



Minnesota Department of Health
Health Partnerships Division – Public Health Practice Section
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2014 Local Public Health Act Performance Measures

SEPTEMBER 2015 | DATA BOOK

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BACKGROUND AND CONTEXT

ABOUT THE DATA BOOK

Minnesota community health boards (CHBs) report annually into the Planning and Performance Measurement Reporting System (PPMRS), on Local Public Health Act (LPH Act) performance measures that span six areas of public health responsibility (see [appendices](#) for six areas).

The purpose of this data book is to present state-level findings for each of the LPH Act measures. This report communicates findings from the 2014 reporting period. For more information on tailored reports specific to each community health board, contact:

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MDH Performance Management Framework

REPORTING INSTRUCTIONS AND GUIDANCE

Instructions for reporting on all six areas of public health responsibility can be found online: www.health.state.mn.us/ppmrs/resources/performanceasures/. Data reported was collected between Jan. 1 and Dec. 31, 2014.

INTERPRETATION AND ASSISTANCE

In the interest of swift release and of transparency, the MDH Public Health Practice Section has released this data book. We understand that there are data limitations and that measures are not fully described here. If there are measures that interest you, or you would like further assistance, we are happy to discuss these with you. Please contact us using the information above. You can also find information on Minnesota’s accreditation efforts and Local Public Health Assessment and Planning process online: www.health.state.mn.us/lphap.

The SCHSAC Performance Improvement Steering Committee has reviewed these findings and will release recommendations for system improvement later this year. For more information, visit www.health.state.mn.us/schsac, and select “Workgroups,” then “Performance Improvement Steering Committee.”

CHB POPULATIONS AND SIZES

In this report, you will often data broken out by CHB population; for more information on how CHBs are divided, please refer to the [appendices](#).

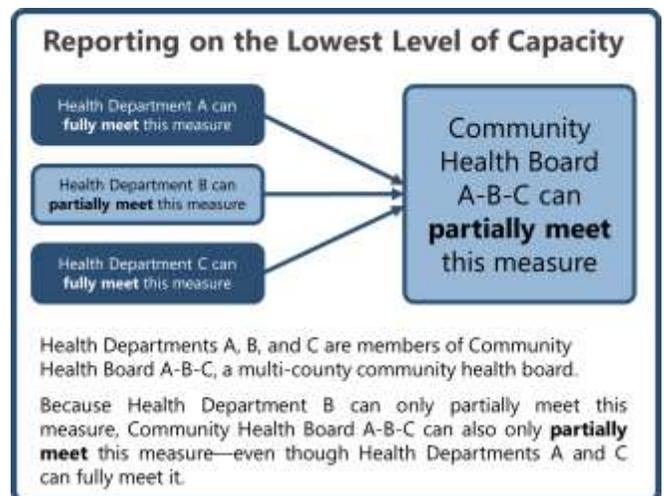
ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: CAPACITY MEASURES FROM NATIONAL STANDARDS

ABOUT THE STANDARDS

In spring 2015, Minnesota CHBs reported on national public health measures, rather than just a subset as in previous years. This is why trend data is included for some measures and not others. You’ll see these key measures and the state’s progress on them between 2012 and 2014 throughout this area of responsibility.

The Public Health Accreditation Board (PHAB) revised the national standards and measures in 2014 (to version 1.5). Minnesota’s Local Public Health Act performance measures—and guidance for reporting on them—were updated to be consistent with this version. For more information on PHAB Standards and Measures version 1.5, visit www.phaboard.org/.

Multi-county CHBs were asked to report on the lowest level of capacity of their individual health departments for measures within “Capacity Measures from National Standards” (see right). For a full list of single-county/city CHBs and multi-county CHBs, please refer to the [appendices](#).



ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: CAPACITY MEASURES FROM NATIONAL STANDARDS

100 NATIONAL PUBLIC HEALTH MEASURES

CAPACITY TO MEET 100 NATIONAL PUBLIC HEALTH MEASURES, MINNESOTA CHBS, 2014

Each horizontal bar of the tables below corresponds to an individual CHB. The shading within each bar reflects the number of measures that were reported as either fully met (green), partially met (yellow), or not met (red) by each CHB. The CHBs grouped in the first quartile rank highest in the number of measures they reported as fully met. The CHBs in the fourth quartile rank lowest in the number of measures they reported as fully met.

Capacity of Minnesota CHBs to meet 100 national public health measures, 2014

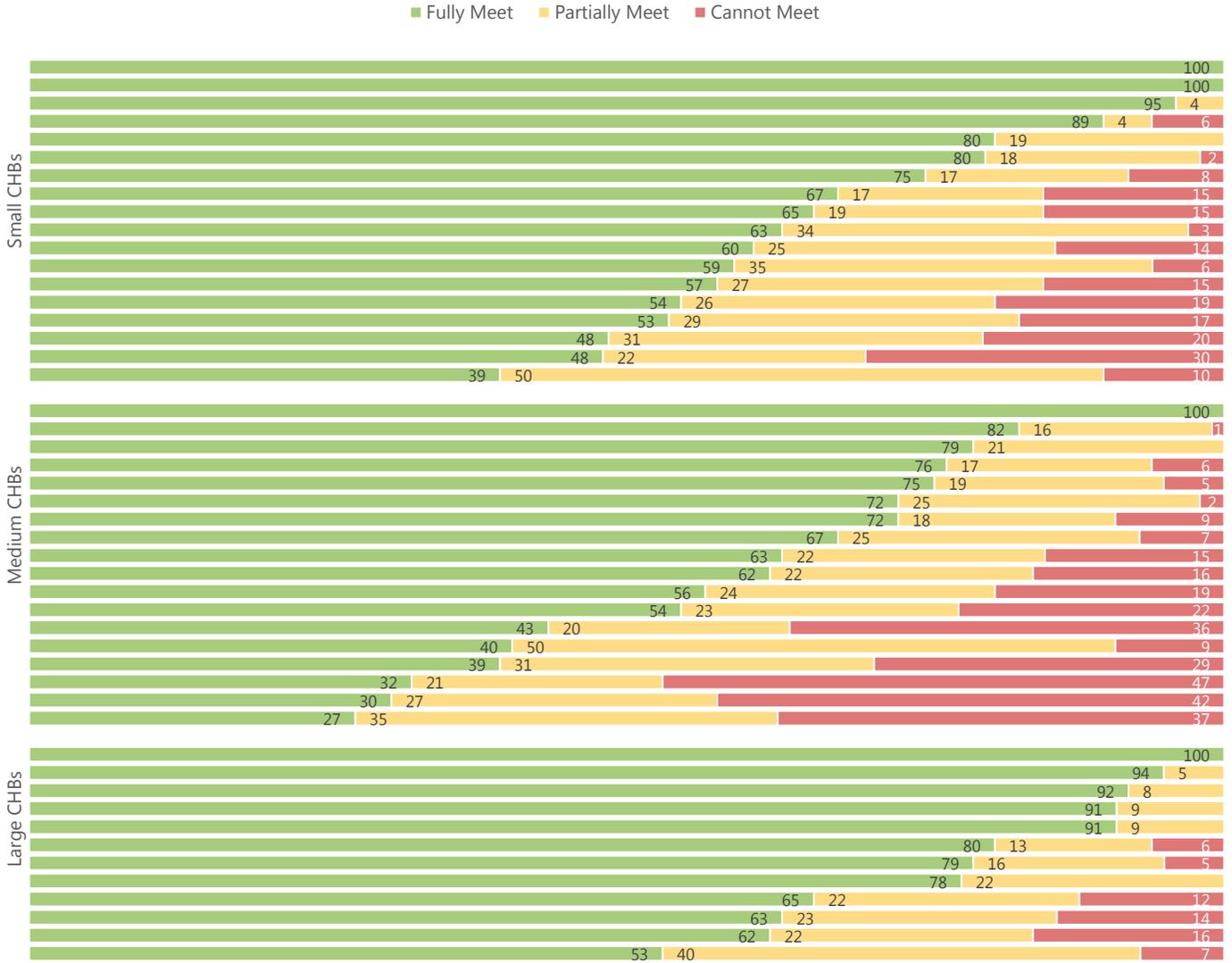
■ Fully Meet ■ Partially Meet ■ Cannot Meet



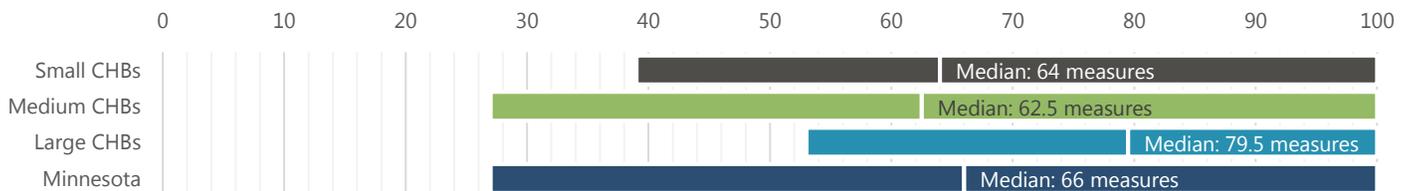
CAPACITY TO MEET 100 NATIONAL PUBLIC HEALTH MEASURES, BY CHB POPULATION, 2014

The CHBs below are organized by population. Each horizontal bar of the tables below corresponds to an individual CHB. The shading within each bar reflects the number of measures that were reported as either fully met (green), partially met (yellow), or not met (red) by each CHB.

Capacity of Minnesota CHBs to meet 100 national public health measures, by population and measures met, 2014



Range and median: National public health measures fully met, by population, Minnesota CHBs, 2014



Range: Measures fully met, by population, Minnesota CHBs, 2014	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
Minimum	39 measures	27 measures	53 measures	27 measures
Median	64 measures	62.5 measures	79.5 measures	66 measures
Maximum	100 measures	100 measures	100 measures	100 measures

MEASURES MET BY GREATEST AND FEWEST CHBS, MINNESOTA, 2014

Measures fully met by the greatest and fewest number of CHBs, Minnesota, 2014

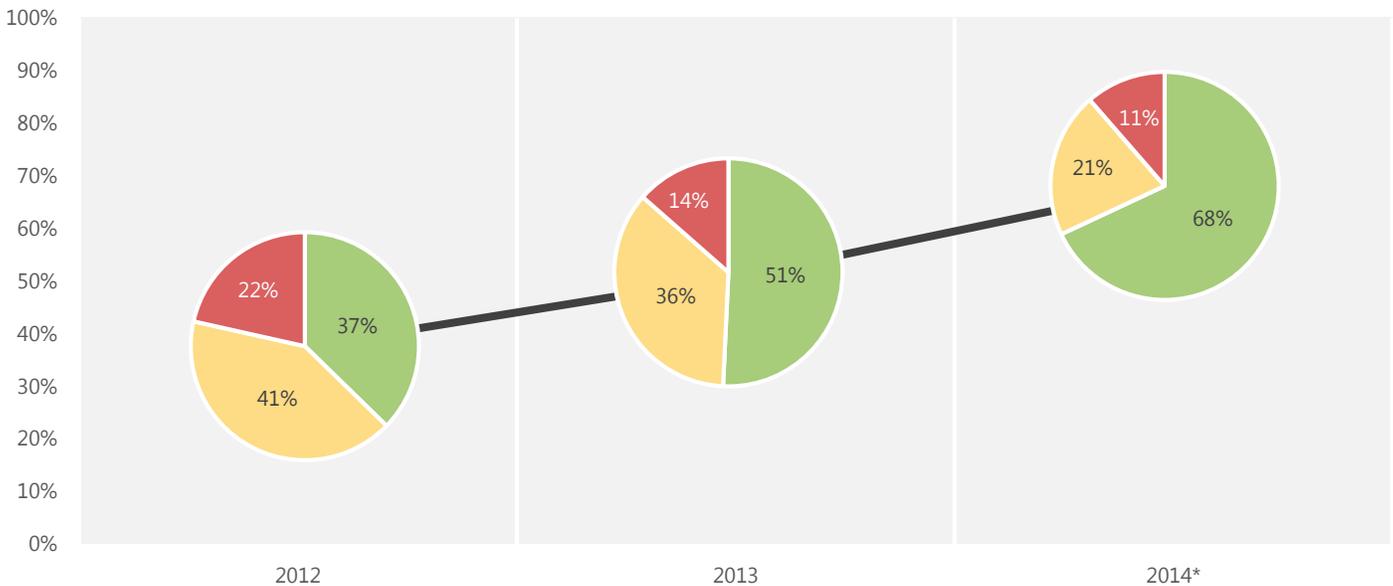


ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: CAPACITY MEASURES FROM NATIONAL STANDARDS

35 KEY MEASURES

Between 2012 and 2014, Minnesota CHBs reported on subset of 35 key public health national measures.* The SCHSAC Performance Improvement Steering Committee monitors CHBs' ability to achieve 35 national measures as an indicator of overall capacity of the state's public health system. The figure below illustrates the state's collective progress toward meeting those key measures.

Key measures fully met by all Minnesota CHBs, 2012-2014



* In 2012-2013, MDH used 35 key measures from PHAB Standards and Measures v1.0 to assess CHB capacity. In 2014, MDH used the revised PHAB Standards and Measures v1.5 to assess capacity; in v1.5, PHAB combined two measures into one, resulting in a total of 34 measures.

ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: CAPACITY MEASURES FROM NATIONAL STANDARDS

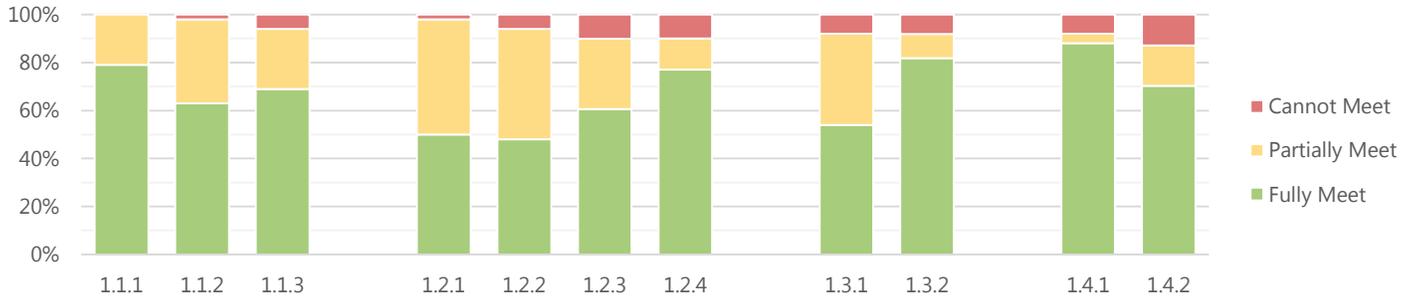
100 MEASURES BY DOMAIN

DOMAIN 1: ASSESS

Conduct and disseminate assessments focused on population health status and public health issues facing the community

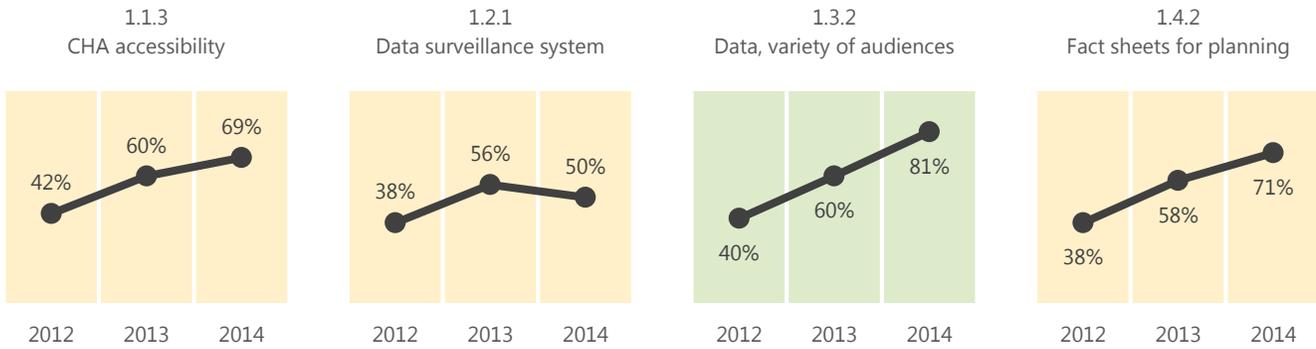
ALL MEASURES IN DOMAIN 1, MINNESOTA CHBS, 2014

CHB capacity to meet measures in Domain 1, Minnesota, 2014

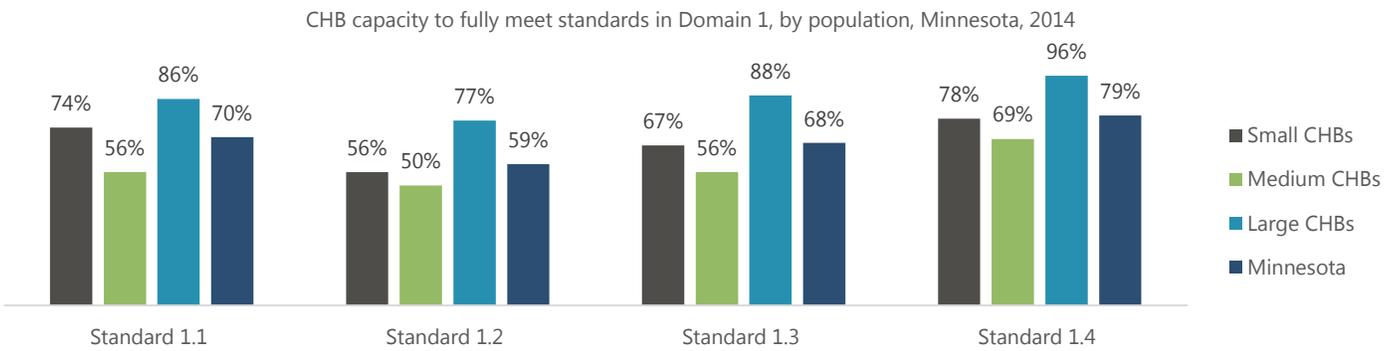


CHB capacity to meet measures in Domain 1, Minnesota, 2014 (n=48)		Fully Meet	Partially Meet	Cannot Meet
1.1	Community Health Assessment (CHA)			
1.1.1	Partnership for CHA	79%	21%	0%
1.1.2	CHA	63%	35%	2%
1.1.3	Accessibility of CHA	69%	25%	6%
1.2	Data Collection and Maintenance			
1.2.1	Surveillance system	50%	48%	2%
1.2.2	Communication with surveillance sites	48%	46%	6%
1.2.3	Primary data	60%	29%	10%
1.2.4	Shared data with state, tribal health departments	77%	13%	10%
1.3	Data Analysis			
1.3.1	Data analysis and conclusions	54%	38%	8%
1.3.2	Data to a variety of audiences	81%	10%	8%
1.4	Data Use			
1.4.1	Informing policy, processes, programs with data	88%	4%	8%
1.4.2	Summaries, fact sheets to support planning	71%	17%	13%

KEY MEASURES IN DOMAIN 1, % FULLY MET, MINNESOTA CHBS, 2012-2014*



STANDARDS IN DOMAIN 1, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014



CHB capacity to meet measures in Domain 1, by population, Minnesota, 2014

	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
1.1 Community Health Assessment (CHA)				
1.1.1 Partnership for CHA	83%	67%	92%	79%
1.1.2 CHA	67%	44%	83%	63%
1.1.3 Accessibility of CHA	72%	56%	83%	69%
1.2 Data Collection and Maintenance				
1.2.1 Surveillance system	39%	39%	83%	50%
1.2.2 Communication with surveillance sites	50%	39%	58%	48%
1.2.3 Primary data	56%	50%	83%	60%
1.2.4 Shared data with state, tribal health departments	78%	72%	83%	77%
1.3 Data Analysis				
1.3.1 Data analysis and conclusions	50%	44%	75%	54%
1.3.2 Data to a variety of audiences	83%	67%	100%	81%
1.4 Data Use				
1.4.1 Informing policy, processes, programs with data	83%	83%	100%	88%
1.4.2 Summaries, fact sheets to support planning	72%	56%	92%	71%

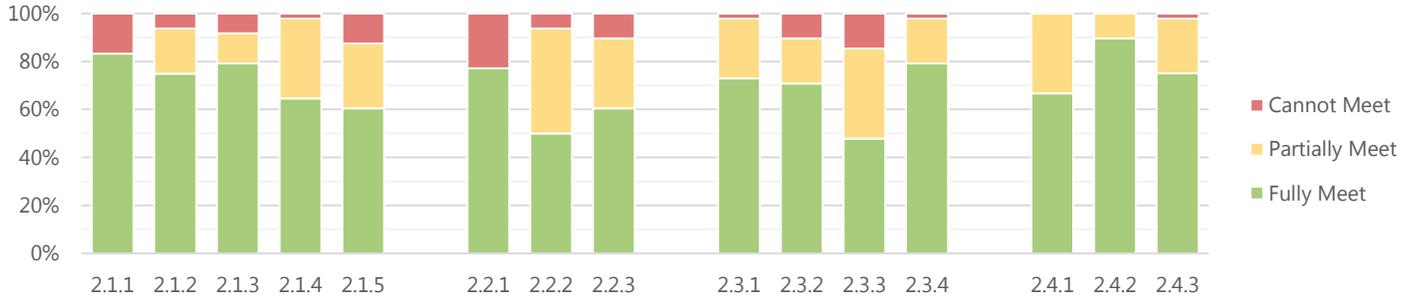
* 2012-2014 trends for key measures show different background colors, depending on whether over 80 percent of CHBs can fully meet the measure (green), 50 percent to 79 percent can fully meet the measure (yellow), or less than 50 percent can fully meet the measure (red).

DOMAIN 2: INVESTIGATE

Investigate health problems and environmental public health hazards to protect the community

ALL MEASURES IN DOMAIN 2, MINNESOTA CHBS, 2014

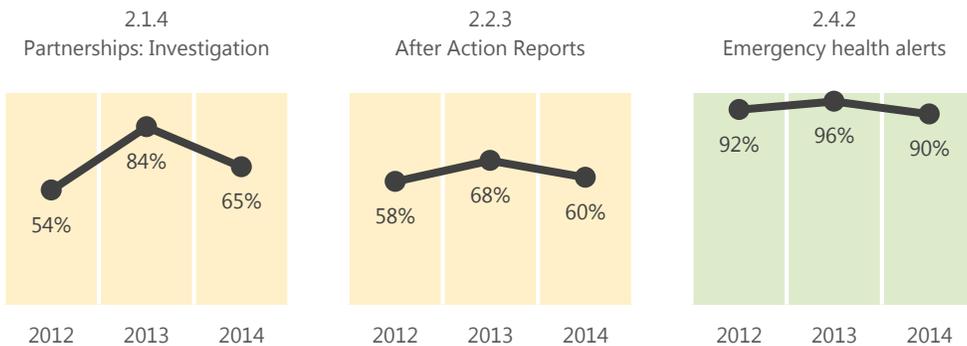
CHB capacity to meet measures in Domain 2, Minnesota, 2014



CHB capacity to meet measures in Domain 2, Minnesota, 2014 (n=48)

	Fully Meet	Partially Meet	Cannot Meet
2.1 Investigating Problems and Hazards			
2.1.1 Protocols for investigation	83%	n/a*	17%
2.1.2 Infectious disease investigation	75%	19%	6%
2.1.3 Non-infectious investigation capacity	79%	13%	8%
2.1.4 Partnerships for investigation	65%	33%	2%
2.1.5 Timely reporting	60%	27%	13%
2.2 Containing/Mitigating Problems, Hazards			
2.2.1 Protocols for containment, mitigation	77%	n/a	23%
2.2.2 Emergency operations plan (EOP)	50%	44%	6%
2.2.3 After Action Reports (AAR)	60%	29%	10%
2.3 Emergency Access to Expertise, Capacity			
2.3.1 24/7 emergency access to epi, environmental resources	73%	25%	2%
2.3.2 24/7 access to laboratory resources	71%	19%	10%
2.3.3 Access to infrastructure capable of providing surge capacity	48%	38%	15%
2.3.4 CHB-state-tribal collaboration to build capacity for crises	79%	19%	2%
2.4 Emergency Communications			
2.4.1 24/7 communications protocols	67%	33%	0%
2.4.2 Health alerts	90%	10%	0%
2.4.3 Timely communication during emergencies	75%	23%	2%

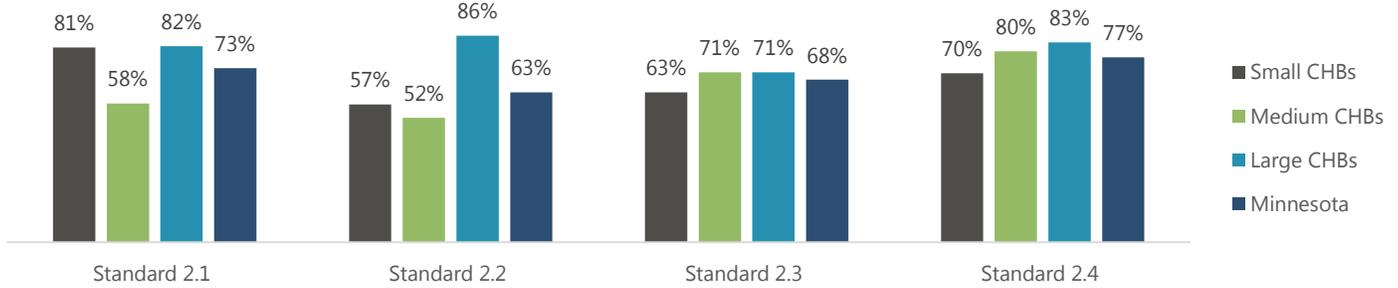
KEY MEASURES IN DOMAIN 2, % FULLY MET, MINNESOTA CHBS, 2012-2014



* Participants could only choose from "Fully Meet" and "Cannot Meet" in 2014.

STANDARDS IN DOMAIN 2, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014

CHB capacity to fully meet standards in Domain 2, by population, Minnesota, 2014



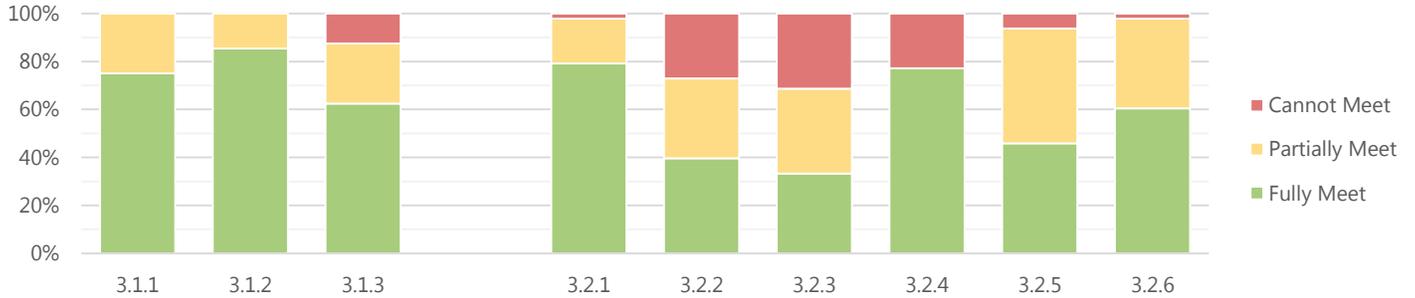
CHB capacity to meet measures in Domain 2, by population, Minnesota, 2014	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
2.1 Investigating Problems and Hazards				
2.1.1 Protocols for investigation	83%	72%	100%	83%
2.1.2 Infectious disease investigation	83%	56%	92%	75%
2.1.3 Non-infectious investigation capacity	89%	72%	75%	79%
2.1.4 Partnerships for investigation	78%	44%	75%	65%
2.1.5 Timely reporting	72%	44%	67%	60%
2.2 Containing/Mitigating Problems, Hazards				
2.2.1 Protocols for containment, mitigation	67%	78%	92%	77%
2.2.2 Emergency operations plan (EOP)	44%	39%	75%	50%
2.2.3 After Action Reports (AAR)	61%	39%	92%	60%
2.3 Emergency Access to Expertise, Capacity				
2.3.1 24/7 emergency access to epi, environmental resources	67%	78%	75%	73%
2.3.2 24/7 access to laboratory resources	67%	72%	75%	71%
2.3.3 Access to infrastructure capable of providing surge capacity	39%	50%	58%	48%
2.3.4 CHB-state-tribal collaboration to build capacity for crises	78%	83%	75%	79%
2.4 Emergency Communications				
2.4.1 24/7 communications protocols	61%	72%	67%	67%
2.4.2 Health alerts	83%	94%	92%	90%
2.4.3 Timely communication during emergencies	67%	72%	92%	75%

DOMAIN 3: INFORM AND EDUCATE

Inform and educate about public health issues and functions

ALL MEASURES IN DOMAIN 3, MINNESOTA CHBS, 2014

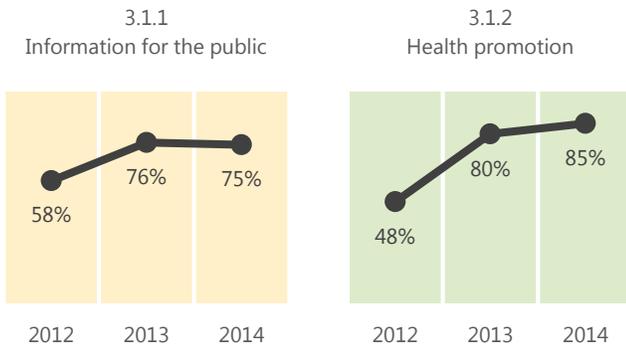
CHB capacity to meet measures in Domain 3, Minnesota, 2014



CHB capacity to meet measures in Domain 3, Minnesota, 2014 (n=48)

	Fully Meet	Partially Meet	Cannot Meet
3.1 Health Education and Promotion			
3.1.1 Information for the public	75%	25%	0%
3.1.2 Health promotion	85%	15%	0%
3.1.3 Health equity	63%	25%	13%
3.2 Communications			
3.2.1 Information for the public	79%	19%	2%
3.2.2 Branding	37%	33%	27%
3.2.3 External communications procedures	33%	35%	31%
3.2.4 Risk communication plan	77%	n/a*	23%
3.2.5 Variety of methods	46%	48%	6%
3.2.6 Culturally sensitive formats	60%	38%	2%

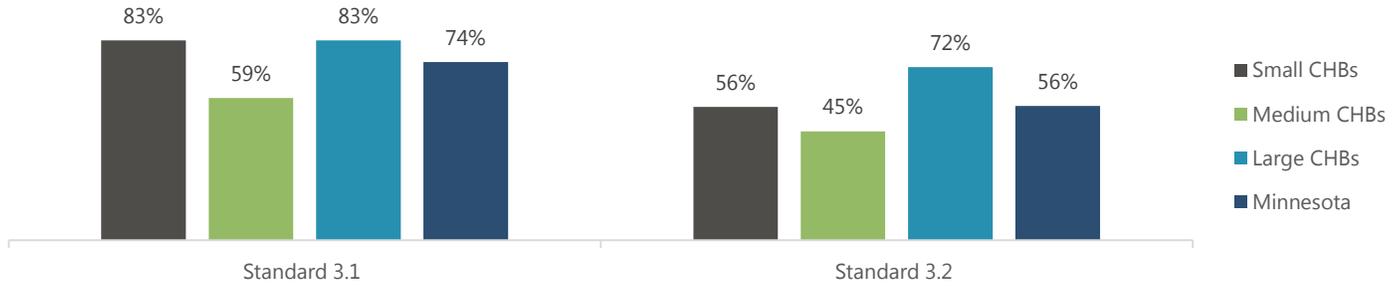
KEY MEASURES IN DOMAIN 3, % FULLY MET, MINNESOTA CHBS, 2012-2014



* Participants could only choose from "Fully Meet" and "Cannot Meet" in 2014.

