

2015 Local Public Health Act Performance Measures

DATA BOOK

AUGUST 2016



HEALTH PARTNERSHIPS DIVISION, PUBLIC HEALTH PRACTICE SECTION

MDH Health Partnerships Division

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About the Annual Reporting Data Book

Minnesota community health boards report annually to the Minnesota Department of Health 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 2015 reporting period. For more information on tailored reports specific to each community health board, contact:

Minnesota Department of Health
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This report does not include data on the area of public health responsibility “Prepare and respond to emergencies;” data for that area of responsibility is collected by the [MDH Emergency Preparedness and Response Section](#).



Minnesota Public Health System
 Performance Management Cycle

Reporting Instructions

Instructions for reporting on all six areas of public health responsibility can be found online: www.health.state.mn.us/ppmrs/. Data reported was collected between January 1 and December 31, 2015.

Interpretation and Assistance

In the interest of swift release and of transparency, the 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.

The [State Community Health Services Advisory Committee \(SCHSAC\) Performance Improvement Steering Committee](#) has reviewed these findings and will release recommendations for system improvement later this year.

Community Health Board Population

In this report, you will often see data broken out by community health board population; for more information on how community health boards are divided by population, please refer to the [appendices](#). MDH has used population data from 2014 for this report, which is the most recently available population data.

Funding for This Report

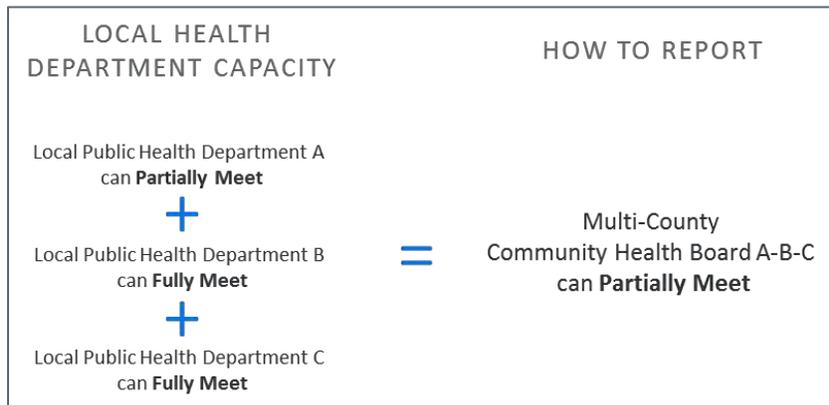
This report was supported by funds made available from the Centers for Disease Control and Prevention, Office for State, Tribal, Local, and Territorial Support, under Federal Award Identification Number (FAIN) B01OT009029. The content in this report is that of the authors, and does not necessarily represent the official position of or endorsement by the Centers for Disease Control and Prevention.

Assure an Adequate Local Public Health Infrastructure: Capacity Measures from National Standards

In spring 2016, Minnesota community health boards reported on a key subset of 37 national public health measures selected by the SCHSAC Performance Improvement Steering Committee. This subset differs from the subset tracked from 2012 to 2014, though some measures have been included in both subsets. This is why trend data is included from 2012 to the present for some measures, and from 2014 to the present for others.

Minnesota’s Local Public Health Act performance measures—and instructions for reporting on them—are based on PHAB Standards and Measures version 1.5. For more information, visit www.phaboard.org/.

Multi-county community health boards were directed to report on the lowest level of capacity of their individual health departments for these measures (see below). For a full list of single-county/city community health boards and multi-county community health boards, please refer to the appendices.



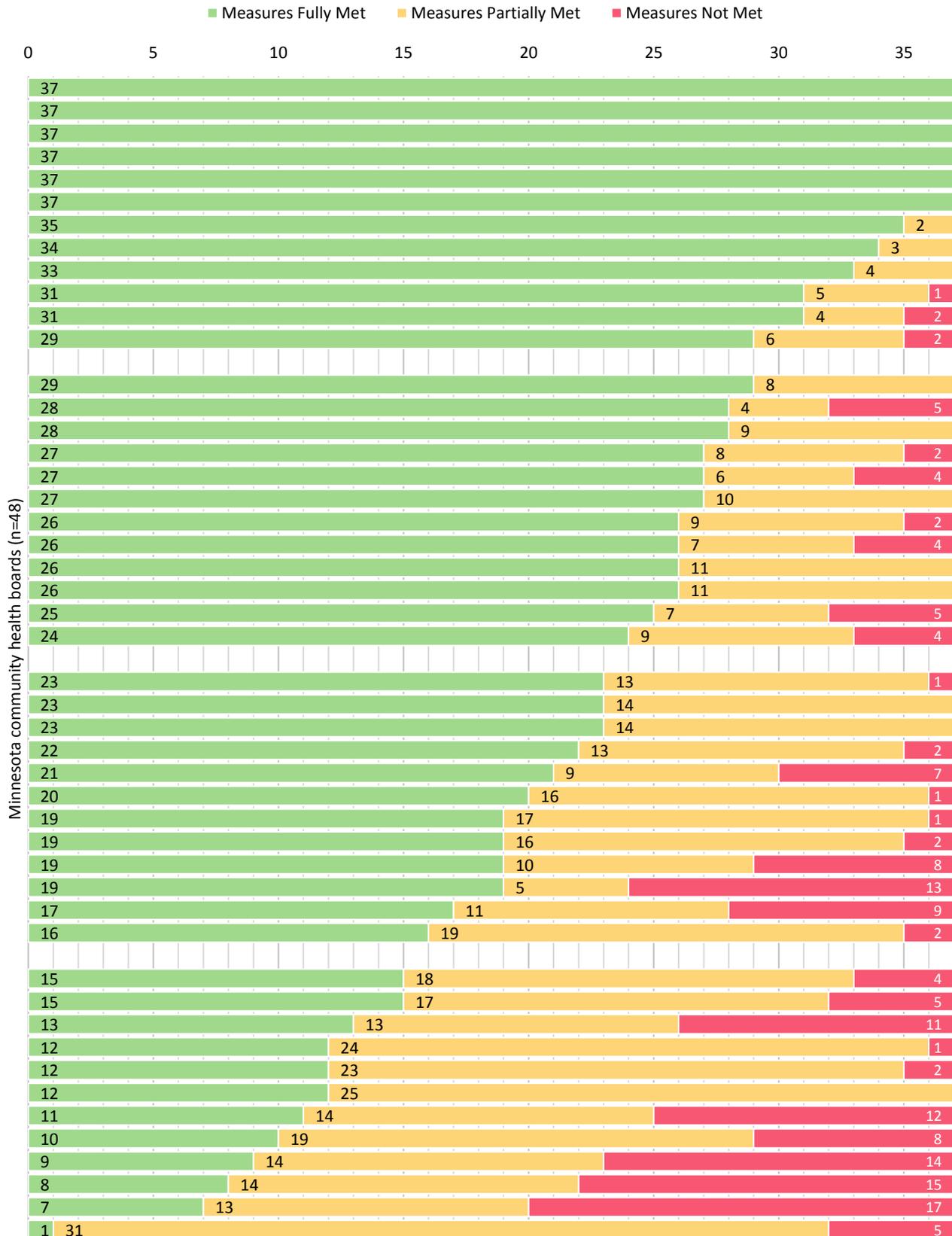
Subset of 37 Key Public Health Measures, 2015-2018

This subset of 37 key national public health measures was selected by the Minnesota Performance Improvement Steering Committee, for annual reporting in 2015-2018. Starred measures were also tracked in the 2012-2014 subset.

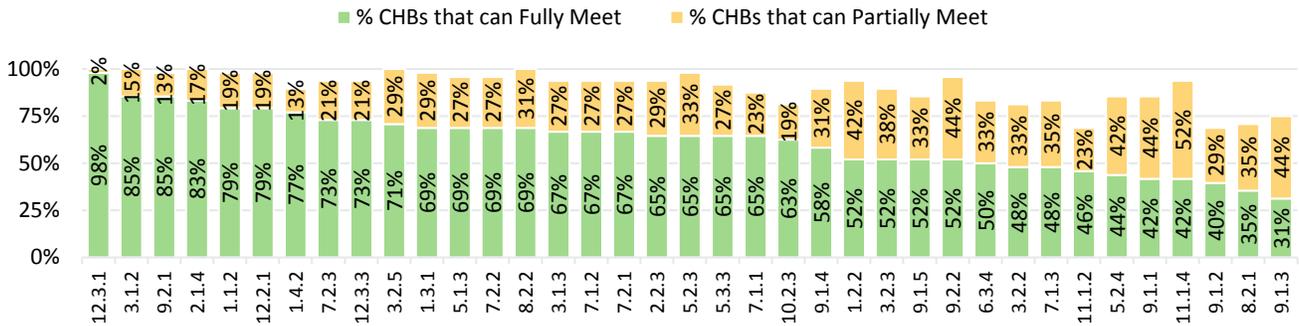
1.1.2	A local community health assessment	7.2.2**	Implemented strategies to increase access to health care services
1.2.2	Communication with surveillance sites	7.2.3**	Implemented culturally competent initiatives to increase access to health care services for those who may experience barriers to care due to cultural, language, or literacy differences
1.3.1	Data analyzed and public health conclusions drawn	8.2.1**	Workforce development strategies
1.4.2**	Community summaries or fact sheets of data to support public health improvement planning processes at the local level	8.2.2	A competent community health board workforce
2.1.4**	Collaborative work through established governmental and community partnerships on investigations of reportable diseases, disease outbreaks, and environmental public health issues	9.1.1**	Staff at all organizational levels engaged in establishing and/or updating a performance management system
2.2.3**	Complete After Action Reports (AARs)	9.1.2**	Performance management policy/system
3.1.2**	Health promotion strategies to mitigate preventable health conditions	9.1.3**	Implemented performance management system
3.1.3	Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes	9.1.4**	Implemented systematic process for assessing customer satisfaction with community health board services
3.2.2	Organizational branding strategy	9.1.5**	Opportunities provided to staff for involvement in the community health board's performance management
3.2.3	Communication procedures to provide information outside the health department	9.2.1**	Established quality improvement program based on organizational policies and direction
3.2.5	Information available to the public through a variety of methods	9.2.2**	Implemented quality improvement activities
5.1.3	Informed governing entities, elected officials, and/or the public of potential intended or unintended public health impacts from current and/or proposed policies	10.2.3	Communicated research findings, including public health implications
5.2.3**	Elements and strategies of the health improvement plan implemented in partnership with others	11.1.2	Ethical issues identified and ethical decisions made
5.2.4**	Monitor the strategies in the community health improvement plan, and revise as needed, in collaboration and with broad participation from stakeholders and partners	11.1.4	Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes
5.3.3**	Implemented community health board strategic plan	12.2.1**	Communication with the governing entity regarding the responsibilities of the community health board and of the responsibilities of the governing entity
6.3.4**	Patterns or trends identified in compliance from enforcement activities and complaints	12.3.1**	Information provided to the governing entity about important public health issues facing the community, the community health board, and/or the recent actions of the community health board
7.1.1	Process to assess the availability of health care services	12.3.3**	Communication with the governing entity about the community health board performance assessment and improvement
7.1.2	Identification of populations who experience barriers to health care services		
7.1.3**	Identification of gaps in access to health care services, and barriers to the receipt of health care services		
7.2.1	Process to develop strategies to improve access to health care services		

No measures are tracked in Domain 4 for this subset.

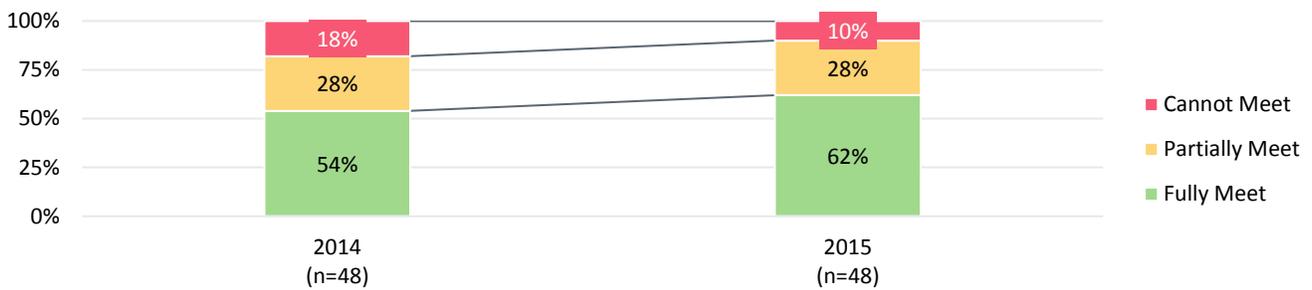
Capacity of Minnesota community health boards to meet 37 key national public health measures, by quartile, 2015



Percentage of national public health measures in key subset met by Minnesota community health boards, by most fully met, 2015 (n=48)

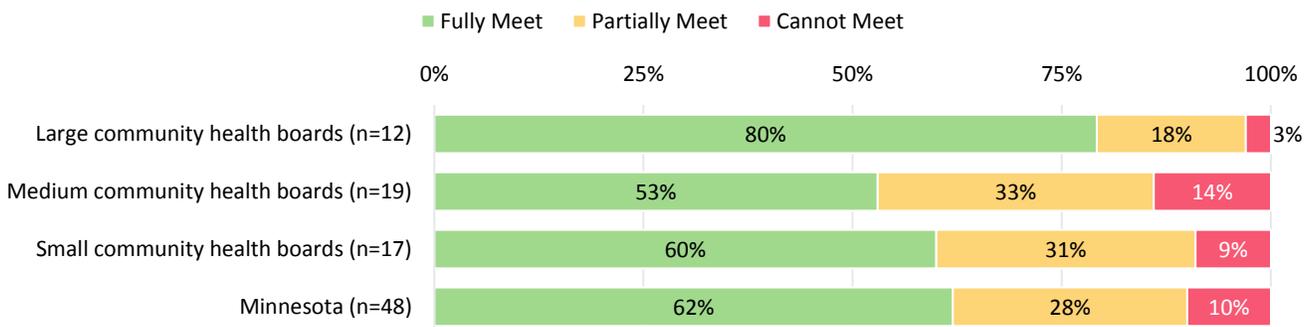


Progress: Community health board capacity to meet national public health measures in key subset, Minnesota, 2014-2015

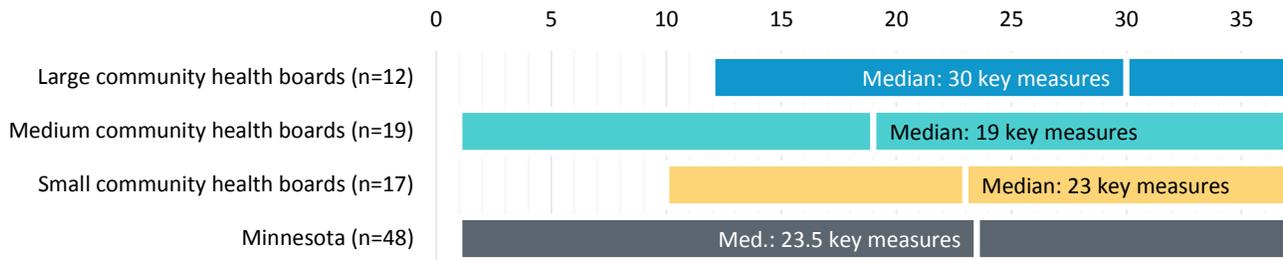


Key Subset of Public Health Measures by Population

Comparison: Minnesota community health board capacity to meet key subset of national public health measures, by population, 2015

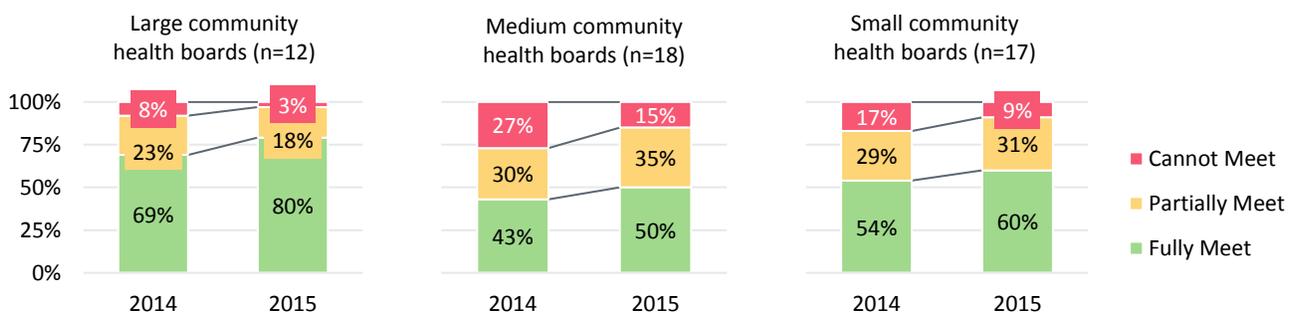


Comparison: Range and median of national public health measures fully met, Minnesota community health boards, by population, 2015



National public health measures most and least able to be fully met by Minnesota community health boards, by population, 2015	Large boards (n=12)	Medium boards (n=19)	Small boards (n=17)	Minnesota (n=48)
Most able to meet	(tied)			
2.1.4: Collaborative partnerships for investigation	✓			
9.2.1: Established QI program	✓			
12.2.1: Communication with governing entity RE: responsibilities	✓			
12.3.1: Info. provided to governing entity	✓	✓	✓	✓
Least able to meet	(tied)		(tied)	
3.2.2: Organizational branding strategies			✓	
6.3.4: Compliance patterns from enforcement	✓			
8.2.1: Workforce development strategies		✓		
9.1.1: Engagement in performance management system			✓	
9.1.3: Implemented performance management system		✓	✓	✓

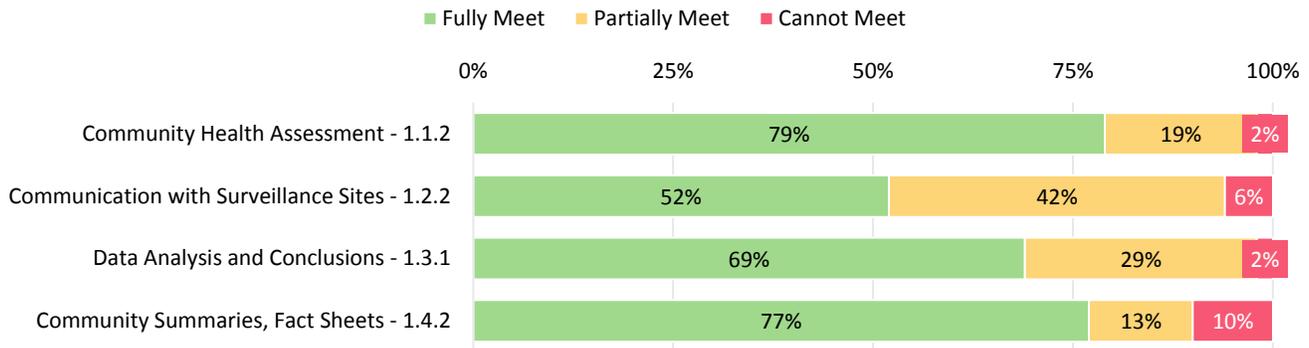
Progress and comparison: Community health board capacity to fully meet key subset of national public health measures, by population, Minnesota, 2014-2015



Not included: Edina (population growth moved it from a "small" to a "medium" community health board between 2014 and 2015).

Domain 1: Conduct and Disseminate Assessments Focused on Population Health Status and Public Health Issues Facing the Community

Minnesota community health board capacity to meet key measures in Domain 1, 2015 (n=48)

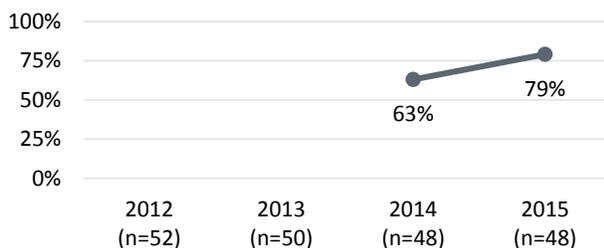


Minnesota community health board capacity to meet key measures in Domain 1, 2015 (n=48)	Fully Meet		Partially Meet		Cannot Meet	
	#	%	#	%	#	%
1.1.2 – Community Health Assessment <i>A local community health assessment</i>	38	79%	9	19%	1	2%
1.2.2 – Communication with Surveillance Sites <i>Communication with surveillance sites</i>	25	52%	20	42%	3	6%
1.3.1 – Data Analysis and Conclusions <i>Data analyzed and public health conclusions drawn</i>	33	69%	14	29%	1	2%
1.4.2 – Community Summaries, Fact Sheets <i>Community summaries or fact sheets of data to support public health improvement planning processes at the local level</i>	37	77%	6	13%	5	10%

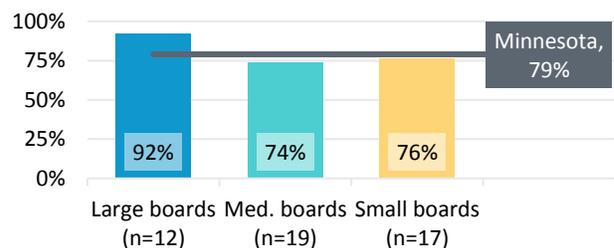
Measure 1.1.2: Community Health Assessment

A local community health assessment

Progress: 1.1.2 (fully met), Minnesota, 2014-2015



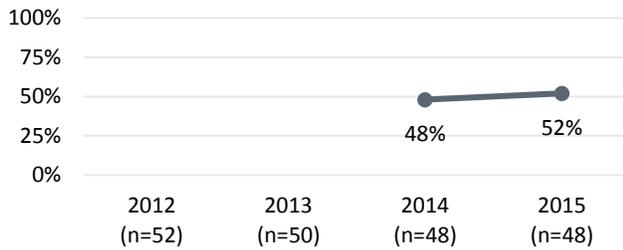
Comparison: 1.1.2 (fully met), by population, 2015



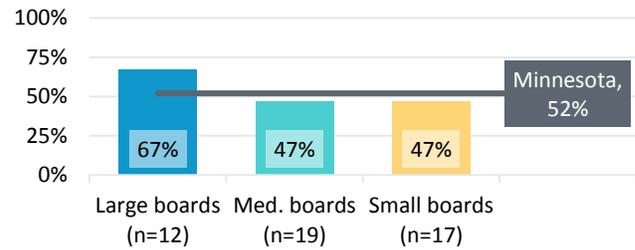
Measure 1.2.2: Communication with Surveillance Sites

Communication with surveillance sites

Progress: 1.2.2 (fully met), Minnesota, 2014-2015



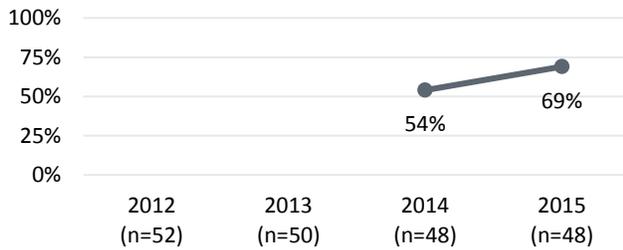
Comparison: 1.2.2 (fully met), by population, 2015



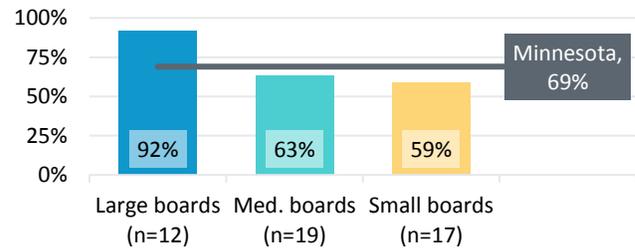
Measure 1.3.1: Data Analysis and Conclusions

Data analyzed and public health conclusions drawn

Progress: 1.3.1 (fully met), Minnesota, 2014-2015



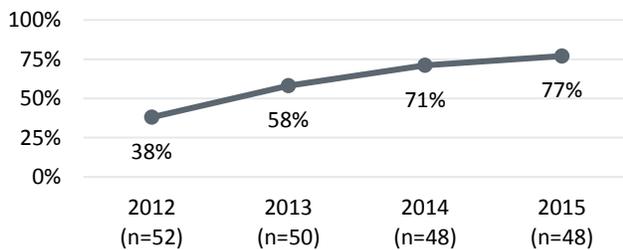
Comparison: 1.3.1 (fully met), by population, 2015



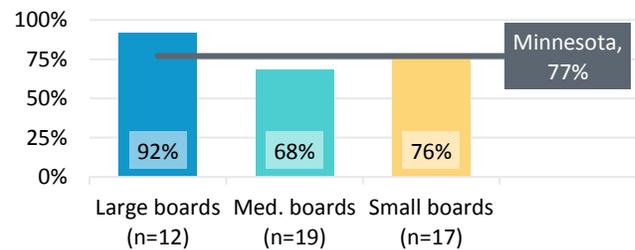
Measure 1.4.2: Community Summaries, Fact Sheets

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

Progress: 1.4.2 (fully met), Minnesota, 2012-2015

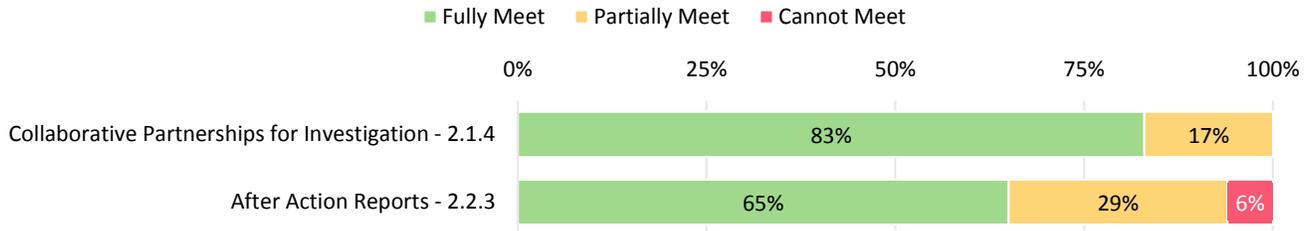


Comparison: 1.4.2 (fully met), by population, 2015



Domain 2: Investigate Health Problems and Environmental Public Health Hazards to Protect the Community

Minnesota community health board capacity to meet key measures in Domain 2, 2015 (n=48)

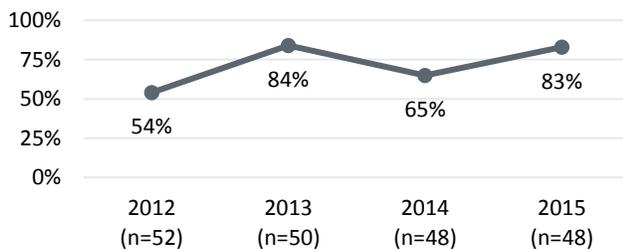


Minnesota community health board capacity to meet key measures in Domain 2, 2015 (n=48)	Fully Meet		Partially Meet		Cannot Meet	
	#	%	#	%	#	%
2.1.4 – Collaborative Partnerships for Investigation <i>Collaborative work through established governmental and community partnerships on investigations of reportable diseases, disease outbreaks, and environmental public health issues</i>	40	83%	8	17%	0	0%
2.2.3 – After Action Reports <i>Complete After Action Reports</i>	31	65%	14	29%	3	6%

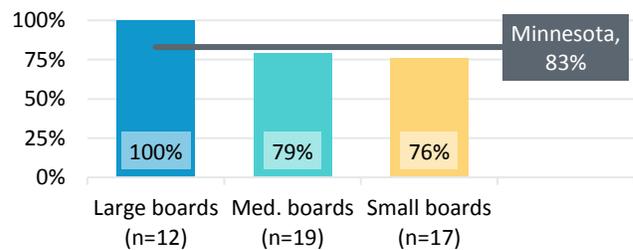
Measure 2.1.4: Collaborative Partnerships for Investigation

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

Progress: 2.1.4 (fully met), Minnesota, 2012-2015



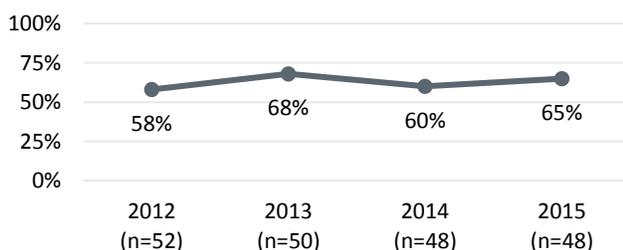
Comparison: 2.1.4 (fully met), by population, 2015



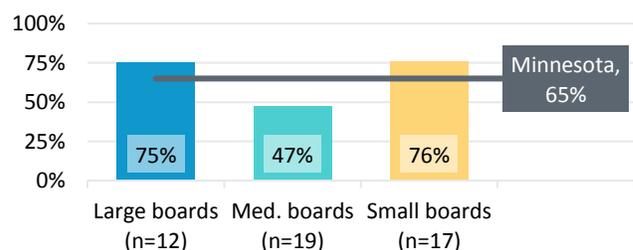
Measure 2.2.3: After Action Reports (AARs)

Complete After Action Reports (AARs)

Progress: 2.2.3 (fully met), Minnesota, 2012-2015

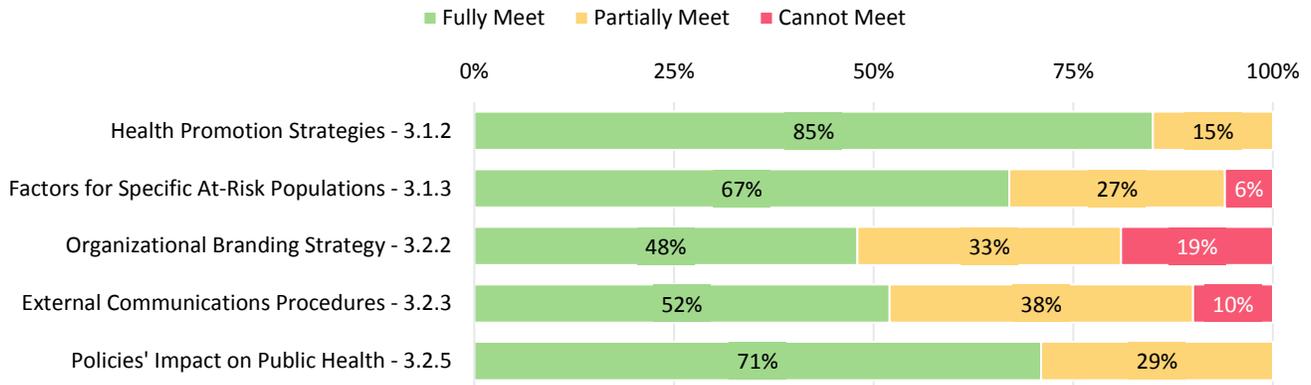


Comparison: 2.2.3 (fully met), by population, 2015



Domain 3: Inform and Educate about Public Health Issues and Functions

Minnesota community health board capacity to meet key measures in Domain 3, 2015 (n=48)

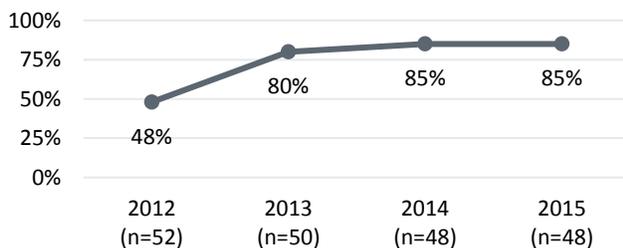


Minnesota community health board capacity to meet key measures in Domain 3, 2015 (n=48)	Fully Meet		Partially Meet		Cannot Meet	
	#	%	#	%	#	%
3.1.2 – Health Promotion Strategies <i>Health promotion strategies to mitigate preventable health conditions</i>	41	85%	7	15%	0	0%
3.1.3 – Factors for Specific At-Risk Populations <i>Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes</i>	32	67%	13	27%	3	6%
3.2.2 – Organizational Branding Strategy <i>Organizational branding strategy</i>	23	48%	16	33%	9	19%
3.2.3 – External Communications Procedures <i>Communication procedures to provide information outside the community health board</i>	25	52%	18	38%	5	10%
3.2.5 – Policies' Impact on Public Health <i>Informed governing entities, elected officials, and/or the public of potential intended or unintended public health impacts from current and/or proposed policies</i>	34	71%	14	29%	0	0%

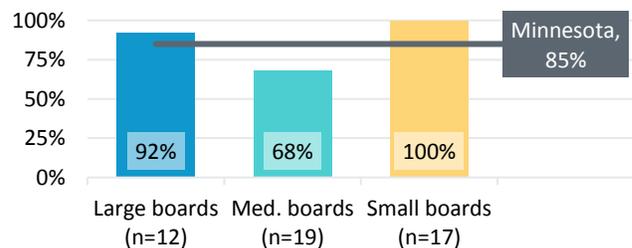
Measure 3.1.2: Health Promotion Strategies

Health promotion strategies to mitigate preventable health conditions

Progress: 3.1.2 (fully met), Minnesota, 2012-2015



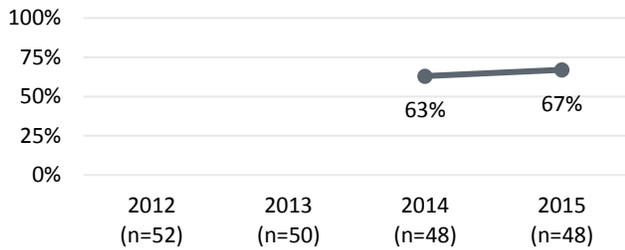
Comparison: 3.1.2 (fully met), by population, 2015



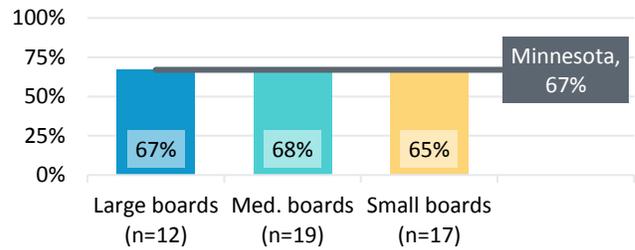
Measure 3.1.3: Factors for Specific At-Risk Populations

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

Progress: 3.1.3 (fully met), Minnesota, 2014-2015



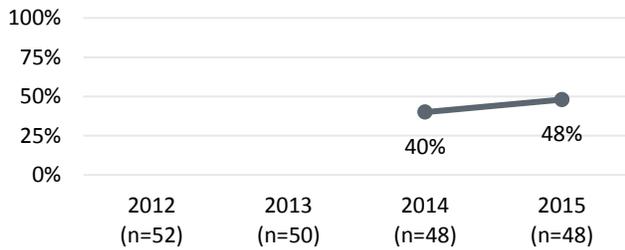
Comparison: 3.1.3 (fully met), by population, 2015



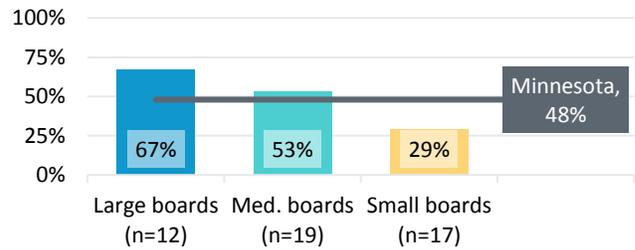
3.2.2: Organizational Branding Strategy

Organizational branding strategy

Progress: 3.2.2 (fully met), Minnesota, 2014-2015



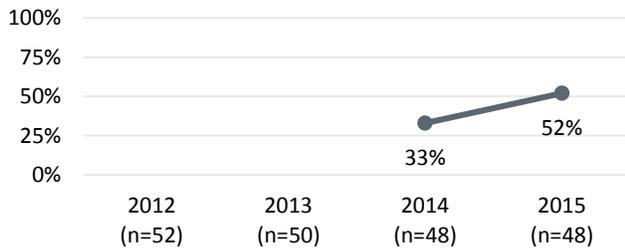
Comparison: 3.2.2 (fully met), by population, 2015



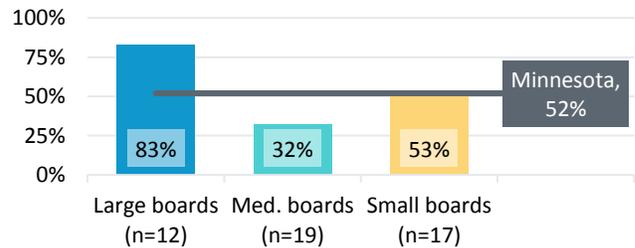
Measure 3.2.3: External Communications Procedures

Communication procedures to provide information outside the health department

Progress: 3.2.3 (fully met), Minnesota, 2014-2015



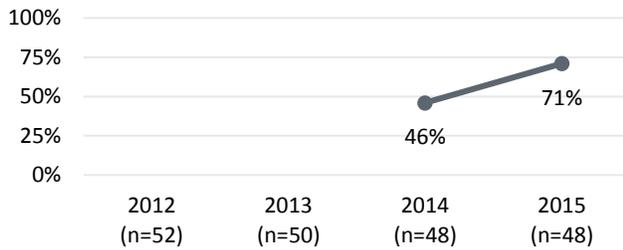
Comparison: 3.2.3 (fully met), by population, 2015



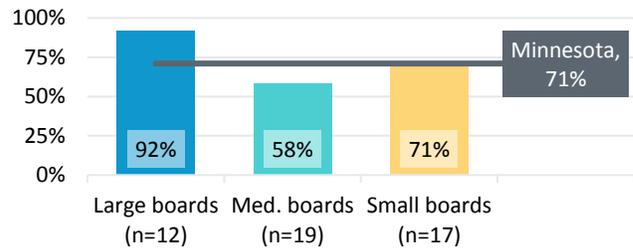
Measure 3.2.5: Variety of Publicly Available Information

Information available to the public through a variety of methods

Progress: 3.2.5 (fully met), Minnesota, 2014-2015

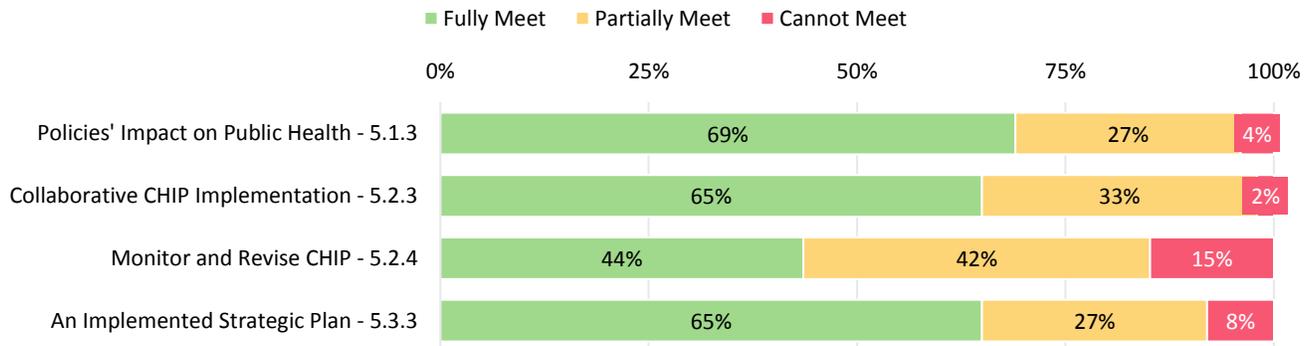


Comparison: 3.2.5 (fully met), by population, 2015



Domain 5: Develop Public Health Policies and Plans

Minnesota community health board capacity to meet key measures in Domain 5, 2015 (n=48)

