



STATE COMMUNITY HEALTH SERVICES ADVISORY COMMITTEE (SCHSAC)
Minnesota Department of Health
PO Box 64975 Saint Paul, MN 55164-0975
651-201-3880 www.health.state.mn.us/schsac

SEPTEMBER 30, 2014

SCHSAC STRATEGIC PLAN: 2014-2018

SCHSAC STRATEGIC PLANNING WORKGROUP

CONTENTS

SCHSAC STRATEGIC PLAN: 2014-2018

SCHSAC Chair’s Letter	3
Commissioner’s Letter.....	4
Introduction.....	5
Vision.....	6
Strategic Priorities.....	7
SCHSAC Strategic Plan: 2014-2018	8
Tell Minnesota’s Public Health Stories	9
Ensure Adequate Resources for Public Health.....	10
Use Data and Technology to Our Advantage	11
Support Strong, Mission-Driven Leadership.....	12
Engage Local Elected Officials to Support Public Health	13
Appendix A: Workgroup Charge	14
Appendix B: Wave Trends Analysis.....	15



For more information, contact:

Office of Performance Improvement
Minnesota Dept. of Health
PO Box 64975
St. Paul, MN 55164-0975

Phone: 651-201-3880
Fax: 651-201-5099
Email: health.ophp@state.mn.us
Online: www.health.state.mn.us/schsac

If you require this document in a different format, such as large print, Braille, or cassette tape, call 651-201-3880 or email health.ophp@state.mn.us.

POPE MINNESOTA COUNTY

*Enhancing quality of life by providing innovative
services for our community every day*

September 22, 2014

Ed Ehlinger, MD, MSPH
Commissioner
Minnesota Department of Health
625 Robert Street North
St. Paul, MN 55155-2538

Dear Commissioner Ehlinger:

I am pleased to present to you the 2014-2018 Strategic Plan of the State Community Health Services Advisory Committee (SCHSAC). SCHSAC approved the plan at its meeting on September 17, 2014.

The SCHSAC Strategic Plan reflects the priorities of the state-local partnership. The plan calls for adequate resources, data and technology investments and guidance, strong public health leadership, and engaged local elected officials. The fifth overarching priority, to improve our ability to tell Minnesota's public health stories, is fundamental. We need policymakers, partners and the public to understand the role, value, and importance of public health and to use the Health in All Policies approach.

The SCHSAC Strategic Plan was generated through workgroup discussions at two facilitated sessions with participation from elected local officials, local public health leaders, and representatives from the Minnesota Department of Health. The final version was created with input from the full SCHSAC and the SCHSAC Executive Committee.

The five overarching strategic priorities will move us toward achieving our practical vision and will direct SCHSAC's annual work plans.

I look forward to working with you as we implement the 2014-2018 SCHSAC Strategic Plan.

Sincerely,



Larry Kittelson, 2014 SCHSAC Chair
Pope County Commissioner
Horizon Community Health Board



Protecting, maintaining, and improving the health of all Minnesotans

September 25, 2014

Larry Kittelson, SCHSAC Chair
Pope County Commissioner
301 7th Street
PO Box 666
Starbuck, MN 56381

Dear Commissioner Kittelson:

Thank you for sending me the 2014-2018 Strategic Plan of the State Community Health Services Advisory Committee (SCHSAC).

I applaud the in-depth process used to gather input and select SCHSAC's overarching strategic priorities. Local public health leaders and the Minnesota Department of Health are aligned in efforts to strengthen and improve Minnesota's public health through a variety of means.

Promoting the Health in All Policies approach will engage local elected officials in public health by connecting policy decision related to education, housing, transportation, and other sectors with health outcomes. I hope local leaders will seek opportunities to advance health equity and improve the health of all members of their communities.

SCHSAC is an outstanding example of the state-local partnership for public health. The focus on continuous process improvement and engagement of its members is one of the main reasons this long-standing committee positively impacts health policy and serves as an example for other states.

I look forward to working with you and SCHSAC as this plan is implemented and revised to address new challenges and opportunities. Thank you for the excellent work.

Sincerely,

A handwritten signature in black ink that reads "Edmund P. Ehlinger".

