Public health system development in Minnesota

REPORT TO THE LEGISLATURE

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Public health system development in Minnesota: Report to the Legislature

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Contents

Introduction

This report on the State of Minnesota's local public health system has been published every two years since 1992. State statute requires this report on how the state's local public health system is meeting its responsibility to deliver core public health activities to the people of Minnesota.

Previous versions of this report, and a host of other Minnesota Department of Health (MDH) publications and testimony have repeatedly raised alarm, by painting a precarious picture of local health departments that do not have sufficient funding or staff to carry out core activities. Local health directors have long predicted that their departments would be overwhelmed by even a small infectious diseases outbreak.

The coronavirus pandemic is testing Minnesota's public health departments to a degree we dared not imagine. In many ways, local health departments have risen to the occasion. However, a lack of basic infrastructure has slowed response and led to frustration. This year's report will capture early lessons from the coronavirus pandemic, and provide an update on the state of Minnesota's local public health system.

Harvesting early lessons from 2020

Minnesota's public health workforce has shown leadership, skill, dedication, and compassion throughout a pandemic that has lasted far longer and turned far worse than any anticipated. When COVID-19 reached Minnesota in early 2020, local health departments ramped up to mount and sustain intense effort that continues today. The response showcases important strengths and validates longstanding concerns about the local public health infrastructure (e.g., communications, data systems and technology, community relationships). Indeed, past versions of this report characterize the infrastructure as insufficient to support even routine operations, let alone enable a coordinated, statewide pandemic response tailored to each of Minnesota's unique geographic and cultural communities.

To harvest early lessons from Minnesota's local public health response to COVID-19, MDH reached out to select state, local and tribal public health decision-makers, leaders and staff. Meetings tapped an eagerness to share and repeated familiar concerns. MDH also conducted brief individual interviews in several Minnesota communities with a cross-section of local leaders (e.g., representing businesses, law enforcement, education, health care and community-based organizations). Comments showcase the multi-faceted and too-often overlooked contributions of local public health in Minnesota. These collective insights are woven throughout the report.

Community leaders rely on their local health departments

Three dominant themes emerged when talking with local leaders about how they count on their local health departments.

- Local public health provides leadership and localized expertise.
- Local public health simplifies and tailors state guidance.
- Local public health brings people and organizations together to work as a community.

Interviewees' thoughts, below, reflect these overarching themes.

"It would be hard to exaggerate the degree to which we have become dependent on local public health to lead the pandemic effort." (Director, local chamber of commerce in northern Minnesota)

"[Local public health] brings an understanding of our local situation. They have a direct connection to MDH and can get advice, recommendations and resources. Local public health lives here, works here, understands local people and problems. And it's their job—partnering and working with everyone." (Central Minnesota sheriff)

"The health department takes guidance and makes it relatable for us….so it isn't just a Twin Cities perspective, but a local perspective." (City manager and director of economic development, southwest Minnesota)

"Public health played a lead role in pulling together [a multidisciplinary group of local leaders that] knit different facets of our community together so it's not business vs. health community, with businesses wanting to take risks and public health urging everyone not to. We worked together to figure out how to balance… the health perspective and business perspective. It has worked really well." (Resort owner)

Public information and communication

Overall, local public health departments made great strides in communications during 2020, with significantly enhanced social media, mass media, engagement of trusted messengers, and use of multiple languages and formats. The demand for information has been overwhelming, and local health departments feel the pressure to communicate nuanced public health guidance to multiple audiences that want quick, easily digestible, visual pieces of information. Local public health departments recognize the need to be even more proactive and more sophisticated in reaching multiple audiences, and more unified and consistent in statewide public health messaging. Misinformation and lack of trust continue as major challenges.

Data systems and technology

Minnesota counts on public health for timely, accurate and credible data. Yet there are large gaps in availability of local data, and local expertise to interpret and present data. In many cases, software and technology is outdated. Many systems lack interoperability and have reached the limits of capacity. As a result of these limitations, Minnesota health departments, community members, partners, and elected officials endure costly inefficiencies, and base decisions on old or less relevant information that doesn't reflect the local context.

