State Community Health Services Advisory Committee
Blueprint for Successful Local Health Departments
Work Group

Updating Minnesota's Blueprint for Public Health

December 20, 2010

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Sanne Magnan, MD, PhD
Commissioner of Health
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Dear Commissioner Magnan:

I am pleased to present to you the final report of the Blueprint for Successful Local Health Departments Work Group of the State Community Health Services Advisory Committee (SCHSAC). The SCHSAC approved this report at its meeting on September 29, 2010.

The Work Group was charged with answering the following questions: What makes a strong local public health organization? What factors contribute to its success? How do different "operating environments" influence public health outcomes for the community? Additionally, the Work Group was to identify positive and negative trends in organizational change currently affecting local health departments, and recommend strategies for maintaining and strengthening public health roles and responsibilities in today's complex operating environments.

Using the current science and the collective wisdom and experience the Work Group strove to answer these questions throughout the report. Strategies for strengthening the roles of local health departments, community health boards, their leadership and the local public health system as a whole, were addressed through the 17 recommendations. This report points out many opportunities for change and improvement, and sets out a philosophy and vision for achieving that change.

Additionally, this report sparked a lively discussion at the SCHSAC meeting, leading the members to request that the work group reconvene in order to develop a communication plan for addressing specific audiences, including County Administrators. The work group reconvened on November 15, 2010 and revised the wording, but did not change the intent of recommendations #5 and #8. They also developed a communication plan for several critical local audiences, including county administrators.

On behalf the SCHSAC I request your acceptance and approval of this report.

Sincerely,

Susan Morris, SCHSAC Chair
Isanti County Commissioner
Government Center
555 18th Ave SW
Cambridge, MN 55008

Protecting, maintaining and improving the health of all Minnesotans

December 20, 2010

Susan Morris, SCHSAC Chair 2010
Isanti County Commissioner
Government Center
555 18th Ave SW
Cambridge, MN 55008

Dear Commissioner Morris:

Thank you for sending me the final report of the Blueprint for Successful Local Health Departments Work Group of the State Community Health Services Advisory Committee (SCHSAC). The recommendations and report thoroughly address the issues detailed in the work group charge and provide a vision and philosophy to lead that change for the local public health system in Minnesota. I accept this report and the recommendations.

I applaud the work group for its tenacity in grappling with these complex issues, and for reaching consensus on the strategies for improvement. I believe that this report sets a course that helps ensure another three decades of success for Minnesota's local public health system. While I may not have the privilege of continuing to work with you on this issue as Commissioner of Health, I will continue to watch your process with interest and recommend support to my incoming successor. Again, thank you for the excellent report.

Sincerely,

Sanne Magnan, M.D., Ph.D.
Commissioner
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State Community Health Services Advisory Committee
Blueprint for Successful Local Health Departments
Work Group

Updating Minnesota's Blueprint for Public Health

Approved by SCHSAC: September 29, 2010

Revised: December 20, 2010

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EXECUTIVE SUMMARY

The New Blueprint

When the original CHS Act was passed in 1976 a blueprint was laid out for Minnesota's local public health system. This blueprint represented the best thinking of the time on what would make a strong and successful system. The CHS Act and its accompanying subsidy dollars spurred the development of community health boards (CHBs) across Minnesota.

Over the past decade, several counties have made changes to their organizational structures that affect public health, such as merging departments within a city or county or contracting with hospitals. Changes have also been made to public health governance structures, such as splitting up multi-county CHBs, forming single-county human services boards or forming new CHBs. More changes are currently being considered as local elected officials look for ways to address significant budget concerns, create efficiencies and anticipate other looming changes, including retirements of public health leaders.

In 2009, SCHSAC called for a work group to investigate the apparent increase in organizational and governance structure changes at the local level. Later the work group's scope was broadened to encompass a discussion about the foundations underpinning the local public health system and to update the blueprint for strong and successful local health departments (LHDs).

Philosophy and Vision

During discussions, the work group developed a philosophy and vision for the future of Minnesota's local public health system. The philosophy of the work group and the overarching message of this report can be summarized in three points.

1. *It's time to "raise the bar"*. To ensure the future strength of our system we need to set a vision and establish "stretch goals" for ourselves. The work group developed recommendations which they believe raise the bar and provide opportunities for continuous improvement throughout the system.
2. *This is the "new normal"*. According to Minnesota's State Demographer, Tom Gillaspy and State Economist, Tom Stinson, there will never be more resources again:" this is the new normal". They argue that this new normal presents opportunities to be creative and innovative in the way business is done, and the Blueprint work group agrees.
3. *We need to create our own future.* This report helps set a new course for the future of local public health in Minnesota - a course which was established with the passage of the original 1976 Act and the revisions to 2003 Local Public Health Act - but which is now better understood and more clearly defined.

To meet their charge, the work group went back to the original foundations of the CHS system: *community involvement*, *local control*, *integrated system*, *adequate population base*, *funding* and the *role of the Minnesota Department of Health (MDH)*. Work group members also carefully

examined the issue of *leadership* provided by community health services administrators. They discussed how and whether these foundations continue to be applicable to Minnesota's current local public health system, as well as how they can be used to help revise the blueprint for Minnesota's system.

Governance

Position statement: Governing structures for public health need to be vibrant, responsive to changes, and grounded in Minnesota's foundations for public health.

A number of key governance-related issues were identified during the work group discussions. First, the challenges of governing for public health have changed over the years as public health has become more complex. Also, the current economic environment has increased the pressure and challenges on governing bodies to respond in ways that focus on the bottom line. Changes proposed by local governments may attempt to fix their current situation through new internal organizational structures, but the implications of these changes on governance are sometimes overlooked.

Most CHBs use thoughtful, deliberative processes, asking MDH and other partners for assistance when they consider making a change to their governance structure. Nevertheless, there have been situations where governance structure changes have been made with incorrect or incomplete information and without the involvement of public health. Finally, communication between MDH and local public health about governing structures has been more limited in recent years. The working relationship between MDH and local public health has changed, resulting in a lack of communication about governance, which has contributed to less well informed decision making.

CHS Administration

Position statement: Today's public health field is increasingly demanding and complex. It requires strong – *qualified, authoritative, and responsible* – leadership. CHS administrators should provide visionary and strategic public health leadership at the local and state levels. They should have clear roles, responsibilities and authorities which are documented, shared and visible. Additionally, the role of the CHS administrator must remain responsive to the ever changing field of public health and should be periodically updated and evaluated.

The community health services (CHS) administrator has been an important leadership position in Minnesota's CHS system from the beginning. The work group re-evaluated the requirements, responsibilities and authorities of CHS administrators and looked for ways to strengthen this position for the future.

The original focus of the job was seen as providing visionary leadership and direction for the CHB, as well as for the statewide system. Many in the system have expressed concern that the

role, responsibility and authorities of the CHS administrator have been diminished over the years. This has been detrimental to public health locally and statewide.

While the required *qualifications* of the CHS administrator role haven't changed since 1994 both the role and the field of public health have changed significantly. There are concerns that the qualifications have not kept pace with the demands of the position or national expectations for local public health leadership.

The work group drew upon many external sources of evidence to find ways to strengthen and update the expectations for CHS administrators including: evidence and best practices from the current science and literature; the Core Competencies (appendix B); the national public health standards and measures developed by the *Public Health Accreditation Board or "PHAB" (appendix C)*; as well as local public health administration models from within Minnesota as well as from other states.

Integration

Position statement: Integration is an important strategy *for streamlining, economizing and improving quality* to ensure successful local health departments and the success of the CHS system.

Local public health departments and their CHBs are looking for ways to streamline, economize, improve quality, modernize, and coordinate activities for their communities. Many are considering integrating their public health activities across county borders, or between public health and other services within their jurisdictions.

The consensus of the work group was that integration remains as important and relevant to the local public health system as it was when the system was conceived. However, an updated definition or framework for understanding integration is required. With that in mind, the following definition was developed:

> *Integration is a systematic process of planning, implementing and evaluating delivery systems which share goals and resources. It seeks to improve the quality of population health in the community and to create economies of scale. The outcome of such a process is good quality public health activities provided for the population.*

The concept of integration is important to the system, because it can help improve the public's health. SCHSAC has previously stated that it wants all Minnesotans to be served by a LHD that carries out the essential local public health activities. In this era of declining resources, delivering some of the essential local public health activities in coordination with other departments or partners may be more cost effective, and efficient.

Population-Size Served

> **Position statement:** Population-size served is an important consideration for optimal public health practice. CHB's have a variety of options available to help them achieve an adequate population-base to optimize their effectiveness and efficiency.

The scientific literature confirms that population-size served by a LHD is a strong predictor of performance, as measured by success the 10 Essential Public Health Services (EPHS). The literature shows that LHDs serving 50,000 to 500,000 people perform significantly better on nearly all 10 EPHS compared to their larger and smaller counterparts. The study authors attribute this success to health departments being large enough to achieve some economies of scale; employ enough staff to allow for staff specialization on key public health issues; and have a sufficient population base to provide an adequate local tax base.

After having reviewed the literature, Minnesota data, and historical information regarding population-size and its impact on performance, the work group members discussed making various types of recommendations. Some members asserted that changing Minnesota's minimum population requirement for a CHB would result in unproductive debate on the accuracy of "the number" and would distract from productive discussions on how to incentivize and improve performance in LHDs of all sizes and governance arrangements.

Most members agreed that information on the "optimal" size served should be included in discussions among elected officials as they consider making changes to programs, staffing, budgets and structures. Similarly there was agreement that when planning new programs or grants, MDH should consider the impact of population-size served. There was additional agreement that exemptions to the 30,000 minimum population requirement needs to be further qualified and better enforced.

While the work group stopped short of recommending that the minimum population requirement for CHBs be raised, there was agreement that striving to serve populations of 50,000 to 500,000 was desirable, particularly if it encouraged jurisdictions to work together. While the members found the population-size evidence to be compelling, the work group was dissatisfied that the impact of geographic-size served wasn't similarly explored in the literature.

The Role of MDH

> **Position statement:** MDH must be a steadfast partner of local public health in Minnesota and provide strong support, guidance, advocacy, as well as reliable public health data. Additionally, MDH should continue in its role of providing technical assistance to CHBs. This role is critical to a CHB's ability to effectively carry out its responsibilities.

Over the years, MDH has played a significant role in the development of the local public health system. Much of this was accomplished through MDH's provision of program-specific development and technical assistance; through consultation on administration; by providing guidelines for conducting a comprehensive community health assessment and action planning

process; as well as through the promulgation and enforcement of rules and regulations for CHBs or LHDs in Minnesota. Other areas of support included providing funding; setting and enforcing standards; and undertaking activities to advance CHS system development through evaluation, policy development, analysis and modification.

In considering the original foundations of the CHS Act, the work group believes that the *role of MDH* must continue to be incorporated as part of any blueprint for future success. To strengthen its role for the future, MDH needs to assure involvement of the Office of Performance Improvement (OPI) in discussions of proposed state health policy changes so that the potential impact on local public health is carefully considered.

MDH, via OPI, should continue to help improve local leadership capacity. MDH has a role in assisting LHDs realize high quality public health programs, by providing guidance in planning and assuring timely feedback is given on materials such as reports and plans (e.g., Community Health Assessment and Action Planning process “CHAAP”). MDH must continue to advocate for accountability and continuous quality improvement in public health practice by participating in state and national initiatives, and improve the collection and dissemination of data back to local public health.

Position Statements and Recommendations

Through their deliberations and discussions the Blueprint work group developed position statements and recommendations on the following "foundations" of Minnesota's local public health system:

- Governance
- CHS Administration
- Role of MDH
- Integration
- Population-size Served

The work group concluded that implementing these recommendations is necessary to ensure the future success of both LHDs and CHBs throughout Minnesota. In their final meeting, the work group opted to prioritize their list of 17 recommendations. While the members felt that all the recommendations were important, they wanted to provide some direction for getting started. Each recommendation was independently examined and rated as *high*, *medium* or *low* priority. High priority recommendations were defined as having a long-term, positive impact for the local public health system; requiring a commitment of time and resources; and making a long-term impact. The work group members also identified key partners for implementation of each high priority recommendation. Additional background information on all of recommendations can be found in "The Foundations" section of this report.

Table 1: High priority recommendations and key partners for implementation

High priority recommendations	Key partners
Recommendation #1	CHBs
Recommendation #2	MDH
Recommendation #3	CHBs, CHS administrators, MDH
Recommendation #5	CHBs, MDH
Recommendation #14	MDH
Recommendation #15	MDH
Recommendation #16	MDH
Recommendation #17.1, 17.2, 17.5	MDH

"High priority" recommendations are indicated with an asterisk (*).

Please note, the wording, but not the intent of recommendations #5 and #8 were revised by the Blueprint Work Group in their final meeting on November 15, 2010. Revisions were accepted, and added to by SCHSAC on December 17, 2010. A description of this process, along with the original and revised wording can be found in Appendix J.

Governance

Position statement: Governing structures for public health need to be vibrant, responsive to changes, and grounded in Minnesota's foundations for public health.

1. Regardless of the governance structure, CHBs should ensure direct communication with local public health leadership (i.e., the CHS administrator and/or local public health director) in the jurisdiction. Established communication channels are critical to ensuring flexible, and agile organizations that can respond in a timely manner to public health emergencies, and other needs, as well as to local economic and demographic changes.*

2. MDH should be proactive in providing education about the governance structures that are options in statute to CHS administrators and CHBs. They should offer technical assistance to boards considering governance or organizational changes.*

3. To ensure that public health has a strong presence in the ongoing local government redesign discussions (e.g., human services redesign), local public health and MDH should seek opportunities to contribute ideas and comprehensive options as they relate to public health.*

4. CHBs should regularly evaluate their governance structures to make certain that it is meeting the community's needs. This type of evaluation should always precede decision of governance changes. The "Discussion Guide for Exploring Public Health Governance and Structure Change" is recommended as a resource.

5. There are statutory requirements that CHBs must meet, but there is significant local flexibility in how they meet those requirements. The role of MDH is to provide consultation regarding requirements and options and to ensure that statutory requirements are met.
   5.1: Current state statute (145A.03 subd.3) requires that, "a county of city may withdraw from a joint powers board of health by resolution of its governing body not less than one year after the effective date of the initial joint powers agreement. The withdrawing county or city must notify the commissioner and the other parties to the agreement at least one year before the beginning of the calendar year in which the withdrawal takes effect."
   5.2: We recommend that CHBs should notify MDH six months prior to any final board action on major governance or organizational structural changes within the CHB or its member counties.
   5.3: The annually signed Assurances and Agreements forms should be updated to include this new recommendation.*

6. MDH should work to examine the performance of a CHB and LHDs (LHDs) from an overall management perspective (i.e., beyond individual grant management and fiscal accountability activities) to ensure that CHBs and LHDs are able to deliver public health programs as promised, and spend public health funding as intended.

CHS Administration

Position statement: Today's public health field is increasingly demanding and complex. It requires strong – *qualified, authoritative, and responsible* – leadership. CHS administrators should provide visionary and strategic public health leadership at the local and state levels. They should have clear roles, responsibilities and authorities which are documented, shared and visible. Additionally, the role of the CHS administrator must remain responsive to the ever changing field of public health and should be periodically updated and evaluated.

7. The administrative personnel requirements in Minnesota Rules 4736.0110 should remain the minimum qualifications required for CHS administrators. However, given the increasingly complex nature of the job, the following additional qualifications are recommended as necessary for CHS administrators to effectively carry out their responsibilities.
   7.1. Meet the Tier 3 Core Competencies as defined by the *Council on Linkages between Academia and Public Health Practice* (appendix B);
   7.2. Align with the administration-related national public health standards and measures developed by the *Public Health Accreditation Board* (appendix C); and
   7.3. Participate in continuing education, to be accomplished through yet to be developed CHS administrator orientation, mentorship program, and ongoing training opportunities.

8. In addition to their longstanding roles, CHS administrators *ideally* should:
   - 8.1: Participate in the hiring and direction of upper level LHD staff, particularly in multi-county CHBs;
   - 8.2: Facilitate or direct joint work planning among the counties within a multi-county CHB and/or within a region; and
   - 8.3: Actively engage in succession planning, specifically for the CHS administration role, but also for other leadership positions within the CHB and LHD.

9. Having sufficient authority is critical to strong and effective leadership. As such, CHS administrators should have the following authorities:
   9.1. Sufficient and regular access to the CHB and county boards (or city councils) to provide regular updates and give needed input on matters pertaining to public health; and
   9.2. The authority to oversee the development and execution of the budget for funds or resources going through the CHB.

Integration

Position statement: Integration is an important strategy *for streamlining, economizing and improving quality* to ensure successful LHDs and the success of the CHS system.

10. MDH should develop guiding principles to assist CHBs in determining when, how and to what extent to integrate. Factors necessary for successful integration of public health services or activities should be identified and shared.

11. All CHBs should have the capacity to determine through an assessment and decision-making process, when integration is in the best interest of their programs, departments, and communities.

