MEEKER-McLEOD-SIBLEY COMMUNITY HEALTH BOARD

McLeod County Solid Waste Large Conference Room
1065 5th Avenue SE, Hutchinson MN 55350

July 13th, 2017
9 AM to 11 AM
Agenda

1. Meeting called to order

2. Welcome and Introductions

3. Additions to the Agenda

4. Approval of May 2017 meeting minutes*

5. Presentation: *Creating Opportunities for Everyone to Be Healthy*

6. Review of Community Health Assessment* and MMS Community Health Improvement Plans*
   ***Action Item**:* Approve MMS Community Health Improvement Plans

7. Review of MN State Statute 145A and required Essential Local Activities*
   Action Item: Performance Management Policy*

BREAK

8. Staffing Issues
   ***Action Item*:** Community Health Planner Positions
   Action Item: Project Harmony Recovery Coach Position

9. Review of 2016 Annual MMS CHB Report*

10. Fiscal Officers Report*
    Action Item: Approval of Fiscal Officers Report

11. Administrative Items

    a. Approval of additional funding for Project Harmony
    b. Approval of Family Planning amendment
    c. Approval of PHEP contract
    d. Approval of TANF contract
    e. Approval of MNRAA contract
    f. Approval of American Lung Association contract

12. Updates
    a. SCHSAC*

Adjourn

Attachments:

- May 2017 Meeting minutes

- Collective Action Community Health Assessment
- MMS Community Health Improvement Plan
- Essential Local Activities
- MMS Performance Management Policy and Procedure
- MMS CHB 2016 Annual Report
- Fiscal Officers Report
- SCHSAC Take Home Points

2017 Meeting Dates

July 13th 9-11
August 10th 9-11
October 12th 9-11

Large Conference Room
McLeod Solid Waste Bldg

Public Health
Prevent. Promote. Protect.
Meeker McLeod Sibley
Community Health Services

Meeker-McLeod-Sibley Community Health Services

1805 Ford Avenue, Suite 200
Glencoe, Minnesota 55336

Direct Line (507) 766-3531
Fax Number (320) 864-1484

MEEKER-McLEOD-SIBLEY COMMUNITY HEALTH BOARD Meeting Minutes
Thursday, May 25th , 2017
McLeod County Household Hazardous Waste Building, Hutchinson

Board Members

Beth Oberg…….present	Joe Tacheny……..absent	Ron Shimanski……present
Joe Nagel……absent	Bill Pinske……..present	Bobbie Harder…....present
Mike Housman…..present	Doug Krueger…….absent	Joy Cohrs……..absent

Staff Present

Diane Winter……..present	Jennifer Hauser……..present	Allie Freidrichs……present
John Glisczinski …present	Rachel Fruhwirth……present	Colleen Robeck….absent
Kerry Ward…….present		

Guests: Roxy Traxler-Sibley County Administrator, Paul Viring-Meeker County Administrator, Vince Traver-McLeod County IT Director, Scott Lepak-Attorney at Law

1. **Meeting called to order –** Chair Bobbie Harder called the meeting to order

2. **Additions to the Agenda** Motioned by Bill Pinske and seconded by Mike Housman. Motion carries

3. **Approval of April 13th 2017 meeting minutes*** Motion by Ron Shimanski seconded by Beth Oberg. Discussion- Bobbie Harder asked that in the SCHAC update change state to stories. Motion carries.

4. **CHS Administrative Services- Scott M. Lepak, Attorney at Law**

   a. **Office Space Options*** 150 to 200 square feet per office unless cubicles and a meeting room for 20 to 35 people. ***HHW option***- components need to be discuss why Vince from McLeod IT here, also a conversation from Sarah at HHW regarding cost to rent still under exploration. Paul Viring from Meeker shared contracts with McLeod County to explore how they rent out space in their Family Service Center. Scott and Sarah are working on figuring this out with hopes that there would be answer within a month or so. If breaking away, phones, internet, copier/printer etc. would have to be figured out***. Hutchinson options*** were shared. The one that Allie toured – the company is willing to come present at a future board meeting. A price is not known. The landlord would have to make improvements on top of what a rental fee would be. Cubicles with an executive office and a meeting room would be needed as a set up. Commissioners request price per square foot (which includes utilities and cleaning) along with pricing IT/Phone Support from McLeod County. ***BusinessWare Discussion***- Vince and Allie will be following with them as their proposal is not clear. The quote had to options- one for hosting and one for having equipment on proposed site. Discussion of support between County

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employees vs. CHS employees. Marco might be also looked into Research will continue.

b. **Job Classification and Study Options*** Proposals and a summary document was shared with the board. Options were reviewed with the board. Keystone would classify the job description using the McLeod System piggy backing what has already been done. Some clarification is needed. Discussion on the job descriptions and the possibility of combining the WIC Coordinator and WIC Dietitian. So that is why there is variability of the option provided by Keystone (4 to 5 position reference). Grades for job descriptions were placed to the closest comparable in the McLeod County system. Discussion of budget impact, there are dollars that can be shifted to work needed for job classifications as one subcontract was not renewed for 2017. Job descriptions would have to be revised internally by the CHS prior to working with consultants. Allie felt she would get more support from Springsted with the revamp of job description and further research for other positions, Motion made by Beth Oberg and seconded by Ron Shimanski. Discussion took place regarding if four months is the true time and it was asked if a contract would be signed for this services. Motion carries.

c. **Approval of MMS CHB Medical Consultant Contract*** This contract was sent to the board prior to the meeting. Adjust the insurance and listed as an additional insurer. Per diem of $40.00 a meeting and $80.00 a day patterned from the McLeod scale. Clarification on the contract presented regarding the $75.00 an hour. This would be a charge if for example the consultant needed to read thru a standing order that might be sent over to her. The per diem is charge if she attends the meeting or multiple meetings within a day and does not get paid the hourly rate then. Motion made by Mike Housman and seconded by Bill Pinske. Motion carries.

