

Ability to Meet Minimum Expectations: The Current State of Local Public Health in Minnesota

SUMMARY OF ASSESSMENT FINDINGS

Executive Summary

Minnesota's Local Public Health Act (Minn. Stat. § 145A) provides specific authorities and responsibilities for local public health in the state, and specifies six areas of public health responsibilities in which those authorities and responsibilities occur. Required local public health activities (or "foundational activities") released in 2017 address the six areas of responsibility, and comprise the minimum expectations for local public health in Minnesota. These foundational activities are the public health services that every Minnesotan should be able to expect regardless of where they live.

In fall 2017, 100% of local health departments in Minnesota (n=74) participated in a self-assessment of their ability to carry out these activities. The results of this point-in-time assessment are summarized in this report.

This assessment shows that, statewide, local public health does not meet minimum expectations:

- The majority of Minnesota's local public health departments reported they could not carry out several foundational activities. The largest gaps between expectation and ability related to data, collaboration, workforce, and social factors that create health.
- No single foundational activity was carried out by 100% of departments.
- Most departments reported they could only fully carry out about half of the activities.
- A handful of departments reported they could fully carry out most activities, but they shared their strong performance was tenuous and came at high cost (e.g., working extra hours and not attending to other priorities).
- The lowest-ability health departments rated consistently low across all activities, generally resided in Greater Minnesota, and were more likely to be organized within a hospital setting or a human services agency. The lowest-ability departments disproportionately serve small communities, and collectively serve 19 percent of the state's population.

Local health departments most commonly cited inadequate funding and staffing as barriers to higher performance, and staff expertise and board/leadership support as assets. Many departments work creatively to maximize resources and meet expectations (e.g., through cross-jurisdictional sharing, partnerships, re-structuring, or by relying on the Minnesota Department of Health).

Taken together, these findings paint a precarious picture of local public health in Minnesota. Communities served by departments that are unable to carry out foundational activities may be more vulnerable in the event of outbreaks, emergencies, and other emerging public health issues (for example, the opioid crisis). Moreover, if local public health departments in Minnesota cannot cover the basics, it is doubtful they can modernize into a forward-looking, high-performing system.

Background

In Summer 2017, the Minnesota Department of Health (MDH) released the Required Local Public Health Activities¹ to clarify statutory obligations under the Local Public Health Act (Minn. Stat. § 145A). These activities lay out the minimum expectations for local public health that must be carried out regardless of grant funds.²

The Required Local Public Health Activities updated the 2005 Essential Local Public Health Activities (ELA) Framework³ adopted by the State Community Health Services Advisory Committee (SCHSAC) and MDH. The ELA Framework identified the essential activities that are the responsibility of every community health board in Minnesota, and defined a set of public health activities Minnesotans can count no matter where they live.

In the fall of 2017, public health leaders from all Minnesota local health departments (n=74) completed a self-assessment, in which they reported on the extent to which each foundational activity was carried out in their jurisdiction during the previous 12 months. Respondents categorized activities on a scale from not carried out at all, at a low level, at a moderate level, at a fully level, to at a level believed to surpass minimum expectations. If a department reported it did not carry out the activity, it specified whether another organization carried it out, or that no one else did.

Few Local Health Departments Meet Minimum Expectations

Very few local health departments fully carry out all of the foundational activities, and departments vary widely in their self-reported ability to carry out activities (see **Figure 1**). Some respondents noted they *could* fully carry out activities, but only at a high cost:

“[My southern Minnesota health department] is a lean agency. As director, I am charged with completing the infrastructure requirements...to fit them into my regular full-time responsibilities. I have had to let projects go dormant.”

