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Performance Improvement Steering Committee
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New Local Public Health Act Performance Measures for the Planning and Performance Measurement Reporting System

A Report from the SCHSAC Performance Improvement Steering Committee

September 2012

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Executive Summary

New Local Public Health Act Performance Measures for PPMRS

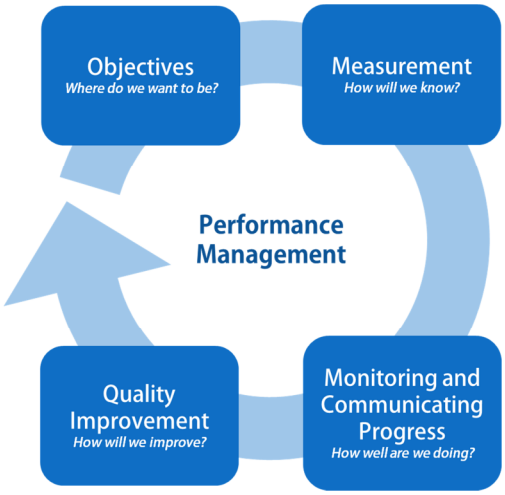
In 2010, the State Community Health Services Advisory Committee recommended substantial changes to Minnesota's local public health improvement system, particularly the Local Public Health Act module of Minnesota's Planning and Performance Measurement System (PPMRS). In essence, SCHSAC recommended aligning with the national standards, developing a performance management system and assisting all community health boards (CHBs) to achieve the national standards.

A new standing committee of SCHSAC—the Performance Improvement Steering Committee—has met monthly since mid-2011 to implement the recommendations and help achieve the vision behind them:

Minnesota's public health system uses performance management for the ultimate purpose of improving and protecting the health of Minnesotans.

The Committee has created a performance management framework and developed new performance measures that align with national standards for state, local and tribal health departments.

Performance Management



This framework is familiar to most public health managers and staff, who routinely set objectives for programs and organizations, and then develop measures to monitor progress and identify improvement opportunities. The Committee has elevated the framework to the system level and moved toward an integrated cycle of performance management that links together components of our current performance improvement system and engages all CHBs in Minnesota.

Local Public Health Act Performance Measures

The Committee focused first on the measurement component of performance management. Preliminary performance measures were developed through a systematic, multi-step process that engaged Minnesota's state and local health leaders; state, regional and local content experts from Minnesota; and state and local public health professionals from Washington State. These performance measures were then strengthened through vetting sessions held during regional meetings of the Minnesota Local Public Health Association. Ultimately, the Committee developed two broad types of performance measures—measures of public health capacity and measures of public health services. These performance measures are organized within Minnesota's six areas of public health responsibility.

Benefits of New Performance Measures and Reporting Processes

More meaningful performance measures will improve the usefulness of reporting for system improvement, communications, accountability, and practice-based research. More coordination within MDH will minimize duplicate reporting and make the most of local public health data already available. Alignment with the Local

Public Health Assessment and Planning Process, and the national public health standards will assist all CHBs in achieving the national standards and minimize duplication for those seeking voluntary national accreditation.

Implementation and Reporting: Implications for Community Health Boards

The measures will phase into the annual reporting cycle of PPMRS beginning in 2013. Webinar trainings and resource materials will facilitate preparation and standardization.

2012

- Participate in training on changes to the performance measures (beginning in the Fall)

2013

- Report on *capacity* measures in the PPMRS Infrastructure Area; includes a subset of 35 measures from the national standards *
- Report on reduced set of current PPMRS measures
- Gather information on public health *services* in 2013 to enable reporting on new measures in 2014 †

2014

- Continue reporting on new capacity measures introduced into the PPMRS Infrastructure Area in 2013 *
- Begin reporting on new measures of public health services †
- Participate in relevant system-wide QI initiative(s)

2015

- Report on more complete set of *capacity* measures *
- Continue reporting on new measures of public health *services* as introduced in 2014 †
- Submit Local Public Health Assessment and Planning deliverables
- Participate in relevant system-wide QI initiative(s)

** These measures will be reported within the assure an adequate local public health infrastructure area of public health responsibility; CHBs will report on the 97 measures of the national standards (PHAB) once every five years; CHBs will report on a subset of those measures (approximately 35) during interim years*

† These measures will be reported within five of the six areas of public health responsibility: promote healthy communities and healthy behaviors; prevent the spread of infectious disease; protect against environmental health hazards; prepare for and respond to disasters and assist communities in recovery; assure the quality and accessibility of health services

A Look to the Future: Next Steps for the Performance Improvement Steering Committee

After the 2013 reporting period (and periodically thereafter), the Committee will gather feedback on the performance measures and reporting processes. The Committee will communicate findings, prioritize and recommend system-level QI initiatives, and incorporate system-level objectives and population health outcomes into the performance management framework. Long term, the Committee aims to (1) compile and integrate data on the resources, capacity, services and outcomes of Minnesota's local public health system, as a crucial step toward understanding the contribution of Minnesota's public health departments toward Minnesota's population health goals; (2) examine emerging issues and monitor trends; (3) retain flexibility to modify the measures; and (4) contribute to practice-based research.

Background

Upon revisions to Minnesota's Local Public Health Act[1] in 2003, the Commissioner of Health sought the input of the State Community Health Services Advisory Committee (SCHSAC) and the Maternal and Child Health Advisory Task Force to develop statewide outcomes for Local Public Health Act funding, and a reporting system to monitor progress and facilitate accountability. In 2005, SCHSAC developed the first set of statewide local public health outcomes, [2] and approved the original set of Local Public Health Act performance measures. A web-based reporting system (the Planning and Performance Measurement Reporting System [PPMRS]) was subsequently implemented in 2006. Together with an annual accountability review process, and guidelines for local public health assessment and planning, these local public health objectives and performance measures comprise Minnesota's local public health performance improvement system.

In February, 2010—in the midst of calls for more accountability and efficiency in governmental services, and in anticipation of the national standards of a voluntary national accreditation program—SCHSAC convened the Performance Improvement and Accreditation (PIA) Work Group. This work group recommended, and SCHSAC approved, substantial system-level changes to the Local Public Health Act module of PPMRS[3] and the other components of Minnesota's public health performance improvement system noted above. In essence, SCHSAC made recommendations to align components of Minnesota's performance improvement system with the national standards, develop a performance management system, and assist all CHBs to achieve the national standards. [4] See Appendix A for the complete list of recommendations. The overall intent of these recommendations is consistent with actions identified through a PPMRS quality improvement project (e.g., enhance use of performance data, minimize duplication and administrative burden of reporting, support documentation for local accreditation, and reinforce a culture of quality).[5]

The SCHSAC Performance Improvement Steering Committee began meeting in mid-2011, and has met monthly for the past year to implement the recommendations and help achieve the vision behind them:

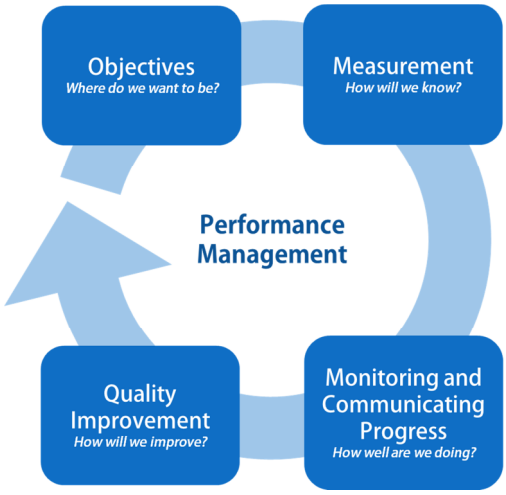
> *Minnesota's public health system uses performance management for the ultimate purpose of improving and protecting the health of Minnesotans.* [6]

Initial work has focused on creating a performance management framework and aligning measures with the national standards. Note that the new measures introduced in this report relate only to the Local Public Health Act module of PPMRS. Other modules of PPMRS (e.g., Family Home Visiting; Policy, Systems and Environmental Change; and Financial) are unaffected and outside the scope of the Committee. The performance measures continue to be organized by Minnesota's six areas of public health responsibility; and provide the basis for the accountability review process specified in Minnesota's Local Public Health Act.

