Local Public Health Act Performance Measures

MEEKER-MCLEOD-SIBLEY, 2015

AUGUST 2016

HEALTH PARTNERSHIPS DIVISION, PUBLIC HEALTH PRACTICE SECTION

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About This Report

This report presents the capacity of your community health board to meet several national public health measures of infrastructure, as well as additional infrastructure measures specific to Minnesota and relating to health equity, organizational QI maturity, and nationals public health accreditation, for the time period between January 1 and December 31, 2015. Community health boards also reported on five other areas of responsibility. Data on all six areas of responsibility is available in the 2015 Annual Reporting Data Book (coming late summer 2016).

For data not included in this particular report, please consult:

- **Your community health board's data**: Use REDCap to access the annual reporting data you entered earlier this year; for instructions on how to pull your data from REDCap, visit MDH: Local Public Health Act Performance Measures (scroll down for REDCap tutorials)
- **System-level data**: 2015 Annual Reporting Data Book (coming late summer 2016)

Taking Action

In the past few years, a number of community health boards have used the data from reports like this to identify and make improvements in their organizations. To learn about those efforts, start by viewing *Using Data to Tell Your Story: Capture and Share Meaningful Data with your CHB-Specific Reports*, available on the MDH Public Health Practice Section website.

You will have also received, along with this report, a set of presentation slides with ideas for sharing your data with your own stakeholders. Community health boards have used these slides as a starting point to share improvement and progress with public health staff, local elected officials, and other partners.

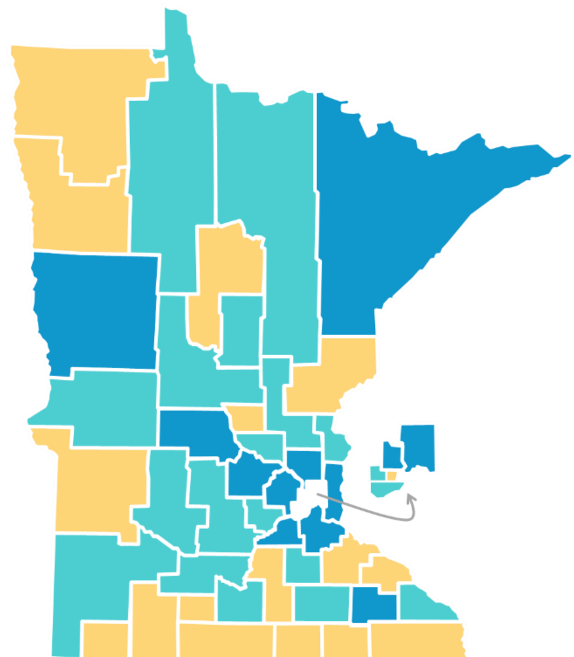
If you would like assistance with interpreting your data, or would like to discuss further ideas on using your data to improve quality and performance, start by contacting your community health board's Public Health Nurse Consultant.

Community Health Board Populations and Sizes

In this report, you will often view your community health board's data alongside aggregate data from similarly-sized community health boards, and Minnesota as a whole. Community health boards are divided into three categories, using 2014 population data: those with more than 100,000 residents (blue; n=12), those with between 50,000 and 100,000 residents (aqua; n=19), and those with fewer than 50,000 residents (yellow; n=17).

Medium Community Health Boards (n=19)

Aitkin-Itasca-Koochiching
Bloomington
Blue Earth
Brown-Nicollet
Carver
Chisago
Crow Wing
Dodge-Steele
Edina
Horizon
(Douglas, Grant, Pope, Stevens, Traverse counties)
Isanti-Mille Lacs
Kandiyohi-Renville
Meeker-McLeod-Sibley
Morrison-Todd-Wadena
North Country
(Beltrami, Clearwater, Hubbard, Lake of the Woods counties)
Rice
Sherburne
SWHHS
(Lincoln, Lyon, Murray, Pipestone, Renville, Rock counties)
Winona



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Assure an Adequate Local Public Health Infrastructure: Capacity Measures from National Standards

Background

In spring 2016, Minnesota community health boards reported on a key subset of 37 national public health measures; this subset is different from the subset tracked from 2012 to 2014, though some measures remain the same. This is why trend data is included from 2012 to the present for some measures, and from 2014 to the present for others.

Minnesota's Local Public Health Act performance measures—and instructions for reporting on them—are based on *PHAB Standards and Measures version 1.5*. MDH strongly encourages community health boards to use these instructions when preparing to report to MDH; community health boards should rely on official PHAB guidance when preparing for national public health accreditation. For more information, visit www.phaboard.org/.

Multi-county community health boards were asked to report on the lowest level of capacity of their individual health departments for measures within "Capacity Measures from National Standards" (see right).

