DEPARTMENT OF HEALTH

State Community Health Services Advisory Committee

# Standards for Fulfillment of Foundational Public Health Responsibilities

## RECOMMENDATIONS OF THE SCHSAC FOUNDATIONAL PUBLIC HEALTH RESPONSIBILITIES WORKGROUP

December 2025

**Standards for Fulfillment of Foundational Public Health Responsibilities:**
**Recommendations of the SCHSAC Foundational Public Health Responsibilities Workgroup**

Minnesota Department of Health
State Community Health Services Advisory Committee (SCHSAC)
PO Box 64975
St. Paul, MN 55164-0975
651-201-3880
health.schsac@state.mn.us
www.health.state.mn.us/schsac

*To obtain this information in a different format, call: 651-201-3880*

## CONTENTS

# Recommendations

In Minnesota, governmental public health agencies work together to help all Minnesotans live their healthiest lives, no matter who they are or where they live. To inform public health work, a set of foundational public health responsibilities defines what must be in place everywhere for public health to work anywhere.

A 2022 assessment of Minnesota state and local health departments' ability to fulfill these foundational responsibilities, and the cost associated with doing so, found that departments' capacity and expertise vary across the state, leaving Minnesotans with a "patchwork" of coverage when it comes to public health.

In response, the State Community Health Services Advisory Committee (SCHSAC), the Local Public Health Association of Minnesota (LPHA), and the Minnesota Department of Health (MDH) demonstrated to the Legislature both the need for a stronger foundation and a shared commitment to improvement. During the 2023 legislative session, the Legislature allocated $9,844,000 to community health boards and $535,000 to Tribal Nations through the Foundational Public Health Responsibilities Grant (FPHR Grant), to strengthen local and Tribal capacity to carry out foundational responsibilities statewide. This ongoing annual funding is intended to build a strong, consistent foundation for public health across Minnesota.

Foundational responsibilities represent the minimum that must be in place everywhere. Community health boards must prioritize using FPHR Grant funds for these responsibilities, consistent with the grant's intent to strengthen the statewide foundational infrastructure of public health. Beyond these foundational responsibilities, governmental public health must also address the unique priorities of the communities they serve, identified through community health assessment and improvement planning processes. However, state statute stipulates that community health boards may spend FPHR Grant funds on community-specific priorities only if they can demonstrate fulfillment of foundational responsibilities in their jurisdiction. This created the need for clear, statewide standards to demonstrate "fulfillment."

To address this need, the SCHSAC Foundational Public Health Responsibilities Workgroup (FPHR Workgroup) formed to develop the recommendations in this report; workgroup representatives hailed from local public health, the Minnesota Department of Health, and SCHSAC. The workgroup convened for 18 months to develop the recommendations in this report, in consultation with subject matter experts from state and local government. These recommendations include proposed standards for the fulfillment of foundational responsibilities, definitions and key terms for each foundational responsibility, and identifying additional work needed to ensure ongoing clarity and alignment of roles and responsibilities across Minnesota's governmental public health system. The SCHSAC FPHR Workgroup developed these recommendations through discussion and consensus among the workgroup's voting members; the recommendations were approved.

**In order to demonstrate fulfillment of foundational responsibilities across Minnesota's public health system, SCHSAC recommends the following to the Minnesota Commissioner of Health:**

1. **Define key terms and clarify what foundational responsibilities mean in practice;**
2. **Set standards for demonstrating fulfillment of foundational responsibilities;**
3. **Describe how MDH should administer a fair and efficient process for assessing fulfillment;**
4. **Establish a schedule for ongoing review and improvement; and**
5. **Identify next steps for continued collaboration to strengthen and align roles across the public health system.**

# Recommendation 1: Define key terms and clarify what foundational responsibilities mean in practice

SCHSAC recommends Minnesota adopt the definitions for foundational responsibilities (pp. 15-36), key terms (pp. 13-14), and criteria for foundational responsibilities (p. 37), to strengthen the system, for the purpose of:

1. Establishing a shared understanding of the responsibilities of governmental public health,
2. Guiding strategic planning and prioritization,
3. Informing performance management,
4. Demonstrating workforce and funding needs,
5. Clarifying the skills, competencies, and staffing levels needed to fulfill responsibilities, and
6. Communicating and advocating about what governmental public health does and why it matters.

The framework of foundational public health responsibilities (https://www.health.state.mn.us/communities/practice/systemtransformation/foundationalresponsibilities.html), definitions of foundational responsibilities, and definitions of key terms reflect our current understanding of foundational responsibilities and represent public health practice in Minnesota.

# Recommendation 2: Set standards for demonstrating fulfillment of foundational responsibilities

SCHSAC recommends adopting the standards in this report (pp. 38-41) for fulfillment of foundational responsibilities. A community health board considering using the FPHR Grant for community-specific priorities developed through the community health assessment and community health improvement planning process must meet all standards for fulfillment of the thirteen foundational responsibilities.

These standards represent the minimum of what a community health board needs to demonstrate if it wants to use the FPHR Grant for work other than foundational activities. Community health boards would only need to demonstrate fulfillment of the foundational responsibilities if they wanted to use the FPHR Grant for work beyond its original, intended purpose.

Community health boards may also use these standards to assess progress towards fulfillment of foundational responsibilities, regardless of interest in using the FPHR Grant for community-specific priorities.

# Recommendation 3: Describe how MDH should administer a fair and efficient process for assessing fulfillment

SCHSAC recommends the Minnesota Department of Health incorporate the following into the process for community health boards to assess and demonstrate fulfillment of foundational public health responsibilities:

1. Use a mixed-method approach (such as attestation, documentation, or qualitative examples) to demonstrate how standards are met, to balance accountability and administrative burden on community health boards. When feasible, accept as documentation existing materials submitted by community health boards (such as community health improvement plans) to avoid duplicate reporting.

2. MDH promptly reviews requests from community health boards to demonstrate fulfillment, and notifies them in a timely manner if their request is approved.
3. Align the information MDH requests to demonstrate fulfillment of foundational responsibilities with Public Health Accreditation Board guidance.
4. Engage with community health boards to ensure the documentation or evidence they submit to demonstrate fulfillment are aligned with MDH expectations and requirements.
5. Refine the process to demonstrate and assess fulfillment of foundational responsibilities, based on implementation experience.
6. Allow fully accredited community health boards to forgo separately demonstrating fulfillment of foundational public health responsibility standards if they want to use FPHR Grant funding for community-specific priorities (as identified in their community health assessment and improvement planning processes). Those community health boards should be required to annually request approval and provide information related to accreditation status. This process should be reviewed periodically for alignment with standards and with evolving expectations. Fully accredited community health boards, like all community health boards, are expected to prioritize and maintain capacity for foundational public health responsibilities.

## Recommendation 4: Establish a schedule for ongoing review and improvement

SCHSAC recommends reviewing standards, processes for demonstration, and definitions after two (2) years initially, and at least once every five (5) years thereafter. Representatives from SCHSAC, MDH, and local public health should collaboratively conduct these reviews.

## Recommendation 5: Identify next steps for continued collaboration to strengthen and align roles across the public health system

SCHSAC recommends it continue to clarify roles and responsibilities for foundational public health responsibilities, and to identify opportunities for shared responsibility and more efficient use of resources. This should be addressed through existing or new SCHSAC workgroups, with ad hoc groups convened for specific responsibilities including but not limited to chronic disease and injury prevention; maternal, child, and family health; and access to and linkage with clinical care.

## Staff support for recommendations and rollout

The MDH Center for Public Health Practice will support rollout of these recommendations, including making information available to assist community health boards.

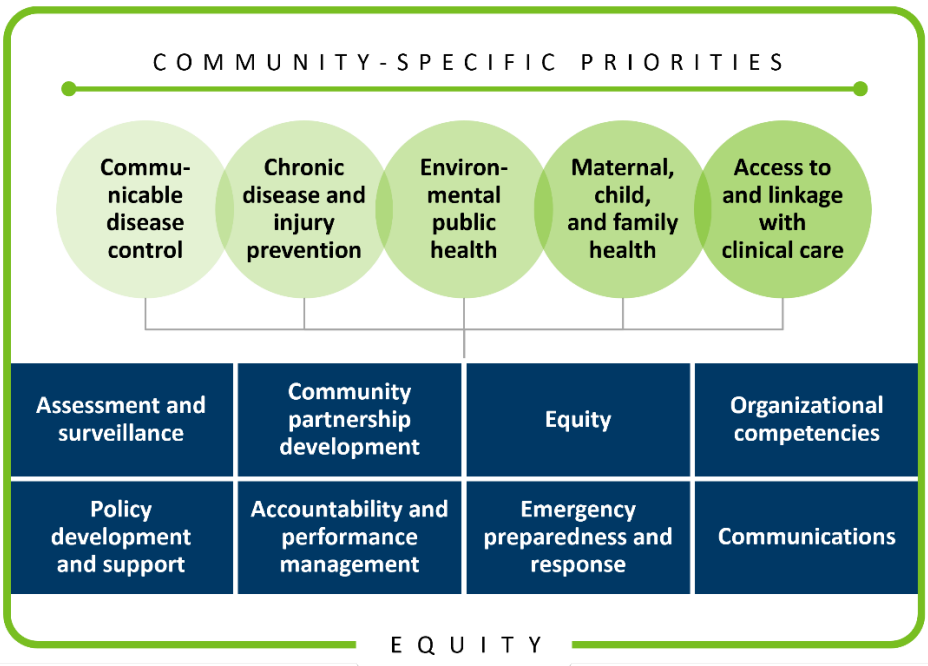
# Background and workgroup membership

Minnesota is working to build a more seamless, responsive, and publicly supported governmental public health system that works closely with communities to ensure healthy, safe, and vibrant communities.

## Path to creating the SCHSAC FPHR Workgroup

In 2023, a Joint Leadership Team with representatives from state and local public health and locally elected officials adopted for Minnesota a national framework of foundational public health responsibilities (https://www.health.state.mn.us/communities/practice/systemtransformation/foundationalresponsibilities.html) to identify what must be in place everywhere for Minnesota's public health system to work anywhere.

