Public Health System Development in Minnesota

A REPORT TO THE MINNESOTA LEGISLATURE FROM THE JOINT LEADERSHIP TEAM FOR PUBLIC HEALTH SYSTEM TRANSFORMATION

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Minnesota Department of Health
Community Health Division
On behalf of the Joint Leadership Team for Public Health System Transformation
PO Box 64975
St. Paul, MN 55164-0975
651-201-3880
health.ophp@state.mn.us
www.health.state.mn.us

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Contents

Introduction

This report describes how Minnesota's public health leaders, elected officials, and community members work together to help our communities thrive by doing the foundational work of public health in innovative and collaborative ways, partnering across sectors and geographies, and working together to meet today's health needs while anticipating tomorrow's.

It was developed under the guidance and collaborative leadership of the Joint Leadership Team for Public Health System Transformation in Minnesota, representing local elected officials who are members of the State Community Health Services Advisory Committee (SCHSAC), the Local Public Health Association of Minnesota (LPHA), and the Minnesota Department of Health (MDH):

- Tarryl Clark, Stearns County Commissioner; 2023-2024 SCHSAC Chair
- Brooke Cunningham, Minnesota Commissioner of Health
- Chelsie Huntley, Director, MDH Community Health Division
- Nick Kelley, Public Health Administrator, City of Bloomington; 2024 LPHA Chair
- Sheila Kiscaden, Olmsted County Commissioner; Immediate Past SCHSAC Chair
- De Malterer, Waseca County Commissioner; SCHSAC Chair-Elect
- Kim Milbrath, Manager, MDH Center for Public Health Practice
- Kari Oldfield-Tabbert, Director, LPHA
- Kris Rhodes, Director, MDH Office of American Indian Health
- Maggie Rothstein, Community Health Services Administrator, Aitkin-Itasca-Koochiching Community Health Board; Immediate Past LPHA Chair
- Maria Sarabia, Assistant Commissioner, MDH Health Improvement Bureau
- Robsan (Halkeno) Tura, Assistant Commissioner, MDH Health Equity Bureau
- Amy Westbrook, Public Health Division Director, St. Louis County; LPHA Chair-Elect

MDH publishes this report every two years on how the local public health system meets its responsibility to deliver core public health activities to the people of Minnesota, as required by Minn. Stat. § 62Q.33 since 1992. Minn. Stat. §145A, the Local Public Health Act, outlines the structure and responsibilities of the state and local public health system. Tribal health departments have their own sovereign authority.

Public health supports thriving communities

Minnesota's quality of life depends on thriving, vibrant communities. Where we live provides the building blocks for long-term health and wellbeing, including protection from the spread of infectious diseases and environmental threats, clean water, strong schools, sustaining jobs, community connectedness, access to health care, and other important community support.

In public health, we work to change these surroundings for the better so that it's easier for all of us in Minnesota to be our healthiest no matter who we are or where we live.

In 2023, the Minnesota Legislature recognized the role and value of public health with a much-needed down payment on Minnesota's public health system. This financial investment into the health of Minnesotans has been long overdue, and more is needed to expand proven public health solutions across the state, continue to test innovative ways to deliver public health, and make sure communities have the resources and supports they need for their health to thrive—**and yet, it's not enough**.

Minnesota's public health system is a responsible and effective steward of this funding; when we prevent illness before it starts, the return we see in both health outcomes and monetary investment pays off for Minnesotans, their families, our state's businesses, government, and more.

Everyone in Minnesota deserves to be their healthiest

Everyone in Minnesota should have the opportunity to be their healthiest, regardless of who they are or where they live.

A healthy and thriving community shapes opportunities for social cohesion, economic vitality, mental health and wellness, and more. Businesses can depend on a healthy workforce. Families want to stay in the community and help build its future across generations. People feel a sense of belonging that, in turn, influences their health.

A community of experts and leaders shape the public's health

In Minnesota, public health experts, elected officials, and community members are proud of their work to keep Minnesotans healthy. Neighbors care for each other, people face problems together with ingenuity and hard work, and community members take pride in their shared history and future.

A healthy, thriving community can face almost any challenge together.

There's nothing public health can't positively impact

Working with public health adds value, saves money, and improves community health. Public health experts partner with their communities to overcome the numerous barriers we face to living our healthiest lives by helping shape the policies, systems, and surroundings that impact Minnesotans' health before they even set foot in a doctor's office.

People working in public health help make sure we have clean air to breathe, safe water to drink, safe food to eat at home and in restaurants, and that we're free to live without being surrounded by harmful nuisances like pollution, commercial tobacco smoke, and more. They use their education and expertise to look beyond individual health, identifying patterns in health across entire communities to **diagnose** population-level health issues, and helping communities find fixes that can help thousands of people at a time—or **prevent** health issues before they start.

To do that, public health leaders bring together and **cooperate** with community members, elected officials, health care workers, businesses, and more, to help communities thrive:

Diagnose: Public health experts diagnose the health of each community by listening to people who live there—and then use data, evidence, and research to offer solutions.

Cooperate: Public health relies on cooperation. To improve the health of the community, different organizations have to work together. Public health brings them together to make decisions and take action.

Prevent: We often end up in the doctor's office after we're sick or injured. Public health experts investigate everything that affects our health to prevent health problems before they start.

Minnesota's approach to public health is out of date

No one wants to be left behind because of who they are or where they live, but even in Minnesota—one of the healthiest states in the nation—some people, groups, and communities don't have a fair shot at health partly because of how our public health system is structured.

Minnesota's approach to public health was designed almost 50 years ago —it wasn't built for today's needs and can't easily anticipate tomorrow's. Our current approach makes it easier for health departments to deliver services to individual people, one by one, instead of capitalizing on public health workers' expertise and experience to diagnose community health, cooperate across sectors, and prevent illness before it starts. Minnesotans spend a lot of money on intractable health problems and short-term medical fixes when policymakers don't consider long-term solutions or ways to prevent health problems at the population level. And the state's current structure has also calcified inequities in how robust and capable public health departments are, depending on factors like geography, population demographics, population size, population density, and rurality—not to mention how state and local public health departments engage (or don't) with 11 sovereign Tribal Nations who have their own public health authority. These gaps impact the effectiveness of the entire public health system.

Minnesota's public health workers take pride in what many call one of the best public health systems in the nation, but cobble it together out of hundreds of disparate funding sources (with thousands of requirements that may not even fit community health needs), while using outdated technology and outdated methods that can't keep up with the needs and expectations of today's Minnesotans.

We need to keep investing in a new approach to public health

Imagine how healthy all Minnesotans could be if Minnesota could better prevent health problems before they start, by changing the policies, systems, and surroundings that impact Minnesotans' health.

We must keep investing in a new approach to public health that embraces creative collaboration, scalable and right-sized solutions, and fair and flexible funding, so that everyone has the opportunity to be their healthiest no matter who they are or where they live.

Vision: A seamless, responsive, publicly-supported public health system

We envision a seamless, responsive, 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.

- **A seamless public health system** works cohesively across jurisdictions, levels of government, geographies, sectors, and more. Where you live shouldn't determine your level of public health protection, and every agency that helps shape opportunities for population health can work together to do so. People, diseases, air, water, and soil aren't bound within jurisdictions—neither is public health.
- **A responsive public health system** can react quickly and effectively to today's opportunities and challenges, plan for tomorrow's, and use lessons learned from the past to grow stronger and more capable.
- **A publicly-supported public health system** has the trust and support of partners and community, and is accountable to itself and to others, in addition to having adequate funding and staffing to be effective.

Every Minnesotan should have access to quality public health, no matter where they live or who they are. Together, MDH, local public health, and SCHSAC are guiding the transformation of Minnesota's public health system to meet the needs of all Minnesotans. These partners look forward to engaging with Tribal Nations to promote and protect health together. And in partnership, all public health experts work with community: listening to needs, amplifying assets, helping us achieve our best health.

State of the public health system: Strengths and challenges

A seamless, responsive, publicly-supported public health system, where all of Minnesota's health departments can do the fundamental, foundational work of public health, can help ensure that where someone lives doesn't determine their opportunity to be their healthiest.

Minnesota's public health system is ready to transform itself to meet the needs of Minnesotans more effectively, but a number of challenges stand in its way. Our public health system needs to shift its focus if we want to make a difference in the health of Minnesotans.

Minnesota's public health system is locally driven, but also fragmented

At a glance

Strength: Minnesota's governmental public health system has a collective responsibility to Minnesotans, and its agencies and workforce are bound together in practice, partnership, and often in statute. This state-local system was built to be responsive to local need and driven by local priorities, and it excels at doing so.

Challenge: However, these varied approaches and structures limit public health departments' ability to collaborate across jurisdictions, which then undermines public health's ability to work across sectors. The factors that shape health cross geographies and sectors—public health must be able to span those boundaries, too.

A versatile, locally-driven public health system

Minnesota's public health system is highly versatile—local health departments and local community health boards can organize and structure themselves in ways that best meet local need and amplify local resources.

The Minnesota Department of Health and local health departments play complementary roles in protecting and improving health within a system of shared responsibility. This enables state and local governments to combine resources to serve public health needs in an efficient, cost-effective way. This partnership is key to each group's success—state and local public health cannot function without the other.