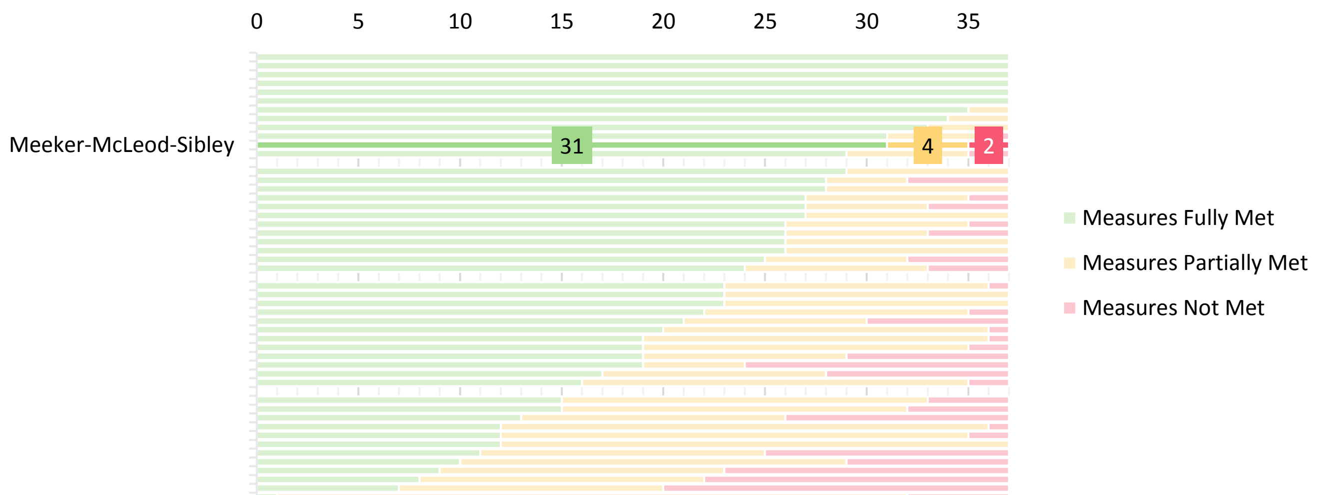
ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: CAPACITY MEASURES FROM NATIONAL STANDARDS

Your Community Health Board

At a Glance: Your Community Health Board and Minnesota's Public Health System

Each horizontal bar of the table below corresponds to an individual community health board. The shading within each bar reflects the number of measures that were reported as either fully met (green), partially met (yellow), or not met (red) by each community health board. The community health boards grouped in the first quartile rank highest in the number of measures they reported as fully met. The community health boards in the fourth quartile rank lowest in the number of measures they reported as fully met.

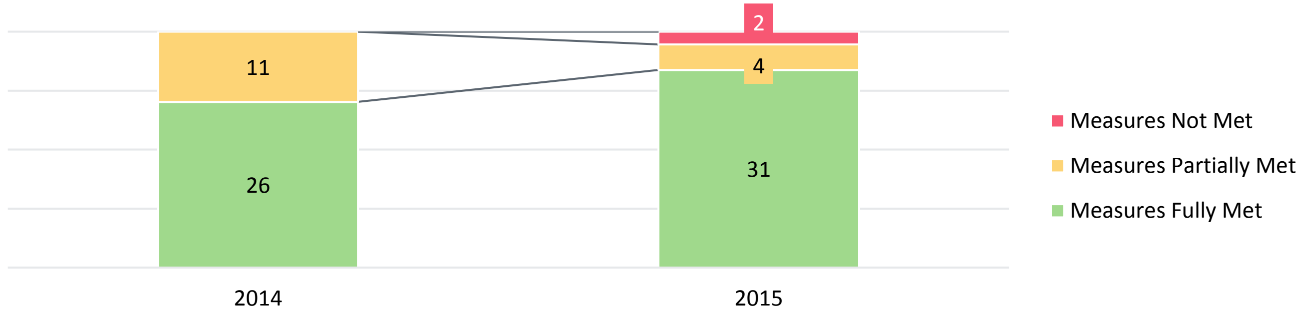
Capacity of Minnesota community health boards to meet 37 key national public health measures, by quartile, 2015



Your Community Health Board's Progress on Key Public Health Measures

The SCHSAC Performance Improvement Steering Committee monitors community health boards' ability to achieve 35 national measures as an indicator of overall capacity of the state's public health system.

Each column below represents a single year of reporting. The portion in green represents the number of measures your community health board could fully meet that year; yellow represents the number of measures you could partially meet; red represents the number of measures you could not meet.



Minnesota community health board capacity to meet 37 key national public health measures, 2015 *** Measure also tracked in 2012-2014 subset*	Your community health board	% Fully Meet Measure	
		Medium CHBs (n=19)	Minnesota (n=48)
Domain 1 – Assess			
1.1.2 – Community Health Assessment *A local community health assessment*	Fully Meet	74%	79%
1.2.2 – Communication with Surveillance Sites *Communication with surveillance sites*	Fully Meet	47%	52%
1.3.1 – Data Analysis and Conclusions *Data analyzed and public health conclusions drawn*	Fully Meet	63%	69%
1.4.2 – Community Summaries, Fact Sheets ** *Community summaries or fact sheets of data to support public health improvement planning processes at the local level*	Fully Meet	68%	77%
Domain 2 – Investigate			
2.1.4 – Collaborative Partnerships for Investigation ** *Collaborative work through established governmental and community partnerships on investigations of reportable diseases, disease outbreaks, and environmental public health issues*	Fully Meet	79%	83%
2.2.3 – After Action Reports ** *Complete After Action Reports*	Fully Meet	47%	65%
Domain 3 – Inform and Educate			
3.1.2 – Health Promotion Strategies ** *Health promotion strategies to mitigate preventable health conditions*	Fully Meet	68%	85%
3.1.3 – Factors for Specific At-Risk Populations *Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes*	Partially Meet	68%	67%
3.2.2 – Organizational Branding Strategies *Organizational branding strategy*	Fully Meet	53%	48%
3.2.3 – External Communications Procedures *Communication procedures to provide information outside the health department*	Fully Meet	32%	52%

