CITY OF MINNEAPOLIS,

HENNEPIN COUNTY

STATE OF MINNESOTA

Public Health Advisory Committee Member Orientation Manual

Minneapolis Health Department

250 S 4th Street - Suite 510 • Minneapolis, MN 55415 • 612-673-2301

PHAC Orientation Manual
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RESOLUTION OF THE CITY OF MINNEAPOLIS

Reestablishing the role and composition of the Public Health Advisory Committee
Approved by Council on May 14, 2010 (*updates noted Feb. 19, 2014*)

Whereas, the Public Health Advisory Committee, a standing advisory committee to the *Minneapolis Health Department* and the Minneapolis City Council, has been in existence through resolution since 1976 in accordance with the provisions of the Community Health Services Act (Minn. Laws 1976, Ch. 9); and

Whereas, changes to the public health system at the state and local levels necessitate that the responsibilities and composition of the Public Health Advisory Committee be updated to allow the committee to most effectively serve the City of Minneapolis;

Whereas, the City Council values the efforts of the Public Health Advisory Committee to provide public health related advice which is representative of and takes into account the viewpoints, concerns and interests of the diverse Minneapolis community;

Whereas, the City of Minneapolis finds the continued existence of the Public Health Advisory Committee benefits the citizens of the City;

Now, Therefore, Be It Resolved by the City Council of the City of Minneapolis:

That the Public Health Advisory Committee (PHAC) for the *Minneapolis Health Department* has the following responsibilities and composition:

A. **Role of the PHAC**

The role of the PHAC is to advise the City Council and the Department on policy matters affecting the health of Minneapolis residents, and to serve as liaisons between the City and the community in addressing health concerns. In this role PHAC shall make every effort to ensure that the concerns represented reflect the diverse viewpoints and interests of the Minneapolis community.

B. ***Committee* Functions**

The PHAC has responsibility for the following functions:

1. To advise the City Council regarding: a) policy matters affecting health of Minneapolis residents, and b) general roles and functions of the *Minneapolis Health Department*;

2. To review the proposed priorities of the *Minneapolis Health Department* and make recommendations to the City Council;

3. To consider complaints and views expressed by residents affecting delivery of public health services in Minneapolis, forward those concerns, and make recommendations as necessary to the City Council and/or the *Minneapolis Health Department*.

C. ***Committee*** **Composition**

The composition shall reflect the diverse interests and perspectives of the Minneapolis community. It is the expectation that all parties responsible for the recruitment, recommendations to and approval of members shall make every effort to ensure this diversity.

The PHAC will have up to twenty-two (22) members composed of fourteen (14) Resident Members, up to six (6) Other Representative Members. *Two (2) ex-officio non-voting representatives may join the committee as needed.* Members will not be compensated for service on the PHAC.

1. **Resident Member appointments**

   The fourteen (14) Resident Members will be selected by having each of the thirteen (13) City Council Members appoint one (1) Residential Member who lives or works in their respective wards; one (1) Residential Member who lives or works in the City of Minneapolis shall be appointed by the Mayor. These Resident Member appointments and terms are subject to Minneapolis Code of Ordinances Title 2 Chapter 14.180. No public hearing is required for Resident Member appointments.

2. **Representative Member appointments**

   a. The 6 Representative Members will be appointed by the City Council by requesting the following organizations to submit one (1) nominee representing their interests:

      - The Minneapolis Public Schools – Health Services;
      - Hennepin County Human Services and Public Health
      - The University of Minnesota-School of Public Health

   b. The PHAC shall recommend up to three (3) at large nominees to the City Council for appointment.

   c. In addition, two (2) representatives from the Minneapolis Health and Human Services Leadership Group: one (1) from the Urban Health Professional Advisory Committee and one (1) from the Urban Health Agenda Community Advisory Committee, shall serve in an ex-officio non-voting capacity *as the need arises.*

   The other Representative Member appointments pursuant to this subsection C.2. shall not be made pursuant to the open appointments process of Minneapolis Code of Ordinances Title 2 Chapter 14.180 and no public hearing is required for these appointments.

D. ***Committee Structure*, Terms, and Meeting Frequency**

1. *Member terms are two years in length; no member will serve more than three consecutive terms. To maintain continuity of membership, approximately half the terms expire each year.*

2. *Anniversary dates are recognized as January 1st, regardless of actual appointment date.*

3. The PHAC will elect a chairperson and vice-chairperson or co-chairs.

4. The PHAC shall establish its own operating rules and procedures and meeting schedule, provided that it meets at least six times each year to conduct its business.

    a. *The current structure includes three sub-committees: Policy & Planning, Communications / Operations, and Collaboration & Engagement. Members choose one sub-committee on which to participate based on their interest, skill set, or experience.*
    b. *Meetings rotate on a monthly basis and are held the fourth Tuesday of each month in City Hall.*

5. Eight (8) members shall constitute a quorum.

E. ***Member Duties***

1. *Members are expected to attend and actively participate in all regularly scheduled meetings. Three unexcused absences may result in termination of membership.*
2. *Members are expected to participate in one sub-committee to carry out the work and functions of the committee as previously listed.*
3. *Members may be asked to review, discuss, modify, and decide upon staff-prepared documents or engage in the original preparation of documents.*
4. *In addition to meetings, members should spend some time reading and reviewing committee materials; connect with City Council members regarding PHAC business or neighborhood concerns; and, be responsive to constituent concerns regarding public health.*

F. **Relationship between the PHAC, City Council, and *Minneapolis Health Department***

(1) The City Council is the Board of Health and makes final decisions regarding policy and programs of the *Minneapolis Health Department*. The City Council's health-related Committee shall review and decide upon *Minneapolis Health Department* matters prior to final action by the City Council.

(2) PHAC members are expected to communicate regularly with their respective appointing authority.

(3) The PHAC is an advisory committee to the City Council and the *Minneapolis Health Department*.

(4) The *Minneapolis Health Department* is responsible for providing staff assistance to the PHAC to carry out its advisory functions.

(5) It is expected that the *Minneapolis Health Department* will give significant weight to the recommendations of PHAC. On those occasions when the Department cannot incorporate these recommendations into its policy and program operations, the Commissioner will provide explanation.

(6) The *Minneapolis Health Department* staff will present department business to the health-related Committee. Such staff presentations shall include an explanation of how such activities fit within the framework of the priorities as approved by the PHAC.

(7) While primary responsibility for presenting PHAC views rests with the *Minneapolis Health Department* staff, the PHAC may elect to designate its members to directly explain PHAC views to the health-related Committee.

Committee records including past minutes, agendas, meeting materials, and annual reports may be found on the Minneapolis Health Department website: **http://www.minneapolismn.gov/health/phac/index.htm**

Minneapolis Health Department
250 South 4th Street, Room 510
Minneapolis, MN 55415
612-673-2301

Minneapolis
Health Department

If you need this material in an alternative format please call the Minneapolis Health Department at (612) 673-2301 or email health@minneapolismn.gov.
Deaf and hard-of-hearing persons may use a relay service to call 311 agents at (612) 673-3000.
TTY users may call (612) 673-2157 or (612) 673-2626.

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Sub Committee Structure of the PHAC

In order to better fulfill our mission and meet the needs of member representatives, the Minneapolis Public Health Advisory Committee (PHAC) will develop three on-going sub-committees. Each PHAC member will serve on at least one sub-committee.

These committees meet a minimum of every other month alternating their meeting schedule with that of full PHAC meetings. For example, the full committee meets in January and sub-committees meet in February. The full committee meets in March where each sub-committee reports on work they completed or topics they learned about during their meeting. The sub-committees may or may not meet at City Hall. These choices are made depending on the priorities and work plan of the sub-committee.

Each committee member is asked to rank their interest in serving on the three sub-committees, with 1 being the sub-committee most preferred and 3 being the sub-committee least preferred. We use these rankings to determine membership for the PHAC sub-committees.

Sub-committee Choices:

Ranking #_____ ***Collaboration & Engagement:*** *engage 2-3 community-based or neighborhood organizations, or culturally-based health networks; close communication circle between department, PHAC & these groups; work with other sub-committees to increase community engagement.*

Ranking #_____ ***Operations / Communications:*** *coordinate internal & external communications, examine committee functions, recruit to fill open/at large seats, work with other sub- committees to increase visibility and communication, streamline operations and increase participation.*

Ranking #_____ ***Policy & Planning:*** *set agenda for Quarterly planning and annual work plan, synthesize info from PHAC meetings into committee action, and flesh out details of policies and recommendations as issues brought to or initiated by the PHAC.*

Each committee member is asked to consider a leadership role on one of the sub-committees:

_____I am willing to take a leadership role and serve as the chair or co-chair for a sub-committee(s).
_____Not as this time
_____Would consider for the future

Each member understands that a leadership role may include: facilitating agenda setting, running sub-committee meetings, tracking sub-committee member attendance, actively engaging other members for note taking at meetings and conducting extra research, reporting back to the larger PHAC committee, and various other duties.

(Place an X on the line above the committee(s) you are willing to lead; more than one sub-committee may be checked based on your interests.)

_____	_____	_____
Collaboration & Engagement	Operations	Policy & Planning

PHAC Member Signature: _____

City of Minneapolis Public Health Advisory Committee

Ethics Education Requirements

Public Health Advisory Committee and other City Boards who are appointed or designated by either the Mayor or the City Council are considered "local officials," and therefore required to complete the **ethics education requirements**.

As a member of the PHAC, please review these requirements and complete this on-line training. The City has developed a new computerized version of the ethics training which you can access at any time through the following link: http://mpls-ethics.appspot.com/

On-line training takes about 40 minutes to complete. At the end, you will be linked to a "training completion certificate" and email. Save a copy of your certificate of completion for your records.

We ask that you also provide a copy to MHD's Don Moody at Don.Moody@minneapolismn.gov.

Thank you for your public service!!!

City of Minneapolis Public Health Advisory Committee

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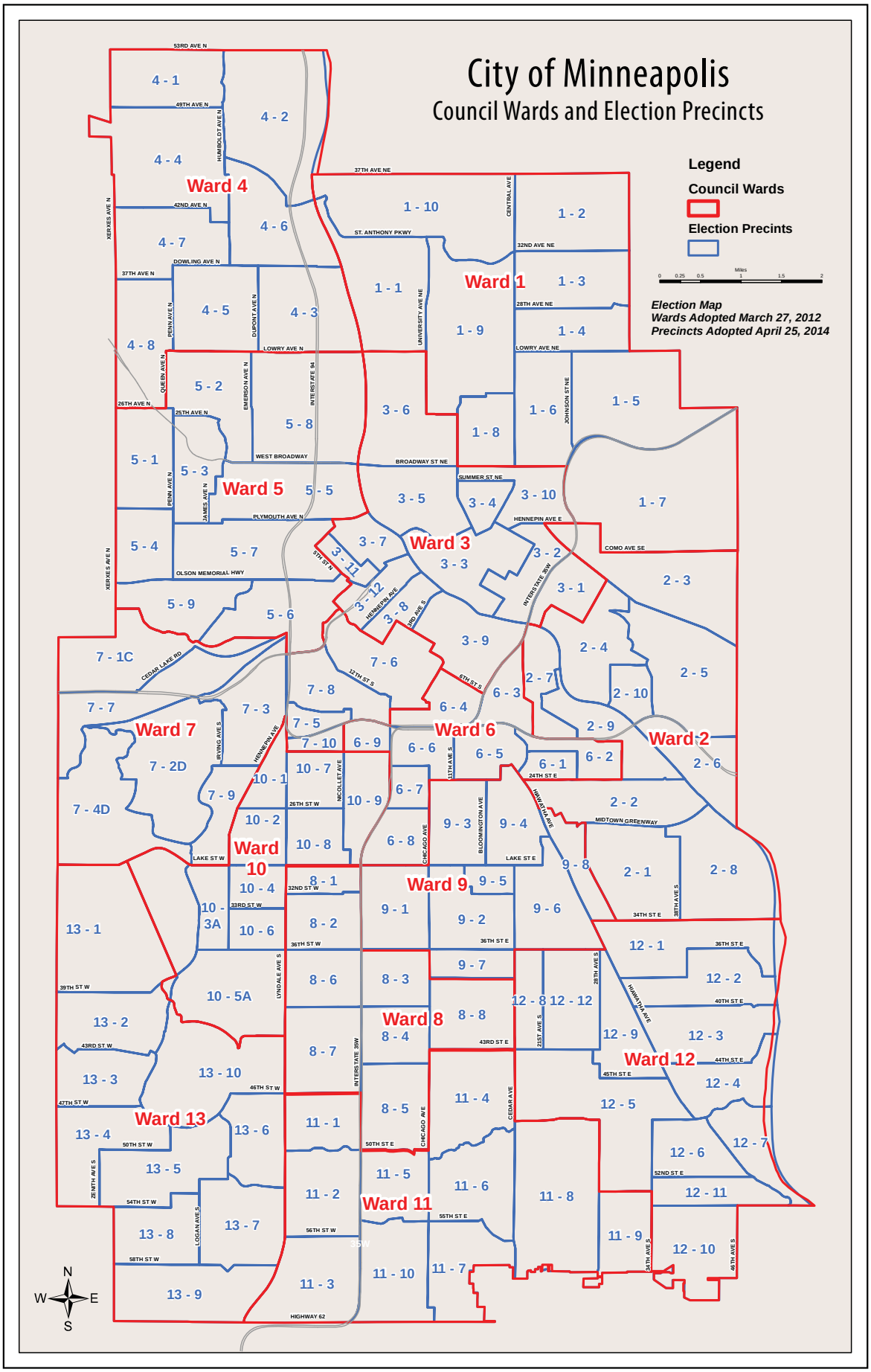
Thank you for your public service!!!

Minneapolis
Health Department

PHAC Membership as of 06/24/2016

Ward	Seat	Committee Member	Public contact info
1	Kevin Reich	***Vacant at this time***	
2	Cam Gordon	**Laurel NIghtingale**	lpnightin@gmail.com
3	Jacob Frey	**Conrad Zbikowski**	Conrad@progress.mn
4	Barbara Johnson	**Akisha Everett**	akisha@neighborhoodhub.org
5	Blong Vang	**Jahana Berry**	ladimedic@gmail.com
6	Abdi Warsame	**Happy Reynolds-Cook**	happy.reynoldsmd@gmail.com
7	Lisa Goodman	**Karen Soderberg****	Phone: 612-710-1470
8	Elizabeth Glidden	***Vacant at this time***	
9	Alondra Cano	**Sarah Jane Keaveny**	keaveny55407@gmail.com
10	Lisa Bender	**Margaret (Peggy) Reinhardt**	peggy55408@gmail.com
11	John Quincy	**Birdie Cunningham**	cunn5603@stthomas.edu
12	Andrew Johnson	**Autumn Chmielewski**	autumn@accessphilanthropy.com
13	Linea Palmisano	**Kathy Tuzinski**	ktuzinski@gmail.com
	Mayor's Representative	**Silvia Perez**	spthalia1103@gmail.comm
	Minneapolis Public Schools	**Cindy Hillyer**	cynthia.hillyer@mpls.k12.mn.us
	Henn. Co. Human Services & Public Health Dept.	**Jane Auger**	jane.auger@hennepin.us
	U of M-School of Public Health	**Dr. Craig Hedberg**	hedbe005@umn.edu
	Member at Large	**Yolonda Adams-Lee**	Phone: 612-486-2329
	Member at Large	**Joseph Desenclos**	Joseph.desenclos@gmail.com
	Member at Large	**Joseph Colianni**	joey@colianni.net
	Urban Health Professional Advisory Committee	**Revolving, as needed**	
	Urban Health Agenda Community Advisory Committee Representative	**Revolving, as needed**	

**indicates co-chair
*indicates sub-committee leader



Minneapolis
City of Lakes

Communities

Neighborhoods

City of Minneapolis

Neighborhoods & Communities

Created July 3, 2008

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GIS Business Services

Minneapolis
City of Lakes

Public Health Advisory Committee

2015 Annual Report

May 2016

Health Department

Executive Summary

The Public Health Advisory Committee (PHAC) is comprised of twenty citizens representing each ward, the Mayor's office, the University of Minnesota School of Public Health, Minneapolis Public Schools, and Hennepin County Public Health, with three members at large. The committee examines current and emerging public health issues, and advises the City Council and the Minneapolis Health Department on policy matters affecting the health of Minneapolis residents. PHAC members also serve as liaisons between the City and the community in addressing health concerns. Monthly meetings alternate between the full committee and three established sub-committees: Policy & Planning, Communications & Operations, and Community Engagement.

During 2015, the PHAC reviewed and discussed the following public health issues:

- Structural and cultural supports and barriers for breastfeeding
- Adverse Childhood Experiences
- Healthy Neighborhoods
- Homelessness and housing
- Access to flavored and e-cig tobacco products
- Air Quality at the neighborhood level
- Healthy Sleep
- Paid Sick Leave

In 2015, the PHAC made recommendations regarding the following:

- Submitted a response letter for the draft Cradle to K plan
- Engaged CMs Bender and Gordon and staff from CPED, Regulatory Services, and Health regarding the establishment of a citizen advisory committee on housing
- Provided public testimony supporting changes in the tobacco sales ordinance to reduce access to flavored tobacco and tobacco products for those under age 18
- Submitted a letter of support to the Workplace Partnership group on Paid Sick Leave for Minneapolis employees

The PHAC endeavors to examine health concerns brought forward by residents, staff, and council members. Committee members continue to review potential action/recommendations regarding homelessness and housing, Adverse Childhood Experiences, insufficient sleep, supports and barriers for breastfeeding, and paid sick leave. Future topics will incorporate issues of mental health, health disparities and health equity, substance abuse, sex trafficking and its link to major sports events, access to healthy foods, youth violence prevention, and the community engagement phase of the Minneapolis climate change vulnerability assessment.

Details about the 2015 public health issues examined plus the PHAC actions and recommendations are described in the following pages.

2015 Annual Report of the Public Health Advisory Committee

The Public Health Advisory Committee (PHAC) sets priorities by aligning committee discussions, actions, and efforts with the goals of the Minneapolis Health Department and City of Minneapolis. These priorities give direction to agenda planning as the Committee considers its topics of learning, speakers and guests, and committee actions.

Priority #1: A Healthy Start to Life & Learning

Breastfeeding rates, supports and challenges within Minneapolis Cultural Communities

The PHAC commissioned a Master's student qualitative research project which concluded in 2015 with a formal report. The goals of this study were to understand from the perspectives of health workers the perceived practices, protective factors and barriers for breastfeeding in the African American, American Indian, Hispanic and Latino, Hmong, and Somali communities. The research also sought to generate ideas for how the City of Minneapolis can create more supportive breastfeeding environments.

Learning:

- Jennie Meinz, University of Minnesota-Master of Public Health candidate presented her findings on **Structural and Cultural Supports and Barriers for Breastfeeding in Minneapolis Cultural Communities** in September 2015. Her report included several recommendations and identified potential next steps.

Actions:

- The report was presented to the PHAC, Allina system-wide breastfeeding committee, Hennepin County Breastfeeding Coalition, Hennepin County WIC All Staff meeting, and to Minneapolis Health Department staff and community partners.

