DEPARTMENT OF HEALTH

Ability to Meet Minimum Expectations: The Current State of Local Public Health in Minnesota

DATA BOOK OF ASSESSMENT FINDINGS

Minnesota's Local Public Health Act (Minn. Stat. § 145A) provides specific authorities and responsibilities for local public health in the state, and specifies six areas of public health responsibilities in which those authorities and responsibilities occur. Required local public health activities (or "foundational activities") released in 2017 address the six areas of responsibility, and comprise the minimum expectations for local public health in Minnesota. These foundational activities are the public health services that every Minnesotan should expect regardless of where they live.

In fall 2017, 100% of local health departments in Minnesota (n=74) participated in a self-assessment of their ability to carry out these activities. The results of this point-in-time assessment are summarized in this report.

For a summary of these findings, visit: SCHSAC Strengthening Public Health in Minnesota Workgroup.

Contents

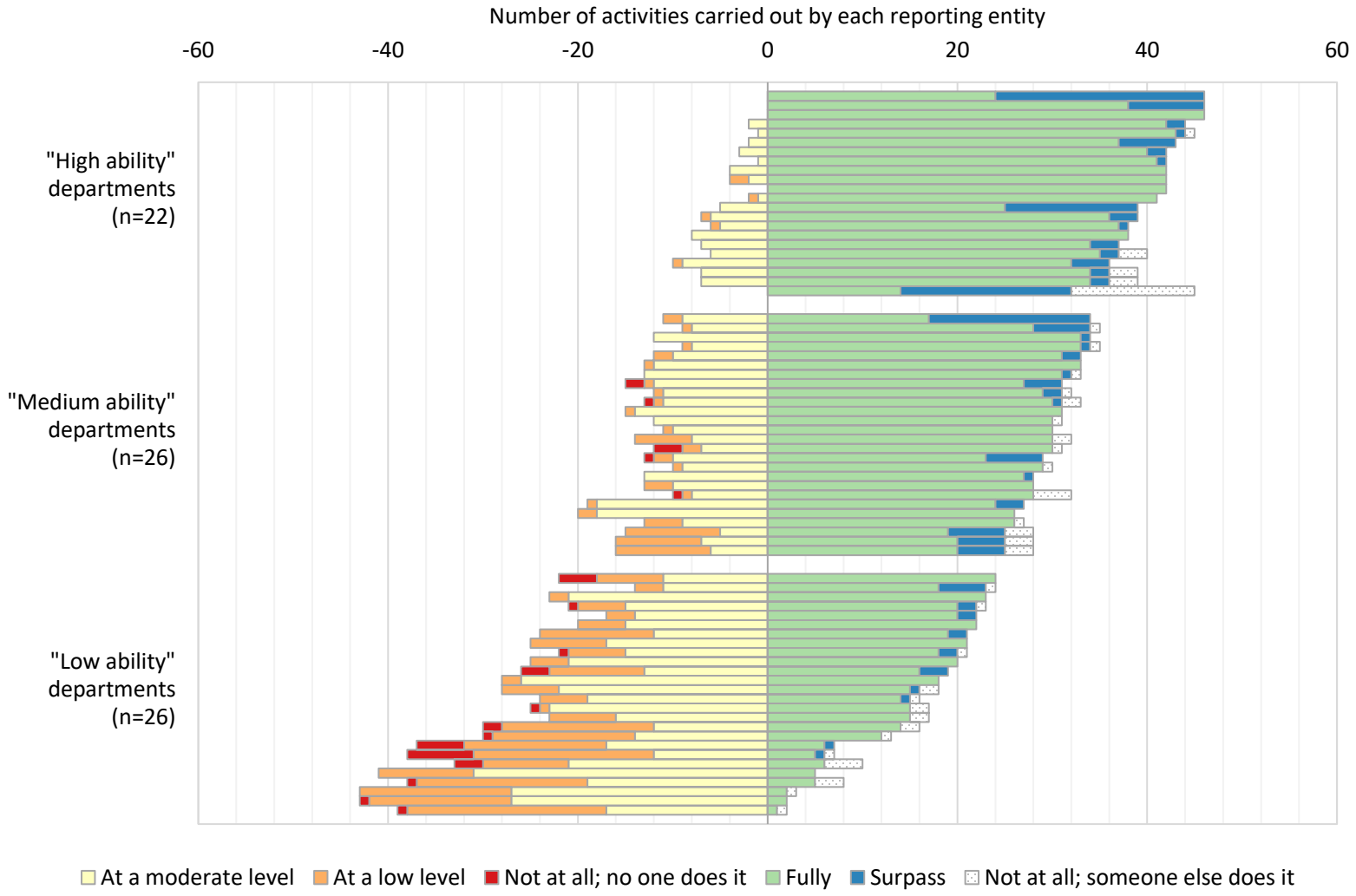
Minnesota Department of Health
Center for Public Health Practice
PO Box 64975 St. Paul, MN 55164-0975
651-201-3880 health.ophp@state.mn.us
www.health.state.mn.us

December 2017

To obtain this information in a different format, call: 651-201-3880.

Current State: Local Health Departments

Figure 1. Required local public health activities in Minnesota, by reporting entity (n=74 local health departments)



Each bar in Figure 1 represents one of Minnesota's seventy-four local health departments. The bars are shaded to show the ability of each local health department to carry out required activities. Departments are ranked based on the number of activities carried out at a level that meets or exceeds minimum expectations (i.e., "fully" or "surpass"). The twenty-two health departments able to fully carry out the most activities, are grouped together at the top of the graph, followed by those with "medium" ability, and "low" ability toward the bottom.

Some required activities are only carried out as circumstances warrant. MDH encouraged reporting entities to select "not applicable" when local conditions did not call for carrying out a particular activity (e.g., issuing emergency orders).

Current State: Areas of Public Health Responsibility

For each area of responsibility, respondents who said that they fully carry out one or more activities and/or carry out activities at a level that surpasses minimum expectations were then asked to identify the assets that enable this high performance. Respondents who reported that they do not fully carry out one or more activities in each area were asked to identify the barriers to meeting the requirement(s). This means that some reported only barriers, some only assets, and some both (see Appendix B).

Assure an Adequate Local Public Health Infrastructure

Figure 2. Required activities in *Assure an Adequate Local Public Health Infrastructure*

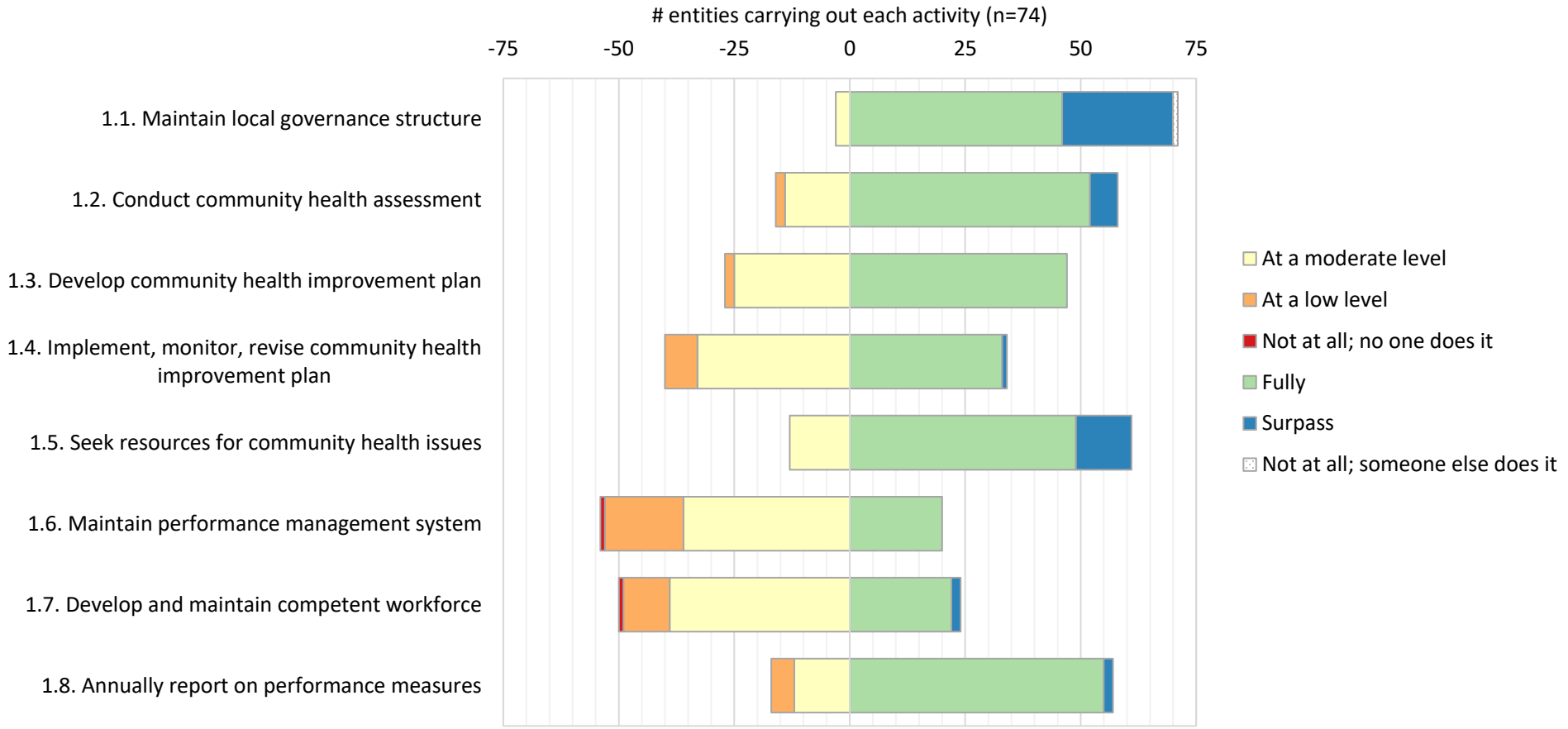


Figure 3. Barriers to meeting minimum expectations,
Assure an Adequate Local Public Health Infrastructure

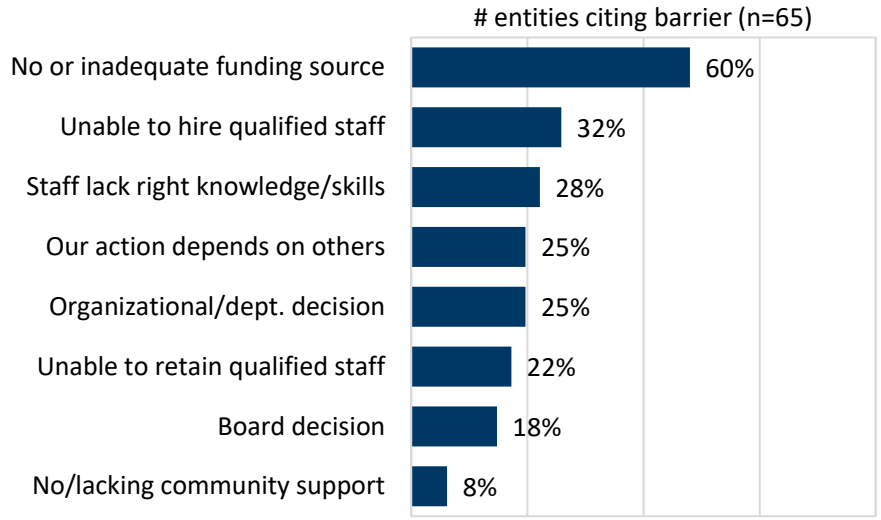
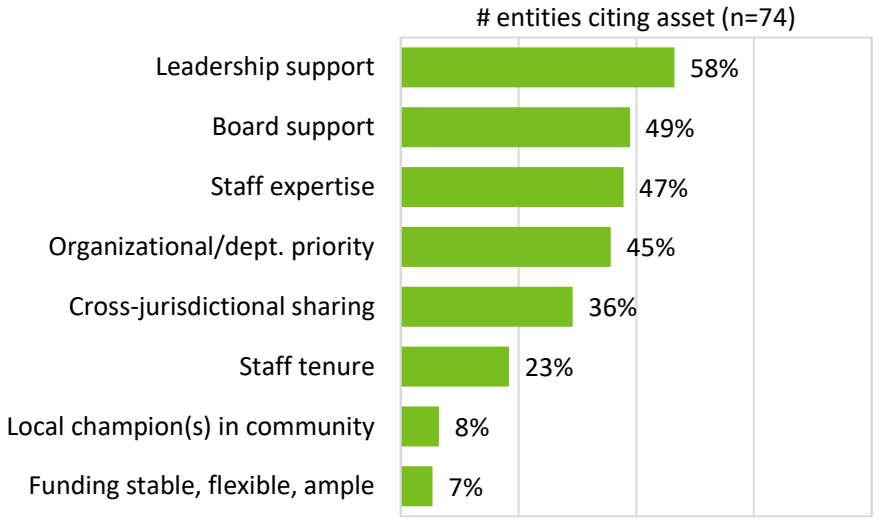