Community engagement and trust

COVID-19 requires health departments to work intensively with many sectors and many communities, especially those that have been historically marginalized or underserved (communities of color, indigenous, immigrants and refugees, disability, and LGBTQ communities). Some local health departments drew on deep community connections and trusted relationships that they had already cultivated and earned. Other departments faced the pandemic with more tenuous relationships and fewer community connections. A pervasive and basic lack of trust hampered Minnesota's ability to navigate the rapidly changing context and widespread misinformation of this pandemic, and will further stymie the routine work of public health in the years ahead. All Minnesotans

should feel heard and respected by the departments that serve them, so that public health in Minnesota can work more aggressively and effectively to assure equal opportunity for health among all Minnesotans.

> *They are with us at every food distribution, answering questions on testing and vaccination. People are misinformed, confused, scared. [It] helps to have a professional who knows. Public health people have such heart. But they need to be more bicultural. More bilingual. This is a barrier for us. We have to have an interpreter and it takes a long time. There is lack of trust. (Community project coordinator, Metro Community Action Partnership)*

Skepticism taxes the public health workforce

In addition to the long hours and insurmountable demands, local leaders have faced public scrutiny and, in some places, lack of support from their leadership. This response has taken an emotional toll on the local public health workforce with potential long-term ramifications. While Minnesota data do not yet indicate a "mass exodus" from the field, we anticipate the response effort will have an impact in local public health leadership and staff turnover.

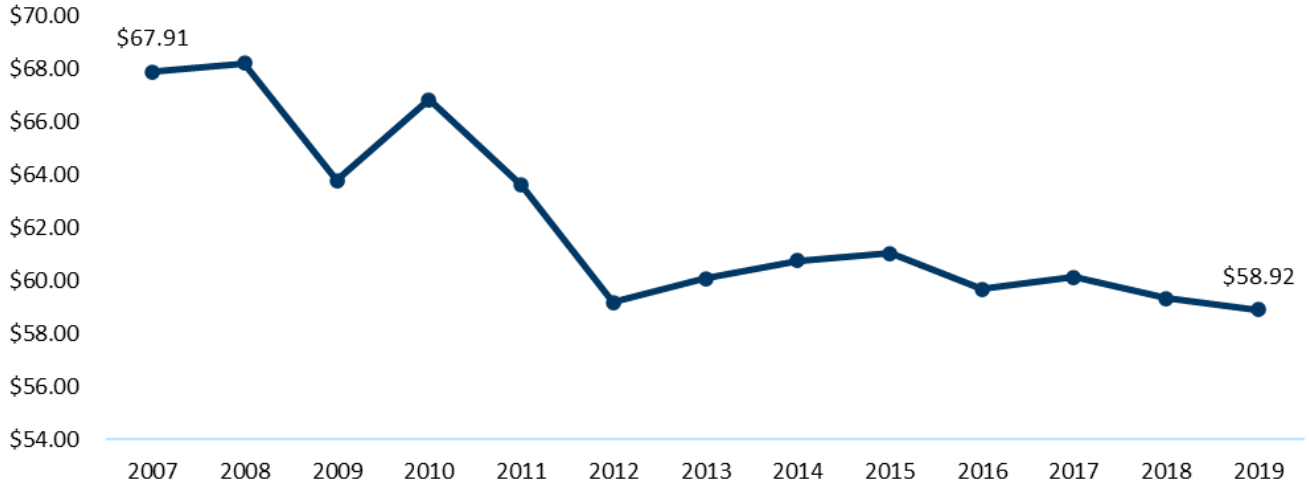
Current state of the system

The pandemic illustrates the grave issues with local public health funding, workforce, and capacity that many local public health leaders have previously voiced in reporting to MDH, [1,2] and during workgroups convened to improve the public health system. [3] These issues have been detailed in prior versions of this legislative report. [4,5]

Eroding investment in local public health

Minnesota's investment in local public health has not kept pace with inflation or need. Inflation-adjusted, per capita local public health expenditures fell sharply from 2007 to 2012 and remain far below pre-recession levels at approximately $59 per capita (Figure 1).

