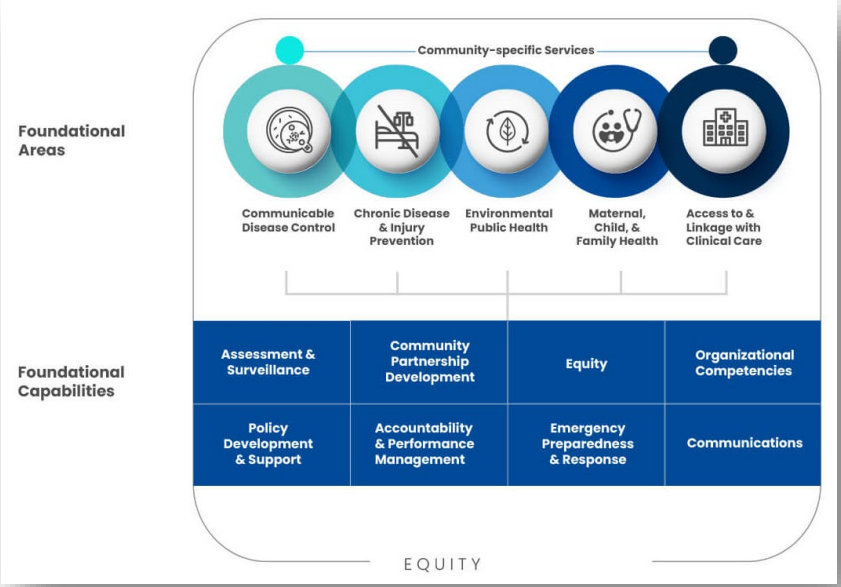
Building a Strong Foundation for a Healthier Minnesota: 2023 Community Health Board Report on Foundational Public Health Capabilities

SCHSAC PERFORMANCE MEASUREMENT WORKGROUP REPORT

Governmental public health is crucial in nurturing healthy, safe, and vibrant communities. Public health experts partner with communities to overcome barriers that prevent people from living their healthiest lives. By shaping policies, systems, and environments, governmental public health can positively impact Minnesotans' health long before they step foot in a doctor's office.

The Foundational Public Health Responsibilities Framework defines what needs to be in place everywhere for our public health system to work anywhere. It outlines foundational areas and capabilities of the governmental public health system.

In 2023, all 51 community health boards reported on 24 national measures related to foundational capabilities. Foundational capabilities are the cross-cutting skills and capacities needed to support basic public health protections, programs, partnerships, and activities to ensure community health, well-being, and equitable outcomes. Just like a house needs a solid foundation to support its walls, roof, and essential functions, these capabilities are the foundation of all public health work. They support the programs and initiatives needed for healthy communities. A list of the 24 measures is included in Appendix B, starting on page 17 of this report.



This workgroup report is a testament to the significant work of Minnesota's community health boards as we work toward a more seamless, responsive, and publicly-supported public health system that works closely with the community to ensure healthy, safe, and vibrant communities. This system of state, local, and Tribal health departments will help Minnesotans be healthy regardless of where they live. This report summarizes the results, key takeaways, and observations from performance measurement data reported by community health boards for calendar year 2023.

Please note that the data presented here is solely from the community health boards and does not include data from the Minnesota Department of Health or Tribal Nations. The sovereignty of

Minnesota's Tribal Nations is affirmed and their authority over their public health data, which remains under their control and ownership, is acknowledged.

What's in this report

- **Results and key findings, including:**
  - Minnesota's public health system has many strengths to celebrate. At the same time, data shows disparities that call for exploration.
    - Figure 1: Minnesota community health board ability to meet a subset of 24 key national measures, by community health board (population served), 2023
    - Figure 2: National measures met, by community health board size (population served), 2023
    - Figure 3: Percent of national measures met by community health boards for each foundational capability, 2023
  - The data suggests a positive impact when there is focus and investment, and a negative impact of COVID-19 on community health boards.
    - Figure 4a-d: Calendar year 2023 compared to calendar years 2017 and 2018
  - Data reflects varied ability to fully meet measures, but the local system is working hard to innovate, learn, and strengthen its foundation.
  - Several limitations and contextual factors should be considered when interpreting the data.
- **Appendix A: Additional graphs, including:**
  - Figure 5: National measures met by community health boards in each SCHSAC region
  - Figure 6a-b: Overview of 24 national measures by the 51 community health boards
  - Figure 7a-b: National measures that community health boards met, organized by foundational capabilities
  - Figure 8a-f: Additional graphs comparing calendar year 2023 to calendar year 2017 and 2018
- **Appendix B: About performance measurement**
- **Appendix C: Workgroup charge and membership**

Results and key takeaways

Minnesota's public health system has many strengths to celebrate. At the same time, data shows disparities that call for exploration.

Good work is happening across Minnesota's local public health system. Out of 51 community health boards, 74.5% (38) report being able to fully or substantially meet over half of the measures.

- The local system is collectively more able to fully or substantially meet measures of assessment and surveillance and organizational competencies, including workforce development measures. Community partnership development and emergency preparedness and response were also strong.
- Measures related to policy development and support were strong for some community health boards and harder to meet for others.
- Community health boards were strong in measures related to statutory obligations, like community health assessments, community health improvement planning, and measures around emergency preparedness.

This report only looked at the ability to meet about 30% of the national measures, but we can see recent investments in funding and system transformation already at work. While we are excited about the good work happening across the state, we still have many community health boards that cannot fully meet many of the measures. We know our work is not done. – Workgroup member

- Some of the data validates investment and efforts put into workforce development, data, policy, systems, and environment work, and emergency preparedness and response.

We see disparities based on population size. Community health boards serving more than 100,000 people were more able to substantially or fully meet measures.

- Health departments serving less than 50,000 people were, on average, able to fully or substantially meet 60% of the performance measures.
- Rural areas and jurisdictions with smaller populations continue to face challenges in providing everyday public health.
- The local system was least able to fully meet measures in the capabilities of communication, accountability and performance management, and equity.

Population size is not the only factor in a community health board's ability to meet performance measures.

- There are several small and medium-sized community health boards able to fully and substantially meet over half of the measures.
- Nearly a quarter (24%) of community health boards, of all sizes, were unable to fully meet 21% of the national measures (5 out of 24).

Figure 1: Minnesota community health board ability to meet a subset of 24 key national measures, by community health board (population served), 2023

