2018 Local Public Health Act performance measures: Data book

LOCAL PUBLIC HEALTH ACT ANNUAL REPORTING

Each spring, Minnesota community health boards report data from the previous year on programs, activities, and resources, to help monitor the health of the state-local public health partnership in three key areas: Finance and Staffing, Title V MCH Block Grant, and Local Public Health Act (LPH Act) performance measures. For more information, visit: Local Public Health Act annual reporting.

What are LPH Act performance measures? This data book shares state-level information on Local Public Health Act (LPH Act) performance measures. The LPH Act performance measures correspond with Minnesota's six areas of public health responsibility: assure an adequate local public health infrastructure (this area includes capacity measures based on national standards and Minnesota-specific measures), promote healthy communities and healthy behavior, prevent the spread of communicable diseases, protect against environmental health hazards, prepare and respond to emergencies, assure health services.

How do community health boards respond? For a majority of measures, a community health board responds based on services provided in one or more of its individual health departments. For capacity measures aligning with national standards, a community health board responds based on the lowest level of capacity of its individual health departments.

In 2018, Minnesota had 51 community health boards. The total number (n) of Minnesota's community health boards can change from year to year as individual health departments dissolve their jurisdictional relationships or join together to form new community health boards.

What does MDH do with the data? MDH and the State Community Health Services Advisory Committee (SCHSAC) use the data submitted by community health boards to monitor the performance of the state's public health system, identify strengths and gaps, and recommend opportunities for improvement.

Where can I find more information? If you would like help interpreting this data or would like to discuss ideas on using your data to communicate progress or improve quality, please contact the MDH Center for Public Health Practice (above), or your public health nurse consultant: Who Is My Public Health Nurse Consultant? (www.health.state.mn.us/communities/practice/ta/phnconsultants/yourphnc.html)

How do I find past years' data? To find system-wide data and analysis from past years, visit: Past data: LPH Act annual reporting (www.health.state.mn.us/communities/practice/lphact/annualreporting/archive.html)

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October 2019. To obtain this information in a different format, call: 651-201-3880.

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Assure an adequate local public health infrastructure: Capacity measures from national standards

The measures in this area of responsibility are based on PHAB Standards and Measures v. 1.5 (http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/), but are not intended to serve as a substitute for PHAB guidance. If you would like to learn more about each measure and requirement, refer directly to Public Health Accreditation Board: Standards and Measures Version 1.5. PHAB language is prescriptive, and frequently uses "must;" to fully meet a measure; this language is used below.

Reporting guidance

Review the 37 key measures in this section on the following pages (pp. 6 to 45), noting each requirement's time frame and examples.

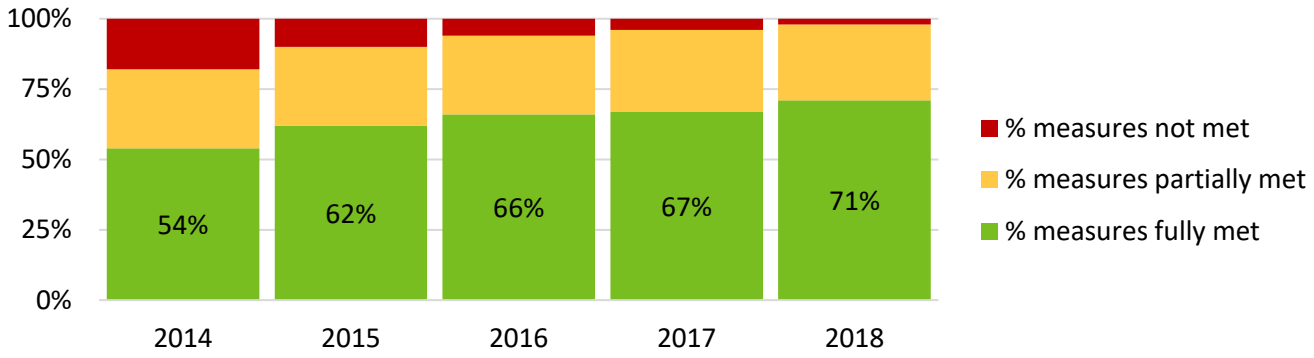
- Less than 14 months old: 11/1/2017–12/31/2018
- Less than two years old: 1/1/2017–12/31/2018
- Less than three years old: 1/1/2016–12/31/2018
- Less than five years old: 1/1/2014–12/31/2018

Note whether your community health board can fully, partially, or not meet each measure, and record your answer on the following page, under "At-a-glance worksheet for data entry."

A multi-county community health board should report on the lowest level of capacity of its individual health departments (see below). That is, if two of three local health departments in a multi-county community health board can fully meet a measure, but the third can only partially meet, the entire community health board should report partially meet. If the third cannot meet the measure at all, the entire community health board should report cannot meet.

Capacity measures from national standards

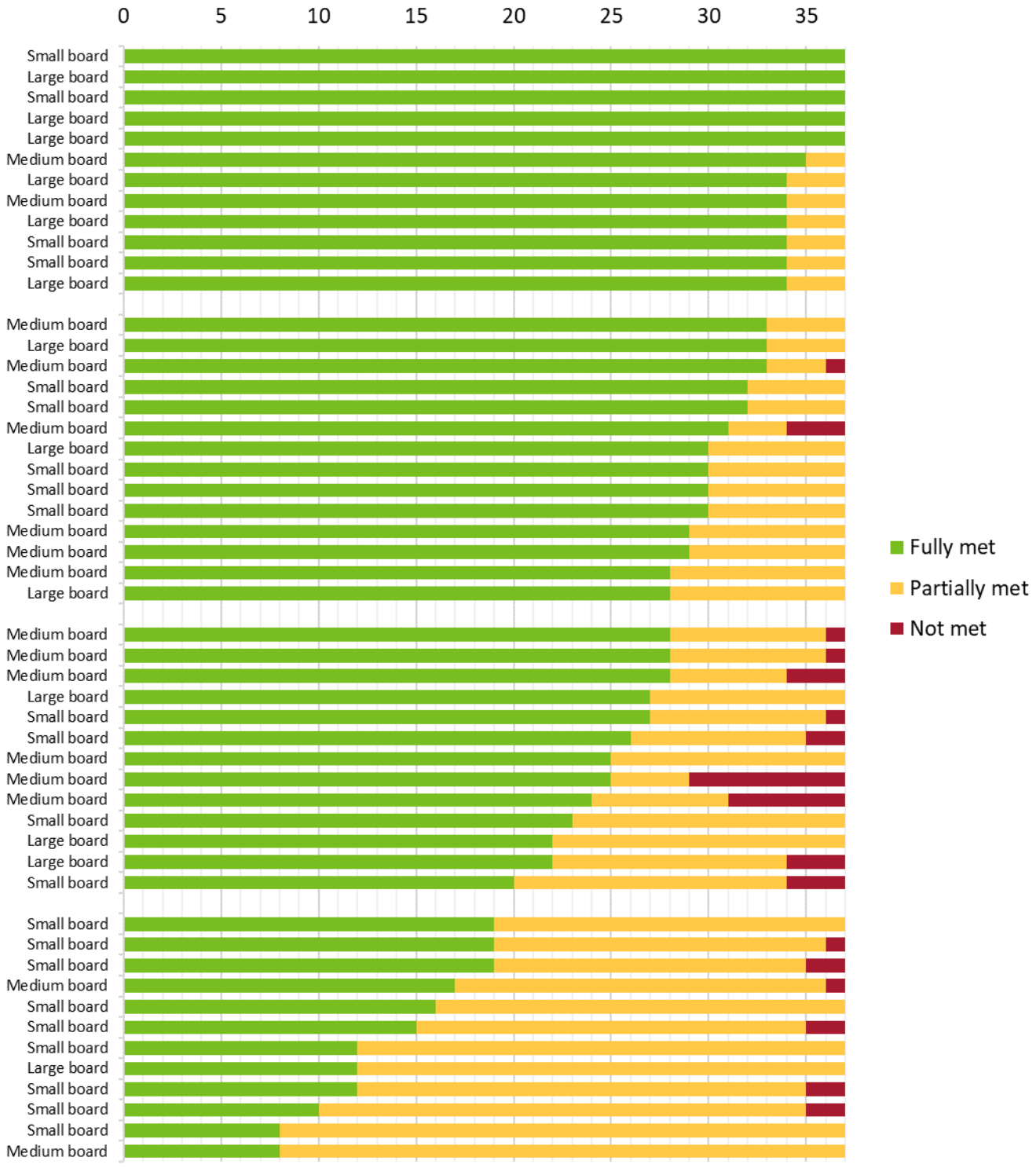
Progress: Minnesota community health board ability to meet 37-measure subset of national public health measures, 2014-present