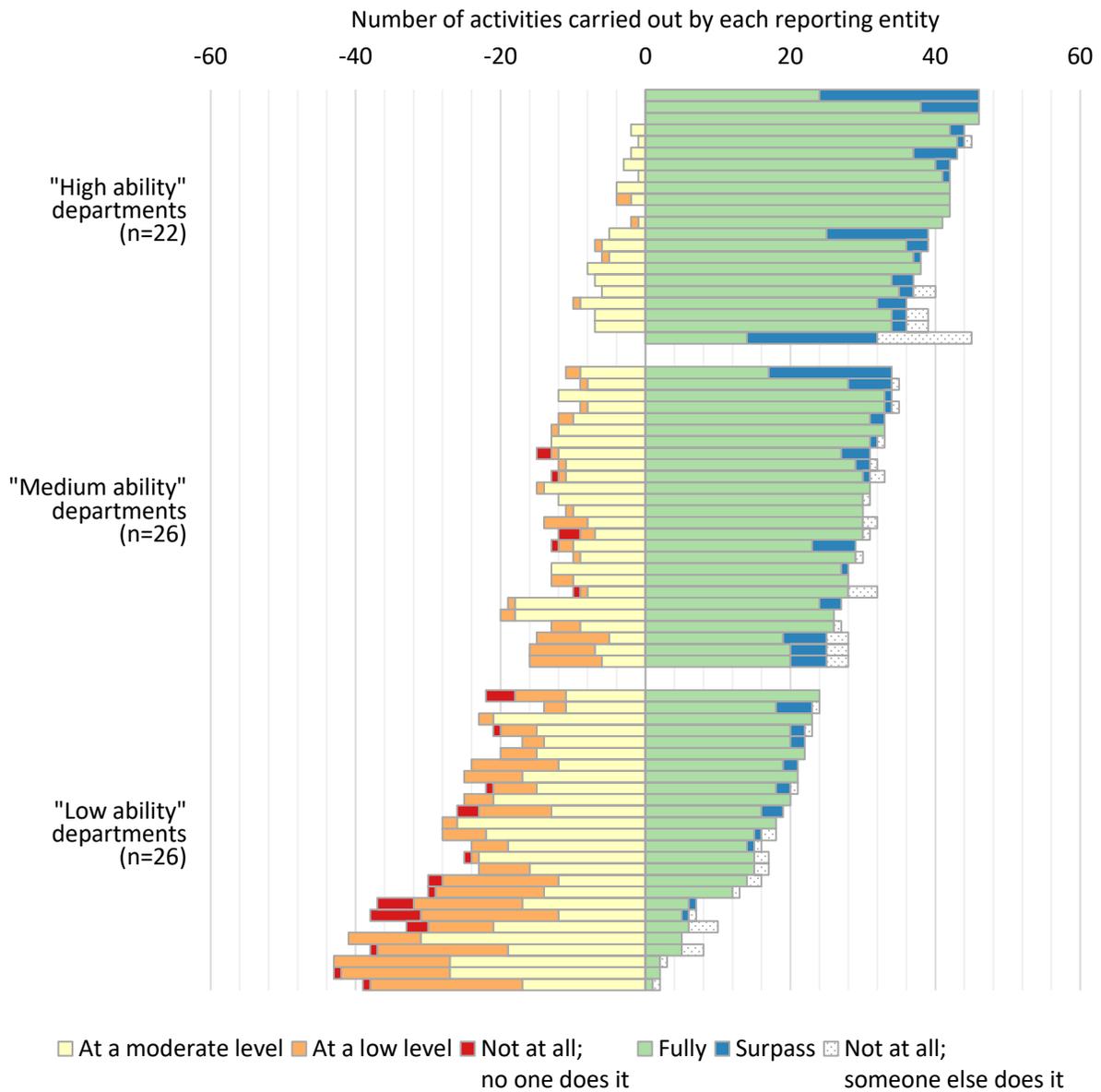
Sometimes local public health directors run departments that are so “lean”—that is, the departments have so few staff— that the director must provide direct services themselves (e.g., family home visiting, WIC clinics). Filling programmatic gaps normally met by staff limits the time and attention directors can devote to department administration and providing public health leadership in the community. In addition, directors in some small health departments reported frequently working evenings and weekends in order to ensure foundational activities were occurring:

“We have met the required expectations for all three of these activities with quite a bit of struggle and certainly not at the level that MDH wants to see based on the comments we received back. We do not have the ability to hire a planner or access to a statistician or [epidemiologist]. The director has to complete the final products—this requires many hours of overtime and time on holidays to get it completed.”

While reprioritization is a normal and expected part of work, no matter the sector, stories shared by local health directors paint a more concerning picture. In a recent report to the legislature, directors from small medium and large health departments shared those concerns that keep them up at night, so to speak, including: “the lack of capacity to: control and prevent infectious outbreaks (including tuberculosis); respond to emergencies or disasters; and support community needs around the opioid epidemic.”⁴

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Figure 1. Required local public health activities in Minnesota, as carried out by 74 local health departments



Each bar in Figure 1 represents one of Minnesota’s seventy-four local health departments. The bars are shaded to show the ability of each local health department to carry out required activities. Departments are ranked based on the number of activities carried out at a level that meets or exceeds minimum expectations (i.e., “fully” or “surpass”). So the twenty-two health departments able to fully carry out the most activities, are grouped together at the top of the graph, followed by those with “medium” ability in the middle, and “low” ability toward the bottom.

