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Performance Improvement Steering Committee
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Communicating Progress on Minnesota's Local Public Health Act Performance Measures

Data book containing information reported into the Local Public Health Planning and Performance Measurement Reporting System for 2012

October 2013

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A summary of this data book (Communicating Progress on Minnesota's Local Public Health Act Performance Measures: A Summary of System-Level Infrastructure Findings for 2012) is available at www.health.state.mn.us/ppmrs.

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Introduction and Purpose

The Minnesota Department of Health Office of Performance Improvement produced this data book in consultation with the Performance Improvement Steering Committee, a standing committee of the State Community Health Services Advisory Committee (SCHSAC). The purpose of the data book is to monitor and communicate Local Public Health Act data collected through the Local Public Health Planning and Performance Measurement Reporting System (PPMRS). This data book provides system results for the Infrastructure Public Health Area of Responsibility.

Transitioning

In 2010, SCHSAC laid out a framework for performance management in Minnesota's local public health system (**above**). In essence, SCHSAC recommended aligning with national public health standards, developing a performance management system, and assisting all community health boards (CHBs) in achieving the national standards. This resulted in changes to the Local Public Health Act performance measures of PPMRS. New infrastructure measures were introduced in 2013, and new measures for other areas of responsibility will be introduced in 2014.

Notes on Interpretation

The data presented here were reported by Minnesota's 52 CHBs in 2013.[1] The guidance provided for reporting on these measures—including guidance specific to multi-county CHBs—is an important resource for interpreting the data of this report. This guidance is available online at: PPMRS: Help for LPH Act Performance Measures.[2]

There are limitations to the data presented. All reporting is self-reported. In 2013, all CHBs began reporting on new infrastructure performance measures and some multi-county CHBs reported together for the first time. MDH consulted with the committee on training and reporting guidance to ease the transition and standardize reporting. Though this data book represents an important milestone, as CHBs become more familiar with the measures, and more consistently use reporting guidance, MDH can be more confident that findings accurately reflect "true" system capacity. During this transition year, CHBs reported on a limited number of measures in the other five areas of responsibility (Appendix A). Also, a separate report summarizes CHB capacity around health informatics, and is available online at: Minnesota e-Health Assessment Reports, Fact Sheets, and Briefs: Local Public Health.[3]

More About PPMRS

PPRMS aims to describe key aspects of Minnesota's public health system, provide consistent and accurate information that can be used to improve delivery of public health, and provide accountability and meet the reporting requirements of the Minnesota Local Public Health Act.

Assistance

For more information on this report, PPMRS reporting guidance, or data from past years, contact Becky Buhler by phone (651-201-5795) or email (becky.buhler@state.mn.us).

[1] On January 1, 2013, the Redwood-Renville CHB split, Redwood joined Southwest HHS, Renville joined Kandiyohi to become Kandiyohi-Renville, and Polk joined Norman-Mahnomen to become Polk-Norman-Mahnomen. Thus, as of 2013, 50 CHBs exist in Minnesota. However, because reporting that occurred in 2013 was on 2012 data, the CHBs noted above reported as their pre-2013 entities, and thus 52 CHBs reported on 2012 data in 2013.

[2] http://www.health.state.mn.us/ppmrs/resources/performancemeasures/2014.html

[3] http://www.health.state.mn.us/e-health/assessment.html#lhds

Assure an Adequate Public Health Infrastructure (Capacity Measures from National Standards)

Table 1 lists the 35 measures from the national standards that were included in 2013 PPMRS reporting. The **bolded frequencies and counts** represent the response option reported by the largest percentage of CHBs for each measure.

Table 1. Minnesota local public health system ability to meet national standards.

Measure *(PHAB Domain, Standard, Measure)*	Fully Met		Part. Met		Not Met	
	Freq.	Count	Freq.	Count	Freq.	Count
Assess						
1. *(1.1.3 A)* Ensure that the community health assessment is accessible to agencies, organizations, and the general public	**42.3%**	**22**	36.5%	19	21.2%	11
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	38.5%	20	**61.5%**	**32**	0.0%	0
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	40.4%	21	**48.1%**	**25**	11.5%	6
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	**38.5%**	**20**	36.5%	19	25.0%	13
Investigate						
5. *(2.1.4 A)* Work collaboratively through established governmental and community partnerships on investigations of reportable/disease outbreaks and environmental public health issues	**53.8%**	**28**	46.2%	24	0.0%	0
6. *(2.2.3 A)* Complete an After Action Report (AAR) following events	**57.7%**	**30**	38.5%	20	3.8%	2
7. *(2.4.2 A)* Implement a system to receive and provide health alerts and to coordinate an appropriate public health response	**92.3%**	**48**	7.7%	4	0.0%	0
Inform and Educate						
8. *(3.1.1 A)* Provide information to the public on protecting their health	**57.7%**	**30**	40.4%	21	1.9%	1
9. *(3.1.2 A)* Implement health promotion strategies to protect the population from preventable health conditions	**48.1%**	**25**	46.2%	24	5.8%	3
Community Engagement						
10. *(4.1.1 A)* Establish and/or actively participate in partnerships and/or coalitions to address specific public health issues or populations	**73.1%**	**38**	25.0%	13	1.9%	1
Policies and Plans						
11. *(5.2.1 L)* Conduct a process to develop community health improvement plan	32.7%	17	**48.1%**	**25**	19.2%	10
12. *(5.2.2 L)* Produce a community health improvement plan as a result of the community health improvement process	23.1%	12	**51.9%**	**27**	25.0%	13
13. *(5.2.3 A)* Implement elements and strategies of the health improvement plan, in partnership with others	25.0%	13	**40.4%**	**21**	34.6%	18

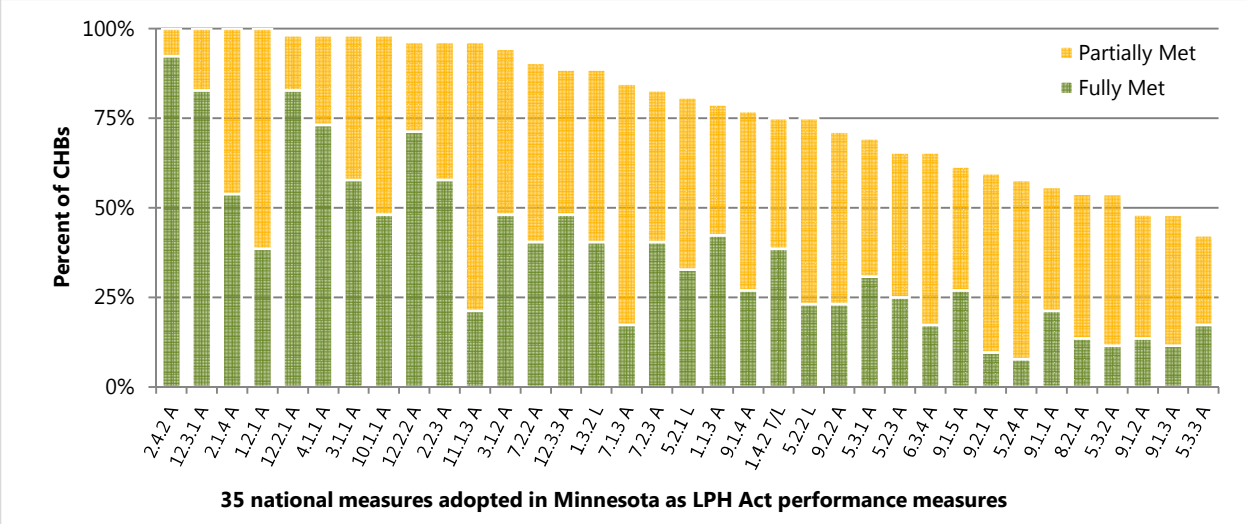
Measure *(PHAB Domain, Standard, Measure)*	Fully Met		Part. Met		Not Met	
	Freq.	Count	Freq.	Count	Freq.	Count
14. *(5.2.4 A)* Monitor progress on implementation of strategies in the community health improvement plan in collaboration with broad participation from stakeholders and partners	7.7%	4	**50.0%**	**26**	42.3%	22
15. *(5.3.1 A)* Conduct a department strategic planning process	30.8%	16	**38.5%**	**20**	30.8%	16
16. *(5.3.2 A)* Adopt a department strategic plan	11.5%	6	42.3%	22	**46.2%**	**24**
17. *(5.3.3 A)* Implement the department strategic plan	17.3%	9	25.0%	13	**57.7%**	**30**
Public Health Laws						
18. *(6.3.4 A)* Determine patterns or trends in compliance from enforcement activities, and complaints	17.3%	9	**48.1%**	**25**	34.6%	18
Access to Care						
19. *(7.1.3 A)* Identify gaps in access to health care services	17.3%	9	**67.3%**	**35**	15.4%	8
20. *(7.2.2 A)* Collaborate to implement strategies to increase access to health care services	40.4%	21	**50.0%**	**26**	9.6%	5
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	40.4%	21	**42.3%**	**22**	17.3%	9
Workforce						
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	13.5%	7	40.4%	21	**46.2%**	**24**
Quality Improvement						
23. *(9.1.1 A)* Engage staff at all organizational levels in establishing or updating a performance management system	21.2%	11	34.6%	18	**44.2%**	**23**
24. *(9.1.2 A)* Implement a performance management system	13.5%	7	34.6%	18	**51.9%**	**27**
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	11.5%	6	36.5%	19	**51.9%**	**27**
26. *(9.1.4 A)* Implement a systematic process for assessing customer satisfaction with health department services	26.9%	14	**50.0%**	**26**	23.1%	12
27. *(9.1.5 A)* Provide staff development opportunities regarding performance management	26.9%	14	34.6%	18	**38.5%**	**20**
28. *(9.2.1 A)* Establish a quality improvement program based on organizational policies and direction	9.6%	5	**50.0%**	**26**	40.4%	21
29. *(9.2.2 A)* Implement quality improvement activities	23.1%	12	**48.1%**	**25**	28.8%	25
Evidence-Based Practices						
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	48.1%	25	**50.0%**	**26**	1.9%	1
Administration and Management						
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	21.2%	11	**75.0%**	**39**	3.8%	2

Measure *(PHAB Domain, Standard, Measure)*	Fully Met Freq.	Fully Met Count	Part. Met Freq.	Part. Met Count	Not Met Freq.	Not Met Count
Governance						
32. *(12.2.1 A)* Communicate with the governing entity regarding the responsibilities of the public health department	**82.7%**	**43**	15.4%	8	1.9%	1
33. *(12.2.2 A)* Communicate with the governing entity regarding the responsibilities of the governing entity	**71.2%**	**37**	25.0%	13	3.8%	2
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	**82.7%**	**43**	17.3%	9	0.0%	0
35. *(12.3.3 A)* Communicate with the governing entity about assessing and improving the performance of the health department	**48.1%**	**25**	40.4%	21	11.5%	6

Figure 1 shows the percentage of CHBs that reported being able to fully or partly meet each of the 35 national measures included in PPMRS. Each bar corresponds to a different measure. Figure 1 reflects the overall picture of the local public health (LPH) system's ability to fully or partially meet the national standards. More than 90 percent of CHBs reported fully or partially meeting at least one-third of the measures. At least 75 percent of CHBs were able to fully or partially meet two-thirds of the measures.

