Chapter 10

Local Health Services

The system of public health – known in Minnesota as Community Health Services (CHS) – includes state and local governments and is designed to:

"...protect and promote the health of the general population...by emphasizing the prevention of disease, injury, disability, and preventable death through the promotion of effective coordination and use of community resources, and by extending health services into the community."

(Minn. Statute 145A.02)

Charles Hewitt, Edward Bracken and other early leaders in Minnesota's public health history advocated a strong local health system as the key to successful public health in the state. This approach, supported by more recent public health leaders as well, calls for a coordinated delivery of services and information through the local government, which also determines the needs of the community. The Department of Health can provide specialized services to local health units, but its main role should be that of giving consultation and advice. Though numerous attempts were made, it wasn't until the 1970s that such a local health services system was achieved in Minnesota.

The difficulties in establishing a strong local health system in Minnesota had their seeds in 1866 when the Legislature authorized township supervisors to become the boards of health.[871] Dr. Hewitt's early zeal to work with the local health services might have also contributed to the later difficulties. He supported legislation, passed into law in 1873, which provided for boards of health in all incorporated towns, villages, boroughs and cities. Health officers, preferably physicians, were to be appointed.[872]

An outgrowth of the 1866 and 1873 laws was the formation of a multitude of local health units. In 1952 there were 2,828 health jurisdictions and 674 full or part-time health officers in the state. Seven hundred physicians served 1,800 townships, and 646 villages had health offices.[873] While such disbursement of units might have been appropriate in the 1800s when transportation limited access, it did not fit the mid-20th century.

The small health units lacked the resources to provide full services, and there weren't enough physicians and nurses to fill the positions. The system was large and

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[871] Harold S. Diehl, M.D., *Public Health in Minnesota: An Overview of the Past and a Glance Toward the Future,* Minnesota Medicine, Volume 42, January 1959, p. 33.
[872] Philip Jordan, *The People's Health,* 1953, p. 116.
[873] BOH, *Minutes,* February 5, 1952, MHS, p. 43.

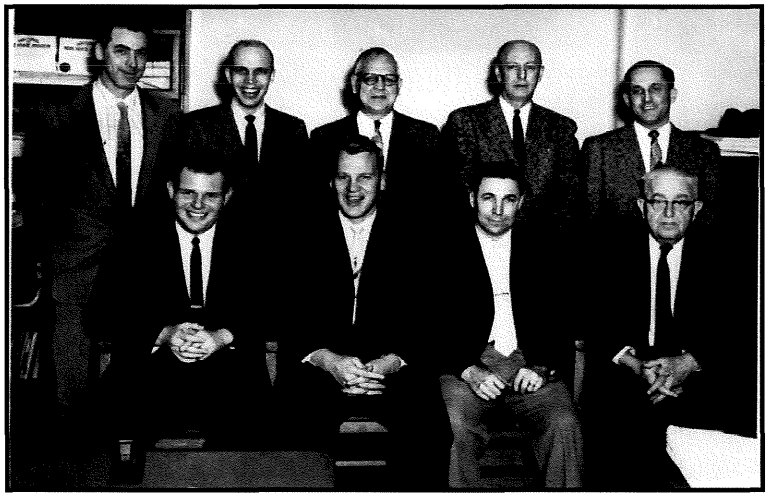
disorganized, but there was a resistance to consolidation. Communities wanted to retain their own health units, no matter how small.

The large number of health units was especially challenging for department employees, who had to contact each local health unit when they tried to assess public health needs, provide health education information, or offer any services and forms of assistance.

Three factors were necessary to develop a strong local health system: a coordinated and centralized system, delivery of services at the local level, and adequate funding to make this possible. By 1949 substantial progress had been made in coordinating public health services for local units of government. By 1980, all areas would be addressed.

Establishing District Offices/Field Offices

In an effort to better coordinate local health services, the department established district offices throughout the state. The first two district offices, in Mankato and Bemidji, were set up in 1936 under the Social Security Act of 1935. These offices provided federal aid to areas particularly hard hit from the Depression. Offices were established in Duluth and Rochester in 1936, Worthington and Minneapolis in 1947 and Fergus Falls and Little Falls in 1948.[874] By 1949 there were eight district offices.



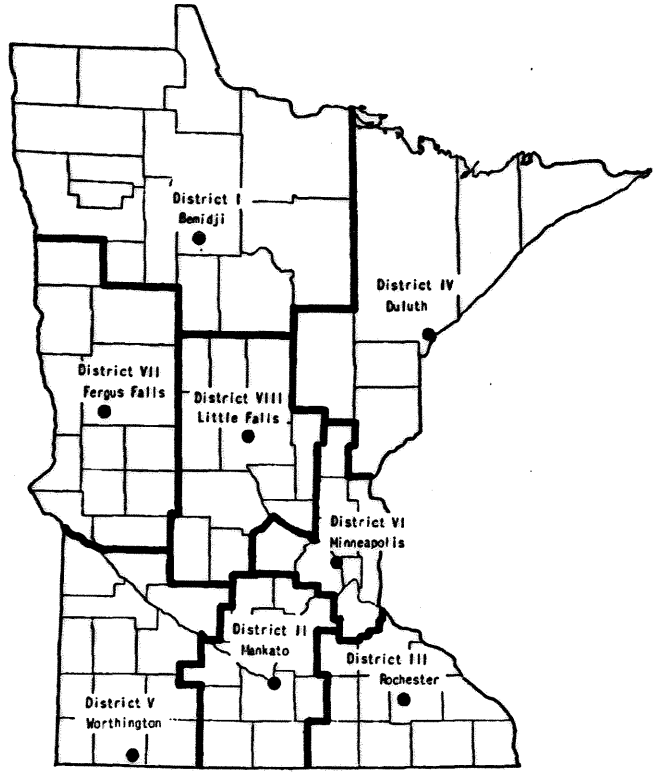
District Engineers – 1959
Standing (l to r): H. A. Starin, L. S. Sku, M.C. Peterson, F. Heisel, P. B. Johnson
Sitting: G. Goldschmidt, D. Hahn, E. Jourdan, A. C. Larson

District offices had a core staff that provided health services at the local level. This decentralized service included expert technical advice, supervision of statewide programs, collection and compilation of vital statistics, laboratory diagnosis for communicable disease control, water pollution control, services of licensing bureaus, health education and industrial health.[875]

In 1949 each district office had a public health engineer or sanitarian, one or more public health nurses, and clerical personnel. In some instances, the district office provided the only health service available for people in a locality.

[874] MDH, Departmental chart titled, "Minnesota Department of Health – District Health Units," December 1948.
[875] MDH, Report by MDH titled *"Public Health in Minnesota is Going Forward Step by Step,"* 1949, p. 1.

District offices provided a number of advantages for the Health Department. The medical director, engineer and nurse in the district office were able to provide consultations and supervision of local activities that would otherwise have to be done by someone from the central office. Being geographically closer to the people in the district, district office staff were in a better position to observe, assess and understand the community and its needs, as well as to establish personal contacts and develop relationships with the people in the community.



District Offices, 1949

The district offices were, and continue to serve as, intermediaries between the central office and local units of government. The district offices play an important role in that they are often the first contact many people have with the department. Requests for assistance from local representatives are channeled through the district offices. When necessary, consultants from the central office travel to the district to help with problems, such as outbreaks, case finding, and surveillance.[876]

The heads of the district offices are listed in the following chart. The first woman to be appointed district health officer was Dr. Helen Wolff in 1949 in District 5, Worthington.

[876] MDH, *Minnesota's Health,* Vol. 13, No. 3, March 1959, pp. 2-3.

