MICA 2010 Legislative Recommendations Public Health

Support Statewide Health Improvement Program (SHIP)

The MICA Board of Directors supports permanent funding for the Statewide Health Improvement Program (SHIP).

Landmark health care reform legislation was passed by the 2008 Legislature. This legislation includes funding of community and systems-based efforts to improve health and reduce demands on the health care system by decreasing the percentage of Minnesotans who are overweight or use tobacco. As supported by research, by addressing these health care issues through policy and system changes Minnesota will have a direct, positive effect on reducing chronic disease and the cost of health care. This legislation was designed to support health care reform by improving the funding imbalance between public health models of evidence-based prevention and medical-based care. In addition, public health has an important role to play in other facets of the 2008 Health Care Reform legislation, including case management/care coordination and working with patients to establish a medical home.

The 2008 legislation provided $47 million in funding for two years (FY2010-11). This funding must now be made permanent and reliable as state and local health departments implement a comprehensive approach to reducing the risk factors for burdensome chronic diseases.

Provide Stable Funding for Family Home Visiting

The MICA Board of Directors supports the allocation of stable and sufficient funding for the state-administered, county-delivered targeted home visiting program.

Home visiting programs address the state's responsibility to provide basic protections and support when families are at risk or are not able to provide basic and essential developmental support for their children.

The 2007 Legislature allocated $4.5 million per year in TANF funds to support home visiting. While this funding will help reinvigorate home visiting programs, this funding source has proven to be unreliable. Base funding from the state's general fund is essential for supporting effective home visiting programs.

Home visiting for at-risk families is a proven and efficient means of investing in the self-sufficiency, health and well being of families, while avoiding high-cost remedial programming required when children are neglected and abused. Families who have voluntarily engaged in quality home visiting programs, which include the involvement of public health nurses and the promotion of mental health through social and emotional screening, have shown:

- improved school readiness
- higher employment rates
- lower public assistance utilization
- lower incidences of child abuse or neglect
- healthier pregnancies and infant brain development outcomes
- lower need for special education, out-of-home placements and corrections

The benefit of home visiting programs, in human and financial terms, is significant. However, previous funding has proven to be unreliable and subject to budget cuts. Several Minnesota counties have funded their own home visiting programs and have experienced the type of success produced by long-run programs. Counties cannot solely sustain funding for this type of high-demand programming. Adequate base funding from the state needs to be allocated to support solid, preventive services to at-risk children. Counties that have funded their own efforts should not be punished by maintenance of efforts (MOE) requirements.

Correctional Health

The MICA Board of Directors supports adequate funding for county health care costs for incarcerated persons.

Counties' health care costs for incarcerated inmates are rising at unprecedented rates for a variety of reasons. Since correctional facilities are designed for security, they are not suitable for the delivery of complete health care. While many inmates have chronic conditions requiring complex and costly management, demand for nursing coverage and other services can vary greatly over short periods of time. There are limited resources for release planning and for services needed upon release. Mental health, chemical dependency and dental services are limited in many communities.

The electronic exchange of health data is growing rapidly in the private sector, and counties will need to automate inmate health records in order to maintain communications with health care providers and meet the legislative mandate for an electronic health data exchange by 2015.

The MICA Board supports:

- policies that limit county responsibility for medical costs to inmates
- funding for demonstration projects to improve health and social services for inmates being released into the community
- diverting the chronically mentally ill to alternate mental health facilities
- funding for the implementation of interoperable electronic medical records for the incarcerated population

Support Local Public Health Emergency Planning, Preparedness and Response

The MICA Board of Directors supports state and federal funding and policy changes that facilitate local public health emergency planning, preparedness and response activities, and to avoid health care workforce shortages.

Although much has been accomplished in public health emergency preparedness, a considerable amount of work remains to be done before we are fully capable of responding to public health emergencies. The coordination of state and local governments with all hospitals, clinics, and other medical entities, including mental health professionals, must continue.

While local governments are taking on public health emergency obligations, federal funding is being reduced, and what is left is largely retained at the state level. Local public health departments now have fully trained staff available to respond to public health emergencies on a 24/7 basis, yet federal

funding to support this activity is shrinking and state funding has not been forthcoming. Necessary equipment must be purchased and the resulting maintenance and training expenses must be paid. Without ongoing funding, equipment will become outdated, and staff will not be trained in its use. The developing threat of a pandemic, along with the existence of other health emergencies, creates a serious vulnerability, especially in light of the present shortage of highly-trained health care workers. As an example, recent outbreaks of e-coli, salmonella and hepatitis and increasing incidents of communicable diseases (i.e., tuberculosis (TB), influenza viruses, etc.) are clear indicators of an escalating threat of infectious disease which requires intensive response and coordination.

The state must provide funding for:

- local public health emergency planning, preparedness and response activities
- equipment purchase, maintenance and training
- permanent flexible funding to maintain a workforce and infrastructure that is able to respond to public health emergencies
- emergency pandemic and other communicable disease crises

Support Statewide Public Health Electronic Data Exchange

The MICA Board of Directors supports state funding for the development and implementation of a statewide public health electronic information system.

All Minnesota health care providers are required to have interoperable electronic health records by 2015 (MS 62J.495). Local public health (LPH) departments must have technology that enables multiple information technology systems and software applications to accurately and effectively communicate and exchange health data. The technology must be capable of allowing LPH departments to produce the information for individual and aggregate reports on health care outcomes.

Currently, LPH departments have stand-alone applications that require duplicate entry or a complex manual transfer of information. LPH departments may have as many as 20 different stand-alone applications. Older, limited function applications and separate data sets result in inefficient and costly use of staff time (i.e., data re-entry). A common set of technical and language standards needs to be developed for local and state data exchange. Counties are committing significant resources, including funding and staff time, for technology and staff development related to the coordination and planning for health information interoperability between local and state government and the private sector.

Anticipated federal funding provides an opportunity for counties to establish interoperable electronic health records, while pursuing the objectives of the Health Information Technology (HIT) program. Under the 2009 federal stimulus package, an estimated $8.4 million will be available in Minnesota to promote HIT.

It is intended that the federal stimulus dollars will be used to improve health care through exchange and use of health information by:

- Developing a HIT architecture that supports a nationwide electronic exchange
- Integrating HIT into training of health care professionals
- Providing training on best practices
- Promoting regional efforts toward the exchange of health information
- Using infrastructure and tools to promote telemedicine
- Promoting interoperability of clinical data repositories or registries