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Mission:

To protect, maintain and improve the health of all Minnesotans..

Statewide Outcome(s):

The Minnesota Department of Health (MDH) supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

People in Minnesota are safe.

A clean, healthy environment with sustainable uses of natural resources.

Efficient and accountable government services.

Context:

MDH is the state's lead public health agency, responsible for operating programs that prevent infectious and chronic diseases and promote clean water, safe food, quality health care and healthy living. The department also plays a significant role in making sure that Minnesota is ready to effectively respond to serious emergencies, such as natural disasters, emerging disease threats and terrorism. The department carries out its mission in close partnership with local public health departments, tribal governments, the federal government, foreign countries and many health-related organizations. The department's priorities are to make Minnesota a place where communities support healthy living, and the health system is prepared to prevent poor health as well as to treat illness. Advancing those priorities requires enhancing public health capacity at the state and local levels, eliminating the significant disparities in health between different racial and cultural groups, giving children a healthy start in life, and adopting health reforms that focus on prevention and primary care as well as a better integration of medical care, public health and other needed services.

Much of Minnesota's state and local public health services are funded by the federal government. More than half of MDH funding comes from federal sources. Less than one-fifth of the budget for MDH is supported by state tax dollars through the general fund, the cigarette tax, or the health care access fund. The remaining budget comes from private grants and fees for licenses and inspections.

Strategies:

MDH's Strategic Plan has six framework goals which focus on preventing health problems before they occur. Embedded in each strategy is the overarching goal of eliminating health disparities and achieving health equity.

- **Prevent the occurrence and spread of diseases:** to ensure that individuals and organizations in Minnesota understand how to prevent diseases and practice disease prevention and disease threats are swiftly detected and contained.
- **Prepare for and respond to disasters and emergencies:** to ensure that emergencies are rapidly identified and evaluated, resources for emergency response are readily mobilized and Minnesota's emergency planning and response protects and restores health.
- **Make physical environments safe and healthy:** to ensure that Minnesotans' food and drinking water is safe, Minnesota's air, water and soils are safe and non-toxic, and the built environment in Minnesota supports safe and healthy living for all.
- **Help all people get quality health care services:** to ensure that health care in Minnesota is safe, family and patient-centered, effective and coordinated; that health care services are available throughout Minnesota and that all Minnesotans have affordable coverage for the health care they need.

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- **Promote health throughout the lifespan:** to ensure that all Minnesotans are given a healthy start in life, Minnesotans make healthy choices and Minnesotans create social environments that support safe and healthy living at all ages.
 - **Assure strong systems for health:** to ensure that Minnesota's infrastructure for health is strong, people-centered and continues to improve, that Minnesota's health systems are transparent, accountable and engage many diverse partners and that government policies and programs support health.

More information about these framework goals can be found at: <http://www.health.state.mn.us/about/goals.pdf>

Measuring Success:

MDH first identifies high priority health issues by measuring health outcomes for the entire population and for targeted subgroups. Then, MDH uses scientific data and methods available to guide programs and policies that most effectively promote the health of all Minnesotans. By relying on evidence-based strategies, MDH can generate the greatest return on the state's investment in public health.

The significant return on investment for public health programs is well-documented. The average lifespan of persons in the United States has increased by more than 30 years since 1900, and 25 years of this gain is attributable to advances in public health. Further, a person's health is largely determined by healthy behaviors (50 percent), genetics (20 percent), the environment (20 percent), and access to appropriate care (ten percent). Yet, 88 percent of our national health-related expenditures are targeted at medical services and only four percent is targeted at supporting healthy behaviors. Compared to other industrialized countries, the United States spends twice the per capita average on health care yet lags behind other countries in life expectancy and productivity loss. Therefore, targeting investments more toward programs that promote healthy behaviors, reduce environmental health risks, and improve access to quality health care will yield the highest impact on Minnesotans' health.

Each program at MDH measures specific health outcomes for Minnesotans and the effectiveness of MDH's efforts to improve those outcomes. In addition, there are a few composite measures that show whether Minnesotans' overall health is improving. For example:

- Minnesota has long been considered one of the healthiest states in the nation, but the state's health ranking has been falling relative to other states in recent years. Minnesota was consistently first or second in the nation for overall health from 1999 to 2006, but the state's ranking has dropped steadily since then, landing at sixth place in 2011. Minnesota's ranking is dropping because of declines in the factors that predict future health outcomes, such as obesity, poverty, and immunization rates—which means the state's overall health ranking can be expected to decline further in the future without major interventions (America's Health Rankings, United Health Foundation, 2011).
- Between 2010 and 2012, Hennepin County's health outcomes ranking dropped from 52nd to 42nd and Dakota County's health factors ranking dropped from second to sixth relative to other Minnesota counties, demonstrating that some of our largest and most diverse counties are struggling to keep pace with demographic shifts and factors like obesity and lack of physical activity, which lead to a variety of poor health outcomes (County Health Rankings, University of Wisconsin, 2012).

Although these measures do not reflect the diversity of public health issues and programming, and many factors affecting health are outside the control of MDH and its partners, these measures are still a useful gauge of whether Minnesota is moving in the right direction. These measures reflect that while significant progress has been made, significant challenges remain in improving the health of all Minnesotans.

Health

Community and Family Health

<http://www.health.state.mn.us/divs/cfh/connect>

Statewide Outcome(s):

Community and Family Health Division supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities.

Context:

The Community and Family Health Division works to protect and improve the health of families. It is focused on making sure that infants have a healthy start in life and that children are ready for school. It supports families in their efforts to provide stability, good food and safe homes for their children. It monitors birth defects and serves families who have children with special health needs, such as heart defects, cerebral palsy, or children with developmental delays in their ability to learn, speak, or play. It helps families access public health, primary care providers and community resources. The Community and Family Health Division helps these children grow and thrive at home, in school, and as they enter their adult lives.

In addition, the division strives to lower health care costs and improve the quality of life for children and adults with diabetes, heart disease, depression, or other chronic or disabling conditions. The division works with primary care clinics in adopting the health care home model, which is a team approach to primary care that is an effective way to improve patient experience, improve health and reduce costs.

Historically, Minnesota has scored at the top of family health measures. This success has masked the fact that families with less money, American Indian families, and those from populations of color consistently have had less opportunity for health in Minnesota and have experienced worse health outcomes. This is a pressing challenge for Minnesota, as the state becomes more diverse. This year about 30 percent of Minnesota's children under age 5 come from communities of color and, in the last five years, the number of children living in poverty in our state has increased by 25 percent.

In summary, the division works to impact those factors which best predict a child's success, such as getting a healthy start at birth, thriving in the early years, doing well in school, avoiding teen pregnancy and substance abuse, staying out of trouble, and becoming connected to their community. The division does much of its work through partnerships with local public health, tribal governments, community groups and health care providers. Its efforts are supported mostly by federal funds, with only about 16 percent of funds coming from state taxes and fees.

Strategies:

The division contributes to the statewide outcome in the following ways.

- Managing the Woman, Infants and Children (WIC) program, which is a nutrition program that helps eligible pregnant women, new mothers, infants and young children eat well, learn about nutrition, and stay healthy. Under the program, counties and tribes provide nutrition education and counseling, breastfeeding support, and health and social service referrals to low income families. The Minnesota WIC program also regulates the grocery stores and other retailers that participate in the program. Healthy eating early in life promotes brain development and healthy growth, while also helping to prevent obesity and other chronic conditions such as high blood pressure.
- Providing funds, oversight and technical assistance to community based organizations, to assure that quality pre-pregnancy family planning services are available for low-income and high risk individuals. These efforts reduce unintended pregnancies and improve pregnancy outcomes.
- Working with health care providers and local public health agencies to improve health and development screenings and follow-up services for children and infants. Children have better outcomes if their health problems or developmental delays are identified early.

- Setting standards for primary care clinics and certifying providers as Health Care Homes improves the health of individuals, their experience with their clinics and works to reduce overall health care costs.
- Supporting evidenced-based home visiting programs reduces child abuse and neglect, improves maternal and child health, helps kids be ready for school, and improves economic stability and self-sufficiency of the family.
- Collecting, analyzing and reporting data, sharing best practices with providers, local public health agencies and other stakeholders, offering training, and developing standards and protocols improves the health of women of child bearing years and their infants. These efforts encourage early access to prenatal care, provide necessary support services to high risk women and increase knowledge of healthy behaviors to reduce premature birth and infant and maternal mortality.

Results:

- Efforts related to promoting breastfeeding for the first six months of life, access to nutritious foods within the community and nutrition counseling appear to have been successful in reducing obesity in WIC enrolled young children. Breastfed babies are less likely to suffer from serious illnesses and are less likely to be obese later in life. There is a 15-30 percent reduction in adolescent and adult obesity rates if any breastfeeding occurred in infancy compared to no breastfeeding. While obesity in children receiving WIC services in Minnesota increased steadily each year from 1990 reaching a peak of 13.8 percent in 2004, the rate of obesity in 2010 was 12.7 percent indicating success in changing the trajectory of this trend.
- Home visiting is an effective method of preventing child abuse and neglect. The burden of child maltreatment is substantial to both the developing child and to society. Abusive and neglectful environments can have significant impact on brain development, with increased cost burden to the child welfare, education, mental health and juvenile justice systems. Between 2007 and 2010 child abuse has declined in Minnesota.
- Minnesota clinics have made significant progress toward becoming health care homes. The early experience in Minnesota indicates that clinics which are certified as health care homes deliver higher quality care. Since July of 2010, over 180 primary care clinics have been certified as health care homes. This means more than two million Minnesotans are now receiving care in innovative clinics that have the capacity to help their patients achieve their health goals. Evaluations are underway to see whether health care homes are improving patient satisfaction and lowering costs as anticipated.