Performance Management

Performance Management uses data for decision-making, by setting objectives, measuring and reporting progress toward those objectives, and engaging in quality improvement activities when desired progress toward those objectives is not being made (See Figure 1).

Figure 1. Minnesota's public health performance management framework



This framework is consistent with the national standards for state, local and tribal health departments. The framework is familiar to most public health managers and staff, who routinely set objectives for programs and organizations, and then develop measures to monitor progress and identify improvement opportunities. The Committee has elevated the framework to the system level and moved toward an integrated cycle of performance management that that links together components of our current performance improvement system and engages all CHBs in Minnesota.

Some components of performance management at the system level are already in place in Minnesota (examples include Local Public Health Act performance measures and statewide local public health objectives) but the Committee has identified important opportunities to improve (e.g., objectives with clearly specified targets, more meaningful measures, more timely feedback that is accessible and useful for decision-making by state and local public health officials and policymakers). The Committee focused initial attention on developing new Local Public Health Act performance measures that align with the national standards. These performance measures will be embedded within this performance management framework and will be used for the purposes of improvement, accountability, communications, and practice-based research.

Development of New Local Public Health Act Performance Measures

The Committee developed the new measures through a multi-step process which included:

- Revising the purpose statement for PPMRS to emphasize system-level improvement related to the national standards (see framed text below);
- Consulting with state and local health officials from Washington State;
- Establishing a sub-committee to consult with the SCHSAC Public Health Emergency Preparedness Workgroup, the MCH Advisory Committee, regional field epidemiologists and district public health nurse consultants, content experts from MDH, and representatives of local public health data user groups;
- Repeatedly reviewing the national standards;
- Developing and applying criteria for final selection of measures; and
- Considering a range of implementation options and reporting scenarios.

The purposes of the local public health PPMRS are to:

- Provide consistent, quality information for ongoing evaluation, state and local decision making and technical assistance for ultimately improving public health performance and people's lives;
- Measure system-level progress toward the national public health standards;
- Describe key aspects of Minnesota's local public health system (e.g., activities, outcomes, funding, staffing, etc.) as determined by the state and local public health departments; and
- Provide accountability for the Local Public Health Act funds, meet LPH Act and federal reporting requirements, and measure local public health departments' contribution to progress on the statewide outcomes.

The Committee developed two broad types of measures—measures of public health *capacity* and measures of public health *services*. The paragraphs below explain the process to develop and implement these measures within the framework of Minnesota's six areas of public health responsibility.

Measures of public health capacity

Measures related to the capacity of community health boards (CHBs) are placed within the infrastructure area of public health responsibility. These measures of capacity were largely adopted from the national standards and measures, [7] but also include some Minnesota-specific measures related to important aspects of public health practice and state statute[8] that are not fully reflected in the national standards. These include measures related to health equity, quality culture, health informatics, workforce competencies, and administration of community health boards.

In the process of developing these capacity measures, the Committee decided that most of the current measures within the Local Public Health Act module of PPMRS are addressed in the national standards, so most current measures in the infrastructure area of responsibility, as well as many current measures in the other areas, could be removed if those national measures were used instead.

The Committee also explored various reporting scenarios, and agreed that there is no need to measure *all* aspects of capacity every year. The Committee developed a set of criteria to determine the subset of measures for annual reporting (see sidebar). These criteria were used to identify 35 measures for reporting in 2013 and 2014.

The Committee recommends the following for phasing in the new capacity measures:

The Committee used criteria to develop measures of local public health *capacity:*

- These measures align with existing Minnesota requirements and are expected of all community health boards.
- These measures track system progress on areas that have been identified for system-wide improvement.
- These measures have the potential to be rapidly changing or dynamic (i.e., anticipate broad changes on these measures across Minnesota's local public health system within a 3-5 year period).
- These measures provide enough information to communicate annually with stakeholders on the work of local public health in Minnesota.
- These measures represent the endpoint (or key step) of a multi-step process.

- Community Health Boards (CHBs) will report annually on some measures of capacity to achieve the national standards for local public health departments.

- In 2015, and every five years thereafter, CHBs will report on all 97 measures within the national standards. This five-year cycle coincides with Minnesota's Local Public Health Assessment and Planning Process.[9]
- In the intervening years of the cycle, and in 2013 and 2014, CHBs will report on a subset of measures within the national standards. This subset will be reviewed and revised as necessary, on a regular basis.

Measures of public health services

Measures related to the public health services of CHBs are organized within the remaining five areas of public health responsibility:

- Promote Healthy Communities and Healthy Behaviors;
- Prevent the Spread of Infectious Disease;
- Prepare For and Respond To Disasters, and Assist Communities in Recovery;
- Protect Against Environmental Health Hazards; [10] and
- Assure the Quality and Accessibility of Health Services.

The term *public health services* is used here to broadly define the full range of local public health activity, including population-focused strategies like policy, systems and environmental (PSE) changes.

Again, the Committee agreed that most current measures within the Local Public Health Act module of PPMRS are addressed in the national standards, so most current measures will be removed from the reporting system. The Committee developed criteria to determine the new service measures for Minnesota's Local Public Health Act (See sidebar).

CHBs will begin reporting on the new service measures in 2014. During the 2013 transition year, CHBs will report on a limited set of the current performance measures.

The committee used criteria used to develop measures of local public health *services*.

- The measures within this area of responsibility reflect important public health services.
- The measures within this area of responsibility represent significant amount of work for staff.
- The measures within this area of responsibility relate to topics addressed by most community health boards in Minnesota.
- It is feasible to develop and/or maintain tracking systems that will enable reporting on these measures.
- The information will be useful for communicating with local stakeholders (i.e. elected officials).
- The information collected through these measures will be useful at the system level.

Vetting process and feedback

Performance Improvement Steering Committee members and staff from the MDH Office of Performance Improvement (OPI) attended regional meetings of the Minnesota Local Public Health Association (LPHA) in July and August 2012 to invite feedback on proposed measures. In addition, LPHA members who were unable to attend a regional vetting session were invited to provide input on the measures in a separately scheduled webinar.

During each session, participants examined the set of measures proposed for each area of public health responsibility and indicated level of agreement (high, moderate, or little to none) with criteria used by the Committee to develop the measures. Overall, participants voiced support for the new measures.