State, local, and Tribal health departments assess the needs of their communities by listening to residents and collecting data about health outcomes and the factors that help or hinder health, and craft programs and activities to address these factors at the root level, working to prevent harm, sickness, and injury before they happen.

Each sector and level of government cooperates with the other to help Minnesotans thrive, and Minnesotans can't be healthy unless all of these groups work together:

- **The Minnesota Department of Health** provides specialized scientific, technical, and program expertise, and serves the entire state.
- **Local health departments** have deep connections within communities and an understanding of local conditions, needs, and resources. As they are able, many health departments work across jurisdictional boundaries to explore economies of scale and maximize resources. Local health departments are organized within **community health boards**. For a list of community health boards, visit the appendix.
- **Sovereign Tribal Nations** that share geography with Minnesota have their own public health authority. MDH and local health departments consult and collaborate with Tribal health departments as each are willing and able.
- In addition to these state, local, and Tribal health departments, the **State Community Health Services Advisory Committee (SCHSAC)** meets quarterly with the commissioner of health and key MDH managers to develop shared goals, clarify roles, and develop agreement on how to address emerging public health issues.
- Each of these governmental partners also **cooperates with other sectors** on behalf of the public's health in Minnesota, including community members and community organizations, health and medical care, health plans, human services agencies, private sector businesses, and more.

A fragmented system expected to address health factors beyond its reach

Despite its obvious strengths, in Minnesota's locally-driven public health system each department may work in unique and distinct ways or is focused on its own priorities and resource constraints, limiting the ability to collaborate across jurisdictions.

As a state, Minnesota is only as healthy as its least-equipped county—our health doesn't stay behind when we travel around the state, and neither should our access to reliable, high-quality public health. However, health departments' ability to do foundational public health work varies widely, leaving Minnesotans with a patchwork of public health coverage. State, local, and Tribal health departments also make important decisions on policies and practices that impact health, but there are inconsistencies in how state and local health departments consult and collaborate with Tribal Nations.

In addition, when each health department applies for its own categorical, program-based funding, this fragmentation grows. Health departments that are neighbors geographically may duplicate roles and responsibilities, unable to collaborate in obvious but impossible ways within the constraints of the only available funding.

Imagine if public health departments could more nimbly work together across county and regional borders, finding economies of scale in cross-cutting work and being more effective with Minnesotans' hard-earned dollars.

This patchwork of capacity and capability undermines public health's ability to work across sectors—a necessary component of public health work, since the health of Minnesotans is impacted by things far beyond the reach of public health, like housing, transportation, wages, and more. The factors that shape health cross geographies and sectors—public health must be able to traverse those boundaries, too.

Research shows that our social conditions—the conditions in which we are born, grow, work, live, and age—determine our health, in addition to personal preferences and lifestyle decisions. No matter how well-

intentioned or motivated we are to be healthy, our social conditions and the political, social, and economic systems that create them influence and limit our choices. These systems help determine whether healthy food is available and affordable where we live, whether the air we breathe is clean, and what educational and job opportunities are available to us (Healthy Minnesota Partnership, 2024).

Imagine if public health departments could more easily convene partners from across sectors like housing, transportation, business, education, and more, to create policies and programs that support community health from the ground up, leading to thriving, vibrant, holistically healthy communities.

Our partnership is timeless, but our approach is outdated

At a glance

Strength: When it was created in 1976, Minnesota's public health system was seen as forward thinking and as a model for other states to follow.

Challenge: Now, 50 years later, Minnesota's public health system struggles to meet today's problems or anticipate tomorrow's without a significant and transformative shift, given substantial changes in data and technology, how we take in news and information, and the public's expectation for engagement and precision. Our outdated approach also undermines public health's ability to work together with community to enact proven, effective interventions that address the root cause of health issues while reflecting local needs and priorities.

Fifty years ago, Minnesota shifted from over 2,100 local boards of health to roughly 50 community health boards, helping public health overcome confusion about roles and authorities, and making communication and collaboration on public health work easier across the state.

The same legislation that responsibly reduced the number of public health jurisdictions also established SCHSAC and, nearly fifty years later, the partnership between MDH, local public health departments, and SCHSAC is stronger than ever—and yet, this partnership still doesn't consistently include Minnesota's Tribal Nations and Tribal health departments.

Just like a 50-year-old car needs significant work to keep driving reliably and effectively, so does Minnesota's 50-year-old public health system.

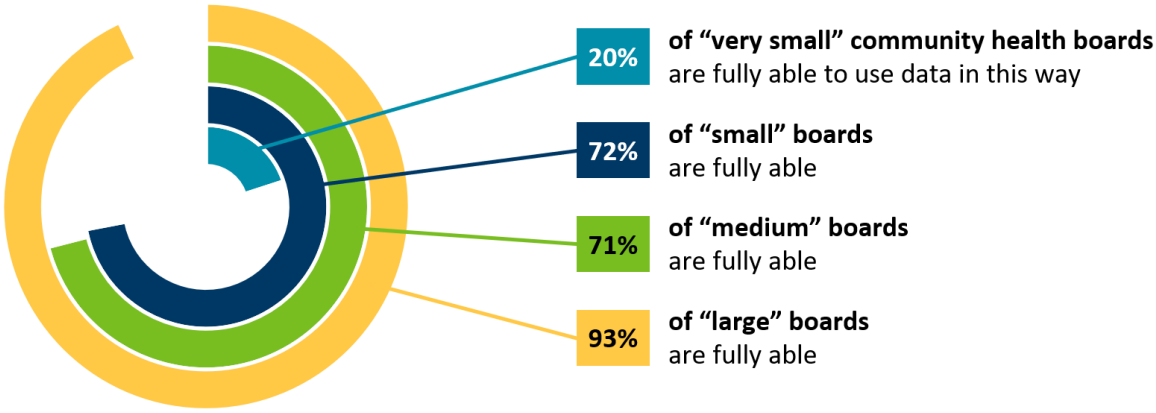
The ways we share and exchange information and data have changed

A seamless public health system depends on our ability to share information, data, and resources quickly and effectively across geographies and even across sectors.

While the U.S. government was once at the forefront of technological innovation (Pahlka, 2023), it's unlikely the architects of Minnesota's 1976 Local Public Health Act could have foreseen the myriad ways we exchange data and information in 2024.

For public health departments to help their communities make data-driven decisions about health and wellness, staff need access to timely, valid, and reliable data, as well as the expertise and ability to analyze and share that data. Many health departments can use available data to help their communities make informed decisions that support public health, but still lack the *right* data. In addition, community health boards with larger populations often have more capacity to use data for decision-making on policies, programs, processes, and action, than smaller boards do (MDH Center for Public Health Practice, 2024).

Local community health board capacity to use data to recommend and inform public health actions, Minnesota, 2023



Source: Local Public Health Act annual reporting, 2023. *Measure 1.3.3: Use data to recommend and inform public health actions*. "Very small" (5 boards) have fewer than 25,000 residents. "Small" (18 boards) have 25,000-50,000 residents. "Medium" (14 boards) have 50,000-100,000 residents. "Large" (14 boards) have greater than 100,000 residents. See the appendix for more information.

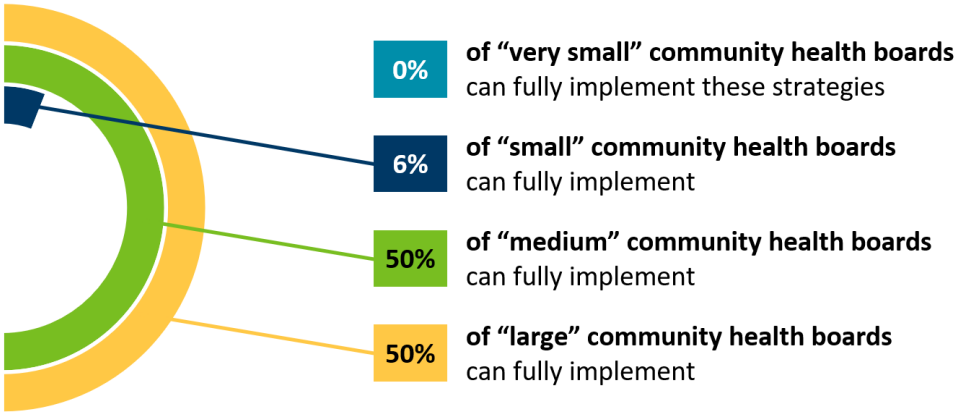
The way we take in news and information, and the sources available to us, have changed

A publicly-supported public health system depends on health departments building trust with their communities, being an effective and reliable source of health information.

It is imperative that public health departments can share credible and reliable health information with their residents. When this happens, community members understand how public health helps keep them safe. Community trust in public health supports engagement and collaboration, so that public health work reflects a community's hopes and goals. When information is perceived as out of touch or outdated, it undermines public trust.

