CHAPTER 145A

LOCAL PUBLIC HEALTH BOARDS

145A.01 CITATION.

This chapter may be cited as the "Local Public Health Act."

History: *1987 c 309 s 1*

145A.02 DEFINITIONS.

Subdivision 1. **Applicability.** Definitions in this section apply to this chapter.

Subd. 2. **Board of health.** "Board of health" or "board" means an administrative authority established under section 145A.03 or 145A.07.

Subd. 3. **City.** "City" means a statutory city or home rule charter city as defined in section 410.015.

Subd. 4. **Commissioner.** "Commissioner" means the Minnesota commissioner of health.

Subd. 5. **Community health board.** "Community health board" means a board of health established, operating, and eligible for a subsidy under sections 145A.09 to 145A.13.

Subd. 6. **Community health services.** "Community health services" means activities designed to protect and promote the health of the general population within a community health service area by emphasizing the prevention of disease, injury, disability, and preventable death through the promotion of effective coordination and use of community resources, and by extending health services into the community. Program categories of community health services include disease prevention and control, emergency medical care, environmental health, family health, health promotion, and home health care.

Subd. 7. **Community health service area.** "Community health service area" means a city, county, or multicounty area that is organized as a community health board under section 145A.09 and for which a subsidy is received under sections 145A.09 to 145A.13.

Subd. 8. **County board.** "County board" or "county" means a county board of commissioners as defined in chapter 375.

Subd. 9. **Disease prevention and control.** "Disease prevention and control" means activities intended to prevent or control communicable diseases. These activities include the coordination or provision of disease surveillance, investigation, reporting, and related counseling, education, screening, immunization, case management and clinical services.

Subd. 10. **Emergency medical care.** "Emergency medical care" means activities intended to protect the health of persons suffering a medical emergency and to ensure rapid and effective emergency medical treatment. These activities include the coordination or provision of training, cooperation with public safety agencies, communications, life-support transportation under sections 144E.06 to 144E.19, public information and involvement, and system management.

Subd. 11. **Environmental health.** "Environmental health" means activities intended to achieve an environment conducive to human health, comfort, safety, and well-being. These activities include the coordination or provision of education, regulation, and consultation related to food protection, hazardous substances and product safety, water supply sanitation, waste disposal, environmental pollution control, occupational health and safety, public health nuisance control, institutional sanitation, recreational sanitation including swimming pool sanitation and safety, and housing code enforcement for health and safety purposes.

Subd. 12. **Family health.** "Family health" means activities intended to promote optimum health outcomes as related to human reproduction and child growth and development. These activities include the coordination or provision of education, counseling, screening, clinical services, school health services, nutrition services, family planning services as defined in section 145.925, and other interventions directed at improving family health. Family health services must not include arrangements, referrals, or counseling for, or provision of, voluntary termination of pregnancy.

Subd. 13. **Health promotion.** "Health promotion" means activities intended to reduce the prevalence of risk conditions or behaviors of individuals or communities for the purpose of preventing chronic disease and effecting other definable advances in health status. These activities include the coordination or provision of community organization, regulation, targeted screening and education, as well as informational and other scientifically supported interventions to foster health by affecting related conditions and behaviors.

Subd. 14. **Home health care.** "Home health care" means activities intended to reduce the ill effects and complications of existing disease and to provide suitable alternatives to inpatient care in a health facility. These activities include the coordination or provision of health assessment, nursing care, education, counseling, nutrition services, delegated medical and ancillary services, case management, referral and follow-up.

Subd. 15. **Medical consultant.** "Medical consultant" means a physician licensed to practice medicine in Minnesota who is working under a written agreement with, employed by, or on contract with a board of health to provide advice and information, to authorize medical procedures through standing orders, and to assist a board of health and its staff in coordinating their activities with local medical practitioners and health care institutions.

Subd. 16. **Population.** "Population" means the total number of residents of the state or any city or county as established by the last federal census, by a special census taken by the United States Bureau of the Census, by the state demographer under section 4A.02, or by an estimate of city population prepared by the metropolitan council, whichever is the most recent as to the stated date of count or estimate.

Subd. 17. **Public health nuisance.** "Public health nuisance" means any activity or failure to act that adversely affects the public health.

Subd. 18. **Public health nurse.** "Public health nurse" means a person who is licensed as a registered nurse by the Minnesota board of nursing under sections 148.171 to 148.285 and who meets the voluntary registration requirements established by the board of nursing.

History: *1987 c 309 s 2; 1989 c 194 s 2; 1991 c 345 art 2 s 43; 1997 c 199 s 14; 1999 c 245 art 9 s 47*

BOARD OF HEALTH

145A.03 ESTABLISHMENT AND ORGANIZATION.

Subdivision 1. **Establishment; assignment of responsibilities.** (a) The governing body of a city or county must undertake the responsibilities of a board of health or establish a board of health and assign to it the powers and duties of a board of health.

(b) A city council may ask a county or joint powers board of health to undertake the responsibilities of a board of health for the city's jurisdiction.

(c) A county board or city council within the jurisdiction of a community health board operating under sections 145A.09 to 145A.13 is preempted from forming a board of health except as specified in section 145A.10, subdivision 2.