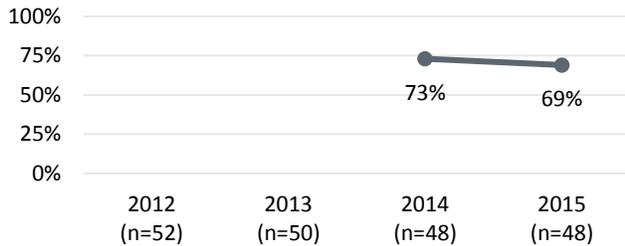


Minnesota community health board capacity to meet key measures in Domain 5, 2015 (n=48)	Fully Meet		Partially Meet		Cannot Meet	
	#	%	#	%	#	%
5.1.3 – Policies' Impact on Public Health <i>Informed governing entities, elected officials, and/or the public of potential intended or unintended public health impacts from current and/or proposed policies</i>	33	69%	13	27%	2	4%
5.2.3 – Collaborative CHIP Implementation <i>Elements and strategies of the health improvement plan implemented in partnership with others</i>	31	65%	16	33%	1	2%
5.2.4 – Monitor and Revise CHIP <i>Monitor the strategies in the community health improvement plan, and revise as needed, in collaboration and with broad participation from stakeholders and partners</i>	21	44%	20	42%	7	15%
5.3.3 – An Implemented Strategic Plan <i>Implemented community health board strategic plan</i>	31	65%	13	27%	4	8%

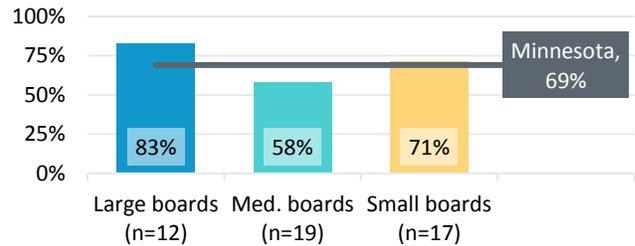
Measure 5.1.3: Policies' Impact on Public Health

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

Progress: 5.1.3 (fully met), Minnesota, 2014-2015



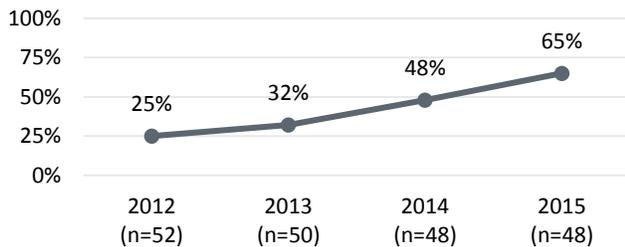
Comparison: 5.1.3 (fully met), by population, 2015



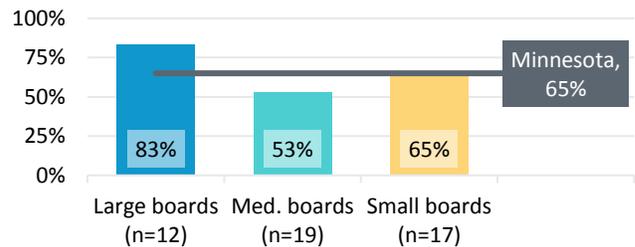
Measure 5.2.3: Collaborative CHIP Implementation

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

Progress: 5.2.3 (fully met), Minnesota, 2012-2015



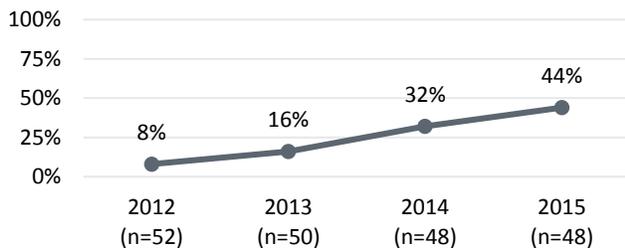
Comparison: 5.2.3 (fully met), by population, 2015



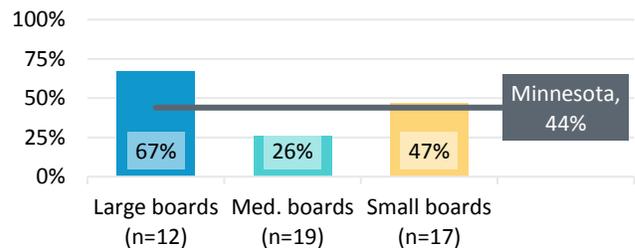
Measure 5.2.4: Monitor and Revise CHIP

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

Progress: 5.2.4. (fully met), Minnesota, 2012-2015



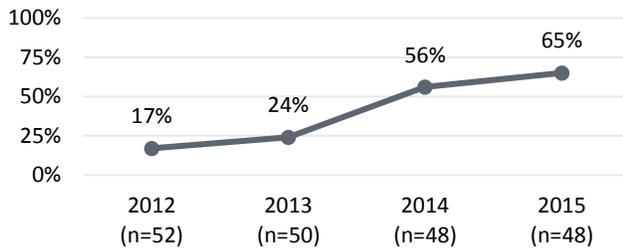
Comparison: 5.2.4 (fully met), by population, 2015



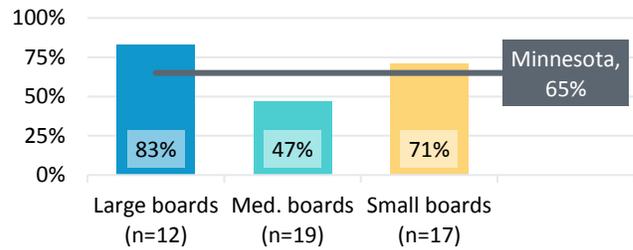
Measure 5.3.3: An Implemented Strategic Plan

Implemented community health board strategic plan

Progress: 5.3.3 (fully met), Minnesota, 2012-2015

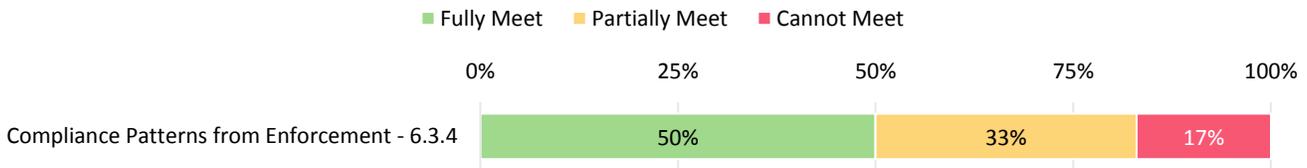


Comparison: 5.3.3 (fully met), by population, 2015



Domain 6: Enforce Public Health Laws

Minnesota community health board capacity to meet key measure in Domain 6, 2015 (n=48)

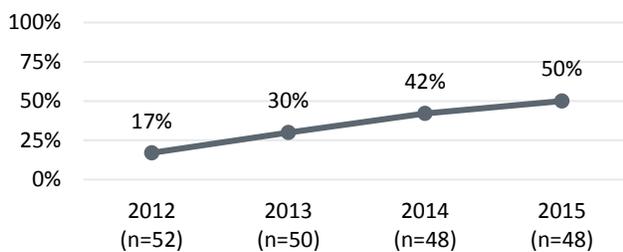


Minnesota community health board capacity to meet key measure in Domain 6, 2015 (n=48)	Fully Meet		Partially Meet		Cannot Meet	
	#	%	#	%	#	%
6.3.4 – Compliance Patterns from Enforcement <i>Patterns or trends identified in compliance from enforcement activities and complaints</i>	24	50%	16	33%	8	17%

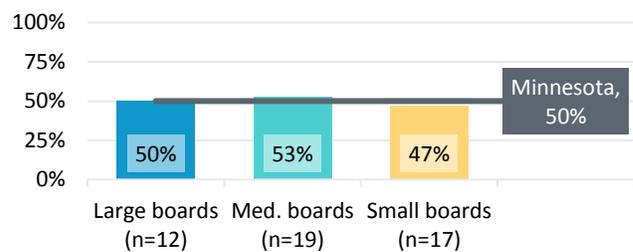
Measure 6.3.4: Compliance Patterns from Enforcement

Patterns or trends identified in compliance from enforcement activities and complaints

Progress: 6.3.4 (fully met), Minnesota, 2012-2015

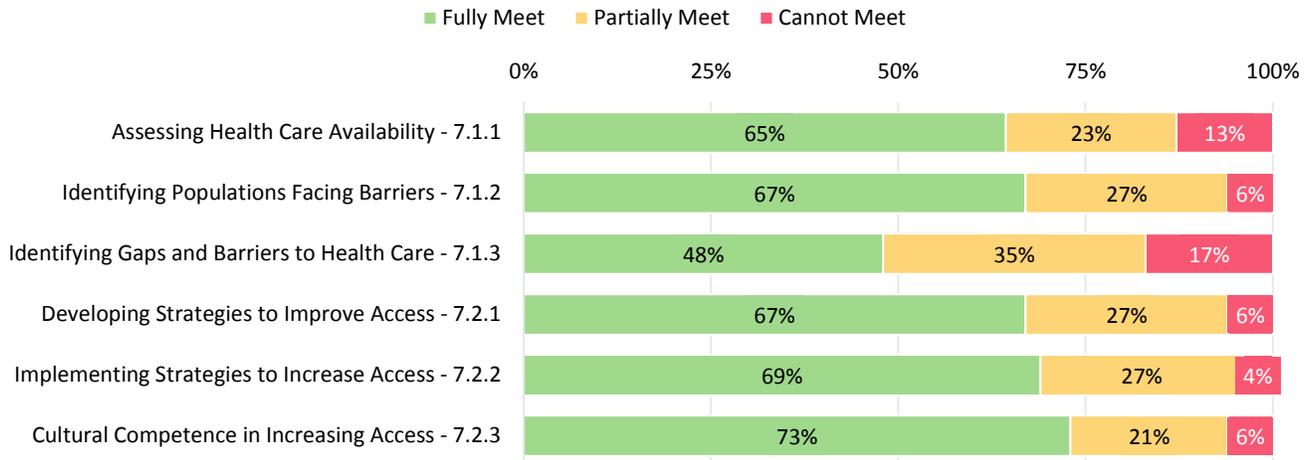


Comparison: 6.3.4 (fully met), by population, 2015



Domain 7: Promote Strategies to Improve Access to Health Care

Minnesota community health board capacity to meet key measures in Domain 7, 2015 (n=48)

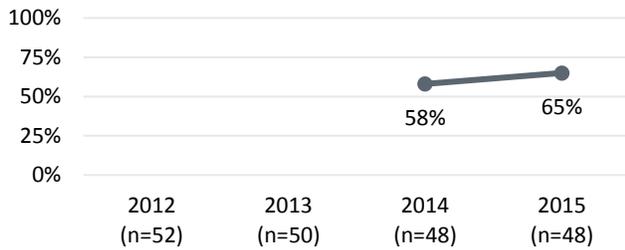


Minnesota community health board capacity to meet key measures in Domain 7, 2015 (n=48)	Fully Meet		Partially Meet		Cannot Meet	
	#	%	#	%	#	%
7.1.1 – Assessing Health Care Availability <i>Process to assess the availability of health care services</i>	31	65%	11	23%	6	13%
7.1.2 – Identifying Populations Facing Barriers <i>Identification of populations who experience barriers to health care services</i>	32	67%	13	27%	3	6%
7.1.3 – Identifying Gaps and Barriers to Health Care <i>Identification of gaps in access to health care services, and barriers to the receipt of health care services</i>	23	48%	17	35%	8	17%
7.2.1 – Developing Strategies to Improve Access <i>Process to develop strategies to improve access to health care services</i>	32	67%	13	27%	3	6%
7.2.2 – Implementing Strategies to Increase Access <i>Implemented strategies to increase access to health care services</i>	33	69%	13	27%	2	4%
7.2.3 – Cultural Competence in Increasing Access <i>Implemented culturally competent initiatives to increase access to health care services for those who may experience barriers to care due to cultural, language, or literacy differences</i>	35	73%	10	21%	3	6%

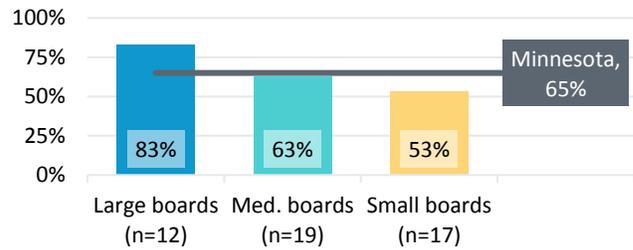
Measure 7.1.1: Assessing Health Care Availability

Process to assess the availability of health care services

Progress: 7.1.1 (fully met), Minnesota, 2014-2015



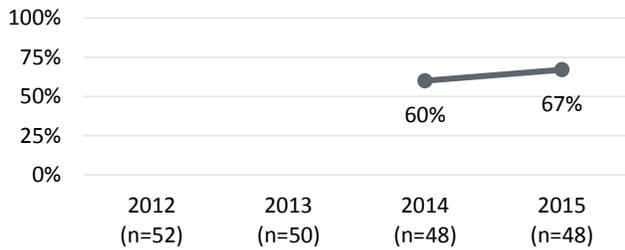
Comparison: 7.1.1 (fully met), by population, 2015



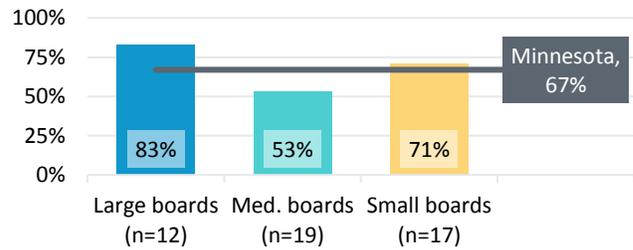
Measure 7.1.2: Identifying Populations Facing Barriers

Identification of populations who experience barriers to health care services

Progress: 7.1.2 (fully met), Minnesota, 2014-2015



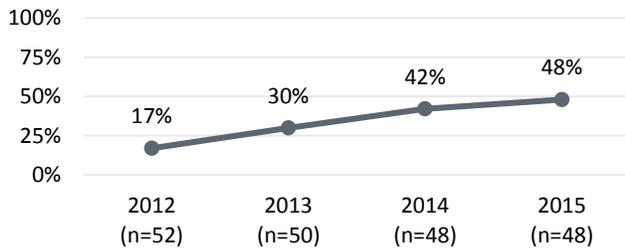
Comparison: 7.1.2 (fully met), by population, 2015



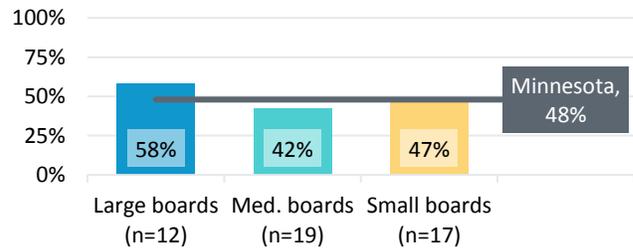
Measure 7.1.3: Identifying Gaps and Barriers to Health Care

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

Progress: 7.1.3 (fully met), Minnesota, 2012-2015



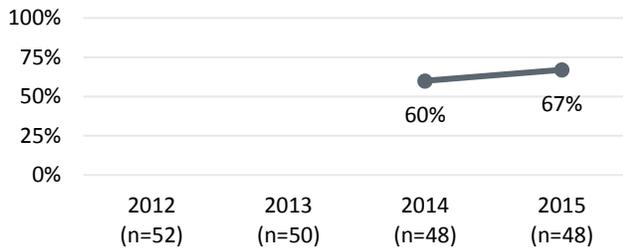
Comparison: 7.1.3 (fully met), by population, 2015



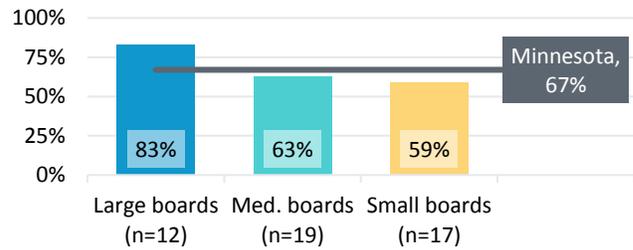
Measure 7.2.1: Developing Strategies to Improve Access

Process to develop strategies to improve access to health care services

Progress: 7.2.1 (fully met), Minnesota, 2014-2015



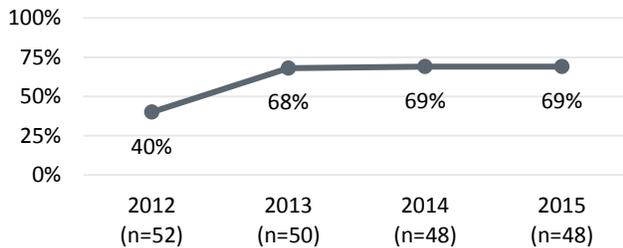
Comparison: 7.2.1 (fully met), by population, 2015



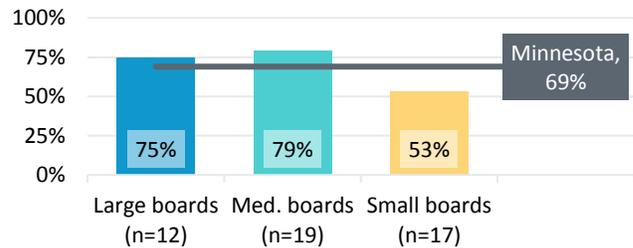
Measure 7.2.2: Implementing Strategies to Increase Access

Implemented strategies to increase access to health care services

Progress: 7.2.2 (fully met), Minnesota, 2012-2015



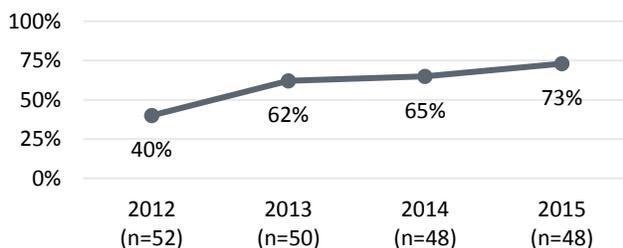
Comparison: 7.2.2 (fully met), by population, 2015



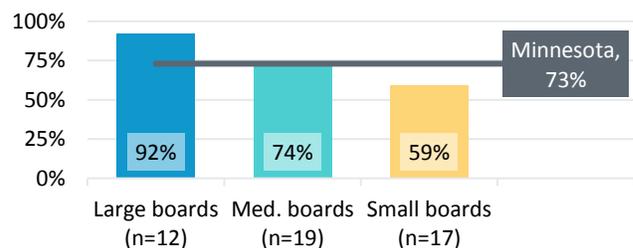
Measure 7.2.3: Cultural Competence in Increasing Access

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

Progress: 7.2.3 (fully met), Minnesota, 2012-2015

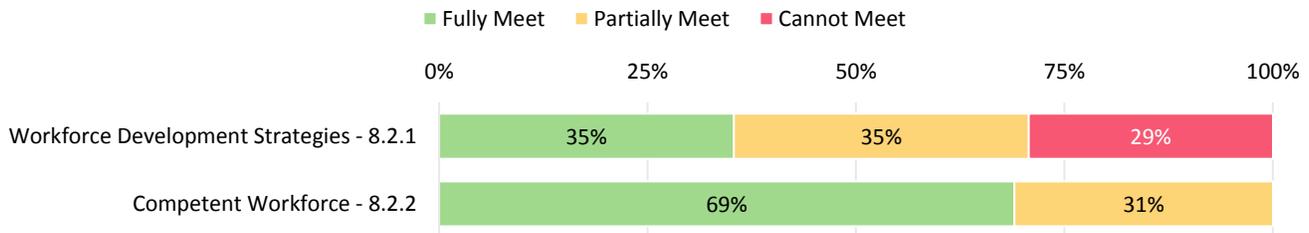


Comparison: 7.2.3 (fully met), by population, 2015



Domain 8: Maintain a Competent Public Health Workforce

Minnesota community health board capacity to meet key measures in Domain 8, 2015 (n=48)

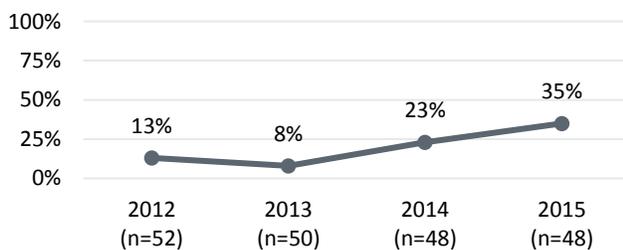


Minnesota community health board capacity to meet key measures in Domain 8, 2015 (n=48)	Fully Meet		Partially Meet		Cannot Meet	
	#	%	#	%	#	%
8.2.1 – Workforce Development Strategies <i>Workforce development strategies</i>	17	35%	17	35%	14	29%
8.2.2 – Competent Workforce <i>A competent community health board workforce</i>	33	69%	15	31%	0	0%

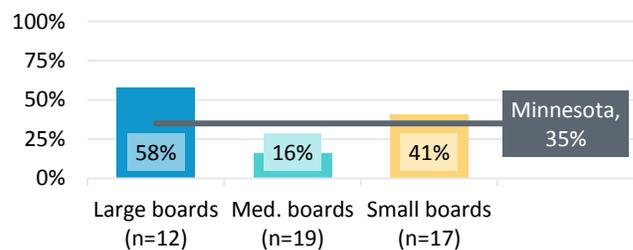
Measure 8.2.1: Workforce Development Strategies

Workforce development strategies

Progress: 8.2.1 (fully met), Minnesota, 2012-2015



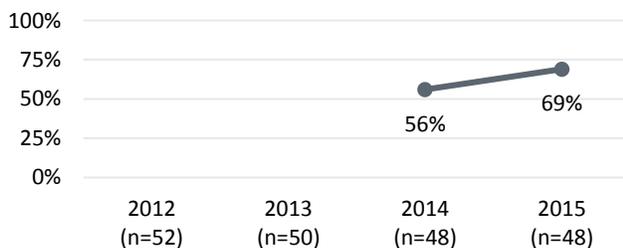
Comparison: 8.2.1 (fully met), by population, 2015



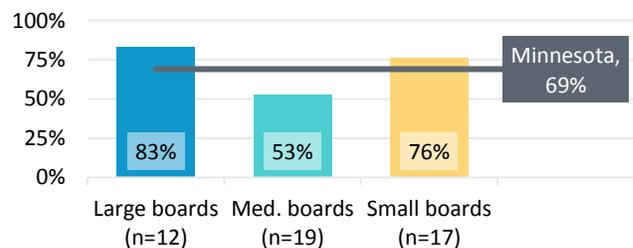
Measure 8.2.2: Competent Workforce

A competent community health board workforce

Progress: 8.2.2 (fully met), Minnesota, 2014-2015

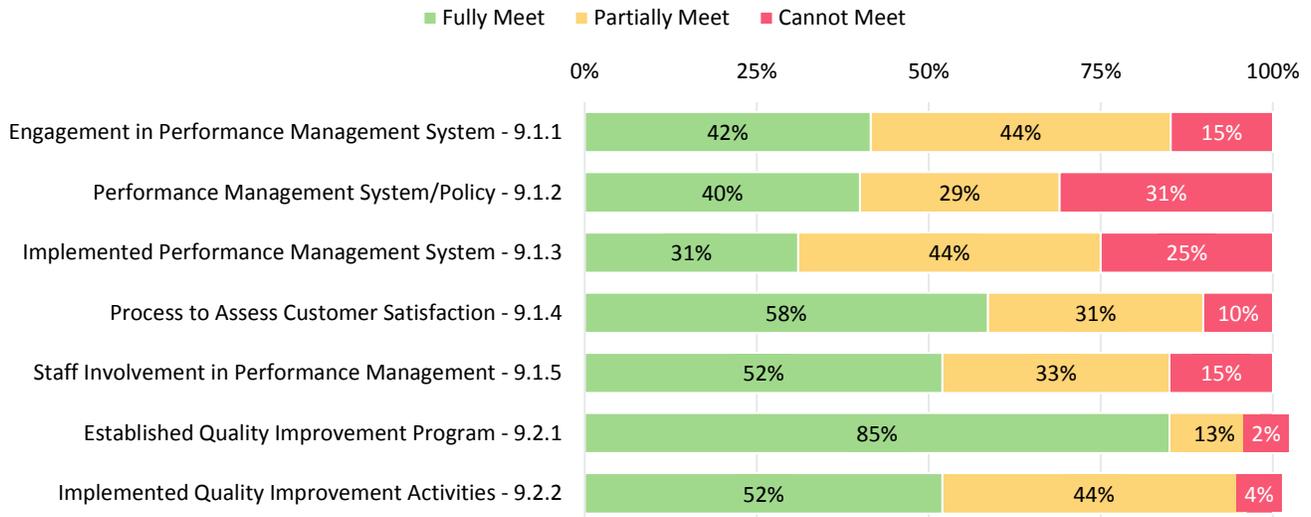


Comparison: 8.2.2 (fully met), by population, 2015



Domain 9: Evaluate and Continuously Improve Processes, Programs, and Interventions

Minnesota community health board capacity to meet key measures in Domain 9, 2015 (n=48)

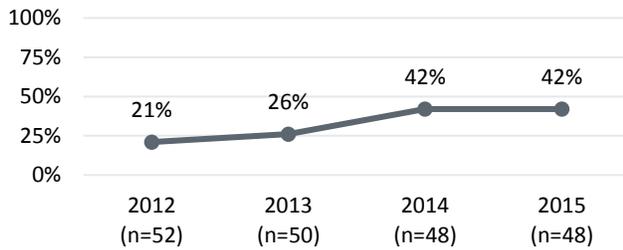


Minnesota community health board capacity to meet key measures in Domain 9, 2015 (n=48)	Fully Meet		Partially Meet		Cannot Meet	
	#	%	#	%	#	%
9.1.1 – Engagement in Performance Management System <i>Staff at all organizational levels engaged in establishing and/or updating a performance management system</i>	20	42%	21	44%	7	15%
9.1.2 – Performance Management System/Policy <i>Performance management policy/system</i>	19	40%	14	29%	15	31%
9.1.3 – Implemented Performance Management System <i>Implemented performance management system</i>	15	31%	21	44%	12	25%
9.1.4 – Process to Assess Customer Satisfaction <i>Implemented systematic process for assessing customer satisfaction with community health board services</i>	28	58%	15	31%	5	10%
9.1.5 – Staff Involvement in Performance Management <i>Opportunities provided to staff for involvement in the community health board's performance management</i>	25	52%	16	33%	7	15%
9.2.1 – Established Quality Improvement Program <i>Established quality improvement program based on organizational policies and direction</i>	41	85%	6	13%	1	2%
9.2.2 – Implemented Quality Improvement Activities <i>Implemented quality improvement activities</i>	25	52%	21	44%	2	4%

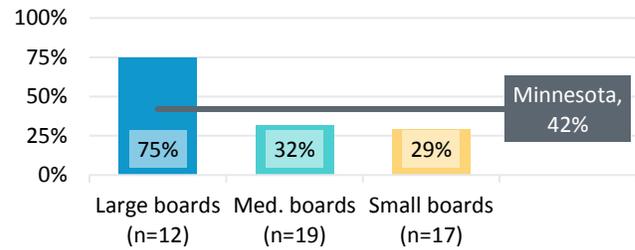
Measure 9.1.1: Engagement in Performance Management System

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

Progress: 9.1.1 (fully met), Minnesota, 2012-2015



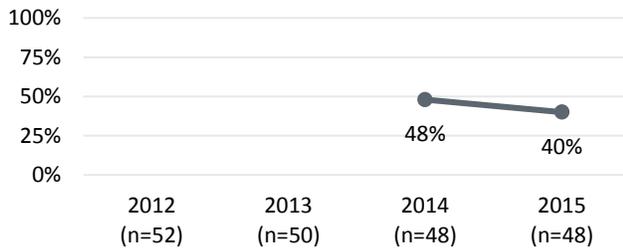
Comparison: 9.1.1 (fully met), by population, 2015



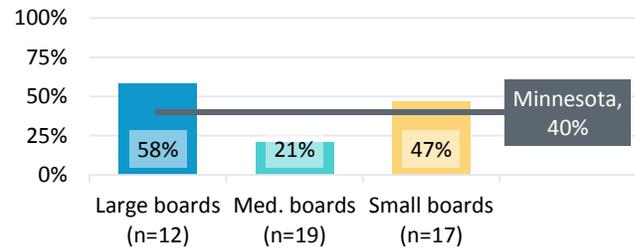
Measure 9.1.2: Performance Management System/Policy

Performance management policy/system

Progress: 9.1.2 (fully met), Minnesota, 2014-2015



Comparison: 9.1.2 (fully met), by population, 2015

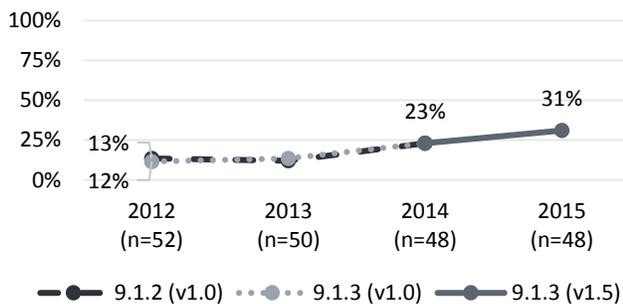


Measure 9.1.3: Implemented Performance Management System

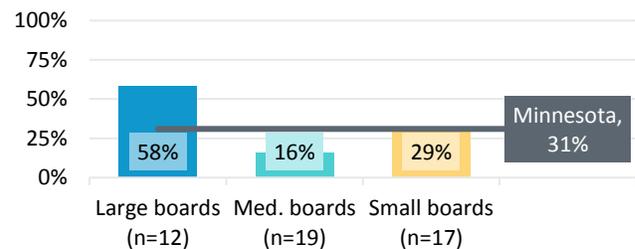
Implemented performance management system

This measure was previously listed as two separate measures in PHAB Standards and Measures 1.0, and was tracked differently by MDH in 2012-2013.

Progress: 9.1.3 (fully met), Minnesota, 2012-2015



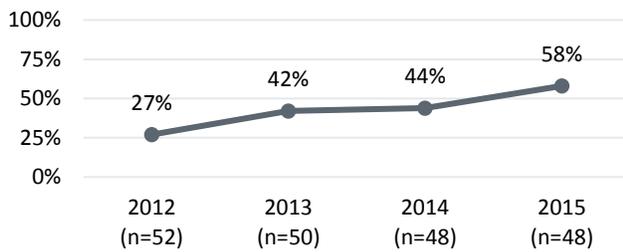
Comparison: 9.1.3 (fully met), by population, 2015



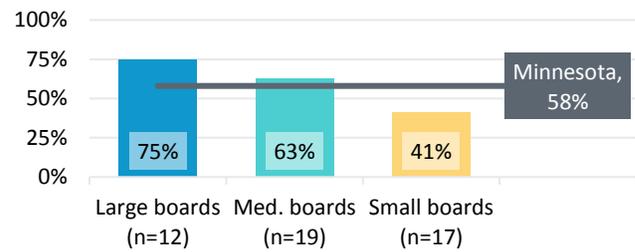
Measure 9.1.4: Process to Assess Customer Satisfaction

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

Progress: 9.1.4 (fully met), Minnesota, 2012-2015



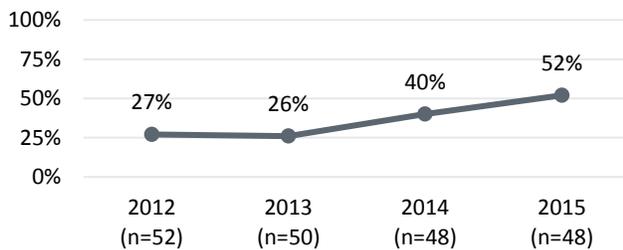
Comparison: 9.1.4 (fully met), by population, 2015



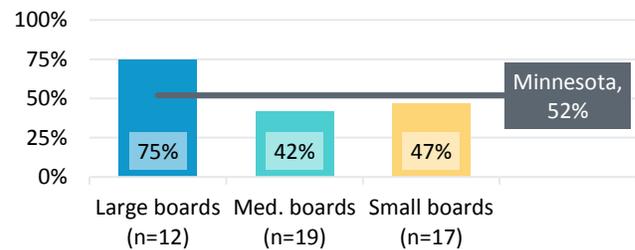
Measure 9.1.5: Staff Involvement in Performance Management

Opportunities provided to staff for involvement in the community health board's performance management

Progress: 9.1.5 (fully met), Minnesota, 2012-2015



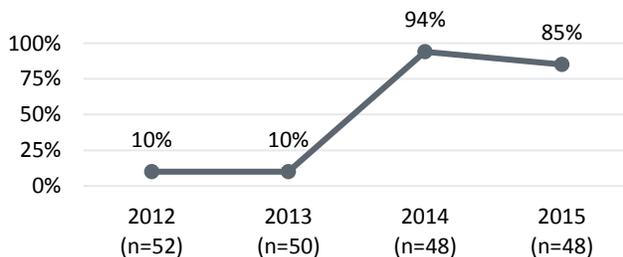
Comparison: 9.1.5 (fully met), by population, 2015



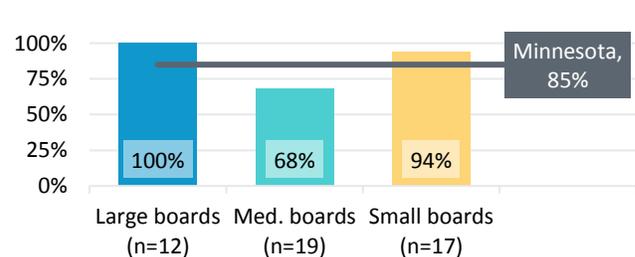
Measure 9.2.1: Established QI Program

Established quality improvement program based on organizational policies and direction

Progress: 9.2.1 (fully met), Minnesota, 2012-2015



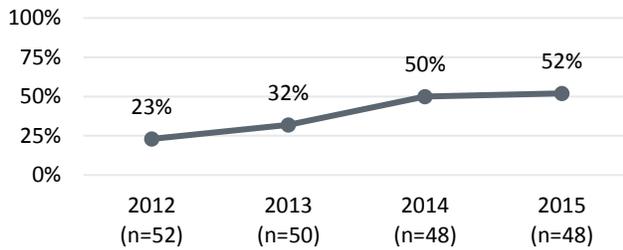
Comparison: 9.2.1 (fully met), by population, 2015



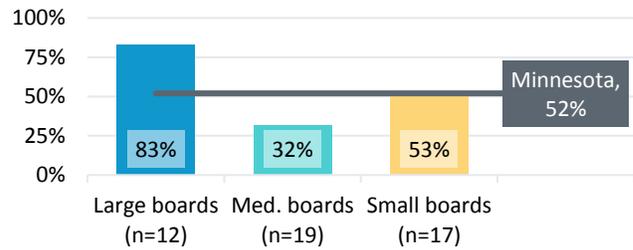
Measure 9.2.2: Implemented QI Activities

Implemented quality improvement activities

Progress: 9.2.2 (fully met), Minnesota, 2012-2015

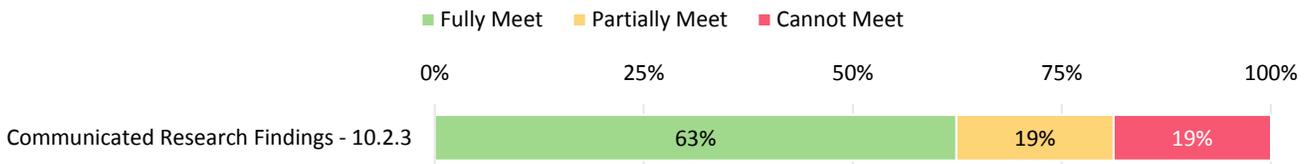


Comparison: 9.2.2 (fully met), by population, 2015



Domain 10: Contribute to and Apply the Evidence Base of Public Health

Minnesota community health board capacity to meet key measure in Domain 10, 2015 (n=48)



Minnesota community health board capacity to meet key measure in Domain 10, 2015 (n=48)	Fully Meet		Partially Meet		Cannot Meet	
	#	%	#	%	#	%
10.2.3 – Communicated Research Findings	30	63%	9	19%	9	19%
<i>Communicated research findings, including public health implications</i>						

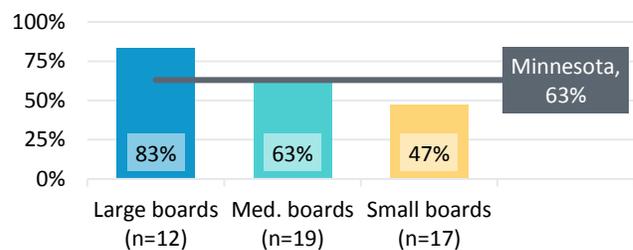
Measure 10.2.3: Communicated Research Findings

Communicated research findings, including public health implications

Progress: 10.2.3 (fully met), Minnesota, 2014-2015

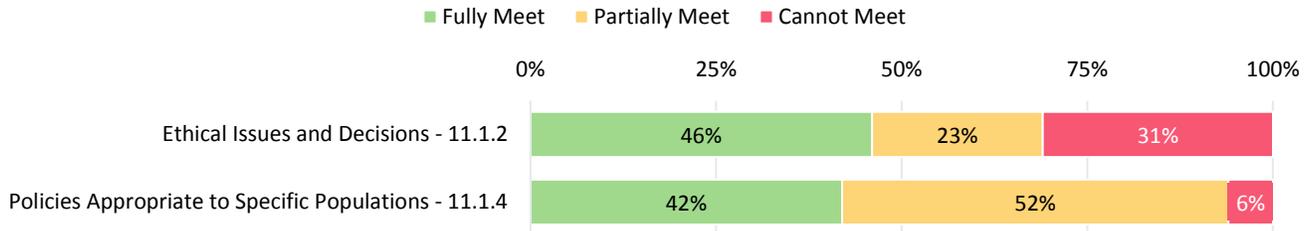


Comparison: 10.2.3 (fully met), by population, 2015



Domain 11: Maintain Administrative and Management Capacity

Minnesota community health board capacity to meet key measures in Domain 11, 2015 (n=48)

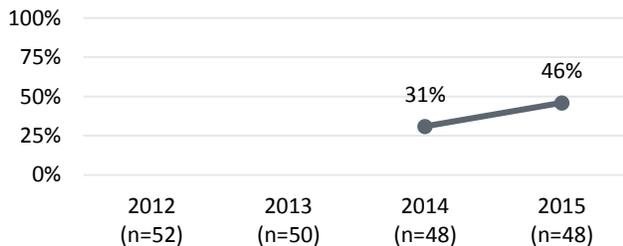


Minnesota community health board capacity to meet key measures in Domain 11, 2015 (n=48)	Fully Meet		Partially Meet		Cannot Meet	
	#	%	#	%	#	%
11.1.2 – Ethical Issues and Decisions <i>Ethical issues identified and ethical decisions made</i>	22	46%	11	23%	15	31%
11.1.4 – Policies Appropriate to Specific Populations <i>Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes</i>	20	42%	25	52%	3	6%

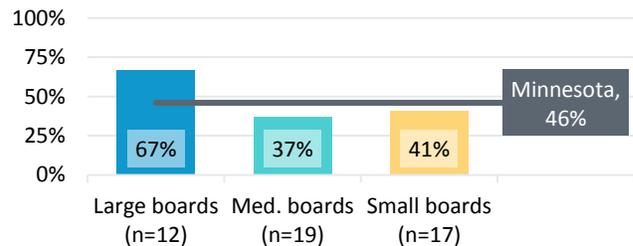
Measure 11.1.2: Ethical Issues and Decisions

Ethical issues identified and ethical decisions made

Progress: 11.1.2 (fully met), Minnesota, 2014-2015



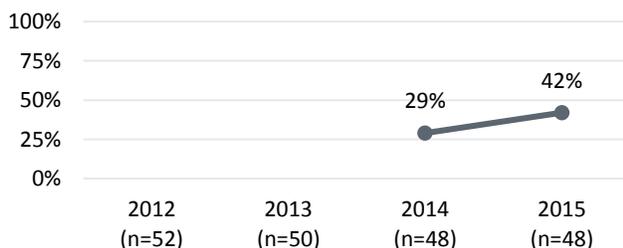
Comparison: 11.1.2 (fully met), by population, 2015



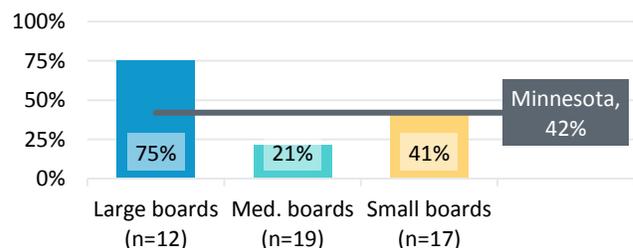
Measure 11.1.4: Policies Appropriate to Specific Populations

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

Progress: 11.1.4 (fully met), Minnesota, 2014-2015

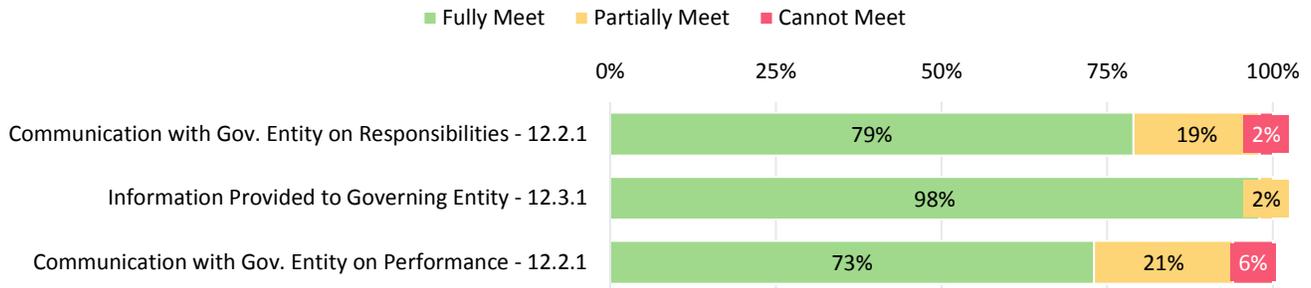


Comparison: 11.1.4 (fully met), by population, 2015



Domain 12: Maintain Capacity to Engage the Public Health Governing Entity

Minnesota community health board capacity to meet key measures in Domain 12, 2015 (n=48)



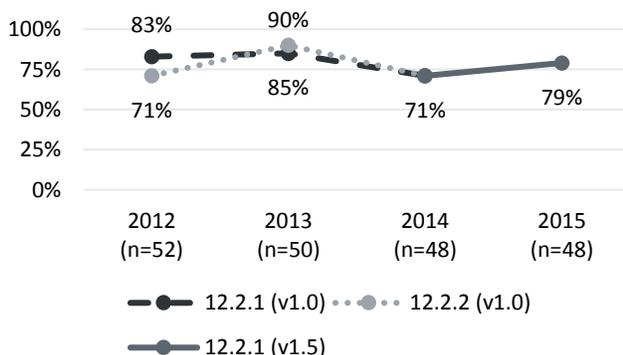
Minnesota community health board capacity to meet key measures in Domain 12, 2015 (n=48)	Fully Meet		Partially Meet		Cannot Meet	
	#	%	#	%	#	%
12.2.1 – Communication with Governing Entity Regarding Community Health Board Responsibilities <i>Communication with the governing entity regarding the responsibilities of the community health board and of the responsibilities of the governing entity</i>	38	79%	9	19%	1	2%
12.3.1 – Information Provided to Governing Entity <i>Information provided to the governing entity about important public health issues facing the community, the community health board, and/or the recent actions of the community health board</i>	47	98%	1	2%	0	0%
12.3.3 – Communication with Governing Entity Regarding Community Health Board Performance <i>Communication with the governing entity about the community health board performance assessment and improvement</i>	35	73%	10	21%	3	6%

Measure 12.2.1: Communication with Governing Entity on Responsibilities

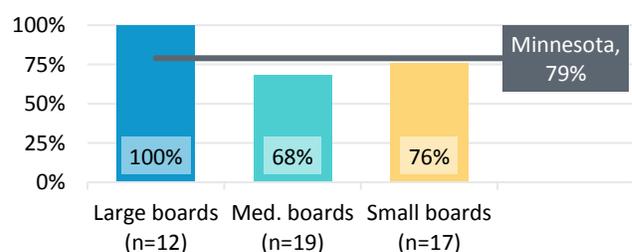
Communication with the governing entity regarding the responsibilities of the community health board and of the responsibilities of the governing entity

This measure was previously listed as two separate measures in PHAB Standards and Measures 1.0 (12.2.1 and 12.2.2), and was tracked differently by MDH in 2012-2013 before being combined into one measure in PHAB Standards and Measures 1.5 (12.2.1).

