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➡ Designates that this item is a change item



Protecting, maintaining and improving the health of all Minnesotans

January 27, 2009

To the 2009 Minnesota Legislature,

As you are aware, Minnesota consistently ranks in the top four as one of the healthiest states in the nation thanks to our commitment to public health and the strength of our unique state/local partnerships. MDH employs a variety of program models and strategies in the pursuit of our mission: to protect, maintain, and improve the health of all Minnesotans. Additionally, our policies reduce overall costs by focusing on immediate interventions and long-term prevention.

We approach this work through core agency values of integrity, collaboration, science, and accountability. Also important are our close partnerships with local public health departments, tribal governments, the federal government, other state agencies, and many health-related organizations.

MDH faces a variety of new concerns in the coming biennium. These include increasing demand for services with decreasing financial resources, growing public concern about new emerging health threats, and maintaining our focus on long-term prevention and reform goals in the midst of immediate short-term needs.

The following pages reflect the difficult economic times facing the state in the coming biennium, and contain strategies MDH believes will address the fiscal realities facing our agency while still accomplishing our goals. These strategies support our recently refocused agency strategic priorities:

- Health care reform
- Focus on prevention risk factors
- Public health threats

There are three strategic themes to incorporate across our strategic priorities: eliminate health disparities, align with and influence the changing culture, and use economic conditions for health's advantage. We are establishing improved goals and performance measures to accompany these priorities and themes to ensure our progress toward cost-effective outcomes for all Minnesotans.

MDH is committed to finding new and innovative ways to accomplish our mission. I look forward to working with you on our FY2010-2011 biennial budget so that Minnesotans can continue to live in one of the healthiest states in the nation.

Sincerely,

A handwritten signature in black ink that reads "Sanne Magnan".

Sanne Magnan, M.D., Ph.D.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

Agency Purpose

The statutory mission of the Minnesota Department of Health (MDH) is to protect, maintain, and improve the health of all Minnesotans. MDH approaches its work through core agency values of integrity, collaboration, respect, science-based decision making, and accountability.

MDH is the state's lead public health agency, responsible for operating programs that prevent infectious and chronic diseases, promote clean water, safe food, quality health care, and healthy living. The department also plays a significant role in making sure that Minnesota is ready to effectively respond to serious emergencies, such as natural disasters, emerging disease threats, and terrorism.

The department carries out its mission in close partnership with local public health departments, tribal governments, the federal government, foreign countries, and many health-related organizations.

Public health programs contribute to longer, healthier lives. According to the federal Centers for Disease Control and Prevention, public health is credited with adding 25 years to the life expectancy of people in the United States over the past century. Minnesota is consistently ranked one of the healthiest states in the country, in part because of its strong public health system, led by the Minnesota Department of Health.

Core Functions

While MDH is perhaps best known for responding to disease outbreaks, the department's core functions are very diverse and far-reaching, and focus on preventing health problems before they occur.

- ◆ Health Care Reform: MDH is the lead agency implementing Minnesota's recently-enacted health reform initiative. The reforms are focused on improving the health of Minnesota's population, improving the effectiveness and efficiency of the health care delivery system, increasing the health status of people with chronic health conditions, and reforming the way we pay for health care services in a way that supports high quality, low cost, efficient health care delivery.
- ◆ Preventing Diseases: MDH detects and investigates disease outbreaks, controls the spread of disease, encourages immunizations, and seeks to prevent chronic and infectious diseases, including HIV/AIDS, tuberculosis, diabetes, asthma, cardiovascular disease, and cancer. The department's public health laboratories analyze complex and dangerous biological, chemical, and radiological substances, employing techniques not available privately or from other government agencies.
- ◆ Preparing for Emergencies: MDH works with many partners – including local public health departments, public safety officials, health care providers, and federal agencies – to prepare for significant public health emergencies. The department takes an "all-hazards" approach to planning so that Minnesota is prepared to respond quickly and effectively to any type of public health emergency, ranging from natural disasters to terrorism to an influenza pandemic.
- ◆ Reducing Environmental Health Hazards: MDH identifies and evaluates potential health hazards in the environment, from simple sanitation to risks associated with toxic waste sites and nuclear power plants. The department protects the safety of public water supplies and the safety of the food eaten in restaurants. It also works to safeguard the air inside public places.
- ◆ Protecting Health Care Consumers: MDH safeguards the quality of health care in the state by regulating many people and institutions that provide care, including hospitals, health maintenance organizations, and nursing homes. Minnesota has pioneered improvements in the health care system, including the development of policies that assure access to affordable, high-quality care which are models for the nation. The department monitors trends in costs, quality, and access in order to inform future policy decisions. The department also reports to consumers on health care quality through the nursing home report card, adverse health events report and other special projects.

At A Glance

- ◆ MDH is one of the top state health departments in the country.
- ◆ MDH has earned an international reputation for being on the cutting edge of disease detection and control, and developing new public health methods.
- ◆ MDH workforce of approximately 1,300 includes many MD's, PhD's, nurses, health educators, biologists, chemists, epidemiologists, and engineers.
- ◆ MDH program resources are deployed in the Twin Cities and seven regional offices statewide, to better serve the state population.

- ◆ Promoting Good Health: MDH provides information and services to help people make healthy choices. Eating nutritiously, being physically active and avoiding unhealthy substances, such as tobacco, can help prevent many serious diseases and improve the overall health of the state. The department also protects the health of mothers and children through the supplemental nutrition program Women, Infants and Children (WIC) and services for children with special health needs. Minnesota was one of the first states to regulate smoking in public places, and has developed tobacco prevention strategies used nationwide. MDH programs also address occupational safety, injury, and violence prevention.
- ◆ Achieving Success Through Partnership: Minnesota has a nationally renowned public health system built on well-articulated state and local government roles. MDH provides both technical and financial assistance to local public health agencies so they can provide programs and services meeting the unique needs of their communities.

Operations

Many core public health functions are carried out directly by MDH staff. Examples include:

- ◆ Scientists and epidemiologists who work in the laboratories and the cities and neighborhoods of the state to identify the nature, sources, and means of treatment of disease outbreaks and food borne illness.
- ◆ Nursing home inspectors who make sure that elderly citizens are provided with safe and appropriate health care, and are treated with respect and dignity.
- ◆ Environmental engineers who work with cities and towns to assure that municipal water systems provide water that is safe for families to drink.
- ◆ Laboratory scientists who conduct sophisticated tests to detect treatable metabolic errors in all newborn babies.
- ◆ Chronic disease specialists who work with health plans, nonprofit organizations and individuals across the state to develop and implement plans and strategies for preventing and reducing the burden of chronic diseases.
- ◆ Scientists and policy experts who collect and evaluate information about environmental trends, the health status of the public, quality of health services, health disparities, and other emerging issues; and carry out public health improvement programs.

MDH provides technical and financial assistance to local public health agencies, public and private care providers, non-governmental organizations, and teaching institutions. Technical assistance provides partners with access to current scientific knowledge and is commonly in the form of direct consultation, formal reports, and training.

Budget

MDH receives approximately 85% of its funding from non-general fund resources – the federal government, dedicated fees, the health care access fund, and other revenues. The general fund accounts for the remaining 15% of the budget. Approximately 62% of the budget is “passed through” to local governments, nonprofit organizations, community hospitals, and teaching institutions in the form of grants; 21% represents the cost of the professional and technical staff that carry out the department’s core functions; and 17% is for other operating costs, primarily for technology and space.

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Agency Overview: <http://www.health.state.mn.us/orginfo.html>

Agency Performance Measures <http://www.departmentresults.state.mn.us/health/index.html>

Dollars in Thousands

	Current		Governor Recomm.		Biennium 2010-11
	FY2008	FY2009	FY2010	FY2011	
<u>Direct Appropriations by Fund</u>					
General					
Current Appropriation	84,814	74,544	74,544	74,544	149,088
Recommended	84,814	74,544	68,309	63,116	131,425
Change		0	(6,235)	(11,428)	(17,663)
% Biennial Change from 2008-09					-17.5%
Petroleum Tank Release Cleanup					
Current Appropriation	1	0	0	0	0
Recommended	1	0	0	0	0
Change		0	0	0	0
% Biennial Change from 2008-09					-100%
State Government Spec Revenue					
Current Appropriation		37	43,767	43,767	87,534
Recommended		37	45,415	45,415	90,830
Change		0	1,648	1,648	3,296
% Biennial Change from 2008-09					3.7%
Health Care Access					
Current Appropriation		38	23,168	23,168	46,336
Recommended	14,130	23,168	20,725	19,094	39,819
Change		0	(2,443)	(4,074)	(6,517)
% Biennial Change from 2008-09					4.9%
Miscellaneous Special Revenue					
Current Appropriation	8,550	8,550	8,550	8,550	17,100
Recommended	8,550	8,550	8,550	8,550	17,100
Change		0	0	0	0
% Biennial Change from 2008-09					0%
Federal Tanf					
Current Appropriation	11,418	11,733	11,733	11,733	23,466
Recommended	11,418	11,733	11,733	11,733	23,466
Change		0	0	0	0
% Biennial Change from 2008-09					1.4%
Clean Water Fund					
Current Appropriation	0	0	0	0	0
Recommended	0	0	1,250	2,500	3,750
Change		0	1,250	2,500	3,750
% Biennial Change from 2008-09					n.m.

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Carry Forward					
State Government Spec Revenue	843	3,625	0	0	0
Health Care Access	296	326	0	0	0
Miscellaneous Special Revenue	382	2,409	0	0	0
Direct Appropriations					
General	80,837	75,352	68,309	63,116	131,425
Petroleum Tank Release Cleanup	1	0	0	0	0
State Government Spec Revenue	36,456	47,250	45,415	45,415	90,830
Health Care Access	11,715	25,342	20,725	19,094	39,819
Federal Tanf	9,997	13,154	11,733	11,733	23,466
Remediation Fund	824	280	0	0	0
Clean Water Fund	0	0	1,250	2,500	3,750
Open Appropriations					
State Government Spec Revenue	157	174	174	174	348
Health Care Access	22	32	32	32	64
Miscellaneous Special Revenue	148	254	150	150	300
Statutory Appropriations					
Drinking Water Revolving Fund	474	521	521	521	1,042
Miscellaneous Special Revenue	49,656	59,304	47,361	47,297	94,658
Federal	206,328	210,309	206,706	206,194	412,900
Medical Education & Research	83,885	79,399	86,642	96,489	183,131
Gift	14	144	0	0	0
Total	482,035	517,875	489,018	492,715	981,733
<u>Expenditures by Category</u>					
Total Compensation	99,306	109,749	107,463	108,137	215,600
Other Operating Expenses	79,228	100,626	65,617	57,201	122,818
Capital Outlay & Real Property	4	0	0	0	0
Payments To Individuals	103,498	109,112	108,366	108,366	216,732
Local Assistance	199,163	192,924	208,147	219,586	427,733
Other Financial Transactions	836	5,464	0	0	0
Transfers	0	0	(575)	(575)	(1,150)
Total	482,035	517,875	489,018	492,715	981,733
<u>Expenditures by Program</u>					
Community & Family Hlth Prom0	212,932	229,784	227,058	221,760	448,818
Policy Quality & Compliance	140,155	149,979	138,452	146,518	284,970
Health Protection	98,200	96,821	91,574	92,503	184,077
Administrative Support Service	30,748	41,291	31,934	31,934	63,868
Total	482,035	517,875	489,018	492,715	981,733
Full-Time Equivalent (FTE)	1,306.7	1,327.4	1,294.4	1,264.0	

<i>Dollars in Thousands</i>				
	FY2009	Governor's Recomm.		Biennium
		FY2010	FY2011	2010-11
Fund: GENERAL				
FY 2009 Appropriations	74,544	74,544	74,544	149,088
Technical Adjustments				
Approved Transfer Between Appr		0	0	0
Current Law Base Change		(3,880)	(3,880)	(7,760)
Fund Changes/consolidation		146	146	292
Pt Contract Base Reduction		(7)	(7)	(14)
Transfers Between Agencies		208	208	416
Subtotal - Forecast Base	74,544	71,011	71,011	142,022
Change Items				
Behavioral Risk Surveillance Survey	0	550	550	1,100
E-Health Initiative	0	350	350	700
Tuberculosis Prevention and Control	0	200	200	400
Grant Elimination	0	(1,208)	(1,208)	(2,416)
Local Public Health Grant Payment Delay	0	0	(5,193)	(5,193)
Grant Reduction - Family Planning	0	(1,050)	(1,050)	(2,100)
General Fund Administrative Reduction	0	(1,834)	(1,834)	(3,668)
2007 & 2008 Session Laws Adjustment	0	290	290	580
Total Governor's Recommendations	74,544	68,309	63,116	131,425
Fund: PETROLEUM TANK RELEASE CLEANUP				
FY 2009 Appropriations	0	0	0	0
Subtotal - Forecast Base	0	0	0	0
Total Governor's Recommendations	0	0	0	0
Fund: STATE GOVERNMENT SPEC REVENUE				
FY 2009 Appropriations	43,767	43,767	43,767	87,534
Technical Adjustments				
Approved Transfer Between Appr		0	0	0
Current Law Base Change		78	78	156
One-time Appropriations		(209)	(209)	(418)
Program/agency Sunset		(200)	(200)	(400)
Subtotal - Forecast Base	43,767	43,436	43,436	86,872
Change Items				
Adverse Health Events Program Fee	0	73	73	146
Food Manager Certification Program	0	163	163	326
Food, Beverage, & Lodging Program	0	823	823	1,646
Youth Camp Licence & Inspection Program	0	50	50	100
Manufactured Home Parks & Rec Camping	0	320	320	640
X-Ray Program Fee	0	250	250	500
Lead Program-Pre-Renovation & Renovation	0	100	100	200
Infected Health Care Workers Program	0	50	50	100
Environmental Certification Fee	0	150	150	300
Total Governor's Recommendations	43,767	45,415	45,415	90,830
Fund: HEALTH CARE ACCESS				
FY 2009 Appropriations	23,168	23,168	23,168	46,336
Technical Adjustments				
Approved Transfer Between Appr		0	0	0
Biennial Appropriations		600	0	600
Current Law Base Change		20,621	27,130	47,751
Fund Changes/consolidation		(146)	(146)	(292)
One-time Appropriations		(9,518)	(9,518)	(19,036)
Subtotal - Forecast Base	23,168	34,725	40,634	75,359

	<i>Dollars in Thousands</i>			Biennium 2010-11
	FY2009	Governor's Recomm. FY2010	FY2011	
Change Items				
Statewide Health Improvement Program	0	(14,000)	(21,000)	(35,000)
Health Reform - Essential Benefit Set	0	0	(540)	(540)
Total Governor's Recommendations	23,168	20,725	19,094	39,819
Fund: MISCELLANEOUS SPECIAL REVENUE				
FY 2009 Appropriations	8,550	8,550	8,550	17,100
Subtotal - Forecast Base	8,550	8,550	8,550	17,100
Total Governor's Recommendations	8,550	8,550	8,550	17,100
Fund: FEDERAL TANF				
FY 2009 Appropriations	11,733	11,733	11,733	23,466
Subtotal - Forecast Base	11,733	11,733	11,733	23,466
Total Governor's Recommendations	11,733	11,733	11,733	23,466
Fund: CLEAN WATER FUND				
FY 2009 Appropriations	0	0	0	0
Subtotal - Forecast Base	0	0	0	0
Change Items				
Drinking Water Contaminants	0	445	890	1,335
Source Water Protection	0	805	1,610	2,415
Total Governor's Recommendations	0	1,250	2,500	3,750
Fund: STATE GOVERNMENT SPEC REVENUE				
Planned Open Spending	174	174	174	348
Total Governor's Recommendations	174	174	174	348
Fund: HEALTH CARE ACCESS				
Planned Open Spending	32	32	32	64
Total Governor's Recommendations	32	32	32	64
Fund: MISCELLANEOUS SPECIAL REVENUE				
Planned Open Spending	254	150	150	300
Total Governor's Recommendations	254	150	150	300
Fund: DRINKING WATER REVOLVING FUND				
Planned Statutory Spending	521	521	521	1,042
Total Governor's Recommendations	521	521	521	1,042
Fund: STATE GOVERNMENT SPEC REVENUE				
Planned Statutory Spending	3,625	0	0	0
Total Governor's Recommendations	3,625	0	0	0
Fund: HEALTH CARE ACCESS				
Planned Statutory Spending	326	0	0	0
Total Governor's Recommendations	326	0	0	0
Fund: MISCELLANEOUS SPECIAL REVENUE				
Planned Statutory Spending	61,713	47,361	47,297	94,658
Total Governor's Recommendations	61,713	47,361	47,297	94,658
Fund: FEDERAL				
Planned Statutory Spending	210,309	206,706	206,194	412,900
Total Governor's Recommendations	210,309	206,706	206,194	412,900
Fund: MEDICAL EDUCATION & RESEARCH				

Dollars in Thousands

	FY2009	Governor's Recomm.		Biennium 2010-11
		FY2010	FY2011	
Planned Statutory Spending	79,399	86,642	96,489	183,131
Total Governor's Recommendations	79,399	86,642	96,489	183,131
<i>Fund: GIFT</i>				
Planned Statutory Spending	144	0	0	0
Total Governor's Recommendations	144	0	0	0
<u>Revenue Change Items</u>				
<i>Fund: STATE GOVERNMENT SPEC REVENUE</i>				
Change Items				
Occupational Therapy Duplicate Lic Fee	0	1	1	2
Hearing Instrument Dispenser Cert Fee	0	204	209	413
Vital Records Technology Improvement Fee	0	1,200	1,200	2,400
Adverse Health Events Program Fee	0	73	73	146
Well Program Fees	0	325	325	650
Swimming Pool Inspection & Plan Review	0	211	211	422
Food Manager Certification Program	0	61	61	122
Food, Beverage, & Lodging Program	0	559	559	1,118
Youth Camp Licence & Inspection Program	0	50	50	100
Manufactured Home Parks & Rec Camping	0	234	234	468
X-Ray Program Fee	0	460	460	920
Lead Program-Pre-Renovation & Renovation	0	50	75	125
Environmental Certification Fee	0	100	150	250

HEALTH DEPT**Program: POLICY QUALITY & COMPLIANCE****Change Item: Behavioral Risk Factor Surveillance Survey**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$550	\$550	\$550	\$550
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	\$550	\$550	\$550	\$550

Recommendation

The Governor recommends funding \$550,000 per year from the general fund to provide stable funding for the Behavioral Risk Factor Surveillance System (BRFSS) and allow for analysis of data by region, as well as collection of data for Minnesota's major racial and ethnic groups.

Background

The BRFSS is a Centers for Disease Control and Prevention (CDC)-sponsored state-based telephone survey that collects information on chronic conditions, including diabetes, asthma, arthritis, high blood pressure, cardiovascular disease, and obesity. The BRFSS survey also collects information on the prevalence of health risk behaviors such as smoking and binge drinking and preventive health practices such as physical activity, nutrition, immunization, and health screenings. The Minnesota Department of Health (MDH) has administered the BRFSS survey annually since 1984.

The BRFSS program is the main source of data for many department and community programs. BRFSS data is used to monitor state-level trends in chronic disease, health risk behavior, and preventive health behavior prevalence, measure progress towards departmental and statewide public health goals, and develop programs designed to decrease the burden of chronic disease in Minnesota.

Currently, the majority of the funding for the BRFSS program comes from federal funds. The CDC, provides BRFSS funding to each state. In addition to the CDC funds, the department has used other federal funding to support the BRFSS. Beginning with the next grant cycle, CDC will require a 4 to 1 match (\$4 federal money must be matched with \$1 state funds.) At the same time, the other federal sources the department has used for BRFSS are becoming less available and the department cannot rely on these grants as a stable funding source.

As health reform moves Minnesota in the direction of increased coordination of care and a growing focus on prevention of chronic disease as a strategy for lowering overall healthcare costs, the BRFSS program will be an ever more important source of data for tracking improvement in the health of Minnesotans. BRFSS data will also be a key element in measuring progress towards departmental and statewide goals related to the elimination of health disparities between and among Minnesota's ethnic and racial communities.

However, while BRFSS has the potential to be an important source of data for evaluation of the Statewide Health Improvement Program (SHIP) program, the Eliminating Health Disparities Initiative (EHDI), and broader health reform efforts, the current sample size for the BRFSS survey limits the usability of the data. Currently, the sample size for BRFSS is slightly less than 5,000 respondents per year. This sample size is insufficient to allow for comparisons of results across racial/ethnic categories, or to allow for analysis of regional data at a level of geographic detail beyond metro/non-metro. The current budget of the BRFSS program, most of which comes from the CDC, is not sufficient to allow expansion of the sample beyond the current size.

For many MDH programs, this lack of geographic and racial/ethnic detail means it is difficult, if not impossible, to compare prevalence data across communities, or to measure awareness of and utilization of preventive measures such as screenings or immunizations. The lack of data on racial/ethnic groups has been a particular challenge for the EHDI program; several EHDI measures could make use of BRFSS data if racial/ethnic data were available.

Proposal

This proposal would provide a stable funding source for the BRFSS program including necessary federal match. The proposal would also allow for the BRFSS to increase the sample size to allow for comparison results across racial/ethnic categories and for analysis of regional data. Absent additional funding, the BRFSS is at risk. Minnesota could be the first and only state not to conduct a BRFSS.

Relationship to Base Budget

There is currently no base funding for this program in the general fund. This proposal would increase Health Policy division general fund administration base by 47% and the overall department's general fund administrative base by 2%.

Key Goals

Minnesota Milestones: Minnesotans will be healthy. By continuing to conduct the BRFSS, the department will be able to measure how the state is performing in reducing health disparities and other health care reform goals.

Key Measures

- ◆ Breast and cervical cancer screening rates by ethnicity
- ◆ Heart disease prevalence by ethnicity
- ◆ Diabetes prevalence by ethnicity

Alternatives Considered

None

Statutory Change: Not applicable.

HEALTH DEPT**Program: POLICY QUALITY & COMPLIANCE****Change Item: E-Health Initiative**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$350	\$350	\$350	\$350
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	\$350	\$350	\$350	\$350

Recommendation

The Governor recommends \$350,000 per year from the general fund for base funding for the Center for Health Informatics in order to ensure statutory mandates are achieved.

Background

The Center for Health Informatics is charged with implementing the following e-health requirements (M.S. 62J.495-.497):

- ◆ Convene the Minnesota e-Health Advisory Committee to provide stakeholders the opportunity to jointly set community priorities for the best use of health information technologies.
- ◆ Develop and maintain a statewide plan to meet the statutory requirement that all health care providers have an interoperable electronic health record by 2015.
- ◆ Develop and maintain a statewide plan to meet the statutory requirement that all health care providers, group purchasers, prescribers, and dispensers must establish and maintain an electronic prescription drug program by 2011.
- ◆ Administer the electronic health record revolving account and loan program.
- ◆ Develop/adopt uniform standards to be used by interoperable electronic health record systems for sharing and synchronizing patient data across systems.
- ◆ Develop recommendations that encourage the use of innovative health information technologies that improve patient care and reduce the cost of care, including applications relating to disease management and personal health management that enable remote monitoring of patients' conditions, especially those with chronic conditions.
- ◆ Develop recommendations to ensure all Minnesotans access to an online personal health portfolio.
- ◆ Develop recommendations and solutions to eliminate or reduce barriers to the exchange of health information, while maintaining or strengthening patient privacy protections.

The 2007 Legislature provided two years of funding for the Center for Health Informatics as part of Governor Pawlenty's e-health budget initiative. Although the Governor's budget proposal provided on-going base funding, the Legislature chose to fund the program for only two years in order to ensure that Minnesota Department of Health (MDH) demonstrated progress toward meeting the statutory requirements. Since that time, much has been accomplished and an additional mandate to achieve electronic prescribing has been passed.

The 2007 funding was used to achieve the following milestones:

- ◆ Completion of the first edition of a Statewide Implementation Plan for the 2015 Electronic Health Record (HER) mandate titled, *A Prescription for Meeting Minnesota's 2015 Interoperable Electronic Health Record Mandate—A Statewide Implementation Plan*. The plan includes a guide to addressing barriers to EHR adoption and to adopting e-health standards in Minnesota.
- ◆ Administer \$14.5 million in funded grants and interest-free loans split over state FY 2008 and 2009.
- ◆ Participate in the development of a public/private collaboration that established the Minnesota Health Information Exchange (MN-HIE) to exchange health information need for treatment.
- ◆ Develop a statutory requirement that all health care providers and payers must establish and use an e-prescribing system by 1/01/2011.
- ◆ Develop statutory standards that all prescription and prescription-related information must be transmitted using HL7 messages or the NCPDP SCRIPT Standard.

- ◆ Develop a statutory standard that all electronic health record systems must be certified by the Certification Commission for Healthcare Information Technology.
- ◆ Provide training and education on the requirements of the Minnesota Health Records Act (M.S. 144.291-.298), which was revised and re-codified in 2007 to ensure that all privacy requirements (e.g., consent) are updated to facilitate the appropriate exchange of data while continuing to ensure patients' confidentiality.
- ◆ Organize and host two forums for 400+ health leaders to increase understanding of progress, barriers and opportunities to more effectively use health information technology and make progress toward the goal of interconnected electronic health records.

This funding is necessary for MDH to retain a leadership role with e-health statewide and help achieve the current mandates. Without this funding MDH would need to reduce almost all of its e-health activities and as a result, Minnesota would:

- ◆ Have a less collaborative and coordinated approach to the use of health information technologies.
- ◆ Be at risk of not meeting the 2011 e-prescribing and 2015 electronic health records mandates.
- ◆ Put rural and underserved communities at greater risk of lagging behind in the use of health information technologies.
- ◆ Need to eliminate its e-health summits.
- ◆ Miss opportunities to leverage state funding for federal funding.

Relationship to Base Budget

There is currently no base budget for this program in the general fund. This proposal would increase the Health Policy division general fund administration base by 29% and the overall department's general fund administrative base by 1.3%.

Key Goals

Minnesota Milestones: Minnesotans will be healthily. This proposal will aid in improve safety and health outcomes for Minnesotans.

