2024 State and Local Performance on Foundational Responsibilities

SCHSAC PERFORMANCE MEASUREMENT WORKGROUP REPORT

November 2025

2024 Local and State Performance on Foundational Responsibilities: SCHSAC Performance Measurement Workgroup Report

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Building a foundation for health everywhere in Minnesota

Governmental public health plays a vital role in keeping our communities healthy every day. It's why we can trust the food we eat, the water we drink, the air we breathe. Public health creates the conditions for all of us to live, work, and age safely.

This everyday protection is only possible with a coordinated governmental public health system – made up of state, local, and Tribal health departments. The Foundational Public Health Responsibilities (FPHR) Framework defines the foundational responsibilities that must be in place everywhere for public health to work anywhere.

In 2024, all 51 community health boards and the Minnesota Department of Health reported on 46 national measures related to foundational responsibilities. A list of the 46 measures is included in Appendix B of this report.

This workgroup report summarizes the results, key takeaways, and observations from performance measurement data reported by community health boards and MDH for calendar year 2024. Data from Tribal nations are not included in this report.

Both foundational responsibilities and community-specific priorities are essential parts of a strong public health system. The Performance Measurement Workgroup is currently focused on measuring foundational responsibilities, as these are the building blocks that create a strong public health foundation and reflect what needs to be in place everywhere for public health to effectively address community priorities. Learn more.

Self-assessment is a common practice in public health

This report reflects self-assessment by community health boards and MDH. While self-assessment carries some subjectivity (e.g., some might rate themselves more strictly or by different reference points), it is a well-established and valuable method of public health evaluation.

Self-assessment captures lived experience and local knowledge that cannot always be measured through numbers alone.

See the limitations section for more information.

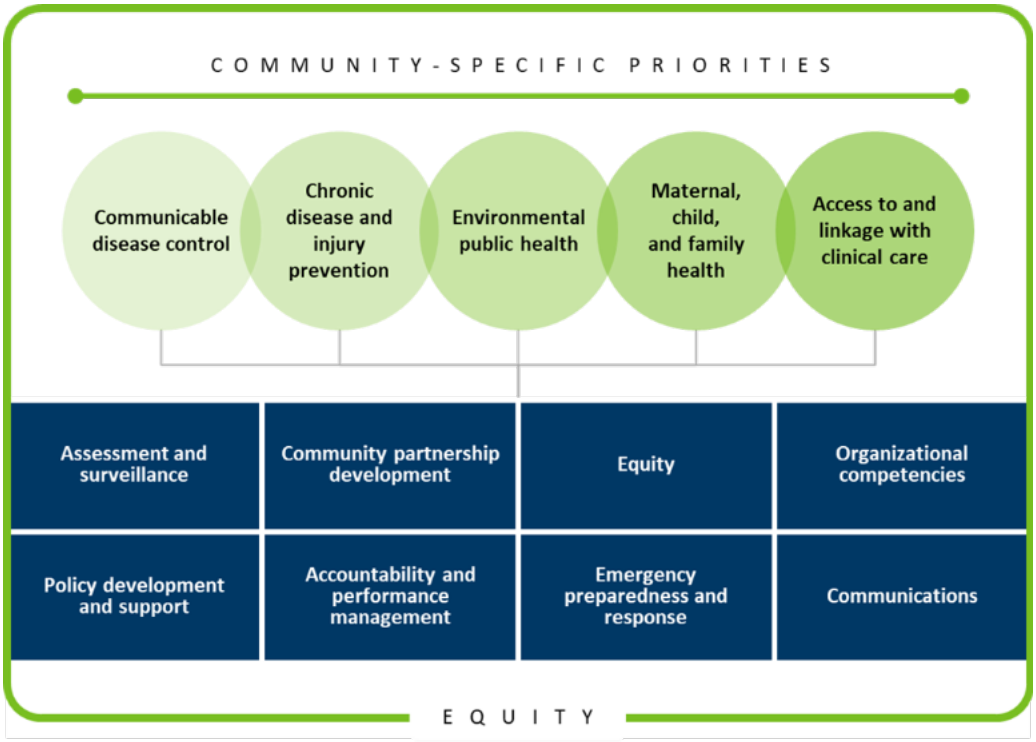
What's in this report

Foundational Public Health Responsibilities Framework

The Foundational Public Health Responsibilities Framework includes the foundational responsibilities of the governmental public health system. It defines what needs to be in place in every community across the state to efficiently and effectively promote and protect the health of all people in Minnesota.

Foundational responsibilities are made up of five areas and eight capabilities, encircled by equity. **Areas** are the population-level, topic-based work unique to governmental public health. **Capabilities** are the cross-cutting skills and abilities that make up the foundation for all public health work. The national measures selected and reported on are related to the foundational responsibilities to assess strengths and challenges of the state and local system.

Foundational Public Health Responsibilities Framework



Key findings from performance measurement data

System progress is real.

We are seeing more measures fully or substantially met – a hopeful sign of progress despite ongoing pressures on public health. However, disparities remain in capacity to meet foundational responsibilities, particularly by population size. Community health boards serving smaller populations are less likely to fully or substantially meet these responsibilities.

In 2024, community health boards in Minnesota fully or substantially met 78% of overall performance measures. In 2023, community health boards fully or substantially met 71% of overall performance measures. Community health boards fully met 56% of overall performance measures. The Minnesota Department of Health, reporting on these measures for the first time in 2024, fully met 91% of overall performance measures.

Figure 1: Percentage of overall performance measures met by Minnesota's community health boards

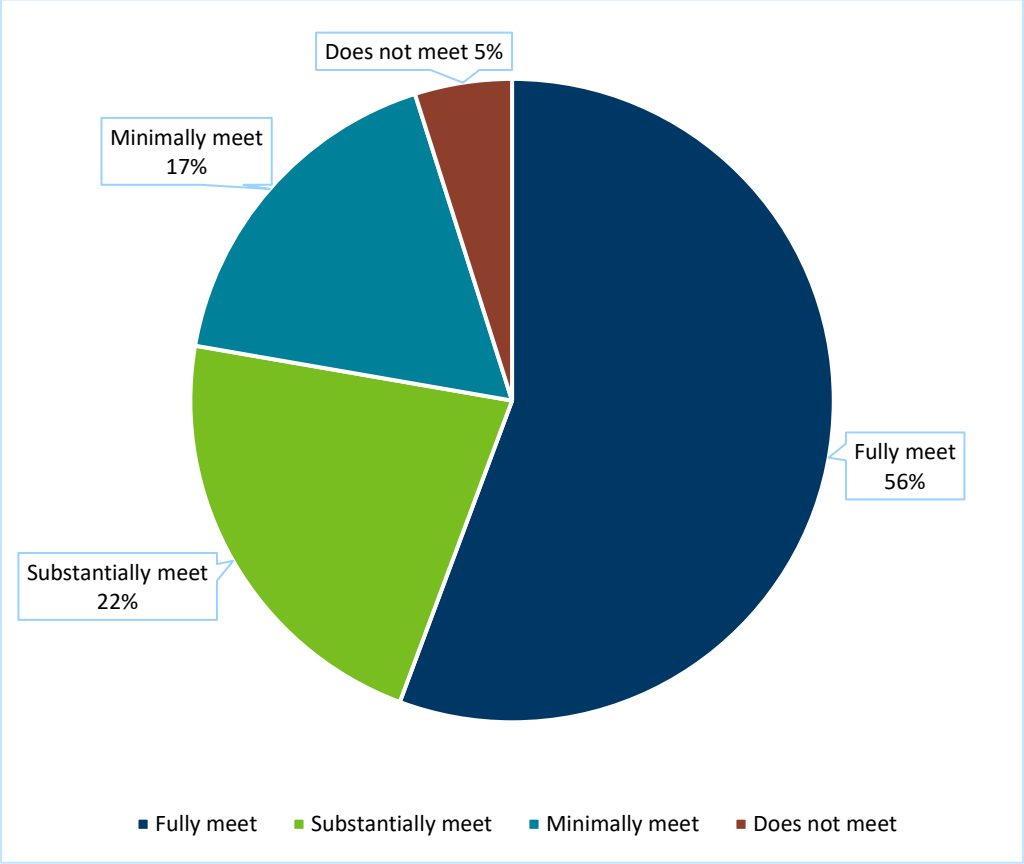


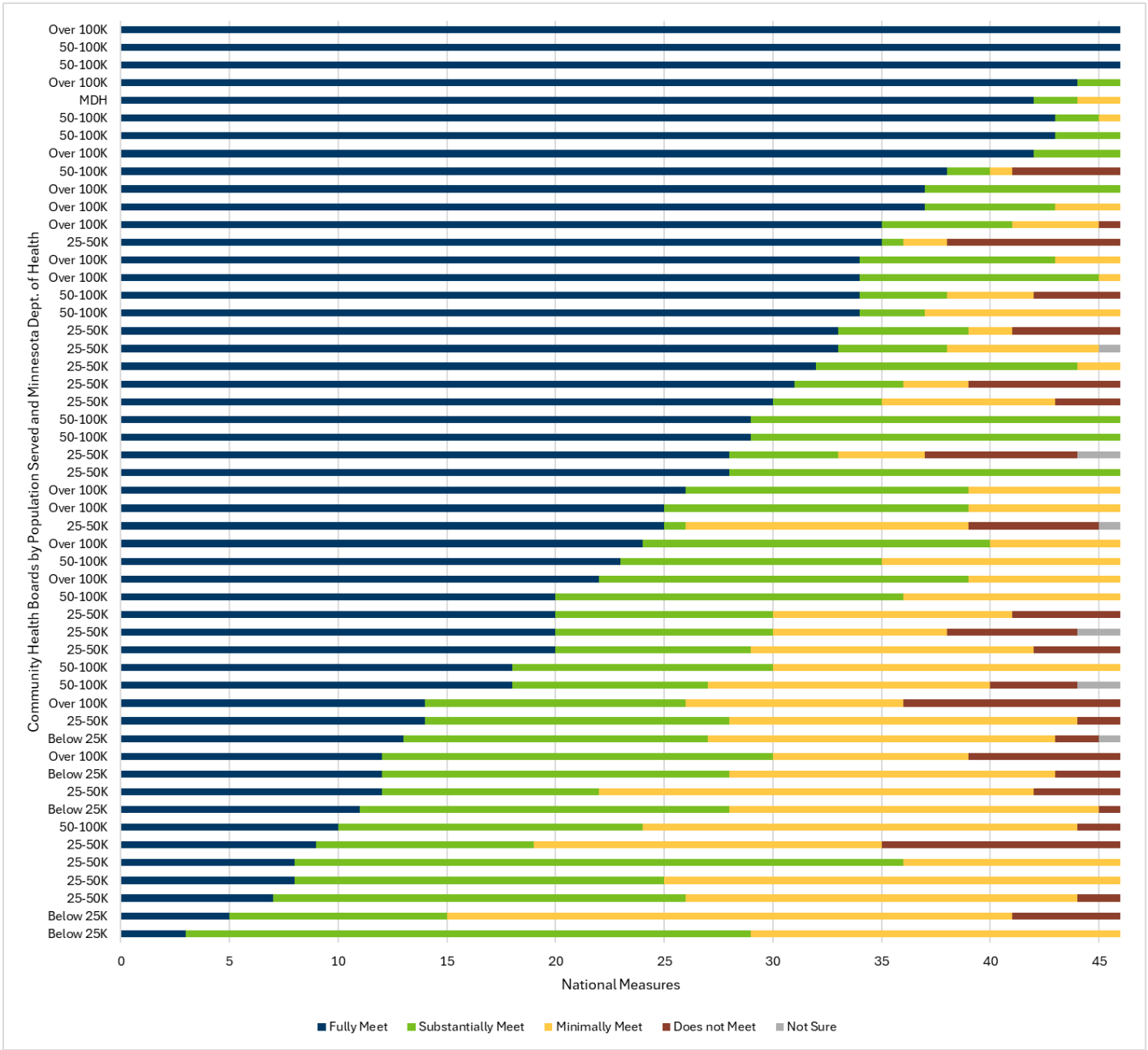
Figure 2 below illustrates the number of measures met by community health board size and the Minnesota Department of Health.