The news and media landscapes have changed dramatically in the last 50 years, and the way we take in news and information on a daily basis has changed, too. Minnesota's health departments are struggling to keep up with these changes and often rely on outdated modes of communication to share vital information. Most of Minnesota's local community health boards aren't fully able to provide ongoing health information to their communities using methods the community needs or in culturally- or linguistically-appropriate ways, or to strategically plan department-wide communications across programs and activities. In addition, smaller community health boards are far less likely to have dedicated communications staff, leading to a significant gap in their capacity to communicate (MDH Center for Public Health Practice, 2024). MDH, too, struggles to keep up with the changing media landscape and to provide messaging across changing social platforms and across diverse cultural communities.

Local community health board capacity to implement health education and communication strategies, Minnesota, 2023



Source: Local Public Health Act annual reporting, 2023.
Measure 3.2.2: Implement health communication strategies to encourage actions to promote health.
"Very small" (5 boards) have fewer than 25,000 residents. "Small" (18 boards) have 25,000-50,000 residents. "Medium" (14 boards) have 50,000-100,000 residents. "Large" (14 boards) have greater than 100,000 residents. See the appendix for more information.

The public's expectations of convenience, specificity, and engagement have changed

A responsive public health system needs to be able to meet community needs, especially where there are disparities, and quickly adapt and adjust to emerging threats, challenges, and opportunities.

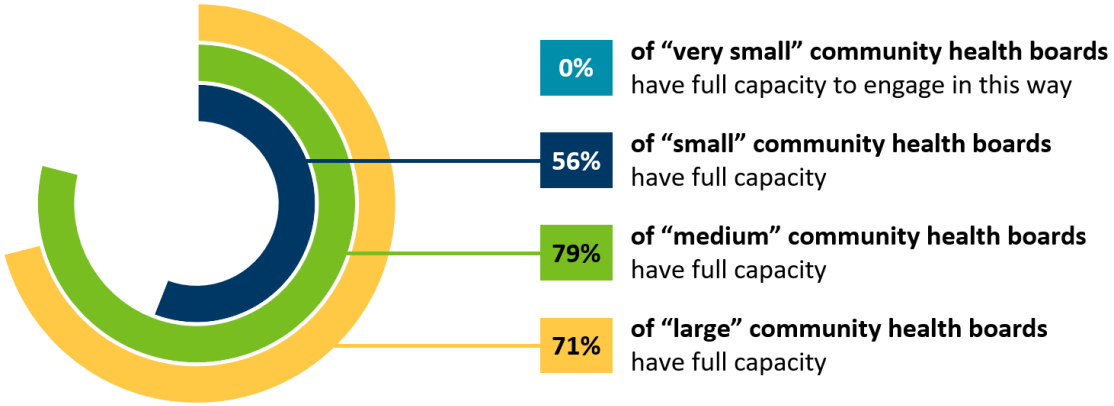
Technological algorithms used by large businesses and social media companies have made it possible to receive marketing tailored directly to your demographics—which we now expect in many forums.

Instead of (or in addition to) data mining and algorithms, health departments use numerous and varied community engagement strategies to make sure their activities and programs reflect their communities' strengths, assets, resources, hopes, needs, and deficits. When health departments and community partners work together, they can share knowledge and information in real time with each other and with their own partners, which can make their work more responsive more quickly to community need.

> *"If we can see the current weather by zip code on our cell phone within seconds, we should be able to pull up community health data, too."*
> – Vivian Singletary, director, Public Health Informatics Institute (in Betts et al., 2021)

The Minnesota Department of Health struggles to find capacity to authentically engage Minnesota's varied and diverse communities, though the department is working to address this on a number of fronts. At the local level community health boards serving populations over 25,000 also have more capacity to engage their communities than those with fewer than 25,000 residents (MDH Center for Public Health Practice, 2024).

Local community health board capacity for community engagement, Minnesota, 2023



Source: Local Public Health Act annual reporting, 2023.
Measure 4.1.3 Engage with community members to address public health issues and promote health.
"Very small" (5 boards) have fewer than 25,000 residents. "Small" (18 boards) have 25,000-50,000 residents. "Medium" (14 boards) have 50,000-100,000 residents. "Large" (14 boards) have greater than 100,000 residents. See the appendix for more information.

Outdated methods undermine trust and partnership with community members and policymakers

When people don't trust government, they may view broad, population-health policies with suspicion or as "government overreach"–even when they directly benefit from those policies. But public health crosses partisan boundaries and impacts us all: we all need clean air, clean water, safe homes and schools, and healthy food. We all have friends, family, and neighbors struggling with mental health issues, opioid and substance abuse, and chronic disease—if we're not struggling ourselves.

But we know policy change impacts health long before someone reaches the doctor's office, and that many of the biggest gains in life expectancy and health of last 100 years are a result of public health policy changes that made life better for everyone (seat belts, improved sanitation, workplace safety, food inspection, and more) (CDC, 1999).

Policy is medicine, just as much as health and medical care. Minnesota's local elected officials in the State Community Health Services Advisory Committee (SCHSAC) see and understand the value of public health in their counties, and understand the magnitude of change that can come from policymaking:

> *"As electeds and public health professionals partner to build strong communities, we have to help our [elected official] colleagues see they already play a role in building health, and they don't even need to change much of what they're doing. We can help them have that "aha, wait a minute!" moment, where they see their work connecting back to health—that public health isn't just vaccines and emergency response, which are very important, but that public health is also about making sure kids are ready for school, using data to drive watershed management, fighting social isolation, soil and water conservation, maternal and child health, working for safe and affordable housing, helping fill food deserts in rural and urban settings."*
> – Tarryl Clark, commissioner, Stearns County (in Joint Leadership Team, 2024)

Imagine a public health system that can better meet local needs; continue to hear and build on local strengths and resources; make sure basic, foundational public health is present statewide, delivered in ways that make sense for communities; and reduce duplicative work, clarify roles and responsibilities, and increase effectiveness.

Governmental public health is small but mighty—and needs more capacity for foundational work

At a glance

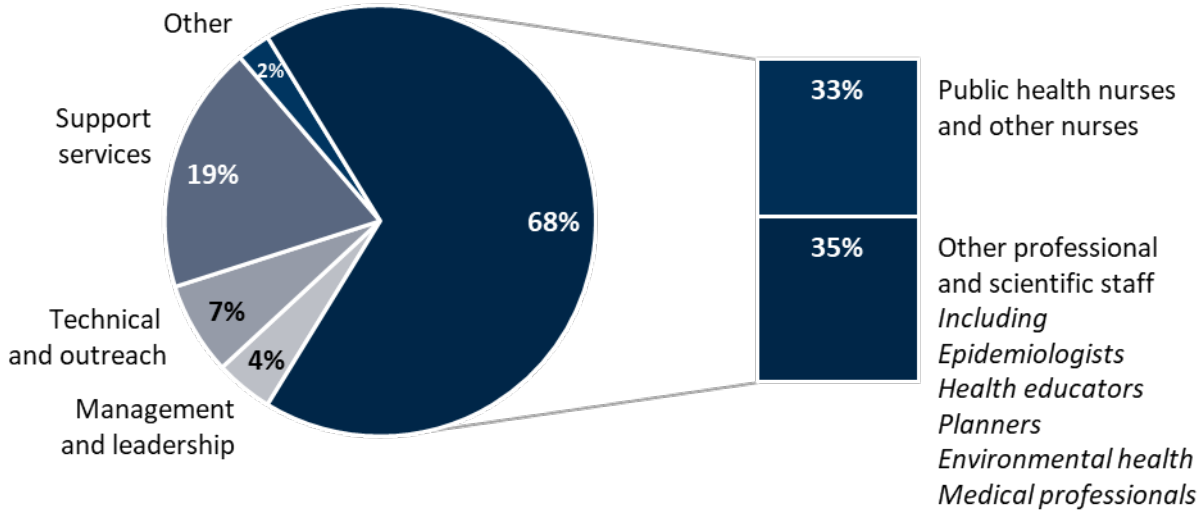
Strength: Minnesota's public health workforce has deep and broad experience and is committed to working with its communities on effective, innovative ways to build community health.

Challenge: Experience, expertise, and commitment aren't enough to make up for the fact that Minnesota's public health system does not have enough capacity to do the fundamental, foundational public health work that helps make communities thrive. Public health's resources, people, and delivery models are out of alignment with each other and with the work of prevention and population health.

Minnesota's public health workforce is small but mighty

Many of us assume that our health is a matter of individual responsibility and that health is primarily determined by each person's individual efforts to make healthy choices and live a healthy lifestyle. For many years, the field of public health reflected this attitude by focusing on improving health through changing individual behaviors (Healthy Minnesota Partnership, 2024).

Distribution of roles and FTEs, Minnesota's local public health workforce, 2023



Source: Local Public Health Act annual reporting, 2023.

Although nearly all of Minnesota's community health boards have at least one public health nurse on staff (MDH Center for Public Health Practice, 2024), the face of public health has changed dramatically over the past century from one of individual care to one of community leadership and cross-sector convening. Public health nurses and staff still visit families and individual people to help connect them to the things they need be healthy, but public health workers now also strive to address the policies, systems, and surroundings that support or hinder a community's health long before the nurse even arrives. Public health workers' deep knowledge, experience, expertise, and community relationships and connections make them uniquely situated to serve as their communities' health strategists, identifying and addressing the factors that can help communities thrive.