Minnesota community health board capacity to meet 37 key national public health measures, 2015 *** Measure also tracked in 2012-2014 subset*	Your community health board	% Fully Meet Measure	
		Medium CHBs (n=19)	Minnesota (n=48)
3.2.5 – Variety of Publicly Available Information *Information available to the public through a variety of methods*	Fully Meet	58%	71%
Domain 4 – Community Engagement			
No key measures were tracked in 2015 in Domain 4.			
Domain 5 – Policies and Plans			
5.1.3 – Policies' Impact on Public Health *Informed governing entities, elected officials, and/or the public of potential intended or unintended public health impacts from current and/or proposed policies*	Fully Meet	58%	69%
5.2.3 – Collaborative CHIP Implementation ** *Elements and strategies of the health improvement plan implemented in partnership with others*	Fully Meet	53%	65%
5.2.4 – Monitor and Revise CHIP ** *Monitor the strategies in the community health improvement plan, and revise as needed, in collaboration and with broad participation from stakeholders and partners*	Partially Meet	26%	44%
5.3.3 – An Implemented Strategic Plan ** *Implemented community health board strategic plan*	Fully Meet	47%	65%
Domain 6 – Public Health Laws			
6.3.4 – Compliance Patterns from Enforcement ** *Patterns or trends identified in compliance from enforcement activities and complaints*	Cannot Meet	53%	50%
Domain 7 – Access to Care			
7.1.1 – Assessing Health Care Availability *Process to assess the availability of health care services*	Fully Meet	63%	65%
7.1.2 – Identifying Populations Facing Barriers *Identification of populations who experience barriers to health care services*	Fully Meet	53%	67%
7.1.3 – Identifying Gaps and Barriers to Health Care ** *Identification of gaps in access to health care services, and barriers to the receipt of health care services*	Fully Meet	42%	48%
7.2.1 – Developing Strategies to Improve Access *Process to develop strategies to improve access to health care services*	Fully Meet	63%	67%
7.2.2 – Implementing Strategies to Increase Access ** *Implemented strategies to increase access to health care services*	Fully Meet	79%	69%
7.2.3 – Cultural Competence in Increasing Access ** *Implemented culturally competent initiatives to increase access to health care services for those who may experience barriers to care due to cultural, language, or literacy differences*	Fully Meet	74%	73%
Domain 8 – Workforce			
8.2.1 – Workforce Development Strategies ** *Workforce development strategies*	Fully Meet	16%	35%
8.2.2 – Competent Workforce *A competent community health board workforce*	Fully Meet	53%	69%
Domain 9 – Quality Improvement			
9.1.1 – Engagement in Performance Management System ** *Staff at all organizational levels engaged in establishing and/or updating a performance management system*	Fully Meet	32%	42%

Minnesota community health board capacity to meet 37 key national public health measures, 2015 *** Measure also tracked in 2012-2014 subset*	Your community health board	% Fully Meet Measure	
		Medium CHBs (n=19)	Minnesota (n=48)
9.1.2 – Performance Management System/Policy ** *Performance management policy/system*	Fully Meet	21%	40%
9.1.3 – Implemented Performance Management System ** *Implemented performance management system*	Partially Meet	16%	31%
9.1.4 – Process to Assess Customer Satisfaction ** *Implemented systematic process for assessing customer satisfaction with community health board services*	Fully Meet	63%	58%
9.1.5 – Staff Involvement in Performance Management ** *Opportunities provided to staff for involvement in the community health board's performance management*	Fully Meet	42%	52%
9.2.1 – Established Quality Improvement Program ** *Established quality improvement program based on organizational policies and direction*	Fully Meet	68%	85%
9.2.2 – Implemented Quality Improvement Activities ** *Implemented quality improvement activities*	Partially Meet	32%	52%
Domain 10 – Evidence-Based Practices			
10.2.3 – Communicated Research Findings *Communicated research findings, including public health implications*	Cannot Meet	63%	63%
Domain 11 – Administration and Management			
11.1.2 – Ethical Issues and Decisions *Ethical issues identified and ethical decisions made*	Fully Meet	37%	46%
11.1.4 – Policies Appropriate to Specific Populations *Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes*	Fully Meet	21%	42%
Domain 12 – Governance			
12.2.1 – Communication with Governing Entity Regarding Community Health Board Responsibilities ** *Communication with the governing entity regarding the responsibilities of the community health board and of the responsibilities of the governing entity*	Fully Meet	68%	79%
12.3.1 – Information Provided to Governing Entity ** *Information provided to the governing entity about important public health issues facing the community, the community health board, and/or the recent actions of the community health board*	Fully Meet	95%	98%
12.3.3 – Communication with Governing Entity Regarding Community Health Board Performance ** *Communication with the governing entity about the community health board performance assessment and improvement*	Fully Meet	53%	73%

Assure an Adequate Local Public Health Infrastructure: Minnesota-Specific Measures

Workforce Competency

Community health boards need a trained and competent workforce. The Core Competencies for Public Health Professionals, developed by the Council on Linkages between Academia and Public Health Practice, offer a starting point to identify professional development needs and develop a training plan.

