

State Community Health Services Advisory Committee (SCHSAC) Handbook





Protecting, maintaining and improving the health of all Minnesotans

February 23, 2007

Dear SCHSAC Members and/or Alternates:

Welcome to the 2007 State CHS Advisory Committee!

The purpose of this handbook is to help you become familiar with the role and purpose of the State Community Health Services Advisory Committee (SCHSAC) and your responsibilities as a SCHSAC member or alternate. It also contains information that will help you become better acquainted with Minnesota's public health system.

The following information is in this handbook:

- *What is SCHSAC?*
- *Shared Vision for Minnesota Public Health System*
- *Mission of Community Health Services*
- *Simple Rules for the State-Local Public Health Partnership*
- *Principles of Public Health*
- *Summary: Minnesota's Public Health System*
- *The Local Public Health (LPH) Act*
- *Board of Health Responsibilities*
- *SCHSAC Operating Procedures*
- *List of Counties/CHBs*
- *Map of CHBs, SCHSAC District Boundary Map*
- *MDH and CFH Organizational Charts*
- *Additional Resources Through MDH*
- *SCHSAC Annual Report/Work Plan*
- *Sample Expense Report*

Please refer to this handbook whenever you have a question about the SCHSAC. If your question is not addressed in the handbook, please feel free to call the Office of Public Health Practice in the Community and Family Health Division at the Minnesota Department of Health (*see contact information listed on the back of this page*).

We look forward to working with you on important public health issues affecting all of us in Minnesota.

The Office of Public Health Practice
Community and Family Health Division
Minnesota Department of Health

STATE CHS ADVISORY COMMITTEE QUESTIONS?

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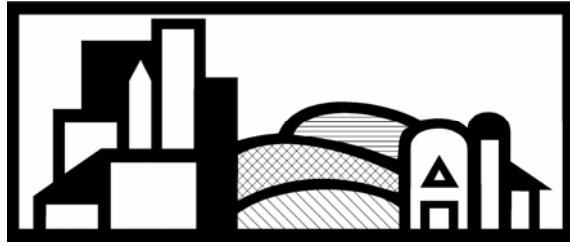
State Community Health Services Advisory Committee (SCHSAC) Handbook

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1: Overview of Minnesota's Public Health System



What is SCHSAC?

The State Community Health Services Advisory Committee (SCHSAC) was created by the Minnesota Legislature in 1976 as one component of the Local Public Health Act. The Local Public Health Act began a unique partnership between the Minnesota Department of Health (MDH) and local government public health agencies. This partnership has since developed into an effective tool for protecting and improving the health of all Minnesotans.

The purpose of the SCHSAC, as described in the Local Public Health Act, is:

To advise, consult with, and make recommendations to the Commissioner of Health on matters relating to the development, funding, and evaluation of community health services in Minnesota.

The SCHSAC has 53 voting members, representing the 53 Community Health Boards in the state. Of the 53 boards, 28 are single county boards, four are city boards, and 21 are multi-county boards. Each Community Health Board selects one person to represent their board on the SCHSAC.

A few more “nuts and bolts” about the SCHSAC:

- Meets four times a year (typically February, May, September and December).
- Agendas and other materials are mailed in advance of the meetings.
- Meetings are held in the Twin Cities metro area from 10:00 - 2:30 p.m.
- Commissioner of Health and other MDH Executive Office staff attend meetings whenever possible.
- Members are reimbursed for travel and parking; lunches are provided at meetings.
- Alternates may be appointed.
- An eleven-member Executive Committee representing all regions of the state meets more frequently to conduct interim business.
- The SCHSAC develops an annual work plan to focus its activities; much of the work plan is accomplished through smaller work groups which may include SCHSAC members, alternates, or others.
- Members receive a handbook which includes the annual work plan, operating procedures, and other materials, and an orientation for new members and alternates is offered in the spring.

Shared Vision for the Minnesota Public Health System

A vision states the outcomes an organization or system hopes to gain in a set amount of time – a picture of the preferred future. This is a vision for the partnership that makes up the governmental public health system in Minnesota.

The vision for the public health system in Minnesota is of a strong and dynamic partnership of governments fully equipped to address the changing needs of the public's health.

Key Elements of the Vision

- **A Partnership of Governments.** This partnership will integrate the long-standing success of the relationship between the MDH and local public health jurisdictions including city, county, and multi-county community health boards and will evolve into a broader partnership of governments including Minnesota's 11 sovereign tribal governments and federal agencies such as the Indian Health Service and the Centers for Disease Control and Prevention.
- **Strong.** This partnership will build upon the strengths of its established, long, and rich history. Strong public health partnerships are those in which all members: share a common understanding of the public health principles that provide direction and the ethical framework for decision-making; maintain meaningful, multi-directional communication with all other members; engage in effective community coalition-building; and sustain a true commitment to reflecting on and continually strengthening member relationships.
- **Dynamic.** Dynamic public health partnerships will be resilient – able to quickly adapt to rapid change and to involve other entities as issues require. This flexibility will require all partners to know their communities well and to be able to creatively and effectively identify, organize, and deploy community resources – including people – as needed.
- **Fully Equipped.** To meet the current and emerging challenges to promoting health and preventing disease, public health partners in Minnesota must have the information, tools, and technology needed to monitor and track health status and disease outbreaks; a professional and culturally-competent workforce that is qualified and prepared to address emerging public health challenges; and stable and sufficient funding to finance their work.

The Mission of Community Health Services

The Mission	...The purpose or aim, based on shared values, which motivates and guides future action.
of the community health services partnership	...State and local governments working together and with other organizations to protect and promote the health of the entire population by emphasizing the prevention of disease, injury, disability, and preventable death through assessment and the promotion of effective coordination and use of community resources, and by extending health services into the community.
is to lead efforts	...Provide leadership by bringing people together to consider scientific principles and community concerns and resources in developing health priorities and actions.
to protect and promote the health	...To assure that all persons have the opportunity to achieve and maintain their best level of health and independence, and lead vital, productive lives.
of all people in Minnesota.	...All persons on the basis of need. No one shall be denied services because of race, color, gender, age, national origin, religion, sexual orientation, political persuasion, physical or mental ability, ability to pay, or place of residence.

Simple Rules for the State-Local Public Health Partnership

To promote communications and strong working relationships, the State Community Health Services Advisory Committee adopted a set of “simple rules” developed by a 1999 SCHSAC work group. The work group was convened to discuss the meaning of *partnership* and to explore the complex relationship between the state and local governments.

The SCHSAC finds it helpful to keep these rules in mind:

Rule 1: Seek first to understand (ask and listen).

Each partner needs to understand the other. Local agencies must seek to understand how the state works and the state must seek to understand how local agencies work. Seeking to understand requires that each understand the perspective of the other partner by asking clarifying questions, listening without judging, removing personal feelings from the situation, and being objective. This rule requires the communication of differences in an atmosphere of trust and respect.

Rule 2: Make expectations explicit (tell).

In each situation the partners must make their expectations of the other explicit and clear. Each partner should communicate what they hope to achieve, what concerns they have, what they feel the problems are, and how they would like the problem to be solved. Together they should determine how they expect the issue to be addressed.

Rule 3: Think about the part and the whole.

Any decision or action by any one part of the system can significantly impact the whole system. The state and local public health partnership is massively entangled: an action by any part can transform the other parts. The state must consider the impact of its actions on local agencies and citizens, and local agencies must examine the impact of their actions on the state and citizens. If a partner only thinks about one part, their actions can have significant (albeit unintended) consequences for the whole system.

Public Health Principles

In Minnesota, a set of public health principles has been specifically articulated to make clear both the intent and the approach of public health practice by governmental public health departments.

The principle of prevention: Public health gives priority to preventing problems over the early detection and treatment of problems.

Preventing problems and promoting health are more cost-effective and humane than treating health problems after they have already occurred. For existing conditions, detecting symptoms early and providing prompt treatment can reduce the negative effects (including, in some cases, the spread of disease to other individuals), help to contain health care costs contained, and maintain a higher quality of life.

The principle of the aggregate: Public health focuses on the health priorities of populations.

The overall goal of public health is to promote, protect, and maintain the health of the *community as a whole*. Yet while taking a population-based approach to assessment, prioritization, and planning, specific services are often provided to groups, families, and individuals within the community as part of meeting overall community needs. For instance, wellhead protection programs are designed to assure safe drinking water for residents by protecting the source of groundwater. This *community* goal, however, is reached by working with *individual* well owners one at a time.

The principle of epidemiology: Public health is based on a thorough scientific understanding of the causes of health problems.

Epidemiology studies the causes of diseases and other health problems, and both explains and predicts how they occur in populations. Most major advances in public health can be attributed to this study of data, a practical interpretation of how to apply those findings in the real world, and from a firm resolve to implement and evaluate the public health programs that are needed.

The principle of the greater good: Public health focuses on providing the greatest good for the greatest number of people.

In trying to get "the biggest bang for the buck," the public health approach tries to achieve the greatest impact for the community as a whole with the most cost-effective means available. The emphasis is on providing basic preventive services with long-lasting positive effects to a large number of people, rather than providing expensive treatments (whose benefits are often short-lived) to a relatively few individuals.

The principle of community organization: Public health organizes and leverages community resources to address community health priorities.

Public health departments have always worked with others to achieve community health goals. Such collaboration is critical in extending limited resources, in encouraging community ownership of a health problem and its solutions, and in building a broad base of support.

The principle of leadership: Public health does what others cannot or will not do.

This principle speaks to the unique responsibility, and power, of government for public health. Government identifies and then assures that the services most needed by a community are provided. At times, this means being the "provider of last resort." Other times, it means working with others to fulfill unmet community health needs. Sometimes the needs are of such scope (e.g., assuring safe water supplies, controlling communicable diseases) that only government has the mandate, authority, and capacity to address them.

2/24/06

MINNESOTA'S PUBLIC HEALTH SYSTEM

**A summary of Minnesota's
state and local governmental
partnership for public health,
leading efforts to protect
and promote the health of
all people in the state.**



**Prepared by the
Office of Public Health Practice
Community and Family Health Division
Minnesota Department of Health**

MINNESOTA'S PUBLIC HEALTH SYSTEM

The vision for the public health system in Minnesota is of a strong and dynamic partnership of governments, fully equipped to address the changing needs of the public's health.

Protecting and improving the health of all Minnesotans is a big job. It is by necessity a responsibility shared by everyone: by individuals for their own health, by families and friends looking out for loved ones, by businesses and other organizations wanting to keep employees well, by community organizations advocating for vulnerable populations, and by health care providers seeking to reduce the need for their services.

Although everyone has a role to play in community health, governments have unique roles and clear responsibilities. Governments protect health by enacting laws and regulations that govern individual and organizational behaviors; they prevent health problems by assessing the community's health and providing critical screening and health care services (such as immunizations); and they promote health by providing science-based information and enacting and encouraging policies that support health.

In Minnesota, the governmental public health system was put in place in 1976 in response to a fragmented and unwieldy assortment of local boards of health (see Figure 1).

At that time, local and state public health activities were regulated by a patchwork of laws. The laws did little to govern the relations among local units of government, there were no provisions for funding general local public health activities, and there were few clear explanations of the relative roles of state and local health authorities.

In 1976, a landmark bill – the Community Health Services (CHS) Act – initiated the CHS system of today. Now known as the

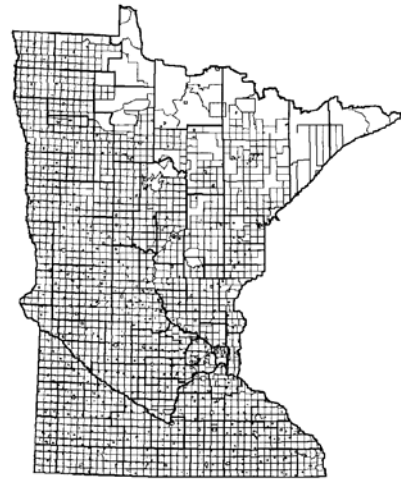


Figure 1.
Boards of health before 1976

Local Public Health Act (Chapter 145A), this legislation established a comprehensive system and an effective public health partnership among state and local governments.

The current public health system has 53 *community health boards* (see Figure 2) working in partnership with the Minnesota Department of Health., the state agency with the lead responsibility for protecting and maintaining health. The specific duties and responsibilities of state and local governments, which include assessing health needs, planning, setting priorities, and measuring progress, are defined in statute.

Now over 30 years strong, Minnesota's public health system is a well-established,

coordinated approach to public health among state and local public health departments.

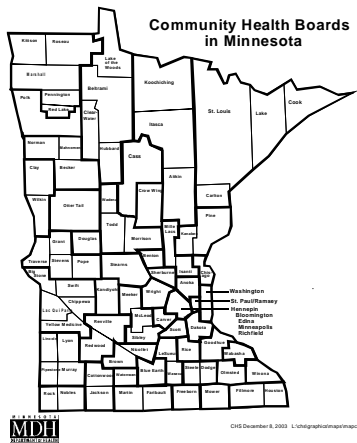


Figure 2.
Community Health Boards in Minnesota today

PARTNERSHIPS FOR PUBLIC HEALTH

The State CHS Advisory Committee

As a part of the original CHS Act, the Minnesota Legislature created the State CHS Advisory Committee (SCHSAC). The SCHSAC continues to play an important role in the state-local CHS partnership.

The purpose of the committee, as described in Chapter 145A, is to *advise, consult with, and make recommendations to the commissioner of health on matters relating to the development, maintenance, funding, and evaluation of community health services in Minnesota (Ch. 145A.10, Subd.5a(a)).*

Each year, through committees, work groups, regular communications, and an annual conference – and because of the commitment of hundreds of state and local public health professionals and local elected officials – the SCHSAC identifies, develops, and responds to critical public health issues.

The influence of this committee is felt in every Minnesota community, as the recommendations of the SCHSAC are not only submitted to the commissioner of health, but are also adopted by community health boards, implemented statewide through guidelines and reporting procedures, and are used as the basis for developing public policy.

Community Partnerships

The partnership between state and local governments is an important part of the overall public health system. But public health partnerships extend well beyond government.

Governments' roles and legal responsibilities for public health take many forms and cover many issues, from encouraging regular exercise and good nutrition to preventing the contamination of water supplies, from providing immunizations to improving access to health care, and from inspecting nursing homes to preparing for disasters. Governments are concerned with the health of the population as a whole.

The interests, however, of the different sectors in a community are likely to be focused on specific populations. School-age children, clinic patients, or health plan enrollees are all examples of groups a specific organization may want to influence. Public health partnerships in the community can include schools, local businesses, dentists, health care clinics, chambers of commerce, and American Indian tribes. Sometimes partnerships form around short-term, specific projects, maybe a school-based exercise campaign, or cancer screening outreach. Sometimes the collaboration is ongoing, such as regular communication among local public health departments and health plans designed to

strengthen the impact of prevention messages in the community.

Other community partnerships are designed to improve the impact of governmental public health programs. Regular involvement of the community in the identification and selection of priority public health issues and in the creation of strategies to address those issues has been shown to be a key factor in the success of those strategies.

Minnesota's public health system supports all these kinds of partnerships and is continually working to identify and strengthen opportunities for collaboration.

QUALITY AND PERFORMANCE

Since its beginnings in 1976, the CHS system has continually looked for ways to improve the practice of public health statewide. A comprehensive planning process is undertaken at regular intervals, and public health professionals from around the state participate in making that process as rigorous and as meaningful as possible.

Starting in 2003 the SCHSAC embarked on the development of a set of *essential local public health activities* that would define what every Minnesotan could expect, no matter where in the state they live. The essential local activities fall into six *areas of public health responsibility*:

- Assure an adequate local public health infrastructure.
- Promote healthy communities and healthy behaviors.
- Prevent the spread of infectious disease.
- Protect against environmental health hazards.
- Prepare for and respond to disasters, and assist communities in recovery.
- Assure the quality and accessibility of health services.

The essential local activities also help to describe local public health to state and local decision makers and to the public, and provide a basis for ongoing measurement, accountability, and quality improvement in public health.

