Local Public Health Association of Minnesota

2017 State Policy Positions

A Strong Local Public Health System Protects the Health and Safety of Minnesotans

Local public health departments play a critical role in bettering the lives of people across our state, and Minnesota's local public health system has long been regarded as one of the strongest in the nation. However, funding challenges at the federal, state and local levels in recent years have compromised the ability of local health departments to provide essential services that protect and improve health, as well as respond to emerging health issues that threaten the safety of our communities.

One of the most basic principles of public health is the focus on the health needs of populations. The overall mission is to promote, protect and maintain the health of the community as a whole. Public health's historical role has been monitoring the health status of the population and promoting health policy through action and advocacy. This is critical when social, economic, environmental and physical determinants pose significant threats to population health. Today, more than ever before, public health also is working to engage communities to address structural racism and inequities that contribute to health disparities so that all individuals have the opportunity to be healthy, regardless of race, place or income.

Emphasis on the prevention of health and social problems is a unique feature of public health. Protecting people from diseases, hazards and debilitating conditions through appropriate prevention services can help to minimize significant long-term social and economic costs. Investments in evidence-based interventions have proven benefits in both health care cost savings and improved health outcomes. Public health utilizes sound science and research in development of its policies and practices.

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Public Health Infrastructure

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Policy Issues	LPHA Policy Positions
A. Funding, including the Local Public Health Grant: Funding cuts at all levels have reduced the capacity of local health departments to carry out mandated public health functions and meet accreditation standards. Even though MN is among the healthiest states, per capita General Fund public health spending has declined, and local health departments are increasingly relying on local tax levies. Budget restrictions, workforce limitations, restructuring, and streamlining of services have impacted the ability of local health departments to meet the six areas of public health responsibility outlined in state statues (Minn. Stat. §145A) and carry out their mission to protect the health and safety of the community In 2015, the MN legislature increased the Local Public Health Grant by $1 million per year for rural community health boards (CHBs) and tribal governments, while funding for metro CHBs was held flat. This is a small step toward fully restoring a 29% cut to local public health funding that occurred in 2003, but the need remains to reinvest in the Grant for CHBs and tribal governments across the state in order to protect and promote the health of all Minnesotans and maintain MN's ranking as one of the healthiest states in the nation.	**1.** LPHA supports adequate funding statewide to offset disproportionate reliance on local tax levy and federal sources for local health departments to protect the health and safety of the public every day and during emergencies. **2.** LPHA supports continued integration of funding into the Local Public Health Grant to limit administrative costs and allow maximum flexibility to meet local needs throughout the state.
B. Performance management and quality improvement: Minnesota's Local Public Health system demonstrates accountability, results and efficiency through the ongoing use of performance standards, measures and outcome reports which guide quality improvement efforts and decision-making to improve and protect the health of Minnesotans.	**3.** LPHA supports policies and initiatives that allow for innovative service delivery while maintaining a strong local public health infrastructure, including the ten essential public health services defined in state statutes (see Minn. Stat. §145A). **4.** LPHA supports efforts of the SCHSAC Performance Improvement Steering Committee, as well as other system-level performance management, to ensure quality and accountability in local services and the broader state-local public health system.
C. Electronic health information exchange: Despite state laws which mandate local health departments to have interoperable electronic health records (EHR) systems by January 2015, state and local health departments continue to operate without a statewide, interconnected electronic system for health information exchange. Each department has developed its own information management system, which operates in isolation of others and poses challenges to data sharing and coordination of care.	**5.** LPHA supports dedicating resources for the development and implementation of a statewide, electronic, interconnected system for collection and exchange of health information. **6.** LPHA supports improved interoperability and systems modernization of public health programs and services, including the Women, Infants and Children (WIC) data system.

	D. Staff retention and succession planning: Local health departments need to hire and retain qualified public health staff reflective of their communities in order to protect the health and safety of the community. According to the national Public Health Workforce Interests and Needs Survey, more than one-third of the current workforce will leave governmental public health by 2020 if workers carry out their current plans.[1]	**7.** LPHA supports policies and initiatives that promote the education, hiring, retention and succession planning of qualified public health leaders and other public health professionals. **8.** LPHA supports efforts to develop a qualified, culturally competent workforce that is representative of the communities served by local public health. **9.** LPHA supports policies and initiatives that promote market equity in the health care field, better enabling public agencies to compete with the private market. **10.** LPHA supports emerging roles such as Community Health Workers to expand the capacity of the public health workforce. **11.** LPHA supports networking and training for correctional health nurses provided by local public health agencies and efforts to address staffing demands in correctional facilities.

Chronic Disease Prevention and Promotion of Healthy Lifestyle Behaviors

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Policy Issues	LPHA Policy Positions
A. Statewide Health Improvement Partnership (SHIP) and other prevention funding: Heart disease, stroke and cancer kill 52 Minnesotans every day and cost nearly $2 billion in healthcare every year. It is estimated that up to 35% of these deaths could be prevented if our cities, towns and schools supported healthy choices.[2] Often low-income populations, communities of color, people with disabilities and other groups (e.g., seniors) experience chronic health conditions at a higher rate than the general population.[3] Addressing key risk factors such as physical inactivity, poor nutrition, and tobacco use and exposure reduces chronic disease over time.[4] Enacted in 2008, the Statewide Health Improvement Partnership (SHIP) is an integral component of MN's bipartisan and nation-leading health reform legislation designed to reduce chronic disease and decrease health care costs. According to MDH, the percentage of obese individuals in Minnesota has stabilized in recent years, while rates in neighboring states that aren't implementing a SHIP-like approach have continued to increase. SHIP strives to help Minnesotans live longer, better, healthier lives by making healthy choices easy where we live, learn, work and play.[5] Minnesota's comprehensive tobacco control programs have helped reduce smoking rates by 29% from 1993 to 2011.[6] However, tobacco use remains the leading cause of preventable death in Minnesota, with 5,900 Minnesotans dying each year from smoking.[7] The CDC recommended funding for tobacco control and prevention in MN is $52.9 million/year. In FY2016, state government spent $21.5 million, or 40.6% of the recommended level. This was down from $22.3 million (42%) in FY 2015. At the same time in FY2016, Minnesota took in $791.7 million in tobacco revenue (taxes and settlement dollars).[8]	**1.** LPHA supports permanent, adequate per capita funding for the Statewide Health Improvement Program to ensure all local health departments and tribal agencies are able to participate. **2.** LPHA supports the dedication of SHIP funding to the prevention of chronic illness, with an emphasis on obesity and tobacco use. **3.** LPHA supports statewide health-related tax increases, like tobacco and sugar-sweetened beverages, and advocates for the use of revenues to fund programs that prevent chronic diseases, such as SHIP.
B. Statewide framework for chronic disease prevention: MN has traditionally had independent statewide plans to address obesity and a number of other chronic conditions, but has not adopted an integrated framework to address common risk factors.	**4.** LPHA supports use of the Minnesota Department of Health (MDH) comprehensive chronic disease strategic prevention framework ("Healthy Minnesota 2020: Chronic Disease & Injury").
C. Obesity prevention: In 2014, 27.6 percent of MN adults were obese, and 36.5 percent were overweight.[9] In 2015, MN's adult obesity rate dropped significantly to 26.1 percent; and ours was the only state in the region (including North Dakota, South Dakota, Wisconsin and Iowa) to succeed in keeping its obesity rates below 30 percent.[10]	**5.** LPHA supports policies related to foods and beverages consumed at home or away from home that contribute to a healthier diet, such as menu labeling, improved product labeling, and food marketing that promotes healthy dietary choices, etc. **6.** LPHA supports policies and programs to ensure access by

