



PHAC Training Manual
Public Health Advisory Committee
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CITY OF MINNEAPOLIS,

HENNEPIN COUNTY

STATE OF MINNESOTA



This training manual will provide an orientation for the membership of the City of Minneapolis Public Health Advisory Committee.

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PHAC Orientation Manual

Public Health in America

Overview



Vision and Mission

As set by the U.S. Department of Health and Human Services

I. Vision

Healthy People in Healthy Communities

II. Vision

Healthy People in Healthy Communities



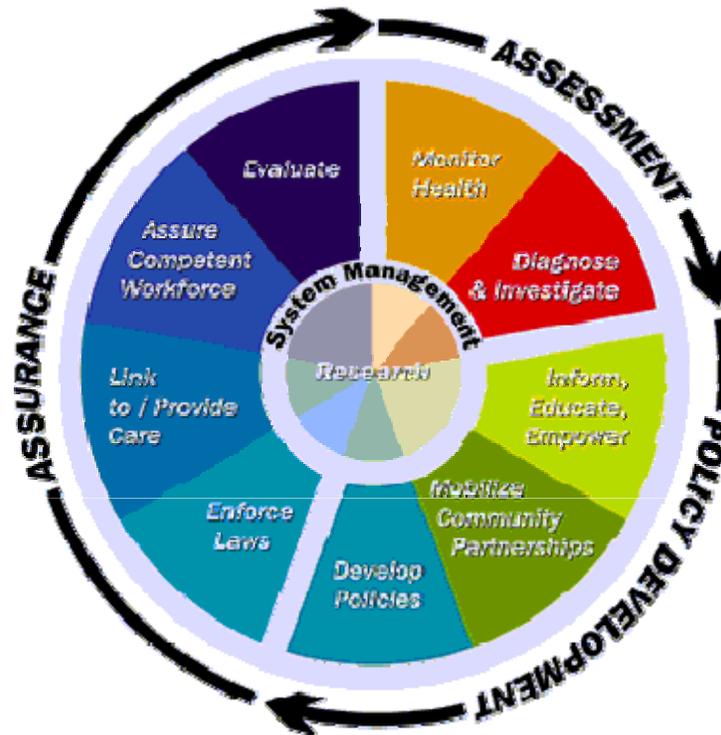
Public Health Definitions

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services



Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems



Adopted: Fall 1994, Source: Public Health Functions Steering Committee, Members (July 1995): American Public Health Association·Association of Schools of Public Health·Association of State and Territorial Health Officials·Environmental Council of the States·National Association of County and City Health Officials·National Association of State Alcohol and Drug Abuse Directors·National Association of State Mental Health Program Directors·Public Health Foundation·U.S. Public Health Service --*Agency for Health Care Policy and Research·Centers for Disease Control and Prevention·Food and Drug Administration·Health Resources and Services Administration·Indian Health Service·National Institutes of Health·Office of the Assistant Secretary for Health·Substance Abuse and Mental Health Services Administration*



Local Public Health in Minnesota

Minnesota's local public health system, also known as the Community Health Services (CHS) system, is designed to assure that the public's health and safety are protected while providing the flexibility local governments need to identify and address local priorities.

What is the local public health system in Minnesota?

- ▶ Responsibilities for health promotion and protection are shared with the Minnesota Department of Health as outlined in Minnesota Statute 145A. This longstanding, unique framework has been nationally recognized.
- ▶ The CHS system consists of 53 community health boards. Each board oversees one or more local health departments that work in tandem with the state to fulfill public health responsibilities. This regional system has proven over time to be an efficient and effective model for assessing community needs, designing appropriate programs to meet local needs, and directing limited resources.
- ▶ Public health departments work across multiple systems, including schools, law enforcement, social services, municipalities, non-profits and private health care providers to coordinate high quality and non-duplicative programs.
- ▶ To monitor health status, the local public health system collects data about the public's health. Just like the medical care system, this data collection needs to be modernized so that it can easily be compared, exchanged, and summarized. That way individual communities and the state can track progress toward health status goals.



Without a strong public health system as a complement, the medical care system cannot succeed in controlling health care costs or improving health. Unfortunately, attention to and investments in public health have been short term and episodic.

Minnesota Medical Association, Physicians Plan for a Healthy Minnesota:
The MMA's Proposal for Health Care Reform.
January 2005.

What do local public health departments do?

The local public health role is to work within communities to provide leadership, facilitate and coordinate partnerships, support other efforts related to individual, family and community health needs.