Figure 1. Per capita expenditures across Minnesota's local public health system, 2007-2019

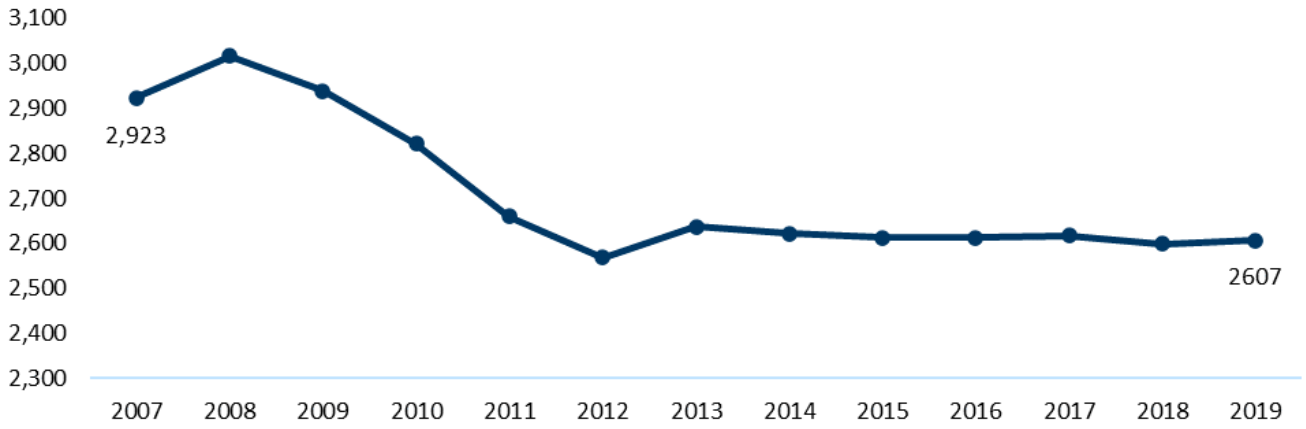


Most local public health funding is generated at the local level (e.g., reimbursements and fees for services, local tax levy, and other local funds). State funds account for 16 percent of total expenditures, and federal funds account for 33 percent. [6]

Shrinking local public health workforce

Between 2007 and 2018, the local public health system lost 325 FTEs, equivalent to 11 percent of the state's local public health workforce. Total FTEs fell sharply from 2008 to 2012 and remains low by historic standard (Figure 2). [7]

Figure 2. Total FTEs in Minnesota's local public health system, 2007-2019



Uneven workforce composition and distribution

Regardless of population size served, all community health boards are expected to carry out foundational responsibilities; yet in many cases, small, rural community health boards lack sufficient staff with necessary skills. [8]

- Only seven community health boards (14 percent) have epidemiologists, and all but one of these community health boards are located in the metro region.
- Total FTEs employed by community health boards range from 6 FTEs to 366 FTEs, with a median of 34 FTEs. Ten community health boards (20 percent) employed fewer than 15 total FTEs.
- The five largest community health boards by population accounted for 38 percent of all FTEs in Minnesota's local public health system—more FTEs than the combined total of the 37 smallest community health boards in the state.

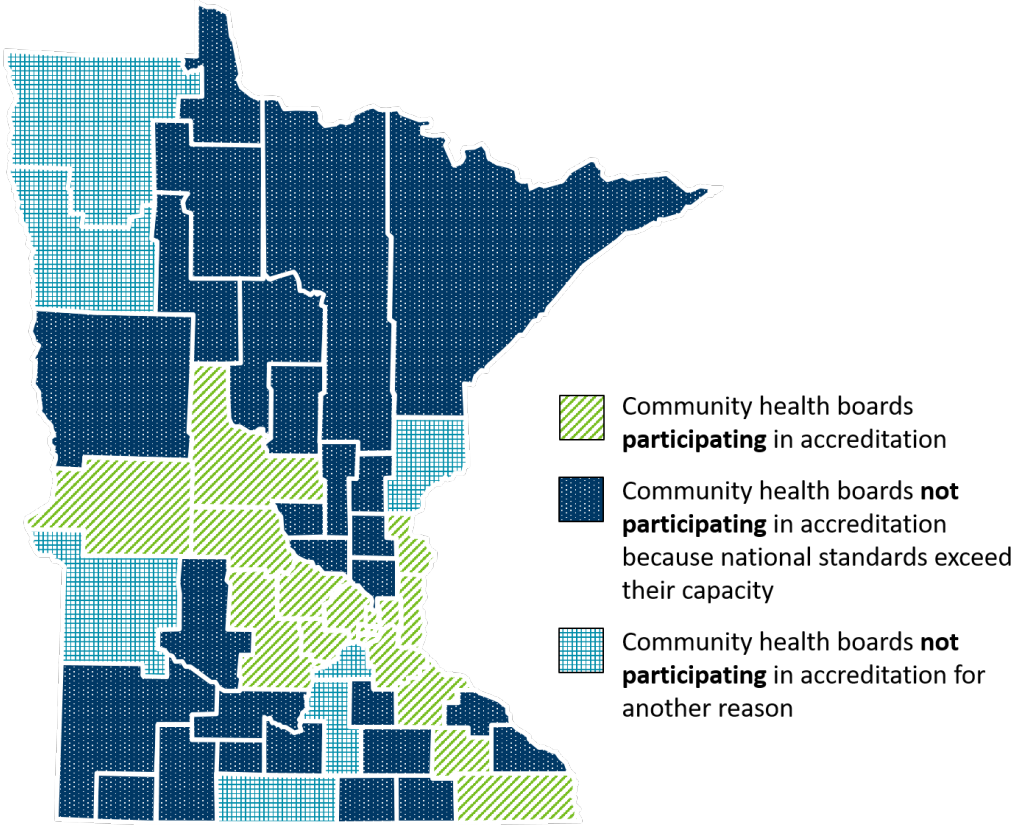
Public health accreditation standards out of reach

