BUILDING A SOLID FOUNDATION FOR HEALTH:

A Report on Public Health System Development

Minnesota Department of Health
January 2007

Commissioner's Office
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Protecting, maintaining and improving the health of all Minnesotans

January 2007

Dear Colleague:

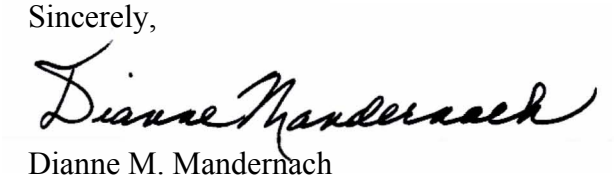
We are pleased to share with you *Building a Solid Foundation for Health: A Report on Public Health System Development for 2007*. The report was prepared to comply with Minnesota Statutes Chapter 62Q.33, which requires a biennial report on public health system development.

We hope you find this report to be a clear and informative description of issues facing the public health system in Minnesota. The report outlines several areas that are currently being addressed, as well as changes that are needed to have an effective and efficient public health infrastructure to keep all Minnesotans healthy.

Today's public health system is operating in a rapidly changing environment. Meeting the challenges presented by those changes and the need to leverage better services to communities is both daunting and exciting. Working together, we can meet these challenges and ensure that Minnesota has a strong public health foundation for the twenty-first century.

If you have any questions, please contact Debra Burns at 651-201-3873.

Sincerely,



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As requested by Minnesota statute 3.197:
This report cost approximately $2,500 to prepare, including staff time, printing, and mailing expenses.
Upon request, this report will be made available in an alternative format, such as large print, Braille or cassette tape.

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Executive Summary

This report describes Minnesota's public health infrastructure and examines several important issues facing the public health system.

Progress: order amid change

Minnesota's public health system is in a period of unprecedented change; e-health, an aging population, projected workforce shortages, the obesity epidemic, and the decline in the proportion of flexible funding are all issues that the 30-year old Community Health Services system must address. In an era of limited resources, and increasing demands, the need for accountability and continuous quality improvement are paramount. Minnesota is making steady progress in modernizing its public health system, while maintaining many of the positive, long-standing components of its 30-year history.

Much of the work of the past two years has been focused on developing Minnesota's *Local Public Health Quality Improvement Process*. This process, based on legislative changes enacted in 2003, is designed to achieve a balance between flexibility and stability, and to ensure that every Minnesotan has access to a basic level of public health service. This quality improvement process includes several key components described in this report; the *Community Health Assessment and Action Planning Process* (CHAAP), the local public health *Planning and Performance Measurement System* (PPMRS), and the *accountability review process*.

Moving forward

The CHAAP is a newly revised version of the process community health boards have long used to identify and act upon the health needs of their communities. CHAAP is **moving the system forward** by asking community health boards to assess their capacity to perform a set of essential local public health activities, and to identify activities that they will undertake in areas needing improvement.

Measuring progress

The PPMRS is a reporting system that allows community health boards to report on their efforts to meet the public health service needs of their communities. The data gathered through this reporting system will allow Minnesota to better understand the strengths and weaknesses of individual community health boards and of the public health system as a whole. PPMRS is a new way of **measuring progress**.

Ensuring stability

When the *Local Public Health Act* was revised in 2003, one of the key changes gave the commissioner of health authority to remove funding from underperforming community health boards. The aim of this change was to increase their accountability. Through the State Community Health Services Advisory Committee (SCHSAC) a process has been developed that holds community health boards accountable, while strengthening and **ensuring the stability** of Minnesota's public health system.

Introduction

This report was prepared to comply with Minnesota Statutes Chapter 62Q.33, which requires the commissioner of health to submit a biennial report to the legislature on local public health system development. It incorporates the discussions and recommendations of advisory groups to the commissioner during 2005 and 2006, including the State Community Health Services Advisory Committee (SCHSAC) and the Maternal and Child Health Advisory Task Force, as well as conversations with public health partners, such as local elected officials, local public health departments and community health boards.

