Local Public Health Act Performance Measures for 2017

DATA BOOK | AUGUST 2018

DEPARTMENT OF HEALTH

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Local Public Health Act Performance Measures for 2017: Data Book

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Introduction: What is Local Public Health Annual Reporting?

Each spring, Minnesota community health boards report data from the previous year on programs, activities, and resources, to help monitor the health of the state-local public health partnership in three key areas: Finance and Staffing, Title V MCH Block Grant, and Local Public Health Act (LPH Act) performance measures. For more information, visit: Annual Reporting for Local Public Health.

What are LPH Act performance measures?

This data book shares state-level information on Local Public Health Act (LPH Act) performance measures. The LPH Act performance measures correspond with Minnesota's six areas of public health responsibility: assure an adequate local public health infrastructure (this area includes capacity measures based on national standards and Minnesota-specific measures), promote healthy communities and healthy behavior, prevent the spread of communicable diseases, protect against environmental health hazards, prepare and respond to emergencies, assure health services.

How do community health boards respond?

For a majority of measures, a community health board responds based on services provided in one or more of its individual health departments. For capacity measures aligning with national standards, a community health board responds based on the lowest level of capacity of its individual health departments (see: Data tables and reporting instructions).

Findings in this data book are noted by year and community health board population. In 2017, Minnesota had 51 community health boards; 13 "large" community health boards had a population of 100,000 residents or more, 16 "medium" boards had a population between 50,000 and 99,999 residents, and 22 "small" boards had a population 49,999 or fewer residents.

n	Large boards	Medium boards	Small boards	Total
Minnesota community health boards in 2017	13	16	22	51

See the appendix for a full list of community health boards by population size.

The total number (n) of Minnesota's community health boards can change from year to year as individual health departments dissolve their jurisdictional relationships or join together to form new community health boards.

n	2012	2013	2014	2015	2016	2017
Minnesota community health boards over time	52	50	48	48	49	51

What does MDH do with the data?

MDH and the Performance Improvement Steering Committee of the State Community Health Services Advisory Committee (SCHSAC) use the data submitted by community health boards to monitor the performance of the state's public health system, identify strengths and gaps, and recommend opportunities for improvement.

Minnesota Public Health System Performance Management Cycle

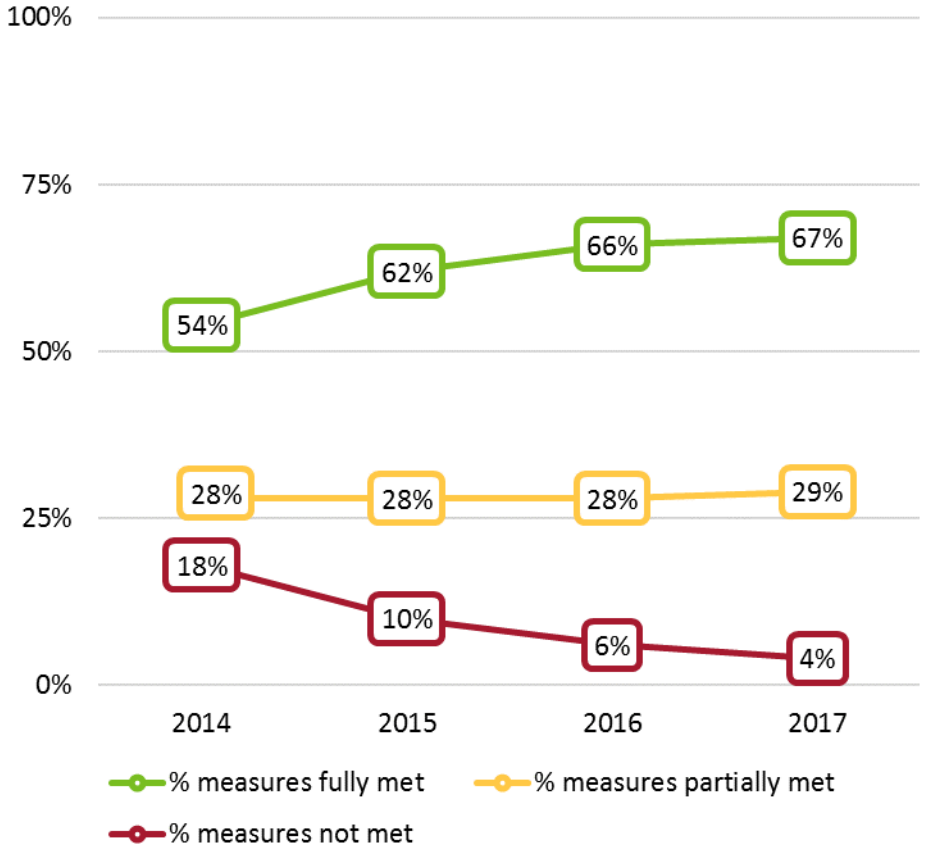
Assure an adequate local public health infrastructure: Capacity measures from national standards

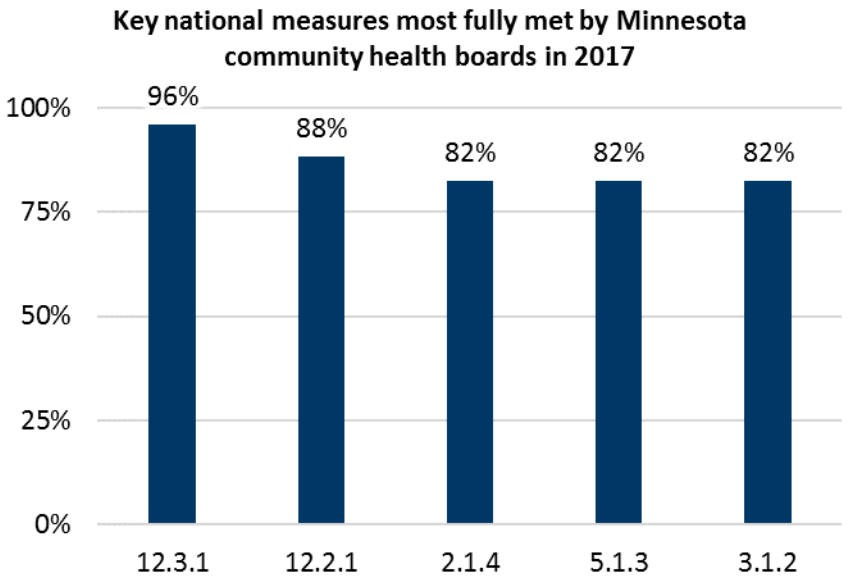
System progress at a glance

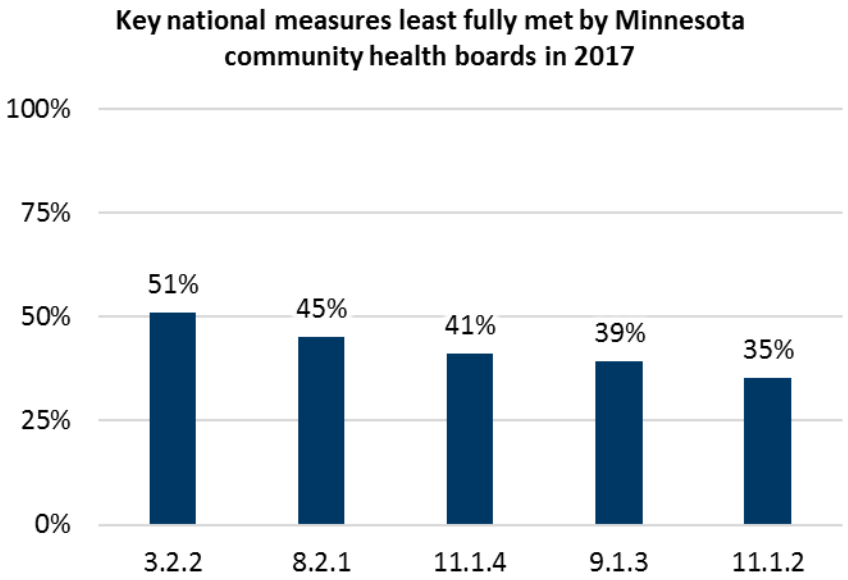
For a full list of performance measures and responses, refer to the data tables for this section.

Community health board ability to meet 37 key national measures in 2017, Minnesota

Progress toward meeting 37 key public health measures, Minn. community health boards







Key national measures most fully met by Minnesota community health boards in 2017

In 2017, 96 percent of community health boards can fully meet measure 12.3.1: *Information provided to governing entity*.

1. **12.3.1**: Information provided to the governing entity about important public health issues facing the community, a community health board, and/or the recent actions of a community health board (96%)
2. **12.2.1**: Communication with the governing entity regarding the responsibilities of a community health board and of the responsibilities of the governing entity (88%)
3. **2.1.4**: Collaborative work through established governmental and community partnerships on investigations of reportable diseases, disease outbreaks, and environmental public health issues (82%)

   5.1.3: Inform governing entities, elected officials, and/or the public of potential intended or unintended public health impacts from current and/or proposed policies (82%)

   3.1.2: Health promotion strategies to mitigate preventable health conditions (82%)

Key national measures least fully met by Minnesota community health boards in 2017

In 2017, 35 percent of community health boards can fully meet measure 11.1.2: *Ethical issues and decisions*.

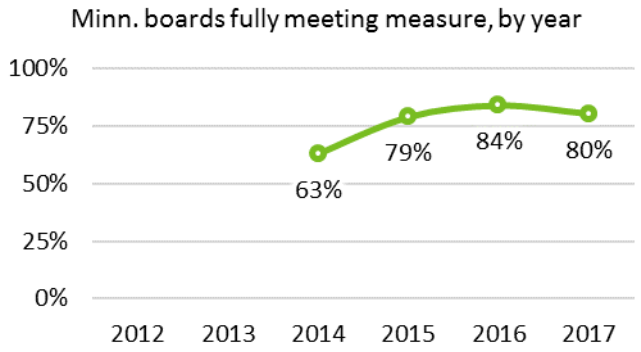
33. **3.2.2**: Organizational branding strategy (51%)
34. **8.2.1**: Workforce development strategies (45%)
35. **11.1.4**: Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes (41%)
36. **9.1.3**: Implemented performance management system (39%)
37. **11.1.2**: Ethical issues identified and ethical decisions made (35%)

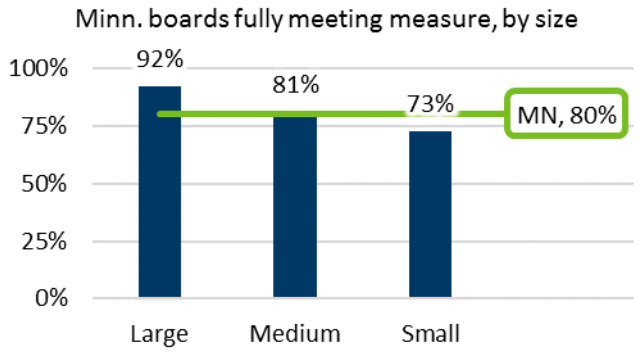
Assure an adequate local public health infrastructure: Capacity measures from national standards

Measure progress over time and comparison by community health board size

1.1.2. A local community health assessment.

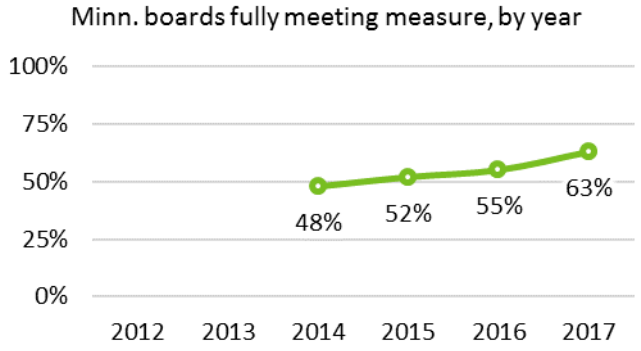
A thorough and valid community health assessment is a customary practice and core function of public health, and also is a national standard for all public health departments. Since the passage of the Local Public Health Act in 1976, Minnesota community health boards have been required to engage in a community health improvement process, beginning with a community health assessment.

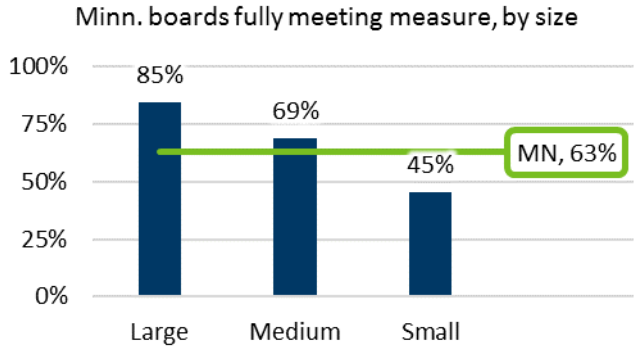




1.2.2. Communication with surveillance sites.

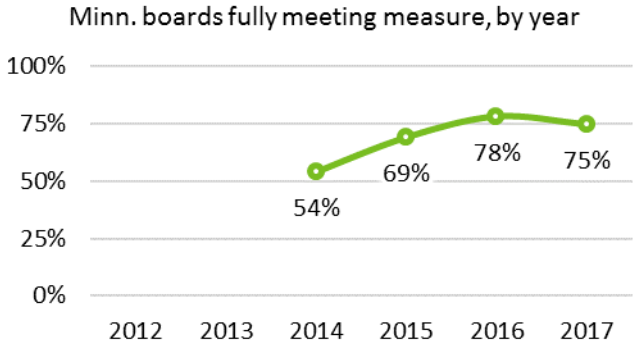
Communicating with surveillance sites about their responsibilities ensures sites are providing timely, accurate, and comprehensive data.

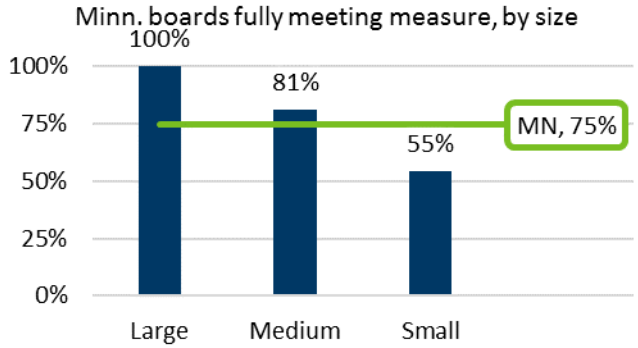




1.3.1. Data analyzed and public health conclusions drawn.

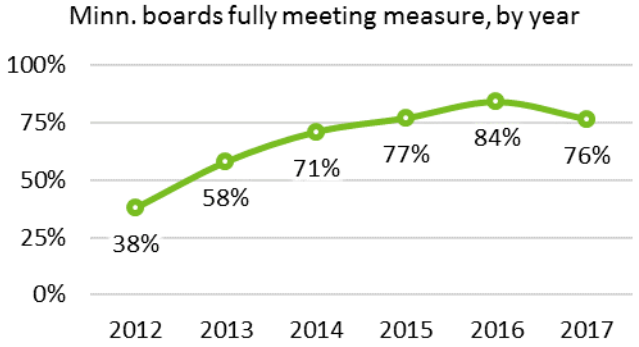
Valid analysis of data is important for assessing a health problem's contributing factors, magnitude, geographic location(s), changing characteristics, and potential interventions, and for designing and evaluating programs for continuous quality improvement.

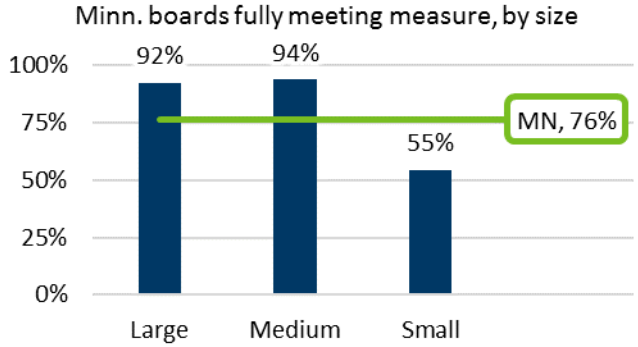




1.4.2. Community summaries or fact sheets of data to support public health improvement planning processes at the local level.

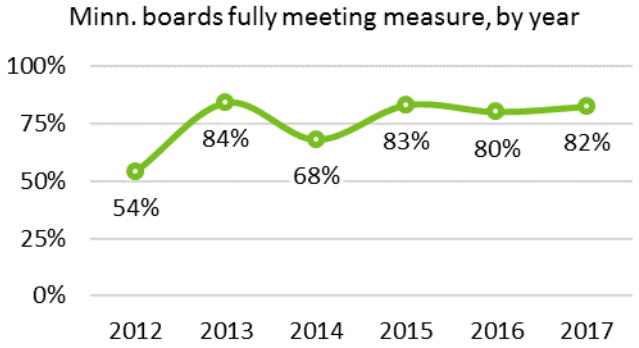
Public health data must inform the development of public health policies, processes, programs, and interventions. Community health boards must share data with other organizations to inform and support others' health improvement efforts.

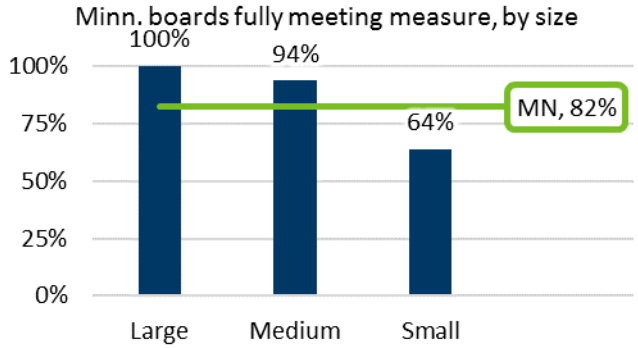




2.1.4. Collaborative work through established governmental and community partnerships on investigations of reportable diseases, disease outbreaks, and environmental public health issues.

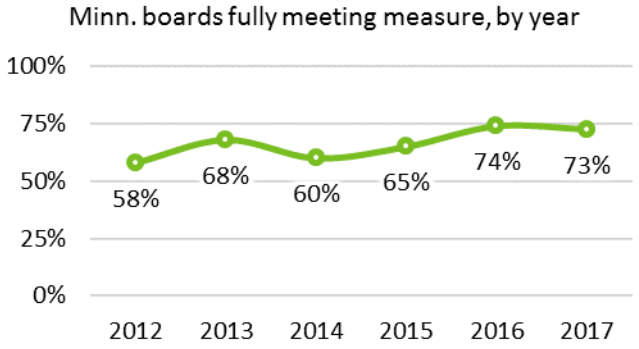
The ability to conduct timely investigations of suspected or identified health problems is necessary for the detection of the source of the problem, the description of those affected, and the prevention of the further spread of the problem.

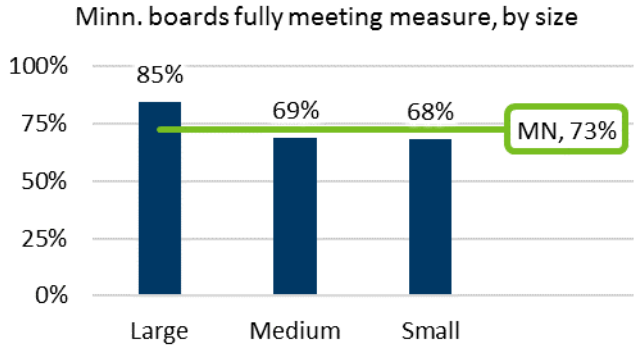




2.2.3. Complete After Action Reports (AARs).

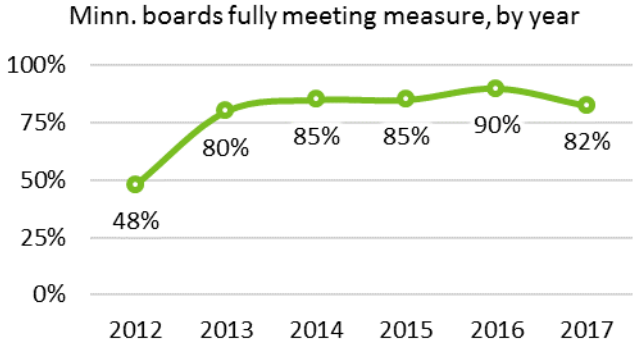
Community health boards must be able to act on information concerning health problems and environmental public health hazards that was obtained through public health investigations, and contain or mitigate those problems and hazards in coordination with other stakeholders. After Action Reports (AARs) can demonstrate a community health board's ability to do this.

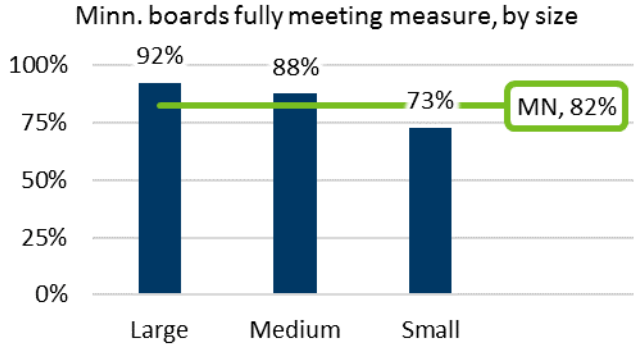




3.1.2. Health promotion strategies to mitigate preventable health conditions.

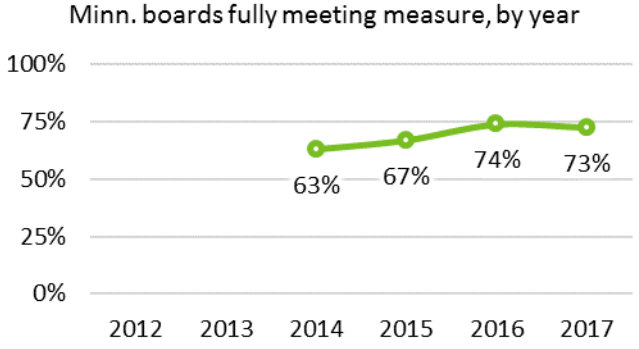
Health promotion aims to enable individuals and communities to protect and improve their own health. Community health boards must establish strategies to promote health and address preventable health conditions.

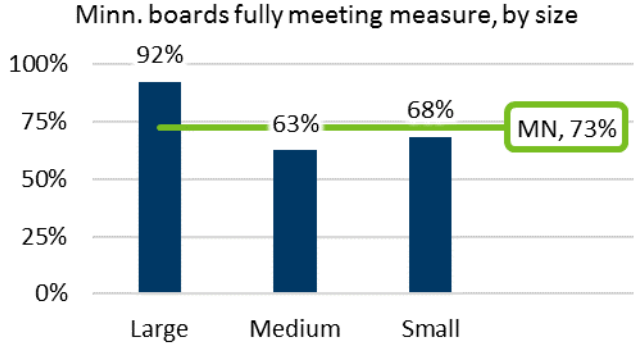




3.1.3. Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes.

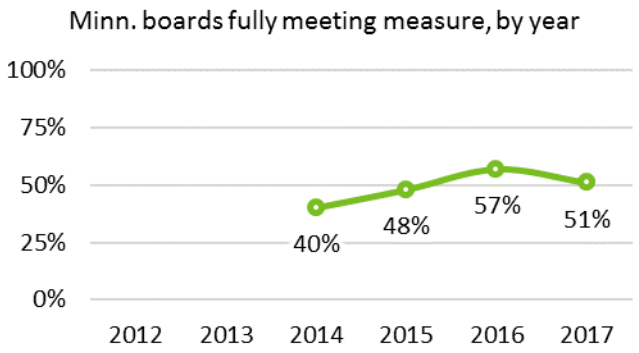
Differences in population health outcomes are well documented. Factors that contribute to these differences are many and varied and include the lack of opportunities and resources, economic and political policies, discrimination, and other aspects of a community that impact on individuals' and populations' resilience.

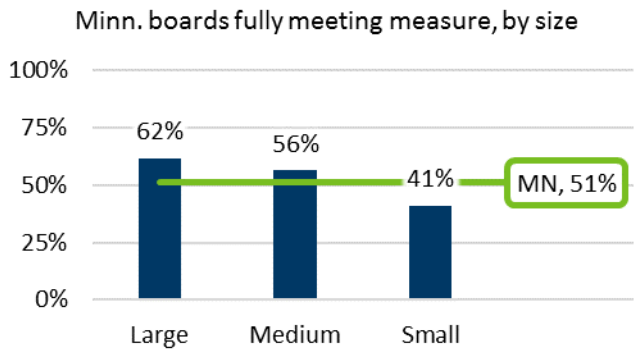




3.2.2. Organizational branding strategy.

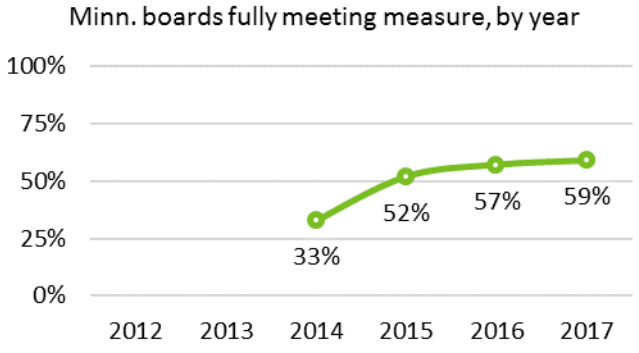
Branding can help to position a community health board as a valued, effective, trusted leader in the community, by communicating what a community health board stands for and what it provides that is unique and differentiated from other agencies and organizations.

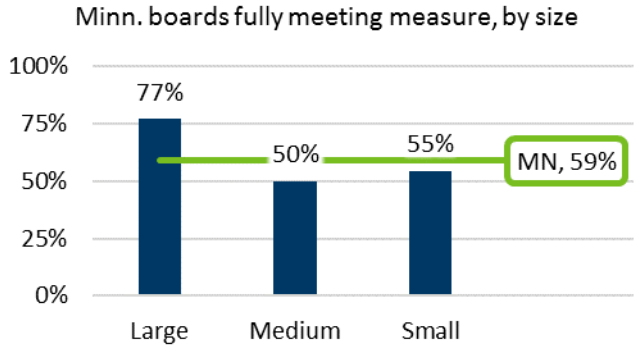




3.2.3. Communication procedures to provide information outside the health department.

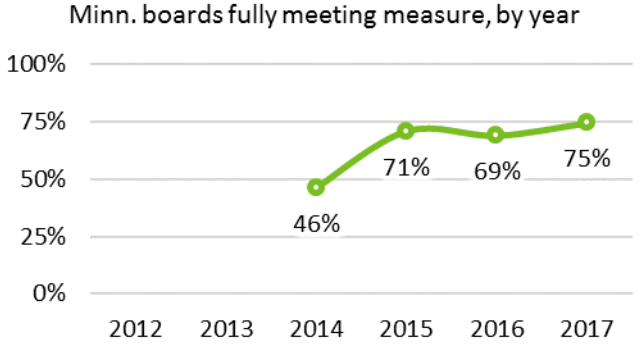
Consistent communication procedures and protocols ensure reliability in the management of communications on public health issues, and that information is in an appropriate format to reach target sectors or audiences.

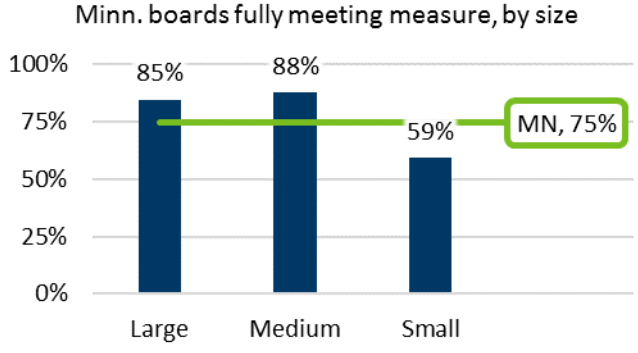




3.2.5. Information available to the public through a variety of methods.

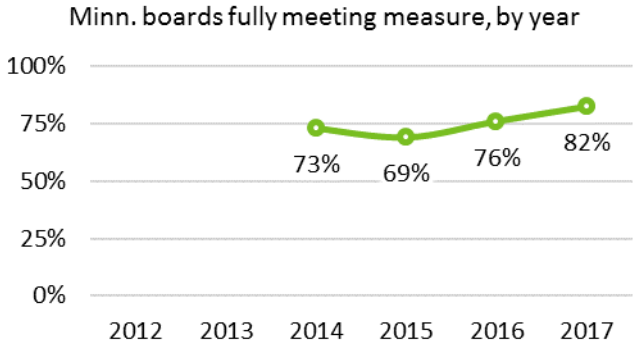
Community health boards need to be able to present information to different audiences through a variety of methods.

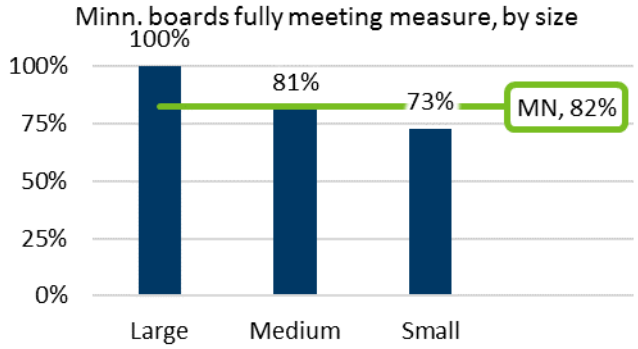




5.1.3. Inform governing entities, elected officials, and/or the public of potential intended or unintended public health impacts from current and/or proposed policies.

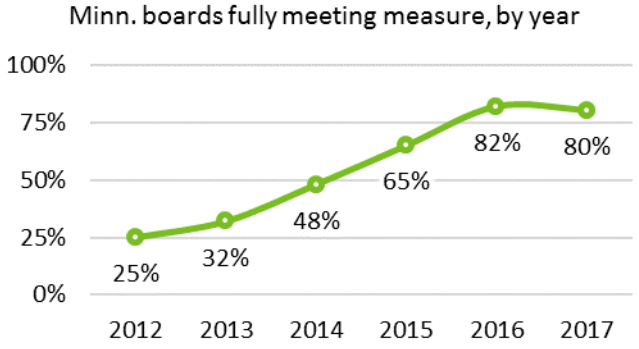
Community health boards must provide policy makers and the public with sound, science-based, current public health information that must be considered in setting or supporting policies.

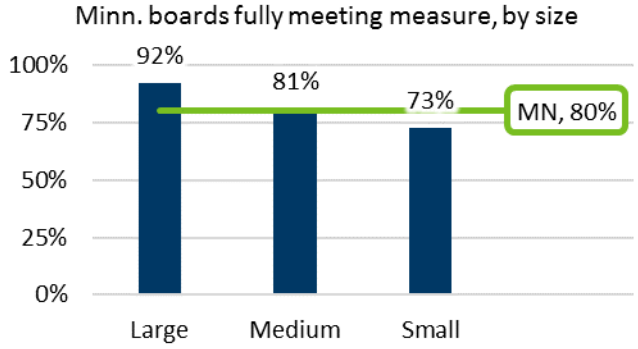




5.2.3. Elements and strategies of the health improvement plan implemented in partnership with others.

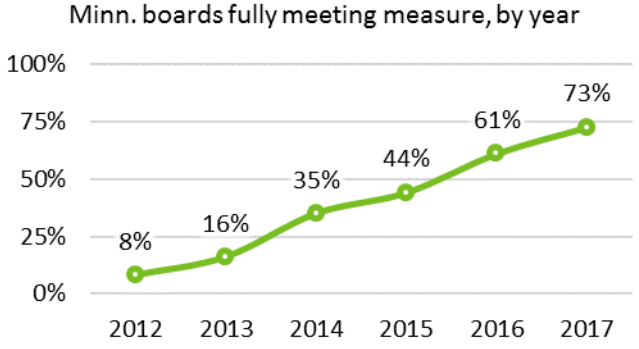
The community health improvement plan is only useful when implemented, and provides guidance for priorities, activities, and resource allocation. A community health board must implement its community health improvement plan in partnership with others.