Some examples of local public health programs and services include:

- ▶ Immunization clinics.
- ▶ Home visiting to high risk pregnant women and new families.
- ▶ Women, Infants, and Children (WIC) clinics.
- ▶ Communicable disease investigation and control.
- ▶ Developing policies to foster healthy communities.
- ▶ Restaurant inspections.
- ▶ Inspections of lodging facilities, campgrounds, manufactured home parks, wells, and public pools.
- ▶ Providing health care services for those in county correctional facilities.
- ▶ Youth tobacco and chemical use prevention programs.
- ▶ Tracking meth labs.
- ▶ Public health nuisance investigations and abatement .
- ▶ Public health emergency planning and response.
- ▶ Activities to support elderly/ disabled in nursing homes or community settings, such as long-term care consultation, personal care assistant assessments, case management for people living in the community, and home health care.



Six Areas of Local Public Health Responsibility

1. **Assure an adequate public health infrastructure.**
2. **Promote healthy communities and healthy behaviors.**
3. **Prevent the spread of infectious disease.**
4. **Protect against environmental health hazards.**
5. **Prepare for and respond to disasters, and assist communities in recovery.**
6. **Assure the quality and accessibility of health services.**



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How are local public health departments funded?

- ▶ Funding for local public health is a mix of local, state and federal funds as well as fees and reimbursements. An annual general fund appropriation of approximately \$21 million (just over \$4 per capita) combined with local tax levy provides the foundation for the local public health infrastructure.
- ▶ Having a base of stable, non-categorical state funding is critical. It has allowed local health departments to respond to a diverse array of public health issues and to meet community-specific needs.

Public health programs are cost effective. For example, for every dollar invested in:

- ▶ WIC services for pregnant women, there is a savings of \$1.92 to \$4.21 in medical assistance (MA) funds for a mother and her newborn. (Nat'l Assoc of WIC Directors).
- ▶ Tobacco prevention, there is a savings of \$3 in direct health care costs. (ANSW Action Alert, 2003).
- ▶ Targeted home visiting, a savings of \$5.78 can be seen in reductions in higher cost treatment and deep end services. (Rand Corporation ROI for the Nurse Family Partnership program).



PHAC Training Manual Public Health in Minnesota

State Community Health Services Advisory Committee (SCHSAC)



What is SCHSAC?

The State Community Health Services Advisory Committee (SCHSAC) - pronounced "shack" - was created by the Minnesota Legislature in 1976 as one component of the Local Public Health Act. The Local Public Health Act began a unique partnership between the Minnesota Department of Health (MDH) and local government public health agencies. This partnership has since developed into an effective tool for protecting and improving the health of all Minnesotans.

The purpose of the SCHSAC, as described in the Local Public Health Act, is:

To advise, consult with, and make recommendations to the Commissioner of Health on matters relating to the development, funding, and evaluation of community health services in Minnesota.

There are currently 52 local public health authorities or Community Health Boards (CHBs).

- 26 counties function as single county CHBs
- 20 multi-county CHBs that encompass 60 counties
- four metropolitan city CHBs

Each Community Health Board selects one member and one alternate to represent their board on the SCHSAC.

A few more "nuts and bolts" about the SCHSAC:

- Meets four times a year (typically February, May, September and December).
 - Agendas and other materials are sent in advance.
 - Three meetings per year are held in the Metro area from 10:00 AM - 2:30 PM; the Fall meeting is held in the Brainerds Lakes area in conjunction with the annual Community Health Conference.
 - Commissioner of Health and other Executive Office staff attend meetings whenever possible.
 - Members are reimbursed for travel and parking.
 - Alternates may be appointed.
 - An eleven-member Executive Committee representing all regions of the state meets more frequently to conduct interim business.
 - The SCHSAC develops an annual work plan to focus its activities; much of the work plan is accomplished through smaller work groups which may include SCHSAC members, alternates, or others.
 - Members receive a handbook, which includes the annual work plan, operating procedures, and other materials.
 - An orientation for new members and alternates is offered at least once a year.
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PHAC Training Manual
Public Health in Minnesota
State Community Health Services Advisory Committee (SCHSAC)



Community Health Services Administration Handbook

Please read the following excerpts of the Community Health Services Administration Handbook located at

<http://www.health.state.mn.us/divs/cfh/ophp/resources/docs/chsadminhandbook.pdf>

CHAPTER TWO: Minnesota's Public Health System

Minnesota's statewide public health system is referred to in state statute as "Community Health Services", or CHS. The CHS system uses a coordinated approach among state and local public health departments to protect, maintain, and improve the health of all Minnesotans.

A history of public health in Minnesota

Minnesota has a long history of commitment to the public's health. Since the first state and local boards of health were established in 1872, the Legislature has recognized the important role of local government to protect the health of their communities.

