DEPARTMENT OF HEALTH

Community health services administration handbook

Revised 2014

Community health services administration handbook

The community health services (CHS) administration handbook was published 1999, updated in 2000, 2005, and 2009, and revised in 2014.

It is intended to provide context for issues frequently encountered by CHS administrators in Minnesota.

Online: www.health.state.mn.us/communities/practice/resources/chsadmin/

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Introduction

Public health in Minnesota

Minnesota's public health system functions as a partnership between state and local governments, and is designed to ensure that the public's health and safety are protected statewide while providing local governments with the flexibility needed to identify and address local needs.

In a time of constrained resources, community health boards need to continue to build capacity to address increasingly complex public health issues. Many regions use similar approaches to maximize resources, including cross-jurisdictional sharing to achieve economies of scale, increasing efficiency, focusing on quality improvement, developing the public health workforce and leadership, and emphasizing the importance of a strong public health infrastructure.

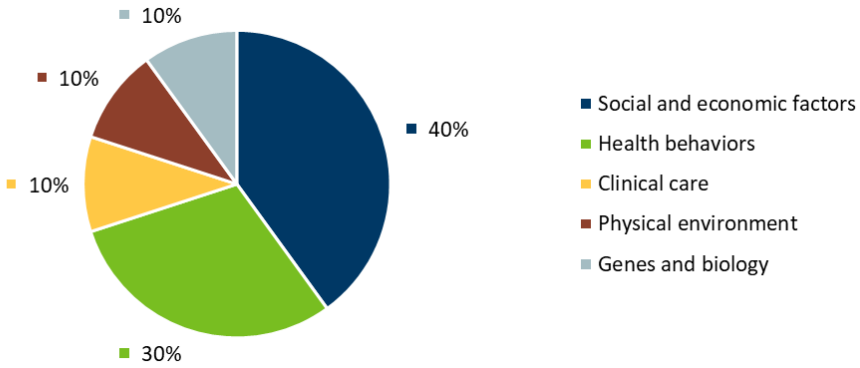
What is public health?

Public health focuses on the health needs of the population as a whole, and gives priority to preventing problems over the early detection and treatment of problems. By focusing on the greatest good for the greatest number of people, public health organizes community resources to meet health needs and takes positive action to address community health issues.

Public health is based on an understanding of the causes of health problems; a person's health outcomes can be impacted by everything from genetics, to environmental factors, to living conditions, to cultural norms, and to individual choices. It is generally accepted that overall population health is determined by the four factors below, approximately weighted according to their impact.

One theory that breaks down the factors that influence health follows:

Factors influencing health and well-being



Public health is closely intertwined with many other issues that affect public health—called social determinants of health. For example, poor health habits like smoking or excess alcohol use can lead to chronic diseases and increased hospital costs. Youth violence can result in increased costs for court time and correctional facilities. It can be difficult to visualize the broad factors that influence health, which can make public health difficult to describe in concrete terms.

The Centers for Disease Control and Prevention (better known as the CDC) compiled the following Ten great health achievements -- United States, 2001-2010:

- Vaccine-preventable diseases
- Prevention and control of infectious diseases
- Tobacco control
- Maternal and infant health
- Motor vehicle safety
- Cardiovascular disease prevention
- Occupational safety
- Cancer prevention
- Childhood lead poisoning prevention
- Public health preparedness and response

This list is based on the opportunity for prevention, and the impact on death, illness, and disability in the United States.

What does public health do?

According to the Institute of Medicine's well-known 1988 study, *The future of public health*, the core functions described below are carried out primarily by government and constitute the most critical foundations of an effective public health system.

Assessment

The assessment function of public health can be viewed as "knowing what needs to be done." This encompasses activities such as epidemiological surveillance, data collection and analysis, monitoring and forecasting, root cause analysis, and other research practices. The assessment function is often used to facilitate decision making by collecting the best evidence with which to weigh competing options and consider the allocation of limited resources.

Policy development

The policy development function of public health can be viewed as "being part of the solution." This includes being involved in the crafting of legislation, rules, policies, practices, and budgets. In its policy development capacity, a public health entity may plan for and set priorities, provide leadership and advocacy, convene and negotiate with stakeholders, mobilize resources, provide training, or encourage private action. In policy development, the process is often just as important as the product—it will ideally be fair, inclusive, and far-sighted.

Assurance

Assurance can also be thought of as "making sure it happens." The government can ensure public health services are delivered by mandating them, providing services directly, or incenting other sectors to take

action. This often requires implementation of legislative language, regulation, reporting on progress, and holding stakeholders accountable. Exercising this authority comes with great responsibility and entails a strong level of commitment to the welfare of the community. In its assurance capacity, the government is challenged to strike the appropriate balance between free market interests and social equity or the greater good.

Minnesota's public health system

Government's responsibility for public health

Public health is one of the greatest things in which a government can invest. Early prevention, which is relatively inexpensive, can prevent dire and expensive health care problems later in life.

Early in their development, both Minnesota and the United States recognized the role of the government in protecting the public's health, and each entity makes reference to this in their constitutions as part of a "general welfare" clause. Public health promotes the welfare of the entire population, ensures its security and protects it from the spread of infectious disease and environmental hazards, and helps to ensure access to safe and quality care to benefit the population.

Governmental responsibilities for public health extend beyond voluntary activities and services to include additional authorities such as quarantine, mandatory immunization laws, and regulatory authorities. The state's partnership functions by encouraging residents to do things that benefit their health (e.g., physical activity) or create conditions to promote good health, and requiring certain actions (e.g., food safety).

Areas of public health responsibility

Minnesota's areas of public health responsibility within the Local Public Health Act follow. They describe what people in Minnesota should expect to receive from their local health department no matter where they live, and are used by community health boards for assessment and planning purposes.

The areas of public health responsibility include (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. You can find more information on public health activities relating to these areas online.

Assure an adequate local public health infrastructure

Assuring an adequate local public health infrastructure means maintaining the basic capacities foundational to a well-functioning public health system such as 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.

Promote healthy communities and healthy behavior

Promoting healthy communities and healthy behaviors means activities that improve health in a population, such as investing in healthy families; engaging communities to change policy, 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 of health.

Prevent the spread of communicable disease

Preventing the spread of infectious disease means preventing diseases that are caused by infectious agents, such as by detecting acute infectious diseases, assuring the reporting of infectious diseases, preventing the transmission of disease, and implementing control measures during infectious disease outbreaks.

Protect against environmental health hazards

Protecting against environmental health hazards means addressing aspects of the environment that pose risks to human health, such as monitoring air and water quality, developing policies and programs to reduce exposure to environmental health risks and promote healthy environments, and identifying and mitigating environmental risks such as foodborne and waterborne diseases, radiation, occupational health hazards, and public health nuisances.

Prepare and respond to emergencies

Preparing and responding to emergencies means engaging in activities that prepare public health departments to respond to events and incidents and assist communities in recovery, such as providing leadership for public health preparedness activities within 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.

Assure health services

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

The roles of local, state, and federal governments

Public health is population-based. Although local health departments and community health boards provide services to individuals, the goal of a population-based approach is very different from that of a patient-based or client-based approach that addresses the needs or concerns of an individual. Since public health activities are based on community needs, resources, funding, and support, services vary among local public health departments.

Minnesota's commissioner of health has the general authority for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens (Minn. Stat. § 144.05). Such programs and services are related, but not limited to,

maternal/child health, environmental health, public health emergency preparedness, disease prevention, control and epidemiology, public health administration, healthy communities and behaviors, licensing and inspection, and health care access.

The Minnesota Department of Health (MDH) is also responsible for monitoring, detecting, and investigating disease outbreaks; researching causes of illness and operating prevention programs; providing laboratory services; safeguarding the quality of health care, working to contain health care costs and assure that all Minnesotans have access to health care; safeguarding the quality of food, drinking water, and indoor air; developing strategies to improve the health of vulnerable populations; and working to eliminate health disparities.

In partnership with local public health entities, MDH helps with everything from developing guidelines, to providing technical assistance and support, to funneling state and federal funds to community health boards. Its specialists and scientists collect and analyze data that are used for research, resource development, and program development throughout the state. Public health system consultants provide specialized assistance on local and tribal public health to regions around the state.

MDH also has staff in seven district offices that provide assistance to local health departments (and others) regarding epidemiological investigations and consultation, emergency preparedness, environmental health, public and nonpublic water supplies, maternal/child health, public health nursing, and the practice of public health, as well as other areas. The MDH district offices are located in Duluth, St. Cloud, Bemire, Fergus Falls, Marshall, Mankato, and Rochester.

Federal influences

State and local health departments work with a number of federal agencies, primarily those within the U.S. Department of Health and Human Services. For example, the Centers for Disease Control and Prevention (CDC) leads efforts to control communicable disease outbreaks and promote mass immunization. The federal government also assists states with funding (when state resources are not available) and guidance for work such as emergency preparedness. At both the state and local level, Minnesota relies on these offices for grant funding and expertise.

Accreditation and national public health standards

Related: Standards and measures for initial accreditation [Public Health Accreditation Board]

In recent years, there has been recognition at the national level of the lack of standardization between health departments, and a need to identify what state and local health departments should do to deliver quality public health programs and services. This led to the development of a set of standards that health departments can put into practice to ensure that they are providing the best services possible to keep their communities safe and healthy.

The Public Health Accreditation Board (PHAB) has developed a national voluntary accreditation program for state, local, territorial, and tribal public health departments. The accreditation process will drive public health departments to continuously improve the quality of the services they deliver to the community, as well as offering the following benefits:

- Accountability and credibility
- Leverage for funding
- Visibility
- Increased efficiency and effectiveness

The State Community Health Services Advisory Committee, or SCHSAC, which is comprised of representatives from across the state, has recommended that Minnesota's local public health annual reporting align with national standards, and that community health boards interested in applying for accreditation will be ready to apply by 2020.

Key resources

- Minnesota Department of Health district office locations
- Public Health Accreditation Board
- Healthy People 2030
- A call to action: Advancing health for all through social and economic change (PDF)
  Minnesota Health Improvement Partnership Social Conditions and Health Action Team
- Making your case known (PDF)
  Governor's Council on Developmental Disabilities
- County government essentials: Educational webinar series
  Association of Minnesota Counties
- National public health standards and voluntary accreditation: Implications and opportunities for public health performance improvement in Minnesota (PDF)
  SCHSAC Performance Improvement and Accreditation Workgroup

Community health services administration

Background on CHS administration

What is a community health services (CHS) administrator? At first glance, this seems like a simple question with a straightforward answer. Minnesota administrative rules (Minn. R. 4736.0110) make it clear that the CHS administrator is a required position for community health board recipients of the Local Public Health Grant funds. Additionally, the administrative rules outline the minimum required qualifications and skills of professionals desiring to fill this role. It is a role that has existed in Minnesota's community health services system since its inception in 1976. Yet, the authorities, responsibilities, and qualifications of this role are poorly understood by many, leading some to question the value of the CHS administrator.

The position of CHS administrator goes back to the first set of administrative rules promulgated for CHS in 1976. In fact, the original rules actually outlined seven "key administrative personnel", including the nursing director; the home health services director; the disease prevention and control director; the

emergency medical services director; the health education director; the environmental health services director; and the community health services administrator.

From the beginning, the CHS administrator role was seen as distinct and important. As evidence of this fact, the personnel rules allowed for a single individual to perform one or more of those roles, with the exception of the CHS administrator. It is believed that the use of the term "administrator" was selected so that the importance of the role would be seen as equal to that of the county social services administrators.

The rules were contentious when adopted, with some counties balking at the seven required administrative positions. Some elected officials of the time proclaimed "the Act doomed to immediate failure" on the basis that they would not be able to find or pay for the required highly trained personnel. Yet, the original rules stood for over 10 years before being revisited by the SCHSAC Administrative Rules Subcommittee in 1988.

At this point, the statutory requirements for the other administrative roles were dropped, though not without controversy. Nevertheless, the role of CHS administrator was still seen as important, and the subcommittee agreed that the position's requirements needed to be stronger, with contention as to what "stronger" meant.

A review of historical documents shows that the 1988 changes to CHS administrator requirements were basically an update of the original requirements. It does not appear that they were modeled after other states' requirements, national standards or scientific literature. After input from regional meetings and much deliberation on the part of the subcommittee and SCHSAC, and delay on the part of the Minnesota Department of Health (MDH) due to a change in administration and the loss of key staff, the revised rules were finally adopted on March 19, 1994.

According to expert opinion, in the beginning the role of the CHS administrator was viewed as a full time position, which entailed the following responsibilities:

- Planning (i.e., "CHS planning")
- County commissioner orientation to public health
- Participation in SCHSAC and SCHSAC workgroups
- Engaging local public health staff in population-based public health activities
- Working with MDH

The focus of the job was seen as providing visionary leadership and direction for the community health board, as well as for the statewide system. Many responsibilities on this list represented new concepts for the time, and consequently represented significantly new ways of doing business for community health boards.

Expectations of CHS administrators

Minnesota state statutes require each community health board to appoint a community health services (CHS) administrator. Minn. R. 4736.01101 (as above) sets forth minimum required qualifications for CHS administrators. The CHS administrator must meet the personnel standards in Minn. R. 4736.0110.

Related chapter: Personnel recommendations

Minimum expectations

A community health board is required to have a community health services administrator who has one of the following:

- A baccalaureate or higher degree in administration, public health, community health, environmental health, or nursing, and two years of documented public health experience in an administrative or supervisory capacity, or be registered as an environmental health specialist or sanitarian in the state of Minnesota and have two years of documented public health experience in an administrative or supervisory capacity; OR
- A master's or higher degree in administration, public health, community health, environmental health, or nursing, and one year of documented public health experience in an administrative or supervisory capacity; OR
- A baccalaureate or higher degree and four years of documented public health experience in an administrative or supervisory capacity.

The documented experience of a community health services administrator must include skills required to:

- Direct and implement health programs;
- Prepare and manage budgets;
- Manage a planning process to identify, coordinate, and deliver necessary services;
- Prepare necessary reports;
- Evaluate programs for efficiency and effectiveness;
- Coordinate the delivery of community health services with other public and private services; and
- Advise and assist the community health board in the selection, direction, and motivation of personnel.

Related appendix: CHS administrator job description [Sample]

Additional expectations

The following is generally expected for public health leadership, in alignment with the Local Public Health Act and the annually-signed assurances and agreements.

- Assure the community health board meets the requirements of Minn. Stat. § 145A (Local Public Health Act), as well as relevant federal requirements
- Assure the community health board meets the responsibilities outlined in the Local Public Health assurances and agreements (signed and updated annually)
- Provide input and involvement in local and state public health policy development (as well as national, where applicable)
- Communicate public health matters to the Board/community health board
- Coordinate (or assure) the Local Public Health assessment and planning cycle
- Possess oversight and approval of Local Public Health Act annual reporting
- Participate in SCHSAC (often as an alternate member) and on SCHSAC workgroups
- Possess signature authority for routine matters of the community health board (serve as the Agent of the Board)

Related:

- Local Public Health Act
- Local Public Health Grant

Variables

Depending on a number of factors, CHS administrators may hold additional responsibilities and authorities. Community health board organizational structure and governance, local decisions, community need, grant requirements, and individual administrator experience/interest all contribute to the ways in which the role of the CHS administrator can vary from community health board to community health board.

For example, many CHS administrators of single-county community health boards also serve as the public health director or the public health nursing director. In some multi-county community health boards, only one of the county directors might also serve as the CHS administrator, either permanently or in rotation with other county directors. Playing dual roles like this may result in additional responsibilities, with one role receiving more attention than the other if it requires more time. In some other multi-county community health boards, the CHS administrator may be a completely separate position from that of the local health directors. The administrator may be employed by the community health board itself, rather than a specific county. In such arrangements, the influence or control that the CHS administrator has over program decisions and implementation varies.

A community's needs and desires can also influence a CHS administrator's authority and responsibilities. A CHS administrator might not be the top executive over public health in his/her agency; some single-county community health boards with combined departments (e.g., health and social services, health and veterans affairs, etc.) are structured this way. The CHS administrator is still recognized as the designated representative of the community health board, and as such has the authority to coordinate public health activities, regardless of organizational structure.

In 2010, the Minnesota Public Health Research to Action Network conducted a comprehensive survey of Minnesota's top local public health officials to assess how CHS administrators and others currently view their roles. The majority of CHS administrators reported filling multiple roles within their community health board. For more information, see *Governance and organization of local public health services in Minnesota* (PDF), March 2011, Minnesota Public Health Research to Action Network.

SCHSAC recommendations for CHS administration

In response to the need to capitalize on organizational trends in local public health, the SCHSAC Blueprint for a Successful Local Health Department Workgroup (or Blueprint Workgroup) developed the following position statement and recommendations for CHS administration (2010):

> *Today's public health field is increasingly demanding and complex. It requires strong (qualified, authoritative, and responsible) leadership. CHS administrators should provide visionary and strategic public health leadership at the local and state levels. They should have clear roles, responsibilities and authorities which are documented, shared and visible. Additionally, the role of the CHS administrator must remain responsive to the ever changing field of public health and should be periodically updated and evaluated.*

The following additional qualifications are recommended as necessary for CHS administrators to effectively carry out their responsibilities.

- Meet the Tier 3 core competencies (PDF) as defined by the Public Health Foundation and the Council on Linkages between Academia and Public Health Practice
- Align with the administration-related national public health standards and measures developed by the Public Health Accreditation Board; and

- Participate in continuing education, to be accomplished through yet to be developed CHS administrator orientation, mentorship program, and ongoing training opportunities.

In addition to their long-standing roles, CHS administrators ideally should:

- Participate in the hiring and direction of upper level local health department staff, particularly in multi-county community health boards;
- Facilitate or direct joint work planning among the counties within a multi-county community health board and/or within a region; and
- Actively engage in succession planning, specifically for the CHS administration role, but also for other leadership positions within the community health board and local health department.

Having sufficient authority is critical to strong and effective leadership. As such, CHS administrators should have the following authorities:

- Sufficient and regular access to the community health board and county boards (or city councils) to provide regular updates and give needed input on matters pertaining to public health; and
- The authority to oversee the development and execution of the budget for funds or resources going through the community health board.