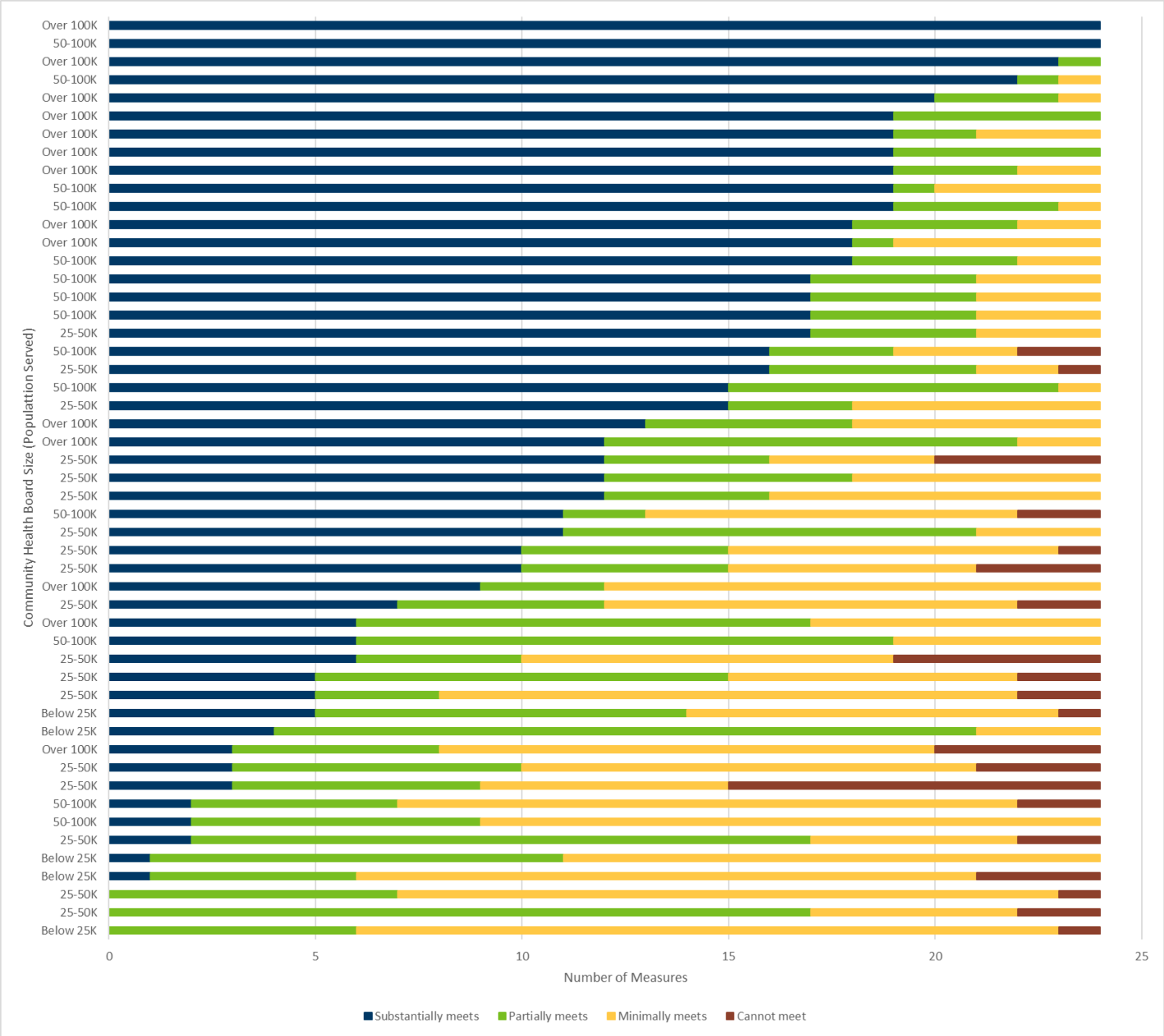


Figure 2: National measures met, by community health board size (population served), 2023

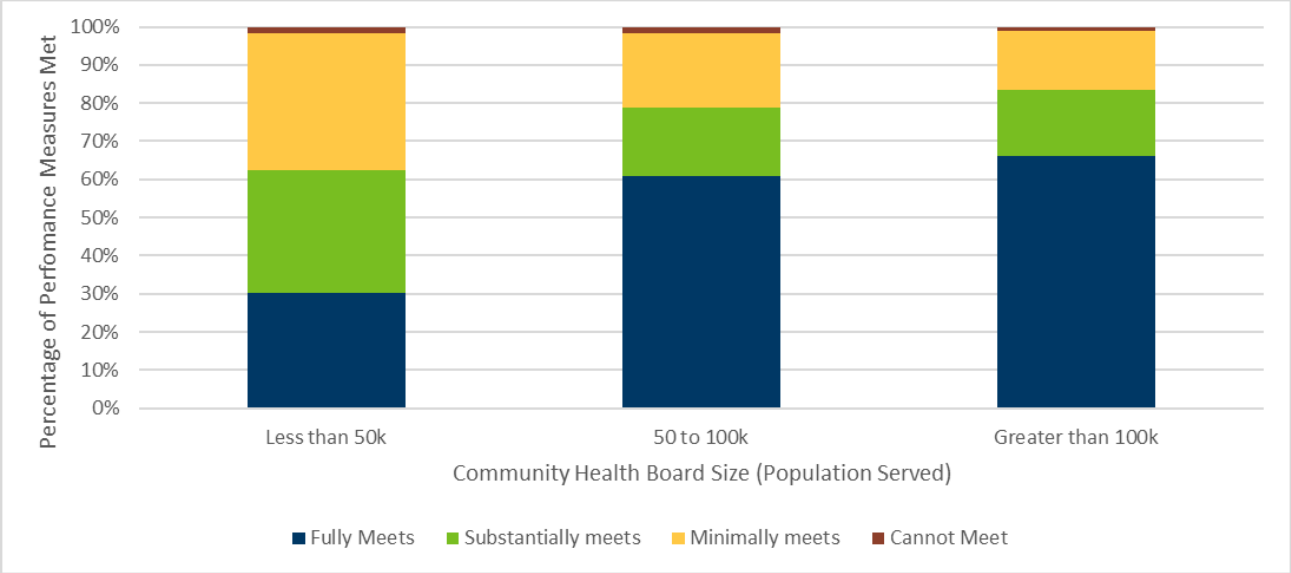
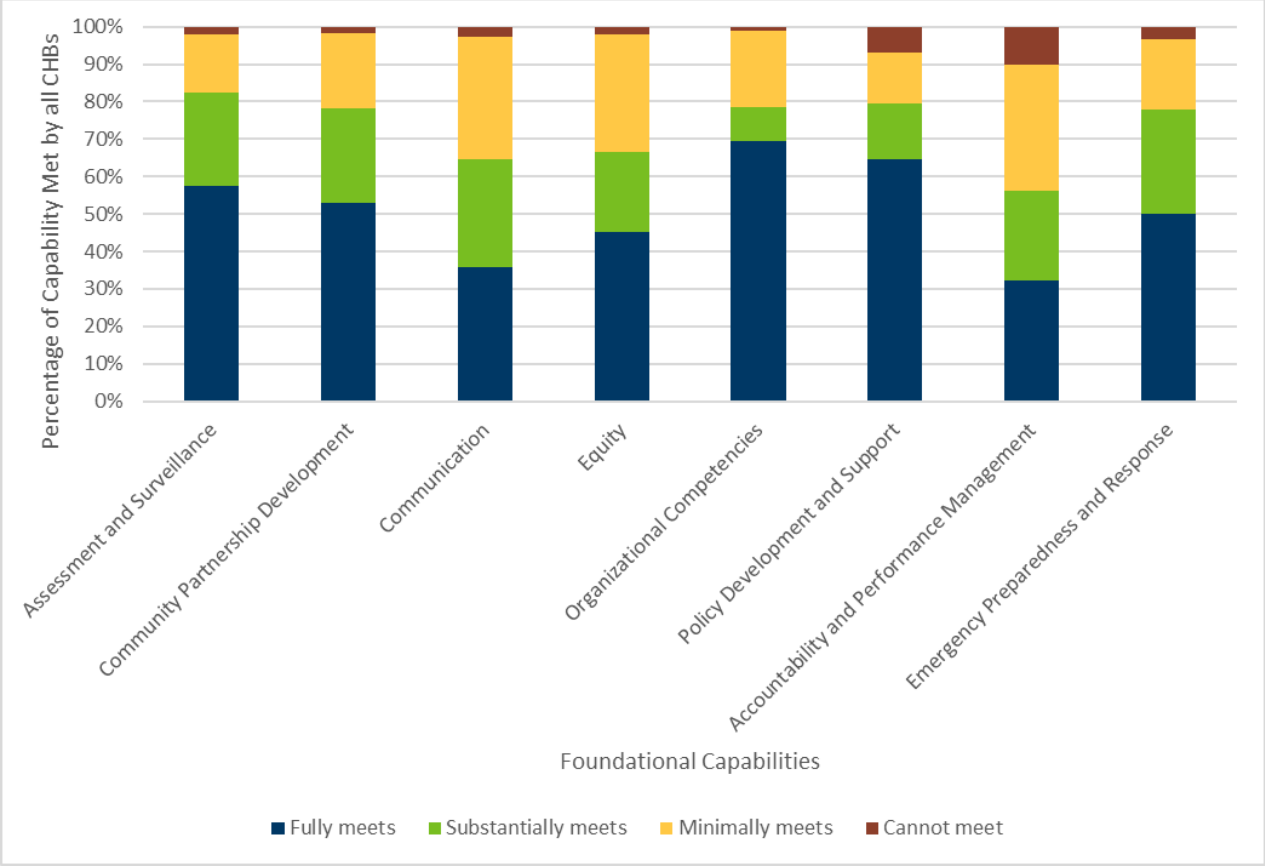