Heads of District Offices/Field Offices (through 1999)[877]

Bemidji – District One-Northwestern
Dr. J.R. Kingston, 1936-38, 1939-42
Dr. D.S. Fleming, 1938-39
Dr. Percy T. Watson, 1942-46
M.D. Peterson, 1947-48
Dr. G.A. Miners, 1948-52
R.H. Pinther, 1952-53
Dr. Mary Ghostly, 1953-57
Dr. Sidney Finkelstein, 1957-67 at least
William Heisenfelt, 1972-89 at least

Mankato – District Two-South Central
Dr. Floyd Feldman, 1936-38
Dr. F.G. Gunlaugson, 1938-40
Dr. F.W. Engdahl, 1941-44
Dr. A. G. Liedloff, 1944-56
Dr. H.J. Nilson, 1956
Dr. Otto Fesenmaier, 1956-67 at least
Harold Anderson, 1972
Rodney Church, 1981-89
Ward Bisping, 1998-99

Rochester – District Three-Southeastern
Dr. Floyd Feldman, 1938-41, 1943-48
Dr. Lester Breslow, 1942-43
Dr. Viktor O. Wilson, 1948-67 at least
Dr. Raymond Jackman, 1972
Eric Anderson, 1975
Eric D. Anderson, 1978-89

Duluth – District Four-Northeastern
Dr. C.A. Scherer, 1937-44
Dr. Mario Fischer, 1944-58, 1963
Dr. C.A.E. Lund, 1958
Dr. Arvid Houglum, 1967
Dr. Harold B. Leppink, 1972
Bruce T. Rowe, 1975
Lamar J. First, 1981-83 at least
Marie Margitan, 1989

Worthington/Marshall (as of 1971) – District Five-Southwestern

Dr. Byron O. Mork, Jr., 1947-49
Dr. Helen Wolff, 1949-51
Amandus Larson, 1951-53
Dr. John Stam, 1953-67 at least
Gary L. Otnes, 1972
John Blohm, 1981-89

Minneapolis – District Six
Dr. A.B. Rosenfield, 1947-50
Dr. John Smiley, 1950-52
Dr. Percy Watson, 1952-56
Dr. W.C. Harrison, 1956-72 at least

Fergus Falls – District Seven-West Central
Frederick Heisel, 1948-66
Robert Poyzer, 1972-89 at least

Little Falls – District Eight
Dr. Edward J. Simons, 1948-50
Dr. A.M. Watson, 1950-
Donald Seifert, 1963-67 at least
Andrew Starin, 1972

St. Cloud – Central District
LeMar "Jack" First, 1981-99

While the district offices weren't true local health services, they did demonstrate what could be accomplished with more coordinated and consolidated efforts in rural Minnesota. In 1951 Mr. Frank Woodward, chief of environmental services, commented: "The thing is that you will notice if you check back over several years, it has only been since the completion of the districts in the state that we have been able to get to all the water supplies...."[878]

[877] MDH, *Minnesota's Health,* Vol. 13, No. 3, March 1959, p. 2.
[878] BOH, *Minutes,* January 25, 1951, MHS, p. 46.

In 1999, the district offices numbered seven, not eight, and had been renamed field offices to better reflect their role, no longer confined to one area of the state. In 1999, field offices ranged in size from eight to 28 employees and were located in St. Cloud, Bemidji, Mankato, Duluth, Marshall, Rochester, and Fergus Falls. Each office covered environmental health, family health, disease prevention and control, and administration. Minnesota has been unique having an epidemiologist in each field office.

Department of Health District Offices in 1999

Many department employees in the field offices have worked as inspectors. In that role they educate and inform, providing the advisory function advocated by early public health leaders in Minnesota. Some offices have had special programs. For example, Fergus Falls had a one-year program studying arsenic.

The field offices have been successfully used to strengthen the relationships between the Health Department and other state agencies. A closer working relationship has ensured a unified approach to problems and in many instances, improved efficiency. The Rochester field office has shared a building with the Pollution Control Agency, making it much easier for the two agencies to coordinate and support one another on environmental issues.

Strengthening Local Health Services in the 1940s and 1950s

The importance of transferring public health activities from the state Health Department to local government was emphasized when the governor's "Little Hoover" Commission released its report in 1950. It made a strong recommendation for improved local health services, recognizing a trend for centralization in the department and recommending decentralization to improve the local health service system:

> ***"Establish single- or multiple-county Health Districts having adequate financial resources to assure necessary local public health services by the respective local health units. Authority and responsibility for public health administration should be transferred to the local health districts as rapidly as possible and the State Department of Health should increasingly limit its activities to educational consultative and supervisory services, except where local health units have not been established."***[879]
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> **Governor's Efficiency in Government Commission, December 1950**

The commission also recommended reorganization, so that the department could better serve local health administration:

> Reorganize the Department of Health on a functional basis by the establishment of four divisions, namely, the Division of Environmental Sanitation, the Division of Local Health Services, the Division of Departmental Administration and the Division of Disease Prevention and Control. The Division of Local Health Services should be under the immediate direction of the Deputy Commissioner of Health and should serve as a central operating division from which all services should be channeled to the district health officers and to the local health units.[880]

Following the release of the commission's report and recommendations in 1950, a citizen's committee met with all division directors and some section chiefs from the department to discuss the report's findings. The committee's recommendations on local health services were fully supportive of the commission's report: They supported the policy of increased local control and recommended strengthening the administration of local health services to facilitate the transfer of more control to local government.

To make it possible for more local units to operate, they recommended a policy of hiring non-medical doctors as district directors, when medical doctors were not available:

- First, establish a policy of local health services with the local people assuming more responsibility both in carrying out the policies and the programs and in supporting them financially. We feel that the closer you can get to the people who are directly involved, the more responsible will be the work and the more effective for the local conditions.

- Second, take steps to recruit a well-qualified person to fill the position of Chief to the Section of Local Health Administration. Dr. Barr's duties take so much of his time that we have felt that probably we will need a Chief under him for that Section, rather than for just part of the work.

- Third, establish a policy on Health Department districts to include the naming of full-time professional persons other than medical as district directors, making provision for adequate

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[879] J. L. Jacobs & Company, "How to Achieve Greater Efficiency and Economy in Minnesota's Government. "Recommendations of the Minnesota Efficiency in Government Commission. December 1950, Chapter VIII, pp. 98-99.

[880] J. L. Jacobs & Company. "How to Achieve Greater Efficiency and Economy in Minnesota's Government. " Recommendations of the Minnesota Efficiency in Government Commission. December 1950, Chapter VIII , pp. 99.

> medical consultation for each of these districts. It has been found impossible to get full-time medical directors for these different district health units and in order to get continuity and effective action we may need to take some person in the district who knows the circumstances there to take over the function of the District Office.[881]

An improved local health system, better coordinated and with increasing local control, was a constant focus of health board members and leaders in the department during the 1940s and 1950s. Like Hewitt and Bracken, Dr. Albert Chesley, executive officer and board secretary, was a strong advocate for a better local system but disappointed at the pace it was making. During one discussion he commented, "The establishment of local health services is proceeding about as fast as it can under present circumstances. Nobody can grant what you want most." [882] The difficulty of accomplishing this was recognized when Dr. Robert Barr, deputy executive officer, introduced Dr. John Smiley as the person who would work with Dr. Percy Watson, chief of the local health services section, on the development of local health services in the state, and he added, "which is a tough job."[883]

The department viewed the eight district offices as only "a partial remedy" for developing a strong local health system.[884] It supported the belief that, "Basic public health policy is developed in local communities which should be able to set up and control their own public health programs."[885] This was one of the factors behind departmental support of the 1949 County Board of Health Act, whereby the state legislature authorized the establishment of county and multi-county health departments.[886] This act encouraged local units to consolidate so full-time health departments would be accessible to all citizens. Counties could levy a tax, not to exceed one mill, to finance the county health department.