Key resources

- Local Public Health Act funding
- Updating Minnesota's blueprint for public health (PDF)
  SCHSAC Blueprint for Successful Local Health Departments Workgroup
- Governance and organization of local public health services in Minnesota (PDF)
  Minnesota Public Health Research to Action Network
- Tier 3 core competencies for public health professionals[1]
  Council on Linkages between Academia and Public Health Practice

Qualification review process

While the required qualifications of the CHS administrator role haven't changed in the last 20 years (since the rules change in the late 1980's) both the role and the field of public health have changed significantly. There are concerns that the required qualification have not kept pace with the demands of the position.

Background

Minnesota state statutes require each community health board to appoint a Community Health Services administrator. Minn. R. § 4736.0110 sets forth minimum required qualifications for CHS administrators to ensure qualified public health leadership at the local level. A recent in-depth study conducted by the State Community Health Services Advisory Committee (SCHSAC) stated,

[1] Note: At the time of publication, the Public Health Foundation was anticipating releasing new core competencies.

> *"Today's public health field is increasingly demanding and complex. It requires strong—qualified, authoritative, and responsible—leadership… [CHS administrators] should have clear roles, responsibilities and authorities which are documented, shared and visible."*

The report recommended additional qualifications for CHS administrators, which reflect the complexity of current public health practice and the competencies needed for effective local leadership.

Review process

The Minnesota Department of Health (MDH) will review the education and experience of all incoming CHS administrators to ensure each meets minimum qualifications outlined in Minn. R. 4736.0110. Community health boards must be in compliance with requirements set out in Minn. Stat. § 145A and Minn. R. 4736.0110 in order to maintain eligibility for MDH funding. Furthermore, community health boards are strongly encouraged—but not required—to appoint CHS administrators who meet the Tier 3 core competencies [Public Health Foundation] for public health leaders as recommended by SCHSAC.

At times, community health boards may wish to appoint an individual to serve as the CHS administrator on an interim basis. The interim appointee must still meet the minimum qualification requirements, and is subject to an MDH review of qualifications.

1. On an ongoing basis, MDH will provide information and education to community health boards to help them understand CHS administrator qualification requirements, and to make them aware that all incoming administrators are subject to a review of qualifications. Methods shall include periodic trainings, informational materials, and a reminder letter to community health board chair when a leadership transition is anticipated.
2. The Center for Public Health Practice at MDH must be informed in writing whenever a community health board appoints a new CHS administrator. The correspondence should include a copy of the community health board resolution appointing the administrator.
3. MDH will send a letter to the newly appointed CHS administrator requesting a copy of their resume or Curriculum Vitae, and any other supporting documentation that helps summarize their educational qualifications and relevant work experience.
4. MDH will promptly review the resume, using the criteria outlined in subparts 1-4 of Minn. R. 4736.0110, and may request additional information or documentation as needed.
5. MDH will inform the new CHS administrator and the chair of the community health board of the results of this review in writing, within 30 days of receipt.
    a. If the prospective administrator is found to meet the required qualifications, s/he and the community health board chair will be notified in writing (via a welcome letter).
    b. If the qualifications of the prospective CHS administrator are found to be deficient, s/he will be notified in writing, and MDH will work with the community health board to identify a qualified candidate within the jurisdiction.

Related: Blueprint for a successful local health department workgroup

Contact information

Please contact the MDH Center for Public Health Practice with any notification, questions or comments pertaining to this process.

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Public health and the community

Building community relationships

Engaging community members in problem-solving solutions to issues that affect them is one of the fundamental principles of public health. The most effective way to achieve public health goals, especially the elimination of disparities in health status, is to actively engage those experiencing the problems in every aspect of addressing them. Community engagement means involving community members in all activities—from identifying the relevant issues and making decisions about how to address them, to evaluating and sharing the results with the community.

Community engagement is a strong value and fundamental practice of public health. The importance of engaging the community is grounded in the belief that the public has a right to participate. The public health community believes that by using our "collective intelligence" and working together, we will more accurately identify problems and develop more elegant and effective solutions. We also believe that conflict will be minimized if people have had a chance to "buy into" the process.

Community engagement is a vital part of conducting a community health assessment and a community health improvement plan, both required components of the Local Public Health Assessment and Planning cycle.

Related chapter: Assessment, planning, and reporting

Benefits of community engagement

- **Focuses on social justice**: Community wisdom and science work in tandem to ensure a more balanced set of political, social, economic and cultural priorities, resulting in shared resources and shared power, thus leading to equity and social justice.
- **Helps shape services**: Including a broad array of community residents from the beginning of a planning process will help shape services so they are culturally acceptable and more closely meet specific needs.
- **Helps build trust**: Inviting leadership from community groups will help demonstrate that their participation is valued and that their views will be considered. This can help to build trust, increase communication and create openness to utilizing services.
- **Helps with outreach**: More residents will feel involved with community activities and decisions and will be able to explain or interpret them positively to others. Spreading the word through this informal approach will improve outreach.
- **Connects people and resources**: Community engagement efforts improve connections between individuals, community associations, businesses, and churches, which in turn creates greater community support for public health.
- **Develops new leaders**: Inviting community members and leaders of community groups into planning processes will help in the identification of champions and development of leaders who understand public health issues.
- **Creates an opportunity for critical reflection**: Community engagement processes provide opportunities for cooperative, co-learning experiences, and critical reflection that benefit from community wisdom.

Principles of community engagement

Before starting a community engagement effort…

1. **Be clear about the purposes or goals** of the engagement effort and the populations and/or communities you want to engage. Those wishing to engage the community need to be able to communicate to that community why its participation is worthwhile.
2. **Become knowledgeable** about the community's culture, economic conditions, social networks, political and power structures, norms and values, demographic trends, history, and experience with efforts by outside groups to engage it in various programs. Learn about the community's perceptions of those initiating the engagement activities. It is important to learn as much about the community as possible, through both data and meeting with community leaders.

For engagement to occur, it is necessary to…

3. **Go to the community, establish relationships**, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community. Engagement is based on community support. Positive change is more likely to occur when community members are an integral part of a program's development and implementation.
4. Remember and accept that **collective self-determination is the responsibility and right of all people in a community**. No external entity should assume it can bestow on a community the power to act in its own self-interest. Just because an institution or organization introduces itself into the community does not mean that it is automatically becomes of the community. An organization is of the community when it is controlled by individuals or groups who are members of the community.

For engagement to succeed…

5. **Partnering with the community** is necessary to create change and improve health. The American Heritage Dictionary defines partnership as "a relationship between individuals or groups that is characterized by mutual cooperation and responsibility, as for the achievement of a specified goal."
6. All aspects of community engagement must **recognize and respect the diversity of the community**. Awareness of the various cultures of a community and other factors affecting diversity must be paramount in planning, designing, and implementing approaches to engaging a community. Diversity may be related to economic, educational, employment, or health status as well as differences in culture, language, race, ethnicity, age, gender, sexual identity, mobility, literacy, or personal interests.
7. Community engagement can only be sustained by **identifying and mobilizing community assets and strengths** and by **developing the community's capacity and resources** to make decisions and take action. Community members and institutions have strength and resources to bring about change and take action.
8. Organizations that wish to engage a community as well as individuals seeking to effect change must be prepared to **release control of actions or interventions to the community** and be flexible enough to meet its changing needs. Engaging the community is ultimately about facilitating community-driven action.
9. Community collaboration requires **long-term commitment** by the engaging organization and its partners. Community participation and mobilization need nurturing over the long term.

Source: CDC/ATSDR Committee on Community Engagement. (2011).

Community engagement models

There are numerous models of community engagement, civic engagement, community involvement and participation. Three examples are highlighted below.

Asset-Based Community Development model

Asset-Based Community Development (ABCD) is a strategy, developed by John McKnight and John Kretzmann, which is used to discover a community's capacities and assets and to mobilize those assets for community improvement. The ABCD process focuses on the strengths of a community and how to bring those strengths to bear in community improvement activities. For example, a typical needs assessment may ask, "What is the problem?" In contrast, ABCD work asks, "How can our community assemble its strengths into new combinations, new structures of opportunity, new sources of income and control, and new possibilities?"

According to McKnight and Kretzmann, each community boasts a unique combination of assets upon which to build its future. One can discover in every community a vast and often surprising array of individual talents and productive skills, few of which are being mobilized for community-building purposes.

Association for Community Health model

The Association for Community Health Improvement works to strengthen community health through education, peer networking, and the dissemination of practical tools. The Association convenes and supports leaders from the health care, public health, community, and philanthropic sectors to identify and achieve shared community health goals. It serves needs in a number of focus areas within community health, including:

- **Access to care**: Primary and specialty care for underserved populations, insurance coverage and barriers to access, disparities in care due to language and cultural differences, transportation, and more.
- **Chronic disease prevention and management**: Community-based approaches to create the conditions for health and reverse the course of chronic disease.
- **Community benefit**: Tools and methods to improve community benefit practices within hospitals and health service organizations.
- **Collaborative strategies**: Effective partnerships based on healthy communities principles to achieve real advances in community health while strengthening the health system.
- **Measurement and evaluation**: Logic models, indicators, and assessments to help establish goals, understand outcomes, and communicate progress.

The Association for Community Health Improvement was conceived in 2002 as a successor to three national community health initiatives that were approaching the end of their grant cycles or were otherwise ripe for renewal and growth: the Community Care Network Demonstration Program, ACT National Outcomes Network, and Coalition for Healthier Cities and Communities. These three programs had made complementary contributions to community health since the mid-1990s, focusing on topics including:

- Health care delivery and preventive health systems that ensure accessibility and are accountable to local needs;
- Careful planning for and measurement of progress toward defined community health goals, and;
- Broad community engagement in resolving systemic challenges to community health and social well-being.

The Association adopted the key tenets of each and blends them with additional ingredients of effective community health practice, to create a unified professional association with broad value as a hub of networking and continual learning. The Association for Community Health Improvement has hundreds of members from 47 states, the District of Columbia, and Canada.

Cultural Complementarity model

In 1993, the Greater Twin Cities United Way's Success by 6 Cultural Dynamics Committee developed and adopted a blueprint for new ways of thinking and discussing culture and race that could be used by individuals and organizations to rebuild relations.

Cultural Complementarity involves diverse people working together, valuing the attributes that such diversity brings to the group, in a combined effort to attain mutually agreed goals that would be difficult to accomplish via separate efforts. Working in a circle using a process of consensus, believing that all cultures and people have different areas of excellence as well as different challenges which, when brought together, will complement each other. The objective of this model is to provide clarity and direction to the efforts to attain equality by people of color through practicing "circle consensus" that exercises the principles described below:

- A sharing of rights and responsibilities among all members.
- A "power with" concept which utilizes personal and community empowerment by acknowledging multiple values, participatory negotiation, nurturing and a spirit of cooperation.
- An attitude of abundance, creativity and the belief that limitless collective power is shared, instead of a scarcity approach for power and resources.
- A positive inclusive approach in communicating that eliminates dualistic thinking.
- A celebration of differences that evolves out of on-going dialogue and exchange among participants.
- A sharing of experiential/active learning based on personal experiences, supporting the premise that knowledge is an on-going, continuous process.
- Sharing equally in the creation of future actions.
- Collective work to eliminate racism, believing that racism is based on basic deceptions about the value of human beings.

Key resources

- Community engagement
- Principles of community engagement
  Centers for Disease Control and Prevention
- Mobilizing for Action through Planning and Partnerships (MAPP)
  National Association of County and City Health Officials (NACCHO)
- The community tool box
  University of Kansas Workgroup for Community Health & Development

Populations of color and American Indians

Minnesota is growing increasingly diverse, necessitating an increase in culturally appropriate care for different racial and ethnic communities. Accessing culturally appropriate care can be a challenge for persons of color throughout the state, regardless of their age, race, ethnicity, first language, or place of birth. Minnesota's main racial/ethnic groups identified by the US Census bureau, aside from white, are African-American, American Indian, Asian, and Hispanic.

As a rule, Minnesota's urban areas are more diverse than its rural areas, but this is quickly changing as businesses and industries around the state recruit a more diverse workforce to Greater Minnesota. To find the population profile for your specific county, as well as other health outcome information, visit: Minnesota County Health Tables.

One cannot talk about improving health in Minnesota without addressing health disparities. Although the health status of Minnesotans overall is quite high—Minnesota is often named one of the healthiest states in the nation—there are significant disparities in health factors and health outcomes in Minnesota between the state's majority white population and its populations of color and American Indians. These disparities are stark and expansive. As part of its mission and goals, MDH seeks to eliminate social disparities in health.

Many of Minnesota's populations of color and American Indians lack the same opportunities to be healthy because of factors such as economic instability, unsafe neighborhoods, and inadequate access to health care. These differences ultimately result in poorer health outcomes, shorter life spans, higher health care costs, and lost productivity.

Given the growing racial and ethnic diversity of Minnesota, these disparities are of increasing importance and urgency. Minnesota's populations of color and American Indians have grown from just over 6 percent of the total population in 1990 to almost 17 percent in 2012. This growth adds people who bring talents, energies, skills, as well as their own languages, customs, diets, and health care practices not only to the Twin Cities but to communities across the state.

Working alongside populations of color and American Indians

Building relationships with diverse communities in your region relies upon the principles of listening and dialogue. It's important to understand, for example, the history of tribes and treaties in Minnesota, the conditions under which refugees come to Minnesota, and the systemic racism experienced by people of color and American Indians in Minnesota.

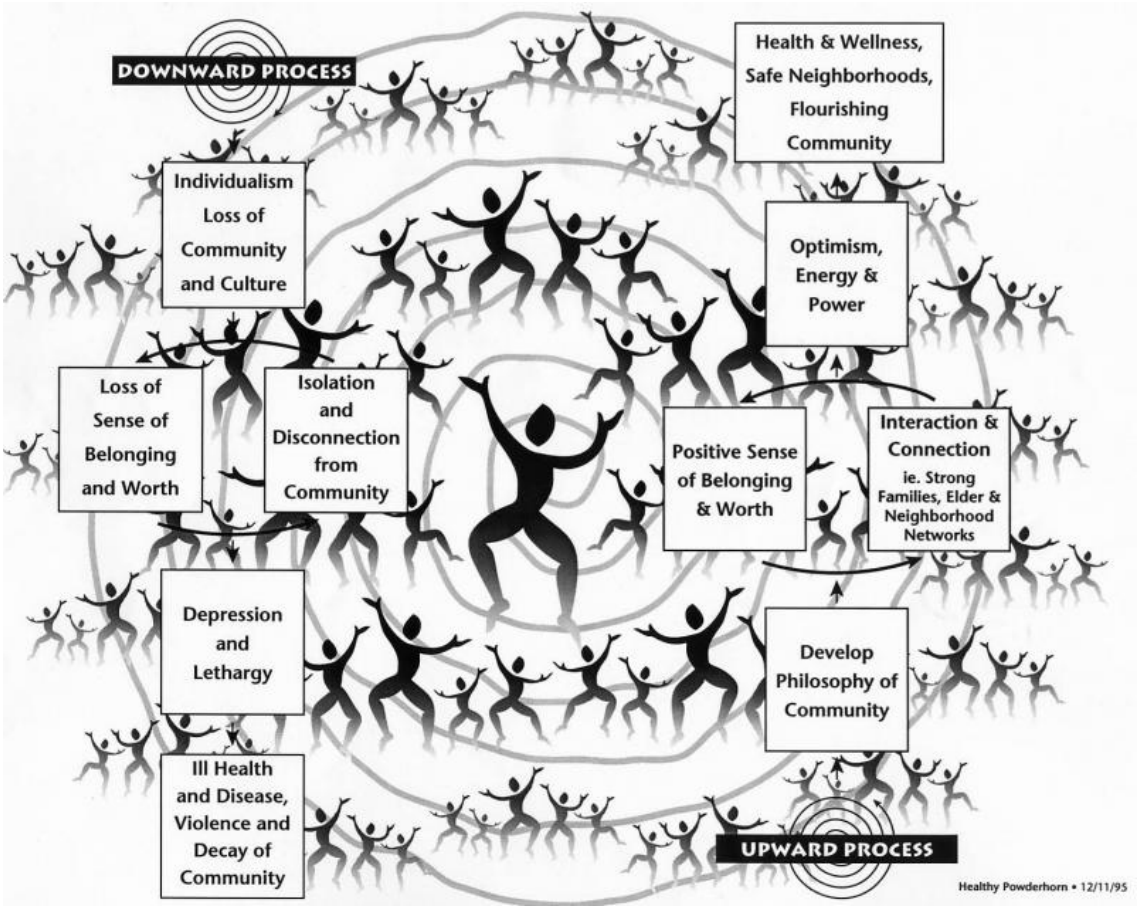
The health outcomes of all races and ethnicities in Minnesota are not only tied to factors such as access to health care and healthy behaviors, but also to community factors like high school graduation rates, unemployment rates, age distribution, home ownership, and a myriad of other **social determinants of health**. Socioeconomic status, which is so often correlated with race and ethnicity, plays a particularly important role in one's health. According to the Wilder Foundation's Health Inequities in the Twin Cities (PDF), health outcomes tend to be better in areas with higher household incomes, less concentrated poverty, and higher levels of income. Rather than focusing on medical care, a number of organizations are shifting their effort to intervene in these social determinants of health—factors that cannot be adjusted by a visit to the doctor, but instead come from other parts of our lives, like education and culture.

The Cultural Awareness Center of Minneapolis recommends an approach that takes into account how integral a community's common culture is to a person's and a group's health, called the People's Theory. Without a strong connection to one's community, an individual's health will fail. The Center recommends organizing local groups to provide health education that includes facilitating dialogue with and coaching from cultural elders; building kinship and cultural reconnection networks, and teaching culturally-based nutrition practices. Collaboration with community members and supporting communities in creating their own programming and interventions are vital to improving the community's health outcomes.

The People's Theory is grounded in the concept that individualism and loss of community and culture make us sick. This theory was developed by Minneapolis' Cultural Awareness Center after speaking with

hundreds of people spanning a number of different cultural groups. By reconnecting to culture and community, the Center advocates, we can help counteract racial disparities in health, economic status, and education.

People's Theory



African-American Minnesotans

Because social determinants of health so greatly affect a community's health outcomes, one cannot discuss the health of African-American Minnesotans without noting that, according to the 2012 Statewide Health Assessment, African-American high school students graduate on time at half the rate of their white peers, three African-American Minnesotans are unemployed for every single white Minnesotan, and African-American per capita income in Minnesota ($14,890 in 2010) is just over half the statewide per capita income ($28,563), and less than half of white per capita income in Minnesota ($31,120). All of these factors impact health in the state's African-American community, and lead to gaping health disparities that cannot be solved by health departments alone. Instead, health departments must work in concert with community partners and other agencies to resolve the social determinants that lead to health disparities between African-American Minnesotans and other state residents.