Figure 3: Percent of national measures met by community health boards for each foundational capability, 2023



The data suggests a positive impact when there is focus and investment and a negative impact of COVID-19 on community health boards.

Figures 4 a to 4 d on page 6 compare 2017/2018 to 2023 data. We see reductions in the number of community health boards fully meeting nearly all the 11 measures with pre-COVID-19 trend data. Additional 2017/2018 to 2023 trend data are in Appendix A, figures 8 a to 8 g.

- Improvement is seen in the measure related to organizational competencies, "Collaborating to promote the development of the future public health workforce."
- The sharpest declines are seen in the trend data for measures related to the capability of accountability and performance management.
- Workgroup members noted COVID-19 and leadership/staff turnover as two interrelated factors that create persistent challenges and likely impact public health performance.

  Between 2020 and 2024 over 49% of community health boards have undergone a change in leadership. These leadership changes only reflect changes in community health services administrators and does not include changes in public health leadership at the county level. Despite receiving funding to hire staff, some community health boards still struggle to attract and retain the required expertise, contributing to persistent challenges.

"The years impacted by COVID have shown that the needle has moved, and not in the most positive direction. COVID's effects aren't just in what we're talking about – it's reflected in the data."
- Workgroup member

It is difficult to sustain work on foundational capabilities, such as communications, equity, and accountability performance measures, without dedicated staff to ensure the work happens. The Foundational Public Health Responsibilities Grant is a start, but it's not enough to fully address the issue. – Workgroup member

Figures 4a-d: Graphs comparing calendar year 2023 to calendar years 2017 and 2018

Figure 4a: Collaborate to promote the development of future public health workers

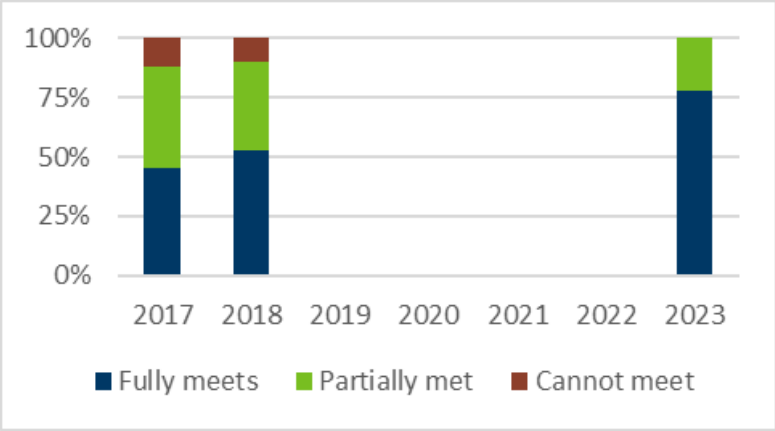


Figure 4b: Establish a performance management system

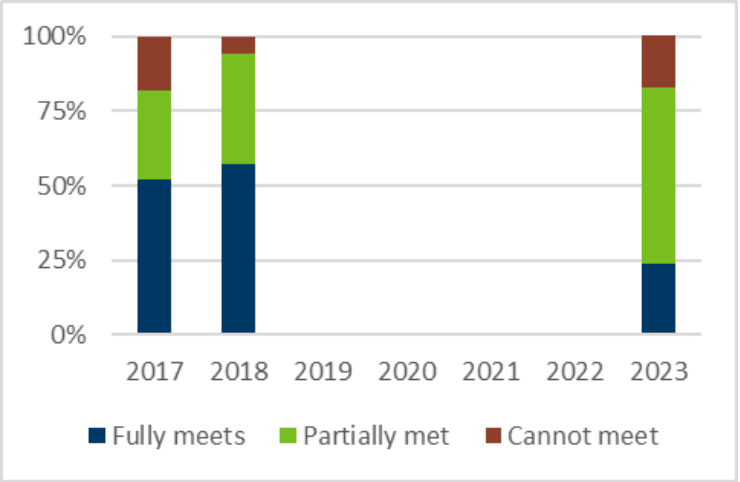


Figure 4c: Implement the performance management system

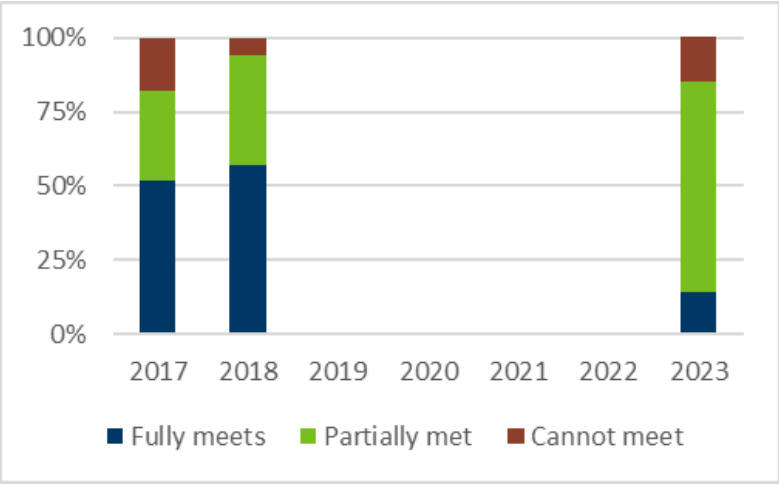
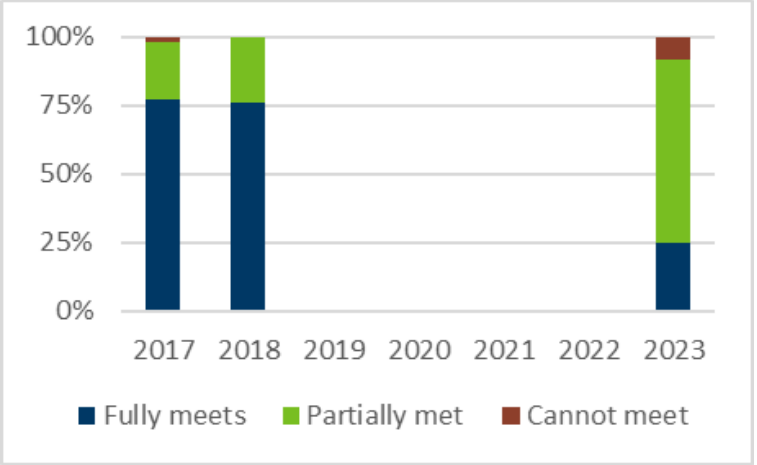


Figure 4d: Implement and evaluate strategies to improve access to health care services



Data reflects varied ability to fully meet measures, but the local system is working hard to strengthen its foundation, innovate, and learn.