Figure 4. Assets supporting meeting minimum expectations,
Assure an Adequate Local Public Health Infrastructure



Barriers to meeting minimum expectations,
***Assure an Adequate Local Public Health Infrastructure* (n=65)**

1. No or inadequate funding source (39)
2. Unable to hire qualified staff (21)
3. Staff lack the right knowledge/skills (18)
4. Our action depends on the work of others (16)
   Organizational/department decision (16)
5. Unable to retain qualified staff (14)
6. Board decision (12)
7. No or inadequate community support (5)

Assets supporting meeting minimum expectations,
***Assure an Adequate Local Public Health Infrastructure* (n=65)**

1. Leadership support (43)
2. Board support (36)
3. Staff expertise (35)
4. Organizational/department priority (33)
5. Cross-jurisdictional sharing (27)
6. Staff tenure (17)
7. Local champion(s) in the community (6)
8. Funding [e.g., is stable, flexible, ample] (5)

Promote Healthy Communities and Healthy Behavior

Figure 5. Required activities in *Promote Healthy Communities and Healthy Behavior*

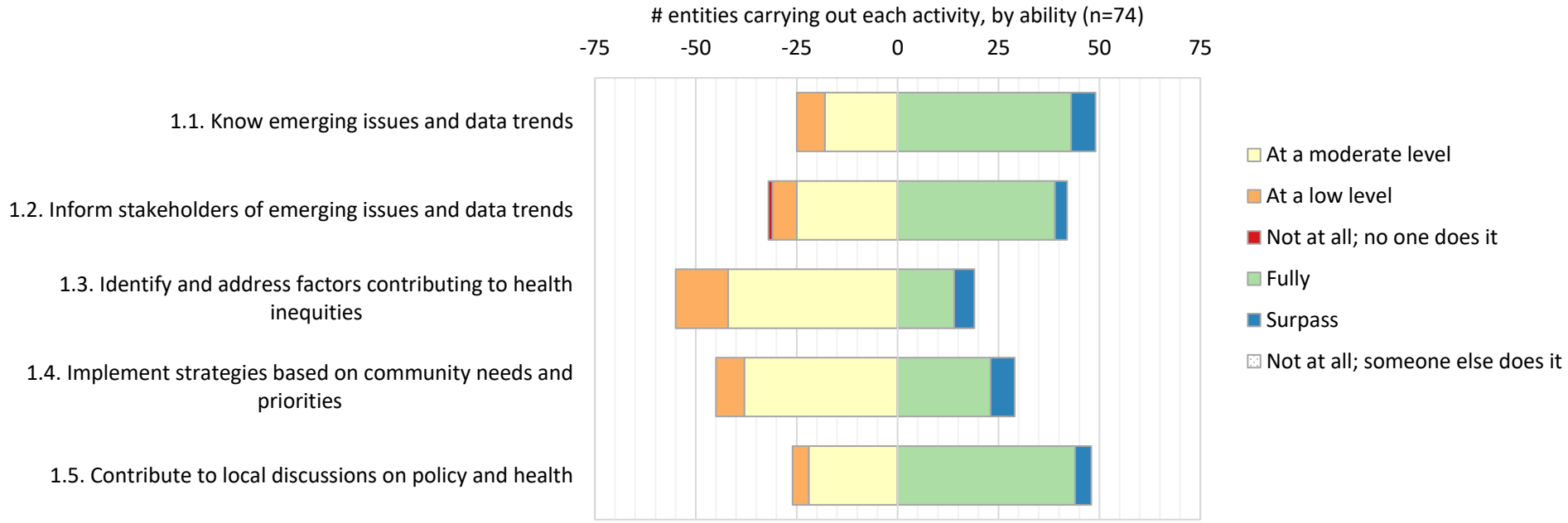


Figure 6. Barriers to meeting minimum expectations, *Promote Healthy Communities and Healthy Behavior*

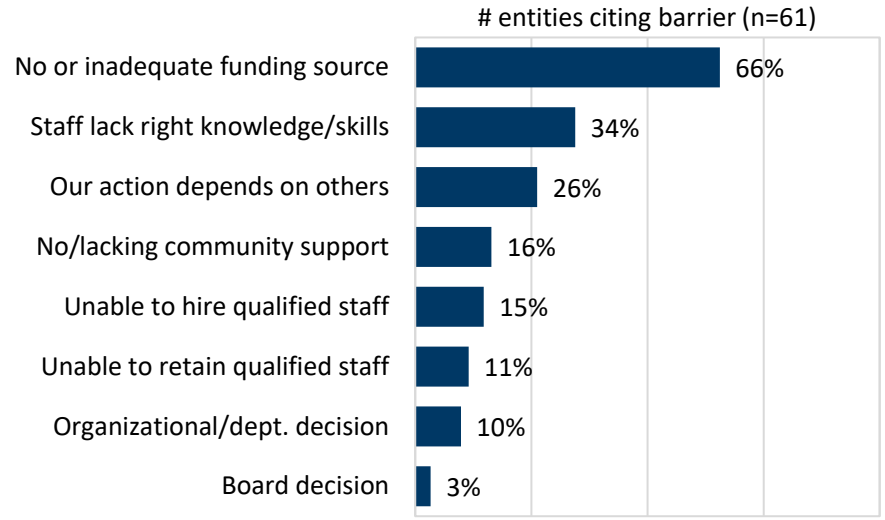
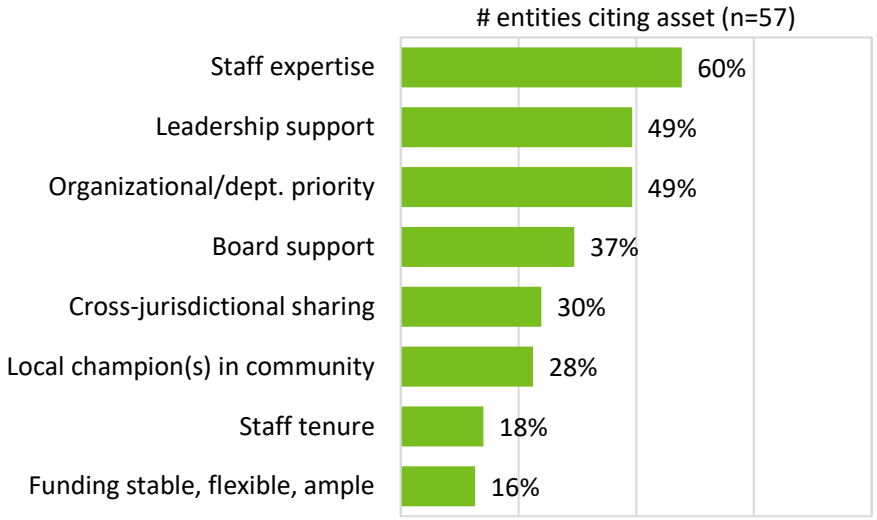


Figure 7. Assets supporting meeting minimum expectations, *Promote Healthy Communities and Healthy Behavior*



Barriers to meeting minimum expectations, *Promote Healthy Communities and Healthy Behavior* (n=61)

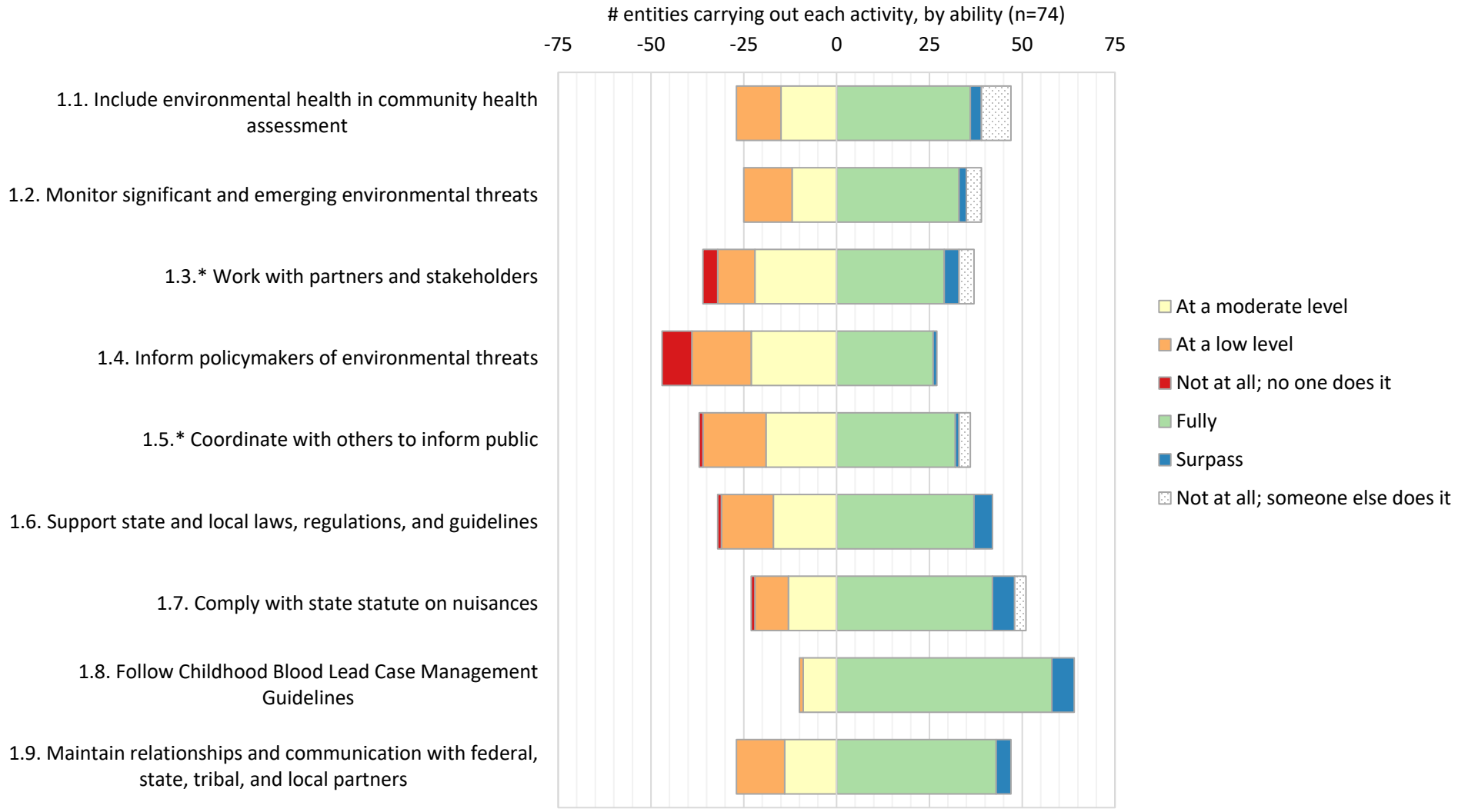
1. No or inadequate funding source (40)
2. Staff lack the right knowledge/skills (21)
3. Our action depends on the work of others (16)
4. No or inadequate community support (10)
5. Unable to hire qualified staff (9)
6. Unable to retain qualified staff (7)
7. Organizational/department decision (6)
8. Board decision (2)

Assets supporting meeting minimum expectations, *Promote Healthy Communities and Healthy Behavior* (n=57)

1. Staff expertise (34)
2. Organizational/department priority (28)
   Leadership support (28)
3. Board support (21)
4. Cross-jurisdictional sharing (17)
5. Local champion(s) in the community (16)
6. Staff tenure (10)
7. Funding [e.g., is stable, flexible, ample] (9)

Protect Against Environmental Health Hazards

Figure 8. Required activities in *Protect Against Environmental Health Hazards*



** Some required activities are only carried out as circumstances warrant. MDH encouraged reporting entities to select "not applicable" when local conditions did not call for carrying out a particular activity.*

Figure 9. Barriers to meeting minimum expectations, *Protect Against Environmental Health Hazards*