5. **Administrative Items**

a. Approval of Federal Mileage Rate- Motion by Bill Pinske and seconded by Beth Oberg. 53 ½ cents mileage reimbursement Discussion on what kind of mileage is being submitted so some reimbursement is offered thru grants to help defray the cost. Motion carries.

b. Approval of Pier Diem for Medical Consultant- Motion by Beth Oberg and Seconded by Mike Housman. Motion carries.

6. **Additional Meeting Dates and Work Session options** Motion made by Ron Shimanski and seconded Mike Housman to have an additional meeting August 10th from 9am to 11am at the McLeod County HHW Large Meeting Room. Motion carries.

Adjourn- Motioned by Doug Krueger and seconded Bill Pinske to adjourn. Motion carries.

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Attachments:

- April 13th 2017 Meeting minutes
- Office Space Options
- Cornerstone Commons Brochure
- Commercial Realty Solutions Brochure
- Lease Agreement with McLeod County
- Job Classification and Compensation Options
- Springsted Proposal
- Keystone Compensation Services
- Bjorklund Compensation Consulting
- Medical Consultant Contract

2017 Meeting Dates

July 13th 9-11
October 12th 9-11
Large Conference Room
McLeod Solid Waste Bldg

_____
Mike Housman, Secretary

Clarification of Required Local Public Health Activities [DRAFT]

The Minnesota Department of Health (MDH) is responding to requests for clarity about the mandated activities that community health boards must undertake in order to meet statutory obligations under the Local Public Health Act (Minn. Stat. § 145A).

The Local Public Health Act provides specific authorities and responsibilities to community health boards in order to protect and promote health in Minnesota. The statute defines six areas of local public health responsibility:

Assure an Adequate Local Public Health Infrastructure 2

Promote Healthy Communities and Healthy Behavior 5

Protect Against Environmental Health Hazards 6

Prepare and Respond to Emergencies 7

Assure Health Services 9

Prevent the Spread of Communicable Diseases 10

The required activities for each area are detailed in the following pages. This document lays out the minimum, or foundational activities. Community health boards should conduct additional public health activities to address local priorities.

This document is a rewrite and update of the Essential Local Public Health Activities Framework adopted by the State Community Health Services Advisory Committee (SCHSAC) and the Minnesota Department of Health in 2005. That framework identified the essential (or basic, indispensable, and necessary) activities that are the responsibility of every community health board in Minnesota.

Next Steps

MDH will elicit feedback on the clarity of these activities and will compile and consider all feedback before finalizing the document. Later this summer, CHS administrators will be asked to report on current capacity to provide them. Findings on current capacity to provide these activities will be brought to a SCHSAC workgroup that will convene this fall to study how we can strengthen public health across the state.

Questions

If you have questions about this feedback process, please contact either Deb Burns (651-201-3873, debra.burns@state.mn.us) or Chelsie Huntley (651-201-3882, chelsie.huntley@state.mn.us).

Assure an Adequate Local Public Health Infrastructure

By maintaining the basic foundational capacities to a well-functioning public health system that includes data analysis and utilization; health planning; partnership development and community mobilization; policy development, analysis, and decision support; communication; and public health research, evaluation, and quality improvement (Minn. Stat. § 145A)**.**

Local Public Health Activities

Maintain a **local governance structure** for public health, consistent with state statutes. At a minimum, the community health board must:

- Have at least five (5) members and must elect a chair and vice-chair.
- Hold at least two (2) meetings per year.
- Appoint, employ or contract with a community health services (CHS) administrator who meets personnel requirements to act on its behalf.
- Appoint, employ, or contract with a medical consultant to provide advice and direction to community health board staff.

Develop a **comprehensive assessment** of the health of the jurisdiction's population and the broad range of factors that impact health at least every five years. At a minimum, the assessment must:

- Be developed through a collaborative assessment process that includes a range of community stakeholders who represent a variety of sectors in the jurisdiction and representatives from populations that are at higher health risk or have poorer health outcomes than the general population;
- Include data and information from a variety of sources;
- Describe the demographics of the population; health issues of the population; factors that contribute to health issues; and existing resources that can be mobilized to address them;
- Describe the existence and extent of health disparities, and the social determinants that contribute to them;
- Shared with community stakeholders and be accessible to the public;
- Be submitted to the Commissioner of Health.

Use data and information from the community health assessment to develop a **community health improvement plan** at least every five years. At a minimum, the plan must:

- Be developed through a collaborative planning process that includes:
    - A range of community stakeholders who represent a variety of sectors in the jurisdiction representatives from populations that are at higher health risk or have poorer health outcomes than the general population;
    - Issues and community assets identified by the community and stakeholders
    - A process to set health priorities

- Include community health priorities, measurable objectives, improvement strategies, and activities with time-framed targets
- Include consideration of the social determinants of health and health inequities
- Include policy changes needed to accomplish objectives
- Designate individuals and organizations responsible for implementing strategies
- Consider relevant state and national health improvement priorities
- Be submitted to the Commissioner of Health

Implement, monitor, and revise (as needed) the strategies in the community health improvement plan. At a minimum, the community health board must:

- Track actions taken;
- Assess the feasibility and effectiveness of the strategies;
- Make revisions with community stakeholders as needed; and
- Produce an annual report of progress and make it available to the public.

