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 local public health grant under sections 145A.09 to 145A.131.

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.

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 local public health grant is received under sections 145A.09 to 145A.131.

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

Subd. 9. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 10. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 11. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 12. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 13. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 14. [Repealed, 1Sp2003 c 14 art 8 s 32]

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; 1Sp2003 c 14 art 8 s 12-14*

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.131 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; 1Sp2003 c 14 art 8 s 31*

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.131. 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. 6a. **Minnesota Responds Medical Reserve Corps; planning.** A board of health receiving funding for emergency preparedness or pandemic influenza planning from the state or from the United States Department of Health and Human Services shall participate in planning for emergency use of volunteer health professionals through the Minnesota Responds Medical Reserve Corps program of the Department of Health. A board of health shall collaborate on volunteer planning with other public and private partners, including but not limited to local or regional health care providers, emergency medical services, hospitals, tribal governments, state and local emergency management, and local disaster relief organizations.

Subd. 6b. **Minnesota Responds Medical Reserve Corps; agreements.** A board of health participating in the Minnesota Responds Medical Reserve Corps program may enter into written mutual aid agreements for deployment of its paid employees and its Minnesota Responds Medical Reserve Corps volunteers with other boards of health, other political subdivisions within the state, or with tribal governments within the state. A board of health may also enter into agreements with the Indian Health Services of the United States Department of Health and Human Services, and with boards of health, political subdivisions, and tribal governments in bordering states and Canadian provinces.

Subd. 6c. **Minnesota Responds Medical Reserve Corps; when mobilized.** When a board of health finds that the prevention, mitigation, response to, or recovery from an actual or threatened public health event or emergency exceeds its local capacity, it shall use available mutual aid agreements. If the event or emergency exceeds mutual aid capacities, a board of health may request the commissioner of health to mobilize Minnesota Responds Medical Reserve Corps volunteers from outside the jurisdiction of the board of health.

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; 1Sp2003 c 14 art 8 s 31; 2008 c 202 s 2-4*

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 countywide 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.

Subdivision 1. **Generally.** In addition to other powers and duties provided by law, the commissioner has the powers listed in subdivisions 2 to 5.

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.

Subd. 6. **Health volunteer program.** (a) The commissioner may accept grants from the United States Department of Health and Human Services for the emergency system for the advanced registration of volunteer health professionals (ESAR-VHP) established under United States Code, title 42, section 247d-7b. The ESAR-VHP program as implemented in Minnesota is known as the Minnesota Responds Medical Reserve Corps.

(b) The commissioner may maintain a registry of volunteers for the Minnesota Responds Medical Reserve Corps and obtain data on volunteers relevant to possible deployments within and outside the state. All state licensing and certifying boards shall cooperate with the Minnesota Responds Medical Reserve Corps and shall verify volunteers' information. The commissioner may also obtain information from other states and national licensing or certifying boards for health practitioners.

(c) The commissioner may share volunteers' data, including any data classified as private data, from the Minnesota Responds Medical Reserve Corps registry with boards of health, the University of Minnesota's Academic Health Center or other public or private emergency preparedness partners, or tribal governments operating Minnesota Responds Medical Reserve Corps units as needed for credentialing, organizing, training, and deploying volunteers. Upon request of another state participating in the ESAR-VHP or of a Canadian government administering a similar health volunteer program, the commissioner may also share the volunteers' data as needed for emergency preparedness and response.

Subd. 7. **Commissioner requests for health volunteers.** (a) When the commissioner receives a request for health volunteers from:

(1) a local board of health according to section 145A.04, subdivision 6c;

(2) the University of Minnesota Academic Health Center;

(3) another state or a territory through the Interstate Emergency Management Assistance Compact authorized under section 192.89;

(4) the federal government through ESAR-VHP or another similar program; or

(5) a tribal or Canadian government;

the commissioner shall determine if deployment of Minnesota Responds Medical Reserve Corps volunteers from outside the requesting jurisdiction is in the public interest. If so, the commissioner may ask for Minnesota Responds Medical Reserve Corps volunteers to respond to the request. The commissioner may also ask for Minnesota Responds Medical Reserve Corps volunteers if the commissioner finds that the state needs health volunteers.