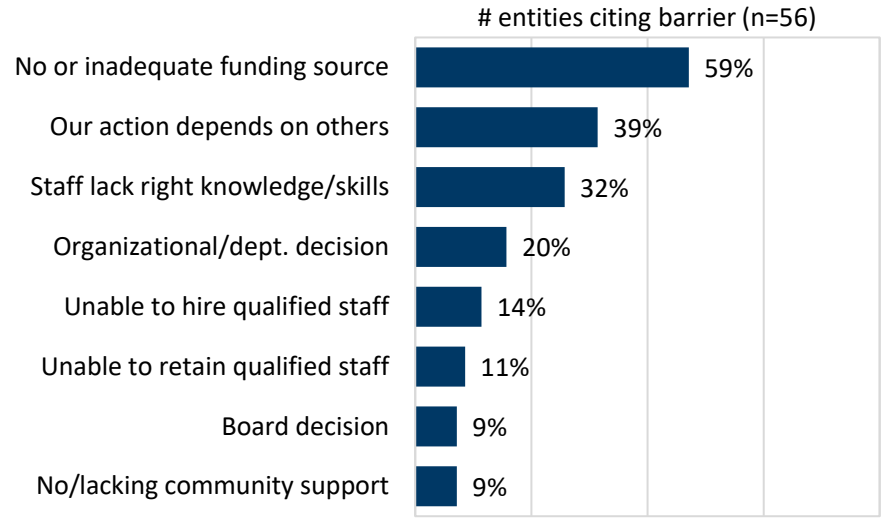
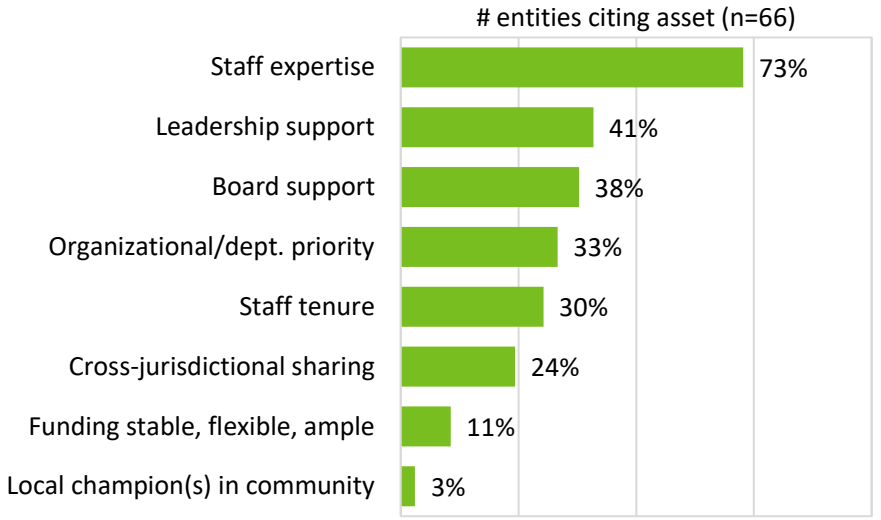


Figure 10. Assets supporting meeting minimum expectations, *Protect Against Environmental Health Hazards*



Barriers to meeting minimum expectations, *Protect Against Environmental Health Hazards* (n=56)

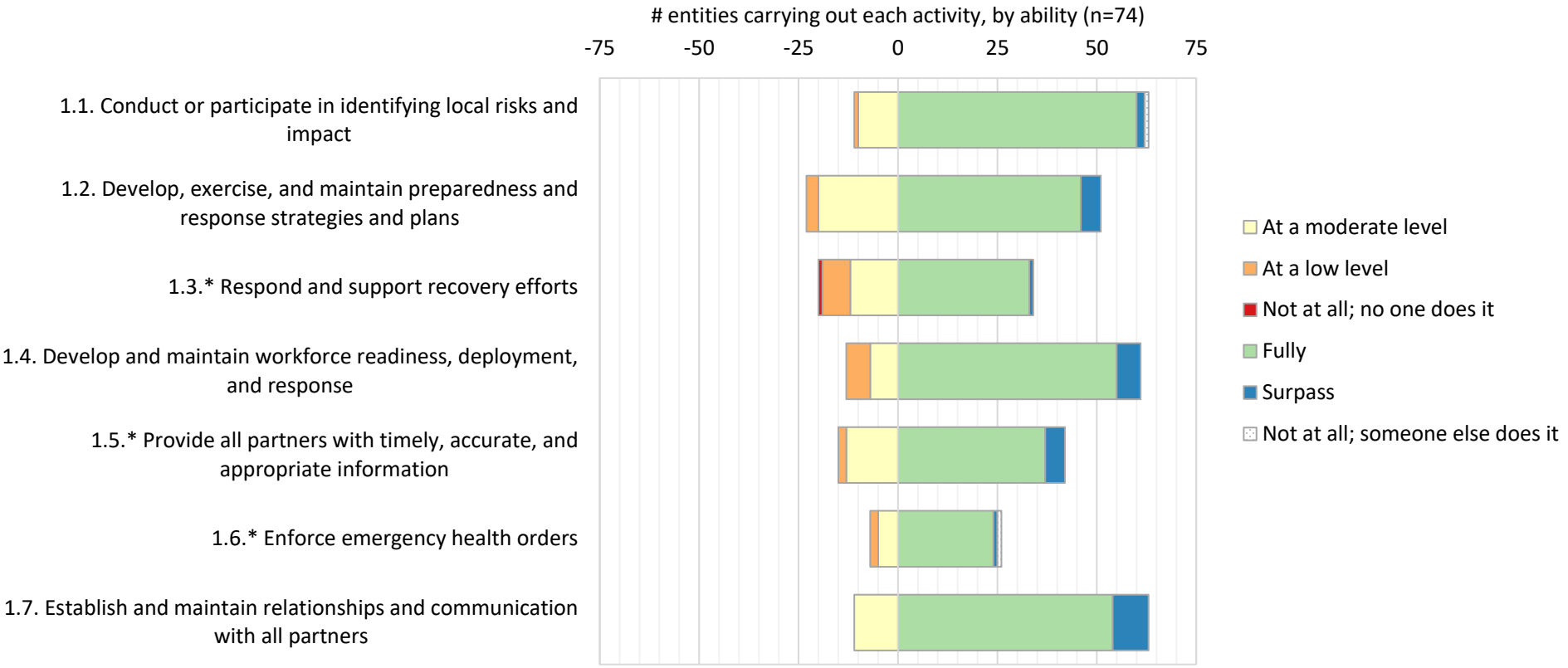
1. No or inadequate funding source (33)
2. Our action depends on the work of others (22)
3. Staff lack the right knowledge/skills (18)
4. Organizational/department decision (11)
5. Unable to hire qualified staff (8)
6. Unable to retain qualified staff (6)
7. Board support (5)
   No or inadequate community support (5)

Assets supporting meeting minimum expectations, *Protect Against Environmental Health Hazards* (n=66)

1. Staff expertise (48)
2. Leadership support (27)
3. Board support (25)
4. Organizational/department priority (22)
5. Staff tenure (20)
6. Cross-jurisdictional sharing (16)
7. Funding [e.g., is stable, flexible, ample] (7)
8. Local champion(s) in the community (2)

Prepare for and Respond to Emergencies

Figure 11. Required activities in *Prepare for and Respond to Emergencies*



** Some required activities are only carried out as circumstances warrant. MDH encouraged reporting entities to select "not applicable" when local conditions did not call for carrying out a particular activity.*

Figure 12. Barriers to meeting minimum expectations, *Prepare for and Respond to Emergencies*

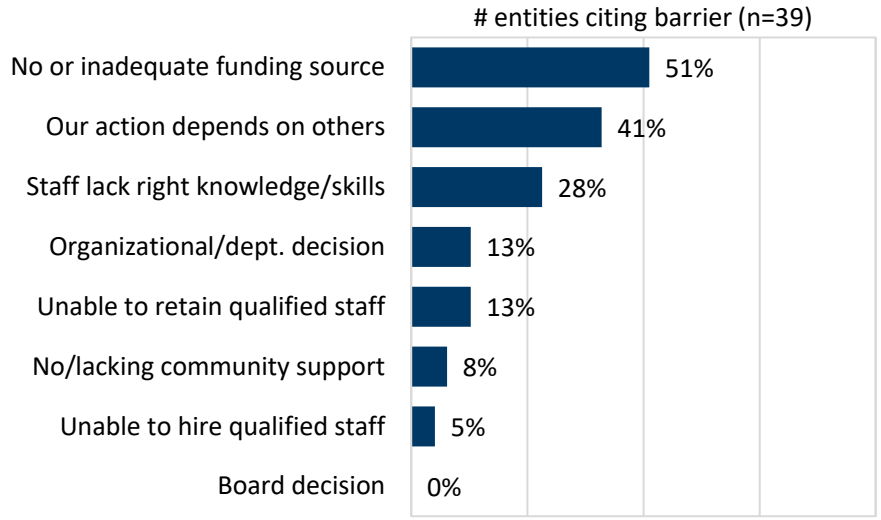
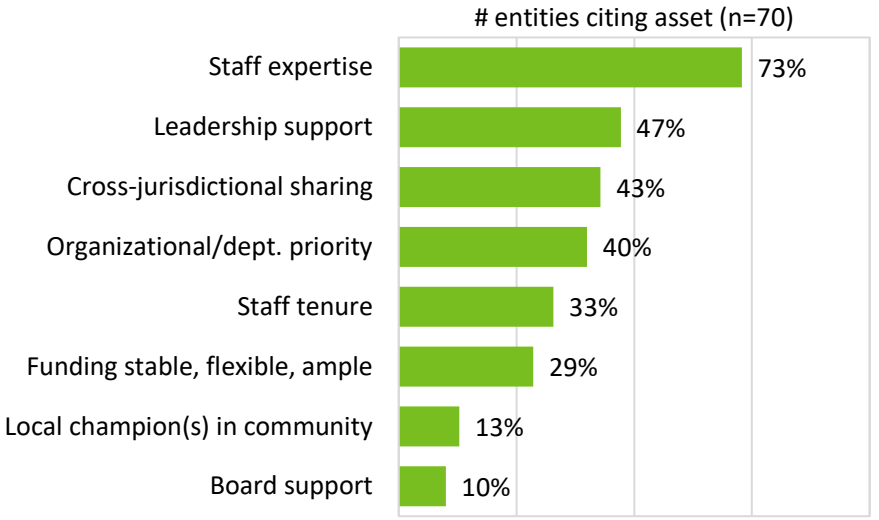


Figure 13. Assets supporting meeting minimum expectations, *Prepare for and Respond to Emergencies*



Barriers to meeting minimum expectations, *Prepare for and Respond to Emergencies* (n=39)

1. No or inadequate funding source (20)
2. Our action depends on the work of others (16)
3. Staff lack the right knowledge/skills (11)
4. Unable to retain qualified staff (5)
   Organizational/department decision (5)
5. No or inadequate community support (3)
6. Unable to hire qualified staff (2)
7. Board decision (0)

Assets supporting meeting minimum expectations, *Prepare for and Respond to Emergencies* (n=70)

1. Staff expertise (51)
2. Leadership support (33)
3. Cross-jurisdictional sharing (30)
4. Organizational/department priority (28)
5. Staff tenure (23)
6. Funding [e.g., is stable, flexible, ample] (20)
7. Local champion(s) in the community (9)
8. Board support (7)