Ed Ehlinger, MD, MSPH
Commissioner
PO Box 64975
St. Paul, MN 55164-0975

INTRODUCTION

Together, Minnesota's state and local public health leaders periodically pause to review progress in maintaining and strengthening the statewide governmental public health system. Members of the State Community Health Services Advisory Committee (SCHSAC) and leaders from the Minnesota Department of Health (MDH) reaffirm the shared vision that guides the state-local partnership, and jointly develop goals and potential strategies to address ongoing and emerging public health issues and challenges.

BACKGROUND

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. In 2008, the SCHSAC Executive Committee agreed the 2003 plan's vision and goals continued to be relevant and opted to "update" rather than develop of a brand new vision, and goals.

PROCESS

In early 2014, a SCHSAC workgroup was convened to once again answer the 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?" These questions were discussed by the SCHSAC Executive Committee, and by the workgroup, which came together for two full-day, professionally facilitated meetings (March 28 and April 14).

The facilitators guided the workgroup members through a series of activities and discussions designed to help the group take stock of accomplishments to-date, identify emerging trends impacting the field, and select strategic priorities for the work of SCHSAC for the next five years. The workgroup's

trend analysis activity is included in [Appendix B](#). A summary diagram of the strategic plan articulated by the workgroup is on page 7, followed by more detail on each priority area.

Brainstorming sessions and discussions were robust. Participants shared their reflections and experiences, asked questions, and sought to maintain a broad, strategic perspective. The workgroup followed the state-local partnership's own "Three Simple Rules" which ask members to 1) Seek first to understand, 2) Make expectations Explicit, and 3) Think about the part and the whole. Participants reflected that public health issues are complex, and authorities and expertise do not always reside within the scope of governmental public health practice. The importance of working with non-governmental public health partners was expressed many times and deemed vital to success.

CURRENT ENVIRONMENT

Many changes have occurred in Minnesota since 1976 when the Community Health Services (CHS) system was created. The state's population has grown and become more diverse, public health issues and problems have increased in complexity, and peoples' expectations of government have changed substantially. State and local governments continue to seek ways to streamline their business practices. Since 1976, the 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. In addition, some issues that existed in 1976 continue today, including gaps in capacity within the public health system, particularly in Greater Minnesota LHDs.

The SCHSAC strategic planning workgroup reviewed the previous strategic plan and did an activity to assess progress on four goals focused on the capacity of the statewide system, the resilience of state and local partnership, the leveraging of information and data in decision making, and support from the public and policy makers for public health initiatives. Overall, the workgroup felt that significant progress had been made in these areas and

listed many achievements. The workgroup noted that more work needs to be done and barriers still exist in achieving the desired goals.

The facilitators lead the workgroup through a wave trend analysis exercise. This activity focused on determining ideas in the categories of boundary, emerging, established, and decreasing relevance. Boundary ideas are new ideas pushing to become accepted practices. Emerging ideas are trends and practices picking up momentum. See the results in [Appendix B](#).

While the public health environment has changed, the strategic priorities of the previous plan remain very relevant. The 2014-2018 Strategic Plan renews the vision of health for all, includes the new dynamics of accreditation, performance management, data and technology, and takes into consideration years of reductions in funding and lack of investment. Barriers still exist and many will remain due to the nature of government and public health work.

VISION

The **practical vision** is the shared picture of the future and asks “What do we want to see in place in the next three to five years as results of our actions?” The practical vision provides a sense of destination of the organization’s efforts and tells us where we are going, what the accomplishments, outcomes, changes and results are that we are seeking by our efforts. As part of the facilitated process, the SCHSAC Strategic Planning Workgroup brainstormed components of a desired future. Many ideas were generated, and then categorized by consensus to formulate a practical vision to direct their strategic planning.

SCHSAC’s practical vision addresses ways to strengthen the state-local partnership and ensure the continuing success of the Minnesota Public Health System. Written more formally, the practical vision becomes:

Practical Vision: SCHSAC and MDH sustain the vital mission of public health by leveraging partnerships and championing public policies to improve practice, strengthen leadership, and increase workforce capacity. These efforts are to be undertaken while engaging partners and the public in creating opportunities to make the healthy choice the easy choice in all Minnesota communities.

SCHSAC is composed of local elected officials, local governmental public health directors and community health services administrators to work with the MDH and state leaders on public health. The plan’s scope will remain in this area with focus on efforts SCHSAC can make to connect and engage other partners, but not on what will be asked of those partners. SCHSAC recognizes that governmental public health doesn’t act alone and needs partnerships with other organizations, sectors and communities to reach the vision of all people in Minnesota enjoy health lives and healthy communities.

