

# Minnesota Community Health Board Medical Consultant Handbook



**Minnesota Department of Health  
Office of Performance Improvement**

**Minnesota Medical Association**

February 2011



# Welcome to the Minnesota Public Health System

This handbook is intended to provide you with an overview of the history of public health in Minnesota, information about state and local public health requirements, and descriptions of the roles that medical consultants play in Minnesota.

## Table of Contents

<b>Introduction</b> . . . . .	<b>i</b>	<b>Roles of Local, State, and Federal Governments</b> . . . . .	<b>8</b>
Who Are the Medical Consultants? . . . . .	1	State and Local Roles . . . . .	8
Qualifications and Skills . . . . .	1	Federal Influences. . . . .	9
Legal Authority . . . . .	1	<b>History</b> . . . . .	<b>9</b>
Roles and Responsibilities . . . . .	2	Medicine and Public Health . . . . .	9
Sample Roles. . . . .	2	Minnesota Public Health. . . . .	10
<b>What is Public Health?</b> . . . . .	<b>3</b>	National Public Health Accreditation	
Principles. . . . .	3	Standards. . . . .	11
Core Functions . . . . .	4	<b>Glossary.</b> . . . . .	<b>12</b>
Minnesota's Six Areas of Responsibility. . . . .	5	<b>Resources.</b> . . . . .	<b>13</b>
Ten Essential Services. . . . .	6		
<b>Public Health in Minnesota</b> . . . . .	<b>6</b>		
Community Health Services			
(CHS) System . . . . .	7		
Local Public Health (LPH) Act . . . . .	7		
CHS Advisory Committee . . . . .	7		

On behalf of the Minnesota Department of Health (MDH) and the Minnesota Medical Association (MMA), thank you for serving as a Community Health Board medical consultant. Medical consultants play a key role in our state's health care system because they link medicine with public health. Medicine and public health have complementary and interconnected roles in treating illness and promoting health. All Minnesotans benefit when those roles are recognized, valued, and leveraged to improve the health of everyone in the state.

During the past year, the MMA and MDH initiated discussions to learn more about the varying roles that you play throughout the state and your day-to-day needs. This handbook is the result of those discussions.

We consider this to be a first step in providing you with greater support, and we look forward to providing you with timely education and networking opportunities that will enhance your role as a medical consultant as well.

Again, on behalf of Minnesota's physicians and public health professionals, we thank you for your dedication to the health of Minnesotans and to our health care system.

Best regards,

*Robert K. Meiches M.D.*

Robert K. Meiches, M.D., M.B.A.  
CEO, Minnesota Medical Association

*Edward I. Ehlinger*

Edward Ehlinger, M.D., M.S.P.H.  
Commissioner, Minnesota Department  
of Health

## Introduction

### Who Are the Medical Consultants?

Minnesota has 61 medical consultants that work with Community Health Boards (CHBs), the legal governing authorities for local public health in Minnesota. All CHBs are required to have a medical consultant, and some multi-county CHBs have one for each county. Medical consultants are physicians who live in the communities they serve; they may be practicing or retired. Medical consultants play a number of roles, and often the responsibilities of one may look quite different from those of another medical consultant in a different county. To some extent, all of the medical consultants serve as liaisons between the medical world and the community health services (CHS) administrators and public health directors.

### Legal Authority

A medical consultant is required for all CHBs in the state. This is documented in Minnesota Statute 145A, also known as the Local Public Health (LPH) Act.

In section 145A.10, Powers and Duties of the Community Health Boards, it states:

*Subd. 3. Medical consultant.*

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

In section 145A.02, Definitions, it states:

*Subd. 15. Medical consultant.*

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

### Qualifications and Skills of the Medical Consultant

A medical consultant for a CHB or Local Health Department (LHD) must be licensed to practice medicine in Minnesota. In addition, the physician should have knowledge of public health principles and practice as well as familiarity with the prevention and treatment of acute and chronic diseases. A medical consultant also should be familiar with the health care system, medical institutions, and medical practitioners in the geographic area, and be respected by his or her peers. A commitment to improving the community's health is equally desired, as well as the ability to:

- Effectively communicate medical information to the CHB, agency staff, and advisory committee;
- Represent the perspectives of both public health and the medical community in assisting with the coordination of CHB/LHD activities;
- Work as a team member in addressing health needs including planning, organizing, and delegating work; and
- Provide the required time and energy.