Recommendations:

- Participants' key recommendations included:
    - Launch a public awareness campaign to normalize breastfeeding
    - Identify and recognize breastfeeding friendly organizations / employers / facilities
    - Create and increase obvious places to breastfeed and spaces for public lactation
    - Make lactation services more culturally specific and available on-site and in-home
    - Enhance support for peer-to-peer programs through community health workers
    - Improve coordination of breastfeeding resources

Cradle to K report

With the release of the Mayor's Cradle to K draft plan, the PHAC saw an opportunity to respond. The Cradle to K initiative aligned with some of the PHAC priorities and Health Department goals. The Policy & Planning sub-committee reviewed the report and prepared a formal response which was then approved by the committee.

Actions:

- Submitted a formal response to the Cradle to K Cabinet with specific recommendations on:
    - greater use of metrics for each goal / strategy
    - clearer link between the goals and key indicators
    - consistency in the format and specificity in the recommendations
    - acknowledging the fact that (at release date) funding sources were as yet unidentified
- Committee members attended the Mayor's listening sessions to provide input

Adverse Childhood Experiences

The Adverse Childhood Experiences (ACE) Study confirmed, with scientific evidence, that adversity early in life (prior to age 18) increases physical, mental and behavioral problems later in life. The ACE Study discovered: how multiple forms of childhood adversity can affect many important public health problems; that ACEs are common; and, where one ACE occurs there are usually others. In addition, it is possible to knock down ACE scores and although it may not be possible to get to a score of zero, everyone can contribute to preventing the accumulation of ACEs.

ACEs are measured by asking participants to complete a simple questionnaire which covers three main areas: household dysfunction, neglect, and abuse. Scores in each category are added together to get a cumulative ACE score. ACE scores reliably predict challenges during the life course and are highly interrelated. As ACE scores increase, so does the percentage of health problems one person may experience. An ACE score of 5 or more can reduce one's life by as much as 20 years.

The 2013 Minnesota Student Survey added questions about seven kinds of ACEs to explore their possible impacts of these experiences among young people.

Learning:

- **Understanding Adverse Childhood Experiences - Building Self-Healing Communities** - Dr. Mark Sander, Senior Clinical Psychologist-Hennepin County; Mental Health Coordinator-Hennepin County and Minneapolis Public Schools Student Support Services.

Actions:

- PHAC members completed the simple questionnaire used by ACE participants. Results showed how common ACEs are regardless of demographics, education, income, and upbringing. This exercise helped members empathize with the trauma many people experience and its impact on their health status.
- The PHAC recognizes that ACEs and other factors significantly impact mental health and well-being. Additional follow up to this presentation is under consideration.

Priority #2: A Healthy Place to Live

Healthy Neighborhoods, Housing, Homelessness

The committee delved into learning about healthy neighborhoods, the complexities of housing disparities, segregation and the concentration of poverty, and homelessness. Key presentations listed below approached housing and homelessness from different perspectives:

Learning:

- **Healthy Communities Transformation Initiative and the Healthy Communities Assessment Tool** (HCAT) – Charlene Muzyka, Sr. Public Health Researcher and Epidemiologist. The Minneapolis Health Department is participated in a three year pilot project on Healthy Communities Transformation. Minneapolis was one of five pilot cities that tested a neighborhood level index for HUD. The HCAT on line tool provides information about the physical, social and economic conditions of community health in Minneapolis by measuring 41 health indicators at the neighborhood level.

- **Heading Home Hennepin – Homelessness in Hennepin County** - Mikkel Beckman, Director Mpls/Hennepin County Office to End Homelessness
  Key messages from this presentation include:
    Housing is ***the*** essential platform by which we accomplish everything else in our lives
    Housing impacts every outcome we can measure
    Nothing positive comes from NOT having a home
    Occupancy in homeless shelters is tight
    Homelessness affects families, singles, youth (especially LGBTQ youth)
  Solutions include:
    Increase available units of truly affordable housing
    Increase personal income and wages for those below the median income
    Change the discussion to 'stable housing' because that is the goal for both consumer *and* developer

Actions:

- PHAC members evaluated the HCTI/HCAT pilot website for Minneapolis: provided feedback on neighborhood indicators, website design and functionality, usefulness of HCAT's information, and helpfulness in making planning decisions.
- Proposed the development of a Housing Advisory Committee to include citizen input and oversight regarding affordable housing and housing development. The proposal was submitted to HE&CE Chair Cam Gordon and Council Member Lisa Bender who called a meeting to discuss. The meeting included PHAC members Dan Brady and Peggy Reinhardt, Health Commissioner Gretchen Musicant, CMs Gordon and Bender, their staff, plus staff from Health, CPED, and Regulatory Services. A summary of key discussion points include:
  - CMs were generally supportive of the idea, but advised against developing another advisory committee without laying the groundwork for its need and its benefits.
  - Much housing related work is underway between CPED, Regulatory Services, Zoning, the Bloomberg Initiative, and Cradle to K, including CPED's long-range planning, mapping and analyzing data (i.e. an inventory).
  - CM Bender suggested working housing into the City's Comprehensive Plan given the current level of activity around this issue and dovetails with work that CPED is doing.
  - The group felt that PHAC or MHD should have a greater voice in these activities as public health has not typically been engaged as a stakeholder. All recognized that there are opportunities for better alignment across the initiatives.

Priority #3: Healthy Weight and Smoke-Free Living

The PHAC receives annual updates from Health Department staff on various initiatives in this priority area. In 2015, several topics informed our actions which included providing public testimony to writing letters of support for ordinance changes:

Learning:

- Update on flavored Tobacco products and e-cigarettes
- Introduced to **reThink Your Drink** campaign which raises awareness of sugar-sweetened beverages
- Review of the State Health Improvement Program – the primary funding source for healthy living initiatives on tobacco (smoke free living), obesity (healthy eating), and physical activity (active living)

Actions:

- Engaged City Council members and neighborhood businesses to support changes to City ordinances on tobacco sales and provided public testimony at the public hearing on tobacco sales
- For **reThink Your Drink** campaign, PHAC members provided additional input for community outreach

Priority #4: Healthy Environment(s)

In 2013, the PHAC was introduced to the Air Quality Study which was designed to provide additional air quality information at the neighborhood level. Several committee members volunteered to place collection units at their homes. At the conclusion of the study, Minneapolis Health Department staff updated the committee on some of the results; a final report is due in 2016.

Learning: **Air Quality in Minneapolis: A neighborhood approach –** Patrick Hanlon, Environmental Initiatives Manager and Project Manager and Jenni Lansing, Air Study Coordinator

Action: Committee members were very engaged in this topic and provided ideas for community outreach and raising awareness with local businesses and the general population.

Priority #5: Other areas of interest & action

Several topics that the PHAC studied this year can be summed up as 'other' or miscellaneous. This does not diminish their significance – it means these topics do not fit neatly into one goal area or may cross several goals.

Healthy sleep

Sleep is fundamental to all aspects of health; when sleep is compromised, people are more susceptible to infectious illness, weight gain, anxiety, depression, drug use and accidents. Sleep quality shows stratification by socioeconomic status with those most economically vulnerable getting the least quality sleep.

Learning: **Insufficient Sleep: An Invisible Public Health Concern** – Dr. J. Roxanne Prichard, Associate Professor of Psychology at the University of St. Thomas.

Action: The PHAC recognizes that insufficient sleep impacts daily functioning, mental health & well-being, and interpersonal relationships. Follow up to this presentation is under consideration.

Paid Sick Leave

The PHAC followed the Mayor's proposed Working Families Agenda which included fair scheduling, protection from wage theft, and earned sick and safe time. As state and local discussions focused in on earned sick and safe time as the primary agenda item, the PHAC further studied the issue.

Learning:

- **White Paper on Paid Leave and Health -** Minnesota Department of Health Center for Health Equity, March 2015
- **Access to paid sick leave among working Minneapolis residents** - Minneapolis Health Department, August 2015
- Updates on Paid Sick Leave efforts from Ben Somogyi, aide to Council Member Lisa Bender.

Actions: The PHAC submitted their letter of support for providing paid sick leave to all Minneapolis workers to the Workplace Partnership Group, the group established by Council action and tasked with studying the issue and making recommendations to the City Council.

Priority #6: Committee Operations

The committee engages in tasks and activities which help inform new and existing members, connect with staff from the Health Department and City Clerk's office, and engage City Council members.

Actions:

- PHAC members helped review nominations for the Local Public Health Heroes awards, the Health Department's public ceremony which honors community partners whose service to public health activities transforms and strengthens the lives of Minneapolis residents and visitors.

- The Communications & Operations (Comm/Ops) sub-committee conducted new member orientation and provided PHAC manuals to each member. As vacancies occurred, Comm/Ops members reviewed new applications, provided feedback on applicants regarding their strengths and the committee's needs, and endeavor to recruit members who represent various cultural communities.

- The Collaboration & Engagement (C&E) sub-committee members participated in two community conversations on the documentary *The Raising of America*. *The Raising of America* is a documentary series that explores how a strong start for all our kids can lead to a healthier, safer, better educated, more prosperous, and equitable America.

2016 Priorities…

- Follow ongoing topics for potential action/recommendations: homelessness and housing, ACEs, insufficient sleep, breastfeeding, and paid sick leave
- Engage new topics: mental health, health disparities and health equity, substance abuse, sex trafficking and its link to major sports events, access to healthy foods, walkability, urban agriculture, youth violence prevention, and the Minneapolis climate change vulnerability assessment (community engagement phase)
- Review PHAC priorities alongside Health Department goals; examine committee understanding of health disparities and health equity
- Plan viewings and community discussions of the documentary *The Raising of America*
- Discuss health concerns and priorities brought forward by Minneapolis residents, Health Department staff, and City Council members

Minneapolis
City of Lakes

Public Health Advisory Committee

Annual Report

February 2015

Health Department

2014 Annual Report of the Public Health Advisory Committee

In fall 2013, the Public Health Advisory Committee (PHAC) engaged in a prioritizing activity to better align its discussions, actions, and efforts with the Minneapolis Health Department and City of Minneapolis goals. The resulting priorities gave direction to 2014 as the Committee considered speakers, topics, and actions.

Priority #1: School ready children & Breastfeeding rates-supports-challenges

The PHAC devoted a number of meetings to learning more about city, local, and statewide breastfeeding initiatives to better understand breastfeeding initiation and continuation rates, supports available to moms / parents and families in and out of the hospital, and barriers encountered.

Learning: PHAC members received presentations from the Minnesota Breastfeeding Coalition, Minneapolis Health Department staff from Healthy Start & its community based partner The Family Partnership, and the Minnesota Visiting Nurse Association.

Actions:

- PHAC hosted a panel discussion with representatives from four Minneapolis hospitals on breastfeeding initiation rates, in-hospital supports, and challenges hospitals encounter. Abbott-Northwestern Hospital, North Memorial Medical Center, Hennepin County Medical Center, and the University of Minnesota Medical Center were represented. Panelists agreed that breastfeeding is one of the most effective preventive health measures for infants and mothers; the most benefits are gained from exclusive breastfeeding during the early stages of life; a mother's experience during her hospital stay has a significant impact on breastfeeding rates; and, mothers and families encounter many barriers and challenges outside the hospital environment.
- PHAC members were very engaged and discussed potential actions / priorities for committee follow-up on this topic. Ideas generated include: reviewing the policies and supports the City of Minneapolis, as an employer, has in place for creating a breastfeeding-friendly work place; discussing ways to provide education and outreach for all women on breastfeeding support and concerns; breastfeeding support call-in lines and/or drop-in breastfeeding support clinics for after the hospital stay; breastfeeding-friendly spaces in all public places; and more.
- PHAC commissioned a study by a Master's student at the University of Minnesota-School of Public Health to examine cultural and structural barriers to breastfeeding in Minneapolis' cultural communities and identify actions the City could take to better support breastfeeding families. The report is expected in summer 2015.

Priority #2: Access to Healthy Foods

The PHAC had previously engaged in a discussion and provided feedback about proposed changes designed to update Minneapolis' Staple Foods Ordinance. PHAC members were interested in the planned healthy food, tobacco, and tobacco alternatives policies and practices for the new Vikings Stadium development.

Learning: Received an update on outreach efforts and proposed changes to Minneapolis' Staple Food Ordinance from Kristen Klingler, Sr. Public Health Specialist – MHD and Robin Garwood, Aide to Council Member Cam Gordon. Proposed changes (later passed by the City Council) updated Minneapolis' ordinance by reducing exemptions, and strengthening staple food stocking requirements in Minneapolis stores in order to increase access to fresh foods for Minneapolis residents. Members of the Policy & Planning sub-committee reviewed the Health Department's Vikings Stadium Health Guidelines and recommendations.

Actions:

- Engaged the Director of Communications for the Minnesota Sports Facilities Authority in discussion around health considerations for the Vikings Stadium development and operation. The discussion ranged from food policies to vendor expectations to tobacco (and tobacco alternatives) policies and other year-round uses for the stadium.
- Submitted a letter to the Health Environment & Community Engagement committee and provided public testimony during the committee's public hearing supporting the proposed changes to the City's Staple Foods Ordinance. *(Ordinance passed unanimously.)*

Priority #3: Smoke-Free Living (E-cigarette regulation)

Learning: Received two presentations: 1) a summary of the health department's recent work on tobacco issues, including a survey of local restaurants, coffee shops and café managers to assess attitudes on e-cigarettes; and, 2) a presentation by the Minneapolis Youth Congress (MYC) Tobacco Initiative on their proposed City Council recommendations for limiting e-cigarette access for youth.

Actions:

- PHAC members urged support for the regulation of e-cigarette use in accordance with the Freedom to Breathe Act. The Committee wrote letters to Governor Dayton, each member of the Minneapolis delegation, and Health Commissioner Ehlinger.
- PHAC supported MYC's work and recommendations, submitted a letter to the City Council's Health, Environment & Community Engagement committee, and provided testimony of that support during MYC's presentation to the HE&CE committee.

- PHAC member, Sahra Noor, provided public testimony during the City Council's public hearing on e-cigarette regulation. *(Ordinance regulating the use of e-cigarettes in indoor public places and places of employment passed.)*

Priority #4: Reduce Youth Violence

Learning: Received an update on the revised Blueprint for Action to Prevent Youth Violence and its goals.

Action:

- Ward 5 representative and PHAC co-chair Tara Jenson invited Sasha Cotton, Youth Violence Prevention Coordinator, to present the revised Blueprint at the Community Health and Advocacy Talks (CHAT), sponsored by Urban Research and Outreach Engagement Centers and UMN North Memorial Family Medicine Residency Program.

Priority #5: Housing and Homelessness

With a collective interest in the complexities of housing disparities, segregation and the concentration of poverty, and homelessness, the PHAC finished the year by studying various aspects of these topics.

Learning: Received a presentation from the University of Minnesota's Institute for Metropolitan Opportunity about housing policies, funding, and development as it relates to segregation, homelessness, and concentrated poverty. Received a presentation from Health Department staff on the public health implications of hoarding disorder and how the City has addressed hoarding behavior.

Actions:

- Invited the Residential Finance Manager from the City's Community Planning & Economic Development office to a meeting of the Policy & Planning sub-committee to discuss housing policies, funding, and development.
- The PHAC strongly recommends development of a Housing Advisory Committee; a recommendation is in draft form at this time.

Priority #6: Committee Operations

Actions:

- PHAC members helped review the nominations for the Local Public Health Heroes awards, the Health Department's public ceremony which honors community partners whose service to public health activities transforms and strengthens the lives of Minneapolis residents and visitors.

- The Communications & Operations (Comm/Ops) sub-committee updated the member orientation manual and provided orientations and new manuals to each member. Additionally, as vacancies occurred, Comm/Ops reviewed new applications and provided feedback on applicants regarding their strengths and the committee's needs.

- The Collaboration & Engagement (C&E) sub-committee members are in the planning phases for viewings and community discussions around *The Raising of America* (scheduled for release summer 2015). *The Raising of America* is a documentary series that explores how a strong start for all our kids can lead to a healthier, safer, better educated, more prosperous, and equitable America.

2015 Priorities…

- Provide feedback on the Cradle to K Cabinet report
- Plan viewings and community discussions around the documentary: *The Raising of America*
- Draft a recommendation for the development of a Housing Advisory Committee
- Review PHAC priorities alongside Health Department goals
- Engage Council Members, community, and partners: discuss health concerns and priorities in Minneapolis

MINNEAPOLIS HEALTH DEPARTMENT

OUR VISION…

Healthy lives, health equity, and healthy environments are the foundations of a vibrant Minneapolis now and into the future.

Minneapolis
Health Department

OUR MISSION…

The Minneapolis Health Department improves the quality of life for all people in the city by protecting the environment, preventing disease and injury, promoting healthy behaviors, and creating a city that is a healthy place to live, work, and play.

OUR VALUES…

Our values provide the foundation for the work we do, how we work together as a department, within city government, and with the community. They inspire and challenge us, and set forth the principles by which we hold ourselves accountable.

Invest in a healthier community

- *We support a holistic sense of health within the context of families and communities across the life span.*
- *We work for sustainable changes to ensure a return on our investment in health outcomes for the most at risk and the community at large.*
- *We bring people and resources together to achieve our common goals and address conditions that influence health.*

Exercise leadership in public health

- *We use sound research, promising strategies, and community input to inform our activities and decisions.*
- *We encourage our mission-focused, passionate staff to be proactive, innovative and flexible, and to share their knowledge with our local community and beyond.*

Quality inspires our work

- *We strive for excellence in our work by being accountable to the public for consistent standards resulting in measurable progress toward desired outcomes.*

Engage with communities

- *We build on our urban community's cultural diversity, wisdom, strengths and resilience, and are directed by the community's voice.*

Protect from harm

- *We protect residents and guests of Minneapolis from disease and injury; assist them in recovery from disaster; and, protect the environment from degradation.*

250 South 4th Street, Room 510 Minneapolis, MN 55415-1384 612.673.2301

OUR GOALS…

A Healthy Start to Life and Learning

- Strengthen systems of care for pregnant and parenting families
- Support and develop policies and partnerships that strengthen families
- Strengthen systems for positive early childhood development

Thriving Youth and Young Adults

- Improve the healthy development, health and well-being of youth
- Reduce unintended pregnancy and STIs among youth and young adults
- Reduce violence among youth and young adults

Healthy Weight and Smoke-Free Living

- Increase availability and affordability of healthy food
- Increase opportunities for physical activity
- Improve health care and community providers' ability to prevent obesity and tobacco use
- Advocate for policy to reduce exposure to second hand smoke and youth tobacco use
- Increase community engagement in creating opportunities for healthy eating, physical activities and tobacco-free living

A Healthy Place to Live

- Reduce lead hazards in homes
- Reduce asthma triggers and home safety hazards in homes
- Strengthen systems that support healthy housing
- Increase community outreach and education around lead poisoning, and other hazards in and around the home

Safe places to eat, swim, and stay

- Reduce the risk of disease and injury from food, lodging and swimming establishments
- Establish a community engagement and education program

A Healthy Environment

- Develop policies & organizational practices that support a clean and healthy natural environment (air, soil, water)
- Monitor and reduce environmental hazards, nuisances and pollution
- Increase education and outreach to improve compliance with existing and new environmental regulations and initiatives

A Strong Urban Public Health Infrastructure

- Increase emergency preparedness capacity internally and for the city as a whole.
- Ensure that residents who lack health insurance receive health care services and assistance with enrolling in government-funded health plans.
- Achieve the high quality standards that merit accreditation from the national Public Health Accreditation Board (PHAB)
- Improve population and environmental health through research and program evaluation.
- Develop, advocate for, and implement policies that improve population and environmental health.
- Assure and maintain a diverse, engaged, and skilled workforce with the resources needed to achieve program goals in an efficient and effective manner.