Obesity is a significant contributor to chronic conditions like diabetes, heart disease, stroke and cancer, which often lead to premature death and raise health care costs for both individuals and the state. Strategies that improve nutrition and increase physical activity through policy, systems and environmental change are fundamental to reducing obesity rates in children and adults. **D. Nutrition and dietary guidelines:** Americans today consume over 200 calories more per day than previous generations.[11] The American diet is very high in sodium, and 27% of children's intake now consists of snacks.12 Food and beverages provided or sold in family-friendly settings such as parks, concessions and vending machines are frequently prepackaged, high in fat and low in nutritional value. Food companies often engage in marketing unhealthy food products to consumers of all ages, sometimes targeting low income individuals and people of color.[13] Over one-half of the U.S. population consumed sugar-sweetened beverages on a given day between 2009 and 2010, which is strongly associated with weight gain in all age groups. The National Dietary Guidelines are a resource and guiding tool for policies, education, outreach, food assistance programs, health officials and more.[14] **E. Nutrition and physical activity in government-funded programs:** The state and county and city governments fund many programs that provide food services to community residents, but guidelines for these programs do not always meet current nutrition standards. Many children, youth and vulnerable adults spend time in settings regulated by the state (e.g., schools, foster care and child care) which likewise do not always offer access to physical activity that meets standards to improve health. **F. Physical activity and the build environment:** The built environment strongly influences whether or not members of a community walk or bike. 93% of Minnesotans believe future transportation projects should integrate walkers, bicycles and motorized vehicles.[15] Sidewalks, crosswalks, bike paths/lanes, mixed-use and transit-oriented buildings, adequate safe lighting, water fountains, and trash removal can all make a difference. There are many and significant benefits to regular physical activity, including but not limited to lowered risk of diabetes and heart disease, decreased risk of falls, weight control, improved mental well-being, etc.	all people to enough nutritious, affordable, safe and culturally-diverse food for an active, healthy life. **7.** LPHA supports comprehensive healthy food and beverage policies in a variety of public settings (parks, schools, hospitals and others), including procurement policies that affect vending and concessions. **8.** LPHA supports policies that reduce the consumption of sugar-sweetened beverages. **9.** LPHA supports requiring all currently subsidized federal, state, and local government programs that serve food to use nutrition standards based on the Dietary Guidelines for Americans including schools, child care facilities, shelters, and tax-supported residential settings. **10.** LPHA supports implementation of the Minnesota Food Charter to address how Minnesota's food system can better support the health of Minnesotans in coordination with local efforts. **11.** LPHA supports increased time and quality of physical and health education in schools. **12.** LPHA supports requiring schools, child care settings, and tax-supported residential settings to provide access to physical activity that meets federal guidelines. **13.** LPHA supports a health in all policies (HiAP) approach to policy making to ensure decisions made outside the traditional health sector—including but not limited to those related to transportation, food access, and neighborhood/community safety—have a positive or neutral impact on the determinants of health and encourage healthier community design (e.g., comprehensive plans that promote safe and active living and transportation).
G. Breastfeeding: In addition to other health benefits, children who are breastfed are less likely to be obese and to develop juvenile diabetes, heart disease or cancer before they reach the age of fifteen. MN law requires employers to provide reasonable break	**14.** LPHA supports policies that strengthen the existing state law to promote breastfeeding and provide adequate time and space for breastfeeding.

	time and private space for an employee to express breast milk for one year after a child's birth.[16]	
	H. Monitoring data trends: MN's Behavioral Risk Factor Surveillance System (BRFSS) tracks overall population trends in adult obesity, but there is not an adequate system to monitor trends in child and youth obesity statewide. BRFSS does not provide sufficient data at the local level, which is needed to target interventions and measure progress. Current BRFSS data methods are self-reported which may not provide fully accurate information.	**15.** LPHA supports the development and funding of strategies to better monitor adult, childhood and youth obesity trends at the state and local levels. **16.** LPHA supports exploration of methods to improve aggregated data collection and analysis, including through the use of electronic health records.
	I. Tobacco prevention and cessation: Tobacco is the leading cause of preventable death and disease among MN residents; over one in six Minnesotans still smoke.[17] Secondhand smoke kills tens of thousands of nonsmoking Americans every year from coronary artery disease and lung cancer. It is estimated that living with a smoker increases the chance of getting lung cancer by 20-30%.[18] **J. Tobacco use by those with mental health and/or substance use disorders**: Smoking is much more common in adults with mental illness and/or substance use disorders than other adults. In 2011, 42% of those with serious mental illness smoke nationwide, compared to 18% in the general population.[19] Persons with a mental health disorder or substance use disorder purchase and consume 30-44% of cigarettes sold in the U.S.[20] Smokers with these conditions are just as ready to quit smoking as the general population of smokers.[21] **K. Electronic delivery devices:** Electronic delivery devices, also called e-cigarettes, are battery operated nicotine vaporizers. Electronic delivery devices are often advertised as a safer alternative to tobacco cigarettes; however, many harms remain unknown and more research is needed.[22] Many electronic delivery devices also glamourize and simulate traditional smoking behavior with products targeted at youth. Recent studies show increased use of electronic delivery devices among youth leading to an increase in smoking rates.[23] **L. Water pipe smoking:** Water pipe ("hookah") smoking delivers the addictive drug nicotine and is at least as toxic as cigarette smoke. Some users report being dependent on hookah and having difficulty quitting. Hookah smokers are at risk for the same kinds of diseases caused by cigarette smoking, which include numerous cancers as well as reduced lung function,	**17.** LPHA supports increasing public funding for tobacco control efforts as a proven way to reduce tobacco use and exposure. **18.** LPHA supports dedicating remaining un-securitized tobacco settlement dollars to fund tobacco prevention and cessation programs and activities. **19.** LPHA supports maintenance of a strong statewide Freedom to Breathe Act and oppose efforts to preempt local government authority to enact additional smoke-free policies. **20.** LPHA supports smoke-free housing policies, especially in multi-family and publically subsidized housing. **21.** LPHA supports policies that protect people of all ages from exposure to secondhand smoke, including statewide policy to prevent children's exposure to tobacco smoke in home-based child care settings. **22.** LPHA supports implementation and follow-up of smoke-free policies in child foster care settings. **23.** LPHA supports policies that regulate the sale and use of electronic delivery devices statewide, such as stricter regulation on product production, packaging and labeling; updating the Minnesota Clean Indoor Air Act to restrict the use of electronic delivery devices wherever conventional smoking is not permitted; and local policies that further restrict the sale and use of these products in our communities. **24.** LPHA supports policies and professional education that will equip professionals serving those with mental health and/or substance use disorders to incorporate tobacco cessation into behavioral health settings. **25.** LPHA supports evidence-based programs and policies that

	and decreased fertility. Secondhand smoke from hookahs poses a serious risk for nonsmokers, particularly because it contains smoke not only from the tobacco but also from the heat source (e.g., charcoal). **M. Youth tobacco use:** Youth using tobacco is a major public health problem. Smoking and smokeless tobacco use are initiated and established primarily during adolescence, as nearly 9 out of 10 smokers start by age 18.[24] Limited state funds are available to prevent youth from initiating tobacco use and engaging in other unhealthy behaviors. Raising the age when one can purchase tobacco will prevent youth tobacco use and save lives. Increasing the age of purchase from 18 to 21 is predicted to reduce smoking initiation among 15-17 year olds by 25%.[25] Nationally, 75% of adults favor raising the minimum legal age.[26] **N. Flavored tobacco products, including menthol:** According to the FDA, flavored tobacco products have become increasingly common in the United States and are especially attractive to youth. They are widely considered to be starter products—establishing smoking habits that can lead to a lifetime of addiction. Menthol tobacco products are highest among African Americans and youth. Like all tobacco products, flavored tobacco products have serious health risks.[27]	are designed to discover the effects of electronic delivery device aerosols to further develop appropriate restrictions. **26.** LPHA supports policies that minimize use of hookahs. **27.** LPHA supports funding for evidence-based programs and policies that discourage youth tobacco use. **28.** LPHA supports policies that raise the legal age for purchasing tobacco products from 18 to 21. **29.** LPHA supports policies that discourage the use of flavored tobacco products (including menthol), as well as novel smoking devices that are or may be found to be harmful to health.
	O. Sports-related injuries / traumatic brain injury: Every year, almost half a million American children visit emergency departments for head injuries, many of which are due to sports-related concussions.[28] In the late 1990s, national sports leagues began instituting concussion policies for testing, treatment and return to play. Many states have begun to explore similar policies, though none focus on preventing concussions in the first place.	**30.** LPHA supports policies that protect people from sports-related injuries and the long-term health consequences of traumatic brain injury or other head trauma.
	P. Skin cancer / tanning beds: Melanoma rates have doubled in the last thirty years, and skin cancer is one of the most common cancers among 20-39 year olds in MN.[29] Tanning beds have been renamed as a Class I carcinogen (in the same category as cigarettes). Just one indoor tanning session increases a user's chance of developing melanoma by 20%.[30]	**31.** LPHA supports and maintain policies that prevent skin cancer by decreasing youth access to tanning facilities.
	Q. Distracted driving: Each year in Minnesota, distracted or inattentive driving is a factor in one in four crashes, resulting in at least 70 deaths and 350 serious injuries.[31] In 2013, inattention was a contributing factor in 17,598 crashes.[32] Office of Traffic Safety	**32.** LPHA supports strengthening laws that address distracted driving (e.g., extending the cell phone ban beyond just bus drivers and individuals under 18 years of age).

	estimates these numbers are vastly underreported due to law enforcement's challenge in determining distraction as a crash factor. Under Minnesota's current "No Texting while Driving" Law: • It is illegal for drivers to read/compose/send text messages and emails, or access the Internet using a wireless device while the vehicle is in motion or a part of traffic—including stopped in traffic or at a traffic light. • Cell phone use is totally banned for school bus drivers. • Cell phone use is totally banned for teen drivers during their permit and provisional license stages (drivers under 18).	

