



Local Public Health Association of Minnesota

2012 LEGISLATIVE ACTION PLATFORM

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

Minnesota's local public health system has long been regarded one of the strongest in the nation. However, in recent years funding reductions at the federal, state and local level have compromised the ability of local public health departments to provide essential health protection and prevention programs and respond to emerging health issues.

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 for health pose significant threats to population health.

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.

Public Health Infrastructure

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Issues	Policy and Legislative Positions
<p>A. Funding cuts at all levels have reduced the capacity of local public health departments to carry out mandated public health functions.</p>	<p>1. Provide adequate funding so that local public health departments have the resources necessary to protect the health and safety of the public every day and during emergencies. Continue to integrate funding into the local public health block grant to limit administrative costs and allow maximum flexibility to meet local needs.</p>
<p>B. Changes at the local level as a result of budget restrictions, workforce limitations, restructuring and streamlining of services has impacted the effectiveness of local public health to meet its mission to protect the health of the community.</p>	<p>2. Support policies and initiatives that allow for innovative service delivery systems while maintaining a strong local public health infrastructure.</p>
<p>C. State and local public health departments operate without the availability of a statewide, interconnected electronic information system for health data exchange; therefore, each department has developed its own information management system, which operates in isolation of others. Local public health departments must meet the legislative mandate for electronic exchange of health data by the year 2015.</p>	<p>3. Provide resources and/or support for the development and implementation of a statewide, electronic, interconnected system for the collection and exchange of health data.</p>
<p>D. Local public health departments need to hire and retain qualified public health staff in order to protect the health and safety of the public.</p>	<p>4. Support policies and initiatives that promote education, hiring and retention of public health workers.</p>
<p>E. Federal health care reform has a strong focus on the prevention of chronic disease. This provision supports the mission of local public health and with initiatives already in progress in Minnesota.</p>	<p>5. Federal health care reform prevention funding dollars should flow directly to the local level in the same manner as public health emergency preparedness dollars with a designated formula to local public health departments.</p>

Chronic Disease Prevention and Promotion of Healthy Lifestyle Behaviors

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Issues	Policy and Legislative Positions
<p>A. On a typical day, an estimated 70 Minnesotans die from a chronic disease. Many of these deaths are premature and preventable, and are exacerbated by the policies, systems and environments in which we live, learn, work and access health care. Addressing key risk factors – physical inactivity, poor nutrition, tobacco use and exposure – in these settings can reduce chronic disease rates over time. Often low-income populations, communities of color, and people with disabilities experience chronic conditions at a higher rate than the general population.</p>	<ol style="list-style-type: none"> 1. Maintain support for the Statewide Health Improvement Program and seek a permanent funding source for this program. Matching fund requirements and the competitive grants should be enacted in ways that ensure that all local and tribal public health departments are able to participate in the program. Advocate for federal health care reform funding that increases the capacity for local public health departments to prevent chronic diseases. 2. Support statewide alcohol and tobacco tax increases and champion the use of new revenues for programs that prevent chronic diseases, like the Statewide Health Improvement Program. 3. The state has received an average of \$162 million dollars in revenue from tobacco companies each year since 2000 as a result of the state’s settlement of the tobacco lawsuit. We support dedicating a portion of the ongoing tobacco settlement revenue to funding the Statewide Health Improvement Program.
<p>B. Obesity is a significant contributor to chronic disease and premature death. Strategies that improve nutrition and increase physical activity through policy, systems and environmental change approaches are fundamental to reducing obesity rates in children and adults.</p>	<ol style="list-style-type: none"> 4. Support policies that encourage healthier community design, including safe environments that promote active living. Community residents who fear for their safety spend less time outdoors making it challenging to access healthy foods and engage in physical activity.
<p>C. Minnesota has statewide plans to address obesity and a number of other chronic conditions, but it lacks a strategic vision to address the cross-sector nature and geographic span of the Minnesota food system, which ultimately impacts access to healthful foods and the opportunity for a healthy life.</p>	<ol style="list-style-type: none"> 5. Support the creation of a comprehensive vision/plan using existing and new MDH chronic disease prevention plans (cardiovascular plan, diabetes plan, childhood obesity plan, etc.) to reduce chronic diseases as well as health care costs associated with these conditions. This plan should be applicable to the work of the state, local