Subd. 2. **Joint powers board of health.** Except as preempted under section 145A.10, subdivision 2, a county may establish a joint board of health by agreement with one or more contiguous counties, or a city may establish a joint board of health with one or more contiguous cities in the same county, or a city may establish a joint board of health with the county or counties within which it is located. The agreements must be established according to section 471.59.

Subd. 3. **Withdrawal from joint powers board of health.** A county or city may withdraw from a joint powers board of health by resolution of its governing body not less than one year after the effective date of the initial joint powers agreement. The withdrawing county or city must notify the commissioner and the other parties to the agreement at least one year before the beginning of the calendar year in which withdrawal takes effect.

Subd. 4. **Membership; duties of chair.** A board of health must have at least five members, one of whom must be elected by the members as chair and one as vice-chair. The chair, or in the chair's absence, the vice-chair, must preside at meetings of the board of health and sign or authorize an agent to sign contracts and other documents requiring signature on behalf of the board of health.

Subd. 5. **Meetings.** A board of health must hold meetings at least twice a year and as determined by its rules of procedure. The board must adopt written procedures for transacting business and must keep a public record of its transactions, findings, and determinations. Members may receive a per diem plus travel and other eligible expenses while engaged in official duties.

Subd. 6. **Duplicate licensing.** A local board of health must work with the commissioner of agriculture to eliminate duplicate licensing and inspection of grocery and convenience stores by no later than March 1, 1992.

History: *1987 c 309 s 3; 1991 c 52 s 3*

145A.04 POWERS AND DUTIES OF BOARD OF HEALTH.

Subdivision 1. **Jurisdiction; enforcement.** A county or multicounty board of health has the powers and duties of a board of health for all territory within its jurisdiction not under the jurisdiction of a city board of health. Under the general supervision of the commissioner, the board shall enforce laws, regulations, and ordinances pertaining to the powers and duties of a board of health within its jurisdictional area.

Subd. 2. **Appointment of agent.** A board of health must appoint, employ, or contract with a person or persons to act on its behalf. The board shall notify the commissioner of the agent's name, address, and phone number where the agent may be reached between board meetings and submit a copy of the resolution authorizing the agent to act on the board's behalf.

Subd. 3. **Employment; medical consultant.** (a) A board of health may establish a health department or other administrative agency and may employ persons as necessary to carry out its duties.

(b) Except where prohibited by law, employees of the board of health may act as its agents.

(c) Employees of the board of health are subject to any personnel administration rules adopted by a city council or county board forming the board of health unless the employees of the board are within the scope of a statewide personnel administration system.

(d) The board of health may appoint, employ, or contract with a medical consultant to receive appropriate medical advice and direction.

Subd. 4. **Acquisition of property; request for and acceptance of funds; collection of fees.** (a) A board of health may acquire and hold in the name of the county or city the lands, buildings, and equipment necessary for the purposes of sections 145A.03 to

145A.13. It may do so by any lawful means, including gifts, purchase, lease, or transfer of custodial control.

(b) A board of health may accept gifts, grants, and subsidies from any lawful source, apply for and accept state and federal funds, and request and accept local tax funds.

(c) A board of health may establish and collect reasonable fees for performing its duties and providing community health services.

(d) With the exception of licensing and inspection activities, access to community health services provided by or on contract with the board of health must not be denied to an individual or family because of inability to pay.

Subd. 5. **Contracts.** To improve efficiency, quality, and effectiveness, avoid unnecessary duplication, and gain cost advantages, a board of health may contract to provide, receive, or ensure provision of services.

Subd. 6. **Investigation; reporting and control of communicable diseases.** A board of health shall make investigations and reports and obey instructions on the control of communicable diseases as the commissioner may direct under section 144.12, 145A.06, subdivision 2, or 145A.07. Boards of health must cooperate so far as practicable to act together to prevent and control epidemic diseases.

Subd. 7. **Entry for inspection.** To enforce public health laws, ordinances or rules, a member or agent of a board of health may enter a building, conveyance, or place where contagion, infection, filth, or other source or cause of preventable disease exists or is reasonably suspected.

Subd. 8. **Removal and abatement of public health nuisances.** (a) If a threat to the public health such as a public health nuisance, source of filth, or cause of sickness is found on any property, the board of health or its agent shall order the owner or occupant of the property to remove or abate the threat within a time specified in the notice but not longer than ten days. Action to recover costs of enforcement under this subdivision must be taken as prescribed in section 145A.08.

(b) Notice for abatement or removal must be served on the owner, occupant, or agent of the property in one of the following ways:

(1) by registered or certified mail;

(2) by an officer authorized to serve a warrant; or

(3) by a person aged 18 years or older who is not reasonably believed to be a party to any action arising from the notice.

(c) If the owner of the property is unknown or absent and has no known representative upon whom notice can be served, the board of health or its agent shall post a written or printed notice on the property stating that, unless the threat to the public health is abated or removed within a period not longer than ten days, the board will have the threat abated or removed at the expense of the owner under section 145A.08 or other applicable state or local law.

(d) If the owner, occupant, or agent fails or neglects to comply with the requirement of the notice provided under paragraphs (b) and (c), then the board of health or its agent shall remove or abate the nuisance, source of filth, or cause of sickness described in the notice from the property.

Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the board of health may bring an action in the court of appropriate jurisdiction to enjoin a violation of statute, rule, or ordinance that the board has power to enforce, or to enjoin as a public health nuisance any activity or failure to act that adversely affects the public health.

