JOINT LEADERSHIP TEAM FOR PUBLIC HEALTH SYSTEM TRANSFORMATION

Systems and Policies that Shape Governmental Public Health in Minnesota

Contents

Purpose, scope, and goal

We envision a seamless, responsive, publicly-supported governmental public health system that works closely with the community to ensure healthy, safe, and vibrant communities. This system of state, local, and tribal health departments will help Minnesotans be healthy regardless of where they live.

To make this vision a reality, we must understand *how* the governmental public health system functions, including policies that shape public health authority, and the formal and informal practices that guide public health practice around the state.

At the direction of the Joint Leadership Team, consultants conducted:

- **An assessment of systems and practices** that influence governmental public health in Minnesota.
- **A review of policies and legal frameworks** that shape local public health authority in Minnesota, the local practices within Minnesota's governmental public health system, and how to leverage the intersection between policy and practice to bring the vision above to life.

These are key steps toward a seamless, responsive, and publicly-supported governmental public health system in Minnesota. By identifying pain points, successes, and possible opportunities to transform Minnesota's governmental public health system, we can confirm what we know, illuminate new considerations and context, and raise questions that the Joint Leadership Team will ponder together with you.

Readers should note that **the scope of this assessment does not include making recommendations for specific next steps in system transformation or for best/ideal governance or organizational structures**. In addition, both the assessment and review largely focus on local public health jurisdictions in Minnesota, but consider some aspects of federal, state, and Tribal public health as they relate to local public health.

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September 2025. To obtain this information in a different format, call 651-201-3880.

Methods

For the assessment of systems and practices, Crucible Consulting used a combination of one-on-one interviews, facilitated group listening sessions, surveys, and supplemental research, covering all three sectors represented by the Joint Leadership Team[1] along with non-governmental (community) partners.

For a review of policies and legal frameworks, Seed2Roots reviewed Minnesota laws that regulate public health, conducted a deep dive into four local health jurisdictions in Minnesota, and reviewed policies in another state with a similar governmental public health system.

A subcommittee with members from LPHA, MDH, and SCHSAC helped shape methodology and analyze findings.

Next steps

The Joint Leadership Team will use the findings below (along with ongoing engagement from represented sectors, emerging findings from Minnesota Infrastructure Grant innovation projects, past assessments like the 2023 cost/capacity assessment), and current context to chart a course forward and collectively transform Minnesota's public health system. To dig more deeply into next steps, visit page 8 in this document.

Questions and assistance

Based on the collaborative nature of this work, please direct any questions or feedback to the Joint Leadership Team members from your sector of the local-state partnership. You can find a roster of members at: Joint Leadership Team (https://www.health.state.mn.us/communities/practice/systemtransformation/jointleadteam.html).

For general questions, please contact the MDH Center for Public Health Practice at health.ophp@state.mn.us.

Systems that shape governmental public health in Minnesota

Governance structures in local public health are varied, with challenges and opportunities

All layers of government work together—including people, resources, funding, and more—to make sure public health responsibilities are fulfilled. Local public health governance structures in Minnesota include single-county, single-city, and multi-county community health boards; and single-county and multi-county human services boards.

- Regardless of their size or governance structure, all of Minnesota's local public health jurisdictions shared strengths that helped and challenges that hindered their ability to fulfill foundational responsibilities and community-specific needs.
- When jurisdictions are aligned, multi-jurisdiction partnerships can lead to shared resources, peer support, and the ability to identify and respond to cross-county trends.
- When jurisdictions have very different demographics or needs, multi-jurisdiction governance structures can encounter significant operational challenges and may not best serve their communities. This is particularly

[1] The three sectors represented by the Joint Leadership Team for Public Health System Transformation in Minnesota are local public health via the Local Public Health Association of Minnesota (LPHA), state public health via the Minnesota Department of Health (MDH), and locally-elected officials via the State Community Health Services Advisory Committee (SCHSAC).

true for jurisdictions required by statute to form a multi-county community health board with adjacent jurisdictions (due to their population size of less than 30,000 residents), which may force partnerships between communities that are different in a number of ways and make it difficult to leverage the multi-jurisdiction partnership for strategic alignment, cooperative programming, or administrative efficiencies.

The assessment raises a number of questions, including:

- It is community health board members' responsibility to make decisions about governmental local public health, and to understand that public health is a responsibility and a function of government (not an optional activity). How are they equipped to do so, and what do they need to carry out that function? What do community health board members need to fulfill their function, and who advises them?
- What does a community health board need to best address upstream, foundational, population-level health needs in its communities?
- How do boards use community input or consult with communities for decision-making? How are communities represented?
- Do boards feel equipped to carry out their governance functions; including implementing policies that protect, promote, and improve the health of the public; assuring the availability of adequate resources to perform foundational public health functions; and provide necessary leadership to support local public health agencies?
- How do community health boards consult and coordinate with Tribal Nations when appropriate?

Organizational structures in local public health are varied, with opportunities and challenges

Minnesota law gives local public health jurisdictions the flexibility to arrange themselves and carry out public health responsibilities in a variety of organizational and operational structures, depending on what best meets the needs of the communities served by the community health board (e.g., standalone public health department for one or multiple counties, public health department integrated with human services across one or multiple counties, or public health contracted to a hospital or health care organization).

- Each structure has strengths and weaknesses in helping fulfill foundational responsibilities and community-specific needs, but all need to intentionally focus on prevention and population health. The leadership and staff at an agency play a key role in its success.
- The assessment calls attention to the challenges present in hospital-contracted public health agencies in particular; this model was found to result in conflicting priorities between hospital business models and public health's broader population health goals.

Reducing health disparities is challenging and inadequately supported

Minnesota is a healthy place to live for many Minnesotans, but not all. Public health has a role to play in reducing these disparities, yet we haven't made the progress we desire—data still shows vast health inequities based on a person's demographics and location.

- There is wide variation across the state in public health agencies' ability to tackle health equity work. Depending on the jurisdiction, several governance, organizational, social, and political factors can make it challenging for local public health agencies to sustain an adequate level of community engagement and power-sharing needed to address health disparities and health inequities.
- Because the word "equity" has become politically charged in some areas, Minnesota's public health system sees an uneven level of focus on equity-centered strategies. Some community health boards can

pursue initiatives related to equity, while governing bodies in some jurisdictions do not think "health equity" applies to their community and/or reject it as a legitimate body of work.

- Rural communities in particular can face heightened systemic challenges to equity work, yet still need to focus on health disparities related to race and ethnicity, both for the benefit of the people they serve and to meet many funding/grant requirements.
- In order to address health disparities and inequities statewide, the Twin Cities Metro Area and Greater Minnesota cannot perceive public health and its resources and attention as a zero-sum game, and must work together across urban-rural divides toward equity.
- The entire governmental public health system in Minnesota must help address the structural and systemic factors that contribute to health disparities, along with community and other sectors. This includes ensuring public health work addresses upstream prevention, populations-systems-environmental change (PSE), and social determinants—not just social needs. The 2023 assessment of capacity to do foundational work in Minnesota shows that this is a gap, and that the public health system needs to develop and implement strategies, and accelerate action, to build capacity for health equity work.

Funding is insufficient and inflexible

This assessment underscores what we know to be true about the insufficient and inflexible nature of public health funding, which is further compounded by recent changes in federal funding.

- When local public health relies on grants and topic-specific/project-specific funding, it often creates administrative burden; leaves critical, foundational public health responsibilities underfunded; and does not allow for local public health agencies to address or engage with communities on health priorities that are unique to their communities or that communities themselves have identified.
- Wide-ranging and diverse local public health funding sources mean staff and leaders often wear many hats, dividing their time and energy across numerous grant requirements without the capacity to fully devote themselves to their agency's work holistically, or to nimbly pivot to meet emerging priorities.
- Topic- and project-specific funding sources usually don't cover foundational work like community partnership development, policy development and support, and communications; this foundational work that glues an agency together often gets set aside because there's no funding to cover it. Some grants, like the Statewide Health Improvement Partnership (SHIP) cover some foundational work, but limit it to specific topics (in the case of SHIP, to tobacco prevention/cessation, active living, and healthy eating).
- In addition, when topic- and project-specific funding supports direct services, it leaves less room for local public health agencies to address population health needs and foundational responsibilities, which is the distinct role and value public health brings to communities. This tension shows up most vividly in local public health agencies organized as hospital-contracted public health agencies, but local public health leaders statewide note this is an issue regardless of organizational structure.

Desire and room to grow relationships with Tribal public health

This assessment was not intended to address local and state relationships with Tribal public health. However, we know that there is often a strong desire and need to partner when appropriate, among all three groups, and the Joint Leadership Team is eager to continue exploring how to help enable this at a systems level.

- The assessment did find that some local public health agencies describe generally positive, collaborative relationships with Tribal public health departments, while other local public health agencies describe more challenging circumstances.

- Each sovereign Tribal Nation also carries its own interests, concerns, and history with the State of Minnesota and the Minnesota Department of Health, and do not (and should not be expected to) move as a single entity of "Tribal public health" as we work to collectively transform the governmental public health system.

Leadership functions don't reflect current and future public health practice

The assessment raised the need to modernize the function, role, title, and requirements of the community health services (CHS) administrator, to reflect current and future local public health practice in Minnesota.

- The public health system lacks clarity in how the roles of CHS administrator and public health director can or should interact with each other.
- There is a great deal of variation across the system in the role of CHS administrator; some can engage in meaningful strategic leadership while others essentially act as grant managers for the community health board.
- The need exists to standardize and set requirements for the role and authority of CHS administrators, especially as it relates to public health expertise.
- Although this assessment didn't make note of high staff and leadership turnover in the public health system, many state and local public health leaders express worry about the high number of both public health leaders and front-line workers leaving the public health system by choice, necessity, or loss of funding.
- How can or should the public health system support local public health leaders?

State-local partnership brings challenges and opportunities

This assessment largely reflected local perspectives and needs regarding the state-local partnership, with a number of challenges and opportunities.

- Local public health agencies share that support and guidance from MDH can be inconsistent, depending on the specific area or individual staff person within MDH.
- Local public health agencies would like more streamlined reporting requirements and funding structures from MDH.
- Local staff see MDH regional colleagues as crucial to their success. The public health system could build on that success in a number of ways to increase regional collaboration.
- Local health departments often struggle to access timely and relevant data from MDH, limiting their ability to act as chief health strategists who can make informed decisions and/or respond effectively to public health threats. Modernizing how data systems are structured, shared, and accessed is especially crucial to a seamless, responsive, and publicly-supported public health system; the Joint Leadership Team is eager to support groups like the SCHSAC Data Modernization Workgroup who are working to address this at a systems level.

Frameworks and statutory language can be unclear

The assessment also noted that, in Minnesota, we talk about the role and value of public health using a number of different frameworks: six areas of public health responsibility, 10 essential public health services, foundational public health responsibilities. These different frameworks, especially as they show up in state statute, can sometimes make clarity challenging for public health workers and decision-makers.

Readers will note that this issue is also raised within the policies and legal frameworks review, below.

Policies and legal frameworks that shape governmental public health in Minnesota

The review of policies and legal frameworks covered four topic areas:

1. **Public health authority under Minnesota law**: How does Minnesota law regulate the authority between state government and local public health governmental entities?
2. **Local public health responsibilities under Minnesota law**: What requirements does Minnesota law create for public health services provided in local communities?
3. **Local public health policies**: Are there specific examples of effective policies local public health entities in Minnesota use to coordinate their work and provide services? What can be learned from these examples? To answer this, reviewers examined policies from four community health boards in Minnesota.
4. **Nation-wide efforts**: Consultants assessed the legal framework governing public health authority and local public health responsibilities of one other state to inform Minnesota work.