**Framework of foundational public health responsibilities**




Also in 2023, the Minnesota Legislature also allocated $9.844 million annually, as part of the state's base budget, for community health boards to fulfill foundational public health responsibilities. This ongoing funding, which began in 2024 and is known as the Foundational Public Health Responsibilities Grant (FPHR Grant), is intended to help build a strong foundation first through the fulfillment of foundational public health responsibilities. State statute stipulates that FPHR Grant funds can be used for local priorities identified through the community health assessment and improvement planning process only after a community health board can demonstrate that foundational public health responsibilities are fulfilled.

In December 2023, the Minnesota Commissioner of Health, in consultation with the State Community Health Services Advisory Committee (SCHSAC), approved the recommendations of the SCHSAC Foundational Public Health Responsibility Funding Workgroup; the workgroup recommended that community health boards could not use FPHR Grant funds for community-specific priorities until Minnesota adopted minimum standards for fulfillment of foundational public health responsibilities. SCHSAC was asked to create another workgroup to recommend those standards, and to inform a process for MDH to determine when foundational public health responsibilities are fulfilled in any jurisdiction. For more information, see: Building

a Strong Foundation for Health from Border to Border (SCHSAC FPHR Funding Workgroup, 2023) (https://www.health.state.mn.us/communities/practice/schsac/workgroups/docs/fundingfphr2023-finalworkgroupreport.pdf).

In June 2024, SCHSAC established the Foundational Public Health Responsibilities Workgroup (FPHR Workgroup), the author of the recommendations found in this report.

# Workgroup membership

SCHSAC FPHR Workgroup members have different and diverse perspectives and experiences within Minnesota's state and local governmental public health system, and include members from the Local Public Health Association of Minnesota (LPHA), SCHSAC, and the Minnesota Department of Health (MDH). The workgroup is co-chaired by a representative from LPHA (Joanne Erspamer, Public Health supervisor for Carlton County Public Health and Human Services) and MDH (Ann Zukoski, director for the MDH Center for Health Promotion). The workgroup was supported by staff from the MDH Center for Public Health Practice. For a full roster of workgroup members, subject matter experts, and support staff, see Appendix A. Workgroup charge and members (p. 42) and Appendix B. Responsibility-specific small groups (pp. 43-45).

SCHSAC charged the FPHR Workgroup with recommending a set of minimum standards for assessing fulfillment of foundational public health responsibilities. These standards will help MDH and community health boards determine when FPHR Grant funding can be used for community-specific priorities. In its charge, SCHSAC also acknowledged that the FPHR Workgroup may need to complete additional work in pursuit of identifying standards.

Tribal Nations sharing geography with Minnesota also receive funding to fulfill foundational public health responsibilities, but SCHSAC does not make recommendations to MDH regarding Tribal Nations.

# Methodology

The SCHSAC FPHR Workgroup met monthly from July 2024 through December 2025 to develop the recommendations in this report. The workgroup used a collaborative, consensus-oriented process, grounded in participatory engagement and inclusive input from workgroup members who represented diverse perspectives across Minnesota's public health system.

Workgroup members identified the following principles to fully embody collaborative work:

- Embrace diverse perspectives and apply an equity lens.
- Communicate honestly and assume positive intent.
- Balance speaking for your organization and seeing the big picture.
- Be kind and constructive, and participate in creating a safe space.
- Aim for progress, not perfection.


## Review process

### Starting point: Full workgroup examined existing documentation and guidance

The workgroup participated in facilitated discussions, iteratively reviewed of materials, and shared continuous feedback to refine ideas and build shared agreement. The workgroup intentionally balanced guidance from national organizations with Minnesota-specific context, so that its recommendations can align with the nationally-adopted framework of foundational public health responsibilities and reflect the governmental public health system in Minnesota.

To clarify definitions for foundational responsibilities, the SCHSAC FPHR Workgroup reviewed existing guidance documents. These included *Foundational Public Health Services* (PHAB, 2022) (https://phaboard.org/wp-content/uploads/FPHS-Factsheet-2022.pdf) *and Foundational Public Health Responsibilities National Headlines: Minnesota Activities* (MDH, 2023) , which organized Minnesota-specific activities within the nationally-recognized framework of foundational responsibilities and was developed collaboratively by state and local public health workers in Minnesota.

### Thirteen small groups clarified each foundational responsibility, defined key terms and criteria, and brainstormed/prioritized standards to demonstrate fulfillment

Before determining standards for fulfillment of foundational responsibilities, the workgroup recognized the need for prerequisite work. This included:

- Clarifying definitions for each responsibility, including criteria for foundational, and
- Defining key terms to ensure shared understanding and consistency of use.

The SCHSAC FPHR Workgroup convened 13 smaller groups to review guidance and refine key terms, one small group for each foundational public health responsibility. Each responsibility-specific smaller group contained subject matter experts from state and local government, along with subsets of members from the SCHSAC FPHR Workgroup. For a full list of responsibility-specific small group members, see Appendix B. Responsibility-specific small groups (pp. 43-45).

Each small group met three to four times to review guidance and refine key terms and definitions related to foundational public health responsibilities. As a small group clarified terminology, it returned to the full SCHSAC FPHR Workgroup for additional discussion, and sought input from colleagues in their LPHA regions, and additional subject matter experts as needed.

### Full workgroup reviews and iteratively refines definitions, key terms, criteria, and standards

Through several iterations of review and revision, the SCHSAC FPHR Workgroup **clarified and aligned existing definitions** (instead of recreating them), to maximize consistency and shared understanding across levels of governmental public health. The SCHSAC FPHR Workgroup applied specific criteria for foundational responsibilities (found immediately below) to ensure the definitions described work that is foundational.

Throughout this process, workgroup members and subject matter experts identified key terms that were used or interpreted differently across documents, or had the potential to be, and deliberated their use and interpretation to ensure accuracy and clarity.

## Developing criteria: Foundational work or community-specific priorities

The framework of foundational public health responsibilities includes a brief description of what is "foundational" and "community-specific;" local public health and MDH have widely used these descriptions to guide understanding of what constitutes foundational work and how it is distinct from community-specific priorities.

> *Foundational public health responsibilities are the minimum package of public health services that governmental public health should deliver to communities, and that should be available everywhere, for public health to work anywhere. It includes foundational capabilities and foundational areas that must be available to all people served by the governmental public health system and that meet one or more of these criteria:*
>
> 1. *Work mandated by federal or state laws;*
> 2. *Work for which the governmental public health system is the only or primary provider statewide; and*
> 3. *Population-based work (versus individual services) focused on disease prevention, protection, and health promotion.*

> *Foundational capabilities are cross-cutting skills, abilities, and knowledge needed in any governmental public health system to provide basic public health protections. Foundational areas are topic-specific public health programs or initiatives aimed at improving the health of a population.*
>
> *In addition to the foundational capabilities and foundational areas, the framework describes community-specific services [sic] as local protections and services that are unique to the needs of a community. These services are essential to that community's health and vary by community or jurisdiction.*

The SCHSAC FPHR Workgroup used this description as a starting point to discuss the boundaries between foundational activities and community-specific activities. Workgroup members confirmed this description aligns with public health work in Minnesota and reflects how foundational work is generally understood by those in Minnesota's governmental public health system, and shared examples from their own practice across Minnesota to illustrate these distinctions. The workgroup developed the following clarifications to complement and further clarify the framework description above.

- **Focus on population health**: An activity is foundational if it occurs at the population level. If an activity happens directly to or with an individual, it is not foundational unless it meets other foundational criteria. However, there may be aspects of services or programs delivered to individuals that cross over into foundational work. For example, creating new partnerships or referral systems to support a family home visiting program is foundational, while one-on-one interactions with clients would not be.
- **System impact**: Foundational work is aimed at maintaining or improving the system of governmental public health, rather than addressing specific programmatic or individual needs. It involves systemic functions like surveillance, assessment, and ensuring core public health infrastructure.
- **Mandated work**: Foundational work includes that which governmental public health is mandated by state or federal law to provide. For example, mandated aspects of infectious disease work (like that involving tuberculosis) could align with foundational responsibilities, but direct individual services may not be foundational unless state or federal law mandates governmental public health provide them.
- **Universal applicability across jurisdictions**: Foundational responsibilities are consistent across regions and throughout the state, though the methods of funding, implementation, roles, and responsibilities might vary. For example, food inspection and oversight is foundational and must be in place everywhere, but is carried out by MDH in some locations and by local public health in others, depending on delegation agreements.
- **Focus on capacity building and relationships**: Foundational work emphasizes building, maintaining, or improving public health capacity and relationships.

# Developing criteria: Standards for measuring fulfillment

The SCHSAC FPHR Workgroup identified the following criteria to inform how it developed and prioritized standards to measure fulfillment foundational responsibilities.

- Align with existing standards from the Public Health Accreditation Board (PHAB), national or state regulations, and recognized best practices.
- Be both achievable and at a threshold reflecting the minimum Minnesotans should expect from their governmental public health system.

- Intentionally incorporate equity.
- Ensure inclusion of dedicated capacity to carry out responsibilities.

Each of the 13 responsibility-specific small groups used these criteria to brainstorm potential standards and then prioritized their standards using these same criteria.

The full SCHSAC FPHR Workgroup reviewed all 13 small groups' standards alongside PHAB Pathways measures (which align with foundational public health capabilities). Building on this review, the workgroup refined the standards, further identifying those considered core or representing the necessary baseline for fulfilling foundational responsibilities. The workgroup also prioritized including PHAB Pathways measures and identified additional standards essential to Minnesota's public health system. To minimize reporting burden, the workgroup removed or consolidated redundant standards.

The workgroup reviewed and deliberated on the standards over several months to ensure clarity, consistency, and feasibility across all foundational responsibilities.