Minnesota community health boards capacity to meet key subset of 37 national public health measures, 2018 (n=51)	% fully meet	% partially meet	% cannot meet
1.1.2. A local community health assessment.	92%	8%	0%
1.2.2. Communication with surveillance sites.	71%	29%	0%
1.3.1. Data analyzed and public health conclusions drawn.	69%	31%	0%
1.4.2. Community summaries or fact sheets of data to support public health improvement planning processes at the local level.	75%	25%	0%
2.1.4. Collaborative work through established governmental and community partnerships on investigations of reportable diseases, disease outbreaks, and environmental public health issues.	82%	18%	0%
2.2.3. Complete After Action Reports (AARs).	75%	24%	2%
3.1.2. Health promotion strategies to mitigate preventable health conditions.	88%	12%	0%
3.1.3. Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes.	75%	25%	0%
3.2.2. Organizational branding strategy.	59%	31%	10%
3.2.3. Communication procedures to provide information outside the health department.	63%	33%	4%
3.2.5. Information available to the public through a variety of methods.	80%	20%	0%
5.1.3. Inform governing entities, elected officials, and/or the public of potential intended or unintended public health impacts from current and/or proposed policies.	80%	18%	2%
5.2.3. Elements and strategies of the health improvement plan implemented in partnership with others.	82%	18%	0%
5.2.4. Monitor the strategies in the community health improvement plan and revise as needed, in collaboration and with broad participation from stakeholders and partners.	73%	27%	0%
5.3.3. Implemented community health board strategic plan.	61%	37%	2%
6.3.4. Patterns or trends identified in compliance from enforcement activities and complaints.	59%	35%	6%
7.1.1. Process to assess the availability of health care services.	78%	22%	0%

Minnesota community health boards capacity to meet key subset of 37 national public health measures, 2018 (n=51)	% fully meet	% partially meet	% cannot meet
7.1.2. Identification of populations who experience barriers to health care services.	78%	22%	0%
7.1.3. Identification of gaps in access to health care services, and barriers to the receipt of health care services.	65%	33%	2%
7.2.1. Process to develop strategies to improve access to health care services.	80%	20%	0%
7.2.2. Implemented strategies to increase access to health care services.	76%	24%	0%
7.2.3. Implemented culturally competent initiatives to increase access to health care services for those who may experience barriers to care due to cultural, language, or literacy differences.	67%	33%	0%
8.2.1. Workforce development strategies.	53%	37%	10%
8.2.2. A competent community health board workforce.	80%	20%	0%
9.1.1. Staff at all organizational levels engaged in establishing and/or updating a performance management system.	57%	41%	2%
9.1.2. Performance management policy/system.	57%	37%	6%
9.1.3. Implemented performance management system.	43%	49%	8%
9.1.4. Implemented systematic process for assessing customer satisfaction with community health board services.	71%	27%	2%
9.1.5. Opportunities provided to staff for involvement in a community health board's performance management.	67%	29%	4%
9.2.1. Established quality improvement program based on organizational policies and direction.	76%	22%	2%
9.2.2. Implemented quality improvement activities.	75%	22%	4%
10.2.3. Communicated research findings, including public health implications.	71%	22%	8%
11.1.2. Ethical issues identified and ethical decisions made.	37%	55%	8%
11.1.4. Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes.	51%	47%	2%
12.2.1. Communication with the governing entity regarding the responsibilities of a community health board and of the responsibilities of the governing entity.	92%	8%	0%
12.3.1. Information provided to the governing entity about important public health issues facing the community, a community health board, and/or the recent actions of a community health board.	96%	4%	0%
12.3.3. Communication with the governing entity about community health board performance assessment and improvement.	82%	18%	0%

Minnesota community health board capacity to meet subset of 37 key national public health measures, by community health board, 2018



Assure an adequate local public health infrastructure: Minnesota-specific measures

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

Workforce core competency skills

Community health boards need a trained and competent workforce. The Core Competencies for Public Health Professionals (www.phf.org/resourcestools/pages/core_public_health_competencies.aspx), developed by the Council on Linkages between Academia and Public Health Practice, offer a starting point to identify workforce gaps.

Reporting guidance

Community health boards will use one of five response options to indicate the extent to which each skill is present in the community health board workforce.

While helpful, an official workforce evaluation or assessment is not necessary to complete this section; a community health board that has not completed an assessment should estimate staff competency.

Community health boards that report having proficiency or expertise **present** in the workforce will also report on the extent to which those skills are **sufficient** to meet the needs of the community health board. The workforce skills and response options are defined in the glossary below.

Please note the following parameters when choosing how to report.

- Everyone on staff does not need to have each of these skills. A community health board may report "proficient" for data analysis, even if only one or two staff are skilled in this area.
- Report on the highest level of skill present in the community health board. Many in the workforce may have a "basic" skill level in a given area, yet the community health board may report "proficient" or "expert" if some in the workforce have more developed skills.
- A multi-county community health board should answer based on the highest level of skill available within the workforce of each local health department—or if skilled staff are shared, the community health board should report based on the highest level of skill available across the community health board.
- This question asks about the highest level of skill available within the community health board workforce. Note that MDH does not ask you to characterize the skill level of everyone in the workforce. Do not try and calculate an 'average' skill level across all employees.

Glossary

Use the following definitions for workforce skills and level of competence when deciding how to report on the workforce competence of your community health board.

- **Data collection**: Collect quantitative and qualitative data and information on community health needs and assets.
- **Data analysis**: Determine validity, reliability, and comparability of data; analyze quantitative and qualitative data; interpret quantitative and qualitative data.

- **Community health improvement planning**: Facilitate a collaborative community health improvement planning process; foster shared ownership and responsibility among the community and stakeholders for the plan's implementation.
- **External policies, programs, and services**: Influence policies, programs, and services external to the organization.
- **Information dissemination**: Determine approaches for conveying and disseminating data and information.
- **Policy, program, and service impacts**: Assess the effects of policies, programs, and services on different populations.
- **Partner collaboration**: Facilitate collaboration among partners.
- **Community engagement**: Engage community members; use community input for policies, programs, and services.
- **Application of public health sciences**: Use public health sciences for policies, programs, services and research; apply public health sciences in administration and management.
- **Public health evidence**: Retrieve evidence from print and electronic sources; determine limitations of evidence; use evidence for policies, programs, and services.
- **Financial planning and management**: Budgeting; justify programs for inclusion in budgets; develop and defend budgets.
- **Performance management**: Develop and use a performance management system.
- **Leadership and systems thinking**: Systems thinking; describe public health as part of a larger system; explain how public health, health care, and other organizations can work together or individually.

Response options

Availability of workforce skill

- **Absent**: Workforce in the community health board has basic awareness of the skill, but limited ability to apply it
- **Basic**: Workforce in the community health board has knowledge of the skill, and can apply it at basic level
- **Proficient**: Workforce in the community health board has this skill, and is adept at applying it
- **Expert**: Workforce in the community health board routinely apply this skill and could teach it to others
- **I don't know**: Skill level within the community health board is unknown

Sufficiency of workforce skill

Community health boards that report proficiency or expertise for a skill, will also report if the skill level in the workforce is adequately meeting community health board needs. For example, having only one or two staff proficient or expert in a skill area, such as epidemiology, is sufficient for a community health board. For others, one or two proficient staff would not be sufficient to meet community health board needs. In the case of budgeting, a small community health board may only need one person who is proficient/expert, while a larger community health board may need multiple staff with this skill.

- **Strongly disagree**: Despite skilled staff; the need for this skill is largely unmet
- **Disagree**: Despite skilled staff, there is a meaningful gap in ability to meet need for this skill in the community health board
- **Neutral**: Neither agree nor disagree
- **Agree**: Skilled staff are available and can generally meet need for this skill in the community health board
- **Strongly agree**: Skilled staff are available and fully meet the need for this skill in the community health board

Measures: Workforce core competency skills

Availability of workforce skill

Minnesota community health boards, 2018 (n=51)	Expert	Proficient	Basic	Absent	I don't know
1. To what extent does the community health board possess data collection skills?	24%	53%	24%	0%	0%
2. To what extent does the community health board possess data analysis skills?	18%	43%	39%	0%	0%
3. To what extent does the community health board possess community health improvement planning skills?	20%	55%	25%	0%	0%
4. To what extent does the community health board possess external policies, programs, and services skills?	10%	57%	33%	0%	0%
5. To what extent does the community health board possess information dissemination skills?	14%	65%	22%	0%	0%
6. To what extent does the community health board possess policy, program, and service impacts skills?	12%	51%	35%	2%	0%
7. To what extent does the community health board possess partner collaboration skills?	53%	41%	6%	0%	0%
8. To what extent does the community health board possess community engagement skills?	29%	53%	18%	0%	0%
9. To what extent does the community health board possess application of public health sciences skills?	14%	47%	37%	2%	0%
10. To what extent does the community health board possess public health evidence skills?	14%	39%	43%	4%	0%
11. To what extent does the community health board possess financial planning and management skills?	33%	49%	18%	0%	0%
12. To what extent does the community health board possess performance management skills?	12%	41%	47%	0%	0%
13. To what extent does the community health board possess leadership and systems thinking skills?	31%	57%	12%	0%	0%

Sufficiency of workforce skill

"Staff" is used generally here and can also refer to managers, supervisors, and/or directors (i.e., any member of the community health board workforce).

1a. My community health board draws on current staff to fully meet its need for data collection.

Answer if you selected "proficient" or "expert" from Q1, above.

Minnesota community health boards, 2018 (n=39)	%
Strongly agree	33%
Agree	51%
Neutral	10%
Disagree	5%
Strongly disagree	0%

2a. My community health board draws on current staff to fully meet its need for data analysis.

Answer if you selected "proficient" or "expert" from Q2, above.

Minnesota community health boards, 2018 (n=31)	%
Strongly agree	32%
Agree	55%
Neutral	3%
Disagree	6%
Strongly disagree	3%

3a. My community health board draws on current staff to fully meet its need for community health improvement planning.

Answer if you selected "proficient" or "expert" from Q3, above.