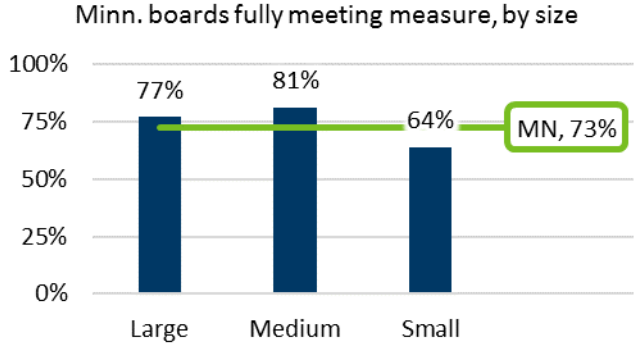




5.2.4. Monitor the strategies in the community health improvement plan and revise as needed, in collaboration and with broad participation from stakeholders and partners.

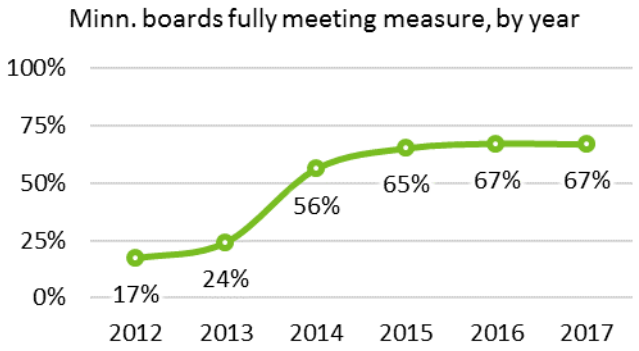
The 2017 and 2018 performance-related accountability measure is 5.2.4. Community health boards work to meet the measure over the course of the year, and report back to MDH in the following year. More information: [Accountability Requirements for the Local Public Health Act](#).

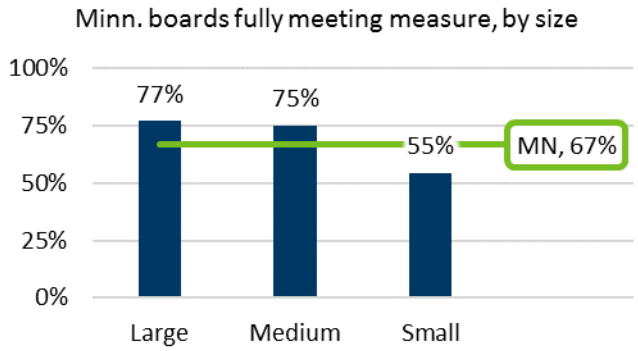




5.3.3. Implemented community health board strategic plan.

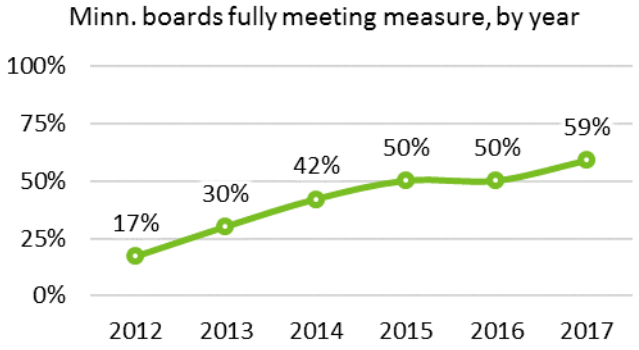
A strategic plan sets forth what a community health board plans to achieve, how a community health board will achieve those plans, and how a community health board will monitor progress (e.g., annual reports of progress toward goals and objectives in the strategic plan). It provides a guide for making decisions on resource and policy priorities.

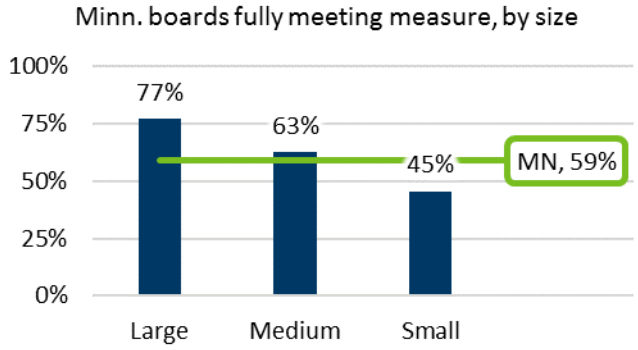




6.3.4. Patterns or trends identified in compliance from enforcement activities and complaints.

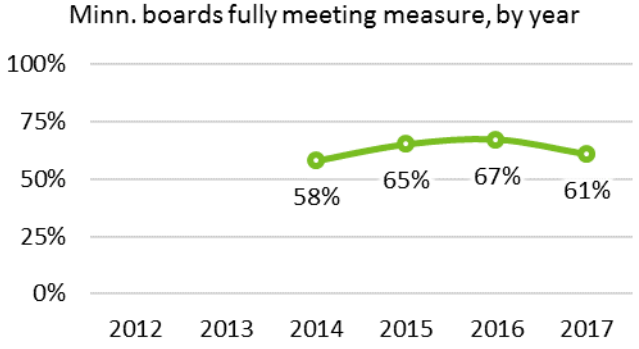
A community health board has a role in ensuring that public health laws are enforced—either by using its authority to enforce, or working with those who have the legal authority to enforce.

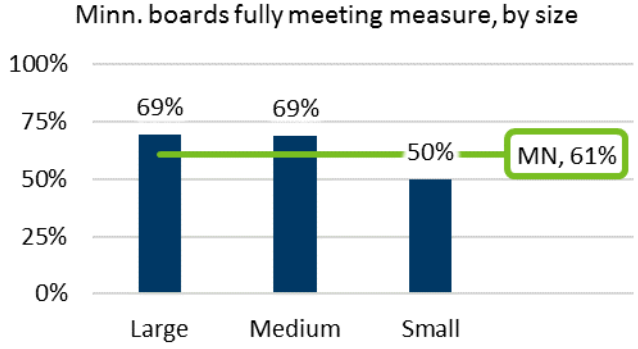




7.1.1. Process to assess the availability of health care services.

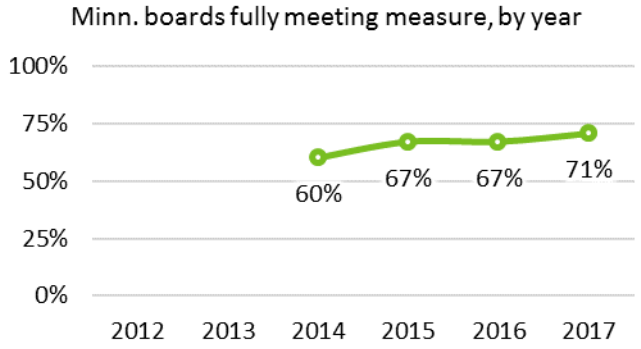
Collaborative efforts are required to assess the health care needs of the population of a tribe, state, or community.

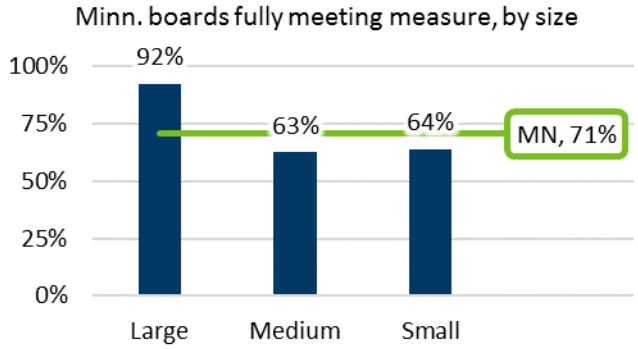




7.1.2. Identification of populations who experience barriers to health care services.

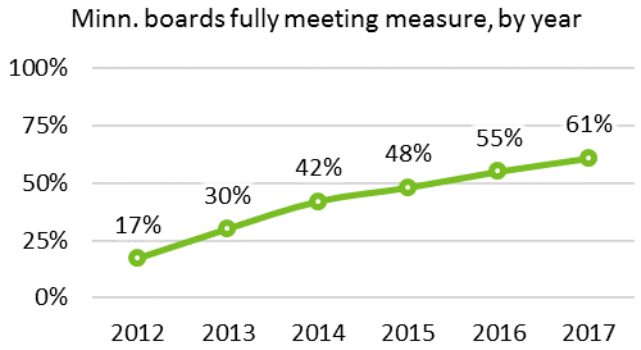
It is important for a community health board to identify populations in its jurisdiction that experience perceived or real barriers to health care. Assessing capacity and access to health care includes the identification of those who are not receiving services, and understanding the reasons that they are not receiving needed care or experiencing barriers to care.

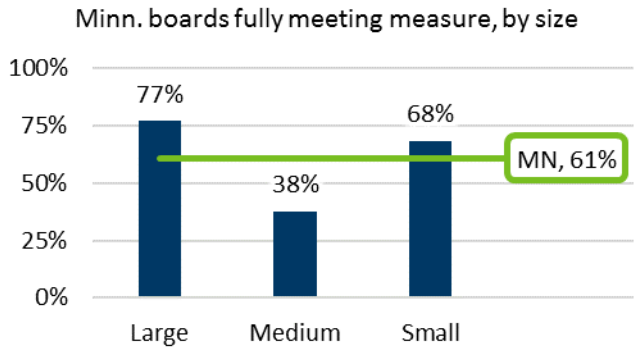




7.1.3. Identification of gaps in access to health care services, and barriers to the receipt of health care services.

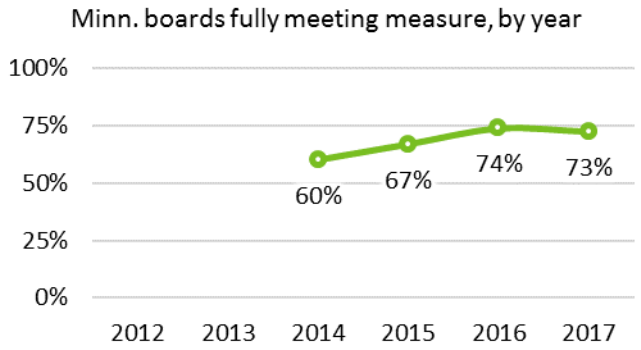
It is important for community health boards to understand the gaps in access to health care, so that effective strategies can be put into place. Community health boards must have reports of data analysis from across the public health system, which identify gaps in access to health care services and causes of access gaps.

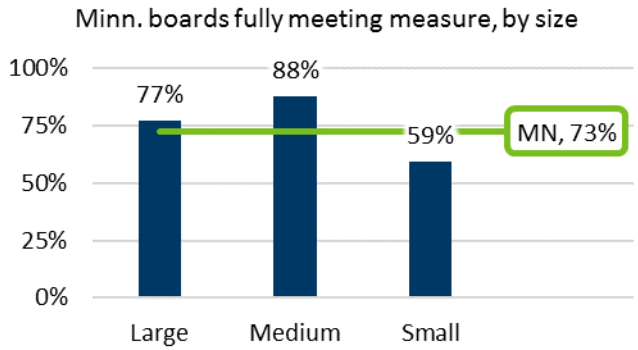




7.2.1. Process to develop strategies to improve access to health care services.

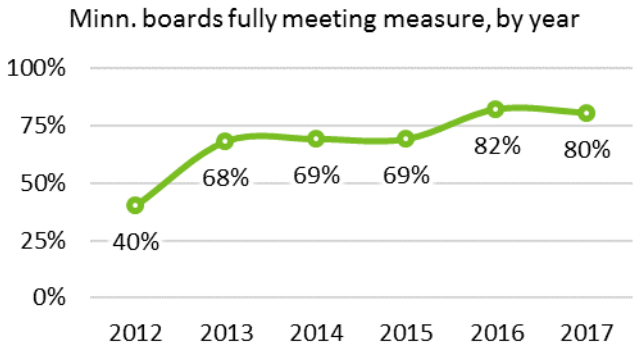
Partnering with other organizations and agencies allows community health boards to address the multiple factors that contribute to poor access, and to coordinate strategies. A community health board does not need to have convened or led the collaborative process, but must have participated in the process.

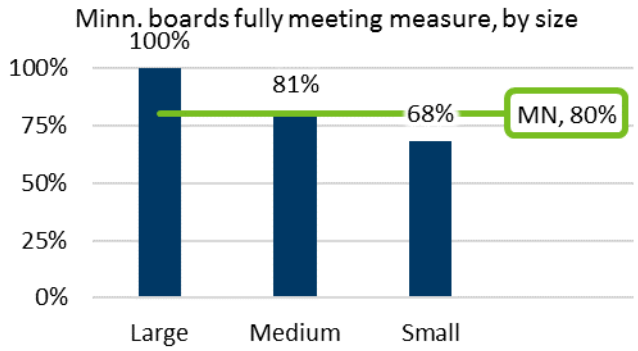




7.2.2. Implemented strategies to increase access to health care services.

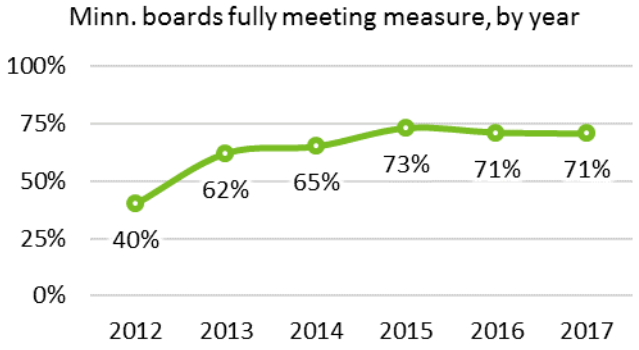
Many factors influence health care access. Community health boards can use their local knowledge of these factors to act collaboratively and implement strategies to increase access.

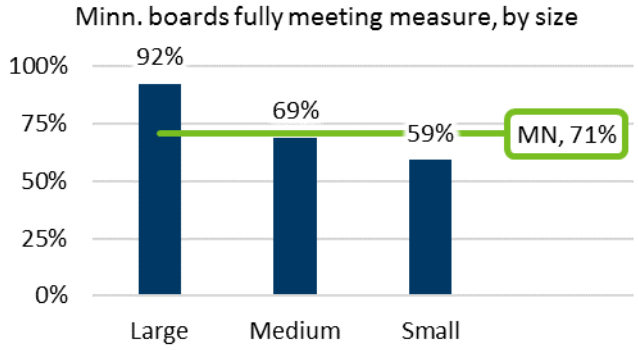




7.2.3. Implemented culturally competent initiatives to increase access to health care services for those who may experience barriers to care due to cultural, language, or literacy differences.

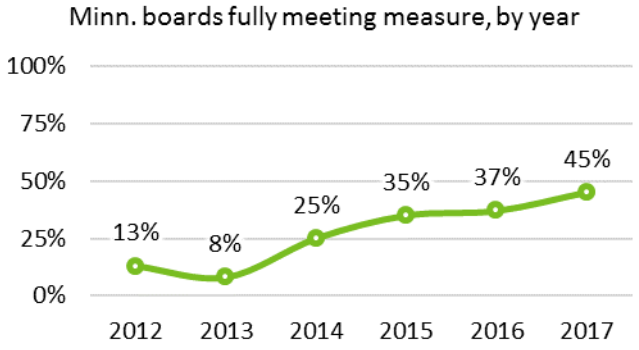
Cultural differences can present serious barriers to receipt of health care services, and must be addressed in strategies if those strategies are going to be successful.

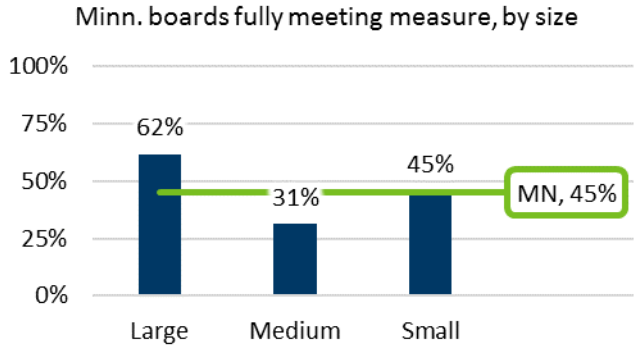




8.2.1. Workforce development strategies.

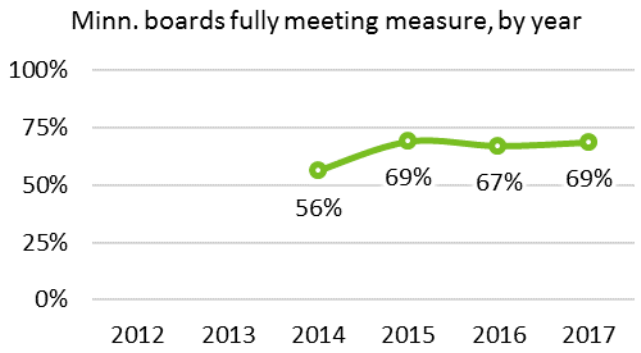
Workforce development strategies can ensure that staff development is addressed, coordinated, and appropriate for a community health board's needs.

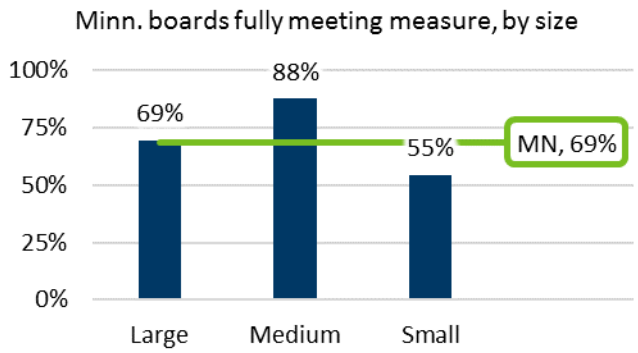




8.2.2. A competent community health board workforce.

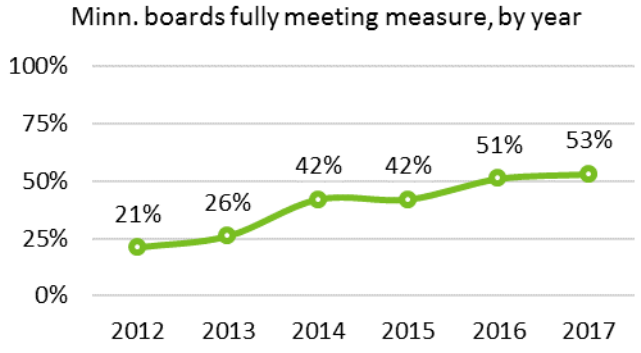
As in all organizations, a community health board's success depends on the capabilities and performance of its staff. In order for a community health board to function at a high level, it must take action to maximize staff capabilities and performance.

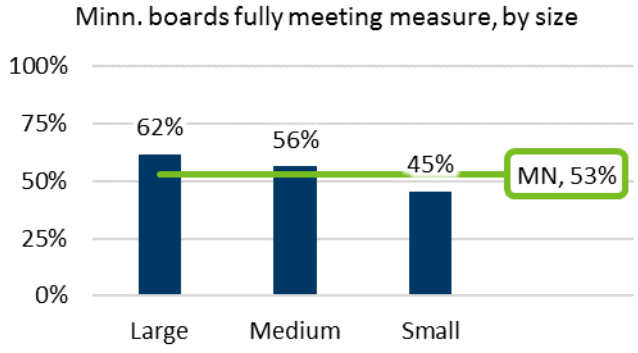




9.1.1. Staff at all organizational levels engaged in establishing and/or updating a performance management system.

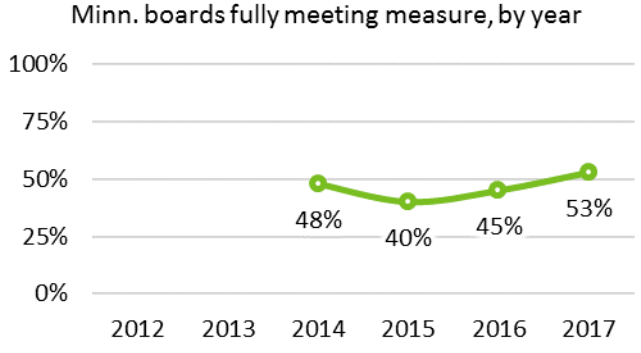
An effective performance management system engages leadership, management, and staff in its development and implementation.

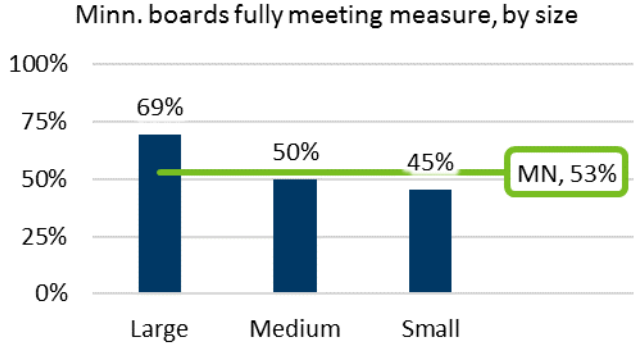




9.1.2. Performance management policy/system.

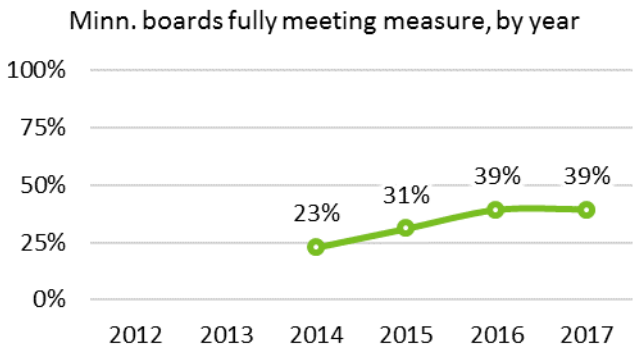
A performance management system encompasses all aspects of using objectives and measurement to evaluate programs, policies, and processes; identify and manage opportunities for improvement; and achieve outcome targets.

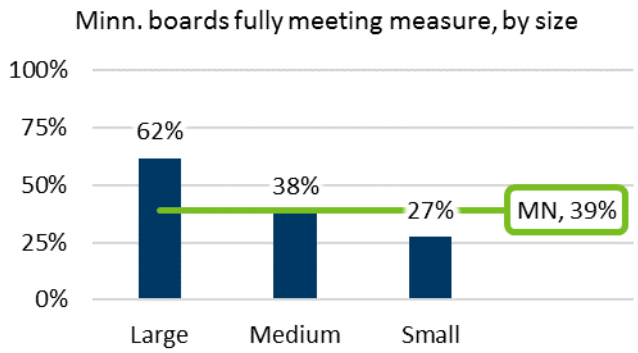




9.1.3. Implemented performance management system.

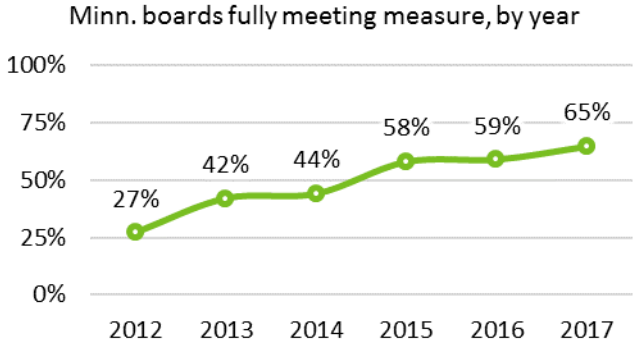
Use of a process to evaluate and report on achievement of goals, objectives, and measures set by the performance management system is critical to improving effectiveness and efficiency.

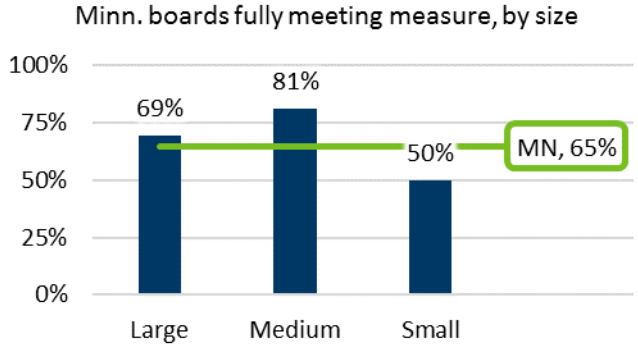




9.1.4. Implemented systematic process for assessing customer satisfaction with community health board services.

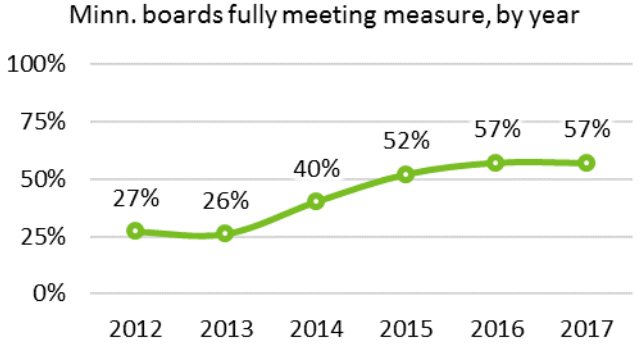
Customer focus is a key part of a community health board's performance management system. A community health board must have the capacity to assess its process to measure the quality of customer relationships and service.

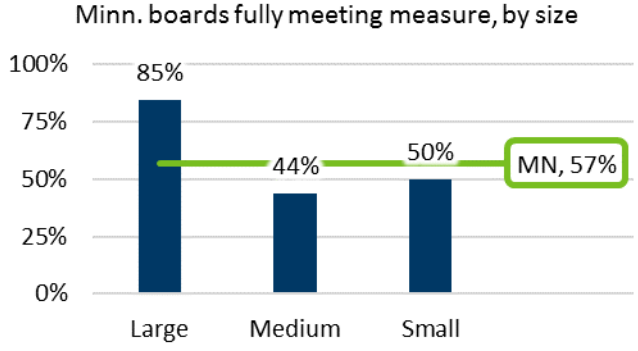




9.1.5. Opportunities provided to staff for involvement in a community health board's performance management.

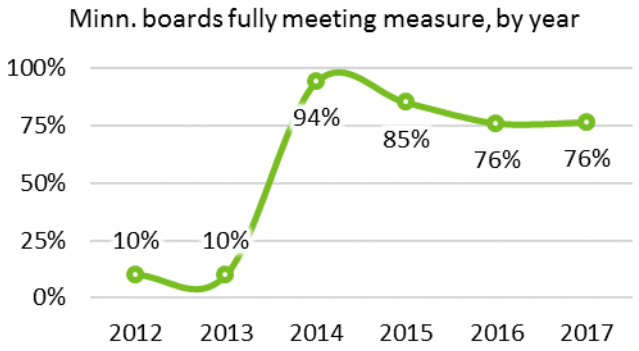
Staff must understand what a performance management system is, and how evaluation integrates with performance management. Community health boards must provide staff with development opportunities help to assure broad engagement in the performance management system.

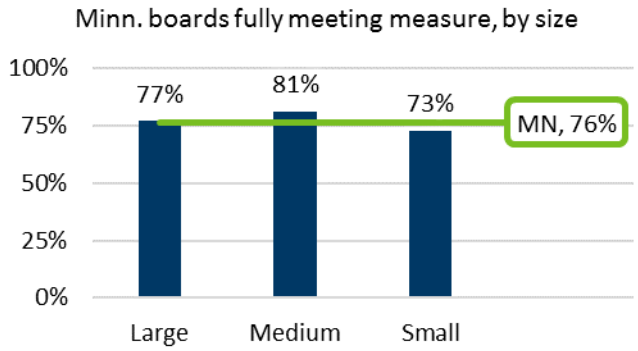




9.2.1. Established quality improvement program based on organizational policies and direction.

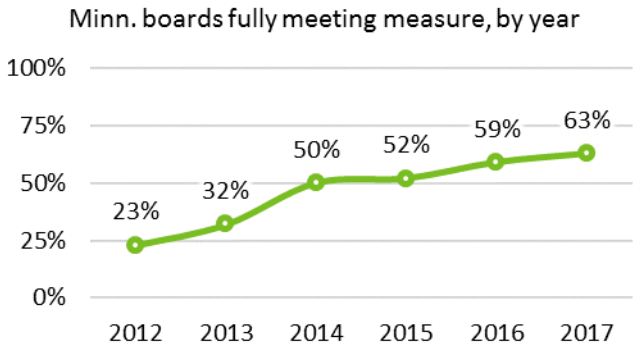
Implementing a quality improvement program is an important requirement of a performance management system, and a quality improvement plan helps create the infrastructure required to make and sustain quality improvement gains.

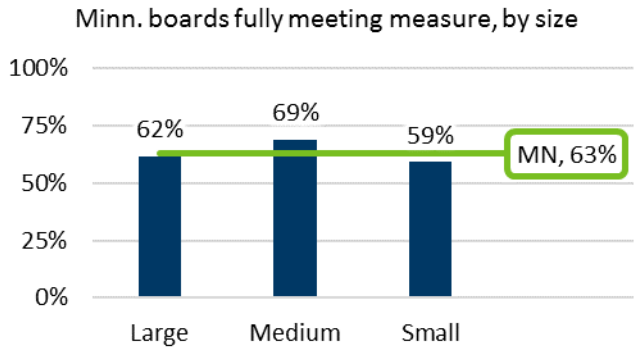




9.2.2. Implemented quality improvement activities.

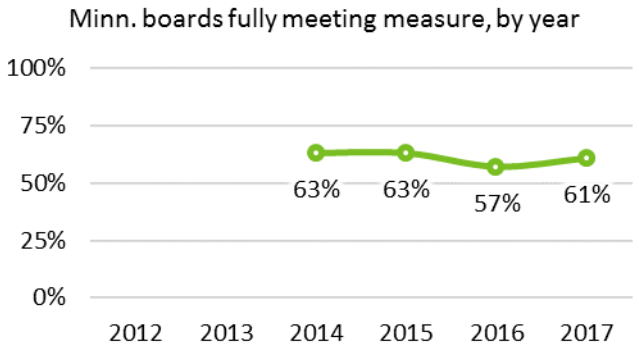
Performance management system concepts and practices serve as the framework to set targets, measure progress, report on progress, and make improvements. Community health boards must use QI activities to improve processes, programs, and interventions.

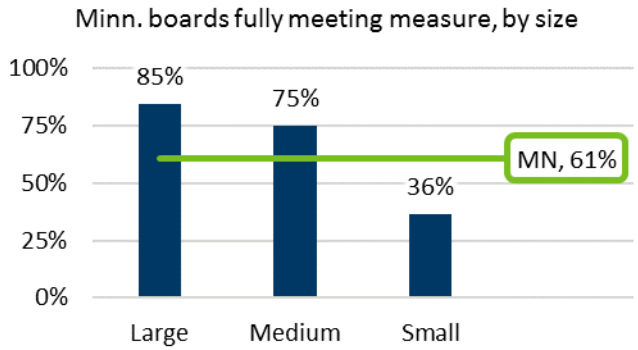




10.2.3. Communicated research findings, including public health implications.

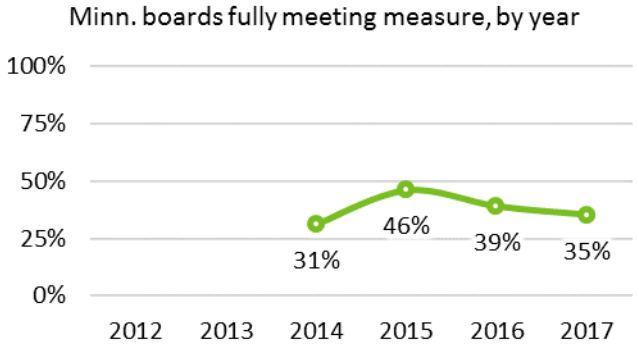
Public health research provides the knowledge and tools that people and communities need to protect their health. However, research findings can be confusing and difficult to translate into knowledge that steers action toward improved public health.

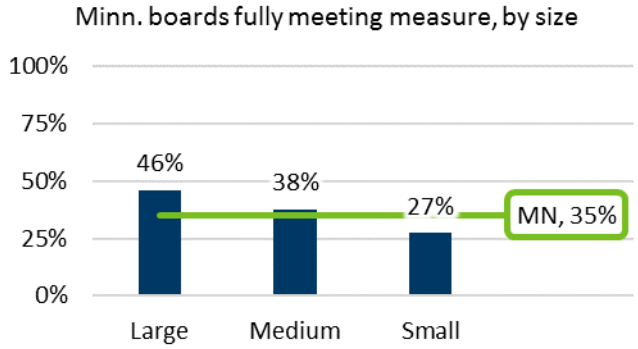




11.1.2. Ethical issues identified and ethical decisions made.

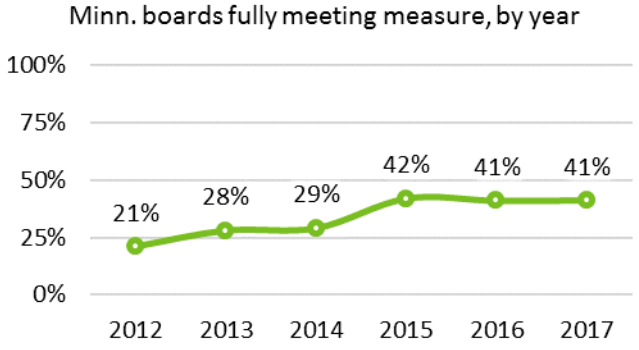
Efforts to achieve the goal of protecting and promoting the public's health have inherent ethical challenges. Employer/employees relations may also raise ethical issues. Understanding the ethical dimensions of policies and decisions is important for the provision of effective public health and public health management.