Subd. 10. **Hindrance of enforcement prohibited; penalty.** It is a misdemeanor deliberately to hinder a member of a board of health or its agent from entering a building, conveyance, or place where contagion, infection, filth, or other source or cause of preventable disease exists or is reasonably suspected, or otherwise to interfere with the performance of the duties of the board of health.

Subd. 11. **Neglect of enforcement prohibited; penalty.** It is a misdemeanor for a member or agent of a board of health to refuse or neglect to perform a duty imposed on a board of health by statute or ordinance.

Subd. 12. **Other powers and duties established by law.** This section does not limit powers and duties of a board of health prescribed in other sections.

History: *1987 c 309 s 4*

145A.05 LOCAL ORDINANCES.

Subdivision 1. **Generally.** A county board may adopt ordinances for all or a part of its jurisdiction to regulate actual or potential threats to the public health under this section and section 375.51, unless the ordinances are preempted by, in conflict with, or less restrictive than standards in state law or rule.

Subd. 2. **Animal control.** In addition to powers under sections 35.67 to 35.69, a county board may adopt ordinances to issue licenses or otherwise regulate the keeping of animals, to restrain animals from running at large, to authorize the impounding and sale or summary destruction of animals, and to establish pounds.

Subd. 3. **Control of unwholesome substances.** Unless preempted by or in conflict with sections 394.21 to 394.37, a county board may adopt ordinances to prevent bringing, depositing, or leaving within the county any unwholesome substance and to require the owners or occupants of lands to remove unwholesome substances or to provide for removal at the expense of the owner or occupant.

Subd. 4. **Regulation of waste.** A county board may adopt ordinances to provide for or regulate the disposal of sewage, garbage, and other refuse.

Subd. 5. **Regulation of water.** A county board may adopt ordinances to provide for cleaning and removal of obstructions from waters in the county and to prevent their obstruction or pollution.

Subd. 6. **Regulation of offensive trades.** A county board may adopt ordinances to regulate offensive trades, unless the ordinances are preempted by, in conflict with, or less restrictive than standards under sections 394.21 to 394.37. In this subdivision, "offensive trade" means a trade or employment that is hurtful to inhabitants within any county, city, or town, dangerous to the public health, injurious to neighboring property, or from which offensive odors arise.

Subd. 7. **Control of public health nuisances.** A county board may adopt ordinances to define public health nuisances and to provide for their prevention or abatement.

Subd. 7a. **Curfew.** A county board may adopt an ordinance establishing a county-wide curfew for unmarried persons under 18 years of age. If the county board of a county located in the seven-county metropolitan area adopts a curfew ordinance under this subdivision, the ordinance shall contain an earlier curfew for children under the age of 12 than for older children.

Subd. 8. **Enforcement of delegated powers.** A county board may adopt ordinances consistent with this section to administer and enforce the powers and duties delegated by agreement with the commissioner under section 145A.07.

Subd. 9. **Relation to cities and towns.** The governing body of a city or town may adopt ordinances relating to the public health authorized by law or agreement with the commissioner under section 145A.07. The ordinances must not conflict with or be less restrictive than ordinances adopted by the county board within whose jurisdiction the city or town is located.

History: *1987 c 309 s 5; 1994 c 636 art 9 s 10; 1995 c 226 art 2 s 1*

145A.06 COMMISSIONER; POWERS AND DUTIES RELATIVE TO BOARDS OF HEALTH.

Subdivision 1. **Generally.** In addition to other powers and duties provided by law, the commissioner has the powers listed in subdivisions 2 to 4.

Subd. 2. **Supervision of local enforcement.** (a) In the absence of provision for a board of health, the commissioner may appoint three or more persons to act as a board

until one is established. The commissioner may fix their compensation, which the county or city must pay.

(b) The commissioner by written order may require any two or more boards of health to act together to prevent or control epidemic diseases.

(c) If a board fails to comply with section 145A.04, subdivision 6, the commissioner may employ medical and other help necessary to control communicable disease at the expense of the board of health involved.

(d) If the commissioner has reason to believe that the provisions of this chapter have been violated, the commissioner shall inform the attorney general and submit information to support the belief. The attorney general shall institute proceedings to enforce the provisions of this chapter or shall direct the county attorney to institute proceedings.

Subd. 3. [Repealed, 1989 c 194 s 22]

Subd. 4. **Assistance to boards of health.** The commissioner shall help and advise boards of health that ask for help in developing, administering, and carrying out public health services and programs.

Subd. 5. **Deadly infectious diseases.** The commissioner shall promote measures aimed at preventing businesses from facilitating sexual practices that transmit deadly infectious diseases by providing technical advice to boards of health to assist them in regulating these practices or closing establishments that constitute a public health nuisance.

History: *1987 c 309 s 6; 1988 c 689 art 2 s 47*

145A.07 DELEGATION OF POWERS AND DUTIES.

Subdivision 1. **Agreements to perform duties of commissioner.** (a) The commissioner of health may enter into an agreement with any board of health to delegate all or part of the licensing, inspection, reporting, and enforcement duties authorized under sections 144.12; 144.381 to 144.387; 144.411 to 144.417; 144.71 to 144.74; 145A.04, subdivision 6; provisions of chapter 103I pertaining to construction, repair, and abandonment of water wells; chapter 157; and sections 327.14 to 327.28.

(b) Agreements are subject to subdivision 3.