Minnesota community health boards, 2018 (n=38)	%
Strongly agree	42%
Agree	53%
Neutral	0%
Disagree	5%
Strongly disagree	0%

4a. My community health board draws on current staff to fully meet its need to influence external policies, programs, and services.

Answer if you selected "proficient" or "expert" from Q4, above.

Minnesota community health boards, 2018 (n=34)	%
Strongly agree	29%
Agree	65%
Neutral	6%
Disagree	0%
Strongly disagree	0%

5a. My community health board draws on current staff to fully meet its need for information dissemination.

Answer if you selected "proficient" or "expert" from Q5, above.

Minnesota community health boards, 2018 (n=40)	%
Strongly agree	33%
Agree	60%
Neutral	8%
Disagree	0%
Strongly disagree	0%

6a. My community health board draws on current staff to fully meet its need to assess policy, program, and service impacts.

Answer if you selected "proficient" or "expert" from Q6, above.

Minnesota community health boards, 2018 (n=32)	%
Strongly agree	38%
Agree	53%
Neutral	9%
Disagree	0%
Strongly disagree	0%

7a. My community health board draws on current staff to fully meet its need for partner collaboration.

Answer if you selected "proficient" or "expert" from Q7, above.

Minnesota community health boards, 2018 (n=48)	%
Strongly agree	63%
Agree	33%
Neutral	4%
Disagree	0%
Strongly disagree	0%

8a. My community health board draws on current staff to fully meet its need for community engagement.

Answer if you selected "proficient" or "expert" from Q8, above.

Minnesota community health boards, 2018 (n=42)	%
Strongly agree	45%
Agree	48%
Neutral	5%
Disagree	2%
Strongly disagree	0%

9a. My community health board draws on current staff to fully meet its need for the application of public health sciences.

Answer if you selected "proficient" or "expert" from Q9, above.

Minnesota community health boards, 2018 (n=31)	%
Strongly agree	26%
Agree	61%
Neutral	10%
Disagree	3%
Strongly disagree	0%

10a. My community health board draws on current staff to fully meet its need for using public health evidence.

Answer if you selected "proficient" or "expert" from Q10, above.

Minnesota community health boards, 2018 (n=27)	%
Strongly agree	33%
Agree	59%
Neutral	4%
Disagree	4%
Strongly disagree	0%

11a. My community health board draws on current staff to fully meet its need for financial planning and management.

Answer if you selected "proficient" or "expert" from Q11, above.

Minnesota community health boards, 2018 (n=42)	%
Strongly agree	43%
Agree	50%
Neutral	5%
Disagree	0%
Strongly disagree	2%

12a. My community health board draws on current staff to fully meet its need for performance management.

Answer if you selected "proficient" or "expert" from Q12, above.

Minnesota community health boards, 2018 (n=27)	%
Strongly agree	22%
Agree	59%
Neutral	7%
Disagree	7%
Strongly disagree	4%

13a. My community health board draws on current staff to fully meet its need for leadership and systems thinking.

Answer if you selected "proficient" or "expert" from Q13, above.

Minnesota community health boards, 2018 (n=45)	%
Strongly agree	36%
Agree	58%
Neutral	4%
Disagree	2%
Strongly disagree	0%

Health equity

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

Reporting guidance

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

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

Glossary

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

- **Health disparity**: The difference in the incidence, prevalence, mortality, and burden of disease and other adverse conditions, which exists between specific population groups.
- **Health equity**: A state where all persons, regardless of race, income, sexual orientation, age, gender, other social/economic factors, have the opportunity to reach their highest potential of health. To achieve health equity, people need healthy living conditions and community space; equitable opportunities in education,

jobs, and economic development; reliable public services and safety; and non-discriminatory practices in organizations.

- **Health inequity**: The difference in health status between more and less socially and economically advantaged groups, caused by systemic differences in social conditions and processes that effectively determine health. Health inequities are avoidable, and unjust, and are therefore actionable.
- **Social determinants of health**: Conditions found in the physical, cultural, social, economic, and political environments that influence individual and population health. The inequities in the distribution of these conditions lead to differences in health outcomes (that is, they lead to health disparities). Conditions include, but are not limited to: socioeconomic factors (e.g., racism, stress, education, income, employment, health literacy); environmental factors (e.g., housing and, environmental hazards); and systems and policies (e.g., health care access, access to healthy foods).
- **Health equity policies**: Policies that address social determinants of health (for example, housing) and focus on the entire community rather than on a single, high-risk individual. For example, a health equity policy would focus on expanding the availability of affordable housing in a community.

Measures: Health equity

Minnesota community health boards, 2018 (n=51)	% very true	% somewhat true	% not true	% I don't know
14. My community health board has identified health equity as a priority, with specific intent to address social determinants of health.	63%	35%	2%	0%
15. My community health board has built capacity (e.g., human resources, funding, training staff) to achieve health equity by addressing social determinants of health.	18%	76%	6%	0%
16. My community health board has established a core contingency of staff who are poised to advance a health equity agenda.	35%	55%	10%	0%
17. My community health board has increased the amount of internal resources directed to addressing social determinants of health.	24%	55%	22%	0%
18. My community health board has engaged with local government agencies or other external organizations to support policies and programs to achieve health equity.	43%	53%	4%	0%
19. My community health board has made deliberate efforts to build the leadership capacity of community members to advocate on issues affecting social determinants of health.	24%	61%	14%	2%
20. My community health board has provided resources to community groups to support their self-identified concerns for achieving health equity in their communities.	20%	59%	18%	4%

21. Please describe one of your community health board's efforts to achieve health equity. Include the name of the policy or program, the health inequity that you identified and the data to support your findings, the communities or partners that you engaged, resources committed, and how you measured and reported on progress.

To view this measure's responses, contact the MDH Center for Public Health Practice.

Organizational quality improvement maturity

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

Many community health boards have already assessed their organizational QI maturity as part of developing, implementing, and maintaining their board's QI plan. The MDH Center for Public Health Practice encourages community health boards to use a collaborative process with multiple staff and/or leadership contributing to an assessment of organizational QI maturity. This may mean having a leadership team, QI council, or the entire staff complete the 10-question QI Maturity Tool (consisting of the same 10 questions below), and using or aggregating those results for reporting purposes.

Reporting guidance

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

Use the descriptions below to indicate your level of agreement with each statement in Questions 22-24 and 26-30. An "I don't know" option is provided for all questions in this set, for those without enough information to respond. Suggested parameters for Question 25 are found within Question 25.

Suggested parameters for Questions 22-24 and Questions 26-30:

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

Measures: Organizational quality improvement maturity

Minnesota community health boards, 2018 (n=51)	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
22. Staff members are routinely asked to contribute to decisions at my community health board.	39%	51%	10%	0%	0%

Minnesota community health boards, 2018 (n=51)	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
23. The leaders of my community health board are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.	39%	43%	14%	2%	2%
24. Job descriptions for many individuals responsible for programs and services in my community health board include specific responsibilities related to measuring and improving quality.	20%	41%	20%	16%	4%
25. My community health board has a quality improvement (QI) plan. [1]	51%	39%	6%	2%	2%
26. Customer satisfaction information is routinely used by many individuals responsible for programs and services in my community health board.	16%	57%	22%	6%	0%
27. When trying to facilitate change, community health board staff has the authority to work within and across program boundaries.	43%	51%	4%	2%	0%
28. The key decision makers in my community health board believe QI is very important.	57%	33%	10%	0%	0%
29. My community health board currently has a pervasive culture that focuses on continuous QI.	16%	59%	25%	0%	0%
30. My community health board currently has aligned its commitment to quality with most of its efforts, policies, and plans.	16%	75%	10%	0%	0%
31. My community health board currently has a high level of capacity to engage in QI efforts.	12%	43%	33%	12%	0%

[1] Suggested parameters for question 25:

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

32. How did your community health board decide how to report on Questions 22-31, above? (Select one.)

Minnesota community health boards, 2018 (n=51)	%
One person (e.g., the CHS administrator, the public health director, etc.) filled out Q22-30, based on their knowledge of the agency, without using the QI maturity survey	18%
A core group of staff (e.g., leadership, QI council, other group of key staff) completed Q22-30 on behalf of staff, without using the QI maturity survey	45%
The agency administered the QI maturity survey to a core group of staff (e.g., leadership team, QI council, etc.), and used those results for answering Q22-30	12%
The agency administered the QI maturity survey to the entire staff, and used those results for answering Q22-30	18%
Other (please explain)	8%

Other (please explain):

- Administered a QI maturity survey to entire staff and also gathered a core group of staff to discuss questions.
- The agency administered the QI maturity survey to the entire staff in October of 2016 and those results were used to answer the questions. Plan is to repeat this survey in Fall of 2019 as it was recommended to do every 3-4 years.
- [Our community health board] administered a department-wide survey approximately two years ago that assisted with these answers, Additionally, we have a small group (TIP - Team for Improving Performance) that reviewed the questions and updated the answers.
- Our agency completed the questions above as "a core group of staff". In addition, [our community health board] administered the QI maturity survey to the entire staff. [Our community health board] then compares the survey results of the staff perspectives with the results of the core group (leadership) perspectives to identify gaps, differences, and similarities.

Voluntary public health accreditation

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

- MDH will summarize your data in a report specific to your community health board, with regional and state comparisons
- MDH will also use system data from all community health boards to guide technical assistance and training
- MDH will share a list of community health boards that are in the process of accreditation or planning to apply for accreditation

Reporting guidance

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

Question 34 is optional.