## Roles and Responsibilities of the Medical Consultant

A CHB or LHD has discretion with respect to the roles and responsibilities that are assigned to a medical consultant and, accordingly, these vary greatly. The activities of a medical consultant in Minnesota fall primarily within three areas: clinical expertise, public health leadership, and advocacy.

### Clinical Expertise

- Authorize standing orders/medical protocols for emergency care, immunization clinics, cholesterol screening, diabetic monitoring, hematocrit and urinalysis testing, postpartum and child health monitoring visits, and treatment for head lice
- Approve and conduct annual review of medical policies
- Provide medical advice in the areas of health promotion, disease prevention and control, emergency preparedness, environmental health, home health, and laboratory performance
- Provide medical direction and consultation to the CHB and agency staff
- Administer direct care from mobile health clinics or at local jails

### Public Health Leadership and Advocacy

- Act as a leader and liaison with physicians, other medical providers, and health care organizations within the community
- Participate in the Community Health Assessment and Action Planning process
- Participate as a member of the local CHS advisory committee or other agency committees
- Help conduct community assessments or outreach and support public health within the community and elsewhere
- Act as the medical spokesperson and liaison for the CHB/LHD
- Supervise medical residents in public health activities

## Sample Roles

There is no specific contract or position description that all counties must use to employ a medical consultant. Some counties and CHBs have a written contract that is reviewed and re-signed annually, while others do not. Compensation and the amount of time spent doing the work are also extremely variable. Some medical consultants work pro bono; others are paid by the hour or given a per diem with travel reimbursement; still others are salaried part-time or full-time employees. Although some physicians work on a regular schedule, others may only dedicate one or two hours per month to their consultant work, depending on the need. Although many medical consultants have spent three or fewer years in

the role, others have been doing it for more than three decades.

The article “Public Servants” in the June 2010 issue of *Minnesota Medicine* ([www.minnesotamedicine.com/PastIssues/June2010/PublicServantsJune2010/tabid/3462/Default.aspx](http://www.minnesotamedicine.com/PastIssues/June2010/PublicServantsJune2010/tabid/3462/Default.aspx)) highlights the unique ways medical consultants play a role by showcasing three physicians who serve as consultants to their local health boards. One is an emergency medicine physician who provides free care twice a month from a mobile clinic, sees inmates at the jail every other week, makes quarterly presentations to the county’s CHB, and communicates with the

nurse coordinator in public health programs. This is in addition to writing standing orders for vaccines, administering clinics, weighing in on local health ordinances, and developing protocols and policies for mental health, sexually transmitted diseases, and emergency preparedness. The physician’s responsibilities evolved over time as he got to know county officials and health care administrators. Another consultant helps local agencies under-

stand how public health programs and other community services fit together. Yet another works toward improving the health status of the community by sitting on advisory committees to the MDH and working with health plans and organized medicine in addition to supervising the public health lab and seeing patients in a tuberculosis clinic. Clearly, the medical consultant role is both variable and valuable.

## What is Public Health?

### Public Health Principles

In taking an approach that is unique and complementary to traditional medicine, public health embraces the following general principles:

#### The PRINCIPLE of the AGGREGATE

Public health focuses on the health needs of the population as a whole.

#### The PRINCIPLE of PREVENTION

Public health gives priority to preventing problems over the early detection and treatment of problems.

#### The PRINCIPLE of COMMUNITY ORGANIZATION

Public health organizes community resources to meet health needs.