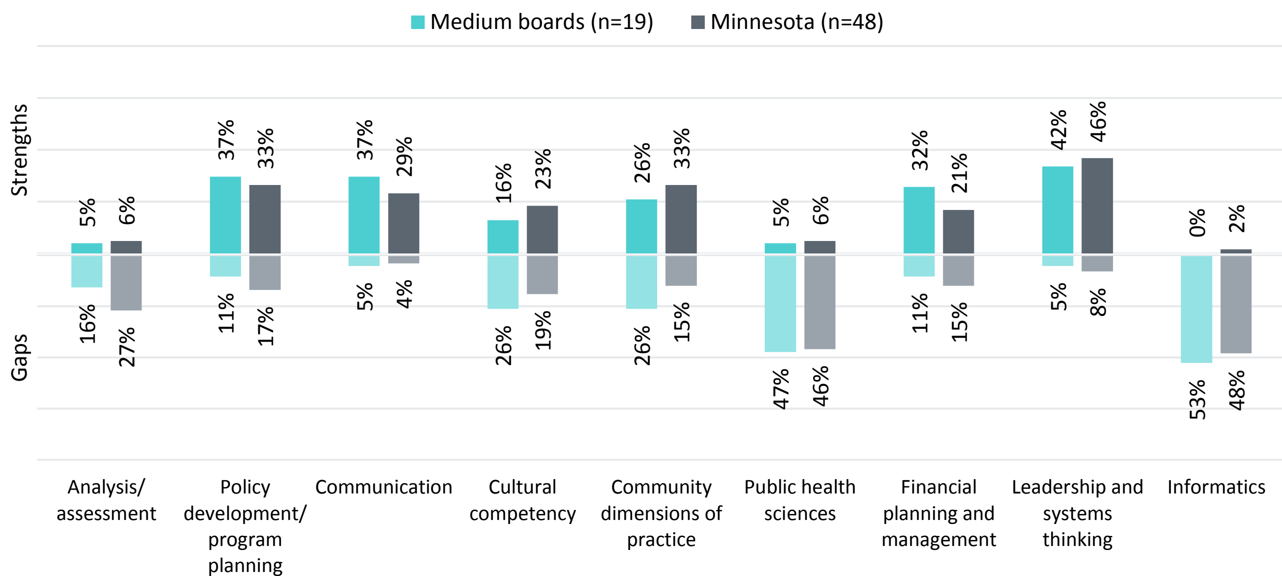
More Information

MDH Health Partnerships Division, Public Health Practice Section
651-201-3880 | health.ophp@state.mn.us
www.health.state.mn.us/divs/opi/pm/corecomp/

Assistance

Community health boards were strongly encouraged to use the Public Health Foundation Competency Assessments for Public Health Professionals prior to responding to these questions. Community health boards were encouraged to consider having each employee complete the self-assessment tool, and then compile responses to determine organizational strengths and gaps. As an alternate approach, community health boards could convene a group of 8-10 individuals who are collectively familiar with the skills and performance of a broad cross-section of public health professionals in the community health board. After agreeing on a rating scale, the group could work toward consensus on the strengths and gaps of the workforce in each of the domains.

The Public Health Foundation has produced the 3-Step Competency Prioritization Sequence, a set of QI tools with step-by-step instructions to build on this initial organizational assessment. These additional tools can help prioritize strengths and gaps, and identify areas to invest limited professional development resources for the largest potential benefit. This approach can be applied at multiple levels—to shape a comprehensive workforce development plan, a division-specific plan, or an individual development plan. **The MDH Public Health Practice Section can provide technical assistance to community health boards that wish to implement the 3-Step Competency Prioritization Sequence. For assistance with implementing the 3-Step Sequence or using the tools noted above, contact the Public Health Practice Section.**



Workforce strengths and gaps, Minnesota community health boards, 2015	Your community health board (not ranked)	Medium community health boards (n=19)	Minnesota (n=48)
Top two workforce strengths	1. Cultural competency 2. Leadership and systems thinking	1. Leadership and systems thinking (42%) 2. Policy development / program planning (37%) Communication (37%)	1. Leadership and systems thinking (46%) 2. Policy development / program planning (33%) Community dimensions of practice (33%)
Top two workforce gaps	1. Public health sciences 2. Financial planning and management	1. Informatics (53%) 2. Public health sciences (47%)	1. Informatics (48%) 2. Public health sciences (46%)

ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

Health Equity

These questions recognize that health disparities reflect longstanding, systemic social and economic factors (e.g., social determinants of health) that have unfairly advantaged and disadvantaged some groups of people. Addressing social and economic factors that influence health is a vital part of efforts to achieve health equity.

More Information

MDH Center for Health Equity
651-201-5813 | health.equity@state.mn.us
www.health.state.mn.us/divs/che

Glossary

Community health boards considered the following definitions when responding to health equity questions with highlighted terms:

Health Disparity: The difference in the incidence, prevalence, mortality, and burden of disease and other adverse conditions, which exists between specific population groups.

Health Equity: A state where all persons, regardless of race, income, sexual orientation, age, gender, other social/economic factors, have the opportunity to reach their highest potential of health. To achieve health equity, people need:

- Healthy living conditions and community space
- Equitable opportunities in education, jobs, and economic development
- Reliable public services and safety
- Non-discriminatory practices in organizations

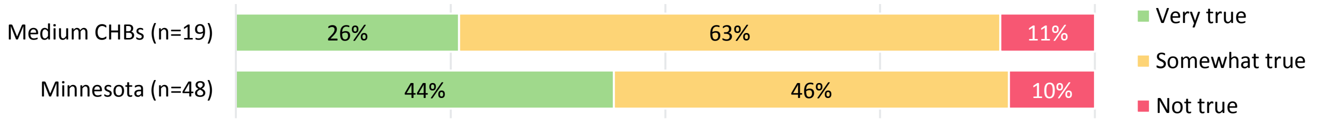
Health Inequity: The difference in health status between more and less socially and economically advantaged groups, caused by systemic differences in social conditions and processes that effectively determine health. Health inequities are avoidable, and unjust, and are therefore actionable.

Social Determinants of Health: Conditions found in the physical, cultural, social, economic, and political environments that influence individual and population health. The inequities in the distribution of these conditions lead to differences in health outcomes (that is, they lead to health disparities). Conditions include, but are not limited to: socioeconomic factors (e.g., racism, stress, education, income, employment, health literacy); environmental factors (e.g., housing and, environmental hazards); and systems and policies (e.g., health care access, access to healthy foods).