- Much like 2023, there remains a persistent variation in capacity across the state.
- Over half of community health boards (51%) and the Minnesota Department of Health can fully meet at least half of the measures, a pattern consistent with findings from previous assessments.

- 24% of community health boards (12 out of 51) reported they cannot meet 5 or more measures.
- Smaller community health boards (less than 50,000 population) are disproportionately represented in this group (75%), with only a few large, multi-county boards experiencing similar challenges.

Workgroup reflection: The data does not tell a one-size-fits all story. Patterns don't always align with community health board size or region.

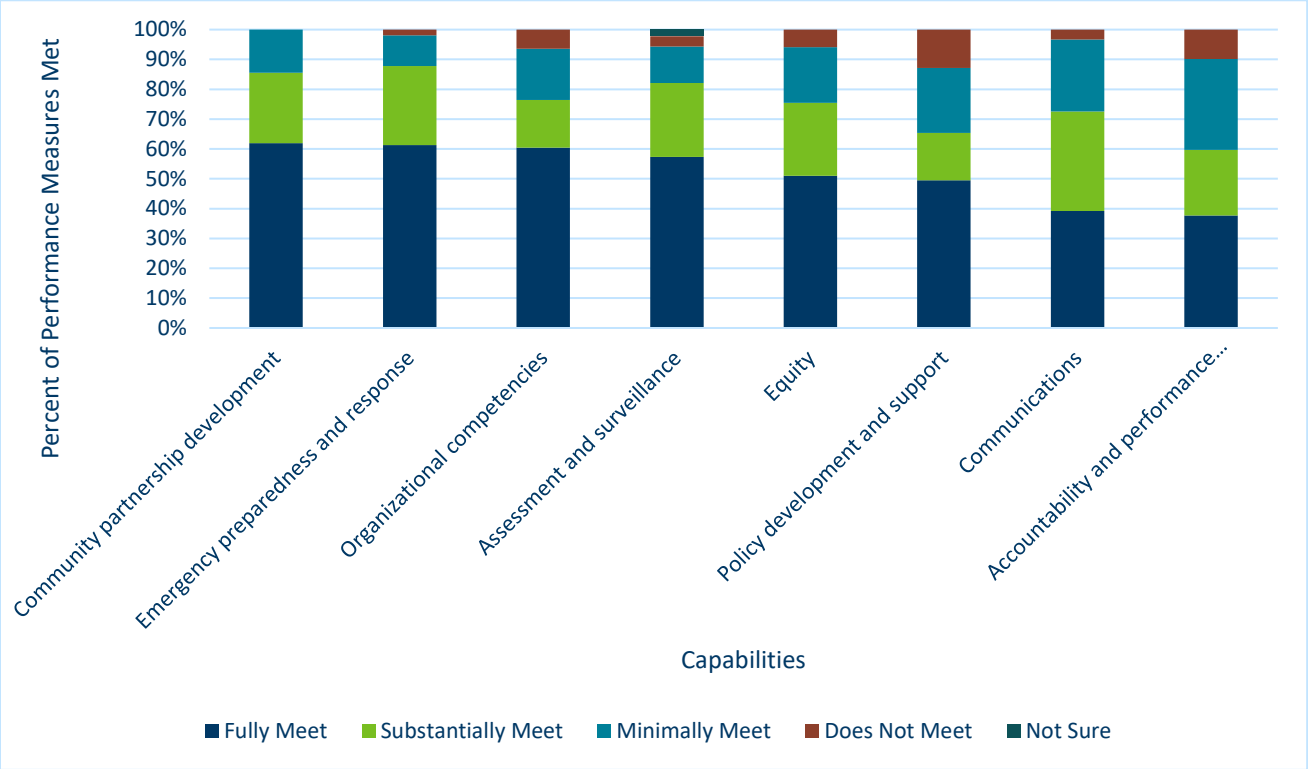
Figure 2: Number of measures met by community health boards and Minnesota Dept of Health (MDH)



There are notable areas of strengths and challenges across the system.

Community health boards and the Minnesota Department of Health are doing well on measures related to the responsibilities of community partnership development, emergency preparedness and response, and organizational competencies. There are challenges with accountability and performance management and communication capabilities.

Figure 3: Percentage of performance measures met by capability, community health boards only



STRENGTHS

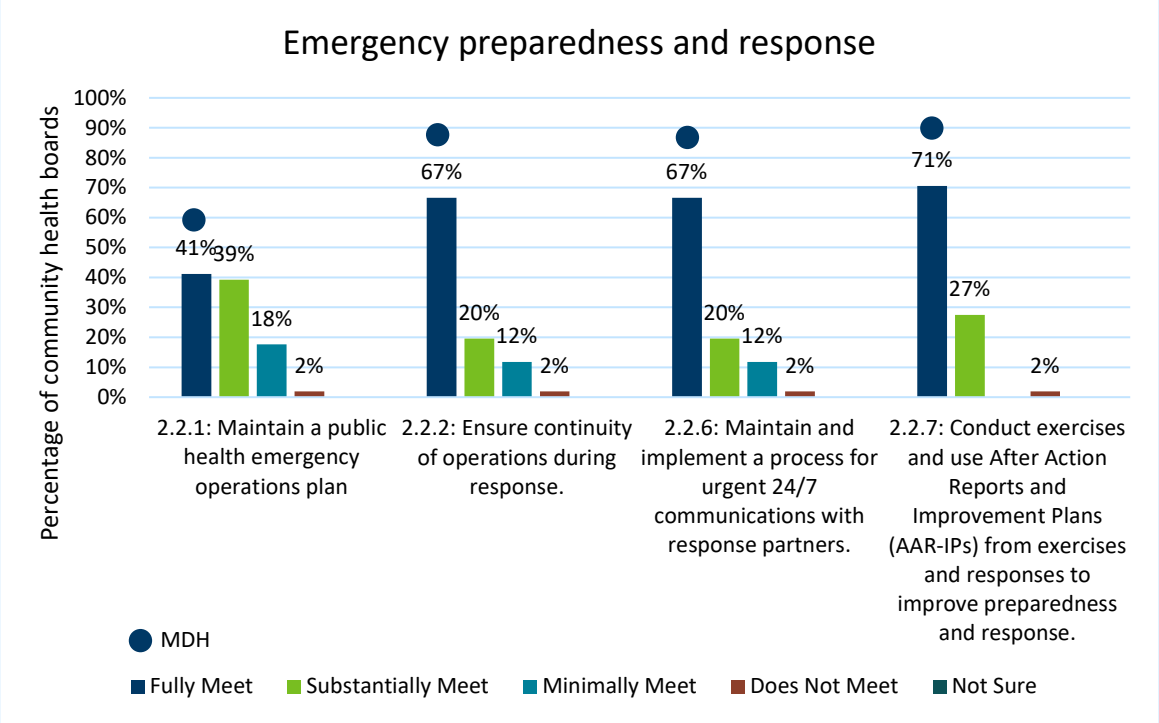
Community partnership development: Nearly all (96%) of community health boards and the Minnesota Department of Health fully or substantially meet the measure for participating in community health coalitions that promote health equity (4.1.2). Additionally, 86% of community health boards and the Minnesota Department of Health fully or substantially meet the measure for engaging community members to address public health issues and promote health (4.1.3).

- **Why this matters:** Community partnerships foster trust, leverage diverse perspectives and resources, and ensure that public health initiatives are responsive to the unique needs of the community. Strong partnerships enable more effective, equitable, and sustainable health outcomes.

- **The Statewide Health Improvement Partnership (SHIP)** illustrates how partnership and collaboration drives impact. In 2024 alone, all community health boards across the state were represented by SHIP. Local public health agencies worked with nearly 2,000 partner sites across the state. These partnerships have led to success on policy, system, and environmental changes to improve physical and mental wellbeing for Minnesotans. In 2024, SHIP initiatives included over 600 policy, system, or environmental changes across the state to support healthy eating, physical activity, mental wellbeing, and reduce commercial tobacco use. See figures 20 through 22 in Appendix A for a breakdown of partnership sites by goals, setting, and stage of change. To see all SHIP data as available, visit their online story map: Statewide Health Improvement Partnership (SHIP) 2024-25

Emergency preparedness and response: Community health boards fully or substantially met 88% of all the measures related to emergency preparedness and response. The Minnesota Department of Health reported fully meeting all these measures.

Figure 4: Community health board and Minnesota Department of Health's ability to meet emergency preparedness and response related measures



- Community health boards demonstrate strong capacity in emergency preparedness and response through intentional planning, partnerships, and community engagement. In 2024, 27 community health boards elected to use Response Sustainability Grant funding to expand or develop over 100 cross-sector partnerships, while another 20 improved community engagement through listening sessions, focus groups, and 1:1 meetings. See table 1 and figure 23 in Appendix A for a summary of these community partnerships and activities.
- In 2024, through the Response Sustainability Grant, over 100 agreements (ie. memorandums of understanding) were revised or developed by community health boards with other agencies or governmental jurisdictions, and over 50 plans and processes were reviewed to better protect

populations disproportionately affected by disasters using a health equity perspective. For more information, see the Response Sustainability Annual Report 2024-2025 (PDF).

Organizational Competencies: Community health boards fully or substantially met 78% of all the measures related to organizational competencies, demonstrating overall strength for this capability. measure related to workforce development was an exception, with 65% of boards reporting they minimally or could not meet workforce development planning and the implementation of strategies. The Minnesota Department of Health reported fully meeting nearly all measures related to organizational competencies.