UNDERLYING CONTRADICTIONS

What is blocking SCHSAC from realizing the practical vision? Underlying contradictions are the current realities facing an organization, which become manifest when placed under the light of a practical vision. Without a vision, problems and anxieties are relegated to “lists of things to do” or are explained away as minor conflicts. As a group considers the range of its issues together, root causes can be uncovered and objectified for thorough consideration and proposed actions. Workgroup members listed the underlying contradictions, or obstacles, in relation to the desired practical vision. These relate to all issues and are fundamental concerns that SCHSAC has discussed and addressed in many ways. Including:

- Scarcity of resources
- Everything is important: where do we start? How to choose?
- Discomfort with storytelling and marketing
- Crumbling public health foundation

STRATEGIC PRIORITIES

Overarching Strategic Priorities are the substantial, innovative actions that move us toward the practical vision.

The elements of the Practical Vision are honed into five Overarching Strategic Priorities that will be addressed in future SCHSAC annual work plans. The work plans will be developed with input from the SCHSAC Executive Committee and MDH, and then approved by the full SCHSAC body. SCHSAC annual work plans will address these strategic priorities and develop action steps and activities to move forward to reach the practical vision.

More information on each Strategic Priority follows.

**TELL MINNESOTA'S
PUBLIC HEALTH
STORIES**

**ENSURE ADEQUATE
RESOURCES FOR
PUBLIC HEALTH**

**USE DATA AND
TECHNOLOGY TO OUR
ADVANTAGE**

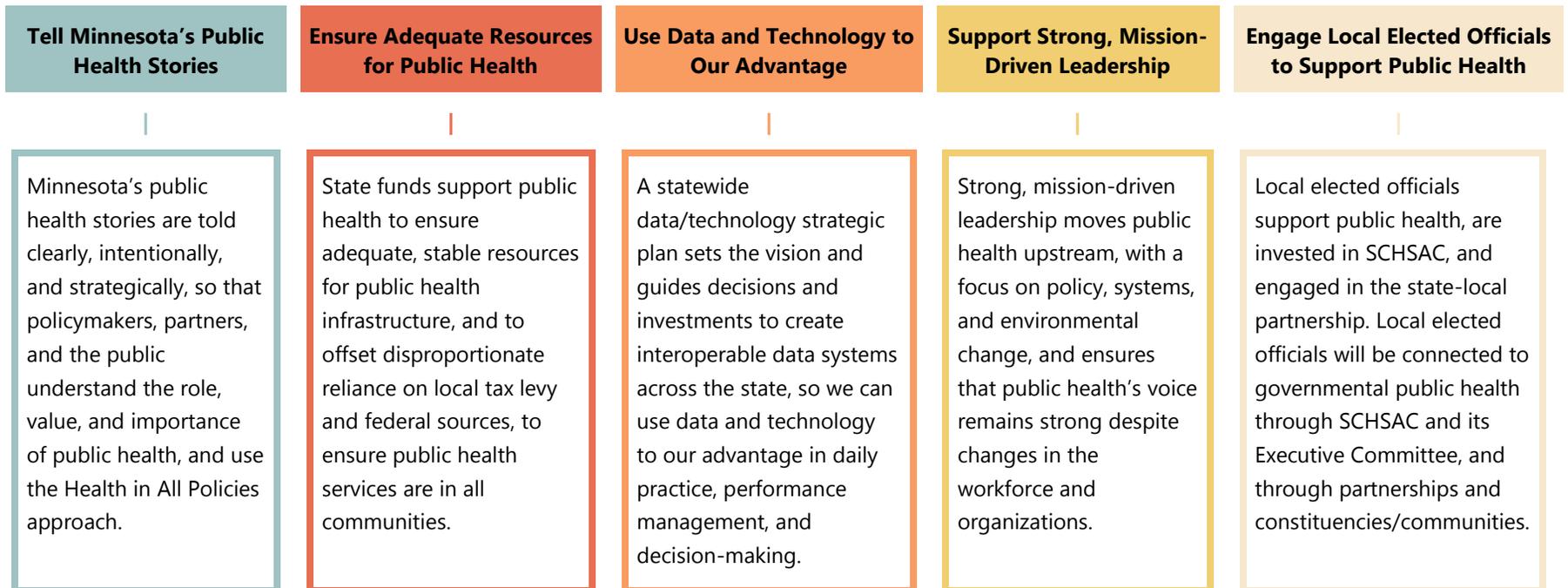
**SUPPORT STRONG,
MISSION-DRIVEN
LEADERSHIP**