		governments and community partners and should address Minnesota's food system and how it can better support the health of Minnesotans.
	D. Minnesota has a statewide data monitoring system to track overall population trends in adult obesity but does not have a system to monitor trends in child and youth obesity. We need this information at the local level to target interventions and measure progress. Current data methods are self-reported which may not provide the most accurate data.	6. Develop and fund strategies to monitor childhood and youth obesity trends at the local level. Explore methods to improve data collection and analysis, particularly for state-funded populations.
	E. Policies that support consumers to make healthier choices when dining out and eating at home can contribute to improved heart health and reduced obesity. Away-from-home foods account for approximately one third of the daily calories consumed by individuals in the United States. Approximately 44% of adults dine at a restaurant on any given day. Restaurant meals are often highly caloric and may also contain trans fats, which increase the risk for coronary heart disease, stroke, type two diabetes and high blood pressure.	7. Support state and local government efforts to enact policies related to food consumed at home or away from home that contribute to a healthier diet. 8. Support policies and programs to ensure access by all people to enough nutritious, affordable, safe and culturally-diverse food for an active healthy life. 9. Support healthy vending machine policies in a variety of public settings (parks, schools, etc).
	F. The State of Minnesota funds many programs that provide food services to community residents, but guidelines for these programs do not always meet current nutrition standards. In addition, many children, youth, and vulnerable adults spend time in settings regulated by the state, for example: schools, foster care homes, and child care settings. Often, these settings do not offer access to physical activity that meets standards that can improve health.	10. Require that all federal and state subsidized programs that serve food use nutrition standards based on the Dietary Guidelines for Americans. This would include schools, day care facilities and tax supported residential settings. 11. Strengthen physical and health education in schools to increase physical activity and prevent obesity. Require schools, daycare settings, and tax-supported residential settings to provide access to physical activity that meets federal guidelines.

<p>G. Primary prevention and asset building early in life can prevent youth from engaging in high risk behaviors, therefore protecting them from the long term health effects of smoking, drinking, drug use, and obesity. A significant portion of the tobacco settlement was originally dedicated to youth development activities, but these funding sources were entirely eliminated to address the state budget shortfall in 2003.</p>	<p>12. Support funding for programs that reduce youth risk taking behavior.</p> <p>13. Support state and local policies that prevent underage alcohol consumption (e.g., social host policies).</p> <p>14. Support better coordination between government agencies (health, human services, law enforcement, corrections) to prevent illegal drug use and inappropriate prescription drug use.</p>
<p>H. Tobacco-related disease is the number one cause of preventable death and disease to Minnesota residents. Secondhand smoke kills tens of thousands of nonsmoking Americans every year from coronary artery disease and lung cancer. Only thirty minutes of secondhand smoke compromises a non-smoker's coronary arteries to the same extent as in smokers.</p>	<p>15. Maintain a strong statewide Freedom to Breathe Act and oppose efforts to weaken the Act or pre-empt local governments' authority to enact additional smoke free policies.</p> <p>16. Support policies that protect children from exposure to secondhand smoke.</p>
<p>I. Youth using tobacco is a major public health problem. One third of all students who try cigarettes become regular, daily smokers before leaving high school. Limited state funds are currently available to prevent youth from tobacco use and engaging in other unhealthy behaviors.</p>	<p>17. Support and fund evidence-based programs and policies that discourage youth tobacco use.</p>
<p>J. Violence, including family and community violence, continues to be a major cause of death and injury in Minnesota.</p>	<p>18. To reduce family, youth and community violence, support primary prevention programs that focus on positive parenting, strengthening families and communities, and developing and supporting youth.</p>

Communicable Disease Prevention and Control

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Issues	Policy and Legislative Positions
<p>A. Minnesota statutes charge state and local public health departments with the responsibility for the control and prevention of the spread of communicable diseases. Limited resources funded with the local tax levy and/or the local public health block grant and ongoing events strain the ability of local public health departments to ensure the protection of the community from these communicable diseases.</p>	<ol style="list-style-type: none"> 1. Maintain funding for the local public health block grant, which supports the local public health infrastructure. 2. Establish a state emergency fund and create a process for local public health departments to recover costs for public health infectious disease outbreak situations where the response required significantly exceeds the local resources.
<p>B. Investigation, control and treatment of tuberculosis cases (active and latent) are labor intensive and costly. 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 for treatment or may be uninsured or under-insured. This results in costly uncompensated care for local public health departments and community health care providers.</p>	<ol style="list-style-type: none"> 3. Increase funding reimbursement to local public health departments for the investigation, control and treatment of tuberculosis disease (latent and active). 4. Support the immediate and full implementation of the Minnesota Electronic Disease Surveillance System including a section on Tuberculosis contact investigation.
<p>C. In recent years there have been efforts to enact laws and policies that are not based on the science of the prevention and control of communicable diseases.</p>	<ol style="list-style-type: none"> 5. Support laws and policies that are based on the science of prevention and control of communicable diseases and oppose laws that are not.
<p>D. Local public health departments bear the uncompensated care costs for treating individuals with tuberculosis when those individuals are uninsured and unable to pay.</p>	<ol style="list-style-type: none"> 6. Support policies that provide health care insurance to additional low-income Minnesotans.
<p>E. Many refugees and immigrants come from countries where communicable diseases are common and public health services are lacking. Local public health departments must address their health needs to ensure the protection of the health of the whole community.</p>	<ol style="list-style-type: none"> 7. Oppose efforts that require local public health officials to report undocumented persons to the state or federal government.