In answering these questions, consultants and a review team noted the following key findings in consultation with assessment subcommittee members, local public health representatives, and members of the Joint Leadership Team.

To dig deeper, consult the full policy review found in the appendix of this document.

Local Public Health Act terminology can be ambiguous, and statutory language is often outdated

Ambiguous/general Local Public Health Act terminology

Similar terminology is used for different concepts and legal requirements, which can create confusion regarding expectations about how community health boards should meet the public health needs of local communities. For example, using similar yet distinct terms like “essential public health services,” “areas of public health responsibility,” “community health services,” and “foundational public health responsibilities” to tease out different aspects of how local public health operates can lead to potential inconsistencies in how different community health boards implement the Local Public Health Act.

Additionally, Minnesota statute requires MDH to create reports on the provision of “core public health functions” by local government public health, yet there is no indication about how this term aligns with the Local Public Health Act. In addition, reviewers noted that some language used in practice, such as a “fully integrated” community health board, is not defined in the Local Public Health Act.

Readers will note that this issue is also raised within the systems summary, above.

To this end, the review group identified the following possible steps to address this confusion:

- Assess cleaning up legal definitions for consistency and accessibility, including terminology that is used in practice but not defined in statute.
- Address duplicative and overlapping language, either through statutory updates, rulemaking, or state guidelines to provide greater distinction between similar terminology.
- Provide clearer guidance regarding required or mandated local public health services to limit different interpretations and implementation at the local level. The Local Public Health Act includes nuance and suggestion, but specific direction regarding specific requirements is limited.
- Consider updates to the Local Public Health Act related to funding, duplicative language, and terminology.

Outdated statutory language

Some Local Public Health Act language is outdated and does not align with how public health practice and priorities are implemented across the state. Specific areas identified include:

- Public health funding program language is outdated, particularly regarding the nurse-family partnership program.
- The Statewide Health Improvement Partnership (SHIP) is noted in statute as a competitive grant program but is awarded via formula.

Room exists to explore state vs. local public health authority

Additional research on the intersection between Minnesota state and local public health authority could be helpful to inform future work to transform Minnesota's public health system to be more seamless, responsive, and publicly-supported.

Specific areas of research identified include:

- Assessing the relationship between MDH and local public health entities in Minnesota within the context of Dillon's Rule[2] where local public health powers are more specific than in some states, particularly regarding delegation, state-local relationships, and preemption.
- Examining separate city authority to regulate/govern public health distinct from Local Public Health Act and independently of community health boards, such as the separate authority granted to cities to govern public health as it relates to tobacco, state personnel rules, government contracting requirements, etc.

Inconsistency in local public health policies limits comparison and learning

Reviewing four jurisdictions' policies in depth revealed a lack of common metrics and standards for assessing and comparing local public health policies across different community health boards. The lack of common metrics and standards limits opportunities for local public health to compare and analyze local policies, and to learn from each other.

Specific recommendations include:

- To combat the inconsistencies in policy and need for best practices, MDH and LPH should work together to determine what public health policies are needed, examine them against best practices and develop a clearinghouse to share these policies among LPH.

Minnesota expertise in public health policy is valuable yet fragile

Minnesota's public health system benefits from the collective public health system policy experience and expertise of its leadership, program staff, and front-line workers, which reflects years of professional experience as leaders, partners, and collaborators within and outside of the governmental public health system.

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[2] A key component of Minnesota's constitutional structure is a legal principle referred to as "Dillon's Rule," which establishes the relationship of power and authority between local and state government whereby local governments possess only those powers that are conferred by state law. In Minnesota, this principle applies to public health powers created by Minnesota's Local Public Health Act. The Local Public Health Act specifically lays out the state and local relationship and responsibilities of local public health governmental entities through delegation, preemption, and other areas that exist. The powers conferred by the LPH Act exist in concert with implied power necessary to carry out legislatively conferred powers.

Several review participants expressed concern about preserving the insights, experiences, and knowledge of individuals who may be nearing retirement and not lose the wisdom and insight of the years of experience.

Assessment of policy vs. practice can inform system transformation

Reviewers discussed how much policy structure is needed to realize the goals of transforming Minnesota's public health system to be more seamless, responsive, and publicly-supported.

Reviewers recognized that too little specificity in structure could lead to greater inequities, while too much specificity in structure could limit local context and innovation.

Opportunity to increase local public health education and training on statute

Reviewers identified the need to create more consistent and ongoing education and training for local public health officials and staff regarding the Local Public Health Act, revisions to statutory language, new statutory and regulatory language, and emerging best practices.

Next steps

The Joint Leadership Team will use the findings from this assessment and current context to chart a course forward and inform how we collectively transform Minnesota's public health system.

Next steps and ongoing work

The Joint Leadership Team, LPHA, MDH, and SCHSAC will continue to move forward in its work on the following areas:

- **Clarifying roles and expectations** for MDH, community health boards, and CHS administrators (as public health officials).
- **Cleaning up statutory language** is a clear need, to ensure language in Minnesota state statute is simplified, up to date, clear, and consistent as it pertains to the state's governmental public health system.

Deeper conversations

The Joint Leadership Team, LPHA, MDH, and SCHSAC will engage in deeper conversations about the following, and together uncover how to resolve them through statute, governance, practice, or another avenue:

- **Ensuring local public health governance** is informed by public health expertise and by community expertise and experience, structured to fulfill foundational public health responsibilities (vs. strictly population), and recognizes the role public health plays in prevention.
- **More clearly describing the governmental public health system**, and that it includes federal, state, local, and Tribal public health agencies
- **Recognition of Tribal sovereignty and public health authority**.

Appendix. A Full Review of the Policies and Legal Frameworks that Shape Governmental Public Health in Minnesota

Contents

Overview

As part of the Minnesota public health system transformation effort,[1] the following report provides an overview of Minnesota statutes, regulations, and select local public health policies that define the structure of Minnesota's public health system.

This document is meant to be a first step in the legal policy analysis of current Minnesota public health statutes and regulations, in addition to local policy, using examples from Minnesota local jurisdictions, as well as Colorado, to identify possible points of future research and next steps.

This resource is intended as an internal reference point for the Joint Leadership Team for Public Health System Transformation in Minnesota and key stakeholders and is not meant to be a public-facing report.

It covers four topic areas:

1. **Public health authority under Minnesota law.**
   Learning question #1: How does Minnesota law regulate the authority between state government and local public health governmental entities?
2. **Local public health responsibilities under Minnesota law**.
   Learning question #2: What requirements does Minnesota law create for public health services provided in local communities?
3. **Local public health policies**.
   Learning question #3: Are there specific examples of effective policies local public health entities in

Minnesota use to coordinate their work and provide services? What can be learned from these examples? To answer this, reviewers examined policies from four community health boards in Minnesota: Carlton-Cook-Lake-St. Louis Community Health Board, City of Bloomington Public Health Division, Goodhue County Public Health Division, and Horizon Public Health.

4. **Nation-wide efforts**.
   Learning question #4: Consultants assessed the legal framework governing public health authority and local public health responsibilities of Colorado, to inform Minnesota work.

Background and methodology

Seed 2 Roots worked with Crucible Strategy, in conversation with the Joint Leadership Team (https://www.health.state.mn.us/communities/practice/systemtransformation/jointleadteam.html), to research and identify the state and local public health policies that define the structure of Minnesota's public health system. This work supports the Minnesota Department of Health assessment and facilitation proposal.

Seed 2 Roots relied heavily on the expertise of a policy and assessment findings and themes review team (review team) that agreed to be part of the MDH 21st century policy draft document review subcommittee. Seed 2 Roots would like to thank these people for their thoughtful review and expert commentary.

As part of Deliverable #1, Seed 2 Roots, Crucible Strategy, and the Joint Leadership Team identified four general research themes and learning questions relating to those themes. Those are:

- Theme 1: Public health authority under Minnesota law.
  Question #1: How does Minnesota law regulate the authority between state government and local public health governmental entities?
- Theme 2: Local public health responsibilities under Minnesota law.
  Question #2: What requirements does Minnesota law create for public health services provided in local communities?
- Theme 3: Local public health policies.
  Question #3: Are there specific examples of effective policies local public health entities in Minnesota use to coordinate their work and provide services? What can be learned from these examples?
- Theme 4: Nation-wide efforts.
  Question #4: Assessment of legal framework governing public health authority and local public health responsibilities of another state to inform Minnesota work.

For Deliverable #2, Seed 2 Roots developed a legal research protocol plan. The legal research protocol plan created the legal research protocol that outlined the basic research protocols informing the research of this document and response to the four learning questions.

Seed 2 Roots used a non-linear, mixed-methods approach to inform the research for this effort. The research process involved multiple steps and methods, each of which yielded insights for answering the questions identified in Deliverable #1. These overlapping research approaches complemented and enriched one another. This non-linear, mixed-method approach was used throughout the project to continue to "reality check" the themes and conclusions that emerged.

The legal research methodology focused on written documents and is meant to be used in conjunction with other qualitative and quantitative methods led by Crucible Strategy.

For Deliverable #3, Seed 2 Roots provided a report responding to learning questions #1 and #2. Using the general research themes and learning questions as the framework and the Legal Research Protocol Plan as the guide, Seed 2

Roots developed an outline of important aspects of Minnesota statutes and regulations for these questions and reviewed this outline with a review team to ensure that key themes and legal issues were included.

Each question has its own section in this document, with specific notations on how the questions have evolved with the project.

Seed 2 Roots then reviewed the draft report responding to learning questions #1 and #2 with the review team and incorporated edits into a draft report.

Deliverable #4 provided a report responding to learning questions #3 and #4 and included a review and feedback from the review team.

Deliverable #5 consolidated the write-up of the previous stages of the project in this final report which includes additional review and feedback from the review team and systems assessment subgroup of the Joint Leadership Team.

Questions and assistance

Based on the collaborative nature of this work, please direct any questions or feedback to the Joint Leadership Team members from your sector of the local-state partnership. You can find a roster of members at: Joint Leadership Team (https://www.health.state.mn.us/communities/practice/systemtransformation/jointleadteam.html).

For general questions, please contact the MDH Center for Public Health Practice at health.ophp@state.mn.us.

Public health authority under Minnesota law

Learning question #1: How does Minnesota law regulate the authority between state government and local public health governmental entities? [a]

Public health legal framework in Minnesota

The relationship between state and local governmental entities is established by Minnesota's Constitution to create the basic structure for the authority between state and local public health governmental entities in Minnesota.[b] As part of this constitutional framework, the public health authority of Minnesota's local and state

[a] Please note: This review is limited to an analysis of the relationship between state and local Minnesota governmental public health entities and does not include an analysis of the relationship between state and Tribal public health entities. Tribes are sovereign nations with unique political and legal status. https://www.publichealthlawcenter.org/sites/default/files/resources/Drafting-Tribal-Public-Health-Laws-2020.pdf (last visited October 30, 2023) for additional context and information about Tribal public health law and policy.

[b] A key component of Minnesota's constitutional structure is a legal principle referred to as "Dillon's Rule." "Dillon's Rule" establishes the relationship of power and authority between local and state government whereby local governments possess only those powers that are conferred by state law. In Minnesota, this principle applies to public health powers created by Minnesota's Local Public Health Act. The Local Public Health Act specifically lays out the state and local relationship and responsibilities of local public health governmental entities through delegation, preemption, and other areas that exist. The powers conferred by the Local Public Health Act exist in concert with implied power necessary to carry out legislatively conferred powers. See MN House Research – State and Local Relations, November 2019, available at https://www.house.mn.gov/hrd/pubs/ss/sslcstrel.pdf (last visited October 30, 2023).

