CHAPTER 145A

COMMUNITY HEALTH BOARDS

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145A.01 CITATION.

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

History: *1987 c 309 s 1*

145A.02 DEFINITIONS.

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

Subd. 1a. **Areas of public health responsibility.** "Areas of public health responsibility" means:

(1) assuring an adequate local public health infrastructure;

(2) promoting healthy communities and healthy behaviors;

(3) preventing the spread of communicable disease;

(4) protecting against environmental health hazards;

(5) preparing for and responding to emergencies; and

(6) assuring health services.

Subd. 2. [Repealed, 2014 c 291 art 7 s 29]

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

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

Subd. 5. **Community health board.** "Community health board" means the governing body for local public health in Minnesota. The community health board may be comprised of a single county, multiple contiguous counties, or in a limited number of cases, a single city as specified in section 145A.03, subdivision 1. CHBs have the responsibilities and authority under this chapter.

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

Subd. 6a. **Community health services administrator.** "Community health services administrator" means a person who meets personnel standards for the position established under section 145A.06, subdivision 3b, and is working under a written agreement with, employed by, or under contract with a community health board to provide public health leadership and to discharge the administrative and program responsibilities on behalf of the board.

Subd. 7. **Community health service area.** "Community health service area" means a city, county, or multicounty area that is organized as a community health board and for which a local public health grant is received under sections 145A.11 to 145A.131.

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

Subd. 8a. **Essential public health services.** "Essential public health services" means the public health activities that all communities should undertake. These services serve as the framework for the National Public Health Performance Standards. In Minnesota they refer to activities that are conducted to accomplish the areas of public health responsibility. The ten essential public health services are to:

(1) monitor health status to identify and solve community health problems;

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

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

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

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

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

(7) link people to needed personal health services and assure the provision of health care when otherwise unavailable;

(8) maintain a competent public health workforce;

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

(10) contribute to research seeking new insights and innovative solutions to health problems.

Subd. 8b. **Local health department.** "Local health department" means an operational entity that is responsible for the administration and implementation of programs and services to address the areas of public health responsibility. It is governed by a community health board.

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

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

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

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

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

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

Subd. 15. **Medical consultant.** "Medical consultant" means an individual who:

(1) is licensed in Minnesota by the Board of Medical Practice as a physician, doctor of osteopathic medicine, or physician assistant or is licensed in Minnesota by the Board of Nursing as an advanced practice registered nurse and is certified to practice as a clinical nurse specialist or nurse practitioner by a national nurse certification organization acceptable to the board; and

(2) is working under a written agreement with, employed by, or on contract with a community health board to provide advice and information, to authorize medical procedures through protocols, and to assist a community health board and its staff in coordinating their activities with local medical practitioners and health care institutions.

Subd. 15a. **Performance management.** "Performance management" means the systematic process of using data for decision making by identifying outcomes and standards; measuring, monitoring, and communicating progress; and engaging in quality improvement activities in order to achieve desired outcomes.

Subd. 15b. **Performance measures.** "Performance measures" means quantitative ways to define and measure performance.

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

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

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

History: *1987 c 309 s 2; 1989 c 194 s 2; 1991 c 345 art 2 s 43; 1997 c 199 s 14; 1999 c 245 art 9 s 47; 1Sp2003 c 14 art 8 s 12-14; 2014 c 291 art 7 s 1-8,29; 2026 c 46 s 1*

COMMUNITY HEALTH BOARDS

145A.03 ESTABLISHMENT AND ORGANIZATION.

Subdivision 1. **Establishment; assignment of responsibilities.** (a) The governing body of a county must undertake the responsibilities of a community health board by establishing or joining a community health board according to paragraphs (b) to (f) and assigning to it the powers and duties specified under section 145A.04.

(b) A community health board must include within its jurisdiction a population of 30,000 or more persons or be composed of three or more contiguous counties.

(c) A county board or city council within the jurisdiction of a community health board operating under sections 145A.11 to 145A.131 is preempted from forming a community health board except as specified in section 145A.131.

(d) A county board or a joint powers board that establishes a community health board and has or establishes an operational human services board under chapter 402 may assign the powers and duties of a

community health board to a human services board. Eligibility for funding from the commissioner will be maintained if all requirements of sections 145A.03 and 145A.04 are met.