(c) This subdivision does not affect agreements entered into under Minnesota Statutes 1986, section 145.031, 145.55, or 145.918, subdivision 2.

Subd. 2. **Agreements to perform duties of board of health.** A board of health may authorize a township board, city council, or county board within its jurisdiction to establish a board of health under section 145A.03 and delegate to the board of health by agreement any powers or duties under sections 145A.04, 145A.07, subdivision 2, and 145A.08. An agreement to delegate powers and duties of a board of health must be approved by the commissioner and is subject to subdivision 3.

Subd. 3. **Terms of agreements.** (a) Agreements authorized under this section must be in writing and signed by the delegating authority and the designated agent.

(b) The agreement must list criteria the delegating authority will use to determine if the designated agent's performance meets appropriate standards and is sufficient to replace performance by the delegating authority.

(c) The agreement may specify minimum staff requirements and qualifications, set procedures for the assessment of costs, and provide for termination procedures if the delegating authority finds that the designated agent fails to comply with the agreement.

(d) A designated agent must not perform licensing, inspection, or enforcement duties under the agreement in territory outside its jurisdiction unless approved by the governing body for that territory through a separate agreement.

(e) The scope of agreements established under this section is limited to duties and responsibilities agreed upon by the parties. The agreement may provide for automatic renewal and for notice of intent to terminate by either party.

(f) During the life of the agreement, the delegating authority shall not perform duties that the designated agent is required to perform under the agreement, except inspections necessary to determine compliance with the agreement and this section or as agreed to by the parties.

(g) The delegating authority shall consult with, advise, and assist a designated agent in the performance of its duties under the agreement.

(h) This section does not alter the responsibility of the delegating authority for the performance of duties specified in law.

History: *1987 c 309 s 7; 1989 c 209 art 2 s 18; 1990 c 426 art 2 s 1; 1993 c 206 s 12; 1995 c 186 s 43*

145A.08 ASSESSMENT OF COSTS; TAX LEVY AUTHORIZED.

Subdivision 1. **Cost of care.** A person who has or whose dependent or spouse has a communicable disease that is subject to control by the board of health is financially liable to the unit or agency of government that paid for the reasonable cost of care provided to control the disease under section 145A.04, subdivision 6.

Subd. 2. **Assessment of costs of enforcement.** (a) If costs are assessed for enforcement of section 145A.04, subdivision 8, and no procedure for the assessment of costs has been specified in an agreement established under section 145A.07, the enforcement costs must be assessed as prescribed in this subdivision.

(b) A debt or claim against an individual owner or single piece of real property resulting from an enforcement action authorized by section 145A.04, subdivision 8, must not exceed the cost of abatement or removal.

(c) The cost of an enforcement action under section 145A.04, subdivision 8, may be assessed and charged against the real property on which the public health nuisance, source of filth, or cause of sickness was located. The auditor of the county in which the action is taken shall extend the cost so assessed and charged on the tax roll of the county against the real property on which the enforcement action was taken.

(d) The cost of an enforcement action taken by a town or city board of health under section 145A.04, subdivision 8, may be recovered from the county in which the town or city is located if the city clerk or other officer certifies the costs of the enforcement action to the county auditor as prescribed in this section. Taxes equal to the full amount of the enforcement action but not exceeding the limit in paragraph (b) must be collected by the county treasurer and paid to the city or town as other taxes are collected and paid.

Subd. 3. **Tax levy authorized.** A city council or county board that has formed or is a member of a board of health may levy taxes on all taxable property in its jurisdiction to pay the cost of performing its duties under this chapter.

History: *1987 c 309 s 8; 1Sp1989 c 1 art 5 s 6*

COMMUNITY HEALTH BOARDS

145A.09 PURPOSE; FORMATION; ELIGIBILITY; WITHDRAWAL.

Subdivision 1. **General purpose.** The purpose of sections 145A.09 to 145A.14 is to develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards.

Subd. 2. **Community health board; eligibility.** A board of health that meets the requirements of sections 145A.09 to 145A.13 is a community health board and is eligible for a community health subsidy under section 145A.13.

Subd. 3. **Population requirement.** A board of health must include within its jurisdiction a population of 30,000 or more persons or be composed of three or more contiguous counties to be eligible to form a community health board.

Subd. 4. **Cities.** A city that received a subsidy under section 145A.13 and that meets the requirements of sections 145A.09 to 145A.13 is eligible for a community health subsidy under section 145A.13.

Subd. 5. **Human services board.** A county board or a joint powers board of health that establishes a community health board and has or establishes an operational human services board under chapter 402 must assign the powers and duties of a community health board to the human services board.

Subd. 6. **Boundaries of community health service areas.** The community health service area of a multicounty or multicity community health board must be within a region designated under sections 462.381 to 462.398, unless this condition is waived by the commissioner with the approval of the regional development commission directly involved or the metropolitan council, if appropriate. In a region without a regional development commission, the commissioner of trade and economic development shall act in place of the regional development commission.

Subd. 7. **Withdrawal.** (a) A county or city that has established or joined a community health board may withdraw from the subsidy program authorized by sections 145A.09 to 145A.13 by resolution of its governing body in accordance with section 145A.03, subdivision 3, and this subdivision.

(b) A county or city may not withdraw from a joint powers community health board during the first two calendar years following that county's or city's initial adoption of the joint powers agreement.