# Considerations: Process to demonstrate fulfillment

The SCHSAC FPHR Workgroup recommends MDH incorporate the following into the process for community health boards to assess and demonstrate fulfillment of foundational public health responsibilities:

- Use a mixed-method approach (such as attestation, documentation, or qualitative examples) to demonstrate how standards are met, to balance accountability and administrative burden on community health boards. When feasible, accept as documentation existing materials submitted by community health boards (such as community health improvement plans) to avoid duplicate reporting.
- MDH promptly reviews requests from community health boards to demonstrate fulfillment and notifies them in a timely manner if their request is approved.
- Align the information MDH requests to demonstrate fulfillment of foundational responsibilities with Public Health Accreditation Board guidance.
- Engage with community health boards to ensure the documentation or evidence they submit to demonstrate fulfillment are aligned with MDH expectations and requirements.
- Refine the process to demonstrate and assess fulfillment of foundational responsibilities, based on implementation experience.
- Allow fully accredited community health boards to forgo separately demonstrating fulfillment of foundational public health responsibility standards if they want to use FPHR Grant funding for community-specific priorities (as identified in their community health assessment and improvement planning processes). Those community health boards should be required to annually request approval and provide information related to accreditation status. This process should be reviewed periodically for alignment with standards and with evolving expectations. Fully accredited community health boards, like all community health boards, are expected to prioritize and maintain capacity for foundational public health responsibilities.

### Rationale: Accreditation and demonstrating fulfillment of foundational responsibilities

After the workgroup determined standards to demonstrate fulfillment of foundational responsibilities, members deliberated how fully accredited community health boards should demonstrate fulfillment of foundational responsibilities. The workgroup noted accreditation requires substantial organizational

effort and already incorporates the expectations laid out within Minnesota's proposed standards for fulfilling foundational public health responsibilities. (That is, the proposed standards for fulfilling foundational responsibilities fall within what is typically expected for accreditation). The workgroup determined community health boards that are currently fully accredited should not be required to submit evidence to demonstrate fulfillment of foundational responsibilities. They should, however, still request to use the FPHR Grant for community-specific priorities each year. This avoids creating duplicative or burdensome requirements, and the approach recognizes the rigor of the accreditation process while maintaining accountability. Requiring community health boards to annually request this also ensures up-to-date information in the event of organizational changes affecting accreditation status or capacity.

In deciding this, the SCHSAC FPHR Workgroup noted the 2022 assessment that measured state and local health departments' ability to fulfill foundational public health responsibilities revealed that no community health board (included those fully accredited) was able to fully meet foundational responsibilities. At the same time, the workgroup ultimately acknowledged community health boards completed this assessment as they were emerging from the COVID-19 pandemic, and those community health boards may have significantly different capacity now.

While the SCHSAC FPHR Workgroup recommends fully accredited agencies do not need to submit additional documentation, the workgroup encourages community health boards to preserve FPHR Grant funding for foundational public health work, promoting strategic investment of limited funds.

The SCHSAC FPHR Workgroup intends that MDH uses these considerations to guide a demonstration process that is practical, consistent with accreditation standards, and responsive to the needs of community health boards while maintaining accountability.

# Glossary (key terms)

- **Address**: Giving attention with or without direct action; recognizing and potentially facilitating action needed. For the purposes of foundational public health responsibilities, address does not imply direct provision or action by the person or agency recognizing it.
- **Administrative and Budget Preparedness**: Also, **ABP**, a plan specific to emergency preparedness and response activities that is outlined and described in guidelines from the Centers for Disease Control and Prevention.
- **All-Hazards**: An approach that is a comprehensive strategy in emergencies that is wide-ranging and focusing on core capabilities.
- **Assure**: Verification that something is happening; largely observational and passive. For the purposes of foundational public health responsibilities, assure does not include doing the actual service.
- **Capacity**: The skills, knowledge, resources, relationships, and abilities—both individual and collective—that enable action and drive change. They encompass elements such as personnel, expertise, tools, and partnerships needed to effectively accomplish goals.
- **Clinical care/Health care**: Clinical care (also medical care) is the direct provision of health care services by professionals; health care encompasses prevention, diagnosis, treatment, and restoration of health. For the purposes of the foundational public health responsibilities, health care is the preferred, broader term to be used to address access and linkages.
- **Collaborate**: Work in partnership with colleagues, partners, or the community to plan, decide, implement or evaluate shared work.
- **Communicable disease**: A subset of infectious disease, these are transmitted from person to person.
- **Community**: A unified body of individuals that share common characteristics, such as geography, interests, culture, or history.
- **Community-driven**: An approach that gives planning, implementation, and decision-making to community groups.
- **Community engagement**: A strategy and process of actively involving community members in discussions, decision-making, and activities that relate to or impact their collective status and well-being.
- **Continuity of Operations**: Also, **COOP**, a plan specific to emergency preparedness and response activities that is outlined and described in guidelines from the Centers for Disease Control and Prevention.
- **Convene**: A tool within a community engagement strategy to intentionally bring people and partners together for a common goal or issue.
- **Crisis and Emergency Risk Communications**: A framework for developing communication during disasters and public health emergencies.
- **Emergency Support Function 8**: Guidelines specific to emergency preparedness and response, developed by the Federal Emergency Management Administration, related to planning and coordination of the public health and medical response.
- **Evidence-informed**: Includes evidence-based, promising, and theory-based or research-informed practices.
- **Foundational**: For the purposes of the foundational public health responsibilities; population-based, universally applicable across the system, mandated for public health, impacting the system, and focusing on capacity building and relationships.

- **High-quality data**: Accurate, complete, consistent, relevant and essential information that can be used in making decisions or developing plans.
- **Infectious disease**: The broader term for illnesses that are spread through bacteria, viruses, fungi, or parasites; these are not all spread from person to person.
- **Infrastructure**: Facilities or systems that serve a community or organization where physical components are required.
- **Laboratory Response Network**: The collaborative and integrated network of laboratories across a geographic area that is charged with responding to biological or chemical threats, or emerging infectious disease; the Laboratory Response Network is a tiered structure and was established by the Centers for Disease Control and Prevention.
- **Organizational culture**: Shared values, beliefs, and practices shaping how the people within an organization behave and work together.
- **Partners**: Groups, communities, and organizations with whom or with which one associates and collaborates.
- **Patient Centered Medical Homes**: Also, **PCMH**, refers to the national model for patient-centered, whole-person, and coordinated care. In Minnesota, this is known as "Minnesota Health Care Homes."
- **Population-based**: Approaches, programs, or interventions that aim to improve health outcomes for entire groups rather than individuals, address the collection condition and systems that influence health outcomes, and involve collaboration and use of data to inform action.
- **Protective factors**: Behaviors or conditions helping to prevent the onset or increasing severity of disease or injury.
- **Provide**: A responsibility to do something; implies a duty to offer concrete resources or actions directly.
- **Quantitative data**: Involves measurable numerical information; anything that can be counted or measured; can answer "how many," "how often," or "how much" questions.
- **Qualitative data**: Involves descriptive information that cannot be measured or counted; expressed with words and describes feelings, colors, or experiences; can answer "why" or "how" questions.
- **Risk factors**: Behaviors or conditions increasing the chances of developing a disease or injury.
- **Social determinants of health**: Also, **structural conditions of health**, the conditions in which people are born, grow, live, work, and age that influence health and well-being. These include factors such as housing, education, income, access to nutritious food, transportation, social connections, and the surrounding policies, systems, and environments.
- **Technical assistance**: A tool that may or may not be within a community engagement strategy to help meet requirements or work on initiatives; may be required in a regulatory situation.
- **Validate**: Check for accuracy; demonstrate, affirm, or support the truth therein.
- **Violence**: Includes sexual violence, human trafficking, traumatic brain injury, falls and motor vehicle crashes, occupational health hazards, sudden infant death and sudden death in the young, and forms of violent death including suicide and homicide.
- **Whole Community**: An approach specific to emergency preparedness that implies the involvement of everyone, not just the government, in activities related to preparedness. This includes, but is not limited to, families, businesses, faith communities, schools, and all levels of government.

# Definitions: Foundational areas

Areas are population-based activities specific to topics and programs.

## Access to and linkage with clinical care: Definitions

### A. Provide timely, complete, and locally relevant information on availability of or barriers to health care (including behavioral health); share information with the community and health care system.

1. Convene and engage community and partners to share experiences and information about gaps related to availability of care, the ability to access care, and community health literacy.
2. Develop and maintain internal electronic systems to share data.
3. Use information from internal and external electronic information systems to examine barriers to care.
4. Collaboratively assess and address the impact of factors and conditions affecting access to, cost, quality, and equitable utilization of health care.
5. Respond to requests for guidance, recommendations, and technical assistance to health care providers on strengthening community-clinical linkages.
6. Raise awareness about social determinants of health impacting access to health care.
7. Assess the quality and effectiveness of health care services to inform public health planning and decision-making.

### B. Assure licensed health care facilities and providers comply with laws and rules as appropriate.

1. Educate providers and facilities to promote understanding of relevant laws and best practices.
2. Review health care providers' qualifications and issue credentials, including registration and licensure.
3. License health care facilities and conduct routine facility inspections.
4. Monitor health care facilities and providers through both routine and targeted oversight to ensure compliance with state and federal law.
5. Investigate complaints against individual providers and health care facilities and, when appropriate, issue disciplinary or enforcement actions.
6. Share investigation results across jurisdictional regulatory and law enforcement agencies to maintain accountability and quality in the health care workforce.
7. Review background studies of individuals working in regulated facilities to mitigate the risks of harmful noncompliance posed by health care facility staff with histories of criminal or maltreatment activity.
8. Conduct physical plant plan reviews and onsite construction inspections of health care facilities.
9. Conduct financial and compliance audits of licensed health care facilities.
10. Collaborate with public health partners to understand the community context related to facilities being inspected/licensed.

### C. Collaborate with national and statewide groups, local providers, and health care partners to develop plans and address funding opportunities for increasing access to patient-centered medical homes, quality health care, and high priority policy initiatives.

1. Identify key health care partners and their skills, expertise, and qualifications to address quality and community-focused care.
2. Build new and strengthen existing relationships with cross-sector and public health partners and communities.
3. Assess the need for and consider the factors and conditions affecting access to health care services, including barriers, within the jurisdiction.
4. Collaborate with partners and communities to understand the quality and effectiveness of health care services and co-create strategies for improving access to quality health care.
5. Convene cross-sector and public health partners, including health care providers and non-governmental and governmental partners, to identify strategies or initiatives addressing factors, conditions, and barriers to care.
6. Develop and maintain a plan and implement population-based strategies to improve access and quality of care.
7. Evaluate implementation of plans and adjust as needed.
8. Collaborate with and assist partners in pursuing and supporting joint funding opportunities while fostering shared responsibility.
9. Sustain work through policy and systems change, capacity building, and integration into existing programs.