Population-Size Served

Position statement: Population-size served is an important consideration for optimal public health practice. CHB's have a variety of options available to help them achieve an adequate population-base to optimize their effectiveness and efficiency.

12. MDH guidelines for new grants, trainings, policies and programs for local public health should take into consideration the impact of population-size served.

13. MDH should develop materials for local elected officials explaining the impact and importance of population-size served for any governance or organizational change.

14. LHDs, MDH, and SCHSAC members should actively work to highlight and promote examples of collaborative relationships and joint work planning that leads to a better product for the community (e.g., economies of scale and/or improved performance).*

Role of MDH

Position statement: MDH must be a steadfast partner of local public health in Minnesota and provide strong support, guidance, advocacy, as well as reliable public health data. Additionally, MDH should continue in its role of providing technical assistance to CHBs. This role is critical to a CHB's ability to effectively carry out its responsibilities.

15. To help realize the CHS administration recommendations, the MDH should develop and implement a CHS administrator training and education (e.g., to include an emphasis on business, financial management and leadership skills).*

16. MDH should continue to provide expertise in program areas of public health, but also provide assistance in working with other local partners and decision-makers. Additionally, MDH can play a role in educating local elected officials about public health as well as provide leadership development training opportunities for those in appointed and elected positions. CHBs will look to MDH for clear guidance on how to develop and implement community health improvement and capacity improvement plans (e.g., CHAAP).*

17. MDH should continue to support the state-local partnership. Particular areas of emphasis include:
    17.1. Continued support and utilization of SCHSAC as a vehicle for local public health system and policy development and to advise the commissioner of health on matters pertaining to local public health*;
    17.2. Advocating for and promoting, local public health with other state agencies, the state legislature, and national partners (e.g., federal agencies, national partners)*;
    17.3. Providing assistance to CHBs in the recruitment of public health leaders (i.e., local public health directors and CHS administrators);
    17.4. Promoting state and local commitment to improvement of the public health system by building the capacity to fulfill the national public health standards and measures developed by the *Public Health Accreditation Board (PHAB);*
    17.5. Advancing a culture of continuous quality improvement throughout the state and local public health system*; and
    17.6. Assessing and describing the capacity of the public health workforce in Minnesota.

THE NEW BLUEPRINT

Introduction

When the original Community Health Services (CHS) Act was passed in 1976 a blueprint was laid out for Minnesota's local public health system. That blueprint represented the best thinking of the time on what would make a strong and successful public health system. The CHS Act, and its accompanying subsidy dollars, spurred the development of CHBs across Minnesota, and ushered in a new way of doing business.

Much has changed over the past 34 years: local public health practice has progressed from primarily providing personal health services (such as home health care) to planning and implementing population-based activities (such as emergency preparedness and the State Health Improvement Plan). Although the system matured, the vision and plan for it was not updated to reflect those changes. As a result changes were without the benefit of clear guidance, evidence or best practices.

Over the past decade, several counties have made changes to their organizational and operating environments that affect local public health, such as merging departments within a city or county, splitting up multi-county CHBs, and changing governance structures. Recently the frequency of these changes seems to have accelerated as local elected officials look for ways to address significant budget concerns, create efficiencies and anticipate or react to other looming changes, such as retirements of public health leaders.

In 2007, the State Community Health Services Advisory Committee (SCHSAC) adopted a strategic plan for 2008 to 2013. In that plan, SCHSAC noted the necessity of "identifying governance, organizational and other characteristics that contribute to strong and effective local health departments" as a priority for the future of the system. Subsequently, in 2009, SCHSAC appointed the Blueprint work group and charged them with determining what effects different operating environments have on public health outcomes for the community and on the success of LHDs.

While the work group started as a call to investigate the increase in organizational and governance structure changes at the local level, to better understand that issue, the work group scope was broadened into a discussion about the foundations which underpin the system. As stated in the charge, this work group sought to understand and update the blueprint for strong and successful LHDs and the local public health system.

To meet the charge (appendix A), the work group went back to the original foundations of the CHS system: *community involvement*, *local control*, *integrated system*, *adequate population base*, *funding* and the *role of MDH* (appendix D). They also carefully examined the issue of leadership provided by CHS administrators. They discussed how and whether these foundations continue to be applicable to Minnesota's local public health departments, as well as how they can be used to help revise the blueprint for Minnesota's system.

The work group also identified two large scale initiatives that are now or will soon be underway, which they believe will significantly impact Minnesota's local public health system in the near future. The first is the work currently being done by the Association of Minnesota Counties (AMC) and the Minnesota Department of Human Services (DHS) to redesign Minnesota's human services system. Additionally, the Voluntary National Accreditation Program is slated to begin in 2011. Due to the timing of these initiatives (neither was completed at the time of publication); the implications of these initiatives were not thoroughly discussed by this work group. Nevertheless they recognize these initiatives as important to the success of LHDs and Minnesota's local public health system, and suggest that SCHSAC and MDH continue to watch these issues.

One of the first activities of the work group was to undertake a thorough review of the Public Health Systems and Services Research (PHSSR), looking at which factors or characteristics of LHDs were correlated with high performance. Most studies reviewed measured LHD performance by success in meeting the 10 Essential Public Health Services (EPHS). The most consistent and strongest predictors of performance were jurisdiction size (i.e., population size served) and expenditures (especially per capita). Funding, particularly locally sourced funding, such as local tax levies, had significant impact on LHD performance as did staffing level. Other important, but more limited predictors of performance included the qualifications of LHD directors, the use of multidisciplinary management teams, LDH structure (e.g., single county vs. multi-county), and the presence/role of a local board of health and the number and types of partnerships maintained by the LHD. While the evidence was compelling and informative to the work group's discussion, it was incomplete and not specific to Minnesota. For more detail, see the full literature review in appendix H.

While the Blueprint work group was unable to pinpoint the direct effects different operating environments have on public health outcomes in the community, they were successful in establishing position statements and recommendations to serve as guides for the development of state and local policies/decisions about public health organizations that can have a positive effect on the future of our public health system in Minnesota.

Philosophy and Vision

During discussions, the work group developed a philosophy and vision for the future of Minnesota's local public health system. The philosophy of the work group and the overarching message of this report can be summarized in three points.

1. It's time to "raise the bar".
2. This is the "new normal".
3. We need to create our own future.

It's time to "raise the bar". Too often we, as a system, have made recommendations and set requirements that everyone can meet (i.e., minimum requirements). Work group members speculated that this approach may have limited our progress and success. The required

minimums for qualifications, performance and reporting are clear. Higher expectations are now needed to "raise the bar" and motivate continuous improvement throughout the system. To ensure the future strength of our system we need to set a vision and establish "stretch goals" for ourselves. The work group developed recommendations which they believe raise the bar and provide opportunities for ongoing system-wide improvement.

This is the "new normal". The current financial hardships facing all levels of government make it appealing and convenient to put off implementing changes until additional resources become available. Yet according to recent presentations by Minnesota's State Demographer, Tom Gillaspy and State Economist, Tom Stinson, there will never be more resources again, "this is the new normal". They argue that this new normal presents opportunities to be creative and innovative in the way we do business, and the Blueprint work group agrees. The work group has put forward recommendations for improvement they believe partners can and should begin to implement right away.

We need to create our own future. We are starting with a strong local public health system and the wisdom of more than 30 years of experience working within it. There are many other things happening in the state and the nation which have the power to influence our direction and impact our success. Setting our vision, selecting recommendations and choosing our own priorities will allow us to chart our own course. This report helps mark the beginning in setting a new course for the future of local public health in Minnesota - a course which was established with the passage of the original 1976 Act and the revisions to the 2003 Local Public Health Act - but which is now better understood and more clearly defined.

Vision

To meet their charge, the work group went back to the original foundations of the CHS system: *community involvement*, *local control*, *integrated system*, *adequate population base*, *funding* and the *role of MDH*. Members also carefully examined the issue of *leadership* provided by community health services administrators. They discussed how and whether these foundations continue to be applicable to Minnesota's current local public health system, as well as how they can be used to help revise the blueprint for Minnesota's system. In doing so, they developed the following vision statement to guide efforts to ensure successful LHDs.

> *Throughout the months of discussion and considering our public health future, the Blueprint work group envisions a Minnesota public health system in which:*
> - *Our state and local partnership promotes public health organizations that are responsive to the evolving public health needs of our ever-changing communities;*
> - *Elected and appointed officials and CHS administrators provide leadership that is grounded in quality, effectiveness, outcomes, state and national standards, and sound/balanced/fair decision-making; and*
> - *Communication between CHBs and local public health leadership and between local public health and MDH is honest, direct and frequent to assure well-functioning public health organizations.*

THE FOUNDATIONS

History and Background

A brief history of Minnesota's local public health system (also known as the "community health services system") is provided here to give context to the "foundations" which follow.

The original blueprint for public health in Minnesota was the Community Health Services (CHS) Act of 1976. Much of the work done by the Blueprint work group was based on the Act, its subsequent revisions, and common understanding of the statute (MN Statute 145A) and the administrative rules (MN Rules 4736.0110) that helps enforce it. The CHS Act created a public health system in which local governments had the flexibility to determine what public health services and activities were needed in their communities. State government provided some funding, technical assistance and guidance to allow for local implementation of those activities.

Prior to passage of the CHS Act of 1976 there were approximately 2,000 local governmental entities (i.e., boards of health) that had authority for public health in Minnesota. The sheer number of boards of health complicated efforts by state and local governments to communicate and share responsibility for public health. The 1976 CHS Act was designed to overcome the confusion over roles and authorities, and to establish a comprehensive system and an effective public health partnership among state and local governments.

The CHB is the legal governing authority for local public health in Minnesota, and is the only governmental entity (other than Minnesota's tribal governing entities) eligible to receive funding from the CHS Act of 1976 (and subsequently the Local Public Health Act of 2003, MN Stat. 145A). The invention of CHBs decreased the number of boards of health in Minnesota from approximately 2,000 to fewer than 60. [*Note*: there are currently 53 CHBs, but the number and configuration of CHBs has fluctuated over the years.]

CHBs must meet certain population and boundary requirements. The CHS Act established a minimum required population of 30,000 in order to be eligible to receive CHS subsidy funds (now called the Local Public Health Act Grant). From the beginning there have been two exemptions to the minimum population requirement. First, a CHB comprised of three or more *contiguous* counties could be a CHB, even if their combined population was less than 30,000. Second, if a single county organized as a Human Services Board (HSB) under Minnesota Statute Chapter 402 (e.g., combined social services, public health, and corrections) then the HSB operates as the CHB, and the 30,000 minimum does not apply. Minnesota's CHB minimum population requirements have not been modified since passage of the original CHS Act in 1976.

In 1976, the legislature provided incentives for an integrated or multi-county work by giving a $5,000 incentive to the CHB for each member county participating in a multi-county CHB. While some multi-county CHB's have retained these funds for CHB infrastructure or programming others pass the financial incentive and delegate certain authorities back to the individual county(s).

Another important facet of the original CHS Act was the creation of the mandated position of the CHS administrator. From the beginning, the CHS administrator role was seen as distinct and important. In 1988, a SCHSAC work group was convened to update the required qualifications included in rule. A review of historical documents shows that the changes were an update of the original requirements based on conventional wisdom. At that time little evidence and few best practices existed to inform their decision making. These qualification changes were formally implemented via Minnesota's Administrative Rules in 1994.

Another unique feature of the original CHS Act was the development of the SCHSAC. Through the joint efforts of the MDH leadership and local CHB representatives on SCHSAC, the relationship - *known as the state-local partnership* - evolved into a vibrant, active and highly valued partnership unlike any other in the state or nation. Few states have a system like Minnesota's: designed so that state and local governments can work in concert to develop policies and to achieve agreed-upon goals. The concept of a state-local public health partnership was particularly ground breaking.

Governance

Governance means "steering"; it involves defining expectations, granting power, and verifying performance. In the case of public health in Minnesota, governance has been deemed so important that its role and requirements are statutorily mandated. The CHB is the legal governing authority for local public health in Minnesota.

A key component of the 1976 CHS Act – *and of the subsequent 1987 and 2003 Local Public Health Acts* – was allowing county and city boards of health to organize themselves as CHBs, provided they met certain population and boundary requirements. By meeting those requirements, counties and cities became eligible to receive a state subsidy. The new CHBs preempted all township and city boards of health within their jurisdictions.

To help better explain governance and governance structures, and how they apply to Minnesota's local public health system, the following definitions are provided.

Governing bodies are made up of local elected officials who are elected to represent the people and oversee the operations of government within a jurisdiction. County boards and the county commissioners that comprise them are generally *elected* officials, and as such have the ultimate authority and responsibility for policy making in their jurisdictions. Nevertheless, CHBs may also include appointed members from the community. In Minnesota there are a number of CHBs which include *appointed* members. In some CHBs those members have voting rights, and in others they serve in an advisory capacity only. Multi-county CHBs, on average, have slightly more non-elected officials represented on their boards.

Governing structures are the ways in which governing bodies are legally organized to do their work. Minnesota Statutes and Rules identify two options for counties and cities to organize themselves to do the work of public health: CHBs or Human Service Boards (HSBs) organized under MN Statute Chapter 402. Multi-county CHBs are formed through joint powers

agreements, which allow them to work across political boundaries. CHBs can be comprised of single counties, provided they meet the minimum 30,000 population requirement. They can also be multiple counties. A two-county CHB is possible if the counties share a border and have a combined population greater than 30,000. CHBs of three counties are possible if the counties are contiguous; there is no minimum population requirement in this configuration. County boards (and in a few cases, city councils) may appoint elected officials and citizen members to these governing structures.

Organizational structure is a term used to describe the way in which a LHD is organized within a city or county. Unlike governing structures, which are dictated by statute, organizational structures are locally determined. Public health in Minnesota operates under many different organizational structures. For example, public health is a stand alone department in 54 counties, and is organized with social services as a part of a human services agency in 28 counties in Minnesota. There are also five counties in Minnesota in which a hospital is contracted to provide public health activities. For a comprehensive listing of current organizational and governance structures, see appendix E.

How was governance identified as an issue?

The SCHSAC Strategic Plan Update 2008-2013 made "identifying governance, organizational and other characteristics that contribute to strong and effective LHDs" a priority for the future of the system. This idea emerged as members of SCHSAC began to anticipate how dwindling resources, changes in population centers and demographics, and workforce changes (particularly retirements) would prompt local elected officials to consider making structural changes.

During the past several years, leaders in Minnesota's public health system began to notice an increase in the number of county governments making changes to the internal organizational structures, and observed that some of these internal changes also had an impact on public health governance. In a number of instances, the discussions which led to these changes were initiated by individuals within government (e.g., county administrators, family service directors, county commissioners) who were not well versed in the statutory framework and responsibilities of public health. Public health leaders developing the SCHSAC strategic plan worried that local officials might, "ponder the advantages and disadvantages of the different models, often with little information to guide their decision making", so a work group was called for to look into the issue.

Late in 2008, SCHSAC put out a call for volunteers for "the SCHSAC Governance and Organizational Structures" work group, to begin work in 2009 and was renamed the "Blueprint for Successful Local Health Departments" work group. As the plan for the work group was developed the charge expanded to include additional topics relevant to ensuring the strength of LHDs. Yet the issues surrounding governance and governance structures remained a priority for the work group and were addressed throughout their year long process.

What is the Blueprint work group's perspective on governance?

At the first Blueprint work group meeting, members were asked why they volunteered for the work group and what they hoped would come out of it. One of the top themes that emerged was "guidance for boards facing restructuring decisions". The limited public health research conducted on the effect of governance structure on LHD performance does not point to one structure being better than another (appendix H). Despite the lack of research the work group decided the issue was too important to drop.

In an effort to meet the need for informed discussions to guide decision making, the work group developed the Discussion Guide for Exploring Governance and Structure Change (appendix F). This tool for local elected officials was developed in fall of 2009 and includes a list of factors that often prompt changes to governance and organizational structures. It recommends a process for exploring change, for developing a plan to evaluate change and then poses discussion questions, which are applicable to governance structure change conversations.

When the work group members revisited the vision and foundations for the 1976 CHS Act they determined that the following foundations remain relevant and relate to governance and governance structures: *community involvement*, *local control*, *integrated system*, *adequate population base*, and *funding*. As the group explored some of these foundations in greater detail, they seemed to be building a new vision for governance for public health in Minnesota.

At one of the very last work group meetings, members again took up the topic of governance and governance structures directly - this time with the benefit of more data about CHBs from a descriptive study implemented by the Minnesota Public Health Research to Action Network survey of "Top Public Health Officials." A key finding of the survey was nearly 30% of CHS administrators reported that their CHB had either made or considered making a change that they believed would impact their governance structure. This new data confirmed what many in the system had long suspected.

The survey also revealed helpful new information about the functioning and composition of CHBs. For example, Table 2 shows the variability in the number of members on CHBs, and shows the single county CHBs tend to have fewer members than multi-county CHBs. Table 3also shows that most multi-county CHBs have non-elected members, whereas most single-county/city CHBs do not.