Assure Health Services

Figure 14. Required activities in *Assure Health Services*

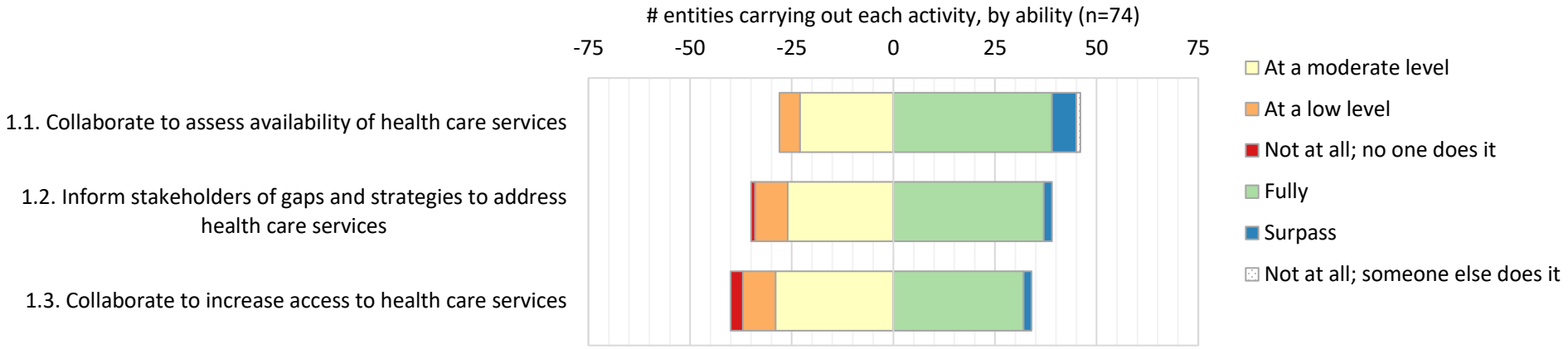


Figure 15. Barriers to meeting minimum expectations, *Assure Health Services*

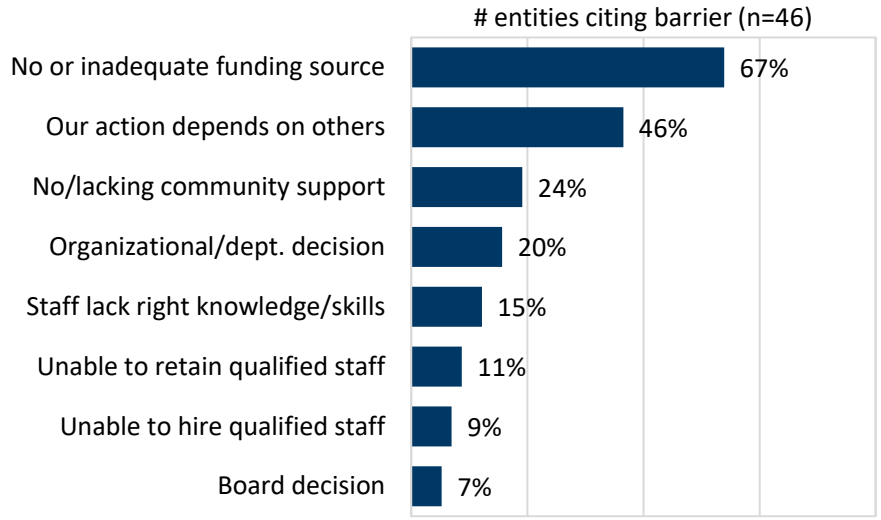
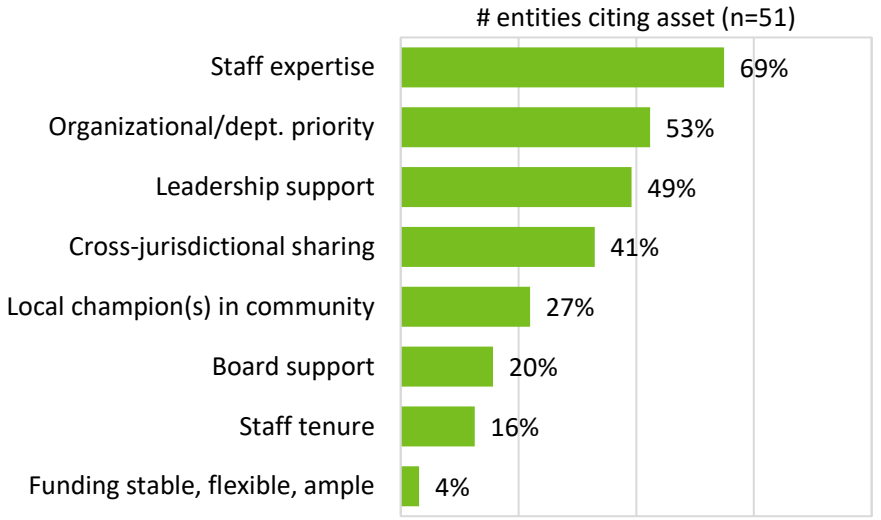


Figure 16. Assets supporting meeting minimum expectations, *Assure Health Services*



Barriers to meeting minimum expectations, *Assure Health Services* (n=46)

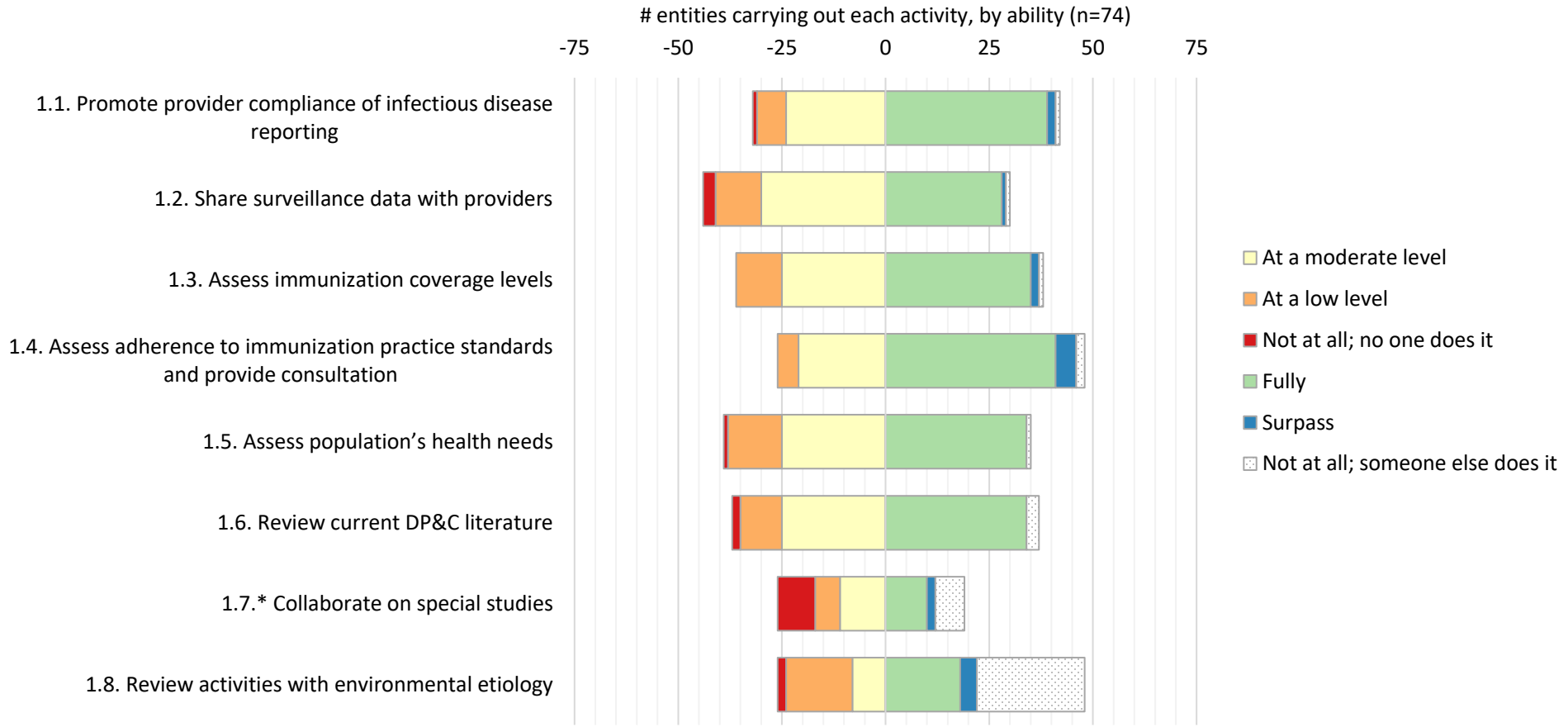
1. No or inadequate funding source (31)
2. Our action depends on the work of others (21)
3. No or inadequate community support (11)
4. Organizational/department decision (9)
5. Staff lack the right knowledge/skills (7)
6. Unable to retain qualified staff (5)
7. Unable to hire qualified staff (4)
8. Board decision (3)

Assets supporting meeting minimum expectations, *Assure Health Services* (n=51)

1. Staff expertise (35)
2. Organizational/department priority (27)
3. Leadership support (25)
4. Cross-jurisdictional sharing (21)
5. Local champion(s) in the community (14)
6. Board support (10)
7. Staff tenure (8)
8. Funding [e.g., is stable, flexible, ample] (2)

Prevent the Spread of Communicable Diseases: Disease Surveillance/Data Collection

Figure 17. Required activities in *Prevent the Spread of Communicable Diseases: Disease Surveillance/Data Collection*



** Some required activities are only carried out as circumstances warrant. MDH encouraged reporting entities to select "not applicable" when local conditions did not call for carrying out a particular activity.*

Figure 18. Barriers to meeting minimum expectations,
Comm. Diseases: Disease Surveillance/Data Collection

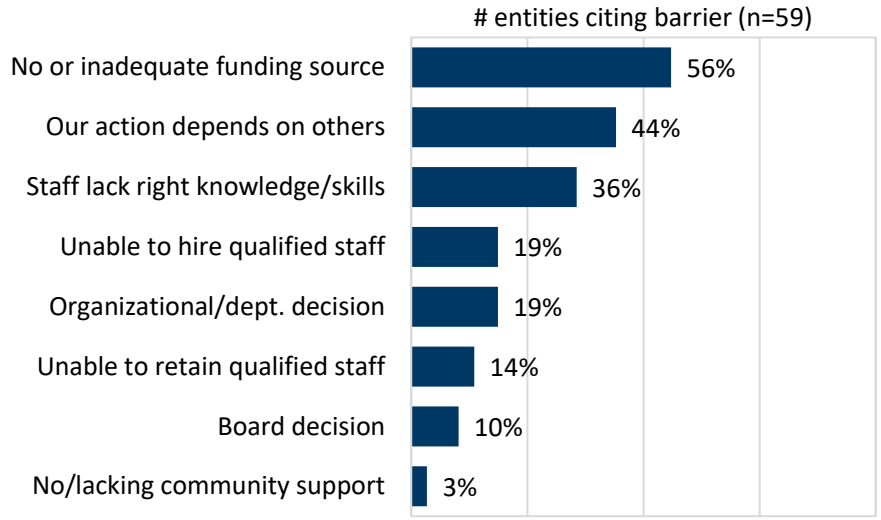
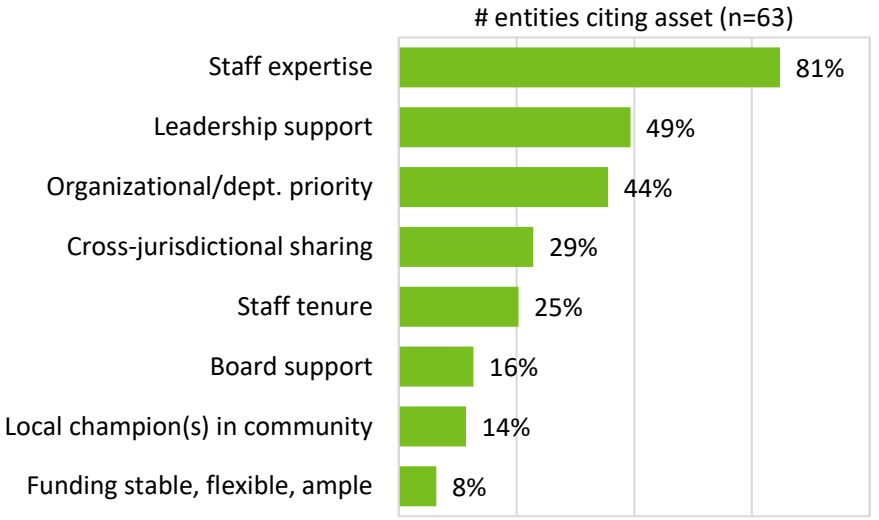


Figure 19. Assets supporting meeting minimum expectations,
Comm. Diseases: Disease Surveillance/Data Collection



Barriers to meeting minimum expectations,
Comm. Diseases: Disease Surveillance/Data Collection **(n=59)**

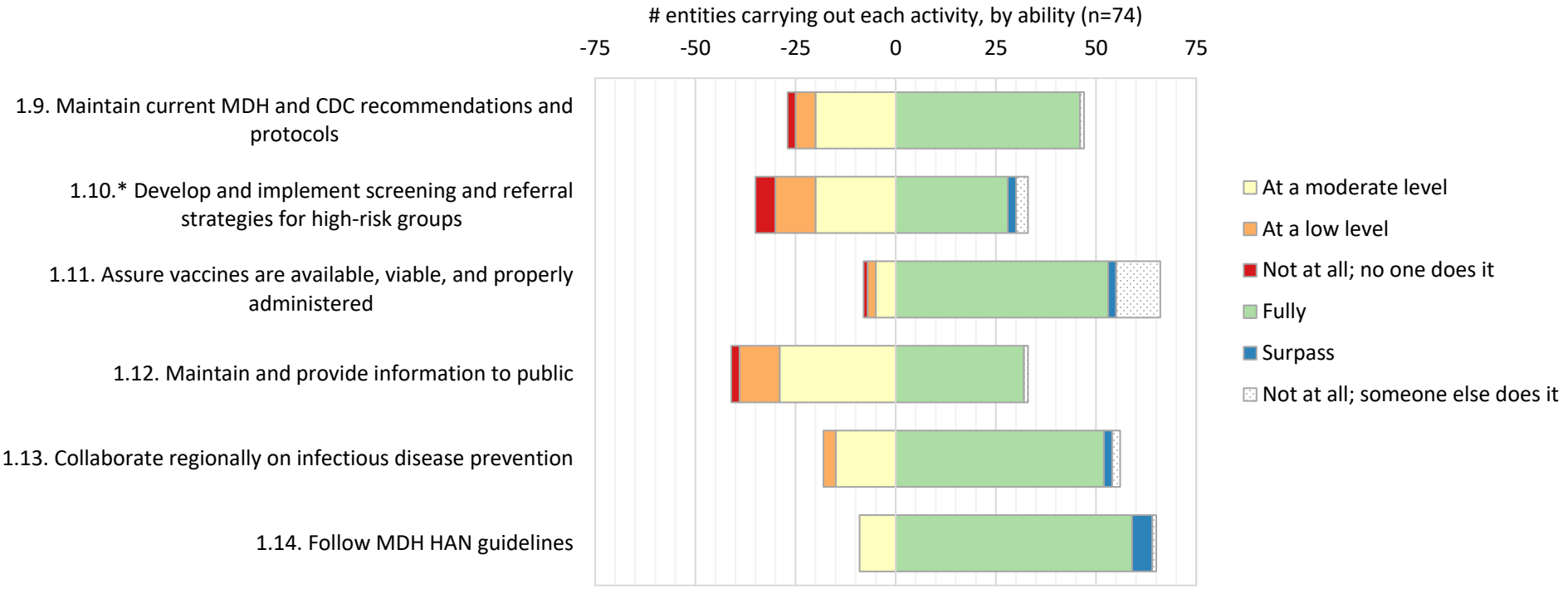
1. No or inadequate funding support (33)
2. Our action depends on the work of others (26)
3. Staff lack the right knowledge/skills (21)
4. Unable to hire qualified staff (11)
   Organizational/department decision (11)
5. Unable to retain qualified staff (8)
6. Board decision (6)
7. No or inadequate community support (2)