Measures: Voluntary public health accreditation

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

Minnesota community health boards, 2018 (n=51)	%
My community health board has achieved accreditation	20%
My community health board is in the process of accreditation (e.g., has submitted a statement of intent)	6%
My community health board is planning to apply (but is not in the process of accreditation)	12%
My community health board is undecided about whether to apply for accreditation	27%
My community health board has decided not to apply at this time	35%
Individual jurisdictions within my community health board are participating in accreditation differently	0%

33a. If your community health board is planning to apply but is not in the process of accreditation, in what calendar year is your community health board planning to apply for accreditation? (Select one.)

Answer if you selected "planning to apply" in Q33, above.

Minnesota community health boards, 2018 (n=6)	%
2019	33%
2020 or later	67%

33b. If your community health board is undecided or has decided not to apply for accreditation at this time, why? (Rank primary and secondary reasons.) [2]

Answer if you selected "undecided about whether to apply" or "decided not to apply at this time" in Q33, above. Rank primary reason as "1" and secondary reason as "2."

Minnesota community health boards, 2018 (n=31)[3]	% primary reason	% secondary reason
Accreditation standards are not appropriate for my community health board	0%	0%
Fees for accreditation are too high	10%	32%
Accreditation standards exceed the capacity of my community health board	58%	26%
Time and effort for accreditation application exceed the benefits of accreditation	32%	32%
No support from governing body for accreditation	6%	6%
Interest/capacity varies within the jurisdictions of my community health board	0%	10%

[2] May not add up to 100%; some community health boards indicate only a primary reason.

[3] One community health board that selected "undecided about whether to apply" or "decided not to apply at this time" in Q33 chose not to answer this question.

33c. If individual jurisdictions within your community health board are participating in accreditation differently, please briefly explain.

Answer if you selected "individual jurisdictions are participating in accreditation differently" in Q33, above.

[n/a]

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

Optional.

- The cost out ways the current projected benefits.
- Fees go far beyond what you pay to PHAB.
- Much of the work between smaller/rural local Public Health and MDH has been informal in the past. Accreditation requires documentation stating who is responsible and how the work will be evaluated and shared. Example: 6.2.3 MOU needed with MDH on school immunization laws. 2.1.2 MOU with state needed as to how infectious disease investigation works between MDH and Local Public Health, how locals receive reporting, etc. 2.1.3 MOU with state needed as to how non-infectious health problems, environmental and/or occupational public health hazards investigation works between MDH and Local Public Health, how locals receive reporting, etc.
- Agency does not have the capacity to take on accreditation. No current staff can devote time to coordinate the process, nor is there money in the budget to hire. Cannot afford to take other staff away from their revenue generating activities.
- We have no time to accomplish accreditation at this time.
- Our small health department lacks the capacity and resources to pursue accreditation.
- With staff turnover, current LPH requirements and funding, accreditation is not a possibility for [our community health board].
- Continued focus on lowering the tax levy in our county. No additional capacity can be added to work towards accreditation.
- Helps to assure that what we are doing is documented. Keeps our health department up to date on what is happening with others around the country.
- We do not have adequate funding to support the FTE of staff to dedicate to accreditation. We see the benefits and would like our CHB and counties to reach accreditation.
- [Our community health board] has an interest in accreditation but staffing capacity does hinder us moving forward. [Our community health board] would also be interested in accreditation for rural/frontier public health organizations.
- We are currently reviewing all the reaccreditation standards to ensure we can meet them by 2021.
- The community health board strives to improve and provide the best public health we can going after accreditation is not in our power at this time.
- We would pursue accreditation if we had the resources to pursue the work to meet the requirements.
- Benefit of documentation and learnings about what outhitting public health is doing around the country.
- [One jurisdiction in our community health board] continues working on accreditation as we move forward with new polices, processes, procedures, and initiatives. [Another jurisdiction in our community health board] has decided not to apply at this time.
- The PHAB Accreditation Committee completed its review of the Action Plan submitted by [our community health board] and approved the Action plan on 03-29-2018. Our health department must submit documentation that we have implemented the Action Plan on or before 03-29-2019.
- [Our community health board] is actively in the process of applying for reaccreditation.
- We are in the process of gathering our documentation with a submit date of September of 2019.
- We have great staff that were engaged in the accreditation process. We're proud of our staff and all the work they put in to accreditation and the re-accreditation process.

- Rural CHS dept with limited funding and minimal staffing.
- Currently our CHB is not in good position to consider applying, staff are at or above maximum capacity for competing tasks; some staff are new; and during this last year we lost some of our positions due to the ending of the CWG (1422) funding
- At this time we continue to be unable to look at or consider accreditation. We do not have the resources ($ for staff time). Each of our LHD are very tightly staffed due to funding. Directors in all 3 counties provide some direct services (in addition to administrative duties) to support their positions and maintain staffing in program areas.
- [Our community health board] submitted our first annual report in June (2018). We are in the process of learning more about reaccreditation efforts.
- Greatest benefit is the benefits of documentation. And learnings from other public health around the country.
- The agency has submitted two Annual Reports to PHAB and will be applying for Reaccreditation in 2021.
- We have hired an accreditation coordinator and we are in the process of identifying gaps in our work in comparison to the accreditation standards.
- We will submit our year 3 annual report and are currently working toward reaccreditation.

Statutory requirements

Community health boards have statutory responsibility under the Local Public Health Act.

Reporting guidance

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

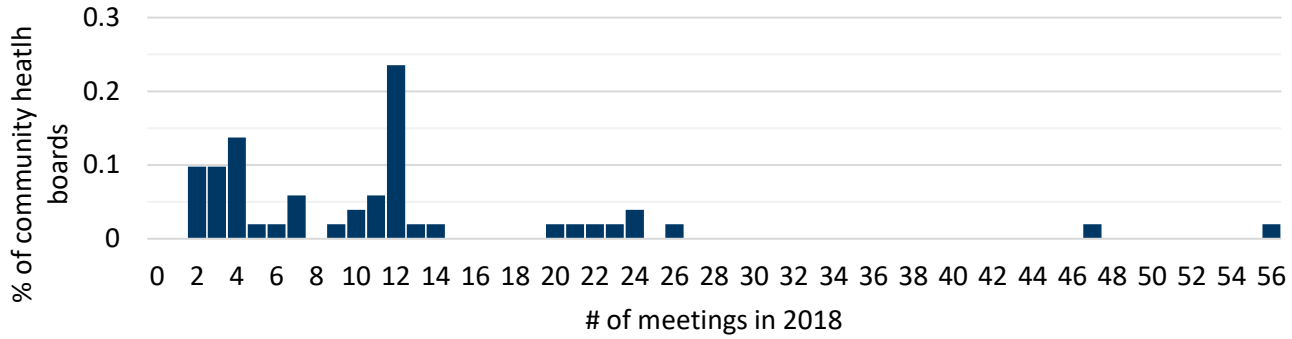
- Minn. Stat. § 145A.03 Establishment and Organization (https://www.revisor.mn.gov/statutes/cite/145A.03)
- Minn. Stat. § 145A.04 Powers and Duties of Community Health Board (https://www.revisor.mn.gov/statutes/cite/145A.04)
- Minn. Rule 4736.0110 Personnel Standards (https://www.revisor.mn.gov/rules/4736.0110/)

Measures: Statutory requirements

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

Minnesota community health boards, 2018 (n=51)	%
Yes	100%
No	0%

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



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

Minnesota community health boards, 2018 (n=51)	%
Yes	100%
No	0%

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

Minnesota community health boards, 2018 (n=51)	%
Yes	100%
No	0%

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

Minnesota community health boards, 2018 (n=51)	%
Yes	100%
No	0%

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

Minnesota community health boards, 2018 (n=51)	%
Yes	100%
No	0%

Local Public Health Grant activities

The Local Public Health Grant is a flexible source of funding, so community health boards use those funds in many different ways. This question asks each community health board to provide an example of how those funds were used in the last year. MDH will summarize this information to communicate with stakeholders.

Reporting guidance

Community health boards must highlight at least one example of how Local Public Health Grant funds were used in the past year in Question 41; Questions 42 and 43 are optional if your community health board would like to highlight more than one program/activity.

Consider the following questions:

- Describe the activity. What did you do? What happened as a result?
- Explain the importance and rationale. How did you identify this need?
- How did this benefit your community? Your organization? What additional resources (if any) did you leverage with these Local Public Health Act funds? Could you have accomplished the work without the funding? What would have happened if you had not had Local Public Health Act funding for this example?

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

Measures: Local Public Health Grant activities

41. Please highlight an activity from the past year supported by Local Public Health Act funding. Describe the activity, explain the importance and rationale, explain the organizational benefit, and explain the community benefit.

To view this measure's responses, contact the MDH Center for Public Health Practice.

41a. In what public health area of responsibility did this activity fall? (Check all that apply.)

To view this measure's responses, contact the MDH Center for Public Health Practice.

42. Please highlight an activity from the past year supported by Local Public Health Act funding. Describe the activity, explain the importance and rationale, explain the organizational benefit, and explain the community benefit.

Optional.

42a. In what public health area of responsibility did this activity fall? (Check all that apply.)

Optional.

To view this measure's responses, contact the MDH Center for Public Health Practice.

43. Please highlight an activity from the past year supported by Local Public Health Act funding. Describe the activity, explain the importance and rationale, explain the organizational benefit, and explain the community benefit.

Optional.

43a. In what public health area of responsibility did this activity fall? (Check all that apply.)