(c) The withdrawal of a county or city from a community health board does not affect the eligibility for the community health subsidy of any remaining county or city for one calendar year following the effective date of withdrawal.

(d) The amount of additional annual payment for calendar year 1985 made pursuant to Minnesota Statutes 1984, section 145.921, subdivision 4, must be subtracted from the subsidy for a county that, due to withdrawal from a community health board, ceases to meet the terms and conditions under which that additional annual payment was made.

History: *1987 c 186 s 15; 1987 c 309 s 9,25; 1991 c 345 art 2 s 44*

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

Subdivision 1. **General.** A community health board has the powers and duties of a board of health prescribed in sections 145A.03, 145A.04, 145A.07, and 145A.08, as well as the general responsibility for development and maintenance of an integrated system of community health services as prescribed in sections 145A.09 to 145A.13.

Subd. 2. **Preemption.** (a) Not later than 365 days after the approval of a community health plan by the commissioner, any other board of health within the community health service area for which the plan has been prepared must cease operation, except as authorized in a joint powers agreement under section 145A.03, subdivision 2, or delegation agreement under section 145A.07, subdivision 2, or as otherwise allowed by this subdivision.

(b) This subdivision does not preempt or otherwise change the powers and duties of any city or county eligible for subsidy under section 145A.09.

(c) This subdivision does not preempt the authority to operate a community health services program of any city of the first or second class operating an existing program of community health services located within a county with a population of 300,000 or more persons until the city council takes action to allow the county to preempt the city's powers and duties.

Subd. 3. **Medical consultant.** The community health board must appoint, employ, or contract with a medical consultant to ensure appropriate medical advice and direction for the board of health and assist the board and its staff in the coordination of community health services with local medical care and other health services.

Subd. 4. **Employees.** Persons employed by a county, city, or the state whose functions and duties are assumed by a community health board shall become employees of the board without loss in benefits, salaries, or rights. Failure to comply with this subdivision does not affect eligibility under section 145A.09.

Subd. 5. **Community health plan.** The community health board must prepare and submit to the commissioner a written plan at times prescribed by the commissioner under section 145A.12, subdivision 3, but no more often than every two years. The community health plan must provide for the assessment of community health status and the integration, development, and provision of community health services that meet the priority needs of the community health service area. The plan must be consistent with the standards and procedures established under section 145A.12, subdivision 3, and must at least include documentation of the following:

(1) a review and assessment of the implementation of the preceding community health plan;

(2) the process used to assess community health status and encourage full community participation in the development of the proposed community health plan;

(3) an identification of personal health services, institutional health services, health-related environmental programs and services, and related human services in the community;

(4) an assessment of community health status, a statement of goals and objectives according to priority, and the reasons for the priority order;

(5) a description of and rationale for the method the community health board plans to use to address each identified community health goal and objective and how each program category defined in section 145A.02 and any agreements entered into under section 145A.07 will be implemented to achieve these goals and objectives;

(6) a description of the ways in which planned community health services defined in section 145A.02 will be coordinated with services and resources identified in clause (2);

(7) the projected annual budgets for expenditure of the subsidy and local match provided for in section 145A.13 and for other sources of funding for the program categories defined in section 145A.02 including a description of the ways this funding is coordinated with funding from other local, state, and federal sources; and

(8) assurances that community health services will comply with applicable state and federal laws.

Subd. 6. **Budget; plan revision.** The community health board must prepare and submit to the commissioner an annual budget for the expenditure of local match and subsidy funds under section 145A.13 and for other sources of funding for community health services. Revisions to the community health plan or annual budgets must be submitted to the commissioner in the same manner as prescribed in section 145A.12, subdivisions 3 and 4.

Subd. 7. **Equal access to services.** The community health board must ensure that community health services are accessible to all persons on the basis of need. No one shall be denied services because of race, color, sex, age, language, religion, nationality, inability to pay, political persuasion, or place of residence.

Subd. 8. **Reports.** The community health board must compile and submit reports to the commissioner on its expenditures and activities as required under section 145A.12, subdivision 5.

Subd. 9. **Recommended legislation.** The community health board may recommend local ordinances pertaining to community health services to any county board or city council within its jurisdiction and advise the commissioner on matters relating to public health that require assistance from the state, or that may be of more than local interest.

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: *1987 c 309 s 10; 2001 c 161 s 25*

145A.11 POWERS AND DUTIES OF CITY AND COUNTY RELATIVE TO SUBSIDY.

Subdivision 1. **Generally.** In addition to the powers and duties prescribed elsewhere in law and in section 145A.05, a city council or county board that has formed or is a member of a community health board has the powers and duties prescribed in this section.

Subd. 2. **Consideration of community health plan in tax levy.** In levying taxes authorized under section 145A.08, subdivision 3, a city council or county board that has formed or is a member of a community health board must consider the income and expenditures required to meet the objectives of the community health plan for its area.

Subd. 3. **Approval of plan and budget.** (a) The county board must review and approve the community health plan and budget or any revision prepared according to section 145A.10, subdivision 6, within 30 days of its receipt and before the submission of the plan, budget, or revision to the commissioner.

(b) The community health plan, budget, or revision submitted to the county board must incorporate the community health plan, budget, or revision developed by any city within its community health service area that has a community health board.

(c) The county board may approve the community health plan, budget, or revision as written or refer it back to the community health board with comments and instructions for further consideration.

