INTRODUCTION

The Center for Sharing Public Health Services visited the Shared Services Learning Community site of Minnesota System Wide on September 30–October 1, 2014.This *Site Visit Report* documents the activities from the site visit as well as some of the Center's observations.

The report includes a lengthy *Background* section for those not familiar with the partnership. For those familiar with the partnership, go directly to the *Observations* section, which starts on page 5.

BACKGROUND

About the Center

The Center for Sharing Public Health Services helps communities learn how to work across jurisdictional boundaries to deliver essential public health services. The Center serves as a national resource on cross-jurisdictional sharing (CJS), building the evidence and producing and disseminating tools, methods and models to assist public health agencies and policymakers as they consider and adopt CJS approaches.

Building Evidence: One way the Center builds evidence is by working closely with a Shared Services Learning Community (SSLC), made up of demonstration projects in several states that encompass a diverse spectrum of CJS initiatives, from small-scale initiatives to full consolidation of health departments. The Center provides technical assistance and a forum that allows these communities to share lessons learned with each other and the Center. In return, the SSLC acts as a learning laboratory by providing real world experiences that the Center collects and analyzes and shares with the nation.

Producing and disseminating tools, methods and models: The experiences of the SSLC, along with other research and expert opinions, provide the knowledge and insight the Center needs to provide tools and assistance to any community or group of communities considering CJS arrangements.

The Center for Sharing Public Health Services is a national initiative managed by the Kansas Health Institute with support from the Robert Wood Johnson Foundation (RWJF).

About the CJS Project

Debra Burns, Director of the Office of Performance Improvement at the Minnesota Department of Health (MDH), is leading this effort, with assistance from Allison Thrash and Phyllis Brashler.

The Minnesota System Wide Initiative is a learning collaborative made up of 11 demonstration sites. Leaders from those sites meet quarterly to learn from each other and to support each other in CJS activities. The collaborative also is developing tools to promote and support future CJS activities in Minnesota.

There are two levels of participation in the collaborative:

- Level 1 (L1) – Four level 1 sites are actively involved in the 'prepare and plan' or 'implement and improve' phases of CJS in their jurisdictions.
- Level 2 (L2) – Seven level 2 sites are in an earlier or more exploratory phase of CJS.

The table that follows lists the jurisdictions involved, the size of their 2013 population and the percent of people living below federal poverty level in each jurisdiction. The last column lists all the jurisdictions involved in the specific demonstration project.

Table 1. **Jurisdictions in the Minnesota System Wide Initiative**

Jurisdiction Name	2013Population	2013 FPL	Project Name (Level)
Becker County	33,231	11.8%	Partnership4Health (L1)
Clay County	60,661	12.5%	Partnership4Health (L1)
City of Bloomington	86,319	9.3%	Bloomington, Edina, and Richfield (L1)
City of Edina	49,376	3.8%	Bloomington, Edina, and Richfield (L1)
City of Richfield	36,175	13.9%	Bloomington, Edina, and Richfield (L1)
Beltrami County	45,670	20.7%	North Country CHB (L2)
Brown County	25,332	9.0%	Brown-Nicollet CHB (L2)
Carlton County	35,460	11.9%	Carlton-Cook-Lake-St. Louis CHB (L2)
Clearwater County	8,838	15.1%	North Country CHB (L2)
Cook County	5,200	9.8%	Carlton-Cook-Lake-St. Louis CHB (L2)
Fillmore County	20,835	12.9%	Fillmore-Houston CHB (L2)
Hennepin County	1,198,778	12.6%	Hennepin CHB and Minneapolis CHB (L2)
Houston County	18,799	9.8%	Fillmore-Houston CHB (L2)
Hubbard County	20,658	12.1%	North Country CHB (L2)
Isanti County	38,204	8.1%	Isanti-Mille Lacs CHB (L2)
Kandiyohi County	42,410	12.9%	Kandiyohi-Renville CHB (L1)
Lake County	10,777	13.1%	Carlton-Cook-Lake-St. Louis CHB (L2)
Lake of the Woods County	3,929	17.7%	North Country CHB (L2)
Mahnomen County	5,532	27.2%	Polk-Norman-Mahnomen CHB (L1)
Mille Lacs County	25,833	14.0%	Isanti-Mille Lacs CHB (L2)
Nicollet County	33,032	11.0%	Brown-Nicollet CHB (L2)
Norman County	6,631	11.3%	Polk-Norman-Mahnomen CHB (L1)
Olmsted County	149,226	8.5%	Olmsted CHB (L2)
Otter Trail County	57,581	12.2%	Partnership4Health (L1)
Polk County	31,569	12.2%	Polk-Norman-Mahnomen CHB (L1)
Renville County	15,166	11.1%	Kandiyohi-Renville CHB (L1)
St. Louis County	200,540	16.1%	Carlton-Cook-Lake-St. Louis CHB (L2)
Wilkin County	6,557	7.0%	Partnership4Health (L1)
City of Minneapolis	400,070	22.5%	Hennepin CHB and Minneapolis CHB (L2)