Visit our website to learn more about the Minneapolis Health Department:

www.minneapolismn.gov/health

MINNEAPOLIS HEALTH DEPARTMENT

NUESTRA VISIÓN…

Vidas sanas, equidad sanitaria, y ambientes sanos forman el fundamento de un Minneapolis vibrante, ahora y hacia el futuro.

Minneapolis
Health Department

NUESTRA MISIÓN…

El Departamento de Salud de Minneapolis mejora la calidad de vida para todas las personas en la ciudad al proteger el medioambiente, prevenir enfermedad y lesión, promover comportamientos sanos, y crear una ciudad que es un lugar sano para vivir, trabajar y jugar.

NUESTROS VALORES …

Nuestros valores constituyen el fundamento del trabajo que hacemos, de como trabajamos juntos como departamento, dentro del gobierno municipal y con la comunidad. Nos inspiran y nos retan, y exponen los principios por los cuales nos hacemos responsables.

Invertir en una comunidad mas sana

- *Estamos de acuerdo con un entendimiento integral de lo que es la salud dentro del contexto de familias y comunidades y a lo largo de la trayectoria de la vida.*
- *Trabajamos para hacer cambios sostenibles para asegurar que nuestra inversión se devuelva con resultados de salud para los más arriesgados y para la comunidad en general.*
- *Unimos gente con recursos para lograr nuestras metas comunes y para dirigirnos a las condiciones que influyen la salud.*

Ejercer liderazgo en salud pública

- *Para informar nuestras actividades y decisiones, confiamos en investigaciones válidas, estrategias confiables y la contribución de ideas de la comunidad.*
- *Nuestro personal está enfocado en la misión y es apasionado. En ellos fomentamos que sean proactivos, innovadores y flexibles y que compartan sus conocimientos con nuestra comunidad local y más allá.*

Calidad inspira nuestro trabajo

- *Nos esforzamos a la excelencia en nuestro trabajo al cumplir con nuestra responsabilidad al público de mantener estándares consistentes que resultan en progreso que se puede medir hacia los resultados deseados.*

Comprometerse con comunidades

- *La diversidad cultural, la sabiduría, los fuertes y la voluntad de superar de nuestra comunidad son nuestro punto de partida y la voz de la comunidad nos dirige.*

Proteger de daños

- *Protegemos a los residentes y visitas a Minneapolis de enfermedad y lesiones; les ayudamos a recuperarse de desastres; y protegemos el medioambiente de daños.*

250 South 4th Street, Room 510 Minneapolis, MN 55415-1384 612.673.2301

NUESTRAS METAS…

Un Comienzo Sano a la Vida y al Aprender

- Fortalecer sistemas de cuidado para familias donde hay embarazo o crianza de hijos
- Apoyar y desarrollar políticas y asociaciones que fortalezcan familias
- Fortalecer sistemas para un desarrollo positivo en la etapa temprana de la niñez

Juventud y Adultos Jóvenes que Medran

- Mejorar el desarrollo sano, salud y bienestar de la juventud
- Reducir el embarazo no intencional y las enfermedades transmitidas sexualmente entre jóvenes y adultos jóvenes
- Reducir violencia entre jóvenes y adultos jóvenes

Peso Sano y Vivir Libre de Humo

- Hacer que la comida saludable esté más disponible y al alcance económico del pueblo
- Aumentar oportunidades para actividad física
- Mejorar el cuidado de salud y la habilidad de los proveedores de cuidados en la comunidad a prevenir la obesidad y el uso de tabaco
- Abogar por políticas que reduzcan la exposición al humo de segunda mano y el uso de tabaco
- Aumentar la participación de la comunidad en la creación de oportunidades para comer sano, actividades físicas y el vivir libre de tabaco

Un lugar sano en donde vivir

- Reducir peligros de plomo en las casas
- Reducir provocaciones de asma y peligros a la seguridad en los hogares
- Fortalecer sistemas que apoyan viviendas sanas
- Aumentar el alcance a la comunidad y la educación en cuanto a envenenamiento con plomo y otros peligros en y alrededor de la casa

Lugares seguros para comer, nadar y alojarse

- Reducir el riesgo de enfermedad y lesión de los establecimientos de comida, alojamientos y natación
- Establecer un programa de participación comunitaria y educación

Un Medioambiente Sano

- Desarrollar políticas y practicas organizacionales que apoyen un ambiente natural (aire, tierra, agua) limpio y sano
- Vigilar y reducir los peligros y molestias medioambientales y la contaminación
- Aumentar la educación y el alcance para mejorar el cumplimiento con los reglamentos e iniciativas medioambientales nuevos y ya existentes

Una Infraestructura de Salud Pública Urbana Fuerte

- Aumentar la capacidad de preparación para emergencias internamente y por toda la ciudad
- Asegurar que los vecinos a quienes les hace falta un plan médico reciban servicios de cuidado de salud y ayuda para inscribirse en planes apoyados por fondos gubernamentales.
- Alcanzar los estándares de alta calidad que meritan acreditación de la Junta Nacional de Acreditación en Salud Pública (PHAB por sus siglas en inglés)
- Mejorar la salud de la población y del medioambiente por medio de investigaciones y la evaluación de programas.
- Desarrollar, interceder por e implementar políticas que mejoren la salud de la población y del medioambiente.
- Asegurar y mantener un cuerpo de trabajo diverso, involucrado y hábil con los recursos necesarios para lograr las metas del programa de manera eficiente y eficaz.

Commissioner of Health
Gretchen Musicant

Finance Dept

HR Generalist

Administration and Assurance
Director, Becky McIntosh

- Contracts and Grants Administration
- Emergency Preparedness
- Public Health Accreditation & Quality Improvement
- Administrative Support

Adolescent Health and Youth Development
Director, Coral Garner

- Youth Development
- Youth Violence Prevention
- School Based Clinics

Environmental Health
Director, Dan Huff

Policy and Public Health Initiatives
Director, Patty Bowler

- Healthy Living
- Healthy Homes and Environments
- UCare Skyway Senior Center
- Maternal/Paternal/Child Health

Research and Program Development
Director, Pat Harrison

- Research
- Healthy Start

Lead and Healthy Homes
Manager, Lisa Smedstad

Environmental Initiatives
Manager, Patrick Hanlon

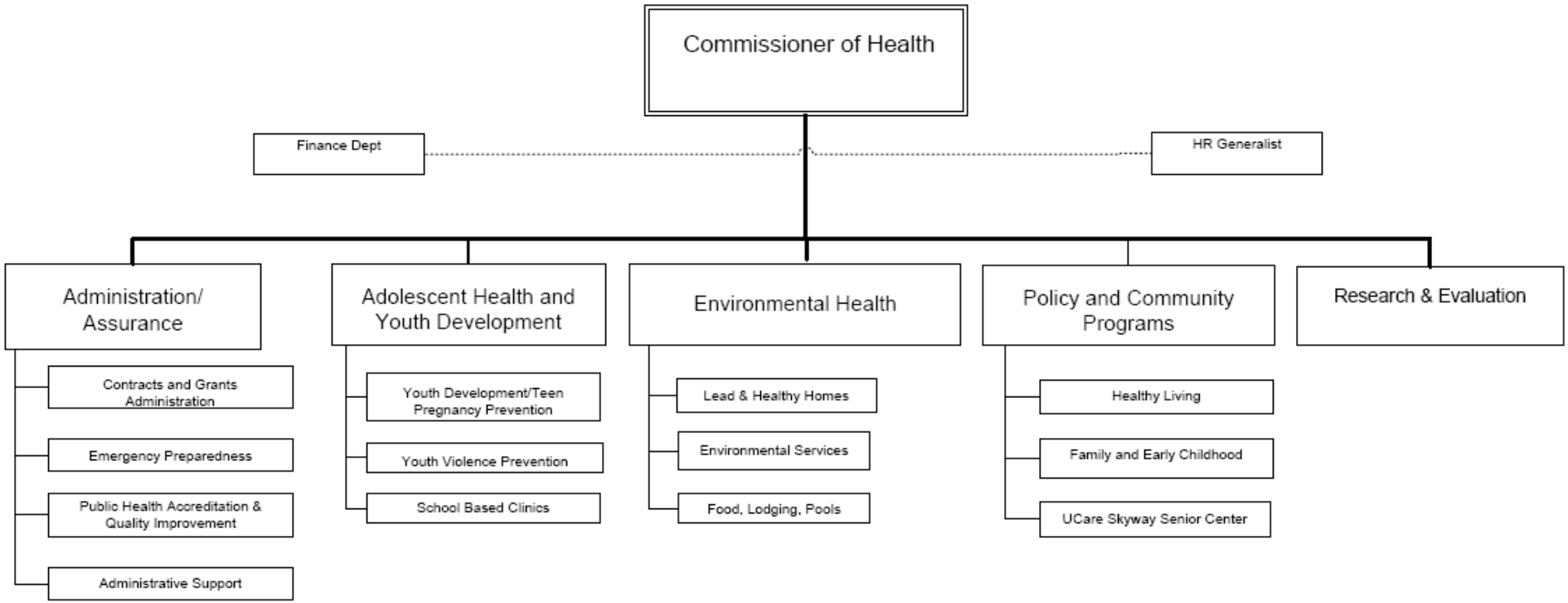
Food, Lodging & Pools
Supervisor, Ryan Krick

Food, Lodging & Pools
Supervisor, Cindy Weckwerth

Minnesota State Statute 145A and the Six Areas of Local Public Health Responsibility

1. **Assure and adequate public health infrastructure.**
2. **Promote healthy communities and healthy behaviors.**
3. **Prevent the spread of infectious disease.**
4. **Protect against environmental health hazards.**
5. **Prepare for and respond to disasters, and assist communities in recovery.**
6. **Assure the quality and accessibility of health services.**

Implementation of the six areas by department division:



1. **Assure and adequate public health infrastructure.**
3. **Prevent the spread of infectious disease. (contracted)**
5. **Prepare for and respond to disasters, and assist communities in recovery.**
6. **Assure the quality and accessibility of health services. (contracted)**

2. **Promote healthy communities and healthy behaviors.**
6. **Assure the quality and accessibility of health services.**

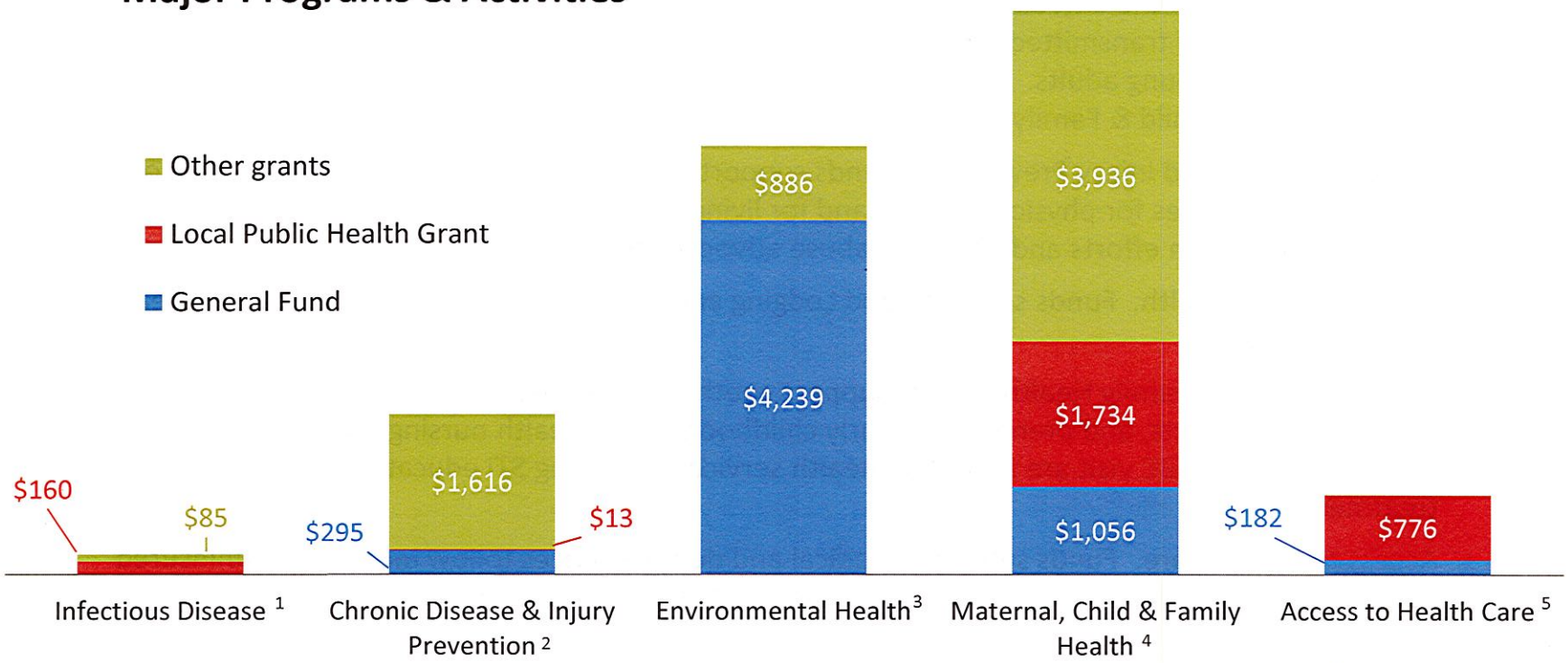
4. **Protect against environmental health hazards.**

1. **Assure and adequate public health infrastructure.**
2. **Promote healthy communities and healthy behaviors.**

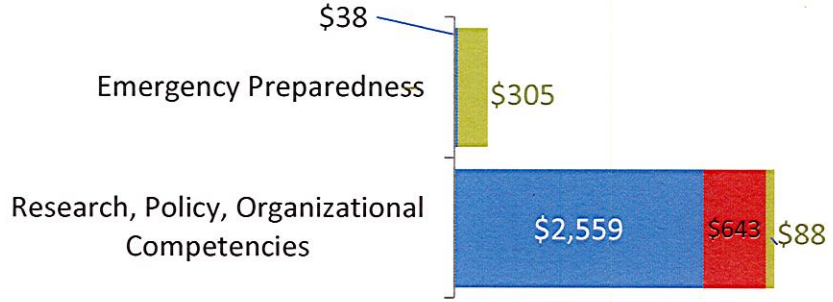
1. **Assure and adequate public health infrastructure.**

Funding for Public Health Services, 2015
(in $ Thousands)

Major Programs & Activities



Foundational Capabilities



1) Infectious Disease. Funds support disease prevention and control work provided by Hennepin County on behalf of the city, support for the regional immunization registry, and male reproductive health and sexually transmitted infection (STI) outreach, education, and treatment for high risk adolescents and young adults. Additional STI work is included within the School Based Clinic program under Maternal, Child & Family Health programs.

2) Chronic Disease and Injury Prevention. Funds support the Healthy Living initiatives to reduce obesity, ensure opportunities for physical activity, and for living tobacco free. Also included are youth violence prevention efforts and domestic abuse advocacy services.

3) Environmental Health. Funds support Food Lodging and Pools, Environmental Services, and Lead and Healthy Homes.

4) Maternal, Child & Family Health. Funds support youth development, School Based Clinics (SBC), community contracts, and prenatal and early childhood public health nursing home visits. An estimated 32% of SBC visit are for sexual health services, including STI education, testing, and treatment.

5) Access to Health Care. Funds subsidize medical and dental services to low income and uninsured Minneapolis residents, and public health nursing visits for families and seniors.

Minneapolismn.gov

Minneapolis Health Department (MHD)

Food, Lodging, and Pools
Food safety, Environmental Health, Inspections

Healthy Homes & Lead Hazard Control
Lead, Radon, Bed Bugs

Healthy & Safe Children & Youth
Healthy Start, School-based Clinics, violence prevention

Healthy Seniors
Skyway Center

Healthy Sexuality
Teen pregnancy reduction, STI information

Prevention & Healthy Living
Healthy eating, physical activity, smoke-free living

Environmental Services
Air quality, odors, noise, water pollution, illegal dumping, chemical spills

Public Health Emergency Preparedness
Report a public health emergency, flu prevention

Toolkits
Resources for health care professionals

Reports
Trends, statistics

Neighborhood Health Indicator Tool | **MNSure** | **311**

Minneapolis Health Department

For reasonable accommodations or alternative formats please contact the Minneapolis Health Department at 612-673-2301 or health@minneapolismn.gov. People who are deaf or hard of hearing can use a relay service to call 311 at 612-673-3000. TTY users call 612-673-2157 or 612-673-2626.

Para asistencia 612-673-2700 - Rau kev pab 612-673-2800 - Hadii aad Caawimaad u baahantahay 612-673-3500.