STANDARDS IN DOMAIN 3, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014

CHB capacity to fully meet standards in Domain 3, by population, Minnesota, 2014



CHB capacity to meet measures in Domain 3, by population, Minnesota, 2014

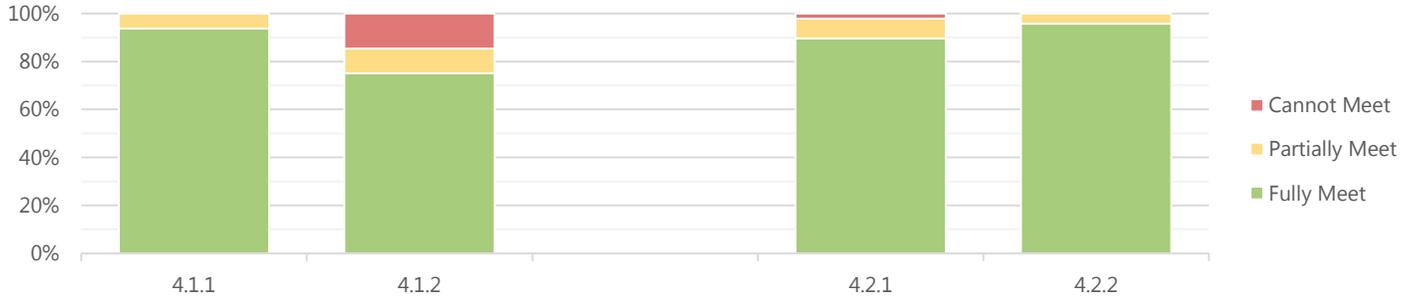
	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
3.1 Health Education and Promotion				
3.1.1 Information for the public	94%	50%	83%	75%
3.1.2 Health promotion	94%	72%	92%	85%
3.1.3 Health equity	61%	56%	75%	63%
3.2 Communications				
3.2.1 Information for the public	78%	67%	100%	79%
3.2.2 Branding	50%	22%	50%	40%
3.2.3 External communications procedures	33%	22%	50%	33%
3.2.4 Risk communication plan	67%	78%	92%	77%
3.2.5 Variety of methods	39%	28%	83%	46%
3.2.6 Culturally sensitive formats	67%	56%	58%	60%

DOMAIN 4: COMMUNITY ENGAGEMENT

Engage with the community to identify and address health problems

ALL MEASURES IN DOMAIN 4, MINNESOTA CHBS, 2014

CHB capacity to meet measures in Domain 4, Minnesota, 2014



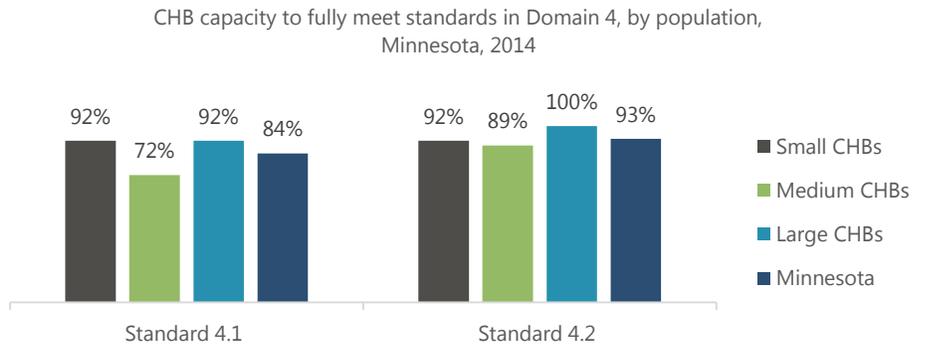
CHB capacity to meet measures in Domain 4, Minnesota, 2014 (n=48)

	Fully Meet	Partially Meet	Cannot Meet
4.1 Collaboration			
4.1.1 Partnerships	94%	6%	0%
4.1.2 Technical assistance	75%	10%	15%
4.2 Policies and Strategies			
4.2.1 Community engagement	90%	8%	2%
4.2.2 Engagement with governance	96%	4%	0%

KEY MEASURES IN DOMAIN 4, % FULLY MET, MINN. CHBS, 2012-2014



STANDARDS IN DOMAIN 4, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014



CHB capacity to meet measures in Domain 4, by population, Minnesota, 2014

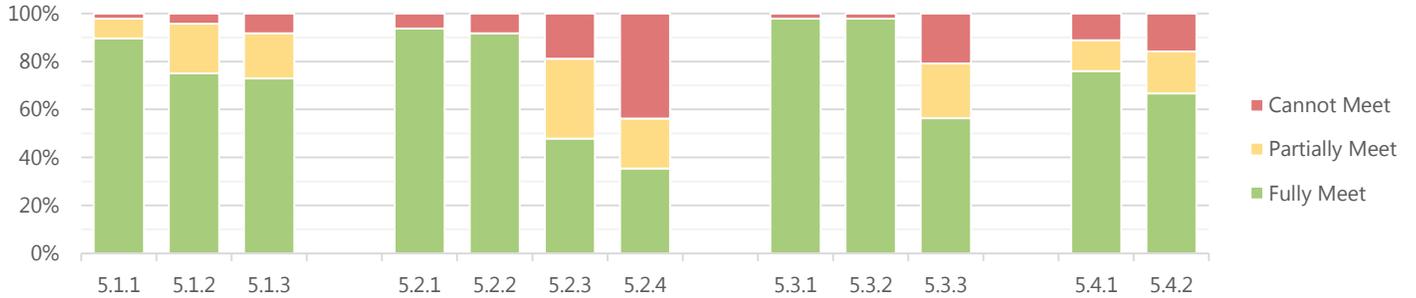
	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
4.1 Collaboration				
4.1.1 Partnerships	100%	83%	100%	94%
4.1.2 Technical assistance	83%	61%	83%	75%
4.2 Policies and Strategies				
4.2.1 Community engagement	89%	83%	100%	90%
4.2.2 Engagement with governance	94%	94%	100%	96%

DOMAIN 5: POLICIES AND PLANS

Develop public health policies and plans

ALL MEASURES IN DOMAIN 5, MINNESOTA CHBS, 2014

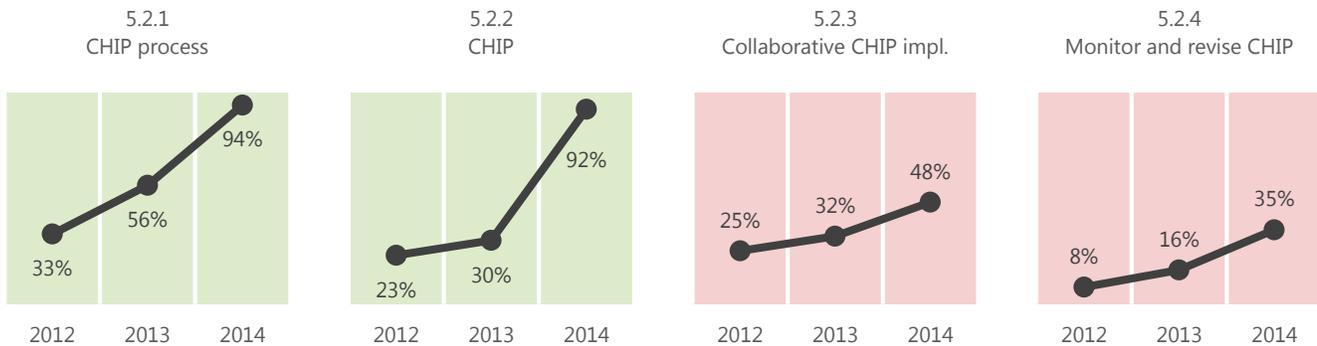
CHB capacity to meet measures in Domain 5, Minnesota, 2014



CHB capacity to meet measures in Domain 5, Minnesota, 2014 (n=48)

	Fully Meet	Partially Meet	Cannot Meet
5.1 Serving as Resource			
5.1.1 Monitor and track issues	90%	8%	2%
5.1.2 Engagement in policy development	75%	21%	4%
5.1.3 Education	73%	19%	8%
5.2 Community Health Improvement Plan (CHIP)			
5.2.1 Process for CHIP	94%	n/a*	6%
5.2.2 CHIP	92%	n/a	8%
5.2.3 Collaborative implementation of CHIP	48%	33%	19%
5.2.4 Monitor and revise CHIP	35%	21%	44%
5.3 Strategic Plan			
5.3.1 Process for strategic plan	98%	n/a	2%
5.3.2 Strategic plan	98%	n/a	2%
5.3.3 Implement strategic plan	56%	23%	21%
5.4 Emergency Operations Plan			
5.4.1 Develop emergency operations plan (EOP)	85%	15%	0%
5.4.2 Emergency operations plan (EOP)	79%	21%	0%

KEY MEASURES IN DOMAIN 5, % FULLY MET, MINNESOTA CHBS, 2012-2014

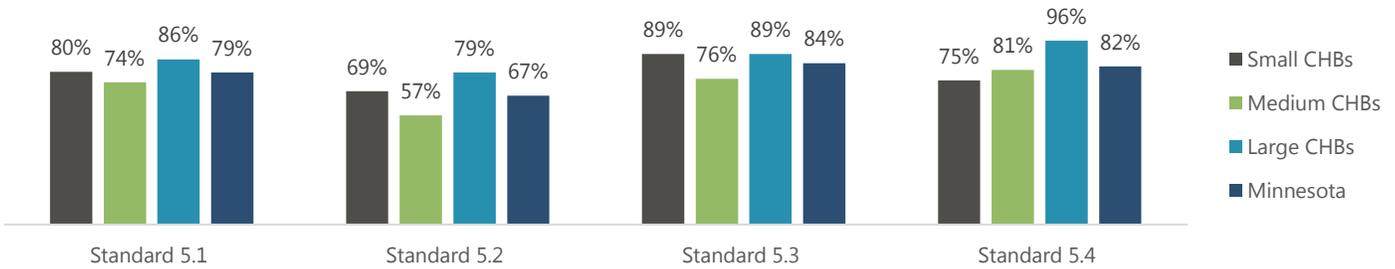


* Participants could only choose from "Fully Meet" and "Cannot Meet" in 2014.



STANDARDS IN DOMAIN 5, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014

CHB capacity to fully meet standards in Domain 5, by population, Minnesota, 2014



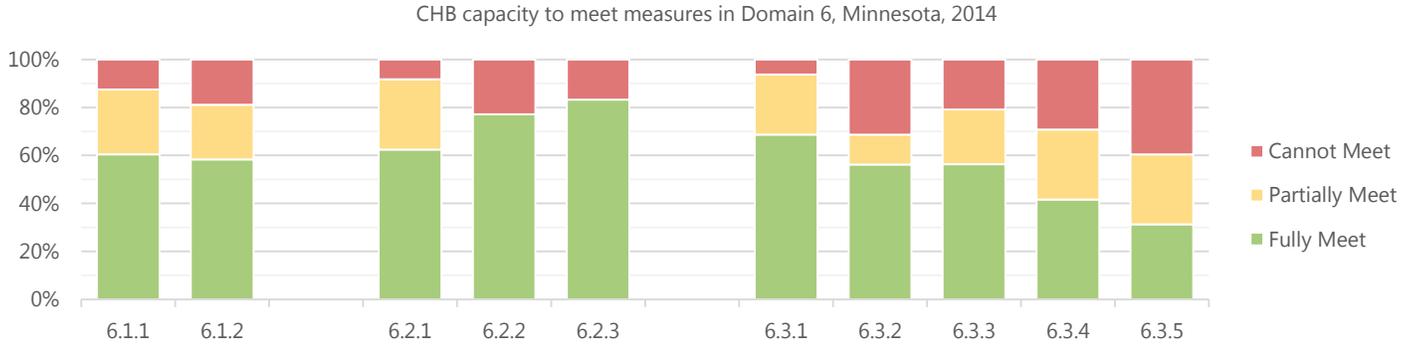
CHB capacity to meet measures in Domain 5, by population, Minnesota, 2014

	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
5.1 Serving as Resource				
5.1.1 Monitor and track issues	89%	89%	92%	90%
5.1.2 Engagement in policy development	72%	67%	92%	75%
5.1.3 Education	78%	67%	75%	73%
5.2 Community Health Improvement Plan (CHIP)				
5.2.1 Process for CHIP	94%	89%	100%	94%
5.2.2 CHIP	94%	89%	92%	92%
5.2.3 Collaborative implementation of CHIP	44%	33%	75%	48%
5.2.4 Monitor and revise CHIP	44%	17%	50%	35%
5.3 Strategic Plan				
5.3.1 Process for strategic plan	100%	94%	100%	98%
5.3.2 Strategic plan	100%	100%	92%	98%
5.3.3 Implement strategic plan	67%	33%	75%	56%
5.4 Emergency Operations Plan				
5.4.1 Develop emergency operations plan (EOP)	78%	83%	100%	85%
5.4.2 Emergency operations plan (EOP)	72%	78%	92%	79%

DOMAIN 6: PUBLIC HEALTH LAWS

Enforce public health laws

ALL MEASURES IN DOMAIN 6, MINNESOTA CHBS, 2014

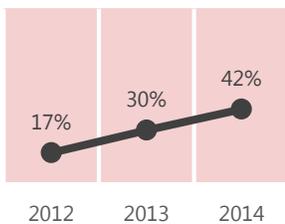


CHB capacity to meet measures in Domain 6, Minnesota, 2014 (n=48)

		Fully Meet	Partially Meet	Cannot Meet
6.1	Review and Update			
6.1.1	Review laws	60%	27%	13%
6.1.2	Communication with governing bodies	58%	23%	19%
6.2	Education			
6.2.1	Consistency	63%	29%	8%
6.2.2	Laws and licenses accessible to public	77%	n/a*	23%
6.2.3	Education	83%	n/a	17%
6.3	Conduct and Monitor Activities			
6.3.1	Enforcement procedures and protocols	69%	25%	6%
6.3.2	Inspection schedule	56%	13%	31%
6.3.3	Following procedures and protocols	56%	23%	21%
6.3.4	Identifying compliance patterns	42%	29%	29%
6.3.5	Coordinated notification	31%	29%	40%

KEY MEASURES IN DOMAIN 6, % FULLY MET, MINNESOTA CHBS, 2012-2014

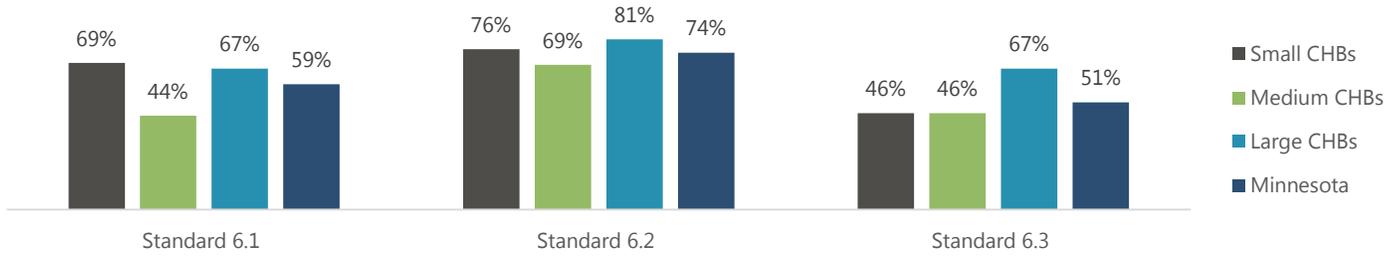
6.3.4
Identifying compl. patterns



* Participants could only choose from "Fully Meet" and "Cannot Meet" in 2014.

STANDARDS IN DOMAIN 6, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014

CHB ability to fully meet standards in Domain 6, by population, Minnesota, 2014



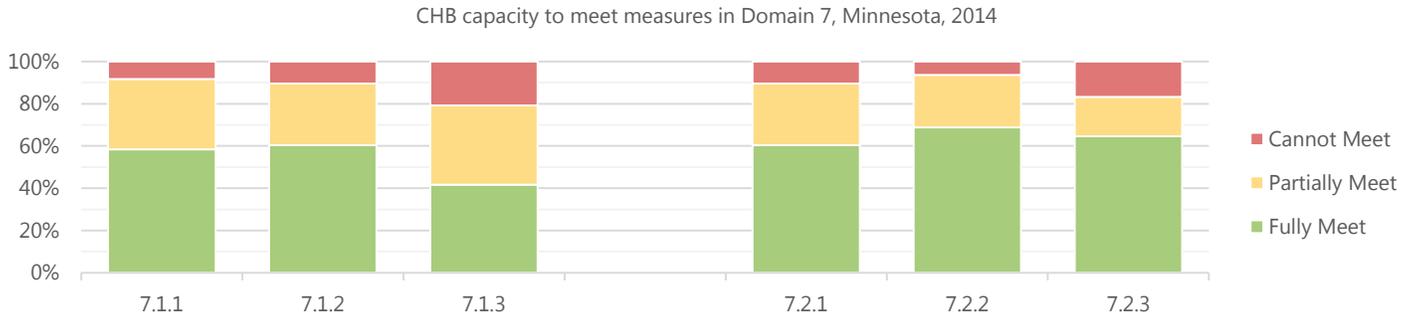
CHB capacity to meet measures in Domain 6, by population, Minnesota, 2014

	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
6.1 Review and Update				
6.1.1 Review laws	61%	50%	75%	60%
6.1.2 Communication with governing bodies	78%	39%	58%	58%
6.2 Education				
6.2.1 Consistency	56%	67%	67%	63%
6.2.2 Laws and licenses accessible to public	78%	72%	83%	77%
6.2.3 Education	94%	67%	92%	83%
6.3 Conduct and Monitor Activities				
6.3.1 Enforcement procedures and protocols	61%	72%	75%	69%
6.3.2 Inspection schedule	44%	50%	83%	56%
6.3.3 Following procedures and protocols	50%	50%	75%	56%
6.3.4 Identifying compliance patterns	39%	39%	50%	42%
6.3.5 Coordinated notification	33%	17%	50%	31%

DOMAIN 7: ACCESS TO CARE

Promote strategies to improve access to health care

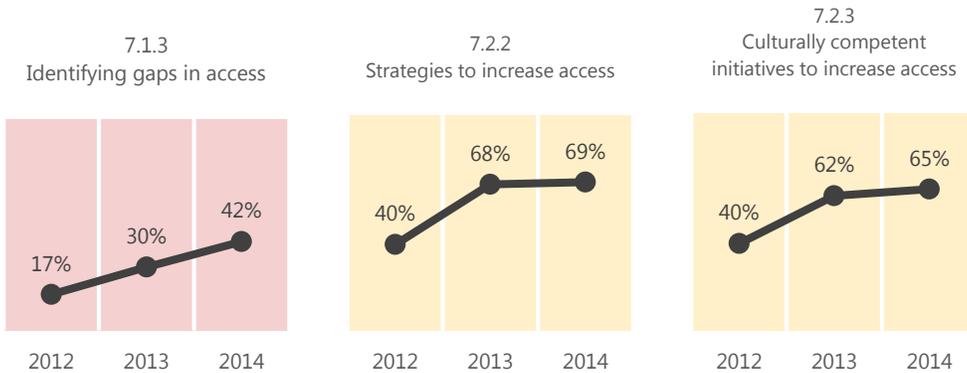
ALL MEASURES IN DOMAIN 7, MINNESOTA CHBS, 2014



CHB capacity to meet measures in Domain 7, Minnesota, 2014 (n=48)

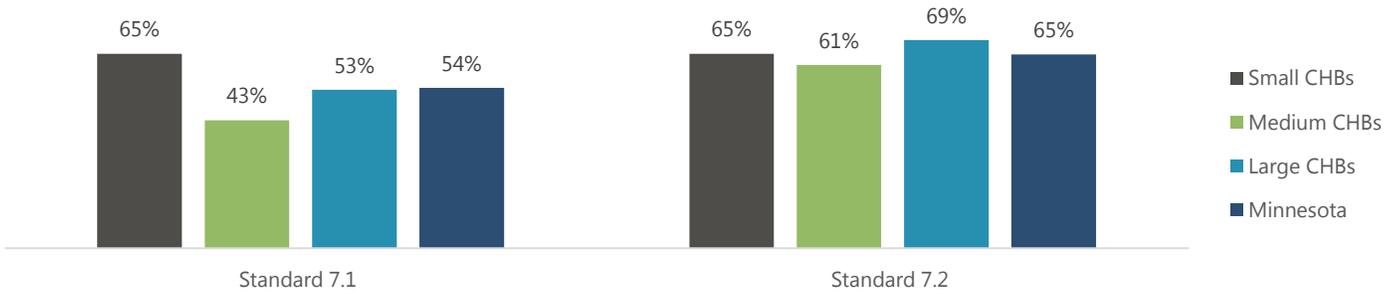
	Fully Meet	Partially Meet	Cannot Meet
7.1 Assess Capacity and Access			
7.1.1 Assessing available health services	58%	33%	8%
7.1.2 Identifying populations with barriers	60%	29%	10%
7.1.3 Identifying gaps in access	42%	38%	21%
7.2 Strategies to Improve Access			
7.2.1 Strategy development process	60%	29%	10%
7.2.2 Implemented strategies	69%	25%	6%
7.2.3 Culturally competent initiatives	65%	19%	17%

KEY MEASURES IN DOMAIN 7, % FULLY MET, MINNESOTA CHBS, 2012-2014



STANDARDS IN DOMAIN 7, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014

CHB capacity to fully meet standards in Domain 7, by population, Minnesota, 2014



CHB capacity to meet measures in Domain 7, by population, Minnesota, 2014

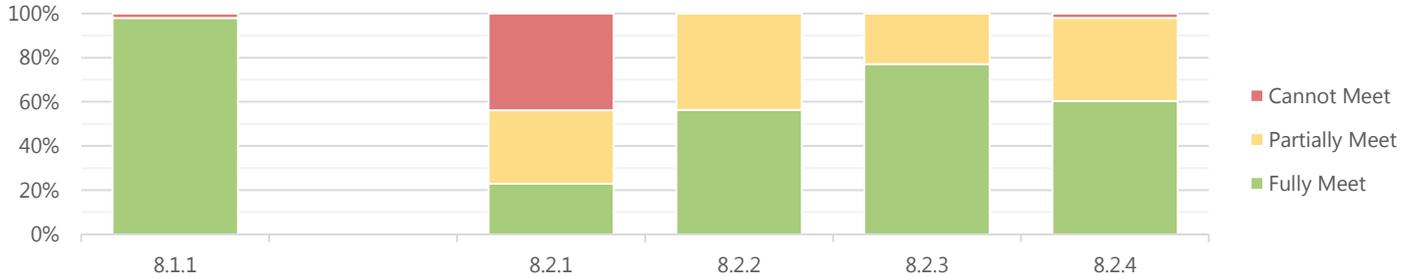
	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
7.1 Assess Capacity and Access				
7.1.1 Assessing available health services	61%	56%	58%	58%
7.1.2 Identifying populations with barriers	83%	39%	58%	60%
7.1.3 Identifying gaps in access	50%	33%	42%	42%
7.2 Strategies to Improve Access				
7.2.1 Strategy development process	56%	61%	67%	60%
7.2.2 Implemented strategies	67%	72%	67%	69%
7.2.3 Culturally competent initiatives	72%	50%	75%	65%

DOMAIN 8: WORKFORCE

Maintain a competent public health workforce

ALL MEASURES IN DOMAIN 8, MINNESOTA CHBS, 2014

CHB capacity to meet measures in Domain 8, Minnesota, 2014



CHB capacity to meet measures in Domain 8, Minnesota, 2014 (n=48)

Fully Meet Partially Meet Cannot Meet

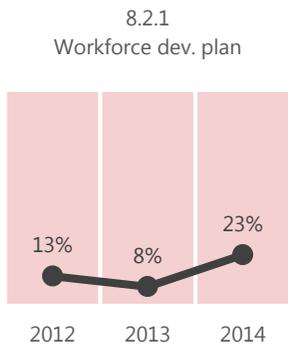
8.1 Sufficient Public Health Workforce

8.1.1	Collaboration to develop future workforce	98%	n/a*	2%
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8.2 Competent Workforce

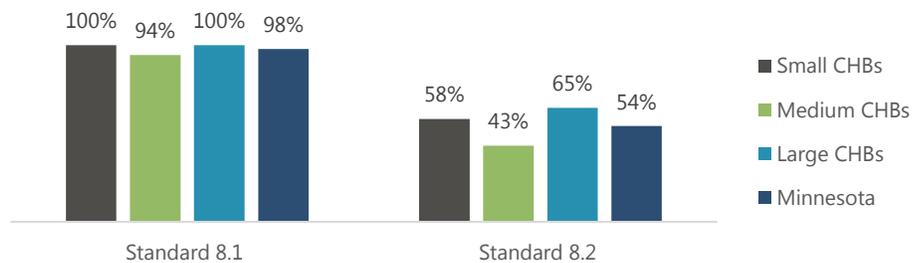
8.2.1	Workforce development plan	23%	33%	44%
8.2.2	Competent workforce	56%	44%	0%
8.2.3	Professional development	77%	23%	0%
8.2.4	Work environment	60%	38%	2%

KEY MEASURES IN DOMAIN 8, % FULLY MET, MINN. CHBS, 2012-2014



STANDARDS IN DOMAIN 8, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014

CHB capacity to fully meet standards in Domain 8, by population, Minnesota, 2014



CHB capacity to meet measures in Domain 8, by population, Minnesota, 2014

	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
8.1 Sufficient Public Health Workforce				
8.1.1 Collaboration to develop future workforce	100%	94%	100%	98%
8.2 Competent Workforce				
8.2.1 Workforce development plan	23%	11%	42%	23%
8.2.2 Competent workforce	67%	39%	67%	56%
8.2.3 Professional development	83%	72%	75%	77%
8.2.4 Work environment	61%	50%	75%	60%

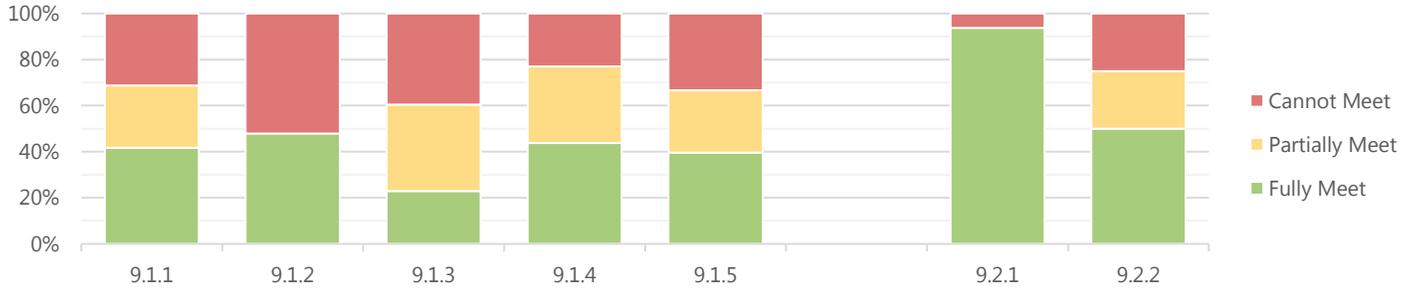
* Participants could only choose from "Fully Meet" and "Cannot Meet" in 2014.

DOMAIN 9: QUALITY IMPROVEMENT

Evaluate and continuously improve processes, programs, and interventions

ALL MEASURES IN DOMAIN 9, MINNESOTA CHBS, 2014

CHB capacity to meet measures in Domain 9, Minnesota, 2014



CHB capacity to meet measures in Domain 9, Minnesota, 2014 (n=48)

Fully Meet Partially Meet Cannot Meet

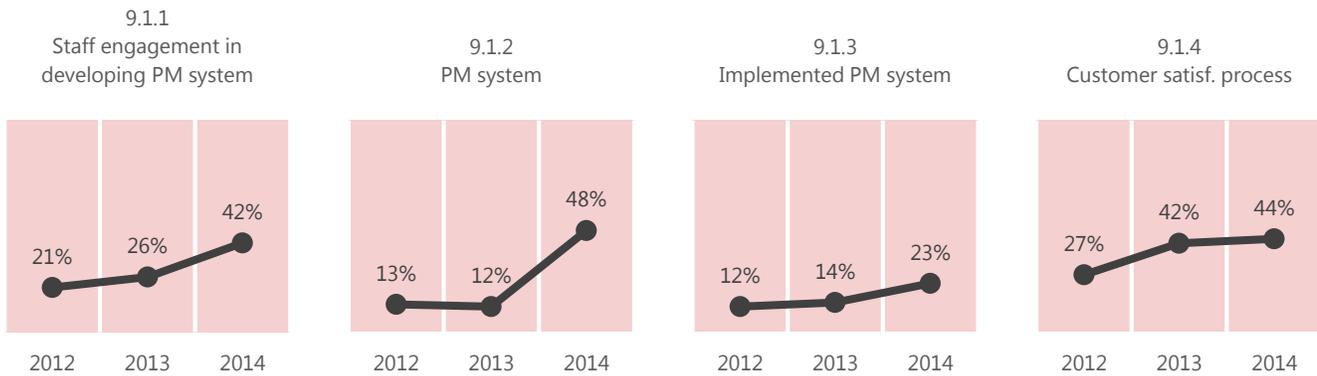
9.1 Performance Management System

9.1.1	Staff engagement in development	42%	27%	31%
9.1.2	Performance management system	48%	n/a*	52%
9.1.3	Implemented performance management system	23%	38%	40%
9.1.4	Customer satisfaction	44%	33%	23%
9.1.5	Opportunities for staff involvement	40%	27%	33%

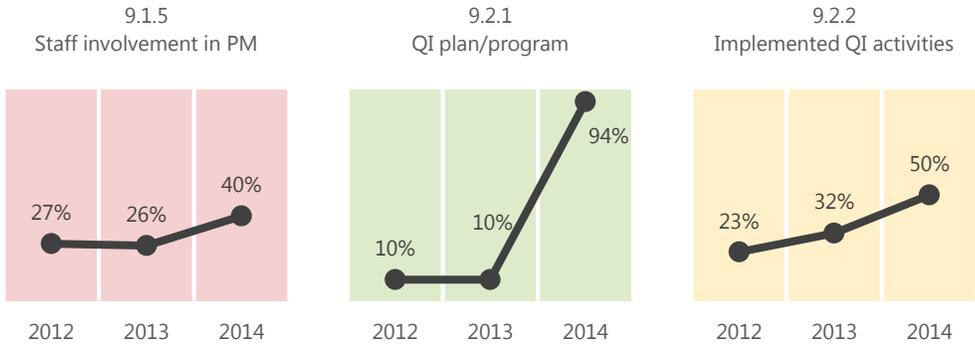
9.2 Quality Improvement

9.2.1	Quality improvement plan/program	94%	0%	6%
9.2.2	Implemented quality improvement activities	50%	25%	25%

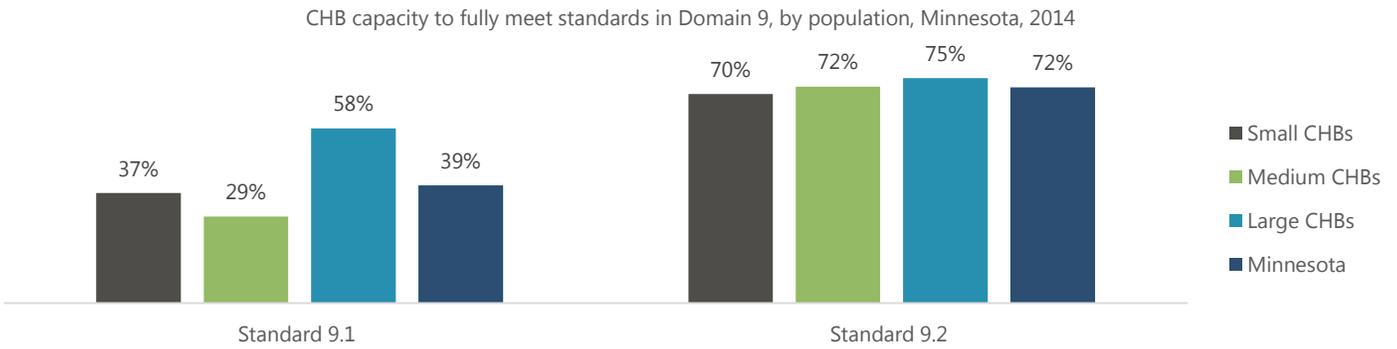
KEY MEASURES IN DOMAIN 9, % FULLY MET, MINNESOTA CHBS, 2012-2014



* Participants could only choose from "Fully Meet" and "Cannot Meet" in 2014.