While the County Board of Health Act was a good idea in theory, it was not practical economically or politically. It was costly to consolidate, and small communities wanted to retain their autonomy. The law's effect was minimal, resulting in only one health department, the Olmsted County Health Department, which was established July 14, 1953.[887] Mr. Jerome Brower, chief of departmental administration, explained to the board, "The problem is to get counties to line up. There just isn't any experience of counties working together on a project of this kind. It is going to take quite a little bit of time."[888]

While the department was unsuccessful in its efforts to establish county health departments, health councils were forming and working. The first health council was established in Lake County in 1947. The purpose of these councils was to coordinate health activities and expand public health programs, through cooperation with

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[881] BOH, *Minutes,* January 12, 1954.
[882] BOH, *Minutes,* July 14, 1949.
[883] BOH, *Minutes,* February 14, 1950, MHC, p. 33.
[884] MDH, report titled *"Public Health in Minnesota Is Going Forward Step By Step,"* 1949, p. 9.
[885] Ibid.
[886] County Board of Health Act of 1949 (M.S. 145.47-145.54)
[887] BOH, *New Dimensions for Minnesota,* p. 21.
[888] BOH, *Minutes,* November 14, 1950. MHC, p. 464.

community agencies. The Lake County Council sponsored a mobile chest x-ray unit, established a county-wide nursing service by transferring school nursing to this broader field, held county-wide immunization programs and adult vaccination clinics, and joined together with the American Cancer Society to sponsor a cancer detection clinic. The Lake County Council met four times a year, and those in attendance included representatives from the hospital, welfare board, Red Cross, sanatorium board, 4-H Club, Farm Bureau, Grange, local tuberculosis, cancer and poliomyelitis associations, county superintendent of schools, school nurses, county commissioners and dentists.[889] By 1951, the counties of Nobles, Cottonwood, Itasca, and South Koochiching also had councils.

Other initiatives to improve the local health services system were made in response to the recommendations by the Governor's Efficiency in Government Commission. The board reorganized the department giving greater importance to local health services. In 1953, local health services became a separate division with these sections: local health administration, public health nursing, dental health, maternal and child health, public health education, and hospital services. Dr. Robert Barr, deputy executive officer, headed the local health services division. Dr. Hilbert Mark was chief of local health administration, which included the district offices.

While the board had a policy of supporting local health services, there seemed to be very little it could do to transfer more responsibility to the local units of government. The board did try. In 1956, when Duluth prepared to enact an ordinance accepting hotel and restaurant inspections by the state's health department in lieu of inspections by its own department, the board didn't approve. Members felt it was contrary to their philosophy and policy of assigning the responsibility to local authorities[890]

Concerns about state vs. local delegation of duties were voiced by long-time board member Dr. Ruth Boynton when the board discussed a bill introduced to the Legislature one year later, in 1957. The bill provided for a tuberculosis control officer, appointed by the sanatorium commission. Dr. Boynton wondered if the bill wasn't "a bit dangerous in view of the fact that we are trying to get a county health officer who will have all of the public health problems in the county." She also wondered if it might deter the establishment of a county health department.

> Mr. President, I hate to pursue this TB control officer matter, but I do want to go on record as expressing a good deal of question as to whether this Board should support that. If this had been suggested 20 years ago when our cases of tuberculosis were ten times what they are now I think there would have been much more logic to it.
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> What bothers me about this whole thing is that you are turning over a public health function to an institution, according to the present wording of the bill, apparently without any necessary relation to the State Health Department or the city and county health department. I think it is a matter of principle. I think if the bill says this person should be employed by, or some arrangements made

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[889] MDH, *Minnesota's Health,* Vol. IV, No. 4, April 1950, p. 3.
[890] BOH, *Minutes,* April 19, 1956, MHC, p. 70.

> with the local health department, that would strengthen it, but to have a tuberculosis officer who has no legal responsibility except this general law, it seems to me is bad.[891]

In 1958, when the board reviewed a proposal to add 11 new employees to the district offices, members questioned the appropriateness of supporting local health services in this way. Vice President Herbert Bosch didn't feel the staffing was excessive, but he pointed out it still wasn't local health services in the sense of actual work at the local level:

> I think this is a matter which the board should give a considerable amount of thought to because very obviously budgets are going to be pared along the line one place or the other. Our subcommittee actually felt the staffing they are talking about here is not excessive for districts. We don't want any implications here of a feeling that this is excessive staffing, but we do want the board to appreciate that what is being discussed in the preliminary stage here is a step-up of appropriations for that single time of about $253,000, which still isn't local health services in the sense or actual work at the local level. It is really decentralized state service.[892]

The cost of a county health department, plus resistance by towns, villages and cities to move health work to the county level, continued to prevent consolidation of local health agencies, leaving many operating part-time and with limited services. Again trying to encourage centralization, the Legislature amended the County Board of Health Act in 1957.[893] The permissible tax levy for a health department was raised from one mill to two mills, with the expectation this would make it possible for more communities to establish county or multi-county health departments, as had been done in Olmsted County.

The amended legislation had minimal effect with only one more county health department. St. Louis County commissioners voted to organize a county board of health in 1959.[894] The state's local health system remained fragmented and without adequate leadership. In June 1960 there were 2,738 units of government in Minnesota with health jurisdictions.[895] Only five had full-time health officers. A total of 1,324 units had no duly appointed health officers.[896]

Local communities were short on resources, not just to support consolidation, but for public health activities in general. While public health authorities had indicated that communities needed about $1.50 per person to provide minimum public health services, few areas of the state spent amounts even close to that figure.[897] To compound the problem, federal funding for local health services decreased in the 1940s, as more federal funds were directed to hospital construction. Up until 1976 there was no specific state legislation that provided funding for community health services in Minnesota, except for a small amount designated for public health nursing.

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[891] BOH, *Minutes,* January 31, 1957, MHC, p. 7.
[892] BOH, *Minutes,* August 13, 1958, MHC, p. 211.
[893] Laws 1957, Ch. 470.
[894] *BOH,* Minutes, January 13, 1959, MHC, p. 10.
[895] BOH, *New Dimensions for Minnesota*, p. 20.
[896] Ibid.
[897] State of Minnesota, "Organization and Management of Public Health Agencies: Summary and Report for Efficiency in Government Commission," 1950, p. 5.