Health Equity Policies: Policies that address social determinants of health (for example, housing) and focus on the entire community rather than on a single, high-risk individual. For example, a health equity policy would focus on expanding the availability of affordable housing in a community.

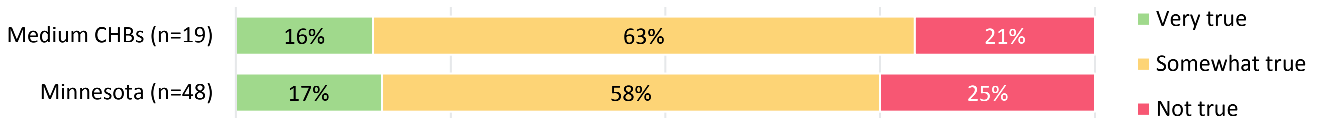
My community health board has identified health equity as a priority, with specific intent to address social determinants of health.

Your community health board: Somewhat true



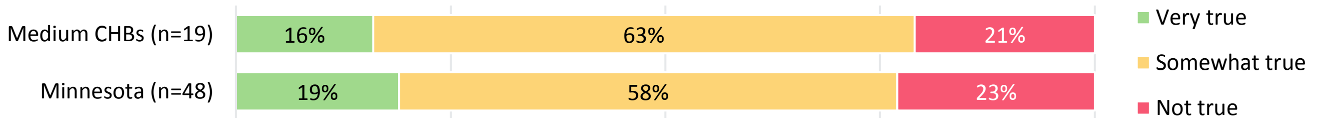
My community health board has built capacity (e.g., human resources, funding, training staff) to achieve health equity by addressing social determinants of health.

Your community health board: Not true



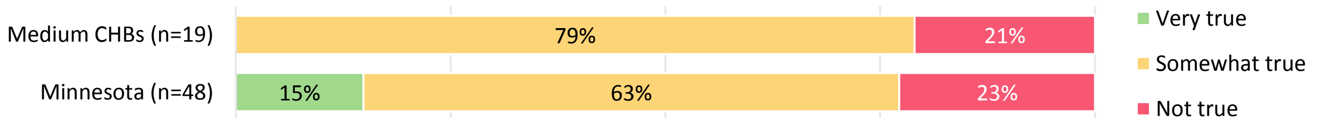
My community health board has established a core contingency of staff who are poised to advance a health equity agenda.

Your community health board: Not true



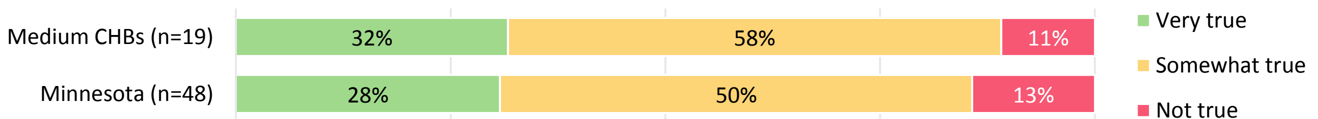
My community health board has increased the amount of internal resources directed to addressing social determinants of health.

Your community health board: Somewhat true



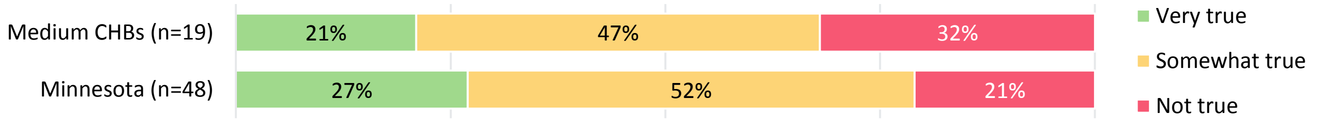
My community health board has engaged with local government agencies or other external organizations to support policies and programs to achieve health equity.

Your community health board: Not true



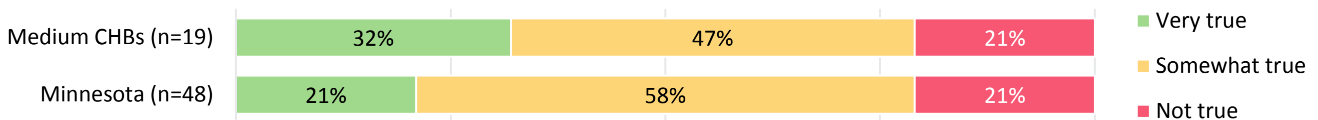
My community health board has made deliberate efforts to build the leadership capacity of community members to advocate on issues affecting social determinants of health.

Your community health board: Not true



My community health board has provided resources to community groups to support their self-identified concerns for achieving health equity in their communities.

Your community health board: Not true



ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

Organizational QI Maturity

Collecting this data allows the measurement and tracking of progress in quality improvement (QI) culture across the local public health system, from year to year. Assessing organizational QI maturity can help a community health board identify key areas for quality improvement, and determine additional education or training needed for staff and leadership.