Health care is particularly expensive for African-Americans in the US, according to the National Urban League's *2012 State of Urban Health* (PDF). In the Midwest, for example, African-Americans comprise 6.5 percent of the minority population, but account for 15.5 percent of minority spending on health care. Health disparities in the Midwest cause African-American Midwesterners to lose nearly $2 billion

each year in lost productivity, compared with $600,000 for Hispanics and $400,000 for Asian Midwesterners.

Hispanic Minnesotans

Minnesotans identifying as Hispanic, Latino, and Chicano come from a various locations, and are born in the US as well as having emigrated here. According to the state's Chicano Latino Affairs Council (CLAC),

> *Latinos in Minnesota face the same health issues that other minority communities face. Such issues include affordable health care, preventative health, diet, immunization, and lack of seeking medical assistance. Additionally, another issue that Latinos face is culturally competent health care practices that have bilingual practitioners or practitioners culturally aware of the clientele.*

The CLAC aims to help the Latino community seek health care when needed, work with state agencies to ensure culturally competent health care providers, help identify specific Latino community health needs, and help deter teenage pregnancy and the growth of STIs.

Asian Pacific Minnesotans

In 2008, the Council on Asian Pacific Minnesotans and the Minnesota Asian/American Health Coalition held an Asian Health Disparities Forum to address the unique health needs of Minnesota's Asian communities. At the forum, both groups gathered stories centering on health access, promotion, data, conditions, issues, professions, and emergency preparedness; the forum was seen by the community as a way to inform city, county, state, and federal government officials about the health of Minnesota's Asian and Pacific Islander communities. Some interesting factors to note about this community, from the forum:

- There are over forty different Asian Pacific groups residing in Minnesota that can be grouped under the umbrella term Asian American and Pacific Islander (AAPI), with a population of over 210,000
- 85 percent of the AAPI community in Minnesota lives in the Twin Cities
- Minnesota is unique in that it has a large number of Korean adoptees, and the largest Tibetan, Karen, and Hmong communities in the US
- Members of the AAPI community are primary first-generation refugees and immigrants to America
- High rates of limited English proficiency exist among the AAPI community in the Twin Cities
- Families are multi-generational, often living within the same household
- The AAPI community houses great religious diversity

Source: Health Disparities / An AAPI Community Response (PDF)

It is this religious and cultural diversity that greatly impacts the way some AAPI community members perceive their health, or what it means to be "healthy." Health may be seen as more holistic, and tied to one's spiritual and mental needs as much as his/her physical needs.

The Forum identified the following as most important to the AAPI community at the time: improving medical interpreter services, increasing health education, improving the availability of data on AAPI health specific to particular sub-populations, mental health (especially among Hmong, Lao, and Karen people), as well as obesity, domestic violence, and lack of emergency preparedness planning.

American Indian Minnesotans

Minnesota's American Indian community is geographically, culturally, and spiritually diverse. Similarly, among American Indians, the ideas of "health" and "wellness" are broad, and may not just encompass one's own physical body, but be more holistic in nature. American Indians also have an especially unique

relationship with local, state, and federal governments based in their history of treaties and sovereign rights, which are still very much at the forefront of how each party interacts with each other.

Related chapter: American Indian tribal governments

(For more information, visit Why treaties matter, a traveling exhibit exploring the relationships between Dakota and Ojibwe nations and the US government.)

Language is also integral to one's health and wellness, and especially so in Minnesota's American Indian communities, where the renewal of native languages is tied to increasing community strength, identity, and wellness. As stated in the *2011 Dakota and Ojibwe language revitalization in Minnesota: Report to the Legislature* (PDF):

> *These languages embody irreplaceable worldviews. They express, reflect, and maintain communal connections and ways of understanding the world. Deeper than the disuse of vocabulary or grammar, the loss of an Indigenous language is destruction of a complex system for ordering the relationships among people and the natural world, for solving social problems, and connecting people to something beyond themselves.*

The Ojibwe People's Dictionary, which seeks to help revitalize the Ojibwe language further, states, "The Ojibwe language is where we turn for philosophy, history, science, medicines, stories, and spirituality. It is our university and the key to our cultural survival." Without the language to adequately describe one's health inside of a world view, a person is rendered partly mute.

The health issues faced by Minnesota's American Indians are not unique, but are often experienced in greater proportion than in white communities and communities of color. Only 55 percent of American Indian people rely on Indian Health Services or tribally-operated clinics/hospitals for care; many access health care outside of the tribal system.

However, American Indian communities rely on a number of strengths when seeking to improve health outcomes:

- Extended family and kinship ties
- A shared sense of collective community responsibility
- Retention and reclamation of traditional language and cultural practices
- The ability to "walk in two worlds" between native and mainstream cultures
- Indigenous generational knowledge and wisdom

When planning interventions with neighboring American Indian communities, it is extremely important to consult with local cultural advisors for questions about, for example, varying disease symptoms or culturally appropriate treatment options.

More resources

In addition to the resources listed throughout this chapter, MDH can help you find connections in your communities when it comes to working together on issues that impact minority health.

MDH health resources directory for diverse cultural communities: This directory provides a listing of hospitals, clinics, organizations and services that serve Minnesota's ever-increasing diverse cultural communities. Information is organized to direct you to general health services, dental services, home care, mental health, and help for sexual assault and battering. The guide covers Anoka, Carver, Dakota, Hennepin, Kandiyohi, Olmsted, Otter Tail, Ramsey, Rice, Scott, Stearns, and Washington counties.

ECHO Minnesota: ECHO bridges the gap for immigrants and refugees in Minnesota. Through close collaborations with health and safety experts, bilingual community leaders and talented spokespersons, ECHO crafts high quality programming for television and radio broadcast and phone, print, web, DVD and partner relay distribution. ECHO's communication tools also function as an emergency infrastructure available to public health and safety agencies during a crisis.

MDH Eliminating Health Disparities Initiative: The Eliminating Health Disparities Initiative (EHDI) grant program was created by the 2001 Minnesota Legislature in Minn. Stat. § 145.928. This competitive grant program provides funds to close the gap in the health status of African/African Americans, American Indians, Asian Americans, and Hispanics/Latinos as compared with Whites in Minnesota in the following priority health areas: breast and cervical cancer screening; diabetes; heart disease and stroke; HIV/AIDS and sexually-transmitted diseases; immunizations for adults and children; infant mortality; teen pregnancy; and unintentional injury and violence.

Healthy Minnesota framework: Healthy Minnesota is a framework for creating and improving health throughout the state of Minnesota, based on the statewide health assessment. The framework features three themes that reflect the importance of social and economic determinants for health: capitalize on the opportunity to influence health in early childhood; assure that the opportunity for health is available everywhere and for everyone, and strengthen communities to create their own healthy futures. The framework also identifies nine core indicators to monitor and provides examples of a range of strategies that relate to each of the three themes.

MDH refugee and international health: Minnesota's Refugee Health Program partners with local health departments, private health care providers, and community organizations to offer each new refugee arrival a comprehensive screening examination, appropriate follow-up or referral and community-based health education.

MDH statewide interpreter roster: Spoken Language, Health Care: The information in the roster is provided by each interpreter and has not been verified by the Minnesota Department of Health. At this time there are no qualifications that must be met to be included on the roster. Inclusion on the Roster is not evidence of being a "certified" health care interpreter. The roster can be searched to show: names, language, geographic area, and health care areas/specialty settings in which the interpreter may have work experience.

MDH translated materials: MDH provides certain materials translated into: Amharic, Arabic, Bosnian/Croatian/Serbian, Chinese, Hindi, Hmong, Karen, Khmer, Korean, Laotian, Nepali, Oromo, Russian, Somali, Spanish, Tibetan, Urdu, and Vietnamese.

Why treaties matter: This traveling exhibit explores relationships between Dakota and Ojibwe Indian Nations and the US government in this place we now call Minnesota. Learn about relationships and context surrounding treaties, and what they mean today to American Indian Minnesotans.

Key resources

- Minnesota Center for Health Statistics
- Chicano Latino Affairs Council (active through 2015)
- Council on Asian Pacific Minnesotans
- Council on Minnesotans of African Heritage
- Minnesota Indian Affairs Council
- Statewide health assessment, statewide health improvement framework
- MDH statewide interpreter roster

Working with advisory committees

Related chapter: Building community relationships

A community health advisory committee can help a community health board connect with its community (along with other important advisory groups like Statewide Health Improvement Partnership leadership, etc.), although they are not required by law. Advisory committees are a formal method for generating public interaction, and are created to advise, consult with, and make recommendations to policymakers. They can also assist the community health board in components of the Local Public Health Assessment and Planning cycle, like strategic planning and community health assessment. Advisory committees may be ad hoc, short-term, or ongoing; community health advisory committees typically play an ongoing role in a community health board, although each community health board determines the number and frequency of meetings.

The advisory committee could, for example:

- Discuss ideas and issues that the community health board is not yet ready to formally consider
- On behalf of the community health board, research new or controversial ideas, specific topics, and professional input
- Help build consensus on difficult issues that may cut across several lines of authority (for example, serve on advisory groups of other agencies with responsibilities that overlap public health to help coordinate planning)
- Serve as a coordinating body to ensure special projects fit within the community health improvement plan
- Provide connections between the many boards that often make up a multi-county community health board (e.g., county boards of commissioners, the community health board, individual boards of health, etc.)

The above duties should only be part of a larger commitment on the part of community health boards to systematic, ongoing, and genuine community participation in public health.

Advisory committees and the planning process

There are a number of ways an advisory committee can assist community health boards and staff in assessment and planning:

Review and approve the community health assessment process. A broad-based advisory group can help in choosing indicators of community health status for a community health assessment, which then identifies the problems that may be highlighted (and later addressed in the community health improvement plan). Group members can also advise on weighting indicators, since neither quantitative (e.g., mortality rate, hospital discharges) nor qualitative indicators (e.g., public meeting minutes, client feedback) will present a complete picture of community health needs. In addition, group members can often provide nuanced interpretation of data, based on their unique knowledge of the community.

Connect community health boards with possible data sources. Many data sources are under-utilized because they aren't widely known of, or they were originally designed for specific and/or narrow purposes. Group members can identify new data sources, and make some judgments about their strengths, weaknesses, and potential applicability to the assessment process.

Provide needed perspective on public health problems. If the advisory committee is representative of the community and the community health board's service area, members should be able to provide varied and representative perspectives on the health problems facing their communities. Their input

could be considered another (but not the sole) source of community input for the community health assessment. Advisory committee members may have knowledge and experience working with specific populations within the community, which is especially valuable in the planning process.

Review and approve problem statements and goals. The advisory committee can help assure that community health board assessments and plans truly align with health problems defined by the community health assessment. The group can also help prioritize problems and goals once identified; importantly, this involves making judgments about scope, social and economic burden, urgency, and existing and potential interventions. Although involving the group may require additional effort, it can help a community health board avoid a narrow or limited perspective during planning.

Provide program evaluation suggestions and expertise. Group members can help a community health board identify which programs to evaluate, key variables to examine, and groups/individuals to survey, as well as pre-testing surveys and interpreting results.

Provide political support for staff's technical judgment. The advisory committee can complement the technical judgment of staff if group members are informed of and involved in staff technical decisions, and convey support to the community health board. This provides political validation.

Advisory committees consist of community volunteers. Volunteer involvement can be a great asset to an organization, but it requires a thoughtful approach to volunteer selection, recruitment, management, and nurturing.

Advisory committee charge

The advisory committee charge should clearly convey the committee's purpose, including its goals, functions, and roles. Volunteers are more productive when a clearly defined charge guides their work. The charge may consist of a mission statement or simply a goal, or can be more detailed. It should serve to guide the group's progress, keep work moving in a systematic way, and be consistent with the community health board's strategic vision.

Committee logistics

Advisory committee size and composition can vary, but should generally represent the community population and area service providers, and have sufficient numbers to represent community diversity; at the same time, the committee should not be so large as to inhibit free discussion. If an advisory committee grows too large, it can involve community members in subcommittees or workgroups, rather than through full advisory committee membership.

It is extremely helpful to build a diverse advisory committee with both county commissioners and board of health members. While elected officials are representatives of the community, they may not be representative of public health **constituents**. Limiting participation to county commissioners advising other county commissioners is not a way of gathering broad or genuine community input, and is inconsistent with the spirit of the Local Public Health Act. However, having some board of health members serve on the advisory committee can help build support, enhance communication, and achieve understanding within the community health board.

It is also important to clearly separate advisory roles from policy and management/administrative roles. Policy is ultimately the responsibility of boards, and management/administration more appropriately belong to staff. The advisory committee can provide valuable review, comment, and recommendations on these matters but it does not have the authority to make final decisions regarding programming or budgets.

Selecting advisory committee members

Choosing the right people for the job is critical. Try to balance geographic and workforce representation. Look for characteristics like:

- Represents an important sector, organization, or group
- Has skills to carry out the committee charge
- Is knowledgeable about the community
- Has a broad community perspective (versus a special interest)
- Is committed to improving the health of area residents
- Is a team player
- Is willing and able to commit time, energy, and effort to the committee, and to actively contribute

The health care sector is broad and diverse; consider selecting members from among the many health-related professions regulated by the state. You can also identify candidates via an open appointment process, by listing openings in county mailings (like tax statements, for example). Public announcements can ask for all persons interested in serving on a committee to apply.

Related: Health professionals services program

Workgroup members

Getting programs up and running requires optimism and energy. Given that special task forces and workgroups exist to plan and implement programs, look for members with a positive, "can do" attitude. Consider recruiting members from other existing committees or community groups, which will enhance communication and coordination, and help to build a constituency of advocates. Remember that work not completed by a workgroup will often fall to program staff, so choose volunteers wisely.

Related appendix: Advisory committee assessment

Recruiting advisory committee members

As you ask members to participate, make sure you know how you'll invite them, and that you can answer the following questions from potential members:

- What am I being asked to do?
- How much time will it take? How much time am I committing?
- What will my role be? Is it a role I can/want to play?
- What are the benefits to me or my organization?

When preparing an advisory committee member job description, include the time commitment, desired skills, roles, and benefits. Benefits can include personal and professional growth, personal/organizational visibility, resume-building, and community service.

Orientation to the advisory committee

A thoughtful and informative orientation to the advisory committee will be of great benefit new committee members. Be sure to review:

- Mission of community health services
- Public health principles
- Advisory committee charge
- Committee member roles, responsibilities, and time commitment

- Examples of past and present committee activities
- Issues and priorities currently addressed by the local public health department(s) and community partners
- Agency staff members and roles

Key resources

- Building an effective advisory committee (PDF)
  US Dept. of Education Office of Safe and Drug-Free Schools

Explaining Minnesota's public health system to policymakers

Engaging local elected officials in public health is an ongoing process that involves making connections among various issues within local government. In Minnesota, state law and funding provide local governments with a framework for community health services (CHS), and local elected officials make final decisions about how programs in their area will be implemented and funded. Helping local government officials understand public health and Minnesota's system will continue to foster collaboration and support for public health issues.

> *"All politics is local." — Former Speaker Tip O'Neill*

Educational strategies

SCHSAC workgroups collaborated to identify the following methods to inform and educate county commissioners about public health, based on interviews with county commissioners and staff. These strategies are intended to be useful during the different phases of a county commissioner's term of office.

Educational strategy phases

1. Before elections
2. Newly elected commissioners
3. Early-term commissioners
4. Crisis event or policy change
5. Ongoing education

1. Before elections

Building on previous local government experience: By providing introductory information on public health to a variety of local elected officials in your communities, you can increase the awareness of future county commissioners, strengthen local intergovernmental relationships, and build broader awareness and support for public health.

Key messages for other local government officials

- Very basic information about the work of the local public health department
- Basic information about public health including disease prevention and health promotion
- Information to enhance the understanding of the relationships among various levels of government
- Basic information on the local public health assessment and planning cycle
- Clarification of roles in specific situations (e.g., public health nuisances) among county public health, community health boards, boards of health, and other local government official

Possible communication methods for other local government officials

- Meet with township associations at association meetings
- Meet with individual township boards, city councils, and school boards
- Invite comments, questions, and concerns regarding public health issues

Resources for other local government officials

- Local public health in Minnesota (PPT)
  Minnesota Local Public Health Association
- An overview of Minnesota's local public health system: Structures, mandates, and funding (PDF)
  Minnesota Local Public Health Association

2. Newly elected commissioners

Commissioners are elected in November, and take office in January. You can use this interim time as an opportunity for newly elected commissioners to get to know public health and public health staff. Newly elected commissioners are generally ready to absorb new information, but aren't yet completely overwhelmed by commissioner duties.

Related appendix: Local elected official orientation [sample]

Key messages for newly elected commissioners

- Clear and concise messages about the value of public health (introduce the broad picture of public health)
- Information from public health staff on what they can do to help commissioners
- Information on who to call in the public health agency
- Introductory information on public health governance responsibilities and the need for a solid infrastructure

Communication methods with newly elected commissioners

- Conduct face-to-face meetings with new commissioners so they get to know staff
- Invite commissioners to visit the local public health department or attend advisory committee and community meetings with a public health role
- Invite commissioners to a quarterly SCHSAC meeting
- Develop a "handbook" describing issues specific to their local public health department
- Meet one-on-one with commissioners to build relationships with, and credibility of, staff
- Ensure new commissioners have a copy of your agency's community health assessment, community health improvement plan, annual report, and/or strategic plan

Resources for newly elected commissioners

- Specific materials from your agency with organizational information, etc.
- Public health infrastructure and workforce
  NACCHO

3. Early-term commissioners

As a commissioner is sworn in and begins work in a new term, s/he will encounter tremendous information overload. This is a time for clear, concise, and thoughtful communication, but also an important time to enhance the commissioner's understanding of the value of public health.