Last updated Jan 25, 2016

Connect with the City

How the Minneapolis Health Department operates—

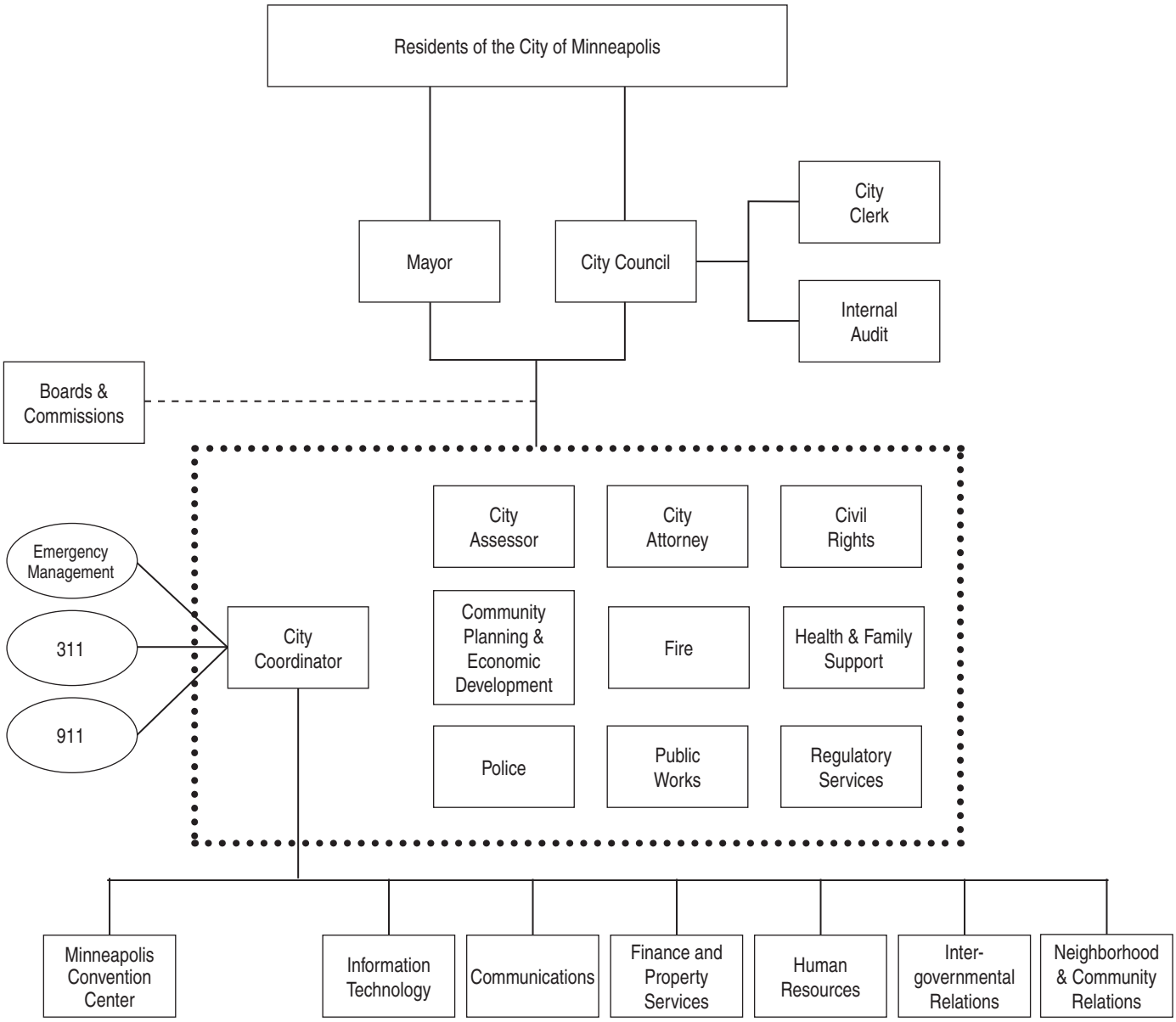
Our values provide a foundation for the work we do: how we work together as a department, within city government, and with the community.

- We bring people and resources together to achieve our common goals and address conditions that influence health.
- We build on our urban community's cultural diversity, wisdom, strengths, and resilience, and are directed by the community's voice.

For every different project or funding source, we have to form partnerships to be effective. How we engage these partners varies by formal and informal arrangements or as contracted partners. We work with community organizations, government agencies, other city departments, health care / health agencies, and other Minneapolis entities such as the Park Board and Minneapolis Public Schools. While this is not an exhaustive list of our partners, it illustrates our close connection to multiple resources and areas of expertise.

City of Minneapolis

Organizational Chart



City Council: Powers & Duties

COUNCIL MEMBERS [back row, left to right]: Blong Yang, Ward 5; Lisa Goodman, Ward 7; John Quincy, Ward 11; Abdi Warsame, Ward 6; Andrew Johnson, Ward 12; Linea Palmisano, Ward 13; Alondra Cano, Ward 9; and Lisa Bender, Ward 10, [front row, left to right]: Jacob Frey, Ward 3; Kevin Reich, Ward 1; Barbara A. Johnson, Ward 4, Council President; Elizabeth Glidden, Ward 8, Council Vice-President; and Cam Gordon, Ward 2.

The City Council is the legislative body of the City of Minneapolis. The following sections describe some of its primary responsibilities. To learn more about any of these duties, click on the corresponding link for additional details.

Legislative Authority:
Through its policy-making powers, the Council governs the community and oversees the delivery of a wide range of municipal services and programs that directly impact the quality of life for residents.

Election & Organizational Issues:
Council Members are elected to concurrent, four-year terms in nonpartisan elections that are conducted in odd-numbered years. The Council elects its officers and establishes its standing committee system to conduct business.

Financial Management:
The Council is the final authority on management of city funds, and the budget is the centerpiece of its local policymaking authority.

Land Use, Development & Zoning:
The Council encourages growth and orderly development through its land use and zoning authority, ensuring a balance among residential, commercial, and public spaces and places.

Executive Oversight:
The Council provides policy direction to City departments and divisions and monitors the execution and implementation of its policies through its standing committee system.

Constituent Representation:
Individually and collectively, Council Members provide a wide range of constituent services and represent the City of Minneapolis at local, regional, state, and national levels.

Last updated Apr. 21, 2014

2016 Council Member Staff Roster

Ward 1	Council Member	**Kevin Reich**	X2201
	Aide	Shannon McDonough	X2003
Office Q	Associate	Lisa Brock	X7920
Ward 2	Council Member	**Cam Gordon***	X2202
	Aide	Robin Garwood	X3654
Office L	Associate	Nancy Olsen	X7142
Ward 3	Council Member	**Jacob Frey***	X2203
	Aide	Heidi Ritchie	X3142
Office P	Associate	Zach Farley	X3126
Ward 4	Council Member	**Barbara Johnson**	X2204
	Aide	Jennifer White	X3313
Office G	Associate	Dawn Snow	X7930
Ward 5	Council Member	**Blong Yang**	X2205
	Aide	Sean Broom	X3198
Office B	Associate	Ger Yang	X7140
Ward 6	Council Member	**Abdi Warsame**	X2206
	Aide	Abdi N. Salah	X3315
Office E	Associate	Marcela Sotela Odor	X7139
Ward 7	Council Member	**Lisa Goodman**	X2207
	Aide	Patrick Sadler	X3195
Office F	Associate	Ruth Hamann Weakly	X7144
Ward 8	Council Member	**Elizabeth Glidden***	X2208
	Aide	Sara Lopez Lara	X3569
Office C	Associate	Deebaa Sirdar	X7114
Ward 9	Council Member	**Alondra Cano***	X2209
	Aide	Aisha Gomez	X3196
Office D	Associate	Coya Artichoker	X7145
Ward 10	Council Member	**Lisa Bender***	X2210
	Aide	Ben Somogyi	X3197
Office O	Associate	Matthew Crockett	X7169
Ward 11	Council Member	**John Quincy**	X2211
	Aide	John Dybvig	X3314
Office N	Associate	Mary Petersen	X7143
Ward 12	Council Member	**Andrew Johnson***	X2212
	Aide	Suzanne Murphy	X2378
Office K	Associate	Kate Nelson	X7138
Ward 13	Council Member	**Linea Palmisano**	X2213
	Aide	Emily Ziring	X3199
Office M	Associate	Ken Dahler	X7147

*** members of Health Committee (HE&CE)**

Mayor Betsy Hodges

Chief of Staff: John Stiles	X3665
Deputy COS: Ben Hecker	X2283
Office Associate: Grace Goodrich	X3742
Office Assoc.: Tou Tou Khamsot	X3252

Mayor and Council Establish Standing Committees

The Claims Committee, chaired by Lisa Goodman, will consider claims filed against the City and appealed from the Staff Claims Committee for reimbursement for injury, property loss or auto damage resulting from fault or liability of the City. Committee members will include John Quincy as vice-chair, Kevin Reich, Cam Gordon, Barbara Johnson and Elizabeth Glidden.

The Committee of the Whole, chaired by Elizabeth Glidden, is responsible for setting and approving policy changes related to the City's vision, goals and strategic directions; considers major enterprise-wide initiatives and programs; and receives reports relating to biannual resident and employee surveys. The committee includes all 13 council members.

The Community Development & Regulatory Services Committee, chaired by Lisa Goodman, oversees all matters related to housing, economic development, employment, and training of City residents. It also approves license applications for business, liquor, beer and wine, gambling, and rental dwellings. Committee members will include Jacob Frey as vice-chair, Kevin Reich, Abdi Warsame, Alondra Cano and John Quincy.

The Elections & Rules Committee, chaired by Jacob Frey, is responsible for all matters related to elections and election administration and the City Council's procedural rules. The committee includes all 13 council members.

The Health, Environment & Community Engagement Committee, chaired by Cam Gordon, has oversight of policies and service delivery related to public health and social service programs, develops programs to promote a sustainable city, champions energy and environment issues, and provides direction and coordination on a host of neighborhood and community engagement initiatives. Committee members will include Andrew Johnson as vice-chair, Jacob Frey, Elizabeth Glidden, Alondra Cano and Lisa Bender.

The Intergovernmental Relations Committee, chaired by Elizabeth Glidden, considers proposed legislation at federal, state, regional and local levels; sets legislative priorities for the City including the development of annual federal and state legislative platforms; provides local approval for legislation passed by the State; and considers amendments proposed to the City of Minneapolis charter. Committee members will include Alondra Cano as vice-chair, Jacob Frey, Barbara Johnson, John Quincy and Andrew Johnson.

The Public Safety, Civil Rights & Emergency Management Committee, chaired by Blong Yang, has oversight of policies and service delivery related to public safety and emergency management, including the Police and Fire departments, and is responsible for setting and approving policies and programs for the Civil Rights Department. Committee members will include Cam Gordon as vice-chair, Kevin Reich, Barbara Johnson, Abdi Warsame and Linea Palmisano.

The Taxes Committee, chaired by Abdi Warsame, is responsible for reviewing and approving recommendations made by the Minneapolis Board of Appeal & Equalization related to the classification and valuation of property within the city. The committee includes all 13 council members.

The Transportation & Public Works Committee, chaired by Kevin Reich, has oversight of infrastructure improvements, traffic and traffic-management issues, special service districts and related assessments, bicycle and pedestrian plans and initiatives, recycling and solid waste disposal issues, and is responsible for considering appeals relating to block events and encroachment permits. Committee members will include Linea Palmisano as vice-chair, Cam Gordon, Blong Yang, Elizabeth Glidden and Lisa Bender.

The Ways & Means Committee, chaired by John Quincy, is responsible for setting and overseeing enterprise financial policies and procedures and for reviewing and approving the expenditure of public funds. Committee members will include Elizabeth Glidden as vice-chair, Blong Yang, Lisa Bender, Andrew Johnson and Linea Palmisano.

Two subcommittees were established under the jurisdiction of the Ways & Means Committee:

The Budget Subcommittee, chaired by John Quincy and including all 13 council members, will be responsible for considering budget proposals submitted by Mayor Betsy Hodges;

The Information Technology Policy Subcommittee, chaired by Andrew Johnson, will oversee enterprise technology investments, policies and operational matters.

More information about City Council committee meetings and the 2016 meeting schedule is online at www.minneapolismn.gov/council.

Governance Structures and Authorities **Last Revised: January 2014**

Public Health Powers and Duties of Local Government

- Boards of Health and Community Health Boards
- Summary of Powers and Duties: Boards of Health and CHBs

As stated earlier, the purpose of Minnesota's community health services system is to "...develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards." (Minn. Stat. § 145A.09, subd. 1.) Under the Local Public Health Act, a community health board organizes to provide that local administration, and has the "...general responsibility for [the] development and maintenance of an integrated system of community health services..." (Minn. Stat. § 145A.10, subd. 1).

Boards of Health and Community Health Boards

The difference between a "board of health" and a "community health board" can be confusing. A good working definition: A community health board (CHB) has all the powers and duties of a board of health, but it has met additional qualifications that allow it to receive funding through the Local Public Health Act.

A CHB also preempts any other boards of health within its area unless those boards of health are authorized by a joint powers agreement or a delegation agreement. For instance, many community health boards are multi-county boards, formed through a joint powers agreement. In many instances, the individual counties that make up a multi-county community health board each have their own county board of health, authorized by agreement with the community health board.

The Local Public Health Act (Minn. Stat. § 145A.09) provides guidance on forming a CHB, including eligibility, population and boundaries requirements, and for withdrawal from a CHB. Please refer to the statute for specific requirements, or contact the MDH Office of Performance Improvement for assistance.

Difference between Governance Structure and Organizational Structure

Governance structure describes the way in which governing bodies are legally organized to do their work. Minnesota statutes and rules identify two options for counties and cities to organize themselves to do the work of public health:

- Community health boards (CHBs), or
- Human service boards (HSBs) organized under Minn. Stat. § 402

CHBs can be comprised of single counties, provided the county meets a minimum population requirement of 30,000 residents. CHBs can also be formed by multiple counties. Multi-county CHBs are formed through joint powers agreements, which allow the CHBs to work across political boundaries. A two-county CHB is possible if the counties share a border and have a combined population greater than 30,000. CHBs of three or more counties are possible if the counties are contiguous; there is no minimum population requirement for CHBs with three or more counties. County boards (and in a few cases, city councils) may appoint elected officials and citizen members to these governing structures.

Organizational structure is a term used to describe the way in which a local health department is organized within a city or county. Unlike governance structures, which are dictated by statute, organizational structures are locally determined. Public health in Minnesota operates under many different organizational structures. In some locations, public health exists as a standalone department; in others, it is organized alongside social services as part of a human services agency. There are also counties in Minnesota in which a hospital is contracted to provide public health services. Visit the MDH Office of Performance Improvement online for a current and comprehensive list of the state's public health organizational and governance structures.

Governance Structure Changes (Changes to the CHB)

If a CHB (or one of its member counties) is considering merging (expanding), withdrawing, or dissolving, the CHB is advised to contact the MDH Office of Performance Improvement, which can discuss and customize resources for the CHB.

The Local Public Health Act contains a provision for counties to withdraw from a multi-county CHB (Minn. Stat. § 145A.09, subd. 7). The withdrawing party must notify the commissioner of health and the other counties in the CHB at least one year before the beginning of the calendar year in which the withdrawal takes effect (Minn. Stat. § 145A.03, subd. 3).

There will be financial consequences for the withdrawing party, and possibly for the remaining county or counties. For example, Local Public Health Act funding includes a multi-county incentive of $5,000 per county in a multi-county CHB, which would be lost if a county withdrew from the multi-county arrangement. Other funding formulas may also be affected.

Organizational Structure Changes

By recommendation of the State Community Health Services Advisory Committee (SCHSAC), the Annual Assurances & Agreements form now requires that CHBs notify MDH six months prior to any final board action on major governance or organizational structural changes within the CHB or its member counties. This notification should occur in writing to the MDH Office of Performance Improvement. While the decision to make an organizational change (within a city or county) ultimately lies with the board, this recommendation is meant to help ensure that local decisions regarding public health organizations are made in a well informed and deliberative manner, and with the benefit of timely advice and assistance from MDH.

County and City Powers

While community health boards and boards of health have broad powers related to public health, cities and counties also have powers relating to public health responsibilities. These powers are usually exercised by the county or city in concert with the general public health responsibilities of a CHB or board of health.

A county may adopt ordinances related to: actual or potential threats to the public health; animal control; control of unwholesome substances; regulation of sewage, garbage and other refuse; the cleaning and removal of obstructions from waters; regulation of offensive trades; the control of public health nuisances; and enforcing and administering powers delegated by agreement with the state commissioner of health (Minn. Stat. § 145A.05). There are specific requirements for adopting ordinances, so consult with your county attorney when developing ordinances. These ordinances cannot be in conflict with or less restrictive than standards in state law or rule. Cities may also adopt similar ordinances under the Specific Powers of the Council granted to statutory cities by Minn. Stat. § 412.221.

Under the authority of Minn. Stat. § 145A.11, a city council or county board that has formed or is part of a CHB must consider the income and expenditures required to meet locally identified priorities. Note: The ability to levy specific taxes for public health purposes (Minn. Stat. § 145A.08, subd. 3) is currently part of the encompassing "levy limit" of local governments.

A county board can review the community health plan and/or budget, or any revisions to the plan or budget. It may refer the plan or budget back to the CHB with comments and instructions for further consideration. A city council or county board that has formed or is part of a CHB may, by ordinance, adopt and enforce minimum standards for community health services. This authority is limited by state preemption. In some cases, local jurisdictions may pass ordinances that are more stringent than state law, but state law sets the minimum standard. (For example, all jurisdictions must comply with and enforce Minnesota's Clean Indoor Air Act and the Freedom to Breathe Provisions. Local jurisdictions may choose to pass more stringent tobacco related ordinances, such as banning smoking in public parks or on patios.)

Township or city health boards, and the health officers appointed by them, do not have statutory power to enforce the provision of the Local Public Health Act. Cities and townships may still call some of their advisors "boards of health" or "health officers," but their legal standing is either advisory, or that of an agent of the city council or town board enforcing validly enacted city or township ordinances on behalf of the city or the township. These ordinances are adopted under the general city or town

ordinance authority, not under the authority of the Local Public Health Act. These "boards of health" or "health officers" have only the authority of the city or town ordinance—they have no statutory public health authority.

Human Services Boards

A human services board (HSB) formed under Minn. Stat. § 402is eligible to serve as the governance structure for public health. It is the only legal alternative to a community health board (CHB) under Minn. Stat. § 145A. As such, an HSB is eligible to receive funds through the Local Public Health Act (e.g., State General Funds, Title V, TANF).

An HSB is held to all other legal requirements of a CHB, including: conducting community health assessment and planning; working to achieve statewide health outcomes; considering the CDC's 10 essential public health services; annual reporting; and appointing or employing a CHS Administrator and a Medical Consultant.

An HSB, under Minn. Stat. § 402 becomes the governing structure for social services, public health, and corrections. (Minn. Stat. § 402.02, subd. 1a).

HSBs of this type require an advisory committee, which with specific requirements for committee membership, including persons receiving services, providers and HSB members. The advisory committee gives the HSB advice on the development, implementation, and operation of programs and services overseen by the board, and makes an annual, formal recommendation on the budget.

It is not necessary to create the HSB governance structure for a county to organize their county functions within a human services agency. Only some of the counties in Minnesota who have combined public health with human services have formed HSBs.

It is important to keep in mind that simply merging a county health department and human services department does not mean that the county has formed a human services board. A human services board that is to function as the CHB must be organized according to the requirements listed in Minn. Stat. § 402. The law further requires the county or counties to combine the programs funded by MDH, the Department of Human Services, and the Department of Corrections into a human services agency.

If you have questions about the human services board structure, or if your county is contemplating forming a human services board, contact your MDH public health nurse consultant.

Summary of Powers and Duties: Boards of Health and Community Health Boards

To view a one-page summary of the powers and duties a CHB "must" and "may" carry out under statute, visit the Summary of Powers and Duties Contained in Minn. Stat. § 145A.03-145A.10.

Key Resources

- Local Public Health Authorities and Mandates (PDF: 302KB / 10 pages)
- Operational Definition of a Functional Local Health Department – *National Association of County and City Health Officials (NACCHO)*

(http://www.health.state.mn.us/index.html)

Minnesota Department of Health

Local Public Health Act - Minn. Stat. § 145A

Areas of Public Health Responsibility

Assure an Adequate Local Public Health Infrastructure

This area of public health responsibility describes aspects of the public health infrastructure that are essential to a well-functioning public health system – including assessment, planning, and policy development. This includes those components of the infrastructure that are required by law for community health boards. It also includes activities that assure the diversity of public health services and prevents the deterioration of the public health system.