Table 2: CHB membership and composition by CHB type

CHB Type	# of Counties	% with non-elected member*	Median CHB size (range)	Median # elected members (range)	Median # non-elected members (range)
Multi-County	21	62%	10 (5-18)	7 (2-15)	2 (0-5)
Single-City/County	32	13%	5 (5-13)	5 (5-13)	0 (0-1)*
All	*53*	*32%*	*6 (5-15)*	*5 (2-15)*	*0 (0-5)*
** Only 4 Single-County/City CHBs have a non-elected member so the percentage approaches* 0.					

Throughout these discussions a number of key governance-related issues were identified. First, the challenges of governing for public health have changed over the years as public health has evolved. For example, CHBs have been asked to steer away from individual health toward population-based health; to hire and retain qualified public health employees from a shrinking pool of eligible applicants; and to adjust to a pace of change which requires local government to respond to very short timelines.

Second, the current economic environment has increased the pressure and challenges on governing bodies to respond in ways that focus on the bottom line. Governing bodies, in an attempt to demonstrate local control and responsibility, are looking at ways to reduce the size and still maintain the effectiveness and efficiency of local government. Changes proposed by local governments may attempt to fix their current situation through new internal organizational structures, but the implications of these changes on governance are sometimes overlooked.

The majority of CHBs have stable governance, use a thoughtful, deliberative process, and ask MDH for assistance when they consider making a change. Nevertheless, there are situations where governance structure changes have been or are being made, with incorrect or incomplete information and without the involvement of local or state public health expertise. After discussing several examples, the work group raised the following concerns: (1) board decisions are difficult and costly to undo, and (2) the public health "voice" is being lost, imperiling the state-local public health partnership, and calling into question their ability to meet the essential local public health activities.

Finally, communication between MDH and local public health about governing structures has been more limited in recent years. The working relationship between MDH and local public health has changed. As departments developed, they relied less and less on MDH for guidance and help and have worked either independently or with other LHDs and related trade associations (e.g., LPHA). Some MDH district office positions were eliminated, decreasing the available resources and expertise to provide assistance on governance structure issues. This lack of communication has likely contributed to less well informed decision making.

CHS Administration

The Blueprint work group identified leadership as a foundation of Minnesota's local public health system; one which was always implied but not explicit in the original vision of Minnesota's local public health system. The CHS administrator has been an important leadership position within Minnesota's CHS system since its inception. The work group re-evaluated the requirements, responsibilities and authorities of CHS administrators and looked for ways to strengthen this position for the future.

Background

According to expert opinion, the role of the CHS administrator was originally viewed as a full time position, which entailed the following responsibilities:

- Planning (i.e., "CHS planning" now called "CHAAP"),
- County commissioner orientation to public health,
- Participation in SCHSAC and SCHSAC work groups;
- Engaging local public health staff in population-based public health activities; and
- Working with MDH.

The focus of the job was seen as providing visionary leadership and direction for the CHB, as well as for the statewide system. Many responsibilities on this list were new concepts at the time, and consequently represented significantly new ways of doing business for LHDs. Many in the system have expressed concern that the role, responsibility and authorities of the CHS administrator have been diminished over the years. This has been detrimental locally and statewide.

While the required *qualifications* of the CHS administrator role haven't changed since 1994, both the role and the field of public health have changed significantly. There are concerns that the qualifications have not kept pace with the demands of the position or national expectations for local public health leadership.

Qualifications, Responsibilities and Authorities

Following are the current personnel standards for CHS administrators (i.e., list of minimum required qualifications, skills and tasks), which are taken directly from Minnesota Administrative Rules 4736.0110. An administrative rule is a general statement adopted by an agency to make the law it enforces or administers more specific or to govern the agency's organization or procedure. In this case rule 4736.0110 enforces Minnesota statute 145A.09 to 145A.131.

A CHB is required to have a CHS administrator who has:

- A baccalaureate or higher degree in administration, public health, community health, environmental health, or nursing, and two years of documented public health experience in an administrative or supervisory capacity, or be registered as an environmental health

specialist or sanitarian in the state of Minnesota and have two years of documented public health experience in an administrative or supervisory capacity;
- A master's or higher degree in administration, public health, community health, environmental health, or nursing, and one year of documented public health experience in an administrative or supervisory capacity; or
- A baccalaureate or higher degree and four years of documented public health experience in an administrative or supervisory capacity.

The documented experience of a community health services administrator must include skills necessary to:
- Direct and implement health programs;
- Prepare and manage budgets;
- Manage a planning process to identify, coordinate, and deliver necessary services;
- Prepare necessary reports;
- Evaluate programs for efficiency and effectiveness;
- Coordinate the delivery of community health services with other public and private services; and
- Advise and assist the CHB in the selection, direction, and motivation of personnel.

The work group agreed that these personnel qualifications should remain the *minimum* standard, but in order to prepare the system for the future they recommended “raising the bar” and setting higher expectations for *optimal* qualifications of CHS administrators. As an example, the work group recommends that CHS administrators strive to meet the Tier 3 Core Competencies *(developed by the Council on Linkages Between Academia and Public Health Practice)* as the optimal standard for CHS administrators (appendix B).

Longstanding MDH Expectations of CHS Administrators

In reviewing the current state of CHS administration in Minnesota (assisted by the Public Health Research to Action Network *Survey of Top Local Health Officials*) the work group found that responsibilities and authorities of administrators were widely variable across the system and not well documented. The members considered this lack of clear expectations problematic. While it has not before been made explicit in a single document, MDH has long held the following expectations for public health leadership (per the Local Public Health Act and the annually signed Assurances and Agreements form).

- Assure that the CHB is meeting the requirements of Minnesota Statute 145A as well as relevant federal requirements;
- Assure that the CHB is meeting the responsibilities outlined in the Assurance and Agreements form (signed and updated annually);
- Be involved in and give input into local and state public health policy development (and national where applicable);
- Communicate public health matters to the board/CHB;
- Coordinate (or assure) the community health assessment and planning process;
- Have oversight and approval of annual reporting for the CHB/member counties;

- Participate in SCHSAC (often as an alternate member) and on SCHSAC work groups; and
- Have signature authority for routine matters of the CHB ("agent of the board").

CHS administrators were surveyed regarding their satisfaction with time spent in several key public health activities and their responses are summarized below (Table 3). Responses of 'too much' or 'too little' time spent were aggregated to indicate overall dissatisfaction. When asked, later, about the desire for technical assistance according to these same areas, the responses were correlated (Table 4).

Table 3: CHB Satisfaction with Time Spent on Public Health Activities

PH Activity	Dissatisfied CHS Administrators, N (%)
Evaluation/Performance Improvement	28 (53)
Policy/Plan Development	24 (45)
Leadership	16 (30)
Administration/Governance	15 (28)
Program Management, Coordination, Oversight	12 (23)
Providing Direct Services (to individuals)	4 (8)

CHS administrators were asked to estimate whether the time they spent on each public health activity in the last year was *too little, too much,* or *just right.* Administrators who reported spending *too much* or *too little* time on each activity were defined as *dissatisfied.*

Table 4: CHB Desire for Technical Assistance by Public Health Activity

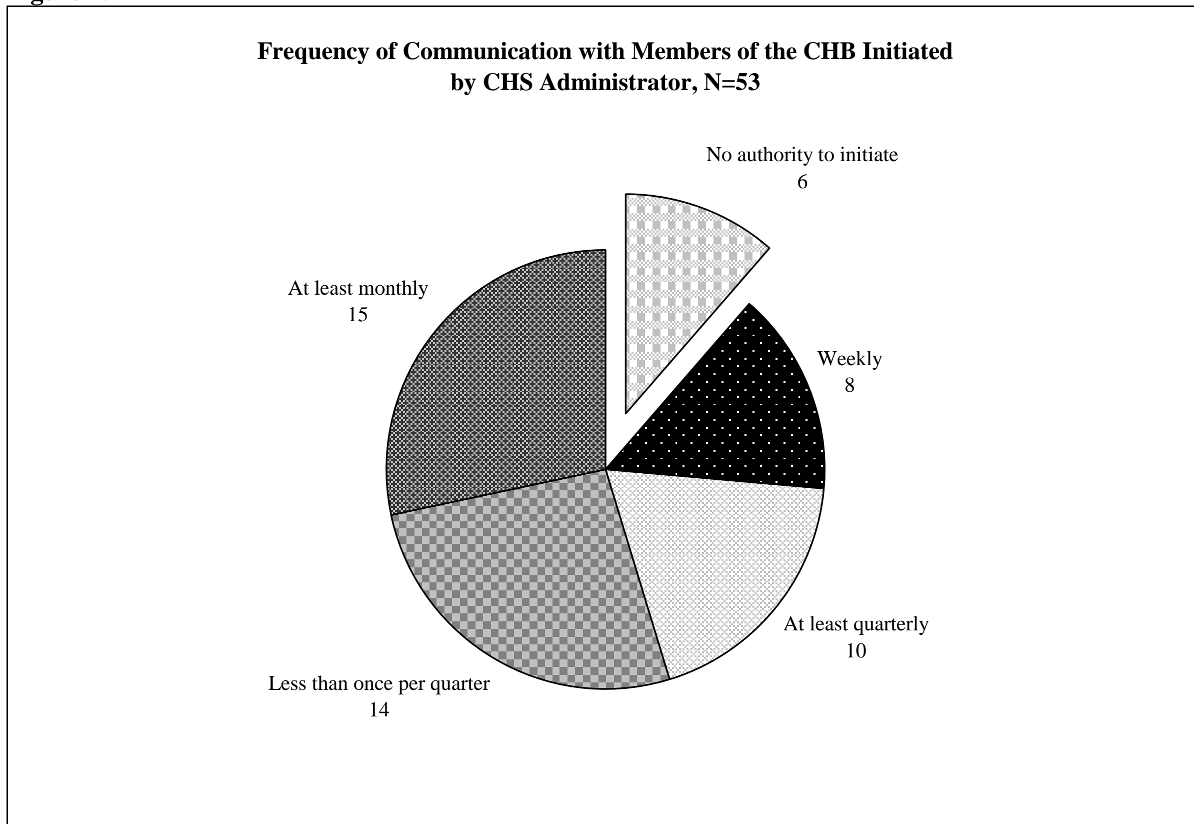
PH Activity	N (%) with High Desire
Evaluation/Performance Improvement	30 (58)
Policy/Plan Development	18 (35)
Leadership	8 (16)
Administration/Governance	10 (19)
Program Management, Coordination, Oversight	1 (2)
Providing Direct Services (to individuals)	0 (0)

CHS administrators overwhelmingly report having desirable authorities. However, a notable minority of administrators lack some important authorities related to budgeting and CHB communications.

To be effective, CHS administrators need authority, positioning, skills and time to be effective, but this may not always be the case. For example, while almost all CHS administrators report having a lead role in developing initial budget priorities, the route to final approval is highly variable. Some CHS administrators (n= 8, 15%) submit the CHB budget directly to the CHB for approval. Others must seek approval from three or more superiors or committees (n=9, 17%) before a final budget is submitted to the CHB for consideration.

Most CHS administrators report that they have authority to initiate communication with members of the CHB between meetings (n = 47, 89%), however, the frequency of communication ranges from *weekly* to *less than once per quarter* (Figure 1).

Figure 1.



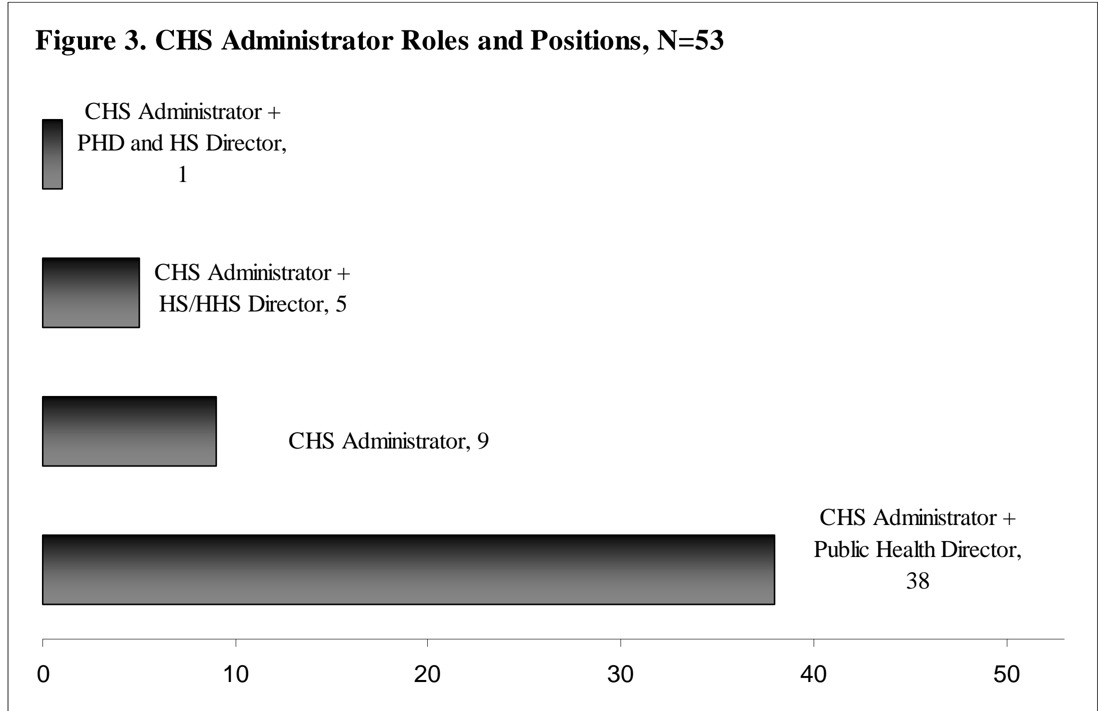
CHS administrators were asked, "In general, how often do you initiative communication with CHB members between meetings? Respondents were asked to include emails, phone calls, and face to face conversations, but not communications for routine tasks such as sending out meeting agendas or minutes. Additionally, it should be noted that most CHS administrators have multiple roles. Three reported that the position of CHS administrator "rotates" in their CHB.

Across the state, CHS administrators in Minnesota have served in their respective positions for an average of 11 years. Administrators from single-county CHBs average nearly 12 years per administrator, approximately two years more than their multi-county counterparts.

Retirement profiles of CHBs are a major concern for the next five to ten years. CHS administrators were surveyed regarding their intention to retire and Table 5 provides a general profile of the impact of these intended retirements over the next five years. Overall, 43% of CHS administrators responded that they plan to retire within five years; however, when broken down by multi-county versus single-county CHB, the impact is greater in the latter (53% vs. 29 %).

Table 5: CHS Administrator Retirement by Expected Date and CHB Type

		CHS Administrators Retiring, N (%)	
CHS Type	**# of CHBs**	**0-5yrs**	**>5yrs**
Multi-county	21	6 (29)	15 (71)
Single-county	32	17 (53)	15 (47)
All	*53*	*23 (43)*	*30 (57)*



It should be noted that near term retirements (within next five years) are not spread evenly across the state. It is likely that some regions won't experience many CHS administrator retirements for several years, while other regions should anticipate significant turnover in administration in the next few years. The pattern of near-term retirements is also different for single and multi jurisdiction CHBs.

One issue regarding CHS administration that the work group was not able to resolve is the title "CHS administrator" itself. Many in the work group found the title to be outdated, in that the term community health services or "CHS" is not often used. Others commented that it has become a meaningless term locally, particularly in single-county CHBs. People in these positions are better known locally by their official title, such as "Public Health Director". Rather than attempt to develop a new title for this mandated role the work group felt that the issue should be looked at again in the future as a part of a reevaluation of a number of local public health titles.

The work group drew upon many external sources to get ideas for ways to strengthen and update the expectations for CHS administrators including, evidence and best practices from the current science and literature; the Core Competencies (appendix B); national public health standards and measures developed by the *PHAB* (appendix C); as well as public health administration models from other states. The influence of these sources can be seen in the position statement and recommendations. Links to these sources and resources are provided in appendix G.

The work group concluded that the CHS administrator is recognized as the designated representative of the CHB. As such they have the authority to coordinate public health activities and lead efforts to meet the performance standards of the local public health system, no matter where they are within their organization.

Integration

LHDs and their CHBs are looking for ways to streamline, economize, improve quality, modernize, and coordinate activities for their communities. Many are considering integrating their public health activities across county borders, or within their jurisdictions.

One of the original foundations of the CHS Act was the concept of an "integrated system". This concept originally referenced performing public health activities or services in tandem versus in isolation.

