SCHSAC IDCIB
Infectious Disease Continuous Improvement Board

April 2, 2018: Meeting Summary
Monday, April 2, 2018
10:00am – 2:30 pm
MDH Freeman Building
625 Robert St. North, St. Paul

Members Present and Absent

- Members present:
  - Jamie Hennen (Partnership4Health) - West Central Region
  - Amy Westbrook (Carlton-Cook-Lake-St. Louis) - Northeast Region
  - Mary Zelenak (Stearns) - Central Region
  - Dave Johnson (Hennepin) - Metro Region
  - Mary Hildebrandt (Brown-Nicollet) - Southwest/South Central
  - Allie Elbert (Meeker-McLeod-Sibley) - South Central Region
  - Deb Purfeerst (Rice) - Southeast Region
  - Cindy Borgen (Beltrami) - Northwest Region
  - Kris Ehresmann, MDH Infectious Disease Epidemiology, Prevention and Control
  - Ellen Hill, MDH Infectious Disease Epidemiology, Prevention and Control

- Members absent:
  - None.

Other Meeting Participants

Kristin Sweet, Julie Hanson, Patti Segal Freeman, Raj Moody, Malini DeSilva, Margaret Roddy, Krissie Guerard, Julie Janson Perez, Kathy Como-Sabetti, Jacy Walters, Rich Danilla, Kirk Smith, Denise Dunn, Marcie Babcock, Ashely Fell, and Stefani Kloiber, MDH, Infectious Disease Epidemiology, Prevention and Control; Becky Buhler, MDH, Center for Public Health Practice

Facilitators

Ellen Hill, MDH, Northeast Region District Epidemiologist; and Chelsie Huntley, MDH, Center for Public Health Practice (PHP)
Welcome and Introductions
The Infectious Disease Continuous Improvement Board’s (IDCIB) co-chair, Kris Ehresmann, MDH, welcomed everyone to the January meeting.

Ms. Ehresmann reviewed the meeting agenda and objectives. Members of IDEPC Division joined the meeting to introduce themselves to IDCIB members.

Meeting Objectives:

1. Share regional feedback to revise Charter
2. Increase understanding of the current state of infectious disease activity in Minnesota
3. Develop goals for the SCHSAC Disease Prevention and Control Common Activities Framework revision

Ms. Ehresmann continued by asking meeting participants to introduce themselves. She acknowledged both EHCIB members and other meeting participants and invited everyone to fully participate in the meeting.

IDCIB Leadership
Amy Westbrook (Carlton-Cook-Lake-St. Louis) was appointed to serve as co-chair with Kris Ehresmann. Ms. Westbrook agree to serve as extended term through December, 2019. Future co-chairs will have one-year terms. Staggered terms (2 or 3 years) were assigned to all members. Members shared regional feedback and drafted objectives and guiding principles for the Board. Revisions will be presented at the August meeting.

Increase Understanding of the Current State of Infectious Disease Activity
IDCIB members reviewed data from the survey on Required Local Activities conducted last summer. The survey asked local health departments the extent they provided the activities in the SCHSAC Disease Prevention and Control Common Activities Framework. Observations included that MDH Regional Epidemiologists provide the majority of disease, prevention and control work for CHBs without an epidemiologist on staff; it’s difficult for LPH to maintain capacity without regular training, especially when only a handful of a specific type of case occurs in the jurisdiction; and barriers and assets to meeting minimum expectations were identified.

Key Survey Findings related to Local Public Health Capacity
- Health departments reported working at a moderate or low level—or not at all—in this area of responsibility more than any other
- A relatively large percent of departments reported that another organization carries out activities for their jurisdiction (most often another local health department or MDH)
MDH staff, listed below, shared information about their infectious disease activities and addressed questions about program strengths, needs and partnerships. Presentations were shared with IDCIB members via email.