Our local public health system remains a "patchwork" of strengths and challenges, as was reflected in the 2022 cost and capacity assessment results.

- Collective work is needed to understand the conditions, including policies, practices, resource flows, power dynamics, and strongly held beliefs or assumptions (mental models) that are contributing to gaps and preventing community health boards from fully meeting all performance measures.
- This data was collected before the Foundational Public Health Responsibilities (FPHR) Grant was made available to community health boards. This down payment of funding is anticipated to help strengthen the foundational capabilities and areas, building a governmental public health system that works everywhere for everyone. Moving forward, insights into the impact of this funding on community health board's ability to meet measures are anticipated.
- There is continued learning from the State Infrastructure Projects, which are pioneering new and innovative approaches to advancing public health and driving larger system transformation. There is an opportunity to keep exploring creative solutions to strengthen our system, such as bolstering existing staff capacity and regional collaboration.

> *"Building regional data capacity has been an incredible learning experience. Needs vary, so there's no one-size-fits-all approach. Every county should have access to their own data and resources for interpreting information, but not every county requires dedicated staff. By providing access to data, we've enabled counties to allocate their resources more effectively, focusing on making the data actionable and relevant." – Local public health leader's reflections from State Infrastructure Fund project*

Several limitations and contextual factors should be considered when interpreting the data.

- The data presented here includes only that of local public health and does not encompass data from the Minnesota Department of Health or Tribal Nations. As such, it does not provide a comprehensive picture of the state's public health system performance. Moving forward, collecting similar performance data from the Minnesota Department of Health will be important. The sovereignty of Minnesota's Tribal Nations is affirmed and their authority over their own public health data, which remains under their control and ownership is acknowledged.
- Self-reporting is a widely used method for collecting data in public health. It comes with limitations, including less objectivity which can impact data quality. In CY2023, effort was made to standardize response options to improve objectivity and consistency in reporting across the state.
- Reporting was done by community health board. For multi-county community health boards, there may be differences between ability to meet by member counties that are not captured in the data. Multi-county community health boards were asked to report based on the lowest ability to meet of member counties.
- The measures assess how well community health boards can perform public health capabilities. However, they do not show if community health boards have what they need to meet the specific needs of their communities since community needs are not measured. This means that even if a larger community health board can carry out core public health capabilities, it does not necessarily mean they have enough resources to address their community's actual needs—or that they are better equipped than smaller community health boards to meet those needs.
- Regarding figures 3 through 13: Comparing the 2017-2018 to 2023 data has limitations. These include:
    - In 2017 and 2018, the measures were based on PHAB version 1.5, whereas the 2023 measures were based on PHAB version 2022. Elements associated with the measures differed between the versions. Community health boards accredited through this earlier version found the later version to be more stringent, which is an important consideration when looking at the results.
    - There were four response options in CY2023 (fully, substantially, minimally, and cannot meet) and three response options in CY2017 and CY2018 (fully, partially, cannot meet), CY2023 responses for substantially and minimally were combined a labeled "partially met" for these comparisons.
    - Community health boards did not report on performance measures from 2019 to 2022, and there was a lot of staff turnover between the reporting periods. It is likely for many community health boards that different staff reported in CY2017 and CY2018 then responded in CY2023, which may have impacted self-reported responses.

Appendix A: Additional graphs for SCHSAC member reference

Figure 5: National measures met by community health boards, by SCHSAC region, 2023

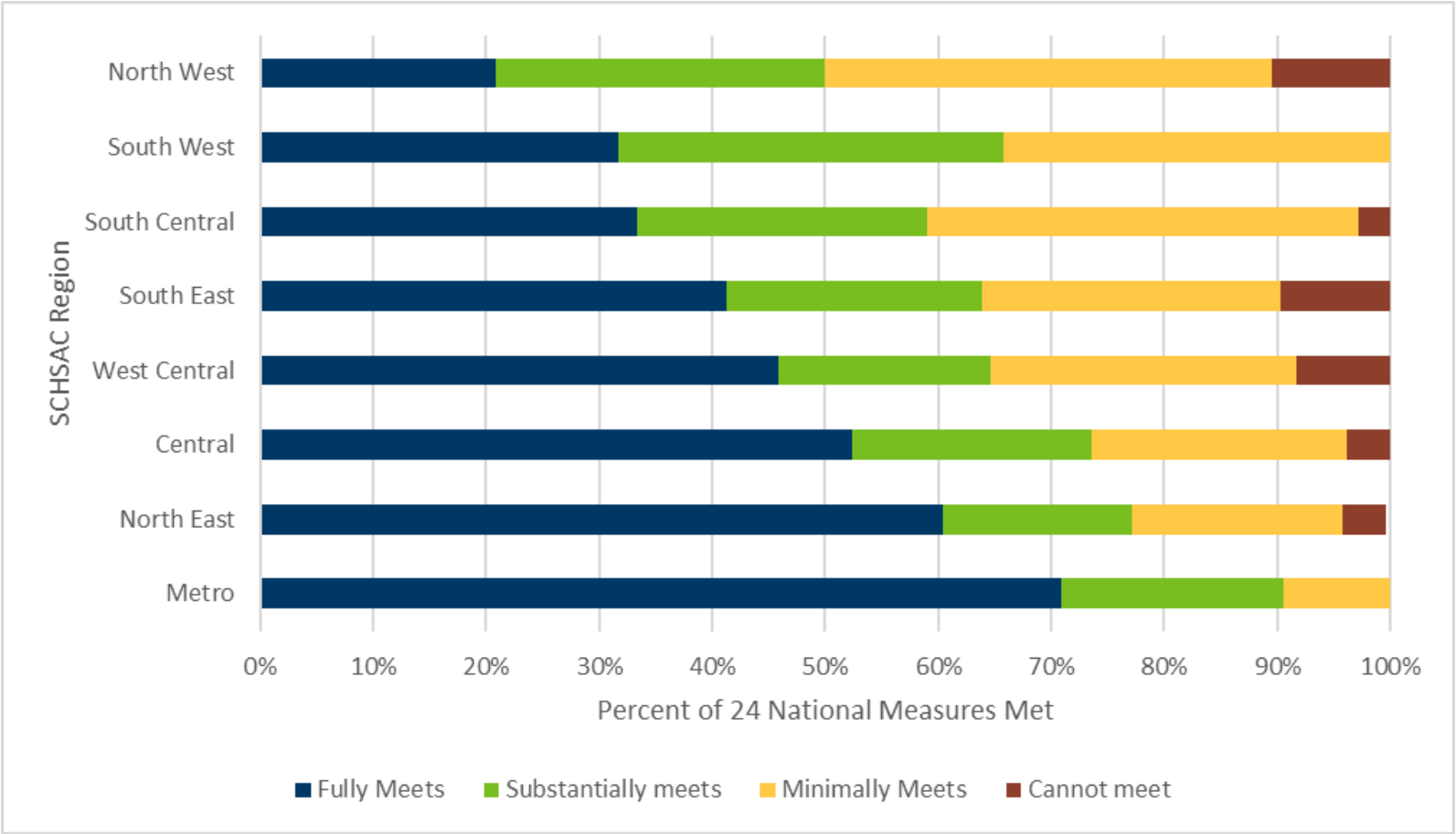


Figure 6a: Overview of 24 national measures met by the 51 community health boards, 2023