Participants posed many questions and offered suggestions for improvement.

Some comments crossed multiple areas of responsibility, whereas other feedback was more focused on individual areas of responsibility and/or specific measures. Substantive discussion also focused on the implementation of the measures (e.g., timing, training, definitions, reporting processes).

Issues related to rolling out the new measures centered on several specific actions, including:

- Clarify the rationale and provide more direction for the shift to CHB only-reporting; [11]
- Provide definitions and guidance for reporting on all performance measures;
- Clarify how and when data will be shared between program areas within MDH, and how this coordination will minimize duplicative reporting;
- Communicate more clearly on how data collected through the new measures will be made available and used by various audience; and
- Provide training and other resource materials to facilitate preparation and standardization in reporting on the new performance measures.

Vetting participants identified changes for moving, deleting, revising, or re-instating various measures. The Committee carefully considered the suggestions before taking action. Major changes include the addition of two questions of public health services to achieve alcohol-related policy, systems or environmental change, improvements that will increase usefulness of the data (e.g., specifying whether a gap in access to dental health services is evident for both Medicaid and privately insured populations) , and including an opportunity for multi-county CHBs to explain unique local achievements or services that would otherwise be "lost" in reporting at the level of the CHB.

The Committee opted not to pursue all suggestions (e.g., including additional measures related to specific populations or programs, or open-ended comment boxes to capture success stories), and decided to revisit some suggestions in the future (developing a transparent process to guide future changes to the measures, and measuring capacity in relation to major system developments, such as cross-jurisdictional sharing).

The Committee did not seek to create a set of measures that reflects *all* local public health activities. Rather, the Committee applied specific criteria to develop consensus on a set of meaningful measures that could be readily analyzed and used for system improvements. The Committee will revisit these decisions in the context of future feedback and refinements.

Over the course of its work, the Committee also considered, and opted not to pursue alternate reporting systems to obtain data from CHBs on the Local Public Health Act Performance Measures. As new technology and data systems develop, the Committee will examine and pursue opportunities to link into those new systems.

Benefits of New Performance Measures and Reporting Processes

The new measures increase the usefulness of the annual reporting for system improvement, communications, accountability and practice-based research. For example:

- Measures will be used to describe the system, and to identify opportunities for improvements.
- Measures will be more meaningful and relevant to public health officials and policy makers;
- Increased coordination within MDH will draw more heavily on information already collected through routine grant reporting, thereby avoiding duplicate reporting;

- Alignment with the local public health planning and assessment process and the national standards for state, local and tribal health departments will promote quality and reduce duplication for those seeking voluntary national accreditation.

In the past, Local Public Health Act performance measures relied heavily on open-ended narrative questions and check boxes to indicate whether or not a certain service was provided. The narrative items provided a wealth of information, but the qualitative summaries were difficult to analyze for improvement purposes. Emphasis on broad types of services also provided important information, but didn't shed light on specific strategies used or quality of services provided.

The new measures will enable a more systematic understanding of the extent of evidence-based and best practices. The new measures rely much more heavily on a multiple choice format. This more standardized approach will make it much easier to identify and monitor system-level changes, and will enable individual CHBs to more readily compare their services and performance with the state as a whole. The Committee is working toward performance measures that expand beyond the type and amount of public health services to also measure the quality of those services. [12] Ultimately the Committee wants to be able to measure the impact of those services.

Information collected through these measures will be analyzed and communicated in multiple ways. For example, CHBs will receive individualized reports highlighting the responses of each CHB in relation to the state as a whole. Alternatively, statewide reports will feature the percentage of CHBs that fully/partly/don't meet each capacity measure, as well as trends in the percentage of CHBs that are providing particular services.

Implementation and Reporting: Implications for Community Health Boards

The Committee aims to phase and coordinate implementation of reporting on these new measures with other components of a broader performance management system (see Figure 1) and with the ongoing work of CHBs. Webinar trainings and resource materials that include definitions and reporting guidance will facilitate preparation and standardization.

2012

- Participate in training on changes to the performance measures (beginning in the Fall)

2013

- Report on *capacity* measures in the PPMRS Infrastructure Area; includes a subset of 35 measures from the national standards *
- Report on reduced set of current PPMRS measures
- Gather information on public health *services* in 2013 to enable reporting on new measures in 2014 †

2014

- Continue reporting on new capacity measures introduced into the PPMRS Infrastructure Area in 2013 *
- Begin reporting on new measures of public health services †
- Participate in relevant system-wide QI initiative(s)

- continued on next page -

2015

- Report on more complete set of *capacity* measures *
- Continue reporting on new measures of public health *services* as introduced in 2014 †
- Submit Local Public Health Assessment and Planning deliverables
- Participate in relevant system-wide QI initiative(s)

** These measures will be reported within the assure an adequate local public health infrastructure area of public health responsibility; CHBs will report on the 97 measures of the national standards (PHAB) once every five years; CHBs will report on a subset of those measures (approximately 35) during interim years*

† These measures will be reported within five of the six areas of public health responsibility: promote healthy communities and healthy behaviors; prevent the spread of infectious disease; protect against environmental health hazards; prepare for and respond to disasters and assist communities in recovery; assure the quality and accessibility of health services

A Look to the Future: Next Steps for the Performance Improvement Steering Committee

Increased calls for accountability and a culture of quality improvement lead us to maximize use of available local data to strengthen the public health infrastructure, and improve performance. A complete picture of system performance requires data related to resources, services, capacity, and outcomes. [13]

Substantial local public health data is currently available within MDH. Yet data files are housed in different areas of the department and often not assembled and linked together for a more complete picture. The timing of this alignment with the national standards coincides with a widespread desire to link and maximize various sources of local data.

After the 2013 reporting period (and periodically thereafter), the Committee will gather feedback on the performance measures and reporting processes. The Committee will also communicate findings, prioritize and recommend system-level QI initiatives, and incorporate system-level objectives and population health outcomes into the performance management framework.

Over the long term, this standing committee of SCHSAC aims to

- Compile and integrate data on the resources, capacity, services and outcomes of Minnesota's local public health system, as a crucial step toward understanding the contribution of Minnesota's public health departments toward Minnesota's population health goals;
- Strategically examine potential emerging issues and monitor long-term trends in public health resources, capacity, services, performance and outcomes;
- Retain the flexibility to incorporate or modify measures as needed to produce timely, relevant and actionable information that is not available elsewhere; and
- Contribute to practice-based research and evaluation of the financing, organization and delivery of Minnesota's public health services.

Conclusion

The new Local Public Health Act performance measures improve the usefulness of annual reporting. Going forward, measures are more meaningful, draw more heavily on information already available within MDH, and align with the national standards. Information collected through these measures will be analyzed and communicated in multiple ways. Trainings will facilitate preparation and more standardization in reporting. Feedback on the new measures and reporting processes will be gathered through an evaluation conducted after the 2013 reporting period.

Appendix A

Recommendations excerpted from the 2010 SCHSAC report entitled "National Public Health Standards and Voluntary Accreditation: Implications and Opportunities for Public Health Performance Improvement in Minnesota"

System-Level Change

1. Minnesota's state-local partnership should transition the local public health performance improvement system to align with the national standards rather than the essential local public health activities (ELAs).