Promote Healthy Communities and Healthy Behaviors

This area of public health responsibility includes activities to promote positive health behaviors and the prevention of adverse health behaviors – in all populations across the lifespan in the areas of alcohol, arthritis, asthma, cancer, cardiovascular/stroke, diabetes, health aging, HIV/AIDS, Infant, child, and adolescent growth and development, injury, mental health, nutrition, oral/dental health, drug use, physical activity, pregnancy and birth, STDs/STIs, tobacco, unintended pregnancies, and violence. It also includes activities that enhance the overall health of communities.

Prevent the Spread of Infectious Disease

This area of responsibility focuses on infectious diseases that are spread person to person, as opposed to diseases that are initially transmitted through the environment (e.g., through food, water, vectors and/or animals). It also includes the public health department activities to detect acute and communicable diseases, assure the reporting of communicable diseases, prevent the transmission of disease (including immunizations), and implement control measures during communicable disease outbreaks.

Protect Against Environmental Health Hazards

This area of responsibility includes aspects of the environment that pose risks to human health (broadly defined as any risk emerging from the environment), but does not include injuries. This area also summarizes activities that identify and mitigate environmental risks, including foodborne and waterborne diseases and public health nuisances.

Prepare for and Respond to Disasters, and Assist Communities in Recovery

This area of responsibility includes activities that prepare public health to respond to disasters and assist communities in responding to and recovering from disasters.

Assure the Quality and Accessibility of Health Services

This area of responsibility includes activities to assess health care capacity and assure access to health care. It also includes activities relate to the identification and reduction of barriers to health services. It describes public health activities to fill health care gaps, reduce barriers and link people to needed services.

651-201-5000 Phone
888-345-0823 Toll-free

Information on this website is available in alternative formats to individuals with disabilities upon request.

Prevent. Promote. Protect.

Local Public Health in Minnesota

Local Public Health Association of Minnesota

Public Health
Prevent. Promote. Protect.

What Is Public Health?

Public health is the art, practice and science of ***protecting and improving*** the health of the population. Public health is about ***what makes us healthy***, what makes us sick, and what we can do ***together*** about it. When we think about health, what often comes to mind is the individual and ways he or she can stay healthy. Public health shifts the focus to the ***population*** – from me to ***all of us***.

Principles of Public Health

- Public health is about PREVENTION. This means intervening early and keeping people from getting sick or injured.
- Public health is about POPULATIONS. This means focusing on groups of people rather than single individuals.
- Public health is about HEALTH. This means the broadest possible view of what makes and keeps us healthy including our mental health, everyday health choices, and our surroundings – not just health care services.
- Public health is about LOCAL NEEDS. This means identifying what a community needs to improve health and assuring effective action which uses local assets to solve unique challenges.

The Value of Local Health Departments

- Local public health departments are an investment in healthy people and healthy communities.
- You may not always see the work of local public health departments, but you are safer and healthier because of it.
- Local public health departments create health and prevent illness where we live, learn, work and play.
- Local public health departments are on the front lines addressing community challenges and opportunities.

Minnesota's local public health system, also known as the Community Health Services (CHS) system, is designed to ensure that the public's health and safety are protected while providing flexibility for local governments to identify and address local needs. The CHS system consists of 50 community health boards – the legally recognized governing bodies for local public health in Minnesota – that work in tandem with the Minnesota Department of Health to fulfill essential local public health responsibilities under Minnesota Statute 145A.

For more information, please contact:
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651-789-4354 or borr@mncounties.org

January 2013

Minnesota's Local Public Health System

Local Public Health Association of Minnesota

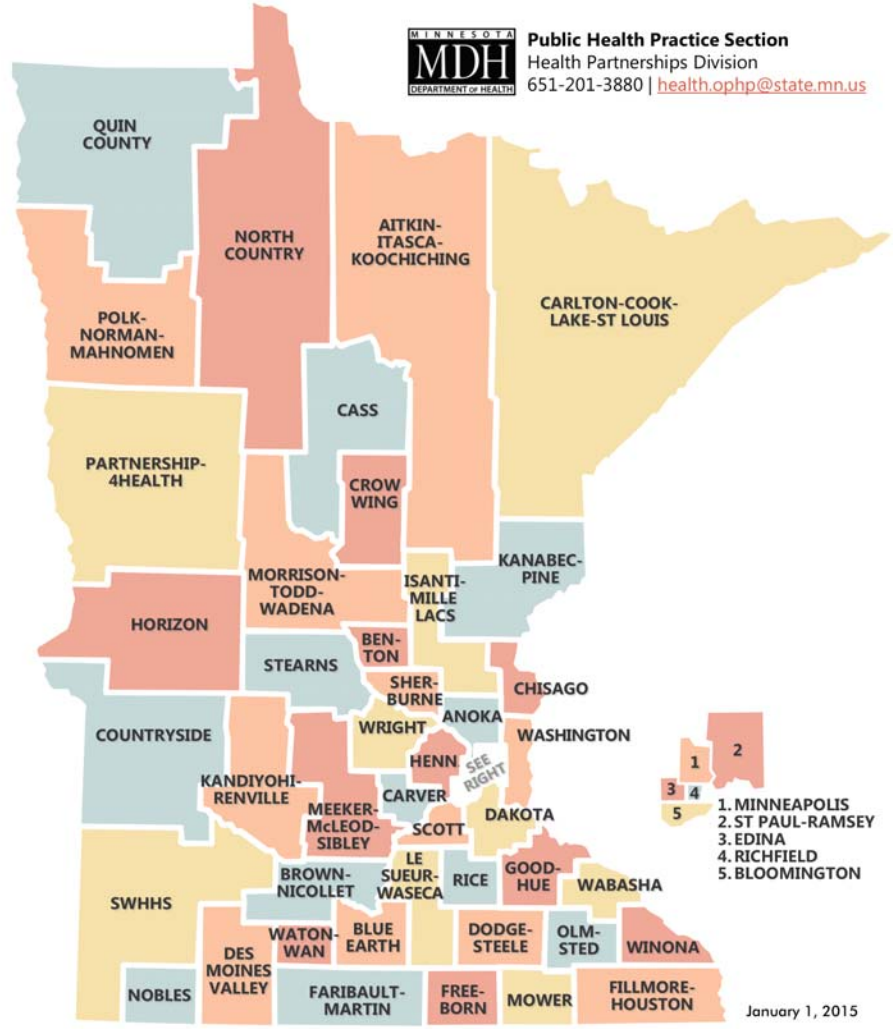
Public Health
Prevent. Promote. Protect.

Public health saves lives.

System Overview

- Since 1976, Minnesota's local public health system, also known as the Community Health Services (CHS) system, has ensured that the public's health and safety are protected while providing flexibility for local governments to identify and address community needs.
- The CHS system consists of 11 tribes and 48 community health boards—the legally recognized governing bodies for local public health in Minnesota—that work in tandem with the Minnesota Department of Health to fulfill essential local public health responsibilities under Minn. Stat. 145A.
- Local public health departments partner with multiple systems including schools, law enforcement, social services, municipalities, non-profits and private health care providers to coordinate high quality, non-duplicative programs.

MINNESOTA COMMUNITY HEALTH BOARDS



Six Areas of Local Public Health Responsibility

1. **Assure an adequate public health infrastructure.**
   For example:
   - Assess health needs of local communities.

2. **Promote healthy communities and healthy behaviors.**
   For example:
   - Develop policies to foster healthy communities.
   - Offer home visits to high-risk pregnant women and new families.
   - Implement youth tobacco and chemical use prevention programs.

3. **Prevent the spread of infectious disease.**
   For example:
   - Investigate and control communicable disease.
   - Run immunization clinics.

4. **Protect against environmental health hazards.**
   For example:
   - License and inspect restaurants, lodging, campgrounds, manufactured home parks, wells, and public pools.
   - Investigate and abate public health nuisances.
   - Inspect and coordinate repairs for lead and other Healthy Homes hazards.

5. **Prepare for and respond to disasters, and assist communities in recovery.**
   For example:
   - Develop response plans for re-emergence of Measles and new emerging threats like Ebola.

6. **Assure the quality and accessibility of health services.**
   For example:
   - Support elderly/disabled in nursing homes or community settings, perform long-term care consultation, personal care assistant assessments and case management duties.
   - Operate Women, Infants, and Children (WIC) clinics.
   - Provide health care services at county correctional facilities.

Funding & Return on Investment

Funding for local public health is a mix of local, state and federal funds as well as fees and reimbursements. An annual state general fund appropriation of approximately $21 million (less than $4 per capita) combined with local tax levy provides the foundation for the local public health infrastructure.[1]

- Having a base of stable, non-categorical state funding is critical. It has allowed local health departments to respond to a diverse array of public health issues and to meet community-specific needs.
- Minnesota currently ranks 44th (below almost all other states) in overall public health funding.[2]
- "Without a strong public health system as a complement, the medical care system cannot succeed in controlling health care costs or improving health. Unfortunately, attention to and investments in public health have been short term and episodic."[3]
- Research shows that every 10% increase in public health system spending results in a 7% decrease in infant mortality and a 3% decrease in heart disease mortality.[4]
- For every $1 invested in WIC services for pregnant women, up to $4.21 is saved in Medicaid funds for a mother and her newborn.[4]
- For every $1 invested in targeted family home visiting, a return of $1.24 to $5.70 can be expected in savings.[6]
- Investing $10 per person per year in proven community-based programs to increase physical activity, improve nutrition and prevent tobacco use could produce annual net savings of $316 million per year in Minnesota (a 6-to-1 return on investment).[7]

For more information, please contact:
Lorna Schmidt, Director, Local Public Health Association of Minnesota
651-789-4354 or lschmidt@mncounties.org

March 2015

[1] Minnesota Department of Health.

[2] United Health Foundation, "American's Health Rankings: A call to action for individuals and their communities,"2014.

[3] Minnesota Medical Association "Physicians Plan for a Healthy Minnesota: The MMA's Proposal for Health Care Reform," 2005.

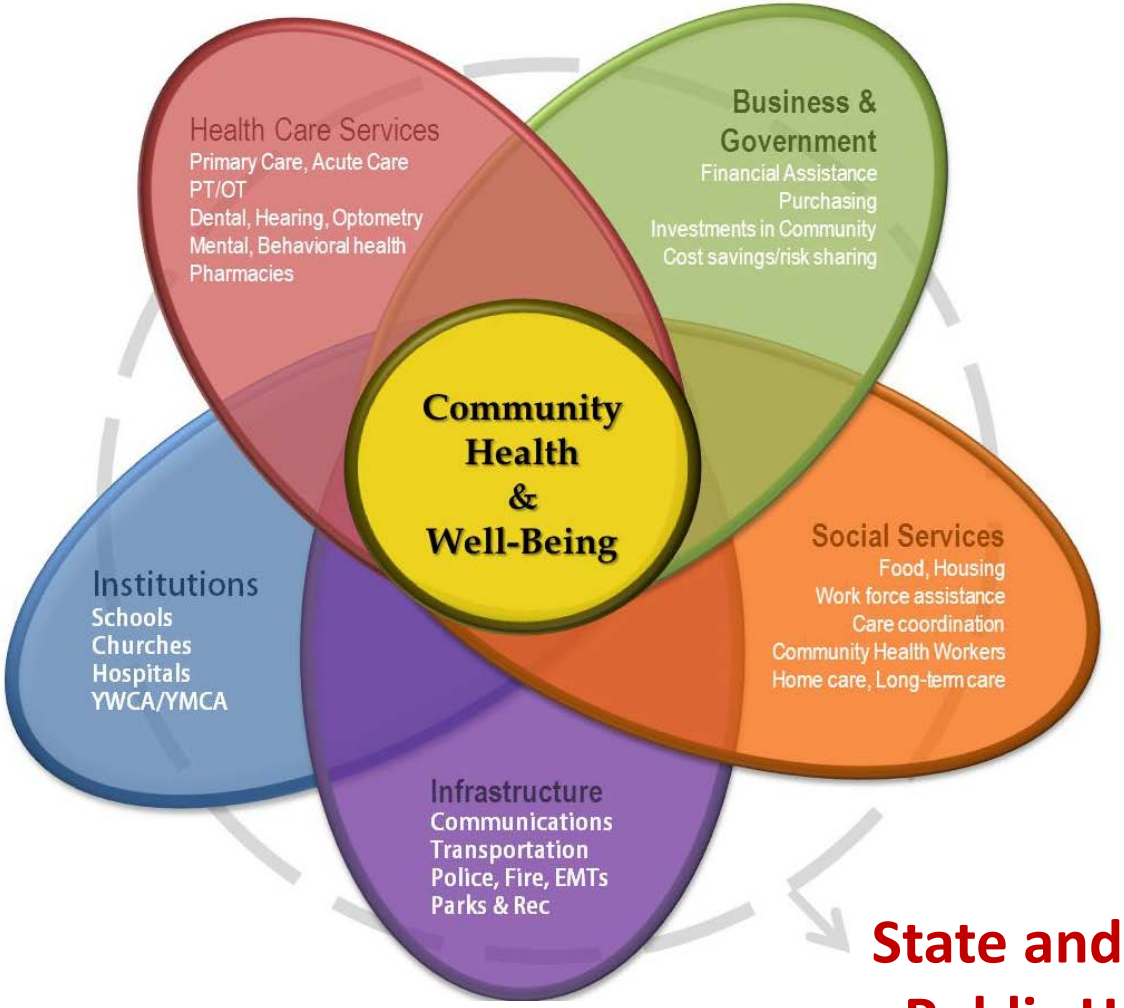
[4]Mays, GP, and Smith, SA, "Evidence Links Increases in Public Health Spending to Declines in Preventable Deaths," Health Affairs, doi:10.1377/hlthaff.2011.0196, 2011

[5] National WIC Association, "WIC: Solid Returns on Investment While Reducing the Deficit," 2011.

[6] Minnesota Department of Health, "Family Home Visiting Program: Report to the Minnesota Legislature 2014," March 2014.

[7] Trust for America's Health, "Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities,' February 2009.

Community Health



State and Local Public Health

CHAPTER 145A
LOCAL PUBLIC HEALTH BOARDS

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145A.02 DEFINITIONS.

BOARD OF HEALTH

145A.03 ESTABLISHMENT AND ORGANIZATION.

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COMMUNITY HEALTH BOARDS

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145A.14 SPECIAL GRANTS.

145A.17 FAMILY HOME VISITING PROGRAMS.

145A.01 CITATION.

This chapter may be cited as the "Local Public Health Act."

History: *1987 c 309 s 1*

145A.02 DEFINITIONS.

Subdivision 1. **Applicability.** Definitions in this section apply to this chapter.

Subd. 1a. **Areas of public health responsibility.** "Areas of public health responsibility" means:

(1) assuring an adequate local public health infrastructure;

(2) promoting healthy communities and healthy behaviors;

(3) preventing the spread of communicable disease;

(4) protecting against environmental health hazards;

(5) preparing for and responding to emergencies; and

(6) assuring health services.

Subd. 2. [Repealed, 2014 c 291 art 7 s 29]

Subd. 3. **City.** "City" means a statutory city or home rule charter city as defined in section 410.015.

Subd. 4. **Commissioner.** "Commissioner" means the Minnesota commissioner of health.

Subd. 5. **Community health board.** "Community health board" means the governing body for local public health in Minnesota. The community health board may be comprised of a single county, multiple contiguous counties, or in a limited number of cases, a single city as specified in section 145A.03, subdivision 1. CHBs have the responsibilities and authority under this chapter.

Subd. 6. **Community health services.** "Community health services" means activities designed to protect and promote the health of the general population within a community health service area by emphasizing the prevention of disease, injury, disability, and preventable death through the promotion

of effective coordination and use of community resources, and by extending health services into the community.

Subd. 6a. **Community health services administrator.** "Community health services administrator" means a person who meets personnel standards for the position established under section 145A.06, subdivision 3b, and is working under a written agreement with, employed by, or under contract with a community health board to provide public health leadership and to discharge the administrative and program responsibilities on behalf of the board.

Subd. 7. **Community health service area.** "Community health service area" means a city, county, or multicounty area that is organized as a community health board and for which a local public health grant is received under sections 145A.11 to 145A.131.

Subd. 8. **County board.** "County board" or "county" means a county board of commissioners as defined in chapter 375.

Subd. 8a. **Essential public health services.** "Essential public health services" means the public health activities that all communities should undertake. These services serve as the framework for the National Public Health Performance Standards. In Minnesota they refer to activities that are conducted to accomplish the areas of public health responsibility. The ten essential public health services are to:

(1) monitor health status to identify and solve community health problems;

(2) diagnose and investigate health problems and health hazards in the community;

(3) inform, educate, and empower people about health issues;

(4) mobilize community partnerships and action to identify and solve health problems;

(5) develop policies and plans that support individual and community health efforts;

(6) enforce laws and regulations that protect health and ensure safety;

(7) link people to needed personal health services and assure the provision of health care when otherwise unavailable;

(8) maintain a competent public health workforce;

(9) evaluate the effectiveness, accessibility, and quality of personal and population-based health services; and

(10) contribute to research seeking new insights and innovative solutions to health problems.

Subd. 8b. **Local health department.** "Local health department" means an operational entity that is responsible for the administration and implementation of programs and services to address the areas of public health responsibility. It is governed by a community health board.

Subd. 9. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 10. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 11. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 12. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 13. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 14. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 15. **Medical consultant.** "Medical consultant" means a physician licensed to practice medicine in Minnesota who is working under a written agreement with, employed by, or on contract with a community health board to provide advice and information, to authorize medical procedures through protocols, and to assist a community health board and its staff in coordinating their activities with local medical practitioners and health care institutions.

Subd. 15a. **Performance management.** "Performance management" means the systematic process of using data for decision making by identifying outcomes and standards; measuring, monitoring, and communicating progress; and engaging in quality improvement activities in order to achieve desired outcomes.

Subd. 15b. **Performance measures.** "Performance measures" means quantitative ways to define and measure performance.

Subd. 16. **Population.** "Population" means the total number of residents of the state or any city or county as established by the last federal census, by a special census taken by the United States Bureau of the Census, by the state demographer under section 4A.02, or by an estimate of city population prepared by the Metropolitan Council, whichever is the most recent as to the stated date of count or estimate.

Subd. 17. **Public health nuisance.** "Public health nuisance" means any activity or failure to act that adversely affects the public health.

Subd. 18. **Public health nurse.** "Public health nurse" means a person who is licensed as a registered nurse by the Minnesota Board of Nursing under sections 148.171 to 148.285 and who meets the voluntary registration requirements established by the Board of Nursing.

History: *1987 c 309 s 2; 1989 c 194 s 2; 1991 c 345 art 2 s 43; 1997 c 199 s 14; 1999 c 245 art 9 s 47; 1Sp2003 c 14 art 8 s 12-14; 2014 c 291 art 7 s 1-8,29*

BOARD OF HEALTH

145A.03 ESTABLISHMENT AND ORGANIZATION.

