



# **A Partnership for Public Health: What Does it Mean?**



**Final Report and Recommendations of the  
Expectations of the CHS Partnership Work Group**

December 1999  
State Community Health Services Advisory Committee



# **Expectations of the CHS Partnership Work Group**

*of the State Community Health Services Advisory Committee*

## **Membership**

|                                |  |
|--------------------------------|--|
| <b>CHB<br/>Representatives</b> | Jane Norbin, Co-Chair, St. Paul-Ramsey CHB<br>Don Adams, Stearns County CHB<br>Judy Barton, Goodhue-Wabasha CHB<br>Nancy Bauer, Becker-Mahnomen-Norman CHB<br>Mike Duffy, Carlton-Cook-Lake-St. Louis CHB<br>Mary Haug, Aitkin-Itasca-Koochiching CHB<br>Heather Robins, Rice County CHB<br>Sharon Smith, Kandiyohi County CHB<br>Karen Zeleznak, City of Bloomington      |
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# ●● *A Partnership for Public Health: What Does it Mean?* ●●

## Report and Recommendations of the Expectations of the CHS Partnership Work Group

### Introduction and Background

The current structure of Minnesota's public health system was created in 1976. Over the past twenty-plus years this system has come to be known as "unique among states for having a public health system that is a partnership of shared responsibility between state and local governments." But what exactly does that mean? The relationship defined as the "partnership" is unique in that state and local government share governmental authority, responsibility, and accountability for promoting and protecting the health of the public. This is not a relationship that exists anywhere else. What makes this relationship even more unique is that these two groups have:

- the authority to delegate duties;
- police power;
- the authority to tax;
- accountability to public officials;
- the ability to pass ordinance or statute and rules (establishing public policy);
- and the authority to share non-public data.

The State Community Health Services Advisory Committee convened a group of state and local public health representatives to discuss the meaning of "partnership" and explore the complex relationship between state and local governments. The events leading up to the development of this work group and the lessons they learned through the process are described in Appendix A.

Approximately one year ago, the state's commitment to this partnership was called into question. This was precipitated by budget cuts that had broad impact on the Minnesota Department of Health (MDH) and its ability to support its local partners, including a reduction in the number of public health nurse consultant positions at the MDH.

A number of events took place to assure that communication continued to occur between state and local public health agencies. These events were also an opportunity for each to explore how state and local agencies viewed the partnership and what each thought could be done to improve the relationship. A time line of these key events is included as Appendix B.

It should be noted that there has been varying levels of tension in the partnership at times during the past 20 years, and recent events are not the only time concerns have been voiced. The recent concerns, however, provide an opportunity to "take stock" of the partnership and consider how it might be strengthened.

### Benefits and Pitfalls of Using the Word "Partnership"

The word "partnership" has historically been used—some say overused—to describe the relationship between state and local government for public health. The work group struggled with the use of the word partnership because:

- it does not adequately express the complexity of the relationship;
- it implies equality between state and local agencies, which is not always the case;

- it means different things to different people;
- it means different things in different situations;
- it does not adequately represent the dynamic nature of the relationship;
- it does not clarify who the relationship is between—city/state, county/state, staff/staff, boards/commissioners, etc.

Despite these problems, the work group felt strongly that the benefits of using the term partnership far outweighed the pitfalls. For over 20 years, MDH and local governments have been working together toward a common mission—to protect and promote the health of all Minnesotans. While it may foster unrealistic expectations, no other term better captures the spirit of cooperation intended by the word partnership.

## **The Use of Authority and Power**

During discussions of the partnership in the work group, the use and origin of authority and power emerged as a critical issue. It became clear that the distribution of authority and power in the partnership cannot be said to be *equal* or described in any *one* way for all situations. Rather, the use of authority and power must be defined in each situation. The key to successful partnering is to be explicit about intentions and expectations regarding the use of authority and power. This issue is addressed in more detail later in this paper and in the recommendations.

## **SCHSAC Work Group: Expectations of the CHS Partnership**

The State CHS Advisory Committee established a work group on *Expectations of the CHS Partnership*, charged to:

- Identify desirable vision for, and future characteristics of, the community health services partnership;
- Define future mutual expectations and needs of the partners, including behavioral indicators of an effective partnership; and
- Recommend ways to further develop the community health services partnership.

Prior to the start of the work group, the Local Public Health Association (LPHA) charged a small group to identify what the LPHA saw as the key components of the partnership and draft a paper for discussion. The MDH also convened a group of MDH staff to develop a “department perspective” for each component presented in the LPHA paper. These papers served as the foundation for the first work group meeting and are included as Appendix C (LPHA paper) and Appendix D (MDH paper). These papers played a significant role in the work of the group. Not only did they serve as a foundation for discussion, but they highlight the complexity of the partnership. The papers reflect that while the two groups have much in common, each group also has its own perspective, its own values, and its own priorities for the relationship.

The work group’s discussion resulted in valuable perspectives on the partnership between MDH and local public health. The following are key observations about the dynamics of the partnership:

- Minnesota’s public health system is a national model for public health services;
- People working in public health believe that the state-local partnership is the best way to provide public health services in Minnesota;
- The partnership for public health has worked well for over 20 years.

However:

- The relationship between state and local public health agencies is extremely complex;
- The feelings of the people associated with the relationship between state and local public health agencies are very intense;
- The complexity of the issues make it impossible to develop a comprehensive set of expectations for each different aspect of the relationship; and
- This is not a relationship that either partner is willing or able to give up on or from which either is willing to walk away.

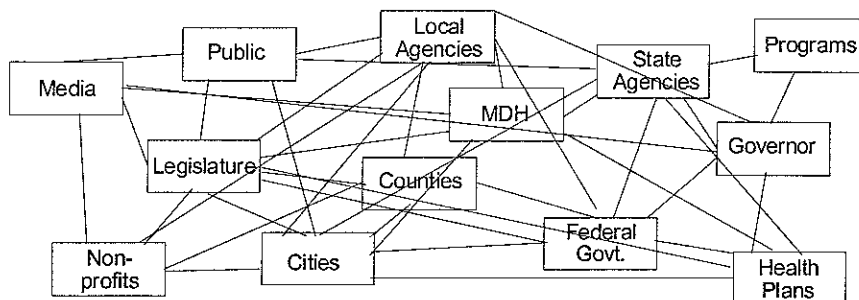
## Recognizing the Complexity

There are many factors that contribute to the complexity of the state and local partnership. Here are just a few:

- The "state and local partnership" is composed of multiple state-local intergovernmental relationships.
- There are divisions and units within the MDH that deal with city/county departments other than public health, such as planning and zoning, etc. In addition, local agencies have a multitude of local and state partners.
- A variety of relationships exist between MDH and local agencies. For example, an MDH division may regulate a city/county program while another may be seeking advice from, or providing assistance to, a local public health agency.
- There are 87 counties, 5 cities and 49 community health boards dealing with a multitude of programs, employees, and partners. The MDH is a large organization with a complex structure interacting with each of these groups about dozens of issues at any given time.