Progress: 12.2.1 (fully met), Minnesota, 2012-2015



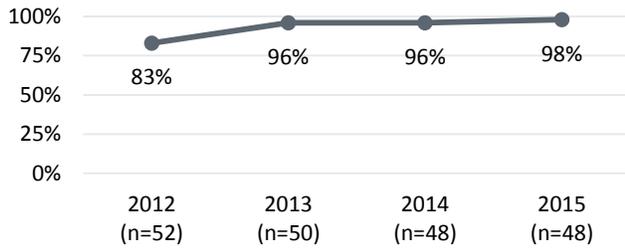
Comparison: 12.2.1 (fully met), by population, 2015



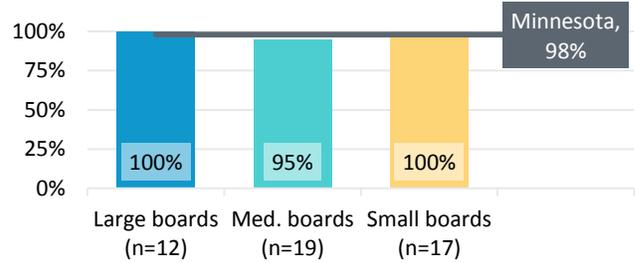
Measure 12.3.1: Information Provided to Governing Entity

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

Progress: 12.3.1 (fully met), Minnesota, 2012-2015



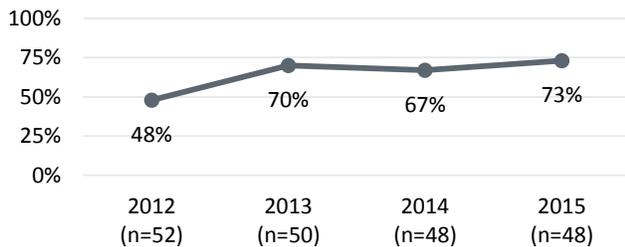
Comparison: 12.3.1 (fully met), by population, 2015



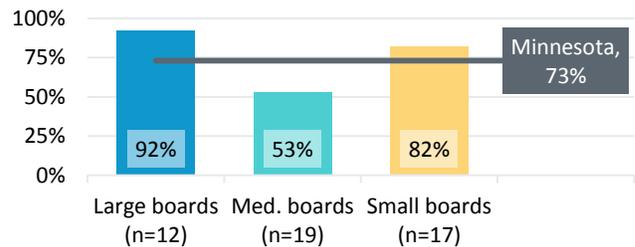
Measure 12.3.3: Communication with Governing Entity on Performance

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

Progress: 12.3.3 (fully met), Minnesota, 2012-2015



Comparison: 12.3.3 (fully met), by population, 2015



Assure an Adequate Local Public Health Infrastructure: Minnesota-Specific Measures

In this area of responsibility:

- [Workforce Competency](#)
- [School Health](#)
- [Health Equity](#)
- [Organizational QI Maturity](#)
- [Health Informatics](#)
- [Public Health Accreditation](#)
- [Statutory Requirements](#)
- [Local Public Health Act Grant Activities](#)

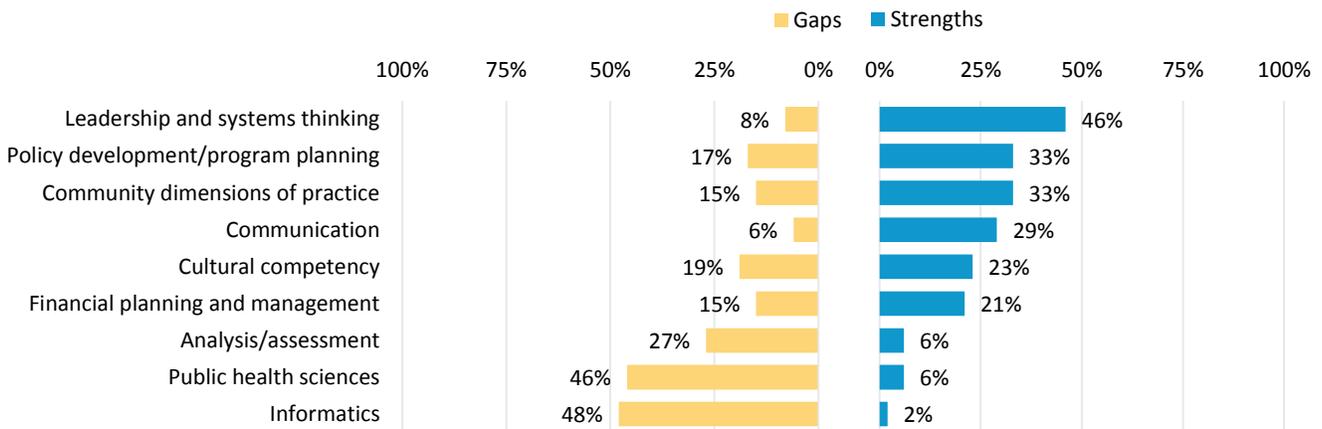
Workforce Competency

Community health boards need a trained and competent workforce. The [Core Competencies for Public Health Professionals](#), developed by the Council on Linkages between Academia and Public Health Practice, offer a starting point to identify professional development needs and develop a training plan.

MORE INFORMATION

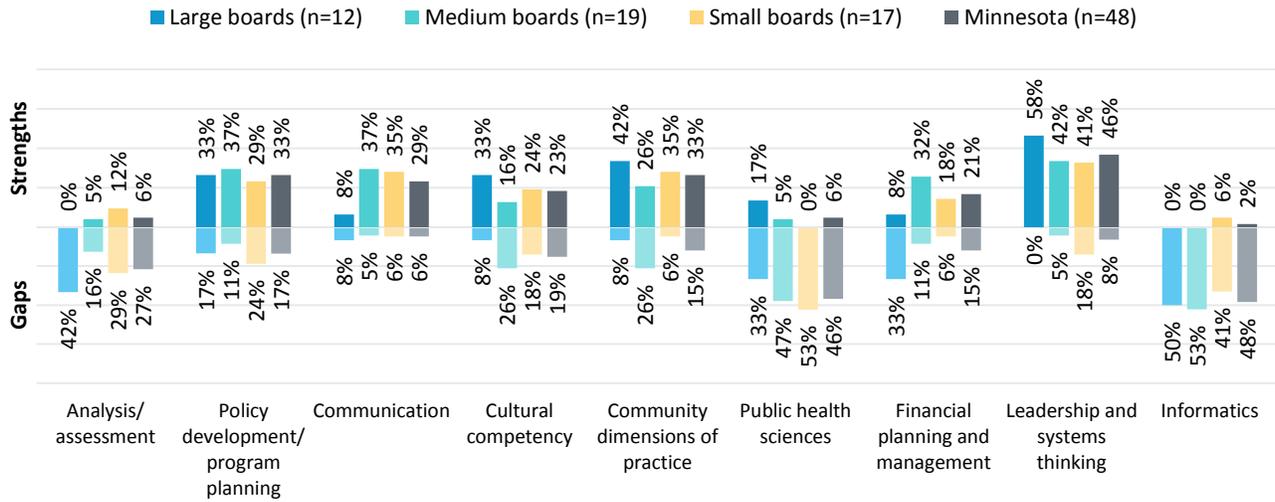
MDH Health Partnerships Division, Public Health Practice Section
 651-201-3880 | health.ophp@state.mn.us
www.health.state.mn.us/divs/opi/pm/corecomp/

Workforce competency strengths and gaps, Minnesota community health boards, 2015 (n=48)



Workforce competency strengths and gaps	Minnesota, 2015 (n=48)			
	Strength		Gap	
	#	%	#	%
1. Please select the top two strengths in the workforce of your CHB. (Select one.)				
2. Please select the top two gaps in the workforce of your CHB. (Select one.)				
Analysis/assessment	3	6%	13	27%
Policy development/program planning	16	33%	8	17%
Communication	14	29%	3	6%
Cultural competency	11	23%	9	19%
Community dimensions of practice	16	33%	7	15%
Public health sciences	3	6%	22	46%
Financial planning and management	10	21%	7	15%
Leadership and systems thinking	22	46%	4	8%
Informatics	1	2%	23	48%

Comparison: Workforce strengths and gaps, Minnesota community health boards, by population, 2015



Workforce competency strengths, by community health board population, Minnesota, 2015

Large community health boards (n=12)	Medium community health boards (n=19)	Small community health boards (n=17)	Minnesota (n=48)
1 Leadership and systems thinking	1 Leadership and systems thinking	1 Leadership and systems thinking	1 Leadership and systems thinking
2 Community dimensions of practice	2 Policy dev./program planning	2 Community dimensions of practice	2 Policy dev./program planning
3 Policy dev./program planning	Communication	Communication	Community dimensions of practice
Cultural competency	4 Financial planning and management	4 Policy dev./program planning	4 Communication
5 Public health sciences	5 Community dimensions of practice	5 Cultural competency	5 Cultural competency
6 Communication	6 Cultural competency	6 Financial planning and management	6 Financial planning and management
Financial planning and management	7 Analysis/assessment	7 Analysis/assessment	7 Analysis/assessment
n/r Analysis/assessment	Public health sciences	8 Informatics	Public health sciences
Informatics	n/r Informatics	n/r Public health sciences	9 Informatics

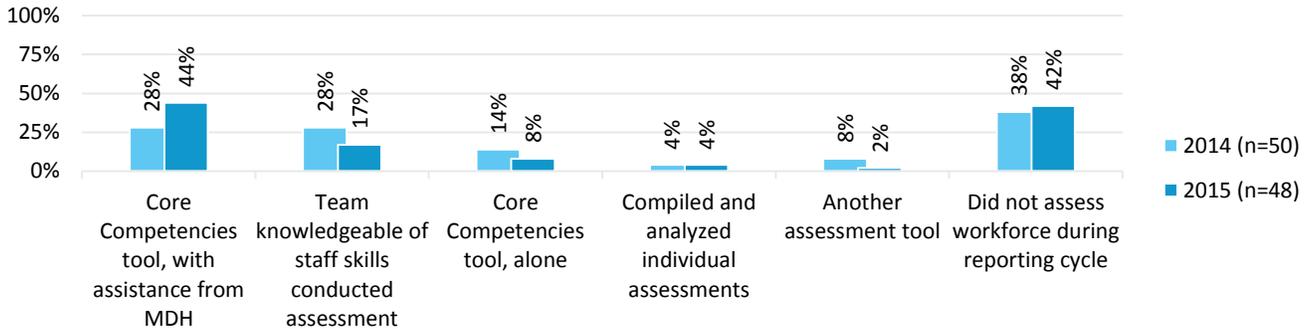
n/r = Not ranked

Workforce competency gaps, by community health board population, Minnesota, 2015

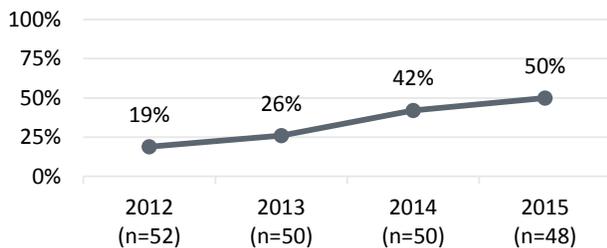
Large community health boards (n=12)	Medium community health boards (n=19)	Small community health boards (n=17)	Minnesota (n=48)
1 Informatics	1 Informatics	1 Public health sciences	1 Informatics
2 Analysis/assessment	2 Public health sciences	2 Informatics	2 Public health sciences
3 Public health sciences	3 Cultural competency	3 Analysis/assessment	3 Analysis/assessment
Financial planning and management	Community dimensions of practice	4 Policy dev./program planning	4 Cultural competency
5 Policy dev./program planning	5 Analysis/assessment	5 Cultural competency	5 Policy dev./program planning
6 Communication	6 Policy dev./program planning	Leadership and systems thinking	6 Community dimensions of practice
Cultural competency	Financial planning and management	7 Communication	Financial planning and management
Community dimensions of practice	8 Communication	Community dimensions of practice	8 Leadership and systems thinking
n/r Leadership and systems thinking	Leadership and systems thinking	Financial planning and management	9 Communication

n/r = Not ranked

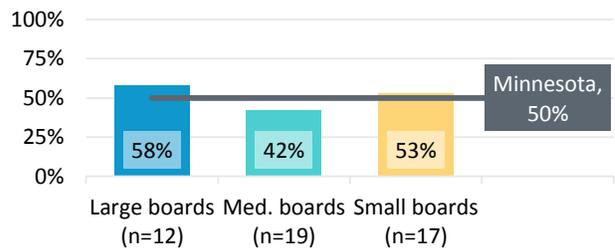
Change: Method of assessing workforce competency among Minnesota community health boards, 2014-2015



Progress: Minnesota community health boards using the Core Competencies Tool to assess workforce, 2012-2015

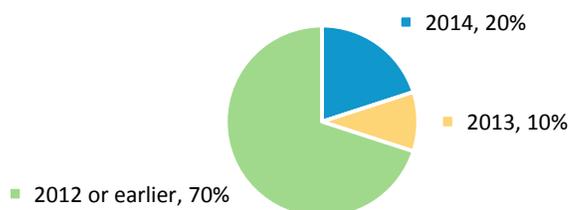


Comparison: Minnesota community health boards using the Core Competencies Tool to assess workforce, by population, 2015



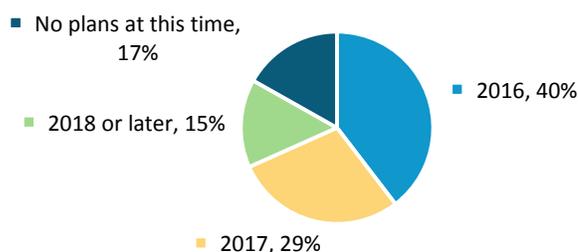
Method of assessing workforce competency	Minnesota, 2015 (n=48)	
	#	%
3. How did your CHB assess the strengths and gaps of its workforce? (Check all that apply.)		
The community health board used the Core Competencies for Public Health Professionals Tool on its own	4	8%
The community health board used the Core Competencies for Public Health Professionals Tool with assistance from MDH	21	44%
The community health board used an assessment tool instead of (or in addition to) the Core Competencies for Public Health Professionals Tool	1	2%
The community health board assembled a team knowledgeable of staff skills to conduct a workforce assessment	8	17%
The community health board compiled and analyzed individual assessments to develop an overall workforce assessment	2	4%
The community health board did not assess workforce strengths or gaps during this reporting cycle *	20	42%

Last workforce assessment completed among Minnesota community health boards that did not assess workforce in 2015 (n=20)



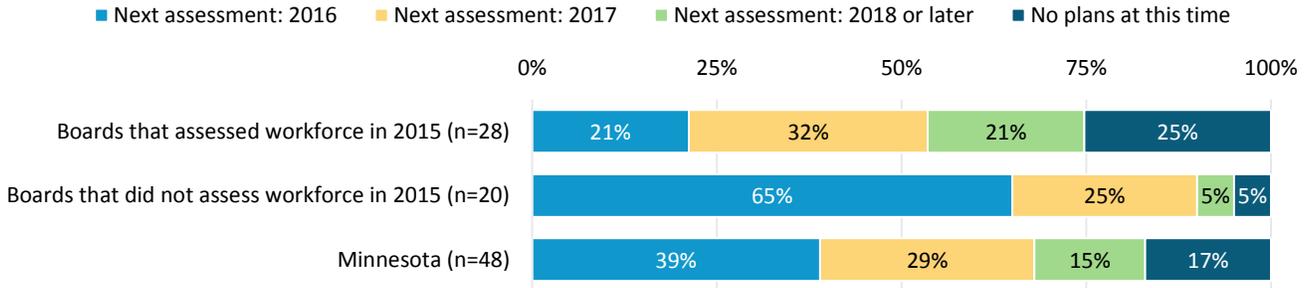
Last workforce assessment completed among Minnesota community health boards not assessing workforce in 2015 (n=20)	Minnesota, 2015 (n=20)	
	#	%
3b. If an assessment was not performed in 2015, when was it last completed? (Select one.) <i>For those community health boards that selected "did not assess workforce strengths or gaps during this reporting cycle" for Q3, above.</i>		
2014	4	20%
2013	2	10%
2012 or earlier	14	70%

Next workforce assessment planned among Minnesota community health boards, 2015 (n=48)



* Data limitations exist due to some reporting inconsistencies within community health boards. For example, one community health board reported "the community health board did not assess workforce strengths or gaps during this reporting cycle," but also indicated methods used to assess strengths/gaps.

Comparison: Next workforce assessment planned among community health boards, by year of most recent assessment completed, 2015 (n=48)



Next workforce assessment planned among Minnesota community health boards		Minnesota, 2015 (n=48)	
4. When does your community health board next plan to assess its workforce? (Select one.)			
	#	%	
2016	19	40%	
2017	14	29%	
2018 or later	7	15%	
No plans to assess workforce at this time	8	17%	

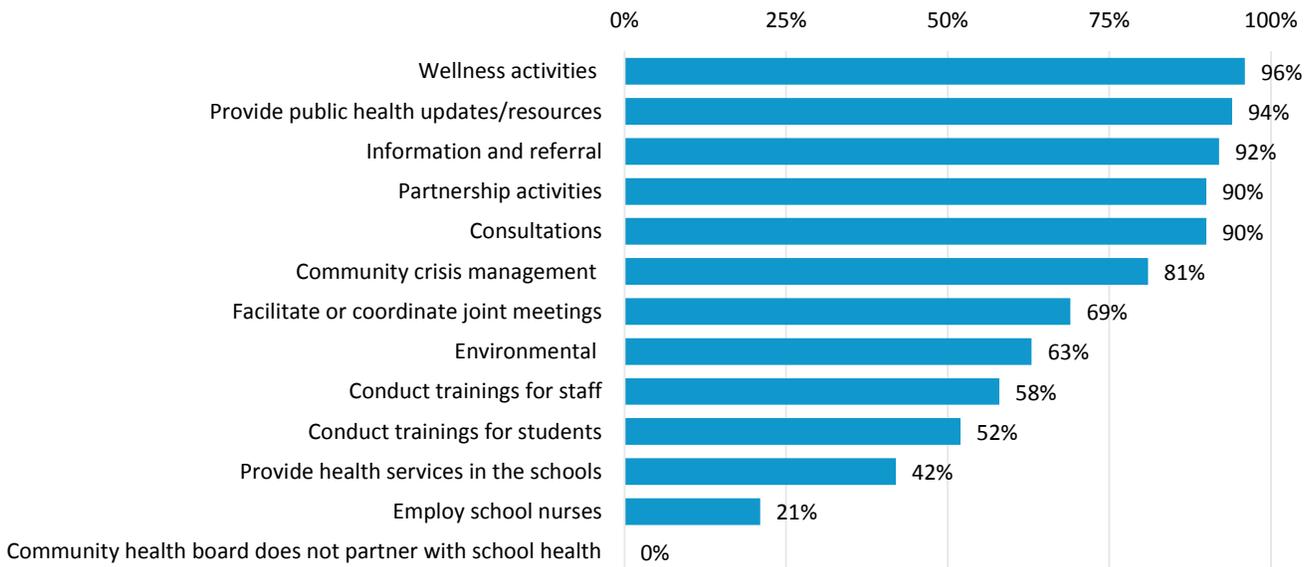
School Health

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

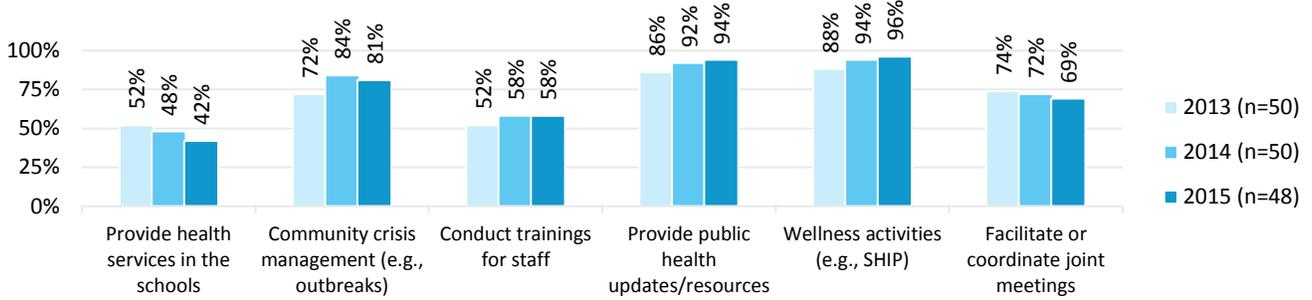
MORE INFORMATION

MDH Community and Family Health Division, School Health Nursing
 (651) 201-3631 | www.health.state.mn.us/divs/cfh/program/shn/

School health activities conducted by Minnesota community health boards, 2015 (n=48)



Greatest change: School health activities conducted by Minnesota community health boards, 2013-2015



School health activities conducted	Minnesota 2015 (n=48)	
	#	%
5. How does your community health board work with school health? (Check all that apply.)		
Employ school nurses	10	21%
Partnership activities	43	90%
Provide health services in the schools	20	42%
Conduct trainings for staff	28	58%
Conduct trainings for students	25	52%
Consultations	43	90%
Facilitate or coordinate joint meetings	33	69%
Provide public health updates/resources	45	94%
Information and referral	44	92%
Community crisis management (e.g., outbreaks)	39	81%
Wellness activities (e.g., SHIP)	46	96%
Environmental (e.g., mold, pesticides, lice)	30	63%
Community health board does not partner with school health	0	0%

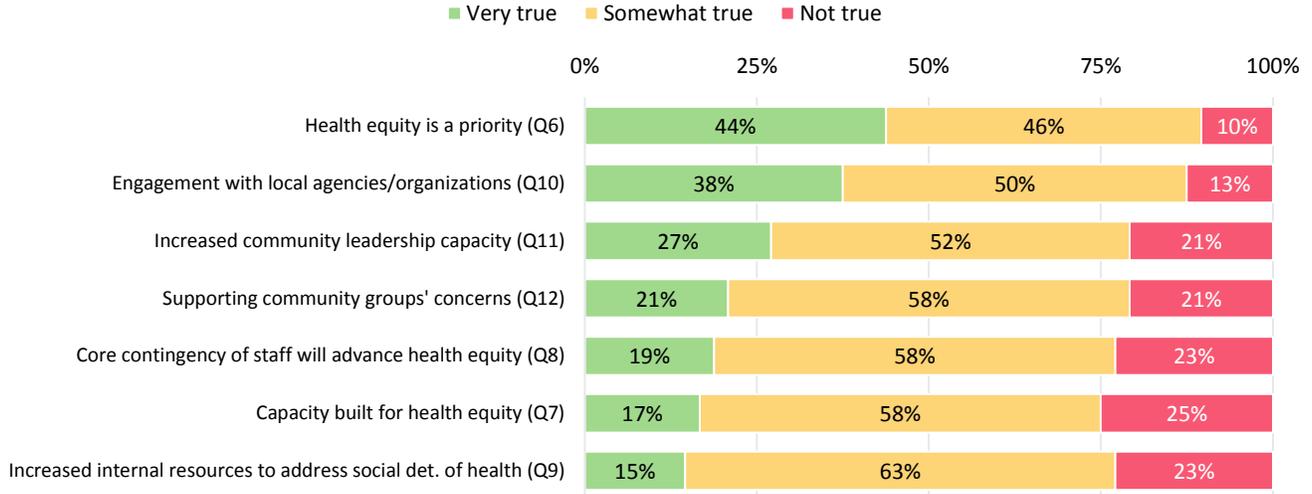
Health Equity

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

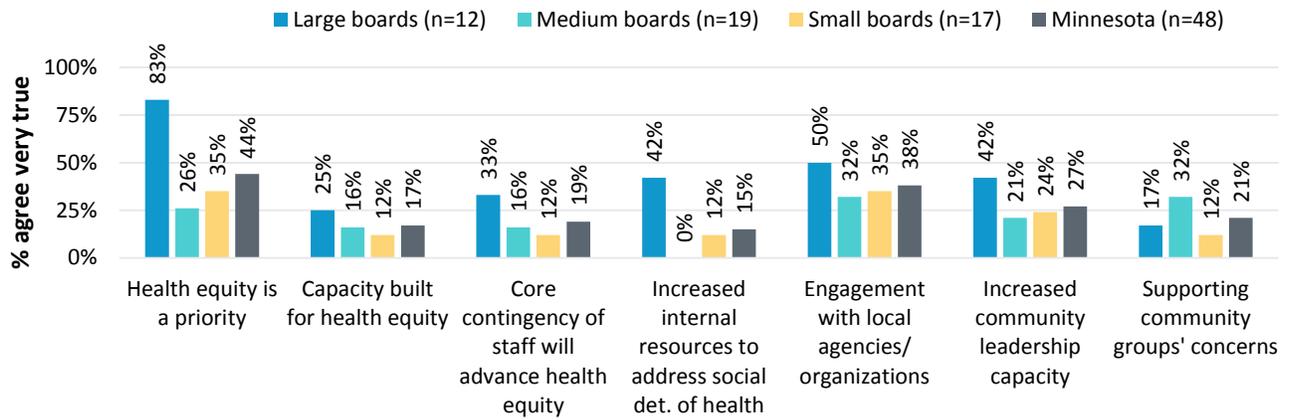
MORE INFORMATION

MDH Center for Health Equity
 651-201-5813 | health.equity@state.mn.us
www.health.state.mn.us/divs/che

At a glance: Health equity in Minnesota community health boards, 2015 (n=48)



Comparison: Agreement that health equity statements are very true, Minnesota community health boards, by population, 2015

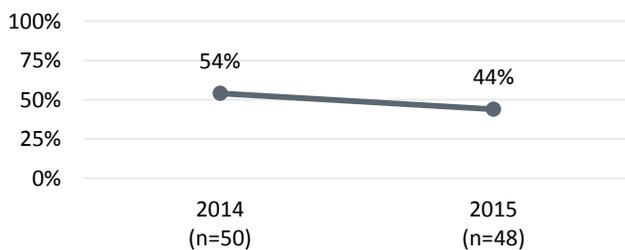


Health equity in Minnesota community health boards, 2015 (n=48)	Very true		Somewhat true		Not true		I don't know	
	#	%	#	%	#	%	#	%
6. Health equity is a priority <i>My community health board has identified health equity as a priority, with specific intent to address social determinants of health.</i>	21	44%	22	46%	5	10%	0	0%
7. Capacity built for health equity <i>My community health board has built capacity (e.g., human resources, funding, training staff) to achieve health equity by addressing social determinants of health.</i>	8	17%	28	58%	12	25%	0	0%
8. Core contingency of staff will advance health equity <i>My community health board has established a core contingency of staff who are poised to advance a health equity agenda.</i>	9	19%	28	58%	11	23%	0	0%
9. Increased internal resources to address social determinants of health <i>My community health board has increased the amount of internal resources directed to addressing social determinants of health.</i>	7	15%	30	63%	11	23%	0	0%
10. Engagement with local agencies/organizations <i>My community health board has engaged with local government agencies or other external organizations to support policies and programs to achieve health equity.</i>	18	28%	24	50%	6	13%	0	0%
11. Increased community leadership capacity <i>My community health board has made deliberate efforts to build the leadership capacity of community members to advocate on issues affecting social determinants of health.</i>	13	27%	25	52%	10	21%	0	0%
12. Supporting community groups' concerns <i>My community health board has provided resources to community groups to support their self-identified concerns for achieving health equity in their communities.</i>	10	21%	28	58%	10	21%	0	0%

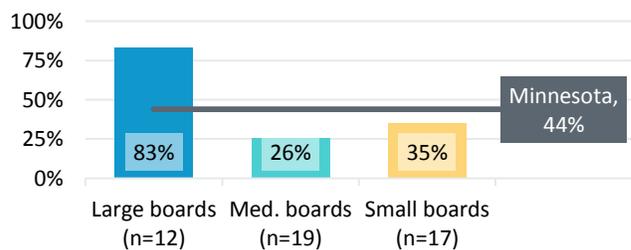
Health equity is a priority

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

Progress: Health equity is a priority (very true), Minnesota, 2014-2015



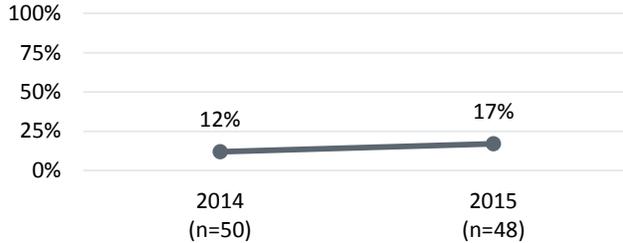
Comparison: Health equity is a priority (very true), by population, 2015



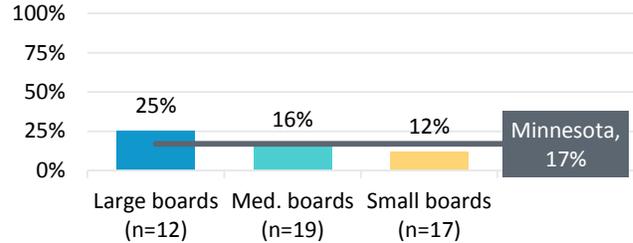
Capacity built for health equity

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

Progress: Capacity built for health equity (very true), Minnesota, 2014-2015



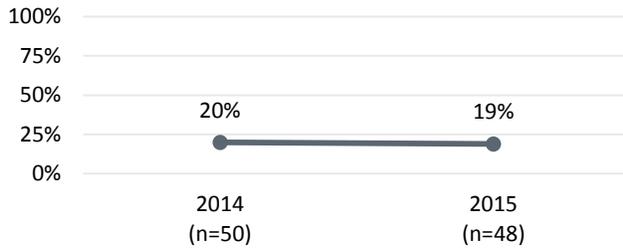
Comparison: Capacity built for health equity (very true), by population, 2015



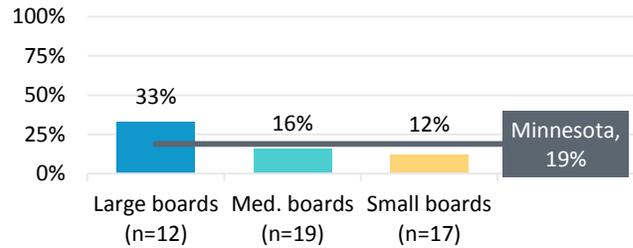
Core contingency of staff will advance health equity

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

Progress: Core contingency of staff will advance health equity (very true), Minnesota, 2014-2015



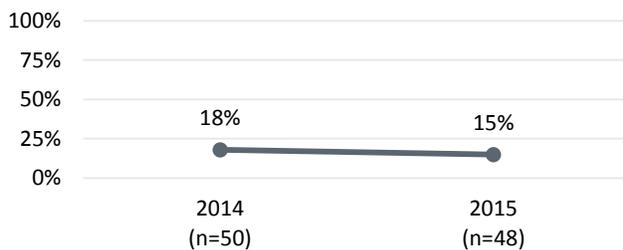
Comparison: Core contingency of staff will advance health equity (very true), by population, 2015



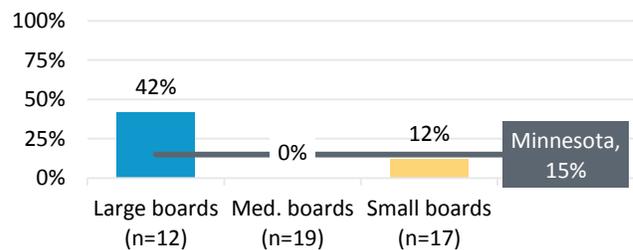
Increased internal resources to address social determinants of health

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

Progress: Increased internal resources to address social determinants of health (very true), Minnesota, 2014-2015



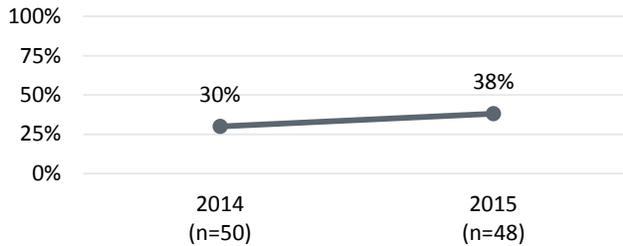
Comparison: Increased internal resources to address social determinants of health (very true), by pop., 2015



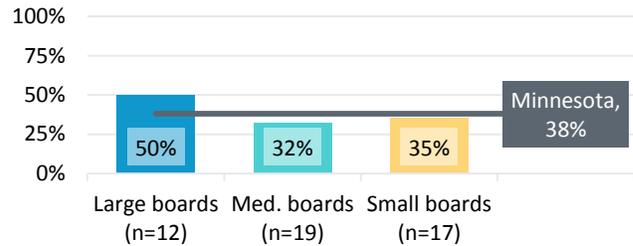
Engagement with local agencies/organizations

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

Progress: Engagement with local agencies/organizations (very true), Minnesota, 2014-2015



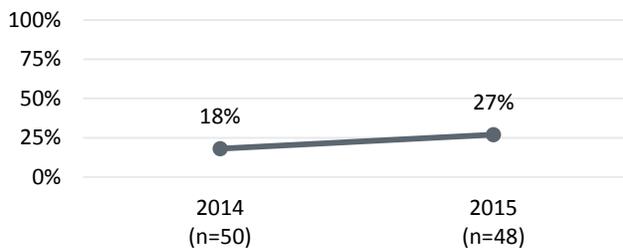
Comparison: Engagement with local agencies/organizations (very true), by population, 2015



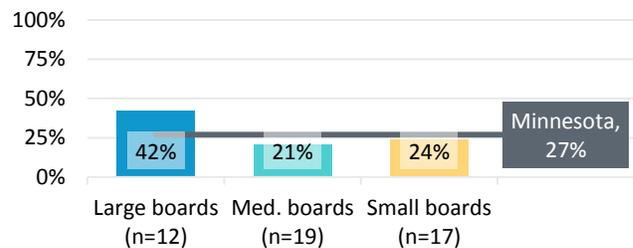
Increased community leadership capacity

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

Progress: Increased community leadership capacity (very true), Minnesota, 2014-2015



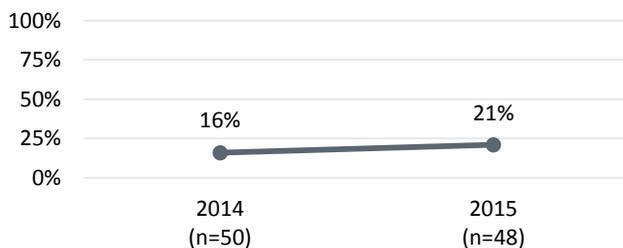
Comparison: Increased community leadership capacity (very true), by population, 2015



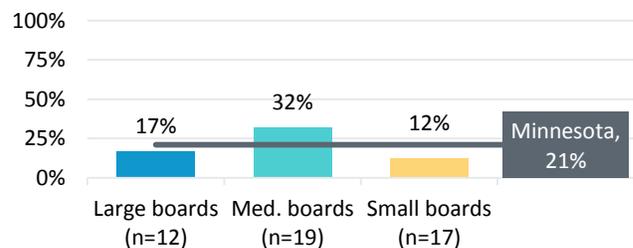
Supporting community groups' concerns

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

Progress: Supporting community groups' concerns (very true), Minnesota, 2014-2015



Comparison: Supporting community groups' concerns (very true), by population, 2015



Organizational Quality Improvement Maturity

Collecting this data allows the measurement and tracking of progress in quality improvement (QI) culture across the local public health system, from year to year. Assessing organizational QI maturity can help a community health board monitor progress, identify key areas for improvement, and determine additional education or training needed for staff and leadership.