The first action of the Legislature related to public health (sometimes referred to as "community health") was to authorize the appointment of local health officers and local health boards for townships and cities. County boards of health were also established, but their jurisdiction was limited to unorganized territories not covered by cities or towns. At that time, public health efforts were directed primarily at the control of communicable diseases and public nuisances. One statutory provision, only just repealed in 1987, stated that "the collection and disposal of night soil from privy vaults and the contents of cesspools shall be under the charge and supervision of, and shall be done by the departments of health in cities of first class."

In 1904, the first public health services were formed, and were financed by the Red Cross and Christmas Seals. The services provided included school nursing, the control of communicable diseases, and infant welfare. Family members usually took care of the sick at home, and were taught how to provide the needed care.

The influenza epidemic of 1918 and high rates of maternal and infant death led to major developments in local public health law. In 1919, local government was authorized to organize and provide public health nursing services. Additional authorities were added in the following decade.

In 1947, the Legislature authorized the formation of county health departments and provided a small amount 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, as well as some bedside nursing.

County public health nursing services grew slowly in the 1950s; at the time only fifteen counties had more than one nurse. By 1955, counties were allowed to adopt a sliding fee scale, which allowed them to hire registered nurses and licensed practical nurses to assist public health nurses.

By this time, the general public health authority of the State Board of Health also was well established. The State Board of Health encouraged communities to create local boards of health. The responsibilities of these boards were three-fold:

- 1) To assess the health of their community, including reporting live births and local 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.

Eventually, all political jurisdictions, townships, counties, villages, and cities were required to appoint health officers.

This effort was so successful that it created a new problem.

At its peak the State Board of Health was expected to communicate with over 2,100 local boards of health statewide (Figure 1). In July of 1977, the State Board of Health was replaced by a state agency, the current Minnesota Department of Health (MDH).

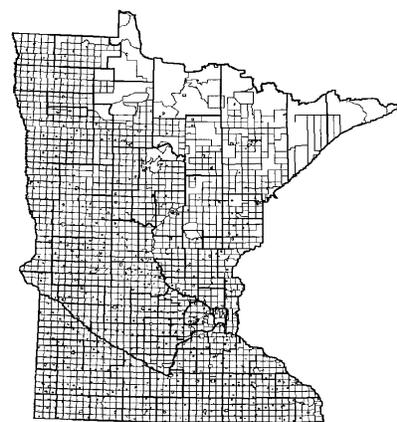


Figure 1:
Boards of Health Before
1976

A system for public health

In the mid-1970's, local and state public health activities were regulated by a patchwork of laws. The laws did little to govern the relations among local units of government, there were no provisions for funding general local public health activities, and there were few clear explanations of the relative roles of state and local health authorities. In addition, the sheer number of boards of health complicated efforts by state and local governments to share responsibility for public health.

In 1976, a landmark bill was passed – the Community Health Services (CHS) Act – this was the birth of the CHS system in Minnesota. The 1976 CHS Act, and its revisions through the 1987 Local Public Health Act, was designed to overcome the confusion regarding roles and authorities. It established a comprehensive system and laid the foundation for the effective state-local public health partnership we currently enjoy.

The 1976 CHS Act allowed county and city boards of health to organize as community health boards (CHBs), provided they met certain population and boundary requirements. By meeting those requirements, counties and cities became eligible to receive a state subsidy. The new CHBs also could preempt all township and city boards of health within their jurisdictions or could decide to authorize and give certain powers and duties to a board of health within its jurisdiction through joint powers or delegation agreements.

In 1987, the Minnesota Legislature further clarified the roles and responsibilities of the state and local public health system and replaced the CHS Act with the Local Public Health Act, also known as Chapter 145A. The Local Public Health Act was again modified in 2003 to streamline administrative requirements and combine several categorical grants.

As of March 2009, local boards of health are consolidated into 53 CHBs. Twenty-eight counties function as single-county CHBs; 59 counties cooperate in 21 multi-county or city-county CHBs; and four city CHBs (see map below). To see a larger map, please visit:

<http://www.health.state.mn.us/divs/cfh/ophp/system/administration/2008chbmap.pdf>.

An Effective Partnership for Public Health

Minnesota's state-local partnership

The state-local public health partnership initiated by the CHS Act is fundamental to the success of Minnesota's public health system. The CHS system is infrastructure for public health in Minnesota. It is a systematic organization of local health authorities that enables state and local governments to combine resources to serve public health needs.

The CHS system is structured to be responsive to the different needs of communities around the state, it provides the flexibility to address specific needs, and promotes direct and timely communications between state and local health departments. The CHS system is a responsive, successful, and cost-effective state and local partnership that relies upon shared goals and a desire to work together to improve the lives of all Minnesotans.