STANDARDS IN DOMAIN 9, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014



CHB capacity to meet measures in Domain 9, by population, Minnesota, 2014

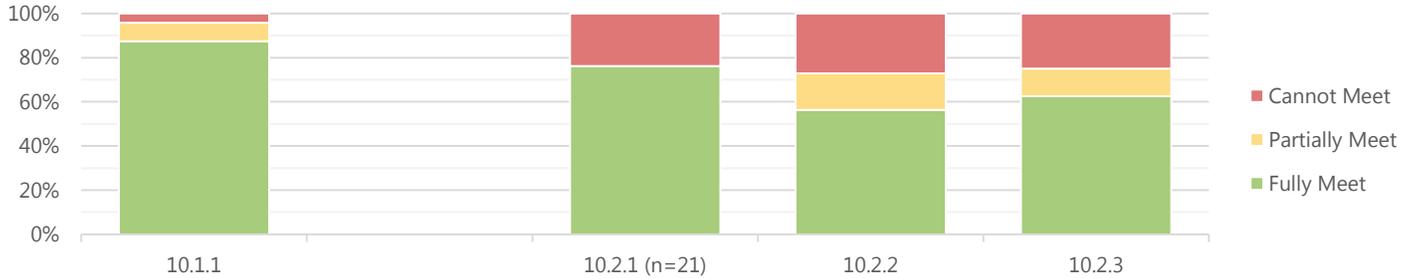
	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
9.1 Performance Management System				
9.1.1 Staff engagement in development	33%	33%	67%	42%
9.1.2 Performance management system	50%	28%	75%	48%
9.1.3 Implemented performance management system	28%	6%	42%	23%
9.1.4 Customer satisfaction	33%	44%	58%	44%
9.1.5 Opportunities for staff involvement	39%	33%	50%	40%
9.2 Quality Improvement				
9.2.1 Quality improvement plan/program	94%	100%	83%	94%
9.2.2 Implemented quality improvement activities	44%	44%	67%	50%

DOMAIN 10: EVIDENCE-BASED PRACTICES

Contribute to and apply the evidence base of public health

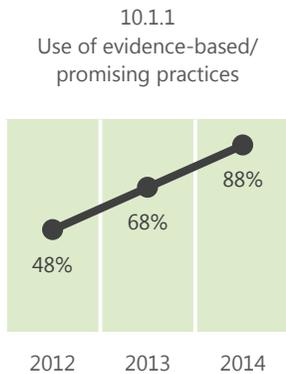
ALL MEASURES IN DOMAIN 10, MINNESOTA CHBS, 2014

CHB capacity to meet measures in Domain 10, Minnesota, 2014

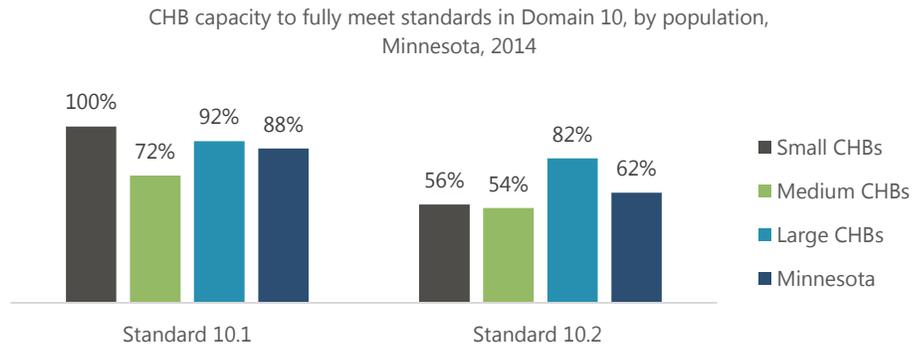


CHB capacity to meet measures in Domain 10, Minnesota, 2014 (n=48)		Fully Meet	Partially Meet	Cannot Meet
10.1	Identification and Use			
10.1.1	Use of evidence-based/promising practices	88%	8%	4%
10.2	Promotion			
10.2.1	Human subject protection	n=21	n/a*	24%
10.2.2	Expert analysis	56%	17%	27%
10.2.3	Communication	63%	13%	25%

KEY MEASURES IN DOMAIN 10, % FULLY MET, MINN. CHBS, 2012-2014



STANDARDS IN DOMAIN 10, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014



CHB capacity to meet measures in Domain 10, by population, Minnesota, 2014

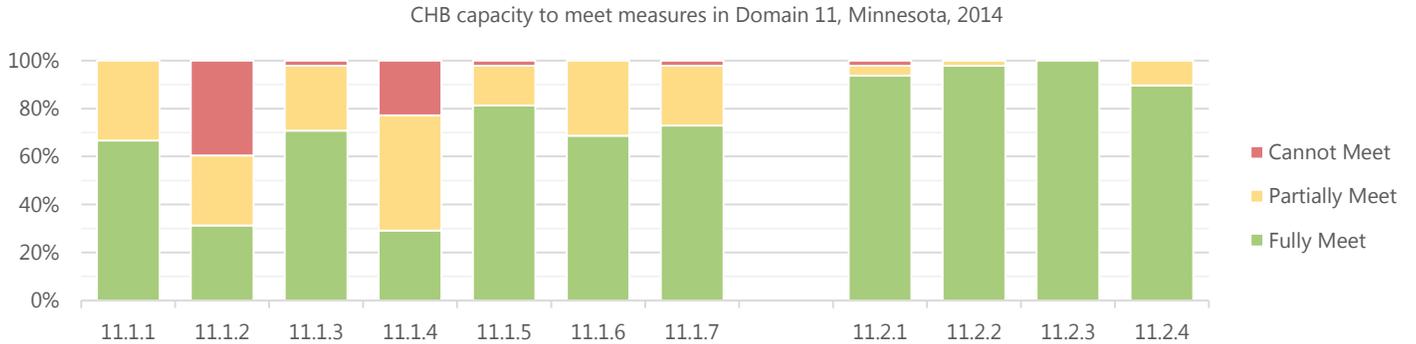
		Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
10.1	Identification and Use				
10.1.1	Use of evidence-based/promising practices	100%	72%	92%	88%
10.2	Promotion				
10.2.1	Human subject protection	71% (n=7)	80% (n=5)	78% (n=9)	76% (n=21)
10.2.2	Expert analysis	50%	44%	83%	56%
10.2.3	Communication	56%	56%	83%	63%

* Participants could only choose from "Fully Meet" and "Cannot Meet" in 2014.

DOMAIN 11: ADMINISTRATION AND MANAGEMENT

Maintain administrative and management capacity

ALL MEASURES IN DOMAIN 11, MINNESOTA CHBS, 2014



CHB capacity to meet measures in Domain 11, Minnesota, 2014 (n=48)

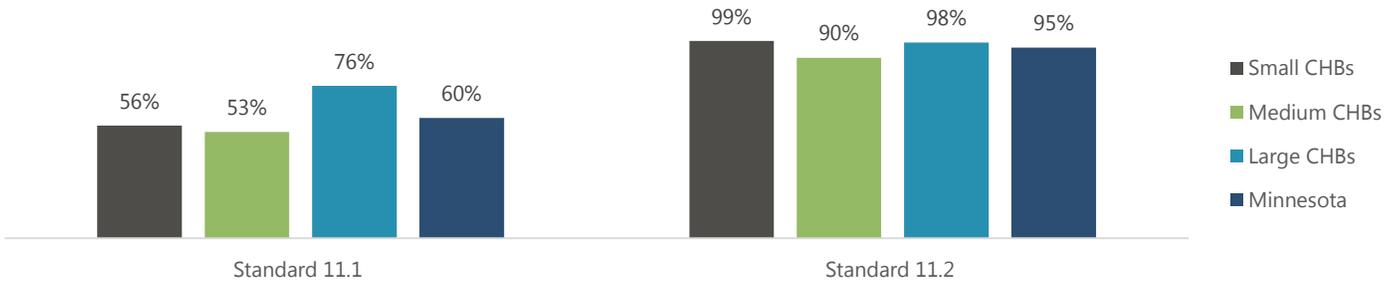
	Fully Meet	Partially Meet	Cannot Meet
11.1 Operational Infrastructure			
11.1.1 CHB policies and procedures	67%	33%	0%
11.1.2 Ethical issues and decisions	31%	29%	40%
11.1.3 Confidentiality policies	71%	27%	2%
11.1.4 Cultural sensitivity	29%	48%	23%
11.1.5 Human resources	81%	17%	2%
11.1.6 Information management	69%	31%	0%
11.1.7 Clean, safe, accessible, and secure facilities	73%	25%	2%
11.2 Financial Management			
11.2.1 Oversight of grants and contracts	94%	4%	2%
11.2.2 Written agreements	98%	2%	0%
11.2.3 Financial management systems	100%	0%	0%
11.2.4 Additional resources to support CHB	90%	10%	0%

KEY MEASURES IN DOMAIN 11, % FULLY MET, MINNESOTA CHBS, 2012-2014



STANDARDS IN DOMAIN 11, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014

CHB capacity to fully meet standards in Domain 11, by population, Minnesota, 2014



CHB capacity to meet measures in Domain 11, by population, Minnesota, 2014

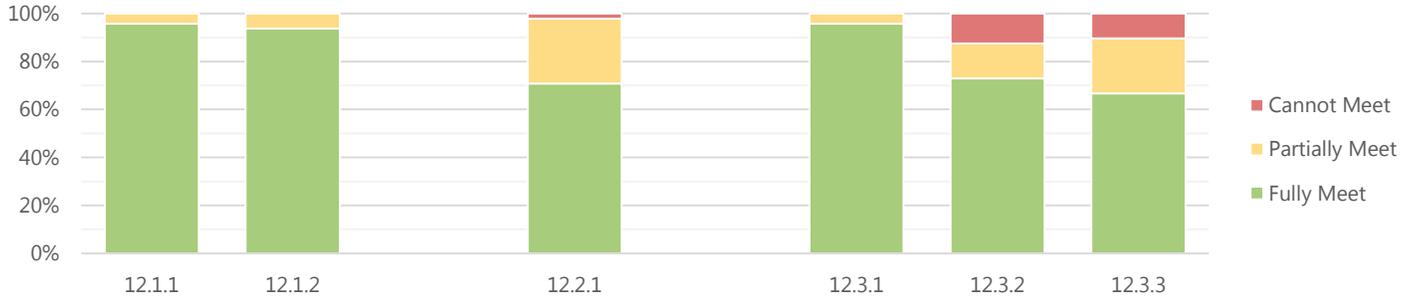
	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
11.1 Operational Infrastructure				
11.1.1 CHB policies and procedures	56%	72%	75%	67%
11.1.2 Ethical issues and decisions	28%	17%	58%	31%
11.1.3 Confidentiality policies	67%	61%	92%	71%
11.1.4 Cultural sensitivity	28%	11%	58%	29%
11.1.5 Human resources	78%	78%	92%	81%
11.1.6 Information management	72%	61%	75%	69%
11.1.7 Clean, safe, accessible, and secure facilities	67%	72%	83%	73%
11.2 Financial Management				
11.2.1 Oversight of grants and contracts	100%	83%	100%	94%
11.2.2 Written agreements	94%	100%	100%	98%
11.2.3 Financial management systems	100%	100%	100%	100%
11.2.4 Additional resources to support CHB	100%	78%	92%	90%

DOMAIN 12: GOVERNANCE

Maintain capacity to engage the public health governing entity

ALL MEASURES IN DOMAIN 12, MINNESOTA CHBS, 2014

CHB capacity to meet measures in Domain 12, Minnesota, 2014

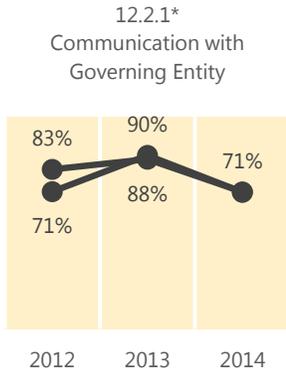


CHB capacity to meet measures in Domain 12, Minnesota, 2014 (n=48)

Fully Meet Partially Meet Cannot Meet

12.1 Roles, Responsibilities, and Authorities		Fully Meet	Partially Meet	Cannot Meet
12.1.1	Mandated operations, programs, and services provided	96%	4%	0%
12.1.2	Operational definitions of governing entity's roles/responsibilities	94%	6%	0%
12.2 Communication		Fully Meet	Partially Meet	Cannot Meet
12.2.1	Communication with governing entity regarding responsibilities	71%	27%	2%
12.3 Engagement		Fully Meet	Partially Meet	Cannot Meet
12.3.1	Providing information to governing entity on important issues/actions	96%	4%	0%
12.3.2	Tracking/reviewing governing entity actions	73%	15%	13%
12.3.3	Communication with governing entity about performance	67%	23%	10%

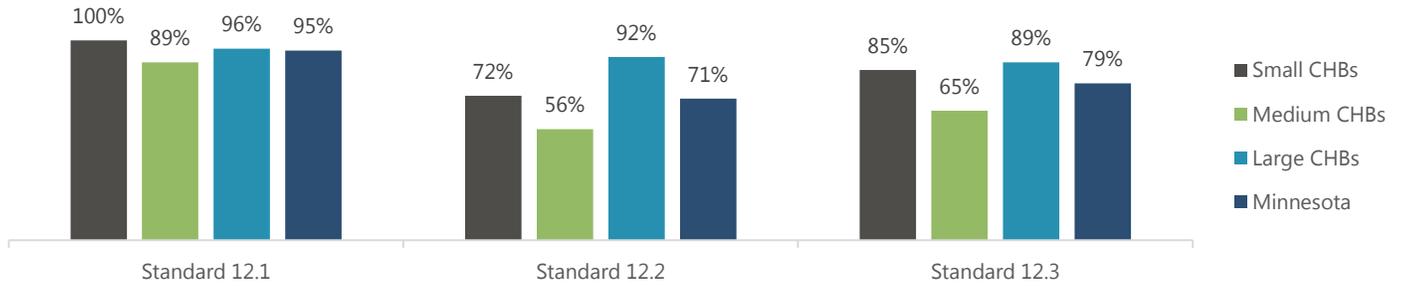
KEY MEASURES* IN DOMAIN 12, % FULLY MET, MINNESOTA CHBS, 2012-2014



* This measure was previously listed as two separate measures in PHAB Standards and Measures v1.0: 12.2.1A and 12.2.2A.

STANDARDS IN DOMAIN 12, % FULLY MET BY POPULATION, MINNESOTA CHBS, 2014

CHB capacity to fully meet standards in Domain 12, by population, Minnesota, 2014



CHB capacity to meet measures in Domain 12, by population, Minnesota, 2014

	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
12.1 Roles, Responsibilities, and Authorities				
12.1.1 Mandated operations, programs, and services provided	100%	89%	100%	96%
12.1.2 Operational definitions of governing entity's roles/responsibilities	100%	90%	92%	94%
12.2 Communication				
12.2.1 Communication with governing entity regarding responsibilities	72%	56%	92%	71%
12.3 Engagement				
12.3.1 Providing information to governing entity on important issues/actions	100%	89%	100%	96%
12.3.2 Tracking/reviewing governing entity actions	83%	56%	83%	73%
12.3.3 Communication with governing entity about performance	72%	50%	83%	67%

ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

WORKFORCE COMPETENCY

WORKFORCE STRENGTHS AND GAPS, MINNESOTA CHBS, 2014



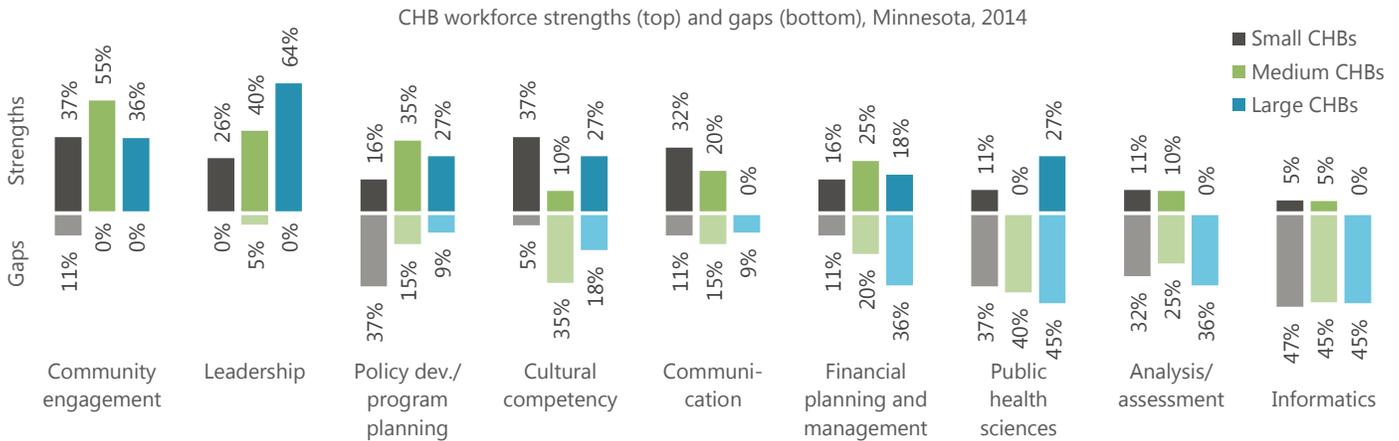
CHB workforce strengths and gaps, Minnesota, 2014 (n=50)

	Strengths	Gaps
Analysis/assessment	8%	31%
Policy development/program planning	27%	22%
Communication	20%	12%
Cultural competency	25%	20%
Community engagement	45%	4%
Public health sciences	10%	41%
Financial planning and management	20%	20%
Leadership	41%	2%
Informatics	4%	47%

CHANGE IN WORKFORCE STRENGTHS AND GAPS, MINNESOTA CHBS, 2014



WORKFORCE STRENGTHS AND GAPS, BY POPULATION, MINNESOTA CHBS, 2014



CHB workforce strengths and gaps, by population, Minnesota, 2014	Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
Workforce Strengths				
Analysis/assessment	11%	10%	0%	8%
Policy development/program planning	16%	35%	27%	27%
Communication	32%	20%	0%	20%
Cultural competency	37%	10%	27%	25%
Community engagement	37%	55%	36%	45%
Public health sciences	11%	0%	27%	10%
Financial planning and management	16%	25%	18%	20%
Leadership	26%	40%	64%	41%
Informatics	5%	5%	0%	4%
Workforce Gaps				
Analysis/assessment	32%	25%	36%	31%
Policy development/program planning	37%	15%	9%	22%
Communication	11%	15%	9%	12%
Cultural competency	5%	35%	18%	20%
Community engagement	11%	0%	0%	4%
Public health sciences	37%	40%	45%	41%
Financial planning and management	11%	20%	36%	20%
Leadership	0%	5%	0%	2%
Informatics	47%	45%	45%	47%

WORKFORCE STRENGTHS, RANKED, BY POPULATION, MINNESOTA CHBS, 2014

Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
1 Community engagement	1 Community engagement	1 Leadership	1 Community engagement
2 Cultural competency	2 Leadership	2 Community engagement	2 Leadership
3 Communication	3 Policy dev./program planning	3 Policy dev./program planning	3 Policy dev./program planning
4 Leadership	4 Financial planning/mgmt.	4 Cultural competency	4 Cultural competency
5 Policy dev./program planning	5 Communication	5 Public health sciences	5 Communication
6 Financial planning/mgmt.	6 Analysis/assessment	6 Financial planning/mgmt.	6 Financial planning/mgmt.
7 Analysis/assessment	7 Cultural competency	n/r Analysis	7 Public health sciences
8 Public health sciences	8 Informatics	n/r Communication	8 Analysis/assessment
9 Informatics	n/r Public health sciences	n/r Informatics	9 Informatics

n/r: Not ranked

WORKFORCE GAPS, RANKED, BY POPULATION, MINNESOTA CHBS, 2014

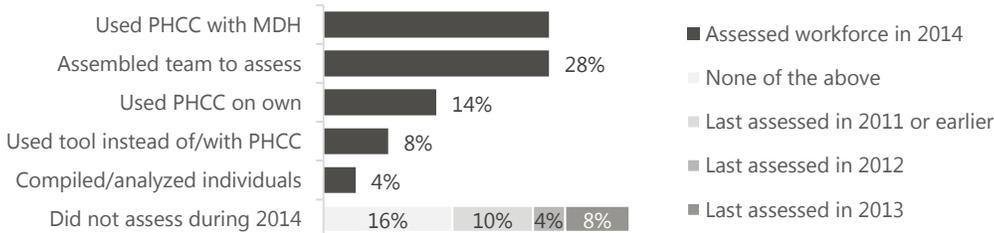
Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
1 Informatics	1 Informatics	1 Informatics	1 Informatics
2 Public health sciences			
3 Policy dev./program planning	3 Cultural competency	3 Analysis/assessment	3 Analysis/assessment
4 Analysis/assessment	4 Analysis/assessment	4 Financial planning and mgmt.	4 Policy dev./program planning
5 Financial planning/mgmt.	5 Financial planning and mgmt.	5 Cultural competency	5 Cultural competency
6 Communication	6 Policy dev./program planning	6 Policy dev./program planning	6 Financial planning and mgmt.
7 Community engagement	7 Communication	7 Communication	7 Communication
8 Cultural competency	8 Leadership	n/r Leadership	8 Community engagement
n/r Leadership	n/r Community engagement	n/r Community engagement	9 Leadership

n/r: Not ranked

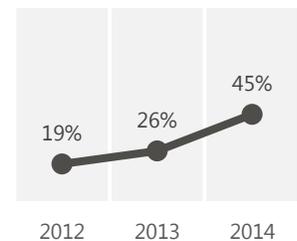
METHOD OF ASSESSING WORKFORCE STRENGTHS AND GAPS, MINNESOTA CHBS, 2014

CHANGE IN METHOD OF ASSESSING WORKFORCE*

Methods used to assess workforce, Minnesota CHBs, 2014



Use of PHCC to assess workforce



Method used to assess workforce strengths/gaps, Minnesota CHBs, 2014

Minnesota (n=50)

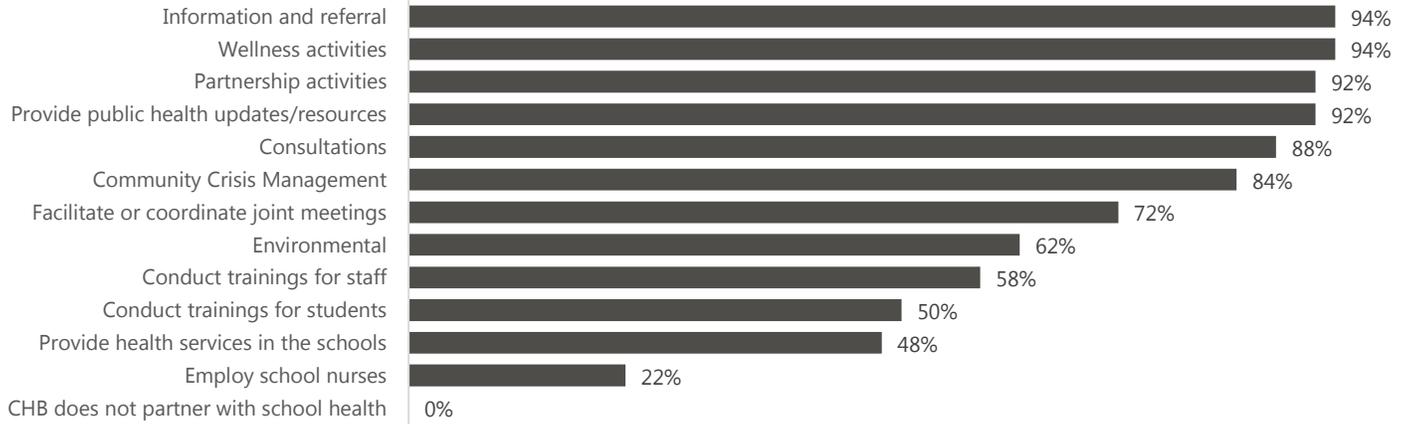
The CHB used the Public Health Core Competencies Tool (PHCC) on its own	14%
The CHB used the Public Health Core Competencies Tool, with assistance from MDH	28%
The CHB used an assessment tool instead of (or in addition to) the PH Core Competencies Tool	8%
The CHB assembled a team knowledgeable of staff skills to conduct a workforce assessment	28%
The CHB compiled and analyzed individual assessments to develop an overall workforce assessment	4%
The CHB did not assess workforce strengths or gaps during this reporting cycle	38%
Most recent CHB workforce assessment performed in 2013	8%
Most recent CHB workforce assessment performed in 2012	4%
Most recent CHB workforce assessment performed in 2011 or earlier	10%
None of the above	16%

* 2014: Includes CHBs that chose "The CHB used the Core Competencies for Public Health Professionals Tool on its own" and "The CHB used the Core Competencies for Public Health Professionals Tool with assistance from MDH." 2012-2013: Includes CHBs that chose "The CHB used the Public Health Core Competencies Tool."

ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

SCHOOL HEALTH

CHB work with school health, Minnesota, 2014



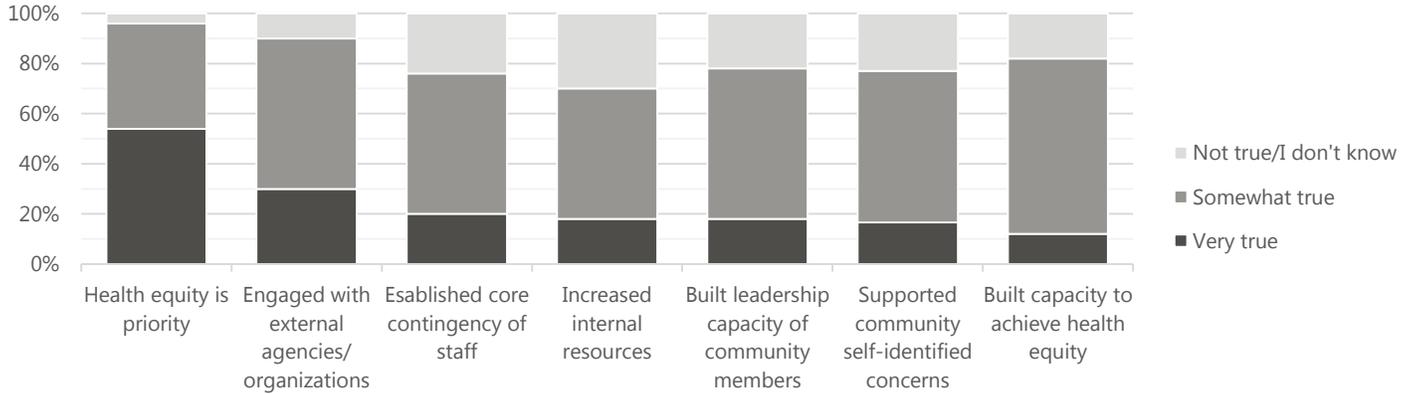
CHB work with school health, Minnesota, 2014	Minnesota (n=50)
Employ school nurses	22%
Partnership activities	92%
Provide health services in the schools	48%
Conduct trainings for staff	58%
Conduct trainings for students	50%
Consultations	88%
Facilitate or coordinate joint meetings	72%
Provide public health updates/resources	92%
Information and referral	94%
Community Crisis Management (e.g., outbreaks)	84%
Wellness activities (e.g., SHIP)	94%
Environmental (e.g., mold, pesticides, lice)	62%
CHB does not partner with school health	0%

ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

HEALTH EQUITY

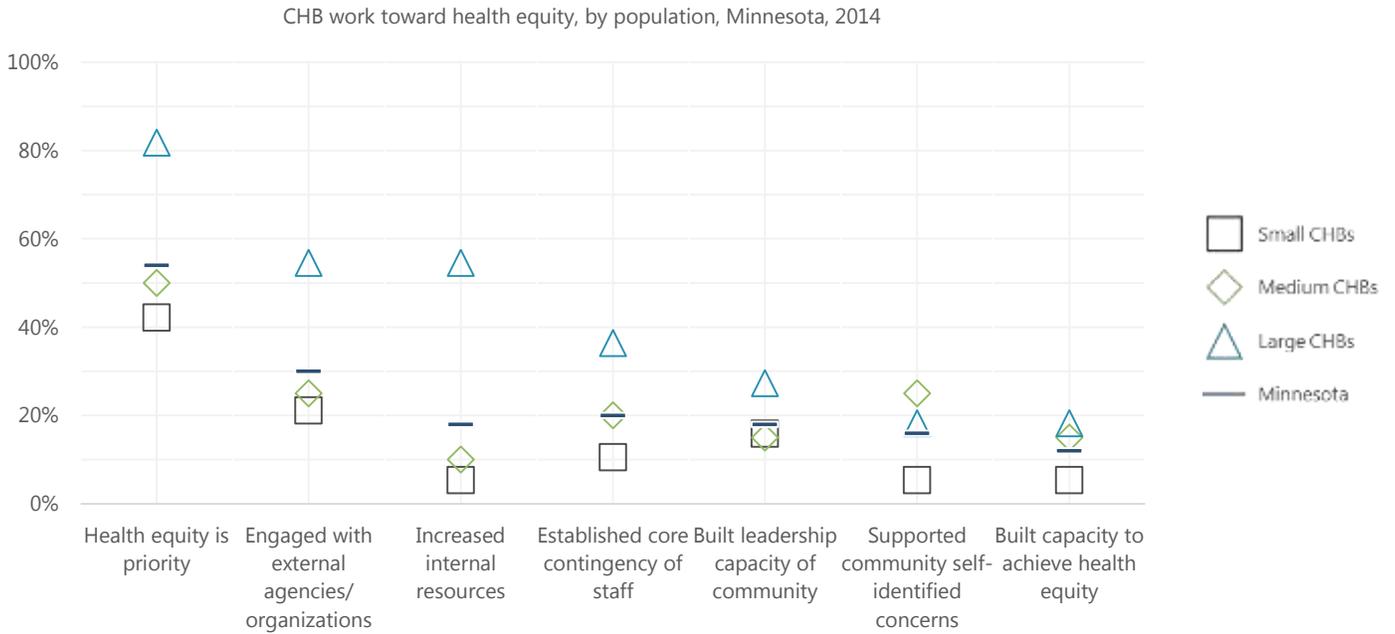
WORK TOWARD HEALTH EQUITY, MINNESOTA CHBS, 2014