Assets supporting meeting minimum expectations,
Comm. Diseases: Disease Surveillance/Data Collection **(n=63)**

1. Staff expertise (51)
2. Leadership support (31)
3. Organizational/department priority (28)
4. Cross-jurisdictional sharing (18)
5. Staff tenure (16)
6. Board support (10)
7. Local champion(s) in the community (9)
8. Funding [e.g., is stable, flexible, ample] (5)

Prevent the Spread of Communicable Diseases: Disease Prevention

Figure 20. Required activities in *Prevent the Spread of Communicable Diseases: Disease Prevention*



** Some required activities are only carried out as circumstances warrant. MDH encouraged reporting entities to select "not applicable" when local conditions did not call for carrying out a particular activity.*

Figure 21. Barriers to meeting minimum expectations, *Comm. Diseases: Disease Prevention*

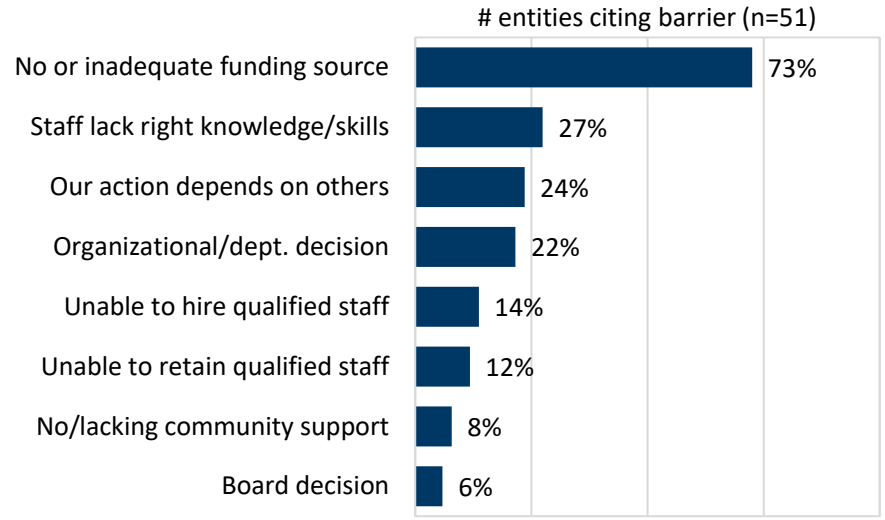
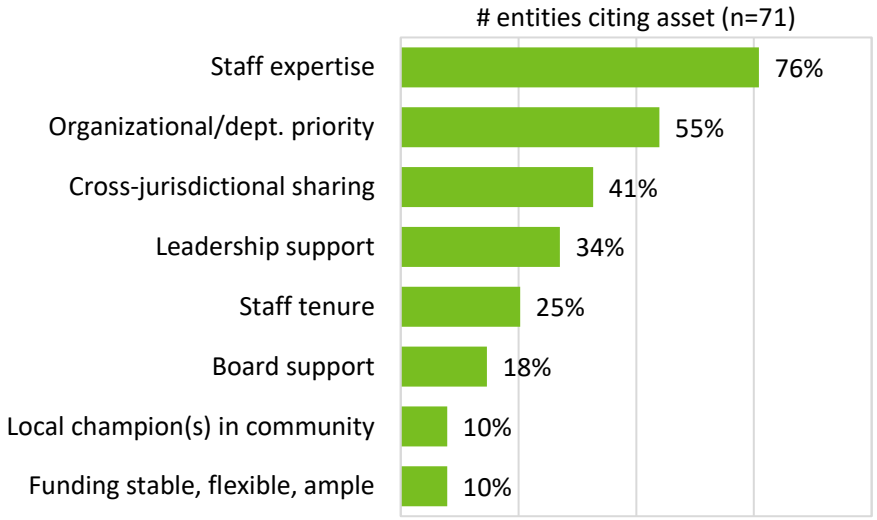


Figure 22. Assets supporting meeting minimum expectations, *Comm. Diseases: Disease Prevention*



Barriers to meeting minimum expectations, *Comm. Diseases: Disease Prevention* (n=51)

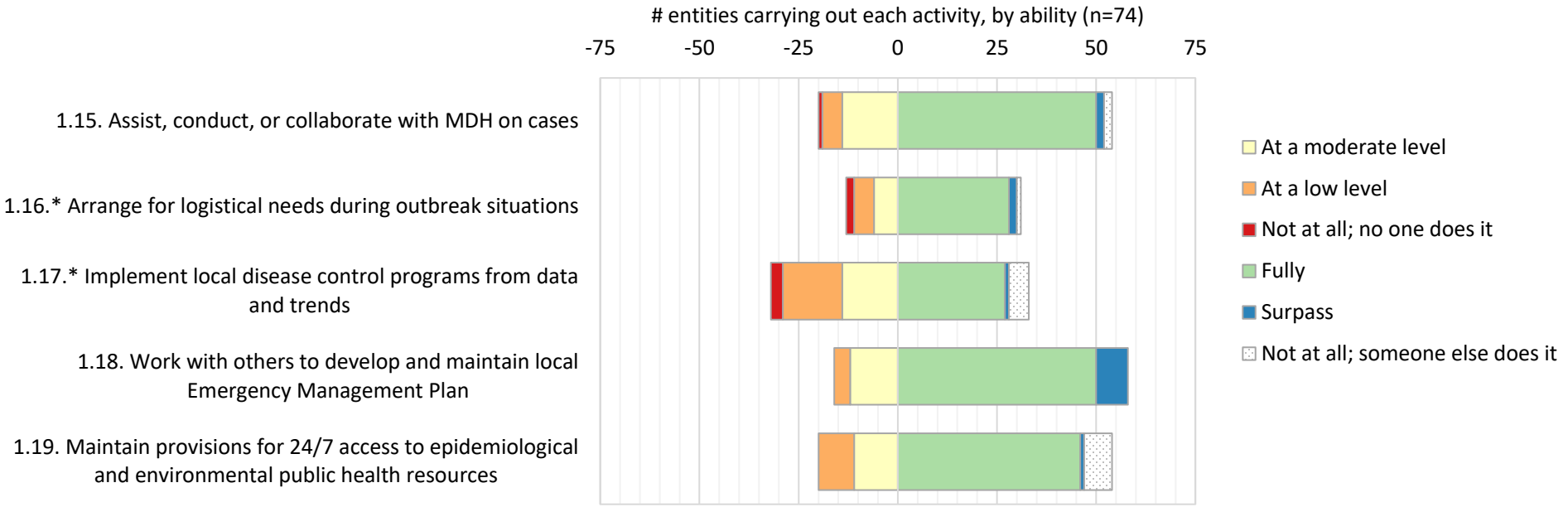
1. No or inadequate funding source (37)
2. Staff lack the right knowledge/skills (14)
3. Our action depends on the work of others (12)
4. Organizational/department decision (11)
5. Unable to hire qualified staff (7)
6. Unable to retain qualified staff (6)
7. No or inadequate community support (4)
8. Board decision (3)

Assets supporting meeting minimum expectations, *Comm. Diseases: Disease Prevention* (n=71)

1. Staff expertise (54)
2. Organizational/department priority (39)
3. Cross-jurisdictional sharing (29)
4. Leadership support (24)
5. Staff tenure (18)
6. Board support (13)
7. Funding [e.g., is stable, flexible, ample] (7)
   Local champion(s) in the community (7)

Prevent the Spread of Communicable Diseases: Disease Control

Figure 23. Required activities in *Prevent the Spread of Communicable Diseases: Disease Control*



** Some required activities are only carried out as circumstances warrant. MDH encouraged reporting entities to select "not applicable" when local conditions did not call for carrying out a particular activity.*

Figure 24. Barriers to meeting minimum expectations, *Comm. Diseases: Disease Control*

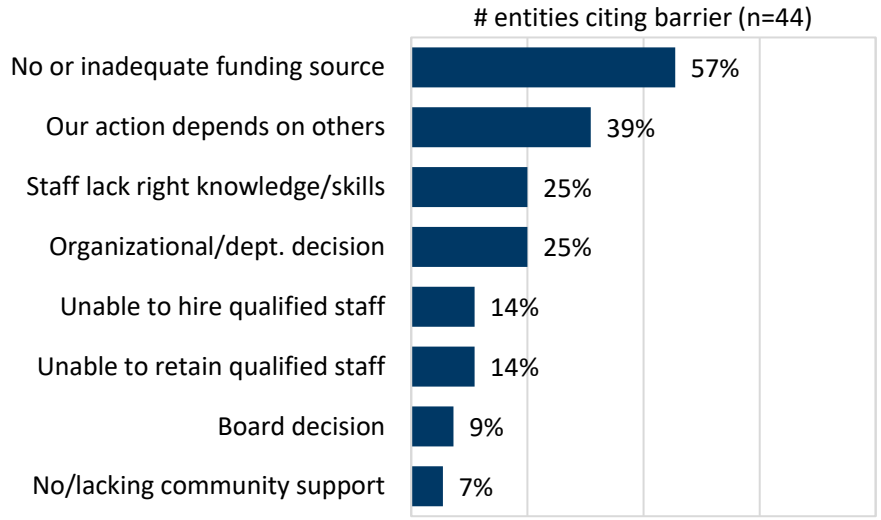
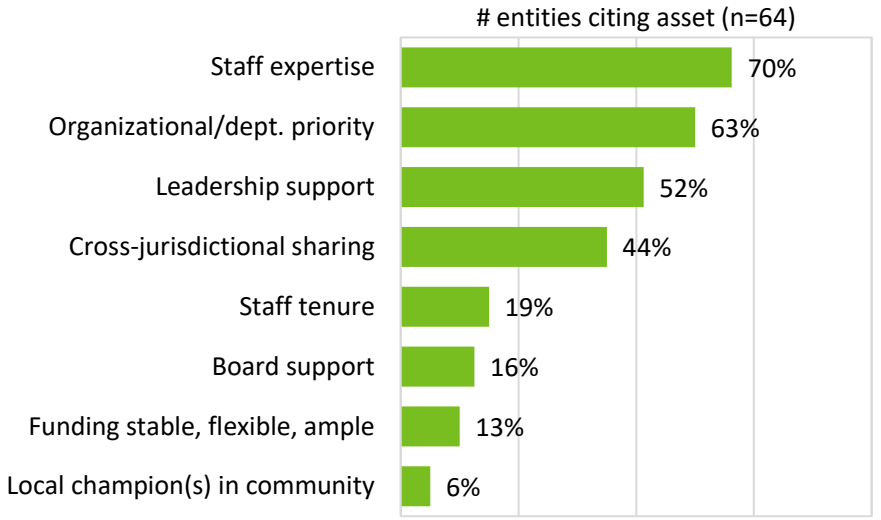


Figure 25. Assets supporting meeting minimum expectations, *Comm. Diseases: Disease Control*



Barriers to meeting minimum expectations, *Comm. Diseases: Disease Control* (n=44)