Some required activities are only carried out as circumstances warrant. MDH encouraged reporting entities to select “not applicable” when local conditions did not call for carrying out a particular activity (e.g., issuing emergency orders).

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In order to try to meet minimum expectations, some maximize resources through cross-jurisdictional sharing, partnerships, re-structuring, or relying on others. In other cases, local public health departments simply do not fully carry out many required activities.

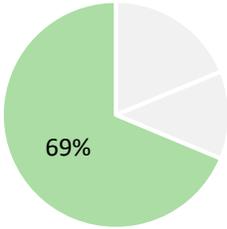
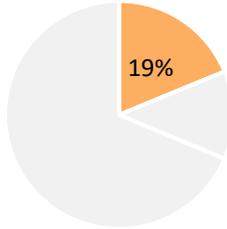
“Restructuring has allowed our [community health services] administrator to back off supervisory duties to focus on community-level/CHS work.”

“If we were not working collaboratively as a [community health board], we would not be able to meet the requirements.”

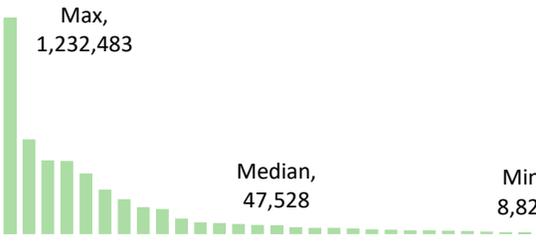
“We are working toward [cross jurisdictional sharing] initiatives. That support, although not formal, is what keeps staff motivated.”

Low-Ability Health Departments Share Features

Compelling patterns emerge when contrasting departments carrying out the greatest and fewest number of activities. The lowest ability health departments (those which carry out the fewest foundational activities) tended to rate themselves consistently low across all areas of responsibility, are typically located in Greater Minnesota, and are more likely to be organized within a human services or hospital-based structure.⁵

“High-ability” local health departments (n=28)	“Low-ability” local health departments (n=26)
High-ability reporting entities can meet or surpass at least 78% of measures	Low-ability reporting entities can meet or surpass less than 50% of measures
When looking within each area of responsibility, high-ability entities move around fluidly among the top 10 in each area, save for Assure Health Services	When looking within each area of responsibility, low-ability entities are consistently among the lowest in each area
36% of high-ability entities sit in the Twin Cities Metro Area ; others are distributed across regions	96% of low-ability entities sit in Greater Minnesota , distributed across regions
High-ability entities cumulatively serve 69% of the state’s population (3,792,901 residents)	Low-ability entities cumulatively serve 19% of the state’s population (1,036,608 residents)
 <p>A pie chart with a large green slice representing 69% and a smaller light grey slice representing 31%.</p>	 <p>A pie chart with a small orange slice representing 19% and a larger light grey slice representing 81%.</p>

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“High-ability” local health departments (n=28)	“Low-ability” local health departments (n=26)																		
<p>Aside from metro counties, high-ability entities serve a variety of population sizes</p> 	<p>Low-ability entities serve mostly smaller counties but include some large population centers</p> 																		
<p>18 high-ability entities are standalone public health departments; 10 are health and human services departments</p> <table border="0"> <tr> <td>Standalone public health</td> <td><div style="width: 64%; background-color: #4CAF50; height: 10px;"></div></td> <td>64%</td> </tr> <tr> <td>Health and human svcs.</td> <td><div style="width: 36%; background-color: #4CAF50; height: 10px;"></div></td> <td>36%</td> </tr> <tr> <td>Hospital-based</td> <td><div style="width: 0%; background-color: #4CAF50; height: 10px;"></div></td> <td>0%</td> </tr> </table>	Standalone public health	<div style="width: 64%; background-color: #4CAF50; height: 10px;"></div>	64%	Health and human svcs.	<div style="width: 36%; background-color: #4CAF50; height: 10px;"></div>	36%	Hospital-based	<div style="width: 0%; background-color: #4CAF50; height: 10px;"></div>	0%	<p>Six low-ability entities are standalone public health departments; 18 are health and human services departments; and two are hospital-based</p> <table border="0"> <tr> <td>Standalone public health</td> <td><div style="width: 23%; background-color: #FF9800; height: 10px;"></div></td> <td>23%</td> </tr> <tr> <td>Health and human svcs.</td> <td><div style="width: 58%; background-color: #FF9800; height: 10px;"></div></td> <td>58%</td> </tr> <tr> <td>Hospital-based</td> <td><div style="width: 8%; background-color: #FF9800; height: 10px;"></div></td> <td>8%</td> </tr> </table>	Standalone public health	<div style="width: 23%; background-color: #FF9800; height: 10px;"></div>	23%	Health and human svcs.	<div style="width: 58%; background-color: #FF9800; height: 10px;"></div>	58%	Hospital-based	<div style="width: 8%; background-color: #FF9800; height: 10px;"></div>	8%
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Limited Ability Spans All Areas of Responsibility