#### The PRINCIPLE of the GREATER GOOD

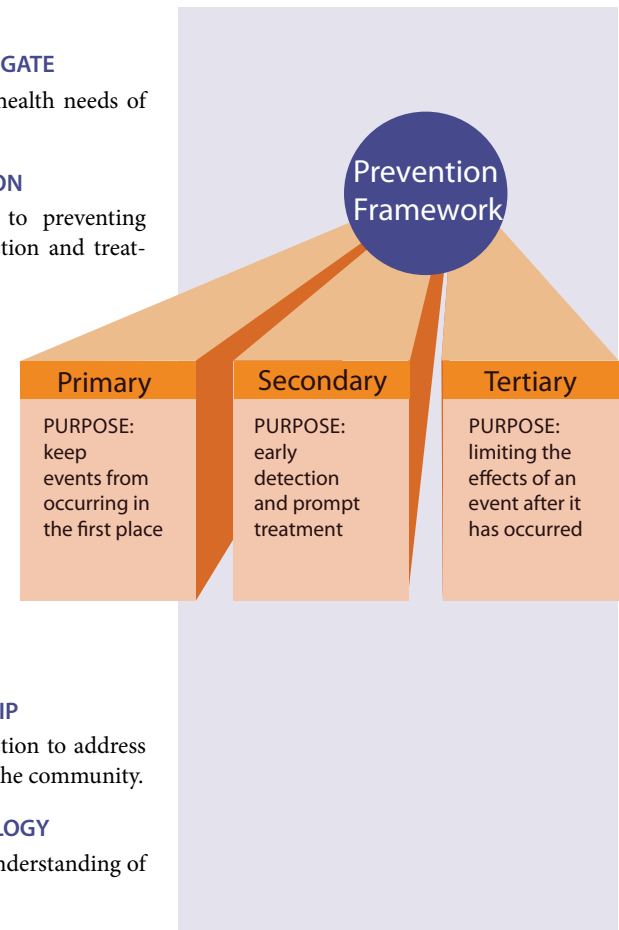
Public health focuses on providing the greatest good for the greatest number of people.

#### The PRINCIPLE of LEADERSHIP

Public health takes positive action to address issues that affect the health of the community.

#### The PRINCIPLE of EPIDEMIOLOGY

Public health is based on an understanding of the causes of health problems.



## Core Public Health Functions

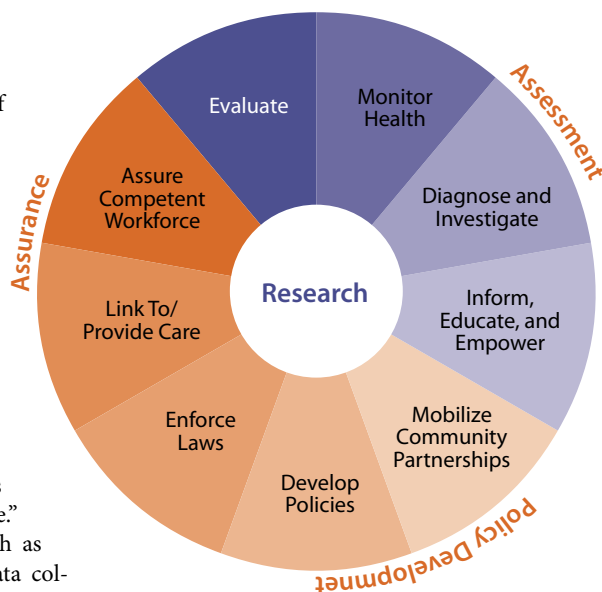
According to the Institute of Medicine's well-known 1988 study, "The Future of Public Health," the core functions described below are carried out primarily by government and constitute the most critical foundations of an effective public health system.

### ASSESSMENT

The assessment function of public health can be viewed as "knowing what needs to be done." This encompasses activities such as epidemiological surveillance, data collection and analysis, monitoring and forecasting, root cause analysis, and other research practices. The assessment function is often used to facilitate decision making by collecting the best evidence with which to weigh competing options and consider the allocation of limited resources.

### POLICY DEVELOPMENT

The policy development function of public health can be viewed as "being part of the solution." This includes being involved in the crafting of legislation, rules, policies, practices, and budgets. In its policy development capacity, a public health entity may plan for and set priorities, provide leadership and advocacy, convene and negotiate with stakeholders, mobilize resources, provide training, or encourage private action. In policy development, the process is often just as important as the product – it will ideally be fair, inclusive, and far-sighted.



### ASSURANCE

Assurance can also be thought of as "making sure it happens." The government can ensure public health services are delivered by mandating them, providing services directly, or incenting other sectors to take action. This often requires implementation of legislative language, regulation, reporting on progress, and holding stakeholders accountable. Exercising this authority comes with great responsibility and entails a strong level of commitment to the welfare of the community. In its assurance capacity, the government is challenged to strike the appropriate balance between free market interests and social equity or the greater good.