(e) Community health boards established prior to January 1, 2014, including city community health boards, are eligible to maintain their status as community health boards as outlined in this subdivision.

(f) A community health board may authorize, by resolution, the community health service administrator or other designated agent or agents to act on behalf of the community health board.

Subd. 2. **Joint powers community health board.** A county may establish a joint community health board by agreement with one or more contiguous counties, or an existing city community health board may establish a joint community health board with one or more contiguous existing city community health boards in the same county in which it is located. The agreements must be established according to section 471.59.

Subd. 3. [Repealed, 2014 c 291 art 7 s 29]

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

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

Subd. 6. [Repealed, 2014 c 291 art 7 s 29]

Subd. 7. **Community health board; eligibility for funding.** A community health board that meets the requirements of this section is eligible to receive the local public health grant under section 145A.131 and for other funds that the commissioner grants to community health boards to carry out public health activities.

History: *1987 c 309 s 3; 1991 c 52 s 3; 1Sp2003 c 14 art 8 s 31; 2014 c 291 art 7 s 9-13,29*

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

Subdivision 1. **Jurisdiction; enforcement.** (a) A community health board has the general responsibility for development and maintenance of a system of community health services under local administration and within a system of state guidelines and standards.

(b) Under the general supervision of the commissioner, the community health board shall recommend the enforcement of laws, regulations, and ordinances pertaining to the powers and duties within its jurisdictional area. In the case of a multicounty or city community health board, the joint powers agreement under section 145A.03, subdivision 2, or delegation agreement under section 145A.07 shall clearly specify enforcement authorities.

(c) A member of a community health board may not withdraw from a joint powers community health board during the first two calendar years following the effective date of the initial joint powers agreement. The withdrawing member must notify the commissioner and the other parties to the agreement at least one year before the beginning of the calendar year in which withdrawal takes effect.

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

(e) The local public health grant for a county or city that chooses to withdraw from a multicounty community health board shall be reduced by the amount of the local partnership incentive.

Subd. 1a. **Duties.** Consistent with the guidelines and standards established under section 145A.06, the community health board shall:

(1) identify local public health priorities and implement activities to address the priorities and the areas of public health responsibility, which include:

(i) assuring an adequate local public health infrastructure by maintaining the basic foundational capacities to a well-functioning public health system that includes data analysis and utilization; health planning; partnership development and community mobilization; policy development, analysis, and decision support; communication; and public health research, evaluation, and quality improvement;

(ii) promoting healthy communities and healthy behavior through activities that improve health in a population, such as investing in healthy families; engaging communities to change policies, systems, or environments to promote positive health or prevent adverse health; providing information and education about healthy communities or population health status; and addressing issues of health equity, health disparities, and the social determinants to health;

(iii) preventing the spread of communicable disease by preventing diseases that are caused by infectious agents through detecting acute infectious diseases, ensuring the reporting of infectious diseases, preventing the transmission of infectious diseases, and implementing control measures during infectious disease outbreaks;

(iv) protecting against environmental health hazards by addressing aspects of the environment that pose risks to human health, such as monitoring air and water quality; developing policies and programs to reduce exposure to environmental health risks and promote healthy environments; and identifying and mitigating environmental risks such as food and waterborne diseases, radiation, occupational health hazards, and public health nuisances;

(v) preparing and responding to emergencies by engaging in activities that prepare public health departments to respond to events and incidents and assist communities in recovery, such as providing leadership for public health preparedness activities with a community; developing, exercising, and periodically reviewing response plans for public health threats; and developing and maintaining a system of public health workforce readiness, deployment, and response; and

(vi) assuring health services by engaging in activities such as assessing the availability of health-related services and health care providers in local communities, identifying gaps and barriers in services; convening community partners to improve community health systems; and providing services identified as priorities by the local assessment and planning process; and

(2) submit to the commissioner of health, at least every five years, a community health assessment and community health improvement plan, which shall be developed with input from the community and take into consideration the statewide outcomes, the areas of responsibility, and essential public health services;

(3) implement a performance management process in order to achieve desired outcomes; and

(4) annually report to the commissioner on a set of performance measures and be prepared to provide documentation of ability to meet the performance measures.