In each of the areas of responsibility on the following pages, local health departments report a wide inability to meet expectations.

Most (46) of the 58 foundational activities serve as minimum expectations *at all times*, and 12 serve as expectations *only when circumstances warrant* (e.g., responding and supporting recovery efforts, enforcing emergency health orders, conducting tuberculosis contact investigations). None of the 46 activities expected of all departments every year were fully implemented by all local health departments.

Fewer than half of departments reported fully carrying out activities related, broadly, to:

- Reviewing, using, and sharing data;
- Collaborating with stakeholders to implement and evaluate joint strategies and plans;
- Developing and maintaining a skilled public health workforce; and
- Promoting social conditions that support healthy communities.

Local public health directors largely cite the same barriers and assets that hinder and support their work, respectively. Local public health departments most commonly note as barriers inadequate funding (across all areas of responsibility), difficulty hiring staff (Assure an Adequate Local Public Health Infrastructure), staff lacking the right knowledge and skills (Promote Healthy Communities and Healthy Behavior), and that public health action depends on the work of others (all other areas). Local public health departments most frequently cite as assets (across all areas) staff expertise, board support, and leadership support.⁶

Assure an Adequate Local Public Health Infrastructure

Context: Local public health assures an adequate local public health infrastructure by maintaining the basic foundational capacities to a well-functioning public health system, which includes data analysis and utilization; health planning; partnership development and community mobilization; policy development, analysis, and decision support; communication; and public health research, evaluation, and quality improvement. These activities are the basic business operations required of a functioning local public health department, and set expectations regarding governance, leadership, workforce, performance management, assessing the health of the community, and making plans to address community health priorities.

In 2017: Overall, most local health departments reported they fully carry out (or surpass) these activities. Three notable exceptions include requirements to (1) use performance management to monitor achievements and apply quality improvement; (2) implement, monitor, and revise the community health improvement plan; and (3) develop and maintain a skilled workforce.

Departments especially noted pressures and barriers to workforce in this area, lacking staff, time, and expertise needed to carry out these expectations, despite considerable effort to recruit and retain:

“I am advertising our positions 2-3 times before we get anyone to even interview and the last 2 hires have been RN’s [rather than PHNs] and the orientation process has been difficult for them. The last 3 positions have left for more money and better benefits.”

Even the director of a high-ability health department in Greater Minnesota described infrastructure as unstable:

“While we currently are able to fully meet all these items, recent staffing situations make this ability tenuous. Additionally, our funding is adequate currently, but not ample. Any decrease in funding due to change in board or legislative support will result in our inability to fully meet measures.”

Without skilled staff, many department leaders report carrying out foundational infrastructure activities almost entirely on their own, often during nights and weekends.

Promote Healthy Communities and Healthy Behavior

Context: Local public health promotes healthy communities and healthy behavior through activities that improve health in a population, such as investing in healthy families; engaging communities to change policies, systems, or environments to promote positive health or prevent adverse health; providing information and education about healthy communities or population health status; and addressing issues of health equity, health disparities, and the social determinants to health. Collectively, these activities relate to knowing, using, and sharing data and information on best practices; acting on community needs and priorities; implementing population-based health promotion strategies; addressing health inequities; and contributing to local health policy discussions.

In 2017: Even for those activities in which many local public health departments excelled, a substantial number struggled. For the two activities where the system performed best (knowing emerging issues and data trends, and contributing to local discussions on policy and health), one-third of health departments were still unable to fully carry out those requirements. Fewer than half (40 percent) met minimum expectations to implement strategies based on community needs and priorities.

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Health departments that excelled at one or more activities in this area noted common assets, including staff expertise, leadership support, having a local champion, and making this area an organizational priority. Many stated the importance of dedicated SHIP funding and cross-jurisdictional sharing mechanisms:

“Each year we are able to fully meet these requirements because of SHIP. Without SHIP funding, we would not have staffing...Even with SHIP, the scope of work is limited – and we are unable to impact some areas of concern (i.e., alcohol and other drugs).”