Many aspects of Minnesota's public health system make it an effective partnership. State and local governments share responsibility and a mission for public health. For example, the State CHS Advisory Committee (SCHSAC, pronounced "shack") helps to coordinate policy development and planning. Through SCHSAC, state and local governments jointly develop goals and guidelines and share responsibility for public health in Minnesota. Additionally, communities regularly assess their health status with the assistance of the MDH. The partnership is supported through ongoing communication and information.

Shared authority, responsibility, and accountability

Through the CHS partnership, state and local public health departments share authority and responsibility for protecting public health. Minnesota Statutes Section 144.05 describes the commissioner of health's general duties, and Chapter 145A describes the purpose of the community health boards (CHBs). These two sections of statute highlight the interdependency of state and local governments in meeting public health responsibilities:

State Government

The state commissioner of health shall have general authority as head of the state's official health agency and shall be responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens... (MN Stat. 144.05).

The state also plays a critical role, both in oversight of county responsibilities and also in assuring that local governments have the resources they need to carry out those responsibilities.

Mutual accountability for public health means that the state must:

- Clearly and consistently communicate the legal expectations of local government and the benefits of maintaining a strong public health system;
- Work with local governments to identify effective tools for management; and
- Assist local governments in securing the financial resources necessary to effectively protect and promote the public's health.

Local Government

The purpose of State Statute section 145A.09 to 145A.14 is to develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards (MN Stat. 145A.09).

When counties form community health boards they retain their local governmental responsibilities for basic health protection. In addition, they are required to assess the health problems and resources in their communities, establish local public health priorities, and determine the mechanisms by which they will address the local priorities and achieve desired outcomes.

An example of this shared responsibility is that the commissioner of health may direct local community health boards to take public health action. For example, in the case of communicable diseases: “A board of health shall make investigations and reports and obey instructions on the control of communicable diseases as the commissioner... [directs]. (MN Stat. 145A.04, Subd. 6)”

In addition, the commissioner may enter into formal or informal agreements with local agencies, such as when the commissioner delegates duties to CHBs (MN Stat. 145A.07).

The CHS system helps to define shared roles among state and local governments. This helps to eliminate the duplication of efforts and to provide a cost-effective means of delivering public health services that are customized to meet the needs of local communities.

A shared mission and vision

Community health services are designed to:

[P]rotect and promote the health of the general population...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. (MN Statutes 145A.02)

The mission of the community health services partnership is to lead efforts to protect and promote the health of all people in Minnesota .

The system also is strengthened by a mission statement shared among state and local public health departments. The CHS mission statement was created jointly by state and local public health representatives in 1990 and revised in 1996. It reflects the positive working relationship and willingness to cooperate and collaborate that characterizes Minnesota's public health system. The mission statement provides a context for community health planning and goal setting that combines the perspectives and strengths of state and local government.

Coordinated policy development

The Minnesota Legislature created the State CHS Advisory Committee (SCHSAC, pronounced “shack”) as a part of the original CHS Act in 1976. More than 30 years later SCHSAC continues to play an important role in many aspects of the state-local partnership. The purpose of the committee, as described in Chapter 145A, is to: “...advise, consult with, and make recommendations to the commissioner of health on matters relating to the development, maintenance, funding, and evaluation of community health services in Minnesota.” (Ch. 145A.10, Subd.5a(a))

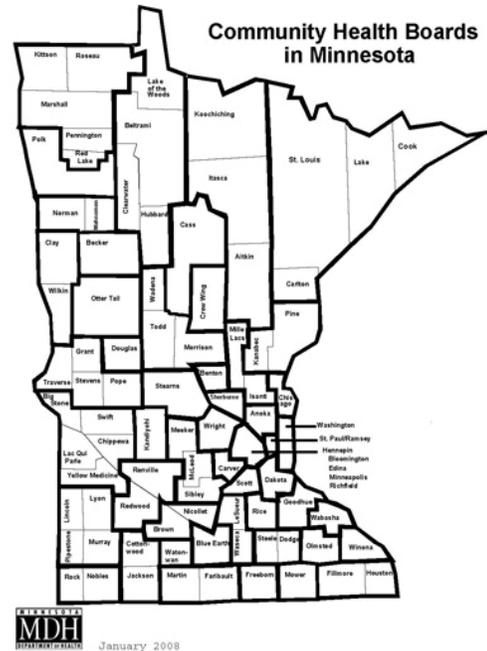
The vision for the public health system in Minnesota is of a strong and dynamic partnership of governments, fully equipped to address the changing needs of the public’s health.

The SCHSAC works together with the MDH to develop public health policies that represent the perspectives of local communities. The SCHSAC provides recommendations to the commissioner of health, and the commissioner in turn may ask the SCHSAC to review public policies of statewide significance.

