STATEWIDE PUBLIC HEALTH OUTCOMES FOR 2004

A WORKING DOCUMENT
OF THE
STATE COMMUNITY HEALTH SERVICES ADVISORY COMMITTEE
AD HOC GROUP ON DEVELOPMENT OF STATEWIDE OUTCOMES

MINNESOTA DEPARTMENT OF HEALTH
SEPTEMBER 2003
September 18, 2003

Dianne M. Mandernach
Commissioner
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164

Dear Commissioner Mandernach:

I am pleased to forward for your approval the Statewide Public Health Outcomes for 2004: A Working Document of the State Community Health Services Advisory Committee (SCHSAC) Ad Hoc Group on Development of Statewide Outcomes. The SCHSAC Ad Hoc Group intends this to be a “working” document, which will change as we learn from implementation this year. This report was approved by the full SCHSAC on September 10, 2003.

The SCHSAC charged the Ad Hoc Group with developing statewide outcomes for the first year of implementation of the Local Public Health Act funding. Their difficult work was completed in record time for a project of this significance.

The group’s definition of “outcomes” emerged as a subset of statewide objectives and corresponding essential local activities derived from Minnesota’s Public Health Improvement Goals. These outcomes reflect the importance of maintaining a strong public health system and will lead to improved health status in Minnesota communities. They are not, however, a comprehensive list of minimum standards nor a list of all the issues that local public health departments must address to adequately protect and promote public health.

These outcomes will be reviewed and will provide a framework for the development of outcomes for the five-year period, beginning January 1, 2005.

I look forward to talking with you further about the recommendations in this report, as we continue our work to define appropriate public health outcomes in Minnesota.

Sincerely,

Ed Larsen, Chair
State Community Health Services Advisory Committee
Crow Wing County Commissioner
September 26, 2003

Commissioner Ed Larsen, Chair
State Community Health Services Advisory Committee
Crow Wing County CHB
3961 West Lake Street
Pequot Lakes, MN 56472

Dear Commissioner Larsen:

Thank you for sending me the Statewide Public Health Outcomes for 2004: A Working Document of the State Community Health Services Advisory Committee (SCHSAC) Ad Hoc Group on Development of Statewide Outcomes. I commend the Ad Hoc Group for taking on the difficult charge of developing statewide outcomes for the Local Public Health Act funds and for adding clarity and specifics to the “statewide outcomes” mentioned in the legislation. I know these decisions were not easy to make, especially within the short time line necessitated by the legislative process.

One of the most significant features of the 2003 Local Public Health Act is that it focuses accountability for the funding on a set of statewide outcomes. The Ad Hoc Group did an excellent job of developing interim statewide outcomes that provide a framework for strengthening the public health system in Minnesota. The group has built a solid foundation for us to use during the next year, as we work on reporting and developing five-year outcomes.

Thank you for your innovative work, and I look forward to continuing to work with the SCHSAC to develop an even stronger public health system.

Sincerely,

Dianne M. Mandernach
Commissioner
P.O. Box 64882
St. Paul, MN 55164-0882
STATEWIDE PUBLIC HEALTH OUTCOMES FOR 2004

A Working Document
of the
State Community Health Services Advisory Committee
Ad Hoc Group on Development of Statewide Outcomes

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STATEWIDE PUBLIC HEALTH OUTCOMES FOR 2004

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STATEWIDE PUBLIC HEALTH OUTCOMES FOR 2004
BACKGROUND

MINNESOTA'S PUBLIC HEALTH SYSTEM: A STATE AND LOCAL PARTNERSHIP

Minnesota’s public health system, known as Community Health Services (CHS), is a partnership of the Minnesota Department of Health (MDH) and Minnesota’s 51 Community Health Boards (CHBs), combinations of city and county boards of health representing all parts of the state. Since 1976, the MDH and CHBs have been working together closely in the areas of policy development, public health planning, and the development of strategies for protecting and promoting the public’s health. Each level of government plays a complimentary role, and each invests resources in the overall system.

The goal of the state and local partnership is to protect and maintain the public’s health. This is achieved by ensuring that all parts of Minnesota are served by a public health system that is able to:

- Assess community health needs;
- Respond to public health emergencies;
- Protect the public from disease and injury;
- Assure a safe and healthy environment;
- Promote healthy behaviors; and
- Link people to the services that they need.

The unique partnership and shared roles of Minnesota’s state and local public health system require that any significant changes to Minnesota’s public health system be developed jointly. The process of searching for creative, mutually beneficial solutions to difficult issues is an important factor that contributes to the ultimate success of those solutions and the promotion of the public’s health.

HISTORICAL FUNDING FOR PUBLIC HEALTH IN MINNESOTA

Community Health Boards (CHBs) in Minnesota oversee a wide spectrum of public health activities and support them with a broad and complex range of funding sources. The activities of public health agencies and their associated funding streams vary widely. Those CHBs with a heavier involvement in direct health care services (for example, general purpose or specialized clinical services, home care and home visiting, implementation of Medical Waiver programs for the elderly and persons with disabilities) have greater fee, insurance, and publicly funded health program revenues, such as Medical Assistance (MA), MinnesotaCare (MNCare), General Assistance Medical Care (GAMC). Those CHBs with a larger emphasis on health promotion, prevention, and population health activities may more actively pursue special purpose grant funding.

All CHBs assume responsibility for some level of basic public health activities funded primarily by property tax funds and state and federal revenues. Until 2002, state and federal funds provided an average of about 30 percent of the total funding for local public health.
One of the largest and longest-running state funded programs was the CHS subsidy, created in 1976. This has averaged 7-8 percent of total revenues of local public health agencies. The purpose of the subsidy was to fund coordinated local planning efforts and to help develop a strong locally-based public health infrastructure in Minnesota.

Although state funds are critical in supporting local public health activities, local governments in Minnesota have invested significant resources toward public health, and the CHS subsidy has become one of many funding sources for local public health activity. In 1979, the first year statewide data were available, the local tax levy for public health exceeded the CHS subsidy appropriation by 1.64 to 1. As time passed, the subsidy did not grow in proportion to local spending. By 2001, the local tax levy exceeded the CHS subsidy appropriation by 3.4 to 1, and the local match (all eligible funds, including federal grants) exceeded the subsidy by a ratio of nearly 10 to 1. In addition to the CHS subsidy, local public health agencies are eligible for, and many receive, additional state competitive grant funds in specific public health program areas, as well as federal grants.

**CURRENT FUNDING FOR PUBLIC HEALTH**

In 2003, the state of Minnesota faced the largest budget crisis in its history – a projected budget shortfall of more than four billion dollars for the two-year state budget that began on July 1, 2003.

To balance the budget without increasing state taxes, the Governor and the state Legislature found it necessary to make cuts to many state-funded programs. Unallotments in FY 2002 reduced funds available to CHS agencies by $6.7 million. For FY 2004, CHS agencies lost all formula-based tobacco endowment funds that supported Youth Risk Behavior prevention activities and six months of funding (out of their original 18-month grant) for their Local Partnership tobacco grant funds. In addition, tobacco prevention funds were reduced from $3.8 million to an ongoing grant pool of approximately $3.3 million, which will be distributed competitively to local public health agencies and other community based organizations. The funds consolidated by the Local Public Health Act (described below in more detail) were distributed on a basis that represents a 29 percent reduction from historical funding levels. For CHS agencies providing direct care, reductions in eligibility for public health coverage programs (MA, GAMC, MNCare) and new premiums and eligibility limitations for the MA waiver programs for persons with disabilities and the elderly present further service and budget challenges.