Key Measures

- ◆ Percentage of health care providers using an electronic health record.
- ◆ Percentage of prescriptions routed electronically.

Statutory Change: Not applicable.

HEALTH DEPTProgram: **HEALTH PROTECTION**

Change Item: Tuberculosis Prevention and Control

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$200	\$200	\$200	\$200
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	\$200	\$200	\$200	\$200

Recommendation

The Governor recommends \$200,000 annually from the general fund to increase funding for Tuberculosis (TB) to address the critical need for laboratory testing, treatment and prevention within Minnesota communities.

Background

Active TB cases in Minnesota have increased 69% in 15 years, from 141 in 1992 to 238 in 2007. TB incidence in Minnesota (4.6 cases/100,000 persons in 2007) now exceeds the national rate (4.4/100,000) for the first time since surveillance began in 1953, and it is 3.5 times higher than in our four neighboring states (1.3/100,000.) Active TB disease is “the tip of the iceberg”; for every TB case, approximately nine others have the latent form of the disease. Minnesota’s first extensively drug-resistant TB case occurred in 2006.

TB is unique because managing and investigating each case requires close, ongoing collaboration between medical providers, laboratories, hospitals, local and state health departments, and others. TB treatment, which requires daily supervision of each patient by a local public health nurse, lasts at least six months for routine cases and up to three years for drug-resistant strains. The public health investigation needed to identify, evaluate and treat exposed contacts of each TB patient can last anywhere from three months to over a year. In addition, TB is becoming much more complex clinically (e.g., HIV co-infection) and socially (e.g., cultural and language differences, substance abuse, and homelessness.) Handling these complexities requires additional resources and new strategies.

According to the Institute of Medicine (2000), “the price of neglect reflected in the funding reductions (of the 1970s and 1980s) was a resurgence of TB throughout the United States.” This resurgence cost New York City alone nearly \$1 billion. Unfortunately, federal TB dollars are again decreasing, and progress toward eliminating TB has slowed. In the opinion of most TB experts, if we let down our guard again, we risk a much more serious situation. Multi- and extensively- drug resistant strains threaten to make TB incurable.

Here in Minnesota, drug-resistant TB has increased in the last decade and is higher than the national average. At the same time, the cost of TB medications is increasing and federal funding for laboratory testing and case management is decreasing. A major consequence of inadequate public health funding is that physicians lack access to timely laboratory testing essential to diagnosing and treating TB. Specifically, inadequate funding has contributed to the Minnesota Department of Health (MDH) TB laboratory’s inability to meet national standards for reporting drug susceptibility results within 28 days. Testing and treatment delays unnecessarily lengthen the period of infectiousness, increasing the chance that TB will spread and that further drug resistance will develop.

Controlling TB requires disease investigation, lengthy case management, and laboratory capacity at the state and local levels. Current state and federal funding are inadequate to support these core programs.

Proposal

This proposal funds \$200,000 annually for two FTEs and laboratory supplies for TB testing. The two FTE’s include: one FTE bacteriologist to perform rapid tests for TB detection and drug sensitivity testing, and one FTE for a TB nurse.

HEALTH DEPT

Program: HEALTH PROTECTION

Change Item: Tuberculosis Prevention and Control

The funding in this proposal will help stop the spread of TB by ensuring prompt laboratory diagnosis of TB and access to treatment and prevention services for patients. The proposal will also reduce the financial burden of TB on the health care system, thereby lowering health care costs.

All Minnesota residents will benefit through (1) reduced risk of acquiring TB, (2) increased chance of being appropriately treated for TB, (3) less upward pressure on the cost of health care, (4) reduced drug resistance, and (5) improved prevention and control of the TB in our communities.

Relationship to Base Budget

This proposal would increase the Infectious Disease Epidemiology Prevention and Control general fund base for administration by 7.5% and the overall department general fund administration base by .7%.

Key Goals

Minnesota Milestones: Minnesotans will be healthy. Detecting and controlling infectious disease is critical to ensuring Minnesotans are healthy.

Key Measures

Percent of new TB patients who complete therapy in 12 months.

Alternatives Considered

None

Statutory Change: Not Applicable.

HEALTH DEPT

Change Item: Statewide Health Improvement Program

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	(14,000)	(21,000)	6,000	6,000
Revenues	0	0	0	0
Net Fiscal Impact	\$(14,000)	\$(21,000)	\$6,000	\$6,000

Recommendation

The Governor recommends reducing and extending this existing program from \$47 million over two years to \$24 million over four years from the Health Care Access Fund. This would maintain a smaller annual funding base but over a longer term, providing \$6 million per year in both competitive grants to Community Health Boards (CHBs) and tribal governments statewide and funding for administrative support. 10% of this funding amount will be designated for program administration each year of the program.

Background

The Statewide Health Improvement Program (SHIP) initiative was passed in the 2008 session, providing \$20 million in FY2010 and \$27 million in FY2011 from the Health Care Access Fund. The SHIP initiative is modeled after a successful comprehensive federal initiative aimed at reducing chronic disease prevalence called Steps to a HealthierUS (<http://www.cdc.gov/steps/>). The Steps Initiative uses effective, evidence-based strategies to create changes in policies, environments, and systems to support healthy behaviors in the population. It targets four major settings for interventions to reach the broadest population possible: communities, schools, worksites, and health care.

The model for the SHIP initiative includes the following components. Together, these components create a sustainable model for a statewide health improvement program.

- ◆ Community input into planning, implementation and evaluation
- ◆ Adherence to the socio-ecological model
- ◆ Health promotion in four settings: community, schools, worksites, and health care
- ◆ Local program advocates
- ◆ Evidence-based interventions
- ◆ Focus on common risk factors; tobacco and obesity
- ◆ Extensive and comprehensive evaluation linked to program planning
- ◆ Policy, systems, and environmental change that supports healthy behavior
- ◆ Accountability and oversight

With SHIP funding reduced in half and spread over four years, grantees will build and maintain a solid infrastructure in order to address obesity and tobacco use prevention in their communities. The grants will be competitively awarded to tribes and CHB's most ready for implementation.

Relationship to Base Budget

This proposal reduces funding for SHIP by \$23 million or 49%. This funding is not part of the agency's base funding, and will end on June 30, 2013. Legislation requires the Commissioner to make a recommendation regarding continued funding of the program beyond this appropriation.

Key Goals and Measures

Minnesota Milestone: Minnesotans will be healthy. This program focuses on issues of obesity and tobacco.

- ◆ Percent of Minnesota adults who meet national recommendations for healthy weight, physical activity and fruit and vegetable consumption.

- ◆ Reducing the percentage of Minnesota high school youth who report that they have used tobacco in the last 30 days.

Alternatives Considered

None

Statutory Change: Rider language indicating the funding changes.

HEALTH DEPT**Program: POLICY QUALITY & COMPLIANCE****Change Item: Health Reform - Essential Benefit Set**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	0	(540)	0	0
Revenues	0	0	0	0
Net Fiscal Impact	\$0	\$(540)	\$0	\$0

Recommendation

The Governor recommends replacing activities associated with defining an “essential benefit set” with a less expensive study on value-based insurance design using existing Health Economics Program research capacity.

Background

As enacted, the 2008 health reform bill requires the Commissioner of Health to convene a workgroup with representation from health care providers, health plans, state agencies, and employers. This workgroup is charged with making recommendations on the design of a health benefit set that:

- ◆ Provides coverage for a broad range of services and technologies;
- ◆ Is based on scientific evidence that the services and technologies are clinically effective and cost-effective; and
- ◆ Provides lower enrollee cost sharing for services and technologies that have been determined to be cost-effective.

This proposal would replace the requirement for Minnesota Department of Health (MDH) to convene, facilitate, and staff a workgroup with a research study to be performed by the Health Economics Program. The study would summarize the “state of the art” of research on value-based insurance design, and could be done using existing Health Economics Program research capacity assuming that no other new studies are required by the 2009 Legislature.

Reasons for scaling back the level of this activity include:

- ◆ Minnesota has attempted to create consensus on a standard benefit set in the past with limited success. The workgroup is not required to consider issues related to the cost of the essential benefit set, which further suggests that the group’s recommendations may not be useful to policymakers who are concerned with affordability as well as adequacy of coverage.
- ◆ Convening, facilitating, and staffing this workgroup will be an expensive and challenging effort. Designing a standardized, value-based benefit set will be a technically complex, time-consuming, and costly undertaking. To our knowledge, no other state has done anything as comprehensive as this effort, although Oregon has had a “prioritized list” of health care services based on clinical and cost effectiveness for many years. The evidence to date on the impact of selectively reducing enrollee cost sharing for certain types of services is extremely limited (especially evidence that has been published in peer-reviewed academic literature), and mostly relates to how reducing enrollee cost sharing for certain types of prescription drugs affects overall use of health care services and health care costs.
- ◆ Lack of clarity on the intended uses of the study results (e.g., to change benefits in public programs, to establish a “benchmark” benefit set for subsidizing the purchase of private insurance, or to establish a market wide standard for adequacy of coverage) further complicates the task, since workgroup members are likely to disagree on the purpose of the work.
- ◆ This work has no connection to any of the other pieces of the 2008 health reform bill. While it may be intended to inform future reform efforts, scaling back this effort will have no impact on the state’s ability to implement the other reforms that were enacted in 2008.

Relationship to Base Budget

This proposal would reduce the Health Policy division health care access fund (HCAF) administration base for fiscal year 2011 by 7.2% and overall MDH HCAF administrative base for fiscal year 2011 by 5.4%. This funding was one-time and is not part of the 2012-13 base.

Key Goals

Reduce the rate of uninsured Minnesotans in 2001 below the 2004 rate.

Key Measures

Reduced long-term health care costs

Alternatives Considered

None

Statutory Change: repeal of M.S. 62U.08

Rider

The commissioner of health, in consultation with the commissioners of human services, commerce, and finance, shall study and report to the Legislature on value-based insurance designs that vary enrollee cost sharing based on clinical or cost-effectiveness of services. In performing this study, the commissioner shall consult with and seek input from health plans, health care providers, and employers. The commissioner shall report to the Legislature by January 15, 2010.

HEALTH DEPT

Change Item: Grant Elimination

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$(1,208)	\$(1,208)	\$(208)	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	\$(1,208)	\$(1,208)	\$(208)	\$0

Recommendation

The Governor recommends elimination of the following time-limited single source grants:

- ◆ Community Health Care Demonstration
- ◆ Medical Education Research Costs – Federal Compliance

Background

The Community-Based Health Care Demonstration Project (CBHC) grant is a five-year grant program that was passed in 2007 to provide funding to a local foundation to coordinate a community-based health care coverage program within Carlton, Cook, Lake, and St. Louis Counties. The program is designed to develop and operate a community-based health care coverage program that offers individuals the option of purchasing health care coverage on a fixed prepaid basis without meeting the usual state health insurance requirements.

The CBGC grant was originally funded at \$212,000 per year but was reduced in the 2008 session by 1.8%, leaving \$208,000 per year for FY 2009-2012. The number of individuals that can be provided health insurance coverage through this project is modest due to the limited funding. This demonstration project will sunset on December 21, 2012.

The Medical Education Research Cost (MERC) Federal Compliance grant is supplemental to the annual MERC grant awarded to the Mayo clinic to compensate a portion of its costs for clinical training programs. Legislation in 2007 changed the distribution formula to comply with federal regulation. The change reduced the annual amount that Mayo receives. This supplemental payment was intended to help the Mayo clinic transition to the new funding level. The MERC Federal Compliance Grant was funded at \$6.250 million in FY 2008 and \$4.240 million in FY 2009. The base for FY 2010 and FY 2011 is \$1 million. This grant will sunset on June 30, 2011.

Proposal

This proposal would eliminate funding for the Community-Based Health Care Demonstration Project and the MERC – Federal Compliance Grant. Neither of these grants have statewide impact, as they are targeted to single entities with no other entities being eligible to apply. The grants are time-limited and this proposal would sunset funding early.

Relationship to Base Budget

This proposal eliminates funding for two grants and reduces Health Policy division general fund grants by 13.3% in FY 2010-11. This proposal reduces overall department's general fund grants by 2.74% in FY 2010 and 2011.

Key Goals

Reduce the rate of uninsured Minnesotans in 2011 below the 2004 rate.

Key Measures

Rate of uninsured Minnesotans.

Statutory Change: Laws 2007, chapter 147, article 19, section 3, subdivision 6, paragraph e, should be stricken.

~~Community-Based Health Care Demonstration Project. Of the general fund appropriation, \$212,000 each year is to be transferred to the commissioner of health for the demonstration project grant described in Minnesota~~

~~Statutes, section 62Q.80, subdivision 1a. This appropriation shall remain part of base level funding until June 30, 2012. Notwithstanding any contrary provision in this article, this rider expires July 1, 2012.~~

There is a rider in Laws 2008, chapter 363, article 18, section 4, subdivision 3. It is recommended the following rider be included in any budget bill to address the issues of the 2008 rider:

MERC Federal Compliance. Notwithstanding Laws 2008, chapter 363, article 18, section 4, subdivision 3, the base level funding for the commissioner to distribute to the Mayo Clinic for transition funding while federal compliance changes are made to the medical education and research cost funding distribution formula shall be \$0 for FY 2010 and 2011.

HEALTH DEPT**Program: COMMUNITY & FAMILY HLTH PROM0****Change Item: Local Public Health Grant Payment Delay**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$(5,193)	\$5,193	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	\$0	\$(5,193)	\$5,193	\$0

Recommendation

The Governor recommends changing the Local Public Health Grants monthly payment schedule to a quarterly payment and delaying the April - June 2011 payment to counties and cities until July 2011. This delay will result in a one time general fund savings of \$5.193 million in state fiscal year 2011 and one-time costs in FY 2012.

Background

Currently, the department awards grants to the counties and cites for Local Public Health activities based on a formula. These awards are then divided into 12 equal parts, and the department processes payments equal to this amount around the 25th of each month. This payment is to reimburse these organizations for expenses incurred for the month.

By switching from a monthly to a quarterly payment, local public health entities will be paid up front for the quarter. By delaying the April quarter payment to July in calendar year 2011, counties and cities would be asked to cash flow their Local Public Health programs for these three months. However, this would be at a time counties and cities are receiving property tax revenue and by delaying implementation until calendar year 2011, counties and cities will have time to plan for the one-time shift. Counties and cites would still receive their full allocation of the Local Public Health Funds for calendar year 2011 under this proposal.

Relationship to Base Budget

The delay of processing the June payments to counties and cites would result in a one time general fund budget reduction of \$5.193 million for state fiscal year 2011 and would have no effect on future base funding.

Local governments would receive the same level of funding for each calendar year.

Key Goals and Measures

Protect public health by increasing the level of essential local public health activities performed by all local health departments.

Percent of essential local public health activities performed by all local public health departments.

Alternatives Considered

Delay grants temporarily within calendar 2011 only. This alternative would result in a cost in FY 2012 equal to the savings for 2011.

Statutory Change: Rider.

FUNDING USAGE: Up to 75% of the fiscal year 2012 appropriation for local public health grants may be used to fund calendar year 2011 allocations for this program. This reduction for FY 2011 is one-time and the base funding for local public health grants shall be increased by \$5.193 million.

HEALTH DEPT**Program: COMMUNITY & FAMILY HLTH PROM0****Change Item: Grant Reduction - Family Planning**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$(1,050)	\$(1,050)	\$(1,050)	\$(1,050)
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	\$(1,050)	\$(1,050)	\$(1,050)	\$(1,050)

Recommendation

The Governor recommends a \$1.05 million reduction in FY 2010 and FY 2011 to base funding for Family Planning Special Project grants in the general fund.

Background

Family Planning Special Project grants were established in 1978 to reduce unintended pregnancies. These grants provide funds to clinics for outreach services, family planning counseling and pregnancy prevention services throughout Minnesota. Grantees include government and non-profit organizations.

In 2006, the Department of Human Services implemented the Minnesota Family Planning Waiver program. The Medical Assistance (MA) waiver program allows family planning services for persons with incomes at or below 200 percent of federal poverty guidelines and who are not enrolled in Minnesota Health Care Programs. The MA waiver program for family planning is funded with state and federal funds with some services funded with 90% federal financial participation. This program served over 25,000 individuals in FY 2007 and 34,000 individuals in FY 2008. The program is anticipated to serve over 39,000 individuals a year by FY 2011.

With the anticipated growth in persons receiving services through the Family Planning Waiver, the reduction of Family Planning Special Project grant funds is not anticipated to have an impact on unintended pregnancies.

Relationship to Base Budget

The departments base for Family Planning Special Project Grants include \$4.197 million in general funds per year and \$1.156 million in Temporary Assistance for Needy Families (TANF) funds. This proposal reduces the Family Planning Special Project Grants by 19.6% (TANF and general fund) and the Community and Family Health division general fund grants by 3.6% in fiscal years 2010-11. This proposal reduces overall department's general fund grants by 2.4% in fiscal years 2010 and 2011.

Key Goals and Measures

Healthy People 2010 Objective: Increase the proportion of pregnancies that are intended.

Number of women who participate in the Minnesota PRAMS survey who indicate they became pregnant intentionally.

Statutory Change: None

HEALTH DEPT**Program: ADMINISTRATIVE SUPPORT SERVICE****Change Item: General Fund Administrative Reduction**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$(1,834)	\$(1,834)	\$(1,834)	\$(1,834)
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	\$(1,834)	\$(1,834)	\$(1,834)	\$(1,834)

Recommendation

The Governor recommends a 7.5% reduction of the Minnesota Department of Health's general fund administrative budget.

Background

The Minnesota Department of Health's FY 2010-11 general fund administration base budget is \$48.9 million. This includes rent, executive office and agency program administration. Rent accounts for \$16.068 or 33% of the department's administrative budget. The balance includes \$1.970 million for the executive office and \$30.862 million for program administration. Since rent is a fixed cost and cannot be reduced, a 7.5% reduction of the administrative budget equates to a 11% reduction to the balance of the department's administrative budget which is mostly program administration.

Proposal

This proposal reduces the department's base general fund administrative budget by 7.5%. Cost savings could be realized through staffing reductions, restructuring, or possible elimination of some services currently provided. Reductions will occur throughout the agency. This reduction equates to 20.3 FTEs or 13.5% of the department's base general fund FTEs.

Relationship to Base Budget

This proposal reduces the department's base general fund administrative budget by 7.5%.

Key Goals

Minnesota Milestones: Government in Minnesota will be cost-efficient, and services will be designed to meet the needs of the people who use them.

Key Measures

See measures included on program budget page narratives.

Statutory Change: None

HEALTH DEPT

Change Item: 2007 & 2008 Session Laws Adjustment

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$290	\$290	\$290	\$290
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	\$290	\$290	\$290	\$290

Recommendation

The Governor recommends a technical adjustment to resolve a discrepancy in the 2007 Health and Human Services (HHS) Omnibus bill and HHS session tracking (\$263,000 each year) and in 2008 Laws (\$27,000 each year). This increase reflects a portion of a general fund lead abatement grant (\$163,000), support for department emergency preparedness and response activities (\$100,000), and to restore reductions from the Federally Qualified Health Centers (\$27,000).

Background

Federally Qualified Health Centers (FQHC): In 2008, session laws reduced the \$1.5 million general fund appropriation for the FQHC program to \$0 (Laws 2008, Chapter 358, Article 5, Section 4, Subdivision 3). In 2008, session laws also directed Minnesota Department of Health (MDH) to reduce grants by 1.8% at the allotment level. The law included FQHC in the reduction calculation and reduced FQHC by 1.8% of \$1.5 million or \$27,000 (Laws 2008 Chapter 363, Article 18, Section 4, Subdivision 3). Since the grants were already reduced to \$0, the total compensation expenditure category was reduced in the Health Statistics section to comply with the duplicated \$27,000 reduction.

This technical adjustment will restore \$27,000 to MDH that was reduced twice in Laws of 2008.

Lead Abatement Grant Program: In 2007, session tracking indicated funding for lead abatement at \$551,000 in fiscal year 2008, and \$225,000 in fiscal year 2009. Appropriations to MDH reflected the funding specified in tracking. However, rider language in the bill directed MDH to spend \$388,000 each fiscal year (Laws 2007, Chapter 147, Article 19, Section 4).

The problem arises in fiscal year 2009 when the MDH appropriation for lead abatement is \$225,000 and the rider directs MDH to spend \$388,000. MDH awarded \$388,000 of the \$551,000 appropriated in fiscal year 2008 and carried forward the remaining \$163,000 into fiscal year 2009 to award at that time to comply with session law.

This technical adjustment will provide funds for MDH to continue to spend \$388,000 each year as indicated in the Laws of 2007.

Emergency Preparedness and Response: In 2007, session tracking indicated funding for emergency preparedness and response activities including epidemiology, laboratory services, exercises, training, and planning (\$115,000), and to purchase antiviral medications and prepare and manage a stockpile of health care supplies (\$3.97 million) in fiscal year 2008. There is not an appropriation in fiscal year 2009.

Session tracking indicated funding for emergency preparedness and response at \$100,000 in fiscal year 2010 and 2011. The problem arises in fiscal year 2010 because rider language was inadvertently omitted in the 2007 session laws that should have directed MDH to enter a base adjustment for fiscal year 2010 and 2011 at \$100,000. This technical change request is needed to carry out legislative intent and restore funding indicated in session tracking.

Relationship to Base Budget

The **Federally Qualified Health Centers** are appropriated \$2,500,000 from the Health Care Access Fund in both fiscal years 2010 and 2011 to offset uncompensated care costs.

The **Lead Abatement Grant Program** was transferred from the Minnesota Department of Education in FY 2006 (Laws of 2005, 1st Special Session, Chapter 5, Article 8) along with \$100,000 per year. In 2007, MDH was appropriated \$388,000 per year for a total grant of \$488,000 per year.

The **Emergency Preparedness and Response Program** was appropriated \$115,000 in fiscal year 2008 to support activities including epidemiology, laboratory services, exercises, training, and planning over the 2008-09 biennium. The current base budget is \$0.

Key Goals and Measures

See program goals on budget page narratives.

Statutory Change: Not Applicable

HEALTH DEPT

Program: **POLICY QUALITY & COMPLIANCE**

Change Item: **Occupational Therapy Duplicate Lic Fee**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	1	1	1	1
Net Fiscal Impact	(\$1)	(\$1)	(\$1)	(\$1)

Recommendation

The Governor recommends establishing a new fee for issuing a duplicate copy of an occupational therapy license. The duplicate license fee will generate an estimated \$1,000 of revenue to the state government special revenue fund and is intended to recover the administrative cost only from those licensees needing a duplicate license.

Background

The Health Occupations Program has regulated Occupational Therapy Practitioners, including both Occupational Therapists (OTs) and Occupational Therapy Assistants (OTAs) since 1996. There are currently 2,663 OTs and 852 OTAs. Currently, there is no fee for requesting a duplicate license. About 40 duplicate licenses are requested annually. The requests are due to some employers seeking original license documents for their files and licensees needing a replacement or duplicate of their wallet cards.

Proposal

This proposal implements a new \$25 fee for Minnesota Department of Health (MDH) to produce a duplicate license document. The fee will pay for staff time, materials and mailing. The new fee has a small fiscal impact on a self-selected group of licensees. The Occupational Therapy licensing program has previously absorbed this cost, but should no longer do so. Issuance of duplicate licenses is a discrete service and one for which many other health licensing programs charge a fee.

Relationship to Base Budget

This is a small change as the additional revenue is 0.2% of total revenue received in the licensing program over the biennium.

Key Goals

Minnesota Milestones: **Government in Minnesota will be cost-efficient, and services will be designed to meet the needs of the people who use them.** The new fee will help assure that total revenues are not less than total costs and will only impact those needing duplicate credentials.

Key Measures

Fees will recover the cost involved in providing services.

Alternatives Considered

None.

Statutory Change: Add a new subdivision to M.S. 148.6445.

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	204	209	103	105
Net Fiscal Impact	(\$204)	(\$209)	(\$103)	(\$105)

Recommendation

The Governor recommends increasing the certification fee and the examination fee for hearing instrument dispensers so that total biennial revenues will approximate biennial expenditures. The program account is annually accruing significant deficits without a fee adjustment, and the increased revenue will reverse accumulation of excessive deficits in the account in the next biennium.

Background

The Health Occupations Program has regulated hearing instrument dispensers (HID's) since 1988, and currently certifies by examination approximately 190 persons. During this period, annual fees for dispensers have ranged from \$140 to \$820, with several fee adjustments occurring to bring account deficits or surpluses into balance so that revenues approximate regulatory expenditures. Fees were last changed in 2003, and currently, primary revenues to cover regulatory costs come from an annual certification fee of \$350. An examination fee of \$250 for each part of the two-part examination (written and practical) is paid only by persons testing to become certified dispensers. In 2003 an account surplus was reduced by a \$51,000 transfer to the general fund, and in 2004, further reduced by a one-year certification fee holiday.

In 2005 legislation repealed the requirement that audiologists be certified, and consequently fee revenues fell in FY 2006 as the number of certified persons decreased from about 450 dispensers to less than 175. Since 2006 the account has been accumulating annual deficits that now total about (\$130,000) and are growing annually by \$90,000. In 2007, the Department requested adjustments to certification and examination fees (from \$350 to \$1200 and from \$250 to \$700 respectively) to address projected deficits in the certification account. The legislature responded by requiring a report regarding the need and reasons for any fee increase.

A 2008 report by the Health Occupations Program found that:

- ◆ An estimated that in 2006 Minnesotans purchased hearing aids valued at over \$100 million,
- ◆ About 180 certified dispensers may have sold a combined total of over \$58 million worth of hearing instruments and services; and
- ◆ The average price of a hearing instrument is more than \$1,900.

The report showed a continuing need to protect the hearing impaired in Minnesota, a population predominately aged 65 or older that is projected to more than double before 2030. The report also showed that regulatory costs (consumer assistance, complaint investigation and credentialing administration) are not covered by current fee levels.

Proposal

This initiative proposes increases to the certification and examination fees to bring the regulatory account into balance. In addition a surcharge fee would be assessed to recover the accumulated deficit. The fee for certification would increase from \$350 to \$700 per year, and the exam fee would increase from \$500 to \$1,000. The surcharge would be \$550 per year for two years.