Optional.

To view this measure's responses, contact the MDH Center for Public Health Practice.

Promote healthy communities and healthy behavior

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

Active living

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

Reporting guidance

These measures align with SHIP Strategies (www.health.state.mn.us/communities/ship/ourwork.html).

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

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

Community

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

Child care

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

Schools

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

Workplace

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

Measures: Active living

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

Minnesota community health boards, 2018 (n=51)	% community setting	% child care setting	% schools setting	% workplace setting
Used SHIP funding and/or SHIP match for strategy	67%	25%	80%	75%
Used other (non-SHIP) funding for strategy	2%	6%	0%	2%
Used both SHIP funding and/or SHIP match AND other (non-SHIP) funding for strategy	29%	10%	18%	24%
Was not involved in strategy	2%	59%	2%	0%

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

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

Setting: Community

Minnesota community health boards, 2018 (n=50)	%
Attended trainings	80%
Conducted assessments	80%
Convened partners or participated in coalitions	100%
Involved with community outreach and education	92%
Educated policymakers	84%
Developed proposal or policy	56%
Implemented policy (this year)	32%
Maintained policy (which was previously implemented)	36%
Evaluated policy impact	18%

Setting: Child care

Minnesota community health boards, 2018 (n=20)	%
Attended trainings	75%
Conducted assessments	70%
Convened partners or participated in coalitions	70%
Involved with community outreach and education	80%
Educated policymakers	60%
Developed proposal or policy	45%
Implemented policy (this year)	25%
Maintained policy (which was previously implemented)	35%
Evaluated policy impact	20%

Setting: Schools

Minnesota community health boards, 2018 (n=50)	%
Attended trainings	96%
Conducted assessments	90%
Convened partners or participated in coalitions	98%
Involved with community outreach and education	94%
Educated policymakers	82%
Developed proposal or policy	74%
Implemented policy (this year)	50%
Maintained policy (which was previously implemented)	58%
Evaluated policy impact	32%

Setting: Workplace

Minnesota community health boards, 2018 (n=51)	%
Attended trainings	92%
Conducted assessments	92%
Convened partners or participated in coalitions	96%
Involved with community outreach and education	82%
Educated policymakers	65%
Developed proposal or policy	61%
Implemented policy (this year)	53%
Maintained policy (which was previously implemented)	51%
Evaluated policy impact	31%

1b. Estimate the top three funding sources that supported your strategies to promote active living.[4]

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

Minnesota community health boards, 2018 (n=51)	% largest source	% second-largest source	% third-largest source
Local tax levy	0%	31%	27%
State general fund (Local Public Health Act)	2%	37%	33%
SHIP	96%	4%	0%
Other state funds (from MDH or from other state agencies)	0%	4%	14%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	2%	14%	0%
Title V Block Grant	0%	0%	0%
Foundation funds	0%	2%	10%
Fees/reimbursement	0%	2%	2%

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

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

Minnesota community health boards, 2018 (n=30)	%
Yes	70%
No	30%

[4] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.

Healthy eating

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

Reporting guidance

These measures align with SHIP Strategies (www.health.state.mn.us/communities/ship/ourwork.html).

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

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

Community

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

Child care

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

School

- Working on engagement or assessment
- Farm to school
- School-based agriculture
- Healthy snacks outside of the school day through vending, concessions, school stores, or snack carts
- Healthy snacks during the school day through celebration, special events, or non-food rewards

- Smarter lunchroom techniques through such behavioral economic activities including, but not limited to, competitive pricing, product enhancements

Workplace

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

Measures: Healthy eating

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

Minnesota community health boards, 2018 (n=51)	% community setting	% child care setting	% schools setting	% workplace setting
Used SHIP funding and/or SHIP match for strategy	61%	27%	75%	71%
Used other (non-SHIP) funding for strategy	2%	6%	0%	2%
Used both SHIP funding and/or SHIP match AND other (non-SHIP) funding for strategy	33%	10%	25%	27%
Was not involved in strategy	4%	57%	0%	0%

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

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

Setting: Community

Minnesota community health boards, 2018 (n=49)	%
Attended trainings	86%
Conducted assessments	90%
Convened partners or participated in coalitions	94%
Involved with community outreach and education	96%
Educated policymakers	80%
Developed proposal or policy	53%
Implemented policy (this year)	31%
Maintained policy (which was previously implemented)	31%
Evaluated policy impact	22%

Setting: Child care

Minnesota community health boards, 2018 (n=22)	%
Attended trainings	77%
Conducted assessments	64%
Convened partners or participated in coalitions	73%
Involved with community outreach and education	91%
Educated policymakers	64%
Developed proposal or policy	32%
Implemented policy (this year)	18%
Maintained policy (which was previously implemented)	32%
Evaluated policy impact	23%

Setting: School

Minnesota community health boards, 2018 (n=51)	%
Attended trainings	88%
Conducted assessments	94%
Convened partners or participated in coalitions	98%
Involved with community outreach and education	90%
Educated policymakers	84%
Developed proposal or policy	76%
Implemented policy (this year)	51%
Maintained policy (which was previously implemented)	61%
Evaluated policy impact	35%

Setting: Workplace

Minnesota community health boards, 2018 (n=51)	%
Attended trainings	82%
Conducted assessments	90%
Convened partners or participated in coalitions	92%
Involved with community outreach and education	88%
Educated policymakers	65%
Developed proposal or policy	59%
Implemented policy (this year)	47%
Maintained policy (which was previously implemented)	47%
Evaluated policy impact	35%

2b. Estimate the top three funding sources that supported your strategies to promote healthy eating.[5]

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

Minnesota community health boards, 2018 (n=51)	% largest source	% second-largest source	% third-largest source
Local tax levy	0%	29%	27%
State general fund (Local Public Health Act)	2%	41%	29%
SHIP	96%	4%	0%
Other state funds (from MDH or from other state agencies)	0%	4%	18%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	2%	8%	0%
Title V Block Grant	0%	0%	2%
Foundation funds	0%	6%	8%
Fees/reimbursement	0%	2%	2%

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

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

Minnesota community health boards, 2018 (n=28)[6]	%
Yes	71%
No	29%

Tobacco-free living

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

Reporting guidance

These measures align with SHIP Strategies (www.health.state.mn.us/communities/ship/ourwork.html).

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

[5] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.
[6] One community health board that selected "undecided about whether to apply" or "decided not to apply at this time" in Q33 chose not to answer this question.

and funding directed toward alcohol use. MDH will analyze data gathered here in close collaboration with the SHIP evaluation team.

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

Community

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

Workplace

- Tobacco-free environments
- Cessation support

Measures: Tobacco-free living

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

Minnesota community health boards, 2018 (n=51)	% community setting	% workplace setting
Used SHIP funding and/or SHIP match for strategy	63%	63%
Used other (non-SHIP) funding for strategy	2%	2%
Used both SHIP funding and/or SHIP match AND other (non-SHIP) funding for strategy	33%	20%
Was not involved in strategy	2%	16%

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

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

Setting: Community

Minnesota community health boards, 2018 (n=50)	%
Attended trainings	86%
Conducted assessments	86%
Convened partners or participated in coalitions	98%
Involved with community outreach and education	100%
Educated policymakers	94%
Developed proposal or policy	80%
Implemented policy (this year)	44%
Maintained policy (which was previously implemented)	42%
Evaluated policy impact	18%

Setting: Workplace

Minnesota community health boards, 2018 (n=43)	%
Attended trainings	84%
Conducted assessments	79%
Convened partners or participated in coalitions	88%
Involved with community outreach and education	84%
Educated policymakers	63%
Developed proposal or policy	42%
Implemented policy (this year)	28%
Maintained policy (which was previously implemented)	35%
Evaluated policy impact	12%

3b. Estimate the top three funding sources that supported your strategies to promote tobacco-free living.[7]

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

Minnesota community health boards, 2018 (n=51)	% largest source	% second-largest source	% third-largest source
Local tax levy	4%	33%	20%
State general fund (Local Public Health Act)	2%	35%	33%
SHIP	84%	12%	0%
Other state funds (from MDH or from other state agencies)	4%	2%	12%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant, 1422 Grant, or Tobacco-Free Communities)	4%	4%	2%
Title V Block Grant	0%	0%	0%
Foundation funds	0%	0%	2%
Fees/reimbursement	2%	2%	10%

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

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

Minnesota community health boards, 2018 (n=28)[8]	%
Yes	75%
No	25%

[7] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.
[8] One community health board that selected "undecided about whether to apply" or "decided not to apply at this time" in Q33 chose not to answer this question.

Alcohol

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

Reporting guidance

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

Measures: Alcohol

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

Minnesota community health boards, 2018 (n=51)	%
Policy advocacy (strengthening local ordinances)	33%
Policies to reduce drink specials in bars and restaurants	2%
Alcohol compliance checks	47%
Beverage server training	43%
Alcohol outlet density in the community	8%
Social host ordinances	39%
Alcohol use at community festivals and county fairs	25%
Drinking and driving	47%
Health education messages	75%
Working on barriers faced by underserved populations to reduce disparities in alcohol use	12%
Screening, counseling, and/or referral in health care settings	18%
Other (please specify)	8%
None of the above	20%

Other (please specify):

- HEROs Coalition - youth leadership development
- Identified issues with binge drinking and underage drinking as part of the community health assessment.
- Active involvement in [Community Health Board] Chemical Mental Health Coalition AND [Community Health Board] Safe Roads Coalition
- Working on health education messages with a school and their coalition.