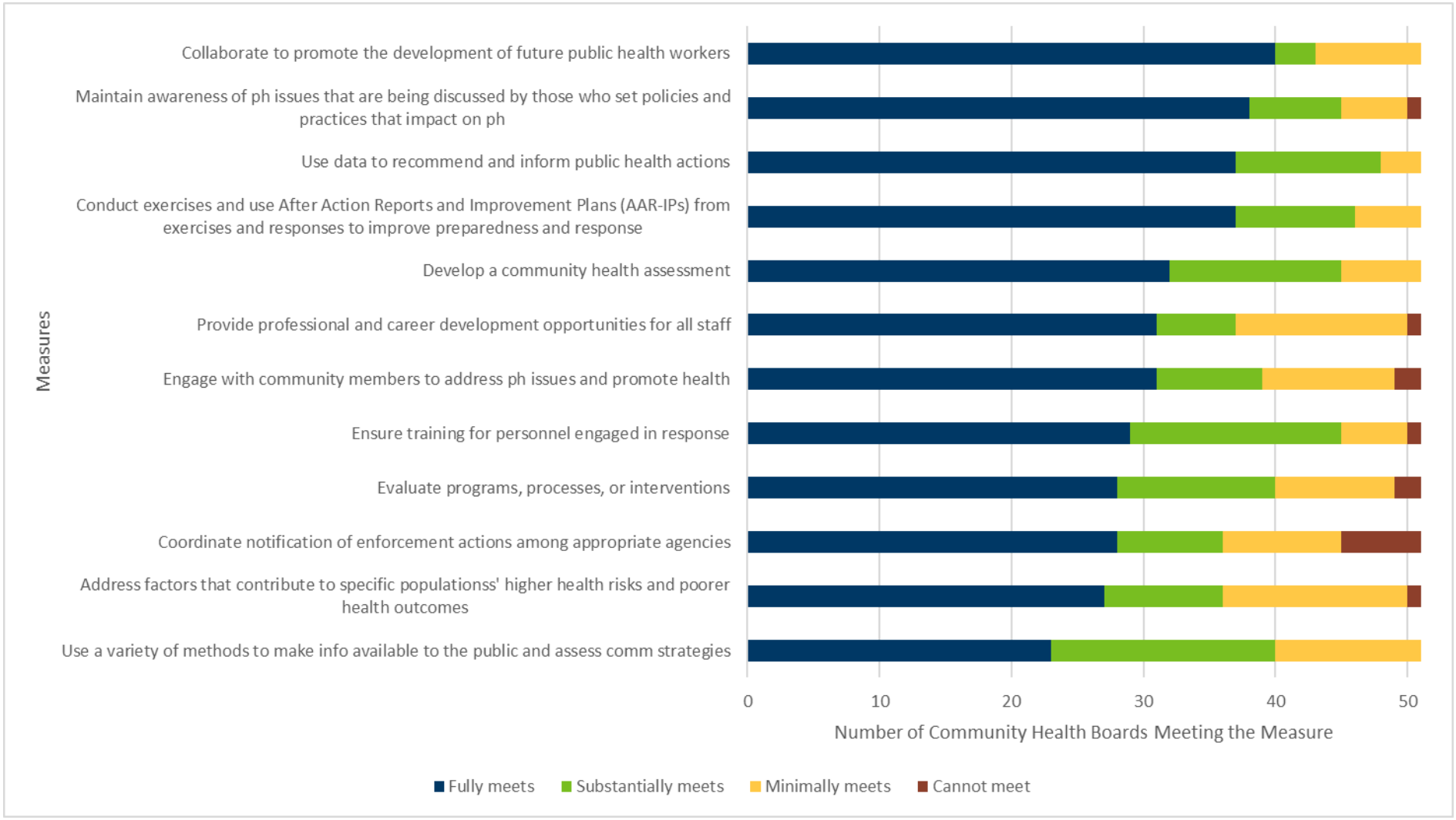


Figure 6b: Overview of 24 national measures met by the 51 community health boards, 2023 (continued)

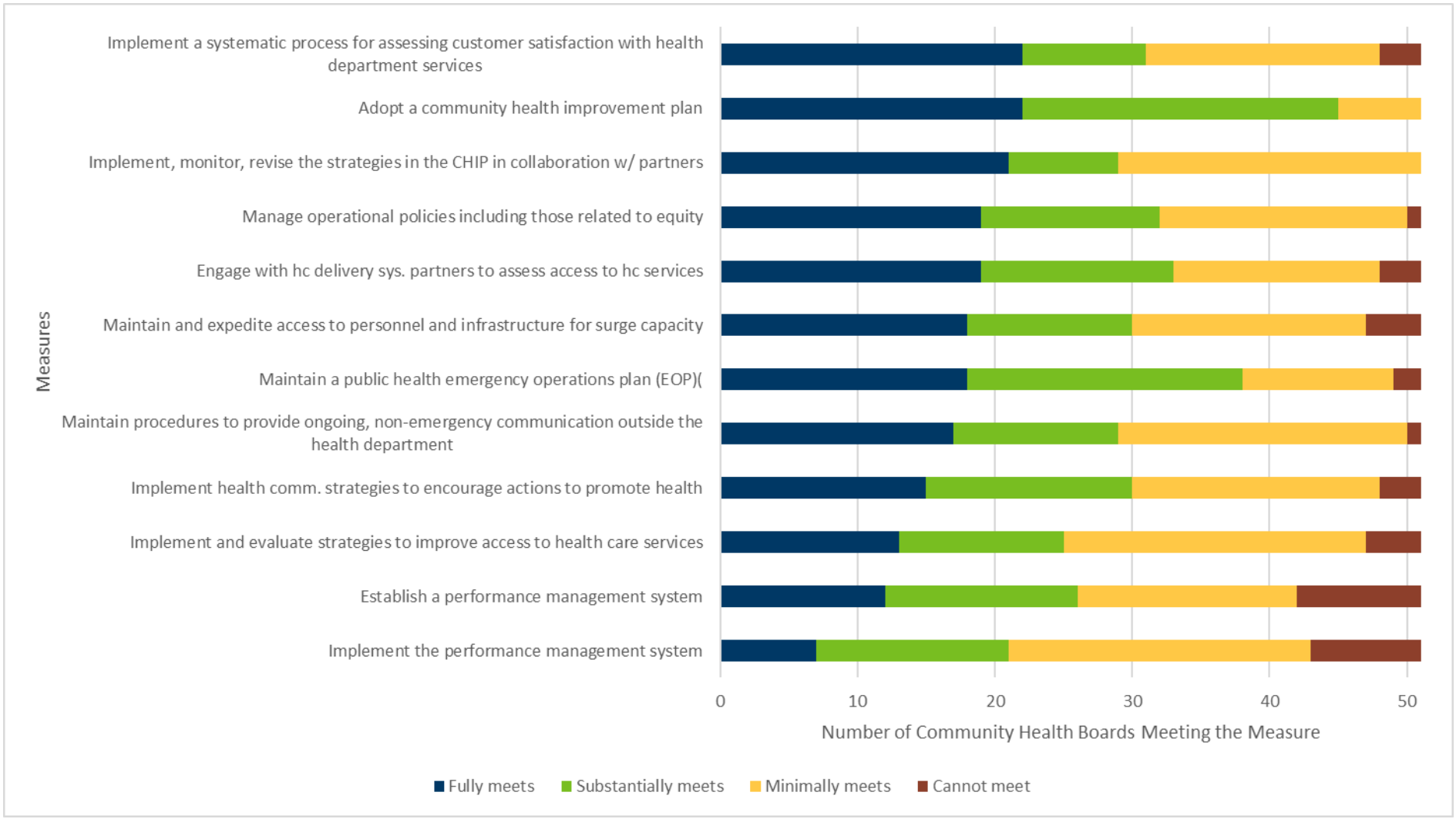


Figure 7a: National measures that community health boards met, organized by foundational capabilities, 2023