PUBLIC HEALTH GOALS

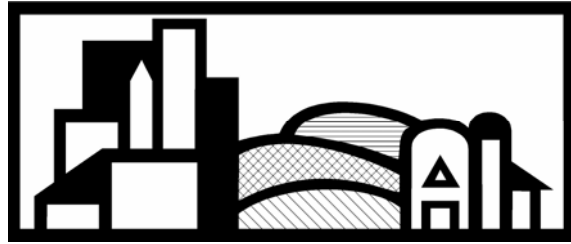
Another hallmark of Minnesota's public health system is the regular identification of statewide public health goals. In 1998 the process of developing public health goals was expanded to include community partners for public health. The product of that collaboration, *Healthy Minnesotans: Public Health Improvement Goals*, defines public health goals that anyone and everyone in the state can work toward. The current goals reflect and build on the six areas of public health responsibility:

- *Assure a strong public health system.*
- *Promote healthy communities and eliminate health disparities throughout the lifespan.*
- *Prevent the spread of infectious disease.*
- *Make environments safe and healthy.*
- *Prepare for disasters and emergencies.*
- *Help all people get quality health services.*

The mission of the community health services partnership is to lead efforts to protect and promote the health of all people in Minnesota.



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<http://health.state.mn.us>



2: The Local Public Health Act

The Local Public Health Act

Introduction and Highlights

Minnesota Statutes, Chapter 145A is known as the Local Public Health Act. Originally enacted in 1976 as the Community Health Services Act, the legislation has been modified twice: in 1987 (when it became the Local Public Health Act) and again in 2003.

Community health services are designed to “...protect and promote the health of the general population...by emphasizing the prevention of disease, injury, disability, and preventable death through the promotion of effective coordination and use of community resources, and by extending health services into the community” (145A.02).

The Local Public Health Act clarifies **state and local roles for public health**. For example, the commissioner of health has the authority, [through the Local Public Health Act], to direct community health boards to take public health action, such as investigating communicable disease (145A.04, Subd. 6). The commissioner also may enter into formal or informal agreements with local public health departments, such as when the commissioner delegates duties to community health boards (145A.07).

The original CHS Act allowed county and city boards of health to organize themselves as **community health boards** providing they met certain population and boundary requirements. Meeting those requirements also made counties and cities eligible to receive certain **state funds for public health**, with a local match (145A.09, 145A.13).

Local planning for public health has always been a cornerstone of Minnesota’s legislation for local public health. Current law establishes a **five-year planning cycle** for assessing community health, developing action plans and reporting on selected local public health priorities (145A.10 Subd. 5a., (a), (b)).

The 2003 law focuses accountability for the funds on a set of **statewide outcomes for improving health**. An **annual report** is required to document progress on the statewide outcomes (145A.10 Subd. 5a., (c)).

The law also established the **State Community Health Services Advisory Committee** (SCHSAC). The purpose of the SCHSAC is to “advise, consult with, and make recommendations to the commissioner of health on matters relating to the development, maintenance, funding, and evaluation of community health services in Minnesota” (145A.10, Subd. 10).

The Local Public Health Act

Minnesota Statutes 2003, Chapter 145A

(Unofficial, prepared by MDH staff)

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The Local Public Health Act

Minnesota Statutes 2003, Chapter 145A.

145A.01

145A.01 Citation.

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

HIST: 1987 c 309 s 1

145A.02

145A.02 Definitions.

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

Subd. 2. **Board of health.** "Board of health" or "board" means an administrative authority established under section 145A.03 or 145A.07.

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

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

Subd. 5. **Community health board.** "Community health board" means a board of health established, operating, and eligible for a local public health grant under sections 145A.09 to 145A.131.

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

Subd. 7. **Community health service area.** "Community health service area" means a city, county, or multicounty area that is organized as a community health board under section 145A.09 and for which a local public health grant is received under sections 145A.09 to 145A.131.

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

Subd. 9. **Repealed, 2003**

Subd. 10. **Repealed, 2003**

Subd. 11. **Repealed, 2003**

Subd. 12. **Repealed, 2003**

Subd. 13. **Repealed, 2003**

Subd. 14. **Repealed, 2003**

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

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

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

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

HIST: 1987 c 309 s 2; 1989 c 194 s 2; 1991 c 345 art 2 s 43; 1997 c 199 s 14

145A.03

145A.03 Establishment and organization.

Subdivision 1. Establishment; assignment of responsibilities.

(a) The governing body of a city or county must undertake the responsibilities of a board of health or establish a board of health and assign to it the powers and duties of a board of health.

(b) A city council may ask a county or joint powers board of health to undertake the responsibilities of a board of health for the city's jurisdiction.

(c) A county board or city council within the jurisdiction of a community health board operating under sections 145A.09 to 145A.131 is preempted from forming a board of health except as specified in section 145A.10, subdivision 2.

Subd. 2. **Joint powers board of health.** Except as preempted under section 145A.10, subdivision 2, a county may establish a joint board of health by agreement with one or more contiguous counties, or a city may establish a joint board of health with one or more contiguous

cities in the same county, or a city may establish a joint board of health with the county or counties within which it is located. The agreements must be established according to section 471.59.

Subd. 3. **Withdrawal from joint powers board of health.** A county or city may withdraw from a joint powers board of health by resolution of its governing body not less than one year after the effective date of the initial joint powers agreement. The withdrawing county or city must notify the commissioner and the other parties to the agreement at least one year before the beginning of the calendar year in which withdrawal takes effect.

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

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

Subd. 6. **Duplicate licensing.** A local board of health must work with the commissioner of agriculture to eliminate duplicate licensing and inspection of grocery and convenience stores by no later than March 1, 1992.

HIST: 1987 c 309 s 3; 1991 c 52 s 3

145A.04

145A.04 Powers and duties of board of health.

Subdivision 1. **Jurisdiction; enforcement.** A county or multicounty board of health has the powers and duties of a board of health for all territory within its jurisdiction not under the jurisdiction of a city board of health. Under the general supervision of the commissioner, the board shall enforce laws, regulations, and ordinances pertaining to the powers and duties of a board of health within its jurisdictional area.

Subd. 2. **Appointment of agent.** A board of health must appoint, employ, or contract with a person or persons to act on its behalf. The board shall notify the commissioner of the agent's name, address, and phone number where the agent may be reached between board meetings and submit a copy of the resolution authorizing the agent to act on the board's behalf.

Subd. 3. **Employment; medical consultant.**

(a) A board of health may establish a health department or other administrative agency and may employ persons as necessary to carry out its duties.

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

(c) Employees of the board of health are subject to any personnel administration rules adopted by a city council or county board forming the board of health unless the employees of the board are within the scope of a statewide personnel administration system.

(d) The board of health may appoint, employ, or contract with a medical consultant to receive appropriate medical advice and direction.

Subd. 4. Acquisition of property; request for and acceptance of funds; collection of fees.

(a) A board of health may acquire and hold in the name of the county or city the lands, buildings, and equipment necessary for the purposes of sections 145A.03 to 145A.131. It may do so by any lawful means, including gifts, purchase, lease, or transfer of custodial control.

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

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

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

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

Subd. 6. Investigation; reporting and control of communicable diseases. A board of health shall make investigations and reports and obey instructions on the control of communicable diseases as the commissioner may direct under section 144.12, 145A.06, subdivision 2, or 145A.07. Boards of health must cooperate so far as practicable to act together to prevent and control epidemic diseases.

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

Subd. 8. Removal and abatement of public health nuisances.

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

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

(1) by registered or certified mail;

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

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

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

(d) If the owner, occupant, or agent fails or neglects to comply with the requirement of the notice provided under paragraphs (b) and (c), then the board of health or its agent shall remove or abate the nuisance, source of filth, or cause of sickness described in the notice from the property.

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

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

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

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

HIST: 1987 c 309 s 4

145A.05

145A.05 Local ordinances.

Subdivision 1. **Generally.** A county board may adopt ordinances for all or a part of its jurisdiction to regulate actual or potential threats to the public health under this section and

section 375.51, unless the ordinances are preempted by, in conflict with, or less restrictive than standards in state law or rule.

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

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

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

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

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

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

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

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

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

HIST: 1987 c 309 s 5; 1994 c 636 art 9 s 10; 1995 c 226 art 2 s 1

145A.06

145A.06 Commissioner; powers and duties relative to boards of health.

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

Subd. 2. Supervision of local enforcement.

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

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

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

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

Subd. 3. Repealed, 1989 c 194 s 22

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

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

HIST: 1987 c 309 s 6; 1988 c 689 art 2 s 47

145A.07

145A.07 Delegation of powers and duties.

Subdivision 1. Agreements to perform duties of commissioner.

(a) The commissioner of health may enter into an agreement with any board of health to delegate all or part of the licensing, inspection, reporting, and enforcement duties authorized under sections 144.12; 144.381 to 144.387; 144.411 to 144.417; 144.71 to 144.74; 145A.04, subdivision 6; provisions of chapter 103I pertaining to construction, repair, and abandonment of water wells; chapter 157; and sections 327.14 to 327.28.

(b) Agreements are subject to subdivision 3.

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

Subd. 2. Agreements to perform duties of the board of health. A board of health may authorize a township board, city council, or county board within its jurisdiction to establish a board of health under section 145A.03 and delegate to the board of health by agreement any powers or duties under sections 145A.04, 145A.07, subdivision 2, and 145A.08. An agreement to delegate powers and duties of a board of health must be approved by the commissioner and is subject to subdivision 3.

Subd. 3. Terms of agreements.

(a) Agreements authorized under this section must be in writing and signed by the delegating authority and the designated agent.

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

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

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

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

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

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

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

HIST: 1987 c 309 s 7; 1989 c 209 art 2 s 18; 1990 c 426 art 2 s 1; 1993 c 206 s 12; 1995 c 186 s 43

145A.08

145A.08 Assessment of costs; tax levy authorized.

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

Subd. 2. Assessment of costs of enforcement.

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

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

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

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

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

HIST: 1987 c 309 s 8; 1Sp1989 c 1 art 5 s 6

145A.09

145A.09 Purpose; formation; eligibility; withdrawal.

Subdivision 1. **General purpose.** The purpose of sections 145A.09 to 145A.14 is to develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards.

Subd. 2. **Community health board; eligibility.** A board of health that meets the requirements of sections 145A.09 to 145A.131 is a community health board and is eligible for a local public health grant under section 145A.131.

Subd. 3. **Population requirement.** A board of health must include within its jurisdiction a population of 30,000 or more persons or be composed of three or more contiguous counties to be eligible to form a community health board.

Subd. 4. **Cities.** A city that received a subsidy under section 145A.13 and that meets the requirements of sections 145A.09 to 145A.131 is eligible for a local public health grant under section 145A.131.

Subd. 5. **Human services board.** A county board or a joint powers board of health that establishes a community health board and has or establishes an operational human services board under chapter 402 must assign the powers and duties of a community health board to the human services board.

Subd. 6. **Repealed, 2003**

Subd. 7. **Withdrawal.**

(a) A county or city that has established or joined a community health board may withdraw from the local public health grant program authorized by sections 145A.09 to 145A.131 by resolution of its governing body in accordance with section 145A.03, subdivision 3, and this subdivision.

(b) A county or city may not withdraw from a joint powers community health board during the first two calendar years following that county's or city's initial adoption of the joint powers agreement.

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

(d) The local public health grant for a county that chooses to withdraw from a multicounty community health board shall be reduced by the amount of the local partnership incentive under section 145A.131, subdivision 2, paragraph (c).

HIST: 1987 c 186 s 15; 1987 c 309 s 9,25; 1991 c 345 art 2 s 44

145A.10

145A.10 Powers and duties of community health boards.

Subdivision 1. **General.** A community health board has the powers and duties of a board of health prescribed in sections 145A.03, 145A.04, 145A.07, and 145A.08, as well as the general responsibility for development and maintenance of an integrated system of community health services as prescribed in sections 145A.09 to 145A.131.

Subd. 2. **Preemption.**

(a) Not later than 365 days after the formation of a community health board, any other board of health within the community health service area for which the plan has been prepared must cease operation, except as authorized in a joint powers agreement under section 145A.03, subdivision 2, or delegation agreement under section 145A.07, subdivision 2, or as otherwise allowed by this subdivision.

(b) This subdivision does not preempt or otherwise change the powers and duties of any city or county eligible for a local public health grant under section 145A.09.

(c) This subdivision does not preempt the authority to operate a community health services program of any city of the first or second class operating an existing program of community health services located within a county with a population of 300,000 or more persons until the city council takes action to allow the county to preempt the city's powers and duties.

Subd. 3. Medical consultant. The community health board must appoint, employ, or contract with a medical consultant to ensure appropriate medical advice and direction for the board of health and assist the board and its staff in the coordination of community health services with local medical care and other health services.

Subd. 4. Employees. Persons employed by a county, city, or the state whose functions and duties are assumed by a community health board shall become employees of the board without loss in benefits, salaries, or rights. Failure to comply with this subdivision does not affect eligibility under section 145A.09.

Subd. 5. Repealed, 2003

Subd. 5a. Duties.

(a) Consistent with the guidelines and standards established under section 145A.12, and with input from the community, the community health board shall:

- (1) establish local public health priorities based on an assessment of community health needs and assets; and
- (2) determine the mechanisms by which the community health board will address the local public health priorities established under clause (1) and achieve the statewide outcomes established under sections 145.8821 and 145A.12, subdivisions 7, within the limits of available funding. In determining the mechanisms to address local public health priorities and achieve statewide outcomes, the community health board shall seek public input or consider the recommendations of the community health advisory committee and the following essential public health services:
 - (i) monitor health status to identify community health problems;
 - (ii) diagnose and investigate problems and health hazards in the community;
 - (iii) inform, educate, and empower people about health issues;

- (iv) mobilize community partnerships to identify and solve health problems;
- (v) develop policies and plans that support individual and community health efforts;
- (vi) enforce laws and regulations that protect health and ensure safety;
- (vii) link people to needed personal health care services;
- (viii) ensure a competent public health and personal health care workforce,
- (ix) evaluate effectiveness, accessibility, and quality of personal and population-based health services; and
- (x) research for new insights and innovative solutions to health problems.

(b) By February 1, 2005, and every five years thereafter, each community health board that receives a local public health grant under section 145A.131 shall notify the commissioner in writing of the statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, that the board will address and the local priorities established under paragraph (a) that the board will address.

(c) Each community health board receiving a local public health grant under section 145A.131 must submit an annual report to the commissioner documenting progress toward the achievement of statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, and the local public health priorities established under paragraph (a), using reporting standards and procedures established by the commissioner and in compliance with all applicable federal requirements. If a community health board has identified additional local priorities for use of the local public health grant since the last notification of outcomes and priorities under paragraph (b), the community health board shall notify the commissioner of the additional local public health priorities in the annual report.

Subd. 6. Repealed, 2003

Subd. 7. Equal access to services. The community health board must ensure that community health services are accessible to all persons on the basis of need. No one shall be denied services because of race, color, sex, age, language, religion, nationality, inability to pay, political persuasion, or place of residence.

Subd. 8. Repealed, 2003

Subd. 9. Recommended legislation. The community health board may recommend local ordinances pertaining to community health services to any county board or city council within its jurisdiction and advise the commissioner on matters relating to public health that require assistance from the state, or that may be of more than local interest.

Subd. 10. State and local advisory committees.

(a) A state community health advisory committee is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of community health services. Section 15.059, subdivision 5, applies to this committee. Each community health board may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. Members or their alternates may be reimbursed for travel and other necessary expenses while engaged in their official duties.

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

HIST: 1987 c 309 s 10

145A.11

145A.11 Powers and duties of city and county relative to subsidy.

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

Subd. 2. **Consideration of local public health priorities and statewide outcomes in tax levy.** In levying taxes authorized under section 145A.08, subdivision 3, a city council or county board that has formed or is a member of a community health board must consider the income and expenditures required to meet local public health priorities established under section 145A.10, subdivision 5a, and statewide outcomes established under section 145A.12, subdivision 7.

Subd. 3. **Repealed, 2003**

Subd. 4. **Ordinances relating to community health services.** A city council or county board that has established or is a member of a community health board may by ordinance adopt and enforce minimum standards for services provided according to sections 145A.02 and 145A.10. An ordinance must not conflict with state law or with more stringent standards established either by rule of an agency of state government or by the provisions of the charter or ordinances of any city organized under section 145A.09, subdivision 4.

HIST: 1987 c 309 s 11

145A.12

145A.12 Powers and duties of commissioner relative to subsidy.

Subdivision 1. **Administrative and program support.** The commissioner must assist community health boards in the development, administration, and implementation of community health services. This assistance may consist of but is not limited to:

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

(2) administrative and program guidelines and standards, developed with the advice of the state community health advisory committee.

Subd. 2. **Personnel standards.** In accordance with chapter 14, and in consultation with the state community health advisory committee, the commissioner may adopt rules to set standards for administrative and program personnel to ensure competence in administration and planning.

