

Meeting notes: Foundational Public Health Responsibility Workgroup

DATE: 11.5.25

ATTENDANCE

Members present:

Joanne Erspamer (NE), Sarah Reese (NW), Katherine Mackedanz (central), Jeff Brown (Metro), Mary Navara (MDH), Kiza Olson (SC), Jody Lien (West Central), Sagar Chowdhury (SE), Odi Akosionu-DeSouza (MDH), Rod Peterson (SCHSAC), David Kurtzon (MDH), and Ann Zukoski (MDH).

Participants present:

Kim Milbrath (MDH), Heather Myhre (MDH)

Workgroup staff:

Ann March

Linda Kopecky

Purpose

Finalize standards and recommendations

Decisions made

No formal decisions made

Action items for members

- LPH workgroup members should be sharing standards and recommendations with regions. Ann and Linda are available to support and assist you if you'd like.
- Review edits to the standards and recommendations.
- Next regular meeting: December 3, 8:30-10:00 a.m.

Talking points

Establishing Clear Standards for Fulfillment: State legislation requires that FPHR Grant funds be used for local priorities only after foundational responsibilities are fulfilled, creating the need for clear, statewide standards of what “fulfillment” means. To meet this need, the SCHSAC FPHR Workgroup convened for 18 months, collaborating with subject matter experts to develop recommendations that clarify each foundational responsibility, propose standards for fulfillment, and outline next steps to strengthen

alignment and accountability across the system. **Only CHBs who want to use FPHR grant for community-specific priorities identified in their CHA and CHIP would need to demonstrate fulfillment of standards.**

Refining Standards: The workgroup focused on continued refinement of foundational responsibility standards, clarifying language, placement, and reducing redundancy. Workgroup used guiding questions to ensure standards reflect baseline expectations and remain within local public health scope. Achieved collective agreement on several refinements, identified a few items for further review, and ensured pathway measures are fully represented.

Accredited Agency Considerations: Discussed how accredited agencies should demonstrate fulfillment of standards. Broad agreement that accreditation should satisfy requirements without requiring duplicative documentation. Explored practical verification options (e.g., annual reports, confirmation of reaccreditation progress).

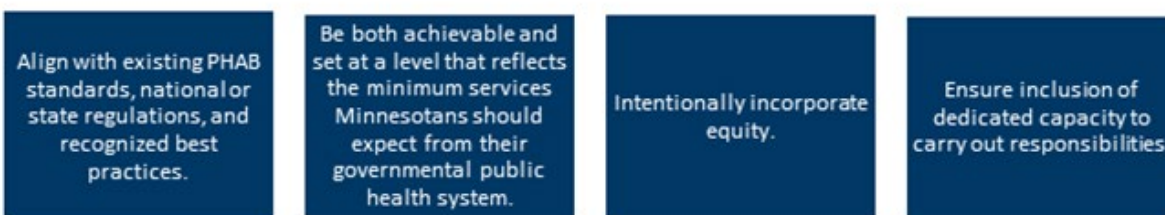
Frequency of Review: Agreed on a structured review cycle: initial review after two years, then at least every five years. Reviews to include MDH, LPHA, and SCHSAC for shared accountability. Ensures standards remain current, relevant, and adaptive to system needs without frequent or burdensome updates.

Meeting notes

Reviewing Standards

The workgroup continued its ongoing work refining and discussing foundational responsibility standards, building on small group conversations from the previous week. Review focused on clarifying language and placement and eliminating redundancies.

As part of the review, they considered the standards through the lens of the following criteria and questions:



Do these reflect a baseline of what should be in place for fulfillment of each responsibility?

Does the standard in the scope of local public health responsibility?

Key Takeaways:

- The discussion helped surface areas of confusion or overlap.
- Collective agreement on several refinements
- A few items were flagged for additional review
- Tightening alignment and shared understanding of the standards.
- Ensured all the pathway measures were represented

Demonstrating fulfillment of standards-pathway for accredited agencies

The workgroup explored how accredited public health agencies should meet expectations under the proposed standards. Discussion centered on whether accreditation status should automatically satisfy requirements or if additional documentation should be required.

Participants considered the workload already involved in maintaining accreditation and emphasized avoiding duplication of effort. There was general agreement that accredited agencies should not have to provide new or separate documentation beyond what is already required for reaccreditation.

The group also discussed simple ways to verify that accredited agencies remain current, such as submitting annual accreditation reports or confirming ongoing progress toward reaccreditation.

Before finalizing this approach, the group planned to gather additional feedback from accredited agencies and local public health leaders to ensure the process is practical and supported.

Frequency of review

The workgroup discussed how often the definitions, standards, and related processes should be reviewed. After deliberation, members agreed on an initial review after two years, followed by subsequent reviews at least every five years. The review process should include MDH, LPHA, and SCHSAC to ensure shared ownership and accountability. This approach allows adequate time for initiation, implementation, and learning, while ensuring the documents remain living resources that evolve with system needs, without requiring frequent revisions.

DRAFT Standards for Fulfillment of Foundational Responsibilities

These standards are still being refined by the workgroup. A (P) after some of the capability standards represent public health accreditation board pathways measures.