In summary, the "partnership" is composed of multiple relationships and may be described as "massively entangled." As depicted in the graphic on the following page, state and local agencies have been trying to describe and set expectations for a relationship that is very complex. This means that the action of one partner affects not only the other partner, but other groups with whom they work. This "massively entangled" relationship shows that there is no single way to relate to each other and that each communication and interaction can transform the relationship in some way.

### Massively Entangled



To help the work group deal with this complexity, a professional facilitator, Glenda Eoyong, was asked to work with the group. Glenda is an expert in complex systems and has experience working with groups to address organizational issues. Glenda worked with the group to accomplish several objectives:

- Understand more about how systems are organized;
- Acknowledge that complex systems, and the feelings and frustrations associated with them, are normal and common among groups;
- Identify techniques for working within a complex system.

## How Complex Systems Are Organized

In any complex system, some aspects are **highly organized** and stable over time. These situations are generally predictable, structured, reliable, and safe. The system works as a machine. Using the example of an airport, many aspects of this system are highly organized. The control tower knows exactly when planes are arriving and departing the terminal. Systems are in place to handle the flow of baggage, ticketing, seat assignments, etc. These aspects of airport activity are organized.

Other aspects of a system appear very **unorganized**. It appears as though the parts are unconnected, there are multiple relationships to manage, there is a lack of understanding of who is in control. Continuing the example of the airport, getting travelers to and from the airport is unorganized. The airlines do not call the passengers' homes and tell them it is time to leave. Cars are arriving and departing with seemingly no order whatsoever. Passengers are walking (or running) around, talking on the phone, eating. These aspects of airport activity appear to be completely unorganized.

Still other situations are **self-organizing**. These systems are in some ways orderly, but in some ways adaptive and flexible. These systems allow for the flow of ideas and information is freely exchanged. At the airport, passengers form lines to travel through the security check. The flow of people through the airport is orderly. Slower travelers are stepping to the side for people in a hurry. Passengers are boarding planes in an orderly fashion. This large group of seemingly unconnected individuals are self-organizing.

## Making it Work

The state-local partnership functions at all three levels of organization. While some aspects of the partnership are highly organized and structured (e.g., statutory advisory committee, contract administration) and a few are probably unorganized (such as in the early stages of a disaster response), many are self-organizing (such as when new initiatives are being defined and developed). Because elements of the system are in constant flux and each element influences the others, standard operating procedures cannot be established that address every situation. Trying to establish a complete and comprehensive set of rules for this self-organizing work is a self-defeating task.

A key point about complex systems is that these relationships change over time. Any situation can move from unorganized, to self organizing, to organized. It is important to acknowledge where the relationship is at a point in time and adapt to that situation accordingly. The relationship between state and local government can and should be flexible enough to operate in an organized, self-organized, and unorganized mode as events require. The remaining information in this paper will focus on using communication techniques and simple rules to work effectively within such a complex system.

## Resolving Differences through Communication

With any given issue there needs to be a fit between the problem and the solution. Another important aspect of making the public health partnership work is communication. Effective, long-term partnerships are especially adept at communicating about (and resolving) differences. However, there are times when communication will be a challenge for the partnership. Communicating about differences of opinion are vital to the strength and success of the partnership. Using the following tool (known as a difference matrix), the work group identified ways in which the partnership communications can occur:

| <b>Communication</b> | <b>Difference</b>                          |   |
|----------------------|--|---|
|                      | (1) High difference and high communication | (2) Low difference and high communication |
|                      | (3) High difference and low communication  | (4) Low difference and low communication  |

- In **quadrant 1** communication is open, opinions are expressed, and differences are heard.
- In **quadrant 2** everyone agrees and you are "preaching to the choir." This quadrant has high energy and can be very reinforcing.
- In **quadrant 3** there are significant differences of opinions, but they are not being expressed by the group (Minnesota nice). Tension grows in this quadrant and people often seek out others of their same opinion and move to quadrant 2 to talk about the issues and those that do not agree with them.
- In **quadrant 4** the group is in agreement and there is not much to discuss.

Understanding these differences in communication can greatly enhance the progress made by a group. If groups are aware of their communication needs and how they are communicating, they can become more productive in resolving differences.

## Simple Rules

Besides understanding the dynamics of a complex system like the partnership, it is helpful to have guides for future action. When many different persons and groups are interacting, they can make their actions coherent and productive by following a short list of simple rules. The rules can be applied in many different contexts by many different individuals. The work group reviewed and accepted the following as rules that should guide the action of all participants in the public health partnership:

1. Seek first to understand
2. Make expectations explicit
3. Think about the part and the whole

The responsibility for the health and safety of the public in Minnesota is shared among state and local governments. The application of these simple rules must take place in an environment that does not question this shared responsibility or either partner's commitment to the partnership. The rules stated below must be applied in an environment of trust, respect, and commitment. The simple rules will benefit the public health partnership by:

- opening lines of communication and clarifying expectations;
- decreasing the pitfalls associated with using the word partnership; and
- establishing norms for behavior.

### **Rule 1: Seek first to understand - ASK & LISTEN**

Each partner needs to understand the other. Local agencies must seek to understand how the state works and the state must seek to understand how local agencies work. Seeking to understand requires that each understand the perspective of the other partner by asking clarifying questions, listening without judging, removing personal feelings from the situation, and being objective. This rule requires the communication of differences (as discussed above) in an atmosphere of trust and respect.



