SCHSAC Strategic Plan provides a blueprint for Minnesota's governmental public health system over the next three to five years. The actions recommended in this strategic plan update will guide the public health system through challenges, prepare it for opportunities, and further strengthen it and the partnership.

Shared Vision for the Minnesota Public Health System

A vision is a picture of the preferred future.

The work group members carefully reviewed the scope of the vision statement. The resulting broad vision statement is: ***“All Minnesotans have the opportunity to achieve optimum health”***, with a visionary goal specific to the governmental public health system: ***“The public health system in Minnesota is a strong and dynamic partnership of governments fully equipped to address the changing needs of the public's health”***.

The vision also stresses the importance of working with many partners

The work group thoughtfully discussed the visionary goal's focus on the governmental public health system. It noted however that because governmental public health must work with many partners to solve complex public health challenges, the role of external partners was under-emphasized. Therefore, the work group added emphasis to the importance of the community partners in discussions.

Vision: All Minnesotans have the opportunity to achieve optimum health.

This vision is resilient, timely, and essential and will continue to guide public health policy and programs long into the future. The vision is neither new, nor unique. Its essence is shared in the mission statements of most state and local health departments. This vision continues to help set into motion significant work, including addressing emerging issues and changes to public health policy and funding.

Attaining this vision requires a strong and efficient state-local system to accurately assess and plan for important public health issues, to carry out science/evidence-based policies and

strategies to protect and improve health, and to document progress toward statewide public health outcomes. To that end, the following visionary goal was established.

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

Key Elements of the Visionary Goal

- **A Partnership of Governments.** This partnership includes the relationship between the MDH and local public health jurisdictions including city, county and multi-county community health boards. It also embraces a broader partnership of other government entities, comprised of city and county departments, Minnesota's 11 sovereign tribal governments and federal agencies such as the Indian Health Service and the Centers for Disease Control and Prevention.
- **Strong.** This partnership will build upon the strengths of its established, long, and rich history. Strong public health partnerships are those in which all members: share a common understanding of the public health principles that provide direction and the ethical framework for decision-making; maintain meaningful, multi-directional communication with all other members; engage in effective community coalition-building; develop relationships with potential partners; and sustain a true commitment to reflecting on and continually strengthening member relationships.
- **Dynamic.** Dynamic public health partnerships will be resilient – able to quickly adapt to rapid change and to involve other entities as issues require. This flexibility will require all partners to know their communities well and to be able to creatively and effectively identify, organize, maximize, and deploy community resources – including people – as needed.
- **Fully Equipped.** In order to meet the current and emerging challenges to promoting health and preventing disease, public health partners in Minnesota must have the information, tools, and technology needed to monitor and track health status and disease outbreaks; a professional and culturally-competent workforce that is qualified and prepared to address emerging public health challenges; and stable and sufficient funding to finance their work.

Public health issues are complex and authorities and expertise do not always reside within the scope of governmental public health practice.

State and local health departments and governmental and non-governmental partners continue to work together to identify, discuss, and reduce the factors that are the major contributors to disability, premature death, and health disparities. Some of those known factors include socioeconomic status, a lack of culturally sensitive or geographically appropriate access to health care, gaps in access to treatment for mental illness, a lack of public transportation (especially in rural Minnesota), a shortage of adequate housing, unequal opportunities for economic

Public health issues are complex – partners of all types must work together to create appropriate and successful solutions.