MORE INFORMATION

MDH Health Partnerships Division, Public Health Practice Section
651-201-3880 | health.ophp@state.mn.us
www.health.state.mn.us/divs/ophp/qi/

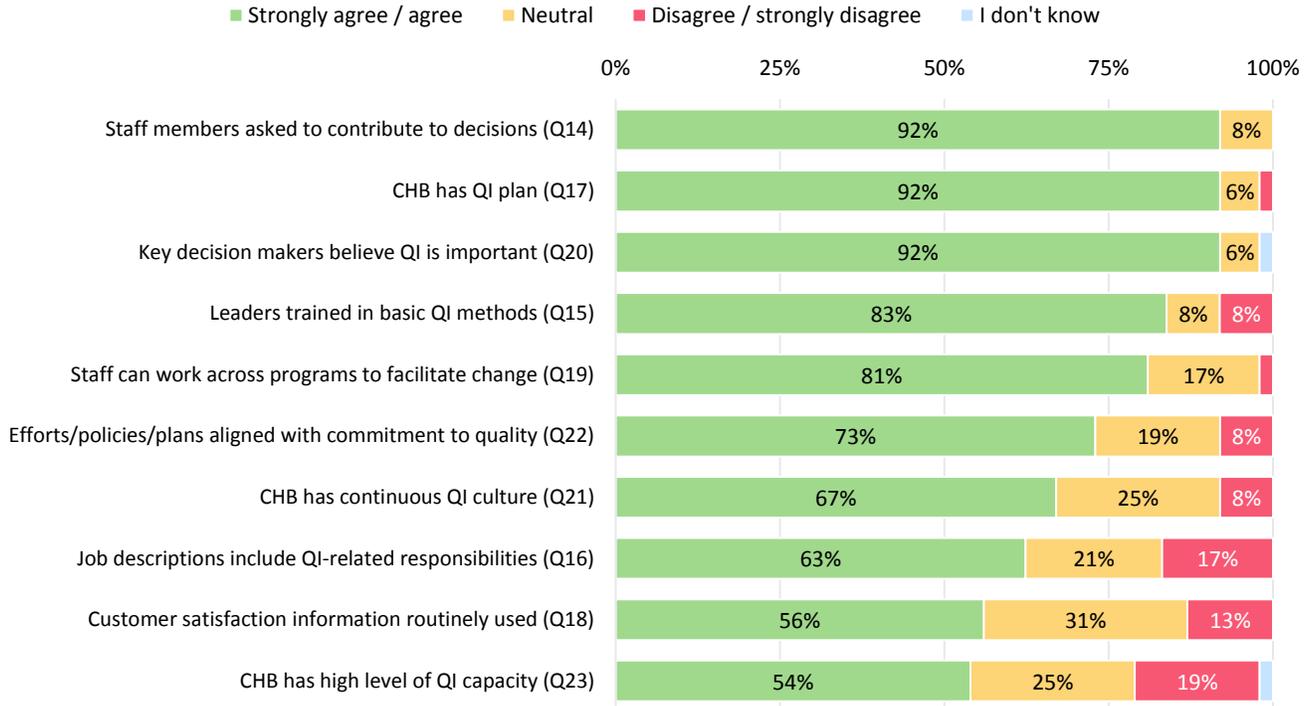
SUGGESTED PARAMETERS FOR QUESTIONS 14-16 AND QUESTIONS 18-23

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

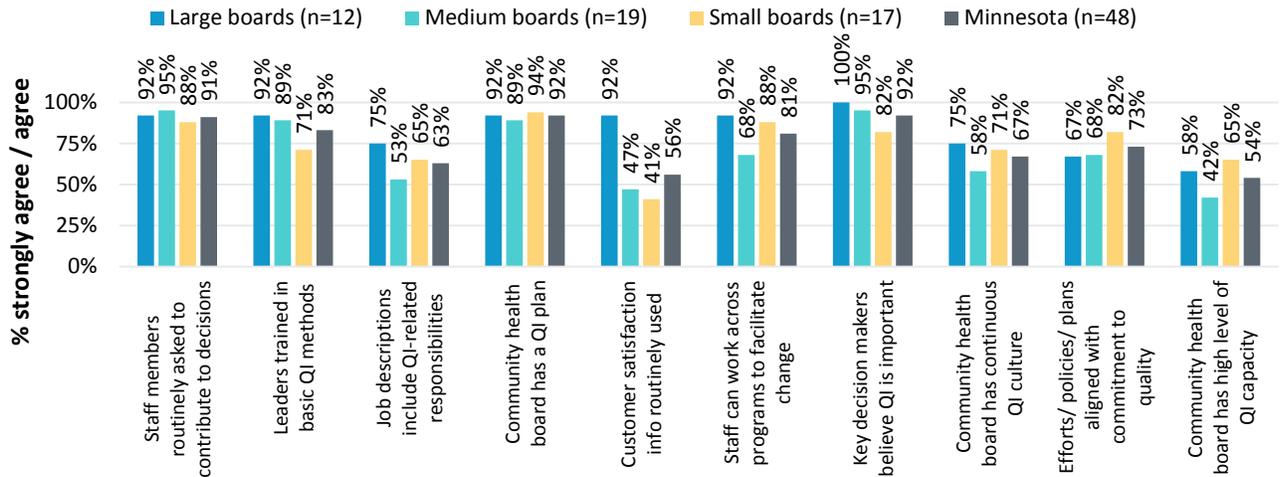
SUGGESTED PARAMETERS FOR QUESTION 17

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

Organizational QI culture in Minnesota community health boards, 2015 (n=48)



Comparison: Minnesota community health boards that strongly agree or agree with QI maturity statements, by population, 2015



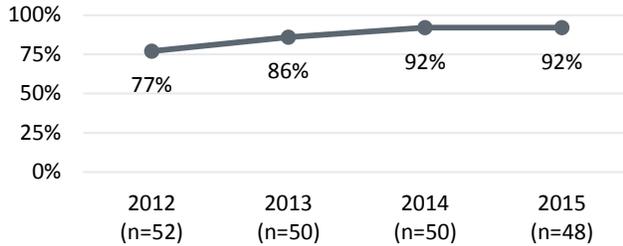
2015 LOCAL PUBLIC HEALTH ACT PERFORMANCE MEASURES [DATA BOOK]
 ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES

Organizational quality improvement culture in Minnesota community health boards, 2015 (n=48)	Strongly agree		Agree		Neutral		Disagree		Strongly disagree		I don't know	
	#	%	#	%	#	%	#	%	#	%	#	%
14. Staff members asked to contribute to decisions <i>Staff members are routinely asked to contribute to decisions at my community health board.</i>	16	33%	28	58%	4	8%	0	0%	0	0%	0	0%
15. Leaders trained in basic QI methods <i>The leaders of my community health board are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.</i>	17	35%	23	48%	4	8%	3	6%	1	2%	0	0%
16. Job descriptions include QI-related responsibilities <i>Job descriptions for many individuals responsible for programs and services in my community health board include specific responsibilities related to measuring and improving quality.</i>	7	15%	23	48%	10	21%	5	10%	3	6%	0	0%
17. Community health board has a QI plan <i>My community health board has a quality improvement (QI) plan.</i>	33	69%	11	23%	3	6%	1	2%	0	0%	0	0%
18. Customer satisfaction information routinely used <i>Customer satisfaction information is routinely used by many individuals responsible for programs and services in my community health board.</i>	8	17%	19	40%	15	31%	4	8%	2	4%	0	0%
19. Staff can work across programs to facilitate change <i>When trying to facilitate change, community health board staff has the authority to work within and across program boundaries.</i>	17	35%	22	46%	8	17%	1	2%	0	0%	0	0%
20. Key decision makers believe QI is important <i>The key decision makers in my community health board believe QI is very important.</i>	26	54%	18	38%	3	6%	0	0%	0	0%	1	2%
21. Community health board has continuous QI culture <i>My community health board currently has a pervasive culture that focuses on continuous QI.</i>	7	15%	25	52%	12	25%	3	6%	1	2%	0	0%
22. Efforts/policies/plans aligned with commitment to quality <i>My community health board currently has aligned its commitment to quality with most of its efforts, policies, and plans.</i>	8	17%	27	56%	9	19%	4	8%	0	0%	0	0%
23. Community health board has high level of QI capacity <i>My community health board currently has a high level of capacity to engage in QI efforts.</i>	4	8%	22	46%	12	25%	9	19%	0	0%	1	2%

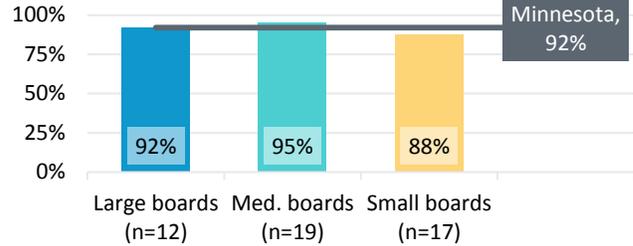
Staff members asked to contribute to decisions

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

Progress: Staff members asked to contribute to decisions (strongly agree, agree), Minnesota, 2012-2015



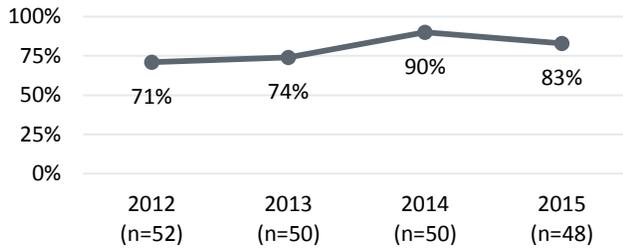
Comparison: Staff members asked to contribute to decisions (strongly agree, agree), by population, 2015



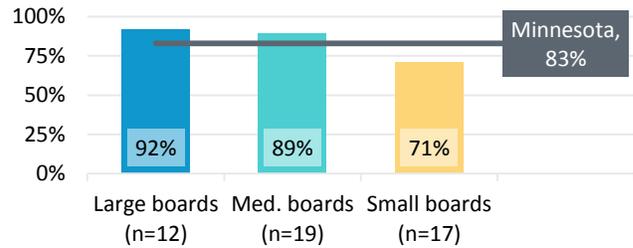
Leaders trained in basic QI methods

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

Progress: Leaders trained in basic QI methods (strongly agree, agree), Minnesota, 2012-2015



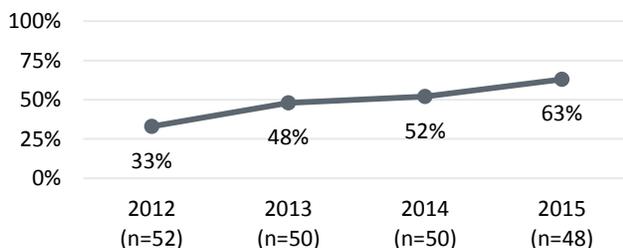
Comparison: Leaders trained in basic QI methods (strongly agree, agree), by population, 2015



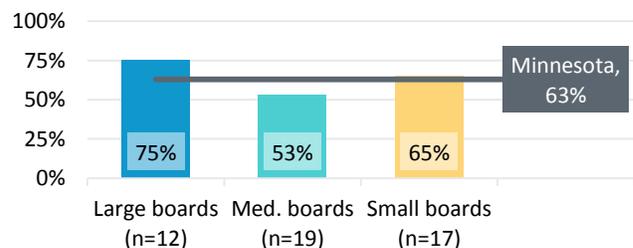
Job descriptions include QI-related responsibilities

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

Progress: Job descriptions include QI-related responsibilities (strongly agree, agree), Minn., 2012-2015



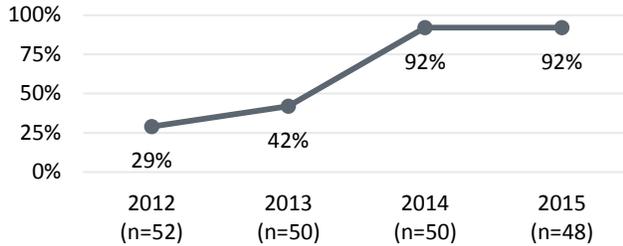
Comparison: Job descriptions include QI-related responsibilities (strongly agree, agree), by pop., 2015



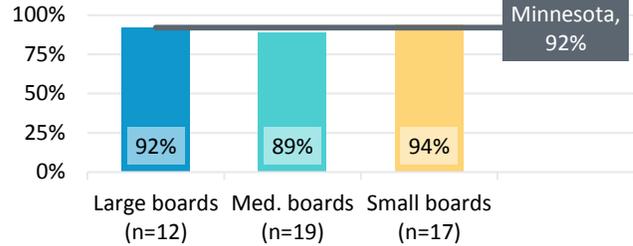
Community health board has a QI plan

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

Progress: Community health board has a QI plan (strongly agree, agree), Minnesota, 2012-2015



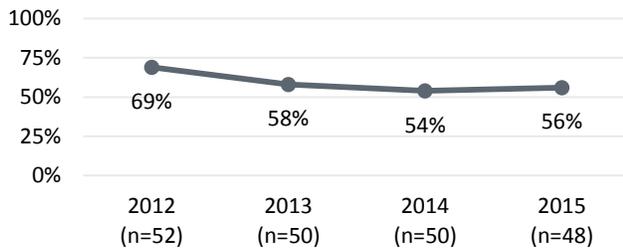
Comparison: Community health board has a QI plan (strongly agree, agree), by population, 2015



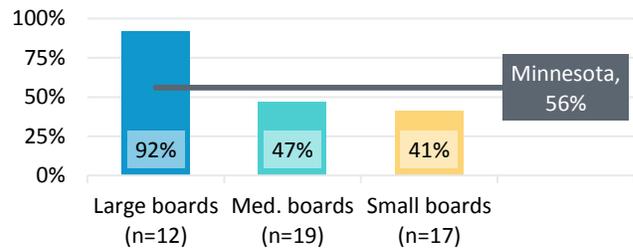
Customer satisfaction information routinely used

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

Progress: Customer satisfaction information routinely used (strongly agree, agree), Minnesota, 2012-2015



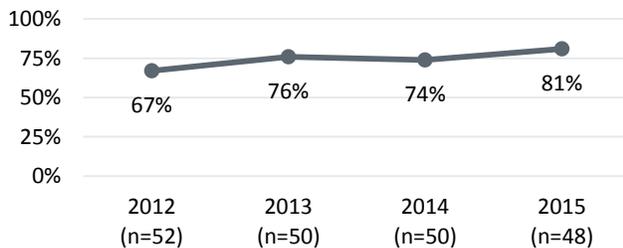
Comparison: Customer satisfaction information routinely used (strongly agree, agree), by population, 2015



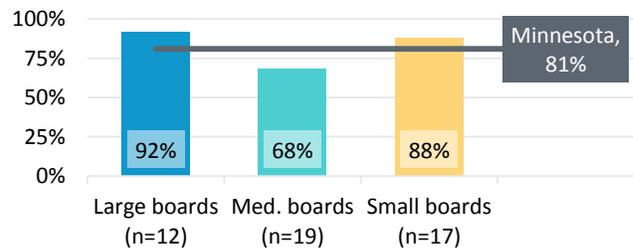
Staff can work across programs to facilitate change

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

Progress: Staff can work across programs to facilitate change (strongly agree, agree), Minnesota, 2012-2015



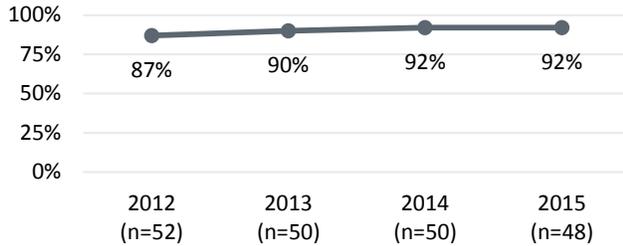
Comparison: Staff can work across programs to facilitate change (strongly agree, agree), by population, 2015



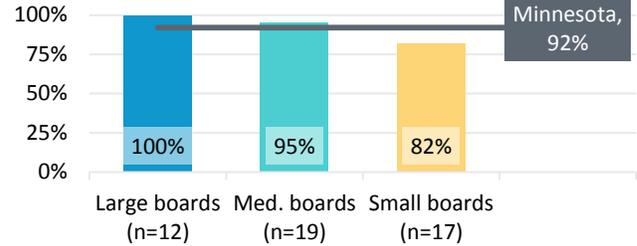
Key decision makers believe QI is important

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

Progress: Key decision makers believe QI is important (strongly agree, agree), Minnesota, 2012-2015



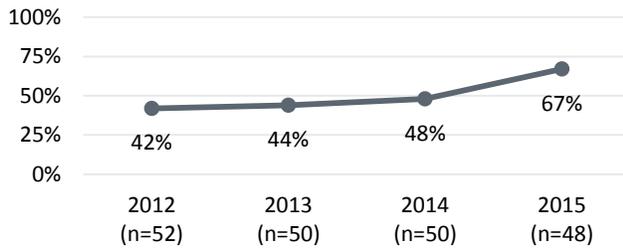
Comparison: Key decision makers believe QI is important (strongly agree, agree), by population, 2015



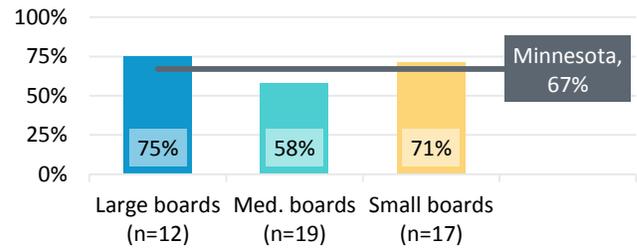
Community health board has continuous QI culture

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

Progress: Community health board has continuous QI culture (strongly agree, agree), Minnesota, 2012-2015



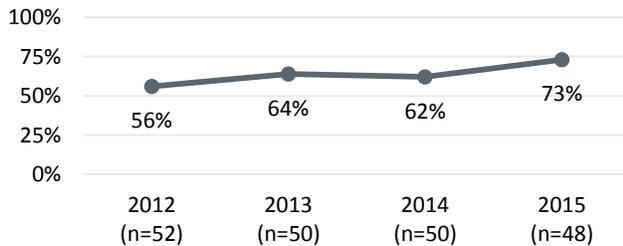
Comparison: Community health board has continuous QI culture (strongly agree, agree), by population, 2015



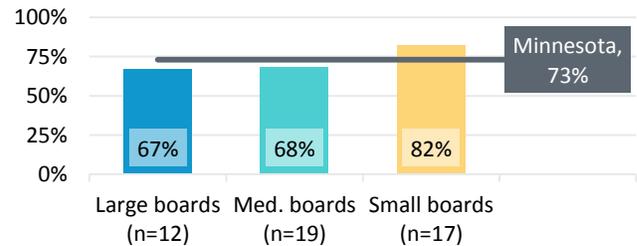
Efforts/policies/plans aligned with commitment to quality

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

Progress: Efforts/policies/plans aligned with commitment to quality (strongly agree, agree), Minnesota, 2012-2015



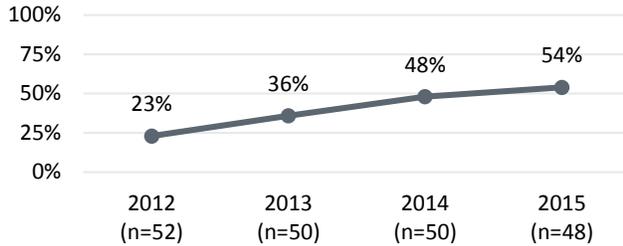
Comparison: Efforts/policies/plans aligned with commitment to quality (strongly agree, agree), by pop., 2015



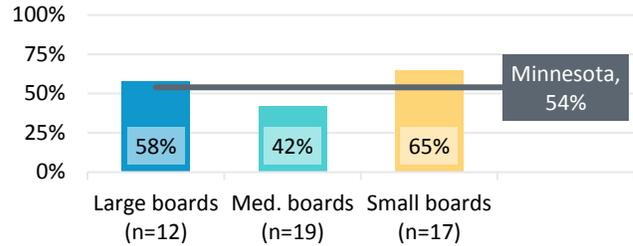
Community health board has high level of QI capacity

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

Progress: Community health board has high level of QI capacity (strongly agree, agree), Minnesota, 2012-2015

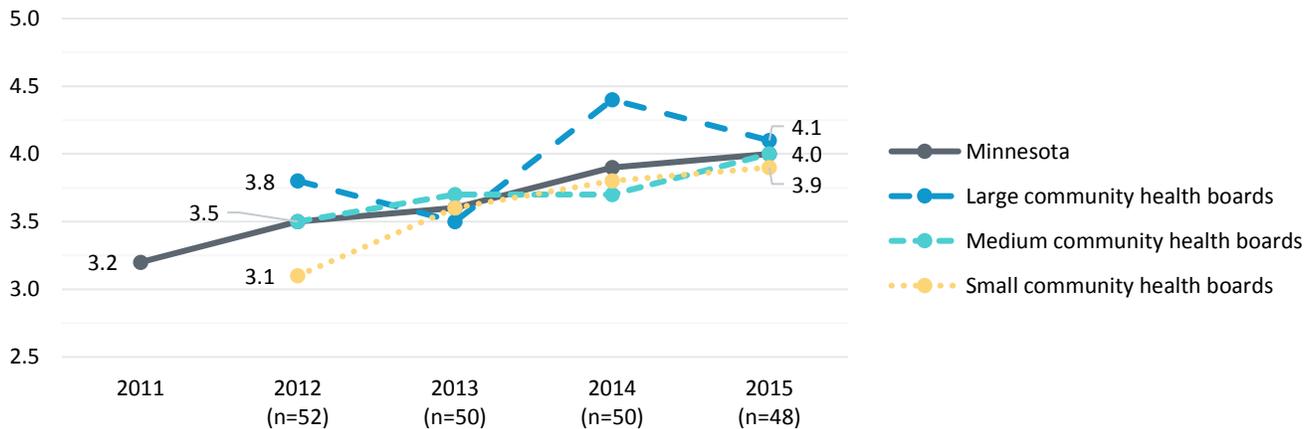


Comparison: Community health board has high level of QI capacity (strongly agree, agree), by population, 2015



Organizational QI Maturity Score

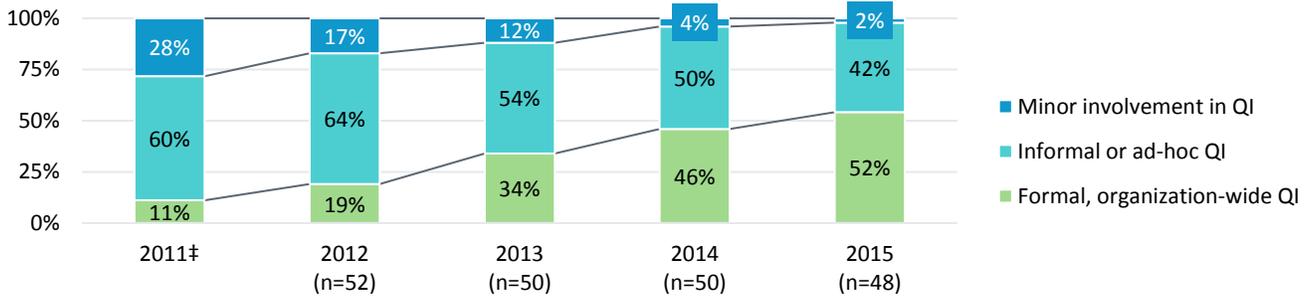
Progress, comparison: Median organizational QI maturity score, Minnesota community health boards, by population, 2012-2015†



Median organizational QI maturity score, Minnesota community health boards,† by population, 2012-2015	2012	2013	2014	2015
Large community health boards	3.8	3.5	4.4	4.1
Medium community health boards	3.5	3.7	3.7	4.0
Small community health boards	3.1	3.6	3.8	3.9
Minnesota	3.5	3.6	3.9	4.0

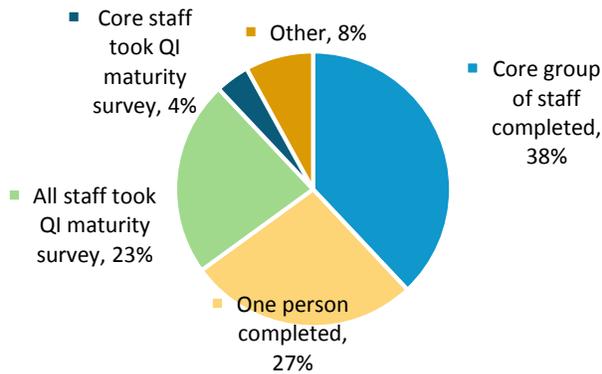
† 2011 data was obtained from the University of Southern Maine as part of the Multi-State Learning Collaborative Survey. MDH was able to obtain data for 56 respondents (80 percent response rate), representing a mix of community health boards and local health departments. Data for 2012-2015 was obtained from annual reporting and the reporting entity was the community health board.

Progress: System-wide organizational QI maturity distribution, Minnesota local health departments (2011)[†] and community health boards (2012-2015)

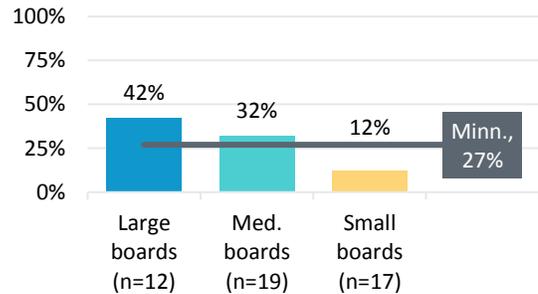


Systemwide organizational QI maturity distribution, Minnesota community health boards, 2011-2015	2011 [†]	2012 (n=52)	2013 (n=50)	2014 (n=50)	2015 (n=48)
Minor involvement in QI (score of 2.9 or less)	28%	17%	12%	4%	2%
Informal or ad-hoc QI (3.0 to 3.9)	60%	64%	54%	50%	42%
Formal, organization-wide QI (4.0 or greater)	11%	19%	34%	46%	52%

Method of assessing organizational QI culture among Minnesota community health boards, 2015 (n=48)



Comparison: Use of 10-question QI maturity survey to assess organizational QI maturity, by pop., 2015



Method of assessing organizational QI culture	Minnesota 2015 (n=48)	
	#	%
24. How did your community health board decide how to report on Questions 14-23, above? (Select one.)		
One person (e.g., the CHS administrator, the public health director, etc.) filled out Q14-23, based on their knowledge of the agency, without using the QI maturity survey	13	27%
A core group of staff (e.g., leadership, QI council, other group of key staff) completed Q14-23 on behalf of staff, without using the QI maturity survey	18	38%
The agency administered the QI maturity survey to a core group of staff (e.g., leadership team, QI council, etc.), and used those results for answering Q14-23	2	4%
The agency administered the QI maturity survey to the entire staff, and used those results for answering Q14-23	11	23%
Other	4	8%

[†] 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 community health boards and local health departments. Data for 2012-2015 was obtained from annual reporting and the reporting entity was the community health board.

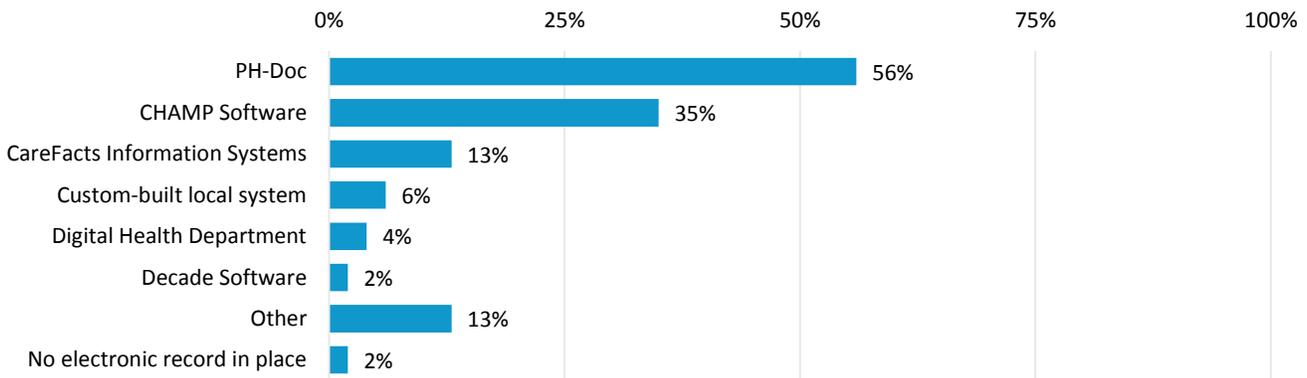
Health Informatics

These questions are used extensively by the [MDH Office of Health Information Technology](#) and the [Minnesota e-Health Advisory Committee](#) to develop programs, inform policy, and support community collaborative efforts. The MDH Office of Health Information Technology cites the data in assessment reports, fact sheets, and briefs.

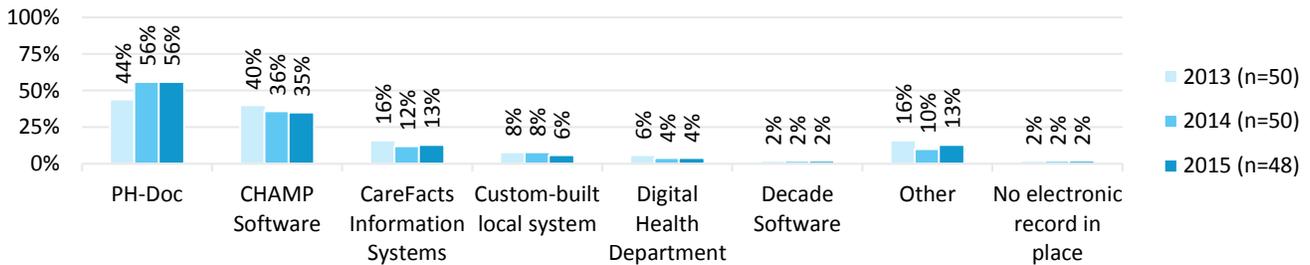
MORE INFORMATION

MDH Office of Health Information Technology
 651-201-5508 | MN.eHealth@state.mn.us
www.health.state.mn.us/divs/hpsc/ohit/

Software applications used by Minnesota community health boards for EHR systems, 2015 (n=48)

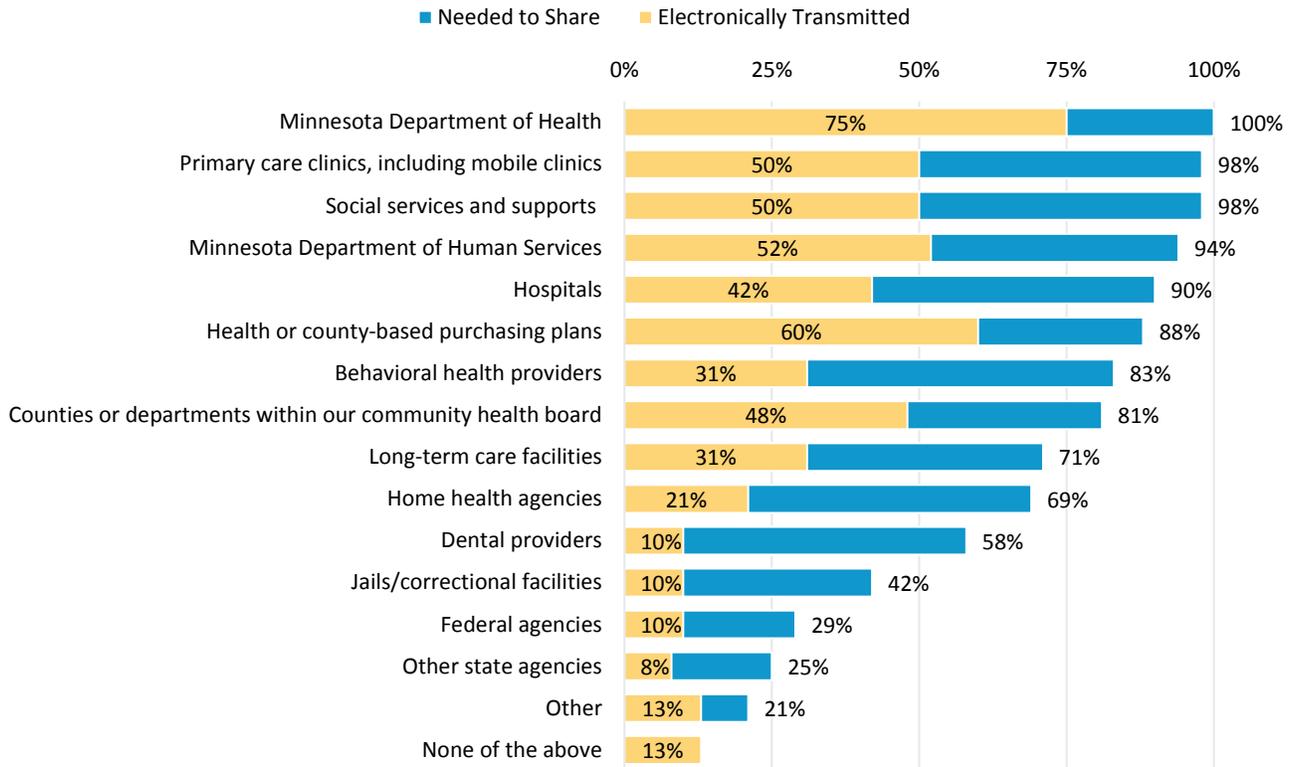


Greatest change: Software applications used by Minnesota community health boards for EHR systems, 2013-2015



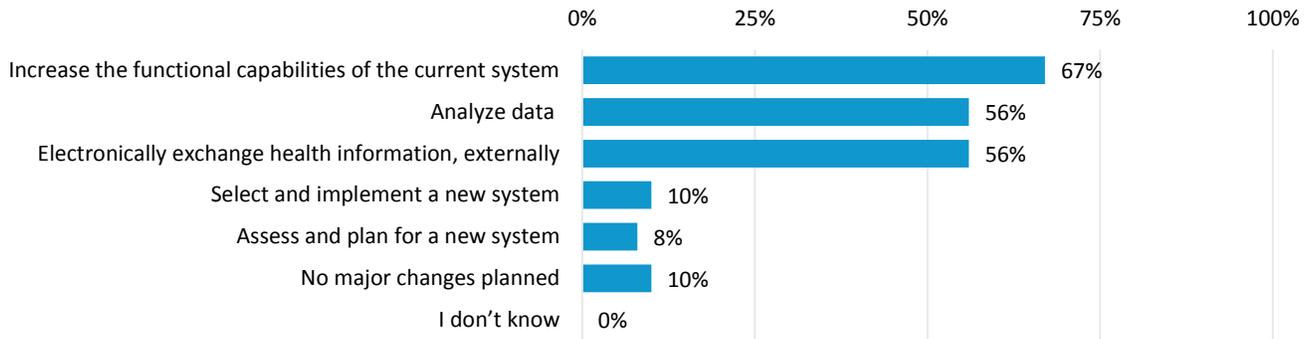
Software applications used for EHR systems		Minnesota 2015 (n=48)	
25. Which software application does your community health board use for the public health electronic health record (EHR) system? (Check all that apply.)			
		#	%
PH-Doc		27	56%
CareFacts Information Systems		6	13%
CHAMP Software		17	35%
Digital Health Department		2	4%
Decade Software		1	2%
Custom-built local system		3	6%
Other		6	13%
No electronic record in place		1	2%

Partners with which Minnesota community health boards electronically transmitted, or needed to share, client/patient information, 2015 (n=48)

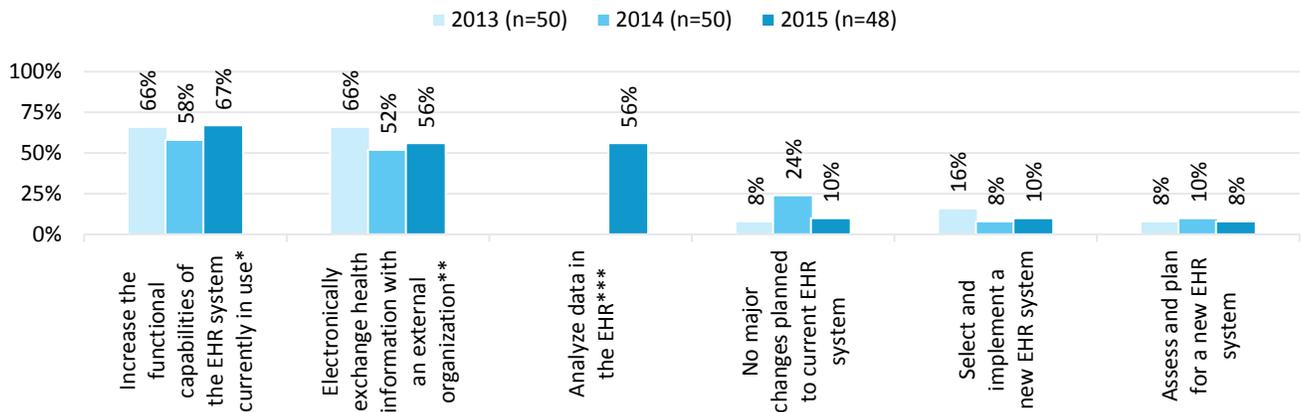


Partners with which community health boards electronically transmitted, or needed to share, client/patient information	Minnesota 2015 (n=48)			
	Needed to Share		Electronically Transmitted	
	#	%	#	%
Primary care clinics, including mobile clinics	47	98%	24	50%
Hospitals	43	90%	20	42%
Behavioral health providers	40	83%	15	31%
Dental providers	28	58%	5	10%
Home health agencies	33	69%	10	21%
Long-term care facilities	34	71%	15	31%
Jails/correctional facilities	20	42%	5	10%
Social services and supports (e.g., housing, transportation, food, legal aid)	47	98%	24	50%
Counties or departments within our community health board	39	81%	23	48%
Health or county-based purchasing plans	42	88%	29	60%
Minnesota Department of Health	48	100%	36	75%
Minnesota Department of Human Services	45	94%	25	52%
Other state agencies	12	25%	4	8%
Federal agencies	14	29%	5	10%
Other	10	21%	6	13%
None of the above	0	0%	6	13%

Changes planned for EHR systems in the next 18 months by Minnesota community health boards, 2015 (n=48)



Greatest change: Changes planned for EHR systems in the next 18 months by Minnesota community health boards, 2013-2015