Seek resources for community health issues based on data and/or community priorities. At a minimum, the community health board must:

- Consider the income and expenditures required to meet local public health priorities and statewide outcomes in levying taxes.
- Provide at least a 75 percent match for the State funds received through the local public health act grant. Eligible match funds include local property taxes, third party reimbursements, fees, other local funds, donations and non-federal grants.

Maintain a **performance management** system to monitor achievement of organizational objectives and apply quality improvement tools and methods as needed.

Develop and maintain a competent workforce, including recruitment, retention, and succession planning; training and performance review and accountability. At a minimum, the community health board must:

- Maintain expertise sufficient to carry out the foundational activities in each of the six areas of public health responsibility.
- Employ a workforce that reflects the cultural and ethnic composition of the jurisdiction.

Provide information and community health data to the community. At a minimum, the community health board must:

- Maintain relationships with the media.
- Ensure materials meet accessibility standards, health literacy needs, and use appropriate communication format(s) and language(s).
- Maintain a public-facing website with updates made to content no less than annually.

Maintain effective community engagement practices that comply with national standards. These include:

- Implementing strategies with stakeholders, partners and the community including populations most affected by health issues, and
- Participating in community coalitions cross-sector private, public, and nonprofit partners that address community conditions, such as housing, transportation, criminal justice, and community planning and development, among others.

Maintain effective business practices that comply with existing standards. These include IT infrastructure and maintenance, interoperability of data systems, fiscal management and procurement systems, safe and accessible facilities, and legal services.

Annually **report to the Commissioner of Health** on a set of performance measures and be prepared to provide documentation of ability to meet the performance measures.

Participate in or maintain awareness of statewide deliberations to improve Minnesota's state-local public health partnership, including the Statewide Community Health Services Advisory Committee (SCHSAC).

Promote Healthy Communities and Healthy Behavior

Through activities that improve health in a population, such as investing in healthy families; engaging communities to change policies, systems, or environments to promote positive health or prevent adverse health; providing information and education about healthy communities or population health status; and addressing issues of health equity, health disparities, and the social determinants to health (Minn. Stat. § 145A)**.**

Local Public Health Activities

Maintain an awareness of trends, new data and emerging health issues related chronic disease, injuries, maternal, child and family health, and mental wellbeing in in the jurisdiction. At a minimum, the community health board must monitor:

- Leading causes of death and disability;
- Trends in disease rates;
- Trends in birth outcomes;
- Trends in health behaviors; and
- Social conditions that influence health behaviors and outcomes.

As data becomes available, or no less than annually, **inform policy makers and other stakeholders** of trends, new data and emerging issues related chronic disease, injuries, maternal, child and family health, and mental wellbeing and potential policies or strategies that promote positive health or prevent adverse health in the jurisdiction.

Implement at least two health promotion strategies based on community needs and priorities. At a minimum, the community health board must:

- Engage with population(s) most affected by the health issue(s) to develop and implement the strategy;
- Implement strategies that are evidence-based, rooted in sound theory, practice-based evidence, and/or promising practice;
- Implement strategies that focus on social and environmental factors that influence health or health behaviors; and
- Implement strategies in collaboration with stakeholders, partners, and the community.

Identify and address factors that contribute to health inequities.

Contribute to deliberations concerning public policy and its impact on health at least one time per year. This may include informational materials, public testimony, and/or participation in advisory or work groups tasked with providing advice or influencing policies that impact health.

Protect Against Environmental Health Hazards

By addressing aspects of the environment that pose risks to human health, such as monitoring air and water quality; developing policies and programs to reduce exposure to environmental health risks and promote healthy environments; and identifying and mitigating environmental risks such as food and waterborne diseases, radiation, occupational health hazards, and public health nuisances (Minn. Stat. § 145A)**.**

Local Public Health Activities

Include environmental health in the CHB's comprehensive community health assessment at least once every five years. At a minimum, the CHB must look at the impact of air quality, water quality, the built environment, and food safety on the health of the jurisdiction's population.

Monitor significant and emerging environmental threats to human health in jurisdiction. At a minimum, the CHB must maintain an awareness of:

- Blood lead surveillance data;
- Food, water and vector borne illness data;
- Safety of food, pools, and lodging establishments;
- Safety of drinking water sources and systems;
- Air quality alerts; and
- Extreme heat or cold events

Work with partners and stakeholders to **identify and implement strategies to address** environmental threats to human health as needed.

At least annually, **inform policy makers** of the environmental threats to human health in the jurisdiction, the prevention activities already taking place, and additional strategies for mitigating those threats.

Coordinate with others to **provide the public with information on how to protect their health** from or reduce exposure to environmental health hazards that pose a risk to human health as needed.

Support implementation of state and local laws, regulations, and guidelines that seek to protect the public's health from environmental health risks.

Comply with state statutes for removal and abatement of public health nuisances (MN Stat. 145A.04, Subds.1 (b), 7-10**.)**

Follow the Childhood Blood Lead Case Management Guidelines for Minnesota.

Maintain relationships with federal, state, tribal and local agencies with regulatory authority and/or providing environmental health services in the jurisdiction.

Prepare and Respond to Emergencies

By engaging in activities that prepare public health departments to respond to events and incidents and assist communities in recovery, such as providing leadership for public health preparedness activities with a community; developing, exercising, and periodically reviewing response plans for public health threats; and developing and maintaining a system of public health workforce readiness, deployment, and response (Minn. Stat. § 145A)**.**

Local Public Health Activities

Conduct or participate in **assessments** to identify hazards that impact the public's health at least every five years. Assessments must be done in conjunction with key stakeholders such as emergency management and healthcare coalitions.