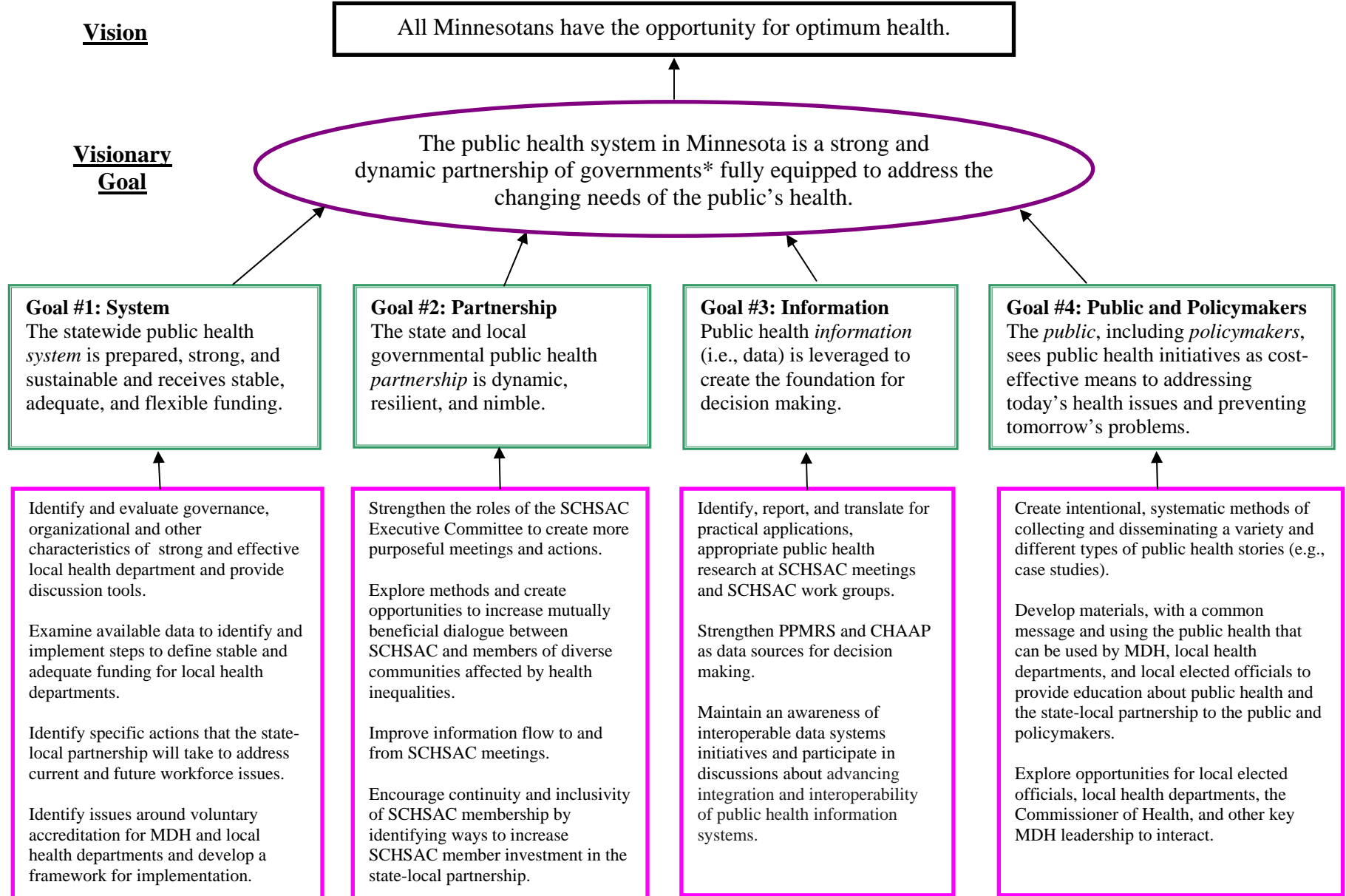
security, and numerous others, which affect many health issues, but are largely outside the scope or control of public health practice.

Acknowledging that many critical factors that affect health are out of the scope of the state and local health departments, this strategic plan update is focused on goals and strategies to assure that Minnesota's state and local public health system can effectively fulfill its responsibilities. To that end, the work group identified four public health systems goals (listed below). Those four goals frame the state and local public health infrastructure issues. The goals inform strategies that can be incorporated into SCHSAC's annual work plan during the next five years.

Goals

- Goal 1: The statewide public health *system* is prepared, strong, and sustainable and receives stable, adequate, and flexible funding
- Goal 2: The state and local governmental public health *partnership* is dynamic, resilient, and nimble
- Goal 3: Public health *information* (i.e., data) is leveraged to create the foundation for decision making
- Goal 4: The public, including *policymakers*, sees public health initiatives as cost-effective means to addressing today's health issues and preventing tomorrow's problems

SCHSAC Strategic Plan Diagram



*The important role of partners outside the governmental public health system is addressed in the narrative portion of the report.