CHB work toward health equity, Minnesota, 2014



CHB work toward health equity, Minnesota, 2014 (n=50)	Very true	Somewhat true	Not true	I don't know
My CHB has identified health equity as a priority, with a specific intent to address social determinants of health.	54%	42%	2%	2%
My CHB has built capacity (e.g., human resources, funding, training of staff) to achieve health equity by addressing social determinants of health.	12%	70%	18%	0%
My CHB has established a core contingency of CHB staff who are poised to advance a health equity agenda.	20%	56%	24%	0%
My CHB has increased the amount of internal resources directed to addressing social determinants of health.	18%	52%	30%	0%
My CHB has engaged with local government agencies or other external organizations to support policies and programs to achieve health equity.	30%	60%	10%	0%
My CHB has made deliberate efforts to build the leadership capacity of community members to advocate on issues affecting social determinants of health.	18%	60%	22%	0%
My CHB has provided resources to community groups to support their self-identified concerns for achieving health equity in their community.	16%	58%	22%	0%

AGREEMENT THAT WORK TOWARD HEALTH EQUITY IS “VERY TRUE” IN OWN CHB, BY POPULATION, MINNESOTA CHBS, 2014



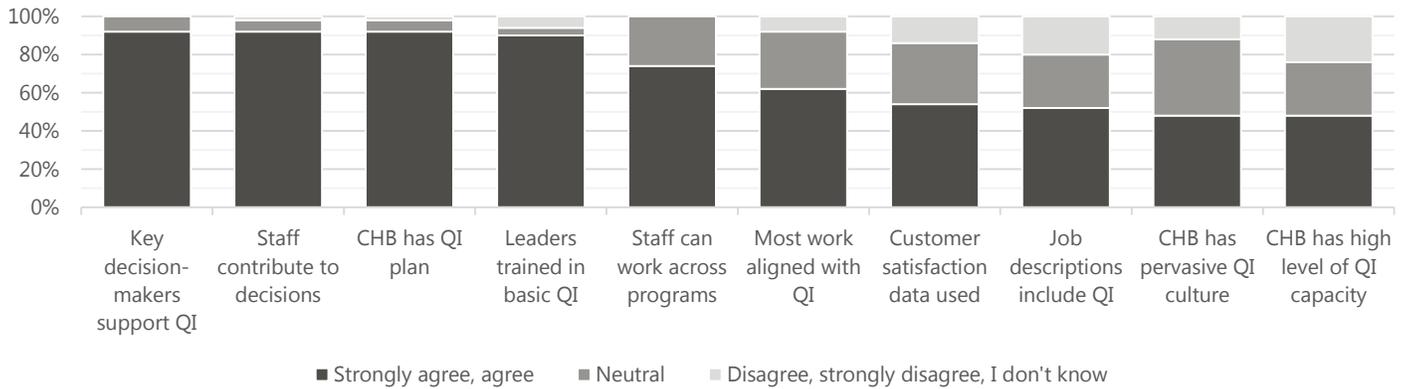
CHB work toward health equity, by population, Minnesota, 2014	Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
My CHB has identified health equity as a priority, with a specific intent to address social determinants of health.	42%	50%	82%	54%
My CHB has built capacity (e.g., human resources, funding, training of staff) to achieve health equity by addressing social determinants of health.	5%	15%	18%	12%
My CHB has established a core contingency of CHB staff who are poised to advance a health equity agenda.	11%	20%	36%	20%
My CHB has increased the amount of internal resources directed to addressing social determinants of health.	5%	10%	55%	18%
My CHB has engaged with local government agencies or other external organizations to support policies and programs to achieve health equity.	21%	25%	55%	30%
My CHB has made deliberate efforts to build the leadership capacity of community members to advocate on issues affecting social determinants of health.	16%	15%	27%	18%
My CHB has provided resources to community groups to support their self-identified concerns for achieving health equity in their community.	5%	25%	18%	16%

ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

ORGANIZATIONAL QUALITY IMPROVEMENT MATURITY

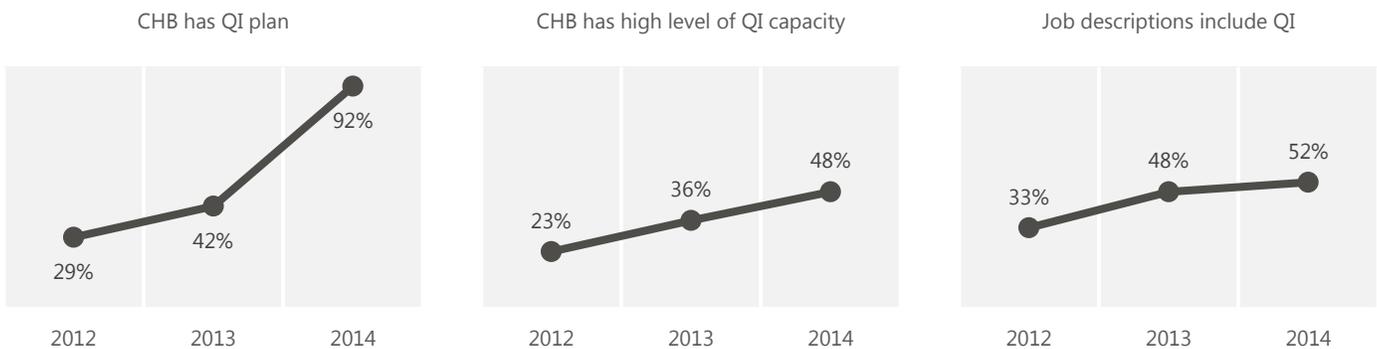
WORK TOWARD ORGANIZATIONAL QUALITY IMPROVEMENT MATURITY, MINNESOTA CHBS, 2014

CHB work toward organizational QI maturity, Minnesota, 2014

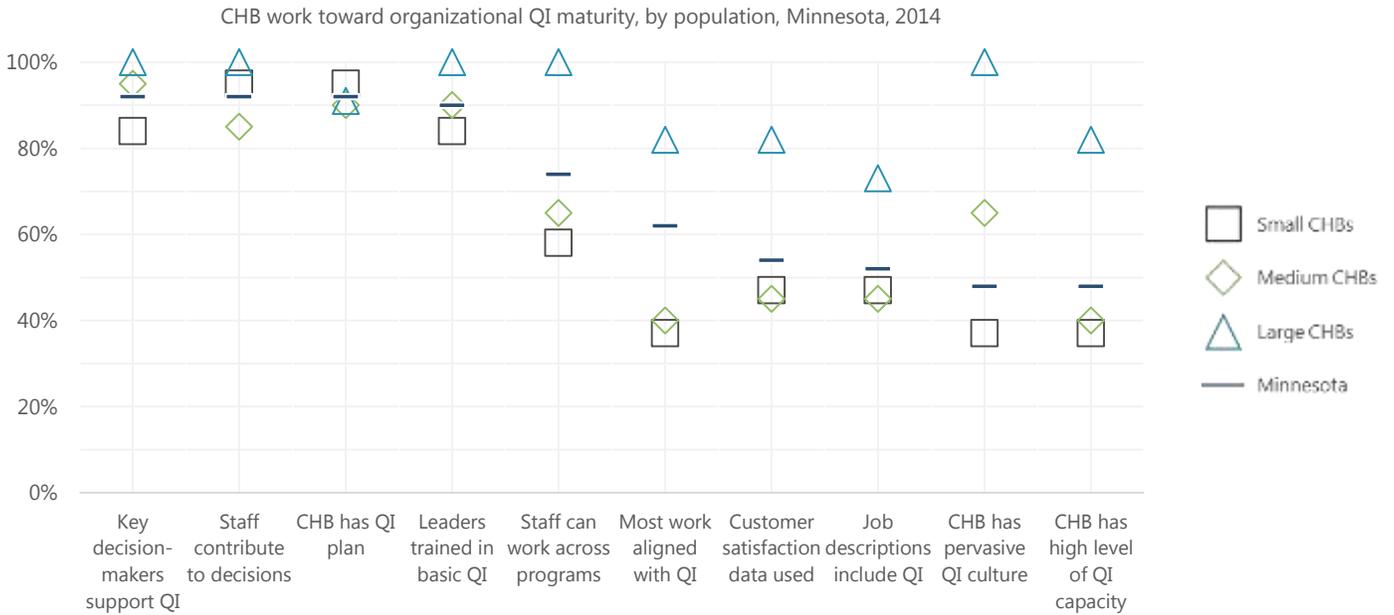


CHB work toward organizational QI maturity, Minnesota, 2014 (n=50)	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
Staff members are routinely asked to contribute to decisions at my CHB.	24%	68%	6%	0%	2%	0%
The leaders of the CHB are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.	36%	54%	4%	4%	0%	2%
Job descriptions for many individuals responsible for programs and services in my CHB include specific responsibilities related to measuring and improving quality.	8%	44%	28%	18%	2%	0%
My CHB has a quality improvement (QI) plan.	66%	26%	6%	2%	0%	0%
Customer satisfaction information is routinely used by many individuals responsible for programs and services in my CHB.	6%	48%	32%	12%	2%	0%
When trying to facilitate change, staff has the authority to work within and across program boundaries.	28%	46%	26%	0%	0%	0%
The key decision makers in my CHB believe QI is very important.	56%	36%	8%	0%	0%	0%
My CHB currently has a pervasive culture that focuses on continuous QI.	10%	38%	40%	10%	2%	0%
My CHB currently has aligned our commitment to quality with most of our efforts, policies, and plans.	12%	50%	30%	8%	0%	0%
My CHB currently has a high level of capacity to engage in QI efforts.	6%	42%	28%	24%	0%	0%

GREATEST CHANGE IN ORGANIZATIONAL QI MATURITY (CHBS THAT AGREE/STRONGLY AGREE), MINNESOTA CHBS, 2014



WORK TOWARD ORGANIZATIONAL QI MATURITY (CHBS THAT STRONGLY AGREE/AGREE), BY POPULATION, MINNESOTA CHBS, 2014

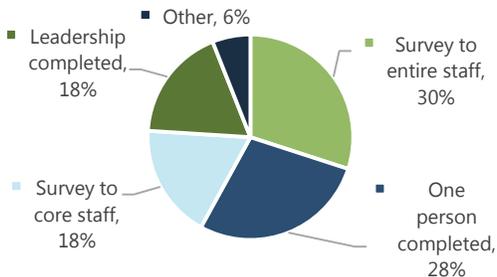


CHB work toward organizational QI maturity (CHBs that strongly agree/agree), by population, Minnesota, 2014

CHB work toward organizational QI maturity (CHBs that strongly agree/agree), by population, Minnesota, 2014	Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
Staff members are routinely asked to contribute to decisions at my CHB.	95%	85%	100%	92%
The leaders of the CHB are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.	84%	90%	100%	90%
Job descriptions for many individuals responsible for programs and services in my CHB include specific responsibilities related to measuring and improving quality.	47%	45%	73%	52%
My CHB has a quality improvement (QI) plan.	95%	90%	91%	92%
Customer satisfaction information is routinely used by many individuals responsible for programs and services in my CHB.	47%	45%	82%	54%
When trying to facilitate change, staff has the authority to work within and across program boundaries.	58%	65%	100%	74%
The key decision makers in my CHB believe QI is very important.	84%	95%	100%	92%
My CHB currently has a pervasive culture that focuses on continuous QI.	37%	65%	100%	48%
My CHB currently has aligned our commitment to quality with most of our efforts, policies, and plans.	37%	40%	82%	62%
My CHB currently has a high level of capacity to engage in QI efforts.	37%	40%	82%	48%

METHOD OF ASSESSING ORGANIZATIONAL QI MATURITY, MINNESOTA CHBS, 2014

Method of assessing organizational quality improvement maturity, Minnesota CHBs, 2014



Method used to assess organizational quality improvement maturity (i.e., completing questions 13-22), Minn. CHBs, 2014	Minnesota (n=50)
One person (e.g., the CHS administrator, public health director, etc.) filled out Q13-22, based on their knowledge of the agency	28%
The agency administered the QI maturity survey to a core group of staff (e.g., leadership team, QI council, etc.), and used those results for answering Q13-22	18%
The agency administered the QI maturity survey to the entire staff, and used those results for answering Q13-22	30%
The agency used another assessment tool (instead of the QI maturity survey) to answer Q13-22	0%
Other	24%

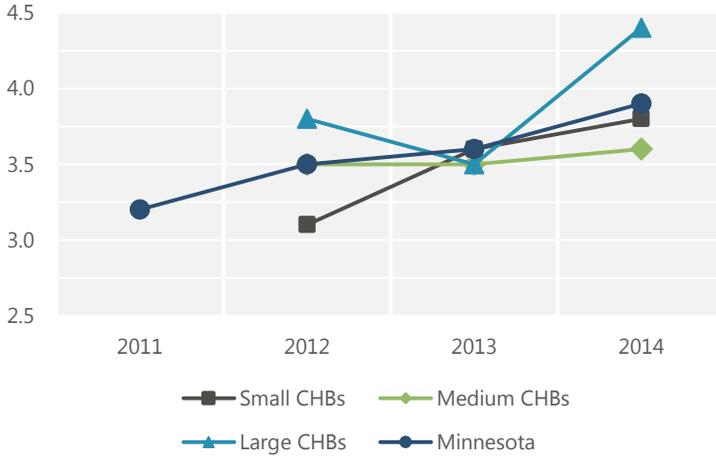
ORGANIZATIONAL QUALITY IMPROVEMENT MATURITY SCORE

The following CHBs are not included in rates below due to governance changes between 2012 and 2014: Horizon, Kandiyohi-Renville, Nobles, Polk-Norman-Mahnomen, SWHHS (Southwest Health and Human Services).

MEDIAN QUALITY IMPROVEMENT MATURITY SCORE, MINNESOTA, 2012-2014

Quality improvement maturity scores can range from 0.0 to 5.0; for the sake of clarity, the full range of available scores is not shown on the vertical axis of the figure below.

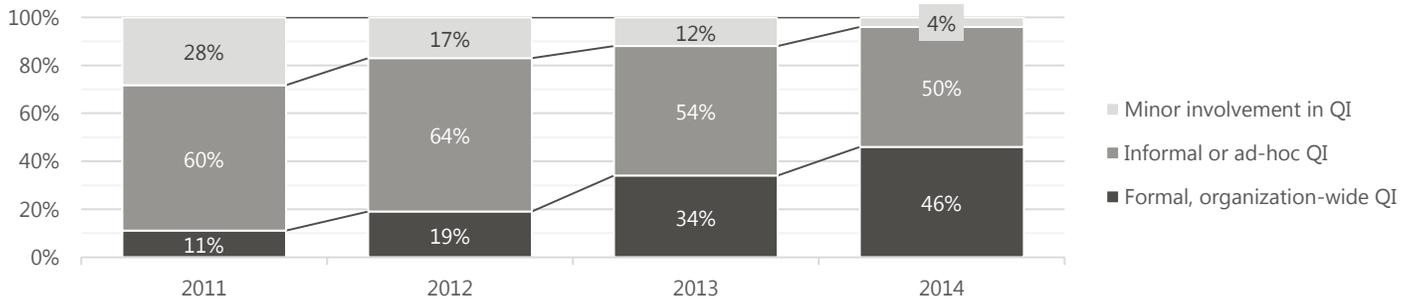
Median quality improvement maturity score, by population, Minnesota, 2012-2014



Median QI maturity score, by pop., Minn., 2012-2014	Small CHBs	Med. CHBs	Large CHBs	Minn.
2011*	n/a	n/a	n/a	3.2
2012	3.1	3.5	3.8	3.5
2013	3.6	3.5	3.5	3.6
2014	3.8	3.6	4.4	3.9

CHANGE IN STATEWIDE QUALITY IMPROVEMENT MATURITY, MINNESOTA, 2012-2014

Statewide organizational QI maturity, Minnesota, 2011-2014



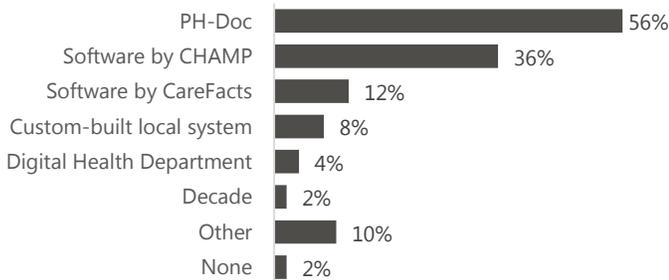
Statewide organizational QI maturity, Minnesota, 2011-2014	Formal, organization-wide QI (score of 4.0 or greater)	Informal or ad-hoc QI (score of 3.0 to 3.9)	Minor involvement in QI (score of 2.9 or less)
2011*	11%	60%	28%
2012	19%	64%	17%
2013	34%	54%	12%
2014	46%	50%	4%

* 2011 data was obtained from the University of Southern Maine as part of the MLC (Multi-State Learning Collaborative) Survey. MDH was able to obtain data for 56 respondents (80 percent response rate), representing a mix of CHBs and LHDs. Data for 2012-2014 was obtained from PPMRS and the reporting entity was the CHB.

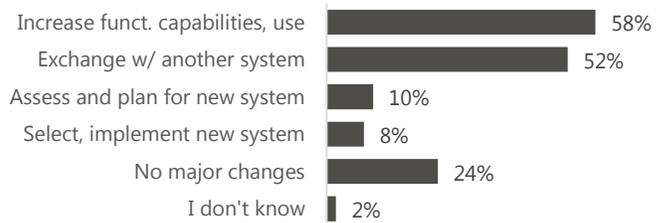
ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

HEALTH INFORMATION TECHNOLOGY

Software used for public health EHR, Minnesota CHBs, 2014



Planned EHR system changes in next 18 months, Minnesota CHBs, 2014



Software applications used for the electronic public health record, Minnesota CHBs, 2014

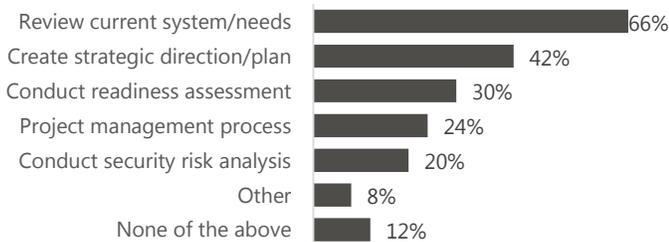
Software applications used for the electronic public health record, Minnesota CHBs, 2014	Minnesota (n=50)
PH-Doc (Public Health Documentation System by MCCC)	56%
Software by CareFacts Information Systems, Inc.	12%
Software by CHAMP Software, Inc.	36%
Digital Health Department (by Garrison Enterprises, Inc.)	4%
Decade (by DECADE Software Company)	2%
Custom-built local system	8%
No electronic system in place	2%
Other	10%

Planned electronic health record system changes in the next 18 months, Minnesota CHBs, 2014

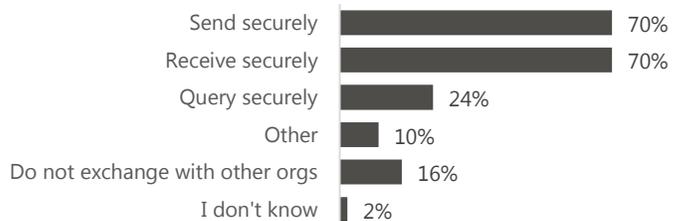
Planned electronic health record system changes in the next 18 months, Minnesota CHBs, 2014	Minnesota (n=50)
Assess and plan for a new EHR system	10%
Select and implement a new EHR system	8%
Increase the functional capabilities or use of the EHR system	58%
Electronically exchange health information with another system	52%
No major changes planned to current EHR system	24%
I don't know	2%

CURRENT HIT/HIE ACTIVITIES, MINNESOTA CHBS, 2014

Current organizational activities related to informatics, Minnesota CHBs, 2014



Current health information exchange activities, Minnesota CHBs, 2014



Current organizational activities related to health informatics, Minnesota CHBs, 2014

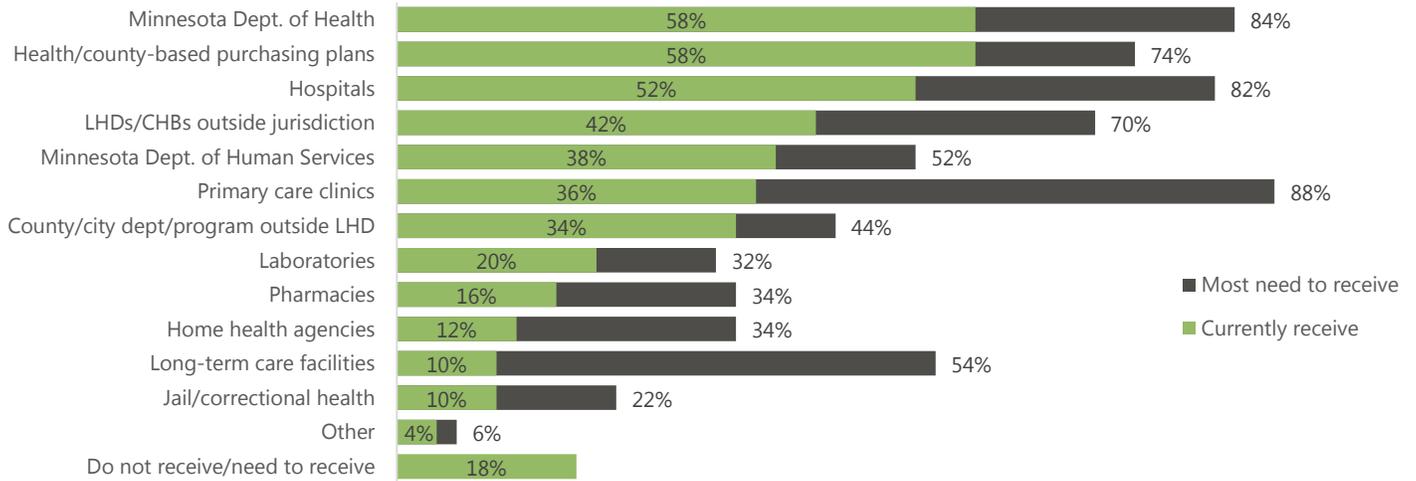
Current organizational activities related to health informatics, Minnesota CHBs, 2014	Minnesota (n=50)
Review current system and determine information needs of your organization	66%
Create a strategic direction or plan for public health EHR	42%
Implement a formal project management process (i.e., use of project charter)	20%
Conduct or review security risk analysis information and privacy/confidentiality control in regard to EHR system	30%
Conduct a readiness assessment for exchange (e.g., Public Health Informatics Profile Toolkit)	24%
Other	8%
None	12%

Current activities related to health information exchange, Minnesota CHBs, 2014

Current activities related to health information exchange, Minnesota CHBs, 2014	Minnesota (n=50)
Send secure messages or attachments to providers/facilities/organizations (e.g., during referrals, care transitions)	70%
Receive secure messages or attachments from providers/facilities/ organizations (e.g., information from specialists, hospitals to which your patients were referred)	70%
Securely query for patient records from providers/facilities/organizations	24%
I don't know	2%
Do not exchange with other organizations	16%
Other	10%

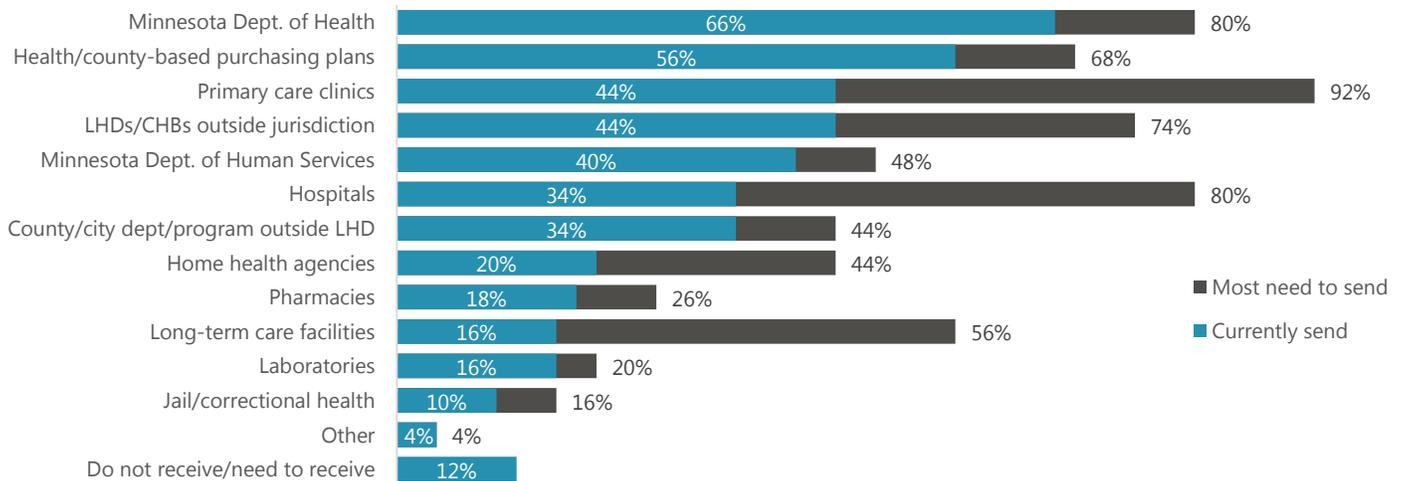
EXCHANGING WITH PARTNERS, MINNESOTA CHBS, 2014

Current and most needed partners from which Minnesota CHBs need to electronically receive health information, 2014



Current partners from which Minnesota CHBs electronically receive health information, and partners from which Minnesota CHBs most need to electronically receive health information, 2014 (n=50)	Currently receive	Most need to receive
County/city department/program outside or inside jurisdiction but outside local health department	34%	44%
Health or county-based purchasing plans	58%	74%
Home health agencies	12%	34%
Hospitals	52%	82%
Jail/correctional health	10%	22%
Laboratories	20%	32%
Local health departments/CHBs outside jurisdiction	42%	70%
Long-term care facilities	10%	54%
Minnesota Dept. of Health	58%	84%
Minnesota Dept. of Human Services	38%	52%
Pharmacies	16%	34%
Primary care clinics	36%	88%
Other	4%	6%
Do not electronically receive/need to receive health information	18%	0%

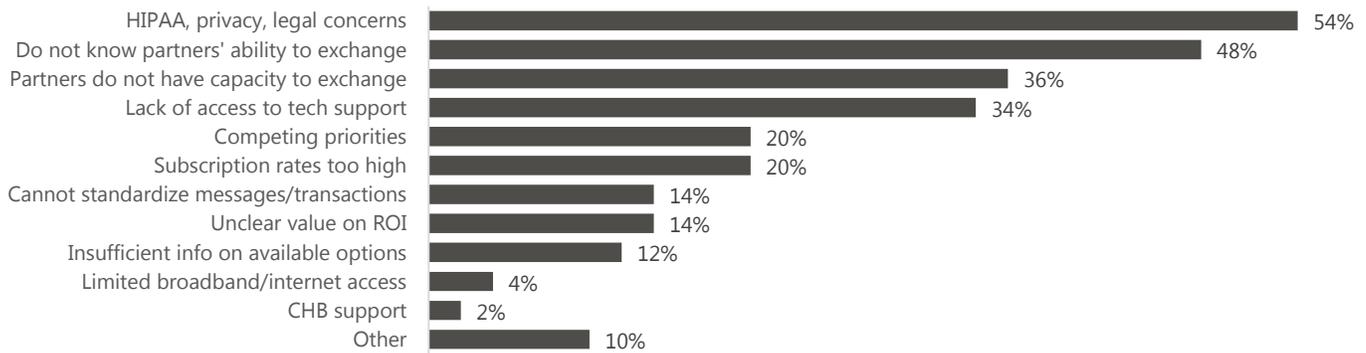
Current and most needed partners from which Minnesota CHBs need to electronically receive health information, 2014



Current partners from which Minnesota CHBs electronically send health information, and partners from which Minnesota CHBs most need to electronically send health information, 2014 (n=50)	Currently send	Most need to send
County/city department/program outside or inside jurisdiction but outside local health department	34%	44%
Health or county-based purchasing plans	56%	68%
Home health agencies	20%	44%
Hospitals	34%	80%
Jail/correctional health	10%	16%
Laboratories	16%	20%
Local health departments/CHBs outside jurisdiction	44%	74%
Long-term care facilities	16%	56%
Minnesota Dept. of Health	66%	80%
Minnesota Dept. of Human Services	40%	48%
Pharmacies	18%	26%
Primary care clinics	44%	92%
Other	4%	4%
Do not electronically receive/need to receive health information	12%	0%

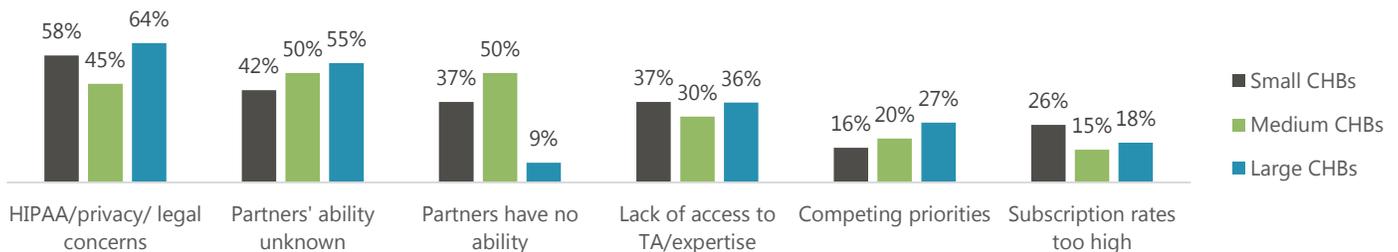
CHALLENGES RELATED TO ELECTRONIC EXCHANGE, MINNESOTA CHBS, 2014

Largest challenges related to health information exchange with external organizations, Minnesota CHBs, 2014



Largest challenges related to health information exchange with external organizations, Minnesota CHBs, 2014	Minnesota (n=50)
CHB support	2%
Competing priorities	20%
Do not know exchange partners' ability to electronically exchange health information	48%
Exchange partners do not have the ability to electronically exchange health information	36%
HIPAA, privacy, or legal concerns	54%
Inability of our organization's EHR system to generate/receive electronic messages/transactions in standardized format	14%
Insufficient information on exchange options available	12%
Lack of access to technical support or expertise	34%
Limited broadband/Internet access	4%
Subscription rates for exchange services are too high	20%
Unclear value on return on investment (ROI)	14%
Other	10%

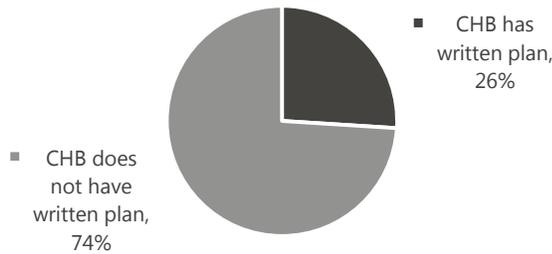
Largest challenges related to health information exchange with external organizations, by population, Minnesota CHBs, 2014



