DEPARTMENT OF HEALTH

State Community Health Services Advisory Committee

Building a Strong Foundation for Health from Border to Border

FINAL REPORT OF THE SCHSAC FOUNDATIONAL PUBLIC HEALTH RESPONSIBILITIES FUNDING WORKGROUP

November 2023

Building a Strong Foundation for Health from Border to Border: Final Report of the SCHSAC Foundational Public Health Responsibilities Funding Workgroup

Minnesota Department of Health
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CONTENTS

State Community Health Services Advisory Committee

December 14, 2023

Commissioner Brooke Cunningham
Minnesota Department of Health
P.O. Box 64975
St. Paul, MN 55164-0975

Dear Commissioner Cunningham:

On behalf of Minnesota's State Community Health Services Advisory Committee (SCHSAC), I am pleased to present to you the final report of our Foundational Public Health Responsibilities Funding Workgroup. SCHSAC members approved this report and recommendations at our meeting on December 6, 2023.

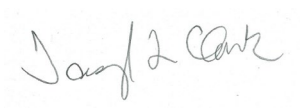
In 2023, the Minnesota legislature allocated funding for community health boards to fulfill foundational public health responsibilities and required MDH to consult with SCHSAC on the distribution of these funds. This workgroup was created to carry out that consultation process, including the development of a recommended funding formula, a method for incorporating equity into the formula, definitions for foundational public health responsibilities, and other recommendations related to the distribution of these funds.

Workgroup members included representatives from SCHSAC, local public health and MDH. They met numerous times, considered needs throughout Minnesota and demonstrated thoughtfulness in their approach. I am grateful for their commitment and for the leadership of co-chairs De Malterer (SCHSAC Vice Chair) and Nick Kelley (LPHA Chair-Elect) as well as the skillful facilitation of MDH's own Phyllis Brashler.

This report outlines the workgroup's approach and recommendations adopted by SCHSAC. I am especially proud of how the workgroup grounded their decisions in philosophical principles that reflect the needs of Minnesota's public health system as a whole and the importance of improving health equity. These guiding principles will set the stage for long-term success.

I truly believe these recommendations help Minnesota take the first steps toward a more seamless, responsive, and publicly supported public health system. On behalf of SCHSAC, I request your acceptance and approval of this report and the recommendations expressed therein.

Sincerely,



Tarryl Clark, SCHSAC Chair
Stearns County Commissioner

State Community Health Services Advisory Committee
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 14, 2023

Commissioner Tarryl Clark, Chair
State Community Health Services Advisory Committee (SCHSAC)
705 Courthouse Square
St. Cloud, MN 56303

Dear Chair Clark,

Thank you for your report and recommendations from the SCHSAC Foundational Public Health Responsibilities Funding Workgroup. I am proud of the success of the partnership in securing additional funding for community health boards and tribal governments to implement foundational public health responsibilities and transform the public health system for the future.

I appreciate the diligent and hard work in developing a set of guiding principles, recommendations and formula that incorporate the need to provide a base of funding for all CHBs, recognizes that some CHBs may need additional capacity, and acknowledges the need to address equity through this funding. These discussions are never easy, and the workgroup represented different perspectives to come to the best solution.

I accept your recommendations for the funding formula and other recommendations related to the implementation of this funding. I know that this is new funding and will take some time to establish a solid implementation and reporting mechanism. I look forward to hearing about the progress being made by CHBs and welcome adjustment over time as the CHBs begin their work.

Public health is changing, and I look forward to working in partnership with SCHSAC to prepare for and guide this change. I look forward to working with you and SCHSAC as the recommended next steps are implemented. Thank you for your excellent work.

Sincerely,

Brooke Cunningham, MD, PhD, Commissioner
Minnesota Department of Health

Background and workgroup charge

In 2023, the Minnesota legislature allocated $9,844,000 per year, as part of the state's base budget, for community health boards to fulfill Foundational Public Health Responsibilities (https://www.health.state.mn.us/communities/practice/systemtransformation/foundationalresponsibilities.html) (see Appendix B: Legislative language and Appendix E: Foundational public health responsibilities in this document).[1] The legislation requires MDH to consult with the State Community Health Services Advisory Committee (SCHSAC) on the distribution of these funds. To meet this requirement, SCHSAC created the Foundational Public Health Responsibilities (FPHR) Funding Workgroup to develop, for consideration and approval by the full SCHSAC, a set of recommendations to the Commissioner of Health that includes:

- A funding formula to determine allocations to community health boards for funding to implement foundational public health responsibilities;
- A method for incorporating equity into the funding formula;
- Considerations for reporting and accountability mechanisms for this funding; and
- Other recommendations related to these funds as needed.

The workgroup did not provide recommendations related to funds for tribal governments.

Workgroup membership included people with different perspectives and experiences within Minnesota's state and local governmental public health system, including the Local Public Health Association (LPHA), SCHSAC, and Minnesota Department of Health (MDH).

- Local public health representatives were elected by LPHA regional directors' groups.
- SCHSAC appointed four elected officials to participate.
- MDH had one voting member and contributed staff time to support workgroup facilitation and logistics.

The workgroup was co-chaired by a representative from SCHSAC and LPHA (De Malterer, commissioner, Waseca County and SCHSAC vice-chair; and Nick Kelley, public health administrator, City of Bloomington, and LPHA chair-elect). The workgroup was supported by staff from the MDH Center for Public Health Practice. Effort was made to ensure representation from different types of local public health governance and organizational structures.