Communicable Disease Prevention and Control

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Policy Issues	LPHA Policy Positions
A. Local Public Health Grant and state emergency fund: Minnesota statute charges state and local health departments with responsibility for controlling and preventing the spread of communicable diseases. Limited resources funded by local tax levy and/or the Local Public Health Grant coupled with continually emerging outbreaks (TB, Measles, Avian Flu, Zika) strain the ability of local health departments to ensure community protection.	**1.** LPHA supports increasing the Local Public Health Grant—which is the foundational funding source of Minnesota's local health departments—to at least the 2003 level. **2.** LPHA supports establishment of an emergency fund and the creation of a process for local jurisdictions to recover costs related to infectious disease outbreaks when the response required significantly exceeds local resources.
B. Data collection and management: Preventing and effectively responding to communicable disease outbreaks requires access to disease-related data that can be collected, shared and analyzed in a timely manner across local public health agencies, the state health department and physicians.	**3.** LPHA supports funding and policies that provide access to real-time data in order to effectively investigate and follow-up on infectious diseases. **4.** LPHA supports immediate and full implementation of a bidirectional, interoperable surveillance system that serves both public and private providers at the state and local level. **5.** LPHA supports policies and funding for pilot programs to increase technological advances like tele-health.
C. Tuberculosis: Investigation, control and treatment of tuberculosis cases (active and latent) are labor-intensive and costly. Once thought to be "eliminated", TB is slowing making a comeback in Minnesota. While a very small amount of money is available for tuberculosis control from the Eliminating Health Disparities grant, people diagnosed with tuberculosis may have no payment source or may be uninsured or under-insured. This results in costly uncompensated care for local health departments and community health care providers.	**6.** LPHA supports increased funding reimbursement to local health departments for the investigation, control and treatment of active and latent tuberculosis. **7.** LPHA supports creating a fund (similar to FEMA) to which counties can apply to help offset costs for expensive tuberculosis case follow up.
D. Evidence-based policy: Public Health is a discipline grounded in science. In past years there have been efforts to enact laws and policies that are not grounded in the science of prevention and control of communicable diseases.	**8.** LPHA supports laws and policies that are grounded in the science of prevention and control of communicable diseases and opposes laws that are not.
E. Immigrant health: Many refugees and immigrants come from countries where communicable diseases are common and public health services are lacking. Local health departments must address immigrant/refugee health needs to ensure protection of the whole	**9.** LPHA opposes efforts that require local health department officials to report undocumented persons to the state or federal government.

	community.	
	F. Sexually transmitted infections: In Minnesota, sexually transmitted infections are the most commonly reported communicable diseases and account for nearly 70% of all notifiable diseases reported to MDH.[33] Data continues to show increases to a number of STIs, including chlamydia.[34]	**10.** LPHA supports increased public health funding for sexually transmitted infection prevention, health education, testing, counseling and referral.
	G. Immunizations: Immunization is a key method of keeping our children safe by preventing the spread of deadly communicable diseases. Minnesota's immunization rates for children age 24-35 months range from approximately 55-85%, depending on the vaccine.[35] It will take both private and public sector efforts to move these rates upward. In recent years, immunization rates have waned, leading to various outbreaks across the country, including Minnesota. These outbreaks put populations who are not adequately protected at greater risk for disease, as seen in the ongoing outbreaks of measles and pertussis in Minnesota over the past 10 years.	**11.** LPHA supports funding for statewide, consistent public and provider education and outreach for vaccinations, as well as funding for local health department outreach to health care practitioners and their communities. **12.** LPHA supports maintained MDH support and provision of adult and children vaccines to local health departments. **13.** LPHA supports updates to Minnesota's school immunization requirements that follow best immunization practices as outlined by the national Advisory Committee on Immunization Practices and opposes efforts to weaken the existing requirements. **14.** LPHA supports increased funding and policies for the Minnesota Immunization Information Connection (the state immunization registry) that assure maximum use by schools, clinics, pharmacies and other immunization providers.

Ensuring Health and Social Equity

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Policy Issues	LPHA Policy Positions
A. Funding for health equity initiatives: Serious health inequities exist between populations of color, persons living in poverty, and the rest of Minnesota's population. Life expectancy within Minnesota varies by zip code. African American and American Indian babies die in the first year of life at twice the rate of white babies.[36] Populations of color in Minnesota are at greater risk of many leading causes of death including cancer, heart disease, diabetes, homicide, suicide, unintentional injury and HIV/AIDS. Advancing health equity requires authentic engagement with diverse communities, as efforts are more successful when designed with (not simply for) communities experiencing health disparities. Health is shaped at the community level, and the whole community is needed to address community conditions for health. Community history, wisdom and knowledge are critical sources of information and experience that should be considered with public health practice and evidence.[37]	**1.** LPHA supports maintenance of funding for MDH's Eliminating Health Disparities initiative, as well as additional funding for state and local governments to work together on health equity issues. **2.** LPHA supports implementation of the recommendations from the SCHSAC Advancing Health Equity Workgroup. **3.** LPHA supports a dedicated focus within MDH to advance the recommendations of *Advancing Health Equity in Minnesota: Report to the Legislature* (February 2014). **4.** LPHA supports that health equity is addressed in state-funded programs allocated to either MDH or to local health departments. **5.** LPHA supports the use of SHIP funding (focused on obesity and tobacco prevention) by statewide partners and local health departments to assure the health equity of all people living in Minnesota and SHIP-funded communities. **6.** LPHA supports state and local analysis of the health impact of public policies on populations that experience health inequities such as communities of color and LGBTQ individuals.
B. Social determinants of health: Social and economic conditions that are strong predictors of health outcomes are not favorable for populations that experience health disparities. Unemployment is highest among populations of color, American Indians, and people who live in rural Minnesota, as well as individuals with disabilities. American Indian, Hispanic/Latino, and African American youth in Minnesota have the lowest rates of on-time graduation.[38] Prolonged poverty is generally the leading cause associated with health inequities. Inequities are caused by a variety of other social conditions including racial and cultural barriers to care, disparate access to preventive health resources, unemployment, the lack of a livable wage, and unsafe and unstable housing.	**7.** LPHA supports a health in all policies (HiAP) approach to policy making to ensure decisions made outside the traditional health sector have a positive or neutral impact on determinants of health. This includes the expansion of cross-sector work to develop healthy public policies which address structural racism. **8.** LPHA supports investment in proven efforts and promising practices to advance health and social equity and demonstrate positive outcomes for those experiencing the impact of health inequities and disparities. **9.** LPHA supports efforts to increase the income for the poorest Minnesotans (e.g., increasing MFIP cash assistance for individuals and families, the statewide minimum wage, etc.) **10.** LPHA supports alignment of efforts at the state level to leverage funding for regions and populations disproportionately affected by employment, education, transportation, and housing inequities.

	C. Health care access: Medicaid and other public programs can be important catalysts for efforts to eliminate racial and ethnic disparities. Accountable Care Communities provide a multi-sector framework to evaluate the health inequities of a population and tailor interventions based on the community's shared vision and goals.	**11.** LPHA supports proposals to protect health care access and increase resources to help those most affected by health disparities obtain health care coverage and health services. **12.** LPHA supports efforts to strengthen the health care safety net and continue health care coverage for the poorest adults in the state. **13.** LPHA supports guaranteed comprehensive health coverage and services for every child and pregnant woman. **14.** LPHA supports utilization of State Innovation Model (SIM) grants and other funding by local health departments and statewide partners to move communities closer to adopting a health in all policies approach to advance health equity. **15.** LPHA supports the state's use of regulatory and purchasing influence to engage managed care organizations and providers in identifying and actively addressing racial and ethnic disparities in care. Specifically, LPHA supports that state agencies: • Strengthen and standardize efforts to collect information on the race, language and ethnicity of enrollees, either directly or indirectly; • Incorporate disparities reduction goals and objectives into health plan and provider contracts; and • Ensure tele-health and other electronic resources are available where needed.
	D. Data collection and sharing: Efforts to eliminate racial and ethnic disparities in health care must begin with valid and reliable data on race, ethnicity and language preference. Multiple data challenges exist, including diversity within population groups, a lack of LGBTQ data elements and the need to connect demographic information with data on the social and economic factors that create health. While collecting such data alone cannot reduce or eliminate disparities, gathering these data is a necessary first step in identifying disparities and targeting strategies to address inequalities in care.	**16.** LPHA supports funding and policy proposals which will improve health equity data collection and sharing between MDH and key outside partners, while ensuring data privacy. **17.** LPHA supports funding and policy proposals to ensure implementation of a race/ethnicity/language (REL) data collection standard for public health data.