Subd. 3. **Repealed, 2003**

Subd. 4. **Repealed, 2003**

Subd. 5. **Repealed, 2003**

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

Subd. 7. **Statewide outcomes.**

(a) The commissioner, in consultation with the state community health advisory committee established under section 145A.10, subdivision 10, paragraph (a), shall establish statewide outcomes for local public health grant funds allocated to community health boards between January 1, 2004, and December 31, 2005.

(b) At least one statewide outcome must be established in each of the following public health areas:

- (1) preventing diseases;
- (2) protecting against environmental hazards;
- (3) preventing injuries;
- (4) promoting healthy behavior;
- (5) responding to disasters; and
- (6) ensuring access to health services.

(c) The commissioner shall use Minnesota's public health goals established under section 62J.212 and the essential public health services under section 145A.10, subdivision 5a, as a basis for the development of statewide outcomes.

(d) The statewide maternal and child health outcomes established under section 145.8821 shall be included as statewide outcomes under this section.

(e) By December 31, 2004, and every five years thereafter, the commissioner, in consultation with the state community health advisory committee established under section 145A.10, subdivision 10, paragraph (a), and the maternal and child health advisory task force established under section 145.881, shall develop statewide outcomes for the local public health grant established under section 145A.131, based on state and local assessment data regarding the health of Minnesota residents, the essential public health services under section 145A.10, and current Minnesota public health goals established under section 62J.212.

HIST: 1987 c 309 s 12

145A.13

145A.13 Community health services subsidy.

Subdivision 1. **Subsidy formula.** The commissioner of health shall distribute a subsidy for the operations of community health boards organized and operating under sections 145A.09 to 145A.13.

(a) Each city or county eligible for a subsidy under section 145A.09, subdivision 2, shall receive no less for any calendar year than the total community health services subsidy that was allocated for that city or county by the commissioner of health under this section for calendar year 1985.

(b) Additional money appropriated for the operations of community health boards organized and operating under sections 145A.09 to 145A.13 shall be distributed in proportion to population.

Subd. 2. **Local match.** Each community health board that receives a subsidy shall provide local matching money equal to that subsidy during the year for which the subsidy is made, subject to the following provisions:

(a) the local matching funds may include local tax levies, gifts, fees for services, and revenues from contracts;

(b) when the amount of local matching funds for a community health board is less than the amount specified, the subsidy provided for that community health board under this section shall be reduced proportionally;

(c) when a community health board fails to expend the full amount of the subsidy to which it would be entitled in any one year under the provisions of sections 145A.09 to 145A.13, the state commissioner of health may retain the surplus, subject to disbursement to the community health board in the following calendar year if the community health board can demonstrate a need for and ability to expend the surplus for the purposes provided in section 145A.10; and

(d) a city organized under the provisions of sections 145A.09 to 145A.13 that levies a tax for provision of community health services shall be exempted from any county levy for the same services to the extent of the levy imposed by the city.

Subd. 3. **Payment.** When a community health board meets the requirements prescribed in section 145A.09, subdivision 2, the state commissioner of health shall pay the amount of subsidy to the community health board or its designee according to applicable rules from the money appropriated for the purpose and according to the following:

(a) the commissioner of health shall make payments for community health services to each community health board or its designee in 12 installments a year;

(b) the commissioner shall ensure that the pertinent payment of the allotment for each month is made on the first working day after the end of each month of the calendar year, except for the last month of the calendar year;

(c) the commissioner shall ensure that each community health board or its designee receives its payment of the allotment for that month no later than the last working day of that month. The payment described in this subdivision for services rendered during June, 1985, shall be made on the first working day of July, 1985; and

(d) the commissioner shall make payment to a human services board organized and operating under section 145A.09, subdivision 5, or to its designee, as prescribed in section 402.02, subdivision 4.

Subd. 4. **Expiration.** This section expires January 1, 2004.

HIST: 1976 c 9 s 11; 1977 c 305 s 45; 1983 c 312 art 1 s 19; 1985 c 248 s 70; 1Sp1985 c 9 art 2 s 20; 1987 c 309 s 24,25; 1989 c 209 art 2 s 19

145A.131

145A.131 Local public health grant.

Subdivision 1. Funding formula for community health boards.

(a) Base funding for each community health board eligible for a local public health grant under section 145A.09, subdivision 2, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants, TANF MN ENABL grants, TANF youth risk behavior grants, and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.09, subdivision 2, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty community health boards shall receive a local partnership based of up to \$5000 per year for each county included in the community health board.

(d) The state community health advisory committee may recommend a formula to the commissioner to use in distributing state and federal funds to community health boards organized and operating under sections 145A.09 to 145A.131 to achieve locally identified priorities under section 145A.12, subdivision 7, by July 1, 2004, for use in distributing funds to community health boards beginning January 1, 2006, and thereafter.

Subd. 2. Local match.

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

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

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

(d) A city organized under the provision of sections 145A.09 to 145A.131 that levies a tax for provision of community health services is exempt from any county levy for the same services to the extent of the levy imposed by the city.

Subd. 3. Accountability.

(a) Community health boards accepting local public health grants must document progress toward the statewide outcomes established in section 145A.12, subdivision 7, to maintain eligibility to receive the local public health grant.

(b) In determining whether or not the community health board is documenting progress toward statewide outcomes, the commissioner shall consider the following factors:

- (1) whether the community health board has documented progress to meeting essential local activities related to the statewide outcomes, as specified in the grant agreement;
- (2) the effort put forth by the community health board toward the selected statewide outcomes;
- (3) whether the community health board has previously failed to document progress toward selected statewide outcomes under this section;
- (4) the amount of funding received by the community health board to address the statewide outcomes; and

(5) other factors as the commissioner may require, if the commissioner specifically identifies the additional factors in the commissioner's written notice of determination.

(c) If the commissioner determines that a community health board has not by the applicable deadline documented progress toward the selected statewide outcomes established under section 145.8821 or 145A.12, subdivision 7, the commissioner shall notify the community health board in writing and recommend specific actions that the community health board should take over the following 12 months to maintain eligibility for the local public health grant.

(d) During the 12 months following the written notification, the commissioner shall provide administrative and program support to assist the community health board in taking the actions recommended in the written notification.

(e) If the community health board has not taken the specific actions recommended by the commissioner within 12 months following written notification, the commissioner may determine not to distribute funds to the community health board under section 145A.12, subdivision 2, for the next fiscal year.

(f) If the commissioner determines not to distribute funds for the next fiscal year, the commissioner must give the community health board written notice of this determination and allow the community health board to appeal the determination in writing.

(g) If the commissioner determines not to distribute funds for the next fiscal year to a community health board that has not documented progress toward the statewide outcomes and not taken the actions recommended by the commissioner, the commissioner may retain local public health grant funds that the community health board would have otherwise received and directly carry out essential local activities to meet the statewide outcomes, or contract with other units of government or community-based organizations to carry out essential local activities related to the statewide outcomes.

(h) If the community health board that does not document progress toward the statewide outcomes is a city, the commissioner shall distribute the local public health funds that would have been allocated to that city to the county in which the city is located, if that county is part of a community health board.

(i) The commissioner shall establish a reporting system by which community health boards will document their progress toward statewide outcomes. This system will be developed in consultation with the state community health services advisory committee established in section 145A.10, subdivision 10, paragraph (a), and the maternal and the child health advisory committee established in section 145.881.

Subd. 4. Responsibility of commissioner to ensure a statewide public health system. If a county withdraws from a community health board and operates as a board of health or if a community health board elects not to accept the local public health grant, the commissioner may retain the amount of funding that would have been allocated to the community health board using the formula described in subdivision 1 and assume responsibility for public health activities to meet the statewide outcomes in the geographic area served by the board of health or

community health board. The commissioner may elect to directly provide public health activities to meet the statewide outcomes or contract with other units of government or with community-based organizations. If a city that is currently a community health board withdraws from a community health board or elects not to accept the local public health grant, the local public health grant funds that would have been allocated to that city shall be distributed to the county in which the city is located, if the county is part of a community health board.

Subd. 5. **Local public health priorities.** Community health boards may use their local public health grant to address local public health priorities identified under section 145A.10, subdivision 5a.

145A.14

145A.14 Special grants.

Subdivision 1. Migrant health grants

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

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

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

Subd. 2. Indian health grants.

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

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

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

Subd. 2a. Tribal governments.

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

- (1) maternal and child health activities under section 145.882, subdivision 7;
- (2) activities to reduce health disparities under section 145.928, subdivision 10; and
- (3) emergency preparedness.

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

HIST: 1Sp1985 c 14 art 19 s 24; 1987 c 309 s 13,19,25; 1989 c 120 s

145A.15

145A.15 Home visiting program.

Subdivision 1. **Establishment.** The commissioner of health shall expand the current grant program to fund additional projects designed to prevent child abuse and neglect and reduce juvenile delinquency by promoting positive parenting, resiliency in children, and a healthy beginning for children by providing early intervention services for families in need. Grant dollars shall be available to train paraprofessionals to provide in-home intervention services and to allow public health nurses to do case management of services. The grant program shall provide early intervention services for families in need and will include:

- (1) expansion of current public health nurse and family aide home visiting programs and public health home visiting projects which prevent child abuse and neglect, prevent juvenile delinquency, and build resiliency in children;
- (2) early intervention to promote a healthy and nurturing beginning;
- (3) distribution of educational and public information programs and materials in hospital maternity divisions, well-baby clinics, obstetrical clinics, and community clinics; and
- (4) training of home visitors in skills necessary for comprehensive home visiting which promotes a healthy and nurturing beginning for the child.

Subd. 2. **Grant recipients.** The commissioner is authorized to award grants to programs that meet the requirements of subdivision 3 and include a strong child abuse and neglect prevention focus for families in need of services. Priority will be given to families considered to be in need of additional services. These families include, but are not limited to, families with:

- (1) adolescent parents;
- (2) a history of alcohol and other drug abuse;
- (3) a history of child abuse, domestic abuse, or other types of violence in the family of origin;
- (4) a history of domestic abuse, rape, or other forms of victimization;

- (5) reduced cognitive functioning;
- (6) a lack of knowledge of child growth and development stages;
- (7) low resiliency to adversities and environmental stresses; or
- (8) lack of sufficient financial resources to meet their needs.

Subd. 3. Program requirements.

(a) The commissioner shall award grants, using a request for proposal system, to programs designed to:

- (1) contact families at the birth of the child through a public health nurse or trained program representative who will meet the family, provide information, describe the benefits of the program, and offer a home visit to the family to occur during the first weeks of the newborn's life in the home setting;
- (2) visit the family and newborn in the home setting at which time the public health nurse or trained individual will answer parents' questions, give information, including information on breast feeding, and make referrals to any other appropriate services.
- (3) conduct a screening process to determine if families need additional support or are at risk for child abuse and neglect and provide additional home visiting services needed by the families including, but not limited to, education on: parenting skills, child development and stages of growth, communication skills, stress management, problem-solving skills, positive child discipline practices, methods to improve parent-child interactions and enhance self-esteem, community support services and other resources, and how to enjoy and have fun with your children;
- (4) establish clear objectives and protocols for the home visits;
- (5) determine the frequency and duration of home visits based on a risk-need assessment of the client; except that home visits may begin as early as the first trimester of pregnancy and continue based on the need of the client until the child reaches age six;
- (6) refer and actively assist the family in accessing new parent and family education, self-help and support services available in the community;
- (7) develop and distribute educational resource materials and offer presentations on the prevention of child abuse and neglect for use in hospital maternity divisions, well-baby clinics, obstetrical clinics, and community clinics; and
- (8) coordinate with other local home visitation programs, particularly those offered by school boards under section 121.882, subdivision 2b, so as to avoid duplication.

(b) Programs must provide at least 40 hours of training for public health nurses, family aides, and other home visitors. Training must include information on the following:

- (1) the dynamics of child abuse and neglect, domestic and nondomestic violence, and victimization within family systems;
- (2) signs of abuse or other indications that a child may be at risk of abuse or neglect;
- (3) what is child abuse and neglect
- (4) how to properly report cases of child abuse and neglect
- (5) sensitivity and respect for diverse cultural practices in child rearing and family systems, including but not limited to complex family relationships, safety, appropriate services, family preservation, family finances for self-sufficiency, and other special needs or circumstances;
- (6) community resources, social service agencies, and family support activities or programs;
- (7) healthy child development and growth;
- (8) parenting skills;
- (9) positive child discipline practices;
- (10) identification of stress factors and stress reduction techniques;
- (11) home visiting techniques;
- (12) needs assessment measures; and
- (13) caring for the special needs of newborns and mothers before and after the birth of the infant.

Program services must be community-based, accessible, and culturally relevant and must be designed to foster collaboration among existing agencies and community-based organizations.

Subd. 4. **Evaluation.** Each program that receives a grant under this section must include a plan for program evaluation designed to measure the effectiveness of the program in preventing child abuse and neglect. On January 1, 1994, and annually thereafter, the commissioner of health shall submit a report to the legislature on all activities initiated in the prior biennium under this section. The report shall include information on the outcomes reported by all programs that received grant funds under this section in that biennium.

HIST: 1992 c 571 art 10 s 9; 1995 c 207 art 9 s 37

145A.16

145A.16 Universally offered home visiting programs for infant care.

Subdivision 1. **Establishment.** The commissioner shall establish a grant program to fund universally offered home visiting programs designed to serve all live births in designated geographic areas. The commissioner shall designate the geographic area to be served by each program. At least one program must provide home visiting services to families within the seven-county metropolitan area, and at least one program must provide home visiting services to families outside the metropolitan area. The purpose of the program is to strengthen families and to promote positive parenting and healthy child development.

Subd. 2. **Steering committee.** The commissioner shall establish an ad hoc steering committee to develop and implement a comprehensive plan for the universally offered home visiting programs. The members of the ad hoc steering committee shall include, at a minimum, representatives of local public health departments, public health nurses, other health care providers, paraprofessionals, community-based family workers, representatives of the state councils of color, representatives of health insurance plans, and other individuals with expertise in the field of home visiting, early childhood health and development, and child abuse prevention.

Subd. 3. **Program requirements.** The commissioner shall award grants using a request for proposal system. Existing home visiting programs or a family services collaborative established under section 256F.13 may apply for the grants. Health information and assessment, counseling, social support, educational services, and referral to community resources must be offered to all families, regardless of need or risk, beginning prenatally or as soon after birth as possible, and continuing as needed. Each program applying for a grant must have access to adequate community resources to complement the home visiting services and must be designed to:

- (1) identify all newborn infants within the geographic area served by the program. Identification may be made prenatally or at the time of birth;
- (2) offer a home visit by a trained home visitor. The offer of a home visit must be made in a way that guarantees that the existence of the pregnancy is not revealed to any other individual without the written consent of the pregnant female. If home visiting is accepted, the first visit must occur prenatally or as soon after birth as possible and must include a public health nursing assessment by a public health nurse;
- (3) offer, at a minimum, information on infant care, child growth and development, positive parenting, the prevention of disease and exposure to environmental hazards, and support services available in the community;
- (4) provide information on and referral to health care services, if needed, including information on health care coverage for which the individual or family may be eligible and information on family planning, pediatric preventive services, immunizations, and developmental assessments, and information on the availability of public assistance programs as appropriate;

(5) recruit home visit workers who will represent, to the extent possible, all the races, cultures, and languages spoken by eligible families in the designated geographic areas; and

(6) train and supervise home visitors in accordance with the requirements established under subdivision 5.

Subd. 4. **Coordination.** To minimize duplication, a program receiving a grant must establish a coalition that includes parents, health care providers who provide services to families with young children in the service area, and representatives of local schools, governmental and nonprofit agencies, community-based organizations, health insurance plans, and local hospitals. A program may use a family services collaborative as the coalition if a collaborative is established in the area served by the program. The coalition must designate the roles of all provider agencies, family identification methods, referral mechanisms, and payment responsibilities appropriate for the existing systems in the program's service area. The coalition must also coordinate with other programs offered by school boards under section 121.882, subdivision 2b, and programs offered under section 145A.15.

Subd. 5. **Training.** The commissioner shall establish training requirements for home visitors and minimum requirements for supervision by a public health nurse. The requirements for nurses must be consistent with chapter 148. Training must include child development, positive parenting techniques, and diverse cultural practices in child rearing and family systems. A program may use grant money to train home visitors.