Only $1,500 a year per county had been available from 1947 to 1965 for public health nursing services.[898]

Efforts to Strengthen Local Health Services in the 1960s

By 1961, the situation with local health services had changed little. Most counties were not able to raise enough funds to support a county health department. Minneapolis, St. Paul, Duluth, Rochester, St. Louis Park and Bloomington were the only counties that had full-time health officers. The lack of resources for local health services continued to be an impediment in most counties. Therefore, when an opportunity to expand county nursing services appeared in 1961, the department was most interested, even though the amount was relatively small.[899]

The opportunity came in the form of proposed federal legislation and was in response to the challenges all states were facing in trying to strengthen their local public health systems. Responding to this national need, in 1961 the federal government proposed legislation that would remove the ceiling for annual assistance to states and increase community health service grants, special project grants, nursing home construction grants and hospital research grants. Eager for any opportunity to receive increased funding for the state, Dr. Robert Barr, executive officer and secretary, testified before the Interstate and Foreign Commerce Committee in support of the Federal Community Health Services and Facilities Act (H.R. 4998) on May 3, 1961:

> There are some of us who are so provincial as to believe that if such an individual simply wants unnecessary special care, such as a pretty nurse to wait on him and hold his hand during his illness, it is hardly society's responsibility to provide for this kind of care. But, we also would add that if there are not enough nurses, either pretty or otherwise, to provide basic care to all who need it, then perhaps even the individual who has resources sufficient to pay for such attention is doing a disservice to society if he demands it and as a result deprives some other less fortunate individual of nursing service that is critically needed.
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> It has been demonstrated that the provision of good home nursing services as well as homemaker's services may not only reduce to some extent the need to provide nursing home beds but will also retain the individual in a family setting in his own community which, in properly selected cases, is best for the individual and is most economic. Unfortunately, such services, which were once provided by neighbors and friends, and are now provided through visiting nursing services in the larger cities, are not available in most areas.
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> There are substantial numbers of trained personnel residing in most communities, particularly nurses, whose children are grown or who, because of other reasons, could give part-time services either in this field of home care or to the hospital or nursing home. The development of local rosters of such individuals would also be of tremendous value in case of a community disaster. Health departments are advocating the development of such for Civil Defense purposes. Several state, like Minnesota, have provisions for the development of home nursing services under the direction of the county public health nursing service and for the payments for

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[898] MDH, *"New Life for Public Health: The Politics of Prevention in Minnesota,"* 1976, p. 1.
[899] BOH, *Minutes,* May 23, 1961, MHC, p. 218.

> care from public welfare funds as well as for the acceptance of private fees from those who are able to pay. [900]

The Community Health Services and Facilities Act of 1961 (PL 87-395) did pass, and it authorized the surgeon general of the U.S. Public Health Services to make one-time project grants to public or non-profit private agencies in counties. The grants were to be used to develop out-of-hospital health services, with particular emphasis on home nursing care and homemaker services. There was an increased amount of funding to improve the quality of care for the chronically ill and aged and for outpatient care. Dr. Barr was disappointed that projects were submitted to the U.S. Public Health Service, not the state Board of Health. Local health units that participated included Morrison County, Minneapolis Health Department and the St. Paul Bureau of Health. [901] [902] The grants awarded totaled $82,000.[903]

Strengthening Local Health Services in the 1970s

In the 1970s the environment changed, and legislative and constituent support for community-based services increased. This could be seen in legislation affecting other state agencies. The Human Services Act of 1973 made it possible for counties to create a single board for the coordination of human services, court services, public health services, public assistance, social services, mental retardation and mental health services.[904] The 1973 Community Corrections Act made it possible for counties to develop and plan community-based correctional programs.[905]

The department had long supported community-based services, and Dr. Warren Lawson, executive officer and secretary of the board, had selected this need as one of his top three priorities. In the early 1970s he described his vision to legislators:

> Chairman Kirchner: (Chair of Joint Subcommittee of Senate Comm. On Health and Welfare) "Dr. Lawson, you made some allusions to the direction of health services from the State level, and then a moment later discussed something about the county agency. I wasn't quite sure what your concept was of the administration of health services as between the State and the local and county levels. Do you feel that the State should be the structurally mechanical unit that directs the activities in each of the various levels, or how would you coordinate between the State level and the community or county level in handling these?"
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> Dr. Lawson: "With the long tradition of home rule in the State, I think it is probably necessary to give local communities some range of option, but I think that we have passed the time when we can afford to have each municipality or each township or each county be markedly different from each other in terms of health programs, whether you are talking about staffing, the kind of program, and what not, that might be involved. Does that answer your question?"

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[900] BOH, *Minutes,* May 23, 1961, MHC, pp. 223-226.
[901] BOH, *Minutes,* October 31, 1961, MHC, p. 375.
[902] BOH, *Minutes,* May 23, 1962, MHC, pp. 213, 240-242.
[903] MDH, *Minnesota's Health,* Vol. 16, No. 1, January 1962, p. 1.
[904] MDH, *"New Life for Public Health: The Politics of Prevention in Minnesota,"* 1976, p. 2
[905] Ibid.

> Chairman Kirchner: "It still leaves me with some thoughts of just how you project that down the line. How do you allow them latitude and still in a sense make many of the decisions for them? Would you do this through regulation or through selection of staff or – "
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> Dr. Lawson: "It seems to me the State has got to lay some kind of a baseline that would have to be met by local agencies and the local agencies then could proceed to elaborate upon this as long as it did not get completely out of bounds, and here I'm thinking in terms of specific regulations. One of the difficulties that has existed is there sometimes tends to be competition in seeing how high standards can be gotten at the local level, and I think this kind of thing is relatively destructive and should be controlled within limits."[906]

Demonstrating his support, in 1973 he renamed the local health administration division as the community services and development division. Headed by Robert Hiller, Ph.D., this division took the lead in getting legislation passed to strengthen local health service.

Key persons who supported Dr. Hiller in his work were Ernie Kramer, head of local health administration; Fred Goff, supervisor of district offices; and Emil Angelica. They realized that a lot of federal funding through categorical grants was available, but many local units were not qualified to receive these funds, as they didn't meet personnel requirements. By combining the federal money in one pot and distributing it throughout the state, the local units might have the resources they needed.[907]

In August 1974 the first planning meeting for the proposed legislation on community health services was held in the department's Chesley Room. Robert Hiller led the meeting, writing ideas on the board. Attendance was large and included representatives from the Regional Development Division, the federal Health Systems Agency, the State Emergency Medical Services, the counties and the department.

The department worked at gaining support for the community health services plan, but it did not always go smoothly. From time to time there were setbacks, as reported on this meeting in St. Cloud in September 1974:

> ....The State Health Department was not present on the panel and Mr. Broeker proceeded to elaborate on this absence, speaking in terms of past bad attitude, indifference towards cooperation and involvement and saying that we had no commitment to the act and because of reorganization and confusion so far had made no attempts to firm up a position. He ended the comment by in effect saying that one could see the lack of interest in Human Services by the Department was quite evident because as all could see the Health Department had not sent a representative. He then called upon Dr. Bond of the U of M School of Public Health to comment and Bond became quite concerned saying he didn't represent the Department but thought Dr. Lawson's plans and the Comprehensive Community Health Services Bill were consistent with and would fit very nicely with the Human Services Act. At any rate, feelings by the crowd toward the Department were very negative.
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> All of the District Representatives agreed that had we been advised of the Health Department's inability to attend and been briefed on the Department's wishes we could have and would have filled in. As it was, everything happened so fast that we were unable to respond, nor were we able to sit on the panel. We fully expected someone to appear from Minneapolis, so we were not prepared.

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[906] Senate Committee on Health and Welfare, Joint Subcommittee meeting, April 17, 1972, pp. 35-36.
[907] Conversation with Robert Hiller, January 29, 1999.