Those CHBs that reported they could fully meet a measure were asked whether they could document fully meeting it. For all of the national measures, the vast majority of those who marked they could fully meet it also were able to document it. While the total number of CHBs who could fully meet each measure varied between measures, over 85 percent of CHBs that marked fully met could document each one.

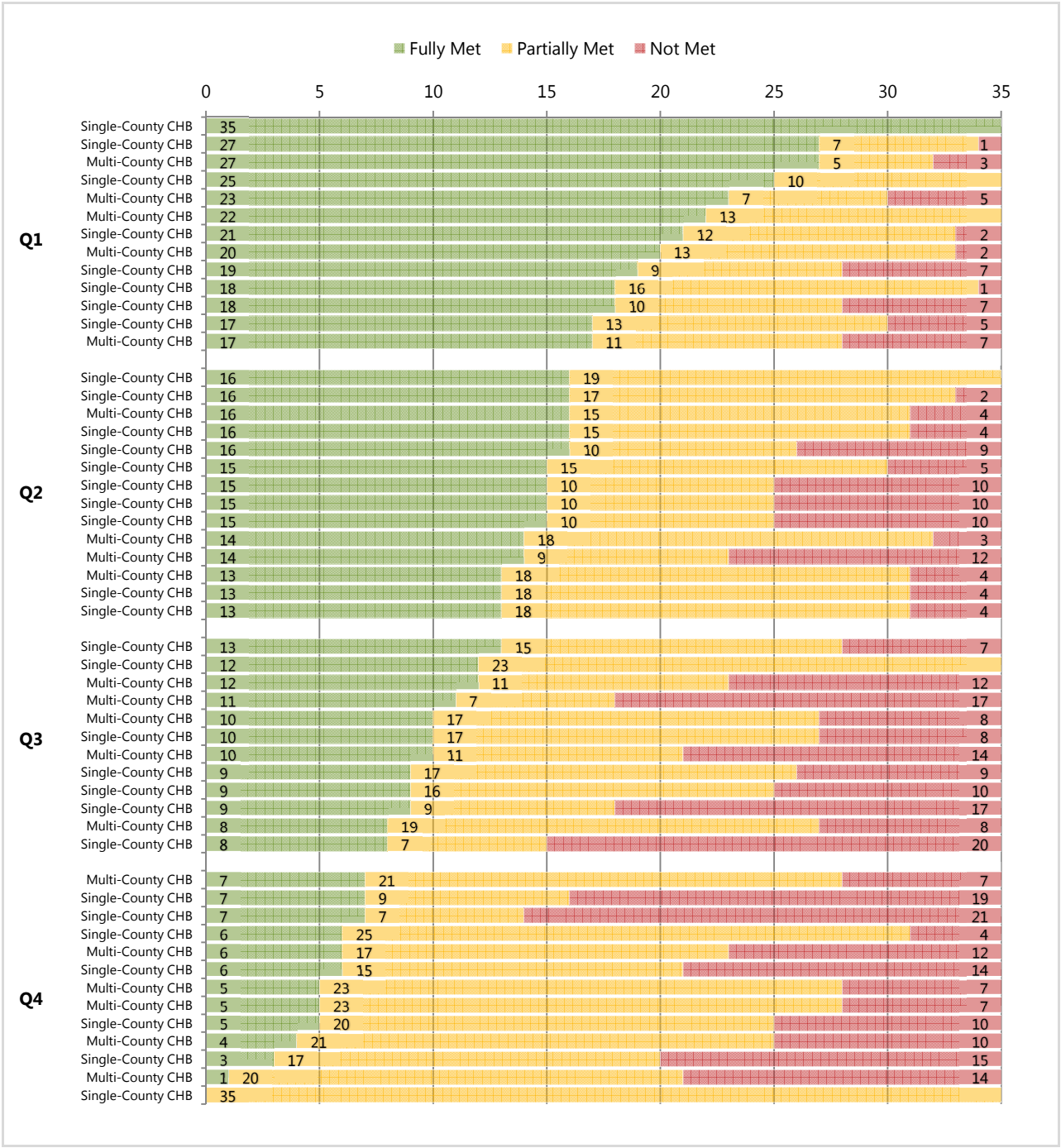
Figure 1. Minnesota local public health system ability to fully or partially meet national standards.



These results were consistent with findings from a self-assessment against national standards, completed by 83 percent of CHBs in 2011. The two areas in which CHBs were less able to demonstrate capacity related to quality improvement (QI) and strategic planning. These are both areas that have been targeted for additional technical assistance and support in Minnesota. The only two measures in the bottom third that were not related to strategic planning or QI were the ability to identify enforcement trends (PHAB, 6.3.4A) and being able to maintain, implement and assess the health department workforce development plan that addresses the training needs of the staff and development of core competencies (PHAB, 8.2.1A).

Figure 2 shows the response pattern for each of the 52 CHBs. Each horizontal bar corresponds to an individual CHB. The numbers in each bar reflect the number of measures that were reported as either fully met, partially met, or not met by each CHB. (Definitions for fully, partly and not meeting each measure are included in reporting guidance posted online.[4]) The 13 CHBs grouped in Quartile 1 (Q1) rank highest in the number of measures they reported being able to fully or partly meet. The 13 CHBs in Quartile 4 (Q4) rank lowest in the number of measures that they reported being able to fully or partly meet.

Figure 2. Distribution in CHB reporting on capacity to meet measures from national standards.



[4] http://www.health.state.mn.us/ppmrs/resources/performancemeasures/

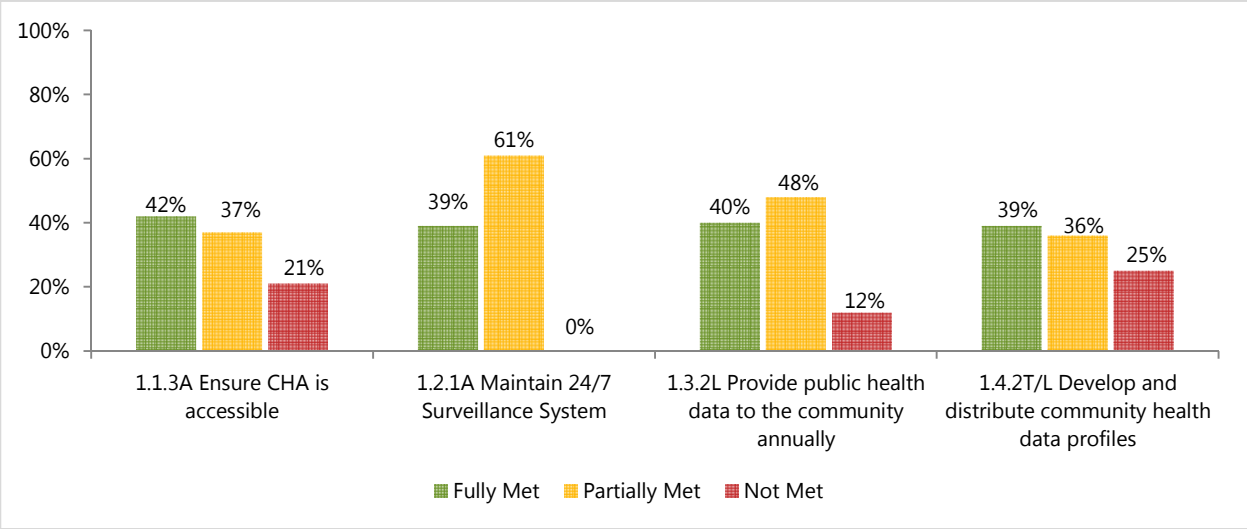
CHBs in Minnesota vary in their capacity to meet measures from the national standards (**Figure 2**). Almost one-fourth of CHBs were able to fully meet at least half of the measures. At the same time, many CHBs reported in 2013 that they did not meet almost half of the measures. CHBs that reported relatively high or low capacity to meet the national standards represented many regions and all types of structures, suggesting that there is no single best structure or superior geographic area of the state.

Assess

Conducting and disseminating assessment information focused on population health status is a traditional function of the LPH system. Community health assessments describe the health status of the population, identify areas for health improvement, determine factors that contribute to health issues, and identify assets and resources that can be mobilized to address population health improvement.

Minnesota's LPH system has a history of health assessment, which is clearly reflected in the capacity responses related to this area (**Figure 3**). Yet even though this is a traditional public health function in Minnesota, only 42 percent of CHBs were able to fully meet the measure related to having an accessible community health assessment (CHA). This measure requires that CHBs could provide two examples of dissemination of their community health assessments to partner organizations and to the public.

Figure 3. CHB ability to conduct and disseminate assessments focused on population health status and public health issues facing the community.



All CHBs reported being able to fully or partially meet the measure related to maintaining a 24/7 surveillance system. A lower percent of CHBs could fully or partially meet the standards related to ensuring the CHA is accessible and providing public health data to the community annually. In particular, development and distribution of community health data profiles to support public health improvement planning was not met by 25 percent of CHBs (PHAB, 1.4.2A).

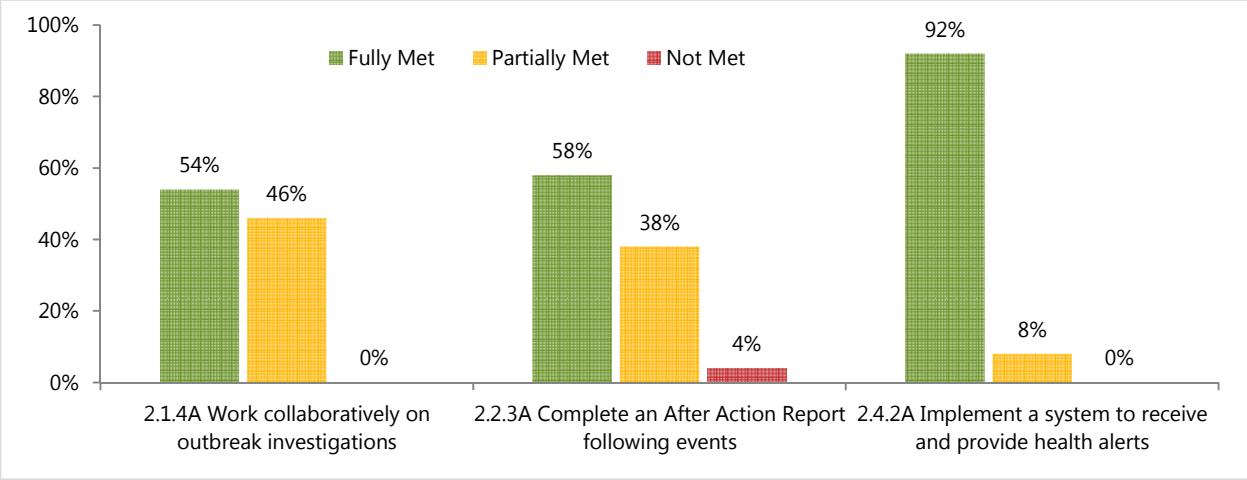
Investigate

The ability to **conduct timely investigations of suspected or identified health threats** is important to detecting the source of the problem, identifying the range of the population affected and prevent further spread or severity of the problem.

