CHAPTER 145A

LOCAL PUBLIC HEALTH BOARDS

145A.10 POWERS AND DUTIES OF COMMUNITY HEALTH BOARDS.

[For text of subds 1 to 9, see M.S.2000]

Subd. 10. **State and local advisory committees.** (a) A state community health advisory committee is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of community health services. Each community health board may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. Members or their alternates may receive a per diem and must be reimbursed for travel and other necessary expenses while engaged in their official duties.

(b) The city councils or county boards that have established or are members of a community health board must appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on matters relating to the development, maintenance, funding, and evaluation of community health services. The committee must consist of at least five members and must be generally representative of the population and health care providers of the community health service area. The committee must meet at least three times a year and at the call of the chair or a majority of the members. Members may receive a per diem and reimbursement for travel and other necessary expenses while engaged in their official duties.

(c) State and local advisory committees must adopt bylaws or operating procedures that specify the length of terms of membership, procedures for assuring that no more than half of these terms expire during the same year, and other matters relating to the conduct of committee business. Bylaws or operating procedures may allow one alternate to be appointed for each member of a state or local advisory committee. Alternates may be given full or partial powers and duties of members.

History: *2001 c 161 s 25*

145A.15 HOME VISITING PROGRAM.

Subdivision 1. **Establishment.** (a) The commissioner of health shall expand the current grant program to fund additional projects designed to prevent child abuse and neglect and reduce juvenile delinquency by promoting positive parenting, resiliency in children, and a healthy beginning for children by providing early intervention services for families in need. Grant dollars shall be available to train paraprofessionals to provide in-home intervention services and to allow public health nurses to do case management of services. The grant program shall provide early intervention services for families in need and will include:

(1) expansion of current public health nurse and family aide home visiting programs and public health home visiting projects which prevent child abuse and neglect, prevent juvenile delinquency, and build resiliency in children;

(2) early intervention to promote a healthy and nurturing beginning;

(3) distribution of educational and public information programs and materials in hospital maternity divisions, well-baby clinics, obstetrical clinics, and community clinics; and

(4) training of home visitors in skills necessary for comprehensive home visiting which promotes a healthy and nurturing beginning for the child.

(b) No new grants shall be awarded under this section after June 30, 2001. Grant contracts awarded and in effect under this section as of July 1, 2001, shall continue until their expiration date.

[For text of subds 2 to 4, see M.S.2000]

Subd. 5. **Expiration.** This section expires June 30, 2003.

History: *1Sp2001 c 9 art 1 s 49,50*

145A.16 UNIVERSALLY OFFERED HOME VISITING PROGRAMS FOR INFANT CARE.

Subdivision 1. **Establishment.** The commissioner shall establish a grant program to fund universally offered home visiting programs designed to serve all live births in designated geographic areas. The commissioner shall designate the geographic area to be served by each program. At least one program must provide home visiting services to families within the seven-county metropolitan area, and at least one program must provide home visiting services to families outside the metropolitan area. The purpose of the program is to strengthen families and to promote positive parenting and healthy child development. No new grants shall be awarded under this section after June 30, 2001. Competitive grant contracts awarded and in effect under this section as of July 1, 2001, shall expire December 31, 2003.

[For text of subds 2 to 9, see M.S.2000]

Subd. 10. **Expiration.** This section expires December 31, 2003.

History: *1Sp2001 c 9 art 1 s 51,52*

145A.17 FAMILY HOME VISITING PROGRAMS.

Subdivision 1. **Establishment; goals.** The commissioner shall establish a program to fund family home visiting programs designed to foster a healthy beginning for children in families at or below 200 percent of the federal poverty guidelines, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency. A program funded under this section must serve families at or below 200 percent of the federal poverty guidelines, and other families determined to be at risk, including but not limited to being at risk for child abuse, child neglect, or juvenile delinquency. Programs must give priority for services to families considered to be in need of services, including but not limited to families with:

(1) adolescent parents;

(2) a history of alcohol or other drug abuse;

(3) a history of child abuse, domestic abuse, or other types of violence;

(4) a history of domestic abuse, rape, or other forms of victimization;

(5) reduced cognitive functioning;

(6) a lack of knowledge of child growth and development stages;

(7) low resiliency to adversities and environmental stresses; or

(8) insufficient financial resources to meet family needs.