4a. Identify the activities carried out by your community health board in the past year related to alcohol use. (Check all that apply.)

Answer for the strategies selected in Q4, above.

Policy advocacy (strengthening local ordinances)

Minnesota community health boards, 2018 (n=17)	%
Attended trainings	76%
Conducted assessments	47%
Convened partners or participated in coalitions	94%
Involved with community outreach and education	76%
Educated policymakers	82%
Developed proposal or policy	41%
Implemented policy (this year)	29%
Maintained policy (which was previously implemented)	47%
Evaluated policy impact	6%

Policies to reduce drink specials in bars and restaurants

Minnesota community health boards, 2018 (n=1)	%
Attended trainings	100%
Conducted assessments	0%
Convened partners or participated in coalitions	100%
Involved with community outreach and education	100%
Educated policymakers	0%
Developed proposal or policy	100%
Implemented policy (this year)	100%
Maintained policy (which was previously implemented)	0%
Evaluated policy impact	0%

Alcohol compliance checks

Minnesota community health boards, 2018 (n=24)	%
Attended trainings	25%
Conducted assessments	46%
Convened partners or participated in coalitions	67%
Involved with community outreach and education	54%
Educated policymakers	38%
Developed proposal or policy	4%
Implemented policy (this year)	8%
Maintained policy (which was previously implemented)	63%
Evaluated policy impact	17%

Beverage server training

Minnesota community health boards, 2018 (n=22)	%
Attended trainings	45%
Conducted assessments	41%
Convened partners or participated in coalitions	82%
Involved with community outreach and education	77%
Educated policymakers	50%
Developed proposal or policy	9%
Implemented policy (this year)	14%
Maintained policy (which was previously implemented)	55%
Evaluated policy impact	23%

Alcohol outlet density in the community

Minnesota community health boards, 2018 (n=4)	%
Attended trainings	25%
Conducted assessments	75%
Convened partners or participated in coalitions	25%
Involved with community outreach and education	50%
Educated policymakers	50%
Developed proposal or policy	25%
Implemented policy (this year)	0%
Maintained policy (which was previously implemented)	0%
Evaluated policy impact	0%

Social host ordinances

Minnesota community health boards, 2018 (n=20)	%
Attended trainings	30%
Conducted assessments	25%
Convened partners or participated in coalitions	65%
Involved with community outreach and education	55%
Educated policymakers	55%
Developed proposal or policy	30%
Implemented policy (this year)	10%
Maintained policy (which was previously implemented)	75%
Evaluated policy impact	0%

Alcohol use at community festivals and county fairs

Minnesota community health boards, 2018 (n=13)	%
Attended trainings	31%
Conducted assessments	31%
Convened partners or participated in coalitions	62%
Involved with community outreach and education	62%
Educated policymakers	46%
Developed proposal or policy	8%
Implemented policy (this year)	8%
Maintained policy (which was previously implemented)	31%
Evaluated policy impact	0%

Drinking and driving

Minnesota community health boards, 2018 (n=24)	%
Attended trainings	67%
Conducted assessments	25%
Convened partners or participated in coalitions	92%
Involved with community outreach and education	96%
Educated policymakers	54%
Developed proposal or policy	4%
Implemented policy (this year)	4%
Maintained policy (which was previously implemented)	21%
Evaluated policy impact	0%

Health education messages

Minnesota community health boards, 2018 (n=38)	%
Attended trainings	61%
Conducted assessments	32%
Convened partners or participated in coalitions	76%
Involved with community outreach and education	87%
Educated policymakers	47%
Developed proposal or policy	5%
Implemented policy (this year)	5%
Maintained policy (which was previously implemented)	16%
Evaluated policy impact	5%

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

Minnesota community health boards, 2018 (n=6)	%
Attended trainings	67%
Conducted assessments	33%
Convened partners or participated in coalitions	67%
Involved with community outreach and education	50%
Educated policymakers	67%
Developed proposal or policy	0%
Implemented policy (this year)	0%
Maintained policy (which was previously implemented)	17%
Evaluated policy impact	0%

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

Minnesota community health boards, 2018 (n=9)	%
Attended trainings	44%
Conducted assessments	89%
Convened partners or participated in coalitions	22%
Involved with community outreach and education	44%
Educated policymakers	11%
Developed proposal or policy	11%
Implemented policy (this year)	11%
Maintained policy (which was previously implemented)	11%
Evaluated policy impact	0%

4b. Estimate the top three funding sources that supported your strategies related to alcohol use.[9]

Answer for the strategies for which you selected "Used SHIP Funding for Strategy" or "Used Other (Non-SHIP) Funding for Strategy" in Q4, above. Rank "1," "2," and "3."

Minnesota community health boards, 2018 (n=41)	% largest source	% second-largest source	% third-largest source
Local tax levy	27%	34%	22%
State general fund (Local Public Health Act)	24%	37%	15%
SHIP	7%	0%	2%
Other state funds (from MDH or from other state agencies)	22%	10%	10%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	50%	5%	7%
Title V Block Grant	0%	2%	7%
Foundation funds	0%	0%	7%
Fees/reimbursement	0%	0%	5%

[9] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.

Maternal and child health

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

Reporting guidance

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

Measures: Maternal and child health

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

MDH will provide this data.

Minnesota community health boards, 2018 (n=51)	#
Women served at WIC clinics (unduplicated)	47,401

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

MDH will provide this data.

Minnesota community health boards, 2018 (n=51)	#
Infants served at WIC clinics (unduplicated)	50,017

7. How many children were served at WIC clinics within your community health board (unduplicated)?

MDH will provide this data.

Minnesota community health boards, 2018 (n=51)	#
Children served at WIC clinics (unduplicated)	74,207

Prevent the spread of communicable diseases

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

Immunization

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

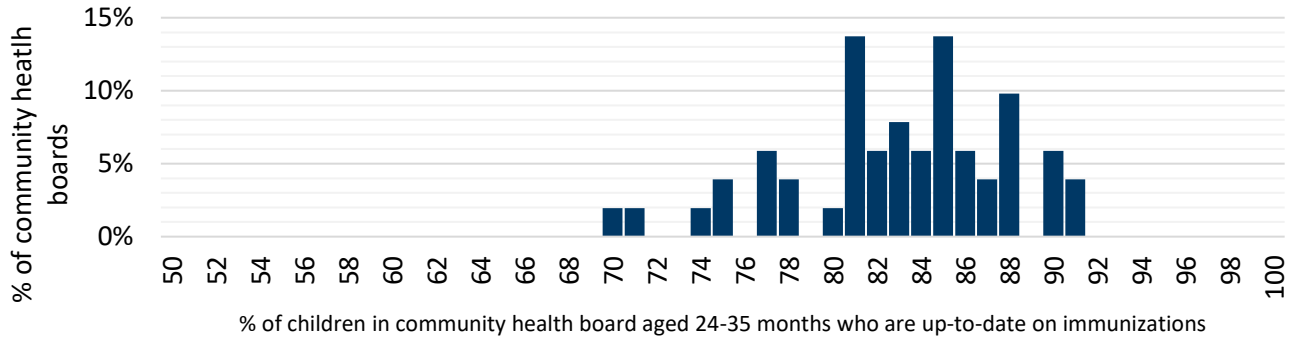
Reporting guidance

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

Measures: Immunizations

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

MDH will provide this data.



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

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

Minnesota community health boards, 2018 (n=51)	%
Yes	92%
No	8%

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

Answer if you selected "yes" to Q2, above.

Minnesota community health boards, 2018 (n=47)	% no	% yes, though doing less in recent years	% yes; relatively stable in recent years	% yes, doing more in recent years
Provide immunization to clients at the time of receiving another public health service (e.g., WIC, family planning, home visit, Child and Teen Checkup, etc.)	26%	26%	36%	13%
Provide immunization to "walk in" community members by request (at the public health department)	13%	34%	38%	15%
Provide immunization during designated clinic(s) conducted jointly with others	32%	23%	30%	15%
Provide immunization during designated clinic(s) conducted as a preparedness exercise (clinic to administer influenza vaccine during typical flu season)	55%	21%	19%	4%
Provide immunization during designated clinic(s) conducted as part of an emergency response (clinic to administer H1N1 vaccine or another type of vaccine during an outbreak)	77%	15%	6%	2%
Provide immunizations timed around reminder/recall efforts within the region	34%	15%	43%	9%

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

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

Minnesota community health boards, 2018 (n=51)	%
No	65%
No, but recently completed	8%
Yes, currently underway	16%
Yes, planned	12%

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

Minnesota community health boards, 2018 (n=51)	%
No	4%
Yes, though doing less in recent years	12%
Yes; relatively stable in recent years	75%
Yes, doing more in recent years	10%