This legal review is based on the authority of statutory cities and counties in Minnesota through the principle of "Dillon's Rule" and does not include an analysis of differences in public health authority between statutory and home rule cities or

governments may be impacted by preemption, "a legal concept where a higher level of government has the authority to limit, or even eliminate, the power of a lower level of government to regulate a certain issue."[2] In Minnesota, preemption can include express preemption, conflict preemption, and field/implied preemption.

"Express preemption" is when "the legislature expressly declares that a state law shall prevail over the [local] ordinance;" "conflict preemption" addresses a situation where a "[local] ordinance conflicts with state law;" and "field/implied preemption" addresses situations where the "legislature has comprehensively addressed the subject matter such that state law now occupies the field."[3]

A number of Minnesota statutes and regulations work within this constitutional framework to create the legal foundation for Minnesota's governmental public health system and provide direction regarding public health responsibilities at the local level. Minnesota's Local Public Health Act creates the framework for Minnesota's local public health system and establishes the relationship between local and state governmental public health entities.

The Local Public Health Act expressly preempts a county board or city council within the jurisdiction of a community health board operating under the Local Public Health Act from forming a community health board except as specified by the Local Public Health Act.[4] The Local Public Health Act uses both express and conflict preemption to prohibit a county board from adopting ordinances regulating actual or potential public health threats that are "preempted by, in conflict with, or less restrictive than standards in state law or rule."[5]

The Local Public Health Act gives the governing body of a city or town the power to "adopt ordinances relating to the public health authorized by law or agreement with [MDH]" so long as these ordinances do not conflict with or are less restrictive than ordinances adopted by the county board within whose jurisdiction the city or town is located.[6] In addition to providing the framework for the local public health system in Minnesota, the Local Public Health Act also provides specificity regarding the duties of local public health governmental entities in meeting the public health needs of the communities they represent.[7]

A number of other Minnesota statutes and regulations also work in concert with the Local Public Health Act to provide a comprehensive state and local public health system. These laws include those governing the Minnesota Departments of Health and Human Services; those establishing the authority of local city and county governments; and those protecting environmental health, in addition to other areas impacting public health.[8]

Minnesota's governmental public health system

Minnesota's governmental public health system involves entities at both the state and local level. Minnesota statutes and regulations provide direction regarding the authority and duties of different governmental entities in providing comprehensive public health services across the state.

Key players

Broadly speaking, Minnesota's governmental public health system includes the Minnesota Department of Health (MDH),[9] local city and county governments, community health boards, and local health departments.[10] While the general relationship between these entities is guided by the legal framework created through

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counties in Minnesota. In general, home rule charter cities and counties can exercise any powers established through their charters as long as these powers do not conflict with state laws. The majority of Minnesota cities are statutory cities (as of 2022, 107 of Minnesota's 853 cities were home rule cities). Ramsey County is the only home rule county in the state.

For additional information see: Immunities and Preemptions CLE, MN Attorney General's Office (March 3, 2022) available at https://www.ag.state.mn.us/Office/CLE/20220309/Default.asp (last visited October 30, 2023); State-Local Relations, MN House Research (November 2019), available at available at https://www.house.mn.gov/hrd/pubs/ss/sslcstrel.pdf (last visited October 30, 2023).

Minnesota's Constitution, the Local Public Health Act directly addresses the authority and power between these entities as part of the state's public health system.[11]

MDH is responsible for developing and maintaining an "organized system of programs and services for protecting, maintaining, and improving the health of citizens."[12] This authority includes coordinating and integrating local, state, and federal programs and services affecting the public's health.[13]

Community health boards are "the governing body for local public health in Minnesota."[14] Community health boards are responsible for developing and maintaining a system of community health services under local administration, within a system of state guidelines and standards as established through the Local Public Health Act.[15]

The governing body of a county is required to undertake the responsibilities of a community health board by establishing or joining a community health board.[16] Community health boards established prior to January 1, 2014, including city community health boards, are allowed to maintain their separate status as a community health board so long as they meet the other legal requirements for a community health board.[17]

In general, a community health board is responsible for governing the activities of a local health department, with local health departments functioning as the operational entity responsible for addressing the areas of public health responsibility[c] through the administration and implementation of programs and services.[d] [18]

Organization of community health boards[19]

The Local Public Health Act identifies two governing structures counties and cities can use to organize their public health work. Counties and cities can organize their public health work through a community health board or a county human services board created pursuant to the requirements of Minnesota Statutes Chapter 402, so long as the human services board meets the same criteria as a community health board, and has assigned powers and duties of a community health board.[20]

The Local Public Health Act identifies different configurations a community health board or human services board can take including as a:

- Single-county, city or county/city community health board;[21]
- Multi-county or city community health board;[e] [22]
- Single-county human services board;[23] or
- Multi-county human services board.[24]

Multi-county and multi-city community health boards are formed through joint powers agreements authorized under Minnesota law.[25] Within these configurations, Minnesota law gives local units of governments flexibility to arrange themselves and carry out public health responsibilities in a variety of operational structures, depending on what best meets the needs of the communities served by the community health board.[26]

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[c] Public health responsibility means: "(1) assuring an adequate local public health infrastructure; (2) promoting healthy communities and healthy behaviors; (3) preventing the spread of communicable disease; (4) protecting against environmental health hazards; (5) preparing for and responding to emergencies; and (6) assuring health services." MINN. STAT. §145A.02, Subd. 1.

[d] In some limited situations the community health board is the operational entity with staff to carry out the duties of a community health board.

[e] Multi-county community health boards can be structured in a number of different ways, depending on what bests serves the needs of the communities served, including those that are fully integrated, operate as distinct county departments, and operate as a partnership. (Information provided by review team.)

State assistance to community health boards

MDH is required to provide help to community health boards that ask for assistance in "developing, administering, and carrying out public health services and programs."[27] This assistance may include "informational resources, consultation, and training" to assist community health boards "plan, develop, integrate, provide, and evaluate community health services."[28] In addition, MDH must provide assistance, when requested, to community health boards regarding compliance with the "administrative and program guidelines and standards developed with the advice of the State Community Health Services Advisory Committee."[29]

Delegation and/or assignment of public health power and duties

The Local Public Health Act gives MDH and community health boards authority to delegate or assign their respective public health powers and duties to another entity in certain situations.

Delegation of powers and duties from MDH to community health board, county, or city

MDH may enter into an agreement with any community health board, or county or city that has an established delegation agreement as of January 1, 2014, to "delegate all or part of the licensing, inspection, reporting, and enforcement duties" in specific areas, including:[30]

- Areas delineated under the regulation, enforcement, license, and fee authority of MDH;[31]
- Safe Drinking Water Act;[32]
- Minnesota Clean Indoor Air Act;[33]
- Youth camps;[34]
- Investigation; reporting and control of communicable diseases;[35]
- Construction, repair, and abandonment of water wells;[36]
- Food, beverage, and lodging establishments;[37] and
- Manufactured home parks and camping areas.[38]

Agreements to perform duties of community health board

A community health board may authorize a city or county within its jurisdiction to carry out activities to fulfill its responsibilities. This agreement must be in writing, meet specific requirements, and be approved by MDH.[39]

Assignment of community health board powers and duties to human services board

A county board or a joint powers board that establishes a community health board may assign the powers and duties of the community health board to a human services board operating in compliance with Minnesota Statutes Chapter 402.[40]

Designated agent

A community health board must authorize, by resolution, a community health services administrator (CHS administrator) or other designated agent or agents to act on behalf of the community health board.[41] The community health board must provide a copy of the resolution to MDH.[42] The resolution must specify the types of action or actions that the CHS administrator is authorized to take on behalf of the board.[43]

Enforcement of state and local public health laws

Enforcing public health laws in Minnesota local communities is a shared responsibility between MDH, Minnesota local city and county governments, and community health boards.

Local enforcement of public health laws

Under the general supervision of MDH, community health boards are required to "recommend the enforcement of laws, regulations, and ordinances pertaining to the powers and duties within its jurisdictional area."[44] A community health board, county, or city may also bring an action "in the court of appropriate jurisdiction to enjoin a violation of statute, rule, or ordinance that the board has power to enforce, or to enjoin as a public health nuisance any activity or failure to act that adversely affects the public health."[45] With multi-county or city community health boards, the joint powers agreement creating the community health board must "clearly specify enforcement authorities."[46]

Additionally, a community health board may recommend local ordinances regarding the provision of community health services to any county board or city council within its jurisdiction. A community health board may also advise MDH on any matters relating to public health requiring assistance from the state, or that may be of more than local interest.[47]

A city council or county board that has established or is a member of a community health board may adopt and enforce minimum standards for public health services so long as the ordinance does not conflict with state law or with more stringent standards established either in Minnesota Rules or by the provisions of the charter ordinances of any city.[48]

County boards have the authority to adopt and enforce ordinances for all or a part of its jurisdiction to regulate actual or potential threats to the public health so long as the local ordinances are not "preempted by, in conflict with, or less restrictive than standards established in state law or rule."[49] This includes the authority of county boards to adopt ordinances consistent with the Local Public Health Act "to administer and enforce the powers and duties delegated by agreement with [MDH]."[50]

Governing bodies of a city or town "may adopt ordinances relating to the public health authorized by law or agreement with [MDH]" so long as these ordinances do not conflict with and are not less restrictive than ordinances adopted by the county board within whose jurisdiction the city or town is located.[51]

A community health board, county, city, or its agent is required to address a threat to public health "such as a public health nuisance, source of filth, or cause of sickness" on any property by ordering "the owner or occupant of the property to remove or abate the threat" within a specific amount of time, no longer than 10 days.[52]

The Local Public Health Act provides specific requirements for how notice must be provided to the property owner.[53] Entities or agents performing enforcement duties under a delegation agreement with MDH are not allowed to operate outside their jurisdiction unless there is a separate agreement with the governing body of the other jurisdiction to provide those services.[54] Failure to perform legally required enforcement duties under state statute or local ordinance by members or agents of a community health board, county, or city is a misdemeanor.[55]

State enforcement of public health laws

MDH is responsible for ensuring that both state and local public health laws are followed.[56] MDH may adopt reasonable rules to preserve public health by requiring licenses or permits, or other appropriate means in a wide range of areas impacting public health.[57] These rules cannot conflict with the charter or ordinance of a city of the first class on the same subject.[58]

MDH has specific power to supervise local enforcement of public health laws, including:[59]

- Appointing three or more individuals to act as a community health board until one is established and fixing their compensation, which the county or city must pay;
- Requiring two or more community health boards, counties, or cities to act together to prevent or control epidemic diseases; and
- Employing medical and other help necessary to control communicable disease at the expense of the involved jurisdiction.