Performance Measures	Previous	Current	Trend
Percent of infants who are breastfed exclusively through 6 months. ¹	16.1%	16.1%	Stable
Rate per thousand of children for whom a report of child abuse or neglect was substantiated. ²	4.9/1000	3.5/1000	Improving
Percent of Minnesota clinics who are certified as a Health Care Home. ³	18.5%	23.5%	Improving

Performance Measures Notes:

1. National Immunization Survey, Centers for Disease Prevention and Control. Compares 2004 to 2009.
2. Child Welfare Report, Minnesota Department of Human Services. Compares 2007 to 2010.
3. Health Care Homes, Minnesota Department of Health. Compares 2011 to 2012.

Health

Health Promo & Chronic Disease

<http://www.health.state.mn.us/divs/hpcd/index.html>

Statewide Outcome(s):

The Health Promotion and Chronic Disease Division supports the following statewide outcome(s).

Minnesotans are healthy.

People in Minnesota are safe.

Strong and stable families and communities.

Context:

The purpose of the Health Promotion and Chronic Disease Division (HPCD) is to reduce the burden of suffering disability and death from injuries, such as falls, violent traumas, workplace injuries, and poisonings, and chronic diseases, such as asthma, cancer, arthritis, diabetes, diseases of the mouth, and heart disease. The division provides leadership in the prevention of diseases and injuries by tracking and addressing these health threats, which are among the most common and prevalent health problems facing Minnesotans today.

In the last 50 years, chronic diseases and injury have emerged as the greatest threat to the overall health and well-being of people in Minnesota. Chronic diseases and injuries accounted for Minnesota's seven leading causes of death and loss of potential life in 2010. Treating chronic disease costs more than \$5 billion a year, and more than \$17 billion a year is lost due to missed workdays and lower employee productivity.

These diseases and injuries also contribute significantly to long-term disability and poor quality of life. In 2010, they accounted for the seven leading causes of death in Minnesota. They shorten people lives, and they impact some Minnesotans more than others with effects varying by gender, socioeconomic status, race and ethnicity, age, insurance status, geography, and sexual orientation. Cancer, heart disease, and unintentional injuries accounted for more than half of the potential years of life lost up to age 75 years in Minnesota in 2010. About 15 percent of the division's funding comes from the state with the remainder coming from federal funds, grants and foundations.

Strategies:

HPCD helps hospitals, clinics, doctors, nurses, dentists and other health care providers to implement changes benefiting all patients and especially those most likely to be disabled or die from a chronic disease and injury, by:

- Facilitating collaboration among public health, health systems, and primary care clinics to improve the delivery of cancer screening and other clinical preventive services;
- Developing and promoting the adoption of proven tools for managing chronic diseases, such as the interactive asthma action plans in clinics and health systems;
- Supporting guidelines and quality measures for identifying and managing chronic disease risk factors, such as obesity, asthma, pre-diabetes, diabetes, hypertension, and high cholesterol in health and clinic systems;
- Providing grants to improve health care, such as school-based dental sealant programs, clinic-based cancer screening, and poison control; and
- Recruiting and paying health care providers to offer free breast, cervical and colorectal cancer screening, follow-up cancer diagnostic services, and cardiovascular risk factor screening, referral, and counseling to low-income, uninsured Minnesotans.

HPCD facilitates links between communities and health care providers to improve the management of chronic conditions, by:

- Disseminating statewide education programs relating to self-care and disease management, such as the diabetes prevention, chronic disease self-management, and matter of balance programs;
- Developing curriculum to train community health workers to work effectively with underserved and at-risk populations to prevent and manage chronic diseases;

- Supporting health care providers, hospitals, clinics, health systems, public health agencies, and community-based organizations to implement statewide plans for heart disease, stroke, cancer, diabetes, asthma, arthritis, oral health, and injury and violence prevention; and
- Providing a grant for medical follow-up, employment, education, and family counseling sessions to Minnesotans with a traumatic brain or spinal cord injury.

HPCD develops, collects, and disseminates data, including data on health disparities, to inform chronic disease and injury prevention and management initiatives, by:

- Operating a statewide registry of all newly-diagnosed cancer cases in the state;
- Analyzing and reporting on the prevalence, disparities between different Minnesotans, and death, disability, and other trends related to heart disease, stroke, cancer, asthma, arthritis, diabetes, oral diseases, injuries, violence, and poisoning;
- Collecting, analyzing, and reporting on occupational health, to identify rates and trends of workplace hazards, illnesses, and injuries and establishing priorities for educational and intervention programs; and
- Using environmental public health tracking and biomonitoring technologies, such as analyzing human tissues of fluids, to identify possible links between chronic diseases and exposure to substances in the environment.

Results:

The 2003 Milken Institute State Chronic Disease Index ranked Minnesota 11th best among all 50 states on the cases of chronic disease per capita. The efforts of many partners across the state, including HPCD, contribute to relatively successful prevention, detection, treatment, and management of chronic diseases and injuries, but much work remains to be done. Since the increase in chronic conditions is an inevitable result of the aging of the population, the challenge for public health is to prevent the onset as long as possible and once it begins, to manage the condition for optimal well-being.

The population indicators below were taken from the draft “Healthy Minnesota 2020: Chronic Disease and Injury Framework.” The performance measures represent the broad range of programs in HPCD.

Performance Measures	Previous	Current	Trend
Years of potential life lost from chronic disease and injuries ¹	171,213	169,870	Improving
Cancer mortality disparity ratio ²	1.27	1.34	Worsening
Number of poison exposure calls funded by HPCD ³	49,632	45,756	Improving
Patients in HPCD’s stroke registry hospitals receiving appropriate therapy ⁴	35%	77%	Improving
Days of school missed per year by children with asthma in HPCD’s RETA program ⁵	7	1	Improving

Performance Measures Notes:

- ¹ Minnesota Center for Health Statistics, 2005 and 2010, combined YPLL to age 75 for cancer, heart disease, unintentional injury, suicide, stroke, diabetes, chronic lower respiratory disease, and Alzheimer’s
- ² Minnesota Cancer Surveillance System, 2000-2004 and 2004-2008, mortality rate for all cancers combined for African Americans divided by the mortality rate for all cancers combined for non-Hispanic whites
- ³ Hennepin Regional Poison Center (MDH grantee), 2002 and 2010, number of calls involving an exposure to a potentially harmful substance
- ⁴ Minnesota Stroke Registry, 2008 and 2011, percent of eligible patients treated at participating hospitals and receiving tPA therapy
- ⁵ Reducing Environmental Triggers of Asthma program evaluation data, average number of days of school missed by children in the program before participation in the program and at the 12-month follow-up visit

Health

Minority and Multicultural Health

<http://www.health.state.mn.us/ommh>

Statewide Outcome(s):

The Office of Minority and Multicultural Health supports the following statewide outcome(s).

Minnesotans are healthy

Strong and stable families and communities

Context:

The Office of Minority and Multicultural Health (OMMH) provides leadership within MDH to strengthen the health and wellness of Minnesota's communities by engaging populations of color and American Indians in actions essential to eliminating health disparities.

While Minnesota continues to be among the healthiest states in the nation, it also continues to have some of the greatest disparities or differences in health outcomes between whites and populations of color and American Indians for a host of conditions, such as breast and cervical cancer, diabetes, heart disease, and infant mortality. These differences are having an increasingly significant impact on Minnesota as the state becomes more diverse. In 2010, nearly 15 percent of Minnesotans were populations of color and American Indians compared to less than 5 percent in 1990. The majority of this population growth has been from immigrant and refugee populations with limited English or literacy skills.

Minnesota has also seen an increase in the number of families lacking the economic resources that a family needs to stay healthy. The number of Minnesota children living in poverty increased by 53 percent between 2000 and 2009. The state's children of color and American Indian children are more likely to live in poverty than whites, and they are much more likely to be uninsured. In 2011, Hispanic/Latino Minnesotans having the highest uninsured rate at 26 percent compared to blacks (17.9 percent), American Indian (14.3 percent), Asians (11.8 percent), compared to whites at (7.6 percent).

These trends indicate an increasing need for Minnesota to focus on creating opportunities for all Minnesotans to be healthy. The office strives to do this by working with its key partners, such as other divisions and bureaus within the department of health, other state agencies, including the Minnesota Department of Human Services, local public health agencies, community organizations, policy makers and researchers. Approximately two-thirds of the OMMH budget comes from the state general fund with the remainder coming from the federal Temporary Assistance for Needy Families (TANF) fund.