## Minnesota's Six Areas of Responsibility

The following are the six responsibilities of the public health system in Minnesota. They describe what people in Minnesota should expect to receive from their LHD no matter where they live and are used by CHBs for planning purposes.

**Assure an adequate public health infrastructure** — addresses functions including assessment, planning, and policy development. Also addresses the staffing for and delivery of public health services. *Examples: using diversity internship programs to recruit and hire staff, promoting smoke-free facilities, improving community engagement processes, ensuring adequate information systems to support activities.*

**Promote healthy communities and healthy behaviors** — promotes positive health behaviors and prevention of adverse health behaviors in all populations across the lifespan. *Examples: fall prevention, healthy food promotion in schools, diabetes education and blood sugar checks at local clinics and fairs, infant and child car seat education and distribution, healthy home assessments, community-wide fitness and wellness programs.*

**Prevent the spread of infectious diseases** — focuses on infectious diseases that are spread person to person. *Examples: training staff on immunization practices, pertussis investigations, promotion of HIV testing, sexually transmitted infection outreach, education, testing, and treatment.*

**Protect against environmental health hazards** — addresses aspects of the environment that pose risks to human health (broadly defined as any risk emerging from the environment but not including injuries). *Examples: radon detection education and tracking, healthy homes initiative, public health nuisance ordinances.*

**Prepare for and respond to disasters, and assist communities in recovery** — addresses activities that prepare public health agencies to respond to disasters and assist communities in responding to and recovering from disasters. *Examples: pandemic planning and response, planning and response to floods, training on incident command.*

**Assure the quality and accessibility of health services** — involves assessing health care capacity and access to health care, identifying and reducing barriers to receiving health services, filling health care gaps, and connecting people to needed services. *Examples: mobile dental clinics for underserved children, low-cost family planning services, expanded tele-health services, expanded and varied clinic hours and locations.*





# Ten Essential Services

Within the core functions of public health, the federal government has defined ten essential public health services that should be undertaken in all communities:

## Assessment

- 1. Monitor health status to identify and solve community health problems
- 2. Diagnose and investigate health problems and health hazards in the community

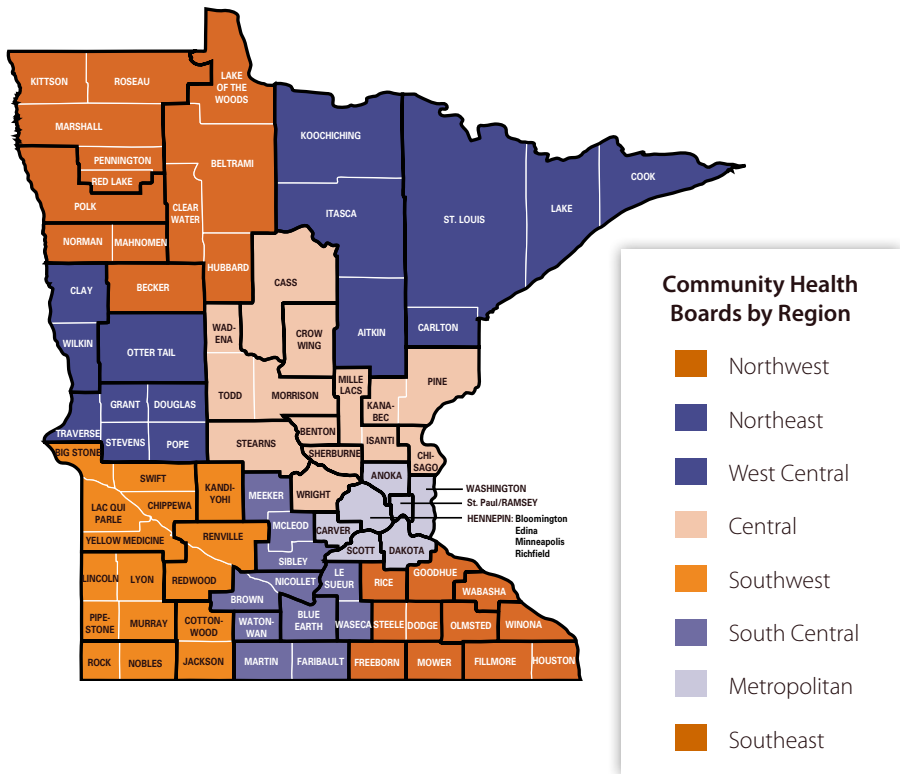
## Policy Development

- 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

## Assurance

- 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. Assure competent public and personal health care workforce
- 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- 10. Research for new insights and innovative solutions to health problems