The vast majority of CHBs were able to report that they fully or partially met the three measures selected in this area (**Figure 4**). In Minnesota, local public health departments have traditionally partnered with the state health

department, as well as other government agencies and community organizations, to address health hazards in their communities. It is possible that some CHBs noted they did not fully meet the measure related to collaborating on outbreak investigations because they did not have outbreaks in their community in the reporting year (PHAB, 2.1.4A).

Figure 4. CHB ability to investigate health problems and environmental health hazards, to protect the community.



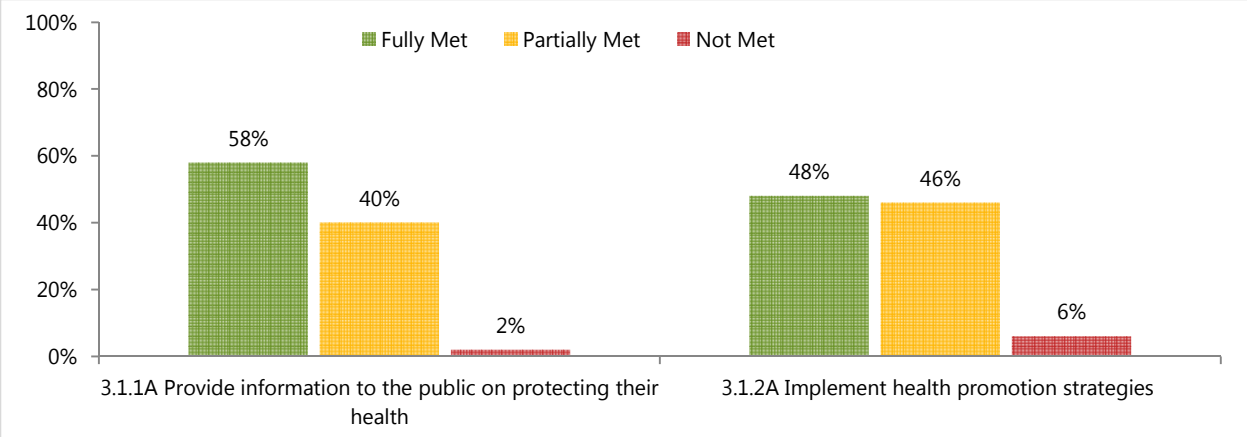
The only measure that any CHBs reported not meeting related to completing an After Action Report (AAR) following events (4 percent). This measure requires two examples of completed AARs for two separate events, thus it is possible that CHBs that only had one event would not fully meet this measure (PHAB, 2.2.3A). Over 90 percent of CHBs were able to fully meet the measure related to health alert networks, which suggests this is a strength of the system (PHAB, 2.4.2A).

Inform and Educate

Health education is a main function of public health and serves to **encourage healthy behaviors and provide the information necessary for the population to improve and protect their health**. Health education includes both gathering relevant health information and sharing that information effectively.

Minnesota CHBs reported high levels of capacity to provide information to the public on health promotion and protection, as well as being able to implement health promotion strategies to reduce preventable health conditions. While responses were distributed across the fully and partially met categories, a very low percentage of CHBs reported that they did not meet these two measures (**Figure 5**).

Figure 5. CHB capacity to inform and educate about public health protection and promotion



Community Engagement

Health improvement efforts are most effective when the **community has been engaged and asked to participate in decision-making**.

A high proportion of CHBs reported capacity to establish and/or actively participate in partnerships and/or coalitions to address specific public health issues or populations (PHAB, 4.1.1). Seventy-three percent of CHBs could fully meet this measure and 25 percent partially met it. Only one CHB (2 percent) reported it did not meet that measure. In addition, for those CHBs that reported they could fully meet that measure, 36 of them (69 percent) reported they could document those activities. Community engagement is an important strength for the system. Write-in comments (**at right**) demonstrated the wide variety of ways in which public health plays a role in their communities.

One area where CHBs reported more detail was on how they worked with their local school districts (**Table 2**). The highest response category was that of providing public health updates and resources, yet several respondents also highlighted partnership activities, consultations, information and referrals, and wellness activities. None of the CHBs reported that they did not partner with school health.

Spotlight on Community Engagement

"What have we learned? Not all change starts with a policy change. Creating welcoming, healthy environments… through staff development sessions and consultations, [and partnering with] organizations have improved service delivery and community/individual outcomes as a result of these efforts."

"[Statewide Health Improvement Program (SHIP)] staff found a way to do what seemed highly improbable—for concessionaires to make money by selling healthy food! For families and individuals who enjoy these venues, it means fun and healthy food CAN coexist—good news for everyone! SHIP staff has been working with concession operators in the three cities to offer healthier foods. One example is replacing a slushy with a yogurt parfait. The aim is to have 40 percent of the menu meet healthier choice guidelines, and to gradually increase that amount."

Table 2. CHB working relationship with schools	**% Yes**
Provide public health updates/resources	92%
Partnership activities	89%
Consultations	87%
Information and referral	87%
Wellness activities (e.g., SHIP)	85%
Community Crisis Management (e.g., outbreaks)	73%
Facilitate or coordinate joint meetings	60%
Conduct trainings: for students	54%
Environmental work (e.g., mold, pesticides, lice)	54%
Provide health services in the schools	48%
Conduct trainings: for staff	48%
Employ school nurses	23%

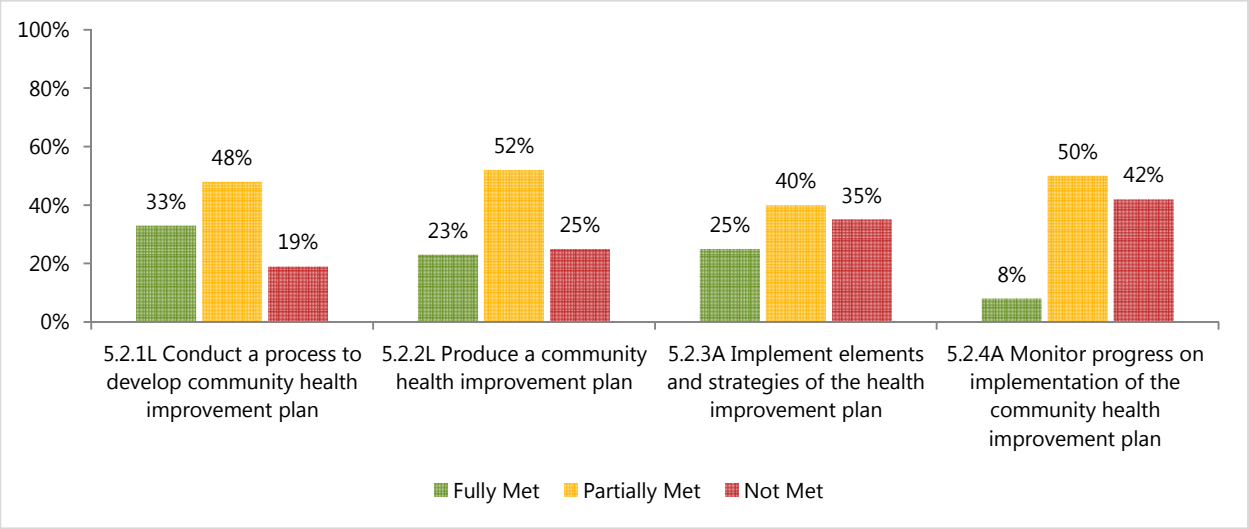
Policies and Plans

Community Health Improvement Plan

Public health has extensive knowledge and expertise on **evidence-based practice and promising practices that are required to develop policy and practice**. The role of public health is central to informing governing entities when they are creating policies that have public health implications.

While CHBs in Minnesota have a long history of creating community health improvement plans through a collaborative, community-focused process, the measures in this report reflect national criteria. CHBs needed to meet all components of the planning process—the plan itself *and* implementation of the plan—to fully meet these measures. So while all CHBs in Minnesota complete a community health improvement plan every five years, the process, plan, and implementation might not meet national criteria. One-third of CHBs reported they could fully meet the criteria required for developing a community health improvement plan, and slightly fewer were able to meet criteria around the components of the plan itself and implementing its elements and strategies (**Figure 6**). Only 8 percent of CHBs reported they could fully meet the requirements around monitoring progress of implementation.

Figure 6. CHB ability to meet components of the community health planning process



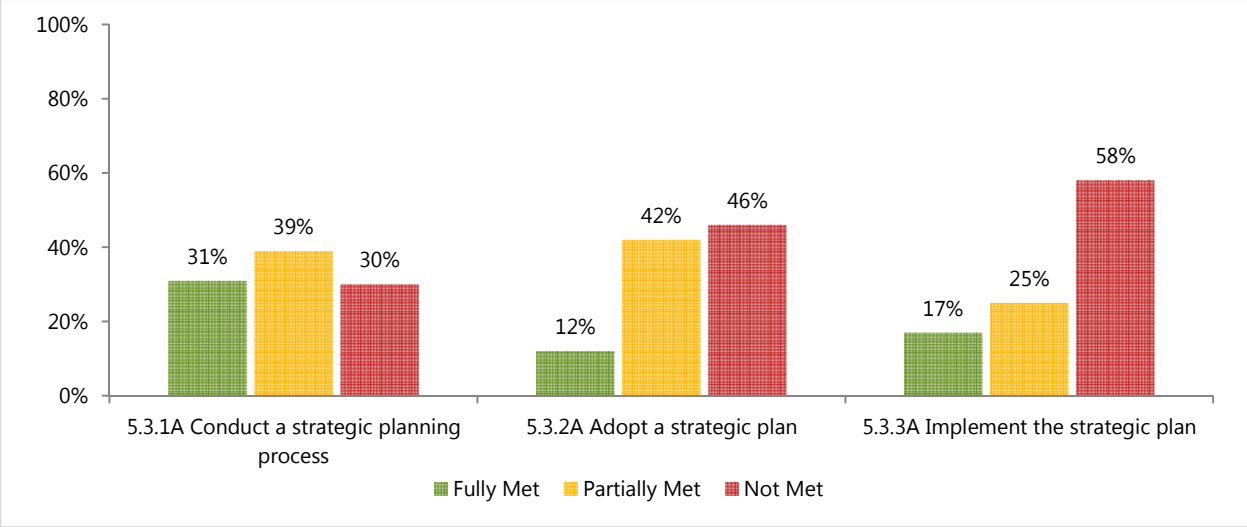
For all of the CHBs that reported they could fully meet these measures, an overwhelming percentage noted they could also document that they met the PHAB criteria.