Strategies:

In its work toward eliminating health disparities, the Office of Minority and Multicultural Health focuses on the following activities:

- Works to collect racial, ethnic, and language data necessary to inform state, local public health, policy makers, and communities about the health of populations of color and American Indians. It also develops appropriate indicators to measure progress;
- Connects populations of color and American Indian community experts with MDH and local public health experts to identify and address actions essential to eliminating health disparities;
- Administers the Eliminating Health Disparities Initiative (EHDI) grant program, which was created by the 2001 Minnesota Legislature (MS 145.928) to close the gap in the health status of African-Americans/Africans, American Indians, Asian Americans, and Latinos in Minnesota compared with whites in the following priority health areas: breast and cervical cancer screening, diabetes, heart disease and stroke, HIV/AIDS and sexually transmitted infections, immunizations for children and adults, infant mortality, teen pregnancy, and unintentional injury and violence; and
- Holds biennial community meetings to disseminate data, obtain community recommendations on how to use data in future planning, and identify gaps in data and community input and outreach (particularly concerning limited English-proficiency populations).

Results:

There has been more attention to race, ethnicity, and language data collection within MDH and in the broader community. Reports from the MDH Center for Health Statistics on the health status of populations of color and American Indians support the ongoing need to continue to focus efforts in eliminating disparities in the eight priority health areas identified in the Eliminating Health Disparities Initiative. These include breast and cervical cancer screening, diabetes, heart disease and stroke, HIV/AIDS and sexually transmitted infections, immunizations for children and adults, infant mortality, teen pregnancy, and unintentional injury and violence. Because of the work of OMMH and its partners, there is a more widespread interest and understanding of the need to focus on health disparities in vulnerable populations, especially in populations of color and with American Indians, in order to achieve health equity.

MDH has defined and standardized the race, ethnicity, and language data to be collected agency-wide and in partnering with our community partners statewide to adopt definitions, collection standards, and to improve sharing and disseminating of data. OMMH has identified EHD priority health areas with ongoing or growing disparities in specific populations of color and American Indians in order to focus efforts on building capacity in communities to address these disparities in a culturally competent manner through EHD grants.

OMMH has issued three requests for proposals since 2010 to increase the number of community minority-led, minority-focused nonprofits able to address our health disparities with support from EHD funds. It has resulted in more than 40 new grantees during 2010-2012 with some ongoing support and partnerships with the original 52 grantees from the first EHD grants in 2001.

Performance Measures	Previous	Current	Trend
Infant mortality disparity difference between African Americans/Africans and population with the lowest rate	7.7	6.4	Improving
Infant mortality disparity difference between American Indians and population with the lowest rate	8.0	5.9	Improving
Percent of Eliminating Health Disparities Initiative grantees receiving evaluation, technical assistance and support. Goal=100%	90% of 29 grantees received technical assistance	100% of 24 grantees received technical assistance	Improving
Percent of grants given to minority-led, minority-focused organizations during each grant cycle. Goal=50%	54%	55%	Improving

Performance Measures Notes:

Infant mortality disparity difference above is the arithmetic difference between two infant mortality rates. For Measure 1 for 1995-1999, it is the African Americans/Africans infant mortality rate (13.2) - Whites rate (5.5). For 2004-2008, it is African Americans/Africans rate (10.8) – Latinos rate (4.4). For Measure 2, the disparity difference for 1995-1999 is the American Indians rate (13.5) – Latinos rate (5.5). For 2004-2008, it is the Americans Indians rate (10.3) – Latinos rate (4.4).

Data on infant mortality is for the periods 1995-1999 and 2004-2008.
 Data on grantees receiving technical assistance is for FY 2011 and FY 2012
 Data on grants awarded to minority organizations is for 2009 and 2011.

Health

Statewide Health Improvement Initiatives

<http://www.health.state.mn.us/divs/oshii/about.html>

Statewide Outcome(s):

The Office of Statewide Health Improvement Initiatives supports the following statewide outcome(s).

Minnesotans are healthy.

Strong and stable families and communities

Context:

The Office of Statewide Health Improvement Initiatives (OSHII) supports all Minnesotans in leading healthier lives, raising healthier families and building healthier communities by preventing chronic disease before it starts. Chronic diseases such as diabetes, stroke, heart disease, and cancer are among the most common, costly and preventable of all health problems in the U.S. The effects of these diseases are staggering:

- Nearly two-thirds of Minnesota adults are overweight or obese, and childhood obesity has tripled in just 30 years;
- Chronic diseases like diabetes, cancer, and heart disease are estimated to cause 35 percent of all deaths and 75 percent of all health care spending in the U.S each year; and
- Minnesota spends \$2.9 billion in annual medical costs as a result of tobacco (2007). The economic cost associated with obesity in Minnesota is \$2.8 billion (2006) and \$5.06 billion for alcohol (2007).

Research shows that four everyday behaviors – lack of exercise, poor nutrition, tobacco use, and excessive alcohol consumption – are responsible for much of the suffering and early death related to chronic diseases. But changing these behaviors can be difficult without changing everyday places – such as worksites, schools, and communities – to better support healthier choices.

To reduce the harmful effects of chronic disease, OSHII works in partnership with communities, including local and tribal public health agencies, child care sites, health systems, schools, and worksites, to:

- Increase the percentage of Minnesotans who eat more healthy foods and are more physically active;
- Reduce the percentage of Minnesotans who misuse or are harmed by alcohol and other drugs; and
- Reduce the percentage of Minnesotans who use commercial tobacco products or are exposed to second-hand smoke.

Approximately ten percent of this work is funded by the state general fund, with the remaining funding split about equally between the health care access fund and federal grants.

Strategies:

In partnership with the U.S. Centers for Disease Control and Prevention (CDC) and other leaders in public health, MDH has developed a nation-leading set of strategies for supporting healthier living. Instead of focusing on individual behavior change that may be hard to maintain over time, OSHII helps communities make sustainable, systemic changes that create widespread and lasting results. OSHII operates a number of programs including the State Health Improvement Program (SHIP).

For example, instead of trying to convince people to walk more, OSHII-funded communities may design safer, more accessible routes so people can walk more. Instead of encouraging people to eat healthier, a school or worksite may decide to work with local farmers to incorporate fresh produce into the meal plans. Instead of asking people to quit smoking, communities may ask owners of multi-unit housing to make their buildings smoke-free or work with health care providers to refer more people to tobacco quitlines.

OSHII accomplishes this by:

- Supporting change: providing grants and technical assistance for communities to create policy, system, and environmental changes that support healthier living;

- Effectively meeting local needs: helping local public health professionals and their community partners chose what will work best for them from a menu of evidence-based, proven strategies;
- Sustaining success: building public-private partnerships to create more lasting change than government can accomplish alone; and
- Measuring progress: monitoring health trends and conducting rigorous evaluation of improvement efforts.

Results:

OSHII funded programs:

- Increase the percentages of Minnesotans who are practicing healthier behaviors, leading to prevention and better control of chronic diseases;
- Contribute to the containment of health care costs through prevention and/or delay of onset of chronic diseases;
- Contribute to stronger and more stable families and communities because of the impact of healthier behaviors on improved academic achievement, worker performance, social connectedness in communities, community empowerment, and economic vitality of communities; and
- Demonstrate the value of investing in the health of the community and how this leverages the assets of individuals, families, and organizations to become more thriving communities.

During its first two years, as examples, the Statewide Health Improvement Program (SHIP):

- Supported 870 employers in implementing worksite wellness initiatives serving over 138,000 employees across the state;
- Provided healthier food options for 26 percent of all Minnesota K-12 students through Farm to School nutrition initiatives; and
- Created safe walking and/or biking routes to schools for 14 percent of all K–8 schools in the state.

Research shows that over time and with sustained statewide resources and coverage, these efforts will increase the behaviors that prevent chronic disease. For example, a recent article in the journal *Pediatrics* found that adolescents gained less weight in states that have enacted strong laws regulating the nutrition content of foods and beverages sold in schools outside of meal programs

Population Indicators and Performance Measures	Previous	Current	Trend
Healthy eating: Youth who eat the recommended number of fruits and vegetables daily – 9th grade students ¹	18.4%	18.1%	Stable
Physical Activity: Youth who meet physical activity guidelines – 9th grade students ²	47.6%	47.5%	Stable
Tobacco Use: Young adults who smoke – ages 18 to 24 ²	28.4%	27.8%	Stable
Alcohol Abuse: Adult binge drinking – age 18 and older ³	20.2%	17.2%	Improving
Farm to School initiatives in K-12 schools: Percent of students enrolled that were served by the initiative ⁴	N/A	26%	N/A
Safe Routes to School initiatives in K-8 schools: Percent of students enrolled that were served by the initiative ⁵	N/A	14%	N/A

¹ Minnesota Student Survey 1992-2010 Trends, page 38. Data is for 2007 and 200

² Minnesota Adult Tobacco Survey Tobacco Use in Minnesota: 2010 Update, page 2-18. Data is for 2007 and 2010

³ Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2010. Data is for 2007 and 2010

⁴ Grantee reports, K-12 enrollment data. Current data is for 2009-11

⁵ Grantee reports, K-8 enrollment data. Current data is for 2009-11

Health Compliance Monitoring

<http://www.health.state.mn.us/cm>

Statewide Outcome(s):

The Compliance Monitoring Division supports the following statewide outcome(s).