Develop, exercise and maintain preparedness and response strategies and plans to address public health needs during a natural or other disasters and emergencies. At a minimum, the community health board must:

- Participate in jurisdiction's response planning, and ensure public health is in the jurisdiction's all-hazards plan.
- Include access and functional needs of at-risk individuals in plans.
- Maintain public health preparedness plans according to the Centers for Disease Control and Prevention's (CDC's) public health preparedness guidance as it pertains to your role and responsibilities in your jurisdiction.
- Exercise plans with partners at least twice per year.
- Coordinate and exercise plans with health care coalitions.
- Maintain a local continuity of operations plan.

Respond and support recovery efforts in incidents with an impact to the public's health. In the case of an incident, the community health board must:

- Activate public health emergency response personnel.
- Coordinate with federal, state, and county emergency managers and other community partners active in the response.
- Operate within, and as necessary lead, the jurisdiction's incident command system.
- Provide efficient and appropriate situation assessment, determine objectives for the health needs of those affected, allocate resources to address those needs and return to routine operations.
- Develop short and long-term public health goals for recovery operations.
- Activate plans for mass prophylaxis as indicated by the Commissioner of Health (Minn. Stat. § 144.4197, 144.4198).

Develop and maintain a system of public health workforce readiness, deployment and response. The community health board must:

- Follow the Federal Emergency Management Agency's (FEMA's) National Incident Management System for preparedness training.
- Have notification procedures and activation structure for staff and volunteers.
- Test call-down of staff at least once per year.

Provide timely, accurate and appropriate information for elected officials, the public, the media, and community partners in the event of a public health emergency. At a minimum, the community health board must:

- Coordinate with state, local and tribal partners to ensure unified messaging.
- Provide information to the public in a variety of languages as determined by local need.
- Follow the Health Alert Network (HAN) operational guidelines from the Minnesota Department of Health (MDH).
- Provide the community with information about how to protect their health.

Enforce emergency health orders as directed by the Commissioner of Health or as needed.

Establish and maintain relationships with state, and local emergency management, tribal governments, health care coalitions, community partners and state agencies.

Assure Health Services

By engaging in activities such as assessing the availability of health-related services and health care providers in local communities, identifying gaps and barriers in services; convening community partners to improve community health systems; and providing services identified as priorities by the local assessment and planning process (Minn. Stat. § 145A)**.**

Local Public Health Activities

Assess the availability and accessibility of health care services at least once every five years. At a minimum, the community health board must:

- Engage in a collaborative process with the health care system and other stakeholders;
- Identify populations who experience barriers to health care services;
- Identify of gaps in services and barriers to care;
- Consider of emerging issues that may impact access to care (e.g. changes in the structure and the health care system, changes in health care reimbursement);

Inform policy makers and other stakeholders about the gaps in the accessibility of health care services.

Lead or participate in collaborative efforts to increase access to health care services as indicated by data and/or community priorities. The collaborative must be working to implement at least one strategy.

Prevent the Spread of Communicable Diseases

Note: Minnesota's state-local public health partnership has already clarified expectations to prevent the spread of communicable diseases in the Disease Prevention and Control (DP&C) Common Activities Framework. Since the mandated public health services for that area of responsibility are based on the activities in that framework, "preventing the spread of communicable diseases" is not included in this survey.

By preventing diseases that are caused by infectious agents through detecting acute infectious diseases, ensuring the reporting of infectious diseases, preventing the transmission of infectious diseases, and implementing control measures during infectious disease outbreaks (Minn. Stat. § 145A)**.**

The language for this area of responsibility is identical to that in the Disease Prevention and Control Common Activities Framework.

Local Public Health Activities

Designate Staff Roles for all Disease Prevention & Control Activities

1. Each local public health agency will assign a staff person(s) the responsibility of assuring that all infectious disease surveillance, prevention, and control activities as stated in the DP&C Common Activities Framework, and pursuant to Minn. Stat. § 145A, are being performed. The DP&C Coordinator role will assure:
    a) Surveillance activities, and
    b) Response to Infectious Disease, and
    c) Maintain their contact information in the Workspace.
2. Assure local staff is responsible for disease surveillance activities. Staff will:
    a) Enter contact information into Workspace
    b) Submit electronic reporting including the Minnesota Electronic Disease Surveillance System (MEDSS);
    c) Maintain current lists of all providers within jurisdiction;
    d) Assure reporting rules, report cards and MDH toll free reporting phone number (1-877-676-5414) are available to all medical clinics and laboratories, and hospitals;
    e) Respond to inquiries from reporting sources; and
    f) Forward any reports of cases or suspect cases to MDH.
3. Designate staff within the local public health (LPH)/CHS agency to assure infectious disease responsibilities for
    a) Tuberculosis (TB)
    b) Sexually transmitted disease (STD)/HIV
    c) Vaccine-preventable disease surveillance
    d) Refugee health
    e) Flu

f) Immunization Practices Improvement (IPI) visits
g) Foodborne/vector borne diseases
h) Perinatal Hepatitis B
i) Other diseases as deemed necessary by MDH and LPH/CHS.