The workgroup co-chairs and staff made every effort to ensure a rigorous, transparent, and participatory process to achieve the recommendations outlined in this report. Over the course of eight meetings, workgroup members represented their regions and/or their peers (e.g., local elected officials) and served as liaisons between the group they represented and the workgroup. Local public health representatives brought workgroup updates back to their respective regions and collected input to the workgroup to help members hear and understand the perspectives of all regions of the state. Local elected officials brought workgroup discussions to the SCHSAC Executive Committee and contacted peers throughout the workgroup's process to solicit input.

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[1] Minnesota Legislature. (2023). *Health and human services omnibus bill SF 2995*. Retrieved from https://www.revisor.mn.gov/bills/text.php?number=SF2995&version=0&session=ls93.0&session_year=2023&session_number=0&type=ccr
Statutory language: line 238.28 to 239.26; appropriation language: Line 812.19.

A list of workgroup members is included in Appendix A: Workgroup charge and membership in this document. Meeting summaries are available at Standing and Active SCHSAC Workgroups (https://www.health.state.mn.us/communities/practice/schsac/workgroups.html).

What would success look like?

At the first workgroup meeting August 10, 2023, members were asked, "What could a successful funding formula achieve for your jurisdiction, for your region, and for our statewide public health system?" A summary of those perspectives is shared in **Figure A** below.

Figure A: What could a successful funding formula achieve?

Guiding principles

The workgroup recognized the significance of their charge and created shared principles to guide this work. These principles are:

- Every community health board should get enough funding to be able to make meaningful progress on foundational public health responsibilities.
- The funding formula should take into account that not everyone has the same opportunity to be healthy across our state.
- The funding formula should help alleviate variation in capacity across our system.

Recommendations

In accordance with its charge, the workgroup developed recommendations related to a funding formula for distributing these funds and provided additional guidance for implementation, including recommendations related to community health board reporting and future actions that will be needed to manage these funds effectively over time.

Recommended funding formula

Recommendation: Foundational public health responsibility funds should be distributed through a formula that includes base funding for all community health boards, an allocation based on social vulnerability, and an allocation to alleviate variation in capacity across Minnesota's public health system.

In accordance with its guiding principles, the workgroup recommends that MDH distribute foundational public health responsibility funds according to the following formula:

- 59.6% to base funding for all community health boards ($115,000 per community health board)
- 24.3% according to the social vulnerability of the community health board
- 16.2% to community health boards serving fewer than 100,000 people

After allocating most of the funding to base funding for all community health boards, 60% of the remaining funds should be allocated based on the jurisdiction's social vulnerability rating, and 40% of the remaining funds should help alleviate the variation in capacity across Minnesota's public health system, resulting in the final overall percentages of 59.6% to base funding, 24.3% according to social vulnerability of the jurisdiction, and 16.2% to lower capacity community health boards.

- The workgroup recommends that MDH use the CDC/ATSDR Social Vulnerability Index (SVI) to help target funds to the most vulnerable communities in Minnesota. SVI includes a broad set of indicators and correlates strongly with other equity metrics. It is available and easily applicable statewide. This recommendation also assures alignment with other funding formulas that use SVI. See Appendix C: Social Vulnerability Index (SVI) and community health board SVI categories in this document for more information about the indicators that are included in this index.
- Following the findings in the Minnesota Public Health Cost and Capacity Assessment Summative Report (https://www.health.state.mn.us/communities/practice/systemtransformation/docs/202310costcapacity-memoreport-reduced.pdf), the workgroup recommends that the funds remaining after base funding and SVI funding are allocated be distributed to community health boards serving fewer than 100,000 people. The University of Minnesota found that health departments serving fewer than 100,000 people have less capacity than those serving more than 100,000 people. The workgroup recognizes that this metric isn't as nuanced as they would like, but it is the best available right now. An additional recommendation follows regarding updating this metric when better information is available.

Funding estimates and methodologies are included in Appendix D: Funding estimates in this document. If the number of community health boards changes before a future workgroup convenes to reconsider the recommendations in this report, MDH should maintain these percentages when allocating funds.

The workgroup seriously considered including a multi-county collaboration incentive in the formula. After a robust discussion about the purpose and function of multi-county community health boards in Minnesota's public health system, the workgroup voted against including a specific multi-county variable in the recommended funding formula. The workgroup concluded:

- A multi-county collaboration incentive did not align with the workgroup's guiding principles.
- A multi-county incentive will not make a meaningful difference in the public health system's ability to fill in the patchwork of capacity. The workgroup believes a large base will make a more meaningful difference.

- Breaking up small amounts of money even further is not in the interest of small health departments. Money alone does not incentivize collaboration.
- There are other funding sources available to foster multi-county and cross-jurisdictional collaboration, including the Minnesota Public Health Infrastructure Fund, and no funding source discourages collaboration across jurisdictions.

The workgroup often talked about the challenge of making recommendations during a time of system transformation. This was especially felt in the discussion about a potential multi-county incentive. The role, structure, and function of community health boards varies across Minnesota's public health system. Ultimately, the workgroup decided to take advantage of the opportunity these new funds presented to do things differently than they have been done in the past.

Recommendations for implementation

The statutory language for these funds requires that they be used for foundational public health responsibilities as defined by the Commissioner of Health in consultation with SCHSAC. In addition, the language allows community health boards to use these funds for community health priorities identified through the community health assessment and improvement planning process if they can demonstrate that foundational public health responsibilities are fully implemented in their jurisdictions.

