Discussion questions: Updating Minnesota's blueprint for public health

The Minnesota Department of Health (MDH) and State Community Health Services Advisory Committee (SCHSAC) revised these discussion questions after initially publishing them in Updating Minnesota's blueprint for public health (PDF) (https://www.health.state.mn.us/communities/practice/schsac/workgroups/docs/2010-12_f_updatingblueprint.pdf). As noted in the original document, the authors created these questions to help facilitate the exploration of structure and governance change and its impact on public health.

These questions are applicable to all public health structures (this page), with additional questions for policymakers considering combining into a multi-county community health board (p. 2), separating from a multi-county community health board (p. 3), combining departments within a jurisdiction like a county or a city (p. 3), or contracting out for public health services (p. 4).

All structures

- **Would the proposed organizational structure support the population-based, primary prevention approach of public health?** Understanding a population-based approach is the key to understanding the difference between public health, social services, and health care.
- **What effect might the proposed change have on the ability of the organization to fulfill mandated population-based public health responsibilities? How will those mandates be met under a new structure?** The mandates and authorities for public health are distinct from those of other locally delivered services.
- **How will the proposed change affect the community health assessment, prioritization, and planning process? This includes compiling and analyzing quantitative data, gathering public input and other qualitative data, working with community partners, developing plans, and assessing and reporting on accountability in meeting state statutes.** Conducting community health assessments is a specialized skill of public health professionals. It is required by Minnesota statute; failure to meet these requirements can/may prompt the Commissioner of Health to take away LPH Act Grant funds.
- **Who will explain, discuss, and recommend public health policy to the board? Will the top public health leader have access to the board?** To have a sufficient understanding of public health policy, special training is required. In particular, understanding "population-based health" is critical.
- **How will qualified public health staff be involved to address public health policy issues?**
- **How might the proposed change affect the existing "state-local partnership" model that exists between MDH and local governments?**
- **How will the organization apply for public health grants? Who will write the grants?** Specialized knowledge of public health is required in writing successful grants for public health funding.
- **How will the proposed change affect the management structure? Will the top public health manager be in a position of sufficient authority to allow for effective responses to public health issues? Will that person have the authority to put forward the jurisdiction's position in discussions with MDH?** Is it efficient? Does it make it harder for the board to receive first-hand information about public health

issues? The public health partnership model works best when that the top county health officer has the expertise and authority to engage in substantive discussions with MDH.

- **What are the skills, background and training of the director who will oversee public health (e.g., the person who will develop the budget, assess and recommend staffing levels, and have the authority to recommend public health policy to the board)?** In addition to finding candidates with the appropriate background to serve as Director of Public Health, special attention must be paid to the qualifications of CHS administrator. These qualifications are laid out in Minnesota Rules. Regardless, these individuals should be well versed in public health, and skilled in managing across disciplinary boundaries. He or she should be able to effectively manage diverse and distinct program areas.
- **What natural collaborations and partnerships are already occurring (e.g., with other counties or between public health and other county/city programs)?** Are these partnerships working? Are they models that could be expanded without a formal reorganization?
- **What is the history of previous collaborations across jurisdictions (may or may not be public health related)? Were there lessons learned? Are there legal documents already in place such as joint powers agreements or memoranda of understanding?** We can utilize lessons learned from previous collaborations; whether positive or negative in assuring a successful initiative.
- **What steps will be taken to foster and support the change and any resulting transitions?** Change management is a critical element to any successful planning effort.
- **What is the population size served by your jurisdiction?** Public health systems research suggests that an "optimal" population base for a local health jurisdiction is 50,000 to 500,000. Would the proposed change move the CHB toward that population range? Can providing public health services to a larger or smaller population size (i.e., multi-county) help to achieve economies of scale? Can it achieve economy of scope (increase breadth of operations) more effectively than an internal reorganization?
- **What impact might the proposed change have on the ability of the CHB to become accredited in the future?** Voluntary national accreditation of state and local health departments is now in place. A SCHSAC workgroup convened in 2010 recommended that MDH and community health boards strive for accreditation. Financial "incentives" for accreditation are under discussion by national partners (e.g., CDC).
- **What are the opportunities/efficiencies of the proposed structure?** Consider increased specialization, reduced redundancies of effort, or enhanced customer service.
- **What are the barriers/disadvantages of the proposed structure? What are the potential unintended consequences?** Consider the potential for public health to lose its identity, how might values change, or level of staff concern.