Subd. 2. **Appointment of community health service (CHS) administrator.** A community health board must appoint, employ, or contract with a CHS administrator to act on its behalf. The board shall notify the commissioner of the CHS administrator's contact information and submit a copy of the resolution authorizing the CHS administrator to act as an agent on the board's behalf. The resolution must specify the types of action or actions that the CHS administrator is authorized to take on behalf of the board.

Subd. 2a. **Appointment of medical consultant.** The community health board shall appoint, employ, or contract with a medical consultant to ensure appropriate medical advice and direction for the community health board and assist the board and its staff in the coordination of community health services with local medical care and other health services.

Subd. 3. **Employment; employees.** (a) A community health board may employ persons as necessary to carry out its duties.

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

(c) Persons employed by a county, city, or the state whose functions and duties are assumed by a community health board shall become employees of the board without loss in benefits, salaries, or rights.

Subd. 4. **Acquisition of property; request for and acceptance of funds; collection of fees.** (a) A community health board may acquire and hold in the name of the county or city the lands, buildings, and equipment necessary for the purposes of sections 145A.03 to 145A.131. It may do so by any lawful means, including gifts, purchase, lease, or transfer of custodial control.

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

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

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

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

Subd. 6. **Investigation; reporting and control of communicable diseases.** A community health board shall make investigations, or coordinate with any county board or city council within its jurisdiction to make investigations and reports and obey instructions on the control of communicable diseases as the commissioner may direct under section 144.12, 145A.06, subdivision 2, or 145A.07. Community health boards must cooperate so far as practicable to act together to prevent and control epidemic diseases.

Subd. 6a. **Minnesota Responds Medical Reserve Corps; planning.** A community health board receiving funding for emergency preparedness or pandemic influenza planning from the state or from the United States Department of Health and Human Services shall participate in planning for emergency use of volunteer health professionals through the Minnesota Responds Medical Reserve Corps program of the Department of Health. A community health board shall collaborate on volunteer planning with other public and private

partners, including but not limited to local or regional health care providers, emergency medical services, hospitals, Tribal governments, state and local emergency management, and local disaster relief organizations.

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

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

Subd. 6d. **Minnesota Responds Medical Reserve Corps; liability coverage.** A Minnesota Responds Medical Reserve Corps volunteer responding to a request for training or assistance at the call of a community health board, county, or city must be deemed an employee of the jurisdiction for purposes of workers' compensation, tort claim defense, and indemnification.

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

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

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

(1) by registered or certified mail;

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

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

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

(d) If the owner, occupant, or agent fails or neglects to comply with the requirement of the notice provided under paragraphs (b) and (c), then the community health board, county, city, or a designated agent of the

board, county, or city shall remove or abate the nuisance, source of filth, or cause of sickness described in the notice from the property.

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

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

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

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

Subd. 13. **Recommended legislation.** The community health board may recommend local ordinances pertaining to community health services to any county board or city council within its jurisdiction and advise the commissioner on matters relating to public health that require assistance from the state, or that may be of more than local interest.

Subd. 14. **Equal access to services.** The community health board must ensure that community health services are accessible to all persons on the basis of need. No one shall be denied services because of race, color, sex, age, language, religion, nationality, inability to pay, political persuasion, or place of residence.

Subd. 15. **State and local advisory committees.** (a) A state community health services advisory committee is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of local and Tribal public health services. Each community health board may appoint a member to serve on the committee. Each of Minnesota's federally recognized Tribal Nations may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. A Tribal Nation may elect to participate at any time. Members or their alternates may be reimbursed for travel and other necessary expenses while engaged in their official duties.

(b) Notwithstanding section 15.059, the State Community Health Services Advisory Committee does not expire.

(c) The city boards or county boards that have established or are members of a community health board may appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on the duties under subdivision 1a.

History: *1987 c 309 s 4; 1Sp2003 c 14 art 8 s 31; 2008 c 202 s 2-4; 2013 c 43 s 21; 2014 c 291 art 7 s 14; 2015 c 21 art 1 s 109; 2026 c 127 art 1 s 35*

145A.05 LOCAL ORDINANCES.