Subd. 6. **Evaluation.**

(a) The commissioner shall evaluate the effectiveness of the home visiting programs, taking into consideration the following goals:

- (1) appropriate child growth, development, and access to health care;
- (2) appropriate utilization of preventive health care and medical care for acute illnesses;
- (3) lower rates of substantiated child abuse and neglect;
- (4) up-to-date immunizations;
- (5) a reduction in unintended pregnancies;
- (6) increasing families' understanding of lead poisoning prevention;
- (7) lower rates of unintentional injuries; and
- (8) fewer hospitalizations and emergency room visits.

(b) The commissioner shall compare overall outcomes of universally offered home visiting programs with targeted home visiting programs and report the findings to the legislature. The

report must also include information on how home visiting programs will coordinate activities and preventive services provided by health plans and other organizations.

(c) The commissioner shall report to the legislature by February 15, 1998, on the comprehensive plan for the universally offered home visiting programs and recommend any draft legislation needed to implement the plan. The commissioner shall report to the legislature biennially beginning December 15, 2001, on the effectiveness of the universally offered home visiting programs. In the report due December 15, 2001, the commissioner shall include recommendations on the feasibility and cost of expanding the program statewide.

Subd. 7. **Technical assistance.** The commissioner shall provide administrative and technical assistance to each program, including assistance conducting short- and long-term evaluations of the home visiting program required under subdivision 6. The commissioner may request research and evaluation support from the University of Minnesota.

Subd. 8. **Matching funds.** The commissioner and the grant programs shall seek to supplement any state funding with private and other nonstate funding sources, including other grants and insurance coverage for services provided. Program funding may be used only to supplement, not to replace, existing funds being used for home visiting.

Subd. 9. **Payment for home visiting services.** Any health plan that provides services to families or individuals enrolled in medical assistance, general assistance medical care, or the MinnesotaCare program must contract with the programs receiving grants under this section and the programs established under section 145A.15 that are providing home visiting services in the area served by the health plan to provide home visiting services covered under medical assistance, general assistance medical care, or the MinnesotaCare program to their enrollees. A health plan may require a home visiting program to comply with the health plan's requirements on the same basis as the health plan's other participating providers.

HIST: 1997 c 203 art 2 s 16

Rules Relating to the Local Public Health Act

CHAPTER 4736 DEPARTMENT OF HEALTH LOCAL PUBLIC HEALTH ACT

4736.0100 INDIAN HEALTH GRANTS.

Subpart 1. **General.** A community health board that applies for an Indian health grant under Minnesota Statutes, section 145A.14, subdivision 2, must follow the procedures in this part.

Subp. 2. **Definition.** For purposes of an Indian health grant, "reside off reservation" means Indian persons not residing on Indian land who are members of an organized tribe, band, or other group of aboriginal people of the United States, having a treaty relationship with the federal government and who are regarded as Indians by the group in which they claim membership.

Subp. 3. **Requirements for applying for Indian health grant.** The community health plan required in parts 4736.0030 to 4736.0080 must:

A. Specifically address parts 4736.0030, subpart 2, and 4736.0040, subpart 2, as they relate to the Indian community affected by the community health plan.

B. Specifically address parts 4736.0030, subpart 4, item A, and 4736.0040, subpart 4, item A, as they relate to the Indian health grant part of the community health plan.

Subp. 4. **Forms and instructions.** Reports must be completed according to forms and instructions provided by the commissioner and contained in the contract requirements of the grant. Indian health grants must be reported as a special project grant for purposes of part 4736.0090.

STAT AUTH: MS 145A.12
HIST: 18 SR 2044

4736.0110 PERSONNEL STANDARDS.

Subpart 1. **Purpose of standards.** This part establishes minimum standards for training, experience, and skill for the community health services administrator under Minnesota Statutes, sections 145A.09 to 145A.13. This part does not apply to employees of community health boards with a personnel system approved by the United States Civil Service Commission.

Subp. 2. **Persons who must meet standards.** A community health board must have a community health services administrator. Persons who are appointed as community health services administrators after March 21, 1994, must meet the minimum training and experience standards of this part.

Subp. 3. **Minimum training and experience standards for community health services administrators.** A community health services administrator must have:

A. a baccalaureate or higher degree in administration, public health, community health, environmental health, or nursing, and two years of documented public health experience in an administrative or supervisory capacity, or be registered as an environmental health specialist or sanitarian in the state of Minnesota and have two years of documented public health experience in an administrative or supervisory capacity;

B. a master's or higher degree in administration, public health, community health, environmental health, or nursing, and one year of documented public health experience in an administrative or supervisory capacity; or

C. a baccalaureate or higher degree and four years of documented public health experience in an administrative or supervisory capacity.

Subp. 4. **Community health services administrator skills.** The documented experience of a community health services administrator must include skills necessary to:

A. direct and implement health programs;

B. prepare and manage budgets;

C. manage a planning process to identify, coordinate, and deliver necessary services;

D. prepare necessary reports;

E. evaluate programs for efficiency and effectiveness;

F. coordinate the delivery of community health services with other public and private services; and

G. advise and assist the community health board in the selection, direction, and motivation of personnel.

Subp. 5. **Additional personnel standards.** Persons implementing or supervising community health services programs by agreement with the commissioner shall meet the personnel standards required in those agreements.

STAT AUTH: MS 145A.12

HIST: 18 SR 2044

ACCOUNTABILITY REVIEW PROCESS

Background

The Accountability Review Process outlines the steps that will be taken to support the 2003 Local Public Health Act, MS 145A.131, subdivision 3, which states that “community health boards accepting local public health grants must document progress toward the statewide outcomes... to maintain eligibility to receive the local public health grant.” The Local Public Health Act gives the commissioner of health authority to withhold funds when “progress” is not occurring and provides a broad outline of an accountability review process.

Through a SCHSAC Work Group, a more refined framework for the accountability review process was developed. The intent of the accountability review process is to improve the quality of local public health and is one interconnected component of Minnesota’s local public health quality improvement system.

Guiding Principles of the Accountability Review Process

The focus of the accountability review process is to strengthen Minnesota’s public health system. To that end, the following guiding principles have been established. The accountability review process should:

1. Provide a positive opportunity to strengthen Minnesota’s public health infrastructure.
2. Be consistent, but also retain flexibility to evolve as the public health needs of Minnesotans change and evolve.
3. Promote continuous quality improvement.
4. Be aware of the possibility that some local public health departments might fail to meet the standards.
5. Include an element of rehabilitation.
6. Not weaken the strong state and local partnership for public health.

Framework for the Accountability Review Process

The accountability review process was developed to incorporate components of the local public health quality improvement system and the guiding principles. Also considered were the legislative concepts of documenting *progress* and *effort put forth*. The result is three levels of progressive review, in addition to a probation period and an appeals mechanism. Technical assistance from the Minnesota Department of Health is an integral part of the accountability review process.



3: Board of Health Responsibilities

Board of Health Responsibilities

Summary of Powers and Duties contained in Minnesota Statute 145A.03–145A.10

A BOARD OF HEALTH must:

1. Enforce laws, regulations and ordinances pertaining to its powers and duties within its jurisdictional area.
2. Make investigations and reports and obey the instructions of the state commissioner to control communicable diseases.
3. Order the removal or abatement of a public health nuisance, and if the nuisance is not abated, **must** have the nuisance abated or removed at the expense of the property owner (see the Public Health Nuisance Control Guidelines, January 1992).
4. Have at least five members, **must** elect a chair and vice-chair, and **must** hold meetings at least twice a year.
5. **Must** not deny services because of inability to pay.
6. **Must** not refuse or neglect to perform a duty on penalty of a misdemeanor.

A BOARD OF HEALTH may:

1. Enter into agreements: a) with the state commissioner to perform certain licensing, inspection, reporting, and enforcement duties; and b) to authorize townships, cities, or counties within its jurisdiction to establish a Board of Health and **may** then delegate certain powers and duties to the newly-formed Board of Health. Such delegations must be approved by the state commissioner of health.
2. Form a Board of Health through joint powers agreements, and **may** withdraw from the agreement with proper notice.
3. Establish a health department, employ persons as necessary, and appoint, employ, or contract with a medical consultant to receive appropriate medical advice and direction.
4. Acquire property, accept gifts and grants or subsidies, and establish and collect reasonable fees. However, access to services provided by the Board of Health **must not** be denied because of inability to pay.
5. Contract to provide, receive, or ensure provision of services.
6. Enter a building, conveyance, or place where a cause of preventable disease is reasonably expected to exist in order to enforce public health laws, ordinances or rules.
7. Seek an injunction to enjoining the violation of statute, rule or ordinance.

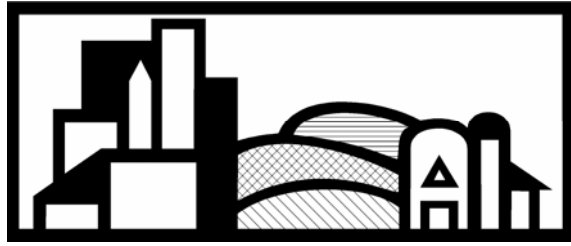
A COMMUNITY HEALTH BOARD has all the powers and duties of a Board of Health, and in addition must:

1. Assess community health needs and assets; establish local public health priorities; determine the mechanisms by which the community health board will address the local public health priorities and statewide outcomes within the limits of available funding; seek public input or consider the recommendations of the community health services advisory committee and the ten essential public health services on the mechanisms to address local priorities and statewide outcomes.
2. Appoint, employ, or contract with a medical consultant.
3. Meet personnel requirements established for the CHS Administrator and the Medical Consultant.
4. Ensure the community health services are accessible to all persons on the basis of need.
5. Notify the commissioner in writing every five years of the statewide outcomes and local priorities that the board will address.
6. Provide the commissioner with annual information necessary to evaluate progress toward selected statewide outcomes and to meet federal reporting requirements.
7. Submit an annual report documenting progress toward the achievement of statewide outcomes and local priorities.
8. Consider the income and expenditures required to meet local public health priorities and statewide outcomes in levying taxes.

A COMMUNITY HEALTH BOARD may:

1. Appoint a Community Health Advisory Committee.
2. Recommend local ordinances to a county board or city council.
3. Appoint a member to the State Community Health Services Advisory Committee.
4. Use local public health grant monies to address local public health priorities.

Last updated September 2003



4: SCHSAC Operating Procedures

SCHSAC OPERATING PROCEDURES

The State Community Health Services Advisory Committee is established in Minnesota Statutes 145A.10, to *advise, consult with, and to make recommendations to the commissioner of health on matters relating to the development, maintenance, funding and evaluation of community health services and to serve as a forum for the exchange of views and information between state and local public health officials.*

The general functions of the Advisory Committee are:

1. To promote and support the development and maintenance of an integrated system of community health services.
2. To identify policies and issues for state and local governments to address jointly.
3. To identify, analyze and develop recommendations for the improvement of the community health services system.
4. To provide a public forum for discussions among the commissioner of health, staff and community health boards on community health services.
5. To make recommendations to the commissioner of health concerning the appropriate and equitable administration of the Local Public Health Act (Minn. Stat. 145A.01-.14) and its supporting rules.
6. To share information and resources among community health boards.

I. MEMBERSHIP, APPOINTMENTS, RESPONSIBILITIES

A. Membership

1. Each community health board may appoint a member to serve on the Committee for a one-year term, which will begin on January 1. Members may serve for an unlimited number of terms.
2. Each community health board represented on the Advisory Committee may appoint one alternate member, whose term coincides with the term of the member. Alternate members may vote and receive reimbursement only when the primary member is absent.
3. Each community health board must send written notification to the commissioner of health and the chair of the Advisory Committee of all appointments.

B. Terminations, Resignations, Vacancies

1. A community health board will be notified by the chair of the Advisory Committee if it is not represented by a member or alternate for three consecutive regular meetings of the Advisory Committee.
2. Members and alternates should communicate in writing their intention to resign to the appointing community health board, the commissioner of health, and the chair of the

Advisory Committee. The community health board may appoint a person to serve for the remaining portion of the term.

C. Orientation

An orientation will be provided on a regular basis for newly appointed Advisory Committee members and their alternates and others who wish to participate. Staff will develop the orientation program with the assistance of the Executive Committee.

D. Responsibilities of Advisory Committee Members

Members and alternates are expected:

1. To attend Advisory Committee and other assigned meetings.
2. To serve on work groups, subcommittees and review groups as requested by the chair.
3. To prepare for active participation in discussion and decision-making by consulting with their Community health boards and CHS staff, and by reviewing meeting materials.
4. To act as the liaison between the community health board and the Advisory Committee.
5. To inform the community health board and alternate member on Advisory Committee activities and actions.

E. Staff Support

1. The commissioner of health will make available staff, space, and other resources as appropriate and available to support the work of the Advisory Committee. To the degree feasible, the commissioner of health will attend Advisory Committee meetings or send a representative from the Executive Office.
2. Staff support for the Advisory Committee will be provided by the director of the Division of Community Health Services, subject to the approval of the commissioner of health.

II. OFFICERS

A. Chair

The duties of the chair are:

1. To preside at all Advisory and Executive Committee meetings.
2. To be the principal spokesperson and representative of the Advisory Committee and to represent the Advisory Committee as necessary.

3. To appoint subcommittees, work groups, and review groups as needed to carry out the Advisory Committee work plan and to consult with staff to assure that support will be available as needed.

B. Chair-elect

The duties of the chair-elect are:

1. To preside at Advisory and Executive Committee meetings in the absence of the chair.
2. To assist the chair and staff as requested.

C. Past Chair

The duties of the past chair are:

1. To advise the chair and serve as a resource to the Committee.
2. To serve as a member of the Executive Committee.
3. The past chair may attend and receive reimbursement for SCHSAC meetings, but may not vote if not also serving as a representative from his/her community health board.

III. ELECTIONS

A. Eligibility for Offices

Persons who are current Advisory Committee members may be nominated for an office if they have served at least one year on the Advisory Committee.

B. Nominating Procedures

Procedures for the nomination of officers consist of the following:

1. A subcommittee on Nominations and Awards will be appointed no later than June 1 of each year to develop or ratify criteria for selection of nominees and to supervise the nomination process.
2. Nominations will be requested from the Advisory Committee at least 30 days prior to the selection of nominees.
3. The Nominating and Awards Subcommittee will review proposed nominees for Advisory Committee offices to determine eligibility.
4. The Nominating and Awards Subcommittee will review all nominations and applications submitted with relevant biographical material and related qualifications and select two nominees as candidates for the position. A list of all nominations for the position of chair-elect will be forwarded to the Committee.

5. The Nominating and Awards Subcommittee will report its final selection of nominees for offices no less than 15 calendar days prior to the meeting at which voting will occur and will supervise the election of officers during that meeting.

C. Election Procedures

1. The chair-elect will be elected by the membership attending the last regular Advisory Committee meeting of the year.
2. Prior to voting, an opportunity will be provided for nominations from the floor.
3. All candidates will be given up to five minutes before the election to present themselves to the Committee.
4. Election will be by a simple majority of those present and voting. In case of a tie, the winner will be decided by the toss of a coin.

D. Terms of Office

1. The terms of office of the chair and chair-elect are one year; from January 1 to December 31.
2. The chair of the Advisory Committee will assume office following the completion of his or her term as the chair-elect.

IV. MEETINGS AND REIMBURSEMENT

This section applies to meetings of the Advisory Committee, Executive Committee, subcommittees, work groups, and review groups unless otherwise noted.

A. Frequency

The Advisory Committee will meet as requested by the chair as frequently as necessary and at least quarterly, as specified in Minnesota Statutes 145A.10.

B. Cancellations

Meetings of the Advisory Committee may be canceled and rescheduled by the Executive Committee or by the commissioner of health in consultation with the chair.

C. Per Diem

In conformance with Minn. Stat. 145A.10, Advisory Committee members may receive per diem expenses from their community health board as provided for in their CHS Plans or local administrative procedures.

D. Expenses

1. The Minnesota Department of Health will reimburse Advisory Committee members for travel and other necessary expenses while engaged in their official duties.
2. Alternate members may receive reimbursement when attending in place of a member.

E. Quorum

1. The **presence of twenty-six** Advisory Committee members or their alternates constitutes a quorum.
2. The **presence of six members** of the Executive Committee constitutes a quorum.

F. Public Meetings

All Committee, subcommittee, and work group meetings are open to the public.

V. GENERAL PROCEDURES

A. Order of Business

1. The Executive Committee will approve an agenda prior to each Advisory Committee meeting.
2. The business of the Advisory Committee will be conducted in the following order:
 - a. call to order and introductions;
 - b. review and approval of agenda;
 - c. approval of minutes of the previous meeting;
 - d. chair's remarks;
 - e. remarks of the commissioner of health and staff;
 - f. reports of the Executive Committee, subcommittees, work groups, and review groups;
 - g. other reports;
 - h. other business; and
 - i. adjournment.