The workgroup discussed both provisions, and recommends the following:

Recommendation: For the purposes of these funds, MDH should use definitions developed for the national Framework for Foundational Public Health Services (https://phaboard.org/wp-content/uploads/FPHS-Factsheet-2022.pdf). See Appendix E: Foundational public health responsibilities in this document.

- 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 the following criteria:
  - Services that are mandated by federal or state laws;
  - Services for which the governmental public health system is the only or primary provider of the service, statewide; and
  - Population-based services (versus individual services) that are 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 the more familiar topic-specific public health programs or services aimed at improving the health of a population.
- The workgroup reviewed materials developed by the Public Health Accreditation Board's Center for Innovation and agreed that their definitions are sufficient to help people understand, at a high level, the areas and capabilities.

- Specific questions about how funds can or cannot be used will be addressed through grant guidance and supporting resources that will be developed as MDH creates the internal infrastructure to support these funds.

Recommendation: Community health boards should not be allowed to use these funds for community health priorities until SCHSAC has adopted a set of minimum standards for foundational public health responsibility implementation.

According to the Minnesota Public Health Cost and Capacity Assessment Summative Report (https://www.health.state.mn.us/communities/practice/systemtransformation/docs/202310costcapacity-memoreport-reduced.pdf), no health departments report full implementation of foundational public health responsibilities in their jurisdictions. In the near term, every community health board should use these funds for foundational public health responsibilities until they can demonstrate that those responsibilities are fully implemented in their community health board.

Recommendation: The FPHR Funding Workgroup recommends that SCHSAC create a workgroup to establish these standards and inform the development of a process by which MDH can determine that foundational public health responsibilities are fully implemented in any given jurisdiction.

Minnesota lacks a set of standards by which to assess full implementation. More work is needed to develop clear standards and inform the development of a process to assure foundational public health responsibilities are fully implemented before funds can be used for local community health priorities. A new workgroup should be created to develop these standards in partnership between MDH, SCHSAC, and local public health leaders.

Recommendations for reporting

This workgroup also developed recommendations to aid MDH in developing a process for community health board reporting on these funds. Workgroup members were asked to consider legislative needs, community health board needs, and MDH needs. Through this discussion, the workgroup created the following recommendations:

Reporting should:

- **Gather stories of impact**. Stories about the impact of this funding should be a key part of the reporting to show the impact on Minnesotans as the system builds capacity.
- **Show that funds are used for foundational public health responsibilities**. To be good stewards of public dollars, MDH needs to be able to demonstrate that the funds are being used as intended by the legislature.
- **Be able to show trends over time**. The purpose of these funds is to build a solid foundation for health from border to border. A reporting process should allow MDH, SCHSAC, and LPHA to monitor trends over time, while also recognizing that it will take time to demonstrate long-term impact.
- **Support a culture of learning**. Information collected from community health boards should be collected in the spirit of learning and development about implementing foundational public health responsibilities and help community health boards learn from each other.

- **Only collect data that will be used**. MDH should keep in mind the growing administrative burden of additional funding for community health boards and make every effort to limit reporting burden for these funds.
- **Be streamlined and simple**. MDH should leverage existing reporting processes already in place to simplify the reporting process for these funds. Reporting for these funds should align with Local Public Health Act annual reporting to the best extent possible.
- **Have clear expectations and instructions**. MDH should support reporting processes with clear expectations, definitions, and instructions.

Recommendation: MDH should work with the SCHSAC Performance Measure Workgroup to align Local Public Health Act annual reporting with the Foundational Public Health Responsibilities to monitor improvement in Minnesota's ability to implement foundational public health responsibilities.

The workgroup recognizes the important work of the SCHSAC Performance Measurement Workgroup, whose purpose is to monitor the performance of Minnesota's statewide public health system. Foundational public health responsibility funding will impact system performance, and as a result, the workgroup sees a need for coordination and alignment between these efforts.

Additional recommendations

The workgroup acknowledges that these recommendations have been developed at a specific point in time in Minnesota's journey to create a solid foundation for health from border to border. Moreover, building a solid foundation for health will not be achieved in one or two years, but over time. The conditions in which SCHSAC, MDH, and LPHA are working together to build a seamless, responsive, publicly supported public health system will continue to develop and evolve.

To that end, the workgroup shares the following recommendations to help guide the path forward as conditions change over time.

A funding workgroup should be reconvened at the request of SCHSAC when there are:

1. Substantial additional investments in public health infrastructure and/or foundational public health responsibilities;
2. Significant changes or developments that affects the distribution or implementation of these funds, including, but no limited to, the development of standards to assess full implementation of foundational public health responsibilities; or
3. Significant progress is made in the system's ability to fulfill foundational public health responsibilities.
4. If none of the conditions above apply, SCHSAC should reconvene a workgroup in four years to affirm or update these recommendations.

When SCHSAC convenes the next funding workgroup, that group should:

- Prioritize funding stability and avoid decreases in funding for individual community health boards;
- Start with the guiding principles developed by this workgroup; and
- Consider options for a more precise capacity metric based on new information and data.

Conclusion

The SCHSAC FPHR Funding Workgroup thoughtfully and enthusiastically presents these recommendations to SCHSAC for their approval and submission to the Minnesota Commissioner of Health. Together, this workgroup discussed difficult and sensitive issues that affect Minnesota's public health system. Throughout the process, we prioritized the best interest of Minnesota's statewide public health system over the needs of any single community health board or region. These recommendations have the full support of workgroup members. We feel honored to have had this opportunity, and humbly submit these recommendations as the starting point for building a strong statewide public health system that works for everyone in Minnesota.