This report describes Minnesota's public health infrastructure and examines several issues facing the public health system. These issues have been identified as strategic opportunities for the public health system and its partners to take action to maintain a strong public health system, which will result in meaningful improvements in the public's health.

Progress: order amid change

Alfred North Whitehead, British born mathematician turned philosopher (1861-1947), is credited with having said, *"The art of progress is to preserve order amid change."*

"Progress" aptly describes the mood and motivation of Minnesota's public health system today. While the constancy of change in the Minnesota's public health system has been discussed in past volumes of this report, not since the passage of the Community Health Services Act in 1976 has the system seen the implementation of so many new features at one-time. Nor has the pressure to move forward, improve and *account* for improvement, ever been so great.

These new components are being built upon the foundation of a 30-year-old partnership between state and local public health departments in Minnesota. With the help of partners from around the state, Minnesota's public health system is making progress; working from the points of strength in the system, while making the changes required, so that Minnesota continues its position as "the healthiest state in the nation".

Minnesota's public health system

Responsibility for the health and safety of the public in Minnesota is shared among state and local governments. Minnesota's public health system, known as Community Health Services (CHS), is designed to assure that the community's health and safety are protected while providing the flexibility local governments need to identify and address local priorities. The CHS system relies upon shared goals and the commitment of state and local governments to work together to improve the lives of all Minnesotans.

The CHS system consists of 53 community health boards, comprised of 28 single-county community health boards, 21 multi-county community health boards (comprised of 59 counties), and 4 major metropolitan cities. All community health boards are comprised of one or more local public health departments (e.g., city or county health department).

To simplify, the term "community health board" will be used to refer to any and all of these departments throughout this report.

Many aspects of this partnership make it effective. State and local governments share responsibility for protecting and improving the public's health; they jointly develop goals and guidelines. The SCHSAC helps to inform policy development. Community health boards and the Minnesota Department of Health (MDH) work jointly to ensure ongoing communication and coordination.

Current Public Health Issues and Challenges

Many recent events and **current issues** demonstrate the important role that public health plays in society, for example:

- The emergence of health threats like avian flu and the potential for pandemic influenza;
- National disasters, such as Hurricanes Katrina and Rita;
- The first baby boomers turning 60 years old, sparking a national debate on the issues of aging and what it means for the U.S. health system;
- The Methamphetamine epidemic, which has left many communities grappling with the problems of decontaminating labs, and has filled many county jails to capacity;
- The ongoing obesity epidemic: the impact it is having on children; and its contributions to costly chronic conditions, such as diabetes, cardiovascular disease and cancer.

In addition to these issues, Minnesota's public health system must address changes in the economy, legislative and funding changes, as well as changes in expectations for public health from both government officials and residents. Despite this, for the past two years Minnesota's public health system has been focused on making progress.

While many strengths of the system acquired during the past thirty years have been preserved, this has not precluded making necessary improvements. Challenges are identified as they emerge, and solutions are developed. Minnesota's public health system is ***making progress, and preserving order amid change***.

Some of the **current challenges** facing Minnesota's public health system include:

Variation in local public health departments
There's a saying in Minnesota's public health community, "if you've seen one local health department, you've seen one local health department." Local health departments vary greatly in the size of their staff, budgets, funding sources and geographic service areas. They also vary according to the unique needs of the communities they serve.

This wide variation makes it challenging to apply the requirements of the Local Public Health Act in a uniform or rigid way. Hence, the three components of the *Local Public Health Quality Improvement* Process, described on pages 4-9, all illustrate the complex balance between flexibility and standardization.

Voluntary national accreditation movement

A group of national organizations representing state and local public health departments and others recently recommended pursuing a voluntary national accreditation program for public health. In addition, the National Association of City and County Health Officials (NACCHO) developed a core set of activities that all local health departments should be able to perform. While the recommendation is for voluntary accreditation, many suspect that eventually, funding could be affected by an agency's accreditation status. Given that accreditation would likely be a challenge for some of Minnesota's local health departments, the current quality improvement efforts are laying important groundwork to help prepare local health departments for future accreditation.