However, there is still a substantial amount of foundational, cross-cutting work that departments often have to leave on the backburner due to lack of funding, capacity, and/or expertise: communications, epidemiology and data analysis, evaluation, and more. Some health departments don't even have the capacity to triage or monitor backburnered work.

Minnesota's Public Health Corps is filling that gap, bringing new and energized public health professionals into the field to focus on prevention and population health across the state. As of June 2024, 85 Public Health Corps members have joined health departments across the state, spanning geography and in agencies of all sizes (Ampact, 2024), and disrupting the traditional funding model for public health where capacity begets more capacity.

> *"Most of the pressing issues that our communities face on a day-to-day basis are public health issues—things like clean drinking water, safe and stable housing. I think that being able to make a difference at that community level with public health... can really inspire people to continue that public health journey in the long term."*
> – Alana Stimes, director of program development, Minnesota Public Health Corps (in Dryden, 2024)

Minnesota's Public Health Corps members are also significantly younger than the state's existing public health workforce and often more racially/ethnically diverse, bringing Minnesota's public health workers closer to reflecting Minnesotans themselves and their demographics. However, Public Health Corps members are a short-term solution for most health departments and often require support that long-term professionals don't need.

Learn more:
Public Health Corps (https://www.ampact.us/public-health)

There simply isn't enough capacity to do needed and necessary work

Our health doesn't stay behind when we travel around the state, and neither should our access to reliable public health. But a system doesn't work unless it meets everyone's needs, and Minnesota's public health system doesn't address the pernicious and systemic inequities that happen partly as a result of where someone lives.

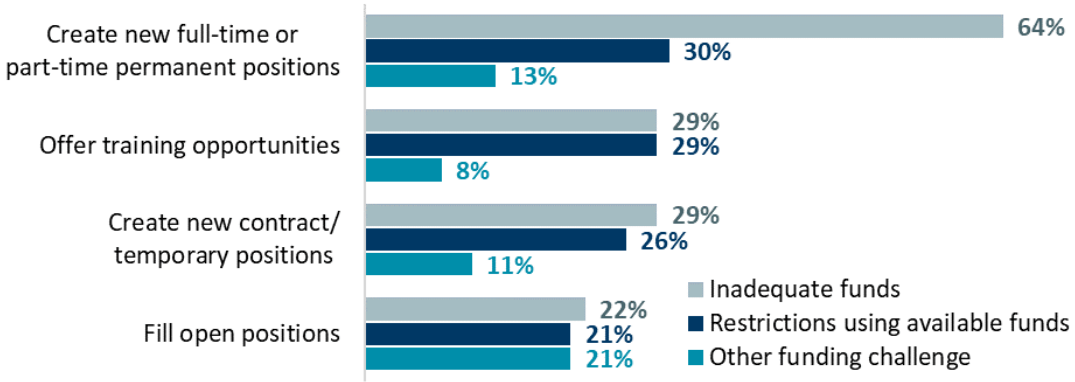
Minnesota's public health system is a patchwork of capacity, in nuanced ways. **None of Minnesota's health departments, local, state, or Tribal, can fully do the needed, necessary, fundamental and foundational work of public health.** Many large health departments are equipped to do the foundational work of prevention and population health, and some aren't (despite having far fewer staff per capita than smaller health departments); many smaller departments can't keep up with foundational work due to a basic lack of capacity, while some can.

FTEs needed to fully implement foundational public health responsibilities in Minnesota, 2022

Source: Minnesota public health cost and capacity assessment, 2023.

The conundrum many public health departments face: try to find someone for a slim, partial FTE, who can make up for slim work with another job, or try to scrounge additional funding to fill in the rest of the FTE not covered by the grant? The former relies on a robust economy to support additional workers or small businesses for contracting (out of the health department's control); the latter relies on a governance board's support for hiring or cooperating with others on prevention or population health work (a challenge facing many health departments) (Karnik et al., 2023). In the meantime, staff at many health departments wear multiple "hats" to cover a broad portfolio of work without enough capacity to address that portfolio's contents to the best of their ability.

Challenges to increasing workforce capacity among Minnesota local health departments prior to the COVID-19 pandemic, 2022

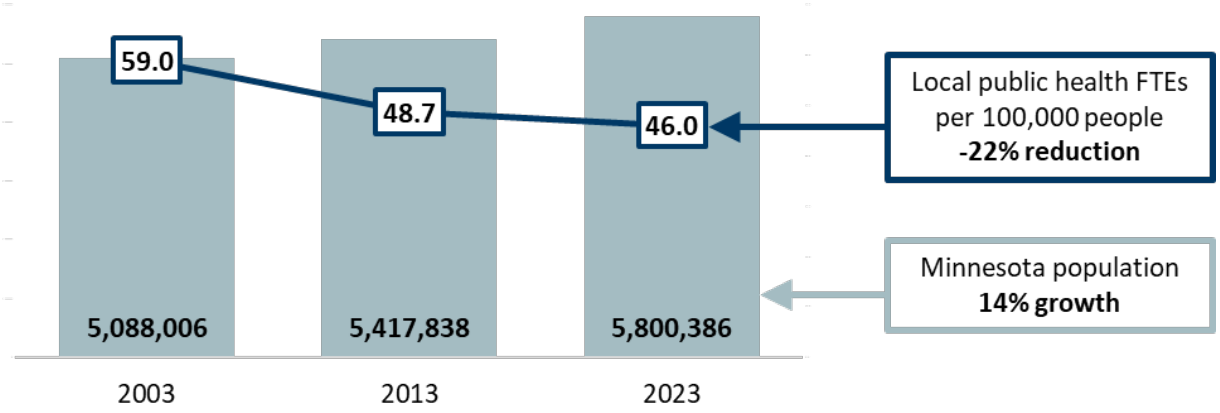


Source: Karnik et al., 2023.

Health departments know what they need to do, but don't have the capacity yet to make it happen, and *can't* make it happen without adequate funding that addresses local needs and ensures flexible use.

Meanwhile, Minnesota's population continues to grow, and a greater number of Minnesotans depend on quality public health to protect and promote their health. Even though the number of local public health workers remained constant over the last decade, thanks to the 2023 legislative investment in foundational public health work, Minnesota's growing population means those public health workers need to stretch further than they did 10 years ago, and *much* further than 20 years ago.

Local public health FTEs per capita, Minnesota, 2003-2023



Source: Local Public Health Act annual reporting, 2023; Minnesota State Demographer, 2024.

Imagine what Minnesota's health departments could do with more fair, flexible funding that fosters right-sized solutions and addresses local needs from the ground up, instead of trying to compete for and then shoehorn their work into those categorical grants that are an imperfect fit.

Deep, broad expertise and experience cannot overcome chronic underfunding

At a glance

Strength: Public health workers have a wealth of experience and expertise. They cooperate across sectors to diagnose health issues happening broadly across the community and work to prevent health problems before they start.

Challenge: However, Minnesota's public health system is funded in large part by a series of categorical, prescriptive, time-limited grants that don't allow for flexibility depending on jurisdictions' needs or assets or cover individual service delivery instead of population-level prevention work. This funding structure also limits public health from scaling up when it's most needed during emergencies, subjecting public health to an ongoing funding roller-coaster of panic booms and neglect busts.

The broad, societal factors that shape our health for better or worse are our constant companions—we can't escape them. *Before* we eat healthy and nutritious food, that food has to be available and affordable to us. *Before* we buckle up in the car, the car manufacturer needs to have installed a seat belt, and we need to know

that other drivers won't be impaired or distracted. *Before* we get enough sleep, we need to snuggle into a bedroom that's free of mold, lead, and other pollutants, in a living space that we can afford.

Policies impact our health by shaping our surroundings, as much as our individual choices do.

Prevention and population-level solutions are chronically underfunded while medical costs balloon

When compared with spending on health care and medical care, the share of public health spending is very small. Public health spending routinely makes up less than one percent of the total money spent on health care and public health, and its growth is much slower than compared to overall health care spending (MDH Center for Public Health Practice, 2024; MDH Health Economics Program, 2024).

In 2021, over half of health care spending in Minnesota was paid by public payers—including Medicare, Medicaid and MinnesotaCare, and other public payers (MDH Health Economics Program, 2024).

Public health and health care spending in Minnesota, 2013-2022

Source: Local Public Health Act annual reporting, 2023; MDH Health Economics Program, 2024.

What if government invested in prevention through public health and changes to the policies, systems, and surroundings that shape the health of entire communities, instead of paying for expensive individual medical care after someone got sick?

Public health is good for businesses, too—investment in prevention is returned to businesses in cost savings. Businesses are already in the "business" of health by subsidizing employee health insurance and supporting workplace wellness programs. Chronic disease drives substantial medical care costs, which in turn cut into company profits (through increased medical care expenditures) and productivity (through missed workdays).

What could investing in public health save?

Minnesota's Statewide Health Improvement Program **saved Minnesotans $365 million** in spending on obesity by putting the brakes on rising adult obesity rates (2017).

Studies evaluating the return on investment of public health found that, **for every $1 invested in public health interventions, the median return on investment was $14.30** (2017).