Finally, most public health agencies historically have benefited from local property tax levies and the distribution of property tax related Homestead and Agricultural Credit Aid (HACA) and local government aids. County and city level reductions in these programs and the resulting competition for remaining property tax funds may further constrain the resources available.
2003 Changes to the Local Public Health Act

Why were changes made?
In the 2003 legislative session, a proposed solution to the budget crisis was to make changes to the Local Public Health Act and consolidate the CHS subsidy with seven other grants (described more fully in the following pages). The consolidation of funding sources is consistent with previous recommendations of the State Community Health Services Advisory Committee (SCHSAC) – representing all 51 CHBs – to streamline administrative requirements for grants, reduce categorical grant requirements, and focus resources to achieve results. The consolidation also was designed to maintain local flexibility and provide a base of state funding to partially support the local portion of Minnesota’s public health system. This is consistent with the commitment of the MDH “to seek stable and discretionary funding to maintain a strong and stable public health system” (Streamlining Grant Funding for Minnesota’s Public Health System, December 2000).

Changes to the Local Public Health Act (LPH Act), as passed by the Legislature, both consolidated the CHS subsidy with other grants and reduced funding levels. Although consolidation of funding sources is consistent with the goals of the public health system, it is important to note that in addition to this reduction of funds, public health agencies are facing significant budget cuts at the local level. The public health system in Minnesota cannot absorb all of these reductions and continue to maintain the level of public health protection Minnesotans have come to expect.

What programs are included in the consolidation?
The LPH Act combined the CHS subsidy with seven other categorical and federal grants, including:
- Maternal and Child Health Block Grant;
- Family Home Visiting;
- WIC (state funding only);
- Eliminating Health Disparities – Tribal Government Funding;
- TANF Youth Risk Behavior;
- MN ENABL (TANF funding only); and
- Infant Mortality.

How does this affect CHS planning and reporting requirements?
CHBs are no longer required to submit a CHS Plan to MDH every four years. Instead, the Local Public Health Act requires CHBs to 1) establish local priorities based on an assessment of community health needs and assets, and 2) determine mechanisms to address the priorities and achieve statewide outcomes within the limits of available funding. The assessment, prioritization, and planning processes still require community input, but CHBs have additional flexibility in obtaining community input, with a community advisory committee being one method. The assessment, prioritization, and planning processes also are to take into consideration the ten essential public health services.

After the initial year, the new statute establishes a five-year cycle for developing and reporting statewide outcomes and selected local priorities the CHB will address. An annual report is also
required from each CHB. The mechanism for completing these reports is to be developed by the
Commissioner of Health in consultation with the SCHSAC and the Maternal and Child Health
Advisory Task Force.

**WHAT IS THE TIMELINE FOR THESE CHANGES?**
The following is a tentative timeline for the implementation of changes to the Local Public
Health Act.

- **July – December 2003**  Transition period for implementing changes to the Local Public
  Health Act.

- **September 2003**  This report, including the statewide objectives and essential local
  activities, is presented to the full SCHSAC for a vote.

- **January 2004**  Changes to the Local Public Health Act are implemented; CHBs
  begin implementing and tracking the essential local activities contained within this document for
  the time period of January 1, 2004 to December 31, 2004.

- **February 1, 2004**  CHBs notify the MDH of local priorities.

- **March 31, 2004**  Narrative and statistical reports due to MDH from CHBs
  for the time period of January 1, 2003 to December 31, 2003.

- **November 2004**  Statewide objectives and essential local activities finalized for
  implementation for the five-year period beginning January 1, 2005 through December 31, 2009.

- **February 2005**  CHBs notify the MDH of local public health priorities for the five-
  year period beginning January 1, 2005 through December 31, 2009.
DEFINING THE STATEWIDE OUTCOMES

SCHSAC Ad Hoc Group on Development of Statewide Outcomes

Specific changes to the LPH Act sought to move the measurement of accountability for how public funds are used towards a set of defined outcomes reflecting public health efforts. Anticipating these legislative changes, the SCHSAC established a work group – the Ad Hoc Group on Development of Statewide Outcomes (Outcomes Group) – to advise the Commissioner of Health on the development of the statewide outcomes. The Outcomes Group members represented County Commissioners, CHS Administrators, Public Health Nursing Directors, and Maternal and Child Health Advisory Task Force members. (See Appendix A for a list of members.) The group met seven times between March 2003 and July 2003.

The main charge of the Outcomes Group was to establish the uses of the LPH Act funds and define them in the form of outcomes in order to provide a measure of accountability for the funds. The Outcomes Group defined “outcomes” as a set of statewide objectives and essential local public health activities that measure improvement/change in health status or the accomplishment of key activities in public health.

The Outcomes Group found it critical that the set of statewide objectives and essential local public health activities both reflect the importance of maintaining a strong public health system and lead to improved health status in Minnesota communities. To assure a basic and diverse level of public health activities in all parts of the state, the essential local public health activities were selected in the following areas:

- Prevention of chronic disease and the promotion of healthy behaviors;
- Prevention and control of communicable disease;
- Reduction in exposure to environmental health hazards;
- Improvement in the health of families; and
- Preparation for public health emergencies.

Within each of these areas, activities were selected that CHBs could carry out regardless of their size. The list is also intended to identify areas where, with limited resources to address complex public health problems, focused local efforts can be most effective. A detailed list of the statewide objectives and essential local activities begins on page 7.

The statewide objectives and essential local activities described in this document are for one year, beginning January 1, 2004. By December 31, 2004, and every five years thereafter, the Commissioner of Health, in consultation with the SCHSAC and the Maternal and Child Health Advisory Task Force, will revise the statewide objectives and essential local activities, as needed.
STATEWIDE OBJECTIVES

The statewide objectives are designed to be measured on a statewide level and reflect the actions of all the players in public health, including state and local public health agencies as well as non-profit and for-profit public health and health care organizations. The statewide objectives will be measured in aggregate and will not be used to measure individual CHB performance.

*Improvement in public health objectives is only accomplished by the efforts of many individuals, organizations, and systems in a community. The LPH Act funds and local matching funds are not, nor should be, the sole source of resources required to reach statewide objectives.*

The statewide objectives are drawn from *Healthy Minnesotans: Public Health Improvement Goals 2004* that soon will be reviewed and revised. (See Web site: http://www.health.state.mn.us/divs/chs/ophp/goals.htm for more information.)

ESSENTIAL LOCAL ACTIVITIES

Essential local activities are a critical subset of those governmental public health activities that are necessary to protect and promote the public’s health. *The essential local activities are neither a comprehensive list of minimum standards nor a list of all the issues that CHBs must address to adequately protect and promote public health.* They are, however, considered “essential” and as such should be considered a subset of the public health activities needed at the local level. CHBs will be required to perform all the essential local activities listed in this document, within the limits of available funding.

The defining of the “essential local activities” was guided by the “core functions of public health,” which were first identified in 1988 in a report called *The Future of Public Health* (see Appendix B for core functions), published by the National Institute of Medicine. The essential local activities address all three core functions of public health (i.e., assessment, policy development, and assurance). The essential local activities also are consistent with the ten “essential public health services” (see Appendix C), adopted by the Public Health Functions Steering Committee in 1994, which serve to articulate activities encompassed by the core functions.

The essential local public health activities are activities and processes that are intended to help forward the achievement of the statewide objectives. Continued work is needed to clarify and define the relationship between the essential local public health activities and the statewide objectives. This includes developing models for all the essential activities and objectives to clearly demonstrate the connection between implementation of local activities and the achievement of statewide objectives. See Appendix D for sample logic models that describe the relationship between implementing selected essential local activities and achieving some of the statewide objectives.
FUNDING FOR THE ESSENTIAL LOCAL ACTIVITIES

The LPH Act funds, local match dollars, and bioterrorism dollars contribute to the funding of the essential local activities. The LPH Act funds consist of state dollars, federal dollars from the Maternal and Child Health (MCH) Block Grant, and federal TANF dollars. State dollars from the LPH Act funds and local match dollars contribute to the funding of the essential local activities. In addition to local match and state dollars, federal MCH Block Grant and TANF dollars contained within the LPH Act funds help fund the family health activities. However, MCH Title V Block Grant dollars must be used solely for MCH activities. The Centers for Disease Control and Prevention public health preparedness funds (bioterrorism dollars), which are distributed separately from the LPH Act funds, contribute to funding the emergency preparedness essential local activities. Below is a graph that describes the composition of funds in the LPH Act for the essential local activities.