Disease Surveillance/Data Collection

1. Promote provider compliance of infectious disease reporting pursuant to Minn. Rule 4605.
    a) Disseminate guidelines to local providers (e.g., vaccine schedules and recommendations; STD/HIV prevention, testing, and treatment including perinatal; TB prevention, diagnosis, and treatment; food-and waterborne illness).
2. Share surveillance data with providers at least annually.
    a) Review surveillance data with staff.
    b) Identify any local barriers to the reporting process; and
    c) Assess LPH/CHS program effectiveness.
    d) May also share data with other interested parties (e.g., CHS board, health advisory board, local legislators)
3. Assess immunization coverage levels:
    a) assess immunization levels in public health clinics, if appropriate, and encourage and support private clinic assessment using the Minnesota Immunization Information Connection (MIIC); and
    b) Share state and local immunization reports with schools, policy makers, providers, regional coordinators, and others such as daycare providers.
    c) assess gaps and barriers to age-appropriate immunizations as warranted by local immunization coverage data
4. Assess adherence to immunization practice standards (i.e., Advisory Committee on Immunization Practices recommended schedules) and provide consultation, as needed.
5. Assess health needs of the population living in the LPH/CHS jurisdiction related to infectious diseases.
6. Review current DP&C literature related to incidence of disease, barriers to health care and other needs of the public and disenfranchised from the health care delivery system.
7. Collaborate on special studies, as warranted, to better understand epidemiology of infectious diseases.
    a) Identify and/or recruit surveillance sites upon request.
8. Review the environmental health program activities related to food- and waterborne diseases and other infectious diseases with environmental etiology. Communicate surveillance data to MDH.

Disease Prevention

1. Maintain current MDH and Centers for Disease Control and Prevention (CDC) infectious disease recommendations and protocols.

   a) develop policies and plans (e.g. All-Hazards, Pandemic) to assure capacity to respond to cases of infectious disease (Minn. Rule 4605).
   b) disseminate guidelines to local providers
2. Develop and implement screening and referral strategies for high-risk groups when indicated and clinically appropriate.
3. Assure vaccines for immunizations are available, viable and properly administered. Establish and manage public immunization clinics, as needed, based on population-based assessment data. Follow best practice vaccine management standards.
   a) Participate in annual IPI Advisor training.
   b) Perform Minnesota Vaccines for Children (MnVFC) site visits with MnVFC providers.
4. Maintain and provide consumer education information based on community needs to the public and:
   a) develop local community education programs;
   b) maintain current lists of local providers and resources for people infected with STD/HIV; and
   c) develop a communication plan for infectious disease issues
   d) maintain ability receive and forward health alert information to local health care providers and others, as needed.
5. Collaborate regionally on infectious disease prevention efforts:
   a) identify staff that need training;
   b) LPH/CHS agencies in a region will exchange information on infectious disease prevention and control activities on a regular basis; and
   c) maintain contact with regional and state MIIC registry contacts.
   d) Assure immunization responsibilities are maintained
6. Follow the Health Alert Network (HAN) operational guidelines from MDH, including to:
   a) Receive and promptly acknowledge any Health Alert Network message sent by MDH.
   b) Review MDH HAN messages in a timely way, adding additional information of local relevance as appropriate, and forwarding the message to local HAN recipients.
   c) Serve as an information resource to local HAN recipients in response to HAN messages.
   d) Assure the capacity to initiate a HAN

Disease Control

1. Assist and/or conduct investigations on infectious diseases in collaboration with the MDH and/or refer information related to cases and suspect cases to the MDH.
2. In outbreak situations conduct mass or targeted immunization clinics, arranging for staffing, training, emergency supplies, and other logistical needs.

3. Proactively implement local disease control programs, as indicated, from local surveillance data and trends. These programs should then be part of the Framework and included as part of the LPH/CHS Plan.
4. LPH/CHS agencies will work with the local emergency management agency and others to develop and maintain a local Emergency Management Plan.
5. Maintain provisions for 24/7 emergency access to epidemiological and environmental public health resources capable of providing rapid detection, investigation, and containment/mitigation of public health problems and environmental public health hazards

Tuberculosis

1. Designate staff within the LPH/CHS agency to perform TB control responsibilities.
2. Assess health needs of populations living in the LPH/CHS jurisdiction:
    a) Assure that immigrants and refugees with overseas chest x-ray findings consistent with possible active TB (i.e., TB Class B1 conditions) receive medical evaluation and follow-up, as needed, after arrival in the LPH/CHS jurisdiction. Report results of evaluations to MDH.
3. Assure 100% of persons with TB disease in LPH/CHS jurisdiction complete TB treatment by providing nurse case management and directly observed therapy (DOT) or other treatment supervision according to CDC/MDH standards.
    a) Assure that infectious TB patients residing in the LPH/CHS jurisdiction adhere to appropriate infection control precautions. Notify MDH of individuals who will not adhere to precautions.
    b) Notify MDH or LPH/CHS agency of patients who are non-adherent to TB treatment.
    c) Notify MDH and refer treatment supervision and case management to another state or county if patient leaves jurisdiction before treatment is completed;
4. Conduct contact investigations on infectious TB patients in the LPH/CHS jurisdiction and report results to MDH. Notify other jurisdictions of contacts residing in those jurisdictions (i.e., Minnesota counties). Evaluate and follow-up on contacts to cases that occur in other jurisdictions and who reside in the LPH/CHS jurisdiction and report results to those jurisdictions.

Meeker-McLeod-Sibley Community Health Services Performance Management Policy and Procedure

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Purpose

This policy establishes the framework for Meeker-McLeod-Sibley Community Health Services (MMS CHS)Performance Management System to guide all planning and performance management work. The goal of the Performance Management System is to use continuous improvement to carry out the mission, vision and values of MMS CHS through consistent assessment, planning, implementation and evaluation at all levels of MMS CHS.