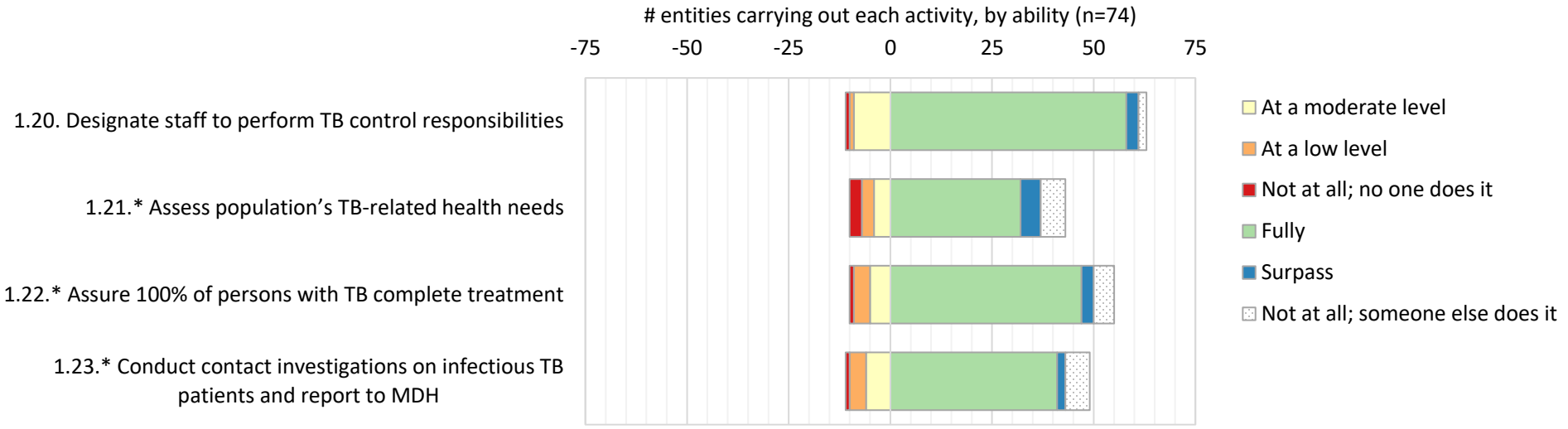
1. No or inadequate funding source (25)
2. Our action depends on the work of others (17)
3. Staff lack the right knowledge/skills (11)
   Organizational/department decision (11)
4. Unable to hire qualified staff (6)
   Unable to retain qualified staff (6)
5. Board decision (4)
6. No or inadequate community support (3)

Assets supporting meeting minimum expectations, *Comm. Diseases: Disease Control* (n=64)

1. Staff expertise (45)
2. Organizational/department priority (40)
3. Leadership support (33)
4. Cross-jurisdictional sharing (28)
5. Staff tenure (12)
6. Board support (10)
7. Funding [e.g., is stable, flexible, ample] (8)
8. Local champion(s) in the community (4)

Prevent the Spread of Communicable Diseases: Tuberculosis

Figure 26. Required activities in *Prevent the Spread of Communicable Diseases: Tuberculosis*



** Some required activities are only carried out as circumstances warrant. MDH encouraged reporting entities to select "not applicable" when local conditions did not call for carrying out a particular activity.*

Figure 27. Barriers to meeting minimum expectations, *Comm. Diseases: Tuberculosis*

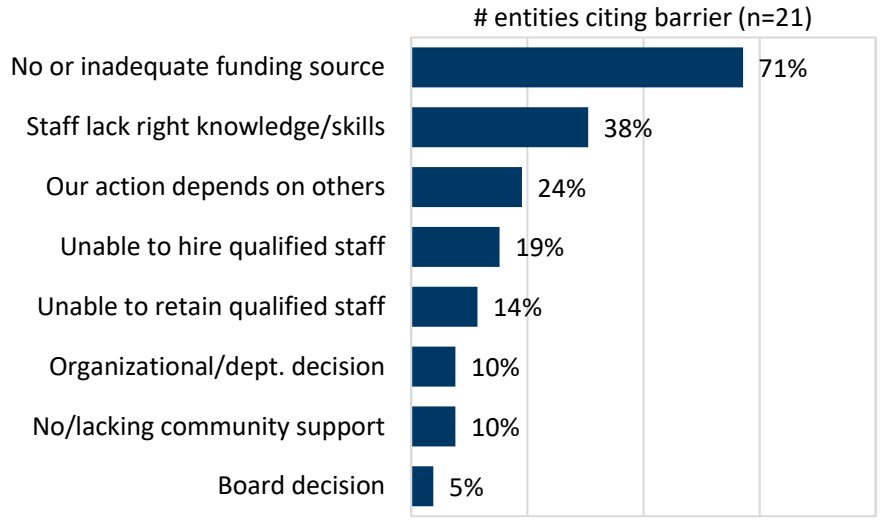
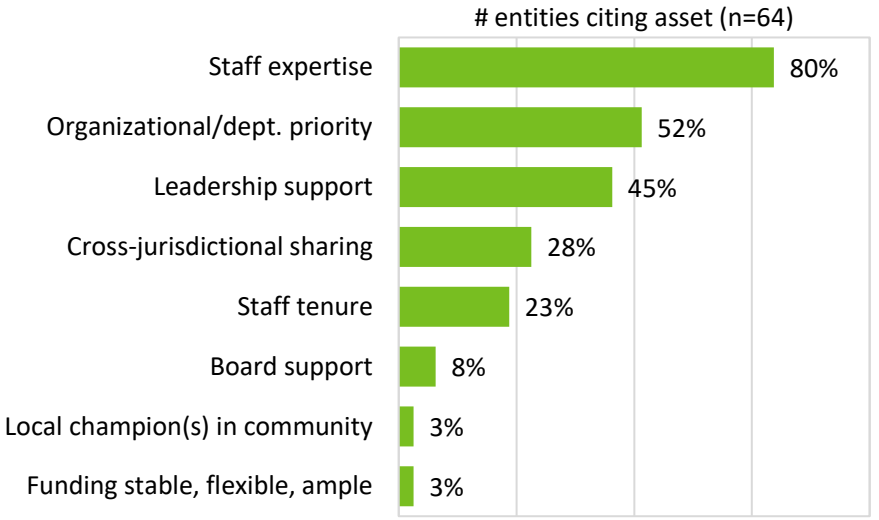


Figure 28. Assets supporting meeting minimum expectations, *Comm. Diseases: Tuberculosis*



Barriers to meeting minimum expectations, *Comm. Diseases: Tuberculosis* (n=21)

1. No or inadequate funding source (15)
2. Staff lack the right knowledge/skills (8)
3. Our action depends on the work of others (5)
4. Unable to hire qualified staff (4)
5. Unable to retain qualified staff (3)
6. Organizational/department decision (2)
   No or inadequate community support (2)
7. Board decision (1)

Assets supporting meeting minimum expectations, *Comm. Diseases: Tuberculosis* (n=64)

1. Staff expertise (51)
2. Organizational/department priority (33)
3. Leadership support (29)
4. Cross-jurisdictional sharing (18)
5. Staff tenure (15)
6. Board support (5)
7. Funding [e.g., is stable, flexible, ample] (2)
   Local champion(s) in the community (2)

Prevent the Spread of Communicable Diseases: Designate Staff Roles for All DP&C Activities

Figure 29. Required activities in *Prevent the Spread of Communicable Diseases: Designate Staff Roles for All DP&C Activities*

Figure 30. Barriers to meeting minimum expectations,
Comm. Diseases: Designate Staff Roles for All DP&C Activities

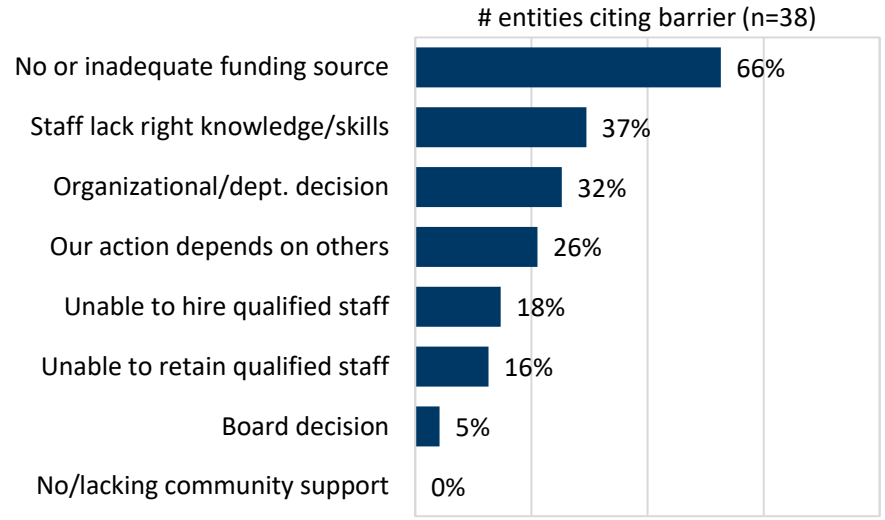
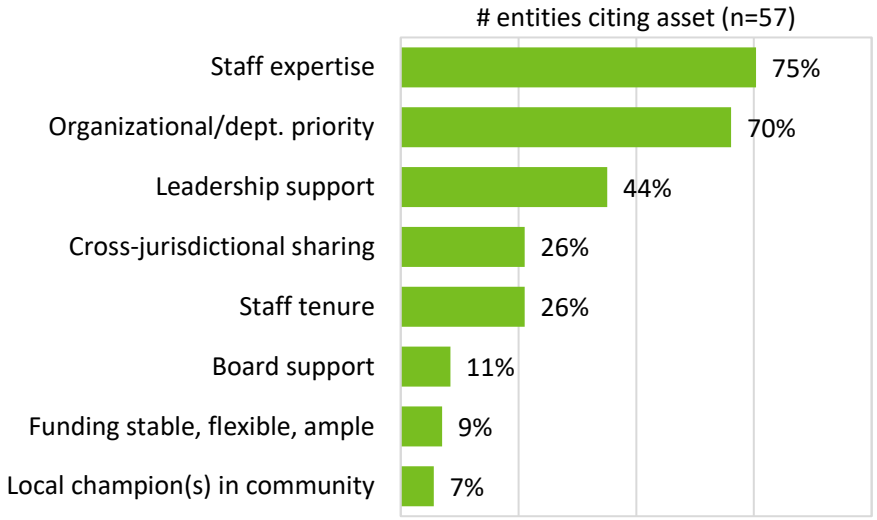


Figure 31. Assets supporting meeting minimum expectations,
Comm. Diseases: Designate Staff Roles for All DP&C Activities



Barriers to meeting minimum expectations,
***Comm. Diseases: Designate Staff Roles for All DP&C Activities* (n=38)**

1. No or inadequate funding source (25)
2. Staff lack the right knowledge/skills (14)
3. Organizational/department decision (12)
4. Our action depends on the work of others (10)
5. Unable to hire qualified staff (7)
6. Unable to retain qualified staff (6)
7. Board decision (2)
8. No or inadequate community support (0)

Assets supporting meeting minimum expectations,
***Comm. Diseases: Designate Staff Roles for All DP&C Activities* (n=57)**

1. Staff expertise (43)
2. Organizational/department priority (40)
3. Leadership support (25)
4. Staff tenure (15)
   Cross-jurisdictional sharing (15)
5. Board support (6)
6. Funding [e.g., is stable, flexible, ample] (5)
7. Local champion(s) in the community (4)

Appendix A. 2017 Capacity Assessment Reporting Entities

Reporting Entities (n=74)	2016 Population
Hennepin	1,232,483
Ramsey	540,649
Minneapolis	419,952
Dakota	417,486
Anoka	345,957
Washington	253,117
St. Louis	199,980
Stearns	155,652
Olmsted	153,102
Scott	143,680
Wright	132,550
Carver	100,262
Sherburne	93,528
Bloomington	88,299
SWHHS *(Lincoln, Lyon, Murray, Pipestone, Redwood, Rock)*	73,840
Horizon *(Douglas, Grant, Pope, Stevens, Traverse)*	67,510
Blue Earth	66,441
Rice	65,622
Crow Wing	63,940
Clay	62,875
Otter Tail	58,085
Chisago	54,748
Edina	51,804
Winona	50,948

Reporting Entities (n=74)	2016 Population
Goodhue	46,676
Beltrami	46,106
Itasca	45,242
Countryside *(Big Stone, Chippewa, Lac qui Parle, Swift, Yellow Medicine)*	43,252
Kandiyohi	42,495
Benton	39,992
Mower	39,163
Isanti	39,025
Steele	36,805
Richfield	36,338
McLeod	35,842
Carlton	35,738
Faribault-Martin	33,764
Becker	33,734
Nicollet	33,575
Morrison	32,821
Polk	31,660
Freeborn	30,446
Cass	28,993
Pine	28,874
Le Sueur	27,591
Mille Lacs	25,866
Brown	25,331
Todd	24,233
Meeker	23,110

Reporting Entities (n=74)	2016 Population
Nobles	21,848
Des Moines Valley *(Cottonwood, Jackson)*	21,414
Wabasha	21,273
Fillmore	21,003
Hubbard	20,718
Dodge	20,506
Waseca	18,911
Houston	18,814
Pennington-Red Lake	18,242
Kanabec	15,830
Roseau	15,626
Aitkin	15,583
Sibley	14,827
Renville	14,660
Wadena	13,761
Koochiching	12,628
Norman-Mahnomen	12,044
Watonwan	10,908
Lake	10,625
Marshall	9,324
Clearwater	8,827
Wilkin	6,358
Cook	5,286
Kittson	4,333
Lake of the Woods	3,814

Appendix B. 2017 Capacity Assessment Guidance

This guide provides both background information on the self-assessment, as well as detailed instructions to help you complete your assessment.