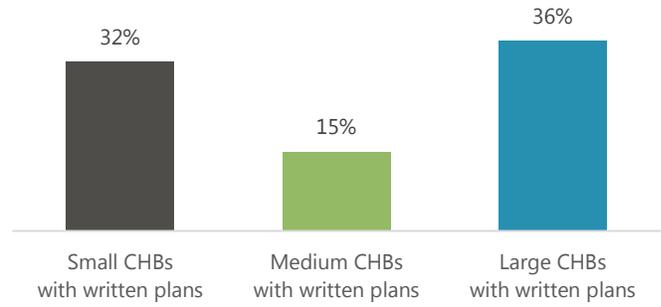
Largest challenges related to HIE with external organizations, by population, Minnesota CHBs, 2014	Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
CHB support	5%	0%	0%	2%
Competing priorities	16%	20%	27%	20%
Do not know partners' ability to electronically exchange health info.	42%	50%	55%	48%
Partners do not have the ability to electronically exchange health info.	37%	50%	9%	36%
HIPAA, privacy, or legal concerns	58%	45%	64%	54%
Inability of our organization's EHR system to generate/receive electronic messages/transactions in standardized format	0%	20%	27%	14%
Insufficient information on exchange options available	11%	10%	18%	12%
Lack of access to technical support or expertise	37%	30%	36%	34%
Limited broadband/internet access	5%	5%	0%	4%
Subscription rates for exchange services are too high	26%	15%	18%	20%
Unclear value on return on investment (ROI)	16%	15%	9%	14%
Other	5%	10%	18%	10%

WRITTEN ELECTRONIC HEALTH INFORMATION EXCHANGE PLANS, MINNESOTA CHBS, 2014

Electronic HIE plans, Minnesota CHBs, 2014



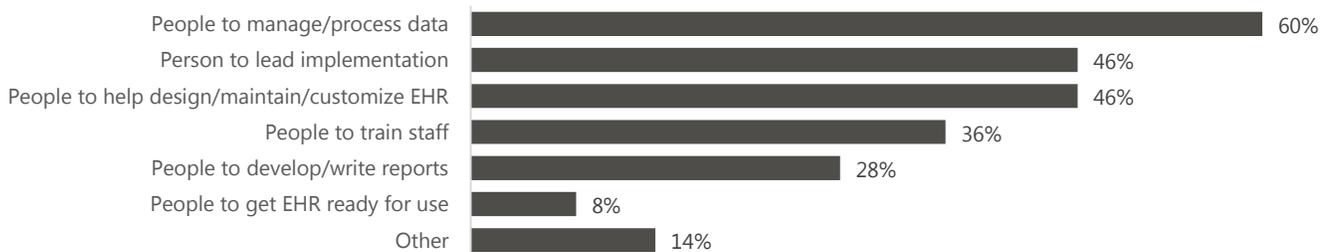
Electronic HIE plans, by population, Minnesota CHBs, 2014



	Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
CHB has written plan	32%	15%	36%	26%
CHB does not have written plan	68%	85%	64%	74%

SKILLS AND ROLES NEEDED RELATED TO ELECTRONIC HEALTH RECORDS, MINNESOTA CHBS, 2014

Most needed skills and roles related to electronic health records, Minnesota CHBs, 2014



Most needed skills and roles related to electronic health records, Minnesota CHBs, 2014	Minnesota (n=50)
A person to lead the implementation of an EHR	46%
People to develop and write reports from an EHR	28%
People to help design, maintain and customize an EHR for use in our facility	46%
People to get the EHR ready for use (e.g., entering orders, patient information, etc.)	8%
People to manage and process the data, information, and knowledge (e.g., informatics nurse or public health professional)	60%
People to train staff on how to use the EHR	36%
Other	14%

MOST NEEDED EHR-RELATED SKILLS AND ROLES, BY POPULATION, MINNESOTA CHBS, 2014

Most needed skills and roles related to electronic health records, by population, Minnesota CHBs, 2014



	Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
A person to lead the implementation of an EHR	37%	65%	27%	46%
People to develop and write reports from an EHR	0%	35%	64%	28%
People to help design, maintain and customize an EHR for use in our facility	32%	65%	36%	46%
People to get the EHR ready for use (e.g., entering orders, patient information, etc.)	16%	0%	9%	8%
People to manage and process the data, information, and knowledge (e.g., informatics nurse or public health professional)	68%	55%	55%	60%
People to train staff on how to use the EHR	47%	20%	46%	36%
Other	10%	25%	0%	14%

MOST NEEDED EHR-RELATED SKILLS AND ROLES, RANKED, BY POPULATION, MINNESOTA CHBS, 2014

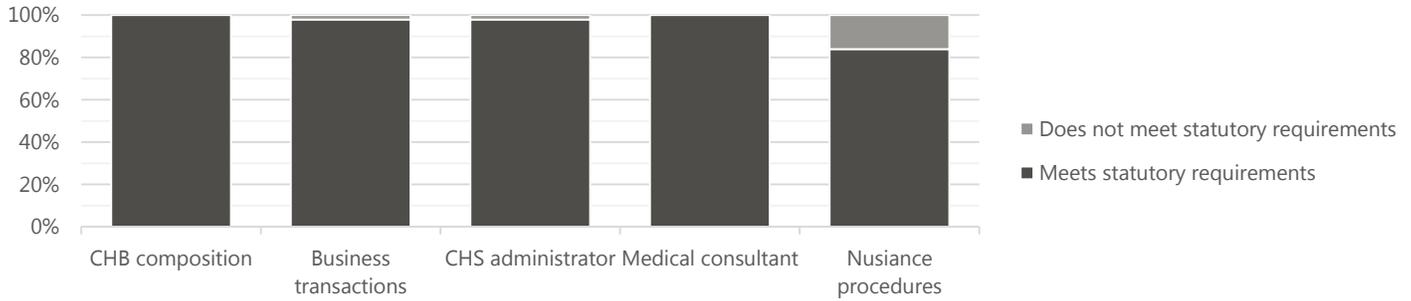
Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
1 People to manage/process data	1 Person to lead implementation	1 People to develop/write reports	1 People to manage/process data
2 People to train staff	2 People to help design/maintain/customize EHR	2 People to manage/process data	2 Person to lead implementation
3 Person to lead implementation	3 People to manage/process data	3 People to train staff	3 People to help design/maintain/customize EHR
4 People to help design/maintain/customize EHR	4 People to develop/write reports	4 People to help design/maintain/customize EHR	4 People to train staff
5 People to get EHR ready for use	5 People to train staff	5 Person to lead implementation	5 People to develop/write reports
n/r People to develop/write reports	n/r People to get EHR ready for use	6 People to get EHR ready for use	6 People to get EHR ready for use

n/r: Not ranked

ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

STATUTORY REQUIREMENTS

Meeting state statutory requirements, Minnesota CHBs, 2014



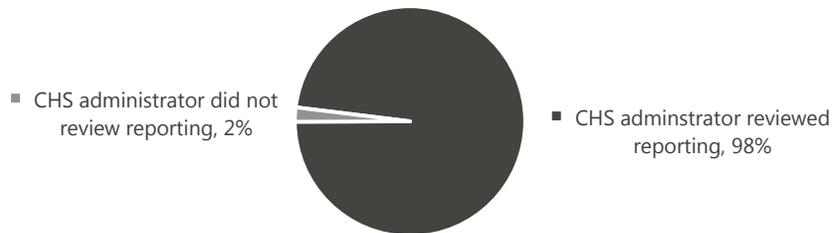
Meeting state statutory requirements, Minnesota CHBs, 2014

Minnesota (n=50)

The composition of the CHB meets the requirements required by Minn. Stat. § 145A.03, subd. 1.	100%
The CHB has in place written procedures for transacting business and has kept a public record of its transactions, findings, and determinations, as required by Minn. Stat. § 145A.03, subd. 5.	98%
The CHB has a CHS administrator who meets the requirements of Minn. Rule 4736.0110.	98%
The CHB has a medical consultant in accordance with Minn. Stat. § 145A.04, subd. 2a.	100%
The CHB has written policies and procedures for implementing the removal and abatement of public health nuisances specified in Minn. Stat. § 145A.04, subd. 8.	84%
The CHS administrator reviewed and assured the accuracy of all reporting related to the Local Public Health Act, Title V, and TANF, prior to submission.	98%

BOARD MEETINGS IN 2014, MINNESOTA CHBS

Review of annual reporting by CHS administrator, Minnesota CHBs, 2014

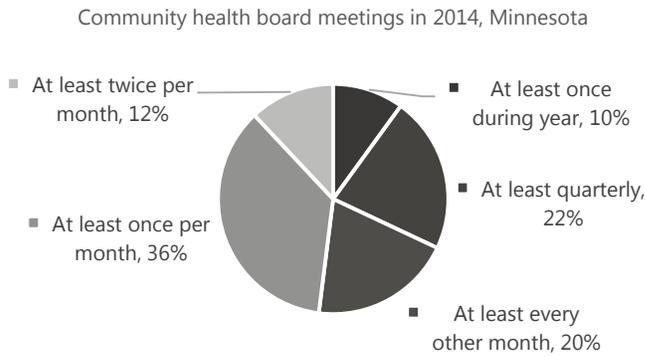


Meeting state statutory requirements, Minnesota CHBs, 2014

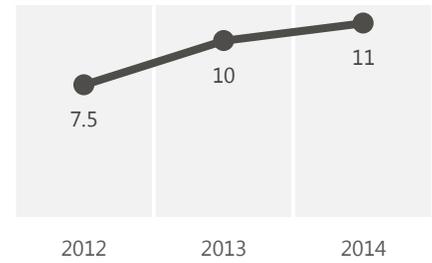
Minnesota (n=50)

The CHS administrator reviewed and assured the accuracy of all reporting related to the Local Public Health Act, Title V, and TANF, prior to submission.	98%
The CHS administrator did not review and assure the accuracy of all reporting related to the Local Public Health Act, Title V, and TANF, prior to submission.	2%

COMMUNITY HEALTH BOARD MEETINGS, MINNESOTA, 2014



Median number of board meetings/year, Minnesota CHBs, 2012-2014



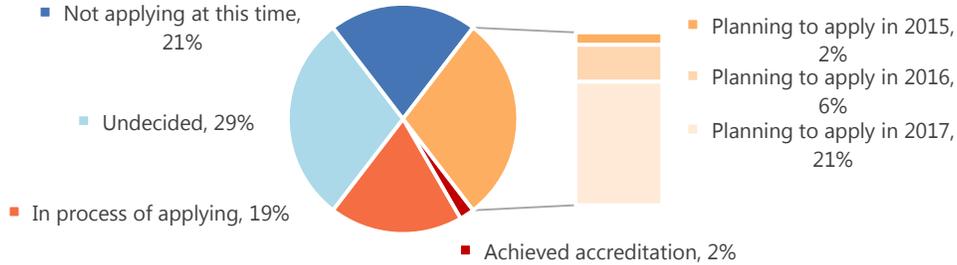
Community health board meetings in 2014, Minnesota	Minnesota (n=50)
1 to 3 meetings in 2014 (at least once during year)	10%
4 to 5 meetings in 2014 (at least quarterly)	22%
6 to 11 meetings in 2014 (at least every other month)	20%
12 to 25 meetings in 2014 (at once per month)	36%
26 to 52 meetings in 2014 (at least twice per month)	12%

	Minimum	Median	Maximum
Number of meetings	2	11	52

ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

PUBLIC HEALTH ACCREDITATION

Participation in public health accreditation, Minnesota CHBs, 2014

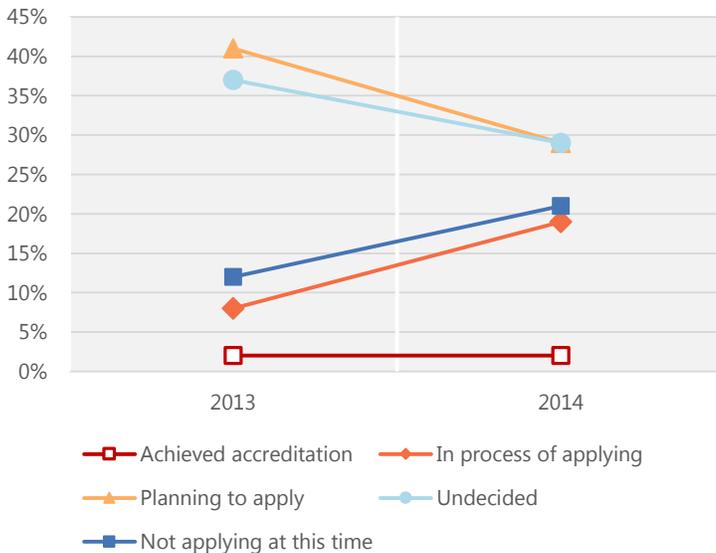


Participation in national voluntary public health accreditation, Minnesota CHBs, 2014

Minnesota (n=48)

My CHB has achieved accreditation	2%
My CHB is in the process of accreditation (e.g., has submitted a statement of intent)	19%
My CHB is planning to apply (but is not in the process of accreditation)	29%
My CHB is undecided about whether to apply for accreditation	29%
My CHB has decided not to apply at this time	21%
Individual jurisdictions within my CHB are participating in accreditation differently	0%

Participation in public health accreditation, Minnesota CHBs, 2013-2014



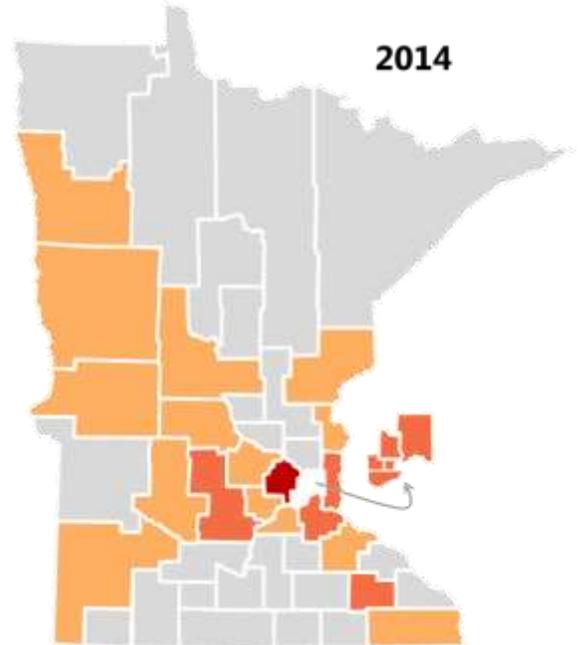
Participation in national voluntary public health accreditation, Minnesota CHBs, 2014

	2013	2014
My CHB has achieved accreditation	2%	2%
My CHB is in the process of accreditation (e.g., has submitted a statement of intent)	8%	19%
My CHB is planning to apply (but is not in the process of accreditation)	41%	29%
My CHB is undecided about whether to apply for accreditation	37%	29%
My CHB has decided not to apply at this time	12%	21%
Individual jurisdictions within my CHB are participating in accreditation differently	0%	0%

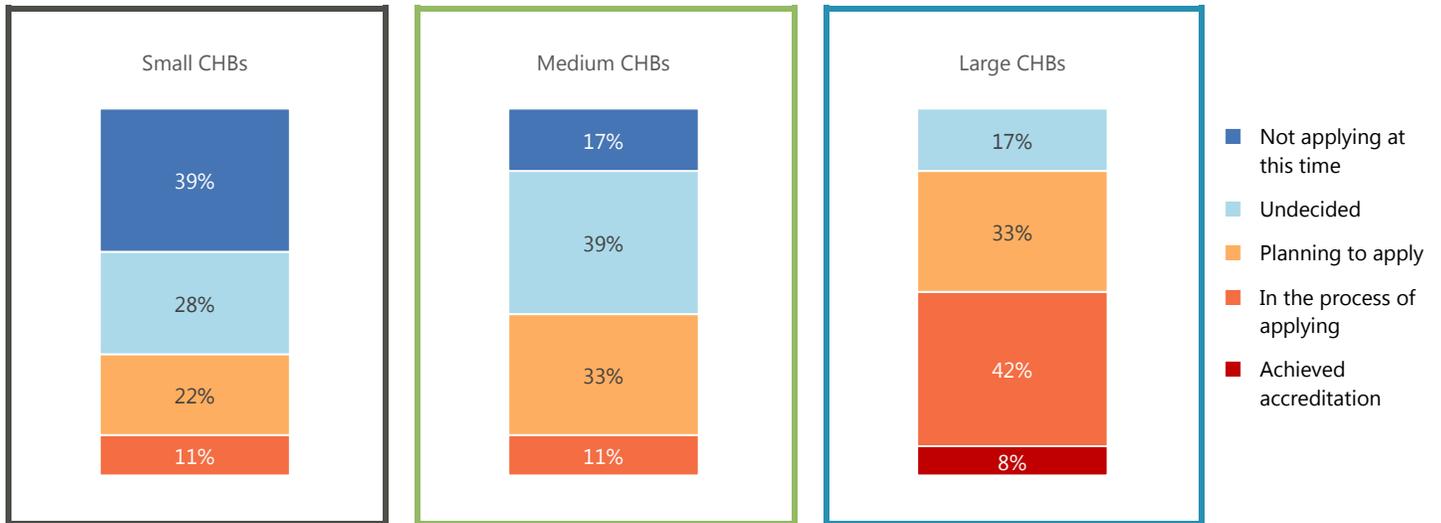
GEOGRAPHIC SPREAD OF CHBS PARTICIPATING IN PUBLIC HEALTH ACCREDITATION, MINNESOTA CHBS, 2014

Participation in national voluntary public health accreditation, Minnesota CHBs, 2014

■ CHB has achieved accreditation (1)	Hennepin	
■ CHB is in the process of accreditation (9)	Bloomington	Olmsted
	Dakota	Richfield
	Edina	St. Paul-Ramsey
	Meeker-McLeod-Sibley	Washington
	Minneapolis	
■ CHB is planning to apply (14)	Carver	Morrison-Todd-Wadena
	Chisago	Partnership4Health
	Fillmore-Houston	Polk-Norman-Mahnomen
	Goodhue	Scott
	Horizon	Stearns
	Kanabec-Pine	SWHHS
	Kandiyohi-Renville	Wright
■ CHB is undecided about whether to apply for accreditation		
■ CHB has decided not to apply at this time		



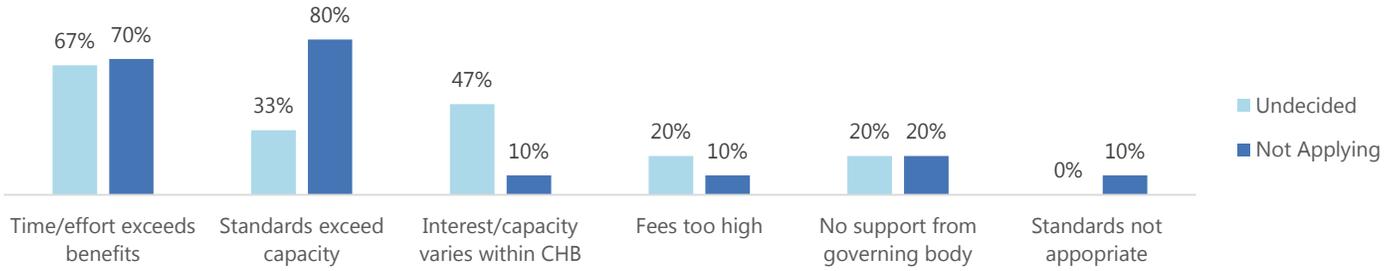
PARTICIPATION IN PUBLIC HEALTH ACCREDITATION, BY POPULATION, MINNESOTA CHBS, 2014



	Small CHBs (n=18)	Medium CHBs (n=18)	Large CHBs (n=12)	Minnesota (n=48)
My CHB has achieved accreditation	0%	0%	8%	2%
My CHB is in the process of accreditation (e.g., has submitted a statement of intent)	11%	11%	42%	19%
My CHB is planning to apply (but is not in the process of accreditation)	22%	33%	33%	29%
My CHB is undecided about whether to apply for accreditation	28%	39%	17%	29%
My CHB has decided not to apply at this time	39%	17%	0%	21%
Individual jurisdictions within my CHB are participating in accreditation differently	0%	0%	0%	0%

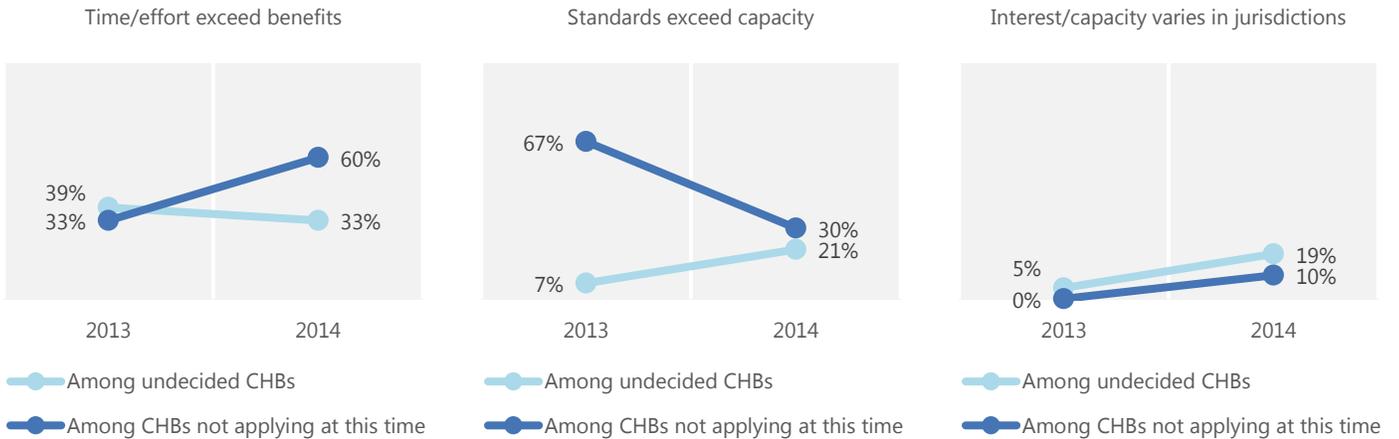
REASON(S) FOR NOT PARTICIPATING IN PUBLIC HEALTH ACCREDITATION AT THIS TIME, BY POPULATION, MINNESOTA CHBS, 2014

Reasons CHBs are undecided or will not apply for accreditation at this time, Minnesota, 2014



Reason(s) CHBs are undecided or will not apply for accreditation at this time, Minnesota, 2014	Undecided (n=15)		Not applying at this time (n=10)	
	1° reason	2° reason	1° reason	2° reason
Time and effort for accreditation application exceed the benefits of accreditation	33%	33%	10%	60%
Accreditation standards exceed the capacity of my CHB	13%	20%	50%	40%
Interest/capacity varies within the jurisdictions of my CHB	27%	20%	0%	10%
Fees for accreditation are too high	13%	7%	10%	0%
No support from governing body for accreditation	7%	13%	20%	0%
Accreditation standards are not appropriate for my CHB	0%	0%	10%	0%

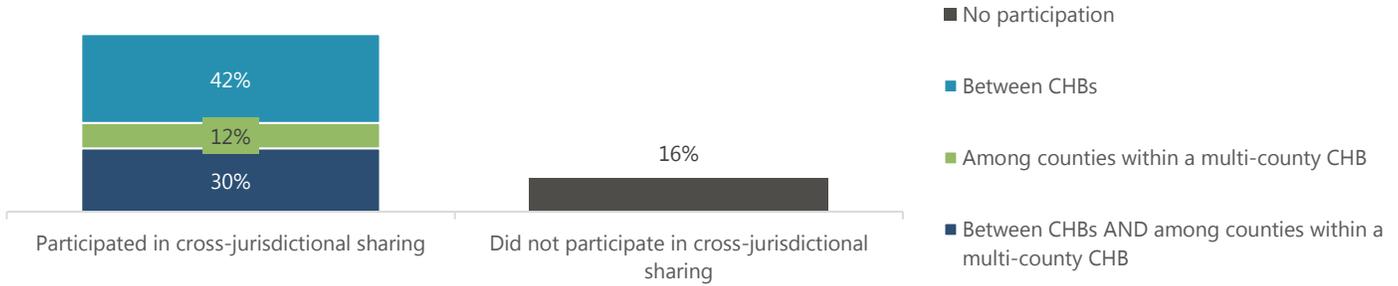
CHANGE IN PRIMARY REASON(S) FOR NOT PARTICIPATING IN ACCREDITATION AT THIS TIME, MINNESOTA CHBS, 2014



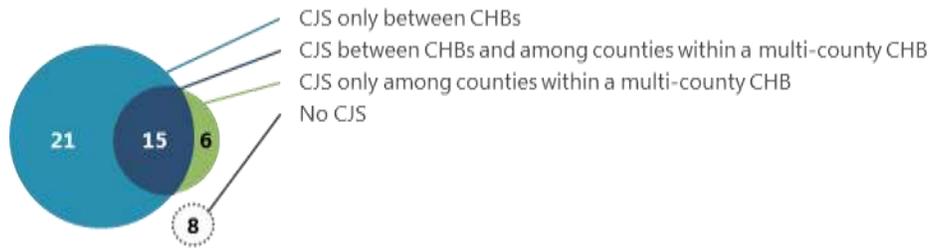
ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

CROSS-JURISDICTIONAL SHARING

Participation in cross-jurisdictional sharing, Minnesota CHBs, 2014



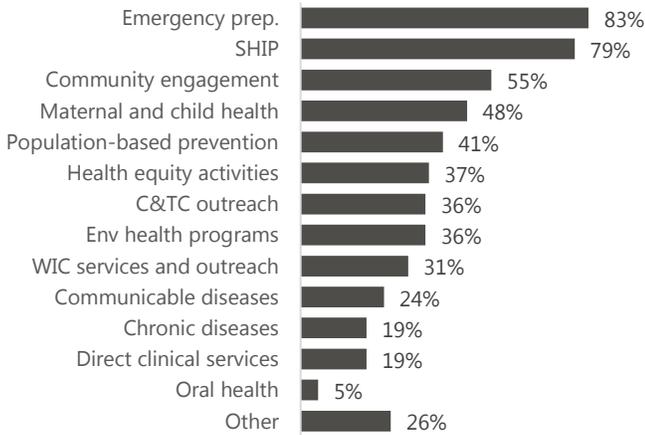
Participation in cross-jurisdictional sharing, Minnesota CHBs, 2014



Participation in cross-jurisdictional sharing, Minnesota CHBs, 2014	Minnesota (n=50)
Between CHBs [only]	42%
Among counties within a multi-county CHB [only]	12%
Between CHBs AND counties within a multi-county CHB	30%
Did not participate in cross-jurisdictional sharing	16%

FUNCTIONS PERFORMED WITH CROSS-JURISDICTIONAL SHARING, MINNESOTA CHBS, 2014

Cross-jurisdictional sharing of programmatic functions, Minnesota CHBs, 2014



Cross-jurisdictional sharing of rganizational and administrative functions, Minnesota CHBs, 2014



Programmatic functions for which CHBs shared services across jurisdictions, Minnesota, 2014	Minnesota (n=42)
Child and Teen Checkups (C&TC) outreach	36%
Chronic disease screening or treatment	19%
Communicable disease screening or treatment	24%
Community engagement	55%
Direct clinical services	19%
Emergency preparedness planning, reporting, or other ongoing activities	83%
Environmental health programs (other than inspection or licensing)	36%
Health equity activities	38%
Maternal and child health services (e.g., family home visiting, early hearing detection and intervention, birth defects)	48%
Oral health	5%
SHIP (Statewide Health Improvement Program)	79%
Population-based prevention programs other than SHIP	41%
WIC services and outreach	31%
Other	26%
None of the above	0%

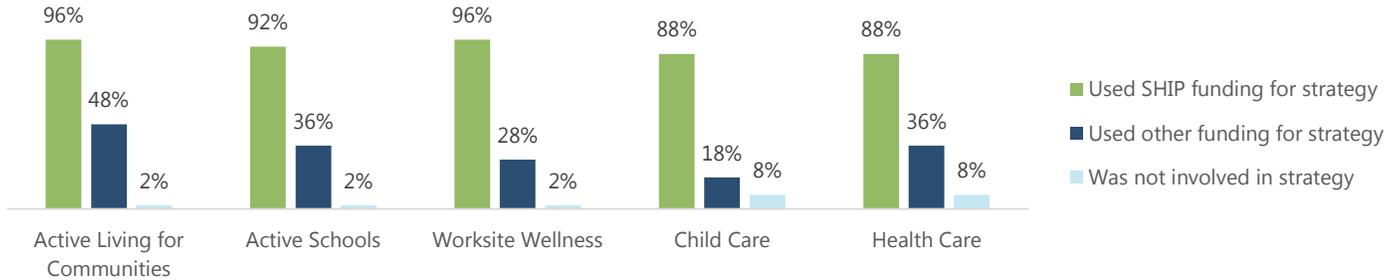
Organizational and administrative functions for which CHBs shared services across jurisdictions, Minnesota, 2014	Minnesota (n=42)
Assessment and planning	74%
Communications or public information	47%
Epidemiology or surveillance	29%
Financial management	43%
CHS administration	43%
Human resources	7%
Health information technology or management	29%
Inspection, permit or licensing	26%
Laboratory services	10%
Organizational structure and governance	38%
Performance management/quality improvement	50%
Purchasing	17%
Staff training	62%
Strategic planning	52%
Workforce assessment and planning	26%
Other	17%
None of the above	10%

PROMOTE HEALTHY COMMUNITIES AND HEALTHY BEHAVIORS

PHYSICAL ACTIVITY

PHYSICAL ACTIVITY STRATEGIES AND FUNDING SOURCES, MINNESOTA CHBS, 2014

Physical activity strategies and funding sources, Minnesota CHBs, 2014



Strategies (below) and funding sources (at right) used to promote physical activity, Minnesota CHBs, 2014

	Used SHIP funding	Used other (non-SHIP) funding	No involvement
Active Living for Communities	96%	48%	2%
Active Schools	92%	36%	2%
Worksite Wellness	96%	28%	2%
Child Care	88%	18%	8%
Health Care	88%	36%	8%

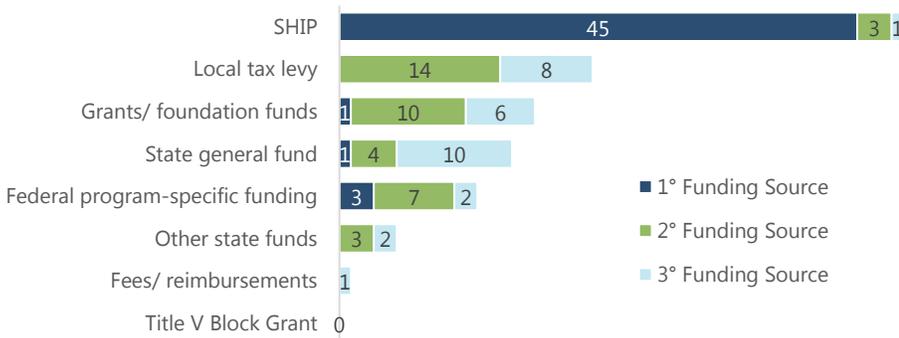
ACTIVITIES RELATED TO PHYSICAL ACTIVITY STRATEGIES, MINNESOTA CHBS, 2014

Activities (below) related to strategies used (right) to promote physical activity, Minnesota CHBs, 2014