	<p>F. In Minnesota, sexually transmitted infections are the most commonly reported communicable diseases and account for nearly 70% of all notifiable diseases reported to the Minnesota Department of Health (MDH).</p>	<p>8. Funding to combat sexually transmitted infections should focus on prevention methods in addition to treatment options.</p>
	<p>G. Immunization is a key method of keeping our children safe by preventing the spread of deadly communicable diseases. Immunization rates in Minnesota are eroding, leaving many children at risk for communicable diseases. The CDC reports that Minnesota's childhood immunization rate slipped to 76.9 percent in 2009 from 80.5 percent in 2007. Minnesota has dropped 13 spots in two years – from seventh place in 2007 to 20th place in 2009 – for vaccination coverage rates for the primary series of shots among all children 19 months through 35 months of age. (CDC 2009 Immunization Survey)</p>	<p>9. Support funding for statewide, consistent public education and outreach for vaccinations, as well as funding for local public health department's outreach to health care practitioners and their communities.</p> <p>10. Maintain Minnesota's current immunization requirements for school entry. Oppose efforts to weaken this law.</p>

Correctional Health

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Issues	Policy and Legislative Positions
<p>A. Counties are responsible for health care costs for incarcerated persons, placing a heavy burden on the tax levy. These costs are rising at unprecedented rates due to the number of people entering the corrections system, increased language and cultural needs, complex physical care needs (acute and chronic), mental health and dental needs, rising prescription drug costs, and increasing chemical dependency needs.</p>	<ol style="list-style-type: none"> 1. Support policies that limit county responsibility for medical costs while maintaining a basic standard of health care for inmates. 2. Create a task force that includes representation of impacted partners (including elected officials) to review and make policy, program and funding recommendations that limit county responsibility for medical costs. 3. Support a regional approach for cost containment.
<p>B. Mental health, dental health, and chemical health resources are limited in many communities, making it particularly challenging to meet the health needs of inmates while incarcerated as well as when they are being transitioned back into the community.</p>	<ol style="list-style-type: none"> 4. Support funding and policies to create better discharge planning that improves the coordination of health and social resources for inmates being released into the community. 5. Propose a statewide consortium of partners (including legislators) to review and recommend policy, program and funding changes to address persons with mental illness in the jail setting.
<p>C. Correctional facilities are designed for security, not for complex health care delivery. Many jails do not have accommodations for handicapped inmates. When inmates require major health services, specialized care or basic assistance with daily life activities, local jails are not staffed nor equipped to meet these needs.</p> <p>D. Medication management and administration is complex and costly. Many inmates have chronic and multiple conditions, requiring involved medication regimes.</p>	<ol style="list-style-type: none"> 6. Support alternative sites for county detainees who do not require hospitalization, but have complex medical conditions (such as paraplegia) that require care and accommodations not available in most county jails.

	<p>E. Local correctional facilities have varying demands for nursing coverage to meet the health needs of incarcerated inmates, ranging from a less than a one FTE per week to several FTEs per day. This also means most do not have availability of nursing or medical staff beyond the regular work day.</p>	<p>7. Review and implement recommendations from the 2007 SCHSAC workgroup on “Health Services in County Correctional Settings” including support efforts to study staffing levels in the jail to assure safe and adequate staffing ratio of RN to inmates.</p>
	<p>F. Correctional health care providers must meet the legislative mandate for electronic exchange of health data by the year 2015. As with private providers, an electronic health record system that also provides access to electronic pharmacy and laboratory services would improve quality of care, reduce medication errors, increase efficiencies and reduce costs.</p>	<p>8. Develop and support information systems for the electronic collection, storage, and exchange of inmate health data.</p>