1.1. SCHSAC should provide oversight and input during the transition to align Minnesota's current performance improvement system with the national standards.

1.2. The six areas of public health responsibility should remain as a framework to describe the work of public health, organize community health assessments and improvement plans; and report planning, staffing, financial and performance data.

1.3. The performance measures used in the local public health reporting system and the key indicators used in the local public health accountability review process should be revised to reflect the national standards and measures rather than the ELAs.

1.4. The PHAB *Local Standards and Measures Self-Assessment Tool* should replace the current capacity assessment in the Community Health Assessment and Action Planning Process (CHAAP).

2. CHBs should complete the PHAB *Local Standards and Measures Self-Assessment*, prioritize areas for improvement, and develop an improvement plan by the end of 2014. This process should engage staff, management, advisory boards and governing entities.

Technical Assistance and Support

3. MDH should develop and implement a plan to help CHBs and MDH improve performance and achieve the national standards.

4. MDH should *lead* outreach to state policy makers and *support* outreach to local policy makers, to educate policy makers on the importance of national standards, performance improvement, and voluntary national accreditation.

Voluntary National Accreditation through the Public Health Accreditation Board

5. MDH should lead the way by preparing for state-level accreditation, and seeking voluntary national accreditation at the earliest opportunity (no later than 2013).

6. MDH and CHBs should work together so that all CHBs are prepared to apply for voluntary national accreditation by 2015.

7. CHBs and local health departments should review their governance and organizational structures, responsibilities, authorities and current legal agreements in relation to the national standards and the voluntary national accreditation program. The MDH Office of Performance Improvement (OPI) should continue to provide information and technical assistance as needed on CHB governance and administration.

8. SCHSAC should convene a work group in 2013 to examine progress on the PIA Work Group's recommendations, assess developments with the voluntary national accreditation program, and revise these recommendations if appropriate.

Appendix B

New Local Public Health Act Performance Measures

In this appendix:

Measures of Public Health Capacity

- Measures from National Standards
- Minnesota-specific measures

Measures of Local Public Health Services

- Promote Healthy Communities and Healthy Behaviors
- Prevent the Spread of Infectious Disease
- Prepare/Respond to Disaster, Assist Communities in Recovery
- Assure the Quality and Accessibility of Health Services

Please note: CHBs already report to MDH on some Local Public Health Act performance measures within three areas of public health responsibility (Promote Healthy Communities and Healthy Behaviors, Prevent the Spread of Infectious Disease, and Prepare/Respond to Disaster, Assist Communities in Recovery). The Office of Performance Improvement will obtain data for those measures directly from those program areas within MDH. This means that *CHBs will not report separately into PPMRS on any measures designated with* **MDH**.

The Committee continues to work on definitions and reporting guidance, which may result in minor changes to refine the measures before training begins in Fall 2012. Any additional questions added prior to the trainings will be considered developmental and initial reporting on them will be optional.

Measures from National Standards

PPMRS Performance Measures of Public Health Capacity – Updated October 2012

The following questions relate to the capacity of the CHB to meet national standards. Therefore, when indicating the appropriate response category, please consider the CHB as a whole. If one LHD within a multi-county CHB was "fully met," but one or more of the LHDs was not, then the CHB would be classified based on the lowest level of capacity (e.g., "partially met" or "not met").

Measure *(PHAB Domain. Standard. Measure)*	**Fully Met**	**Partially Met**	**Not Met**
1. *(1.1.3 A)* Ensure that the community health assessment is accessible to agencies, organizations, and the general public			
2. *(1.2.1 A)* Maintain a surveillance system for receiving reports 24/7 in order to identify health problems, public health threats, and environmental public health hazards			
3. *(1.3.2 L)* Provide public health data to the community in the form of reports on a variety of public health issues, at least annually			
4. *(1.4.2 T/L)* Develop and distribute Tribal/community health data profiles to support public health improvement planning processes at the Tribal or local level			
5. *(2.1.4 A)* Work collaboratively through established governmental and community partnerships on investigations of reportable/disease outbreaks and environmental public health issues			
6. *(2.2.3 A)* Complete an After Action Report (AAR) following events			
7. *(2.4.2 A)* Implement a system to receive and provide health alerts and to coordinate an appropriate public health response			
8. *(3.1.1 A)* Provide information to the public on protecting their health			
9. *(3.1.2 A)* Implement health promotion strategies to protect the population from preventable health conditions			
10. *(4.1.1 A)* Establish and/or actively participate in partnerships and/or coalitions to address specific public health issues or populations			
11. *(5.2.1 L)* Conduct a process to develop community health improvement plan			
12. *(5.2.2 L)* Produce a community health improvement plan as a result of the community health improvement process			
13. *(5.2.3 A)* Implement elements and strategies of the health improvement plan, in partnership with others			
14. *(5.2.4 A)* Monitor progress on implementation of strategies in the community health improvement plan in collaboration with broad participation from stakeholders and partners			
15. *(5.3.1 A)* Conduct a department strategic planning process			
16. *(5.3.2 A)* Adopt a department strategic plan			
17. *(5.3.3 A)* Implement the department strategic plan			
18. *(6.3.4 A)* Determine patterns or trends in compliance from enforcement activities, and complaints			
19. *(7.1.3 A)* Identify gaps in access to health care services			
20. *(7.2.2 A)* Collaborate to implement strategies to increase access to health care services			

Measure *(PHAB Domain. Standard. Measure)*	**Fully Met**	**Partially Met**	**Not Met**
21. *(7.2.3 A)* Lead or collaborate in culturally competent initiatives to increase access to health care services for those who may experience barriers due to cultural, language, or literacy differences			
22. *(8.2.1 A)* Maintain, implement and assess the health department workforce development plan that addresses the training needs of the staff and the development of core competencies			
23. *(9.1.1 A)* Engage staff at all organizational levels in establishing or updating a performance management system			
24. *(9.1.2 A)* Implement a performance management system			
25. *(9.1.3 A)* Use a process to determine and report on achievement of goals, objectives, and measures set by the performance management system			
26. *(9.1.4 A)* Implement a systematic process for assessing customer satisfaction with health department services			
27. *(9.1.5 A)* Provide staff development opportunities regarding performance management			
28. *(9.2.1 A)* Establish a quality improvement program based on organizational policies and direction			
29. *(9.2.2 A)* Implement quality improvement activities			
30. *(10.1.1 A)* Identify and use applicable evidence-based and/or promising practices when implementing new or revised processes, programs and/or interventions			
31. *(11.1.3 A)* Maintain socially, culturally, and linguistically appropriate approaches in health department processes, programs, and interventions, relevant to the population served in its jurisdiction			
32. *(12.2.1 A)* Communicate with the governing entity regarding the responsibilities of the public health department			
33. *(12.2.2 A)* Communicate with the governing entity regarding the responsibilities of the governing entity			
34. *(12.3.1 A)* Provide the governing entity with information about important public health issues facing the health department and/or the recent actions of the health department			
35. *(12.3.3 A)* Communicate with the governing entity about assessing and improving the performance of the health department			

OPTIONAL For Multi-County CHBs: If there is substantial variation in the capacity of individual health departments within your CHB, please use the comment box below to elaborate on those differences.