Organizational Strategic Planning

Strategic planning is a process for defining and determining an organization's roles, priorities, and direction over three to five years.

Minnesota CHBs identified organizational strategic planning as an area in most need of improvement in the 2011 CHB self-assessment against national standards. Since that time, technical assistance around organizational strategic planning has been provided to over half the CHBs across the state. These data suggest that progress has already been made in increasing the percent of CHBs who are fully and partially meeting national standards around organizational strategic planning (**Figure 7**). Thirty-one percent of CHBs indicated that they could fully meet the criteria around conducting a strategic planning process (PHAB, 5.3.1A). MDH Public Health Nurse Consultants (PHNCs) continue to work with CHBs on all aspects of organizational strategic planning, from those beginning the process to those that are well into the development and implementation of their plans.

Figure 7. CHB ability to meet components of the strategic planning process

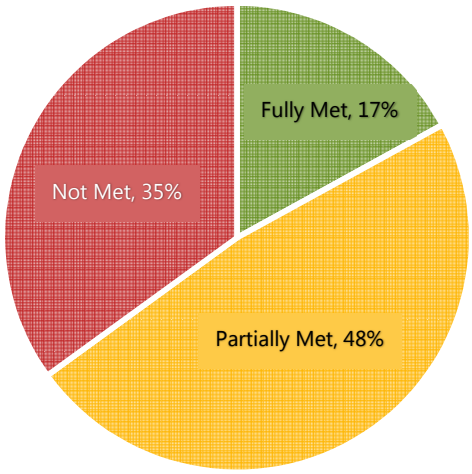


Public Health Laws

Enforcement of public health laws is a critical function in protecting the health of the population. There is variation in whether laws or ordinances are enacted at the state or local level in Minnesota. In addition, public health is not necessarily responsible for enforcement of many or all of these laws. However, it is important for public health to be involved in monitoring enforcement, providing follow-up services and/or education and educating policymakers and the public about their importance and impact.

Seventeen percent of CHBs report fully meeting criteria related to monitoring their enforcement activities, although an additional 48 percent could partially meet this capacity (**Figure 8**). These functions include annual reporting that summarizes complaints, enforcement activities, and compliance, as well as the ways in which they evaluated what was going well, problems that arose and recommended changes to their procedures (PHAB, 6.3.4A). For those CHBs that don't directly provide enforcement actions, having another entity (such as MDH) perform those activities does allow the CHB to report meeting this measure.

Figure 8. CHB ability to determine patterns or trends in compliance from enforcement activities.



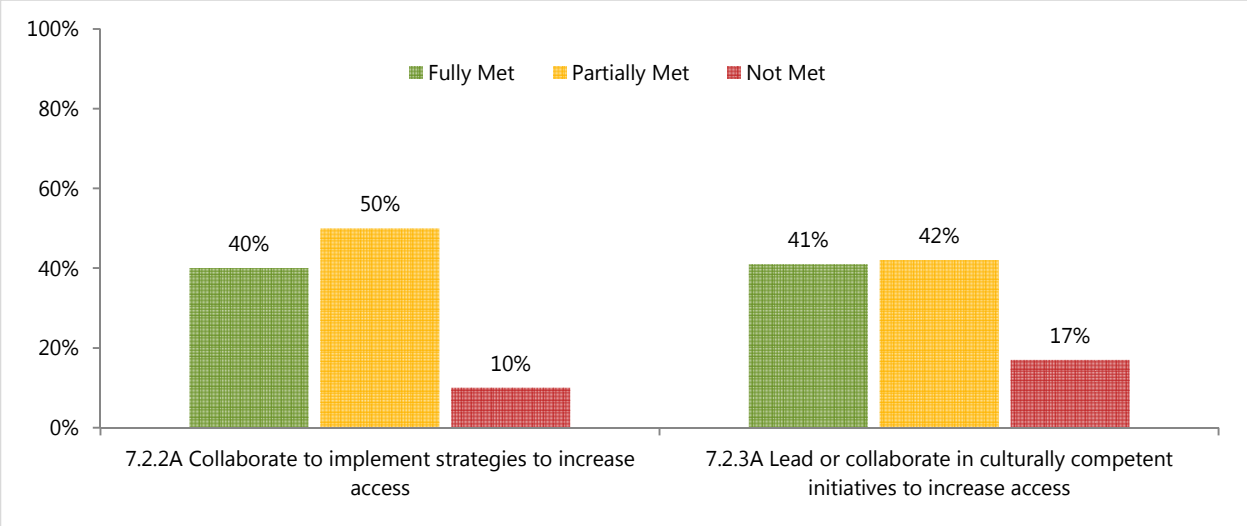
Access to Care

One role for public health relates to connections made with health care systems to **ensure that there is continuity of services for the population**.

CHBs in Minnesota work to identify gaps and barriers to access to health care for the population, as well as whether there are specific populations who experience those barriers. Seventeen percent of CHBs could fully meet the measure related to identifying gaps in access to health care services, and another 67 percent could partially meet it (PHAB, 7.1.3A).

PHAB standards emphasize the collaborative aspect of implementing strategies to address these barriers. The health care system is one partner engaged in access, given the role of social determinants of health, a variety of other organizations and agencies may also be involved. While the CHB does not need to convene these partnerships, it must participate in the collaborative work. Forty percent of CHBs were able to fully meet the measure related to collaboratively addressing gaps or barriers in health care access (**Figure 9**). About the same percentage of CHBs were able to do so in relation to populations that may experience barriers due to cultural, language or literacy differences, but close to 20 percent of CHBs did not meet that measure (PHAB, 7.2.3A).

Figure 9. CHB ability to collaborate on strategies to increase access to health care services.



Workforce

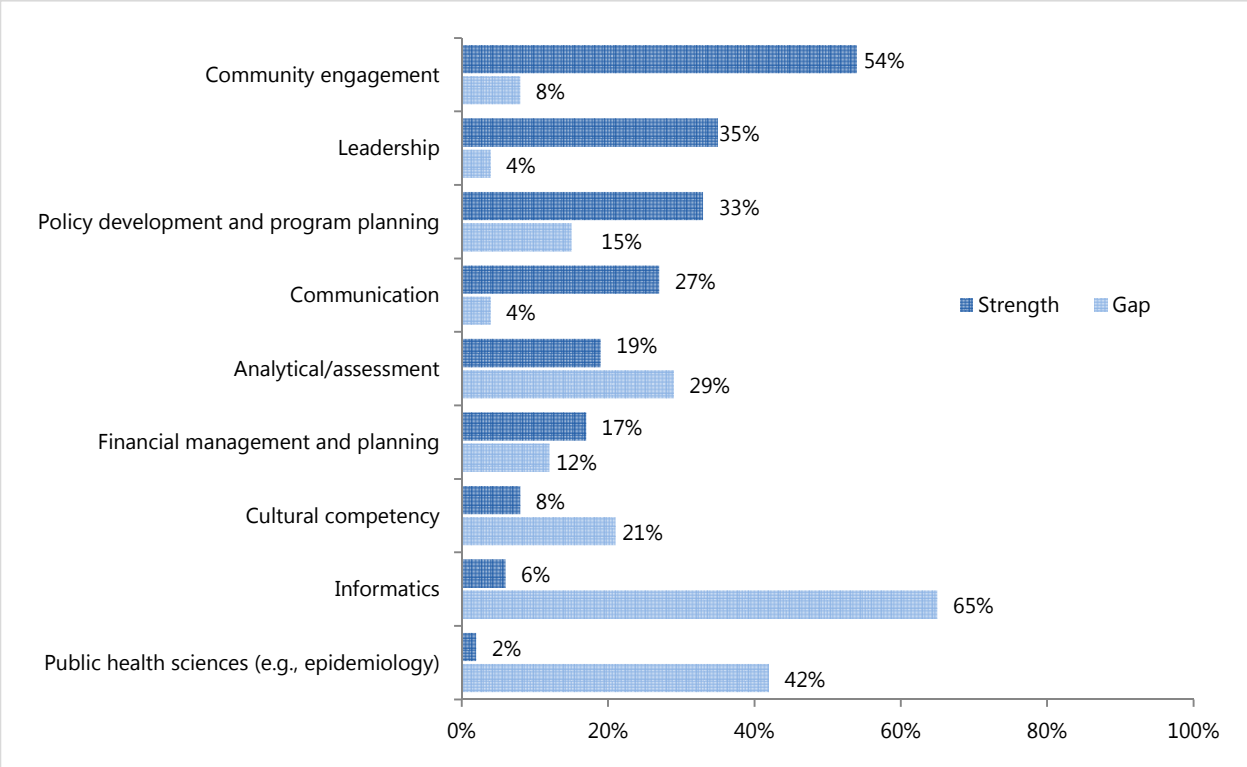
A **well-trained and competent workforce** is critical for CHBs to be able to perform public health duties. Further, more attention is being directed at a multi-disciplinary workforce, with the necessary competencies, that can facilitate the interdisciplinary approaches necessary to promote population health.

CHBs were asked to report their level of capacity to meet national measure 8.2.1A, which requires the maintenance, implementation and assessment of a workforce development plan. National criteria stipulate that the plan should incorporate nationally-adopted core competencies, curricula and training schedules, and documentation of development of that plan. Fourteen percent of CHBs were able to fully meet this measure and 40 percent could partially meet it (PHAB, 8.2.1A). This means that almost half of CHBs responded they did not meet this measure (46 percent).