# Public Health in Minnesota



# The Community Health Services (CHS) System

Minnesota's public health system can best be described as a state and local partnership. It was created with the passage of the Community Health Services Act (Minnesota Statute 145A) in 1976, which was subsequently revised in 1987 and 2003. Now called the Local Public Health Act, the legislation delineates the responsibilities of the state (MDH) and city and county governments in the planning, development, funding, and delivery of public health services.

This partnership, known as the CHS system, enables state and local governments to combine resources to serve public health needs in an efficient, cost-effective way. It is fundamental to the success of Minnesota's public health system because it is the infrastructure for nearly all public health efforts in Minnesota. The system is structured to be flexible so it can meet the different needs of communities around the state and promote direct and timely communications between state and local health departments. The CHS system relies on shared goals and a desire to work together to improve the lives of all Minnesotans.

# The Local Public Health (LPH) Act

Minnesota Statute 145A outlines the shared public health responsibilities of the state and local governments in Minnesota and establishes accountability for funding on statewide initiatives, provides guidelines for assessment and planning, requires documented progress toward the achievement of statewide goals, and assigns oversight of the statewide system to the commissioner of health.

The CHB is the legally recognized governing body for local public health in Minnesota. It is the only governmental entity eligible for funding under the LPH Act grant. CHBs work in partnership with the MDH to prevent dis-

eases, protect against environmental hazards, promote healthy behaviors and healthy communities, respond to disasters, ensure access to health services, and assure an adequate local public health infrastructure.

CHBs have statutory responsibility under the LPH Act and must address and implement the essential local public health activities. Additionally, CHBs must assure that:

- A community health assessment and plan are completed on a regular cycle;
- Community health needs are prioritized in a manner that involves community participation; and
- Needed public health services are developed and implemented.

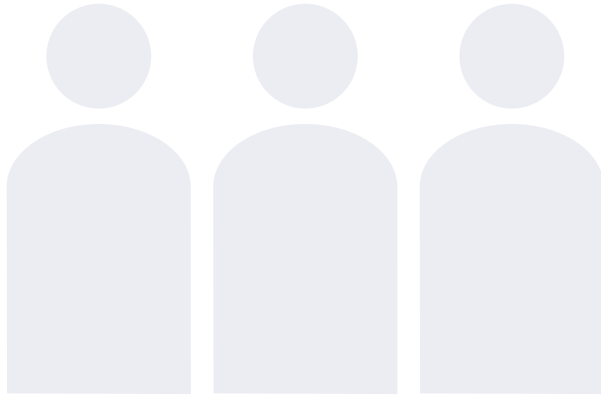
The LPH Act requires each CHB to serve a population of at least 30,000 people. If a single county doesn't meet the population requirement, it can form a CHB with one or more neighboring counties. If a CHB serves three or more contiguous counties, the minimum population requirement does not apply. There are currently 52 CHBs in Minnesota; of those, 27 are single-county CHBs and 21 are multi-county CHBs (serving 58 counties). Four metropolitan cities (Minneapolis, Bloomington, Edina, and Richfield) each have their own CHB. The number of CHBs in the system has varied over time and is subject to change.

CHBs are required to have a community health services administrator and a medical consultant. Members of the CHB are either elected or appointed; the membership, composition, and business practices of CHBs vary throughout the state.

# The CHS Advisory Committee

Minnesota's CHS Advisory Committee provides a forum for local public health entities to exchange information and jointly address key public health issues. The group itself is made up of a representative from each CHB.

Its work is accomplished through quarterly meetings, conferences, work groups, and distance learning. Established to “advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of community health services” (Minn. Stat. § 145A.10), this group also advocates for public health in Minnesota.



## The Roles of the Local, State, and Federal Governments

### State and Local Roles

Public health in Minnesota is primarily population-based. Although local health departments provide services to individuals, the goal of a population-based approach is very different from that of a patient-based or client-based approach that addresses the needs or concerns of an individual. Since public health activities are based on community needs and resources, services vary among local public health departments.