	E. Diverse and culturally competent workforce: A culturally competent health care system and public health environment reduces health inequities and ultimately reduces total health care costs. Culturally-specific health care approaches work because people seek help from those with whom they feel comfortable, and culturally diverse providers may more readily respect and understand unique cultural values that affect health. Health care providers frequently do not reflect the ethnicity of those most affected by health disparities. Increased recruitment, training and certification programs are needed to attract a variety of providers of color and American Indians to health care and public health careers.	**18.** LPHA supports a health care workforce that will advance health equity. **19.** LPHA proposes that local health departments develop a plan and a set of standards for increasing the cultural competencies of existing staff and for recruitment of staff and consultants representing populations experiencing health inequities. **20.** LPHA supports additional training and expansion of the use of Community Health Workers. **21.** LPHA supports the development of statewide standards, a certification process and registry and training for medical interpreters to ensure quality interpretation and translation services for limited English-proficient patients. **22.** LPHA supports policies and resources to enable incentive programs such as scholarships for minority students, loan forgiveness for those committed to practicing in their own communities and internships that encourage minorities to enter the medical and public health fields. **23.** LPHA supports policies and resources that examine (or amend) licensure statutes to incorporate demographics analysis of populations seeking licensure, as a way to determine if there are structural barriers that limit access to these occupations.

Environmental Health

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Policy Issues	LPHA Policy Positions
A. Local control and state-local partnerships: Environmental health services are best delivered when they can be flexible to meet local needs. In MN, all establishments that serve food are regulated to protect the public from food-borne illness. In 2014/2015, legislation passed affecting Minn. Stat. 145A, 28A and 157 that impacts local programs and future opportunities for local delivery of environmental health services.	**1.** LPHA supports exploration of models for delivering evidence-based environmental health services that emphasize and incorporate evidence-based practice. **2.** LPHA supports the work of the Environmental Health Continuous Improvement Board (EHCIB) in establishing standards for state review of all environmental health programs in the prevention of food-borne illness and the spread of infectious disease. **3.** LPHA supports the authority and opportunity of all counties and cities to locally operate delegated food, pool and lodging establishment programs supported by a locally determined fee structure. **4.** LPHA supports the work of the Environmental Health Continuous Improvement Board (EHCIB) created to strengthen the partnership between state and local environmental health programs and ensure quality environmental health programs that are coordinated and comprehensive- across Minnesota. **5.** LPHA supports legislation that provides continued support of locally delivered environmental health services. **6.** LPHA supports legislation that unifies state agency programs that govern retail food safety.
B. Children's health: Children are at greater risk than adults of negative health conditions and diseases that result from naturally occurring environmental factors, the built environment, or the byproducts of built environments.	**7.** LPHA supports policies that are child-focused and prevention-oriented regarding the environment and children's health. (see "Chronic Disease Prevention & Promotion of Healthy Lifestyle Behaviors" section)
C. Research and health assessments: The environment we live in can negatively impact our health. For example: • Inadequate or non-existent building and housing codes can negatively affect homes and their occupants. • Mercury, a toxic heavy metal that interferes with brain development, is found throughout Minnesota's air, water and soil. • Poor indoor and outdoor air quality contributes to asthma and other negative health effects. New information regarding environmental health risk factors becomes available on a regular basis.	**8.** LPHA supports science-based studies to improve our knowledge of environmental health hazards. **9.** LPHA supports policies and funding based on peer-reviewed scientific research and observation to mitigate environmental health risks. **10.** LPHA supports expansion of technical capacity and adequate funding to conduct health impact assessments to address complex and emerging environmental concerns (e.g., silica sand mining or Bisphenyl A and Phalates).
D. Radon: Minnesota is an EPA-designated "high radon"	**11.** LPHA supports a statewide law to require radon testing prior to

state. Radon, a naturally occurring radioactive gas, is a leading cause of lung cancer and is a significant threat to human health. The Radon Awareness Act (passed in 2013) was legislation intended to increase public awareness and statewide testing.	occupancy or sale of a home and mitigation when tests indicate an unsafe level of radon is present.
E. "Healthy Homes," including lead and asthma interventions: Approximately 90% of time is spent indoors with the largest percentage of that time within homes.[39] In 2012, federal funds for healthy homes were cut by 94% limiting MDH and Local Public Health's ability to implement The Minnesota Healthy Homes Strategic Plan. Poor housing conditions can contribute to asthma, lead poisoning, injury, respiratory illness and poor mental health. For example, lead poisoning in young children is preventable, yet many are needlessly exposed and many at risk do not receive lead screening. Minnesota's lead surveillance system—which has enabled local health departments to think and act strategically, resulting in a profound reduction of blood lead levels for children across the state—has been defunded. A healthy homes approach to housing-based health threats identifies and mitigates exposure to hazards like lead, radon, mold and pests in an efficient and comprehensive manner, thus providing public health professionals the opportunity to impact social determinants of health.	**12.** LPHA supports policies that promote early intervention to remove healthy homes hazards before children are exposed. **13.** LPHA supports maintaining or increasing state funding to prevent and remediate healthy homes issues including outreach and education, in-home risk assessments, home visits, the provision of low-cost products and remediation. **14.** LPHA supports lead screening for at-risk children. **15.** LPHA supports sustained funding for MDH's lead surveillance system.
F. Sewage treatment systems: Many subsurface sewage treatment systems are non-complying and have the potential to impact surface and groundwater, thus negatively affecting human health. Presently, 69% of counties, 64% of cities, and 45% of townships require point of sale compliance inspections of subsurface sewage treatment systems (SSTS).[40]	**16.** LPHA supports county policies that require point of sale compliance inspections for subsurface sewage treatment systems (SSTSs). **17.** LPHA supports adequate funding from state agencies to cover the costs to LGUs for implementation, programming, enforcement and administration of rules while allowing counties to focus on systems that are failing and considered an imminent public health threat. **18.** LPHA supports an ongoing state grant and loan assistance program to assist landowners in upgrading or replacing non-compliant SSTSs.
G. Drinking water: Water is essential for life. The amount of fresh water on earth is limited, and its quality is under constant pressure. Preserving the quality of fresh water is important for the drinking water supply, food production, and recreational water use. Water quality can be compromised by the presence of infectious agents, toxic chemicals, and radiological hazards.[41]	**19.** LPHA supports policies that require point of sale water testing for private drinking water wells. **20.** LPHA supports policies and funding that will ensure safe and reliable drinking water from municipal water supply systems and protect drinking water supply sources from contamination. **21.** LPHA supports policies and funding for monitoring the health of individuals or communities affected by exposure to an unsafe water supply.

		22. LPHA supports policies and funding to ensure that local environmental public health departments develop and maintain the capacity to assist in the response to public health concerns related to contamination of the water supply by chemical or biological agents. **23.** LPHA supports policies and funding for testing of water in schools for lead and for replacement of lead-containing fixtures and lead water supply services lines. **24.** LPHA supports policies and funding for water supply infrastructure improvements including but not limited to replacement of lead water supply service lines to homes, businesses and schools.
	H. Pharmaceuticals: Disposal of unused pharmaceuticals in public and private sewer systems has resulted in contamination of ground water and drinking water by endocrine disrupters and other dangerous chemicals. Disposal of medical facility, health care facility and household pharmaceuticals—particularly DEA controlled substances—can be very difficult due to the regulatory environment.	**25.** LPHA supports policies that encourage collection, proper management, and disposal of pharmaceuticals from medical and health care facilities and households—including controlled substances—by reducing the regulatory burden and exploring cost-effective options.
	I. Environmental justice/health equity: Many environmental issues disproportionately affect people of color and people living in poverty. Special attention should be paid to eliminating disparities in environmental health impacts.	**26.** LPHA supports that state-funded initiatives address environmental justice issues like safe and healthy housing, increased community green space and reduced air and water pollution.
	J. Climate change: Minnesota's climate is changing. Increased heat and severe weather events have the potential to impact human health through direct weather-related events as well as changes in disease vectors, water quality, and air quality.	**27.** LPHA supports state-level data collection, risk identification, and planning activities related to climate change in partnership with local health departments.