In addition, CHBs were asked to report their top two workforce strengths and gaps (**Figure 10**). Community engagement, leadership, and policy development and program planning were the most frequently identified

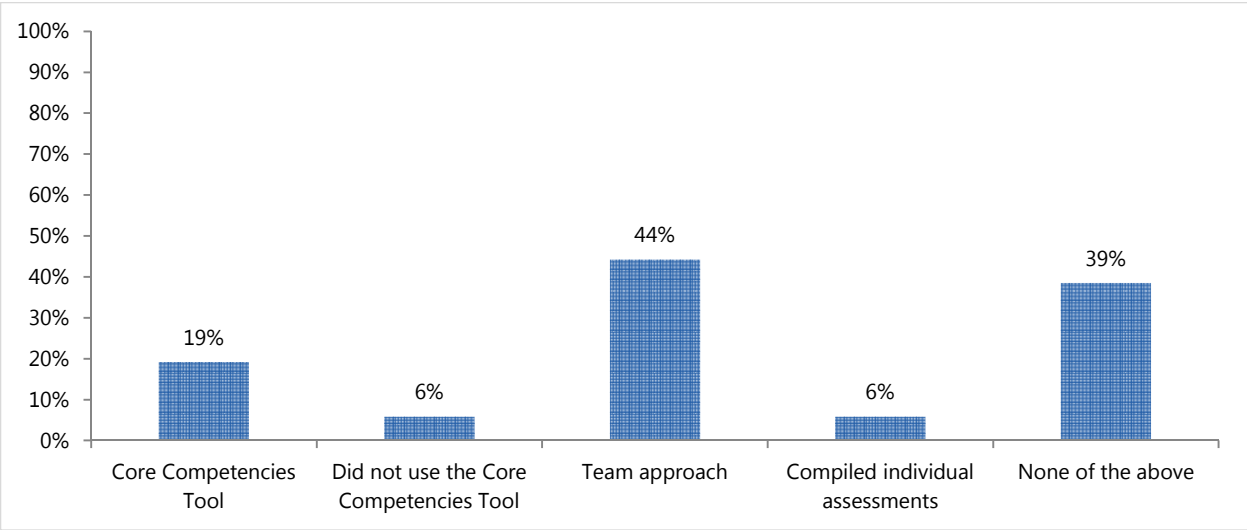
workforce strengths for the system. Informatics, public health sciences, and analytical/assessment skills were the most frequently cited gaps.

Figure 10. Top two workforce strengths and gaps within the Minnesota local public health system.



CHBs varied in how they assessed their workforce strengths and gaps. Although the national standards emphasize using the Core Competencies for Public Health Professionals Tool, only 19 percent of CHBs formally used that tool for this assessment (**Figure 11**).

Figure 11. Activities used to assess the strengths and gaps in the public health workforce of the CHB.
(CHBs were able to select more than one answer.)



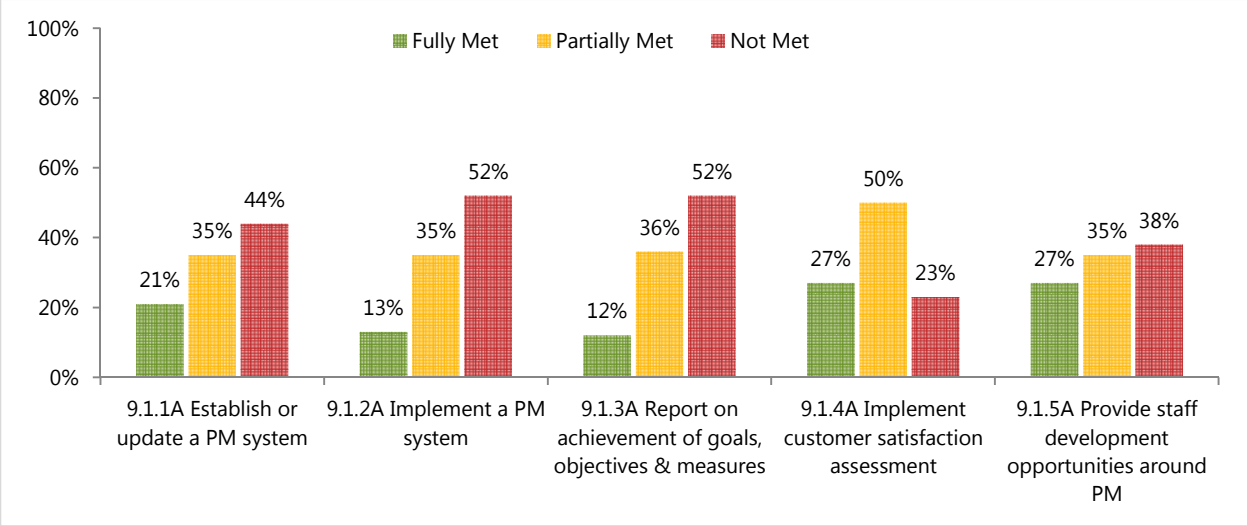
Performance Management

For the public health system to most effectively and efficiently improve population health status, it is critical to **monitor the quality of the performance of that system**.

The national domain focused on performance management (PM) and quality improvement was one of the areas noted as needing improvement in the 2011 CHB self-assessment against the national standards. The use of performance management to monitor the quality of public health process, programs, interventions and other activities has been elevated in the field of public health in recent years. While many CHBs were likely doing some of these activities already, pulling them together within a cohesive performance management system, is still new in Minnesota.

Data suggest the system is already making progress at incorporating the components of performance management into daily practice, but there is also continued room for improvement. CHBs seem to have made the most progress in implementing customer satisfaction assessment into their service provision. Over 75 percent of CHBs were able to fully or partially meet that measure (PHAB, 9.1.4A). Closer to 50 percent of CHBs were able to fully or partially meet the other measures related to the establishment, implementation, and reporting of their performance management systems (**Figure 12**).

Figure 12. CHB capacity related to the establishment, implementation, and reporting of a performance management system.

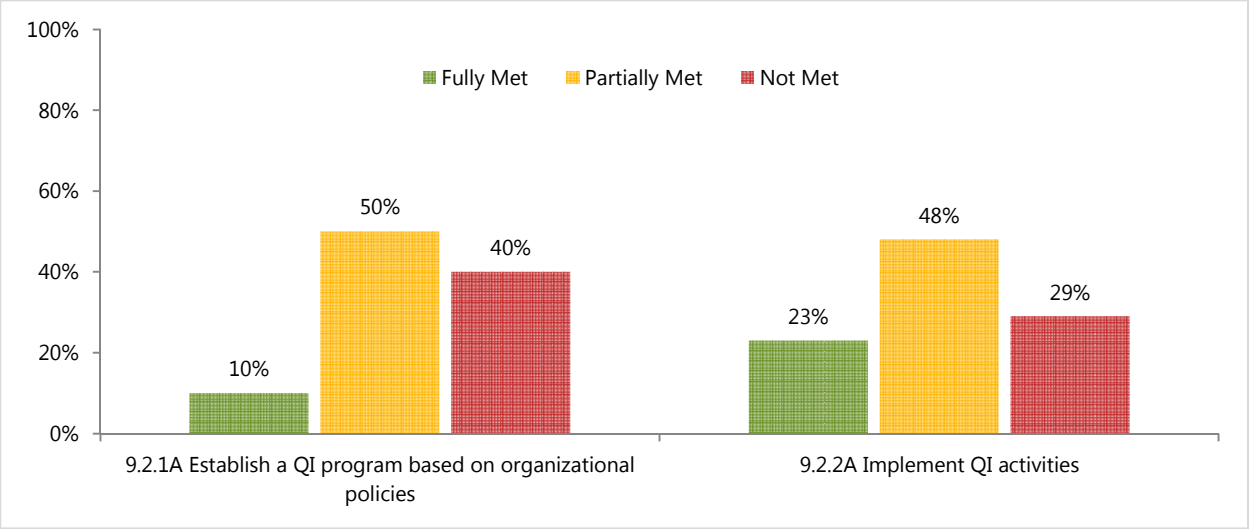


Quality Improvement

An important component of the performance management system is quality improvement (QI) and implementation of a QI program. To truly integrate QI into CHBs requires the support of leadership, staff commitment at all levels of an organization, and the regular use of QI approaches, methods, tools, and techniques.

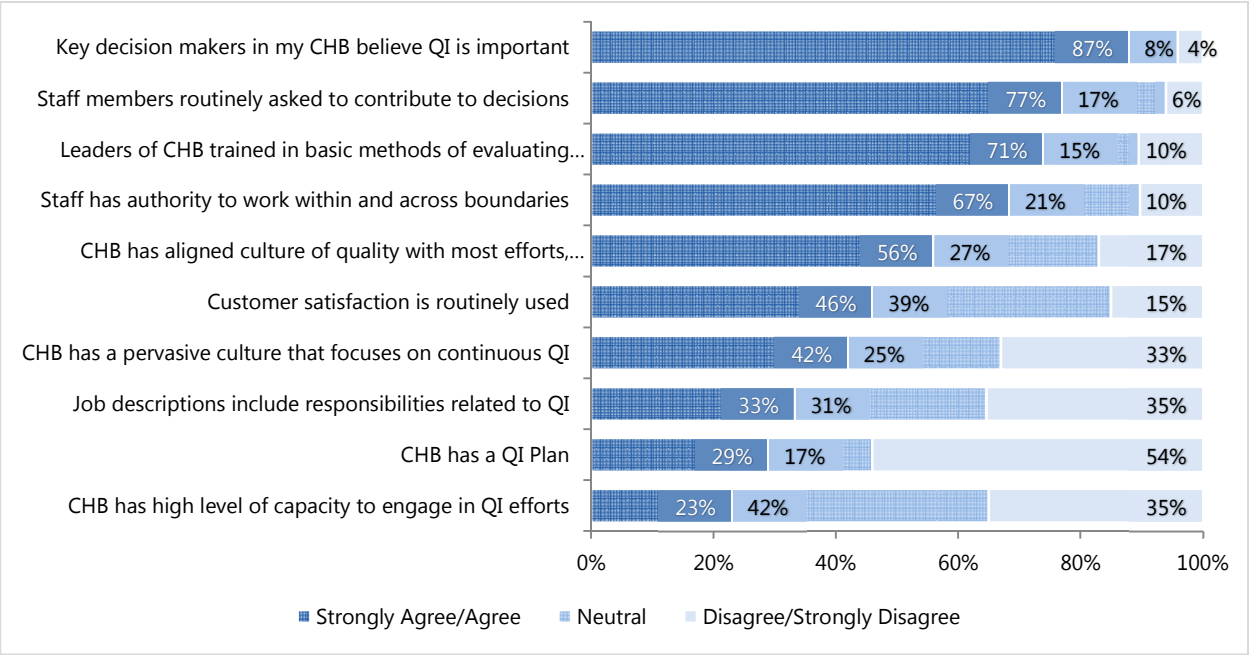
CHBs in Minnesota are varied in their knowledge and use of QI, but overall, CHBs appear to be making progress on incorporating QI practices into their organizations (**Figure 13**). To be able to fully meet measure 9.2.1A, CHBs would need to have a QI plan, with all the components outlined by PHAB. To fully meet measure 9.2.2A, CHBs needed to report QI activities and staff involvement in the activities that were outlined in the QI plan. Only 10 percent of CHBs could fully meet the measure related to establishing a QI program, a QI plan that has all of the national requirements. A slightly greater number of CHBs reported they could fully meet the implementation of QI activities. This suggests that QI is becoming a more comfortable concept for Minnesota CHBs, although it may not be as formalized as is outlined by the national standards.