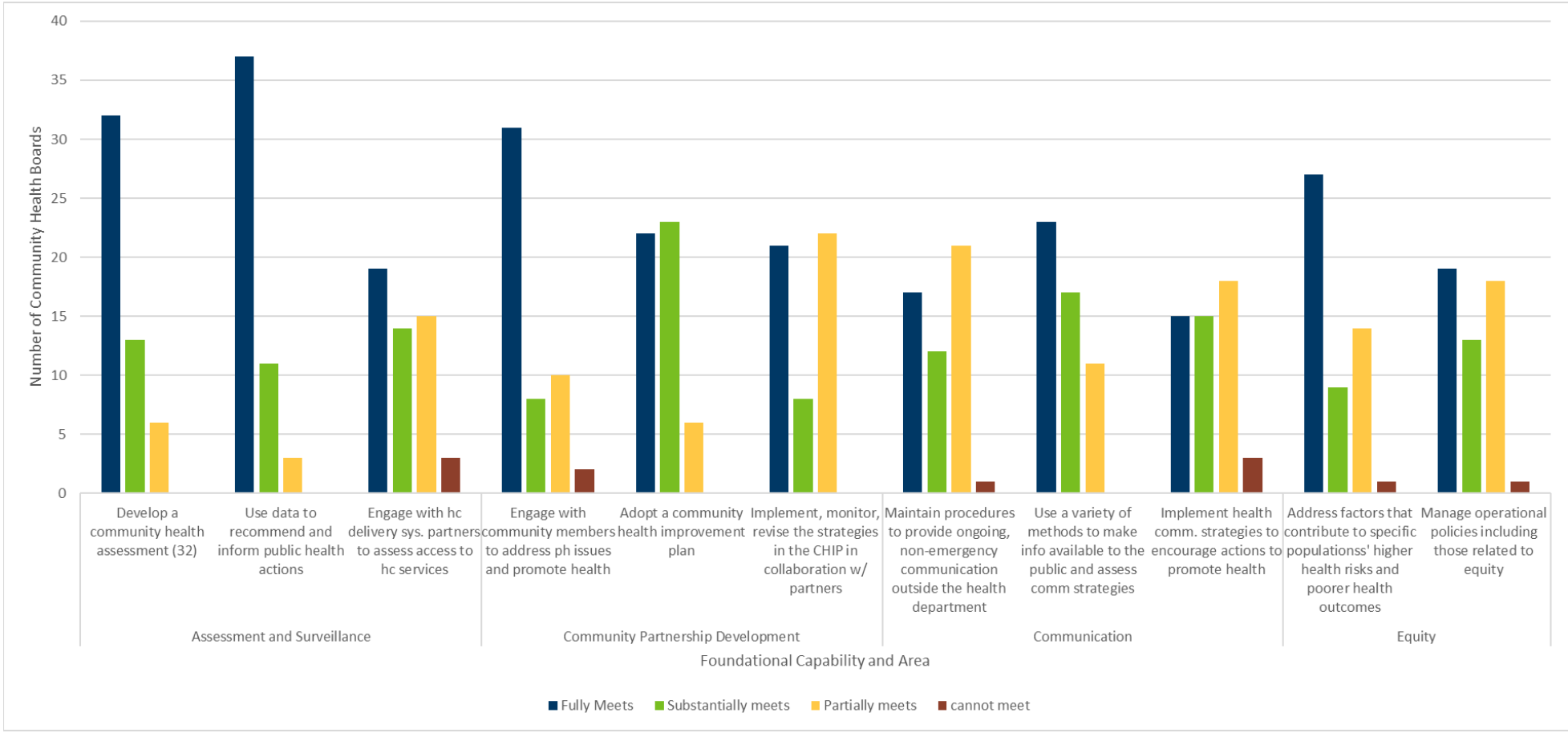


Figure 7b: National measures that community health boards met, organized by foundational capabilities, 2023(continued)

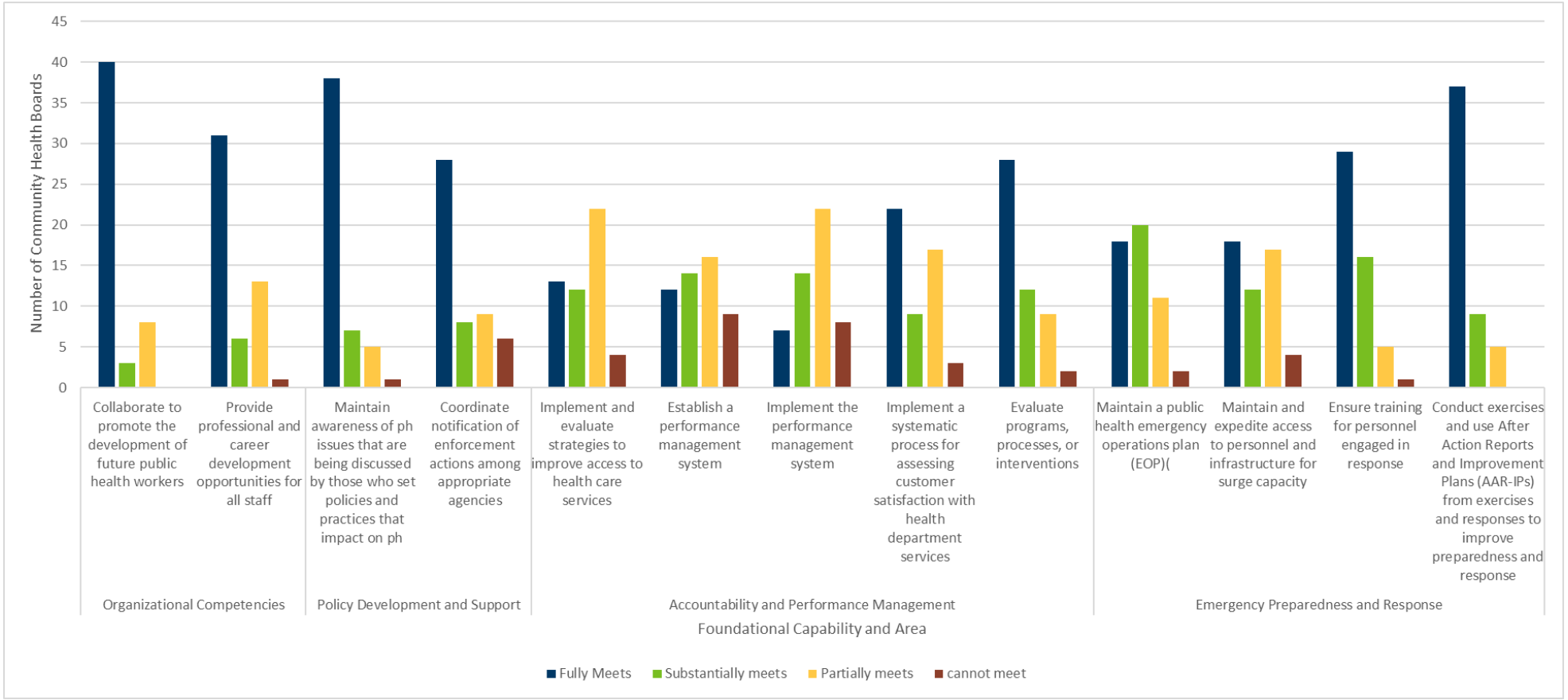


Figure 8a-d: Additional graphs comparing calendar year 2023 to calendar years 2017 and 2018

Figure 8a: Maintain procedures to provide ongoing non-emergency communication outside the health dept.