Focus on emergency preparedness

Since 9-11 there has been increased focus on the role of public health in emergency preparedness. This increased focus has come with additional funding for preparedness. However, local health departments in Minnesota report that for many, the preparedness funding covers only a small portion of the expected activities. For example, over half of local health departments receive less than $25,000 per year. The expectation has been that they will continue to do what they have always done to protect the public's health (including responding to emerging threats, like Methamphetamine), while also undertaking intensive emergency preparedness activities. Of course, this is simply not realistic. The result, according to many leaders at the local level, is unevenness in the provision of services with less attention given to other areas of public health.

Strategic Issues for Minnesota's Public Health System

Minnesota's Local Public Health Quality Improvement Process

Moving forward, measuring progress, ensuring stability

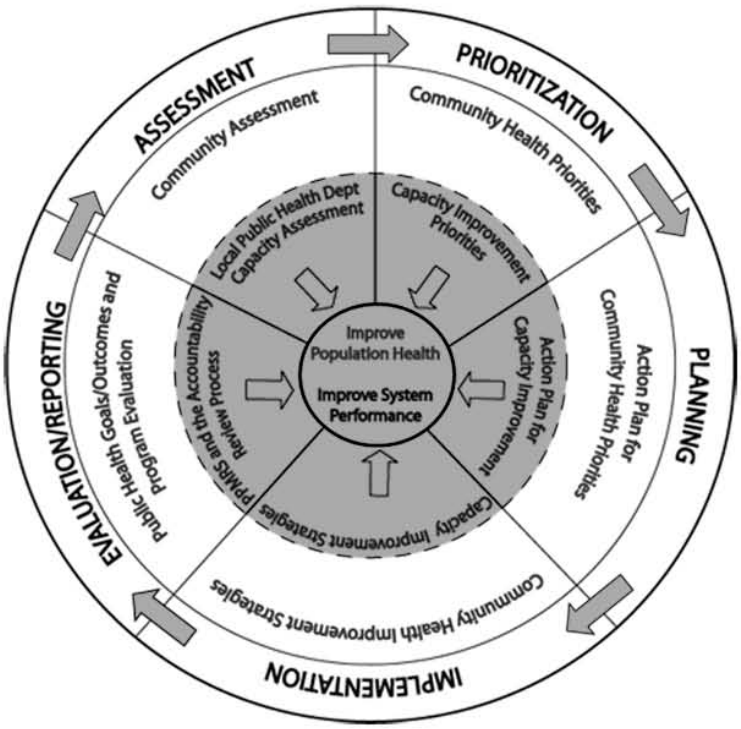
The *Local Public Health Quality Improvement Process* is a new and evolving way of describing the multi-faceted work and ongoing improvement of Minnesota's local public health system (see Figure 1). It is based on successful activities of the past 30-years of the CHS system and has been developed in response to the Local Public Health Act statute changes enacted in 2003. The revised legislation:

- Consolidated several categorical grants into LPH Act funds;
- Revised accountability provisions in the law; and
- Charged the commissioner of health, along with the SCHSAC and the MCH Advisory Task Force, to develop a new system for local health departments to report to the MDH.

The two main goals of the *Local Public Health Quality Improvement Process* (here forward referred to as the "QI process") are to **improve population health**, and to **improve system performance**. The QI process can be described as *moving the system forward*, *measuring progress*, and *ensuring the stability of the local public health system*.

Local Public Health Quality Improvement Process diagram

Figure 1



The *QI process* has been designed to achieve a balance between flexibility and standardization, as a means of ensuring that every Minnesotan has access to a basic level and quality of public health service. Each local public health department in Minnesota is unique. Hence, a flexible and customizable QI process is necessary. Yet, each local public health department represents an important link in the chain that is the local public health system. If there are weaknesses in the chain, the entire system – and ultimately the health of Minnesotans – will suffer. Therefore, ensuring a strong statewide local public health infrastructure is very important.

The QI process is comprised of five main components, as depicted in Figure 1: assessment, prioritization, planning, implementation and evaluation/reporting. These components are part of a continuous improvement feedback loop. Within each of these five components there are important processes and tools that have been developed over the past several years. Three of those recently developed processes are described below.