<table>
<thead>
<tr>
<th>HEALTH AREA</th>
<th>FUNDING SOURCES FOR ESSENTIAL LOCAL ACTIVITIES</th>
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<tbody>
<tr>
<td>Chronic Disease Prevention and</td>
<td>State funds and local match dollars</td>
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<tr>
<td>Health Promotion</td>
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<tr>
<td>Communicable Disease</td>
<td>State funds and local match dollars</td>
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<tr>
<td>Environmental Health</td>
<td>State funds and local match dollars</td>
</tr>
<tr>
<td>Family Health</td>
<td>State funds, federal MCH Block Grant dollars, local match dollars, and federal TANF</td>
</tr>
<tr>
<td>Emergency Preparedness</td>
<td>CDC public health preparedness funds</td>
</tr>
</tbody>
</table>

Funds from the LPH Act and local match dollars must be used for performing the essential local activities. Remaining funds may be used for local public health priorities identified by the CHB, based on locally identified needs and priorities. These include, but are not limited to, the previous categorical grant-funded program areas that were folded into the LPH Act.

See Web site: http://www.health.state.mn.us/divs/opa/budget/summary.html for more information about the legislative changes, including local match requirements and the new formula.

ACCOUNTABILITY FOR LOCAL PUBLIC HEALTH ACT FUNDS

CHBs are required to perform all the essential local activities within the limits of available funding. This means that while all CHBs are expected to perform some level of each essential local activity, the level is expected to vary based on the amount of available funding. Continued funding will be contingent upon the CHB performing the essential local activities. If a CHB is not documenting activity, the legislation has dictated a process for the CHB to come into compliance before any funds are withdrawn. (See statute language, Minn. Laws 2003, Chapter 14 First Special Session, Article 8, Sec. 28, Subd. 3, in Appendix E for more information.)

The following pages describe the draft statewide objectives and essential local public health activities proposed by the Outcomes Group.
STATEWIDE OBJECTIVES AND ESSENTIAL LOCAL ACTIVITIES FOR 2004

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Statewide Objectives

- Increase the levels of physical activity among Minnesota adults and children.
- Increase fruit and vegetable consumption among Minnesota adults and children.
- Decrease the level of tobacco use among Minnesota adults and children.
- Decrease the level of alcohol use among Minnesota adults and children.

Essential Local Activities (to be performed within the limits of available funding)

- Designate staff to have health promotion/chronic disease responsibilities, including linking people to needed resources.
- Select one or more of the major behavioral risk factors for chronic disease (physical activity, fruit and vegetable consumption, or alcohol, tobacco, or other drug use) based on local assessment and local priorities:
  - Assess prevalence of selected risk factor(s) in community and specific populations (e.g., those experiencing health disparities, elderly, and disabled) via Minnesota Student Survey, Behavioral Risk Factor Surveillance System (BRFSS), local, or regional community assessment.
  - Become familiar with current literature for selected risk factor(s) relationships to chronic disease; high-risk populations disproportionately affected by the risk factor(s), including populations of color; and evidence-based practices for reducing the prevalence of selected risk factor(s).
  - Develop policies and plans that support individual and community health efforts based on results of assessment and literature review.
COMMUNICABLE DISEASE

Statewide Objectives

- Reduce the incidence of active tuberculosis disease to no more than 3.5 cases per 100,000.
- Reduce the incidence of specific vaccine-preventable diseases that originate in Minnesota to zero. These diseases include measles, rubella, congenital rubella syndrome, mumps, polio, and tetanus. Reduce the incidence of *Haemophilus influenzae* type B (Hib) in children under 73 months of age to zero.
- Because pertussis incidence rates may reflect the quality of surveillance rather than the success of prevention and control efforts, the objectives are: 80 percent of pertussis cases will be diagnosed within two weeks of cough onset, and 95 percent of close household contacts of infectious pertussis cases will be provided appropriate antibiotic.
- All reportable communicable diseases are reported according to Minnesota Department of Health rules, enabling prevention and control measures to take place.

Essential Local Activities (to be performed within the limits of available funding)

- Designate staff to have communicable disease responsibilities for tuberculosis, vaccine-preventable diseases, refugee health, and surveillance activities.
- Assure directly observed therapy (DOT) for tuberculosis or other supervision of therapy, as indicated, according to Centers for Disease Control and Prevention/Minnesota Department of Health standards.
- Assure that contacts of respiratory tuberculosis cases in the Community Health Board’s jurisdiction are identified, located, evaluated, treated if indicated and followed appropriately according to Centers for Disease Control and Prevention/Minnesota Department of Health standards.
- Assure that all newly arrived primary refugees and immigrants who arrive in Minnesota with a “tuberculosis class” condition identified in screening overseas are referred to a healthcare provider and receive appropriate evaluation, screening, and treatment, if indicated.
- Assist in assessing immunization levels in selected populations.
- Develop policies and plans to support national objectives to assure that children from all geographic areas, racial and ethnic groups, and socio-economic strata are up-to-date with their recommended shots.
- Assure screening and referral strategies for high-risk groups for tuberculosis and vaccine-preventable diseases.
- Promote provider compliance of infectious disease reporting, pursuant to Minnesota Reporting Rules.
- In an outbreak situation, in partnership with Minnesota Department of Health, assure the provision of mass or targeted clinics, arranging for staffing, training, emergency supplies, and other logistical needs.
ENVIRONMENTAL HEALTH

Statewide Objectives
- 100 percent of Community Health Boards have policies and procedures that conform to state standards regarding public health nuisance abatement.

Essential Local Activities (to be performed within the limits of available funding)
- Designate and train staff regarding environmental health and/or public health nuisances.
- Assess for major environmental risk conditions in the community.
- Assure the enforcement of laws and regulations that protect health and ensure safety related to public health nuisances.*
- Develop policies and plans to respond to public health nuisances.

*Where appropriate (reflecting different environmental health structures within counties and delegation agreements).
STATEWIDE PUBLIC HEALTH OUTCOMES FOR 2004

**Family Health**

Statewide Objectives

- Decrease the percent of low birth weight infants (less than 2500 grams or 5 lbs 8 oz.) to no more than 5 percent of all births.
- Maintain the number of WIC clinics in Community Health Boards’ jurisdiction.
- Maintain or increase the percent of eligible families participating in WIC.
- Maintain or increase the percent of infants and children with, or at risk for, poor health and developmental outcomes who are identified and referred to appropriate services.
- Maintain the percent of Community Health Boards that have a system, which identifies, monitors, and tracks infants and young children with, or at risk for, poor health and developmental outcomes.
- Decrease the incidence of injury (violent/unintended, fatal/nonfatal) to all maternal and child health populations.

Essential Local Activities (to be performed within the limits of available funding)

- Designate staff to have maternal and child health responsibilities and training.
- Assure services in one or more of the following areas: improved pregnancy outcomes, family planning, children with special health needs, childhood and adolescent health, family health economic sufficiency through public health nurse home visits, and WIC clinic services.
- Monitor health status of maternal and child health populations through existing datasets.
- Assure WIC services are available to eligible families within limits of funding.
- Assure a system is in place to identify, monitor and track infants and young children with, or at risk for, poor health and developmental outcomes.
- Provide parents, families, youth, and the community with education and information on injury prevention and healthy development, including positive social and emotional development and available community resources.

**Community Health Boards will continue to use their federal Title V dollars for the purposes listed in the current Maternal and Child Health statute: improved pregnancy outcomes, children with special health needs, and family planning or injury prevention (see Minn. Stat. 145.882, subd. 7). This statutory language is revised in the Local Public Health Act to include more service options to provide even greater flexibility to Community Health Boards. Consistent with current practice, local public health agencies must continue to provide the Commissioner of Health with the annual information necessary to meet federal Title V reporting requirements.**
EMERGENCY PREPAREDNESS

While the Local Public Health Act was originally envisioned as incorporating the Centers for Disease Control and Prevention (CDC) public health preparedness funds (bioterrorism dollars), the final legislation did not include them. However, the final legislation requires the Commissioner of Health to establish at least one statewide indicator on emergency preparedness. The SCHSAC Ad Hoc Group on Development of Statewide Outcomes developed and agreed on the emergency preparedness statewide objectives and essential local activities listed below. These activities are funded by CDC public health preparedness funds and are intended to be incorporated into the grant agreements. A separate SCHSAC work group is currently further developing the deliverables for the public health preparedness funds.