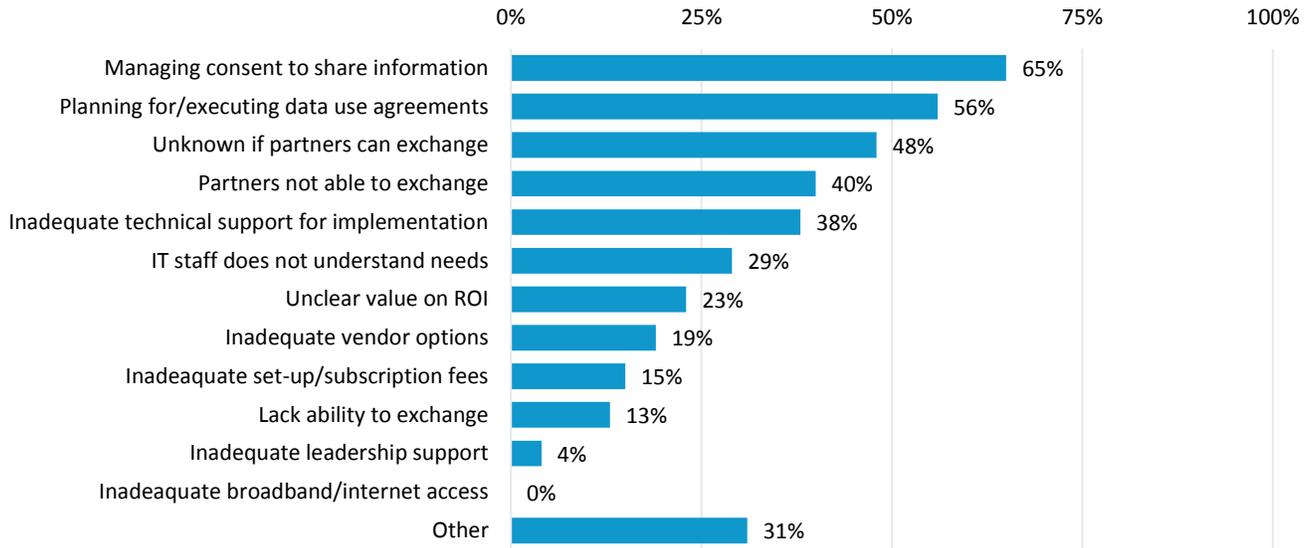
* Response option changed slightly from 2013-2014: Increase the functional capabilities or use of the EHR system

** Response option changed slightly from 2013-2014: Electronically exchange health information with another system

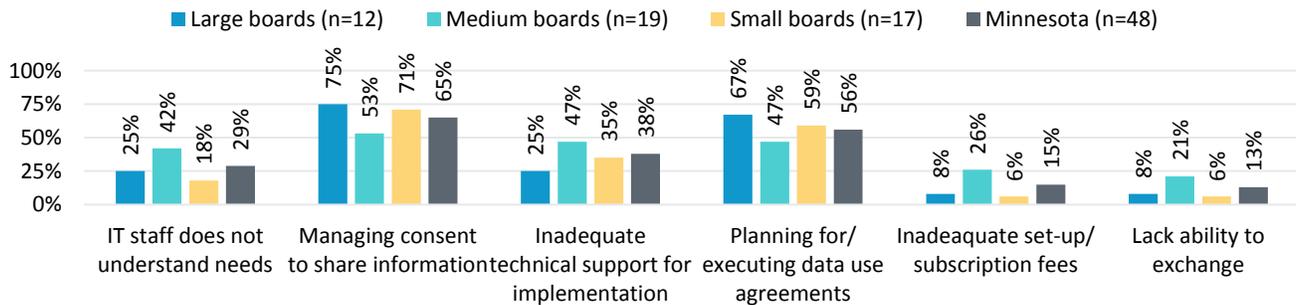
*** Response option new for 2015

Changes planned for EHR systems in the next 18 months 28. Indicate which of the following changes your community health board is planning for its EHR system within the next 18 months. (Check all that apply.)	Minnesota 2015 (n=48)	
	#	%
Assess and plan for a new EHR system	4	8%
Select and implement a new EHR system	5	10%
Increase the functional capabilities of the EHR system currently in use	32	67%
Analyze data in the EHR	27	56%
Electronically exchange health information with an external organization (not including paper, mail, phone, fax, or non-secure email)	27	56%
No major changes planned to current EHR system	5	10%
I don't know	0	0%

Greatest challenges related to secure electronic exchange of health information with outside organizations, Minnesota community health boards, 2015 (n=48)

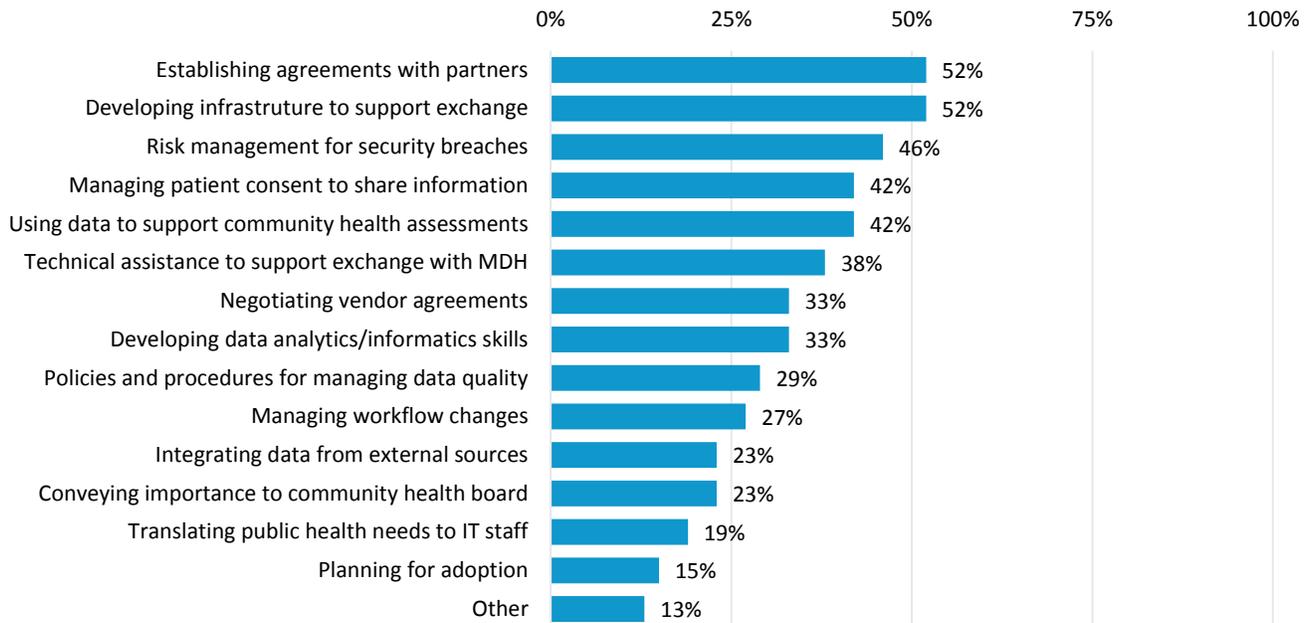


Comparison: Greatest challenges related to secure electronic exchange of information with outside organizations, Minnesota community health boards, by population and greatest spread, 2015



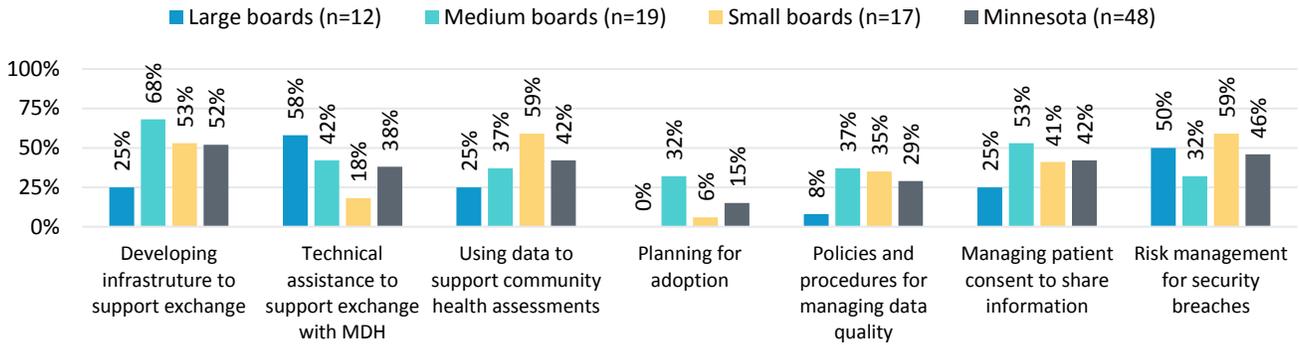
Greatest challenges related to secure electronic exchange of health information with outside organizations	Minnesota 2015 (n=48)	
	#	%
29. Indicate your greatest challenges related to secure electronic exchange of health information with outside organizations (e.g., health providers, social services, state agencies)? (Select up to five items.)		
We lack the ability to electronically exchange health information	6	13%
Our partners are not able to electronically exchange health information	19	40%
We do not know if our partners are able to electronically exchange health information	23	48%
Managing consent to share information (e.g., HIPAA, privacy, or legal concerns)	31	65%
Planning for and executing data use agreements	27	56%
Inadequate vendor options for health information exchange	9	19%
Inadequate technical support to implement health information exchange	18	38%
Our IT staff do not understand our needs for health IT and/or health informatics	14	29%
Inadequate broadband/Internet access	0	0%
Inadequate set-up and/or subscription fees for health information exchange	7	15%
Inadequate leadership support (e.g., community health board, management)	2	4%
Unclear value on return on investment	11	23%
Other	15	31%

E-health resources that would most help Minnesota community health boards to advance electronic exchange of health information, 2015 (n=48)



E-health resources that would most help to advance electronic exchange of health information 30. Which of the following e-health resources (templates, tools, etc.) would help your community health board to advance electronic exchange of health information? (Select up to five items.)	Minnesota 2015 (n=48)	
	#	%
Planning for EHR adoption	7	15%
Negotiating EHR and HIE vendor agreements	16	33%
Technical assistance to support information exchange with MDH	18	38%
Translating public health needs to IT staff	9	19%
Managing workflow changes	13	27%
Managing patient consent to share health information	20	42%
Risk management for security breaches	22	46%
Establishing agreements with exchange partners	25	52%
Developing infrastructure to support information exchange	25	52%
Integrating patient/client data from external sources into our EHR	11	23%
Developing data analytics and/or informatics skills	16	33%
Using data in the EHR to support community health assessments	20	42%
Policies and procedures for managing data quality	14	29%
Conveying the importance of informatics to the community health board (e.g., talking points, communications templates)	11	23%
Other	6	13%

Comparison: E-health resources that would most help Minnesota community health boards to advance electronic exchange of health information, by population and greatest spread, 2015



Top three E-health resources that would most help Minnesota community health boards to advance electronic exchange of health information, by population, 2015

Large community health boards (n=12)	Medium community health boards (n=19)	Small community health boards (n=17)	Minnesota (n=48)
1 Technical assistance to support exchange with MDH	1 Developing infrastructure to support exchange	1 Risk management for security breaches	1 Establishing agreements with partners
2 Risk management for security breaches	2 Establishing agreements with partners	Using data to support community health assessments	Developing infrastructure to support exchange
3 Establishing agreements with partners	3 Managing patient consent to share information	3 Establishing agreements with partners	3 Risk management for security breaches
		Developing infrastructure to support exchange	

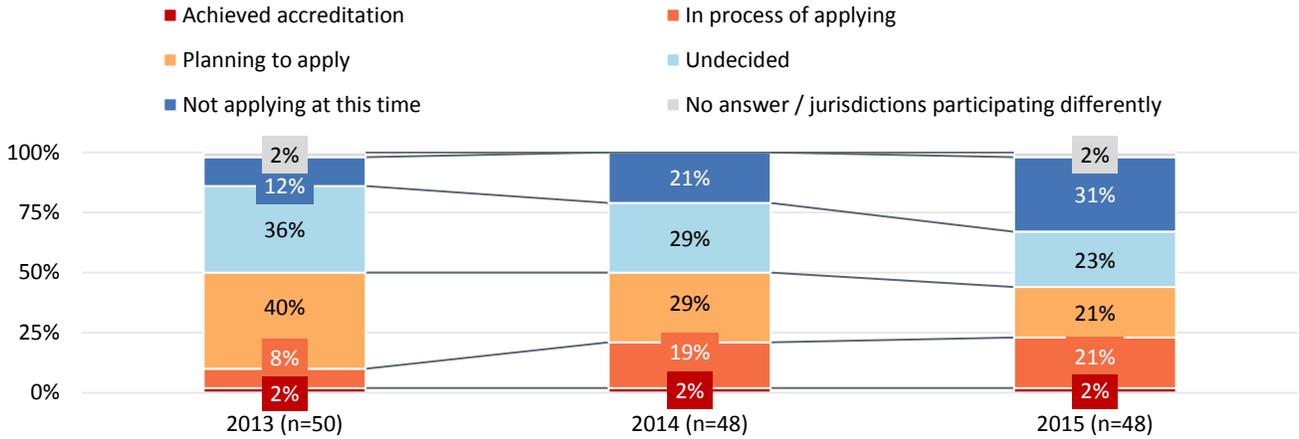
Voluntary Public Health Accreditation

This information is used to help understand and improve Minnesota’s public health system. Systematic information on accreditation preparation is useful for networking, mentoring, and sharing among community health boards, and enables monitoring system-level progress to implement the SCHSAC recommendation that all community health boards are prepared to apply for voluntary national accreditation by 2020 (as well as a national goal to increase percentage of population served by an accredited health department). Additional benefits of these measures include information to target technical assistance and training, and information for community health boards on how their decisions/actions related to accreditation compare to others.

MORE INFORMATION

MDH Health Partnerships Division, Public Health Practice Section
 651-201-3880 | health.ophp@state.mn.us
www.health.state.mn.us/divs/opi/

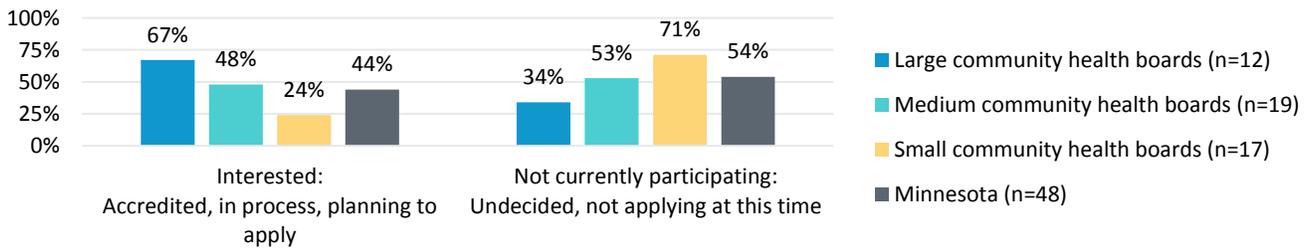
Progress: Participation in national public health accreditation, Minnesota community health boards, 2013-2015



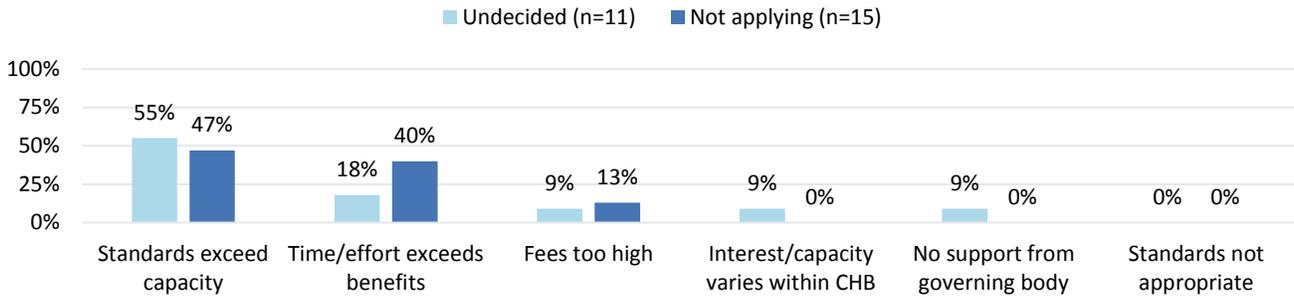
Participation in national public health accreditation 32. Which of the following best describes your community health board with respect to participation in the Public Health Accreditation Board accreditation program? (Select one.)	Minnesota 2015 (n=48)	
	#	%
My community health board has achieved accreditation	1	2% *
My community health board is in the process of accreditation (e.g., has submitted a statement of intent)	10	21%
My community health board is planning to apply (but is not in the process of accreditation)	10	21%
...in 2016	0	0%
...in 2017	2	4%
...in 2018 or later	8	17%
My community health board is undecided about whether to apply for accreditation	11	23%
My community health board has decided not to apply at this time	15	31%
Individual jurisdictions within my community health board are participating in accreditation differently	1	2%

* Washington achieved accreditation in March 2016, and is counted as "in process of applying" for 2015.

Comparison: Interest in participating in accreditation, by population, Minnesota, 2015

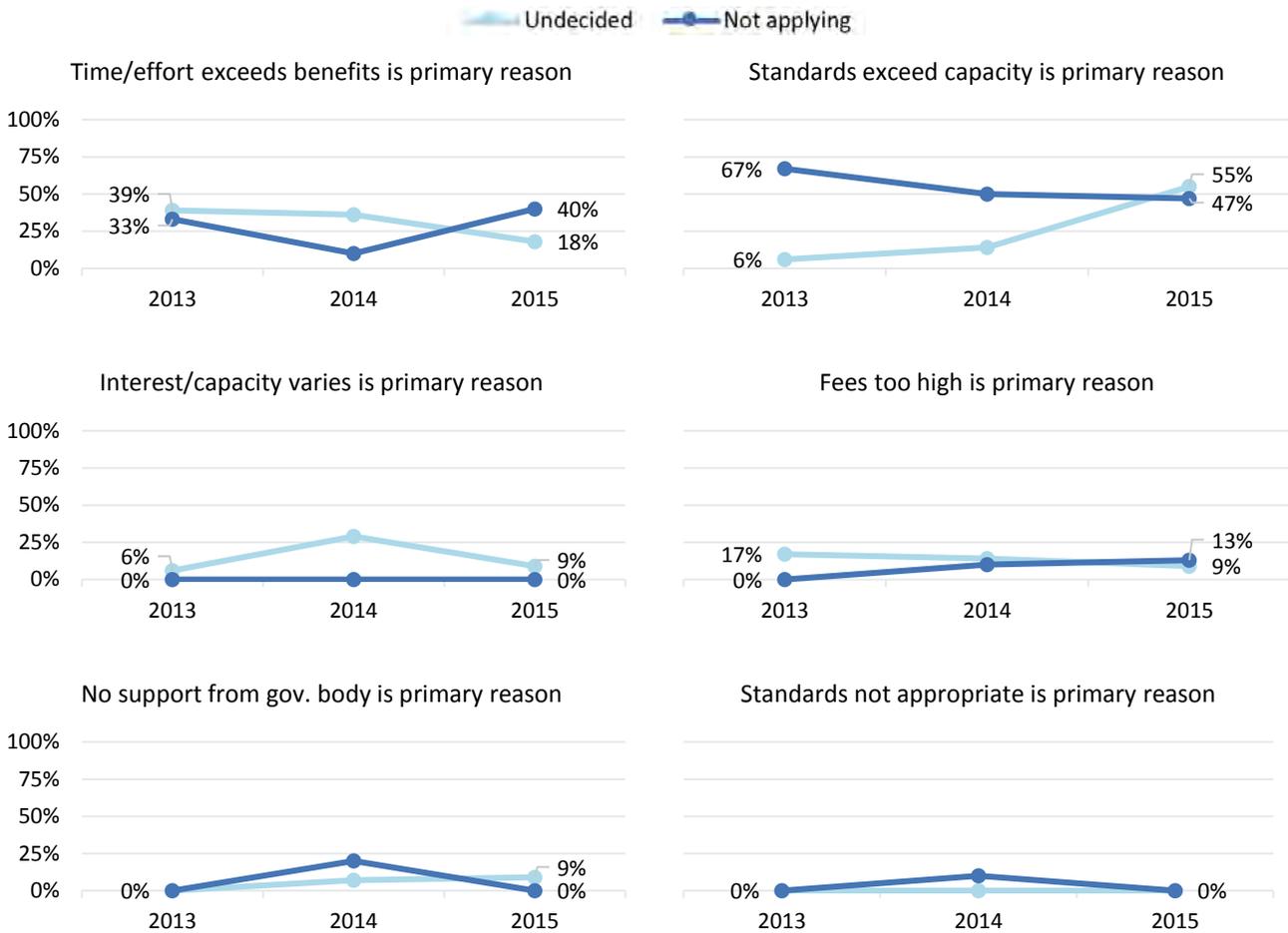


Primary reason Minnesota community health boards are undecided or are not applying for national public health accreditation at this time, 2015



Reasons Minnesota community health boards are undecided or are not applying for national public health accreditation at this time 32b. If your community health board is undecided or has decided not to apply for accreditation at this time, why? (Rank primary and secondary reasons.) Minnesota, 2015. For those community health boards that selected “undecided about whether to apply” or “decided not to apply at this time” in Q32, above.	Undecided (n=11)				Not Applying (n=15)			
	Primary Reason		Secondary Reason		Primary Reason		Secondary Reason	
	#	%	#	%	#	%	#	%
Accreditation standards are not appropriate for my community health board	0	0%	0	0%	0	0%	0	0%
Fees for accreditation are too high	1	9%	1	9%	2	13%	2	13%
Accreditation standards exceed the capacity of my community health board	6	55%	1	9%	7	47%	4	27%
Time and effort for accreditation application exceed the benefits of accreditation	2	18%	7	64%	6	40%	5	33%
No support from governing body for accreditation	1	9%	0	0%	0	0%	2	13%
Interest/capacity varies within the jurisdictions of my community health board	1	9%	2	18%	0	0%	0	0%

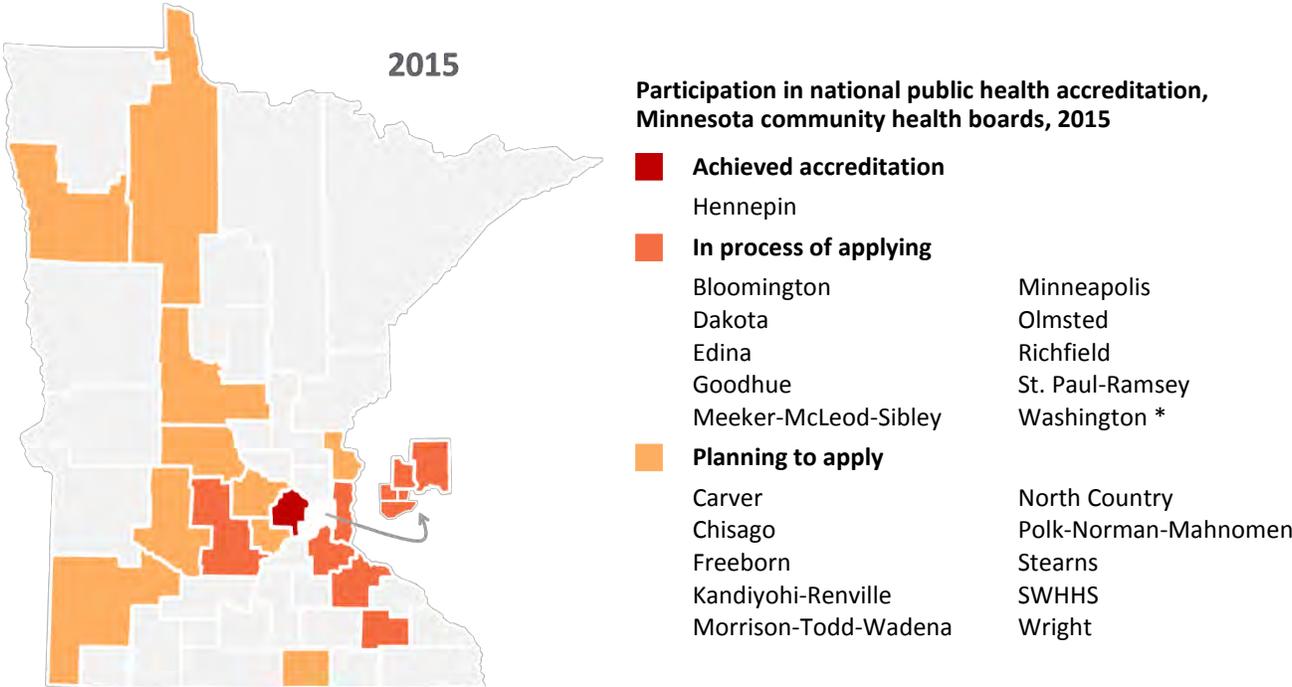
Change: Primary reason Minnesota community health boards are undecided or are not applying for national public health accreditation at this time, 2013-2015[§]



[§] Community health boards undecided or not applying for accreditation, 2013-2015

Year	Undecided	Not applying
2013	18 of 50 community health boards	6 of 50 community health boards
2014	14 of 48 community health boards	10 of 48 community health boards
2015	11 of 48 community health boards	15 of 48 community health boards

2015 LOCAL PUBLIC HEALTH ACT PERFORMANCE MEASURES [DATA BOOK]
 ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE: MINNESOTA-SPECIFIC MEASURES



* Washington achieved accreditation in March 2016, and is counted as "in process of applying" for 2015.

Promote Healthy Communities and Healthy Behaviors

In this area of responsibility:

- [Active Living](#)
- [Healthy Eating](#)
- [Tobacco-Free Living](#)
- [Alcohol](#)
- [Maternal and Child Health \(WIC\)](#)

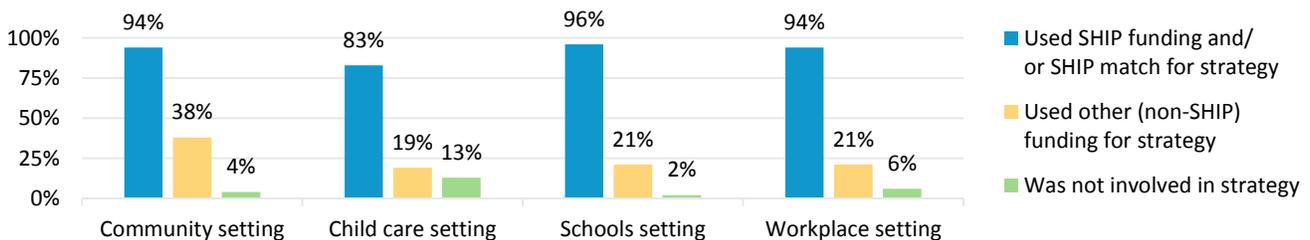
Active Living

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

MORE INFORMATION

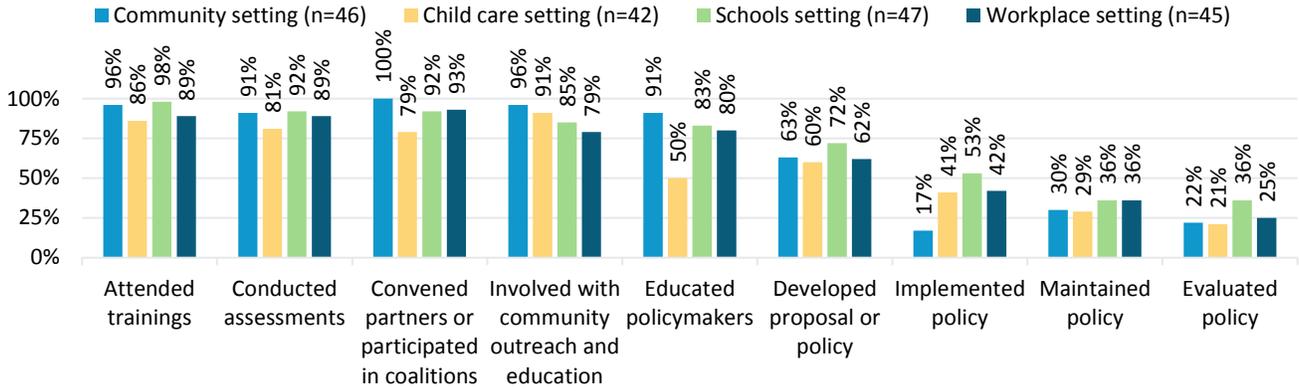
MDH Office of Statewide Health Improvement Initiatives, Physical Activity Unit
 651-201-5443 | health.oshii@state.mn.us
 SHIP Grantee Support: www.health.state.mn.us/healthreform/ship/

Settings in which Minnesota community health boards implemented evidence-based strategies to promote active living, 2015 (n=48)



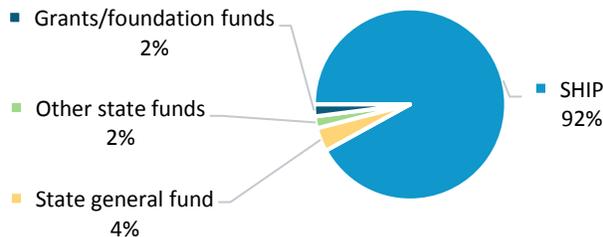
Settings in which community health boards implemented evidence-based strategies to promote active living 1. Indicate the settings where your community health board implemented evidence-based strategies to promote active living, and whether your community health board used SHIP and/or non-SHIP funding. (Check all that apply.)	Minnesota, 2015 (n=48)					
	Used SHIP funding and/or SHIP match for strategy		Used other (non-SHIP) funding for strategy		Was not involved in strategy	
	#	%	#	%	#	%
Community	45	94%	18	38%	2	4%
Child care	40	83%	9	19%	6	13%
Schools	46	96%	10	21%	1	2%
Workplace	45	94%	10	21%	3	6%

Activities carried out by Minnesota community health boards to promote active living, 2015

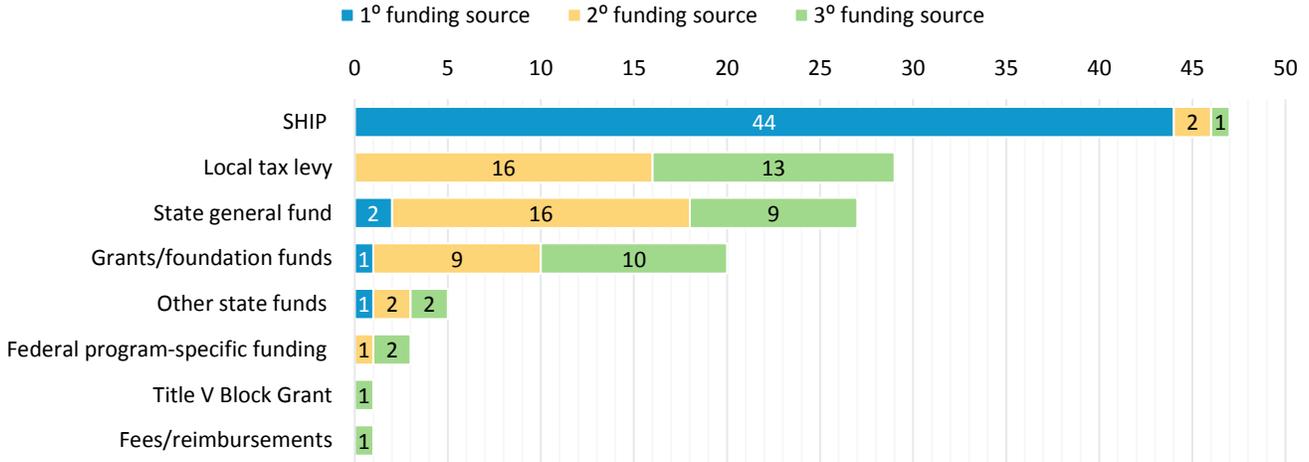


Activities carried out by community health boards to promote active living 1a. Identify the activities carried out by your community health board to implement evidence-based strategies to promote active living in each setting. (Check all that apply.) Minnesota, 2015. For those strategies for which community health boards selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q1, above.	Minnesota, 2015							
	Community setting (n=46)		Child care setting (n=42)		Schools setting (n=47)		Workplace setting (n=45)	
	#	%	#	%	#	%	#	%
Attended trainings	44	96%	36	86%	46	98%	40	89%
Conducted assessments	42	91%	34	81%	43	92%	40	89%
Convened partners or participated in coalitions	46	100%	33	79%	43	92%	42	93%
Involved with community outreach and education	44	96%	30	91%	40	85%	35	79%
Educated policymakers	42	91%	21	50%	39	83%	36	80%
Developed proposal or policy	29	63%	25	60%	34	72%	28	62%
Implemented policy	17	17%	17	41%	25	53%	19	42%
Maintained policy	14	30%	12	29%	17	36%	16	36%
Evaluated policy	10	22%	9	21%	17	36%	11	25%

Primary funding source supporting work by Minnesota community health boards to promote active living, 2015 (n=48)

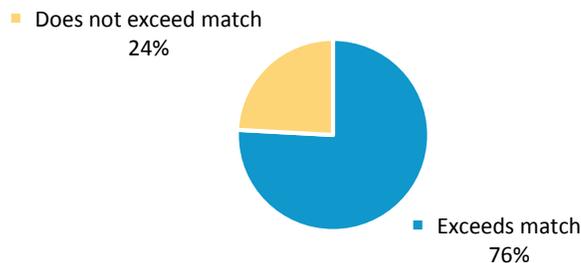


All funding sources supporting work by Minnesota community health boards to promote active living, 2015 (n=48)



Funding sources supporting work by community health boards to promote active living 1b. Estimate the top three funding sources that supported your strategies to promote active living. For those strategies for which community health boards selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q1, above.	Minnesota, 2015 (n=48)		
	Primary funding source #	Secondary funding source #	Tertiary funding source #
Local tax levy	0	16	13
State general fund (Local Public Health Act)	2	16	9
SHIP (including SHIP Innovation Grants)	44	2	1
Other state funds (from MDH or from other state agencies)	1	2	2
Federal program-specific funding (including federal funds that flow through the state to local public health, such as Tobacco-Free Communities)	0	1	2
Title V Block Grant	0	0	1
Grants/foundation funds	1	9	10
Fees/reimbursements	0	0	1

Minnesota community health boards in which the local tax levy investment for active living exceeds the required state match, among those that used local tax levy funding, 2015 (n=29)



Community health boards in which the local tax levy investment for active living exceeds the required state match, among those that used local tax levy funding 1c. Does the local tax levy investment of your community health board exceed the required state match? <i>Among those community health boards that selected "local tax levy" as one of their top three funding sources in Q1b, above.</i>	Minnesota, 2015 (n=29)	
	#	%
Yes	22	76%
No	7	24%

Healthy Eating

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

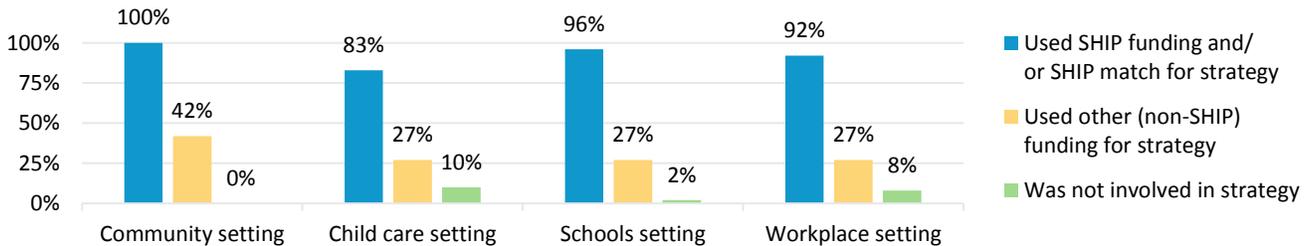
MORE INFORMATION

MDH Office of Statewide Health Improvement Initiatives, Healthy Eating and Health Systems Unit

651-201-5443 | health.oshii@state.mn.us

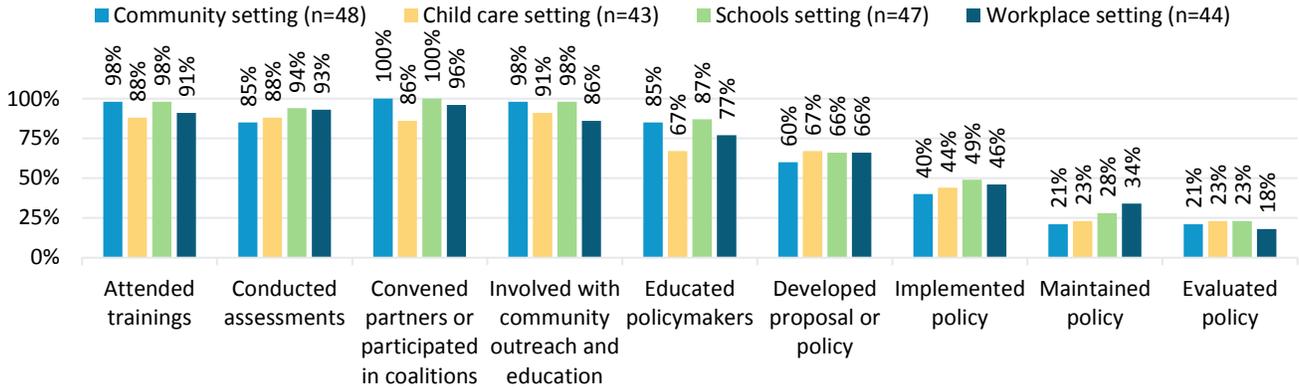
SHIP Grantee Support: www.health.state.mn.us/healthreform/ship/

Settings in which Minnesota community health boards implemented evidence-based strategies to promote healthy eating, 2015 (n=48)



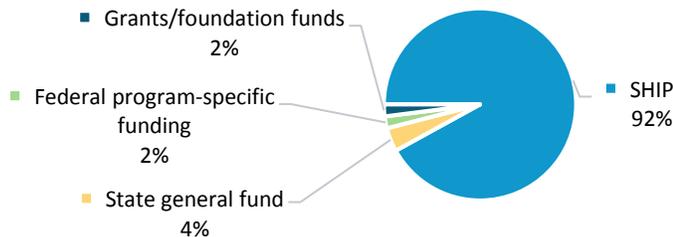
Settings in which community health boards implemented evidence-based strategies to promote healthy eating 2. Indicate the settings where your community health board took action to promote healthy eating, and whether your community health board used SHIP and/or non-SHIP funding. (Check all that apply.)	Minnesota, 2015 (n=48)					
	Used SHIP funding and/or SHIP match for strategy		Used other (non-SHIP) funding for strategy		Was not involved in strategy	
	#	%	#	%	#	%
Community	48	100%	20	42%	0	0%
Child care	40	83%	13	27%	5	10%
Schools	46	96%	13	27%	1	2%
Workplace	44	92%	13	27%	4	8%

Activities carried out by Minnesota community health boards to promote healthy eating, 2015