## **Rule 2: Make expectations explicit - TELL**

In each situation the partners must make their expectations of the other explicit and clear. Each partner should communicate what they hope to achieve, what concerns they have, what they feel the problems are, and how they would like the problem to be solved. Together they should determine how they expect the issue to be addressed.

Within the context of this rule, the work group recognized that some expectations are long-standing. Others need to be renegotiated for specific situations. To practice negotiating expectations and to build a foundation of long-term expectations, the group divided into two and stated sample expectations that each would have of the other. These are presented as an exercise and are not intended to be inclusive.

### **Sample Exercise for Making Expectations Explicit**

*To practice negotiating expectations and to build a foundation of long-term expectations, the group divided into two and stated sample expectations that each would have of the other. These are presented as an exercise and are not intended to be inclusive.*

*Sample expectations of local agencies for MDH:*

- Get input on decisions that affect local health departments, including the legislative agenda and the budget
- Each person in MDH and in the counties should follow the three simple rules.
- Use CHS system and plan to allocate funds as much as possible.
- Provide consistency among MDH departments, divisions, and persons.

*Sample expectations of MDH for local agencies:*

- Not to be treated like the enemy.
- Local agencies understand and support the fact that the state needs funding, too.
- Local agencies help MDH use LPHA and AMC successfully.
- Local agencies work through SCHSAC for appropriate issues.
- MDH is a complex adaptive system communicating with a complex adaptive system (the partnership is complex and continually changing and adapting). Let's cut each other some slack.

## **Rule 3: Think about the part and the whole**

Any decision or action by any one part of the system can significantly impact the whole system. As noted above, the state and local public health partnership is massively entangled. Therefore, an action by any part can transform the other parts. The state must view how its actions impact the local agencies and their citizens, and local agencies must examine how their actions impact the state and their citizens. If a partner only thinks about one part, their actions can have significant (albeit unintended) consequences for the whole system.

## **Recommendations: Where Do We Go from Here?**

The Expectations of the CHS Partnership Work Group made significant progress in describing the complex relationship between state and local government, in general, and the aspect of the relationship referred to as the partnership, specifically. However, the group felt strongly that their work was not the end of a process but the beginning. The work of this group and the following recommendations are intended as a foundation for how both state and local agencies will work together in the partnership.

### **Recommendation 1: MDH and local governmental agencies should continue to use the word partnership to describe their relationship.**

Despite the confusion associated with the word partnership (as discussed in this paper) no word better defines the atmosphere of cooperation and coordination that exists between state and local agencies. The strength of the public health partnership lies in each partner's commitment, flexibility, honesty and respect of the other.

### **Recommendation 2: Undertake a process to assure that both state and local partners are aware that the partnership is a massively entangled complex system.**

One of the most important realizations of the work group members was to discover that the confusion associated with the partnership is "normal." Efforts should be made to help both state and local staff and elected officials understand the concepts presented in this paper. This could be accomplished, for example, through the use of videoconferencing to present the information in the paper and/or a presentation by Glenda Eoyang at a forum accessible to both state and local staff and elected officials (e.g., Community Health Conference, videoconference).

### **Recommendation 3: Assure that everyone involved in the public health partnership is aware of and understands the three simple rules for interactions between state and local partners.**

To accomplish this, the work group suggests that both MDH and local agencies look for opportunities to discuss the simple rules. As appropriate, these rules should be presented jointly by both state and local work group representatives. The rules should be communicated at all levels of both organizations, from the county board to local public health staff and from the commissioner to state public health staff. Other suggestions included weaving the three simple rules into meeting agendas, prepare materials that include the simple rules, incorporating the simple rules into the SCHSAC work plan.

### **Recommendation 4: Consistently apply the three simple rules in interactions between state and local partners.**

Work group members felt strongly that everyone involved in the public health partnership commit to the application of the three simple rules. These rules should guide interactions between state and local agencies. In particular, the work group suggested that the use of the simple rules would be especially helpful in:

- Discussion and development of legislative initiatives for 2000 and 2001.

- Discussions regarding streamlining of the grant process.
- Discussion of MDH budget issues that impact local health departments.

**Recommendation 5: Review the role of SCHSAC in the public health partnership.**

The work group recommends that the SCHSAC Executive Committee, the Commissioner of Health, and representatives of local public health agencies discuss the role of SCHSAC and county commissioners in the public health partnership. Issues regarding the public health partnership arise at both policy and programmatic levels. Because of this, SCHSAC has historically focused on detailed administrative issues (e.g., CHS planning guidelines, nuisance control) as well as broad policy issues (e.g., Local Public Health Act, core function funding, etc.). It would be helpful to have an executive level discussion of expectations and hopes for the work of the SCHSAC in the partnership.

**Recommendation 6: Evaluate how the partnership has changed as a result of the work of this group and the consistent application of the three simple rules.**

The work group recommends that the application of the three simple rules be used as indicators of an effective partnership. Therefore, they suggest that the SCHSAC annual report and work plan include a regular assessment of how effectively the rules have been applied, perhaps by examining two to three situations where the simple rules were applied and assess whether the partnership is stronger and more successful as a result of their use.

### ● The Partnership in Crisis?

In the summer of 1998, the MDH was required to make significant reductions in its budget. One of the outcomes of these budget reductions involved the elimination of two Public Health Nursing Consultant positions. These reductions (combined with previous budget reductions and loss of staff in the district offices) heightened concern about the viability of the state and local public health partnership because these staff were seen as a communication link between state and local public health agencies. Between September 1998 and November 1998, staff from the MDH met with local public health staff to discuss the MDH budget problem, its implications for state and local public health efforts, and to identify actions to improve the state and local public health system. MDH staff developed a paper – *Maintaining a Strong Public Health Partnership* – to summarize these regional meetings.

This paper served as the foundation for a “Partnership Summit.” This Summit was a meeting of 16 local public health staff (representing each of the eight regions of the state and environmental health directors), 15 MDH staff (representing 4 MDH divisions and the Executive Office) and 5 county commissioners.

The purposes of the Partnership Summit were to affirm findings from regional meetings regarding MDH budget reductions and the state and local partnership; and identify steps and timeline for actions to strengthen state and local government two-way communication and mutual support efforts.

Issues identified at the summit and during the regional meetings were very broad. Summit participants identified five priority areas: 1) develop systematic two-way communication; 2) enhance district office role and staffing (generalist position); 3) expand use of technology (Internet connections); 4) improve state-level coordination (legislative communication); 5) streamline grants administration.