Advisory Committee agendas may deviate from the above format at the request of the Commissioner of health in consultation with the chair and approval of the Committee.

B. Conduct of Business

1. Agendas will be prepared for all meetings of the Advisory and Executive Committees, subcommittees, work groups, and review groups and distributed to Committee members and alternates, subcommittee members, work group members, and review group members at least one week prior to each meeting.

2. All proceedings are governed by Robert's Rules of Order, newly revised, except as specified in these operating procedures.
3. Advisory Committee operating procedures may be suspended for a stated purpose during a single meeting by a two-thirds vote of those present and voting.
4. Voting on any matter will be by voice vote. A roll call vote will be recorded on any issue when requested by one or more of those present and voting. Upon request of any member or alternate, the recorder will repeat the motion and the name of the maker and seconder of the motion immediately preceding a vote. There will be no voting by proxy, and each member is entitled to only one vote on any issue. The chair is a voting member of the Advisory and Executive Committee.
5. Minutes will be kept of all meetings of the Advisory Committee, Executive Committee, subcommittees, work groups, and review groups and will be submitted for approval at the subsequent meeting. Summary minutes of all Advisory Committee meetings will be prepared and forwarded to the commissioner of health and Committee members in advance of the meeting.

C. Annual Report and Proposed Work Plan

The Advisory Committee will prepare and present to the commissioner of health prior to the first meeting of the calendar year a brief annual report of activities, projects, concerns, and suggestions for future involvement. A proposed work plan for the upcoming year will also be included in the report.

D. Communication

Advisory Committee members must refrain from writing letters or engaging in other kinds of communication in the name of the Advisory Committee, unless such communication has been specifically authorized by the chair, Executive Committee, or full Committee.

VI. COMMITTEES, WORK GROUPS, AND REVIEW GROUPS

A. Executive Committee

1. An Executive Committee will be responsible for conducting the interim business of the Advisory Committee and developing recommendations for decision by the State CHS Advisory Committee. As part of its duties, the Executive Committee will host an annual meeting with MDH staff and various organizations (including, but not limited to, the Association of Minnesota Counties (AMC), Local Public Health Association (LPHA), Metropolitan Inter-County Association (MICA) to discuss upcoming legislative topics. The Executive Committee will serve as an ongoing forum for providing updates on legislative issues.

2. The Executive Committee will be appointed by the chair using the following method:
 - a. The chair and vice-chair of the Executive Committee will be, respectively, the chair and chair-elect of the Advisory Committee.
 - b. One member of the Advisory Committee from each of eight districts defined by the Department of Health will be elected to the Executive Committee by members from that district. Each district will also elect an alternate to the Executive Committee who will serve and vote in the district representative's absence. A map of these districts is attached and made a part of these Operating Procedures. Elections for the Executive Committee representative and alternate will take place at the last meeting of the year. During the meeting, time will be set aside for members in each of the eight MDH districts to caucus and then to decide by written ballot their choice for Executive Committee representative and Executive Committee alternate. Each community health board represented on the Advisory Committee and whose member is present at the meeting will have one vote for its representative or alternate on the Executive Committee.
 - c. Only members or alternate members of the Advisory Committee may serve on the Executive Committee. Alternates who are serving as members when the Executive Committee district representatives are selected may vote to select a representative from their districts.
 - d. The chair from the previous year will serve as a voting member.
 - e. A member who misses more than two meetings without prior notice to the chair and a satisfactory justification will be replaced by a new member selected by the chair, subject to approval at the next Advisory Committee meeting by the members from the affected district.
 - f. If an Executive Committee member cannot serve the full one-year term, election of a new member will proceed, using the method described in Section VI.A.2.(b).

B. Subcommittees

1. Subcommittees created by the Advisory Committee should be composed of not more than fifteen members or alternates of the Advisory Committee.
2. Subcommittees must be appointed by the State CHS Advisory Committee chair, subject to Executive Committee approval, and must be given a specified charge and period of time to fulfill that charge.
3. The composition of subcommittees should, to the extent practical, reflect the overall composition of the Advisory Committee.
4. The chair, vice-chair (if needed), and members of a subcommittee will be appointed by the Advisory Committee chair, subject to Executive Committee approval. Chairs are encouraged to consult *Tips for Work Group Chairs* (attached) in thinking about ways to facilitate participation by guests.
5. Alternates are not permitted for subcommittees. Persons other than members may attend meetings; these individuals may participate in discussions as invited by the subcommittee chair.

6. Subcommittees will bring all recommendations to the Advisory Committee for approval or action but may report to the Executive Committee when necessary due to time constraints.

C. Work Groups

1. The chair may, subject to Advisory Committee approval, establish work groups to assist the Advisory Committee or staff. Work groups may consist of not more than fifteen members.
2. The chair, vice-chair (if needed) and members of work groups will be appointed by the Advisory Committee chair, subject to Executive Committee approval. Chairs are encouraged to consult *Tips for Work Group Chairs* (attached) in thinking about ways to facilitate participation by guests.
3. The members of work groups will serve for specified terms consistent with the work group's charge.
4. Persons who are not Advisory Committee members or alternates may be appointed to work groups as necessary to fulfill a specialized or technical charge.
5. Alternates are not permitted for work groups. Persons other than members may attend meetings; these individuals may participate in discussions as invited by the work group chair.
6. Work groups will report to the Advisory Committee at regular intervals and may report to the Executive Committee when necessary due to time constraints.

D. Review Groups

1. The chair may establish, subject to Executive Committee approval, short-term (one to three meetings) review groups to assist the Advisory Committee and staff. The purpose of a review group is to offer advice to the Commissioner on technical issues related to CHS that do not have major policy implications.
2. The chair, vice-chair (if needed), and members of review groups will be appointed by the Advisory Committee chair, subject to Executive Committee approval.
3. Persons who are not Advisory Committee members or alternates may be appointed to review groups. Chairs are encouraged to consult *Tips for Work Group Chairs* (attached) in thinking about ways to facilitate participation by guests.
4. Alternates are not permitted for review groups. Persons other than members may attend meetings; these individuals may participate in discussions as invited by the review group chair.
5. Review groups will present a final report and recommendations to the Advisory Committee or Executive Committee for approval at completion of its charge.

E. Other

Other methods, such as forming short-term informal groups or appointing members to other task forces within MDH or other state agencies, may be utilized at discretion of the Chair and commissioner of health when necessary to accomplish the work plan of the Advisory Committee.

VII. ANNUAL CHS AWARDS AND CERTIFICATES OF RECOGNITION

An annual Jim Parker Leadership Award, an annual Commissioner's Award for Distinguished Service in CHS, an annual award for Outstanding Dedication to Local Public Health, and an annual Jack Korlath Partnership Award will be given to individuals or groups who meet the criteria described below. A CHS Certificate of Recognition may also be awarded to an individual or group. The procedure for selection of the recipients of the awards will consist of the following:

1. The Nominating and Awards Subcommittee will supervise the nomination process and select candidates for the CHS awards. Subcommittee members will not be eligible as candidates or award recipients during the year in which they serve.
2. Criteria for selection of nominees will be approved by the Advisory Committee based on the recommendation of the Nominating and Awards Subcommittee.
3. A letter and a form specifying the nomination procedures and selection criteria will be sent to all State Advisory Committee members, chairs of community health boards, CHS administrators, and Public Health Nursing directors at least 60 days before the Annual Community Health Conference.
4. The Nominating and Awards Subcommittee will review all nominations and select award recipients according to the criteria for selection specified in the letter requesting nominations.
5. The commissioner of health will present the Jim Parker Leadership Award, the Commissioner's Award for Distinguished Service in CHS, Award for Outstanding Dedication to Local Public Health, and the Certificates of Recognition at the Annual Community Health Conference.

A. Jim Parker Leadership Award

An annual Jim Parker Leadership Award will be given to an individual or group who has demonstrated leadership, originality, and innovation in community health services, and has made a significant statewide contribution to CHS in Minnesota. The following principles and procedures will be observed in making this award:

1. Eligibility for the award is restricted to members of the State CHS Advisory Committee or their alternates, local CHS staff, members of local advisory committees, elected officials, and volunteers.

2. The recipient of the Jim Parker Leadership Award will have demonstrated leadership in community health services by:
 - a. demonstrating originality and innovation in CHS;
 - b. developing creative solutions to public health problems;
 - c. promoting collaboration and cooperation between individuals, organizations, and agencies;
 - d. shaping public health policy and practices with decision-making bodies; and
 - e. contributing to effective planning and administration of CHS.

B. Commissioner's Award for Distinguished Service in CHS

An annual Commissioner's Award for Distinguished Service in CHS will be given to an individual or group who has demonstrated long-term, outstanding involvement in and commitment to CHS, and will have contributed to the advancement of the public health field.

1. Eligibility for the Commissioner's Award is restricted to members of the State Community Health Services Advisory Committee or their alternates, local CHS staff, members of local advisory committees, elected officials, volunteers, and past state public health staff (currently employed state staff are not eligible).
2. The recipient of the Commissioner's Award for Distinguished Service in CHS will have demonstrated long-term commitment to public health through:
 - a. long-term involvement in public health;
 - b. advocacy and being a proponent for public health;
 - c. distinguished service to CHS;
 - d. evidence of statewide effect on public health policy; and
 - e. contributions to advancement in the public health field.

C. Award for Outstanding Dedication to Local Public Health

An annual award for Outstanding Dedication to Local Public Health will be given to an individual who has made a significant contribution to promoting and implementing local public health in Minnesota.

The following principles will be observed in making this award:

1. Eligibility for the award is restricted to a person who is one of the following: a local elected official, a former or retired elected official, or an appointed representative to a community health board or local board of health. Personnel paid by a community health board or local public health agency are not eligible for this award.
2. The recipient of this award will have demonstrated outstanding dedication to public health in one or more of the following:
 - a. provide ongoing support to local public health activities;
 - b. serve as a champion for a strong local public health system;
 - c. show significant leadership and advocacy for policies that strengthen local public health;
 - d. promote a strong government public health system through:
 - i. helping to develop or support laws and ordinances which effectively protect and promote the health of the public;

- ii. supporting funding for state and local public health activities;
- iii. advocating for individuals, families, and communities at high risk for public health problems;
- iv. promoting community support for public health at the local level; and
- v. showing leadership in statewide committees, task forces, etc., which address public health.

D. Jack Korlath Partnership Award

An annual Jack Korlath Partnership Award will be given to an individual or group who has demonstrated a commitment to developing and maintaining close collaborative relationships between state and local public health agencies in Minnesota. The following principles and procedures will be observed in making this award:

1. Eligibility for the award is restricted to state and local public health staff.
2. The recipient of the Jack Korlath Partnership Award will have demonstrated leadership through:
 - a. long term involvement in public health;
 - b. advocacy for the value of the state and local partnership in strengthening Minnesota's public health system;
 - c. focusing on implementing effective public health programs;
 - d. support from both state and local public health staff; and
 - e. gaining professional respect for considering differing opinions and approaches to an issue or problems.

E. CHS Certificates of Recognition

The Nominating and Awards Subcommittee may also select up to three individuals and/or committees, task forces, or other local groups to receive "CHS Certificates of Recognition."

F. Certificate of Appreciation to Outgoing SCHSAC Members and Alternates

All SCHSAC members and alternates who serve terms on the State CHS Advisory Committee should receive a Certificate of Appreciation from the commissioner of health. The commissioner will present the Certificate of Appreciation to members after being notified that they no longer serve on the committee.

VIII. AMENDMENTS

Amendments of these Operating Procedures may be made only after notification of the Advisory Committee at least thirty (30) days in advance of a regularly scheduled meeting. Amendment requires a vote of two-thirds of the members present. Suspension of rules or operating procedures does not constitute amendment.

Tips for SCHSAC Work Group Chairs

Background

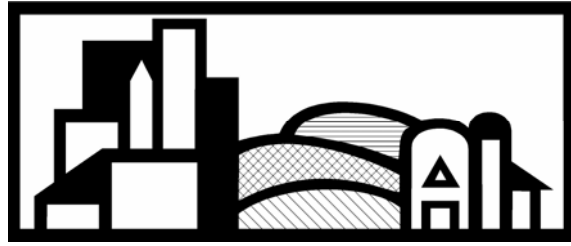
Work and review group members are appointed by the Executive Committee based on their expertise and interest, and to ensure representation from all geographic areas of the state. Work groups sometimes have MDH staff and other appropriate organizational representatives as members (e.g., Conference Planning, Partnership, and Collaboration Work Groups). In addition, work groups often invite experts on the subject to participate in work group discussions. Work groups frequently address controversial and complex issues.

Each work group chair determines how they would like to manage the group's discussion. In doing so, they must balance the need to hear from all members with the value of getting input from guests, resource persons, and MDH staff (all SCHSAC and work group meetings are open to the public). SCHSAC work group chairs have often made efforts to be inclusive of guests by inviting them to sit at the table and participate in the work group discussions. At times this has caused confusion regarding the role of members versus guests.

The following suggestions may be helpful in allowing members to fully share their expertise and opinions while respectfully considering the opinions and expertise of guests.

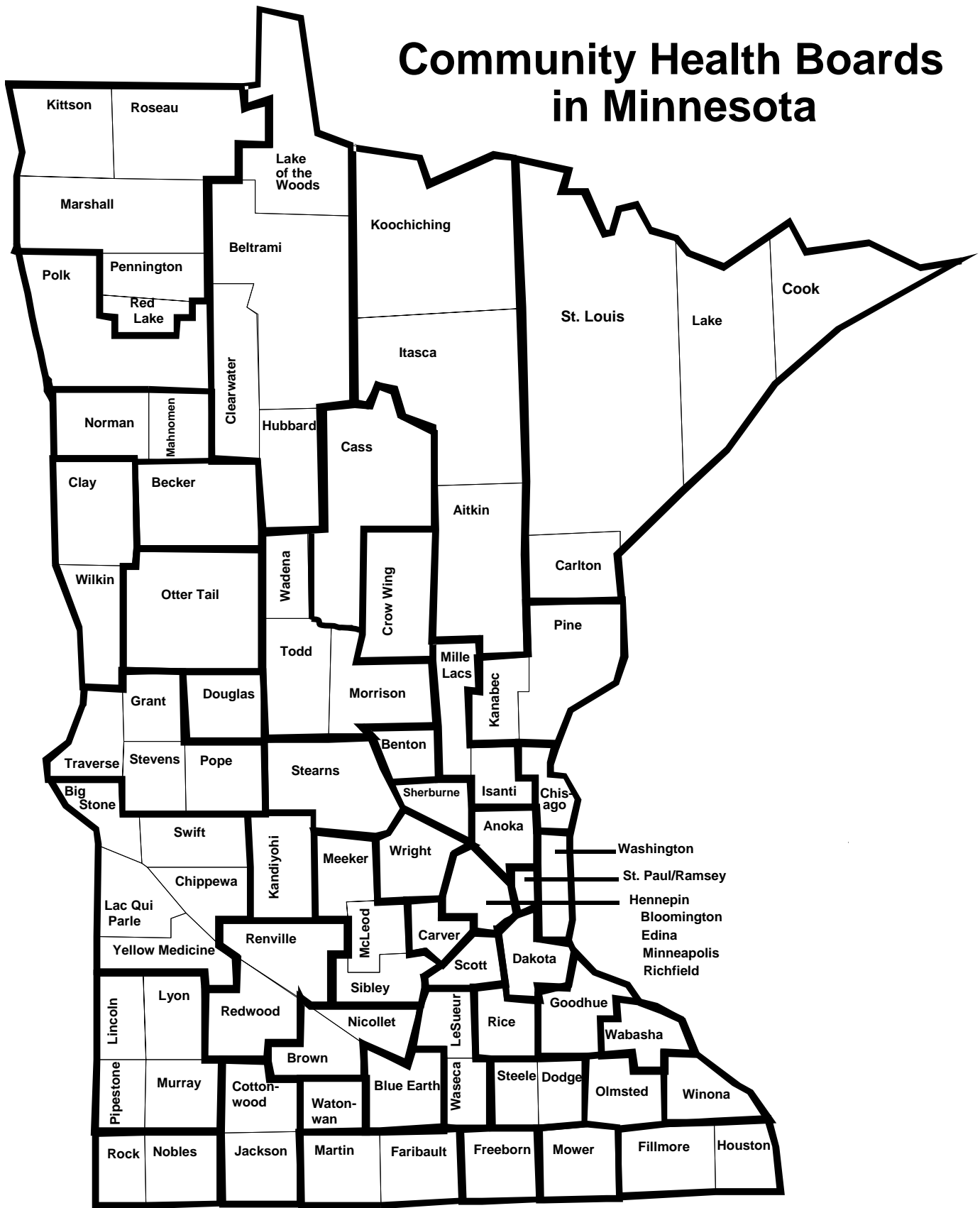
Tips for Work Group Chairs

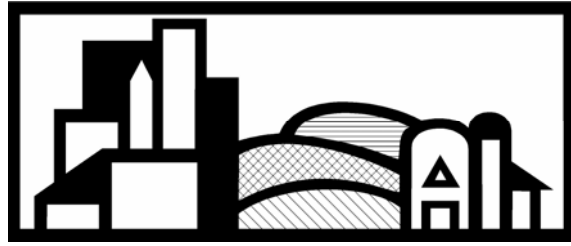
- Work group chairs should determine “norms” for how they intend to manage the group at the beginning of the work group process.
- When developing these norms, work group chairs should consider:
 - How will the group most effectively accomplish its charge?
 - What structure will best allow for information to be provided to and discussed by members?
 - In what way will guests' input be solicited?
 - What structure will allow guests the opportunity to share information and opinions while still allowing for full work group discussion?
- Possible work group norms include:
 - All of those attending may sit at the table as room permits (priority to work group members and staff) OR
 - Only work group members and staff should sit at the table.
 - All attendees may participate freely in the discussion OR
 - Guests should wait until the chair solicits their comments.
- These group norms for members and guests should be made clear (as ground rules) at the beginning of the work group process.
- The chair should discuss with the work group staff what role the staff should play in the work group (both participation and group management).
- During the work group meetings, the chair should determine if any deviations from the norms are needed and explicitly share these with staff and members.
- Operating Procedures of the SCHSAC will be followed (e.g., only members are allowed to vote, a quorum must be present, etc.).