What can $10 more per capita of public health spending buy? According to research, a 0.6% increase in people reporting very good or excellent health (in Minnesota, that's over 34,000 people), and a decrease of 3-6% of county-level rates of sexually transmitted diseases (2018).

When accounting for all other factors, investing in health *outside* of hospital settings results in **reduced death from all causes** (2018).

Sources: MDH Office of Statewide Health Improvement Initiatives, 2021; Masters et al., 2017; Trust for America's Health, 2018; Lieder et al., 2018.

It's not hyperbole to say that an ounce of prevention is worth a pound of cure. Public health and prevention provide a good return on investment and make good business sense for the entire state.

Public health practice focuses on population health, but funding directed to governmental public health often pays for individual services

Much of the funding that supports public health doesn't enable broad, population-based preventive changes and cures to the policies, systems, and surroundings that impact health; instead, it supports delivering services to individual people (social needs), minimizing public health's ability to do what it does best—prevention on a broad scale (social determinants).

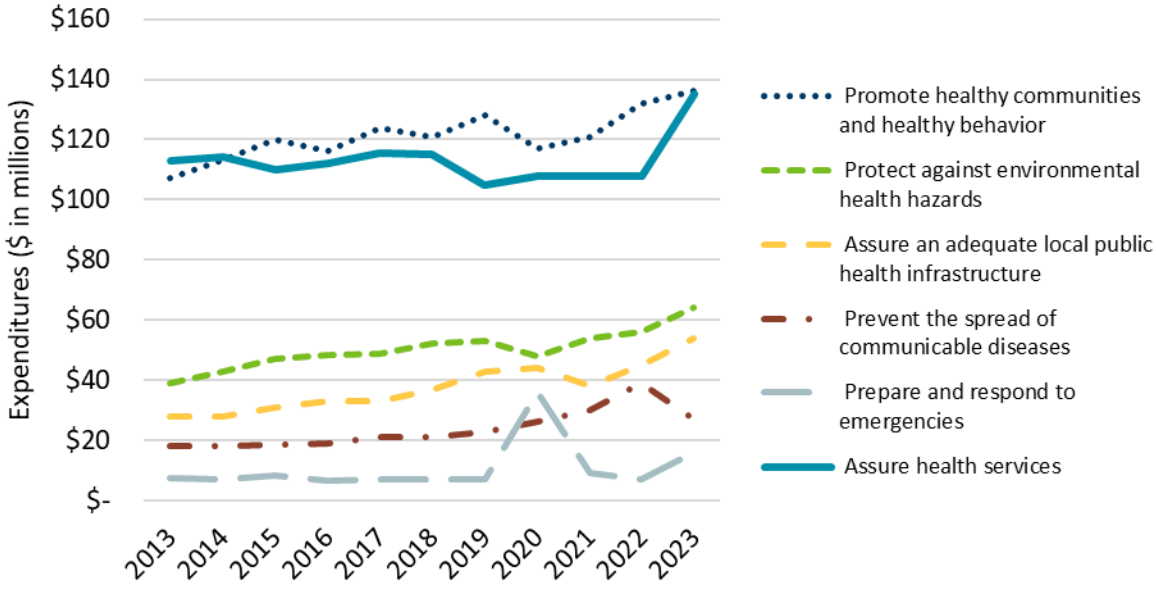
- **Social needs**: Programs, patients, individuals
- **Social determinants**: Populations, policies, systems

The public health workforce—in Minnesota and nationwide—has evolved to deliver a number of direct services as a reflection of available funding—much of it from program-specific grants. However, these service grants often do not call for staff doing work in foundational capabilities (assessment and surveillance, communications, equity, engagement, etc.), and some grants even *disallow* spending on foundational work—leaving health departments to piece together funding for foundational work alongside utility bills, human resources, and other infrastructure (Orr et al., 2024).

> *"Considering new hires for foundational public health work supported by projected core funds requires tremendous confidence."*
> – Orr et al. in Annual Review of Public Health, 2024

Nearly one-third of spending in Minnesota's local community health boards is devoted to assuring health services, including things like home health care, hospice, correctional health, and emergency medical services programs. Between 2022 and 2023, local spending on assuring health services grew by over $27 million.

Local public health spending by area of responsibility, 2013-2023



Source: Local Public Health Act annual reporting, 2013-2023.

Public health cannot scale to meet emergencies—but Minnesota needs it to

As a society, we scramble for a solution to the problems directly in front of us, right now, without investigating whether there's a more sustainable solution to preventing the problems in the first place—often without much more effort or money needed. The lack of funding for public health reflects this, leaving our communities vulnerable to preventable health threats.

Perhaps we can imagine that Minnesota's public health system is sort of like its electrical grid—much like the electrical grid, public health infrastructure needs to be able to adapt to surges in demand (like during a pandemic or natural disaster), and sustain its capacity when its role is less obvious (but still necessary: we need public health just as we need daily power to our homes, businesses, and neighborhoods).

However, we can't throttle demand on the public health system in the same way we can ask people to turn down their air conditioning on hot days—the factors that boost or harm our health are always present, and always will be. But we can impact some of the demand on health and medical systems by investing in policies, systems, and surroundings that help us thrive and prevent illness in the first place.

> *"Something happens, we throw a ton of money at it, and then in a year or two we go back to our shrunken budgets and we can't do the minimum things we have to do day in and day out, let alone be prepared for the next emergency."* – Chrissie Juliano, Big Cities Health Coalition (in Smith et al., 2021)

Our collective inability to prioritize prevention means public health funding is stuck in cycles of panic and neglect, leaving public health unable to scale when its most needed, and leaving Minnesotans stuck trying to manage their health against forces beyond their control, and unable to live their healthiest lives.

A vast number of public health programs rely on categorical grant funds, which support specific and discrete work, and are time-limited

Continually applying for and managing these time-limited grants and their reporting requirements is an inefficient drain on public health capacity. If each grant is like a cat, public health departments are managing an entire herd.

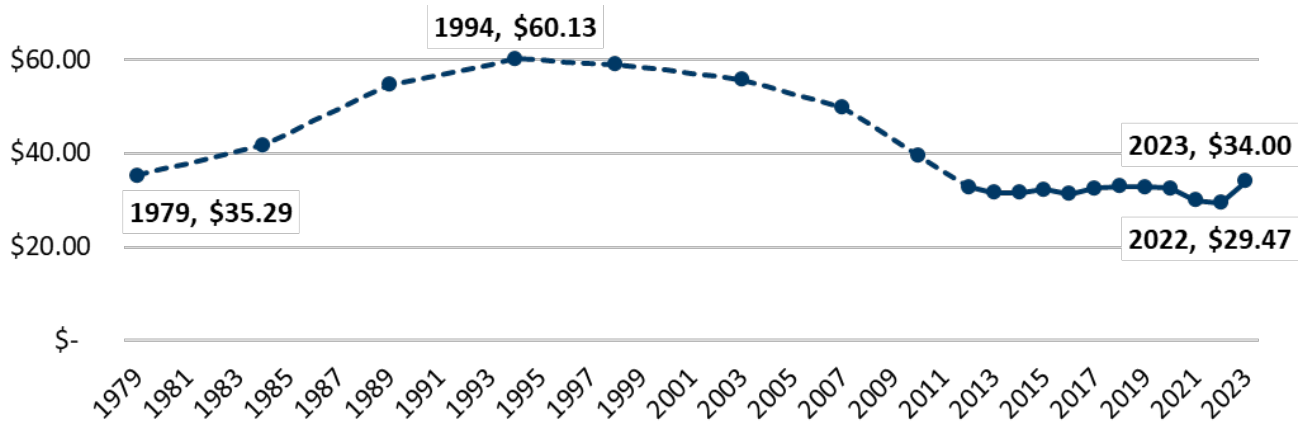
> *"I spend 85% of my time on grant writing and fundraising rather than using 20 years of experience as a professional in this community. I should be serving the families, but I'm not."*
> – Minnesota local public health leader (in Hattaway, 2023)

At the same time, it's hard to maintain sustained, authentic community relationships when a grant's end date is in sight and there's no further funding to support convening and cooperating—and public health loses trust with community members when it can't show up because the money's run out.

Many of these categorical grants also don't support the "in-between" work that binds an organization's categorical work together holistically and strategically

Public health departments could be far more efficient if they could hire staff to connect a department's functional work across multiple disparate grant-based programs—for example, one person to just manage communications strategies and make connections between similar audiences and campaigns, or just manage data analysis and evaluation to show connections where different grant managers might not be able to. Adolph P. Falcón of the National Alliance for Hispanic Health calls this sort of funding "glue money"—the kind of funding that's needed to bind together an organization that spans numerous topics and categories (in Grimm et al., 2024). All organizations, regardless of sector or profit, need glue money to be efficient and effective.

Flexible local public health funding per capita, Minnesota, 1979-present



Source: Local Public Health Act annual reporting, 1979-2023. Flexible funding is the sum of the permanent Local Public Health Grant (state general funds), local tax levy, client fees, other fees non-client, and other local funds.

The Minnesota Local Public Health Grant, a **permanent** source of flexible funding that supports cross-cutting work in community health boards, has declined steadily over the past 35 years, leaving other sources like local tax levy to pick up the slack.

