

# Local Public Health Act Performance Measures Data Book, 2016

JULY 2017

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*Upon request, this material will be made available in an alternative format such as large print, Braille, or audio recording.  
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*Contact your local public health agency for more information.*

## Contents

About this Data Book .....	4
Assure an Adequate Local Public Health System: Capacity Measures from National Standards .....	5
Assure an Adequate Local Public Health Infrastructure: Minnesota-Specific Measures.....	19
Workforce Competency .....	19
School Health .....	21
Health Equity .....	22
Organizational QI Maturity.....	24
Organizational QI Maturity Score .....	27
Health Informatics.....	28
Voluntary Public Health Accreditation .....	33
Promote Healthy Communities and Healthy Behaviors .....	35
Active Living.....	35
Healthy Eating .....	36
Tobacco-Free Living.....	37
Alcohol.....	39
Maternal and Child Health .....	41
Prevent the Spread of Communicable Diseases .....	42
Immunization .....	42
Protect Against Environmental Health Hazards.....	45
Indoor Air: Minnesota Clean Indoor Air Act .....	45
Indoor Air: Mold .....	46
Blood Lead .....	47
Drinking Water Protection and Well Management.....	48
Extreme Weather .....	49
Nuisance Investigations.....	50
Food, Pools, and Lodging Services.....	51
Assure Health Services.....	52
Clinical-Community Linkages.....	52
Provision of Public Health Services .....	53
Appendix A: Tables .....	55
Assure an Adequate Local Public Health Infrastructure: Capacity Measures from National Standards .....	55
Assure an Adequate Local Public Health Infrastructure: Minnesota-Specific Measures .....	57
Promote Healthy Communities and Healthy Behaviors .....	71
Prevent the Spread of Communicable Diseases.....	81
Protect Against Environmental Health Hazards .....	84
Assure Health Services .....	93
Appendix B: Community Health Board Sizes, 2016 .....	96

## About this Data Book

Minnesota community health boards report annually to the Minnesota Department of Health on Local Public Health Act performance measures that span six areas of public health responsibility.

This data book presents state-level findings for each Local Public Health Act measure. Data reported was collected by Minnesota community health boards between January 1 and December 31, 2016. For more information on tailored reports specific to each community health board, contact the MDH Center for Public Health Practice.

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 Center for Emergency Preparedness and Response.

Instructions for reporting on all six areas of public health responsibility can be found online at [Annual Reporting for Public Health](#).



Minnesota Public Health System Performance Management Cycle

### Interpretation and Assistance

The [State Community Health Services Advisory Committee \(SCHSAC\) Performance Improvement Steering Committee](#) has reviewed these findings. 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.

### Community Health Boards' 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 2015 for this report, which is the most recently available population data.

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

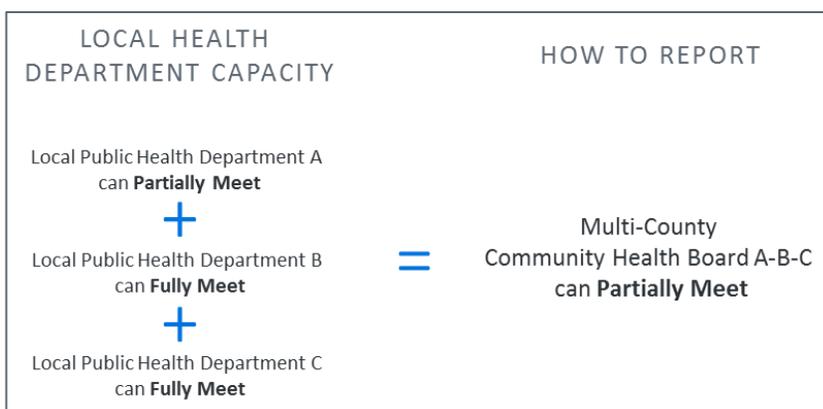
Per Minn. Stat. § 145A (Local Public Health Act), Minnesota community health boards are expected to assure an adequate local public health infrastructure by maintaining the basic foundational capacities to a well-functioning public health system that includes data analysis and utilization; health planning; partnership development and community mobilization; policy development, analysis, and decision support; communication; and public health research, evaluation, and quality improvement.

## Background

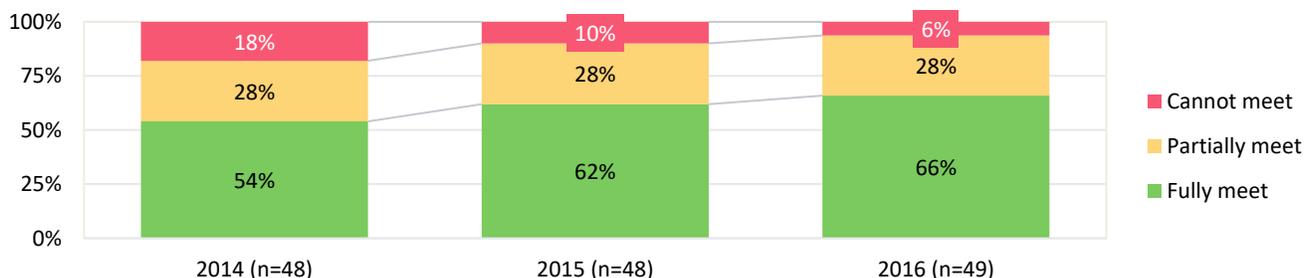
In spring 2017, Minnesota community health boards reported on a key subset of 37 national public health measures selected by the SCHSAC Performance Improvement Steering Committee. This subset differs from the subset tracked from 2012 to 2014, though some measures have been included in both subsets. This 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 for Initial Accreditation](#) (version 1.5).

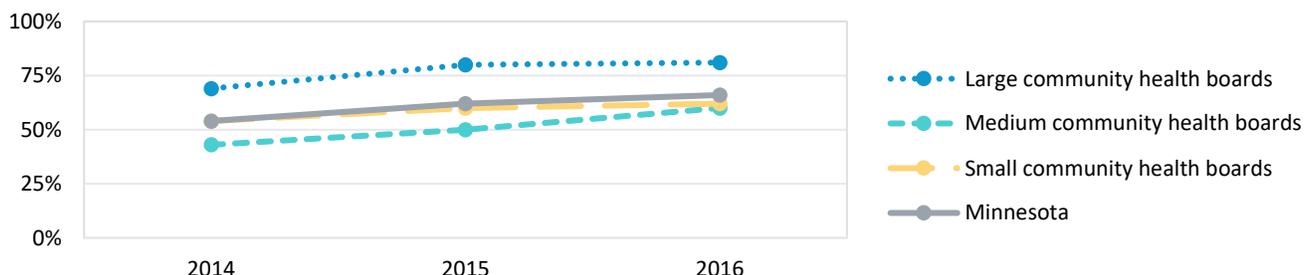
MDH directed multi-county community health boards to report on the lowest level of capacity of their individual health departments for these measures (see right). For a full list of community health boards, please refer to [Appendix B](#).



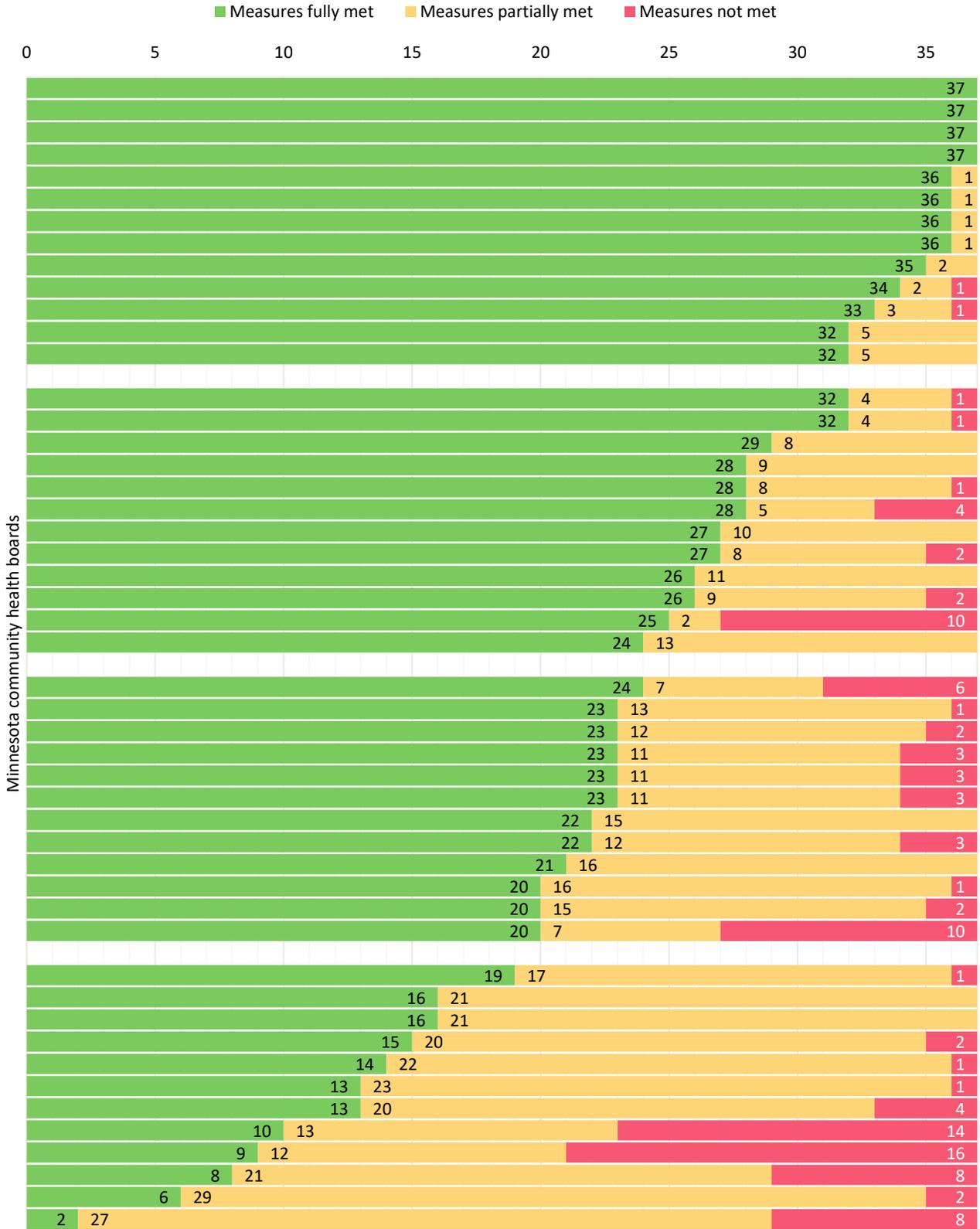
### Progress: Capacity to meet key national public health measures, Minnesota community health boards, 2014-present



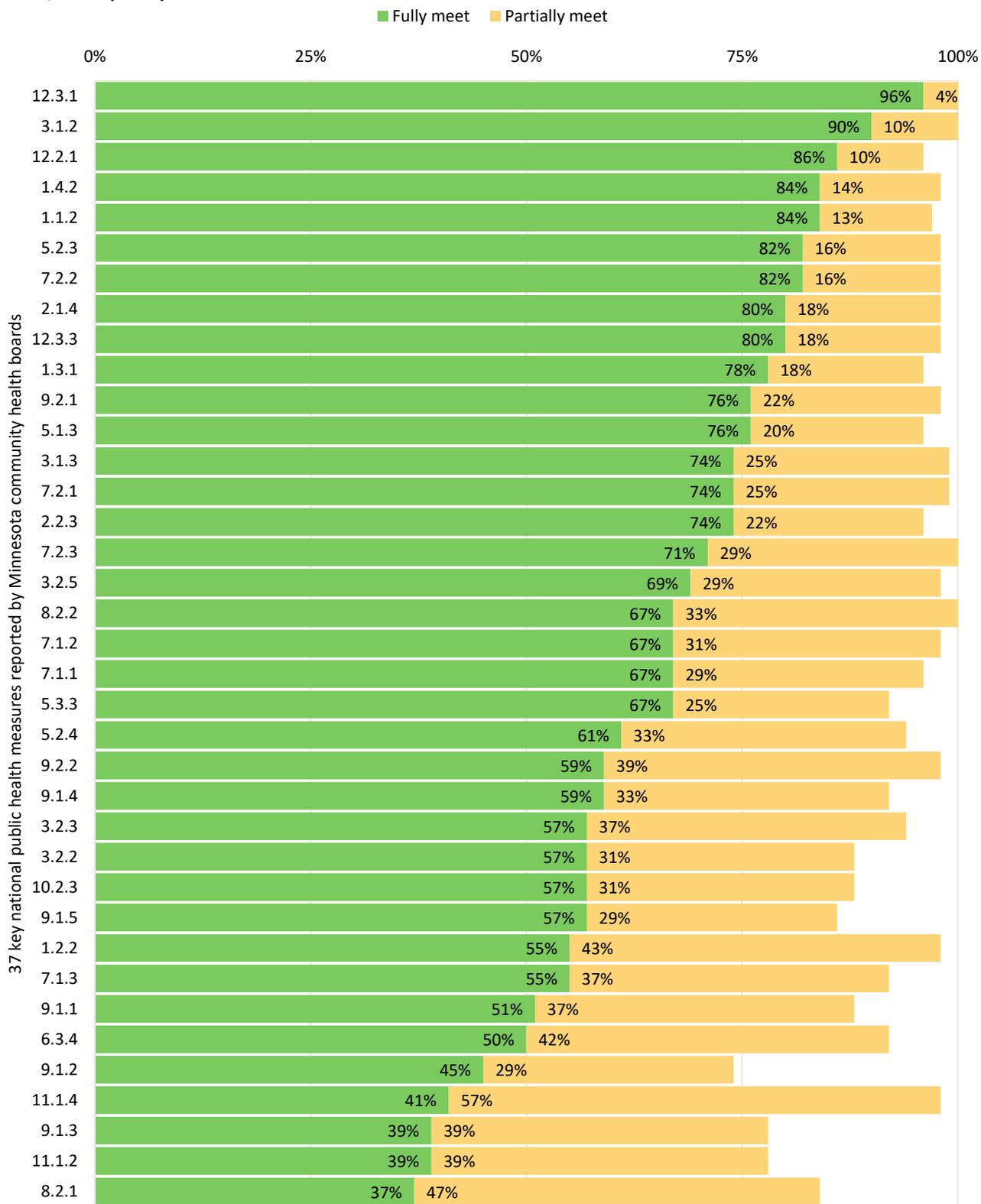
### Progress and comparison: Capacity to fully meet key national public health measures, by population, Minnesota community health boards, 2014-present



Capacity to meet key national public health measures, Minnesota community health boards, 2016 (n=49)



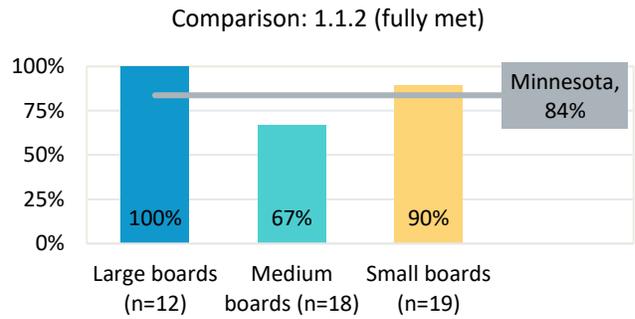
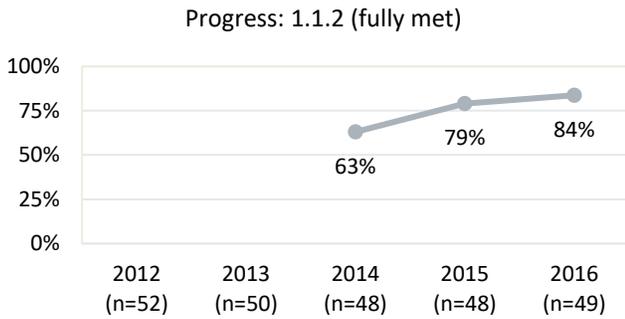
**Key national public health measures fully/partially met by Minnesota community health boards, 2016 (n=49)**



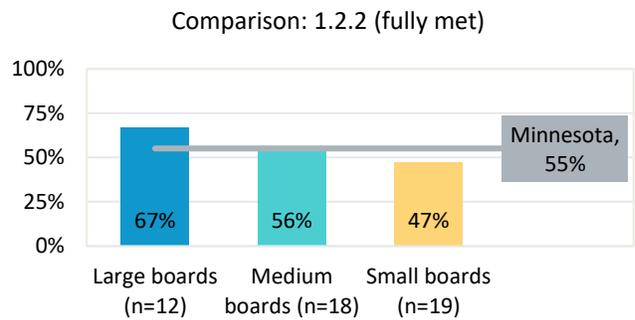
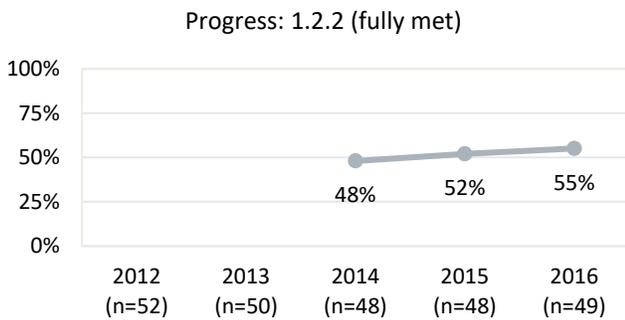
**Capacity to fully meet key national public health measures, by population, Minnesota community health boards, 2016**

	Large boards (n=12)	Medium boards (n=18)	Small boards (n=19)	Minn. (n=49)
1.1.2: Community Health Assessment	100%	72%	68%	78%
1.2.2: Communication with Surveillance Sites	92%	89%	74%	84%
1.3.1: Data Analysis and Conclusions	92%	83%	68%	80%
1.4.2: Community Summaries, Fact Sheets	92%	61%	74%	73%
2.1.4: Collaborative Partnerships for Investigation	92%	83%	95%	90%
2.2.3: After Action Reports (AARs)	83%	72%	68%	73%
3.1.2: Health Promotion Strategies	75%	56%	47%	57%
3.1.3: Factors for Specific At-Risk Populations	83%	28%	68%	57%
3.2.2: Organizational Branding Strategy	83%	56%	74%	69%
3.2.3: External Communications Procedures	83%	61%	84%	76%
3.2.5: Variety of Publicly Available Information	100%	72%	79%	82%
5.1.3: Policies' Impact on Public Health	75%	50%	63%	61%
5.2.3: Collaborative CHIP Implementation	83%	61%	63%	67%
5.2.4: Monitor and Revise CHIP	75%	44%	37%	49%
5.3.3: An Implemented Strategic Plan	83%	67%	58%	67%
6.3.4: Compliance Patterns from Enforcement	92%	67%	53%	67%
7.1.1: Assessing Health Care Availability	75%	39%	58%	55%
7.1.2: Identifying Populations Facing Barriers	83%	67%	74%	73%
7.1.3: Identifying Gaps and Barriers to Health Care	92%	78%	79%	82%
7.2.1: Developing Strategies to Improve Access	83%	78%	58%	71%
7.2.2: Implementing Strategies to Increase Access	58%	17%	42%	37%
7.2.3: Cultural Competence in Increasing Access	75%	72%	58%	67%
8.2.1: Workforce Development Strategies	75%	44%	42%	51%
8.2.2: Competent Workforce	75%	28%	42%	45%
9.1.1: Engagement in Performance Management System	67%	22%	37%	39%
9.1.2: Performance Management System/Policy	50%	78%	47%	59%
9.1.3: Implemented Performance Management System	83%	50%	47%	57%
9.1.4: Process to Assess Customer Satisfaction	83%	72%	74%	76%
9.1.5: Staff Involvement in Performance Management	75%	44%	63%	59%
9.2.1: Established QI Program	75%	61%	42%	57%
9.2.2: Implemented QI Activities	50%	33%	37%	39%
10.2.3: Communicated Research Findings	58%	33%	37%	41%
11.1.2: Ethical Issues and Decisions	100%	78%	84%	86%
11.1.4: Policies Appropriate to Specific Populations	100%	100%	89%	96%
12.2.1: Communication with Gov. Entity on Responsibilities	100%	61%	84%	80%
12.3.1: Information Provided to Governing Entity	100%	72%	68%	78%
12.3.3: Communication with Gov. Entity on Performance	92%	89%	74%	84%

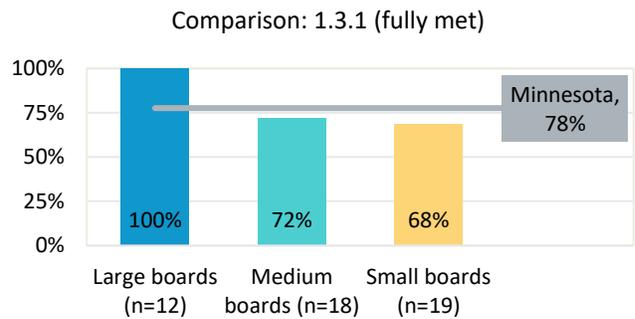
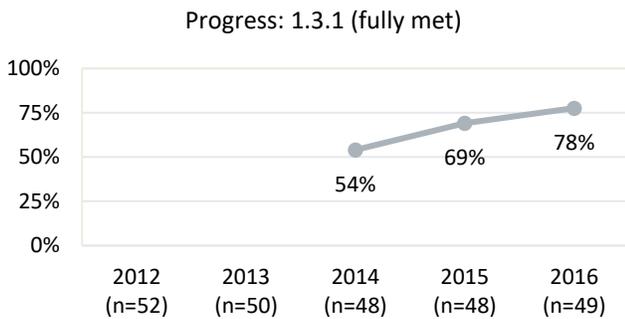
**Measure 1.1.2: Community Health Assessment**



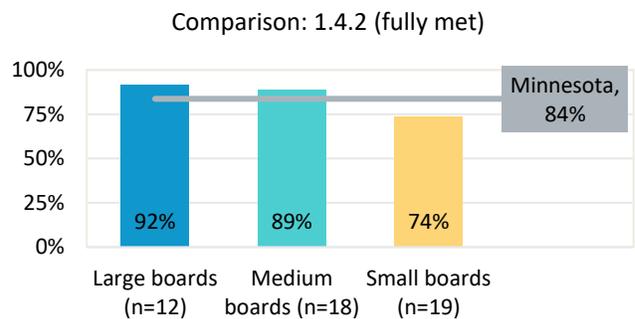
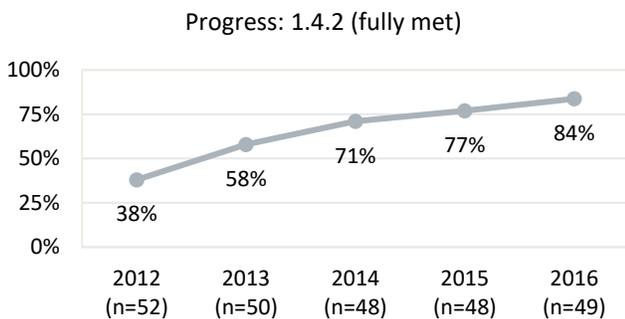
**Measure 1.2.2: Communication with Surveillance Sites**



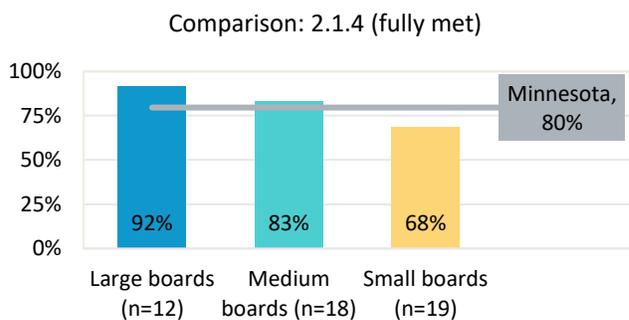
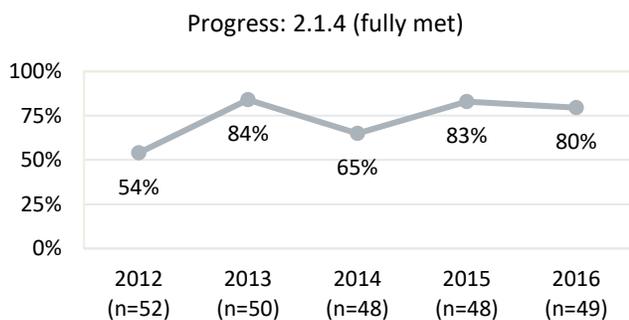
**Measure 1.3.1: Data Analysis and Conclusions**



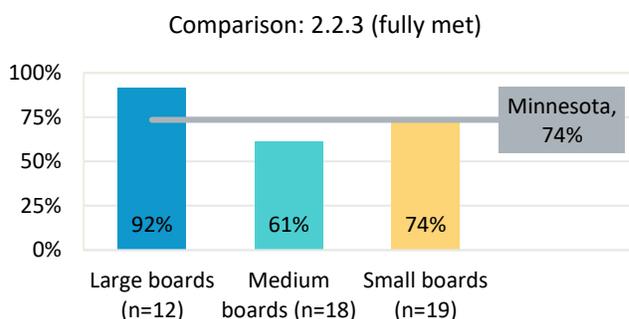
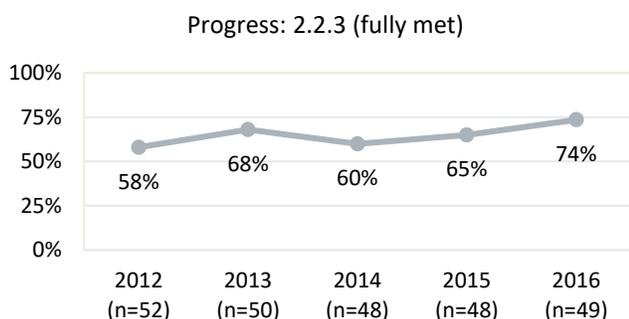
**Measure 1.4.2: Community Summaries, Fact Sheets**



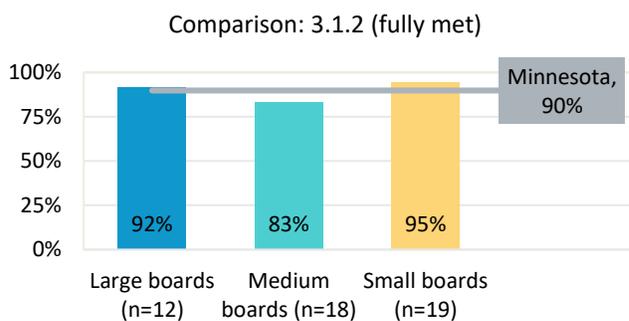
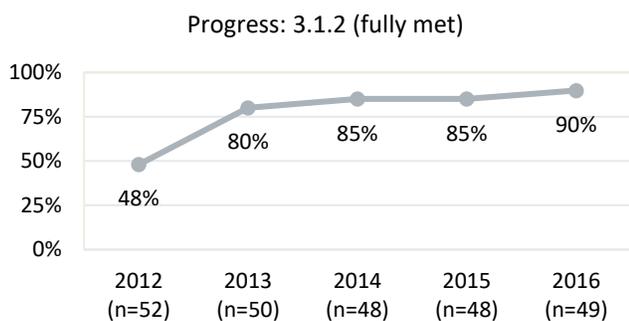
**Measure 2.1.4: Collaborative Partnerships for Investigation**



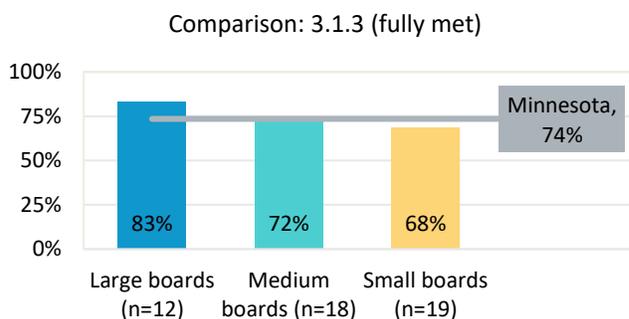
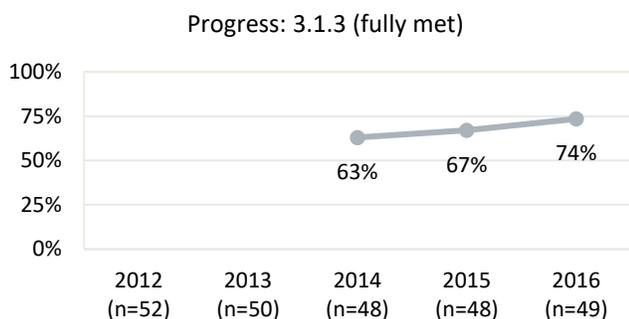
**Measure 2.2.3: After Action Reports (AARs)**



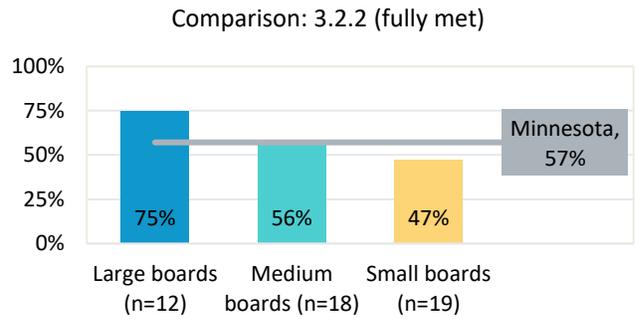
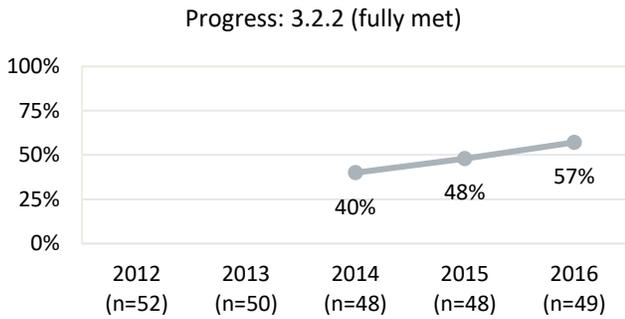
**Measure 3.1.2: Health Promotion Strategies**



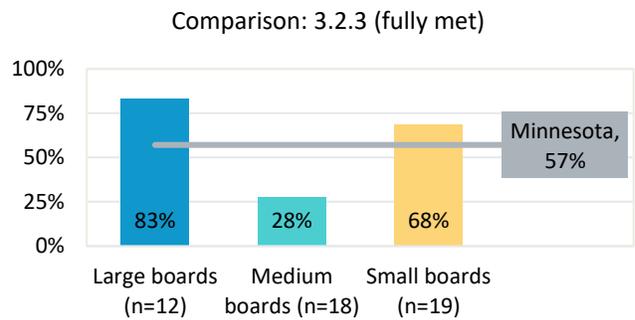
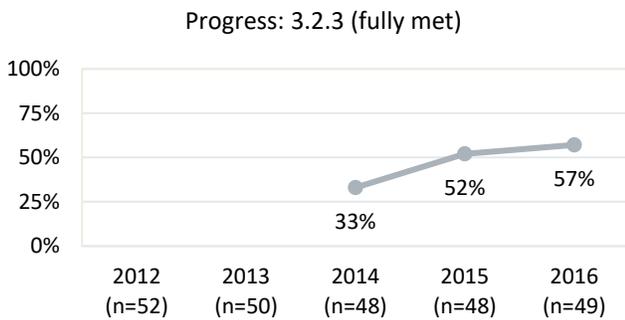
**Measure 3.1.3: Factors for Specific At-Risk Populations**



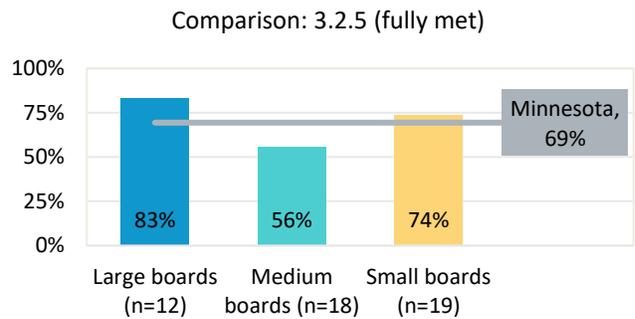
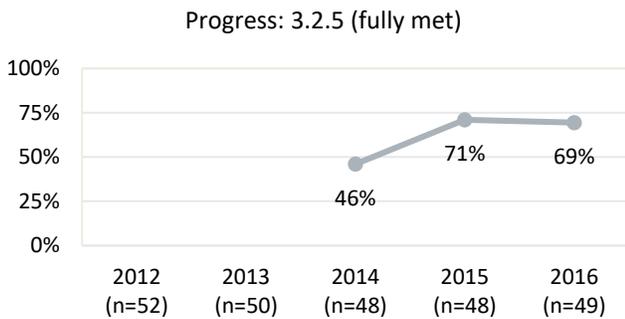
**Measure 3.2.2: Organizational Branding Strategy**



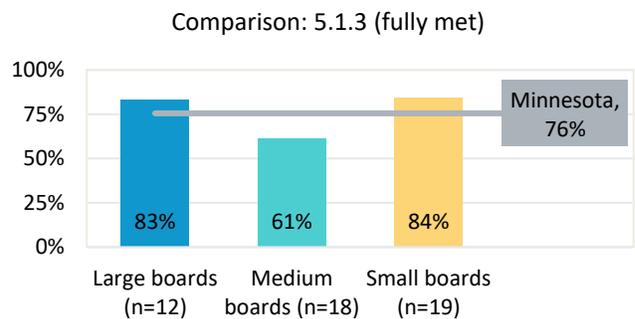
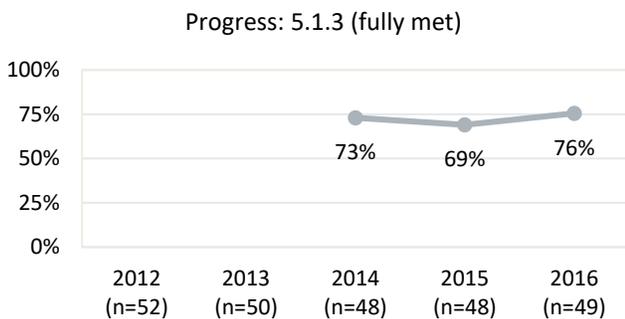
**Measure 3.2.3: External Communications Procedures**



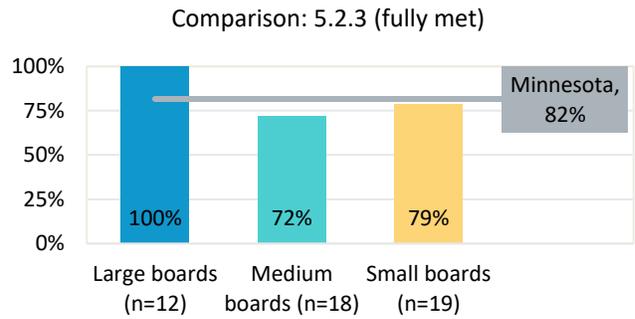
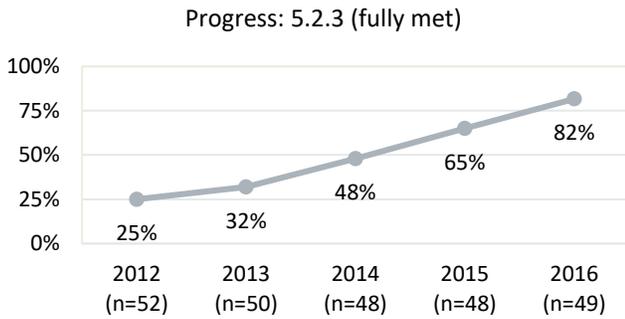
**Measure 3.2.5: Variety of Publicly Available Information**