Rationale

The use of performance management facilitates the achievement of improved community health outcomes and also builds accountability and transparency into MMS CHS operations. MMS CHS will use population indicators and performance measures to drive improvements. Benefits of performance management include:

- Organizational alignment and the ability to identify, examine and address issues with CHS-wide implications;
- Increased ability to use data to communicate successes and tell our story
- Specific improvement projects resulting in increased efficiencies
- Increased customer satisfaction

Consistent with organizational best practices, MMS CHS engages in performance management at all levels: community(population based), agency, and program level.

Policy

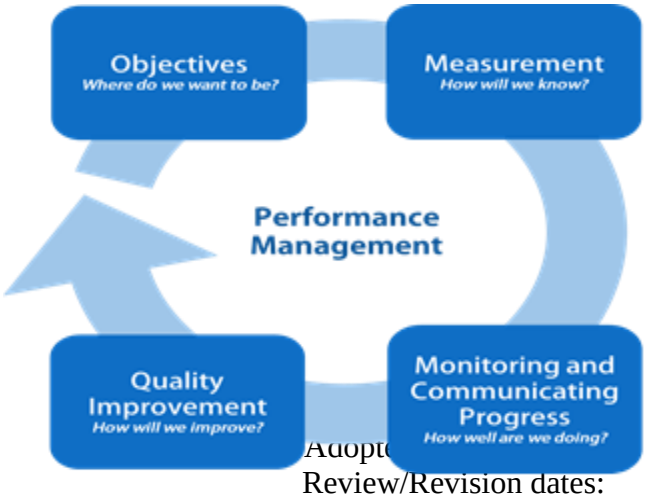
Performance management at MMS CHS is the practice of using data for decision-making by establishing results and standards; measuring, monitoring and communicating progress toward those results; and engaging in quality improvement activities when desired progress is not being made. Performance management includes the following components:

Results/Objectives – Where do we want to be?

Measurement – How will we know?

Monitoring and Communication Progress – How well are we doing?

Quality improvement – How will we improve?



Adopt

Review/Revision dates:

Performance Excellence Team Expectations

The PET consists of the Public Health Directors from each of the counties including the MMS CHS Director and staff from each of the counties. Staff were identified by each of the public health directors based on specific criteria for the nature of this work and staff interest in quality improvement and data monitoring. PET will have scheduled meeting dates on a regular basis (minimum of quarterly). PET members will make every effort to come to consensus on issues requiring a decision. However, if consensus cannot be reached, the team will make decisions by a majority vote. Final decision regarding any processes voted on will be made by the CHS Management Team which includes each of the counties Director/Supervisor and the MMS CHS Director. PET will provide overall oversight and accountability on all performance measures; community, agency, and program level.

- At a minimum PET review community level performance measures at least biannually.
- PET will complete annual agency performance management assessment
- At a minimum, progress on key agency performance measures will be reviewed biannually and opportunities for improvement identified.
- PET members will review annual performance measures submitted by program areas.
- PET will provide accountability for monitoring and reporting of performance measures by program area, by inviting teams to attend PET, or attendance at team meeting, emails, or other forms of communication
- PET is tasked with oversight of the MMS CHS Quality Improvement plan. At least annually, PET will provide a report of the QI progress to the MMS Community Health Board.
- PET is tasked with development, implementation and monitoring of the MMS CHS strategic plan
- PET members will be identified as local technical assistance (TA) advisors at the individual county level.
- Appropriate training will be provided in order for PET member to be comfortable as TA advisors
- MMS CHS key agency performance measures and the results of the biannual review will be communicated to employees.
- Identified opportunities for improvement will be referred will be prioritized and acted upon as outlined in MMS CHS Quality Improvement Plan.
- PET members will participate in the annual review and revision this policy.

Program Performance

- Each team will be responsible for identifying at least one performance measure and submit to PET on an annual basis.
- Team members will be expected to monitor and report to PET at least biannually.
- When selecting performance measures, customer satisfaction should be strongly considered
- Team members are expected to identify and submit opportunities for improvement.
- Appropriate training will be provided at least annually.

Staff Expectations

- It is expected that staff at all levels are engaged in the development and monitoring of performance measures.

Policy Adopted: July 13, 2017
Review/Revision dates:

- Staff identifying possible opportunities for improvement will submit information to PET.

Definitions

Result: A condition of well-being for children, adults, families or communities.
Indicator: A measure which helps quantify the achievement of a result.
Performance Measure: A measure of how well a program, agency or service system is working. Performance measures can be categorized into three main categories:

- How much did we do?
- How well did we do it?
- Is anyone (the customer) better off?

Quality Improvement: The use of a deliberate and defined improvement process & the continuous and ongoing effort to achieve measurable improvements. MDH has adopted the following principles of continuous quality improvement:

- Intentionally and continually looking for ways to do our work better and adapt to change
- Meeting the needs of our customers
- Empowering employees to identify and make improvements
- Using data and information for decision-making

Public Health Accreditation Board (PHAB): PHAB is a non-profit entity which was formed in 2007 to oversee national public health department accreditation.

Procedure

1. The MMS CHS Directors and Public Health Directors will establish the process and set expectations for implementation of the performance management system. Including performance measures development, data collection, monitoring, and identification of opportunities for improvement.
2. The Performance Excellence Team oversees implementation, revisions, monitoring, evaluation and reporting of the performance management system.
3. All key performance activities will be documented within appropriate action plans and meeting minutes and reported at least bi-annually to the MMS Community Health Board.