Minnesotans are healthy

People in Minnesota are safe

Context:

The Compliance Monitoring Division monitors compliance with laws and rules designed to protect the health and safety of Minnesota's nursing home residents, home care clients, hospital patients, developmentally disabled clients, enrollees of health maintenance organizations (HMOs) and county based purchasing plans, patients of birth centers, clients of body art establishments, and clients of certain allied health professional groups.

This activity serves patients, consumers, and providers of health care services, as well as state and local policy makers. The work involves protecting the health and safety of consumers of all ages. However, a great deal of the division's work is especially important for older Minnesotans. The need for services to support Minnesota's vulnerable adult population will increase as Minnesota's population ages. Baby boomers started turning age 65 years old in 2011, and Minnesota ranks second nationally with a life expectancy of about 79 years. The number of Minnesotans older than 65 years will increase 40 percent faster than the under-65-year-old population between 2010 and 2030, and the number of Minnesotans 85 years or older is expected to double to 250,000. Compliance monitoring is funding almost entirely by cost sharing with Medicare and Medicaid (63 percent) and fees (37 percent).

Strategies:

Compliance monitoring uses the following strategies to achieve desired outcomes.

- Monitor compliance with federal and state laws and rules designed to protect health and safety, through unannounced inspections and surveys.
- Investigate reports of maltreatment in accordance with the Vulnerable Adult Act and other complaints of abuse, neglect, or maltreatment; investigate complaints against HMOs filed by enrollees and providers.
- Conduct reviews of requests for set-asides of criminal /maltreatment cases; in limited cases, this allows persons to work even though they were found to have neglected a vulnerable adult.
- Approve architectural and engineering plans for all new construction or remodeling of health care facilities to assure that the facilities' physical plants meet life safety and health standards.
- Conduct annual reviews of at least 15 percent of Medicaid and private pay residents in certified nursing facilities to verify that payment classification matches acuity needs.
- Regulate funeral service providers to ensure the proper care and disposition of the dead.
- Regulate individuals who want to practice as audiologists, hearing instruments dispensers, speech language pathologists, occupational therapists, and body art technicians.
- Regulate body art establishments to ensure adequate health and safety standards.
- Regulate HMOs and County Based Purchasing entities to ensure compliance with statutes and rules governing financial solvency, quality assurance, and consumer protection.
- Respond to several thousand calls annually seeking information and assistance from the health information clearinghouse.
- Provide information to regulated entities regarding current standards.

Results:

The three performance measures listed below contribute to the goal that all vulnerable adults in Minnesota are safe.

Performance Measures	Previous	Current	Trend
Compliance Monitoring staff will visit each Skilled Nursing Facility and each Intermediate Care Facility for the Intellectually Disabled at least once per year. See Note 1.	Not achieved	On track to achieve	Improving
Compliance Monitoring staff handle complaints concerning vulnerable adults on a timely and accurate basis. See Note 2.	Not achieved	On track to achieve	Improving
Compliance Monitoring staff will increase the number of visits to currently licensed home care providers and visit every newly licensed home care provider within the first year of licensure. See Note 3.	Not achieved	On track to achieve	Improving

Performance Measures Notes:

Note 1: The division is on track to complete all required visits in federal fiscal year 2012. There are 384 federally certified nursing homes, and 100 percent of them were surveyed in federal fiscal year 2011; there are 212 intermediate care facilities for the intellectually disabled in Minnesota, and the division surveyed 211 of them, or 99.5 percent, in fiscal year 2011.

Source: Centers for Medicare and Medicaid Services Federal Fiscal Year 2012 mid-year performance measures and Final Fiscal Year 2011 State Performance Measures Review.

Note 2: Due to a change in federal triage interpretations, the number of investigations requiring a two-day turnaround time have increased, resulting in decreased resources available to conduct lower priority investigations within the required timeframes. However, in FY 2012, the division is on track to meet this performance measure due to a reallocation of resources.

Source: Centers for Medicare and Medicaid Services Federal Fiscal Year 2012 mid-year performance measures.

Note 3: The division had previously not been able to achieve these measures due to resource limitations. However, the department is working with stakeholders to develop a new licensure and fee structure that would enable the division to devote more resources to conducting site visits of home care providers.

Source: Compliance Monitoring Division inspection and investigation data.

Health Health Policy

<http://www.health.state.mn.us/divs/hpsc/>

Statewide Outcome(s):

The Health Policy Division supports the following statewide outcome(s).

Minnesotans are healthy

Context:

Keeping Minnesotans healthy is a team effort, involving public health, the health care system, and the public. When the health care system is not performing as effectively as possible, it diminishes the health of Minnesotans in two ways: the cascading, adverse impacts of illness and injury are more pronounced; and it consumes scarce resources that are needed for wages, jobs, education, the environment and other determinants of overall health.

Like the nation overall, Minnesota has unsustainable rates of health care spending growth. In the past ten years, health care spending more than doubled, reaching \$37.7 billion in 2010. Without any changes to the underlying trends, spending is projected to double again in ten years, consuming about \$1 out of every \$5 of the state's economy. At the same time, the quality and safety of health care in Minnesota markedly varies between different clinics, hospitals, and health care providers. Many providers are still working towards adoption and effective use of health information technology. Minnesota faces potential workforce shortages that may worsen due to population trends and new demands associated with health reform initiatives. These challenges present unique opportunities to implement thoughtful, data-driven policy solutions to meet the state's current and future health and health care needs.

The Division of Health Policy (DHP) is an important part of the team that helps keep Minnesotans healthy. The health policy division provides credible, objective policy research, analysis, design, and implementation of programs and reforms to improve population health and health care value, quality, efficiency and accessibility. Its products – data, analysis, recommendations, alternatives, standards, and reports – are used by policy makers, consumers, health professionals, payers, and purchasers. The division's work focuses on the following policy areas:

- Healthcare cost/spending and utilization, access to healthcare, insurance coverage, and cost drivers;
- Healthcare workforce supply/demand, workforce projections, and support for workforce development;
- Measurement of provider quality, cost and safety;
- Administrative simplification;
- Adoption/use of health information technology;
- Maintenance of the state's vital records system;
- Trends in health behaviors, health status, and health disparities; and
- Federal/state health reform issues, including payment reform and care delivery innovation.

The health policy division's work helps slow the growth of health spending while increasing affordable access to quality health care for all Minnesotans. Its work to support local public health helps to ensure that local agencies are able to appropriately plan for and implement interventions to improve population health and to reduce health disparities between different groups of Minnesotans. Approximately 60 percent of the division's budget comes from a fund that supports medical education (which includes both state and federal dollars), 15 percent comes from federal grants and the remaining amount comes from a mix of state funding and fees.

Strategies:

- Collect data and perform research to inform policy makers; analyze data to monitor and understand health care access and quality, market conditions and trends, health care spending, capital investments, health status and disparities, health behaviors and conditions, impact of state/federal health and payment reform initiatives, and prevalence of disease and risk behaviors.
- Collaborate with providers, payers, consumers and other stakeholders to develop standards and best practices for exchange of business and clinical data.

- Provide leadership and technical assistance to health care organizations and consumers on statutory mandates for use of health information technology, such as electronic medical records, and simplifying administrative processes, such as billing.
- Provide technical assistance to local public health, consumers, and other stakeholders about using data effectively for planning and taking steps and actions to improve local health.
- Administer the statewide hospital trauma system, collect and analyze trauma data for system improvement and interagency coordination, and provide technical expertise to hospitals caring for trauma patients.
- Award \$30-\$40 million in MERC funds each year to clinical training sites for doctors and other clinicians.
- Strengthen Minnesotans' access to quality health care services by directing state and federal assistance to safety net health care providers, including community clinics and rural providers.
- Analyze and report on Minnesota's rural and underserved urban health care delivery system and health workforce in order to focus planning for future needs.
- Collect information on adverse health events in Minnesota hospitals and ambulatory surgical centers, and provide information about patient safety in Minnesota to providers, health plans, patients, and others.
- Administer a secure, integrated web-based vital records system so that health care providers can enter accurate birth and death information, citizens can obtain birth and death records and health researchers have timely information that will help improve response to public health issues and emergencies.

Our key partners in performing this work include other state agencies (particularly the Departments of Human Services and Commerce), providers, payers, consumers, non-profit organizations such as Minnesota Community Measurement and Stratis Health, academic organizations, and numerous state/national organizations.

Results:

In large part as a result of work led by DHP, Minnesota has made great strides in achieving adoption and meaningful use of electronic health records and expanding use of e-prescribing, with significant potential to reduce medical errors and improve patient care; in establishing a robust, statewide trauma system that helps to ensure that trauma patients get to the appropriate level of care as quickly as possible in order to save lives; in processing birth and death records efficiently using a secure, web-based system, and in reducing health care administrative costs an estimated \$40- \$60 million, among other goals. The indicators below were chosen to illustrate a cross-section of the work that DHP performs, though they do not cover all areas of DHP's work.