Minnesota's Local Public Health Act provides specific authorities and responsibilities to community health boards in order to protect and promote health in Minnesota. These responsibilities are organized under the six areas of public health responsibility, and are defined in statute. The purpose of this capacity assessment—via an online survey—is to illustrate the extent to which required local public health activities are in place statewide.

Stated another way, this assessment will identify gaps where the public health needs of Minnesota communities are not being fully met. We need your help in identifying these gaps, so that the upcoming SCHSAC "Strengthening Public Health in Minnesota" Workgroup can develop solutions to strengthen our statewide system. The success of this assessment depends entirely upon your participation and willingness to provide an honest, self-critical, and detailed self-assessment. Data provided in this assessment will not be used to punish or embarrass community health boards, individual local health departments, their staff, or leadership. We do not plan to share data about individual local health departments (or community health boards) with the workgroup; instead, we will share aggregate data. However, please note that this and all community health board reporting data is legally classified as public information.

This self-assessment is distinct from annual performance measure reporting (aka "PPMRS"). Survey respondents will not report their community health board's performance on a subset of national performance measures. Instead, for each area of responsibility, respondents will estimate the extent to which their organization carries out the required activities.

Survey respondents will have received prior communication informing them of the organization for whom they are reporting. For example, in a single-county or city community health board, the CHS administrator will be assigned to respond. In a multi-county community health board—where activities are not all carried out at the community health board level—a local public health director from each county in that community health board will be asked to respond.

Response Options

For each of the required activities in each area of responsibility, respondents will estimate the extent to which his/her organization carries out the required activities. For local health departments (or health and human services departments) within multi-county community health boards, you may lead or participate in the activity with others in your community health board.

Not at all: We did not carry out this activity in our jurisdiction.

If a respondent indicates that the organization does not carry out an activity in the jurisdiction, s/he is prompted to identify whether:

- *This activity was carried out by someone else and we did not participate*
- *To my knowledge, no other entity carried out this activity in our jurisdiction*

If the respondent indicates the activity was carried out by someone else, s/he is prompted to specify:

- *Another local public health department (e.g., city or county)*
- *Another local department (i.e., another part of city/county government outside of public health)*
- *A community health board*
- *The Minnesota Department of Health*
- *Another organization (outside of governmental public health system in Minnesota)*

At a low level: There were large gaps in how we carried out this activity (e.g., we were unable to meet most stated expectations; activities were provided in some communities, but not in most communities; activities were provided on a small scale; when partners or stakeholders ask us to do more related to this activity, we consistently decline; etc.).

At a moderate level: There were notable gaps in how we carried out this activity (e.g., we were unable to meet some stated expectations; activities were provided on a substantially smaller scale than desired; activities were provided in limited area(s) or with limited stakeholder engagement; etc.).

If a respondent reports that their organization doesn't carry out an activity (and neither does anyone else), and/or that the organization carries out one or more activity(s) at a low or moderate level, then the respondent is prompted to

identify up to three barriers that keep the organization from carrying out the activities in this entire area of responsibility at a higher level. Barriers options include:

- *Unable to hire qualified staff*
- *Unable to retain qualified staff*
- *Staff lack the right knowledge/skills*
- *Our action depends on the work of others*
- *Board decision*
- *Organizational/department decision*
- *No or inadequate community support*
- *No or inadequate funding source*
- *Other (explain)*

Fully: We carried out all of the minimum requirements associated with this activity.

Surpass: We carried out all of the minimum requirements more frequently than stated and/or consistently excel at this activity (i.e., have been recognized for achievements/work in this area).

If a respondent reports that the organization fully meets—or surpasses—requirements, then the respondent is prompted to select up to three assets that enable the organization to perform at this level through the entire area of responsibility. Assets listed include:

- *Staff expertise*
- *Staff tenure*
- *Board support*
- *Organizational/department priority*
- *Funding (e.g., funding is stable, flexible, ample)*
- *Leadership support*
- *Local champion(s) in the community*
- *Cross-jurisdictional sharing (i.e., working across jurisdictional boundaries to carry out activities)*
- *Other (explain)*

N/A: The circumstances during the previous 12 months did not warrant this action (e.g., the Commissioner did not issue orders that required us to take action). Note: Not all activities will have an N/A response option.

Appendix C. Required Local Public Health Activities

This document is intended to respond to requests for clarity about the mandated activities that community health boards must undertake in order to meet statutory obligations under the Local Public Health Act (Minn. Stat. § 145A).

The Local Public Health Act provides specific authorities and responsibilities to community health boards in order to protect and promote health in Minnesota. The statute defines six areas of local public health responsibility:

- Assure an Adequate Local Public Health Infrastructure
- Promote Healthy Communities and Healthy Behaviors
- Protect Against Environmental Health Hazards
- Prepare and Respond to Emergencies
- Assure Health Services
- Prevent the Spread of Communicable Diseases

This document lays out the minimum or foundational activities that are required of community health boards. These requirements are detailed for each area of public health responsibility on the following pages. These activities represent expectations that must be carried out regardless of whether or not a community health board has grant funds to support them. In addition, community health boards should conduct additional public health activities to address locally identified priorities.

This document is an update of the Essential Local Public Health Activities Framework adopted by the State Community Health Services Advisory Committee (SCHSAC) and the Minnesota Department of Health in 2005. That framework identified the essential activities that are the responsibility of every community health board in Minnesota and was intended to: define a set of public health activities on which Minnesotans can count no matter where they live; provide a consistent framework for describing local public health; and provide a basis for ongoing measurement, accountability, and improvement.

#	Measure
	Assure an Adequate Local Public Health Infrastructure Assure an adequate local public health infrastructure *"by maintaining the basic foundational capacities to a well-functioning public health system that includes data analysis and utilization; health planning; partnership development and community mobilization; policy development, analysis, and decision support; communication; and public health research, evaluation, and quality improvement."*
1.1	**Maintain a local governance structure** for public health, consistent with state statutes. At a minimum, the community health board must: ▪ Have at least five members and must elect a chair and vice-chair; ▪ Hold at least two meetings per year; ▪ Appoint, employ or contract with a CHS administrator who meets personnel requirements to act on its behalf; and ▪ Appoint, employ, or contract with a medical consultant to provide advice and direction to community health board staff.

#	Measure
1.2	At least every five years, **conduct a comprehensive assessment** of the health of the jurisdiction's population and the broad range of factors that impact health. At a minimum, the community health board must: ▪ Develop the assessment through a collaborative process that includes a range of community stakeholders who represent a variety of sectors in the jurisdiction and representatives from populations that are at higher health risk or have poorer health outcomes than the general population; ▪ Include data and information from a variety of sources; ▪ Describe the demographics of the population, health issues of the population, factors that contribute to health issues, and existing resources that can be mobilized to address them; ▪ Describe the existence and extent of health inequities and the factors that contribute to them; ▪ Share the assessment with community stakeholders and make the assessment accessible to the public; and ▪ Submit the assessment to the commissioner of health.

#	Measure
1.3	At least every five years, **develop a community health improvement plan**. At a minimum, the plan must: ▪ Be developed through a collaborative planning process that includes: ▪ A range of community stakeholders who represent a variety of sectors in the jurisdiction and representatives from populations that are at higher health risk or have poorer health outcomes than the general population; ▪ Issues and community assets identified by the community and stakeholders; and ▪ A process to set health priorities. ▪ Be informed by the data and information from the community health assessment; ▪ Include community health priorities, measurable objectives, improvement strategies, and activities with time-framed targets; ▪ Include consideration of health inequities and the factors that contribute to them; ▪ Include policy changes needed to accomplish objectives; ▪ Designate individuals and organizations responsible for implementing strategies; ▪ Consider relevant state and national health improvement priorities; and ▪ Be submitted to the commissioner of health.
1.4	**Implement, monitor, and revise** (as needed) the strategies in the community health improvement plan. At a minimum, the community health board must: ▪ Track actions taken; ▪ Assess the feasibility and effectiveness of the strategies no less than annually; ▪ Make revisions with community stakeholders; and ▪ Produce an annual report of progress and make it available to the public.

#	Measure
1.5	**Seek resources for community health issues** based on data and/or community priorities. At a minimum, the community health board must: ▪ Consider the income and expenditures required to meet local public health priorities and statewide outcomes in levying taxes; and ▪ Provide at least a 75 percent match for the State funds received through the Local Public Health Act grant. Eligible match funds include local property taxes, third party reimbursements, fees, other local funds, donations and non-federal grants.
1.6	**Maintain a performance management system** to monitor achievement of organizational objectives and apply quality improvement tools and methods. At a minimum the community health board must: ▪ Set organizational objectives and strategies at all levels of the community health board; ▪ Measure, monitor, analyze, and share progress towards achieving objectives; and ▪ Use data to identify and address performance gaps.
1.7	**Develop and maintain a competent workforce** to carry out the required activities in each of the six areas of public health responsibility. This includes recruitment, retention, succession planning, and staff development. At a minimum, the community health board must: ▪ Consider necessary public health competencies such as the nationally adopted Core Competencies for Public Health Professionals; and ▪ Recruit a workforce that reflects the demographics (e.g., race, ethnicity, language, etc.) of the jurisdiction.

#	Measure
1.8	Annually **report to the commissioner** on a set of performance measures, be prepared to provide documentation of ability to meet the performance measures, and comply with accountability requirements outlined each year.
	Promote Healthy Communities and Healthy Behavior Promote healthy communities and healthy behavior *"through activities that improve health in a population, such as investing in healthy families; engaging communities to change policies, systems, or environments to promote positive health or prevent adverse health; providing information and education about healthy communities or population health status; and addressing issues of health equity, health disparities, and the social determinants to health."*
1.1	**Maintain an awareness of emerging issues and data trends** in the jurisdiction related healthy communities and healthy behaviors. At a minimum, the community health board must monitor each of the following for the overall population and sub-populations within the jurisdiction: ▪ Leading causes of death and disability; ▪ Disease rates; ▪ Birth outcomes; ▪ Health behaviors; and ▪ Factors that impact health such as income, education, and employment.
1.2	At least annually, **inform policy makers and other stakeholders of emerging issues and data trends** in the jurisdiction (including health inequities), and potential policies or strategies that promote positive health or prevent adverse health.

#	Measure
1.3	**Identify and address factors that contribute to health inequities**. At a minimum the community health board must: ▪ Use data and input from the community to identify health inequities and the factors that contribute to them; ▪ Engage with the populations experiencing health inequities to develop and implement strategies; and ▪ Participate in cross-sector efforts to address the community conditions that contribute to health inequities.
1.4	**Implement population-based health promotion strategies** based on community needs and priorities. At a minimum, the community health board must: ▪ Engage with population(s) most affected by the health issue(s) to develop and implement the strategy/s; ▪ Implement evidence-based strategies or in cases where an evidence-base does not exist use promising or emerging practices; ▪ Implement strategies that focus on social and environmental factors that influence health and health behaviors; and ▪ Implement strategies in collaboration with stakeholders, partners, and the community.
1.5	**Contribute to local discussions concerning public policy and its impact on health** at least one time per year. This may include providing informational materials (fact sheets and data), public testimony, and/or participation in advisory or work groups tasked with providing advice or influencing policies that impact health.

#	Measure
	Protect Against Environmental Health Hazards Protect against environmental health hazards *"by addressing aspects of the environment that pose risks to human health, such as monitoring air and water quality; developing policies and programs to reduce exposure to environmental health risks and promote healthy environments; and identifying and mitigating environmental risks such as food and waterborne diseases, radiation, occupational health hazards, and public health nuisances."*
1.1	**Include environmental health in the community health board's comprehensive community health assessment** at least once every five years. At a minimum, the community health board must look at the impact of air quality, water quality, the built environment, and food safety on the health of the jurisdiction's population.
1.2	**Monitor significant and emerging environmental threats to human health** in the jurisdiction. At a minimum, the community health board must maintain an awareness of the following, regardless the community health board's role in providing environmental health programs: ▪ Blood lead surveillance data; ▪ Food-, water-, and vector-borne illness data; ▪ Safety of food, pools, and lodging establishments; ▪ Safety of drinking water sources and systems; ▪ Air quality alerts; and ▪ Extreme heat or cold events.
1.3	Work with partners and stakeholders to **identify and implement strategies to address environmental threats to human health** as needed.