Fee calculations assume a growth in the number of hearing instrument dispensers of five per year. This assumption was reduced from ten per year on advice of dispenser representatives who see industry changes adversely affecting the occupation. Lesser or greater numbers of new entrants to the occupation will affect the account balance. These fee increases are lower than estimated in 2007 due to assigning support staff to handle consumer information and assistance, and not filling a staff vacancy. Reducing staffing further will compromise

consumer protection. Current and future staffing for consumer protection, including investigation and credentialing activity, totals 1.45 FTEs.

Relationship to Base Budget

The changes in the fee amounts represent a 100 percent increase. However, practitioners who have been in the field for the last five years have also experienced one fee holiday, as well as four years of no fee increases.

Key Goals

Minnesota Milestones: Government in Minnesota will be cost-efficient, and services will be designed to meet the needs of the people who use them. As current fees under recover the regulatory cost for this hearing instrument consumer protection service, it is appropriate to establish a fee that will recover the cost.

Key Measures

Fees will recover the cost involved in providing services.

Alternatives Considered

Changes to program operations have maintained effectiveness and reduced service costs. Staff levels have been reduced, but further reductions will compromise consumer protection. The amount of the current account deficit attributable to unrecovered costs incurred in FY 2006 and FY 2007 could be excluded from the surcharge fee calculation under legislative policy stated in M.S. 16A.1285, subd. 2. However, limiting recovery to the two fiscal years immediately preceding the fee adjustment shifts recovery of the costs to other unrelated regulatory programs funded by the state government special revenue fund.

Statutory Change: Chapter 153A

HEALTH DEPT

Program: **POLICY QUALITY & COMPLIANCE**

Change Item: **Vital Records Technology Improvement Fee**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	1,200	1,200	1,200	1,200
Net Fiscal Impact	(\$1,200)	(\$1,200)	(\$1,200)	(\$1,200)

Recommendation

The Governor recommends maintaining the Vital Records Technology Improvement Fee at current levels. Adequate funding ensures that the Minnesota vital records system can be continually maintained and upgraded for efficient collection with greatly enhanced security, improved data accuracy, and ease of use. This proposal does not require an increase in program appropriations, only maintenance of the current fee structure that will support the current level of spending.

Background

The Minnesota Department of Health's (MDH's) Office of the State Registrar (OSR) registers all births and deaths in Minnesota through a secure centralized electronic system. Together with funeral homes, medical examiner and coroner offices, hospitals, and hundreds of physicians throughout Minnesota, OSR expects to register over 75,000 births and 38,000 deaths for Minnesota this year. In addition, OSR and local registrar staff in 110 city and county offices use this system to issue over 750,000 birth and death certificates and process over 35,000 corrections, amendments to, and replacements of records each year. It is imperative that these identity documents are held securely yet are accessible for citizens with tangible interest who need certificates for legal purposes.

The \$2 under consideration here was enacted 8/01/2005 to fund information technology for Minnesota's vital records system. With the added \$2, Minnesota's fees for birth (\$16) and death (\$13) certificates are comparable to other states. The surcharge is funding the development of a new, highly secure, rapid and accurate statewide vital records system that will replace the current system in 2010. On June 30, 2009, this \$2 surcharge on the sale of birth and death certificates will sunset.

Proposal

This proposal maintains the current \$2 surcharge for Vital Records Technology Improvement in the vital records program fee structure. Ongoing implementation funding is needed to ensure proper completion, training, support, software and hardware maintenance, and upgrades to the system. Keeping pace with the latest in secure technology is essential because this mission-critical system must prevent unauthorized access to Minnesotans' most fundamental identity documents—birth and death certificates. It is estimated that approximately \$1.2 million will be collected from the surcharge each year.

Relationship to Base Budget

Maintaining the surcharge will continue the current fee structure and will not require an increase in program appropriations. The OSR is funded through fees. If money to properly support the vital records system cannot be raised through fees, then maintenance and upgrades to the hardware application will need to be prioritized, scaled back, and replacement delayed.

Key Goals and Measures

Minnesota Milestones: Government in Minnesota will be cost-efficient, and services will be designed to meet the needs of the people who use them. Maintaining the vital records system appropriately will uphold the public's trust in MDH to provide strong protection of identity documents.

Key Measure

- ◆ Number of birth certificates processed
- ◆ Number of death certificates processed

Alternatives Considered

None

Statutory Change: The sunset in M.S. 144.226, Subd. 4 (b), will be removed, making the technology surcharge permanent.

HEALTH DEPT**Program: POLICY QUALITY & COMPLIANCE****Change Item: Adverse Health Events Program Fee**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	73	73	73	73
Revenues	73	73	73	73
Net Fiscal Impact	\$0	\$0	\$0	\$0

Recommendation

The Governor recommends increasing the fee for the adverse health events reporting program for hospitals and ambulatory surgical centers, to provide an additional \$73,000 annually to support the program. This change will allow the program to continue to operate at its current level.

Background

The adverse health care events reporting law was passed in 2003, and amended in 2004 and 2007. It mandates that all Minnesota hospitals and ambulatory surgical centers report to the Minnesota Department of Health (MDH) whenever one of 28 serious adverse events occurs. As part of the Department's responsibilities under the reporting law, MDH is required to review all events, along with the accompanying root cause analyses and corrective action plans, to determine patterns of systemic failure in the health care system and successful methods to correct these failures.

As originally passed in 2003, the adverse health care events reporting law required reporting of 27 serious adverse events. A revision to the statute was passed during the 2007 legislative session, updating the list of reportable events to include a 28th event and to modify several existing events. At the same time, MDH and the Minnesota Hospital Association agreed on a change in the definition of an existing event, broadening its scope. As a result of these two changes, the number of adverse health events reported to the Department annually has significantly increased. During 2008, the first year in which these changes went into effect, the number of reported events was more than double that of previous years as a result of these definitional changes.

The increased number of adverse events has significantly increased the work required to administer the adverse health events law. A team of clinical and quality improvement experts evaluates the root cause analyses and corrective actions for every event; the work of this group has increased proportionately to the increase in events.

The adverse health events reporting system is funded through a fee on hospitals and ambulatory surgical centers. This fee has not increased since the system was first established despite a significant increase in the number of events and in the amount of outreach, education, and research that is conducted as a part of the reporting system.

Proposal

This proposal would increase the fees for both hospitals and ambulatory surgical by about 21.5 percent. This proposal would increase funding by \$73,000 a year for the adverse health events reporting system. This program has been in place for five years with no budget adjustment, during a time period in which the requirements of the law have expanded significantly.

	Current	Proposed	Percent Increase
Hospital Fees	\$500 + \$13 per bed	\$600 + \$16 per bed	~22 percent
Ambulatory Surgical Center Fees	\$1,837	\$2,200	~20 percent
Total Budget	\$340,000	\$412,500	~21.5 percent

Relationship to Base Budget

The current base for the adverse health events programs is \$340,000. This fee increase represents an increase of approximately 21.5 percent over the current budget for the adverse health events reporting system (see table). The adverse health events program is funded through fees. If money to properly support the program cannot be raised through fees, then the review process for all reported events will need to be prioritized, scaled back, and potentially delayed.

Key Goals

Minnesota Milestones: Minnesotans will be healthy. The fee increase will allow for increased resources to be dedicated to the review process, so that serious reportable events can be reviewed as quickly as possible by MDH, and will also allow for the development of additional resources (such as adverse event prevention toolkits, sample forms, best practices, and other tools) for the prevention of these events.

Key Measures

- ◆ The number of events that are reported each year.
- ◆ The timeliness with which adverse events are reviewed by a clinical team and feedback given to reporting facilities.

Alternatives Considered

None.

Statutory Change: Minnesota Statutes, section 144.122.

HEALTH DEPTProgram: **HEALTH PROTECTION**Change Item: **Drinking Water Contaminants**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	445	890	890	890
Revenues	0	0	0	0
Net Fiscal Impact	\$445	\$890	\$890	\$890

Recommendation

The Governor recommends that Clean Water Land and Legacy Amendment funding be appropriated to assess and address public health concerns related to contaminants found in Minnesota drinking water for which no health-based drinking water standard is available.

Background

Emerging contaminants may be substances that the Minnesota Department of Health (MDH) has not yet studied or detected in Minnesota drinking water and for which no Minnesota drinking water standards are available. This proposal is intended to expand MDH's capacity for identifying and researching emerging contaminants, developing and implementing water analysis for emerging contaminants, analyzing risks from exposures to contaminants of concern, and communicating results of these activities to the public and other public health and environmental protection programs.

Fundamental to this new activity is coordination and communication with stakeholders (including other state agencies, academic and industry researchers, nonprofit environmental groups and organizations, and federal programs) in order to solicit advice and research support on candidates for further research; set priorities for investigating emerging contaminants; and plan and conduct research on substances. Also fundamental to this work is research on toxicity and exposure data, and development of health-based guidance for exposures. MDH will communicate the results of research on emerging contaminants with well owners, the general public, policy makers, and peer scientists.

MDH could initiate these activities in the first biennium that Clean Water Land and Legacy Amendment funding is available. These activities form a Center for Emerging Drinking Water Contaminants that will focus initially (first biennium) on planning and coordination to research and recommend to the state contaminants of concern, and shift (late in first biennium and future years) to conducting laboratory and risk analysis, and communicating results; work that is likely to continue for the next decade. All of the activities planned for the Center are either designated as new or as underfunded drinking water protection efforts. These activities will protect and plan for use of drinking water resources; and support and complement drinking water protection and public health efforts by local government and state agencies.

Additional information about current MDH activities on emerging issues may be found at <http://www.health.state.mn.us/divs/eh/eissues/>.

Relationship to Base Budget

The base budget for the MDH Section of Drinking Water Protection, which includes the Source Water Protection Unit, is \$14.1 million annually. \$8.5 million of the current budget of the Section is from fees and \$5.6 million from federal funds and grants.

Key Goals

Minnesotans will be healthy, Minnesotans will conserve natural resources to give future generations a healthy environment and a strong economy; and Minnesotans will improve the quality of the air, water and earth. In addition, MDH's Environmental Health activities respond to two MDH goals: 1) all children get a healthy start in life; and 2) prepare for emergencies.

Key Activity Measures

Characterize potential new contaminants in Minnesota drinking water: Based on public input, stakeholder involvement, thorough research, and scientific review, new priority contaminants to investigate in Minnesota drinking water will be identified, assessed for potential risk (including developing health-based guidance), investigated through further research, and the results of this work communicated to regulators, stakeholders, and the public. These are new activities that do not have baseline measures.

Measure	Current	2010-11	2012-13	2014-15
Number of emerging drinking water contaminants researched and characterized (cumulative)	0	10	22	34

Alternatives Considered

The alternative considered was to address issues on an ad hoc basis, as done currently. The work MDH conducted to characterize exposure and toxicity of perfluorochemicals is an example of the effort that has been necessary to respond to a new drinking water contaminant.

Statutory Change: Not Applicable.

HEALTH DEPT

Program: HEALTH PROTECTION

Change Item: Source Water Protection

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Fund				
Expenditures	\$805	\$1,610	\$1,610	\$1,610
Revenues	0	0	0	0
Net Fiscal Impact	\$805	\$1,610	\$1,610	\$1,610

Recommendation

The Governor recommends that Clean Water Land and Legacy Amendment funding be appropriated to strengthen protection of drinking water sources by providing enhancing source water characterization, accelerating the development of source protection plans, improving data sharing, and enhancing technical assistance.

Background

This proposal is intended to strengthen drinking water source protection, including: 1) drinking water resource characterization to define the physical and chemical characteristics of untreated drinking water; 2) accelerate the development and implementation of wellhead or surface water intake protection plans for public water suppliers whose source of drinking water is at risk of contamination from human activities; 3) technical assistance focused on enabling private citizens and local governments to more directly protect their drinking water; and 4) improved access to drinking water data to support public and private drinking water protection efforts.

The Minnesota Department of Health (MDH) could initiate these activities in the first biennium that Clean Water Land and Legacy Amendment funding is available. All activities listed are either designated as new or as expanded drinking water protection efforts. Some activities may be completed in the first biennium whereas others may require multiple years to complete. These activities will protect and plan for use of surface and groundwater resources used as drinking water sources and will complement drinking water protection efforts by local government units and state agencies including the Minnesota Department of Natural Resources, Pollution Control Agency, Department of Agriculture, Public Finance Authority, and Board of Water and Soil Resources. A correlated goal is to increase coordination of agencies' drinking water protection efforts.

Drinking water source protection planning efforts are authorized by M.S. 103I.101 and related Minn. Rules, parts 4720.5100 – 4720.5590. Plans help to protect groundwater from contamination and are required to be updated every 10 years. Additional information about MDH Source Water Protection efforts can be found at <http://www.health.state.mn.us/divs/eh/water/swp/index.htm>.

Relationship to Base Budget

The base budget for the MDH section of Drinking Water Protection, which includes the Source Water Protection Unit, is \$14.1 million. \$8.5 million of the current budget of the Section is from fee revenues (SGSR) and \$5.6 million from federal funds and grants. The current base budget for specifically for MDH Source Water Protection activities is \$2.0 million per year. The \$1.6 million proposed in this change item is a significant increase for this program, of approximately 75 percent.

\$370,000 per year of the funding is proposed as grants to public water suppliers and local agencies for a variety of related source water protection activities.

Key Goals

Minnesota Milestones: Minnesotans will be healthy. Minnesotans will conserve natural resources to give future generations a healthy environment and a strong economy; and Minnesotans will improve the quality of the air, water and earth.

Key Activity Measures

- ◆ Accelerate the development of community-based wellhead protection plans

	History	In process	Current	Target	Target
Number of wellhead protection plans completed (cumulative)	2000	2008	2008	2011	2019
	0	125	175	350	1200

Alternatives Considered

The alternative considered was to not support or accomplish the activities proposed, or to take a longer time frame to complete these activities.

Statutory Change: Not Applicable.

HEALTH DEPT**Program: HEALTH PROTECTION****Change Item: Well Program Fees**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	325	325	325	325
Net Fiscal Impact	\$(325)	\$(325)	\$(325)	\$(325)

Recommendation

The Governor recommends the following changes to address the current budget shortfall, and to ensure minimum operating levels of the state Well Program:

- ◆ removing the current government exemption from Well Program fees;
- ◆ creating a reduced fee for government-owned monitoring well maintenance permits, and;
- ◆ creating a graduated fee structure for larger groundwater thermal heat exchange systems.

Background**Well Management Program**

The state Well Program performs two essential functions to protect the health and safety of Minnesotans: the protection of the drinking water sources for 70% of all Minnesotans, and the finding and sealing of abandoned wells, which, when buried and forgotten, act as permanent conduits for any future contamination to drain into our deep, geologically-protected water bearing aquifers.

During the past two decades, the Well Program has protected drinking water by dramatically improving the sanitary construction of new water wells, and by nearly eliminating wells constructed too close to landfills, sewers, and septic systems, wells constructed with reject casing pipe salvaged from oil fields, and runaway flowing wells, which can wash out hillsides and permanently devalue property. It is estimated that in 1989 between one third and one half of all new water wells were not constructed to minimum sanitary standards. The program now inspects 20-25% of all new wells, and assures that every well contractor in the state receives a minimum amount of inspections each year. Under this program, 96% of new water wells now meet all sanitary requirements.

There are an estimated half million abandoned wells in Minnesota, some of which are buried or bulldozed every year, lost from memory, and thereafter can spread groundwater contamination. This program works actively with many industries and private citizens to have abandoned wells properly sealed, especially after property transfer. During the past 18 years, the well program has overseen the permanent sealing of more than 225,000 abandoned wells in the state, strengthening the protection of one of Minnesota's greatest natural assets, its groundwater.

Monitoring wells that are placed on or near contamination sites to monitor contaminant levels can present a particularly significant risk to groundwater. To prevent contaminant spread, monitoring wells are only allowed under a permit, and monitoring wells in existence more than 14 months must be under an annual "maintenance permit." An annual maintenance permit fee of \$175 is assessed to fund the prevention activities of the program, and to provide a disincentive to leaving an unused monitoring well unsealed when it is no longer needed. This has worked very well for the private sector, but because federal, state, and local agencies have been exempt from the fees, they have had less incentive to track and seal their unused monitoring wells.

When the Well Program's fee structure was originally established in 1989, a provision was included in M.S. 1031 to exempt governments from paying the fees for the program services provided to them. Therefore, during the past two decades, federal, state, and local agencies in Minnesota have been receiving considerable Well Program services for free, even though most of those same governmental agencies charge other governmental agencies for services they provide. Because the annual permits have been free, many governmental agencies automatically renew all their permits, whether the wells are still in use or not. Consequently, there is a growing number of unused government-owned monitoring wells that are not being sealed and present an increased threat to groundwater.

Proposal

This proposal will require local governments to begin paying Well Program fees, including a reduced fee of \$50 (the usual fee is \$175) for each annual monitoring well maintenance permit. This will result in an increase in annual program revenue of approximately \$325,000, which will help offset the current budget shortfall caused by the housing market collapse, and help to maintain the state Well Program at minimum operating levels. Typical costs to federal, state, and local governments will be \$215 to construct a new public well, \$50 to seal an unused well, and \$50 per year to operate a monitoring well.

Ground Water Thermal Exchange

Groundwater thermal exchange systems are becoming increasingly popular as a cost-effective means of heating and cooling with a renewable source of energy. Some systems use "vertical heat loops" that are installed in borings 150-200 feet deep, and the number of vertical heat loop systems installed in Minnesota has doubled in just the past year. The fee to install any vertical heat loop system is currently \$215, even though some of the larger systems have dozens or even hundreds of loops, and often require much more time to approve and inspect.

Proposal

This proposal would retain the current fee to install a heat loop system serving an individual residence (typically less than 10 "tons" of heating/cooling capacity), double the fee (to \$425) for systems of 10 to 50 tons, and triple the fee (to \$650) for systems greater than 50 tons.

Relationship to Base Budget

Base funding from the state government special revenue (SGSR) fund for the Well Management Program is currently \$3.807 million. No change in base funding is requested during this biennium.

Key Goals and Measures

Drinking Water Safety: Proper location and construction of wells protects the safety of our drinking water, and usually eliminates the need for costly water treatment. During this biennium, the program will strive to assure that at least **95%** of all new wells meet all sanitary standards, and that all violations of standards are corrected.

Sealing Abandoned Wells: Abandoned wells threaten groundwater by acting as channels for contaminated surface water to drain deep into the ground, contaminating deeper, geologically protected groundwater. During this biennium, the program plans to oversee the permanent sealing of approximately 10,000 more abandoned wells, bringing the total number sealed during the past two decades to more than 235,000.

Sealing Unused Government-owned Monitoring Wells: During this biennium, the program will work with governmental agencies to assure that their unused monitoring wells are identified, that all unused monitoring wells are placed on a schedule for sealing, and that at least **35%** are properly and permanently sealed.

Vertical Heat Loop Construction: Vertical heat loops must be properly constructed to assure that they will not spread groundwater contamination. During this biennium, the program will strive to assure that at least **95%** of new vertical heat loops meet all construction requirements.

Alternatives Considered

None.

Statutory Changes: This proposal removes the government exemption from Well Program fees, in M.S. 103I.112. This proposal also modifies M.S.103I.208 to create several new fees as described above.

HEALTH DEPT

Program: HEALTH PROTECTION

Change Item: Swimming Pool Inspection & Plan Review

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	211	211	211	211
Net Fiscal Impact	\$(211)	\$(211)	\$(211)	\$(211)

Recommendation

The Governor recommends an adjustment to the public swimming pool licensing and plan review fees to reflect cost of service and to maintain staffing levels needed to perform legislatively mandated requirements.

Background

The Minnesota Department of Health (MDH) swimming pool program is an effective means to ensure health protection through comprehensive, consistent oversight for construction of public swimming pools and spas. The purpose of the public swimming pool program is to ensure proper design, construction, maintenance and operation of public swimming pools and spas. The MDH provides public swimming pool and spa plan review and construction inspection for all public pools throughout Minnesota. Ongoing compliance inspection responsibilities are conducted in 48 Minnesota counties. The compliance inspection responsibility is shared with 41 local health agencies that establish their own license fees for service. Staff also provides technical assistance to the local health agencies on issues related to pool safety and sanitation.

In 2008, M.S. 144.1222 was amended to create the Abigail Taylor Pool Safety act. Plan review and license fees were not adjusted at that time. The present fees do not support the enhanced and expanded inspections, plan review, or administrative requirements to carry out the mandates of the act. The last fee adjustment for plan review was in 2003 and for licensing in 2005. Ensuring adequate funding allows program services to continue to be provided.

To see more about this program, visit the web site at <http://www.health.state.mn.us/divs/eh/pools/index.html>.

Proposal

This proposal will adjust public swimming pool licensing and plan review fees to reflect cost of service and to provide funding necessary to maintain staffing levels needed to perform legislatively mandated requirements. New fees will increase revenues approximately 45%.

Relationship to Base Budget

No change in base funding is requested during this biennium. The current annual revenue for this program is \$465,000. The requested fee increase will raise revenue by \$211,000 annually, for total projected annual revenue of \$676,000.

Key Goals and Measures

Goal: Minnesotans will be healthy. Inspecting for safe and sanitary conditions reduces health risks and hazards at regulated establishments.

Inspections of regulated establishments will meet statutory requirements.

HEALTH DEPT

Program: HEALTH PROTECTION

Change Item: Swimming Pool Inspection & Plan Review

Measures:

- ◆ Number of plans reviewed
- ◆ Average time to review a plan
- ◆ Number and percent of establishments inspected

Alternatives Considered

None

Statutory Change: M.S. 144.1222 and 157.16

HEALTH DEPT

Program: HEALTH PROTECTION

Change Item: Food Manager Certification Program

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	163	163	163	163
Revenues	61	61	61	61
Net Fiscal Impact	\$102	\$102	\$102	\$102

Recommendation

The Governor recommends adjusting the Food Manager Certification fees and appropriation level to reflect cost of service.

Background

The current Food Managers Certification program requires statewide professional certification for managers of food establishments. Food service managers are required to complete a training course that teaches safe food preparation, handling, sanitation and the prevention of food borne illness.

This program provides support to 41 local health programs that have delegation agreements for the food, beverage and lodging program and the Minnesota Department of Agriculture. In addition, this program works with the hospitality industry and educators.

Food Manager Certification fees are expected to cover the cost of service and provide funding necessary to administer the program. The current fee for certification is \$28 every three years. There is also a \$15 fee for issuing duplicate certifications.

Proposal

This proposal increases the appropriation for the Food Certification Program by \$163,000 per year. The increased appropriation will enable improved services to the public and regulated parties by increasing the number of food establishments with a certified food manager; and provide needed program oversight and transparency. This proposal also raises the certification fee from \$28 to \$35 and the duplicate certification fee from \$15 to \$20 to ensure the revenues of the program cover the costs.

Relationship to Base Budget

The current appropriation for this program is \$207,000. This proposal would increase the base for this program by 27%. Costs for this program are borne by food service workers and managers.

Key Goals and Measures

Goals: Minnesotans will be healthy. Increasing the number of food establishments with certified food managers will reduce risks to the public for food born illness.

Measures:

Number and percent of food establishments that have a certified food manager: as of July 2008, there are 28,195 current certified food managers in Minnesota. In 2006, 85% of the establishments inspected had a certified food manager. That number has increased to nearly 87% in 2007.

Alternatives Considered

None

Statutory Change: M.S. 157.16

HEALTH DEPT

Program: HEALTH PROTECTION

Change Item: Food, Beverage, & Lodging Program

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	823	823	823	823
Revenues	559	559	559	559
Net Fiscal Impact	\$264	\$264	\$264	\$264

Recommendation

The Governor recommends fee and appropriation adjustments for food, beverage and lodging establishment activities related to licensing, inspection and plan review. These adjustments reflect cost of service, adjustments to staffing levels, and restructuring of programs needed to perform legislatively mandated requirements.

Background

Minnesota Department of Health (MDH) license fees support the inspection, licensing, and plan review activity for approximately 9,000 restaurants, bars, hotels, motels, resorts and lodging establishments, and 2,500 temporary food stands in 48 counties. Establishments are routinely inspected to identify and reduce risk factors found to cause illness. Fees reflect cost of service and provide funding necessary to maintain the staffing levels needed to perform legislatively mandated requirements. The last fee adjustment was in 2005.

Ongoing demands resulting from a global food supply, emergency preparedness, increase tourism and technological advances continually challenge the program and require improved services and approaches.

Proposal

This proposal would increase fees under the food, beverage and lodging program. Most current fees would increase about 20%. This proposal will also restructure new construction and remodeling fees for inspection and plan review. It is estimated that the fee increases will generate \$559,000 in additional revenue per year. The proposal will also increase appropriation for the food, beverage and lodging establishments licensing, inspection and plan review program by \$823,000 per year.

If the food, beverage and lodging fees are not increased, there will be a reduction of inspection staff, and elimination or reduction of inspections for licensed establishments. A reduction in the inspection frequency level would put the program in violation of statute. In addition, patrons will be placed at an increased level of risk of illness or injury at these establishments and the department's ability to respond to emergencies will be reduced. The increased funding will allow the program to restructure and adjust staffing, which will improve services to the public, regulated parties, provide greater program efficiency, and provide needed program oversight and transparency.

Relationship to Base Budget

The current appropriation for this program is \$4.277 million. This proposal will increase the appropriation by 19%, which will be funded with a combination of existing fee revenue plus the revenue generated by the requested fee increase of \$559,000. An increase in fees and appropriation will fund staff and program improvements. Costs for this program are borne by owners of food, beverage and lodging establishments.

Key Goals and Measures

Goal: Minnesotans will be healthy. Inspecting for safe and sanitary conditions reduces health risks and hazards at regulated establishments.

Inspections of regulated establishments will meet statutory requirements.

HEALTH DEPT

Program: HEALTH PROTECTION

Change Item: Food, Beverage, & Lodging Program

Measures:

- ◆ Number and percent of inspection of regulated establishments.
- ◆ Average time to complete plans reviews.
- ◆ Number of training and evaluation programs offered.