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

Minnesota community health boards, 2018 (n=51)	% routinely	% during an emergency response	% for influenza vaccination	% for non-influenza vaccination	% not performed
Provided education to the community	88%	16%	63%	57%	0%
Engaged with immunization providers to discuss immunization coverage	84%	12%	35%	49%	4%
Engaged with partners to coordinate services	76%	4%	39%	43%	6%
Used MIIC data to engage immunization providers in immunization improvement activities	69%	4%	12%	37%	22%
Used MIIC data to conduct reminder/recall outreach for clients of the community health board	75%	4%	10%	37%	20%
Used MIIC data to conduct reminder/recall outreach for residents of the jurisdiction (not only those who attended a clinic held by the community health board)	63%	2%	2%	29%	33%
Used QI tools and processes to improve immunization practices or delivery in the community health board	57%	0%	20%	35%	31%
Served as a resource [to immunization providers in your community health board's jurisdiction] on current recommendations and best practices regarding immunization	92%	12%	33%	43%	8%
Conducted population-based needs assessment informed by immunization coverage levels in MIIC	53%	2%	6%	24%	45%
Mentored one or more community health boards to help them improve immunization rates	25%	0%	8%	8%	73%
Coordinated with community health board's MIIC regional coordinator (e.g., to conduct outreach to clients needing immunizations, to conduct reminder/ recall, and/or to get immunization coverage data)	88%	6%	16%	31%	4%
Other (please specify)	16%	0%	4%	4%	80%

Other (please specify):

- As a result of an AFIX visit, we will be adding a QI project with aim to increase completed HPV rates in 11 - 12 year olds. Reminder cards with education included are sent to parent/caregivers. Nursing staff has had further information on HPV including "Talking Points" with parent/caregivers.
- [Community health board] is the regional coordinator for MIIC
- Provide 17 year olds that are eligible for Child and Teen Checkups with their MIIC record to encourage completion of high school graduation immunizations.
- We do follow up phone calls based on immunization needs and requests.
- Administered influenza vaccination to [community health board] staff only fall 2018.
- Focus on school population in high schools within a School Based Clinic
- 2018- Assess discrepancies in vaccine compliance in the school setting. / Assess county/community vulnerability for herd immunity. / Implement Performance Management System to monitor immunization rates.

- Targeted immunizations provided off site at community school locations and at community clinic site -- uninsured diabetic group.
- Provided influenza immunizations at Hmong-specific health clinics and summer health fairs with community partners.
- Provided education to the community via a table display at the County Admin Center and Service Center during National Infant Immunization Week. Materials were taken from the tables indicating interest.
- Initiate efforts to evaluate Adolescent Immunization Rates in our jurisdiction
- Conduct immunizations with the Amish Community.

Protect against environmental health hazards

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

Indoor air

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

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

Reporting guidance

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

Glossary

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

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

Measures: Indoor air

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

Minnesota community health boards, 2018 (n=51)	%
Refer to MDH Indoor Air Unit	78%
Investigate complaints	47%
Administer enforcement, as necessary	41%
Community education	43%
Other (please specify)	10%
None of the above	2%

Other (please specify):

- policy advocacy: e-cigs
- Tobacco Compliance Checks-[member jurisdiction of community health board]
- [Community health board] jurisdiction excludes the following community health boards and EH program delegation agreements located in [community health board]: [city, city, city, city, city, city, city]
- We provide information and education when requested with in-person conversation, brochures, pamphlets. etc.
- Distribute Radon kits and instructions for use to County residents.

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

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

Minnesota community health boards, 2018 (n=21)	%
All public places and places of employment	43%
Food, beverage, and lodging establishments only	57%
Neither (none)	0%

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

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

Minnesota community health boards, 2018 (n=21)	%
All public places and places of employment	38%
Food, beverage, and lodging establishments only	33%
Neither (none)	29%

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

Minnesota community health boards, 2018 (n=51)	%
Provided information (including training) to the general public	71%
Provided technical information (including training) to professionals	12%
Provided information to policymakers	16%
Coordinated services	24%
Made referrals	53%
Included a check for the presence of mold	27%
Conducted inspections specifically for mold (this includes accompanying inspectors from another department)	18%
None of these preventive actions related to mold	16%

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

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

Minnesota community health boards, 2018 (n=9)	%
Residence: Owner-occupied	56%
Residence: Rented	78%
Commercial: Owned	22%
Commercial: Rented	11%
Licensed (e.g., food, lodging, etc.)	67%
Public (e.g., school, government)	22%
Other (please specify)	0%

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

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

Minnesota community health boards, 2018 (n=9)	%
Residence: Owner-occupied	0%
Residence: Rented	11%
Commercial: Owned	11%
Commercial: Rented	0%
Licensed (e.g., food, lodging, etc.)	56%
Public (e.g., school, government)	11%
Other (please specify)	11%
Community health board does not issue orders to building owners or operators to correct mold or moisture problems as a preventive measure	33%

Other (please specify):

- landlord instructed to fix it

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

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

Minnesota community health boards, 2018 (n=6)	%
Minnesota Local Public Health Act (Minn. Stat. § 145A.04)	33%
Local public nuisance ordinance	17%
Building code	17%
Other ordinance/rule/statute (please specify)	83%

Other ordinance/rule/statute (please specify):

- [Community health board member jurisdictions] Ordinance Providing for the Regulation of Lodging Establishments.
- MN food code chapter 4626 and MN lodging code Chapter 4625
- FBL orders issued in licensed establishment
- Ordinance 272, Rental Dwelling Units
- [Community health board] ordinance providing for the regulation of lodging establishments

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

Minnesota community health boards, 2018 (n=51)	%
Provided information (including training) to the general public	78%
Provided technical information (including training) to professionals	14%
Provided information to policymakers	16%
Coordinated services	35%
Made referrals	65%
Included a check for the presence of mold	33%
Conducted inspections specifically for mold (this includes accompanying inspectors from another department)	27%
Community health board did not take any of these actions in response to mold-related complaints and/or emergencies	4%

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

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

Minnesota community health boards, 2018 (n=14)	%
Residence: Owner-occupied	50%
Residence: Rented	86%
Commercial: Owned	14%
Commercial: Rented	7%
Licensed (e.g., food, lodging, etc.)	36%
Public (e.g., school, government)	14%
Other (please specify)	0%

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

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

Minnesota community health boards, 2018 (n=14)	%
Residence: Owner-occupied	7%
Residence: Rented	29%
Commercial: Owned	7%
Commercial: Rented	0%
Licensed (e.g., food, lodging, etc.)	36%
Public (e.g., school, government)	7%
Other (please specify)	43%
Community health board does not issue orders to building owners or operators to correct mold or moisture problems as a preventive measure	14%

Other (please specify):

- landlords
- We provide recommendation only to non-licensed facilities. With licensed establishments issue orders only to licensed food, pool, and lodging establishments.
- none issued in 2018
- No orders issued
- Owners were in the process of cleaning up the moisture and mold so no orders necessary.
- No mold found, ventilation issue.

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

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

Minnesota community health boards, 2018 (n=12)	%
Minnesota Local Public Health Act (Minn. Stat. § 145A.04)	42%
Local public nuisance ordinance	25%
Building code	17%
Other ordinance/rule/statute (please specify)	50%

Other (please specify):

- 2012 International Property Maintenance Code as adopted by reference into [city] City Code.
- [Community health board] Ordinance Providing for the Regulation of Lodging Establishments.
- FBL orders issued in licensed establishment
- N/A
- no citation
- County Rental Ordinance

Blood lead

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

Reporting guidance

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

Measures: Blood lead

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

Minnesota community health boards, 2018 (n=51)	%
Community health board responds to blood lead test results	98%
Community health board does not respond to elevated blood lead test results	0%
Not applicable: Community health board did not receive blood lead test results during reporting period	2%

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

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

Minnesota community health boards, 2018 (n=50)	%
Send family a letter	98%
Call family to discuss	94%
Schedule home visit and provide educational materials	68%
Track/assure follow-up blood lead testing	90%
Provide public health referrals (e.g., WIC, MA, follow-up testing) and/or contact medical provider	100%
Review additional housing-based threats (e.g., Healthy Homes)	50%
Do follow-up visit	34%
Other (please specify)	10%

Other (please specify):

- Mail out letter with educational information and materials.
- Provide follow up telephone calls, HV only if necessary
- Offer enrollment in lead hazard control mitigation program (HUD Grants)
- Partner with the Environmental Health Division to conduct an environmental investigation.
- Offer home visit, send letter to MD, and include copy of the MDH Childhood Blood Lead Treatment Guidelines.

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

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

Minnesota community health boards, 2018 (n=50)	%
Send family a letter	92%
Call family to discuss	98%
Schedule home visit and provide educational materials	96%
Track/assure follow-up blood lead testing	90%
Provide public health referrals (e.g., WIC, MA, follow-up testing) and/or contact medical provider	100%
Review additional housing-based threats (e.g., Healthy Homes)	64%
Do follow-up visit	68%
Other (please specify)	26%

Other (please specify):

- partner with MDH
- Refer to MDH for home visit and testing.
- Home visit with state lead inspector
- Test items in home as needed for lead.
- Partner with MDH
- Offer enrollment in lead hazard control mitigation program (HUD Grants)
- Send appropriate educational materials
- Visits are made in coordination with MDH Environmental Health Specialist.
- Work collaboratively with MDH content experts.
- Partner with the Environmental Health Division to conduct a mandatory environmental investigation.
- MDH Risk Assessor Visit
- Connect with MDH Lead staff
- Coordinate home visiting with MDH Lead Assessor. Make referrals and assist in locating funding sources for abatement.