With new flexible funding from the permanent Foundational Public Health Responsibilities Grant, allocated by the Minnesota Legislature in 2023, Minnesota's community health boards are chipping away at shortages in these cross-cutting capabilities like communications, assessment and surveillance, equity, and more. This leads to more effective and responsive operations locally and regionally, but it's still not enough.

"It is difficult to sustain work on foundational capabilities, such as communications, equity, and accountability… 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."
– SCHSAC Performance Measurement Workgroup member (in SCHSAC, 2024)

Imagine what our businesses, communities, neighborhoods, and families could do with the money saved on medical care if Minnesota invested in more of the policies, systems, and surroundings that prevent sickness and harm in the first place, and if our public health workers had the resources to dig down to the root cause of health problems and help prevent them in the first place.

A new path forward

While our system continues to face challenges, over the last several years, Minnesota has taken many steps to strengthen and improve the public health system. These include implementing the following strategies:

- **21st century tools**: Developing and implementing new tools and technology that will help meet modern challenges.
- **21st century practice**: Addressing the upstream, root causes of health inequities by implementing foundational public health responsibilities.
- **Sustained investment**: Increasing ongoing, flexible funding for foundational public health work.
- **Local innovation**: Piloting and scaling locally developed service delivery models to the public health system.

Below are several examples of current activities to embed these strategies in Minnesota's public health system.

21st century tools

Ensuring that all public health partners have access to functional, modern tools and technologies is critical to strengthening our public health system. Several national organizations, including the Centers for Disease Control and Prevention (n.d.), the Public Health Accreditation Board (n.d.), the Robert Wood Johnson Foundation (2021), and MDH (n.d.), have outlined approaches to address this need ranging from collecting actionable data across populations and geographies to understand disparities to prioritizing data sharing through dashboards and other accessible platforms across levels of government and sectors.

> *"We often hear a call for government to be more like businesses. When it comes to investments in technology and customer-focused services, these are business practices we can all agree government should emulate."* – Julie Ring, Director, Association of Minnesota Counties (2023)

Modern data systems can support data driven decision making, allowing public health officials to deploy human and financial resources where they can make the greatest impact. Minnesota is implementing strategies to improve the quality and availability of data and technology at the state and local level.

Health Trends Across Communities in Minnesota (HTAC)

Health Trends Across Communities in Minnesota (HTAC) is a novel partnership between the Center for Community Health in the Twin Cities seven-county metro area and the Minnesota Electronic Health Record (EHR) Consortium, funded through Minnesota Infrastructure Fund grants. HTAC opens the doors to sharing data between health systems and local public health departments—and also shows how health systems that may see each other as competitors can be collaborators when there's a common goal.

HTAC partners collaboratively developed a common data model across participating health systems that provides timely data while protecting patient privacy. They also selected a set of 28 priority health indicators to collect and developed a public-facing dashboard where anybody can access the data. Data from the 11

participating health systems represents 90% of health care received by Minnesotans across the state, making this a useful tool for looking at key health indicators across the entire state, not just in the Twin Cities metro.

> *"[The local public health sector] has been dreaming of utilizing aggregate hospital data for decades. This is a huge milestone!"* – Minnesota Infrastructure Fund Grant recipient (in MDH, 2024)

With projects like HTAC, local public health agencies can tap into EHR data to access timely, reliable data on health indicators, while freeing up staff time and capacity to do what they do best—gather local population-level data on social determinants of health and policy, systems, and environmental change, to support community health assessments, program and policy planning, and other efforts to protect and promote community health.

Learn more: Health Trends Across Communities in Minnesota Dashboard (https://mnehrconsortium.org/health-trends-across-communities-minnesota-dashboard)

A modern approach to data

MDH, in partnership with local and Tribal health and community partners, is working to improve how it collect, analyzes, uses, and shares data with its partners and the public. This is part of an effort to create a modern data system that is responsive, transparent, consistent, equitable, and community-centered whenever possible. MDH's data strategy will ensure all programs are using data in ways that advance strategic priorities and are in line with agreed-upon goals. While this work is still in progress, it lays the groundwork for creating a modern data infrastructure that can support responsive, data-driven work across all parts of the public health system.

21st century practice

As part of strengthening our public health system for the future, state and local departments must work to address the upstream causes of health inequities, by centering collaboration, community voice, and equity.

Public health as community health strategists

Public health workers in Minnesota are already working as their communities' health strategists, convening broad coalitions to examine and address the upstream causes of health problems and amplifying existing resources for the benefit of their communities. Continuing to engage more sectors and sustaining these partnerships and collaboration structures will allow us to make meaningful progress toward addressing the social determinants of health (De Salvo et al, 2017). Embedding community engagement activities to hear directly from communities impacted by public health challenges and interventions is also a necessary step in building a responsive public health system (NACCHO, 2017).

The Statewide Health Improvement Partnership (SHIP) demonstrates how this is possible. SHIP, created by the legislature in 2008, is a statewide partnership with local and Tribal health partners. SHIP brings to the table expertise, strong relationships, and connections in a variety of fields, leveraging the strengths of local public

health and their partner organizations, through community leadership teams (CLTs), to determine and establish lasting changes. Through the program, communities implement locally-developed policy, system, and environmental changes that support active living, healthy eating, and commercial tobacco-free living, with the goal of preventing chronic disease.

Learn more: Statewide Health Improvement Partnership (SHIP) (https://www.health.state.mn.us/communities/ship/)

Trusted messengers across cultures and communities

Another effort to address the root causes of health inequities through collaboration and partnership is St. Paul-Ramsey County Public Health's trusted cultural community messenger program, funded through an Infrastructure Fund grant. Through the program, St. Paul-Ramsey County Public Health is investing in community partnerships and centering community voice to increase access to culturally and linguistically appropriate public health information and services and to promote policy, system, and environment changes that community is seeking.

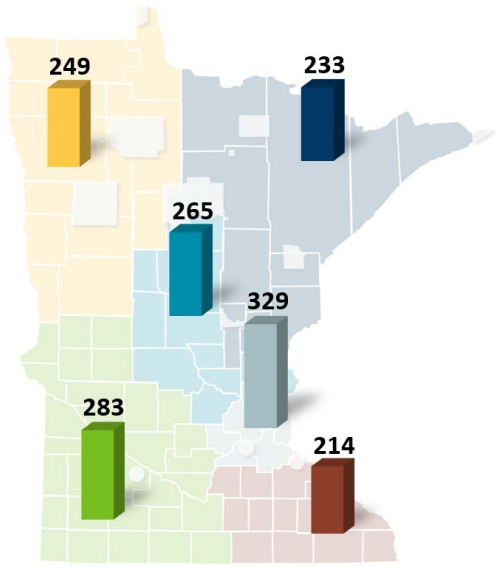
> *"Community input connects us to actual community needs so we aren't guessing and getting it wrong."* – 2023 Trusted Messenger Convening Report

Learn more: St. Paul-Ramsey Public Health Community Engagement (https://www.ramseycounty.us/residents/health-medical/public-health-community-engagement/)

Regional networks amplify, strengthen, and connect local health equity work

From the ground up, across Minnesota, six regional Health Equity Networks are growing the connective tissue between community and governmental health equity work, and are exponentially increasing the ability of both to collectively address health disparities and inequities at the population level. Six regional coordinators based at MDH work alongside network members from local health departments, Tribal health, and community organizations in regional and statewide gatherings to learn from each other through tailored training and resource-sharing online and in person, while simultaneously building the relationships and connections that are the lifeblood of public health. These networks were initially established as part of the COVID-19 recovery effort, but now play an integral role in connecting, strengthening, and amplifying health equity work across Minnesota, from the ground up.

Health Equity Network regional gathering participants, through May 2024



Learn more: Minnesota Health Equity Networks (https://www.health.state.mn.us/equitynetworks)

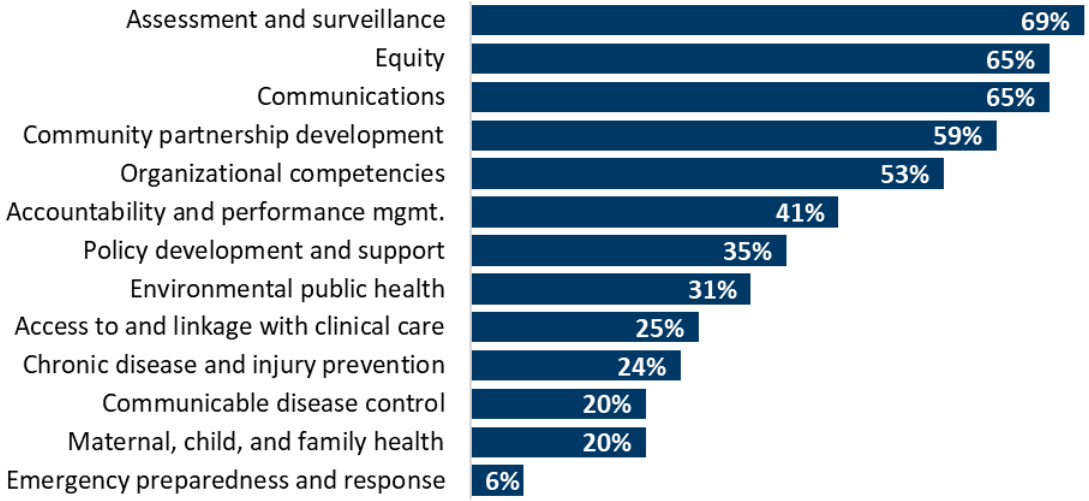
Sustained investment

Insufficient public health investment has compromised the ability of public health departments at all levels to address emergent public health threats and community priorities. At the federal level, CDC funding has stagnated or decreased, even for urgent topics such as emergency preparedness (Trust for America's Health, 2024). While significant investments were made during the COVID-19 public health emergency, most of those funds were one-time, temporary investments that have ended or are sunsetting soon. In addition to increased, sustainable funding, innovative and flexible funding models are needed to break down silos and support core public health infrastructure building that is aligned with community need (De Salvo et al., 2017).