A. The Community Health Assessment and Action Planning Process

Moving forward

Assessing the health of the community and acting to address the health issues identified are long-standing foundations of public health practice. Community health boards in Minnesota now undertake a process called "Community Health Assessment and Action Planning", or CHAAP, on a five-year cycle. The CHAAP is an important mechanism for *moving Minnesota's local public health system forward*.

Overview

The CHAAP process is based on the former Community Health Services (CHS) planning process. It is similar to that process in that it includes community health assessment and planning components. Yet, the process also includes several newly designed components, including a capacity self-assessment and an action plan designed around the six areas of public health responsibility (see Table 1). In addition, CHAAP stresses the importance of engaging the community and provides strategies and tips for facilitating community engagement.

Table 1: The Six Areas of Public Health Responsibility

1. Assure an adequate local public health infrastructure
2. Promote healthy communities and healthy behaviors
3. Prevent the spread of infectious disease
4. Protect against environmental health hazards
5. Prepare for and respond to disasters, and assist communities in recovery
6. Assure the quality and accessibility of health services

Minnesota's state-local public health partnership - through the work of the State Community Health Services Advisory Committee (SCHSAC) and the Minnesota Department of Health (MDH) - has spent the past few years developing tools to assure continuous quality improvement and accountability in Minnesota's public health system.

The CHAAP includes three main parts:

1. Community health assessment and priority setting
2. Capacity assessment and priority setting
3. Community health improvement planning (action planning)

The Community Health Assessment and Planning Process (CHAAP) has been designed to move individual community health boards forward, by walking them through a customizable, step-by-step process of assessment, planning and action, leading to continuous community health improvement. This stepwise process will ultimately lead to a stronger public health system in Minnesota.

B. Planning and Performance Measurement Reporting System (PPMRS)

Measuring progress

The Local Public Health Planning and Performance Measurement Reporting System (PPMRS) is a reporting system that will allow community health boards to report on their efforts to meet the public health needs of their communities and document their progress toward meeting statewide public health outcomes. Data from the PPMRS will help community health boards and the MDH tell a story about the successful activities of Minnesota's local public health system. The PPMRS is *a new way of measuring progress*.

Purpose

In addition to measuring the contribution of community health boards' toward progress on the statewide outcomes, there are three key purposes of the PPMRS:

1. To describe key aspects of Minnesota's local public health system (e.g., activities, outcomes, funding, staffing, etc.);

2. To provide consistent, quality information for ongoing evaluation, decision-making, and technical assistance to improving public health activities; and

3. To provide accountability for the Local Public Health Act funds and to meet state and federal reporting requirements.

Background

The PPMRS was developed as a result of changes that were made to the Local Public Health Act (LPH Act) in 2003. The LPH Act requires that a community assessment be completed; that community input is sought; and that local priorities are identified and a plan to act on them is developed.

The LPH Act shifted accountability for the funds from a focus on administrative requirements to working towards a set of statewide public health outcomes. The statewide outcomes measure both improvements and changes in health status in the population and key public health infrastructure components (see appendix A for the list of statewide outcomes).

The statewide outcomes are measured at the state level. Community health boards, MDH, and other partners all contribute to achieving the statewide outcomes. The statewide outcomes are goals for improving the public's health as well as improving Minnesota's public health infrastructure. Community health boards work towards achieving the statewide outcomes by performing the essential local activities, which are organized according to the six Areas of Public Health Responsibility (see appendix B for the list of the essential local activities). The PPMRS data is gathered according to the six Areas of Public Health Responsibility.

PPMRS Pilot Test

In 2005, community health boards completed the first pilot test of the PPMRS. All community health boards in Minnesota participated in the pilot. The collective responses offer a rich description of local public health activity. Key themes and findings that emerged are briefly described below.

1. Assure an adequate local public health infrastructure: nearly all local public health departments (87%) initiate health communications, and respond to requests for local public health data (96%). Nearly all have designated staff trained in risk communications (96%), and 78 percent reported utilizing those skills in 2005. Public health departments tune into the social fabric of their communities; 84 percent participated in one or more community collaboratives affecting health. Local health departments introduced new policies and participated in many enforcement activities. The most commonly reported were newly developed Methamphetamine policies (45%).