Goal 1: The statewide public health *system* is prepared, strong, and sustainable and receives stable, adequate, and flexible funding

In Minnesota, the state and local health departments are responsible for promoting and protecting health, preventing epidemics and the spread of disease, responding to disasters, and protecting against environmental hazards. A prepared, strong, and sustainable public health system from border to border is necessary to carry out these responsibilities.

Several characteristics of the public health system in Minnesota have fostered effective public health practice to date. This includes the early development of broad-based statutory authority for governmental public health, considerable local financial commitment to public health and a history of high standards for the state and local health departments' workforce. There is also a long-standing history of state and local government working in partnership to achieve public health goals and a willingness to change and improve the system. The Work Group discussed a number of factors and issues that will affect public health practice and the ability of Minnesota's public health system to fulfill its responsibilities.

Population-based practice

A population-based approach is very different in its goals than a patient-based or client-based approach, which seeks to address individual needs or issues. In recent years, public health has increasingly emphasized population-based practice. Population-based programs, policies, and practice share five characteristics:

- Population-based public health approaches are founded on community need, which is determined through a systematic assessment of the health status of the whole population and community input.
- Population-based approaches consider all members of an entire population that have the same risks, concerns, or characteristics.
- Population-based approaches consider the broad determinants of health.
- Population-based approaches include a strong prevention component.
- Population-based approaches rely on all levels of intervention – interventions focused on whole communities, on individuals, on families, and on systems [called population health].

A population-based approach emphasizing health interventions focused on whole communities has been called, by some, the best investment that can be made.

Maintaining an appropriate balance between flexibility and standardization, in order to assure a basic level and quality of services in every community

Flexibility, accountability, and attention to outcome measures are essential components of public health practice. In Minnesota, local health department services are based on an assessment of local needs, and operate within a broad framework of statewide guidelines with a minimum of state mandates. Because of the local control and significant local investment of resources, the type and level of local health department services provided by Community Health Boards has varied throughout the state. The Essential Local Public Health Activities (ELAs) were developed to assure that all Minnesotans receive at least a core set of public health services and simplify

efforts to describe the system and its benefits to the Legislature, locally elected officials, and citizens. An online reporting system was created (the local public health planning and performance measurement system – PPMRS) to assess progress in meeting the ELAs. enhanced accountability review process was created and implemented, as required by the 2003 revisions to the Local Public Health Act (MS 145A.131, subdivision 3), which states that “community health boards accepting local public health grants must document progress toward the statewide outcomes... to maintain eligibility to receive the local public health grant.”

SCHSAC work groups worked to forge an appropriate balance between flexibility and accountability while developing planning, performance, and accountability standards. The work groups used guiding principles, which included the following:

- All parts of the state should be adequately served by a local health department and all Minnesotans should expect an essential set of public health activities.
- A consistent framework is used to describe governmental public health to state and local policy makers and the public, but a “one size fits all approach” would not succeed because local public health problems vary throughout the state.
- A basis for ongoing measurement, accountability, and quality improvement related to the implementation or assurance of essential local activities is critical to success.
- Quality improvement methods are used to improve practice continuously over time.
- Keep it simple.

Movement forward: voluntary accreditation and quality improvement

The voluntary accreditation program for state and local health departments that is under development at the national level will likely have significant implications for Minnesota’s public health system. For the first time there will be a set of national standards and indicators which set uniform expectations for the practice of public health in the U.S. Although the full implications of this development will emerge only over a period of years, it is essential to begin examining how this common set of standards can be used to strengthen public health practice in Minnesota, and to anticipate and address potential issues up front, e.g., how these standards will affect smaller health departments that may not currently be providing the range of public health activities included in the national standards. The work done by SCHSAC related to local planning, performance, and accountability will help position Minnesota’s local health departments for this new paradigm. Additionally, Minnesota has worked to develop competence in quality improvement practices at the local levels. Quality improvement is a key component of the national accreditation program, so efforts to increase the workforce’s skills and competence in using quality improvement practices and to integrate these concepts into public health practice are timely and important. Although initial efforts related to quality improvement and accreditation focused primarily on local health departments, it is important to consider both the state and local health departments.

