

Strengthening Public Health Workgroup

FINAL REPORT TO SCHSAC
MAY 2018

Strengthening Public Health Workgroup Final Report

Draft: February 2018

Final: May 2018

Minnesota Department of Health
Center for Public Health Practice
PO Box 64975
St. Paul, MN 55164-0975
651-201-3880
health.ophp@state.mn.us
<http://www.health.state.mn.us>

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- District 5 Kip Bruender

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Mankato, MN 56002

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May 4, 2018

Jan K. Malcolm
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

Dear Commissioner Jan Malcolm,

I would like to present you with a report and recommended next steps of the *Strengthening Public Health in Minnesota Workgroup*. This State Community Health Services Advisory Committee (SCHSAC) workgroup convened to address concerns about the wide variation in capacity and performance among Minnesota's Community Health Boards. The workgroup was asked to identify, examine and recommend a set of promising strategies to assure that: 1) basic local public health services are in place in all locations of Minnesota; and 2) Minnesota's Public Health System is evolving to meet modern community health issues. This report was formally approved by SCHSAC at the February 23, 2018 meeting.

This workgroup was unique to SCHSAC in that the membership was very broad which included county commissioners, county administrators, human service directors, tribal health, academics, legislators, community organizations and healthcare providers. Workgroup members came together and experienced robust discussions on the strengths and challenges of our public health system in Minnesota. These discussions also led to the prioritization of actions which could be taken to strengthen our current public health system.

SCHSAC members understand that strengthening the public health system is an extremely critical issue for our state. We are committed to providing the leadership necessary to move this work forward. We also embrace a continuing tradition of partnership, working with the Minnesota Department of Health, to identify and implement solutions to these complex issues at hand.

As the SCHSAC chair, I appreciate your knowledge, experience, leadership, and efforts towards supporting local public health, as well as to the state and local public health partnership. The public health system will be stronger and better prepared as we move into the future together. On behalf of the SCHSAC I request your acceptance and approval of this report and recommended next steps.

Sincerely,

Drew Campbell, SCHSAC Chair,
Blue Earth County Commissioner
Blue Earth County Community Health Board



Protecting, Maintaining and Improving the Health of All Minnesotans

May 18, 2018

Commissioner Drew Campbell, SCHSAC Chair
Blue Earth County Commissioner
Blue Earth County Community Health Board
204 S. Fifth Street
Mankato, MN 56002

Dear Commissioner Campbell:

Thank you for the State Community Health Services Advisory Committee's (SCHSAC) report and recommended next steps from the *Strengthening Public Health in Minnesota Workgroup*. The report lays out practical and tangible next steps that we can take together to address the challenges facing our public health system and make sure basic public health services are available across the state.

As you said, these issues are complex, but these priority action steps are a good start. We must work together to move forward and prepare the public health system for the future. We know that we cannot do this alone. I commend SCHSAC for convening a group that included a broad representation of public health partners – this will serve us well. Through the work of the group, you have not only heard from new partners, but have increased the understanding of public health among leaders that can help support the public health system moving forward.

Public health is changing and the state and local partnership needs to adapt and prepare for that change. I look forward to working with you and SCHSAC as these recommended next steps are implemented. Thank you for the excellent work.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jan K. Malcolm'.

Jan K. Malcolm
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975
www.health.state.mn.us

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Executive Summary

Purpose

The Strengthening Public Health Workgroup was formed by SCHSAC in response to mounting concerns about persistent resource constraints and wide variability among community health boards related to performance. The workgroup was asked to identify, examine and recommend a set of promising strategies to assure that: 1) basic local public health activities are in place in all parts of Minnesota; and 2) Minnesota's public health system is evolving to meet modern community health issues. The workgroup, which met three times between October 2017 and January 2018, included a broader membership than is typical for a SCHSAC workgroup, drawing members from both inside and outside public health (see membership list in Appendix A).

Overview of activities

Over the course of three full-day meetings members received a large volume of in-depth information on the current state of Minnesota's public health system, including information on organization, governance, basic public health responsibilities, funding, leadership, and workforce issues. Through discussions and group activities, the workgroup synthesized this information into a set of observations about the system. They concluded by creating prioritized actions and future directions for consideration by SCHSAC.

Observations

Each of these observations is complex and has a number of factors that contribute to fully understanding the issues facing Minnesota's public health system. An expanded list is in Appendix B.