Drinking water protection and well management

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

Reporting guidance

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

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

Measures: Drinking water protection and well management

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

Minnesota community health boards, 2018 (n=51)	%
Attend water quality trainings	47%
Educate policymakers or the public on drinking water quality	39%
Provide technical assistance on drinking water issues	57%
Provide or facilitate water testing services for residents	59%
Operates a delegated well program	22%
Other (please specify)	29%
None of the above	12%

Other (please specify):

- Public Health does little environmental health work in [community health board], The supervisor has participated on occasion in the Water Resource Advisory Committee governed by the [community health board] Soil and Water Conservation District. They have completed their water plan this past year and it does have strategies for drinking water. The [community health board] District does not report to the Human Services Board, only to the County Board. The components around health are not typically the focus of this group. Our SCHSAC representative does sit on this committee. Our PH unit does not have the capacity to do more than attend an occasional meeting and provide feedback as able.
- Refer to environmental services.
- Refer to [community health board] Environmental Services
- provide well test kits
- Work collaboratively with the unit conducting delegated well and well water testing on public health response.
- [Community health board] has a delegation agreement with MDH for Transient, non-community well water owners/operators.
- Facilitate sampling of establishments that do not fall under Safe Drinking Water Protection definition
- Well water kits available for purchase. Printed information available for the public.
- TNCWS well Construction Sealing Maintenance
- Send appropriate educational materials
- Teaching and assist per request to obtain testing
- The [community health board] Environmental Team via the County Planning, and Environmental Resources Departments addresses ground water protection and monitoring.
- [Community health board] had a delegation agreement with MDH for non-community public water supply inspections through 2018, but has terminated that agreement beginning in 2019.
- Refer public to MDH Well Sealing Cost Share, cost share agricultural practices that reduce nitrate run-off, septic repair loan program, septic replacement assistance.
- Involved in perfluoro-alkyl substance (PFAS) issues and 3M settlement in south [community health board]

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

Minnesota community health boards, 2018 (n=51)	%
Collect well water samples for testing	29%
Promote well water testing	75%
Provide private well owners with well information	69%
Well Sealing Cost Share	20%
Other (please specify)	22%

Other (please specify):

- Refer to environmental services.
- [Community health board] Planning and Management sponsor a cost share program to protect and restore quality water. Funding is used for rain gardens, shoreline restoration, native plantings, and other projects.
- Refer to environmental services
- We provide well test kits along with instruction, lab fees and drop of locations for tests. We provide referral/contact information to the county environmental services dept as they handle water testing and information on septic systems, wells, etc..
- We coordinate education provided to well owners with our environmental resources unit who conducts the testing.
- Provide information and education on testing
- None - City Water
- Provide consultation regarding private well water quality and testing
- [Community health board] Well Sealing cost share program is administered by another county department outside of the Public Health Department.
- Permits: construction, sealing and maintenance TNCWS
- none

Extreme weather

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

Reporting guidance

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

Glossary

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

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

Measures: Extreme weather

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

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

Minnesota community health boards, 2018 (n=51)	%
Attend extreme weather trainings	55%
Educate policymakers or the public on the health impacts of extreme weather	41%
Convene partners or participate in coalitions to mitigate or adapt to extreme weather	39%
Develop or implement a plan or policy to mitigate or adapt to extreme weather (e.g., heat response plan or policy to turn vacant lots into community gardens)	47%
Conduct assessments on extreme weather vulnerability	43%
Pursue funding to address extreme weather (e.g., grants)	6%
Other (please specify)	4%
Community health board has not considered extreme weather	10%

Other (please specify):

- Participate in tabletop exercises; [community health board] Sheriff's Office oversees extreme weather
- work is done through Emergency Preparedness related to extreme weather

Nuisance investigations

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

Reporting guidance

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

Measures: Nuisance investigations

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

Minnesota community health boards, 2018 (n=51)	%
Garbage/junk house	61%
Mold	55%
Improper sewage disposal, discharging to surface/groundwater/into structure	22%
Accumulation of rubbish or junk	45%
Accumulation of decaying animal or vegetable matter	2%
Hazardous building or unsanitary dwelling	25%
Vermin or vector infestations	31%
Clandestine drug labs	4%
Failure to keep waste, refuse, or garbage properly	24%
Contaminated drinking water	2%
Elevated radon	8%
Contaminated surface water	0%
Hazardous waste	2%
Unsecured hole or opening (abandoned well, well pit, sewage treatment system, non-maintained swimming pool, mine shaft, tunnel)	2%
Accumulation of carcasses of animals or failure to dispose of carcasses in a sanitary manner	0%
Chemical spill	2%
Contaminated ground water	0%
Other (please specify)	8%

Other (please specify):

- Bed Bugs Infestations-Worked with Management of Apartment Building and Exterminator was hired to eradicate the bed bugs
- Tenant complaints of rental housing
- Possible foodborne illness
- Bedbugs

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

Answer for those items checked in Q8, above.

Minnesota community health boards, 2018 (n=51)	n	% removal, abatement, or resolution	% evidence-based strategies on prevention	% partnered with other agencies to address
Garbage/junk house	n=31	81%	23%	77%
Mold	n=28	29%	71%	61%
Improper sewage disposal, discharging to surface/groundwater/into structure	n=11	82%	18%	82%
Accumulation of rubbish or junk	n=23	83%	22%	65%
Accumulation of decaying animal or vegetable matter	n=1	100%	0%	0%
Hazardous building or unsanitary dwelling	n=13	77%	31%	77%
Vermin or vector infestations	n=16	63%	50%	69%
Clandestine drug labs	n=2	100%	0%	100%
Failure to keep waste, refuse, or garbage properly	n=12	83%	8%	67%
Contaminated drinking water	n=1	0%	100%	0%
Elevated radon	n=4	0%	75%	75%
Contaminated surface water	n=0	n/a	n/a	n/a
Hazardous waste	n=1	100%	100%	100%
Unsecured hole or opening (abandoned well, well pit, sewage treatment system, non-maintained swimming pool, mine shaft, tunnel)	n=1	100%	0%	100%
Accumulation of carcasses of animals or failure to dispose of carcasses in a sanitary manner	n=0	n/a	n/a	n/a
Chemical spill	n=1	100%	0%	0%
Contaminated ground water	n=0	n/a	n/a	n/a

Emerging issues

There is a long history of state and local collaboration to improve environmental health across Minnesota. Local health departments and community health boards are at the forefront of promoting environmental health, and may see emerging issues and trends at the local level that are not yet apparent statewide.

Reporting guidance

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

Question 9 is optional.

Measures: Emerging issues

9. Please describe any emerging environmental health issues in your community health board, the challenges they pose, and how you are working to address them.

Optional.

To view this measure's responses, contact the MDH Center for Public Health Practice.

Food, pools, and lodging services

In 2017, the Environmental Health Continuous Improvement Board (EHCIB) collected and monitored statewide performance measures for food, pools, and lodging services (FPLS); the EHCIB will repeat this again this year. When available, MDH will also provide the data to those without FPLS delegation agreements, as it did in 2017.

Reporting guidance

Community health boards will not report on FPLS measures as part of the LPH Act Annual Reporting Performance Measures module. The EHCIB will collect FPLS data separately but also through REDCap. For measure text and instructions for reporting on these measures, visit: Environmental Health Continuous Improvement Board (www.health.state.mn.us/ehcib).

Assure health services

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

Clinical-community linkages

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

Reporting guidance

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

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

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

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

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

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

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

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

Measures: Clinical-community linkages

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

Minnesota community health boards, 2018 (n=51)	% workplace strategy in the health care setting	% Screen-Counsel-Refer-Follow-Up (SCRF) in the clinical setting	% establishing a community evidence-based practice (EBP) program	% other (please specify)
Used SHIP funding and/or SHIP match for strategy	57	31	39	16
Used other (non-SHIP) funding for strategy	4	14	10	4
Used both SHIP funding and/or SHIP match AND other (non-SHIP) funding for strategy	18	18	20	4
Was not involved in strategy	22	37	31	76

Other (please specify):

- tobacco cessation training with Dental community
- Support and coordinate [city] Area Collaborative Network
- Clinic Connect and Mom & Baby Cafe
- Breastfeeding support
- Quit Plan Resource
- Health Care Coaching
- CHA/CHIP data steering committee and community dialog event
- Helping to connect Community Health Workers to School Based Clinic patients,
- CHA/CHIP with local hospital
- Breastfeeding Collaborative Work; Central Minnesota ACEs Collaborative
- Completing CHIP; Using healthcare, public health and community input to develop CHIP
- Opioid Pilot funded by SHIP clinical-community linkages include prescribing guidelines and SBRT

1a. Estimate the top three funding sources that supported your strategies related to clinical-community linkages. [10]

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

Minnesota community health boards, 2018 (n=49)	% largest source	% second-largest source	% third-largest source
Local tax levy	6%	24%	37%
State general fund (Local Public Health Act)	6%	37%	24%
SHIP	73%	18%	2%
Other state funds (from MDH or from other state agencies)	1%	1%	40%
Federal program-specific funding (including federal funds that flow through the state to local public health, such as CDC Community Wellness Grant or 1422 Grant)	10%	2%	0%
Title V Block Grant	0%	0%	4%
Foundation funds	0%	4%	2%
Fees/reimbursement	0%	2%	4%

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

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

Minnesota community health boards, 2018 (n=33)	%
Yes	73%
No	27%

Provision of public health services

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

Reporting guidance

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

Glossary

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

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

[10] May not add up to 100%; some community health boards indicate only a primary or primary and secondary source.

Measures: Provision of public health services

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

Minnesota community health boards, 2018 (n=51)	% primary care: medical	% primary care: dental	% licensed home care	% correctional health
Provided services	14%	4%	24%	22%
Contracted for services	8%	25%	4%	4%
Provided services AND contracted for services	10%	4%	0%	6%
Did not provide services	69%	67%	73%	69%