> *"An integrated system simply implies effective systems of communication, coordination and cooperation in planning and delivery of services. There are a variety of techniques for integrating services, which include information and referral services, formalized coordination, consolidation or merger of independent agencies, and purchase of service contracts. The 'best' integrative technique will of course vary from program to program and from place to place within the state."*
>
> *Warren Lawson, Commissioner of Health*
> *(Written communication, 1974)*

This vision for what was considered "integrated" was limited and focused mainly on removing artificial barriers around programs or services within LHDs. Over the years, the primary focus of local public health in Minnesota has shifted from services provided to individuals (such as home health care) to population-based activities and programs planned and delivered with community partners (such as SHIP). With that in mind, the following question was posed to the work group, *"Is integration still an important foundation of the CHS system, and if so, why?"*

Defining Integration

The consensus of the work group was that integration remains important and relevant to the local public health system. They felt that an updated definition or framework for understanding integration was required. With that in mind, the following definition was developed:

> *Integration is a systematic process of planning, implementing and evaluating delivery systems which share goals and resources. It seeks to improve the quality of population health in the community and to create economies of scale. The outcome of such a process is good quality public health activities provided for the population.*

The reason that the concept of integration is important to the system is that it can help improve the public's health. As previously stated by SCHSAC, the essential local public health activities are "What every Minnesotan should be able to expect from their LHD no matter where in the state they live". In this era of declining resources, delivering some of the essential local public health activities in coordination with other programs or departments may be more cost effective, and efficient. Integration of services may be an important strategy for local public health departments to ensure that the essential local activities are being delivered.

Examples of Integration

As a process, the work group concluded that integration evolves and occurs along a continuum of cooperation striving to achieve balance between breadth (i.e., geographic or jurisdictional) and depth (i.e., programmatic and administrative).

To illustrate this continuum, the work group identified the following types of integration that currently exist in Minnesota's local public health system.

- ***Public Health Service Integration***: when programs or activities are implemented collaboratively through shared staff and/or through shared administrative process, usually with the intent to serve clients in a more comprehensive, convenient and efficient way.

- ***County Interdepartmental Integration***: when departments or divisions within a county (or city) governmental unit work together to achieve an objective.

- ***Inter-organizational Integration*****:** when organizations within a county (or city), not limited to governmental programs, work together to achieve an objective.

- ***Multi-county Integration*****:** when programs or activities are implemented collaboratively across governmental jurisdictions, like within a multi-county CHB or when two or more single county CHBs work together, not limited to public health departments.

- ***Regional Integration****:* an extension of multi-county integration, but defined by the work group as two or more (multi-county) CHBs working together and/or Inter-organizational Integration that goes beyond the county (or city) boundaries.

- ***Community Integration****:* a type of integration that can happen at any or all of the aforementioned levels of integration, but which includes collaboration with non-governmental partners.

In the view of the work group, integration represents the tightest level of cooperation among partners and may even involve some type of formal agreement. Consequently, as one work group member said, "Integration is hard to undo."

Multi-county integration was explored in the CHS administrator portion of the "Top Local Officials" survey. Multi-county CHBs were asked about their level of integration across six key areas: *strategic planning, development of programmatic work plans, CHAAP assessments, CHAAP improvement planning, grant writing, and budgeting*. Greater than 60% of respondents indicated that they 'usually' or 'always' perform CHAAP assessments, CHAAP improvement planning, and grant writing as joint activities. On the other hand, more than 50% of respondents indicated that they 'usually' or 'always' carried out budgeting and development of programmatic work plans as separate activities.

In general, 43% of multi-county CHBs reported high levels of integration in the above mentioned areas and responded that joint activities were 'usually' or 'always' carried out. To

better understand the extent of multi-county integration, CHS administrators of Minnesota's 21 multi-county CHBs were asked rate the extent of joint activity between their local health departments in six key areas (Strategic Planning, Programmatic Workplan Development, Conducting CHAAP Assessments, CHAAP Improvement Plans, Grant writing, and Budgeting). More than half reported that they *always* or *usually* develop program work plans and budgets separately. Joint work was reported most often for CHAAP and grant writing, with more than half reporting that they *usually* or *always* do these activities jointly. In some cases, the level of integration reported was very high. Five multi-county CHS administrators (24%) reported that all six of these activities were *always* done jointly. On the other hand, four (20%) administrators reported that these activities are usually or always done separately.

In reaching this conclusion, the work group made the following observations. First, **integration is not the goal**. Integration is a strategy for achieving the goals of *quality* and *economies of scale.* Given a deliberative and comprehensive approach, integration of systems within public health may create better access, reduce duplication, provide opportunities to increase the expertise, quality and capacity of staff, and help LHDs to get "more bang for their buck".

Deciding to implement an integration strategy **requires careful consideration**. Pre-requisites for successful integration include: support from policy makers; adequate funding and people resources; a shared vision for what the integration effort needs to accomplish; and a clear sense of priorities. Importantly, a strategy, integration is **"a process not a thing"**, and as such it is never truly finished. People who are involved in the process and their relationships are critical to its success.

Additionally, successful integration calls for stakeholders, including policy makers, who can grapple with challenging ideas, and who are committed team players. Further, **successful integration requires leadership,** which requires a clear vision about the shared goals, as well as the skills to lead staff through the transition. Other essential ingredients for integration include interdependence (between the partners), commitment, and shared decision-making.

Finally, because integration is about **doing things in a new way**, it is important that all involved maintain open minds which value creativity, new approaches, and diversity.

It is worth noting that integration has risks and may not be the most appropriate strategy to meet all challenges. It's important to be aware that any of the following can block efforts at successful integration: turf protection; power issues; lack of incentives for all involved; the need for a monumental change; lack of a clear understanding between potential partners; philosophical disagreements; different information systems; and requirements of unions, management, mandates and statutes.

Population-Size Served

The Blueprint work group has focused on the characteristics of successful public health departments in an effort to make recommendations about what LHDs need to consider as they move forward in a resource-limited environment.

The scientific literature strongly suggests that population-size served by a LHD is a strong predictor of performance (i.e., as measured by success the 10 EPHS). The literature shows that LHDs serving 50,000 to 500,000 people perform significantly better on nearly all 10 EPHS compared to their larger and smaller counterparts. The study authors attribute this success to being large enough to achieve some economies of scale; employ enough staff to allow for staff specialization on key public health issues; and have a sufficient population base to provide an adequate local tax base. For more information, and specific citations, see the literature review in appendix H. It should be noted that there are limitations to this research, including that it is not specific to Minnesota. While evidence is currently limited this is an intense area of research that MDH and partners in the public health system will continue to monitor.

Background

The current understanding of the original rationale for setting the population minimum at 30,000 was that MDH and the legislature believed that Minnesotans would be best served by *comprehensive* community health services agencies. To be comprehensive, an agency required sufficient staff and a budget to support them.

Over the years, the CHB landscape has been re-configured in a number of different ways. Multi-county CHBs have broken apart; single county CHBs have joined with neighboring counties; while some other single county organizations have opted to be governed by HSBs (i.e., under MN Statue Chapter 402, HSBs can serve as the CHB). There are multi-county CHBs which are so highly integrated that they function like a single LHD. There are also multi-county CHBs that are integrated in name only, because they have delegated nearly all of their authority and activities back to their individual county members.

Currently, there are 53 CHBs including 28 single county CHBs, 21 multi-county CHBs and four city CHBs. There are currently nine single-county Human Services Boards (HSBs) and one multi-county HSB. Of the 21 multi-county CHBs, 10 report to PPMRS as a combined CHB, while the remaining 11 CHBs report as 31 individual counties.

Minnesota Specific Data

Public health research and other evidence on the impact of population-size on LHD performance are limited. The literature shows that population-size is one of the strongest and most consistent predictors of LHD performance: performance drops off when the population-size served is fewer than 50,000 or more than 500,000.

Minnesota population projections for 2010 suggest that 49% (26 of 53) CHB's will serve populations of fewer than 50,000 (Table 6). These 26 CHBs serve 16% of Minnesota's total projected 2010 population. Conversely, only one CHB will serve a population greater than 500,000.

Table 6. CHB Jurisdiction-size by Population Categories (N=53)

	2010 Projection	2020 Projection
< 50,000	26 (49%)	20 (38%)
50,000 – 500,000	26 (49%)	32 (60%)
> 500,000	1 (2%)	1 (2%)

In 2010, 26 CHBs will serve populations in the optimal performance range of 50,000 to 500,000. By 2020 that number is expected to grow to 32 CHBs, which will be serving 79% of the population of Minnesota. In 2020, it is predicted that four CHBs will continue to serve fewer than 25,000 people. While this can be interpreted as progress in the right direction, it bears mentioning that the optimal population-size noted in the literature refers to LHDs, not CHBs. In a few cases CHBs operate as a single LHD, but in most cases they do not. So it is also important to look at this projected population shifts at the LHD or reporting entity level. Currently, annual reporting in PPMRS is permitted at either the LHD or CHB level, whichever is preferred locally and best reflects the way in which public health activities are carried out. There are currently 73 reporting entities in Minnesota, a combination of LHD and CHBs.

Projections for Minnesota's reporting entities for 2010 indicate that 70% (51 of 73) will have populations of fewer than 50,000 and 21 reporting entities will have populations in the optimal range of 50,000 to 500,000 (Table 7). By 2020, 24 reporting entities will serve fewer than 30,000 people.

Table 7. Reporting Entity Jurisdiction-size by Population Categories (N=73)

	2010 Projection	2020 Projection
< 50,000	51 (70%)	46 (63%)
50,000 – 500,000	21 (29%)	26 (36%)
> 500,000	1 (1%)	1 (1%)

Future population projections appear to show that the population will grow in the twin cities suburbs and the areas surrounding Rochester and St. Cloud. While slow growth or a decline in population is expected in much of western Minnesota and in the urban metro counties. These changes are likely to result in the shifts to more optimally sized CHB's as illustrated above

After having reviewed data and historical information regarding population-size and its impact on performance of public health services the work group members discussed making various types of recommendations. The subsequent discussion revealed the following key insights.

First, some members asserted that changing Minnesota's minimum population requirement for a CHB would result in unproductive debate on the accuracy of "the number" and would distract from productive discussions on how to incentivize and improve performance in local public health departments of all sizes and governance arrangements.

Members agreed that information on the “optimal” size served should be included in discussions among elected officials as they consider making changes to programs, staffing, budgets and structures. The recommendations of this work group need to be framed to help officials understand the potential benefits of striving to achieve the optimal population range of 50,000 to 500,000.

It was pointed out that some small counties (e.g., those with populations below both the CHB minimum and the optimal range) have found unique ways to work with neighboring counties and community organizations that not only enhance their ability to deliver services but also increases the benefit of public funds to more people. This is done through strategic partnerships such as contracts, joint powers agreements, and grant arrangements.

Additionally, with respect to the funding incentives for multi-county CHB’s, the work group suggested adding additional requirements, such as joint work planning and/or joint annual reporting. Such changes would be in line with the original intent of providing funding incentives for integrated programming.

Exemptions to the 30,000 minimum population requirement need to be further qualified and better enforced. Suggestions included asking CHBs to demonstrate stronger integration and collaboration to achieve economies of scale and improved performance; and MDH oversight to ensure that expectations are being met and funds are spent appropriately.

While the work group stopped short of recommending that the minimum population requirement be raised, there was agreement that striving to achieve to serve population of 50,000 to 500,000 was desirable, particularly if it encouraged jurisdictions to work together. While they found the population-size evidence to be compelling, the work group was dissatisfied that the impact of geographic size or distance wasn’t similarly explored in the literature. Some in the work group hypothesized that the benefits of striving to serve larger populations might be mitigated if it required staff or clients to travel long distances.

The Role of MDH

Over the years, MDH has played a significant role in the development of the local public health system. Much of this was accomplished through the MDH's provision of program or initiative-specific development and technical assistance; through consultation on administration; by providing guidelines for conducting a comprehensive community health assessment and action planning process; and through the promulgation and enforcement of rules and regulations for CHBs or LHDs in Minnesota. Other areas of support included providing funding; setting and enforcing standards; and undertaking activities to advance CHS system development through evaluation, policy development, analysis and modification.

In considering the original foundations of the CHS Act, the work group believes that the *role of MDH* must continue to be incorporated as part of any blueprint for future success. They acknowledged that the role has been eroded over time. Two areas where this has been especially evident are in communication with and funding for local public health. While the Local Public Health Act of 2003 provided fewer mandates and less regulation than earlier versions of the Act (widely viewed as improvements), it also provided less funding. Additionally, communication between the partners has become more complicated and less effective over time. The work group affirmed that strong leadership is needed from the MDH in order to better position LHDs in Minnesota to respond in the future. In short, the r*ole of MDH* must be strengthened.

Role of MDH

The work group appreciates the continuing respectful partnership between MDH, CHBs and LHDs, exemplified by the policy work of the SCHSAC. Going forward MDH needs to assure involvement of OPI in internal discussions about proposed state health policy changes and initiatives so that critical consideration of their potential impact on local public health occurs. Such involvement should inform MDH and strengthen OPI to advocate for and educate others within MDH and other state agencies about the work of local public health.

MDH needs to coordinate and assure timely communication to local public health. In addition, local public health needs technical support from MDH through public relations campaigns on the roles and issues critical to public health.

MDH, through OPI can continue to help improve local leadership capacity. The OPI regional public health nurse consultants can assist with the recruitment, hiring, orientation, and training of professionals who are hired to lead local public health departments. OPI can also assist in strengthening local capacity with orientation and public health information updates for elected and appointed officials. These activities are currently offered by OPI, but the work group indicated these are highly valued and needed activities that must be continued.

MDH has a role in assisting LHDs realize high quality public health programs, by providing guidance in planning and assuring timely feedback is given on materials such as reports and plans (i.e., CHAAP).

MDH should continue to advocate for accountability and continuous quality improvement in public health practice by participating in state and national initiatives, such as voluntary national accreditation through PHAB, and the Multi-state Learning Collaborative on Quality Improvement through the Robert Wood Johnson Foundation.

The MDH should improve the collection and dissemination of data back to local public health. The MDH collects a large amount of data from LHDs and CHBs, including but not limited to data collected through the PPMRS. What is currently lacking is:

- Interoperability among reporting systems and requirements of MDH programs;
- Quick turnaround on data submitted by local public health, in the form of local reports presented in formats useful to local public health; and
- Reports on the status of public health in Minnesota based on empirical evidence. Such information regularly needs to be made available for local decision-makers.

APPENDICES

A. Work Group Charge and Membership

B. Selected Tier 3 Core Competencies

C. Selected Public Health Accreditation Standards and Performance Measures

D. "Revisiting the Vision"

E. Local Public Health Governance and Organizational Structures table

F. A Discussion Guide for Exploring Public Health Governance and Structure Change

G. CHS Administration: *What it is and why it matters*

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I. MDH Perspectives on the SCHSAC Blueprint Work Group

J. Revised Recommendation Language for SCHSAC: November 15, 2010

Appendix A: Work Group Charge and Membership

State Community Health Services Advisory Committee
Blueprint for Successful Local Health Departments
Work Group

Charge
This work group will answer the following questions: What makes a strong local public health organization? What factors contribute to its success? How do different "operating environments" (e.g., the unique local mix of politics, finances, personalities and geography) influence public health outcomes for the community? The work group will identify both positive and negative trends in organizational change currently affecting local health departments, and will identify and recommend strategies for maintaining and strengthening public health roles and responsibilities in today's operating environments.

Background
Local public health in Minnesota functions within a wide variety of governance and organizational structures. Most jurisdictions provide public health through the oversight of a CHB; several others function within a human services board. Local public health in some cities/counties is organized as a stand-alone department, and in others is part of a larger department (e.g., human services) or organization (e.g., hospitals). Some local public health departments include two or more counties, while others are comprised of a single county, or even a single city. Operating environments also vary, from those in which public health has a strong presence within its organizational structure (including autonomy, a separate budget, access to the county board, etc.), to those in which public health plays a more limited role.

In 1976, when the Community Health Services Act was passed, a "blueprint" was laid out for local health department and CHB governance and structure. CHBs, and by extension local health departments, were allowed to organize themselves according to certain parameters set by the legislation and with guidance from the Minnesota Department of Health (MDH). This original blueprint represented the best thinking of the time on what would make a strong and successful local public health system. As the system matured, CHBs made adjustments to their public health structures based on the needs and desires, as well as the political and fiscal realities of their communities.

Over the last decade a handful of counties have made changes to their organizational and operating environments that affect local public health, either by merging departments, changing the governance structure, or both. The frequency of this kind of discussion and decision now appears to be increasing as local elected officials look for ways to address significant budget concerns.

Thus far the system has changed in a piecemeal fashion, and without the benefit of clear guidelines (either based on experience or science). This work group seeks to update the blueprint for a strong and successful local health department in Minnesota. It will work to identify the factors which ensure the strength and efficacy of a local health department. The recommendations and products created by this group will be developed through a consensus process and will combine over 30 years of experience with an understanding of the emerging scientific evidence on this topic.

Issues related to governance and organizational structures for public health that may be considered by this work group include:

- Missions, funding, and staffing;
- Leadership and authority;

- Issues posed by potential accreditation (e.g., functions that local health departments will be required to carry out; the voluntary nature of accreditation; what it would mean for some of Minnesota's local health departments to be accredited and others not, etc.);
- 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
- Multi-county, regional and/or other models of shared services.