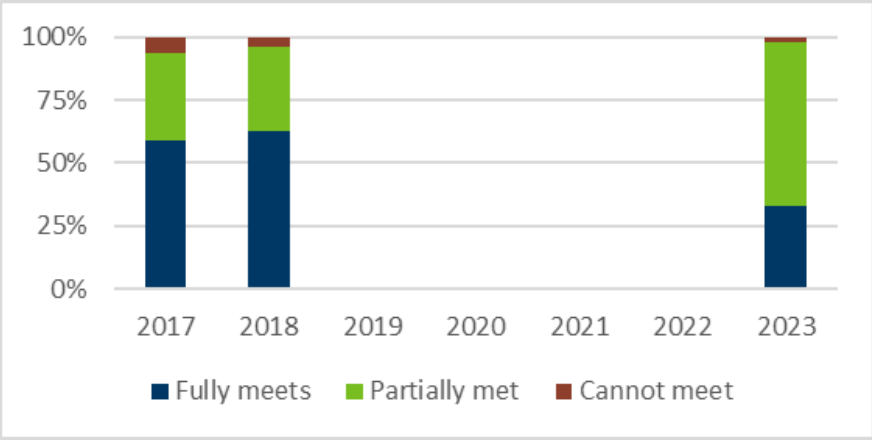


Figure 8b: Implement, monitor, and revise as needed, the strategies in the CHIP collaboration with partners

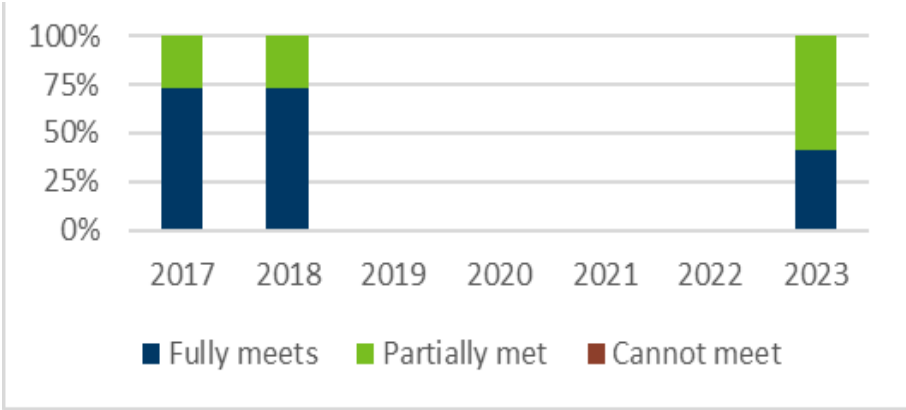


Figure 8c: Implement health communication strategies to encourage actions to promote health

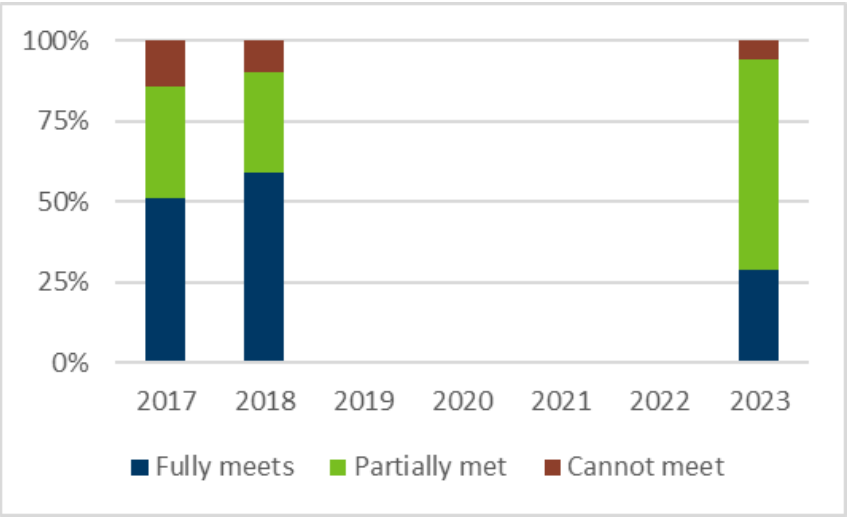


Figure 8d: Address factors that contribute to specific populations' higher health risks and poorer health outcomes

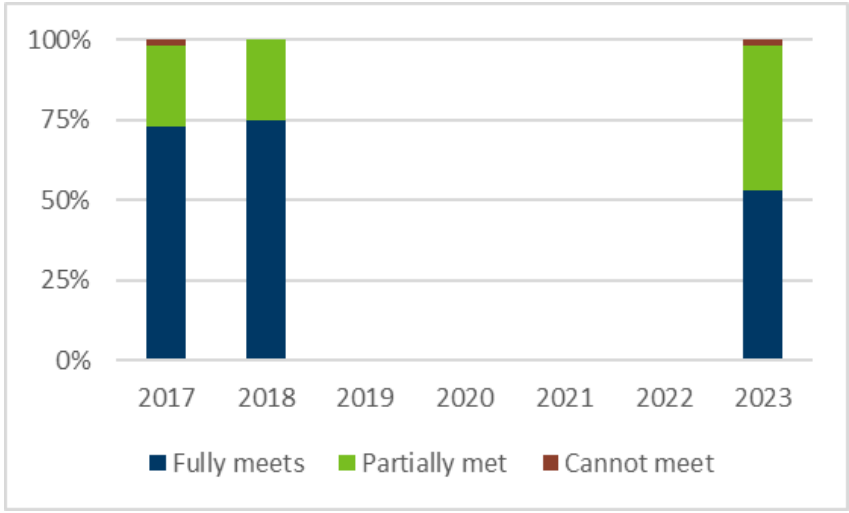


Figure 8e: Engage with health care delivery system partners to assess access to health care services