5: Directories & Maps

Community Health Boards in Minnesota





**6: Resources
at the Minnesota
Department of Health**



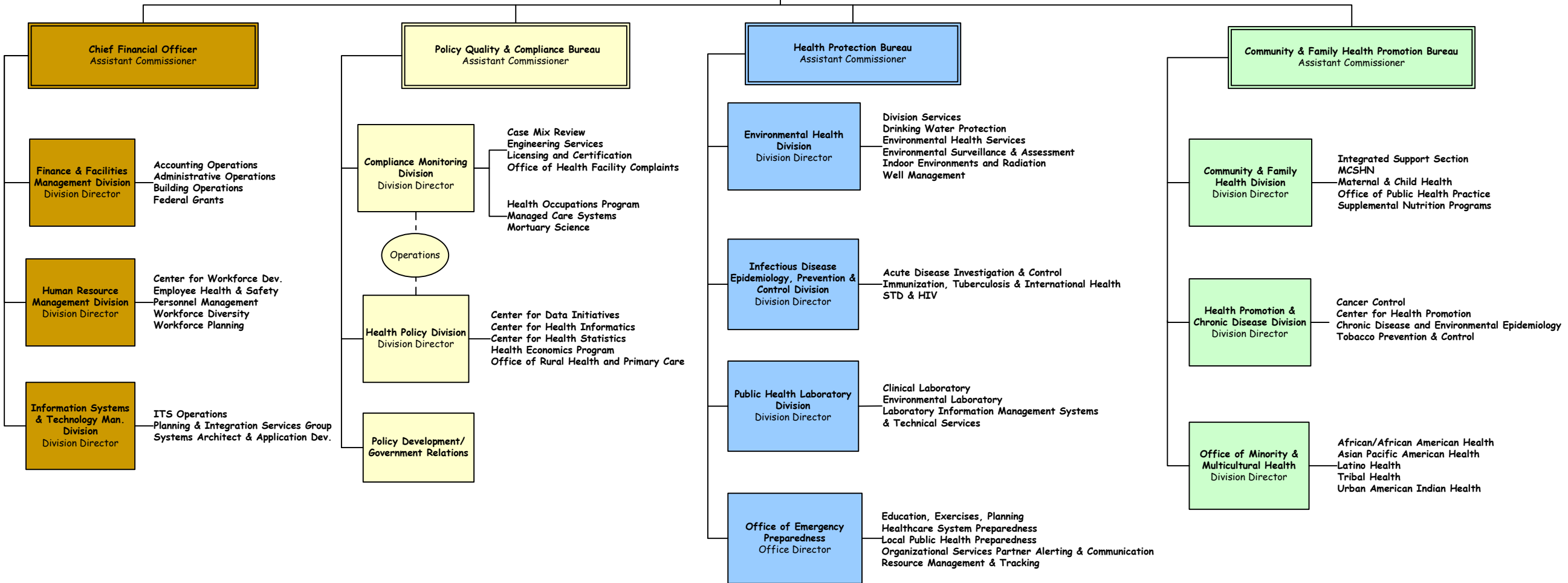
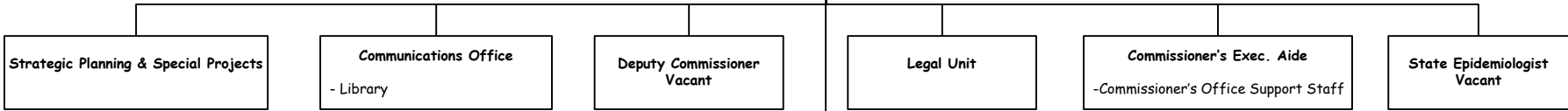
Location:
625 Robert St N
St. Paul, MN 55155-2538
Mailing Address:
Post Office Box 64975
St. Paul, MN 55164-0975
Information:
651.201.5000

www.health.state.mn.us

GOVERNOR
Tim Pawlenty

COMMISSIONER
Dianne Mandernach

Click in the dashed boxes to view more detail.



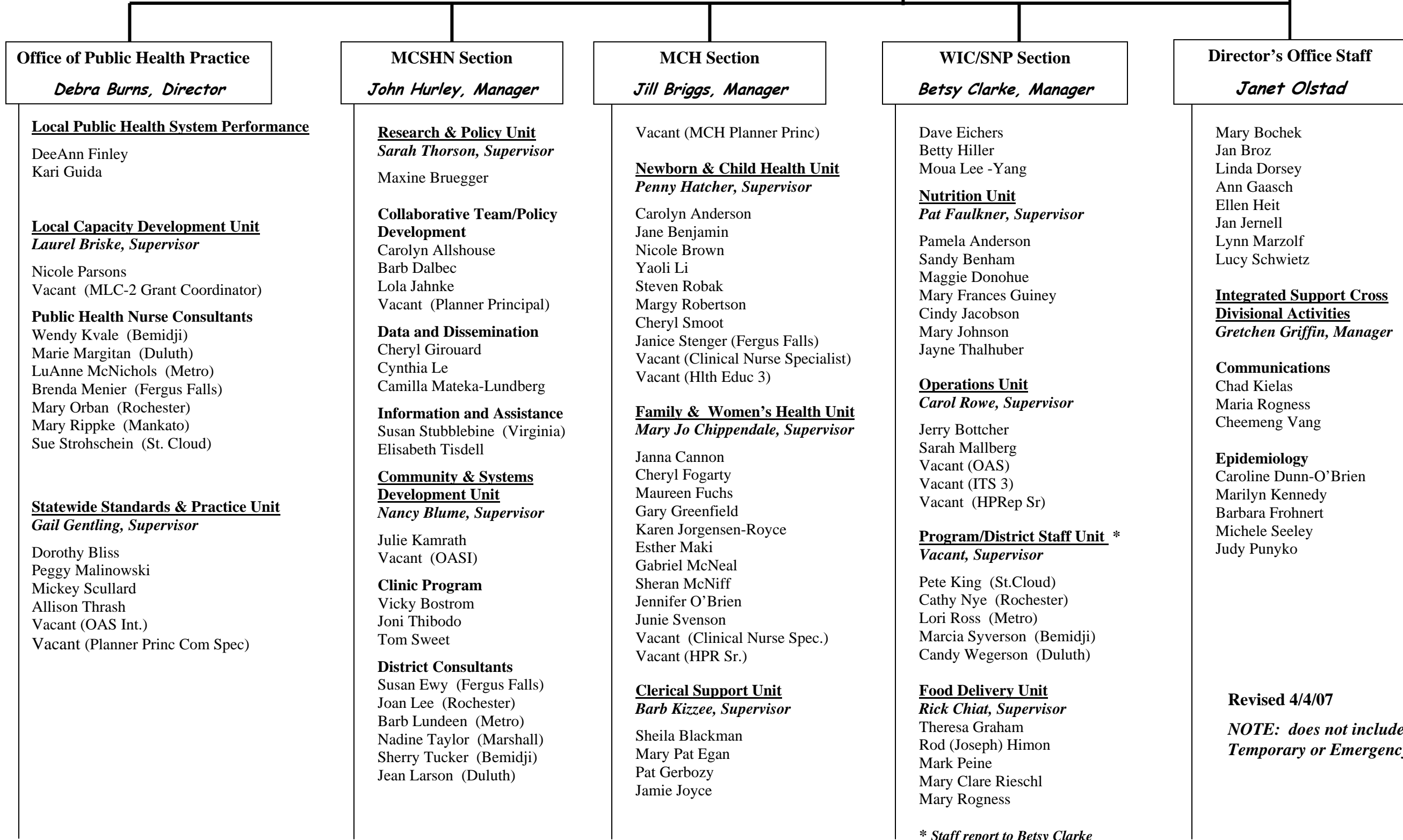
DIVISION OF COMMUNITY & FAMILY HEALTH



Community & Family Health Promotion Bureau
Carol Woolverton, Assistant Commissioner

Maggie Diebel
Director

Janet Olstad
Assistant Director



Additional Resources

Available through the Minnesota Department of Health

SCHSAC and SCHSAC Reports

Information about the State CHS Advisory Committee is available online through the MDH website. These pages include the current SCHSAC chair, work group reports, meeting agendas, meeting minutes, and more.

<http://www.health.state.mn.us/divs/cfh/ophp/system/schsac/index.html>

Community Health Conference

Come to the annual Community Health Conference and learn even more about public health! Find dates and registration information here.

<http://www.health.state.mn.us/divs/cfh/ophp/system/conference/index.html>

Local Public Health Trailhead

The purpose of this website is to help local public health professionals and local elected officials quickly and easily find the information they need on the Minnesota Department of Health (MDH) website.

<http://www.health.state.mn.us/trailhead/>

Local Public Health Departments

Find all of Minnesota's local public health departments here, with links to local websites.

<http://www.health.state.mn.us/divs/cfh/ophp/system/administration/counties.html>

MDH Home Page

A vast array of information is available through the MDH home page, including the latest news releases, emergency preparedness information, legislative updates, methamphetamine, and much more.

<http://www.health.state.mn.us/>

RN Barr Library at MDH

The MDH library has an extensive collection of public health books, journals, and videos, and provides lending, reference, interlibrary loan, and other services to Minnesota's public health and school health professionals.

<http://www.health.state.mn.us/library/index.html>

Newsletters and other communications

The CH Commentary

The *CH Commentary* newsletter highlights the activities and accomplishments of local public health agencies in Minnesota; shares information on current events, opportunities and resources relevant to local government officials and local public health professionals; and provides updates on MDH programs, policies and activities.

<http://www.health.state.mn.us/divs/cfh/ophp/resources/commentary/index.html>

The CHS Mailbag and Calendar

The *CHS Mailbag* is a regular email that includes information of interest to local public health, including grant opportunities, legislative updates, information on new resources, open positions, links to other MDH bulletins and newsletters, a listing of Distance Learning Opportunities and more. The *CHS Calendar* includes information on upcoming events, trainings and meetings important to local public health in Minnesota.

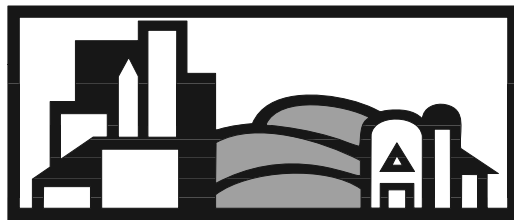
<http://www.health.state.mn.us/divs/cfh/ophp/resources/mailbag/index.html>





7: SCHSAC Annual Report and Work Plan

State Community Health Services Advisory Committee



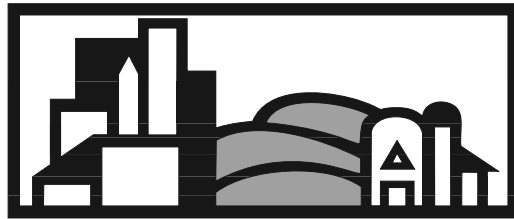
FINAL

2006 Annual Report and 2007 Work Plan

Community and Family Health Division
Office of Public Health Practice
Statewide Standards and Practice Unit



State Community Health Services Advisory Committee



2006 Annual Report and 2007 Work Plan

Office of Public Health Practice
Community and Family Health Division
Golden Rule Building
85 East 7th Place
P.O. Box 64882
Saint Paul, MN 55164-0882

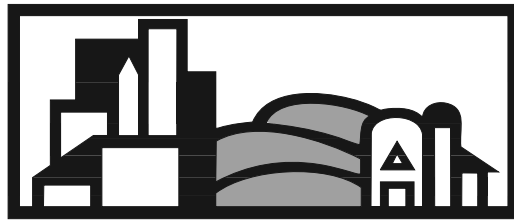
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TDD/TTY: 651-201-5797

State Community Health Services Advisory Committee 2006 Annual Report and 2007 Work Plan

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State Community Health Services Advisory Committee



STATE AND LOCAL PARTNERS
Keeping Minnesotans Healthy

2006 Annual Report

State Community Health Services Advisory Committee

2006 Annual Report

What is SCHSAC?

In 1976, the Minnesota Legislature created the State Community Health Services Advisory Committee (SCHSAC) as one component of the Community Health Services (CHS) Act. The CHS Act (later renamed the Local Public Health Act) began a unique partnership between the Minnesota Department of Health (MDH) and local government public health agencies. This partnership has since developed into an effective tool for protecting and improving the health of all Minnesotans.

The purpose of the SCHSAC, as described in the Local Public Health Act, is:

To advise, consult with, and make recommendations to the commissioner of health on matters relating to the development, funding, and evaluation of community health services in Minnesota.

The SCHSAC has 53 voting members, representing the 53 Community Health Boards in the state. Of the 53 boards, 28 are single county boards, four are city boards, and 21 are multi-county boards. Each Community Health Board selects one person to represent their board on the SCHSAC.

Each year, the SCHSAC prepares a report, the SCHSAC Annual Report and Work Plan, to highlight its accomplishments and present a plan for the next year's activities.

The SCHSAC has developed a shared vision statement (see box) for Minnesota's public health system, grounded in the mission that guides the current activities of the state and local public health departments. The vision was developed by a SCHSAC strategic planning work group of state and local public health partners and was approved by the SCHSAC and the Commissioner of Health in 2003.

The vision for the public health system in Minnesota is of a strong and dynamic partnership of governments fully equipped to address the changing needs of the public's health.

Overview of 2006 SCHSAC Work

In 2006, over 130 people participated in nine SCHSAC work groups and review groups. Much of the work once again centered on the 2003 legislative changes to the Local Public Health Act, but it also included efforts to update the *Healthy Minnesotans: Public Health Improvement Goals for 2010* and to address issues related to the strategic direction and federal funding of emergency preparedness. In addition, SCHSAC representatives participated in a number of public health-related committees.

The Executive Committee, the Community Health Conference Planning Work Group, and the Nominating and Awards Subcommittee successfully completed their charges, enabling SCHSAC to function efficiently.

SCHSAC members discussed several public health-related topics this year, including food-borne illness surveillance, counties' readiness to meet the needs of returning soldiers, and worksite wellness. Members also toured the new MDH space and laboratory in the Orville Freeman Building.

2006 SCHSAC Work Groups

Accountability Review Process

Charge

- Review Minnesota Statute 145A.131 Subdivision 3. (Accountability) and make recommendations to operationalize the provisions of the law that allow the Commissioner to withhold Local Public Health Act funding under certain circumstances.

Summary of Activities

During 2006, the Accountability Review Process work group used the *Guiding Principles*, agreed upon in 2005, to steer their work. Many issues related to accountability and the accountability review process were addressed by the Work Group including funding and accountability; roles of state and local entities; reporting levels; enhanced technical assistance; and monitoring. The Work Group developed an accountability review process with three levels in addition to a probation period and an appeals mechanism. These recommendations address issues of purpose, structure and implementation of the accountability review process.