Key messages for early-term commissioners

- Information on how public health works with other local governmental agencies (including the connection between these agencies)
- Information that reinforces and builds on the public health governance responsibilities introduced in the previous phase ("newly elected"), including a brief summary or examples of legal requirements
- Information on key public health events/issues (routine public health events that may become controversial—such as family planning, tobacco ordinances, food irradiation, immunizations)
- Increase information on the public health role in disease prevention and health promotion
- Budget/funding sources for public health
- Information on Minnesota's public health system and structure, including information on governmental public health at the local, state, and federal levels

Possible communication methods for early-term commissioners

- Interview new commissioners to get to know their interests and information needs. New commissioners may not yet be able to indicate positions on issues, but you may be able to identify what they think is important
- Develop a list of frequently asked questions from citizens
- Develop a list of frequently asked questions from commissioners
- Develop a time line or calendar of important public health events
- Incorporate public health information into the Association of Minnesota Counties' "New Commissioner School"
- Encourage participation in MDH orientation to local public health video conference for newly elected officials
- Continue to meet one-on-one with commissioners to develop relationships and credibility

Resources for early-term commissioners

- An overview of Minnesota's local public health system: Structures, mandates, and funding (PDF)
  Minnesota Local Public Health Association
- Disease prevention and control common activities framework
- Local Public Health Grant funding
- Basic legislative principles (PDF)
  Association of Minnesota Counties (AMC)
- Public health leader orientation and resource guide

4. Crisis event or policy change

Times of crisis or policy change have been identified as "teachable moments," when public health will potentially be most visible and valued—and often when commissioners need additional information on public health. Examples of changes or emergencies might include funding changes or budget decisions, policy or program changes that may be seen as controversial by the community, disease outbreaks, and/or disasters and emergencies (natural or technological).

Key messages for crisis event / policy change

- Governance responsibilities (e.g., crises and policy change will require a thorough understanding of public health statutory requirements)
- Public health aspects of disaster and emergency preparedness materials (e.g., are they ready for a crisis, how would they handle a certain situation, if involved in a previous disaster/crisis, ask what worked, what did not)
- Changing policies, practices, and scope of public health
- Information on the need for a solid public health infrastructure to assure a foundation for dealing with a crisis event or major policy change
- Understanding of the local jurisdictions, staff roles, agency roles, and available resources Possible

Communication methods for crisis event / policy change

- Use policy changes or crises as leadership opportunities for commissioners (e.g., commissioner as spokes-person for an event)
- Use public health events taking place in other parts of the state or the nation as teachable moments (e.g., ask, "How would we deal with that here?")
- Localize statewide press releases (how does this affect my community, my commissioners?) **See**: MDH news releases
- Conduct strategic planning exercises to prepare for crises and policy change
- Develop relationships or informal ties with county commissioners, to prepare for political/funding changes
- Consult with the MDH as necessary on legal and governance issues as well as a public health crises and communication issues

Resources for crisis event / policy change

- Local Public Health Act: Minn. Stat. § 145A
- Emergency preparedness and response
- BeReadyMN
  State of Minnesota

5. Ongoing education

When there isn't an emergency or a pressing need, sometimes it can be hard to get and keep the interest of commissioners in public health. It can be a challenging time, but is a great opportunity to increase commissioners' under-standing of the value of public health, or find commissioners with a special interest in public health who can be nurtured into becoming public health advocates.

Key messages for ongoing education

- Reiterate and strengthen messaging from each of the previous "phases."
- Work to strengthen the commissioner's relationship with, and the credibility of, local public health staff.

Possible communication methods for ongoing education

- Increase the understanding of public health governance responsibilities
- Reinforce and build on information about their governance responsibilities
- Remind the county board of the statutory requirement that the board of health meet two times per year
- Encourage frequent inclusion of public health issues on county board agendas
- Increase understanding of public health programs
- Begin to introduce more specific program issues
- Reinforce and build on previous general public health messages (support the public health basics)
- Involve commissioners in public health program or issues discussions and decisions (work with the county board to solve problems)
- Conduct "get to know your public health agency" tours, presentations or open houses
- Develop and deliver public health quality reports (present the "results" of public health programs, policy decisions, and public health goals to the county board)

Building relationships

- Build the credibility of staff and allow for the development of interpersonal relationships by allowing frequent interaction between public health staff and commissioners.

Ongoing education

- Keep commissioners aware of key public health events/issues
- Identify the "hot buttons" of resistant commissioners and connect those issues to public health
- Maintain ongoing, clear, concise communication with county commissioners
- Include public health issues workshops at the Association of Minnesota Counties (AMC) legislative conference
- Encourage participation by county commissioners at the annual MDH Community Health Conference

Other audiences

- Develop a public health education plan for the county coordinator/administrator.

Health plan collaboration plans

The recommendations and advice in earlier chapters of this section on public health and the community certainly apply to health plans and health care providers. There is an additional legal requirement that applies specifically to health plans, which requires them to have conversations with public health.

The early 1990s saw significant discussions of health reform that included the public health system. During that time, the Department of Human Services was restructuring its public programs for health care, looking to managed care organizations to provide capitated services under the new Prepaid Medical Assistance Program, or "PMAP." The Minnesota Department of Health and local public health

departments raised important concerns about how the transfer of Medical Assistance dollars (including administration) from counties to private organizations—organizations typically focused primarily on individual health care—would undermine the ability of counties to maintain important population-level public health activities. Managed care organizations taking funds for public health care programs should also be expected to take some responsibility for population health.

A key response to this concern was the development of a law in 2001 (Minn. Stat. § 62Q.075) that requires licensed Health Maintenance Organizations (HMOs) and Community Integrated Service Networks to submit a plan to the state health commissioner. This "collaboration plan" would describe how the organization would collaborate with community health boards and other community health-related organizations to achieve high-priority public health goals in the communities they served. Health plans were (and are) required to develop their collaboration plans in concert with local public health departments and other community organizations providing health services within the same health plan service area.

The stated purposes of collaboration plans are to:

- Promote an exchange of information that allows the public and private sectors to begin to identify areas of mutual interest
- Focus the collective efforts of the public and private sectors on a few, high-priority health problems in a community

According to statute, collaboration plans must address the following:

- Specific measurement strategies and a description of any activities which contribute to one or more high priority public health goals
- A description of the process by which the health plan will coordinate its activities with the community health boards, and other relevant community organizations servicing the same areas
- Documentation indicating that local public health units and local government unit designees were involved in the development of the plan
- Documentation of compliance with the plan filed previously, including data on the previously identified progress measures

In 1995, the first legislatively mandated Collaboration Plans formalized dialogues among public health and organized systems of health care. As a result, these groups started to develop a common language and to identify and undertake common efforts to achieve goals that prevent disease and improve the health of the people of Minnesota. They began to build collaborative relationships, and have learned to appreciate and understand each other's language, strengths, and positions. Today, health plans engage in many collaborative activities to achieve public health goals with many community partners.

Collaboration Plans today take the form of a combined plan, prepared by the Minnesota Council of Health Plans (MCHP). The plan combines into one document an extensive list of committees and regional groups that health plans participate on together with local health departments. The plan also describes the public health work that these committees accomplish and the public health goals that they are addressing.

Regional public health / health plan collaboration groups

Private organizations, especially health plan companies and health systems, can play a strong role, through collaboration with public health professionals, in achieving shared public health goals. Through the collaboration planning process, local public health departments and local public health departments have the opportunity to exchange information with the health care sector about the specific goals they are pursuing, and to discuss (and potentially collaborate on) their respective activities.

As of 2013, three regional groups comprised of local public health departments and health plan representatives are actively discussing public health goals, strategies, and health plan/public health collaboration. These are:

- The Northeast Public Health Cooperative
- The Collaborative for a Healthy Population in southeast Minnesota
- The Prairie Regional Health Alliance in southwest Minnesota

You can find more information about health plan collaboration plans online: MDH: Health plan collaboration plans.

Key resources

- Health plan collaboration plans
- Minn. Stat. § 62Q.075 (2001): Local public health accountability and collaboration plan

Governance structures and authorities

Public health powers and duties of local government

As stated earlier, the purpose of Minnesota's community health services system is to "...develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards." (Minn. Stat. § 145A.09, subd. 1.) Under the Local Public Health Act, a community health board organizes to provide that local administration, and has the "...general responsibility for [the] development and maintenance of an integrated system of community health services..." (Minn. Stat. § 145A.10, subd. 1).

Boards of health and community health boards

The difference between a "board of health" and a "community health board" can be confusing. A good working definition: A community health board has all the powers and duties of a board of health, but it has met additional qualifications that allow it to receive funding through the Local Public Health Act.

A community health board also preempts any other boards of health within its area unless those boards of health are authorized by a joint powers agreement or a delegation agreement. For instance, many

community health boards are multi-county boards, formed through a joint powers agreement. In many instances, the individual counties that make up a multi-county community health board each have their own county board of health, authorized by agreement with the community health board.

The Local Public Health Act (Minn. Stat. § 145A.09) provides guidance on forming a community health board, including eligibility, population and boundaries requirements, and for withdrawal from a community health board. Please refer to the statute for specific requirements, or contact the MDH Center for Public Health Practice for assistance.

Difference between governance structure and organizational structure

Governance structure describes the way in which governing bodies are legally organized to do their work. Minnesota statutes and rules identify two options for counties and cities to organize themselves to do the work of public health:

- Community health boards, or
- Human service boards organized under Minn. Stat. § 402

Community health boards can be comprised of single counties, provided the county meets a minimum population requirement of 30,000 residents. Community health boards can also be formed by multiple counties. Multi-county community health boards are formed through joint powers agreements, which allow the community health boards to work across political boundaries. A two-county community health board is possible if the counties share a border and have a combined population greater than 30,000. Community health boards of three or more counties are possible if the counties are contiguous; there is no minimum population requirement for community health boards with three or more counties. County boards (and in a few cases, city councils) may appoint elected officials and citizen members to these governing structures.

Organizational structure is a term used to describe the way in which a local health department is organized within a city or county. Unlike governance structures, which are dictated by statute, organizational structures are locally determined. Public health in Minnesota operates under many different organizational structures. In some locations, public health exists as a standalone department; in others, it is organized alongside social services as part of a human services agency. There are also counties in Minnesota in which a hospital is contracted to provide public health services. Visit the MDH Center for Public Health Practice online for a current and comprehensive list of the state's public health organizational and governance structures.

Governance structure changes (changes to the community health board)

If a community health board (or one of its member counties) is considering merging (expanding), withdrawing, or dissolving, the community health board is advised to contact the MDH Center for Public Health Practice, which can discuss and customize resources for the community health board.

The Local Public Health Act contains a provision for counties to withdraw from a multi-county community health board (Minn. Stat. § 145A.09, subd. 7). The withdrawing party must notify the commissioner of health and the other counties in the community health board at least one year before the beginning of the calendar year in which the withdrawal takes effect (Minn. Stat. § 145A.03, subd. 3).

There will be financial consequences for the withdrawing party, and possibly for the remaining county or counties. For example, Local Public Health Act funding includes a multi-county incentive of $5,000 per county in a multi-county community health board, which would be lost if a county withdrew from the multi-county arrangement. Other funding formulas may also be affected.

Organizational structure changes

By recommendation of the State Community Health Services Advisory Committee (SCHSAC), the Annual Assurances & Agreements form now requires that community health boards notify MDH six months prior to any final board action on major governance or organizational structural changes within the community health board or its member counties. This notification should occur in writing to the MDH Center for Public Health Practice. While the decision to make an organizational change (within a city or county) ultimately lies with the board, this recommendation is meant to help ensure that local decisions regarding public health organizations are made in a well informed and deliberative manner, and with the benefit of timely advice and assistance from MDH.

County and city powers

While community health boards and boards of health have broad powers related to public health, cities and counties also have powers relating to public health responsibilities. These powers are usually exercised by the county or city in concert with the general public health responsibilities of a community health board or board of health.

A county may adopt ordinances related to: actual or potential threats to the public health; animal control; control of unwholesome substances; regulation of sewage, garbage and other refuse; the cleaning and removal of obstructions from waters; regulation of offensive trades; the control of public health nuisances; and enforcing and administering powers delegated by agreement with the state commissioner of health (Minn. Stat. § 145A.05). There are specific requirements for adopting ordinances, so consult with your county attorney when developing ordinances. These ordinances cannot be in conflict with or less restrictive than standards in state law or rule. Cities may also adopt similar ordinances under the Specific Powers of the Council granted to statutory cities by Minn. Stat. § 412.221.

Under the authority of Minn. Stat. § 145A.11, a city council or county board that has formed or is part of a community health board must consider the income and expenditures required to meet locally identified priorities. Note: The ability to levy specific taxes for public health purposes (Minn. Stat. § 145A.08, subd. 3) is currently part of the encompassing "levy limit" of local governments.

A county board can review the community health plan and/or budget, or any revisions to the plan or budget. It may refer the plan or budget back to the community health board with comments and instructions for further consideration. A city council or county board that has formed or is part of a community health board may, by ordinance, adopt and enforce minimum standards for community health services. This authority is limited by state preemption. In some cases, local jurisdictions may pass ordinances that are more stringent than state law, but state law sets the minimum standard. (For example, all jurisdictions must comply with and enforce Clean Indoor Air Act and the Freedom to Breathe provisions. Local jurisdictions may choose to pass more stringent tobacco related ordinances, such as banning smoking in public parks or on patios.)

Township or city health boards, and the health officers appointed by them, do not have statutory power to enforce the provision of the Local Public Health Act. Cities and townships may still call some of their advisors "boards of health" or "health officers," but their legal standing is either advisory, or that of an agent of the city council or town board enforcing validly enacted city or township ordinances on behalf of the city or the township. These ordinances are adopted under the general city or town ordinance authority, not under the authority of the Local Public Health Act. These "boards of health" or "health officers" have only the authority of the city or town ordinance—they have no statutory public health authority.

Human services boards

A human services board formed under Minn. Stat. § 402 is eligible to serve as the governance structure for public health. It is the only legal alternative to a community health board under Minn. Stat. § 145A. As such, an human services board is eligible to receive funds through the Local Public Health Act (e.g., State General Funds, Title V, TANF).

A human services board is held to all other legal requirements of a community health board, including: conducting community health assessment and planning; working to achieve statewide health outcomes; considering the 10 Essential Public Health Services [CDC]; annual reporting; and appointing or employing a CHS administrator and a medical consultant.

A human services board, under Minn. Stat. § 402 becomes the governing structure for social services, public health, and corrections. (Minn. Stat. § 402.02, subd. 1a).

Human services boards of this type require an advisory committee, which with specific requirements for committee membership, including persons receiving services, providers and human services board members. The advisory committee gives the human services board advice on the development, implementation, and operation of programs and services overseen by the board, and makes an annual, formal recommendation on the budget.

It is not necessary to create the human services board governance structure for a county to organize their county functions within a human services agency. Only some of the counties in Minnesota who have combined public health with human services have formed human services boards.

It is important to keep in mind that simply merging a county health department and human services department does not mean that the county has formed a human services board. A human services board that is to function as the community health board must be organized according to the requirements listed in Minn. Stat. § 402.The law further requires the county or counties to combine the programs funded by MDH, the Department of Human Services, and the Department of Corrections into a human services agency.

If you have questions about the human services board structure, or if your county is contemplating forming a human services board, contact your MDH public health system consultant.

Summary of powers and duties: Boards of health and community health boards

To view a one-page summary of the powers and duties a community health board "must" and "may" carry out under statute, visit Minnesota Local Public Health Act: Summary of Minn. Stat. § 145A (PDF).

Key resources

- Minnesota Local Public Health Act: Summary of Minn. Stat. § 145A (PDF)
- Operational definition of a functional local health department
  National Association of County and City Health Officials (NACCHO)

Environmental health delegation agreements

Environmental health programs protect Minnesotans from environmental hazards by ensuring that they have clean drinking water, safe food, sanitary lodgings, and protection from hazardous materials and public health nuisances in their environment. The Division of Environmental Health at the Minnesota Department of Health (MDH) operates programs in these areas to achieve that goal:

- Water Well Code
- Safe Drinking Water
- Manufactured Home Parks, Recreational Camping Areas and Youth Camps
- Swimming Pools
- Food, Beverage and Lodging
- Indoor Environments, including the Minnesota Clean Indoor Air Act
- Radiation Equipment and Sources
- Human Health Risks/Toxicology

Minn. Stat. § 145A.07 states that the commissioner of health may enter into an agreement with any board of health to delegate all or part of the licensing, inspection, reporting, and enforcement duties authorized under a variety of statutes including the Safe Drinking Water Act; Minnesota Clean Indoor Air Act; investigation, reporting and control of communicable diseases; provisions of Minn. Stat. § 103I pertaining to construction, repair, and abandonment of water wells; Food, Beverage and Lodging; Youth Camps; Manufactured Home Parks and Recreational Camping Areas.

As of January 2012, responsibility for regulating all or some of these programs is delegated by the commissioner of health to 35 cities and counties. The existing delegation agreements were signed in 2010. The delegation agreement contains standards that promote uniformity and consistency statewide.

All of the supporting materials for the environmental health delegation agreement can be found online. Companion documents to the EHS delegation agreement are the Evaluation Protocol, Evaluation Tools and the Best Practices Manual (also found online).

See: Environmental Health Division: Delegated programs

Rather than a single blanket agreement for all environmental health programs, three separate agreements exist:

- Environmental health services (food, beverage and lodging)
- Well management program
- Non-community water supply program

The reason for having three separate agreements is that the three programs are run independently and if there are changes in one program, the entire agreement will not need to be renegotiated. Fewer counties have well program delegation than the environmental health services (EHS) delegation. Also, the EHS programs are closely linked to federal FDA food safety regulations and the drinking water protection programs are tied to federal US EPA regulations. It is expected that any changes in federal law will necessitate changes in the state program. Separating the agreements will streamline future adjustments.

Because of the 2007 Legislative changes that the Freedom to Breathe Act made in the Minnesota Clean Indoor Air Act, any local agency that operates a delegated EHS program will enforce the MCIAA through the Minnesota Food Code (Minn. R. 4626.1820) and local law enforcement authority.

For more information about these agreements, please contact the MDH Environmental Health Division.

Disasters and emergency preparedness

Related:

- Appendix: Emergency preparedness glossary
- Minnesota's statutes and rules on emergency preparedness, disease outbreaks, and volunteer protections

In both the distant and near past, Minnesota has responded to a number of disasters: floods, tornados, wildfires, infectious diseases, and more recently, the collapse of the I-35W bridge in Minneapolis. Since 1965, each of Minnesota's 87 counties has been declared a Presidential disaster area at least once, and some multiple times.