Methods

- A work group will be convened, with membership representing all types of public health governance and organizational structures currently in Minnesota, including local public health professionals, local elected officials, human services directors, and some members from outside the public health system.

Potential Products

- Recommendations for assuring strong public health roles and responsibilities throughout Minnesota.
- A communications tool (e.g., talking points) for local decision makers.
- Regional workshops for local public health leaders and decision makers.
- A resource packet for local public health leaders of strategies for keeping public health strong in an environment of organizational change.
- A communications plan for disseminating the findings and recommendations of the work group.

Membership

Larry Kittelson, Chair	Mid-State CHB
Elizabeth Auch	Countryside CHB
John Baerg	Watonwan CHB
Ann Bajari	Meeker-McLeod-Sibley CHB
David Benson	Nobles-Rock CHB
Merrilee Brown	Scott CHB
Patricia Coldwell	Association of Minnesota Counties (AMC)
Christopher Dahlberg	Carlton-Cook-Lake-St. Louis CHB
Renee Frauendienst	Stearns CHB
Rachel Green	Quin County CHB
Lester Kachinske	Itasca County Human Services
Karen Main	Goodhue CHB
Susan Morris	Isanti-Mille Lacs CHB
Julie Ring	Local Public Health Association (LPHA)
Diane Thorson	Ottertail CHB

MDH Representative

Pat Adams

Resources

The Community and Family Health Division, Office of Public Health Practice, will provide staff support to this activity.

Appendix B: Selected Tier 3 Core Competencies

Selected Tier 3 Core Competencies

(Finalized by the Council on Linkages Between Academia and Public Health Practice on, May 3, 2010)

Analytic and Assessment Skills
Reviews the health status of populations and their related determinants of health and illness.
Incorporates data into the resolution of scientific, political, ethical and social public health issues.
Policy Development and Program Planning Skills
Decides policy options for the public health organization.
Ensures public health programs are consistent with public health laws and regulations.
Integrates emerging trends of the fiscal, social and political environment in public health strategic planning.
Communication Skills
Ensures that the public health organization seeks input from other organizations and individuals.
Communicates the role of public health within the overall health system.
Cultural Competency Skills
Ensures the consideration of the role of cultural, social and behavioral factors in the accessibility, availability, acceptability and delivery of public health services.
Community Dimensions of Practice Sills
Integrates the role of governmental and non-governmental organizations in the delivery of community health services.
Defends public health policies, programs and resources.
Public Health Sciences Skills
Incorporates the Core Public Health Functions and Ten Essential Services of Public Health in the practice of the public health sciences.
Financial Planning and Management Skills
Leverages the organizational structures, functions, and authorities of local, state, and federal public health agencies for public health program management.
Develops partnerships with agencies at all levels of government that have authority over public health situations.
Manages the implementation of the judicial and operational procedures of the governing body and/or administrative unit that oversees the operations of the public health organization.
Leadership and Systems Thinking Skills
Integrates systems thinking into public health practice.
Resolves internal and external problems that may affect the delivery of essential public health services.
Ensures the management of organizational change.

Appendix C: Selected Public Health Accreditation Standards and Performance Measures

Draft Accreditation Standards and Measures that apply to CHS Administration
Public Health Accreditation Board (PHAB) draft standards, July 16, 2009

Develop and maintain an operational infrastructure to support the performance of public health functions (A1 B).
Maintain socially, culturally and linguistically relevant approaches in agency processes, programs and interventions.
Establish effective financial management systems (A2 B).
Comply with requirements for externally funded programs.
Maintain written agreements with entities providing processes, programs and/or interventions delegated or purchased by the public health agency.
Maintain financial management systems.
Seek resources to support agency infrastructure and processes, programs and interventions.
Maintain current operational definitions and statements of the public health roles and responsibilities of specific authorities (A3 B).
Provide mandated public health operations and services.
Demonstrate that the governing entity complies with regulations regarding governing entities.
Demonstrate evaluation of the agency director by the governing entity.
Provide orientation and regular information to members of the governing entity regarding their responsibilities and those of the public health agency (A4 B).
Provide orientation and regular information to the governing entity regarding the responsibilities of the public health agency.
Provide orientation and regular information to the governing entity regarding their responsibilities.
Serve as a primary resource to governing entities and elected officials to establish and maintain public health policies, practices, and capacity based on current science and/or promising practice (5.1 B).
Monitor public health issues under discussion by governing entities and elected officials
Contribute to the development and/or modification of public health policy by facilitating community involvement and engaging in activities that inform the policy development process
Inform governing entities, elected officials and the public of potential public health impacts (both intended and unintended) from current and/or proposed policies

Appendix D: "Revisiting the Vision"

Revisiting the Vision:
Foundations for Public Health in MN from the 1976 CHS Act
SCHSAC Blueprint Workgroup 9/23/09 Discussion Document

Several key principles or "foundations" of the original CHS Act were identified through a review of historical documents and conversations with several people involved in the early days of CHS.

Community Involvement: In 1976, the discussion was about "Grassroots", or bottom up planning and implementation. An assessment was required to identify *local* needs and priorities. This involved a *health advisory committee* (also a requirement). The advisory committee role and participation was identified in statute with detail provided by a Task Force of SCHSAC. This was, in part, carry-over from Medicare requirements and in part, strong encouragement for locals to identify and engage key *community members* in the process. Once an assessment and proposed plan was completed, public health had to post a *public meeting notice* in the "county newspaper," make copies available for *public review* in the county library, and hold a *public meeting*. Originally, much of this activity was monitored by the MDH District Representative and PHN Consultant.

Local Control: The CHS System was set up to be locally administered meaning the decision-making occurred at a local level, there was local control, and counties could function autonomously. In a 1974 memo during the development of the CHS Act Commissioner of Health Warren Lawson stated:

> "A locally controlled system will require strong and effective local leadership and commitment. There will necessarily be local funds along with the proposed state subsidies and federal assistance. The issue of "how local is local" will arise along with considerations related to the design of administratively efficient and effective service delivery systems. In rural areas, "local" will often mean multi-county or even whole regions. It may at times appear to local officials that there has been a loss of local control rather than a gain. However, economic considerations will require that local communities organize themselves to ensure an adequate tax base and population to have an efficient effective organization which can provide the best preventive and personal health services."

An early document describes very general expectations for program areas provided by sized CHBS in the areas of Administration, Community Nursing Services, Home Health Services, Disease Prevention and Control, Emergency Medical Services, Health Education, and Environmental Health Services. However, decision making about what services and programs would be implemented was clearly a local decision.

Integrated System: Originally, this referred to public health activities, performing in tandem vs. isolation. A memo from Warren Lawson, then Commissioner of Health, states:

> "An integrated system simply implies effective systems of communication, coordination and cooperation in planning and delivery of services. There are a variety of techniques for integrating services which include information and referral services, formalized coordination, consolidation or merger of independent agencies, and purchase of service contracts. The "best" integrative technique will of course vary from program to program and from place to place within the state."

For some, that came to mean integration with other counties as part of a multi-county CHB. For others that were organized as Human Service Boards, that became integration of public health, social services, income maintenance, and mental health to create a "seamless service system" for clients.

(**Note**: The term "partnership" was not included in original documents about the CHS Act; however, the development of SCHSAC – which was included – was intended to establish and maintain effective communication and working relationships between the State and local public health systems.

As many know, before the CHS Act we had over 1,790 local boards of health in MN. Again, there was no way to effectively communicate and coordinate among State and the many local Boards of Health. The Act sought to address not only the inactive Boards of Health but also developing effective systems for communication, coordination, and cooperation.)

Adequate Population Base/ Economies of Scale: As originally proposed, the CHS Act would have required a population base of 50,000 to form a CHB. During the Legislative process the population requirement was reduced to 30,000. The intent was to ensure a population base that was sufficient to support community assessment, public health planning, program evaluation, and to provide services that smaller counties could not or would not support – a presumption of economy of scale.

Funding: Subsidy dollars were available to stimulate formation into CHBs and to add state funding support. The original subsidy formula took into consideration local per capita income; per capita taxable value; and per capita local expenditures for preventive and public health services. It also had a $.25 per capita additional payment for each county in a CHB with more than 50,000 population; and the $5,000 for each county in a multi-county CHB that remains today. The formula was substantially revised at some point after passage.

The intent of those dollars was to have money available to support an infrastructure and some basic public health services across the state.

Role of MDH: 1980 guidelines summarized the role of MDH with respect to the CHS System as carrying out the specific duties defined in statute:

- provide consultation and technical assistance;
- develop guidelines and recommend administrative procedures;
- promulgate regulations to establish standards for training, credentialing and experience requirements for key administrative personnel, a uniform reporting system and a planning process that will encourage full community participation;
- review and act on CHS Plans and revision within 60 days of receipt;
- provide application forms and instructions.

Three additional areas of MDH responsibility were identified as

- financial support (including administration of the CHS Subsidy; special grants; and the incorporation of other federal and state money into the state CHS subsidy to maximize available funding sources for CHS development);
- general standard setting, enforcement authority, and program guidelines
- evaluation of the CHS system, policy development, analysis and modification.

Appendix E: Local Public Health Governance and Organizational Structures table

Local Public Health Governance and Organizational Structures
Current as of November 18, 2010

A: Local Public Health Governance Structures

<table>
<tr><td colspan="3">Single county, city, or county/city Community Health Board (CHB): minimum 30,000 population; the county board assumes the duties of the CHB OR appoints a CHB. (20 CHBs)</td></tr>
<tr><td>Anoka
Becker
Bloomington
Carver
Chisago
Edina
Freeborn</td><td>Goodhue
Hennepin
Kandiyohi
Minneapolis
Mower
Olmsted
Polk</td><td>Ramsey/St. Paul
Rice
Richfield
Sherburne
Washington
Winona</td></tr>
<tr><td colspan="3">Multi-county CHB: joint powers; minimum 30,000 population; the county boards appoint representatives to the CHB. (20 CHBs)</td></tr>
<tr><td>Aitkin-Itasca-Koochiching

Beltrami-Clearwater-Hubbard-Lake of the Woods (North Country)

Big Stone-Chippewa-Lac Qui Parle-Swift-Yellow Medicine (Countryside)

Brown-Nicollet

Carlton-Cook-Lake-St. Louis

Clay-Wilkin</td><td>Cottonwood-Jackson

Dodge-Steele

Fillmore-Houston

Grant-Stevens-Traverse- Pope-Douglas (Horizon) (effective Jan. 2011)

Isanti-Mille Lacs

Kanabec-Pine

Morrison -Todd-Wadena

Kittson-Marshall-Pennington-Red Lake-Roseau (Quin County)</td><td>Le Sueur-Waseca

Lincoln-Lyon-Murray-Pipestone (SWHHS) (effective Jan. 2011)

Norman-Mahnomen

Meeker-McLeod-Sibley

Nobles-Rock

Redwood-Renville</td></tr>
<tr><td colspan="3">Single county Human Services Board (HSB): no minimum population required; assumes the duties of the CHB. (11 HSBs)</td></tr>
<tr><td>Benton
Blue Earth
Cass
Crow Wing</td><td>Dakota
Otter Tail
Scott
Stearns</td><td>Wabasha
Watonwan
Wright</td></tr>
<tr><td colspan="3">Multiple-county HSB: no minimum population required; assumes the duties of the CHB. (1 HSB)</td></tr>
<tr><td colspan="3">Faribault-Martin</td></tr>
</table>

B: Local Public Health Organizational Structures

*** Organized as Human Services Board (per MN Stat Chapter 402)*

Counties/cities organized with stand-alone public health departments: (54 counties, 5 cities)		
Big Stone-Chippewa-Lac Qui Parle-Swift-Yellow Medicine (Countryside) Bloomington Brown Carver Clay Clearwater Cottonwood-Jackson Dodge-Steele Douglas Edina Fillmore Freeborn Houston Isanti	Kanabec Kandiyohi Koochiching Le Sueur Lincoln-Lyon-Murray-Pipestone Norman-Mahnomen Meeker McLeod Minneapolis Mower Nicollet Nobles-Rock Pope Olmsted Otter Tail**	Pennington-Red Lake Polk Ramsey/St. Paul Redwood Renville Rice Richfield Sibley Stevens-Traverse-Grant Todd Wadena Waseca Washington Wilkin Winona
Counties organized with social services and public health as parts of a human services agency (NOTE: these departments may operate jointly or independently): (28 counties)		
Aitkin Anoka Becker** Beltrami Benton** Blue Earth** Carlton Cass Chisago	Cook Crow Wing** Dakota** Faribault-Martin** Goodhue Hennepin Itasca Lake	Mille Lacs (effective Jan. 2011) Morrison Pine St. Louis Scott** Sherburne (effective Jan. 2011) Stearns** Wabasha** Watonwan** Wright**
Counties with a hospital/health care organization contract for public health activities: (5 counties)		
Hubbard Kittson	Lake of the Woods Marshall	Roseau

Appendix F: A Discussion Guide for Exploring Public Health Governance and Structure Change

A Discussion Guide for Exploring Public Health Governance and Structure Change

A Product of the SCHSAC Blueprint for Successful Local Health Departments Work Group

December 11, 2009

The decision to change local public health governance or organizational structure is ultimately a policy change. As such, a thoughtful and comprehensive process for exploring change is needed to inform local decision making.

The purpose of this discussion guide is to assist local elected officials who are considering making a change to the governance and/or organizational structure of the public health department in their jurisdiction. The processes outlined in this document may also be useful to local governments that wish to periodically and proactively review their current public health structure and governance to ensure continued strength.

This discussion guide suggests processes to use in exploring the feasibility and impact of changes on public health. The SCHSAC *Blueprint for Successful Local Health Departments Work Group* approached this issue from a desire to keep public health departments *vibrant* and *successful* no matter how they are locally organized. This discussion guide does not suggest an "ideal" model for governance or structure, nor does it endorse any particular way of delivering public health services.

It should be noted that what is described herein is actually the second step in a larger assessment process. The first step is for local jurisdictions to understand their existing structure and governance and evaluate how well it is currently meeting local identified public health goals and objectives. The Blueprint work group is currently identifying useful evaluation tools and will share information about any promising tools in a forthcoming companion document.

Processes for Exploring Change

The issues that cities and counties in Minnesota face with respect to local governance and structure are not unique to public health or to Minnesota. Two recent Minnesota reports on providing correctional services and social services at the county level touched on these issues, as did a 2009 report by the National Association for Local Boards of Health (NALBOH). These reports include complementary processes for local discussion and decision making, and are summarized below.

As a starting point, the NALBOH report "A Guide for Local Boards of Health Considering the Feasibility of a Consolidation of Independent Local Public Health Jurisdictions" (2009) recommends identifying a contact person whose main responsibility will be to communicate with

all of the stakeholders throughout the process, because "the key to the success of any proposed [change] is the communication process. All parties need to have the same information in order to make rational decisions."

The Minnesota Department of Corrections (DOC), with input from county corrections leaders, recently released a guidebook for Minnesota counties on "The Delivery Systems Change Process" (2008). The guidebook recommends steps for local elected officials to undertake (with the assistance of county staff and other experts) when considering and implementing a change. While correctional services are quite different from public health, they have many structure and governance challenges in common. The steps recommended in the corrections guidebook are summarized in Figure 1.

Figure 1. Steps for considering and implementing change

The decision makers may not perform the work to accomplish these steps, but provide approval, oversight, and guidance:

1. Form an advisory group of key policymakers;
2. Get critical input from key staff and advisory people as well as other counties;
3. **Complete a policy analysis on the impact of a change;**
4. Compare various models of public health department organization;
5. Determine whether a change in the system will make a significant difference;
6. Determine the structure and organization of the new department;
7. Support and take care of staff during organizational change;
8. Dedicate the necessary resources for the project planning and implementation.

Figure 1: Adapted from "The Delivery Systems Change Process" (2008), Minnesota Department of Corrections.

Similarly, the aforementioned NALBOH report recommends "steps to consider", including convening a joint feasibility committee (to include representatives of each board of health and other elected governing bodies to oversee the feasibility study); engaging elected officials early to identify challenges; identifying community resources to assist in undertaking the study; and considering engaging a neutral "third party" to carry out the feasibility study.

Additionally, a report by the Minnesota Association of County Social Service Administrators (MACSSA) "Exploring Voluntary Human Services Multi-County Collaboration: *Guidelines for Counties to Consider*" (2008), offers a simple but analogous process. Since the MACSSA approach was developed by and for local policymakers in Minnesota, it seems particularly applicable to the issue at hand. This four step process for analyzing change is outlined in Figure 2 and explained in detail below.

Figure 2. Process for analyzing change

1. **Define the issues**: be clear and explicit about the reason(s) a change is being considered.
2. **Gather data:** is there data to support making this change?
3. **Develop potential solutions:** consider more than one solution to the stated issue.
4. **Identify evaluation criteria:** identify specific criteria to be used in evaluating the merits of each potential solution.

Figure 2: Adapted from "Exploring Voluntary Human Services Multi-County Collaboration: *Guidelines for Counties to Consider*" (2008), Minnesota Association of County Social Services Administrators (MACSSA).