Minnesota’s commissioner of health has the general authority for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens (Minn. Stat. § 144.05). Such programs and services are related, but not limited to, maternal/child health, environmental health, public health emergency preparedness, disease prevention, control and epidemiology, public health administration, healthy communities and behaviors, licensing and inspection, and health care access.

The MDH is also responsible for monitoring, detecting, and investigating disease outbreaks; researching causes of illness and operating prevention programs; providing laboratory services; safeguarding the quality of health care, working to contain health care costs and assure that all Minnesotans have access to health care; safeguarding the quality of food, drinking water, and indoor air; developing strategies to improve the health of vulnerable populations; and working to eliminate health disparities.

In partnership with local public health entities, the MDH helps with everything from developing guidelines to providing technical assistance and support to funneling state and federal funds to CHBs. Its specialists and scientists collect and analyze data that are used for research, resource development, and program development throughout the state. The MDH also has staff in seven district offices who provide assistance to LHDs (and others) regarding epidemiological investigations and consultation, emergency preparedness, environmental health, public and nonpublic water supplies, maternal/child health, public health nursing,

and the practice of public health, as well as other areas. The seven MDH district offices are located in Duluth, St. Cloud, Bemidji, Fergus Falls, Marshall, Mankato, and Rochester.

### Federal Influences

State and local health departments work with a number of federal agencies, primarily those within the U.S. Department of Health and Human Services. For example, the Centers for

Disease Control and Prevention leads efforts to control communicable disease outbreaks and promote mass immunization. The federal government also assists states with funding (when state resources are not available) and guidance for work such as emergency preparedness. At both the state and local level, Minnesota relies on these offices for grant funding and expertise.

## History



### History of Medicine and Public Health

Historically, the relationship between medicine and public health in the United States can be characterized as having proceeded in three phases: an early supportive relationship prior to the beginning of the 20th century; a period of professionalization and practice transformation spurred by the emergence of bacteriology; and an acceleration of functional separation in the post-World War II era.

For a comprehensive look at the history of medicine and public health, read:

*Medicine and Public Health: the Power of Collaboration*, a landmark analysis of the history of the two healthcare sectors, a collection of 400 case studies on medicine and public health collaboration, and an initiative to encourage further collaboration (available at <http://www.cacsh.org/pdf/MPH.pdf>).

“Bridging the cultures of medical care and public health is not choosing one or the other, nor is it creating an artificial culture which denies their diversity. Rather, it requires grasping and making real a whole which encompasses both, and which requires the contributions of both to achieve the goals of either”

*Kristine M. Gebbie, 1992*

## History of Minnesota Public Health

The public health responsibilities of both local and state governments in Minnesota date back to the mid-1800s when towns and cities were authorized to enact regulations for controlling infectious disease. They formed township boards of health, and all early public health work was done at the local level. There was no central or organized public health body in the state.



Minnesota's first State Board of Health facility in Red Wing, MN.

Change came with the arrival of Charles Nathaniel Hewitt. As an Army surgeon in the Civil War, Hewitt clearly saw that poor sanitation and hygiene were related to disease and death among the troops. After the war, he found the transition to civilian medical practice difficult. Hewitt accepted an invitation to come to Red Wing, bringing with him his convictions that improving and restoring health was about more than medical practice – it was also about social change and environmental engineering. In 1872, a State Board of Health was established in Red Wing and Dr. Hewitt became Minnesota's first health officer. Eventually, all political jurisdictions, townships, counties, villages, and cities were required to appoint health officers.

Recognizing that local communities often are more

aware of local threats to health than the state, and are better-suited to address specific issues, the State Board of Health encouraged communities to create local boards of health in the 1900s.

The responsibilities of these local boards were three-fold:

1. To assess the health of their community, including reporting live births and causes of death and disease;
2. To develop policies to limit the spread of communicable disease; and
3. To assure sanitary conditions conducive to a healthy community.