Subd. 2. **Allocation of funds.** The commissioner shall distribute funds available under this section to community health boards, as defined in section 145A.02, and to tribal governments. Funds shall be distributed to community health boards as follows: (1) each community health board shall receive an allocation of $25,000 per year; and (2) remaining funds available to community health boards shall be distributed according to the formula in section 256J.625, subdivision 3. The commissioner, in consultation with tribal governments, shall establish a formula for distributing funds to tribal governments.

Subd. 3. **Requirements for programs; process.** (a) Before a community health board or tribal government may receive an allocation under subdivision 2, a community health board or tribal government must submit a proposal to the commissioner that

includes identification, based on a community assessment, of the populations at or below 200 percent of the federal poverty guidelines that will be served and the other populations that will be served. Each program that receives funds must:

(1) use either a broad community-based or selective community-based strategy to provide preventive and early intervention home visiting services;

(2) offer a home visit by a trained home visitor. If a home visit is accepted, the first home visit must occur prenatally or as soon after birth as possible and must include a public health nursing assessment by a public health nurse;

(3) offer, at a minimum, information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services available in the community;

(4) provide information on and referrals to health care services, if needed, including information on health care coverage for which the child or family may be eligible; and provide information on preventive services, developmental assessments, and the availability of public assistance programs as appropriate;

(5) provide youth development programs;

(6) recruit home visitors who will represent, to the extent possible, the races, cultures, and languages spoken by families that may be served;

(7) train and supervise home visitors in accordance with the requirements established under subdivision 4;

(8) maximize resources and minimize duplication by coordinating activities with local social and human services organizations, education organizations, and other appropriate governmental entities and community-based organizations and agencies; and

(9) utilize appropriate racial and ethnic approaches to providing home visiting services.

(b) Funds available under this section shall not be used for medical services. The commissioner shall establish an administrative cost limit for recipients of funds. The outcome measures established under subdivision 6 must be specified to recipients of funds at the time the funds are distributed.

(c) Data collected on individuals served by the home visiting programs must remain confidential and must not be disclosed by providers of home visiting services without a specific informed written consent that identifies disclosures to be made. Upon request, agencies providing home visiting services must provide recipients with information on disclosures, including the names of entities and individuals receiving the information and the general purpose of the disclosure. Prospective and current recipients of home visiting services must be told and informed in writing that written consent for disclosure of data is not required for access to home visiting services.

Subd. 4. **Training.** The commissioner shall establish training requirements for home visitors and minimum requirements for supervision by a public health nurse. The requirements for nurses must be consistent with chapter 148. Training must include child development, positive parenting techniques, screening and referrals for child abuse and neglect, and diverse cultural practices in child rearing and family systems.

Subd. 5. **Technical assistance.** The commissioner shall provide administrative and technical assistance to each program, including assistance in data collection and other activities related to conducting short- and long-term evaluations of the programs as required under subdivision 7. The commissioner may request research and evaluation support from the University of Minnesota.

Subd. 6. **Outcome measures.** The commissioner shall establish outcomes to determine the impact of family home visiting programs funded under this section on the following areas:

(1) appropriate utilization of preventive health care;

(2) rates of substantiated child abuse and neglect;

(3) rates of unintentional child injuries;

(4) rates of children who are screened and who pass early childhood screening; and

(5) any additional qualitative goals and quantitative measures established by the commissioner.

Subd. 7. **Evaluation.** Using the qualitative goals and quantitative outcome measures established under subdivisions 1 and 6, the commissioner shall conduct ongoing evaluations of the programs funded under this section. Community health boards and tribal governments shall cooperate with the commissioner in the evaluations and shall provide the commissioner with the information necessary to conduct the evaluations. As part of the ongoing evaluations, the commissioner shall rate the impact of the programs on the outcome measures listed in subdivision 6, and shall periodically determine whether home visiting programs are the best way to achieve the qualitative goals established under subdivisions 1 and 6. If the commissioner determines that home visiting programs are not the best way to achieve these goals, the commissioner shall provide the legislature with alternative methods for achieving them.

Subd. 8. **Report.** By January 15, 2002, and January 15 of each even-numbered year thereafter, the commissioner shall submit a report to the legislature on the family home visiting programs funded under this section and on the results of the evaluations conducted under subdivision 7.

Subd. 9. **No supplanting of existing funds.** Funding available under this section may be used only to supplement, not to replace, nonstate funds being used for home visiting services as of July 1, 2001.

History: *1Sp2001 c 9 art 1 s 53*