Statewide Objectives
- The Minnesota Department of Health and each Community Health Board will have, or participate in, the development of a response plan for disease outbreaks and natural and human-made disasters.
- The Minnesota Department of Health and each Community Health Board will efficiently and effectively fulfill government public health responsibilities to respond to disease outbreaks as well as natural and human-made disasters.

Essential Local Activities (to be funded by the CDC public health preparedness funds)
- Designate staff for the coordination and management of public health planning for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies.
- Lead or participate in the response to any event of bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies within the jurisdiction.
- Assure the development and exercise of a comprehensive public health emergency preparedness and response plan.
- Assure the completion of an integrated assessment of local public health capacity for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies.
- Establish and maintain 24/7 communications capacity via the Health Alert Network, in order to receive and respond to information sent from the Minnesota Department of Health and Centers for Disease Control and Prevention within two hours of receipt.
- Designate an emergency spokesperson and identify roles and responsibilities for providing information to the media and the public in the event of a bioterrorist attack, outbreak of infectious disease, or other public health emergency.
RECOMMENDATIONS

The Ad Hoc Group on Development of Statewide Outcomes recommends the following:

- To determine progress on the statewide objectives, the MDH needs to clearly define the measurable indicators for each statewide objective. Further, progress for Minnesota on the statewide objectives should be evaluated in the aggregate, i.e., at the state level rather than the local level, for the following reasons:
  
  - Small data numbers at the local level make the data unstable (vary widely) and difficult to interpret.
  - The influence of public health programs on communities and systems, as well as on individual behavior, is not limited by geographic boundaries, particularly at the county level. Public health messages are more locally effective when they are reinforced in communities throughout the state. Progress on the objectives, therefore, is more meaningful when measured at the state level.
  - Community Health Boards may place differing levels of emphasis on different activities depending upon their local priorities and available resources. The rate of change on any particular objective could vary significantly around the state.

- The essential local activities, as described in this and future documents, should be adopted as the means to hold the Community Health Services system accountable for the funding provided through the Local Public Health Act.

- The statewide objectives and essential local activities, as they are reviewed and updated for 2005 and every five years thereafter, should reflect changes in the health status of Minnesotans and reflect emerging public health issues.

- Reporting for the Local Public Health Act funds should be based on the essential local activities. Discussions of a reporting system for the Local Public Health Act funds should be framed within a broader context of a statewide public health information reporting system and should promote local measurement, given the public health value of assessment data to identify needs, inform planning, and measure outcomes. Data collected at the local level can identify successful strategies, support local accountability, and provide local elected officials with results of their investment of local property tax dollars for health initiatives.

- The proposed SCHSAC work group on ensuring essential public health services ("minimum standards"), which is scheduled to begin later in 2003, should use the essential local activities as the starting point for their discussions.

- As work progresses on developing the essential local public health activities and statewide objectives for the first five-year period, additional areas, such as public health/environmental health infrastructure and capacity building as well as the public health needs of the growing elderly/disabled populations should be explored as possible additions to the essential local activities and objectives, as future funding will allow.
The Minnesota Department of Health should continue to define the relationship between the essential local public health activities and the statewide objectives. This includes developing logic models for all the essential activities and objectives in order to demonstrate the connection between implementation of the local activities and achievement of the objectives.

As work progresses on developing the essential local public health activities and statewide objectives for the first five-year period, other models, such as the Family Home Visiting Outcome Measurement System, should be explored.
APPENDICES

Appendix A. Members on SCHSAC Ad Hoc Group on Statewide Outcomes
Appendix B. Core Functions of Public Health
Appendix C. Ten Essential Public Health Services
Appendix D. Logic Models
Appendix E. 2003 Changes to the Local Public Health Act
APPENDIX A

MEMBERS OF THE SCHSAC
AD HOC GROUP ON DEVELOPMENT OF STATEWIDE OUTCOMES

- Becky Felling, McLeod County Public Health
- Bonnie Frederickson, Nobles-Rock Public Health Service
- Anita Hoffmann, Brown-Nicollet Public Health
- Karen Johnson, Carver County Community Health Services
- Laura LaCroix, Local Public Health Association
- Gwen Leifermann, Crow Wing County Health Department
- Cheri Lewer, Le Sueur-Waseca CHB
- Linda Matti, MCH Task Force
- Todd Monson, Hennepin County Community Health
- Julie Myhre, Carlton-Cook-Lake-St. Louis CHB
- Jane Norbin, St. Paul/Ramsey Public Health
- Heather Robins, Rice County CHB
- Kaye Stennes, North Country CHS
- Lila Taft, Dakota County Public Health
- Diane Thorson, Otter Tail County Public Health
- Mary Wellik, Olmsted County Public Health
- Karen Zeleznak, City of Bloomington Division of Health
APPENDIX B

CORE FUNCTIONS OF PUBLIC HEALTH

In 1988, the Institute of Medicine released its report on the Future of Public Health. This report defined three core functions of public health—assessment, policy development, and assurance. These core public health functions serve as a broad framework for governmental public health agencies to describe the scope of their activities. The core functions of public health are defined as follows:

- **Assessment** means to regularly and systematically collect, assemble, analyze and make available information on the health of the community, including statistics on health status, community health needs, and epidemiologic and other studies of health problems.

- **Policy Development** means efforts to serve the public interest in the development of comprehensive public health policies by promoting the use of the scientific knowledge base in decisions making about public health and by leading in developing comprehensive public health policies.

- **Assurance** means public health efforts to assure citizens that services necessary to achieve agreed upon goals are provided either by encouraging actions by other entities, by requiring such action through regulation, or by providing services directly.
Vision:

Healthy People in Healthy Communities

Mission:

Promote Physical and Mental Health and Prevent Disease, Injury, and Disability

Public Health

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

Ten Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems
APPENDIX D

LOGIC MODELS: FROM ACTIVITIES TO OUTCOMES

Included in the Appendix are five sample “logic models” to accompany each of the five areas covered in the Local Public Health Act: Chronic Disease, Communicable Disease, Emergency Preparedness, Environmental Health, and Family Health.

The logic models included here start with the defined essential local activities and demonstrate, through a series of steps, how these inputs and activities lead to broad, long-term outcomes.

WHAT IS A LOGIC MODEL?

A logic model is a “picture” or graphic representation of the progression of a public health program from the commitment of money and staffing to the eventual outcomes. In the business world, logic models are sometimes known as “value chains.” Each link in the chain adds value to the overall process, leading to the desired result.

The purpose of a logic model or a value chain is to reveal the theory behind decisions to engage in certain kinds of activities. By following the expected chain of events through the chart, both the strengths and the weaknesses of particular strategies may be revealed.

Logic models can be very simple or extremely complex. Some have loops and arrows while others only have boxes. Typically they are in the form of a flow chart.