#	Measure
1.4	At least annually, **inform policy makers of the environmental threats to human health** in the jurisdiction, the prevention activities already taking place, and additional strategies for mitigating those threats. This may be done in coordination with others but must address human health.
1.5	Coordinate with others to **provide the public with information on how to protect their health** from or reduce exposure to environmental threats that pose a risk to human health as needed.
1.6	**Support implementation of state and local laws, regulations, and guidelines** that seek to protect the public's health from environmental health risks.
1.7	**Comply with state statutes for removal and abatement of public health nuisances** (Minn. Stat. § 145A.04, subd. 8).
1.8	**Follow the Childhood Blood Lead Case Management Guidelines for Minnesota**.
1.9	**Maintain relationships and regular communication** with federal, state, tribal, and local agencies with regulatory authority and/or provide environmental health services in the jurisdiction.
Prepare and Respond to Emergencies Prepare and respond to emergencies *"by engaging in activities that prepare public health departments to respond to events and incidents and assist communities in recovery, such as providing leadership for public health preparedness activities with a community; developing, exercising, and periodically reviewing response plans for public health threats; and developing and maintaining a system of public health workforce readiness, deployment, and response."*	

#	Measure
1.1	**Conduct or participate in assessments** to identify jurisdictional risks and their impact on the public's health at least every five years. Assessments must be done in conjunction with key stakeholders such as emergency management and healthcare coalitions.
1.2	**Develop, exercise, and maintain preparedness and response strategies and plans** to address public health needs during all types of disasters and emergencies. At a minimum, the community health board must: ▪ Participate in jurisdiction's response planning and ensure public health is in the jurisdiction's all-hazards plan; ▪ Include access and functional needs of at-risk individuals in plans; ▪ Maintain public health preparedness plans according to the Center for Disease Control's public health preparedness guidance as it pertains to the community health board's role and responsibilities in the jurisdiction; ▪ Exercise components of response plans with key stakeholders such as emergency management and healthcare coalitions at least twice per year; ▪ Coordinate plans and exercises with healthcare coalitions; and ▪ Maintain a local continuity of operations plan.

#	Measure
1.3	**Respond and support recovery efforts** in incidents with an impact to the public's health. In the case of an incident, the community health board must: ▪ Activate public health emergency response personnel; ▪ Coordinate with federal, state, and county emergency managers and other community partners active in the response; ▪ Operate within, and as necessary lead, the jurisdiction's incident command system; ▪ Provide efficient and appropriate situation assessment, determine objectives for the health needs of those affected (including access and functional needs of at-risk individuals), allocate resources to address those needs, and return to routine operations; ▪ Develop short- and long-term public health goals for recovery operations; and ▪ Activate plans for mass prophylaxis as indicated by the Commissioner of Health (Minn. Stat. § 144.4197, § 144.4198).
1.4	**Develop and maintain a system of public health workforce readiness, deployment, and response**. The community health board must: ▪ Follow FEMA's National Incident Management System (NIMS) for preparedness training; ▪ Have notification procedures and activation structure for staff and volunteers; and ▪ Test call-down of staff at least once per year.

#	Measure
1.5	**Provide timely, accurate, and appropriate information** to elected officials, the public, the media, and community partners in the event of a public health emergency. At a minimum, the community health board must: ▪ Coordinate with state, local, and tribal partners to ensure unified messaging; ▪ Provide information to the public in a variety of languages as determined by local need; ▪ Follow the Health Alert Network (HAN) operational guidelines from MDH; and ▪ Provide the community with information about how to protect their health.
1.6	**Enforce emergency health orders** as directed by the Commissioner of Health or as needed.
1.7	**Establish and maintain relationships and regular communication** with state and local emergency management, tribal governments, healthcare coalitions, community partners, and state agencies.
Assure Health Services	
Assure health services *"by engaging in activities such as assessing the availability of health-related services and healthcare providers in local communities; identifying gaps and barriers in services; convening community partners to improve community health systems; and providing services identified as priorities by the local assessment and planning process."*	

#	Measure
1.1	**Lead or participate in a collaborative process to assess the availability of health care services** at least once every five years. At a minimum, the community health board must: ▪ Collaborate with the healthcare system and other stakeholders; ▪ Identify barriers to healthcare services and populations that experience them; ▪ Identify gaps in service and populations that experience them; and ▪ Consider emerging issues that may impact access to care (e.g. changes in healthcare system structure or healthcare reimbursement).
1.2	**Inform policy makers and other stakeholders** about gaps in the availability of health care services and potential strategies for addressing the identified gaps.
1.3	**Lead or participate in collaborative efforts to identify and implement strategies to increase access to health care services**.
Prevent the Spread of Communicable Diseases Prevent the spread of communicable diseases *"by preventing diseases that are caused by infectious agents through detecting acute infectious diseases, ensuring the reporting of infectious diseases, preventing the transmission of infectious diseases, and implementing control measures during infectious disease outbreaks."* Requirements for this area have been developed through SCHSAC and outlined in the Disease Prevention and Control Common Activities Framework since 1999. The Common Activities Framework was last updated in July 2015; the next update is planned for 2018.	
Disease Surveillance/Data Collection	

#	Measure
1.1	Promote provider compliance of infectious disease reporting pursuant to Minn. Rule 4605. ▪ Disseminate guidelines to local providers (e.g., vaccine schedules and recommendations; sexually transmitted diseases (STD)/HIV prevention, testing, and treatment including perinatal; tuberculosis (TB) prevention, diagnosis, and treatment; food- and waterborne illness).
1.2	Share surveillance data with providers at least annually. ▪ Review surveillance data with staff. ▪ Identify any local barriers to the reporting process; and ▪ Assess LPH/CHB program effectiveness. ▪ May also share data with other interested parties (e.g., community health board, health advisory board, local legislators)
1.3	Assess immunization coverage levels: ▪ Assess immunization levels in public health clinics, if appropriate, and encourage and support private clinic assessment using the Minnesota Immunization Information Connection (MIIC); and ▪ Share state and local immunization reports with schools, policy makers, providers, regional coordinators, and others such as daycare providers. ▪ Assess gaps and barriers to age-appropriate immunizations as warranted by local immunization coverage data
1.4	Assess adherence to immunization practice standards (i.e., Advisory Committee on Immunization Practices recommended schedules) and provide consultation, as needed.
1.5	Assess health needs of the population living in the LPH/CHB jurisdiction related to infectious diseases.
1.6	Review current DP&C literature related to incidence of disease, barriers to health care and other needs of the public and disenfranchised from the health care delivery system.

#	Measure
1.7	Collaborate on special studies, as warranted, to better understand epidemiology of infectious diseases. ▪ Identify and/or recruit surveillance sites upon request.
1.8	Review the environmental health program activities related to food- and waterborne diseases and other infectious diseases with environmental etiology. Communicate surveillance data to MDH.
Disease Prevention	
1.9	Maintain current MDH and Centers for Disease Control and Prevention (CDC) infectious disease recommendations and protocols. ▪ Develop policies and plans (e.g. All-Hazards, Pandemic) to assure capacity to respond to cases of infectious disease (Minn. Rule 4605). ▪ Disseminate guidelines to local providers
1.10	Develop and implement screening and referral strategies for high-risk groups when indicated and clinically appropriate.
1.11	Assure vaccines for immunizations are available, viable, and properly administered. Establish and manage public immunization clinics, as needed, based on population-based assessment data. Follow best practice vaccine management standards. ▪ Participate in annual Immunization Practices Improvement (IPI) Advisor training. ▪ Perform Minnesota Vaccines for Children (MnVFC) site visits with MnVFC providers.

#	Measure
1.12	Maintain and provide consumer education information based on community needs to the public and: ▪ Develop local community education programs; ▪ Maintain current lists of local providers and resources for people infected with STD/HIV; and ▪ Develop a communication plan for infectious disease issues ▪ Maintain ability receive and forward health alert information to local health care providers and others, as needed.
1.13	Collaborate regionally on infectious disease prevention efforts: ▪ Identify staff that need training; ▪ LPH/CHB agencies in a region will exchange information on infectious disease prevention and control activities on a regular basis; ▪ Maintain contact with regional and state MIIC registry contacts; and ▪ Assure immunization responsibilities are maintained.
1.14	Follow the Health Alert Network (HAN) operational guidelines from MDH, including to: ▪ Receive and promptly acknowledge any Health Alert Network message sent by MDH. ▪ Review MDH HAN messages in a timely way, adding additional information of local relevance as appropriate, and forwarding the message to local HAN recipients. ▪ Serve as an information resource to local HAN recipients in response to HAN messages. ▪ Assure the capacity to initiate a HAN
Disease Control	
1.15	Assist and/or conduct investigations on infectious diseases in collaboration with the MDH and/or refer information related to cases and suspect cases to the MDH.

#	Measure
1.16	In outbreak situations conduct mass or targeted immunization clinics, arranging for staffing, training, emergency supplies, and other logistical needs.
1.17	Proactively implement local disease control programs, as indicated, from local surveillance data and trends. These programs should then be part of the Framework and included as part of the LPH/CHB Plan.
1.18	LPH/CHB agencies will work with the local emergency management agency and others to develop and maintain a local Emergency Management Plan.
1.19	Maintain provisions for 24/7 emergency access to epidemiological and environmental public health resources capable of providing rapid detection, investigation, and containment/mitigation of public health problems and environmental public health hazards.
Tuberculosis	
1.20	Designate staff within the LPH/CHB agency to perform TB control responsibilities.
1.21	Assess health needs of populations living in the LPH/CHB jurisdiction: ▪ Assure that immigrants and refugees with overseas chest x-ray findings consistent with possible active TB (i.e., TB Class B1 conditions) receive medical evaluation and follow-up, as needed, after arrival in the LPH/CHB jurisdiction. Report results of evaluations to MDH.
1.22	Assure 100% of persons with TB disease in LPH/CHB jurisdiction complete TB treatment by providing nurse case management and directly observed therapy (DOT) or other treatment supervision according to CDC/MDH standards. ▪ Assure that infectious TB patients residing in the LPH/CHB jurisdiction adhere to appropriate infection control precautions. Notify MDH of individuals who will not adhere to precautions. ▪ Notify MDH or LPH/CHB agency of patients who are non-adherent to TB treatment. ▪ Notify MDH and refer treatment supervision and case management to another state or county if patient leaves jurisdiction before treatment is completed.
1.23	Conduct contact investigations on infectious TB patients in the LPH/CHB jurisdiction and report results to MDH. Notify other jurisdictions of contacts residing in those jurisdictions (i.e., Minnesota counties). Evaluate and follow-up on contacts to cases that occur in other jurisdictions and who reside in the LPH/CHB jurisdiction and report results to those jurisdictions.
Designate Staff Roles for All DP&C Activities	
1.24	Each local public health agency will assign a staff person(s) the responsibility of assuring that all infectious disease surveillance, prevention, and control activities as stated in the DP&C Common Activities Framework, and pursuant to Minn. Stat. § 145A, are being performed. The DP&C Coordinator role will assure: ▪ Surveillance activities, and ▪ Response to Infectious Disease, and ▪ Maintain their contact information in the Workspace.

#	Measure
1.25	Assure local staff is responsible for disease surveillance activities. Staff will: ▪ Enter contact information into Workspace ▪ Submit electronic reporting including the Minnesota Electronic Disease Surveillance System (MEDSS); ▪ Maintain current lists of all providers within jurisdiction; ▪ Assure reporting rules, report cards and MDH toll free reporting phone number (1-877-676-5414) are available to all medical clinics and laboratories, and hospitals; ▪ Respond to inquiries from reporting sources; and ▪ Forward any reports of cases or suspect cases to MDH.

#	Measure
1.26	Designate staff within the local public health (LPH)/CHB agency to assure infectious disease responsibilities for: ▪ TB ▪ STD/HIV ▪ Vaccine-preventable disease surveillance ▪ Refugee health ▪ Flu ▪ IPI visits ▪ Foodborne/vector borne diseases ▪ Perinatal Hepatitis B ▪ Other diseases as deemed necessary by MDH and LPH/CHB

Appendix D. SCHSAC Strengthening Public Health in Minnesota Workgroup

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 the 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, Minnesota community health boards struggle with persistent resource constraints that prevent effective responses to current public health threats and challenges. There is also 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 our system's practitioners: 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 many pressing, near-term issues and the mandated services counties must prioritize.

The commissioner of health does have the authority to withhold funding if community health boards are not performing, and to assume responsibility for public health activities in the local jurisdiction. However, both MDH and local public health practitioners believe they should consider other solutions.

To date, public health practitioners have primarily discussed concerns and potential solutions, through SCHSAC workgroups, Local Public Health Association committees, 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.

During three meetings between October 2017 and January 2018, this 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

For more information, visit: SCHSAC Strengthening Public Health in Minnesota Workgroup.