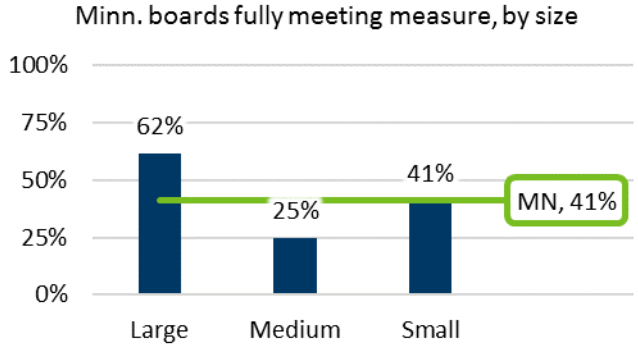




11.1.4. Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes.

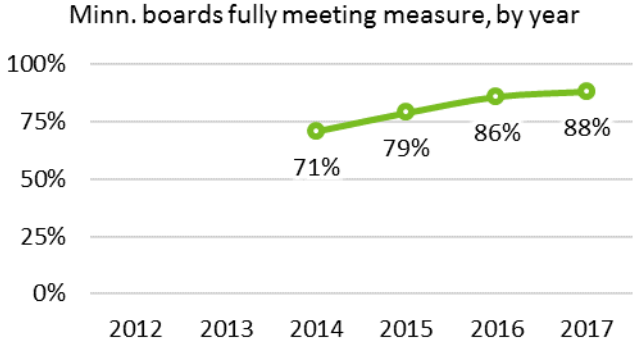
A community health board needs to cultivate social, cultural, and linguistic competence in working with its own employees, and in providing public health programs to populations in its jurisdiction.

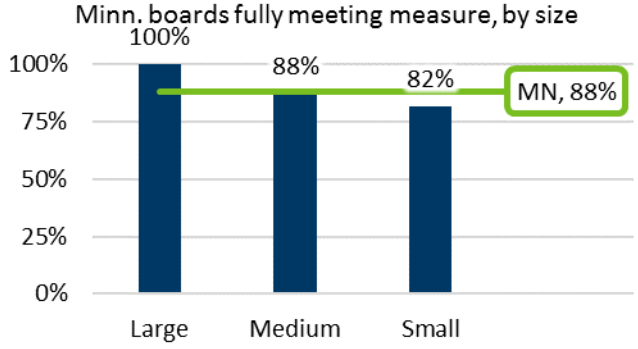




12.2.1. Communication with the governing entity regarding the responsibilities of a community health board and of the responsibilities of the governing entity.

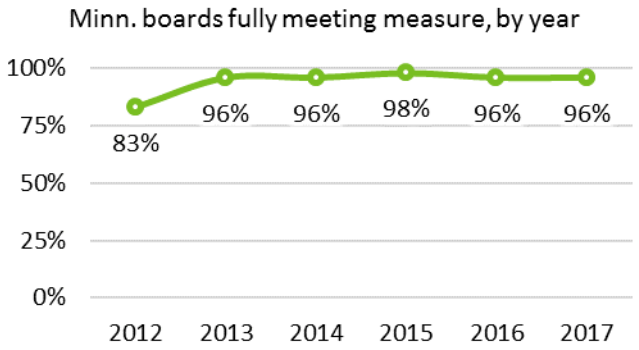
The governing entity is accountable for a community health board achieving its mission, goals, and objectives, to protect and preserve the health of the population within its jurisdiction.

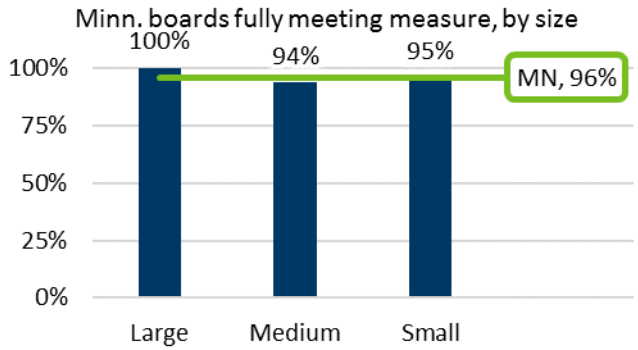




12.3.1. Information provided to the governing entity about important public health issues facing the community, a community health board, and/or the recent actions of a community health board.

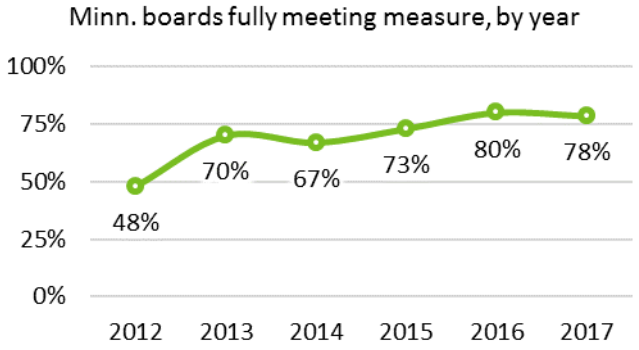
Public health governing entities exercise a wide range of responsibilities, which demand that the governing entity is well-versed in public health and in the work of a community health board.

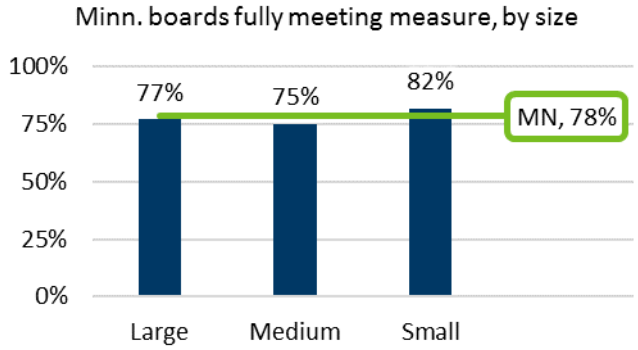




12.3.3. Communication with the governing entity about community health board performance assessment and improvement.

Public health governing agencies exercise a wide range of responsibilities, which demand that the governing entity is well-versed in public health and in the work of a community health board. A community health board must communicate with the governing entity on assessing and improving the overall performance of a community health board.



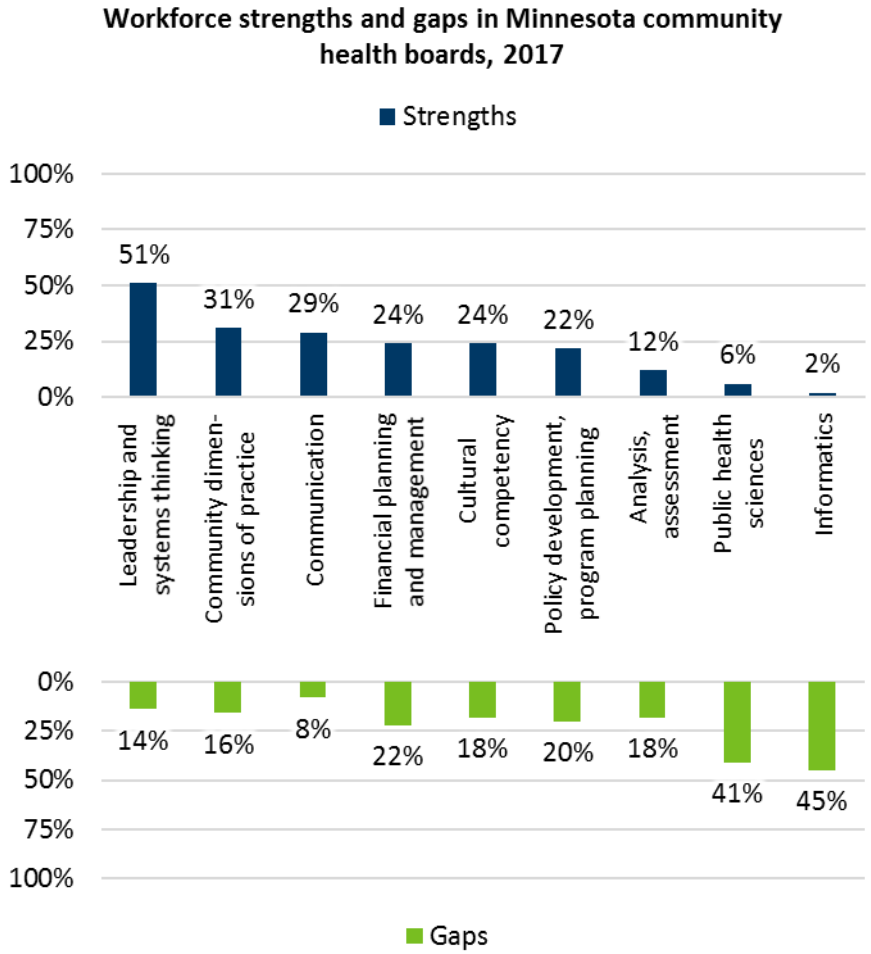


Assure an adequate local public health infrastructure: Minnesota-specific measures

Workforce competency

For a full list of performance measures and responses, refer to the data tables for this section.

Community health boards need a trained and competent workforce. The Core Competencies for Public Health Professionals, developed by the Council on Linkages between Academia and Public Health Practice, offer a starting point to identify professional development needs and develop a training plan. These response options are based on the Core Competencies for Public Health Professionals' eight domains, with the addition of *Informatics*.



	Strengths			Gaps		
	Large boards	Medium boards	Small boards	Large boards	Medium boards	Small boards
Analysis, assessment	8%	13%	14%	15%	13%	23%
Policy development, program planning	23%	25%	18%	0%	31%	23%
Communication	8%	38%	**36%**	23%	0%	5%
Cultural competency	31%	19%	23%	23%	0%	23%
Community dimensions of practice	23%	31%	**36%**	8%	25%	14%
Public health sciences	15%	0%	5%	**46%**	**56%**	23%
Financial planning and management	31%	13%	27%	31%	25%	14%
Leadership and systems thinking	**62%**	**63%**	**36%**	8%	6%	23%
Informatics	0%	0%	5%	31%	44%	**55%**

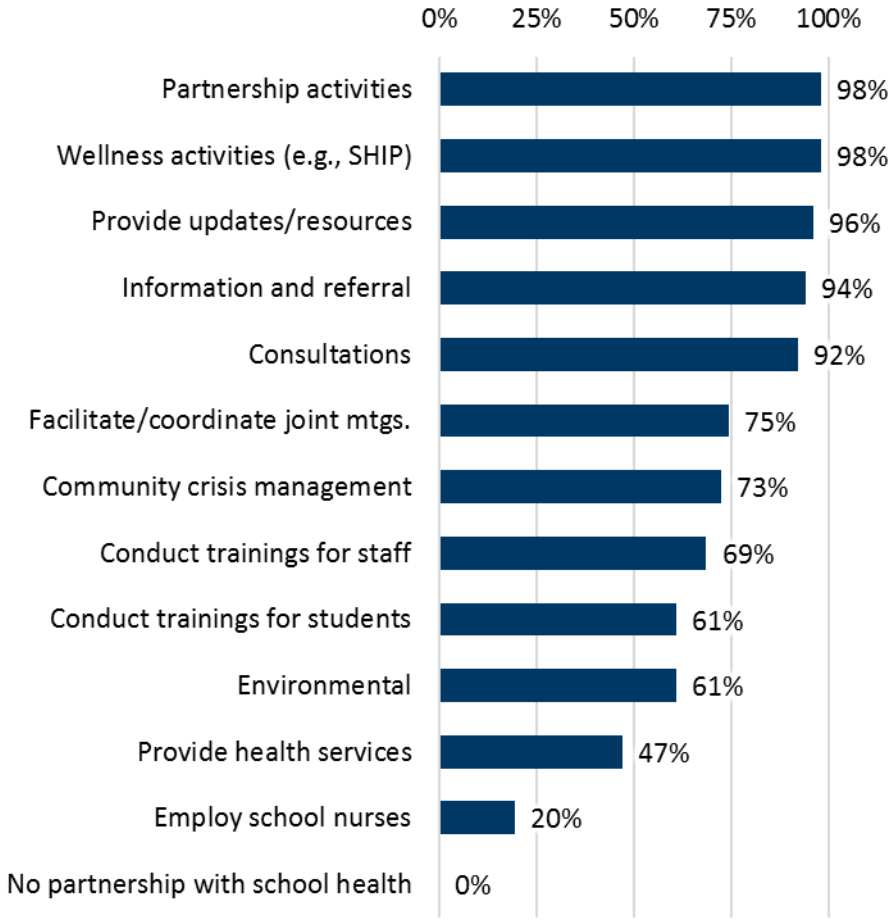
Assure an adequate local public health infrastructure: Minnesota-specific measures

School health

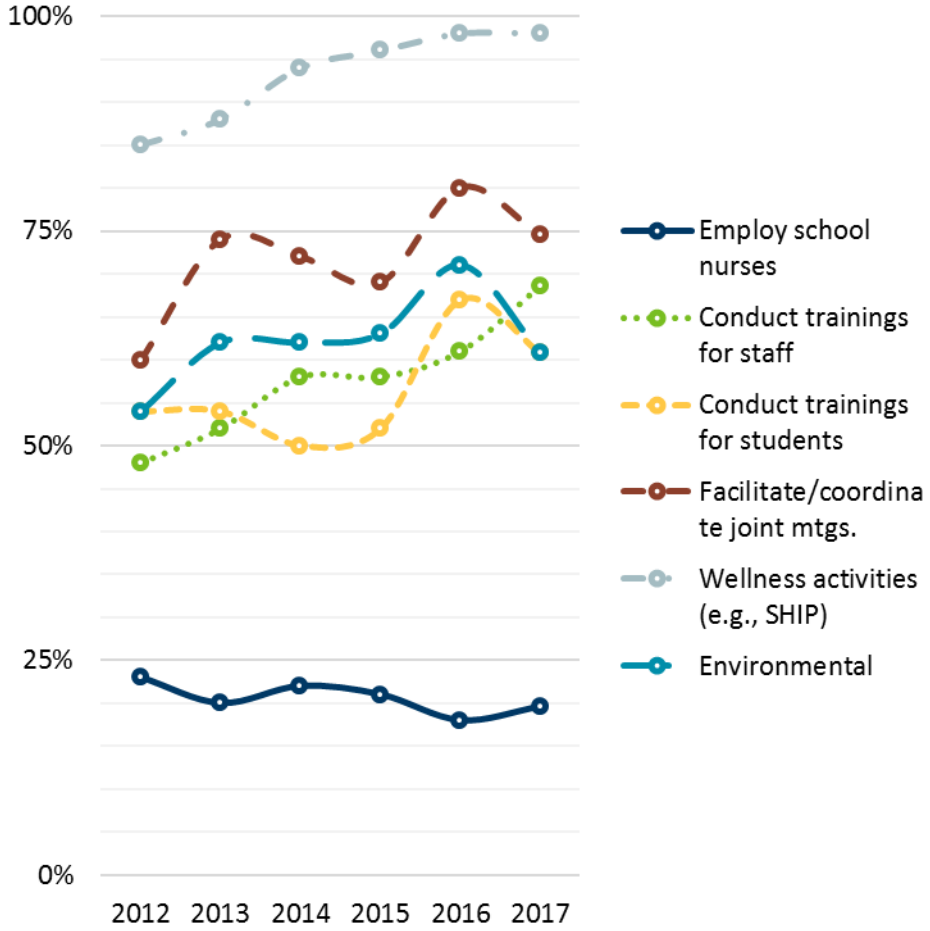
For a full list of performance measures and responses, refer to the data tables for this section.

Public health nurses and staff within the Minnesota school system work to support positive health outcomes for children and youth in all school settings.

Engagement with school health, Minnesota community health boards, 2017



Activities with largest change, engagement with school health, Minnesota community health boards



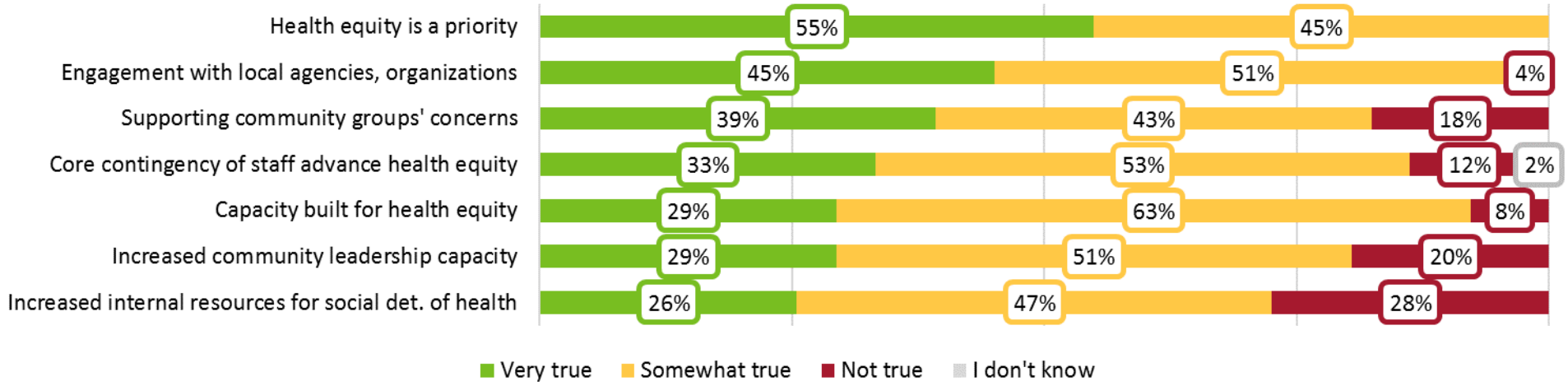
Assure an adequate local public health infrastructure: Minnesota-specific measures

Health equity

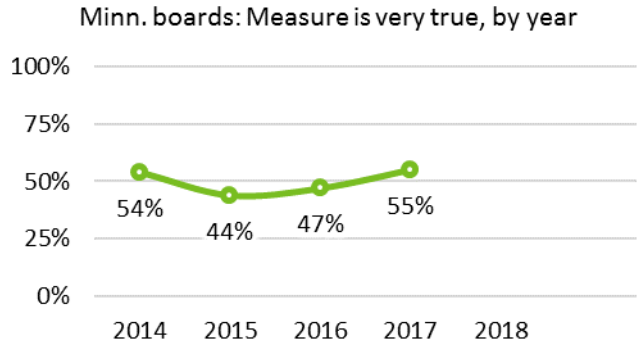
For a full list of performance measures and responses, refer to the data tables for this section.

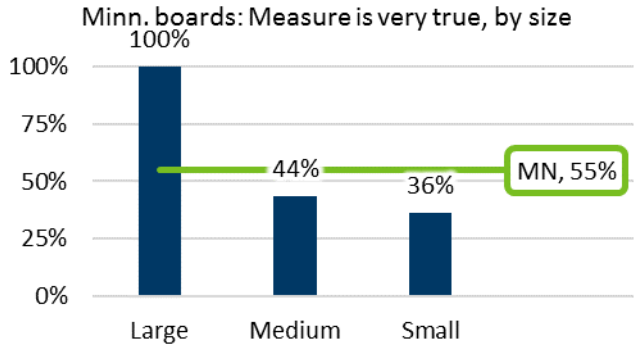
These questions recognize that health disparities are primarily the result of longstanding, systemic social and economic factors (e.g., social determinants of health) that have unfairly advantaged and disadvantaged some groups of people. Addressing social and economic factors that influence health is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

Minnesota community health board agreement with health equity measure, 2017

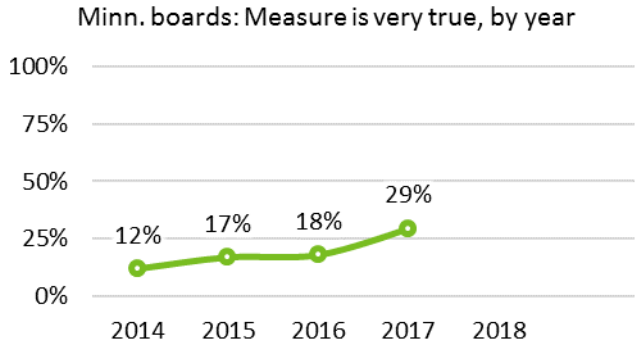


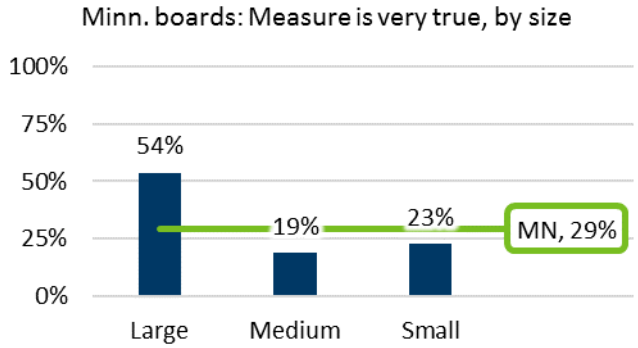
My community health board has identified health equity as a priority, with specific intent to address social determinants of health.



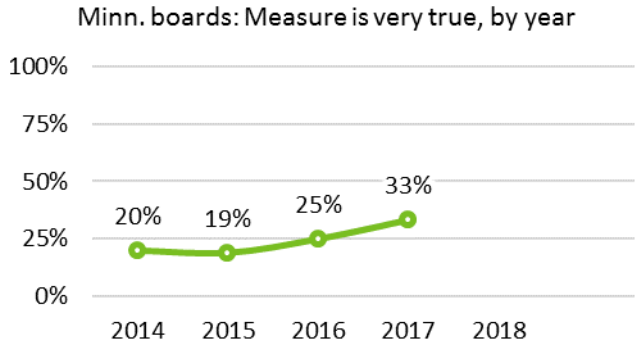


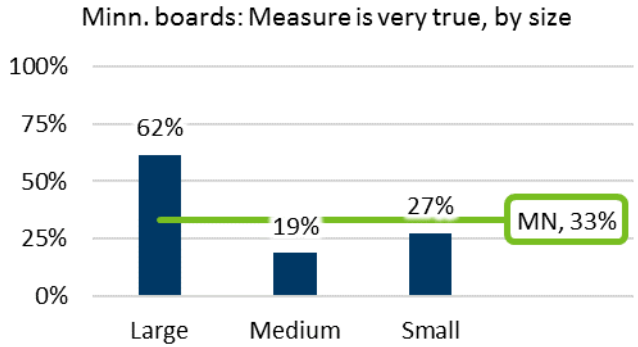
My community health board has built capacity to achieve health equity (e.g., human resources, funding, training staff) by addressing social determinants of health.



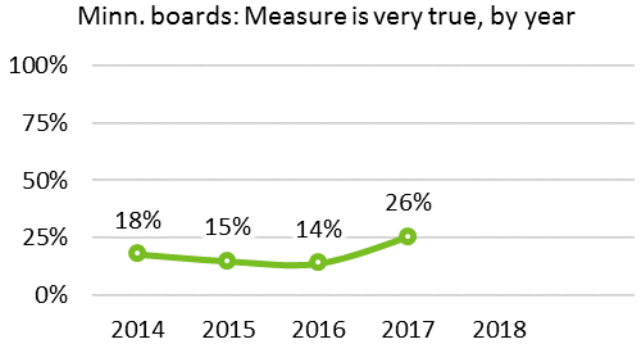


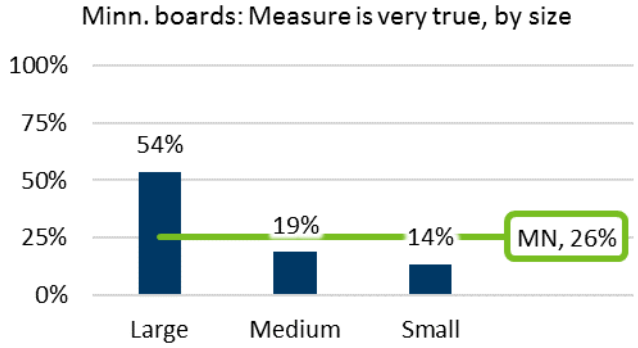
My community health board has established a core contingency of staff who are poised to advance a health equity agenda.



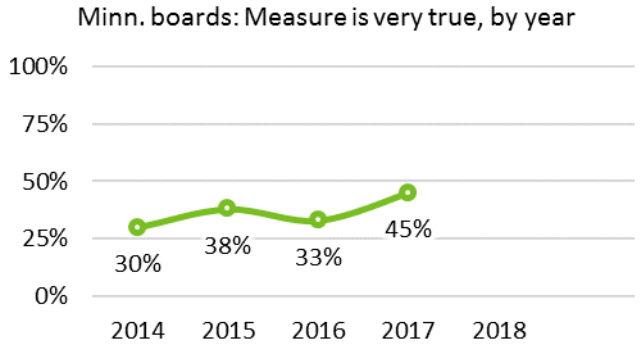


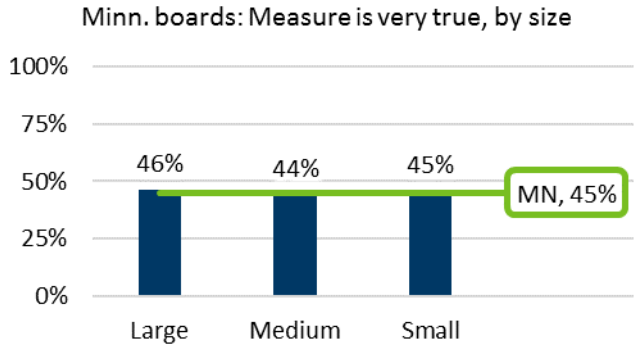
My community health board has increased the amount of internal resources directed to addressing social determinants of health.



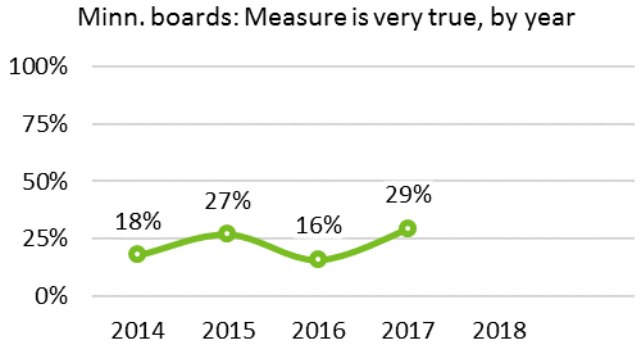


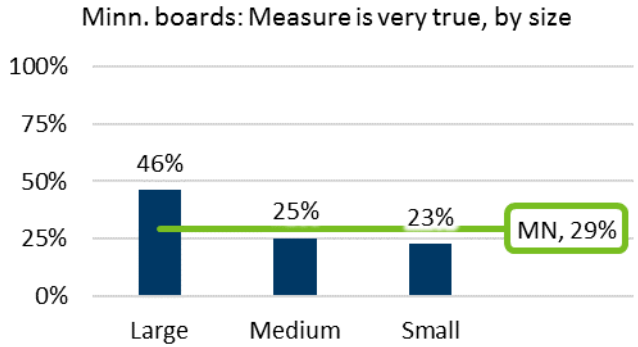
My community health board has engaged with local government agencies or other external organizations to support policies and programs to achieve health equity.



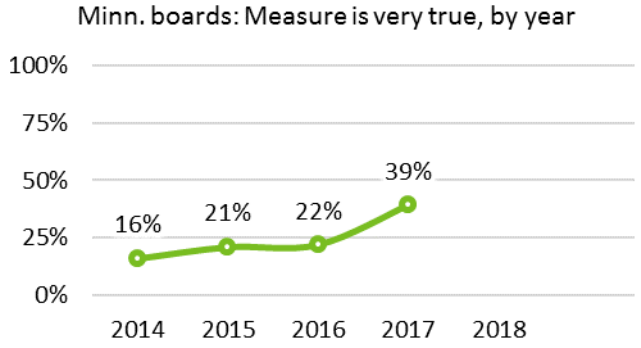


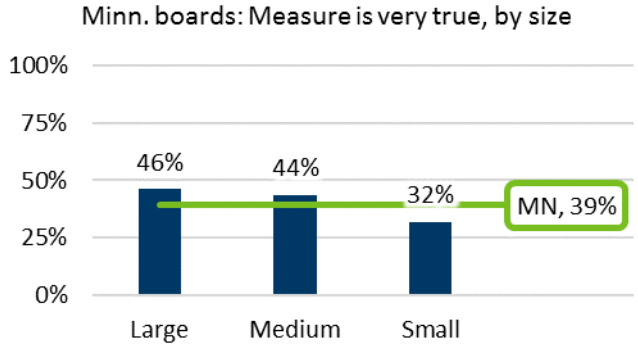
My community health board has made deliberate efforts to build the leadership capacity of community members to advocate on issues affecting social determinants of health.