Process for Analyzing Change

Step 1: Define the issues

What is prompting the city/county to consider a change? It is important to be clear and explicit about the reasons for the change, because doing so allows for better evaluation of whether or not the change is likely to bring about the desired outcomes. Clearly stating and understanding the reasons for change will be helpful in thinking through any possible drawbacks or consequences. Through their discussions, the *Blueprint work group* has generated a list of factors, or "common reasons" that might precipitate considering a change to the way public health is delivered. While this list is not comprehensive, it can provide a starting point for many discussions.

Common reasons for considering a structural or governance change *(may be actual or perceived):*

- ✓ Reduce costs
- ✓ Increase efficiency
- ✓ Eliminate duplication
- ✓ Streamline service delivery
- ✓ Improve quality of services
- ✓ Increase capacity to respond to traditional and emerging health threats
- ✓ Improve ability to meet performance standards
- ✓ Address workforce issues
- ✓ Address changes in jurisdiction population size and demographics

Step 2: Gather data

What data or evidence exists to support the reason(s) identified for change? Try to gather data that is relevant to the issue(s) defined in the previous step. For example, if financial constraints are driving the need for change, a careful study of the public health budget and expenditures, and a comparison with other city/county department budgets should be undertaken.

Learning from other cities/counties provides an important source of evidence. It is a good idea to talk with jurisdictions that have made changes to their structure or governance, as well as those that considered making a change, but decided against it.

Another strategy is to consider contacting content and governance experts for assistance, such as the Minnesota Department of Health - Office of Performance Improvement, the Association of Minnesota Counties (AMC), the Local Public Health Association (LPHA), the National

Association of Local Boards of Health (NALBOH) or others. Such organizations may be able to provide important sources of data, contacts or resources. Contact information for these organizations is listed in the appendix.

Step 3: Develop potential solutions
Once the reasons for seeking change have been clearly articulated and supported with data, then policymakers can turn their attention to generating possible solutions. For example, by talking with a variety of other counties that operate in similar and different structures and governances (as outlined in the previous step) additional options may arise. While it is important to be realistic about what is feasible, it is also important not to hastily disregard any and all possible solutions.

If a workable solution has been identified after a thoughtful and thorough process of *defining the issue*, *gathering data* and *developing other potential solutions* then local policymakers will be ready to proceed to the next step: *identify evaluation criteria*. However, if a solution was selected before working through steps 1, 2, and 3 (above) it will still be valuable to go back and work through that process. Working through the four-step *Process for Analyzing Change* will better position policymakers to evaluate their success. It is important to note that other, better solutions may yet be developed by working though the process; solutions which may better serve the community.

Step 4: Identify evaluation criteria
I*dentifying evaluation criteria means identifying the outcomes that are being sought.* It allows for examination of the relative merits of each of the different potential solutions identified in the previous step. The evaluation criteria selected should also directly relate to the reasons for change defined in the first step. For example, evaluation criteria could include (but are not limited to):

- ✓ Feasibility
- ✓ Sustainability
- ✓ Time
- ✓ Cost benefit
- ✓ Improvements to performance or quality

An additional method for selecting the solution is to engage the advisory group (referenced in Figure 1, step 1) in thinking through the pro's and con's of each potential solution in relation to the city/county's mission, vision and goals; as well as thinking through the priorities and responsibilities, authorities, and mandates of the local public health department.

Discussion Questions

To help facilitate the exploration of structure and governance change and its impact on public health, the *work group* developed a series of discussion questions for local policy makers. It

includes questions applicable to all public health structures, plus additional questions for policymakers considering combining into a multi-county CHB, splitting into a single-county CHB, combining departments within a jurisdiction, or contracting out for public health services.

DISCUSSION QUESTIONS	
For all structures	
Would the proposed organizational structure support the population-based, primary prevention approach of public health?	Understanding a population-based approach is the key to understanding the difference between Public Health, Social Services, and Health Care.
What effect might the proposed change have on the ability of the organization to fulfill mandated population-based public health responsibilities? How will those mandates be met under a new structure?	The mandates and authorities for public health are distinct from those of other locally delivered services.
How will the proposed change affect the community health assessment, prioritization and planning process, including gathering public input and filing reports (as required in statute)?	Conducting community health assessments is a specialized skill of public health professionals. It is required by MN State Statute; failure to meet these requirements can prompt the Commissioner of Health to take away LPH Act Grant funds.
Who will explain, discuss and recommend public health policy to the board?	To have a sufficient understanding of public health policy, special training is required. In particular, an understanding of "population based health" is critical.
How will qualified public health staff be involved to address public health policy issues?	
How might the proposed change affect the existing "state-local partnership" model that exists between MDH and local governments?	
How will the organization apply for public health grants? Who will write the grants?	Specialized knowledge of public health is required in writing successful grants for public health funding.
How will the proposed change affect the management structure? Will the top public health manager be in a position of sufficient authority to allow for effective responses to public health issues? Will that person have the authority to put forward the jurisdiction's position in discussions with MDH?	Is it efficient? Does it make it harder for the board to receive first hand information about public health issues? The public health partnership model works best when that the top county health officer has the expertise and authority to engage in substantive discussions with MDH.
What are the skills, background and training of the director who will oversee public health (e.g., the person who will have budgeting, staffing and the authority to recommend public health policy to the board)?	If they are going to serve as the CHS Administrator they must meet certain qualifications laid out in Minnesota Rules. Regardless, they should be well versed in public health, and skilled in managing across disciplinary boundaries. They should be able to effectively manage diverse and distinct program areas.
What natural collaborations and partnerships are already occurring (e.g., with other counties or between public health and other county/city programs)?	Are these partnerships working? Are they models that could be expanded without a formal reorganization?

DISCUSSION QUESTIONS	
What steps will be taken to foster and support the change and any resulting transitions?	
What is the population size served by your jurisdiction?	Public health systems research suggests that an "optimal" population base for a local health jurisdiction is 50,000 to 500,000. Would the proposed change move the CHB toward that population range? Can providing public health services to a larger or smaller population size (i.e., multi-county) help to achieve economies of scale? Can it achieve economy of scope (increase breadth of operations) more effectively than an internal reorganization?
What impact might the proposed change have on the ability of the CHB to become accredited in the future?	A voluntary national accreditation of state and local health departments will begin in 2011. Financial "incentives" for accreditation are under discussion by national partners (e.g. CDC).
For combining into a multi-county CHB	
How will services be provided in each county? What measures will be put in place to ensure equitable distribution of resources, and what does equitable mean for those counties? Will all services be provided at a multi-county level, or will some be specific to a particular county?	
What are potential disadvantages of combining into a larger jurisdiction? How might these challenges be addressed in the planning phase of the transition?	
Does this structure take into consideration natural partnerships that have developed between counties?	
How will the hiring and supervision of staff be conducted? How will the budget process work?	
How will the joint powers be developed and enforced?	
For separating from a multi-county CHB	
How will services be provided in the county? How will continuity of services be assured? Will any services continue to be provided through collaboration or by another county?	
How will funding be affected? How will combined funds be divided?	
What are the potential disadvantages of becoming a smaller jurisdiction? How might these challenges be addressed in the planning phase of a transition?	
How will relationships and collaborations be maintained, established or reestablished?	

DISCUSSION QUESTIONS

For combining departments within a county/city	
How do the missions of the departments being combined align? How will the mission of public health be maintained? Is the pubic health mission aligned with the mission of the reorganized entity?	Understanding the difference between missions will help explain the tension and competition for approaches and resources. Understanding the differences between primary, secondary and tertiary prevention will also be important.
Is one department likely to emerge as dominant due to budget size, immediacy of need, public engagement or other factors? What mechanisms will be put into place to ensure that the other functions within the department are visible and "have a voice"?	
If the change involves combining with social services, will the merit system of employee pay hinder the county ability to offer competitive wages for nurses?	Many of the Essential Local Public Health Activities (ELAs) are carried out by PHNs around the state. Many LHDs already report difficulty in recruiting and maintaining their PHN staff with future nursing shortages projected. Offering lower wages for nurses may compromise a county's ability to meet the public health mandates and ELAs.
Will you continue to employ a public health director, and what will their required qualifications be?	The literature in this area suggests that the educational background and professional experience of local public health directors and administrators is an important predictor of local health department performance.
What lines of authority are necessary to assure public health core functions are maintained in the jurisdiction	What is the title of the lead public worker? Is it director, manager, supervisor? How does that impact public health's presence with the board?
If your county restructures, what will happen to existing public health staff?	Are there retirement or union contract issues? Are the personnel practices of the two departments the same? If not, how do they differ? Are there differences in wage scales?
For restructuring involving contracting out public health services	
What is the mission of the contracting organization? How does that mission fit with the population-based, primary prevention mission of public health? How will the mission of public health be maintained?	
How will the board assure that all requirements are met?	How will it assure that the ELAs are met? How will it assure that the LPH Act state general funds are expended correctly?
Is the service area of the hospital (or other contractor) the same as the city/county? If not, will public health services be delivered beyond the county border if the hospital service area is broader?	

DISCUSSION QUESTIONS	
Will organizational affiliations affect public health service delivery (e.g., religious affiliation affecting the provision of family planning services)?	
Who makes up the board of directors of the hospital or contracting organization?	What impact might this have on the provision of public health services? Given that organizations select their own boards, what responsibilities will elected officials assume and how?
Are there data practice issues if the agency collecting the data is a public hospital? A private hospital?	

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Appendix G: CHS Administration: *What it is and why it matters*

CHS Administration: *What it is and why it matters*

A background paper prepared for the SCHSAC Blueprint Work Group

Introduction

"What is a CHS administrator?" At first glance, this seems like a simple question with a straightforward answer. Minnesota administrative rules (Minnesota Rule 4736.0110) make it clear that the community health services (CHS) administrator is a required position for community health board (CHB) recipients of the Local Public Health Act[1] grant funds. Additionally, the administrative rules[2] outline the minimum required qualifications and skills of professionals desiring to fill this role. It is a role that has existed in Minnesota's community health services system since its inception in 1976. Yet, the authorities, responsibilities, and qualifications of this role are poorly understood by many, leading some to question the value of the CHS administrator.

The State Community Health Services Advisory Committee (SCHSAC) Blueprint for Successful Local Health Departments work group (2009-2010) was been charged with understanding what makes a "strong" local public health department. They are also interested in ensuring the strength and success of Minnesota's community health services system. The CHS administrator has been an important and longstanding component of Minnesota's local public health system; as such the work group wishes to explore what it should mean to be a CHS administrator as they consider the future of local public health leadership. The purpose of such discussion is to evaluate the role of the CHS administrator and develop a position statement and recommendations for the future. The purpose of this document is to inform that discussion and decision making.

This document describes current models of CHS administration in Minnesota; it shows the variety of models of administration that have evolved from the administrative rules governing the original CHS Act; it highlights some of the ways in which administrators add value to their organizations; and it summarizes the current scientific and national practice literature, competencies and accreditation standards related to public health leadership.

History

The position of CHS administrator goes back to the first set of administrative rules promulgated for CHS in 1976. In fact, the original rules actually outlined seven "key administrative personnel", including the nursing director; the home health services director; the disease prevention and control director; the emergency medical services director; the health education director; the environmental health services director; and the community health services administrator.

> *The position of CHS administrator goes back to the first set of rules promulgated in 1976.*

From the beginning, the CHS administrator role was seen as distinct and important. As evidence of this fact, the personnel rules allowed for a single

individual to perform one or more of those roles, with the exception of the CHS administrator. It is believed that the use of the term "administrator" was selected so that the importance of the role would be seen as equal to that of the county social services administrators.

The rules were contentious when adopted, with some counties balking at the seven required administrative positions. Some elected officials of the time proclaimed "the Act doomed to immediate failure" on the basis that they would not be able to find or pay for the required highly trained personnel. Yet, the original rules stood for over 10 years before being revisited by the SCHSAC *Administrative Rules Subcommittee* in 1988.

It was at this point that the statutory requirements for the other six administrative roles were dropped, though not without controversy. In particular, the decision to drop the requirements for public health nursing directors from the rules proved very contentious. Nevertheless, the role of CHS administrator was still seen as important, and there was agreement in the *subcommittee* that the requirements for that position needed strengthening, but what that meant and how to do was hotly debated.

A review of historical documents shows that the 1988 changes to CHS administrator requirements were basically an update of the original requirements. It does not appear that they were modeled after other states' requirements, national standards or scientific literature.

Initially, the focus of the job was seen as providing visionary leadership and direction for the CHB, as well as for the statewide system.

The meeting minutes of the 1988 subcommittee imply that the group was split. Some members advocated for requiring advanced public health degrees; others emphasized the importance of having a public health nurse (PHN) pointing out the supervisory needs of single county CHBs. Still others argued that any professional experience or training in administration should be considered. One member noted that the public health administration field should be given enough room to "evolve" and argued that overly prescriptive requirements might hinder progress. Some members noted the difficulty in hiring in smaller agencies as evidence for lowering the requirements. Additionally, there was considerable concern that many existing CHS administrators would not meet the minimum requirements; hence the grandfather clause – *stating that the new requirements applied only to those appointed after the new rules were enacted* - was inserted[3].

The draft requirements were put out for public comment through regional meetings, with the end result of lowering the length of required public health experience from the subcommittee's preference for four to six years experience, down to two years experience. After much deliberation on the part of the subcommittee and SCHSAC, and delay on the part of the Minnesota Department of Health (MDH) due to a change in administration and the loss of key staff, the revised rules were finally adopted on March 19, 1994.

According to expert opinion, in the beginning the role of the CHS administrator was viewed as a full time position, which entailed the following responsibilities[4]:

- Planning (i.e., "CHS planning"),

- County commissioner orientation to public health,
- Participation in SCHSAC and SCHSAC work groups;
- Engaging local public health staff in population-based public health activities; and
- Working with MDH.

The focus of the job was seen as providing visionary leadership and direction for the CHB, as well as for the statewide system. Many responsibilities on this list represented new concepts for the time, and consequently represented significantly new ways of doing business for local health departments and CHBs. Many in the system have expressed concern that the role, responsibilities and authorities of the CHS administrator has been diminished over the years.

While the required *qualifications* of the CHS administrator role haven't changed in the last 20 years (since the rules change in the late 1980's) both the role and the field of public health have changed significantly. There are concerns that the required qualification have not kept pace with the demands of the position. A reevaluation of this position is long overdue. The following sections will describe CHS administration as it currently exists and provide evidence and examples that may help in strengthening it.

Qualifications

The following personnel standards for CHS administrators (i.e., list of minimum required qualifications, skills and tasks) are taken directly from Minnesota Administrative Rules 4736.0110 [2]. An administrative rule is a general statement adopted by an agency to make the law it enforces or administers more specific or to govern the agency's organization or procedure. In this case rule 4736.0110 enforces Minnesota statute 145A.09 to 145A.131.

A CHB is required to have a community health services administrator who has:

- A baccalaureate or higher degree in administration, public health, community health, environmental health, or nursing, and two years of documented public health experience in an administrative or supervisory capacity, or be registered as an environmental health specialist or sanitarian in the state of Minnesota and have two years of documented public health experience in an administrative or supervisory capacity;
- A master's or higher degree in administration, public health, community health, environmental health, or nursing, and one year of documented public health experience in an administrative or supervisory capacity; or
- A baccalaureate or higher degree and four years of documented public health experience in an administrative or supervisory capacity.

The documented experience of a community health services administrator must include skills necessary to:

- Direct and implement health programs;
- Prepare and manage budgets;
- Manage a planning process to identify, coordinate, and deliver necessary services;
- Prepare necessary reports;
- Evaluate programs for efficiency and effectiveness;

- Coordinate the delivery of community health services with other public and private services; and
- Advise and assist the community health board in the selection, direction, and motivation of personnel.

MDH, via the regional public health nurse consultants, provides consultation to CHBs and local health departments (LHDs) seeking to hire new CHS administrators (and local health department directors) by assisting them in developing or modifying position descriptions, advertising open positions, and providing assistance in interviewing and candidate selection. The consultation helps to assure that the requirements are understood and that the new CHS administrator meets the requirements. MDH reviews the qualifications of newly hired CHS administrators to ensure that they meet these qualifications.

Longstanding MDH Expectations of CHS Administrators

Assisted by the Public Health Research to Action Network *Survey of Top Local Health Officials* the work group studied the current state of CHS administration in Minnesota and found that responsibilities and authorities of administrators were widely variable across the system and not well documented. They considered this lack of clear expectations problematic. While it has not before been made explicit in a single document, MDH has long held the following expectations for public health leadership (per the Local Public Health Act and the annually signed Assurances and Agreements form).

- Assure that the CHB is meeting the requirements of Minnesota Statute 145A as well as relevant federal requirements;
- Assure that the CHB is meeting the responsibilities outlined in the Assurance and Agreements form (signed and updated annually);
- Be involved in and give input into local and state public health policy development (and national where applicable);
- Communicate public health matters to the board/CHB;
- Coordinate (or assure) the community health assessment and planning process;
- Have oversight and approval of annual reporting for the CHB/member counties;
- Participate in SCHSAC (often as an alternate member) and on SCHSAC work groups;
- Have signature authority for routine matters of the CHB ("agent of the board").