SITE VISIT

Participants

The following members of the host team participated in the site visit:

- Debra Burns, Director of the Office of Performance Improvement at MDH
- LuAnne McNichols, Assistant Director of the Office of Performance Improvement at MDH
- Allison Thrash, Supervisor in the Office of Performance Improvement at MDH
- Phyllis Brashler, Community Health Planner and SSLC Project Manager at the Office of Performance Improvement at MDH
- Julia Ashley, Public Health Nurse Consultant at the Office of Performance Improvement at MDH
- Linda Bauck-Todd, Public Health Nurse Consultant at the Office of Performance Improvement at MDH
- Beth Gyllstrom, Senior Research Scientist at the Office of Performance Improvement at MDH
- Wendy Kvale, Public Health Nurse Consultant for the Office of Performance Improvement at MDH
- Brenda Menier, Public Health Nurse Consultant at the Office of Performance Improvement at MDH
- Becky Sechrist, Community Health Planner at the Office of Performance Improvement at MDH
- Janelle Schroeder, Public Health Nurse Consultant at the Office of Performance Improvement at MDH

The following local elected officials participated:

- Karen Ahmann, Commissioner of Mahnomen County
- Jon Evert, Commissioner of Clay County
- Sheila Kiscaden, Commissioner of Olmsted County
- Harlan Madsen, Commissioner of Kandiyohi County
- Joe Vene, Commissioner of Beltrami County

The following local public health partners participated:

- Sharon Braaten, Horizon CHB Administrator and Pope County Public Health Director
- Lisa Brodsky, Assistant Public Health Administrator at Bloomington CHB
- Jeff Brown, CHS Administrator at Edina CHB
- Jill Bruns, CHS Administrator/PHN Director at Renville County
- Bonnie Engen, CHS Administrator at North Country CHB
- Toni Hauser, Emergency Preparedness Specialist at Minneapolis CHB
- Margene Gunderson, Associate Director at Olmsted CHB
- Jamie Hennen, PHN Director at Norman and Mahnomen Public Health and Co-CHS Administrator at Polk-Norman-Mahnomen CHB
- Mary Hildebrandt, PHN Director at Brown-Nicollet CHB
- Denise Kragenbring, Supervisor at Kandiyohi-Renville CHB

- Karen Moritz, PHN Director at Brown County Public Health and CHS Administrator at Brown-Nicollet CHB
- Betsy Osborn, CHS Administrator at Richfield CHB
- Bonnie Paulsen, CHS Administrator at Bloomington CHB
- Diane Thorson, Public Health Director/CHS Administrator at Partnership4Health CHB
- Sandy Tubbs, Douglas County Public Health Director at Horizon CHB (Team lead for the Horizon SSLC demonstration site in MN)
- Courtney Wetternach, Principal Planner at Hennepin CHB

One representative from the Robert Wood Johnson Foundation participated in the site visit:

- Andrea Ducas, Program Officer at the Robert Wood Johnson Foundation

Visitors from one other Shared Services Learning Community Sites attended the site visit:

- San Luis Valley (CO) Team
    - Kathleen Matthews, Director of Planning and Partnerships at the Colorado Department of Public Health and Environment

Four representatives from the Center for Sharing Public Health Services participated in the site visit:

- Pat Libbey, Co-Director at the Center for Sharing Public Health Services
- Gianfranco Pezzino, Co-Director at the Center for Sharing Public Health Services
- Katie Sellers, Chief Program Officer of Science and Strategy at the Association of State and Territorial Health Officials and member of the Center's Technical Advisors Team
- Jessica Solomon-Fisher, Senior Advisor and Chief of Public Health Programs at the National Association of County and City Health Officials and member of the Center's Technical Advisors Team

Site Visit Activities

Site visitors met at MDH with the host team first being briefed on how local governmental public health is organized and operates in MN and then how the MN demonstration site itself is structured. The visitors then interacted with the host team as they share their perspectives on working within a statewide Learning Collaborative model. Later, the site visitors and host team met with members of the learning collaborative to discuss their perspectives on both the CJS work in which they have been engaged and their experience of working within a statewide learning collaborative. The following morning a full meeting of the collaborative including level one and two sites was held with site visitors observing and interacting with collaborative members. This was followed with a presentation by the Center co-directors describing the Center, the SSLC and what the Center is learning about CJS. Next there was a facilitated discussion with a panel of policy makers from several of the participating jurisdictions and then a facilitated open meeting discussion with public health leaders from the participating jurisdictions. The visit ended with a general wrap up identifying key take aways for participants and overall themes that emerged during the site visit.