(b) The commissioner may request Minnesota Responds Medical Reserve Corps volunteers to work on the Minnesota Mobile Medical Unit (MMU), or on other mobile or temporary units providing emergency patient stabilization, medical transport, or ambulatory care. The commissioner may utilize the volunteers for training, mobilization or demobilization, inspection, maintenance, repair, or other support functions for the MMU facility or for other emergency units, as well as for provision of health care services.

(c) A volunteer's rights and benefits under this chapter as a Minnesota Responds Medical Reserve Corps volunteer is not affected by any vacation leave, pay, or other compensation provided by the volunteer's employer during volunteer service requested by the commissioner. An employer is not liable for actions of an employee while serving as a Minnesota Responds Medical Reserve Corps volunteer.

(d) If the commissioner matches the request under paragraph (a) with Minnesota Responds Medical Reserve Corps volunteers, the commissioner shall facilitate deployment of the volunteers from the sending Minnesota Responds Medical Reserve Corps units to the receiving jurisdiction. The commissioner shall track volunteer deployments and assist sending and receiving jurisdictions in monitoring deployments, and shall coordinate efforts with the division of homeland security and emergency management for out-of-state deployments through the Interstate Emergency Management Assistance Compact or other emergency management compacts.

(e) Where the commissioner has deployed Minnesota Responds Medical Reserve Corps volunteers within or outside the state, the provisions of paragraphs (f) and (g) must apply. Where Minnesota Responds Medical Reserve Corps volunteers were deployed across jurisdictions by mutual aid or similar agreements prior to a commissioner's call, the provisions of paragraphs (f) and (g) must apply retroactively to volunteers deployed as of their initial deployment in response to the event or emergency that triggered a subsequent commissioner's call.

(f) (1) A Minnesota Responds Medical Reserve Corps volunteer responding to a request for assistance at the call of the commissioner must be deemed an employee of the state for purposes of workers' compensation and tort claim defense and indemnification under section 3.736, without regard to whether the volunteer's activity is under the direction and control of the commissioner, the division of homeland security and emergency management, the sending jurisdiction, the receiving jurisdiction, or of a hospital, alternate care site, or other health care provider treating patients from the public health event or emergency.

(2) For purposes of calculating workers' compensation benefits under chapter 176, the daily wage must be the usual wage paid at the time of injury or death for similar services performed by paid employees in the community where the volunteer regularly resides, or the wage paid to the volunteer in the volunteer's regular employment, whichever is greater.

(g) The Minnesota Responds Medical Reserve Corps volunteer must receive reimbursement for travel and subsistence expenses during a deployment approved by the commissioner under this subdivision according to reimbursement limits established for paid state employees. Deployment begins when the volunteer leaves on the deployment until the volunteer returns from the deployment, including all travel related to the deployment. The Department of Health shall initially review and pay those expenses to the volunteer. Except as otherwise provided by the Interstate Emergency Management Assistance Compact in section 192.89 or agreements made thereunder, the department shall bill the jurisdiction receiving assistance and that jurisdiction shall reimburse the department for expenses of the volunteers.

(h) In the event Minnesota Responds Medical Reserve Corps volunteers are deployed outside the state pursuant to the Interstate Emergency Management Assistance Compact, the provisions of the Interstate Emergency Management Assistance Compact must control over any inconsistent provisions in this section.

(i) When a Minnesota Responds Medical Reserve Corps volunteer makes a claim for workers' compensation arising out of a deployment under this section or out of a training exercise conducted by the commissioner, the volunteer's workers compensation benefits must

be determined under section 176.011, subdivision 9, clause (25), even if the volunteer may also qualify under other clauses of section 176.011, subdivision 9.