Appendix A: Workgroup charge and membership

The Foundational Public Health Responsibilities (FPHR) Funding Workgroup will develop for consideration and approval by the full State Community Health Services Advisory Committee (SCHSAC) a set of recommendations to the Commissioner of Health that includes, but is not limited to:

- A funding formula that would determine allocations to community health boards for funding to implement foundational public health responsibilities;
- A method for incorporating equity into the funding formula;
- Reporting and accountability mechanisms for this funding.

The workgroup will align its efforts with relevant Foundational Public Health Responsibilities framework discussions and decisions. It will not provide recommendations related to funds for Tribal governments.

Background

In 2023, the Minnesota legislature allocated $9,844,000 for community health boards to fulfill Foundational Public Health Responsibilities (https://www.health.state.mn.us/communities/practice/systemtransformation/foundationalresponsibilities.html).[2]

The statutory language states that these funds:

- Must be used to fulfill foundational public health responsibilities as defined by the commissioner in consultation with SCHSAC.
- Will be distributed based on a formula determined by the Commissioner in consultation with SCHSAC.

This workgroup fulfills the consultation components of the authorizing language.

If a community health board can demonstrate foundational public health responsibilities are fulfilled, the board may use funds for local priorities developed through the community health assessment and community health improvement planning process.

The Minnesota legislature also allocated funds Tribal governments for foundational public health responsibilities as defined by each Tribal government.

Methods and member commitments

Approach

The workgroup will carry out its charge by reviewing relevant materials (including existing funding formulas in Minnesota and elsewhere, as appropriate) and engaging in discussion and collaborative decision-making grounded in shared values. The workgroup will engage people with different

[2] Minnesota Legislature. (2023). *Health and human services omnibus bill SF 2995*. Retrieved from https://www.revisor.mn.gov/bills/text.php?number=SF2995&version=0&session=ls93.0&session_year=2023&session_number=0&type=ccr
Statutory language: line 238.28 to 239.26; appropriation language: Line 812.19.

perspectives and experience within Minnesota's governmental public health system, including the Local Public Health Association (LPHA), SCHSAC, and Minnesota Department of Health (MDH).

- LPHA representatives will include CHS administrator or local health director from each of the seven LPHA regions.
- SCHSAC will identify at least four elected officials to participate.
- MDH will have one voting member and will contribute staff time to support workgroup facilitation and logistics.

The workgroup will be limited in size to 15 members to support success in fulfilling its charge and will be co-chaired by an elected official and a local health director from two different community health boards. Every effort will be made to assure representation from different types of local public health governance and organizational structures.

Workgroup meetings and time commitment

MDH staff to the workgroup understand the existing demands on workgroup members' time and will endeavor to strike a balance between meaningful, generative discussion and efficiency in decision-making.

- MDH will facilitate four to six virtual meetings between July and October 2023.
- Meetings will be scheduled for 1.5 to two hours in length.
- Workgroup members may occasionally need 30 minutes between meetings to review materials.
- MDH staff will consult with workgroup co-chairs before each meeting, for a total of approximately two to four additional hours for co-chairs.
- The total estimated time commitment for workgroup members is approximately eight to 15 hours over the course of four months; for workgroup co-chairs, approximately 10-20 hours over four months.

Member expectations

- Active participation in discussion
- Communicate with represented entities to share information and gather input as needed (SCHSAC, LPHA, MDH)
- Follow SCHSAC's Three Simple Rules of the State-Local Partnership:
  - Seek first to understand
  - Make expectations explicit
  - Think about the part and the whole
- Communicate questions or concerns with workgroup staff (see below)

Workgroup membership

Workgroup co-chairs

- Nick Kelley, Public Health Administrator, City of Bloomington, and LPHA Chair-Elect (nkelley@bloomingtonMN.gov)
- De Malterer, Commissioner, Waseca County, and SCHSAC Vice-Chair (de.malterer@co.waseca.mn.us)

Workgroup members

- Bree Allen, Southwest/South Central LPHA, Brown Nicollet Community Health Board (Jaimee Brand, Brown Nicollet Community Health Board, alternate)
- Amy Evans, Southeast LPHA, Dodge-Steele Community Health Board
- Laurie Halverson, Commissioner, Dakota County
- Marissa Hetland, Northwest LPHA, North Country Community Health Board
- Chelsie Huntley, Community Health Division Director, Minnesota Department of Health
- Joan Lee, Commissioner, Polk County
- Dave Lieser, Commissioner, Chippewa County, Countryside Community Health Board
- Samantha Lo, Central LPHA, Pine Community Health Board
- Susan Michels, Northeast LPHA, Carlton Cook Lake St. Louis Community Health Board
- Susan Palchick, Metro LPHA, Hennepin County Public Health
- Ann Stehn, West Central LPHA, Horizon Public Health

MDH staff lead

- Phyllis Brashler, Supervisor, Center for Public Health Practice (phyllis.brashler@state.mn.us)

Appendix B: Legislative language

Funding was allocated from the Minnesota legislature during the 2023 legislative session to support local public health and tribes in fulfilling the foundational public health responsibilities. The legislature allocated $9,844,000 for community health boards and $535,000 for Tribes. This is ongoing funding.