Much of DHP's work focuses on providing high-quality, reliable research, policy and data analysis, and standards development work for legislators, policymakers, providers, payers, and consumers. DHP's work creates an environment in which these entities have the information they need to improve healthcare quality/safety, reduce costs and improve population health. Seeing changes in statewide indicators related to these efforts will be difficult in the short term, given that many factors outside of MDH's control may influence the outcomes, but they are critical in order to achieve MDH's – and the state's – long term goals.

Performance Measures	Previous	Current	Trend
<i>Percent of prescriptions routed electronically</i>	3.6%	61%	Improving
<i>Statewide uninsured rate</i>	6.1%	9.1%	Worsening*
<i>Number of designated trauma centers in MN</i>	0	124	Improving
<i>Percent of MN death registrations collected entirely electronically</i>	47%	61%	Improving

Performance Measures Notes:

* DHP staff provides advice to the Governor's health reform task force on coverage options that will link more Minnesotans with affordable health care coverage options. HP staff also closely monitor progress to ensure that policies have the intended outcomes or can be appropriately revised.

Sources: Minnesota Department of Health
 Data for percentage of prescriptions routed electronically is for 2008 and 2011
 Data for state wide uninsured rate is for 2001 and 2011
 Data on trauma centers is for 2006 and 2011
 Data for death registrations is for 2010 and 2012

Health

Environmental Health Division

<http://www.health.state.mn.us/divs/eh/index.html>

Statewide Outcome(s):

Environmental Health Division supports the following statewide outcome(s).

Minnesotans are healthy.

People in Minnesota are safe.

Context:

Environmental health programs are an integral part of Minnesota's public health system, working to educate, prevent, control, mitigate and respond to health hazards in the environment. We assure that Minnesotans have safe drinking water and food, and are protected from hazardous materials in their homes, workplace, and communities. We identify and respond to emerging environmental health threats and public health emergencies. As a result of research on environmental hazards and greater awareness of the environment's impact on overall health, the public increasingly looks toward the environmental health community for its expertise and leadership.

This activity serves the entire population of Minnesota by ensuring that all Minnesotans have clean drinking water, safe food, sanitary lodging, and are protected from hazardous materials in their homes and the environment. In the event of natural disasters, such as floods, drinking water contamination, chemical spills and nuclear power plant emergencies, the affected area is directly served. Water systems, the hospitality industry, water well contractors, the health care industry, construction firms, public and private building owners, homeowners and associated customers as well as disaster victims are the primary customers of our programs.

Factors that affect the work of this division include the housing market, natural disasters, chemicals in the environment and in consumer products, and changes in related federal program regulations where we have parallel authority.

This activity is funded from a variety of sources: state government special revenue fund; general fund; clean water legacy funding. In addition, the division also receives federal funds, special revenue funds, drinking water revolving funds and resources from other miscellaneous funds. Funding sources are divided into the following categories: fees and contracts – 66 percent; federal grants – 26 percent and state general fund – eight percent.

Strategies:

Prevent health risks by protecting the quality of water.

- Monitor public drinking water systems.
- Inspect water well construction and sealing.
- License professions impacting drinking water.
- Educate citizens about safe drinking water.

Prevent health risks by protecting the safety of food.

- Inspect food establishments to ensure safe food handling and certify professionals in food safety.
- Monitor and assist community-based delegated programs for food, beverage and lodging establishments.
- Educate citizens and professionals regarding the safe handling of food.
- Develop guidelines for the safe consumption of fish.

Prevent health risks by protecting the quality of indoor environments and public swimming pool safety.

- License and inspect public swimming pools and spas. Educate owners and operators in safe pool operations.
- Develop standards for safe levels of contaminants in air and abatement methods for asbestos and lead.
- Monitor the exposure of citizens to lead and issue guidelines on screening and treatment.
- Ensure that the provisions of the MN Clean Indoor Air Act are equitably enforced.
- Inspect and monitor lodging, manufactured home parks, and recreational camping areas.

-
- Educate citizens, communities, and medical professionals.
 - Collaborate with partners to promote healthy homes and healthy schools.

Respond to emerging health risks.

- Focus attention on children to ensure they are protected from harmful chemicals and other hazards.
- Evaluate human health risks from chemical and physical agents in the environment.
- License and inspect the use of radioactive materials and x-ray equipment.
- Assess and prevent possible human health risks from accidental spills, waste disposal, and agricultural and industrial activities.
- Integrate health impacts into the assessment of policies and projects.
- Evaluate and strategize responses to the potential impact of climate change on public health.
- Develop health education programs and information materials for communities.

See <http://www.health.state.mn.us/divs/eh/topics.html> for more specific information about these topics.

Results:

Minnesota's first public health laws, passed in 1872, focused on environmental health threats – the provision of safe drinking water, sewage disposal, wastewater treatment, and milk sanitation. Since 1900, the average lifespan of people in the United States has lengthened by 25 years due to advances in public health, many of which involved environmental health protection. Clean water and improved sanitation have resulted in the control of infectious diseases. Improvement in food preparation procedures and a decrease in food and environmental contamination have resulted in safer and healthier foods. Today, the department continues prevention efforts to ensure the environmental health and safety of Minnesotans is protected at home, at work, and in public places.

Prevent ground water contamination sealing unused, abandoned wells. Unused, unsealed wells, can pose a threat to groundwater quality and public health by providing a direct conduit from the surface to groundwater allowing contaminants to travel deep into the ground, bypassing the natural protection usually provided by layers of clay, silt, and other geologic materials. Although Minnesota leads the nation in sealing unused wells (MDH was awarded the Groundwater Protection Award in 2006 by the National Ground Water Association), and has sealed 250,000 wells in the past 25 years, an estimated 500,000 unused wells remain unsealed.

Assure safe food. Safe food handling is critical to ensure the public is safe from food related diseases. Through education and compliance activities prevention is emphasized in order to reduce the risk to the population and the burden on the health care system. In our global economy, the potential sources of food poisoning are increasing. At the same time, our knowledge and educational approaches to safe food handling are improving. Training programs for certified food managers are continually updated to incorporate the latest knowledge. When food poisoning occurs it can be devastating to an individual, families and a community. In one example it is estimated that 3,468 healthy hours were lost to a community when 51 people became ill with vomiting and diarrhea after attending a community meal. Seven people were taken to the hospital, four were taken by ambulance and five of the ill were hospitalized with an average of a three night stay. The length of illness averaged 68 hours.

Reduce health disparities by decreasing the percent of children with elevated blood lead levels. Since 1994, the CDC has funded the Childhood Lead Poisoning Prevention Program to test for elevated blood leads in children. In 2012, the federal funding has been eliminated but the need has not gone away. In fact, the CDC has recently determined that there is no safe level of blood lead for children. At the same time, the CDC, HUD, and EPA have moved to a Healthy Homes approach, rather than the focus on just lead paint. This evolution makes sense because approximately 90 percent of time is spent indoors, with the largest amount spent in homes.

Health-based guidance values. In Minnesota, health-based guidance for drinking water is developed for chemicals found in groundwater in the state, typically in response to identified contamination. There is health-based guidance available for only a few hundred chemicals. There are over 84,000 chemicals in use, with 700 new chemicals being introduced every year. Studies are finding unexpected chemicals in lakes, rivers, and drinking water. These are often chemicals that we know little about. They may or may not be “new” contaminants, but their presence in our water may be new or unexpected. The Contaminants of Emerging Concern program (<http://www.health.state.mn.us/cec>) allows for proactive assessment of the potential health effects (screening and guidance development) of these chemicals, including pharmaceuticals and personal care products in both groundwater and surface water.

Communities in the wellhead protection program. The Drinking Water Protection Section has accelerated the rate at which the 935 community public water supply systems that use groundwater are being brought into the source water protection program. Approximately 2.5 million Minnesotans obtain their drinking water from 3,000 community water supply wells. MDH has set a goal to have all of community water supply systems implementing wellhead protection plans by the year 2020.

Performance Measures	Previous	Current	Trend
70% of the state population receives their drinking water from ground water. Prevent ground water contamination by sealing unused, abandoned wells – number of wells sealed (cumulative).	149,000	250,000	Improving
Assure safe food through registration and training of certified food managers (11,000 renewed each year)	0	55,000	Improving
Reduce health disparities by decreasing the percent of children with elevated blood lead levels	2.7%	0.6%	Improving
Expand Drinking Water protection activities. -Health-based guidance values (# of values established): <i>Characterize health risks from drinking water exposures to contaminants of emerging health concern.</i>	3	17	Improving
-Communities in the wellhead protection program (# of communities): <i>Accelerate the development and implementation of community-based wellhead protection plans, with all communities in the process of implementing plans by 2020</i>	357	579	Improving

Performance Measures Notes:

- First PM-Housing sales and floods influence the first performance measure. Source: MDH Well Program. See: <http://www.health.state.mn.us/divs/eh/wells/sealing/abandwel.html#Law> Data is for 2000 and 2012
- Second PM-Prior to 2000 there was not a requirement for certification of food managers. Source: MDH Food, Pools, Lodging Services Program. See: <http://www.health.state.mn.us/divs/eh/food/fmc/index.html> Data is for 1998 and 2011
- Third PM-Includes influence from renovation of old homes and rental properties, plus child and teen check-ups. Source: MDH Lead Surveillance Program. See: <http://www.health.state.mn.us/divs/eh/lead/reports/index.html#surv> Data is for 2003 and 2010
- Fourth and Fifth PM-Source water protection planning activities are influenced by local zoning activities. Source: MDH Clean Water Fund Activities. See: <http://www.health.state.mn.us/divs/eh/cwl/index.html> Data is for 2010 and 2012

Health

Infectious Disease Epidemiology, Prevention and Control

<http://www.health.state.mn.us/divs/idepc/index.html>

Statewide Outcome(s):

The Infectious Disease Epidemiology, Prevention and Control Division supports the following statewide outcome(s).