Alternatives Considered

None

Statutory Change: M.S. 157.01 – 157.22

HEALTH DEPT

Program: HEALTH PROTECTION

Change Item: Youth Camp License & Inspection Program

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Fund				
Expenditures	\$50	\$50	\$50	\$50
Revenues	\$50	\$50	\$50	\$50
Net Fiscal Impact	0	0	0	0

Recommendation

The Governor recommends creating a youth camp licensing fee and appropriating funds to cover the costs of inspection of youth camps.

Background

The Minnesota Department of Health currently carries out youth camp inspections and illness investigations without a fee, accruing a cost to the state. There are approximately 100 youth camps in the state that the department inspects annually and which do not pay a licensing fee.

Youth camps are regulated under Minnesota Statutes, section 144.71 to 144.74. These camps prepare, serve food, and provide lodging to youth. It is in the interest of public health to continue to inspect for safe and sanitary conditions at these camps and it is in the interest of the state to recover the cost of providing services through a fee.

Proposal

This proposal creates a licensing fee for youth camps of \$500 per year to cover the cost of inspections and food-borne illness investigations conducted at youth camps. The license fee will be added to Minnesota Statutes 157 and is similar to other food and lodging establishments covered by that statute. By implementing a fee, a level playing field will be created for all camp operators statewide. This initiative relates to the division's strategic plan in that it is sound public policy to develop fees that are fair and equitable for both the agency and operators.

Relationship to Base Budget

There is currently no appropriation for this program. This request provides a \$50,000 in base funding in the state government special revenue fund, which will be funded by the requested fee revenue of \$50,000.

Key Goals and Measures

Goals: Minnesotans will be healthy. Inspecting for safe and sanitary conditions reduces health risks and hazards at regulated establishments

Meet statutory requirements for inspections of youth camps.

Measures:

- Number and percent of youth camps inspected per year.

Alternatives Considered

None

Statutory Change: Minnesota Statutes, sections 157.15-157.16 and 144.72

HEALTH DEPT

Program: HEALTH PROTECTION

Change Item: Manufactured Home Parks & Rec Camping

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	320	320	320	320
Revenues	234	234	234	234
Net Fiscal Impact	\$86	\$86	\$86	\$86

Recommendation

The Governor recommends creating statutory language for operating standards for special event camping areas, a license fee category for these short term camping areas, and adjustment of fees and appropriation for year round camping areas and manufactured home parks.

Background

The Minnesota Department of Health (MDH) licenses approximately 1200 Manufactured Home Parks (MHP) and Recreational Camping Areas (RCA). The manufactured home park/recreational camping area license fees have not been changed since 1991. The current fees are considerably less than required to provide required services. The current fees for year round camping areas and manufactured home parks are in rule, and are being moved to statute as required by M.S. 16A.1283.

In addition, the department licenses approximately 15 Special Event Camping Areas (SECA) each year. SECAs are events that typically operate a few days a year. Variances from Recreational Camping Area standards have been allowed at SECAs because of the special conditions that exist for these short term events. In addition, SECAs are charged the same licensing fee as permanent RCAs because there is no specific fee structure for these events that reflect cost of service. As an example, the Minnesota State Fair sought legislative relief in the 2008 legislative session to reduce their fee from \$20,000 to \$9,000. This proposal creates specific operating standards, and a separate licensing fees structure for SECAs.

Proposal

This proposal includes standardization and simplification of the fee structure and moves license fees for manufactured home parks and recreational camping areas from rule into statute. In addition, this proposal codifies standards that reflect the conditions that are currently applied through a variance process for SECAs.

This proposal also adjusts fees for year round camping areas and manufactured home parks and creates a reasonable license fee category for short term camping areas. The resulting 110% increase in revenue will allow the MDH to restructure this program and adjust staffing, which will improve services to the public and regulated parties, provide greater program efficiency, and provide needed program oversight and transparency.

Relationship to Base Budget

The current appropriation for this program is \$160,000. This proposal requests a 200% increase in appropriation, which will be funded with a combination of existing fee revenue plus the revenue generated by the requested fee increase of \$234,000. An increase in fees will fund staff and program improvements. Costs for this program are borne by licensed operators.

Key Goals and Measures

Goal: Minnesotans will be healthy. Inspecting for safe and sanitary conditions reduces health risks and hazards at regulated establishments.

Inspections of regulated establishments will meet statutory requirements

Measures:

- ◆ Number and percent of establishments inspected.
- ◆ Number of plans reviewed per year.
- ◆ Number of days to complete a review.

Alternatives Considered

None

Statutory Change: M.S. 327.14 – 327.20

HEALTH DEPT**Program: HEALTH PROTECTION****Change Item: X-Ray Program Fee**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	250	250	250	250
Revenues	460	460	460	460
Net Fiscal Impact	\$(210)	\$(210)	\$(210)	\$(210)

Recommendation

The Governor recommends increasing the appropriations and fees for the x-ray licensing and inspection program to ensure compliance with statutory requirements to inspect all x-ray facilities every four years, develop a electronic data systems and electronic business transactions and recover the cost of the program.

Background

The X-ray program is a fee based inspection program established in 1973. It was established to protect the citizens of Minnesota from receiving unnecessary exposure to ionizing radiation. This is accomplished through:

- ◆ Establishing public health standards for ionizing radiation producing equipment in all facilities - medical, veterinary, industrial, research, and educational,
- ◆ Providing educational standards for operators of radiation producing equipment,
- ◆ Providing public information, answering consumer concerns, and working with health licensing boards and associations to inform facilities and staff of regulatory and compliance issues,
- ◆ Registering and thereby maintaining an inventory of radiation producing equipment used in Minnesota,
- ◆ Identifying service providers and assuring that training is appropriate for the equipment that they install, maintain, and repair, and
- ◆ Annually inspecting one quarter of the 4,400 facilities having ionizing radiation-producing equipment.

The currently set fees have not kept pace with the cost of providing this service. Fees for the x-ray program have not been increased since 1997. In FY 2008, registration fees were converted from biannual to annual. The fees also support the following activities that do not currently generate revenue for the program:

- ◆ Shielding Plan Review;
- ◆ Diagnostic Screening Plan Review, and;
- ◆ Service Provider Registration.

These activities are required under rule amendments that were developed and established in 2007. The program has continuously struggled to achieve its statutorily mandated requirement to inspect each facility every four years because of inadequate staffing levels. With current staff levels the program has progressed towards that goal. Studies in other states have shown that compliance is most successful on a three-year inspection cycle. The program is also working towards efficiencies in business operations through electronic business processes and enhanced inspection procedures. With the increasing demand for electronic business operations, the need to replace antiquated field inspection equipment, increased department indirect costs and appropriate staff levels the program will need to expend additional funds in order to efficiently provide services.

Proposal

This proposal seeks to increase the current fees and appropriation for services in order to support operation of the program. This proposal also seeks an increased appropriation to ensure compliance with statutory requirements to inspect all x-ray facilities every four years, develop a electronic data systems and electronic business transactions and recover the cost of the program

Fees that will be increased include:

- ◆ Facility base fee: proposed fee = \$100, existing fee = \$66;
- ◆ Dental equipment fee (Non-CT): proposed fee = \$40, existing fee = \$33;

HEALTH DEPT

Program: HEALTH PROTECTION

Change Item: X-Ray Program Fee

- ◆ Dental CT and non-dental equipment fee: proposed fee = \$100, existing fee = \$53;
- ◆ Accelerators – flat fee per facility and dropping equipment fee: proposed fee = \$500, existing fee = base fee plus per equipment fee.

Fees that will be eliminated are:

- ◆ Electron microscopes – current configuration of these devices does not present a hazard to operators or the public. This will cause minimal fiscal impact to the overall program budget. The compliance activity associated with this equipment will also be eliminated.

More information on the program can be found at <http://www.health.state.mn.us/xray> .

Relationship to Base Budget

The current base funding for the x-ray program is \$1.108 million. This proposal would increase funding by 22.5%. As indicated previously, the increase is essential to maintain sufficient staff to meet the legislative mandate to inspect these facilities every four years. The increase will also speed up the process of developing electronic business processes to make transactions easier for the regulated community.

Key Goals and Measures

Goal: Minnesotans will be healthy. This initiative focuses on clear priorities for improving health outcomes by ensuring the safe operation of x-ray equipment through establishment of standards and inspecting for compliance.

Inspections of regulated establishments will meet statutory requirements.

Measures:

- ◆ Facilities will be inspected every four years – 4,400 total facilities of which 1,900 are dental facilities.
- ◆ Electronic business transactions available for the regulated community.

Alternatives Considered

None

Statutory Change: M.S. 144.121

Technology Funding Detail

(Dollars in thousands)

Funding Distribution	FY 2010-11 Biennium		FY 2012-13 Biennium		FY 2014-15 Biennium	
	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Personnel	\$14	\$13	\$29	\$37	\$7	\$7
Supplies						
Hardware						
Software	3	3	4	4	3	3
Facilities						
Services			10	10	10	10
Training						
Grants						
TOTAL	\$17	\$16	\$43	\$51	\$20	\$20

NOTE: Personnel: planning and development of improved compliance monitoring data base system along with electronic business applications [submission of e-payments and records]. Services: estimated cost for e-business transactions.

HEALTH DEPT**Program: HEALTH PROTECTION****Change Item: Lead Program-Pre-Renovation & Renovation**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	100	100	100	100
Revenues	50	75	100	125
Net Fiscal Impact	\$50	\$25	\$0	\$(25)

Recommendation

The Governor recommends that the department be given the authority to develop rules to adjust fees for pre-renovation notification of lead hazards and the regulation of renovation, repair and painting activities that impact lead based paint in child occupied facilities. These activities are currently mandated by the U.S. Environmental Protection Agency (EPA). Development of this program will ultimately result in the department seeking approval to operate the program in lieu of EPA

It is anticipated that this initiative will support lead reduction activities in housing and reduce unnecessary exposure of children to lead.

Background

In April 2008, EPA established work practice, cleaning, and certification requirements for contractors performing renovation, repair and painting activities in pre-1978 child occupied facilities. These activities were exempt from the licensing requirements established in 1998. Renovation, repair and painting activities are not currently regulated by the state. The federal requirements call for contractors to pay a certification fee for performing renovation, repair and painting activities. Individuals are required to be trained through an approved course and their training course diploma becomes their certification. Renovator and dust sampling technician training courses are also required to receive approval to provide courses and pay a fee.

Development of these requirements at the state level would ensure continued federal Housing and Urban Development (HUD) funding to the state for lead hazard reduction activities for both state and local programs. One of the requirements for local and state agencies when applying to HUD for activities impacting lead is that the state has a lead compliance program that is recognized by EPA. Future federal healthy homes funding opportunities may also be impacted by the status of a state's full implementation of an EPA recognized lead program.

Proposal

This initiative would incorporate the 2008 EPA requirements into existing statute which would allow the department to develop rules and seek authority from EPA to administer these program elements within the state.

Current state fee that will be used to facilitate implementation of this program are as follows:

- ◆ Lead Firm Certification: \$100 initial;
- ◆ Lead Firm Certification: \$100 renewal/every year;
- ◆ Initial Training Course Permit: \$500 initial;
- ◆ Initial Training Course Permit: \$250 renewal/every year;
- ◆ Refresher Training Course Permit: \$250 initial;
- ◆ Refresher Training Course Permit: \$125 renewal/every year;
- ◆ Lead Supervisor: \$100 initial, and;
- ◆ Lead Supervisor: \$100 renewal/every year.

These fees along with certification fees for lead supervisors, workers, inspectors, risk assessors and management planners currently generate approximately \$50,000 per year.

Equivalent federal fees are as follows:

- ◆ Renovation Firm Certification: \$300 initial;
- ◆ Renovation Firm Certification: \$300 renewal/every five years;
- ◆ Initial Renovator or Dust Sampling Technician Course: \$560 initial;
- ◆ Initial Renovator or Dust Sampling Technician Course: \$340 renewal/every four years;
- ◆ Refresher Renovator or Dust Sampling Technician Course: \$400 initial, and;
- ◆ Refresher Renovator or Dust Sampling Technician Course: \$340 renewal/ every four years.

This change will impact firms or contractors that conduct renovation work in pre-1978 housing by requiring them to work safely with potential lead hazards. There are approximately 15,000 licensed general contractors through Department of Labor and Industry (DOLI). The Minnesota Home Builders Association which includes home renovators has approximately 5,000 members state wide in 14 regional associations. This initiative will have a positive impact on reducing potential lead exposures in the state, it is difficult to determine to what extent. National studies have indicated that up to 30% of lead poisonings are the result of renovation activities.

Additional information:

Minnesota Department of Health Lead Program: <http://www.health.state.mn.us/divs/eh/lead/index.html>

US EPA Pre-Renovation Lead Education Rule: <http://www.epa.gov/lead/pubs/leadrenf.htm>

US EPA Renovation, Repair and Painting Rule: <http://www.epa.gov/lead/pubs/renovation.htm>

Relationship to Base Budget

This proposal requests an additional \$100,000 per year. This is an increase from the current base budget of \$50,000. Increased staff activity would be required initially to develop the proposed program and there after to maintain the program and provide technical assistance and compliance activity. The licensing activity would increase the fees generated under the existing program. Over time, adoption of this program could reduce the state's dependence on US EPA to fund the operation of the lead compliance program.

Key Goals and Measures

Goal: Minnesotans will be healthy. Reduced exposure of children to lead hazards from renovation work will result in reduced societal costs in the future.

Increase the number of contractors trained in lead safe work practices.

Measures:

- ◆ Number of contractors trained in lead safe work practices.
- ◆ Number of contractors licensed for lead work.
- ◆ Compliance activity associated with renovation work.
- ◆ Elevated blood lead levels continue to drop within the state.

Alternatives Considered

None

Statutory Change: Changes to M.S. 144.9501-9509

HEALTH DEPT**Program: HEALTH PROTECTION****Change Item: Infected Health Care Workers Program**

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	50	50	50	50
Revenues	0	0	0	0
Net Fiscal Impact	\$50	\$50	\$50	\$50

Recommendation

The Governor recommends an increase in appropriations of \$50,000 for the Infected Health Care Worker Monitoring Program from the state government special revenue (SGSR) fund. This increase will ensure that the state is able to effectively evaluate and monitor all health care workers who are infected with HIV, hepatitis B (HBV), and hepatitis C (HCV).

Background

The Infected Health Care Worker Monitoring Program was created in 1992. M.S. 214.19, requires certain persons or institutions that know that a "regulated person" (e.g., dentist, physician, registered nurse) is infected with HIV, HBV, or HCV to report that person to the commissioner of health. M.S. 214.23, further requires the boards of dentistry, medical practice, nursing, and podiatric medication to enter into a contract with the commissioner of health to evaluate and monitor these infected health care workers.

The Minnesota Department of Health (MDH) has administered the Infected Health Care Worker Program since 1992. The program ensures that licensed health care professionals infected with diseases transmissible by blood and body fluid contact (i.e., HIV, HBV, and HCV) are evaluated and monitored on an ongoing basis so they can safely continue to practice. This reduces the threat that a health care worker infected with one of these diseases will infect a patient.

Over time the number of health care workers evaluated and monitored by the program has grown. In 1992, MDH only monitored for HIV and HBV. From 1992 through 1999, the number of new cases remained relatively small; an average of four per year, thus resulting in about 20 that required monitoring on an ongoing basis. However in 2000, statute was amended and now requires monitoring of health care workers infected with HCV. Currently, the program is monitoring or investigating 140 infected health care workers. As a result, program costs have increased.

Proposal

This proposal asks for an additional \$50,000 to fund the Infected Health Care Worker Program to ensure that the MDH is able to effectively investigate and monitor health care workers infected with HIV, HBV, and HCV so these infectious diseases do not spread beyond the health care worker to their patients or family members.

Relationship to Base Budget

Currently, MDH receives \$162,000 annually in SGSR funding for the Infected Health Care Worker Program. This proposal requests a 31 percent increase in funding to maintain current service levels. This additional funding will be used to cover rising programmatic costs, and additional funding will be used for .2 FTE to fund a supervisor to support the health care worker program. Other additional funding will go to increased Attorney General costs, travel, and educational materials needed to address the increase in health care workers monitored under this program.

Key Goals and Measures

Minnesota Milestones Goal: Minnesotans will be healthy. Preventing, detecting, and controlling infectious disease is critical to ensuring Minnesotans are healthy. For example, due to public health interventions and improved treatment, years of potential life lost to HIV/AIDS and hepatitis B and C have decreased over the last decade.

Key Measures

- ◆ Percent of all Health Care Workers reported to the commissioner of health by licensing boards that are evaluated and monitored on an ongoing basis so they can safely continue to practice. (Goal 100 percent)

Alternatives Considered

None

Statutory Change: Not Applicable.

Fiscal Impact (\$000s)	FY 2010	FY 2011	FY 2012	FY 2013
General Fund				
Expenditures	\$0	\$0	\$0	\$0
Revenues	0	0	0	0
Other Fund				
Expenditures	150	150	150	150
Revenues	100	150	200	200
Net Fiscal Impact	\$50	\$0	(\$50)	(\$50)

Recommendation

The Governor recommends an appropriation of \$150,000 in FY 2010 and \$150,000 in FY 2011 to support the continuation of Minnesota's Environmental Laboratory Accreditation Program. The Governor further recommends changing fees from biannual to annual and increasing fees to ensure recovery of costs.

Background

The Environmental Laboratory Accreditation Program provides assurance to the U.S. Environmental Protection Agency (EPA) that federal regulatory program testing is performed by laboratories accredited to meet EPA specifications and the State of Minnesota is in compliance with EPA primacy requirements.

The Environmental Laboratory Accreditation Program evaluates and inspects municipal and private laboratories that perform testing for the state of Minnesota. Laboratories must be accredited to conduct testing for the federal Safe Drinking Water, Clean Water, Resource Conservation and Recovery, and Underground Storage Tank Programs in Minnesota. To be accredited for a specific program, the laboratory must use the data quality assurance, sample collection, analysis, preservation and handling techniques specified by EPA. The state of Minnesota must guarantee that accredited laboratories perform this testing. These federal programs are administered in Minnesota by the Minnesota Department of Health (Safe Drinking Water), and the Minnesota Pollution Control Agency (Clean Water, Resource Conservation and Recovery, and Underground Storage Tank).

The state of Minnesota requires that laboratories which perform water, soil, and waste testing for government agencies for regulatory purposes must be accredited as specified in M.S. 144 and Minn. Rule 4740. The department's Environmental Laboratory Accreditation Program accredits laboratories that have provided assurance that appropriate systems are in place to generate reliable data.

Minnesota Department of Health (MDH) must meet program requirements that are specified in statute and be supported entirely by fees. The program last requested and received a fee increase in 2005. The current program costs now exceed program revenues. Growing demands from the laboratory community for services such as training, database management, and technical consultations have also caused pressure to the program.

To reduce expenditures, the program would severely limit its on-site inspections, training sessions, and technical consultations to private testing laboratories and municipalities. In addition, without a fee increase the program cannot add staff to meet the growing expectations by the laboratory community for services such as training, database management, and technical consultations.

Proposal

This proposal would increase the appropriation and fees for the Environmental Laboratory Accreditation Program to meet current service demands and ensure statutory requirements are met. The increased appropriation will cover the cost of staff, supplies and training at a level needed to meet statutory requirements. This proposal also changes the fees for the Environmental Laboratory Accreditation Program from biannual to annual and proposes an increase of fees. Without the recommended increase in user fees, the MDH Environmental Laboratory Accreditation Program will run a financial deficit within a year.

Relationship to Base Budget

The current base for the lab certification program is \$581,000. This proposal will increase the base by 25 percent.

Key Goals and Measures

- ◆ Quality Assurance – The program will improve its ability to assure the quality of data generated by Minnesota accredited laboratories by maintaining an average frequency of inspections once every two years.
- ◆ Compliance with Federal Requirements – The program will provide assurance to EPA that federal regulatory program testing is performed by laboratories accredited to meet EPA specifications.
- ◆ Cost Effective Service Delivery – The program will continue its emphasis on minimizing costs to the regulated community by striving for uniformity in accreditation programs nationwide and building mutually beneficial reciprocal arrangements with other states.
- ◆ Collaboration with Other Agencies – The program will continue to work closely with the Minnesota Pollution Control Agency and environmental health programs within the MDH to assure the accuracy of data used to make decisions of public health significance.

Alternatives Considered

The program has considered the reduction of expenditures as an alternative to a user fee increase. However, this alternative would impact the ability of Minnesota to meet the primacy compliance requirements of the EPA.

Statutory Change: Fees are established in M.S. 144.98.

Program Description

The purpose of the Community and Family Health Promotion Program is to improve health through bringing together diverse expertise and systems to effectively direct resources to measurably improve the health of individuals, families, and communities – with particular attention to those experiencing health disparities.

Budget Activities

- ◆ Community and Family Health
- ◆ Health Promotion and Chronic Disease
- ◆ Office of Minority and Multicultural Health

HEALTH DEPT

Program: COMMUNITY & FAMILY HLTH PROMO

Program Summary

<i>Dollars in Thousands</i>					
	Current		Governor Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Direct Appropriations by Fund</u>					
General					
Current Appropriation	49,118	47,928	47,928	47,928	95,856
Technical Adjustments					
Approved Transfer Between Appr			(3,448)	(3,448)	(6,896)
Subtotal - Forecast Base	49,118	47,928	44,480	44,480	88,960
Governor's Recommendations					
Local Public Health Grant Payment Delay		0	0	(5,193)	(5,193)
Grant Reduction - Family Planning		0	(1,050)	(1,050)	(2,100)
Total	49,118	47,928	43,430	38,237	81,667
State Government Spec Revenue					
Current Appropriation	870	875	875	875	1,750
Technical Adjustments					
Approved Transfer Between Appr			358	358	716
Program/agency Sunset			(200)	(200)	(400)
Subtotal - Forecast Base	870	875	1,033	1,033	2,066
Total	870	875	1,033	1,033	2,066
Health Care Access					
Current Appropriation	4,050	5,274	5,274	5,274	10,548
Technical Adjustments					
Approved Transfer Between Appr			(3,586)	(3,586)	(7,172)
Current Law Base Change			20,454	27,531	47,985
One-time Appropriations			(500)	(500)	(1,000)
Subtotal - Forecast Base	4,050	5,274	21,642	28,719	50,361
Governor's Recommendations					
Statewide Health Improvement Program		0	(14,000)	(21,000)	(35,000)
Total	4,050	5,274	7,642	7,719	15,361
Federal Tanf					
Current Appropriation	11,418	11,733	11,733	11,733	23,466
Subtotal - Forecast Base	11,418	11,733	11,733	11,733	23,466
Total	11,418	11,733	11,733	11,733	23,466
<u>Expenditures by Fund</u>					
Carry Forward					
Miscellaneous Special Revenue	32	155	0	0	0
Direct Appropriations					
General	45,029	46,657	43,430	38,237	81,667
State Government Spec Revenue	676	1,466	1,033	1,033	2,066
Health Care Access	404	1,784	7,642	7,719	15,361
Federal Tanf	9,997	13,154	11,733	11,733	23,466
Statutory Appropriations					
Miscellaneous Special Revenue	3,001	4,355	2,872	2,841	5,713
Federal	153,787	162,155	160,348	160,197	320,545
Gift	6	58	0	0	0
Total	212,932	229,784	227,058	221,760	448,818

HEALTH DEPT

Program: COMMUNITY & FAMILY HLTH PROM0

Program Summary

<i>Dollars in Thousands</i>					
	Current		Governor Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Category</u>					
Total Compensation	19,269	22,794	22,205	22,445	44,650
Other Operating Expenses	10,497	17,303	(1,029)	(7,949)	(8,978)
Payments To Individuals	102,184	107,208	106,830	106,830	213,660
Local Assistance	80,982	82,479	99,354	100,736	200,090
Transfers	0	0	(302)	(302)	(604)
Total	212,932	229,784	227,058	221,760	448,818
<u>Expenditures by Activity</u>					
Community & Family Health	178,825	190,631	186,703	181,563	368,266
Health Promo & Chronic Disease	26,557	30,686	32,224	32,066	64,290
Minority & Multicultural Hlth	7,550	8,467	8,131	8,131	16,262
Total	212,932	229,784	227,058	221,760	448,818
Full-Time Equivalent (FTE)	251.6	286.4	275.6	267.8	

Activity Description

Through partnerships with local and tribal governments, health care providers, and community organizations, this activity ensures a coordinated state and local public health infrastructure; works to improve the health of mothers, children, and families; promotes access to quality health care for vulnerable and underserved populations; and provides financial support, technical assistance, and accurate information to strengthen community-based health systems.

Population Served

The entire population of the state is served by this activity with special emphasis on: mothers and children (especially those experiencing the greatest disparities in health outcomes) and children with special health care needs and their families.

Services Provided

- ◆ Help local health departments fulfill a set of essential local public health activities by administering state and federal funding, providing technical assistance to local health boards and staff, and providing public health training to local public health staff.
- ◆ Improve the health and nutritional status of pregnant and postpartum women, infants, young children, and the elderly by providing nutrition education and counseling, foods to meet key nutritional needs, and referrals for health and social services.
- ◆ Maintain access to quality health care services by providing statewide grants for pre-pregnancy family planning services and by providing specialized medical assessments to children with chronic illness and disabilities.
- ◆ Improve the health and development of infants and children by supporting programs that provide early, comprehensive and on going screening, intervention and follow up.
- ◆ Improve pregnancy outcomes and enhance the health of pregnant and postpartum women and their infants by supporting programs that encourage early access to prenatal care, provide necessary support services, and increase knowledge of healthy behaviors.
- ◆ Assess and monitor maternal and child health status, including children with special health care needs.
- ◆ Collaborate with the public and private sectors for quality improvement and measurement of health status to ensure accountability.