To assure that action was taken on each of the priority areas identified at the Summit, several participants agreed to work in 5 small teams, each team to continue discussions on one of the priority areas. In February 1999, a smaller group, representing members of each of these teams, met to discuss progress in each of the priorities.

### ● A Vision for the Future

Many local Summit participants felt that one of the short-comings of the Partnership Summit was the focus on specific tasks and the “action plan,” versus a broader “vision” for the state and local public health partnership. To address this need, the Local Public Health Association (LPHA), charged a small group to identify what the LPHA saw as the key components of the partnership and draft of paper for discussion. The MDH also convened a group of MDH staff to develop a “department perspective” for each component presented in the LPHA paper.

## Expectations of the CHS Partnership

### How did we get here?

| 9/98 to 11/98  | 11/13/98  | 11/98  | 11/7/98   | 12/11/98  | 12/17/98   | 1/11/99   | 1/21/99  | 1/29/99   | 5/3/99   | 7/23/99   | 10/8/99   | 11/19/99  |
|--|---|--|---|---|--|---|--|---|--|---|---|---|
| Regional Meetings  | Partnership Summit  | LPHA Meeting   | LPHA Small Group Meeting  | SCHSAC Meeting  | Follow-up Meeting  | SCHSAC Executive Committee Meeting  | LPHA Meeting   | SCHSAC Meeting  | MDH Meeting  | Expectations of the Partnership Work Group  | Expectations of the Partnership Work Group  | Expectations of the Partnership Work Group  |
| Meetings between MDH division directors and local public health administration/staff to identify partnership issues. | Meeting of local public health representatives, county commissioners, and MDH staff to identify an action plan for strengthening the partnership. | Meeting to review the Partnership Summit and begin discussions on defining the expectations of the partnership. Also charged small group to further expand on the key components of the partnership. | Convened small group to identify and examine key components of partnership and begin draft of paper for discussion. | Discussion of 1999 work plan, including discussion on the possibility of a work group to examine expectations of, develop a long-range vision for, the partnership. | Meeting of a representative sample of Partnership Summit participants to review progress on each of the priority areas (see below) identified at the Summit. | Meeting to review 1999 work plan with the possibility of a work group on Expectations of the CHS Partnership. | Group will examine draft paper on key components of the partnership developed by small group. This will include links with MDH on content and discussion of the paper. | Meeting for review and approval of the 1999 SCHSAC work plan.<br><br><b>See 1999 SCHSAC Work Plan</b> | Convene MDH staff to develop MDH expectations of the partnership | First meeting of work group with equal representation from MDH and local agencies. Also membership that participated in the Summit. | Meeting facilitated by Glenda Eoyang to discuss complex adaptive systems and better understand the dynamics of the partnership. | Final meeting of the work group to finalize paper and develop recommendations for further action. |

#### Priority areas identified at the Partnership Summit for strengthening the CHS partnership:

- a) develop systematic two-way communication;
- b) enhance district office role and staffing;
- c) expand use of technology;
- d) improve state-level coordination; and
- e) streamline grant.



LOCAL PUBLIC HEALTH ASSOCIATION OF MINNESOTA  
125 Charles Avenue • St. Paul, Minnesota 55103-2108

February 24, 1999

Honorable Audrey Richardson, Chair  
State Community Health Services Advisory Committee  
P.O. Box 228  
Bemidji, MN 56601

Dear Commissioner Richardson:

Attached is a paper, entitled "Intergovernmental Partnership for Public Health" that was composed and reviewed by the Local Public Health Association membership during the latter part of 1998 and in January of 1999. This paper was approved during the Association's February 1999 meeting. The intent of the paper was to serve as a starting point, for the SCHSAC workgroup on expectations of the state and local government partnership, by providing a local staff perspective.

The public health intergovernmental partnership has been discussed at many places including the Minnesota Department of Health, the Local Public Health Association, AMC policy committees and throughout the state. The paper, identifies four key components of the partnership and for each of the key components puts forth collectively what the partnership can aspire to, comments on the current status of the partnership and ends with some suggestions as to how participants can determine whether or not the partnership is on course to ensuring Minnesota's public health.

The statement, "A Paper in Progress", fronts the paper. This statement is necessary as the partnership is in constant use. This paper brings to the discussion arena LPHA's best thoughts and views about the public health intergovernmental partnership to help ready it for 2000 and beyond. LPHA hopes that this paper not only clarifies what one is referencing when referring to the public health intergovernmental partnership but can also add to the dialogue that will occur during the next several months.

If the SCHSAC Executive Committee would like to discuss the concepts outlined in the paper prior to referring the paper to SCHSAC work group, please don't hesitate to contact me at 320-286-2672 or LPHA staff Lee Helgen at 651-224-3344.

Sincerely,

*Ann Bajari*

Ann Bajari, Chair  
Local Public Health Association



Cc: Jan Malcolm, Commissioner of Health  
✓ Ryan Church, MDH Director Community Health Services Division  
Jan Jernell, MDH Director Family Health Division  
Aggie Leitheiser, MDH Director Disease Prevention and Control Division  
Pat Bloomgren, MDH Director Environmental Health Division

LOCAL PUBLIC HEALTH ASSOCIATION OF MINNESOTA



## A PAPER IN PROGRESS;

### INTERGOVERNMENTAL PARTNERSHIP FOR PUBLIC HEALTH (from the perspective of staff working in local public health)

#### What is the State/local intergovernmental partnership?

The state/local partnership is a partnering of shared responsibility and authority to meet local and state public health needs. Language to undergird a strong, viable partnership is in place. Such language is contained within the 1987 Local Public Health Act.

#### From the 1987 Local Public Health Act:

##### 145A.09 PURPOSE; FORMATION; ELIGIBILITY; WITHDRAWAL.

Subdivision 1. General purpose. The purpose of sections 145A.09 to 145A.14 is to develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards.