Logic models fit into a broader framework

Logic models are one component of a broader conceptual framework (think-act-learn-adapt) that goes something like this:

Identify or develop theory to guide your action...
    ...Construct a logic model that illustrates this theory of action...
        ...Take action and evaluate your results...
            ...Learn from your findings; revise your theory (new logic model)...
                ...Adapt your actions to improve your results

Please keep in mind that every logic model, even the most complicated, is limited. Human behavior and systems are extremely complex and are difficult to reduce to one page in two dimensions. Logic models can be exceedingly useful, however, for communicating the essential components and goals of a program.
**Logic Model: Chronic Disease**

<table>
<thead>
<tr>
<th>Area: Chronic Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Longer-term Outcomes</strong></td>
</tr>
<tr>
<td>Reduced risks for chronic diseases along with improved general health and well-being</td>
</tr>
<tr>
<td><strong>Intermediate Outcomes</strong></td>
</tr>
<tr>
<td>Youth will adopt active lifestyle that continues into adulthood</td>
</tr>
<tr>
<td><strong>Initial Outcomes</strong></td>
</tr>
<tr>
<td>Youth will gain an understanding of the importance of physical activity</td>
</tr>
<tr>
<td><strong>Output Examples</strong></td>
</tr>
<tr>
<td>Establish comprehensive, daily physical education programs for students in the schools</td>
</tr>
<tr>
<td><strong>Activities</strong></td>
</tr>
<tr>
<td>Develop working partnerships with local schools and school districts*</td>
</tr>
<tr>
<td><strong>Inputs</strong></td>
</tr>
<tr>
<td>Local agency staff with designated health promotion/chronic disease responsibilities*</td>
</tr>
</tbody>
</table>

*Essential local activities

Note that the Essential Local Activities may have been abbreviated here or otherwise edited for space. The logic models do not necessarily include all of the Essential Local Activities in every area.
## Logic Model: Communicable Disease

<table>
<thead>
<tr>
<th>Area: Communicable Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Longer-term Outcomes</strong></td>
</tr>
<tr>
<td><strong>Intermediate Outcomes</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Initial Outcomes</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Output Examples</strong></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Activities</strong></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Inputs</strong></td>
</tr>
</tbody>
</table>

*Essential local activities

Note that the Essential Local Activities may have been abbreviated, combined, or otherwise edited for space. The logic models do not necessarily include all of the Essential Local Activities in every area.
## Logic Model: Environmental Health

<table>
<thead>
<tr>
<th>Area: Environmental Health</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Longer-term Outcomes</th>
<th>Exposure to environmental health hazards is reduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Outcomes</td>
<td>Policies, procedures and outreach opportunities are tailored to meet common community public health nuisance threats identified</td>
</tr>
<tr>
<td>Initial Outcomes</td>
<td>Public health nuisance threats to community are identified</td>
</tr>
<tr>
<td>Output Examples</td>
<td>Examine historical health records/data; survey health staff nuisance activities; survey building and/or public safety officials/survey community</td>
</tr>
<tr>
<td>Activities</td>
<td>Assess for major environmental risk conditions in the community*</td>
</tr>
<tr>
<td>Inputs</td>
<td>Designate and train staff regarding environmental health and/or public health nuisances*</td>
</tr>
</tbody>
</table>

*Essential local activities

Note that the Essential Local Activities may have been abbreviated here or otherwise edited for space. The logic models do not necessarily include all of the Essential Local Activities in every area.
<table>
<thead>
<tr>
<th>Logic Model: Family Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Area:</strong> Family Health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long-term Outcomes</th>
<th>Improved birth outcomes and improved health for children and adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Outcomes</td>
<td>Weight of infants and children are within acceptable standards</td>
</tr>
<tr>
<td>Initial Outcomes</td>
<td>Women are able to purchase nutritious food</td>
</tr>
<tr>
<td>Output Examples</td>
<td>WIC clinics and WIC vouchers are provided</td>
</tr>
<tr>
<td>Activities</td>
<td>Assure WIC services are available to eligible families*</td>
</tr>
<tr>
<td>Inputs</td>
<td>Designate staff to have maternal and child health responsibilities and training*</td>
</tr>
</tbody>
</table>

*Essential local activities

Note that the Essential Local Activities may have been abbreviated here or otherwise edited for space. The logic models do not necessarily include all of the Essential Local Activities in every area.
## Logic Model: Emergency Preparedness

**Area:** Emergency Preparedness

<table>
<thead>
<tr>
<th>Longer-term Outcomes</th>
<th>Intermediate Outcome Examples</th>
<th>Intermediate Outcome Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health is protected before, during and after an emergency event</td>
<td>New cases/exposures are limited or prevented</td>
<td>Public is well-informed and calm</td>
</tr>
<tr>
<td></td>
<td>Health needs of emergency victims are met</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Water-borne illnesses are prevented</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Food-borne illnesses in mass shelters are prevented</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Outcome Examples</th>
<th></th>
<th>Communications are coordinated and content is appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threats are contained quickly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public is protected from exposure after the release of the health threat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public health concerns are anticipated and identified early in an emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe drinking water and food are supplied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency health services are provided</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Output Examples</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Local agency leads/participates in response to emergency (bioterrorism, infectious disease outbreak, other public health threats)</td>
<td></td>
<td>Public health emergency response and emergency communications plans are tested and adapted to address multiple scenarios</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activities</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess local public health capacity for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies*</td>
<td>Develop a comprehensive public health emergency preparedness and response plan*</td>
<td>Establish/maintain 24/7 communications capacity via the Health Alert Network*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inputs</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Designated local staff with responsibility for the planning of the public health response to bioterrorism, infectious disease outbreaks, and other public health threats and emergencies*</td>
<td></td>
<td>Designated emergency spokesperson with clear roles and responsibilities for providing information to the public*</td>
</tr>
</tbody>
</table>

*Essential local activities

Note that the Essential Local Activities may have been abbreviated here or otherwise edited for space. The logic models do not necessarily include all of the Essential Local Activities in every area.
APPENDIX E

2003 CHANGES TO THE LOCAL PUBLIC HEALTH ACT

502.27  **ARTICLE 8**
502.28  **LOCAL PUBLIC HEALTH GRANTS**
502.29  Section 1. Minnesota Statutes 2002, section 144E.11,
502.30  subdivision 6, is amended to read:
502.31  Subd. 6. [REVIEW CRITERIA.] When reviewing an application
502.32  for licensure, the board and administrative law judge shall
502.33  consider the following factors:
502.34  (1) the relationship of the proposed service or expansion
502.35  in primary service area to the current community health plan as
502.36  approved by the commissioner of health under section 145A.12,
502.37  subdivision 4;
502.38  (2) the recommendations or comments of the governing bodies
502.39  of the counties, municipalities, community health boards as
502.40  defined under section 145A.09, subdivision 2, and regional
502.41  emergency medical services system designated under section
502.42  144E.50 in which the service would be provided;
502.43  (3) the deleterious effects on the public health from
502.44  duplication, if any, of ambulance services that would result
502.45  from granting the license;
502.46  (4) the estimated effect of the proposed service or
502.47  expansion in primary service area on the public health; and
502.48  (5) whether any benefit accruing to the public health
502.49  would outweigh the costs associated with the proposed service or
502.50  expansion in primary service area. The administrative law judge
502.51  shall recommend that the board either grant or deny a license or
502.52  recommend that a modified license be granted. The reasons for
502.53  the recommendation shall be set forth in detail. The
502.54  administrative law judge shall make the recommendations and
502.55  reasons available to any individual requesting them.
502.56  Sec. 2. Minnesota Statutes 2002, section 145.88, is
502.57  amended to read:
502.58  145.88 [PURPOSE.]
502.59  The legislature finds that it is in the public interest to
502.60  assure:
502.61  (a) statewide planning and coordination of maternal and
502.62  child health services through the acquisition and analysis of
502.63  population-based health data, provision of technical support and
502.64  training, and coordination of the various public and private
502.65  maternal and child health efforts; and
502.66  (b) support for targeted maternal and child health services
502.67  in communities with significant populations of high risk, low
502.68  income families through a grants process.
502.69  Federal money received by the Minnesota department of
502.70  health, pursuant to United States Code, title 42, sections 701
to 709, shall be expended to:
502.71  (1) assure access to quality maternal and child health
504.1 services for mothers and children, especially those of low
504.2 income and with limited availability to health services and
504.3 those children at risk of physical, neurological, emotional, and
504.4 developmental problems arising from chemical abuse by a mother
504.5 during pregnancy;
504.6 (2) reduce infant mortality and the incidence of
504.7 preventable diseases and handicapping conditions among children;
504.8 (3) reduce the need for inpatient and long-term care
504.9 services and to otherwise promote the health of mothers and
504.10 children, especially by providing preventive and primary care
504.11 services for low-income mothers and children and prenatal,
504.12 delivery and postpartum care for low-income mothers;
504.13 (4) provide rehabilitative services for blind and disabled
504.14 children under age 16 receiving benefits under title XVI of the
504.15 Social Security Act; and
504.16 (5) provide and locate medical, surgical, corrective and
504.17 other service for children who are crippled or who are suffering
504.18 from conditions that lead to crippling.
504.19 Sec. 3. Minnesota Statutes 2002, section 145.881,
504.20 subdivision 2, is amended to read:
504.21 Subd. 2. [DUTIES.] The advisory task force shall meet on a
504.22 regular basis to perform the following duties:
504.23 (a) review and report on the health care needs of mothers
504.24 and children throughout the state of Minnesota;
504.25 (b) review and report on the type, frequency and impact of
504.26 maternal and child health care services provided to mothers and
504.27 children under existing maternal and child health care programs,
504.28 including programs administered by the commissioner of health;
504.29 (c) establish, review, and report to the commissioner a
504.30 list of program guidelines and criteria which the advisory task
504.31 force considers essential to providing an effective maternal and
504.32 child health care program to low income populations and high
504.33 risk persons and fulfilling the purposes defined in section
504.34 145.88;
504.35 (d) review staff recommendations of the department of
504.36 health regarding maternal and child health grant awards before
504.37 the awards are made;
504.38 (e) make recommendations to the commissioner for the use of
504.39 other federal and state funds available to meet maternal and
504.40 child health needs;
504.41 (f) make recommendations to the commissioner of health
504.42 on priorities for funding the following maternal and child
504.43 health services: (1) prenatal, delivery and postpartum care, (2)
504.44 comprehensive health care for children, especially from birth
504.45 through five years of age, (3) adolescent health services, (4)
504.46 family planning services, (5) preventive dental care, (6)
504.47 special services for chronically ill and handicapped children
504.48 and (7) any other services which promote the health of mothers
504.49 and children, and
504.50 (g) make recommendations to the commissioner of health on
504.51 the process to distribute, award and administer the maternal and
(h) review the measures that are used to define the variables of the funding distribution formula in section 145.882, subdivision 4, every two years and make recommendations to the commissioner of health for changes based upon principles established by the advisory task force for this purpose.