If MDH believes that the Local Public Health Act is being violated, it must inform the attorney general and provide information to support this belief. The attorney general is then responsible for instituting proceedings to enforce the provisions of the Local Public Health Act or direct the county attorney to institute proceedings.[60] At the local level, MDH has the authority to "bring an action in the court of appropriate jurisdiction to enjoin any violation of a statute or rule which [MDH] is empowered to enforce or adopt, or to enjoin as a public health nuisance any activity or failure to act that adversely affects the public health."[61]

Community health board staffing requirements[62]

The Local Public Health Act creates basic staffing requirements for community health boards, including a requirement that community health boards work with a CHS administrator[63] and a medical consultant.[64] A community health board is responsible for appointing the services of a CHS administrator and medical consultant to support its operations.[65]

MDH adopted rules setting personnel standards for administrative and program personnel to ensure competence in administration and planning.[66] As part of the rule-making process, MDH, in consultation with the State Community Health Services Advisory Committee (SCHSAC),[f] established minimum personnel standards for the CHS administrator and other individuals "implementing or supervising community health services programs by agreement with [MDH]."[67]

These rules establish "minimum standards for training, experience, and skill" for these individuals except for those community health boards with a personnel system approved by the United States Civil Service Commission.[68]

The CHS administrator is responsible for providing public health leadership and discharging the administrative and program responsibilities on behalf of the community health board.[69] The CHS administrator must work under a written agreement, be employed by, or work under contract with the community health board and meet personnel standards established by MDH.[70] The community health board is required to notify MDH of the CHS administrator's contact information and provide a copy of the resolution authorizing the CHS administrator to act on behalf of the community health board to MDH.[71]

Community health boards are also required to appoint, employ, or contract with a medical consultant to provide appropriate medical advice and direction for the community health board.[72] The medical consultant must be a physician licensed to practice medicine in Minnesota who is working under a written agreement with, employed by, or on contract with the community health board.[73] The medical consultant is responsible for providing advice and information, authorizing medical procedures through protocols, and assisting the community health board and its staff in the coordination of community health services and activities with local medical practitioners, health care institutions, and other health services.[74]

Public health funding mechanisms

Local public health is supported by a range of federal, state, and local funding streams.[g] [75] While the framework for local public health funding is created by the Local Public Health Act, state funding to support

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[f] The Local Public Health Act created a state community health services advisory committee (SCHSAC) to "advise, consult with, and make recommendations to [MDH] on the development, maintenance, funding, and evaluation of local public health services." Every community health board has the option of appointing a member to serve on the committee. This committee "must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members." MINN. STAT. §145A.04, Subd. 15.

[g] The majority of federal funding for local public health passes through the state to local public health. Federal funding can include funds specifically naming local public health as a recipient in addition to other funds that the state can decide to allocate to local public health. (Information provided by review team).

local public health is also provided through a range of other state entities and funding sources, including human service financing, climate change initiatives, and other grants naming community health boards as recipients.[76] In addition, the Minnesota Legislature regularly appropriates additional state funding to support local public health entities and activities.[h] [77]

MDH is required to present a report and recommendations to the state legislature by January 15 of every odd-numbered year on local government core public health functions.[78] In developing this report, MDH must coordinate the process for defining implementation and financial responsibilities of the local government core public health functions with SCHSAC and the Department of Human Services, in addition to representatives of local health departments, county government, a municipal government acting as a community health board, area Indian health services, health care providers, and citizens concerned about public health.[79]

State public health funding sources

A number of state funding sources provide support for local public health activities. The Local Public Health Act establishes base funding for eligible community health boards through the local public health grant.[80] The amount of the local public health base funding for a community health board is established through a formula included in the Local Public Health Act.[81] Community health boards have flexibility in how they use their local public health grant to "address the areas of public health responsibility and local priorities developed through the community health assessment and community health improvement planning process."[82] Amendments to the Local Public Health Act in 2023 identified additional state funding for community health boards in meeting foundational public health responsibilities.[83] Funding to support work on the foundational public health responsibilities must be distributed based on a formula determined by MDH in consultation with SCHSAC.[84]

Community health boards must prioritize the use of these funds to fulfill foundational public health responsibilities as defined by MDH in consultation with SCHSAC.[85] If a community health board can demonstrate the foundational public health responsibilities are fulfilled, the community health board may use these funds for local priorities developed through the community health assessment and community health improvement planning process.[86]

The Local Public Health Act also identifies funding to support specific public health programs in local communities. For example, state grants support expansion of nurse-family partnership programs[87] and family home visiting programs,[88] in addition to funding for approved activities through the Statewide Health Improvement Program (SHIP)[89] and the Local and Tribal Public Health Emergency Preparedness and Response Grant Program.[90]

Local public health funding sources

Community health boards are required to provide at least 75% in matching funds to receive the full amount of the local public health grant allowed under the Local Public Health Act.[91] If a community health board fails to provide the required local matching funds, the local public health grant provided for that community health board will be reduced proportionally.[92] Community health boards must use eligible funds to meet their local public health grant match. Eligible funds include local property taxes; reimbursements from third parties; fees; other local funds; and donations or nonfederal grants used for community health services as provided by the Local Public Health Act.[93] Cities organized under the Local Public Health Act that levy a tax to provide community health services are exempt from any county levy for the same services to the extent of the levy imposed by the city.[94]

County boards and city councils that have formed or are a member of a community health board are allowed to levy taxes on all taxable property in their jurisdiction to fund public health requirements under the Local

[h] In some cases the legislature names public health as recipient, in other cases local public health may have to compete for those funds. (Information provided by review group.)

Public Health Act.[95] In addition, a person who has or whose dependent or spouse has received care to control a communicable disease under the control of a community health board, is financially liable to the local government that paid for the cost of care provided to control the disease.[96] Local governments may also assess and charge the costs of enforcing public health laws against the real property on which the public health nuisance, source of filth, or cause of sickness was located.[97]

Local public health policies under Minnesota law

Learning question #2: What requirements does Minnesota law create for public health services provided in local communities?

Public health services in local communities

The responsibilities of governmental public health entities in providing public health services for local Minnesota communities overlaps and requires collaboration with key state and local partners. Minnesota law creates different frameworks to provide direction to these entities about what is expected and how governmental public health services should be provided. The extent to which each of these frameworks requires specific, measurable action varies. Even when Minnesota law requires specific public health activities or services, there is often room for interpretation and flexibility in how governmental public health entities implement specific public health services in local communities.

Duties of MDH

MDH is responsible for developing and maintaining an "organized system of programs and services for protecting, maintaining, and improving the health of the citizens."[98] This authority includes coordinating and integrating local, state, and federal programs and services affecting the public's health.[99] MDH, in consultation with SCHSAC, is responsible for developing performance measures[i] to "improve public health and ensure the integrity and accountability of the statewide local public health system" and "implement a process to monitor statewide outcomes and performance improvement."[100]

In addition, MDH is "responsible for the collection and review of disease reports, epidemiologic investigations, and control of disease in all areas of the state."[101] As part of fulfilling these responsibilities, MDH may enter into written agreements with community health boards to specify shared responsibilities for the collection of data and information regarding communicable diseases.[102]

MDH is also required to bring to the attention of a community health board "any conditions within the jurisdiction of the community health board which represent the potential for a public health hazard."[103] MDH must provide technical assistance and personnel that are available and necessary to "answer the requests of the community health board for assistance in the investigation and control of disease."[104]

In the event of a public health emergency, MDH may, after giving reasonable notice to a community health board, suspend all or certain terms of a written agreement regarding the collection of data and information for controlling disease with the community health board for a period of time sufficient to respond to the public health emergency.[105]

MDH has the authority to require any two or more community health boards, counties, or cities to act together to prevent or control both communicable and epidemic diseases.[106] In addition, if MDH determines that a community health board, county, or city has failed to meet its duty to investigate, report and control

[i] "Performance measures" are "quantitative ways to define and measure performance." MINN. Stat. §145A.02, Subd. 15(b).

communicable diseases, MDH may employ medical and other help necessary to control communicable disease at the expense of the involved jurisdiction.[107]

Duties of local governmental public health entities

Community health boards accepting local public health grants must perform duties described in the Local Public Health Act to maintain eligibility to receive the local public health grant.[108] As part of these duties, a community health board is generally responsible for developing and maintaining "a system of community health services under local administration"[j] within a system of state guidelines and standards.[109] Community health boards are required to provide equal access to these services and ensure that "community health services are accessible to all persons on the basis of need"[110] and that no one is "denied services because of race, color, sex, age, language, religion, nationality, inability to pay, political persuasion, or place of residence."[111] In addition to these general responsibilities, a community health board must also "bring to the attention of [MDH] any conditions which represent the potential for a public health hazard."[112]

As discussed, below, the Local Public Health Act directs community health boards to address "public health responsibilities,"[113] "essential public health services,"[114] and most recently, "foundational public health responsibilities."[115] Each of these frameworks works in concert with the others to provide direction to governmental public health entities about how to comprehensively address the public health needs of Minnesotans.

Public health responsibilities

A community health board must identify local public health priorities and implement activities to address these priorities and the areas of public health responsibility, which include:[116]

- Assuring an adequate local public health infrastructure;
- Promoting healthy communities and healthy behaviors;
- Preventing the spread of communicable disease;
- Protecting against environmental health hazards;
- Preparing for and responding to emergencies; and
- Assuring the availability of health services.

Each of these public health responsibilities is discussed separately, below.

Assuring an adequate local public health infrastructure

Community health boards are required to assure that there is an adequate local public health infrastructure by maintaining basic foundational capacities to a well-functioning public health system. These foundational capacities include:[117]

- 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.

[j] "Community health services" are "activities designed to protect and promote the health of the general population within a community health service area by emphasizing the prevention of disease, injury, disability, and preventable death through the promotion of effective coordination and use of community resources, and by extending health services into the community." MINN Stat. §145A.02, Subd. 6.

Promoting healthy communities and healthy behaviors

Community health boards are required to promote healthy communities and behaviors. Specific activities supporting improving population health in this area include:[118]

- 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.

Preventing and controlling communicable and epidemic disease

MDH, community health boards, county boards, city councils, and their agents share responsibility to prevent or control communicable and epidemic diseases.[119] Community health boards are required to prevent the spread of communicable disease by preventing diseases caused by infectious agents through the detection of acute infectious diseases, ensuring the reporting of infectious diseases, preventing the transmission of infectious diseases, and implementing control measures during infectious disease outbreaks.[120]

As part of these responsibilities, a community health board must coordinate with county boards or city councils in its jurisdiction and cooperate with other community health boards as practical and needed to obey instructions and direction from MDH to prevent and control epidemic diseases.[121]

In addition, community health boards are required to inform MDH of any information or other knowledge of specific cases, suspected cases, carriers, or death of specific diseases.[k] [122] A community health board must request assistance from MDH for the investigation and control of disease "when the public health hazard exceeds the capacity of the community health board to respond."[123]

If a threat to the public health, including a "cause of sickness is found on property" in its jurisdiction, the community health board, county, city, or its agent must order the owner or occupant of the property "to remove or abate the threat" within a specific amount of time, but no longer than 10 days.[124] If the owner, occupant, or agent of the property where the public health nuisance is located fails or neglects to abate the problem within the required 10-day period, a community health board, county, city or designated agent must remove or abate the cause of sickness from the property.[125]

Protecting against environmental health hazards

Community health boards, counties, cities, and their agents must work together to address environmental health hazards in local communities. Community health boards are required to protect against environmental health hazards by addressing aspects of the environment that pose risks to human health.[126] Specific areas of responsibility include:[127]

- 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.

If a threat to the public health, such as a public health nuisance, source of filth, or cause of sickness is found on property in its jurisdiction, the community health board, county, city, or its agent must order the owner or occupant of the property "to remove or abate the threat" within a specific amount of time, but no longer than 10 days.[128]

[k] See MINN. R. 4605.7040 for list of specific disease reporting requirements.

If the owner, occupant, or agent of the property where the public health nuisance is located fails or neglects to abate the problem within the required 10-day period, a community health board must remove or abate the nuisance or source of filth from the property.[129]

Preparing and responding to emergencies

The Local Public Health Act provides specific direction regarding a community health board's responsibility to prepare for and respond to public health emergencies in local communities and opportunities to collaborate across jurisdictional borders to respond to public health emergencies.[130] Community health boards must prepare for and respond to emergencies by "engaging in activities that prepare public health departments to respond to events and incidents and assist communities in recovery."[131]

These activities include:[132]

- Providing leadership for public health preparedness activities with a community;
- Developing, exercising, and periodically reviewing response plans for public health threats; and
- Developing and maintaining a system of public health workforce readiness, deployment, and response.