The foundational public health responsibilities funding is amended language to the current Local Public Health Grant legislation (Minn. Stat. § 145A.131 [https://www.revisor.mn.gov/statutes/cite/145A.131]). The legislature made three revisions to the statute:

- Under Subdivision 1: **Funding formula for community health board**, the following language was added:

  (f) Funding for foundational public health responsibilities must be distributed based on a formula determined by the commissioner in consultation with the State Community Health Services Advisory Committee. These funds must be used as described in subdivision 5.

- Under Subdivision 2: **Local match**, the following change was made:

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

- Under Subdivision 5: **Use of funds**, the following change was made:

  (a) Community health boards may use the base funding of their local public health grant funds as described in subdivision 1, paragraphs (a) to (e), to address the areas of public health responsibility and local priorities developed through the community health assessment and community health improvement planning process.

  (b) Except as otherwise provided in this paragraph, funding for foundational public health responsibilities as described in subdivision 1, paragraph (f), must be used to fulfill foundational public health responsibilities as defined by the commissioner in consultation with the state community health service advisory committee. If a community health board can demonstrate foundational public health responsibilities are fulfilled, the board may use funds for local priorities developed through the community health assessment and community health improvement planning process.

Required match

As stated in the revised Local Public Health Grant legislation, community health boards must match the new foundational public health responsibilities funding as they do the current Local Public Health Grant. Sources of the match are the same is the Local Public Health Grant as outlined in statute:

(b) Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other local funds, and donations or nonfederal grants that are used for community health services described in Minn. Stat. § 145A.02, subd. 6 (https://www.revisor.mn.gov/statutes/cite/145A.02#stat.145A.02.6).

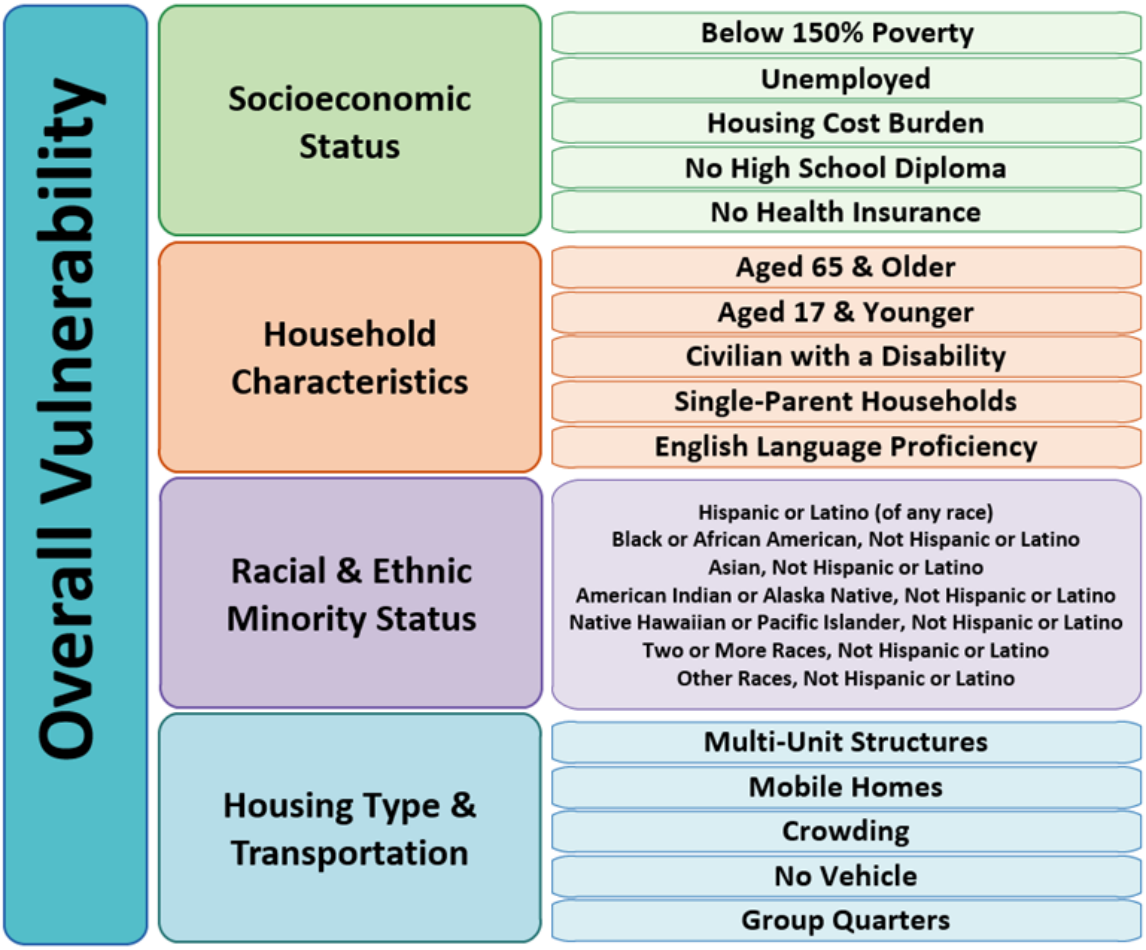
Appendix C: Social Vulnerability Index (SVI) and community health board SVI categories

The workgroup recommends using a metric called the CDC/ATSDR Social Vulnerability Index (SVI) to help direct resources to the most vulnerable communities in Minnesota. It has a straightforward computation, incorporates a broad and inclusive set of indicators, and correlates strongly with other measures. It has been used in Minnesota's COVID-19 response and is also used in other funding formulas. For the workgroup's purpose, it is most important that an index be available at the county level; have ongoing support for future use; that it has logical components in the index; that the scoring can be clearly understood; and that the scores generally align with what we know to be true about Minnesota based on our experience.