(d) A city council or county board that is a member of a community health board may appeal to the commissioner for resolution of differences regarding the community health plan, budget, or revision.

(e) Failure to act within the specified time constitutes approval.

Subd. 4. **Ordinances relating to community health services.** A city council or county board that has established or is a member of a community health board may by ordinance adopt and enforce minimum standards for services provided according to sections 145A.02 and 145A.10, subdivision 5. An ordinance must not conflict with state law or with more stringent standards established either by rule of an agency of state government or by the provisions of the charter or ordinances of any city organized under section 145A.09, subdivision 4.

History: *1987 c 309 s 11*

145A.12 POWERS AND DUTIES OF COMMISSIONER RELATIVE TO SUBSIDY.

Subdivision 1. **Administrative and program support.** The commissioner must assist community health boards in the development, administration, and implementation of community health services. This assistance may consist of but is not limited to:

(1) informational resources, consultation, and training to help community health boards plan, develop, integrate, provide and evaluate community health services; and

(2) administrative and program guidelines, developed with the advice of the state community health advisory committee. Adoption of these guidelines by a community health board is not a prerequisite for plan approval as prescribed in subdivision 4.

Subd. 2. **Personnel standards.** In accordance with chapter 14, and in consultation with the state community health advisory committee, the commissioner may adopt rules to set standards for administrative and program personnel to ensure competence in administration and planning and in each program area defined in section 145A.02.

Subd. 3. **Planning standards; budgets; revisions.** The commissioner may, in accordance with chapter 14 and in consultation with the state community health advisory committee, adopt rules to set submission dates, procedures, and standards for community health plans, budgets, and revisions prepared according to section 145A.10, subdivisions 5 and 6.

Subd. 4. **Review and approval of plan, budget or revision.** The commissioner must review and act on the community health plan, budget, or any proposed revision within 60 days after receiving the plan, budget, or revision. The commissioner may approve the plan, budget, or revision as written or refer it back to the community health board with comments and instructions for further consideration. Failure to act within the specified time constitutes approval.

Subd. 5. **Reporting standards.** The commissioner may, in accordance with chapter 14 and in consultation with the state community health advisory committee, adopt rules establishing standards and procedures for a uniform reporting system that will permit the evaluation of the efficiency and effectiveness of community health services.

Subd. 6. [Repealed, 1997 c 7 art 2 s 67]

History: *1987 c 309 s 12*

145A.13 COMMUNITY HEALTH SERVICES SUBSIDY.

Subdivision 1. **Subsidy formula.** The commissioner of health shall distribute a subsidy for the operations of community health boards organized and operating under sections 145A.09 to 145A.13.

(a) Each city or county eligible for a subsidy under section 145A.09, subdivision 2, shall receive no less for any calendar year than the total community health services subsidy that was allocated for that city or county by the commissioner of health under this section for calendar year 1985.

(b) Additional money appropriated for the operations of community health boards organized and operating under sections 145A.09 to 145A.13 shall be distributed in proportion to population.

Subd. 2. **Local match.** Each community health board that receives a subsidy shall provide local matching money equal to that subsidy during the year for which the subsidy is made, subject to the following provisions:

(a) the local matching funds may include local tax levies, gifts, fees for services, and revenues from contracts;

(b) when the amount of local matching funds for a community health board is less than the amount specified, the subsidy provided for that community health board under this section shall be reduced proportionally;

(c) when a community health board fails to expend the full amount of the subsidy to which it would be entitled in any one year under the provisions of sections 145A.09 to 145A.13, the state commissioner of health may retain the surplus, subject to disbursement to the community health board in the following calendar year if the community health board can demonstrate a need for and ability to expend the surplus for the purposes provided in section 145A.10; and

(d) a city organized under the provisions of sections 145A.09 to 145A.13 that levies a tax for provision of community health services shall be exempted from any county levy for the same services to the extent of the levy imposed by the city.

Subd. 3. **Payment.** When a community health board meets the requirements prescribed in section 145A.09, subdivision 2, the state commissioner of health shall pay the amount of subsidy to the community health board or its designee according to applicable rules from the money appropriated for the purpose and according to the following:

(a) the commissioner of health shall make payments for community health services to each community health board or its designee in 12 installments a year;

(b) the commissioner shall ensure that the pertinent payment of the allotment for each month is made on the first working day after the end of each month of the calendar year, except for the last month of the calendar year;

(c) the commissioner shall ensure that each community health board or its designee receives its payment of the allotment for that month no later than the last working day of that month. The payment described in this subdivision for services rendered during June, 1985, shall be made on the first working day of July, 1985; and

(d) the commissioner shall make payment to a human services board organized and operating under section 145A.09, subdivision 5, or to its designee, as prescribed in section 402.02, subdivision 4.

History: *1976 c 9 s 11; 1977 c 305 s 45; 1983 c 312 art 1 s 19; 1985 c 248 s 70; 1Sp1985 c 9 art 2 s 20; 1987 c 309 s 24,25; 1989 c 209 art 2 s 19*

145A.14 SPECIAL GRANTS.

Subdivision 1. **Migrant health grants.** (a) The commissioner may make special grants to cities, counties, groups of cities or counties, or nonprofit corporations to establish, operate, or subsidize clinic facilities and services, including mobile clinics, to furnish health services for migrant agricultural workers and their families in areas of the state where significant numbers of migrant workers are located. "Migrant agricultural worker" means any individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the past 24 months, and who has established a temporary residence for the purpose of such employment.