- **Why it matters:** Organizational competencies include leadership and governance, information technology, financial management, legal services, and workforce development. Having strong organizational competencies help agencies function effectively and respond to community needs.

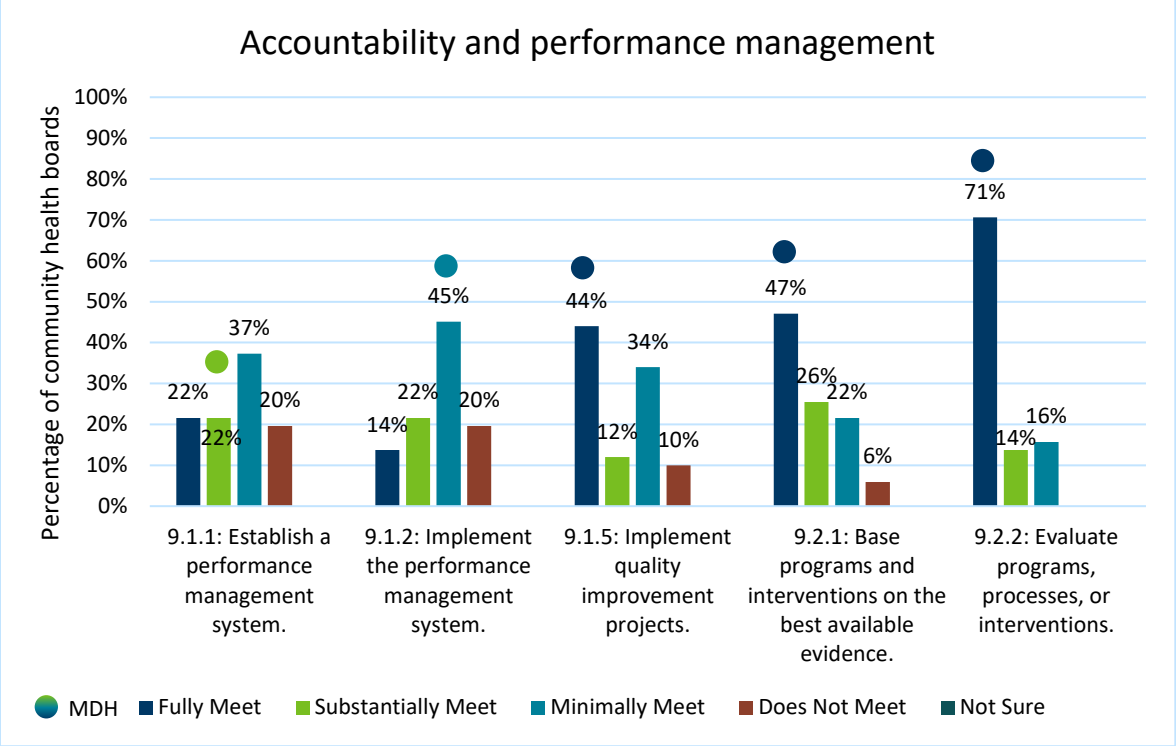
CHALLENGES

Accountability and performance management: Less than half of community health boards, only 43%, fully or substantially meet the measure for establishing a performance management system (9.1.1). Even fewer, 35%, are fully or substantially implementing these systems (9.1.2). These measures were also a challenge for the Minnesota Department of Health to fully meet, reporting substantially and minimally meeting these measures respectively. This gap highlights ongoing challenges rebuilding post COVID-19 pandemic, and limited staff capacity and expertise that can hinder progress.

- **Yes, but:** Many community health boards are working to improve, with over half planning to use FPHR Grant funds to strengthen accountability and performance management systems. Many community health boards are already engaging with MDH experts on this work.

Performance management is important because it makes public health work visible, measurable, and impactful. It provides the information needed for effective decision-making and drives continuous improvement across all parts of public health practice.

Figure 5: Community health board and Minnesota Department of Health's ability to meet accountability and performance management-related measures



Communications: Nearly a third (31%) of community health boards reported minimally or not meeting communication measures related to maintaining risk communication plans and processes for urgent communication with response partners (2.2.5) and procedures for ongoing, non-emergency communication outside the health department (3.1.1). The Minnesota Department of Health was able to fully meet all measures related to communications.

- **Yes, and:** At the same time, 80% of boards reported fully or substantially meeting the measure related to implementing communication strategies to encourage actions to promote health (3.2.2). This strength demonstrates the system's capacity to engage communities in proactive health promotion.
- **MDH's rural communications assessment** (2025) found that rural agencies with dedicated staff had greater capacity and could take a more strategic approach, while those without relied on reactive communication.

Workgroup reflections: Community health boards and the Minnesota Department of Health are still rebuilding capacity after pandemic-related strain. Additionally, community health boards, particularly small ones, may face difficulty sustaining specialized roles (e.g., communications) due to workload scope and resource limitations.

Community health boards tend to perform better in areas and capabilities where there is dedicated attention and funding.

For example, capabilities funded by the State Infrastructure (Innovation) Grant and the Foundational Public Health Responsibilities Grant boost capacity.

Positive impacts of funding include:

- Improved communication and relationships with communities, including more culturally appropriate public health campaigns.

  Minnesota Public Health Infrastructure Fund example: The St. Paul–Ramsey County Public Health Trusted Messenger Initiative is partnering with cultural communities to co-create and share vital health information in multiple languages and culturally meaningful ways.

  FPHR Grant example: The FPHR Grant enabled the Meeker, McLeod, and Sibley Community Health Board to create a long-needed communications position, transforming how they connect with partners and the community.

- Better data collection, interpretation, and use for decision-making.

  Minnesota Public Health Infrastructure Fund example: The Northwest Eight (Polk, Norman, and Mahnomen and Quin) shared data for community health assessments and planning processes and developed a regional data team to improve data collection, interpretation, and use.

  FPHR Grant example: Sherburne County was able to create a dedicated planner position, critical for assessment and surveillance work. It's allowed them to prioritize the needs assessment process and strengthen data-focused collaboration across partners.

- Regional coordination, shared staffing, and higher education partnerships increase capacity without requiring each community health board to hire dedicated staff.

  Minnesota Public Health Infrastructure Fund example: The Collaborative for Rural Public Health Innovation (CRPHI) brings together local public health leaders from 25 counties in South Central and Southwest Minnesota, Minnesota State University, Mankato, and MDH. This partnership addresses rural workforce shortages by coordinating shared expertise, developing student pathways into local public health, and ensuring students graduate with the skills needed to meet the realities of public health practice in rural communities.

  FPHR Grant example: Olmsted County used grant funding to hire an epidemiologist to strengthen its regional data model. This investment is expanding data access and analytical capacity for smaller health departments in the region that lack dedicated epidemiology staff.

- Some accredited agencies were already meeting measures, but these grants strengthened their efforts.

  Minnesota Public Health Infrastructure Fund example: MN Electronic Health Records Consortium's Health Trends Across Communities innovation project is improving access to timely, medical-record data. Community health boards across the state now have access to richer, real-time data, strengthening their ability to understand community needs, plan, and make decisions.

FPHR Grant example: Horizon Public Health hired a Population Health Supervisor to significantly expand capacity across several foundational capabilities, with a particular focus this past year on supporting communities in policy development.

Workgroup reflection: Sustainability is a concern from community health boards. Improvements made from grant-funded staff or initiatives risk plateauing without continued or increased funding.

Next steps: Strengthen our public health system through sustainable funding, collaboration, and modern approaches.

Flexible funding, regional and cross-sector partnerships, and better coordination between local and state agencies will strengthen efforts, drive new ways of delivering public health, and ensure communities are better set up to thrive.

Flexible funding: Our public health system depends on flexible funding to stay strong and responsive. Sustaining and strengthening our system requires dedicated and flexible funding, including tax levy dollars. Current funding models are insufficient to meet system needs, and funding in part through tax levy provides the flexibility needed for community health boards to meet the needs of their community.

Collaboration: This report emphasizes the value of collaboration. Community health boards should continue to focus on strengthening regional collaboration to share work across geography and encourage innovative partnerships, such as those with universities and community-based organizations, to continue building expertise and capacity.

Meet community members where they are at: Modern practices and tools can be key paths forward for Minnesota's public health system. This means using better, more adaptable ways to reach people, like through technology and authentic community engagement that reflects the state's changing demographics and growing diversity. Modern practice includes elevating collaboration, community voice, and equity; developing a workforce that acts as community health strategists; and focusing on prevention and the root causes of disease. Modern tools are things like sharing data with each other and communities and using responsive, relevant communication methods (such as using platforms like TikTok and Instagram) to meet people where they are already getting their information.

Strengthen the foundation and drive innovation: Sustaining progress on strengthening the public health foundation requires ongoing and increased investment. At the same time, supporting innovation is essential to finding better ways of doing public health work. Community health boards are embracing creativity and moving beyond "the way it's always been done," but resources are needed to fuel and sustain this transformation.

System-level coordination: It's important to continue work toward system-level coordination of the responsibilities, such as clarifying which practices are best led by locals versus MDH, improving communication and coordination between them, and leveraging MDH data systems alongside local data to reduce redundancies and fill gaps.

Limitations

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

Scope: The data presented here includes that of local public health community health boards and the Minnesota Department of Health. It does not include Tribal Nations, which are important partners of our public health system. 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.