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



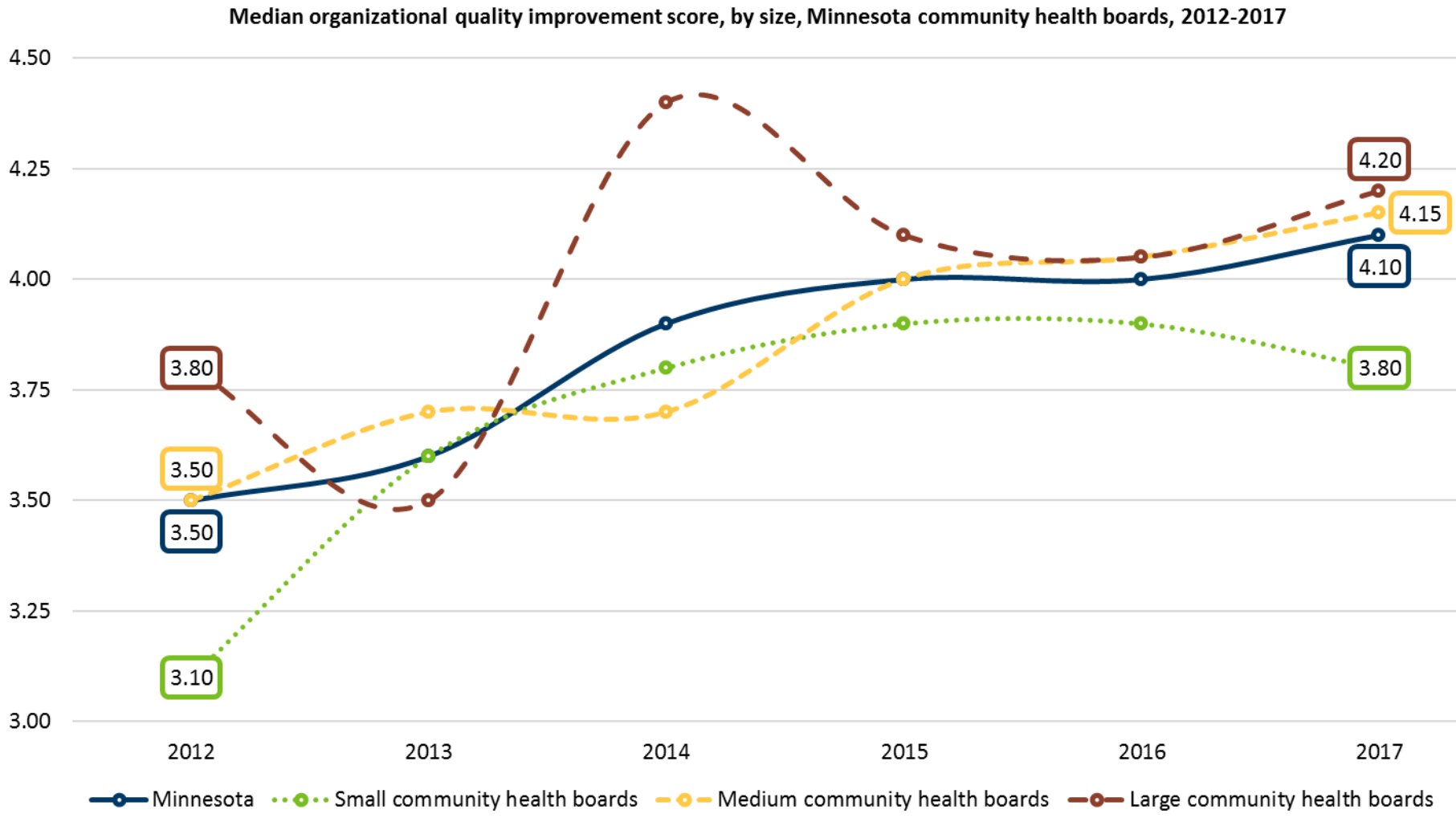


Assure an adequate local public health infrastructure: Minnesota-specific measures

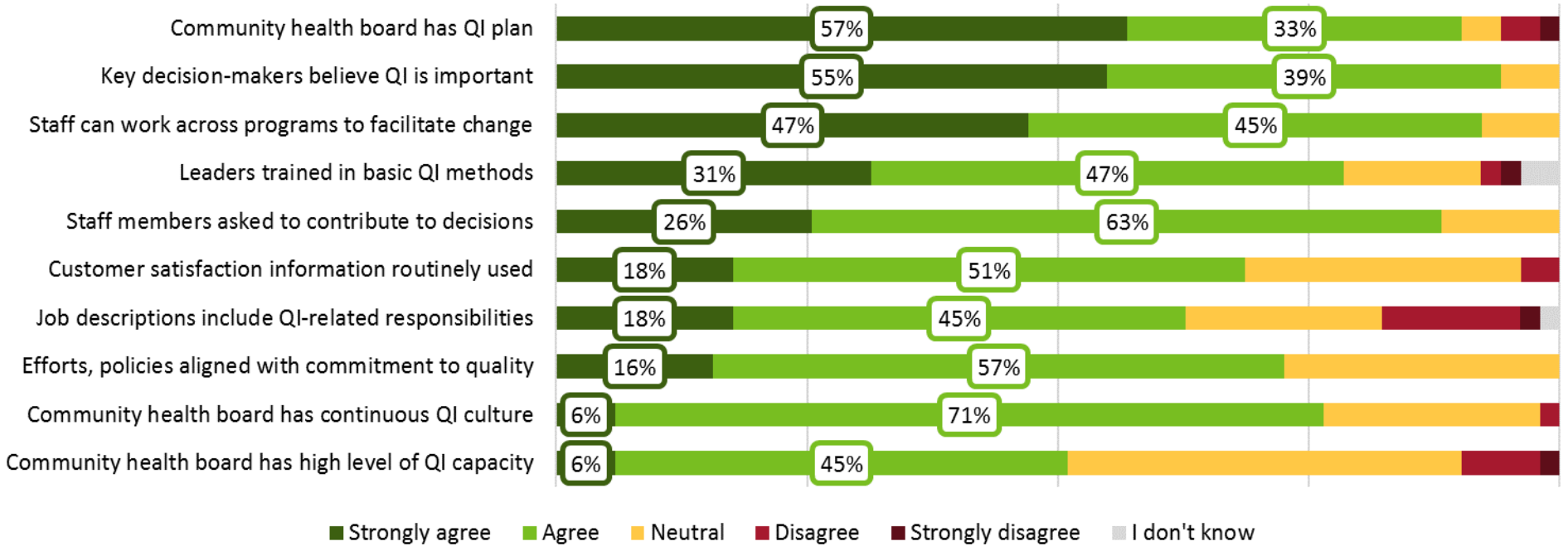
Organizational quality improvement maturity

For a full list of performance measures and responses, refer to the data tables for this section.

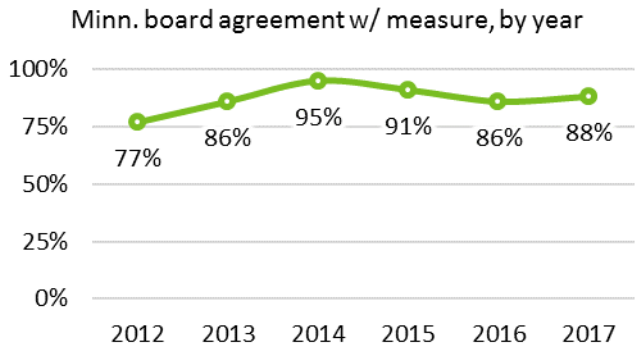
Assessing organizational QI maturity can help a community health board identify key areas for quality improvement, and determine additional education or training needed for staff and leadership.

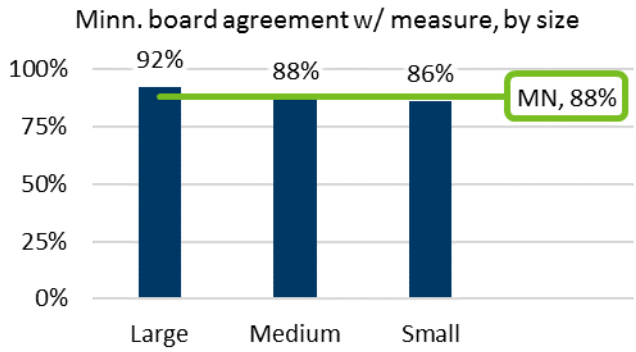


Minnesota community health board agreement with QI measure, 2017

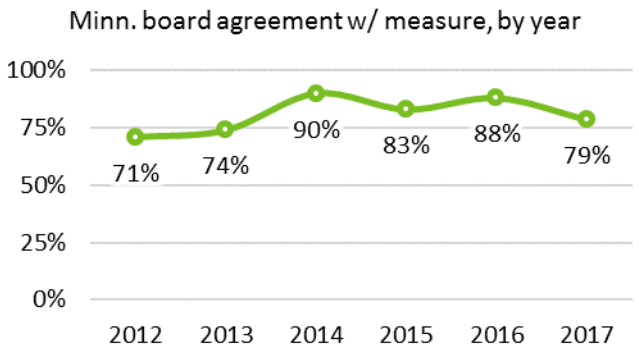


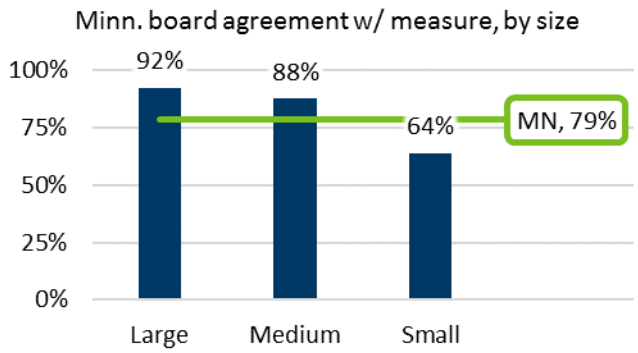
Staff members are routinely asked to contribute to decisions at my community health board.



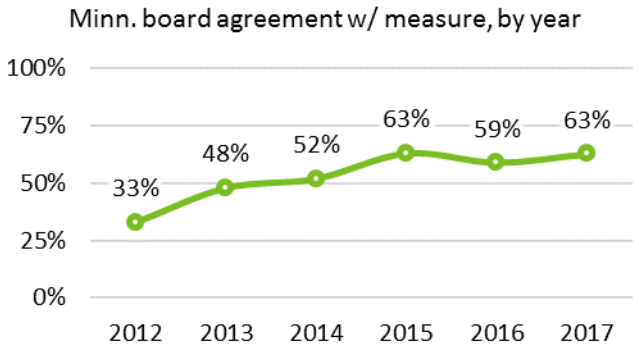


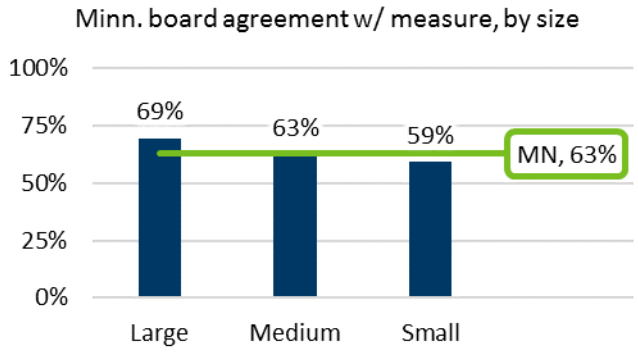
The leaders of my community health board are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.



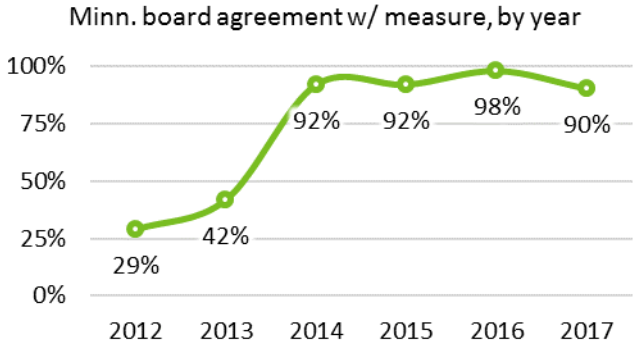


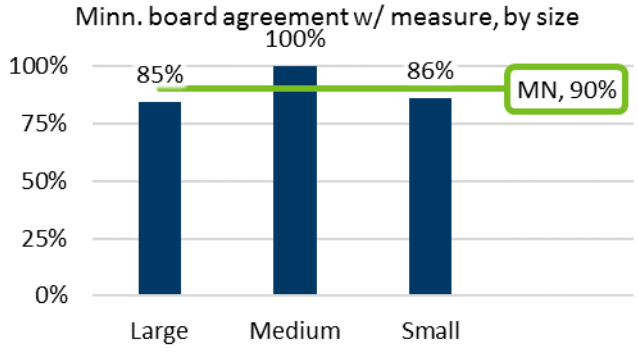
For many individuals responsible for programs and services in my community health board, job descriptions include specific responsibilities related to measuring and improving quality.



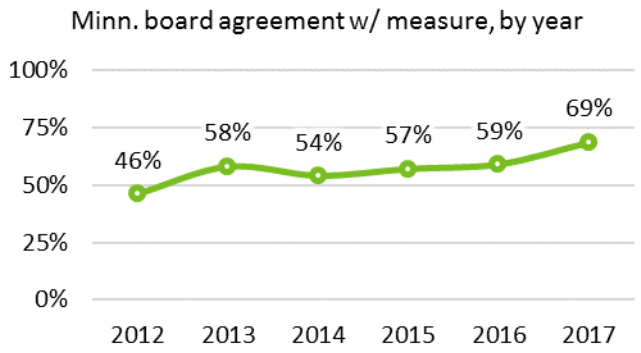


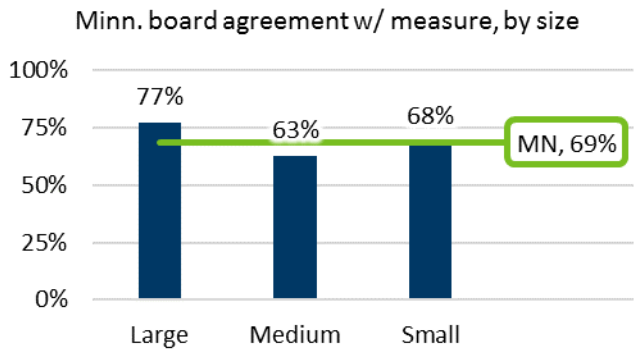
My community health board has a quality improvement (QI) plan.



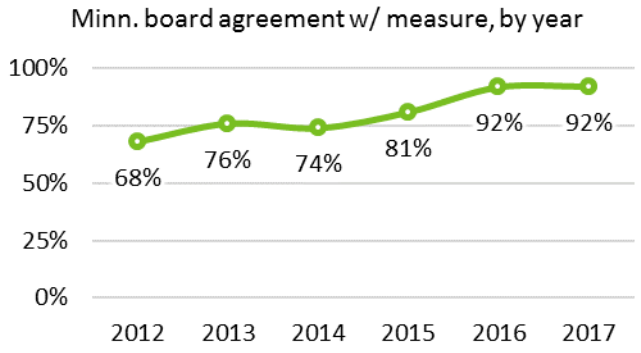


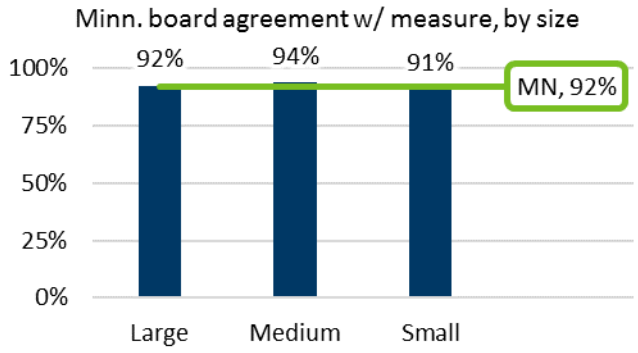
Customer satisfaction information is routinely used by many individuals responsible for programs and services in my community health board.



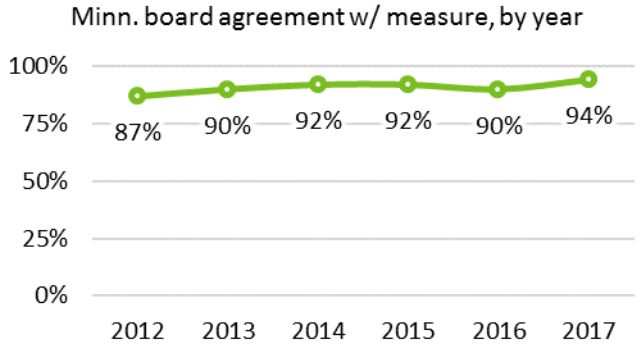


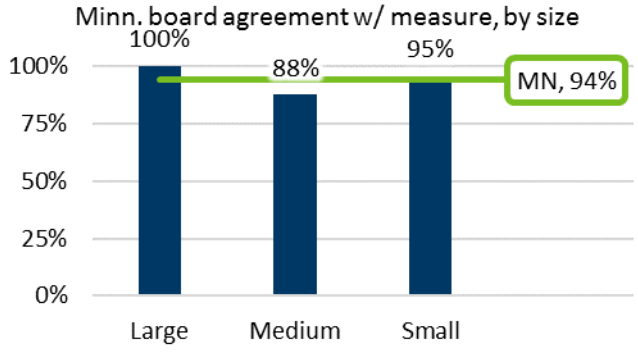
When trying to facilitate change, community health board staff has the authority to work within and across program boundaries.



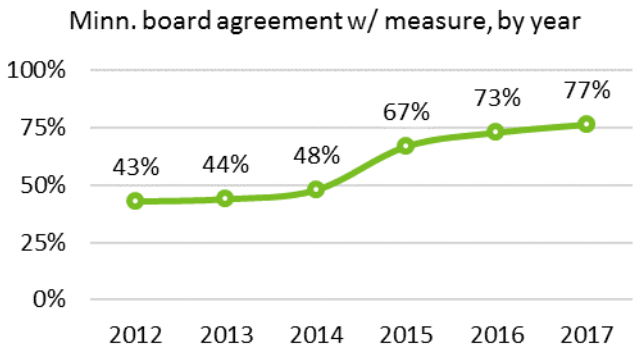


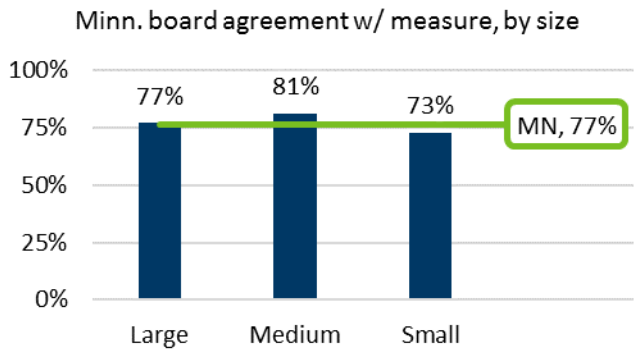
The key decision makers in my community health board believe QI is very important.



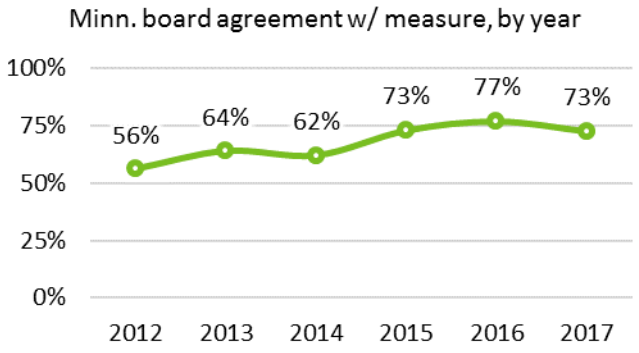


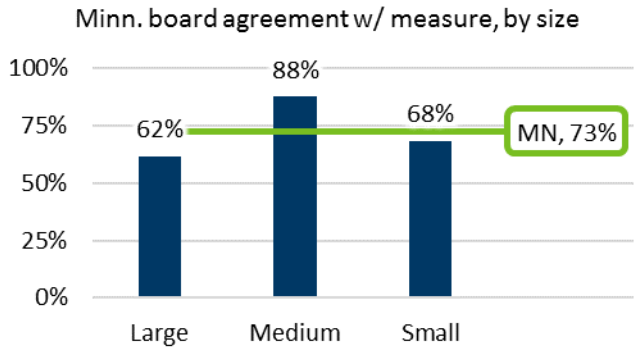
My community health board currently has a pervasive culture that focuses on continuous QI.



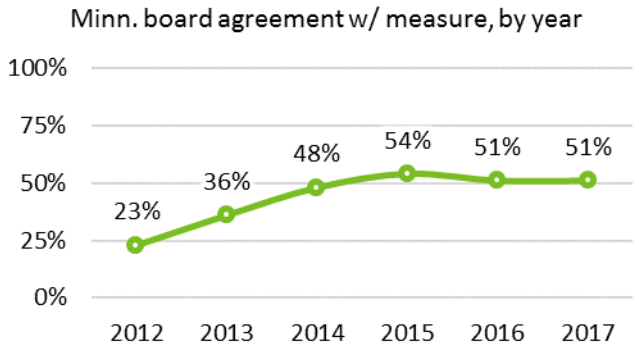


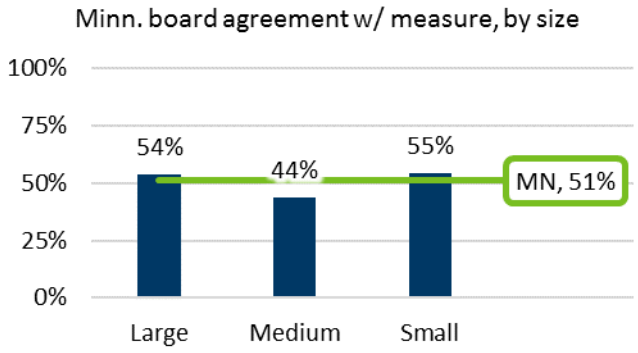
My community health board currently has aligned its commitment to quality with most of its efforts, policies, and plans.





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





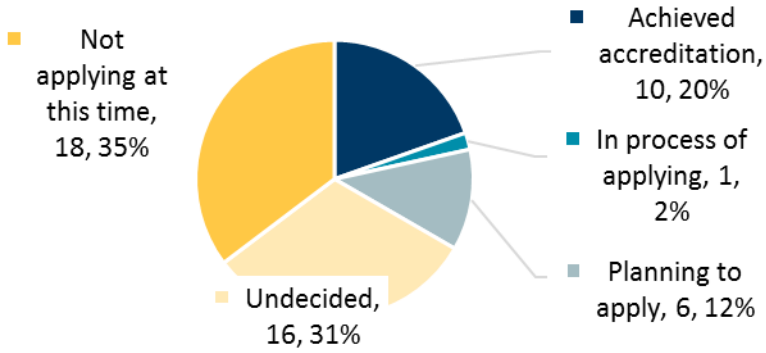
Assure an adequate local public health infrastructure: Minnesota-specific measures

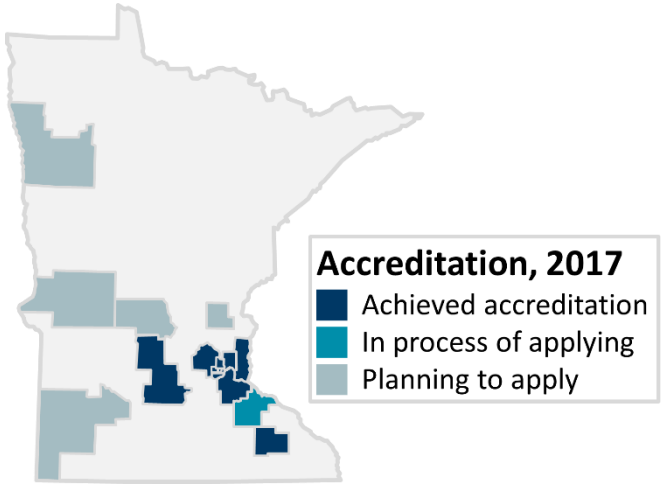
Voluntary public health accreditation

For a full list of performance measures and responses, refer to the data tables for this section.

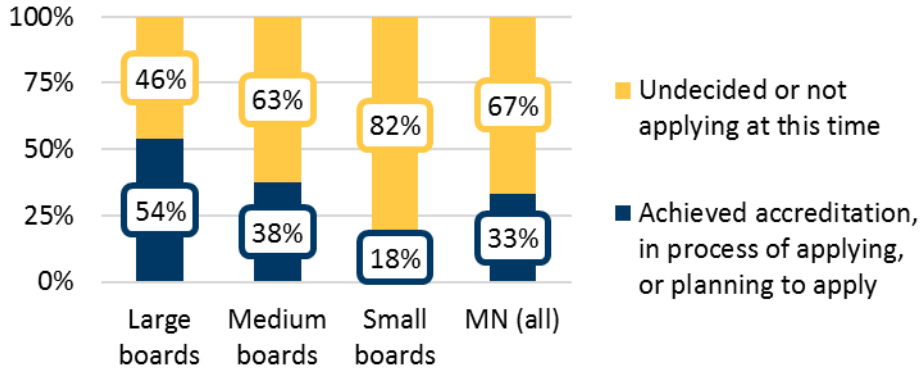
Systematic information on accreditation preparation is useful for networking, mentoring, and sharing among community health boards, and enables monitoring system-level progress to implement the SCHSAC recommendation that all community health boards are prepared to apply for voluntary national accreditation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

Minnesota community health board participation in national voluntary public health accreditation, 2017

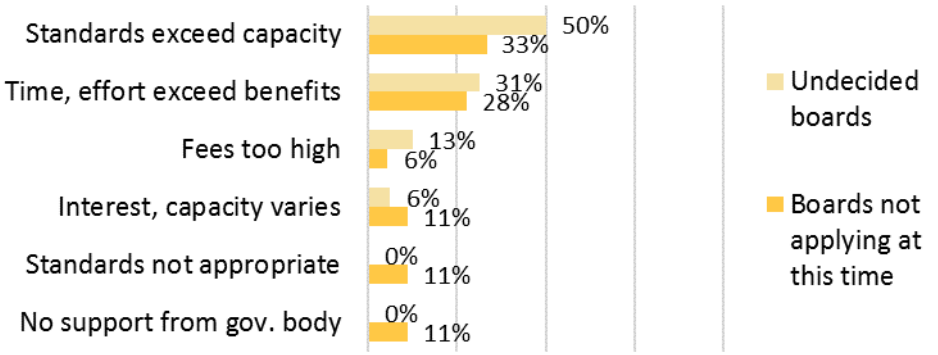




Minnesota community health board participation in accreditation, by population, 2017



Why Minnesota community health boards choose not to participate in accreditation, 2017



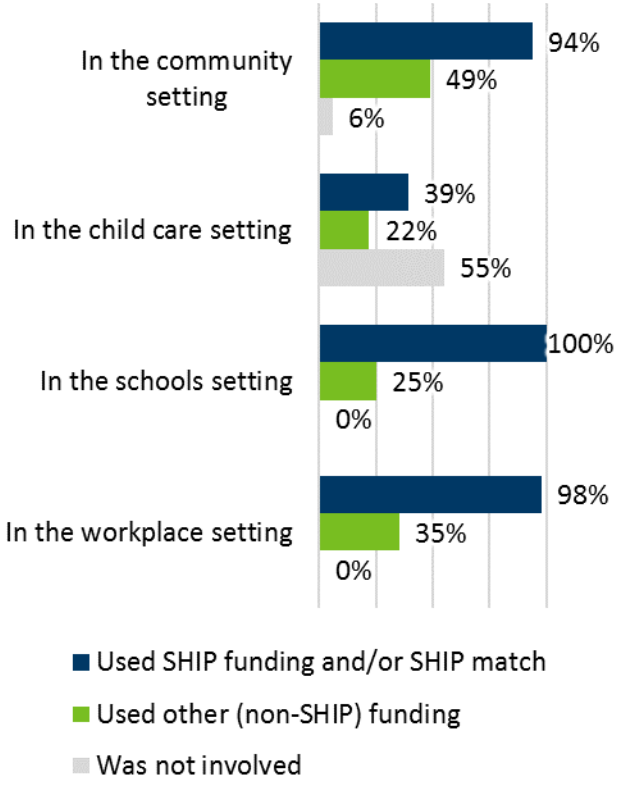
Promote healthy communities and healthy behavior

Active living

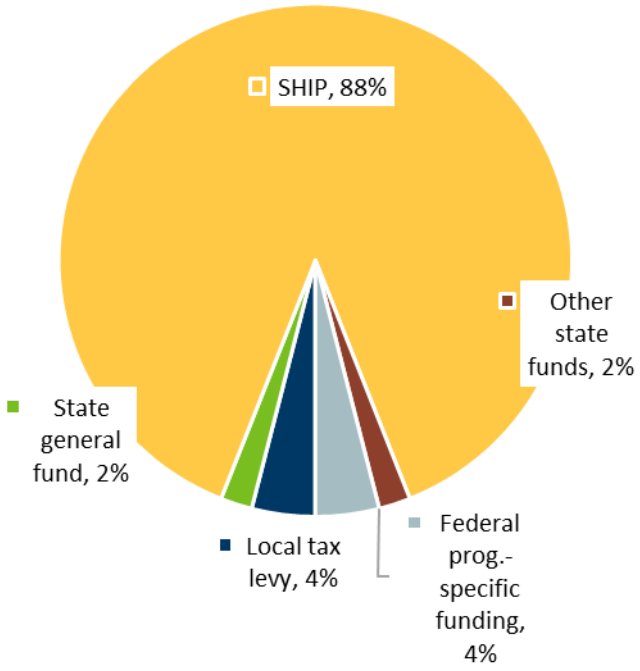
For a full list of performance measures and responses, refer to the data tables for this section.

These strategies have strong evidence-based support for their efficacy and align with current Statewide Health Improvement Partnership (SHIP) reporting and focus. Funding-related questions could be important for tracking what happens to services when funds are made available as well as the ramifications of funding cuts to service provision.

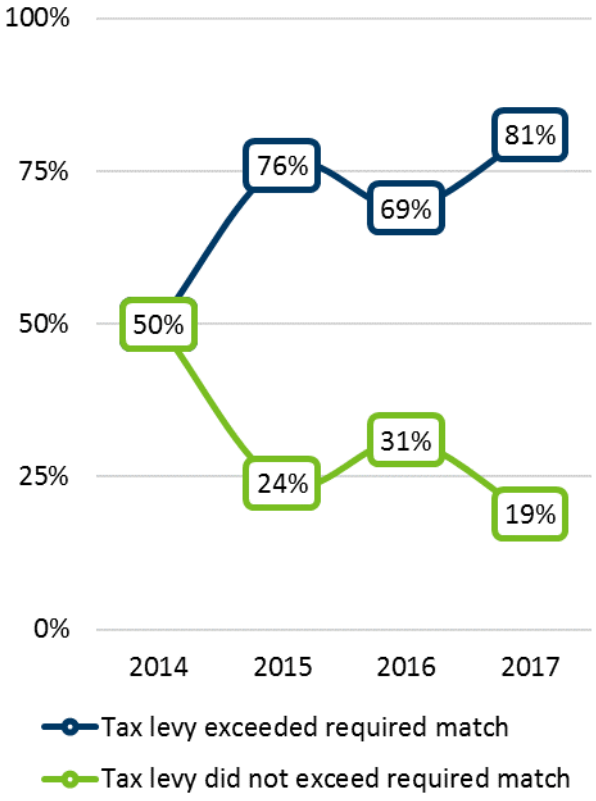
Minn. community health board implementation of strategies to promote active living, 2017



Primary funding source supporting strategies to promote active living for Minn. community health boards, 2017



Tax levy support of community health board work in active living, Minnesota, 2017



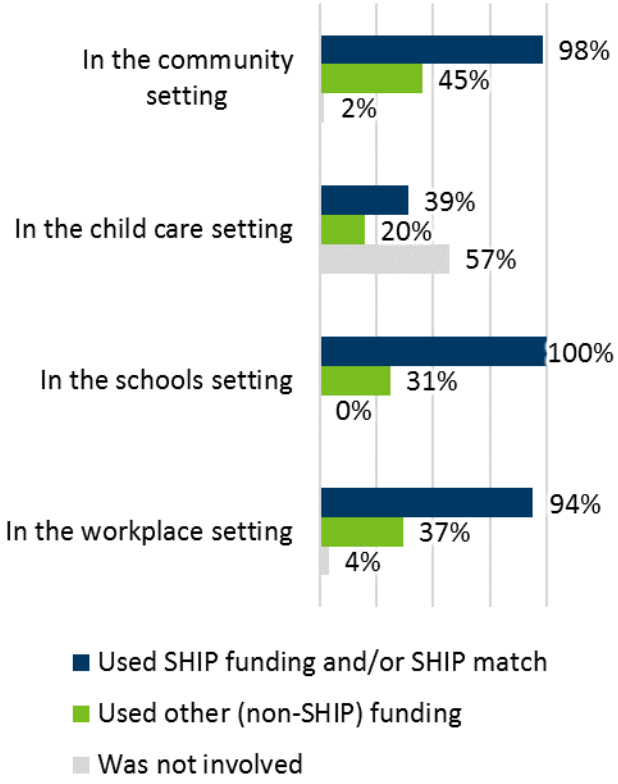
Promote healthy communities and healthy behavior

Healthy eating

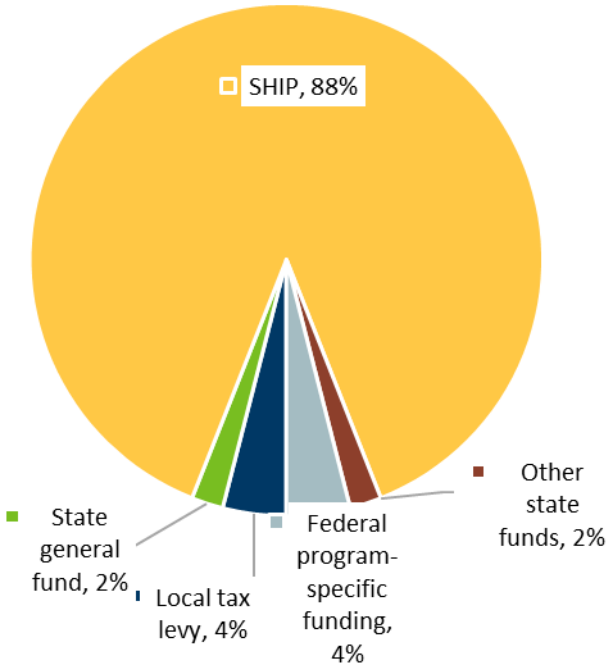
For a full list of performance measures and responses, refer to the data tables for this section.

These strategies have strong evidence-based support for their efficacy and align with current Statewide Health Improvement Partnership (SHIP) reporting and focus. Funding-related questions could be important for tracking what happens to services when funds are made available as well as the ramifications of funding cuts to service provision.