Ensuring a ready and capable workforce

Workforce issues continue to be of major concern to public health practitioners in Minnesota. Those workforce issues include:

- A public health workforce shortage throughout Minnesota.

- A large number of retirements from leadership positions at the state and local health departments.
- The need for a more diverse and culturally competent work force that reflects the racial and ethnic diversity of Minnesota residents.
- Developing and maintaining a ready and capable workforce.

Workforce shortage: Probably the most visible shortage is the nursing workforce. Two of the most pressing nursing workforce issues are a lack of certified public health nurses and the competition from area hospitals, which are able to pay more than local health departments.

Retirements: Succession planning at the state and local levels is critical to sustaining the strength of the state and local public health system. Yet a systematic approach to this issue has not been developed and the leadership training options which exist only accommodate small numbers of people. Additionally, many years of collective wisdom leaves the system when retirements occur and therefore, it is important to consider ways to capture their knowledge and experiences before those workers leave.

Diversity of workforce: Attracting and retaining a diverse workforce is a process that requires organizations to establish and adhere to practices that attract, retain, and promote personnel who reflect the cultural and ethnic diversity of the communities served.

Partners: All health organizations and many of the governmental public health system's partners are facing these same workforce issues.

Ensuring stable, adequate, and flexible funding

Developing sufficient and sustainable funding has been a pressing issue at the federal, state, and local levels for many years. Minnesota's funding system for local health departments has been shaped by years of incremental decisions, many tied to specific programs and resources. As a result, it is a labyrinth of local, state, and federal funding sources; distribution formulas; and categorical restrictions. Further, many sources of relatively flexible funding have eroded and more narrowly-focused, competitive grants have proliferated, further exacerbating the fragmented funding structure for local CHS activities. This mix of funding delivers inconsistent support across local health department jurisdictions and causes some high-priority needs to go unmet.

Identifying governance, organizational and other characteristics that contribute to strong and effective local health departments

Local health departments in Minnesota and nationally differ in governance and structure; as well as in how they operate. Very little attention has been paid to examining factors that support effective and efficient local health department operations. As resources, population centers and the work force change, local elected officials ponder the advantages and disadvantages of the different models, often with little information available to guide their decision making. Understanding and articulating the characteristics of strong local health departments will provide

local elected officials with important facts to help them decide what will work best in their jurisdictions.

Strategies

1. Identify and evaluate characteristics that contribute to a strong and effective local health department, including:
 - Missions, funding, and staffing,
 - Leadership and management
 - Issues posed by potential accreditation,
 - Strategies for maintaining focus on the public health mission of primary prevention and population-based practice,
 - Impact of various structures on the state-local partnership,
 - Best practices/methods for maintaining strong public health functions within various structures, and
 - Regionalization and/or other models of shared services.
2. Examine available data from PPMRS, the Cost Model Project for Local Health Departments, and other sources to identify and implement steps to define stable and adequate funding for local health departments, including:
 - Determine to what extent current funding sources
 - Support the public health mission of primary prevention and population-based practice, and
 - Allow for the number and types of staff necessary to achieve the mission.
3. Identify specific actions that the state-local partnership will take to address current and future workforce issues, including:
 - Succession issues,
 - Leadership development,
 - Matching staffing complement with skill sets that are and will be needed in the future, and
 - Developing and retaining a ready and capable workforce by:
 - Strengthening and enhancing relationships with academic institutions, including those in neighboring states,
 - Identifying reciprocity or exchange of services (e.g., state or local health departments accept student workers and in exchange, professional development opportunities provided to staff), and
 - Identifying and implementing retention strategies.
4. Identify issues around voluntary accreditation for MDH and local health departments (LHDs) and develop a framework for implementation, including:
 - An examination of the impact of accreditation on varying sizes and structures of LHDs and on MDH,
 - The impact of accreditation on existing systems (e.g., PPMRS, CHAAP),
 - The costs associated with accreditation (e.g., site visits, documentation, etc.),

- The potential implications for a local health department if it chooses not to become accredited, and
- The identification of potential incentives for accreditation (e.g. financial support, enhanced technical assistance, or reductions in administrative requirements).