OBSERVATIONS

Site visits provide a valuable learning opportunity, both for the Center staff and for the participants. There is only so much information the Center can gather from reports or phone calls. Meeting with people in their actual environment completes the picture and contributes to a better understanding of the project.

Some observations gleaned by the Center as a result of participating in the site visit follow.

The state has a unique public health system that naturally supports CJS.

Minnesota's Local Public Health Act was passed in 1976 designating Community Health Boards (CHBs) as the legally recognized governing body for local public health in Minnesota. It is the only governmental entity eligible for funds provided through the Local Public Health Act grant. Minnesota's statute requires that CHBs have at least a population of 30,000 or are made up of at least three contiguous counties. While this appears to (and in a number of instances actually does) contribute to a broader sense of regions (e.g., northwest, northeast, west central, central, southwest, south central, southeast, and metro), public health across jurisdictions it is not an inherent outcome of the structure. Several local jurisdiction (usually county) health departments can exist within a multi-county CHB. There is a range of CJS and collaboration within CHBs with multiple local health departments. In some there is considerable joint work across the departments while in others the CHB serves primarily to allocate funding with little attention to shared services. That said, even this level of shared oversight and governance does foster a shared relationship as well as a platform to support exploration of CJS arrangements.

The state sets policies, incentives and expectations for CHBs to provide public health services in an effective and efficient way. CHBs then implement local public health activities and assure regular assessment, prioritization and action on community health needs.

Under this unique and long-standing system, Minnesota has developed a strong partnership between the state health agency and local health departments.

Policymakers understand and support public health.

The State Community Health Services Advisory Committee (SCHSAC) plays a key role in the state/local partnership in Minnesota. The committee is made up of representatives from each CHB, including both public health administrators and local elected officials. The purpose of SCHSAC, as described in the Local Public Health Act, is to advise, consult with, and make recommendations to the Commissioner of Health on matters relating to the development, funding, and evaluation of community health services in Minnesota.

Over time, many county commissioners have served on the SCHSAC or its committees. As new issues emerge related to public health programs or administration that need clarity or development, workgroups are convened to study the issue and develop recommendations to be approved by the full committee and presented to the Commissioner of Health.

MDH also works closely with the Association of Minnesota Counties (AMC). AMC is a member/advocacy organization of county commissioners, many of whom have also served on SCHSAC. This paid membership organization works on a wide range of concerns related to county government.

Because of their involvement with the SCHSAC, policymakers throughout Minnesota are better and/or more uniformly informed about public health than are many of their national counterparts.

CJS work is not new in Minnesota.

Many of the sites in this learning collaborative — especially the Level 1 sites — have worked on CJS arrangements in the past, even *before* they received support from the RWJF grant to MDH.

Sharing activities in the past have been done in fragmented and reactive ways. The RWJF grant allowed Level 1 sites to pause and pursue sharing arrangements in a more deliberate way.

The approach this demonstration site took in distinguishing Level 1 and Level 2 participating partners proved helpful. It allowed the less-experienced Level 2 sites to explore sharing without making a commitment to share.

Karen Ahmann, a Commissioner from Mahnomen County, said this about CJS initiatives in Minnesota: *"Collaborating is nothing new for rural America...but CJS has really defined it in a different way, and made the process more deliberate...rather than us floundering to put through joint powers agreements, etc. in an ad hoc process, we look at opportunities deliberately, through a different lens, with an eye toward what the future might bring."*

In addition to federal grants and pass through funding the CHBs and local health departments are also supported with state general funds.

The state of Minnesota has a state general fund block grant of $20 million dollars a year for CHBs. That is a relatively large amount of general fund support when compared to other states with similar populations. The money is a guaranteed base for public health functions. Even in financial hardships, that base does not change.

The MDH has provided additional resources for the sites in this collaborative beyond the RWJF funding.

All of the grant money that this demonstration site received by participating in the Center 's SSLC was passed on to the Level 1 sites. That money was then augmented by funds from other sources to support Level 2 sites as well as staff time to coordinate the state level collaborative, provide support to local sites, and conduct an evaluation.

The Center's Roadmap and tools developed by the host team helped these sites to be proactive.

Members of the learning collaborative discussed the importance of tools and resources — in particular the Center's *Roadmap to Cross-Jurisdictional Sharing Initiatives* and MDH's *Blueprint for Public Health*.

The *Roadmap* is a guide to help jurisdictions explore and establish CJS arrangements. The *Blueprint* is a general vision for public health in Minnesota. Together, the two documents provide structured guidance and a more thorough and proactive way to look at collaboration.

CJS takes time and trust.

CJS work takes time. Even with the level of coordination that MDH provides, it still takes time to do it well. CJS work also requires trust between the jurisdictions and people involved. Minnesota's long history of engagement, treating partners as equals and with respect has helped build a strong climate of trust overall.