Health Care System Improvement

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Committee Members:
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Policy Issues	LPHA Policy Positions
A. Coordination of care: Health care reform is evolving at the state and federal levels. Local health departments are in a position to be key strategists to implement changes that reduce chronic health conditions, control health care expenditures, and improve population health. Public health and health care providers are challenged to collaborate to address policy, systems and environmental changes and to enhance care coordination with Accountable Care Organizations (ACOs)/Integrated Health Partnerships (IHPs) and other reform initiatives. Local health departments should be at the center of planning the local reform agenda as these agencies lead Community Health Assessment and Community Health Improvement Plan processes to advance long-term, systematic efforts to address public health problems in a community.	**1.** LPHA supports coordination, planning and implementation activities between public health and primary care to address identified community health priorities. **2.** LPHA supports local health departments as a key convener of community partners to address public health issues. **3.** LPHA supports opportunities for federal funding to enhance state-funded prevention activities. **4.** LPHA supports policies and legislation that promote the unique public health role to assure access to care utilizing case management/care coordination and working with consumers to establish a health care home.
B. Healthcare access: An individual health insurance coverage mandate now applies in Minnesota under the Affordable Care Act, but there will still remain a percentage of uninsured and underinsured individuals in the state.	**5.** LPHA supports proposals that have the goal of providing access to health care coverage for all Minnesotans, with a priority of providing coverage for infants and children, and assuring there is a safety net of coverage for as long as it is needed. **6.** LPHA supports expanded and stabilized eligibility for public health care programs to promote preventive care and timely access to treatment in order to allow earlier coverage, reduce uncompensated care and mitigate premium increases that result from more expensive acute care episodes. **7.** LPHA supports proposals that provide incentives to employers to offer adequate and affordable health insurance to employees.
C. Access to mental and chemical health services: Federal legislation was passed in 2009 for parity between mental health and physical health services within health insurance coverage. Minnesota has not developed an adequate system for either insured or uninsured persons to receive care for mental health issues.	**8.** LPHA supports policies or incentives that require health plan companies to improve treatment benefits for alcohol and other drug use and mental health care, including reimbursement for tele-medicine modalities. **9.** LPHA supports policies that close gaps in access to mental health services, especially in rural areas.

	D. Emphasizing prevention to reduce health care costs: Rising health care costs are associated with inappropriate use of the health care system, the use of expensive technology without proper cost-benefit analysis, a limited focus on prevention before treatment, recurring acute care episodes and chronic conditions and high administrative costs for both health plans and health care providers due to differing benefit sets and administrative requirements.	**10.** LPHA supports policies and incentives, such as Accountable Communities for Health, for individuals to utilize preventive health services and other community resources rather than waiting to use urgent or emergent care. **11.** LPHA supports expansion of ACOs, IHPs, and other incentives that promote utilization of preventive health strategies, including early intervention treatment for chronic conditions as well as dental and mental health care. **12.** LPHA supports policies and proposals that reduce health care administrative costs by streamlining health care program/payer administrative requirements.
	E. Community-based care: A population-based approach is critical to health reform and system innovation, and there is a key role for local government. County-based health care purchasing, ACOs, and IHPs provide an opportunity to build a prevention-focused, community-based local care system that optimizes health while controlling costs for the Medical Assistance population.	**13.** LPHA supports policies that promote a public health role in provider and payer initiatives that seek cost-effective and quality care services, with a focus on prevention, community integrated care services and accountable communities for health. **14.** LPHA supports the county option to participate in county-based health care purchasing and expansion to include additional populations.
	F. Access to dental care: Access to dental care is limited due to the lack of a sustainable, statewide model of care for persons on public programs. This is influenced by a shortage of dental health care workers and reimbursement practices for persons on government health programs.	**15.** LPHA supports improved access to dental services by encouraging the development of a sustainable, statewide model of care for persons using new dental provider practice models. **16.** LPHA supports critical access provider status for dental care providers who are currently providing services to public enrollees and providers who are willing to expand their service to other areas within the state.
	G. Community health assessments: Federal guidelines now require non-profit hospitals to assess local community health needs and work together with local health departments to identify and address population health issues.	**17.** LPHA supports opportunities for local health departments to work with hospitals and clinic systems to identify community health issues and coordinate and integrate efficient and effective services across community organizations to improve population health. **18.** LPHA supports alignment of funding with hospital/community health assessment for population-based initiatives. **19.** LPHA supports the reinvestment of financial savings into community prevention as the primary community benefit priority for non-profit hospitals. **20.** LPHA supports efforts to aggregate health system electronic health records to enhance population level community health assessment information.

	H. Electronic health data: An interoperable health IT ecosystem makes the right data available to the right people at the right time across products and organizations in a way that can be relied upon and meaningfully used by recipients. By 2024, individuals, care providers, communities and researchers should have an array of interoperable health IT products and services that allow the health care system to continuously learn and advance the goal of improved care.	**21.** LPHA supports policies for consumers to make use of health information to support their own health and wellness and to securely share electronic health care information with care providers. **22.** LPHA supports the collection of aggregated population level data to improve critical public health functions such as real time disease surveillance, disaster response and measurement of performance toward population health goals.

Healthy Children and Families

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Policy Issues	LPHA Policy Positions
A. Family home visiting: Public health interventions that begin prenatally and continue through preschool age promote healthy birth outcomes, promote bonding and attachment, identify and address maternal depression, improve parenting, reduce child abuse and neglect, and prepare children for school. While recent dedicated funding for Nurse Family Partnership (NFP) home visiting will reach some low income first time parents, many parents who have more than one child or who are referred post-partum could benefit from parenting support from other home visiting programs, as well. Local health departments vary in their ability to implement the current MIECHV-identified models of Nurse Family Partnership (NFP), HFA (Healthy Families America), and Family Spirit. Further exploration is needed by MDH to better understand the needs and gaps across the state, in order to build a quality system of family home visiting throughout Minnesota.	**1.** LPHA supports the sustainability of TANF funding to assist public health in forging local partnerships around home visiting services. **2.** LPHA supports sustainable, statewide funding for public health family home visiting programs, including supporting MDH and DHS collaborative efforts to increase MA reimbursement for public health nurse home visiting. LPHA supports efforts to explore and establish reimbursements for family home visits provided by other professionals, as well as trained paraprofessional staff. **3.** LPHA supports maintaining the requirement of at least an initial public health nursing assessment for family home visiting programs, as mandated in Minnesota Statute. **4.** LPHA supports the role of public health in assuring that there are effective local efforts in public awareness and skilled intervention available to address maternal depression and other family challenges that put both the family and the child at risk. **5.** LPHA supports the implementation and expansion of quality family home visiting programs throughout Minnesota.* This includes support for exploring other evidence-based models and those that are evidence-informed or recognized as a promising practice.
B. Early childhood intervention: Recent restructuring of the Interagency Early Intervention Committees into a regional model has decreased funding for Follow Along and other early intervention programs without another agency being able to pick up these high benefit services. Technical assistance from the National Help Me Grow model is moving toward easier access to early childhood resources for providers and families. These programs aim to connect high-risk families to services. Responding to identified issues early is both preventative and cost effective. Currently, the state Help Me Grow model provides referrals to school districts for Early Childhood Special Education assessments. For many children and families, additional services are needed. Full funding to implement the National Help Me Grow Model would complement MN's existing program and support providing information, resources and referrals to families seeking early intervention services for children birth to age 8.	**6.** LPHA supports requiring a local health department representative in every regional Interagency Early Intervention Committee to ensure adequate attention and funding for public health early interventions such as Child Find and Follow Along. **7.** LPHA supports other potential dedicated funding streams and alternative methods of delivery for the Follow Along Program. **8.** LPHA supports funding for implementation of the National Help Me Grow program in Minnesota, with an emphasis on reaching at-risk families. **9.** LPHA supports increased screening and referral to services for children under age 3 who are exposed to violence.

C. Maternal and child health: Federal and state funding reductions are threatening core maternal and child health programs that serve teen parents, as well as high-risk and low-income mothers and children (e.g., the Maternal and Child Health Block Grant, Local Collaborative Time Study funding, WIC and TANF). Significant disparities exist within the African American and American Indian community related to infant mortality. Prematurity is the leading cause of infant deaths among African Americans, and Sudden Unexpected Infant Deaths (SUID) and sleep-related deaths are the leading cause of death among American Indian infants.[42]	**10.** LPHA supports increased or stable, ongoing funding for evidence-based programs that serve teen parents, as well as high-risk and low-income mothers and children including home visiting, WIC, maternal and child health and family planning. **11.** LPHA supports funding for school readiness, youth risk behavior reduction and teen pregnancy prevention. **12.** LPHA supports reinstating legislative authority and funding to conduct voluntary infant and maternal death reviews in communities experiencing health disparities to assist in planning, implementation, and evaluation of medical, health, social service, and community systems to improve pregnancy outcomes and reduce the numbers of preventable infant and maternal deaths. **13.** LPHA supports funding for MDH to implement evidence-based strategies to assist families in creating safe sleep environments for infants.
D. Early childhood care and education: Despite some improvements, child care funding continues to be inadequate. Too few skilled child care providers, along with reductions in child care services create waiting lists and put children at risk for unsafe care or care minimally focused on child development. Lack of accessible child care leaves parents at risk for leaving or losing their employment.	**14.** LPHA supports increased funding for scholarships, the Child Care Assistance Fund and other early childhood care/education support programs to eliminate waiting lists for child care services and enable families to seek and obtain quality care. **15.** LPHA supports initiatives that help families better understand the importance of early brain development and that provide activities known to enhance brain development in children ages prenatal to 3. This includes activities/initiatives such as those included in the *Statewide Health Improvement Framework*. **16.** LPHA supports funding to recruit and train child care providers to increase access to skilled (licensed) child care for families. **17.** LPHA supports MDH collaboration and implementation of initiatives regarding ACEs and the promotion of infant and child mental health.
E. Violence and substance abuse: The health of children, adolescents and families is negatively affected by violence, alcohol, tobacco, illegal drug use, poverty and a lack of health care access.	**18.** LPHA supports state funding and policies to assist local community efforts to prevent violence and the use of and exposure to alcohol, tobacco and illegal drugs. **19.** LPHA supports efforts and legislation to raise awareness of and promote safe, stable, nurturing relationships and environments and prevent child maltreatment. **20.** LPHA supports using local data to raise community awareness of child maltreatment and to inform strategies; this may include vital statistics, hospital ER data, criminal justice data, child protection and welfare data, educational data and demographic data.
F. Evidence-based sex education and family planning: Evidence-based sex education and	**21.** LPHA supports policies that promote access to confidential physical, mental