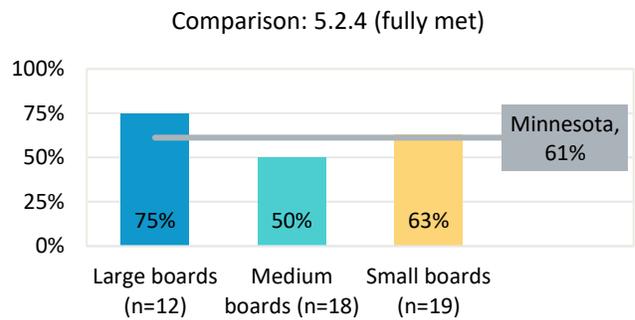
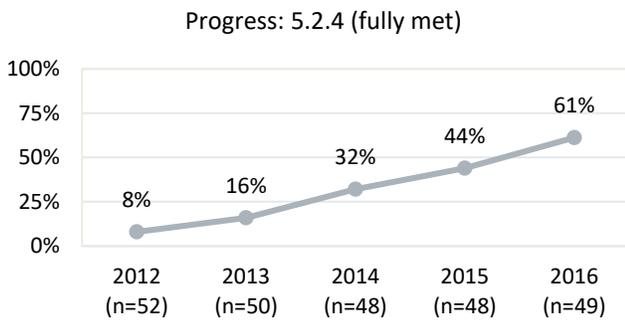
**Measure 5.1.3: Policies' Impact on Public Health**



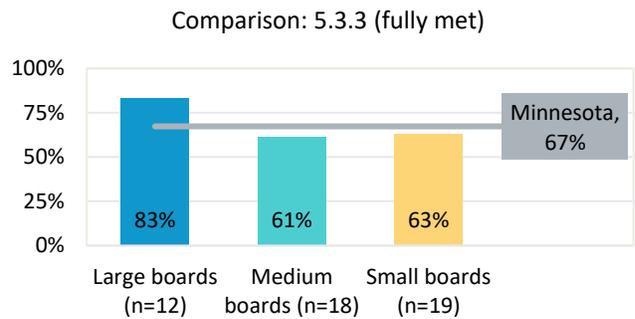
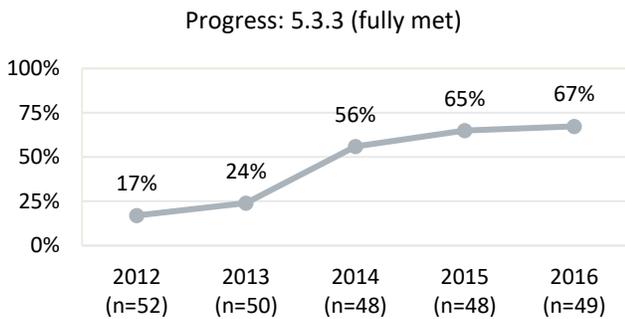
**Measure 5.2.3: Collaborative CHIP Implementation**



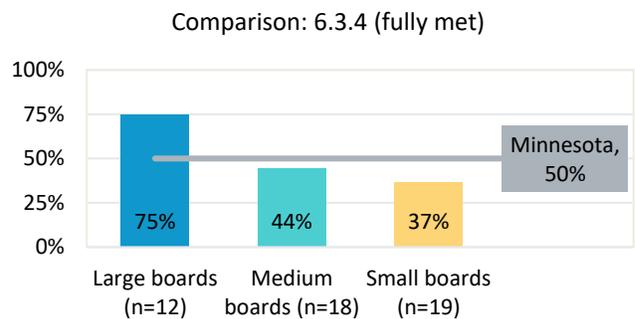
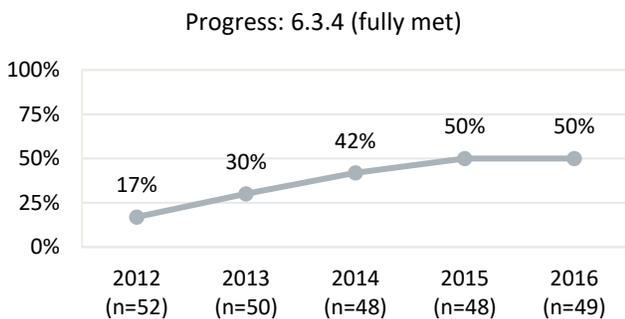
**Measure 5.2.4: Monitor and Revise CHIP**



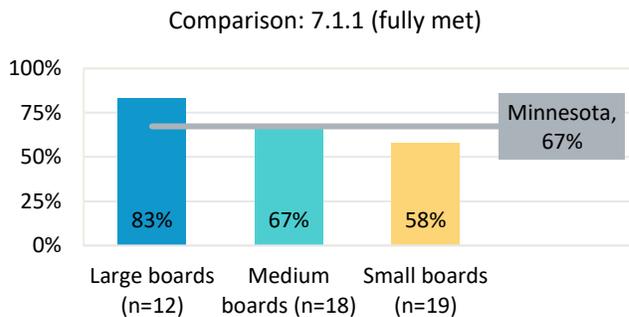
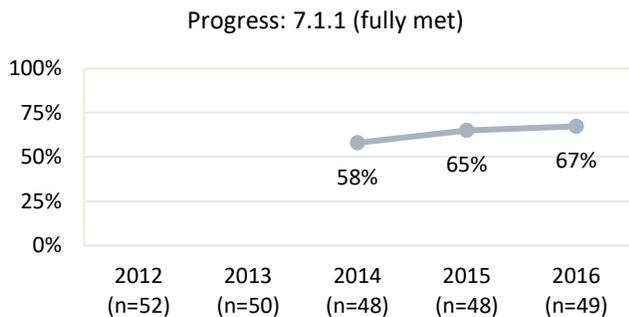
**Measure 5.3.3: An Implemented Strategic Plan**



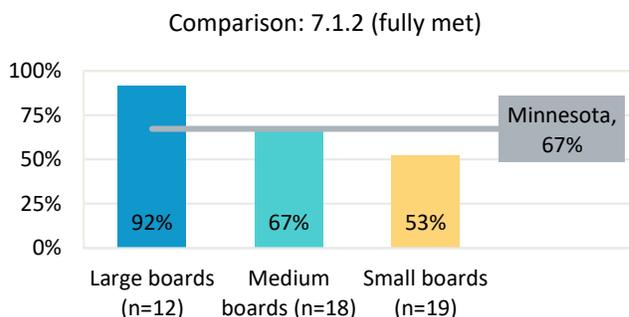
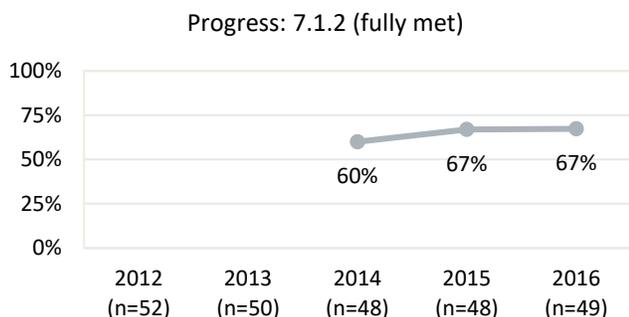
**Measure 6.3.4: Compliance Patterns from Enforcement**



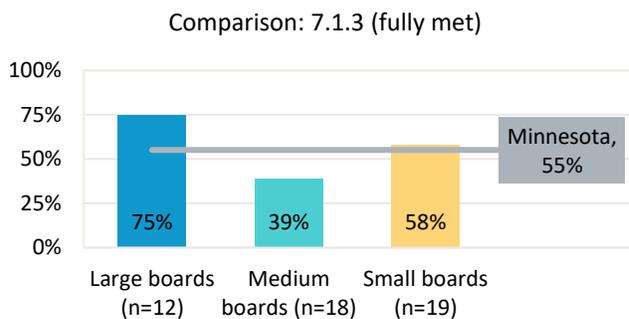
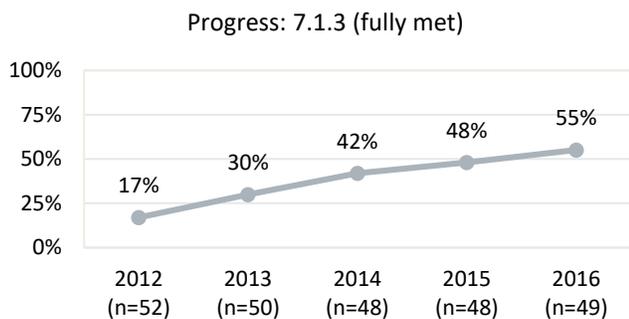
**Measure 7.1.1: Assessing Health Care Availability**



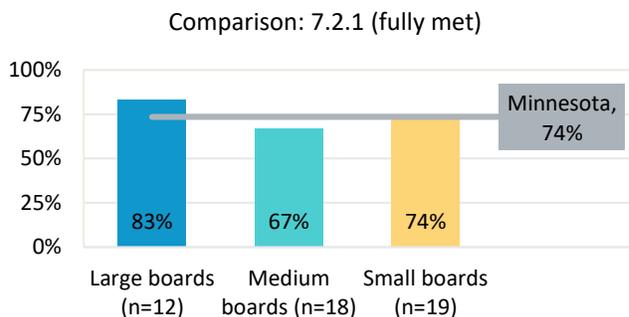
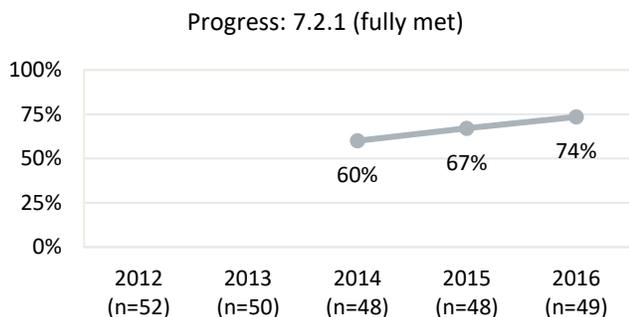
**Measure 7.1.2: Identifying Populations Facing Barriers**



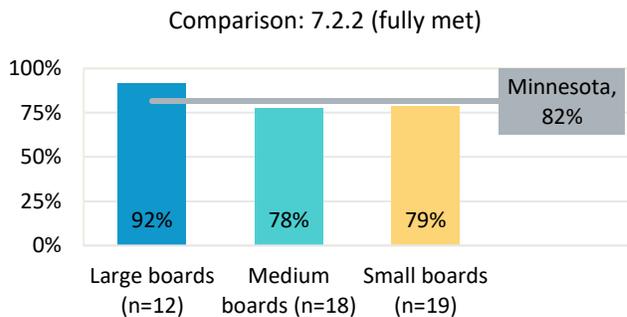
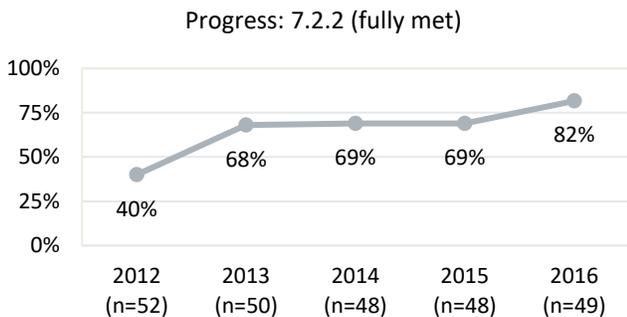
**Measure 7.1.3: Identifying Gaps and Barriers to Health Care**



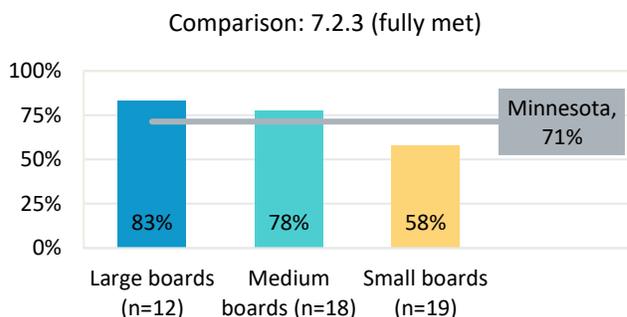
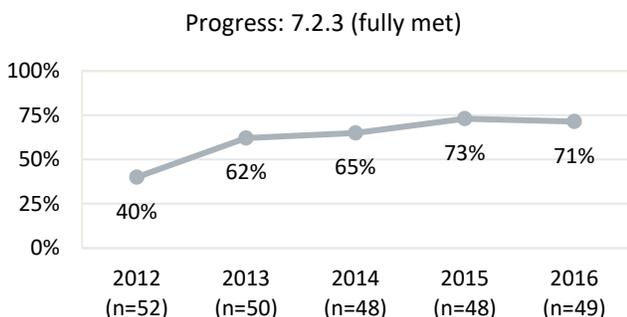
**Measure 7.2.1: Developing Strategies to Improve Access**



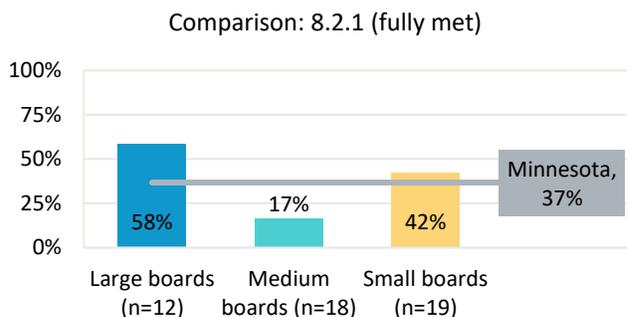
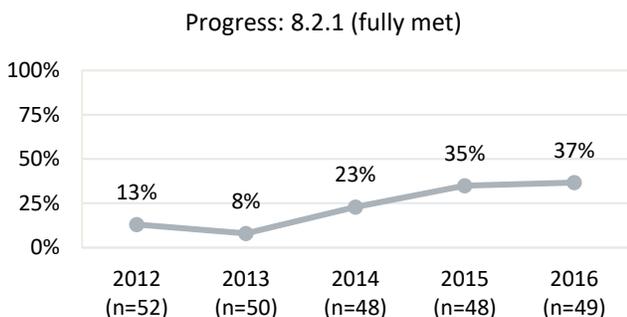
**Measure 7.2.2: Implementing Strategies to Increase Access**



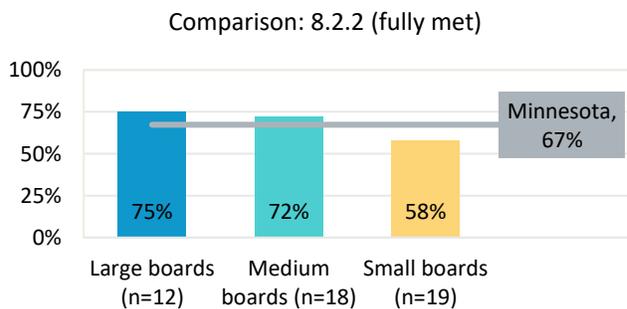
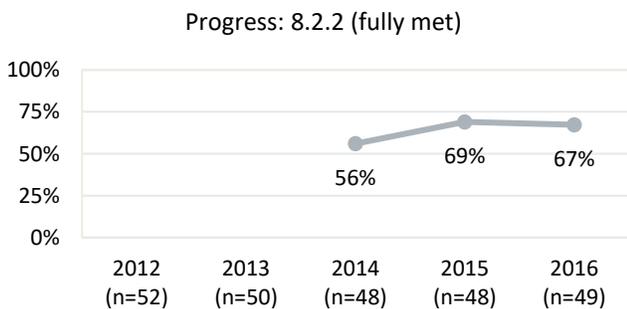
**Measure 7.2.3: Cultural Competence in Increasing Access**



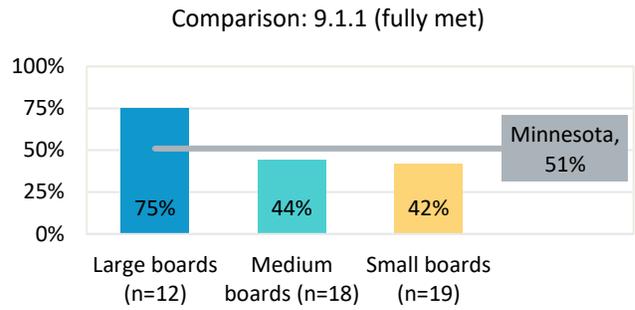
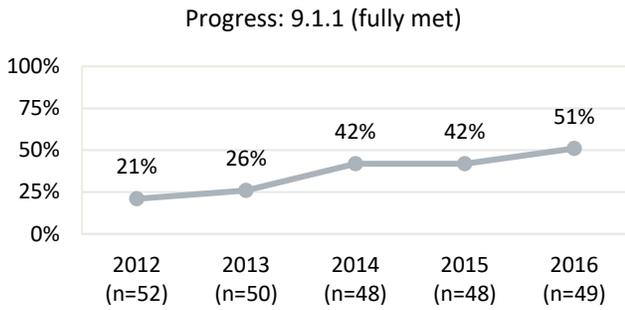
**Measure 8.2.1: Workforce Development Strategies**



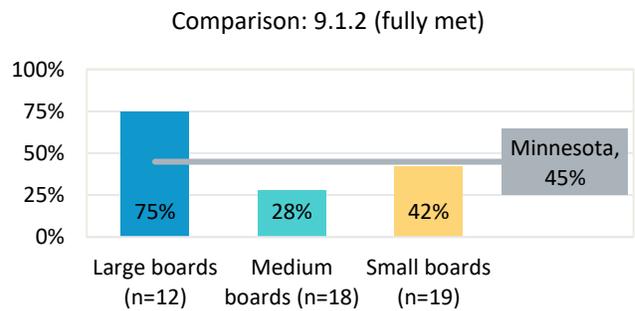
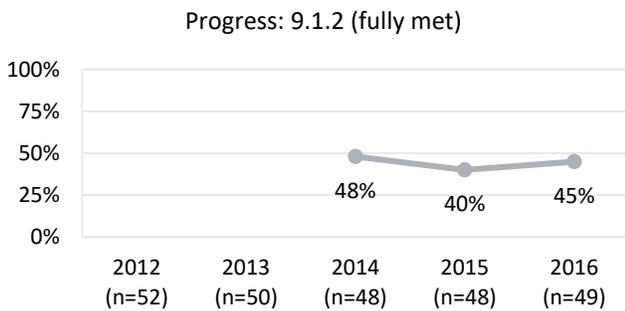
**Measure 8.2.2: Competent Workforce**



**Measure 9.1.1: Engagement in Performance Management System**

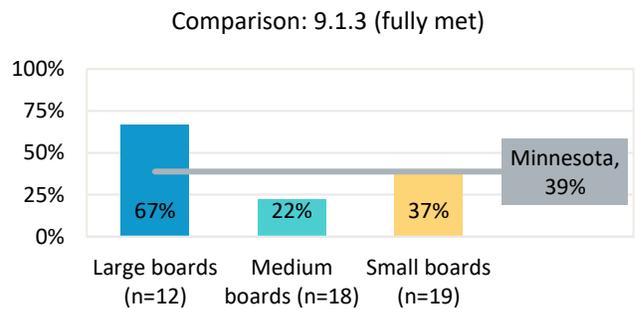
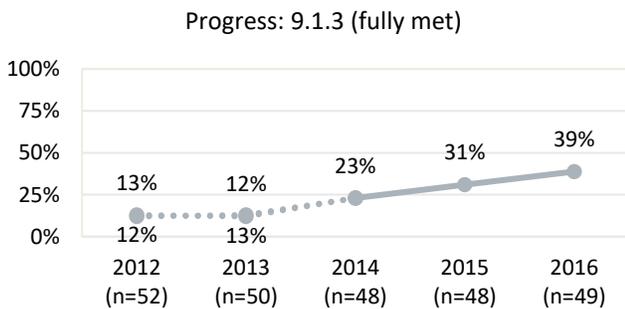


**Measure 9.1.2: Performance Management System/Policy**

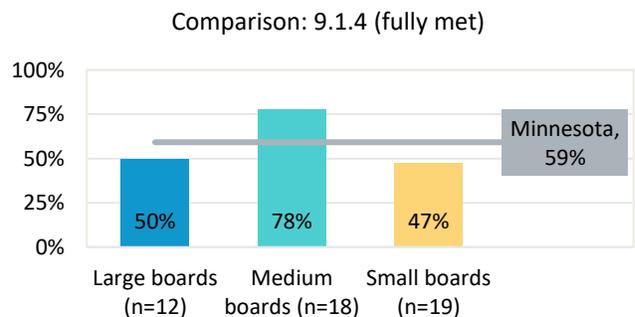
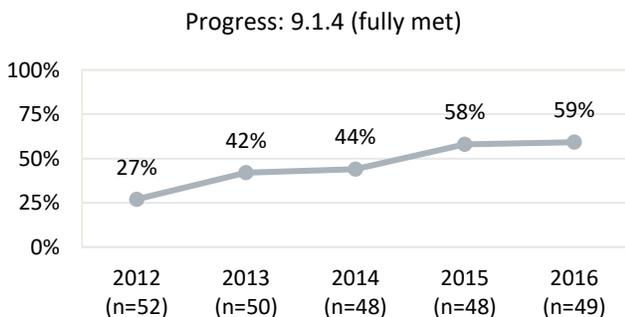


**Measure 9.1.3: Implemented Performance Management System**

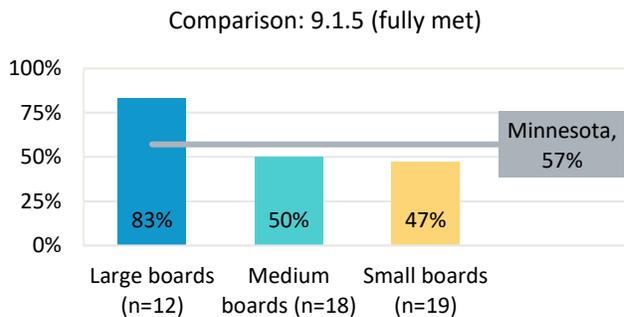
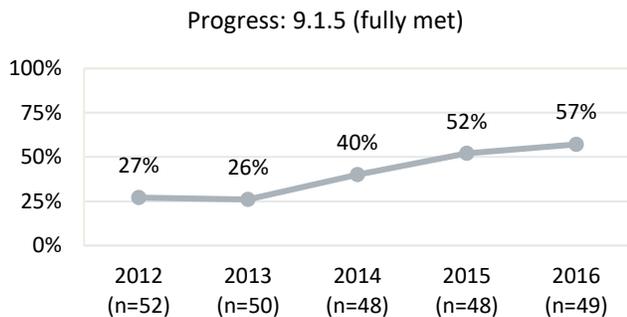
*This measure was previously listed as two separate measures in PHAB Standards & Measures 1.0, and was tracked differently by MDH in 2012-2013.*



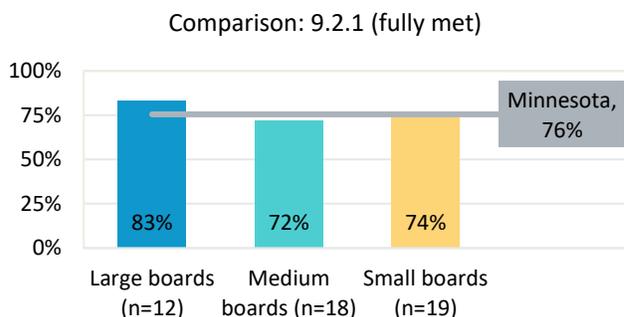
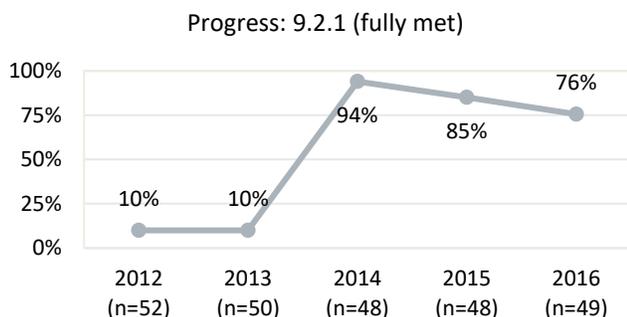
**Measure 9.1.4: Process to Assess Customer Satisfaction**



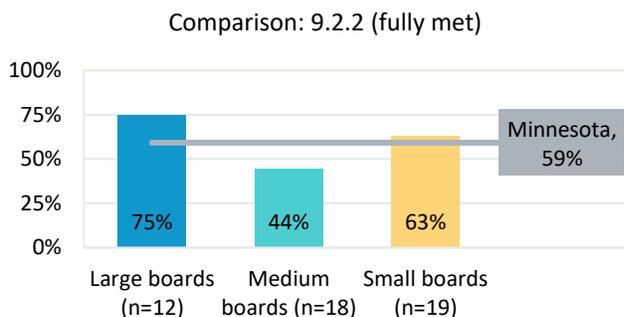
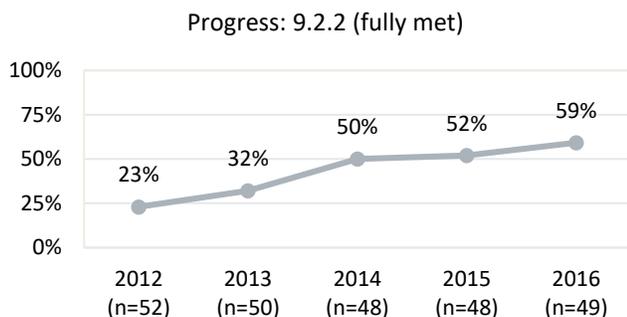
**Measure 9.1.5: Staff Involvement in Performance Management**



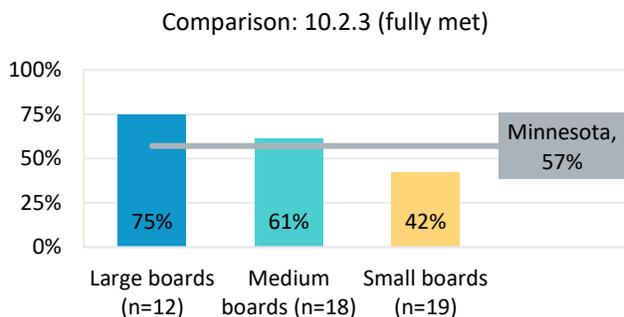
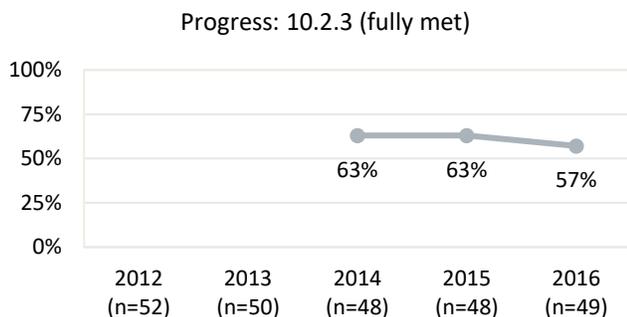
**Measure 9.2.1: Established QI Program**



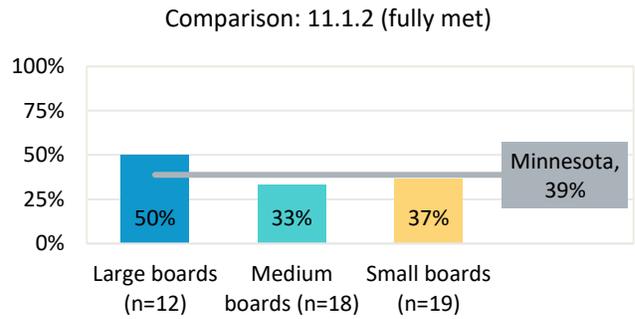
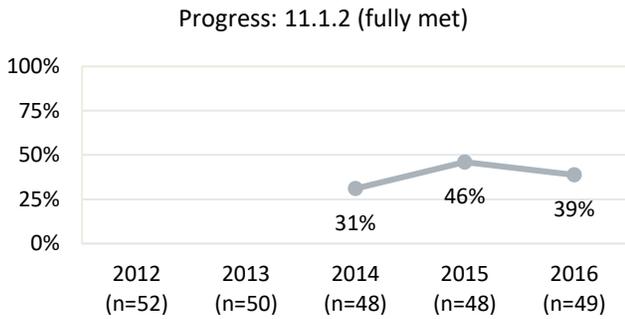
**Measure 9.2.2: Implemented QI Activities**



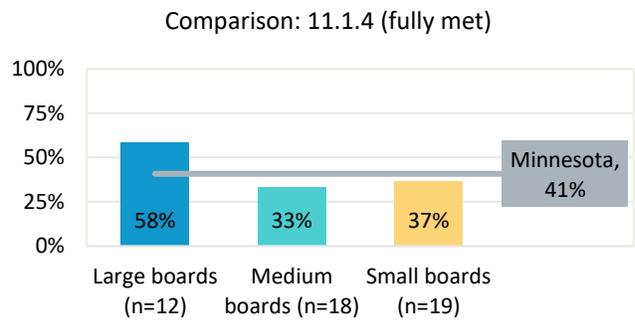
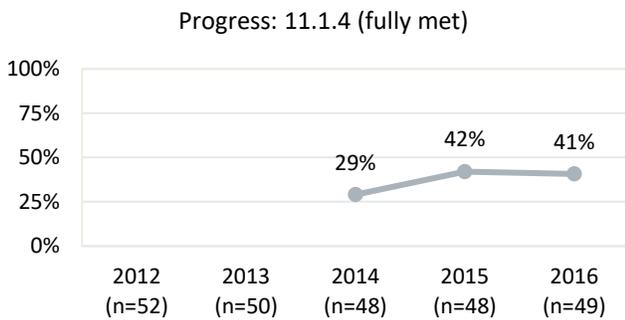
**Measure 10.2.3: Communicated Research Findings**



**Measure 11.1.2: Ethical Issues and Decisions**

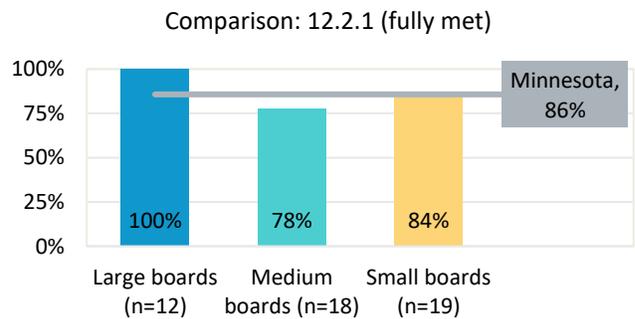
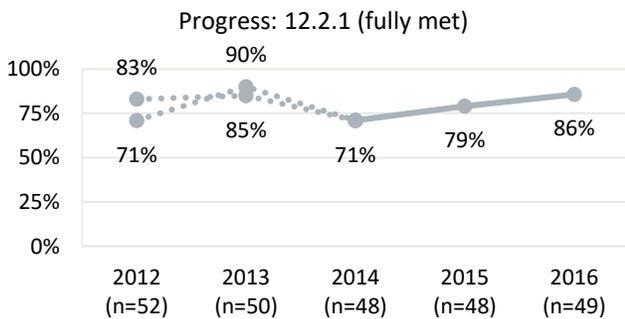


**Measure 11.1.4: Policies Appropriate to Specific Populations**

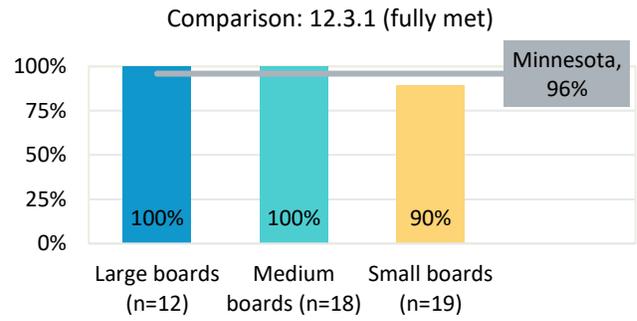
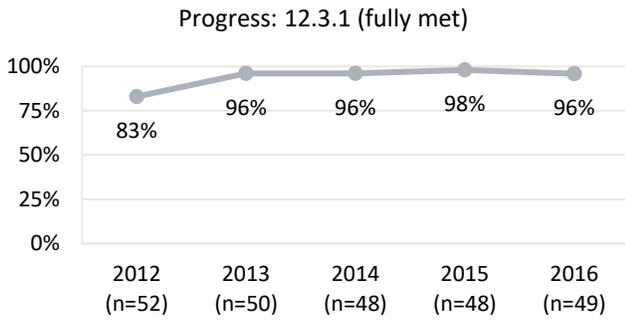


**Measure 12.2.1: Communication with Governing Entity on Responsibilities**

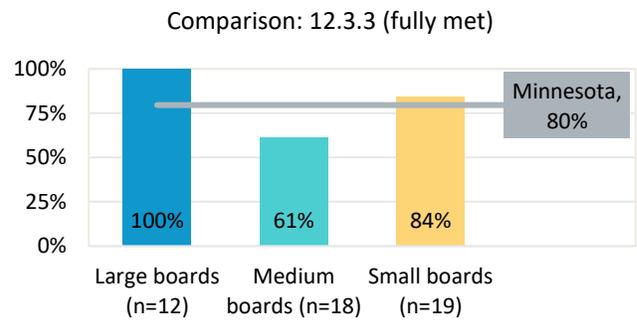
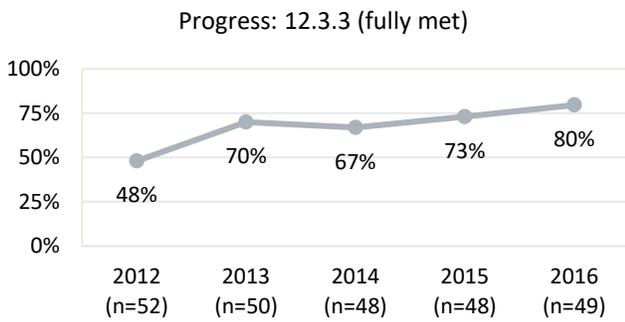
*This measure was previously listed as two separate measures in PHAB Standards & Measures 1.0 (12.2.1 and 12.2.2), and was tracked differently by MDH in 2012-2013 before combining into one measure in PHAB Standards & Measures 1.5 (12.2.1).*



**Measure 12.3.1: Information Provided to Governing Entity**



**Measure 12.3.3: Communication with Governing Entity on Performance**



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

Per Minn. Stat. § 145A (Local Public Health Act), Minnesota community health boards are expected to 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.