(b) Applicants must submit for approval a plan and budget for the use of the funds in the form and detail specified by the commissioner.

(c) Applicants must keep records, including records of expenditures to be audited, as the commissioner specifies.

Subd. 2. **Indian health grants.** (a) The commissioner may make special grants to community health boards to establish, operate, or subsidize clinic facilities and services to furnish health services for American Indians who reside off reservations.

(b) To qualify for a grant under this subdivision the community health plan submitted by the community health board must contain a proposal for the delivery of the services and documentation that representatives of the Indian community affected by the plan were involved in its development.

(c) Applicants must submit for approval a plan and budget for the use of the funds in the form and detail specified by the commissioner.

(d) Applicants must keep records, including records of expenditures to be audited, as the commissioner specifies.

Subd. 3. **Grants to prevent tobacco use.** The commissioner of health may award special grants to community boards of health to conduct communitywide programs or to community health boards or nonprofit corporations to conduct statewide programs to prevent tobacco use.

Subd. 4. **Health promotion team.** (a) The community health board may establish a community-based health promotion team made up of representatives of business and industry, public health, labor, voluntary agencies, hospitals, medical clinics, churches, media, schools, civic groups, local government and elected officials, nursing homes, consumers, and others as appropriate.

(b) A community-based health promotion team shall:

(1) collect and summarize community health data relating to behavioral risk factors such as smoking, consumption of alcoholic beverages, and poor nutrition habits;

(2) identify, rank, and prioritize lifestyle-based health problems;

(3) develop strategies to address health promotion concerns;

(4) implement a five-year health promotion plan that includes an annual evaluation component and establish a mechanism for program maintenance following completion of the plan;

(5) design and implement a "healthy messages" media plan; and

(6) seek grants and other funding from foundations, educational institutions, and other nonprofit entities.

(c) Within the limit of available appropriations, the commissioner may grant money to a community health board to enable the board to establish a community-based health promotion team. The commissioner shall monitor the activities of teams under this section and report to the legislature by January 1, 1991, on the teams' operation and progress.

History: *1Sp1985 c 14 art 19 s 24; 1987 c 309 s 13,19,25; 1989 c 120 s 1*

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.

Subd. 2. **Grant recipients.** (a) The commissioner is authorized to award grants to programs that meet the requirements of subdivision 3 and include a strong child abuse and neglect prevention focus for families in need of services. Priority will be given to families considered to be in need of additional services. These families include, but are not limited to, families with:

(1) adolescent parents;

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

(3) a history of child abuse, domestic abuse, or other types of violence in the family of origin;

(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) lack of sufficient financial resources to meet their needs.

(b) Grants made under this section shall be used to fund existing and new home visiting programs. In awarding grants under this section, the commissioner shall give priority to new home visiting programs with local matching funds.

Subd. 3. **Program requirements.** (a) The commissioner shall award grants, using a request for proposal system, to programs designed to:

(1) contact families at the birth of the child through a public health nurse or trained program representative who will meet the family, provide information, describe the benefits of the program, and offer a home visit to the family to occur during the first weeks of the newborn's life in the home setting;

(2) visit the family and newborn in the home setting at which time the public health nurse or trained individual will answer parents' questions, give information, including information on breast feeding, and make referrals to any other appropriate services;

(3) conduct a screening process to determine if families need additional support or are at risk for child abuse and neglect and provide additional home visiting services needed by the families including, but not limited to, education on: parenting skills, child development and stages of growth, communication skills, stress management, problem-solving skills, positive child discipline practices, methods to improve parent-child interactions and enhance self-esteem, community support services and other resources, and how to enjoy and have fun with your children;

(4) establish clear objectives and protocols for the home visits;

(5) determine the frequency and duration of home visits based on a risk-need assessment of the client; except that home visits may begin as early as the first trimester of pregnancy and continue based on the need of the client until the child reaches age six;

(6) refer and actively assist the family in accessing new parent and family education, self-help and support services available in the community;

(7) develop and distribute educational resource materials and offer presentations on the prevention of child abuse and neglect for use in hospital maternity divisions, well-baby clinics, obstetrical clinics, and community clinics; and

(8) coordinate with other local home visitation programs, particularly those offered by school boards under section 124D.13, subdivision 4, so as to avoid duplication.

(b) Programs must provide at least 40 hours of training for public health nurses, family aides, and other home visitors. Training must include information on the following:

(1) the dynamics of child abuse and neglect, domestic and nondomestic violence, and victimization within family systems;

(2) signs of abuse or other indications that a child may be at risk of abuse or neglect;

(3) what is child abuse and neglect;

(4) how to properly report cases of child abuse and neglect;

(5) sensitivity and respect for diverse cultural practices in child rearing and family systems, including but not limited to complex family relationships, safety, appropriate services, family preservation, family finances for self-sufficiency, and other special needs or circumstances;

(6) community resources, social service agencies, and family support activities or programs;

(7) healthy child development and growth;

(8) parenting skills;

(9) positive child discipline practices;

(10) identification of stress factors and stress reduction techniques;

(11) home visiting techniques;

(12) needs assessment measures; and

(13) caring for the special needs of newborns and mothers before and after the birth of the infant.