#### What does this citation from the 1987 Local Public Health Act mean?

*The following list is meant to touch upon some of the successes the public health intergovernmental partnership has had since its inception in 1976 and to help ensure that the path the partnership takes through year 2000 and beyond leads to continued protection and improvement for the public's health.*

- Where feasible, services provided at the local level
- Counties/CHS and the State are empowered to be the best that they can be
- State and local health departments partner to set policies, develop and adopt guidelines and standards, and discuss and set legislative priorities
- A system that is sensitive to respective county and CHS capabilities
- State does what counties/CHS do not have capacity for or choose not to do
- State doing things that are best done from a State wide perspective such as media campaigns
- State providing public health leadership; MDH being public health's beacon in Minnesota and a public health force nationally
- State and local health departments share expertise and consultation
- State acting as an advocate for its local CHS/county partners as it dialogues with other States, Federal agencies and collaboratives
- State providing adequate public health resources in the most unrestricted form possible
- Timely county/CHS accessibility to MDH sections
- Both county/CHS and State personnel informed and supportive of the State/Local partnership
- Each partner holding the other accountable to the 1987 Local Public Health Act
- Sharing of information from county to county, State to county, county to State and from other states
- An environment of respect for each others experience, intelligence, and knowledge
- An appreciation for each others contributions
- Seeing each other as equals

Two other sources, one recent and one not, that describe this public health intergovernmental partnership include:

From Governing for Public Health, SCHSAC Report, November, 1998: Governing for public health is defined as "the determination, development, and administration of public policy to protect and promote the health of the public." Protecting

the public's health is so basic, and the consequences of not protecting the public's health are so serious, that both the state and federal constitution contain provisions to ensure protection.

Responsibility for the health and safety of the public in Minnesota is shared among state and local governments. The community health services system has been designed to assure that the community's health and safety are protected and to allow local government to identify and address local health priorities.

**From Merriam Webster's Collegiate Dictionary Tenth Edition:** A relationship resembling a legal partnership and usually involving close cooperation between parties having specified and joint rights and responsibilities.

*Key components of the partnership follow. These components were identified by an informal workgroup of the LPHA that was charged at its November, 1998 meeting with helping start the discussion of adding definition to the State/local partnership. The workgroup also created the questions that are asked of each key component.*



# Functional Components of State/Local Intergovernmental Relationship

## 1; Communication and Culture

### *The Ideal?*

- A shared understanding and implementation of the responsibility, roles, duties and authorities of official public health agencies
- A system where timely communication flows freely both ways
- Ready access to public health information and expertise
- Lead people from both State and local public health supporting the intergovernmental system and commitment to an overarching vision of public health
- State of the art information systems that meet both State and local public health agency needs to share and access information
- Actions based upon public input and epidemiological analysis to determine what is best for the public health

### *What is there?*

- Lack of understanding of the complexities of each others domain
- In places at MDH a paternalistic "we know what is best for you" attitude exists
- An MDH organizational structure that supports a "silo" mentality
- Local public health more reactive than proactive
- Incomplete understanding of each other's mission and functions
- Lack of acknowledgment of state/local intergovernmental interdependence

### *What can be done to improve?*

- Identify what is needed to build trust, streamline accountability and improve the quality of communication
- Agree on respective responsibilities, roles, duties and authorities
- Improved communication of changes impacting each others domain; i.e. legislative proposals, budget cuts, organizational changes, etc.
- Focus on intergovernmental relationships and responsibilities
- Public health policy or position papers discussed in open LPHA/State forums before adoption
- Improve access to State and local government
- Decentralize MDH staffing from the metro area to various State regions

### *Indicator/Measurements*

- State and local government offer staff orientation and staff training designed to explain what the intergovernmental relationship is and how it is to be utilized
- State and local government have a communication system that facilitates ready access to expertise
- All public health staff, local and State, have direct access and utilize latest technology
- Legislation and policy papers are being developed jointly and are debated in open forums
- The Executive Committee of LPHA meets regularly with the MDH Executive Office and division directors to discuss issues of mutual concern

## 2; Utilization of CHS System

### *The Ideal?*

- Single community assessment would be the basis for funding all local public health activity
- CHS Plans reflect community needs and priorities with strong local commitment/input
- CHS Plans recognize fundamental public health responsibilities and assure they are met
- Timely and relevant data available from MDH with appropriate analysis as to public health significance
- Implementation of evaluation projects of local and statewide public health significance
- Local governmental priority setting and Statewide public health goals are interdependent and build on one another
- State system of guidelines and standards that are reviewed and updated regularly with State and local input

### *What is there?*

- Numerous competitive categorical grants with small amounts of funding, some with their own timelines and assessments
- Inefficiencies and wasted resource due to chasing competitive grants
- Common, well developed, and comprehensive planning guidelines throughout the State
- Resource allocations, MDH and past history controlling what is done as opposed to the CHS assessment, prioritization process and plan being the driving force

### *What can be done to improve?*

- Continued utilization and refinement of CHS plan and process for determining and funding local public health priorities
- Resource allocation would be grounded in CHS assessment and prioritization processes at State and local levels and reflect the unique needs of local communities in fulfilling basic governmental responsibility for public health
- Additional data analysis by MDH
- Strengthen CHS Plan accountability

### *Indicator/Measurements*

- Decrease in categorical grants
- Local staff understand the importance of the assessment and planning and utilize the CHS process to make epidemiologically based decisions
- The State is utilizing CHS plans to develop appropriate support and to target episodic funding
- CHS plans are being constructed in a manner that facilitates accountability

### 3; Accountability

#### *The Ideal?*

- Necessary State/local public infrastructure in place and preserves the capacity to meet fundamental public health responsibilities in the State
- Shared leadership to maintain a strong public health system that prevents epidemics and the spread of disease, protects against environmental hazards, prevents injuries, promotes and encourages healthy behaviors, responds to disasters and assists communities in recovery and assures the quality and accessibility of health services
- Assurance that local government and the State are accountable to the 1987 Local Public Health Act and public health goals
- Clearly defined roles and responsibilities between State and local health departments

#### *What is there?*

- The CHS assessment and planning provide a basis for identifying and prioritizing local public health needs
- State and local governments, based upon their complementary capability, investigate health problems and health hazards in the community
- Through the CHS plan implementation and other local community activities, education to empower people about health issues and mobilize community partnerships is occurring to identify and solve public health problems
- Policies and plans that support community and individual efforts are being formulated
- An insufficient reporting system that has little relation to the CHS Plan accountability
- Significant program accountability differences between State/local programs
- A basic system is in place, but there are regional and local variations in implementation