Ongoing flexible funding to community health boards and Tribal Nations

The Minnesota Legislature acknowledged this in its 2023 session, and it allocated ongoing flexible funding to community health boards and Tribal Nations to support foundational public health work. Allocations included $9,844,000 to local public health community health boards, and $535,000 to Tribal Nations. This funding is noncompetitive, meaning it's open for all community health boards and Tribal Nations in Minnesota. For local community health boards, the funding formula prioritizes a board's Social Vulnerability Index, as well as boards serving smaller populations; a workgroup representing local public health, MDH, and county commissioners (via SCHSAC) developed this innovative formula to account for local need and capacity.

Foundational responsibilities addressed by Minnesota community health boards, using permanent Foundational Public Health Responsibility Grant funding, 2024



Source: Minnesota Department of Health Center for Public Health Practice, 2024. Note: Community health boards may have access to additional funding sources for a specific area or capability; if a workplan noted above doesn't address a specific responsibility, it doesn't mean the community health board isn't still working on it with another funding stream (for example, the CDC Public Health Infrastructure Grant for cross-cutting work, or the MDH Response Sustainability Grant for emergency preparedness and response). Many community health boards are also addressing more than one responsibility using foundational funding. For more information on foundational responsibilities and associated activities, visit Foundational Public Health Responsibilities and Framework (https://www.health.state.mn.us/communities/practice/systemtransformation/foundationalresponsibilities.html).

These flexible funds allow community health boards and Tribal Nations to address foundational responsibilities that should be in place in all communities across the state, and that may have been underfunded in the past including the following:

- New staff roles including population and public health strategists, data analysts, communications coordinators, and billing specialists.
- Expanded Tribal and community health board needs assessments and strategic planning efforts to inform new programs and services, especially to high-risk or special populations.
- Work to support health equity within and across public health departments, including individual and organizational assessment, education, and training.
- Developing new community partnerships and collaboratives to address transportation needs, health access, and cannabis regulation.
- Tribal investment in a robust electronic health record system to improvement information systems.

Learn more: Funding for Foundational Public Health Responsibilities (FPHR Grant) (https://www.health.state.mn.us/communities/practice/systemtransformation/foundationalfunding.html)

Strengthening Tribal Nations' public health infrastructure and capacity

Tribal public health systems across Minnesota are also working to strengthen their Tribal Nations' public health infrastructure and capacity by assessing their ability to meet national public health standards alongside their interest in partnering with state and local health departments. Historically, minimal investment in Tribal health infrastructure has made it especially challenging for Tribal Nations to enact broad-reaching population health and prevention work, which are necessary to help Native Americans overcome centuries of harm and health inequities due to colonialism. Nine Tribal Nations have completed a public health capacity assessment and are identifying opportunities for change and cooperation with each other and with state/local public health.

Increasing the availability of sustainable, flexible funding and using innovative funding models to allocate resources is helping to close gaps across our system and strengthen the infrastructure needed to help all communities stay healthy.

Learn more: Measuring Capacity and Building Infrastructure in Partnership with Tribal Public Health (https://www.health.state.mn.us/communities/practice/systemtransformation/tribalhealth.html)

Local innovation

With each emerging public health challenge, it has become increasingly clear that the established ways of working in public health have not always been "sufficient or efficient" (PHAB, 2023). Innovation that challenges the status quo is needed to develop novel, creative approaches to improving the public health system. Local communities are often best positioned to implement these novel approaches because they are on the front lines, identifying the gaps and problems in the current system. They are also able to adapt, iterate, and scale innovative approaches quickly for maximum impact.

Minnesota is testing local innovations to improve the public health system. As previously described, the Infrastructure Fund grants provide an opportunity for local health departments and Tribal Nations to pilot new approaches to public health, in new topic areas or using new approaches or methods. A number of local health jurisdictions that participated in the first round of the Infrastructure Fund Grant in one capability are using what they've learned to expand into a new capability in the second round (for example, first-round communications projects using lessons learned to expand into data capacity-building in Horizon and Countryside public health departments). Minnesota has also received requests from other states to learn more about local jurisdictions' new approaches to foundational work.

Local public health innovation projects supported by the Infrastructure Fund

Some local health jurisdictions have also moved their innovation work out of the pilot phase into "business as usual," further strengthening their ability to do foundational work in a sustainable way. In response to local innovation and need, MDH has changed the way it provides support and assistance to local public health, by incorporating a cycle of continuous improvement grounded in partnership and listening (for example, an info-savvy assessment process, which helps local public health agencies identify and prioritize data projects and ways that MDH could support them better).

Learn more: State Infrastructure Fund Projects (https://www.health.state.mn.us/communities/practice/systemtransformation/infrastructurefund.html)

A closer look at three Minnesota Infrastructure Fund projects

Several projects are piloting new service delivery innovations to improve the public health system, including:

Through the Southeast Minnesota Regional Data Model, Olmsted County partnered with 10 surrounding counties in the Southeast region of Minnesota to build data infrastructure to implement a regional assessment and surveillance model. This regional collaboration allows participating health departments to use economies of scale for data collection and analysis, and the region retains knowledge and expertise specific to the region and its unique needs. As part of the work, Olmsted County developed data sharing agreements with partner counties and MDH to request, analyze, and share dashboards with public health departments. These dashboards provide county-level population health data across topics from chronic disease to injury prevention to maternal health and, in addition to showing data and trends, provide context on what the data means and how it could be interpreted—helping to inform prevention and program work across the region.

> *"With data, we were able to drive programs [that] impact the lives of moms and babies by starting initiatives to improve prenatal access and care; we were able to partner with schools to prevent youth self-harm and suicide; we were able to provide education and prevent youth from using harmful nicotine products; and we were able to implement community-wide strategies to mitigate the opioid crisis at a local level."* – Minnesota Infrastructure Fund Grant recipient (in MDH, 2024)

By leveraging their data expertise on behalf of their regional county partners, many with limited data capacity, Olmsted County is ensuring all 10 participating counties, regardless of size, have information for assessment and surveillance activities needed to address local public health issues. This project allows participating counties' data staff to mentor and connect with each other across geography, building skills and knowledge, as they work together on behalf of an entire region. It is also allowing counties with similar challenges to collaborate on data-driven solutions. The project is grounded in relationships across organizations, jurisdictions, and the southeast region itself—vital groundwork that takes time but isn't always supported by other funding sources.

Learn more: Olmsted County pilots a regional population health data hub to improve data accessibility (https://www.astho.org/topic/brief/olmsted-county-pilots-regional-population-health-data-hub/)

Within the Carlton-Cook-Lake-St. Louis Community Health Board, which unites four county health departments, a new communications lead has helped each county share consistent information about health. For example, each county doesn't have to create its own messaging around youth mental health supports. They created regional messaging and branding under the tagline "Be There." This enhances recognition within the community and connects work with shared goals. It can also be tailored to meet local needs.

Learn more: Building public health infrastructure (https://communityhealthboard.org/building-public-health-infrastructure/)

A pilot program between Human Services of Faribault and Martin Counties (the Faribault-Martin community health board) and Minnesota State University-Mankato (MSU) is providing internship opportunities at Faribault-Martin for public health students, for credit. This mutually beneficial partnership allows the community health board to address some capacity gaps while building applied public health skills in a new workforce. With Infrastructure Funds, Faribault-Martin is expanding this successful program to include other community health boards in their region, more departments at MSU, and other universities in the region. Through this partnership, local public health agencies receive access to human and technology resources that they lack, such as data analysis software, and students and faculty receive opportunity to do hands on public health work that may not be available in academic settings.

Learn more: Human Services of Faribault and Martin Counties (https://www.fmchs.com/)
Minnesota State University, Mankato (https://www.mnsu.edu/)

As each of these innovative pilots are implemented, staff are learning what is working and not working well to improve the public health system, with the goal of scaling those that work to additional jurisdictions.

On the horizon: Recommendations and next steps

As we build on these successes, the Joint Leadership Team and its partners remain committed to realizing a vision of a seamless, responsive, and publicly-supported public health system that protects and promotes the health of all Minnesotans no matter who they are or where they live. To continue this progress, it is crucial to partner with local, state, and federal elected officials.