Subdivision 1. **Establishment; assignment of responsibilities.** (a) The governing body of a county must undertake the responsibilities of a community health board by establishing or joining a community health board according to paragraphs (b) to (f) and assigning to it the powers and duties specified under section 145A.04.

(b) A community health board must include within its jurisdiction a population of 30,000 or more persons or be composed of three or more contiguous counties.

(c) A county board or city council within the jurisdiction of a community health board operating under sections 145A.11 to 145A.131 is preempted from forming a community health board except as specified in section 145A.131.

(d) A county board or a joint powers board that establishes a community health board and has or establishes an operational human services board under chapter 402 may assign the powers and duties of a community health board to a human services board. Eligibility for funding from the commissioner will be maintained if all requirements of sections 145A.03 and 145A.04 are met.

(e) Community health boards established prior to January 1, 2014, including city community health boards, are eligible to maintain their status as community health boards as outlined in this subdivision.

(f) A community health board may authorize, by resolution, the community health service administrator or other designated agent or agents to act on behalf of the community health board.

Subd. 2. **Joint powers community health board.** A county may establish a joint community health board by agreement with one or more contiguous counties, or an existing city community health board may establish a joint community health board with one or more contiguous existing city community health boards in the same county in which it is located. The agreements must be established according to section 471.59.

Subd. 3. [Repealed, 2014 c 291 art 7 s 29]

Subd. 4. **Membership; duties of chair.** A community health board must have at least five members, one of whom must be elected by the members as chair and one as vice-chair. The chair, or in the chair's absence, the vice-chair, must preside at meetings of the community health board and sign or authorize an agent to sign contracts and other documents requiring signature on behalf of the community health board.

Subd. 5. **Meetings.** A community health board must hold meetings at least twice a year and as determined by its rules of procedure. The board must adopt written procedures for transacting business and must keep a public record of its transactions, findings, and determinations. Members may receive a per diem plus travel and other eligible expenses while engaged in official duties.

Subd. 6. [Repealed, 2014 c 291 art 7 s 29]

Subd. 7. **Community health board; eligibility for funding.** A community health board that meets the requirements of this section is eligible to receive the local public health grant under section 145A.131 and for other funds that the commissioner grants to community health boards to carry out public health activities.

History: *1987 c 309 s 3; 1991 c 52 s 3; 1Sp2003 c 14 art 8 s 31; 2014 c 291 art 7 s 9-13,29*

145A.04 POWERS AND DUTIES OF COMMUNITY HEALTH BOARD.

Subdivision 1. **Jurisdiction; enforcement.** (a) A community health board has the general responsibility for development and maintenance of a system of community health services under local administration and within a system of state guidelines and standards.

(b) Under the general supervision of the commissioner, the community health board shall recommend the enforcement of laws, regulations, and ordinances pertaining to the powers and duties within its jurisdictional area. In the case of a multicounty or city community health board, the joint powers agreement under section 145A.03, subdivision 2, or delegation agreement under section 145A.07 shall clearly specify enforcement authorities.

(c) A member of a community health board may not withdraw from a joint powers community health board during the first two calendar years following the effective date of the initial joint powers agreement. The withdrawing member must notify the commissioner and the other parties to the agreement at least one year before the beginning of the calendar year in which withdrawal takes effect.

(d) The withdrawal of a county or city from a community health board does not affect the eligibility for the local public health grant of any remaining county or city for one calendar year following the effective date of withdrawal.

(e) The local public health grant for a county or city that chooses to withdraw from a multicounty community health board shall be reduced by the amount of the local partnership incentive.

Subd. 1a. **Duties.** Consistent with the guidelines and standards established under section 145A.06, the community health board shall:

(1) identify local public health priorities and implement activities to address the priorities and the areas of public health responsibility, which include:

(i) assuring 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;

(ii) promoting 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;

(iii) preventing the spread of communicable disease 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;

(iv) protecting 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;

(v) preparing and responding 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; and

(vi) assuring health services by engaging in activities such as assessing the availability of health-related services and health care 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; and

(2) submit to the commissioner of health, at least every five years, a community health assessment and community health improvement plan, which shall be developed with input from the community and take into consideration the statewide outcomes, the areas of responsibility, and essential public health services;

(3) implement a performance management process in order to achieve desired outcomes; and

(4) annually report to the commissioner on a set of performance measures and be prepared to provide documentation of ability to meet the performance measures.

Subd. 2. **Appointment of community health service (CHS) administrator.** A community health board must appoint, employ, or contract with a CHS administrator to act on its behalf. The board shall notify the commissioner of the CHS administrator's contact information and submit a copy of the resolution authorizing the CHS administrator to act as an agent on the board's behalf. The resolution must specify the types of action or actions that the CHS administrator is authorized to take on behalf of the board.

Subd. 2a. **Appointment of medical consultant.** The community health board shall appoint, employ, or contract with a medical consultant to ensure appropriate medical advice and direction for the community health board and assist the board and its staff in the coordination of community health services with local medical care and other health services.

Subd. 3. **Employment; employees.** (a) A community health board may employ persons as necessary to carry out its duties.

(b) Except where prohibited by law, employees of the community health board may act as its agents.

(c) Persons employed by a county, city, or the state whose functions and duties are assumed by a community health board shall become employees of the board without loss in benefits, salaries, or rights.

Subd. 4. **Acquisition of property; request for and acceptance of funds; collection of fees.** (a) A community health board may acquire and hold in the name of the county or city the lands, buildings, and equipment necessary for the purposes of sections 145A.03 to 145A.131. It may do so by any lawful means, including gifts, purchase, lease, or transfer of custodial control.

(b) A community health board may accept gifts, grants, and subsidies from any lawful source, apply for and accept state and federal funds, and request and accept local tax funds.

(c) A community health board may establish and collect reasonable fees for performing its duties and providing community health services.

(d) With the exception of licensing and inspection activities, access to community health services provided by or on contract with the community health board must not be denied to an individual or family because of inability to pay.

Subd. 5. **Contracts.** To improve efficiency, quality, and effectiveness, avoid unnecessary duplication, and gain cost advantages, a community health board may contract to provide, receive, or ensure provision of services.

Subd. 6. **Investigation; reporting and control of communicable diseases.** A community health board shall make investigations, or coordinate with any county board or city council within its jurisdiction to make investigations and reports and obey instructions on the control of communicable diseases as the commissioner may direct under section 144.12, 145A.06, subdivision 2, or 145A.07. Community health boards must cooperate so far as practicable to act together to prevent and control epidemic diseases.

Subd. 6a. **Minnesota Responds Medical Reserve Corps; planning.** A community health board receiving funding for emergency preparedness or pandemic influenza planning from the state or from the United States Department of Health and Human Services shall participate in planning for emergency use of volunteer health professionals through the Minnesota Responds Medical Reserve Corps program of the Department of Health. A community health board shall collaborate on volunteer planning with other public and private partners, including but not limited to local or regional health care providers, emergency medical

services, hospitals, tribal governments, state and local emergency management, and local disaster relief organizations.

Subd. 6b. **Minnesota Responds Medical Reserve Corps; agreements.** A community health board, county, or city participating in the Minnesota Responds Medical Reserve Corps program may enter into written mutual aid agreements for deployment of its paid employees and its Minnesota Responds Medical Reserve Corps volunteers with other community health boards, other political subdivisions within the state, or with tribal governments within the state. A community health board may also enter into agreements with the Indian Health Services of the United States Department of Health and Human Services, and with boards of health, political subdivisions, and tribal governments in bordering states and Canadian provinces.

Subd. 6c. **Minnesota Responds Medical Reserve Corps; when mobilized.** When a community health board, county, or city finds that the prevention, mitigation, response to, or recovery from an actual or threatened public health event or emergency exceeds its local capacity, it shall use available mutual aid agreements. If the event or emergency exceeds mutual aid capacities, a community health board, county, or city may request the commissioner of health to mobilize Minnesota Responds Medical Reserve Corps volunteers from outside the jurisdiction of the community health board, county, or city.

Subd. 6d. **Minnesota Responds Medical Reserve Corps; liability coverage.** A Minnesota Responds Medical Reserve Corps volunteer responding to a request for training or assistance at the call of a community health board, county, or city must be deemed an employee of the jurisdiction for purposes of workers' compensation, tort claim defense, and indemnification.

Subd. 7. **Entry for inspection.** To enforce public health laws, ordinances or rules, a member or agent of a community health board, county, or city may enter a building, conveyance, or place where contagion, infection, filth, or other source or cause of preventable disease exists or is reasonably suspected.

Subd. 8. **Removal and abatement of public health nuisances.** (a) If a threat to the public health such as a public health nuisance, source of filth, or cause of sickness is found on any property, the community health board, county, city, or its agent shall order the owner or occupant of the property to remove or abate the threat within a time specified in the notice but not longer than ten days. Action to recover costs of enforcement under this subdivision must be taken as prescribed in section 145A.08.

(b) Notice for abatement or removal must be served on the owner, occupant, or agent of the property in one of the following ways:

(1) by registered or certified mail;

(2) by an officer authorized to serve a warrant; or

(3) by a person aged 18 years or older who is not reasonably believed to be a party to any action arising from the notice.

(c) If the owner of the property is unknown or absent and has no known representative upon whom notice can be served, the community health board, county, or city, or its agent, shall post a written or printed notice on the property stating that, unless the threat to the public health is abated or removed within a period not longer than ten days, the community health board, county, or city will have the threat abated or removed at the expense of the owner under section 145A.08 or other applicable state or local law.

(d) If the owner, occupant, or agent fails or neglects to comply with the requirement of the notice provided under paragraphs (b) and (c), then the community health board, county, city, or a designated agent

of the board, county, or city shall remove or abate the nuisance, source of filth, or cause of sickness described in the notice from the property.

Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the community health board, county, or city may bring an action in the court of appropriate jurisdiction to enjoin a violation of statute, rule, or ordinance that the board has power to enforce, or to enjoin as a public health nuisance any activity or failure to act that adversely affects the public health.

Subd. 10. **Hindrance of enforcement prohibited; penalty.** It is a misdemeanor to deliberately hinder a member of a community health board, county or city, or its agent from entering a building, conveyance, or place where contagion, infection, filth, or other source or cause of preventable disease exists or is reasonably suspected, or otherwise to interfere with the performance of the duties of the responsible jurisdiction.

Subd. 11. **Neglect of enforcement prohibited; penalty.** It is a misdemeanor for a member or agent of a community health board, county, or city to refuse or neglect to perform a duty imposed on an applicable jurisdiction by statute or ordinance.

Subd. 12. **Other powers and duties established by law.** This section does not limit powers and duties of a community health board, county, or city prescribed in other sections.

Subd. 13. **Recommended legislation.** The community health board may recommend local ordinances pertaining to community health services to any county board or city council within its jurisdiction and advise the commissioner on matters relating to public health that require assistance from the state, or that may be of more than local interest.

Subd. 14. **Equal access to services.** The community health board must ensure that community health services are accessible to all persons on the basis of need. No one shall be denied services because of race, color, sex, age, language, religion, nationality, inability to pay, political persuasion, or place of residence.

Subd. 15. **State and local advisory committees.** (a) A state community health services advisory committee is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of local public health services. Each community health board may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. Members or their alternates may be reimbursed for travel and other necessary expenses while engaged in their official duties.

(b) Notwithstanding section 15.059, the State Community Health Services Advisory Committee does not expire.

(c) The city boards or county boards that have established or are members of a community health board may appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on the duties under subdivision 1a.

History: *1987 c 309 s 4; 1Sp2003 c 14 art 8 s 31; 2008 c 202 s 2-4; 2013 c 43 s 21; 2014 c 291 art 7 s 14*

145A.05 LOCAL ORDINANCES.

Subdivision 1. **Generally.** A county board may adopt ordinances for all or a part of its jurisdiction to regulate actual or potential threats to the public health under this section and section 375.51, unless the ordinances are preempted by, in conflict with, or less restrictive than standards in state law or rule.

Subd. 2. **Animal control.** In addition to powers under sections 35.67 to 35.69, a county board, city council, or municipality may adopt ordinances to issue licenses or otherwise regulate the keeping of animals, to restrain animals from running at large, to authorize the impounding and sale or summary destruction of animals, and to establish pounds.

Subd. 3. **Control of unwholesome substances.** Unless preempted by or in conflict with sections 394.21 to 394.37, a county board may adopt ordinances to prevent bringing, depositing, or leaving within the county any unwholesome substance and to require the owners or occupants of lands to remove unwholesome substances or to provide for removal at the expense of the owner or occupant.

Subd. 4. **Regulation of waste.** A county board may adopt ordinances to provide for or regulate the disposal of sewage, garbage, and other refuse.

Subd. 5. **Regulation of water.** A county board may adopt ordinances to provide for cleaning and removal of obstructions from waters in the county and to prevent their obstruction or pollution.

Subd. 6. **Regulation of offensive trades.** A county board may adopt ordinances to regulate offensive trades, unless the ordinances are preempted by, in conflict with, or less restrictive than standards under sections 394.21 to 394.37. In this subdivision, "offensive trade" means a trade or employment that is hurtful to inhabitants within any county, city, or town, dangerous to the public health, injurious to neighboring property, or from which offensive odors arise.

Subd. 7. **Control of public health nuisances.** A county board may adopt ordinances to define public health nuisances and to provide for their prevention or abatement.

Subd. 7a. **Curfew.** A county board may adopt an ordinance establishing a countywide curfew for unmarried persons under 18 years of age. If the county board of a county located in the seven-county metropolitan area adopts a curfew ordinance under this subdivision, the ordinance shall contain an earlier curfew for children under the age of 12 than for older children.

Subd. 8. **Enforcement of delegated powers.** A county board may adopt ordinances consistent with this section to administer and enforce the powers and duties delegated by agreement with the commissioner under section 145A.07.

Subd. 9. **Relation to cities and towns.** The governing body of a city or town may adopt ordinances relating to the public health authorized by law or agreement with the commissioner under section 145A.07. The ordinances must not conflict with or be less restrictive than ordinances adopted by the county board within whose jurisdiction the city or town is located.

History: *1987 c 309 s 5; 1994 c 636 art 9 s 10; 1995 c 226 art 2 s 1; 2014 c 291 art 7 s 15*

145A.06 COMMISSIONER; POWERS AND DUTIES.

Subdivision 1. **Generally.** In addition to other powers and duties provided by law, the commissioner has the powers listed in subdivisions 2 to 5.

Subd. 2. **Supervision of local enforcement.** (a) In the absence of provision for a community health board, the commissioner may appoint three or more persons to act as a board until one is established. The commissioner may fix their compensation, which the county or city must pay.

(b) The commissioner by written order may require any two or more community health boards, counties, or cities to act together to prevent or control epidemic diseases.

(c) If a community health board, county, or city fails to comply with section 145A.04, subdivision 6, the commissioner may employ medical and other help necessary to control communicable disease at the expense of the jurisdiction involved.

(d) If the commissioner has reason to believe that the provisions of this chapter have been violated, the commissioner shall inform the attorney general and submit information to support the belief. The attorney general shall institute proceedings to enforce the provisions of this chapter or shall direct the county attorney to institute proceedings.

Subd. 3. [Repealed, 1989 c 194 s 22]

Subd. 3a. **Assistance to community health boards.** The commissioner shall help and advise community health boards that ask for assistance in developing, administering, and carrying out public health services and programs. This assistance may consist of, but is not limited to:

(1) informational resources, consultation, and training to assist community health boards plan, develop, integrate, provide, and evaluate community health services; and

(2) administrative and program guidelines and standards developed with the advice of the State Community Health Services Advisory Committee.

Subd. 3b. **Personnel standards.** In accordance with chapter 14, and in consultation with the State Community Health Services Advisory Committee, the commissioner may adopt rules to set standards for administrative and program personnel to ensure competence in administration and planning.

Subd. 4. **Assistance to boards of health.** The commissioner shall help and advise boards of health that ask for help in developing, administering, and carrying out public health services and programs.

Subd. 5. **Deadly infectious diseases.** The commissioner shall promote measures aimed at preventing businesses from facilitating sexual practices that transmit deadly infectious diseases by providing technical advice to community health boards to assist them in regulating these practices or closing establishments that constitute a public health nuisance.

Subd. 5a. **System-level performance management.** To improve public health and ensure the integrity and accountability of the statewide local public health system, the commissioner, in consultation with the State Community Health Services Advisory Committee, shall develop performance measures and implement a process to monitor statewide outcomes and performance improvement.

Subd. 6. **Health volunteer program.** (a) The commissioner may accept grants from the United States Department of Health and Human Services for the emergency system for the advanced registration of volunteer health professionals (ESAR-VHP) established under United States Code, title 42, section 247d-7b. The ESAR-VHP program as implemented in Minnesota is known as the Minnesota Responds Medical Reserve Corps.

(b) The commissioner may maintain a registry of volunteers for the Minnesota Responds Medical Reserve Corps and obtain data on volunteers relevant to possible deployments within and outside the state. All state licensing and certifying boards shall cooperate with the Minnesota Responds Medical Reserve Corps and shall verify volunteers' information. The commissioner may also obtain information from other states and national licensing or certifying boards for health practitioners.

(c) The commissioner may share volunteers' data, including any data classified as private data, from the Minnesota Responds Medical Reserve Corps registry with community health boards, cities or counties, the University of Minnesota's Academic Health Center or other public or private emergency preparedness partners, or tribal governments operating Minnesota Responds Medical Reserve Corps units as needed for credentialing, organizing, training, and deploying volunteers. Upon request of another state participating in the ESAR-VHP or of a Canadian government administering a similar health volunteer program, the commissioner may also share the volunteers' data as needed for emergency preparedness and response.

Subd. 7. **Commissioner requests for health volunteers.** (a) When the commissioner receives a request for health volunteers from:

(1) a community health board, county, or city according to section 145A.04, subdivision 6c;

(2) the University of Minnesota Academic Health Center;

(3) another state or a territory through the Interstate Emergency Management Assistance Compact authorized under section 192.89;

(4) the federal government through ESAR-VHP or another similar program; or

(5) a tribal or Canadian government;

the commissioner shall determine if deployment of Minnesota Responds Medical Reserve Corps volunteers from outside the requesting jurisdiction is in the public interest. If so, the commissioner may ask for Minnesota Responds Medical Reserve Corps volunteers to respond to the request. The commissioner may also ask for Minnesota Responds Medical Reserve Corps volunteers if the commissioner finds that the state needs health volunteers.

(b) The commissioner may request Minnesota Responds Medical Reserve Corps volunteers to work on the Minnesota Mobile Medical Unit (MMU), or on other mobile or temporary units providing emergency patient stabilization, medical transport, or ambulatory care. The commissioner may utilize the volunteers for training, mobilization or demobilization, inspection, maintenance, repair, or other support functions for the MMU facility or for other emergency units, as well as for provision of health care services.

(c) A volunteer's rights and benefits under this chapter as a Minnesota Responds Medical Reserve Corps volunteer is not affected by any vacation leave, pay, or other compensation provided by the volunteer's employer during volunteer service requested by the commissioner. An employer is not liable for actions of an employee while serving as a Minnesota Responds Medical Reserve Corps volunteer.