Goal 2: The state and local governmental public health *partnership* is dynamic, resilient, and nimble

State and local governmental public health officials share a long and rich history marked with significant accomplishments in working cooperatively to improve the public's health. This partnership of governments is an important accomplishment and a source of great pride.

Government health departments are responsible for promoting and protecting the health of the entire population. Minnesota's state and local public health system is accountable for that responsibility. It accomplishes this responsibility through policy, population-based (as opposed to individual patient-based) programs, and partners. The state and local health departments use science-based strategies, based on information collected about different groups, communities, and individuals (data). Governmental public health also partners with many other organizations and groups who contribute, in different ways and from different perspectives, to public health initiatives. Hallmarks of Minnesota's state-local partnership include:

- Engaged decision-makers at the state, county, and city levels,
- Commitment to collaborative leadership and approaches to problem solving, and
- Respectful participation in dialogue about tough issues.

Despite its maturity, the partnership is not static and requires nurturing and ongoing attention. This is important for several reasons. First, new individuals regularly enter the system, so it is critical that the partners regularly discuss and affirm this inter-governmental relationship. Second, as in any long-lasting relationship it is important to identify areas for improvement and celebrate successes. Those steps will help during times of perceived and real struggles and disagreements that are bound to occur. Maintaining a healthy partnership into the future requires an ongoing commitment on the part of both state and local governments.

The partnership must also grow. There are others within state and local government that are critical to the success of public health efforts. These include local environmental health entities, tribal governments, cities, and administrators (city, county, and human services). Additionally, little attention has been given to the relationship of local governments to each other. Not only does the existing state and local public health partnership need to strengthen ties to other governmental entities, it is critical to also embrace non-governmental partners. These other partners include private, non-profit, and voluntary organizations, and academic institutes, among others. Additional partners can bring new approaches and creative solutions to multi-faceted public health problems. They can also bring resources and knowledge of diverse communities that can help address health disparities.

The State Community Health Services Advisory Committee, or SCHSAC, is a primary mechanism for maintaining the state and local partnership. SCHSAC has existed as a strong and successful group for over 30 years by bringing together the Commissioner and key MDH leadership with representatives of local government to jointly address issues of shared interest. A hallmark of any successful organization is the ability to continually strive to improve, and SCHSAC is no exception. Several strategies are presented below to enhance the operations of SCHSAC.

Strategies

1. Strengthen the roles of the SCHSAC Executive Committee to create more purposeful meetings and actions.
 - Engage the Executive Committee in a deliberation of substantive issues and report on results at SCHSAC meetings.
 - Engage the Executive Committee in the development of the SCHSAC meeting agendas, including establishing guidelines for item/topic inclusion.
2. Create opportunities for mutually beneficial dialogue between SCHSAC and communities impacted by health inequalities on issues that stretch beyond the boundaries of governmental public health.
 - Work with the MDH Office of Minority and Multicultural Health (OMMH), other MDH program areas and other key representatives to identify diverse communities and contacts to participate in the expanded dialogue and clarify purposes.
 - Identify meaningful methods of engaging in conversations between SCHSAC and representatives of diverse communities, when appropriate.
3. Improve information flow to and from SCHSAC meetings.
 - Solicit ideas for SCHSAC meeting topics from key partners and programs, assuring that local health departments know about potential presentations by programs in their jurisdiction.
 - Develop tools and mechanisms to encourage sharing information about SCHSAC meetings with community health boards, other county commissioners, within MDH, and other key partners.
 - Provide a brief overview of each meeting's business, presentations, and discussions for SCHSAC members to use when they return to their home communities.
 - Develop a Train-the-Trainer opportunity for local health department staff and local elected officials to help them articulate and promote public health.
 - Provide Executive Committee members with a list of the SCHSAC members in the regions they represent and encourage regular communication.
 - Promote a consistent SCHSAC presence on Association of Minnesota Counties (AMC) District meeting agendas.
4. Encourage continuity and inclusivity of SCHSAC membership by identifying ways to increase SCHSAC member investment in the state-local partnership by:
 - Developing, in addition to the regular new member orientation, an ongoing orientation for new members and encourage informal mentoring from long-time SCHSAC members,
 - Query SCHSAC members about specific health topics interests, expertise, etc., to create a pool of people to draw on as issues arise,
 - Developing a paper or recording with SCHSAC members telling their stories of their involvement with SCHSAC,
 - Highlighting a local health department or region with brief presentations at each SCHSAC meeting, focusing on specific and timely public health issues, and

- Exploring multiple ways to engage SCHSAC members in conversations (at meetings as well as between meetings), such as: emerging or timely public health issues and topics, providing time for discussion.