Minnesota-Specific Measures

PPMRS Performance Measures of Public Health Capacity – Updated October 2012

1. In what skill sets does the CHB workforce have strengths (check all that apply)?

- ❑ Analytical/Assessment
- ❑ Policy development/program planning
- ❑ Communication
- ❑ Cultural Competency
- ❑ Community Engagement
- ❑ Public health sciences (e.g., epidemiology, biostatistics, etc.)
- ❑ Financial planning and management
- ❑ Leadership
- ❑ Informatics

2. In what skill sets does the CHB workforce have gaps (check all that apply)?

- ❑ Analytical/Assessment
- ❑ Policy development/program planning
- ❑ Communication
- ❑ Cultural Competency
- ❑ Community Engagement
- ❑ Public health sciences (e.g., epidemiology, biostatistics, etc.)
- ❑ Financial planning and management
- ❑ Leadership
- ❑ Informatics

3. Check each activity that your CHB has done in the past year (check all that apply):

- ❑ Describing health inequities in your jurisdiction using data
- ❑ Conducting original research that links health to differences in social or environmental conditions
- ❑ Educating elected or appointed officials about health inequities and their causes
- ❑ Training your workforce on health inequities and their causes
- ❑ Recruiting workforce from communities adversely impacted by health inequities
- ❑ Prioritizing resources and programs specifically for the reduction in health inequities
- ❑ Taking public policy positions (through testimony, written statements, media, etc.)
- ❑ Supporting community efforts to change the causes of health inequities
- ❑ None of the above

4. Identify all policy areas through which your CHB has worked on the issue of health inequities in the past year (check all that apply):

- ❑ Environment
- ❑ Land Use
- ❑ Housing
- ❑ Transportation
- ❑ Labor
- ❑ Occupational Health
- ❑ Welfare
- ❑ Food
- ❑ Schools
- ❑ Correctional System
- ❑ Other: _____
- ❑ None of the above

5. **Check each statement that accurately characterizes the status of efforts in your CHB to address health inequities (check all that apply):**
   - ❑ Most staff understands the causes and consequences of health inequities
   - ❑ Administration believes that work on health inequities is beyond our agency mandate
   - ❑ Staff have at least some tools and resources necessary to address health inequities
   - ❑ Dedicated staff focuses on health inequity efforts in our CHB
   - ❑ Health inequity efforts are integrated into the work of many programs
   - ❑ The CHB applied for/received grants to reduce health inequities
   - ❑ None of the above

6. **How does the CHB work with school health (check all that apply)?**
   - ❑ Employ school nurses
   - ❑ Partnership activities
   - ❑ Provide health services in the schools
   - ❑ Conduct trainings for staff
   - ❑ Conduct trainings for students
   - ❑ Consultations
   - ❑ Facilitate or coordinate joint meetings
   - ❑ Provide public health updates/resources
   - ❑ CHB does not partner with school health
   - ❑ Information and referral
   - ❑ Community Crisis Management (e.g., outbreaks)
   - ❑ Wellness activities (e.g., SHIP)
   - ❑ Environmental (e.g., mold, pesticides, lice)

7. **Measures of organizational quality improvement (QI) maturity. Please answer these questions with respect to the CHB for the past year.**

	Strongly Disagree 1	**2**	**3**	**4**	**Strongly Agree 5**	**I don't know**
Staff members are routinely asked to contribute to decisions at my public health agency.						
The *leaders* of my public health agency are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.						
Job descriptions for many individuals responsible for programs and services at my public health agency include specific responsibilities related to measuring and improving quality.						
My public health agency has a quality improvement plan.						
Customer satisfaction information is routinely used by many individuals responsible for programs and services in my public health agency.						
When trying to facilitate change, staff has the authority to work within and across program boundaries.						
The key decision makers in my agency believe quality improvement is very important.						
My public health agency *currently* has a *pervasive culture* that focuses on continuous quality improvement.						

	Strongly Disagree 1	2	3	4	Strongly Agree 5	I don't know
My public health agency *currently* has *aligned our commitment* to quality with most of our efforts, policies and plans.						
My public health agency *currently* has a *high level of capacity* to engage in quality improvement efforts.						

8. **In the current year, which software application will be used for the public health electronic health record? This does not include systems that the state or federal government provide (e.g., MIIC, HuBERT, SSIS) nor does it include Excel, Access, or similar tools. (Please check all that apply.)**
   - ❑ PH-Doc (Public Health Documentation System by MCCC)
   - ❑ Software by CareFacts Information Systems, Inc
   - ❑ Software by CHAMP Software, Inc
   - ❑ Digital Health Department (by Garrison Enterprises, Inc)
   - ❑ Decade (by DECADE Software Company)
   - ❑ Custom-built local system
   - ❑ No electronic system in place
   - ❑ Other

   If other or custom-built local systems please list and briefly explain.

9. **What changes, if any, are you planning for your EHR system within the next 18 months? (Please check all that apply.)**
   - ❑ Assess and plan for a new EHR system
   - ❑ Select and implement a new EHR system
   - ❑ Increase the functional capabilities or use of the EHR system
   - ❑ Electronically exchange health information with another system
   - ❑ No major changes planned to current EHR system
   - ❑ Do not know

10. **Indicate which of the organizational activities relating to informatics your organization has conducted in the last year (check all that apply).**
    - ❑ Review current system and determine information needs of your organization)
    - ❑ Create a strategic direction or plan for public health EHR
    - ❑ Implement a formal project management process (i.e., use of project charter)
    - ❑ Conduct or review security risk analysis information and privacy/confidentiality control in regards to EHR system
    - ❑ Conduct a readiness assessment for exchange (e.g. Public Health Informatics Profile Toolkit)
    - ❑ Other
    - ❑ None

    If other, please explain.

11. Which of the following health information exchange activities are currently used by your local health department to electronically exchange health information (send or receive) with other organizations, assuming appropriate consents have been obtained? (Please check all that apply.)

Health information exchange or HIE means the electronic transmission of health-related information between organizations according to nationally recognized standards. Health information exchange does not include paper, mail, phone, fax, or standard/regular email exchange of information.

Secure messaging is an approach to protect sensitive data using industry standards. It includes security features that go beyond typical email to (1) protect the confidentiality and integrity of sensitive data transmitted between systems or organizations and (2) provides proof of the origin of the data. Secure messages are encrypted bi-directionally and are stored on network or Internet servers that are protected by login. Secure messaging functionality may be integrated with the EHR or maintained in a system separate and distinct from the EHR.

- ❑ Send secure messages or attachments to providers/facilities/organizations (e.g. during referrals, transitions of care)
- ❑ Receive secure messages or attachments from providers/facilities/organizations (e.g. information from specialists, hospitals to whom your patients were referred)
- ❑ Securely query for patient records from providers/facilities/organizations
- ❑ Do not know
- ❑ Do not exchange with other organizations
- ❑ Other

If other, please explain.

12. Does your local health department electronically receive health information with any of the organizations listed below? (Please check all that apply.)