Subd. 8. **Volunteer health practitioners licensed in other states.** (a) While an emergency declaration is in effect, a volunteer health practitioner who is (1) registered with a registration system that complies with the emergency system for the advanced registration of volunteer health professionals (ESAR-VHP) established under United States Code, title 42, section 247d-7b; (2) licensed and in good standing in the state upon which the practitioner's registration is based; and (3) (i) requested for deployment by the state's authorized representative under section 192.89, or (ii) deployed pursuant to an agreement between the disaster relief organization, professional association of health practitioners, health care facilities or providers, or other individuals or entities and the state's authorized representative under section 192.89, may practice in this state within the scope of practice authorized in the licensing state and to the extent authorized by this section as if the practitioner were licensed in this state. A "volunteer health practitioner" means a health practitioner who provides health or veterinary services, whether or not the practitioner receives compensation for those services. The term does not include a practitioner who receives compensation pursuant to a preexisting employment relationship with a host entity or affiliate which requires the practitioner to provide health services in this state, unless the practitioner is not a resident of this state and is employed by a disaster relief organization providing services in this state while an emergency declaration is in effect.

(b) A volunteer health practitioner qualified under paragraph (a) is entitled to the liability protections of section 192.89, subdivision 6, unless any license of the practitioner in any state has been suspended, revoked, or subject to an agency order limiting or restricting practice privileges, or has been voluntarily terminated under threat of sanction.

History: *1987 c 309 s 6; 1988 c 689 art 2 s 47; 1Sp2003 c 14 art 8 s 15; 2008 c 202 s 5-7; 2009 c 41 s 7; 2009 c 72 s 1*

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.131 is a community health board and is eligible for a local public health grant under section 145A.131.

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 meets the requirements of sections 145A.09 to 145A.131 is eligible for a local public health grant under section 145A.131.

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. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 7. **Withdrawal.** (a) A county or city that has established or joined a community health board may withdraw from the local public health grant program authorized by sections 145A.09 to 145A.131 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 local public health grant of any remaining county or city for one calendar year following the effective date of withdrawal.

(d) The local public health grant for a county that chooses to withdraw from a multicounty community health board shall be reduced by the amount of the local partnership incentive under section 145A.131, subdivision 2, paragraph (c).

History: *1987 c 186 s 15; 1987 c 309 s 9,25; 1991 c 345 art 2 s 44; 1Sp2003 c 14 art 8 s 16-18; 2006 c 212 art 3 s 13*

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.131.

Subd. 2. **Preemption.** (a) Not later than 365 days after the formation of a community health board, 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 a local public health grant 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. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 5a. **Duties.** (a) Consistent with the guidelines and standards established under section 145A.12, and with input from the community, the community health board shall:

(1) establish local public health priorities based on an assessment of community health needs and assets; and

(2) determine the mechanisms by which the community health board will address the local public health priorities established under clause (1) and achieve the statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, within the limits of available funding. In determining the mechanisms to address local public health priorities and achieve statewide outcomes, the community health board shall seek public input or consider the recommendations of the community health advisory committee and the following essential public health services:

(i) monitor health status to identify community health problems;

(ii) diagnose and investigate problems and health hazards in the community;

(iii) inform, educate, and empower people about health issues;

(iv) mobilize community partnerships to identify and solve health problems;

(v) develop policies and plans that support individual and community health efforts;

(vi) enforce laws and regulations that protect health and ensure safety;

(vii) link people to needed personal health care services;

(viii) ensure a competent public health and personal health care workforce;

(ix) evaluate effectiveness, accessibility, and quality of personal and population-based health services; and

(x) research for new insights and innovative solutions to health problems.

(b) By February 1, 2005, and every five years thereafter, each community health board that receives a local public health grant under section 145A.131 shall notify the commissioner in writing of the statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, that the board will address and the local priorities established under paragraph (a) that the board will address.

(c) Each community health board receiving a local public health grant under section 145A.131 must submit an annual report to the commissioner documenting progress toward the achievement of statewide outcomes established under sections 145.8821 and 145A.12, subdivision 7, and the local public health priorities established under paragraph (a), using reporting standards and procedures established by the commissioner and in compliance with all applicable federal requirements. If a community health board has identified additional local priorities for use of the local public health grant since the last notification of outcomes and priorities under paragraph (b), the community health board shall notify the commissioner of the additional local public health priorities in the annual report.