The Essential Local Activities

An important example of the type of guidance and recommendation that SCHSAC makes for Minnesota local public health system is their 2004 recommendation that CHBs work toward outcomes on the Essential Local Public Health Activities or the "ELAs" in order to meet the intent of the Local Public Health Act.

The ELAs are a set of activities that all local public health departments in Minnesota are expected to be able to perform. They were developed by a SCHSAC work group which included local public health staff, local elected officials and representatives from the Minnesota Department of Health (MDH). The ELAs are sometimes described as, "What every Minnesotan should be able to expect from their local health department no matter where in the state they live." These activities are organized according to six "areas of public health responsibility".



1. Assure an adequate local public health infrastructure;
2. Promote healthy communities and healthy behavior;
3. Prevent the spread of infectious disease;
4. Protect against environmental health hazards;
5. Prepare for and respond to disasters and assist communities in recovery; and
6. Assure the quality and accessibility of health services.

The ELAs serve as the foundation for the "CHAAP" (Community Health Assessment and Action Planning Process) as well as for the "PPPMRS" (Local Public Health Planning and Performance Measurement Reporting System), which are described in Chapter 19. For the full text of the ELAs, please visit: <http://www.health.state.mn.us/divs/cfh/ela/index.html>.

Jointly created goals and guidelines

Shared goals are another product of the state-local partnership. State and local governments jointly determine both long-term and short-term goals for public health in Minnesota. These goals are used as guidelines for state and local priority setting. Jointly created goals also provide a standard for evaluating performance.

Public Health Goals

The national Healthy People 2020 Goals and Minnesota's "Healthy Minnesotans: Public Health Improvement Goals" were both under development at the time of publishing of this document. For more information on the national goals, please visit: <http://www.healthypeople.gov/hp2020/>. For updated information on the timeline for the release of Minnesota's new goals, please contact the Office of Public Health Practice, at the Minnesota Department of Health at (651) 201-3880.

Guidelines

Each year, the SCHSAC works with the MDH to design an annual work plan to address the important issues related to community health services, and to develop policy recommendations for the commissioner. After the work plan is determined, the SCHSAC works with MDH staff to address the issues. Work groups are formed to develop policy recommendations for the commissioner. The standards and guidelines developed through the SCHSAC serve as policies that CHBs may use to address public health problems within their community.

Effective communication channels

Communication between state and local public health occurs through several channels, including:

- Regular meetings of the SCHSAC and its subcommittees;
- Consultation and technical assistance provided by MDH program and district office staff;
- Vital statistics and surveillance data provided from the MDH;
- The Health Alert Network (HAN), an electronic resource for the exchange information during a disease outbreak or disaster;
- Conferences, including the jointly-planned annual Community Health Conference;
- The weekly, electronic CHS Mailbag & Calendar;
- Video conferencing and Webinars, including communication from MDH about national programs; and
- Development and maintenance by MDH of listservs (e.g., the CHS-PHN GovDelivery list), Web sites, and other methods of rapid communication.

To learn more about these communication vehicles and opportunities please visit: <http://www.health.state.mn.us/divs/ophp/>.

CHAPTER NINETEEN: CHS Planning and Reporting: CHAAP & PPMRS

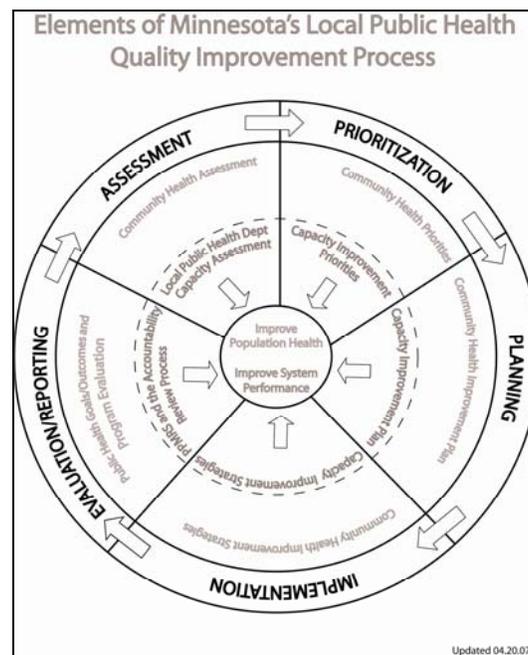
The Local Public Health Act of 2003 established a five-year cycle (which began in 2005) for developing and reporting local priorities and essential local activities. What was once known as “CHS planning and reporting” is now known as the Community Health Assessment and Action Planning Process (“CHAAP”) and the Local Public Health Planning and Performance Measurement Reporting Process (LPH PPMRS).