Health information exchange or HIE means the electronic transmission of health-related information between organizations according to nationally recognized standards. Health information exchange does not include paper, mail, phone, fax, or standard/regular email exchange of information.

- ❑ County/city departments/program outside or inside jurisdiction but outside local health department
- ❑ Health or county-based purchasing plans
- ❑ Home Health Agencies
- ❑ Hospitals
- ❑ Jail/Correctional Health
- ❑ Laboratories
- ❑ Local health departments/CHBs outside jurisdiction
- ❑ Long Term Care Facilities
- ❑ Minnesota Department of Health
- ❑ Minnesota Department of Human Services
- ❑ Pharmacies
- ❑ Primary Care Clinics
- ❑ Other
- ❑ Do not electronically receive health information

If other, please explain.

13. Does your local health department electronically send health information with any of the organizations listed below? (Please check all that apply.)

Health information exchange or HIE means the electronic transmission of health-related information between organizations according to nationally recognized standards. Health information exchange does not include paper, mail, phone, fax, or standard/regular email exchange of information.

- ❑ County/city departments/program outside or inside jurisdiction but outside local health department
- ❑ Health or county-based purchasing plans
- ❑ Home Health Agencies
- ❑ Hospitals
- ❑ Jail/Correctional Health
- ❑ Laboratories
- ❑ Local health departments/CHBs outside jurisdiction
- ❑ Long Term Care Facilities
- ❑ Minnesota Department of Health
- ❑ Minnesota Department of Human Services
- ❑ Pharmacies (for e-prescribing)
- ❑ Primary Care Clinics
- ❑ Other
- ❑ Do not electronically receive health information

If other, please explain.

14. From which partners do you have the greatest need to electronically receive health information? (Please check top 5 priorities.)

Health information exchange or HIE means the electronic transmission of health related information between organizations according to nationally recognized standards. Health information exchange does not include paper, mail, phone, fax, or standard/regular email exchange of information.

- ❑ County/city departments/program outside or inside jurisdiction but outside local health department
- ❑ Health or county-based purchasing plans
- ❑ Home Health Agencies
- ❑ Hospitals
- ❑ Jail/Correctional Health
- ❑ Laboratories
- ❑ Local health departments/CHBs outside jurisdiction
- ❑ Long Term Care Facilities
- ❑ Minnesota Department of Health
- ❑ Minnesota Department of Human Services
- ❑ Pharmacies (for e-prescribing)
- ❑ Primary Care Clinics
- ❑ Other
- ❑ Do not electronically receive health information

If other, please explain.

15. To which partners do you have the greatest need to electronically send health information? (Please check top 5 priorities.)

Health information exchange or HIE means the electronic transmission of health related information between organizations according to nationally recognized standards. Health information exchange does not include paper, mail, phone, fax, or standard/regular email exchange of information.

- ❑ County/city departments/program outside or inside jurisdiction but outside local health department
- ❑ Health or county-based purchasing plans
- ❑ Home Health Agencies
- ❑ Hospitals
- ❑ Jail/Correctional Health
- ❑ Laboratories
- ❑ Local health departments/CHBs outside jurisdiction
- ❑ Long Term Care Facilities
- ❑ Minnesota Department of Health
- ❑ Minnesota Department of Human Services
- ❑ Pharmacies (for e-prescribing)
- ❑ Primary Care Clinics
- ❑ Other
- ❑ Do not electronically receive health information

If other, please explain.

16. Indicate the largest challenges related to electronic exchange of health information with outside organizations. (Select up to 3.)

Health information exchange or HIE means the electronic transmission of health related information between organizations according to nationally recognized standards. Health information exchange does not include paper, mail, phone, fax, or email exchange of information.

- ❑ CHB Support
- ❑ Competing priorities
- ❑ Do not know exchange partners' ability to electronically exchange health information.
- ❑ Exchange partners do not have the ability to electronically exchange health information.
- ❑ HIPAA, privacy or legal concerns
- ❑ Inability of our organization's EHR system to generate/receive electronic messages/transactions in standardized format
- ❑ Insufficient information on exchange options available.
- ❑ Lack of or access to technical support or expertise.
- ❑ Limited broadband/Internet access.
- ❑ Subscription rates for exchange services are too high.
- ❑ Unclear value on return on investment (ROI).
- ❑ Other

If other, specify.

If you indicated competing priorities, please briefly list or explain the competing priorities.

17. Does your local health department have a written plan to achieve electronic health information exchange?

- ❑ Yes
- ❑ No

18. Which EHR-related skills and/or roles are in greatest need within your organization? This includes adding new staff or developing the current staff. (Select up to 3.)

- ❑ A person to lead the implementation of an EHR.
- ❑ People to develop and write reports from an EHR.
- ❑ People to help design, maintain and customize an EHR for use in our facility.
- ❑ People to get the EHR ready for use (e.g. entering orders, patient information, etc.).
- ❑ People to manage and process the data, information, and knowledge (e.g. informatics nurse or public health professional).
- ❑ People to train staff on how to use the EHR.
- ❑ Other

If other, specify.

Assure an Adequate Local Public Health Infrastructure CHB Questions

	Yes
19. The composition of the CHB meets the requirements required by Minn. Stat. § 145A.03, subd. 4	
20. The CHB met at least twice during the past year as required by Minn. Stat. § 145A.03, subd. 5	
21. The CHB has in place written procedures for transacting business and has kept a public record of its transactions, findings and determinations as required by Minn. Stat. § 145A.03, subd.5	
22. The CHB has CHS Administrator who meets the requirements of Minn. Rule 4736.0110 (Note: these requirements pertain to CHS Administrators who were appointed after March 21, 1994)	
23. The CHB has a medical consultant in accordance with Minn. Stat. § 1451.10, subd. 3	

24. The CHS Administrator reviewed and assured the accuracy of all reporting related to the Local Public Health Act, Title V and TANF prior to submission:

- ❑ Yes
- ❑ No

OPTIONAL For Multi-County CHBs: If there is substantial variation in the capacity of individual health departments within your CHB, please use the comment box below to elaborate on those differences.

Promote Healthy Communities and Healthy Behaviors

PPMRS Performance Measures of Local Public Health Services – Updated October 2012

Note: CHBs already report to MDH on some Local Public Health Act performance measures within this area of public health responsibility. The Office of Performance Improvement will obtain data for those measures directly from those program areas within MDH. *This means that CHBs will not report separately into PPMRS on any measures designated with* **MDH**.

1. **Please indicate if your CHB was involved in the following initiatives:**
   - ❑ Physical Activity (Community): Enhance infrastructure supporting walking or biking
   - ❑ Physical Activity (Schools): Active School Day/Safe Routes to School (increase opportunities for children to be active)
   - **MDH** Nutrition (Community): Community Healthy Food Environment
   - **MDH** Nutrition (Schools): Restrict availability of unhealthy foods and increase availability of healthy foods in schools

   Checking any of the above Physical Activity initiatives will trigger two additional questions for each initiative; MDH will complete the additional questions for the Nutrition initiatives if appropriate.