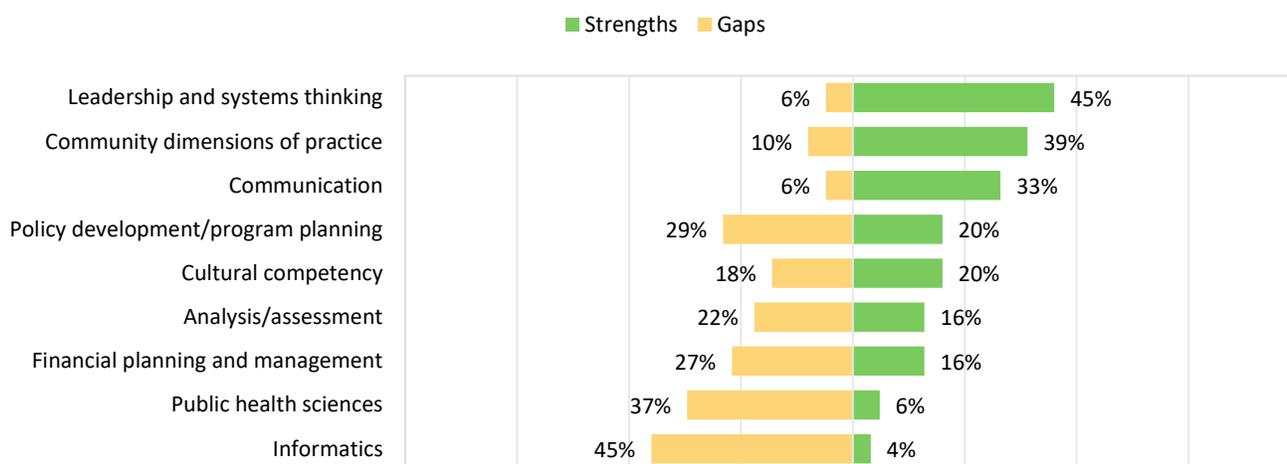
## Workforce Competency

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 Center for Public Health Practice  
 651-201-3880 | [health.ophp@state.mn.us](mailto:health.ophp@state.mn.us)  
[www.health.state.mn.us/divs/opi/pm/corecomp](http://www.health.state.mn.us/divs/opi/pm/corecomp)

### Workforce strengths and gaps, Minnesota community health boards, 2016 (n=49)

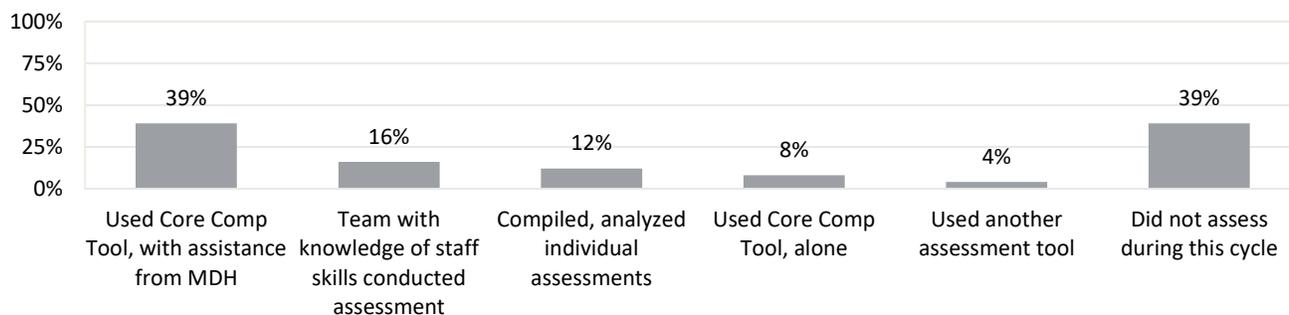


### Comparison: Top workforce strengths, by population, Minnesota community health boards, 2016

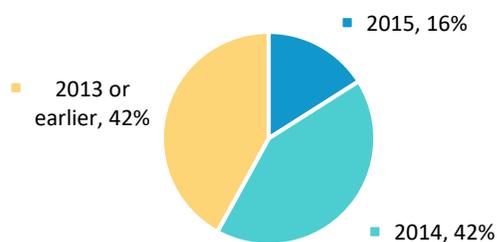
	Large boards (n=12)	Medium boards (n=18)	Small boards (n=19)	Minnesota (n=49)
<b>Strengths</b>				
Analysis/assessment	17%	17%	16%	16%
Policy development/program planning	17%	28%	16%	20%
Communication	0%	39%	47%	33%
Cultural competency	33%	17%	16%	20%
Community dimensions of practice	42%	28%	47%	39%
Public health sciences	25%	0%	0%	6%
Financial planning and management	8%	22%	16%	16%
Leadership and systems thinking	58%	50%	32%	45%
Informatics	0%	0%	11%	4%

	Large boards (n=12)	Medium boards (n=18)	Small boards (n=19)	Minnesota (n=49)
<b>Gaps</b>				
Analysis/assessment	8%	17%	37%	22%
Policy development/program planning	8%	39%	32%	29%
Communication	25%	0%	0%	6%
Cultural competency	17%	17%	21%	18%
Community dimensions of practice	8%	17%	5%	10%
Public health sciences	25%	39%	42%	37%
Financial planning and management	42%	28%	16%	27%
Leadership and systems thinking	17%	0%	5%	6%
Informatics	50%	50%	37%	45%

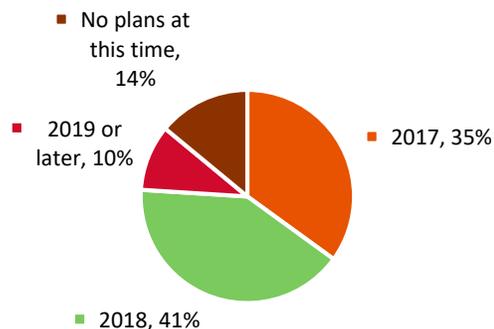
**Method used to assess workforce competencies, Minnesota community health boards, 2014-present**



**Last workforce assessment completed (if not during cycle), Minnesota community health boards, 2016 (n=19)**



**Next workforce assessment planned, Minnesota community health boards, 2016 (n=49)**



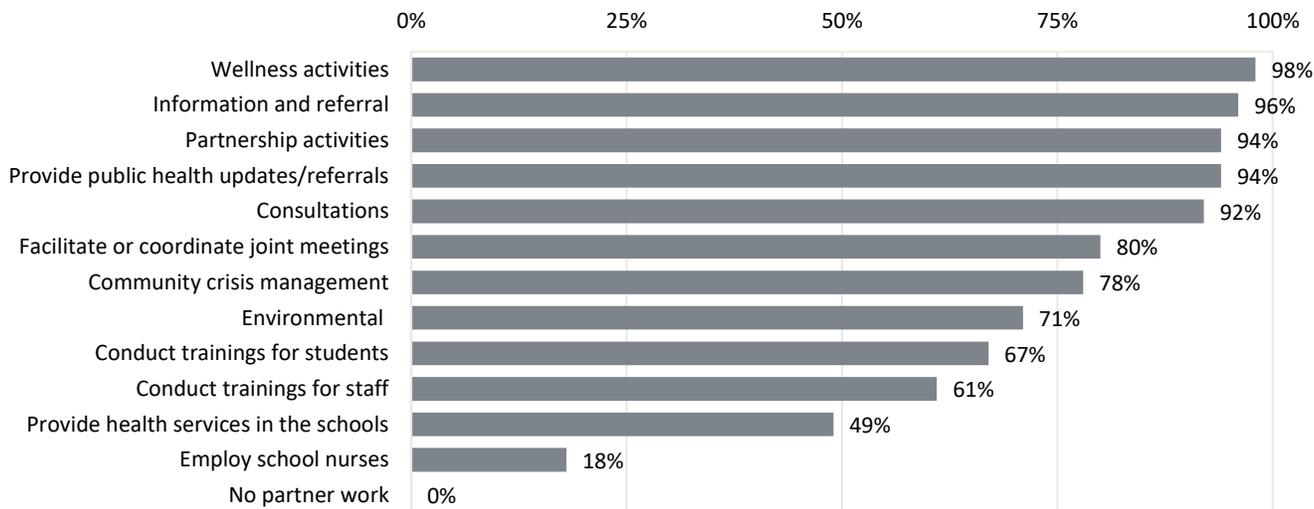
## School Health

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

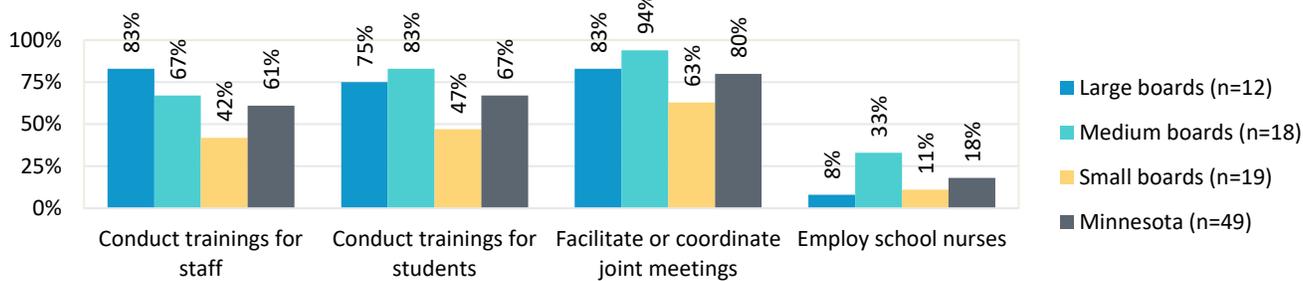
### More Information

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

### School health activities, Minnesota community health boards, 2016 (n=49)



### Comparison: School health activities, by population, Minnesota community health boards, 2016



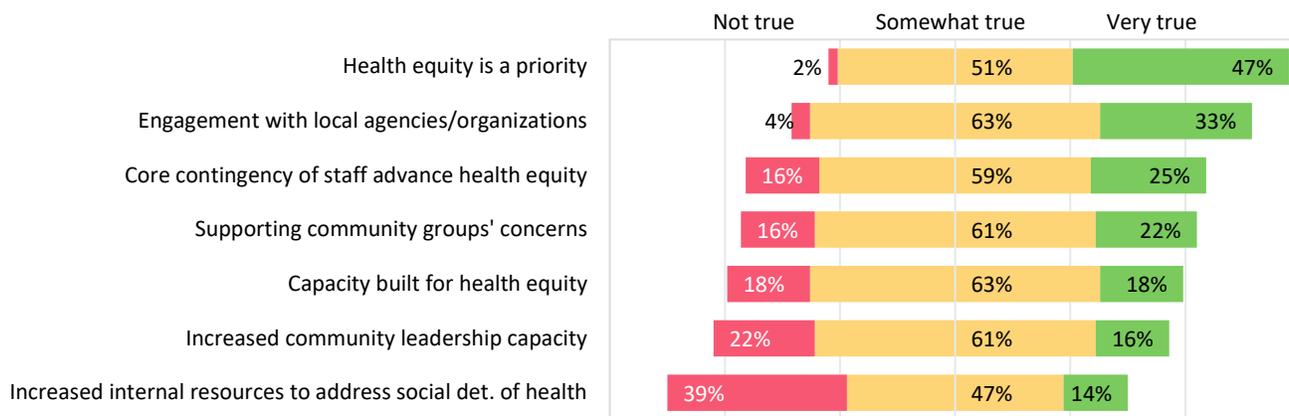
## Health Equity

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.

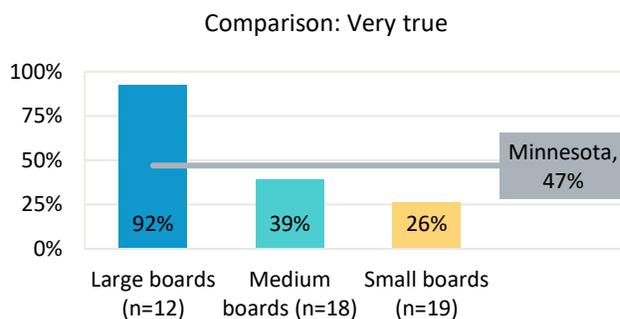
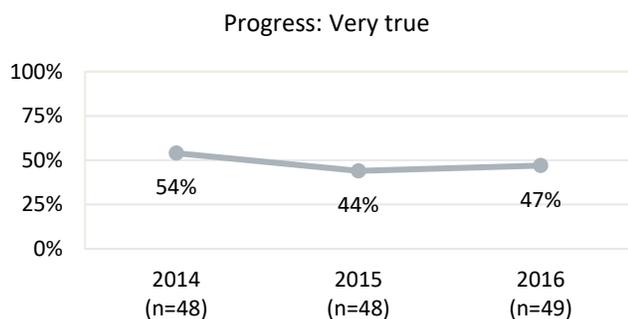
### More Information

MDH Center for Health Equity  
 651-201-5813 | [health.equity@state.mn.us](mailto:health.equity@state.mn.us)  
[www.health.state.mn.us/divs/che](http://www.health.state.mn.us/divs/che)

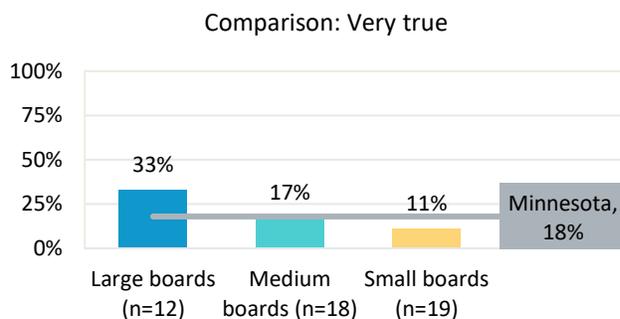
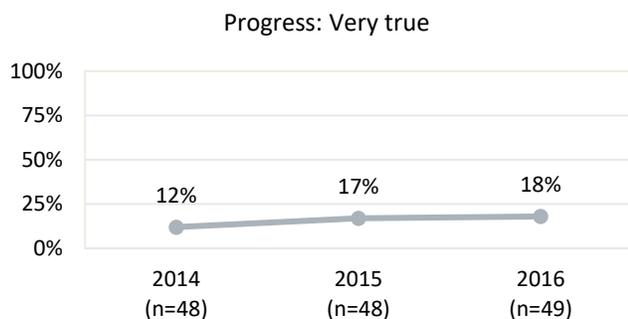
### At a glance: Health equity efforts in Minnesota community health boards, 2016 (n=49)



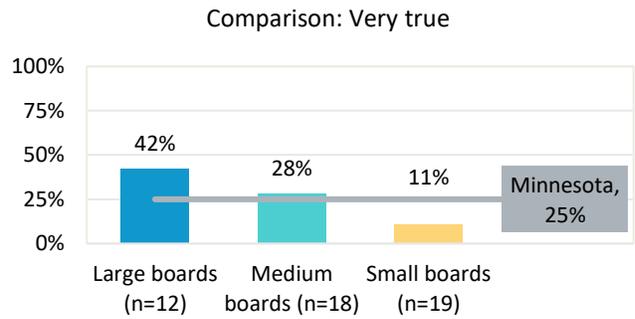
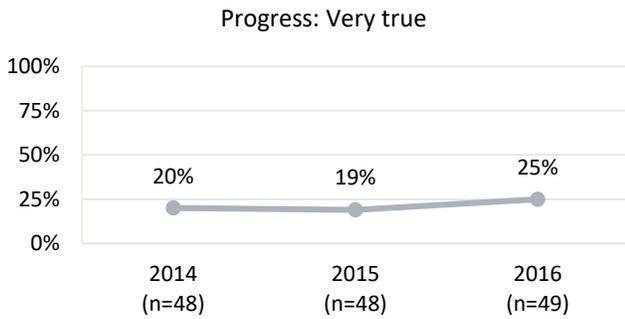
### Health Equity is a Priority



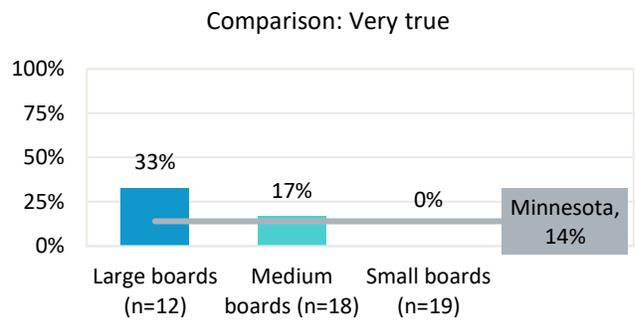
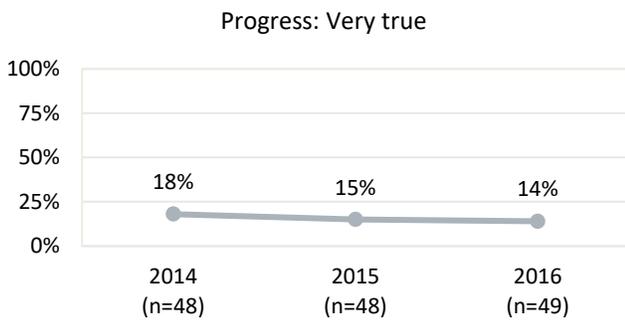
### Capacity Built for Health Equity



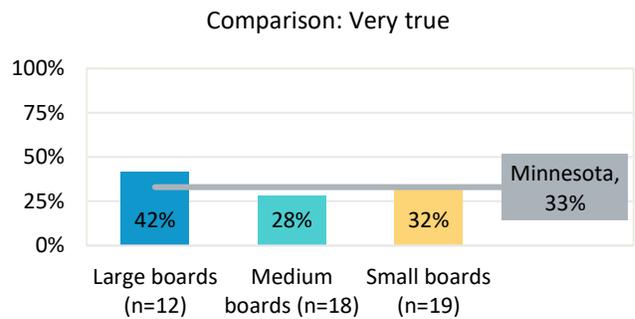
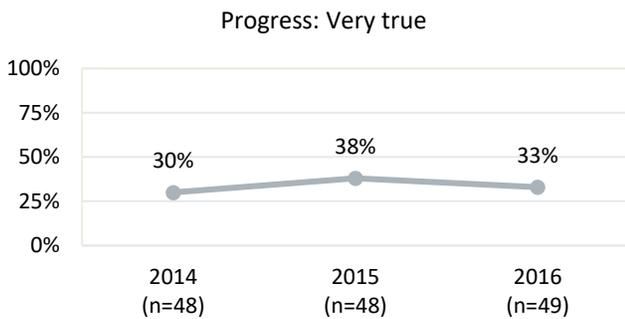
**Core Contingency of Staff Advance Health Equity**



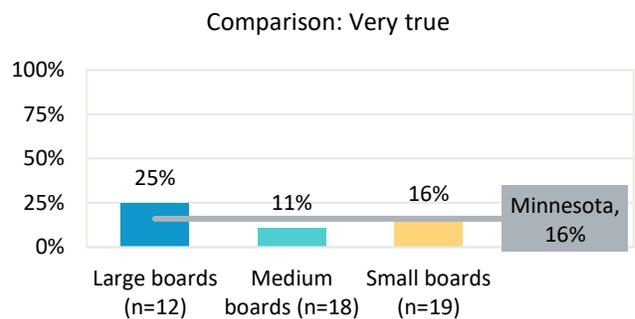
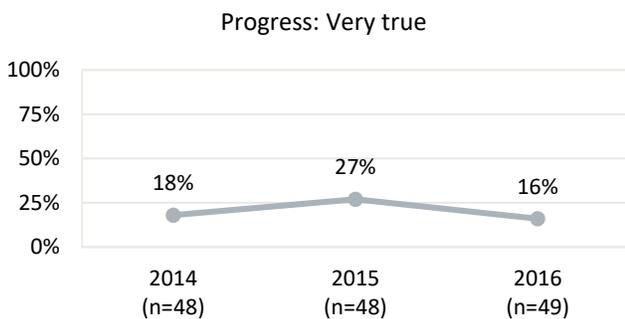
**Increased Internal Resources to Address Social Determinants of Health**



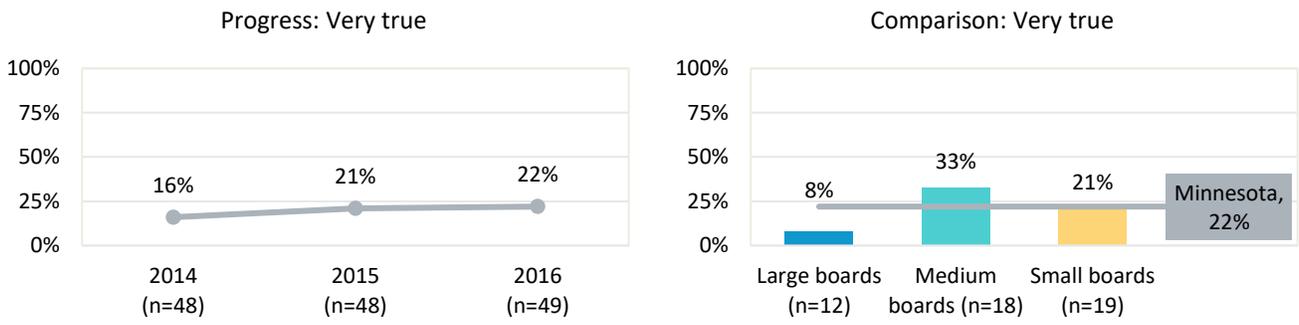
**Engagement with Local Agencies/Organizations**



**Increased Community Leadership Capacity**



### Supporting Community Groups' Concerns



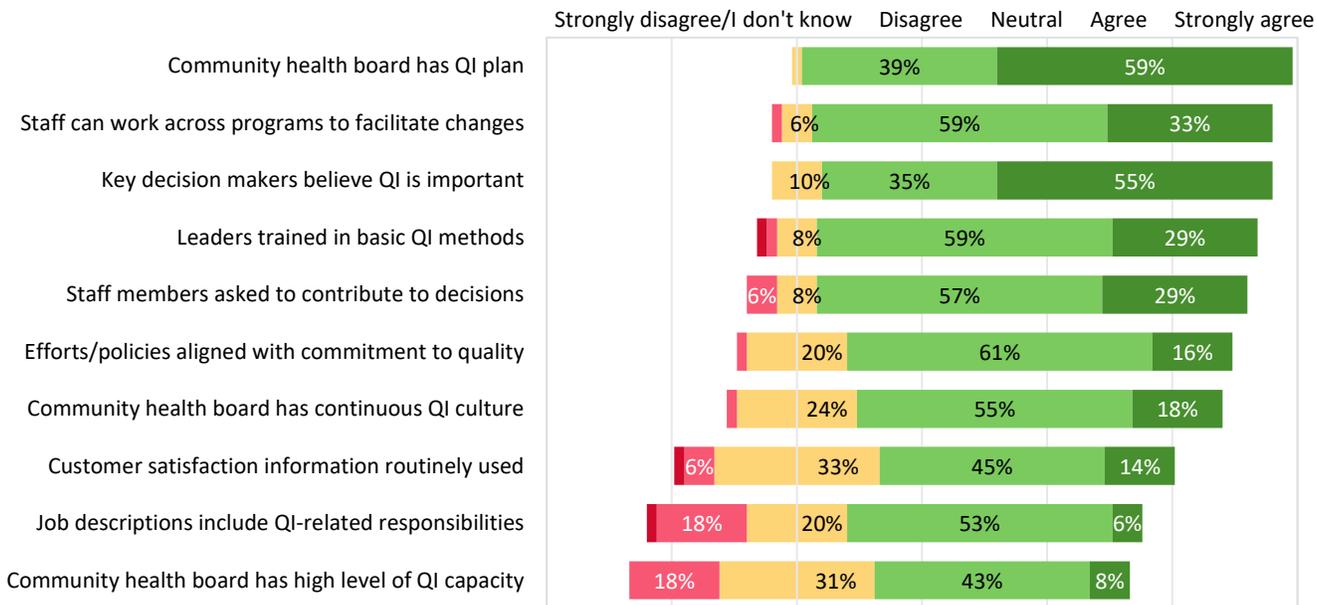
## Organizational QI Maturity

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 identify key areas for quality improvement, and determine additional education or training needed for staff and leadership.

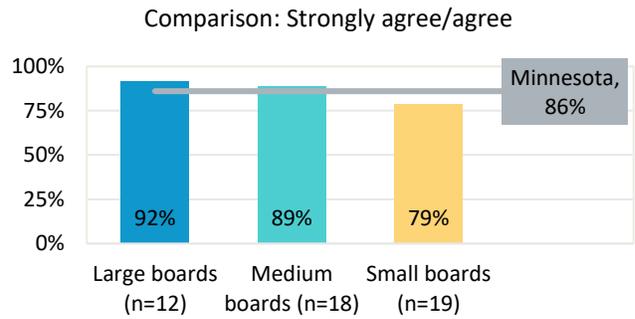
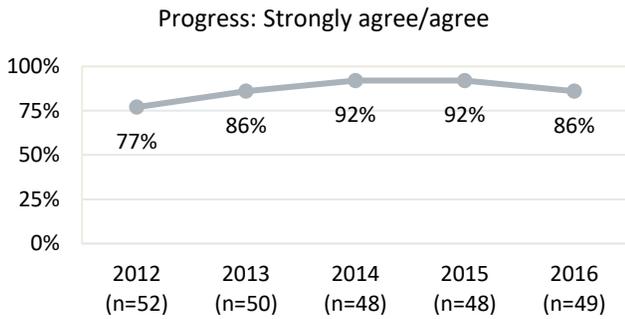
#### More Information

MDH Center for Public Health Practice  
 651-201-3880 | [health.ophp@state.mn.us](mailto:health.ophp@state.mn.us)  
[www.health.state.mn.us/divs/opi/qi](http://www.health.state.mn.us/divs/opi/qi)

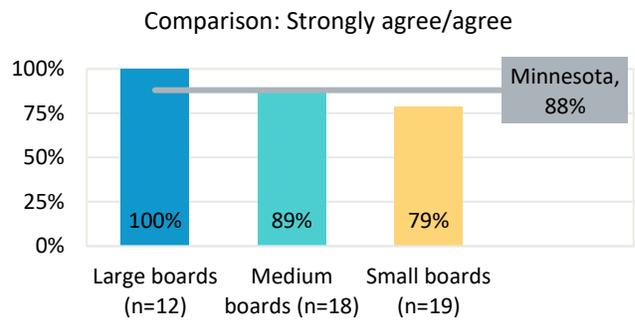
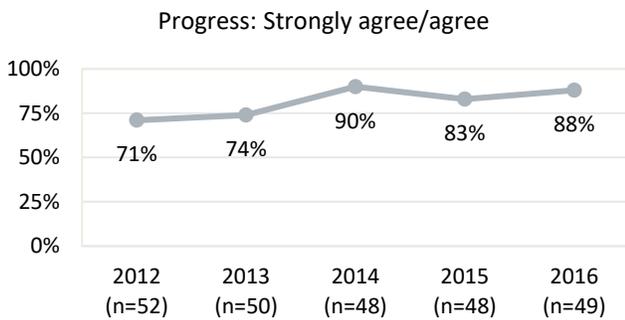
#### At a glance: Health equity efforts in Minnesota community health boards, 2016 (n=49)



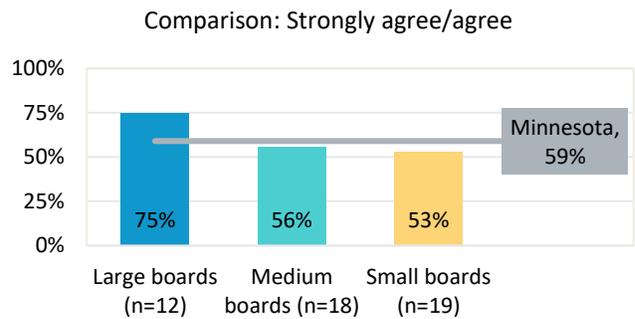
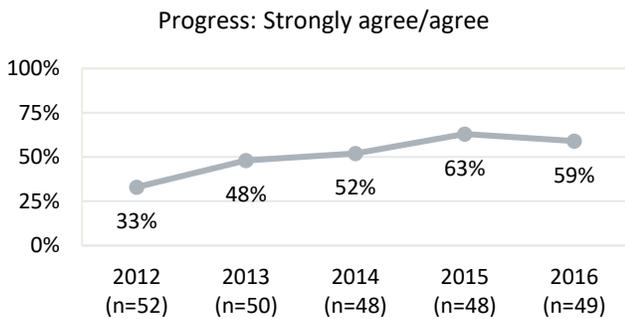
**Staff Members Asked to Contribute to Decisions**



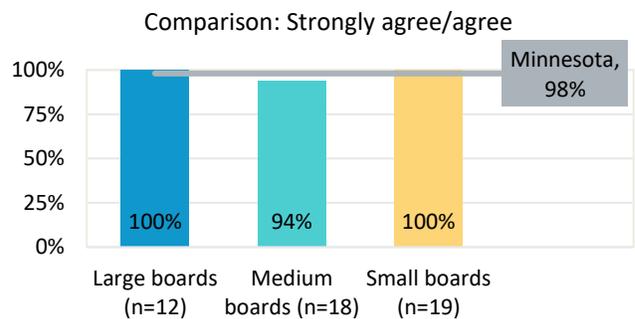
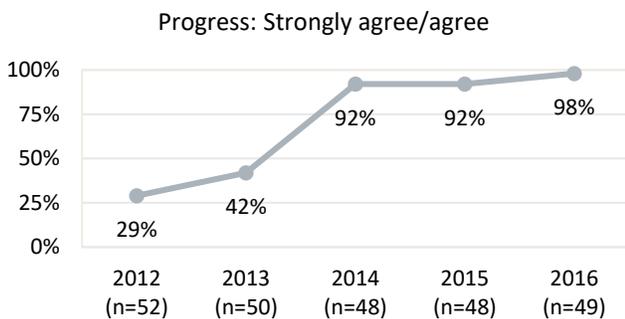
**Leaders Trained in Basic QI Methods**



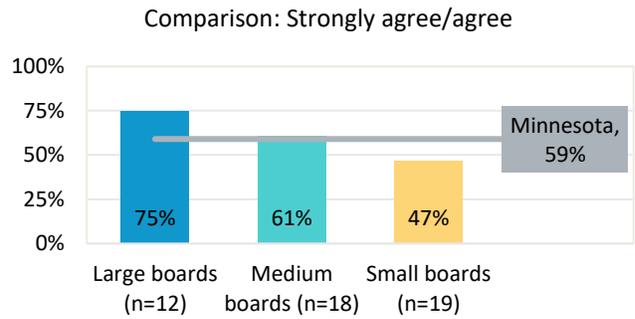
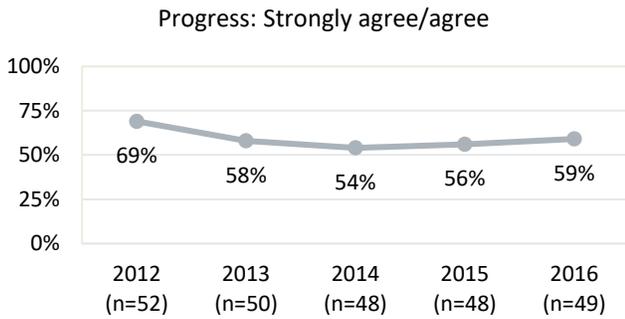
**Job Descriptions Include QI-Related Responsibilities**



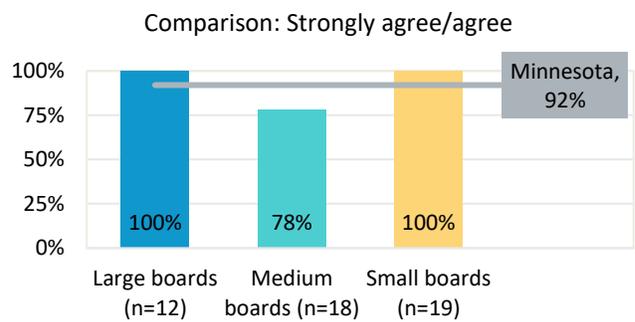
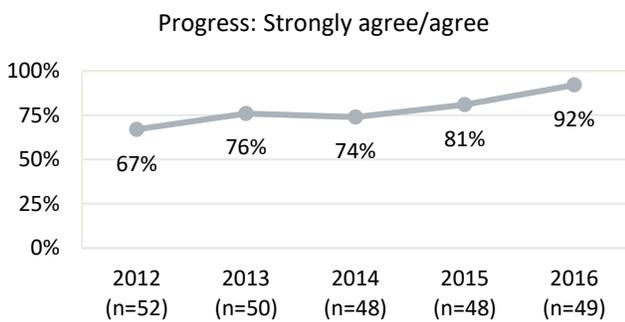
**Community Health Board has QI Plan**



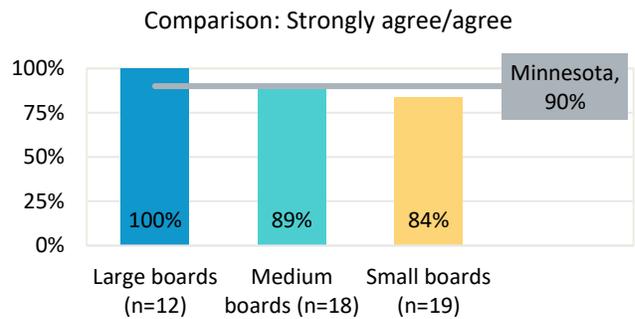
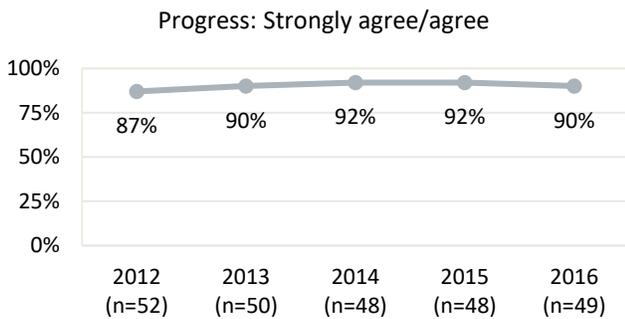
**Customer Satisfaction Information Routinely Used**



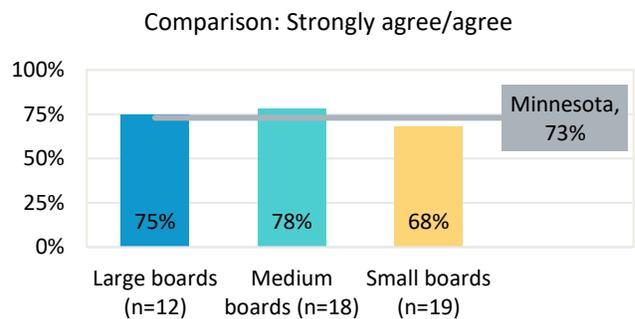
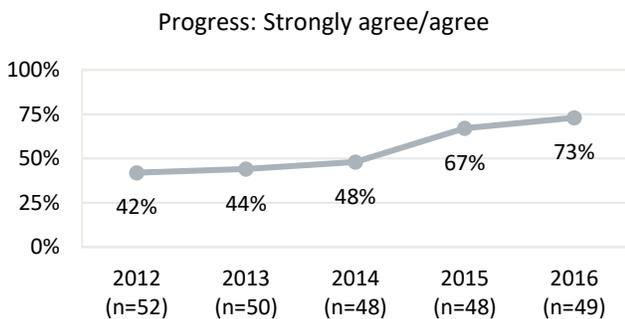
**Staff Can Work Across Programs to Facilitate Changes**



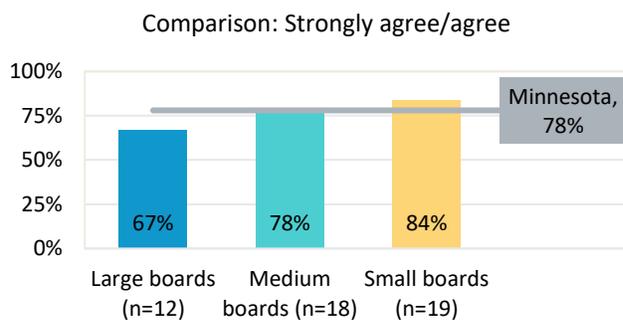
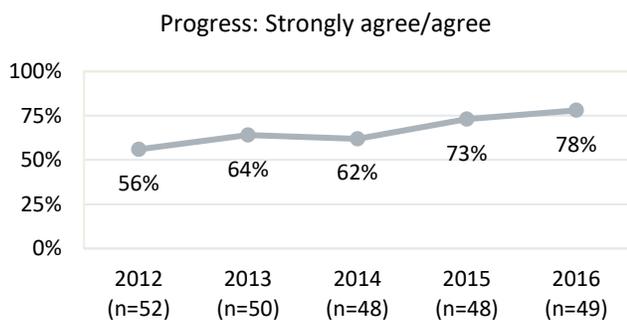
**Key Decision Makers Believe QI is Important**



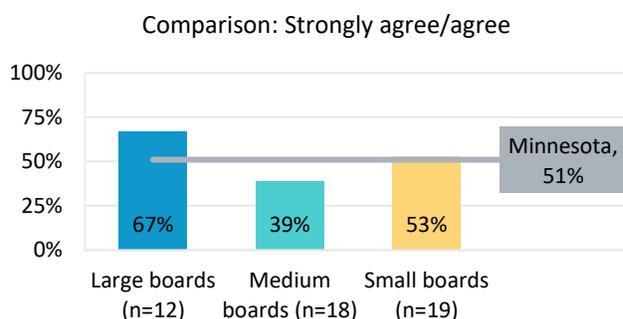
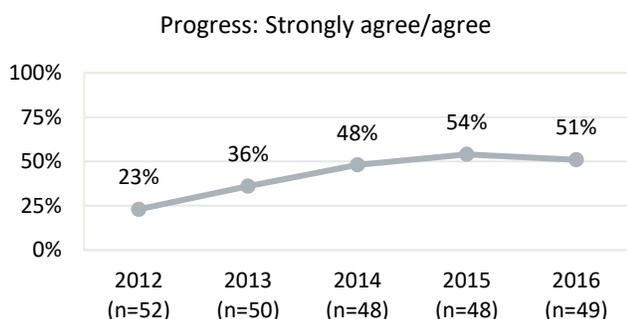
**Community Health Board has Continuous QI Culture**



### Efforts/Policies Aligned with Commitment to Quality

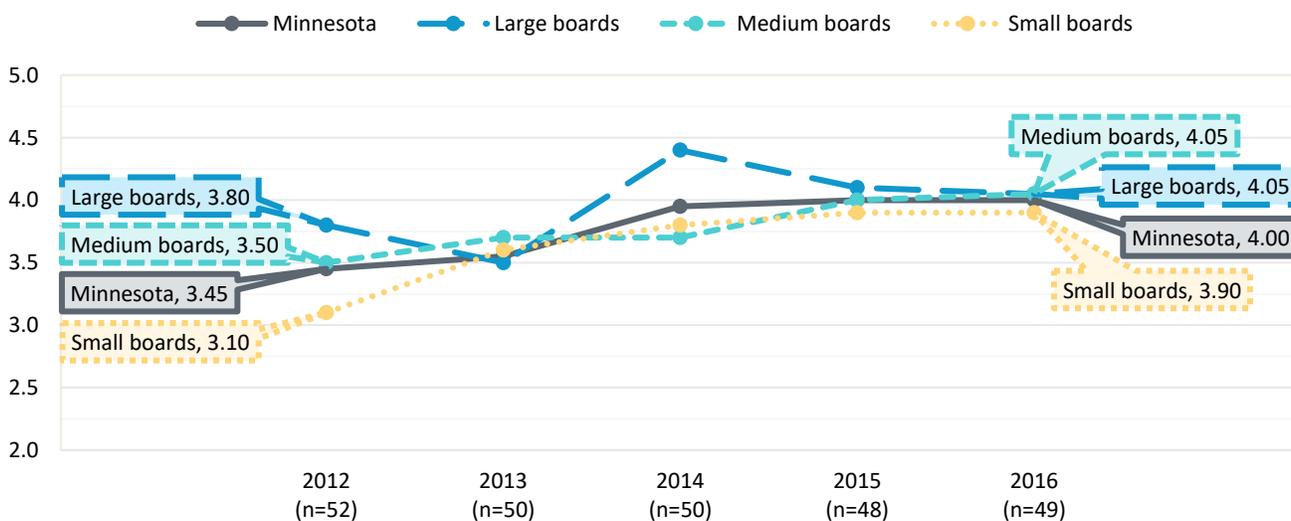


### Community Health Board Has a High Level of QI Capacity



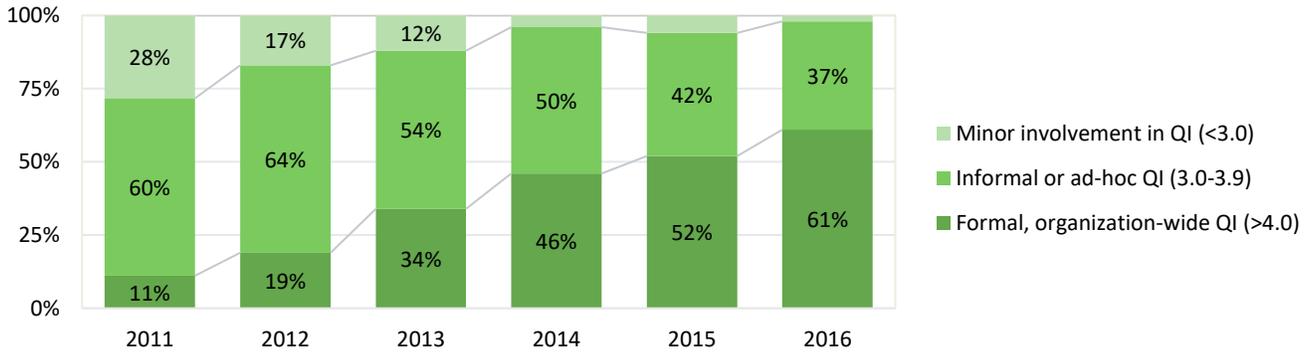
## Organizational QI Maturity Score

Progress: Median QI maturity score, by population, Minnesota community health boards, 2012-present



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 2012-2016 was obtained from annual reporting and the reporting entity was the community health board.