The State of Minnesota relies on the following definitions of "disaster" and "emergency":

- **Disaster** means a situation that creates an actual or imminent serious threat to the health and safety of persons, or a situation that has resulted or is likely to result in catastrophic loss to property or the environment, and for which traditional sources of relief and assistance within the affected area are unable to repair or pre-vent the injury or loss (Minn. Stat. § 12.03, subd. 2).
- **Emergency** means an unforeseen combination of circumstances that calls for immediate action to prevent a disaster from developing or occurring (Minn. Stat. § 12.03, subd. 3).

Responding to disasters has always been an essential part of public health activity, and while public health has focused more on prevention activities than emergency response in the past few decades, its role in preparing for, responding to, and recovering from incidents has becoming increasingly important. Recent emergency preparedness funding has allowed public health agencies to improve preparedness infrastructure, identify public health hazards, create and revise preparedness plans, and conduct exercises to test those plans.

Public health has moved toward approaching emergency preparedness from a more holistic angle, called an "all-hazards" approach—that is, disasters and emergencies contain problems that can be solved by public health. For ex-ample: contaminated drinking water in a flood, food-borne illness in a shelter for tornado victims, air quality during wildfires, or public exposure to hazardous materials from a train wreck.

Partnerships

Building and strengthening partnerships is a critical preparedness activity in order for effective planning to occur prior to responses. By knowing your partners' responsibilities, skills, and resources (as well as your own), you can help facilitate a fast and effective response. This is reflected in a common disaster planning adage: "You don't want to be exchanging business cards during the disaster."

Emergency management

Emergency management departments serve as a major partner to public health during responses. However, the emergency management culture can be quite different from that found in a public health agency. You may find it useful to ponder the following:

Emergency management, like public health, has its own "language" consisting of a myriad of acronyms and jargon. This language is common to the national emergency management system, and it is helpful to learn it. Emergency management is likely just as baffled by public health's unique language, but working together will introduce both parties to new concepts and principles.

Related appendix: Emergency preparedness glossary

The culture of emergency management is steeped in its history of being closely associated with the military. Many emergency managers have been trained in civil defense, military, law enforcement, and/or other first responder professions; many also carry emergency management duties in addition to full-time careers as veterans' services directors, dispatchers, sheriffs, etc. Emergency management also has a different proportion of genders in leadership, as does public health, although both are changing. These differences can create tension and communication gaps. It's important to learn how to be comfortable in the emergency management system and with the command style, and to work cooperatively to achieve an effective disaster response. Exercises, trainings, and planning meetings can help those new to the emergency management system become more comfortable with new terminology and structure.

Emergency management policies, plans, and processes are highly formalized and very detailed, but for a very important reason: this allows organizations to facilitate rapid disaster containment, and ensure that other partners (like public health) can start to help as soon as possible. Despite this level of detail, emergency managers also highly value flexibility and creativity, and believe that "thinking on your feet" is an essential skill in the face of a disaster.

Assistance

A number of excellent resources exist to help you learn about the requirements that accompany different preparedness funding streams, activities that have taken place in the recent past, and the impact of preparedness work. Some include:

- Staff members in your department assigned to preparedness
- MDH regional Public health preparedness consultant (PHPC) or regional health care preparedness coordinator (RHPC)
- County emergency manager [Minnesota Dept. of Public Safety]

Preparing for emergency preparedness

The MDH Office of Emergency Preparedness recommends that all CHS administrators take, at minimum, the FEMA course IS-100.c: Introduction to Incident Command System.

Key resources

- Emergency preparedness and response
  Minnesota Dept. of Health
- Public health preparedness consultants (PHPCs)
- County emergency managers
  Minnesota Dept. of Public Safety
- Individual/family preparedness
- Emergency preparedness and response
  Centers for Disease Control and Prevention
  Note: Some CDC recommendations may differ from those in Minnesota
- Public health preparedness
  National Association of County and City Health Officials (NACCHO)
- Homeland Security and Emergency Management Division
  Minnesota Dept. of Public Safety

- Current, past Minnesota disaster declarations
  Federal Emergency Management Agency (FEMA)
- Independent study program
  FEMA Emergency Management Institute
- BeReadyMN
  State of Minnesota

American Indian tribal governments

As the administrator of a government agency, it is important to be aware of and informed about both the public health issues affecting American Indians and the unique nature of the government-to-government relationship between American Indian tribes and U.S. federal, state and local governments. Collaborations between government and tribal entities can be fraught with historic distrust, but local governments that have persisted in trying to establish meaningful, respectful relationships with neighboring tribal systems have found these relationships to be very rewarding and important in accomplishing mutual public health goals.

Tribes experience great diversity across and within themselves, as a result of the tribal system created in the late 1800s, historical rivalries and politics between tribes or nations, and cultures adapted to natural environments and trade influence. Many American Indians have relocated from reservations to urban areas—for example, the community of Little Earth in Minneapolis—and may be geographically invisible and multi-racial. Specific cultural customs among American Indian groups may vary significantly even within a single community, and some tribal meetings may open or close with a prayer, depending on how much the group's spirituality is integrated with its community. Elders play a significant role in tribal communities, and it is customary in many communities to allow elders to speak first, or to ask their permission or defer to them when speaking. Some community members may value nonverbal or indirect communication, preferring to address a sensitive issue more subtly or tactfully. Storytelling can also be an important tool for community members to convey a message.

Above: The Mobile Unit of the Shakopee Mdewakanton Sioux Community brings free medical, dental and vision care to communities across Minnesota. Image: Shakopee Mdewakanton Sioux Community Wacipi.

Government and tribal nation relationships

Relations between tribal nations and US federal, state, and local governments are based on three fundamental principles:

1. Sovereignty
2. Treaty rights
3. Trust responsibility

Sovereignty

American Indian tribes have a unique political and legal status within the boundaries of the United States, which is different than any minority group or population. Tribal sovereignty allows each tribe to manage its own affairs, independent of the governing structure of state and federal government. Each tribe in Minnesota is independent and self-regulating, and has always governed itself; this right to sovereignty was retained by tribes throughout the negotiations with the US government that devastated many tribes.

Sovereignty gives tribes the power to hold elections, determine their own citizenship (enrollment), and to consult directly with the US government on policy, regulations, legislation, and funding. Tribes also carry "domestic dependent nation" status within the US, which means they are subject to the legislative power of the United States, and do not have external powers of sovereignty (such as the power to enter into treaties with foreign nations). Tribal governments can create laws that are stricter or more lenient than state laws, but they are not subservient to state law. State law cannot supersede tribal law when it affects the right of the tribe to legislate its own health and welfare, or where it would interfere with federal interest.

Sovereignty can create complex working relationships, as each nation or tribe is independent of other nations and tribes, and should be approached as an independent government entity.

Treaty rights

Sovereignty has its basis in treaties. Treaties formalized the nation-to-nation relationship between the nation's American Indian tribes and the US government. The issue of treaty rights and treaty violations is a vast and complex area of current and historical laws and actions.

Minnesota's Anishinaabe reservations were originally established by treaty, considered separate and distinct nations by the United States. Six of the state's seven reservations were allotted during the General Allotment Act (also known as the Dawes Act of 1887), which authorized the US President to survey American Indian tribal lands and divide them into allotments for individuals. The Red Lake Reservation is the only Anishinaabe reservation to remain unallotted and held in common by all tribal members.

Minnesota's original Dakota Community was established in 1851 by treaty, as a 10-mile portion of land surrounding the Minnesota River; this community was dissolved by Congress in the aftermath of the US-Dakota War of 1862, and the Dakota were forced from their homes in Minnesota and expelled from the state. The four current Dakota communities were reestablished in their current locations by Congress in 1886, and are small segments of the original reservation.

> *"The history of Indian treaties is the history of all Minnesotans and all Americans…We cannot have a complete understanding of what it means to be Americans without knowing about these relationships, whether we are Native Americans or not." — Kevin Gover, Director, Smithsonian National Museum of the American Indian*

Trust responsibility

The US government has a moral obligation to honor commitments made through treaties with American Indian tribes, and to aspire to the best interest of tribes and their members. Trust responsibility includes the obligation to protect American Indian land and resources, and to provide the economic and social programs necessary to raise the standard of living of American Indian people to that of the non-Indian population. An important implication of this principle is that state and local governments are constitutionally required to extend services to American Indians within reservations despite their lack of jurisdiction. Beyond extending services, local and state governments must include American Indian tribal governments in assessment, planning, setting priorities, and strategic development, in order to make decisions that reflect and protect the needs and interests of all populations.

Tribal government structures

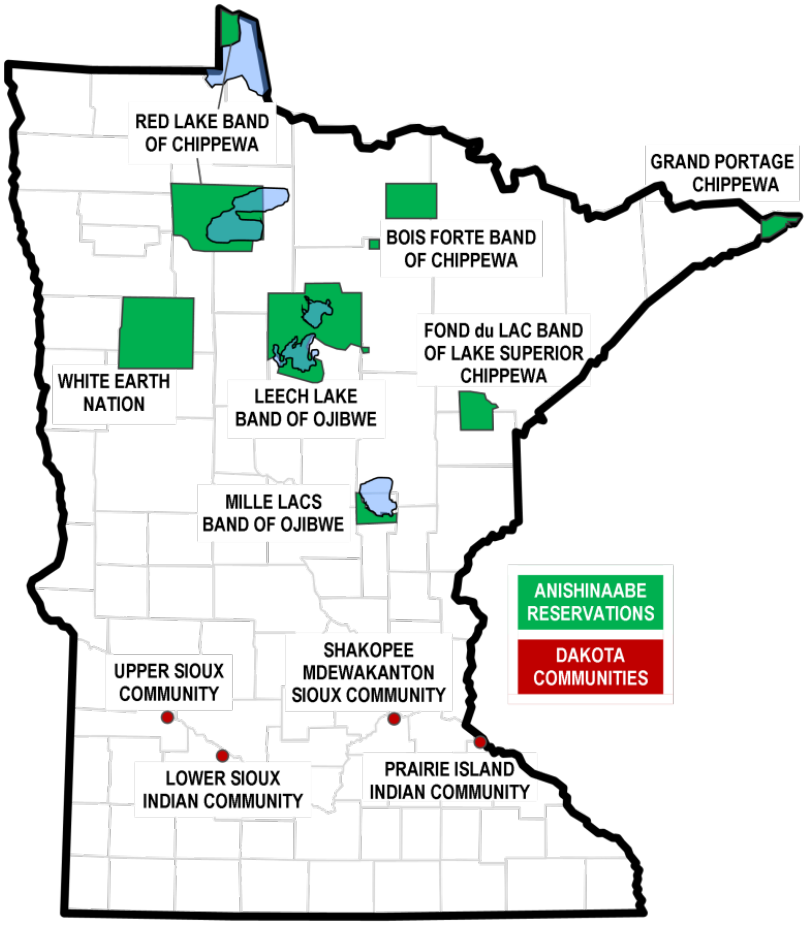
Minnesota's tribal government structures vary, due to differences in past treaties and agreements. Each tribe has a unique leadership structure, and operates by a set of laws and codes approved by the governing body. Some nations have tribal councils with a set number of members, while others include all tribal members in voting on tribal affairs. Heads of tribal government may be called Chairman, Chairperson, President, or Chief Executive.

American Indian tribes, reservations, and communities in Minnesota

Minnesota's tribal reservations and communities In Minnesota, there are two tribes: the Anishinaabe (also known as Chippewa and/or Ojibwe) and the Dakota (also known as Sioux). There are seven Anishinaabe reservations within Minnesota boundaries, and four Dakota communities. From the Minnesota Indian Affairs Council:

> *A reservation or community is a segment of land that belongs to one or more groups of American Indians. It is land that was retained by American Indian tribes after ceding large portions of the original homelands to the United States through treaty agreements. It is not land that was given to American Indians by the federal government. There are hundreds of state and federally recognized American Indian reservations located in 35 states. These reservations have boundary lines much like a county or state has boundary lines. The American Indian reservations were created through treaties, and after 1871, some were created by Executive Order of the President of the United States or by other agreements.*

Minnesota's tribal reservations and communities



Anishinaabe reservations in Minnesota

Tribal nation	Shares land with	Administered by
Zagaakwaandagowininiwag / Bois Forte Band of Chippewa	Koochiching, St. Louis counties	Executive Director, Tribal Council
Nah-gah-chi-wa-nong / Fond du Lac Band of Lake Superior Chippewa	Carlton, St. Louis counties	Chairperson, Business Committee
Gichi-Onigaming / Grand Portage Band of Lake Superior Chippewa	Cook County	Chairperson, Tribal Council
Gaa-zagaskwaabiganikaag / Leech Lake Band of Ojibwe	Beltrami, Cass, Hubbard, Itasca counties	Chairperson, Tribal Council
Misi-zaaga'iganiing / Mille Lacs Band of Ojibwe	Mille Lacs County	Chief Executive, Band Assembly, Tribal Court

Tribal nation	Shares land with	Administered by
Mis-Qua-Mi-Saga-Eh-Ganing / Red Lake Nation	Beltrami, Clearwater counties	Chairperson, Tribal Council, advised by Hereditary Chiefs
Gaa-waabaabiganikaag / White Earth Nation	Becker, Clearwater, Mahnomen counties	Independent executive, legislative, and judicial branches

Dakota communities in Minnesota

Tribal nation	Shares land with	Administered by
Cansa'yapi / Lower Sioux Indian Community	Redwood County	Tribal Council
Tinta Winta / Prairie Island Indian Community	Goodhue County	Tribal Council
Medwakanton / Shakopee Mdewakanton Sioux Community	Scott County	Business Council
Pezihutazizi / Oyate (Upper Sioux Community)	Yellow Medicine County	Board of Trustees

For more information on the history of Minnesota's Anishinaabe reservations and Dakota communities, visit the state's Indian Affairs Council online, where a great deal of information resides on each nation.

Key resources

Jackie Dionne,
MDH American Indian Health Director
Minnesota Department of Health
Phone: 651-201-3521
Email: jackie.a.dionne@state.mn.us

- Minnesota Indian Affairs Council
- Indian Health Service (IHS)
- A guide to cultural qwareness of Minnesota's American Indians (PDF)
  US Dept. of Health and Human Services
- Why treaties matter

Administrative duties

Budgets and audits

Budgets

Budgets are a key component of fiscal planning for a local health department. Health departments are required to develop budgets within the framework established by their county or community health board. In addition, most funders require that program specific budgets be submitted as a part of the funding process. For example, most MDH grant programs require budgets be submitted to the MDH as a part of the grant monitoring process.

Audits

All community health boards are subject to state audit requirements if they receive any state funds. That means that all of the agency's books, records, documents, and accounting procedures and practices must be available for examination by the MDH, the legislative auditor, and the state auditor for a minimum period of six years.

In addition, if your agency receives any federal funding from the federal government (either directly or passed through a state agency), you are subject to federal audit guidelines. For example, all community health boards in Minnesota receive federal money in from the Title V Block Grant. Your state or federal grant manager can provide specific information about those guidelines, as they vary based on dollar amounts. As with all legal issues, you should consult your county guidelines, too.

MDH recommends that the community health boards fiscal agent be a county auditor, as county auditors are aware of state audit guidelines and are subject to regular audits. If the community health board instead chooses to name its administrative office or CHS administrator as the fiscal agent, the administrative office or administrator is responsible for ensuring that regular audits occur.

Invoicing and reconciliation

In order to comply with Minnesota Office of Grants Management policies, MDH grant payments for the Local Public Health Act and the federal Title V MCH Block Grant to Community Health Boards will be administered on a reimbursement basis beginning January 1, 2013. MDH will reimburse community health boards for expenses based on invoices submitted to MDH on either a monthly or quarterly basis.

See: Grants management policies, statutes, and forms [Minnesota Dept. of Administration]

Local public health uses this invoice to report grant expenditures paid for by community health boards and that are eligible for reimbursement under the following programs: Local Public Health Grant (Minn. Stat. § 145A.131), Maternal and Child Health Block Grant (Minn. Stat. § 145.882), and Family Home Visiting Programs (Minn. Stat. § 145A.17).

Local public health can download the invoice and instructions online at LPH Act: Invoice and reconciliation instructions.

Assessment, planning, and reporting

The Local Public Health Act of 2003 established a five-year cycle (which began again in 2010) for developing and reporting local priorities and essential local activities. A very limited amount of detail is included in this chapter, as both processes may evolve in the future. For assistance with both of these processes, please contact your public health system consultant.

Assessment and planning

The LPH assessment and planning process was revised at the end of the 2005-2009 reporting cycle, to reflect changes recommended by local public health officials and by an ad hoc group of the State Community Health Services Advisory Committee (SCHSAC). These changes were made to increase the process' clarity and utility, ensure adequate technical assistance is available, and to align reporting standards with national public health accreditation standards.

The LPH assessment and planning cycle aims to help local health departments assess and prioritize the health needs of their communities, assess and prioritize their own internal capacity to meet those health needs, and develop action plans to meet those needs.

This process is one component of a larger local public health quality improvement process. Other components of the larger improvement process include LPH Act annual reporting (below) and the accountability review process.

LPH Act annual reporting

Minnesota's local public health Local Public Health Act annual reporting is a web-based information system that collects and reports on the activities, funding, staffing and performance of Minnesota's local public health departments. LPH Act annual reporting aims to describe key aspects of Minnesota's public health system, provide consistent and accurate information that can be used to improve delivery of public health, and provide accountability and meet the reporting requirements of the Local Public Health Act.

Key resources

- Minnesota for Center Health Statistics
- Public health and quality improvement toolbox
- Community toolbox
  University of Kansas

Personnel recommendations

In considering candidates for a position on your staff, you need to consider both the legal requirements and the other qualifications and qualities that will help a candidate become a resourceful, committed, and valued member of your team. The personal qualities and skills of an individual complement and strengthen their academic preparation and professional certifications. Characteristics such as being a "team player," having a positive outlook, being able to effectively communicate with clients and

colleagues, having a public health perspective, and being creative in facing challenges are universally desirable traits in staff.

CHS administrators

For background, expectations, and qualifications of CHS administrators, visit the chapter Expectations of CHS administrators.

CHS medical consultants

The community health board must appoint, employ, or contract with a medical consultant to ensure appropriate medical advice and direction for the board of health and assist the board and its staff in the coordination of community health services with local medical care and other health services (Minn. Stat. § 145A.10, subd. 3).