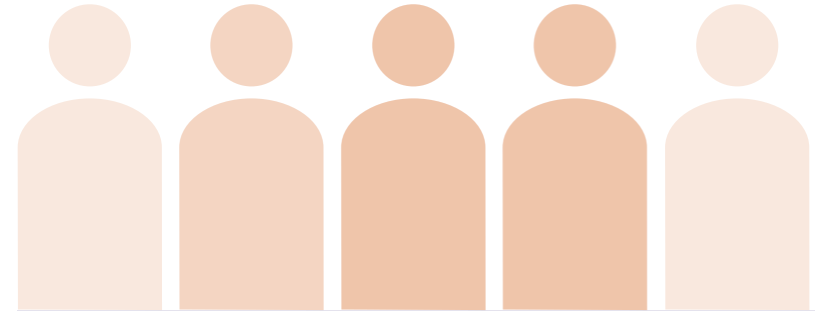
State field offices opened to support the local boards of health in the 1930s. Each was staffed with a medical director, an engineer, and a public health nurse. In the mid-1940s, legislation gave LHDs updated authority including responsibility in the areas of maternal and child health, health education, disease prevention, and restaurant inspections. In addition, the Legislature provided small amounts of state aid for the cost of providing local public health nursing services. Such services typically included maternity services, health supervision of infants and children, communicable disease control with immunizations for diphtheria/tetanus and smallpox, and some bedside nursing. Other early activities of the state and local health boards focused on four areas – sewage management, restaurant and food inspections, milk quality, and meat inspections.

## National Public Health Accreditation Standards

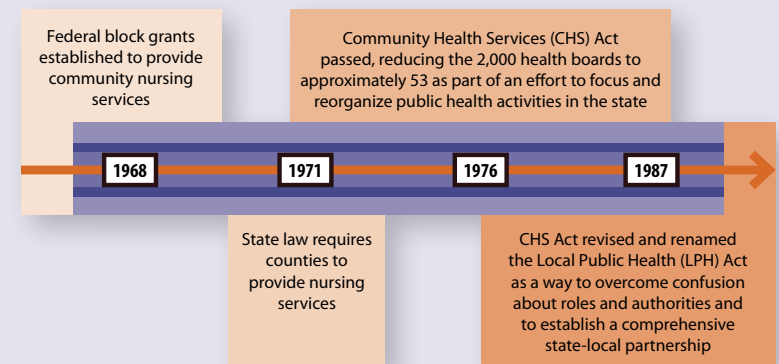
In recent years, there has been recognition at the national level of the lack of standardization between health departments, and a need to identify what state and local health departments should do to deliver quality public health programs and services. This led to the development of a set of standards that health departments can put into practice to ensure that they are providing the best services possible to keep their communities safe and healthy. The Public Health Accreditation Board has developed a national voluntary accreditation program for state, local, territorial, and tribal public health departments. The accreditation process will drive public health de-

partments to continuously improve the quality of the services they deliver to the community. Ways that the medical consultants may play a role in this are by:

- Promoting the value of having an accredited health department in their communities;
- Speaking to the media, health care providers, the public, and policy makers on behalf of their CHB;
- Assisting their CHB in meeting standards such as analysis and consultation on surveillance data; and
- Participating in community health assessment and improvement planning processes.



Public health activity in Minnesota continued to increase throughout the 20th century. Today, the work of public health has expanded to many other governmental agencies and private industries. The following timeline shows some of the significant changes that have taken place since the 1960s:



## Glossary

The **community health services (CHS)** system is Minnesota's statutorily defined local public health system. The purpose of the CHS system is to develop and maintain an integrated network of community health services under local administration within a broad set of state guidelines and standards (Minn. Stat. § 145A.09). Minnesota's CHS system is designed to help the state and local governments fulfill their governmental public health responsibilities in a coordinated and effective way so as to protect, maintain, and improve the health of all Minnesotans.

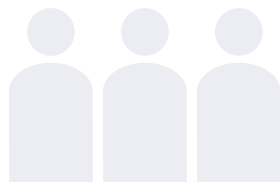
A **community health board (CHB)** is the legal governing authority for local public health in Minnesota and is the only entity able to receive the Local Public Health Act funding. There are 53 CHBs in Minnesota covering all 87 counties.

**Governmental public health** refers to federal, state, and local governments that have been granted authority to act on behalf of people within a jurisdiction through rules and regulations to protect a population's health. Examples include disease-reporting requirements, environmental protection laws, and legislation. Governments — local, state, and federal — have an obligation and a mandate to assure that the health of the public is protected, maintained, and enhanced. In Minnesota, this responsibility is shared between state and local governments.