> In our estimation, this was another black day for the Health Department. We also believe that it will now be tougher than ever to enlist support from local government for the Community Health Services Bill.
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> I was asked to prepare this memo so that Community Services and Development can in the future be better prepared. Much, much closer communication between the Metro Office and the districts must occur if we are to perform in a creditable manner.[908]

Significant support was gained, and the proposed community health services bill that was presented to the 1975 Legislature was influenced by department policies that included:

- Prevention of illness, disability and premature death must be the cornerstone of the state effort to protect, maintain and improve the health of the people.
- Preventive health services must be delivered through a system with extensive local administration and fiscal control, within state guidelines and standards.
- The proper role of state government is long-range planning, standard setting, and provision of technical support, while the proper role of local government is to plan, develop, administer and deliver preventive and personal health services within an integrated local system.
- The existing fragmented health services system requires communication, coordination and cooperation in planning and delivery of health services to be effective.[909]

Passage of the Community Health Services Act of 1976

Politically, the Community Health Services Act was non-partisan. It had the backing of both parties, with a sprinkling of support from very liberal Democrats and a sprinkling of support from far-right Republicans. Most of the support came from somewhere in between. Much of the testimony in support of the bill was given by local representatives. There was general agreement on the bill's focus on prevention, state-local partnership and need for an integrated approach. Disagreement arose related to the roles of county and municipal government, compatibility with existing tax policies and sexuality-related issues of family planning and abortion.[910] One obstacle to the bill's passage was Gov. Wendell Anderson's support of a Community Health and Social Services Act, which would have combined the activities of the departments of Health and Human Services.[911]

The Minnesota House and Senate approved the community health services bill during the 1975 legislative session. The conference committee report that reconciled differences, however, was not approved by the end of the session. During the next six

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[908] Memo from R. Poyzer, district representative, to E. Kramer, community services and development, October 1, 1974.

[909] MDH, *"New Life for Public Health: The Politics of Prevention in Minnesota,,"* Presented at 104th Annual Meeting of the American Public Health Association in Miami Beach, Florida, October 17-21, 1976, p.p. 2-4.

[910] Ibid., p. 5.

[911] Conversation with Robert Hiller, January 29, 1999.

months support for the bill grew, and was strengthened when Gov. Anderson stated in a press release that, "There has been too little activity in the area of preventive medicine. We would be better off spending much more money on preventive care."[912]

Early in 1976 both houses of the Legislature passed the bill, and it was enacted into law on February 6, 1976. The initial appropriation was $2.75 million for the period February 6, 1976, through June 30, 1977.[913]

The purpose of the Community Health Services Act, stated in Section 1, is "the development and maintenance of an integrated system of community health services under local administration with a system of state guidelines and standards." State statute defined "community health services" as:

> "...those services designed to protect and improve the people's health within a geographically defined community by emphasizing services to prevent illness, disease, and disability, by promoting effective coordination and use of community resources, and by extending health services into the community. These services include community nursing services, home health services, disease prevention and control services, family planning services, nutritional services, dental public health services, emergency medical services, health education and environmental health services.[914]

> ***The CHS Legislation..."is the most significant legislation in public health since the Minnesota Board of Health was established in 1872."***[915]
>
> **Commissioner of Health Warren Lawson, 1977**

Unlike other legislative efforts to improve the local health system in Minnesota, the Community Health Services Act of 1976 (the "CHS Act") offered attractive subsidy funding. To be eligible, the community must have a local board of health and the community's population must exceed 30,000. This population requirement was an incentive to consolidate for those counties with populations under 30,000. This requirement addressed the long-term problem of multiple health units throughout the state.

The CHS Act stressed local control and options, and there was flexibility in such legislative requirements as having a local board of health. This board could be the county board of commissioners, the human services board, or an administrative board of elected officials, health care providers and laypersons, depending on the community's choice.

In addition to having a local board of health and a population in excess of 30,000, in order to receive funding the community must create a community health services plan, approved by both the county board of commissioners and the state Board of Health.

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[912] MDH, "New Life for Public Health: The Politics of Prevention in Minnesota," presented at 104th annual meeting of the American Public Health Association, Miami Beach, Florida, October 17-21, 1976, p.5.
[913] Ibid., pp. 2-4.
[914] Ibid., p. 5.
[915] *St. Paul Pioneer Press*, "Two Minnesota Counties Get First Health Service Grants," January 13, 1977, p. 7.

The community must also comply with state rules and must provide local matching funds.

Each community health service plan submitted to the department for approval was required to include the following:

- A community participation process that will assure involvement of all interested citizens. This includes establishing broadly representative advisory committees and task forces, public notices, media involvement, public forums and hearings, and plan review and comment.
- A quarterly work outline defining the steps and process within a specified time frame.
- Demographic data and health services inventory, including descriptions of existing programs that can serve as a base for future planning and services delivery.
- Identification of needs using a community participation process.
- Identification of priorities using a community participation process. This will become the basis for determining the priority health needs of the community that should have first attention for subsidy and in delivery of services.
- An administrative structure for fiscal control, developing the plan, and delivery of services and evaluation of impact.[916]

Implementation of the Community Health Services Act of 1976

Since its formation in 1872, the department had been fighting to strengthen its local health services. With the passage of the CHS Act, this could become a reality – if the law was successfully implemented. Designated for this formidable task was Robert Hiller, department employee since 1962.

Robert Hiller determined that in order to successfully implement the CHS Act, a CHS representative and nurse to help with the process was needed for each district office. The district CHS representative was charged with getting the system organized and operating. This was a political role in that each CHS district representative had to mobilize community leaders.

Mankato was the first location to have a district representative, Bemidji was second, and soon all districts had a representative. Robert Hiller planned that once the system was operating successfully at the local level, there would be no need for district representatives. The position would be eliminated, and the territory of nurses expanded. When Dr. Petterson became commissioner, however, he decided to retain the district office representatives. The CHS district representatives remained until the 1990s when they were gradually phased out.

The first CHS district representatives were: Bob Poyzer, Fergus Falls and Little Falls; Bill Hiesenfelt, Bemidji and Duluth; and Harold Anderson, Mankato, Worthington and Rochester.

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[916] MDH, "New Life for Public Health: The Politics of Prevention in Minnesota," presented at 104th annual meeting of the American Public Health Association, Miami Beach, Florida, October 17-21, 1976, pp. 7-8.

Nursing consultants played a major role in implementing the CHS Act. Speaking with county public health nurses, they gave advice on what to say to get their commissioner's interest. Some county commissioners resisted implementing the act due to recent experiences with federal seed money. Federal funding for a program might be provided for a short while and then cut, leaving the commissioners with an unfunded program and no available funding to continue activities.[917]

However, through the efforts of department representatives, more than half of the state's counties agreed to participate in the statewide Community Health Services system that first year. By October 1976, the board had received 26 planning grant applications, representing 46 of the 87 Minnesota counties and over 75 percent of the state's population.[918]

The first CHS plan reviews, held in the Chesley Room of 717 Delaware Street, were called "The Inquisition" by participants. Representatives of the community responded to questions regarding their plans to spend a portion of the $2.75 million in grant money from the state that was available through fiscal year June 30. The first two awards, totaling $420,110.50, were made in January 1977.[919] St. Louis County received $322,500, and Olmsted County received $97,610.50.

After the first group of counties had agreed to participate, department representatives had to work harder to get other counties involved. Department employees became salespersons. They talked with Lions Clubs, Kiwanis Clubs and other community groups; they primed these people to talk with their county commissioners in support of the CHS Act.

Seemingly minor actions sometimes made the difference between whether or not a county chose to participate in the CHS system. For example, Benton County requested maps to distribute at their county fair. The state was unable to provide the maps. If they had, one department employee believes they would have joined a year sooner.[920]

Sometimes conflict occurred when communities were asked to designate a primary hospital and a secondary hospital as part of the CHS plan. Federal legislation had established seven health systems agencies in Minnesota for the purpose of monitoring and preventing unnecessary health expenses. These did not always match well with the CHS areas.