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

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

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

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

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

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

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

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

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

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

History: *1987 c 309 s 5; 1994 c 636 art 9 s 10; 1995 c 226 art 2 s 1; 2014 c 291 art 7 s 15*

145A.06 COMMISSIONER; POWERS AND DUTIES.

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

Subd. 2. **Supervision of local enforcement.** (a) In the absence of provision for a community health board, the commissioner may appoint three or more persons to act as a board until one is established. The commissioner may fix their compensation, which the county or city must pay.

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

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

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

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

Subd. 3a. **Assistance to community health boards.** The commissioner shall help and advise community health boards that ask for assistance in developing, administering, and carrying out public health services and programs. This assistance may consist of, but is not limited to:

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

(2) administrative and program guidelines and standards developed with the advice of the State Community Health Services Advisory Committee.

Subd. 3b. **Personnel standards.** In accordance with chapter 14, and in consultation with the State Community Health Services Advisory Committee, the commissioner may adopt rules to set standards for administrative and program personnel to ensure competence in administration and planning.

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

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

Subd. 5a. **System-level performance management.** To improve public health and ensure the integrity and accountability of the statewide local public health system, the commissioner, in consultation with the State Community Health Services Advisory Committee, shall develop performance measures and implement a process to monitor statewide outcomes and performance improvement.

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

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

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

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

(1) a community health board, county, or city according to section 145A.04, subdivision 6c;

(2) the University of Minnesota Academic Health Center;

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

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

(5) a Tribal or Canadian government;

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

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

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

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

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

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

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

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

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

(i) When a Minnesota Responds Medical Reserve Corps volunteer makes a claim for workers' compensation arising out of a deployment under this section or out of a training exercise conducted by the commissioner, the volunteer's workers compensation benefits must be determined under section 176.011, subdivision 9, clause (25), even if the volunteer may also qualify under other clauses of section 176.011, subdivision 9.

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

employment relationship with a host entity or affiliate which requires the practitioner to provide health services in this state, unless the practitioner is not a resident of this state and is employed by a disaster relief organization providing services in this state while an emergency declaration is in effect.

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

History: *1987 c 309 s 6; 1988 c 689 art 2 s 47; 1Sp2003 c 14 art 8 s 15; 2008 c 202 s 5-7; 2009 c 41 s 7; 2009 c 72 s 1; 2013 c 43 s 22; 2014 c 291 art 7 s 16-22; 2015 c 21 art 1 s 109*

145A.061 CRIMINAL BACKGROUND STUDIES.

Subdivision 1. **Agreements to conduct criminal background studies.** The commissioner of health may develop agreements to conduct criminal background studies on each person who registers as a volunteer in the Minnesota Responds Medical Reserve Corps and applies for membership in the Minnesota behavioral health or mobile medical teams. The background study is for the purpose of determining the applicant's suitability and eligibility for membership. Each applicant must provide written consent authorizing the Department of Health to obtain the applicant's state criminal background information.

Subd. 2. **Opportunity to challenge accuracy of report.** Before denying the applicant the opportunity to serve as a health volunteer due to information obtained from a background study, the commissioner shall provide the applicant with the opportunity to complete, or challenge the accuracy of, the criminal justice information reported to the commissioner. The applicant shall have 30 calendar days to correct or complete the record prior to the commissioner taking final action based on the report.

Subd. 3. **Denial of service.** The commissioner may deny an application from any applicant who has been convicted of any of the following crimes:

Section 609.185 (murder in the first degree); section 609.19 (murder in the second degree); section 609.195 (murder in the third degree); section 609.20 (manslaughter in the first degree); section 609.205 (manslaughter in the second degree); section 609.25 (kidnapping); section 609.2661 (murder of an unborn child in the first degree); section 609.2662 (murder of an unborn child in the second degree); section 609.2663 (murder of an unborn child in the third degree); section 609.342 (criminal sexual conduct in the first degree); section 609.343 (criminal sexual conduct in the second degree); section 609.344 (criminal sexual conduct in the third degree); section 609.345 (criminal sexual conduct in the fourth degree); section 609.3451 (criminal sexual conduct in the fifth degree); section 609.3453 (criminal sexual predatory conduct); section 609.352 (solicitation of children to engage in sexual conduct); section 609.352 (communication of sexually explicit materials to children); section 609.365 (incest); section 609.377 (felony malicious punishment of a child); section 609.378 (felony neglect or endangerment of a child); section 609.561 (arson in the first degree); section 609.562 (arson in the second degree); section 609.563 (arson in the third degree); section 609.749, subdivision 3, 4, or 5 (felony harassment or stalking); section 152.021 (controlled substance crimes in the first degree); section 152.022 (controlled substance crimes in the second degree); section 152.023 (controlled substance crimes in the third degree); section 152.024 (controlled substance crimes in the fourth degree); section 152.025 (controlled substance crimes in the fifth degree); section 243.166 (violation of predatory offender registration law); section 617.23, subdivision 2, clause (1), or subdivision 3, clause (1) (indecent exposure involving a minor); section 617.246 (use of minors in sexual performance); section 617.247 (possession of child sexual abuse material); section 609.221 (assault in the first degree); section 609.222 (assault in the second degree); section 609.223 (assault in the third degree); section 609.2231 (assault in the

fourth degree); section 609.224 (assault in the fifth degree); section 609.2242 (domestic assault); section 609.2247 (domestic assault by strangulation); section 609.228 (great bodily harm caused by distribution of drugs); section 609.23 (mistreatment of persons confined); section 609.231 (mistreatment of residents or patients); section 609.2325 (criminal abuse); section 609.233 (criminal neglect); section 609.2335 (financial exploitation of a vulnerable adult); section 609.234 (failure to report); section 609.24 (simple robbery); section 609.245 (aggravated robbery); section 609.247 (carjacking); section 609.255 (false imprisonment); section 609.322 (solicitation, inducement, and promotion of prostitution and sex trafficking); section 609.324, subdivision 1 (hiring or engaging minors in prostitution); section 609.465 (presenting false claims to a public officer or body); Minnesota Statutes 2024, section 609.466 or section 609.467 (medical assistance fraud); section 609.52 (felony theft); section 609.82 (felony fraud in obtaining credit); section 609.527 (felony identity theft); section 609.582 (felony burglary); section 609.611 (felony insurance fraud); section 609.625 (aggravated forgery); section 609.63 (forgery); section 609.631 (felony check forgery); section 609.66, subdivision 1e (felony drive-by shooting); section 609.71 (felony riot); section 609.713 (terroristic threats); section 609.72, subdivision 3 (disorderly conduct by a caregiver against a vulnerable adult); section 609.821 (felony financial transaction card fraud); section 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); or aiding and abetting, attempting, or conspiring to commit any of the offenses in this subdivision.

Subd. 4. **Conviction.** For purposes of this section, an applicant is considered to have been convicted of a crime if the applicant was convicted, or otherwise found guilty, including by entering an Alford plea; was found guilty but the adjudication of guilt was stayed or withheld; or was convicted but the imposition or execution of a sentence was stayed.

Subd. 5. **Data practices.** All state criminal history record information or data obtained by the commissioner from the Bureau of Criminal Apprehension is private data on individuals under section 13.02, subdivision 12, and restricted to the exclusive use of the commissioner for the purpose of evaluating an applicant's eligibility for participation in the behavioral health or mobile field medical team.

Subd. 6. **Use of volunteers by commissioner.** The commissioner may deny a volunteer membership on a mobile medical team or behavioral health team for any reason, and is only required to communicate the reason when membership is denied as a result of information received from a criminal background study. The commissioner is exempt from the Criminal Offenders Rehabilitation Act under chapter 364 in the selection of volunteers for any position or activity including the Minnesota Responds Medical Reserve Corps, the Minnesota behavioral health team, and the mobile medical team.

History: *2013 c 43 s 23; 2014 c 275 art 1 s 28; 1Sp2019 c 5 art 2 s 29; 2023 c 52 art 20 s 2; 2025 c 35 art 5 s 27; 2026 c 127 art 8 s 1*

145A.07 DELEGATION OF POWERS AND DUTIES.