"Medical consultant" means a physician licensed to practice medicine in Minnesota who is working under a written agreement with, employed by, or on contract with a board of health to provide advice and information, to authorize medical procedures through standing orders, and to assist a board of health and its staff in coordinating their activities with local medical practitioners and health care institutions. (Minn. Stat. § 145A.02, subd. 15)

Disease prevention and control / health promotion staff

As part of the collaborative agreement between MDH and local public health), MDH asks that local public health designate staff to have communicable disease responsibilities for Tuberculosis; STI/HIV; vaccine-preventable disease; refugee health; and surveillance activities. The MDH provides consultation and training to local Disease Prevention & Control staff as requested, so that local staff are prepared to carry out the Disease Prevention and Control duties outlined in their DP&C common activities framework.

Similarly, all local health departments are expected to designate a staff person to serve as a health promotion contact for MDH staff (per the key indicators, accountability review).

Public health nurses

Public health departments in Minnesota employ public health nurses. According to Minnesota State Statute (Minn. Stat. § 148.232), a public health nurse must be certified for public health duties by registration. Minn. R. 6316 lists the requirements for registration. This includes a baccalaureate or higher degree with a major in nursing and minimum public health nursing coursework.

Other public health professions

- Provider certifications, licenses, registrations, and rosters
- Licenses and permits administered by MDH

Includes:

- Environmental health sanitarians
- Environmental health specialists
- Well inspectors

- Supervision of skilled nursing
- Home health aides
- WIC staff
- Child and Teen Checkup clinics
- Elderly waiver and long-term care consultation
- Personal care assistants

Data practices

Government records and retention

Excerpted from: *Managing your government records: Guidelines for archives and agencies* (Minnesota Historical Society, v3, rev. 2009).

Government records are of great value to the State of Minnesota and its citizens—they are necessary for conducting government business; they help preserve our heritage by documenting our historical places, people, and events; and they are used frequently for research and investigations. As a government agency or historical society, you take on the many responsibilities that come with holding and managing these vital documents.

What is a government record?

Related chapter: Minnesota Government Data Practices Act

Government records are defined as state and local records that are created in accordance with state law or in connection with public business transactions. Government records are created by officers or agencies of the state, counties, cities, towns, school districts, municipal subdivisions, organizations, or any other public authorities or political entities.

Examples of government records include correspondence, maps, memoranda, papers, photographs, reports, writings, recordings, e-mail, and other data, information, or documentary material. Records can be stored on various media such as paper, microform, audio and video tape, photographic materials, computer hard drives, or removable media. It is important to remember that **government records refer to the recorded data or information regardless of the media it is recorded on or format it is in**. For example, the information found on a birth certificate is considered the record, not the paper document or the microfilm it is recorded on.

Records retention schedules

Records retention schedules are an essential tool for managing your government records. These schedules specify minimum retention periods for records based on the records' administrative, fiscal, legal, and historical value. The Minnesota Historical Society maintains records retention schedules, including schedules for Minnesota counties, cities, townships, school districts, district courts, human resources schedules for state agencies, and financial schedules for state agencies.

State or local government agencies may create their own records retention schedules, but each schedule must have the proper review and approval prior to use.

In September 2016, members of the Minnesota Local Public Health Association Policy and Practice Committee, local county record managers, the Minnesota Historical Society, and Minnesota Department of Health staff worked on a complete revision/update of the 1988 retention schedule titled "Community Health/Nursing Services." The revised schedule, "The Local Public Health Section (Schedule no. 016-095)," supersedes the 1988 schedule, and most counties can start using it without any further action. However, some counties may require a board resolution to begin using it. Check with your county administrator or the Minnesota Historical Society for more information.

How do you provide access to government records?

Granting access to government records is one of the most important services you provide as you fulfill your mission as a government agency or historical society. Minnesota statutes that govern access apply not only to those records that remain in their local jurisdiction, but also to those that are moved to another location or another repository.

What is the responsibility of a local government entity?

As a government entity, you must be in compliance with the Minnesota Government Data Practices Act. This means you need to designate a responsible authority and a data practices compliance official, and establish your own specific data practices policies and procedures.

Key resources

Webinars: Records retention series: These webinars are part of a series for local public health staff to become familiar with the basics of records management, retention schedules, proper destruction of records, and disaster recovery for records.

Minnesota Historical Society, state archives: The State Archives provides information on and assistance with historically valuable government records.

Minnesota Department of Administration: Data Practices Office: This office provides assistance and advice on data practices and open meetings to the public and government.

Local Public Health Association: 2016 local public health section records retention schedule is now available for use: LPHA provides information about the 2016 record retention schedule along with FAQs.

The Minnesota Government Data Practices Act

This chapter is intended only as a very basic and superficial overview of some of the more important provisions of the Minnesota Government Data Practices Act and should not be construed as legal advice. The MGDPA creates legal obligations and requirements on the governmental organizations and other individuals to whom the MGDPA applies. Failing to comply with any particular provision of the MGDPA, for example by releasing information that should not have been disclosed or by not releasing data to a person entitled to it, could result in monetary fines and penalties for the agency and criminal prosecution and job loss for the individual government workers responsible for not complying with the MGDPA. As many of the MGDPA's provisions can be described as unclear, complicated, and confusing, it is highly recommended that all issues pertaining to the receipt, classification, storage, use, and dissemination of in-formation be referred to the entity's Responsible Authority and legal counsel.

What is the Minnesota Government Data Practices Act?

The Minnesota Government Data Practices Act (MGDPA), Minn. Stat. § 13, is a state law that controls how government data are collected, created, stored (maintained), used and released (disseminated). The MGDPA sets out certain requirements relating to the right of the public to access government data and the rights of individuals who are the subjects of government data.

Briefly, the MGDPA regulates:

- What information can be collected
- Who may see or have the information
- Classification of specific types of government data
- Duties of government personnel in administering the provisions of the MGDPA
- Procedures for access to the information
- Procedures for classifying information
- Civil penalties for violation of the MGDPA
- Charging fees for copies of government data

The actual text of Minn. Stat. § 13, and Minn. R. 1205, the Rules Governing Data Practices as promulgated by the Minnesota Department of Administration, can be found online.

What are government data?

Government data is defined as "all data collected, created, received, maintained, or disseminated by any government entity regardless of its physical form, storage media, or conditions of use." Thus, as long as information is recorded or stored in some way by a government entity, they are government data, no matter what physical form they are in, or how they are stored or used. Government data may be stored on paper, in electronic form, on audio or videotape, on charts, maps, etc. Government data do not include mental impressions.

It is important to remember that government data are regulated at the level of individual items or elements of data. A document, record, or file contains many data elements.

Who must comply with the MGDPA?

The MGDPA applies to all data collected, created, received, maintained or disseminated by any government entity. The MGDPA defines "government entity" as "a state agency, statewide system, or political subdivision." The term "political subdivision," for purposes of the MGDPA, includes counties,

cities, school districts, special districts, boards, commissions, and district; as well as authorities created by law, local ordinance or charter provision. State-level entities include the University of Minnesota and state-level offices, departments, commissions, officers, bureaus, divisions, boards, authorities, districts, and agencies.

Statewide systems are also subject to the MGDPA. A statewide system is any record keeping or data administering system that is established by federal law, state statute, administrative decision, or agreement, or joint powers agreement, and that is common to any combination of state agencies and/or political subdivisions.

Additionally, if a government entity enters a contractual arrangement with a private party to perform any governmental function, that private party is subject to the MGDPA with regards to any of the data created, collected, received, stored, used, maintained or disseminated in the performance of the agreement and must comply with the MGDPA as if it were a government entity.

What are the consequences for MGDPA noncompliance?

A government entity may be sued for violating any MGDPA provisions. An action to compel a government entity to comply with the MGDPA may be brought in either a Minnesota District Court or with the Minnesota Office of Administrative Hearings. A government entity found to be in violation may be ordered to comply with the MGDPA, pay a civil penalty up to $1,000, and pay the aggrieved person's costs and disbursements including attorney's fees. Additionally, the MGDPA provides criminal penalties, and disciplinary action including dismissal from public employment, for anyone who willfully (knowingly) violates a provision of the MGDPA.

Where can more information about the MGDPA be found?

The following sources may provide helpful information about the MGDPA and other data practices laws.

Local government associations may be consulted for information specific to data practices matters within their jurisdiction.

- Association of Minnesota Counties
- Minnesota County Intergovernmental Trust
- League of Minnesota Cities
- Minnesota School Boards Association
- Minnesota Association of County Officers
- Minnesota Police and Peace Officers Association

Additional information, educational resources, and assistance with data practices issues is available at: Minnesota Dept. of Administration: Data Practices Office.

Opinions issued by the Commissioner of Administration, pursuant to Minn. Stat. §13.072, are available on the IPAD website. Copies of individual opinions, an opinion summary, and an index to Commissioner's Opinions are available from IPAD upon request.

Definitions and classifications of data

The MGDPA establishes a system of data classifications that define, in general terms, who is legally authorized to access government data. This classification system is constructed from the definitions provided in Minn. Stat. §13.02. See also: Minn. R. 1205.0200.

Almost all government data are either data on individuals or data not on individuals. The MGDPA defines an "individual" as a natural person, and, in the case of a minor or incapacitated person, a parent

or guardian. Thus, other legal entities such as corporations are not considered an "individual" for purposes of the MGDPA. "Data on individuals" is all government data in which any individual is or can be identified as the subject of that data. Data on individuals are classified as public, private, or confidential. In contrast, "Data not on individuals" is all government data which is not data on individuals, and are classified as public, nonpublic, or protected nonpublic. This classification system determines how government data are handled.

- **Public data**: Public data is accessible by anyone. The MGDPA provides that, unless specifically authorized by statute, a government entity may not require persons to identify themselves, state a reason for, or justify a request to gain access to public government data.
- **Private data**: Private data on individuals is data classified by statute or federal law as not public but accessible to the individual subject of that data.
- **Confidential data**: Confidential data on individuals is data made not public by statute or federal law and is inaccessible to the subject of that data.
- **Nonpublic data**: Nonpublic data is data not on individuals that a statute or federal law makes not accessible to the public but accessible to any subject of that data.
- **Protected nonpublic data**: Protected nonpublic data is data not on individuals which is both not public and not accessible to the subject of that data.

The MGDPA specifies that all government data is public unless a statute, a temporary classification issued by the Commissioner of Administration, or a federal law classifies the data as, with respect to data on individuals, private or confidential; or, in the case of data not on individuals, as nonpublic or protected nonpublic. In this regard:

Data on individuals	Data on decedents	Data not on individuals
Public (Minn. Stat § 13.02, subd. 5) Accessible to anyone for any or no reason	**Public** (Minn. Stat. § 13.10, subd. 1) Accessible to anyone for any or no reason	**Public** (Minn. Stat § 13.02, subd. 4) Accessible to anyone for any or no reason
Private (Minn. Stat § 13.02, subd. 12) Accessible to data subject; not available to public	**Private**[2] (Minn. Stat. § 13.10, subd. 1b) Accessible to representative of decedent; not accessible to public	**Nonpublic** (Minn. Stat § 13.02, subd. 9) Accessible to subject of the data, if any; not accessible to public
Confidential (Minn. Stat § 13.02, subd. 3) Not accessible to data subject; not accessible to public	**Confidential**[3] (Minn. Stat. § 13.10, subd. 1a) Not accessible to representative of decedent; not accessible to public	**Protected nonpublic** (Minn. Stat § 13.02, subd. 13) Not accessible to data subject; not accessible to public

[2] Private data on decedents become public data ten years after the death of the data subject and 30 years after the creation of the data.

[3] Confidential data on decedents become public data ten years after the death of the data subject and 30 years after the creation of the data.

Collecting and storing data

Related chapter: Government records and retention

What controls are placed on the collection and storage of data on individuals?

Government entities may collect and store public, private, and/or confidential data on individuals only if necessary to administer or manage a program that is authorized by state law or local ordinance, or mandated by the federal government. An entity may not collect or store any data on individuals without proper legal authority, either express or implied.

Before the Minnesota legislature ended its 2012-2013 session, it passed a bill that revises the Minnesota Data Practices Act to classify "individual personal e-mail addresses and telephone numbers collected by government entities for notification purposes as private data on individuals and allowing data sharing among government entities."

What actions must a government entity take before collecting and storing data on individuals?

- Identify its specific legal authority(ies) for collecting, using, disseminating, and storing public, private, or confidential data on individuals.
- Determine what types of data on individuals it collects or stores, and how those data are classified.
- Designate a "Responsible Authority," who is the individual ultimately responsible for the collection, use, and dissemination of government data.
- Pursuant to Minn. Stat. §13.05, subd. 1, prepare a public document containing, among other information, a description of each category of record, file, or process relating to private or confidential data on individuals maintained by that entity. This public document must contain the name, title, and address of the entity's responsible authority. Forms that are used by the entity to collect private and confidential data on individuals must be included in the document. The document must be updated annually. Entities are not required to prepare a public document for data not on individuals.

Tennessen warnings

Whenever a government entity asks an individual to provide private or confidential data about her/himself, the entity must give that individual a notice—sometimes called a Tennessen Warning.

What must be included in the notice?

Pursuant to Minn. Stat. §13.04, subd. 1, an individual asked to supply private or confidential data concerning the individual shall be informed of:

- **The purpose and intended use of the data within the collecting government entity**. This is why the data are requested and how they will be used within the collecting entity;
- **Whether the individual may refuse or is legally required to supply the data**. The subject has the right to know whether or not s/he is required by law to provide the data requested;
- **Any known consequences to the individual of either supplying or refusing to supply the data**. The entity is required to state the consequences known to the entity at the time when the notice is given; and
- **The identity of other persons or entities that are authorized by law to receive the data**. The notice must specifically identify recipients that are known to the entity at the time the notice is given.

When must the Tennessen warning be given?

The Tennessen warning is given at the point of data collection. The notice must be given whenever:

- A government entity requests data;
- The data are requested from an individual;
- The data requested are private or confidential; and
- The data are about the individual from whom they are requested.

All four of these conditions must be present before a Tennessen warning must be given.

When is a Tennessen warning not required?

The notice does not have to be given by law enforcement officers who are investigating a crime. The notice does not have to be given to the data subject when:

- the data subject is not an individual;
- the subject offers information that has not been requested by the government entity;
- the information requested from the subject is about someone else;
- the entity requests or receives information about the subject from someone else; or
- the information requested from the subject is public data about that subject.

How does a government entity decide what to include in a Tennessen warning?

Preparation of a Tennessen warning should only be done by, or in close consultation with, the entity's legal advisor. Each notice must be "tailored" to the requirements of the specific entity, program, or data collection event for which it is being prepared. Within any given entity, it is likely that more than one notice will be needed.

In choosing words and phrasing for the Tennessen warning, it is important to use language that most people easily understand. The goal is to allow the data subject to make a meaningful decision to supply—or not supply—the information requested. Assuming the notice is complete and accurate, that choice can be meaningful only if the subject clearly understands the notice. Also, the subject should be given the opportunity to ask questions about the Tennessen warning and receive a clear explanation.

To protect the government entity against potential future claims, the Tennessen warning should be given in writing or in another recorded format, although the law does not specifically require it. In this regard, the individual should sign an acknowledgment that s/he has received the notice and a copy of a written notice should be given to the data subject and the original kept by the government entity with the relevant data. When information is collected over the phone, the notice should be provided orally. The entity should record such details as whether the notice was given, the date given, and the identity of the person giving the notice. If the notice is given orally, the government entity may also want to give the notice in writing as soon as practicable.

Does this mean that the data never can be stored if a Tennessen warning was not given?

Private or confidential data collected before August 1, 1975 (the effective date of the Tennessen warning requirement), may be stored for the reasons the data were collected. These data also may be stored for reasons of public health, safety, or welfare, if the entity obtains the approval of the Commissioner of Administration.

Releasing data

The MGDPA gives every member of the public the right to see and have copies of all public data kept by government entities. The MGDPA also places upon government entities various obligations relating to this right.

What is the most basic requirement for properly responding to a data request?

In order to properly respond to requests for government data, each government entity must identify the types of data it maintains and determine how each type of data is classified.

Who can make a data request?

Anyone may exercise the right to access public government data by making a data request.

What kinds of data may a person request?

The person requesting government data may request access to specific types of data or data elements, to specific documents or portions of documents, to entire records, files, or databases, or to all public data maintained by the entity.

The person may request to either inspect (or view) the data or have the government reproduce and provide a copy of that data. Generally, a governmental entity may not charge a fee for merely inspecting data, but a requesting party may be required to pay for copies or electronic transmission of data. Issues regarding whether or not a requesting person may be charged fees, and if so what activities may be subject to reimbursement and the amount of the charges, should be referred to the entity's Responsible Authority or legal counsel.

Must a government entity respond to a data request?

Once an entity has received a request, it must respond to the request appropriately and promptly. What is considered appropriate and prompt depends upon the scope of the request, and may vary depending upon such factors as the size and complexity of the entity, the type and/or quantity of data requested, the clarity of the data request, and the number of staff available to respond to the request. All data requests should be immediately referred to the Responsible Authority or legal counsel.

What is the appropriate response if the requested data are not public?

An entity may not disseminate any private or confidential data on individuals without proper legal authority. As noted, the subject of data is entitled to see data about themselves properly classified as private but may not be entitled to data classified as confidential.

If the entity determines that the requested data are not public, it must inform the requestor. This may be done orally at the time of the request, or may be done in writing as soon as possible after the request is made. When informing the requestor, the entity must cite the specific statutory section, temporary classification, or specific provision of federal law that classifies the data as private, confidential, nonpublic or protected nonpublic. Making a general statement such as, "We can't give you the data because of the data privacy act," is not an appropriate response. The entity must cite the specific section of law that classifies the data as not public.

If the requestor asks for a written certification that the request has been denied, the entity must provide the certification, citing the specific statutory section, temporary classification, or specific provision of federal law upon which the denial was based.

A government entity may disclose private, confidential, nonpublic, or protected nonpublic data (1) if such disclosure is specifically authorized by state, local, or federal law; or (2) pursuant to an order of a District Court Judge or Administrative Hearing Officer.

The rights of subjects of government data

The MGDPA establishes specific rights for individuals who are the subjects of government data, and establishes controls on how government entities collect, store, use, and release data about individuals. The Legislature established these rights and controls because the decisions that government entities make, when using information about those individuals, can have a great effect on their lives.