2. Promote healthy communities and healthy behaviors: all local public health departments were asked to report on their activities and services related to a list of 21 topics. One hundred percent reported acting on four topics: injury prevention, child growth and development, nutrition, and preventing unintended pregnancy. Additionally, over 90 percent reported taking action on the following issues: promoting physical activity, cardiovascular disease and stroke, diabetes, cancer and STDs.

3. Prevent the spread of infectious disease: More than 90 percent of local health departments confirmed that they monitor and analyze infectious disease risk, occurrence and reporting to identify disease trends and reporting gaps. More than half (54%) identified important local trends or gaps related to infectious disease. Of the 40 local public health departments that explained a local trend or gap, half cited an increase in Pertussis cases (whooping cough); a result corroborated by state level disease investigation.

Additionally, local departments monitored and analyzed immunization data and provided thousands of immunizations. More than 85 percent provided immunizations to children and/or adults in 2005. Finally, local health departments provide information to the general public, and target programs to high risk groups; 99 percent reported communication activities focused on aspects of immunization.

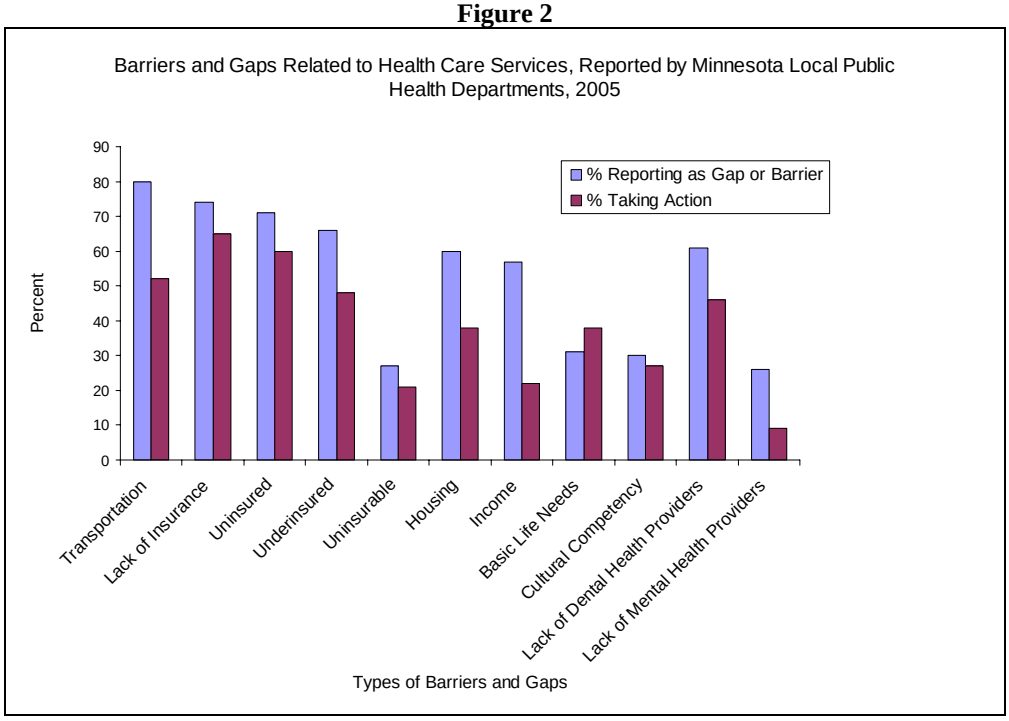
4. Protect against environmental health hazards: all local public health departments were asked to report on their activities and services related to a list of 29 environmental health topics. More than 90 percent reported taking action on four topics: environmental tobacco smoke, lead,

mold and clandestine drug labs. Over two-thirds reported acting on eight additional topics (in order of frequency) animals/pests, radon, garbage houses, indoor air, well testing, daycare establishments, food service, and consumer food safety. Fifty-five percent (42 community health boards) reported identifying an "emerging environmental health hazard", the most common of which was Methamphetamine. Seventy-one percent reported fielding complaints from concerned resident and nearly one fourth (22%) conducted case investigations into foodborne outbreaks.