Program services must be community-based, accessible, and culturally relevant and must be designed to foster collaboration among existing agencies and community-based organizations.

Subd. 4. **Evaluation.** Each program that receives a grant under this section must include a plan for program evaluation designed to measure the effectiveness of the program in preventing child abuse and neglect. On January 1, 1994, and annually thereafter, the commissioner of health shall submit a report to the legislature on all activities initiated in the prior biennium under this section. The report shall include information on the outcomes reported by all programs that received grant funds under this section in that biennium.

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

History: *1992 c 571 art 10 s 9; 1995 c 207 art 9 s 37; 1998 c 397 art 11 s 3; 1998 c 407 art 2 s 86; 1Sp2001 c 9 art 1 s 49,50; 2002 c 379 art 1 s 113*

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.

Subd. 2. **Steering committee.** The commissioner shall establish an ad hoc steering committee to develop and implement a comprehensive plan for the universally offered home visiting programs. The members of the ad hoc steering committee shall include, at a minimum, representatives of local public health departments, public health nurses, other health care providers, paraprofessionals, community-based family workers, representatives of the state councils of color, representatives of health insurance plans, and other individuals with expertise in the field of home visiting, early childhood health and development, and child abuse prevention.

Subd. 3. **Program requirements.** The commissioner shall award grants using a request for proposal system. Existing home visiting programs or a family services collaborative established under section 256F.13 may apply for the grants. Health information and assessment, counseling, social support, educational services, and referral to community resources must be offered to all families, regardless of need or risk, beginning prenatally or as soon after birth as possible, and continuing as needed. Each program applying for a grant must have access to adequate community resources to complement the home visiting services and must be designed to:

(1) identify all newborn infants within the geographic area served by the program. Identification may be made prenatally or at the time of birth;

(2) offer a home visit by a trained home visitor. The offer of a home visit must be made in a way that guarantees that the existence of the pregnancy is not revealed to any other individual without the written consent of the pregnant female. If home visiting is accepted, the first 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, the prevention of disease and exposure to environmental hazards, and support services available in the community;

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

(5) recruit home visit workers who will represent, to the extent possible, all the races, cultures, and languages spoken by eligible families in the designated geographic areas; and

(6) train and supervise home visitors in accordance with the requirements established under subdivision 5.

Subd. 4. **Coordination.** To minimize duplication, a program receiving a grant must establish a coalition that includes parents, health care providers who provide services to families with young children in the service area, and representatives of local schools, governmental and nonprofit agencies, community-based organizations, health insurance plans, and local hospitals. A program may use a family services collaborative as the coalition if a collaborative is established in the area served by the program. The coalition must designate the roles of all provider agencies, family identification methods, referral mechanisms, and payment responsibilities appropriate for the existing systems in the program's service area. The coalition must also coordinate with other programs offered by school boards under section 124D.13, subdivision 4, and programs offered under section 145A.15.

Subd. 5. **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, and diverse cultural practices in child rearing and family systems. A program may use grant money to train home visitors.

Subd. 6. **Evaluation.** (a) The commissioner shall evaluate the effectiveness of the home visiting programs, taking into consideration the following goals:

(1) appropriate child growth, development, and access to health care;

(2) appropriate utilization of preventive health care and medical care for acute illnesses;

(3) lower rates of substantiated child abuse and neglect;

(4) up-to-date immunizations;

(5) a reduction in unintended pregnancies;

(6) increasing families' understanding of lead poisoning prevention;

(7) lower rates of unintentional injuries; and

(8) fewer hospitalizations and emergency room visits.

(b) The commissioner shall compare overall outcomes of universally offered home visiting programs with targeted home visiting programs and report the findings to the legislature. The report must also include information on how home visiting programs will coordinate activities and preventive services provided by health plans and other organizations.

(c) The commissioner shall report to the legislature by February 15, 1998, on the comprehensive plan for the universally offered home visiting programs and recommend any draft legislation needed to implement the plan. The commissioner shall report to the legislature biennially beginning December 15, 2001, on the effectiveness of the universally offered home visiting programs. In the report due December 15, 2001, the commissioner shall include recommendations on the feasibility and cost of expanding the program statewide.

Subd. 7. **Technical assistance.** The commissioner shall provide administrative and technical assistance to each program, including assistance conducting short- and long-term evaluations of the home visiting program required under subdivision 6. The commissioner may request research and evaluation support from the University of Minnesota.

Subd. 8. **Matching funds.** The commissioner and the grant programs shall seek to supplement any state funding with private and other nonstate funding sources, including other grants and insurance coverage for services provided. Program funding may be used only to supplement, not to replace, existing funds being used for home visiting.

Subd. 9. **Payment for home visiting services.** Any health plan that provides services to families or individuals enrolled in medical assistance, general assistance medical care, or the MinnesotaCare program must contract with the programs receiving grants under this section and the programs established under section 145A.15 that are providing home visiting services in the area served by the health plan to provide home visiting services covered under medical assistance, general assistance medical care, or the MinnesotaCare program to their enrollees. A health plan may require a home visiting program to comply with the health plan's requirements on the same basis as the health plan's other participating providers.

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

History: *1997 c 203 art 2 s 16; 1998 c 397 art 11 s 3; 1Sp2001 c 9 art 1 s 51,52; 2002 c 379 art 1 s 113*

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; 2002 c 379 art 1 s 113*