Membership

Gary Sorenson, Chair, Cottonwood-Jackson CHB
Ann Bajari, Meeker-McLeod-Sibley CHB
Bonnie Engen, Clearwater County Nursing Service
Robert Fulton, St. Paul-Ramsey CHB
Vonna Henry, Sherburn County CHB
Mary Ho, Rice County CHB
Julie Myhre, Carlton-Cook-Lake-St. Louis CHB
Kathy Paulsen, Carver County CHB
Randy Rehnstrand, Aitkin-Itasca-Koochiching CHB
Rhonda Sivarajah, Anoka County CHB
Betty Windom-Kirsch, Stevens-Traverse-Grant CHB

MDH Representatives

Carol Woolverton, Assistant Commissioner, Community and Family Health Promotion Bureau
Jan Jernell, Community and Family Health Division

MDH Staff to the Work Group

Debra Burns, Office of Public Health Practice
Kari Guida, Office of Public Health Practice
Marie Margitan, Office of Public Health Practice

Local Public Health Planning and Performance Measurement Reporting System (PPMRS)

Charge

- Oversee and facilitate the development of the LPH PPMRS
- Make recommendations to address key questions related to the development of the LPH PPMRS during 2006
- Assign work to subgroups as needed
- Develop mechanisms to get local input on key issues

Summary of Activities

In March 2006, local public health departments in Minnesota submitted reports on the new performance measures, including statistical, staffing and financial information. This first reporting cycle piloted the new measures and will be used to identify any needed changes to the measures. The data were reviewed by the Work Group and revisions were made in every area of public health responsibility. Two areas of responsibility: (1) Promote Healthy Communities and Healthy Behaviors, and (2) Prevent Environmental Health Hazards needed major revisions in the measures. The Work Group made several future-oriented recommendations that focused on the technical development of the LPH PPMRS, standardizing performance measures and language, and further revisions to the performance measures. Additionally, the Work Group suggested determining the utility of collecting information on policy and legislative accomplishments, determining how local public health departments would report on environmental health activities and expenditures, and discussing ways to document unmet local public health needs using the LPH PPMRS.

Membership

Sue Hedlund, Chair, Washington County CHB
Ann Bajari, Meeker-McLeod-Sibley CHB
Kristin Eggerling, Kittson-Marshall-Pennington-Red Lake-Roseau CHB
Kathy Minkler, Isanti-Mille Lacs CHB
Julie Myhre, Carlton-Cook-Lake-St. Louis CHB
Jane Norbin, St. Paul-Ramsey County CHB
Karen Nelson, Morrison-Todd-Wadena CHB
Linda Norland/Liz Auch, Countryside CHB
Cathy Sandmann, Blue Earth County CHB
Sharon Serfling, Fillmore-Houston CHB
Lila Taft, Dakota County CHB
Karen Zeleznak, City of Bloomington CHB

MDH Representatives

John Clare, Infectious Disease Epidemiology, Prevention and Control Division
Mary Manning/Mary Winnet, Health Promotion and Chronic Disease Division
Jennifer Miller, Environmental Health Division
Janet Olstad, Community and Family Health Division
Steve Ring, Information Systems and Technology Management

MDH Staff to the Work Group

Kristin Raab, Office of Public Health Practice
Kari Guida, Office of Public Health Practice
Gail Gentling, Office of Public Health Practice

Ad Hoc Work Groups

Funding Formulas

Charge

- Review the funding formula for the community health boards' portion of the CDC public health preparedness funds (possibly including one-time CDC pandemic influenza funding) and recommend any necessary changes.

Summary of Activities

The Funding Formula Work Group met twice and recommended that base funding for the CDC public health preparedness grants to local public health agencies remain level at \$18,356 per county/city or a per capita, whichever is higher. The grant awards to community health boards were reduced due to the reduction in the amount of federal monies Minnesota was awarded. The work group also recommended that funding for Phase II Pandemic Flu Supplemental funding be distributed 70% to local public health agencies and tribes, and 30% to MDH, with each county/city receiving a base of \$7,500 plus a per capita amount. The final recommendation of the Work Group was to convene a SCHSAC committee to plan Minnesota's strategic direction and shared local-state public health preparedness priorities for the future.

Membership

Nancy Schouweiler, Chair, Dakota CHB
Nita Aasen, Brown-Nicollet CHB
Pat Adams, Dakota County CHB
John Baerg, Watonwan CHB
Allain Hankey, Hennepin County CHB
Del Hurt, Carver County CHB
Lowell Johnson, Washington County CHB
Ed Larsen, Crow Wing County CHB
Marina McManus, Anoka County CHB
Gretchen Musicant, City of Minneapolis CHB
Julie Myhre, Carlton-Cook-Lake-St. Louis CHB
Jane Norbin, St. Paul-Ramsey County CHB
Janice Rettman, St. Paul-Ramsey County CHB
Ann Stehn, Kandiyohi County CHB
Diane Thorson, Otter Tail County CHB
Mary Wellik, Olmsted County CHB
Karen Zeleznak, City of Bloomington CHB

MDH Representatives

Pat Bloomgren, Infectious Disease Epidemiology, Prevention and Control Division
Debra Burns, Community and Family Health Division
Laurel Briske, Community and Family Health Division
Norm Crouch, Public Health Laboratory Division
Buddy Ferguson, Communications Office
Carol Heimsoth, Community and Family Health Division
Aggie Leitheiser, Office of Emergency Preparedness
John Stine, Environmental Health Division

MDH Staff to the Work Group

Dee Finley, Office of Public Health Practice
Laurel Briske, Office of Public Health Practice

Public Health Preparedness

Charge

- Clarify the activities, outcomes, and reporting mechanism for the local Community Health Board public health preparedness grant project agreement so that local grantees and MDH are successful in meeting the benchmarks established by the Centers for Disease Control and Prevention (CDC).

Summary of Activities

The Public Health Preparedness Review Group met twice. They recommended that while the 2006-2007 local public health preparedness grant duties are similar to those of previous years, they should be broadened to reflect the diversity of planning needs throughout the state and because the grant duties are only one part of emergency preparedness planning. The group recommended the following: (1) The duties should continue to be based on the essential local public health activities specific to emergency preparedness; (2) The reporting requirements for the local duties should be based on three measures: grant accountability, CDC performance measures, and local public health emergency preparedness measures.

Membership

Pete Giesen, Chair, Olmsted County CHB
John Baerg, Watonwan County CHB
David Benson, Nobles-Rock CHB
Marilyn Cluka, Carlton, Cook, Lake, St. Louis CHB
Mary Jo Fritz, Hennepin County CHB
Anita Hoffmann, Brown-Nicollet CHB
Debra Jacobs, Wilkin County CHB
RaeAnn Mayer, North Country CHB
Kathy Nowak, Meeker-McLeod-Sibley CHB
Jeff Peterson, Winona County CHB
Brenda Pohlman, Fillmore-Houston CHB
Carol Schefers, Wright County CHB
Carolyn Schmidt, Carver County CHB
Gary Sorenson, Cottonwood-Jackson CHB
Lynn Theurer, Winona County CHB

MDH Staff to the Work Group

DeeAnn Finley, Office of Public Health Practice
Laurel Briske, Office of Public Health Practice
Ralph Morris, Office of Public Health Practice

SCHSAC Review Group

Public Health Goals Update Review Group

Charge

- Develop a framework for the update and reorganization of the *Healthy Minnesotans: Public Health Improvement Goals*.
- Identify additional issues and/or indicators that should be included in the update of the goals.

Summary of Activities

The Public Health Goals Update Review Group met twice during 2006 in order to produce an update on the *Healthy Minnesotans Public Health Goals* that follows or works logically with the new *areas of public health responsibility* and *essential local public health activities*. The updated goals also needed to reflect local public health priorities; be brief and to the point, and have links to detailed and in-depth information. The review group made two recommendations: ((1) Create six statewide public health goals to correspond to the six areas of public health responsibility, and (2) Assign two or three “sentinel” indicators for each of the six goals. The review group felt that a small number of indicators would most readily engage a statewide audience in the goals’ progress. The group identified criteria for selecting the sentinel indicators, and also suggested reporting on the status of the sentinel indicators annually, possibly using the Planning and Performance Measurement Reporting System (PPMRS).

Membership

Ed Larsen, Chair, Crow Wing County CHB
Carol Berg, Minnesota Council of Health Plans
Jesse Bethke Gomez, Comunidades Latinas Unidas en Servicio (CLUES)
Bonnie Brueshoff, Dakota County CHB
Jill Bruns, Redwood-Renville CHB
Vinodh Kutty, Hennepin County/Office of Multicultural Services
Cheri Lewer, Le Sueur-Waseca CHB
Gloria Lewis, Big Brothers/Big Sisters of the Greater Twin Cities
Jan Malcolm, Minnesota Public Health Association
Julie Myhre, Carlton-Cook-Lake-St. Louis CHB
Gretchen Musicant, Minneapolis Department of Health and Family Support
Debra K. Olson, University of Minnesota, School of Public Health
Dick Ragan, St. Paul-Ramsey County CHB
Deb Smith, Fond du Lac Reservation
Mary Wellik, Olmsted County CHB
Carol Woolverton, Assistant Commissioner, Minnesota Department of Health

MDH Staff to the Review Group

Dorothy Bliss, Office of Public Health Practice
Lee Kingsbury, Office of Public Health Practice

Standing Committees

Executive Committee

Charge

- Develop the annual work plan for the SCHSAC.
- Conduct interim business of the advisory committee and develop recommendations for decision by the SCHSAC.
- Provide input to the Commissioner of Health upon request.

Summary of Activities

The major work of the SCHSAC Executive Committee included:

- Providing orientation for new SCHSAC members.
- Conducting interim business to ensure smooth operations.
- Initiating a successful statewide videoconference on pandemic influenza. Over 340 local elected officials, mayors and school officials participated at 41 sites.

Membership

Beverly Wangerin, Chair, Meeker-McLeod-Sibley CHB

John Baerg, Watonwan County CHB

David Benson, Nobles-Rock CHB

Ben Brunsvold, Clay-Wilkin CHB

Bette Friederichs, Chisago County CHB

Jim Ische, Carver County CHB

Bill Montague, Polk County CHB

Ted Seifert, Goodhue County CHB

Gary Sorenson, Cottonwood-Jackson CHB

Peg Sweeney, Carlton-Cook-Lake-St. Louis CHB

Marcia Ward, Winona County CHB

MDH Staff to the Committee

Mickey Scullard, Office of Public Health Practice

Community Health Conference Planning Work Group

Charge

- Select a theme, objectives, format, and speakers for the 2006 Community Health Conference and assist MDH staff in hosting the conference.

Summary of Activities

This Work Group organized the program and speakers for the Minnesota Department of Health 2006 Community Health Conference: *Navigating an Era of Change: Working Together, Making Connections* held September 27-29, 2006 at Cragun's Resort and Conference Center in Brainerd, Minnesota. Nearly 380 people from across the state attended the conference.

Conference goals focused on helping participants learn how to maintain energy, passion and focus during times of stress and transition; discover how to build relationships that result in successful outcomes; find new ways to connect with partners in the community to accomplish common goals; examine trends for the future of health, economics and demographics in Minnesota; and renew participants' commitment and revitalize their enthusiasm for the state-local public health partnership in Minnesota.

The conference featured keynote speaker Tony Moore, who spoke on *Charting a Course Through Turbulent Times*; a panel discussing *The Healthiest State in the Nation...But What About Tomorrow*; an address by Commissioner Dianne Mandernach of MDH; plenary address by Gloria Lewis, on *And the Circle Goes Round and Round*; and a closing presentation by Kevin Lee Smith, *The Art and Science of Humor: Are you Joking?* Nearly 20 concurrent sessions focused on topics that included public health informatics, correctional health, preconception care, pandemic influenza, eliminating health disparities and several environmental health concerns, and many more.

The community health awards and reception celebrated some of Minnesota's outstanding public health programs and leaders. The award recipients are listed in the Nominating and Awards Subcommittee report.

Membership

Marcia Ward, Chair, Winona County CHB
David Benson, Nobles County CHB
Sharon Braaten, Grant-Pope-Stevens-Traverse CHB
Linda Bruemmer, Environmental Health, MDH
Jill Bruns, Redwood-Renville CHB
John Clare, Infectious Disease Epidemiology, Prevention and Control, MDH
Jennifer Deschaine, Scott County CHB
Rob Fulton, St. Paul-Ramsey County CHB
Anita Hoffman, Brown-Nicollet CHB
Jan Jernell, Community and Family Health, MDH
Janice Jones, Compliance Monitoring, MDH
Helene Kahlstorf, North Country CHB
Ann Kinney, Minnesota Center for Health Statistics, MDH
Pamela LeMaster, Infectious Disease Epidemiology, Prevention and Control, MDH
Julie Myhre, Carlton-Cook-Lake-St. Louis County CHB
Myrlah Olson, Office of Emergency Preparedness, MDH
Denton Peterson, Information Systems and Technology, MDH
DeeAnn Pettyjohn, Dodge-Steele CHB
Cheryl Schneider, Todd County CHB

Sharon T. Smith, Office of Minority and Multicultural Health, MDH
Christina Thill, Health Promotion Chronic Disease, MDH
Bev Wangerin, McLeod County CHB

MDH Staff to the Work Group

Peggy Malinowski, Office of Public Health Practice
Allison Thrash, Office of Public Health Practice

Nominating and Awards Subcommittee

Charge

- Review the awards process and recommend to the Executive Committee modifications, as necessary, to fulfill the intent of the awards.
- Solicit and select nominees for the Jim Parker Leadership Award, Commissioner's Award for Distinguished Service in Community Health Services, Award for Outstanding Dedication to Local Public Health, the Jack Korlath Partnership Award, and the Certificates of Recognition, to be presented at the annual Community Health Conference.
- Prepare a ballot for the SCHSAC election of Chair-Elect in December.

Summary of Activities

The Nominating and Awards Subcommittee communicated by conference call to review the nominating process and to select the recipients for the 2006 Community Health Service Awards.

The following individuals received awards at the 2006 Community Health Conference:

- *Award for Outstanding Dedication to Local Public Health*
Marvin Tinklenberg, Pipestone County Commissioner
- *Commissioner's Award for Distinguished Service in Community Health Services*
Wayne Carlson, Retired – Minnesota Department of Health
- *Jack Korlath Partnership Award*
Deborah Durkin, Minnesota Department of Health
- *Jim Parker Leadership Award*
Paul Wilson, Olmsted County Commissioner
- *Certificates of Recognition*
 - Aitkin, Carlton, Cook, Koochiching, Lake, and St. Louis Counties' Public Health Departments
 - Cheryl Sapp, Clay County Public Health
 - Litchfield Area Rural Partners in Prevention, Meeker County
 - Rochester Downtown Farmers' Market, Olmsted County
 - Smoke-Free Coalitions, Meeker and McLeod Counties

In addition to the CHS Awards, the Nominating and Awards Subcommittee prepared a slate of nominees and supervised the election of the new SCHSAC Chair-Elect.

Membership

Bev Bales, Chair, Douglas County CHB
Susan Congrave, Aitkin-Itasca-Koochiching CHB
Bette Friederichs, Chisago County CHB
Bruce Tolzmann, Redwood-Renville CHB
Paul Wilson, Olmsted County CHB

MDH Staff to the Subcommittee

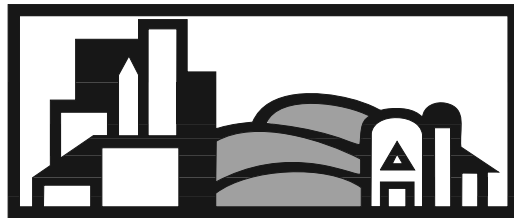
Peggy Malinowski, Office of Public Health Practice

Related Issues

The SCHSAC was kept apprised of a number of issues during 2006, including: legislative issues, pandemic influenza and other infectious disease updates; the Minnesota Public Health Information Network (MN-PHIN), food born-illness surveillance, worksite wellness, and counties' readiness to provide services and be prepared for soldiers returning from Iraq and Afghanistan.

The SCHSAC also was informed throughout the year of efforts by other groups including: the Diabetes Steering Committee; the Food Safety Partnership; the Immunization Practices Advisory Committee; the Maternal and Child Health Advisory Task Force; and the State Preventive Health Advisory Committee.