Figure 13. CHB ability to develop and implement QI processes integrated into organizational practice, programs, processes, and interventions



Further evidence of progress on incorporating QI into standard practice is evidenced by a set of indicators related to organizational QI maturity (**Figure 14**). Leadership is extremely important to developing strong QI programs within organizations, and 87 percent of CHBs strongly agreed or agreed that "key decision makers in my CHB believe QI is very important." Further, 71 percent of CHBs had a high level of agreement with the statement that leaders in their organizations were trained in basic methods for evaluating and improving quality. Engaging staff at all levels of the organization is another important aspect of QI, and CHBs also had high levels of agreement with statements related to staff members routinely being asked to contribute to decisions (77 percent) and having the authority to work within and across program boundaries when trying to facilitate change (67 percent). These statements suggest that there is strong leadership support and engaged staff involvement across the system in supporting efforts related to an organizational culture of QI.

Figure 14. Organizational QI maturity in the Minnesota local public health system.



These data also provide some interesting nuance to the national standards results. While only 10 percent of CHBs could fully meet the measure related to development and implementation of a QI plan, almost 30 percent of CHBs reported that they did in fact have a QI plan. A next step might be to work to help CHBs include the important elements of QI into existing plans. Thus, there are tangible opportunities for improvement, which specifically relate to incorporating QI job responsibilities into job descriptions, creating formal QI plans, and increasing capacity to engage in QI.

These 10 indicators were used to calculate a median QI maturity score for the system. While caution should be used in comparing 2011 and 2012 data because of differences in reporting entities between the two time frames, these data reflect a slight increase in both the system median QI score and the distribution of scores among CHBs (**Table 3**).

Table 3. QI Maturity	**2011**	**2012**
System QI Maturity Score (median)	3.2	3.5
System QI Maturity Score Distribution		
2.0 – 2.9	28.3%	17.3%
3.0 – 3.9	60.4%	63.5%
4.0 and greater	11.3%	19.2%

Evidence-Based Practice

Public health evidence-based practice requires that a CHB **use the best available information for decision-making and ensures that resources are being used in the most effective manner**.

The national measures suggest that CHBs identify and use applicable evidence-based and/or promising practices when implementing new or revised processes, programs, and/or interventions. Close to 50 percent of CHBs reported they could fully meet that measure (PHAB, 10.1.1A) and of those, almost all could document that status. In addition, another 50 percent could partially meet the measure. This suggests that CHBs in Minnesota are doing a good job of incorporating evidence-based practices into their programs and interventions.

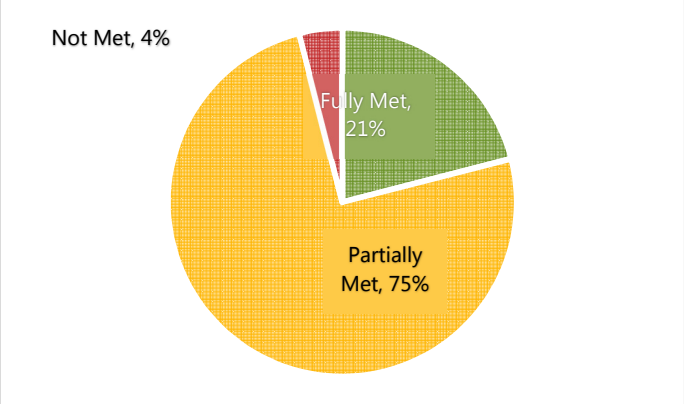
CHBs also reported on developmental measures aimed at assessing their activities related to implementing evidence-based strategies related to chronic disease prevention. These developmental measures are part of a larger, national study, and a summary of those results is provided in Appendix B.

Administration and Management

CHBs are responsible for a diverse population of residents within their jurisdictions, which can include people of various backgrounds and cultures.

Twenty-one percent of CHBs were able to fully meet the standard related to social, cultural and linguistic competence, which required that CHBs have a written policy or procedure, demonstrate two different processes, programs or interventions where they provided culturally competent services, document at least one staff training session and complete a cultural and linguistic competence assessment of the CHB (**Figure 15**).

Figure 15. Minnesota local public health system ability to meet standards of social, cultural, and linguistic competence.

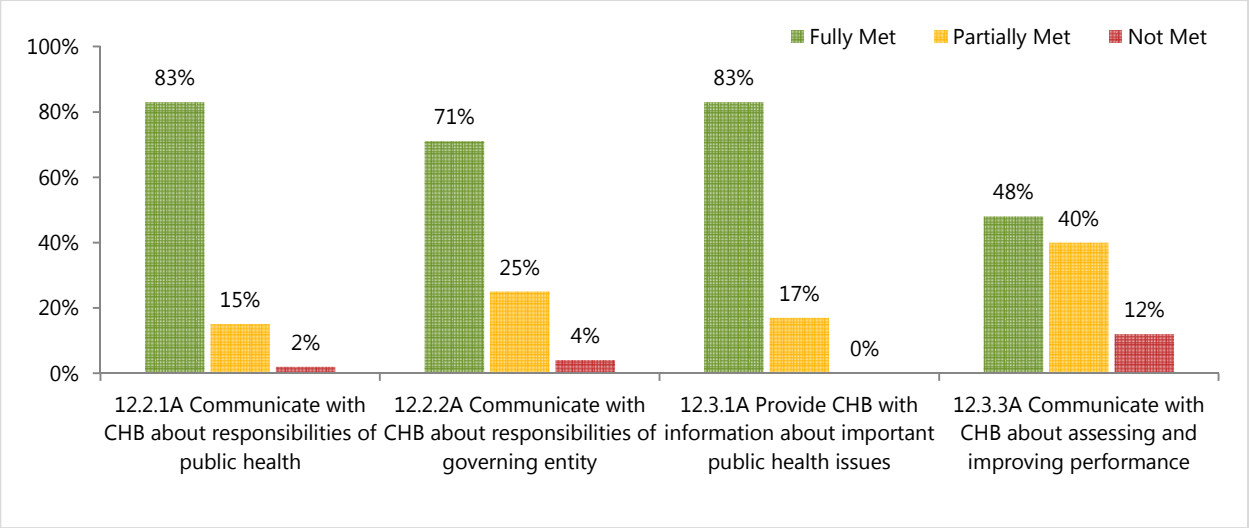


Governance

Governing entities play an important role in public health, and the national standards dedicate an entire domain to this capacity. Public health staff in Minnesota relate to their governing entities, the CHBs, in a variety of ways. One role relates to how public health operates with specific authorities to promote and protect the health of the population within its jurisdiction. These authorities can take many forms, but a major implication is that public health staff understand their authority and that of the governing entity. In addition, public health plays a role in providing the governing entity with information about important public health issues and the value of assessing and improving the performance of health departments.

This is an area of strength for Minnesota's public health system (**Figure 16**). The vast majority of CHBs could fully meet these measures and almost all of the rest could partially meet it. One area that could be improved relates to communication around assessing and improving performance. This is likely connected to CHB capacity around performance management in general, and it is expected that as they become more proficient in incorporating performance management into daily operations, being able to communicate those results to their governing entity will also be easier. Some CHBs may not be sure yet as to how to incorporate performance management into their daily operations, but this is a growth opportunity within the system.

Figure 16. Minnesota local public health system engagement with governing entities.



CHS Administrator Questions

Statutory Requirements	% Yes
The composition of the CHB meets the requirements required by Minnesota Statute §145A.03, subd. 4	100%
The CHB has in place written procedures for transacting business and has kept a record of its transactions, findings and determinations as required by Minn. Stat. § 45A.03, subd. 5	98%
The CHB has a CHS Administrator who meets the requirements of Minn. Rule 4736.0110 (these requirements pertain to CHS Administrators who were appointed after March 21, 1994)	100%
The CHB has a medical consultant in accordance with Minn. Stat. § 1451.10, subd. 3	100%
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.	100%
The CHB has written policies and procedures for implementing the removal and abatement of public health nuisances specified in Minn. Stat. § 145A.04, subd. 8	83%

Statutory Requirements	Mean
How many times did the CHB meet in the past year? The CHB is required to meet at least twice, per Minn. Stat. §145A.03, subd. 5.	9.9

All CHBs met the statutory requirement to meet at least twice during the reporting year. Yet there was variation in how frequently CHBs met, with a range of two times per year up to 48 times per year. The majority of CHBs met 12 times per year or fewer, with a system mean of 9.9 meetings per year.

Appendix A. CHB Reporting on Other Five Areas of Responsibility

Promote Healthy Communities and Healthy Behaviors

■ **QUESTION** ■ Highlight one program or accomplishment related to promoting health behavior or community health from the reporting year. Please indicate what you did, what you achieved (outcomes or impact), and what you learned.

CHBs reported a wide variety of health promotion activities that are underway within their communities. Public health in Minnesota is playing a role in promoting health through traditional methods, such as family home visiting and immunizations. When given the opportunity to comment on their activities, many chose to highlight population-based policy, system and environmental change strategies. Approximately 65 percent of the highlighted programs were identified as community-based approaches, and 35 percent were individual- or family-based. These ranged in focus from promoting breastfeeding, to addressing bullying in schools, to promoting health nutrition through increased farmers markets. A common thread was the innovative approaches being implemented across the state in partnership with a variety of local partners. The number of WIC clients served by each CHB was also reported into the system (statewide data not shown).

Prevent the Spread of Infectious Diseases

	Response	Frequency	Count
The CHB monitored and reviewed infectious disease data to identify disease trends and reporting gaps.	Yes	82.7%	43
	No	17.1%	9
The CHB monitored and reviewed immunization data and practices to identify immunization trends and practice gaps.	Yes	90.4%	47
	No	9.6%	5
The CHB provided infectious disease and immunization information and education to local providers on pertinent topics.	Yes	98.1%	51
	No	1.9%	1
The CHB provided correctional health services.	Yes	44.2%	23
	No	55.8%	29
If yes, indicate the most common infectious diseases seen:	Common Cold	62.5%	15
	Tuberculosis (TB); including latent TB infection (LTBI)	47.8%	11
	Other	43.5%	10
	Chlamydia	34.8%	8
	Hepatitis C	30.4%	7
	Gonorrhea	4.3%	1
	Hepatitis B	4.3%	1
	Do not know	8.7%	2
The CHB has the capability to provide directly observed therapy (DOT) to persons with active tuberculosis (TB) disease. DOT means that a health care worker or another designated person (not a family member) watches the TB patient swallow each dose of the anti-TB drugs.	Yes	88.5%	46
	No	11.5%	6
The CHB has the capability to do contact investigations for infectious TB cases (that is, locate, evaluate, and monitor close contacts).	Yes	85.5%	45
	No	13.5%	7
Percent of children aged 24-35 months who are up-to-date on immunizations:	In Minnesota	61%	
	Range: CHBs	29% – 86%	

Protect Against Environmental Health Hazards

■ QUESTION ■ Please give up to three examples of vector-borne, foodborne, and/or waterborne disease response activities (excluding infectious disease).