- Minnesota's governmental public health system has served us well, but much has changed since it was established in 1976.
- The current partnership between MDH and local public health is a major strength of Minnesota's governmental public health system. SCHSAC is an integral aspect of the partnership.
- Tribal health departments are an important part of Minnesota's governmental public health system, but are not always considered or fully included.
- Basic public health responsibilities must be carried out in all parts of Minnesota in order to protect and promote the health of the public and prevent disease and injury. However, a number of local health departments do not and cannot realistically carry them out. Further clarification of those responsibilities is both needed and desired.
- Funding for public health is largely categorical and has very limited flexibility.
- The community health board has responsibility for public health in their jurisdiction. To be successful in governing, they must engage a diverse set of individuals and groups including communities and elected officials at all levels.
- It is the role of the community health services (CHS) administrator to be the lead local public health official. Currently, they face many challenges in carrying out this role successfully.
- Public health departments across the state face significant workforce challenges.

Prioritized actions

The workgroup recommended 11 future directions for Minnesota’s public health system (pp. 5-7). Their top three priorities for action are:

1. Clarify the basic public health responsibilities for Minnesota and identify new ways to carry them out.
2. Take steps to align public health funding and resources with local needs.
3. Take a comprehensive and multisectoral approach to public health workforce development.

Next steps

While the workgroup recognizes that there are many other areas where important work should be undertaken to strengthen, and “future-proof” Minnesota’s public health system, they respectfully request that SCHSAC focus all available energy on addressing the three priorities first. It is the workgroup’s belief that in doing so, the foundation for other future improvements will have been laid. The SCHSAC executive committee and MDH will continue to refine the priorities into short and long-term action steps over the next few years; they will be included in the annual SCHSAC work plan.

Other next steps include:

- Approval and acceptance of this report by SCHSAC and the commissioner of health;
- SCHSAC executive committee will provide leadership for implementation and ensure the annual SCHSAC work plan is updated to reflect the future directions and;
- MDH will work with local and tribal public health to identify tasks and activities that can be undertaken in the next year; and
- MDH will work with local public health to undertake an analysis of the future directions, in order to identify any needed statute, rule or policy changes.

Background

The SCHSAC Strengthening Public Health Workgroup was convened in response to mounting concerns about persistent resource constraints that prevent effective responses to current public health threats and challenges and wide variability among community health boards related to performance and resources. They were given the following charge:

Convene a broad set of stakeholders of governmental public health to identify, examine, and recommend a set of promising strategies to assure that: (1) required local public health activities are in place in all parts of Minnesota; and (2) Minnesota's public health system is evolving to meet modern community health issues.

The workgroup met three times between October 2017 and January 2018. The membership of the workgroup was purposely broad in order to include perspectives of multiple stakeholders who are interested in protecting and improving the health of Minnesota residents. Members included county commissioners, state legislators, community health services administrators, health and human services directors, county administrators, tribal health directors, healthcare providers, and community organizations. A full list of members can be found in Appendix B.

At the first meeting, members received information on Minnesota's governmental public health system, including: how public health is organized in Minnesota; the role of state and local public health agencies; the public health partnership; and the capacity of local public health departments to carry out a set of basic public health activities.

At the second meeting, members received more in-depth information regarding the differences in the capacity of local public health departments to meet basic public health activities and met in small groups to further discuss decision-making; leadership; state and local roles; and resources.

At the third and final meeting, members refined their observations regarding the current state of Minnesota's public health system. They developed and prioritized a set of directions for strengthening public health in Minnesota. A high-level overview of their observations and priorities for action is below.

Summary of observations

Workgroup members had several observations regarding the current state of Minnesota's public health system, summarized in the bullets below. Each of these observations is complex and has a number of factors that contribute to fully understanding the issues facing local public health in Minnesota. These observations formed the basis for the workgroup's recommended actions and future directions to SCHSAC. The full text version of their observations from meeting 3 is in Appendix A.

- Minnesota's governmental public health system has served us well, but much has changed since it was established in 1976.
- The current partnership between MDH and local public health is a major strength of Minnesota's governmental public health system. SCHSAC is an integral aspect of the partnership.
- Tribal health departments are an important part of Minnesota's governmental public health system, but are not always considered or fully included.
- Basic public health responsibilities must be carried out in all parts of Minnesota in order to protect and promote the health of the public and prevent disease and injury. However, a number of local

health departments do not, and cannot, realistically carry them out. Further clarification of these responsibilities is both needed and desired.