The SVI uses data from sixteen social factors based on census data to create a composite vulnerability measure. The social factors included in the measure are depicted below (**Figure B**).

Figure B: Social factors included in the Social Vulnerability Index

American Community Survey (ACS), 2016-2020 (5-year) data for the following estimates:



For the purposes of the recommended funding formula, SVI scores were obtained from CDC/ATSDR Social Vulnerability Index (SVI) (https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html). The most current data for this is 2020. Each county and Census tract is assigned an SVI score, ranging from 0 to 1. These scores are derived from ranking within Minnesota across 16 Census variables. For funding score, SVI scores were converted into quartiles for cutoffs for each funding score. Community health boards receive their score's portion of the overall SVI funding. This is consistent with the scoring used previous for Public Health Emergency Preparedness funding and for the new state emergency preparedness funding. Multi-county community health boards were assigned the highest SVI score of any county in their community health board because they must serve the highest-risk SVI areas in their respective community health board.

Table C. Social Vulnerability Index ranking, quartiles, and scores

Ranking	Quartile	Score
0 - 0.25	Low	20
0.2501 - 0.50	Low to medium	40
0.5001 - 0.75	Medium to high	60
0.7501 - 1.0	High	80

For the four city-based community health boards (Bloomington, Edina, Minneapolis, and Richfield), rankings by Census tract were recorded and each city was given an SVI score for the highest-ranking Census tract within city boundaries. Hennepin County was given the SVI score for the highest-ranking Census tract outside city lines for Bloomington, Edina, Minneapolis, and Richfield. Census tracts that cross city lines were excluded from this analysis. This process provided consistency with multi-county community health boards, as both types of entities serve the most vulnerable areas within their purview.

Appendix D: Funding estimates

The table below provides funding estimates for community health boards. Current SVI rankings and associated SVI scores for community health boards will be posted on the MDH Center for Public Health Practice website. **Please note: all funding amounts are estimates only and will be refined prior to distribution of any funding**. Specific funding amounts may vary over time as community health boards move above or below 100,000 population served and as the number of community health boards changes.

Table D. Funding estimates

	Base	Capacity	SVI	Total
Under 100,000 population				
SVI 20	$115,000	$41,884	$15,916	$172,800
SVI 40	$115,000	$41,884	$31,832	$188,716
SVI 60	$115,000	$41,884	$47,784	$204,632
SVI 80	$115,000	$41,884	$63,664	$220,548
Over 100,000 population				
SVI 20	$115,000	$0	$15,916	$130,916
SVI 40	$115,000	$0	$31,832	$146,832
SVI 60	$115,000	$0	$47,784	$162,748
SVI 80	$115,000	$0	$63,664	$178,664

Appendix E: Foundational public health responsibilities

The workgroup recommends using the definitions associated with the national Framework for Foundational Public Health Services to define foundational public health responsibilities for the purpose of this funding.

Refer to the following pages for the list and definitions. This document is also located online: Foundational Public Health Services (https://phaboard.org/wp-content/uploads/FPHS-Factsheet-2022.pdf).

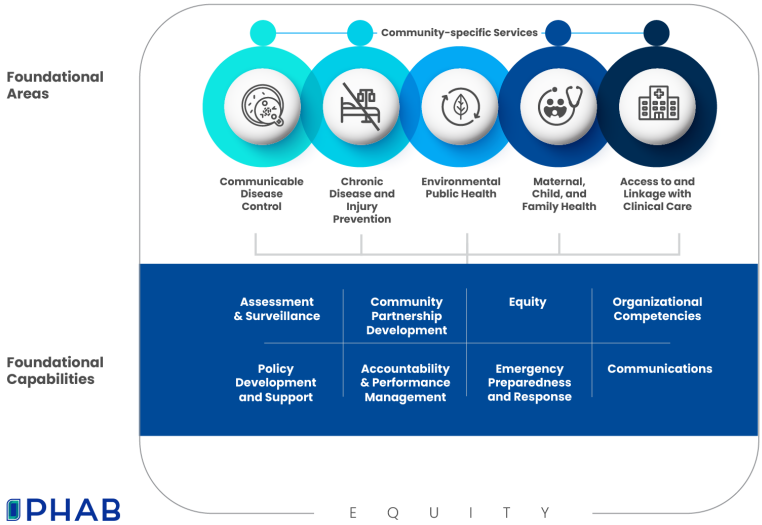
Foundational Public Health Services

Health departments have a fundamental responsibility to provide public health protections and services in a number of areas, including: preventing the spread of communicable disease; ensuring food, air, and water quality are safe; supporting maternal and child health; improving access to clinical care services; and preventing chronic disease and injury. In addition, public health departments provide local protections and services specific to their community's needs.

Health departments serve their communities 24/7 and require access to a wide range of critical data sources, robust laboratory capacity, preparedness and policy planning capacity, partnerships with community, and expert staff to leverage them in support of public health protections.

The Foundational Public Health Services framework outlines the unique responsibilities of governmental public health and defines a minimum set of Foundational Capabilities and Foundational Areas that must be available in every community.

Foundational Public Health Services Framework



Community-specific Services are 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 jurisdiction.

Foundational Areas

Public health programs, or Foundational Areas, are basic public health, topic-specific programs and services aimed at improving the health of the community. The Foundational Areas reflect the minimum level of service that should be available in all communities.