CHBs discussed a variety of work they have done in this area, including: nuisance investigations and follow-up; foodborne and waterborne outbreak investigations; food, beverage, and lodging inspections; providing prevention information to the community; well management; and other education and referrals for residents with questions, complaints, or requests for inspections.

Prepare for and Respond to Disaster, and Assist Communities in Recovery

	Response	Frequency	Count
The CHB updated the public health contact information in the CHB's Emergency Operations Plan (EOP).	Yes	98.1%	51
	No	1.9%	1
The CHB has trained appropriate staff in the National Incident Management System (NIMS).	Yes	98.1%	51
	No	1.9%	1
The CHB tested the notification and deployment system.	Yes	92.3%	48
	No	7.7%	4
The CHB has an emergency response plan that includes how the public health department will communicate with the media and public.	Yes	98.1%	51
	No	1.9%	1

Assure the Quality and Accessibility of Health Services

■ QUESTION ■ Identify the gaps in health care services or barriers to health care access in your community (check all that apply).

■ QUESTION ■ Which gaps in health care access in your community did the CHB address in the past year (check all that apply)?

Figure 1. Gaps or barriers in health care services or access and those addressed by the CHB in the past year: Basic Needs.

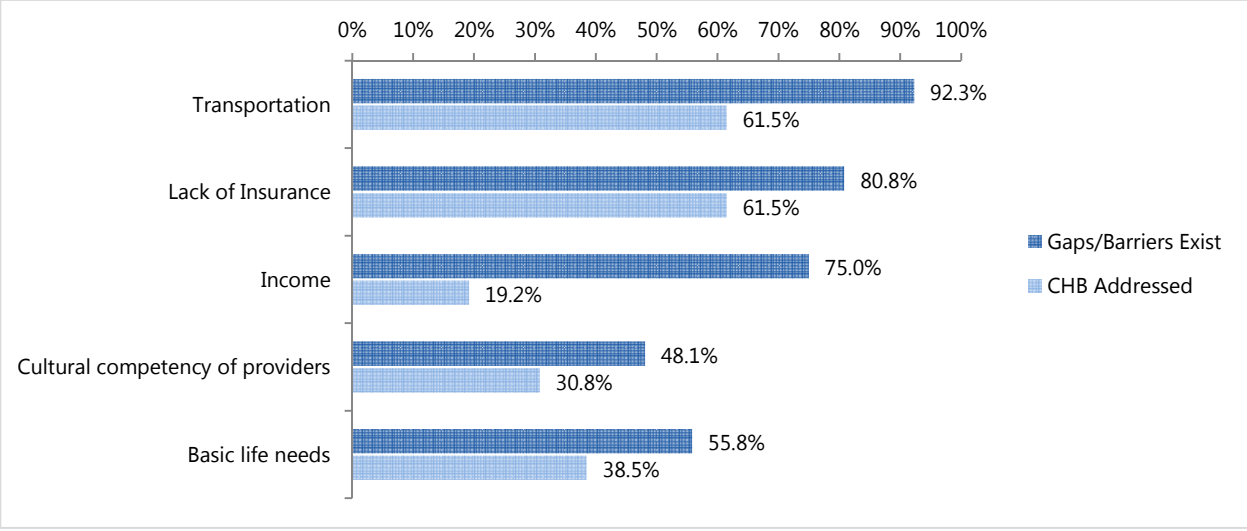


Figure 2. Gaps or barriers in health care services or access and those addressed by the CHB in the past year: Lack of providers.

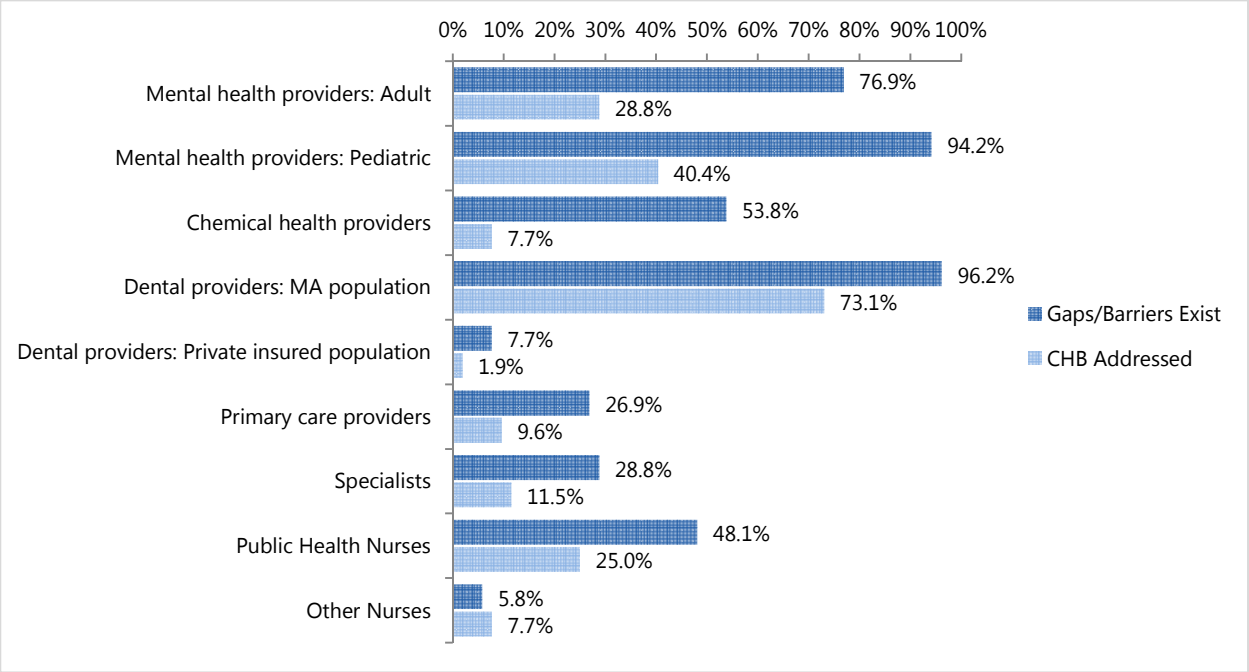
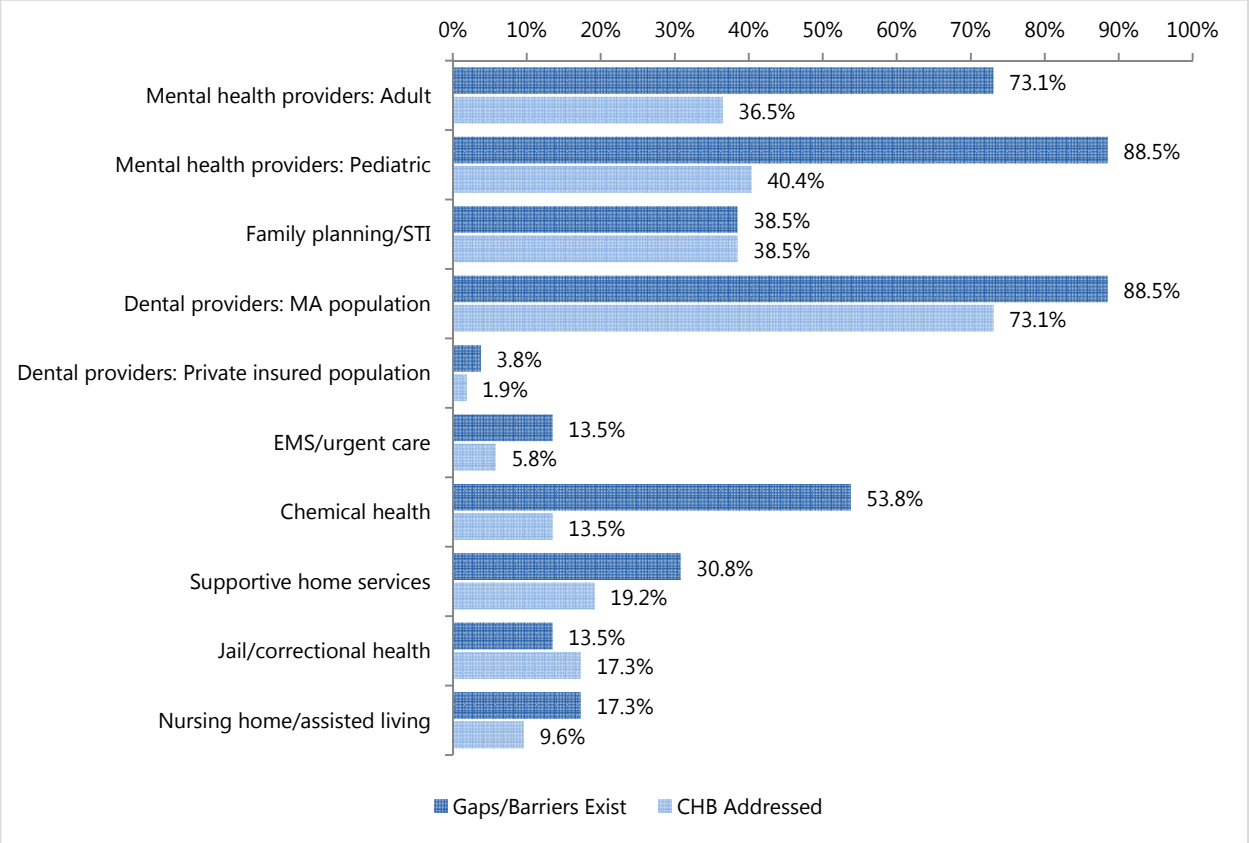