5. Prepare for and respond to disasters and assist communities in recovery: In 2005, 39 percent of local health departments reported responding to local emergencies. Of the 30 departments that described the emergency they responded to, ten departments cited helping to prepare for the arrival of Hurricane Katrina evacuees; six identified a disease outbreak; six identified a weather-related incident (e.g., an ice storm), and two described responses to chemical spills.

6. Assure the quality and accessibility of health services: the local health departments were asked to report on the types of barriers and gaps that limit local access to health care services along with the public health actions taken in response. Several barriers/gaps were identified by most departments, and most took action to address them (see Figure 3).

Figure 2



In 2005, most (71%) local health departments worked to improve cultural competence. Many (71%) also reported assessing all clients for insurance status. Most reported progress toward reducing gaps and barriers related to health care services. For example, of the 87 percent that described their progress in this area, one fourth (18 departments) described efforts to improve access to dental care.

The results of this pilot test recommend several improvements to the PPMRS, including asking questions in such a way that the responses are comparable over time, developing standard definitions and supplementing some of the findings with other data from county-level surveys.

The local public health *Planning and Performance Measuring System* (PPMRS) is a new way of measuring progress toward achieving statewide outcomes in Minnesota. It is also a powerful new tool for documenting the activities and successes of local health departments and community health boards. The PPMRS will provide more information about Minnesota's public health system than we have ever had before. It will help us to share successes and best practices statewide, and will become an integral component in promoting continuous quality improvement in the system.

C. The Accountability Review Process

Ensuring stability

Accountability review is another component, which has been redesigned to ensure that community health boards are meeting quality and performance expectations. By supporting and reviewing the quality and performance of community health boards the accountability review process is *helping to ensure the stability of Minnesota's public health system*.

Background

The *Local Public Health Act of 2003* gave the commissioner of health the authority to remove state funding from an underperforming community health board. Since this represents a departure from the old way of doing business, processes and procedures to determine when and how this should happen, needed to be developed.

The accountability review process was developed by a SCHSAC work group comprised of experienced local elected officials, Community Health Service administrators, and local public health department directors. The accountability review process is a series of steps that would be taken prior to the commissioner making the decision to remove funding.

The Accountability Review Framework

The accountability review framework has three levels in addition to a probation period and an appeals mechanism. Each level includes a series of criteria that community health boards must meet. For example, level one asks six questions of each community health board, including, "is a current action plan on file that addresses the essential local public health activities and community health issues?" If the answer to any of the six questions is "no" the accountability review would consider the conditions "unmet", prompting MDH to send a letter to the community health board chairperson, the CHS administrator, and the lead public health staff person, noting the areas that need additional follow up.

Community health boards will be evaluated on an individual basis. All technical assistance and rehabilitative support provided by MDH will be tailored to the individual needs and circumstances of each community health board. The aim of that support provided will be to foster continuous quality improvement, not just minimal compliance with the criteria.

The accountability review process also provides a mechanism for local elected officials and community members to receive notification of their local progress and standing.

The work group recommended this phased approach to accountability review, because they believe it will help ensure stability and promote continuous quality improvement in Minnesota's public health system. Highly functioning community health boards will be regularly recognized and lower performing departments will be identified early, and provided support to ensure their ongoing improvement.

Conclusion

Minnesota's public health system is undergoing an era of unprecedented change and facing many new issues that challenge the system. Responses to these issues are being built upon the strong foundation of the long-standing state-local public health partnership in Minnesota. With the help of experienced partners from around the state, Minnesota's public health system is making progress, and preserving order amid change.

APPENDIX A

STATEWIDE OUTCOMES FOR THE LOCAL PUBLIC HEALTH ACT

Assure an Adequate Local Public Health Infrastructure

1) Increase the number of Community Health Boards that assess health disparities and the social conditions that underlie health and address them in their action plans.

2) Increase the number of Community Health Boards that perform 100% of the essential local public health activities.