Foundational Capabilities

Public health infrastructure consists of Foundational Capabilities that are the cross-cutting skills and capacities needed to support basic public health protections, programs, and activities key to ensuring community health, well-being and achieving equitable outcomes.

Foundational Capabilities

There are eight Foundational Capabilities that are needed in Public Health Infrastructure.

Assessment & Surveillance

- Ability to collect timely and sufficient foundational data to guide public health planning and decision making at the state and local level, including the personnel and technology that enable collection.
- Ability to collect, access, analyze, interpret, and use data from a variety of sources including granular data and data disaggregated by geography (e.g., census tract, zip code), sub-populations, race, ethnicity, and other variables that fully describe the health and well-being of a community and the factors that influence health.
- Ability to assess and analyze disparities and inequities in the distribution of disease and social determinants of health, that contribute to higher health risks and poorer health outcomes.
- Ability to prioritize and respond to data requests and translate data into information and reports that are valid, complete, statistically accurate, and accessible to the intended audiences.
- Ability to conduct a collaborative community or statewide health assessment and identify health priorities arising from that assessment, including analysis of root causes of health disparities and inequities.
- Ability to access 24/7 laboratory resources capable of providing rapid detection.
- Ability to participate in or support surveillance systems to rapidly detect emerging health issues and threats.
- Ability to work with community partners to collect, report and use public health data that is relevant to communities experiencing health inequities or ability to support community-led data processes.

Community Partnership Development

- Ability to create, convene, support, and sustain strategic, non-program specific relationships with key community groups or organizations 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.
- Ability to leverage and engage partnerships and community in equity solutions.
- Ability to establish and maintain trust with and authentically engage community members and populations most impacted by inequities in key public health decision-making and use community-driven approaches.
- Ability to convene across governmental agencies, such as departments of transportation, aging, substance abuse/mental health, education, planning and development, or others, to promote health, prevent disease, and protect community members of the health department's jurisdiction.
- Ability to engage members of the community and multi-sector partners in a community health improvement process that draws from community health assessment data and establishes a plan for addressing priorities. The community health improvement plan can serve as the basis for coordination of effort and resources across partners.

Equity

- Ability to strategically address social and structural determinants of health through policy, programs, and services as a necessary pathway to achieve equity.
- Ability to systematically integrate equity into each aspect of the FPHS, strategic priorities, and include equity-related accountability metrics into all programs and services.
- Ability to work collaboratively across the department and the community to build support for and foster a shared understanding of the critical importance of equity to achieve community health and well-being.
- Ability to develop and support staff to address equity.
- Ability to create a shared understanding of what creates health including structural and systemic factors that produce and reproduce inequities.

Organizational Competencies

- **Leadership & Governance:** Ability to lead internal and external stakeholders to consensus, with movement to action, and to serve as the face of governmental public health in the department's jurisdiction. Ability to directly engage in health policy development, discussion, and adoption with local, state, and national policymakers, and to define a strategic direction for public health initiatives, including the advancement of equity. Ability to prioritize and implement diversity, equity, and inclusion within the organization. Ability to engage with appropriate governing entities about the department's public health legal authorities and what new laws and policies might be needed. Ability to ensure diverse representation on public health boards and councils.
- **Information Technology Services, including Privacy & Security:** Ability to maintain and procure the hardware and software needed to access electronic health information to support the department's operations and analysis of health data. Ability to support, use, and maintain communication technologies and systems needed to interact with community members. Ability to have the proper systems and controls in place to keep health and human resources data confidential and maintain security of IT systems.
- **Workforce Development & Human Resources:** Ability to develop and maintain a diverse and inclusive workforce with the cross-cutting skills and competencies needed to implement the FPHS effectively and equitably. Ability to manage human resource functions including recruitment, retention, and succession planning; training; and performance review and accountability.
- **Financial Management, Contract, & Procurement Services, including Facilities and Operations:** Ability to establish a budgeting, auditing, billing, and financial system and chart of expense and revenue accounts in compliance with federal, state, and local standards and policies. Ability to secure grants or other funding (governmental and not) and demonstrate compliance with an audit required for the sources of funding utilized. Ability to procure, maintain, and manage safe facilities and efficient operations. Ability to leverage funding and ensure resources are allocated to address equity and social determinants of health.
- **Legal Services & Analysis:** Ability to access and appropriately use legal services in planning, implementing, and enforcing, public health initiatives, including relevant administrative rules and due process

Policy Development and Support

- Ability to serve as a primary and expert resource for establishing, maintaining, and developing basic public health policy recommendations that are evidence-based and grounded in law. This includes researching, analyzing, costing out, and articulating the impact of such policies and rules where appropriate, as well as the ability to organize support for these policies and rules and place them before an entity with the legal authority to adopt them.
- Ability to effectively inform and influence policies being considered by other governmental and non-governmental agencies that can improve the physical, environmental, social, and economic conditions affecting health but are beyond the immediate scope or authority of the governmental public health department.
- Ability to effectively advocate for policies that address social determinants of health, health disparities and equity.
- Ability to issue, promote compliance with or, as mandated, enforce compliance with public health regulations.

Accountability & Performance Management

- Ability to perform according to accepted business standards in accordance with applicable federal, state, and local laws and policies and assure compliance with national and Public Health Accreditation Board Standards.
- Ability to maintain a performance management system to monitor achievement of organizational objectives.
- Ability to identify and use evidence-based or promising practices when implementing new or revised processes, programs and/or interventions.
- Ability to maintain an organization-wide culture of quality and to use quality improvement tools and methods.
- Ability to create accountability structures and internal and external equity-related metrics to measure the equity impact of a department's efforts and performance.