#### *How can it be improved?*

- Evaluation of health department performance (i.e. APEX, CPH, CEH) for both State and local government
- Additional research for new insights and innovative solutions to public health issues
- Resources and training to assure a competent public health workforce
- Better definition of public health functions and goals
- Development of a reporting system that will provide information on identified public health outcomes
- Increased accountability to CHS Plans
- Inclusion of local government in State planning processes

#### *Indicators/measurement*

- Health department assessments are being routinely performed
- County boards, CHB's, and State government understand public health governance
- CHB's are actively participating in SCHSAC activities
- County participation is occurring at AMC public health policy discussions
- Public health is effectively addressing public health priorities
- Best practices and science are being practiced
- Public health infrastructure maintains the capacity to meet public health responsibilities
- Complimentary local and State Department of Health performance



## 4; Resource Allocation

### *The Ideal?*

- Complementary effort to procure funding to meet state and local public health requirements and needs from public, private and non-profit sources
- A balanced level of fiscal participation from the State and from local government to support the public health infrastructure and its activities
- Funds allocated to local CHS agencies are based on the respective CHS plan and flow through the CHS subsidy system
- The CHS assessment and planning system is utilized to tap into other governmental and collaborative funding sources
- State maintains capability for necessary support, assurance and oversight of the entire public health system
- State maintains capability to provide necessary public health services when local governmental structure is incapable
- Intergovernmental and public accountability for efficiency and effectiveness of public health programs

### *What is there?*

- A subsidy system for local government public health is in place
- Slow, cumbersome, competitive and inefficient grants processes
- Inadequate funding; CHS subsidy is less than 10% of local public expenditures
- State government using other systems to transfer money intended for public health purposes
- SCHSAC workgroup system to address public health issues of significance
- Short term workgroups to address specific problems and projects
- Lack of expertise from MDH to assist local governmental units to develop local public health capacity to meet fundamental public health responsibilities
- Lack of clarity between State and local public health roles

### *What can be done to improve?*

- Apply for waivers to eliminate categorical grants
- In the interim, simplify and make more efficient the categorical grants process to allow additional flexibility for both State and local government
- Augment the CHS subsidy to a State/local agreed upon amount and tie that amount to a cost of living index
- Connect public health outcomes to funding
- Targeted formulas with established base funding level
- Local government and State working together to influence Federal public policy and funding
- Local Government and State capacity building to enhance general administration of public health system in Minnesota
- Clarify who can do something the best (intergovernmental) and appropriate funding mechanism

### *Indicator/Measurements*

- The number of small categorical grants is decreasing
- If there are categorical grants, they are being used to stimulate local government to experiment with new public health interventions and management
- The subsidy is being augmented for 1). cost of living increases, 2). special public health need, 3). absorbing special grants, 4). basic core functions, 5). etc.
- Local public health capacity is sufficient to meet basic public health responsibilities
- MDH and other State partners are evolving to ensure their public health practice is consistent with best practices, scientific knowledge, etc.

- ✓ Funds are allocated for public health purposes and are being spent consistent with public health principles
- ✓ Funds are being utilized based on the CHS Plan and sound epidemiological practice

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## MDH PERSPECTIVES ON PARTNERING WITH COMMUNITY HEALTH BOARDS

DRAFT

The State CHS Advisory Committee has approved the development of a work group on *Expectations of the Partnership*. This work group is charged with: identifying a desirable vision for, and future characteristics of, the community health services partnership defining future mutual expectations and needs of the partners, including behavioral indicators of an effective partnership; and recommending ways to further develop the community health services partnership. Background information on this work group is included as attachment A.

As part of this process, the Local Public Health Association (LPHA), charged a small group to identify what the LPHA saw as the key components of the partnership and draft a paper for discussion. The Minnesota Department of Health (MDH) also convened a group of MDH staff to develop a “department perspective” for each component presented in the LPHA paper. This paper is a result of that meeting.

### Governmental Authority to Protect Health

Minnesota Statutes, Chapter 144 provides the state commissioner of health with general authority as the state’s official health agency. This statute states that the commissioner “shall be responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens” (Minnesota Statutes, Chapter 144.05, subd. 1).

### How MDH Carries Out Its Mission

The MDH works with many different state and community organizations, including various local government entities, to carry out its public health mission. These relationships take on a variety of forms, ranging from “partnering” to “regulating.” For example, Minnesota Statutes, Chapter 144.3351 allows sharing of immunization data among health care providers, with local public health, day care, and schools, with the MDH supporting this activity—a “partnering role.” In the relationship between the MDH and county government for County-Based Purchasing (CBP) and the Demonstration Projects for Persons with Disabilities (DPPD), the MDH plays a “regulatory role.” In this case the MDH is responsible for consumer protection and must assure that the requirements of Chapters 62D, 62N, 62M, 62J, 62Q and 72A, which apply to these arrangements, are met. (CBP is authorized under Minnesota Statutes, section 256B.692 and DPPD is authorized under section 256B.77).

Additionally, while the MDH recognizes that protecting the health of the public is a basic responsibility of government – both state and local – it also acknowledges that government alone does not have the resources to address the needs of all citizens. Therefore, the MDH and community health boards (CHBs) must work with a variety of organizations (both public and private) to achieve their goals.

### MDH's Relationship with Local Government

One very important way that MDH carries out its mission and statutory authority is through the community health services system, which is the primary statutory relationship between MDH and county government (and a few cities which were grandfathered in when the law was passed). Technically, counties in Minnesota are considered “involuntary corporations organized as political subdivisions of the state” (Currie, House Research, 1985). Therefore, under Minnesota’s state constitution, the state could legally retain all authority for public health. However, because of the strong presence of local government, the Minnesota legislature has chosen to extend some responsibility and authority for public health to local boards of health through the community health services system. This relationship between state and local government for public health is defined in Minnesota Statutes 145A, the Local Public Health Act. This law, passed in 1976 and recodified in 1987, is “to develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards.” (Minnesota Statutes 145A.09, subd.1.) Under this law, responsibility for public



health is shared between state and local governments organized as “community health boards.”<sup>1</sup> The law provides local governments with considerable flexibility to organize as community health boards, to work with their communities to identify health problems and address them. It also provides MDH with oversight authority and directs them to provide [administrative and program] support. This relationship is an important means by which the MDH carries out its constitutional and statutory responsibilities.