Another challenge was clarification of the different roles the district offices and CHS system each played. The district offices were originally established to help coordinate the local health services. The CHS Act added one more player with whom they would need to consult. While activities were overlapping and could be confusing, Robert

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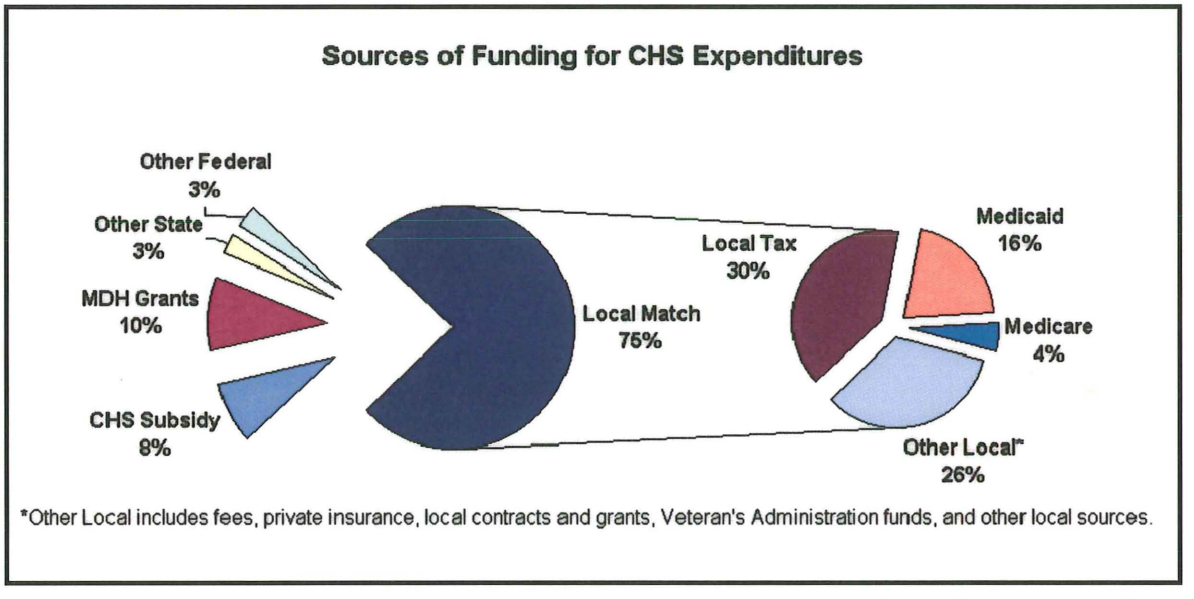
[917] Conversation with Robert Hiller, January 29, 1999.
[918] MDH, "New Life for Public Health: The Politics of Prevention in Minnesota," presented at 104th annual meeting of the American Public Health Association, Miami Beach, Florida, October 17-21, 1976, p. 9.
[919] *St. Paul Pioneer Press*, "Two Minnesota Counties Get First Health Service Grants," January 13, 1977, p. 7.
[920] Conversation with MDH employee, 1999.

Hiller's original decision to place CHS representatives in each district office helped prevent misunderstandings.

While many people were involved with the implementation of the CHS Act, there were several key individuals. One was Margaret Sandberg, a planner from the Metropolitan Council Health Board, who understood politics.[921] Others were Dr. Valentine O'Malley, member of the State Board of Health; Fred Goff; Ernie Kramer, Jack First and Robert Hiller. They traveled throughout the state, introducing the CHS program to communities.

Implementation of the CHS Act required commitment, dedication and hard work. One of the department's older employees, who played an active role in the process, questioned whether it would be possible to do the same in 1999, as he felt the "zealots" who pushed through the CHS Act would, by then, have become a dying breed. Would it be possible to gather the momentum to undertake such an initiative today? With changes in the social structure, the employee wondered if the commitment and time needed would still be present.



In the formation of CHS areas, several unique arrangements developed. The first multi-county CHS area was Carleton/St. Louis/Lake. Bruce Rowe, district representative from Duluth, helped put the CHS system in place in Lake County, and then he worked as the CHS administrator. One multi-county area hired the regional development commission to help with the administrative work, and the public health nursing director from each of the four counties took turns acting as the CHS administrator.

The CHS Act was originally skewed with the greatest benefit being received by poor counties that had been trying to implement public health activities. This was changed through legislation in 1986. The year 1985 was used as a base for future funding, and

[921] Conversation with Robert Hiller, January 29, 1999.

any new money was distributed on a per capita basis. This was most advantageous to cities and rapidly growing areas.

In 1987 the Community Health Services Act became the Local Public Health Act. This change was made following a review of all state statutes related to local public health by the State Community Health Services Advisory Committee (SCHSAC). This review was made to clarify the relationships between statutory, departmental and local authorities.

The committee was formed to provide consultation and make recommendations to the health commissioner. Comprised of representatives from each community health board in Minnesota, SCHSAC has worked with the commissioner to develop public health policy and address legislative and other issues impacting state and local public health agencies. Meetings have often been active and loud, as issues were discussed and decisions made. Those in attendance might not have agreed, but they usually left with a clear understanding of the policy.

Work by the SCHSAC has been accomplished through task forces, committees and groups. In addition to regular planning and administrative committees, SCHSAC addresses issues of concern, often producing reports and recommendations. Special task forces and work groups that have existed since 1979 include the following and are indicative of the public health areas of concern in the local community:

- Home Care Task Force, 1979-81
- Environmental Health Policy Study, 1979
- Long Term Care Task Force, 1982-83
- Emergency Medical Services Task Force, 1982-84
- Fellowship for Physicians in Community Health Planning Task Force, 1985
- Environmental Health Task Force, 1986
- Environmental Health Work Group, 1987, 1992
- Health Promotion Work Group, 1987
- Community Emergency Medical Care Work Group, 1987-88
- HIV Subcommittee, 1988
- Home Care Subcommittee, 1989
- Disease Prevention and Control Agreements Subcommittee, 1989
- Water Well Attachment Review Group, 1990-91
- Interagency Community Health and Social Services Subcommittee, 1990-93
- Chemical Health Promotion Work Group, 1991
- Public Health Nuisance Control Work Group, 1991
- Immunization Review Group, 1992
- Health Care Reform Work Group, 1992
- Health Care Reform Implementation Work Group, 1993-94
- Violence Prevention Work Group, 1993-94
- Well Moratorium Work Group, 1994
- Capacity Building Action Team, 1994-95
- Assurance Work Group, 1994
- Assurance Under Managed Care Work Group, 1995
- Disease Prevention and Control Work Group, 1996
- Environmental Health Services Review Group, 1996
- Correctional Health Work Group, 1997
- Local Public Health and Hospital Coordination Work Group, 1997
- Clarifying Roles in a Changing Health System Review Group, 1997
- Public Health Governance/Education Work Group, 1998
- Local Public Health Accreditation Work Group, 1998
- Information Management/Integration Review Group, 1998
- Disaster and Emergency Preparedness Work Group, 1999
- Assessing Organizational Capacity Work Group, 1999
- Educational Strategies Discussion Group, 1999
- Youth Risk Behavior Endowment Review Group, 1999 [923]

The SCHSAC meets four times a year at the department in Minneapolis. Meetings are led by a chairperson who is elected for a one-year term. Chairpersons of SCHSAC have been:

1976 – Ellen Alkon
1977 – Ellen Alkon
1978 – Ray Cink
1979 – Cal Condon
1980 – Ray Eckes
1981 – Ray Eckes
1982 – Harold Trende
1983 – Vernon "Bob" Haglund
1984 – Arvid Thompson
1985 – Frank Jungas
1986 – Lee Luebbe
1987 – Richard Jacobson
1988 – Arlyn Nelson
1989 – Bill Brakke
1990 – Kal Michels
1991 – Howard Warnberg
1992 – Warren Rodning
1993 – Delores Baumhofer
1994 – Jean Michels
1995 – Mary Haug
1996 – Donald Peterson
1997 – Dean Massett
1998 – Harlan Madsen
1999 – Audrey Richardson[922]