Ensuring Health Equity

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Issues	Policy and Legislative Positions
<p>A. Overall, Minnesotans are healthy. Look closer and it is evident that serious health inequities exist between populations of color, persons living in poverty and the rest of Minnesota’s population.</p>	<ol style="list-style-type: none"> 1. Maintain funding for Minnesota Department of Health’s Eliminating Health Disparities Initiative, and additional funding for state and local governments to work on this issue together. Support a dedicated focus within MDH to address this work. Ensure that funding is strategically allocated across ethnic communities. 2. Ensure that health equity is addressed with other state funded programs allocated to either the Minnesota Department of Health or to local public health agencies. Programs funded through state grants should include the perspectives of those most affected by health inequities and coalitions should include participants from communities most impacted by disparities.
<p>B. Prolonged poverty is generally the leading cause (i.e., social conditions) associated with health inequities. In addition, inequities are caused by a variety of social conditions including racial and cultural barriers to care, compromised health conditions due to disparate access to preventative health resources, employment, lack of a livable wage, safe and stable housing, etc.</p>	<ol style="list-style-type: none"> 3. Support programs that lift people out of poverty. (i.e. access to employment, a livable wage, education, and housing stability).
<p>C. Medicaid and public programs like MinnesotaCare can be important catalysts for efforts to eliminate racial and ethnic disparities. However, asset tests can be barriers to enrolling low-income Minnesotans into public health care coverage.</p>	<ol style="list-style-type: none"> 4. Support proposals to protect health care access and increase resources to help those most affected by health disparities obtain health care coverage and health services. Maintain, strengthen and improve the safety net by continuing health care coverage for the poorest adults in the state. Guarantee every child and pregnant woman comprehensive health coverage and services. 5. The State should use its regulatory and purchasing influence to engage managed care organizations and providers in identifying and actively addressing racial and ethnic disparities in care. Specifically, state agencies

		<p>should:</p> <ul style="list-style-type: none"> • Strengthen and standardize efforts to collect information on the race and ethnicity of enrollees, either directly or indirectly; • Incorporate disparities reduction goals and objectives into health plan and provider contracts; and • Link monetary incentives to initiatives to reduce disparities in health care.
	<p>D. 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.</p>	<p>6. Encourage statewide partners and local public health departments to utilize Statewide Health Improvement Program (SHIP) funding focused on obesity and tobacco prevention to assure the health equity of all Minnesotans. Work towards SHIP community leadership teams that are racially and ethnically diverse. Ensure that SHIP grantees leverage partnerships with culturally specific community based organizations to develop culturally relevant health messages and resources to support PSE changes in communities.</p>
	<p>E. Efforts to eliminate racial and ethnic disparities in health care must begin with valid and reliable data on race, ethnicity, and language preference. 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. These data are important to understanding the health care needs of specific populations, and planning customized programs and interventions. Without such data, health care organizations cannot effectively define the problem or devise targeted, meaningful solutions.</p>	<p>7. Support funding and policy proposals to ensure that public health data is more culturally specific for all communities.</p>
	<p>F. 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</p>	<p>8. Ensure that the health care work force is reflective of the populations most affected by health disparities. Direct local public health organizations to develop a plan and a set of standards for increasing the cultural competencies</p>

help from people they feel comfortable with, and culturally diverse providers may more readily respect and understand 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.

of existing staff; for recruitment of staff and consultants representing populations experiencing health inequities. Support the additional training and expansion of the use of Community Health Workers.

9. Support the development of statewide standards and the development of a certification process and training for medical interpreters. In addition, provide funding to state and local agencies for interpretation and translation services. Continue to work with statewide partners to promote adequate training and a registry and certification process to ensure quality interpretation and translation services for limited English proficient patients.
10. Support resources/policies that provide 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 medical and public health fields.

Environmental Health

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Issues	Policy and Legislative Positions
<p>A. Environmental health services are best delivered when integrated in the community health system and provided by local units of government, with oversight and technical assistance from the state.</p>	<p>1. Explore models for delivering evidence-based environmental health services that emphasize and incorporate evidence-based practice.</p> <p>2. Establish standards for state review of local programs that focus on measurable outcomes related to the prevention of food-borne illness and the spread of infectious disease.</p>
<p>B. Minnesota, all establishments that serve food are regulated to protect the public from foodborne illness. They pay fees that provide funding for direct program costs and important statewide consultation, education, and communication efforts.</p>	<p>3. All food establishments should pay a share of these costs. When funding for such services is not equitably shared by the businesses that generate the risk and associated public costs, the costs become transferred to the remaining licensees and/or to the public through cost of illness and taxes.</p>
<p>C. Children are at greater risk of negative health conditions and diseases that result from naturally occurring environmental factors, the built environment or the by-products of built environments.</p>	<p>4. Support policies that are child-focused and prevention-oriented regarding the environment and children's health.</p>
<p>D. Community design, land-use decisions and built environments affect the ways people behave and can lead to unhealthy lifestyle choices (e.g., lack of sidewalks can lead to more driving and less walking, thereby increasing obesity).</p>	<p>5. Promote the incorporation of "walkable and bikeable community design" as part of comprehensive planning. Walking and biking remain the cheapest form of transport for all people and the most affordable transportation system a community can plan, design, construct, and maintain. Walkable/bikeable communities lead to more social interaction, physical fitness, and diminished crime and other social problems.</p>
<p>E. The environment we live in can negatively impact our health. For example:</p> <ul style="list-style-type: none"> • 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. 	<p>6. Support science based studies to improve our knowledge of environmental health hazards and support policies and funding that mitigate these risks.</p>