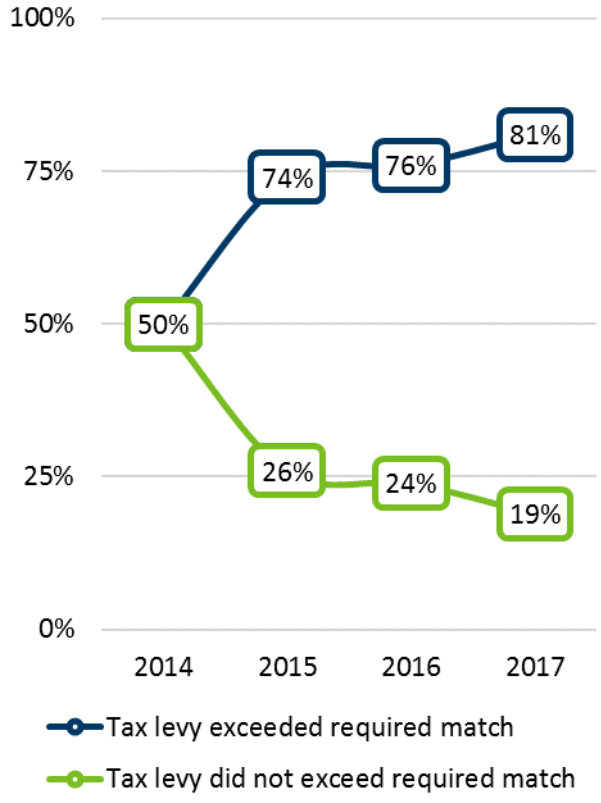
Minn. community health board implementation of strategies to promote healthy eating, 2017



Primary funding source supporting strategies to promote healthy eating for Minn. community health boards, 2017



Tax levy support of community health board work in healthy eating, Minnesota, 2017



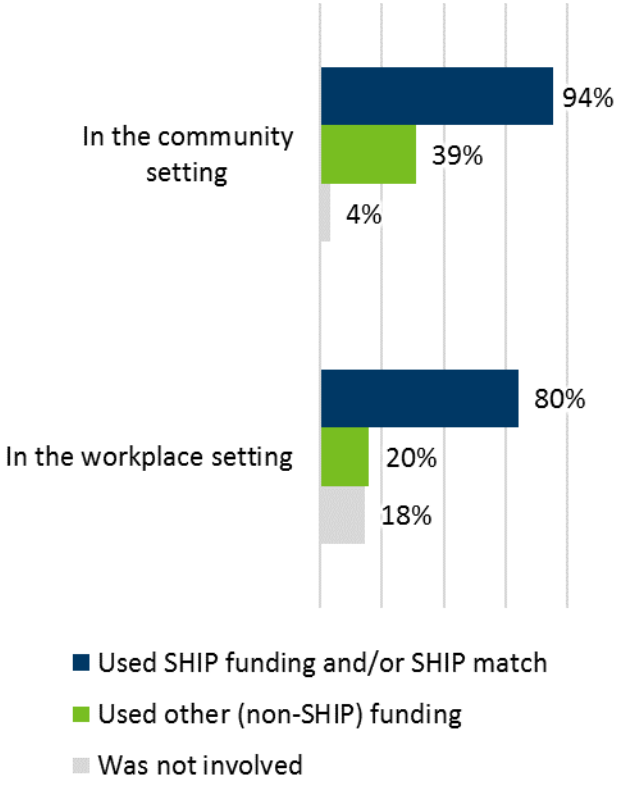
Promote healthy communities and healthy behavior

Tobacco-free living

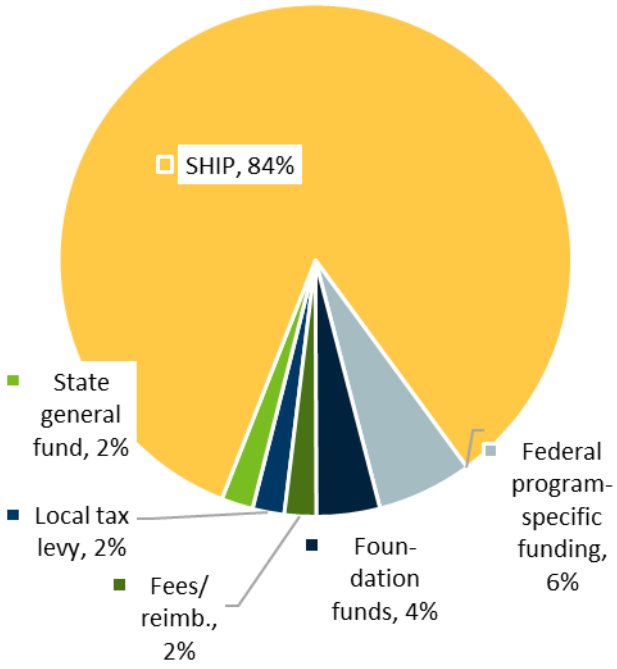
For a full list of performance measures and responses, refer to the data tables for this section.

These strategies have strong evidence-based support for their efficacy and align with current Statewide Health Improvement Partnership (SHIP) reporting and focus. Funding-related questions could be important for tracking what happens to services when funds are made available as well as the ramifications of funding cuts to service provision.

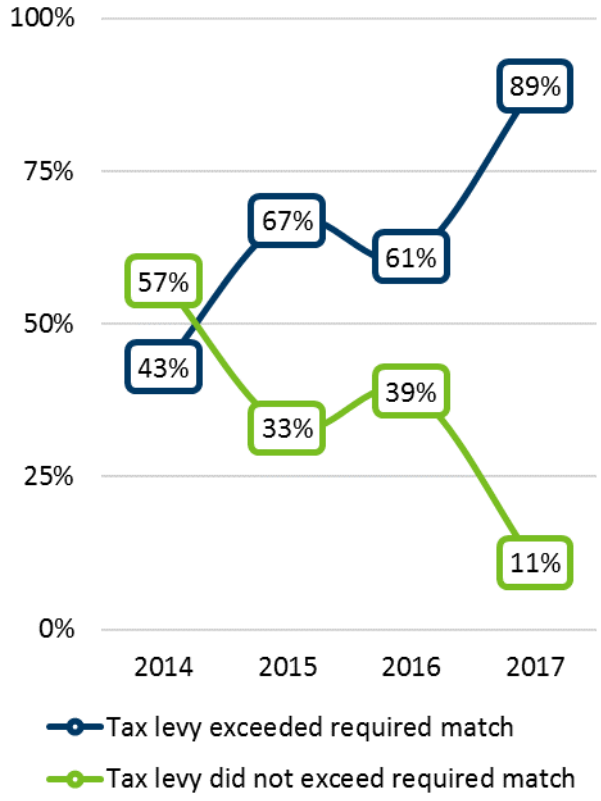
Minnesota community health board implementation of strategies to promote tobacco-free living, 2017



Primary funding source supporting strategies to promote tobacco-free living for Minn. comm. health boards, 2017



Tax levy support of community health board work in tobacco-free living, Minnesota, 2017



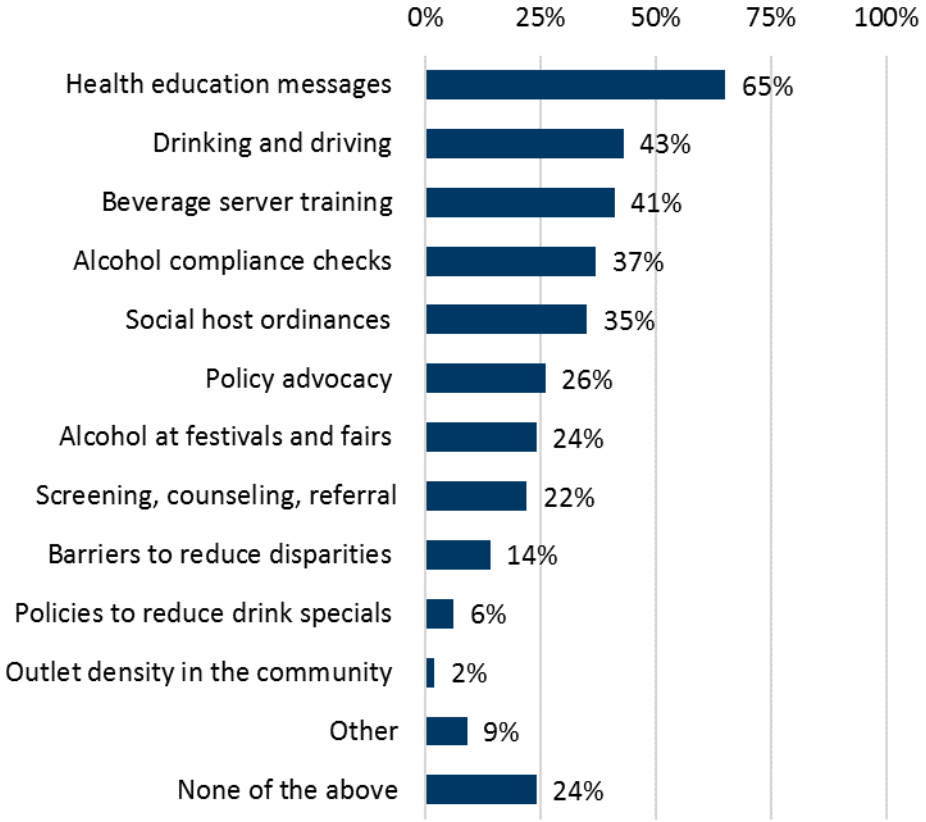
Promote healthy communities and healthy behavior

Alcohol

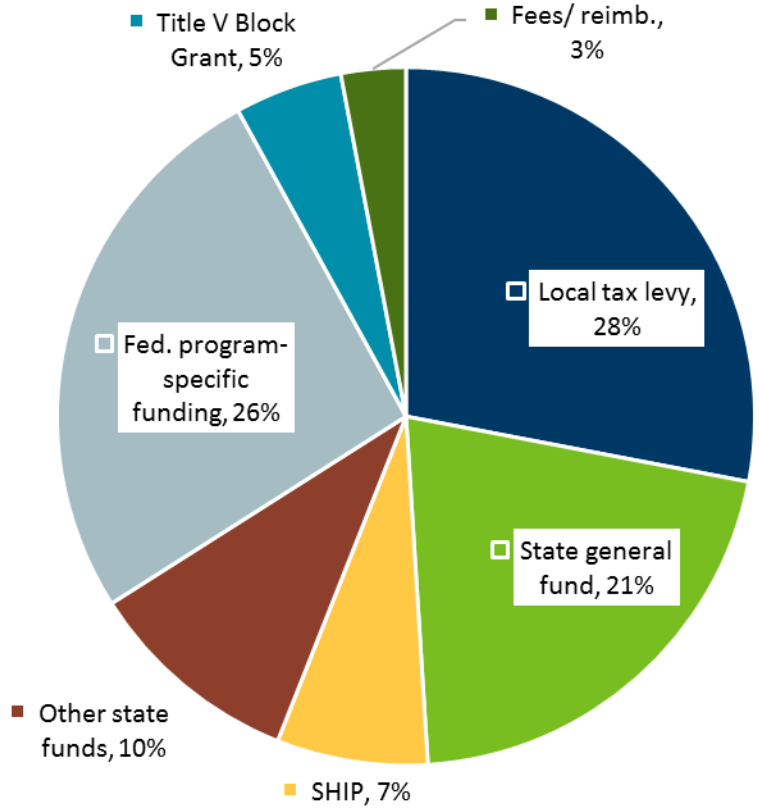
For a full list of performance measures and responses, refer to the data tables for this section.

More people use alcohol than tobacco or any other drug, and it is a major risk factor for some diseases. Community health boards play a critical role in alcohol control through advocacy and education, and help mobilize communities to develop and implement policies and programs.

Community health board strategies related to alcohol use, Minnesota, 2017

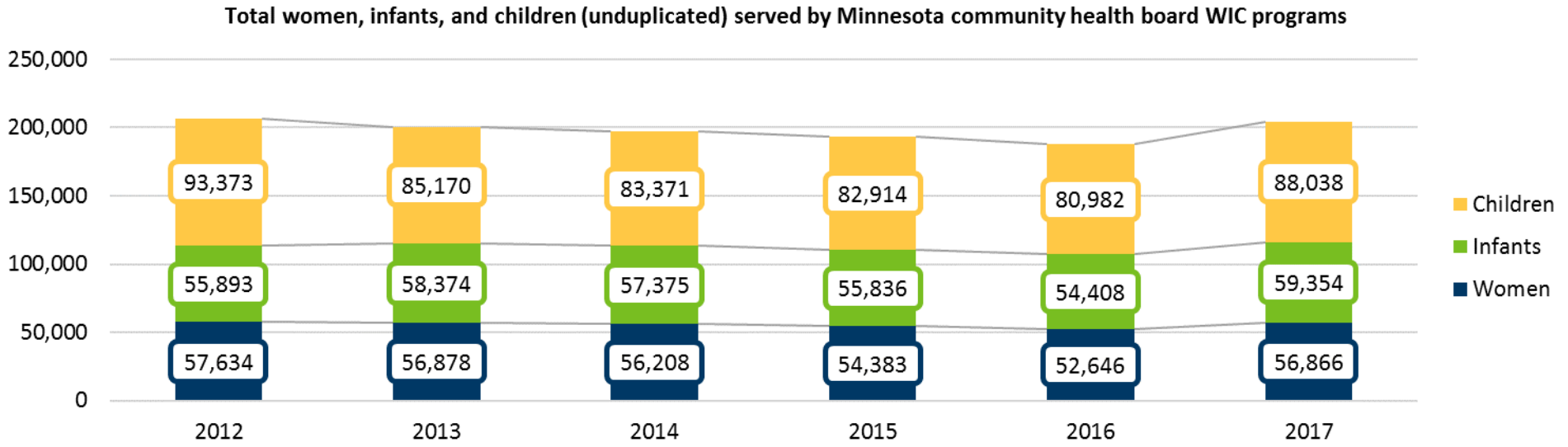


Primary funding source supporting strategies on alcohol use for Minnesota community health boards, 2017



Promote healthy communities and healthy behavior

Maternal and child health

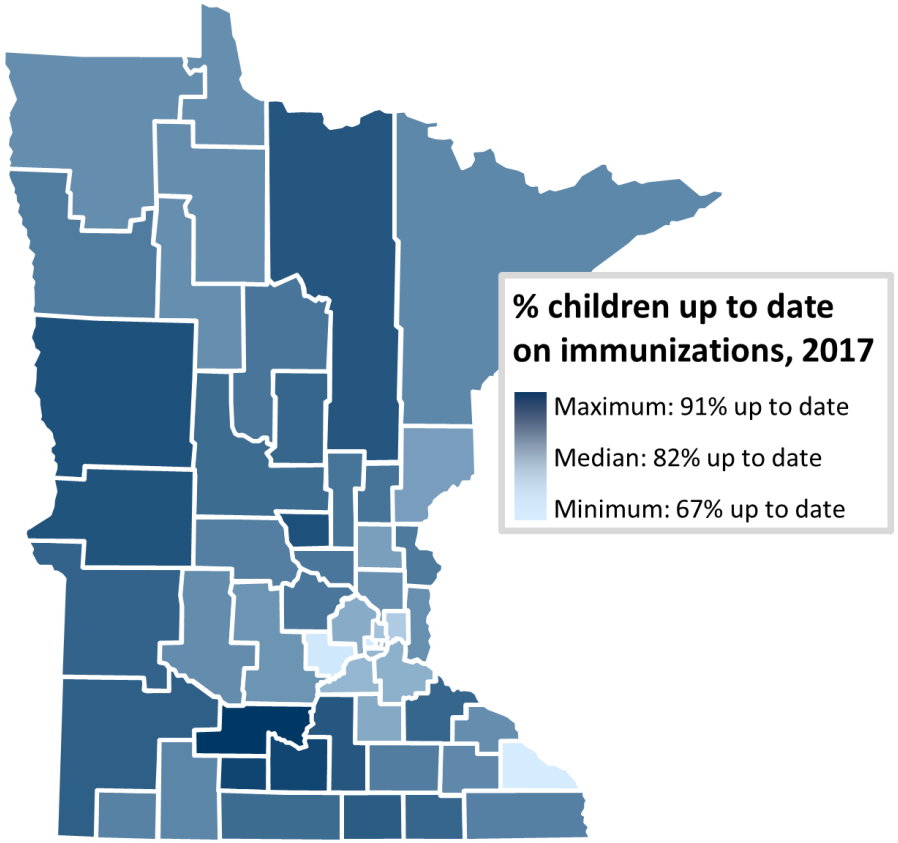


Prevent the spread of communicable diseases

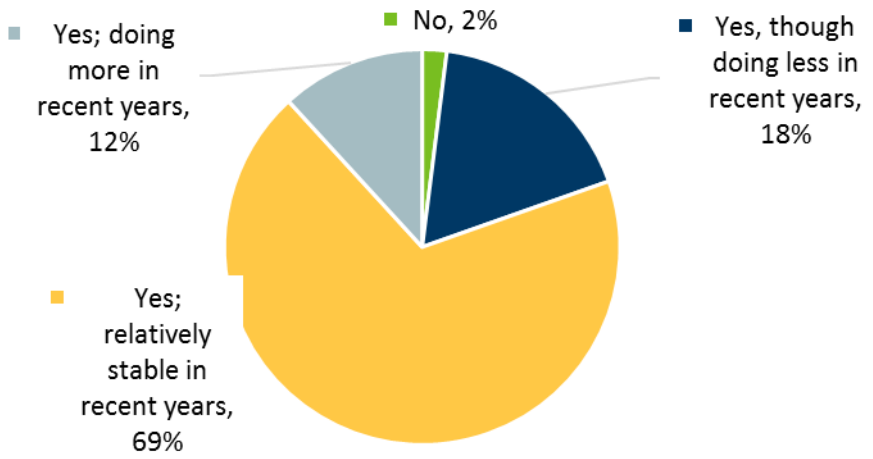
Immunization

For a full list of performance measures and responses, refer to the data tables for this section.

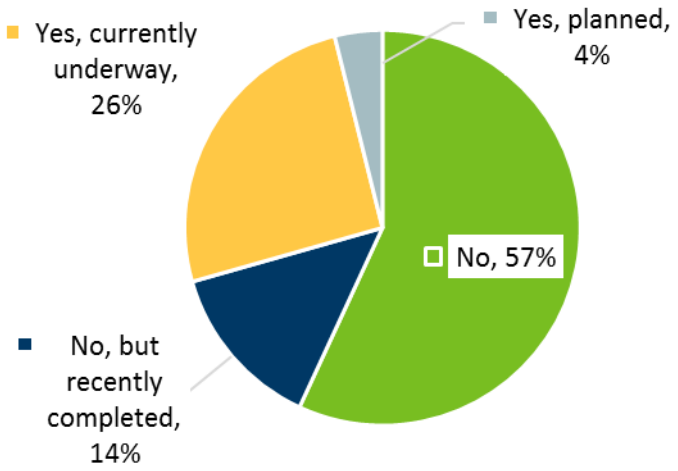
Immunization rates serve as an important measure of preventive care and overall public health.



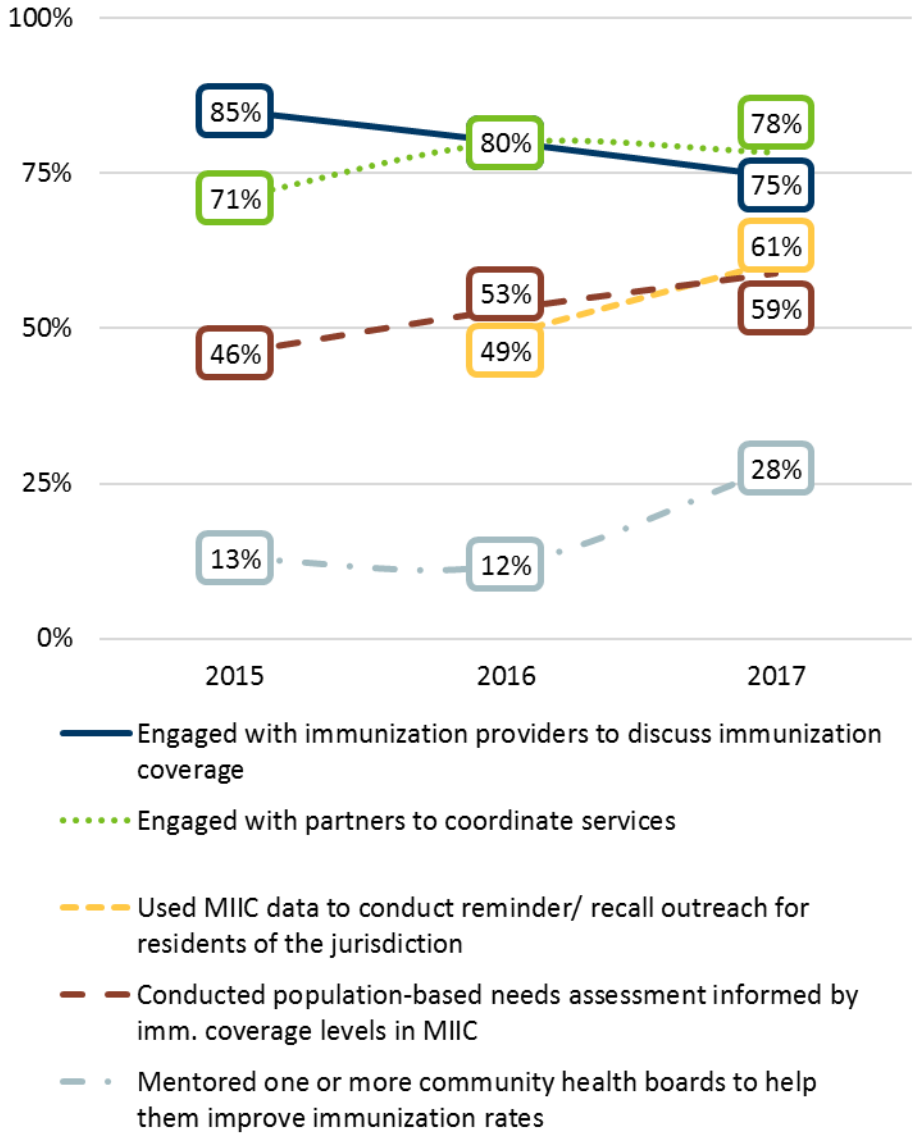
Community health boards referring clients for immunizations, Minnesota, 2017



Community health boards re-examining their roles in providing immunization services, Minnesota, 2017



Trends in selected immunization-related activities routinely performed by Minnesota community health boards, 2017



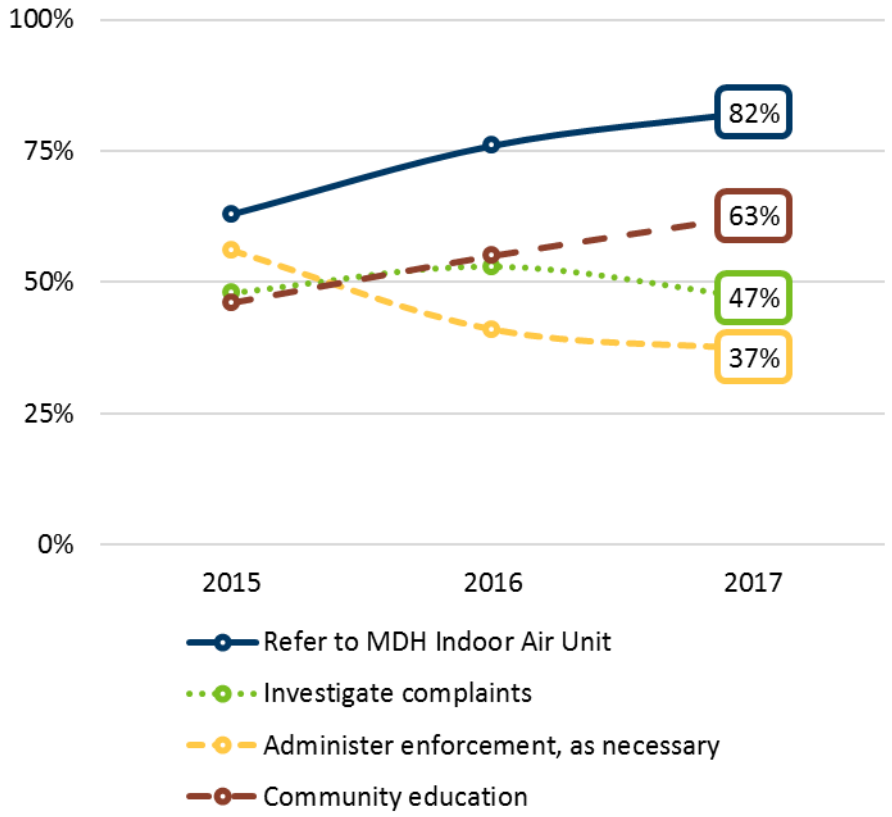
Protect against environmental health hazards

Indoor air

For a full list of performance measures and responses, refer to the data tables for this section.

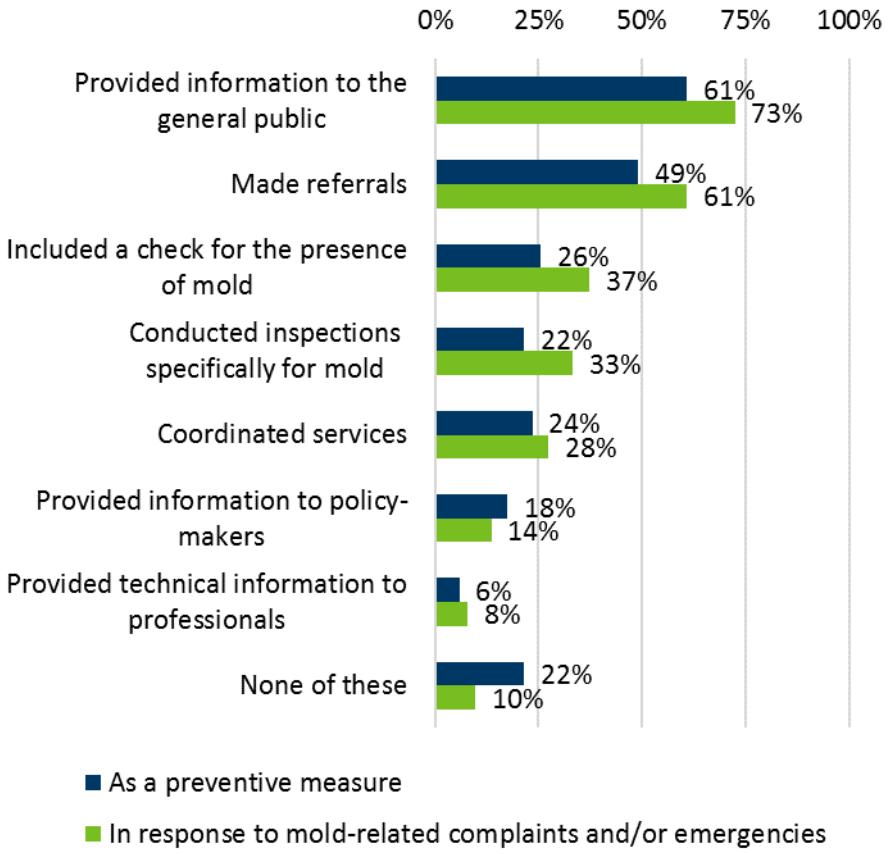
These questions provide a picture of the statewide impact of community health board efforts surrounding support for the Minnesota Clean Indoor Air Act, which regulates exposure to secondhand smoke, thereby preventing the incidence of lung cancer due to secondhand smoke.

Community health board support of the Minnesota Clean Indoor Air Act, 2017



Growing awareness of the health effects of mold exposure has prompted some community health boards to play a variety of roles in promoting mold awareness, cleanup and removal.

Minnesota community health board actions taken related to mold, 2017



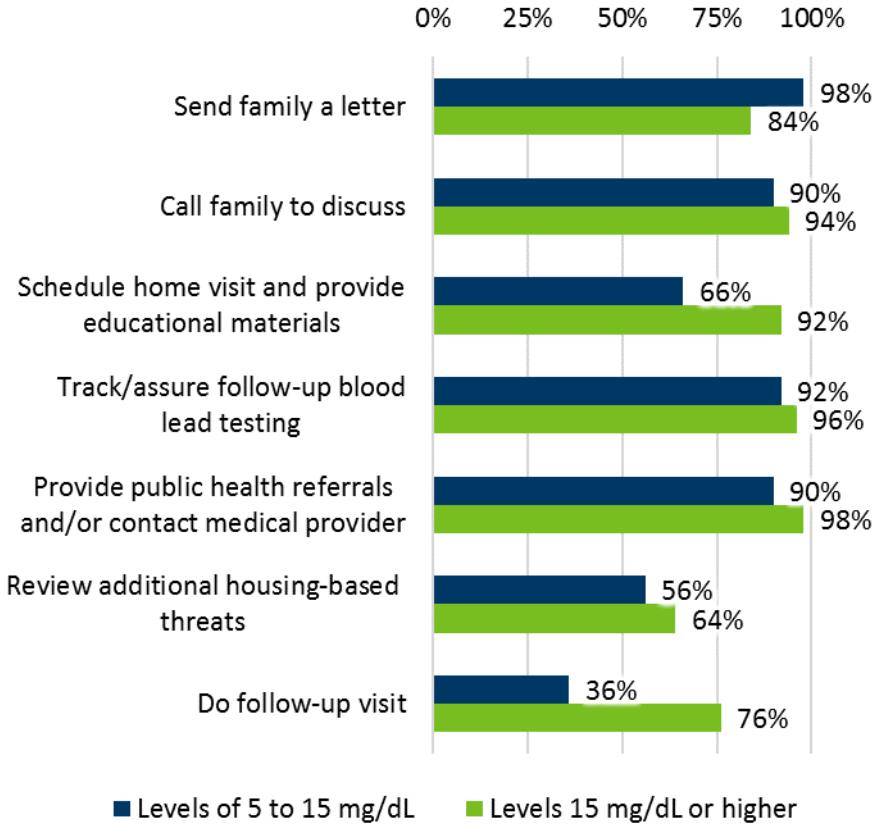
Protect against environmental health hazards

Blood lead

For a full list of performance measures and responses, refer to the data tables for this section.

Community health board case management efforts are critical to continuing lead hazard reduction. The Childhood Blood Lead Case Management Guidelines for Minnesota (PDF) recommend 5.0 µg/dL as the threshold for public health actions.

Minnesota community health board response to elevated blood lead levels, 2017



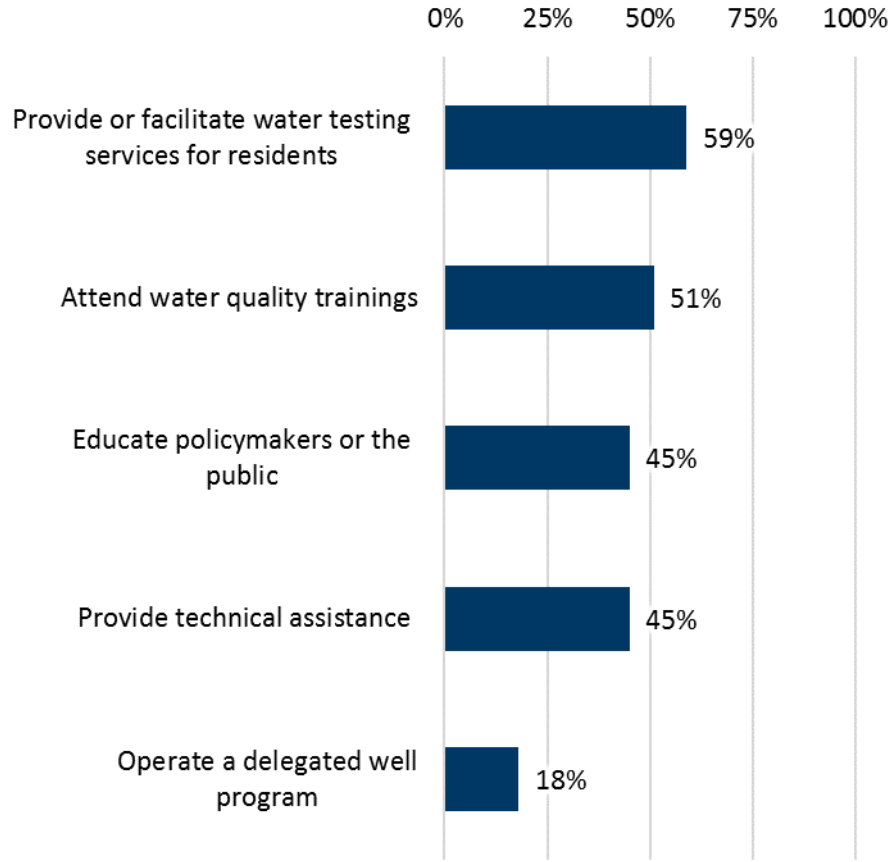
Protect against environmental health hazards

Drinking water protection and well management

For a full list of performance measures and responses, refer to the data tables for this section.