Subd. 6. [Repealed, 1Sp2003 c 14 art 8 s 32]

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. [Repealed, 1Sp2003 c 14 art 8 s 32]

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 be reimbursed for travel and other necessary expenses while engaged in their official duties. Notwithstanding section 15.059, the State Community Health Advisory Committee does not expire.

(b) The city councils or county boards that have established or are members of a community health board may appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on the duties under subdivision 5a.

History: *1987 c 309 s 10; 2001 c 161 s 25; 1Sp2003 c 14 art 7 s 46; art 8 s 19-21,31*

145A.11 POWERS AND DUTIES OF CITY AND COUNTY.

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. **Levying taxes.** 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 local public health priorities established under section 145A.10, subdivision 5a, and statewide outcomes established under section 145A.12, subdivision 7.

Subd. 3. [Repealed, 1Sp2003 c 14 art 8 s 32]

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. 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; 1Sp2003 c 14 art 8 s 22,23*

145A.12 POWERS AND DUTIES OF COMMISSIONER.

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 and standards, developed with the advice of the State Community Health Advisory Committee.

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.

Subd. 3. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 4. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 5. [Repealed, 1Sp2003 c 14 art 8 s 32]

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

Subd. 7. **Statewide outcomes.** (a) The commissioner, in consultation with the State Community Health Advisory Committee established under section 145A.10, subdivision 10, paragraph (a), shall establish statewide outcomes for local public health grant funds allocated to community health boards between January 1, 2004, and December 31, 2005.

(b) At least one statewide outcome must be established in each of the following public health areas:

(1) preventing diseases;

(2) protecting against environmental hazards;

(3) preventing injuries;

(4) promoting healthy behavior;

(5) responding to disasters; and

(6) ensuring access to health services.

(c) The commissioner shall use Minnesota's public health goals established under section 62J.212 and the essential public health services under section 145A.10, subdivision 5a, as a basis for the development of statewide outcomes.

(d) The statewide maternal and child health outcomes established under section 145.8821 shall be included as statewide outcomes under this section.

(e) By December 31, 2004, and every five years thereafter, the commissioner, in consultation with the State Community Health Advisory Committee established under section 145A.10, subdivision 10, paragraph (a), and the Maternal and Child Health Advisory Task Force established under section 145.881, shall develop statewide outcomes for the local public health grant established under section 145A.131, based on state and local assessment data regarding the health of Minnesota residents, the essential public health services under section 145A.10, and current Minnesota public health goals established under section 62J.212.

History: *1987 c 309 s 12; 1Sp2003 c 14 art 8 s 24-26*

145A.13 MS 2003 Supp [Expired]

145A.131 LOCAL PUBLIC HEALTH GRANT.

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.09, subdivision 2, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.09, subdivision 2, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty community health boards shall receive a local partnership base of up to $5,000 per year for each county included in the community health board.

(d) The State Community Health Advisory Committee may recommend a formula to the commissioner to use in distributing state and federal funds to community health boards organized and operating under sections 145A.09 to 145A.131 to achieve locally identified priorities under section 145A.12, subdivision 7, by July 1, 2004, for use in distributing funds to community health boards beginning January 1, 2006, and thereafter.

Subd. 2. **Local match.** (a) A community health board that receives a local public health grant shall provide at least a 75 percent match for the state funds received through the local public health grant described in subdivision 1 and subject to paragraphs (b) to (d).

(b) Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other local funds, and donations or nonfederal grants that are used for community health services described in section 145A.02, subdivision 6.

(c) When the amount of local matching funds for a community health board is less than the amount required under paragraph (a), the local public health grant provided for that community health board under this section shall be reduced proportionally.

(d) A city organized under the provision of sections 145A.09 to 145A.131 that levies a tax for provision of community health services is exempt from any county levy for the same services to the extent of the levy imposed by the city.