## Chronic disease and injury prevention: Definitions

### A. Provide timely, relevant, and accurate information to partners and the public on population health trends related to chronic disease and injury prevention.

1. Develop and maintain internal information systems and access external information systems for prevention and population health—including systems for chronic disease and injury prevention.
2. Collaborate with community to conduct surveillance of the population with respect to chronic disease and injury and use information to educate partners and the community.
3. Establish metrics and evaluate prevention and population health improvement activities.
4. Collect, analyze, validate, and share data related to chronic disease and injury prevention.
5. Provide education and technical assistance to organizations involved in improving health and preventing harm.

### B. Develop a prevention plan for chronic disease and injury prevention in collaboration with community partners.

1. Collaborate with partners and communities to address chronic disease and injury prevention through the following actions:
    a. Building new and strengthening existing relationships,

b. Assessing need and considering factors and conditions influencing these issues,

c. Creating plans, implementing, and evaluating population-based strategies,

d. Pursuing joint funding or supporting partners in identification and pursuit of funding, and

e. Sustaining work through policy and systems change, capacity building, and integration into existing programs.

### C. Coordinate, integrate, address funding opportunities, and align chronic disease and injury prevention programs and initiatives.

1. Work together to plan and connect efforts to prevent chronic diseases and injuries.
2. Identify ways to better align and coordinate programs already funded or required by law, so they support each other and have greater impact.
3. Support partners in understanding funding limitations, flexibilities, and explore creative and innovative approaches and opportunities.
4. Educate decision-makers about resources needed for chronic disease and injury prevention.
5. Assure and maintain baseline funding for chronic disease and injury prevention programs and initiatives.
6. Seek out, apply, and manage funding opportunities.

### D. Work actively with statewide and community partners to implement population-based strategies to increase protective factors and reduce modifiable risk factors for chronic disease and injury.

1. Collaborate to implement population-based strategies to:
   a. Increase healthy eating, active living, mental wellbeing and community connectedness.
   b. Reduce statewide and community rates of alcohol, commercial tobacco, and other drug use.
   c. Identify, manage, and live well with chronic disease.
   d. Understand, respond to, and prevent occurrence of and harm caused by forms of injury and violence.
2. Develop, implement, and maintain systems and infrastructure for policy, system, and environmental change.
3. Develop and maintain written training materials, provide training to appropriate staff.
4. Utilize evidence-informed practices aligned with national, state, and local guidelines.
5. Establish a system for tracking efforts toward agreed upon responsibilities for governmental public health, and partners, track these efforts.
6. Verify equitable access to and availability of screening, referrals, and treatment of chronic diseases and injuries.

# Communicable disease control: Definitions

### A. Provide timely, relevant, and accurate information to partners and the public on communicable diseases and their control.

1. Develop, maintain, and share internal electronic information systems and access external systems for reporting and surveillance.
2. Establish metrics and monitor quality of infectious disease prevention and control activities.
3. Collect data per Minnesota Administrative Rules, and analyze data related to infectious diseases.
4. Develop, maintain, and share an immunization information system.
5. Assure education about vaccine preventable diseases, Minnesota immunization requirements, and the statewide immunization information system among health care providers, pharmacists, school officials, and the public.
6. Assure education about infectious diseases and emerging disease prevention and control situations for health care providers, pharmacists, long-term care facility staff, infection control specialists, school officials, the public, and others.

### B. Develop a prevention plan for communicable disease control in collaboration with community partners.

1. Assess the factors and conditions affecting infectious disease prevention and control.
2. Collaborate with and educate partners and communities including those disproportionately affected by infectious diseases, to understand infectious disease prevention and control from the perspective of lived experience.
3. Collaborate with and convene partners and communities to create and implement strategies or initiatives for infectious disease prevention and control.
4. Develop, implement, and maintain written plans, systems, and infrastructure, and train relevant staff.
5. Assess how external factors and conditions affect implementation of infectious disease prevention and control plans.

### C. Identify and respond to communicable disease outbreaks for notifiable conditions in accordance with local, state, and national requirements.

1. Coordinate response to assure all appropriate partners are notified and there are clear roles and responsibilities.
2. Assure identification and notification of close contacts at risk for disease transmission with Centers for Disease Control and Prevention (CDC) guidelines.
3. Assure appropriate treatment and prevention of disease in people who have reportable diseases in accordance with local, state, and national mandates and CDC guidelines.

### D. Support the recognition of outbreaks and other events of public health significance.

1. Assure capacity for the identification and characterization of the causative agents of disease and their origin, including the rare and unusual.
2. Verify availability of screening for infectious diseases of public health importance.

3. Conduct timely investigations for reportable infectious diseases.
4. Identify and respond to emerging issues.
5. Report diseases in accordance with the communicable disease reporting rule in state statute (Minn. R. 4605).

### E. Coordinate, integrate, align, and address funding opportunities for statutorily required communicable disease programs and activities.

1. Educate decision-makers about resources needed for infectious disease prevention and control activities and advocate for needed funds.
2. Seek out, apply, and manage funding opportunities.
3. Assure and maintain baseline funding is being provided to support mandated infectious disease prevention and control activities.
4. Assure access to the safe and effective administration of vaccinations for the public.

## Environmental public health: Definitions

### A. Provide timely, relevant, and accurate information to partners and the public on environmental public health threats and health impacts.

1. Collect, analyze, and interpret data and information related to environmental health.
2. Validate information, data, analysis, and findings.
3. Assure education and technical assistance are provided for prevention, abatement, and compliance, or refer as appropriate.

### B. Develop a prevention plan for environmental public health in collaboration with partners.

1. Build and maintain relationships with appropriate audiences.
2. Engage with the community to assess the need for prevention or abatement activities.
3. Collaborate with and educate partners and communities.
4. Convene cross-sector, cross-agency, and public health partners to identify strategies or initiatives.
5. Develop, implement, and maintain a written plan.
6. Engage with partners and communities to collect feedback.
7. Participate in opportunities to address sustainability, land use planning, and climate efforts promoting positive public health outcomes and resilient communities.

### C. Conduct mandated environmental public health activities and oversight to protect the public from hazards in accordance with local, state, and federal laws and regulations.

1. Develop and maintain written training materials, provide training to appropriate staff.
2. Investigate and document environmental health complaints.
3. Conduct timely investigations in response to environmental health risks.

4. License, certify, or permit regulated parties or entities within the jurisdiction.
5. Inspect regulated parties or entities within the jurisdiction.
6. Issue, enforce, and document corrective actions with respect to environmental health violations.
7. Perform and document follow-up activities for remediation.
8. Assure water and solid waste systems are managed safely.
9. Assure availability of environmental, biological, and chemical laboratory testing.

### D. Identify and address radiation, chemical, and other public health hazards related to environmental factors in accordance with local, state, and federal laws and regulations.

1. Partner across agencies to assure protection of workers and the public from hazards related to environmental factors.
2. Establish a system for tracking efforts toward agreed upon responsibilities, track these efforts.
3. Implement prioritized strategies or initiatives and assess how external factors and conditions affect implementation.
4. Identify and respond to emerging issues.

### E. Coordinate, integrate, align, and address funding opportunities for environmental public health work across public health programs and activities, and partner agencies.

1. Assure and maintain baseline funding to support mandated environmental public health programs and activities.
2. Seek out, apply for, and manage funding opportunities.
3. Coordinate environmental public health programs and activities with governmental agencies.
4. Assure training about environmental public health roles and responsibilities for agency staff.

## Maternal, child, and family health: Definitions

### A. Provide complete, accurate, and locally relevant data and information as available to partners and the public on maternal, child, and family health trends.

1. Develop systems for collecting, analyzing, and sharing data related to maternal, child, and family health indicators, outcomes, and trends.
2. Access data from external sources for prevention and population health.
3. Analyze and validate data related to maternal and child health.
4. Provide surveillance of the population with respect to maternal and child health.
5. Establish metrics and monitor quality of prevention and population health improvement activities.
6. Provide education and technical assistance to organizations involved in preventing harm and improving health.

### B. Develop a prevention plan for maternal, child, and family health in collaboration with community partners.

1. Identify and create connections with partners and communities, particularly those disproportionately affected by health inequities.
2. Assess the factors and conditions affecting maternal, child, and family health programs and their implementation.
3. Collaborate with partners and communities to understand maternal, child, and family health issues and culturally affirming programs.
4. Collaborate with partners and communities to create and implement maternal, child, and family health programs and strategies.
5. Develop, implement, maintain, and evaluate plans, systems, and infrastructure to address maternal, child, and family health issues.

### C. Identify, disseminate, and promote emerging and evidence-based practices and programs which promote lifelong health and wellbeing.

1. Educate partners and communities on maternal, child, and family health risks, including prevention and control of those risks.
2. Develop, implement, and maintain systems and infrastructure for identifying and promoting evidence-based practices and programs.
3. Modify and adapt existing practices and programs to meet community and family needs.
4. Establish and document a process to review and continually improve practices and programs.

### D. Maintain and utilize newborn screening and identification of infants with birth defects to support and coordinate follow up.

1. Support systems to assure infants with birth defects and/or newborn screening conditions are identified as soon as possible after birth.
2. Establish and maintain systems for follow-up, reporting, and connection to clinical care and early intervention for infants with newborn screening conditions.
3. Assure infants identified with a newborn screening condition have access to prompt diagnostic assessments.
4. Assure a complete referral from the state health department to local health departments for nursing follow-up, including documentation from the local health department to the state health department of the outcomes of the referral.
5. Assure the families of infants identified with birth defects and/or newborn screening conditions receive prompt nursing follow-up including health education and connection to clinical, educational, and social services.
6. Assess the availability, capacity, and distribution (or gaps therein) of clinical care for infants with birth defects and/or newborn screening conditions, including any barriers to accessing care.
7. Monitor the effectiveness of public health programs serving infants with birth defects and/or newborn screening conditions.

8. Inform and influence state policy related to newborn screening according to evidence-based practice and standards.

## E. Coordinate, integrate, align, and address funding opportunities for maternal, child, and family health programs and activities.