- Funding for public health is largely categorical and has very limited flexibility.
- The community health board has responsibility for public health in their jurisdiction. To be successful in governing, they must engage a diverse set of individuals and groups including communities and elected officials at all levels.
- It is the role of the community health services (CHS) administrator to be the lead local public health official. Currently, they face many challenges to carrying out this role successfully.
- Public health departments across the state face significant workforce challenges.

Priorities for action and future directions

Workgroup discussions over the course of three meetings resulted in the members recommending actions needed to strengthen public health in Minnesota. While all the actions were deemed important, members were asked to select their top three priorities (see items 1-3 below). All the recommended actions are listed below and are in the order of priority identified by the workgroup. The SCHSAC executive committee and MDH will continue to refine these into short and long-term action steps over the next few years; they will be included in the annual SCHSAC work plan.

Priorities for action

Priority 1: Clarify the basic public health responsibilities for Minnesota and identify new ways to carry them out.

The workgroup agreed that public health's upstream approach is vitally important protect and promote the health of the public and prevent disease an injury. The workgroup also agreed that there are certain, basic, public health responsibilities that must be carried out statewide. These responsibilities must be understood by local elected officials and public health leaders who govern and carryout public health locally. While a number of documents and definitions currently exist, they are not well understood or clearly communicated. MDH and SCHSAC should work together to clarify and increase understanding of the basic public health responsibilities including the scope and scale of those responsibilities.

Community health boards and local health departments, in consultation with MDH, should locally determine the best way to carry out these responsibilities. While some jurisdictions may be already adequately carrying out the basic responsibilities, others may need to explore new and innovative ways of meeting their responsibilities (e.g. models for cross-jurisdictional sharing).

Priority 2: Take steps to align public health funding and resources with local needs.

The workgroup felt strongly that public health funding should be aligned to meet the needs of local communities in a way that balances flexibility and accountability. Currently, resources for public health are primarily driven by categorical grants, not by community priorities. Community health boards have limited capacity to address health needs identified by the community, or emerging and unexpected situations (i.e., outbreaks, disasters). A vision for public health funding should be set and stakeholders, including those in the position to fund public health, should be engaged to achieve the vision.

Priority 3: Take a comprehensive and multisectoral approach to public health workforce development.

Workgroup members recommended the creation of a public health workforce development plan. They felt that to be sufficiently broad and future oriented, it should be created by MDH and local public health in partnership with higher education programs, and other public health organizations (e.g., Local Public Health Association, Minnesota Public Health Association).

Public health departments across the state are facing workforce challenges. Challenges include competition with other sectors for staff, lack of ongoing skill development opportunities, and a mismatch in existing hiring practices and necessary emerging skills and professions. The field of public health is evolving and the skills and composition of the workforce must evolve with it. The plan should include strategies to address workforce training and development for leadership and staff. It should include expansion of the types of professionals in the public health workforce; an emphasis on increasing the racial and ethnic diversity of professionals in the field; ongoing leadership development; and creation of a “pipeline” of future public health workers.

Additional future directions

The workgroup made additional recommendations for future action to strengthen Minnesota’s public health system. While these actions did not rise to the level of the top three priority actions, the workgroup felt they were important and agreed to forward them to SCHSAC for consideration.

Align MDH regional resources to meet local needs

Local health departments value the MDH regional resources available to them, like the public health nurse consultants, regional epidemiologists, and public health preparedness consultants. While the roles of these staff have evolved over time, a comprehensive evaluation of the alignment of these resources with local needs has not occurred.

The workgroup agreed that MDH and local public health should work together to examine the roles of the MDH regional staff. This examination should include determining activities that could be done more efficiently at the regional or state level, versus activities best carried out at the local level. Differences between regions and new approaches to working together, such as co-locating regional MDH staff within a local health department and cross-jurisdictional sharing, should be considered.

Increase local capacity to identify and address community health issues

According to a recent survey of local capacity, many community health boards are not adequately equipped to identify and address local needs in a way that engages the community, uses a variety of sources of data, and works in partnership with diverse community stakeholders. The workgroup suggested leveraging additional support and resources to build the capacity (i.e., time, expertise and staffing) of community health boards to do community health assessment, and community health improvement planning. Additional support could include technical assistance from MDH, alignment with federally required local hospital-based community assessments, regional approaches, or partnerships with higher education. It bears mentioning that some, but not all, community health boards need help in developing, implementing and monitoring those plans to address community needs.