CHS administrators may hold additional responsibilities and authorities due to a variety of outside factors, including but not limited to:

- CHB/LHD organizational structure;
- CHB governance;
- Local decisions;
- Community, and local health department needs;
- Grant requirements; and
- Personality, skills, and interests of individual administrators.

For example, with regard to both the CHB organizational structure, many CHS administrators of single-county CHBs also serve as the public health director or the public health nursing director. In some multi-county CHBs, one of the county directors might also serve as the CHS administrator on either a permanent or rotating basis. Wearing these “dual hats” may result in additional responsibilities, with one role getting short changed if the other requires more time.

In other cases, like some multi-county CHBs, the CHS administrator position may be completely separate from that of the local health directors. The administrator may actually be employed by the CHB rather than a specific county. In such arrangements, the influence or span of control that the CHS administrator has over program decisions and implementation varies. The degree to which these CHS administrators meet with individual county boards (in addition to the CHB) also varies. Many of these examples also illustrate how the CHB’s governance structure can significantly impact a CHS administrator’s responsibilities and authorities.

Another important distinction is that some CHS administrators are filling a “role”, while others are in a “position”.

Another important distinction is that some CHS administrators are filling a “role”, while others are in a “position”. For those in a “position”, a position description exists and details their responsibilities and authorities. Those responsibilities are generally assumed to be a full-time. For those in a “role” the CHS administration functions may be invisible or difficult to tease out from their other job responsibilities. The percentage of their time devoted to administrative issues of the CHB may be small or difficult to enumerate.

The needs and desires of a community can also influence the authority and roles of CHS administrators. For example, there are a few single-county CHBs with combined departments (e.g., health and social services, or health and veterans affairs, etc), who have appointed CHS administrators who are not the top executive over public health in their agency. While they may not be the top appointed public health official within their county, the CHS administrator is recognized as the designated representative of the CHB. As such they have the authority to coordinate public health activities and lead efforts to meet the performance standards of the local public health system, no matter where they are within their organization.

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To help understand the roles and functions of Minnesota’s CHS administrators (and others); the PUBLIC HEALTH RESEARCH TO ACTION NETWORK completed a comprehensive survey of Minnesota’s top local public health officials. Survey findings confirm that the majority of CHS administrators (83 percent) fill multiple roles (see table 1).

Table 1: Descriptive Data on CHS Administrators ***Category***	***Number/Percent***
Total # CHS Administrators	53 (100%)
CHS Administrators with multiple roles	44 (83%)
a. Dual role: CHS Admin + PH Directors	a. 39 (74%)
b. Human Services Directors	b. 5 (9%)
CHS Administrators in single role	9 (17%)

Current Science and Literature
In the late 1980's, when the qualifications for CHS administrator were last updated, there was little to no evidence and few best practices available to guide the work group's recommendations. In the last several years a number of studies have come out identifying the factors that influence the performance of public health departments. Of particular relevance to this discussion are the factors of *public health director qualifications* of and the *use of interdisciplinary management teams*.

With regard to director qualifications, one article identified local public health agency capacity characteristics that are related to their local public health systems' performance scores on the Center for Disease Control and Prevention's (CDC) National Public Health Performance Standards Program assessment instrument. The results showed that having a director with a master's or bachelor's degree and training in public health was more strongly correlated with system performance than other health agency capacities[5].

LHDs often use multidisciplinary top management teams (TMTs) to organize the work of the agency. By "multi-disciplinary" the authors mean drawing from various public health sub-specialties such as health promotion, epidemiology or environmental health, to name a few. One study found that health departments that used TMT performed significantly better. It also showed that the more frequently they met, the better the health department's performance. The findings are partially explained because they have more interaction with the community and have a broader public health expertise to draw from at the decision-making table[6]. The findings of this study are relevant to the practice of CHS administration, in that TMTs parallel the activities and operations of many effective administrators in Minnesota's public health system.

Competencies
While the title "CHS administrator" is unique to Minnesota, the qualifications and experiences outlined by national professional groups and associations can be instructive in evaluating and updating our current administrator qualifications, and can be used to help describe what they do and why it is important to public health.

Development of competencies for public health professionals was stimulated by the release of the Institute of Medicine (IOM) report "The Future of Public Health" in 1988. That report argued that public health will serve society effectively only if a more efficient, scientifically sound system of practitioner and leadership development is established. This call to action spurred groups, like the *National Public Health Leadership Network*, to develop an extensive framework for "Public Health Leadership Competency" in the late 1990's[7]. Over the years that framework has been updated and tailored to different public health disciplines. The most recent and up-to-date iterations are the "Core Competencies for Public Health Professionals" developed by the *Council on Linkages between Academia and Public Health Practice*.

The *Council on Linkages Between Academia and Public Health Practice* adapted the framework to three different "tiers" or levels of professionals. The Tier 3 Core Competencies are the most relevant to this discussion. Tier 3 Core Competencies apply to individuals at a senior/management level and leaders of public health organizations. In general, an individual

who is responsible for the major programs or functions of an organization, setting a strategy and vision for the organization, and/or building the organization's culture can be considered to be a Tier 3 public health professional. Tier 3 public health professionals (e.g., health officers, executive directors, CEOs, etc.) typically have staff that report to them, and are educated at a similar or higher level than their Tier 2 counterparts (e.g., MPH or related degree and have at least five years of work experience in public health or a related field or individuals who do not have an MPH or related degree, but have at least 10 years of experience working in the public health field) [8].

The Core Competencies are categorized into eight domains; under each is a list of expected skills. Only examples most relevant to CHS administration have been provided for each domain. To view the full competency framework, please visit: http://www.phf.org/link/competenciesinformation.htm.

Table 2: Selected Tier 3 Core Competencies
Analytic and Assessment Skills
Reviews the health status of populations and their related determinants of health and illness.
Incorporates data into the resolution of scientific, political, ethical and social public health issues.
Policy Development and Program Planning Skills
Decides policy options for the public health organization.
Ensures public health programs are consistent with public health laws and regulations.
Integrates emerging trends of the fiscal, social and political environment in public health strategic planning.
Communication Skills
Ensures that the public health organization seeks input from other organizations and individuals.
Communicates the role of public health within the overall health system.
Cultural Competency Skills
Ensures the consideration of the role of cultural, social and behavioral factors in the accessibility, availability, acceptability and delivery of public health services.
Community Dimensions of Practice Sills
Integrates the role of governmental and non-governmental organizations in the delivery of community health services.
Defends public health policies, programs and resources.
Public Health Sciences Skills
Incorporates the Core Public Health Functions and Ten Essential Services of Public Health in the practice of the public health sciences.
Financial Planning and Management Skills
Leverages the organizational structures, functions, and authorities of local, state, and federal public health agencies for public health program management.
Develops partnerships with agencies at all levels of government that have authority over public health situations.
Manages the implementation of the judicial and operational procedures of the governing body and/or administrative unit that oversees the operations of the public health organization.
Leadership and Systems Thinking Skills
Integrates systems thinking into public health practice.
Resolves internal and external problems that may affect the delivery of essential public health services.
Ensures the management of organizational change.

Accreditation

The Blueprint work group believes that CHS administrators will have an important role to play in ensuring that local health departments and/or CHBs in Minnesota are prepared for voluntary national accreditation.

> *"The governmental entity that has the primary statutory or legal responsibility for public health in the state, a territory, a tribe, or at the local level is eligible for accreditation."* (PHAB)

The draft standards recently put forth for the voluntary national accreditation program address the issues of leadership and administration in local health departments. The Public Health Accreditation Board (PHAB) states on their Web site, "The governmental entity that has the primary statutory or legal responsibility for public health in the state, a territory, a tribe, or at the local level is eligible for accreditation"[9].

The standards listed in table 3 seem most relevant to the responsibilities of CHS administrators. Most of the list within table 3 is from the standards area on *Administrative Capacity and Governance*; additional relevant standards from other areas also have been included. The work group is not endorsing the draft accreditation standards or recommending that CHBs seek accreditation. They are noting that accreditation will soon be a reality, and it will have implications for Minnesota. Entities that wish to pursue accreditation, should note that Minnesota's mandated minimum qualifications for CHS administrator may not be sufficient.

Table 3: Draft Accreditation Standards that apply to CHS Administration (July 2009 version)

Develop and maintain an operational infrastructure to support the performance of public health functions (A1 B).
Maintain socially, culturally and linguistically relevant approaches in agency processes, programs and interventions.
Establish effective financial management systems (A2 B).
Comply with requirements for externally funded programs.
Maintain written agreements with entities providing processes, programs and/or interventions delegated or purchased by the public health agency.
Maintain financial management systems.
Seek resources to support agency infrastructure and processes, programs and interventions.
Maintain current operational definitions and statements of the public health roles and responsibilities of specific authorities (A3 B).
Provide mandated public health operations and services.
Demonstrate that the governing entity complies with regulations regarding governing entities.
Demonstrate evaluation of the agency director by the governing entity.
Provide orientation and regular information to members of the governing entity regarding their responsibilities and those of the public health agency (A4 B).
Provide orientation and regular information to the governing entity regarding the responsibilities of the public health agency.
Provide orientation and regular information to the governing entity regarding their responsibilities.
Serve as a primary resource to governing entities and elected officials to establish and maintain public health policies, practices, and capacity based on current science and/or promising practice (5.1 B).
Monitor public health issues under discussion by governing entities and elected officials.
Contribute to the development and/or modification of public health policy by facilitating community involvement

and engaging in activities that inform the policy development process.
Inform governing entities, elected officials and the public of potential public health impacts (both intended and unintended) from current and/or proposed policies.

Models from Other States

Looking at the qualifications and requirements for local public health leadership in other states may also be instructive. Six other states' public health leadership qualifications were examined: Colorado, Missouri, New Jersey, New York, North Carolina, and Washington. This was not a comprehensive, nationwide analysis, so it is very difficult to draw conclusions. Nevertheless, the following basic points and comparisons can be made.

Several states top administrative positions specifically required physician candidates. The titles included "Health Officer", "Medical Officer" or "Health Commissioner". While technically these are *top* local (i.e., county) public health officials in these states, the examples are not very relevant to CHS administration, so the second level leadership positions from these states were used for comparison.

Four of the six states (CO, NJ, NY, NC) have a minimum requirement of a Masters degree in a public health discipline "or related field". One state allows a Masters degree in a "related field" but for those candidates it requires a transcript review to ensure the candidate's program provided training in line with the Core Competencies.

These same four states also require several years experience in a public health related field. The experience requirements varied from two years of "public health practice experience" to "five years (of the past 10) in 'successful and responsible' administrative experience in public health". A few states specifically note the importance of experience in *supervising* public health staff.

A few unique features of individual states include:

- NJ requires licensure (via state exam) for their top administrators, which must be annually maintained through continuing education contact hours.
- NY requires that appointments be approved by the State Commissioner of Health.
- For non-physician directors, CO requires that the county further designate a medical officer (physician) to be contracted or employed by the county.
- WA State does not determine requirements for local health jurisdiction administrators; those decisions are left to the counties.

Missouri's administrator qualifications provide a different example. MO has its own local health department accreditation system. They have three tiers or accreditation levels: *primary* (lowest), *advanced* and *comprehensive* (highest). The tiers correspond to the population-size served by the jurisdiction. The smallest and lowest capacity health departments are "primary". MO has three tiers of administrators, which correspond to these accreditation levels. Comprehensive level administrators are required to have a Masters degree (or higher) and five years of management or administrative experience. Whereas, primary level administrators in the MO system need only have a Bachelor's degree and training and certification in public health administration.

Collaborative Leadership

In addition to drawing upon external sources to gain wisdom for strengthening CHS administration, the work group was asked to consider unique or important characteristics of Minnesota's local public health system. They identified the following characteristics as important to the system: the pre-eminence of "local control"; the state-local public health partnership (in particular, SCHSAC); and the existence of multi-county CHBs.

These characteristics of Minnesota's system have created a particular demand for collaborative leaders. Due to their positioning between MDH and LHDs, CHS administrators often need to function as collaborative leaders.

> Due to their positioning between MDH and local health departments, CHS administrators often need to function as collaborative leaders.

What is collaborative leadership in public health? The *Turning Point National Leadership Development Excellence Collaborative* defines it as, "Leadership shown by a group that is acting collaboratively to solve agreed upon issues. It uses supportive and inclusive methods to ensure that all people affected by a decision are part of the change process. It requires a new notion of power...the more power we share, the more power we have to use." [10]

While it is a relatively new term, *collaborative leadership* is an old concept to public health. Public health touches so many different aspects of life, which require many different people to work together that collaborative leadership is a natural fit for the field. This seems especially true to governmental public health in Minnesota.

Six key practices of collaborative leaders are:

- Assessing the environment for collaboration;
- Developing trust and safety;
- Developing clarity (visualizing and mobilizing);
- Sharing power and influence;
- Mentoring and coaching; and
- Self reflection.

Some of these practices are implicit in the Core Competencies and the National Accreditation Standards, but others, like "developing trust and safety" or "sharing power and influence" are not. Yet these key practices may be as important to *art* of effective CHS administration, as easier to measure skills such as "establish effective financial management systems".

Additionally, these skills are seen as important to establishing the credibility of leaders. When asked to describe what characteristics elected officials find most important in CHS administrators, one county commissioner on the work group explained that his CHS administrator has a lot of trust and credibility with the commissioners in her CHB and that is important to their successful working relationship.

How CHS Administrators Add Value

There are many ways that CHS administrators add value to CHBs, and the local health departments that comprise them. Following are some examples of some of the unique contributions that can be made by full-time CHS administrators.

- Full-time CHS administrators can serve as the lead for grant writing/management and evaluation for the counties in their CHB, because they may have more time to devote to it. If they are from a multi-county CHB, this may reduce the workload on the member county public health directors. Further, they may be able to obtain grants on behalf of the CHB more easily than their individual county members, because they serve larger populations and can reference the specialization of staff from throughout the CHB.

- Because they are accountable to each county that is a member of the CHB, and do not hold the interests of one above another. CHS administrators are in a good position to serve as the lead for public health program and financial accountability. They can assist with the program budgets and work plan development for grants flowing through the CHB, while providing program oversight in the form of budget and program reports of the individual counties for funders. This coordination puts them in an ideal position to serve as point person for annual reporting via the Planning and Performance Measurement Reporting System (PPMRS).

- Not all counties within a CHB have the same capacity (e.g., resources, expertise, staffing) for every public health issue or project. CHS administrators can help increase the capacity of the total agency to meet public health needs by leveraging strengthens in one county to enhance capacity within another county.

- Full time CHS administrators who lead the Community Health Assessment and Action Planning Process (CHAAP) for their CHB are in an ideal position to leverage resources to improve the health of each of their communities. Further, it is anticipated that they will be well positioned to lead efforts to prepare the CHB to meet accreditation standards.

- As the official administrator to the CHB, they may have more direct and regular access to elected officials than their county public health directors have to their county boards. Additionally, they set the CHB agenda, and determine the frequency of meetings. These factors provide them with more opportunities to engage in discussions of local public health policy with the CHB.

- While *nearly* all CHS administrators occasionally attend SCHSAC meetings, and periodically participate in SCHSAC work groups, full-time CHS administrators are typically better represented in these statewide activities. Full time administrators may be able to participate in additional regional groups and task forces, such as the Local Public Health Association, county-based purchasing projects, and Nurse Family Partnership projects. This is likely due to having more time to devote to statewide leadership activities. Such activities allow for them to advocate on behalf of the CHB (and its members) at regional and state levels.

Conclusion

After more than 30 years since passage of the original CHS Act, many aspects of Minnesota's local public health system, like CHS administrators, are still poorly understood leading some to question their value. The SCHSAC Blueprint work group was charged with ensuring the success of LHDs, and the Minnesota public health system, now and for the future. Clarifying the expectations for CHS administrators, as well as strengthening their qualifications, responsibilities and authorities was a priority of the work group.

This document explains the history, and presents the current state of CHS administration. It also shares the sources of evidence used by the work group to inform their decision making on strengthening CHS administration for the future. For their resulting position statement and recommendations on CHS administration, please see the final report of the *SCHSAC Blueprint for Successful Local Health Departments Work Group report* (anticipated autumn 2010).

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Appendix H: Blueprint Work Group Literature Review

Factors Positively Associated with Local Health Department Performance: *SCHSAC Blueprint for Successful Local Health Departments Work Group Literature Review*

May 2009

This literature review was undertaken in spring 2009 to provide background information and evidence to assist the "Blueprint for Successful Local Health Departments SCHSAC Workgroup". In particular, the literature was reviewed for evidence on the factors or features of a local health department (LHD) contribute to improved performance, generally as measured by the 10 Essential Public Health Services (Table 1). Articles were found by conducting a Medline search on the following terms: l*ocal health departments + performance, funding, leadership, management, governance, organizational structures and mission*. No relevant articles were found for "*organizational structures*" or "*mission*". Several review articles were found to be particularly helpful and are frequently mentioned below.