Activity at a Glance

- ◆ Provide administrative oversight of approximately \$168 million in grant funds.
- ◆ Provide technical and financial assistance to the state's 53 local public health boards.
- ◆ Provide nutrition services and supplemental food to over 140,000 low-income pregnant women and young children.
- ◆ Provide commodity food products to over 14,000 children and seniors each month.
- ◆ Provide prenatal services to almost 11,000 women.
- ◆ Provide family planning services to almost 30,000 individuals.
- ◆ Provide services to more than 7,000 children with special health care needs.

Historical Perspective

The federal Women, Infant and Children (WIC) Program and Title V Maternal Child Health (MCH) Block Grant have long provided a foundation for ensuring the health of Minnesota's mothers and children. Minnesota enjoys some of the best health status and health system measures for mothers, infants, and children. However, there remain significant issues that need ongoing attention: disparities in health status based on race, ethnicity, and poverty; improved pregnancy outcomes; early identification and intervention services; oral health promotion; mental health promotion; and obesity reduction. Community and Family Health provides leadership, accountability, resources, and partnerships for continued work on these challenging issues.

The Office of Public Health Practice provides coordination and support to the local public health system which works in tandem with MDH to fulfill public health responsibilities. This interlocking system of state and local effort is critical to mounting an effective response to public health threats. Minnesota has delineated a set of essential local public health activities that characterize local roles for carrying out disease prevention, public health emergency preparedness, environmental health, health promotion, maternal and child health, and connecting people to needed health services.

HEALTH DEPT

Program: COMMUNITY & FAMILY HEALTH PROMOTION

Activity: COMMUNITY & FAMILY HEALTH

Narrative

Key Activity Goals

"All children get a healthy start in life" is a primary goal of this activity. This is one of the department's identified primary goals and is tracked under department results at www.departmentresults.state.mn.us/health/index.html.

Key Measures

These measures will help us achieve the goal of all children having a healthy start in life.

- ◆ Protect public health by increasing the level of essential local public health activities performed by all local health departments.

History	Current	Target
2006	2008	2010
47%	55%	75%

Source: Minnesota Department of Health

- ◆ Increase the percent of Minnesota parents with a child with a special health care need who report that their child has a "medical home". A "medical home" in this national telephone survey is defined as comprehensive, recurring medical care from a regular primary health care professional that assures that all the child's medical and non-medical needs are met.

History	Current	Target
2002	2008	2010
48%	52%	55%

Source: National Survey of Children with Special Health Care Needs – CDC

- ◆ Decrease the percentage of children, ages two to five years, receiving WIC services that are at risk for being overweight or who are overweight. (Body Mass Index [BMI] at or above the 85th percentile).

History	Current	Target
2002	2008	2010
29%	30%	28%

Source: Pediatric Nutrition Surveillance System - CDC

- ◆ Decrease the disparity in infant mortality rates for American Indians and populations of color as compared to whites.

Ethnicity	1995-1999	2001-2005	EHDI Target*
African American	13.2	9.3	9.4
American Indian	13.5	10.3	9.5
Asian/Pacific	7.1	4.8	6.3
Hispanic/Latino	7.0	4.9	6.3
White	5.5	4.4	--

*Target is 50% deduction in disparity between Populations of Color and White rate

Source: Minnesota Department of Health

Activity Funding

This activity is funded primarily from appropriations from the general fund, health care access fund, state government special revenue fund, and from various federal grants.

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HEALTH DEPT

Program: COMMUNITY & FAMILY HLTH PROMO

Activity: COMMUNITY & FAMILY HEALTH

Budget Activity Summary

<i>Dollars in Thousands</i>					
	Current		Governor's Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Carry Forward					
Miscellaneous Special Revenue	30	0	0	0	0
Direct Appropriations					
General	31,968	32,315	30,658	25,465	56,123
State Government Spec Revenue	633	1,418	1,033	1,033	2,066
Health Care Access	404	1,784	1,642	1,719	3,361
Federal Tanf	7,500	9,970	8,735	8,735	17,470
Statutory Appropriations					
Miscellaneous Special Revenue	471	960	542	543	1,085
Federal	137,818	144,162	144,093	144,068	288,161
Gift	1	22	0	0	0
Total	178,825	190,631	186,703	181,563	368,266
<u>Expenditures by Category</u>					
Total Compensation	8,537	9,910	9,710	9,630	19,340
Other Operating Expenses	6,408	8,813	7,711	7,844	15,555
Payments To Individuals	98,631	103,816	103,876	103,876	207,752
Local Assistance	65,249	68,092	65,406	60,213	125,619
Total	178,825	190,631	186,703	181,563	368,266
Full-Time Equivalents (FTE)	111.2	129.1	124.9	118.5	

Activity Description

The Health Promotion and Chronic Disease Division improves the health of all Minnesotans by implementing public health interventions to prevent and control chronic diseases and injuries, by monitoring the occurrence of chronic diseases and injuries, and by providing leadership in the development of statewide programs and policies to reduce the burden of tobacco use, obesity, injuries, cancer, heart disease, stroke, diabetes, asthma, arthritis, oral ill health, and other chronic diseases in Minnesota.

Population Served

This activity serves the entire population of Minnesota. Efforts are focused on youth, among whom prevention efforts have the biggest potential impact; on women, who are disproportionately disabled by chronic disease; and on American Indians and populations of color, who are more likely than white Minnesotans to die from chronic diseases and injuries.

Activity at a Glance

- ◆ Screened 17,200 low-income women for breast and cervical cancer in FY 2008, at more than 380 clinics across the state.
- ◆ Registered 24,260 newly-diagnosed invasive cancers in the Minnesota Cancer Surveillance System in 2005.
- ◆ Registered almost 7,500 people for the on-line Get Fit Twin Cities 2008 physical activity challenge, which included activity tracking, tips, resources, and incentives.
- ◆ Provided 21 grants in FY 2008 to community organizations and tribes to reduce youth exposure to tobacco influences and create tobacco-free environments.

Services Provided**Help Minnesotans adopt healthy behaviors to prevent and control chronic diseases and injuries:**

- ◆ Develop and disseminate innovative and effective policy, systems, and environmental health improvement strategies, consistent with best practices and statewide chronic disease prevention and control plans.
- ◆ Support health care providers and systems, public health agencies, community-based organizations, and employers in their prevention efforts.
- ◆ Fund and support community-driven interventions to reduce obesity, the use of tobacco, and exposure to secondhand smoke.
- ◆ Provide information to health care providers and the public about identifying and treating persons at risk for or affected by: cancer, diabetes, heart disease, stroke, asthma, arthritis, and traumatic brain and spinal cord injury.

Monitor the occurrence of cancer, stroke, injuries, and other chronic diseases:

- ◆ Operate a statewide system of surveillance for all newly-diagnosed cancer cases in the state.
- ◆ Examine and report on the disparities in and the prevalence and trends of heart disease, stroke, cancer, asthma, diabetes, obesity, tobacco use, injuries, and oral health.
- ◆ Identify workplace hazards, illnesses, and injuries and investigate work-related deaths.

Increase access to services and improve the quality of health care to reduce death and illness due to chronic diseases:

- ◆ Provide free breast and cervical cancer screening, follow-up cancer diagnostic services, and cardiovascular risk factor screening, referral, and counseling to medically underserved women.
- ◆ Work with health care providers to develop, accept, implement, and evaluate best practices to prevent, detect, and control chronic diseases and injuries.
- ◆ Provide physicians, individuals, and families with the tools to better manage asthma, diabetes, cancer, heart disease, stroke, and arthritis.
- ◆ Translate health research and information into practice.

Provide leadership in the development and maintenance of effective public/private partnerships to prevent and control chronic diseases and injuries:

- ◆ Facilitate effective collaborations and partnerships.
- ◆ Convene forums to identify common interests and foster action.

- ◆ Work with and support health care providers and systems, public health agencies, and other community-based organizations involved in statewide prevention and planning efforts.
- ◆ Support the implementation of statewide plans for heart disease, stroke, cancer, diabetes, asthma, arthritis, oral health, obesity, and injury and violence prevention with multiple partners.

Historical Perspective

Chronic diseases, such as cancer, heart disease, stroke, diabetes, and arthritis, are the leading causes of death and disability in Minnesota. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable; adopting healthy behaviors can prevent or control these diseases. Injuries are also a serious public health problem because of their health impact, including premature death, disability, and the burden on our health care system. Like many chronic diseases, many injuries are preventable.

Key Activity Goals

This activity supports the Minnesota Milestones statewide goal “Minnesotans will be healthy,” particularly the indicators for life expectancy, premature death, smoking and tobacco use, and suicide.

Key Activity Measures

- ◆ Reduce deaths from colorectal, cervical, lung, and female breast cancer through improvements in healthy behaviors, screening and treatment. (Mortality rate is number of deaths per 100,000, by year of diagnosis, age-adjusted.)

	History		Current	Target
	2000-01	2003-04	2005-06	2010
Colorectal	18.2	16.8	15.1	13.0
Cervical	1.4	1.8	1.6	1.0
Female Breast	25.7	22.6	21.4	19.0
Lung	46.8	46.5	45.0	44.0

Source: Minnesota Cancer Surveillance System based on deaths reported to the Center for Health Statistics

- ◆ Improve health by increasing the percent of Minnesota adults who meet national recommendations for healthy weight, physical activity, and fruit and vegetable consumption.

	History		Current	Target
	2003	2005	2007	2018
Healthy Weight	39%	39%	38%	47%
Physical Activity	49%	51%	49%	75%
Fruits & Vegetables	24%	24%	19%	48%

Source: Minnesota Behavior Risk Factor Surveillance Survey

- ◆ Improve youth health by reducing the percent of Minnesota high school youth who report that they have used tobacco in the last 30 days.

	History			Current	Target
	2000	2002	2005	2008	2011
Youth tobacco use	39%	34%	29%	avail. in Sept.	23%

Source: MN Youth Tobacco Survey

HEALTH DEPT

Program: COMMUNITY & FAMILY HEALTH PROMOTION

Activity: HEALTH PROMO & CHRONIC DISEASE

Narrative

- ◆ Eliminate racial and ethnic disparities in the burden of chronic disease and injury.

Breast and Cervical Cancer Screening	History		Current	MN Population 2007
	1995-99	2000-04	2007	
African American	2.5%	3.8%	5.1%	2.8%
American Indian	10.3%	6.4%	7.7%	0.9%
Asian	0.7%	1.1%	2.0%	2.4%
Latino	3.7%	7.7%	16.0%	2.0%

Sources: Sage Screening Program (percentage of women screened) and US Census Bureau population estimates (percentage of Minnesota women ages 40-64)

Heart Disease Mortality Rate	History		Current	2002-06 White Rate
	1995-99	2000-04	2002-06	
African American	221.6	159.4	147.0	146.1
American Indian	263.3	239.7	225.3	
Asian	112.4	71.4	72.5	
Latino	155.5	107.8	74.5	

Source: Deaths reported to the Minnesota Center for Health Statistics

Mortality rate is age-adjusted and per 100,000 population

Diabetes Mortality Rate	History		Current	2002-06 White Rate
	1995-99	2000-04	2002-06	
African American	59.7	54.6	53.4	22.4
American Indian	108.8	86.5	92.7	
Asian	21.1	22.5	20.6	
Latino	37.7	37.5	33.9	

Source: Deaths reported to the Minnesota Center for Health Statistics

Mortality rate is age-adjusted and per 100,000 population

Unintentional Injury Mortality Rate	History		Current	2002-06 White Rate
	1995-99	2000-04	2002-06	
African American	40.7	35.7	32.4	34.8
American Indian	75.8	95.4	88.5	
Asian	36.1	24.0	23.4	
Latino	40.2	31.0	27.9	

Source: Deaths reported to the Minnesota Center for Health Statistics

Mortality rate is age-adjusted and per 100,000 population

Activity Funding

This activity is funded primarily by federal funds and appropriations from the general fund.

Contact

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HEALTH DEPT

Program: COMMUNITY & FAMILY HLTH PROMO

Activity: HEALTH PROMO & CHRONIC DISEASE

Budget Activity Summary

	Current		Governor's Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<i>Dollars in Thousands</i>					
<u>Expenditures by Fund</u>					
Carry Forward					
Miscellaneous Special Revenue	2	155	0	0	0
Direct Appropriations					
General	8,022	9,399	7,837	7,837	15,674
State Government Spec Revenue	43	48	0	0	0
Health Care Access	0	0	6,000	6,000	12,000
Statutory Appropriations					
Miscellaneous Special Revenue	2,516	3,250	2,325	2,293	4,618
Federal	15,969	17,800	16,062	15,936	31,998
Gift	5	34	0	0	0
Total	26,557	30,686	32,224	32,066	64,290
<u>Expenditures by Category</u>					
Total Compensation	10,154	12,120	11,753	12,073	23,826
Other Operating Expenses	3,882	7,932	(9,079)	(16,132)	(25,211)
Payments To Individuals	3,553	3,392	2,954	2,954	5,908
Local Assistance	8,968	7,242	26,898	33,473	60,371
Transfers	0	0	(302)	(302)	(604)
Total	26,557	30,686	32,224	32,066	64,290
Full-Time Equivalents (FTE)	133.4	150.0	144.1	143.5	

Program Description

The Office of Minority and Multicultural Health exists to close the gap in health disparities affecting American Indians and populations of color in Minnesota and to improve the overall health of the state's racially and ethnically diverse communities.

Population Served

This activity serves Minnesota's tribal communities and populations of color. Disparities in health status between European majority and other populations in Minnesota exist. These disparities are a result of a complex interplay of many factors, including cultural barriers, access to health care, genetics, social conditions, and health behaviors.

Services Provided

Provide leadership to improve the health status of American Indians and populations of color in Minnesota:

- ◆ Develop and implement a comprehensive and coordinated plan to reduce health disparities.
- ◆ Build capacity to meet the needs of people of color in the areas of health promotion, disease prevention, and the health care delivery system.
- ◆ Promote workforce diversity and cultural proficiency in workplaces and health care settings.

Support local efforts to improve the health status of American Indians and populations of color in Minnesota:

- ◆ Award/manage grants and provide technical assistance to community organizations and tribal governments to address racial and ethnic health disparities.
- ◆ Assist communities to assess the public health needs of American Indians and populations of color and to close the Minnesota health disparity gap through solutions grounded in community asset strategies and interventions.
- ◆ Partner with existing Minnesota Department of Health (MDH) grant programs to increase their impact on closing health disparities gaps.

Ensure valid, available, and reliable data about the health status of American Indians and populations of color in Minnesota:

- ◆ Assess risk behaviors associated with health disparities.
- ◆ Establish measurable outcomes to track Minnesota's progress in reducing health disparities.
- ◆ Support ongoing research and studies regarding health status and concerns of American Indians and populations of color.
- ◆ Raise awareness of the recording and reporting of race/ethnicity health-related data.

Historical Perspective

MDH established the Office of Minority Health in 1993 to assist in improving the quality of health and eliminating the burden of preventable disease and illness in populations of color. In 2001, it became Office of Minority and Multicultural Health to reflect the ethnic specific focus on health with a multicultural approach to eliminating health disparities in populations of color and American Indians. The office works collaboratively with other divisions in MDH, other state departments, community-based agencies, health plans, and others to address the needs of populations of color and American Indians. In 2002, the Eliminating Health Disparities Initiative was launched.

Activity at a Glance

- ◆ Continue to track outcomes to measure Minnesota's progress toward reducing health disparities.
- ◆ Award grants (15 in 2008) to address immunizations for adults and children and infant mortality in American Indians and populations of color.
- ◆ Award grants (52 in 2008) to address breast and cervical cancer, HIV/AIDS and sexually transmitted infections, cardiovascular disease, diabetes, and unintentional injuries and violence in American Indians and populations of color.
- ◆ Award grants (21 in 2008) to promote healthy youth development by promoting healthy nutrition, and reduce infant mortality by addressing high teen pregnancies rates in American Indians and populations of color.
- ◆ Mobilize and work with American Indians and populations of color to practice healthy lifestyle choices.

HEALTH DEPT

Program: COMMUNITY & FAMILY HEALTH PROMOTION

Activity: MINORITY & MULTICULTURAL HEALTH

Narrative

Minnesota's population is becoming increasingly diverse. In the 1980 census, 3.4% of Minnesotans identified themselves as non-white or Hispanic/Latino; in the 2007 census estimate update, 14.7% did so.

Minnesota Population Change: 1980-2007

Racial/Ethnic Group	1980 Census	1990 Census	2000 Census ¹	2007 Census ¹	Average Annual Percent Change
African American	53,344	94,944	171,731	232,909	13%
American Indian	35,016	49,909	54,967	60,928	3%
Asian	32,226	77,886	143,947	182,473	18%
Hispanic	32,123	53,884	143,382	205,896	21%
White	3,935,770	4,130,395	4,400,282	4,640,074	1%
Total Population²	4,075,970	4,375,099	4,919,479	5,197,621	1%

Source: U.S. Bureau of Census

¹The population base for 2000 and 2005 Census data is using the "race alone."

²The population count for each racial/ethnic group does not add up to "Total Population" because Hispanic, who can be of any race, are counted in the racial groups and because "Some other race alone" and "Two or more races" categories are excluded from the table.

Key Activity Goals

This activity supports the Minnesota Milestones statewide goal "Minnesotans will be healthy," focusing on reducing racial and ethnic health disparities.

Priority Health Area	Disparity Status by Race/Ethnicity			
	African American	American Indian	Asian	Latino
Breast cancer deaths	Better	Lack of Data	No Disparity	Lack of Data
Cervical cancer deaths	Lack of Data	Lack of Data	No Disparity	Lack of Data
Cardiovascular Disease	Better	Better	Better	Better
Diabetes	Better	Better	Worse	Better
Healthy Youth Development	Better	Better	Better	Better
HIV/AIDS	Worse	Better	No Disparity	Better
Immunizations	Better	Better	Better	Better
Unintentional Injury	Better	Worse	Better	Better

Source: 2007 EHDI Legislative Report

Key Measures

- ◆ Improve health by decreasing the disparity in infant mortality rates for American Indians and populations of color, as compared to rates for whites.

Number of deaths of live-born infants before age one, per 1,000 births

Racial/Ethnic Group	History			Target	Progress
	1989-1993	1995-1999	2000-2004	2010	
American Indian	16.2	13.5	10.2	9.5	
Asian/Pacific Islander	6.2	7.1	5.0	6.3	Met Target
Black/African American	16.5	13.2	9.5	9.4	
Hispanic or Latino	7.3	7.0	5.3	6.3	Met Target
White Population	6.4	5.5	4.5	5.5	Met Target

Source: MDH Center for Health Statistics

HEALTH DEPT

Program: COMMUNITY & FAMILY HEALTH PROMOTION

Activity: MINORITY & MULTICULTURAL HEALTH

Narrative

Activity Funding

The office is funded by appropriations from the general fund and also receives federal funding.

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HEALTH DEPT

Program: COMMUNITY & FAMILY HLTH PROMO

Activity: MINORITY & MULTICULTURAL HLTH

Budget Activity Summary

<i>Dollars in Thousands</i>					
	Current		Governor's Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Direct Appropriations					
General	5,039	4,943	4,935	4,935	9,870
Federal Tanf	2,497	3,184	2,998	2,998	5,996
Statutory Appropriations					
Miscellaneous Special Revenue	14	145	5	5	10
Federal	0	193	193	193	386
Gift	0	2	0	0	0
Total	7,550	8,467	8,131	8,131	16,262
<u>Expenditures by Category</u>					
Total Compensation	578	764	742	742	1,484
Other Operating Expenses	207	558	339	339	678
Local Assistance	6,765	7,145	7,050	7,050	14,100
Total	7,550	8,467	8,131	8,131	16,262
Full-Time Equivalents (FTE)	7.0	7.3	6.6	5.8	

Program Description

The purpose of the Policy, Quality, and Compliance Program is to promote access to quality health care at a reasonable cost for Minnesotans; assess and report on the health of the population; and monitor compliance with laws and rules designed to protect the health and safety of Minnesota's nursing home residents, home care clients, hospital patients, and clients of certain allied health professional groups.

Budget Activities

- ◆ Compliance Monitoring
- ◆ Health Policy

HEALTH DEPT

Program: POLICY QUALITY & COMPLIANCE

Program Summary

	Current		Governor Recomm.		Biennium 2010-11
	FY2008	FY2009	FY2010	FY2011	
<i>Dollars in Thousands</i>					
<u>Direct Appropriations by Fund</u>					
General					
Current Appropriation	11,862	8,686	8,686	8,686	17,372
Technical Adjustments					
Approved Transfer Between Appr			2,760	2,760	5,520
Current Law Base Change			(3,926)	(3,926)	(7,852)
Fund Changes/consolidation			146	146	292
Transfers Between Agencies			208	208	416
Subtotal - Forecast Base	11,862	8,686	7,874	7,874	15,748
Governor's Recommendations					
Behavioral Risk Surveillance Survey		0	550	550	1,100
E-Health Initiative		0	350	350	700
Grant Elimination		0	(1,208)	(1,208)	(2,416)
2007 & 2008 Session Laws Adjustment		0	27	27	54
Total	11,862	8,686	7,593	7,593	15,186
State Government Spec Revenue					
Current Appropriation	13,469	13,920	13,920	13,920	27,840
Technical Adjustments					
Approved Transfer Between Appr			400	400	800
Current Law Base Change			(11)	(11)	(22)
One-time Appropriations			(209)	(209)	(418)
Program/agency Sunset			0	0	0
Subtotal - Forecast Base	13,469	13,920	14,100	14,100	28,200
Governor's Recommendations					
Adverse Health Events Program Fee		0	73	73	146
Total	13,469	13,920	14,173	14,173	28,346
Health Care Access					
Current Appropriation	10,748	17,894	17,894	17,894	35,788
Technical Adjustments					
Approved Transfer Between Appr			3,586	3,586	7,172
Biennial Appropriations			600	0	600
Current Law Base Change			167	(401)	(234)
Fund Changes/consolidation			(146)	(146)	(292)
One-time Appropriations			(9,018)	(9,018)	(18,036)
Subtotal - Forecast Base	10,748	17,894	13,083	11,915	24,998
Governor's Recommendations					
Health Reform - Essential Benefit Set		0	0	(540)	(540)
Total	10,748	17,894	13,083	11,375	24,458
Miscellaneous Special Revenue					
Current Appropriation	8,550	8,550	8,550	8,550	17,100
Subtotal - Forecast Base	8,550	8,550	8,550	8,550	17,100
Total	8,550	8,550	8,550	8,550	17,100

HEALTH DEPT

Program: POLICY QUALITY & COMPLIANCE

Program Summary

<i>Dollars in Thousands</i>					
	Current		Governor Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Carry Forward					
State Government Spec Revenue	785	10	0	0	0
Health Care Access	296	0	0	0	0
Direct Appropriations					
General	12,441	8,771	7,593	7,593	15,186
State Government Spec Revenue	10,436	14,278	14,173	14,173	28,346
Health Care Access	11,311	23,558	13,083	11,375	24,458
Open Appropriations					
Health Care Access	22	32	32	32	64
Miscellaneous Special Revenue	148	254	150	150	300
Statutory Appropriations					
Miscellaneous Special Revenue	17,998	19,405	13,104	13,063	26,167
Federal	2,833	4,230	3,675	3,643	7,318
Medical Education & Research	83,885	79,399	86,642	96,489	183,131
Gift	0	42	0	0	0
Total	140,155	149,979	138,452	146,518	284,970
<u>Expenditures by Category</u>					
Total Compensation	22,990	25,181	24,566	24,520	49,086
Other Operating Expenses	15,493	21,950	18,399	16,664	35,063
Payments To Individuals	1,304	1,880	1,512	1,512	3,024
Local Assistance	99,532	95,504	93,898	103,745	197,643
Other Financial Transactions	836	5,464	0	0	0
Transfers	0	0	77	77	154
Total	140,155	149,979	138,452	146,518	284,970
<u>Expenditures by Activity</u>					
Compliance Monitoring	24,275	26,748	24,987	24,997	49,984
Health Policy	115,880	123,231	113,465	121,521	234,986
Total	140,155	149,979	138,452	146,518	284,970
Full-Time Equivalent (FTE)	288.7	295.2	279.7	267.5	

Activity Description

The Compliance Monitoring Division monitors compliance with laws and rules designed to protect the health and safety of Minnesota's nursing home residents, home care clients, hospital patients, developmentally disabled clients, enrollees of health maintenance organizations and county based purchasing plans, and clients of certain allied health professional groups.

Population Served

This activity serves patients, consumers, and providers of health care services; state and local policy makers.

Services Provided

- ◆ Monitor compliance with federal and state laws and rules designed to protect health and safety, through unannounced inspections and surveys.
- ◆ Investigate reports of maltreatment in accordance with the Vulnerable Adult Act and other complaints of abuse, neglect, or maltreatment; investigate complaints against HMOs filed by enrollees and providers.
- ◆ Conduct reviews of requests for set-asides of criminal /maltreatment cases.
- ◆ Approve architectural and engineering plans for all new construction or remodeling of health care facilities to assure that the facilities' physical plants meet life safety and health standards.
- ◆ Conduct annual reviews of at least 15% of Medicaid and private pay residents in certified nursing facilities to verify that payment classification matches acuity needs.
- ◆ Regulate funeral service providers to ensure the proper care and disposition of the dead.
- ◆ Regulate individuals who want to practice as audiologists, hearing instruments dispensers, speech language pathologists, and occupational therapists.
- ◆ Regulate HMOs and County Based Purchasing entities to ensure compliance with statutes and rules governing financial solvency, quality assurance, and consumer protection.
- ◆ Respond to several thousand calls annually seeking information and assistance from the health information clearinghouse.
- ◆ Provide information to regulated entities regarding current standards.

Activity at a Glance

- ◆ Monitor 7260 health care facilities and providers for safety and quality
- ◆ Review qualifications and regulate more than 5,000 allied health practitioners
- ◆ Monitor ten health maintenance organizations (HMOs) and three county based purchasing organizations that provide health care services to 1.2 million Minnesotans
- ◆ Conduct hospital and nursing home construction plan reviews.
- ◆ Ensure criminal background checks are conducted on 136,000 applicants for employment in health care facilities.
- ◆ Maintain a registry of more than 53,000 nursing assistants.
- ◆ Maintain the nursing home report card web site, which has had more than 107,000 visits since it was introduced in January 2006.
- ◆ Inspect 350 funeral establishments and license 1300 morticians and funeral directors each year.