The Minnesota Department of Health helps local health departments seek and maintain public health accreditation to ensure that Minnesota's public health system meets and exceeds national Public Health Accreditation Board standards. [9] Ten of Minnesota's 51 community health boards (20 percent) have achieved voluntary national accreditation. Some of Minnesota's non-accredited health departments are in the process or

planning to apply (18 percent), but most are undecided, or have decided not to pursue national accreditation (62 percent).

These community health boards aren't merely dismissing the accreditation standards. Not a single community health board reports to MDH that the standards are inappropriate. The leading reason community health boards provide for not pursuing accreditation—as reported by 26 community health boards that serve more than 1.8 million Minnesotans (29 percent of the state population)—is that *the accreditation standards exceed their capacity* (Figure 4). [10]

Figure 4. Minnesota community health boards participating in accreditation, 2018



Going forward

2020 raised expectations and heightened visibility of Minnesota's public health system. Stakes are high with large and lasting implications for the economy and quality of life. Early lessons and demands from the COVID-19 pandemic necessitate bold action to shore up the foundational public health infrastructure, and to position Minnesota to meet public health challenges in the years ahead.

End notes

[1] Minnesota Department of Health. (2017). *Ability to Meet Minimum Expectations: The Current State of Local Public Health in Minnesota*. Online: https://www.health.state.mn.us/communities/practice/schsac/workgroups/docs/2017-11_capassessment-summ.pdf

[2] Minnesota Department of Health. (2019). *2018 Local Public Health Act performance measures: Data book*. Online: https://www.health.state.mn.us/communities/practice/lphact/annualreporting/docs/2018databook.pdf

[3] Minnesota Department of Health. (2018). *Strengthening Public Health Workgroup: Final Report to the State Community Health Services Advisory Committee.* Online: https://www.health.state.mn.us/communities/practice/schsac/workgroups/docs/2018-05_strengtheningPH.pdf

[4] Minnesota Department of Health. (2019). *Public Health System Development in Minnesota: Report to the Legislature*. Online: https://www.leg.mn.gov/docs/2019/mandated/190494.pdf

[5]Minnesota Department of Health. (2017). *Public Health System Development in Minnesota: Report to the Legislature*. Online: https://www.health.state.mn.us/communities/practice/resources/publications/docs/1701legreport.pdf

6Minnesota Department of Health. (2021). Expenditures summary for Minnesota's local public health system in 2019.

7 Minnesota Department of Health. (2021). Workforce summary for Minnesota's local public health system in 2019.

8 Minnesota Department of Health. (2021). Workforce summary for Minnesota's local public health system in 2019.

[9] 2020-2021 *Governor's biennial budget recommendations*. Online: https://mn.gov/mmb-stat/documents/budget/2020-21-biennial-budget-books/governors-revised-march/health-department.pdf, p. 109.

[10]Minnesota Department of Health. (2019). *2018 Local Public Health Act performance measures: Data book.* https://www.health.state.mn.us/communities/practice/lphact/annualreporting/docs/2018databook.pdf, p. 18.