A community health board that receives "funding for emergency preparedness or pandemic influenza planning from the state or from the United States Department of Health and Human Services" must "participate in planning for emergency use of volunteer health professionals through the Minnesota Responds Medical Reserve Corps program of [MDH]."[133]

As part of this emergency preparedness or pandemic influenza planning, community health boards are required to "collaborate on volunteer planning with other public and private partners, including but not limited to local or regional health care providers, emergency medical services, hospitals, tribal governments, state and local emergency management, and local disaster relief organizations."[134]

Assuring health services

Community health boards must assure the availability of health services by engaging in a wide range of activities, including:[135]

- Assessing the availability of health-related services and health care providers in local communities and identifying gaps and barriers in services;
- Convening community partners to improve community health systems; and
- Providing services identified as priorities through the local assessment and planning process.

Essential public health services

All communities should have the capacity to address "essential public health services," which are those activities "that are conducted to accomplish the areas of public health responsibility." The 10 essential public health services include the following activities:[136]

- Monitoring health status to identify and solve community health problems;
- Diagnosing and investigating health problems and health hazards in the community;
- Informing, educating, and empowering people about health issues;
- Mobilizing community partnerships and action to identify and solve health problems;
- Developing policies and plans that support individual and community health efforts;
- Enforcing laws and regulations that protect health and ensure safety;
- Linking people to needed personal health services and assuring the provision of health care when otherwise unavailable;
- Maintaining a competent public health workforce;

- Evaluating the effectiveness, accessibility, and quality of personal and population-based health services; and
- Contributing to research seeking new insights and innovative solutions to health problems.

Foundational public health responsibilities

The Minnesota legislature amended the Local Public Health Act in 2023 to include provisions regarding "foundational public health responsibilities."[137] According to the new statutory language, MDH, in consultation with SCHSAC, is responsible for developing a definition for foundational public health responsibilities and providing funding to community health boards to fulfill these foundational public health responsibilities.[138] Community health boards are required to first use this designated funding to fulfill the foundational public health responsibilities before using these funds for other local priorities developed through the community health assessment and community improvement planning process.[139]

Performance management and reporting requirements

Community health boards are required to implement a performance management process to achieve desired outcomes[140] and provide an annual report to MDH on performance measures and the ability of the community health board to meet the performance measures.[141]

In addition, community health boards are required to submit a community health assessment and community health improvement plan to MDH every five years. The community health assessment and community health improvement plan must include input from the community about local conditions in addition to a consideration of "statewide outcomes, the areas of [public health] responsibility, and essential public health services."[142]

Health reform and local government public health functions

The Minnesota legislature recognizes that site-based and population-based services provided by state and local health departments are critical strategies for the long-term containment of health care costs.[143] In particular, the local government public health functions of "community assessment, policy development, and assurance of service delivery are essential elements in consumer protection and in achieving the objectives of health care reform in Minnesota."[144]

MDH is responsible for presenting regular reports to the legislature describing local government core public health functions every odd-numbered year.[l] These reports must include recommendations on implementing and financing these core public health functions.[145]

In developing these reports, MDH must consult with SCHSAC and the Department of Human Services, in addition to representatives of local health departments, county governments, municipal governments acting as a community health board, area Indian health services, health care providers, and citizens concerned about public health.[146] These reports must describe activities for implementing the core public health functions that are the continuing responsibility of the local government public health system, taking into account the ongoing reform of the health care delivery system.[147]

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[l] "Core public health functions" include, but are not limited to: "(1) consumer protection and advocacy; (2) targeted outreach and linkage to personal services; (3) health status monitoring and disease surveillance; (4) investigation and control of diseases and injuries; (5) protection of the environment, work places, housing, food, and water; (6) laboratory services to support disease control and environmental protection; (7) health education and information; (8) community mobilization for health-related issues; (9) training and education of public health professionals; (10) public health leadership and administration; (11) emergency medical services; (12) violence prevention; and (13) other activities that have the potential to improve the health of the population or special needs populations and reduce the need for or cost of health care services." MINN. STAT. § 62Q.33, Subd. 3.

Local public health policies

Learning question #3: Are there specific examples of effective policies local public health entities in Minnesota use to coordinate their work and provide services? What can be learned from these examples?[m]

Local jurisdictions reviewed for project[n]

The jurisdictions chosen for this analysis were identified through a survey of the Joint Leadership Team and systems assessment subgroup for the project. Considerations in selecting these jurisdictions included regional representation across Minnesota and a variety of community health board structures. Seed 2 Roots met separately with each jurisdiction to discuss the project and request assistance in identifying and providing effective policies used by each community health board to coordinate their work and provide services.

Local public health entities reviewed:

- City of Bloomington Public Health Division;
- Carlton-Cook-Lake-St. Louis Community Health Board;
- Goodhue County Public Health Division; and
- Horizon Public Health (Douglas, Grant, Pope, Stevens, and Traverse Counties).

A list of the policies provided by each of these local jurisdictions is available upon request. The four jurisdictions selected for review represent a cross section of different types of community health board structures, organization, and regional representation as follows:[148]

Community health board	Jurisdiction covered	Organizational structure	Location
Carlton-Cook-Lake-St. Louis	Multi-county community health board	Multi-county community health board	Northeast Minn. / Arrowhead region
Bloomington	City of Bloomington	Standalone public health department as a city department	Twin Cities metro
Goodhue	Single county	Health and human services agency within county gov.	Southeast Minnesota
Horizon Public Health	Multi-county community health board	Standalone, fully integrated public health department[o]	Western Minnesota

[m] Note: The review team had some questions about what was meant by some of the terminology in learning question #3, specifically regarding what would constitute the effectiveness of a policy and what was meant by "coordinate their work" in regards to what community health board policies to review. These terms were not defined and left up to the interpretation of each community health board to determine what an "effective" policy would include that was used to "coordinate their work." The review team indicated one possible interpretation of "coordinate" in this context would be the role of public health as a convenor or community hub for public health services.

[n] Note: The review team indicated interest in a more in-depth analysis of local community health board policies at some point. However, all agreed that before this type of analysis was possible, metrics needed to be established to provide a framework for analyzing the local policies. Additional discussion regarding this issue is provided, below.

[o] Note: While "fully integrated" is a term that is used to describe the organizational structure of some of Minnesota's community health boards, there is no official or legal definition of this term. For the purposes of this review, the term

Bloomington Community Health Board[p]

Bloomington Community Health Board is the governing body for the municipal Public Health Division as part of the City of Bloomington, a southern suburb of Minneapolis, bordered, in part, by the Minnesota River and Minneapolis-Saint Paul International Airport. As of 2020 Bloomington had a population of 89,987.

The Bloomington Department of Health initially started providing school nursing services in 1946 and became a division of the village of Bloomington in 1960. At that time, it provided services to Edina, Richfield, St. Louis Park, and a few other cities until Hennepin County developed its health department. Bloomington Community Health Board was accredited through PHAB in 2016.

Bloomington Community Health Board provides many public health services to the neighboring cities of Richfield and Edina through contracts specifying public health services Bloomington Community Health Board provides to residents in Edina and Richfield.[149] Bloomington also cooperates with health departments in Minneapolis and Hennepin County on activities such as community health assessments/improvement plans.[150]

In Bloomington, Edina, and Richfield, each city's governing body—its city council—acts as a community health board.[151] Additionally, Bloomington's City Council appoints an advisory Board of Health, "comprised of both providers and consumers of health services," to advise and recommend to the city council on issues concerning health and the environment.[152]

Carlton-Cook-Lake-St. Louis[q]

As its name suggests, the Carlton-Cook-Lake-St. Louis Community Health Board is the community health board serving Carlton, Cook, Lake, and St. Louis counties, in the northeast part of Minnesota, mostly along Lake Superior and the eastern portion of the state's border with Canada.

Combined, the four counties had a combined population of 252,943 in 2020, with the vast majority (200,231, or 79.1%) residing in St. Louis County. Its administrative offices are also in Duluth, which is the largest city and county seat of St. Louis County. The Carlton-Cook-Lake-St. Louis Community Health Board is not accredited.

The Carlton-Cook-Lake-St. Louis Community Health Board was formed under a joint powers agreement in 1977. It is comprised of nine board members—three from St. Louis County, and two members each from Carlton, Cook, and Lake counties. For each county, at least one member must be a county commissioner, while each county's additional member(s) can be health professionals, lay people, or additional county commissioners. The meetings of the Carlton-Cook-Lake-St. Louis Community Health Board are public and take place approximately bi-monthly.

Although Carlton-Cook-Lake-St. Louis Community Health Board is the governing body for public health in the participating four counties, most direct client services within the boundaries of each county are conducted directly by the counties themselves.

"fully integrated" means that for a multi-county community health board, there is one health department providing public health services for all of the counties that is fully coterminous with the community health board's boundaries.

[p] Public Health, Bloomington, available at https://www.bloomingtonmn.gov/ph/public-health (last visited Nov. 2, 2023).

[q] Carlton-Cook-Lake-St. Louis Community Health Board, available at https://communityhealthboard.org/about-us/ (last visited Nov. 7. 2023).

Goodhue County Health and Human Services Board[r]

Goodhue County Health and Human Services board is the governing body for public health in Goodhue County, Minnesota, which is in the southeast portion of the state along the Mississippi River. As of 2020 it had a population of 47,582. In 2010, the Goodhue County Public Health and Goodhue County Social Services integrated to form Goodhue County Health and Human Services and has operated as a combined health and human services agency since that time.[153]

The Goodhue County Health and Human Services board consists of seven members, five of whom are Goodhue County Commissioners and two of whom are lay members appointed by the Goodhue County Board of Commissioners.[154] Goodhue County Health and Human Services was accredited through the Public Health Accreditation Board (PHAB) in 2019.[155]

Horizon Public Health[s]

Horizon Public Health is a fully integrated local public health organization serving Douglas, Grant, Pope, Stevens, and Traverse Counties, in the western part of Minnesota. It has offices in the seat of each county—Alexandria, Elbow Lake, Glenwood, Morris, and Wheaton. In total, Horizon Public Health served a population of 69,419 as of 2020. Horizon Public Health was accredited through PHAB in 2021.[156]

The governing body of Horizon Public Health is the Horizon community health board, which has 13 members—11 elected officials from the five counties, and two community representatives appointed by the community health board.[157]

Its administrative team is comprised of a Public Health Administrator, two Assistant Administrators, and six Public Health Supervisors. Horizon Public Health was created in 2010 through the merger of the Mid-State Community Health Board (comprising of Stevens-Traverse-Grant Public Health and Pope County Public Health)[158] and the Douglas County Local Board of Health, accomplished through a joint powers agreement between Douglas County, Pope County, and Stevens-Traverse-Grant Public Health.[159]

Horizon fully integrated as a health department in 2015.

Nation-wide efforts

Learning question #4: Assessment of legal framework governing public health authority and local public health responsibilities of Colorado to inform Minnesota work.[t]

Summary

The state of Colorado was chosen for this analysis based on input from the Joint Leadership Team and systems assessment subgroup for the project. Key considerations for choosing Colorado included the following:

- Location
- Similar public health structure to Minnesota
- Urban and rural divide in the state

[r] Goodhue County Health & Human Services Board, available at https://co.goodhue.mn.us/648/Health-Human-Services-Board (last visited Nov. 9, 2023).

[s] Horizon Public Health, available at https://horizonpublichealth.org/about-us/ (last visited Nov. 2, 2023).

[t] MDH staff reviewed and provided feedback on learning question #4 based on prior experience working in the public health system in Colorado.

Colorado passed the Colorado Public Health Act in 2008 which created a new framework for the governmental public health system in the state.[160] In revamping its public health legal framework, Colorado was able to benefit and learn from both the time and experience of other states, like Minnesota, who have been implementing and revising their governmental public health system and legal structure for decades.