Public health helps protect drinking water supplies by reducing the potential for contamination.

Means used to address drinking water quality by Minnesota community health boards, 2017



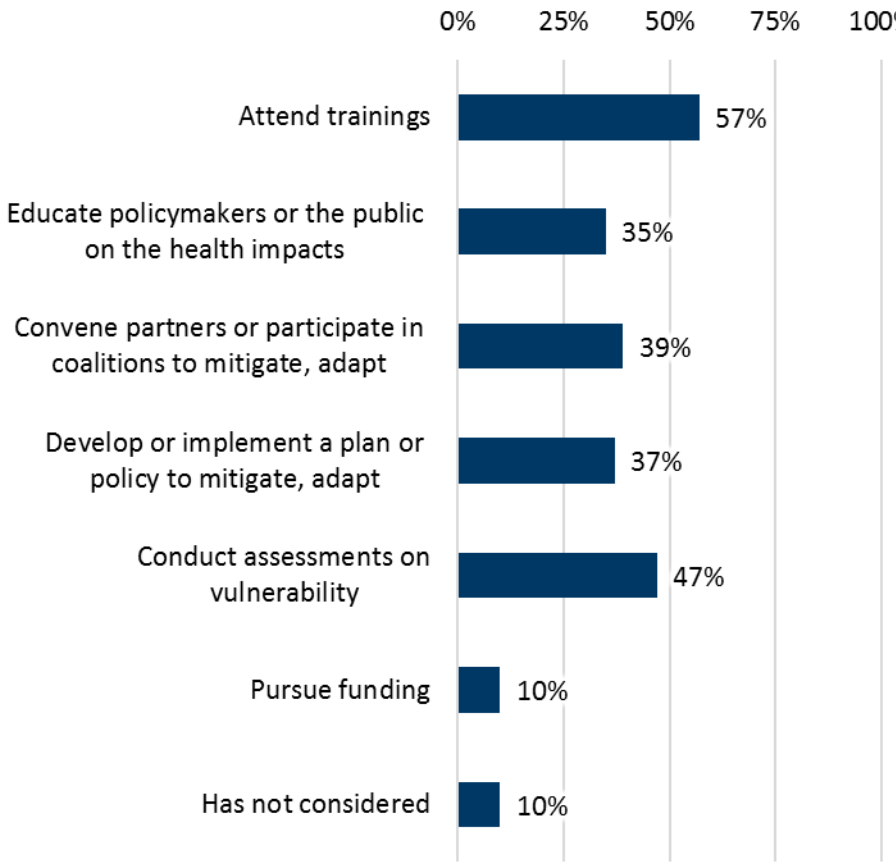
Protect against environmental health hazards

Extreme weather

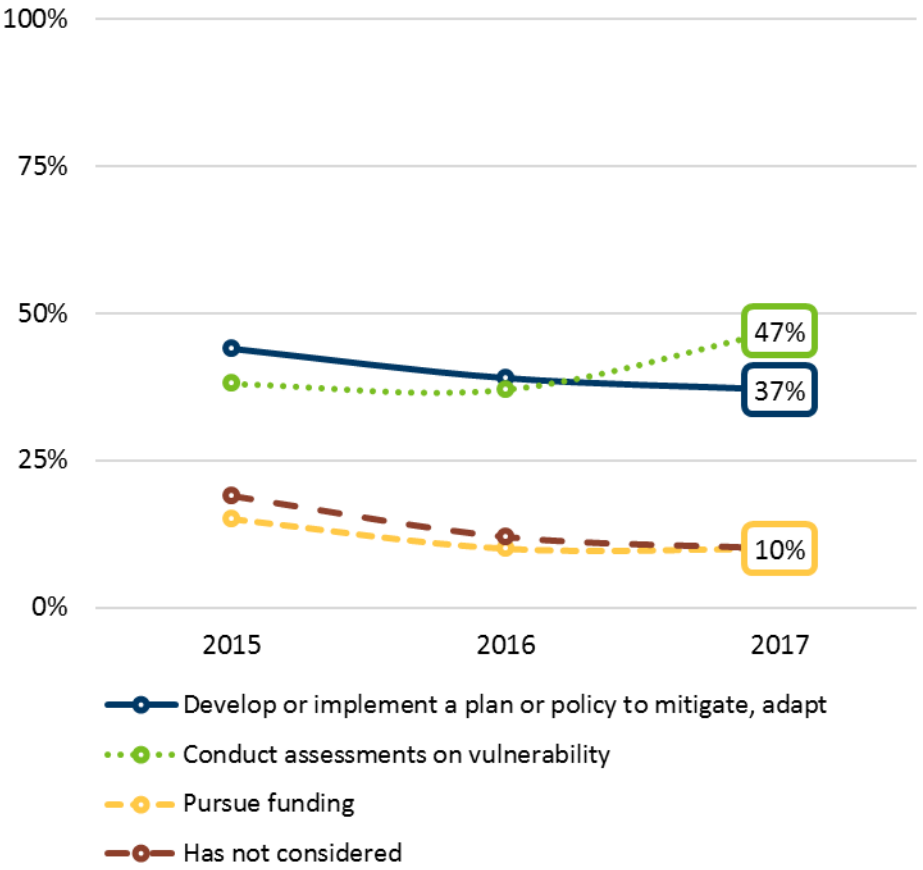
For a full list of performance measures and responses, refer to the data tables for this section.

Changes are occurring in Minnesota's climate with serious consequences for human health and well-being. Minnesota has become measurably warmer, particularly in the last few decades, and precipitation patterns have become more erratic, including heavier rainfall events. Climate projections for the state indicate that these trends are likely to continue well into the current century and according to some scenarios, may worsen.

Minnesota community health board consideration of extreme weather, 2017



Change in Minnesota community health board consideration of extreme weather, selected activities

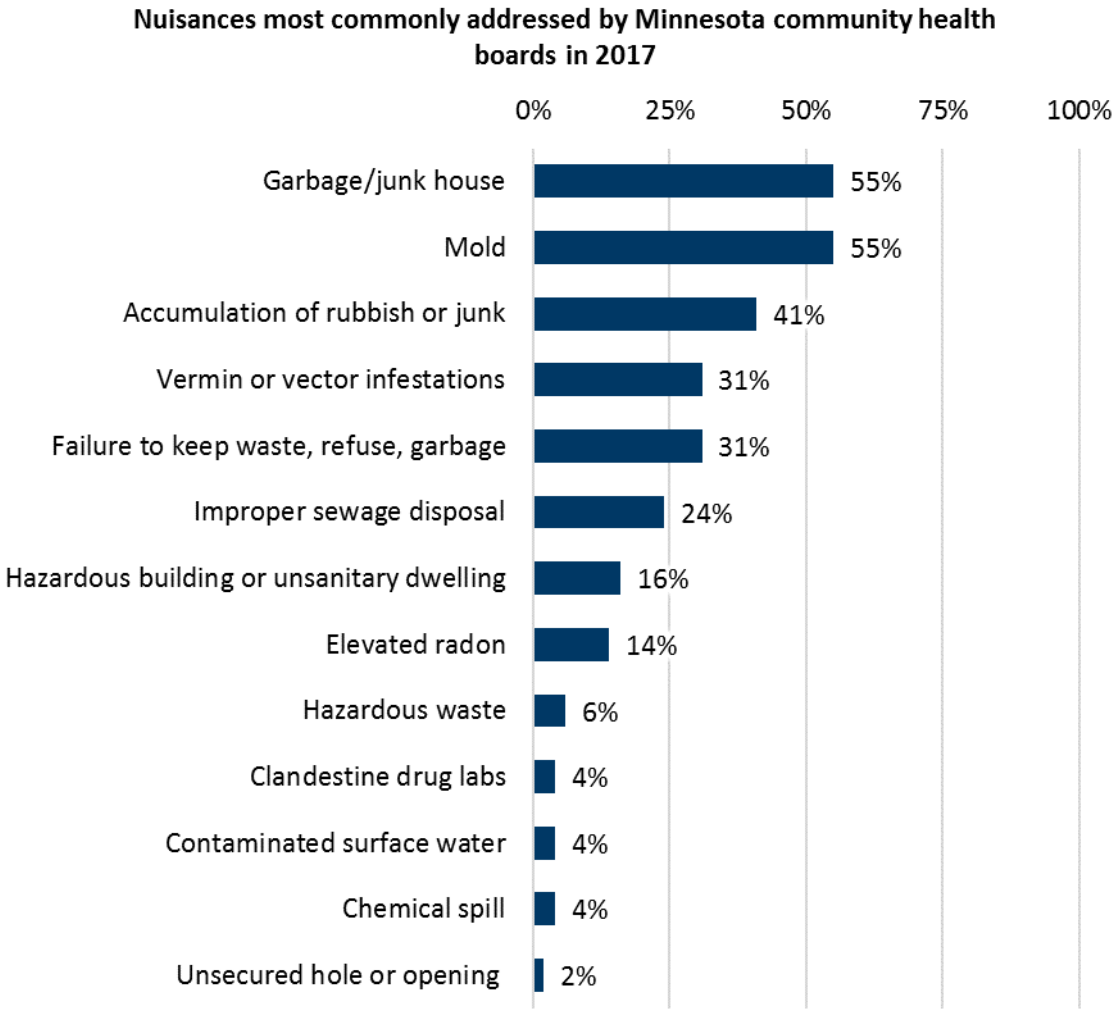


Protect against environmental health hazards

Nuisance investigations

For a full list of performance measures and responses, refer to the data tables for this section.

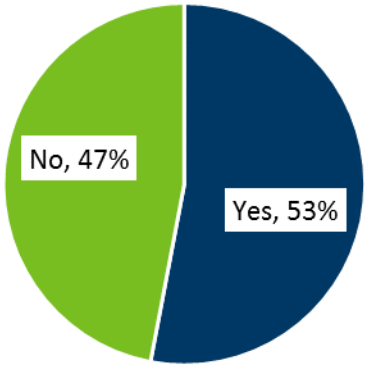
Maintaining a healthy environment, free of potential hazards, is critical to promoting the health of the population. The nuisance complaint process can be a vital part of this effort.



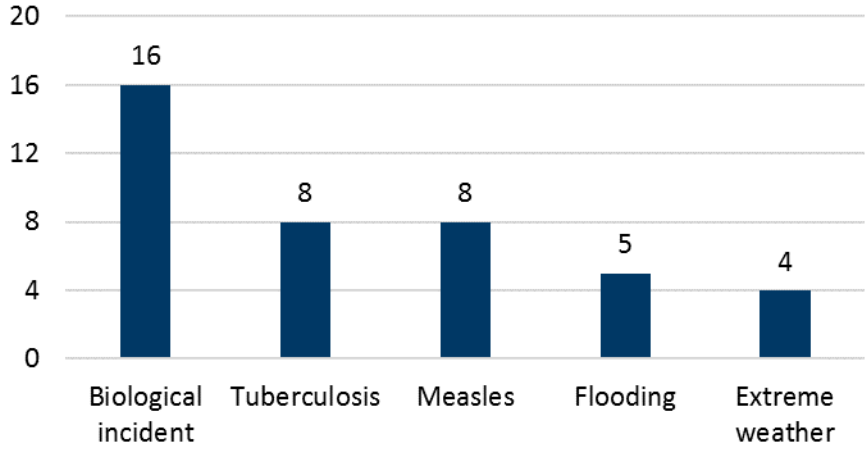
Prepare and respond to emergencies

For a full list of performance measures and responses, refer to the data tables for this section.

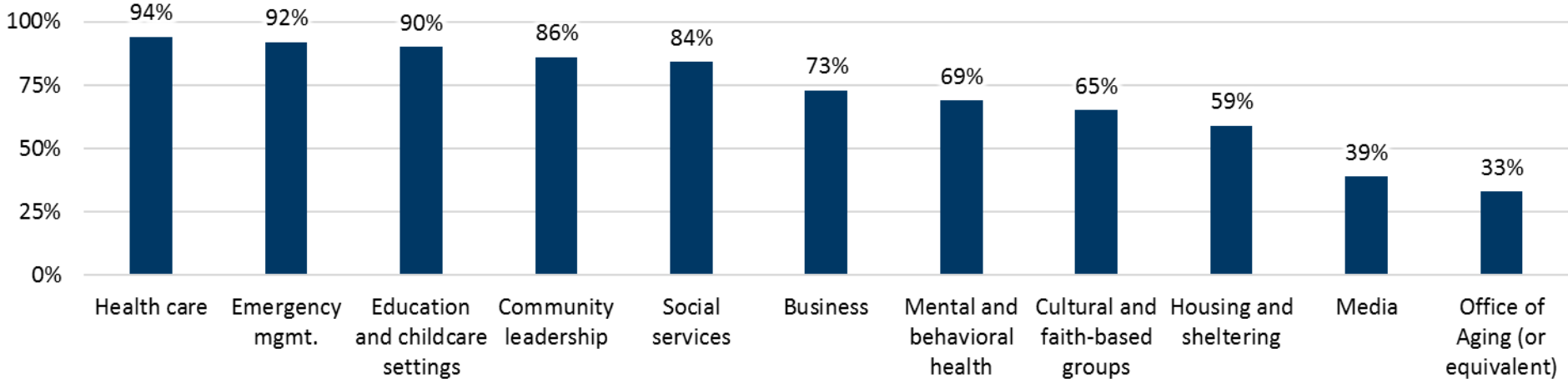
Minnesota community health boards that responded to an emergency in 2017



Most common emergencies to which Minnesota community health boards responded in 2017



Sectors engaged by Minnesota community health boards, 2017



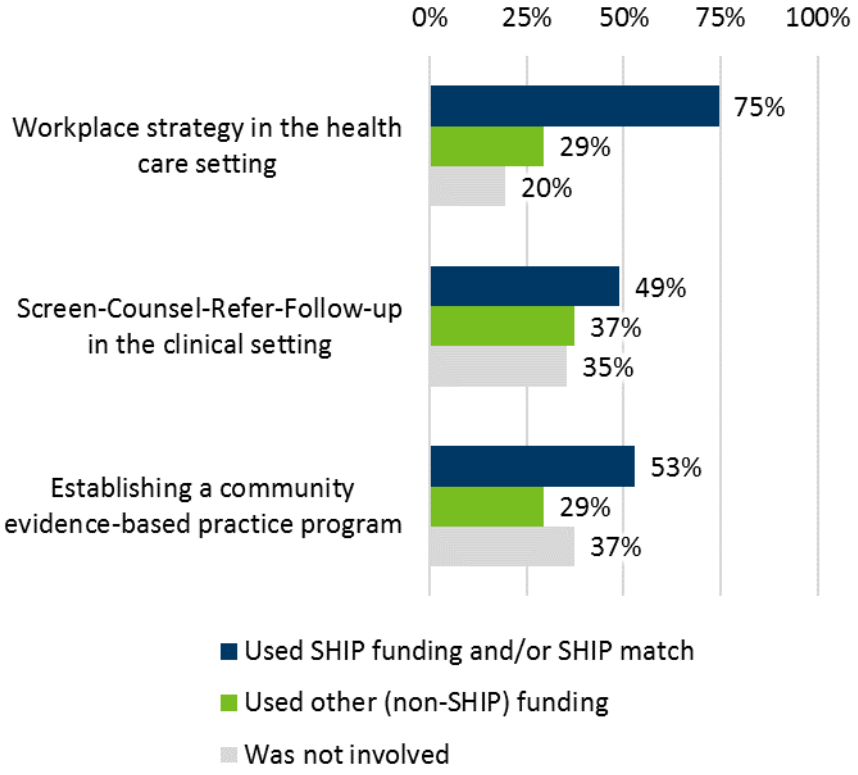
Assure health services

Clinical-community linkages

For a full list of performance measures and responses, refer to the data tables for this section.

There is growing local, state, and national awareness about the importance of clinical-community linkages to support health promotion and prevention activities, and facilitate smooth health care delivery. This question characterizes the role of public health in such activities.

Strategies used by Minnesota community health boards to promote clinical-community linkages for prevention, 2017



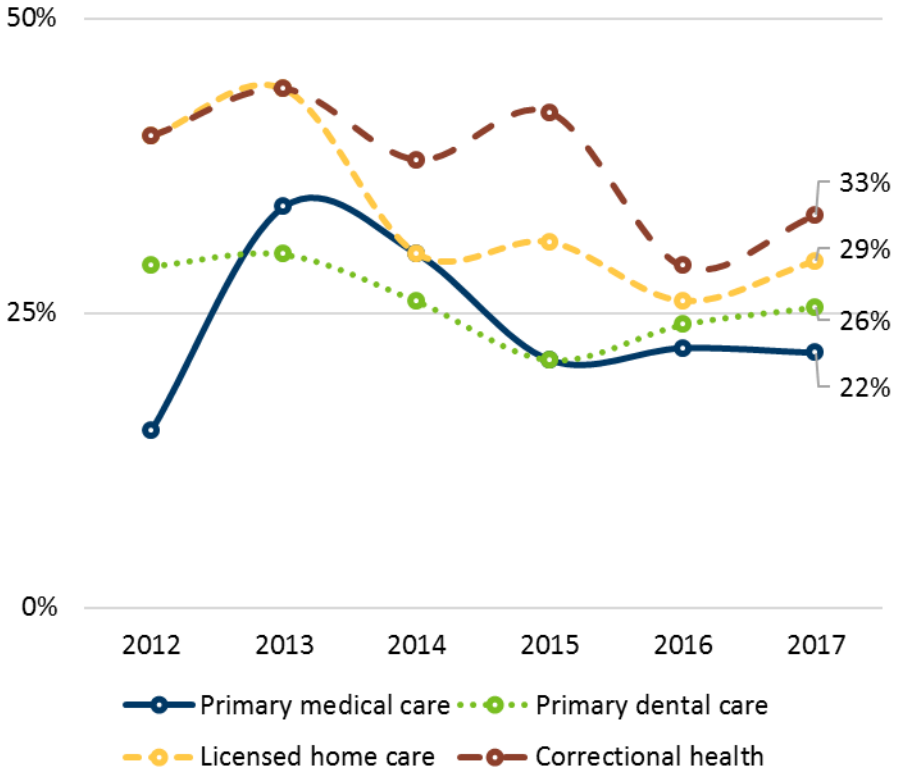
Assure health services

Provision of public health services

For a full list of performance measures and responses, refer to the data tables for this section.

MDH understands that home health and correctional health services are not provided in all community health boards. These services are included here to track, over time, how widely they are provided by community health boards.

Minnesota community health board provision of / contracting for public health services, 2017



Data tables and reporting instructions

Assure an adequate local public health infrastructure: Capacity measures from national standards

2017 instructions are based on PHAB Standards and Measures v. 1.5, but are not intended to serve as a substitute for PHAB guidance. If you would like to learn more about each measure and requirement, refer directly to Public Health Accreditation Board: Standards and Measures Version 1.5. PHAB language is prescriptive, and frequently uses "must;" to fully meet a measure; this language is used below.

Review the 37 key measures in this section, noting each requirement's time frame and examples. Note whether your community health board can fully, partially, or not meet each measure.

A multi-county community health board should report on the lowest level of capacity of its individual health departments (see right). That is, if two of three local health departments in a multi-county community health board can fully meet a measure, but the third can only partially meet, the entire community health board should report partially meet. If the third cannot meet the measure at all, the entire community health board should report cannot meet.

	Minnesota community health boards, 2017 (n=51)	% fully meet	% partially meet	% cannot meet
1.1.2.	Community health assessment	**80%**	20%	0%
1.2.2.	Communication with surveillance sites	**63%**	35%	2%
1.3.1.	Data analysis and conclusions	**75%**	25%	0%
1.4.2.	Community summaries, fact sheets	**76%**	24%	0%
2.1.4.	Collaborative partnerships for investigation	**82%**	16%	2%
2.2.3.	After Action Reports	**73%**	24%	4%
3.1.2.	Health promotion strategies	**82%**	16%	2%
3.1.3.	Factors for specific at-risk populations	**73%**	25%	2%
3.2.2.	Organizational branding strategies	**51%**	35%	14%
3.2.3.	External communications procedures	**59%**	35%	6%
3.2.5.	Variety of publicly available information	**75%**	24%	2%
5.1.3.	Policies' impact on public health	**82%**	16%	2%
5.2.3.	Collaborative CHIP implementation	**80%**	20%	0%
5.2.4.	Monitor and revise CHIP	**73%**	27%	0%
5.3.3.	An implemented strategic plan	**67%**	27%	6%
6.3.4.	Compliance patterns from enforcement	**59%**	37%	4%
7.1.1.	Assessing health care availability	**61%**	39%	0%
7.1.2.	Identifying populations facing barriers	**71%**	27%	2%

Minnesota community health boards, 2017 (n=51)		% fully meet	% partially meet	% cannot meet
7.1.3.	Identifying gaps and barriers to health care	**61%**	37%	2%
7.2.1.	Developing strategies to improve access	**73%**	25%	2%
7.2.2.	Implementing strategies to increase access	**80%**	18%	2%
7.2.3.	Cultural competence in increasing access	**71%**	29%	0%
8.2.1.	Workforce development strategies	**45%**	43%	12%
8.2.2.	Competent workforce	**69%**	31%	0%
9.1.1.	Engagement in performance management system	**53%**	41%	6%
9.1.2.	Performance management system/policy	**53%**	31%	16%
9.1.3.	Implemented performance management system	39%	**43**%	18%
9.1.4.	Process to assess customer satisfaction	**65%**	27%	8%
9.1.5.	Staff involvement in performance management	**57%**	33%	10%
9.2.1.	Established quality improvement program	**76%**	20%	4%
9.2.2.	Implemented quality improvement activities	**63%**	31%	6%
10.2.3.	Communicated research findings	**61%**	33%	6%
11.1.2.	Ethical issues and decisions	35%	**53%**	12%
11.1.4.	Policies appropriate to specific populations	41%	**57%**	2%
12.2.1.	Communication with governing entity regarding responsibilities	**88%**	12%	0%
12.3.1.	Information provided to governing entity	**96%**	4%	0%
12.3.3.	Communication with governing entity regarding performance	**78%**	22%	0%

Assure an adequate local public health infrastructure: Minnesota-specific measures

Workforce competency

Response options for Questions 1 and 2 are based on the eight domains for the Core Competencies for Public Health Professionals, with the addition of *Informatics*. Use these definitions to think about your workforce.

A multi-county community health board should answer based on services provided within one or more of its individual health departments.

1. Please select the top two strengths in the workforce of your community health board. (Select no more than two.)

Minnesota community health boards, 2017 (n=51)	%
Analysis/assessment	12%
Policy development/program planning	22%
Communication	29%
Cultural competency	24%
Community dimensions of practice	31%
Public health sciences	6%
Financial planning and management	24%
Leadership and systems thinking	**51%**
Informatics	2%

2. Please select the top two gaps in the workforce of your community health board. (Select no more than two.)

Minnesota community health boards, 2017 (n=51)	%
Analysis/assessment	18%
Policy development/program planning	20%
Communication	8%
Cultural competency	18%
Community dimensions of practice	16%
Public health sciences	**41%**
Financial planning and management	22%
Leadership and systems thinking	14%
Informatics	**45%**

3. How did your community health board assess the strengths and gaps of its workforce? (Check all that apply.)

Community health boards should indicate whether and how they may have used the Core Competencies for Public Health Professionals to assess the community health board's workforce.

Minnesota community health boards, 2017 (n=51)	%
The community health board used the Core Competencies for Public Health Professionals Tool on its own	4%
The community health board used the Core Competencies for Public Health Professionals Tool with assistance from MDH	**55%**
The community health board used an assessment tool instead of (or in addition to) the Core Competencies for Public Health Professionals Tool	4%
The community health board assembled a team knowledgeable of staff skills to conduct a workforce assessment	24%
The community health board compiled and analyzed individual assessments to develop an overall workforce assessment	2%
The community health board did not assess workforce strengths or gaps during this reporting cycle	27%

3a. To recommend another workforce assessment tool, please list it here.

- In addition to the Core Competencies for Public Health Professionals Tool our county used in 2017, our county also conducts an annual employee survey to gauge the needs and interests of staff.
- We did use Core Competencies and added a fourth tier to be more inclusive of additional staff within the organization.

3b. If an assessment was not performed in 2017, when was it last completed? (Select one.)

Answer if you selected "the community health board did not assess workforce strengths or gaps…" in Q3, above.

Minnesota community health boards, 2017 (n=14)	%
2016	7%
2015	21%
2014 or earlier	**71%**

4. When does your community health board next plan to assess its workforce? (Select one.)

Minnesota community health boards, 2017 (n=51)	%
2018	**43%**
2019	26%
2020 or later	16%
No plans to assess workforce at this time	16%

School health

A multi-county community health board should answer based on services provided within one or more of its individual health departments.

5. How does your community health board work with school health? (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	%
Employ school nurses	20%
Partnership activities	**98%**
Provide health services in the schools	47%
Conduct trainings for staff	69%
Conduct trainings for students	61%
Consultations	92%
Facilitate or coordinate joint meetings	75%
Provide public health updates/resources	96%
Information and referral	94%
Community crisis management (e.g., outbreaks)	73%
Wellness activities (e.g., SHIP)	**98%**
Environmental (e.g., mold, pesticides, lice)	61%
Community health board does not partner with school health	0%

Health equity

A multi-county community health board should answer based on services provided within one or more of its individual health departments.

Community health boards will use a three-point Likert scale to indicate their level of agreement with each statement. An "I don't know" option is provided for all questions in this set, for those without enough information to respond.

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

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

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

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

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

Social Determinants of Health: Conditions found in the physical, cultural, social, economic, and political environments that influence individual and population health. The inequities in the distribution of these conditions lead to differences in health

outcomes (that is, they lead to health disparities). Conditions include, but are not limited to: socioeconomic factors (e.g., racism, stress, education, income, employment, health literacy); environmental factors (e.g., housing and, environmental hazards); and systems and policies (e.g., health care access, access to healthy foods).

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

Minnesota community health boards, 2017 (n=51)	% very true	% somewhat true	% not true	% I don't know
6. My community health board has identified health equity as a priority, with specific intent to address social determinants of health.	**55%**	45%	0%	0%
7. My community health board has built capacity (e.g., human resources, funding, training staff) to achieve health equity by addressing social determinants of health.	29%	**63%**	8%	0%
8. My community health board has established a core contingency of staff who are poised to advance a health equity agenda.	33%	**53%**	12%	2%
9. My community health board has increased the amount of internal resources directed to addressing social determinants of health.	26%	**47%**	28%	0%
10. My community health board has engaged with local government agencies or other external organizations to support policies and programs to achieve health equity.	45%	**51%**	4%	0%
11. My community health board has made deliberate efforts to build the leadership capacity of community members to advocate on issues affecting social determinants of health.	29%	**51%**	20%	0%
12. My community health board has provided resources to community groups to support their self-identified concerns for achieving health equity in their communities.	39%	**43%**	18%	0%

13. Please describe one of your community health board's efforts to achieve health equity. Include the name of the policy or program, the health inequity that you identified and the data to support your findings, the communities or partners that you engaged, resources committed, and how you measured and reported on progress.

To view this measure's responses, contact the MDH Center for Public Health Practice.

Organizational quality improvement maturity

A multi-county community health board should answer based on services provided within one or more of its individual health departments.

Suggested Parameters: Use the descriptions below to indicate your level of agreement with each statement in Questions 14-16 and 18-23. An "I don't know" option is provided for all questions in this set, for those without enough information to respond.

Suggested parameters for Question 17 are found within Question 17.

Suggested Parameters for Questions 14-16 and Questions 18-23:

- **Strongly agree** suggests that the statement is **consistently true** within the community health board—whether the community health board includes one or many local health departments.
- **Agree** suggests the statement is **generally true** within the community health board. In a multi-county community health board, this may mean that the statement is consistently true in one local health department, but not generally evident in another.
- **Neutral** suggests that the statement is **neither true nor untrue**. Perhaps the statement is widely inconsistent across program areas of a single-county or city community health board, or across individual health departments of a multi-county community health board.
- **Disagree** suggests that the statement is **not generally evident** within the community health board.
- **Strongly disagree** suggests the statement is **not at all true or evident** within the community health board—whether the community health board includes one or more local health departments.

Minnesota community health boards, 2017 (n=51)	% strongly agree	% agree	% neutral	% disagree	% strongly disagree	% I don't know
14. Staff members are routinely asked to contribute to decisions at my community health board.	26%	**63%**	12%	0%	0%	0%
15. The *leaders* of my community health board are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.	31%	**47%**	14%	2%	2%	4%
16. Job descriptions for many individuals responsible for programs and services in my community health board include specific responsibilities related to measuring and improving quality.	18%	**45%**	20%	14%	2%	2%
17. My community health board has a quality improvement (QI) plan.[1]	**57%**	33%	4%	4%	2%	0%
18. Customer satisfaction information is routinely used by many individuals responsible for programs and services in my community health board.	18%	**51%**	28%	4%	0%	0%
19. When trying to facilitate change, community health board staff has the authority to work within and across program boundaries.	**47%**	45%	8%	0%	0%	0%
20. The key decision makers in my community health board believe QI is very important.	**55%**	39%	6%	0%	0%	0%

[1] Suggested parameters for Question 17:
Strongly agree suggests that the entire community health board is covered by a QI plan (via a single community health board QI plan, or the individual plans of separate health departments).
Agree suggests the entire community health board is covered by a QI plan (via a single community health board QI plan or the individual plans of separate health departments), but the plan(s) is/are not being implemented across the community health board.
Neutral suggests a QI plan is (or plans are) being developed.
Disagree suggests the entire community health board is not covered by a QI plan, although a planning team(s) is/are in development.
Strongly disagree suggests the entire community health board is not covered by a plan, and there is no progress to develop one.

Minnesota community health boards, 2017 (n=51)	% strongly agree	% agree	% neutral	% disagree	% strongly disagree	% I don't know
21. My community health board currently has a pervasive culture that focuses on continuous QI. "Pervasive" means present everywhere, spreading widely, or present throughout the community health board.	6%	**71%**	22%	2%	0%	0%
22. My community health board currently has aligned its commitment to quality with most of its efforts, policies, and plans.	16%	**57%**	28%	0%	0%	0%
23. My community health board currently has a high level of capacity to engage in QI efforts.	6%	**45%**	39%	8%	2%	0%

24. How did your community health board decide how to report on Questions 14-23, above? (Select one.)

Minnesota community health boards, 2017 (n=51)	%
One person (e.g., the CHS administrator, the public health director, etc.) filled out Q14-23, based on their knowledge of the agency, without using the QI maturity survey	16%
A core group of staff (e.g., leadership, QI council, other group of key staff) completed Q14-23 on behalf of staff, without using the QI maturity survey	**51%**
The agency administered the QI maturity survey to a core group of staff (e.g., leadership team, QI council, etc.), and used those results for answering Q14-23	4%
The agency administered the QI maturity survey to the entire staff, and used those results for answering Q14-23	20%
Other (please explain)	10%

Other (please explain):

- The agency administered the QI maturity survey to the entire staff in October of 2016, and used those results for answering Q14-23.
- Our agency, through its QI Council, utilizes the NACCHO Roadmap to a Culture of Quality Improvement to assess it progression through the six phases of an organizational QI Culture. A broad all staff survey is conducted biennially (most recently in 2016) which indicated our agency is at Phase Five: Formal Agency Wide QI. We are holding the gains at Phase Five and will repeat for our all-staff survey in 2018 as we strive to achieve Phase Six: QI Culture.
- Directors extrapolated data from 2016 when the QI maturity survey was administered to the entire staff.
- Questions answered by the three County PH Directors
- All agency public health directors submitted answer along with CHS administrator.

Health informatics

The purpose of several of the health informatics questions is to determine the types of strategies or services in place anywhere within the community health board (designated with instructions to "check all that apply"). On these questions, a multi-county community health board should check all responses that are true within the community health board. In some cases, one response may be true for multiple local health departments in the community health board. In other cases, a response may be true for only one health department in the community health board. As long as a response is true within the community health board, the community health board should check it when reporting.