- Rich Danilla, Emerging Infections Unit (EIP)
- Kirk Smith, Foodborne, Waterborne, Vectorborne and Zoonotic Diseases (FWVZD)
- Denise Dunn, Vaccine Preventable Disease (VPD)
- Marcie Babcock, Sexually Transmitted Diseases, HIV and Tuberculosis (STD/HIV/TB)
- Kristin Sweet, Cross-Cutting Epidemiology Programs and Partnerships (CCEPP) – includes MDH Regional Epidemiologists
- Ashley Fell, Healthcare-Associated Infections and Antimicrobial Resistance (HAI/AR)
- Stefani Kloiber, Communications

**Observations about State and Local Infectious Disease Activities**

The Board made the following observations based on the presentations on local and state activities.

- Information reinforces the need for a good partnerships with clear expectations
  - Shared information validates the level of expertise at MDH; LPH staff are experts on their communities and people
- Funding is an issue for local and state public health
  - When funded by grants, staff must fulfill grant duties in addition to other work. How do MDH grant duties affect MDH’s work with LPH?
- Heavy reliance on MDH Regional Epidemiologists by LPH
  - Locals are unsure who to contact at MDH; District Epis are first line of support for LPH; LPH trusts that Regional Epi talks to MDH experts
- Perception that only big numbers get MDH’s attention; a small number can be a big concern to LPH
  - A lot of rural counties feel that MDH is very metro centric because the big cases are in the Metro
  - If not used to handling a particular infectious disease situation, LPH may need immediate assistance from MDH even for one or two cases
  - MDH prioritizes infectious disease activities based on the severity of the disease, not just on the number of cases; this is an opportunity for MDH to improve communication with LPH
- Without strong local infrastructure, state expertise cannot get to communities
  - Technical assistance (TA) can’t solve all the problems; How can we maximize state technical capacity with practically no technical capacity at local level; locals need a local expert to access MDH expertise and best utilize it for their community
- MDH staff wants to understand LPH needs
  - MDH Infectious Disease staff must share and collaborate across internal and external partnerships; need to identify local leaders and engage with communities; MDH wants to support LPH
SCHSAC Disease Prevention and Control Common Activities Framework

Board members shared regional feedback gathered about the SCHSAC Disease Prevention and Control Common Activities Framework and discussed how to approach the Framework.

Key points include

- What lens to use for update?
  - Board can review the Framework using different lens; such as PHAB standards, advancing health equity, local capacity for infectious disease activity, maximizing capacity and capability through the state-local partnership, supporting collaboration
  - Framework doesn’t reflect the growth in Infectious Disease activities since its origination
  - How does IDCIB manage expectations for revision?

- Use of framework
  - Framework is used in a variety of ways such as for orientation, position description for DP&C Coordinator, improving public health practice, and PHAB documentation
  - The Framework is often not used frequently by LPH
  - MDH needs accountability for using the Framework; not active framework at MDH

- Should Framework be the minimum expected?
  - Originally, the Framework was the minimum set of responsibilities; is this still the best approach?
  - Consider tiered approach based on local capacity;
  - Expectations for response differ from expectations for prevention efforts

- Clarify expectations in the Framework
  - Consider Framework functioning as Infectious Disease Work Plan to direct resources and activities
  - Focus Framework on roles for MDH and LPH; consider assigning specific staff to specific responsibilities; don’t include suggested roles for providers
  - Feedback that the format and layout of the Framework is helpful; separation of roles by agency
  - Framework needs more up-to-date details; need commitment to keep it updated with new terms, systems, who should be reporting, etc.
  - LPH needs to know the details, so they can count the costs
  - What training is needed
  - Need to improve communication between LPH and MDH, when MDH provides services and LPH responsible for assuring them (ex. PHAB)

- Decision process
Who decides who does what? What is the decision process for whether an activity should be done by LPH or by MDH?

How to decide when to centralize functions or decentralize them?

Next Meeting

- Next meeting will be Friday, August 17, 2018

Three Simple Rules of the State-Local Public Health Partnership

1. Seek First to Understand
2. Make Expectations Explicit
3. Think About the Part and the Whole