<p>F. Minnesota is an EPA-designated “high radon” state. Radon, a naturally occurring radioactive gas, is a leading cause of lung cancer and is a significant threat to human health.</p>	<p>7. Support a statewide law to require radon testing prior to occupancy or sale of a home and mitigation when tests indicate an unsafe level of radon is present.</p>
<p>G. Lead poisoning in young children is preventable yet many are needlessly exposed to lead. Many at-risk children do not receive lead screening.</p>	<p>8. Support policies that promote early intervention to remove lead hazards in homes before children are poisoned. Promote lead screening for at-risk children.</p>
<p>H. Many subsurface sewage treatment systems are non-complying and have the potential to impact surface and groundwater, thus negatively affecting human health. Presently, only 50% of counties require point of sale compliance inspections on individual sewage treatment systems.</p>	<p>9. Support county policies that require point of sale compliance inspections. Support adequate funding from state agencies to cover the costs to LGU’s 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. Support an ongoing state grant and loan assistance program to assist landowners in upgrading or replacing non-compliant SSTS’s.</p>
<p>I. 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. Readily available and cost effective mechanisms for disposal of medical facility, healthcare facility and household pharmaceuticals, particularly DEA controlled substances, generally are non-existent.</p>	<p>10. Support policies that encourage collection and proper management and disposal of pharmaceuticals from medical and healthcare facilities and households, including controlled substances, by reducing the regulatory burden and exploring cost effective options.</p>
<p>J. 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.</p>	<p>11. State funded initiatives should address environmental justice issues like safe and healthy housing, increasing community green space, reducing air and water pollution.</p>
<p>K. New information regarding environmental health risk factors becomes available on a regular basis.</p>	<p>12. Continue to support policies that use peer-reviewed scientific research and observation to address emerging environmental health issues, such as Bisphenyl A and Phalates, as they occur.</p>
<p>L. 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.</p>	<p>13. State level data collection, risk identification and planning activities should be funded, and strong partnerships with local public health encouraged.</p>

Health Care System Improvement

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Issues	Policy and Legislative Positions
<p>A. Landmark health care reform legislation has been passed at the state and federal level. Public health will be a key player to implement changes to control health care expenditures related to chronic health conditions utilizing policy, system, and environmental changes within the Statewide Health Improvement Plan funding and through the provision of case management/care coordination is developed for health care homes and accountable care organizations (ACOs). The federal funding for public health prevention programming over the next five years is being developed.</p>	<ol style="list-style-type: none"> 1. Support sustainable funding for the Statewide Health Improvement Plan (SHIP). Seek opportunities for federal funding to enhance state funded prevention activities. 2. Support policies and legislation that promotes the unique public health role to assure access to care utilizing case management/care coordination and working with patients to establish a health care home.
<p>B. Eligibility for publicly funded health care programs including General Assistance Medical Care, Medical Assistance and MinnesotaCare has eroded during the past several years. Changing eligibility and benefits forces many children and adults to go without health insurance or be denied coverage for health care services. Enrollment in employer-based programs has decreased during the past several years. As a result increasing numbers of Minnesotans lack insurance coverage or have high deductibles and co-pays. The federal health reform legislation is still under development and will not be completely implemented until 2014. The Minnesota plan to expand coverage through the federal health reform plans needs to be monitored.</p>	<ol style="list-style-type: none"> 3. Support 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. 4. Expand and stabilize eligibility for MinnesotaCare to allow earlier coverage and reduce uncompensated care and premium increases resulting from more acute care episodes. 5. Support proposals to restore, stabilize and expand publicly funded health care (General Assistance Medical Care, Medical Assistance and MinnesotaCare) programs. 6. Support proposals that provide incentives to employers to offer adequate and affordable health insurance to employees.
<p>C. 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 the insured and uninsured persons to receive care for mental health issues.</p>	<ol style="list-style-type: none"> 7. Support policies or incentives that require health plan companies to improve treatment benefits for alcohol and other drug use and mental health care.