These rights allow the data subject to decide whether to provide the data being requested; to see what information the entity maintains about that subject; to determine whether that information is accurate, complete and current and what impact the data may have (or have had) on decisions the entity has made; and to prevent inaccurate and/or incomplete data from creating problems for the individual.

Individual rights to access data about herself or himself

The MGDPA gives specific rights to individuals who are the subjects of government data. One of these rights is the right of the data subject to access data about him or herself:

- The data subject has the right to ask and be told whether the entity maintains data about her/him, and whether those data are classified as public, private or confidential.
- The data subject has the right to see all public and private data about her/himself.
- Under certain circumstances, data about a minor data subject may be withheld from a parent or guardian.
- The entity may not charge a fee for letting the subject see data about her/himself.
- The subject has the right to be informed of the content and meaning of public and private data about her/himself upon request.
- The subject has the right to have copies of all public and private data about her/himself.
- The entity may charge a fee for providing a data subject with copies of public and/or private data about her/himself.

Individual rights to challenge the accuracy and/or completeness of public and private data about her/himself

- The data subject has the right to challenge the accuracy and/or completeness of public and private data about her/himself.
- The data subject has the right to include a statement of disagreement with disputed data.
- If an entity determines that challenged data are accurate and/or complete, and the data subject disagrees with that determination, the subject has the right to appeal the entity's determination to the Commissioner of Administration.

Informed consent for the release of government data for government entities subject to the Minnesota Government Data Practices Act

Minn. Stat. § 13.05, sub. 4, limits the subsequent use and dissemination of private or confidential data, collected from an individual, to what was described in the Tennessen warning. If the entity wishes to use

or release the data in a way not communicated in the Tennessen warning, this statutory section requires the entity to obtain the individual's in-formed consent.

The standards for obtaining an informed consent are set out at Minn. Stat. § 13.05, subd. 4(d), and Minn. R. 1205.1400. A consent form must be completed in order to disseminate private data on individuals when a) the release of the data is necessary to administer or manage a legally authorized program and b) one of the following conditions applies:

- The data subject was not given a Tennessen warning when the data were collected from that subject.
- The release of the data is for a purpose or to a recipient which was not included in the Tennessen warning.
- A Tennessen warning was not given because the data were not collected from the data subject.
- In other situations where the consent of the data subject is required in order to release data about that subject.

Data protection and security

Related chapters:

- Government records and retention
- Minnesota Government Data Practices Act

Data protection and security applies to electronic security as well as securing data kept in paper files. Data protection and security is necessary to adequately facilitate retrieval and protect data that are classified as "not public."

All government entities that collect data and keep government records must ensure the integrity and physical security of these resources by protecting them from unauthorized access, modification, destruction, or unauthorized disclosure.

Risks to information and data security include loss of privacy (reading of information by unauthorized persons), loss of data (corruption or erasure of information), and loss of service (filling of data storage space, use of computational resources, denials of network access). Although intruders on security systems and computer viruses are the most highly publicized security breaches, many computer security surveys show that the risk of loss (often unintentional) from individuals working inside an organization is much greater.

Every person in your department who has access to government data and records should be informed of and required to abide by a data protection and security policy. Check with your local government attorney to determine if a policy has been developed for your local jurisdiction.

The objectives of a security policy include:

- Providing an overview of security requirements for the entity
- Providing baseline criteria for technical practices related to data security
- Delineating the responsibilities of government employees for data security

Elements of data protection and security

While your local jurisdiction should have guidelines in place for data security, it is incumbent upon managers to know what kinds of data their programs collect, what levels of security the data require, and the methods by which data are protected.

Firewalls

A firewall is a network router or host that enforces security rules at the boundary between two electronic domains. A firewall is part of a strategy for protecting an organization's Internet-reachable resources. The main function of a firewall is to centralize access control. If outsiders or remote users can access the internal networks without going through the firewall, its effectiveness is diminished. Firewalls can provide several types of protection:

- Blocking unwanted traffic
- Directing incoming traffic to more trustworthy internal systems
- Hiding vulnerable systems that cannot easily be secured from the Internet
- Logging traffic to and from the private network
- Hiding information like system names, network topology, network device types, and internal user IDs from the Internet
- Providing more robust authentication than standard applications might be able to do

Virus protection

Viruses are a malicious kind of unauthorized software. Unregulated sharing of software, regardless of whether it started out as shareware or commercial programs, is a culprit in spreading viruses. The ease of downloading software from the Internet or receiving an "infected" email attachment is of particular concern.

For virus protection software to work effectively, the virus protection files must be kept up-to-date and users must be informed, trained and reminded about the ways that viruses are transmitted and the proper precautions for use of email and the Internet.

Encryption

Encryption of data is essential to protecting private or confidential data and for communications. Simple password protection at the file level is often not adequate for data protection, as it may easily be broken. In addition, when private or confidential data are sent via the Internet, or transported in electronic format (e.g., laptop, disc, flash drive, etc.) they should be encrypted.

Access control and authentication

Controlling access to data is a critical function of security. User authorization for access should be limited to the level necessary to perform job duties, and adjusted as duties change.

There are several approaches to granting and checking authorization. Developing user roles and granting permissions based on user roles is a very effective system for maintaining and documenting access control. Because of changes in work assignments and personnel, maintaining access control should be viewed as an ongoing activity and roles/permissions should be monitored regularly.

Authorized hardware and software

Most organizations insist upon a standard set of hardware and software for all employees to avoid possible problems with data security introduced by untested hardware and software.

Remote access points and electronic communications

With more people carrying out their job functions at varying distances from central offices (e.g., telecommuting, etc.) some unique security concerns have arisen. Interception of data transmission is one security risk; the loss or theft of equipment and/or data is another security risk heightened by the

use of portable systems. Be sure that your employees are aware of the security risks and concerns and know what they have to do to comply with your local jurisdiction's data security policy.

Disaster recovery and backup

Disaster recovery plans are crucial to the operation of information systems. The requirements for development of disaster recovery plans are meant to ensure that adequate information exists and that planning has taken place to enable the continued functioning of the department in case of any disaster. While your systems administrator is thinking of how to preserve the functioning of the electronic equipment, you will need to determine which are your most "mission critical" data, make sure that paper copies are stored properly, and confirm that electronic data are backed up and maintained in a secure location.

User notification and training

Training employees in security concepts and practices is one of the most effective means of reducing vulnerability to attack, errors, and fraud. Make sure your employees understand the importance of data security measures and their role in protection the security and integrity of information.

Data storage and protection

Related chapter: Government records and retention

Data stored on paper

Most data still starts out as a paper record—a chart or a formed filled out, a questionnaire, an application. How paper is handled in your office can have a significant effect on data security. You will want to make sure that everyone in your department understands the following methods of keeping data on paper secure:

- Keep files that contain "not public" data behind two locks, such as the locked entrance or secured door and a locked file cabinet. This includes systems documentation and data dictionaries defining "not public" data.
- Put away "not public" data when you leave your desk. "Not public" data and files include information that describes "not public" data such as documentation or data dictionaries.
- Pick up print outs and faxes that contain "not public" data immediately.
- Print or copy "not public" data only when necessary and shred copies when they are no longer needed.

Data stored electronically

- Limit your access to data that you need to do your daily work. Work with your systems administrator to define the appropriate level of access for each employee.
- Limit the number of copies of a data set or partial data set. Ensure that all changes to data sets are documented and made on the appropriate version.
- Document data so the potential uses and limitations of the data are clear.
- Use passwords (login, screensaver, and shared calendars).
- Store files in the appropriate location on network drives so that access to the data will be controlled and the data will be backed up and secure.
- Use secure file transfer methods.
- If a laptop is taken out of your department offices, make sure staff knows what files are stored on the laptop and the level of security they must maintain.

Data disposal

Once an electronic record has been created, a simple "delete" does not actually destroy that record. Check with your local systems administrator on the proper and effective ways to "clean" hard drives, floppy discs, and other electronic storage units, as well as printer/typewriter ribbons and other potential "shadow copies" of data.

Appendices

Sample: CHS administrator job description

JOB TITLE: CHS Administrator/Public Health Director, Maple-Tree Community Health Board

EXEMPT: YES

DIVISION: PUBLIC HEALTH

REPORTS TO: County Administrator, Board of Commissioners, Community Health Board

ORIGINALLY PREPARED BY: _____

PREP. DATE: May 1, 1994

COMMUNITY HEALTH BOARD REVISIONS: March 1, 1997; May 1, 1999; February 1, 2013

Summary

The CHS administrator/public health director develops, implements and directs public health program for the Maple-Tree Community Health Board. This position is also responsible to prepare and manage budgets, manage strategic planning to identify, coordinate, and deliver necessary services, prepare reports, evaluate programs and staff for efficiency and effectiveness, coordinate public health services with other public and private services, and is an advisor to the Maple-Tree Community Health Board.

Essential duties and responsibilities

1. To regularly monitor, analyze and report on the status of community health within the county.
    a. Prepare annual report on the county resident's use of public health services and related health services for the Minnesota Department of Health (MDH) and the community health board
    b. Interpret and gather statistical data on morbidity and mortality. Identify, collect, analyze and present appropriate statistical measurements which illustrate the county's public health status and gaps in services

   c. Report to the community health board the effect of state and local government policies and actions on the health care delivery system within the county. Interacts with legislators, legislative commit-tees, and special interest groups
2. To provide direction to the planning, program design, and operation of the public health agency
   a. Annually review the program organization and staffing assignments and report to the county public health advisory committee and the community health board
   b. Develop, maintain, and review agency policies and procedures
   c. Establishes and maintains standards of nursing and environmental health practice and procedures in determining agency public health priorities
   d. Collect and compile statistics and summaries describing the ongoing performance of the programs
   e. Complete one or more needs assessment activities annually to identify the level of need for public health activities and programs through input from staff, citizens providers, advisory members, and the Board
   f. Directs the preparation of reports, program materials and other agency documentation. Prepares grant applications and reports with staff assistance
   g. Monitors records to correct and complete documentation and assures adherence to client bill of rights, data privacy, record protection, HIPAA regulations and retention policies
3. To provide direct supervision of and consultation with agency staff
   a. Hires, orientates, and disciplines, and discharges agency personnel
   b. Leads the staff in agency team building activities and plans agency-wide meetings, including Public Health Management Team and All Staff Meetings
   c. Conduct a formal performance appraisal at least one per year
   d. Discipline agency employees in a manner consistent with all personnel rules and regulations
   e. Supervision of staff will focus on goal setting, time management, and personal growth.
   f. Assign program and project coordinators
4. To provide fiscal policy oversight of the Public Health Services agency and the Maple-Tree Community Health Services
   a. Prepare and administer the annual budget in accordance with the legal and timing requirements of the community health board, MDH, and county board
   b. Leads agency financial team to study, and be accountable for, the financial well-being of the department, including accounts payable, accounts receivable, accurate accounting records, and quality financial procedures to reduce error, increase accountability, and respond to changing financial circumstances
   c. Approve quarterly financial reports for MDH
   d. Approve and code agency expenditures and revenues
5. To oversee the procurement and maintenance of the necessary workforce, supplies, equipment, and space for efficient operation of the department
   a. Determines and justifies public health agency staff requirements necessary to meet identified community health needs through the ongoing evaluation of public health core functions: assessment, policy development and assurance
   b. Develop and enforce standards concerning the safety and cleanliness of the work areas
   c. Review adequacy of equipment and space in the department and recommendations presented to the County Board
   d. Performs selective direct service work within the department as required by staffing levels and program needs
6. To serve as the Public Health Officer for the Maple-Tree Community Health Board
   a. Assures that public health nuisances, disease outbreaks, and public health emergencies are dealt with in accordance with state and local laws

   b. Works with other local government bodies and other community groups on matters related to environmental health, infection control and emergency response
7. To provide educational, information, analysis and administrative consultative services to the County Board and the Maple-Tree Community Health Board in assisting its policy development, decision making, and priority setting
   a. Provide orientation and updates to the County Board and Advisory Committee about public health services provided within the counties
   b. Drafts ordinances and policies related to public health issues for the community health board or county board consideration and/or approval
   c. Reports recommendation of the Advisory Committee to the community health board
8. To develop and maintain community awareness of public health program availability to residents and the conditions for receipt of such services
   a. Provide presentation regarding the public health service programs before civic, school, and health related organizations
   b. Provide public information such as news releases and radio talks regarding the public health issues
   c. Prepare and update brochures describing public health services to display throughout the county
   d. Participate in cooperative efforts to develop county and regional information and referral programs and materials
9. To develop and maintain awareness of advance events in professional health fields which potentially affect the future availability of health resources to the residents of the county
   a. Review all relevant inter-governmental communication and professional literatures.
   b. Participates in community organizations and collaborations which will enhance the public's health locally, regionally or state-wide. Represents the agency in professional and community activities
   c. Promotes and participates in student education, special projects, research or demonstration pro-grams relating to public health
10. To participate in the cooperative management of the county organization
   a. Attend all regularly scheduled Division Director meetings
   b. Additional duties and responsibilities will be undertaken in accordance with conditions negotiated with the county board

Supervisory responsibilities

Directly supervises 29 full-time and part-time nurses, 8 part-time LPNs, 2 health educators, 2 environmental health specialists, 7 full and part-time office personnel, and contract employees. Carries out supervisory responsibilities in accordance with the organization's policies and applicable laws. Responsibilities include interviewing, hiring, and training employees' planning, assigning and directing work; appraising performance; rewarding and disciplining employees; addressing complaints and resolving problems.

Job relationships

Internal Interactions with: County Board, CHS Advisory Committee, Maple-Tree Community Health Board, Auditor, Human Services, Recorder, Assessor, County Attorney, Sheriff, Veteran Services, County Administrator, Planning and Zoning, Emergency Management Services, Court Administration, Community Action Agency, Extension, Custodians, Hospital, Probation.

External Interactions with: Schools, municipal clerks, township officers, extension service, health care providers within the county, ambulance and policing agencies within the county, families, public, and clients. Secondary relationships include Minnesota Department of Health, Department of Human Services, Department of Children, Families, and Learning, news media, other Administrators and directors, professional health associations, county coroner, ministers, mental health centers, Medicare, insurance companies, senior groups, hospice, medical salesmen, and volunteers.

Requires ability to deal with customers who are under stress and who may be angry, hostile, verbally or physically aggressive, and may use language or behaviors that would be considered inappropriate in normal business interactions. The ability to diffuse these situations is highly desirable.

Qualification requirements

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed above represent the knowledge, skill, and abilities required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and experience

- The CHS administrator must meet the personnel standards in Minn. R. 4736.0110
- Bachelor's Degree from accredited college, including course work and field experience in public health
- Fifteen hours of continuing education credits each year
- Minimum of five years of generalized public health experience, plus three years supervisory experience of professional staff
- Upon hiring, requires six months of formal orientation and a two year period of adjustment to the job

Knowledge, abilities, and skills

- Thorough knowledge of the principles of public health policy and practice
- Considerable knowledge of public health administration, including finance; budget management, personnel; contracts; local, state and federal rules, requirements and best practice
- Considerable knowledge of the organization of public health programs
- Considerable knowledge of the current trends in the public health care service delivery
- Considerable knowledge of available public and private community health and social services resources and their functions
- Ability to apply principles of the public health to communities, families, and individuals
- Ability to establish and maintain cooperative relationships with agency staff, representative of other agencies, clients and the general public

Language skills

Ability to read, analyze, and interpret common scientific, medical, and technical journals, financial reports, and legal documents. Ability to respond to common inquires or complaints from customers, regulatory agencies, or members of the community. Ability to effectively present information to management, public groups, advisory committee, or Board.

Mathematical skills

Ability to work with mathematical concepts such as probability and statistical inference, and fundamental of algebra, physics, geometry, and trigonometry. Ability to apply concepts such as fractions, percentages, ratios, and proportions to practical situations.

Reasoning ability

Ability to define problems, collect data, establish facts, and draw valid conclusions. Ability to interpret an extensive variety of technical instruction in mathematical or diagram form and deal with several abstract and concrete variables.

Physical demands

The physical demands described here represent those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to use hands and fingers; handle and feel objects, tools or controls; reach with hands and arms; and talk and hear. The employee is regularly required to stand, sit, climb, or balance.

The employee must occasionally lift and/or move more than _____ pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, and depth perception.

Work environment

Work is preformed primarily within the public health office, as well as in community settings. Demands flexibility in hours to respond to client, family and community requests and need to service. Includes evening, weekend, night, and holiday work. Work demands often require longer than a regular 8-hour day or 40-hour work week.

Requires regular travel and exposure to environments under less than optimum conditions.

Work is designed to respond to emergencies, crisis and frequent problem solving situations over which there is little control. The noise level in the work environment is usually moderate. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Advisory committee assessment

To ensure your advisory committee is both meeting statutory requirements and operating effectively/productively, ask these key questions:

- Does the advisory committee have at least five members?
- Are the members broadly representative of the community and health care providers?
- Is there a clear process for selecting members and assuring representation?
- Does the advisory committee meet at least three times a year?
- Does it have written bylaws or operating procedures?

- Are its responsibilities and authority clearly stated?
- Does it have a clear charge or purpose?
- Is an annual review of the charge provided for all members?
- Does the charge include advising and making recommendations to the community health board?
- Are the roles of staff in relation to the advisory committee clearly defined?
- Is an orientation provided for new members?
- Is adequate and ongoing education provided so that the advisory committee has an increasing capacity to analyze issues and make recommendations?
- Is the advisory committee given enough information so that they can provide sound advice and recommendations?
- Does the advisory committee have a chair that effectively leads them in achieving their charge?
- Does the advisory committee provide advice based on the community good (versus narrow or special interests)?
- Is the special knowledge or expertise of advisory committee members used well?
- Are members free to speak out?
- Is the advisory committee informed of subsequent community health board action?
- Do they coordinate, or are they at least informed of, other health advisory committees functioning under the community health board?

Local elected official orientation

CHS Administrator Jill Bruns of Kandiyohi-Renville developed the orientation below, intended to be a half-day meeting with discussions for new county commissioners (or, also, new staff). An orientation like the one below, along with a manual or set of important documents, can help board members and staff better understand each other's roles, leading both to be more informed, invested, and committed.

In Kandiyohi-Renville, Ms. Bruns and her staff also invite new commissioners to spend a day with public health staff in the fall, after elections. The commissioners attend home visits for families and vulnerable adults, jail, restaurant inspections, schools, etc. Shadowing public health staff for a day can make a powerful impact on commissioners, and can inform their interactions with public health for years to come.