Minnesotans are healthy.

People in Minnesota are safe.

Context:

The Infectious Disease Epidemiology, Prevention and Control Division (IDEPC) assures the health and safety of Minnesotans by maintaining strong public health systems and capabilities to protect the public from infectious diseases and to save lives during infectious disease outbreaks and other unusual public health events.

Today's infectious disease challenges are broader and more complex than ever. The diversity of organisms and their ability to evolve and adapt to changing populations, environments, practices, and technologies creates ongoing threats to health as well as challenges to disease prevention and control activities.

- Food safety, respiratory infections, vaccine-preventable diseases, zoonotic and vector borne diseases, HIV/AIDS, sexually transmitted disease, chronic viral hepatitis, healthcare associated infections and antimicrobial resistance continue to be infectious disease issues of special concern.
- Infectious diseases such as SARS and H1N1 underscore the importance of developing a "One Health" approach which advocates for a better understanding of the linkages between human, animal, and environmental factors on infectious disease.
- Changes in the way we live, eat, travel, etc. all contribute to infectious disease illness and death.
 - The aging population is more susceptible to infectious disease, and youth, females, African-Americans and Hispanics are disproportionately impacted by Chlamydia, which is reaching epidemic levels in Minnesota.
 - International travel has created the potential for rapid transmission of infectious diseases like pandemic influenza;
 - Immigration of world populations increases the potential for introduction of diseases such as measles or tuberculosis;
 - Changes in climate can cause infectious diseases to emerge in new areas; and human encroachment on wilderness areas increases the contact with zoonotic and vectorborne diseases such as Lyme disease and West Nile virus.
 - Also, international political and social unrest has created the urgent need to be prepared to detect and respond to potentially devastating biological terrorism.

All Minnesota residents are served by the work of IDEPC. Specific populations who are served include infants and children, adolescents, high-risk adults, older adults, those with chronic disease, refugees, immigrants and other foreign-born individuals, patients in hospitals and long-term care facilities, and health care workers.

Minnesota's infectious disease control system is funded almost entirely by federal grants, with only 15 percent of funding coming from state taxes and fees.

Strategies:

IDEPC protects the health and safety of Minnesotans and addresses the many challenges of disease control and prevention through a broad array of strategies:

- Assures early and rapid detection, investigation, and mitigation of infectious disease health threats by maintaining a 24/7 response capability to identify and respond to infectious disease threats;
- Conducts real-time statewide monitoring for infectious disease health threats;
- Detects and investigates infectious disease outbreaks, identifies newly emerging health threats, such as Powassan virus, as well as rare and highly dangerous health threats, such as *Naegleria fowleri*, the organism that causes primary amebic meningocencephalitis (PAM);

- Continuously looks for emerging infectious disease trends and recommends evidence-based policy for infectious disease prevention measures;
- Recommends evidence-based and cost-effective policies to reduce infectious diseases, and collaborates with public and private partners to improve prevention, detection, and control of infectious diseases;
- Promotes vaccine to prevent disease, and provides vaccines for children whose families can't afford them; and

Collaborates with a variety of federal, state, and local partners to prevent and control infectious disease.

Significant IDEPC activities that serve to carry out these strategies include:

- Maintain the 24/7 Epidemiology On-call Disease Reporting Line to assure early detection and response to disease outbreaks and public health threats;
- Maintain the Foodborne Illness Hotline (1-877-FOOD-ILL) to receive reports of foodborne illness;
- Analyze disease reports to detect outbreaks, identify the source, and implement control measures;
- Alert health care providers, local public health, and the public about outbreaks and preventive measures;
- Continuously monitor for unusual patterns of infectious disease;
- Prevent the spread of infectious disease by providing HIV prevention grants to community groups for screening and testing, by promoting and distributing vaccines for children and adults, by providing medications for tuberculosis (TB) patients, and by coordinating refugee health screenings to identify and treat health problems;
- Notify federal and state officials, hospitals and clinics, and the general public about products that present a public health threat and should be removed from the market;
- Help medical professionals managing persons ill with, or exposed to, infectious disease; and
- Locate epidemiologists in eight regions in outstate Minnesota to provide technical assistance to local public health and health care providers on infectious disease issues.

Key Partners

IDEPC collaborates with a variety of partners including: local, state, and federal public health officials including local public health agencies and the Centers for Disease Prevention & Control; local, state public safety officials including emergency preparedness personnel, Homeland Security Emergency Management, and the Federal Bureau of Investigation; local veterinarians and the Board of Animal Health; and other state agencies including Agriculture, Human Services, and the Minnesota Pollution Control Agency; community organizations; and infection control specialists, public and private health care facilities, and laboratories.

Results:

Although tuberculosis (TB) cases reported in Minnesota declined from 238 in 2007 to 137 in 2011, TB remains a significant health problem in MN. The total number of cases can fluctuate from year to year, depending on a number of factors outside the control of MDH. Making sure patients complete their therapy prevents the spread of TB and reduces the development of resistant strains of the disease. State funding provides access to medication and reduces barriers to the completion of therapy.

Minnesota is well-known nationally for its ability to identify and trace the source of foodborne disease outbreaks. In 2008 it correctly identified jalapeno peppers as the source for an outbreak that sickened more than a thousand people in 43 states. In 2009, it identified a certain brand of peanut butter as the source for a major national outbreak of salmonella. Identifying and tracking the source of foodborne disease outbreaks helps to identify steps needed to prevent the spread of disease, including food recalls, or changes to food handling practices.

Screening of newly arrived refugees is an effective public health tool used to identify and treat health problems and prevent the spread of infectious disease.

The Minnesota Immunization Practices Advisory Committee has identified adolescent vaccination as a priority. Rates of vaccination are impacted by a variety of partners and factors.

Performance Measures	Previous	Current	Trend
Percent of tuberculosis (TB) patients who complete therapy in 12 months. (1)	89%	88%	Stable
Percent of foodborne disease outbreaks in which the source of the outbreak was identified. (2)	68%	54%	Worsening
Percent of newly arriving refugees in MN who initiate a health screening within three months of arrival. (3)	96.8%	98.3%	Stable
Percent of Adolescents Receiving >1 Tdap vaccination. (4)	40.7%	70.3%	Improving

Performance Measures Notes:

1. MDH TB Program Data. Data is from 2008 and 2010
2. MDH Foodborne Outbreak Data. Data is from 2005 and 2011
3. MDH Refugee Health Program Data. Data is from 2010 and 2011
4. National Immunization Survey-Teen, 2010. Data is from 2008 and 2010

Health

Public Health Laboratory

<http://www.health.state.mn.us/divs/phl/index.html>

Statewide Outcome(s):

The Public Health Laboratory supports the following statewide outcome(s).

Minnesotans are healthy.

Context:

The Minnesota Public Health Laboratory (PHL) focuses on surveillance for early detection of disease outbreaks and other public health threats, identification of rare chemical, radiological and biological hazards, emergency preparedness and response, and assurance of quality laboratory data through collaborative partnerships with clinical and environmental laboratories throughout the state. The PHL relocated to a new laboratory building in 2005.

The PHL conducts analyses on clinical and environmental samples to provide chemical, bacterial (infectious disease), and radiological data of known and documented quality to partner state and federal programs. The data provided by the PHL is used for the purposes of assessment, intervention, and making science-based policy decisions. In addition, the PHL screens babies born in the state for rare, life-threatening congenital and hereditary disorders that are treatable if detected soon after birth. The PHL also accredits laboratories that conduct regulated environmental testing in Minnesota.

The PHL collaborates with local, state, and federal officials; public and private hospitals; laboratories; and other entities throughout the state to analyze environmental samples, screen newborns, provide reference testing for infectious disease agents, and analyze specimens for diagnosing rare infectious diseases (e.g., rabies, polio, anthrax). These activities ultimately benefit all Minnesotans.

New technologies, maintaining existing technologies, and staff expertise, along with variable funding sources are important factors that impact the laboratory. The impact of national and state health reform on the laboratory is uncertain.

The laboratory is funded by a combination of federal grants, fees and reimbursements for its services, and general fund appropriations.

Strategies:

Environmental Health

- Analyze air, water, wastewater, sludge, sediment, soil, wildlife, vegetation, and hazardous waste for chemical, bacterial, and radiological contaminants in partnership with local and state government agencies.
- Accredit public and private environmental laboratories that conduct testing for the federal safe drinking water, clean water, resource conservation and recovery, and underground storage tank programs in Minnesota.
- Test reference and confirmatory environmental samples using scientific expertise and state-of-the-art methods not available in other laboratories.
- Develop analytical methods for emerging environmental health threats (e.g. perfluorochemicals, pharmaceuticals) and the human body burden of environmental chemical contamination (biomonitoring).