The "predictive" factors are described in more detail below (Table 2). The most consistent and strongest predictors of performance (as measured by the 10 EPHS) are jurisdiction size and expenditures (especially per capita). Funding, particularly locally sourced funding, like local tax levies, have significant impact on LHD performance as does staffing level. Other important, but more limited predictors of performance include the qualifications of LHD directors, the use of management teams, LDH structure (e.g., single county vs. multi-county), and the presence/role of a local board of health and the number and types of partnerships maintained by the LHD.

Several of the authors try to put their study findings into the context of current public health practice in the real world. A common refrain in this body of literature is that the 10 Essential Public Health Services (EPHS) or the National Public Health Performance Standards are useful and reliable ways to measure LHD performance and to compare performance across jurisdictions. As such, most authors studying this area appear strongly in favor of voluntary national accreditation. Some go as far as to say that funding should be linked to accreditation (Levi, 2009). Others point out that some, likely smaller and poorer LHDs, will have difficulty achieving accreditation raising serious questions about their ability to provide the essential public health services to their communities.

It is in this context that the issue of "regionalization" comes up as a strategy in the national public health dialog. Note that "regionalization" is not well defined in the literature. In some states, becoming regionalized is equivalent to MN's current CHS System. In other places regionalization is not systematized, but described more like "marriages of convenience" or a practical way to share resources and de-duplicate services between jurisdictions serving similar geographic areas. One recent paper on the topic, authored by NACCHO (Bernet, 2007), states, "there are no universally accepted standards for the best way to organize the delivery of public health services. Regionalization is one organization structure that may help localities do more with limited budgets."

Aside from emphasizing the importance of accreditation and looking at the possibility of regionalization, the literature offers few specific strategies for improving LHD performance. It is important to note that a limited amount of research exists in this area, making it difficult to reliably compare one study to another and tempting but inappropriate to draw broad conclusions. While all the factors listed below have been found to be "predictive" - correlated or associated - with positive local health department performance, their impact on performance is not uniform. Some factors, like jurisdiction size and expenditures, appear more broadly predictive. Other factors, like partnerships, seem to have more influence on just a few of the 10 EPHS, lending credibility to the argument that there's no silver bullet for improving or predicting LHD performance. LHD performance is appropriately complex, and multifaceted.

Table 1: The Ten Essential Public Health Services

1	Monitor health status to identify community health problems
2	Diagnose and investigate health problems and health hazards
3	Inform, educate and empower people about health issues
4	Mobilize community partnerships to identify and solve health problems
5	Develop policies and plans that support individual and community health efforts
6	Enforce laws and regulations that protect health and ensure safety
7	Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8	Assure a competent public and personal health care workforce
9	Evaluate effectiveness, accessibility and quality of personal and population-based health services
10	Research for new insights and innovative solutions to health problems

Table 2: "Predictive" Factors

Factor	Notes	Citation
Jurisdiction size/population served	▪ Population size served is a consistent predictor across the literature. ▪ LHDs serving populations > 50,000 performed better. ▪ There is a drop off in performance for those serving <25,000 and for those serving >500,000. ▪ Mays review noted it was the "strongest predictor".	Suen, 2004; Erwin review, 2008; Mays, 2006
Expenditures ▪ Total ▪ Per capita ▪ Per staff FTE	▪ Mays noted that spending was "the most consistent" predictor of performance. ▪ Although *total spending* does not appear to be as consistent a predictor as *spending per capita* or *per staff FTE* (i.e., the ratio of LHD annual expenditures to total staff FTEs). ▪ Several studies found that *local* per capita spending was more strongly associated with performance than either state or federal spending (which had smaller positive effects). ▪ Several studies found that *expenditures per capita* were related to higher performance on all of the EPHS. ▪ Several studies found that *expenditures per staff FTE* were related to higher performance on 9 of 10 EPHS.	Erwin review, 2008; Scutchfield, 2004; Mays 2006

Factor	Notes	Citation
Funding ▪ Per capita ▪ Local tax levy	▪ There are very few studies in this area. ▪ One study found that higher *taxes per capita*, a higher *overall tax rate*, and LHDs with a greater percentage of revenue from taxes, along with LHDs that "deficit spend" were all correlated with performance on the 10 EPHS (as measured by the LPH Performance Assessment Instrument). ▪ This study showed that high scoring systems has taxes per capita 38% greater ($9.60) than low scoring systems ($6.96). ▪ The author believes that the relationship between taxes per capita and performance might be explained by the ability to determine use of revenues at the local level (i.e., more flexible than other sources of funding.)	Honore, 2004; Mays, 2004; Erwin review, 2008
Staffing levels	▪ Mays (2006) found that staffing level was positively associated with one EPHS (i.e., #3 - informing and educating the pubic). ▪ Earlier studies found greater overall number of staff and higher staff per population ratios were characteristic of higher performing LHDs.	Erwin review, 2008; Mays, 2006
Director qualifications	▪ Previous studies found higher performance related to the presence of a full time, female director – likely a proxy for the number of directors with PHN degrees. ▪ Scutchfield (2004) found that the highest degree of the health agency director "appeared important" to LHD capacity. ▪ LHDs with directors that had a Master's or Bachelor's (but not doctoral) degrees had significantly higher performance compared to those directors with medical degrees (e.g., MD's). ▪ Interestingly, in this study, a degree or certification in public health was *negatively* associated with performance. The authors speculate this might be explained by the public health specialist's ability to more critically evaluate and rate their system performance.	Erwin, 2008; Scutchfield, 2004
Management team operations	▪ There are few studies comparing management operations to LHD performance. ▪ One study found that LHDs often use multi-disciplinary top management teams (TMTs) to organize the work of the agency. ▪ This study found that the use of TMTs was correlated with performance. ▪ The authors speculate that TMTs improve performance by having more extensive interactions with the community, and having broader PH expertise at the decision making table.	Lovelace, 2001; Erwin 2008

Factor	Notes	Citation
Organizational structure	▪ Mays (2006) found that performance varied widely by the type of governmental structure at the local level with county and combined city-county jurisdictions achieving significantly higher performance (note: MN was included in this study). ▪ They found that multi-county jurisdictions showed lower performance than city-county jurisdictions in the study. ▪ They found that decentralized systems (like MN's) performed better in three EPHS (i.e., health status monitoring, educating the public, workforce development), but performed worse on investigation and research (EPHS # 2 & 10). ▪ No literature was found comparing human service agencies with local health departments or hospital based agencies.	Mays, 2006
Organizational leadership ▪ Board of Health ▪ Governing role of Board	▪ Having a board of health was associated with higher performance in several early studies. One study found that having a board that did not recommend the budget was related to higher performance. ▪ Scutchfield (2004) found that boards of health with governing and policy roles were associated with higher performance, but had the most direct impact on EPHS #4 (mobilize community).	Scutchfield, 2004
Partnerships	▪ The importance of partnerships to LHD performance is noted in several studies. ▪ One study found that LHDs had an average of nine different types of partnerships. ▪ Relationships with universities and partnerships with business showed strong positive associations but with different EPHS. For example, partnerships with universities were associated with EPHS #1, 2, and 6. But, partnerships with business were associated with improved performance on EPHS #7, 8 and 9.	Scutchfield, 2004
Community characteristics	▪ Apart from local spending and funding, community interaction, governance structure and jurisdiction size, one study looked at the community characteristics of **local poverty rate** and **physician-to-population ratio** and found both to be significantly associated with performance. ▪ A review of the literature found that LHDs in communities with greater **economic means**; that had more **partnerships** and **community interaction**; and had **support from local elected officials** generally performed better.	Mays, 2006; Erwin, 2008

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Appendix I: MDH Perspectives on the SCHSAC Blueprint Work Group

MDH's Perspectives on the SCHSAC Blueprint Work Group

Presented at the Community Health Conference on October 2, 2009

We are committed to the partnership process.
The MDH is committed to our state-local partnership process for all issues impacting the CHS system.

- The CHS system itself is specifically designed to *recognize the different needs* of communities around the state and *allow flexibility* to address those needs.
- We will work with our local public health partners to come to consensus on the best solution(s) for the organization and governance of local public health.

We want all Minnesotans to be served by a local health department that carries out the essential local public health activities.
As previously stated by SCHSAC, we want people - *no matter where they live in the state* - to receive the same quality of public health service.

- The growing body of literature on public health systems and services research suggests that performance of essential public health services is tied to a number of characteristics (e.g., population size served, funding, staffing, qualifications of director).
- At MDH, one of our stated values is to "use the best scientific data and methods available to guide our policies and actions to promote healthy living in Minnesota." We believe the work group should strive to incorporate findings from the literature into their work.

We want the public health system to remain strong throughout the state.
MDH has a strong interest in ensuring a robust, statewide local public health infrastructure, which is critical to successfully protecting, maintaining and improving the health of Minnesota residents.

- Because we depend upon local public health, MDH has a keen interest in making sure that structural changes don't weaken public health locally or the system as a whole.
- We would have concerns if restructuring decisions were made: without criteria to ensure that public health is protected; to avoid the statutory requirements of the Local Public Health Act; or made hastily, to relieve current financial pressures, without consideration for the longer term costs of such actions.

We are committed to the Blueprint work group process to undertake an honest and future-oriented exploration of the issues, and to identify needed changes.
Our commitment for this work group - *and for all SCHSAC work groups* - is to have an honest exploration of the issues.

- The continued search for effective and cost efficient ways to provide public health may lead this work group, and by extension SCHSAC, to consider new, more coordinated strategies for operating the CHS system; strategies which ensure that the appropriate mix of skills and services are available across the entire system (and all CHBs).
- We want to garner the group's best thinking and recommendations for actions that will position Minnesota to have a strong local public health system into the foreseeable future.

We predict that public health issues will become more, not less complex.
Looking forward, the practice of public health will likely continue to increase in complexity and scope (e.g., pandemic influenza). This increasing complexity has implications for work group discussions.

We believe that work group's efforts to retool Minnesota's public health system should take into consideration the following:

1) **Local health departments will need diverse and comprehensive leadership, management, and staff and skills.** We envision an evolution towards more comprehensive local health departments that have access to the staff skills necessary to meet accreditation standards and deal with the complex issues they will be called upon to address.
   - The individual in a local jurisdiction with lead responsibility for public health will need: a thorough understanding of the practice of public health and how it is different from the provision of health care or human services; highly developed skill sets that continue to develop to meet new demands; and sufficient authorities to be effective in their position.

2) **Accreditation is on the horizon and we want Minnesota's local health departments well positioned for that future.** We want Minnesota's local health departments to be well positioned to apply for national accreditation if they so choose. To be accredited a local health department will need to be able to document that the essential public health services are being met in their jurisdiction.
   - There is growing consensus in the public health community that administration of future federal funding will be tied to accreditation status in some way. We do not want Minnesota to be at a disadvantage when it comes to funding.

3) **Current trends point toward larger service areas.** The scientific literature suggests that serving a population of 50,000 - 500,000 is the strongest predictor of local health department performance.
   - CHBs may need to reconsider the population base that is sufficient to support a comprehensive local health department, and this may move the system toward larger public health jurisdictions and multi-county CHBs.
   - Multi-county CHBs currently operating primarily as separate local health departments may want to consider new, potentially combined or coordinated ways of operating in the future.

4) **Local public health can play an important role within a reformed health care system.**
   - For the next phase of health reform in Minnesota, the concept of Accountable Care Organizations (ACOs) is being discussed. The idea behind ACOs is to bring providers together, in either a real or a virtually integrated system, to take ownership of the total cost and quality of the care their patients receive.
   - In addition to the ACOs, there is interest in the creation of communities that are accountable for population health. Accountable Health Communities (AHCs) would be geographically defined communities responsible for creating policies, behaviors and structures that support the health of their citizens. AHCs offer a model where ACOs play a vital role in moving health out of the doctor's office and into the community.
   - Thanks to our strong local public health system and investment via the Statewide Health Improvement Program (SHIP), Minnesota is well positioned to create the community partnerships necessary to improve population health outcomes. Accountable Health Communities will deliver on improved health outcomes that will, in turn, create a healthier population, as well as a healthier business environment.

MDH is committed to participating in this discussion as a full and engaged partner. We are committed to the consensus-based, work group process and to thoughtfully considering any recommendations made to the commissioner of health via SCHSAC.

Appendix J: Revised Recommendation Language for SCHSAC: November 15, 2010

Revised Recommendation Language for SCHSAC

On September 29, 2010 the State Community Health Services Advisory Committee (SCHSAC) reviewed and approved the draft report "Updating Minnesota's Blueprint for Public Health" and the seventeen recommendations contained therein. At that meeting, SCHSAC requested that the work group be reconvened for one additional meeting in order to develop a communications plan to ensure distribution of the report to key audiences, including county administrators and human services directors. After the SCHSAC meeting, it became clear that the wording of a few of the approved recommendations were causing confusion and concern.

The Blueprint work group was reconvened for a final time on November 15, 2010. The work group members identified the wording of recommendations #8 and #5 as problematic.

ORIGINAL WORDING: Recommendation #8

In addition to their longstanding roles, CHS administrators should also:

- 8.1: Facilitate or direct joint work planning among the counties within a multi-county CHB and/or within a region;
- **8.2: Participate in the hiring and direction of upper level LHD staff, particularly in multi-county CHBs; and**
- 8.3: Actively engage in succession planning, specifically for the CHS administration role, but also for other leadership positions within the CHB and LHD.

Some found the wording of #8.2 to be heavy handed, and felt that it sounded like the work group was recommending that CHS administrators supervise local public health directors (i.e., county staff), exceeding jurisdictional authority in some cases. Work group members agreed that the intent of this recommendation was for CHS administrators to be a resource to local health departments in the hiring process to help ensure qualified public health leadership at all levels throughout the state. An example given for this recommendation was that a CHS administrator could serve on an interview panel hiring a local public health director. The revised and reordered the recommendation language for #8 is given below.

REVISED WORDING: Recommendation #8

#8: In addition to their longstanding roles, CHS administrators **ideally** should:

- **8.1: Participate in the hiring and direction of upper level LHD staff, particularly in multi-county CHBs;**
- 8.2: Facilitate or direct joint work planning among the counties within a multi-county CHB and/or within a region; and
- 8.3: Actively engage in succession planning, specifically for the CHS administration role, but also for other leadership positions within the CHB and LHD.

There were two general issues of conflict surrounding recommendation #5. Some elected officials expressed that they felt this was more of a mandate than any of the other recommendations put forward by the Blueprint work group. On the other hand some local public health leaders felt that as originally written, the recommendation does not go far enough to ensure a thoughtful and well informed local change process.

ORIGINAL WORDING: Recommendation #5

- Oversight of the local public health system should be strengthened by requiring MDH to review and comment on proposed changes to local public health governance structures. This review is to be prompted by advance notification of proposed structural changes from the CHB to the Department (i.e., requiring formal notification 6 months prior to final board action). As a part of the review, the CHB should be required to provide evidence that the essential local public health activities and statutory requirements will continue to be met under the proposed governance structure. It is further recommended that this be included in the annual Assurances and Agreements form.*

A work group member noted that at the SCHSAC meeting in September there appeared to be broad acceptance of this recommendation, but by the comments made by SCHSAC members during the meeting it seemed that they didn't understand that the recommendation applied only to changes to the CHB (i.e., governance structure changes). It was further noted SCHSAC members seemed to believe that the recommendation included notification of major internal organizational structure changes, and that they supported that broad interpretation.

There was consensus in the work group that "Recommendation #5 is our future; times will get tougher" and that it is needed to ensure the strength and future of public health in this state. It was suggested that the wording be changed to "proposed major changes to local public health governance and organizational structures" and include reference to the existing statute language regarding the conditions for withdrawal or dissolution of a CHB.

While MDH is invested in assuring a strong local public health system in Minnesota, decision making authority ultimately lies with the local board. Additionally, the consultative role of MDH needs to be better emphasized. The work group agreed that while the intent of the recommendation did not need to change, the wording should be clarified. *Note*: The SCHSAC accepted the revised language and added additional clarifying words to recommendation 5.2 at their meeting on December 17, 2010. Those words are in bold below.

REVISED WORDING: Recommendation #5

#5: There are statutory requirements that CHBs must meet, but there is significant local flexibility in how they meet those requirements. The role of MDH is to provide consultation regarding requirements and options and to ensure that statutory requirements are met.

- 5.1: Current state statute (145A.03 subd.3) requires that, "a county of city may withdraw from a joint powers board of health by resolution of its governing body not less than one year after the effective date of the initial joint powers agreement. The withdrawing county or city must notify the commissioner and the other parties to the agreement at least one year before the beginning of the calendar year in which the withdrawal takes effect."
- 5.2: We recommend that CHBs should notify MDH six months prior to any final board action on major governance or organizational structural change **within the CHB or its member counties**.
- 5.3: The annually signed Assurances and Agreements forms should be updated to include this new recommendation.

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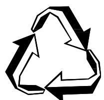

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