State Community Health Services Advisory Committee



STATE AND LOCAL PARTNERS
Keeping Minnesotans Healthy

2007 Work Plan

State Community Health Services Advisory Committee

2007 SCHSAC Work Plan

Summary

The SCHSAC will continue to focus its work on policies and actions that will strengthen the public health system at the state and local levels. The expectation of mutual accountability for public health between the state and local governments continues to provide the impetus for discussions and activities.

The three standing committees, the Executive Committee, the Community Health Conference Planning Work Group, and the Nominating and Awards Subcommittee will carry out activities that support the SCHSAC and the ongoing partnership between the state and local public health.

In 2007, the Minnesota Department of Health-Local Public Health (MDH-LPH) Preparedness Committee will develop a strategic direction for public health preparedness work in Minnesota that includes shared preparedness priorities for three to five years; the roles that local public health departments and MDH should play in achieving them; measurable outcomes; and how to monitor performance over time.

Several public health issues will be examined by SCHSAC through presentations and discussions. These issues include eliminating health disparities and next steps in quality improvement for the system. Two public health videoconferences for local elected officials will be conducted to engage and inform local elected officials and other community partners about public health topics that impact their counties and constituents.

SCHSAC will work to improve understanding of health disparities in Minnesota among its members and to identify and apply strategies to eliminate those disparities in everyday public health practice. Activities will include: examining statewide demographic trends; collecting and sharing stories about current efforts; hosting presentations and participating in discussions about health disparities and strategies to eliminate them; and reviewing the Culturally and Linguistically Appropriate Services (CLAS) standards and developing a tool for public health application.

The next steps in quality improvement are a conjoining of several separate but related efforts, including the recently completed accountability review process developed by a SCHSAC work group and efforts of a new Multi-State Learning Collaborative Grant (MLC-2). An expert review of Minnesota's quality improvement process will be conducted and SCHSAC will participate in an on-site visit with representatives from the Centers for Disease Control and Prevention, the National Association of County and City Health Officials, the Association of State and Territorial Health Officers, and the Robert Wood Johnson Foundation.

Other Issues of Interest that may be explored at SCHSAC meetings include the implications of telehealth on public health practice and developing a process for identifying key indicators related to the recently revised Minnesota Public Health Goals. Several ongoing initiatives, such as the Minnesota Public Health Information Network and public health workforce development, will be visited as new developments occur.

Standing Committees

Executive Committee

Charge

- Develop the annual work plan for SCHSAC.
- Conduct interim business of the advisory committee and develop recommendations for decision by SCHSAC.
- Examine ways to increase the capacity of SCHSAC.

Background

The functions of the Executive Committee are to assist the MDH in preparing issues for discussion by the SCHSAC; to assist the SCHSAC in managing its business efficiently; and, under special circumstances, to act in the name of the SCHSAC – subject to formal approval by the SCHSAC at its next meeting. The Executive Committee is responsible for preparing the annual SCHSAC work plan.

The Executive Committee briefly meets prior to the full SCHSAC meetings to make final changes to the agenda and to discuss related issues. Additional meetings are scheduled throughout the year, as needed.

Methods

There are eleven members, representing the eight Community Health Board (CHB) districts, plus the SCHSAC Chair, Chair-Elect, and Past Chair. Usually, four to eight meetings (including at least one prior to each full SCHSAC meeting) are held.

Resources

The Community and Family Health Division, Office of Public Health Practice, will provide staff support to this activity, and the MDH Executive Office and senior staff will be involved.

Community Health Conference Planning Work Group

Charge

- Select a theme, topic, and format for the 2007 Community Health Conference and assist staff in hosting the conference.

Background

This Work Group determines a theme appropriate for the annual Community Health Conference, selects the keynote and concurrent speakers, and assures that these speakers address the needs of the broad public health audience. The 2007 conference will be held September 26-28 at Cragun's Conference Center and Resort in Brainerd, Minnesota.

Methods

The work group membership will be comprised of equal numbers of representatives from Community Health Boards and the MDH. Two meetings are planned for 2007.

Resources

The Community and Family Health Division, Office of Public Health Practice, will provide staff support for this activity.

Nominating and Awards Subcommittee

Charge

- Review the awards process and recommend to the Executive Committee modifications, as necessary, to fulfill the intent of the awards.
- Solicit and select nominees for the Jim Parker Leadership Award, Commissioner's Award for Distinguished Service in Community Health Services, Award for Outstanding Dedication to Local Public Health, the Jack Korlath Partnership Award, and the Certificates of Recognition, to be presented at the annual Community Health Conference.
- Prepare a ballot for the election of the SCHSAC Chair-Elect in December.

Background

The Nominating and Awards Subcommittee is responsible for establishing a nominating process and selecting recipients for the annual Community Health Service awards; the Jim Parker Leadership Award; the Commissioner's Award for Distinguished Service in Community Health Services; the Award for Outstanding Dedication to Local Public Health; the Jack Korlath Partnership Award; and the CHS Certificates of Recognition.

The Nominating and Awards Subcommittee is an ongoing committee of the SCHSAC. The subcommittee may consider changes to the selection criteria for the CHS awards and also may make recommendations to the SCHSAC for new awards. The SCHSAC Operating Procedures provide guidance on the awards and nomination process.

The Nominating and Awards Subcommittee is also responsible for supervising the nominations and election of the Chair-Elect, as specified in the SCHSAC Operating Procedures.

Methods

Membership will consist of three to five representatives of community health boards. The subcommittee will meet two to three times via conference calls.

Resources

The Community and Family Health Division, Office of Public Health Practice, will provide staff support to this activity.

SCHSAC Work Group

Minnesota Department of Health-Local Public Health Preparedness Committee

Charge

- Articulate the strategic direction and shared Minnesota Department of Health-Local Public Health (MDH-LPH) preparedness priorities for three to five years; describe the roles that local public health departments and MDH should play in achieving them; establish measurable outcomes; and monitor performance over time.
- Present a report of their activities, accomplishments and recommendations at the September 2007 SCHSAC meeting, including a recommendation whether to continue the group and a proposed charge and work products for the coming year if the recommendation is to continue.

Background

A plethora of activities are underway at MDH and in local public health departments to promote public health preparedness. Those activities are on a fast-track and are driven in part by grant requirements. Due to the complexity of the subject matter and the need for rapid development, there has been no joint MDH and local public health effort to identify shared priorities or describe local, regional and state public health roles in accomplishing those priorities. Joint MDH-local public health department work to develop the Disease Prevention and Control Common Activities Framework can serve as a model for this work.

Monitoring progress over time will enable Minnesota's public health system to articulate whether and how Minnesota is better prepared as a result of the infusion of funds to assure public health preparedness.

Another implication of the rapid paced environment for public health preparedness is the lack of structured ways to coordinate development and sharing of information and resource materials within the state. Improving this exchange can maximize efficiency and effectiveness of local public health department and MDH resources; avoid redundancy; and increase coordinated activity. In order to work most effectively with the range of partners involved in preparedness, it is essential that MDH and local public health departments have a strong shared vision.

Methods

A committee consisting of SCHSAC members, local public health department representatives, and MDH representatives will identify shared priorities and roles. The group will meet as needed to assure coordination and monitor progress. Other preparedness-focused subgroups may need to be formed to work at a more detailed level (e.g., this committee would serve as an umbrella for the grant duties group).

Resources

The Community and Family Health Division, Office of Public Health Practice, and the Office of Emergency Preparedness, will provide staff support to this activity.

Public Health Topics

Eliminating Health Disparities

Background

While Minnesota consistently ranks as the healthiest state in the nation, serious disparities in health status persist among communities of color, American Indians, and other populations in the state. During 2007, SCHSAC will examine what Community Health Boards can do to help eliminate health disparities in Minnesota.

Methods

SCHSAC will work to improve understanding of health disparities in Minnesota among its members and to identify and apply strategies to eliminate those disparities in everyday public health practice. Activities will include: examining statewide demographic trends; collecting and sharing stories about current efforts; hosting presentations and participating in discussions about health disparities and strategies to eliminate them; and reviewing the Culturally and Linguistically Appropriate Services (CLAS) standards and developing a tool for public health application.

Resources

The Community and Family Health Division, Office of Public Health Practice, in consultation with the Office of Minority and Multicultural Health, will provide staff support to this activity.

Next Steps in Quality Improvement

Background

SCHSAC has recently developed several components of an overall quality improvement system for local public health departments (e.g. Essential Local Public Health Activities, performance measures, accountability review process, capacity assessment and improvement planning). A grant from the Robert Wood Johnson Foundation, *the Multi-state Learning Collaborative-2*, will provide a framework to continue this work on quality improvement. Expert review, onsite visits with representatives from the Centers for Disease Control and Prevention, National Association of City and County Health Officials, Association of State and Territorial Health Officers, and the Robert Wood Johnson Foundation will help strengthen Minnesota's processes. Additionally, the ongoing review of the data submitted via the Local Public Health Planning and Performance Measurement Reporting System will provide a continuous feedback loop for quality improvement.

Methods

Every effort will be made to coordinate the onsite visits with SCHSAC meetings. SCHSAC members will be involved in the expert review. SCHSAC will receive regular updates on grant activities and on findings from the LPH PPMRS data.

Resources

The Community and Family Health Division, Office of Public Health Practice, will provide staff support to this activity.

Videoconferences Series: Hot Topics in Public Health

Background

Local elected officials routinely examine and make decisions affecting local public health programs and activities. It is difficult to bring together local elected officials and state health department officials to discuss important statewide issues and to share timely and accurate information so informed decisions can be made at both levels. Past success with videoconferences has identified this as an efficient way to reach local elected officials.

Methods

Topics for two videoconferences will be identified with the assistance of the SCHSAC Executive Committee. Videoconference sites will be available across the state. All videoconferences will be taped and distributed as requested.

Resources

The Community and Family Health Division, Office of Public Health Practice, will provide staff support to this activity.

Special Issues of Interest

Minnesota Public Health Goals

A recommendation of the Minnesota Public Health Goals Review Group was to identify a small number of sentinel or key indicators for each goal. These indicators would be used to engage a statewide audience to help achieve the goals. SCHSAC will provide input on the development of the sentinel indicators.

Tele-health

Tele-health is a rapidly expanding new method of healthcare delivery throughout the state. In 2007, SCHSAC will explore the implications and possible uses of tele-health for public health practice.

February 2007



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Community and Family Health Division
Golden Rule Building
85 East 7th Place
P.O. Box 64882
Saint Paul, MN 55164-0882

651-201-3880
MN Relay Service: 1-800-627-3529
TDD/TTY: 651-201-5797

*This report was supported by the Preventive Health and Health Services (PHHS) Block Grant from the Centers for Disease Control and Prevention (CDC).
Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.*

*If you require this document in another format, such as large print, Braille or cassette tape.
Please call (651) 201-3880.*

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8: Appendix



DATE: February 23, 2007
TO: State CHS Advisory Committee Members, Alternates, and Work Group Members
FROM: Peggy Malinowski, Planner
Division of Community and Family Health
PHONE: 651/201-3878 / peggy.malinowski@health.state.mn.us
SUBJECT: EXPENSE REIMBURSEMENT CLAIMS

Expenses for members of the State CHS Advisory Committee and work group members will be paid after approval by the Division of Community and Family Health according to the following schedule:

	Mileage	.485 cents per mile
	Breakfast	\$7.00 (maximum) - must leave home before 6:00 AM
**	Lunch	\$9.00 (maximum)
	Dinner	\$15.00 (maximum) - must return home after 7:00 PM
	Lodging	\$80.00 + tax/night - show county/city business card to receive government rate
**	If a meeting extends beyond the lunch period, a lunch will be provided for members or alternates of the Committee/Work Group.	

NOTE: If you are a new member, please write your Social Security Number on the top of the form the first time you fill out the Expense Report Form to get your name and address entered into our accounting system; it is not required thereafter.

Also, it would be helpful in keeping up-to-date with our budget if you could submit your expense claims within *one week* of attending a meeting. We also request that you *claim only one meeting per form*. Reimbursement checks will be made out to you and sent to your *home address, checks can not be made payable to your agency*.

A sample of how to fill out an Expense Report Form is located on the back of this memo. (You are required to complete items A-R.):

- (A) through (E) are self-explanatory.
- The job title (F) should be your working title as it relates to the Department, e.g., SCHSAC Member.
- For all travel, please include: Date (G), Daily Description (type of meeting) (H), Time (of departure and arrival (O), Location (P), and Trip and Trip/Local Miles (Q).
- If applicable, please complete items (I) through (N).
- **Do not total any of the columns; this will be done by the Division of Community and Family Health.**
- Sign, date, and add phone number to the form in the lower left corner on the line for Employee's Signature (R).
- Attach all necessary receipts, i.e., lodging (need original hotel receipt, not credit card receipt), plane fare, parking, etc. (We do not need receipts for meals or parking meters.)
- Submit your completed forms to the Division of Community Health for processing to:

Minnesota Department of Health
Community and Family Health Division
Office of Public Health Practice
P. O. Box 64882
St. Paul, MN 55164-0882

EXPENSE REPORT - MAPS Accounting Component - Only for Persons Not on SEMA4*

<input type="checkbox"/>	IN-STATE	<input type="checkbox"/>	SHORT TERM ADVANCE	Reason for Travel/Advance (30 char. max)	Employee Name	Home Address (include City and State)	Social Security Number *						
<input type="checkbox"/>	OUT-STATE	<input type="checkbox"/>	RECURRING ADVANCE	SCHSAC MEETING	Your Name Here (A)	Home Address Here (B)	Enter 1st Meeting Only						
<input checked="" type="checkbox"/>	REIMBURSEMENT			Trip Dates: Start/End	Permanent Work Station (include City and State)	Agency	Job Title						
<input checked="" type="checkbox"/>	FINAL EXPENSE FOR THIS TRIP?			Meeting Date Here (C)	Work Address Here (D)	Your Agency Here (E)	Committee Member (F)						
MAPS CODE BLOCK													
%	Agency	REQ	FY	Fund	Org	SOrg	Appr	Actv	Object	SObj	Rpt Cat	Project/Job	Description
%	Agency	REQ	FY	Fund	Org	SOrg	Appr	Actv	Object	SObj	Rpt Cat	Project/Job	Description

Date	Daily Description/Comments	MEALS			Total All Meals W/O Lodging	Total All Meals With Lodging	Lodging	Conference Fee	Air Fare Parking	Other Expenses	ITINERARY		Trip Miles	Total Trip and Local Miles	Mileage Rate	Mileage Amount	Total	
		B	L	D							Time	Location						
(G)	(H)			(I)	(J)	(K)	(L)		(M)	(N)	(O)	Departure	(P)		(Q)			
2/27/2007	SCHSAC Meeting										7:00 AM	Depart	Your City					
											10:00 AM	Arrival	St. Paul					
												2:30 PM	Depart	St. Paul				
												5:30 PM	Arrival	Your City				
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TOTALS:		Enter subtotal of these totals at far right			Total 1	Total 2	Total 3	Total 4	Total 5	Total 6		VEHICLE CONTROL #		Total Miles (Q)	Rate	Total 7	Subtotal	

If using private car for out-of-state travel: What would lowest air fare to destination be? \$ _____
 Travel not to exceed this amount

An individual and other officials using state funds traveling on state business and using commercial airlines cannot claim frequent flyer mileage as their own. An individual must certify that s/he has not claimed frequent flyer mileage for personal use when applying for travel reimbursement. Any benefits received belong to the state.

Sign Here (R) _____ **Date Here** _____ **Work Phone Here** _____
 Non-Employee Signature _____ Date _____ Work Phone _____

I declare under the penalties of perjury that this claim is just and correct and that no part of it has been paid except with respect to those advance amounts shown.

Supervisor Signature _____ Date _____ Work Phone _____
 Approved: Based on knowledge of the necessity for travel and expense and on the basis of compliance with all provisions of applicable travel regulations.

FOR ACCOUNTING AND INPUT USE ONLY			
INPUT OBJECT CODES & AMOUNTS	Obj. code	Column From Above	Amount
Living Expense	2G01 or 2H01	2,3	
Travel Expense	2G00 or 2H00	5	
Conference Regist. Fees	2L01 or 2L02	4	
Mileage - IRS Rate	2G10 or 2H10	7	
Advance Payment	2G03 or 2H03	All	
Meals w/o Lodging	2G02 or 2H02	1	
Other		6	
Document I.D.		DOCUMENT TOTAL	

* This information is required by the State of Minnesota to reference a tax identification number for every vendor and to provide a current mailing address. The information you provide is confidential and will be used solely for the purpose of creating a vendor number. If you fail to provide this information, payment will be denied. This form is to be used only for non-employee expense reimbursement.