3) Increase the number of Community Health Boards that have designated staff with knowledge and experience in

- Maternal and child health/family health
- Public health administration and management
- Infectious diseases
- Health promotion
- Environmental health
- Emergency preparedness
- Risk communications

Promote Healthy Communities and Healthy Behaviors

4) Decrease the percentage of adults ages 18 and older who are overweight or obese.

5) Increase the percentage of adults ages 18 and older who are physically active.

6) Increase the percentage of youth in 9th grade who are physically active.

7) Decrease the percentage of children ages 2-5 who are overweight.

8) Decrease the percentage of adults ages 18 and older who smoke cigarettes.

9) Decrease the percentage of youth in 9th grade who smoke cigarettes.

10) Decrease the percentage of adults ages 18 and older who binge drink.

11) Decrease the percentage of youth in 9th grade who use alcohol.

12) Decrease the percentage of youth in 9th grade who use marijuana.

13) Decrease the rate of births/pregnancies to adolescents ages 15-17.

14) Decrease the rate of suicides.

15) Decrease the rate of hospital-treated self-inflicted injuries.

16) Increase the screening for mental health needs for adolescents, children with special health needs, and pregnant and postpartum women.

17) Decrease the rate of very low birth weight infants among all live births.

18) Increase the percentage of children ages 0-3 who are screened for developmental and social/emotional issues every 4-6 months.

19) Decrease the rate of persons killed and injured in motor vehicle crashes.

20) Decrease the rate of hospital admissions for falls in persons aged 65 and older.

21) Decrease the rate of maltreatment and sexual assault of children ages 0-17.

Prevent the Spread of Infectious Disease

22) Decrease the spread of active tuberculosis (TB) disease.

23) Increase the number of vulnerable adults immunized for influenza.

24) Increase the percentage of 2-year olds that have been age appropriately immunized.

25) Decrease the incidence of Chlamydia.

26) Decrease the incidence of HIV infection.

Protect Against Environmental Health Hazards

27) Increase the percent of public health nuisances that were abated.

28) Decrease the average number of foodborne illness risk factors per establishment.

29) Increase the number of CHBs that assessed the status of drinking water quality.

Prepare For and Respond to Disasters, and Assist Communities in Recovery

30) Increase the number of Community Health Boards that have a local public health department emergency operations plan that is exercised and updated annually.

Assure the Quality and Accessibility of Health Services

31) Increase the participation rate of Medical Assistance and MinnesotaCare enrolled children aged 0 to 21 in the Child and Teen Check-Up Program.

32) Increase the number of pregnant women receiving early and adequate prenatal care.

33) Increase the percentage of families of children with special health care needs ages 0-18 that partner in decision-making at all levels and are satisfied with services they receive.

34) Increase the percentage of children with special health care needs ages 0-18 whose families report that community-based service systems are organized for easy use.

35) Increase the number of clients who are enrolled in health insurance programs.

APPENDIX B

MINNESOTA'S ESSENTIAL LOCAL PUBLIC HEALTH ACTIVITIES

Assure an Adequate Local Public Health Infrastructure

IN1: Maintain a local governance structure for public health, consistent with state statutes.

IN2: Assess and monitor community health needs and assets on an ongoing basis for each of the 6 areas of public health responsibility in this framework.

IN3: Identify community health and prevention priorities every five years with input from community members and key partners, including communities of color, tribal representatives and special populations, ensuring that community wisdom and cultural diversity are used to understand and interpret qualitative and quantitative information.

IN4: Every five years, develop an action plan with evaluation measures and recommended policy options to address essential local activities and local priorities.

IN5: Convene community members and key community partners, including communities of color, tribal representatives and people with special needs to build community collaborations, determine roles, identify and leverage community assets/resources and participate in research that benefits the community, as resources allow.

IN6: Advocate for policy changes needed to improve the health of populations and individuals.

IN7: Lead or participate in efforts to foster healthy physical, economic, and social environments (e.g., participate in community improvement and development decisions).

IN8: Provide annual information to MDH to evaluate progress toward statewide outcomes and local priorities, and to meet federal reporting requirements.