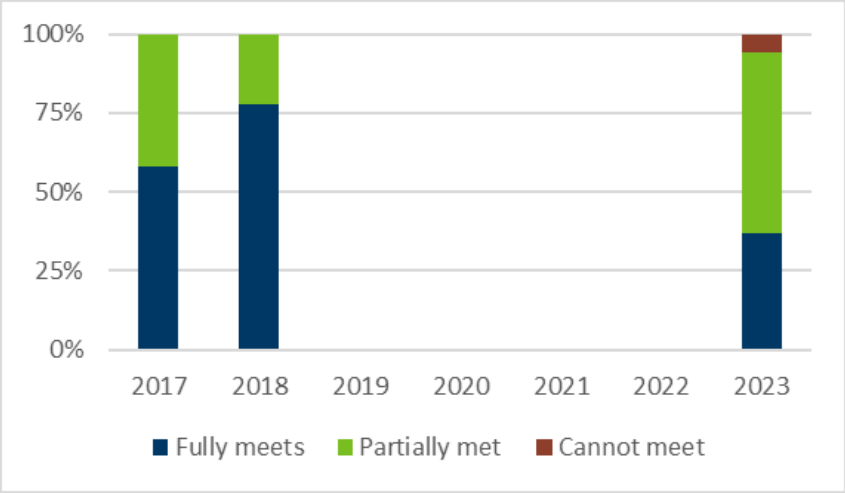


Figure 8f: Develop a community health assessment

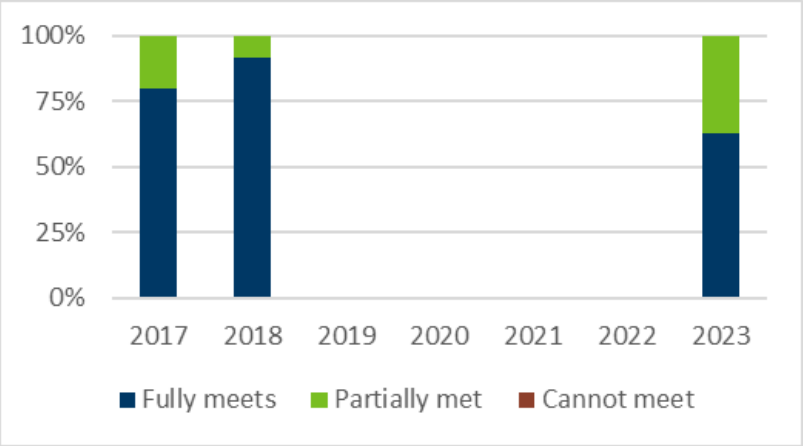
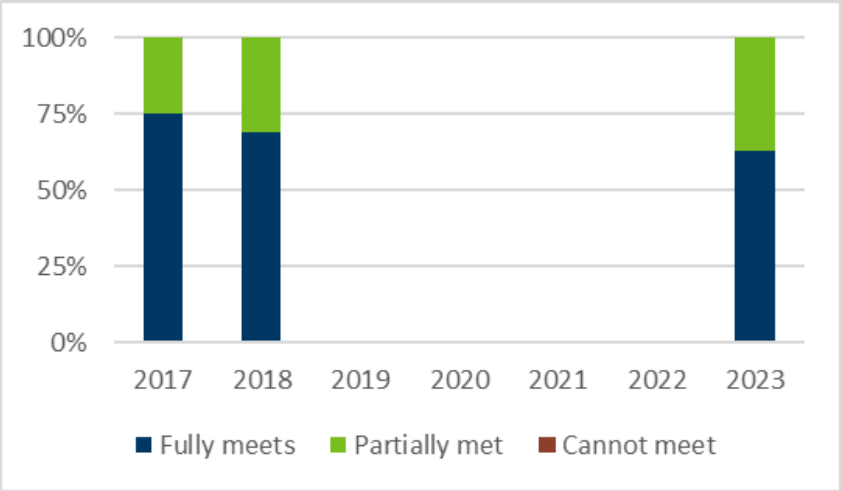


Figure 8g: Use data to recommend and inform public health actions



Appendix B: About performance measurement

What was measured

The Local Public Health Act performance measures for calendar year 2023 correspond with the Foundational Public Health Responsibility Framework. The 24 national measures are a subset of Public Health Accreditation Board measures and align with foundational capabilities that are part of the Foundational Public Health Responsibilities Framework. Public Health Accreditation Board standards and measures for initial accreditation, version 2022.(https://phaboard.org/wp-content/uploads/Standards-Measures-Initial-Accreditation-Version-2022.pdf). In Minnesota, community health boards are not required to become accredited; however, these national measures represent best practices for governmental public health work.

Community health board responses reflected the status of the community health board between the reporting period Jan. 1, 2023, through Dec. 31, 2023.

Community health boards reported on the following 24 national measures

The (E) after some of the measures denotes there is an equity component related to that measure.

Foundational capability	National measures
Assessment and surveillance	1.1.1 Develop a community health assessment. (E) 1.3.3: Use data to recommend and inform public health actions. 7.1.1: Engage with health care delivery system partners to assess access to health care services. (E)
Community Partnership Development	4.1.3: Engage with community members to address public health issues and promote health. (E) 5.2.2: Adopt a community health improvement plan. (E) 5.2.3: Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners.
Communications	3.1.1: Maintain procedures to provide ongoing, non-emergency communication outside the health department. (E) 3.2.2: Implement health communication strategies to encourage actions to promote health. (E) 3.1.4: Use a variety of methods to make information available to the public and assess communication strategies.
Equity	5.2.4: Address factors that contribute to specific populations' higher health risks and poorer health outcomes. 10.2.1: Manage operational policies including those related to equity.
Organizational Competencies	8.2.2: Provide professional and career development opportunities for all staff. 8.1.1: Collaborate to promote the development of future public health workers.
Policy Development and Support	5.1.1: Maintain awareness of public health issues that are being discussed by those who set policies and practices that impact on public health. 6.1.5: Coordinate notification of enforcement actions among appropriate agencies.
Accountability and Performance Management	9.1.1: Establish a performance management system. 9.1.2: Implement the performance management system. 9.1.3: Implement a systematic process for assessing customer satisfaction with health department services. (E) 9.2.2: Evaluate programs, processes, or interventions. 7.1.2: Implement and evaluate strategies to improve access to health care services. (E)

Foundational capability	National measures
Emergency Preparedness and Response	2.2.1: Maintain a public health emergency operations plan (EOP)(E) 2.2.3: Maintain and expedite access to personnel and infrastructure for surge capacity. 2.2.4: Ensure training for personnel engaged in response. 2.2.7: Conduct exercises and use After Action Reports and Improvement Plans (AAR-IPs) from exercises and responses to improve preparedness and response.

Reporting guidance

Community health boards were asked to engage key staff in reviewing the 24 measures and consider the requirements and related elements for each measure. In an effort for consistency in reporting, the measures with several requirements and elements were numbered, and the number accomplished used to consider the response selection. Community health boards were asked to consider thoroughness and quality in selecting their response. Community health boards were not required to submit any documentation.

Community health boards selected from the following response options:

- Fully meet
- Substantially meet
- Minimally meet
- Cannot meet

Multi-county community health boards were asked to report on the lowest level of capacity of member health departments. That is, if two of three local health departments in a multi-county community health board can fully meet a measure, but the third can only minimally meet, the entire community health board should report minimally meet. If the third cannot meet the measure at all, the entire community health board should report cannot meet (see example).

Example for multi-county community health boards:

1.1.1 Develop a Community Health Assessment	Health dept 1	Health dept 2	Health dept 3	CHB (select the lowest level of capacity)
Fully meets	X		X	
Substantially meets				
Minimally meets		X		X
Does not meet				

Appendix C: Workgroup charge and membership

The Performance Measurement Workgroup leads efforts to measure and assess the performance of Minnesota's governmental public health system and its capacity to carry out public health responsibilities.

As part of this work, the workgroup analyzes performance data from local public health annual reporting. By reflecting on this data, we can uncover our system's strengths, identify its gaps, and assess the effectiveness of our efforts. This insight allows us to see the big picture, revealing how local health challenges connect to larger systemic issues.

This workgroup report summarizes the results and key takeaways gleaned from local public health annual reporting data from 2023. For the full workgroup charge, please visit: Standing and active SCHSAC workgroups - MN Dept. of Health.

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Amy Bowles, Beltrami

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Susan Michels, Carlton, Cook, Lake, St. Louis Community Health Board
Angie Hasbrouck, Horizon Public Health
Janet Goligowski, Stearns County Health and Human Services
Amina Abdullahi, City of Bloomington Public Health
Michelle Ebbers, DesMoines Valley Health and Human Services
Chera Sevcik, Health and Human Services, Faribault and Martin Counties
Meaghan Sherden, Olmsted County Public Health
Rodney Peterson, Dodge County Commissioner
Mark Dehen, Nicollet County Commissioner
Chris Brueske, Minnesota Department of Health, Office of Data Strategy and Interoperability
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