(f) establish, in consultation with the commissioner and the state community health advisory committee established under section 145A.10, subdivision 10, paragraph (a), statewide outcomes that will improve the health status of mothers and children as required in section 145A.12, subdivision 7.

Sec. 4. Minnesota Statutes 2002, section 145.882, subdivision 1, is amended to read:

Subdivision 1. [FUNDING LEVELS AND ADVISORY TASK FORCE REVIEW.] Any decrease in the amount of federal funding to the state for the maternal and child health block grant must be apportioned to reflect a proportional decrease for each recipient. Any increase in the amount of federal funding to the state must be distributed under subdivisions 2, and 3, and 4.

The advisory task force shall review and recommend the proportion of maternal and child health block grant funds to be expended for indirect costs, direct services and special projects.

Sec. 5. Minnesota Statutes 2002, section 145.882, subdivision 2, is amended to read:

Subd. 2. [ALLOCATION TO THE COMMISSIONER OF HEALTH.] Beginning January 1, 1986, up to one-third of the total maternal and child health block grant money may be retained by the commissioner of health for administrative and technical assistance services, projects of regional or statewide significance, direct services to children with handicaps, and other activities of the commissioner, to:

(1) meet federal maternal and child block grant requirements of a statewide needs assessment every five years and prepare the annual federal block grant application and report;

(2) collect and disseminate statewide data on the health status of mothers and children within one year of the end of the year;

(3) provide technical assistance to community health boards in meeting statewide outcomes under section 145A.12, subdivision 7;

(4) evaluate the impact of maternal and child health activities on the health status of mothers and children;

(5) provide services to children under age 16 receiving benefits under title XVI of the Social Security Act; and

(6) perform other maternal and child health activities listed in section 145.88 and as deemed necessary by the commissioner.

Sec. 6. Minnesota Statutes 2002, section 145.882, subdivision 3, is amended to read:
Subd. 3. [ALLOCATION TO COMMUNITY HEALTH SERVICES AREAS.] (a) The maternal and child health block grant money remaining after distributions made under subdivision 2 must be allocated according to the formula in subdivision 4 to community health services areas section 145A.131, subdivision 2, for distribution by to community health boards, as defined in section 145A.02, subdivision 5, to qualified programs that provide essential services within the community health services area as long as:

(1) the Minneapolis community health service area is allocated at least $1,626,215 per year;
(2) the St. Paul community health service area is allocated at least $822,931 per year; and
(3) all other community health service areas are allocated at least $30,000 per county per year or their 1988-1989 funding cycle award, whichever is less.

(b) Notwithstanding paragraph (a), if the total amount of maternal and child health block grant funding decreases, the decrease must be apportioned to reflect a proportional decrease for each recipient, including recipients who would otherwise receive a guaranteed minimum allocation under paragraph (a). A community health board that receives funding under this section shall provide at least a 50 percent match for funds received under United States Code, title 42, sections 701 to 709. Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other funds, donations, nonfederal grants, or state funds received under the local public health grant defined in section 145A.131, that are used for maternal and child health activities as described in section 145.882, subdivision 7.

Sec. 7. Minnesota Statutes 2002, section 145.882, subdivision 7, is amended to read:

Subd. 5a. [NONPARTICIPATING COMMUNITY HEALTH BOARDS.] If a community health board decides not to participate in maternal and child health block grant activities under subdivision 3 or the commissioner determines under section 145A.131, subdivision 7, not to fund the community health board, the commissioner is responsible for directing maternal and child health block grant activities in that community health board's geographic area. The commissioner may elect to directly provide public health activities to meet the statewide outcomes or to contract with other governmental units or nonprofit organizations.

Sec. 8. Minnesota Statutes 2002, section 145.882, subdivision 7, is amended to read:

Subd. 7. [USE OF BLOCK GRANT MONEY.] (a) Maternal and child health block grant money allocated to a community health board or community health services area under this section must be used for qualified programs for high risk and low-income individuals. Block grant money must be used for programs that:

(1) specifically address the highest risk populations,
particularly low-income and minority groups with a high rate of infant mortality and children with low birth weight, by providing services, including prepregnancy family planning services, calculated to produce measurable decreases in infant mortality rates, instances of children with low birth weight, and medical complications associated with pregnancy and childbirth, including infant mortality, low birth rates, and medical complications arising from chemical abuse by a mother during pregnancy;

(2) specifically target pregnant women whose age, medical condition, maternal history, or chemical abuse substantially increases the likelihood of complications associated with pregnancy and childbirth or the birth of a child with an illness, disability, or special medical needs;

(3) specifically address the health needs of young children who have or are likely to have a chronic disease or disability or special medical needs, including physical, neurological, emotional, and developmental problems that arise from chemical abuse by a mother during pregnancy;

(4) provide family planning and preventive medical care for specifically identified target populations, such as minority and low-income teenagers, in a manner calculated to decrease the occurrence of inappropriate pregnancy and minimize the risk of complications associated with pregnancy and childbirth; or

(5) specifically address the frequency and severity of childhood and adolescent health issues, including injuries in high risk target populations by providing services calculated to produce measurable decreases in mortality and morbidity.

However, money may be used for this purpose only if the community health board's application includes program components for the purposes in clauses (1) to (4) in the proposed geographic service area and the total expenditure for injury-related programs under this clause does not exceed ten percent of the total allocation under subdivision 3.

(b) Maternal and child health block grant money may be used for purposes other than the purposes listed in this subdivision only under the following conditions:

(1) the community health board or community health services area can demonstrate that existing programs fully address the needs of the highest risk target populations described in this subdivision; or

(2) the money is used to continue projects that received funding before creation of the maternal and child health block grant in 1981.