REVIEWED and APPROVED:

_____

MMS CHB Chair Date

Policy Adopted: July 13, 2017
Review/Revision dates:

Public Health
Prevent. Promote. Protect.
Meeker McLeod Sibley
Community Health Services

2016 Review of Community Health Services Board Actions

DATE OF MEETING	**SUBJECT**	**TYPE OF ACTION** *(discussion, education, information sharing, training, motions)*	**Brief Description** *(ppt, handouts provided, speaker presented, motion approved, motion denied, tabled)*
January 14th, 2016	Performance Management Progress Reports	Education	Speaker presented, handout provided
January 14th, 2016	MDH presentation- Authorities, Duties and Responsibilities of the CHS	Education	Speaker presented, handout provided
January 14th, 2016	Presentation by Janet Yeats – Hoarding Project	Education	Speaker presented, handout provided
April 14th, 2016	CHA and Performance Management Update	Education	Speaker presented
April 14th, 2016	Discussion on the need for a Record Retention Policy	Information	Discussion took place
July 14th, 2016	Update on the progress for CHA/CHIP; Strategic Plan, Performance Management	Education	Speaker presented, handout provided
July 14th, 2016	Food Pool and Lodging Presentation by MDH	Education	Speaker presented, handout provided
October 13th, 2016	Community Health Services Bylaws Approval	Motion needed	Motion approved
October 13th, 2016	Children of Incarcerated Parents: The County's Role Presentation given by Rebecca Rebecca Shlafer Nealy Assistant Professor U of M	Education	Speaker presented, handout provided
October 13th, 2016	Update on Performance Management	Education	Speaker presented, handouts given

MEEKER - MCLEOD - SIBLEY COMMUNITY HEALTH SERVICES
2017 STATEMENT OF RECEIPTS AND DISBURSEMENTS

Grant Programs	Balance Forward as of 1/1/2017	2017 Receipts			2017 Disbursements					Balance on Hand as of 6/30/2017
		Grant Dollars	Other Dollars	Total Revenue	Vendors	Meeker County	McLeod County	Sibley County	Total Expenses	
848 WIC Peer	(2,364.79)	13,621.00	0.00	13,621.00	13,338.23	228.00	3,855.00	1,329.18	18,750.41	(7,494.20)
849 Immunization Grant	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
852 Project Harmony	(5,309.36)	45,232.00	0.00	45,232.00	18,752.56	11,961.68	19,350.36	3,863.60	53,928.20	(14,005.56)
853 Local Public Health Grant	182,029.32	288,506.17	0.00	288,506.17	99,106.93	37,541.80	47,363.75	27,869.21	211,881.69	258,653.80
854 WIC	(20,976.41)	328,095.00	0.00	328,095.00	65,809.47	105,465.64	97,435.42	61,721.95	330,432.48	(23,313.89)
856 FPSP	(7,042.48)	20,720.84	0.00	20,720.84	7,509.41	5,915.22	5,111.24	2,651.90	21,187.77	(7,509.41)
857 Healthy Homes	(423.29)	20,479.93	0.00	20,479.93	11.54	10,460.46	5,952.08	3,644.10	20,068.18	(11.54)
858 Early Hearing Detection & Intervention	0.00	1,600.00	0.00	1,600.00	0.00	1,150.00	300.00	150.00	1,600.00	0.00
859 Healthy Communities Activities	21,529.71	0.00	4,500.00	4,500.00	0.00	0.00	0.00	0.00	0.00	26,029.71
862 SHIP	(9,012.02)	95,771.75	0.00	95,771.75	22,146.45	26,886.38	11,038.65	40,579.01	100,650.49	(13,890.76)
866 Emergency Preparedness	(22,900.75)	41,132.37	0.00	41,132.37	27,031.59	0.00	0.00	0.00	27,031.59	(8,799.97)
872 Child & Teen Checkups (C&TC)	0.00	80,174.58	0.00	80,174.58	22.95	37,696.00	33,884.39	8,571.24	80,174.58	0.00
Total	135,529.93	935,333.64	4,500.00	939,833.64	253,729.13	237,305.18	224,290.89	150,380.19	865,705.39	209,658.18

WIC - Women Infants Children Grant

FPSP - Family Planning Special Project

SHIP - Statewide Health Improvement Program

State Community Health Services Advisory Committee (SCHSAC)

Take Home Points

Friday, June 16, 2017
Wilder Foundation, St. Paul
10:00 AM – 2:30 PM

Next SCHSAC Meeting

Wednesday, September 27, 2017, 1:00pm – 4:30pm, Breezy Point Conference Center, Breezy Point, MN

Nominations for Community Health Awards due July 19th

The annual Community Health Awards will be presented the evening of September 27th at Breezy Point. Please nominate your colleague and partners for an award by July 19th. Nomination forms and past recipients can be found online at http://www.health.state.mn.us/divs/opi/pm/awards/.

Community Health Conference Registration Opens July 14th

The Community Health Conference begins Thursday, September 28th, and ends at noon on Friday, September 29th. Conference registration and lodging/meal reservation will be open July 14th. Breezy Point offers many lodging options if you would like to share with friends. Find the details online at http://www.health.state.mn.us/chc. SCHSAC members/alternates will also be sent a memo explaining expense reimbursement related to the fall meeting and the conference.