**Progress: System-wide QI maturity score distribution, Minnesota local public health, 2011-present**



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 2012-2016 was obtained from annual reporting and the reporting entity was the community health board.

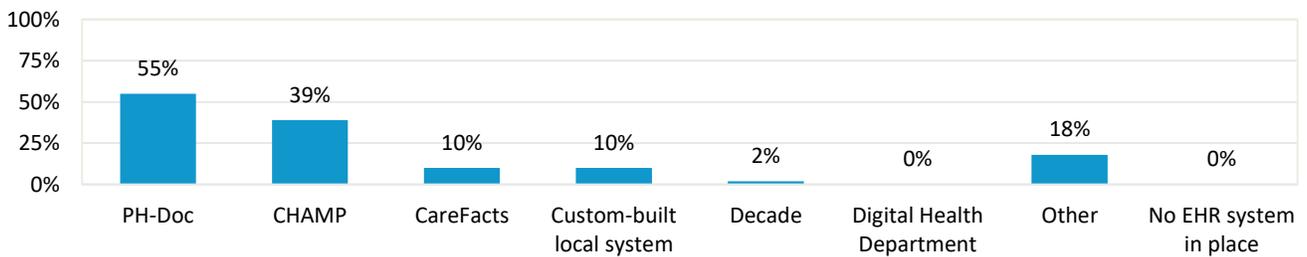
## Health Informatics

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.

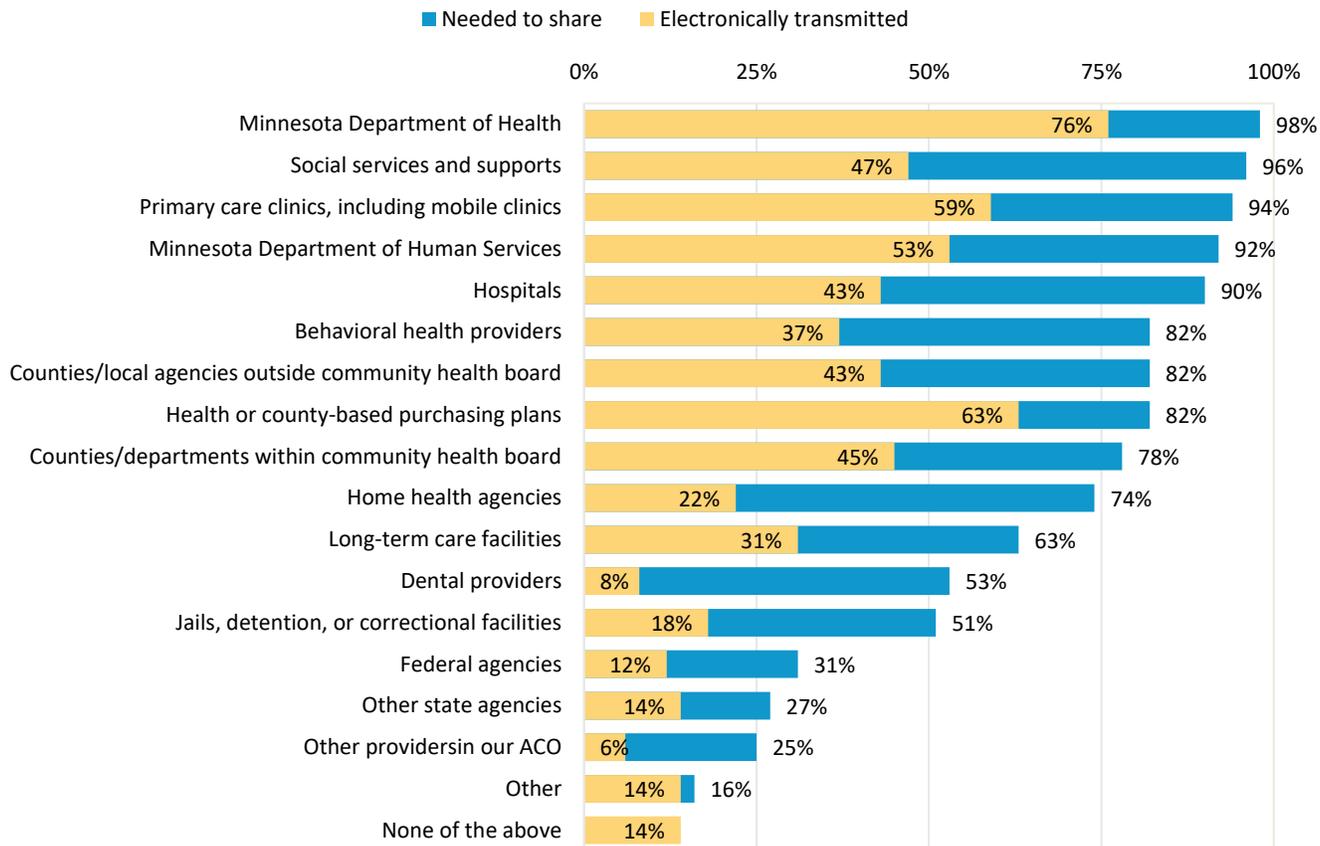
**More Information**

MDH Office of Health Information Technology  
 651-201-5508 | [MN.eHealth@state.mn.us](mailto:MN.eHealth@state.mn.us)  
[www.health.state.mn.us/divs/hpsc/ohit](http://www.health.state.mn.us/divs/hpsc/ohit)

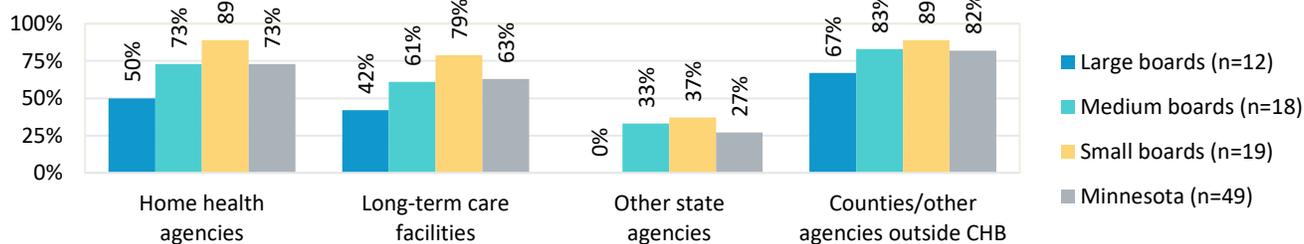
**EHR system software used, Minnesota community health boards, 2016 (n=49)**



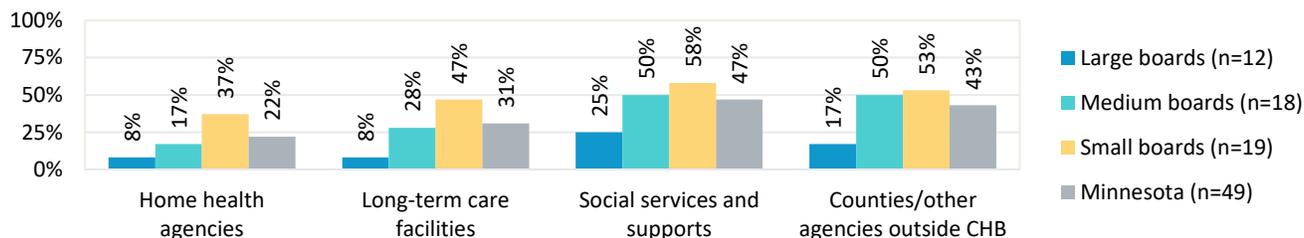
**Partners with which Minnesota community health boards needed to share information, 2016 (n=49)**



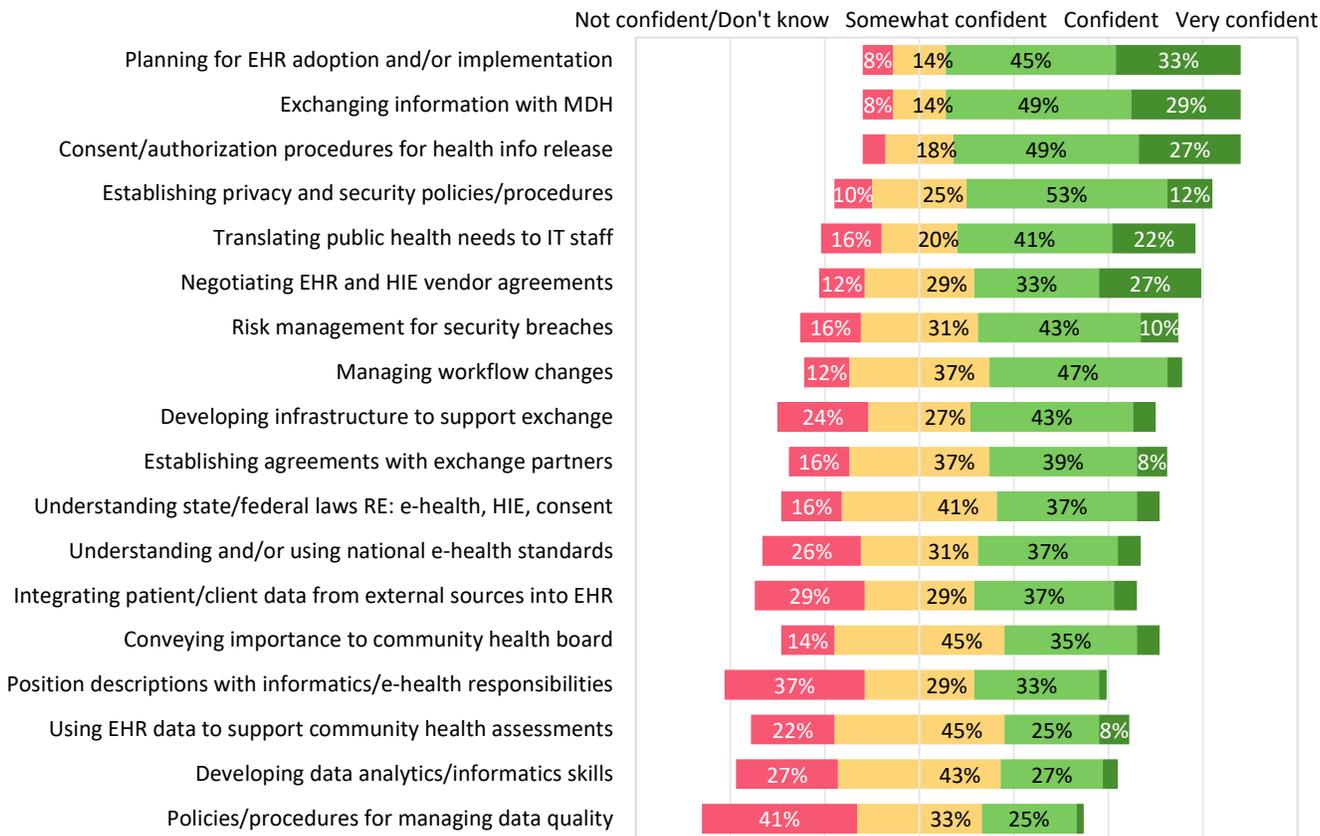
**Comparison: Partners with which Minnesota community health boards needed to share information, by population, 2016**



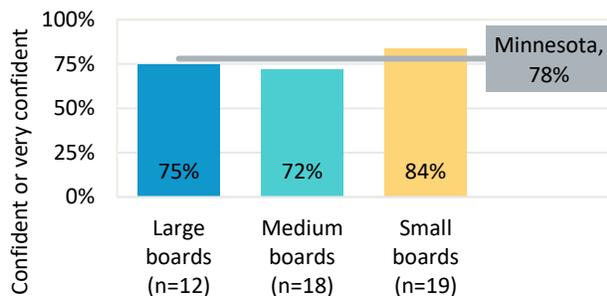
**Comparison: Partners with which Minnesota community health boards electronically transmitted information, by population, 2016**



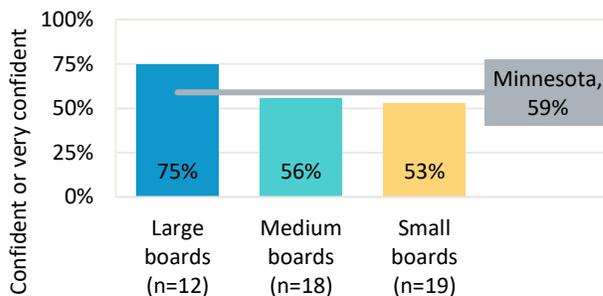
**At a glance: Confidence in e-health/informatics skills Minnesota community health boards, 2016 (n=49)**



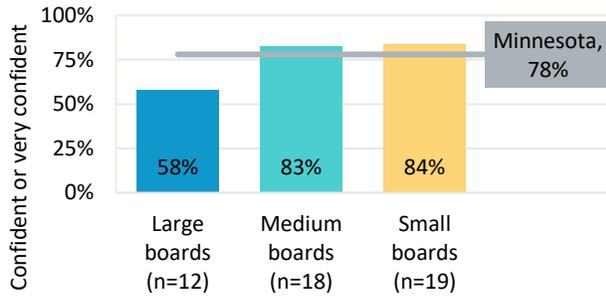
**Comparison: Capacity to plan for EHR adoption and/or implementation**



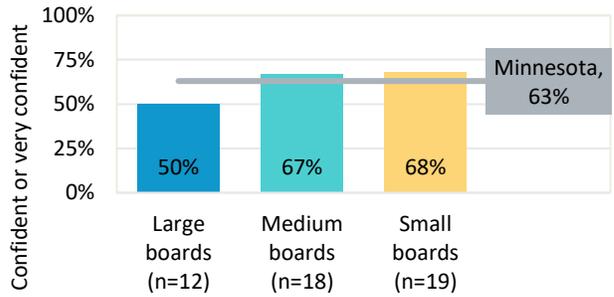
**Comparison: Capacity to negotiate EHR and HIE vendor agreements**



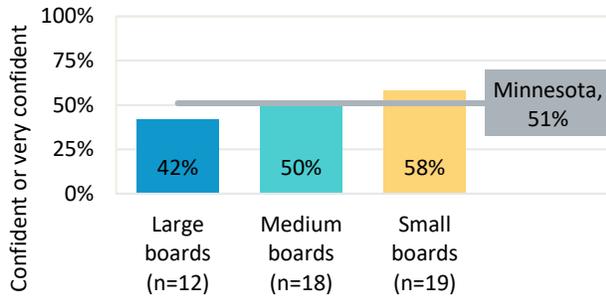
**Comparison: Capacity to exchange information with MDH**



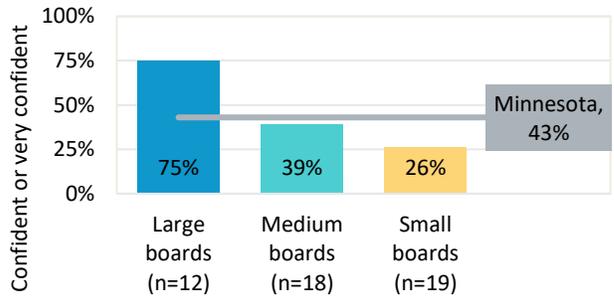
**Comparison: Capacity to translate public health needs to IT staff**



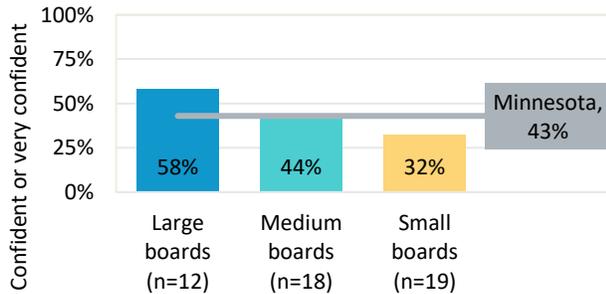
**Comparison: Capacity to manage workflow changes**



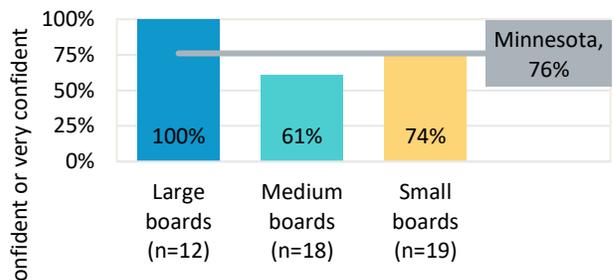
**Comparison: Capacity to understand and/or using national e-health standards**



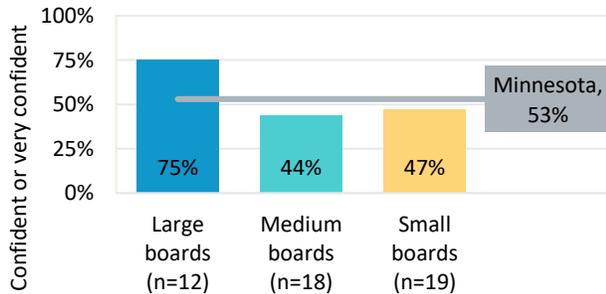
**Comparison: Capacity to understand state/federal laws RE: e-health, HIE, consent**



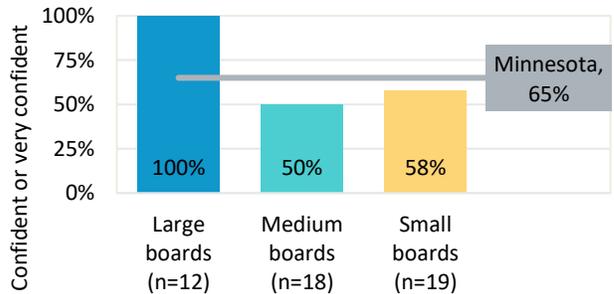
**Comparison: Capacity RE: consent/ authorization procedures for health info release**



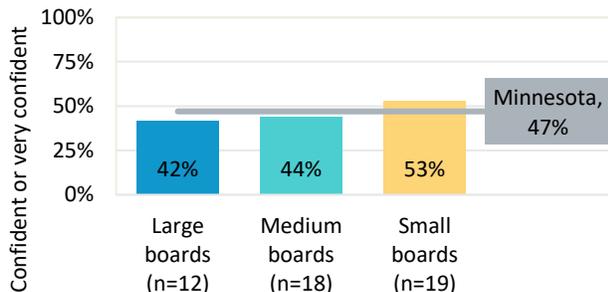
**Comparison: Capacity RE: risk management for security breaches**



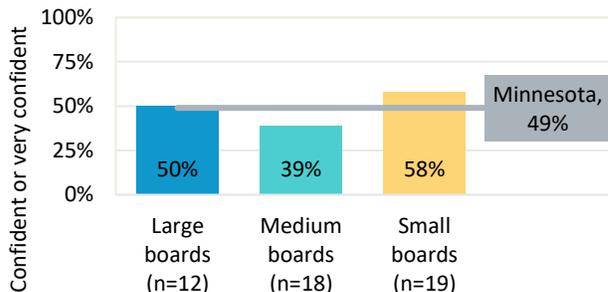
**Comparison: Capacity to establish privacy and security policies/ procedures**



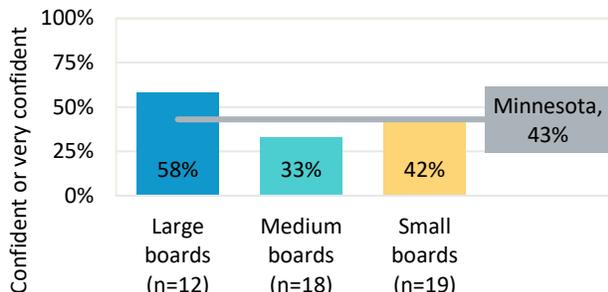
**Comparison: Capacity to establish agreements with exchange partners**



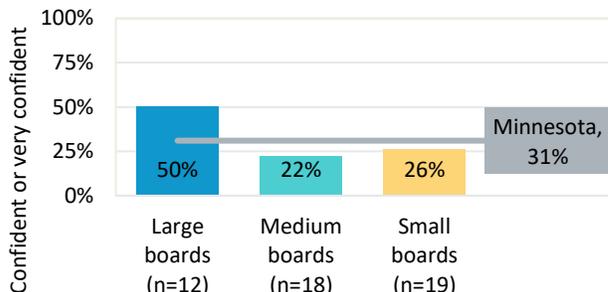
**Comparison: Capacity to develop infrastructure to support exchange**



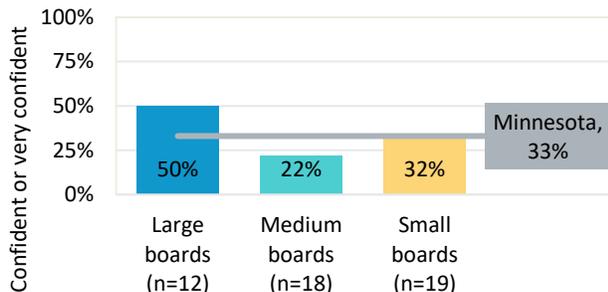
**Comparison: Capacity to integrate patient/client data from external sources into EHR**



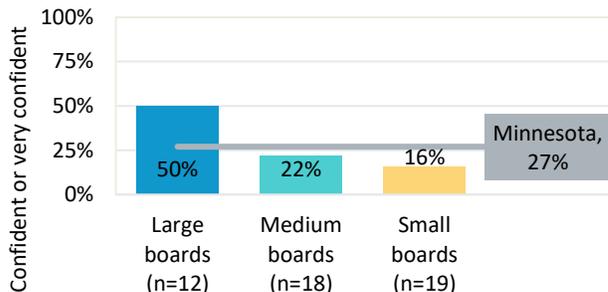
**Comparison: Capacity to develop data analytics/informatics skills**



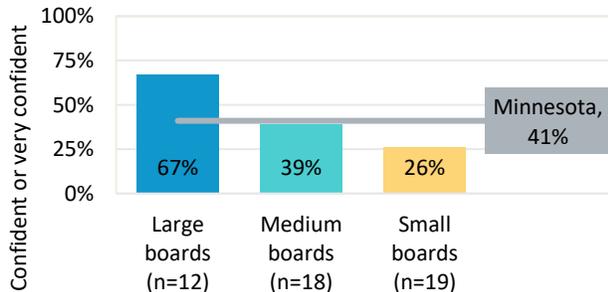
**Comparison: Capacity to use EHR data to support community health assessments**



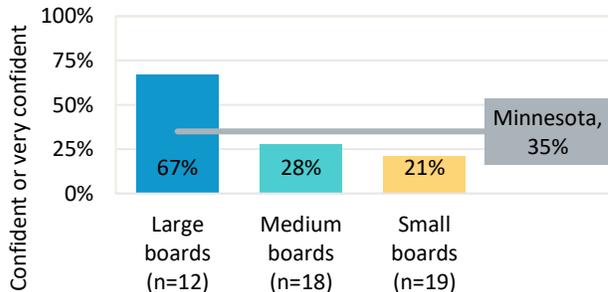
**Comparison: Capacity RE: policies/procedures for managing data quality**



**Comparison: Capacity to convey importance of informatics to CHB**



**Comparison: Capacity to develop position descriptions with e-health responsibilities**



## Voluntary Public Health Accreditation

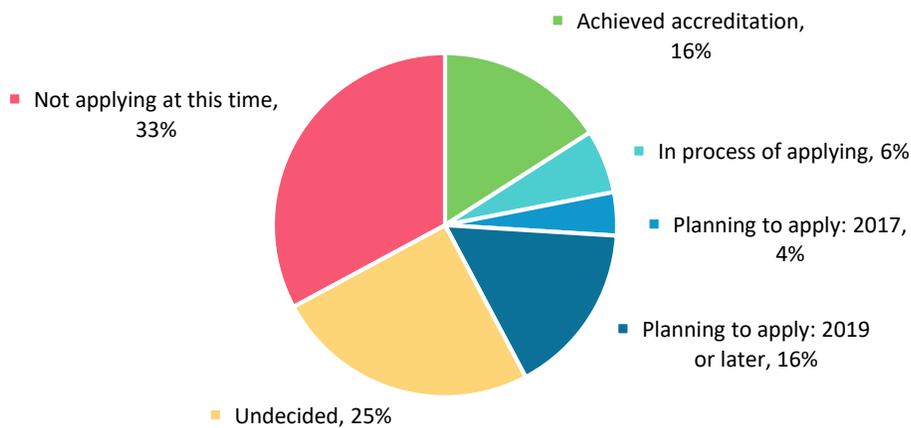
MDH uses this information to help understand and improve Minnesota’s public health system. Systematic information on accreditation preparation will be useful for networking, mentoring, and sharing among community health boards, and would enable monitoring system-level progress to implement the SCHSAC 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).

### More Information

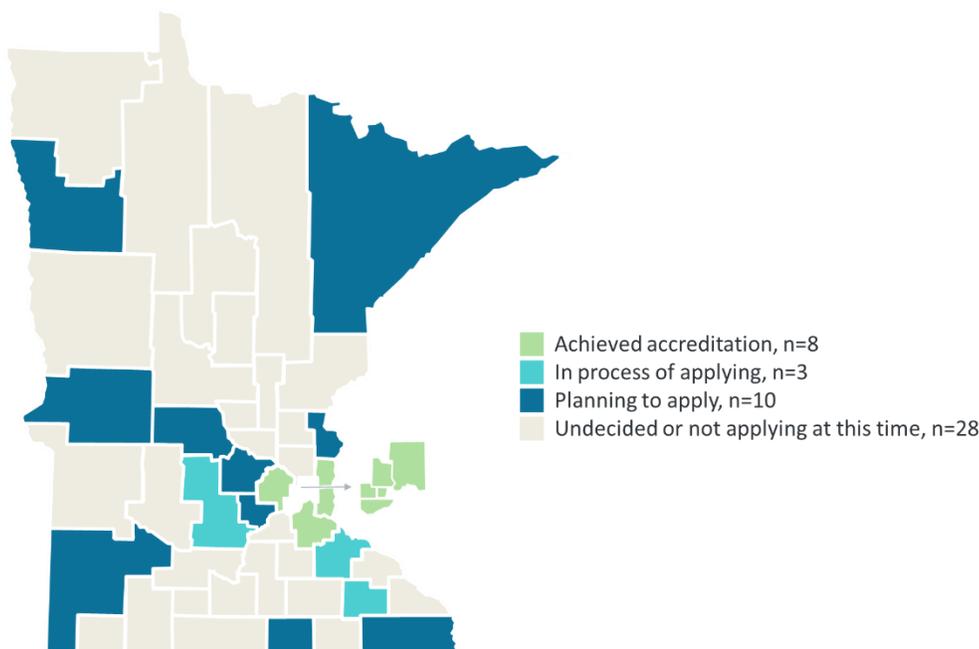
MDH Center for Public Health Practice  
 651-201-3880 | [health.ophp@state.mn.us](mailto:health.ophp@state.mn.us)  
[www.health.state.mn.us/divs/opi](http://www.health.state.mn.us/divs/opi)

Public Health Accreditation Board  
[www.phaboard.org](http://www.phaboard.org)

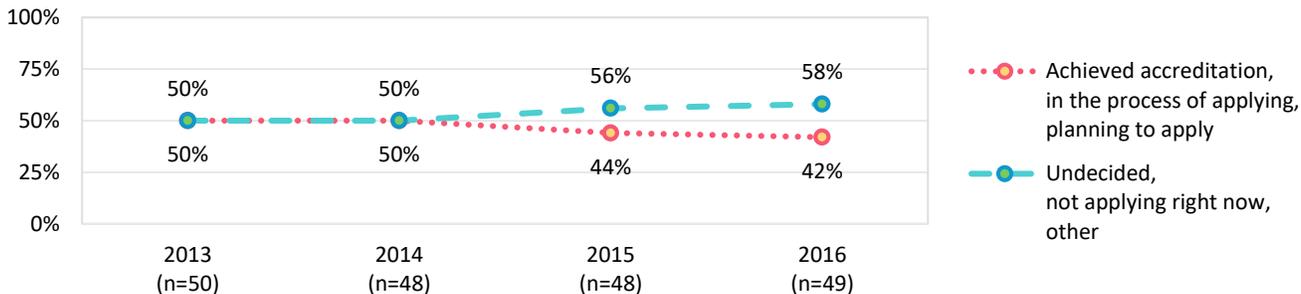
### Participation in national public health accreditation, Minnesota community health boards, 2016 (n=49)



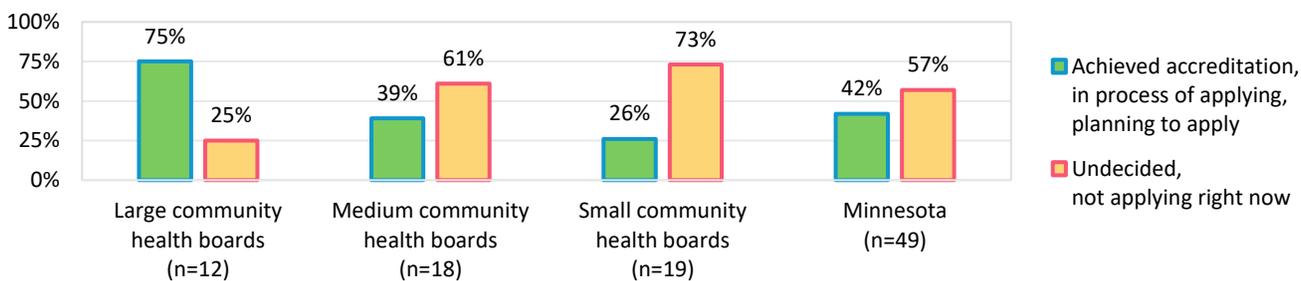
### Accreditation status, Minnesota community health boards, 2016



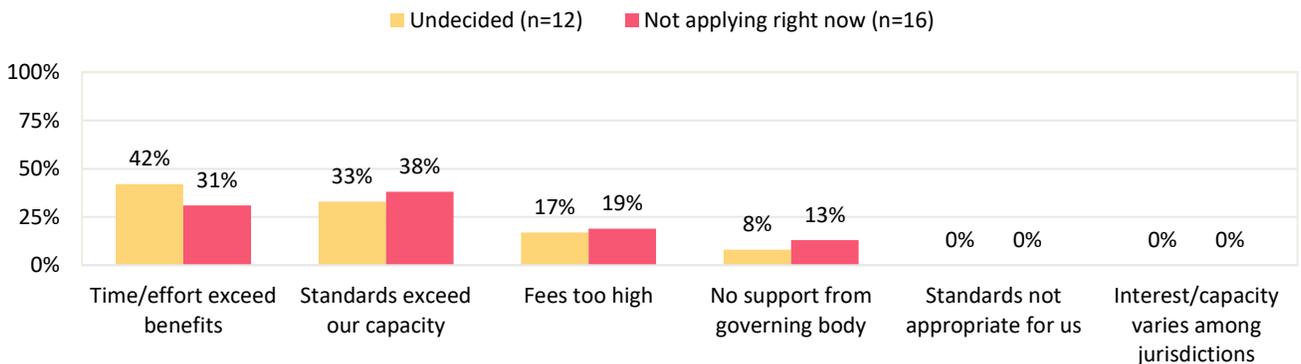
**Progress: Participation in national public health accreditation, Minnesota community health boards, 2013-present**



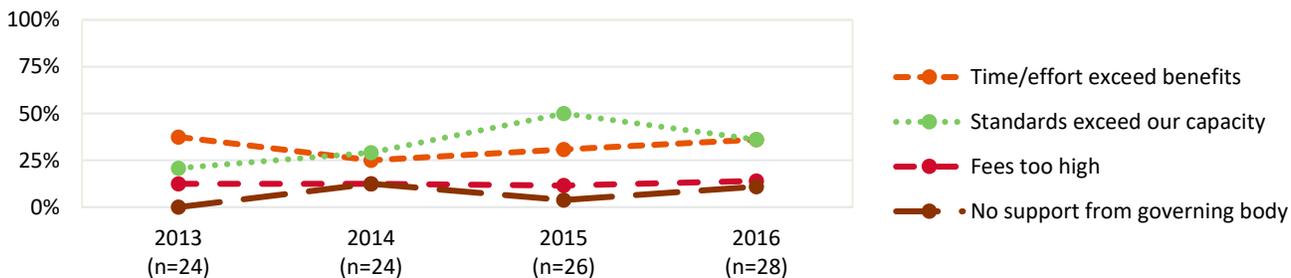
**Comparison: Participation in national public health accreditation, by population, Minnesota community health boards, 2016**



**Primary reason for not participating in accreditation, by current status, Minnesota community health boards, 2016**



**Change: Primary reason for not participating in accreditation, Minnesota community health boards, 2013-present**



# Promote Healthy Communities and Healthy Behaviors

Per Minn. Stat. § 145A (Local Public Health Act), Minnesota community health boards are expected to 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.