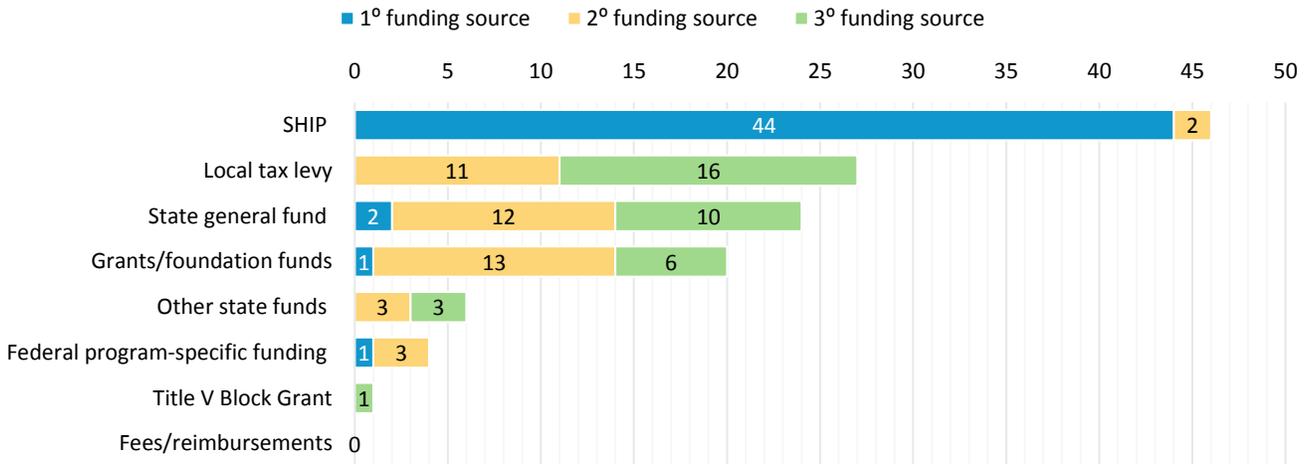


Activities carried out by community health boards to promote healthy eating 2a. Identify the activities carried out by your community health board to implement evidence-based strategies to promote healthy eating in each setting. (Check all that apply.) For those strategies for which community health boards selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q2, above.	Minnesota, 2015							
	Community setting (n=48)		Child care setting (n=43)		Schools setting (n=47)		Workplace setting	
	#	%	#	%	#	%	#	%
Attended trainings	47	98%	38	88%	46	98%	40	91%
Conducted assessments	41	85%	38	88%	44	94%	41	93%
Convened partners or participated in coalitions	48	100%	37	86%	47	100%	42	96%
Involved with community outreach and education	47	98%	39	91%	46	98%	38	86%
Educated policymakers	41	85%	29	67%	41	87%	34	77%
Developed proposal or policy	29	60%	29	67%	31	66%	29	66%
Implemented policy	19	40%	19	44%	23	49%	20	46%
Maintained policy	10	21%	10	23%	13	28%	15	34%
Evaluated policy	10	21%	10	23%	11	23%	8	18%

Primary funding source supporting work by Minnesota community health boards to promote healthy eating, 2015 (n=48)

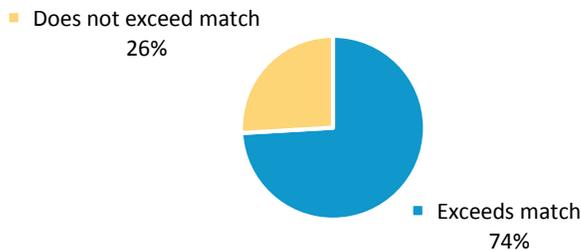


All funding sources supporting work by Minnesota community health boards to promote healthy eating, 2015 (n=48)



Funding sources supporting work by community health boards to promote healthy eating 2b. Estimate the top three funding sources that supported your strategies to promote healthy eating. For those strategies for which community health boards selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q2, above.	Minnesota, 2015 (n=48)		
	Primary funding source #	Secondary funding source #	Tertiary funding source #
Local tax levy	0	11	16
State general fund (Local Public Health Act)	2	12	10
SHIP (including SHIP Innovation Grants)	44	2	0
Other state funds (from MDH or from other state agencies)	0	3	3
Federal program-specific funding (including federal funds that flow through the state to local public health, such as Tobacco-Free Communities)	1	3	0
Title V Block Grant	0	0	1
Grants/foundation funds	1	13	6
Fees/reimbursements	0	0	0

Minnesota community health boards in which the local tax levy investment for healthy eating exceeds the required state match, among those that used local tax levy funding, 2015 (n=27)



Community health boards in which the local tax levy investment for healthy eating exceeds the required state match, among those that used local tax levy funding 2c. Does the local tax levy investment of your community health board exceed the required state match? Among those community health boards that selected "local tax levy" as one of their top three funding sources in Q2b, above.	Minnesota, 2015 (n=27)	
	#	%
Yes	20	74%
No	7	26%

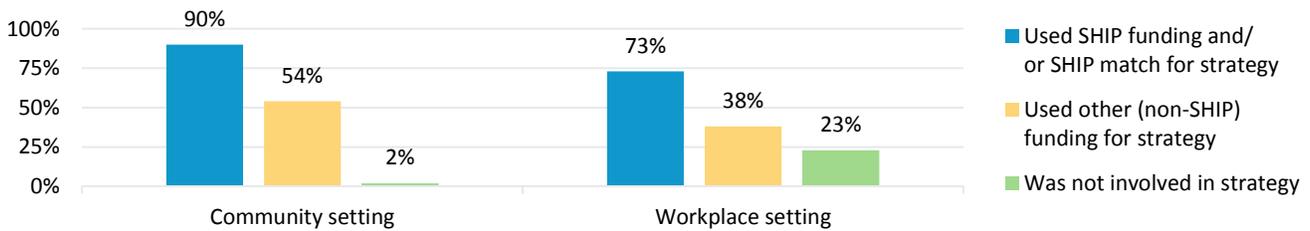
Tobacco-Free Living

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

MORE INFORMATION

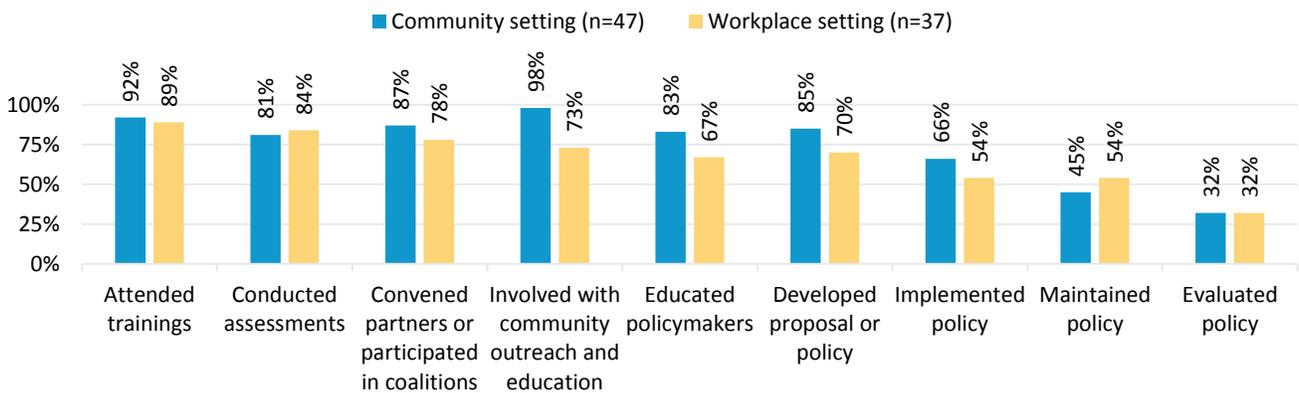
MDH Office of Statewide Health Improvement Initiatives, and Tobacco Prevention and Control
 651-201-5443 | health.oshii@state.mn.us
 SHIP Grantee Support: www.health.state.mn.us/healthreform/ship/

Settings in which Minnesota community health boards implemented evidence-based strategies to promote tobacco-free living, 2015 (n=48)



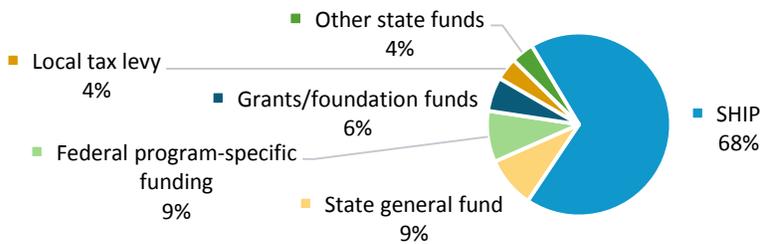
Settings in which community health boards implemented evidence-based strategies to promote tobacco-free living 3. Indicate the settings where your community health board implemented strategies to promote tobacco-free living, and whether your community health board used SHIP and/or non-SHIP funding. (Check all that apply.)	Minnesota, 2015 (n=48)					
	Used SHIP funding and/or SHIP match for strategy		Used other (non-SHIP) funding for strategy		Was not involved in strategy	
	#	%	#	%	#	%
Community	43	90%	26	54%	1	2%
Workplace	35	73%	18	38%	11	23%

Activities carried out by Minnesota community health boards to promote tobacco-free living, 2015

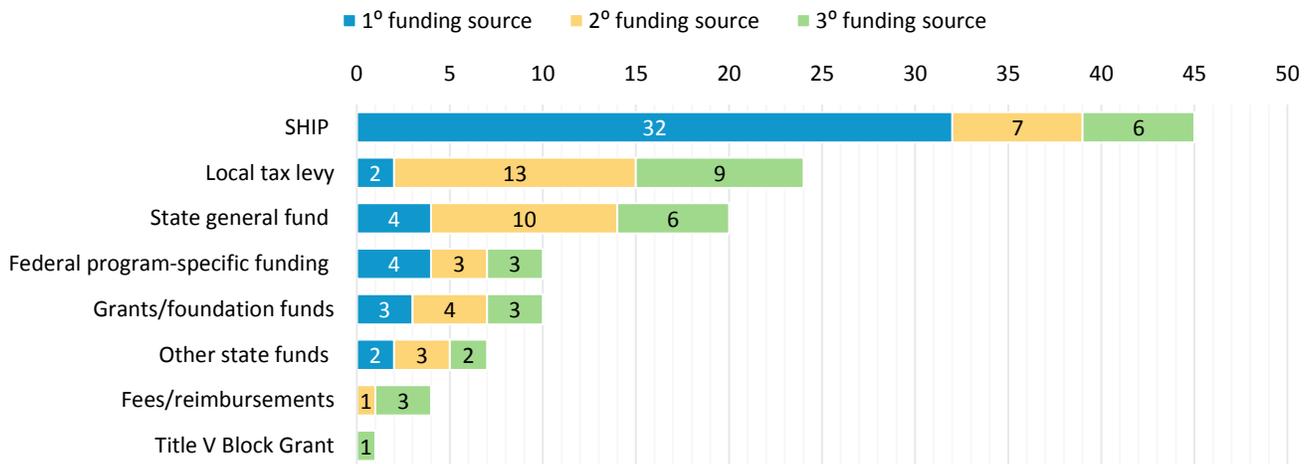


Activities carried out by community health boards to promote tobacco-free living 3a. Identify the activities carried out by your community health board to promote tobacco free living. (Check all that apply.) For those strategies for which community health boards selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q3, above.	Minnesota, 2015			
	Community setting (n=47)		Workplace setting (n=37)	
	#	%	#	%
Attended trainings	43	92%	33	89%
Conducted assessments	38	81%	31	84%
Convened partners or participated in coalitions	41	87%	29	78%
Involved with community outreach and education	46	98%	27	73%
Educated policymakers	39	83%	25	67%
Developed proposal or policy	40	85%	26	70%
Implemented policy	31	66%	20	54%
Maintained policy	21	45%	20	54%
Evaluated policy	15	32%	12	32%

Primary funding source supporting work by Minnesota community health boards to promote tobacco-free living, 2015 (n=47)

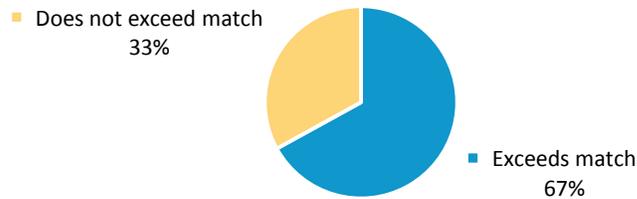


All funding sources supporting work by Minnesota community health boards to promote tobacco-free living, 2015 (n=47)



Funding sources supporting work by community health boards to promote tobacco-free living 3b. Estimate the top three funding sources that supported your strategies related to tobacco prevention and control. <i>For those strategies for which community health boards selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q3, above.</i>	Minnesota, 2015 (n=47)		
	Primary funding source #	Secondary funding source #	Tertiary funding source #
Local tax levy	2	13	9
State general fund (Local Public Health Act)	4	10	6
SHIP (including SHIP Innovation Grants)	32	7	6
Other state funds (from MDH or from other state agencies)	2	3	2
Federal program-specific funding (including federal funds that flow through the state to local public health, such as Tobacco-Free Communities)	4	3	3
Title V Block Grant	0	0	1
Grants/foundation funds	3	4	3
Fees/reimbursements	0	1	3

Minnesota community health boards in which the local tax levy investment for tobacco-free living exceeds the required state match, among those that used local tax levy funding, 2015 (n=29)



Community health boards in which the local tax levy investment for tobacco-free living exceeds the required state match, among those that used local tax levy funding 3c. Does the local tax levy investment of your community health board exceed the required state match? <i>Among those community health boards that selected "local tax levy" as one of their top three funding sources in Q3b, above.</i>	Minnesota, 2015 (n=24)	
	#	%
Yes	16	67%
No	8	33%

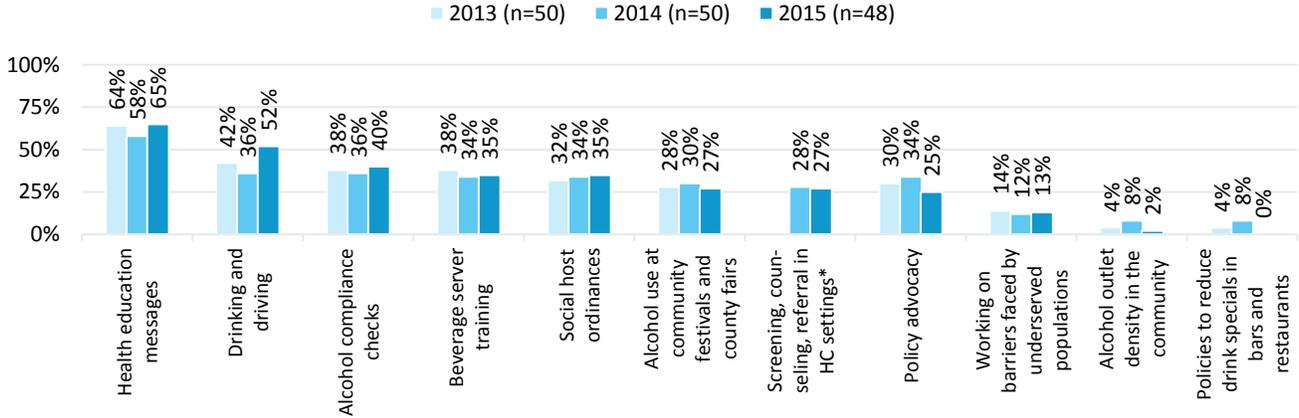
Alcohol

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

[MORE INFORMATION](#)

MDH Office of Statewide Health Improvement Initiatives
651-201-5443 | health.oshii@state.mn.us

Change: Strategies used by Minnesota community health boards related to alcohol use, 2013-2015



*Not asked in 2013.

Strategies used by community health boards related to alcohol use 4. Indicate the strategies used by your community health board related to alcohol use. (Check all that apply.)	Minnesota 2015 (n=48)	
	#	%
Policy advocacy (strengthening local ordinances)	12	25%
Policies to reduce drink specials in bars and restaurants	0	0%
Alcohol compliance checks	19	40%
Beverage server training	17	35%
Alcohol outlet density in the community	1	2%
Social host ordinances	17	35%
Alcohol use at community festivals and county fairs	13	27%
Drinking and driving	25	52%
Health education messages	31	65%
Working on barriers faced by underserved populations to reduce disparities in alcohol use	6	13%
Screening, counseling, and/or referral in health care settings	13	27%
Other	9	19%
None of the above	6	13%

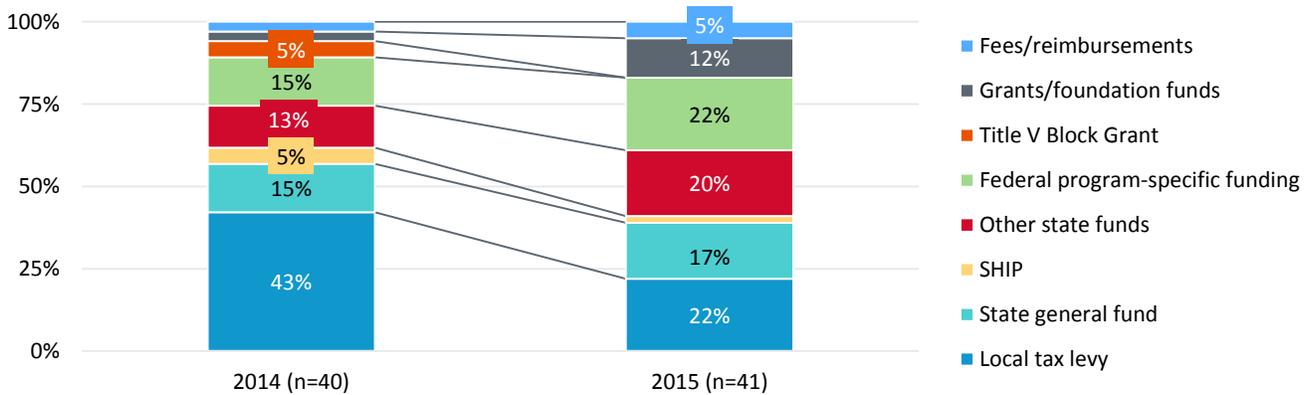
Other examples:

- Health department staff facilitated a community chemical health initiative focused on prevention of alcohol and drug use with youth
- ----- County has a SAMSHA Drug Free Coalition grant; the above work is done through that coalition, and has two public health staff and one community health board commissioner on the coalition
- ----- County Substance Prevention and Intervention Initiative DWI Court
- Public health staff participate in community chemical health coalitions; patients of our various public health clinics are provided information/referrals to resources and services for chemical health addiction
- Source investigation: Law enforcement strategy where an investigation is carried out at underage drinking parties to identify the person who was the source of providing the alcohol
- Youth groups regarding ATOD
- Through a DHS grant, we have a program called Project Harmony, which is a multi-disciplinary case management program that assists pregnant women or parenting women of children under eight years old to obtain and maintain sobriety; we have employed a recovery coach that plays a pivotal role in this program

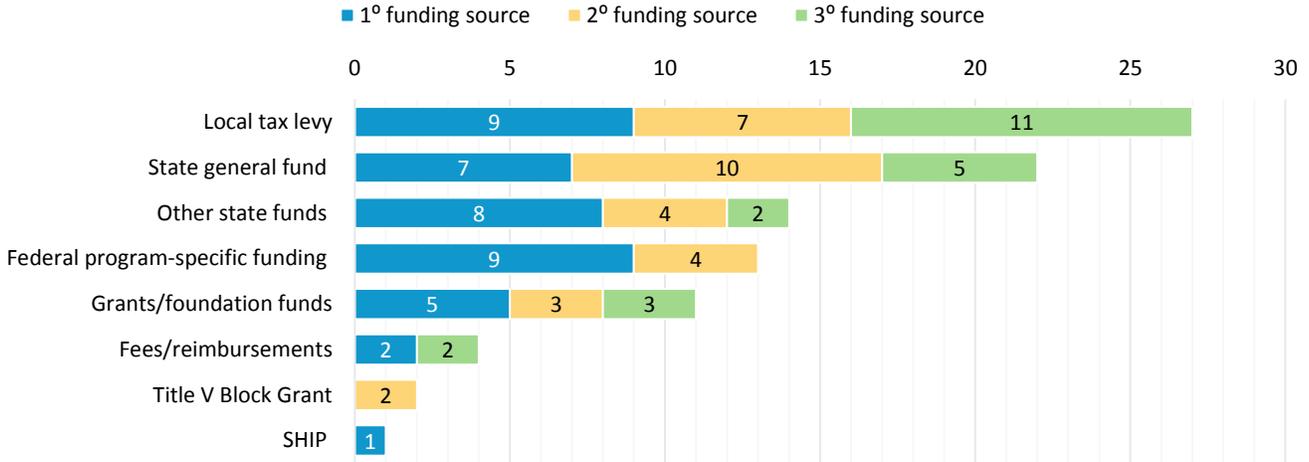
- ----- County Health and Human Services plays an active role in the community's 'Drug Task Force,' this group of community partners advocates for decreased use of alcohol among youth, and also works on strategies to reduce the use of drugs both illicit and prescription in the community
- Evaluation and education in our WIC clinics

Activities carried out by community health boards related to alcohol use 4a. Identify the activities carried out by your community health board in relation to alcohol use. (Check all that apply.) Among those community health boards that selected strategies below in Q4, above.	Minnesota, 2015									
	n	Attended trainings	Conducted assessments	Convened partners or participate in coalitions	Involved with community outreach and education	Educated policymakers	Developed proposal or policy	Implemented policy	Maintained policy	Evaluated policy
Policy advocacy (strengthening local ordinances)	12	83%	50%	83%	75%	67%	58%	50%	33%	25%
Alcohol compliance checks	19	26%	47%	68%	63%	42%	21%	21%	37%	16%
Beverage server training	17	71%	29%	88%	88%	59%	24%	24%	24%	24%
Alcohol outlet density in the community	1	0%	0%	100%	100%	100%	0%	0%	0%	0%
Social host ordinances	17	29%	29%	53%	77%	41%	35%	41%	47%	18%
Alcohol use at community festivals and county fairs	13	31%	46%	69%	54%	31%	31%	23%	31%	15%
Drinking and driving	25	60%	32%	96%	92%	52%	4%	4%	8%	4%
Health education messages	31	55%	26%	81%	90%	55%	3%	3%	3%	3%
Working on barriers faced by underserved populations to reduce disparities in alcohol use	6	83%	50%	83%	67%	67%	0%	0%	17%	0%
Screening, counseling, and/or referral in health care settings	13	54%	62%	34%	62%	8%	0%	0%	0%	0%

Change: **Primary** funding source supporting work by Minnesota community health boards related to alcohol use, 2014-2015



All funding sources supporting work by Minnesota community health boards related to alcohol use, 2015 (n=4)



Funding sources supporting work by community health boards related to alcohol use 4b. Estimate the top three funding sources that supported your strategies related to alcohol use. Minnesota, 2015. <i>Among those community health boards that selected strategies below in Q4, above.</i> (n=41)	Minnesota 2015 (n=48)		
	Primary funding source #	Secondary funding source #	Tertiary funding source #
Local tax levy	9	7	11
State general fund (Local Public Health Act)	7	10	5
SHIP (including SHIP Innovation Grants)	1	0	0
Other state funds (from MDH or from other state agencies)	8	4	2
Federal program-specific funding (including federal funds that flow through the state to local public health, such as Tobacco-Free Communities)	9	4	0
Title V Block Grant	0	2	0
Grants/foundation funds	5	3	3
Fees/reimbursements	2	0	2

Maternal and Child Health (WIC)

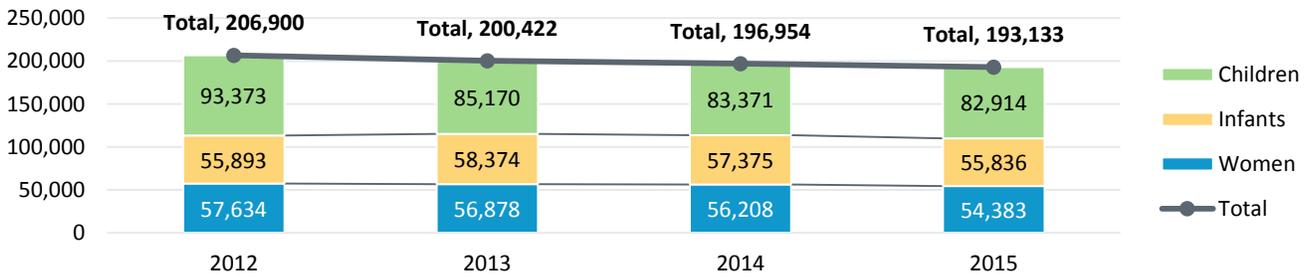
It is important to monitor emerging maternal and child health issues to develop a baseline for community health board, population-based activities around maternal and child health.

MORE INFORMATION

MDH Community and Family Health Division, Maternal and Child Health Section
 651-201-3760 | health.cfhcommunications@state.mn.us
www.health.state.mn.us/divs/cfh/program/mch/

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

Change: Total women, infants, and children served (unduplicated) by WIC programs, Minnesota community health boards, 2012-2015



Total women, infants, and children served (unduplicated) by WIC programs	Minnesota, 2015
Women (unduplicated)	54,383
Infants (unduplicated)	55,836
Children (unduplicated)	82,914
Total	193,133

Prevent the Spread of Communicable Diseases

In this area of responsibility:

- [Immunizations](#)
- [Infectious Disease Services](#)

Immunizations

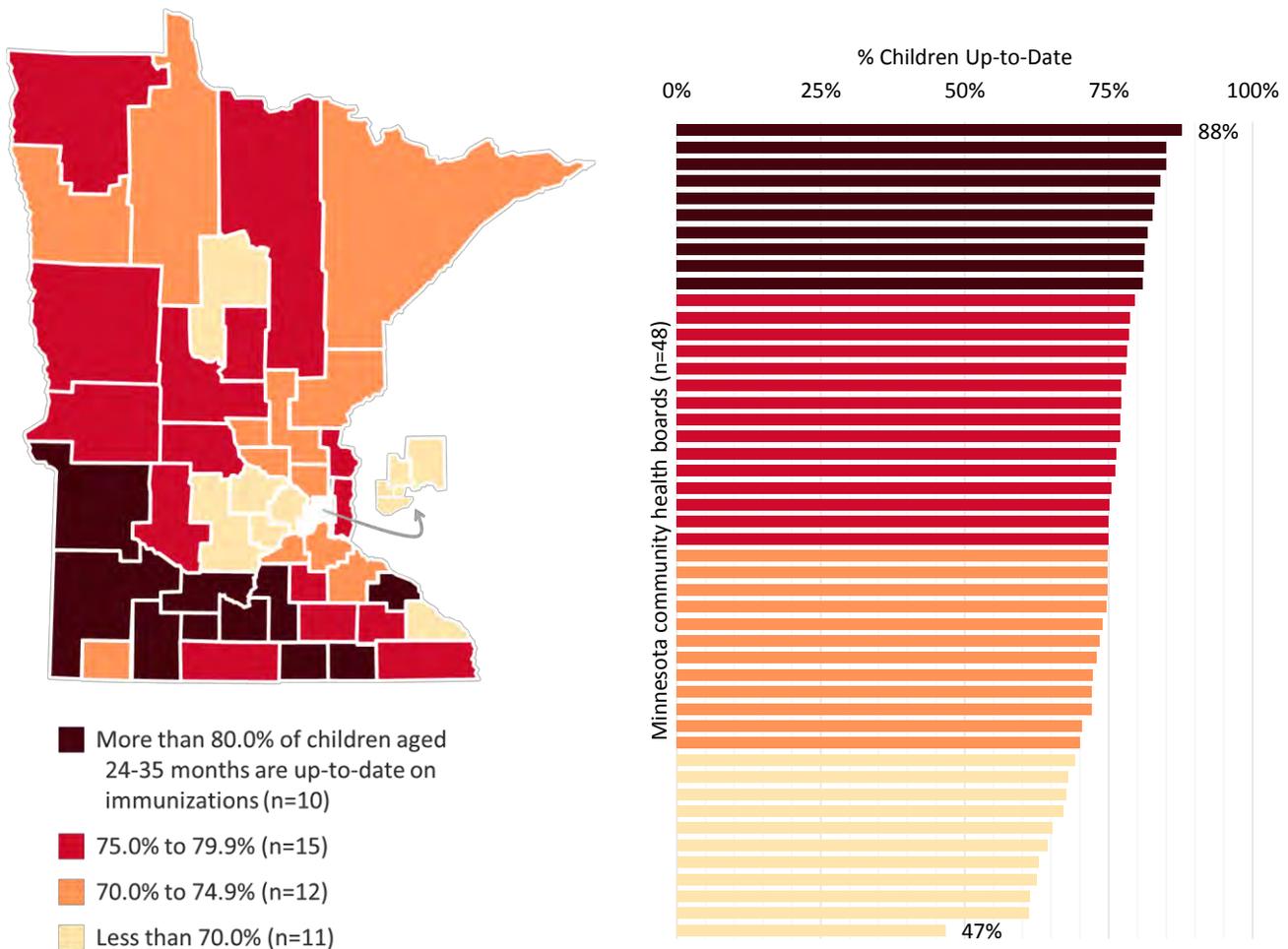
Immunization rates serve as an important measure of preventive care and overall public health.

MORE INFORMATION

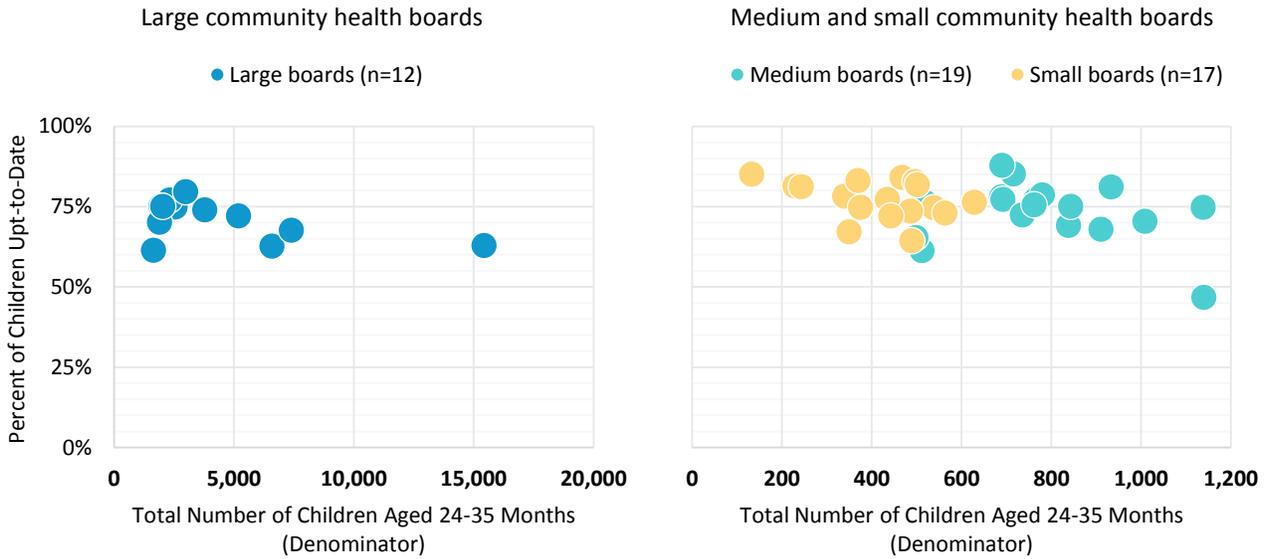
MDH Infectious Disease Epidemiology, Prevention, and Control Division, Vaccine Preventable Disease Section
651-201-5414 | www.health.state.mn.us/divs/idepc/immunize/

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

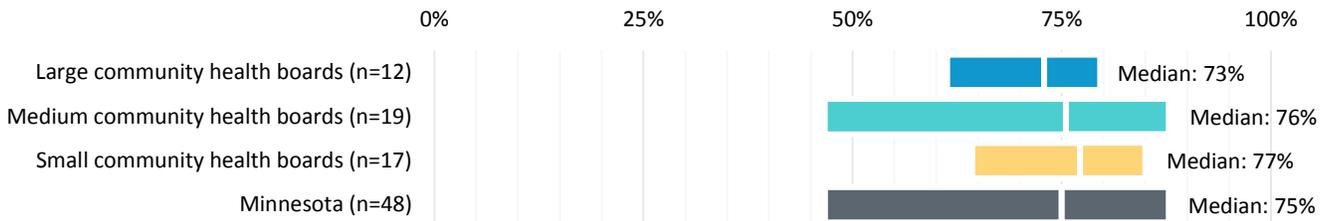
Rate of children aged 24-35 months who are up-to-date on immunizations, Minnesota community health boards, 2015 (n=48)



Comparison: Rate of children aged 24-35 months who are up-to-date on immunizations, Minnesota community health boards, by population, 2015

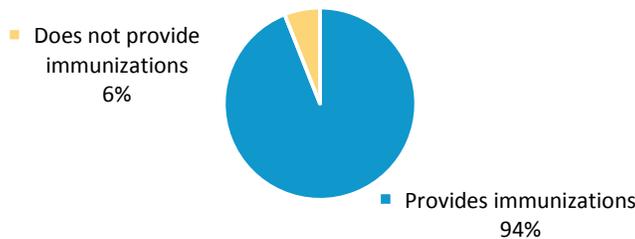


Comparison: Range and median: Rate of children aged 24-35 months who are up-to-date on immunizations, by community health board population, Minnesota, 2015



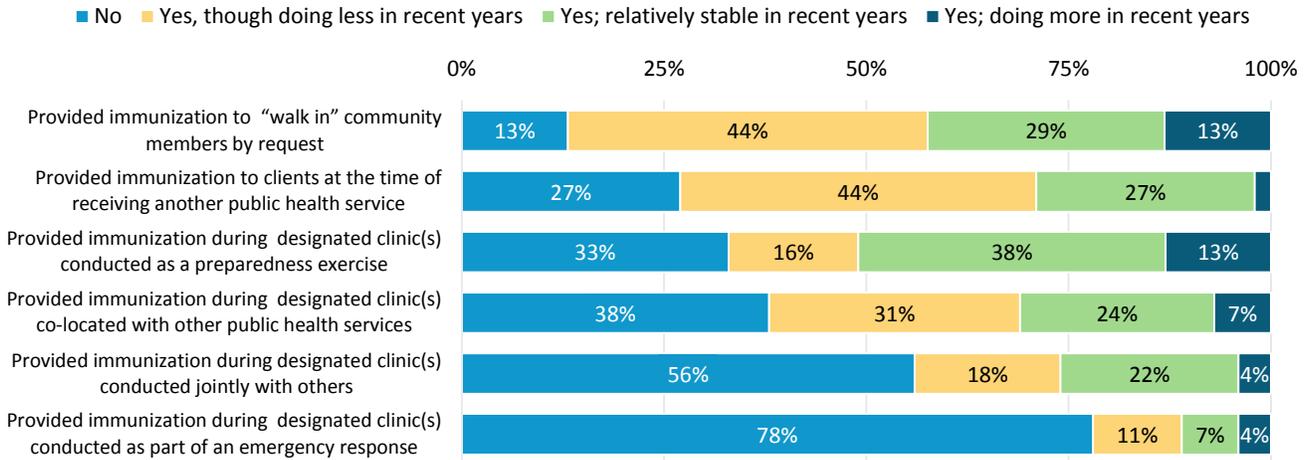
Range, median: Child immunizations, 2015	Large community health boards (n=12)	Medium community health boards (n=19)	Small community health boards (n=17)	Minnesota (n=48)
Minimum	61%	47%	64%	47%
Median	73%	76%	77%	75%
Maximum	80%	88%	85%	88%

Minnesota community health boards providing immunizations, 2015 (n=48)



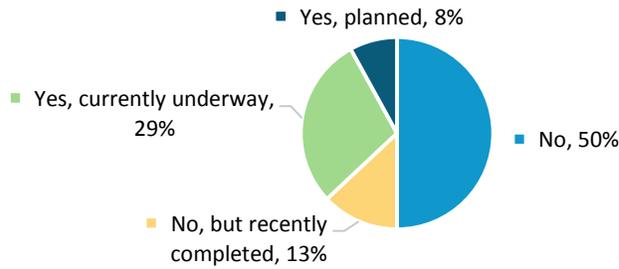
Providing immunizations 2. Does your community health board provide immunizations? (Choose one.)	Minnesota 2015 (n=48)	
	#	%
Yes	45	94%
No	3	6%

Immunization-related services and trends of the last year among Minnesota community health boards, 2015 (n=45)



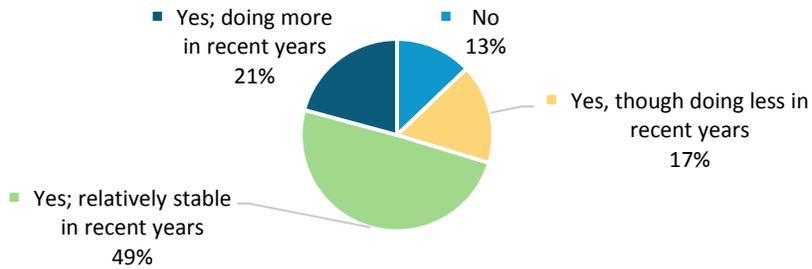
Immunization-related services and trends of the last year 2a. If your community health board provides immunizations, indicate the immunization-related services and trends of the last year. (Select the best response.) <i>Among those community health boards that selected "yes" to Q2, above.</i>	Minnesota, 2015 (n=45)							
	No		Yes, though doing less in recent years		Yes; relatively stable in recent years		Yes; doing more in recent years	
	#	%	#	%	#	%	#	%
Provide immunization to clients at the time of receiving another public health service (e.g., WIC, family planning, home visit, Child and Teen Checkup, etc.)	12	27%	20	44%	12	27%	1	2%
Provide immunization to "walk in" community members by request (at the public health department)	6	13%	20	44%	13	29%	6	13%
Provide immunization during designated clinic(s) conducted jointly with others	25	56%	8	18%	10	22%	2	4%
Provide immunization during designated clinic(s) conducted as a preparedness exercise (clinic to administer influenza vaccine during typical flu season)	15	33%	7	16%	17	38%	6	13%
Provide immunization during designated clinic(s) conducted as part of an emergency response (clinic to administer H ₁ N ₁ vaccine or another type of vaccine during an outbreak)	35	78%	5	11%	3	7%	2	4%
Provide immunization during designated clinic(s) co-located with other public health services (e.g., an immunization clinic at the same time and location as a WIC clinic)	17	38%	14	31%	11	24%	3	7%

Minnesota community health boards intentionally re-examining role in providing immunization services, 2015 (n=48)



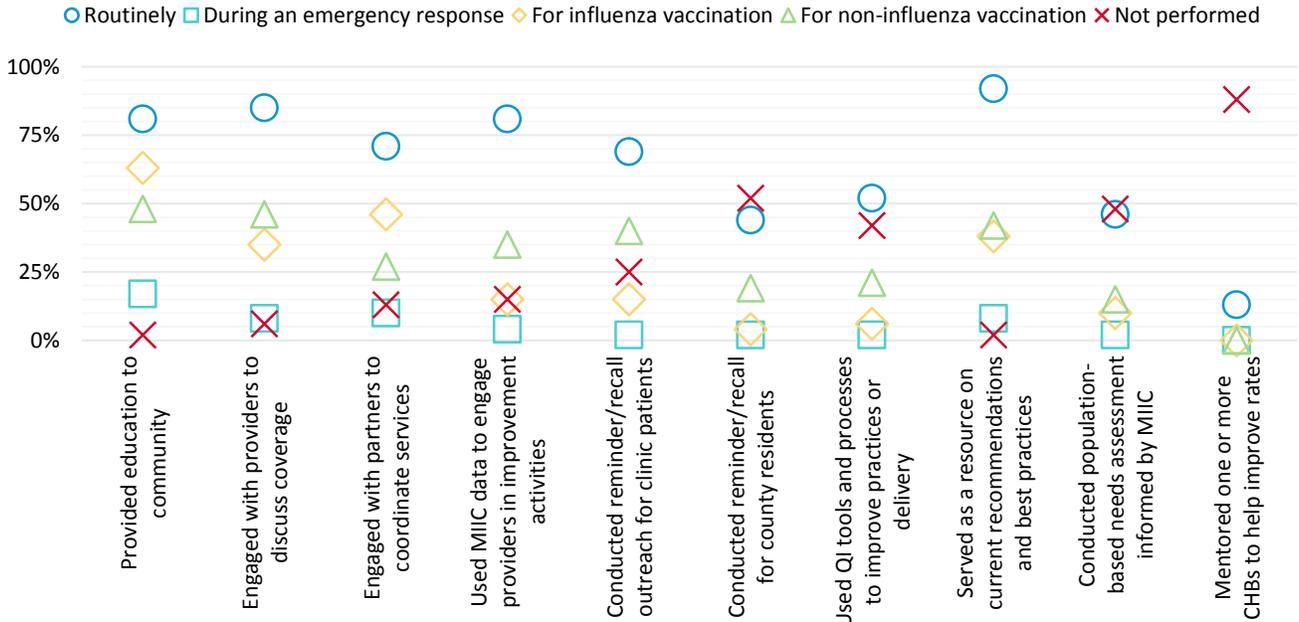
Intentional re-examination of role in providing immunization services 3. Is your community health board intentionally re-examining its role in providing immunization services? (Select the best response.)	Minnesota 2015 (n=48)	
	#	%
No	24	50%
No, but recently completed	6	13%
Yes, currently underway	14	29%
Yes, planned	4	8%

Minnesota community health boards that refer clients for immunizations, 2015 (n=48)



Referring clients for immunizations 4. Does your community health board refer clients for immunizations (e.g., medical home, Federally Qualified Health Center, Rural Health Clinic, etc.)? (Select the best response.)	Minnesota 2015 (n=48)	
	#	%
No	6	13%
Yes, though doing less in recent years	8	17%
Yes; relatively stable in recent years	24	50%
Yes; doing more in recent years	10	21%

Immunization-related activities performed by Minn. community health boards, 2015 (n=48)



Immunization-related activities 5. Which of the following immunization-related activities did your community health board perform last year? (Check all that apply.)	Minnesota, 2015 (n=48)									
	Routinely		During an emergency response		For influenza vaccination		For non-influenza vaccination		Not performed	
	#	%	#	%	#	%	#	%	#	%
Provided education to the community	39	81%	8	17%	30	63%	23	48%	1	2%
Engaged with immunization providers to discuss immunization coverage	41	85%	4	8%	17	35%	22	46%	3	6%
Engaged with partners to coordinate services	34	71%	5	10%	22	46%	13	27%	6	13%
Used MIIC data to engage immunization providers in immunization improvement activities	39	81%	2	4%	7	15%	17	35%	7	15%
Conducted reminder/recall outreach for county/community health board clinic patients	33	69%	1	2%	7	15%	19	40%	12	25%
Conducted reminder/recall for county residents	21	44%	1	2%	2	4%	9	19%	25	52%
Used QI tools and processes to improve immunization practices or delivery in the community health board	25	52%	1	2%	3	6%	10	21%	20	42%
Served as a resource [to immunization providers in your community health board's jurisdiction] on current recommendations and best practices regarding immunization	44	92%	4	8%	18	38%	20	42%	1	2%
Conducted population-based needs assessment informed by immunization coverage levels in MIIC	22	46%	1	2%	5	10%	7	15%	23	48%
Mentored one or more community health boards to help them improve immunization rates	6	13%	0	0%	0	0%	0	0%	42	88%
Other	1	2%	0	0%	0	0%	0	0%	47	98%

Infectious Disease Services

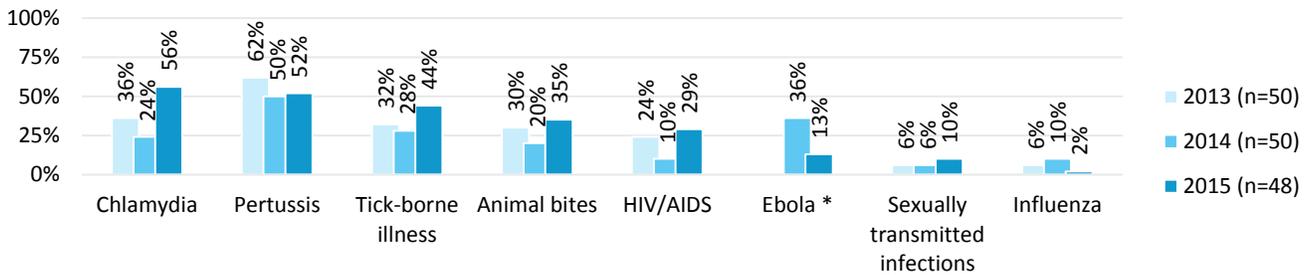
Controlling communicable diseases is perhaps the oldest and most fundamental public health responsibility. For decades, it was the primary responsibility of local boards of health and, in fact, the main reason for their creation. In Minnesota, it is a statutory mandate of local boards of health to control communicable diseases in their jurisdiction.