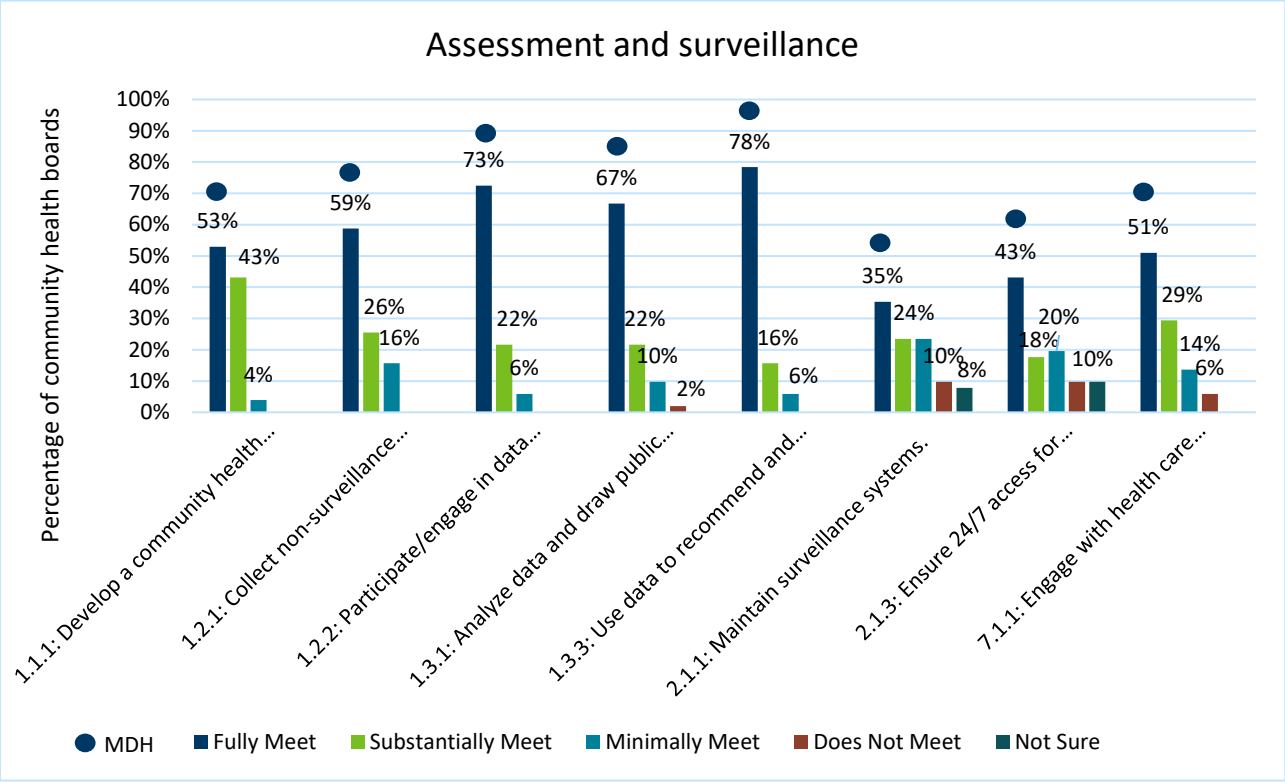
Self-reporting: Self-reporting is a widely used method for collecting data in public health. It comes with limitations, including less objectivity, which can impact data quality. In 2023, effort was made to standardize response options to improve objectivity and consistency in reporting across the state.

Differences across counties: Reporting was done by community health boards. For multi-county community health boards (who operate more than one health department), there may be differences between ability to meet by the counties the community health board governs not captured in the data. Multi-county community health boards were asked to report based on the lowest ability to meet of member health departments to reveal system strengths and gaps.

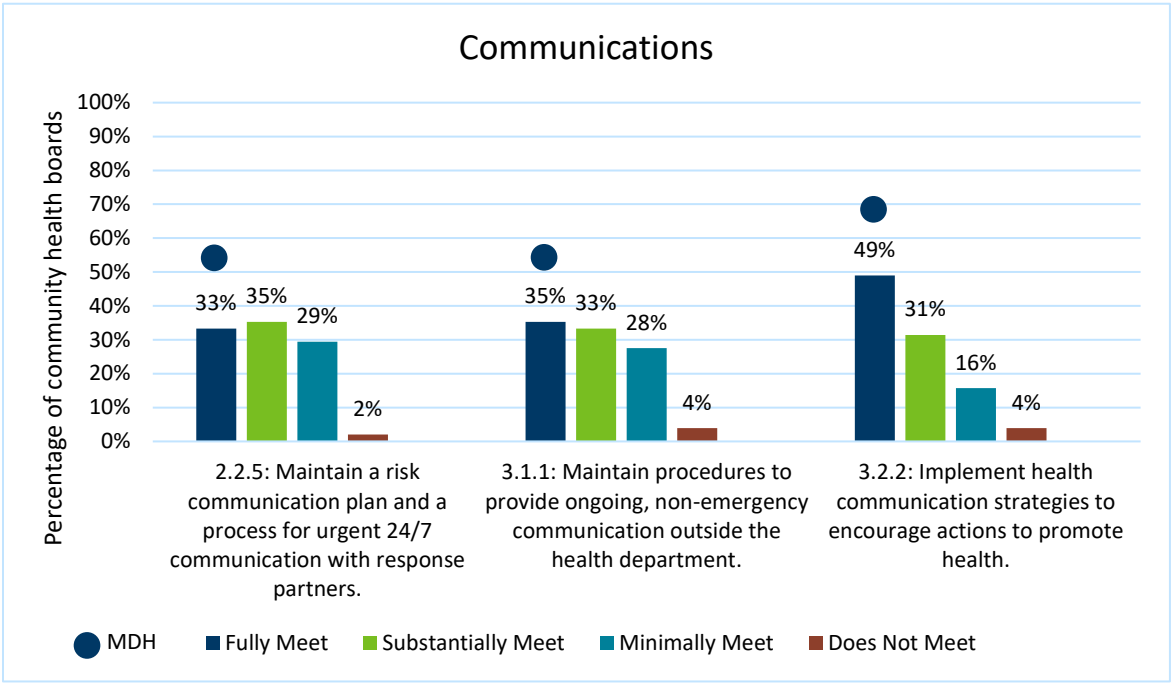
Community needs and impact are not measured: The measures assess how well community health boards can perform foundational public health capabilities. However, they do not show if community health boards have what they need to meet the specific needs of their communities since community needs are not 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.

Appendix A: Additional figures and tables

Figures 6-11: Community health board and Minnesota Department of Health's ability to meet measures by foundational capabilities[1]



[1] Within the Foundational Public Health Responsibilities Framework, the foundational capabilities represent the foundation: Using the metaphor of a house, all houses need a strong foundation for the rest of the house to function properly. All public health's work is undergirded by a strong foundation, built of these capabilities, across all areas of work.


Communications
Percentage of community health boards
100%
90%
80%
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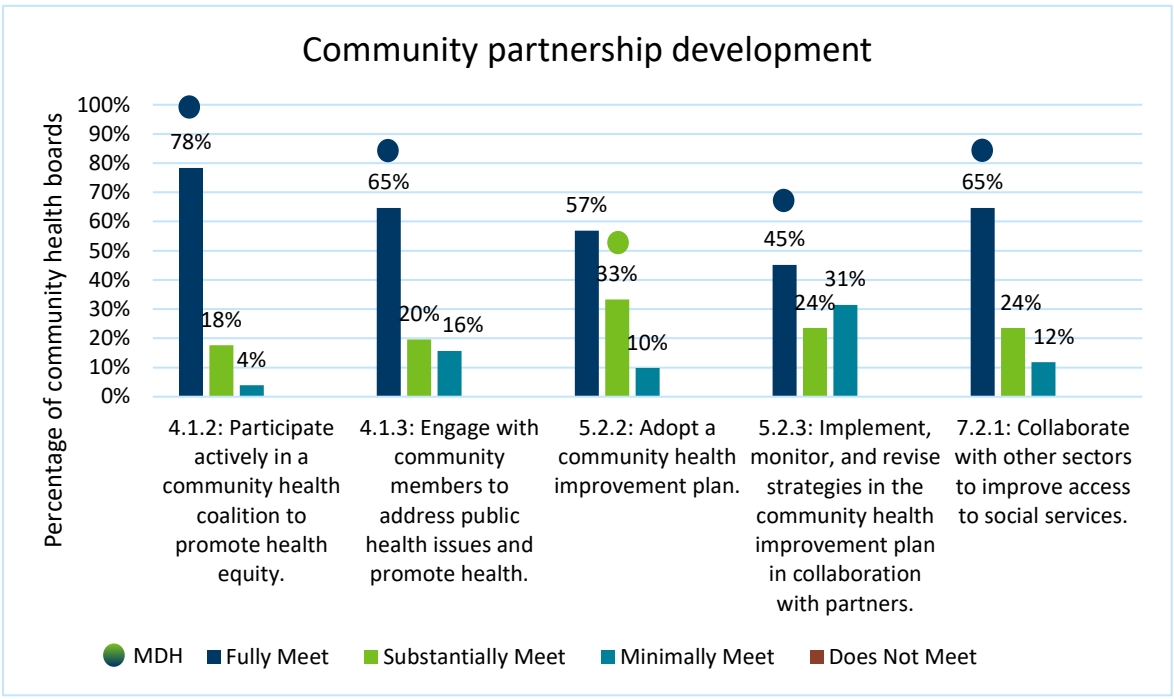
10%
0%
33%
35%
29%
2%
35%
33%
28%
4%
49%
31%
16%
4%
2.2.5: Maintain a risk communication plan and a process for urgent 24/7 communication with response partners.
3.1.1: Maintain procedures to provide ongoing, non-emergency communication outside the health department.
3.2.2: Implement health communication strategies to encourage actions to promote health.
MDH
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet


Community partnership development
Percentage of community health boards
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78%
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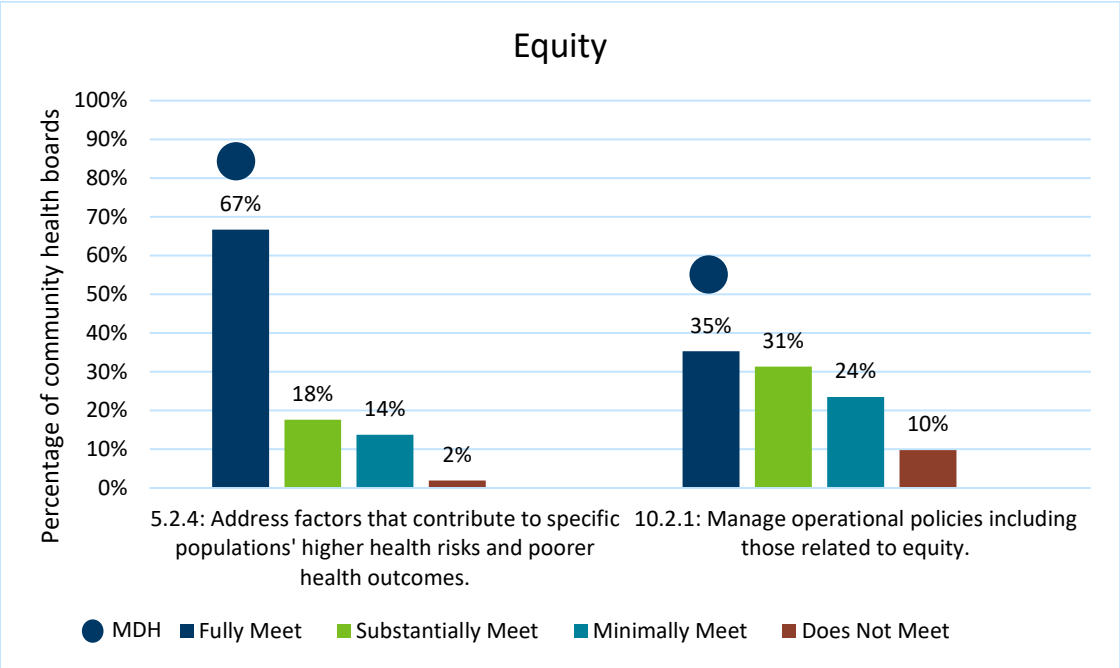
57%
33%
10%
45%
24%
31%
65%
24%
12%
4.1.2: Participate actively in a community health coalition to promote health equity.
4.1.3: Engage with community members to address public health issues and promote health.
5.2.2: Adopt a community health improvement plan.
5.2.3: Implement, monitor, and revise strategies in the community health improvement plan in collaboration with partners.
7.2.1: Collaborate with other sectors to improve access to social services.
MDH
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet


Equity
Percentage of community health boards
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67%
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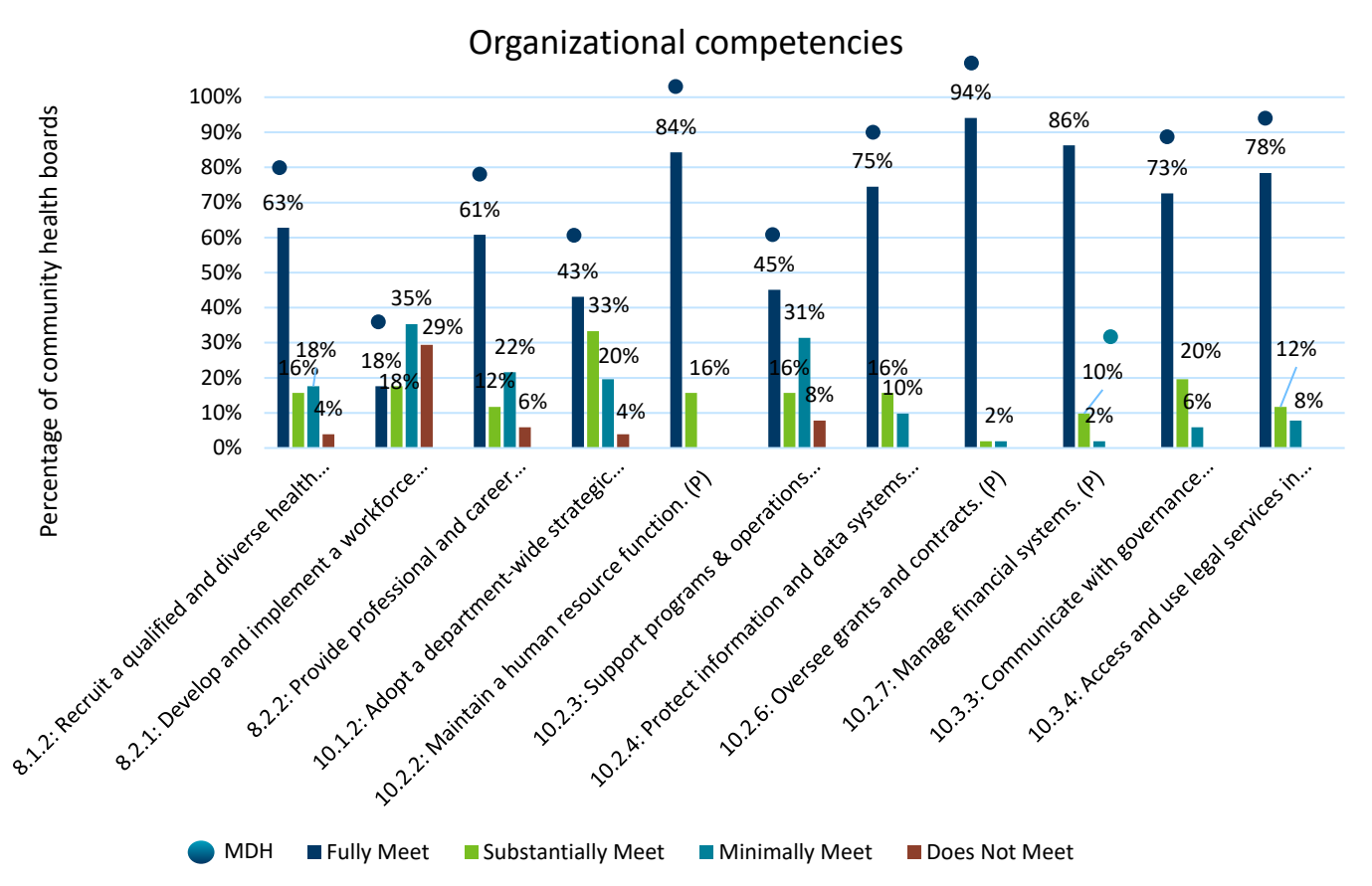
14%
2%
35%
31%
24%
10%
5.2.4: Address factors that contribute to specific populations' higher health risks and poorer health outcomes.
10.2.1: Manage operational policies including those related to equity.
MDH
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet


Organizational competencies
Percentage of community health boards
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63%
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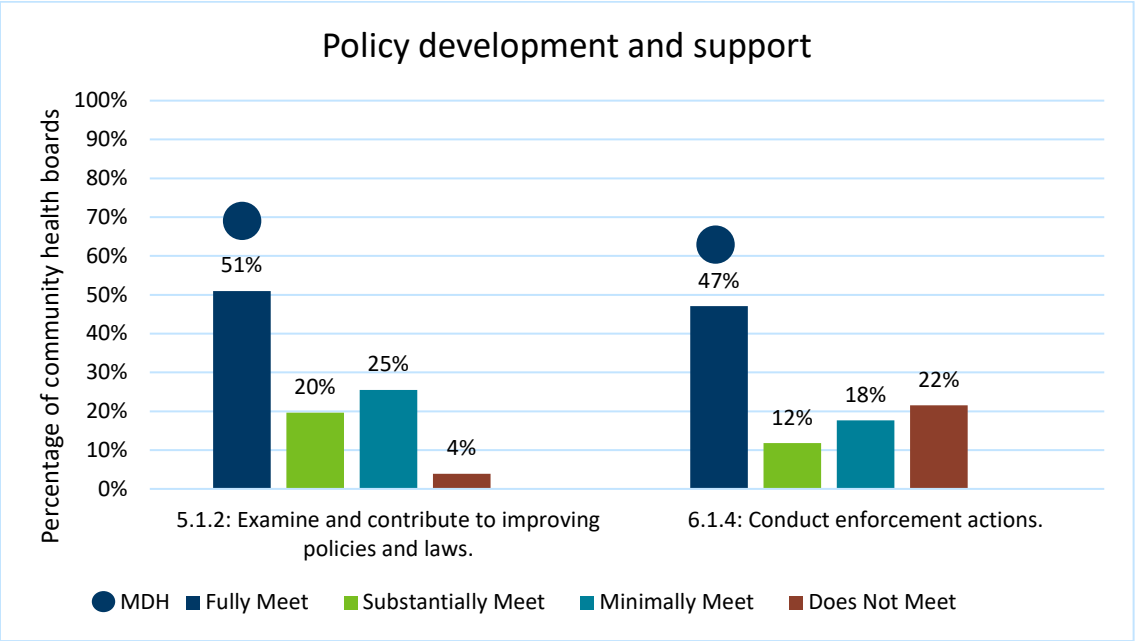
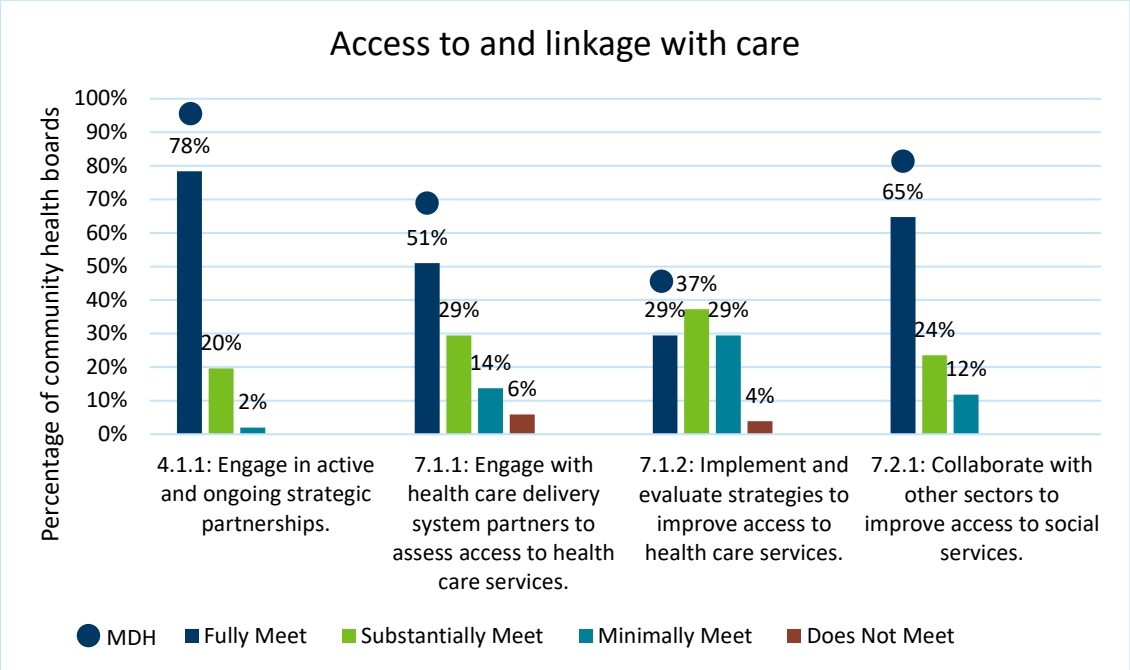
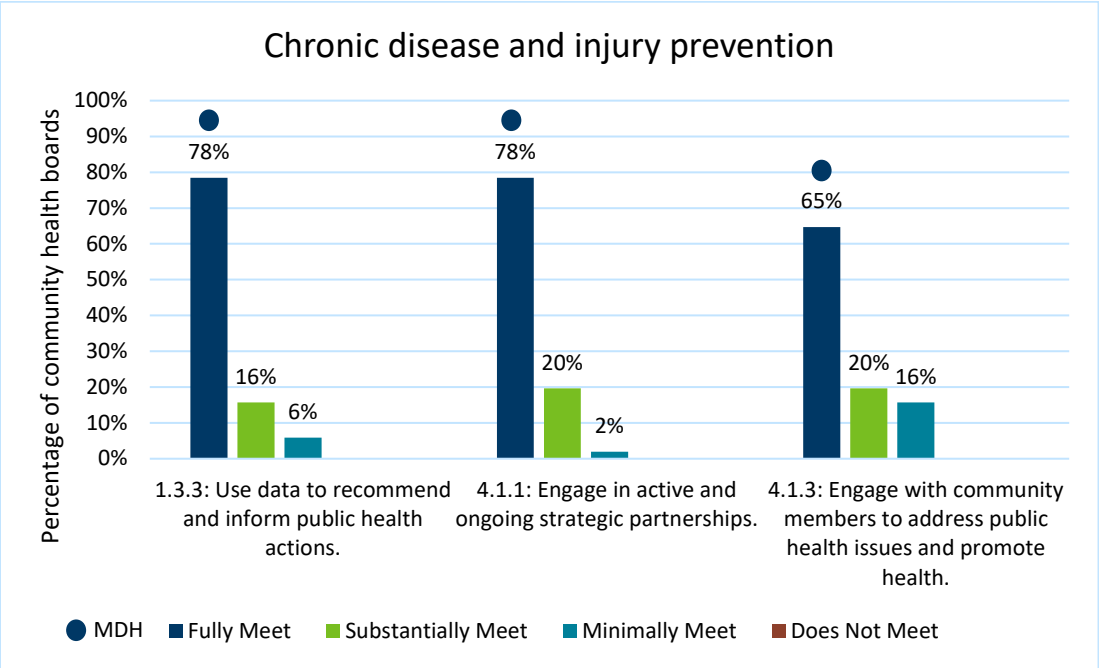
6%
43%
33%
20%
4%
84%
16%
45%
16%
31%
8%
75%
16%
10%
94%
2%
86%
10%
2%
73%
20%
6%
78%
12%
8%
8.1.2: Recruit a qualified and diverse health...
8.2.1: Develop and implement a workforce...
8.2.2: Provide professional and career...
10.1.2: Adopt a department-wide strategic...
10.2.2: Maintain a human resource function. (P)
10.2.3: Support programs & operations...
10.2.4: Protect information and data systems...
10.2.6: Oversee grants and contracts. (P)
10.2.7: Manage financial systems. (P)
10.3.3: Communicate with governance...
10.3.4: Access and use legal services in...
MDH
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet

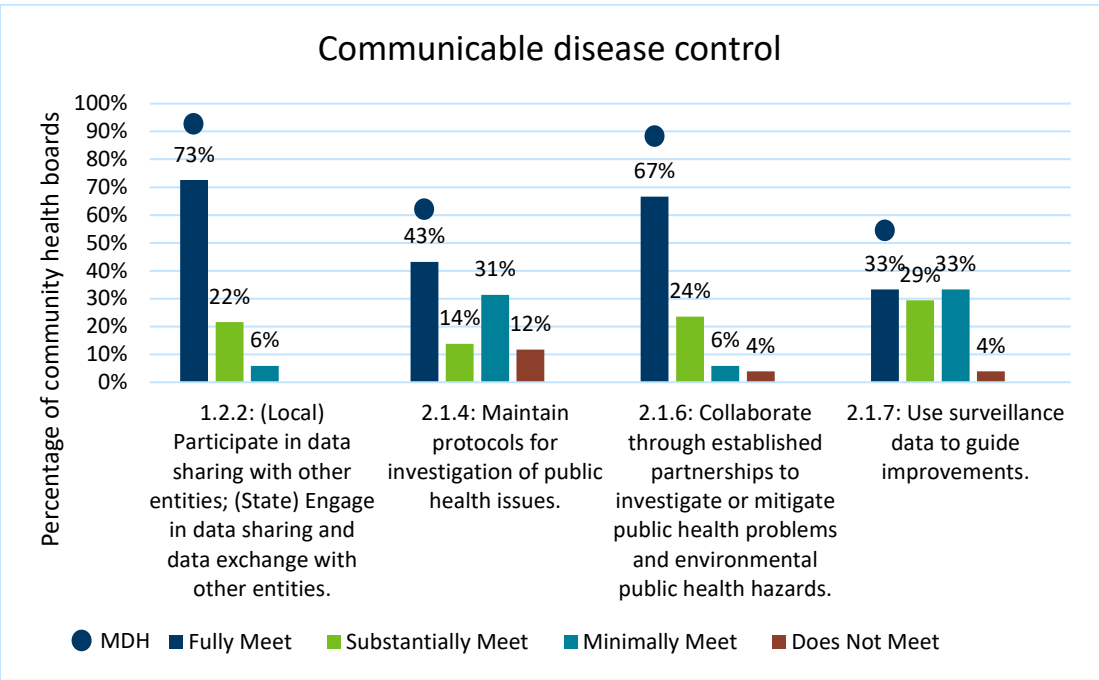


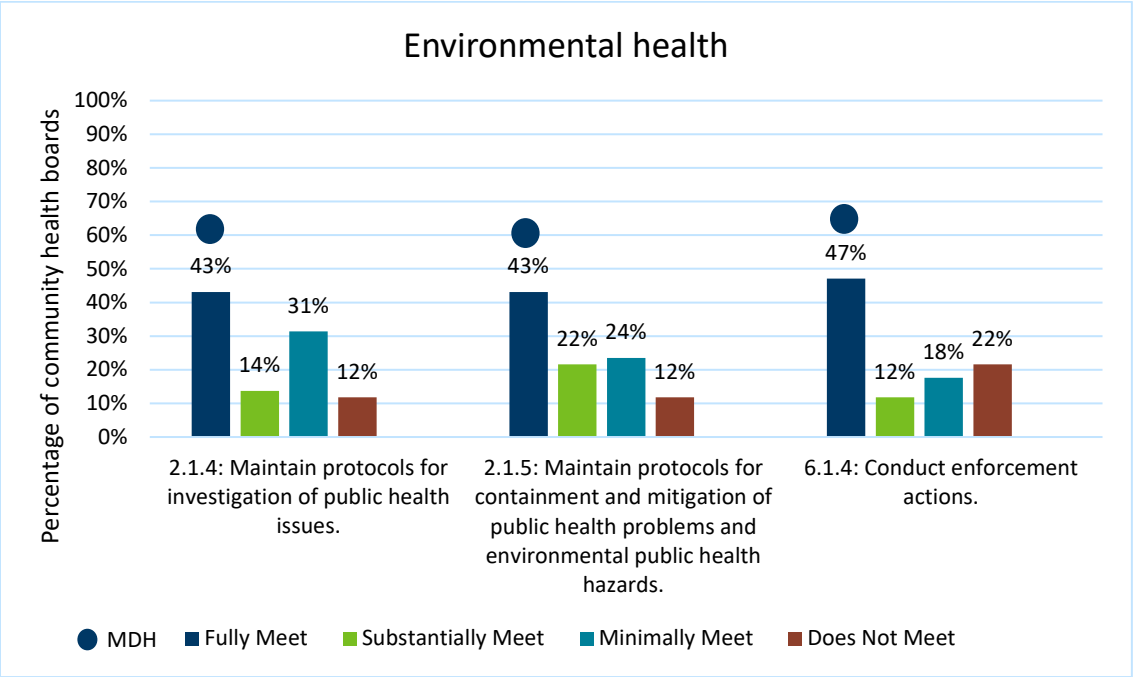
Figures 12-17: Community health boards' ability to meet measures by foundational areas[2]



[2] Within the Foundational Public Health Responsibilities Framework, foundational areas represent the rooms of our "house": There are some parts of a house that are universal--we expect houses all have a kitchen, bathroom, bedrooms, etc. In the same way, Minnesotans should see public health working in their jurisdictions in these five areas of work, no matter where they live. *NOTE*: *The measures reported on by community health boards for the foundational areas are national measures from PHAB, but PHAB does not identify them as tied to specific areas. The workgroup applied its discretion in aligning measures with areas, based on where community health boards would reasonably draw examples to demonstrate meeting the measure for accreditation purposes.*


Chronic disease and injury prevention
Percentage of community health boards
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
78%
16%
6%
78%
20%
2%
65%
20%
16%
1.3.3: Use data to recommend and inform public health actions.
4.1.1: Engage in active and ongoing strategic partnerships.
4.1.3: Engage with community members to address public health issues and promote health.
MDH
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet


Communicable disease control
Percentage of community health boards
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
73%
22%
6%
43%
14%
31%
12%
67%
24%
6%
4%
33%
29%
33%
4%
1.2.2: (Local) Participate in data sharing with other entities; (State) Engage in data sharing and data exchange with other entities.
2.1.4: Maintain protocols for investigation of public health issues.
2.1.6: Collaborate through established partnerships to investigate or mitigate public health problems and environmental public health hazards.
2.1.7: Use surveillance data to guide improvements.
MDH
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet


Environmental health
Percentage of community health boards
100%
90%
80%
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30%
20%
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43%
14%
31%
12%
43%
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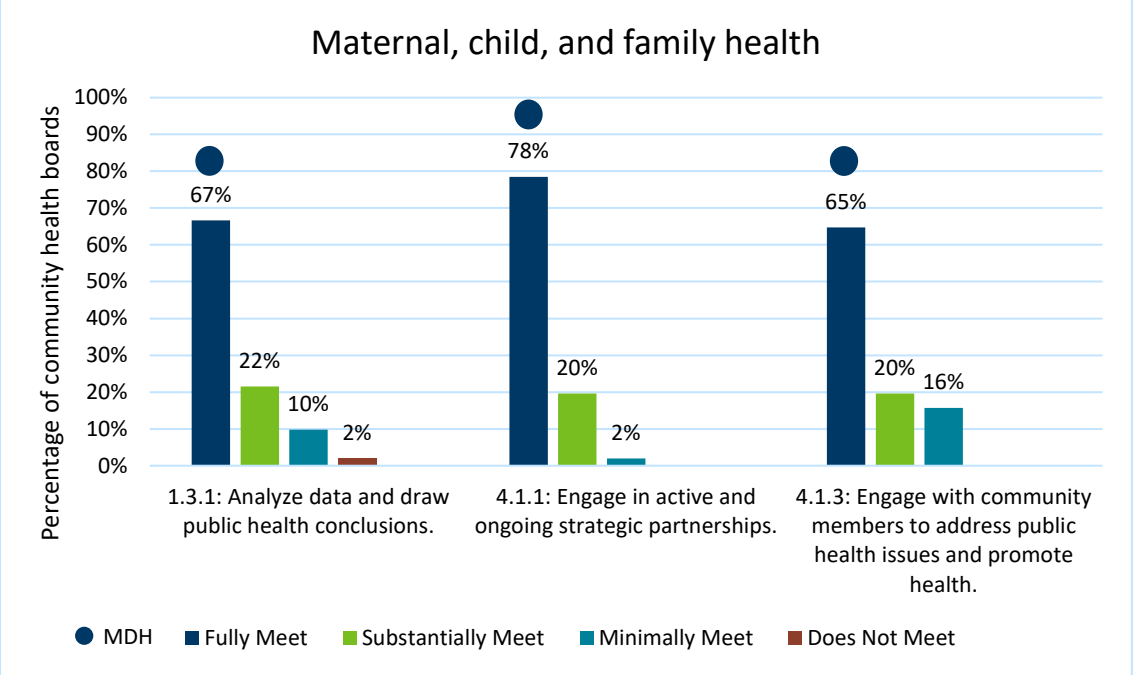
24%
12%
47%
12%
18%
22%
2.1.4: Maintain protocols for investigation of public health issues.
2.1.5: Maintain protocols for containment and mitigation of public health problems and environmental public health hazards.
6.1.4: Conduct enforcement actions.
MDH
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet


Maternal, child, and family health
Percentage of community health boards
100%
90%
80%
70%
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50%
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30%
20%
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0%
67%
22%
10%
2%
78%
20%
2%
65%
20%
16%
1.3.1: Analyze data and draw public health conclusions.
4.1.1: Engage in active and ongoing strategic partnerships.
4.1.3: Engage with community members to address public health issues and promote health.
MDH
Fully Meet
Substantially Meet
Minimally Meet
Does Not Meet

Figure 18: Percent of 46 national measures met by community health board size (population served)

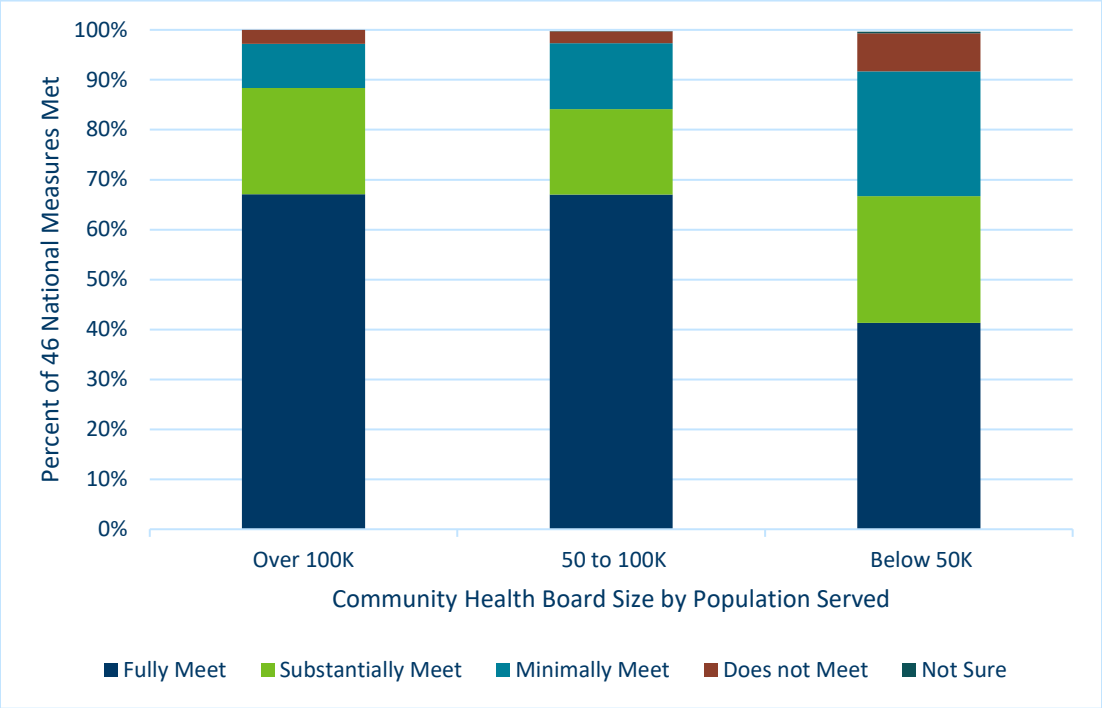


Figure 19: Percent of 46 national measures met by SCHSAC regions

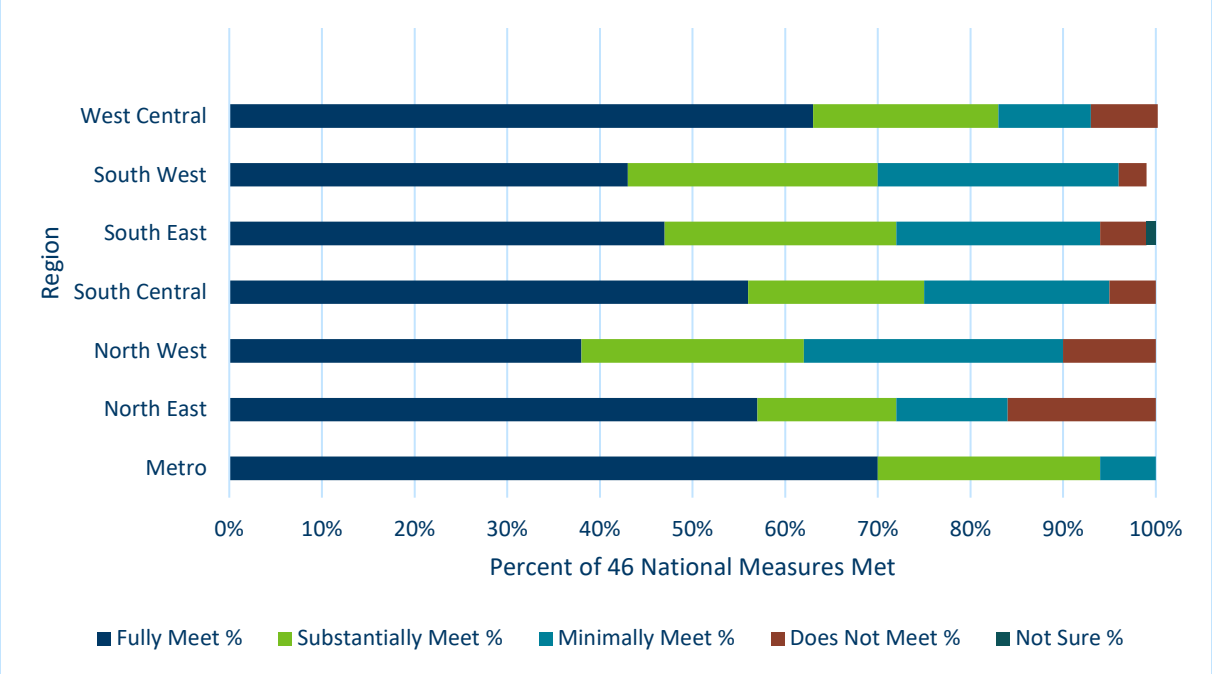
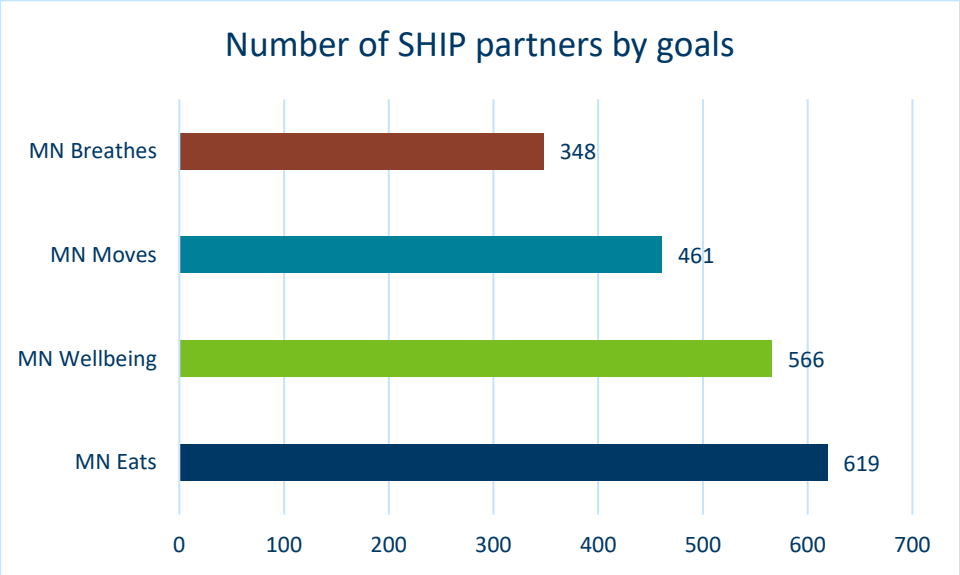


Figure 20-22: Total number of Statewide Health Improvement Partnership sites (1,994), by goals, setting, and stage of change

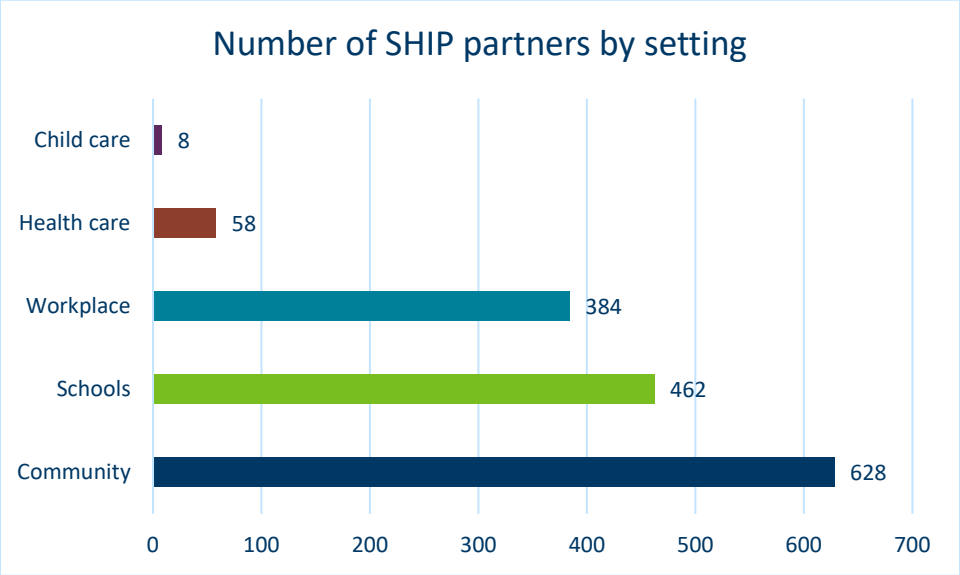


MN Eats: Ensures that all people in Minnesota experience an equitable, just, nourishing, and resilient food system that is responsive to change

MN Moves: Supports systemic change in transportation and recreation to increase active living opportunities, especially people of color, those with disabilities, low-income and low-wealth communities, youth and older adults

MN Breathes: Empowers communities facing tobacco-related disparities and most targeted by the tobacco industry, recognizing social determinants of health and lifting up community assets

MN Wellbeing: Invests in opportunities to create equitable, healthy, and positive conditions that promote trauma-informed approaches to increased well-being for all Minnesotans



*One partner can participate in multiple settings.