Infectious Disease

- Perform surveillance, reference and confirmatory testing of clinical specimens for infectious bacteria, parasites, fungi, and viruses, including rare, emerging, and re-emerging diseases.
- Provide for early detection of infectious disease outbreaks, and identification of infectious agents through the use of classical techniques and sophisticated molecular methods such as DNA fingerprinting, amplification, and sequencing.
- Characterize pathogens to describe trends in type, virulence, and resistance to treatment.
- Communicate of laboratory data to epidemiologists and healthcare providers to inform treatment, prevention and control of infectious disease pathogens.

Newborn Screening

- Screen all Minnesota newborns for over 50 treatable congenital and hereditary disorders, including hearing loss.

Emergency Preparedness and Response

- Emergency readiness activities to assure early detection and rapid response to all hazards, including agents of chemical, radiological, and biological terrorism.
- Participation on Minnesota's radiochemical emergency response team, which responds in the event of a release of radioactive chemicals at Minnesota's nuclear power plants.
- Operate the "Minnesota Laboratory System" to assure that public and private laboratories are trained for early recognition and referral of possible agents of chemical and biological terrorism, as well as other public health threats.
- Help ensure the safety of the public by hosting the federal BioWatch air-monitoring program.
- CDC Designated PHL as a LRN Level 1 Chemical Terrorism preparedness laboratory to serve to provide surge capacity in response to a mass casualty event involving chemical agents.

Results:

Timely identification and DNA fingerprinting of pathogens ensures rapid recognition, investigation and control of outbreaks thereby preventing additional cases of illness. The ability to generate the data quickly is dependent on resource allocation, which has been relatively stable, but is being impacted by changes in testing performed by the clinical labs that provide the PHL with the bacterial isolates. These labs are increasingly using non-culture based methods that necessitate that PHL do an additional step to obtain the isolate necessary for fingerprinting.

Novel test methods are developed to assess new threats to public health as these threats are identified. These new tests require advanced instrumentation and workforce expertise. PHL demonstrates readiness to respond to public health threats by successfully completing proficiency testing and maintaining quality in the analysis of chemical and biological terrorism agents. Corrective actions are written and implemented based on the results of these proficiency tests. This measure will assess the effectiveness of those actions.

Screening all babies shortly after birth for treatable congenital and hereditary disorders including hearing loss ensures that these babies receive follow up assessment, resulting in improved clinical outcomes and quality of life for these babies and their parents.

Accreditation of environmental laboratories by the Minnesota Environmental Laboratory Accreditation Program (ELAP) helps ensure that data provided for purposes of assessing the quality of Minnesota's water is of known and documented quality. New quality standards were implemented in late 2010 requiring that ELAP conduct an on-site laboratory assessment every 24 months instead of the previous requirement of every 36 months. The trend in the performance measures reflects the transition from a 36 month to 24 month assessment interval.

Performance Measures	Previous	Current	Trend
Percent of <i>E. coli</i> O157 and <i>Listeria monocytogenes</i> fingerprint results reported within four days of arrival at the PHL. ¹	95%	97%	Improving
Percent of proficiency tests successfully completed for chemical (CT) and biological (BT) terrorism agents of public health concern. ²	CT: 100% BT: 100%	CT: 94.3% BT: 100%	CT: Worsening BT: Stable
Percent of newborns screened that are identified with hereditary disorders (including hearing loss) that have the opportunity to benefit from treatment. ³	0.57% or 400 of 69,636	0.57% or 385 of 67,872	Stable
Percent of environmental laboratory assessments completed within 24 months of previous assessment. ⁴	22%	88%	Improving

Performance Measures Notes:

1. Data is from the PHL for fiscal year 2011 (Previous) and 2012 (Current).
2. Data is from the PHL for fiscal year 2011 (Previous) and fiscal year 2012 (Current). This data is a measure of readiness to perform sample analysis for the 11 validated CT methods for 36 compounds, and 14 validated BT methods.
3. Data is from the PHL for fiscal years 2010 (Previous) and 2011 (current).
4. Data are from fiscal year 2011 (previous) and 2012 (current).

Health Emergency Preparedness

<http://www.health.state.mn.us/macros/topics/emergency.html>

Statewide Outcome(s):

The Office of Emergency Preparedness supports the following statewide outcome(s).

Minnesotans are healthy

People in Minnesota are safe.

Context:

The Office of Emergency Preparedness (OEP) ensures local, tribal, and state public health and healthcare partners have the personnel, plans, training, communication tools and expertise to prevent or respond to public health emergencies, pandemic influenza, infectious disease outbreaks, bioterrorism, chemical exposures, natural disasters, and other incidents. This activity serves all residents of the State of Minnesota.

Emergencies are happening with increasing frequency, and the role of public health officials in response and recovery activities has expanded as emergency managers and other partners have observed the breadth of health issues and the capabilities of public health and healthcare partners.

The Office is responsible for continuity of operations planning, training and exercising to determine how to maintain facilities and reassign resources to support priority services identified by individual programs in the event of a business continuity interruption.

The Office of Emergency Preparedness is funded approximately 97 percent by federal grants and three percent from the general fund.

Strategies:

Examples of program efforts have included preparation for, response to, and recovery from the H1N1 pandemic influenza outbreak, seasonal flooding along the Red River, recent flash floods in Northeastern and Southeastern Minnesota, power interruptions, the Minneapolis tornado and other weather-related emergencies. OEP provides the infrastructure to support all other parts of the agency in protecting Minnesotans during emergencies, and in ensuring the ability of the department to continue operations should there be a loss of facilities, technology, or staff.

Effective and timely response and recovery requires coordination between public safety officials, healthcare providers, voluntary and non-profit organizations, public health officials at the federal, state, local and tribal level, multiple state agencies, elected officials, media organizations, and many others. This involves extensive planning, training, exercising, communication systems development, acquisition and replenishment of supplies, and administrative preparedness for legal and procurement issues.

The Office is responsible for development and maintenance of the Minnesota Department of Health's All-Hazard Response and Recovery Plan and the MDH portion of the Minnesota Emergency Operations Plan so roles and responsibilities are clear to all responders.

Specific activities include development of and practicing plans for managing federal pharmaceutical and other supplies, updating statutes and regulations to assure needed authority for implementing emergency health measures, supporting a web-based system to monitor healthcare system capacity and support the rapid expansion of healthcare services in an emergency, and assuring compliance with requirements of grants from the Centers for Disease Control and Prevention and the Assistant Secretary for Preparedness and Response of the Department of Health and Human Services.

In addition to the extensive coordinating role, the Office administers about \$6 million in grants to community health boards and tribes, and about \$5 million in grants to regional healthcare coalitions to build public health and health care preparedness statewide.

Results:

It is difficult to measure emergencies that don't happen because people or systems were prepared, or disasters that weren't as bad as they could have been because response was swift and effective, or people whose suffering from an emergency was lessened by work to build resilience. Efforts in preparedness, response, and recovery do, however, have some measureable indicators.

The number of times partners work together to develop, test, and improve their plans indicates coordination and improved capacity and capability. The Office conducts exercises with staff department-wide, and assists local, tribal, and healthcare partners with their exercise programs. Exercises follow a progression to build capability to respond to emergencies—moving from seminars, tabletop discussions, drills, and functional exercises to full-scale exercises. An important component is the after-action report and improvement plan, where the lessons learned are examined, modifications to plans or procedures are made, and components are re-tested in subsequent exercises. Local and Tribal Health Departments and Healthcare Coalitions submit exercise plans and After Action Reports to the Office to meet the federal grant requirements and allow MDH to learn and share best practices.

Minnesota's Health Alert Network (HAN) connects the Centers for Disease Control and Prevention, MDH, state agency partners, local health departments, and tribal governments by disseminating time sensitive health threat information when needed. Every local health department has developed a local HAN that they may use independently for local issues or to cascade on federal or state alerts to clinics, hospitals, long term care, specific medical providers, veterinarians, emergency managers and others within their jurisdictions. In addition to its use during major emergencies, HAN is used frequently to quickly distribute information throughout the state regarding food-borne and infectious disease outbreaks, and environmental health threats.

The Office coordinates recruitment and registration of Medical Reserve Corps volunteers through local chapters. The chapters conduct training and exercises to ensure the Medical Reserve Corps will be ready and able to respond to disasters by providing needed care and intervention services. Medical Reserve Corps volunteers include a wide variety of clinicians and support personnel—physicians, nurses, dentists, veterinarians, morticians, pharmacists, counselors, logistics experts, supply chain staff, etc. A critical feature of this program is to continually confirm that volunteers remain interested and eligible, and to increase their number. MDH also focuses on broadening the number of disciplines represented—for example, the recent collaboration with Environmental Health staff to add a Radiation Emergency Volunteers group to provide the specialty expertise of health physicists and others in the event of a large-scale radiological incident.