More Information

MDH Health Partnerships Division, Public Health Practice Section
651-201-3880 | health.ophp@state.mn.us
www.health.state.mn.us/divs/opi/qi/

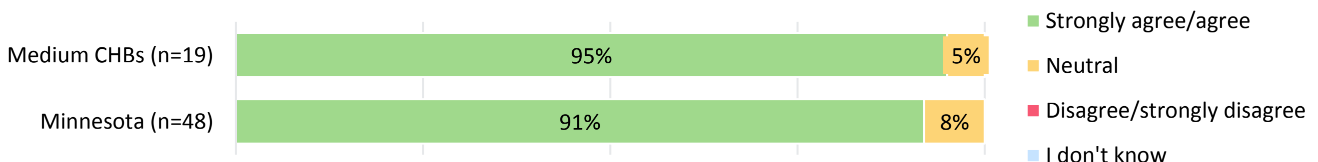
Assistance

Many community health boards already assess their organizational QI maturity as part of developing, implementing, and maintaining their board's QI plan. Evidence suggests that assessments are more accurate and useful when staff representing all levels and areas of an organization are involved. The MDH Public Health Practice Section encourages community health boards to use a collaborative process with multiple staff and/or leadership contributing to an assessment of organizational QI maturity. This may mean having a leadership team, QI council, or the entire staff complete the 10-question QI Maturity Tool (PDF), and using those results for reporting purposes. **The MDH Public Health Practice Section can help you survey your staff to assess your community health board's organizational QI maturity; if you would like assistance surveying your staff using the same 10-question set used below, contact the Public Health Practice Section.**

Organizational Quality Improvement Maturity 10-Question Subset

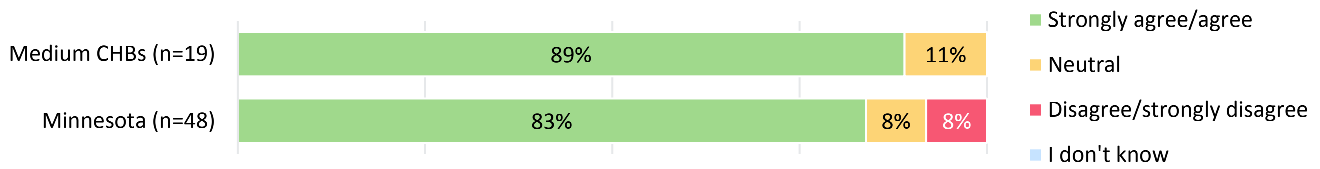
Staff members are routinely asked to contribute to decisions at my community health board.

Your community health board: Strongly agree



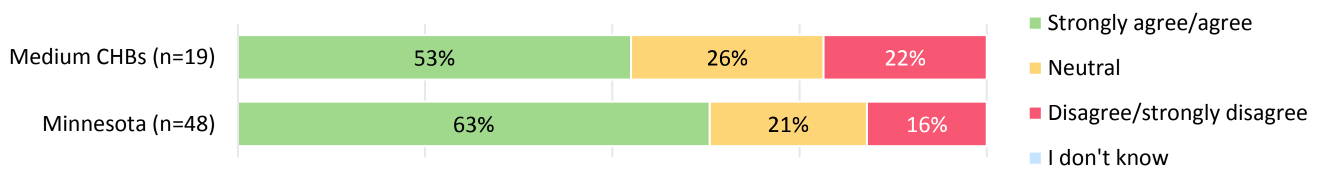
The *leaders* of my community health board are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.

Your community health board: Agree



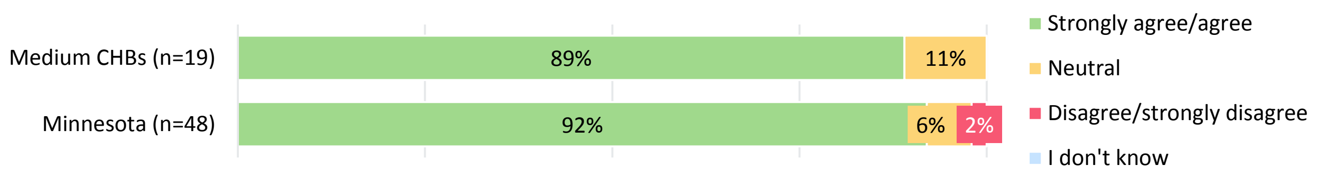
Job descriptions for many individuals responsible for programs and services in my community health board include specific responsibilities related to measuring and improving quality.

Your community health board: Strongly agree



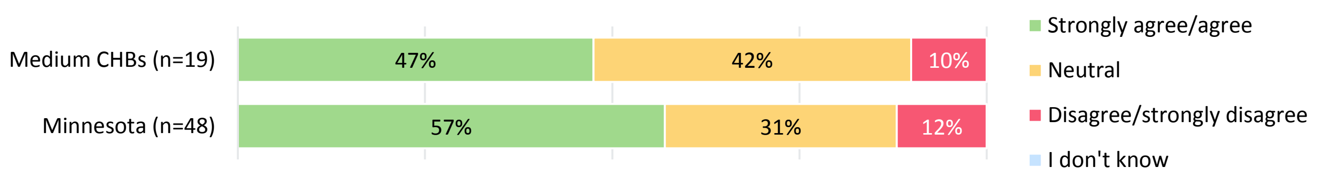
My community health board has a quality improvement (QI) plan.

Your community health board: Strongly agree



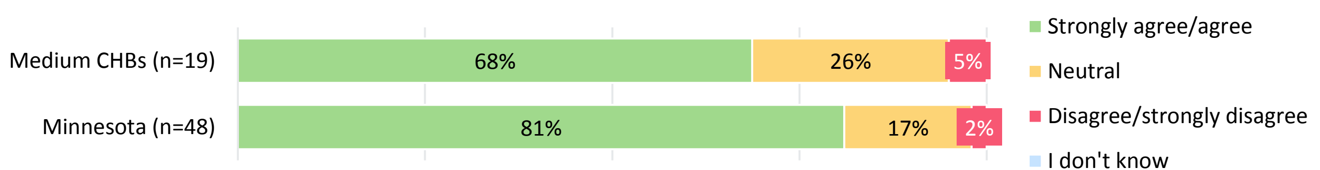
Customer satisfaction information is routinely used by many individuals responsible for programs and services in my community health board.