Some departments are able to leverage their community health assessment efforts to engage the broader community, in order to mobilize *local* resources toward *local* priorities:

“We published a health status report for the county. Through this, we identified which areas of the county experienced the greatest health inequities. Community partners also used this report in prioritizing their work. Collaborations have been strengthened with community-wide priorities...the report has driven much of our work in community-based initiatives and partnerships.”

Protect Against Environmental Health Hazards

Context: Local public health protects against environmental health hazards by addressing aspects of the environment that pose risks to human health, such as monitoring air and water quality; developing policies and programs to reduce exposure to environmental health risks and promote healthy environments; and identifying and mitigating environmental risks such as food and waterborne diseases, radiation, occupational health hazards, and public health nuisances. These activities call for understanding environmental threats to human health and working to address them, including monitoring and documenting threats; working with partners to identify and implement solutions; and supporting (and at times) implementing or enforcing laws and regulations that seek to protect the health of the public from environmental risks. An explicit, statutory, local public health responsibility exists for the removal and abatement of nuisances.

In 2017: In this area of responsibility, health departments performed best on nuisance-related activities (57 percent fully) and activities to address elevated blood lead levels in children (87 percent fully). Far fewer reported meeting minimum expectations for working with partners and stakeholders (45 percent) or informing policymakers of environmental health threats (36 percent). Many local health departments report relying on MDH and/or other local partners to carry out foundational activities:

“MDH assumes primary responsibility for the majority of these activities. We do not have the funding or staff expertise to complete these activities on our own.”

Respondents also suggest state and local roles related to the foundational activities for environmental health are unclear.

Prepare and Respond to Emergencies

Context: Local public health prepares and responds to emergencies by engaging in activities that prepare public health departments to respond to events and incidents and assist communities in recovery, such as providing leadership for public health preparedness activities with a community; developing, exercising, and periodically reviewing response plans for public health threats; and

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developing and maintaining a system of public health workforce readiness, deployment, and response. Activities in this area include assessing their jurisdiction's risks and vulnerabilities, and then developing and exercising plans to maintain their preparedness and readiness to respond. Local public health has responsibility to respond to incidents affecting the public's health. Departments must maintain the readiness of the workforce and are expected to provide timely, accurate information to elected officials and their community during an emergency. Further, local public health is responsible for enforcing emergency health orders as directed by the Commissioner of Health.

In 2017: Overall, the system seems to perform best in this area of responsibility; more than 80 percent of departments carry out foundational activities to identify local risks and impact, develop and maintain the preparedness workforce, and communicate with partners. Even with higher capacity to carry out activities, departments noted concerns:

"We do well overall with emergency preparedness; however, I would not say that are plans are robust."

"We have support for this in our agency but with the very limited funds it is very difficult to do more than what our grant duties outline, and even these are hard to meet with our limited capacity."

Several departments emphasized the importance of dedicated preparedness funding, staff expertise and tenure, and the value of collaboration:

"Our department has an excellent relationship with our Emergency Manager who is also grounded in public health expertise. Our cross-jurisdictional sharing arrangement allows for duties to be divided between the three staff and coverage across county lines for some of the required preparedness duties."

"We appreciate the great resources from MDH Emergency Preparedness PHPCs, regional meetings and regional sharing. Emergency preparedness grant funding is crucial."

Assure Health Services

Context: Local public health assures health services by engaging in activities such as assessing the availability of health-related services and health care providers in local communities; identifying gaps and barriers in services; convening community partners to improve community health systems; and providing services identified as priorities by the local assessment and planning process. This area speaks to the population-based approach of public health and the responsibility of local health departments to ensure that all community members' health care needs are met. Activities include assessing the availability of healthcare services, informing policymakers of gaps in services, and working with partners to find solutions to those gaps.

In 2017: Like in other areas of responsibility, local public health departments vary in their ability to meet minimum expectations. The majority of local health departments are able to assess availability of health care services in collaboration with others (61 percent) and inform stakeholders of gaps and promising strategies (53 percent). However, fewer than half of departments (46 percent) reported collaborating fully to increase access to health care services.

One department serves as a prime example of meeting and surpassing expectations:

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“We have established relationships with health care providers in various settings and many are fully engaged and align with our priorities. The PH Director in our county is a trustee on our largest hospital/clinic board.”

More often, administrators and directors find the process of collaboration frustrating, given their limited time and lack of authority within those collaborations.