(d) If the commissioner matches the request under paragraph (a) with Minnesota Responds Medical Reserve Corps volunteers, the commissioner shall facilitate deployment of the volunteers from the sending Minnesota Responds Medical Reserve Corps units to the receiving jurisdiction. The commissioner shall track volunteer deployments and assist sending and receiving jurisdictions in monitoring deployments, and shall coordinate efforts with the division of homeland security and emergency management for out-of-state deployments through the Interstate Emergency Management Assistance Compact or other emergency management compacts.

(e) Where the commissioner has deployed Minnesota Responds Medical Reserve Corps volunteers within or outside the state, the provisions of paragraphs (f) and (g) must apply. Where Minnesota Responds

Medical Reserve Corps volunteers were deployed across jurisdictions by mutual aid or similar agreements prior to a commissioner's call, the provisions of paragraphs (f) and (g) must apply retroactively to volunteers deployed as of their initial deployment in response to the event or emergency that triggered a subsequent commissioner's call.

(f)(1) A Minnesota Responds Medical Reserve Corps volunteer responding to a request for training or assistance at the call of the commissioner must be deemed an employee of the state for purposes of workers' compensation and tort claim defense and indemnification under section 3.736, without regard to whether the volunteer's activity is under the direction and control of the commissioner, the division of homeland security and emergency management, the sending jurisdiction, the receiving jurisdiction, or of a hospital, alternate care site, or other health care provider treating patients from the public health event or emergency.

(2) For purposes of calculating workers' compensation benefits under chapter 176, the daily wage must be the usual wage paid at the time of injury or death for similar services performed by paid employees in the community where the volunteer regularly resides, or the wage paid to the volunteer in the volunteer's regular employment, whichever is greater.

(g) The Minnesota Responds Medical Reserve Corps volunteer must receive reimbursement for travel and subsistence expenses during a deployment approved by the commissioner under this subdivision according to reimbursement limits established for paid state employees. Deployment begins when the volunteer leaves on the deployment until the volunteer returns from the deployment, including all travel related to the deployment. The Department of Health shall initially review and pay those expenses to the volunteer. Except as otherwise provided by the Interstate Emergency Management Assistance Compact in section 192.89 or agreements made thereunder, the department shall bill the jurisdiction receiving assistance and that jurisdiction shall reimburse the department for expenses of the volunteers.

(h) In the event Minnesota Responds Medical Reserve Corps volunteers are deployed outside the state pursuant to the Interstate Emergency Management Assistance Compact, the provisions of the Interstate Emergency Management Assistance Compact must control over any inconsistent provisions in this section.

(i) When a Minnesota Responds Medical Reserve Corps volunteer makes a claim for workers' compensation arising out of a deployment under this section or out of a training exercise conducted by the commissioner, the volunteer's workers compensation benefits must be determined under section 176.011, subdivision 9, clause (25), even if the volunteer may also qualify under other clauses of section 176.011, subdivision 9.

Subd. 8. **Volunteer health practitioners licensed in other states.** (a) While an emergency declaration is in effect, a volunteer health practitioner who is (1) registered with a registration system that complies with the emergency system for the advanced registration of volunteer health professionals (ESAR-VHP) established under United States Code, title 42, section 247d-7b; (2) licensed and in good standing in the state upon which the practitioner's registration is based; and (3) (i) requested for deployment by the state's authorized representative under section 192.89, or (ii) deployed pursuant to an agreement between the disaster relief organization, professional association of health practitioners, health care facilities or providers, or other individuals or entities and the state's authorized representative under section 192.89, may practice in this state within the scope of practice authorized in the licensing state and to the extent authorized by this section as if the practitioner were licensed in this state. A "volunteer health practitioner" means a health practitioner who provides health or veterinary services, whether or not the practitioner receives compensation for those services. The term does not include a practitioner who receives compensation pursuant to a preexisting employment relationship with a host entity or affiliate which requires the practitioner to provide

health services in this state, unless the practitioner is not a resident of this state and is employed by a disaster relief organization providing services in this state while an emergency declaration is in effect.

(b) A volunteer health practitioner qualified under paragraph (a) is entitled to the liability protections of section 192.89, subdivision 6, unless any license of the practitioner in any state has been suspended, revoked, or subject to an agency order limiting or restricting practice privileges, or has been voluntarily terminated under threat of sanction.

History: *1987 c 309 s 6; 1988 c 689 art 2 s 47; 1Sp2003 c 14 art 8 s 15; 2008 c 202 s 5-7; 2009 c 41 s 7; 2009 c 72 s 1; 2013 c 43 s 22; 2014 c 291 art 7 s 16-22*

145A.061 CRIMINAL BACKGROUND STUDIES.

Subdivision 1. **Agreements to conduct criminal background studies.** The commissioner of health may develop agreements to conduct criminal background studies on each person who registers as a volunteer in the Minnesota Responds Medical Reserve Corps and applies for membership in the Minnesota behavioral health or mobile medical teams. The background study is for the purpose of determining the applicant's suitability and eligibility for membership. Each applicant must provide written consent authorizing the Department of Health to obtain the applicant's state criminal background information.

Subd. 2. **Opportunity to challenge accuracy of report.** Before denying the applicant the opportunity to serve as a health volunteer due to information obtained from a background study, the commissioner shall provide the applicant with the opportunity to complete, or challenge the accuracy of, the criminal justice information reported to the commissioner. The applicant shall have 30 calendar days to correct or complete the record prior to the commissioner taking final action based on the report.

Subd. 3. **Denial of service.** The commissioner may deny an application from any applicant who has been convicted of any of the following crimes:

Section 609.185 (murder in the first degree); section 609.19 (murder in the second degree); section 609.195 (murder in the third degree); section 609.20 (manslaughter in the first degree); section 609.205 (manslaughter in the second degree); section 609.25 (kidnapping); section 609.2661 (murder of an unborn child in the first degree); section 609.2662 (murder of an unborn child in the second degree); section 609.2663 (murder of an unborn child in the third degree); section 609.342 (criminal sexual conduct in the first degree); section 609.343 (criminal sexual conduct in the second degree); section 609.344 (criminal sexual conduct in the third degree); section 609.345 (criminal sexual conduct in the fourth degree); section 609.3451 (criminal sexual conduct in the fifth degree); section 609.3453 (criminal sexual predatory conduct); section 609.352 (solicitation of children to engage in sexual conduct); section 609.352 (communication of sexually explicit materials to children); section 609.365 (incest); section 609.377 (felony malicious punishment of a child); section 609.378 (felony neglect or endangerment of a child); section 609.561 (arson in the first degree); section 609.562 (arson in the second degree); section 609.563 (arson in the third degree); section 609.749, subdivision 3, 4, or 5 (felony stalking); section 152.021 (controlled substance crimes in the first degree); section 152.022 (controlled substance crimes in the second degree); section 152.023 (controlled substance crimes in the third degree); section 152.024 (controlled substance crimes in the fourth degree); section 152.025 (controlled substance crimes in the fifth degree); section 243.166 (violation of predatory offender registration law); section 617.23, subdivision 2, clause (1), or subdivision 3, clause (1) (indecent exposure involving a minor); section 617.246 (use of minors in sexual performance); section 617.247 (possession of pornographic work involving minors); section 609.221 (assault in the first degree); section 609.222 (assault in the second degree); section 609.223 (assault in the third

degree); section 609.2231 (assault in the fourth degree); section 609.224 (assault in the fifth degree); section 609.2242 (domestic assault); section 609.2247 (domestic assault by strangulation); section 609.228 (great bodily harm caused by distribution of drugs); section 609.23 (mistreatment of persons confined); section 609.231 (mistreatment of residents or patients); section 609.2325 (criminal abuse); section 609.233 (criminal neglect); section 609.2335 (financial exploitation of a vulnerable adult); section 609.234 (failure to report); section 609.24 (simple robbery); section 609.245 (aggravated robbery); section 609.255 (false imprisonment); section 609.322 (solicitation, inducement, and promotion of prostitution and sex trafficking); section 609.324, subdivision 1 (hiring or engaging minors in prostitution); section 609.465 (presenting false claims to a public officer or body); section 609.466 (medical assistance fraud); section 609.52 (felony theft); section 609.82 (felony fraud in obtaining credit); section 609.527 (felony identity theft); section 609.582 (felony burglary); section 609.611 (felony insurance fraud); section 609.625 (aggravated forgery); section 609.63 (forgery); section 609.631 (felony check forgery); section 609.66, subdivision 1e (felony drive-by shooting); section 609.71 (felony riot); section 609.713 (terroristic threats); section 609.72, subdivision 3 (disorderly conduct by a caregiver against a vulnerable adult); section 609.821 (felony financial transaction card fraud); section 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); or aiding and abetting, attempting, or conspiring to commit any of the offenses in this subdivision.

Subd. 4. **Conviction.** For purposes of this section, an applicant is considered to have been convicted of a crime if the applicant was convicted, or otherwise found guilty, including by entering an Alford plea; was found guilty but the adjudication of guilt was stayed or withheld; or was convicted but the imposition or execution of a sentence was stayed.

Subd. 5. **Data practices.** All state criminal history record information or data obtained by the commissioner from the Bureau of Criminal Apprehension is private data on individuals under section 13.02, subdivision 12, and restricted to the exclusive use of the commissioner for the purpose of evaluating an applicant's eligibility for participation in the behavioral health or mobile field medical team.

Subd. 6. **Use of volunteers by commissioner.** The commissioner may deny a volunteer membership on a mobile medical team or behavioral health team for any reason, and is only required to communicate the reason when membership is denied as a result of information received from a criminal background study. The commissioner is exempt from the Criminal Offenders Rehabilitation Act under chapter 364 in the selection of volunteers for any position or activity including the Minnesota Responds Medical Reserve Corps, the Minnesota behavioral health team, and the mobile medical team.

History: *2013 c 43 s 23; 2014 c 275 art 1 s 28*

145A.07 DELEGATION OF POWERS AND DUTIES.

Subdivision 1. **Agreements to perform duties of commissioner.** (a) The commissioner of health may enter into an agreement with any community health board, or county or city that has an established delegation agreement as of January 1, 2014, to delegate all or part of the licensing, inspection, reporting, and enforcement duties authorized under sections 144.12; 144.381 to 144.387; 144.411 to 144.417; 144.71 to 144.74; 145A.04, subdivision 6; provisions of chapter 103I pertaining to construction, repair, and abandonment of water wells; chapter 157; and sections 327.14 to 327.28.

(b) Agreements are subject to subdivision 3.

(c) This subdivision does not affect agreements entered into under Minnesota Statutes 1986, section 145.031, 145.55, or 145.918, subdivision 2.

Subd. 2. **Agreements to perform duties of community health board.** A community health board may authorize a city or county within its jurisdiction to carry out activities to fulfill community health board responsibilities. An agreement to delegate community health board powers and duties to a county or city must be approved by the commissioner.

Subd. 3. **Terms of agreements.** (a) Agreements authorized under this section must be in writing and signed by the delegating authority and the designated agent.

(b) The agreement must list criteria the delegating authority will use to determine if the designated agent's performance meets appropriate standards and is sufficient to replace performance by the delegating authority.

(c) The agreement may specify minimum staff requirements and qualifications, set procedures for the assessment of costs, and provide for termination procedures if the delegating authority finds that the designated agent fails to comply with the agreement.

(d) A designated agent must not perform licensing, inspection, or enforcement duties under the agreement in territory outside its jurisdiction unless approved by the governing body for that territory through a separate agreement.

(e) The scope of agreements established under this section is limited to duties and responsibilities agreed upon by the parties. The agreement may provide for automatic renewal and for notice of intent to terminate by either party.

(f) During the life of the agreement, the delegating authority shall not perform duties that the designated agent is required to perform under the agreement, except inspections necessary to determine compliance with the agreement and this section or as agreed to by the parties.

(g) The delegating authority shall consult with, advise, and assist a designated agent in the performance of its duties under the agreement.

(h) This section does not alter the responsibility of the delegating authority for the performance of duties specified in law.

History: *1987 c 309 s 7; 1989 c 209 art 2 s 18; 1990 c 426 art 2 s 1; 1993 c 206 s 12; 1995 c 186 s 43; 2014 c 291 art 7 s 23,24*

145A.08 ASSESSMENT OF COSTS; TAX LEVY AUTHORIZED.

Subdivision 1. **Cost of care.** A person who has or whose dependent or spouse has a communicable disease that is subject to control by the community health board is financially liable to the unit or agency of government that paid for the reasonable cost of care provided to control the disease under section 145A.04, subdivision 6.

Subd. 2. **Assessment of costs of enforcement.** (a) If costs are assessed for enforcement of section 145A.04, subdivision 8, and no procedure for the assessment of costs has been specified in an agreement established under section 145A.07, the enforcement costs must be assessed as prescribed in this subdivision.

(b) A debt or claim against an individual owner or single piece of real property resulting from an enforcement action authorized by section 145A.04, subdivision 8, must not exceed the cost of abatement or removal.

(c) The cost of an enforcement action under section 145A.04, subdivision 8, may be assessed and charged against the real property on which the public health nuisance, source of filth, or cause of sickness was located. The auditor of the county in which the action is taken shall extend the cost so assessed and charged on the tax roll of the county against the real property on which the enforcement action was taken.

(d) The cost of an enforcement action taken by a town or city under section 145A.04, subdivision 8, may be recovered from the county in which the town or city is located if the city clerk or other officer certifies the costs of the enforcement action to the county auditor as prescribed in this section. Taxes equal to the full amount of the enforcement action but not exceeding the limit in paragraph (b) must be collected by the county treasurer and paid to the city or town as other taxes are collected and paid.

Subd. 3. **Tax levy authorized.** A city council or county board that has formed or is a member of a community health board may levy taxes on all taxable property in its jurisdiction to pay the cost of performing its duties under this chapter.

History: *1987 c 309 s 8; 1Sp1989 c 1 art 5 s 6; 2014 c 291 art 7 s 25*

COMMUNITY HEALTH BOARDS

145A.09 Subdivision 1. [Repealed, 2014 c 291 art 7 s 29]

Subd. 2. [Repealed, 2014 c 291 art 7 s 29]

Subd. 3. [Repealed, 2014 c 291 art 7 s 29]

Subd. 4. [Repealed, 2014 c 291 art 7 s 29]

Subd. 5. [Repealed, 2014 c 291 art 7 s 29]

Subd. 6. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 7. [Repealed, 2014 c 291 art 7 s 29]

145A.10 Subdivision 1. [Repealed, 2014 c 291 art 7 s 29]

Subd. 2. [Repealed, 2014 c 291 art 7 s 29]

Subd. 3. [Repealed, 2014 c 291 art 7 s 29]

Subd. 4. [Repealed, 2014 c 291 art 7 s 29]

Subd. 5. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 5a. [Repealed, 2014 c 291 art 7 s 29]

Subd. 6. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 7. [Repealed, 2014 c 291 art 7 s 29]

Subd. 8. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 9. [Repealed, 2014 c 291 art 7 s 29]

Subd. 10. [Repealed, 2014 c 291 art 7 s 29]

NOTE: Subdivision 10 was also amended by Laws 2014, chapter 286, article 8, section 19, to read as follows:

"Subd. 10. **State and local advisory committees.** (a) A State Community Health Advisory Committee is established to advise, consult with, and make recommendations to the commissioner on the development,

maintenance, funding, and evaluation of community health services. Each community health board may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. Members or their alternates may be reimbursed for travel and other necessary expenses while engaged in their official duties.

(b) The city councils or county boards that have established or are members of a community health board may appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on the duties under subdivision 5a."

145A.11 POWERS AND DUTIES OF CITY AND COUNTY.

Subdivision 1. **Generally.** In addition to the powers and duties prescribed elsewhere in law and in section 145A.05, a city council or county board that has formed or is a member of a community health board has the powers and duties prescribed in this section.

Subd. 2. **Levying taxes.** In levying taxes authorized under section 145A.08, subdivision 3, a city council or county board that has formed or is a member of a community health board must consider the income and expenditures required to meet local public health priorities established under section 145A.04, subdivision 1a, clause (2), and statewide outcomes under section 145A.04, subdivision 1a, clause (1).

Subd. 3. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 4. **Ordinances relating to community health services.** A city council or county board that has established or is a member of a community health board may by ordinance adopt and enforce minimum standards for services provided according to section 145A.02. An ordinance must not conflict with state law or with more stringent standards established either by rule of an agency of state government or by the provisions of the charter or ordinances of any city.

History: *1987 c 309 s 11; 1Sp2003 c 14 art 8 s 22,23; 2014 c 291 art 7 s 26,29*

145A.12 Subdivision 1. [Repealed, 2014 c 291 art 7 s 29]

Subd. 2. [Repealed, 2014 c 291 art 7 s 29]

Subd. 3. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 4. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 5. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 6. [Repealed, 1997 c 7 art 2 s 67]

Subd. 7. [Repealed, 2014 c 291 art 7 s 29]

145A.13 MS 2003 Supp [Expired]

145A.131 LOCAL PUBLIC HEALTH GRANT.

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and

available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty or multicity community health boards shall receive a local partnership base of up to $5,000 per year for each county or city in the case of a multicity community health board included in the community health board.

(d) The State Community Health Advisory Committee may recommend a formula to the commissioner to use in distributing state and federal funds to community health boards organized and operating under sections 145A.03 to 145A.131 to achieve locally identified priorities under section 145A.04, subdivision 1a, for use in distributing funds to community health boards beginning January 1, 2006, and thereafter.

Subd. 2. **Local match.** (a) A community health board that receives a local public health grant shall provide at least a 75 percent match for the state funds received through the local public health grant described in subdivision 1 and subject to paragraphs (b) to (d).

(b) Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other local funds, and donations or nonfederal grants that are used for community health services described in section 145A.02, subdivision 6.

(c) When the amount of local matching funds for a community health board is less than the amount required under paragraph (a), the local public health grant provided for that community health board under this section shall be reduced proportionally.

(d) A city organized under the provision of sections 145A.03 to 145A.131 that levies a tax for provision of community health services is exempt from any county levy for the same services to the extent of the levy imposed by the city.

Subd. 3. **Accountability.** (a) Community health boards accepting local public health grants must meet all of the requirements and perform all of the duties described in sections 145A.03 and 145A.04, to maintain eligibility to receive the local public health grant.

(b) By January 1 of each year, the commissioner shall notify community health boards of the performance-related accountability requirements of the local public health grant for that calendar year. Performance-related accountability requirements will be comprised of a subset of the annual performance measures and will be selected in consultation with the State Community Health Services Advisory Committee.

(c) If the commissioner determines that a community health board has not met the accountability requirements, the commissioner shall notify the community health board in writing and recommend specific actions the community health board must take over the next six months in order to maintain eligibility for the Local Public Health Act grant.

(d) Following the written notification in paragraph (c), the commissioner shall provide administrative and program support to assist the community health board as required in section 145A.06, subdivision 3a.

(e) The commissioner shall provide the community health board two months following the written notification to appeal the determination in writing.