Historical Perspective

Housing with services providers are the fastest growing industry in the long-term care arena. This is reflective of consumer desires for less institutional care and more demand for community-based options by the elderly. Compliance monitoring is working with providers, consumer representatives, and advocates to determine the proper alignment of regulatory activities to assure consumers safety while maintaining affordable fees to support the regulation. In addition, division staff members have been involved with numerous projects to develop additional options along a "care continuum," including the "Care Center of the Future" project, the Culture Change Coalition, Transform 2010, and the Community Consortium project.

Key Activity Goals

- ◆ Ensuring quality care in nursing homes and other health care facilities--see department website at <http://www.health.state.mn.us/about/mission.html>
- ◆ Preparing for an aging population--develop regulatory infrastructure that will be needed as we change from nursing homes to home care.

- ◆ Prevent nearly 1,900 persons from working in health care facilities due to past maltreatment, neglect, or other disqualifying activity.

Key Activity Measures

- ◆ Remain below the current national average of 48% of low risk residents that are incontinent and to reduce to 42% by 2013 – see the department results website at: http://www.departmentresults.state.mn.us/health/DeptDetail.htm#Everyone_living_healthy_from_adolescence_into_old_age. This is important because incontinence is often a pivotal factor in determining whether a person can live at home or needs care in a facility. In addition, incontinence increases the risk of skin breakdown and pressure ulcers.
- ◆ Continue to meet the two indicators under the federal Government Performance Results Act (GPRA) for nursing facilities collectively in the state. The first is to have no more than 6.4% of patients whose care assessments indicate the use of physical restraints; Minnesota currently satisfies this overall goal at 3.5%. The second is for no more than 8.8% of patients whose care assessments indicate pressure ulcers; Minnesota currently satisfies this overall goal at 6.1% of residents with pressure ulcers. The additional goal for both measures is to increase compliance so that each nursing home meets these goals.

Activity Funding

This activity is funded primarily by federal funding, the state government special revenue fund and the general fund.

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HEALTH DEPT

Program: POLICY QUALITY & COMPLIANCE

Activity: COMPLIANCE MONITORING

Budget Activity Summary

<i>Dollars in Thousands</i>					
	Current		Governor's Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Carry Forward					
State Government Spec Revenue	478	0	0	0	0
Direct Appropriations					
General	165	171	2,994	2,994	5,988
State Government Spec Revenue	6,197	8,932	9,577	9,577	19,154
Statutory Appropriations					
Miscellaneous Special Revenue	16,997	17,248	12,020	12,030	24,050
Federal	438	397	396	396	792
Total	24,275	26,748	24,987	24,997	49,984
<u>Expenditures by Category</u>					
Total Compensation	15,448	16,021	15,835	15,845	31,680
Other Operating Expenses	8,707	10,727	9,075	9,075	18,150
Local Assistance	120	0	0	0	0
Transfers	0	0	77	77	154
Total	24,275	26,748	24,987	24,997	49,984
Full-Time Equivalent (FTE)	186.1	180.4	170.0	159.7	

Activity Description

The Health Policy Division provides policy research, analysis, design, and implementation of programs and reforms to improve health care value, quality, and accessibility. We promote access to quality, affordable health care for vulnerable, underserved, and rural populations. We streamline and reduce health care administrative burdens and costs; accelerate electronic health records and e-prescribing use; provide financial and technical assistance to community-based health systems; improve vital records data collection and distribution; and support medical professionals' training. We assess and report on population health, adverse health events, the health care marketplace, and workforce issues to help target programs and funding to their best use.

Population Served

We serve all Minnesota citizens, including health care providers, purchasers, payers, and policy makers.

Services Provided

- ◆ Provide support of health reforms, including payment system reforms, performance measurement, and increased transparency of health care quality and cost.
- ◆ Assist health care payers and providers to standardize administrative processes to reduce health care costs.
- ◆ Conduct surveys and perform research to inform policy makers; analyze data to monitor and understand access; health market conditions, trends and competition; health care spending; and capital expenditures.
- ◆ Conduct surveys and report on health status, trends, disparities, health behaviors, conditions, and disease.
- ◆ Collaborate with health care organizations, providers and consumers to provide informatics leadership and technical assistance to meet statutory mandates for use of health information technology.
- ◆ Administer the statewide trauma system, including trauma hospital designations, collection and analysis of trauma data for statewide system improvement, and interagency coordination. Provide consultative and technical expertise to hospitals caring for trauma patients
- ◆ Provides \$40-\$50 million in funds each year to clinical health professional training sites in Minnesota.
- ◆ Maintain statewide access to quality health care services by directing state and federal assistance to Minnesota's safety net health care providers, including community clinics and rural providers.
- ◆ Analyze and report on Minnesota's rural and underserved urban health care delivery system and health workforce in order to focus planning for future needs.
- ◆ Collect information on adverse health events in Minnesota hospitals and ambulatory surgical centers; and provide information to providers, health plans, patients, and others about patient safety in Minnesota.
- ◆ Maintain birth and death records which are needed by citizens who need records for legal purposes and used by researchers to enhance timely response to public health issues.

Historical Perspective

Private and public health care spending in Minnesota totals over \$35 billion annually and is the state's single fastest growing budget item. To fight this trend, the Health Policy Division has significant new responsibilities for implementing health care payment reform, administrative simplification, and e-health mandates. The division gives technical assistance in the development of state health policy by serving as an unbiased source of timely information and analysis to policymakers. The staff monitors key indicators such as the rate of uninsurance, overall health care spending, the rate of growth of health insurance premiums, and the use of health information

Activity at a Glance

- ◆ Track and report health care cost growth and trends in the health care marketplace.
- ◆ Produce more than 500,000 legal birth and death certificates each year.
- ◆ Identify e-health standards and best practices required to meet the 2015 interoperable electronic health record mandate.
- ◆ Adopt rules for standard health care electronic transactions for providers and payers.
- ◆ Conduct surveys to determine insurance coverage and access to health care.
- ◆ Monitor and report on the prevalence of adverse events in Minnesota hospitals.
- ◆ Provide grants and loan forgiveness to support medical education activities.
- ◆ Provide grant funding and technical support to health care providers to accelerate the adoption of health information technology.

technologies (e.g., electronic health records and e-prescribing) to help policy makers understand how and why the health care delivery system changes over time as well as the potential impacts of proposed policy changes.

The division also supports the statewide health care safety net, rural providers, providers in the underserved urban areas, and the statewide trauma system through planning, analysis, and program efforts that support quality patient care, stabilize and strengthen the health care system, build up the health care workforce, encourage regional cooperation, and support information technology development.

Key Goals

The division meets the goals to keep Minnesotans healthy and strengthen our health care system by developing and implementing health reforms and ongoing programmatic efforts designed to: improve health care payment systems to ensure we are paying for superior performance—not just procedures; reduce administrative costs; accelerate standard, interoperable, secure exchange of clinical data to improve health and reduce costs; provide more affordable health coverage arrangements to help more Minnesotans get insured; provide financial and technical assistance to strengthen community-based health systems; improve vital records data collection and analysis to enhance response to public health issues; support medical professionals' training; and other initiatives that provide information to consumers, policy makers, health professionals, payers, and purchasers.

Key Measures

- ◆ Support the development of health policy in Minnesota that will reduce the rate of uninsured Minnesotans in 2011 below the 2004 rate.

History	Current	Target
2004	2007	2011
7.7%*	7.2%*	4.0%

Source: MN Health Access Survey 2007 and 2004

- ◆ Improve safety and health outcomes by improving the Minnesota Ranking in terms of the percentage of prescriptions routed electronically.

History	Current	Target
2005	2007	2011
0.00%	1.20%	80.00%
Rank 42	Rank 26	Rank in Top 10 States

Source: SureScripts / RXHub and MDH

- ◆ Improve health outcomes by increasing the number of hospitals participating in a statewide trauma system and registry.

History	Current	Target
2006	2008	2010
0%	25%	70%

Source: Office of Rural Health and Primary Care

Activity Funding

This activity is funded from direct appropriations from state government special revenue fund, the general fund, the health care access fund; medical education and research costs funds, special revenue funds, federal and private grants and contracts.

Contact

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HEALTH DEPT

Program: POLICY QUALITY & COMPLIANCE

Activity: HEALTH POLICY

Budget Activity Summary

<i>Dollars in Thousands</i>					
	Current		Governor's Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Carry Forward					
State Government Spec Revenue	307	10	0	0	0
Health Care Access	296	0	0	0	0
Direct Appropriations					
General	12,276	8,600	4,599	4,599	9,198
State Government Spec Revenue	4,239	5,346	4,596	4,596	9,192
Health Care Access	11,311	23,558	13,083	11,375	24,458
Open Appropriations					
Health Care Access	22	32	32	32	64
Miscellaneous Special Revenue	148	254	150	150	300
Statutory Appropriations					
Miscellaneous Special Revenue	1,001	2,157	1,084	1,033	2,117
Federal	2,395	3,833	3,279	3,247	6,526
Medical Education & Research	83,885	79,399	86,642	96,489	183,131
Gift	0	42	0	0	0
Total	115,880	123,231	113,465	121,521	234,986
<u>Expenditures by Category</u>					
Total Compensation	7,542	9,160	8,731	8,675	17,406
Other Operating Expenses	6,786	11,223	9,324	7,589	16,913
Payments To Individuals	1,304	1,880	1,512	1,512	3,024
Local Assistance	99,412	95,504	93,898	103,745	197,643
Other Financial Transactions	836	5,464	0	0	0
Total	115,880	123,231	113,465	121,521	234,986
Full-Time Equivalent (FTE)	102.6	114.8	109.7	107.8	

Program Description

The purpose of the Health Protection Program is to protect the public from dangerous diseases, exposures, and events through monitoring and assessment of health threats; developing and evaluating intervention strategies to combat disease and exposures; monitoring and inspections of potential health problems; and providing scientific laboratory, environmental health, and epidemiological capacity.

Budget Activities

- ⇒ Environmental Health
- ⇒ Infectious Disease Epidemiology, Prevention & Control
- ⇒ Public Health Laboratory
- ⇒ Office of Emergency Preparedness

HEALTH DEPT

Program: HEALTH PROTECTION

Program Summary

<i>Dollars in Thousands</i>					
	Current		Governor Recomm.		Biennium 2010-11
	FY2008	FY2009	FY2010	FY2011	
<i>Direct Appropriations by Fund</i>					
General					
Current Appropriation	15,335	10,506	10,506	10,506	21,012
Technical Adjustments					
Approved Transfer Between Appr			(1,032)	(1,032)	(2,064)
Pt Contract Base Reduction			(7)	(7)	(14)
Subtotal - Forecast Base	15,335	10,506	9,467	9,467	18,934
Governor's Recommendations					
Tuberculosis Prevention and Control		0	200	200	400
2007 & 2008 Session Laws Adjustment		0	263	263	526
Total	15,335	10,506	9,930	9,930	19,860
State Government Spec Revenue					
Current Appropriation	27,475	28,972	28,972	28,972	57,944
Technical Adjustments					
Approved Transfer Between Appr			(758)	(758)	(1,516)
Current Law Base Change			89	89	178
Subtotal - Forecast Base	27,475	28,972	28,303	28,303	56,606
Governor's Recommendations					
Food Manager Certification Program		0	163	163	326
Food, Beverage, & Lodging Program		0	823	823	1,646
Youth Camp Licence & Inspection Program		0	50	50	100
Manufactured Home Parks & Rec Camping		0	320	320	640
X-Ray Program Fee		0	250	250	500
Lead Program-Pre-Renovation & Renovation		0	100	100	200
Infected Health Care Workers Program		0	50	50	100
Environmental Certification Fee		0	150	150	300
Total	27,475	28,972	30,209	30,209	60,418
Clean Water Fund					
Current Appropriation	0	0	0	0	0
Subtotal - Forecast Base	0	0	0	0	0
Governor's Recommendations					
Drinking Water Contaminants		0	445	890	1,335
Source Water Protection		0	805	1,610	2,415
Total	0	0	1,250	2,500	3,750

HEALTH DEPT

Program: HEALTH PROTECTION

Program Summary

<i>Dollars in Thousands</i>					
	Current		Governor Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Carry Forward					
State Government Spec Revenue	58	368	0	0	0
Miscellaneous Special Revenue	211	437	0	0	0
Direct Appropriations					
General	14,528	10,518	9,930	9,930	19,860
Petroleum Tank Release Cleanup	1	0	0	0	0
State Government Spec Revenue	25,324	29,617	30,209	30,209	60,418
Remediation Fund	824	280	0	0	0
Clean Water Fund	0	0	1,250	2,500	3,750
Open Appropriations					
State Government Spec Revenue	157	174	174	174	348
Statutory Appropriations					
Drinking Water Revolving Fund	474	521	521	521	1,042
Miscellaneous Special Revenue	7,236	11,195	7,055	7,063	14,118
Federal	49,380	43,676	42,435	42,106	84,541
Gift	7	35	0	0	0
Total	98,200	96,821	91,574	92,503	184,077
<u>Expenditures by Category</u>					
Total Compensation	44,705	45,853	46,255	46,735	92,990
Other Operating Expenses	34,839	36,003	30,714	30,953	61,667
Payments To Individuals	10	24	24	24	48
Local Assistance	18,646	14,941	14,895	15,105	30,000
Transfers	0	0	(314)	(314)	(628)
Total	98,200	96,821	91,574	92,503	184,077
<u>Expenditures by Activity</u>					
Environmental Health	33,676	34,880	35,551	36,480	72,031
Infect Disease Epid Prev Cntrl	22,830	24,222	20,679	20,679	41,358
Public Health Laboratory	17,829	21,883	19,431	19,431	38,862
Office Emergency Preparedness	23,865	15,836	15,913	15,913	31,826
Total	98,200	96,821	91,574	92,503	184,077
Full-Time Equivalents (FTE)	609.5	584.3	577.6	567.2	

Activity Description

Environmental health programs are an integral part of Minnesota's public health system, working to prevent, control, mitigate and respond to health hazards in the environment. We assure that Minnesotans have safe drinking water and food, and are protected from hazardous materials in their homes, workplace, and communities. We identify and respond to emerging environmental health threats and public health emergencies. As research sheds light on environmental hazards and on the environment's impact on overall health, the public increasingly looks toward the environmental health community for its expertise and leadership.

Population Served

This activity serves the entire population of Minnesota by ensuring that all Minnesotans have clean drinking water, safe food, sanitary lodging, and are protected from hazardous materials in their homes and the environment. In the event of natural disasters, such as floods, drinking water contamination or nuclear power plant emergencies, the affected area is directly served.

Services Provided**Prevent health risks by protecting the quality of water:**

- ◆ Monitor public drinking water systems.
- ◆ Inspect water well construction and sealing.
- ◆ License professions impacting drinking water.
- ◆ Educate citizens regarding safe drinking water.

Prevent health risks by protecting the safety of food:

- ◆ Inspect food establishments to ensure safe food handling and certify professionals in food safety.
- ◆ Monitor and assist community-based delegated programs for food, beverage and lodging establishments.
- ◆ Educate citizens and professionals regarding the safe handling of food.
- ◆ Develop guidelines for the safe consumption of fish.

Prevent health risks by protecting the quality of indoor environments and public swimming pool safety:

- ◆ License and inspect public swimming pools and spas. Educate owners and operators in safe pool operations.
- ◆ Develop standards for safe levels of contaminants in air and abatement methods for asbestos and lead.
- ◆ Monitor the exposure of citizens to lead and issue guidelines on screening and treatment.
- ◆ Ensure that the provisions of the MN Clean Indoor Air Act are equitably enforced.
- ◆ Inspect and monitor lodging, manufactured home parks, and recreational camping areas.
- ◆ Educate citizens, communities, and medical professionals.

Respond to emerging health risks:

- ◆ Focus attention on children to ensure they are protected from harmful chemicals and other hazards.
- ◆ Evaluate human health risks from chemical and physical agents in the environment.
- ◆ Develop a birth conditions information system to understand, treat, and prevent birth defects
- ◆ License and inspect the use of radioactive materials and x-ray equipment.

Activity at a Glance

- ◆ Respond to environmental health threats during natural disasters and biological, chemical and radiological emergencies.
- ◆ Test drinking water at more than 8,000 public water systems. 95% of Minnesotans served by community water systems receive water that meets or exceeds all health-based drinking water standards.
- ◆ Test private wells and issue drinking water advisories in areas of contaminated groundwater. In 2007, 278 private wells were sampled and 889 results letters were issued in regard to the East Metro PFC and TCE contamination.
- ◆ Assure safe food, drinking water, lodging, and swimming pools in 21,000 licensed restaurants and hotels statewide. 8300 certified food managers (CFM) are registered annually; there are currently 28,195 CFM's in the state.
- ◆ Assure asbestos and well contractors comply with codes for their work, which are both currently at a 96% compliance rate.
- ◆ Promote radon awareness and mitigation in homes. Work with state building code officials to establish radon resistant new construction requirements.

HEALTH DEPT**Program: HEALTH PROTECTION****Activity: ENVIRONMENTAL HEALTH**

Narrative

- ◆ Assess and prevent possible human health risks from accidental spills, waste disposal, and agricultural and industrial activities.
- ◆ Develop health education programs and information materials for communities.

Historical Perspective

Minnesota's first public health laws, passed in 1872, focused on environmental health threats – the provision of safe drinking water, sewage disposal, wastewater treatment, and milk sanitation. Since 1900, the average lifespan of people in the United States has lengthened by 25 years due to advances in public health, many of which involved environmental health protection. Clean water and improved sanitation have resulted in the control of infectious diseases. Improvement in food preparation procedures and a decrease in food and environmental contamination have resulted in safer and healthier foods. Today, the department continues prevention efforts to ensure the environmental health and safety of Minnesotans are protected at home, at work, and in public places.

Key Activity Goals

Environmental Health activities respond to Minnesota Milestones: *Minnesotans will be healthy, Minnesotans will conserve natural resources to give future generations a healthy environment and a strong economy; and Minnesotans will improve the quality of the air, water and earth.* In addition, MDH's Environmental Health activities respond to two departmental goals: 1) *all children get a healthy start in life;* and 2) *prepare for emergencies.*

Key Activity Measures

- ◆ Prevent ground water contamination sealing unused, abandoned wells.

	History	Past	Current	Target	Target
	1987	2000	2008	2011	2050
Number of wells sealed (cumulative)	3,275	149,000	200,000	240,000	750,000 (est.)

Source: MDH well sealing records, reported as required by licensed well contractors

- ◆ Reduce health disparities by decreasing the % of children with elevated blood lead levels (above 10µg/dl).

	Baseline	Past	Current	Target
	1995	2003	2007	2010
Elevated blood lead reported	11.6%	2.7%	1.2%	0%

Source: MDH Environmental Surveillance and Assessment Section

- ◆ Assess 100% of Minnesota newborn children for 46 birth conditions (birth defects & fetal alcohol syndrome).

	Baseline	Past	Current	Target
	2006	2007	2008	2011
Percent of MN newborns assessed for birth defects	32%*	36%	40% (est.)	50%

Source: MDH Environmental Surveillance and Assessment Section; *Live births annually in MN total approx. 73,000.

Activity Funding

The division is funded by appropriations from the state government special revenue fund and the general fund. In addition, the division also receives federal funds, special revenue funds, drinking water revolving fund, and resources from other miscellaneous funds.

HEALTH DEPT

Program: HEALTH PROTECTION

Activity: ENVIRONMENTAL HEALTH

Narrative

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HEALTH DEPT

Program: HEALTH PROTECTION

Activity: ENVIRONMENTAL HEALTH

Budget Activity Summary

<i>Dollars in Thousands</i>					
	Current		Governor's Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Carry Forward					
State Government Spec Revenue	58	15	0	0	0
Direct Appropriations					
General	3,358	3,389	3,029	3,029	6,058
Petroleum Tank Release Cleanup	1	0	0	0	0
State Government Spec Revenue	18,701	21,170	22,204	22,204	44,408
Remediation Fund	824	280	0	0	0
Clean Water Fund	0	0	1,250	2,500	3,750
Open Appropriations					
State Government Spec Revenue	157	174	174	174	348
Statutory Appropriations					
Drinking Water Revolving Fund	474	521	521	521	1,042
Miscellaneous Special Revenue	1,571	1,049	336	344	680
Federal	8,532	8,282	8,037	7,708	15,745
Total	33,676	34,880	35,551	36,480	72,031
<u>Expenditures by Category</u>					
Total Compensation	20,217	21,003	21,776	22,256	44,032
Other Operating Expenses	11,979	12,906	12,975	13,214	26,189
Local Assistance	1,480	971	1,114	1,324	2,438
Transfers	0	0	(314)	(314)	(628)
Total	33,676	34,880	35,551	36,480	72,031
Full-Time Equivalents (FTE)	267.9	255.8	253.4	247.0	

Activity Description

The Infectious Disease Epidemiology, Prevention and Control (IDEPC) Division provides statewide leadership to protect Minnesotans from infectious diseases. We assure Minnesotans are safe from infectious diseases by detecting, investigating and mitigating outbreaks. We prevent infectious diseases by promoting and distributing vaccines, providing TB medications, coordinating refugee screenings, and providing funding for STD and HIV testing.

Population Served

All residents of Minnesota are served by this activity. Specific target populations include infants and children, adolescents, high-risk adults, refugees, immigrants and other foreign-born individuals, restaurant workers, and patients in hospitals and long-term care facilities.

Services Provided**Respond to Public Health Threats:**

- ◆ Monitor for unusual patterns of infectious disease.
- ◆ Lead efforts to detect and control pandemic influenza.
- ◆ Establish systems to implement isolation and quarantine provisions of the Minnesota Emergency Health Powers Act.

Detect, investigate, and mitigate infectious disease outbreaks:

- ◆ Maintain a 24/7 system to detect and investigate cases of infectious disease.
- ◆ Analyze disease reports to detect outbreaks, identify the cause, and implement control measures.
- ◆ Alert health professionals and the public about outbreaks and how to control them.
- ◆ Help medical professionals manage persons ill with, or exposed to, infectious disease.
- ◆ Maintain food-borne illness hotline to receive citizen complaints and detect outbreaks.
- ◆ Manage treatment of and provide medications for tuberculosis (TB) patients to prevent spread of disease.
- ◆ Provide vaccines and other biologics to prevent and control outbreaks of vaccine-preventable disease.
- ◆ Conduct follow-up activities to facilitate testing, treatment, and counseling of HIV, STDs, and TB patients and their contacts to prevent disease transmission.
- ◆ Provide technical support to localities dealing with infectious diseases; MDH field epidemiologists serve in eight regions across the state.

Prevent infectious disease:

- ◆ Distribute publicly purchased vaccines for children whose families are unable to afford them.
- ◆ Coordinate medical screening programs for newly arrived refugees.
- ◆ Provide leadership for development of a statewide immunization information system.
- ◆ Conduct specialized studies on diseases of high concern to the public and the medical community.
- ◆ Educate health care providers on management of infectious diseases via the web, through publications, and by direct telephone consultation (24/7 on-call system).
- ◆ Educate the public, including high-risk populations, on disease testing, treatment, and prevention methods.
- ◆ Provide grants to local public health agencies and nonprofit organizations for prevention activities.

Activity at a Glance

- ◆ Maintain systems to respond to biological terrorism and other emergencies.
- ◆ Detect state and national outbreaks such as *E. coli* O157:H7 associated with pre-packaged salads, spinach, and jalapeños.
- ◆ Investigate intestinal disease outbreaks (more than 4,000 persons were affected in 2007).
- ◆ Provide funding for STD and HIV testing (In 2006, Minnesota Department of Health (MDH) funded clinics that tested more than 28,000 people for STDs, treated more than 2,600 infected persons, and tested 11,000 people for HIV).
- ◆ Coordinate programs to immunize 70,000 babies annually to prevent serious diseases.
- ◆ Manage treatment for TB cases (238 in 2007 and evaluated 1,109 contacts to cases).
- ◆ Investigate the spread of West Nile virus (101 cases and two deaths in 2007).
- ◆ Coordinate health screenings for newly arrived refugees-in 2007, 98% received a screening within three months of arrival.

HEALTH DEPT

Program: HEALTH PROTECTION

Activity: INFECTIOUS DISEASE EPIDEMIOLOGY PREVENTION & CONTROL

Narrative

- ◆ Involve high-risk communities, health care providers, and concerned citizens in responding to infectious disease challenges. Advisory committees have been established to address vaccines, TB, and HIV/STD.

Key Activity Goals

- ◆ **Minnesota Milestones Goal: Minnesotans will be healthy.** Detecting and controlling infectious disease is critical to ensuring Minnesotans are healthy. For example, years of potential life lost to HIV/AIDS have decreased over the last decade due to public health interventions and improved treatment. Refugee health screenings identify and treat health problems that may interfere with resettlement and protect the health of all Minnesotans. Vaccine-preventable diseases are at historic lows as a result of immunization. Investigation of food-borne illness results in activities to prevent future outbreaks.

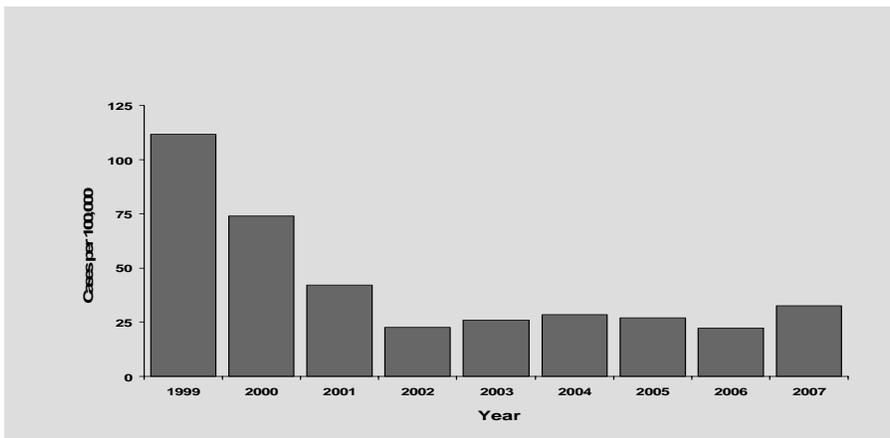
Key Measures

- ◆ **Increase the percent of new TB patients who complete therapy in 12 months.** Completion of TB therapy prevents spread and reduces the development of resistant strains of TB. State funding for TB medication allows MDH to distribute medications without cost to the patient to reduce barriers to completion of therapy.