**ENGAGE LOCAL ELECTED
OFFICIALS TO SUPPORT
PUBLIC HEALTH**

SCHSAC STRATEGIC PLAN: 2014-2018

Practical Vision: SCHSAC and MDH sustain the vital mission of public health by leveraging partnerships and championing public policies to improve practice, strengthen leadership, and increase workforce capacity. These efforts are to be undertaken while engaging partners and the public in creating opportunities to make the healthy choice the easy choice in all Minnesota communities.

Overarching Strategic Priorities (5): Substantial, innovative actions that move us toward the Practical Vision



TELL MINNESOTA'S PUBLIC HEALTH STORIES

WHAT WE WANT TO ACHIEVE

Minnesota's public health stories are told clearly, intentionally, and strategically, so that policymakers, partners, and the public understand the role, value, and importance of public health, and use the Health in All Policies approach.

WHAT'S IN OUR WAY

Discomfort with storytelling and marketing

Examples:

- We get in our own way (e.g., data isn't always the answer)
- Politics—whose story is it?
- We assume people know the story
- It's not in our culture to take credit
- Much of our work is complex and inaccessible
- We are afraid to tell our story

WHY THIS IS IMPORTANT

- We need to keep public health strong, regardless of the organizational/governance structure of local public health
- Community needs to feel represented in public health and educated on the role of public health

HOW WE CAN DO THIS

What are innovative, substantial actions that will address our blocks and move us toward our 3-5 year vision?

Examples:

- Use social media to educate the public
- Train elected officials and public health leaders how to share emotional stories
- Build public awareness through SCHSAC
- Invest in building communications capacity
- Host roundtables on Health in All Policies
- Seek partnerships and advocates from other sectors

ENSURE ADEQUATE RESOURCES FOR PUBLIC HEALTH

WHAT WE WANT TO ACHIEVE

State funds support public health to ensure adequate, stable resources for public health infrastructure, and to offset disproportionate reliance on local tax levy and federal sources, to ensure adequate public health services in all communities.

WHAT'S IN OUR WAY

Scarcity of resources

Examples:

- LPH generally lack the staff capacity to do infrastructure development such as quality improvement or health information exchange)
- Accreditation: the return on investment is unclear for some
- County commissioners and city council members and county/city administrators will support the public health mission when they understand the need
- Decision makers need more information about the benefits and responsibilities of public health to allocate resources
- Competitive, conflicting interests and priorities

WHY THIS IS IMPORTANT

- Community health boards need additional funding for infrastructure (health information exchange, quality improvement, health equity)
- Investment is need in public health state & local initiatives
- Funding has been decreased and does not meet needs
- Implement statewide health-equity driven resource allocation to build local public health capacity

HOW WE CAN DO THIS

- Build on the support of the state-local partnership to make a successful legislative request for increased public health investment
- Partner with others, such as accountable care organizations, to show return on public health investment
- Partner with hospitals and other community organizations to leverage community assessment data to direct adequate resources to local and statewide public health priorities

USE DATA AND TECHNOLOGY TO OUR ADVANTAGE

WHAT WE WANT TO ACHIEVE

A statewide data/technology strategic plan sets the vision and guides decisions and investments to create interoperable data systems across the state. Such investments will allow us use data and technology to our advantage in daily practice, performance management, and decision-making.

WHAT'S IN OUR WAY

Unclear ownership of vision for data/technology systems

Examples:

- Lack of clarity and buy-in around vision for statewide public health data/tech
- Established and agreed upon standards to lead to improve practice are needed
- Uniformity in state for data collection and reporting are needed
- Outdated, obsolete data systems
- Technology development is too costly for local public health departments

WHY THIS IS IMPORTANT

- Greater health information exchange
- Interoperability in place and you can pull data easier
- Current data and research drives the system

HOW WE CAN DO THIS

Examples:

- Mandate use of IT systems (e.g., PH-Doc or Champ)
- Drive development of statewide data/tech strategic plan
- Recommend a Governor's directive (cabinet) on health information exchange
- High level positions at MDH responsible for coordinating IT development with state and local public health
- Share best practices and evidence-based strategies in data system development

SUPPORT STRONG, MISSION-DRIVEN LEADERSHIP

WHAT WE WANT TO ACHIEVE

Strong, mission-driven leadership moves public health upstream with a focus on policy, systems, and environmental change. It ensures that public health's voice remains strong despite changes in the workforce and organizations.