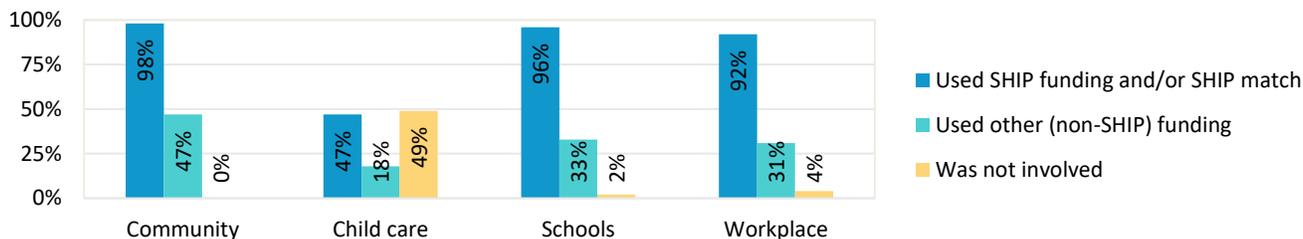
## Active Living

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

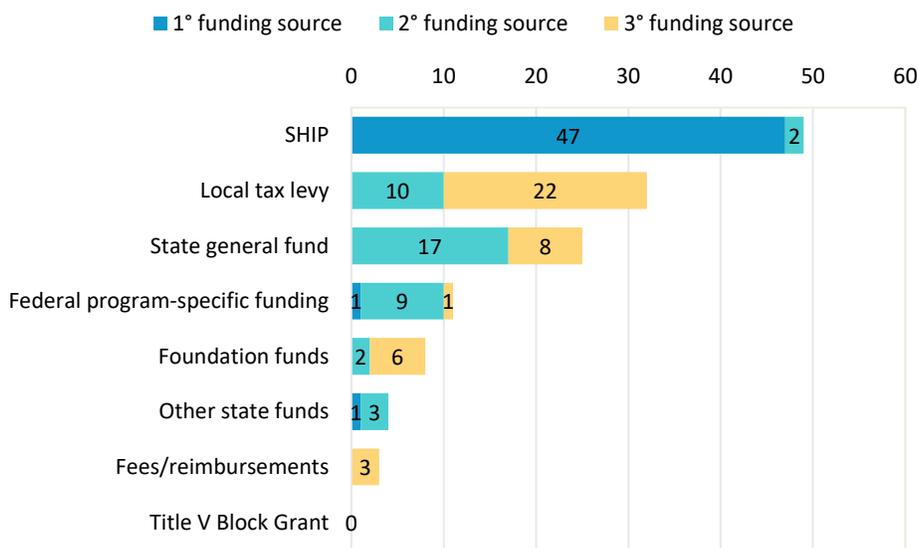
### More Information

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

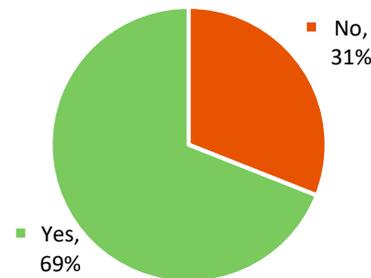
**Activities and funding supporting active living, Minnesota community health boards, 2016 (n=49)**



**All funding sources supporting active living, Minnesota community health boards, 2016 (n=49)**



**Local tax levy investment exceeds required state match (n=32)**



**Activities carried out to promote active living, Minnesota community health boards, 2016**

	Community (n=49)	Child care (n=25)	School (n=48)	Workplace (n=47)
Attended trainings	88%	76%	96%	96%
Conducted assessments	84%	84%	90%	96%
<b>Convened partners or participated in coalitions</b>	90%	68%	<b>98%</b>	<b>98%</b>
<b>Involved with community outreach and education</b>	<b>96%</b>	<b>92%</b>	83%	87%
Educated policymakers	84%	40%	77%	75%
Developed proposal or policy	61%	32%	71%	60%
Implemented policy (this year)	33%	28%	44%	43%
Maintained policy (previously implemented)	29%	32%	50%	23%
Evaluated policy impact	22%	12%	31%	23%

## Healthy Eating

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

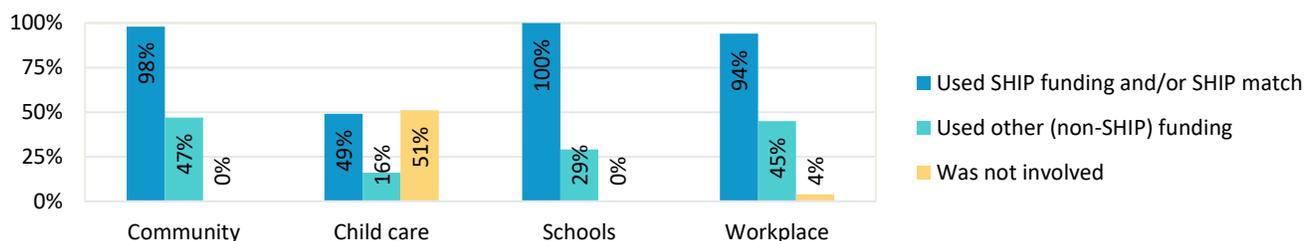
**More Information**

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

651-201-5443 | [health.oshii@state.mn.us](mailto:health.oshii@state.mn.us)

SHIP Grantee Support: [www.health.state.mn.us/healthreform/ship](http://www.health.state.mn.us/healthreform/ship)

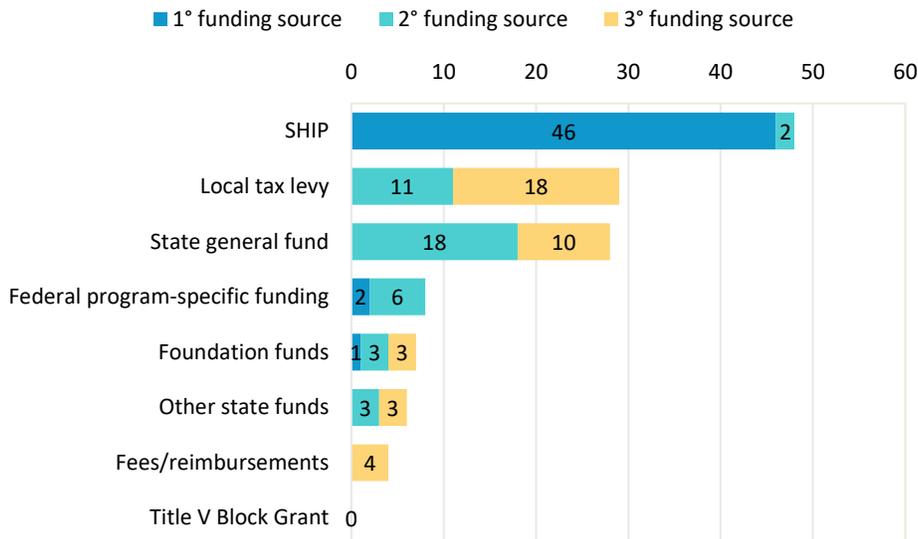
**Activities and funding supporting healthy eating, Minnesota community health boards, 2016 (n=49)**



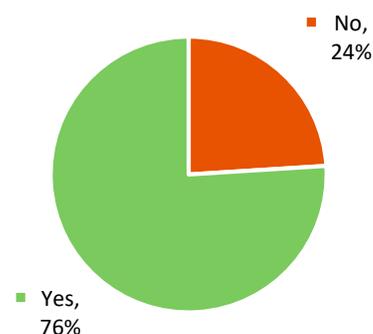
**Activities carried out to promote healthy eating, Minnesota community health boards, 2016**

	Community (n=49)	Child care (n=24)	School (n=49)	Workplace (n=47)
Attended trainings	98%	88%	96%	92%
Conducted assessments	82%	83%	96%	87%
<b>Convened partners or participated in coalitions</b>	<b>100%</b>	75%	<b>100%</b>	<b>100%</b>
<b>Involved with community outreach and education</b>	<b>96%</b>	<b>92%</b>	96%	89%
Educated policymakers	82%	50%	80%	75%
Developed proposal or policy	63%	46%	71%	53%
Implemented policy (this year)	39%	29%	47%	36%
Maintained policy (previously implemented)	27%	29%	47%	36%
Evaluated policy impact	25%	13%	27%	19%

**All funding sources supporting healthy eating, Minnesota community health boards, 2016 (n=49)**



**Local tax levy investment exceeds required state match (n=29)**



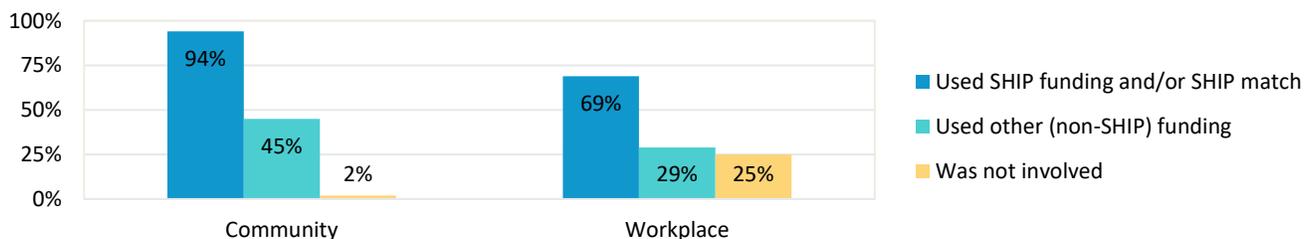
**Tobacco-Free Living**

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

**More Information**

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

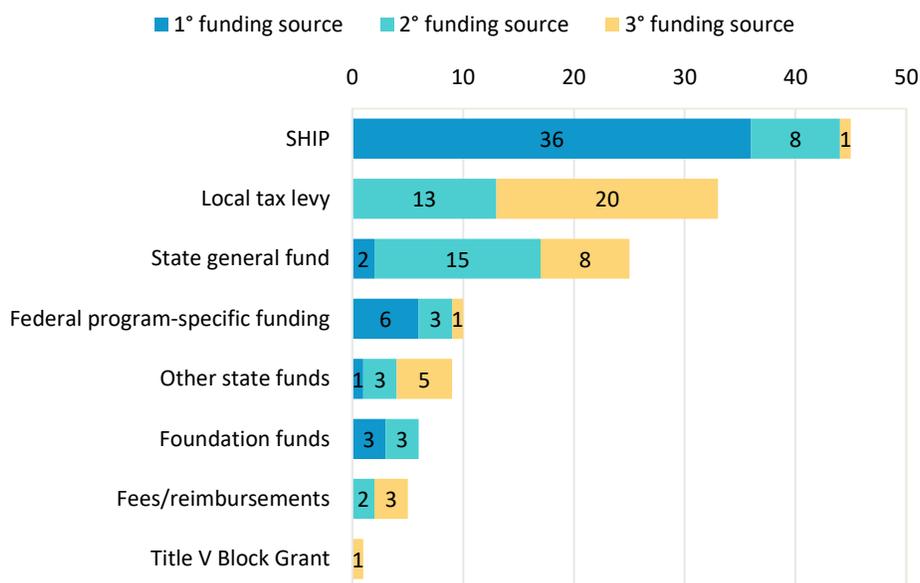
**Activities and funding supporting tobacco-free living, Minnesota community health boards, 2016 (n=49)**



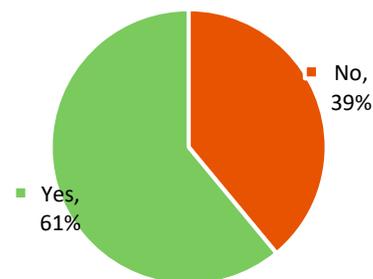
**Activities carried out to promote tobacco-free living, Minnesota community health boards, 2016**

	Community (n=48)	Workplace (n=37)
Attended trainings	88%	84%
<b>Conducted assessments</b>	88%	<b>95%</b>
<b>Convened partners or participated in coalitions</b>	92%	<b>95%</b>
<b>Involved with community outreach and education</b>	<b>94%</b>	89%
Educated policymakers	75%	73%
Developed proposal or policy	63%	73%
Implemented policy (this year)	46%	54%
Maintained policy (previously implemented)	56%	54%
Evaluated policy impact	23%	27%

**All funding sources supporting tobacco-free living, Minnesota community health boards, 2016 (n=48)**



**Local tax levy investment exceeds required state match (n=33)**



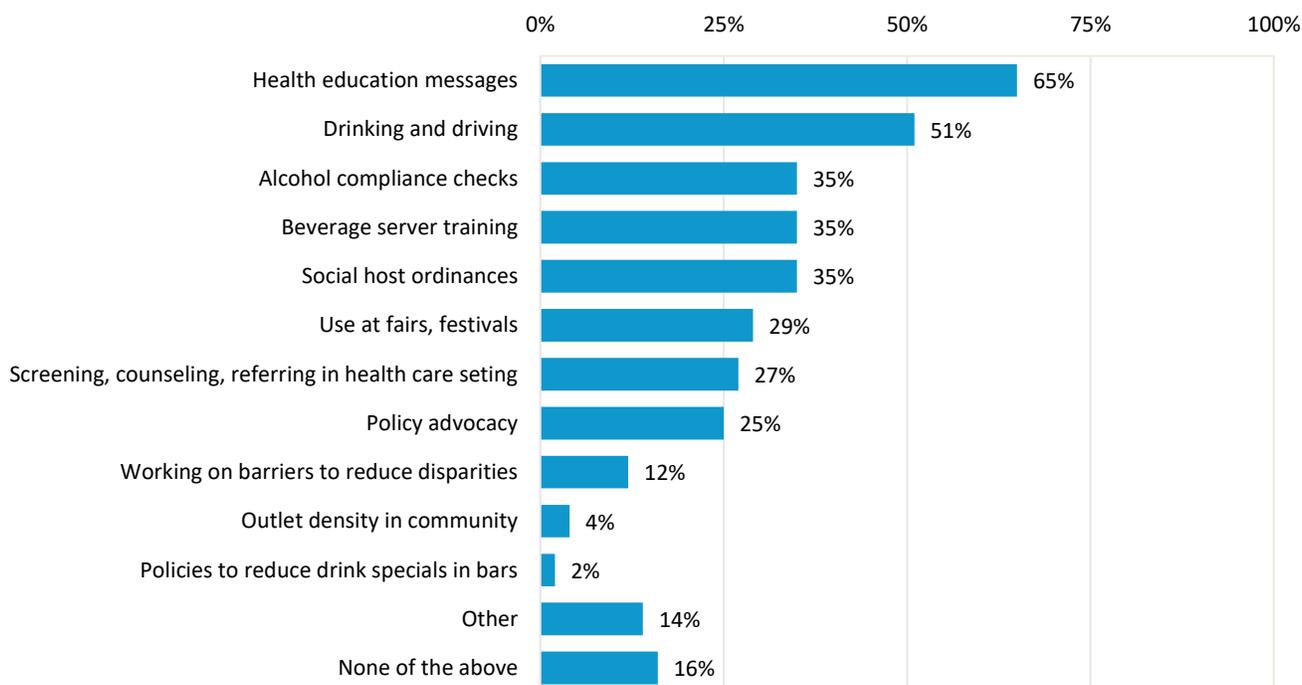
## Alcohol

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

### More Information

MDH Health Promotion and Chronic Disease Division, Injury and Violence Prevention Unit  
651-201-5400 | [health.injuryprevention@state.mn.us](mailto:health.injuryprevention@state.mn.us)

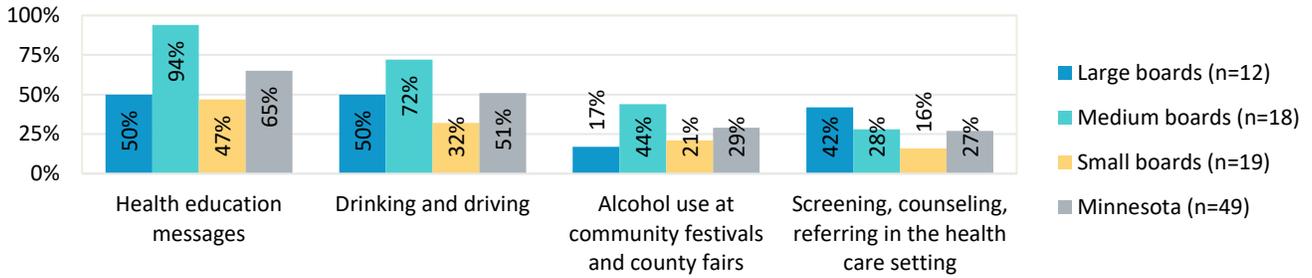
### Strategies used related to alcohol use, Minnesota community health boards, 2016 (n=49)



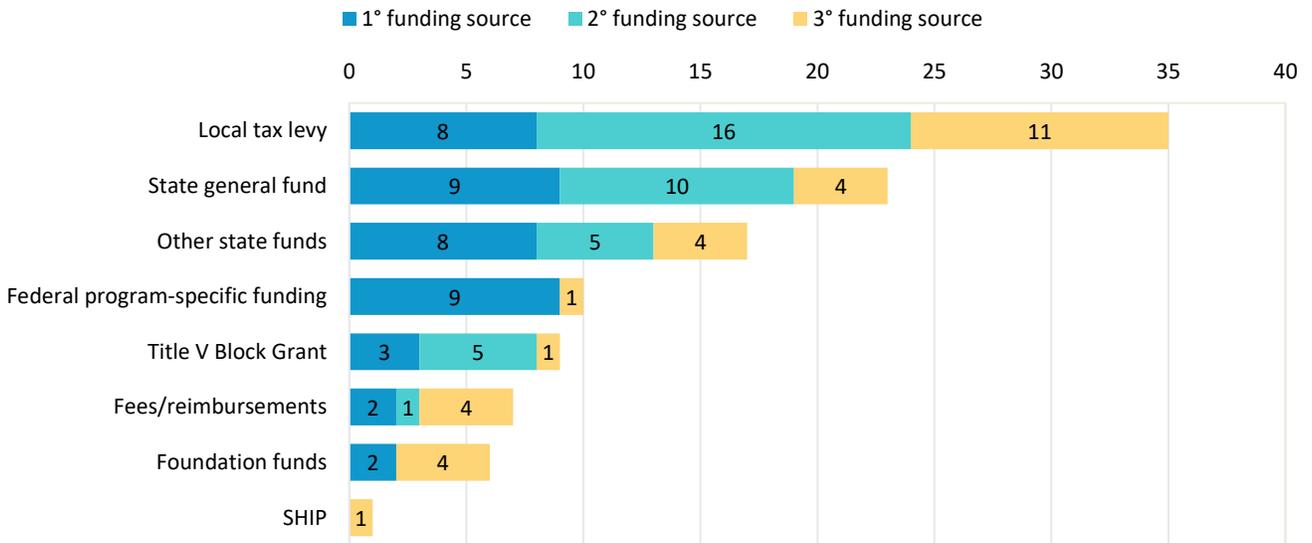
### Top activities carried out related to alcohol use, Minnesota community health boards, 2016

	Health education messages (n=32)	Drinking and driving (n=25)	Alcohol compliance checks (n=17)	Beverage server training (n=17)	Social host ordinances (n=17)
Attended trainings	50%	48%	12%	53%	24%
Conducted assessments	25%	16%	41%	24%	18%
<b>Convened partners or participated in coalitions</b>	<b>88%</b>	<b>88%</b>	53%	<b>94%</b>	<b>77%</b>
<b>Involved with community outreach and education</b>	<b>94%</b>	<b>88%</b>	41%	71%	59%
Educated policymakers	47%	56%	41%	59%	47%
Developed proposal or policy	3%	0%	6%	6%	29%
Implemented policy (this year)	3%	0%	6%	6%	29%
<b>Maintained policy (previously implemented)</b>	3%	4%	<b>71%</b>	24%	59%
Evaluated policy impact	0%	4%	12%	12%	12%

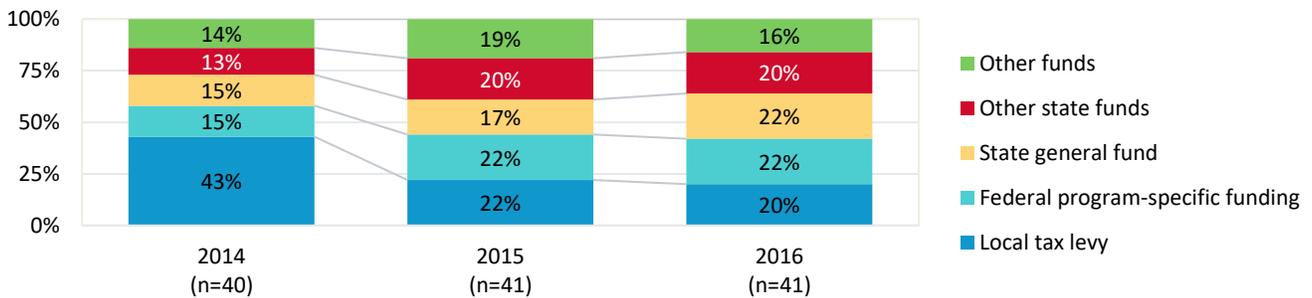
**Comparison: Strategies used related to alcohol use, by population, Minnesota community health boards, 2016**



**All funding sources related to alcohol use, Minnesota community health boards, 2016 (n=41)**



**Change: Primary funding source related to alcohol use, Minnesota community health boards, 2014-present**



## Maternal and Child Health

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.

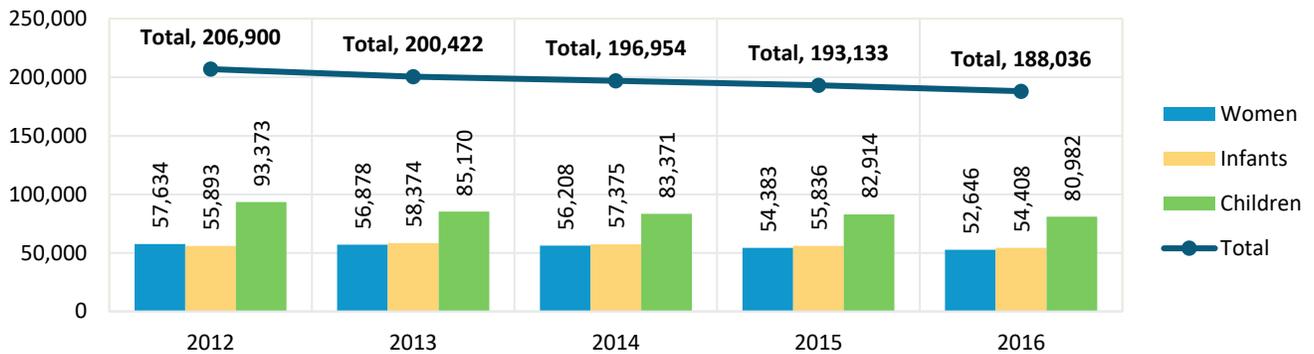
### More Information

MDH Community and Family Health Division, Maternal and Child Health Section

651-201-3760 | [health.cfhcommunications@state.mn.us](mailto:health.cfhcommunications@state.mn.us)

[www.health.state.mn.us/divs/cfh/program/mch](http://www.health.state.mn.us/divs/cfh/program/mch)

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



# Prevent the Spread of Communicable Diseases

Per Minn. Stat. § 145A (Local Public Health Act), Minnesota community health boards are expected to 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.

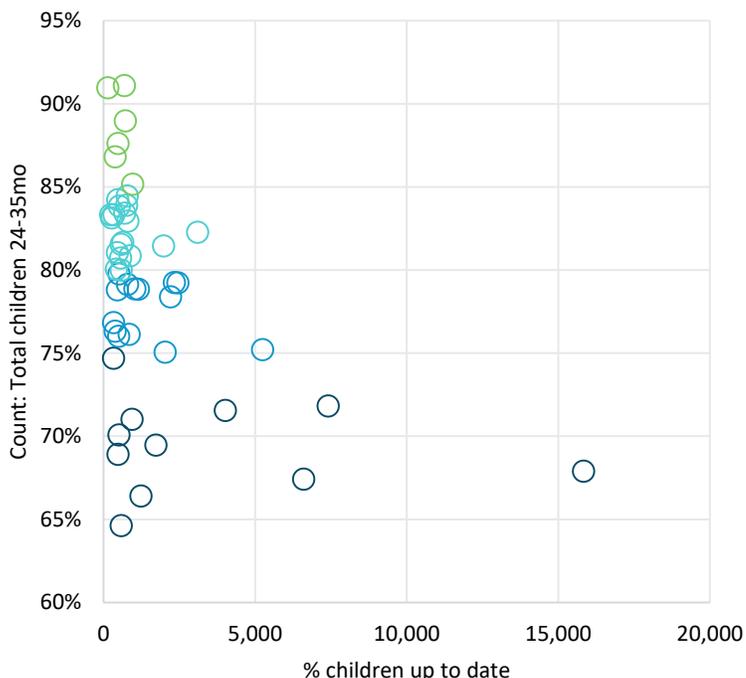
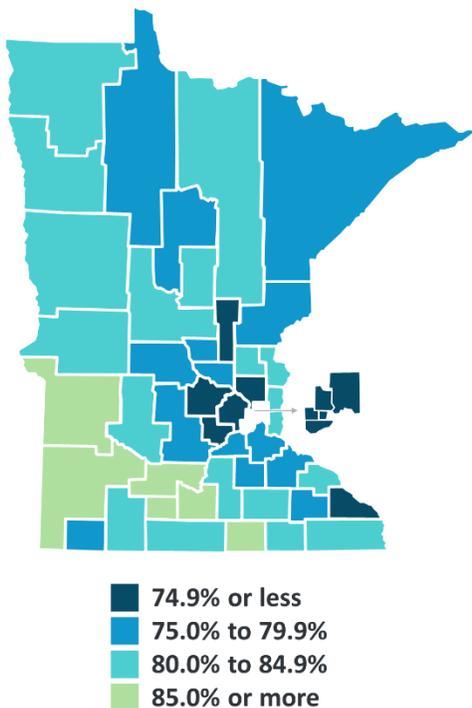
## Immunization

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

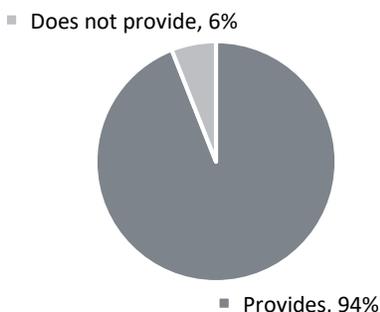
### More Information

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

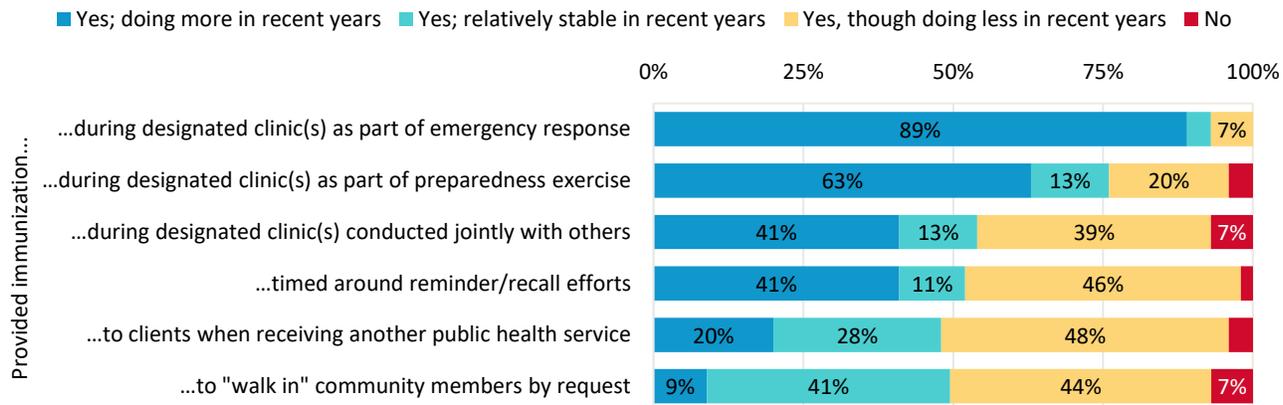
### Children aged 24-35 months who are up to date on immunizations, Minnesota community health boards, 2016 (n=49)



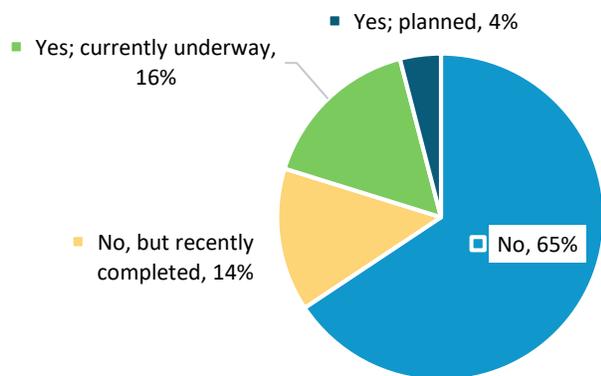
### Community health boards providing immunizations, Minnesota, 2016 (n=49)



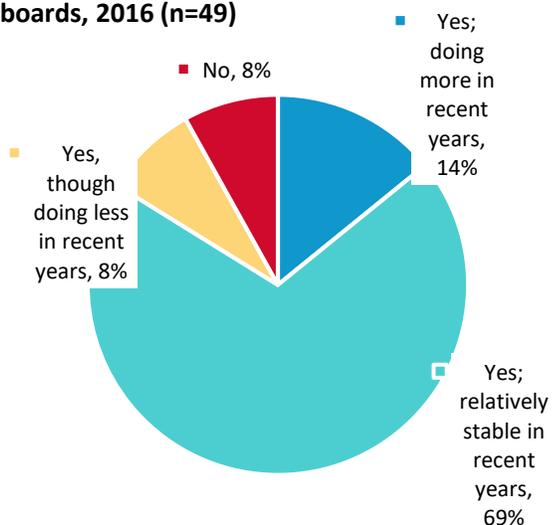
**Trends in immunization-related services, Minnesota community health boards, 2016 (n=46)**



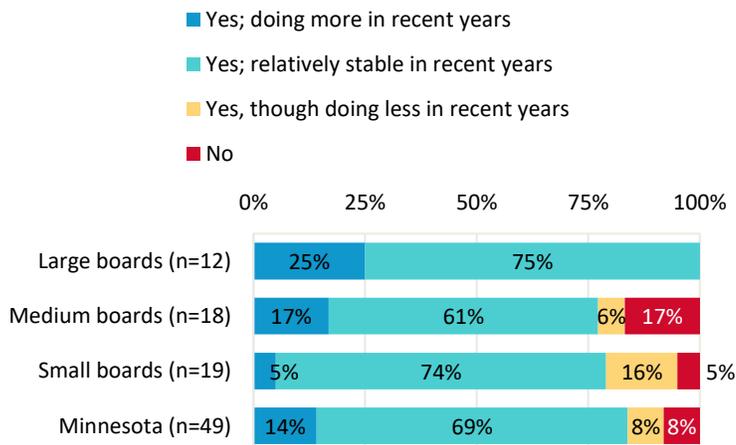
**Re-examination of role in providing immunization services, Minnesota community health boards, 2016 (n=49)**



**Referring clients for immunizations, Minnesota community health boards, 2016 (n=49)**



**Comparison: Referring clients for immunizations, by population, Minnesota community health boards, 2016**



**Immunization-related activities performed by Minnesota community health boards, 2016 (n=49)**

	Routinely	During an emergency response	For influenza vaccination	For non-influenza immunization	Not performed
Provided education to community	90%	6%	53%	47%	2%
Engaged with immunization providers to discuss immunization coverage	80%	6%	31%	43%	6%
Engaged with partners to coordinate services	80%	6%	45%	35%	10%
Used MIIC data to engage immunization providers in immunization improvement activities	82%	2%	10%	35%	10%
Used MIIC data to conduct reminder/recall outreach for clients of the community health board	78%	2%	6%	27%	20%
Used MIIC data to conduct reminder/recall outreach for residents of the jurisdiction	49%	2%	2%	20%	43%
Used QI tools and processes to improve immunization practices or delivery in the community health board	51%	0%	12%	27%	41%
Served as a resource on current recommendations and best practices regarding immunization	96%	6%	29%	38%	4%
Conducted population-based needs assessment informed by immunization coverage levels in MIIC	53%	2%	12%	25%	41%
Mentored one or more community health boards to help them improve immunization rates	12%	0%	0%	2%	88%
Coordinated with community health board's MIIC regional coordinator	82%	0%	10%	27%	10%

# Protect Against Environmental Health Hazards

Per Minn. Stat. § 145A (Local Public Health Act), Minnesota community health boards are expected to 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.