The purpose of other health informatics questions is to characterize the overall status approach to services within the community health board. For questions like this, the CHS administrator should identify the best response(s) in consultation with directors and/or supervisors of individual local health departments within the community health board.

Community health boards should consider the following definitions when responding to health informatics questions with highlighted terms:

Health Informatics: The use of data to support comprehensible display of information, automated decision-making, and effective delivery of health and healthcare services.

Health Information Exchange (HIE): The electronic transmission of health-related information between organizations according to nationally recognized standards. Health information exchange does not include paper, mail, phone, fax, or standard/regular email exchange of information.

25. Which software application does your community health board use for the public health electronic health record (EHR) system? (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	%
PH-Doc	**55%**
CareFacts Information Systems	8%
CHAMP Software	39%
Digital Health Department	4%
Decade Software	2%
Custom-built local system (please specify)	10%
Other (please specify)	20%
No electronic health record system in place	0%

Custom-built local system (please specify):

- MAHF
- Our agency has a custom built software named Hummingbird and custom built software for billing as well.
- MAHF
- MAHF
- Custom built hybrid system - transitioning to NexGen

Other (please specify):

- Securus (Uniek) Health EMR
- SAGE, MEDFS, HUBERT, MIIC
- SAGE, MEDFS, HUBERT, MIIC
- CCM-Managed Care documentation system and we also have an electronic document management system (on base) for some of our agency's functions.
- Epic (as an affiliate of our county hospital); additionally, we use Digital Health Department for the Environmental Health program.
- CCM (through South Country Health Alliance)
- NextGen
- SAGE, MEDFS, HUBERT, MIIC
- CATCH, Neo, ReTrac, Minnesota WIC HuBERT system
- Next Gen for Jail Medical; also transitioning to PHDoc for Public health EHR in 2018

26. In the past year, with which of the following partners did you need to share client/patient health information (using any method or format, either electronic or manual)? (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	%
Primary care clinics, including mobile clinics	96%
Hospitals	92%
Behavioral health providers	77%
Dental providers	55%
Home health agencies	73%
Long-term care facilities	63%
Jails, detention, or correctional facilities	55%
Social services and supports (e.g., housing, transportation, food, legal aid)	94%
Other providers in our ACO	16%
Counties or departments within our community health board	75%
Counties or local agencies outside of our community health board	90%
Health or county-based purchasing plans	77%
Minnesota Department of Health	**100%**
Minnesota Department of Human Services	86%
Other state agencies	28%
Federal agencies	26%
Other (please specify)	16%
None of the above	0%

Other (please specify):

- Pharmacies
- School Districts, ICFs
- Data for grants
- Southern Prairie Community Care
- North Dakota Department of Health (example TB contact investigation of a mutual client) and Nurse Family Partnership- NSO
- Victim Agencies, schools
- Minnesota WIC programs, PHNs share information with other client providers within the HIPPA requirements.
- Healthy Families America

27. In the past year, with which of the following partners did you electronically transmit (send or receive) patient/client health information, assuming appropriate consents were obtained? (Check all that apply.)

"Electronic" exchange does not include phone, fax, non-secure email, or view/download access from another organization's EHR.

Minnesota community health boards, 2017 (n=51)	%
Primary care clinics, including mobile clinics	59%
Hospitals	65%
Behavioral health providers	35%
Dental providers	14%
Home health agencies	31%
Long-term care facilities	31%
Jails, detention, or correctional facilities	14%
Social services and supports (e.g., housing, transportation, food, legal aid)	47%
Other providers in our ACO	8%
Counties or departments within our community health board	45%
Counties or local agencies outside of our community health board	49%
Health or county-based purchasing plans	53%
Minnesota Department of Health	**78%**
Minnesota Department of Human Services	53%
Other state agencies	14%
Federal agencies	14%
Other (please specify)	20%
Our community health board did not electronically send or receive health information	8%

Other (please specify):

- Pharmacy Orders, Labs and X-Rays
- Southern Prairie
- Pharmacies
- School Districts, ICF
- SPCLink
- Pharmacies for prescriptions
- Southern Prairie Community Care - tests to system.
- ACO
- other Minnesota WIC programs
- Healthy Families America

28. For each of the following e-health/informatics skills, indicate your level of confidence that your community health board has the capacity (skills, expertise, resources) to meet your needs.

Minnesota community health boards, 2017 (n=51)	% very confident	% confident	% somewhat confident	% not confident	% I don't know
Planning for EHR adoption and/or implementation	33%	**39%**	22%	4%	2%
Negotiating EHR and HIE vendor agreements	24%	**31%**	24%	18%	4%
Exchanging information with MDH	33%	**49%**	16%	2%	0%
Translating public health needs to IT staff	22%	**51%**	18%	10%	0%
Managing workflow changes	4%	**59%**	35%	2%	0%
Understanding and/or using nationally recognized e-health standards	6%	29%	**37%**	22%	6%
Understanding federal and state laws relating to e-health, health information exchange, and consent	6%	**43%**	39%	12%	0%
Implement consent and authorization procedures for release of health information	35%	**41%**	20%	2%	2%
Risk management for security breaches	14%	**41%**	26%	16%	4%
Establishing privacy and security policies and procedures	22%	**43%**	24%	8%	4%
Establishing agreements with exchange partners	8%	26%	**43%**	18%	6%
Developing infrastructure to support information exchange	8%	**39%**	26%	24%	4%
Integrating patient/client data from external sources into our EHR	10%	**33%**	29%	26%	2%
Developing data analytics and/or informatics skills	2%	33%	**41%**	20%	4%
Using data in the EHR to support community health assessments	2%	35%	**43%**	16%	4%
Policies and procedures for managing data quality	0%	35%	**37%**	22%	6%
Conveying the importance of informatics to the community health board (e.g., talking points, communications templates)	6%	**41%**	39%	14%	0%
Developing position descriptions that include informatics and e-health activities and responsibilities	4%	**33%**	31%	29%	2%

Other (please specify):

- **Confident**: Funding and staff are not available to be dedicated to move towards accreditation. Limited resources with the current level of funding. Staff time is already fully exhausted.
- **Confident**: Assessing informatics maturity.
- **Confident**: Our data group has been very involved in data discussions with CHIP and with the Center for Community Health. These are cross sector discussions of ways to share data across systems and have been very productive.
- **Confident**: The department has the capacity to meet current and future needs.
- **Confident**: Already using electronic record system developed by Minnesota WIC
- **Somewhat confident**: Attempts have been made to provide a software package that would allow the sharing of information with other local partners, however this never materialized dur to difficulty obtaining permission from clients and other factors.
- **I don't know**: Limited capacity to develop a systematic approach to using data and information. Potential project with Steans county to do a self assessment and development of a workplan in the spring of 2018.
- **I don't know**: We feel we lack capacity to even work toward compliance with EHR.

Voluntary public health accreditation

A multi-county community health board should answer based on services provided within one or more of its individual health departments, unless otherwise indicated in the question.

Question 30 is optional.

29. Which of the following best describes your community health board with respect to participation in the Public Health Accreditation Board accreditation program? (Select one.)

Minnesota community health boards, 2017 (n=51)	%
My community health board has achieved accreditation	20%
My community health board is in the process of accreditation (e.g., has submitted a statement of intent)	2%
My community health board is planning to apply (but is not in the process of accreditation)	12%
My community health board is undecided about whether to apply for accreditation	31%
My community health board has decided not to apply at this time	**35%**
Individual jurisdictions within my community health board are participating in accreditation differently	0%

29a. If your community health board is planning to apply but is not in the process of accreditation, in what calendar year is your community health board planning to apply for accreditation? (Select one.)

Answer if you selected "planning to apply" in Q29, above.

Minnesota community health boards, 2017 (n=6)	%
2018	33%
2019	17%
2020 or later	**50%**

29b. If your community health board is undecided or has decided not to apply for accreditation at this time, why? (Rank primary and secondary reasons.)

Answer if you selected "undecided about whether to apply" or "decided not to apply at this time" in Q29, above. Rank primary reason as "1" and secondary reason as "2."

Minnesota community health boards, 2017 (n=34)	% primary reason	% secondary reason
Accreditation standards are not appropriate for my community health board	6%	3%
Fees for accreditation are too high	9%	21%
Accreditation standards exceed the capacity of my community health board	**41%**	**35%**
Time and effort for accreditation application exceed the benefits of accreditation	29%	29%
No support from governing body for accreditation	6%	6%
Interest/capacity varies within the jurisdictions of my community health board	9%	6%

29c. If individual jurisdictions within your community health board are participating in accreditation differently, please briefly explain.

Answer if you selected "individual jurisdictions are participating in accreditation differently" in Q29, above.

[n/a]

30. What else would you like to share about your community health board and accreditation?

Optional.

- Instructions for HS/PH have been to do the 'minimum', any additional costs for system changes cannot be funded as they are focused on lowering the tax levy.
- Some counties in our CHB have greater capacity to pursue accreditation. Others have low capacity.
- Our CHB is finishing an inventory of the status of the domains and standards in order to better understand the burden of work accreditation might entail. We intend on deciding whether or not to apply for accreditation within the calendar year.
- We do not have the capacity nor support to work to accreditation.
- Our agency has been fairly stable with staffing the past year and the team is reviewing all plans (strategic, QI, CHIP) in order to evaluate and compare with PHAB standards. We plan to continue to align and prepare for application in 2019. In 2017 we hired a planner but the position turned over quickly thus setting us back slightly.
- I attended a national training and was told accreditation is being studied for smaller CHB's. My local governing board and leadership team is awaiting the information regarding smaller CHB's under 50,000 population.
- We have completed our first annual report to PHAB and are currently reviewing reaccreditation standards.
- Small CHB with staff and capacity limitations- not something we can work towards without financial and consultant assistance.
- We are small agencies that do not have capacity to obtain accreditation.
- Response to Completeness Review 01-17-2017 Response to Pre-Site Visit Questions & Requests 06-16-2017 Site Visit 07-18-2017-07-19-2017 Accreditation Decision, Action Plan Required 11-20-2017 We used our PHAB Site Visit Report to complete Infrastructure: Capacity Measures from National Standards.
- Our community health board was the first health department in Minnesota to become accredited. We are currently preparing for reaccreditation (2019).
- An Accreditation Coordinator and an Accreditation Team have been appointed. Domain teams were also identified in 2017 and most, if not all, of them convened at least one meeting in 2017.
- We continue to strive for national measures -- 'Accreditation Like'. The Community Health Board advised us to run a slower marathon and not a speed race
- We feel we meet the PHAB standards, however we do not have the capacity to document and apply.
- As rural multi-county CHB, a significant portion of the accreditation efforts relied on the relationship and communication with MDH. In particular Domain 6 was especially difficult to demonstrate because our community health board does not have a delegated environmental health program.
- We are looking forward to having accreditation tied to increase grant funding.
- Accreditation standards are used for guidance for our current public health work
- Currently, our CHB is not in a good position to consider applying for accreditation. Once we are fully staffed and staff are fully trained we would like to revisit the opportunity.
- At this time the LPH departments in our CHB do not have the resources (money for staff) to work on this. We are staffed tightly as we do not receive much assistance from our counties. LPH directors in this CHB all provide direct services in addition to administration.
- The community health board was informed and involved in the preparation process for accreditation and during the accreditation site visit which strengthened knowledge, commitment and practice around population health.
- -Holding for the PHAB 'Smaller Health Department' Criteria -MDH/LPH - MDH documentation of FPLS/Regional and State Epis/Infectious Disease Lab Roles and Responsibilities, Authority, Communication, etc necessary for PHAB documentation of services
- This would be a definite staffing challenge for our agency. I would need to assign I believe a full time equivalency to this work.
- The fees of becoming accredited far exceed the capacity of my jurisdiction. It is beyond what we would need to pay to the PHAB Board. We would need one-two full time staff to work on this for one-two years as well as continuing

requirements once accredited. The estimated true cost is closer to $250,000. If this is the gold standard, and what MDH wants all jurisdictions to do, then we will need additional funding.

- Our community health board achieved PHAB accreditation status in August 2016.
- Our counties are working on cross-jurisdictional public health work. Part of that process includes discussion of applying jointly for accreditation. Additionally, one county's LPH staff are all participating in Domain Workgroups for accreditation work.
- Our small health department lacks the capacity and resources to pursue accreditation.
- The CHB has been accredited for two years and is in the process of conducting a capacity self-assessment against the reaccreditation standards and measures as we prepare for 2021 reaccreditation.
- As a small, single county CHB this doesn't seem possible at this point.
- Staff may revisit the topic of accreditation with the community health board once the new supervisor has had time to review accredidation requierments.
- As a new director I am still assessing if it is appropriate for us to move forward with accreditation. In addition as a combined health and human services agency accreditation has to be seen as important not only to the CHS Administrator but also the Human Services Director.
- This seems to be a moving target for our CHB based on infrastructure and resources available locally. At some points because of staffing levels, knowledge, skills, etc. we feel ready to seriously assess accreditation but all it takes is one person or skill set to move or leave and we start over.
- Funding and staff are not available to be dedicated to move towards accreditation. Limited resources with the current level of funding. Staff time is already fully exhausted.
- Our county is in the process of building it's community health board and we are working toward HFA Accreditation and after this is complete then we would look at PHAB Accreditation, but this could be out 5-6 years.

Statutory requirements

You can find the full text of the Minnesota Local Public Health Act (Minn. Stat. § 145A) online. Specific sections of the Local Public Health Act referenced in the questions below are:

- Minn. Stat. § 145A.03 – Establishment and Organization
- Minn. Stat. § 145A.04 – Powers and Duties of Community Health Board
- Minn. Rule 4736.0110 – Personnel Standards

31. The composition of the community health board meets the requirements called for by Minn. Stat. § 145A.03.

Minnesota community health boards, 2017 (n=51)	%
Yes	**100%**
No	0%

32. How many times did the community health board meet during the reporting period?

2	4	4	8	12	12	16	22
2	4	5	9	12	12	18	23
2	4	6	10	12	12	20	24
2	4	6	10	12	12	20	48
3	4	6	11	12	13	20	50
3	4	7	11	12	13	21	50
3		8		12			

33. The community health board has written procedures in place for transacting business, and has kept a public record of its transactions, findings, and determinations, as required by Minn. Stat. § 145A.03, subd. 5.

Minnesota community health boards, 2017 (n=51)	%
Yes	**100%**
No	0%

34. The community health board has a CHS administrator who meets the requirements of Minn. Rule 4736.0110.

Minnesota community health boards, 2017 (n=51)	%
Yes	**100%**
No	0%

35. The community health board has a medical consultant in accordance with Minn. Stat. § 145A.04, subd. 2a.

Minnesota community health boards, 2017 (n=51)	%
Yes	**100%**
No	0%

36. The CHS administrator reviewed and assured the accuracy of all reporting related to the Local Public Health Act, Title V, and TANF, prior to submission.

Minnesota community health boards, 2017 (n=51)	%
Yes	**100%**
No	0%

Local public health act grant activities

Community health boards must highlight at least one example of how Local Public Health Act Grant funds were used in the past year in Question 37; Questions 38 and 39 are optional if your community health board would like to highlight more than one program/activity.

Consider the following questions:

- **Describe the activity**. What did you do? What happened as a result?
- **Explain the importance and rationale**. How did you identify this need?
- **How did this benefit your community? Your organization?** What additional resources (if any) did you leverage with these Local Public Health Act funds? Could you have accomplished the work without the funding? What would have happened if you had not had Local Public Health Act funding for this example?

A multi-county community health board should answer based on services provided within one or more of its individual health departments, unless otherwise indicated in the question.

37. Please highlight an activity from the past year supported by Local Public Health Act funding. Describe the activity, explain the importance and rationale, explain the organizational benefit, and explain the community benefit.

To view this measure's responses, contact the MDH Center for Public Health Practice.

37a. In what public health area of responsibility did this activity fall? (Check all that apply.)

To view this measure's responses, contact the MDH Center for Public Health Practice.

38. Please highlight an activity from the past year supported by Local Public Health Act funding. Describe the activity, explain the importance and rationale, explain the organizational benefit, and explain the community benefit.

Optional.

To view this measure's responses, contact the MDH Center for Public Health Practice.

38a. In what public health area of responsibility did this activity fall? (Check all that apply.)

Optional.

To view this measure's responses, contact the MDH Center for Public Health Practice.

39. Please highlight an activity from the past year supported by Local Public Health Act funding. Describe the activity, explain the importance and rationale, explain the organizational benefit, and explain the community benefit.

Optional.

To view this measure's responses, contact the MDH Center for Public Health Practice.

39a. In what public health area of responsibility did this activity fall? (Check all that apply.)

Optional.

To view this measure's responses, contact the MDH Center for Public Health Practice.

Promote healthy communities and healthy behavior

Active living

These measures align with the SHIP strategies and sub-strategies.

In the following questions, community health boards should report on all strategies in which the community health board was involved during the reporting period, not just those implemented with SHIP funding. Because the Local Public Health Act performance measures are not specific to any single funding source, whereas SHIP grantee reporting is focused on work performed with SHIP funding, the information gathered from these questions will complement and extend SHIP reporting to provide a broader understanding of all strategies and funding directed toward physical activity, nutrition, and tobacco. It will also enable comparisons with strategies and funding directed toward alcohol use. MDH will analyze data gathered here in close collaboration with the SHIP evaluation team.

Active Living activities can happen in a number of settings; evidence-based activities for each setting are:

Community

- Working on engagement or assessment
- Master and Comprehensive Plans; e.g. pedestrian and bicycle master plans, regional trails plan, Safe Routes to School
- Land use and zoning regulations; includes streetscape and mixed use, preferred emphasis on walking
- Increased access to facilities and opportunities (health equity focus, can include Safe Routes to School)

Child Care

- Working on engagement or assessment
- Breastfeeding support
- Healthy eating (infant feeding practices, including introduction of solid foods [non-breastfeeding practices], menu changes and improved feeding practices for children older than infants, local food procurement)
- Physical activity (increased opportunities for structured and unstructured physical activity, both indoors and outdoors, improved caregiver and environmental supports for physical activity, both indoors and outdoors, limiting screen time)

Schools

- Working on engagement or assessment
- Quality physical education (curriculum review, new physical education content, lengthening classes)
- Active recess
- Active classrooms
- Before and/or after school through physical activity opportunities (intramurals, physical activity clubs, integration with school child care, offering open gym opportunities)
- Safe Routes to School (walking school bus, Walk!Bike!Fun! curriculum, travel plans); layer opportunity in community setting

Workplace

- Access to opportunities and facilities
- Flexible scheduling
- Active commuting

1. Indicate the settings where your community health board implemented evidence-based strategies to promote active living, and whether your community health board used SHIP and/or non-SHIP funding. (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	% in setting: Community	% in setting: Child care	% in setting: School	% in setting: Workplace
Used SHIP funding and/or SHIP match for strategy	**94%**	39%	**100%**	**98%**
Used other (non-SHIP) funding for strategy	49**%**	22%	25%	35%
Was not involved in strategy	6**%**	**55%**	0%	0%

1a. Identify the activities carried out by your community health board in the last year to implement evidence-based strategies to promote active living in each setting. (Check all that apply.)

Answer for the strategies for which you selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q1, above.

Minnesota community health boards, 2017	% in setting: Community (n=47)	% in setting: Child care (n=22)	% in setting: School (n=51)	% in setting: Workplace (n=50)
Attended trainings	89%	77%	88%	88%
Conducted assessments	85%	77%	92%	94%
Convened partners or participated in coalitions	**100%**	86%	**100%**	**98%**
Involved with community outreach and education	98%	**96%**	90%	84%
Educated policymakers	83%	55%	78%	60%
Developed proposal or policy	66%	46%	75%	72%
Implemented policy (this year)	36%	41%	69%	60%
Maintained policy (which was previously implemented)	38%	41%	67%	56%
Evaluated policy impact	19%	36%	35%	28%

1b. Estimate the top three funding sources that supported your strategies to promote active living.

Answer for the strategies for which you selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q1, above. Rank "1," "2," and "3."

Minnesota community health boards, 2017 (n=51)	% largest source	% second-largest source[2]	% third-largest source[3]
Local tax levy	4%	31%	35%
State general fund (Local Public Health Act)	2%	35%	24%
SHIP	**88%**	10%	2%
Other state funds (from MDH or from other state agencies)	2%	2%	8%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	4%	10%	6%
Title V Block Grant	0%	0%	2%
Foundation funds	0%	6%	2%
Fees/reimbursement	0%	2%	6%

1c. Does the local tax levy investment of your community health board exceed the required state match?

Answer if you selected "local tax levy" as one of your top three funding sources in Q1b, above.

Minnesota community health boards, 2017 (n=36)	%
Yes	**81%**
No	19%

Healthy eating

These measures align with the SHIP strategies and sub-strategies.

In the following questions, community health boards should report on all strategies in which the community health board was involved during the reporting period, not just those implemented with SHIP funding. Because the Local Public Health Act performance measures are not specific to any single funding source, whereas SHIP grantee reporting is focused on work performed with SHIP funding, the information gathered from these questions will complement and extend SHIP reporting to provide a broader understanding of all strategies and funding directed toward physical activity, nutrition, and tobacco. It will also enable comparisons with strategies and funding directed toward alcohol use. MDH will analyze data gathered here in close collaboration with the SHIP evaluation team.

Healthy Eating activities can happen in a number of settings; the evidence-based activities are:

[2] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.
[3] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.

Community

- Working on engagement or assessment
- Farmers markets
- Community-based agriculture
- Emergency food systems/programs
- Food retail: Corner stores
- Food retail: Other (includes mobile markets, catering, vending, catering, restaurants/cafeterias, and grocers)
- Increase healthy food infrastructure through support of local or regional food policy councils, which could include access for growers to reach underserved consumer markets and increase overall demand for healthy food
- Comprehensive plans

Child Care

- Working on engagement or assessment
- Breastfeeding support
- Healthy eating (infant feeding practices, including introduction of solid foods [non-breastfeeding practices], menu changes and improved feeding practices for children older than infants, local food procurement
- Physical activity (increased opportunities for structure and unstructured physical activity, both indoors and outdoors, improved caregiver and environmental supports for physical activity, both indoors and outdoors, limiting screen time)

School

- Working on engagement or assessment
- Farm to school
- School-based agriculture
- Healthy snacks outside of the school day through vending, concessions, school stores, or snack carts
- Healthy snacks during the school day through celebration, special events, or non-food rewards
- Smarter lunchroom techniques through such behavioral economic activities including, but not limited to, competitive pricing, product enhancements

Workplace

- Comprehensive healthy eating planning
- Vending or healthy snack stations
- Cafeteria offerings
- Catering

2. Indicate the settings where your community health board took action to promote healthy eating, and whether your community health board used SHIP and/or non-SHIP funding. (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	% in setting: Community	% in setting: Child care	% in setting: School	% in setting: Workplace
Used SHIP funding and/or SHIP match for strategy	**98%**	39%	**100%**	**94%**
Used other (non-SHIP) funding for strategy	45%	20**%**	31%	37%
Was not involved in strategy	2%	**57%**	0%	4%

2a. Identify the activities carried out by your community health board in the past year to implement evidence-based strategies to promote healthy eating in each setting. (Check all that apply.)

Answer for the strategies for which you selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q2, above.

Minnesota community health boards, 2017	% in setting: Community (n=50)	% in setting: Child care (n=21)	% in setting: School (n=51)	% in setting: Workplace (n=49)
Attended trainings	92%	91%	96%	92%
Conducted assessments	80%	67%	92%	**96%**
Convened partners or participated in coalitions	**96%**	91%	**100%**	**96%**
Involved with community outreach and education	**96%**	**100%**	92%	84%
Educated policymakers	78%	62%	76%	65%
Developed proposal or policy	52%	52%	80%	65%
Implemented policy (this year)	40%	38%	71%	53%
Maintained policy (which was previously implemented)	34%	33%	57%	43%
Evaluated policy impact	26%	24%	31%	24%

2b. Estimate the top three funding sources that supported your strategies to promote healthy eating.

Answer for the strategies for which you selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q2, above. Rank "1," "2," and "3."

Minnesota community health boards, 2017 (n=51)	% largest source	% second-largest source[4]	% third-largest source[5]
Local tax levy	2%	31%	37%
State general fund (Local Public Health Act)	4%	35%	24%
SHIP	**88%**	12%	0%
Other state funds (from MDH or from other state agencies)	0%	0%	10%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	4%	10%	4%
Title V Block Grant	0%	0%	4%
Foundation funds	2%	4%	2%
Fees/reimbursement	0%	2%	4%

[4] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.
[5] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.

2c. Does the local tax levy investment of your community health board exceed the required state match?

Answer if you selected "local tax levy" as one of your top three funding sources in Q2b, above.

Minnesota community health boards, 2017 (n=36)	%
Yes	**81%**
No	19%

Tobacco-free living

These measures align with the SHIP strategies and sub-strategies.

In the following questions, community health boards should report on all strategies in which the community health board was involved during the reporting period, not just those implemented with SHIP funding. Because the Local Public Health Act performance measures are not specific to any single funding source, whereas SHIP grantee reporting is focused on work performed with SHIP funding, the information gathered from these questions will complement and extend SHIP reporting to provide a broader understanding of all strategies and funding directed toward physical activity, nutrition, and tobacco. It will also enable comparisons with strategies and funding directed toward alcohol use. MDH will analyze data gathered here in close collaboration with the SHIP evaluation team.

Tobacco-Free Living activities can happen in a number of settings; the evidence-based activities are:

Community

- Working on engagement or assessment
- Smoke-free housing
- Point of sale

Workplace

- Tobacco-free environments
- Cessation support

3. Indicate the settings where your community health board implemented strategies to promote tobacco-free living, and whether your community health board used SHIP and/or non-SHIP funding. (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	% in setting: Community	% in setting: Workplace
Used SHIP funding and/or SHIP match for strategy	**94%**	**80%**
Used other (non-SHIP) funding for strategy	39%	20**%**
Was not involved in strategy	4%	18**%**

3a. Identify the activities carried out by your community health board in the past year to promote tobacco free living. (Check all that apply.)

Answer for the strategies for which you selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q3, above.

Minnesota community health boards, 2017	% in setting: Community (n=49)	% in setting: Workplace (n=42)
Attended trainings	92%	**88%**
Conducted assessments	76%	79**%**
Convened partners or participated in coalitions	94%	**88%**
Involved with community outreach and education	**96%**	86**%**
Educated policymakers	90%	67**%**
Developed proposal or policy	71%	52**%**
Implemented policy (this year)	47%	36**%**
Maintained policy (which was previously implemented)	51%	45**%**
Evaluated policy impact	22%	14**%**

3b. Estimate the top three funding sources that supported your strategies to promote tobacco-free living.

Answer for the strategies for which you selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q3, above. Rank "1," "2," and "3."

Minnesota community health boards, 2017 (n=50)	% largest source	% second-largest source[6]	% third-largest source[7]
Local tax levy	2%	36%	34%
State general fund (Local Public Health Act)	2%	28%	32%
SHIP	**84%**	12%	2%
Other state funds (from MDH or from other state agencies)	0%	4%	8%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	6%	4%	2%
Title V Block Grant	0%	4%	0%
Foundation funds	4%	2%	0%
Fees/reimbursement	2%	2%	4%

[6] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.
[7] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.

3c. Does the local tax levy investment of your community health board exceed the required state match?

Answer if you selected "local tax levy" as one of your top three funding sources in Q3b, above.

Minnesota community health boards, 2017 (n=36)	%
Yes	**89%**
No	11%

Alcohol

In the following questions, community health boards should report on their alcohol-related funding sources, strategies, and activities.

4. Indicate the strategies used by your community health board in the past year related to alcohol use. (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	%
Policy advocacy (strengthening local ordinances)	26%
Policies to reduce drink specials in bars and restaurants	6%
Alcohol compliance checks	37%
Beverage server training	41%
Alcohol outlet density in the community	2%
Social host ordinances	35%
Alcohol use at community festivals and county fairs	24%
Drinking and driving	43%
Health education messages	**65%**
Working on barriers faced by underserved populations to reduce disparities in alcohol use	14%
Screening, counseling, and/or referral in health care settings	22%
Other (please explain)	9%
None of the above	24%

Other (please explain):

- Assessment of community chemical use among adolescents and young adults in local city.
- Youth Groups regarding ATOD
- Key partner with our county based Chemical Health Coalition
- Screening, counseling and referral in home visits
- Working on health education messages with a school and their coalition.

4a. Identify the activities carried out by your community health board in the past year related to alcohol use. (Check all that apply.)

Answer for the strategies selected in Q4, above.

Minnesota community health boards, 2017	Policy advocacy (strengthening local ordinances) (n=13)	Policies to reduce drink specials in bars and restaurants (n=3)	Alcohol compliance checks (n=19)	Beverage server training (n=21)	Alcohol outlet density in the community (n=1)	Social host ordinances (n=18)	Alcohol use at community festivals and county fairs (n=12)	Drinking and driving (n=22)	Health education messages (n=33)	Working on barriers faced by underserved populations to reduce disparities in alcohol use (n=7)	Screening, counseling, and/or referral in health care settings (n=11)
Attended trainings	54%	67%	58%	47%	0%	11%	33%	59%	64%	57%	36%
Conducted assessments	39%	33%	47%	38%	**100%**	17%	33%	32%	39%	14%	**73%**
Convened partners or participated in coalitions	**77%**	**100%**	**84%**	**81%**	**100%**	**72%**	83%	91%	85%	**86%**	27%
Involved with community outreach and education	**77%**	67%	74%	**81%**	0%	50%	**92%**	**100%**	**91%**	**86%**	46%
Educated policymakers	54%	67%	53%	48%	0%	39%	58%	46%	42%	43%	9%
Developed proposal or policy	8%	0%	5%	0%	0%	22%	8%	5%	3%	14%	0%
Implemented policy (this year)	0%	0%	11%	5%	0%	17%	0%	0%	3%	14%	0%
Maintained policy (which was previously implemented)	54%	0%	53%	29%	0%	67%	8%	9%	15%	14%	27%
Evaluated policy impact	0%	0%	16%	5%	0%	6%	0%	0%	3%	14%	0%

4b. Estimate the top three funding sources that supported your strategies related to alcohol use.

Answer for the strategies for which you selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q4, above. Rank "1," "2," and "3."

Minnesota community health boards, 2017 (n=39)	% largest source	% second-largest source[8]	% third-largest source[9]
Local tax levy	**28%**	31%	23%
State general fund (Local Public Health Act)	21%	31%	26%
SHIP	7%	0%	5%
Other state funds (from MDH or from other state agencies)	10%	5%	7%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	26%	3%	5%
Title V Block Grant	5%	13%	3%
Foundation funds	0%	3%	10%
Fees/reimbursement	3%	5%	5%

Maternal and child health

Community health boards will respond to the Local Public Health Act performance measures for Maternal and Child Health through existing reporting channels, to the MDH Community and Family Health Division. This includes the WIC Program, as well as the Minnesota Follow Along Program Index of Standards Assessment. Community health boards should follow guidance for reporting through those existing systems.

5. How many women were served at WIC clinics within your community health board (unduplicated)?

MDH will provide this data.

Minnesota community health boards, 2017 (n=51)	#
Women served at WIC clinics (unduplicated)	56,866

6. How many infants were served at WIC clinics within your community health board (unduplicated)?

MDH will provide this data.

Minnesota community health boards, 2017 (n=51)	#
Infants served at WIC clinics (unduplicated)	59,354

7. How many children were served at WIC clinics within your community health board (unduplicated)?

MDH will provide this data.

Minnesota community health boards, 2017 (n=51)	#
Children served at WIC clinics (unduplicated)	88,038

[8] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.
[9] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.

Prevent the spread of communicable diseases

Immunization

A multi-county community health board should answer based on services provided within one or more of its individual health departments.

1. What is the number and percent of children in your community health board aged 24-35 months who are up-to-date on immunizations?

MDH will provide this data.

Minnesota community health boards, 2017 (n=51)	%

2. Does your community health board provide immunizations? (Choose one.)

Note: Multi-county community health boards should reply "yes" if any health department in community health board provides immunizations, and "no" only if none of the health departments in the community health board provide immunizations.

Minnesota community health boards, 2017 (n=51)	%
Yes	**94%**
No	6%

2a. If your community health board provides immunizations, indicate the immunization-related services and trends of the last year. (Select the best response.)

Answer if you selected "yes" to Q2, above.