1996	2000	2002	2004	2006	2010 (Target)
63% (n=78)	79% (n=136)	84% (n=184)	93% (n=188)	91 % (n=199)	94%

Source: MDH Tuberculosis Annual Progress Report

- ◆ **Increased use of a vaccine against pneumococcus.** This vaccine, which protects against meningitis and blood poisoning, has reduced serious pneumococcal infections in children less than five years old by **75%**. MDH makes the pneumococcal vaccine available without cost barriers by administering the federal Vaccines for Children Program. Minnesota distributed \$26 million in vaccine in 2007 through this program.



Source: MDH Infectious Disease Surveillance System.

Activity Funding

The division is funded primarily from federal funds and appropriations from the general fund.

HEALTH DEPT

Program: HEALTH PROTECTION

Activity: INFECTIOUS DISEASE EPIDEMIOLOGY PREVENTION &
CONTROL

Narrative

Contact

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HEALTH DEPT

Program: HEALTH PROTECTION

Activity: INFECT DISEASE EPID PREV CNTRL

Budget Activity Summary

<i>Dollars in Thousands</i>					
	Current		Governor's Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Carry Forward					
Miscellaneous Special Revenue	0	48	0	0	0
Direct Appropriations					
General	4,809	4,473	4,535	4,535	9,070
State Government Spec Revenue	150	172	214	214	428
Statutory Appropriations					
Miscellaneous Special Revenue	1,310	4,094	1,875	1,875	3,750
Federal	16,554	15,401	14,055	14,055	28,110
Gift	7	34	0	0	0
Total	22,830	24,222	20,679	20,679	41,358
<u>Expenditures by Category</u>					
Total Compensation	11,873	11,927	11,270	11,270	22,540
Other Operating Expenses	6,223	8,439	5,742	5,742	11,484
Payments To Individuals	10	24	24	24	48
Local Assistance	4,724	3,832	3,643	3,643	7,286
Total	22,830	24,222	20,679	20,679	41,358
Full-Time Equivalent (FTE)	170.2	166.5	156.2	152.2	

Activity Description

The Minnesota Public Health Laboratory (PHL) provides testing and data used by public health partners for detection, assessment, and control of biological, chemical, and radiological threats. In addition, the PHL screens all babies born in the state for rare, life-threatening congenital and heritable disorders that are treatable if detected soon after birth. The PHL also certifies all laboratories that conduct regulated environmental testing in Minnesota.

Population Served

All residents of Minnesota are served by the PHL. The PHL collaborates with local, state, and federal officials; public and private hospitals; laboratories; and other entities throughout the state to analyze environmental samples, screen newborns, provide reference testing for infectious disease agents, and analyze specimens for diagnosing rare infectious diseases (e.g., rabies).

Services Provided**Environmental Health**

- ◆ Analysis of air, water, wastewater, sludge, sediment, soil, wildlife, vegetation, and hazardous waste for chemical and bacterial contaminants in partnership with local and state government agencies.
- ◆ Certification of public and private environmental laboratories that conducts testing for the federal safe drinking water, clean water, resource conservation and recovery, and underground storage tank programs in Minnesota.
- ◆ Reference and confirmatory testing of environmental samples using scientific expertise and state-of-the-art methods not available in other laboratories.

Infectious Disease

- ◆ Surveillance, reference and confirmatory testing of clinical specimens for infectious bacteria, parasites, fungi, and viruses, including potential pandemic influenza.
- ◆ Early detection of infectious disease outbreaks, and identification of infectious agents through the use of high-tech molecular methods such as DNA fingerprinting, amplification, and sequencing.

Newborn Screening

- ◆ Screening of all Minnesota newborns for over 50 treatable congenital and heritable disorders, including hearing.

Emergency Preparedness and Response

- ◆ Emergency preparedness and response in collaboration with public health and public safety officials at the local, state, and federal levels to assure early detection and rapid response to all hazards, including agents of chemical, radiological, and biological terrorism.
- ◆ Participation on Minnesota's radiochemical emergency response team, which responds in the event of a release of radioactive chemicals at Minnesota's nuclear power plants.
- ◆ Development and maintenance of the "Minnesota Laboratory System" to assure that public and private laboratories are trained for early recognition and referral of possible agents of chemical and biological terrorism, as well as other public health threats.
- ◆ Help ensure the safety of the public by hosting the federal BioWatch air-monitoring program.
- ◆ Designated by CDC as one of ten Level 1 Chemical Terrorism preparedness laboratories.
- ◆ Working with six other states to create capacity to exchange pandemic flu testing data electronically.

Activity at a Glance

- ◆ Analyzed 48,889 clinical specimens for infectious bacteria, viruses, fungi, and parasites in FY 2008 for assessment of infectious disease trends and investigation of food and water borne disease outbreaks.
- ◆ Analyzed 56,052 samples to detect chemical and bacterial contaminants in water, soil, and air in FY 2008 to assess potential threats to human health.
- ◆ Screened 72,984 newborn babies for more than 50 treatable, life-threatening congenital and heritable disorders FY 2008.
- ◆ Certified 147 public and private environmental laboratories to assure quality in FY 2008.

Historical Perspective

The Minnesota PHL was first established more than 100 years ago. This was during a time in history when the germ theory of infectious disease was first established and little was known about the impact of environmental contamination on the public's health. In the early 1900s, with development of more sophisticated testing methods and instruments, the PHL became the premier laboratory in Minnesota with the ability to identify environmental hazards and diagnose epidemic infectious diseases. Today, the PHL focuses on surveillance for early detection of public health threats, identification of rare chemical, radiological and biological hazards, emergency preparedness and response, and assurance of quality laboratory data through collaborative partnerships with clinical and environmental laboratories throughout the state. Construction of a new laboratory building was completed in 2005, and the PHL relocated to the new building in November 2005.

Key Activity Goals

The PHL supports both the MDH mission to protect, maintain, and improve the health of all Minnesotans as well as the following MDH goals:

- ◆ All children get a healthy start in life; and
- ◆ Prepare for and respond to public health emergencies.

Key Measures

- ◆ Improve health outcomes for Minnesota newborn babies by ensuring that all babies are screened for treatable congenital and heritable disorders and hearing loss.

Number of newborns identified with treatable heritable disorders (non-hearing)

Historical 1993-2007	Actual (FY 2007)	Actual (FY 2008)	Estimate (FY 2009)
32-120 (range)	135	132	135

Number of newborns identified with hearing loss

Actual (FY 2007)	Actual (FY 2008)	Estimate (FY 2009)
76	134	175

Source: Minnesota Public Health Laboratory

- ◆ Improve Minnesota laboratory preparedness for pandemic influenza by increasing the number of Minnesota laboratories providing influenza surveillance data to MDH.

Number of laboratories reporting results to MDH

Pilot Program 2006-2007	Actual (FY 2008)	Estimate (FY 2009)
45	90	100

Source: Minnesota Public Health Laboratory

- ◆ Improve Minnesota laboratory preparedness for bioterrorism, pandemic influenza, and other emerging health threats by providing training opportunities for Minnesota Laboratory professionals.

Number of laboratory training activities provided in the Public Health Laboratory training facility

Historical (FY 2008)	Estimate (FY 2009)
10	10

Source: Minnesota Public Health Laboratory

Activity Funding

The laboratory is funded by appropriations from the general fund and state government special revenue fund. It also receives federal and special revenue funds.

HEALTH DEPT

Program: HEALTH PROTECTION

Activity: PUBLIC HEALTH LABORATORY

Narrative

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HEALTH DEPT

Program: HEALTH PROTECTION

Activity: PUBLIC HEALTH LABORATORY

Budget Activity Summary

<i>Dollars in Thousands</i>					
	Current		Governor's Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Carry Forward					
State Government Spec Revenue	0	353	0	0	0
Miscellaneous Special Revenue	211	389	0	0	0
Direct Appropriations					
General	2,298	2,634	2,266	2,266	4,532
State Government Spec Revenue	6,473	8,275	7,791	7,791	15,582
Statutory Appropriations					
Miscellaneous Special Revenue	4,017	5,965	4,757	4,757	9,514
Federal	4,830	4,267	4,617	4,617	9,234
Total	17,829	21,883	19,431	19,431	38,862
<u>Expenditures by Category</u>					
Total Compensation	9,162	9,680	9,866	9,866	19,732
Other Operating Expenses	8,667	12,203	9,565	9,565	19,130
Total	17,829	21,883	19,431	19,431	38,862
Full-Time Equivalents (FTE)	133.6	135.6	141.6	141.6	

Activity Description

The Office of Emergency Preparedness (OEP) ensures local and state public health and healthcare partners have the personnel, plans, training, communication tools, and expertise to prevent or respond to bioterrorism, pandemic influenza, infectious disease outbreaks, natural disasters, and other public health emergencies. Response to the 35W bridge collapse, floods and tornados, and preparation for the Republican National Convention are examples of program efforts.

Population Served

All residents of the state of Minnesota are served by this activity. Primary partners are local health departments, American Indian Tribes, the hospital and healthcare provider community, emergency management agencies, law enforcement, volunteer organizations, the University of Minnesota, and other response organizations.

Services Provided

- ◆ Plan, implement, and practice components of the Minnesota Department of Health's (MDH) All-Hazard Response Plan and the MDH portion of the Minnesota Emergency Operations Plan so roles and responsibilities are clear to all responders.
- ◆ Develop and practice plans for managing federal pharmaceutical and other medical supplies in the strategic national stockpile (SNS) for a public health emergency. Maintain stockpiles of state and regional medications and medical supplies.
- ◆ Identify needs and develop programs for the public health and healthcare system about preparing for and responding to emergencies.
- ◆ Developed a state/local partnership of registration and support of volunteers to be called on in an emergency to increase public health and healthcare capacity. An example of this program is the behavioral health volunteers used at the Family Assistance Centers for the 35W bridge collapse and SE MN floods.
- ◆ Update statutes and regulations to assure needed authority for implementing emergency health measures.
- ◆ Operate the health alert network, the department's tool for timely threat communications to local public health, hospitals, and other health care providers.
- ◆ Manage and support MN *Trac*, a web based system to monitor health care system capacity, notify healthcare responders of emergencies, track patient transport during emergencies, and support the rapid expansion of healthcare services for emergencies.
- ◆ Coordinate the development of education and training materials and oversee a comprehensive exercise plan for building the capacity of state and local public health and the healthcare system.
- ◆ Prepare for the potential pandemic influenza impact on Minnesota through planning, training, exercising, and providing public information.
- ◆ Administer about \$6 million in grants to community health boards and tribes, and about \$5 million in grants to hospitals to build public health and health care preparedness.
- ◆ Assure compliance with requirements of grants from the Centers for Disease Control (CDC) and Assistant Secretary for Preparedness and Response (ASPR) of the Department of Health and Human Services.

Activity at a Glance

- ◆ Established a new system to classify local health departments as Base, Mid-Level, or Comprehensive to more accurately reflect capability and capacity, and determine when extra assistance will be needed.
- ◆ Responded to events with public health impact including hepatitis A outbreak, 35W bridge collapse, floods, and tornadoes.
- ◆ Managed grants to all 53 local departments of health, ten of 11 tribes and eight regional hospital collaboratives that cover all MN hospitals.
- ◆ Registered over 7,000 volunteers in Minnesota Responds Medical Reserve Corps
- ◆ In FY08, sent 54 health alert messages to partners about time-sensitive health related information.
- ◆ Completed installation of high frequency and amateur radio systems for backup communications with CDC and local partners statewide. Systems are tested weekly.
- ◆ Purchased and managing approximately 500,000 courses of medication for pandemic influenza.
- ◆ Sponsored "Ready to Respond" training and sharing conference with over 300 participants.

Historical Perspective

The OEP was established in 2002, as required by the first public health preparedness and response for bioterrorism grant from the CDC. This grant now includes the cities readiness initiative to distribute medications to everyone in the metropolitan area within 48 hours. The healthcare system grant started in 2003 to expand preparedness efforts involving the department, hospitals, and other healthcare system partners.

Key Activity Goals

The MDH Strategic Plan for 2005-2008 is to “Strengthen our impact on the health of Minnesotans in the face of threats and challenges,” and this activity is essential to the implementation of the Strategic Plan. A department priority is “preparing for public health emergencies”.

Key Activity Measures

Exercises: Preparedness requires the ability to rapidly put plans into action. That requires practice in the form of discussion and exercises. For FY 2008, MDH completed an average of five exercises per month and 23 exercises were conducted monthly by the local or regional level. This high level of activity was cited by many responders as critical to the successful response to FY 2008 incidents.

Type of exercise	Department of Health	Local health department, tribal government, and healthcare system	Total
Tabletop	28	107	135
Drill	16	71	87
Functional	17	39	56
Full-scale/actual events	5	55	60
TOTAL	66	272	338

Definitions:

- ◆ Tabletop: a discussion of planned responses to emergency scenario (pandemic influenza plans).
- ◆ Drill: practice one part of a response (set up a hotline).
- ◆ Functional: simulate a response activity (distribute vaccine from the state to healthcare providers).
- ◆ Full Scale: demonstrate response to a situation (set up clinics and provide “services” to volunteers).

Communication:

- ◆ Rapid, accurate communication is the backbone of our response. The federal goal is the ability to reach pre-designated staff within 60 minutes. Using the communication system designed to provide secure 24/7 notice to key department staff, we averaged 19 minutes based on three drills in FY 2008. One of the drills was unannounced and one was after normal work hours. This highlights our ability to respond quickly to an event that affects the public’s health. This system was used for incidents in FY 2008 to coordinate public health response.
- ◆ We worked with hospitals and others to expand the *MNTrac* system to track additional healthcare resources. We are able to collect and use information about available hospital beds across the state in minutes. Without this system, it would take hours or days to locate this information that is used to coordinate patient care services.

Activity Funding

The OEP is funded primarily with federal funds and with a one-time FY 2008 general fund allocation to purchase pandemic influenza medications and supplies.

HEALTH DEPT

Program: HEALTH PROTECTION

Activity: OFFICE EMERGENCY PREPAREDNESS

Narrative

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HEALTH DEPT

Program: HEALTH PROTECTION

Activity: OFFICE EMERGENCY PREPAREDNESS

Budget Activity Summary

<i>Dollars in Thousands</i>					
	Current		Governor's Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Direct Appropriations					
General	4,063	22	100	100	200
Statutory Appropriations					
Miscellaneous Special Revenue	338	87	87	87	174
Federal	19,464	15,726	15,726	15,726	31,452
Gift	0	1	0	0	0
Total	23,865	15,836	15,913	15,913	31,826
<u>Expenditures by Category</u>					
Total Compensation	3,453	3,243	3,343	3,343	6,686
Other Operating Expenses	7,970	2,455	2,432	2,432	4,864
Local Assistance	12,442	10,138	10,138	10,138	20,276
Total	23,865	15,836	15,913	15,913	31,826
Full-Time Equivalents (FTE)	37.8	26.4	26.4	26.4	

Program Description

The purpose of the Administrative Support Service Program is to provide the executive leadership and business systems underlying and supporting all of the department's public health programs.

Budget Activities

- ⇒ Administrative Services
- ⇒ Executive Office

HEALTH DEPT

Program: ADMINISTRATIVE SUPPORT SERVICE

Program Summary

<i>Dollars in Thousands</i>					
	Current		Governor Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Direct Appropriations by Fund</u>					
General					
Current Appropriation	8,497	7,424	7,424	7,424	14,848
Technical Adjustments					
Approved Transfer Between Appr			1,720	1,720	3,440
Current Law Base Change			46	46	92
Subtotal - Forecast Base	8,497	7,424	9,190	9,190	18,380
Governor's Recommendations					
General Fund Administrative Reduction		0	(1,834)	(1,834)	(3,668)
Total	8,497	7,424	7,356	7,356	14,712
State Government Spec Revenue					
Current Appropriation	2,000	0	0	0	0
Subtotal - Forecast Base	2,000	0	0	0	0
Total	2,000	0	0	0	0
<u>Expenditures by Fund</u>					
Carry Forward					
State Government Spec Revenue	0	3,247	0	0	0
Health Care Access	0	326	0	0	0
Miscellaneous Special Revenue	139	1,817	0	0	0
Direct Appropriations					
General	8,839	9,406	7,356	7,356	14,712
State Government Spec Revenue	20	1,889	0	0	0
Statutory Appropriations					
Miscellaneous Special Revenue	21,421	24,349	24,330	24,330	48,660
Federal	328	248	248	248	496
Gift	1	9	0	0	0
Total	30,748	41,291	31,934	31,934	63,868
<u>Expenditures by Category</u>					
Total Compensation	12,342	15,921	14,437	14,437	28,874
Other Operating Expenses	18,399	25,370	17,533	17,533	35,066
Capital Outlay & Real Property	4	0	0	0	0
Local Assistance	3	0	0	0	0
Transfers	0	0	(36)	(36)	(72)
Total	30,748	41,291	31,934	31,934	63,868
<u>Expenditures by Activity</u>					
Administrative Services	27,412	35,817	28,357	28,357	56,714
Executive Office	3,336	5,474	3,577	3,577	7,154
Total	30,748	41,291	31,934	31,934	63,868
Full-Time Equivalent (FTE)	156.9	161.5	161.5	161.5	

Activity Description

Administrative services provide internal business systems and central support services to all programs of the department in order to best use agency resources. This area continuously reviews the need for and quality of its services to assure they are provided in the most cost efficient manner.

Population Served

This activity serves all 1,300 employees of the department by:

- ◆ Providing facilities, human resources, financial, and information technology services;
- ◆ Working with the vendors who provide goods and services needed to carry out state public health programs;
- ◆ Aiding and assisting grantees receiving funds through the department;
- ◆ Working with landlords providing space needed to carry out programs; and
- ◆ Working with job applicants seeking employment with the department.

Services Provided**Facilities Management:**

- ◆ Manage building operations of all Minnesota Department of Health (MDH) office facilities including physical security, mail distribution, warehousing of materials, and parking.
- ◆ Provide administrative support in all MDH district offices across the state.
- ◆ Provide centralized procurement of goods and contract services.

Financial Management:

- ◆ Provide budget planning and development for all departmental resources.
- ◆ Manage centralized budget management, accounting, reporting, and cash management.
- ◆ Provide monitoring, financial reporting, and technical assistance required for federal grants.

Human Resources:

- ◆ Manage the recruitment, development, and retention of qualified staff.
- ◆ Administer all departmental labor relations, employee benefits, and health and safety activities.
- ◆ Manage employee compensation and provide payroll services for all departmental staff.
- ◆ Oversee departmental equal opportunity and affirmative action activities.

Information Systems and Technology Management:

- ◆ Provide technical expertise, planning, and development of technology systems and data architectures.
- ◆ Supply high-level security for all departmental data, systems, and communications.
- ◆ Manage departmental communications networks and telecommunications systems.
- ◆ Supervise and manage MDH central networks and infrastructure connecting all employees and 11 building locations.
- ◆ Provide user support, training and problem resolution to MDH staff.

Key Goal

Government in Minnesota will be cost-efficient, and services will be designed to meet the needs of the people who use them" is a goal of this activity, which is one of the Minnesota Milestones – see <http://server.admin.state.mn.us/mm/goal.html>.

Activity at a Glance

- ◆ Maintain 99.9% availability and functionality of core network infrastructure.
- ◆ Recruit more than 200 new employees annually.
- ◆ Pay 99% of all vendor invoices in 30 days or less.
- ◆ Implement improved physical and systems/ data security at all office facilities.

Key Measures

- ◆ The department will increase the percentage of receipts received electronically through electronic fund transfers, online credit card payments, and interagency transfers.

History	Current	Target
2006	2008	2010
N/A	65%	80%

- ◆ The department will increase the percentage of people of color in the MDH workforce to a proportion reflective of Minnesota's demographics.

History	Current	Target
2006	2008	2010
10.1%	11%	12%

- ◆ The department will reduce the number of written findings in its Annual Federal Compliance Audit to zero.

History	Current	Target
2006	2008	2010
3	2	0

Activity Funding

This activity is funded primarily from special revenue funds and from appropriations from the general fund.

Contact

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HEALTH DEPT

Program: ADMINISTRATIVE SUPPORT SERVICE

Activity: ADMINISTRATIVE SERVICES

Budget Activity Summary

<i>Dollars in Thousands</i>					
	Current		Governor's Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Carry Forward					
State Government Spec Revenue	0	3,247	0	0	0
Health Care Access	0	326	0	0	0
Miscellaneous Special Revenue	89	40	0	0	0
Direct Appropriations					
General	7,969	8,311	6,371	6,371	12,742
State Government Spec Revenue	20	1,889	0	0	0
Statutory Appropriations					
Miscellaneous Special Revenue	19,334	22,003	21,986	21,986	43,972
Gift	0	1	0	0	0
Total	27,412	35,817	28,357	28,357	56,714
<u>Expenditures by Category</u>					
Total Compensation	9,755	13,046	11,562	11,562	23,124
Other Operating Expenses	17,650	22,771	16,831	16,831	33,662
Capital Outlay & Real Property	4	0	0	0	0
Local Assistance	3	0	0	0	0
Transfers	0	0	(36)	(36)	(72)
Total	27,412	35,817	28,357	28,357	56,714
Full-Time Equivalents (FTE)	128.4	131.6	131.6	131.6	

Activity Description

The Executive Office provides the vision and strategic leadership for creating effective public health policy for the state of Minnesota. It also oversees the management of the entire agency, including administrative functions and oversight of the department's six divisions. It carries out its mission in partnership with a wide range of external organizations that help to promote and protect the health of all Minnesotans.

Several key functions take place through the commissioner's office, including planning, policy development, government relations, communications, and legal services.

Activity at a Glance

- ◆ Conduct strategic leadership and planning for the department.
- ◆ Coordinate government relations and policy development.
- ◆ Coordinate internal and external communications and public awareness.
- ◆ Provide department-wide legal services.

Population Served

The department's 1,300 employees work to protect and promote the health of all Minnesotans. The department carries out its mission in close partnership with local public health departments, other state agencies, elected officials, health care and community organizations, and public health officials at the federal, state, and local levels.

Services Provided**Commissioner's Office:**

- ◆ The commissioner's office develops and implements department policies and provides leadership to the state in developing public health priorities.
- ◆ The commissioner's office directs the annual development of a set of public health strategies to provide guidance for agency activities and to more effectively engage the department's public health partners.
- ◆ The commissioner's office also directs the strategic planning and implementation of department-wide initiatives.

Government Relations:

- ◆ Government relations is responsible for leading and coordinating state legislative activities and monitoring federal legislative activities to advance the departments' priorities and mission.
- ◆ Throughout the legislative session and during the interim, government relations is a contact for the public, other departments, legislators, and legislative staff.
- ◆ This activity works closely with the governor's office, department divisions, legislators, legislative staff, and other state agencies to communicate the department's strategies and priorities.

Communications:

- ◆ The communications office is responsible for leading and coordinating communications on statewide public health issues and programs. This includes coordinating community outreach and managing more than 30,000 pages of information on the department's website.
- ◆ The office works closely with the news media, including issuing an average of 75 news releases and responding to thousands of media inquiries each year.
- ◆ The office also oversees the R.N. Barr Library, which provides access to information for department staff, local public health agencies, and school nurses.

Legal Services:

- ◆ The MDH Legal Unit serves the Commissioner in a general counsel capacity, while providing overall direction to and oversight of legal services provided to MDH by in-house counsel and the Attorney General's office (AG's).
- ◆ While the Legal Unit will respond to any legal need, its primary focus is in the areas of emergency preparedness, rulemaking, data practices and privacy, delegations of authority, and HIPAA.

- ◆ The Legal Unit also acts as a liaison with the AG's office for MDH litigation and other legal services requested by MDH.

Key Activity Goals

The functions of this activity provide administrative support needed for the agency to achieve its statutory mission to protect, maintain, and improve the health of all Minnesotans, and the support for individual program areas to achieve their specific goals. A second goal the activity supports is "government in Minnesota will be cost-efficient, and services will be designed to meet the needs of the people who use them," which is one of the Minnesota Milestones – see <http://server.admin.state.mn.us/mm/goal.html>.

Key Measures

The key measures identified for the administrative services activity are also applicable here.

Activity Funding

The office is funded from appropriations from the general fund and from special revenue funds.