Subd. 3. **Accountability.** (a) Community health boards accepting local public health grants must document progress toward the statewide outcomes established in section 145A.12, subdivision 7, to maintain eligibility to receive the local public health grant.

(b) In determining whether or not the community health board is documenting progress toward statewide outcomes, the commissioner shall consider the following factors:

(1) whether the community health board has documented progress to meeting essential local activities related to the statewide outcomes, as specified in the grant agreement;

(2) the effort put forth by the community health board toward the selected statewide outcomes;

(3) whether the community health board has previously failed to document progress toward selected statewide outcomes under this section;

(4) the amount of funding received by the community health board to address the statewide outcomes; and

(5) other factors as the commissioner may require, if the commissioner specifically identifies the additional factors in the commissioner's written notice of determination.

(c) If the commissioner determines that a community health board has not by the applicable deadline documented progress toward the selected statewide outcomes established under section 145.8821 or 145A.12, subdivision 7, the commissioner shall notify the community health board in writing and recommend specific actions that the community health board should take over the following 12 months to maintain eligibility for the local public health grant.

(d) During the 12 months following the written notification, the commissioner shall provide administrative and program support to assist the community health board in taking the actions recommended in the written notification.

(e) If the community health board has not taken the specific actions recommended by the commissioner within 12 months following written notification, the commissioner may determine not to distribute funds to the community health board under section 145A.12, subdivision 2, for the next fiscal year.

(f) If the commissioner determines not to distribute funds for the next fiscal year, the commissioner must give the community health board written notice of this determination and allow the community health board to appeal the determination in writing.

(g) If the commissioner determines not to distribute funds for the next fiscal year to a community health board that has not documented progress toward the statewide outcomes and not taken the actions recommended by the commissioner, the commissioner may retain local public

health grant funds that the community health board would have otherwise received and directly carry out essential local activities to meet the statewide outcomes, or contract with other units of government or community-based organizations to carry out essential local activities related to the statewide outcomes.

(h) If the community health board that does not document progress toward the statewide outcomes is a city, the commissioner shall distribute the local public health funds that would have been allocated to that city to the county in which the city is located, if that county is part of a community health board.

(i) The commissioner shall establish a reporting system by which community health boards will document their progress toward statewide outcomes. This system will be developed in consultation with the State Community Health Services Advisory Committee established in section 145A.10, subdivision 10, paragraph (a), and the Maternal and Child Health Advisory Committee established in section 145.881.

Subd. 4. **Responsibility of commissioner to ensure a statewide public health system.** If a county withdraws from a community health board and operates as a board of health or if a community health board elects not to accept the local public health grant, the commissioner may retain the amount of funding that would have been allocated to the community health board using the formula described in subdivision 1 and assume responsibility for public health activities to meet the statewide outcomes in the geographic area served by the board of health or community health board. The commissioner may elect to directly provide public health activities to meet the statewide outcomes or contract with other units of government or with community-based organizations. If a city that is currently a community health board withdraws from a community health board or elects not to accept the local public health grant, the local public health grant funds that would have been allocated to that city shall be distributed to the county in which the city is located, if the county is part of a community health board.

Subd. 5. **Local public health priorities.** Community health boards may use their local public health grant to address local public health priorities identified under section 145A.10, subdivision 5a.

History: *1Sp2003 c 14 art 8 s 28*

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 establish, operate, or subsidize clinic facilities and services to furnish health services for American Indians

who reside off reservations.

(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. 2a. **Tribal governments.** (a) Of the funding available for local public health grants, $1,500,000 per year is available to tribal governments for:

(1) maternal and child health activities under section 145.882, subdivision 7;

(2) activities to reduce health disparities under section 145.928, subdivision 10; and

(3) emergency preparedness.

(b) The commissioner, in consultation with tribal governments, shall establish a formula for distributing the funds and developing the outcomes to be measured.