Goal 3: Public health *information* (i.e., data) is leveraged to create the foundation for decision making

Optimally, decision making will include a progression from data analysis to information to knowledge to wisdom to practice.

Policy decisions are often based on anecdotal information. Public health practitioners can often add depth to policy discussions because they collect accurate and timely data that can show the relative importance of perceived problems. Historically, scientific expertise has been the foundation of credible public health information and it should continue to be the hallmark of public health policy advice. Moreover, efficiency in changing the health profile of the population is dependent on the ability to identify and monitor trends for the major factors that give shape to that profile. Another critical component is the establishment of outcome measures. Outcomes show policymakers and the public that public health measures do make a difference. The state-local partnership has made progress in developing performance measures and outcomes to inform policy decisions. However, sustained efforts are needed to continue that progress. The emerging field of public health informatics provides language to describe the progression that is sought – a movement from data analysis to information to knowledge to wisdom to practice.

Initiatives such as e-health and new data collection systems under development (i.e., Minnesota Electronic Disease Surveillance System - MEDSS) have the potential to move the public health system toward this goal, and it is vital that the public health workforce become familiar with these efforts. Public health professionals have gained expertise in data management systems and e-health and efforts should build upon their knowledge and experiences. It is also critical that public health workforce continue to interpret, analyze, and “translate” the information in understandable terms for partners and the public. State and local health departments must continue to identify and integrate new data collection technologies and approaches.

Despite progress over the past few years, significant issues still remain, including:

- Counties have invested in multiple data management systems to share data, report activities and expenditures, and for other data and information exchange purposes, and
- A legislative mandate states that all health care providers and hospitals have an interoperable electronic health record (EHR) system by 2015. Much work remains to be done within the local public health system to meet that mandate.

Strategies

1. Identify, report, and translate for practical applications, appropriate public health research at SCHSAC meetings and SCHSAC work groups.
2. Strengthen PPMRS and CHAAP as data sources for decision making.
 - Provide partners with information about the PPMRS and CHAAP systems review and revision process.
 - Provide ongoing education and information of available PPMRS and CHAAP data, its value and ways the data and information can be used, e.g., real-time information and descriptions of local programs.

3. Maintain an awareness and understanding of interoperable data systems initiatives as a health issue.
 - Participate in discussions about advancing integration and interoperability of public health information systems and the implications for the state-local partnership and local health department practice.
 - Support work groups efforts and strengthen connections (e.g., SCHSAC representation on work group).

Goal 4: The public, including *policymakers*, sees public health initiatives as a cost-effective means to addressing today's health issues and preventing tomorrow's problems

The public generally understands the functions of a fire department, police department, or a school district. And they understand that those services have important effects on their quality of life. Surveys indicate that the public values clean water, safe food, and swift, accurate responses to dangerous and stressful events such as disease outbreaks and natural or manmade disasters. However, many Minnesotans, including local and state policy makers, do not understand that state and local health departments play a key role in those functions. Nor do they understand the related costs of delivering such services.

Concerns about the cost of health care provide an opportunity to discuss the cost saving benefits of primary prevention. For example, the Minnesota Legislature has enacted tobacco control measures, appropriated funding to specifically focus on reducing obesity and tobacco use – known risks that contribute to preventable disease. Those actions were based on strong evidence and a compelling case made by state and local governmental public health leaders and many key partners that investments in prevention can reduce health care costs. Moreover, because of its population-based perspective, the state and local governmental public health system are often charged with serving as the focal point for new and ongoing initiatives (e.g., Statewide Health Improvement Program).