(e) Projects that received funding before creation of the maternal and child health block grant in 1981, must be allocated at least the amount of maternal and child health special project grant funds received in 1989, unless (1) the local board of health provides equivalent alternative funding for the project from another source; or (2) the local board of health demonstrates that the need for the specific services provided by
the project has significantly decreased as a result of changes
in the demographic characteristics of the population, or other
factors that have a major impact on the demand for services. If
the amount of federal funding to the state for the maternal and
child health block grant is decreased, these projects must
receive a proportional decrease as required in subdivision 1.
Increases in allocation amounts to local boards of health under
subdivision 4 may be used to increase funding levels for these
projects.
(6) specifically address preventing child abuse and
neglect, reducing juvenile delinquency, promoting positive
parenting and resiliency in children, and promoting family
health and economic sufficiency through public health nurse home
visits under section 145A.17; or
(7) specifically address nutritional issues of women,
infants, and young children through WIC clinic services.
Sec. 9. [145.8821] [ACCOUNTABILITY.]
(a) Coordinating with the statewide outcomes established
under section 145A.12, subdivision 7, and with accountability
measures outlined in section 145A.131, subdivision 7, each
community health board that receives money under section
145.882, subdivision 3, shall select by February 1, 2005, and
every five years thereafter, up to two statewide maternal and
child health outcomes.
(b) For the period January 1, 2004, to December 31, 2005,
each community health board must work toward the Healthy People
2010 goal to reduce the state's percentage of low birth weight
infants.
(c) The commissioner shall monitor and evaluate whether
each community health board has made sufficient progress toward
the selected outcomes established in paragraph (b) and under
section 145A.12, subdivision 7.
(d) Community health boards shall provide the commissioner
with annual information necessary to evaluate progress toward
selected statewide outcomes and to meet federal reporting
requirements.
Subdivision 1. [SCOPE.] For purposes of sections 145.881
to 145.888, the terms defined in this section shall have
the meanings given them.
Sec. 11. Minnesota Statutes 2002, section 145A.02,
subdivision 9, is amended to read:
"Community health services area board" means a city, county, or
multicounty area that is organized as a community health board
under section 145A.09 and for which a state subsidy is received
under sections 145A.09 to 145A.13 a board of health established.
operating, and eligible for a local public health grant under
sections 145A.09 to 145A.131.
Sec. 12. Minnesota Statutes 2002, section 145A.02,
511.4 subdivision 5, is amended to read:
511.5 Subd. 5. [COMMUNITY HEALTH BOARD.] "Community health
511.6 board" means a board of health established, operating, and
511.7 eligible for a subsidy local public health grant under sections
511.8 145A.09 to 145A.13 145A.131.
511.9 Sec. 13. Minnesota Statutes 2002, section 145A.02,
511.10 subdivision 6, is amended to read:
511.11 Subd. 6. [COMMUNITY HEALTH SERVICES.] "Community health
511.12 services" means activities designed to protect and promote the
511.13 health of the general population within a community health
511.14 service area by emphasizing the prevention of disease, injury,
511.15 disability, and preventable death through the promotion of
511.16 effective coordination and use of community resources, and by
511.17 extending health services into the community. Program
511.18 categories of community health services include disease
511.19 prevention and control, emergency medical care, environmental
511.20 health, family health, health promotion, and home health care.
511.21 Sec. 14. Minnesota Statutes 2002, section 145A.02,
511.22 subdivision 7, is amended to read:
511.23 Subd. 7. [COMMUNITY HEALTH SERVICE AREA.] "Community
511.24 health service area" means a city, county, or multicounty area
511.25 that is organized as a community health board under section
511.26 145A.09 and for which a subsidy local public health grant is
511.27 received under sections 145A.09 to 145A.13 145A.131.
511.28 Sec. 15. Minnesota Statutes 2002, section 145A.06,
511.29 subdivision 1, is amended to read:
511.30 Subdivision 1. [GENERALLY.] In addition to other powers
511.31 and duties provided by law, the commissioner has the powers
511.32 listed in subdivisions 2 to 4 §.
511.33 Sec. 16. Minnesota Statutes 2002, section 145A.09,
511.34 subdivision 2, is amended to read:
511.35 Subd. 2. [COMMUNITY HEALTH BOARD: ELIGIBILITY.] A board of
511.36 health that meets the requirements of sections 145A.09
511.37 to 145A.13 145A.131 is a community health board and is eligible
511.38 for a community health subsidy local public health grant under
511.40 Sec. 17. Minnesota Statutes 2002, section 145A.09,
511.41 subdivision 4, is amended to read:
511.42 Subd. 4. [CITIES.] A city that received a subsidy under
511.43 section 145A.13 and that meets the requirements of sections
511.44 145A.09 to 145A.13 145A.131 is eligible for a community health
511.45 subsidy local public health grant under section
511.46 145A.13 145A.131.
511.47 Sec. 18. Minnesota Statutes 2002, section 145A.09,
511.48 subdivision 7, is amended to read:
511.49 Subd. 7. [WITHDRAWAL.] (a) A county or city that has
511.50 established or joined a community health board may withdraw from
511.51 the subsidy local public health grant program authorized by
511.52 sections 145A.09 to 145A.13 145A.131 by resolution of its
511.53 governing body in accordance with section 145A.03, subdivision
511.54 3, and this subdivision.
(b) A county or city may not withdraw from a joint powers community health board during the first two calendar years following that county's or city's initial adoption of the joint powers agreement.

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

d) The amount of additional annual payment for the calendar year 1985 made pursuant to Minnesota Statutes 1984, section 145.921, subdivision 4, must be subtracted from the subsidy for a county that, due to withdrawal from a community health board, ceases to meet the terms and conditions under which that additional annual payment was made. The local public health grant for a county that chooses to withdraw from a multicounty community health board shall be reduced by the amount of the local partnership incentive under section 145A.131, subdivision 2, paragraph (c).

Sec. 19. Minnesota Statutes 2002, section 145A.10, subdivision 2, is amended to read:

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

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

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

Sec. 20. Minnesota Statutes 2002, section 145A.10, is amended by adding a subdivision to read:

Subd. 5a. [DUTIES.] (a) Consistent with the guidelines and standards established under section 145A.12, and with input from the community, the community health board shall:

(1) establish local public health priorities based on an assessment of community health needs and assets; and

(2) determine the mechanisms by which the community health board will address the local public health priorities established under clause (1) and achieve the statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, within the limits of available funding. In determining the mechanisms to address local public health priorities and achieve

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Statewide Public Health Outcomes for 2004 Appendices
statewide outcomes, the community health board shall seek public
input or consider the recommendations of the community health
advisory committee and the following essential public health
services:

(i) monitor health status to identify community health
problems;

(ii) diagnose and investigate problems and health hazards
in the community;

(iii) inform, educate, and empower people about health
issues;

(iv) mobilize community partnerships to identify and solve
health problems;

(v) develop policies and plans that support individual and
community health efforts;

(vi) enforce laws and regulations that protect health and
ensure safety;

(vii) link people to needed personal health care services;

(viii) ensure a competent public health and personal health
care workforce;

(ix) evaluate effectiveness, accessibility, and quality of
personal and population-based health services; and

(x) research for new insights and innovative solutions to
health problems.

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

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

Sec. 21. Minnesota Statutes 2002, section 145A.10,
subdivision 10, is amended to read:

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

(b) The city councils or county boards that have established or are members of a community health board may appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on matters relating to the development, maintenance, funding, and evaluation of community health services. The committee must consist of at least five members and must be generally representative of the population and health care providers of the community health service area. The committee must meet at least three times a year and at the call of the chair or a majority of the members. Members may receive a per diem and reimbursement for travel and other necessary expenses while engaged in their official duties.

(c) State and local advisory committees must adopt bylaws or operating procedures that specify the length of terms of membership, procedures for assuring that no more than half of these terms expire during the same year, and other matters relating to the conduct of committee business. Bylaws or operating procedures may allow one alternate to be appointed for each member of a state or local advisory committee. Alternates may be given full or partial powers and duties of members the duties under subdivision 5a.