Additionally, Colorado had the benefit of building off of the broader evolution of measurable national standards developed by the Public Health Accreditation Board that provide a widely accepted definition and best practices of a well-functioning public health agency.

Colorado is in the process of implementing the new public health framework created by the 2008 Colorado Public Health Act, as follows:

- The State Board of Health completed foundational rule making (https://www.sos.state.co.us/CCR/NumericalCCRDocList.do?deptID=16&agencyID=15) addressing required by the Colorado Public Health Act in 2019;[161]
- The Colorado Department of Public Health and Environment released a Pocket Guide for Local Boards of Health (https://cdphe-lpha.colorado.gov/sites/cdphe-lpha/files/LBOH_Pocket%20Guide_Revised%20June%202023%20Updated%20Logos.pdf) in June 2023;[162] and
- The Colorado Association of Local Public Health Officials[u] released resources to support Colorado's Public Health System Transformation through the Core Public Health Services Operational Definitions Manual (https://www.calpho.org/uploads/6/8/7/2/68728279/co_cphs_definitions_manual_final_draft_clean_2019_0510.pdf) in May 2019[163] and the Colorado Public Health System Transformation Brief (https://www.calpho.org/uploads/6/8/7/2/68728279/colorado_public_health_system_transformation_brief_updated_2018_0826.pdf) in August 2018.[164]

Colorado public health leaders recognize the overhaul of Colorado's public health system through the 2008 Colorado Public Health Act as the most significant event in the history of public health in Colorado since the state passed foundational health laws in 1947.

Revising the legal structure of the public health system in Colorado was possible due to a coordinated effort and support of key public health organizations in the state that came together as the Public Health Alliance of Colorado. This group harnessed political will and collective desire to revamp Colorado's public health system and update the state's public health legal system.

The Colorado Association of Local Public Health Officials released Colorado's Public Health System: History, Structure, and Future (https://www.calpho.org/uploads/6/8/7/2/68728279/co_public_health_system_history_and_structure_-_2021_final.pdf) in 2021 to provide historical context for the changes made through the 2008 Colorado Public Health Act, 61 years after the initial foundational health laws for the state were passed in 1947.[165]

The overhaul of Colorado's public health system through the 2008 Colorado Public Health Act seems akin to the overhaul of Minnesota's public health system in 1976 with the passage of Minnesota's Community Health Services Act. Minnesota's current Local Public Health Act has evolved over the last 47 years, including several statutory revisions since 1976.[166] These revisions include adding new concepts and terminology to respond to the latest challenges, needs, and evolution of the state's public health system.

Unlike Colorado's use of rulemaking to build out specific aspects of the 2008 Colorado Public Health Act, Minnesota's rulemaking process does not appear to be a key tool that the state has used to revise and update Minnesota's Local Public Health Act.

[u] The Colorado Association of Local Public Health Officials (CALPHO) is the counterpart to Minnesota's Local Public Health Association (LPHA).

Minnesota's rulemaking process has several steps and can take a long time. The process has "stringent safeguards or checks and balances to ensure an agency's rule is legal and reasonable."[167] This often means it is easier to go to the legislature to amend a statute, rather than changing implementing regulations.

Over the past several decades, the Minnesota Legislature has added new terminology and public health concepts. This can create challenges when done within an existing framework and terminology, resulting in some overlapping terminology, as discussed in the previous sections.

When comparing Colorado's Public Health Act to Minnesota's Local Public Health Act, it is important to recognize that Colorado basically reset its public health framework in 2008, similarly to what Minnesota did in 1976. Colorado is in the earlier stages of implementing the Colorado Public Health Act and has not had the time or opportunity to add additional layers of terminology or respond to the evolving needs of Colorado's public health system over time.

As Minnesota considers how to move forward with its 21st Century Public Health Initiative, it could be helpful to have conversations with Colorado's public health leaders working to pass and implement the 2008 Colorado Public Health Act. Colorado's experience could provide a valuable example of how a state restructured the foundation of its governmental public health system. This approach provides a contrast to Minnesota's incremental efforts to amend and update the state's governmental public health structure created in 1976.

While the Colorado Public Health Act shares many of the same conceptual and structural components as Minnesota's Local Public Health Act, this review identified some potential differences of interest, which are included as observations in shaded boxes in the text in the following pages.[v]

Legal framework of Colorado public health system

In passing the 2008 Colorado Public Health Act, the Colorado Legislature recognized the public health system as a critical part of health-care reform efforts in reducing health-care costs by "preventing disease and injury, promoting healthy behavior, and reducing the incidents of chronic diseases and conditions."[168] The purpose of the Colorado Public Health Act is to "…ensure that core public health services, which are critical to ensuring the health and safety of Coloradans and preventing public health emergencies, are available with a consistent standard of quality, to every person in Colorado, regardless of where they live."[169]

Observation: The Colorado Public Health Act uses the state and local public health plans as a key mechanism to assess and ensure accountability for the implementation of public health services across the state. The reliance on these plans seems more central than Minnesota's approach.

For the state of Colorado, public health is "the prevention of injury, disease, and premature mortality; the promotion of health in the community; and the response to public and environmental health needs and emergencies" accomplished "through the provision of essential public health services."[w] [170]

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[v] Please note: Observations included, herein, do not identify all differences between the Colorado Public Health Act and Minnesota's Local Public Health Act, but highlight some differences of potential interest based on discussions with the review group and MDH staff.

[w] Essential health services means to: "(a) Monitor health status to identify and solve community health problems; (b) Investigate and diagnose health problems and health hazards in the community; (c) Inform, educate, and empower individuals about health issues; (d) Mobilize public and private sector collaboration and action to identify and solve health problems; (e) Develop policies, plans, and programs that support individual and community health efforts; (f) Enforce laws and rules that protect health and promote safety; (g) Link individuals to needed personal health services and ensure the provision of health care; (h) Encourage a competent public health workforce; (i) Evaluate effectiveness, accessibility, and

The Colorado Public Health Act recognizes that the state's public health infrastructure is "a shared responsibility among state and local public health agencies and their partners within the public health system."[171]

This public health infrastructure requires coordinated efforts to identify and provide leadership for the provision of essential public health services; develop and support information infrastructure that supports essential public health services and functions; develop and provide effective education and training for members of the public health workforce; develop performance management standards for the public health system that are tied to improvements in public health outcomes or other measures; and develop a comprehensive plan and set priorities for providing essential public health services.[172]

The Colorado Public Health Act seeks to ensure that high-quality public health services, regardless of location, are provided through the development and implementation of comprehensive public health plans for the state as well as for each local public health agency.[173]

Colorado's governmental public health system

Key players of Colorado governmental public health system

Colorado's governmental public health system includes the State Board of Health; the Colorado Department of Public Health and Environment (CDPHE); county or district boards of public health; and county or district public health agencies.[174]

Other state boards and commissions related to public health are integral components of Colorado's governmental public health system, including but not limited to, the Air Quality Control Commission, Solid and Hazardous Waste Commission, Water and Wastewater Facility Operators Certification Board, and Water Quality Control Commission.[175]

Organization of local public health agencies

Colorado's county and district public health agencies can be organized in one of three different structures—as a county public health agency, a district public health agency, or a municipal health department.[176]

Observation: The Colorado Public Health Act provides different types of local public health agency structures than Minnesota's Local Public Health Act does. While Colorado's county and district agency structures are similar to Minnesota, Colorado does not include a public health/human services model. In addition, any Colorado municipality can have its own health department, although it appears that few municipalities have their own health department.

County public health agency[x]

All Colorado counties, by resolution of their board of county commissioners, must "establish and maintain a county public health agency or … participate in a district public health agency."[177] The jurisdiction of a county public health agency includes all unincorporated areas of the county and any municipalities that do not have a health department.[178]

quality of personal and population-based public health services; and (j) Contribute to research into insightful and innovative solutions to health problems." COLO. STAT. § 25-1-502 (3).

[x] A county board of health in a home-rule county must comply with the requirements of its home-rule charter. COLO. STAT. § 25-1-508 (2)(d).

District public health agency

Any two or more contiguous counties may establish and maintain a district public health agency by resolutions of the boards of county commissioners of the respective counties.[179] The jurisdiction of a district public health agency includes all unincorporated areas of the counties comprising the district, but not over the territory of a municipality that has established its own public health agency.[180]

Any county contiguous to a district with a district public health agency may become a part of the district public health agency through an agreement between the county's board of county commissioners and the boards of the county commissioners from the counties comprising the district.[181]

Likewise, any county in a district public health agency may withdraw from the district through a resolution of its board of county commissioners. However, a county may not withdraw from a district within the two-year period following the establishment of the district or the county becoming a part of the district. In addition, a county must give one year's written notice to the district public health agency prior to withdrawing from the district.[182]

Municipal board of health

Unless otherwise prohibited by state or local law, all incorporated towns or cities may "establish a municipal health agency and appoint a municipal board of health."[183]

A municipal board of health has "all of the powers and responsibilities" and is responsible for performing the duties of a county or district board of health required by the Colorado Public Health Act, within the limits of the local laws of each respective city or town.[184]

A municipal corporation that has voluntarily merged its public health agency with a county or district public health agency may withdraw from the county or district public health agency by resolution of its city council, board of trustees, or other governing body. However, a municipal corporation may not withdraw from a district public health agency within the two-year period following the municipal corporation becoming a part of the public health agency.[185]

Public health powers and duties

State board of health

The Colorado State Board of Health (Board of Health) is charged with specific duties and functions, including, but not limited to, promulgating rules related to Colorado public health; approving funding for public health grant programs; appointing members to specific department committees; and advising the director of the CDPHE.[186] Colorado regulations provide specific details about the rulemaking process and procedures that the Board must follow when engaged in rulemaking.[187]

The Board of Health is appointed by the governor of Colorado and operates under the direction and supervision of the CDPHE.[188] The Board of Health must include a representative from each congressional district and two at-large members. One member must be a county commissioner. No more than a "minimum majority of the members of the board may be affiliated with the same political party."[189]

Observation: Colorado's State Board of Health consists of individuals with some medical or public health training or expertise and has rule-making authority. This make-up and authority are different than any similar body in Minnesota.

Between 2008 and 2019, the Board of Health promulgated several rules as directed by the 2008 Colorado Public Health Act to establish:[190]

- the core public health services that each county and district public health agency must provide or arrange for the provision of said services;[191]

- the minimum quality standards for public health services;[192]
- the minimum qualifications for county and district public health directors and medical officers;[193] and
- a formula for allocating moneys to county or district public health agencies based on input from the state department and from county or district public health agencies every year.[194]

In addition to these specific rule-making responsibilities, the Colorado Public Health Act requires the Board of Health to ensure the development and implementation of a comprehensive, statewide public health improvement plan and to review and evaluate all county and district public health agency public health plans, based on criteria established by rule by the Board of Health.[195]

Observation: The requirements included in the Colorado Public Health Act for the development and implementation of a comprehensive, statewide public health improvement plan seem more specific and direct than what is included in Minnesota's Local Public Health Act. While Minnesota's Local Public Health Act requires community health boards to develop public health improvement plans every five years, Colorado's Public Health Act specifically links the local plans to a broader state plan, with responsibility of the state board to review and approve these plans.

County or district board of health

After establishing a county or district public health agency, the board of county commissioners must organize the agency by appointing a county or district board of health.[196]

The Colorado Public Health Act provides specific requirements regarding the establishment of a county or district board of health, including the composition of the board, number of board members, residency requirements of board members, filling of board vacancies, the frequency of meetings, and process for calling special meetings.[197] The county or district board of health is responsible for establishing the officers of the board.[198]

In counties with less than 100,000 residents that do not have a separate board of health from the board of county commissioners, the board of county commissioners may designate itself as the county board of health as of July 1, 2008.[199] In this situation, the terms of the members of the county board of health must coincide with their terms as commissioners. These county boards of health must assume all the duties of appointed county boards of health.[200]

Observation: This provision indicates a general expectation that the county board of health is a different entity than the board of county commissioners, except for counties with smaller populations. This structure seems to provide some separation between local government and the board of public health.