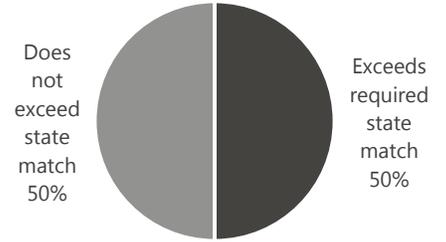
	Active Living for Communities (n=49)	Active Schools (n=49)	Worksite Wellness (n=49)	Child Care (n=46)	Health Care (n=46)
Attended trainings	90%	92%	94%	96%	85%
Conducted assessments	82%	88%	96%	96%	65%
Convened partners or participated in coalitions	98%	96%	94%	85%	89%
Involved with community outreach and education	94%	76%	80%	83%	61%
Educated policymakers	80%	69%	74%	52%	54%
Developed proposal or policy	55%	61%	61%	52%	35%
Implemented policy	29%	43%	47%	33%	24%
Maintained policy	29%	35%	27%	20%	17%
Evaluated policy	27%	33%	27%	20%	15%
None of the above	0%	0%	0%	0%	4%

FUNDING SOURCES SUPPORTING PHYSICAL ACTIVITY STRATEGIES, MINNESOTA CHBS, 2014

Top funding sources supporting physical activity strategies, Minnesota CHBs, 2014



CHBs in which local tax levy investment in physical activity exceeds required state match, Minnesota, 2014 (n=22)



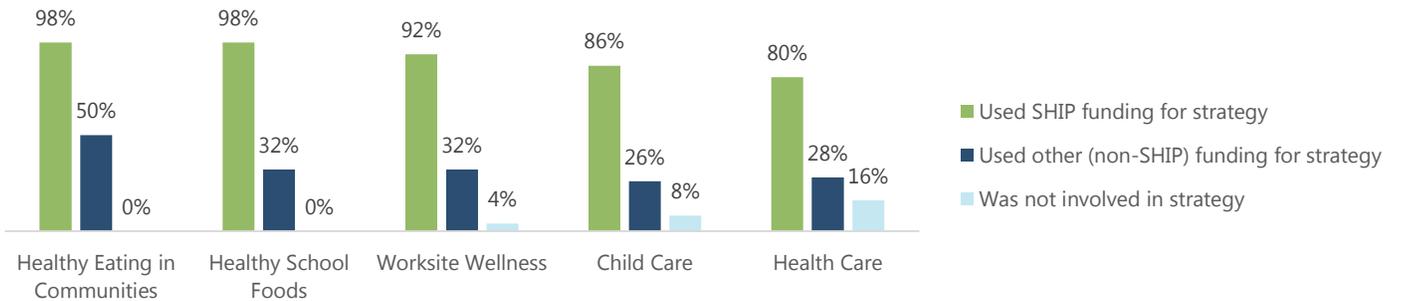
Top funding sources used to support physical activity strategies, Minnesota CHBs, 2014	1° funding source	2° funding source	3° funding source
Local tax levy	0	14	8
State general fund	1	4	10
SHIP	45	3	1
Other state funds	0	3	2
Federal program-specific funding	3	7	2
Title V Block Grant	0	0	0
Grants/foundation funds	1	10	6
Fees/reimbursements	0	0	1

PROMOTE HEALTHY COMMUNITIES AND HEALTHY BEHAVIORS

NUTRITION

NUTRITION STRATEGIES AND FUNDING SOURCES, MINNESOTA CHBS, 2014

Nutrition strategies and funding sources, Minnesota CHBs, 2014



Strategies (below) and funding sources (at right) used to promote nutrition, Minnesota CHBs, 2014

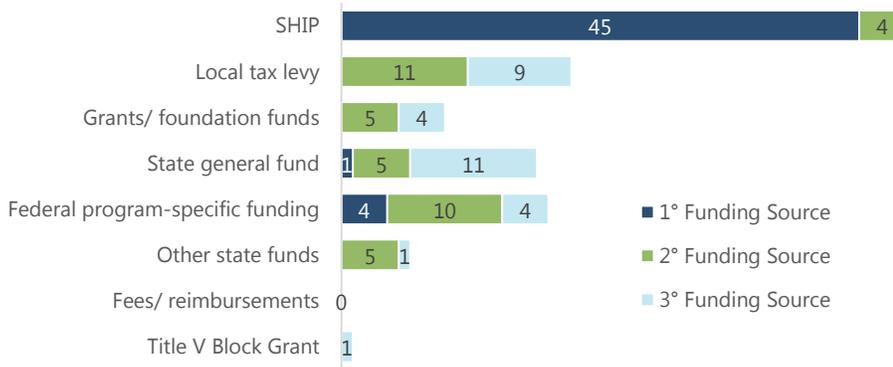
Strategies (below) and funding sources (at right) used to promote nutrition, Minnesota CHBs, 2014	Used SHIP funding	Used other (non-SHIP) funding	No involvement
Healthy Eating in Communities	98%	50%	0%
Healthy School Foods	98%	32%	0%
Worksite Wellness	92%	32%	4%
Child Care	86%	26%	8%
Health Care	80%	28%	16%

ACTIVITIES RELATED TO NUTRITION STRATEGIES, MINNESOTA CHBS, 2014

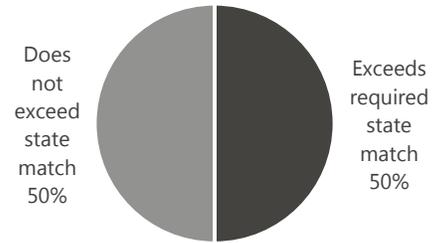
Activities (below) related to strategies used (right) to promote nutrition, Minnesota CHBs, 2014	Healthy Eating in Communities (n=50)	Healthy School Foods (n=50)	Worksite Wellness (n=48)	Child Care (n=46)	Health Care (n=42)
Attended trainings	92%	92%	90%	96%	88%
Conducted assessments	90%	88%	94%	96%	74%
Convened partners or participated in coalitions	96%	98%	96%	85%	83%
Involved with community outreach and education	98%	88%	77%	80%	64%
Educated policymakers	68%	76%	67%	54%	57%
Developed proposal or policy	52%	62%	46%	50%	38%
Implemented policy	44%	52%	33%	41%	33%
Maintained policy	20%	38%	25%	15%	19%
Evaluated policy	20%	36%	27%	17%	14%
None of the above	0%	0%	0%	0%	2%

FUNDING SOURCES SUPPORTING NUTRITION STRATEGIES, MINNESOTA CHBS, 2014

Top funding sources supporting nutrition strategies, Minnesota CHBs, 2014



CHBs in which local tax levy investment in nutrition exceeds required state match, Minnesota, 2014 (n=20)



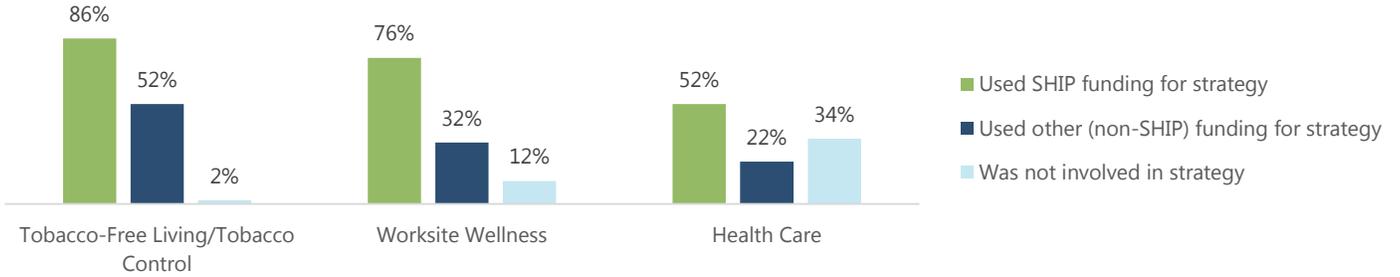
Top funding sources used to support nutrition strategies, Minnesota CHBs, 2014	1° funding source	2° funding source	3° funding source
Local tax levy	0	11	9
State general fund	1	5	11
SHIP	45	4	0
Other state funds	0	5	1
Federal program-specific funding	4	10	4
Title V Block Grant	0	0	1
Grants/foundation funds	0	5	4
Fees/reimbursements	0	0	0

PROMOTE HEALTHY COMMUNITIES AND HEALTHY BEHAVIORS

TOBACCO

TOBACCO STRATEGIES AND FUNDING SOURCES, MINNESOTA CHBS, 2014

Tobacco prevention and control strategies and funding sources, Minnesota CHBs, 2014



Strategies (below) and funding sources (at right) used to promote tobacco prevention and control, Minnesota CHBs, 2014

	Used SHIP funding	Used other (non-SHIP) funding	No involvement
Tobacco-Free Living/Tobacco Control	86%	52%	2%
Worksite Wellness	76%	32%	12%
Health Care	52%	22%	34%

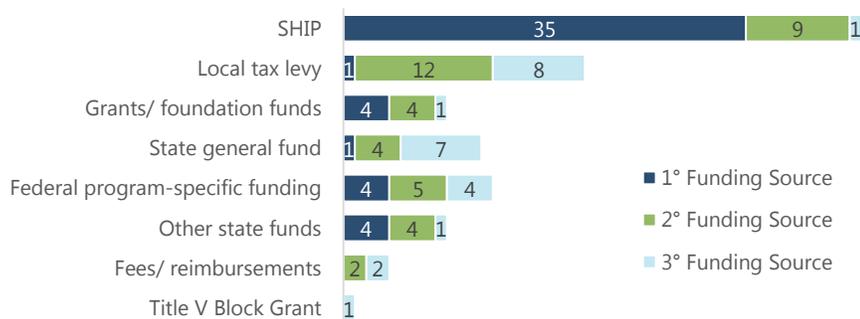
ACTIVITIES RELATED TO TOBACCO STRATEGIES, MINNESOTA CHBS, 2014

Activities (below) related to strategies used (right) to promote tobacco prevention and control, Minnesota CHBs, 2014

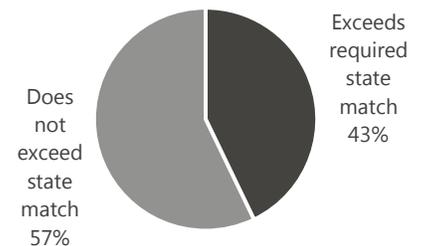
	Tobacco-Free Living/Tobacco Control (n=49)	Worksite Wellness (n=44)	Health Care (n=33)
Attended trainings	88%	86%	76%
Conducted assessments	94%	84%	73%
Convened partners or participated in coalitions	90%	84%	67%
Involved with community outreach and education	90%	71%	70%
Educated policymakers	76%	71%	49%
Developed proposal or policy	80%	55%	42%
Implemented policy	63%	36%	33%
Maintained policy	51%	32%	27%
Evaluated policy	35%	18%	12%
None of the above	0%	0%	3%

FUNDING SOURCES SUPPORTING TOBACCO STRATEGIES, MINNESOTA CHBS, 2014

Top funding sources supporting tobacco prevention and control strategies, Minnesota CHBs, 2014



CHBs in which local tax levy investment in tobacco prevention and control exceeds required state match, Minnesota, 2014 (n=21)



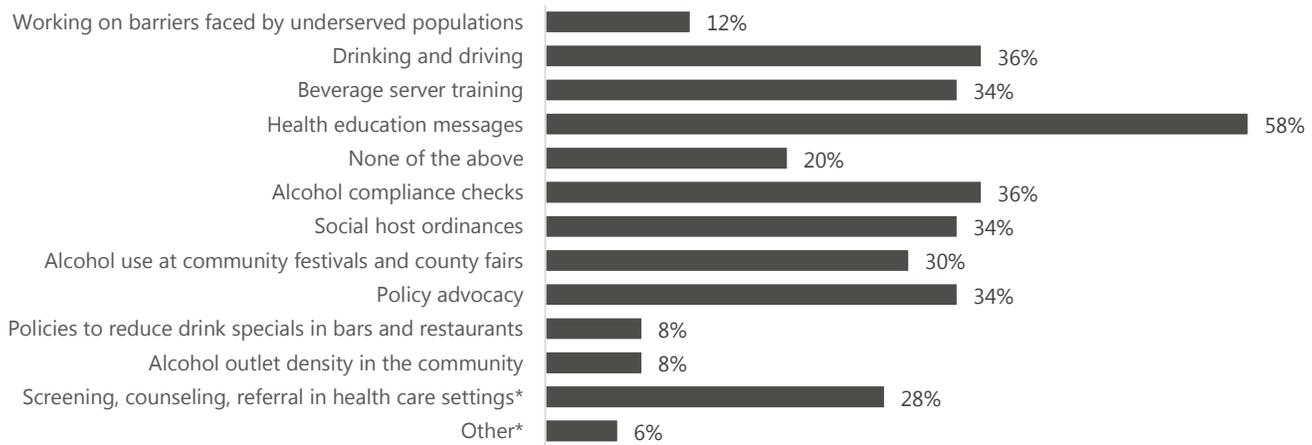
Top funding sources used to support tobacco prevention and control strategies, Minnesota CHBs, 2014	1° funding source	2° funding source	3° funding source
Local tax levy	1	12	8
State general fund	1	4	7
SHIP	35	9	1
Other state funds	4	4	1
Federal program-specific funding	4	5	4
Title V Block Grant	0	0	1
Grants/foundation funds	4	4	1
Fees/reimbursements	0	2	2

PROMOTE HEALTHY COMMUNITIES AND HEALTHY BEHAVIORS

ALCOHOL

ALCOHOL STRATEGIES AND FUNDING SOURCES, MINNESOTA CHBS, 2014

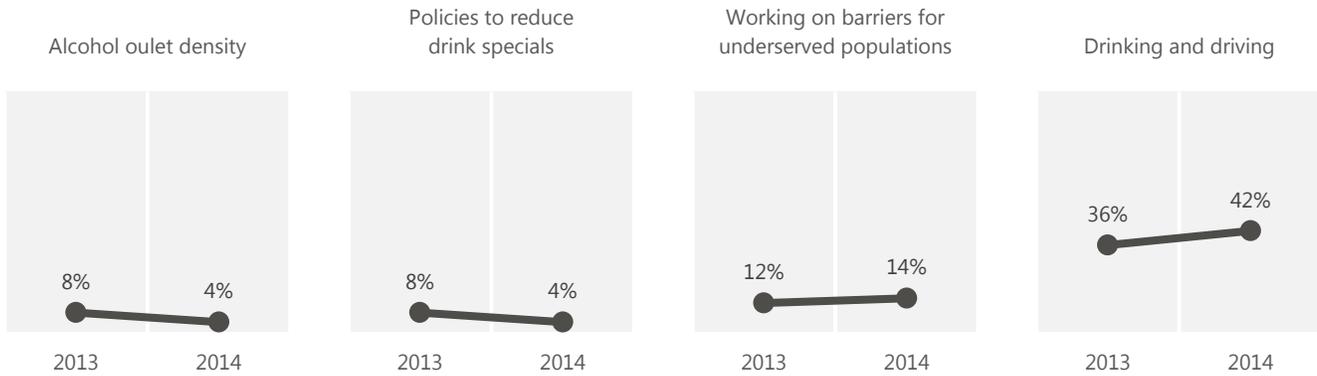
Strategies used related to alcohol use, Minnesota CHBs, 2014



* not asked in 2013.

Strategies used related to alcohol use, Minnesota CHBs, 2014	Minnesota (n=50)
Policy advocacy (strengthening local ordinances)	34%
Policies to reduce drink specials in bars and restaurants	8%
Alcohol compliance checks	36%
Beverage server training	34%
Alcohol outlet density in the community	8%
Social host ordinances	34%
Alcohol use at community festivals and county fairs	30%
Drinking and driving	36%
Health education messages	58%
Working on barriers faced by underserved populations to reduce disparities in alcohol use	12%
Screening, counseling, and/or referral in health care settings	28%
Other	6%
None of the above	20%

GREATEST CHANGE IN STRATEGIES RELATED TO ALCOHOL USE, MINNESOTA CHBS, 2013-2014

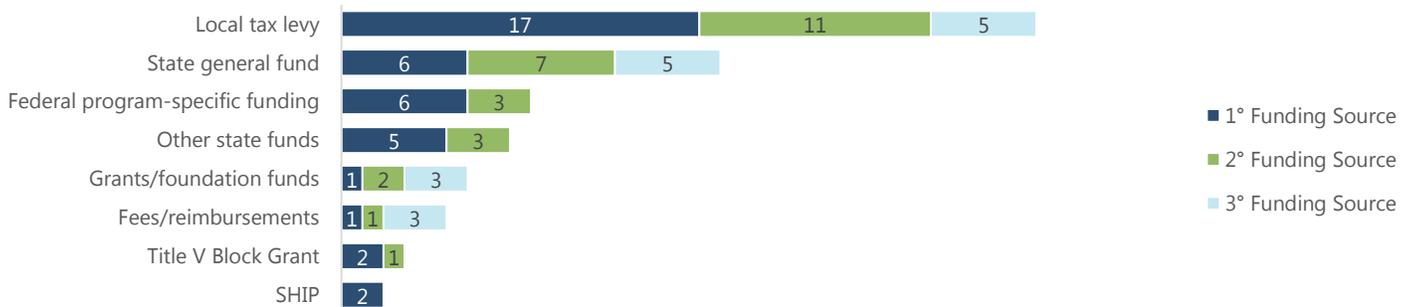


ACTIVITIES RELATED TO ALCOHOL STRATEGIES, MINNESOTA CHBS, 2014

Activities related to most frequently used strategies related to alcohol use, Minnesota CHBs, 2014	Health education messages (n=29)	Alcohol compliance checks (n=18)	Drinking and driving (n=18)	Policy advocacy (n=17)	Beverage server training (n=17)	Social host ordinances (n=17)
Attended trainings	62%	56%	61%	82%	76%	41%
Conducted assessments	55%	50%	50%	47%	47%	35%
Convened partners or participated in coalitions	66%	67%	89%	82%	82%	76%
Involved with community outreach and education	86%	56%	94%	88%	82%	65%
Educated policymakers	41%	50%	61%	82%	76%	59%
Developed proposal or policy	14%	17%	11%	53%	35%	41%
Implemented policy	7%	17%	0%	29%	41%	18%
Maintained policy	14%	39%	17%	53%	41%	53%
Evaluated policy	7%	11%	11%	29%	18%	24%
None of the above	3%	6%	0%	0%	0%	6%

FUNDING SOURCES SUPPORTING ALCOHOL STRATEGIES, MINNESOTA CHBS, 2014

Top funding sources supporting alcohol use strategies, Minnesota CHBs, 2014

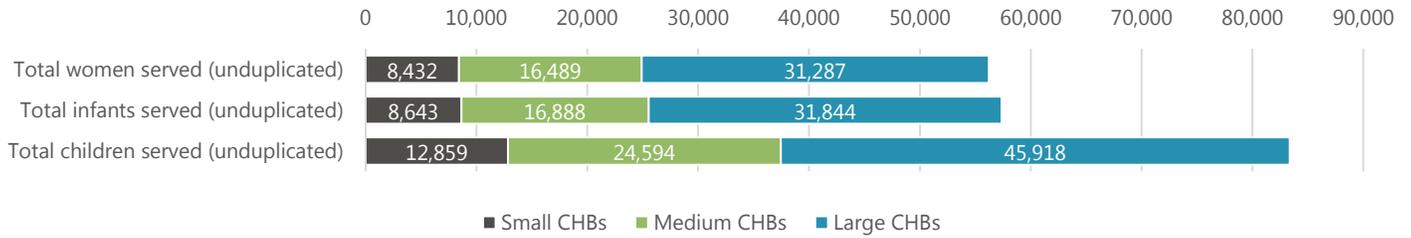


Top funding sources used related to alcohol use strategies, Minnesota CHBs, 2014	1° funding source	2° funding source	3° funding source
Local tax levy	17	11	5
State general fund	6	7	5
SHIP	2	0	0
Other state funds	5	3	0
Federal program-specific funding	6	3	0
Title V Block Grant	2	1	0
Grants/foundation funds	1	2	3
Fees/reimbursements	1	1	3

PROMOTE HEALTHY COMMUNITIES AND HEALTHY BEHAVIORS

MATERNAL AND CHILD HEALTH

Total women, infants, and children served by the WIC program, by population Minnesota CHBs, 2014

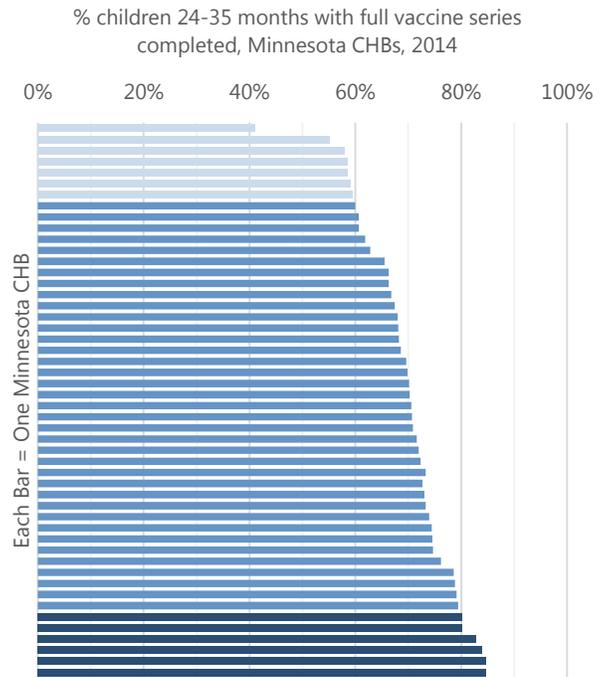
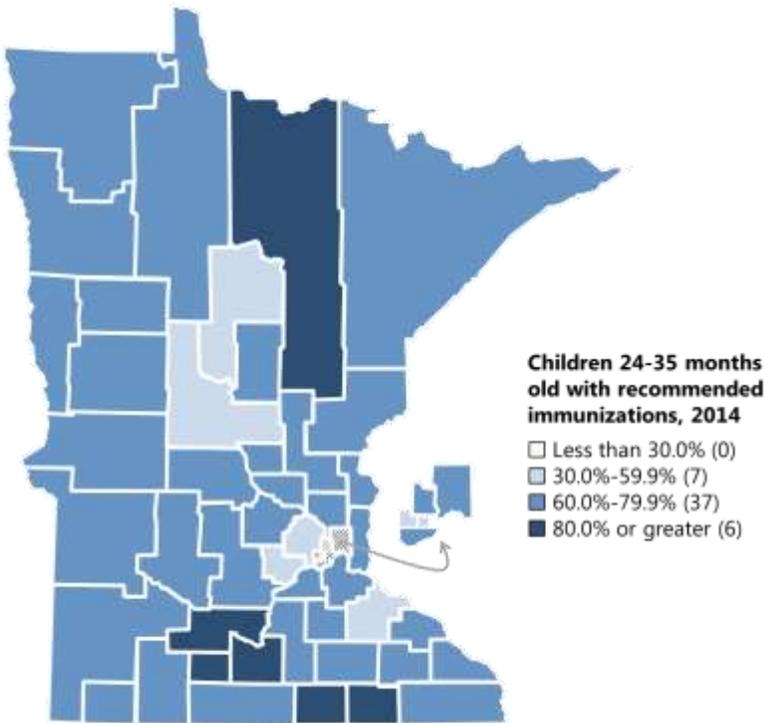


Total women, infants, and children served by the WIC program, Minnesota CHBs, 2014	Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Total: MN (n=50)
Women served (unduplicated)	8,432	16,489	31,287	56,208
Infants served (unduplicated)	8,643	16,888	31,844	57,375
Children served (unduplicated)	12,859	24,594	45,918	83,371

PREVENT THE SPREAD OF INFECTIOUS DISEASES

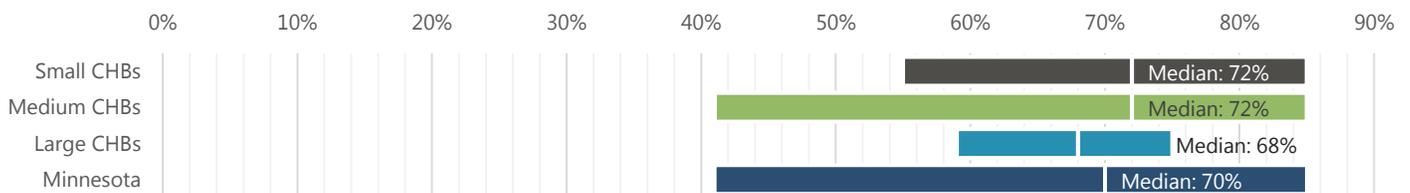
IMMUNIZATIONS

RANGE OF VACCINATED CHILDREN, MINNESOTA CHBS, 2014



RANGE OF VACCINATED CHILDREN, BY POPULATION, MINNESOTA CHBS, 2014

Range and median: Children 24-35 months with full vaccine series completed, by population, Minnesota CHBs, 2014

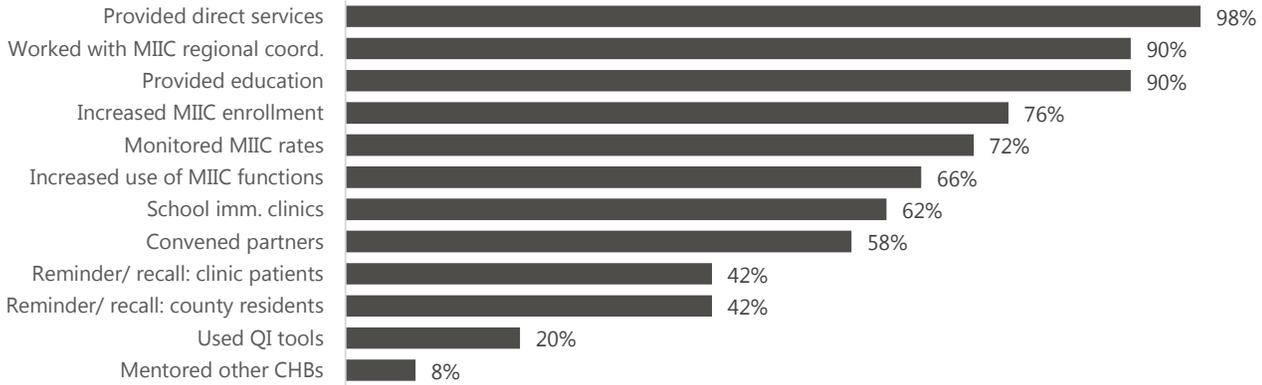


Range: Children 24-35 months with full vaccine series completed, by population, Minnesota CHBs, 2014

	Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
Minimum	55%	41%	59%	41%
Median	72%	72%	68%	70%
Maximum	85%	85%	75%	85%

STRATEGIES TO INCREASE IMMUNIZATION RATES, MINNESOTA CHBS, 2014

Strategies used to increase immunization rates, Minnesota CHBs, 2014



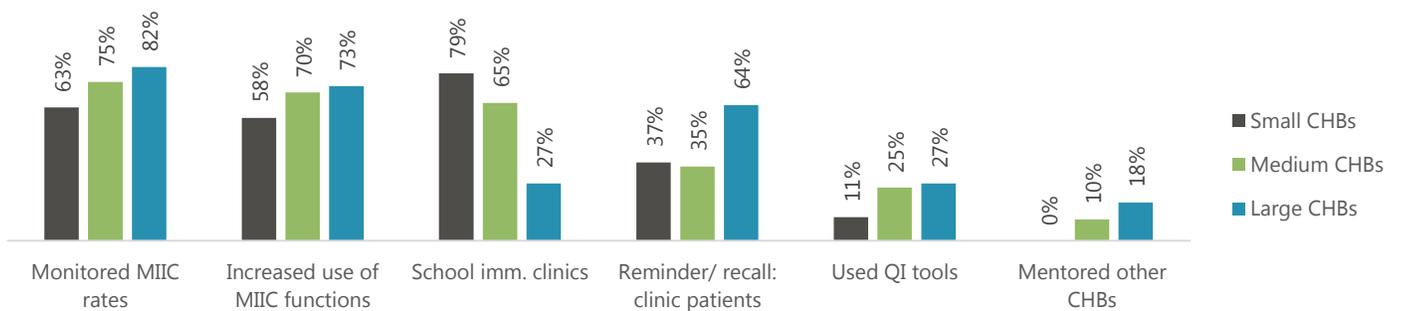
Strategies used to increase immunization rates, Minnesota CHBs, 2014

Minnesota (n=50)

Participated in or convened school-located immunization clinics	62%
Convened partners in both public and private sectors to discuss immunization status and strategies	58%
Engaged health care providers to increase Minnesota Immunization Information Connection (MIIC) enrollment and reporting	76%
Engaged health care providers to increase use of MIIC functions (e.g., assessment, client follow-up)	66%
Worked with CHB's corresponding MIIC Regional Coordinator	90%
Actively monitored and tracked MIIC immunization assessment rates over time	72%
Conducted reminder/recall outreach for clinic patients	42%
Conducted reminder/recall for county residents	42%
Provided direct services (gave immunizations)	98%
Provided education to the community	90%
Mentored one or more CHBs to help them improve immunization rates	8%
Used QI tools and processes to improve CHB immunization rates	20%
None of the above	0%

STRATEGIES TO INCREASE IMMUNIZATION RATES, BY POPULATION, MINNESOTA CHBS, 2014

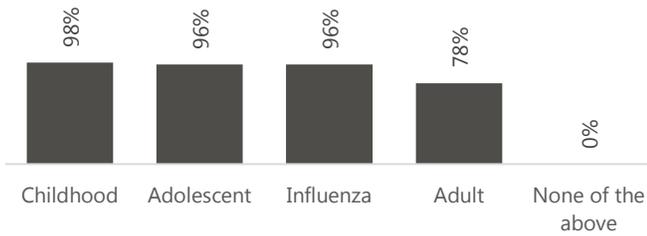
Selected strategies used to increase immunization rates, by population, Minnesota CHBs, 2014



Strategies used to increase immunization rates, by population, Minnesota CHBs, 2014	Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
Participated in or convened school-located immunization clinics	79%	65%	27%	62%
Convened partners in both public and private sectors to discuss immunization status and strategies	53%	65%	55%	58%
Engaged health care providers to increase Minnesota Immunization Information Connection (MIIC) enrollment and reporting	74%	80%	73%	76%
Engaged health care providers to increase use of MIIC functions (e.g., assessment, client follow-up)	58%	70%	73%	66%
Worked with CHB's corresponding MIIC Regional Coordinator	95%	90%	82%	90%
Actively monitored and tracked MIIC immunization assessment rates over time	63%	75%	82%	72%
Conducted reminder/recall outreach for clinic patients	37%	35%	64%	42%
Conducted reminder/recall for county residents	47%	40%	36%	42%
Provided direct services (gave immunizations)	100%	95%	100%	98%
Provided education to the community	84%	95%	91%	90%
Mentored one or more CHBs to help them improve immunization rates	0%	10%	18%	8%
Used QI tools and processes to improve CHB immunization rates	11%	25%	27%	20%
None of the above	0%	0%	0%	0%