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HEALTH DEPT

Program: ADMINISTRATIVE SUPPORT SERVICE

Activity: EXECUTIVE OFFICE

Budget Activity Summary

<i>Dollars in Thousands</i>					
	Current		Governor's Recomm.		Biennium
	FY2008	FY2009	FY2010	FY2011	2010-11
<u>Expenditures by Fund</u>					
Carry Forward					
Miscellaneous Special Revenue	50	1,777	0	0	0
Direct Appropriations					
General	870	1,095	985	985	1,970
Statutory Appropriations					
Miscellaneous Special Revenue	2,087	2,346	2,344	2,344	4,688
Federal	328	248	248	248	496
Gift	1	8	0	0	0
Total	3,336	5,474	3,577	3,577	7,154
<u>Expenditures by Category</u>					
Total Compensation	2,587	2,875	2,875	2,875	5,750
Other Operating Expenses	749	2,599	702	702	1,404
Total	3,336	5,474	3,577	3,577	7,154
Full-Time Equivalentents (FTE)	28.5	29.9	29.9	29.9	

HEALTH DEPT

Agency Revenue Summary

Dollars in Thousands

	Actual FY2008	Budgeted FY2009	Governor's Recomm. FY2010 FY2011		Biennium 2010-11
<u>Non Dedicated Revenue:</u>					
Departmental Earnings:					
General	357	0	0	0	0
State Government Spec Revenue	36,967	37,812	41,725	41,823	83,548
Other Revenues:					
General	23	0	0	0	0
Health Care Access	0	675	675	675	1,350
Total Non-Dedicated Receipts	37,347	38,487	42,400	42,498	84,898
<u>Dedicated Receipts:</u>					
Departmental Earnings (Inter-Agency):					
State Government Spec Revenue	0	144	0	0	0
Departmental Earnings:					
Health Care Access	2	0	0	0	0
Miscellaneous Special Revenue	10	0	0	0	0
Grants:					
Drinking Water Revolving Fund	474	521	521	521	1,042
Miscellaneous Special Revenue	773	998	693	693	1,386
Federal	212,013	215,916	212,381	211,894	424,275
Other Revenues:					
Miscellaneous Special Revenue	38,486	40,590	38,546	38,495	77,041
Federal	465	300	300	300	600
Medical Education & Research	77,767	78,242	88,089	95,562	183,651
Miscellaneous Agency	91	120	120	120	240
Gift	18	64	0	0	0
Total Dedicated Receipts	330,099	336,895	340,650	347,585	688,235
Agency Total Revenue	367,446	375,382	383,050	390,083	773,133

Program Name Federal or State or Both (citation)	Purpose	Recipient Type (s) Eligibility Criteria	Budgeted FY 2009	Most Recent Federal Award (cite year)
Program: Community and Family Health Promotion Budget Activity: Community and Family Health				
Fetal Alcohol Spectrum Disorders Grant (State) <i>Laws of MN 2004, Chapter 288, Art. 6, Sec. 27</i>	Provide prevention and intervention services related to fetal alcohol spectrum disorder.	Statewide non-profit organization (1 grantee)	\$1,660	n/a
Maternal and Child Health Block Grant (Federal) <i>Title V, SSA and M.S. 145.88 – 145.883</i>	Supports public health services to low-income, high-risk mothers and children.	Community Health Boards (53 grantees); Children's Hospital and Clinic (1 grantee SIDS)	\$6,089	2009
Family Planning Special Projects (Both) <i>M.S. 145.925</i>	Provide pre-pregnancy family planning services to high risk low income individuals.	Government and non-profit organizations (42 grantees)	\$4,862	2009
Family Planning Grants Greater Minnesota (State)	Support family Planning Clinics serving out state Minnesota that are experiencing financial need.	Government and non-profit organizations serving out state Minnesota (18 grantees)	\$491	n/a
Positive Alternative Grants (State)	Provide support encouragement, and assistance to pregnant women.	Non-profit organizations that have had a program in existence for at least one year as of 7/1/2005 (31 grantees)	\$2,357	n/a
Family Home Visiting Program (Federal) <i>M.S. 145A.17</i>	Promote family health and self sufficiency.	Community Health Boards (53 grantees)	\$7,785	2009
MN Children with Special Health Needs (State)	Provide specialty diagnostic services in underserved regions of the state.	Government and non-profit organizations (3 grantees)	\$260	n/a
Suicide Prevention (State)	Grants for Suicide prevention activities.	Government and non-profit organizations (5 grantees)	\$498	n/a
Hearing Aid Loan Bank (State)	Support statewide hearing aid and instrument loan bank to families with children newly diagnosed with hearing loss from birth to the age of ten.	Government and non-profit organizations (1 grantee)	\$69	n/a
Commodity Supplemental Food Program (CSFP) (State) <i>Agriculture Appropriation Act</i>	Provide nutrition information and supplemental foods.	Government and non-profit organizations (4 grantees)	\$779	2009
WIC (Federal)	Provides Nutrition education and healthy foods to low-income pregnant women and young children.	Community Health Boards, non-profit organizations and tribal governments (57 grantees)	\$110,915	2009
WIC Breastfeeding Peer Counsel (Federal)	Promote and support breastfeeding among WIC recipients.	Community Health Boards, non-profit organizations and tribal governments who provide WIC services (4 grantees)	\$190	2009

Program Name Federal or State or Both (citation)	Purpose	Recipient Type (s) Eligibility Criteria	Budgeted FY 2009	Most Recent Federal Award (cite year)
Local Public Health Grants (State) <i>M.S. 145A.131</i>	Develops and maintains an integrated system of community health services under local administration and within a system of state guidelines and standards.	Community Health Boards (53 grantees)	\$20,771	n/a
Pediatric Medical Home Project (State)	Services support a medical home model for children with special health care needs.	Non-profit organizations	\$337	n/a
Minnesota Evidence-Based Home Visiting Project	Support local public health departments and tribal governments implementing an evidence-based home visiting program that prevents child maltreatment.	Government/utilize an identified evidence-based home visiting program – 7 grants (currently Nurse-Family Partnership, may include others in the future).	\$225	2009
Program: Community and Family Health Promotion Budget Activity: Health Promotion and Chronic Disease				
Poison Control (Both) <i>M.S. 145.93</i>	Identify appropriate home management or referral of cases of human poisoning; provide statewide information and education services.	Government, non-profit and for-profit organizations; competitive (1 grantee)	\$1,279	2009
Comprehensive Cancer (Federal)	Support development and implementation of the comprehensive cancer plan.	Cancer centers; non-profit organizations; noncompetitive	\$85	2009
Prostate Cancer (Federal)	Support prostate cancer screening education among high risk populations.	Non-profit cancer organization; noncompetitive	\$125	2009
Breast and Cervical Cancer Detection Program (Both) <i>M.S. 144.671 and M.S. 145.928</i>	Breast and cervical cancer screening, diagnostic and follow-up services. Recruitment/outreach activities to increase and provide breast and cervical cancer screening.	Private and community clinics, other health care providers and Community Health Boards; noncompetitive	\$2,912	2009
Rape Prevention and Education (Federal)	Build prevention capacity of Minnesota's sexual assault coalition.	Not for profit, statewide sexual assault coalition (1 grantee)	\$250	2009
Addressing Asthma from a Public Health Perspective (Federal)	To conduct asthma surveillance and implement portions of the "Strategic Plan for Addressing Asthma in Minnesota."	Local public health and non-profit and for-profit organizations	\$143	2009
Tobacco Use Prevention (State) <i>M.S. 144.395-396</i>	Reduce youth tobacco use.	Government, non-profit, and for-profit entities; competitive	\$3,456	n/a

Program Name Federal or State or Both (citation)	Purpose	Recipient Type (s) Eligibility Criteria	Budgeted FY 2009	Most Recent Federal Award (cite year)
WISEWOMAN Screening (Federal)	Heart disease risk factor screening and lifestyle counseling for age-eligible Breast and Cervical Cancer Detection Program clients.	Private and community clinics, other health care providers and Community Health Board; noncompetitive	\$234	2009
Reducing Arthritis (Federal)	Increase the quality of life and decrease health care costs for persons with arthritis through strategies in early identification, self-management and health communications.	Counties and non-government organizations; noncompetitive	\$55	2009
Sexual Assault Prevention (Federal)	Prevent sexual assault, provide services to victims of sexual assault, provide public education regarding sexual assault.	Interagency agreement; 1 noncompetitive grantee with competitive sub-grants to government organizations, schools, non-profit organizations	\$120	2009
Race for the Cure – Screening and Diagnostics (State)	Breast cancer screening, diagnostic and follow-up services.	Private and community clinics, other health care providers; noncompetitive	\$885	2009
Brain Injury/Trauma (State)	Provide service and best practice prevention information to persons injured, professionals and communities.	Not for Profit community-based organization able to deliver prescribed services	\$1,188	2009
Spinal Cord Injury/Trauma (State)	Provide service and best practice prevention information to persons injured, professionals and communities.	Not for Profit community-based organization able to deliver prescribed services	\$12	2009
Minnesota Stroke Registry (Federal)	Support Minnesota hospitals to improve the quality of care to stroke patients by developing and using the stroke registry.	Minnesota Hospitals	\$149	2009
Program: Community Family Health Promotion Budget Activity: Office of Minority & Multicultural Health				
Local Public Health Grants for Tribal Governments (State)	Develops and maintains an integrated system of American Indian tribal health services under tribal administration and within a system of state guidelines and standards.	American Indian Tribal Governments	\$1,060	n/a
Eliminating Health Disparities Initiative Grants (Both)	Improves the health of the four minority racial/ethnic groups in MN (American Indians, Asian Americans, African Americans, Latinos/Hispanics). Grants focus on 7 health priorities.	Eligible applicants are local/county public health agencies, community based organizations, faith-based, and tribal governments.	\$5,142	2009

Program Name Federal or State or Both (citation)	Purpose	Recipient Type (s) Eligibility Criteria	Budgeted FY 2009	Most Recent Federal Award (cite year)
Program: Policy Quality and Compliance Budget Activity: Health Policy				
Medical Education and Research Cost Trust Fund (Both) <i>M.S. 256B.69; M.S. 297F.10; M.S. 62J.692</i>	The MERC trust fund was established to address the increasing financial difficulties of Minnesota's medical education organizations.	Eligible applicants are accredited medical education teaching institutions, consortia, and programs operating in Minnesota (22 sponsoring institutions pass through grants to several hundred training sites)	\$88,790	2009
Dental Innovations Grants (Both) <i>M.S. 62J.692</i>	To promote innovative clinical training for dental professionals and programs that increase access to dental care for underserved populations.	Eligible applicants are sponsoring institutions, training sites, or consortia that provide clinical education to dental professionals	\$2,432	2009
Indian Health Grants (State) <i>M.S. 145A.14, Subd. 2</i>	Provides health service assistance to Native Americans who reside off reservations.	Community Health Boards (5 grantees)	\$174	n/a
Migrant Grants (State) <i>M.S. 145A.14, Subd. 1</i>	Subsidizes health services, including mobile, to migrant workers and their families.	Cities, counties, groups of cities or counties, or non-profit corporations (1 grantee)	\$102	n/a
Rural Hospital Capital Improvement Grant Program (State) <i>M.S. 256B.195</i>	Update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of small rural hospitals.	Rural hospitals with 50 or fewer beds (21 grantees)	\$1,755	n/a
Small Hospital Improvement Program (Federal)	Supports small hospital Health Insurance Portability and Accountability Act (HIPAA) compliance, patient safety, quality improvement, and Prospective Payment System (PPS) costs.	Rural hospitals of 50 or fewer beds (82 grantees)	\$679	2009
Community Clinic Grant Program (State) <i>M.S. 145.9268</i>	Assist clinics to serve low- income populations, reduce uncompensated care burdens or improve care delivery infrastructure.	Nonprofit community clinics (15 grantees)	\$561	n/a

Program Name Federal or State or Both (citation)	Purpose	Recipient Type (s) Eligibility Criteria	Budgeted FY 2009	Most Recent Federal Award (cite year)
Pharmacy Preservation Grants (State) <i>M.S. 144.1476</i>	Planning, establishing, keeping in operation, or preserving access to prescription medications and the skills of a pharmacist.	Eligible rural communities or health care providers in eligible rural communities (6 grantees)	\$180	n/a
Donated Dental Services (State) <i>M.S. 150A.22</i>	To provide dental care to low-income or uninsured recipients.	Non-profit organization (1 grantee)	\$63	n/a
Rural Hospital Planning & Transition Grant (State) <i>M.S. 144.147</i>	Assist with strategic planning; transition projects.	Rural hospitals with 50 or fewer beds (15 grantees)	\$300	n/a
Summer Health Care Internships (State) <i>M.S. 144.1464</i>	Summer internship program for high school and college students.	Statewide non-profit organization representing health facilities (1 grantee/multiple sub-grantees)	\$300	n/a
Health and Long Term Care Career Promotion Grant Program (State) <i>M.S. 144.1499</i>	Develop or implement health and long term care career curriculum for K-12.	Consortia of K-12 districts, post-secondary schools and health/long term care employers	\$147	n/a
Loan Forgiveness Program (State) <i>M.S. 144.1501</i>	Health education loan forgiveness for physicians, nurses, nurse practitioners, and physician assistants, in rural and urban underserved areas.	Average number of grantees—Faculty (22), Dentist (9), Pharmacist (13) Nurses practicing in nursing homes (7) Midlevel (4); (38 new and 13 continuing participants)	\$1,132	n/a
National Health Service Corp (Both) <i>M.S. 144.1487</i>	Health education loan forgiveness for physicians in rural and urban underserved areas.	Physicians (4 grantees per year)	\$202	2009
Nurses Loan Forgiveness (State) <i>M.S. 144.1501</i>	Health education loan forgiveness for nurses, allied health faculty, nurse faculty.	Nurses (17 new and 1 continuing)	\$295	n/a
Physicians Loan Forgiveness (State) <i>M.S. 144.1501</i>	Health education loan forgiveness for physicians in rural and urban underserved areas.	Physicians (7 new and 1 continuing)	\$251	n/a
Critical Access Hospital HIT Implementation Grant (Federal)	Pilot program to implement health information technology in Critical Access Hospital community health systems.	Lac qui Parle Health Network Stratis Health, Inc.	\$1,502	2009
Rural Hospital Flexibility (Federal)	Strengthen Critical Access Hospitals and rural health systems; improve quality, safety and access.	Critical Access Hospitals, ambulance services, other rural providers (20 Grantees)	\$388	2009
Federally Qualified Health Center (State)	Support Minnesota FQHCs to continue, expand and improve services to populations with low incomes.	HRSA designated FQHCs and FQHC Look Alikes operating in Minnesota	\$2,473	n/a
Health Care Demonstration Project (State)	Community-based health care coverage program demonstration	Health Share, Inc., Duluth	\$208	n/a

Program Name Federal or State or Both (citation)	Purpose	Recipient Type (s) Eligibility Criteria	Budgeted FY 2009	Most Recent Federal Award (cite year)
Electronic Health Record Grants (State) <i>M.S. 144.3345</i>	Support implementation and use of interoperable electronic health records.	Community e-health collaboratives (2 or more rural hospitals, clinics, nursing homes, others); community clinics; RHIOs	\$3,500	n/a
Open Door Center (State) <i>Laws of 2008, Chapter 358, Article 5, Section 4, Subdivision 3</i>	Operational Support	Open Door Health Center. Mankato	\$350	n/a
Program: Health Protection Budget Activity: Environmental Health				
Lead Base Program Grants (State) <i>M.S. 119A.46</i>	For lead training to workers and property owners, and to provide lead cleaning services in housing with elevated blood lead level children.	Eligible applicants include: qualified lead professionals; cities; local public health agencies; community action groups	\$98	n/a
State Lead Safe Housing Grant (State) <i>M.S. 144.9507, Subd. 3</i>	For costs related to relocation of families needing lead safe housing.	Local Public Health Agencies (typically 2 grantees)	\$25	n/a
Lead Abatement Grant (State) <i>M.S. 119A.46</i>	To train workers and to provide swab team services for residential properties.	Nonprofit organization currently operating the CLEARCorps lead hazard reduction project within MN	\$381	n/a
Drinking Water Technical Assistance (Federal) <i>M.S. 144.383</i>	Provides technical assistance to owners and operators of public water systems.	Minnesota Rural Water Association	\$273	2009
Wellhead Protection (Federal)	Provide technical assistance to small public water systems to initiate their wellhead protection plan.	Minnesota Rural Water Association	\$40	2009
Operator Training Expense Reimbursement (Federal)	Provide training to small system operators at no cost.	Minnesota Rural Water Association	\$54	2009
Federal Environmental Protection Agency States Indoor Radon Grant (SIRG) (Federal)	For public education and targeted outreach on radon testing, mitigation, and radon resistant new construction.	Competitive grant process available to local public health agencies and non-profit organizations	\$100	2009
Program: Health Protection Budget Activity: Infectious Disease Epidemiology, Prevention, and Control				
Tuberculosis Program (Both)	Outreach Grants for TB case management services for foreign-born persons.	Hennepin, Olmstead, and Ramsey counties; others as TB caseload need & funding allow	\$197	2009
Eliminating Health Disparities—Refugee Health (State)	Health screening and follow- up services for foreign-born persons with TB proportionally based on legislative formula.	All Community Health Boards are eligible	\$250	n/a

Program Name Federal or State or Both (citation)	Purpose	Recipient Type (s) Eligibility Criteria	Budgeted FY 2009	Most Recent Federal Award (cite year)
AIDS Prevention Grants (Both) <i>M.S. 145.924</i>	Health education/risk reduction and AIDS/HIV testing for high-risk individuals.	Community-based organizations, clinics (16 grantees)	\$1,544	2009
Active Surveillance for Pertussis (Federal)	To plan, coordinate, and enroll healthcare facilities throughout the county in a pertussis active surveillance project.	Dakota and Ramsey Counties	\$107	2009
Refugee Health (Federal)	Coordination of Refugee Health Assessments.	Counties resettling the largest number of refugees (5 grantees)	\$120	2009
Immunization Registries (Federal)	To establish/maintain immunization registries.	Seven community-based registries and four local public health agencies	\$400	2009
Refugee Health Screenings (Federal)	To reimburse public and private providers for refugee health assessments completed upon arrival to the United States.	Community Health Boards (3 grantees) and any private clinic providing services to newly arrived refugees	\$170	2009
Perinatal Hepatitis B (Federal)	Case management for perinatal hepatitis B.	CHS Boards (Saint Paul/Ramsey, Hennepin counties get large awards)	\$320	2009
Immunization Practices Improvement (Federal)	Clinic site visits by local public health staff to check vaccine storage and handling, review immunization practices, and audit pediatric immunization records.	Community Health Boards	\$100	2009
Prevention and Treatment of Sexually Transmitted Infections (Federal) <i>M.S. 144.065</i>	Test high risk individuals for STDs.	Community-based organizations and clinics	\$245	2009
HIV Counseling and Testing (Federal)	Testing high-risk individuals for HIV.	Clinical facilities (7)	\$497	2009
Program: Health Protection Budget Activity: Office of Emergency Preparedness				
Local Public Health Preparedness Grants (Federal) <i>(PAHPA, P.L. 109-417)</i>	Plan, exercise and prepare local health departments and communities to respond to and recover from events that affect the public's health.	Community health boards (53 grantees)	\$4,735	2009
OEP Hospital Preparedness (Federal) <i>(PAHPA, P.L. 109-417)</i>	Plan, exercise, and prepare individual hospitals and hospital regions to provide health care during emergencies and events that affect the public's health.	Regional Hospital Resource Centers designated in each of the 8 regions	\$4,423	2009
Tribal Preparedness Grants (Federal)	Plan, exercise and prepare tribal governments and tribal communities to respond to	Tribal governments (11 grantees)	\$180	2009

Program Name Federal or State or Both (citation)	Purpose	Recipient Type (s) Eligibility Criteria	Budgeted FY 2009	Most Recent Federal Award (cite year)
<i>(PAHPA, P.L. 109-417)</i>	and recover from events that affect the public's health.			
Cities Readiness Initiative Grants (Federal) <i>(PAHPA, P.L. 109-417)</i>	Plan, exercise, and prepare to have distributed medications to the metropolitan area within 48 hours of an accident.	Local health departments in the Twin Cities Metropolitan Statistical Area (14 grantees)	\$800	2009

Federal Program (\$ in Thousands)	Related SFY 2006 Spending	Primary Purpose	SFY 2006 Revenues	SFY 2007 Revenues	Estimated SFY 2008 Revenues	Estimated SFY 2009 Revenues
Women, Infants & Children		SO SOGPS GI GCBO	100,675	110,711	124,598	131,408
Temporary Assistance for Needy Families (TANF)		GPS GCBO	5,806	6,159	9,997	13,153
Public Health Emergency Preparedness		SO GPS GCBO	16,024	17,620	15,657	13,095
Maternal & Child Health Block Grant	6,950	SO GPS GCBO	8,953	9,183	9,334	9,047
Healthcare System Preparedness		SO GPS GCBO	9,270	8,608	7,196	6,761
Medicare		SO	6,610	6,242	6,230	5,950
National Breast and Cervical Cancer Early Detection Program	1,498	SO GPS GI GCBO	4,447	4,663	4,753	4,536
Immunization		SO GPS GCBO	3,868	4,431	4,534	4,529
AIDS/HIV Prevention		SO GPS GCBO	2,985	3,261	2,982	3,162
Emerging Infections Program		SO GPS	2,537	2,679	3,116	3,015
Preventive Health and Health Services Block Grant		SO GCBO	2,850	1,707	3,211	2,819
Safe Drinking Water Program	3,000	SO	2,739	2,335	2,534	2,424
Drinking Water Revolving Fund		SO GCBO	2,035	2,886	2,163	2,163
Steps to decrease Asthma, Diabetes and Obesity	294	SO GPS	2,110	2,441	2,125	2,080
Flex Critical Access Hospital HIT Implementation Grant		GCBO	0	0	89	1,511
National Program of Cancer Registries and National Comprehensive Cancer Control Program	316	SO GPS GCBO	1,165	1,569	1,364	1,451
National Tobacco Control Program	256	SO	1,266	1,223	1,331	1,314
Comprehensive Diabetes	276	SO	1,126	1,119	1,080	1,187
Expanding Lab & Epidemiology Capacity		SO	0	254	1,223	1,175
Prevention of Sexually Transmitted Diseases		SO GPS GCBO	891	1,246	1,122	1,121

HEALTH DEPT

Federal Funds Summary

Tuberculosis Cooperative Agreement		SO GPS	871	837	905	1,004
Commodity Supplemental Food Program		SO GCBO	788	809	880	881
WISEWOMAN	130	SO GPS GI GCBO	364	459	601	745
Small Rural Hospital Improvement Program		SO GCBO	628	716	711	715
Addressing Asthma		SO	768	653	614	700
Sexual Violence Prevention		SO GPS GCBO	723	393	605	678
Minnesota Nutrition Physical Activity and Obesity		SO	0	0	0	646
Rural Hospital Flexibility Program		SO GCBO	570	567	647	642
Small Cities Lead Hazard Reduction Project		SO GI	0	0	97	600
Childhood Lead Poisoning		SO GPS	779	600	595	590
Stroke Registry		SO GCBO	0	0	368	564
Minnesota Arthritis Program		SO GPS GCBO	319	256	245	553
Breast & Prostate Cancer Data Surveillance		SO	66	95	160	478
Agency for Toxic Substance Disease Registry (ATSDR)		SO	447	452	462	457
Fetal Alcohol Syndrome Prevention		SO	446	432	396	407
Minnesota Heart Disease and Stroke Prevention		SO	0	0	351	400
Particulate Matter Reduction		SO GPS	0	0	64	400
Integrated Core Injury Prevention and Control Program		SO	353	390	381	391
EPA Indoor Radon Grant	562	SO GPS GCBO	562	619	507	379
HIV/AIDS Surveillance		SO	0	0	137	375
Child Maltreatment Prevention		SO GCBO	0	0	0	375
Cooperative Agreement to Support State Assessment Initiatives		SO	128	137	238	329
Department of Education Community Based Systems for Children with Special Health Care Needs		SO	539	424	465	300
EPA Lead Cooperative Agreement	50	SO	267	250	305	273

HEALTH DEPT

Federal Funds Summary

Behavioral Risk Factor Surveillance		SO	393	353	397	272
Oral Disease Prevention Program		SO	0	0	0	270
Counter Terrorism Coordination for Public Water Supplies		SO	92	106	238	245
Medical Assistance Health Plan	151	SO	151	144	172	229
Early Head Start (Hearing)		SO	0	0	0	225
Refugee Health Services		SO GPS	134	223	223	222
Healthy Homes Demonstration		SO GCBO	0	0	0	219
Primary Care Cooperative Agreement		SO	194	184	195	190
Newborn Screening and Hearing Program		SO	160	149	103	175
New Refugee Disease Surveillance		SO GPS	0	0	60	175
Clinical Lab Improvement Act Program (CLIA)		SO	162	185	159	168
Evaluating Surveillance Methods for Monitoring Atypical HIV Strains		SO	188	142	168	161
Oral Health Assessment and Planning		SO	0	0	0	158
Lab-NBS Early Hearing Detection & Intervention		SO	0	0	0	152
Pregnancy Risk Assessment Monitoring System (PRAMS)		SO	162	127	146	149
Office of Rural Health Program	444	SO	144	150	149	148
Community Integrated Service System		SO	113	102	134	140
Develop Improved Population Based Birth Defects Information		SO	115	114	125	120
Active Surveillance for Pertussis		SO	381	318	307	101
National Health Service Corp Loan Repayment Program	83	GI	108	99	110	100
State System Development Initiative		SO	123	110	82	100
OMH Partnership Grant		SO	0	0	0	96
Surveillance of Hazardous Substance Emergencies		SO	96	89	101	94
5-A-Day Power Plus Program		SO GCBO	623	464	320	90
Adult Viral Hepatitis Prevention Coordinator		SO	0	0	37	84
Genomics Program		SO	174	194	194	83

Wellhead Protection		SO	66	111	26	70
Water Protection Coordination		SO	0	0	49	65
Crash Outcome Data Evaluation Systems (DPS)		SO	47	42	34	58
Water Operators Training Grant		SO	545	915	937	54
Surveillance of Serious Trauma Injuries		SO	53	54	57	51
Tools for Schools		SO	26	34	0	50
Federal CODES		SO	0	0	0	47
Brownsfield/Land Reuse		SO	0	0	0	45
STD Surveillance Network		SO	26	92	91	42
EHDI Surveillance, Tracking and Intervention		SO	168	178	134	41
Lake Superior Basin Mercury in the Blood of Newborns		SO	0	0	15	40
Asthma Training		SO	0	0	0	40
Hydro Geologic Barrier Study		SO	11	0	0	20
Capture Stroke Network		SO	20	19	15	16
Food Safety: Discovering Novel Causes of Foodborne Illness		SO	270	276	42	0
Cardiovascular Health Programs		SO	404	336	39	0
HIV/AIDS Surveillance		SO	178	203	171	0
Addressing The Transmission and Prevention of MSRA		SO	103	166	5	0
Applied Research on Antimicrobial Resistance		SO	234	254	69	0
Promoting Child Mental Health		SO	30	54	7	0
Childhood Oral Healthcare Access Program		SO	96	43	1	0
Asthma Triggers		SO	4	34	12	0
Pandemic Flu Project		SO	0	0	2,214	0

Key:

Primary Purpose

SO = State Operations

GPS = Grants to Political Subdivision

GI = Grants to Individuals

GCBO = Grants to Community Based Organizations