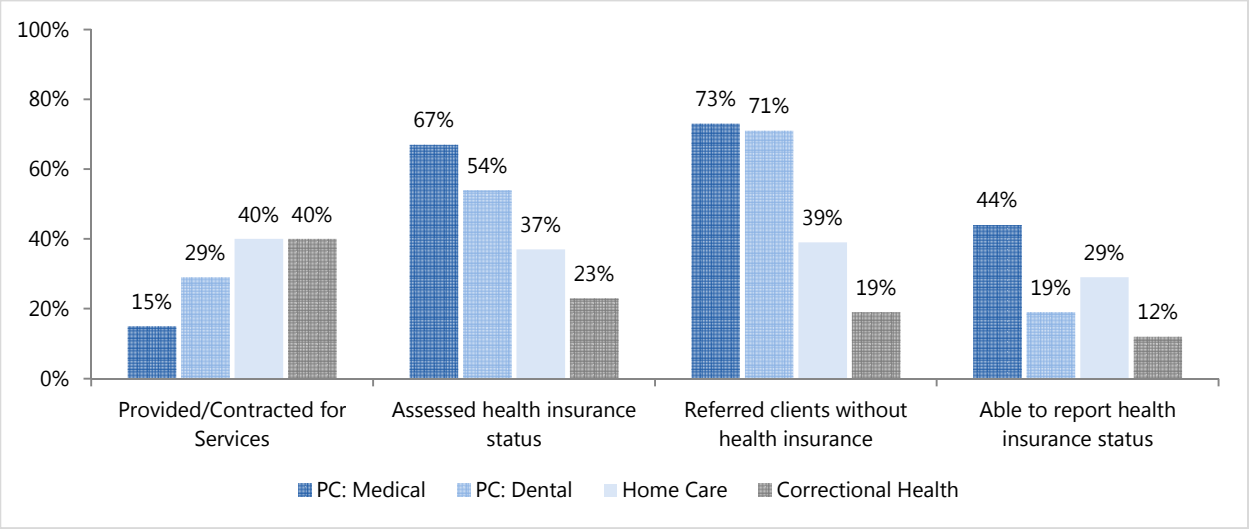
Figure 3. Gaps or barriers in health care services or access and those addressed by the CHB in the past year: Lack of services.



■ **QUESTION** ■ For the following topics, please indicate whether you did the following activities:

CHB Services		CHB Provided or contracted for services	CHB Routinely assessed health insurance status	CHB Routinely referred clients without health insurance	CHB able to report health insurance status
Primary Care: Medical	Count	8	35	**38**	23
	% by Row	15.4%	67.3%	**73.1%**	44.2%
Primary Care: Dental	Count	15	28	**37**	10
	% by Row	28.8%	53.8%	**71.2%**	19.2%
Licensed Home Care	Count	**21**	19	20	15
	% by Row	**40.4%**	36.5%	38.5%	28.8%
Correctional Health	Count	**21**	12	10	6
	% by Row	**40.4%**	23.1%	19.2%	11.5%

Figure 4. CHB services and actions regarding insurance status

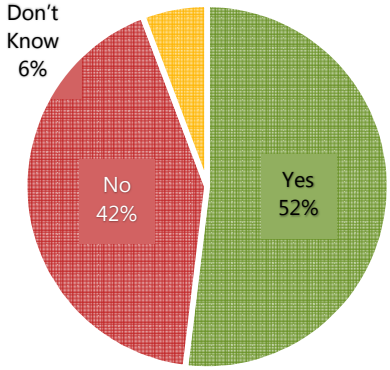


Appendix B. A Snapshot of Findings for 2012 Developmental Measures

Minnesota capitalized on existing data and data collection systems (PPMRS) to advance the national agenda for public health systems and services research through the Multi-network Practice and Outcome Examination (MPROVE) Study.

This brief highlights Minnesota-specific findings on measures reported into the Healthy Communities/Healthy Behaviors area of PPMRS (the Planning and Performance Measurement Reporting System) in 2013 as part of a multi-state study to examine levels of variation in public health services, and explore the relationship between public health services and population health. Minnesota contributed to measure development and selection through the Research to Action Network steering committee and the Performance Improvement Steering Committee. For more information, refer to: Research to Action Network: Publications and Presentations,[5] or contact Beth Gyllstrom (beth.gyllstrom@state.mn.us) or Kim Gearin (kim.gearin@state.mn.us).

Figure 1. Percentage of CHBs that allocated funding for physical activity promotion, 2012.



Physical Activity

More than half of CHBs (54%) reported involvement in an initiative to increase access to free or low cost recreational opportunities for physical activity. A similar percentage (52%) reported that the CHB allocated funding to promote physical activity. Estimated allocations ranged from $500 to $1,000,000. Per capita funding for physical activity promotion ranged from less than $0.01 to $18.70.

Most CHBs reported that some community-wide physical activity initiatives were underway within the jurisdiction(s) served by the CHB. (See **Table 1**).

Table 1. Community-wide physical activity initiative	**% underway within CHB**
Initiatives to Create or Enhance Opportunities for Physical Activity (Policy, Systems and Environmental change approach [PSE]: increase access to trails, worksite interventions)	92.3%
Community-Level Urban Design Initiatives (PSE approach: increase green space, Safe Streets, developments to increase % of residents living within walking distance of shopping, work and school)	69.2%
Social Support Interventions in Community (e.g., focus on changing physical activity behavior through creating, strengthening and maintaining social networks that provide supportive relationships for behavior change)	66.7%
Community-Wide Health Education Campaigns (e.g., large-scale, highly visible messages directed to large audiences through media typically combined with other approaches including support or self-help groups, community events or screenings)	62.7%
Individually-Adapted Health Behavior Change Programs (e.g., teaching goal setting/self-monitoring of progress, structured problem solving and relapse prevention)	57.7%
School-Based PE Programs (e.g., programs to increase time students spend in PE class)	40.0%
Community-Wide Stair Use Campaigns (e.g., signs by elevators/escalators)	21.2%

[5] http://www.health.state.mn.us/divs/opi/pm/ran/publications.html

This research brief was supported by the Public Health PBRN Multi-Network Research Implementation Award (69956), a part of the national Public Health Practice Based Research Network Program of the Robert Wood Johnson Foundation.

Nutrition Promotion

Most CHBs (81%) reported being involved in an initiative to increase access to healthy foods in the community. Twenty percent of CHBs reported that they did not dedicate any staff full-time equivalent (FTE) hours to increasing healthy foods during 2012, though eight CHBs (15%) reported two or more FTE. The median FTE dedicated to increasing healthy foods was 0.50.

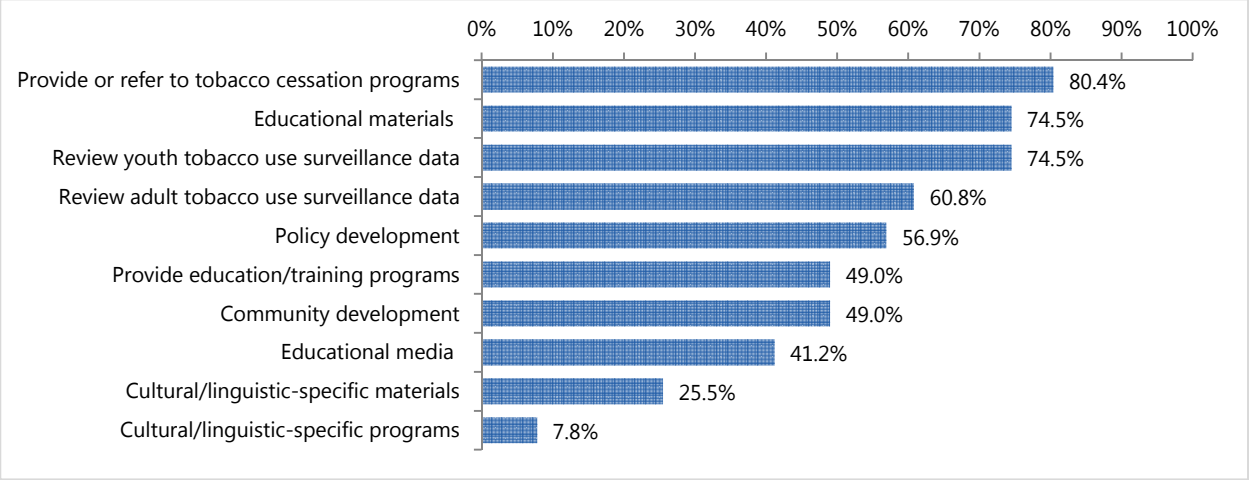
Oral Health

The clear majority of CHBs (75%) provided oral health prevention and promotion services (including dental screening). Of the 13 CHBs that did not provide oral health prevention and promotion, almost all of them (n=11) indicated there is a need for the services. The estimated number of screenings provided for dental/oral health conditions varied widely, from fewer than 10 to more than 2,000.

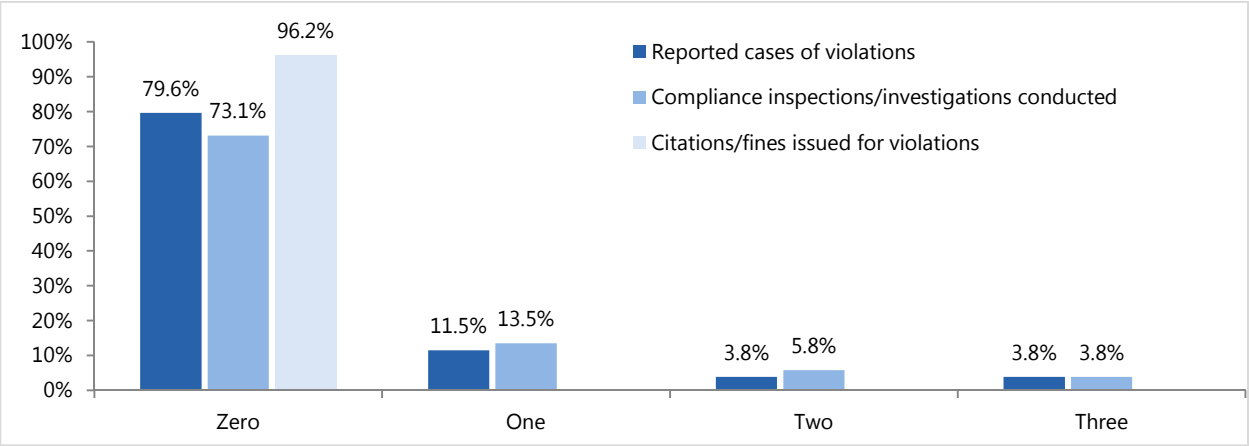
Tobacco Prevention and Clean Indoor Air

More than 70 percent of CHBs reported that they provided or referred to tobacco cessation programs, provided educational materials, and reviewed youth tobacco use surveillance data. Substantially fewer provided cultural/linguistic-specific materials or programs.

Figure 2. Percentage of Minnesota CHBs that participated in tobacco prevention, cessation, or control initiatives, 2012.



Very few local case violations and compliance inspections or investigations were reported or conducted with regard to enforcing the Freedom to Breathe Act.



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