	family planning services are proven methods of preventing unplanned pregnancies and improving pregnancy outcomes. Funding for these services is insufficient.	health and chemical dependency services for adolescents. **22.** LPHA supports increased family planning funding and partner with the Minnesota Department of Human Services (DHS) to improve implementation of the federal 1115 Waiver.
	G. Maternal and child health in correctional facilities: Women are the fastest growing population in today's U.S. prisons. 80% of all female inmates are mothers of school-aged children. The vast majority of prisoners are still men, however, and of them 92% have (minor) children.[43] State law now requires that women under age 50 must be offered pregnancy testing on or before 14 days of incarceration, but early prenatal care and/or postpartum care after delivery are a challenge in the correctional setting.	**23.** LPHA supports policies and programs that strengthen families impacted by parental incarceration. **24.** LPHA supports policies, resources, training and programs that provide prenatal care and postpartum care for incarcerated women (e.g., "Nursing Care of Pregnant & Postpartum Care in MN Jail and Workhouses: Education and Training Manual 2011" by Mary Rossi).

** Recognizing that current evidence-based models of NFP, HFA and Family Spirit are not adequate to serve all families in MN, the LPHA supports efforts to expand the use of other evidence-based models and explore the potential role of state standards. Any work in this area must include: a needs assessment to better identify current gaps in services, an examination of how standards would impact LPH, vetting by LPH staff, assessment and discussion of MDH capacity to support and oversee standards, and discussion of ways to better promote collaboration between LPH and community non-profit agencies.*

Healthy Aging & Long-Term Care

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Committee Members:
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Policy Issues	LPHA Policy Positions
A. **Healthy aging:** Promoting healthy aging throughout the life span and preventing chronic diseases is key to long-term care cost containment and quality of life improvement.	**1.** LPHA supports funding and policies that encourage coordinated prevention and early intervention activities with counties, health plans and other health care systems to support healthy aging throughout the life span. **2.** LPHA supports the need to get midlife and older adults to adopt healthier lifestyles through inclusion in SHIP and other initiatives using evidence-based models.
B. **Financial planning:** DHS continues to project that individuals are not adequately preparing financially and planning for the care they will need as they age.	**3.** LPHA supports policies that encourage more realistic planning for post-retirement living costs, promote an earlier focus on the need to save and expand the availability of quality long-term care insurance and other strategies that promote planning for future health care needs.
C. **Home and community-based services:** There is uneven and inadequate availability of affordable home and community-based services. MN has succeeded in reducing the number of persons who live in nursing homes; now persons with disabilities or the elderly and their families see community living as the norm. While people want home and community-based services, there are barriers that limit the availability of those services, including issues around accessibility and affordability. Specifically, there is limited availability of housing with mental health supports for seniors, affordable customized living options for seniors, housing for the under age 65 population with high behavioral health needs, and a shortage of crisis beds. Nurses and social workers have unique and specialized skills to offer consumers as we look at client centered care planning and service delivery.	**4.** LPHA supports DHS in seeking new federal waivers with adequate dollars and supports for mental and behavioral health needs to give families and people with disabilities more options for home and community-based services. **5.** LPHA supports DHS collaboration with the Housing Finance Agency, cities, and others to promote accessible housing and "aging in place" housing models. **6.** LPHA supports equity across all waivers and across the age span. All waivers should have: • A common menu of services available; • Appropriate funding to meet assessed needs; • Consumer directed options. **7.** LPHA supports a multidisciplinary approach for assessment and case management.
D. **MnCHOICES assessments and reimbursements:** Counties need to be fully reimbursed for their mandated functions. Through comprehensive assessments, counties serve a vital role in providing information on local, community-based long-term care services that keep the elderly and disabled in home and community-based settings rather than in more expensive nursing home settings. However, the payment methodology for counties has changed from primarily fee-for-service to time study reimbursement. Counties who are using the LCTS reimbursement methodology are not being full reimbursed, as promised, and this issue must be addressed.	**8.** LPHA supports equitable and appropriate reimbursement for the MnCHOICES assessment functions regardless of the time study (Local Collaborative Time Study—LCTS—or Social Services Time Study—SSTS). **9.** LPHA supports strategies that enable counties who are using current LCTS and SSTS reimbursement methodologies to be fully reimbursed for their assessments and for the costs counties are incurring for the administrative work related to the MnCHOICES assessment.

E. Funding to support county services: Counties retain key roles that should be recognized and funded so that all seniors and persons with disabilities have adequate information and quality services and supports available as their needs change. The role of the public sector in long-term care has shifted significantly in the last several years, particularly for elderly residents. The state has shifted funding from counties to health plans for Elderly Waiver services, and the state has assumed a number of administrative functions for the waivers for people under 65 who are disabled. There continues to be a need for counties to be involved in quality assurance and home and community-based long-term care network development so that the public receives appropriate care, but there is no funding source for this role.	**10.** LPHA continues to support adequate and equitable state funding for the county role, including: • Providing access to information and appropriate community services and supports; • Completing comprehensive assessments and execution of individual plans of care, as well as initiation of fee-for-service care, waiver programs, or private pay (prior to HMO involvement). Counties continue to provide unfunded case management for: persons eligible for Rule 185; persons not on MA (in process or gap in coverage) with assessed needs; and persons eligible for PCA/state plan services. • Managing key steps in the delivery of community-based services, including managing the first steps in the disability waiver rate system (which involves working with hundreds of providers); managing contracts for case management services; managing aggregate spending; and performing local quality assurance functions such as monitoring compliance/satisfaction performance, resolving problems/incidents and consulting on best practices. • Maintaining an adequate safety net of home/community/health care in light of workforce and reimbursement issues. Critical workforce shortages exist particularly related to complex medical care and PCA services. • Assuring county residents are safe and secure in their home and community and that county adult protection services are fully available to address the concerns of vulnerable people. (Currently, the county adult protection program is co-funded by state and local dollars.) • Participating in the state's oversight of strengths/challenges of client care and quality assurance functions, such as case management and network development/gaps analysis in the local home and community-based services system. • Supporting the development of new services and resources.
F. Standardize health plan forms / expectations: Managed care organizations develop their own forms rather than using a common format. This creates unnecessary complexity for counties contracting with multiple health plans for care coordination/case management services and also affects the quality and timeliness of service provided to clients.	**11.** LPHA supports DHS in developing universal processes for counties and health plans in the delivery of home and community-based long-term care services (e.g., standardized forms). **12.** LPHA supports DHS in requiring that Health Plans serving MA populations attest to/have processes to promote continuity of MA

Standardizing forms and processes would reduce unnecessary administrative burdens. Health Plans play a significant role in assuring continuity of long term services/supports, especially to seniors. Counties engage with Health Plans at varying levels including: transition many Seniors on LTSS as they move from MA FFS (fee for service) to MN Senior plans; contractually provide care coordination/case management services; as seniors lose MA eligibility provide ongoing LTSS services.	and long term services/supports.
G. Evaluation of assisted living counseling: The use of customized (assisted) living has grown to the extent that there are more customized living units than nursing home beds in MN. The Legislature created a process for area agencies to provide information to people prior to entering customized living. However, the effectiveness of this new process is unclear. The process and the impact of changes that occurred as part of it must be evaluated.	**13.** LPHA supports DHS in evaluating the outcomes (including cost-effectiveness) of Area Agencies on Aging options counseling, which individuals must now complete before they enter customized living.
H. Transitioning in and out of institutional care: There are a number of inefficiencies and additional complexities/expenditures at both the state and local level due to interruptions in program eligibility for both elderly and disabled individuals, in particular related to people either entering or leaving institutional care (e.g., the mandated Pre-Admission Screening and the Omnibus Budget Reconciliation Act could be streamlined).	**14.** LPHA supports DHS initiation of a systems analysis regarding the multiple processes currently mandated when people either enter or leave institutional care.
I. Serving high-needs adults under age 65: Costs for persons in long-term care facilities under age 65 are shared between federal, state and local government. Since 2003, local governments have been responsible for paying 20% of the state's share. The counties have reduced the number of people under age 65 who have been in nursing homes more than 90 days; however, some individuals require nursing facility level of care and there are no local community options for them to safely relocate.	**15.** LPHA supports elimination of the county share of nursing home costs for those under age 65 and instead providing service and housing funding to establish more community options for high-needs adults under age 65.
J. Inmates with disabilities, complex medical needs and/or behavioral support needs: Correctional facilities are designed for security, not for complex health care delivery. Many jails do not have appropriate/accessible accommodations for disabled inmates. When inmates require major health services, specialized care or basic assistance	**16.** LPHA supports the development of and payment for alternative care sites for county detainees who do not require hospitalization but have disabilities, complex medical and/or behavioral health supports needs that require care and accommodations not available in most county jails. **17.** LPHA supports new funding reimbursement initiatives that cover

	with daily life activities, local jails are neither staffed nor equipped to meet these needs. Medication management and administration is complex and costly. Many inmates have chronic and multiple conditions, requiring involved medication regimens.	medication costs for inmates.