Public health professionals should continue to employ similar strategies to inform partners, the public, and policymakers about the value of a strong public health system. It is critical that the public, including policymakers, see population-based public health efforts as a cost-effective means to address today's health issues and prevent tomorrow's problems. Messages about the roles of state and local health departments must be crafted and delivered in a way that the intended audience hears, understands, and is able to take action.

Strategies

1. Develop materials, with a common message and using the public health brand that can be used by MDH, local health departments, and local elected officials to provide education about public health and the state-local partnership to the public and policymakers.
 - Develop resources regarding the cost-benefit of public health services that can be used to discuss the cost-benefits of public health measures (e.g., a dollar bill listing “for every dollar spent on x, y dollars are saved”).
 - Develop a template that could be easily tailored by a health department, community health board, or county (i.e., fill-in-the blank documents) to discuss cost-savings of specific public health measures.
2. Create intentional, systematic methods of collecting and disseminating a variety and different types of public health stories (e.g., case studies).

3. Explore opportunities for local elected officials (city council and county commissioners), local health departments, the Commissioner of Health, district offices, and other key partners to interact (e.g. regional dialogues).

Appendix A

SCHSAC Strategic Vision from the 2003 SCHSAC Strategic Planning Report

This 2003 Vision statement is included as a reference for readers.

2003 Vision

Shared Vision for the Minnesota Public Health System

A vision states the outcomes an organization or system hopes to gain in a set amount of time. It is a picture of the preferred future. This is a vision for the partnership that makes up the governmental public health system in Minnesota.

Based on feedback from the data collection phase of this strategic planning process, the work group decided to significantly edit the vision statement that was originally adopted as part of the strategic planning process of 1993. Following a lengthy discussion that took place over the course of two meetings, the work group agreed upon the following vision statement.

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

Key Elements of the Vision

- **A Partnership of Governments.** This partnership will integrate the long-standing success of the relationship between the MDH and local public health jurisdictions including city, county, and multi-county community health boards and will evolve into a broader partnership of governments including Minnesota's 11 sovereign tribal governments and federal agencies such as the Indian Health Service and the Centers for Disease Control and Prevention.
- **Strong.** This partnership will build upon the strengths of its established, long, and rich history. Strong public health partnerships are those in which all members: share a common understanding of the public health principles that provide direction and the ethical framework for decision-making; maintain meaningful, multi-directional communication with all other members; engage in effective community coalition-building; and sustain a true commitment to reflecting on and continually strengthening member relationships.
- **Dynamic.** Dynamic public health partnerships will be resilient – able to quickly adapt to rapid change and to involve other entities as issues require. This flexibility will require all partners to know their communities well and to be able to creatively and effectively identify, organize, and deploy community resources – including people – as needed.
- **Fully Equipped.** In order to meet the current and emerging challenges to promoting health and preventing disease, public health partners in Minnesota must have the information, tools, and technology needed to monitor and track health status and disease outbreaks; a professional and culturally-competent workforce that is qualified and prepared to address emerging public health challenges; and stable and sufficient funding to finance their work.

Appendix B

Goals from the 2003 SCHSAC Strategic Plan

The 2003 Strategic Goals have been included as a reference for readers.

2003 Strategic Goals

The SCHSAC Strategic Planning Work Group was asked to answer two key questions: “*What do you want to accomplish in the next three to five years?*” and, “*What do you want the system/organization to look like in the next three to five years?*” Responses to these questions were clustered into common theme areas. Using the clusters as an organizing framework, work group members developed an overarching goal and a number of strategic goals.

These follow:

- All Minnesotans have the opportunity to achieve optimum health.
- Health status improvement is accomplished through population-based programs and policy.
- The public health system is prepared to detect and respond to public health emergencies.
- The statewide public health system is prepared, strong, and sustainable and receives stable, adequate, and flexible funding.
- Public health information (e.g., data) is leveraged to create the foundation for decision making.
- Governmental partnerships for health are continuously improved.
- The public, including policymakers, sees public health as a cost-effective means to address today’s health issues and preventing tomorrow’s problems.