Over the years, this relationship between the state and CHBs has become more complicated. The scope of the MDH’s activities has broadened due to health reform legislation, federal authority for drinking water protection, and many federal and state categorical grants. In some cases, these changes have increased the MDH’s regulatory authority over local government and in other cases, the changes have stimulated MDH’s forming or strengthening relationships with other entities. What was once seen as a relatively simple “partnership” between levels of government that share responsibility for public health has become a complex set of relationships – some regulatory, some partnership, some where MDH serves as the lead, some where community health boards lead the MDH. MDH staff interact with many people and parts of county government, and local staff interact with many different people and organizational units within MDH and other state agencies. In addition, local staff and MDH staff interact for many different purposes. This makes relationships diverse and complex.

Concerns expressed by CHBs (staff and commissioners) regarding MDH stem from three factors:

1. The MDH regulates local governments in some areas. In this case, the relationship is not of shared decision-making, but of MDH carrying out its statutory authority for health protection.
2. The MDH is a large, complex organization that has experienced rapid growth. This has made communication cumbersome and often uncoordinated.
3. Because of its broad scope of authority, its complex structure, the timeliness in which decisions must often be made, and the nature of some of the MDH’s decisions, the MDH will not always involve CHBs in decisions when they may feel it is appropriate and/or necessary to do so.

These issues have led to a relationship that is seen as “top down” and ineffective by some local agencies. MDH staff acknowledge that communication and decision making could be improved. However, modifications should consider the structures that are already in place (e.g., SCHSAC, SCHSAC work groups, MCH Task Force, etc.) to receive input from local agencies.

## **The Benefits of Partnering with Community Health Boards**

While the MDH struggles to manage its changing relationships with local governments, no one disputes that the MDH and CHBs share governmental authority to protect the public’s health. Effective working relationships between the MDH and CHBs in Minnesota are needed to carry out this authority. Significant MDH and CHB efforts have focused on maintaining and strengthening the partnership including, for example, the development of a partnership mission – *The mission of the Community Health Services partnership is to lead efforts to protect and promote the health of all people in Minnesota.*

The MDH and local agencies both contribute many unique characteristics to the partnership. This paper highlights those attributes MDH staff felt local agencies uniquely brought to the partnership. Local agencies:

- are an organized statewide public health system
- serve as the eyes and ears of the people of Minnesota

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<sup>1</sup> A “community health board” is a county, group of counties, or city that is eligible to receive the CHS subsidy under 145A. There are currently 49 community health boards, representing county, multicounty, 4 city, and one city-county organization. The terms “local health department”, local public health agency, and “community health board” are often used interchangeably. MDH has relationships with many different staff, with county boards, and with community health boards. In this paper, the term “community health boards” is used to be consistent with the legal authority in 145A.

- are a vehicle for the delivery of services
- are a way to achieve public health goals
- contribute as many resources to public health as the state
- know the community and its “power players” in the case of an emergency
- can mobilize local resources
- can mobilize the community to solve problems that affect them
- are able to reinforce the state’s (Governor’s) legislative agenda
- have significant influence with local elected officials
- enforce laws and rules required by delegated agreement
- develop and enforce local ordinances
- provide a network to coordinate the achievement of statewide goals
- strengthen the public health system by helping to maintain a trusting, honest partnership
- are MDH’s colleagues at the local level that “speak our language”

The following reflect a range of MDH perspectives on the *functional components of the partnership* identified by the LPHA.



**Goal/vision statement:** Develop and maintain a system of communication that is two-way, timely, coordinated across divisions, and reflective of local differences. Develop an understanding of the complexities, duties, and authorities of both the state and local public health system.

**The ideal:**

- All community health boards have access to technology that can enhance two-way communication.
- A system is in place within the MDH that supports streamlined communication to community health boards.
- There is a CHS agency liaison within each MDH division (triage points by region, or division).
- The MDH and CHBs have clarity on what is meant by “two way” communication. What does that mean to community health boards and what does it mean to the MDH?
- All MDH and local public health staff have an understanding of the CHS system and how public health is carried out in Minnesota.
- MDH and CHS agencies share a common language to add clarity to communication.
- The MDH develops a coordinated system of communication that crosses all divisions and addresses the issues of: 1) sharing of information, 2) how, when, and for what purpose we solicit input from community health boards, 3) how frequently and in what format we communicate with agencies.
- Regardless of mechanisms developed to communicate with community health boards, there is a need for some face-to-face communication.
- Both MDH and local public health agencies will develop the ability to work through conflict.
- Coordinate technical assistance to and training of local public health agencies (skills needed by local staff to accomplish their multiple responsibilities are similar, regardless of the topic area).
- Create an atmosphere of more open and honest communication.

**What is there?**

- Lack of MDH staff understanding of the impact of our current method of communicating with community health boards.
- Formal and policy-level communication through SCHSAC and other MDH advisory committees.
- MDH communications to community health boards are increasingly fragmented.
- Work has been done on “how” we communicate with community health boards, but not on defining “what” (from their point of view) needs to be communicated. Determine what local agencies think we HAVE NOT been communicating about.
- In an attempt to compensate for what the community health boards saw as a lack of communication, the MDH now runs the risk of overloading community health boards with more information than they can or will absorb.
- CHBs are asked to provide input on an overwhelming number of MDH issues, some often trivial. CHBs are often not asked to provide input on larger policy issues.
- There is concern within the MDH that the vision for a streamlined system of communication within the MDH (one with decreased redundancy and increased frequency) is perhaps something the MDH is unable to achieve.
- Multiple newsletters, mailings, etc.
- CHS Mailbag not always used well/efficiently by MDH divisions.

**What can be done to improve?**

- Develop a mechanism to enhance two-way communication.
- Enhance the role of SCHSAC in communication to local elected officials about public health policy.
- Create access points into MDH within each Division, or by region, for information exchange and to coordinate technical assistance.

- Educate MDH staff about current communication mechanisms.
- Streamline communications to CHBs.

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**Indicators/measurements:**

- Appropriate, timely communication to CHBs.
- All community health boards have Internet access.
- SCHSAC members communicate back to their boards and staff about issues and decisions.