June 16th SCHSAC Business

- There were 86 in attendance. Thirty-nine of the 51 CHBs were represented.
- The Executive Committee met via conference call in May and in-person on June 16th. The committee approved the charge for the new **Strengthening Public Health in Minnesota Workgroup**. This group will meet 3-4 times October through December to review information about the current status of public health activities across the state and to recommend steps to assure that foundational public health activities are available to all Minnesotans. Membership will be sought to represent a variety of perspectives including SCHSAC members, the Association of MN Counties, local elected officials, county administrators, CHS Administrators and public health directors, human services directors, members of local coalitions, local medical consultants, legislators and other important stakeholders. The work group will be co-chaired by the Commissioner of Health.
- **Call for Volunteers**: members are still needed for new **Infectious Disease Prevention and Control Continuous Improvement Board**. Local public health directors and CHS administrators are encouraged to volunteer by July 21st. Email Becky Buhler at becky.buhler@state.mn.us.
- SCHSAC heard from Susan Morris, Co-Chair, SCHSAC Public Health Emergency Preparedness Oversight Group. Recently, the work group reviewed the proposed 2017-2018 PHEP duties for community health boards.

FROM THE COMMISSIONER and MDH

- Unfortunately, Commissioner Ehlinger was out of town for the SCHSAC meeting. He will be traveling the state this summer hosting **"Pitch the Commissioner"** events.
- SCHSAC was introduced to the new director for the **MDH Center for Health Equity**, Mr. Bruce Thao, MA, MS. Mr. Thao has lived and worked in rural and urban communities across the United States, but now calls Minnesota home. He is deeply committed to ensuring that all Minnesotans are able to thrive and prosper. Sara Chute, who has been serving as the acting director of the Center for Health Equity since last fall, has accepted a position as the assistant director of Health Equity.
- Assistant Commissioner Paul Allwood spoke about the ongoing measles outbreak in Minnesota and informed SCHSAC that the Centers for Disease Control (CDC) issued a **health advisory on a lead testing device** used around the country by healthcare providers to test blood lead levels.
- Kris Ehresmann, Director, Infectious Disease Epidemiology Prevention and Control, shared a presentation on **current outbreaks of measles, mumps and syphilis** in Minnesota. SCHSAC members will be sent the presentation. The measles outbreak is primarily impacting unvaccinated people and many of those people are in the Somali community. Ms. Ehresmann noted that the issue is about not being vaccinated and not about ethnicity.
- Assistant Commissioner Jeanne Ayers shared news about the development of the **Statewide Health Assessment** by the Healthy Minnesota Partnership and MDH. The assessment expands the understanding of what creates health. The Partnership will be launching a group this summer focused on early childhood and health. Ms. Ayers stated that the Statewide Health Improvement Partnership (SHIP) received support during the legislative session. SHIP faced no significant cuts and a few SHIP grantees will look at opioid use in the context of their policy, environment and systems change work. Jeannette Raymond, Center for Public Health Practice, provided SCHSAC with additional details about the statewide health assessment (SHA).
- Ms. Burns congratulated **Olmsted County Public Health** on receiving national accreditation through the Public Health Accreditation Board (PHAB). So far, seven local health departments and the state health department have received accreditation.
- Brian Awsumb, MDH Budget Director, provided an overview of MDH funding and updates about the **state and federal budgets**. Slides will be sent to SCHSAC members. If Congress repeals the Affordable Care Act, without reallocating funds included in the Prevention and Public Health Fund (PPHF), public health will lose funds because the PPHF includes the Preventive Block Grant and other public health funding. More details are provided in the briefing on the ACA sent to SCHSAC members.
- Kris Lohrke, MDH, gave an update on legislation to **protect vulnerable adults**. The Office of Health Facility Complaints in the Health Regulation Division of the Minnesota Department of Health investigates complaints against licensed home care providers. If you have witnessed or know of a vulnerable adult or minor who has been the victim of physical or mental abuse, neglect, financial exploitation or unexplained injuries act now to file a complaint or report an incident. Complaints can be reported to the Minnesota Adult Abuse Reporting Center (MAARC) by calling (844) 880-1574 (toll free). You can find more information at their website here: http://www.health.state.mn.us/divs/fpc/homecare/providers/maltreatment.html

FAMILY HOME VISITING

The Family Home Visiting (FHV) section in the Minnesota Department of Health will be seeking community and key stakeholder input over the next two months regarding the recent legislation to increase state funding for evidence based home visiting. The governor and legislature awarded $12 million in funding over the next biennium and $16.5 million/year starting in state fiscal year 2020. This funding will support start-up and expansion of evidence based home visiting with a focus on collaboration at the local level. More details regarding how community and key stakeholders can provide input will follow in the next few weeks via LPHA e-mails and MDH's Tuesday Topics (can be subscribed to via the FHV section on the MDH website). Contact Dawn Reckinger at dawn.reckinger@state.mn.us with questions.

INFECTIOUS DISEASE OUTBREAKS

Kris Ehresmann, Director, Infectious Disease Epidemiology Prevention and Control, shared a presentation on current outbreaks of measles, mumps and syphilis in Minnesota. SCHSAC members will be sent the presentation. The measles outbreak is primarily impacting unvaccinated people and many of those are in the Somali community. Ms. Ehresmann noted that the issue is about not being vaccinated and not about ethnicity. MDH and local public health departments in Hennepin, Ramsey, and other impacted areas are investing staff and resources to work with 78 confirmed cases and almost 9,000 exposures as of June 16th. The newly created Public Health Contingency Fund begins on July 1st and will cover resources for future costs of the measles outbreak.

MORE ABOUT SCHSAC

If you have questions or need copies of any materials sent to SCHSAC members, please contact Becky Buhler, MDH, at becky.buhler@state.mn.us or 651-201-5795.