Performance Measures	Previous	Current	Trend
Number of exercises conducted by state, tribal, and local health departments	261	387	Improving
Percent of local and tribal health departments completing the two required Health Alert Network notifications annually	78.4%	89.8%	Improving
Number of currently active, credentialed volunteers registered in the Minnesota Responds Medical Reserve Corps to assist state and local officials in caring for Minnesotans	9200	9831	Improving

Performance Measures Notes:

Exercise data from Office tracking of state, local, and tribal

Health Alert Network data from MDH performance tracking database.

Medical Reserve Corps data from the Minnesota Responds Medical Reserve Corps database.

(All performance measures compare data from FY 2012 to FY 2013)

Health Administrative Services

<http://www.health.state.mn.us/>

Statewide Outcomes:

Administrative Services supports the following statewide outcome(s).

- Minnesotans are healthy.
- Efficient and accountable government services.

Context:

The Administrative Services divisions provide stewardship of MDH human, capital, and technology resources through the following services:

- **Financial Management** ensures resources are properly tracked, budgets are well-planned and communicated, and financial activities meet standards set by federal, state, and private funders.
- **Human Resource Management** attracts, develops, and serves the department's highly-qualified, diverse workforce while fostering a respectful, safe, and inclusive work environment.
- **Facilities Management** provides the facilities and support services needed for MDH programs to operate efficiently.
- **MN.IT @ MDH** provides and supports agency-wide and specialized technology systems and services through leadership, strategic planning, management, administration, and technical support.

The Administrative Services division is funded through special revenue funds financed by other divisions' budgets, because they support all MDH programs and 1,500 MDH employees in successfully fulfilling the agency mission. Important factors that continue to impact the divisions' work are:

- The evolving deployment of the Statewide Integrated Financial Tools (SWIFT) system; including the need to redesign related business processes and technology systems.
- Our aging workforce (one-third of staff are 55+) signaling a large number of coming retirements and resulting loss of substantial subject matter expertise and leadership.
- Significant challenges in recruiting and hiring in an increasingly competitive labor market, particularly for high-level jobs requiring specialized degrees or leadership experience, due in part to the inability to offer compensation levels that applicants expect and the statewide compression of salaries.
- The recent consolidation of IT services, which will result in new processes, standards and policies.

Strategies:

The Administrative Services divisions promote efficient and accountable government services by using business systems optimally and by listening to and working with management and staff to ensure that MDH's program needs are fully understood and properly addressed.

Financial Management provides stewardship of MDH financial resources through:

- Centralized accounting, cash management, and procurement of goods and contract services;
- Monitoring, financial reporting, and technical assistance required for federal grants;
- Coordinated budget planning and reporting for all department resources; and
- Guidance to MDH employees on financial best practices and how to comply with financial laws, policies, and procedures.

Human Resource Management facilitates strategic personnel management and development by:

- Managing staffing, labor relations, health and safety activities;
- Ensuring accurate administration of compensation, benefits, and payroll services;
- Offering training programs to strengthen current leadership capacity and to develop future leaders;

- Promoting an inclusive workplace with equal opportunity and affirmative action programs; and
- Addressing complex employment issues by consulting with employees, supervisors, and managers.

Facilities Management supports efficient operations through:

- Space planning, physical security, lease management, and operations support for nearly 490,000 square feet of space at five metro and eight greater Minnesota locations; and
- Centralized delivery, shipping/receiving, warehousing, fleet, and duplicating services in metro locations as well as shared administrative support in district offices.

MN.IT @ MDH ensures that technology meets business needs by:

- Administering memoranda of understanding with 11 MDH divisions and offices that define partnerships and clarify budgets, roles and responsibilities;
- Providing expertise, planning and development of technology systems and data architectures;
- Supplying high-level security for all departmental data, systems, and communications;
- Managing communications networks and telecommunications systems;
- Administering networks and infrastructure connecting all employees and 11 building connections; and
- Providing user support, training, and problem resolution.

Results:

The value of a top performer is two to three times that of an average employee so the ability to retain stellar employees profoundly impacts productivity and the department's salary budget. HRM's succession planning strategy is to develop identified employees' leadership skills in order to build an engaged workforce with opportunities and abilities to advance.

Minnesota is still in the early stages of consolidating all agencies' IT staff into a single agency. Timely resolution of help desk requests and client satisfaction are key indicators that show how consolidation is affecting customer service.

Efficient finance and facilities services allow MDH programs to focus energy and resources on fulfilling the department's mission. Cost effective space and quick purchasing are essential to MDH programs.

Performance Measures	Previous	Current	Trend
Successfully identified and trained potential/future leaders in Everyday Leaders Program, measured as percent of participants at six months and two years after graduation who were: retained as an employee at MDH and promoted to a leadership position.	2010-2011 class: 75% retained as employees; 22% promoted	2011-2012 class: 96% retained as employees, 4%	Stable
Successfully met information technology service expectations as measured by the percent of request tickets resolved on time and the percent of staff satisfied with the resolution.	87% tickets closed on time; 96% satisfaction	88% tickets closed on time; 95% satisfaction	Stable
Provided a safe, efficient amount of facilities space to support health programs, measured as number of accidents in the workplace and square footage per person. ¹	FY 2010: 32 workers comp claims; 314 sq ft per person	FY 2012: 17 workers comp claims; 293 sq ft per person	Improving
Provided quick, efficient purchasing services to support health programs, measured as the average time from request to purchase order and average number of requisitions per purchasing staff person.	FY 2010: 4.29 days; 45,263 requisitions/person	FY 2011: 4.86 days; 60,008 requisitions/person	Stable/Improving

Notes

¹ Excludes warehouse space for materials storage/transfer and hangar space for mobile medical/morgue units

Health Executive Office

www.health.state.mn.us/

Statewide Outcome(s):

The Executive Office supports the following statewide outcome(s).

Minnesotans are healthy

Efficient and accountable government services

Context:

The Executive Office provides the vision and strategic leadership for creating effective public health policy for the state of Minnesota. It also oversees the management of the entire agency, including administrative functions and oversight of the department's seven program divisions and three offices. It carries out its mission in partnership with a wide range of external organizations that help to promote and protect the health of all Minnesotans.

Several key functions take place through the commissioner's office, including planning, policy development, legislative relations, internal and external communications and legal services.

The department's 1,500 employees work to protect and promote the health of all Minnesotans. The department carries out its mission in close partnership with local public health departments, other state agencies, elected officials, health care and community organizations, and public health officials at the federal, state, local and tribal levels.

The office is funded from special revenue funds.

Strategies:

Commissioner's Office

- The commissioner's office develops and implements department policies and provides leadership to the state in developing public health priorities.
- The commissioner's office directs the annual development of a set of public health strategies to provide guidance for agency activities and to more effectively engage the department's public health partners.
- The commissioner's office also directs the strategic planning and implementation of department-wide initiatives.

Legislative Relations

- The legislative relations office leads and coordinates state legislative activities and monitors federal legislative activities to advance the departments' priorities and mission. It works closely with the governor's office, department divisions, legislators, legislative staff, and other state agencies on the department's strategies and priorities.
- Throughout the legislative session and during the interim, legislative relations is a contact for the public, other departments, legislators, and legislative staff.

Communications

- The communications office is responsible for leading and coordinating communications on statewide public health issues and programs. This includes coordinating public awareness activities and community outreach and managing more than 30,000 pages of information on the department's website.
- The office works closely with the news media, ensuring that accurate and timely information on a wide range of public health topics is shared with the general public.

Legal Services

- The MDH Legal Unit serves the Commissioner in a general counsel capacity, while providing overall direction to and oversight of legal services provided to MDH by in-house counsel and the attorney general's office.
- While the Legal Unit will respond to any legal need, its primary focus is in the areas of emergency preparedness, rulemaking, data practices and privacy, contracts, records management, delegations of authority, and HIPAA. The Legal Unit also acts as a liaison with the AG's Office for MDH litigation and other legal services requested by MDH.

Results:

Since the Executive Office's primary function is to provide leadership and support for the work of all program areas, the effectiveness of the Executive Office can be measured in large part by the results and performance measures of the divisions and offices of MDH. However, a number of distinct measures (below) can serve to help gauge the performance of the EO.

Performance Measures	Previous	Current	Trend
Total subscribers to MDH website bulletins through GovDelivery	42,692	54,659	Improving
Total messages sent from MDH website through GovDelivery	2,747,064	3,068,848	Improving
Number of news releases completed and issued per year*	72	81 (projected)	Stable
Number of fiscal notes completed	95	72	Stable
Average days to complete fiscal notes	10.4	4.2	Improving
Percent of fiscal notes completed on time	47%	78%	Improving

Performance Measures Notes:

*The number of news releases issued can depend on factors such as the number of foodborne or other illness outbreaks that need to be reported, so a decline in needed news releases could be a sign of fewer outbreaks, better prevention or improved h2food safety systems, etc. Also, some instances in which news releases previously were issued are now handled through more routine GovDelivery subscriber notices.

Data on bulletin subscribers and message delivery through the MDH Web site is from 2010 and 2012 (as of 6/30)

Data new releases is from 2005 and (projected) 2012 (as of 6/30)

Data on fiscal notes is 2007 and 2010