1. Educate decision-makers about and advocate for resources needed for maternal, child, and family health programs and activities.
2. Seek out, apply for, and manage funding opportunities.
3. Assure and maintain baseline funding is being provided to support mandated maternal, child, and family health programs and activities.
4. Assure and maintain a competent and trained public health workforce specific to maternal, child, and family health programs and activities, including training on emerging and culturally affirming practices and programs.
5. Create and maintain a systematic intake, internal, and external referral process so referrals across available programs are well-coordinated.

# Definitions: Foundational capabilities

Minnesota's governmental public health system must have the ability to carry out these activities and categories of activities.

## Accountability and performance management: Definitions

### A. Perform business and public health practices in alignment with applicable federal, state, and local laws, policies, and Public Health Accreditation Board standards and practices.

1. Establish a system for tracking efforts toward agreed upon responsibilities, and monitor actions taken by governmental public health and partners.
2. Develop, implement, and maintain systems and infrastructure for organizational performance management.
3. Regularly review and apply all relevant federal, state, and local laws, policies, and accreditation requirements affecting public health practice.

### B. Maintain a performance management system to monitor achievement of organizational objectives and an organization-wide quality improvement culture.

1. Develop, implement, and maintain a documented process for creating performance management metrics. This may include a written performance management plan.
2. Establish reliable, high-quality, and actionable metrics to monitor performance and drive continuous improvement.
3. Develop performance management plans for all teams, including data collection, analysis, and reporting, and establish a centralized system for storing and accessing performance management data.
4. Develop, implement, and maintain a quality improvement plan (according to PHAB Domain 9 guidance).
5. Cultivate an organizational culture of quality improvement (including but not limited to leadership commitment, quality improvement infrastructure, employee empowerment, customer focus, etc. (*Elements of a QI Culture, Roadmap to a Culture of Quality Improvement*).
6. Establish metrics and monitor quality of the governmental public health system.
7. Analyze performance data to inform decision-making.

### C. Use best available evidence when implementing new or revised processes, programs, and/or interventions.

1. Have capacity and competency to review research and literature.
2. Establish and document a process to review evidence-based, promising, and theory- or research-informed practices when a program or intervention is developed or revised, including evidence specific to various communities.
3. Customize or adapt to assure the practice is tailored to the community.
4. Have organizational and staff competency in evaluation.
5. Make decisions for improvements based on the evaluation of a program, process, or intervention.

6. Use evaluation data to test and refine new and innovative approaches.

### D. Measure the impact of governmental public health's contribution to improving health equity.

1. Use disaggregated performance data to identify disparities and prioritize areas for improvement.
2. Develop, implement, and maintain a system to gather feedback from groups affected by agency goals to assure their perspectives inform decision-making.
3. Engage and share data findings with affected groups and interested parties. This could include activities such as reporting on progress, facilitating discussion to encourage data use, or gathering additional insights for interpretation of findings.
4. Develop shared measures across the governmental public health system.

## Assessment and surveillance: Definitions

### A. Use data to guide public health planning and decision making.

1. Develop, implement, and maintain an information technology infrastructure (internet, computer hardware, software) and a data infrastructure (people, training, standards, permissions, workflows, informatics, etc.)
2. Access training, technical assistance, or expertise for data collection and making strategic and data-driven decisions.
3. Assure data-driven decisions are based on high-quality data appropriate for the decision to be made.
4. Use data to identify factors which influence health, including strengths and assets.
5. Establish metrics and monitor data on public health issues, including root causes.
6. Design and identify metrics which will guide action and measure impact.
7. Share and disseminate findings with partners and community.

### B. Collect, access, analyze, and interpret data from a variety of sources.

1. Collect, access, analyze, and interpret both quantitative (includes granular data disaggregated by geography, sub-populations, race, ethnicity) and qualitative data (e.g., feedback from interviews or focus groups) to guide planning and decision-making.
2. Engage community and partners in data collection processes, including decisions about what data to collect and methodology for collection.
3. Research and review of existing data sources to inform the need for additional data collection.
4. Analyze data and findings in collaboration with partners, communities, and those with lived experience.
5. Validate information, data, analysis, and findings.

### C. Assess and analyze disparities and inequities in the distribution of disease and social determinants of health.

1. Analyze data in collaboration with partners and communities with lived experience; includes engaging populations most impacted to make sure data reflects real-world conditions and lived experience.

2. Identify community assets, strengths, and resources.
3. Communicate data (accurate, tailored for specific audience, and with health equity in mind) with community members or partners.
4. Use data to act and/or drive future work to identify and address inequities.

### D. Develop and maintain internal systems and processes for receiving and responding to data requests from the public, policy makers, media, and others.

1. Assure data is available and complies with data standards, statutory requirements, and other legal obligations.
2. Translate data into information and reports which are valid, complete, statistically accurate, and accessible to the intended audiences.
3. Identify the most effective method for sharing data in response to requests and to assure timely dissemination.

### E. Conduct a collaborative community or statewide health assessment and identify health priorities, including analysis of root causes of health disparities and inequities.

1. Engage partners and community in all aspects of a community or statewide health assessment, from initial planning through final development.
2. Examine community involvement and outreach; refine the engagement strategy as needed to enhance effectiveness.
3. Convene public health partners and community to understand public health issues and the need for prevention activities, and to develop a health assessment.
4. Identify and leverage community strengths and assets as part of the assessment.
5. Work with partners conducting other types of health assessments within the jurisdiction for learning and alignment.
6. Disseminate final health assessment for awareness, and to inform related and subsequent activities.

### F. Access 24/7 laboratory and other resources for rapid detection.

1. Access resources for rapid detection, investigation, containment, and mitigation of public health problems and environmental public health hazards.
2. Assure coordination and communication with public and private laboratories.
3. Assure availability of environmental, biological, and chemical laboratory testing, including for maternal and child health, chronic disease, and injury issues.
4. Function as a Laboratory Response Network (LRN) Reference laboratory.

### G. Participate in or support surveillance systems to rapidly detect emerging health issues and threats.

1. Provide or access epidemiological services.
2. Use epidemiological practices to explain the distribution of disease, death, health outcomes, health disparities and systemic inequities.

3. Identify and investigate emerging public health issues.
4. Provide surveillance of the population related to emerging health issues and threats.
5. Participate in or support syndromic surveillance and other emerging technology and data sets for rapid detection of emerging health issues and threats.

### H. Collaborate with community partners in collecting, reporting, and using public health data.

1. Validate information, data, analysis, and findings with community partners.
2. Convene and collaborate with partners (across sectors and with those affected by health inequities) and communities to strategize data usage.
3. Facilitate community-led data processes by providing structure and support for how communities gather and use data.

## Communications: Definitions

### A. Develop and implement a communications plan to assure routine public health communications.

1. Develop, implement, and maintain systems for communications with public health, cross-sector partners and the public.
2. Include methods to engage communities not reached through traditional public health channels in communication plans.
3. Collaborate with partners and communities to co-create communications strategies.
4. Establish metrics and monitor quality of public health communications.
5. Assure all communications are clear, inclusive, and available in multiple formats to meet diverse needs, including language accessibility, readability/plain language, and accommodations for disabilities.

### B. Maintain ongoing media relations to assure information and messages of public health importance are conveyed to the community.

1. Develop, implement, and maintain organizational communication policies (including standard operating procedures, identification of spokesperson, process for responding to media requests, and media contact list) related to media engagement.
2. Develop, implement, and maintain organizational communication templates (such as news release templates and contact lists) for media engagement.
3. Assure information and messages of public health importance are shared proactively with the media, including but not limited to, disseminating news releases, conducting news conferences, and using electronic/digital communication tools to interact with the media.
4. Strategically evaluate media coverage and outreach to assure reach across all communities, leveraging trusted communicators to enhance credibility and engagement.
5. Assure communication training to subject matter experts and leadership.

### C. Use social media and other platforms to communicate and engage directly with the community.

1. Assess and identify which social media and other digital platforms (such as blogs, podcasts, and email newsletters) are available for use.
2. Develop, implement, and maintain policies for using social media and other digital platforms. This may include protocol for responding to comments and concerns and responding to feedback, such as a social media policy.
3. Build in-house capacity to use social media and other digital platforms, including building infrastructure (information technology capabilities and permissions, software, and apps) and engaging in training.
4. Assess and determine effective social media or other platforms to reach the focus audience, and develop aligned content and messaging based on audience insights, including active listening and engagement.
5. Leverage partnerships to expand reach.
6. Use analytics, and other data sources, to evaluate impact of and engagement with social media and other platform. Implement necessary improvements accordingly.

### D. Tailor messages and communications channels for various audiences.

1. Develop, implement, and maintain systems for communications (communication channels) with public health organizations, other cross-sector partners, and the public.
2. Provide training and skill development for communicators.
3. Develop relationships with trusted community leaders.
4. Develop and adapt messages to fit the needs (such as culture, language, and literacy level) of key audiences, engage trusted community messengers, and practice deep listening. Pilot test messaging to assure content reflects the needs and perspectives of the focus population.

### E. Develop and implement a risk communications strategy to use during a public health crisis or emergency.

1. Lead and coordinate messaging using Crisis and Emergency Risk Communications principles to assure consistency in messaging around critical public information, with intentional focus on communicating with accessible language and cultural humility.
2. Transmit and receive routine communications to and from the public in an appropriate, timely, and accurate manner.
3. Assess and prioritize products, tactics, and channels for public-facing communications.
4. Collaborate with partners and communities to co-create strategies for risk communication, including strategies for addressing mis- and dis-information.
5. In the event of a public health crisis or event, lead and/or coordinate communication between public health, health organizations, national organizations, and federal and state agencies.

### F. Develop and implement a proactive health education strategy for providing timely and accurate information.

1. Design and implement a health education strategy which encourages actions to promote health in culturally and linguistically appropriate ways, including using electronic communication tools.
2. Assess and prioritize products, tactics, and channels for public-facing communications.
3. Engage community members and partners to co-create proactive health education communication strategy.