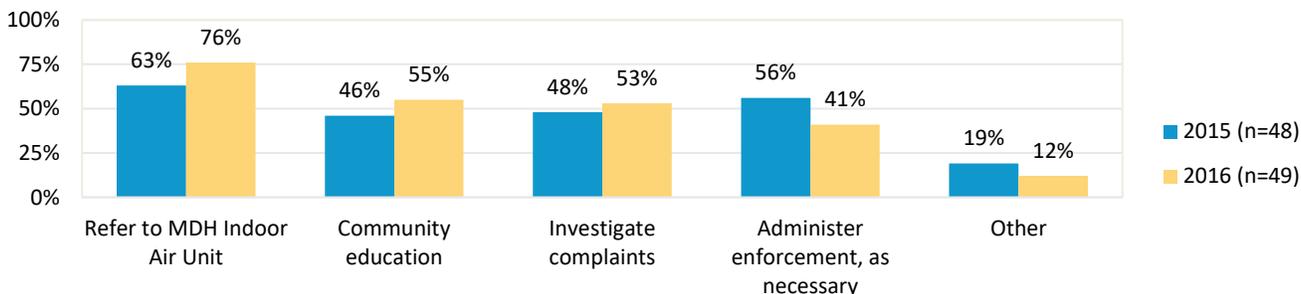
## Indoor Air: Minnesota Clean Indoor Air Act

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

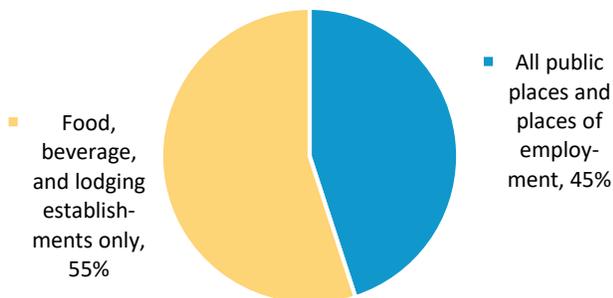
### More Information

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

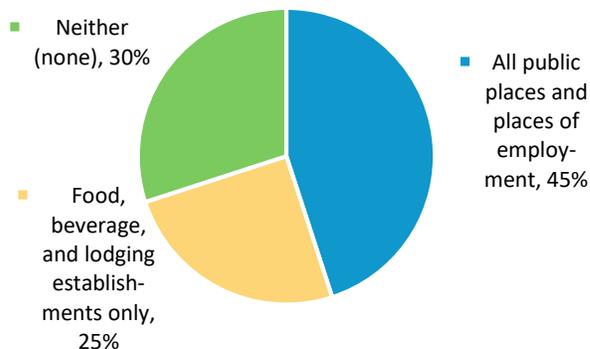
### Ways community health boards support the Minnesota Clean Indoor Air Act, 2015-present



### Facilities where community health boards enforce the Minnesota Clean Indoor Air Act, 2016 (n=20)



### Facilities where community health boards enforce smoking-related ordinances, Minnesota, 2016 (n=20)



## 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, cleanup and removal.

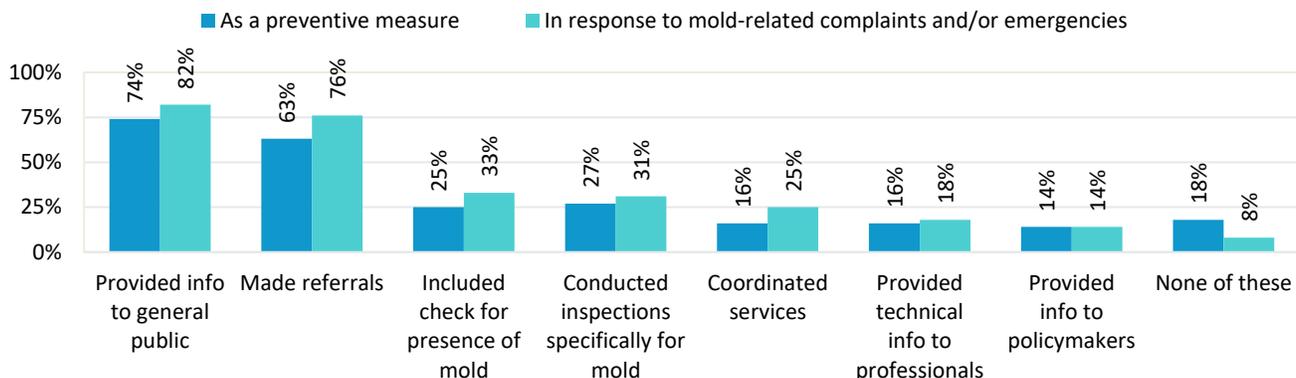
### More Information

MDH Environmental Health Division, Indoor Air Program

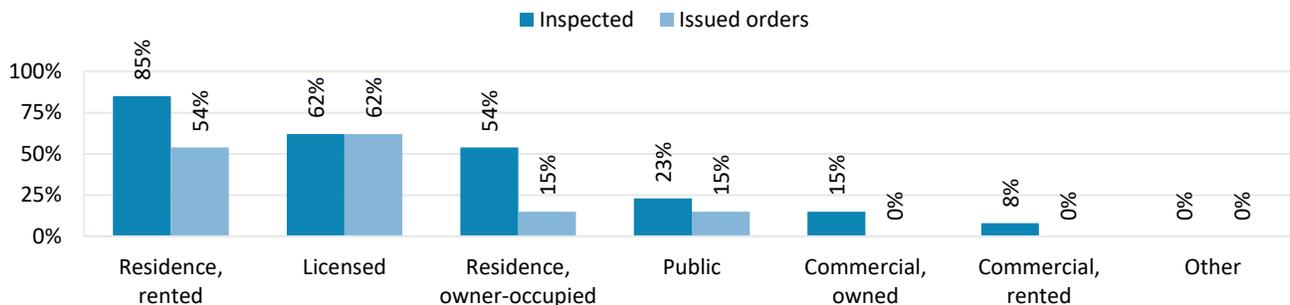
651-201-4601 | [health.indoorair@state.mn.us](mailto:health.indoorair@state.mn.us)

[www.health.state.mn.us/divs/eh/indoorair/mold](http://www.health.state.mn.us/divs/eh/indoorair/mold)

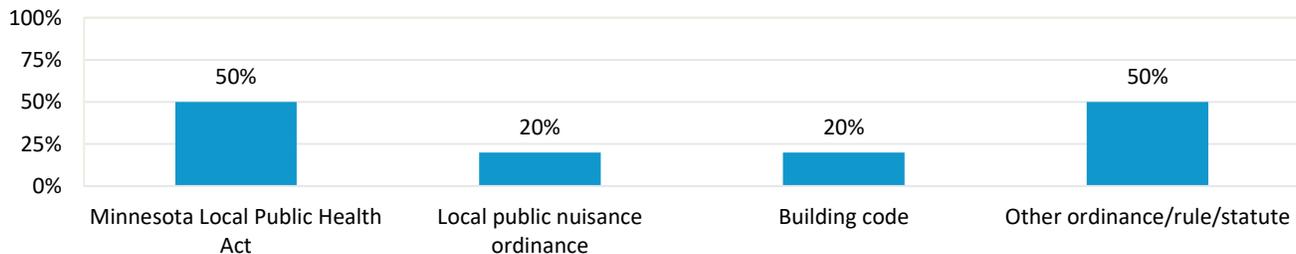
### Mold-related actions taken by community health boards, Minnesota, 2016 (n=49)



### Inspections and orders issued to correct mold or moisture problems as a preventive measure, Minnesota community health boards, 2016 (n=13)



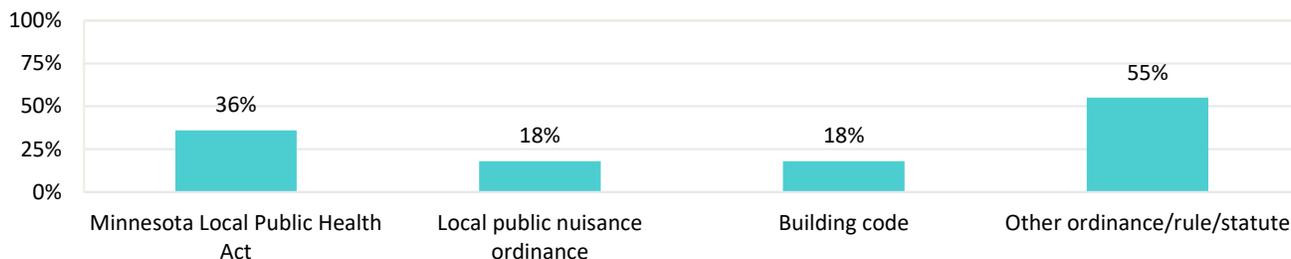
### Statute, rule, or ordinance cited when issuing orders to establishments as a preventive measure, Minnesota community health boards, 2016 (n=10)



**Inspections and orders issued to correct mold or moisture problems *in response to mold-related complaints and/or emergencies*, Minnesota community health boards, 2016 (n=15)**



**Statute, rule, or ordinance cited when issuing orders to establishments *in response to mold-related complaints and/or emergencies*, Minnesota community health boards, 2016 (n=11)**



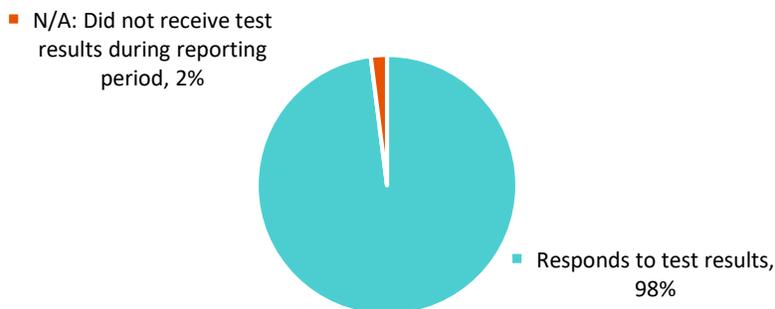
## Blood Lead

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.

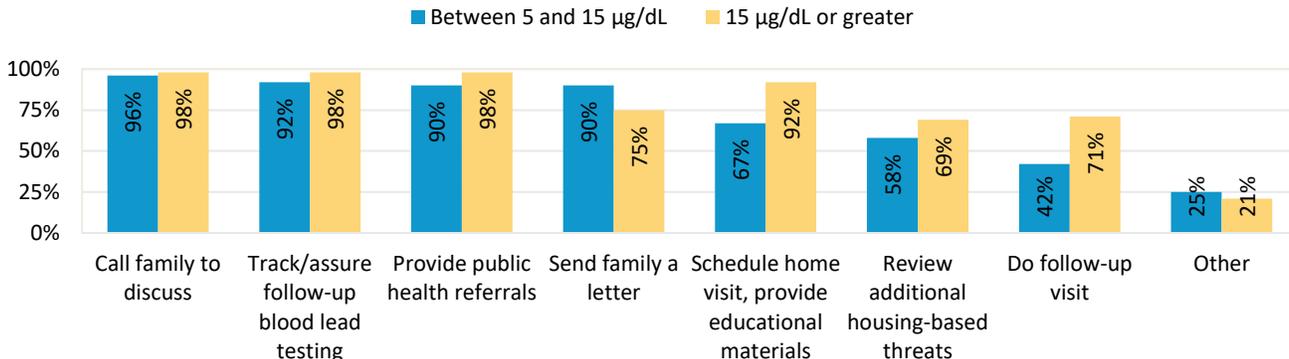
### More Information

MDH Environmental Health Division, Health Risk Intervention Unit  
 651-201-4620 | [health.asbestos-lead@state.mn.us](mailto:health.asbestos-lead@state.mn.us)  
[www.health.state.mn.us/divs/eh/lead](http://www.health.state.mn.us/divs/eh/lead)

**Community health board response to elevated blood lead levels, Minnesota, 2016 (n=49)**



**Level of response to elevated blood lead levels, Minnesota community health boards, 2016 (n=48)**



## Drinking Water Protection and Well Management

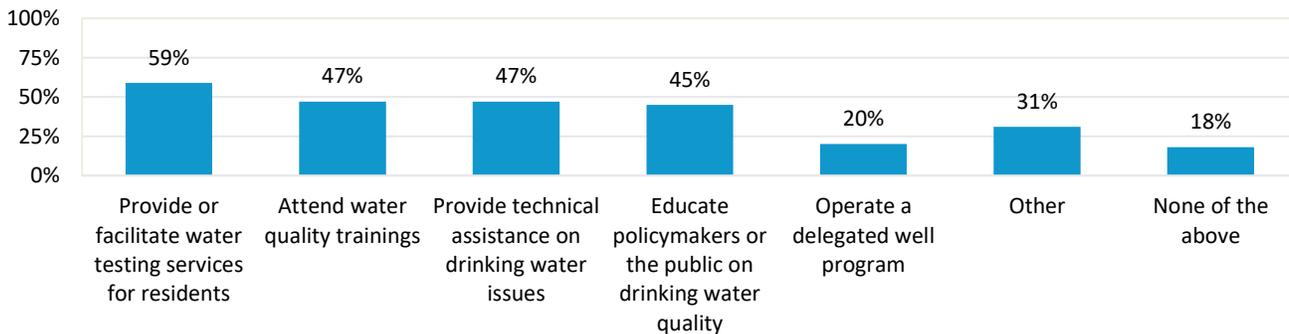
Public health helps protect drinking water supplies by reducing the potential for contamination.

**More Information**

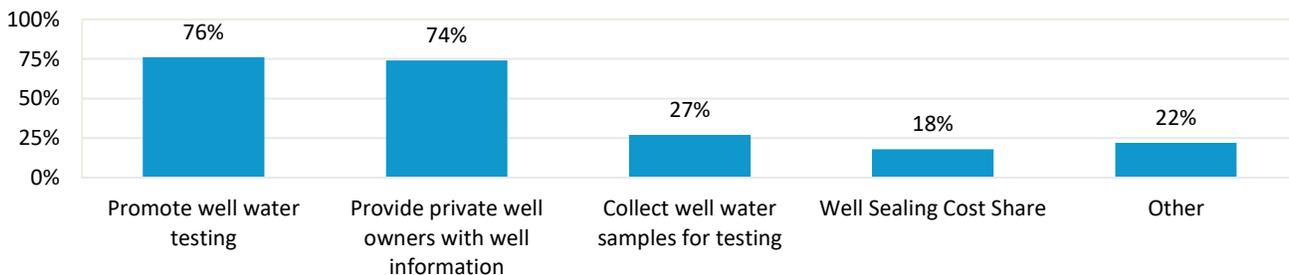
MDH Environmental Health Division,  
 Drinking Water Protection Program  
 651-201-4700 | [health.drinkingwater@state.mn.us](mailto:health.drinkingwater@state.mn.us)  
[www.health.state.mn.us/divs/eh/water](http://www.health.state.mn.us/divs/eh/water)

MDH Environmental Health Division,  
 Well Management Section  
 651-201-4600 | [health.wells@state.mn.us](mailto:health.wells@state.mn.us)  
[www.health.state.mn.us/divs/eh/wells](http://www.health.state.mn.us/divs/eh/wells)

**Means used to address drinking water quality, Minnesota community health boards, 2016 (n=49)**



**Services provided to private well owners in community health board jurisdiction, Minnesota, 2016 (n=49)**



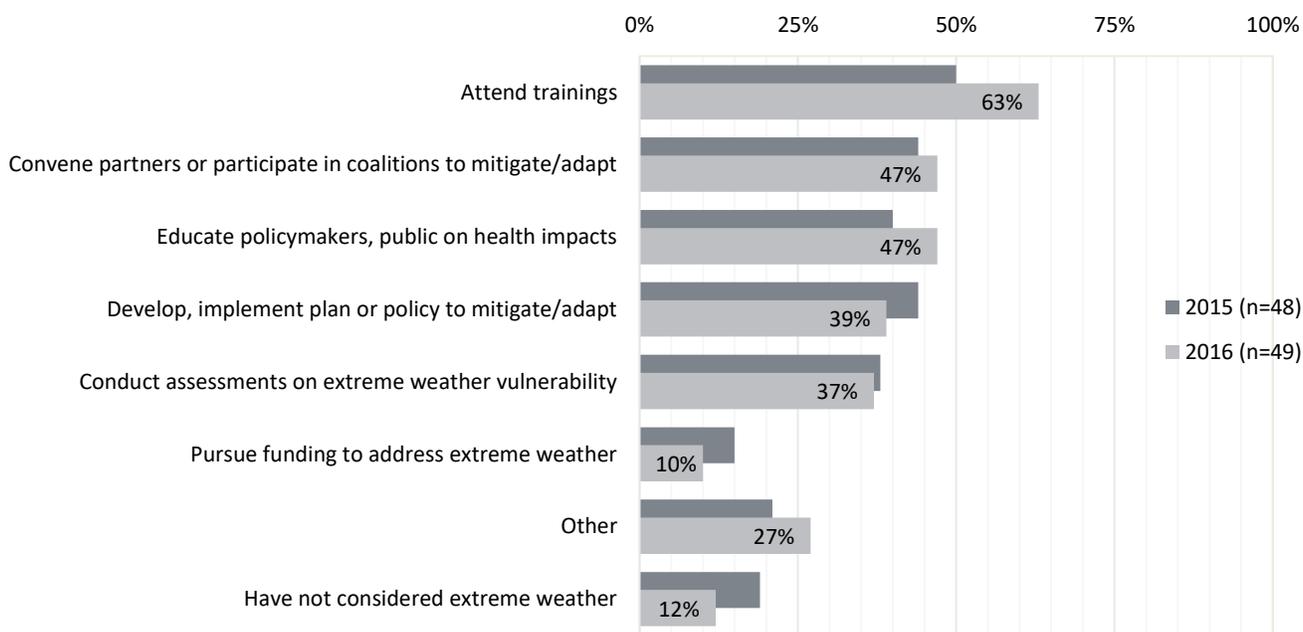
## Extreme Weather

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.

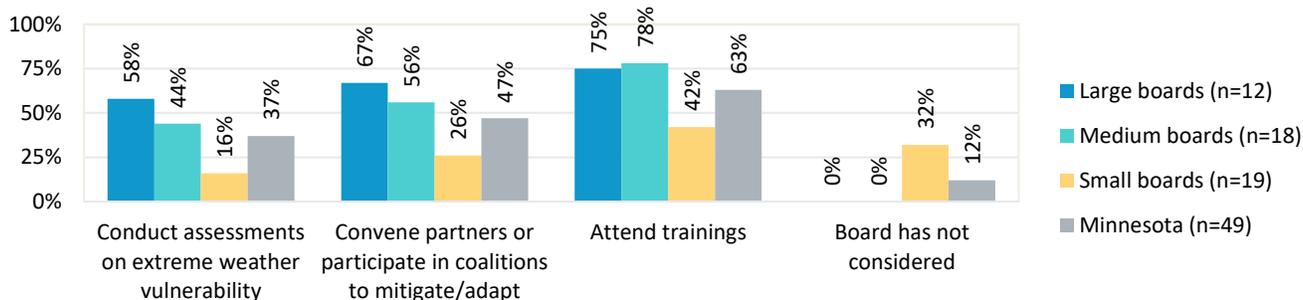
### More Information

MDH Environmental Health Division, Environmental Surveillance and Assessment Section,  
 Environmental Impacts Analysis Unit  
 651-201-4899 | [health.climatechange@state.mn.us](mailto:health.climatechange@state.mn.us)  
[www.health.state.mn.us/divs/climatechange](http://www.health.state.mn.us/divs/climatechange)

### Considering/addressing extreme weather, Minnesota community health boards, 2015-present (n=49)



### Comparison: Considering/addressing extreme weather, by population, Minnesota community health boards, 2016



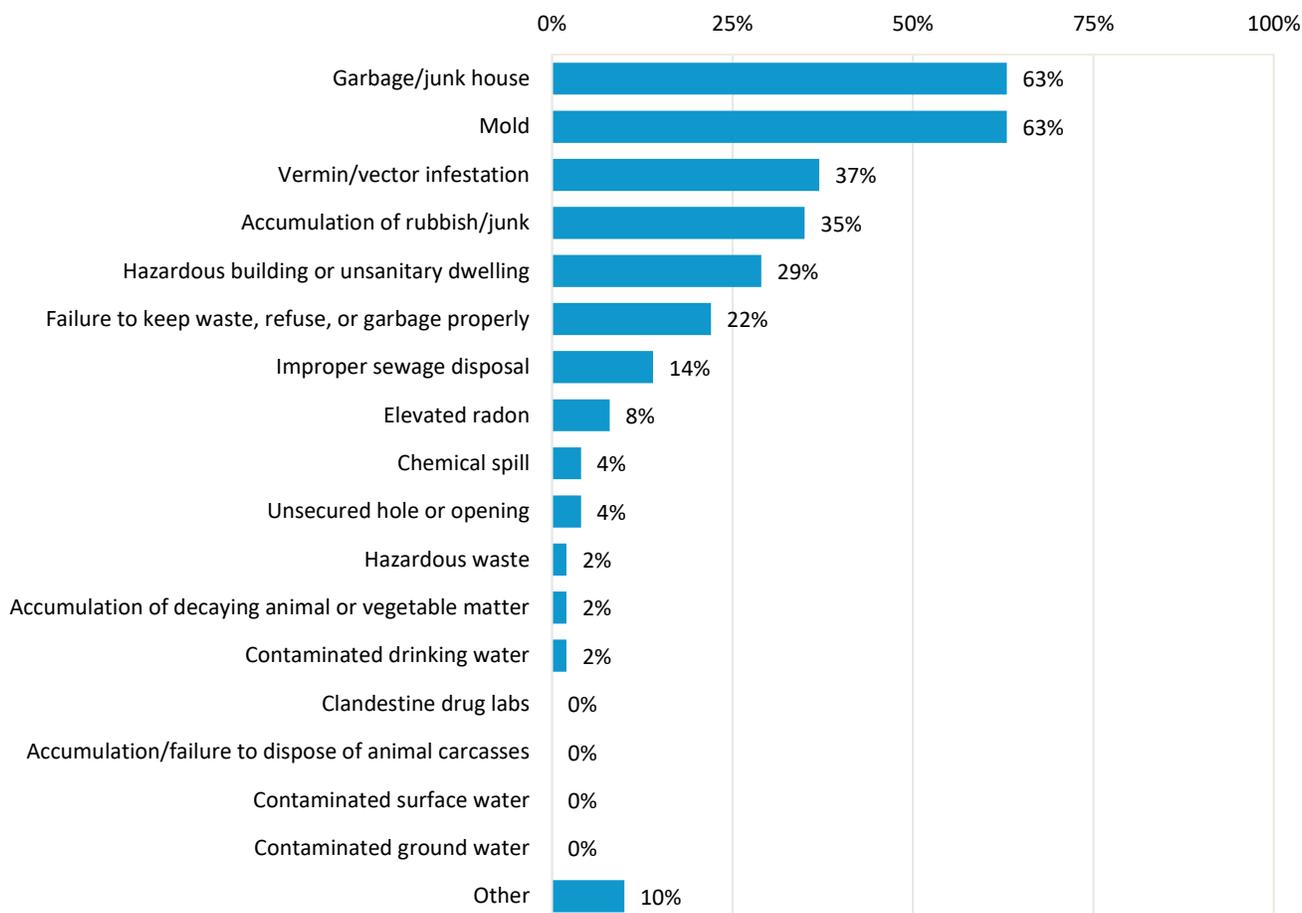
## Nuisance Investigations

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, 2016 (n=49)



### Comparison: Most commonly addressed nuisances, by population, Minnesota community health boards, 2016

Large community health boards (n=12)	Medium community health boards (n=18)	Small community health boards (n=19)	Minnesota (n=49)
1. (tied) Garbage/junk house, Mold	1. Mold	1. Garbage/junk house	1. (tied) Garbage/junk house, Mold
3. Hazardous building or unsanitary dwelling	2. Garbage/junk house	2. Mold	3. Vermin/vector infestation
	3. Accumulation of rubbish or junk	3. Vermin/vector infestation	

## Food, Pools, and Lodging Services

In 2016, the Environmental Health Continuous Improvement Board (EHCIB) developed performance measures for food, pools, and lodging services (FPLS), and the SCHSAC Performance Improvement Steering Committee adopted those measures as Local Public Health Act performance measures.

In 2017, the EHCIB collected (and will begin to monitor) statewide annual performance measures for FPLS. When available, MDH will also provide the data to those without FPLS delegation agreements. The EHCIB will provide data gathered to the Centers for Health Equity and Community Health, which will report on statewide performance on these measures.

**For information on Food, Pools, and Lodging Services inspections, please contact:**

MDH Food, Pools, and Lodging Services Section  
651-201-4500 | [health.foodlodging@state.mn.us](mailto:health.foodlodging@state.mn.us)

**For information on Food, Pools, and Lodging Services data, please contact:**

Environmental Health Continuous Improvement Board  
[www.health.state.mn.us/divs/eh/local/cib](http://www.health.state.mn.us/divs/eh/local/cib)

# Assure Health Services

Per Minn. Stat. § 145A (Local Public Health Act), Minnesota community health boards are expected to 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.

## Clinical-Community Linkages

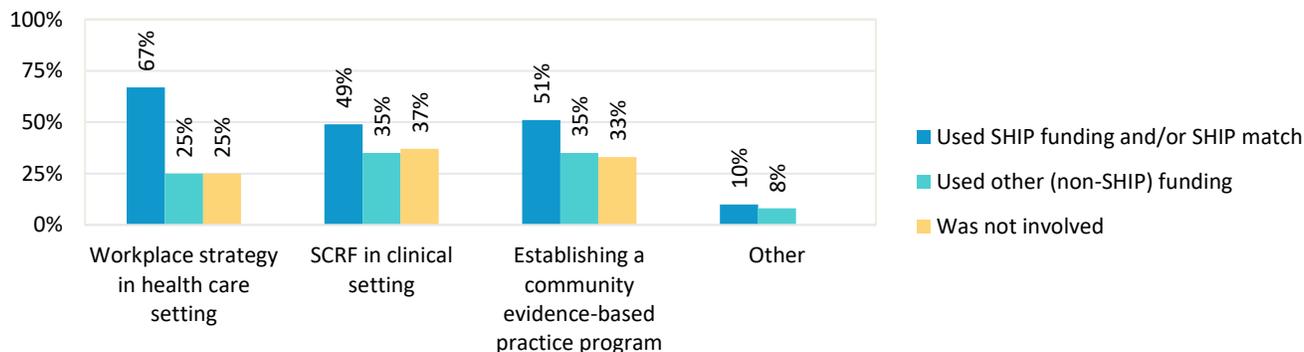
There is growing local, state, and national awareness about the importance of clinical-community linkages to support health promotion and prevention activities, and facilitate smooth health care delivery. This question characterizes the role of public health in such activities.

### More Information

MDH Office of Statewide Health Improvement Initiatives  
651-201-5443 | [Health.OSHII@state.mn.us](mailto:Health.OSHII@state.mn.us)  
[www.health.state.mn.us/divs/oshii](http://www.health.state.mn.us/divs/oshii)

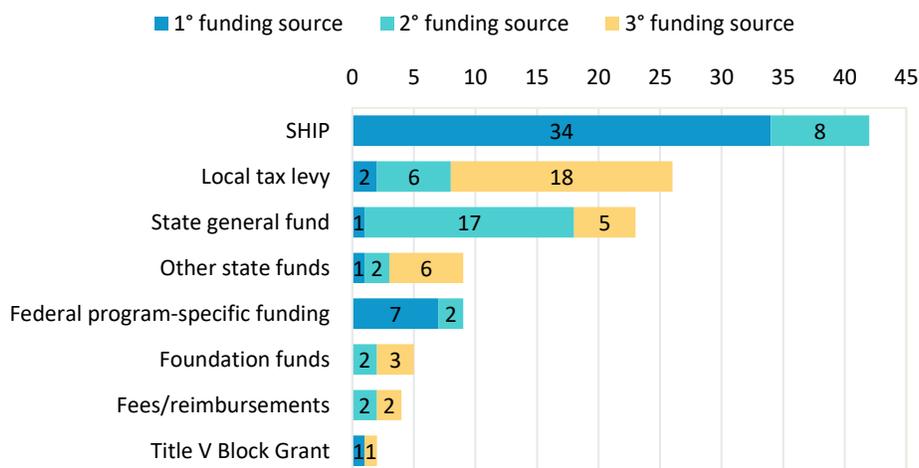
MDH Health Promotion and Chronic Disease Division  
651-201-3600 | [www.health.state.mn.us/divs/hpcd](http://www.health.state.mn.us/divs/hpcd)

### Strategies implemented to promote clinical-community linkages for prevention, Minnesota community health boards, 2016 (n=49)

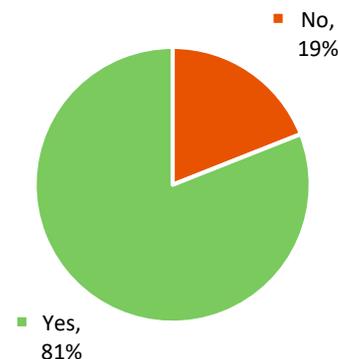


SCRF: Screen-Counsel-Refer-Follow-up

### All funding sources supporting clinical-community linkages, Minnesota community health boards, 2016 (n=46)



### Local tax levy investment exceeds required state match (n=26)



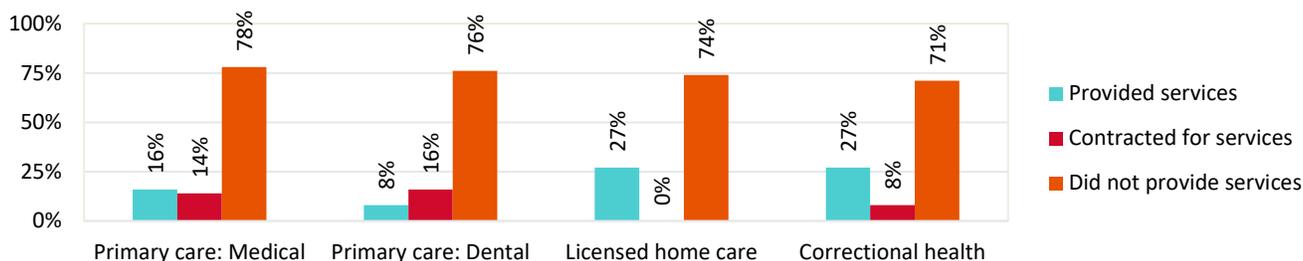
## Provision of Public Health Services

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

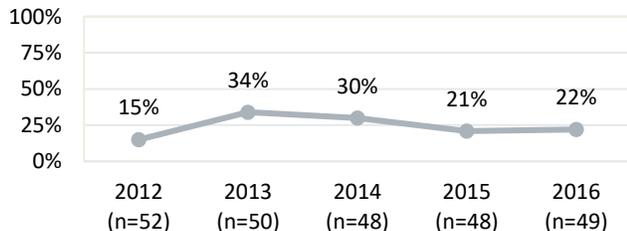
MDH Office of Rural Health and Primary Care  
 651-201-3838 | [health.orhpc@state.mn.us](mailto:health.orhpc@state.mn.us)  
[www.health.state.mn.us/divs/orhpc](http://www.health.state.mn.us/divs/orhpc)

### Strategies implemented to promote clinical-community linkages for prevention, Minnesota community health boards, 2016 (n=49)

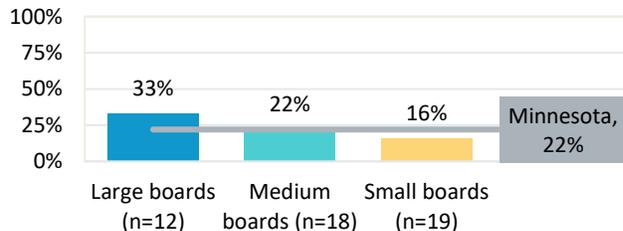


### Primary Medical Care

Change: Providing/contracting for primary medical care

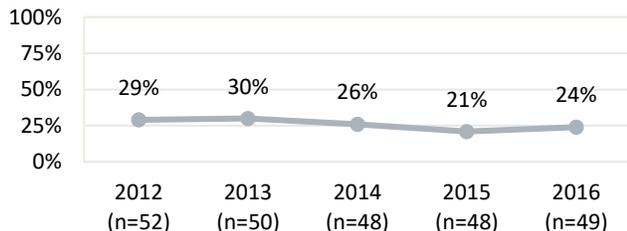


Comparison: Providing/contracting for primary medical care

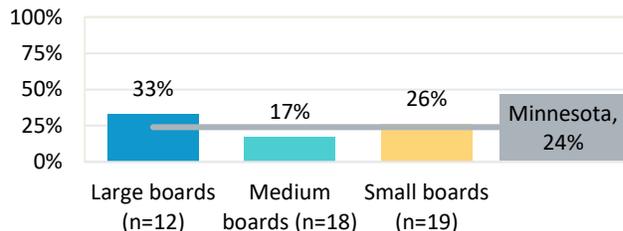


### Primary Dental Care

Change: Providing/contracting for primary dental care

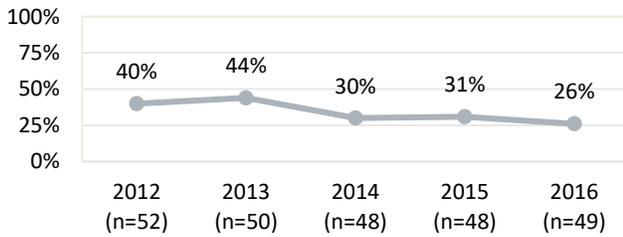


Comparison: Providing/contracting for dental care

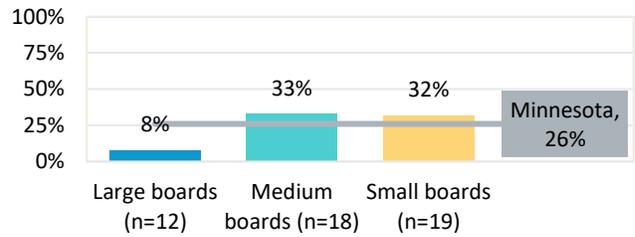


### Licensed Home Care

Change: Providing/contracting for licensed home care

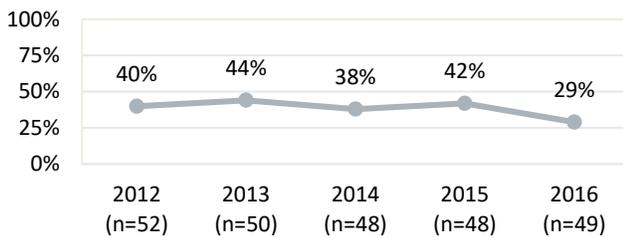


Comparison: Providing/contracting for licensed home care

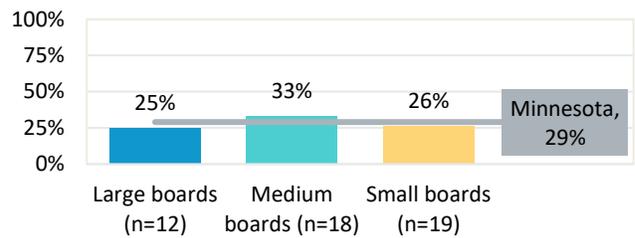


### Correctional Health

Change: Providing/contracting for correctional health



Comparison: Providing/contracting for correctional health



## Appendix A: Tables

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

Minnesota, 2016 (n=49)	Fully meet		Partially meet		Cannot meet	
	#	%	#	%	#	%
1.1.2: Community Health Assessment <i>A local community health assessment</i>	<b>47</b>	<b>84%</b>	7	14%	1	2%
1.2.2: Communication with Surveillance Sites <i>Communication with surveillance sites</i>	<b>27</b>	<b>55%</b>	21	43%	1	2%
1.3.1: Data Analysis and Conclusions <i>Data analyzed and public health conclusions drawn</i>	<b>38</b>	<b>78%</b>	9	18%	2	4%
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>	<b>47</b>	<b>84%</b>	7	14%	1	2%
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>	<b>39</b>	<b>80%</b>	9	18%	1	2%
2.2.3: After Action Reports (AARs) <i>Complete After Action Reports (AARs)</i>	<b>36</b>	<b>74%</b>	11	22%	2	4%
3.1.2: Health Promotion Strategies <i>Health promotion strategies to mitigate preventable health conditions</i>	<b>44</b>	<b>90%</b>	5	10%	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>	<b>36</b>	<b>74%</b>	12	25%	1	2%
3.2.2: Organizational Branding Strategy <i>Organizational branding strategy</i>	<b>28</b>	<b>57%</b>	15	31%	6	12%
3.2.3: External Communications Procedures <i>Communication procedures to provide information outside the health department</i>	<b>28</b>	<b>57%</b>	18	37%	3	6%
3.2.5: Variety of Publicly Available Information <i>Information available to the public through a variety of methods</i>	<b>34</b>	<b>69%</b>	14	29%	1	2%
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>	<b>37</b>	<b>76%</b>	10	20%	2	4%
5.2.3: Collaborative CHIP Implementation <i>Elements and strategies of the health improvement plan implemented in partnership with others</i>	<b>40</b>	<b>82%</b>	8	16%	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>	<b>30</b>	<b>61%</b>	16	33%	3	6%
5.3.3: An Implemented Strategic Plan <i>Implemented community health board strategic plan</i>	<b>33</b>	<b>67%</b>	12	25%	4	8%
6.3.4: Compliance Patterns from Enforcement <i>Patterns or trends identified in compliance from enforcement activities and complaints</i>	<b>24</b>	<b>50%</b>	21	42%	4	8%

2016 LOCAL PUBLIC HEALTH ACT PERFORMANCE MEASURES: DATA BOOK

Minnesota, 2016 (n=49)	Fully meet		Partially meet		Cannot meet	
	#	%	#	%	#	%
7.1.1: Assessing Health Care Availability <i>Process to assess the availability of health care services</i>	<b>33</b>	<b>67%</b>	14	29%	2	4%
7.1.2: Identifying Populations Facing Barriers <i>Identification of populations who experience barriers to health care services</i>	<b>33</b>	<b>67%</b>	15	31%	1	2%
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>	<b>27</b>	<b>55%</b>	18	37%	4	8%
7.2.1: Developing Strategies to Improve Access <i>Process to develop strategies to improve access to health care services</i>	<b>36</b>	<b>74%</b>	12	25%	1	2%
7.2.2: Implementing Strategies to Increase Access <i>Implemented strategies to increase access to health care services</i>	<b>40</b>	<b>82%</b>	8	16%	1	2%
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>	<b>35</b>	<b>71%</b>	14	29%	0	0%
8.2.1: Workforce Development Strategies <i>Workforce development strategies</i>	18	37%	<b>23</b>	<b>47%</b>	8	16%
8.2.2: Competent Workforce <i>A competent community health board workforce</i>	<b>33</b>	<b>67%</b>	16	33%	0	0%
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>	<b>25</b>	<b>51%</b>	18	37%	6	12%
9.1.2: Performance Management System/Policy <i>Performance management policy/system</i>	<b>22</b>	<b>45%</b>	14	29%	13	27%
9.1.3: Implemented Performance Management System <i>Implemented performance management system</i>	<b>19</b>	<b>39%</b>	<b>19</b>	<b>39%</b>	11	22%
9.1.4: Process to Assess Customer Satisfaction <i>Implemented systematic process for assessing customer satisfaction with community health board services</i>	<b>29</b>	<b>59%</b>	16	33%	4	8%
9.1.5: Staff Involvement in Performance Management <i>Opportunities provided to staff for involvement in the community health board's performance management</i>	<b>28</b>	<b>57%</b>	14	29%	7	14%
9.2.1: Established QI Program <i>Established quality improvement program based on organizational policies and direction</i>	<b>37</b>	<b>76%</b>	11	22%	1	2%
9.2.2: Implemented QI Activities <i>Implemented quality improvement activities</i>	<b>29</b>	<b>59%</b>	19	39%	1	2%
10.2.3: Communicated Research Findings <i>Communicated research findings, including public health implications</i>	<b>28</b>	<b>57%</b>	15	31%	6	12%
11.1.2: Ethical Issues and Decisions <i>Ethical issues identified and ethical decisions made</i>	<b>19</b>	<b>39%</b>	<b>19</b>	<b>39%</b>	11	22%
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	41%	<b>28</b>	<b>57%</b>	1	2%

Minnesota, 2016 (n=49)	Fully meet		Partially meet		Cannot meet	
	#	%	#	%	#	%
12.2.1: Communication with Governing Entity on Responsibilities <i>Communication with the governing entity regarding the responsibilities of the community health board and of the responsibilities of the governing entity</i>	42	86%	5	10%	2	4%
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	96%	2	4%	0	0%
12.3.3: Communication with Governing Entity on Performance <i>Communication with the governing entity about the community health board performance assessment and improvement</i>	39	80%	9	18%	1	2%

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

### Workforce Competency

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

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

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

Minnesota, 2016 (n=49)	#	%
Analysis/assessment	8	16%
Policy development/program planning	10	20%
Communication	16	33%
Cultural competency	10	20%
Community dimensions of practice	19	39%
Public health sciences	3	6%
Financial planning and management	8	16%
<b>Leadership and systems thinking</b>	<b>22</b>	<b>45%</b>
Informatics	2	4%

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

Minnesota, 2016 (n=49)	#	%
Analysis/assessment	11	22%
Policy development/program planning	14	29%
Communication	3	6%
Cultural competency	9	18%
Community dimensions of practice	5	10%
Public health sciences	18	37%
Financial planning and management	13	27%
Leadership and systems thinking	3	6%
<b>Informatics</b>	<b>22</b>	<b>45%</b>

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

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

Minnesota, 2016 (n=49)	#	%
The community health board used the Core Competencies for Public Health Professionals Tool on its own	4	8%
<b>The community health board used the Core Competencies for Public Health Professionals Tool with assistance from MDH</b>	<b>19</b>	<b>39%</b>
The community health board used an assessment tool instead of (or in addition to) the Core Competencies for Public Health Professionals Tool	2	4%
The community health board assembled a team knowledgeable of staff skills to conduct a workforce assessment	8	16%
The community health board compiled and analyzed individual assessments to develop an overall workforce assessment	6	12%
<b>The community health board did not assess workforce strengths or gaps during this reporting cycle</b>	<b>19</b>	<b>39%</b>

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

Our county conducts an annual employee survey to gauge the needs and interests of staff. In May of 2017, our county will use the Core Competencies for Public Health Professionals Tool with assistance from MDH.
Our county did use the Core Competencies Tool in our assessment, but enhanced it. Instead of only 3 tiers, we created a fourth tier to account for staff that are not trained in Public Health. We would also like further assistance from MDH to identify novel strategies to improve our gaps.