<p>D. 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.</p>	<p>8. Support policies and incentives for individuals to utilize preventive health services and other community resources rather than waiting to use urgent or emergency care. In addition, support incentives for providers to utilize preventive health strategies including prevention and early intervention treatment for chronic conditions, dental and mental health care.</p> <p>9. Support policies and proposals that reduce health care administrative costs by streamlining of health care program/payers administrative requirements and adopting uniform benefit sets.</p>
<p>E. County-based health care purchasing provides an opportunity to build a prevention-focused, community-based local care system that optimizes health while controlling costs for the medical assistance population. Several benefits of county-based purchasing include local control, protection of local employment base, improved coordination between medical care and community care, reinvestment of “profits” back into the community, and flexibility to tailor services to meet clients’ needs and maintain quality.</p>	<p>10. Support continuing the county option to participate in county-based health care purchasing and expansion to include additional populations.</p>
<p>F. Access to dental care is limited due to a 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. There was legislation passed in 2009 that creates an expanded role for dental hygienists.</p>	<p>11. Improve access to dental services by encouraging the development of a sustainable statewide model of care for persons using new dental provider practice models.</p> <p>12. Support critical access provider status for dental care providers that are currently providing services and willing to expand their service area to other areas within the state.</p>
<p>G. Legislative changes in how health plans bid for public program contracts may impact the performance goals for public health issues such as lead testing, chlamydia rates, etc.</p>	<p>13. As health care reimbursement changes, the impact on overall population health goals should be measured and considered as part of the total cost impact.</p>

Healthy Children and Families

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Issues	Policy and Legislative Positions
<p>A. 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.</p>	<p>1. Support the continuation of Temporary Assistance to Needy Families (TANF) funding for public health family home visiting programs. Support the necessity of at least an initial public health nursing assessment for family home visiting programs. Public health should assure that there are effective local efforts in public awareness and skilled intervention available in addressing maternal depression and other family challenges that put both the family and the child at risk. TANF funding should be available to assist public health in forging local partnerships to address this.</p>
<p>B. Recent restructuring of the Interagency Early Intervention Committees (IEICs) into a regional model has decreased funding for follow along and other early intervention programs without any other agency being able to pick up these high benefit services. These programs efficiently and effectively connect high risk families to services. Responding to identified issues early is both preventative and cost effective.</p>	<p>2. Require a public health representative in every regional IEIC to ensure adequate attention and funding supports for public health early interventions such as Child Find and follow along.</p>
<p>C. Federal and state funding reductions are threatening core maternal and child health programs that serve teen parents, high risk and low income mothers and children (e.g., Maternal and Child Health Block Grant, Local Collaborative Time Study funding, WIC, and TANF).</p>	<p>3. To assure long-term gains in health status and reduce health and human services costs the state should increase or maintain stable, ongoing funding for evidence based public health services that address those goals. This would include home visiting, WIC, maternal and child health (MCH), family planning, and support funding for school readiness, youth risk behavior reduction, and teen pregnancy prevention.</p>
<p>D. Child care funding continues to be inadequate. Reductions in child care services create waiting lists for child care services; put children at risk for unsafe or less child development focused care; and put parents at risk for leaving or losing their employment.</p>	<p>4. Support increased funding for the Child Care Assistance Fund to eliminate waiting lists for child care services and enable families to seek and obtain quality care. Support initiatives that help families better understand the importance of early brain development and to seek and provide activities that enhance that in their children ages 0-3.</p>

	<p>E. The health of children, adolescents and families are negatively affected by violence and alcohol, tobacco, illegal drug use, poverty and lack of health care access.</p>	<p>5. Support state funding and policies to assist local community efforts to prevent family violence and the use of and exposure to alcohol, tobacco and illegal drugs.</p>
	<p>F. Evidence-based sex education and family planning services are proven methods of preventing unplanned pregnancies and improving pregnancy outcomes, and funding for these services is insufficient.</p>	<p>6. Support policies that promote access to confidential physical, mental health and chemical dependency services for adolescents.</p> <p>7. Support increased family planning funding and partner with the Department of Human Services to improve the implementation of the federal 1115 Waiver.</p> <p>8. Identify opportunities for increased services and funding through federal health reform legislation.</p>