## Community partnership development: Definitions

### A. Create, convene, support, and sustain strategic, non-program specific relationships with partners.

1. Engage community groups or organizations, particularly those representing populations experiencing health disparities or inequities; private businesses and health care organizations; relevant federal, Tribal, state, and local government agencies; elected and non-elected officials.
2. Dedicate resources to community partnership development and engagement.
3. Identify power dynamics and relationships to understand how different communities are organized.
4. Create and maintain organizational policies and practices which advance relationship building and authentic engagement.
5. Identify and convene strategic public health partnerships across sectors and governmental agencies.

### B. Leverage and engage partnerships and community to advance health equity.

1. Create organizational policies and practices to advance relationship development and effective community engagement methods.
2. Identify and implement processes which advance health equity.
3. Facilitate gatherings which encourage community-driven approaches.
4. Assure community members, including those most affected by health inequities and those with lived experience, are engaged in bi-directional information sharing.

### C. Establish trust and engage populations most impacted by inequities in public health decision-making using community-driven approaches.

1. Collaborate with community partners by participating in their discussions, planning, and program development and implementation.
2. Convene communities at the grassroots level to support bi-directional information sharing, foster leadership opportunities, and facilitate participatory decision-making and action.
3. Develop a broad understanding of how communities within the jurisdiction are organized and how community relationships and history may affect the public's health.
4. Establish relationships with communities located within the jurisdiction with the goal of building trust and authentically engaging through community-driven approaches, particularly in historically

marginalized and underserved communities and those most impacted by health disparities and underlying inequities.

### D. Use collaborative processes to develop community or statewide health improvement plans to address identified priorities.

1. Engage partners and community in a health improvement process and developing plan(s) to improve health outcomes by addressing priorities most important to them.
2. Use health assessment data, including root cause analysis, to establish plan(s) for addressing priorities.
3. Coordinate efforts, resources, and policy agendas across partners for awareness of priorities and to implement the plan(s).
4. Convene and collaborate with partners and community to evaluate and monitor the health improvement plan(s) and associated interventions, making updates and improvements as appropriate.

## Emergency preparedness and response: Definitions

### A. Develop, exercise, and update All-Hazards preparedness and response plans using established guidelines to address acute and long duration incidents and events.

1. Develop, implement, and maintain written policies and procedures to activate and alert public health personnel and response partners during an emergency.
2. Develop, exercise, and update emergency preparedness and response plans based on identified risk assessments.
3. Establish the response and recovery role of public health in incidents and events, in collaboration with partners.
4. Inform staff and appropriate partners of public health roles in response plans.
5. Train staff and provide opportunities to exercise the response plan.
6. Collaborate with community-based organizations and partners to provide and participate in training events and exercises.
7. Evaluate and continuously improve the response of the governmental public health system and the health department to incidents, using after-action reports and improvement plans (AAR-IPs).

### B. Integrate environmental, social, physical, and economic conditions to protect the needs and abilities of all people in response and recovery activities and plans.

1. Build and maintain relationships with the public and partners to establish trust with governmental public health.
2. Convene cross-sector partners to identify strategies or initiatives for community-based organizations and governmental partners.
3. Collaboratively assess and plan for the considerations of access and functional needs of at-risk populations.

### C. Lead the public health and medical response strategies for the jurisdiction and state, also known as Emergency Support Function 8.

1. Assure staff are adequately trained on emergency preparedness and response competencies and plans in the incident command system.
2. Assure leadership of governmental public health is trained and equipped to lead response and recovery activities.
3. Assess the scope and responsibility for public health response internally and externally.
4. Governmental Public Health participates and partners with regional Health Care Preparedness Coalitions, or other similarly positioned coalitions.

### D. Assure mobilization of personnel and partners for emergency response, using the incident management system for coordination.

1. Activate and alert public health response personnel using established communication systems.
2. Operate within, and as necessary lead, the established incident command system according to the role of public health.
3. Convene public health partners to identify strategies for governmental public health response to incidents, and to assess the need for community incident response efforts.
4. Coordinate with local, state, Tribal, and federal emergency managers and other first responders, health care coalitions, and private sector and nonprofit partners.

### E. Maintain operational plans for Continuity of Operations and Administrative and Budget Preparedness for response and recovery.

1. Identify priorities or essential public health functions and the staff, resources, and facilities needed for continuity of operations during an incident.
2. Collaborate with public health leadership and staff to clarify roles and responsibilities during a continuity incident.
3. Assure administrative and budget processes and systems are documented, tested, and evaluated to assure public health can rapidly receive and use funds; procure resources, materials, and supplies; execute contracts; and hire personnel during incidents and events.
4. Conduct training and exercises for public health leadership and staff on both plans.

### F. Promote readiness and resilience of communities and partners, enabling necessary action before, during, or after an emergency.

1. Convene public health and community partners to jointly strategize response actions.
2. Conduct community engagement activities to promote Whole Community planning, response, and recovery.

### G. Plan for and lead public health recovery initiatives.

1. Assess the need for incident recovery efforts for communities, jurisdictions, and governmental public health staff.
2. Implement prioritized strategies or initiatives to support recovery from incidents.

3. Collaborate when feasible with disaster behavioral health specialists, mental health professionals, and/or partners in recovery activities.
4. Assess the behavioral health needs of and implement strategies to support public health staff recovery following an incident or event.

### H. Strengthen and maintain the infrastructure for public health emergency response.

1. Assess the legal and statutory process for issuing and enforcing state and local emergency health orders.
2. Issue and enforce emergency health orders, as necessary and appropriate, inclusive of prevention or control of infectious diseases and environmental health risks.
3. Develop, implement, and maintain a situation and information sharing infrastructure which may receive notice of emergencies on a 24/7 basis.
4. Provide information before, during, and after a public health emergency per Communications capability standards and crisis and emergency risk communication (CERC) principles.
5. Access and utilize a Laboratory Response Network (LRN) Reference laboratory for biological agents and an LRN chemical laboratory at a level designated by CDC.

## Equity: Definitions

### A. Develop a shared understanding of what creates health including structural and systemic factors advancing health equity.

1. Cultivate an organizational culture of health equity.
2. Develop staff skills and understanding regarding equity, racial and social justice, and a systems change approach.

### B. Achieve health equity through integration across all foundational public health responsibilities.

1. Create training and conversation to understand equity, racial and social justice, and systems change.
2. Create ongoing opportunities to discuss the ways health equity shows up in the work of public health and foster a space to grow.
3. Establish and incorporate organizational values, including equity, when determining priorities, making decisions, and setting policies.
4. Develop and build staff capacity to address equity.

### C. Work collaboratively to support and foster a shared understanding of the critical importance of equity to achieve community health and well-being.

1. Convene and collaborate with cross-sector and public health partners to identify strategies, initiatives, shared goals, and outcomes.
2. Collaborate with partners and communities disproportionately affected by health inequities, including those working with such communities.
3. Collaborate within the organization and across organizational teams to impact health equity.
4. Develop, train, and support staff to address equity through multi-sector collaborations.

### D. Work towards health equity by strategically addressing social and structural determinants of health through policy, programs, and initiatives.

1. Inform and influence the development and adoption of laws and policies which advance health equity.
2. Create equity-centered public health policy, inclusive of research, analysis, and calculating costs.

### E. Measure and track progress to assure accountability for health equity, make improvements, and adapt to changing needs.

1. Develop measures to track community engagement with impacted communities; measures will center trust, shared decision-making, and active listening.
2. Create regular opportunities to review and evaluate progress based on data measures.
3. Utilize a combination of quantitative and qualitative datasets.

## Organizational competencies: Definitions

#### LEADERSHIP AND GOVERNANCE

### A. Lead internal and external partners to consensus, with movement to action, and serve as the face of governmental public health.

1. Collaborate with partners and communities including those disproportionately affected by health disparities to increase knowledge about the role of governmental public health.
2. Convene cross-sector partners to increase knowledge about the role of non-governmental partners.
3. Advocate and communicate about the value and role of public health in the community.

### B. Define a strategic direction for public health initiatives.

1. Engage in health policy development, discussion, and adoption with local, state, and national policy makers.
2. Convene public health partners to identify strategies or initiatives.
3. Develop, implement, and maintain an agency strategic plan with metrics to monitor implementation; track implementation and report on progress.
4. Assess how external factors and conditions affect implementation of the agency strategic plan.

### C. Prioritize and implement diversity, equity, and inclusion within governmental public health.

1. Assure representation on public health boards and councils is reflective of the community.
2. Develop and maintain an internal assessment of policies and practices.

### D. Engage with appropriate governing entities about the department's public health legal authorities.

1. Engage with and support the appropriate governing entity about the public health agency's role and legal authority around public health priorities, policies, and laws.

2. Promote and assist governing entities in examining, understanding, and modifying public health authorities; educate and support appropriate governing entities.
3. Develop, implement, and maintain a governance system and infrastructure for governmental public health, including organizational policies.
4. Maintain current operational definitions and statements of public health roles, responsibilities, and authorities.

## INFORMATION TECHNOLOGY SERVICES, INCLUDING PRIVACY AND SECURITY

### A. Maintain or procure the hardware and software needed to access electronic health information internal to the agency to support operations and analysis of health data.

1. Develop, implement, and maintain systems and infrastructure for information technology and electronic information systems within the organization.
2. Implement prioritized strategies or initiatives identified to support optimization of technology, information systems, and data.

### B. Support, use, and maintain communication technologies and systems, such as websites and social media, needed to interact with community members.

1. Support and maintain technologies and systems for external communications and interactions with the public.
2. Assure continuity of technical operations and connectivity to networks in an emergency.

### C. Have systems and controls in place to keep any data collected confidential and maintain security of information technology systems.

1. Develop, maintain, and share internal electronic information systems.
2. Develop, implement, and maintain written organizational policies in alignment with data privacy and retention laws.
3. Build organizational and staff competency around information systems.

## WORKFORCE DEVELOPMENT AND HUMAN RESOURCES

### A. Develop and maintain a workforce representative of the community, with competencies needed to implement the foundational public health responsibilities effectively.

1. Develop, implement, and maintain policies, practices, and a written plan for workforce development.
2. Assess and review hiring and contracting policies and practices.

### B. Manage human resource functions including recruitment, retention, and succession planning, training, performance review, and accountability.

1. Cultivate a supportive work environment for staff wellness, which includes employee satisfaction, engagement, and recognition.
2. Develop, implement, and maintain systems and infrastructure for human resource management, recruitment, and employee retention.