Your community health board: Neutral



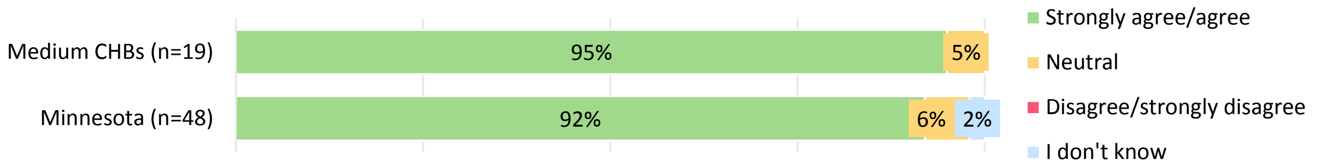
When trying to facilitate change, community health board staff has the authority to work within and across program boundaries.

Your community health board: Strongly agree



The key decision makers in my community health board believe QI is very important.

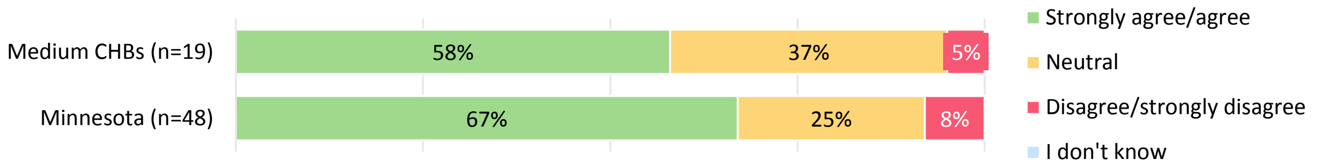
Your community health board: Strongly agree



My community health board *currently* has a *pervasive culture* that focuses on continuous QI.

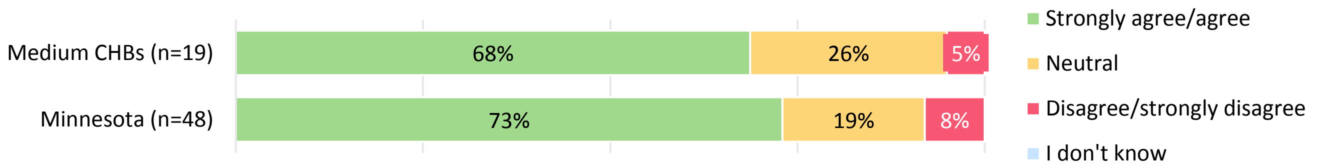
"Pervasive" means present everywhere, spreading widely, or present throughout the community health board.

Your community health board: Agree



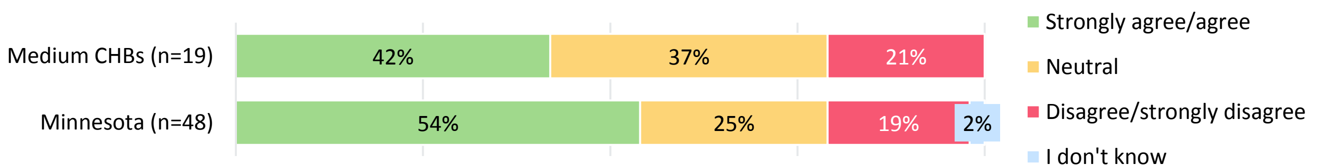
My community health board *currently* has *aligned its commitment* to quality with *most* of its efforts, policies, and plans.

Your community health board: Strongly agree



My community health board *currently* has a high level of capacity to engage in QI efforts.

Your community health board: Agree

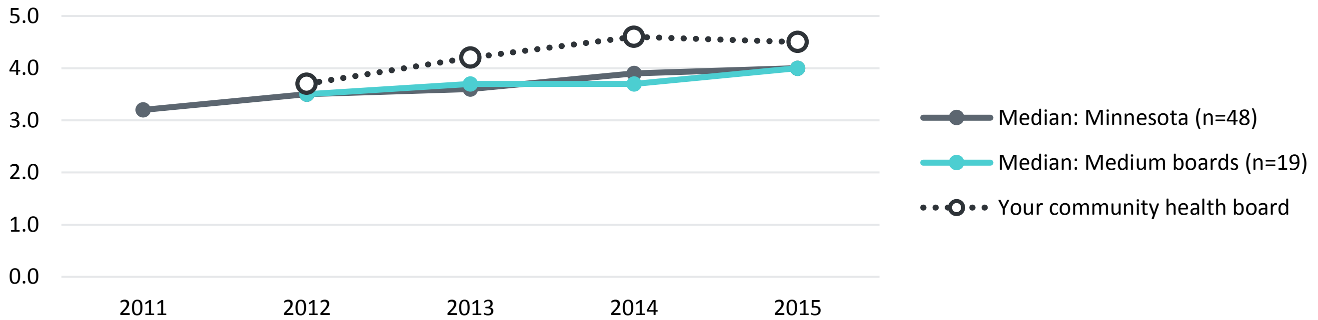


Organizational QI Maturity Score

To monitor system level changes in QI maturity, the Minnesota Public Health Research to Action Network developed methods to calculate an organizational QI maturity score, which corresponds to the NACCHO Roadmap to a Culture of Quality Improvement.