Long Term Care

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Issues	Policy and Legislative Positions
A. Promoting healthy aging and preventing chronic diseases is key to long-term care cost containment and quality of life improvement.	1. Support funding and policies of prevention and early intervention for programs that encourage healthy aging throughout the life span.
B. The state of Minnesota has succeeded in reducing the number of elderly people who live in nursing homes and now elderly people and their families see community living as the norm. While people want home and community-based services, there are restrictions that limit the availability of those services, e.g., limited waiver growth, eligibility changes to state plan benefits (for example PCA services).	2. The Department of Human Services should seek new federal waivers to give families and people with disabilities more options for home and community-based services, e.g., 1915 I, J, and K waivers that leverages federal funds. In addition, DHS should track the effects on local property tax of the restrictions on Medicaid funded community-based services. 3. Promote policies for flexible housing with services to ensure quality, availability, affordability, accessibility, and consumer choice.
C. 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 care settings. However, the funding formula for counties is changing and we need to ensure that counties are fully reimbursed for their mandated functions.	4. The Department of Human Services, the Local Public Health Association and the Minnesota Association of County Social Services Administrators should work together to better define their roles in long-term care for the elderly and people with disabilities. All roles at the state and local should be adequately funded. In particular, in development of the new Minnesota Choices assessment tool, it is essential to ensure adequate funding for the mandated county assessment functions.
D. 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 beginning in 2013 the state will assume a number of administrative functions for the waivers for people under 65 who are disabled. In many cases, health plans have chosen to contract with local public health departments to provide	5. It is critical that medical care, health care homes and community supports are able to communicate and coordinate services that support healthy aging. Some of the county functions include: <ul style="list-style-type: none"> • Comprehensive assessments and initiation of fee for services care, waiver programs, or private pay (prior to HMO involvement) • Maintenance of an adequate safety net of

<p>some services, but the ongoing role of counties as a service provider is still undefined. At the same time, there is clearly 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.</p>	<p>home/community/health care in light of the 2009 Legislative changes in eligibility for PCA services.</p> <ul style="list-style-type: none"> • Oversight of strengths/challenges of client care and quality assurance functions such as network development and gaps analysis in the local home and community-based service system
<p>E. Long term care consultation (LTCC) is mandated for anyone who requests the service from counties, but it is chronically under-funded. In addition, counties are required to send a portion of our allocation to the Area Agencies on Aging (AAA) for their work. One of the requirements is that the Area Agencies on Aging refer callers to the county for LTCC. Yet, some counties have never received a single referral from their AAA.</p>	<p>6. LTCC should be fully reimbursed at the cost of the service. In addition, the Area Agencies on Aging use of this funding should be monitored and evaluated.</p>
<p>F. 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 case manager services, and also effects the quality and timelines of services provided to clients.</p>	<p>7. DHS should develop universal processes for counties and health plans in the delivery of home and community-based long-term care services, e.g., standardized forms. This will be exacerbated when individuals who receive Medical Assistance are passively switched to managed care.</p>
<p>G. The use of customized (assisted) living has grown to the extent that there are more customized (assisted) living units than nursing home beds in Minnesota. The Legislature created a process for area agencies to provide information to people prior to entering customized (assisted) living. However, we are uncertain about the effectiveness of this new process and it will need to be evaluated.</p>	<p>8. DHS should evaluate the outcomes, including cost effectiveness of the Area Agencies on Aging options counseling, which individuals must now complete before they enter customized (assisted) living.</p>
<p>H. There are a number of inefficiencies in the current system, in particular related to people either entering nursing homes or leaving nursing homes, e.g., the mandated Pre-Admission Screening and OBRA that could be streamlined or changed.</p>	<p>9. DHS should initiate a systems process analysis regarding the multiple processes currently mandated when people either enter or leave nursing homes in order to be more effective and efficient.</p>
<p>I. The county function of doing Personal Care Assistant assessments for Medical Assistance recipients is critical to</p>	<p>10. The Legislature should remove the administrative penalty for the late submission of PCA screens because</p>

	<p>providing assistance to recipients and educating them about their options for Personal Care Assistant services and other home and community-based services, but there are some issues with the administrative penalty for the late submission of screenings that need to be addressed with the development of the comprehensive assessment tool and process.</p>	<p>the comprehensive assessment is replacement the PCA assessment and thus there is no longer a PCA assessment.</p>
	<p>J. 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. Some of these individuals would choose to relocate from the nursing facility but are restricted by a lack of community residential options. The moratorium on the development of new corporate foster care is a further challenge to developing alternatives. The result is people staying longer in nursing facilities than needed.</p>	<p>11. Modify the county share of nursing home costs for those under age 65 to allow exemptions for some people who chose to live in nursing homes and for individuals enrolled in managed care.</p>
	<p>K. DHS Projects 2020 and 2030 have demonstrated that individuals are not adequately preparing financially and planning for the care they will need as they age.</p>	<p>12. Encourage policies that expand the availability of quality long-term care insurance and other strategies that promote planning for future health care needs.</p>
	<p>L. In 2011 a new law was enacted creating a transitional service plan for individuals reasonably expected to improve. One requirement of this plan is that the county must reassess clients every six months until they stabilize or can move off of services. These reassessments are unfunded, creating a new cost shift to counties.</p>	<p>13. Oppose and work to reverse the requirements for assessments and reassessments every six months with no additional funding.</p>