The county or district board of health is responsible for:

- Developing and promoting public policies to ensure conditions necessary for a healthy community;[201]
- Approving the local public health plan completed by the county or district public health agency and submitting the local plan to the state board for review;[202]
- Selecting a public health director meeting minimum requirements established by the State Board of Health and ensuring that the public health director position is filled if there is a vacancy in that position;[203]
- Ensuring that the county or district public health agency has the necessary infrastructure, including offices and related facilities, to provide the core public health services;[204]
- Determining general policies for the public health director to use in administering and enforcing the public health laws, orders, and rules within the agency's jurisdiction, including orders, rules, and standards of the State Board of Health;[205]

- Issuing orders and adopting rules necessary to fulfill the responsibilities of a county or district public health agency so long as these orders and rules are consistent with Colorado's public health laws and orders or rules of the State Board of Health;[206]

Observation: This structure seems different than Minnesota's. In Colorado, the county and district boards of health have independent authority to issue orders and rules to fulfill the public health agencies responsibilities. In Minnesota, the community health board does not have independent authority to issue rules and orders and must recommend rules/ordinances to the county board of commissioners to pass.

- Advising the public health director on all matters related to public health;[207]
- Holding hearings, administering oaths, subpoenaing witnesses, and taking testimony in all matters relating to the exercise and performance of the powers and duties held by the county or district board of health;[208]
- Providing environmental health services and assessing fees to offset actual costs of these services unless a person has already paid a fee to the state or federal government for that service. Fees for retail food establishments inspections must follow the fee schedule established as part of Colorado's Food Protection Act;[209]

Observation: This provision differs from Minnesota as the Colorado county or district board of health has the independent authority to provide environmental health services rather than needing a delegation agreement from the CDPHE to provide these services.

- Accepting and, through the public health director, using, disbursing, and administering dedicated and general funds, property, services, and other financial resources provided to the agency to support county or district public health functions. This authority includes prescribing by rule the conditions under which the property, services, or funds will be accepted and administered and making agreements required to receive this funding or other assistance.[210]
- In addition to the responsibilities identified, above, a county or district board of health may approve a clean syringe exchange program proposed by a county or district public health agency but is not required to do so.[211]

Observation: The county or district board of health structure in Colorado is different from how Minnesota's local governmental public health system is organized. Specifically, the Colorado Public Health Act includes details about the required makeup of the local boards of health that Minnesota's Local Public Health Act does not include. Also, Minnesota's community health boards are dependent on the county board of commissioners to establish local public health ordinances and rules and enforce these. Colorado's county and district boards of health have the authority to enact and enforce public health ordinances, rules and orders, independently from municipal or county local governments. This includes authority to hold hearings, administer oaths, subpoena witnesses, etc. in matters related to the powers and duties of the board of health.

County or district public health agency

County and district public health agencies have the powers granted to them through the Colorado Public Health Act in addition to other local government powers established through Colorado's constitution and

statutes, so long as those powers do not conflict with the specific powers and duties included in the Colorado Public Health Act.[y] [212]

County and district public health agencies are responsible for initiating and carrying out health programs consistent with state law necessary or desirable by the county or district board to protect public health and the environment.[213]

County and district public health agencies can expand the local public health services provided beyond the core public health services and obtain additional resources for these additional services, so long as the core public health services are provided.[214]

Observation: The Colorado Public Health Act does not include provisions for delegation of authority between the state department of health to county or district public health agencies.

In fulfilling its duties, a county and district public health agency must arrange for "the provisions of services necessary to carry out the public health laws and rules of the state board, the water quality control commission, the air quality control commission, and the solid and hazardous waste commission according to the specific needs and resources available within the community" as determined by both the state public health improvement plan and the county or district public health plan.[215]

Policy

County and district public health agencies are responsible for advising the county or district board on public policy issues necessary to protect public health and the environment.[216]

Environmental health

County and district public health agencies must provide or arrange for the provisions of services to implement and enforce state and local environmental health laws and rules regarding air quality, solid and hazardous waste, and water quality.[217]

Vital statistics

County and district public health agencies are responsible for oversight of information regarding vital statistics in their jurisdiction, including the collection, compilation, and tabulation of reports of marriages, dissolutions of marriage, and declarations of invalidity of marriage, births, deaths, and morbidity, and requiring those with this information to develop reports and submit this information as required by Colorado law.[218]

Core public health services

County and district public health agencies must provide or arrange for the provision of quality, core public health services identified by the State Board of Health and the comprehensive statewide public health improvement plan.[219] A local public health agency can meet this requirement if it "can demonstrate to the county or district board that other providers offer core public health services that are sufficient to meet the local needs as determined by the plan."[220]

[y] "Most Colorado counties are governed by Dillon's Rule authority in that they act as arms of the state and are restricted to the powers that are explicitly vested in them by the state's legislature." Counties have the option to be home rule, but very few are. See Colorado County Government Overview, National Association of Counties (2022), available at https://www.naco.org/sites/default/files/event_attachments/DRAFT_Colorado_012022.pdf (last visited Nov. 7, 2023).

Local public health plan

County and district public health agencies must complete a community health assessment and prepare a local public health plan that aligns with the state's public health improvement plan at least every five years.[221] These local plans are reviewed by the county and district public health agency board and the state board and must include, at a minimum the following information:[222]

- Examination of data about health status and risk factors of the local community;
- Assessment of the capacity and performance of the county or district public health system;
- Identification of goals and strategies for improving the health of the local community;
- Description of the involvement of local community members in the development and implementation of the local plan;
- How the local public health agencies coordinate with the state department and others within the public health system to accomplish goals and priorities identified in the statewide public health improvement plan; and
- Identification of financial resources available to meet the identified public health needs and core public health services for the local community.

Epidemic and communicable disease control

County and district public health agencies are responsible for investigating and controlling the causes of epidemic or communicable diseases and conditions affecting public health.[223]

This responsibility includes:

- Establishing, maintaining, and enforcing isolation and quarantine when needed to protect public health in addition to exercising physical control over property and individuals within the jurisdiction of the agency necessary to protect public health;[224]
- Closing schools and public places and prohibiting gatherings of people when necessary to protect public health;[225]
- Establishing, maintaining, or making available chemical, bacteriological, and biological laboratories, and conducting laboratory investigations and examinations as necessary or proper for the protection of the public health;[226] and
- Purchasing and distributing to licensed physicians and veterinarians, with or without charge, based on emergency or need, approved biological or therapeutic products necessary for the protection of public health.[227]

Public health nuisances

County and district public health agencies are required to investigate and abate public health nuisances. This responsibility includes making necessary sanitation and health investigations and inspections, on its own initiative or in cooperation with the CDPHE, for matters affecting public health within the jurisdiction and control of the county or district agency.[228] County and district public health agencies must destroy, remove or prevent the nuisance, source of filth, or cause of sickness, depending on the situation.[229] This may include cleaning unhealthy premises and removing unsafe structures determined to present a risk to the health of the inhabitants of the agency's jurisdiction.[230]

Child fatality prevention

County and district public health agencies must establish a local or regional child fatality prevention review team.[231]

Colorado Department of Public Health and Environment (CDPHE)

The Colorado Department of Public Health and Environment (CDPHE) is the state department charged with protecting and maintaining the health and environment of the citizens of Colorado.[232]

Annual public health trainings

The CDPHE is responsible for developing and providing two annual trainings for members of county and district boards of health and the State Board of Health. These annual trainings include an annual public health training developed with the Colorado School of Public Health, in addition to an annual public health training developed and provided in partnership with the Colorado Office of Emergency Management regarding the role of a board of health in preparing for, responding to, and recovering from an emergency disaster.[z] [233]

Observation: The specific training requirements for the state and local boards of health go beyond what the Minnesota Local Public Health Act requires.

Statewide public health improvement plan

The CDPHE must develop a "comprehensive, statewide public health improvement plan" at least every five years. This plan assesses and sets priorities for the state's public health system.[234]

The plan must be developed in consultation with the State Board of Health and representatives from the state department, county, or district public health agencies, and their partners within the public health system.[235]

County or district health improvement plans

CDPHE must "encourage and provide technical assistance to county or district public health agencies that request such assistance and otherwise work with the county or district public health agencies to generate their local plans."[236]

Recruitment assistance for county and district boards of health

The CDPHE is charged with providing guidance on recruiting individuals who are eligible and willing to serve on county and district boards of health to any board of county commissioners, county board of health, or district board of health requesting this assistance.[237]

State assistance to county and district public health agencies

The CDPHE must provide assistance to county and district public health agencies, when requested.[238]

Enforcement of Colorado state and local public health laws

Local public health enforcement

The Colorado Public Health Act provides specific direction regarding the process through which local and state public health laws are enforced, including protection of the constitutional rights through judicial review of individuals aggrieved by a decision of a county or district board of health or a public health director.[239]

The county or district public health director is charged with administering and enforcing state public health laws of Colorado, and public health orders, rules, and standards of CDPHE pursuant to county powers and

[z] Note: The Colorado School of Public Health was established in 2008, the same general time frame as the updated Colorado Public Health Act. Embedding trainings developed with the Colorado School of Public Health into the new Colorado Public Health Act may reflect some coordination between the new School of Public Health with the development of the new Colorado Public Health Act. Observation by MDH staff.

functions under Colorado law, in addition to the orders and rules of the county or district board of health.[240] Individuals, associations, and corporations must abate any nuisance, source of filth, or cause of sickness, except for a condition due to an act of God, within 48 hours after being ordered to do so by the county or district public health agency.[241]

The Colorado Public Health Act details specific civil and criminal penalties when an individual, association, or corporation fails to comply with a public health order, including the payment of any expenses incurred by health authorities to remove any public health nuisance, source of filth, or cause of sickness.[242]

When requested by a county or district public health director, the county or district attorney for a specific jurisdiction must bring a civil or criminal action to "abate a condition that exists in violation of, or to restrain or enjoin any action that is in violation of, or to prosecute for the violation of or for the enforcement of, the public health laws and the standards, orders, and rules of the state board or a county or district board of health."[243]

If the county or district attorney fails to act, the public health director may bring an action and be represented by special counsel employed by the director with the approval of the county or district board.[244]

County and district boards of health are prohibited from imposing on any person a mode of treatment inconsistent with "the creed or tenets of any religious denomination of which he or she is an adherent if the person complies with sanitary and quarantine laws and rules."[245]

CDPHE enforcement authority

The CDPHE may assume all powers of a county or district board of health if the county or district board is unable or unwilling to act.[246] As part of this authority, the CDPHE may reallocate state funds from a local public health agency "that is not able to provide core public health services or standards to another entity to deliver services in that agency's jurisdiction."[247]

Staffing requirements of county or district public health agency

A county or district public health agency must include a county or district board of health, a public health director, a treasurer, and other personnel employed or retained to fulfill the agency's duties as required by the Colorado Public Health Act.[248] As discussed, below, a medical officer may be required.

Public health director

Colorado county and district public health agencies must have a public health director. The public health director is "the administrative and executive head of each county or district public health agency."[249] The public health director has the authority to select any other personnel required by the public health agency needed to provide public health services.[250]

The public health director is required to meet minimum qualifications determined by the state board of health.[251] These qualifications differ depending on whether or not the public health director is a licensed physician.