Increase engagement with local and state policymakers

Local and state elected officials (policymakers) have an important role in advancing the health of their communities. It is critical that they understand the relationship between policies and health, and are equipped to consider health in decision-making. In addition, local community health board members need to understand their responsibility for assuring that basic public health responsibilities are carried

out, and that local health needs are addressed. In order to ensure well-informed public health policy and decision making the workgroup recommended increasing efforts to engage community health board members and local and state policy makers.

Strengthen and support the role of the CHS administrator

Community health services (CHS) administrators play an important role acting on behalf of their community health board and providing leadership for public health in their jurisdiction. Many factors contribute to the wide variation in the level of authority, role and skillset possessed by CHS administrators around the state. The workgroup recommended taking steps to clarify and standardize expectations for the CHS administrator role. Additionally they recommended providing more training and ongoing professional development opportunities to better support leaders currently who are serving as CHS administrators. Some workgroup members expressed interest in renaming this important position to be more descriptive and consistent with the role of a local health official.

Strengthen SCHSAC through continuous improvement

The State Community Health Services Advisory Committee (SCHSAC) is an important component of the state-local public health partnership. SCHSAC should continue to celebrate its strengths, partnerships and successes while recognizing and adapting to the changing public health landscape. In the spirit of continuous improvement, the following areas should be reviewed: the level of engagement of current members; effectiveness of the SCHSAC meeting structure; engagement of tribal partners; multi-county community health board membership; promotion/marketing of SCHSAC to county commissioners who are not members, and engagement of state and local elected officials.

Engage tribal governments in local public health governance

Each of the 11 tribal nations in Minnesota have their own sovereign governments, cultures and community health priorities. Local health departments and community health boards must be knowledgeable about the unique role and sovereignty of tribal governments and should engage with tribes appropriately. Community health boards should involve tribes who reside within the borders of their jurisdictions in public health decision-making. This could involve having tribal governments represented on the community health board, as well as engaging them in the planning and delivery of activities and services that affect their community.

Increase consistency across MDH programs to reduce administrative burden for local and tribal health departments

Many programs across MDH interact with and provide funding to local and tribal health departments. Duplicative requests for documentation, cumbersome reporting requirements, and lack of consistency across MDH programs place undue administrative burdens on local and tribal public health. MDH should streamline their grant management processes. Efforts should be made to increase consistency in how grants are administered (i.e., use consistent management processes throughout the grant cycle). Additionally, MDH should work to increase the flexibility of categorical grants, so those funds can be used to address local needs and support local public health infrastructure activities.

Review and clarify the role of the community health board medical consultant

The Local Public Health Act (Minn. Stat. § 145A) requires community health boards to appoint a medical consultant to “ensure appropriate medical advice and direction for the community health board and assist the board and its staff in the coordination of community health services with local medical care and other health services.” The role and qualifications of the medical consultant should be updated to reflect the current interplay of healthcare and public health, and the needs of local health departments and community health boards.

Conclusion

An engaged and forward-thinking group of leaders, with a shared interest in ensuring the strength of Minnesota's public health system, came together for three productive meetings at the end of 2017. In their brief time together, these members – *local public health directors, human services directors, county commissioners, county administrators, state legislators, tribal health, academics, healthcare professionals, and community partners* – learned a great deal about the current state of Minnesota's public health system. They asked difficult questions, and had frank conversations about the challenges facing the system. They engaged in robust, creative and future-oriented discussions, which led them to develop priorities for action and future directions.

The workgroup's top three priorities for action were:

- Priority 1: Clarify the basic public health responsibilities for Minnesota and identify new ways to carry them out.
- Priority 2: Take steps to align public health funding and resources with local needs.
- Priority 3: Take a comprehensive and multisectoral approach to public health workforce development.

While the workgroup recognizes that there are many other areas where important work should be undertaken to strengthen, and “future-proof” Minnesota's public health system, they respectfully request that SCHSAC focus all available energy on addressing these first three priorities. It is the workgroup's belief that in doing so, the foundation for other future improvements will have been laid.