Subdivision 1. **Agreements to perform duties of commissioner.** (a) The commissioner of health may enter into an agreement with any community health board, or county or city that has an established delegation agreement as of January 1, 2014, to delegate all or part of the licensing, inspection, reporting, and enforcement duties authorized under sections 144.12; 144.381 to 144.387; 144.411 to 144.417; 144.71 to 144.74; 145A.04, subdivision 6; provisions of chapter 103I pertaining to construction, repair, and abandonment of water wells; chapter 157; and sections 327.14 to 327.28.

(b) Agreements are subject to subdivision 3.

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

Subd. 2. **Agreements to perform duties of community health board.** A community health board may authorize a city or county within its jurisdiction to carry out activities to fulfill community health board responsibilities. An agreement to delegate community health board powers and duties to a county or city must be approved by the commissioner.

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

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

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

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

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

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

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

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

History: *1987 c 309 s 7; 1989 c 209 art 2 s 18; 1990 c 426 art 2 s 1; 1993 c 206 s 12; 1995 c 186 s 43; 2014 c 291 art 7 s 23,24*

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

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

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

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

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

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

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

History: *1987 c 309 s 8; 1Sp1989 c 1 art 5 s 6; 2014 c 291 art 7 s 25*

145A.09 Subdivision 1. [Repealed, 2014 c 291 art 7 s 29]

Subd. 2. [Repealed, 2014 c 291 art 7 s 29]

Subd. 3. [Repealed, 2014 c 291 art 7 s 29]

Subd. 4. [Repealed, 2014 c 291 art 7 s 29]

Subd. 5. [Repealed, 2014 c 291 art 7 s 29]

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

Subd. 7. [Repealed, 2014 c 291 art 7 s 29]

145A.10 Subdivision 1. [Repealed, 2014 c 291 art 7 s 29]

Subd. 2. [Repealed, 2014 c 291 art 7 s 29]

Subd. 3. [Repealed, 2014 c 291 art 7 s 29]

Subd. 4. [Repealed, 2014 c 291 art 7 s 29]

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

Subd. 5a. [Repealed, 2014 c 291 art 7 s 29]

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

Subd. 7. [Repealed, 2014 c 291 art 7 s 29]

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

Subd. 9. [Repealed, 2014 c 291 art 7 s 29]

Subd. 10. [Repealed, 2014 c 291 art 7 s 29]

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

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

Subd. 2. **Levying taxes.** In levying taxes authorized under section 145A.08, subdivision 3, a city council or county board that has formed or is a member of a community health board must consider the income and expenditures required to meet local public health priorities established under section 145A.04, subdivision 1a, clause (2), and statewide outcomes under section 145A.04, subdivision 1a, clause (1).

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

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

History: *1987 c 309 s 11; 1Sp2003 c 14 art 8 s 22,23; 2014 c 291 art 7 s 26,29*

145A.12 Subdivision 1. [Repealed, 2014 c 291 art 7 s 29]

Subd. 2. [Repealed, 2014 c 291 art 7 s 29]

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

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

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

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

Subd. 7. [Repealed, 2014 c 291 art 7 s 29]

145A.13 MS 2003 Supp [Expired]

145A.131 LOCAL PUBLIC HEALTH GRANT.

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

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

(d) The State Community Health Services Advisory Committee may recommend a formula to the commissioner to use in distributing funds to community health boards.

(e) Notwithstanding any adjustment in paragraph (b), community health boards, all or a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive an increase equal to ten percent of the grant award to the community health board under paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for the last six months of the year. For calendar years beginning on or after January 1, 2016, the amount distributed under this paragraph shall be adjusted each year based on available funding and the number of eligible community health boards.

(f) Funding for foundational public health responsibilities must be distributed based on a formula determined by the commissioner in consultation with the State Community Health Services Advisory Committee. These funds must be used as described in subdivision 5.

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

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

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

(d) A city organized under the provision of sections 145A.03 to 145A.131 that levies a tax for provision of community health services is exempt from any county levy for the same services to the extent of the levy imposed by the city.