“[Local public health] has been working extremely hard in this area. When [public health] isn't in a leadership role or director level it can be difficult to engage with enough authority with community partners. Much of the work has been behind the scenes, having community partners bring the message to Admin/Board as they tend to respond better to ‘outside experts.’”

Departments state that sometimes health care partners do not want to engage in these conversations about gaps, barriers, and collaborative partnerships.

Prevent the Spread of Communicable Diseases⁷

Context: Local public health prevents the spread of communicable disease by preventing diseases that are caused by infectious agents through detecting acute infectious diseases, ensuring the reporting of infectious diseases, preventing the transmission of infectious diseases, and implementing control measures during infectious disease outbreaks. This area addresses the oldest and most fundamental public health responsibility. In Minnesota, state and local public health partners have agreed to a framework that outlines the shared responsibilities between MDH and local public health. The DP&C Common Activities Framework specifies that: all local public health agencies will provide disease surveillance, prevention and control for tuberculosis (TB) with support from the Minnesota Department of Health as needed; responsibilities for all other infectious diseases follow-up will be determined jointly by local public health and MDH as necessary based on local capacity and other factors; and lists disease prevention and control activities that are conducted jointly by MDH and local public health agencies.

In 2017: Health departments reported working at a moderate or low level—or not at all—in this area of responsibility more than any other. For example, over half (55 percent) reported sharing surveillance data with providers at a moderate or low level, and a similar number (57 percent) provide information to the public at a moderate level or lower.

Overall, a relatively large percent of departments reported that another organization carries out activities for their jurisdiction (most often another local health department or MDH). Departments noted barriers in workforce recruitment and retention, and in sustaining staff with specialized knowledge. Respondents cited staff expertise, MDH support, and cross-jurisdictional sharing as assets:

“Our agency is able to respond to some of the communicable diseases listed, but relies on MDH to follow up on others. Our agency would also depend on mutual-aid agreements and assistance from MDH in the event of a larger scale outbreak of any communicable disease. Our agency also contracts out with another vendor to assist with some immunization clinics. Significant turnover in staff and leadership has caused a disruption in continuity of programs and capability to fully meet all activities.”

Conclusion

Taken together, these findings illustrate the precarious existence of local public health in Minnesota. Communities served by departments that are unable to carry out foundational activities may be more vulnerable in the event of outbreaks, emergencies, and other emerging public health issues (e.g. Opioid crisis). Moreover, if local public health departments in Minnesota cannot cover the basics, their ability to modernize into a forward-looking, high-performing system is doubtful.

Though these findings rely on self-report from local public health directors and administrators, they represent the best current point-in-time understanding of public health system performance in Minnesota. Moreover, they reinforce findings from Local Public Health Act Annual Reporting, and extend recent SCHSAC observations: **The public health infrastructure is crumbling and steps should be taken to reestablish a strong statewide public health infrastructure.**⁸

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¹ See: [Required Local Public Health Activities](#).

² Though the *governance structure* for local public health (the community health board) is uniform across the state, *organizational structures* vary widely. In some cases, public health departments function cohesively across several counties to carry out local public health activities; in other cases, public health departments act more independently to serve individual counties or cities. In addition, local public health can be organized as a “freestanding” public health department, can combined with other local services (for example, in a human services agency), or can be housed within a hospital or health care organization. There are also governance and organizational changes from year to year, making the system dynamic. The 2017 assessment sought to understand the current state of required local public health activities at the most local level, so leaders of all 74 local health departments provided information.

³ See: [Essential Local Public Health Activities Framework \(PDF\)](#).

⁴ See: [Public Health Systems Development in Minnesota: Report to the Legislature \(PDF\)](#).

⁵ Governance and organizational structures are not static, and MDH categorizes local public health departments based on current of local structures.

⁶ For each area of responsibility, respondents who said that they fully carry out one more activities, and/or carry out activities at a level that surpasses minimum expectations, were then asked to identify the assets that enable this high performance. Respondents who reported that they do not fully carry out one or more activities in each area, were asked to identify the barriers that get in the way of meeting the requirement(s). This means that some reported only barriers, some only assets, and some both.

⁷ The activities in this area of responsibility are based on the [Disease Prevention & Control Framework \(rev. July 2015\)](#). That framework is currently being reviewed and revised, therefore some of the activities above may change moving forward.

⁸ For more information, see: [Final Report from the SCHSAC Technical Assistance Ad Hoc Group, March 2017 \(PDF\)](#).