(f) If the community health board has not submitted an appeal within two months or has not taken the specific actions recommended by the commissioner within six months following written notification, the commissioner may elect to not reimburse invoices for funds submitted after the six-month compliance period and shall reduce by 1/12 the community health board's annual award allocation for every successive month of noncompliance.

(g) The commissioner may retain the amount of funding that would have been allocated to the community health board and assume responsibility for public health activities in the geographic area served by the community health board.

Subd. 4. **Responsibility of commissioner to ensure a statewide public health system.** If a community health board elects not to accept the local public health grant, the commissioner may retain the amount of funding that would have been allocated to the community health board and assume responsibility for public health activities in the geographic area served. The commissioner may elect to directly provide public health activities or contract with other units of government or with community-based organizations. If a city that is currently a community health board withdraws from a community health board or elects not to accept the local public health grant, the local public health grant funds that would have been allocated to that city shall be distributed to the county in which the city is located.

Subd. 5. **Use of funds.** Community health boards may use their local public health grant funds to address the areas of public health responsibility and local priorities developed through the community health assessment and community health improvement planning process.

History: *1Sp2003 c 14 art 8 s 28; 2012 c 187 art 1 s 25; 2014 c 291 art 7 s 27*

145A.14 SPECIAL GRANTS.

Subdivision 1. **Migrant health grants.** (a) The commissioner may make special grants to cities, counties, groups of cities or counties, or nonprofit corporations to establish, operate, or subsidize clinic facilities and services, including mobile clinics, to furnish health services for migrant agricultural workers and their families in areas of the state where significant numbers of migrant workers are located. "Migrant agricultural worker" means any individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the past 24 months, and who has established a temporary residence for the purpose of such employment.

(b) Applicants must submit for approval a plan and budget for the use of the funds in the form and detail specified by the commissioner.

(c) Applicants must keep records, including records of expenditures to be audited, as the commissioner specifies.

Subd. 2. **Indian health grants.** (a) The commissioner may make special grants to establish, operate, or subsidize clinic facilities and services to furnish health services for American Indians who reside off reservations.

(b) Applicants must submit for approval a plan and budget for the use of the funds in the form and detail specified by the commissioner.

(c) Applicants must keep records, including records of expenditures to be audited, as the commissioner specifies.

Subd. 2a. **Tribal governments.** (a) Of the funding available for local public health grants, $1,500,000 per year is available to tribal governments for:

(1) maternal and child health activities under section 145.882, subdivision 7;

(2) activities to reduce health disparities under section 145.928, subdivision 10; and

(3) emergency preparedness.

(b) The commissioner, in consultation with tribal governments, shall establish a formula for distributing the funds and developing the outcomes to be measured.

Subd. 3. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 4. [Repealed, 1Sp2003 c 14 art 8 s 32]

History: *1Sp1985 c 14 art 19 s 24; 1987 c 309 s 13,19,25; 1989 c 120 s 1; 1Sp2003 c 14 art 8 s 29,30*

145A.15 MS 2002 [Expired]

145A.16 MS 2002 [Expired]

145A.17 FAMILY HOME VISITING PROGRAMS.

Subdivision 1. **Establishment; goals.** The commissioner shall establish a program to fund family home visiting programs designed to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. The commissioner shall promote partnerships, collaboration, and multidisciplinary visiting done by teams of professionals and paraprofessionals from the fields of public health nursing, social work, and early childhood education. A program funded under this section must serve families at or below 200 percent of the federal poverty guidelines, and other families determined to be at risk, including but not limited to being at risk for child abuse, child neglect, or juvenile delinquency. Programs must begin prenatally whenever possible and must be targeted to families with:

(1) adolescent parents;

(2) a history of alcohol or other drug abuse;

(3) a history of child abuse, domestic abuse, or other types of violence;

(4) a history of domestic abuse, rape, or other forms of victimization;

(5) reduced cognitive functioning;

(6) a lack of knowledge of child growth and development stages;

(7) low resiliency to adversities and environmental stresses;

(8) insufficient financial resources to meet family needs;

(9) a history of homelessness;

(10) a risk of long-term welfare dependence or family instability due to employment barriers;

(11) a serious mental health disorder, including maternal depression as defined in section 145.907; or

(12) other risk factors as determined by the commissioner.

Subd. 2. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 3. **Requirements for programs; process.** (a) Community health boards and tribal governments that receive funding under this section must submit a plan to the commissioner describing a multidisciplinary approach to targeted home visiting for families. The plan must be submitted on forms provided by the commissioner. At a minimum, the plan must include the following:

(1) a description of outreach strategies to families prenatally or at birth;

(2) provisions for the seamless delivery of health, safety, and early learning services;

(3) methods to promote continuity of services when families move within the state;

(4) a description of the community demographics;

(5) a plan for meeting outcome measures; and

(6) a proposed work plan that includes:

(i) coordination to ensure nonduplication of services for children and families;

(ii) a description of the strategies to ensure that children and families at greatest risk receive appropriate services; and

(iii) collaboration with multidisciplinary partners including public health, ECFE, Head Start, community health workers, social workers, community home visiting programs, school districts, and other relevant partners. Letters of intent from multidisciplinary partners must be submitted with the plan.

(b) Each program that receives funds must accomplish the following program requirements:

(1) use a community-based strategy to provide preventive and early intervention home visiting services;

(2) offer a home visit by a trained home visitor. If a home visit is accepted, the first home visit must occur prenatally or as soon after birth as possible and must include a public health nursing assessment by a public health nurse;

(3) offer, at a minimum, information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services available in the community;

(4) provide information on and referrals to health care services, if needed, including information on and assistance in applying for health care coverage for which the child or family may be eligible; and provide information on preventive services, developmental assessments, and the availability of public assistance programs as appropriate;

(5) provide youth development programs when appropriate;

(6) recruit home visitors who will represent, to the extent possible, the races, cultures, and languages spoken by families that may be served;

(7) train and supervise home visitors in accordance with the requirements established under subdivision 4;

(8) maximize resources and minimize duplication by coordinating or contracting with local social and human services organizations, education organizations, and other appropriate governmental entities and community-based organizations and agencies;

(9) utilize appropriate racial and ethnic approaches to providing home visiting services; and

(10) connect eligible families, as needed, to additional resources available in the community, including, but not limited to, early care and education programs, health or mental health services, family literacy programs, employment agencies, social services, and child care resources and referral agencies.

(c) When available, programs that receive funds under this section must offer or provide the family with a referral to center-based or group meetings that meet at least once per month for those families identified with additional needs. The meetings must focus on further enhancing the information, activities, and skill-building addressed during home visitation; offering opportunities for parents to meet with and support each other; and offering infants and toddlers a safe, nurturing, and stimulating environment for socialization and supervised play with qualified teachers.

(d) Funds available under this section shall not be used for medical services. The commissioner shall establish an administrative cost limit for recipients of funds. The outcome measures established under subdivision 6 must be specified to recipients of funds at the time the funds are distributed.

(e) Data collected on individuals served by the home visiting programs must remain confidential and must not be disclosed by providers of home visiting services without a specific informed written consent that identifies disclosures to be made. Upon request, agencies providing home visiting services must provide recipients with information on disclosures, including the names of entities and individuals receiving the information and the general purpose of the disclosure. Prospective and current recipients of home visiting services must be told and informed in writing that written consent for disclosure of data is not required for access to home visiting services.

(f) Upon initial contact with a family, programs that receive funding under this section must receive permission from the family to share with other family service providers information about services the family is receiving and unmet needs of the family in order to select a lead agency for the family and coordinate available resources. For purposes of this paragraph, the term "family service providers" includes local public health, social services, school districts, Head Start programs, health care providers, and other public agencies.

Subd. 4. **Training.** The commissioner shall establish training requirements for home visitors and minimum requirements for supervision. The requirements for nurses must be consistent with chapter 148. The commissioner must provide training for home visitors. Training must include the following:

(1) effective relationships for engaging and retaining families and ensuring family health, safety, and early learning;

(2) effective methods of implementing parent education, conducting home visiting, and promoting quality early childhood development;

(3) early childhood development from birth to age five;

(4) diverse cultural practices in child rearing and family systems;

(5) recruiting, supervising, and retaining qualified staff;

(6) increasing services for underserved populations; and

(7) relevant issues related to child welfare and protective services, with information provided being consistent with state child welfare agency training.

Subd. 4a. **Home visitors as MFIP employment and training service providers.** The county social service agency and the local public health department may mutually agree to utilize home visitors under this section as MFIP employment and training service providers under section 256J.49, subdivision 4, for MFIP participants who are: (1) ill or incapacitated under section 256J.425, subdivision 2; or (2) minor caregivers under section 256J.54. The county social service agency and the local public health department may also mutually agree to utilize home visitors to provide outreach to MFIP families who are being sanctioned or who have been terminated from MFIP due to the 60-month time limit.

Subd. 5. **Technical assistance.** The commissioner shall provide administrative and technical assistance to each program, including assistance in data collection and other activities related to conducting short- and long-term evaluations of the programs as required under subdivision 7. The commissioner may request research and evaluation support from the University of Minnesota.

Subd. 6. **Outcome and performance measures.** The commissioner shall establish measures to determine the impact of family home visiting programs funded under this section on the following areas:

(1) appropriate utilization of preventive health care;

(2) rates of substantiated child abuse and neglect;

(3) rates of unintentional child injuries;

(4) rates of children who are screened and who pass early childhood screening;

(5) rates of children accessing early care and educational services;

(6) program retention rates;

(7) number of home visits provided compared to the number of home visits planned;

(8) participant satisfaction;

(9) rates of at-risk populations reached; and

(10) any additional qualitative goals and quantitative measures established by the commissioner.

Subd. 7. **Evaluation.** Using the qualitative goals and quantitative outcome and performance measures established under subdivisions 1 and 6, the commissioner shall conduct ongoing evaluations of the programs

funded under this section. Community health boards and tribal governments shall cooperate with the commissioner in the evaluations and shall provide the commissioner with the information necessary to conduct the evaluations. As part of the ongoing evaluations, the commissioner shall rate the impact of the programs on the outcome measures listed in subdivision 6, and shall periodically determine whether home visiting programs are the best way to achieve the qualitative goals established under subdivisions 1 and 6. If the commissioner determines that home visiting programs are not the best way to achieve these goals, the commissioner shall provide the legislature with alternative methods for achieving them.

Subd. 8. **Report.** By January 15, 2002, and January 15 of each even-numbered year thereafter, the commissioner shall submit a report to the legislature on the family home visiting programs funded under this section and on the results of the evaluations conducted under subdivision 7.

Subd. 9. **No supplanting of existing funds.** Funding available under this section may be used only to supplement, not to replace, nonstate funds being used for home visiting services as of July 1, 2001.

History: *1Sp2001 c 9 art 1 s 53; 2002 c 379 art 1 s 113; 2007 c 147 art 17 s 1; 2009 c 79 art 2 s 8; 1Sp2011 c 9 art 2 s 22; 2013 c 108 art 12 s 49*

The Public Health System and

The 10 Essential Public Health Services

Figure 1: The Public Health System

The Public Health System

Public health systems are commonly defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction." This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services.

The public health system includes

- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies and organizations

The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake and serve as the framework for the NPHPS instruments. Public health systems should:

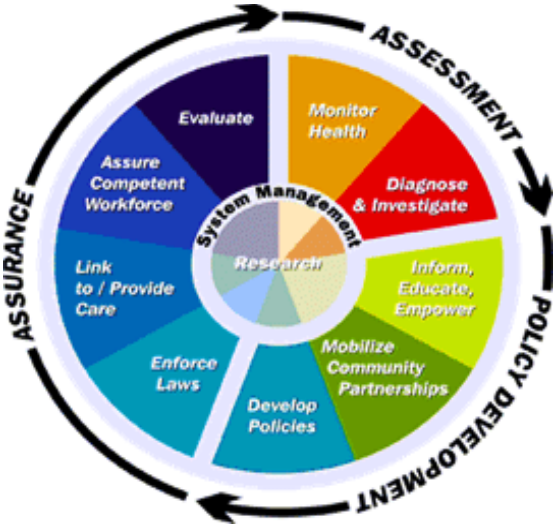


Figure 2: The 10 Essential Public Health Services

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

The 10 Essential Public Health Services: An Overview (PPT[3.85MB], PDF[892KB])

The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. The committee included representatives from US Public Health Service agencies and other major public health organizations. For more information, see the Public Health Functions Project website.

October 2013

What is Public Health Accreditation?

- The measurement of health department performance against a set of nationally recognized, practice-focused and evidenced-based standards.
- The issuance of recognition of achievement of accreditation within a specified time frame by a nationally recognized entity.
- The continual development, revision, and distribution of public health standards.

Goal of Accreditation

The goal of the national public health department accreditation program is to improve and protect the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments

Accreditation can help your health department…

- Identify successes and opportunities for improvement
- Promote quality initiatives
- Energize the workforce and develop a strong team
- Focus the health department on common goals
- Evaluate your health department's performance
- Align your resources with your strategic objectives
- Deliver results

Accreditation looks at…

- Leadership
- Strategic planning
- Community engagement
- Customer focus
- Workforce development
- Evaluation and quality improvement
- Governance

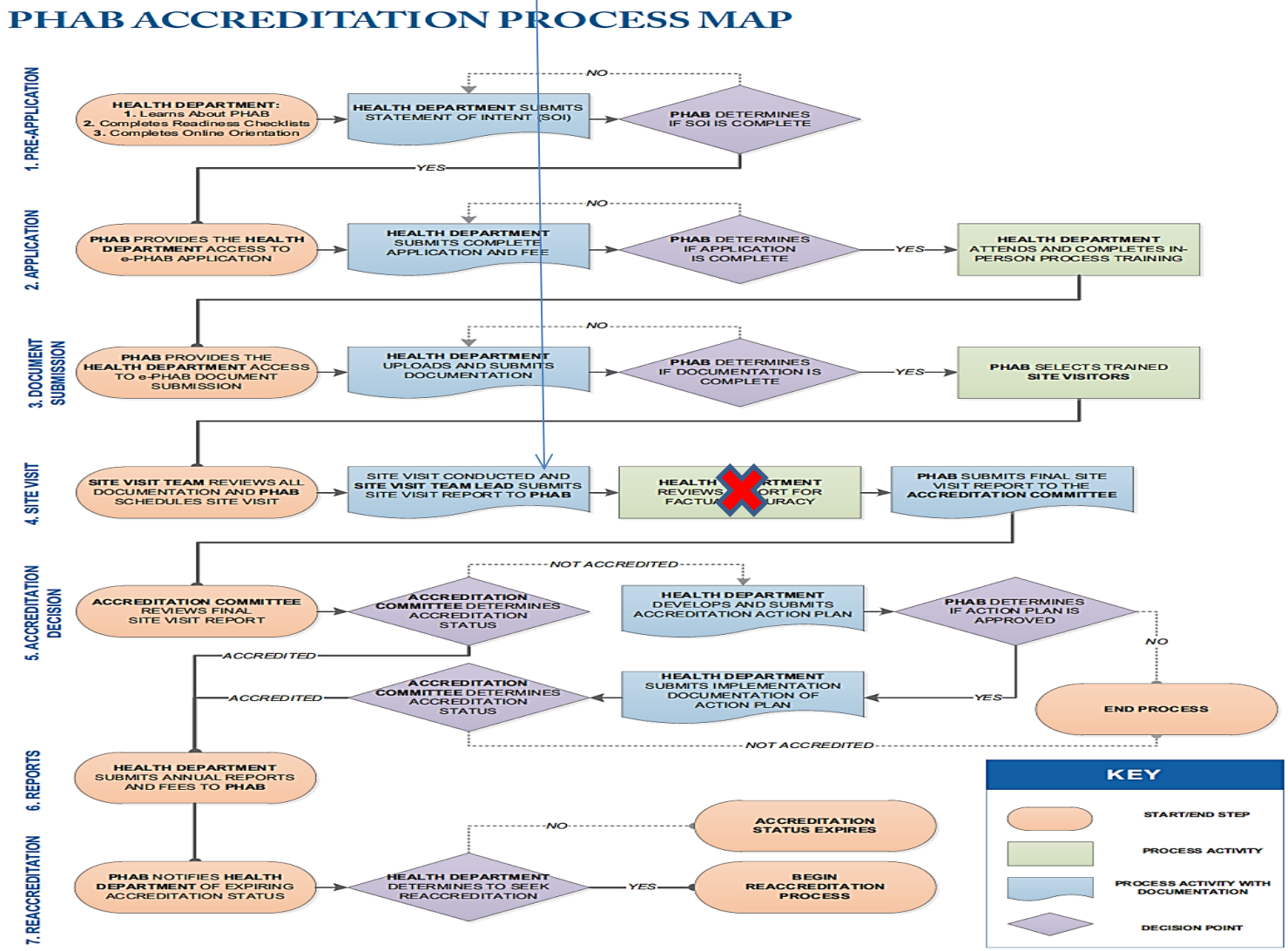
Why Seek Accreditation?

- Become responsive to change
- Shared decision-making
- Implement workforce development
- Evaluate services and programs
- Increase performance improvement
- Develop strong partnerships

Incentives

- National recognition for public health practice
- Opportunity to engage the public health workforce
- Access to network of public health experts
- Focus on improving the health department
- Potential access to new funding streams
- Potential streamlining of grant reporting
- Participation in developing a strong data base for exploring best practices

Where are we in the Accreditation Process? We are HERE: Site Visit completed! We await the Site Visit report, which is the same report that goes to the PHAB Accreditation committee for a final decision. Formal accreditation decision expected third week of August 2016. PHAB deleted the step marked with the red X.



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- Chipotle Mexican Grill – *E. coli* O26 (http://www.cdc.gov/ecoli/2015/O26-11-15/index.html)
- Cucumbers – *Salmonella* Poona (http://www.cdc.gov/salmonella/poona-09-15/index.html)

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CDC Newsroom (http://www.cdc.gov/media/index.html) ›

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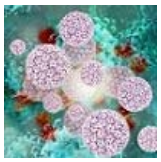
Ebola One Year Report (http://www.cdc.gov/about/ebola/index.html)

In the Spotlight



Guide to HPV Resources for Local Health Departments

NACCHO has released the *Guide to HPV Resources for Local Health Departments* to assist local health departments with increasing HPV vaccination rates. More »

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The 2014 Forces of Change survey contains new findings on the forces that affect change in our nation's local health departments. Economic forces, health reform, and health department accreditation are among the greatest contributors to change. More »

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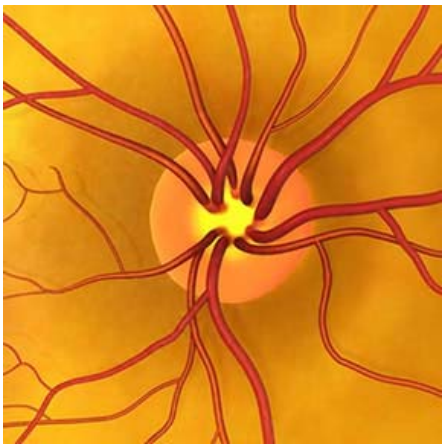

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