Subd. 3. **Accountability.** (a) Community health boards accepting local public health grants must meet all of the requirements and perform all of the duties described in sections 145A.03 and 145A.04, to maintain eligibility to receive the local public health grant.

(b) By January 1 of each year, the commissioner shall notify community health boards of the performance-related accountability requirements of the local public health grant for that calendar year. Performance-related accountability requirements will be comprised of a subset of the annual performance measures and will be selected in consultation with the State Community Health Services Advisory Committee.

(c) If the commissioner determines that a community health board has not met the accountability requirements, the commissioner shall notify the community health board in writing and recommend specific actions the community health board must take over the next six months in order to maintain eligibility for the Local Public Health Act grant.

(d) Following the written notification in paragraph (c), the commissioner shall provide administrative and program support to assist the community health board as required in section 145A.06, subdivision 3a.

(e) The commissioner shall provide the community health board two months following the written notification to appeal the determination in writing.

(f) If the community health board has not submitted an appeal within two months or has not taken the specific actions recommended by the commissioner within six months following written notification, the commissioner may elect to not reimburse invoices for funds submitted after the six-month compliance period and shall reduce by 1/12 the community health board's annual award allocation for every successive month of noncompliance.

(g) The commissioner may retain the amount of funding that would have been allocated to the community health board and assume responsibility for public health activities in the geographic area served by the community health board.

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

Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their local public health grant funds as described in subdivision 1, paragraphs (a) to (e), to address the areas of public health responsibility and local priorities developed through the community health assessment and community health improvement planning process.

(b) Except as otherwise provided in this paragraph, funding for foundational public health responsibilities as described in subdivision 1, paragraph (f), must be used to fulfill foundational public health responsibilities as defined by the commissioner in consultation with the state community health service advisory committee. If a community health board can demonstrate foundational public health responsibilities are fulfilled, the board may use funds for local priorities developed through the community health assessment and community health improvement planning process.

History: *1Sp2003 c 14 art 8 s 28; 2012 c 187 art 1 s 25; 2014 c 291 art 7 s 27; 2015 c 71 art 8 s 50; 2023 c 70 art 4 s 72-74*

145A.135 LOCAL AND TRIBAL PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE GRANT PROGRAM.

Subdivision 1. **Establishment.** The commissioner of health must establish a local and Tribal public health emergency preparedness and response grant program.

Subd. 2. **Funding formula; use.** (a) The commissioner must distribute funding for emergency preparedness and response activities to community health boards and Tribal public health departments based on a formula determined by the commissioner, in consultation with the State Community Health Services Advisory Committee.

(b) Grant proceeds must align with the Centers for Disease Control and Prevention's issued report: Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health.

Subd. 3. **Reporting.** (a) Each grantee must submit a report to the commissioner, in a manner and on a timeline specified by the commissioner, on how the grant funds were spent and the purposes for which they were spent.

(b) By January 15 of each year, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health policy and finance. The report must include information on how the grant funds were distributed and used at the local and Tribal level.

History: *2023 c 70 art 4 s 75*

HEALTH PROGRAMS

145A.14 SPECIAL GRANTS.

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

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

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

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

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

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

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

(1) maternal and child health activities;

(2) activities to reduce health disparities;

(3) emergency preparedness; and

(4) additional public health activities identified by each Tribal government.

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

Subd. 2b. **Grants to Tribes.** The commissioner must distribute grants to Tribal governments for foundational public health responsibilities as defined by each Tribal government.

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

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

History: *1Sp1985 c 14 art 19 s 24; 1987 c 309 s 13,19,25; 1989 c 120 s 1; 1Sp2003 c 14 art 8 s 29,30; 2023 c 70 art 4 s 76; 2026 c 127 art 1 s 36*

145A.145 NURSE-FAMILY PARTNERSHIP PROGRAMS.

(a) The commissioner of health shall award expansion grants to community health boards and Tribal Nations to expand existing nurse-family partnership programs. Grant funds must be used to start up, expand, or sustain nurse-family partnership programs in the county, reservation, or region to serve families in accordance with the Nurse-Family Partnership Service Office nurse-family partnership model. The commissioner shall award grants to community health boards, nonprofit organizations, or Tribal Nations in metropolitan and rural areas of the state.