Finally, despite the significant challenges currently facing the system, the workgroup members were very impressed by the breadth of issues addressed by Minnesota's public health professionals. They extend their thanks and appreciation for the work done, every day, to protect and improve the health of Minnesotans.

Appendix A: Workgroup membership and charge

SCHSAC will convene a broad set of stakeholders of governmental public health to identify, examine, and recommend a set of promising strategies to assure that: 1) required local public health activities are in place in all parts of Minnesota; and 2) Minnesota's public health system is evolving to meet modern community health issues.

Background

The Community Health Services Act (now the Local Public Health Act) passed in 1976 laid out a vision for a public health system in Minnesota. The Local Public Health Act has been updated several times with relatively minor changes, and SCHSAC has produced a number of reports with recommendations for strengthening the system. Some of those recommendations have been implemented, and others have not.

Currently, community health boards in Minnesota are struggling against persistent resource constraints that prevent effective responses to current public health threats and challenges. Additionally, there is wide variability among community health boards related to performance and resources. This means that where a person lives may have a significant impact on the level, range and quality of public health services available in their community.

To put it in the words of practitioners in the system, there is concern that Minnesota's public health infrastructure is crumbling and it is an imminent threat both to the integrity of our public health system and ultimately the health of all Minnesotans. The long-term public health focus on prevention is often lost in the many pressing, near-term issues and mandated services counties must prioritize.

To date, the concerns and potential solutions have been discussed primarily by public health practitioners, through workgroups of the State Community Health Advisory; committees of the Local Public Health Association; and the Minnesota Department of Health. Those conversations need to broaden to include perspectives of other stakeholders interested in protecting and improving the health of Minnesota residents.

Meetings

During three meetings between October and January the workgroup will:

- Develop a common understanding of Minnesota's governmental public health system.
- Identify strengths and challenges of current system.
- Brainstorm potential strategies for strengthening Minnesota's governmental public health system.
- Explore and refine potential strategies for strengthening Minnesota's governmental public health system.
- Continue to explore potential strategies and select the most promising strategies for SCHSAC and MDH to investigate further.

Membership (as of 10/12/17)

Name	Title/Role	Organization
Ed Ehlinger (Co-chair)	Commissioner of Health	MDH
Susan Morris (Co-chair)	Isanti County Commissioner/ SCHSAC Member	Isanti County Community Health Board
Richard Anderson	Beltrami County Commissioner	Beltrami County Community Health Board
Steven Belton	Community Partner	Minneapolis Urban League
Michelle Benson	State Senator, District 31	Chair, HHS Finance and Policy Committee, Republican
Kodjo Bossou*	Medical Consultant	Goodhue County Community Health Board
Patrick Boyle*	St. Louis County Commissioner	Carlton-Cook-Lake-St. Louis Community Health Board
Charles Bransford	Medical Consultant	Washington County Community Health Board
Drew Campbell	Blue Earth County Commissioner/ SCHSAC Member	Blue Earth County Community Health Board
Jill DeBoer	Community Partner	U of M, Center for Infectious Disease Research and Policy
Renee Frauendienst	CHS Administrator	Stearns County Community Health Board
Mike Freiberg	State Representative, District 45B	Member, HHS Reform Committee, DFL
Rachel Hardeman	Community Partner	U of M, School of Public Health
Kelly Harder	Health & Human Services Director	Dakota County
Doug Huebsch*	Otter Tail County Commissioner/ SCHSAC Member	Partnership4Health Community Health Board
Mónica Hurtado	Community Partner	Voices for Racial Justice
Lowell Johnson	CHS Administrator	Washington County Community Health Board
Sheila Kiscaden	Olmsted County Commissioner/ SCHSAC Member	Olmsted County Community Health Board
Deatrick LaPointe	Community Partner	St Paul-Ramsey Community Health Board Advisory Committee member
Warren Larson	Community Partner	Sanford Health
Harlan Madsen	Kandiyohi County Commissioner/ SCHSAC Member	Kandiyohi-Renville Community Health Board
Todd Patzer	Lac qui Parle County Commissioner	Countryside Community Health Board
Nels Pierson	State Representative, District 26B	Member, HHS Finance Committee, Republican
Michael Plante	County Administrator	Wabasha County
Cyndy Rastedt*	Tribal Health	White Earth Nation