If a public health director is a physician, they must be licensed in the state of Colorado within six months of hire, have graduated from an approved medical school (MD or DO), and have successful and responsible experience in public health or a related field in at least five of the past 10 years, including at least 2 years supervising public health professionals.

Physicians with one year of graduate study in a recognized school of public health are preferred.[aa] [252]

[aa] Note: The different staffing structures between Colorado and Minnesota local health departments may be worth exploring. Specifically, MDH staff indicated that "in Colorado each public health agency has a public health director and is

If a public health director is not a physician, the director must have a master's degree in a public health discipline such as environmental health, health education, epidemiology, health administration/policy, biostatistics, nursing, public administration, health administration or a closely related discipline. In addition, the director must have successful and responsible experience in public health or a related field in at least five of the past 10 years, including at least two years supervising public health professionals. Nurse candidates must be licensed to practice in the state of Colorado within six months of being hired.[253]

Within 30 days of appointing a new public health director, the county or district board of health must submit documentation summarizing the recruitment efforts for and the qualifications of the newly appointed public health director as required by CDPHE.[254]

Medical officer

A medical officer is "a volunteer or paid licensed physician who contracts with or is employed by a county or district public health agency to advise the public health director on medical decisions if the public health director is not a licensed physician."[255]

A county or district public health agency is required to employ or contract (paid or volunteer) with a medical officer if the public health director is not a licensed physician.[256] The medical officer must be a graduate from an approved medical school (MD or DO) and be licensed to practice medicine in the state of Colorado.[257]

Substitutions and waivers

A county or district board of health may substitute professional experience for certain academic requirements or exceptional academic preparation for certain required experiences for a public health director candidate. When making these substitutions, the local board of health must consider the relevance of the experience or education to the public health director's duties and the resources and needs of the county or district.[258]

If the county or district board of health is unable to recruit a public health director meeting the minimum qualifications, the board may waive minimum qualifications. Information about the waiver must be provided to the CDPHE within 60 days of appointing the new director. When waiving minimum qualifications, the local board of health must consider the population of the jurisdiction and its ability to recruit a qualified candidate; if the candidate for public health director will seek to obtain additional public health education and experience within five years of the waiver; and if the county or district board of health has explored joining with a county or establishing a district public health agency that has a qualified public health director.[259]

Treasurer

A local public health agency must have a treasurer meeting specific requirements identified by the Colorado Public Health Act. In the case of a county public health agency, the county's treasurer must serve as the treasurer of the public health agency as part of their official duties as county treasurer.[260]

For district public health agencies, the county treasurer for the county having the largest population serves as treasurer of the district agency, unless the combined population of the district public health agency is 4,000 or fewer. In this case, the boards of county commissioners of these counties may select the county whose treasurer serves as treasurer of the district public health agency.[261]

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required to have a director, so someone with public health background and expertise who oversees the public health agency and its operations. In Minnesota it is much more of a patchwork, with public health directors, community health board administrators (those two can both be present in one jurisdiction), and public health supervisors where there is an human services director." As a result, there is not the same level of consistency with role, scope, and potentially expertise or experience. Observation by MDH staff.

The treasurer of a public health agency is responsible for creating a county or district public health agency fund where appropriated county general funds and money from state or federal appropriations or other gifts, grants, donations, or fees for local public health purposes must be held.[262]

Observation: The specificity regarding the treasurer requirement and responsibilities in Colorado is different than Minnesota.

Funds must be utilized for their intended purposes in providing public health services authorized by the Colorado Public Health Act.[263]

Distribution of public health funds is only allowed if "certified by the public health director and the president of the county or district board or any other member of the county or district board designated by the president for such purpose."[264]

Continuing education requirements

Members of a county or district board of health and the members of the State Board of Health are required to attend two annual trainings, including a:

- Public health training provided by the CDPHE, developed with the Colorado School of Public Health;[265] and
- Public health training developed and provided by the CDPHE and the Colorado Office of Emergency Management regarding the role of aboard of health in preparing for, responding to, and recovering from an emergency disaster.[266]

Observation: This type of continuing education requirement is not included in the Minnesota Local Public Health Act.

Public health funding

Funding for local public health is a shared responsibility of Colorado's state and local governments. As of 2018, the focus for public health funding in Colorado was on modernizing and funding public health and building on lessons learned from several states pursuing public health system transformation through the nationally-recognized foundational public health services framework.[267]

State funding for local public health agencies

The State Board of Health developed a funding formula to allocate state funds to county and district public health agencies and must review this formula every five years, or earlier, if necessary, with input from CDPHE and local public health agencies.[268]

Each local public health department operating under the Colorado Public Health Act receives funding based on this formula.[269] The CDPHE is responsible for allocating funds appropriated by the general assembly for distribution to county or district public health agencies as directed by the Board of Health.[270] The formula determines funding amounts based on considerations, including:

- **Core services base funding**: The State Board of Health determines the amount of the base funding for core services based on several factors related to the provision or assurance of these core services, which include assessment, planning, and communication; vital records and statistics; communicable disease prevention, investigation, and control; prevention and population health promotion; emergency preparedness and response; environmental health; and administration and governance.[271]
- **Regional distribution**: District public health agencies serving multiple counties receive a regional distribution equal to the annual minimum core services base funding for each additional county served.[272]

- **Per capita**: After consideration of funding needed to support core services base funding and regional distribution of these funds, any remaining funding is distributed on a per capita basis using population estimates for the fiscal year from the Department of Local Affairs.[273]

Local funding for county and district public health agencies

County and district boards of health are required to annually estimate the total cost of maintaining the public health agency for the ensuing year; determine the availability of funds to meet these needs from unexpended surpluses, state or federal funds, or other grants or donations; and identify other financial resources available to meet identified public health needs and provide core public health services.[274]

To qualify for state assistance, each county and city must contribute "a minimum of one dollar fifty cents per capita for its local health services."[275] Federal and state funding for special projects and demonstrations are not allowed to be used for the per capita minimum contribution.[276]

Counties and cities may provide additional amounts as necessary to meet local health needs.[277] The board of county commissioners may provide additional funds needed to cover the total cost of maintaining the agency for the ensuing fiscal year by an appropriation from the county general fund.[278]

If a county or district public health agency does not have sufficient appropriations to fulfill all of the duties required by the Colorado Public Health Act, it must "set priorities for fulfilling the duties" and "include the list of priorities in the local public health plan."[279] The local board of health may limit the scope of the core public health services provided it can show that there is limited need for the core public health services in the community or other providers offer core public health services sufficient to meet the local need.[280]

Legal responsibilities of Colorado local public health agencies

Minimum quality standards for public health services

To support implementation of the 2008 Colorado Public Health Act, the State Board of Health passed a rule to develop minimum quality standards for public health services in the state.[281] These minimum standards recognize that "each community in Colorado should provide high-quality public health services regardless of its location."[282]

The new rule, effective in 2013, adopts measurable standards for public health services, using national standards developed by the Public Health Accreditation Board as a basis to direct local public health agencies across Colorado to work toward a level of capacity and process that is indicative of a widely accepted definition of a well-functioning public health agency.[283]

Observation: Colorado specifically links its public health services to national public health accreditation standards.

Minimum quality standards for public health services established by the Board of Health indicate that all county and district public health agencies should meet these standards through a process of continuous quality improvement in accordance with the core public health services. For full text of 2013 Colorado regulation laying out Colorado's core public health services, see 6 COLO. R. 1014-7.[284]

Colorado core public health services framework

As part of the 2008 Colorado Public Health Act, the Colorado Legislature incorporated a framework of "core public health services" to create consistent standards for the provision of governmental public health services

across the state and charged the Board of Health with developing definitions for these services.[bb] For consistency with the Colorado Public Health Act, the Board of Health refers to its foundational public health services framework as core public health services in Colorado regulations that were effective January 2020.[cc] [285] Colorado recognizes the foundational capabilities and foundational services as "the limited statewide set of core public health services that must exist everywhere for services to work anywhere."[286]

The Colorado Association of Local Public Health Officials (CALPHO) and CDPHE determined "that the Foundational Public Health Services (FPHS) system transformation model is the best model for Colorado's public health system transformation efforts and are following the example of other states engaged in similar public health system transformation efforts."[287]

CALPHO and CDPHE published the Colorado Public Health System Transformation Core Public Health Services Operational Definitions Manual (https://www.calpho.org/uploads/6/8/7/2/68728279/co_cphs_definitions_manual_final_draft_clean_2019_0510.pdf) to provide additional detail for Colorado's governmental public health system to successfully and consistently implement the core public health services. The definitions in this manual add "functions, definitions, and operational definitions that define the functions, elements, and activities that the governmental public health system must deliver for residents for core public health services to be fully implemented."[288]

CALPHO and CDPHE indicate that they expect that the definitions will continue to evolve and will establish a process to periodically update the core public health services operational definitions as needed.[289]

Observation: As part of the 2023 amendments to Minnesota's Local Public Health Act, MDH and SCHSAC are responsible for providing direction on definitions for foundational public health responsibilities, including how best to match up these definitions with the activities listed in the national framework guidelines. The Colorado Public Health System Transformation Core Public Health Services Operational Definitions Manual (https://www.calpho.org/uploads/6/8/7/2/68728279/co_cphs_definitions_manual_final_draft_clean_2019_0510.pdf) developed by CALPHO and CDPHE may be of interest to Minnesota's current efforts to develop resources to guide Minnesota's governmental public health entities in implementing these foundational public health responsibilities.

[bb] The Colorado Legislature indicated that core public health services must include, but need not be limited to, "the assessment of health status and health risks, development of policies to protect and promote health, and assurance of the provision of the essential public health services." See COLO. STAT. § 25-1-502 (2).

[cc] The foundational public health services framework "are a subset of all public health services and include foundational capabilities and services that (1) must be available to all people served by the governmental public health system, and (2) meet one or more of the following criteria: ▪ Services that are mandated by federal or state laws. ▪ Services for which the governmental public health system is the only or primary provider of the service, statewide. ▪ Population-based services (versus individual services) that are focused on disease prevention and protection and promotion of health." COLO. Public Health System Transformation: Core Public Health Services Operational Definitions Manual, CDPHE (May 2019), available at https://www.calpho.org/uploads/6/8/7/2/68728279/co_cphs_definitions_manual_final_draft_clean_2019_0510.pdf (last visited Nov. 8, 2023).

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[7] See generally, Minn. Stat. Ch. 145A.

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[9] MINN. STAT. §144.05, Subd. 1; MINN. STAT. §144.011.

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[27] MINN. STAT. §145A.06, Subd. 3a.

[28] MINN. STAT. §145A.06, Subd. 3a (1).

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[31] See MINN. STAT. §144.12. Please note: MDH, community health boards, and public health departments are prohibited from adopting "any rule or regulation for the treatment in any penal or correctional institution of any person suffering from any communicable disease or venereal disease or infection, which requires the involuntary detention of any person after the expiration of the period of sentence to the penal or correctional institution, or after the expiration of the period

to which the sentence may be reduced by good time allowance or by the lawful order of any judge or the Department of Corrections." See MINN. STAT. §144.12, Subd. 1(7).

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[222] COLO. STAT. §§ 25-1-505(2); 25-1-508 (5)(b).

[223] COLO. STAT. § 25-1-506 (3)(b)(V).

[224] COLO. STAT. § 25-1-506 (3)(b)(VI).

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[226] COLO. STAT. § 25-1-506 (3)(b)(IX).

[227] COLO. STAT. § 25-1-506 (3)(b)(X).

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[229] COLO. STAT. § 25-1-518.

[230] COLO. STAT. § 25-1-518.

[231] COLO. STAT. § 25-1-506 (3)(b)(XV).

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[233] COLO. STAT. § 25-1-508 (7).

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