The **Local Public Health (LPH) Act**, Minnesota Statute 145A, outlines the duties and responsibilities of a CHB. With funding from the state, CHBs are tasked with a variety of responsibilities such as assessing and prioritizing public health issues and delivering a minimum set of services.

**Population-based health** encompasses public health programs, initiatives, and interventions intended to improve or protect the health status of an entire population. Public health interventions are population-based if they do the following: 1) focus on the needs of entire populations possessing similar health concerns or characteristics; 2) are guided by an assessment of the health status of a population through a community health assessment; 3) consider the social determinants of health; 4) are based on all levels of prevention, with a preference for primary prevention; and 5) are focused on individuals, families, communities, and systems.

**Public health** was defined by the Institute of Medicine in 1988 as “the fulfillment of society's interest in assuring the conditions in which people can be healthy” (The Future of Public Health, The Institute of Medicine, 1988). It has also been defined as “the science and art of preventing disease, prolonging life, and promoting health and efficiency through organized community effort for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and for the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity” (C. E. A. Winslow, 1920).



## Resources

**MDH Website** – provides information on public health topics, current issues and activities, and information for providers and consumers. The ‘About Us’ section provides an overview of the organization through listings of divisions and units and descriptions of its mission and goals. <http://www.health.state.mn.us/index.html>

**Community Health Services Administration Handbook** – useful in day-to-day public health practice in Minnesota. <http://www.health.state.mn.us/divs/cfh/ophp/resources/docs/chsadminhandbook.pdf>

**LPH Authorities and Mandates Grid** – summarizes selected state and federal statutes and rules that pertain to community health boards with regard to public health in Minnesota. <http://www.health.state.mn.us/divs/cfh/ophp/system/administration/index.html>

**MMA Website**  
<http://www.mnmed.org>

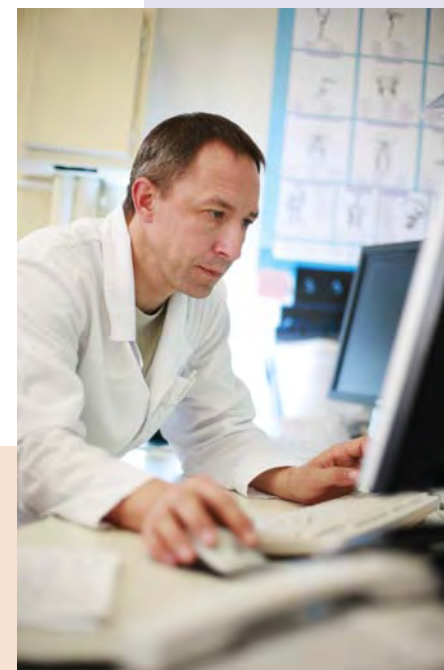
### Other Sites of Interest

**CDC Website**  
<http://www.cdc.gov>

**Public Health Accreditation Board**  
<http://www.phaboard.org>

**“Overcoming Obstacles to Health”**  
Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America, February 2008.  
<http://www.rwjf.org/files/research/obstaclestohealth.pdf>

**Unnatural Causes – Is Inequality Making Us Sick?**  
<http://www.unnaturalcauses.org>





February 2011

Special thanks to the medical consultants, public health directors, community health services administrators, and representatives of organized medicine who contributed to the production of this handbook by sharing from their own experiences and offering valuable feedback:

Tom Clifford, M.D., Ed Ehlinger, M.D., Sue Erzar, Allie Freidrichs, Cris Gilb, Amy Gilbert, M.D., Sue Hedlund, Neal Holtan, M.D., Lowell Johnson, Ron Johnson, M.D., Leonard Lamberty, M.D., Steven Meister, M.D., Ralph Morris, M.D., Karen Nelson, Michelle Rein, M.D., Deb Rock, Linda Yourczek, and the Twin Cities Medical Society.



Minnesota Department of Health  
Office of Performance Improvement  
PO Box 64882  
St Paul MN 55164-0882  
651-201-3880  
TTY – 651-201-5797



Minnesota Medical Association  
1300 Godward St NE Suite 2500  
Minneapolis MN 55413  
612-378-1875  
800-342-5662