**Goal/vision statement:** Rely on the CHS system to identify local public health priorities and to address local public health needs. CHS plans should inform state priorities (e.g., goals, funding streams, developing resources to support local planning around content areas).

**The ideal:**

- CHS planning process provides the basis for identifying and addressing local health problems.
- Local community assessment and CHS planning goals are based on a consistent set of easily accessible health status data.
- Local CHS plans and goals can be consolidated to drive the state priorities and impact the legislature's decision on public health needs for the state.
- MDH and local agencies are accountable to the public health goals.
- CHS reporting data is used as a resource to evaluate and modify state and local public health activities.
- Minnesota has a competent state and local workforce.

**What is there?**

- Extensive analysis and training to support planning process.
- Categorical grants and "what we/they have always done" drives priorities.
- CHS plans are cumbersome and hard to consolidate the key points.
- If able to use plans and set priorities, policy makers may not necessarily follow and fund identified priorities.
- CHBs have varying views on the purpose and benefits of the CHS planning process (i.e., some agencies see the planning process as a legal requirement for the MDH, not a plan for the community or for their agency).
- Training and support to build skills in program or topic areas.

**What can be done to improve?**

- Increase the MDH understanding of the impact MDH policy may have on community health boards.
- Provide individual feedback to agencies on CHS plans.
- Resources to support local planning around specific content areas.
- Agency-wide discussion on how to use CHS plan in MDH priority setting.
- Explore what is possible to change with categorical grants, what is not.

**Indicators/measurements:**

- MDH uses priority areas identified in CHS plans to target support to community health boards and to pursue grants, etc.

**Goal/vision statement:** Assure that local government and the MDH are accountable to the 1987 Local Public Health Act and public health goals.

**The ideal:**

- All CHBs meet responsibilities under 145A and other grants.
- All CHBs carry out core functions/essential services.
- The MDH monitors compliance of CHBs and enforces statute and rules where appropriate.
- State and local governments have clearly defined and complementary roles in carrying out their public health responsibilities (e.g., investigation and control of disease).
- The MDH has developed clear examples for our various relationships (i.e., with counties, cities, CHBs).
- Public health funding to local public health agencies is connected to performance.
- The MDH reviews the CHS plans and responds with useful and timely feedback and is accountable for what it does with the CHS plans and data reports.

**What is there?**

- The CHS data reporting system provides limited accountability (annually tracks activities and expenditures, but does not specify any performance expectations or “standards”).
- MDH has limited resources to conduct oversight function aside from monitoring contracts for categorical grants. In addition, definitions of “success” with categorical grants vary.
- The capacity of community health boards to carry out public health responsibilities varies by agency (e.g., disease investigations).

**What can be done to improve?**

- Redesign data system to track activities identified in plans.
- Pilot test a performance based contract.
- All contracts are performance- or outcome-based.

**Indicators/measurements:**

- Reporting system tracks progress toward addressing problems identified in CHS plans.



**Goal/vision statement:** Local governments, through the CHS system, have stable, broad-based funding to address locally identified health problems, based on active community engagement and careful analysis of health status data.

**The ideal:**

- The CHS subsidy provides an adequate base to identify and address local health problems.
- The MDH provides some categorical grants to targeted efforts to address specific health problems.
- Local government contributes significant resources to support locally identified health issues.
- There is support and understanding that adequate resources are needed at the state level in order to provide support to local public health agencies and to fulfill other responsibilities.
- Funding to CHBs follows the *MDH Vision for Funding Public Health Activities* (12/97).

**What is there?**

- The CHS subsidy is less than 10% of total resources spent by local government public health.
- Funding may be used to support existing activities rather than based on true assessment of data and community priorities.
- Continual frustration from CHBs on the number of categorical grants and time needed to develop proposals for these grants.
- Legislature and federal government do not want to fund state or local infrastructure.

**What can be done to improve?**

- Increase community health boards', understanding of the barriers to using the CHS subsidy system as the primary funding mechanism for community health boards.
- Increase the MDH understanding of the challenges created by multiple, short-term, categorical grants.
- Consolidation of grant programs.
- Increase the understanding policy makers have of public health's importance.

**Indicators/measurements:**

- Decrease in the number of competitive grants.
- Increase the number of formula grants whose reporting requirements are tied to the annual CHS reporting system.

## BACKGROUND

**The Partnership in Crisis?**

In the summer of 1998, the MDH was required to make significant reductions in its budget. One of the outcomes of these budget reductions involved the elimination of two Public Health Nursing Consultant positions. These reductions, combined with previous budget reductions and loss of staff in the district offices, heightened concern about the viability of the state and local public health partnership. Between September 1998 and November 1998, staff from the MDH met with local public staff to discuss the MDH budget problem, its implications for state and local public health efforts, and to identify actions to improve the state and local public health system. MDH staff developed a paper – *Maintaining a Strong Public Health Partnership* – to summarize these regional meetings.

This paper served as the foundation for a “Partnership Summit.” This Summit was a meeting of 16 local public health staff (representing each of the eight regions of the state and environmental health directors), 15 MDH staff (representing 4 MDH divisions and the Executive Office) and 5 county commissioners.

The purposes of the Partnership Summit were to affirm findings from regional meetings regarding MDH budget reductions and the state and local partnership; and identify steps and timeline for actions to strengthen state and local government two-way communication and mutual support efforts.

Issues identified at the summit and during the regional meetings were very broad. Summit participants identified five priority areas: 1) develop systematic two-way communication; 2) enhance district office role and staffing (generalist position); 3) expand use of technology (Internet connections); 4) improve state-level coordination (legislative communication); 5) streamline grants administration.

To assure that action was taken on each of the priority areas identified at the Summit, several participants agreed to work in 5 small teams, each team to continue discussions on one of the priority areas. In February 1999, a smaller group, representing members of each of these teams, met to discuss progress in each of the priority.

**A Vision for the Future**

Many local Summit participants felt that one of the short-comings of the Partnership Summit was the focus on specific tasks and the “action plan,” versus a broader “vision” for the state and local public health partnership. To address this need, the Local Public Health Association (LPHA), charged a small group to identify what the LPHA saw as the key components of the partnership and draft of paper for discussion. The MDH also convened a group of MDH staff to develop a “department perspective” for each component presented in the LPHA paper.