Mental Health

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Issues	Policy and Legislative Positions
<p>A. Mental health is as essential as physical health in the overall well-being of individuals. Most mental health services focus on individuals after mental illness has developed. Mental health promotion can improve quality of life and early intervention services can lessen the burden of mental illness. Intervening early with at-risk families can prevent child and parent mental health problems. People with chronic mental illness who are on public health care programs die, on average, 25 years prematurely.</p>	<ol style="list-style-type: none"> 1. Support the role of local public health agencies in the model of prevention, early identification and intervention for mental health. 2. Support efforts to increase public and policymaker awareness of the importance of mental health and encourage the appropriate use of early intervention mental health services. 3. Support mental health policies and funding that encompass health care reform, including a focus on mental health promotion.
<p>B. When a child is born into poverty, the chaotic and often unstable environment can cause a damaging brain condition known as toxic stress. Poverty is a demonstrated risk factor for increased mental health problems and, given the recession, there are more families that could benefit from early intervention.</p>	<ol style="list-style-type: none"> 4. Support full funding for evidence-based family home visiting for at-risk families with newborns.
<p>C. Within the context of health care reform, public health needs to play a strong role in the development of medical homes and other health promotion and prevention activities targeted at children with mental health issues.</p>	<ol style="list-style-type: none"> 5. Support policies that focus on a public health model of prevention, early identification and intervention for mental illness. 6. Support policies that encourage coordination of mental health services along with other physical health care and social services with the development of health care homes and other models that are emerging through the federal and state health care reform efforts.
<p>D. The cost of mental health services for high-risk populations has been shifted to counties. For example, in 2011 the county cost share for sex offenders increased substantially and the mental health block grant was reduced by 10%.</p>	<ol style="list-style-type: none"> 7. Support proposals to restore, stabilize and expand publicly funded health care programs and other funding sources for mental health.
<p>E. Funding for mental health services focuses on reimbursement of expensive treatment services rather than innovative community-based prevention programs.</p>	<ol style="list-style-type: none"> 8. Support a public health approach to adolescent mental health, particularly for high-risk populations of adolescents.
<p>F. Few accurate, all-service-inclusive data systems on children and adult mental health exist in Minnesota. This information is needed to monitor change, plan for unmet needs, and raise public awareness about mental health issues.</p>	<ol style="list-style-type: none"> 9. Develop an accurate, replicable statewide data system that regularly monitors a core set of mental health indicators for children, adolescents, and adults.

Public Health Emergency Preparedness and Response

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Issues

- A. Local public health departments are mandated by the federal and state government to prepare for and respond to public health emergencies and disasters in their communities. The H1N1 response highlighted the importance of ongoing planning and response capacity by public health in order to meet the critical needs in the communities. Clinics, schools and other agencies look to public health for guidance on preparation, response and now recovery. Other recent Minnesota disasters, such as tornados, floods, wildfires and widespread food borne outbreaks, have highlighted the role of local public health departments in responding to emergencies and caring for individuals and communities in crisis. This work is essential for the health and well-being of our citizens.
- B. Local public health departments now have fully trained staff, available 24/7, to respond to public health emergencies, yet the core federal funding that supports local public health staff continues to be reduced. State funding has not been provided and local tax levy for this federal and state mandated function has not been able to fill the gap. Local public health capacity is eroding as public federal dollars decline. Local public health cannot maintain this asset without stable and adequate funding to maintain this essential infrastructure.
- C. Training and exercising are part of the industry standards related to emergency preparedness. All staff need to be kept current and practiced in their response roles. During a disaster or emergency, our communities expect to see public health staff who are knowledge and competent in their response roles. This will not occur without adequate funding.
- D. Acquiring and maintaining equipment and supplies to respond to public health emergencies are a necessary part of any emergency response. Equipment must be updated and current staff must be trained and ready to use it. Without ongoing funding, equipment will soon be outdated and staff will not be trained on its use.

Policy and Legislative Positions

1. Provide state funding that is flexible and permanent to supplement local and federal funding for local public health emergency planning 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.
2. Assure local concurrence with the MDH applications for federal emergency preparedness funding.
3. Align grant expectations with level of available funding. Reduce administrative burden associated with the grant.