Subd. 3. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 4. [Repealed, 1Sp2003 c 14 art 8 s 32]

History: *1Sp1985 c 14 art 19 s 24; 1987 c 309 s 13,19,25; 1989 c 120 s 1; 1Sp2003 c 14 art 8 s 29,30*

145A.15 MS 2002 [Expired]

145A.16 MS 2002 [Expired]

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 healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. The commissioner shall promote partnerships, collaboration, and multidisciplinary visiting done by teams of professionals and paraprofessionals from the fields of public health nursing, social work, and early childhood education. 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 begin prenatally whenever possible and must be targeted 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;

(8) insufficient financial resources to meet family needs;

(9) a history of homelessness;

(10) a risk of long-term welfare dependence or family instability due to employment barriers; or

(11) other risk factors as determined by the commissioner.

Subd. 2. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 3. **Requirements for programs; process.** (a) Community health boards and tribal governments that receive funding under this section must submit a plan to the commissioner describing a multidisciplinary approach to targeted home visiting for families. The plan must be submitted on forms provided by the commissioner. At a minimum, the plan must include the following:

(1) a description of outreach strategies to families prenatally or at birth;

(2) provisions for the seamless delivery of health, safety, and early learning services;

(3) methods to promote continuity of services when families move within the state;

(4) a description of the community demographics;

(5) a plan for meeting outcome measures; and

(6) a proposed work plan that includes:

(i) coordination to ensure nonduplication of services for children and families;

(ii) a description of the strategies to ensure that children and families at greatest risk receive appropriate services; and

(iii) collaboration with multidisciplinary partners including public health, ECFE, Head Start, community health workers, social workers, community home visiting programs, school districts, and other relevant partners. Letters of intent from multidisciplinary partners must be submitted with the plan.

(b) Each program that receives funds must accomplish the following program requirements:

(1) use a 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 and assistance in applying for 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 when appropriate;

(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 or contracting with local social and human services organizations, education organizations, and other appropriate governmental entities and community-based organizations and agencies;

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

(10) connect eligible families, as needed, to additional resources available in the community, including, but not limited to, early care and education programs, health or mental health services, family literacy programs, employment agencies, social services, and child care resources and referral agencies.

(c) When available, programs that receive funds under this section must offer or provide the family with a referral to center-based or group meetings that meet at least once per month for those families identified with additional needs. The meetings must focus on further enhancing the information, activities, and skill-building addressed during home visitation; offering opportunities for parents to meet with and support each other; and offering infants and toddlers a safe, nurturing, and stimulating environment for socialization and supervised play with qualified teachers.

(d) 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.

(e) 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. The requirements for nurses must be consistent with chapter 148. The commissioner must provide training for home visitors. Training must include the following:

(1) effective relationships for engaging and retaining families and ensuring family health, safety, and early learning;

(2) effective methods of implementing parent education, conducting home visiting, and promoting quality early childhood development;

(3) early childhood development from birth to age five;

(4) diverse cultural practices in child rearing and family systems;

(5) recruiting, supervising, and retaining qualified staff;

(6) increasing services for underserved populations; and

(7) relevant issues related to child welfare and protective services, with information provided being consistent with state child welfare agency training.

Subd. 4a. **Home visitors as MFIP employment and training service providers.** The county social service agency and the local public health department may mutually agree to utilize home visitors under this section as MFIP employment and training service providers under section

256J.49, subdivision 4, for MFIP participants who are: (1) ill or incapacitated under section 256J.425, subdivision 2; or (2) minor caregivers under section 256J.54. The county social service agency and the local public health department may also mutually agree to utilize home visitors to provide outreach to MFIP families who are being sanctioned or who have been terminated from MFIP due to the 60-month time limit.

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 and performance measures.** The commissioner shall establish measures 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;

(5) rates of children accessing early care and educational services;

(6) program retention rates;

(7) number of home visits provided compared to the number of home visits planned;

(8) participant satisfaction;

(9) rates of at-risk populations reached; and

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

Subd. 7. **Evaluation.** Using the qualitative goals and quantitative outcome and performance 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; 2007 c 147 art 17 s 1; 2009 c 79 art 2 s 8*