Small sharing initiatives can pave the way for larger ones.

Some of the Level 2 sites stated they wanted to start with sharing initiatives that were either small or non-threatening. From there they plan to graduate to bigger initiatives. Community Health Assessments (CHA) and Community Health Improvement Plans (CHIPS) provided an opportunity in some areas to experience success with CJS. Because these activities are relatively new they proved to be nonthreatening, as they did not appear to challenge the status quo organizationally. The state saw the possibility of moving shared service arrangements more systematically into different areas with mention of emergency preparedness specifically.

Collaboration extends beyond public health.

Policymakers from various jurisdictions participating in the site visit tended to view the Center's and the state's tools as valuable in most CJS arrangements, not just those involving public health services.

During a discussion, it was mentioned that arrangements dealing with specific types of collaboration among jurisdictions can be threatening because there is often concern that jurisdictions may relinquish authority or lose track of accountability for those services. But it can be less threatening to talk about collaboration in general. Therefore, when talking with governing boards, it may be helpful to focus on an agreement that allows jurisdictions to collaborate where it makes sense, instead of specifying discrete services to be shared.

It is important to have a shared vision.

The success of CJS efforts is often dependent on a shared vision. The MDH sees this work as aligned with their overall mission/vision. Alignment across partner organizations is also important. CHBs have realigned in the past due to differences in vision. During the site visit, there were a lot of marriage analogies when talking about shared vision and its impact on working relationships: *Was there a divorce among the counties involved? Did you immediately "hook up" with someone else, or did you play the field?*

It helps to have a third party facilitator.

Many of the Level 1 participants and several of the Level 2 teams used the state public health nurse consultant as a convener/facilitator. They all spoke strongly to the importance of having a third party facilitator who is knowledgeable and perceived as a neutral party. That allowed the team leader to be a participant. It also removed the notion of the team leader using the platform for his or her own agenda.

Regional identity plays a role in some of the demonstration sites.

There was some discussion about regional identity. Some of the partnerships had it, specifically the ones located in the northern part of the state. Others did not.

There is a tribal presence in some areas.

There are several American Indian reservations in Minnesota. As independent, sovereign nations, tribes generally run their own parallel systems. Relationships between CHBs and reservations in their area vary across the state. There is some interest in learning more about CJS between local governmental public health entities and tribal communities.

Lessons Learned

As a result of participating in this site visit, the Center staff came away with several insights that could be useful in this project and when working with other jurisdictions considering sharing arrangements.

Sustainability is important.

Try to find ways to keep supporting the existing collaboration, even after the grant funding expires. Site efforts should be seen as a starting point for continuing effort rather than a single “start to finish” activity. The work of the state and the SCHSAC are well positioned to reinforce this perspective. Some sentiment was expressed by an elected county policy maker to extend CJS thinking beyond just governmental structured public health to include health care and human services as a way to deepen the construct of health in all policies.

In order to continue CJS work participants expressed a need for continued access to tools, resources and consultation and support. For the Center specifically, participants would like to continue to be able to link with experts, network around problem solving, be kept aware of new information and resources and a continuing update for the Roadmap linked to tools.

Engage champions.

Policymakers can speak to the value of public health as a way to improve quality of life in their communities. There are several champions among the policymakers in this collaborative. In addition, use other collaborative members as champions to expand interest of CJS to other parts of the state. In

order to do this elected officials need to be equipped with the necessary information to describe how a CJS arrangement benefits the community and is not a loss of local control.

Efficiency versus effectiveness.

Try to maintain a balance between the objectives of increased efficiency and improved effectiveness. Most successful CJS arrangements strive to maximize investment by achieving the best results with the amount of money available. In one county a CJS arrangement was necessary to receive certain funding thereby expanding services available to all the participating jurisdictions.

SELECTED COMMENTS AND QUOTES FROM THE SITE VISIT AND FOLLOW-UP EVALUATIONS

Shortly after the visit, the Center sent out an electronic evaluation. The comments below came from the site team and the site visitors via the evaluations.

I learned a great deal about MN's public health system, which is more complex than I realized. I realized also how they are working to implement CJS across the entire system and attributes of their system that are facilitators of success.

I learned the importance of relationships in cross jurisdictional work.

It helped me continue to expand my knowledge of, and appreciation for, our state-local partnership. I have a lot of first-hand knowledge of the workings of LPH in MN, but our local partners shared some stories and examples of CJS that even I was not aware of. For example, I see very clearly now that both SHIP and the Blueprint documents have been drivers of our CJS work in MN.

The power point on CJS was very helpful. It was interesting to learn that CJS can occur across a spectrum and not necessarily on a continuum. Trust was emphasized. Buy-in from partners was important. Taking the time to explore and study the CJS and then making a plan.

The need for us to hone in on our sustainability plan was crystalized for me. I wasn't thinking that far ahead!