Mental and Chemical Health

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Policy Issues

A. Funding for mental and chemical health promotion and early intervention Mental and chemical health promotion can improve quality of life and physical health, and early intervention services can lessen the burden of both. Unrecognized and untreated mental and chemical health conditions can disrupt development across the lifespan, social connections, family life, education, employment and economic stability, and full community participation. Early intervention and support for families can prevent child and parent mental and chemical health problems and promote overall health and resiliency at all stages of life. When left untreated, mental and chemical health conditions can worsen and become disabling or less amenable to treatment.

B. Holistic approach to health. Mental and chemical health are as essential as, and closely linked with, physical health in the well-being of individuals. Lack of resources has resulted in limited treatment options and a system focus on treatment after mental health and chemical health issues emerge. People with more severe mental illnesses are more likely to die, on average, 25 years prematurely when compared to the rest of the Minnesota population and would benefit from a health promotion, prevention and intervention strategy that integrates physical, mental, and chemical health.

C. Burden of health care and indirect costs on counties, individuals and their families: Shortfalls in insurance, state, and federal dollars burden local governments to cover indirect costs, gaps, and lack of capacity. Individuals affected by mental and chemical health issues and their families shoulder significant emotional and financial burdens as well, and may experience loss of employment, housing, and other supports as a result of illness and disability.

LPHA Policy Positions

1. LPHA supports a public health approach to mental and chemical health across the lifespan, particularly for children, adolescents and young adults, and early in the life of problems.
2. LPHA supports the role of local health departments in the model of prevention, early identification and intervention for mental and chemical health conditions and parity of mental and chemical health with other health conditions.
3. LPHA supports efforts to increase public and policymaker awareness of the importance of mental and chemical health as part of overall health and wellbeing and encourage the appropriate use of early intervention services.
4. LPHA supports mental and chemical health policies and funding that encompass health care reform, including a focus on mental and chemical health promotion.
5. LPHA supports funding to promote access to early intervention and community-based treatment for mental illness, increase the supply of mental and chemical health professionals and practitioners from many language and cultural groups, and promote outreach to individuals who are unable to seek care with tele-medicine, mobile services, and co-located, integrated services in health care and other community settings.
6. LPHA supports evidence-based recommendations of the SCHSAC Mental Health Work Group and other committees and task forces addressing mental and chemical health.
7. LPHA supports recommendations for early intervention programs for pregnant women who have chemical and mental health issues.
8. LPHA supports full funding for evidence-based family home visiting for at-risk families with newborns and children 0-3, including mental and chemical health screening and referrals and focus on the parent-child attachment as part of the home visit.
9. LPHA supports modifying state service rules that may be counterproductive in serving parents who are mentally ill and need non-mental health services, such as basic sliding fee child care programs or housing solutions with supports for parents with mental illnesses). Programs frequently have long waiting lists and children age out before they and their families

	move to the top of the list. **10.** LPHA supports strengthening screening and referral activities for children in child protection or corrections programs. **11.** LPHA supports collaborative, regional approaches for provision of care-sharing services, joint contracting or other cost-containment initiatives.
D. Social determinants of health: Anyone can be affected by mental health or chemical health issues. Poverty is a demonstrated risk factor for increased mental and chemical health problems, since it limits the resources available and in some cases affects the treatment and services offered. There can be significant economic and emotional burden as a result of mental and chemical health disability. Social inequity has been associated with global increases in mental health disorders and cannot be addressed through treatment alone. Prejudice and discrimination against persons with mental health and chemical health disorders and their families make it difficult to seek care, find support, and engage in prevention and recovery planning for overall health. Participation in community life can be curtailed and social rejection a trauma and a risk factor for suicide. **E. Toxic stress and ACEs.** Toxic stress and Adverse Childhood Experiences (ACEs) can create physiological changes that alter the lifespan trajectory for individuals and reduce their capacity for health and wellbeing.	**12.** LPHA supports efforts to maintain eligibility for financial support and Medical Assistance for families and single adults with mental illness and substance use disorder. **13.** LPHA supports health promotion campaigns to increase compassion and inclusion of persons with mental health and chemical health concerns. **14.** LPHA supports employment programs and safe supportive housing for persons with mental health and chemical health issues. **15.** LPHA supports health care models that address social determinants of health. **16.** LPHA supports programs, services and tools that address ACEs and collaborate with partners to have a positive impact. **17.** LPHA encourages use of current research on the relationship between trauma, culture, inequity, and protective factors to promote health. **18.** LPHA supports trauma-informed services and initiatives to foster population health and prevent or reduce the impact of mental health and chemical health issues.
F. Health care homes: Within the context of health care reform, local health departments can to play a strong role in the development of health care homes and other health promotion and prevention activities targeted at children and adults with, or at risk for, mental and chemical health issues.	**19.** LPHA supports policies that encourage coordination of mental and chemical health services with other physical health care and social services through the development of behavioral health care homes and other models emerging through federal and state health care reform. **20.** LPHA supports eliminating barriers to same day billing for medical and mental health conditions by creating a reimbursement mechanism for same day integrated visits outside of health care home certification.
G. Expanding mental and chemical health services: By 2020, mental health and substance use disorders will surpass all physical diseases as major causes of disability and likely limit progress in prevention of physical health issues. Capacity issues in treatment and community programs interfere with timely access and may result in individuals receiving more intensive treatment or	**21.** LPHA supports proposals to restore, stabilize and expand state and federal funding for mental and chemical health services, and improve access to adjunctive services including employment programs and supportive housing, while reducing reliance on local taxation.

placement in restrictive environments, including jail. The 2015 Legislature made major investments in additional crisis services, first episode psychosis care, intensive residential treatment beds and other supports to expand the availability of community services must continue to improve outcomes and reduce the cost of care.	**22.** LPHA supports continued and expanded investments in mental health crisis services to avoid use of unnecessarily intensive or restrictive care by offering emergency care in the community, improving access to mental health and other resources for underserved populations, and reaching individuals who are reluctant or unable to use services. **23.** LPHA supports community based solutions and alternatives to more intensive and restrictive levels of care (i.e., hospital, regional treatment center, jail, civil commitment) when possible.
H. Access to recovery management and individualized treatment services: The course of mental and chemical health conditions varies from person to person and calls for an individualized approach. An emphasis on long term recovery management (similar to disease management), improved access to re-engage services, and for persons whose symptoms may work against their ability to initiate or participate in care are needed.	**24.** LPHA supports service models and reimbursement structures that fit individuals' needs for long term management, improved access to continue services, and other individualized models of care. **25.** LPHA supports mental health parity efforts in Minnesota. **26.** LPHA encourages partnering with the Minnesota Office to Prevent and End Homelessness to develop aftercare facilities specifically for individuals experiencing homelessness to be discharged to post-hospitalization.
I. Statewide data system: Few accurate, all-service-inclusive data systems on childhood and adult mental and chemical health exist in Minnesota. This information is needed to monitor change, plan for unmet needs, facilitate cross-system collaboration, and raise public awareness about mental and chemical health issues.	**27.** LPHA supports the development of an accurate, replicable statewide data system that regularly monitors a core set of mental and chemical health indicators for children, adolescents and adults.
J. Suicide prevention Suicide rates in Minnesota continue to be unacceptably high among all age groups**.** Mobile crisis teams provide strong 24-7 outreach, therapeutic intervention, and family support to persons in suicide crisis and may offer Means Restriction Education and secure storage of means for suicide and postvention with suicide survivors. Crisis programs received increased funds in 2016 to make expand and add teams across the state. Funding for TXT4LIFE, a service that targets the needs of younger populations, was increased by $1 million in 2015. Services such as this, coupled with outreach and training, will help prevent further suicides of Minnesota residents but would benefit from further expansion and coordination with existing suicide prevention and intervention resources.	**28.** LPHA recognizes the role of community and social connection in suicide prevention and promotes the use of best practices such as gatekeeper training (i.e., QPR), screening, 24-7 crisis teams, Means Restriction training and practice, the National Suicide Hotline, screening, DBT skills for adolescents, and public education and training about suicide and stigma reduction. **29.** LPHA supports legislative funding to continue and increase assertive outreach to persons in suicide crisis with 24-7 phone, mobile, and text services, with a goal of Zero Suicide in Minnesota. **30.** LPHA supports timely use of data and coordination with state and national Suicide Prevention Plans to assess progress and target local resources.
K. Opiate abuse: Opiate abuse has become a major health	**31.** LPHA supports policies and efforts to increase cross disciplinary