CHAAP

The Community Health Assessment and Action Planning process or "CHAAP" is the process that local public health departments in Minnesota will use to:

- Assess and prioritize the health needs of their communities;
- Assess and prioritize their own internal capacity to meet those health needs; and
- Develop an action plan (community health improvement plan and capacity improvement plan) to meet those needs.

Minnesota’s Community Health Assessment and Action Planning (CHAAP) process is one component of a larger local public health quality improvement process. Other components of the larger improvement process include the local public health Planning and Performance Measurement System (PPMRS) and the Accountability Review Process.



The CHAAP process is based on the former CHS planning process. It is similar to that process in that it includes community health assessment and planning components. Yet, the process also includes several newly designed components, including a capacity self-assessment and an action plan designed around the six areas of public health responsibility. In addition, CHAAP stresses the importance of engaging the community. For more information on CHAPP, please contact your Public Health Nurse Consultant or visit:

<http://www.health.state.mn.us/divs/cfh/ophp/system/planning/chaap/index.html>.

PPMRS

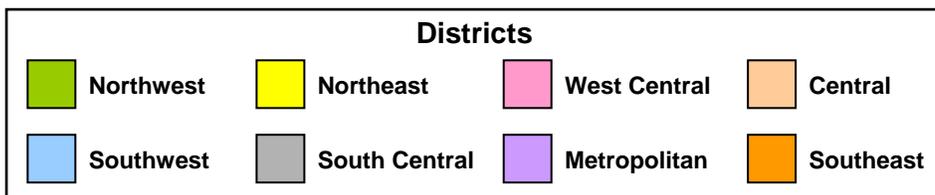
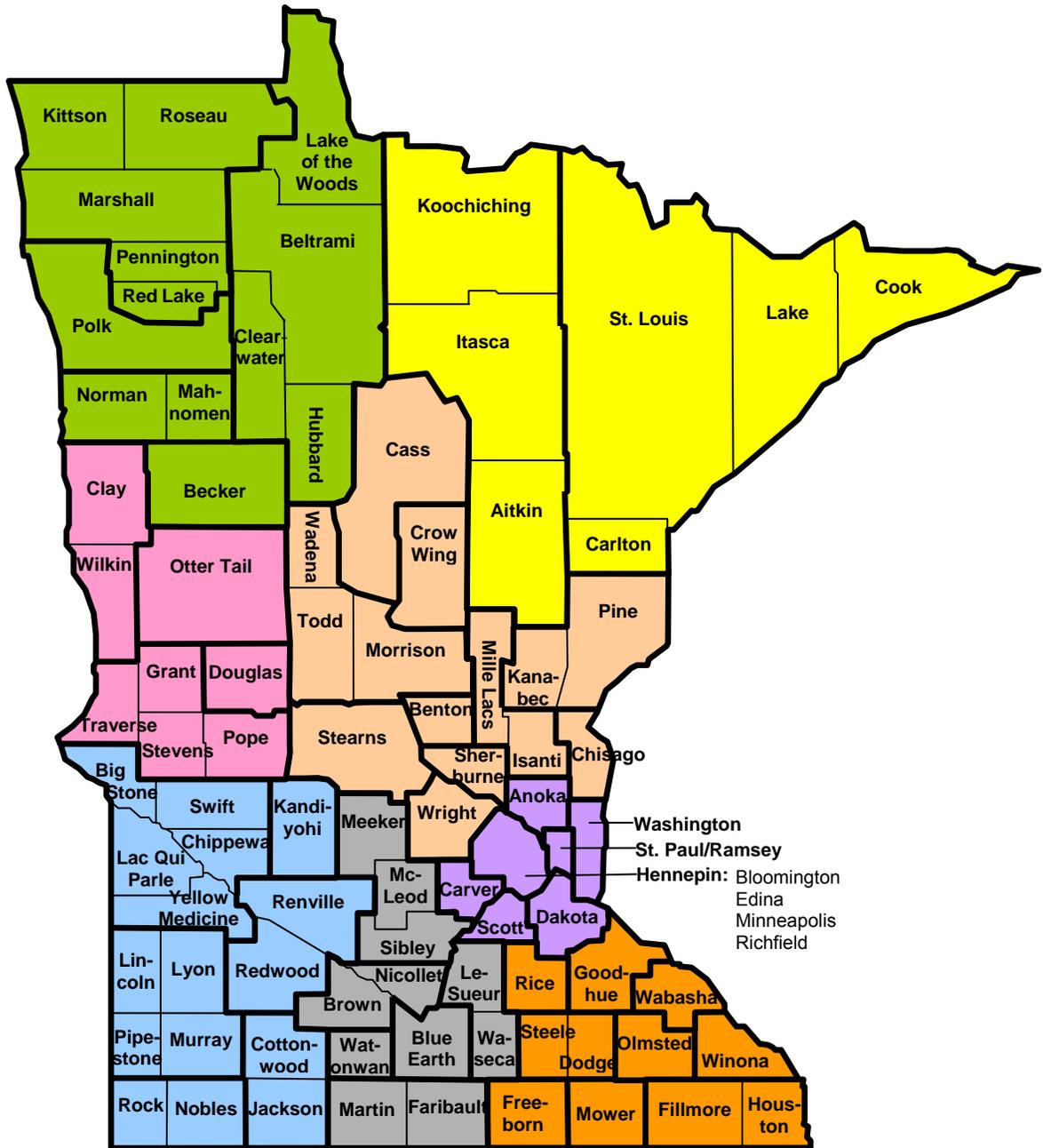
The Minnesota Department of Health along with SCHSAC has developed a Web-based information system that collects and reports on the activities, funding, staffing and performance of Minnesota's local public health departments. This system, the Planning and Performance Measurement Reporting System (PPMRS) provides to the MDH and local public health:

- A description of the key aspects of Minnesota's local public health system;
- Standardized quality reports for ongoing evaluation, decision making, and technical assistance for improving local public health services;
- Information for accountability for local public health and MDH to meet the requirements of state and federal reporting requirements; and
- Up-to-date contact information for local health departments and community health boards.

For more information on reporting, please visit the Local Public Health Planning and Performance Measurement Reporting System (PPMRS) site at:

<http://www.health.state.mn.us/ppmrs> .

Community Health Boards in Minnesota by Region



Minnesota

Areas of Public Health Responsibility and Essential Local Public Health Activities

Area 1: Assure an Adequate Local Public Health Infrastructure

- IN1 Maintain a local governance structure for public health, consistent with state statutes.
- IN2 Assess and monitor community health needs and assets on an ongoing basis for each of the six areas of public health responsibility in this framework.
- IN3 Identify community health and prevention priorities every five years with input from community members and key partners, including communities of color, tribal representatives and special populations, ensuring that community wisdom and cultural diversity are used to understand and interpret qualitative and quantitative information.
- IN4 Every five years, develop an action plan with evaluation measures and recommended policy options to address essential local activities and local priorities.
- IN5 Convene community members and key community partners, including communities of color, tribal representatives and people with special needs to build community collaborations, determine roles, identify and leverage community assets/resources and participate in research that benefits the community, as resources allow.
- IN6 Advocate for policy changes needed to improve the health of populations and individuals.
- IN7 Lead or participate in efforts to foster healthy physical, economic, and social environments (e.g., participate in community improvement and development decisions).
- IN8 Provide annual information to MDH to evaluate progress toward statewide outcomes and local priorities, and to meet federal reporting requirements.
- IN9 Meet personnel requirements for the CHS Administrator and the Medical Consultant.
- IN10 Designate, recruit, train and retain local public health staff so that every local agency has appropriate expertise in each of the six areas of public health responsibility.
- IN11 Recruit local public health staff who reflect the cultural and ethnic communities served.

Area 2: Promote Healthy Communities and Healthy Behaviors

- HC1 Engage the community on an on-going basis to promote healthy communities and behaviors through activities including but not limited to (a) assessment, prioritization and developing action plans, (b) coalition building, (c) community readiness, (d) empowerment, and (e) decision making.
- HC2 Based on community assessment, resources, and capacity, include in the five-year action plan: the promotion of healthy communities; healthy behaviors (e.g., physical activity, nutrition, tobacco, alcohol and other drug use, unintentional pregnancy, HIV/AIDS/STD); mental health; maternal and child health; and the prevention of injury and violence.
- HC3 Conduct evidence-based, culturally sensitive programs, and disseminate information on services and resources to promote healthy behaviors and communities (e.g., physical activity, nutrition, tobacco, alcohol and other drug use, unintentional pregnancy, HIV/AIDS/STD), mental health, maternal and child health, and/or the prevention of injury and violence.
- HC4 Inform and educate different audiences, e.g., general public, providers and policy leaders, about healthy communities and population health status.
- HC5 Support the development and enforcement of policies, and encourage cultural norms that promote healthy communities.
- HC6 Participate in decisions about community improvement and development to promote healthy behaviors and communities.
- HC7 Promote healthy growth, development, aging, and management of chronic diseases across the lifespan.
- HC8 Identify and address the needs of vulnerable populations, e.g.: high-risk pregnant women, mothers, and children; the frail elderly; persons with mental illness; and people experiencing health disparities.