**3b. If an assessment was not performed in 2016, when was it last completed? (Select one.)**

Minnesota, 2016 (n=19)	#	%
2015	3	16%
<b>2014</b>	<b>8</b>	<b>42%</b>
<b>2013 or earlier</b>	<b>8</b>	<b>42%</b>

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

Minnesota, 2016 (n=49)	#	%
2017	17	35%
<b>2018</b>	<b>20</b>	<b>41%</b>
2019 or later	5	10%
No plans to assess workforce at this time	7	14%

## School Health

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

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

Minnesota, 2016 (n=49)	#	%
Employ school nurses	9	18%
Partnership activities	46	94%
Provide health services in the schools	24	49%
Conduct trainings for staff	30	61%
Conduct trainings for students	33	67%
Consultations	45	92%

Minnesota, 2016 (n=49)	#	%
Facilitate or coordinate joint meetings	39	80%
Provide public health updates/resources	46	94%
<b>Information and referral</b>	<b>47</b>	<b>96%</b>
Community crisis management (e.g., outbreaks)	38	78%
Wellness activities (e.g., SHIP)	48	98%
Environmental (e.g., mold, pesticides, lice)	35	71%
Community health board does not partner with school health	0	0%

## Health Equity

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

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

### Glossary

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

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

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

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

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

**Social Determinants of Health:** Conditions found in the physical, cultural, social, economic, and political environments that influence individual and population health. The inequities in the distribution of these conditions lead to differences in health outcomes (that is, they lead to health disparities). Conditions include, but are not limited to: socioeconomic factors (e.g., racism, stress, education, income, employment, health literacy); environmental factors (e.g., housing and, environmental hazards); and systems and policies (e.g., health care access, access to healthy foods).

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

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

Minnesota, 2016 (n=49)	#	%
Very true	23	47%
<b>Somewhat true</b>	<b>25</b>	<b>51%</b>
Not true	1	2%
I don’t know	0	0%

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

Minnesota, 2016 (n=49)	#	%
Very true	9	18%
<b>Somewhat true</b>	<b>31</b>	<b>63%</b>
Not true	9	18%
I don't know	0	0%

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

Minnesota, 2016 (n=49)	#	%
Very true	12	25%
<b>Somewhat true</b>	<b>29</b>	<b>59%</b>
Not true	8	16%
I don't know	0	0%

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

Minnesota, 2016 (n=49)	#	%
Very true	7	14%
<b>Somewhat true</b>	<b>23</b>	<b>47%</b>
Not true	19	39%
I don't know	0	0%

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

Minnesota, 2016 (n=49)	#	%
Very true	16	33%
<b>Somewhat true</b>	<b>31</b>	<b>63%</b>
Not true	2	4%
I don't know	0	0%

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

Minnesota, 2016 (n=49)	#	%
Very true	8	16%
<b>Somewhat true</b>	<b>30</b>	<b>61%</b>
Not true	11	22%
I don't know	0	0%

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

Minnesota, 2016 (n=49)	#	%
Very true	11	22%
<b>Somewhat true</b>	<b>30</b>	<b>61%</b>
Not true	8	16%
I don't know	0	0%

## Organizational QI Maturity

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

An “I don’t know” option is provided for all questions in this set, for those without enough information to respond.

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.

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

Minnesota, 2016 (n=49)	#	%
Strongly agree	14	29%
<b>Agree</b>	<b>28</b>	<b>57%</b>
Neutral	4	8%
Disagree	3	6%
Strongly disagree	0	0%
I don’t know	0	0%

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

Minnesota, 2016 (n=49)	#	%
Strongly agree	14	29%
<b>Agree</b>	<b>29</b>	<b>59%</b>
Neutral	4	8%
Disagree	1	2%
Strongly disagree	0	0%
I don’t know	1	2%

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

Minnesota, 2016 (n=49)	#	%
Strongly agree	3	6%
<b>Agree</b>	<b>26</b>	<b>53%</b>
Neutral	10	20%
Disagree	9	18%
Strongly disagree	1	2%
I don’t know	0	0%

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

Suggested parameters for Question 17:

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

Minnesota, 2016 (n=49)	#	%
<b>Strongly agree</b>	<b>29</b>	<b>59%</b>
Agree	19	39%
Neutral	1	2%
Disagree	0	0%
Strongly disagree	0	0%
I don't know	0	0%

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

Minnesota, 2016 (n=49)	#	%
Strongly agree	7	14%
<b>Agree</b>	<b>22</b>	<b>45%</b>
Neutral	16	33%
Disagree	3	6%
Strongly disagree	1	2%
I don't know	0	0%

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

Minnesota, 2016 (n=49)	#	%
Strongly agree	16	33%
<b>Agree</b>	<b>29</b>	<b>59%</b>
Neutral	3	6%
Disagree	1	2%
Strongly disagree	0	0%
I don't know	0	0%

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

Minnesota, 2016 (n=49)	#	%
<b>Strongly agree</b>	<b>27</b>	<b>55%</b>
Agree	17	35%
Neutral	5	10%
Disagree	0	0%
Strongly disagree	0	0%
I don't know	0	0%

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

“Pervasive” means present everywhere, spreading widely, or present throughout the community health board.

Minnesota, 2016 (n=49)	#	%
Strongly agree	9	18%
<b>Agree</b>	<b>27</b>	<b>55%</b>
Neutral	12	24%
Disagree	1	2%
Strongly disagree	0	0%
I don't know	0	0%

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

Minnesota, 2016 (n=49)	#	%
Strongly agree	8	16%
<b>Agree</b>	<b>30</b>	<b>61%</b>
Neutral	10	20%
Disagree	1	2%
Strongly disagree	0	0%
I don't know	0	0%

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

Minnesota, 2016 (n=49)	#	%
Strongly agree	4	8%
<b>Agree</b>	<b>21</b>	<b>43%</b>
Neutral	15	31%
Disagree	9	18%
Strongly disagree	0	0%
I don't know	0	0%

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

Minnesota, 2016 (n=49)	#	%
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	12	24%
<b>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</b>	<b>20</b>	<b>41%</b>
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	1	2%
The agency administered the QI maturity survey to the entire staff, and used those results for answering Q14-23	15	31%
Other (please specify)	1	2%

Other:

Organization QI maturity 10 question subset completed in Dec 2015, work in QI has began and is gaining momentum. In 2016 our WIC QI project focused on Improving outcomes with Risk codes and initial Alcohol/Tobacco education for clients. This was our first attempt at QI. Our work was interrupted when started due to Infectious Disease work that took priority. With this years WIC Evaluation of the program, this initial stab at QI was successful in a Eval without improvements needed. 2016 QI team has met when able and with progress made in this team, the original QI results were evaluated against work done since that time to determine this scoring.

## Health Informatics

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

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

### Glossary

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

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

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

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

Minnesota, 2016 (n=49)	#	%
<b>PH-Doc</b>	<b>27</b>	<b>55%</b>
CareFacts Information Systems	5	10%
CHAMP Software	19	39%
Digital Health Department	0	0%
Decade Software	1	2%
Custom-built local system (please specify)	5	10%
Other (please specify)	9	18%
No electronic health record system in place	0	0%

Custom-built local system:

Neogov MEDSS Catch Access database Custom built for clinical system
MAHF
MAHF
Custom-built software named hummingbird-electronic health record and billing software
MAHF

Other:

Uniek - Correctional Health. HuBERT - WIC. Catch 3 and Provide - C&TC.
Epic (as an affiliate of our agency)
NextGen for School Based Clinic program
Next Gen in our Jail Medical Unit. CareFacts is our Family Health/DPC HV EHR system, along with a shared metro data system for the Metro Alliance for Health Families joint powers. These are in addition to the CTC and FAP datasystems as well as the MEDSS system.
SAGE, MEDFS, MIIC, HUBERT
SAGE, MEDFS, MIIC, HUBERT
CCM (part of our agency)
Client Contact Manager (SCHA)
SAGE, MEDFS, HUBERT, MIIC

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

Minnesota, 2016 (n=49)	#	%
Primary care clinics, including mobile clinics	46	94%
Hospitals	44	90%
Behavioral health providers	40	82%
Dental providers	26	53%
Home health agencies	36	74%
Long-term care facilities	31	63%
Jails, detention, or correctional facilities	25	51%
Social services and supports (e.g., housing, transportation, food, legal aid)	47	96%
Other providers in our ACO	12	25%
Counties or departments within our community health board	38	78%
Counties or local agencies outside of our community health board	40	82%
Health or county-based purchasing plans	40	82%
<b>Minnesota Department of Health</b>	<b>48</b>	<b>98%</b>
Minnesota Department of Human Services	45	92%
Other state agencies	13	27%
Federal agencies	15	31%
Other (please specify)	8	16%
None of the above	0	0%

Other:

Tribal partners, National Service Office
School districts
Reference Lab
Schools
Pharmacies
State WIC
Victim Agency and Schools
Healthy Families America

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

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

Minnesota, 2016 (n=49)	#	%
Primary care clinics, including mobile clinics	29	59%
Hospitals	21	43%
Behavioral health providers	18	37%
Dental providers	4	8%
Home health agencies	11	22%
Long-term care facilities	15	31%
Jails, detention, or correctional facilities	9	18%
Social services and supports (e.g., housing, transportation, food, legal aid)	23	47%
Other providers in our ACO	3	6%
Counties or departments within our community health board	22	45%
Counties or local agencies outside of our community health board	21	43%
Health or county-based purchasing plans	31	63%
<b>Minnesota Department of Health</b>	<b>37</b>	<b>76%</b>
Minnesota Department of Human Services	26	53%

2016 LOCAL PUBLIC HEALTH ACT PERFORMANCE MEASURES: DATA BOOK

Minnesota, 2016 (n=49)	#	%
Other state agencies	7	14%
Federal agencies	6	12%
Other (please specify)	7	14%
Our community health board did not electronically send or receive health information	7	14%

Other:

Pharmacies
Reference Lab
VOLAGS
For all of the above, we are not exchanging from our EHR but are utilizing their systems, which they have granted us access to, in order to enter data. All our disparate systems we log into.
ACO
Senior Linkage Line
Healthy Families America

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

	Very confident		Confident		Somewhat confident		Not confident		I don't know	
	#	%	#	%	#	%	#	%	#	%
Minnesota, 2016 (n=49)										
Planning for EHR adoption and/or implementation	16	33%	22	45%	7	14%	3	6%	1	2%
Negotiating EHR and HIE vendor agreements	13	27%	16	33%	14	29%	5	10%	1	2%
Exchanging information with MDH	14	29%	24	49%	7	14%	4	8%	0	0%
Translating public health needs to IT staff	11	22%	20	41%	10	20%	7	14%	1	2%
Managing workflow changes	2	4%	23	47%	18	37%	5	10%	1	2%
Understanding and/or using nationally recognized e-health standards	3	6%	18	37%	15	31%	11	22%	2	4%
Understanding federal and state laws relating to e-health, health information exchange, and consent	3	6%	18	37%	20	41%	6	12%	2	4%
Implement consent and authorization procedures for release of health information	13	27%	24	49%	9	18%	2	4%	1	2%
Risk management for security breaches	5	10%	21	43%	15	31%	7	14%	1	2%
Establishing privacy and security policies and procedures	6	12%	26	53%	12	25%	4	8%	1	2%
Establishing agreements with exchange partners	4	8%	19	39%	18	37%	7	14%	1	2%
Developing infrastructure to support information exchange	3	6%	21	43%	13	27%	10	20%	2	4%
Integrating patient/client data from external sources into our EHR	3	6%	18	37%	14	29%	13	27%	1	2%
Developing data analytics and/or informatics skills	2	4%	13	27%	21	43%	13	27%	0	0%
Using data in the EHR to support community health assessments	4	8%	12	25%	22	45%	10	20%	1	2%
Policies and procedures for managing data quality	1	2%	12	25%	16	33%	17	35%	3	6%
Conveying the importance of informatics to the community health board (e.g., talking points, communications templates)	3	6%	17	35%	22	45%	6	12%	1	2%

	Very confident		Confident		Somewhat confident		Not confident		I don't know	
	#	%	#	%	#	%	#	%	#	%
Minnesota, 2016 (n=49)										
Developing position descriptions that include informatics and e-health activities and responsibilities	1	2%	16	33%	14	29%	15	31%	3	6%
Other (please specify)	0	0%	2	4%	0	0%	4	8%	0	0%

Other:

<b>Confident:</b> Our data group has been very involved in data discussions with CHIP and with Center for Community Health. These are cross sector discussions of ways to share data across systems and have been very productive.
<b>Confident:</b> We have made progress in this area, the public Health staff mostly have been trained on the utilization of a HIE that we are working with Southern Prairie Community Care to implement Relay Health HIE for direct secure messaging and exchange of PHI. We had begun a contract with Stratis Health earlier in 2016 to complete the risk assessment for Data Privacy and help with policies for this work. Halfway through contract we had to discontinue work due to lack of staff to complete the work. We had allotted funds for this work in 2016, however, will need to work on this once again in 2017. This is a hard concept for some persons to understand and much ground work to put in place related to policies that our hope is to contract for the remainder of the work needed with a consultant that can provide hands on assistance due to staff challenges and expert knowledge needed in this area to be effective.
<b>Not Confident:</b> Monetary Resources
<b>Not Confident:</b> Our IT Department is very behind on projects. Because of this we really do not know when we will truly be doing e-health as it relates to using PH-DOC to do this with other entities. The most we have on their plan is to do Direct ---which is a direct and sure mail box with other entities. This is not even completed yet and has been on the agenda for about a year and a half.

## Voluntary Public Health Accreditation

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

Question 30 is optional.

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

Minnesota, 2016 (n=49)	#	%
My community health board has achieved accreditation	8	16%
My community health board is in the process of accreditation (e.g., has submitted a statement of intent)	3	6%
My community health board is planning to apply (but is not in the process of accreditation)	10	20%
My community health board is undecided about whether to apply for accreditation	12	25%
<b>My community health board has decided not to apply at this time</b>	<b>16</b>	<b>33%</b>
Individual jurisdictions within my community health board are participating in accreditation differently	0	0%

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

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

Minnesota, 2016 (n=10)	#	%
2017	2	20%
2018	0	0%
<b>2019 or later</b>	<b>8</b>	<b>80%</b>

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

Answer if you selected “undecided about whether to apply” or “decided not to apply at this time” in Q29, above.

Rank primary reason as “1” and secondary reason as “2.”

Minnesota, 2016 (n=28)	Primary		Secondary	
	#	%	#	%
Accreditation standards are not appropriate for my community health board	0	0%	0	0%
Fees for accreditation are too high	5	14%	5	14%
Accreditation standards exceed the capacity of my community health board	10	36%	8	29%
<b>Time and effort for accreditation application exceed the benefits of accreditation</b>	<b>10</b>	<b>36%</b>	<b>10</b>	<b>36%</b>
No support from governing body for accreditation	3	11%	2	7%
Interest/capacity varies within the jurisdictions of my community health board	0	0%	3	11%

My community health board is undecided about whether to apply for accreditation

Minnesota, 2016 (n=12)	Primary		Secondary	
	#	%	#	%
Accreditation standards are not appropriate for my community health board	0	0%	0	0%
Fees for accreditation are too high	2	17%	1	8%
Accreditation standards exceed the capacity of my community health board	4	33%	3	25%
<b>Time and effort for accreditation application exceed the benefits of accreditation</b>	<b>5</b>	<b>42%</b>	<b>4</b>	<b>33%</b>
No support from governing body for accreditation	1	8%	1	8%
Interest/capacity varies within the jurisdictions of my community health board	0	0%	3	25%

My community health board has decided not to apply at this time

Minnesota, 2016 (n=16)	Primary		Secondary	
	#	%	#	%
Accreditation standards are not appropriate for my community health board	0	0%	0	0%
Fees for accreditation are too high	3	19%	3	19%
<b>Accreditation standards exceed the capacity of my community health board</b>	<b>6</b>	<b>38%</b>	<b>5</b>	<b>31%</b>
Time and effort for accreditation application exceed the benefits of accreditation	5	31%	6	38%
No support from governing body for accreditation	2	13%	1	6%
Interest/capacity varies within the jurisdictions of my community health board	0	0%	1	6%

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

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

*No community health boards responded to this question.*

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

Optional.

At least one county in our CHB does not think that they will have capacity to apply for accreditation, but we hope that our CHB can still make application for accreditation (as a CHB). With current CHB and County PH Dept. staffing levels, it is very difficult to have enough dedicated staff time to walk the journey for accreditation.
We appreciate the technical resources from MDH as we prepared for accreditation. We are so proud, thrilled and pleased to be accredited! We are willing to share resources/information with others who are working towards accreditation and have done so already (mainly on ethics) since we were the first to receive PHAB Accreditation in MN under the PHAB 1.5 standards.
Our county was the first health department in MN to become accredited. We are currently preparing for reaccreditation.
The site visit went very smoothly, and the reviewers were very complimentary about the work done by the department. The areas that continue to need work were not surprises. Very pleased with the outcome.

We had our Site Visit on March 8 & 9, 2017 - rescheduled from January. Our agency will seek assistance from MDH with regards to our results - either guidance with action plan or annual reports and re-accreditation.
We are using the PHAB standards and measures to improve policies and procedures in order to meet the standards.
The true cost of Accreditation, including fees and staff time, is a burden on our CHB. We would need an additional 1 - 2 full time staff to successfully collect and submit all the required documentation, plus additional time on an already busy staff. If we had an additional \$200,000 - \$250,000, we would rather use it to provide more services to our clients.
We are currently participating with an Accreditation Learning Community and working on our PHAB Annual Report due in the Fall of 2017.
Our county just completed and submitted their first annual report in March.
It has been difficult to find staff time to put everything together for Accreditation.
CHB continues to work towards implementing accreditation standards, however as noted in this report lacks resources to fully implement and maintain fully met accreditation standards.
We would need an additional 1.0 FTE position to manage the process and we do not have support from our governing body to hire a person.
We started this process in 2014 but lost several key facilitators in 2016 so had to put this on hold.
We do not feel we have the staff and financial capacity to do this at this time.
In December 2016, we established a Community Health Strategist/Accreditation Coordinator position, which will move our efforts forward. Without this position, staff resources were not available to focus on these efforts.
We are committed to being accredited-like. Continue to work on performance management and the National Measures and Standards.
We recieved an action plan that is due in August. It has been a challenge for our agency to demonstrate how we meet standards and measures when the task/duty/responsibility is not our responsibility. MDH staff have been excellent to work with and have been very helpful.
We use the accreditation standards as guidance for current public health work
We have had too many staff and director changes in the past year to make any commitments at this time.
Staffing challenge. I believe I would need a full time staff position to move this work forward. No support from governing board to add staff for this purpose.
Staffing capacity is very limited at this time. A supervisor position remains open, as does a nutritionist position. Not sure if or when these positions may be filled. Staffing workflow is at capacity and span of control is thin.
We are not pursuing accreditation at this time.
Our CHB is currently not pursuing.
With the newness of our agency, our board is just now adjusting to the understanding of all of the broad range of programing. Our agency does not have a person with the time to contribute to the process of Accreditation.
We are not in a position to move forward with a formal accreditation process at this time.
We are still trying to justify all the work and the cost of the process.
We are very proud of the work that has taken place towards our Public Health Accreditation. We are currently in a process of setting up a site visit for July of 2017.
We need tangible examples of how accreditation will make us more efficient, produce more, or other financial or social benefits.
Staff changes have led to our CHB needing to focus on other things other than accreditation at this time.
Funding and staff are not available to be dedicated to move towards accreditation. Limited resources with the current level of funding. Staff time is already fully exhausted.
Our county provides good public health services to the citizens. The ability to achieve national accreditation should not be the standard used to determine which health departments in the state are actually doing good work. Most smaller agencies lack capacity to hire someone or hire a team to take responsibility for putting the accreditation documents together. I urge MDH to look at other ways to determine if the needs of that community are being met. It can be somewhat disheartening to be judged up against the metro counties that have the infrastructure to achieve the national accreditation. When the Minnesota Department of Health says in their report to the legislature that those few metro counties are the 'best of the best', it certainly sends a message to the majority of health departments that at this time are trying to prioritize local services and community engagement first before accreditation.
While it is important to achieve National Standards of Public Health in our agency, we have other mandated work to complete that is challenging to do due to staffing. Thus until the right vendor can allow some additional help on site for this work and funding is re-evaluated, We may have delays with implementation and full use of the system.

=rural/small CHB- staff time to analyze/prep for accreditation submission and all The actual docs in The format requested is difficult (i.e. lack capacity of human and financial resources) -It would be helpful if MDH could provide LPH some applicable docs- agreements/roles, etc for programs such as Regional Epi, FPL delegation and Inf Dis Labs (where we partner with MDH closely)

We don't have the staff time available to document accreditation activities. Limited budgets makes it unlikely our county will add staff to accomplish accreditation until it becomes mandatory to get grants/funding etc.

As a small, single county CHB, doesn't seem plausible at this point.

## Statutory Requirements

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

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

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

Minnesota, 2016 (n=49)	#	%
Yes	49	100%
No	0	0%

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

2	4	7	12	12	26
2	4	7	12	12	29
2	4	8	12	13	46
3	5	9	12	14	50
4	5	10	12	15	
4	5	11	12	21	
4	5	11	12	23	
4	6	12	12	23	
4	7	12	12	24	

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

Minnesota, 2016 (n=49)	#	%
Yes	49	100%
No	0	0%

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

Minnesota, 2016 (n=49)	#	%
Yes	49	100%
No	0	0%

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

Minnesota, 2016 (n=49)	#	%
Yes	49	100%
No	0	0%

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

Minnesota, 2016 (n=49)	#	%
Yes	49	100%
No	0	0%

## Promote Healthy Communities and Healthy Behaviors

### Active Living

These measures align with the [SHIP strategies and sub-strategies](#).

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

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

#### Community

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

#### Child Care

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

#### Schools

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

#### Workplace

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

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

Minnesota, 2016 (n=49)	Community		Child care		Schools		Workplace	
	#	%	#	%	#	%	#	%
<b>Used SHIP funding and/or SHIP match for strategy</b>	<b>48</b>	<b>98%</b>	23	47%	<b>47</b>	<b>96%</b>	<b>45</b>	<b>92%</b>
Used other (non-SHIP) funding for strategy	23	47%	9	18%	16	33%	15	31%
<b>Was not involved in strategy</b>	0	0%	<b>24</b>	<b>49%</b>	1	2%	2	4%

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

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

Minnesota, 2016	Community (n=49)		Child care (n=25)		School (n=48)		Workplace (n=47)	
	#	%	#	%	#	%	#	%
Attended trainings	43	88%	19	76%	46	96%	45	96%
Conducted assessments	41	84%	21	84%	43	90%	45	96%
<b>Convened partners or participated in coalitions</b>	44	90%	17	68%	<b>47</b>	<b>98%</b>	<b>46</b>	<b>98%</b>
<b>Involved with community outreach and education</b>	<b>47</b>	<b>96%</b>	<b>23</b>	<b>92%</b>	40	83%	41	87%
Educated policymakers	41	84%	10	40%	37	77%	35	75%
Developed proposal or policy	30	61%	8	32%	34	71%	28	60%
Implemented policy (this year)	16	33%	7	28%	21	44%	20	43%
Maintained policy (which was previously implemented)	14	29%	8	32%	24	50%	11	23%
Evaluated policy impact	11	22%	3	12%	15	31%	11	23%

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

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

Minnesota, 2016 (n=49)	Primary		Secondary		Tertiary	
	#	%	#	%	#	%
Local tax levy	0	0%	10	20%	22	45%
State general fund (Local Public Health Act)	0	0%	17	35%	8	16%
<b>SHIP</b>	<b>47</b>	<b>96%</b>	2	4%	0	0%
Other state funds (from MDH or from other state agencies)	1	2%	3	6%	0	0%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	1	2%	9	18%	1	2%
Title V Block Grant	0	0%	0	0%	0	0%
Foundation funds	0	0%	2	4%	6	12%
Fees/reimbursement	0	0%	0	0%	3	6%

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

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

Minnesota, 2016 (n=32)	#	%
<b>Yes</b>	<b>22</b>	<b>69%</b>
No	10	31%

## Healthy Eating

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

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

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

### Community

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

### Child Care

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

### School

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

### Workplace

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

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

Minnesota, 2016 (n=49)	Community		Child care		Schools		Workplace	
	#	%	#	%	#	%	#	%
<b>Used SHIP funding and/or SHIP match for strategy</b>	<b>48</b>	<b>98%</b>	24	49%	<b>49</b>	<b>100%</b>	<b>46</b>	<b>94%</b>
Used other (non-SHIP) funding for strategy	23	47%	8	16%	14	29%	22	45%
<b>Was not involved in strategy</b>	0	0%	<b>25</b>	<b>51%</b>	0	0%	2	4%

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

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

Minnesota, 2016	Community (n=49)		Child care (n=24)		School (n=49)		Workplace (n=47)	
	#	%	#	%	#	%	#	%
Attended trainings	48	98%	21	88%	47	96%	43	92%
Conducted assessments	40	82%	20	83%	47	96%	41	87%
<b>Convened partners or participated in coalitions</b>	<b>49</b>	<b>100%</b>	18	75%	<b>49</b>	<b>100%</b>	<b>49</b>	<b>100%</b>
<b>Involved with community outreach and education</b>	47	96%	<b>22</b>	<b>92%</b>	47	96%	42	89%
Educated policymakers	40	82%	12	50%	39	80%	35	75%
Developed proposal or policy	31	63%	11	46%	35	71%	25	53%
Implemented policy (this year)	19	39%	7	29%	23	47%	17	36%
Maintained policy (which was previously implemented)	13	27%	7	29%	23	47%	17	36%
Evaluated policy impact	12	25%	3	13%	13	27%	9	19%

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

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

Minnesota, 2016 (n=49)	Primary		Secondary		Tertiary	
	#	%	#	%	#	%
Local tax levy	0	0%	11	22%	18	37%
State general fund (Local Public Health Act)	0	0%	18	37%	10	20%
<b>SHIP</b>	<b>46</b>	<b>94%</b>	2	4%	0	0%
Other state funds (from MDH or from other state agencies)	0	0%	3	6%	3	6%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	2	4%	6	12%	0	0%
Title V Block Grant	0	0%	0	0%	0	0%
Foundation funds	1	2%	3	6%	3	6%
Fees/reimbursement	0	0%	0	0%	4	8%

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

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

Minnesota, 2016 (n=29)	#	%
<b>Yes</b>	<b>22</b>	<b>76%</b>
No	7	24%

## Tobacco-Free Living

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

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

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

### Community

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

### Workplace

- Tobacco-free environments
- Cessation support

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

Minnesota, 2016 (n=49)	Community		Workplace	
	#	%	#	%
<b>Used SHIP funding and/or SHIP match for strategy</b>	<b>46</b>	<b>94%</b>	<b>34</b>	<b>69%</b>
Used other (non-SHIP) funding for strategy	22	45%	14	29%
Was not involved in strategy	1	2%	12	25%

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

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

Minnesota, 2016	Community (n=48)		Workplace (n=37)	
	#	%	#	%
Attended trainings	42	88%	31	84%
<b>Conducted assessments</b>	42	88%	<b>35</b>	<b>95%</b>
<b>Convened partners or participated in coalitions</b>	44	92%	<b>35</b>	<b>95%</b>
<b>Involved with community outreach and education</b>	<b>45</b>	<b>94%</b>	33	89%
Educated policymakers	36	75%	27	73%
Developed proposal or policy	30	63%	27	73%
Implemented policy (this year)	22	46%	20	54%
Maintained policy (which was previously implemented)	27	56%	20	54%
Evaluated policy impact	11	23%	10	27%

**3b. Estimate the top three funding sources that supported your strategies related to tobacco prevention and control.**

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

Minnesota, 2016 (n=48)	Primary		Secondary		Tertiary	
	#	%	#	%	#	%
Local tax levy	0	0%	13	27%	20	42%
State general fund (Local Public Health Act)	2	4%	15	31%	8	17%
<b>SHIP</b>	<b>36</b>	<b>75%</b>	8	17%	1	2%
Other state funds (from MDH or from other state agencies)	1	2%	3	6%	5	10%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	6	13%	3	6%	1	2%
Title V Block Grant	0	0%	0	0%	1	2%
Foundation funds	3	6%	3	6%	0	0%
Fees/reimbursement	0	0%	2	4%	3	6%

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

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

Minnesota, 2016 (n=33)	#	%
<b>Yes</b>	<b>20</b>	<b>61%</b>
No	13	39%

## Alcohol

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

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

Minnesota, 2016 (n=49)	#	%
Policy advocacy (strengthening local ordinances)	12	25%
Policies to reduce drink specials in bars and restaurants	1	2%
Alcohol compliance checks	17	35%
Beverage server training	17	35%
Alcohol outlet density in the community	2	4%
Social host ordinances	17	35%
Alcohol use at community festivals and county fairs	14	29%
Drinking and driving	25	51%
<b>Health education messages</b>	<b>32</b>	<b>65%</b>
Working on barriers faced by underserved populations to reduce disparities in alcohol use	6	12%
Screening, counseling, and/or referral in health care settings	13	27%
Other (please explain)	7	14%
None of the above	8	16%

Other:

JoyRide event in partnership with law enforcement and Prairie Five rides to provide rides in our city the day before Thanksgiving. NO DUI arrests were made in our city that day.
Public Health staff participate in community chemical health coalition.
Youth Groups regarding ATOD
Public Health is represented on a local drug task force and is a community partner supporting a community partner P&I grant
Active participant in Local Chemical Health Coalition

Detox in correctional facilities
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Supporting local community work to address alcohol use in one school
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**4a. Identify the activities carried out by your community health board in the past year related to alcohol use. (Check all that apply.)**

Answer for the strategies selected in Q4, above.