WHAT'S IN OUR WAY

Crumbling public health foundation

Examples:

- Staff allocations and expertise is missing due to retirements and high turnover
- Decision makers need more information about the benefits and responsibilities of public health to allocate resources

WHY THIS IS IMPORTANT

- Need to cultivate and support the next generation of highly-qualified and engaged public health leaders/ CHS administrators
- Need to build equitable public health capacity throughout the system
- Need to define a vision for what local public health capacity/capability should look like
- Need continued strong public health presence in counties

HOW WE CAN DO THIS

Examples:

- Develop or identify low cost and accessible public health courses for local leaders
- Develop training and orientation to increase local public health capacity
- Establish PH learning collaboratives and cohorts
- Use older generation to teach PH to younger generation (actively seek ways to pass on institutional knowledge)
- Local public health leadership to engage in succession planning

ENGAGE LOCAL ELECTED OFFICIALS TO SUPPORT PUBLIC HEALTH

WHAT WE WANT TO ACHIEVE

Local elected officials support public health, are invested in SCHSAC, and engaged in the state-local partnership. Local elected officials will be connected to governmental public health through SCHSAC and its Executive Committee, and through partnerships constituencies, and communities.

WHAT'S IN OUR WAY

Everything is important. How do we choose?

Examples:

- Poor attendance to SCHSAC quarterly meetings due to competing interests and/or unclear expectations
- Public health not viewed as high priority
- Competitive, conflicting interests and priorities
- Decision makers need more information about the benefits and responsibilities of public health to allocate resources

WHY THIS IS IMPORTANT

- Health in all policies will become the standard
- Public health is everyone's responsibility: we want a "Minnesota Miracle" for public health (like Minnesota did with education in the 1970's)
- Decisions makers can support additional funding and investment in prevention

HOW WE CAN DO THIS

Examples:

- Restructure SCHSAC to engage more elected local officials
- Occasionally offer a virtual SCHSAC meeting (i.e., minimize travel and materials, utilize communications technology)
- Survey SCHSAC on needed/desired improvements to meetings
- Actively invite other elected officials to attend SCHSAC
- Revitalize the SCHSAC Executive Committee to further engage these leaders in decision-making on public health issues

APPENDIX A: WORKGROUP CHARGE

Original charge approved December 6, 2013 by the Executive Committee.

CHARGE

The SCHSAC Strategic Planning Team will:

- Develop a Strategic Plan with a shared vision for the Minnesota Public Health System. The Strategic Plan will direct SCHSAC's work for the next five years
- Recommend activities that the MDH, community health boards (CHBs), and SCHSAC should undertake to implement the plan

BACKGROUND

Public health policy and practice have evolved since 2008 when the latest SCHSAC Strategic Plan (2009-2013) was drafted. It is time to convene state and local public health partners to answer the key questions: "What do you want to accomplish in the next five years?" and, "What do you want the system/organization to look like in the next five years?"

METHODS

The Planning Team will meet in early 2014 for two day-long planning sessions. The team will be comprised of county commissioners; local health department administrators, directors, and staff; and MDH leadership. Additional input may be sought from the working session participants via email or conference call. The SCHSAC Executive Committee will provide input on the plan before it is presented for approval by the full committee.

PRODUCTS

A SCHSAC Strategic Plan for 2014-2018 will be created to guide SCHSAC's work plans over the next five years.

RESOURCES

The MDH Office of Performance Improvement will provide a facilitator to lead the working sessions and additional staff to support to this activity.