1a.For [Name of Initiative], please describe which project tasks your CHB worked on in the past year:

- ❑ Attend trainings
- ❑ Conduct assessments
- ❑ Convene partners or participate in coalitions
- ❑ Develop proposal or policy
- ❑ Engage stakeholders
- ❑ Educate policy makers
- ❑ Implement policy
- ❑ Maintain policy
- ❑ Evaluate policy

1b. For [Name of Initiative], please indicate the funding source:

- ❑ SHIP funding
- ❑ Local tax levy
- ❑ CTG funding
- ❑ Other state or federal funding
- ❑ Grants/foundation funds

2. **What types of tobacco prevention did the CHB work on during the previous year?**
   - ❑ Policy advocacy (e.g., strengthening local ordinances)
   - ❑ Multi-unit housing smoke-free initiatives
   - ❑ Smoke-free campus initiatives
   - ❑ Convene partners or participate in coalitions
   - ❑ Health education messages
   - ❑ Smoke-free advertising at tobacco point of sale
   - ❑ Working on barriers faced by underserved populations to reduce disparities in tobacco use

   When any of the above items are checked, the system will prompt an additional question:

2a. For [Name of Activity], please indicate the funding source:

- ❑ SHIP funding
- ❑ Local tax levy
- ❑ Other state or federal funds
- ❑ Grants/foundation funds
- ❑ CTG funding

3. **What types of alcohol prevention activities did the CHB work on during the previous year?**

- ❑ Policy advocacy (e.g., strengthening local ordinances)
- ❑ Policies to reduce drink specials in bars and restaurants
- ❑ Alcohol compliance checks
- ❑ Beverage server training
- ❑ Alcohol outlet density in the community
- ❑ Social host ordinances
- ❑ Alcohol use at community festivals and county fairs
- ❑ Drinking and driving
- ❑ Convene partners or participate in coalitions
- ❑ Health education messages
- ❑ Working on barriers faced by underserved populations to reduce disparities in alcohol use

When any of the above items are checked, the system will prompt an additional question:

3a. For [Name of Activity], please indicate the funding source:

- ❑ Local tax levy
- ❑ Other state or federal funding
- ❑ Grants/foundation funds

4. **Total unduplicated number of women served at WIC clinics MDH**

5. **Total unduplicated number of infants and children served at WIC clinics MDH**

6. **Please indicate the initiatives your CHB worked on during the past year related to infant mortality reduction and premature birth reduction/prevention (check all that apply):**

Initiatives	Infant Mortality Reduction	Premature Birth Reduction/ Prevention
We used evidence-based home visiting to address these topics		
Population-Based Activities		
Tobacco Cessation classes or interventions		
Pre-conception and inter-conception health promotion through culturally specific outreach and education		
Screen pregnant women for stressful life events (e.g., emotional, financial, partner-related, etc.) and refer to resources as appropriate		

Initiatives	Infant Mortality Reduction	Premature Birth Reduction/ Prevention
Partner with clinics to provide culturally-relevant prenatal care, childbirth and parenting education and support (e.g. Center Pregnancy Program, doulas)		
Folic acid education to all women of childbearing age		
Conduct prenatal or childbirth preparation classes		
Targeted outreach and education to women at high risk for premature birth		
Promote access to health care through policy development		
Promote policies and procedures ensuing first trimester medical visits and regular prenatal care		
Encourage and support women to initiate first trimester prenatal care and receive regular prenatal care		
Screen or maternal drug use and refer to resources as needed		
Discourage elective inductions prior to 39 completed weeks gestation through policy development or community education		
SIDS risk reduction and safe sleep education in hospitals		
SIDS risk reduction and safe sleep education with child care providers		
SIDS risk reduction and safe sleep education at community events		
Shaken Baby Syndrome prevention education		
Secondhand smoke exposure risk reduction and intervention		
Infant injury prevention and home safety education		
Breastfeeding promotion and education with hospitals		
Breastfeeding promotion and education in the community		
Other* If this box is checked, prompts write-in screen		

7. Please indicate the service provided related to Child Care Health and Safety:

- ❑ Technical assistance/consultation to child care providers
- ❑ Education/training to child care providers (individuals/groups)
- ❑ Conduct screenings or children in child care settings (e.g., vision, hearing, developmental, etc.)
- ❑ Consult or educate on topics such as "How to Choose Quality Child Care: to parents, clinic staff, community
- ❑ Participate in meetings or advisory groups at local, county or state level with primary focus on health and safety in child care settings
- ❑ Other: _____

8. Please indicate the services provided related to Developmental Screening:

- ❑ Implement the Follow-Along Program
  If Yes:
  - ❑ **8a.** All (universal) eligible
    Only at-risk eligible
  - ❑ **8b.** ASQ only
    ASQ-SE only
    Both ASQ and ASQ-SE
- ❑ Technical assistance provided to local health care providers on use of standardized screening tools
- ❑ Other: _____

9. Highlight at least one and no more than three programs or accomplishments related to promoting health behavior or community health from the past year. For each activity, please indicate what activities were done, what you achieved (outcomes or impact) and what you learned.

There will be three separate text fields for this question.

Prevent the Spread of Infectious Disease

PPMRS Performance Measures of Local Public Health Services – Updated October 2012

1.

Immunization coverage rates:

Number and percent of children aged 24-35 months who are up-to-date on immunizations **MDH**

2. Please indicate what strategies were used by the CHB to increase immunization rates in the past year:

- ❑ Provide immunizations directly
- ❑ Perform Immunization Practices Improvement (IPI) visits
  If Yes, how many clinics were visited in the past year? _____
- ❑ Educational activities
  If Yes:
  - ❑ **2a. What types of information was provided?**
    College health
    Childhood immunizations
    Hepatitus B
    Influenza outreach
- ❑ School-based clinics
- ❑ Work to increase MN Immunization Information Connection (MIIC) entry by providers

3. Percent of contacts with newly diagnosed latent TB infection who start and complete treatment MDH

4. Percent of refugees and immigrants diagnosed with latent TB infection who complete treatment MDH

5. If your CHB was significantly involved in other infectious-disease related prevention, activities or services, please describe their focus on the following list (check all that apply):

- ❑ Active TB
- ❑ Chlamydia
- ❑ Tickborne Illness
- ❑ Quarantine
- ❑ Pertussis
- ❑ HIV/AIDS
- ❑ Animal Bites
- ❑ Nuisance (lice, bedbugs)
- ❑ Other: _____

*For each topic checked, link to follow-up question:

5a. For [Focus Area], how did you address the issue (please check all that apply)?

- ❑ Attend trainings
- ❑ Conduct assessments
- ❑ Convene partners
- ❑ Participate in coalitions
- ❑ Provide direct services
- ❑ Provide referrals for clients without health insurance
- ❑ Engage stakeholders
- ❑ Educate policymakers
- ❑ Educate public
- ❑ Contract with other entities to provide services

6. **Did you CHB work on infectious-disease prevention, activities or services with a specific population focus?**
   - ❑ Refugee/Immigrant Health
   - ❑ Correctional Health
   - ❑ Urban American Indian/Tribal Health

For Multi-County CHBs

7. **If there is variation in the types of services or activities provided by individual health departments within your CHB, please use the comment box below to elaborate on those differences.**

Prepare/Respond to Disaster, Assist Communities in Recovery

PPMRS Performance Measures of Local Public Health Services – Updated October 2012

Note: CHBs already report to MDH on all but one Local Public Health Act performance measure within this area of public health responsibility. The Office of Performance Improvement will obtain data for those measures directly from the Office of Emergency Preparedness. *CHBs will not report separately into PPMRS on any measures designated with* **MDH**.