3. Develop and maintain written training materials on pertinent topics and provide staff onboarding and ongoing training.
4. Develop, implement, and maintain written succession plan(s) for the organization.

### FINANCIAL MANAGEMENT, CONTRACTS, AND PROCUREMENT SERVICES, INCLUDING FACILITIES AND OPERATIONS

#### A. Establish a financial management system in compliance with local, state, and federal standards and policies.

1. Develop, implement, and maintain systems and infrastructure for financial management, oversight, and internal auditing of financial operations, which includes budgeting, projections, billing, and chart of expense and revenue accounts.
2. Develop, implement, and maintain systems for contracts and procurement.

#### B. Secure grants or other funding (governmental and not) and demonstrate compliance with an audit required for the sources of funding utilized.

1. Advocate for, procure, maintain, and manage financial resources for organizational operations.
2. Leverage funding and assure resources are allocated for population health and informed by social determinants of health.

#### C. Procure, maintain, and manage safe facilities and efficient operations.

1. Assure maintenance and, as necessary, replacement of long-term or capital assets for organizational operations.
2. Manage and operate facilities as safe, physically secure, and accessible public-facing workplaces.
3. Procure, maintain, and manage necessary goods and services, and interchangeable assets.

### LEGAL SERVICES AND ANALYSIS

#### A. Access and appropriately use legal services in planning, implementing, and enforcing public health contracts and programs, including relevant administrative rules and due process.

1. Have organizational and staff competency in understanding and interpreting statutes, regulations, rules, ordinances.
2. Develop, implement, and maintain systems and infrastructure for legal services and analysis.

## Policy development and support: Definitions

#### A. Advocate for policies addressing environmental, social, and economic conditions which impact health disparities and equity.

1. Understand policies which create or lessen health disparities and communicate about related policy and legislative activities.
2. Collaborate with partners and community to identify gaps in policies and ordinances.

3. Collaborate with partners and policy makers to enact new, evidence-based policies.
4. Convene partners and community to identify policy strategies or initiatives which improve health equity.
5. Organize support for public health statutes, regulations, rules, ordinances, and other policies.
6. Provide education and technical assistance to help to empower people to share their perspectives on and understand policies which impact health.

### B. Develop and maintain public health policies which are evidence-based, locally relevant, and meet legal requirements.

1. Research, analyze, conduct cost analysis, and articulate the impact of public health policies and rules where appropriate; assure community concerns are considered and integrated into the analysis and decision-making process.
2. Assess existing public health policies, identify the need for new policies, and evaluate the impact of their implementation.
3. Engage with appropriate governing entities about the purpose, intent, and outcomes of public health laws, policies, and ordinances.
4. Organize support for public health policies, rules, and regulations and collaborate with the entity having the legal authority to adopt them.
5. Develop and maintain written organizational policies to support staff in rapidly responding to emerging issues.

### C. Serve as a primary resource to inform and influence policies by other governmental and non-governmental agencies for improving environmental, social, and economic conditions.

1. Foster and maintain relationships with partners developing policies which affect physical and mental health outside the immediate scope of governmental public health.
2. Convene or participate in discussions with cross-sector partners to identify strategies or initiatives which help non-governmental partners to consider health impacts in all decision-making (Health in All Policies).
3. Share data, information, recommendations, and subject matter expertise to bring a health lens (Health in All Policies framework) to local decision-making.
4. Collaborate with partners to develop long-term strategies and system changes which improve public health.
5. Monitor the impact of changing state and federal laws on public health to anticipate and articulate health implications.

### D. Support compliance with and enforcement of public health regulations or legislation.

1. Participate in state-local collaboration and communication to support and uphold public health regulations.
2. Develop, implement, and maintain organizational policies aligned with local, state, and federal regulations.
3. Educate the community and key partners on the meaning, purpose, and benefits of public health laws.
4. Develop and maintain written training materials on public health laws, policies, and ordinances.

5. Connect regulated entities to appropriate training, resources, support, and education to reduce risks, increase compliance with, and/or take corrective actions.
6. Engage with the appropriate governing entity about the public health agency's role and legal authority around environmental health policy.
7. Conduct, monitor, and report public health enforcement activities, including issuing violations and enforcing laws, rules, policies, and procedures to prevent the spread of disease.
8. Assure the consistent application of public health laws, policies, and ordinances.

# Criteria: Foundational work or community-specific priorities

The following criteria can help Minnesota's governmental public health system distinguish foundational responsibilities from community-specific priorities.

Foundational public health responsibilities are the minimum package of public health services that governmental public health should deliver to communities, and that should be available everywhere, for public health to work anywhere. It includes foundational capabilities and foundational areas that must be available to all people served by the governmental public health system and that meet one or more of these criteria:

1. **Mandated by federal or state laws.**

   Foundational includes work mandated by state or federal law for governmental public health to provide.

2. **Governmental public health system is the only or primary provider statewide.**

   Foundational responsibilities are consistent across regions and throughout the state, though the methods of funding, implementation, and roles and responsibilities to carry out functions might vary.

3. **Population-based (versus individual services), focused on disease prevention, protection, and health promotion.**

   Population-based approaches, programs, or interventions aim to improve health outcomes for entire groups rather than individuals, address the collective conditions and systems that influence health outcomes, and involve collaboration and use of data to inform action.

Foundational capabilities are cross-cutting skills, abilities, and knowledge needed in any governmental public health system to provide basic public health protections.

Foundational areas are topic-specific public health programs or initiatives aimed at improving the health of a population.

In addition to the foundational capabilities and foundational areas, the framework developed by the Public Health Accreditation Board (PHAB) Center for Innovation describes community-specific services (sic) as local protections and services that are unique to a community. These services are essential to that community's health and vary by community or jurisdiction.

# Standards for demonstrating fulfillment

(P) indicates PHAB Pathways measures.

## Standards: Foundational areas

### Applicable to all foundational areas

- Plans and initiatives for all areas reflect collaboration with community partners.
- Programs in all areas measure progress, outcomes, and equity impacts, and share findings to guide decision-making and make improvements.
- Professional development includes skills-based training for staff in all areas, including ongoing training in equity-centered, trauma-informed, and evidence-based public health practices.
- Activities for all areas meet appropriate statutory requirements and align with state and federal guidelines.

### Access to and linkage with clinical care

- Collect and analyze data on access to care, to identify gaps and barriers including, but not limited to, gaps in services, affordability, transportation barriers, and workforce availability.
- Use data on access to care to inform planning, advocate for policy change, guide resource allocation, and collaborate on improvement initiatives (e.g., behavioral health access, provider shortages).
- Adhere to all relevant public health laws and guidance, understanding mandatory responsibilities.
- Support (or lead when appropriate) coordination of access-to-care efforts across sectors.
- Partner with providers and health systems to improve access to primary care and patient-centered care.

### Chronic disease and injury prevention

- Track and communicate population health trends for chronic disease and injury, to inform partners and the public.
- Use policy, systems, and environmental (PSE) and evidence-based approaches to address chronic disease and injury.

### Communicable disease control

- Align data collection with applicable local, state, and federal requirements, using guidance from the Minnesota Infectious Disease Operations Guide, or MIDOG, section D.
- Implement and tailor communication strategies for various audiences. (MIDOG, Section F)
- During infectious disease response, coordinate and document messaging, outreach, and response activities with communicable disease partners (governmental and non-governmental).
- Identify and clearly define infectious disease roles (as outlined in MIDOG); staff are prepared to perform them.
- Maintain the statewide immunization information system (MIIC) and use it to support immunization coverage.

### Environmental public health

- Align work and activities with the current food, pools, and lodging delegation agreement language and update practices accordingly (for delegated agencies only).
- Train staff responsible for public health nuisance response in enforcement and abatement.
- Guide enforcement and abatement activities with clear, documented policies and procedures in accordance with statutory and, where applicable, delegation requirements.
- Ensure continuity of essential programs and activities during periods of decreased funding or staffing shortages.
- Tailor education, outreach, and technical assistance related to prevention, mitigation, abatement, and compliance to meet the needs of specific communities or audiences.
- Ensure environmental public health services and coordination efforts address hazards from environmental factors to ensure readiness across communities, particularly for emergency response situations.

### Maternal, child, and family health

- Use data to align and adapt programs and activities.
- Use community input (including service recipients) to inform maternal, child, and family health programs and initiatives.
- Align maternal, child, and family health activities with appropriate statutory requirements.

## Standards for Foundational capabilities

### Accountability and performance management

- Establish a performance management system. (P)
- Implement a performance management system.
- Align performance measures, where appropriate, with relevant local, state, Tribal, and federal strategies.
- Base programs and interventions on the best available evidence. (P)
- Implement quality improvement projects are implemented. (P)

### Assessment and surveillance

- Develop a community health assessment in collaboration with partners and community, using a variety of data from many sources, and including strengths and assets. (P)
- Collect non-surveillance population health data. (P)
- Participate in data sharing with other entities. (P)
- Analyze and use data to draw public health conclusions. (P)
- Maintain surveillance systems. (P)
- Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards. (P)

### Communications

- Implement health communication strategies to encourage actions to promote health. (P)
- Maintain procedures to provide ongoing, nonemergency communication outside the health department. (P)
- Maintain a risk communication plan and a process for urgent 24/7 communications with response partners (P) (outline roles, protocols, and messaging strategies for emergencies and public health threats).