MORE INFORMATION

MDH Infectious Disease Epidemiology, Prevention and Control Division, Field Services Epidemiologists
 651-201-5414 | www.health.state.mn.us/divs/idepc/epis.html

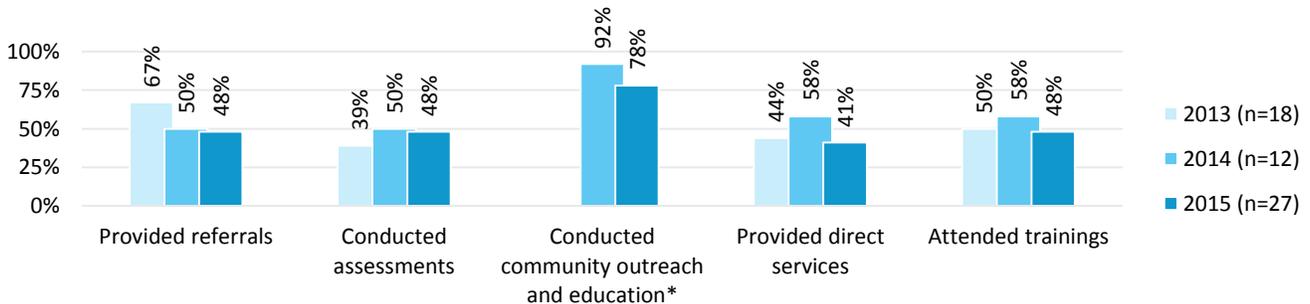
Change: Minnesota community health boards' significant involvement in infectious disease-related prevention, 2013-2015

"Significant involvement" relates to staff resources (i.e., time spent and activities performed by staff in your community health board), not necessarily the number of cases of a particular infection.



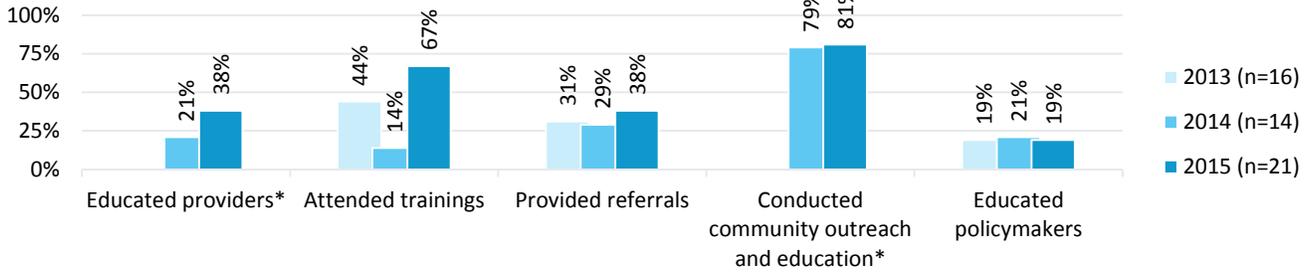
Involvement in infectious disease-related prevention		
6. If your community health board was significantly involved in other infectious disease-related prevention, activities, or services, please indicate its focus on the following list. (Check all that apply.) <i>"Significant involvement" relates to staff resources (i.e., time spent and activities performed by staff in your community health board), not necessarily the number of cases of a particular infection.</i>	Minnesota 2015 (n=48)	
	#	%
Chlamydia	27	56%
Tick-borne illness	21	44%
Animal bites	17	35%
Pertussis	25	52%
HIV/AIDS	14	29%
Tuberculosis	14	29%
Ebola	5	10%
Sexually transmitted infections (other than chlamydia)	5	10%
Other	22	46%
None of the above	8	17%

Greatest change: Ways in which Minnesota community health boards most frequently addressed *chlamydia*, 2013-2015



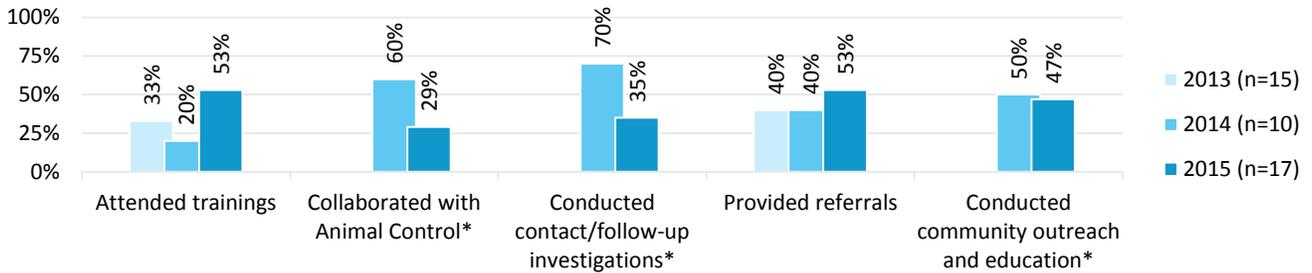
*Not asked in 2013.

Greatest change: Ways in which Minn. community health boards most frequently addressed *tick-borne illness*, 2013-2015



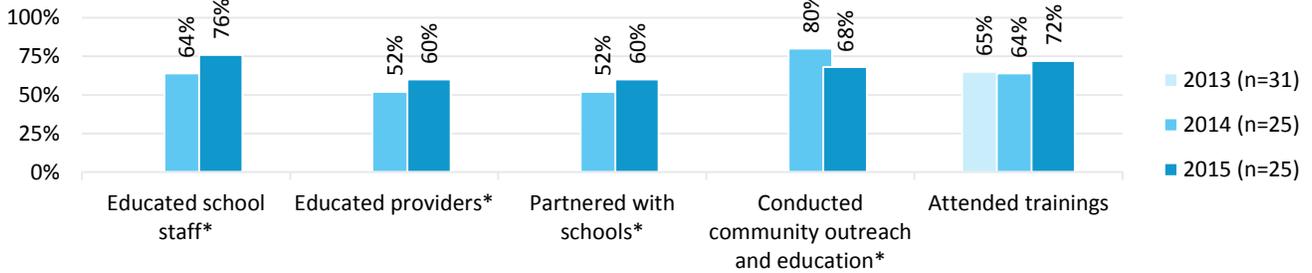
*Not asked in 2013.

Greatest change: Ways in which Minn. community health boards most frequently addressed *animal bites*, 2013-2015



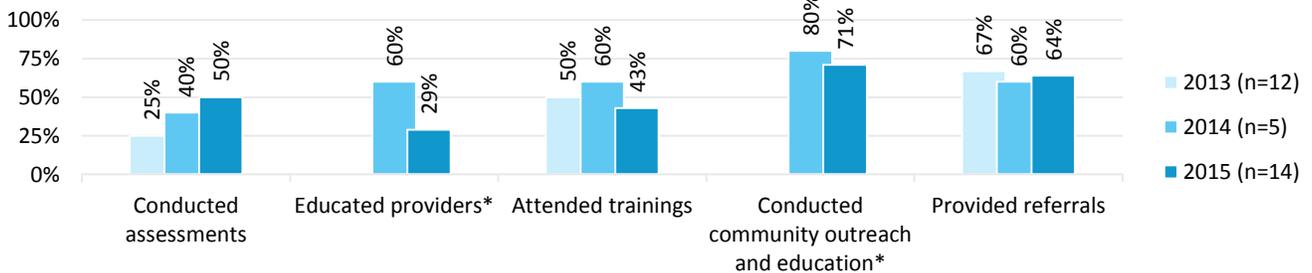
*Not asked in 2013.

Greatest change: Ways in which Minnesota community health boards most frequently addressed *pertussis*, 2013-2015



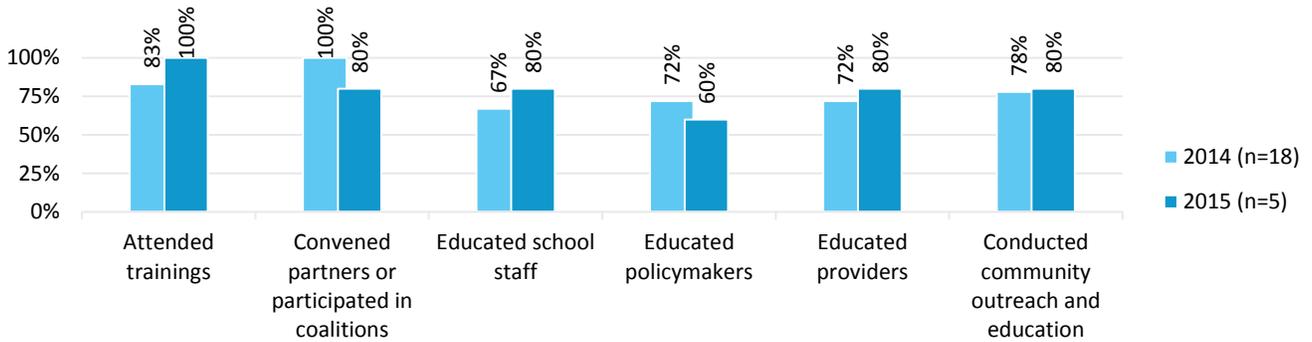
*Not asked in 2013.

Greatest change: Ways in which Minnesota community health boards most frequently addressed *HIV/AIDS*, 2013-2015

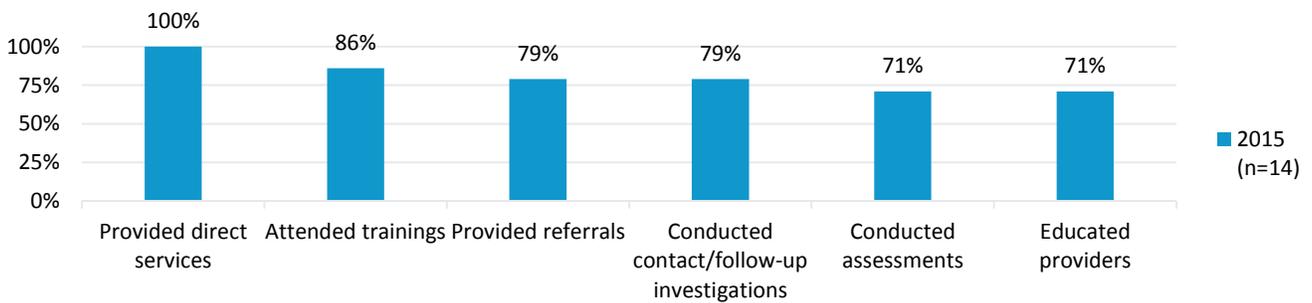


*Not asked in 2013.

Greatest change: Ways in which Minnesota community health boards most frequently addressed *Ebola*, 2014-2015



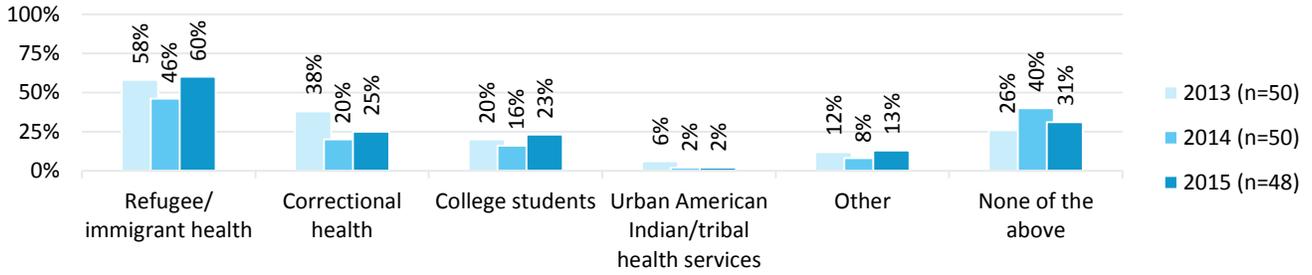
Ways in which Minnesota community health boards most frequently addressed *tuberculosis*, 2015*



* Different question/methodology used to determine local public health involvement with tuberculosis from 2014-2015.

Ways in which community health boards most frequently addressed common infectious diseases 6a. How did your community health board address... (Check all that apply.) For those community health boards that selected the infectious diseases listed at right.	Minnesota, 2015						
	Chlamydia (n=27)	Tick-borne illness (n=21)	Animal bites (n=17)	Pertussis (n=25)	HIV/AIDS (n=14)	Write in: Tuberculosis (n=14)	Write in: Ebola (n=5)
Attended trainings	48%	67%	53%	72%	43%	86%	100%
Conducted assessments	48%	5%	41%	40%	50%	71%	40%
Convened partners or participated in coalitions	19%	10%	18%	28%	14%	43%	80%
Provided direct services	41%	--	--	20%	36%	100%	0%
Provided referrals	48%	38%	53%	44%	64%	79%	20%
Educated policymakers	30%	19%	12%	32%	14%	36%	60%
Educated providers	22%	38%	18%	60%	29%	71%	80%
Conducted community outreach and education	78%	81%	47%	68%	71%	43%	80%
Reported cases	26%	--	--	--	14%	64%	0%
Educated school staff	--	--	--	76%	--	36%	80%
Partnered with schools	--	--	--	60%	--	43%	20%
Contracted with other entities to provide services	30%	--	--	8%	21%	43%	0%
Conducted contact/follow-up investigations	11%	--	35%	52%	--	79%	20%
Voluntary quarantine/isolation	--	--	--	--	--	57%	0%
Collaboration with Animal Control	--	--	29%	--	--	--	--
None of the above	0%	0%	0%	0%	0%	0%	0%

Change: Minnesota community health board involvement in infectious disease-related prevention, 2013-2015



Involvement in infectious disease-related prevention		Minnesota 2015 (n=48)	
7. Please indicate whether your community health board was significantly involved in infectious disease surveillance, prevention, and control with any of the specific populations listed below. (Check all that apply.)		#	%
Refugee/immigrant health		29	60%
Correctional health		12	25%
Urban American Indian/tribal health services		1	2%
College students		11	23%
Other		6	13%
None of the above		15	31%

Protect Against Environmental Health Hazards

In this area of responsibility:

- [Indoor Air: Minnesota Clean Indoor Air Act](#)
- [Indoor Air: Mold](#)
- [Blood Lead](#)
- [Drinking Water Protection and Well Management](#)
- [Extreme Weather](#)
- [Nuisance Investigations](#)
- [Emerging Issues](#)

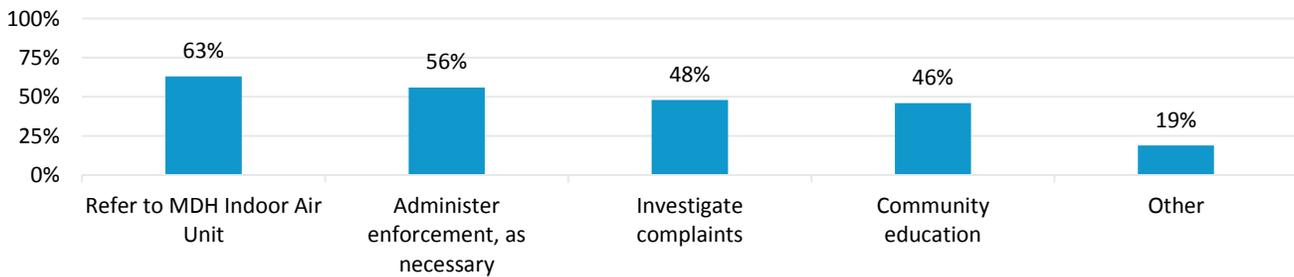
Indoor Air: Minnesota Clean Indoor Air Act

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

MORE INFORMATION

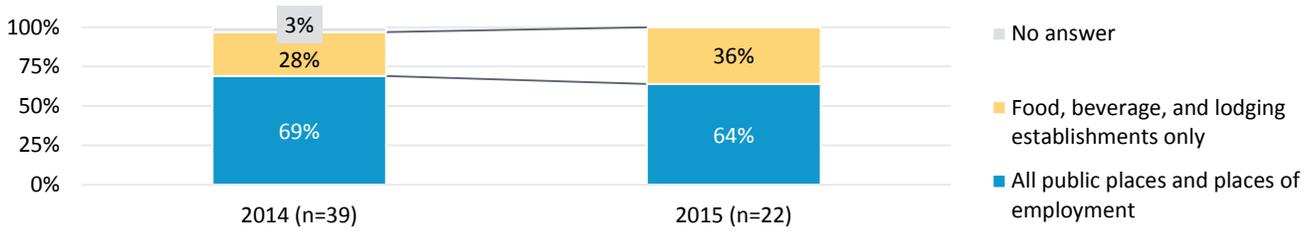
MDH Environmental Health Division, Indoor Environments and Radiation Section
 651-201-4601 | health.indoorair@state.mn.us
www.health.state.mn.us/divs/eh/indoorair/mciaa/ftb/

Ways in which Minnesota community health boards support the Minnesota Clean Indoor Air Act, 2015 (n=48)



Ways in which community health boards support the Minnesota Clean Indoor Air Act 1. How does your community health board support the Minnesota Clean Indoor Air Act? (Check all that apply.)	Minnesota 2015 (n=48)	
	#	%
Refer to MDH Indoor Air Unit	30	63%
Investigate complaints	23	48%
Administer enforcement, as necessary	22	46%
Community education	27	56%
Other	9	19%
None of the above	4	8%

Change: Types of facilities for which Minnesota community health boards enforce MCIAA, 2014-2015



Types of facilities for which community health boards enforce the Minnesota Clean Indoor Air Act 1a. For what types of facilities does your community health board enforce the Minnesota Clean Indoor Air Act? (Select one.) Among those community health boards that selected "administer enforcement, as necessary" from Q1, above.	Minnesota 2015 (n=22)	
	#	%
All public places and places of employment	14	64%
Food, beverage, and lodging establishments only	8	36%

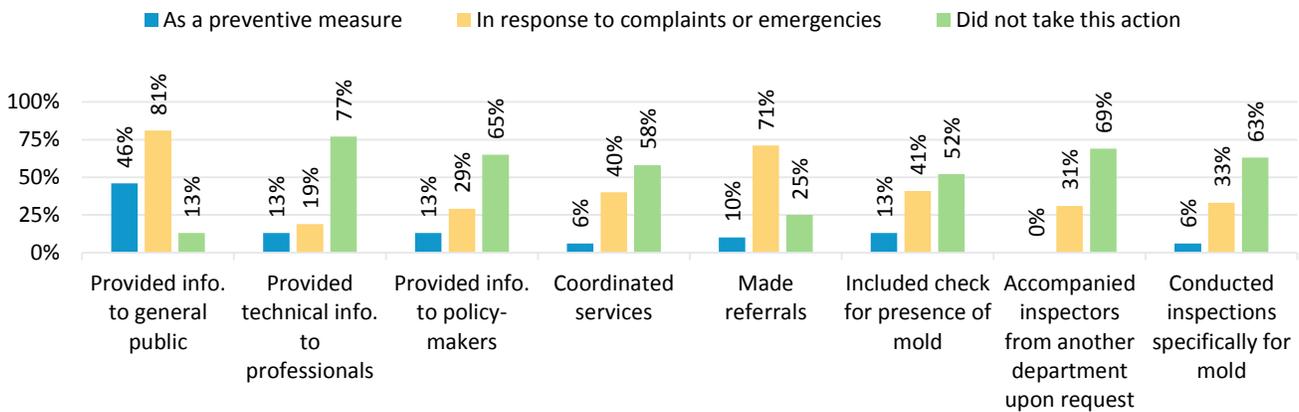
Indoor Air: Mold

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

MORE INFORMATION

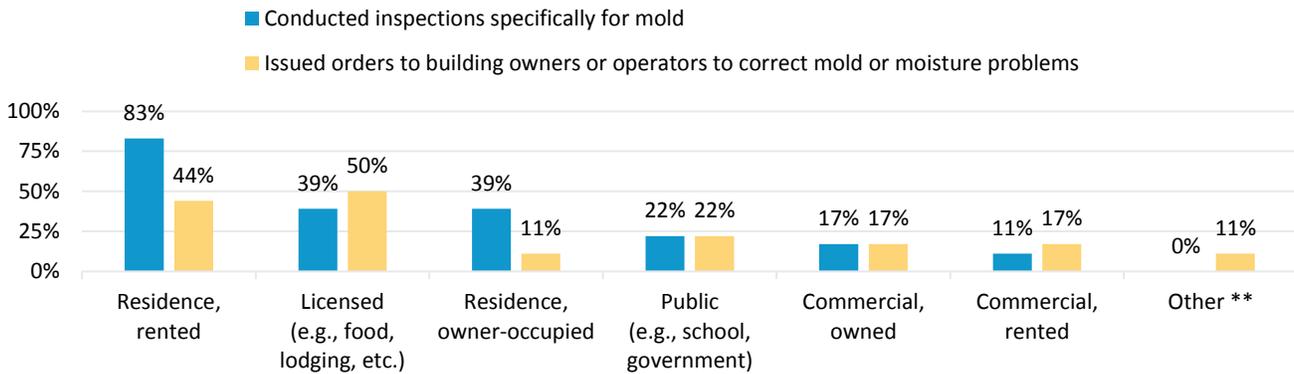
MDH Environmental Health Division, Indoor Air Program
 651-201-4601 | health.indoorair@state.mn.us
www.health.state.mn.us/divs/eh/indoorair/mold/

Mold-related actions taken by Minnesota community health boards, 2015 (n=48)



Mold-related actions taken by community health boards 2. Identify the actions related to mold taken by your community health board in the past year, and indicate whether the action taken was as a preventive measure, in response to complaints/emergencies, or both. (Check all that apply.)	Minnesota, 2015 (n=48)					
	As a preventive measure		In response to complaints or emergencies		Did not take this action	
	#	%	#	%	#	%
Provided information (including training) to the general public	22	46%	39	81%	6	13%
Provided technical information (including training) to professionals	6	13%	9	19%	37	77%
Provided information to policymakers	6	13%	14	29%	31	65%
Coordinated services	3	6%	19	40%	28	58%
Made referrals	5	10%	34	71%	12	25%
Included a check for the presence of mold	6	13%	20	41%	25	52%
Accompanied inspectors from another department upon request	0	0%	15	31%	33	69%
Conducted inspections specifically for mold	3	6%	16	33%	30	63%

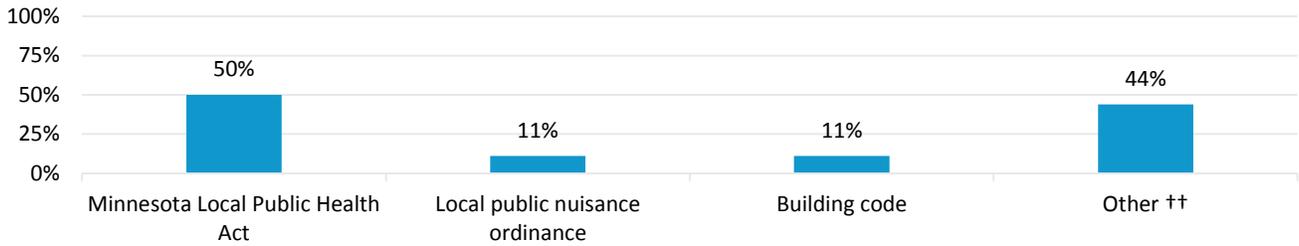
Actions taken by Minnesota community health boards that conducted inspections specifically for mold, 2015 (n=18)



Actions taken by comm. health boards that conducted inspections specifically for mold 2a. If your community health board conducted inspections specifically for mold, what types of establishments were inspected? (Check all that apply.) 2b. If your community health board conducted inspections specifically for mold, does the community health board issue orders to building owners or operators to correct mold or moisture problems? (If yes, check all that apply.) <i>For those community health boards that selected “conducted inspections specifically for mold as a preventive measure” and/or “conducted inspections specifically for mold in response to complaints or emergencies” in Q2, above.</i>	Minnesota, 2015 (n=18)			
	Conducted inspections specifically for mold		Issued orders to building owners or operators to correct mold or moisture problems	
	#	%	#	%
Residence, owner-occupied	7	39%	2	11%
Residence, rented	15	83%	8	44%
Commercial, owned	3	17%	3	17%
Commercial, rented	2	11%	3	17%
Licensed (e.g., food, lodging, etc.)	7	39%	9	50%
Public (e.g., school, government)	4	22%	4	22%
Other **	0	0%	2	11%
Community health board does not issue orders to building owners or operators to correct mold or moisture problems	---	---	5	28%

** Data limitations exist due to some reporting inconsistencies within community health boards. For example, one community health board reported “other” and wrote in that they only issue recommendations, but then indicated the statute/rule/ordinance cited when they issued orders.

Statutes, rules, and ordinances cited by Minnesota community health boards that issue orders regarding mold, 2015 (n=18)



Statutes, rules, ordinances cited by community health boards that issue orders regarding mold 3. If the community health board issues orders regarding mold, what statute, rule, or ordinance is cited? (Check all that apply.) For those community health boards that selected “conducted inspections specifically for mold as a preventive measure” and/or “conducted inspections specifically for mold in response to complaints or emergencies” in Q2, above.	Minnesota 2015 (n=18)	
	#	%
Minnesota Local Public Health Act (Minn. Stat. § 145A.04)	9	50%
Local public nuisance ordinance	2	11%
Building code	2	11%
Other **	8	44%

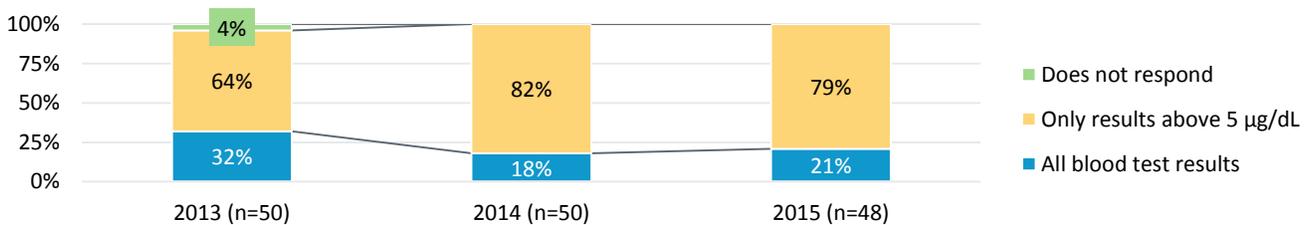
Blood Lead

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

MORE INFORMATION

MDH Environmental Health Division, Health Risk Intervention Unit
 651-201-4620 | health.asbestos-lead@state.mn.us
www.health.state.mn.us/divs/eh/lead/

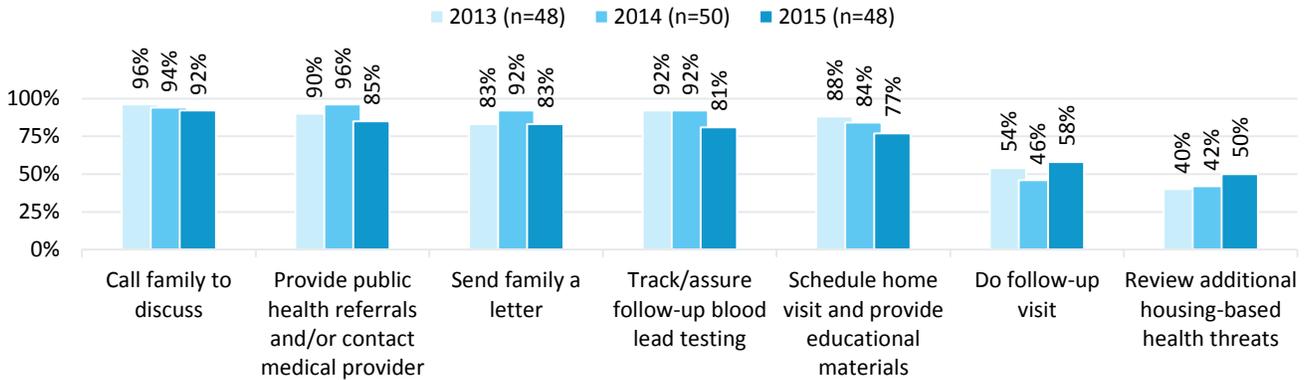
Change: Minnesota community health board response to elevated blood lead levels, 2013-2015



** Data limitations exist due to some reporting inconsistencies within community health boards. For example, one community health board reported “other” and wrote in that they only issue recommendations, but then indicated the statute/rule/ordinance cited when they issued orders.

Response to elevated blood lead levels	Minnesota 2015 (n=48)	
4. How does your community health board respond to elevated blood lead levels above 5.0 µg/dL? (Select one.)	#	%
Community health board responds to all blood lead test results, regardless of level	10	21%
Community health board only responds to results above 5 µg/dL	38	79%
Community health board does not respond to elevated blood lead test results	0	0%
Not applicable: Community health board did not receive blood lead test results during reporting period	0	0%

Change: Minnesota community health board response to elevated blood lead (all response levels), 2014-2015



Response to elevated blood lead, by level required for response	Minnesota 2015 (n=48)	
4a. How does your community health board respond to elevated blood lead levels? (Check all that apply.)	#	%
Send family a letter	40	83%
Call family to discuss	44	92%
Schedule home visit and provide educational materials	37	77%
Track/assure follow-up blood lead testing	39	81%
Provide public health referrals (e.g., WIC, MA, follow-up testing) and/or contact medical provider	41	85%
Review additional housing-based health threats (e.g., Healthy Homes)	24	50%
Do follow-up visit	28	58%
Other	12	25%

Drinking Water Protection and Well Management

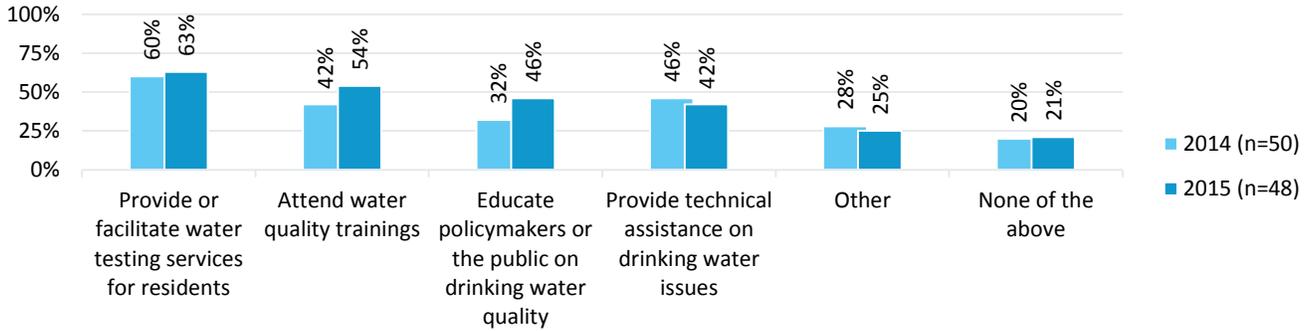
Public health helps protect drinking water supplies by reducing the potential for contamination.