COIMMUNITY EDUCATION RELATED TO IMMUNIZATIONS, SELECTED MINNESOTA CHBS, 2014

Focus of education provided by those CHBs engaged in immunization-related community education, Minnesota, 2014 (n=45)



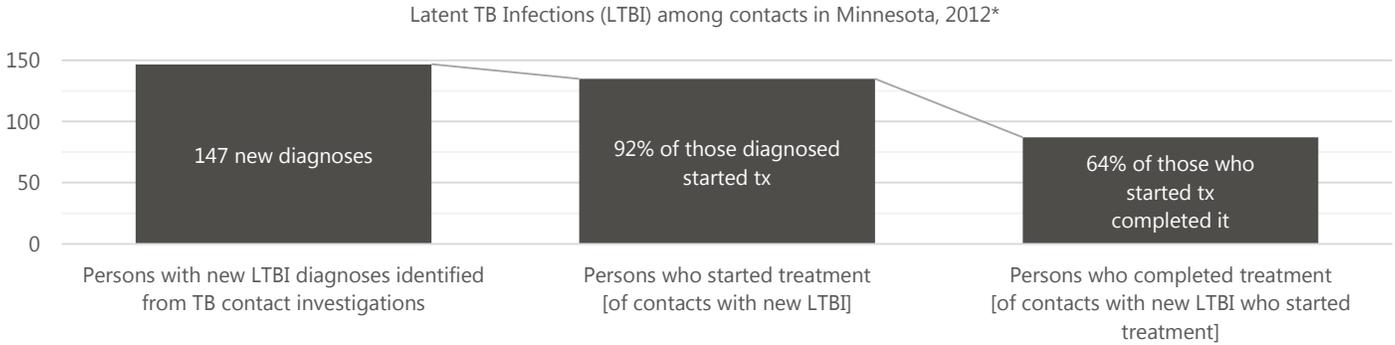
Focus of education provided by those CHBs engaged in immunization-related community education, Minnesota, 2014 (n=45)

Focus of Education	Minnesota (n=45)
Childhood immunizations	98%
Adolescent immunizations	96%
Adult immunizations	78%
Influenza immunizations	96%
None of the above	0%

PREVENT THE SPREAD OF INFECTIOUS DISEASES

TUBERCULOSIS

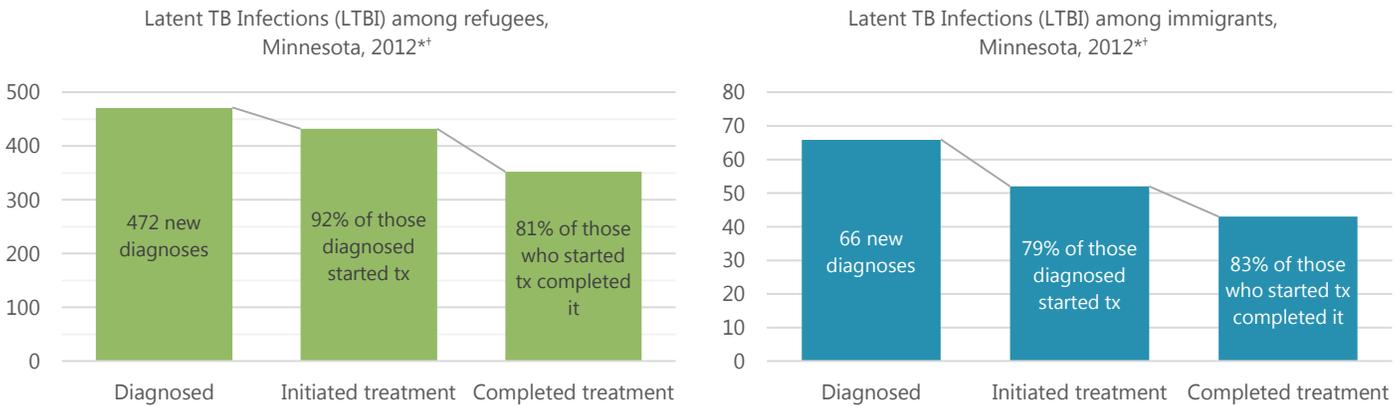
TUBERCULOSIS AMONG CONTACTS IN MINNESOTA, 2012



Latent TB Infections (LTBI) among contacts in Minnesota, 2012*	Count
Persons with new LTBI diagnoses identified from contact investigations of TB cases in 2012	147
Started treatment [of contacts with new LTBI]	135
Completed treatment [of contacts with new LTBI who started treatment]	87

TUBERCULOSIS AMONG REFUGEES AND IMMIGRANTS IN MINNESOTA, 2012

The Centers for Disease Control and Prevention (CDC) recommends that immigrants with TB Class conditions identified overseas and all new refugees are offered a comprehensive screening for TB shortly after arrival. The Minnesota Department of Health works closely with local public health to coordinate these screenings and facilitate treatment for those diagnosed with latent TB infection (LTBI). This partnership is crucial to preventing future cases of TB disease. Minnesota is one of the national leaders in successful LTBI treatment for immigrants and refugees.



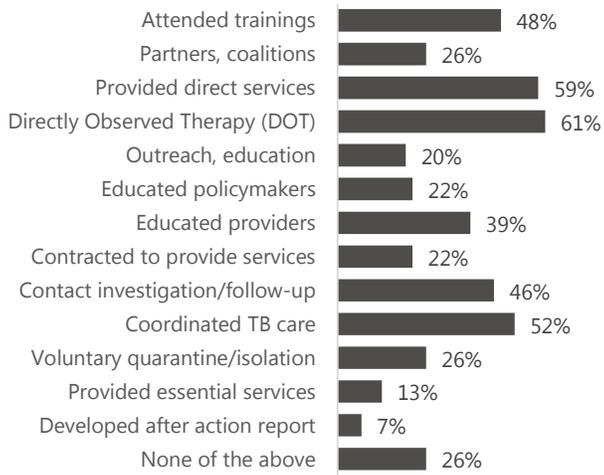
Latent TB Infections (LTBI) among refugees and immigrants, Minnesota, 2012*	Visa Status: Refugee	Visa Status: Immigrant	Both
Diagnosed with LTBI	472	66	538
Initiated LTBI treatment [among those diagnosed with LTBI]	432	52	484
Completed LTBI treatment [among those who initiated LTBI treatment]	352	43	395

* Most recent finalized data available is from 2012; lag in finalizing is due to the long nature of LTBI treatment (3-9 months, depending on the drug[s] used).

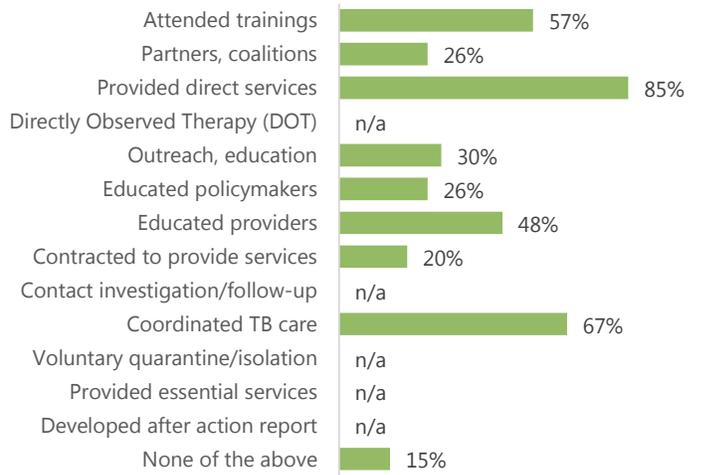
† Data only includes immigrants (with a TB Class designation on their pre-immigration exam) and/or refugees who were admitted to the US in 2012, and whose original destination was Minnesota.

ACTIVITIES RELATED TO TUBERCULOSIS, MINNESOTA CHBS, 2014

Methods used to address active TB, Minnesota CHBs, 2014



Methods used to address latent TB infections (LTBI), Minnesota CHBs, 2014



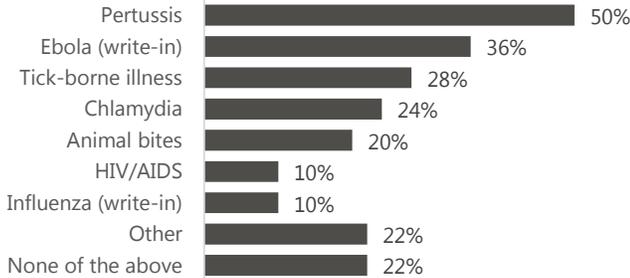
Methods used to address tuberculosis (active and latent), Minnesota CHBs, 2014	Active TB Minnesota (n=50)	LTBI Minnesota (n=50)
Attended trainings	48%	57%
Convened partners or participated in coalitions	26%	26%
Provided direct services	59%	85%
Directly Observed Therapy (DOT)	61%	n/a
Conducted community outreach and education	20%	30%
Educated policymakers	22%	26%
Educated providers	39%	48%
Contracted with other entities to provide services	22%	20%
Contact investigation/follow-up	46%	n/a
Coordinated TB care	52%	67%
Voluntary quarantine/isolation	26%	n/a
Provided essential services	13%	n/a
Developed after action report	7%	n/a
None of the above	26%	15%

PREVENT THE SPREAD OF INFECTIOUS DISEASES

OVERALL INFECTIOUS DISEASES

OTHER INFECTIOUS DISEASES, MINNESOTA CHBS, 2014

Involvement in other infectious disease-related prevention, activities, or services; Minnesota CHBs, 2014



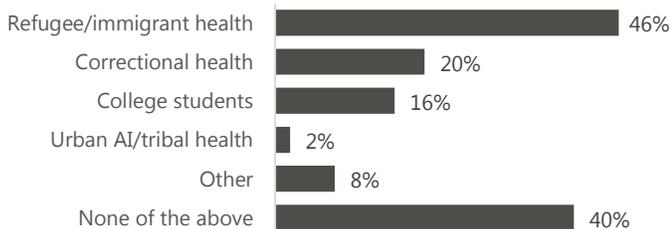
Involvement in other infectious disease-related prevention, activities, or services, Minn. CHBs, 2014	Minnesota (n=50)
Chlamydia	24%
Tick-borne illness	28%
Animal bites	20%
Pertussis	50%
HIV/AIDS	10%
Write In: Ebola	36%
Write In: Influenza	10%
Other	22%
None of the above	22%

ACTIVITIES RELATED TO OTHER INFECTIOUS DISEASES, MINNESOTA CHBS, 2014

	Pertussis (n=25)	Ebola (n=18)	Tick-borne illness (n=14)	Chlamydia (n=12)	Animal bites (n=10)	HIV/AIDS (n=5)	Influenza (n=5)
Attended trainings	64%	83%	14%	58%	20%	60%	80%
Conducted assessments	24%	22%	7%	50%	20%	40%	0%
Convened partners or participated in coalitions	28%	100%	14%	33%	10%	40%	40%
Provided referrals	48%	11%	29%	50%	40%	60%	60%
Educated policymakers	24%	72%	21%	17%	10%	20%	20%
Educated providers	52%	72%	21%	25%	30%	60%	80%
Conducted community outreach and education	80%	78%	79%	92%	50%	80%	80%
Provided direct services	n/a	11%	n/a	58%	n/a	40%	40%
Reported cases	n/a	6%	n/a	25%	n/a	40%	20%
Contracted with other entities to provide services	0%	n/a	n/a	17%	n/a	40%	n/a
Conducted contact/follow-up investigations	44%	11%	n/a	25%	70%	n/a	0%
Educated school staff	64%	67%	n/a	n/a	n/a	n/a	80%
Partnered with schools	52%	28%	n/a	n/a	n/a	n/a	40%
Voluntary quarantine/isolation	n/a	6%	n/a	n/a	n/a	n/a	0%
Collaborated with Animal Control	n/a	n/a	n/a	n/a	60%	n/a	n/a

INFECTIOUS DISEASE SURVEILLANCE, PREVENTION, AND CONTROL FOR SPECIFIC POPULATIONS; MINNESOTA CHBS, 2014

Involvement in other infectious disease surveillance, prevention, and control for specific populations; Minnesota CHBs, 2014

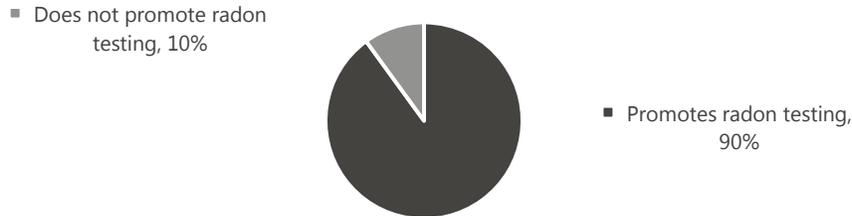


Involvement in other infectious disease surveillance, prevention, and control for specific populations; Minnesota CHBs, 2014	Minnesota (n=50)
Refugee/immigrant health	46%
Correctional health	20%
Urban American Indian/tribal health	2%
College students	16%
Other	8%
None of the above	40%

PROTECT AGAINST ENVIRONMENTAL HEALTH HAZARDS

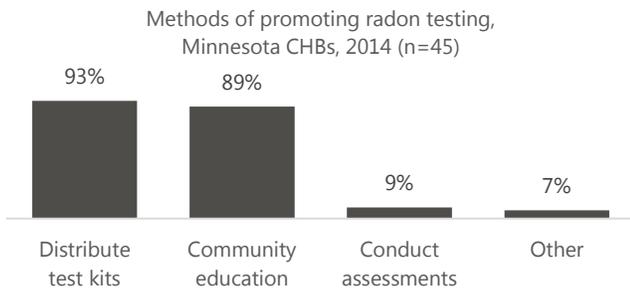
INDOOR AIR: RADON

Promotion of radon testing, Minnesota CHBs, 2014

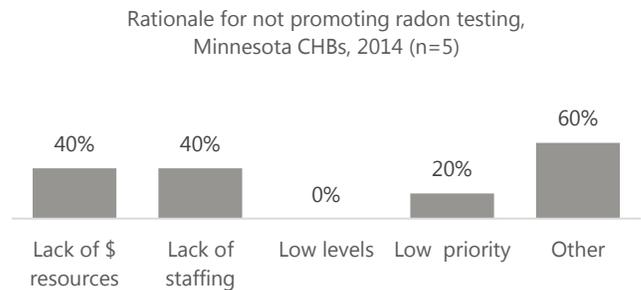


Promotion of radon testing	Minnesota (n=50)
CHB promotes radon testing	90%
CHB does not promote radon testing	10%

METHOD OF PROMOTING/RATIONALE FOR NOT PROMOTING RADON TESTING, MINNESOTA CHBS, 2014



Methods of promoting radon testing, Minnesota CHBs, 2014	Minnesota (n=45)
Distribute test kits	93%
Provide community education to promote testing	89%
Conduct assessments	9%
Other	7%

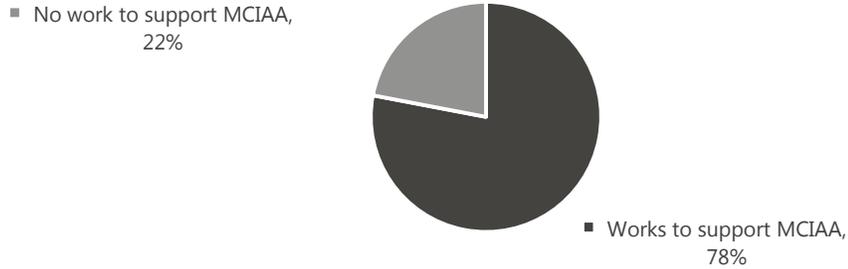


Rationale for not promoting radon testing, Minnesota CHBs, 2014	Minnesota (n=5)
Lack of financial resources	40%
Lack of staffing	40%
Low radon levels in jurisdiction	0%
Low organizational priority	20%
Other	60%

PROTECT AGAINST ENVIRONMENTAL HEALTH HAZARDS

INDOOR AIR: MINNESOTA CLEAN INDOOR AIR ACT

Minnesota Clean Indoor Air Act (MCIAA) support, Minnesota CHBs, 2014



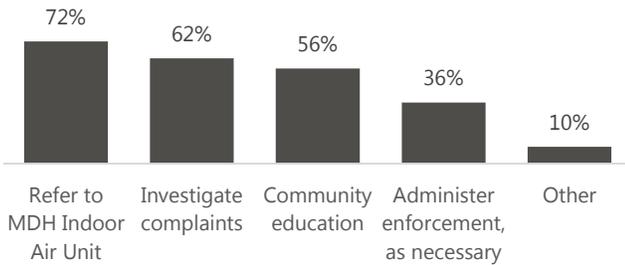
MCIAA support, Minnesota CHBs, 2014

Minnesota (n=50)

CHB works to support MCIAA	78%
CHB does not work to support MCIAA	22%

ADDRESSING AND ENFORCING MCIAA, MINNESOTA CHBS, 2014

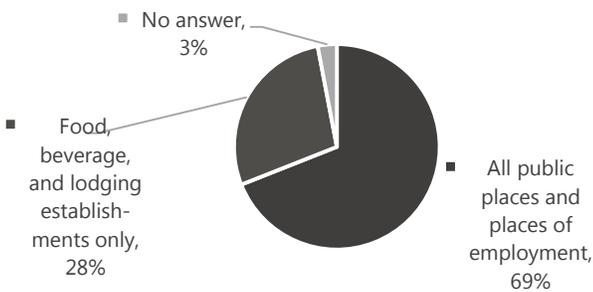
Methods used to address MCIAA complaints, Minnesota CHBs, 2014 (n=39)



Methods used to address MCIAA complaints, Minnesota CHBs, 2014

Method	Minnesota (n=39)
Refer to MDH Indoor Air Unit	72%
Investigate complaints	62%
Administer enforcement, as necessary	36%
Community education	56%
Other	10%

Facilities in which MCIAA is enforced, Minnesota CHBs, 2014 (n=39)



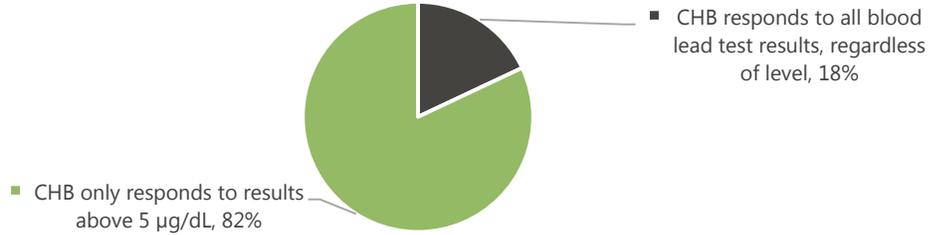
Facilities in which MCIAA is enforced, Minnesota CHBs, 2014

Facility Type	Minnesota (n=39)
All public places and places of employment	69%
Food, beverage and lodging establishments only	28%
No answer	3%

PROTECT AGAINST ENVIRONMENTAL HEALTH HAZARDS

BLOOD LEAD

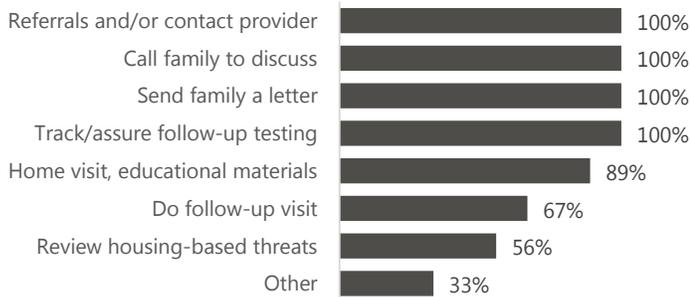
Response to elevated blood lead, Minnesota CHBs, 2014



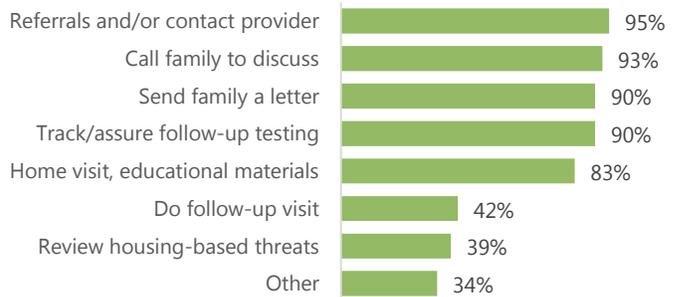
Response to elevated blood lead, Minnesota CHBs, 2014	Minnesota (n=50)
CHB responds to all blood lead test results, regardless of level	18%
CHB only responds to results above 5 µg/dL	82%
CHB does not respond to elevated blood lead test results	0%
Not applicable: CHB did not receive blood lead test results during reporting period	0%

RESPONDING TO ELEVATED BLOOD LEAD, MINNESOTA CHBS, 2014

Method of response to elevated blood lead for CHBs that respond to all levels, Minnesota, 2014 (n=9)



Method of response to elevated blood lead for CHBs that respond only to above 5 µg/dL, Minnesota, 2014 (n=41)



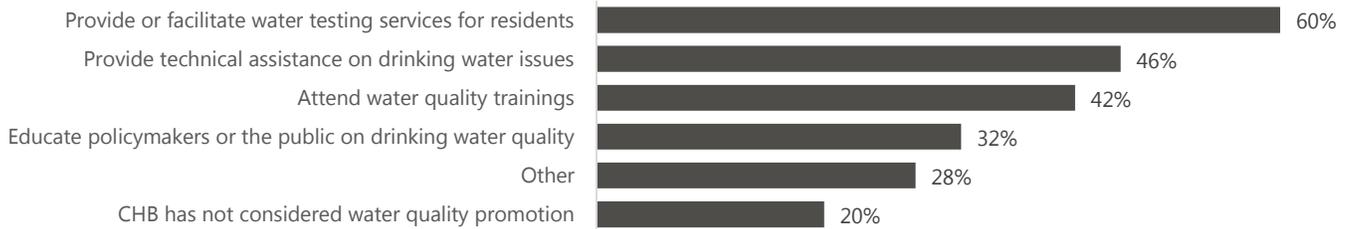
	CHBs responding to all levels (n=9)	CHBs responding only to above 5 µg/dL (n=41)
Send family a letter	100%	90%
Call family to discuss	100%	93%
Schedule home visit and provide educational materials	89%	83%
Track/assure follow-up blood lead testing	100%	90%
Provide public health referrals (e.g., WIC, MA, follow-up testing) and/or contact medical provider	100%	95%
Review additional housing-based health threats (e.g., Healthy Homes)	56%	39%
Do follow-up visit	67%	42%
Other	33%	34%

PROTECT AGAINST ENVIRONMENTAL HEALTH HAZARDS

DRINKING WATER PROTECTION AND WELL MANAGEMENT

PROMOTING WATER QUALITY, MINNESOTA CHBS, 2014

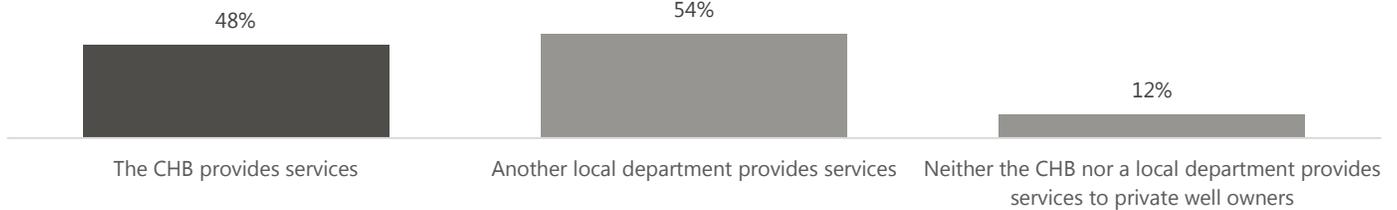
Methods used to promote water quality, Minnesota CHBs, 2014



Methods used to promote water quality, Minnesota CHBs, 2014	Minnesota (n=50)
Attend water quality trainings	42%
Educate policymakers or the public on drinking water quality	32%
Provide technical assistance on drinking water issues	46%
Provide or facilitate water testing services for residents	60%
Other	28%
CHB has not considered water quality promotion	20%

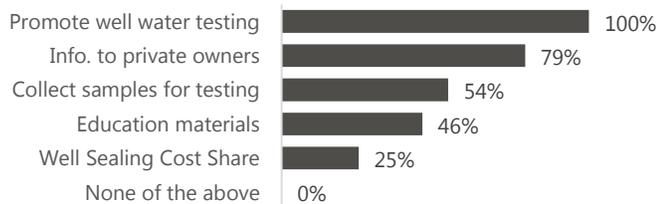
SERVICES PROVIDED TO PRIVATE WELL OWNERS, MINNESOTA CHBS, 2014

Service provider(s) for private well owners, Minnesota CHBs, 2014



Service provider(s) for private well owners, Minnesota CHBs, 2014	Minnesota (n=50)
The CHB provides services	48%
Another local department provides services	54%
Neither the CHB nor a local department provides services to private well owners	12%

Services provided to private well owners by Minnesota CHBs, 2014 (n=24)



Services provided to private well owners by Minnesota CHBs, 2014

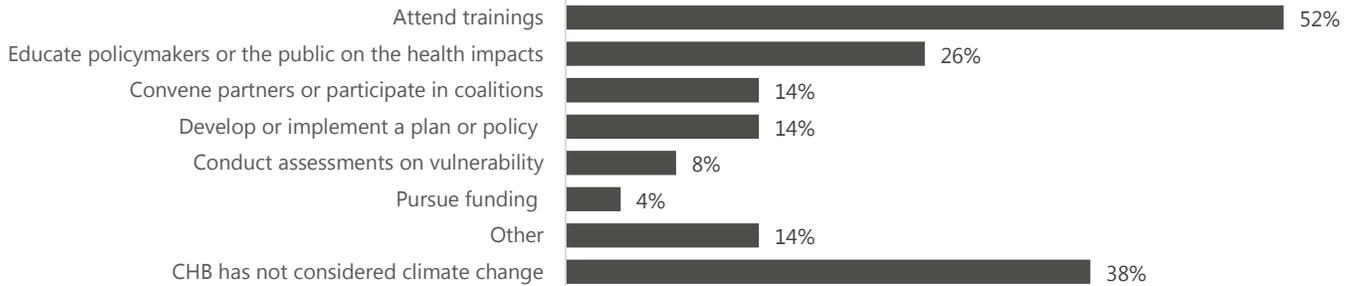
Services provided to private well owners by Minnesota CHBs, 2014	Minnesota (n=24)
Collect well water samples for testing	54%
Promote well water testing	100%
Well information provided to private well owners	79%
Well management education materials broadly provided	45%
Well Sealing Cost Share	25%
None of the above	0%

PROTECT AGAINST ENVIRONMENTAL HEALTH HAZARDS

ENVIRONMENTAL SURVEILLANCE AND ASSESSMENT

ADDRESSING CLIMATE CHANGE, MINNESOTA CHBS, 2014

Methods used to consider climate change, Minnesota CHBs, 2014



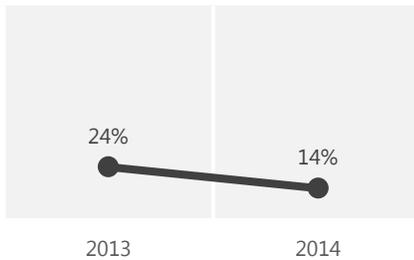
Methods used to consider climate change, Minnesota CHBs, 2014

Minnesota (n=50)

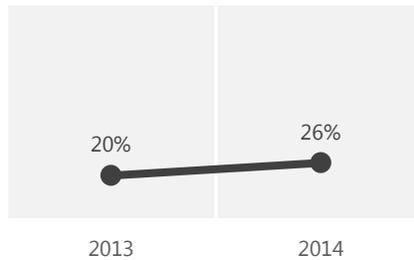
Method	Percentage
Attend climate change trainings	52%
Educate policymakers or the public on the health impacts of climate change	26%
Convene partners or participate in coalitions or mitigate or adapt to climate change	14%
Develop or implement a plan or policy to mitigate or adapt to climate change (e.g., heat response plan or policy to turn vacant lots into community gardens)	14%
Conduct assessments on climate change vulnerability	8%
Pursue funding to address climate change (e.g., grants)	4%
Other	14%
CHB has not considered climate change	38%

CHANGE IN ADDRESSING CLIMATE CHANGE, MINNESOTA CHBS, 2013-2014

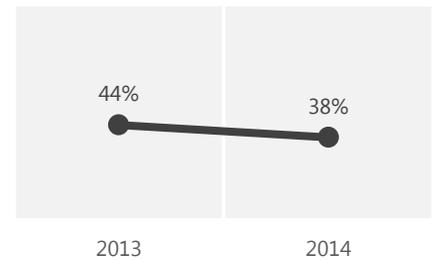
CHBs developing a plan or implementing a policy to consider climate change, Minnesota, 2013-2014



CHBs educating policymakers as a means of considering climate change, Minnesota, 2013-2014



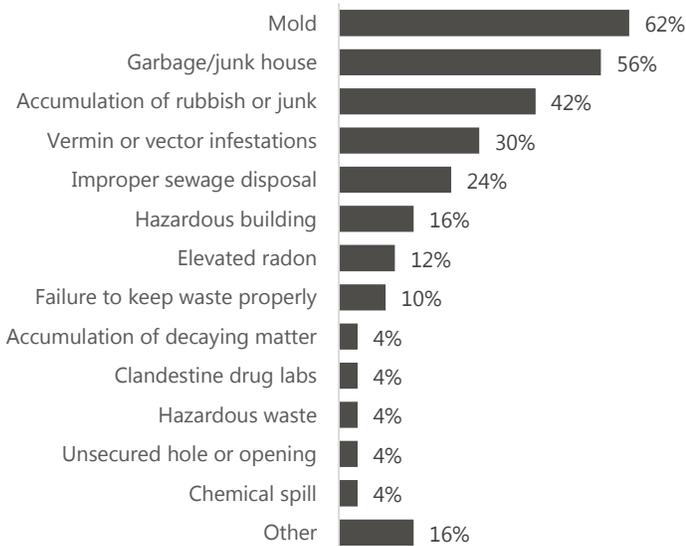
CHBs that have not considered climate change, Minnesota, 2013-2014



PROTECT AGAINST ENVIRONMENTAL HEALTH HAZARDS

NUISANCE INVESTIGATION

Environmental health complaints most frequently addressed by Minnesota CHBs, 2014