For combining into a multi-county community health board

- **How will services be provided in each county? What measures will be put in place to ensure equitable distribution of resources, and what does equitable mean for those counties? Will all services be provided at a multi-county level, or will some be specific to a particular county (based on an assessment of needs)?**
- **What are potential disadvantages of combining into a larger jurisdiction? How might these challenges be addressed in the planning phase of the transition?**
- **Does this structure take into consideration natural partnerships that have developed between counties?**

- **How will the hiring and supervision of staff be conducted? How will the budget process work?**
- **How will the joint powers agreement be developed and enforced?** Minnesota Counties Intergovernmental Trust (MCIT) and MDH staff are available for consultation related to joint powers issues. However, counties must be a member of MCIT to access services.
- **How will the roles and responsibilities be divided up among key leadership staff?**
- **How will the following issues be addressed? IT/data, reporting, allocation of revenues/funding issues, facilities/assets, fund balance, medical director, legal consultation, administrative services such as payroll, etc.**

For separating from a multi-county community health board

- **How will services be provided in the county? How will continuity of services be assured? Are there services that will continue to be provided through collaboration or by another county?**
- **How will funding be affected? How will combined funds be divided?**
- **What are the potential disadvantages of becoming a smaller jurisdiction? How might these challenges be addressed in the planning phase of a transition?**
- **How will relationships and collaborations be maintained, established, or reestablished?** Consider the impact on community relationships and community partners that are key to a successful public health department.

For combining departments within a county/city

- **How do the missions of the departments being combined align? How will the mission of public health be maintained? Is the public health mission aligned with the mission of the reorganized entity?** Understanding the difference between missions will help explain the tension and competition for approaches and resources. Understanding the differences between primary, secondary, and tertiary prevention will also be important.
- **Is one department likely to emerge as dominant due to budget size, immediacy of need, public engagement, or other factors? What mechanisms will be put into place to ensure that the other functions within the department are visible and "have a voice"?**
- **If the change involves combining with social services, will the merit system of employee pay hinder the county ability to offer competitive wages for nurses?** Many of the essential public health services are carried out by public health nurses around the state. A number of local health departments currently report difficulty in recruiting and maintaining their public health nursing staff. Additionally, future nursing shortages are projected. Offering lower wages for nurses may compromise a county's ability to meet the public health mandates and areas of public health responsibilities.
- **Who will provide public health leadership? Who will be the CHS administrator? Will you continue to employ a public health director, and what will their required qualifications be?** The literature in this area suggests that the educational background and professional experience of local public health directors and administrators is an important predictor of local health department performance. The term CHS administrator is now defined in statute.

- **What lines of authority are necessary to assure public health core functions are maintained in the jurisdiction?** What is the title of the lead public worker? Is it director, manager, supervisor? How does that impact public health's presence with the board?
- **If your county restructures, what will happen to existing public health staff?** Are there retirement or union contract issues? Are the personnel practices of the two departments the same? If not, how do they differ? Are there differences in wage scales and benefits?

For restructuring involving contracting out public health services

- **What is the mission of the contracting organization? How does that mission fit with the population-based, primary prevention mission of public health? How will the mission of public health be maintained?**
- **How will the county board assure that all requirements are met? Who has the authority to intervene if problems surface? What kind of provisions will be made for oversight?** How will the county board assure that the essential local activities are met? How will it assure that the LPH Act state general funds are expended correctly?
- **Is the service area of the hospital (or other contractor) the same as the city/county? If not, will public health services be delivered beyond the county border if the hospital service area is broader?**
- **Will organizational affiliations affect public health service delivery (e.g., religious affiliation affecting the provision of family planning services)?**
- **Who makes up the board of directors of the hospital or contracting organization?** What impact might this have on the provision of public health services? Given that organizations select their own boards, what responsibilities will elected officials assume and how?
- **Are there data practice issues if the agency collecting the data is a public hospital? A private hospital?**

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January 2015

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