WORKGROUP MEMBERS

Karen Ahmann, Mahnom County Commissioner (Polk-Norman-Mahnomen CHB / NW Region)
Terri Allen, Carlton Public Health Supervisor (Carlton-Cook-Lake-St. Louis CHB / NE Region)
Merrilee Brown, CHS Administrator (Scott CHB / Metro Region)
Bonnie Brueshoff, CHS Administrator (Dakota CHB / Metro Region)
Carol Biren, CHS Administrator (Southwest Health and Human Services CHB / SW Region)
Renee Frauendienst, CHS Administrator (Stearns CHB / Central Region)
Pete Giesen, CHS Administrator (Olmsted CHB / SE Region)
Bill Groskreutz, Faribault County Commissioner (Faribault-Martin CHB / SC Region)
Lowell Johnson, CHS Administrator (Washington County CHB / Metro Region)
Larry Kittelson, Pope County Commissioner (Horizon CHB / WC Region)
Susan Morris, Isanti County Commissioner (Isanti-Mille Lacs CHB / Central Region)
Bonnie Paulsen, Morrison Public Health Director (Morrison-Todd-Wadena CHB / Central Region)
Amy Roggenbuck, CHS Administrator (Le-Sueur-Waseca CHB / SC Region)
Deb Schuhmacher, CHS Administrator (Chisago CHB / Central Region)
Marcia Ward, Winona County Commissioner (Winona CHB / SE Region)
Sue Yost, CHS Administrator (Freeborn CHB / SE Region)

Becky Buhler, Office of Performance Improvement, MDH
Deb Burns, Office of Performance Improvement, MDH
Maggie Diebel, Community and Family Health, MDH
Kris Ehresmann, Infectious Disease Epidemiology Prevention and Control, MDH
Jim Koppel, Deputy Commissioner, MDH
Allison Thrash, Office of Performance Improvement, MDH

APPENDIX B: WAVE TRENDS ANALYSIS

FACILITATED STRATEGIC PLANNING TOOL



This environmental scan activity was conducted with the SCHSAC Strategic Planning Workgroup on March 28, 2014, to launch the planning process. The workgroup members were asked to brainstorm and discuss trends, practices, and ideas in SCHSAC that fall into these four categories.

BOUNDARY Which new ideas are pushing to become accepted practices?	EMERGING Which trends and practices are picking up momentum?	ESTABLISHED Which trends and practices are mainstream?	DECREASING RELEVANCE Which trends and practices are no longer relevant?
<ul style="list-style-type: none"> ■ Partnering with others beyond the health arena ■ Data Sharing (Working thru data privacy/HIPAA issues) ■ Health in all policies ■ Maintaining capacity for surge (ex. tuberculosis follow-up) if organization is providing less direct services ■ Community engagement/input ■ Importance of data analysis and timely data ■ Need SharePoint site or tool for SCHSAC workgroups ■ Using research to drive system ■ Financial penalties for not keeping "healthy" ■ Prevention focus (Accountable Care Organizations; Affordable Care Act) ■ Partnering in community assessments and improvement plans, especially with hospitals ■ Public health accreditation ■ Use of technology and social media to communicate (i.e. text messaging) ■ Representing the underserved or special needs 	<ul style="list-style-type: none"> ■ Emphasis on partnerships/relationships ■ Regional approaches to Public Health in order to leverage /share resources ■ Health in all policies ■ Primary care is not the same as public health ■ Return on investment ■ Evidence-based Practice ■ Public Health Systems and Services Research (national, state, local) ■ Public health partnering with clinics, hospitals, and others on community wellness, community health assessment and planning ■ Use of social media to communicate with each other 	<ul style="list-style-type: none"> ■ Affordable Care Act message: having insurance doesn't mean you have health ■ Health inequities and disparities vary across communities ■ Accreditation ■ Development of performance management system ■ Global health: "just a plane ride away" ■ Keeping Public Health strong in changing, combined structures (ex. merge with human services) ■ Population focus ■ Environmental issues as public health ■ Reliance on federal funding requires federal legislative platform for local public health ■ More policy, system, and environmental changes compared to direct services/individual focus 	<ul style="list-style-type: none"> ■ Full-day in-person workgroup meetings are dying (too long, hard to travel) ■ Hard copy materials and handouts(dying) ■ Local elected officials participation in SCHSAC meetings declining ■ Not as much "going it alone" for Public Health (more cross-jurisdictional sharing, more multi-county community health boards, working with one voice to advocate for SHIP, changes to Local Public Health Act) ■ Traditional systems (such as publication in state register) aren't effective in recruiting participation from diverse populations ■ Direct client services (home care) ■ Paper-charting

Facilitators: Linda Alton and Ann Gomez, MNTOP