### Community partnership development

- Participate in a community health coalition to promote health equity (convener or participant). (P)
- Train staff on authentically engaging community.
- Maintain ongoing, trust-based relationships with community leaders, beyond crisis events or project-specific outreach.
- Collaborate with other sectors to improve access to social services. (P)
- Implement strategies to remove barriers to community member participation.
- Adopt a community health improvement plan. (P)

### Emergency preparedness and response

- Maintain a public health emergency operations plan (EOP).
- Conduct exercises and use after action reports and improvement plans (AAR-IPs) to improve preparedness and response. (P)
- Using Incident Command System (ICS) language, structure, and guidelines, maintain at least one staff person with readiness, response, and recovery expertise in a leadership position, and includes support activities in position descriptions of additional staff.
- Staff have at a minimum, a basic understanding and training for responding to and recovering from an emergency.
- Ensure operations during response. (P)
- Maintain and implement a process for urgent 24/7 communications with response partners. (P)

### Equity

- Develop a shared understanding amongst staff and community members about the elements driving health and related inequities in their jurisdictions.
- Document mechanism to include health equity and environmental conditions, such as social determinants of health, in planning, program strategy, policy development, staff training, and resource development.
- Manage operational policies, including those related to equity. (P)
- Address factors that contribute to specific populations' higher health risks and poorer health outcomes. (P)

## Organizational competencies

- Adopt a department-wide strategic plan. (P)
- Maintain public health director or supervisor designated to provide oversight of public health functions; ideally this position is full time.
- Ensure the community health services administrator meets requirements under Minn. Stat. § 145A.04, subd. 2 and Minn. R. 4736.0110.
- Support programs and operations through an information management infrastructure (P) (with a built, internal system or through a vendor contract).
- Protect information and data systems through security and confidentiality policies. (P)
- Recruit a qualified and diverse health department workforce. (P)
- Develop and implement a workforce development plan and strategies. (P)
- Provide professional and career development opportunities for staff. (P)
- Have a financial management system.
- Oversee grants and contracts. (P)
- Manage financial systems. (P)
- Access and use legal services in planning, implementing, and enforcing public health initiatives (either through the organization's legal services or through contracted legal counsel). (P)
- At the leadership level, annually discuss and recognize the presence and scope of legal services with the community health board.
- Maintain a human resource function. (P)
- Communicate with governance routinely and on an as-needed basis. (P)

## Policy development and support

- Consistently use community data and assessments to shape policy priorities.
- Examine and contribute to improving policies and laws. (P)
- Conduct enforcement actions. (P)

# Appendix A. Workgroup charge and members

## Charge

The State Community Health Services Advisory Committee (SCHSAC) Foundational Public Health Responsibilities (FPHR) Workgroup will develop for consideration and approval by the full SCHSAC membership a recommendation to the Minnesota Commissioner of Health that includes, but is not limited to, a set of minimum standards* by which full implementation of foundational public health responsibilities (areas and capabilities) can be assessed.

** In this context, the term "standard" means a measure of quality or attainment to deem responsibilities fulfilled.*

The need for a set of minimum standards to assess implementation of foundational public health responsibilities was identified in response to the Minnesota legislature's allocation of new funds to community health boards to fulfill foundational public health responsibilities, and the stipulation that funds can be used for community priorities if a community health board can demonstrate fulfilling foundational public health responsibilities.

These standards will inform the development of a process by which Minnesota Department of Health can determine that foundational public health responsibilities are fully implemented in any given jurisdiction requesting use of funds outside of foundational responsibilities.

Tribes also received funding to fulfill foundational public health responsibilities. SCHSAC does not make recommendations to MDH related to tribes.

## Membership

In alphabetical order:

Odi Akosionu-DeSouza, MDH Health Equity Strategy and Innovation Division
Elizabeth Auch, Countryside Public Health, Southwest Region
Jeff Brown, City of Edina, Metro Region
Sagar Chowdhury, Olmsted County, Southeast Region
Joanne Erspamer, Carlton County (Carlton-Cook-Lake-St. Louis) Northeast Region
David Kurtzon, MDH Health Policy Division
Jody Lien, Otter Tail County (Partnership4Health), West Central Region
Katherine Mackedanz, Todd County (Morrison-Todd-Wadena), Central Region
Gabriel McNeal, Saint Paul-Ramsey County, Metro Region
Mary Navara, MDH Environmental Health Division
Kiza Olson, Meeker-McLeod-Sibley Community Health Services, South Central Region
Commissioner Rodney R. Peterson, Dodge County (Dodge-Steele), SCHSAC
Sarah Reese, Polk County (Polk-Norman-Mahnomen), Northwest Region
Ann Zukoski, MDH Health Promotion and Chronic Disease Division

## Staff and support

Linda Kopecky, MDH Public Health Strategy and Partnership Division
Ann March, MDH Public Health Strategy and Partnership Division

# Appendix B. Responsibility-specific small groups

Small group facilitators: Linda Kopecky and Ann March, MDH Public Health Strategy and Partnership Division

## Foundational areas

### Access to and linkage with clinical care

Sagar Chowdhury, Olmsted County
Alex Dahlquist, MDH Health Promotion and Chronic Disease Division
Bridget Ideker, MDH Health Promotion and Chronic Disease Division
Kayla Jore, Pennington County (Healthy Quin County)
David Kurtzon, MDH Health Policy Division
Tina Peters, MDH Health Policy Division
Richard Scott, Carver County
Ann Zukoski, MDH Health Promotion and Chronic Disease Division

### Chronic disease and injury prevention

Paula Hedlund, Roseau County (Healthy Quin County)
Jody Lien, Otter Tail County (Partnership4Health)
Beatriz Menanteau, MDH Injury Prevention and Mental Health Division
Mary Navara, MDH Environmental Health Division
Jim Peacock, MDH Health Promotion and Chronic Disease Division
Cherylee Sherry, MDH Health Promotion and Chronic Disease Division
Ann Zukoski, MDH Health Promotion and Chronic Disease Division

### Communicable disease control

Elizabeth Auch, Countryside Public Health
Jenny Barta, Carlton County (Carlton-Cook-Lake-St. Louis)
Sagar Chowdhury, Olmsted County
Dawn Huspeni, MDH Infectious Disease Epidemiology, Prevention, and Control Division
Christine Lees, City of Bloomington
Katherine Mackedanz, Todd County (Morrison-Todd-Wadena)

### Environmental public health

Jeff Brown, City of Edina
Sagar Chowdhury, Olmsted County
Andrea Hickle, MDH Health Promotion and Chronic Disease Division
Jody Lien, Otter Tail County (Partnership4Health)
Katherine Mackedanz, Todd County (Morrison-Todd-Wadena)
Mary Navara, MDH Environmental Health Division
Angie Wheeler, MDH Environmental Health Division

### Maternal, child, and family health

Melanie Frazier, MDH Child and Family Health Division
Sarah Henry, MDH Child and Family Health Division

Dana Janowiak, MDH Child and Family Health Division
Katherine Mackedanz, Todd County (Morrison-Todd-Wadena)
Gabriel McNeal, St. Paul-Ramsey County
Commissioner Rodney R. Peterson, Dodge County (Dodge-Steele)

# Foundational capabilities

### Accountability and performance management

Odi Akosionu-DeSouza, MDH Health Equity Strategy and Innovation Division
Emily Becher, MDH Health Improvement and Chronic Disease Division
Ruth Greenslade, Goodhue County
Leah Jesser, MDH Public Health Strategy and Partnership Division
Kelly Nagel, MDH Public Health Strategy and Partnership Division
Kiza Olson, Meeker-McLeod-Sibley Community Health Services
Commissioner Rodney R. Peterson, Dodge County (Dodge-Steele)
Sarah Reese, Polk County (Polk-Norman-Mahnomen)

### Assessment and surveillance

Emily Becher, MDH Health Improvement and Chronic Disease Division
Chris Brueske, MDH Office of Data and Analytics
Karen Martin, MDH Infectious Disease Epidemiology, Prevention, and Control Division
Kiza Olson, Meeker-McLeod-Sibley Community Health Services
Sarah Reese, Polk County (Polk-Norman-Mahnomen)
Meaghan Sherden, Olmsted County
Ann Zukoski, MDH Health Promotion and Chronic Disease Division

### Communications

Murphy Anderson, MDH Public Health Strategy and Partnership Division
Elizabeth Auch, Countryside Public Health
Joanne Erspamer, Carlton County (Carlton-Cook-Lake-St. Louis)
Karen Grasmon, MDH Communications Office
Gabriel McNeal, St. Paul-Ramsey County
Bridget Pouladian, MDH Health Equity Strategy and Innovation Division
Sarah Reese, Polk County (Polk-Norman-Mahnomen)
Allison Thrash, MDH Communications Office

### Community partnership development

Odi Akosionu-DeSouza, MDH Health Equity Strategy and Innovation Division
Joanne Erspamer, Carlton County (Carlton-Cook-Lake-St. Louis)
David Kurtzon, MDH Health Policy Division
Katherine Mackedanz, Todd County (Morrison-Todd-Wadena)
Gabriel McNeal, St. Paul-Ramsey County
Andrea Mills, Countryside Public Health
Anna Oldenberg, Olmsted County

### Emergency preparedness and response

Dave Brummel, Washington County
Sagar Chowdhury, Olmsted County
Joanne Erspamer, Carlton County (Carlton-Cook-Lake-St. Louis)
Sandra Hanson, MDH Emergency Preparedness and Response Division
Mary Navara, MDH Environmental Health Division
Cheryl Petersen-Kroeber, MDH Emergency Preparedness and Response Division
Mickey Scullard, MDH Emergency Preparedness and Response Division

### Equity

Odi Akosionu-DeSouza, MDH Health Equity Strategy and Innovation Division
Jeff Brown, City of Edina
TC Duong, MDH Office of Diversity, Inclusion, Belonging, and Equity Strategy
Michelle Ebbers, Des Moines Valley Health and Human Services
David Kurtzon, MDH Health Policy Division
Gabriel McNeal, St. Paul-Ramsey County
Wynfred Russell, Anoka County
Shor Salkas, MDH Office of Diversity, Inclusion, Belonging, and Equity Strategy

### Organizational competencies

Elizabeth Auch, Countryside Public Health
Arin Babakhani, City of Bloomington
Joanne Erspamer, Carlton County (Carlton-Cook-Lake-St. Louis)
Leah Jesser, MDH Public Health Strategy and Partnership Division
Jody Lien, Otter Tail County (Partnership4Health)
Commissioner Rodney R. Peterson, Dodge County (Dodge-Steele)

### Policy development and support

Odi Akosionu-DeSouza, MDH Health Equity Strategy and Innovation Division
Jeff Brown, City of Edina
Kate Erickson, MDH Health Promotion and Chronic Disease Division
Kiona Hermanson, Countryside Public Health
Kiza Olson, Meeker-McLeod-Sibley Community Health Services
Nicole Ruhoff, Sherburne County
Pa Houa Shasky, St. Paul-Ramsey County