Standards for Foundational Areas

Overarching standards for foundational areas

- Plans and initiatives for all areas reflect collaboration with community partners.
- Programs in all areas measure progress, outcomes, and equity impacts, and findings are shared to guide decision-making and make improvements.
- Professional development includes skills-based training for staff in all areas, including ongoing training in equity-centered, trauma-informed, and evidence-based public health practices.

Communicable Disease Control

- Data collection is aligned with applicable local, state, and federal requirements, utilizing guidance from the MIDOG, section D.
- Communication strategies are implemented and tailored for various audiences. (MIDOG, Section F)
- During infectious disease response, messaging, outreach, and response activities are coordinated with communicable disease partners (governmental and non-governmental) and documented.
- Infectious disease roles are identified and clearly defined (as outlined in MIDOG) and staff are prepared to perform them.
- The statewide immunization information system (MIIC) is maintained and used to support immunization coverage.

Chronic Disease and Injury Prevention

- Population health trends for chronic disease and injury are tracked and communicated to inform partners and the public.
- Policy, systems, and environmental (PSE) and evidence-based approaches are used to address chronic disease and injury.

Environmental Public Health

- Alignment with the current Food, Pools, and Lodging (FPL) delegation agreement language and ensures practices are updated accordingly. (for delegated agencies only)
- Staff responsible for public health nuisance response are trained in enforcement and abatement.
- Enforcement and abatement activities are guided by clear, documented policies and procedures in accordance with statutory and, where applicable, delegation requirements.
- Ensure continuity of essential programs and activities during periods of decreased funding or staffing shortages.
- Education, outreach, and technical assistance related to prevention, mitigation, abatement, and compliance are tailored to meet the needs of specific communities or audiences.
- Environmental public health services and coordination efforts address hazards from environmental factors to ensure readiness across communities, particularly for emergency response situations.

Maternal, Child, and Family Health

- Data is used to align and adapt programs and activities.
- Community input (including service recipients) informs MCFH programs and initiatives.
- MCFH activities align with appropriate statutory requirements.

Access to and Linkage with Clinical Care

- Access-to-care data is collected and analyzed to identify gaps and barriers, including but not limited to gaps in services, affordability, transportation barriers, and workforce availability.
- Access-to-care data is used to inform planning, advocate for policy change, guide resource allocation, and collaborate on improvement initiatives (e.g., behavioral health access or provider shortages).
- Adhere to all relevant public health laws and guidance, understanding mandatory responsibilities.

- Support (or lead when appropriate) coordination of access-to-care efforts across sectors.
- Partner with providers and health systems to improve access to primary care and patient-centered care.

Standards for Foundational Capabilities

Accountability and Performance Management

- A performance management system is established (P)
- A performance management system is implemented.
- Performance measures are aligned, where appropriate, with relevant local, state, tribal, and federal strategies.
- Programs and interventions are based on the best available evidence. (P)
- Quality improvement projects are implemented. (P)

Assessment and Surveillance

A community health assessment is developed in collaboration with partners and community, using a variety of data from many sources, include strengths and assets. (P)

- Non-surveillance population health data is collected. (P)
- Participation in data sharing with other entities. (P)
- Analyze data and draw public health conclusions. (P)
- Maintain surveillance systems. (P)
- Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards. (P)

Communications

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

Community Partnership Development

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

Emergency Preparedness and Response

- Maintain a public health emergency operations plan (EOP).
- Conduct exercises and use After Action Reports and Improvement Plans (AAR-IPs) to improve preparedness and response. (P)
- Using ICS language, structure, and guidelines, the agency maintains at least one staff person with readiness, response, and recovery expertise in a leadership position, and include support activities in position descriptions of additional staff.
- All agency staff have at a minimum, a basic understanding and training for responding to and recovering from an emergency.
- Ensure of operations during response. (P)
- Maintain and implement a process for urgent 24/7 communications with response partners. (P)

Equity

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

Organizational Competencies

- Adopt a department-wide strategic plan. (P)
- The local public health agency must have a full-time director or supervisor overseeing public health functions.
- The CHS administrator meets requirements under 145A.04 Subd.2, Minnesota Rules 4736.0110
- Support programs and operations through an information management infrastructure (P). (with a built, internal system or through a vendor contract)
- Protect information and data systems through security and confidentiality policies. (P)
- Recruit a qualified and diverse health department workforce. (P)
- Develop and implement a workforce development plan and strategies. (P)
- Provide professional and career development opportunities for staff (P)
- The agency must have a financial management system.
- Oversee grants and contracts (P)
- Manage financial systems (P)
- Access and use legal services in planning, implementing, and enforcing public health initiatives (either through their organization's legal services or through contracted legal counsel) (P).
- The agency leadership must discuss and recognize the presence and scope of legal services with the Community Health Board annually.
- Maintain a human resource function (P)
- Communicate with governance routinely and on an as-needed basis. (P)

Policy Development and Support

- Community data and assessments consistently used to shape policy priorities.
- Examine and contribute to improving policies and laws (P).

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- Conduct enforcement actions. (P)