Minnesota must prioritize the following actions, to continue to strengthen its public health system:

- LPHA, SCHSAC, and MDH should continue to partner and cooperate to build a stronger public health system, through the Joint Leadership Team. They should also work with the MDH Office of American Indian Health to consult with Tribal partners, and should incorporate community perspective on how to create a truly coordinated public health system.

- While recent state investments are a helpful down payment to build the capacity of the public health system, Minnesota needs more ongoing and sustainable federal and state funding to make sure every health department has access to the human and technical resources to meet foundational public health needs. Investments in public health, especially in prevention programs and policies, provide tremendous returns on investments by saving on future social service, education, health care costs, among others.

- Local public health and MDH should keep using data to understand current system gaps, use available resources to build foundational public health capacity statewide, and test and scale new service models.

Statewide partners are working hard to build the roads to a healthy, thriving Minnesota. While Minnesota's public health system faces challenges, we have made great strides in building capacity, modernizing our tools, and ensuring local, community-based solutions are prioritized. With the partnership and support of the state legislature, we will continue to build a public health system to ensure everyone in Minnesota can be their healthiest, regardless of who they are or where they live.

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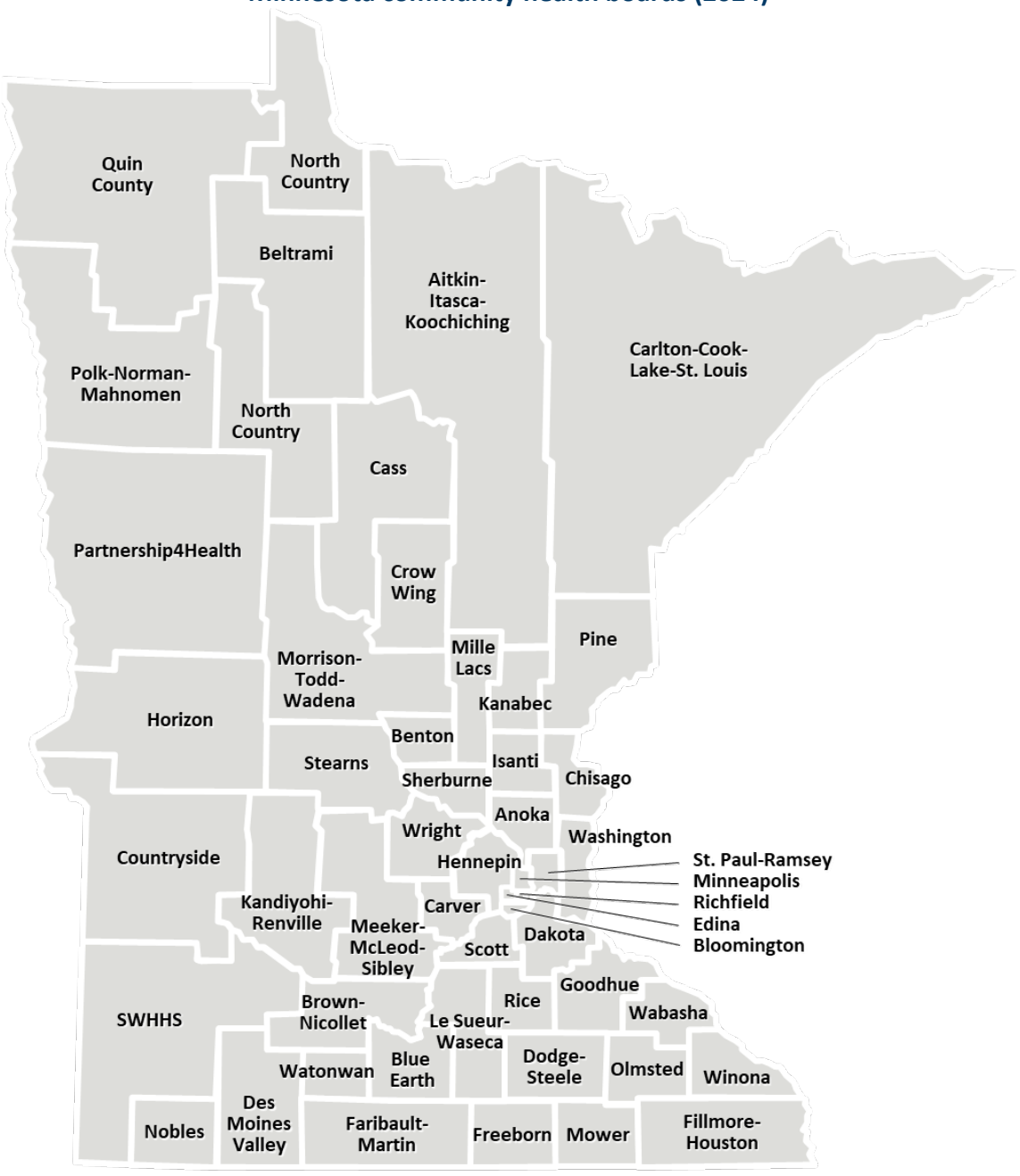
Appendix. Minnesota community health boards and local health departments

Minnesotans can find the most up-to-date list of community health boards and their member health departments online: [Find a Local or Tribal Health Department or Community Health Board (https://www.health.state.mn.us/communities/practice/connect/findlph.html)](https://www.health.state.mn.us/communities/practice/connect/findlph.html)

Minnesota community health boards (2024)



Community health board	Counties/cities	Population (2023)
Aitkin-Itasca-Koochiching	Aitkin, Itasca, Koochiching counties	50,000-100,000
Anoka	Anoka County	Greater than 100,000
Beltrami	Beltrami County	25,000-50,000
Benton	Benton County	25,000-50,000
Bloomington	City of Bloomington (Bloomington is an independent health department located within Hennepin County)	50,000-100,000
Blue Earth	Blue Earth County	50,000-100,000
Brown-Nicollet	Brown, Nicollet counties	50,000-100,000
Carlton-Cook-Lake-Saint Louis	Carlton, Cook, Lake, Saint Louis counties	Greater than 100,000
Carver	Carver County	Greater than 100,000
Cass	Cass County	25,000-50,000
Chisago	Chisago County	50,000-100,000
Countryside	Big Stone, Chippewa, Lac qui Parle, Swift, Yellow Medicine counties	25,000-50,000
Crow Wing	Crow Wing County	50,000-100,000
Dakota	Dakota County es	Greater than 100,000
Des Moines Valley	Cottonwood, Jackson counties	Less than 25,000
Dodge-Steele	Dodge, Steele counties	50,000-100,000
Edina	City of Edina (Edina is an independent health department located within Hennepin County)	50,000-100,000
Human Services of Faribault and Martin Counties	Faribault, Martin counties	25,000-50,000
Fillmore-Houston	Fillmore, Houston counties	25,000-50,000
Freeborn	Freeborn County	25,000-50,000
Goodhue	Goodhue County	25,000-50,000
Hennepin	Hennepin County (Bloomington, Edina, Minneapolis, and Richfield are independent health departments located within Hennepin County)	Greater than 100,000
Horizon	Douglas, Grant, Pope, Stevens, Traverse counties	50,000-100,000
Isanti	Isanti County	25,000-50,000
Kanabec	Kanabec County	Less than 25,000
Kandiyohi-Renville	Kandiyohi, Renville counties	50,000-100,000
Le Sueur-Waseca	Le Sueur, Waseca counties	25,000-50,000

Community health board	Counties/cities	Population (2023)
Meeker-McLeod-Sibley	McLeod, Meeker, Sibley counties	50,000-100,000
Mille Lacs	Mille Lacs County	25,000-50,000
Minneapolis	City of Minneapolis (Minneapolis is an independent health department located within Hennepin County)	Greater than 100,000
Morrison-Todd-Wadena	Morrison, Todd, Wadena counties	50,000-100,000
Mower	Mower County	25,000-50,000
Nobles	Nobles County	Less than 25,000
North Country	Clearwater, Hubbard, Lake of the Woods counties	25,000-50,000
Olmsted	Olmsted County	Greater than 100,000
Partnership4Health	Becker, Clay, Otter Tail, Wilkin counties	Greater than 100,000
Pine	Pine County	25,000-50,000
Polk-Norman-Mahnomen	Mahnomen, Norman, Polk counties	25,000-50,000
Quin County	Kittson, Marshall, Pennington, Red Lake, Roseau counties	25,000-50,000
Rice	Rice County	50,000-100,000
Richfield	City of Richfield (Richfield is an independent health department located within Hennepin County)	25,000-50,000
Scott	Scott County	Greater than 100,000
Sherburne	Sherburne County	Greater than 100,000
Southwest Health & Human Services	Lincoln, Lyon, Murray, Pipestone, Rock, Redwood counties	50,000-100,000
Saint Paul-Ramsey	Ramsey County, City of Saint Paul	Greater than 100,000
Stearns	Stearns County	Greater than 100,000
Wabasha	Wabasha County	Less than 25,000
Washington	Washington County	Greater than 100,000
Watonwan	Watonwan County	Less than 25,000
Winona	Winona Count	25,000-50,000
Wright	Wright County	Greater than 100,000