Emergency Preparedness and Response

- Ability to develop, exercise, and maintain preparedness and response strategies and plans, in accordance with established guidelines, and to address a range of events including natural or other disasters, communicable disease outbreaks, environmental emergencies, or other events, which may be acute or occur over time.
- Ability to integrate social determinants of health, and actions to address inequities, including ensuring the protection of high-risk populations, into all plans, programs, and services.
- Ability to lead the Emergency Support Function 8 — Public Health & Medical for the county, region, jurisdiction, and state.
- Ability to activate the emergency response personnel and communications systems in the event of a public health crisis; coordinate with federal, state, and local emergency managers and other first responders, and private sector and non-profit partners; and operate within, and as necessary lead, the incident management system.
- Ability to maintain and execute a continuity of operations plan that includes a plan to access financial resources to execute an emergency and recovery response.
- Ability to establish and promote basic, ongoing community readiness, resilience, and preparedness by enabling the public to take necessary action before, during, or after a disaster, emergency, or public health event.
- Ability to issue and enforce emergency health orders.
- Ability to be notified of and respond to events on a 24/7 basis.
- Ability to access and utilize a Laboratory Response Network (LRN) Reference laboratory for biological agents and an LRN chemical laboratory at a level designated by CDC.

Communications

- Ability to maintain ongoing relations with local and statewide media including the ability to write a press release, conduct a press conference, and use electronic communication tools to interact with the media.
- Ability to effectively use social media to communicate directly with community members.
- Ability to appropriately tailor communications and communications mechanisms for various audiences.
- Ability to write and implement a routine communications plan and develop routine public health communications including to reach communities not traditionally reached through public health channels.
- Ability to develop and implement a risk communication strategy for communicating with the public during a public health crisis or emergency. This includes the ability to provide accurate and timely information and to address misconceptions and misinformation, and to assure information is accessible to and appropriate for all audiences.
- Ability to transmit and receive routine communications to and from the public in an appropriate, timely, and accurate manner, on a 24/7 basis.
- Ability to develop and implement a proactive health education/health communication strategy (distinct from risk communication) that disseminates timely and accurate information to the public designed to encourage actions to promote health in culturally and linguistically appropriate formats for the various communities served, including using electronic communication tools.

Foundational Areas

There are five Foundational Areas, also known as Public Health Programs. Social determinants of health and actions to address health inequities should be integrated throughout all activities.

Communicable Disease Control

- Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control.
- Identify statewide and local communicable disease control community partners and their capacities, develop, and implement a prioritized communicable disease control plan, and ability to seek and secure funding for high priority initiatives.
- Receive laboratory reports and other relevant data; conduct disease investigations, including contact tracing and notification; and recognize, identify, and respond to communicable disease outbreaks for notifiable conditions in accordance with local, national, and state mandates and guidelines.
- Assure the availability of partner notification services for newly diagnosed cases of communicable diseases according to Centers for Disease Control and Prevention (CDC) guidelines.
- Assure the appropriate treatment of individuals who have reportable communicable diseases, such as TB, STIs, and HIV in accordance with local and state laws and CDC guidelines.
- Support the recognition of outbreaks and other events of public health significance by assuring capacity for the identification and characterization of the causative agents of disease and their origin, including those that are rare and unusual.
- Coordinate and integrate categorically-funded communicable disease programs and services.

Chronic Disease & Injury Prevention

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on chronic disease and injury prevention and control.
- Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop, and implement a prioritized prevention plan, and ability to seek and secure funding for high priority initiatives.
- Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand exposure to harmful substances.
- Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and promising practices aligned with national, state, and local guidelines for healthy eating and active living.
- Coordinate and integrate categorically-funded chronic disease and injury prevention programs and services.

Environmental Public Health

- Provide timely, statewide, and locally relevant, complete, and accurate information to the state, health care system, and community on environmental public health threats and health impacts from common environmental or toxic exposures.
- Identify statewide and local community environmental public health partners and their capacities, develop, and implement a prioritized plan, and ability to seek and secure action funding for high priority initiatives.
- Conduct mandated environmental public health laboratory testing, inspections, and oversight to protect food, recreation sites, and drinking water; manage liquid and solid waste streams safely; and identify other public health hazards related to environmental factors in accordance with federal, state, and local laws and regulations.
- Protect workers and the public from chemical and radiation hazards in accordance with federal, state, and local laws and regulations.
- Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes and resilient communities (e.g., housing and urban development, recreational facilities, transportation systems and climate change).
- Coordinate and integrate categorically-funded environmental public health programs and services.

Maternal, Child and Family Health

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on emerging and on-going maternal child health trends.
- Identify local maternal and child health community partners and their capacities; using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and ability to seek and secure funding for high priority initiatives.
- Identify, disseminate, and promote emerging and evidence-based early interventions in the prenatal and early childhood period that promote lifelong health and positive social-emotional development.
- Assure newborn screening as mandated by a state or local governing body including wraparound services, reporting back, following up, and service engagement activities.
- Coordinate and integrate categorically funded maternal, child, and family health programs and services.

Access to & Linkage with Care

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on access and linkage to clinical care (including behavioral health), healthcare system access, quality, and cost.
- Inspect and license healthcare facilities, and license, monitor, and discipline healthcare providers, where applicable.
- In concert with national and statewide groups and local providers of healthcare, identify healthcare partners and competencies, develop prioritized plans for increasing access to health homes and quality health care, and seek funding for high priority policy initiatives.