Minnesota community health boards, 2017 (n=51)	% no	% yes, though doing less in recent years	% yes; relatively stable in recent years	% yes; doing more in recent years
Provide immunization to clients at the time of receiving another public health service (e.g., WIC, family planning, home visit, Child and Teen Checkup, etc.)	23%	27%	**44%**	6%
Provide immunization to "walk in" community members by request (at the public health department)	19%	25%	**46%**	10%
Provide immunization during designated clinic(s) conducted jointly with others	**50%**	19%	27%	4%
Provide immunization during designated clinic(s) conducted as a preparedness exercise (clinic to administer influenza vaccine during typical flu season)	**58%**	15%	27%	0%
Provide immunization during designated clinic(s) conducted as part of an emergency response (clinic to administer H1N1 vaccine or another type of vaccine during an outbreak)	**85%**	2%	13%	0%
Provide immunizations timed around reminder/recall efforts within the region	35%	21%	**38%**	4%

3. Is your community health board intentionally re-examining its role in providing immunization services? (Select the best response.)

"Intentionally" is defined as engaging others and using data to inform the process.

Minnesota community health boards, 2017 (n=51)	%
Yes	**57%**
No, but recently completed	14%
Yes, currently underway	26%
Yes, planned	4%

4. Does your community health board refer clients for immunizations (e.g., medical home, Federally Qualified Health Center, Rural Health Clinic, etc.)? (Select the best response.)

Minnesota community health boards, 2017 (n=51)	%
No	2%
Yes, though doing less in recent years	18%
Yes; relatively stable in recent years	**69%**
Yes, doing more in recent years	12%

5. Which of the following immunization-related activities did your community health board perform last year? (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	% routinely	% during an emergency response	% for influenza vaccination	% for non-influenza vaccination	% not performed
Provided education to the community	**88%**	16%	47%	45%	4%
Engaged with immunization providers to discuss immunization coverage	**75%**	16%	31%	43%	4%
Engaged with partners to coordinate services	**78%**	10%	41%	41%	4%
Used MIIC data to engage immunization providers in immunization improvement activities	**75%**	12%	12%	27%	24%
Used MIIC data to conduct reminder/recall outreach for clients of the community health board	**76%**	14%	4%	25%	20%
Used MIIC data to conduct reminder/recall outreach for residents of the jurisdiction (not only those who attended a clinic held by the community health board)	**61%**	6%	4%	24%	35%
Used QI tools and processes to improve immunization practices or delivery in the community health board	**51%**	4%	4%	14%	39%
Served as a resource [to immunization providers in your community health board's jurisdiction] on current recommendations and best practices regarding immunization	**94%**	20%	31%	37%	2%
Conducted population-based needs assessment informed by immunization coverage levels in MIIC	**59%**	18%	10%	24%	27%
Mentored one or more community health boards to help them improve immunization rates	27%	2%	2%	4%	**71%**
Coordinated with community health board's MIIC regional coordinator (e.g., to conduct outreach to clients needing immunizations, to conduct reminder/ recall, and/or to get immunization coverage data)	**84%**	12%	8%	22%	8%

Other:

- **Routinely**: Addressing underserved populations that were behind or not receiving childhhood immunizations.
- **Routinely**: immunizations provide 4x across multiple county locations through the county's WOW van
- **Not performed**: Immunizations provided only to students being served through the School Based Clinic program.
- **For non-influenza vaccination**: Initiated a review of CHB immunization rates in an effort to understand underlying reasons for not reaching the 80% target rate.
- **During an emergency response**: Measles and syphilis outbreak
- **Routinely; for non-influenza vaccination**: Provided culturally appropriate immunization outreach using CHW (Community Health Worker)
- **Routinely**: Vaccine for Reminder Recall program started in Fall 2017- postcard reminder and follow-up phone call
- **Not performed**: We no longer have a MIIC coordinator. We also lack capacity to carry out IPI visits.
- **Routinely**: Worked with other CHB's in the Central Region to perform CMIC duties-another County as the fiscal host of CMIC and with CMIC Regional Coordinator in another County for this part of the Central Region. The our CHS Administrator attended Governance meetings during the year for CMIC.

Protect against environmental health hazards

Indoor air

A multi-county community health board should answer based on services provided within one or more of its individual health departments.

Community health boards should consider the following definition when responding to questions with highlighted terms:

Minnesota Clean Indoor Air Act: The Freedom to Breathe (FTB) provisions amended the Minnesota Clean Indoor Air Act (MCIAA) to further protect employees and the public from the health hazards of secondhand smoke, by restricting smoking in public and work places.

1. How does your community health board support the Minnesota Clean Indoor Air Act? (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	%
Refer to MDH Indoor Air Unit	**82%**
Investigate complaints	47%
Administer enforcement, as necessary	37%
Community education	63%
Other (please specify)	8%
None of the above	4%

Other (please specify):

- SHIP worksites, Smoke-Free MUH (SHIP), FFF, smoke-free childcare signage
- Refer to city officials first for enforcement/regulatory.
- We provide radon test kits. We are a clearing house of information on a variety of Indoor Air Quality issues for the community (mold, etc...)
- signage on public buildings

1a. For what types of facilities does your community health board enforce the Minnesota Clean Indoor Air Act? (Select one.)

Answer if you selected "administer enforcement, as necessary" from Q1, above.

Minnesota community health boards, 2017 (n=37)	%
All public places and places of employment	32%
Food, beverage, and lodging establishments only	**68%**
Neither (none)	0%

1b. For what types of facilities does your community health board enforce other smoking-related ordinances? (Select one.)

Answer if you selected "administer enforcement, as necessary" from Q1, above.

Minnesota community health boards, 2017 (n=37)	%
All public places and places of employment	**37%**
Food, beverage, and lodging establishments only	**37%**
Neither (none)	26%

2. Identify the mold-related actions taken by your community health board as a preventive measure in the past year. (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	%
Provided information (including training) to the general public	**61%**
Provided technical information (including training) to professionals	6%
Provided information to policymakers	18%
Coordinated services	24%
Made referrals	49%
Included a check for the presence of mold	26%
Conducted inspections specifically for mold (this includes accompanying inspectors from another department)	24%
None of these preventive actions related to mold	20%

2a. What types of establishments were inspected as a preventive measure? (Check all that apply.)

Answer if you selected "conducted inspections specifically for mold" in Q2, above.

Minnesota community health boards, 2017 (n=12)	%
Residence: Owner-occupied	42%
Residence: Rented	**75%**
Commercial: Owned	17%
Commercial: Rented	8%
Licensed (e.g., food, lodging, etc.)	42%
Public (e.g., school, government)	17%
Other (please specify)	0%

2b. Were orders issued to building owners or operators to correct mold or moisture problems, as a preventive measure? (Check all that apply.)

Answer if you selected "conducted inspections specifically for mold" in Q2, above.

Minnesota community health boards, 2017 (n=12)	%
Residence: Owner-occupied	8%
Residence: Rented	25%
Commercial: Owned	8%
Commercial: Rented	0%
Licensed (e.g., food, lodging, etc.)	**42%**
Public (e.g., school, government)	17%
Other (please specify)	25%
Community health board does not issue orders to building owners or operators to correct mold or moisture problems as a preventive measure	25%

2c. What statute, rule, or ordinance was cited? (Check all that apply.)

Answer if you indicated issuing orders for any of the establishments listed in Q2b. Do not answer if you checked "community health board does not issue orders…"

Minnesota community health boards, 2017 (n=9)	%
Minnesota Local Public Health Act (Minn. Stat. § 145A.04)	22%
Local public nuisance ordinance	22%
Building code	11%
Other ordinance/rule/statute (please specify)	67%

Other ordinance/rule/statute:

- Community Health Board Regulation of Lodging Establishments
- City Code of Ordinances, Chapters 240 and 244.
- State Lodging code
- County Rental Ordinance
- Orders not issued
- Regulation of lodging estabolishments ordinance

3. Identify the mold-related actions taken by your community health board in response to mold-related complaints and/or emergencies in the past year. (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	%
Provided information (including training) to the general public	**73%**
Provided technical information (including training) to professionals	8%
Provided information to policymakers	14%
Coordinated services	27%
Made referrals	61%
Included a check for the presence of mold	37%
Conducted inspections specifically for mold (this includes accompanying inspectors from another department)	33%
Community health board did not take any of these actions in response to mold-related complaints and/or emergencies	10%

3a. What types of establishments were inspected in response to mold-related complaints and/or emergencies? (Check all that apply.)

Answer if you selected "conducted inspections specifically for mold" in Q3, above.

Minnesota community health boards, 2017 (n=17)	%
Residence: Owner-occupied	47%
Residence: Rented	**82%**
Commercial: Owned	12%
Commercial: Rented	6%
Licensed (e.g., food, lodging, etc.)	41%
Public (e.g., school, government)	29%
Other (please specify)	0%

3b. Were orders issued to building owners or operators to correct mold or moisture problems, in response to mold-related complaints and/or emergencies? (Check all that apply.)

Answer if you selected "conducted inspections specifically for mold" in Q3, above.

Minnesota community health boards, 2017 (n=17)	%
Residence: Owner-occupied	18%
Residence: Rented	35%
Commercial: Owned	12%
Commercial: Rented	0%
Licensed (e.g., food, lodging, etc.)	29%
Public (e.g., school, government)	18%
Other (please specify)	6%
Community health board does not issue orders to building owners or operators to correct mold or moisture problems in response to mold-related complaints and/or emergencies	**47%**

3c. What statute, rule, or ordinance was cited? (Check all that apply.)

Answer if you indicated issuing orders for any of the establishments listed in Q3b, above.

Minnesota community health boards, 2017 (n=9)	%
Minnesota Local Public Health Act (Minn. Stat. § 145A.04)	**56%**
Local public nuisance ordinance	33%
Building code	11%
Other ordinance/rule/statute (please specify)	44%

Other ordinance/rule/statute (please specify):

- City's rental housing code and the International Property Maintenance Code
- Counties' Regulation of Lodging Establishments
- City Rental Housing Ordinance
- County Rental Ordinance

Blood lead

A multi-county community health board should answer based on services provided within one or more of its individual health departments.

4. How does your community health board respond to elevated blood lead levels? (Select one.)

Minnesota community health boards, 2017 (n=51)	%
Community health board responds to blood lead test results	**98%**
Community health board does not respond to elevated blood lead test results	0%
Not applicable: Community health board did not receive blood lead test results during reporting period	2%

4a. How does your community health board respond to blood lead levels between 5 and 15 µg/dL? (Check all that apply.)

Answer if you selected "Community health board responds to blood lead test results" in Q4, above.

Minnesota community health boards, 2017 (n=50)	%
Send family a letter	**98%**
Call family to discuss	90%
Schedule home visit and provide educational materials	66%
Track/assure follow-up blood lead testing	92%
Provide public health referrals (e.g., WIC, MA, follow-up testing) and/or contact medical provider	90%
Review additional housing-based threats (e.g., Healthy Homes)	56%
Do follow-up visit	36%
Other (please specify)	28%

Other (please specify):

- Provide educational materials to the family.
- Collaborate with MDH on certain cases of elevated lead to determine source
- Request MDH to visit the home and provide education and assessment after venous blood level.
- FAP, ASD, ASQSE
- Provide educational materials to all families. Home visits on request.
- Will schedule a visit if the family requests if level is under 15 mcg/dL
- Follow up phone calls are provided by agency staff to determine status of blood lead testing and determine if family needs help with follow through.
- Provide paint inspection/risk assessment (PIRA). Issue corrective orders for any hazards found. Provide grant resources for renovation activities. Provide in-home visit from public health nurse (MVNA).
- provide educational materials as requested
- schedule home visit if needed.
- Offer home visit, Send letter to MD, and include copy of the MDH Childhood Blood Lead Treatment Guidelines.
- Our agency conducts environmental assessment for sources of lead.
- All Families get education Materials; If the blood lead level is above 10, families receive a call, and a home visit is offered. If accepted, housing based threats are reviewed and an additional follow up visit is offered if the next blood lead level is higher than the most recent (Essentially, because our EBLL case numbers are low enough, we treat 10 mcg/dL like 15 mcg/dL.
- Follow-up with medical doctor

4b. How does your community health board respond to blood lead levels of 15 µg/dL or greater? (Check all that apply.)

Answer if you selected "Community health board responds to blood lead test results" in Q4, above.

Minnesota community health boards, 2017 (n=50)	%
Send family a letter	84%
Call family to discuss	94%
Schedule home visit and provide educational materials	92%
Track/assure follow-up blood lead testing	96%
Provide public health referrals (e.g., WIC, MA, follow-up testing) and/or contact medical provider	**98%**
Review additional housing-based threats (e.g., Healthy Homes)	64%
Do follow-up visit	76%
Other (please specify)	34%

Other (please specify):

- Collaborate with MDH on certain cases of elevated lead to determine source
- Request MDH to visit the home and provide education and assessment after venous blood level.
- possible ASQ/ASQSE
- 2017 follow up with false lab results- joint visit with MDH (faulty blood lab machine)
- We do this in coordination with MDH
- Staff will notify MDH of concern and identify if need for dual home visit to address lead in the home.
- Provide paint inspection/risk assessment (PIRA). Issue corrective orders for any hazards found. Provide grant resources for renovation activities. Provide in-home visit from public health nurse (MVNA).
- Visit is made in coordination with the Environmental Health Specialist from the Blood Lead section at MDH.
- schedule visit and f/u home visit if needed.
- MDH Risk Assessor visit
- Coordination with Environmental Health (MDH)
- Our agency conducts environmental assessment for sources of lead.
- Connect with MDH Lead staff
- Coordinate home visiting with MDH Lead Assessor. Make referrals and assist in locating funding sources for abatement.
- Provide additional resources &/or services as needed
- Follow-up with medical doctor
- MDH will come and make a home visit with the nurse at the CHB that is assigned to Lead calls and referrals follow-ups.

Drinking water protection and well management

Community health boards may work in drinking water protection and/or well management via partnerships with others in the county/community health board.

A multi-county community health board should answer based on services provided within one or more of its individual health departments.

5. How has your community health board considered or addressed drinking water quality? (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	%
Attend water quality trainings	51%
Educate policymakers or the public on drinking water quality	45%
Provide technical assistance on drinking water issues	45%
Provide or facilitate water testing services for residents	**59%**
Operates a delegated well program	18%
Other (please specify)	20%
None of the above	18%

Other (please specify):

- Public Health does very little environmental health work in our County. Supervisor has participated on occasion in the Water Resource Advisory Committee governed by the County Soil and Water Conservation District. They have been updating the water plan and it includes strategies on drinking water. They do not report to the Human Service Board, only the County Board and the connection to health may not be a priority. Our PH unit does not have capacity to do more than attend an occasional meeting and provide feedback as able.
- Refer to MDH.
- Environmental Services, separate division of the county, completes water testing (private well and groundwater)
- Administers a SSTS (septic) program. Ensuring proper on-site waste water disposal and the protection of well water sources.
- Facilitate sampling of establishments that do not fall under Safe Drinking Water Protection definition.
- Water samples are collected from the county's licensed food, pools and lodging establishments who are on private wells for compliance with the safe drinking water act.
- education and referrals provided if needed-none in 2017
- County Environmental Management Team and associated departments address ground water protection and monitoring.
- Refer public to MDH Well Sealing Cost Share, cost share agricultural practices that reduce nitrate run-off, septic repair loan program, septic replacement assistance.
- Coordinate with MDH on PFC testing

6. What services are provided to private well owners in the jurisdiction served by your community health board? (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	%
Collect well water samples for testing	27%
Promote well water testing	**80%**
Provide private well owners with well information	71%
Well Sealing Cost Share	20%
Other (please specify)	16%

Other (please specify):

- Refer to MDH, or planning and zoning.
- Environmental Services, separate division of the county, completes water testing (private well and groundwater)
- This is a service provided by environmental health at our Court House location.
- Provide information and education on testing.
- None
- A well sealing cost share program is administered through another County Department, Environment & Energy.
- none
- Refer to U of M Extension services for well water test kits

Extreme weather

A multi-county community health board should answer based on services provided within one or more of its individual health departments.

Community health boards should consider the following definition when responding to questions with highlighted terms:

Extreme Weather: Unusual or unseasonal weather, sometimes severe, at the extremes of normal historical distribution.

7. How has your community health board considered or addressed extreme weather? (Check all that apply.)

Work in extreme weather could be related to any subject area; it does not need to be related to a specific project.

Minnesota community health boards, 2017 (n=51)	%
Attend extreme weather trainings	**57%**
Educate policymakers or the public on the health impacts of extreme weather	35%
Convene partners or participate in coalitions to mitigate or adapt to extreme weather	39%
Develop or implement a plan or policy to mitigate or adapt to extreme weather (e.g., heat response plan or policy to turn vacant lots into community gardens)	37%
Conduct assessments on extreme weather vulnerability	47%
Pursue funding to address extreme weather (e.g., grants)	10%
Other (please specify)	18%
Community health board has not considered extreme weather	10%

Other (please specify):

- Partner with Emergency Management to provide situational awareness
- Climate change surveys and policies. Our County has created public information (webpages) for the community to use in instances of extreme weather. County Emergency Management is very involved in extreme weather - provide email notifications and developing policies for employees and public to follow.
- Extreme weather events. Coordinate response and educational messages with Emergency Manager.
- Worked with community groups to educate/mitigate impacts of extreme weather.
- Past trainings have been attended, but department currently does not address extreme weather.
- Our agency has provided extreme weather alerts.
- Extreme weather continues to be an area of focus in the County All Hazards Mitigation Plan
- Surveyed Manufactured Home Parks on storm shelter accessibility.
- Emergency Managers and PHEP
- In Emergency Preparedness Planning - plan for power outages caused by extreme weather, cooling centers, healing centers

Nuisance investigations

A multi-county community health board should answer based on services provided within one or more of its individual health departments.

8. What were the three most commonly addressed complaints in your community health board? (Check no more than three.)

Minnesota community health boards, 2017 (n=51)	%
Garbage/junk house	**55%**
Mold	**55%**
Improper sewage disposal, discharging to surface/groundwater/into structure	24%
Accumulation of rubbish or junk	41%
Accumulation of decaying animal or vegetable matter	0%
Hazardous building or unsanitary dwelling	16%
Vermin or vector infestations	31%
Clandestine drug labs	4%
Failure to keep waste, refuse, or garbage properly	31%
Contaminated drinking water	0%
Elevated radon	14%
Contaminated surface water	4%
Hazardous waste	6%
Unsecured hole or opening (abandoned well, well pit, sewage treatment system, non-maintained swimming pool, mine shaft, tunnel)	2%
Accumulation of carcasses of animals or failure to dispose of carcasses in a sanitary manner	0%
Chemical spill	4%
Contaminated ground water	0%
Other (please specify)	10%

Other (please specify):

- Concerns about storm shelter availability in a mobile park, lice, cleanliness of a fast food building
- Excess animals/Dogs
- Dog bites or aggressive dogs.
- related to mold

8a. How did your community health board address the complaints checked above? (Check all that apply.)

Answer for those items checked in Q8, above.

Minnesota community health boards, 2017	Garbage/junk house (n=28)	Mold (n=28)	Improper sewage disposal (n=12)[10]	Accumulation of rubbish or junk (n=21)	Hazardous building or unsanitary dwelling (n=8)	Vermin or vector infestations (n=16)	Clandestine drug labs (n=2)	Failure to keep waste, refuse, or garbage properly (n=16)	Elevated radon (n=7)	Contaminated surface water (n=2)	Hazardous waste (n=3)	Unsecured hole or opening (n=1)[11]	Chemical spill (n=2)
Removal, abatement, or resolution	75%	14%	**92%**	**76%**	38%	56%	**100%**	**88%**	14%	50%	67%	**100%**	**100%**
Evidence-based strategies on prevention	43%	57%	25%	14%	25%	63%	0%	19%	71%	**100%**	0%	0%	50%
Partnered with other agencies to address	**79%**	**64%**	75%	**76%**	**75%**	**69%**	**100%**	81%	**100%**	**100%**	**100%**	0%	**100%**

Emerging issues

A multi-county community health board should answer based on services provided within one or more of its individual health departments.

Question 9 is optional.

9. Please describe any emerging environmental health issues in your community health board, the challenges they pose, and how you are working to address them.

To view this measure's responses, contact the MDH Center for Public Health Practice.

[10] Full text: Improper sewage disposal, discharging to surface/groundwater/into structure

[11] Full text: Unsecured hole or opening (abandoned well, well pit, sewage treatment system, non-maintained swimming pool, mine shaft, tunnel)

Prepare for and respond to emergencies

Community health boards reported directly to the MDH Center for Emergency Preparedness and Response for this area of responsibility.

1. Did your community health board respond to a real or potential emergency?

MDH will provide this data.

Minnesota community health boards, 2017 (n=51)	%
Yes	**53%**
No	47%

1a. If yes, what was the response?

MDH will provide this data.

- Extreme Weather, Biological Incident
- Water interruption
- Biological Incident, County TB POD
- Biological Incident, Active TB cases
- Biological Incident, Measles
- Extreme Weather
- Biological Incident, Measles
- Heat
- Extreme Weather
- Biological Incident, Measles
- Biological Incident, Active TB disease
- Flooding
- Biological Incident, Tuberculosis (City #1), Tuberculosis (City #2), Measles
- Biological Incident, Measles outbreak Metro, pre-planning in our county
- Flooding
- Biological Incident, Active TB
- Biological Incident, Measles, Planned event, Super Bowl LII
- Biological Incident, Tuberculosis Outbreak
- Biological Incident, Pertussis, Measles
- Other, Grief Counseling response, Biological Incident, TB Screening
- Biological Incident, Measles
- Biological Incident, Foodborne Outbreak, Other Lead in water, Other, PFC's in water
- Other, Missing juvenile
- Flooding
- Extreme Weather, Power outage
- Flooding, Hazardous Material, A tanker truck flipped containing Sodium Hydroxide-the contents did not leak
- Flooding

2. How many partners replied to health alerts sent by your community health board? MDH will provide this data.

Hospitals % (Mid-year = July 1, 2016 - December 30, 2016)	Hospitals % (End of year = January 1, 2017 - June 30, 2017)	Clinics % (Mid-year = July 1, 2016 - December 30, 2016)	Clinics % (End of year = January 1, 2017 - June 30, 2017)
100%	100%	94%	92%
50%	100%	4%	93%
---	---	100%	100%
100%	100%	97%	100%
100%	100%	75%	80%
100%	100%	100%	100%
100%	100%	100%	71%
100%	100%	50%	50%
100%	100%	100%	78%
100%	100%	100%	100%
100%	100%	100%	100%
100%	100%	100%	100%
100%	100%	100%	100%
100%	100%	83%	76%
100%	100%	100%	100%
100%	100%	97%	100%
100%	100%	60%	80%
---	100%	100%	80%
100%	100%	100%	100%
0%	100%	13%	82%
90%	90%	38%	33%
100%	100%	100%	100%
100%	100%	100%	100%
100%	100%	100%	100%
100%	50%	100%	100%
90%	90%	38%	33%
100%	100%	53%	71%
100%	100%	80%	100%
100%	100%	100%	100%
100%	100%	100%	80%
100%	100%	100%	100%
100%	100%	100%	100%
100%	100%	100%	100%
100%	100%	88%	100%
100%	100%	97%	100%
100%	100%	75%	100%
0%	0%	75%	100%
100%	100%	92%	83%
100%	100%	47%	47%
100%	100%	81%	94%
100%	100%	67%	100%
100%	100%	92%	70%
100%	100%	100%	100%
100%	100%	100%	80%
100%	100%	77%	77%
100%	100%	100%	93%
100%	100%	100%	100%
100%	100%	100%	100%
---	100%	---	---
100%	100%	100%	100%
100%	100%	100%	100%

3. Which sectors has your community health board engaged in the past year?

MDH will provide this data.

Minnesota community health boards, 2017 (n=51)	%
Business	73%
Community leadership	86%
Cultural and faith-based groups and organizations	65%
Emergency management	92%
Health care	**94%**
Social services	84%
Housing and sheltering	59%
Media	39%
Mental and behavioral health	69%
Office of Aging (or equivalent)	33%
Education and childcare settings	90%

Assure health services

Clinical-community linkages

A multi-county community health board should answer based on routine or expected practices within one or more of its individual health departments (i.e., things done on a regular basis).

Clinical-community linkages can potentially increase attention and resources for population health improvement. A range of linkages are possible, including those that increase access to prevention services and promote health of employees in health care workplaces. The activities listed below have strong evidence-based support for their efficacy, and align with current Statewide Health Improvement Partnership (SHIP) reporting and focus.

In the question that follows, select the response option(s) that best describe the ways your community health board worked to increase clinic-community linkages over the past year. Include activities implemented through SHIP, as well as other sources of funding. This information will complement and extend SHIP reporting to provide a broader, statewide understanding of local public health activity directed toward clinical-community linkages.

Workplace Strategy in the Health Care Setting: Includes initiatives toward creating an organizational and physical environment that supports employee health and encourages positive lifestyle behaviors such as adequate physical activity, healthful eating, tobacco-free environments, and support for nursing moms. A complete description of these activities can be found in Clinical-Community Linkages for Prevention Health Care Implementation Guide (PDF).

Screen-Counsel-Refer-Follow-up (SCRF) in Clinical Setting

- Working on engagement or assessment
- Tobacco cessation
- Pediatric and/or adult obesity
- Falls prevention
- Breastfeeding support

Establishing a Community EBP (Evidence-Based Practice) Program

- Working on engagement or assessment
- Tobacco cessation
- Diabetes Prevention Program
- Chronic Disease Self-Management Program
- Falls prevention
- Other (per variance)

1. Indicate the strategies your community health board implemented to promote clinical-community linkages for prevention, and whether your community health board used SHIP and/or non-SHIP funding. (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	% workplace strategy in the health care setting	% Screen-Counsel-Refer-Follow-Up (SCRF) in the clinical setting	% establishing a community evidence-based practice (EBP) program
Used SHIP funding and/or SHIP match for strategy	**75%**	**49%**	**53%**
Used other (non-SHIP) funding for strategy	29%	37%	29%
Was not involved in strategy	20%	35%	37%

Other:

Used SHIP funding and/or SHIP match for strategy

- Support and coordinate City Area Collaborative
- SHIP - Breastfeeding Strategy - with health systems/PH
- Breastfeeding support
- Health Care Access Gap Analysis
- HEDA, Diabetes exploration with Hispanic population
- Breastfeeding Friendly PH Department
- Quitplan resources
- Breastfeeding Support
- Health Care Coaching

Used other (non-SHIP) funding for strategy

- Community Health Worker
- Correctional health partnership
- Primary Care-Public Health Learning Community work with CentraCare Health-Long Prairie & County Health & Human Services

1a. Estimate the top three funding sources that supported your strategies related to clinical-community linkages.

Answer for the strategies for which you selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q1, above. Rank "1," "2," and "3."

Minnesota community health boards, 2017 (n=48)	% largest source	% second-largest source[12]	% third-largest source[13]
Local tax levy	8%	23%	40%
State general fund (Local Public Health Act)	6%	33%	27%
SHIP	**71%**	21%	2%
Other state funds (from MDH or from other state agencies)	2%	6%	6%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	13%	2%	4%
Title V Block Grant	0%	0%	2%
Foundation funds	0%	6%	4%
Fees/reimbursement	0%	4%	2%

1b. Does the local tax levy investment of your community health board exceed the required state match?

Answer if you selected "local tax levy" as one of your top three funding sources in Q1a, above.

Minnesota community health boards, 2017 (n=33)	%
Yes	**79%**
No	21%

[12] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.
[13] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.

Provision of public health services

A multi-county community health board should answer based on routine or expected practices within one or more of its individual health departments (i.e., things done on a regular basis).

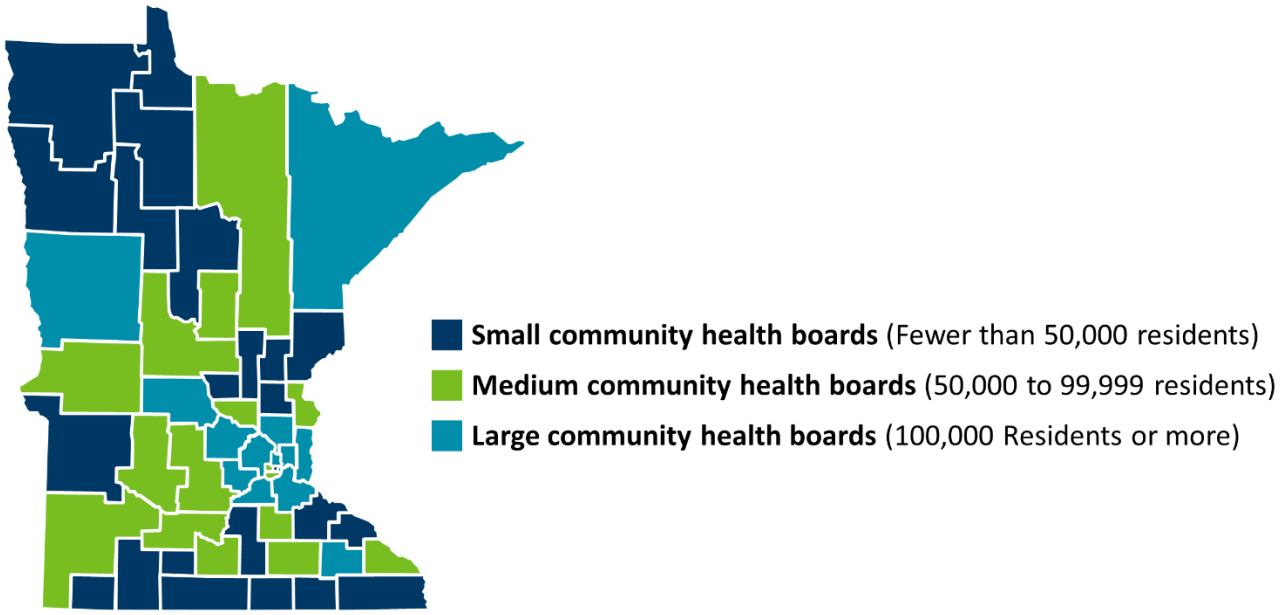
Community health boards should consider the following definition when responding to questions with highlighted terms:

Primary Care (non-specialist care): A patient's main source for regular medical care, ideally providing continuity and integration of health care services. All family physicians and many pediatricians, internists, nurse practitioners and physician assistants, practice primary care.

2. For the following services, indicate whether your community health board performed the activities listed. (Check all that apply.)

Minnesota community health boards, 2017 (n=51)	% in primary care: Medical	% in primary care: Dental	% in licensed home care	% in correctional health
Provided services	14%	9%	26%	28%
Contracted for services	16%	18%	6%	12%
Did not provide services	**78%**	**75%**	**71%**	**67%**

Appendix: Community Health Board Populations and Sizes, 2016[14]



Small community health boards	
Beltrami	46,106
Benton	39,992
Cass	28,993
Countryside	43,252
Des Moines Valley	21,414
Faribault-Martin	33,764
Fillmore-Houston	39,817
Freeborn	30,446
Goodhue	46,676
Isanti	39,025
Kanabec	15,830
Le Sueur-Waseca	46,502
Mille Lacs	25,866
Mower	39,163
Nobles	21,848
North Country	33,359
Pine	28,874
Polk-Norman-Mahnomen	43,704
Quin County	47,525
Richfield	36,338
Wabasha	21,273
Watonwan	10,908

Medium community health boards	
Aitkin-Itasca-Koochiching	73,453
Bloomington	88,299
Blue Earth	66,441
Brown-Nicollet	58,906
Chisago	54,748
Crow Wing	63,940
Dodge-Steele	57,311
Edina	51,804
Horizon	67,510
Kandiyohi-Renville	57,155
Meeker-McLeod-Sibley	73,779
Morrison-Todd-Wadena	70,815
Rice	65,622
Sherburne	93,528
SWHHS	73,840
Winona	50,948

Large community health boards	
Anoka	345,957
Carlton-Cook-Lake-St. Louis	251,629
Carver[15]	100,262
Dakota	417,486
Hennepin	1,368,158
Minneapolis	419,952
Olmsted	153,102
Partnership4Health	161,052
Scott	143,680
St. Paul-Ramsey	540,649
Stearns	155,652
Washington	253,117
Wright	132,550

[14] Most recent population available at time of publication is from 2016.
[15] In 2016 Annual Reporting, Carver was a medium community health board (50,000 to 99,999 residents).