Sec. 22. Minnesota Statutes 2002, section 145A.11, subdivision 2, is amended to read:

Subd. 2. [CONSIDERATION OF COMMUNITY HEALTH PLAN LOCAL PUBLIC HEALTH PRIORITIES AND STATEWIDE OUTCOMES IN TAX LEVY.] In levying taxes authorized under section 145A.08, subdivision 3, a city council or county board that has formed or is a member of a community health board must consider the income and expenditures required to meet the objectives of the community health plan for its area local public health priorities established under section 145A.10, subdivision 5a, and statewide outcomes established under section 145A.12, subdivision 7.

Sec. 23. Minnesota Statutes 2002, section 145A.11, subdivision 4, is amended to read:

Subd. 4. [ORDINANCES RELATING TO COMMUNITY HEALTH SERVICES.] A city council or county board that has established or is a member of a community health board may by ordinance adopt and enforce minimum standards for services provided according to sections 145A.02 and 145A.10, subdivision 5. An ordinance must not conflict with state law or with more stringent standards established either by rule of an agency of state government or by the provisions of the charter or ordinances of any city organized under section 145A.09, subdivision 4.

Sec. 24. Minnesota Statutes 2002, section 145A.12,
subdivision 1, is amended to read:

Subdivision 1. [ADMINISTRATIVE AND PROGRAM SUPPORT.] The commissioner must assist community health boards in the development, administration, and implementation of community health services. This assistance may consist of but is not limited to:

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

(2) administrative and program guidelines and standards, developed with the advice of the state community health advisory committee. Adoption of these guidelines by a community health board is not a prerequisite for plan approval as prescribed in subdivision 4.

Sec. 25. Minnesota Statutes 2002, section 145A.12, subdivision 2, is amended to read:

Subd. 2. [PERSONNEL STANDARDS.] In accordance with chapter 14, and in consultation with the state community health advisory committee, the commissioner may adopt rules to set standards for administrative and program personnel to ensure competence in administration and planning and in each program area defined in section 145A.02.

Sec. 26. Minnesota Statutes 2002, section 145A.12, is amended by adding a subdivision to read:

Subd. 7. [STATEWIDE OUTCOMES.] (a) The commissioner, in consultation with the state community health advisory committee established under section 145A.10, subdivision 10, paragraph (a), shall establish statewide outcomes for local public health grant funds allocated to community health boards between January 1, 2004, and December 31, 2005.

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

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

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

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

(e) By December 31, 2004, and every five years thereafter, the commissioner, in consultation with the state community health advisory committee established under section 145A.10, subdivision 10, paragraph (a), and the maternal and child health advisory task force established under section 145.881, shall develop statewide outcomes for the local public health grant.
Sec. 27. Minnesota Statutes 2002, section 145A.13, is amended by adding a subdivision to read: Subd. 4. [EXPIRATION.] This section expires January 1, 2004.

Sec. 28. [145A.131] [LOCAL PUBLIC HEALTH GRANT.]

Subdivision 1. [FUNDING FORMULA FOR COMMUNITY HEALTH BOARDS.] (a) Base funding for each community health board eligible for a local public health grant under section 145A.09, subdivision 2, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants, TANF MN ENABL grants, TANF youth risk behavior grants, and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

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

(c) Multicounty community health boards shall receive a local partnership base of up to $5,000 per year for each county included in the community health board.

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

Subd. 2. [LOCAL MATCH.] (a) A community health board that receives a local public health grant shall provide at least a 75 percent match for the state funds received through the local public health grant described in subdivision 1, and subject to paragraphs (b) to (d).

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

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

(d) A city organized under the provision of sections 145A.09 to 145A.131 that levies a tax for provision of community services to the extent of the levy imposed by the city.

Subd. 3. [ACCOUNTABILITY.] (a) Community health boards accepting local public health grants must document progress toward the statewide outcomes established in section 145A.12, subdivision 7, to maintain eligibility to receive the local public health grant.

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

(1) whether the community health board has documented progress to meeting essential local activities related to the statewide outcomes, as specified in the grant agreement;

(2) the effort put forth by the community health board toward the selected statewide outcomes;

(3) whether the community health board has previously failed to document progress toward selected statewide outcomes under this section;

(4) the amount of funding received by the community health board to address the statewide outcomes; and

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

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

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

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

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

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

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

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

Subd. 4. [RESPONSIBILITY OF COMMISSIONER TO ENSURE A
STATEWIDE PUBLIC HEALTH SYSTEM.] If a county withdraws from a
community health board and operates as a board of health or if a
community health board elects not to accept the local public
health grant, the commissioner may retain the amount of funding
that would have been allocated to the community health board
using the formula described in subdivision 1 and assume
responsibility for public health activities to meet the
statewide outcomes in the geographic area served by the board of
health or community health board. The commissioner may elect to
directly provide public health activities to meet the statewide
outcomes or contract with other units of government or with
community-based organizations. If a city that is currently a
community health board withdraws from a community health board
or elects not to accept the local public health grant, the local
public health grant funds that would have been allocated to that
city shall be distributed to the county in which the city is
located, if the county is part of a community health board.

Subd. 5. [LOCAL PUBLIC HEALTH PRIORITIES.] Community
health boards may use their local public health grant to address
local public health priorities identified under section 145A.10.

Subdivision 5a.

Sec. 29. Minnesota Statutes 2002, section 145A.14,
subdivision 2, is amended to read:

Subd. 2. [INDIAN HEALTH GRANTS.] (a) The commissioner may
make special grants to community health boards to establish,
operate, or subsidize clinic facilities and services to furnish
health services for American Indians who reside off reservations.
(b) To qualify for a grant under this subdivision the
community health plan submitted by the community health board
must contain a proposal for the delivery of the services and
documentation that representatives of the Indian community
affected by the plan were involved in its development.

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

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

Sec. 30. Minnesota Statutes 2002, section 145A.14, is
amended by adding a subdivision to read:

Subd. 2a. [TRIBAL GOVERNMENTS.] (a) Of the funding
available for local public health grants, $1,500,000 per year is
available to tribal governments for:

(1) maternal and child health activities under section
145.882, subdivision 7;

(2) activities to reduce health disparities under section
145.928, subdivision 10; and

(3) emergency preparedness.

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

Sec. 31. [REVISOR'S INSTRUCTION.]

(a) The revisor of statutes shall delete "145A.13" and
insert "145A.131" in Minnesota Statutes, sections 145A.03,
subdivision 1; 145A.04, subdivision 4; 145A.10, subdivision 1;
256E.03, subdivision 2; 383B.221, subdivision 2; and 402.02,
subdivision 2.

(b) For sections in Minnesota Statutes and Minnesota Rules
affected by the repealed sections in this article, the revisor
shall delete internal cross-references where appropriate and
make changes necessary to correct the punctuation, grammar, or
structure of the remaining text and preserve its meaning.

Sec. 32. [REPEALER.]

(a) Minnesota Statutes 2002, sections 144.401; 145.882,
subdivisions 4, 5, 6, and 8; 145.883, subdivisions 4 and 7;
145.884; 145.885; 145.886; 145.888; 145.890; 145A.02,
subdivisions 9, 10, 11, 12, 13, and 14; 145A.09, subdivision 6;
145A.10, subdivisions 5, 6, and 8; 145A.11, subdivision 3;
145A.12, subdivisions 3, 4, and 5; 145A.14, subdivisions 3 and
4; and 145A.17, subdivision 2, are repealed.

(b) Minnesota Rules, parts 4736.0010; 4736.0020; 4736.0030;
4736.0040; 4736.0050; 4736.0060; 4736.0070; 4736.0080;
4736.0090; 4736.0120; and 4736.0130, are repealed effective

(c) Minnesota Rules, parts 4705.0100; 4705.0200; 4705.0300;
4705.0400; 4705.0500; 4705.0600; 4705.0700; 4705.0800;
4705.0900; 4705.1000; 4705.1100; 4705.1200; 4705.1300;
4705.1400; 4705.1500; and 4705.1600, are repealed effective June
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