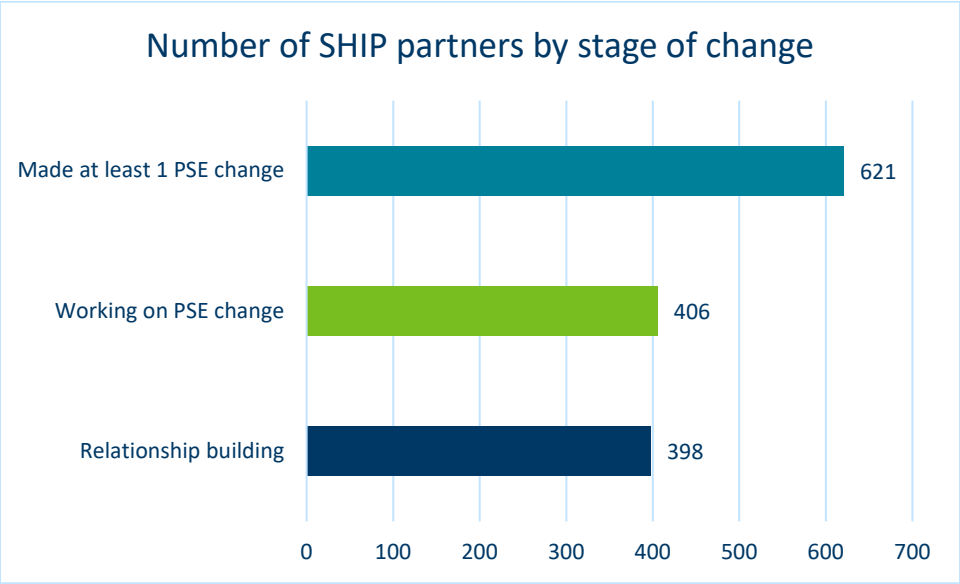


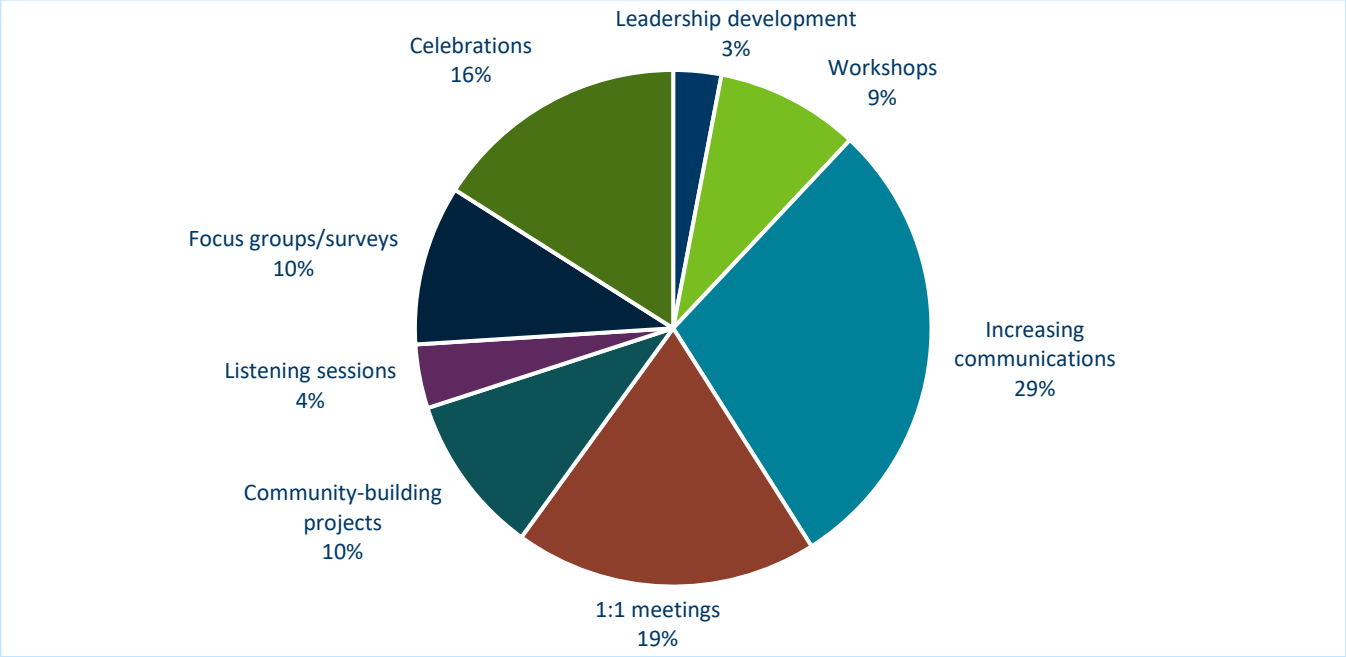
Table 2: Number of new or expanded emergency preparedness and response community partnerships by sector as of Sept. 30, 2024

Table 2 reflects reporting on **Response Sustainability Grant Duty 9: CHBs may develop or expand relationships with community partners.** Twenty-seven (27) community health boards selected this elective duty in the first biennium.

Sector	Number engaged
Health care (hospitals/clinics)	23
Public safety and emergency management	20
cultural and faith-based groups	19
Education and childcare settings	16
Local government	16
Social services	13
Community leadership	11
LTC, assisted living, other senior services	10
Voluntary organizations active in disasters and non-profits	8
Housing and sheltering	6

Sector	Number engaged
Mental/behavioral health	5
Media	5
Business/worksites/agri-business	4
Coroner, medical examiner, funeral homes	4
Total	**160**

Figure 23: Emergency preparedness and response activities with community partners



Appendix B: About performance measurement

What was measured

The performance measures for calendar year 2024 correspond with the Foundational Public Health Responsibilities. The 46 national measures are a subset of Public Health Accreditation Board measures and align with foundational responsibilities. In Minnesota, community health boards are not required to become accredited; however, these national measures represent best practices for governmental public health work. This set of measures is used to assess local and state ability to meet the national standards using a standardized scale, which allows continuity of monitoring the performance.

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

The (P) denotes measures from PHABs Pathways Recognition Program.

There are also references for several of the measures to indicate that it was also prioritized as a measure of foundational areas:

[1] Communicable Disease Control

[2] Chronic Disease and Injury Prevention

[3] Environmental Public Health

[4] Maternal, Child, and Family Health

[5] Access to and Linkage with Care

Foundational responsibility	**National measures**
Assessment and surveillance	1.1.1: Develop a community health assessment. (E) (P) 1.2.1: Collect non-surveillance population health data. (P) 1.2.2: (Local) Participate in data sharing with other entities; (State) Engage in data sharing and data exchange with other entities. (P)[1] 1.3.1: Analyze data and draw public health conclusions. (P) 1.3.3: Use data to recommend and inform public health actions. [2,4] 2.1.1: Maintain Surveillance systems. (E) (P) 2.1.3: Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards. (P) 7.1.1: Engage with health care delivery system partners to assess access to health care services. [5]
Community Partnership Development	4.1.2: Participate actively in a community health coalition to promote health equity. (E) (P) 4.1.3: Engage with community members to address public health issues and promote health. (E) [2,4] 5.2.2: Adopt a community health improvement plan. (E) (P) 5.2.3: Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners. 7.2.1: Collaborate with other sectors to improve access to social services. (P) [5]

Foundational responsibility	National measures
Communications	2.2.5: Maintain a risk communication plan and a process for urgent 24/7 communication with response partners. (E) (P) 3.1.1: Maintain procedures to provide ongoing, non-emergency communication outside the health department. (E) (P) 3.2.2: Implement health communication strategies to encourage actions to promote health. (E) (P)
Equity	5.2.4: Address factors that contribute to specific populations' higher health risks and poorer health outcomes. (P) 10.2.1: Manage operational policies including those related to equity. (P)
Organizational Competencies	8.1.2: Recruit a qualified and diverse health department workforce. (E) (P) 8.2.1: Develop and implement a workforce development plan and strategies. (E) (P) 8.2.2: Provide professional and career development opportunities for all staff. (P) 10.1.2: Adopt a department-wide strategic plan. (P) 10.2.2: Maintain a human resource function. (P) 10.2.3: Support programs & operations through an information management infrastructure. (P) 10.2.4: Protect information and data systems through security and confidentiality policies. (P) 10.2.6: Oversee grants and contracts. (P) 10.2.7: Manage financial systems. (P) 10.3.3: Communicate with governance routinely and on an as-needed basis. (P) 10.3.4: Access and use legal services in planning, implementing, and enforcing public health initiatives. (P)
Policy Development and Support	5.1.2: Examine and contribute to improving policies and laws. (E) (P) 6.1.4: Conduct enforcement actions. (E) (P) [3]
Accountability and Performance Management	9.1.1: Establish a performance management system. (P) 9.1.2: Implement the performance management system. 9.1.5: Implement quality improvement projects. (P) 9.2.1: Base programs and interventions on the best available evidence. (E) (P) 9.2.2: Evaluate programs, processes, or interventions. 7.1.2: Implement and evaluate strategies to improve access to health care services. (E)

Foundational responsibility	National measures
Emergency Preparedness and Response	2.2.1: Maintain a public health emergency operations plan (EOP)(E) (P) 2.2.2: Ensure continuity of operations during response. (P) 2.2.6: Maintain and implement a process for urgent 24/7 communications with response partners. (P) 2.2.7: Conduct exercises and use After Action Reports and Improvement Plans (AAR-IPs) from exercises and responses to improve preparedness and response. (P)
Measures connected to foundational areas	2.1.4: Maintain protocols for investigation of public health issues.[1,3] 2.1.5: Maintain protocols for containment and mitigation of public health problems and environmental public health hazards. [3] 2.1.6: Collaborate through established partnerships to investigate or mitigate public health problems and environmental public health hazards. [1] 2.1.7: Use surveillance data to guide improvements. [1] 4.1.1: Engage in active and ongoing strategic partnerships. [2,4,5]

Reporting guidance for community health boards

Community health boards were asked to engage key staff in reviewing the 46 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. They 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 (operating more than one health department) were asked to report on the lowest level of capacity of member health departments to reveal strengths and gaps. That is, if two of three 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	

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

Minnesota Department of Health Reporting

MDH based its responses on findings from the 2024 reaccreditation readiness assessment, supplemented by measure reviews with accreditation domain leads and subject matter experts.

Data from major grant programs

The performance measurement workgroup reviewed existing data currently reported by community health boards related to grants Statewide Health Improvement Partnership (SHIP) and Emergency Preparedness and Response for incorporation into this report.

From SHIP reporting, the following system-level data was considered:

- Policy, systems, and environment changes in childcare, community, healthcare, school, and workplace settings.
- Stage of policy, systems, and environment work with partner sites.

From the Response Sustainability Grant and Public Health Emergency Preparedness reporting, the following system-level data was considered:

- Training for emergency preparedness (Response Sustainability Grant)
- New, revised, or reviewed memorandum of understandings, memorandum of agreements, and mutual aid agreements (Response Sustainability Grant)
- Health equity assessment of plans, policies, procedures (Response Sustainability Grant)
- Engagement of communities disproportionately impacted in exercises and after-action report/improvement plans. (Public Health Emergency Preparedness reporting)

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

Members

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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
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