Community health services conferences are scheduled annually. These two-day meetings, usually held in conference centers near Brainerd, are for the purpose of improving the administration and delivery of community health services in Minnesota. Conference themes vary each year, and the themes for the last years have been:

1985 – Decision Making in Community Health
1986 – Ethics and Leadership in Community Health
1987 – Collaboration for Quality
1988 – Mobilizing the Community to Promote Health
1989 – Assembling the Public Health Puzzle in the 90s
1990 – Community Health: Mission and Vision
1991 – Translating Vision into Action: Leadership in Changing Times
1992 – Public Health – Health Investment
1993 – Public Health in a Changing World
1994 – Community Health: Moving Ahead in a Competitive Environment
1995 – Today's Challenges, Tomorrow's Solutions: Shaping Policy and Practice
1996 – Twenty Years of Partnership: A Rich Heritage, A Vibrant Future
1997 – Tradition and Change: Working Together to Improve the Health of Communities
1998 – Reaching our Goals, Building our Future
1999 – A Century of Progress[923]

Implementation of the CHS Act was relatively quick and soon reached the maintenance mode. Activities were first located within the department's community development bureau. When it was eliminated in 1979, CHS activities were placed in the community services division. That division was eliminated in 1982, but replaced two years later with the community health services division. Commissioner Mary Madonna Ashton named James Parker the director of the division in 1984. When Mr. Parker died of leukemia in 1991, Ryan Church, a section chief from the division, became director.

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[922] Information from community health services division through department's library.
[923] Ibid.

In 1999 no area of Minnesota was without a locally administered board of health. Minnesota's 49 community health boards provide direction and coordination for local public health departments.

The 1976 Community Health Services Act has had its intended effect of emphasizing local government's role and responsibility in the delivery of health services. Concurrently, the department's role in delivering services to communities has been replaced with increasing focus on regulation and technical assistance. Communities are much more involved in planning, implementing and operating their public health system.

As a result of the field offices and the CHS program, Minnesota has a strong public health program at the local level – something the early formers of the department would find most pleasing.

A 1999 Minnesota Department of Health report reads:

> *"A Partnership that Works*
>
> ***The community health services partnership of state and local governments has been over twenty years in the making. The partnership works! It works because it reflects an ongoing commitment to effective public health services, and because of a shared mission of improving the health of all people in Minnesota."***[924]

Public Health Nurses: A Public Health Cornerstone

The public health nurse is one of the cornerstones of local public health services. They have not, however, always been supported by local or state government. Prior to 1916, public health nursing services in Minnesota communities were financed by voluntary and insurance agencies. This changed in 1916 when the county commissioners of Ramsey, Renville and St. Louis counties established public health nursing services.[925] Public health nursing positions were reduced during the Depression years, but federal funds in 1936 reactivated county nursing services.

> ***"WHAT SPARKS public health in Minnesota? From top state officials to families in remote rural areas, the reply is the same --- 'public health nursing.' "***[926]
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> ***Minnesota's Health*, 1953**

[924] MDH, http://www.health.state.mn.us/divs/chs/comdev.htm, 2000.
[925] MDH (local health administration division), "Growth of Local Health Services in Minnesota," December, 1956.
[926] MDH, *Minnesota's Health,* Vol. 7, No. 6, June 1953, p. 1.

Through much of the period from 1949 to 1999 there was a shortage of county public health nurses. Several initiatives were attempted to increase the supply. On March 5, 1947, Gov. Luther Youngdahl signed a bill that set aside $130,500 annually for state aid to counties wishing to employ public health nurses.[927] Eligible counties could receive $1,500 a year, which covered about half the cost of nursing services in 1947.[928] In 1962, counties could still receive the $1,500 stipend from the state for nursing services, but at that time the amount covered only about a fourth the cost.[929] The stipend remained available through 1965.

District Public Health Nurses, 1958
(l to r) Mary Johnson, Helen O'Dair, Dagmar Johnson, Alberta Wilson, Ruth Abbott, Jane Sheehan, Evi Altschuler, Helen Farrington, Marion Nielsen

In 1950, 64 counties in Minnesota had organized public health nursing services. By December 1952, there were 83 public health nurses serving 57 counties. Other public health nurses served schools and industrial plants.[930] The recommended ratio of public health nurse to population was 1 to 5,000, but in Minnesota there was only one public health nurse for every 15,000 people.[931] In order to meet the demand, counties sometimes had to seek help from volunteers, such as from nursing auxiliaries and laypersons.

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[927] MDH, *Minnesota's Health,* Vol. I., No. 1, March 1947, p. 1.
[928] BOH, *Minutes,* May 23, 1962, MHC, p. 213.
[929] MDH, *Minnesota's Health,* Vol. VI, No. 11, December 1952, p. 4.
[930] Ibid.
[931] MDH, *Minnesota's Health,* Vol. 8, No. 1, January 1954, p. 4.

By 1956 there was a total of 724 public health nursing positions in Minnesota. Of these, 165 were public health nursing positions in rural cities and schools; 431 were positions within health agencies, schools and industries in Rochester, Minneapolis and St. Paul; and 128 were positions in 70 Minnesota counties.[932]

In 1962, most counties had at least one public health nurse. Thirteen had two, one had three, Ramsey had eight, St. Louis had 13, Hennepin had 14 and Olmsted had 15. Fourteen counties, however, still did not have nursing services.[933] Only one county in Minnesota, Olmsted, had the recommended ratio of one public health nurse per 5,000 people in 1962.[934]

While there was a need for public health nurses in general, there was a particular need in the areas of rehabilitative nursing for patients with chronic illness, maternal and child health, school health and accident prevention. A rapidly growing need existed in home nursing care for the aged. To address this need, in 1955 the Legislature passed the Public Health Nursing Law.[935] This law authorized county health boards to hire licensed practical nurses and registered nurses to assist public health nurses with home care. Legislation also made it possible for the county board to accept fees for these services. In 1955 the Board of Health was empowered to set standards and to certify public health nurses.[936]

Later, in 1963, an amendment to the law permitted counties to employ home health aides to help public health nurses.[937] It allowed counties to collect fees for the services of home aides. The Board of Health, charged with setting the fees, in 1963 determined that a county could charge users of this service $1.50 per hour.[938]

Nursing Newsletters

One method public health nurses used to spread their message was through newsletters. In the late 1940s and early 1950s, there were three different newsletters related to nursing produced at the department.

From 1948 to 1952 the department's public health nursing section published a bi-monthly newsletter, *What's Going On*, filled with information on resources for public health nurses and updates on relevant policies. This newsletter was also a means of information exchange, sharing reports from district offices. The newsletter was originally intended for rural public health nurses, but requests were received from directors of urban public health nursing agencies and schools of nursing in Minnesota.

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[932] MDH (local health administration division), "Growth of Local Health Services in Minnesota," December, 1956.
[933] BOH, *Minutes*, May 23, 1962, MHC, p. 213.
[934] BOH, *New Dimensions for Minnesota: Planning Guide for 1963-1973*, p. 22.
[935] Minnesota State Statute 144.08.
[936] MDH (local health administration division), "Growth of Local Health Services in Minnesota," December 1956.
[937] MDH, *Minnesota's Health,* Vol. 17, No. 5, May 1963, p. 3.
[938] BOH, *Minutes,* May 20, 1963, MHC, p. 379.