Policy advocacy (strengthening local ordinances)

Minnesota, 2016 (n=12)	#	%
Attended trainings	9	75%
Conducted assessments	5	42%
<b>Convened partners or participated in coalitions</b>	<b>10</b>	<b>83%</b>
<b>Involved with community outreach and education</b>	<b>10</b>	<b>83%</b>
<b>Educated policymakers</b>	<b>10</b>	<b>83%</b>
Developed proposal or policy	4	33%
Implemented policy (this year)	2	17%
Maintained policy (which was previously implemented)	5	42%
Evaluated policy impact	1	8%

Policies to reduce drink specials in bars and restaurants

Minnesota, 2016 (n=1)	#	%
Attended trainings	0	0%
Conducted assessments	0	0%
<b>Convened partners or participated in coalitions</b>	<b>1</b>	<b>100%</b>
Involved with community outreach and education	0	0%
Educated policymakers	0	0%
Developed proposal or policy	0	0%
Implemented policy (this year)	0	0%
Maintained policy (which was previously implemented)	0	0%
Evaluated policy impact	0	0%

Alcohol compliance checks

Minnesota, 2016 (n=17)	#	%
Attended trainings	2	12%
Conducted assessments	7	41%
Convened partners or participated in coalitions	9	53%
Involved with community outreach and education	7	41%
Educated policymakers	7	41%
Developed proposal or policy	1	6%
Implemented policy (this year)	1	6%
<b>Maintained policy (which was previously implemented)</b>	<b>12</b>	<b>71%</b>
Evaluated policy impact	2	12%

Beverage server training

Minnesota, 2016 (n=17)	#	%
Attended trainings	9	53%
Conducted assessments	4	24%
<b>Convened partners or participated in coalitions</b>	<b>16</b>	<b>94%</b>
Involved with community outreach and education	12	71%
Educated policymakers	10	59%
Developed proposal or policy	1	6%
Implemented policy (this year)	1	6%

2016 LOCAL PUBLIC HEALTH ACT PERFORMANCE MEASURES: DATA BOOK

Minnesota, 2016 (n=17)	#	%
Maintained policy (which was previously implemented)	4	24%
Evaluated policy impact	2	12%

Alcohol outlet density in the community

Minnesota, 2016 (n=2)	#	%
Attended trainings	0	0%
Conducted assessments	2	100%
Convened partners or participated in coalitions	1	50%
Involved with community outreach and education	0	0%
Educated policymakers	0	0%
Developed proposal or policy	0	0%
Implemented policy (this year)	0	0%
Maintained policy (which was previously implemented)	0	0%
Evaluated policy impact	0	0%

Social host ordinances

Minnesota, 2016 (n=17)	#	%
Attended trainings	4	24%
Conducted assessments	3	18%
<b>Convened partners or participated in coalitions</b>	<b>13</b>	<b>77%</b>
Involved with community outreach and education	10	59%
Educated policymakers	8	47%
Developed proposal or policy	5	29%
Implemented policy (this year)	5	29%
Maintained policy (which was previously implemented)	10	59%
Evaluated policy impact	2	12%

Alcohol use at community festivals and county fairs

Minnesota, 2016 (n=14)	#	%
Attended trainings	2	14%
Conducted assessments	3	21%
Convened partners or participated in coalitions	10	71%
<b>Involved with community outreach and education</b>	<b>11</b>	<b>79%</b>
Educated policymakers	6	43%
Developed proposal or policy	2	14%
Implemented policy (this year)	1	7%
Maintained policy (which was previously implemented)	3	21%
Evaluated policy impact	1	7%

Drinking and driving

Minnesota, 2016 (n=25)	#	%
Attended trainings	12	48%
Conducted assessments	4	16%
<b>Convened partners or participated in coalitions</b>	<b>22</b>	<b>88%</b>
<b>Involved with community outreach and education</b>	<b>22</b>	<b>88%</b>
Educated policymakers	14	56%
Developed proposal or policy	0	0%
Implemented policy (this year)	0	0%
Maintained policy (which was previously implemented)	1	4%
Evaluated policy impact	1	4%

Health education messages

Minnesota, 2016 (n=32)	#	%
Attended trainings	16	50%
Conducted assessments	8	25%
Convened partners or participated in coalitions	28	88%
<b>Involved with community outreach and education</b>	<b>30</b>	<b>94%</b>
Educated policymakers	15	47%
Developed proposal or policy	1	3%
Implemented policy (this year)	1	3%
Maintained policy (which was previously implemented)	1	3%
Evaluated policy impact	0	0%

Working on barriers faced by underserved populations to reduce disparities in alcohol use

Minnesota, 2016 (n=6)	#	%
Attended trainings	3	50%
Conducted assessments	3	50%
<b>Convened partners or participated in coalitions</b>	<b>5</b>	<b>83%</b>
Involved with community outreach and education	4	67%
Educated policymakers	2	33%
Developed proposal or policy	0	0%
Implemented policy (this year)	0	0%
Maintained policy (which was previously implemented)	0	0%
Evaluated policy impact	0	0%

Screening, counseling, and/or referral in health care settings

Minnesota, 2016 (n=13)	#	%
Attended trainings	6	46%
<b>Conducted assessments</b>	<b>8</b>	<b>62%</b>
Convened partners or participated in coalitions	5	39%
Involved with community outreach and education	7	54%
Educated policymakers	0	0%
Developed proposal or policy	0	0%
Implemented policy (this year)	0	0%
Maintained policy (which was previously implemented)	6	46%
Evaluated policy impact	0	0%

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

Answer for the strategies selected in Q4, above. Rank "1," "2," and "3."

Minnesota, 2016 (n=41)	Primary		Secondary		Tertiary	
	#	%	#	%	#	%
Local tax levy	8	20%	16	39%	11	27%
<b>State general fund (Local Public Health Act)</b>	<b>9</b>	<b>22%</b>	10	24%	4	10%
SHIP	0	0%	0	0%	1	2%
Other state funds (from MDH or from other state agencies)	8	20%	5	12%	4	10%
<b>Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)</b>	<b>9</b>	<b>22%</b>	0	0%	1	2%
Title V Block Grant	3	7%	5	12%	1	2%
Foundation funds	2	5%	0	0%	4	10%
Fees/reimbursement	2	5%	1	2%	4	10%

## Maternal and Child Health

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

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

Minnesota, 2016	Women
Aitkin-Itasca-Koochiching	667
Anoka	2,629
Benton	434
Bloomington	733
Blue Earth	575
Brown-Nicollet	496
Carlton-Cook-Lake-St. Louis	2,098
Carver	347
Cass	418
Chisago	366
Countryside	533
Crow Wing	673
Dakota	2,925
Des Moines Valley	228
Dodge-Steele	608
Edina	85
Faribault-Martin	403
Fillmore-Houston	306
Freeborn	391
Goodhue	345
Hennepin	4,709
Horizon	562
Isanti	397
Kanabec-Pine	428
Kandiyohi-Renville	899

Minnesota, 2016	Women
Le Sueur-Waseca	426
Meeker-McLeod-Sibley	745
Mille Lacs	343
Minneapolis	5,791
Morrison-Todd-Wadena	815
Mower	560
Nobles	511
North Country	1,202
Olmsted	1,430
Partnership4Health	1,710
Polk-Norman-Mahnomen	612
Quin County	523
Rice	654
Richfield	423
Scott	810
Sherburne	703
St. Paul-Ramsey	7,873
Stearns	1,628
SWHHS	927
Wabasha	176
Washington	1,180
Watonwan	223
Winona	341
Wright	785

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

Minnesota, 2016	Infants	Children
Aitkin-Itasca-Koochiching	738	1,089
Anoka	2,777	3,651
Benton	472	606
Bloomington	701	1,010
Blue Earth	581	812
Brown-Nicollet	515	795
Carlton-Cook-Lake-St. Louis	2,143	3,018
Carver	366	528
Cass	415	714
Chisago	390	529
Countryside	577	859
Crow Wing	685	989
Dakota	3,005	4,247
Des Moines Valley	246	388

Minnesota, 2016	Infants	Children
Dodge-Steele	628	969
Edina	83	139
Faribault-Martin	390	584
Fillmore-Houston	321	459
Freeborn	400	597
Goodhue	355	497
Hennepin	5,023	6,681
Horizon	601	1,021
Isanti	424	593
Kanabec-Pine	451	718
Kandiyohi-Renville	919	1,381
Le Sueur-Waseca	464	657
Meeker-McLeod-Sibley	779	1,168
Mille Lacs	330	501

Minnesota, 2016	Infants	Children
Minneapolis	5,724	8,919
Morrison-Todd-Wadena	865	1,333
Mower	575	838
Nobles	527	714
North Country	1,279	2,077
Olmsted	1,399	2,163
Partnership4Health	1,769	2,802
Polk-Norman-Mahnomen	639	1,065
Quin County	565	957
Rice	658	1,080
Richfield	386	600

Minnesota, 2016	Infants	Children
Scott	864	1,355
Sherburne	746	1,064
St. Paul-Ramsey	8,111	12,640
Stearns	1,746	2,422
SWHHS	944	1,527
Wabasha	179	261
Washington	1,249	1,841
Watonwan	206	297
Winona	338	491
Wright	860	1,336

## Prevent the Spread of Communicable Diseases

### Immunization

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

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

Minnesota, 2016	#	%
Aitkin-Itasca-Koochiching	579	83%
Anoka	2,874	72%
Benton	406	80%
Bloomington	667	71%
Blue Earth	637	89%
Brown-Nicollet	625	91%
Carlton-Cook-Lake-St. Louis	1,943	79%
Carver	816	66%
Cass	249	77%
Chisago	448	81%
Countryside	417	88%
Crow Wing	473	82%
Dakota	3,947	75%
Des Moines Valley	195	83%
Dodge-Steele	661	83%
Edina	378	65%
Faribault-Martin	285	83%
Fillmore-Houston	372	81%
Freeborn	329	87%
Goodhue	374	76%
Hennepin	10,753	68%
Horizon	663	84%
Isanti	341	80%
Kanabec-Pine	361	79%
Kandiyohi-Renville	641	84%

Minnesota, 2016	#	%
Le Sueur-Waseca	395	84%
Meeker-McLeod-Sibley	641	76%
Mille Lacs	245	75%
Minneapolis	4,449	67%
Morrison-Todd-Wadena	706	81%
Mower	436	84%
Nobles	290	76%
North Country	810	79%
Olmsted	1,848	79%
Partnership4Health	1,611	81%
Polk-Norman-Mahnomen	468	80%
Quin County	521	82%
Rice	626	79%
Richfield	328	69%
Scott	1,521	75%
Sherburne	906	79%
St. Paul-Ramsey	5,322	72%
Stearns	1,735	78%
SWHHS	815	85%
Wabasha	217	83%
Washington	2,548	82%
Watonwan	131	91%
Winona	356	70%
Wright	1,200	69%

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

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

Minnesota, 2016 (n=49)	#	%
Yes	<b>46</b>	<b>94%</b>
No	3	6%

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

Answer if you selected “yes” to Q2, above.

	No		Yes, though doing less in recent years		Yes; relatively stable in recent years		Yes; doing more in recent years	
	#	%	#	%	#	%	#	%
Minnesota, 2016 (n=46)								
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.)	9	20%	13	28%	<b>22</b>	<b>48%</b>	2	4%
Provide immunization to “walk in” community members by request (at the public health department)	4	9%	19	41%	<b>20</b>	<b>44%</b>	3	7%
Provide immunization during designated clinic(s) conducted jointly with others	<b>19</b>	<b>41%</b>	6	13%	18	39%	3	7%
Provide immunization during designated clinic(s) conducted as a preparedness exercise (clinic to administer influenza vaccine during typical flu season)	<b>29</b>	<b>63%</b>	6	13%	9	20%	2	4%
Provide immunization during designated clinic(s) conducted as part of an emergency response (clinic to administer H <sub>1</sub> N <sub>1</sub> vaccine or another type of vaccine during an outbreak)	<b>41</b>	<b>89%</b>	2	4%	3	7%	0	0%
Provide immunizations timed around reminder/recall efforts within the region	19	41%	5	11%	<b>21</b>	<b>46%</b>	1	2%

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

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

Minnesota, 2016 (n=49)	#	%
<b>No</b>	<b>32</b>	<b>65%</b>
No, but recently completed	7	14%
Yes, currently underway	8	16%
Yes, planned	2	4%

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

Minnesota, 2016 (n=49)	#	%
No	4	8%
Yes, though doing less in recent years	4	8%
<b>Yes; relatively stable in recent years</b>	<b>34</b>	<b>69%</b>
Yes; doing more in recent years	7	14%

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

Minnesota, 2016 (n=49)	Routinely		During an emergency response		For influenza vaccination		For non-influenza vaccination		Not performed	
	#	%	#	%	#	%	#	%	#	%
Provided education to the community	44	90%	3	6%	26	53%	23	47%	1	2%
Engaged with immunization providers to discuss immunization coverage	39	80%	3	6%	15	31%	21	43%	3	6%
Engaged with partners to coordinate services	39	80%	3	6%	22	45%	17	35%	5	10%
Used MIIC data to engage immunization providers in immunization improvement activities	40	82%	1	2%	5	10%	17	35%	5	10%
Used MIIC data to conduct reminder/recall outreach for clients of the community health board	38	78%	1	2%	3	6%	13	27%	10	20%
Used MIIC data to conduct reminder/recall outreach for residents of the jurisdiction (not only those who attended a clinic held by the community health board)	24	49%	1	2%	1	2%	10	20%	21	43%
Used QI tools and processes to improve immunization practices or delivery in the community health board	25	51%	0	0%	6	12%	13	27%	20	41%
Served as a resource [to immunization providers in your community health board’s jurisdiction] on current recommendations and best practices regarding immunization	47	96%	3	6%	14	29%	18	38%	2	4%
Conducted population-based needs assessment informed by immunization coverage levels in MIIC	26	53%	1	2%	6	12%	12	25%	20	41%

	Routinely		During an emergency response		For influenza vaccination		For non-influenza vaccination		Not performed	
	#	%	#	%	#	%	#	%	#	%
Minnesota, 2016 (n=49)										
Mentored one or more community health boards to help them improve immunization rates	6	12%	0	0%	0	0%	1	2%	<b>43</b>	<b>88%</b>
Coordinated with community health board's MIIC regional coordinator (e.g., to conduct outreach to clients needing immunizations, to conduct reminder/recall, and/or to get immunization coverage data)	<b>40</b>	<b>82%</b>	0	0%	5	10%	13	27%	5	10%
Other (please specify)										

Other:

<b>Routinely:</b> Our county is the Regional MIIC Coordinator for the Metro Region
<b>For non-influenza vaccination:</b> Provided off site clinics for volunteer fireman Hep B series in 2016. Additionally we did IPI visits for 2 clinics in 2016. We provided many skin tests coordinated with several contact investigations for TB in 2016 for our agency. We have greatly seen increase in numbers for immunizations related to immigration requirements as well as school required immunizations for school age children.
<b>Routinely:</b> Coordinate immunization activities with community activities where underserved people may be at (community school locations for flu and other vaccinations; coordinate with 'free clinic' when they do diabetic classes for uninsured--we provide immunizations 1-2 x/year for those attendees.
<b>Routinely, during an emergency response, for influenza vaccination, for non-influenza vaccination:</b> Work with other community health boards on immunization policies and procedures for the region.

## Protect Against Environmental Health Hazards

### Indoor Air

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

#### Glossary

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

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

Minnesota, 2016 (n=49)	#	%
<b>Refer to MDH Indoor Air Unit</b>	<b>37</b>	<b>76%</b>
Investigate complaints	26	53%
Administer enforcement, as necessary	20	41%
Community education	27	55%
Other (please explain)	6	12%
None of the above	1	2%

Other:

Our county’s Public Health administers county ordinance 21, Retail Tobacco Sales, which, in part, regulates indoor air quality.
MN Rules Chapter 4626.1820 MN Clean Indoor Air Act while conducting inspections.
SHIP work on Tobacco free housing and workplace grounds work in progress.
Public education provided throughout the year regarding radon, second hand smoke, etc.
Environmental Health portion of our county website provides radon information.
Our county’s Environmental Health regulates smoking in Food, Beverage & Lodging establishments and regulates smoking within 25 feet of an entry and uses of EDDs in all public places throughout our county.

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

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

Minnesota, 2016 (n=20)	#	%
All public places and places of employment	9	45%
<b>Food, beverage, and lodging establishments only</b>	<b>11</b>	<b>55%</b>
Neither (none)	0	0%

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

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

Minnesota, 2016 (n=20)	#	%
<b>All public places and places of employment</b>	<b>9</b>	<b>45%</b>
Food, beverage, and lodging establishments only	5	25%
Neither (none)	6	30%

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

Minnesota, 2016 (n=49)	#	%
<b>Provided information (including training) to the general public</b>	<b>36</b>	<b>74%</b>
Provided technical information (including training) to professionals	8	16%
Provided information to policymakers	7	14%
Coordinated services	8	16%
Made referrals	31	63%
Included a check for the presence of mold	12	25%
Conducted inspections specifically for mold (this includes accompanying inspectors from another department)	13	27%
None of these preventive actions related to mold	9	18%

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

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

Minnesota, 2016 (n=13)	#	%
Residence: Owner-occupied	7	54%
<b>Residence: Rented</b>	<b>11</b>	<b>85%</b>
Commercial: Owned	2	15%
Commercial: Rented	1	8%
Licensed (e.g., food, lodging, etc.)	8	62%
Public (e.g., school, government)	3	23%
Other (please specify)	0	0%

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

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

Minnesota, 2016 (n=13)	#	%
Residence: Owner-occupied	2	15%
Residence: Rented	7	54%
Commercial: Owned	0	0%
Commercial: Rented	0	0%
<b>Licensed (e.g., food, lodging, etc.)</b>	<b>8</b>	<b>62%</b>
Public (e.g., school, government)	2	15%
Other (please specify)	0	0%
Community health board does not issue orders to building owners or operators to correct mold or moisture problems as a preventive measure	3	23%

Other:

2a. Our agency’s Public Health- Environmental Health Specialists offer 2 options when citizens have mold concerns, including a 'free mold walk through' assessment written recommendations, or an optional general mold test along with an onsite mold assessment and accompanying written recommendations.
2b. Our agency’s Public Health -Environmental Health Specialists write recommendations only related to mold.. No orders are written.

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

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

Minnesota, 2016 (n=10)	#	%
<b>Minnesota Local Public Health Act (Minn. Stat. § 145A.04)</b>	<b>5</b>	<b>50%</b>
Local public nuisance ordinance	2	20%
Building code	2	20%
<b>Other ordinance/rule/statute (please specify)</b>	<b>5</b>	<b>50%</b>

Other ordinance/rule/statute:

Minnesota Rules 4626.0840, 4626.0855, 4626.1520, 4625.0500, 4625.0600, 4626.1100, 4625.1200
MN Food, Lodging and Pool codes
Our County Lodging Establishment Ordinance
MN Food, Lodging and Pool codes
County Rental Ordinance

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

Minnesota, 2016 (n=49)	#	%
<b>Provided information (including training) to the general public</b>	<b>40</b>	<b>82%</b>
Provided technical information (including training) to professionals	9	18%
Provided information to policymakers	7	14%
Coordinated services	12	25%
Made referrals	37	76%
Included a check for the presence of mold	16	33%
Conducted inspections specifically for mold (this includes accompanying inspectors from another department)	15	31%
Community health board did not take any of these actions in response to mold-related complaints and/or emergencies	4	8%

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

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

Minnesota, 2016 (n=15)	#	%
Residence: Owner-occupied	8	53%
<b>Residence: Rented</b>	<b>12</b>	<b>80%</b>
Commercial: Owned	1	7%
Commercial: Rented	1	7%
Licensed (e.g., food, lodging, etc.)	7	47%
Public (e.g., school, government)	3	20%
Other (please specify)	0	0%

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

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

Minnesota, 2016 (n=15)	#	%
Residence: Owner-occupied	3	20%
<b>Residence: Rented</b>	<b>7</b>	<b>47%</b>
Commercial: Owned	1	7%
Commercial: Rented	0	0%
<b>Licensed (e.g., food, lodging, etc.)</b>	<b>7</b>	<b>47%</b>
Public (e.g., school, government)	2	13%
Other (please specify)	2	13%
Community health board does not issue orders to building owners or operators to correct mold or moisture problems in response to mold-related complaints and/or emergencies	4	27%

Other ordinance/rule/statute:

Establishments were inspected as indicated above, but circumstances did not rise to public health nuisance status and thus no orders were written.
No orders issued.

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

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

Minnesota, 2016 (n=11)	#	%
Minnesota Local Public Health Act (Minn. Stat. § 145A.04)	4	36%
Local public nuisance ordinance	2	18%
Building code	2	18%
<b>Other ordinance/rule/statute (please specify)</b>	<b>6</b>	<b>55%</b>

Other ordinance/rule/statute:

Minnesota Rules 4626.0840, 4626.0855, 4626.1520, 4625.0500, 4625.0600, 4626.1100, 4625.1200
MN Food, Lodging and Pool codes
No orders were issued, so not statute, rule or ordinance was cited.
CHB did not issue the orders, but the local governing body issued orders based on their rental ordinance.
MN Food, Lodging and Pool codes
County Rental Ordinance

## Blood Lead

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

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

Minnesota, 2016 (n=49)	#	%
<b>Community health board responds to blood lead test results</b>	<b>48</b>	<b>98%</b>
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	1	2%

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

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

Minnesota, 2016 (n=48)	#	%
Send family a letter	43	90%
<b>Call family to discuss</b>	<b>46</b>	<b>96%</b>
Schedule home visit and provide educational materials	32	67%
Track/assure follow-up blood lead testing	44	92%
Provide public health referrals (e.g., WIC, MA, follow-up testing) and/or contact medical provider	43	90%
Review additional housing-based threats (e.g., Healthy Homes)	28	58%
Do follow-up visit	20	42%
Other (please specify)	12	25%

Other:

Provide educational materials with letter sent.
Request MDH to visit the home and provide education and assessment after venous blood level
May arrange a lead risk assessment with MDH, and provide educational materials.
Provide educational materials
If family is open to home visiting the PHN opened to the case would provide information during a home visit.
We mail family educational materials.
provide educational materials as requested.
Refer to Tribal Health Department when client resides in their jurisdiction.
Our County Public Health Nursing staff coordinate with Minnesota Department of Health Public Health Nurses for case monitoring and follow-up.
Lead swab check on suspected lead sources
provide educational materials
Conduct environmental assessment

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

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

Minnesota, 2016 (n=48)	#	%
Send family a letter	36	75%
<b>Call family to discuss</b>	<b>47</b>	<b>98%</b>
Schedule home visit and provide educational materials	44	92%
<b>Track/assure follow-up blood lead testing</b>	<b>47</b>	<b>98%</b>
<b>Provide public health referrals (e.g., WIC, MA, follow-up testing) and/or contact medical provider</b>	<b>47</b>	<b>98%</b>
Review additional housing-based threats (e.g., Healthy Homes)	33	69%
Do follow-up visit	34	71%
Other (please specify)	10	21%

Other:

Request MDH to visit the home and provide education and assessment after venous blood level
Would arrange for a lead risk assessment with MDH.
State inspection with CCPH- MCH nurse
Staff will notify MDH of concern and request dual home visit to address lead in the home.
Contact MDH for formal lead assessment
Contact MDH for site/face to face visit
Our County Public Health Nursing staff coordinate with Minnesota Department of Health Public Health Nurses for case monitoring and follow-up. Coordination also includes with MDH staff for onsite risk assessment of housing.
If in city limits- work with water department- check water source for potential contamination
coordinate joint visit with MDH environmental health specialist
Environmental assessment and follow up mandated at this EBL (elevated blood level).

## Drinking Water Protection and Well Management

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

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

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

Minnesota, 2016 (n=49)	#	%
Attend water quality trainings	23	47%
Educate policymakers or the public on drinking water quality	22	45%
Provide technical assistance on drinking water issues	23	47%
<b>Provide or facilitate water testing services for residents</b>	<b>29</b>	<b>59%</b>
Operates a delegated well program	10	20%
Other (please specify)	15	31%
None of the above	9	18%

Other:

Facilitate a multi-agency water task force. Compile a water resources report. Post multi-agency drinking water protection information on a website.
Another county department, Environmental Services, does this.
Provide water sample testing kits and refer to environmental services for testing and requirements.
Operates a SSTS (septic) program. Ensuring proper on-site waste water disposal and protection of well water sources.
Facilitate the sampling of water from establishments that do not fit the Safe Drinking Water Protection definition.
Support clean water initiative, provide education as appropriate, make referrals as needed
Our County Environmental Resources Department provides ground water protection and monitoring services.
Serve on the Water Shed Advisory Board
Well water testing is offered through the Planning & Zoning Department. We promote well water testing when working with families with infants and young children.
Operate water testing lab
Operates a delegated program for non-community public water supply.
The county has a state approved Groundwater Protection Plan that provides a framework for our work on groundwater quality and quantity.
Provide kits to residents who have a concern.
We convene learning opportunities for our interns. Most do a clean water treatment plant tour and education and a waste water treatment plant tour and overview.
Our County has well kits available and also provides resources as needed.

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

Minnesota, 2016 (n=49)	#	%
Collect well water samples for testing	13	27%
<b>Promote well water testing</b>	<b>37</b>	<b>76%</b>
Provide private well owners with well information	36	74%
Well Sealing Cost Share	9	18%
Other (please specify)	11	22%

Other:

Promote Well Water Wise week, concurrent with the American Water Works Association Drinking Water Week.
Information is available on county website.
Referral
Refer for water samples, provide fact sheets or defer to MDH website for information regarding nitrates or other contaminants and provide information for flooding.
We provide no well protection activities.
A Well Sealing Cost Share program is operated through another county Department, Environment & Energy Department.
Referrals as needed
Services related to this section are provided by our county's Environmental Resources Department and the Southeast Minnesota Water Resources Lab.
Septic program in Environmental Health includes loan to assist with well-sealing.
Another local department provides services

**Extreme Weather**

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

**Glossary**

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

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

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

Minnesota, 2016 (n=49)	#	%
<b>Attend extreme weather trainings</b>	<b>31</b>	<b>63%</b>
Educate policymakers or the public on the health impacts of extreme weather	23	47%
Convene partners or participate in coalitions to mitigate or adapt to extreme weather	23	47%
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)	19	39%
Conduct assessments on extreme weather vulnerability	18	37%
Pursue funding to address extreme weather (e.g., grants)	5	10%
Other (please specify)	13	27%
Community health board has not considered extreme weather	6	12%

Other:

Work with EM on planning efforts.
There was at least one extreme weather communication/education piece sent to community on 12/15/16.
In relation to PHEP identified threats
Media / education was shared concerning extreme weather in December 2016.
Extreme weather communication/education pieces were sent to the community at large on 12-15-16.

We have a cooling and extreme heat plan. The planning is done with the emergency manager. Most of our Public Health completed sheltering training with our community partners.
Climate change surveys and policies. Our County has created public information (webpages) for the community to use in instances of extreme weather. (E.g.; COOL COUNTY, Hot weather, cooling options, etc.). Our County Emergency Manager is very involved in extreme weather notifications and policies (e.g. major re-evaluation of siren warning system).
Responded to 2016 extreme weather event of torrential rain of 10-11' in a few hours. Worked with Emergency Manager on a coordinated response and educational messages.
In addition to PHEP responsibilities, we are active participants in EMPAC-Emergency Management Planning team with multi discipline partners in our county-fire, police, local hospitals, EMTs, businesses in high potential risk work. Monthly meetings, tabletops and drills attended as needed, policy work to include Haz mat and active shooter training offered by local police.
Extreme weather activities are led by Emergency Management. This is done on an ongoing basis.
ESF 8 & Public Health Hazard Vulnerability assessment starter objectives
Extreme weather topic comes up in areas of aging and health equity (related to who has access to safe places).
Extreme weather has been incorporated into the County All Hazards Mitigation Plan.

### Nuisance Investigations

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

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

Minnesota, 2016 (n=49)	#	%
<b>Garbage/junk house</b>	<b>31</b>	<b>63%</b>
<b>Mold</b>	<b>31</b>	<b>63%</b>
Improper sewage disposal, discharging to surface/groundwater/into structure	7	14%
Accumulation of rubbish or junk	17	35%
Accumulation of decaying animal or vegetable matter	1	2%
Hazardous building or unsanitary dwelling	14	29%
Vermin or vector infestations	18	37%
Clandestine drug labs	0	0%
Failure to keep waste, refuse, or garbage properly	11	22%
Contaminated drinking water	1	2%
Elevated radon	4	8%
Contaminated surface water	0	0%
Hazardous waste	1	2%
Unsecured hole or opening (abandoned well, well pit, sewage treatment system, non-maintained swimming pool, mine shaft, tunnel)	2	4%
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 (please specify)	5	10%

Other:

Bed Bugs
Other landlord maintenance issues
Bedbugs
Possible foodborne illness
Lice

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

Garbage/junk house

Minnesota, 2016 (n=31)	#	%
Removal, abatement, or resolution	20	65%
Evidence-based strategies on prevention	8	26%
<b>Partnered with other agencies to address</b>	<b>24</b>	<b>77%</b>

Mold

Minnesota, 2016 (n=31)	#	%
Removal, abatement, or resolution	8	26%
Evidence-based strategies on prevention	17	55%
<b>Partnered with other agencies to address</b>	<b>22</b>	<b>71%</b>

Improper sewage disposal, discharging to surface/groundwater/into structure

Minnesota, 2016 (n=7)	#	%
<b>Removal, abatement, or resolution</b>	<b>7</b>	<b>100%</b>
Evidence-based strategies on prevention	2	29%
Partnered with other agencies to address	4	57%

Accumulation of rubbish or junk

Minnesota, 2016 (n=17)	#	%
Removal, abatement, or resolution	11	65%
Evidence-based strategies on prevention	2	12%
<b>Partnered with other agencies to address</b>	<b>12</b>	<b>71%</b>

Accumulation of decaying animal or vegetable matter

Minnesota, 2016 (n=1)	#	%
<b>Removal, abatement, or resolution</b>	<b>1</b>	<b>100%</b>
Evidence-based strategies on prevention	0	0%
<b>Partnered with other agencies to address</b>	<b>1</b>	<b>100%</b>

Hazardous building or unsanitary dwelling

Minnesota, 2016 (n=14)	#	%
Removal, abatement, or resolution	9	64%
Evidence-based strategies on prevention	4	29%
<b>Partnered with other agencies to address</b>	<b>12</b>	<b>86%</b>

Vermin or vector infestations

Minnesota, 2016 (n=18)	#	%
Removal, abatement, or resolution	8	44%
Evidence-based strategies on prevention	9	50%
<b>Partnered with other agencies to address</b>	<b>12</b>	<b>67%</b>

Clandestine drug labs

Minnesota, 2016 (n=0)	#	%
Removal, abatement, or resolution	---	---
Evidence-based strategies on prevention	---	---
Partnered with other agencies to address	---	---

Failure to keep waste, refuse, or garbage properly

Minnesota, 2016 (n=11)	#	%
<b>Removal, abatement, or resolution</b>	<b>9</b>	<b>82%</b>
Evidence-based strategies on prevention	1	9%
Partnered with other agencies to address	7	64%

Contaminated drinking water

Minnesota, 2016 (n=1)	#	%
<b>Removal, abatement, or resolution</b>	<b>1</b>	<b>100%</b>
Evidence-based strategies on prevention	0	0%
Partnered with other agencies to address	0	0%

Elevated radon

Minnesota, 2016 (n=4)	#	%
Removal, abatement, or resolution	0	0%
Evidence-based strategies on prevention	2	50%
<b>Partnered with other agencies to address</b>	<b>3</b>	<b>75%</b>

Contaminated surface water

Minnesota, 2016 (n=0)	#	%
Removal, abatement, or resolution	---	---
Evidence-based strategies on prevention	---	---
Partnered with other agencies to address	---	---

Hazardous waste

Minnesota, 2016 (n=1)	#	%
<b>Removal, abatement, or resolution</b>	<b>1</b>	<b>100%</b>
Evidence-based strategies on prevention	0	0%
<b>Partnered with other agencies to address</b>	<b>1</b>	<b>100%</b>

Unsecured hole or opening (abandoned well, well pit, sewage treatment system, non-maintained swimming pool, mine shaft, tunnel)

Minnesota, 2016 (n=2)	#	%
<b>Removal, abatement, or resolution</b>	<b>2</b>	<b>100%</b>
Evidence-based strategies on prevention	0	0%
<b>Partnered with other agencies to address</b>	<b>2</b>	<b>100%</b>

Accumulation of carcasses of animals or failure to dispose of carcasses in a sanitary manner

Minnesota, 2016 (n=0)	#	%
Removal, abatement, or resolution	---	---
Evidence-based strategies on prevention	---	---
Partnered with other agencies to address	---	---

Chemical spill

Minnesota, 2016 (n=2)	#	%
Removal, abatement, or resolution	1	50%
Evidence-based strategies on prevention	1	50%
<b>Partnered with other agencies to address</b>	<b>2</b>	<b>100%</b>

Contaminated ground water

Minnesota, 2016 (n=0)	#	%
Removal, abatement, or resolution	---	---
Evidence-based strategies on prevention	---	---
Partnered with other agencies to address	---	---

## Assure Health Services

### Clinical-Community Linkages

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

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

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

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

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

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

**Establishing a Community EBP (Evidence-Based Practice) Program:**

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

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

	Used SHIP funding and/or SHIP match for strategy		Used other (non-SHIP) funding for strategy		Was not involved in strategy	
	#	%	#	%	#	%
Minnesota, 2016 (n=49)						
Workplace strategy in the health care setting	33	67%	12	25%	12	25%
Screen-Counsel-Refer-Follow-Up (SCRF) in the clinical setting	24	49%	17	35%	18	37%
Establishing a community evidence-based practice (EBP) program	25	51%	17	35%	16	33%
Other (please specify)	5	10%	4	8%	40	82%

Other:

<b>Used SHIP funding and/or SHIP match for strategy:</b> Support and coordinate the Mankato Area Collaborative Network (MACN) meetings involving public health agencies, medical providers, behavioral health, etc.
<b>Used SHIP funding and/or SHIP match for strategy:</b> At least 2 strategies were completed in the workplace setting including setting up a Wellness Coalition in our county, working on SCRF with Fall Prevention at several locations and establishing Matter of Balance classes in multiple counties.
<b>Used SHIP funding and/or SHIP match for strategy:</b> Farmacy (ICPD participants get \$ vouchers for local F/V)- link local foods, ICPD program and local clinic/PH
<b>Used SHIP funding and/or SHIP match for strategy:</b> CentraCare Health System SIM Project regarding diabetes and our county working toward breastfeeding friendly department
<b>Used other (Non-SHIP) funding for strategy:</b> Community Health Worker
<b>Used other (Non-SHIP) funding for strategy:</b> Used Community Wellness Grant to work with local clinics to obtain clinical data for wellness and also to work at the introduction of Community Health Workers within a clinical setting.
<b>Used other (Non-SHIP) funding for strategy:</b> Attempted to develop a referral network between health care and community education organizations. This was not an evidence-based strategy, but an informal network development.
<b>Used other (Non-SHIP) funding for strategy:</b> Community pharmacists partner with public housing
<b>Used other (Non-SHIP) funding for strategy:</b> Child and Teen Check-ups Outreach

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

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

	Primary		Secondary		Tertiary	
	#	%	#	%	#	%
Minnesota, 2016 (n=46)						
Local tax levy	2	4%	6	13%	18	39%
State general fund (Local Public Health Act)	1	2%	17	37%	5	11%
<b>SHIP</b>	<b>34</b>	<b>74%</b>	8	17%	0	0%
Other state funds (from MDH or from other state agencies)	1	2%	2	4%	6	13%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	7	15%	2	4%	0	0%
Title V Block Grant	1	2%	0	0%	1	2%
Foundation funds	0	0%	2	4%	3	7%
Fees/reimbursement	0	0%	2	4%	2	4%

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

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

Minnesota, 2016 (n=26)	#	%
<b>Yes</b>	<b>21</b>	<b>81%</b>
No	5	19%

**Provision of Public Health Services**

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

[Glossary](#)

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

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

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

Minnesota, 2016 (n=49)	Prim. care: Medical		Primary care: Dental		Licensed home care		Correctional health	
	#	%	#	%	#	%	#	%
Provided services	8	16%	4	8%	13	27%	13	27%
Contracted for services	7	14%	8	16%	0	0%	4	8%
<b>Did not provide services</b>	<b>38</b>	<b>78%</b>	<b>37</b>	<b>76%</b>	<b>36</b>	<b>74%</b>	<b>35</b>	<b>71%</b>

## Appendix B: Community Health Board Sizes, 2016

In this report, you will often see data broken out by community health board population. MDH has used population data from 2015 for this report, which is the most recently available population data.

### Small Community Health Boards

Benton	39,710
Cass	28,706
Countryside	43,220
Des Moines Valley	21,628
Faribault-Martin	34,072
Fillmore-Houston	39,607
Freeborn	30,613
Goodhue	46,435
Isanti	38,429
Kanabec-Pine	44,906
Le Sueur-Waseca	46,652
Mille Lacs	25,788
Mower	39,116
Nobles	21,770
Polk-Norman-Mahnomen	43,668
Quin County	47,891
Richfield	36,557
Wabasha	21,239
Watonwan	10,952

### Large Community Health Boards

Anoka	344,151
Carlton-Cook-Lake-St. Louis	251,825
Dakota	414,686
Hennepin	1,223,149
Minneapolis	412,517
Olmsted	151,436
Partnership4Health	159,822
Scott	141,660
St. Paul-Ramsey	538,133
Stearns	154,708
Washington	251,597
Wright	131,311

### Medium Community Health Boards

Aitkin-Itasca-Koochiching	73,978
Bloomington	87,224
Blue Earth	65,787
Brown-Nicollet	58,660
Carver	98,741
Chisago	54,293
Crow Wing	63,428
Dodge-Steele	57,119
Edina	50,766
Horizon	67,216
Kandiyohi-Renville	57,434
Meeker-McLeod-Sibley	73,909
Morrison-Todd-Wadena	70,907
North Country	79,053
Rice	65,400
Sherburne	91,705
SWHHS	74,199
Winona	50,885