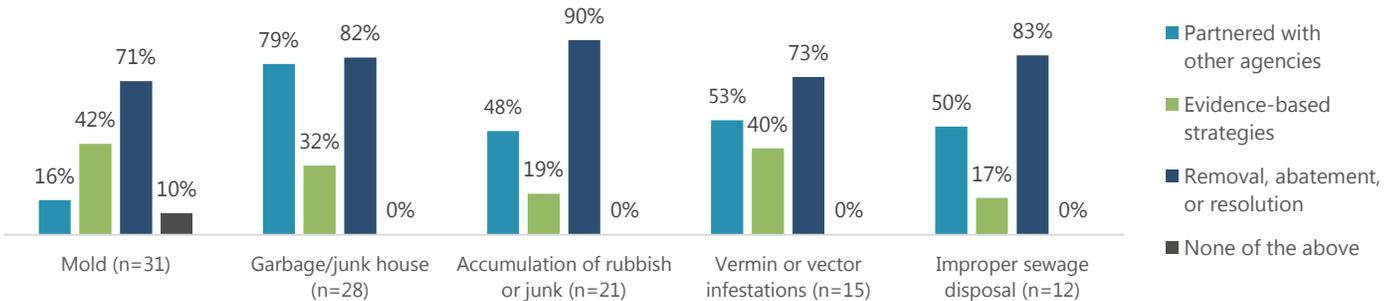


Environmental health complaints most commonly addressed by Minnesota CHBs, 2014

Complaint Type	Minnesota (n=50)
Garbage/junk house	56%
Mold	62%
Improper sewage disposal, discharging to surface/groundwater/into structure	24%
Accumulation of rubbish or junk	42%
Accumulation of decaying animal or vegetable matter	4%
Hazardous building or unsanitary dwelling	16%
Vermin or vector infestations	30%
Clandestine drug labs	4%
Failure to keep waste, refuse, or garbage properly	10%
Contaminated drinking water	0%
Elevated radon	12%
Contaminated surface water	0%
Hazardous waste	4%
Unsecured hole or opening (abandoned well, well pit, sewage treatment system, non-maintained swimming pool, mine shaft, tunnel)	4%
Accumulation of carcasses of animals or failure to dispose of carcasses in sanitary manner	0%
Chemical spill	4%
Contaminated ground water	0%
Other	16%

ADDRESSING MOST COMMON NUISANCE COMPLAINTS, MINNESOTA CHBS, 2014

Methods used to address most common nuisance complaints, Minnesota CHBs, 2014



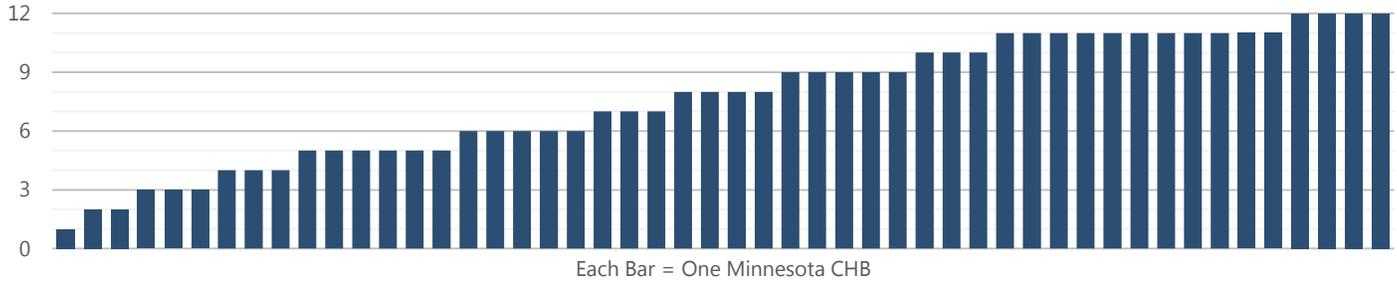
Methods used to address most common nuisance complaints, Minnesota CHBs, 2014	Mold (n=31)	Garbage/junk house (n=28)	Accumulation of rubbish/junk (n=21)	Vermin or vector infestations (n=15)	Improper sewage disposal (n=12)
Partnered with other agencies to address	16%	79%	48%	53%	50%
Evidence-based strategies on prevention	42%	32%	19%	40%	17%
Removal, abatement, or resolution	71%	82%	90%	73%	83%
None of the above	10%	0%	0%	0%	0%

PREPARE FOR AND RESPOND TO DISASTER, AND ASSIST COMMUNITIES IN RECOVERY

PARTNER ENGAGEMENT

ENGAGEMENT WITH CDC EMERGENCY PREPAREDNESS SECTORS, MINNESOTA CHBS, 2014

CDC emergency preparedness sectors engaged (out of 12*) by Minnesota CHBs, 2014



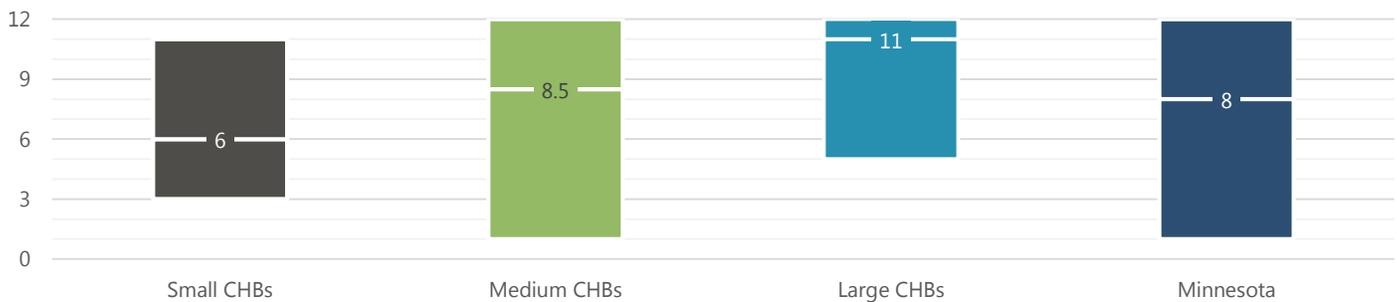
CDC emergency preparedness sectors engaged (out of 12*) by Minnesota CHBs, 2014

Minnesota (n=50)

CDC emergency preparedness sectors engaged (out of 12*)	Minnesota (n=50)
Social services	86%
Cultural and faith-based groups and organizations	84%
Health care	84%
Business	68%
Community leadership	68%
Housing and sheltering	68%
Emergency management	60%
State Office on Aging (or equivalent)	60%
Media	52%
Mental and behavioral health	44%
Education and childcare settings	22%
Other	82%

RANGE OF ENGAGEMENT WITH CDC EMERGENCY PREPAREDNESS SECTORS, MINNESOTA CHBS, 2014

Range and median: CDC emergency preparedness sectors engaged, by population, Minnesota CHBs, 2014



Range: CDC emergency preparedness sectors engaged, by population, Minnesota CHBs, 2014

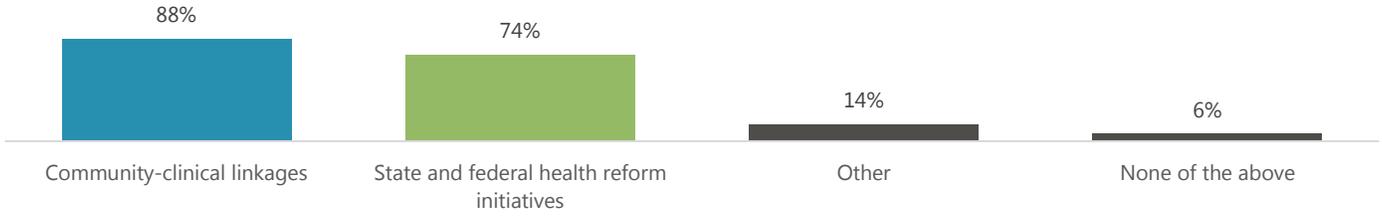
	Small CHBs (n=19)	Medium CHBs (n=20)	Large CHBs (n=11)	Minnesota (n=50)
Minimum	3	1	5	1
Median	6	8.5	11	8
Maximum	11	12	12	12

* Includes 11 sectors noted in table, and "other."

ASSURE THE QUALITY AND ACCESSIBILITY OF HEALTH SERVICES

CLINIC-COMMUNITY LINKAGES

Methods used to promote clinic-community linkages for prevention, Minnesota CHBs, 2014

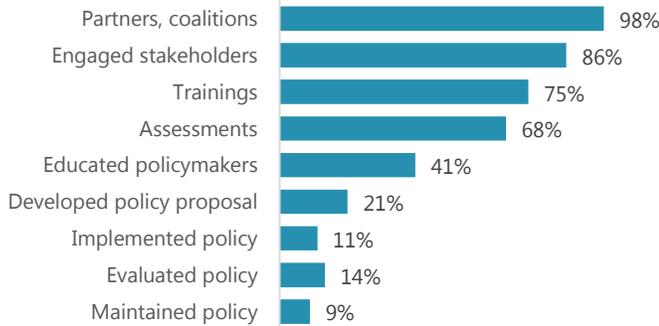


Methods used to promote clinic-community linkages for prevention, Minnesota CHBs, 2014

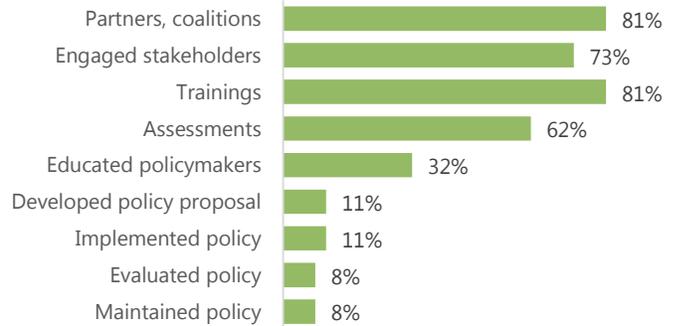
Minnesota (n=50)

Method	Percentage
Community-clinical linkages	88%
Advancing public health, health care, and community linkages with state and federal health reform initiatives	74%
Other	14%
None of the above	6%

Actions taken to use community-clinical linkages to promote clinic-community linkages for prevention, Minnesota CHBs, 2014 (n=44)



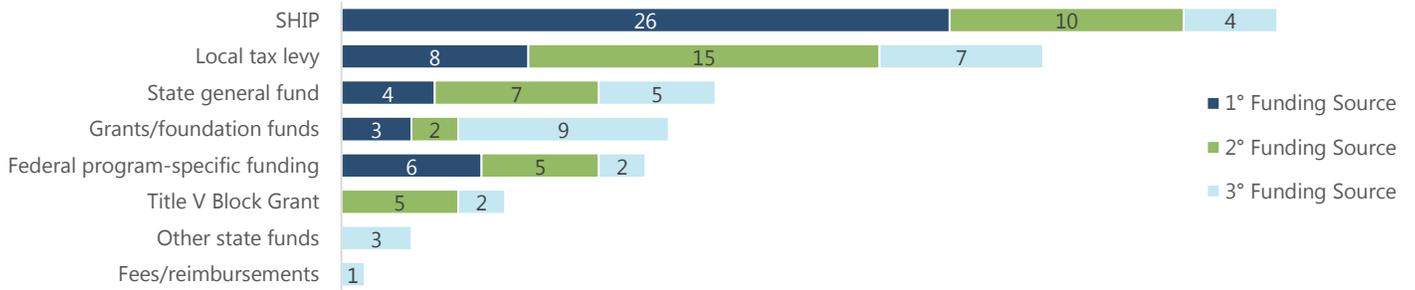
Actions taken to use state/federal health reform initiatives to promote clinic-community linkages for prevention, Minnesota CHBs, 2014 (n=37)



Actions taken to promote clinic-community linkages for prevention, Minnesota CHBs, 2014

	Among CHBs using community-clinical linkages (n=44)	Among CHBs using state/federal health reform initiatives (n=37)
Attended trainings	75%	81%
Conducted assessments	68%	62%
Convened partners or participated in coalitions	98%	81%
Developed policy proposal	21%	11%
Engaged stakeholders	86%	73%
Educated policymakers	41%	32%
Implemented policy	11%	11%
Maintained policy	9%	8%
Evaluated policy	14%	8%
None of the above	0%	0%

Top funding sources used to promote clinic-community linkages for prevention, Minnesota CHBs, 2014



Top funding sources used to promote clinic-community linkages for prevention, Minnesota CHBs, 2014	1° funding source	2° funding source	3° funding source
Local tax levy	8	15	7
State general fund	4	7	5
SHIP	26	10	4
Other state funds	0	0	3
Federal program-specific funding	6	5	2
Title V Block Grant	0	5	2
Grants/foundation funds	3	2	9
Fees/reimbursements	0	0	1

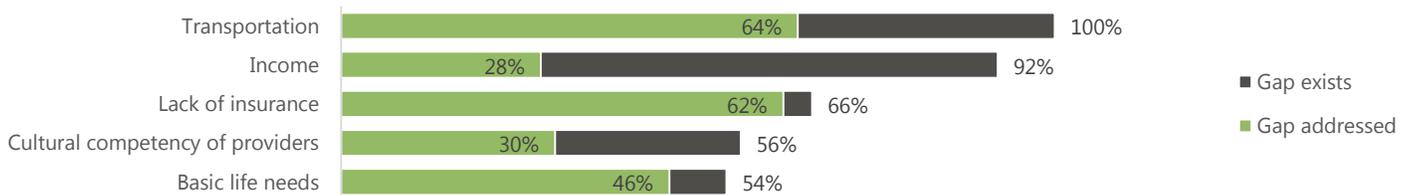
ASSURE THE QUALITY AND ACCESSIBILITY OF HEALTH SERVICES

GAPS IN SERVICES OR BARRIERS TO ACCESS

BASIC NEEDS

GAPS IN BASIC NEEDS, MINNESOTA CHBS, 2014

Gaps in basic needs in communities served by Minnesota CHBs, 2014



Gaps in basic needs related to health care/services, in communities served by Minnesota CHBs, 2014

	Gap exists in CHB Minnesota (n=50)	Gaps addressed in CHB Minnesota (n=50)
Transportation	100%	64%
Lack of insurance	66%	62%
Income	92%	28%
Cultural competency of providers	56%	30%
Basic life needs	54%	46%
None of the above	0%	8%

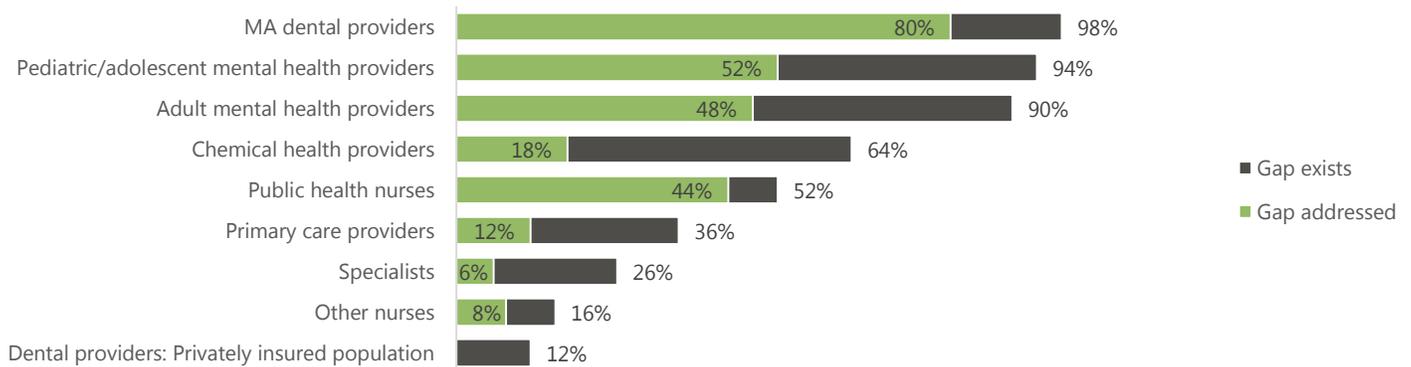
ACTIVITIES CONDUCTED TO ADDRESS GAPS IN BASIC NEEDS, MINNESOTA CHBS, 2014

Activities conducted to address gaps in basic needs related to health care/services, Minnesota CHBs, 2014	Transportation (n=32)	Lack of insurance (n=31)	Income (n=14)	Cultural competency of providers (n=15)	Basic life needs (n=23)
Provided or contracted for services	31%	29%	29%	73%	35%
Outreach	47%	68%	57%	20%	57%
Health education	31%	42%	36%	40%	61%
Case management	50%	39%	43%	20%	65%
Transportation Assistance	53%	35%	43%	13%	35%
Assistance with insurance enrollment/referrals	53%	90%	86%	33%	65%
Partnered in community efforts to reduce barriers	53%	45%	64%	53%	70%
None of the above	0%	0%	0%	0%	0%

HEALTH CARE PROVISION

GAPS IN HEALTH CARE PROVISION, MINNESOTA CHBS, 2014

Gaps in health care provision (i.e., lack of providers) in communities served by Minnesota CHBs, 2014



Gaps in health care provision (i.e., lack of providers) in communities served by Minnesota CHBs, 2014

	Gap exists in CHB Minnesota (n=50)	Gaps addressed in CHB Minnesota (n=50)
Adult mental health providers	90%	48%
Pediatric/adolescent mental health providers	94%	52%
Chemical health providers	64%	18%
MA dental providers	98%	80%
Dental providers: Privately insured population	12%	0%
Primary care providers	36%	12%
Specialists	26%	6%
Public health nurses	52%	44%
Other nurses	16%	8%
None of the above	2%	6%

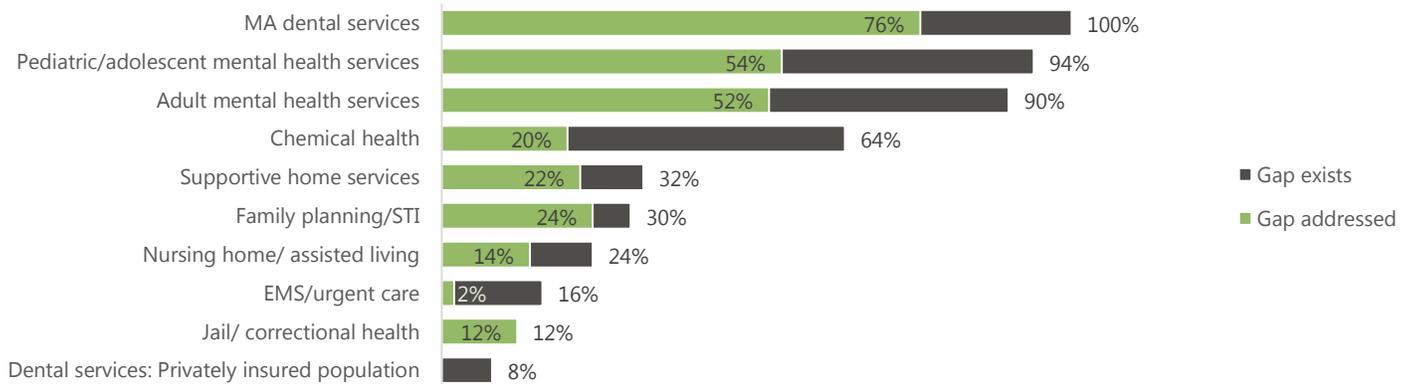
ACTIVITIES CONDUCTED TO ADDRESS GAPS IN HEALTH CARE PROVISION, MINNESOTA CHBS, 2014

Activities conducted to address largest gaps in health care provision, Minnesota CHBs, 2014	MA dental providers (n=40)	Pediatric/adolescent mental health providers (n=26)	Adult mental health providers (n=24)	Public health nurses (n=22)
Provided or contracted for services	23%	46%	33%	36%
Outreach	75%	42%	33%	55%
Health education	45%	23%	25%	23%
Case management	25%	35%	38%	14%
Transportation Assistance	23%	31%	25%	14%
Assistance with insurance enrollment/referrals	45%	54%	54%	5%
Partnered in community efforts to reduce barriers	70%	65%	66%	27%
None of the above	0%	0%	0%	18%

HEALTH CARE SERVICES

GAPS IN HEALTH CARE SERVICES, MINNESOTA CHBS, 2014

Gaps in health care services in communities served by Minnesota CHBs, 2014



Gaps in health care services in communities served by Minnesota CHBs, 2014	Gap exists in CHB Minnesota (n=50)	Gaps addressed in CHB Minnesota (n=50)
Adult mental health services	90%	52%
Pediatric/adolescent mental health services	94%	54%
Family planning/STI	30%	24%
MA dental services	100%	76%
Dental services: Privately insured population	8%	0%
EMS/urgent care	16%	2%
Chemical health	64%	20%
Supportive home services	32%	22%
Jail/correctional health	12%	12%
Nursing home/assisted living	24%	14%
None of the above	0%	6%

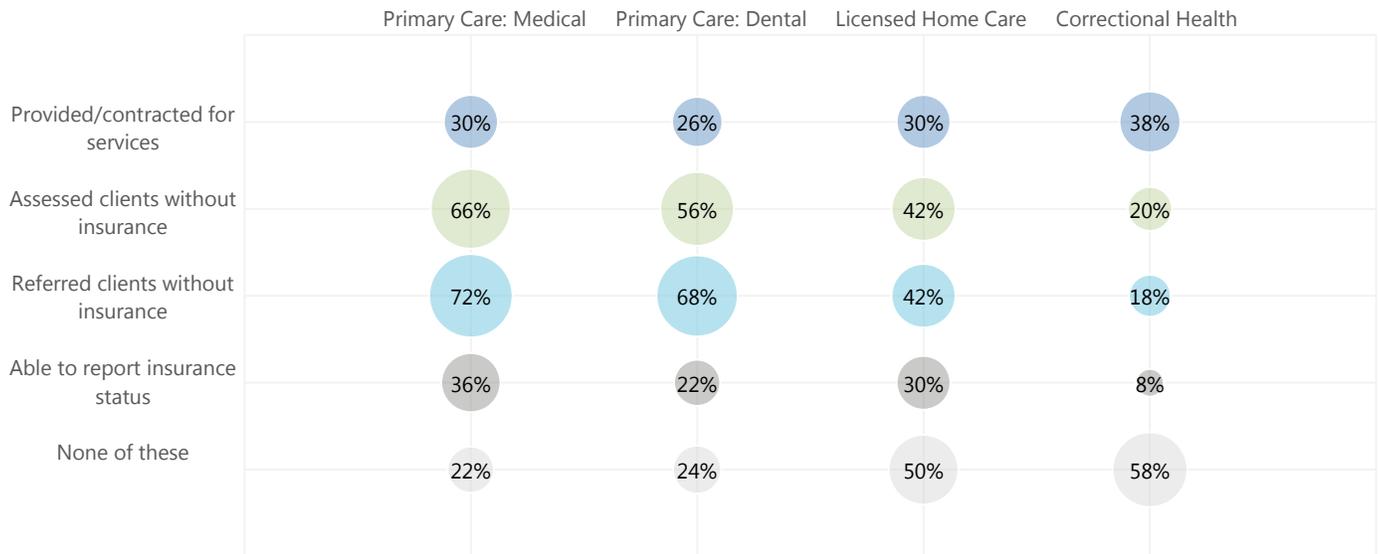
ACTIVITIES CONDUCTED TO ADDRESS GAPS IN HEALTH CARE SERVICES, MINNESOTA CHBS, 2014

Activities conducted to address largest gaps in health care services, Minnesota CHBs, 2014	MA dental services (n=38)	Pediatric/ adolescent mental health services (n=27)	Adult mental health services (n=26)	Family planning/STI (n=12)
Provided or contracted for services	26%	33%	31%	92%
Outreach	68%	52%	42%	75%
Health education	47%	22%	23%	75%
Case management	26%	41%	42%	42%
Transportation Assistance	21%	22%	19%	0%
Assistance with insurance enrollment/referrals	58%	48%	42%	50%
Partnered in community efforts to reduce barriers	63%	70%	62%	50%
None of the above	0%	4%	8%	0%

ASSURE THE QUALITY AND ACCESSIBILITY OF HEALTH SERVICES

SERVICE PROVISION AND HEALTH INSURANCE STRATEGIES

Activities performed related to service provision, Minnesota CHBs, 2014

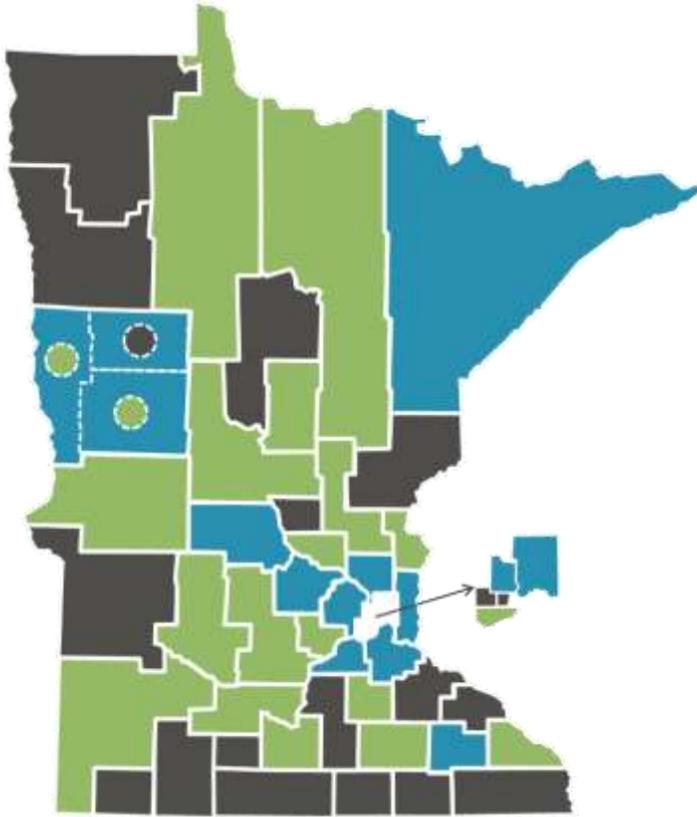


Activities performed related to service provision, Minnesota CHBs, 2014	Primary Care: Medical	Primary Care: Dental	Licensed Home Care	Correctional Health
Provided/contracted for services	30%	26%	30%	38%
Assessed insurance status	66%	56%	42%	20%
Referred clients without insurance	72%	68%	42%	18%
Able to report insurance status	36%	22%	30%	8%
None of these	22%	24%	50%	58%

APPENDICES

MINNESOTA COMMUNITY HEALTH BOARDS BY POPULATION

Contact information on community health boards in Minnesota can be found online: www.health.state.mn.us/divs/opi/gov/find/.



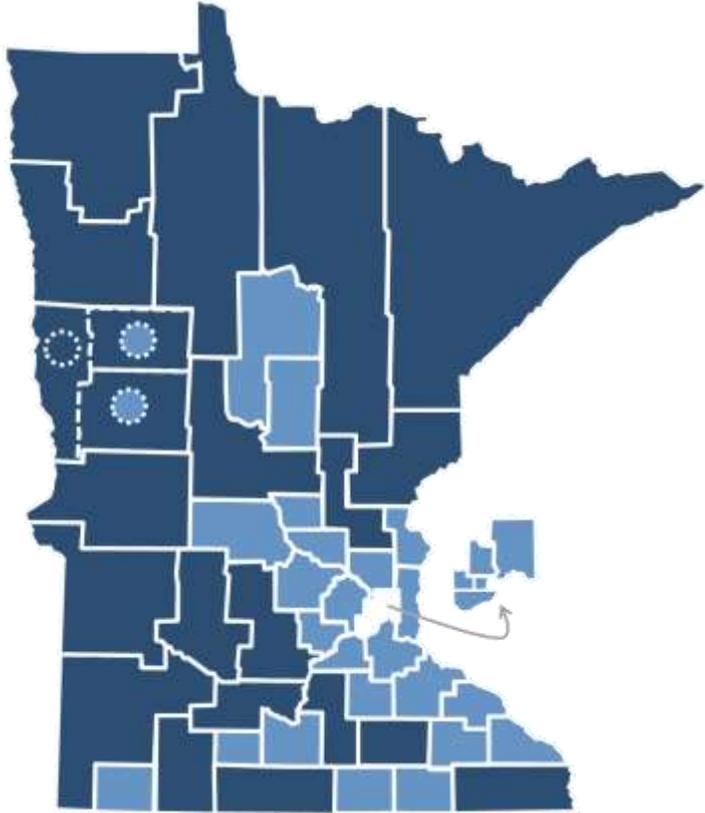
Small CHBs (n=18)		Population of less than 50,000	
Benton		Kanabec-Pine	
Cass		Le Sueur-Waseca	
Countryside		Mower	
Des Moines Valley		Nobles	
Edina		Polk-Norman-Mahnomen	
Faribault-Martin		Quin County	
Fillmore-Houston		Richfield	
Freeborn		Wabasha	
Goodhue		Watonwan	
Medium CHBs (n=18)		Population between 50,000 and 100,000	
Aitkin-Itasca-Koochiching		Isanti-Mille Lacs	
Bloomington		Kandiyohi-Renville	
Blue Earth		Meeker-McLeod-Sibley	
Brown-Nicollet		Morrison-Todd-Wadena	
Carver		North Country	
Chisago		Rice	
Crow Wing		Sherburne	
Dodge-Steele		SWHHS	
Horizon		Winona	
Large CHBs (n=12)		Population of greater than 100,000	
Anoka		Partnership4Health*	
Carlton-Cook-Lake-St. Louis		St. Paul-Ramsey	
Dakota		Scott	
Hennepin		Stearns	
Minneapolis		Washington	
Olmsted		Wright	

* * Throughout this report, you may note differences in the count of small, medium, and large CHBs. This is because Partnership4Health chose to begin reporting as a combined CHB for certain measures during its merger process, which became effective January 1, 2015. Where reporting as separate CHBs on data prior to the merge, Clay-Wilkin and Otter Tail reported as medium CHBs, and Becker as a small CHB (see map, above).

APPENDICES

MINNESOTA COMMUNITY HEALTH BOARDS BY STRUCTURE

Contact information on community health boards in Minnesota can be found online: www.health.state.mn.us/divs/opi/gov/find/.



Single-County CHBs (n=28)

- | | |
|-------------|-----------------|
| Anoka | Mower |
| Benton | Nobles |
| Bloomington | Olmsted |
| Blue Earth | Rice |
| Carver | Richfield |
| Cass | St. Paul-Ramsey |
| Chisago | Scott |
| Crow Wing | Sherburne |
| Dakota | Stearns |
| Edina | Wabasha |
| Freeborn | Washington |
| Goodhue | Watonwan |
| Hennepin | Winona |
| Minneapolis | Wright |

Multi-County CHBs (n=20)

- | | |
|-----------------------------|----------------------|
| Aitkin-Itasca-Koochiching | Kanabec-Pine |
| Brown-Nicollet | Kandiyohi-Renville |
| Carlton-Cook-Lake-St. Louis | Le Sueur-Waseca |
| Countryside | Meeker-McLeod-Sibley |
| Des Moines Valley | Morrison-Todd-Wadena |
| Dodge-Steele | North Country |
| Faribault-Martin | Partnership4Health* |
| Fillmore-Houston | Polk-Norman-Mahnomen |
| Horizon | Quin County |
| Isanti-Mille Lacs | SWHHS |

* Partnership4Health chose to begin reporting as a combined CHB for certain measures during its merger process, which became effective January 1, 2015. Where reporting as separate CHBs on data prior to the merge, Becker and Otter Tail reported as single-county CHBs, and Clay-Wilkin as a multi-county CHB (see map, above).

APPENDICES

AREAS OF PUBLIC HEALTH RESPONSIBILITY

Information on the areas of public health responsibility can be found online: www.health.state.mn.us/divs/opi/gov/lphact/.

ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE

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

In PPMRS reporting, this area of responsibility is split into: **Capacity Measures from National Standards**, and **Minnesota-Specific Measures**.

PROMOTE HEALTHY COMMUNITIES AND HEALTHY BEHAVIORS

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

PREVENT THE SPREAD OF INFECTIOUS DISEASE

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

PROTECT AGAINST ENVIRONMENTAL HEALTH HAZARDS

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

PREPARE FOR AND RESPOND TO DISASTERS, AND ASSIST COMMUNITIES IN RECOVERY

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

ASSURE THE QUALITY AND ACCESSIBILITY OF HEALTH SERVICES

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