Orientation agenda

Attendees: New county commissioners, local public health staff

Part I. Overview of community health in Your county/city

1. History of your county/city public health department
2. Philosophy of public health
    a. Your county/city public health mission statement
    b. Mission statement of community health services from MDH
    c. Principles of public health
    d. Levels of prevention
3. History of Local Public Health Act (Minn. Stat. § 145A)
4. Powers and duties of a community health board and local board of health
5. Public health advisory committee
    a. Purpose and charge
    b. Local membership

   c. State Community Health Services Advisory Committee (SCHSAC)
6. Financing of community health services
   a. Sources of funding for your county/city
   b. Fees for service/sliding fee policy
   c. Annual budget
7. Local public health assessment and planning cycle and Local Public Health Act annual reporting
   a. Overview of planning process
   b. Review of priority issues in your county/city
   c. Required reports
   d. Preparing for national accreditation
8. Staffing for public health services
   a. Staff directories
   b. Definitions of staff positions and responsibilities

Part II. Areas of public health responsibility: Staff presentations

Use this section of the agenda as a sample of what programs and services you would like to highlight under the areas of public health responsibility (below).

You will want to pick several specific programs for presentations under each category, and list them on the agenda, along with the name of the staff person who will be presenting the material. Remember to include your collaborative activities, where appropriate.

Assure an adequate local public health infrastructure

Programs to present/discuss: _____

Promote healthy communities and healthy behavior

Programs to present/discuss: _____

Prevent the spread of communicable diseases

Programs to present/discuss: _____

Protect against environmental health hazards

Programs to present/discuss: _____

Prepare and respond to emergencies

Programs to present/discuss: _____

Assure health services

Programs to present/discuss: _____

Sample: Memorandum of agreement

CHS PERFORMANCE IMPROVEMENT AND PLANNING AGENCY
MEMORANDUM OF AGREEMENT
between the Glacier Community Health Board
and River County
January 1, 2013-December 31, 2013

Article 1. Parties to the agreement

This is a memorandum of agreement between the Glacier Community Health Board, hereafter referred to as Board, and River County, hereafter referred to as County.

Article II. Purpose of the memorandum

This memorandum of agreement is to set forth the terms under which the County will serve as the Performance Improvement and Planning Agency for the Board, including the provision of associated support services.

Article III. Basic agreement

A. The County agrees that its Public Health Director will serve as the Director of Performance Improvement and Planning and will perform the duties specified in the Summary of Responsibilities (attached).
B. The County agrees that its public health department will provide clerical, planning, and administrative support as needed to assure that the County Public Health Director is able to perform the duties specified in the Summary of Responsibilities.
C. The County shall maintain its own liability insurance. The County agrees that the Board and its member counties individually are held harmless from any and all claims or causes of action arising from the performance of this agreement by the County.
D. The County agrees its employees performing the duties outlined in this agreement are maintained as County employees and are not considered employees of the Board.

Article IV. Consideration and terms of payment

Consideration for all services performed pursuant to this memorandum of agreement shall be paid by the Board to the County in an amount to be determined annually. Payment shall be made on a quarterly basis. Total payment shall be $10,000 for January 1, 2013 through December 31, 2013.

Article V. Duration

This memorandum of agreement shall be in effect from January 1, 2013, through December 31, 2013.

Article VI. Amendment

This memorandum of agreement may be amended upon 90 days written notice and consent to all parties.

Article VII. Termination

This memorandum of agreement may be terminated, with or without cause, by either party upon 90 days written notice to the other party.

Article VIII. Review and records

The books, records, documents, accounting procedures, and practices of the County relevant to this memorandum of agreement are subject to examination by the Board, the Minnesota Department of Health, and either the Legislative Auditor or the State Auditor as appropriate.

Execution

In witness whereof, the Board and County have caused this agreement to be duly executed in their respective behalf and hereby agree to the content of this memorandum of agreement.

Board: Signature
Chairperson, Board
Date: January 1, 2013

County: Signature
Chairperson, County
Date: January 1, 2013

Attest: Signature
Date: January 1, 2013

Summary of position responsibilities

Position

Director of Performance Improvement and Planning, Glacier Community Health Board

Summary of position

The Performance Improvement and Planning, in the absence of the Director of Administration and Finance, shall act as the authorized agent on behalf of the Glacier Community Health Board to carry out the statutory duties and other responsibilities identified herein.

Minimum qualifications

The Director of Performance Improvement and Planning must meet the following minimum training and experience standards:

- A baccalaureate or higher degree in public health, administration, community health, or nursing, and two years of documented public health experience in an administrative or supervisory capacity; or
- A master's or higher degree in public health, administration, community health, or nursing, and one year of documented public health experience in an administrative or supervisory capacity; or
- A baccalaureate or higher degree and four years of documented public health experience in an administrative or supervisory capacity.

Optimal qualifications

The Director of Performance Improvement and Planning is able to demonstrate the following Core Competency skills:

1. Analytic/assessment skills
   - Review the health status of populations and their related determinants of health and illness
   - Incorporate data into the resolution of scientific, political, ethical, and social public health issues
2. Policy development/program planning skills
   - Decide policy options for public health organization
   - Ensure public health programs are consistent with public health laws and regulations
   - Integrate emerging trends of the fiscal, social, and political environment into public health strategic planning
3. Communication skills
   - Ensure that the public health organization seeks input from other organizations and individuals
   - Communicate the role of public health within the overall health system
4. Cultural competency skills
   - Ensure the consideration of the role of cultural, social, and behavioral factors in the accessibility, availability, acceptability, and delivery of public health services
5. Community dimensions of practice skills
   - Integrate the role of governmental and non-governmental organizations in the delivery of community health services
   - Defend public health policies, programs, and resources
6. Public health sciences skills
   - Incorporate the Core Public Health Functions and Ten Essential Services of Public Health into the practice of the public health sciences
7. Financial planning and management skills
   - Leverage the organizational structures, functions, and authorities of local, state, and federal public health agencies for public health program management
   - Develop partnerships with agencies at all levels of government that have authority over public health situations
   - Manage the implementation of the judicial and operational procedures of the governing body and/or administrative unit that oversees the operations of the public health organization
8. Leadership and systems thinking skills
   - Integrate systems thinking into public health practice
   - Resolve internal and external problems that may affect the delivery of Essential Public Health Services
   - Ensure the management of organizational change

Experience

The documented experience of the Director of Performance Improvement and Planning must include skills necessary to:

1. Direct and implement public health programs
2. Prepare and manage budgets
3. Direct and support a planning process to identify, coordinate, and deliver necessary services
4. Prepare necessary reports

5. Evaluate programs for efficiency and effectiveness
6. Coordinate the delivery of community health services within a multi-county system in addition to coordinating with other public and private services
7. Advise and assist the community health board in the selection, direction, and motivation of personnel
8. Prepare and monitor grants
9. Facilitate cooperative activities with Public Health Directors in a multi-county CHS system
10. Assess and represent needs/interest of a multi-county CHS organization at the statewide level

Organizational duties and responsibilities

Local public health assessment and planning cycle

1. Assume primary responsibility for coordinating the local public health assessment and planning cycle
2. Assure compliance with current assessment and reporting requirements
3. Have oversight and approval of annual reporting for the community health board/member counties

Facilitate exploration and discussion of optimal community health board / public health agency structure for the future

1. Review research, seek consultation, and provide information to the Glacier Community Health Board regarding organizational infrastructure options that would provide optimal effectiveness and efficiency for current and future public health service delivery
2. Convene meetings, facilitate discussion, and provide information as requested throughout exploration and decision making process

Public health accreditation

1. Develop work plan and timetable for public health accreditation of the Glacier Community Health Board
2. Lead Glacier Community Health Board self-assessment and planning process

Program development and implementation

Together with the Director of Administration and Finance, assure development and implementation of public health programs and services that most efficiently and effectively address the needs identified through the local public health assessment and planning cycle.

Emergency preparedness glossary

Acronyms

- **DMAT**: Federal Disaster Medical Assistance Team
- **EOC**: Emergency Operations Center
- **EOP**: Emergency Operations Plan
- **ESAR-VHP**: Emergency System for Advance Registration of Volunteer Health Professionals
- **ICP**: Incident Command Post
- **ICS**: Incident Command System
- **JPA**: Joint Powers Agreement
- **MAC**: Multi-Agency Coordination Center
- **MMT**: Mobile Medical Team

- **MMU**: Mobile Medical Unit
- **MMU-OOG**: MMU Operations and Oversight Group (MMU governing body)
- **MMU-TOT**: MMU Technical Operations Team
- **MRC**: Medical Reserve Corps
- **NIMS**: National Incident Management System
- **POD**: Point of Distribution
- **PIO**: Public Information Officer
- **RCT**: Readiness Coordinating Team
- **RST**: Readiness Steering Team
- **RSS**: Receipt, Store, Stage
- **RDN**: Regional Distribution Node
- **SME**: Subject Matter Expert

Terminology

Alternate care facility/site. Could include could include tents, parked mobile units, or other facility-based treatment areas.

Catastrophic incident. Any natural or man-made incident, including terrorism, that results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions. A catastrophic event could result in sustained national impacts over a prolonged period of time; almost immediately exceeds resources normally available to state, local, tribal, and private-sector authorities in the impacted area; and significantly interrupts governmental operations and emergency services to such an extent that national security could be threatened. All catastrophic events are Incidents of National Significance.

Chain of command. A series of command, control, executive, or management positions in hierarchical order of authority.

Command staff. In an incident management organization, the Command Staff consists of the Incident Commander and the special staff positions of Public Information Officer, Safety Officer, Liaison Officer, and other positions as required, who report directly to the Incident Commander. They may have an assistant or assistants, as needed.

Department operations center. A pre-determined location at which selected staff from a department can convene to launch an organized response to an emergency.

Disaster. As defined by Minn. Stat. § 12.03, subd. 2, a disaster is "a situation that creates an actual or imminent serious threat to the health and safety of persons, or a situation that has resulted or is likely to result in catastrophic loss to property or the environment, and for which traditional sources of relief and assistance within the affected area are unable to repair or prevent the injury or loss."

Emergency (federal definition). As defined by the Stafford Disaster Relief and Emergency Assistance Act, an emergency is "any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement state and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States."

Emergency (state definition). As defined by Minn. Stat. § 12.03, subd. 3, an emergency is "an unforeseen combination of circumstances that calls for immediate action to prevent a disaster from developing or occurring."

Emergency operations center (EOC). The physical location at which the coordination of information and resources to support domestic incident management activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, and medical services), by jurisdiction (e.g., federal, state, regional, county, city, tribal), or by some combination thereof.

Emergency operations plan (EOP). The "steady-state" plan maintained by various jurisdictional levels for managing a wide variety of potential hazards.

Executive team. Includes the Commissioner of Health, Deputy Commissioner, Assistant Commissioners, Chief Financial Officer, Legal Unit Director, and the Communications Office Director. This team has overall responsibility of the entire health department and communicates with the Governor's Office.

General staff. In an incident management organization, the General Staff consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief and the Finance and Administration Section Chief. These roles work on scene and behind the scene in support of response efforts to an incident.

Hazard. Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

Incident. An occurrence or event, natural or human caused, that requires an emergency response to protect life or property. Incidents can, for example, include Major Disasters, emergencies, terrorist attacks, terrorist threats, wild land and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

Incident action plan. An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.

Incident command post (ICP). The field location at which the primary tactical-level, on-scene incident command functions are performed. The ICP may be co-located with the incident base or other incident facilities, and is normally identified by a green rotating or flashing light.

Incident command system (ICS). A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating with a common organizational structure, designed to aid in the management of resources during incidents. ICS is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, or organized field-level incident management operations.

Incident management system. A standardized management tool for meeting the demands of small or large emergency or non-emergency situations.

Incident manager. Lead figure in the Incident Management System that provides overall leadership for the incident response, delegates authority to others, and takes general direction from agency administrator or official.

Incidents of national significance. Based on criteria established in Homeland Security Presidential Directive 5 (HSPD-5), paragraph 4, an actual or potential high-impact event that requires a coordinated and effective response by an appropriate combination of federal, state, local, tribal, nongovernmental,

and/or private-sector entities in order to save lives and minimize damage, and provide the basis for long-term community recovery and mitigation activities.

Joint information center (JIC). A facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media.

Jurisdiction. A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authorities. Jurisdictional authority at an incident can be political or geographical (e.g., city, county, tribal, state, or federal boundary lines) or functional (e.g., law enforcement, public health).

Major disaster. As defined by the Stafford Act, any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought) or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant Major Disaster assistance under this act to supplement the efforts and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.

Multi-agency coordination center (MAC). An interagency coordination center that allows for span of control in an incident that is geographically dispersed and crosses multiple jurisdictions. The MAC serves as the focal point for interagency planning and coordination.

Multi-agency coordination system. Provides the architecture to support coordination for incident prioritization, critical resource allocation, communications systems integration, and information coordination. The components of Multi-agency Coordination Systems include facilities, equipment, Emergency Operations Centers (EOCs), specific multi-agency coordination entities, personnel, procedures, and communications. The systems assist agencies and organizations to fully integrate the subsystems of the National Incident Management System (NIMS).

National Incident Management System (NIMS). A system mandated by HSPD-5 that provides a consistent, nation-wide approach for federal, state, local, and tribal governments; the private sector; and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. To provide for interoperability and compatibility among federal, state, local, and tribal capabilities, NIMS includes a core set of concepts, principles, and terminology. HSPD-5 identifies these as the Incident Command System (ICS); Multi-agency Coordination Systems; training; identification and management of resources (including systems for classifying types of resources); qualification and certification; and the collection, tracking, and reporting of incident information and incident resources.

Point of distribution (POD). Site that provides distribution of medical materiel in an emergency situation.

Preparedness. The range of deliberate, critical tasks and activities necessary to build, sustain, and improve the operational capability to prevent, protect against, respond to, and recover from domestic incidents. Preparedness is a continuous process involving efforts at all levels of government and between government and private-sector and non-governmental organizations to identify threats, determine vulnerabilities, and identify required resources.

Prevention. Actions taken to avoid an incident or to intervene to stop an incident from occurring. Prevention involves actions taken to protect lives and property. It involves applying intelligence and other information to a range of activities that may include such countermeasures as deterrence operations; heightened inspections; improved surveillance and security operations; investigations to determine the full nature and source of the threat; public health and agricultural surveillance and

testing processes; immunizations, isolation, or quarantine; and, as appropriate, specific law enforcement operations aimed at deterring, preempting, interdicting, or disrupting illegal activity and apprehending potential perpetrators and bringing them to justice.

Public health. Protection, safety, improvement, and interconnections of health and disease prevention among people, domestic animals, and wildlife.

Public information officer (PIO). A member of the Command Staff responsible for interfacing with the public and media or with other agencies with incident related information requirements.

Readiness coordinating team (RCT). Provides a forum for developing, discussing, and evaluating department-wide activities related to emergency preparedness/continuity of operations. The focus of the RCT is to advise the Emergency/Continuity Steering Team on policy and procedures, management and funding issues necessary to manage preparedness/continuity issues on behalf of the Department. In addition, the Coordinating Team will establish methods of communication and processes to ensure close working relationships and sharing of best practices between and across Department divisions.

Readiness steering team (RST). Provides overall coordination of preparedness /response and continuity of operations in the Department by approving policies and procedures, coordinating and prioritizing significant prepared-ness/continuity investments, and making strategic decisions on the development of preparedness/continuity efforts to assure selected activities improve the Department's ability to respond effectively, maintain the Department's ability to deliver critical services, protect employees and resources, and to protect the public's health.

Receipt, store, stage (RSS). A site that maintains and readies supplies for distribution.

Recovery. The development, coordination, and execution of service- and site-restoration plans for impacted communities and the reconstitution of government operations and services through individual, private-sector, nongovernmental, and public assistance programs that: identify needs and define resources; provide housing and promote restoration; address long-term care and treatment of affected persons; implement additional measures for community restoration; incorporate mitigation measures and techniques, as feasible; evaluate the incident to identify lessons learned; and develop initiatives to mitigate the effects of future incidents.

Regional distribution node (RDN). Site designated to receive medical materiel in an emergency; serves as central depot site for further distribution to mass dispensing sites in the region.

Resources. Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained. Resources are described by kind and type, and may be used in operational support or supervisory capacities at an incident or at an Emergency Operations Center (EOC).

Response. Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of Emergency Operations Plans (EOPs) and of incident mitigation activities designed to limit the loss of life, personal injury, property dam-age, and other unfavorable outcomes. As indicated by the situation, response activities include: applying intelligence and other information to lessen the effects or consequences of an incident; increased security operations; continuing investigations into the nature and source of the threat; ongoing public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and specific law enforcement operations aimed at preempting, interdicting, or disrupting illegal activity, and apprehending actual perpetrators and bringing them to justice.

Subject matter expert (SME). An individual who is a technical expert in a specific area or in performing a specialized job, task, or skill.

Terrorism. Any activity that:

1. involves an act that
   a. is dangerous to human life or potentially destructive of critical infrastructure or key resources; and
   b. is a violation of the criminal laws of the United States or of any state or other subdivision of the United States; and
2. appears to be intended
   a. to intimidate or coerce a civilian population;
   b. to influence the policy of a government by intimidation or coercion; or
   c. to affect the conduct of a government by mass destruction, assassination, or kidnapping.

Threat. An indication of possible violence, harm, or danger.

Tribal government. The governing body of any tribe, band, community, village, or group of American Indians.

Local Public Health Act and rules

Visit: Local Public Health Act

Summary of powers and duties contained in the Local Public Health Act

Visit: Minnesota Local Public Health Act: Summary of Minn. Stat. § 145A (PDF)

SCHSAC: State Community Health Services Advisory Committee

Visit: SCHSAC: State Community Health Services Advisory Committee

National public health domains

For current text, always refer to the PHAB standards and measures for accreditation.

21st century public health in Minnesota

Visit: 21st century public health in Minnesota

Healthy Minnesota framework and core indicators

Visit: Healthy Minnesota 2022 statewide health improvement framework

Minnesota's statutes and rules on emergency preparedness, disease outbreaks, and volunteer protections

Visit: Minnesota's Statutes and Rules on Emergency Preparedness, Disease Outbreaks, and Volunteer Protections

Minnesota e-health

Visit: Minnesota e-health