MORE INFORMATION

MDH Environmental Health Division, Drinking Water Protection Program
 651-201-4700 | health.drinkingwater@state.mn.us
www.health.state.mn.us/divs/eh/water/

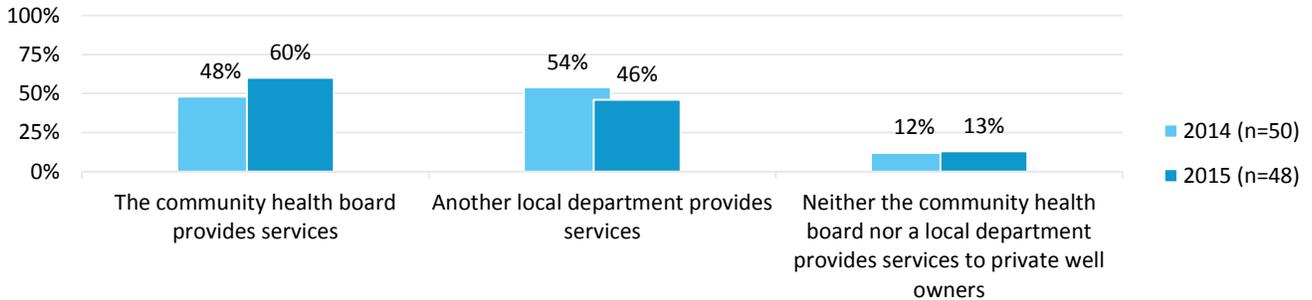
MDH Environmental Health Division, Well Management Section
 651-201-4600 | health.wells@state.mn.us
www.health.state.mn.us/divs/eh/wells/

Change: Ways in which Minnesota community health boards consider/address drinking water quality, 2014-2015**



Considering/addressing drinking water quality** 5. How has your community health board considered or addressed drinking water quality? (Check all that apply.)	Minnesota 2015 (n=48)	
	#	%
Attend water quality trainings	26	54%
Educate policymakers or the public on drinking water quality	22	46%
Provide technical assistance on drinking water issues	20	42%
Provide or facilitate water testing services for residents	30	63%
Other	12	25%
None of the above	10	21%

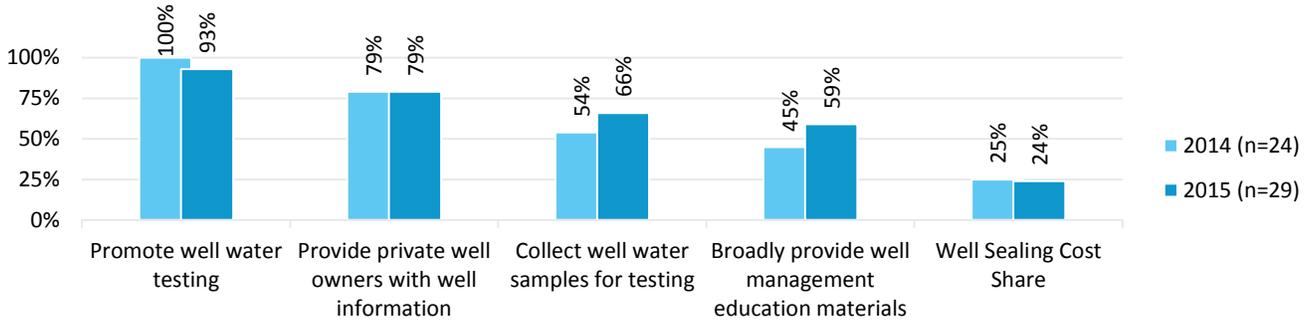
Change: Extent of services provided to private well owners in jurisdictions served by Minnesota community health boards, 2014-2015



Extent of services provided to private well owners in jurisdictions served by community health boards 6. Does your community health board or another local department provide any services to private well owners in the jurisdiction served by your community health board? (Check all that apply.)	Minnesota 2015 (n=48)	
	#	%
The community health board provides services	29	60%
Another local department provides services	22	46%
Neither the community health board nor a local department provides services to private well owners	6	13%

** "Drinking" was added to "water quality" in question stem for 2015.

Change: Services provided to private well owners in jurisdictions served by Minnesota community health boards, among those that provide services to private well owners, 2014-2015



Services provided to private well owners in jurisdictions served by community health boards, among those that provide services to private well owners	Minnesota 2015 (n=29)	
	#	%
6a. What services are provided to private well owners in the jurisdiction served by your community health board? (Check all that apply.) <i>Among those community health boards that selected "the community health board provides services" in Q6, above.</i>		
Collect well water samples for testing	19	66%
Promote well water testing	27	93%
Provide private well owners with well information	23	79%
Broadly provide well management education materials	17	59%
Well Sealing Cost Share	7	24%

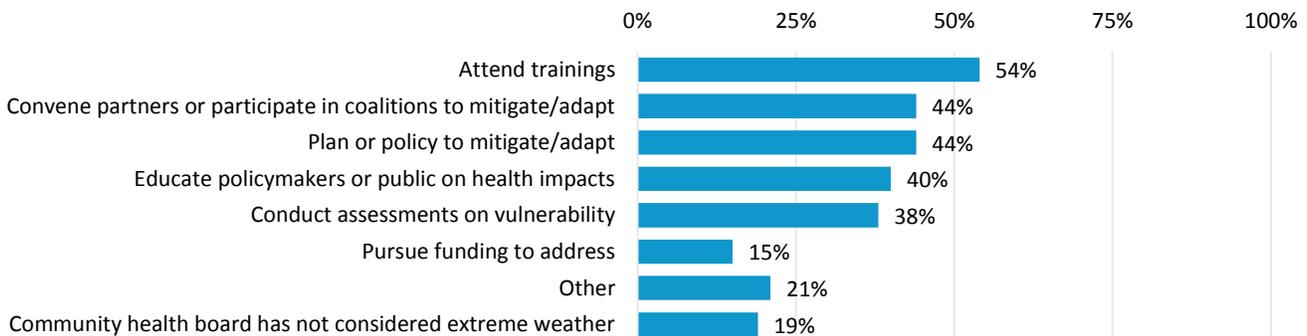
Extreme Weather

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

MORE INFORMATION

MDH Environmental Health Division, Environmental Surveillance and Assessment Section,
 Environmental Impacts Analysis Unit
 651-201-4899 | health.climatechange@state.mn.us
www.health.state.mn.us/divs/climatechange/

Ways in which Minnesota community health boards have considered extreme weather, 2015 (n=48)



Considering extreme weather 7. How has your community health board considered or addressed extreme weather? (Check all that apply.)	Minnesota 2015 (n=48)	
	#	%
Attend extreme weather trainings	26	54%
Educate policymakers or the public on the health impacts of extreme weather	19	40%
Convene partners or participate in coalitions to mitigate or adapt to extreme weather	21	44%
Develop or implement a plan or policy to mitigate or adapt to extreme weather (e.g., heat response plan or policy to turn vacant lots into community gardens)	21	44%
Conduct assessments on extreme weather vulnerability	18	38%
Pursue funding to address extreme weather (e.g., grants)	7	15%
Other	10	21%
Community health board has not considered extreme weather	9	19%

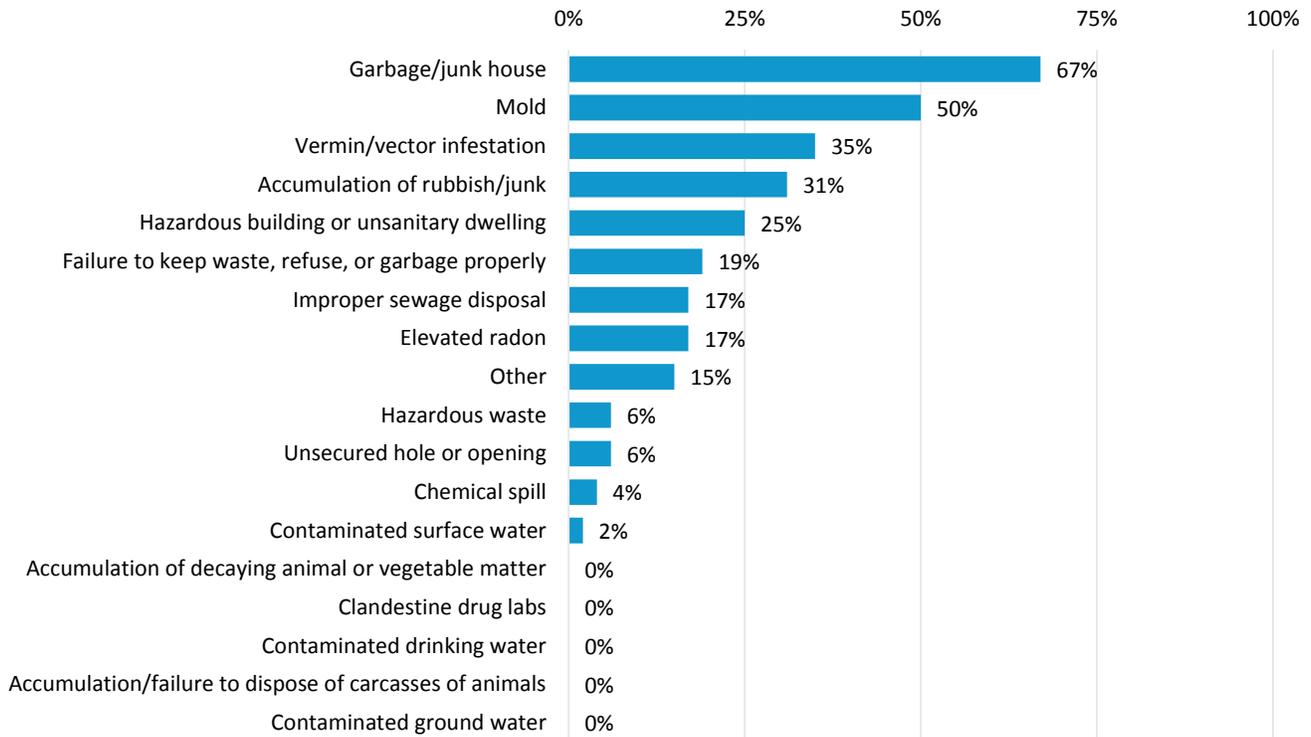
Nuisance Investigations

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

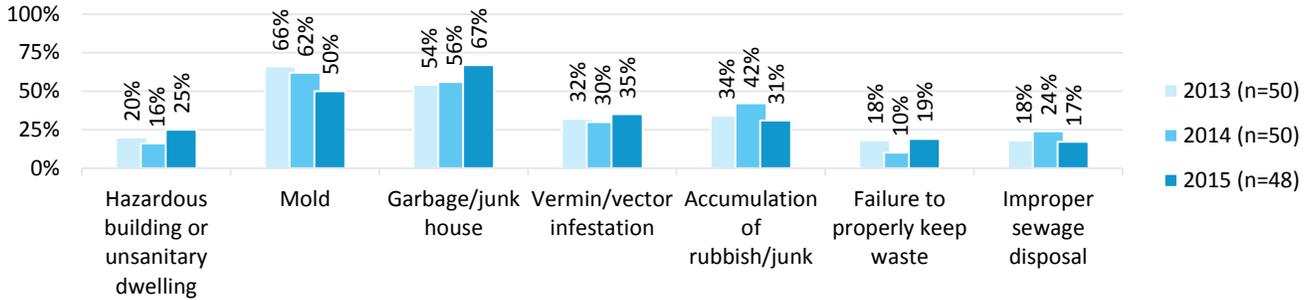
[MORE INFORMATION](#)

MDH Environmental Health Division
 651-201-4571

Environmental health complaints addressed by Minnesota community health boards, 2015 (n=48)

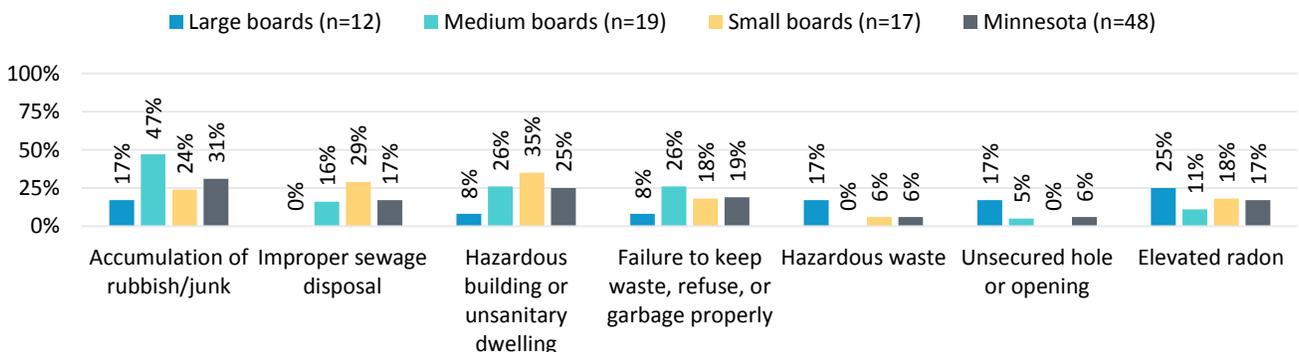


Greatest change: Environmental health complaints most commonly addressed by Minnesota community health boards, 2013-2015

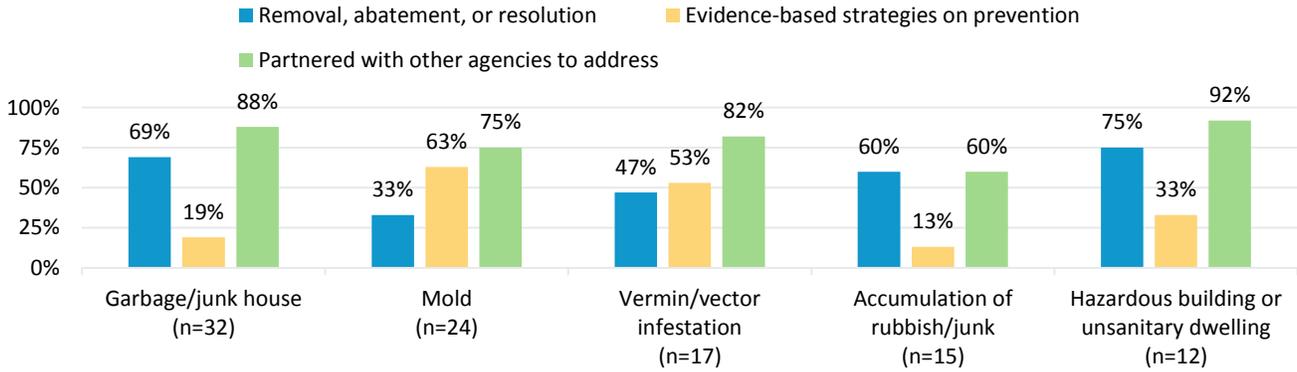


Most commonly addressed environmental health complaints 8. What were the three most commonly addressed complaints in your community health board? (Check no more than three.)	Minnesota 2015 (n=48)	
	#	%
Garbage/junk house	32	67%
Mold	24	50%
Improper sewage disposal, discharging to surface/groundwater/into structure	8	17%
Accumulation of rubbish or junk	15	31%
Accumulation of decaying animal or vegetable matter	0	0%
Hazardous building or unsanitary dwelling	12	25%
Vermin or vector infestations	17	35%
Clandestine drug labs	0	0%
Failure to keep waste, refuse, or garbage properly	9	19%
Contaminated drinking water	0	0%
Elevated radon	8	17%
Contaminated surface water	1	2%
Hazardous waste	3	6%
Unsecured hole or opening (abandoned well, well pit, sewage treatment system, non-maintained swimming pool, mine shaft, tunnel)	3	6%
Accumulation of carcasses of animals or failure to dispose of carcasses in a sanitary manner	0	0%
Chemical spill	2	4%
Contaminated ground water	0	0%
Other	7	15%
None of the above	1	2%

Comparison: Environmental health complaints most frequently addressed by Minnesota community health boards, by population and greatest spread, 2015



Ways in which Minnesota community health boards addressed most common environmental health complaints, 2015



Methods by which community health boards addressed most common environmental health complaints 8a. How did your community health board address the complaints checked above? (Check all that apply.)	n	Minnesota, 2015					
		Removal, abatement, or resolution		Evidence-based strategies on prevention		Partnered with other agencies to address	
		#	%	#	%	#	%
Garbage/junk house	32	22	69%	6	19%	28	88%
Mold	24	8	33%	15	63%	18	75%
Improper sewage disposal, discharging to surface/groundwater/into structure	8	7	88%	2	25%	5	63%
Accumulation of rubbish or junk	15	9	60%	2	13%	9	60%
Hazardous building or unsanitary dwelling	12	9	75%	4	33%	11	92%
Vermin or vector infestations	17	8	47%	9	53%	14	82%
Failure to keep waste, refuse, or garbage properly	9	4	44%	0	0%	7	78%
Elevated radon	8	2	25%	8	100%	6	75%
Contaminated surface water	1	0	0%	0	0%	1	100%
Hazardous waste	3	2	67%	2	67%	3	100%
Unsecured hole or opening (abandoned well, well pit, sewage treatment system, non-maintained swimming pool, mine shaft, tunnel)	3	3	100%	1	33%	3	100%
Chemical spill	2	1	50%	0	0%	2	100%
Other	7	5	71%	4	57%	7	100%

Assure Health Services

In this area of responsibility:

- [Clinical-Community Linkages](#)
- [Barriers and Services](#)
- [Provision of Public Health Services](#)

Clinical-Community Linkages

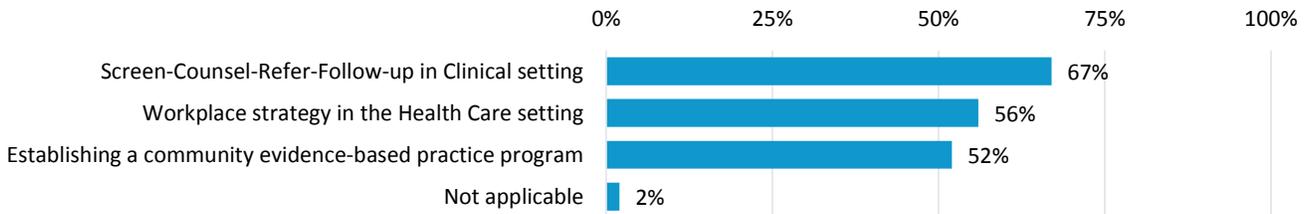
There is growing local, state, and national awareness about the importance of clinical-community linkages to support health promotion and prevention activities, and facilitate smooth health care delivery. This question characterizes the role of public health in such activities.

MORE INFORMATION

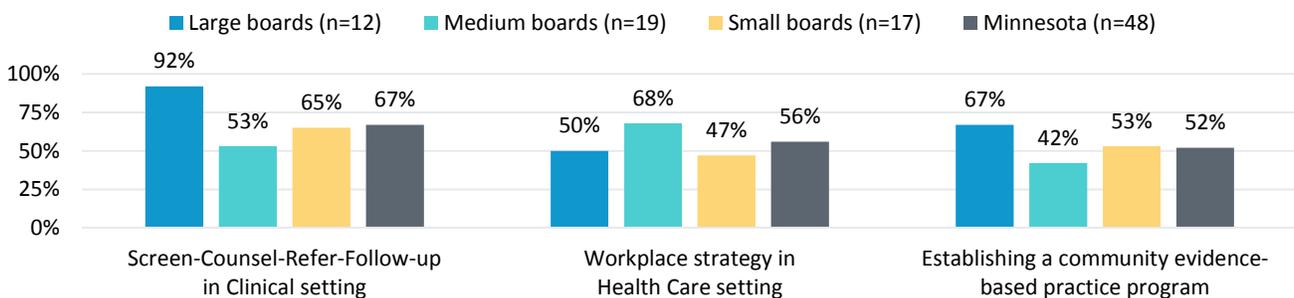
MDH Office of Statewide Health Improvement Initiatives
651-201-5443 | Health.OSHII@state.mn.us
www.health.state.mn.us/divs/oshii/

MDH Health Promotion and Chronic Disease Division
651-201-3600 | www.health.state.mn.us/divs/hpcd/

Ways in which Minnesota community health boards promoted clinical-community linkages, 2015 (n=48)



Comparison: Ways in which Minnesota community health boards promoted clinical-community linkages, 2015 (n=48)



Methods used to promote clinical-community linkages 1. How has your community health board promoted clinical-community linkages for prevention? (Check all that apply.)	Minnesota 2015 (n=48)	
	#	%
Workplace strategy in the Health Care setting	27	56%
Screen-Counsel-Refer-Follow-up in Clinical setting	32	67%
Establishing a community evidence-based practice program	25	52%
Not applicable	2	4%

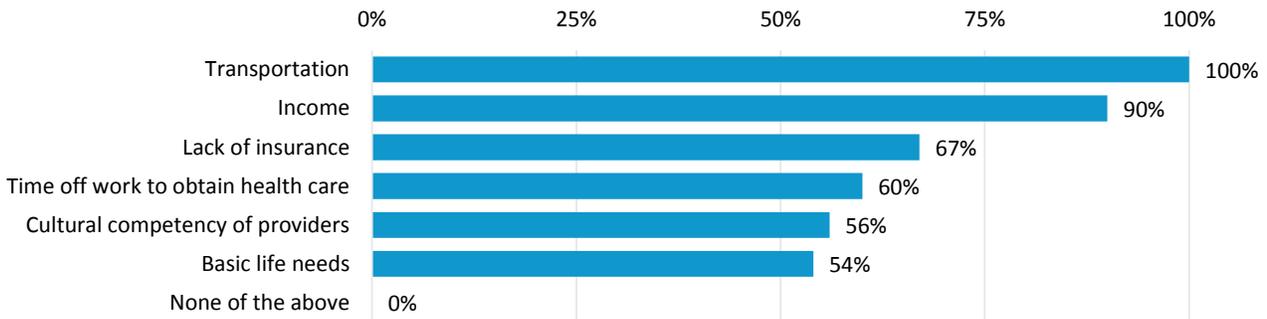
Barriers and Services

Access to health care is an important factor in promoting health. These questions reflect the type and extent of direct care services provided by community health boards, as well barriers and gaps in health care provision across the state.

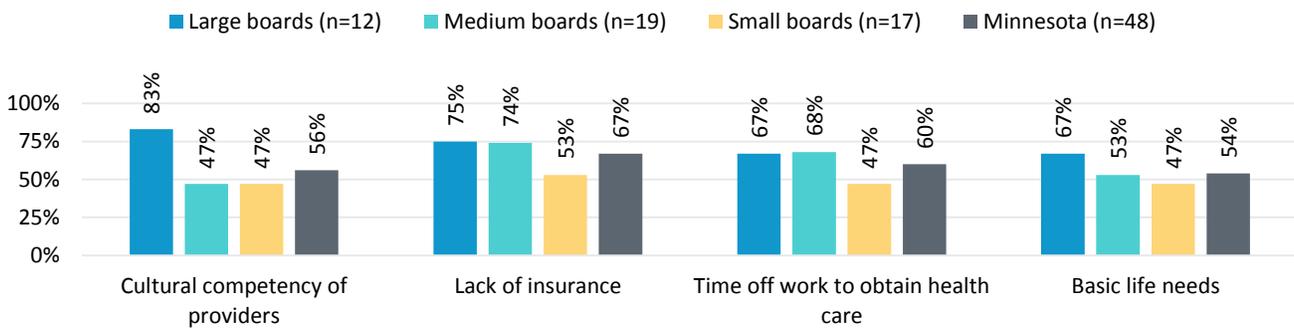
MORE INFORMATION

MDH Office of Rural Health and Primary Care
651-201-3838 | health.orhpc@state.mn.us
www.health.state.mn.us/divs/orhpc

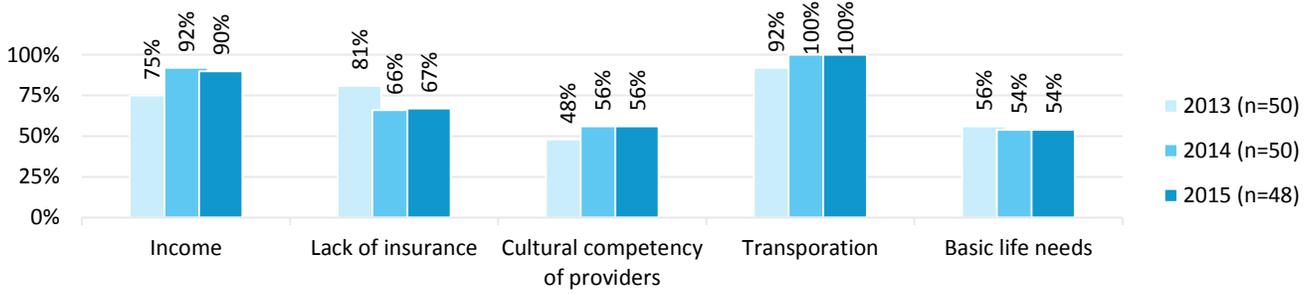
Basic needs: Barriers to health care services in the communities served by Minnesota community health boards, 2015 (n=48)



Basic needs: Comparison: Barriers to health care services in the communities served by Minnesota community health boards, by population, 2015

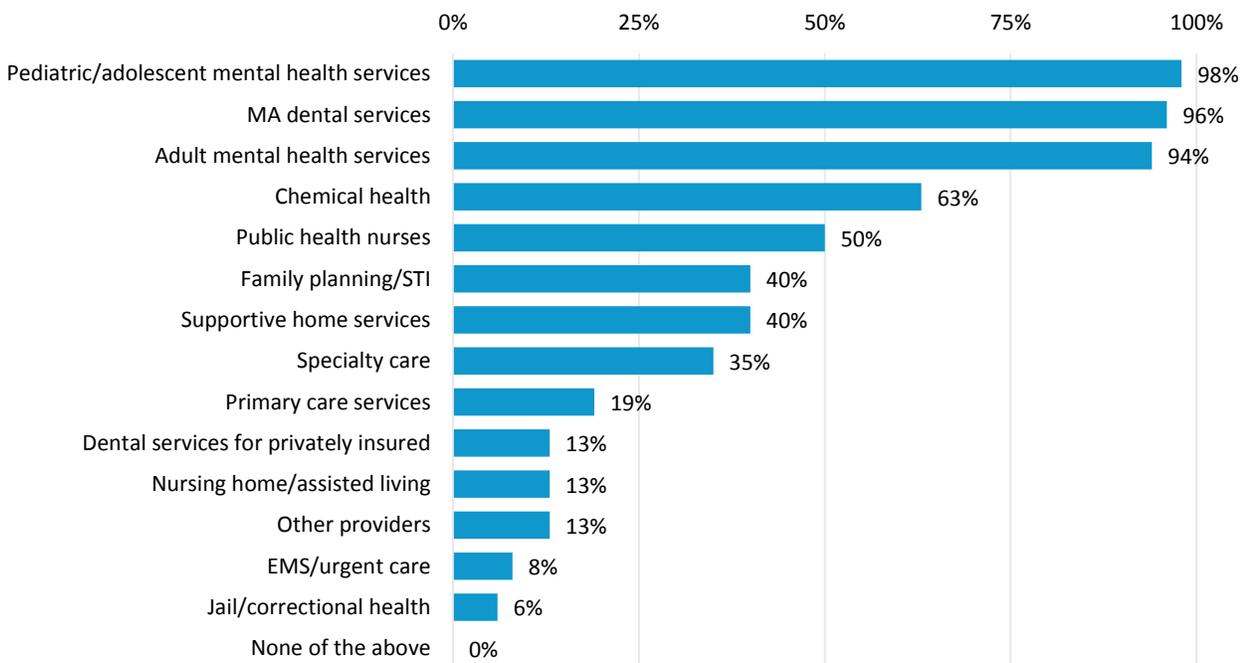


Basic needs: Greatest change: Barriers to health care services in the communities served by Minnesota community health boards, 2013-2015

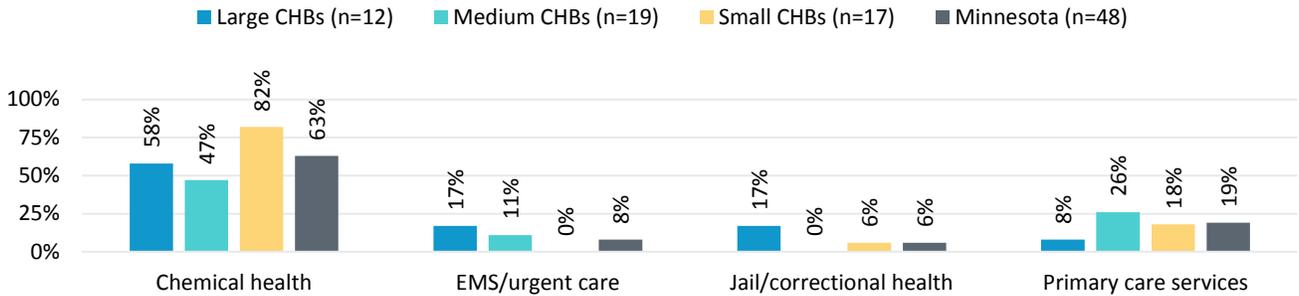


Barriers to health care services: Basic needs		Minnesota 2015 (n=48)	
2. Identify barriers to health care services in the community/communities served by your community health board. (Check all that apply.)		#	%
Transportation		48	100%
Lack of insurance		32	67%
Income		43	90%
Cultural competency of providers		27	56%
Basic life needs		26	54%
Time off work to obtain health care		29	60%
None of the above		0	0%

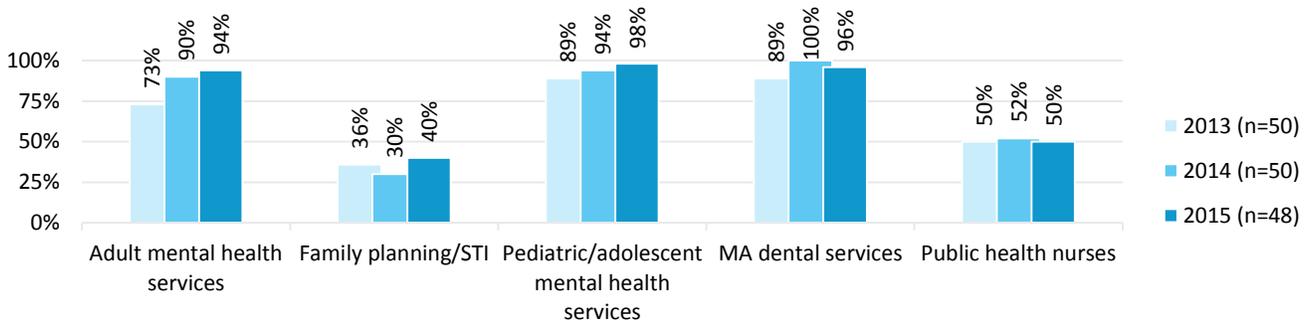
Lack of services and/or providers: Barriers to health care services in the communities served by Minnesota community health boards, 2015 (n=48)



Lack of services and/or providers: Comparison: Barriers to health care services in the communities served by Minnesota community health boards, 2015

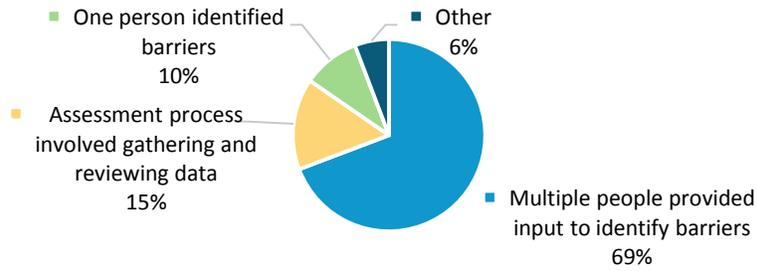


Lack of services and/or providers: Greatest change: Barriers to health care services in the communities served by Minnesota community health boards, 2013-2015



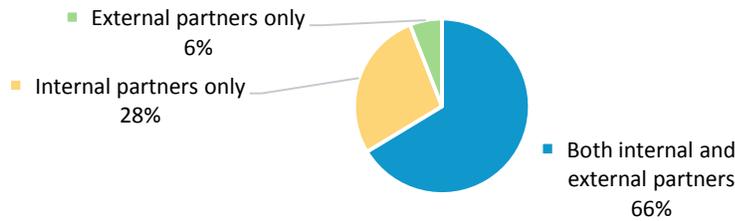
Barriers to health care services: Lack of services/providers		Minnesota 2015 (n=48)	
2. Identify barriers to health care services in the community/communities served by your community health board. (Check all that apply.)		#	%
Adult mental health services		45	94%
Pediatric/adolescent mental health services		47	98%
Family planning/STI		19	40%
MA dental services		46	96%
EMS/urgent care		4	8%
Chemical health		30	63%
Supportive home services		19	40%
Jail/correctional health		3	6%
Dental services for privately insured		6	13%
Nursing home/assisted living		6	13%
Primary care services		9	19%
Specialty care		17	35%
Public health nurses		24	50%
Other providers		6	13%
None of the above		0	0%

Ways in which Minnesota community health boards identified barriers to health care, 2015 (n=48)



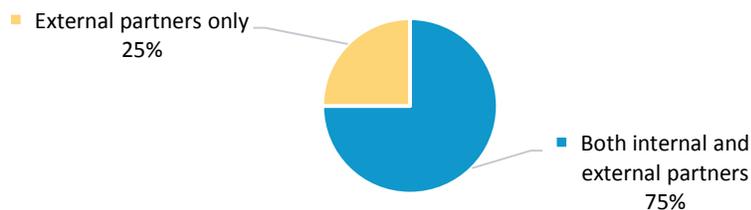
Methods used to identify barriers to health care 2a. How did you identify the health care barriers in your community health board? (Choose the best response.) <i>For those community health boards that identified any barriers in Q2, above.</i>	Minnesota 2015 (n=48)	
	#	%
One person identified the barriers based knowledge of the jurisdiction and/or clients; we did not assemble or review quantitative data	5	10%
Multiple people provided input to identify the barriers based on knowledge of the jurisdiction and/or clients; we did not assemble or review quantitative data	36	75%
An assessment process involved gathering and reviewing quantitative data	8	17%
Other	3	6%

Partners engaged by Minnesota community health boards that used multiple people to provide input on barriers to health care, 2015 (n=36)



Partners engaged by community health boards that used multiple people to provide input on barriers to health care 2b. If multiple people provided input to identify the barriers based on knowledge of the jurisdiction and/or clients, please indicate which partners you engaged. (Check all that apply.) <i>For those community health boards that selected "multiple people provided input" in Q2a, above.</i>	Minnesota 2015 (n=36)	
	#	%
Internal partners only	10	28%
External partners only	2	6%
Both internal and external partners	24	67%

Partners engaged by Minnesota community health boards that used an assessment involving gathering/analyzing data to identify barriers to health care, 2015 (n=8)



Partners engaged by community health boards that used an assessment involving gathering/analyzing data to identify barriers to health care 2c. If an assessment process involved gathering and reviewing quantitative data, please indicate which partners you engaged. (Check all that apply.) For those community health boards that selected "an assessment process involved gathering and reviewing quantitative data" in Q2a, above.	Minnesota 2015 (n=8)	
	#	%
Internal partners only	0	0%
External partners only	2	25%
Both internal and external partners	6	75%
We engaged no partners	0	0%

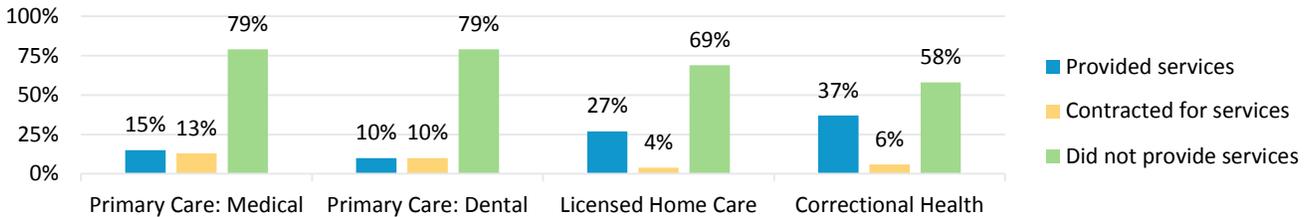
Provision of Public Health Services

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

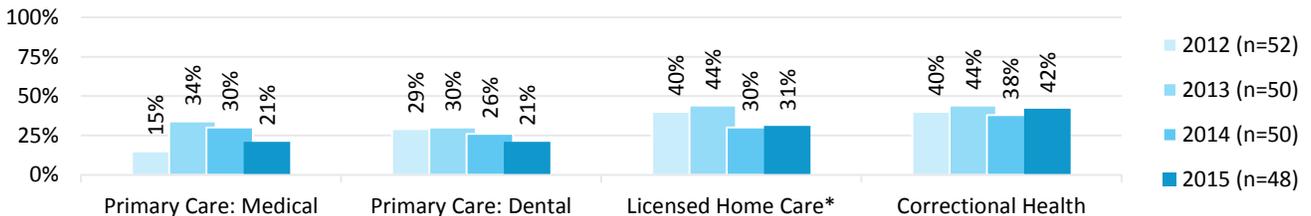
MORE INFORMATION

MDH Office of Rural Health and Primary Care
651-201-3838 | health.orhpc@state.mn.us
www.health.state.mn.us/divs/orhpc

Activities performed by Minnesota community health boards related to public health services, 2015 (n=48)



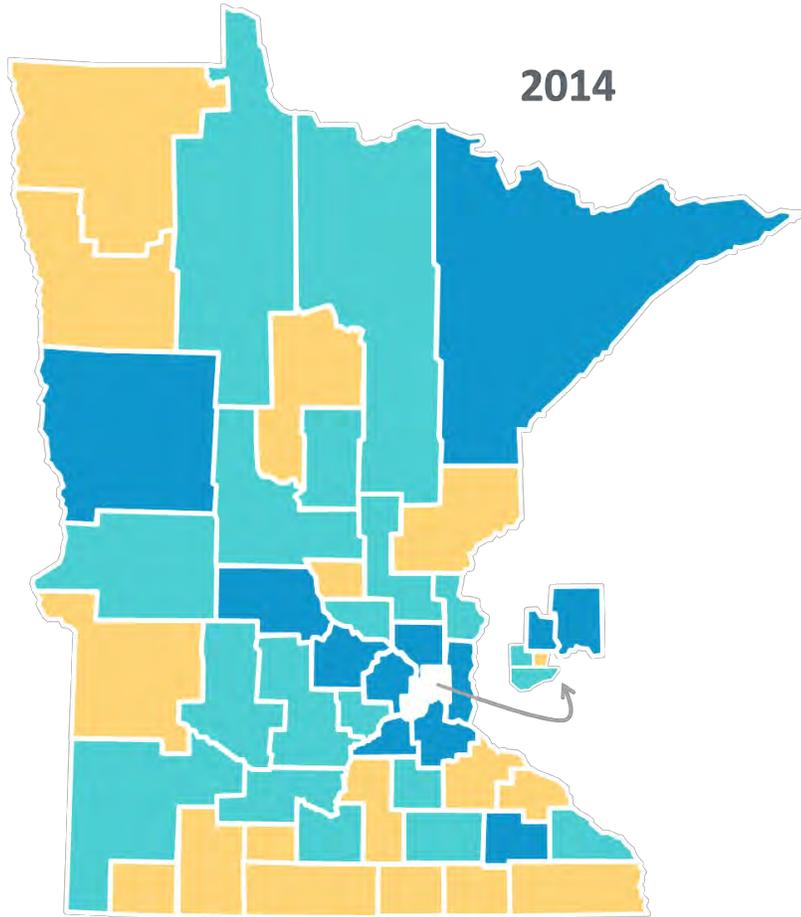
Greatest change: Provision of/contracting for public health services by Minnesota community health boards, 2012-2015



* In 2012, this response option was listed as "Home Care" rather than "Licensed Home Care."

Activities performed related to public health services 3. For the following services, indicate whether your community health board performed the activities listed. (Check all that apply.)	Minnesota, 2015 (n=48)							
	Primary Care: Medical		Primary Care: Dental		Licensed Home Care		Correctional Health	
	#	%	#	%	#	%	#	%
Provided services	7	15%	5	10%	13	27%	19	37%
Contracted for services	6	13%	5	10%	2	4%	3	6%
Did not provide services	38	79%	38	79%	33	69%	28	58%

Community Health Boards by Population



**Large community health boards
(>100,000 residents), n=12**

- Hennepin 1,212,064
- St. Paul-Ramsey 532,655
- Dakota 412,529
- Minneapolis 411,273
- Anoka 341,864
- Carlton-Cook-Lake-St. Louis 252,433
- Washington 249,283
- Partnership4Health 158,675
- Stearns 152,912
- Olmsted 150,287
- Scott 139,672
- Wright 129,918

**Medium community health boards
(50,000-100,000 residents), n=19**

- Carver 97,338
- Sherburne 91,126
- Bloomington 86,652
- North Country 78,946
- SWHHS 74,272
- Aitkin-Itasca-Koochiching 74,216
- Meeker-McLeod-Sibley 73,907
- Morrison-Todd-Wadena 70,831
- Horizon 66,917
- Blue Earth 65,385
- Rice 65,151
- Isanti-Mille Lacs 64,297
- Crow Wing 63,265
- Brown-Nicollet 58,385
- Kandiyohi-Renville 57,310
- Dodge-Steele 56,926
- Chisago 54,025
- Winona 51,097
- Edina 50,261

**Small community health boards
(<50,000 residents), n=17**

- Quin County 47,632
- Le Sueur-Waseca 46,795
- Goodhue 46,423
- Kanabec-Pine 45,025
- Polk-Norman-Mahnomen 43,848
- Countryside 43,673
- Fillmore-Houston 39,514
- Benton 39,506
- Mower 39,323
- Richfield 36,157
- Faribault-Martin 34,412
- Freeborn 30,840
- Cass 28,559
- Des Moines Valley 21,902
- Nobles 21,590
- Wabasha 21,362
- Watonwan 11,083

Areas of Public Health Responsibility

Online: [MDH: Areas of Public Health Responsibility within the Local Public Health Act](#)

Assure an adequate local public health infrastructure

Assure an adequate local public health infrastructure by maintaining the basic foundational capacities to a well-functioning public health system that includes data analysis and utilization; health planning; partnership development and community mobilization; policy development, analysis, and decision support; communication; and public health research, evaluation, and quality improvement.

Promote healthy communities and healthy behavior

Promote healthy communities and healthy behavior through activities that improve health in a population, such as investing in healthy families; engaging communities to change policies, systems, or environments to promote positive health or prevent adverse health; providing information and education about healthy communities or population health status; and addressing issues of health equity, health disparities, and the social determinants to health.

Prevent the spread of communicable diseases

Prevent the spread of communicable disease by preventing diseases that are caused by infectious agents through detecting acute infectious diseases, ensuring the reporting of infectious diseases, preventing the transmission of infectious diseases, and implementing control measures during infectious disease outbreaks.

Protect against environmental health hazards

Protect against environmental health hazards by addressing aspects of the environment that pose risks to human health, such as monitoring air and water quality; developing policies and programs to reduce exposure to environmental health risks and promote healthy environments; and identifying and mitigating environmental risks such as food and waterborne diseases, radiation, occupational health hazards, and public health nuisances.

Prepare and respond to emergencies

Prepare and respond to emergencies by engaging in activities that prepare public health departments to respond to events and incidents and assist communities in recovery, such as providing leadership for public health preparedness activities with a community; developing, exercising, and periodically reviewing response plans for public health threats; and developing and maintaining a system of public health workforce readiness, deployment, and response.

Assure health services

Assure health services by engaging in activities such as assessing the availability of health-related services and health care providers in local communities, identifying gaps and barriers in services; convening community partners to improve community health systems; and providing services identified as priorities by the local assessment and planning process.