(b) Priority for all grants shall be given to nurse-family partnership programs that provide services through a Minnesota health care program-enrolled provider that accepts medical assistance. Priority for grants to rural areas shall be given to community health boards, nonprofit organizations, and Tribal Nations that start up, expand, or sustain services within regional partnerships that provide the nurse-family partnership program.

(c) Funding available under this section may only be used to supplement, not to replace, funds being used for nurse-family partnership home visiting services as of June 30, 2015.

History: *2021 c 30 art 3 s 26*

145A.15 MS 2002 [Expired]

145A.16 MS 2002 [Expired]

145A.17 FAMILY HOME VISITING PROGRAMS.

Subdivision 1. **Establishment; goals.** The commissioner shall establish a program to fund family home visiting programs designed to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. The commissioner shall promote partnerships, collaboration, and multidisciplinary visiting done by teams of professionals and paraprofessionals from the fields of public health nursing, social work, and early childhood education. A program funded under this section must serve families at or below 200 percent of the federal poverty guidelines, and other families determined to be at risk, including but not limited to being at risk for child abuse, child neglect, or juvenile delinquency. Programs must begin prenatally whenever possible and must be targeted to families with:

(1) adolescent parents;

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

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

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

(5) reduced cognitive functioning;

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

(7) low resiliency to adversities and environmental stresses;

(8) insufficient financial resources to meet family needs;

(9) a history of homelessness;

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

(11) a serious mental health disorder, including maternal depression as defined in section 145.907; or

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

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

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

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

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

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

(4) a description of the community demographics;

(5) a plan for meeting outcome measures; and

(6) a proposed work plan that includes:

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

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

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

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

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

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

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

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

(5) provide youth development programs when appropriate;

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

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

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

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

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

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

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

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

(f) Upon initial contact with a family, programs that receive funding under this section must receive permission from the family to share with other family service providers information about services the family is receiving and unmet needs of the family in order to select a lead agency for the family and coordinate available resources. For purposes of this paragraph, the term "family service providers" includes local public health, social services, school districts, Head Start programs, health care providers, and other public agencies.

Subd. 4. **Training.** The commissioner shall establish training requirements for home visitors and minimum requirements for supervision. The requirements for nurses must be consistent with chapter 148. The commissioner must provide training for home visitors. Training must include the following:

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

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

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

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

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

(6) increasing services for underserved populations; and

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

Subd. 4a. **Home visitors as MFIP employment and training service providers.** The county social service agency and the local public health department may mutually agree to utilize home visitors under this section as MFIP employment and training service providers under section 142G.50, subdivision 3, for MFIP participants who are: (1) ill or incapacitated under section 142G.42, subdivision 3; or (2) minor caregivers under section 142G.57. The county social service agency and the local public health department may also mutually agree to utilize home visitors to provide outreach to MFIP families who are being sanctioned or who have been terminated from MFIP due to the 60-month time limit.

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

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

(1) appropriate utilization of preventive health care;

(2) rates of substantiated child abuse and neglect;

(3) rates of unintentional child injuries;

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

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

(6) program retention rates;

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

(8) participant satisfaction;

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

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

Subd. 7. **Evaluation.** Using the qualitative goals and quantitative outcome and performance measures established under subdivisions 1 and 6, the commissioner shall conduct ongoing evaluations of the programs funded under this section. Community health boards and Tribal governments shall cooperate with the commissioner in the evaluations and shall provide the commissioner with the information necessary to conduct the evaluations. As part of the ongoing evaluations, the commissioner shall rate the impact of the programs on the outcome measures listed in subdivision 6, and shall periodically determine whether home visiting programs are the best way to achieve the qualitative goals established under subdivisions 1 and 6.

If the commissioner determines that home visiting programs are not the best way to achieve these goals, the commissioner shall provide the legislature with alternative methods for achieving them.

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

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

History: *1Sp2001 c 9 art 1 s 53; 2002 c 379 art 1 s 113; 2007 c 147 art 17 s 1; 2009 c 79 art 2 s 8; 1Sp2011 c 9 art 2 s 22; 2013 c 108 art 12 s 49; 2024 c 80 art 7 s 12*