1. **Did your CHB respond to a real or potential emergency? MDH**
   - ❑ Yes
   - ❑ No

   If Yes:

   - ❑ **1a. In what area?**
     Infectious Disease Outbreak
     Environmental Health Hazard
     Community Emergency
     Health Care Emergency
     Other: _____
   - ❑ **1b. What was the duration of the response? _____**
     Months/Weeks (please circle)

2. **How many exercises did you conduct or actively participate in during the past year? MDH**
   - ❑ **2a. What was the highest level exercise?**
     Full-scale
     Functional
     Drill
     Tabletop
     Workshop
     Seminar

3. **What percent of partners replied to health alerts sent out by your CHB? MDH**

4. **Which partners have you engaged in the past year (check all that apply)? MDH**
   - ❑ Business
   - ❑ Community Leadership
   - ❑ Cultural and faith-based groups and organizations
   - ❑ Emergency Management
   - ❑ Healthcare
   - ❑ Social Services
   - ❑ Housing and sheltering
   - ❑ Media
   - ❑ Mental and behavioral health
   - ❑ State Office of Aging (or equivalent)
   - ❑ Education and childcare settings

5. **How many improvement plans have come out of the exercises? MDH**

   - ❑ **5a. How many corrective action(s) have been taken? MDH**

For Multi-County CHBs

6. **If there is variation in the types of services or activities provided by individual health departments within your CHB, please use the comment box below to elaborate on those differences.**

Assure the Quality and Accessibility of Health Services

PPMRS Performance Measures of Local Public Health Services – Updated October 2012

1. Identify the major gaps in health care services or barriers to health care access in your community:

Basic Needs	Lack of Providers	Lack of Services
Transportation	Mental health providers	Mental health
Lack of insurance	Adult	Adult
Income	Pediatric	Pediatric
Cultural competency of providers	Chemical health providers	Family planning/STI
Basic life needs	Dental providers	Dental
	MA population	MA population
	Privately insured population	Privately insured population
	Primary care providers	EMS/urgent care
	Specialists	Chemical health
	Public health nurses	Supportive home services
	Other nurses	Jail/correctional health
		Nursing home/assisted living

2. Which gaps in health care access in your community did the CHB address in the past year?

Basic Needs	Lack of Providers	Lack of Services
Transportation	Mental health providers	Mental health
Lack of insurance	Adult	Adult
Income	Pediatric	Pediatric
Cultural competency of providers	Chemical health providers	Family planning/STI
Basic life needs	Dental providers	Dental
	MA population	MA population
	Privately insured population	Privately insured population
	Primary care providers	EMS/urgent care
	Specialists	Chemical health
	Public health nurses	Supportive home services
	Other nurses	Jail/correctional health
		Nursing home/assisted living

* For those items checked in 2, follow-up screen will occur:

2a. For [gap], how did the CHB address that gap in the past year?

- ❑ CHB provided or contracted for services
- ❑ Outreach
- ❑ Health Education
- ❑ Case Management
- ❑ Transportation Assistance
- ❑ Assist in health insurance enrollment/referrals
- ❑ Partner in community efforts to reduce barriers

3. For the following topics, please indicate whether you did the following activities:

	CHB provided or contracted for services	Health insurance routinely assessed	Routine referrals for clients without health insurance	CHB able to report health insurance status
Primary Care – Medical				
Primary Care – Dental				
Licensed Home Care				
Correctional Health				

For Multi-County CHBs

4. If there is variation in the types of services or activities provided by individual health departments within your CHB, please use the comment box below to elaborate on those differences.

Appendix C

Performance Improvement Steering Committee Membership

Membership

Bonnie Brueshoff, Dakota County Human Services Board, Chair
Cindy Borgen, MDH Office of Emergency Preparedness
Susan Brace-Adkins, Goodhue CHB
Dave Brummel, Hennepin County CHB
Deb Burns, MDH Office of Performance Improvement
Dee Finley, MDH Office of Maternal and Child Health
Allie Friedrichs, Meeker-McCloud-Sibley CHB
Cris Gilb, Southwest HHS CHB
Karen Moritz, Brown-Nicollet CHB
Julie Myhre, Carlton-Cook-Lake-St. Louis CHB
Cheryl Schneider, Morrison-Todd-Wadena CHB
Ann Stehn, Kandiyohi CHB
Sandy Tubbs, Horizon CHB
Karen Zeleznak, City of Bloomington CHB

Resources

The MDH Office of Performance Improvement will provide staff support to the Steering Committee.

References

[1]See Minn. Stat. § 145.A available at: https://www.revisor.mn.gov/statutes/?id=145A.131
[2] State Community Health Services Advisory Committee and the Maternal and Child Health Advisory Committee. 2010. Statewide Local Public Health Objectives Work Group. St Paul, MN. Available at: http://www.health.state.mn.us/divs/cfh/ophp/system/schsac/reports/docs/slpowg_finalreport_dec2010.pdf
[3] Note that PPMRS has grown to include several distinct modules related to several major program areas, including home visiting, the MCH Title V block grant, and SHIP. All of the changes to PPMRS noted in this document pertain to the Local Public Health Act module, which includes reporting on financing, staffing, and performance measures organized by the Minnesota's six areas of public health responsibility.
[4]State Community Health Services Advisory Committee. 2010. National public health standards and voluntary accreditation: Implications and opportunities for public health performance improvement in Minnesota. Minnesota Department of Health: St Paul, MN. Available at: http://www.health.state.mn.us/divs/cfh/ophp/system/schsac/reports/docs/piawg_finalreport_dec2010.pdf
[5]*Improving the Planning and Performance Measurement Reporting System (PPMRS)* available at: http://www.phf.org/resourcestools/Documents/Improving_the_Planning_and_Performance_Measurement_Reporting_System.pdf
[6] State Community Health Services Advisory Committee. 2010. National public health standards and voluntary accreditation: Implications and opportunities for public health performance improvement in Minnesota. Minnesota Department of Health: St Paul, MN. Available at: http://www.health.state.mn.us/divs/cfh/ophp/system/schsac/reports/docs/piawg_finalreport_dec2010.pdf
[7] For more information about the national standards for state, local and tribal health departments, or voluntary national accreditation see http://www.phaboard.org
[8]See Minn. Stat. § 145.A available at: https://www.revisor.mn.gov/statutes/?id=145A.131
[9]For more information on Minnesota's Local Public Health Planning And Assessment Process, navigate to http://www.health.state.mn.us/divs/cfh/ophp/system/planning/
[10]The area *Protect Against Environmental Health Hazards* is in development.
[11] In recent years, approximately one half of multi-county CHBs have reported into PPMRS as individual health departments. The MDH Office of Performance Improvement has decided that beginning with 2012 budget reporting, all reporting into PPMRS will by CHB.
[12]*For the Public's Health: The Role of Measurement in Action and Accountability* available at: http://iom.edu/Reports/2010/For-the-Publics-Health-The-Role-of-Measurement-in-Action-and-Accountability.aspx