problem in Minnesota. For example, more people now die annually from unintentional overdoses of opiates than from cocaine and heroin combined.	awareness and approaches to address opiate prescription health issues. **32.** LPHA supports prevention and intervention services for opiate and other alcohol and drug abuse issues, in particular those targeting pregnant women and health disparities. **33.** LPHA supports expansion of treatment services to prevent lack of access to timely services.
L. Drug use prevention: Drug use is a major public health problem which can increase the risk of injuries, violence, HIV infection and other diseases. Drug overdose deaths in MN increased 11% percent between 2014 and 2015 (from 516 deaths in 2014 to 572 deaths in 2015) and are over four times as high as in the year 2000, when there were 129 drug overdose deaths. In 2015, more than half of the drug-related deaths were related to prescription medications rather than illegal street drugs.[44] Nationally, "overdoses from prescription opioid pain relievers are a driving factor in the 15-year increase in opioid overdose deaths. Since 1999, the amount of prescription opioids sold in the U.S. nearly quadrupled yet there has not been an overall change in the amount of pain that Americans report."[45] **M. Alcohol prevention:** Alcohol use is reported by over half of all adults in the United States and is the most widely used drug in MN—even more prevalent than tobacco.[46] Excessive alcohol consumption contributes to a number of negative consequences, including unintentional injuries, violent acts, chronic diseases and unintended or unhealthy pregnancies. The economic costs associated with alcohol use in MN are estimated at over $5 billion annually—17 times greater than the tax revenues collected from alcohol sales.[47] Increasing the price of alcohol through a small tax increase has been shown to reduce excessive drinking and alcohol related injuries.[48]	**34.** LPHA supports better coordination between state government agencies (health, human services, law enforcement and corrections) to prevent alcohol, illegal drug and inappropriate prescription drug use. **35.** LPHA supports policy and professional education that will improve the way opioids are prescribed. **36.** LPHA supports funding for community efforts to easily dispose of prescription drugs. **37.** LPHA supports statewide alcohol tax increases and use of the revenue for programs that support primary prevention for alcohol and substance abuse. **38.** LPHA supports increased funding for primary prevention efforts to address alcohol and drug abuse. **39.** LPHA supports policies that prevent underage alcohol consumption (e.g., social host ordinances, responsible beverage server training and compliance checks).

Public Health Emergency Preparedness and Response

Lead Contact:
Liz Auch, Countryside Public Health

Committee Members:
Sharon Braaten, Pope County; Tony Buttacavoli, Isanti County; Pam Blixt, City of Minneapolis; and Bonnie Brueshoff, Dakota County

Policy Issues

A. Local public health role in preparation and response activities: Local health departments are mandated by the federal and state government to prepare for and respond to all-hazard emergencies and disasters in their communities. The recent Ebola and Zika responses as well as ongoing vaccine preventable disease outbreaks and active TB investigations highlight the importance of continual planning and response capacity by local public health in order to meet critical needs in communities. Recent changes in federal funding align preparedness capabilities and duties between local public health and other medical providers. As a result, clinics, schools and other agencies now look to local health departments for guidance on preparation, response and recovery. Recurring MN disasters—such as infectious disease outbreaks, tornados, floods, wildfires and widespread food-borne outbreaks—have demonstrated the valuable role played by local health departments in responding to emergencies and caring for individuals and communities in crisis and in recovery. This work is considered essential for the health, safety and well-being of our community by our citizens.

B. Assuring and maintaining staff capacity and training: Local public health departments are required to assure their capacity includes fully-trained staff, available 24/7, to respond to public health emergencies, yet the core federal funding that supports local public health department staff continues to be reduced. Since 2005, federal funding for Public Health Emergency Preparedness (PHEP) has been cut by more than 30 percent (from $15 million in 2005 to $10.4 million in 2016).[49] State funding has not been provided to support the state mandated functions, and local tax levies do not provide enough funding to make up for the cuts of federal funding. The capacity for local health departments to respond effectively is eroding. Local public health departments cannot maintain this asset without stable and adequate funding.

Training and exercising are part of the industry standards related to emergency preparedness. Much like firemen and police who train weekly, local public health department staff need to be kept current and practiced in their response roles. Local health public departments are also responsible to recruit, train and coordinate volunteers who respond to public health emergencies (e.g., Medical Reserve Corps/MN Responds). During a disaster or emergency, communities expect to see responders who are knowledgeable and competent in their response roles. This will not occur without adequate funding.

C. Health and medical equipment: Acquiring and maintaining health and medical equipment and supplies needed to respond to

LPHA Policy Positions

1. LPHA supports alignment of public health emergency preparedness and response grant expectations with the level of available funding.
2. LPHA supports reduced administrative burdens associated with grant funds.
3. LPHA supports state funding that is flexible and permanent to supplement local and federal funding for lab work at the state level, as well as local health department emergency planning, capacity building and response activities, including ongoing training and equipment purchase that will ensure the public health workforce and infrastructure is able to respond to public health emergencies.
4. LPHA supports assuring local concurrence with MDH applications for federal emergency preparedness funding.
5. LPHA supports state funding to be set aside for local public health volunteer recruitment, registration, training, networking, and implementation to augment daily workforce infrastructure and increase emergency response capacity.

	incidences are necessary to any emergency response. Equipment must be updated and current staff must be trained and ready to use it. Without ongoing funding, equipment will soon become outdated and staff will not be trained on its use. **D. Medical Reserve Corps:** Local public health departments have a coordinated process to train and utilize volunteer during an emergency response. Federal funding has eroded, and the responsibility to maintain volunteers is a local public health role.	

Injury and Violence Prevention

Lead Contact:
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Renee Frauendienst, Stearns County

Policy Issues

A. Injury and violence prevention: Unintentional injury and violence, including family and community violence, continue to be major causes of death and injury in Minnesota and inflict a significant public health burden. Across the lifespan, youth violence, child maltreatment, domestic violence and community violence impact premature death and disability, productivity, mental health and health care costs in Minnesota's communities.

Injury and violence are predictable and preventable. They warrant comprehensive, proactive solutions to reduce their occurrence and minimize their negative effects. [50] Effective approaches to injury prevention include modifications of the environment, improvements in product safety, legislation and enforcement, education and behavioral change, and technology and engineering.[51]

As public health practitioners, we know comprehensive strategies that prevent firearm-related suicide, homicide and other violence and unintentional firearm-related injuries and death. In mass casualty events, local health departments may play a role in providing and coordinating response and recovery activities, including behavioral health services.

Local health departments should be involved in the development, implementation and evaluation of comprehensive plans that address risk and protective factors for violence at the individual, interpersonal, community and societal levels.

LPHA Policy Positions

1. LPHA supports building capacity at the state and local level to address and prevent violence, including but not limited to formal training and education for all institutions, organizations and policymakers to raise awareness of violence as a preventable public health issue.

2. LPHA supports funding for primary prevention programs that focus on positive parenting, strengthening families and communities and developing and supporting youth in order to reduce family, youth and community violence.

3. LPHA supports the development and implementation of evidence-based prevention strategies that address risk and protective factors for multiple forms of violence.

4. LPHA supports the coordination and integration of injury and violence prevention into other related public health efforts (e.g., maternal and child health, chronic disease prevention, infectious disease prevention).

5. LPHA supports the implementation and strengthening of partnerships between local public health, healthcare, education, law enforcement, mental health, social services, and other partners to develop comprehensive violence prevention approaches that align with community needs.

6. LPHA supports expanding through research and evaluation the evidence base related to the causes of firearm-related injury and death and the effectiveness of prevention strategies.

7. LPHA supports the development of local capacity to prepare for, respond to, and recover from active shooter and terrorist situations in schools, workplaces, places of worship, public gathering spaces and other settings.

8. LPHA supports the prevention and mitigation of children's exposure to neglect, abuse, trauma,

		toxic stress and violence, as well as the promotion of safe, stable, nurturing relationships for children to reduce the risk of future violence.
	B. Data collection and sharing: Efforts to reduce violence must begin with valid and informative data. Improvements in data collection and availability will allow for epidemiologic approaches that help characterize the problem and identify modifiable risk factors.	**9.** LPHA supports a robust infrastructure for violence surveillance, data collection and research, as well as the evaluation of violence prevention initiatives.

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