IN9: Meet personnel requirements for the CHS Administrator and the Medical Consultant.

IN10: Designate, recruit, train and retain local public health staff so that every local agency has appropriate expertise in each of the 6 areas of public health responsibility.

IN11: Recruit local public health staff who reflect the cultural and ethnic communities served.

Promote Healthy Communities and Healthy Behaviors

HC1: Engage the community on an on-going basis to promote healthy communities and behaviors through activities including but not limited to (a) assessment, prioritization and developing action plans, (b) coalition building, (c) community readiness, (d) empowerment, and (e) decision making.

HC2: Based on community assessment, resources, and capacity, include the promotion of healthy communities, healthy behaviors (e.g., physical activity, nutrition, tobacco, alcohol and other drug use, unintentional pregnancy, HIV/AIDS/STD), mental health, maternal and child health, and the prevention of injury and violence in the five-year action plan.

HC3: Conduct evidence-based, culturally sensitive programs, and disseminate information on services and resources to promote healthy behaviors and communities (e.g., physical activity, nutrition, tobacco, alcohol and other drug use, unintentional pregnancy, HIV/AIDS/STD), mental health, maternal and child health, and/or the prevention of injury and violence.

HC4: Inform and educate different audiences, e.g., general public, providers and policy leaders, about healthy communities and population health status.

HC5: Support the development and enforcement of policies, and encourage cultural norms that promote healthy communities.

HC6: Participate in decisions about community improvement and development to promote healthy behaviors and communities.

HC7: Promote healthy growth, development, aging, and management of chronic diseases across the lifespan.

HC8: Identify and address the needs of vulnerable populations e.g., high-risk pregnant women, mothers, children; frail elderly, persons with mental illness, and people experiencing health disparities.

Prevent the Spread of Infectious Disease

ID1: Work with providers and other community partners to facilitate disease reporting and address problems with compliance.

ID2: Assess immunization levels and practice standards, and promote/provide age appropriate immunization delivery.

ID3: Assess infectious disease risks in jurisdiction, apprise community of risks and assure appropriate interventions.

ID4: Based on surveillance data, develop strategies and plans to detect and respond to infectious disease problems and outbreaks within jurisdiction/region.

ID5: Assist and/or conduct infectious disease investigations with MDH.

ID6: When surveillance detects an imminent threat of infectious disease outbreak or epidemic, implement appropriate local disease control programs, including but not limited to mass treatment clinics, mass immunizations clinics, and isolation and quarantine.

Protect Against Environmental Health Hazards

EH1: Provide the general public and policy leaders with information on health risk, health status, and environmental health needs in the community as well as information on policies and programs regarding environmental health threats to humans.

EH2: Identify the federal, state, tribal or local agencies with regulatory authority and bring people together to address compliance with public health standards.

EH3: Develop public health nuisance policies and plans, and assure enforcement of public health nuisance requirements.

EH4: Monitor the community for significant and emerging environmental health threats, and develop strategies to address these threats.

Prepare for and Respond to Disasters, and Assist Communities in Recovery

EP1: Provide leadership for public health preparedness activities in the community by developing relationships with community partners at the local, regional, and state level.

EP2: Conduct or participate ongoing assessments to identify potential public health hazards and the capacity to respond.

EP3: Develop, exercise and periodically review all threats to the public's health.

EP4: Participate in surveillance and monitoring activities to detect patterns of unusual events; implement appropriate actions.

EP5 Participate in an all hazard response and recovery.

EP6 Develop and maintain a system of public health workforce readiness, deployment and response.

EP7 Develop and implement a system to provide timely, accurate and appropriate information in a variety of languages for elected officials and the public, the media, and community partners in the event of all types of public health emergencies.

Assure the Quality and Accessibility of Health Services

HS1: Identify gaps in the quality and accessibility of health care services.

HS2: Based on the on-going community assessment, inform and educate the public and providers on issues related to the quality and accessibility of health care services in the community.

HS3: Lead efforts to establish, maintain and/or improve access to personal health services, including culturally competent preventive and health promotion services, as identified in the planning process.

HS4: Promote activities to identify and link people to needed services.

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