In 1952 a decision was made to discontinue the newsletter and absorb its contents into an enlarged *Minnesota's Health*, the department's official newsletter.[939]

Another nursing newsletter, *Nursing Home News*, was sent out every other month to chronic and convalescent homes, county welfare boards, public health nurses, and other individuals and agencies interested in improving care of aged and chronically ill. It was intended as a medium for the exchange of ideas and to bring attention to the work being done in these facilities. [940] Published from 1948 through 1951, the newsletter was produced by the department's hospital licensing unit. Publication ended when the Minnesota Association of Nursing Homes voted to begin publishing *The Nursing Home Voice*. Existing information and reports would be included in this new publication.

Nursing in Industry was a third newsletter targeted at nurses, this one for those who worked in the field of industrial health. Like the other newsletters, this publication provided a forum for exchanging ideas, as well as providing information.[941] Produced monthly by Heide L. Henriksen, R.N. and industrial nursing consultant, the newsletter was published until February 1952. All recipients were then placed on the mailing list of *Minnesota's Health*, in an effort to reduce duplication.

Public Health Nursing Section

Public health nursing is one of a few department sections that has been located in more than one division. Between 1949 and 1999 the section has been part of five different divisions.

In 1949, it was located within the special services division, and in 1956 was moved to the newly created local health administration division. It remained there until 1963 when it was transferred to the administrative services division. The move was made to emphasize the broader role public health nursing had, its activities considered departmental, rather than confined to one division.[942] When the community services and development division replaced the local health administration division in 1973, community nursing was included as one of the sections. In 1982, the community services division was eliminated, and public health nursing was placed in the disease prevention and control division where it remained until 1984. At that time it was placed in the recreated community health services division and has remained there.

Public health nursing has had five different directors between 1949 and 1999. Ann Nyquist was director through 1954, and Alberta Wilson followed her, serving from 1955 to 1971. After Alberta Wilson came Francis Decker, LaVohn Josten and Mary Rippke, who assumed the position as chief in 1992.

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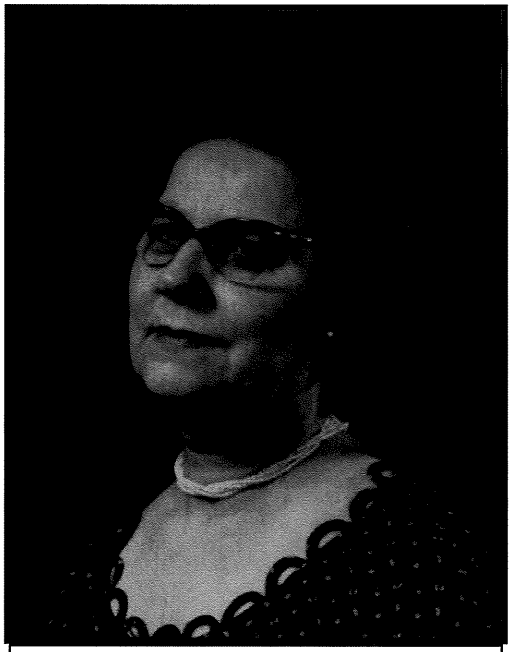
[939] MDH, *What's Going On*, March 1952, PHN-479.2.
[940] MDH, *Nursing Home News,* Volume III, No. 4, October, November and December 1951, p. 1.
[941] MDH, *Nursing in Industry,* Vol. 1, No. 1, October 10, 1944, PHN-95-1, p. 1.
[942] BOH, *Minutes,* January 22, 1963, MHC, p. 19.

Notable Public Health Nurses

Throughout the years, there have been many public health nurse greats. One of the pioneer public health nurses was Caroline G. Walz. She resigned in 1951 after serving the people of Crow Wing for more than 23 years. Regardless of blizzards or other bad conditions, she provided services to families and she "set a goal for others to duplicate."[943]

Ann S. Nyquist joined the department in 1925 and was director of the public health nursing program from 1941 until her death in 1954. According to department files, she was "well known...as a type of person who never seeks publicity for herself but who has done a marvelous job and deserves the highest commendation."[944] A film about public health nursing, "Your Friend in Blue," was produced by the department and two other voluntary organizations in 1949. Ann Nyquist had a major role in producing the film, and it was dedicated to her.[945]



Ann Nyquist

In 1966, Mary Johnson, a public health nurse for more than 35 years, retired from the department. Dr. Robert Barr first knew Miss Johnson when she was a county public health nurse in Traverse County. He was athletic coach at Wheaton, and they ate at the same boarding house.

Miss Johnson began with the department in 1929, a time when the Depression caused a large load of relief work to be added to the public health nurse's duties. She also worked during World War II, another time when the demands on the public health nurse increased. As a public health nurse into the 1960s, Miss Johnson was faced with providing home nursing care for the aged, the sick, the disabled, the mentally ill and the mentally retarded. Traditional duties, including pre- and postnatal visits, tuberculosis case finding and follow-up, and immunizations were part of her duties.[946]

Laura Hegstad joined the department in 1931. A 33-year veteran of public health, she received the Board of Health's certificate for meritorious service when she retired on July 14, 1964. Later, in 1965, she was awarded the Albert Justus Chesley Award by the Minnesota Public Health Association..

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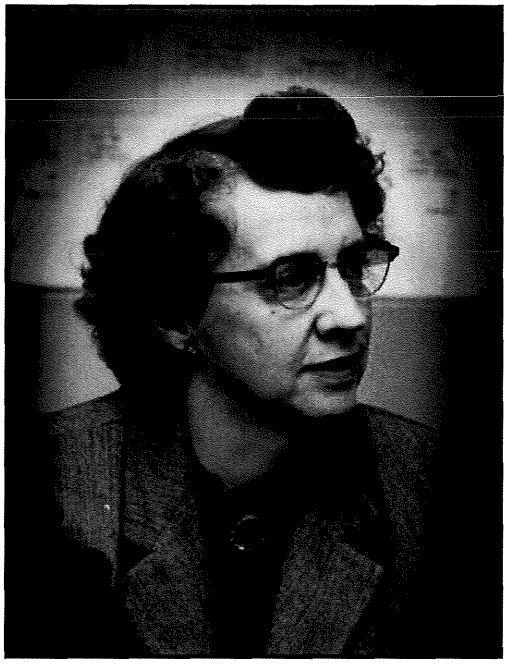
[943] MDH, *Minnesota's Health,* Vol. VI, No. 1, January 1952, p. 2.
[944] MDH files kept at the Minnesota Historical Center.
[945] MDH, *Minnesota's Health,* Vol. 9, No. 1, January 1955, p. 2.
[946] MDH, *Minnesota's Health,* Vol. 20, No. 1, January 1966, pp. 1 and 4.



Alberta Wilson

Alberta Wilson, R.N., M.S., active in many organizations, worked at the department from 1953[947] until her retirement in 1971. Named chief of the public health nursing section at the beginning of 1955, Ms. Wilson was known to tug at her belt, and say, "I have to go work with the boys." Alberta Wilson had the distinction of being the department's first female employee to wear slacks to work

Eleanor Conrad was a public health nurse from St. Cloud. She worked on developing home health services statewide. Ann Moorhous joined the department as a public health nursing advisor in community services in 1974. Some of the many other public health nurses who worked at the department from 1949 to 1999 include:

Ruth Abbott
Ev. Altschuler
Helen Farrington
Dagmar Johnson
Linda Keller
Sara Mullett
Roxanne Newland
Marion Nielsen
Helen O'Dair
Mary Rippke
Jane Sheehan
Cheryl Smoot
Terry Tange from Bemidji
Lorene Wedeking

[947] MDH employee records.