Appendix C

SWOT Analysis conducted by the SCHSAC Strategic Plan Update Work Group

In order to determine the needs and issues currently faced by local health departments, the 2008 SCHSAC Strategic Plan Update Work Group conducted an analysis of the strengths, weaknesses, opportunities, and threats (SWOT) facing the governmental public health system. The points listed below were identified through this process.

SCHSAC Strategic Plan Update Work Group, July 14, 2008

Key Points from SWOT Analysis Strengths

- Strong state-local partnership
 - Positive approach and roles
 - Skilled at community processes, which helps to leverage resources
 - Opportunities to work across the system
- Strong framework, envied by other states
 - Willingness as a system to change and improve
 - Can manage any needs
 - Defined essential local activities
- Dedicated staff, whose primary motivation is not money
 - History of high standards for workforce

Weaknesses

- The system is not nimble
- Always being asked to do more with less
- Subject to changes in government leadership
- Inconsistencies
 - Capacity
 - Communication
- Workforce issues
 - Turnover
 - Retirement – no way to capture the knowledge and experience of people leaving
 - Next generation employees have many job opportunities and tend to be more mobile

Opportunities

- Economic crisis is changing people's opinions and behaviors
 - Makes them more willing to change
 - Community partners have a vested interest in public health outcomes
- Increasing numbers of diverse populations
 - Includes the aging population
- Healthcare Reform (SHIP)
- Technology
 - Electronic health records (EHR)

Threats

- Funding
 - Decreased public and categorical funding
 - Funding streams don't match messages or needs
- Systems' issues
 - Private organizations not involved in public health issues for the "long haul"
 - Special interest or advocate groups can undermine efforts
 - Power struggle and philosophical differences between the healthcare system and public health
- Information overload
- Workforce issues, including competing professions, job sites and salaries
- Power struggles
- Climate change
- Economic crisis' affect on families

Appendix D

Discussion summary from the May 9, 2008 SCHSAC Executive Committee meeting

The SCHSAC Executive Committee, at their May 9 meeting, discussed the challenges and strengths of Minnesota's governmental public health system and ways to strengthen the state and local partnership. They also identified current and emerging issues.

Strategic Planning Discussion at SCHSAC Executive Committee Meeting, May 9, 2008

What works well? Strength and Integrity

- SCHSAC meetings
- Peoples' commitment to attending and participating
- Balanced and respectful partnership
- Collaboration between and across counties

Comment: Public Health is poised to expand and we need to do the legwork to be ready

Challenges

- Need more money
- Philosophical differences about how to do government
- So much of LHD work is grant funded
- Need state funding commitment
- Dollars run out/end even when a program works
- Spend a lot of time working on grants

Data/communicate about work

- Staff works with minimum of direction
- Communicate with LHDs what works well – the directors need to be informed
- CHB city/county commissioners' representation differs so info does not always reach all local elected officials
- CHBs not all equally active, varying lengths of time spent on public health issues
- LHD director/CHB Administrator have an important role in helping educate and inform the Board
- Gap in how information is distributed – if not at a meeting, don't get information
- Need to identify/find successful channels to highlight public health success

Suggestions on how to better inform city/county boards

- Inform/communicate to city/county administrator the top/key points and share the key points directly with the city/county board
- Learning sessions with city/county board
- Information that comes directly from the LHD Director/CHB administrator has a little more impact
- Engaging commissioner may be a challenge
- Health tips for SCHSAC members to share
- Local media – articles for adaptation

Comment: We don't tell the good stories/successes – only hear about the failures – we don't usually focus on what is working

Human Resources issues

- State Department “Heads” are political appointees
- More dialogue between human services and public health
- Issues around the combining of human services and public health
- Nurses pay starts at the lowest end
- Recruitment – partnering with institutes of higher education
 - Start early
 - List the benefits

Miscellaneous points/questions

- Where should the funding come from?
- How much?
- County-based funding – local taxes dollars – “Blues” – health systems, etc.
- Public health does a lot without sufficient pay

Issues/Emerging/Important over the next five years

- Immigrant/refugee health
- Childhood and adult vaccines
- Food-borne illnesses
- Emergency Preparedness (it seems to be falling of the radar) and public health has been in the forefront



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