STRENGTHENING PUBLIC HEALTH WORKGROUP FINAL REPORT

Name	Title/Role	Organization
Sarah Reese	CHS Administrator	Polk-Norman-Mahnomen Community Health Board
Nate Sandman	Tribal Health	Fond du Lac Band of Lake Superior Chippewa
Chera Sevcik	CHS Administrator	Faribault-Martin Community Health Board
Ann Stehn	Health & Human Services Director	Kandiyohi County
Sandy Tubbs	CHS Administrator	Horizon Community Health Board
Wendy Underwood	Director of County Relations	Minnesota Department of Human Services
PaHoua Vang	Community Partner	Minnesota Public Health Association
Melissa Wiklund	State Senator, District 50	Member, HHS Finance and Policy Committee, DFL
Michael Williams	County Administrator	Stearns County

*Indicates members who were **unable** to attend meetings.

Appendix B: Workgroup observations

While Minnesota's governmental public health system has served us well, much has changed since it was first established in 1976. Periodic, regular review of the public health system is important for ensuring that it meets the needs of today and is flexible enough to meet the needs of the future.

Governmental public health partnership

- The current partnership between MDH and local public health is a major strength of Minnesota's governmental public health system.
- The State Community Health Services Advisory Committee (SCHSAC) is an important and integral component of the state-local partnership. It is also an important mechanism for communicating with local policy makers. However, the work and role of SCHSAC is not well known among those not involved.
- MDH technical expertise is important to many local health departments and some rely on having access to this expertise. Likewise, MDH relies on local public health for their community expertise and action locally.
- Tribal health departments are an important component of Minnesota's governmental public health system that are not always considered and/or included. State and local health departments and community health boards must be knowledgeable about the unique role and sovereignty of tribal governments and engage with tribes appropriately.

Basic public health responsibilities

- In order to protect and promote the health of the public and prevent disease an injury, basic public health responsibilities must be carried out in all parts of Minnesota. Examples of basic responsibilities include: looking at data and engaging the community to understand what health issues exist in the community; working with others to plan for and respond to emergencies that may impact the health of the community; working with MDH to detect and respond to disease outbreaks.
- A number of sources of information indicate that many local health departments across the state do not and cannot realistically carry out basic public health responsibilities. Contributing factors include resource limitations (funding and workforce), unanticipated events, and locally-driven decisions.
- Clarity is needed on what is considered a basic public health responsibility. Once defined, local jurisdictions are in the best position to determine how basic public health responsibilities are carried out. For example, another health department, regional entity or local organization might be best equipped to carry out the responsibilities.

Public health funding

- Funding for public health is largely categorical and has very limited flexibility. This is problematic because in many cases:
 - Local activities are driven by grant obligations instead of community priorities;
 - Community health boards' ability to address new and emerging issues is limited; and
 - The amount of funding available for basic public health responsibilities like community health assessment, partnership development, and control of tuberculosis or other infectious diseases is limited.
- Funding mechanisms, timeframes and priorities at the federal, state and local levels (e.g. two-year biennium) are not structured to fund long-term prevention activities.

Effective local governance

- The community health board has responsibility for public health in their jurisdiction.

- To be successful in governing public health, community health boards need to:
 - Assure members of the community health board (local elected officials, community representative, etc.) understand their role in governing public health;
 - Engage with the various communities in their jurisdiction, particularly marginalized groups like people of color, American Indians and the elderly; and
 - Have access to public health expertise.

Leadership

- The role of the community health services (CHS) administrator is to be the lead local public health official, providing public health expertise in the community and the community health board.
- While every community health board has a CHS administrator, the role is not being fulfilled as intended everywhere due to a number of challenges including overwhelming responsibilities; lack of skillsets; lack of local support for them to serve as the local public health official; and a misunderstanding of the role.
- As the issues that public health must address have become more complex, the skill sets of health department leaders has needed to evolve and include skills needed for population based practice.

Public health workforce

- Public health departments across the state face workforce challenges including recruitment of qualified staff, retaining staff, and providing ongoing skill development. These challenges are exacerbated in, but not limited to, greater Minnesota health departments.
- As the field of public health continues to move from a more clinical focus to a focus on the social determinants of health, there is a greater need for a workforce that mirrors the population in the community and has skills in community engagement, planning, data analysis, communications and engaging with multiple sectors.
- New pipelines to careers in public health are needed to assure the future public health workforce reflects the general population and has the needed skills.