You may see your CHB's QI maturity score fluctuate, as your CHB becomes more immersed in quality improvement activities and has a better understanding of what quality improvement looks like in your own organization.

Organizational QI maturity score, your community health board and other Minnesota community health boards, 2011-2015 *



Organizational QI maturity score (median), Minnesota community health boards, 2011-2015	2011	2012	2013	2014	2015
Your community health board	not available	3.7	4.2	4.6	4.5
Median: Medium community health boards	not available	3.5	3.7	3.7	4.0
Median: Minnesota	3.2	3.5	3.6	3.9	4.0

Note: Median CHB scores unavailable in 2011 (2011 scores calculated by local health department). The following CHBs are not included in counts due to governance changes between 2012 and 2014: SWHHS, Nobles, Kandiyohi-Renville, Horizon, Polk-Norman-Mahnomen.

ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

Public Health Accreditation

This information is used to help understand and improve Minnesota's public health system. Annual information on accreditation preparation is useful for networking, mentoring, and sharing among community health boards, and enables monitoring system-level progress to implement the SCHSAC recommendation that all community health boards are prepared to apply for voluntary national accreditation by 2020 (as well as a national goal to increase percentage of population served by an accredited health department).

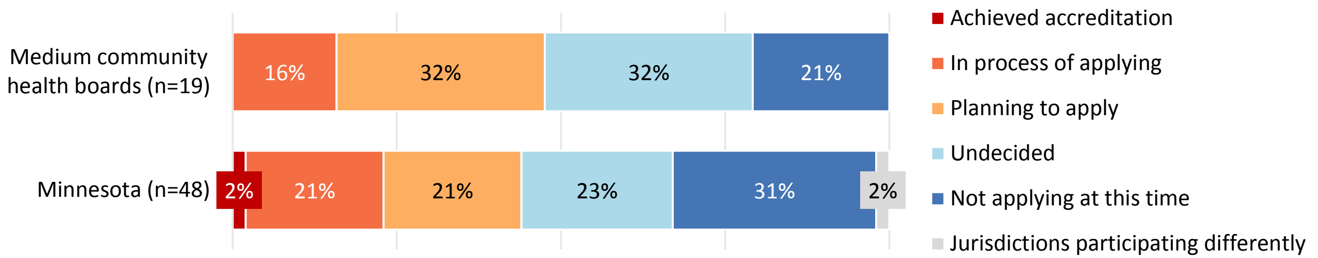
This can happen by: (1) Increasing the number of accredited community health boards, (2) Increasing the number of community health boards that fully meet all of the measures, (3) Ensuring each community health board makes individual progress toward meeting all of the measures, (4) Ensuring all community health boards make progress toward meeting measures they identified as needing improvement.

Additional benefits of these measures include information to target technical assistance and training, and information for community health boards on how their decisions/actions related to accreditation compare to others.

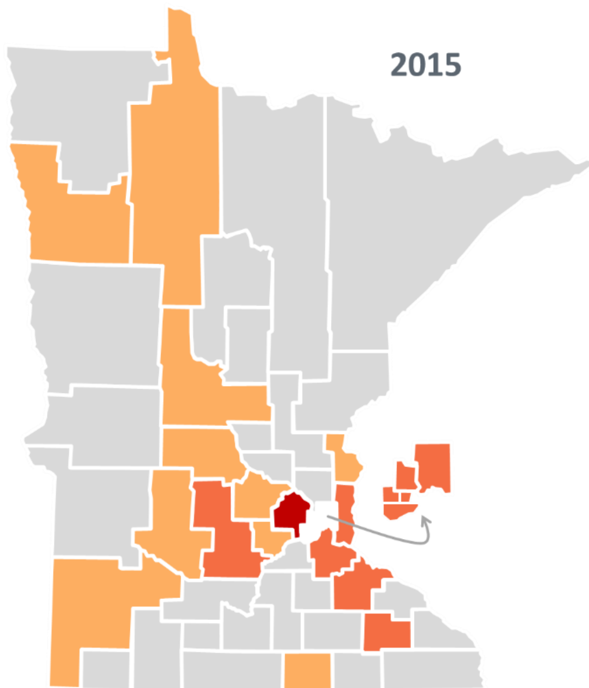
More Information

MDH Health Partnerships Division, Public Health Practice Section
651-201-3880 | health.ophp@state.mn.us
www.health.state.mn.us/divs/opi/

Participation in national public health accreditation, Minnesota community health boards, by size, 2015



Participation in national public health accreditation, Minnesota community health boards, by population, 2015	Your community health board	Medium CHBs (n=19)	Minnesota (n=48)
My community health board has achieved accreditation		0%	2%
My community health board is in the process of accreditation (e.g., has submitted a statement of intent)	X	16%	21%
My community health board is planning to apply (but is not in the process of accreditation)		**32%**	21%
My community health board is undecided about whether to apply for accreditation		**32%**	23%
My community health board has decided not to apply at this time		21%	**31%**
Individual jurisdictions within my community health board are participating in accreditation differently		0%	2%



Participation in national public health accreditation, Minnesota, 2015

Achieved accreditation (1)

Hennepin

In process of applying (10)

Bloomington
Dakota
Edina
Goodhue
Meeker-McLeod-Sibley
Minneapolis
Olmsted
Richfield
St. Paul-Ramsey
Washington *

Planning to apply (10)

Carver
Chisago
Freeborn
Kandiyohi-Renville
Morrison-Todd-Wadena
North Country
Polk-Norman-Mahnomen
Stearns
SWHHS
Wright

** Washington achieved accreditation in March 2016, and is counted as "in process of applying" for 2015*