(cont'd)

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 651-201-3880 / 651-215-8980 TDD
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Minnesota

Areas of Public Health Responsibility and Essential Local Public Health Activities

Area 3: Prevent the Spread of Infectious Disease

- ID1 Work with medical providers and other community partners to facilitate disease reporting and address problems with compliance.
- ID2 Assess immunization levels and practice standards, and promote/provide age appropriate immunization delivery.
- ID3 Assess infectious disease risks in jurisdiction, apprise community of risks and assure appropriate interventions.
- ID4 Based on surveillance data, develop strategies and plans to detect and respond to infectious disease problems and outbreaks within jurisdiction/region.
- ID5 Assist and/or conduct infectious disease investigations with MDH.
- ID6 When surveillance detects an imminent threat of infectious disease outbreak or epidemic, implement appropriate local disease control programs, including but not limited to mass treatment clinics, mass immunizations clinics, and isolation and quarantine.

Area 4: Protect Against Environmental Health Hazards

- EH1 Provide the general public and policy leaders with information on health risk, health status, and environmental health needs in the community as well as information on policies and programs regarding environmental health threats to humans.
- EH2 Identify the federal, state, tribal or local agencies with regulatory authority and bring people together to address compliance with public health standards.
- EH3 Develop public health nuisance policies and plans, and assure enforcement of public health nuisance requirements.
- EH4 Monitor the community for significant and emerging environmental health threats, and develop strategies to address these threats.

Area 5: Prepare For and Respond To Disasters, and Assist Communities in Recovery

- EP1 Provide leadership for public health preparedness activities in the community by developing and maintaining relationships with community partners at the local, regional, and state levels.
- EP2 Conduct or participate in ongoing assessments to identify potential public health hazards and the capacity to respond.
- EP3 Develop, exercise and periodically review threats to the public's health.
- EP4 Participate in surveillance and monitoring activities to detect patterns of unusual events; implement appropriate actions.
- EP5 Participate in all hazard response and recovery.
- EP6 Develop and maintain a system of public health workforce readiness, deployment and response.
- EP7 Develop and implement a system to provide timely, accurate and appropriate information in a variety of languages for elected officials and the public, the media, and community partners in the event of all types of public health emergencies.

Area 6: Assure the Quality and Accessibility of Health Services

- HS1 Identify gaps in the quality and accessibility of health care services.
- HS2 Based on the on-going community assessment, inform and educate the public and providers on issues related to the quality and accessibility of health care services in the community.
- HS3 Lead efforts to establish, maintain, and/or improve access to personal health services, including culturally competent preventive and health promotion services, as identified in the planning process.
- HS4 Promote activities to identify and link people to needed services.

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651-201-3880 / 651-215-8980 TDD
www.health.state.mn.us



Summary of Powers and Duties for Minnesota Local Boards of Health

A BOARD OF HEALTH must:

1. Enforce laws, regulations and ordinances pertaining to its powers and duties within its jurisdictional area.
2. Make investigations and reports and obey the instructions of the state commissioner to control communicable diseases.
3. Order the removal or abatement of a public health nuisance, and if the nuisance is not abated, **must** have the nuisance abated or removed at the expense of the property owner (see *Public Health Nuisance Control Guidelines*, January 1992).
4. Have at least five members, **must** elect a chair and vice-chair, and **must** hold meetings at least twice a year.
5. **Must not** deny services because of inability to pay.
6. **Must not** refuse or neglect to perform a duty on penalty of a misdemeanor.

A BOARD OF HEALTH may:

1. Enter into agreements: a) with the state commissioner to perform certain licensing, inspection, reporting, and enforcement duties; and b) to authorize townships, cities, or counties within its jurisdiction to establish a Board of Health, and **may** then delegate certain powers and duties to the newly-formed Board of Health. Such delegations must be approved by the state commissioner of health.
2. Form a Board of Health through joint powers agreements, and **may** withdraw from the agreement with proper notice.
3. Establish a health department, employ persons as necessary, and appoint, employ, or contract with a medical consultant to receive appropriate medical advice and direction.
4. Acquire property, accept gifts and grants or subsidies, and establish and collect reasonable fees. However, access to services provided by the Board of Health **must not** be denied because of inability to pay.
5. Contract to provide, receive, or ensure provision of services.
6. Enter a building, conveyance, or place where a cause of preventable disease is reasonably expected to exist in order to enforce public health laws, ordinances or rules.
7. Seek an injunction to enjoin the violation of statute, rule or ordinance.

A COMMUNITY HEALTH BOARD has all the powers and duties of a Board of Health, and in addition must:

1. Assess community health needs and assets; establish local public health priorities; and determine the mechanisms by which the community health board will address the local public health priorities and statewide outcomes within the limits of available funding. To determine these mechanisms, the CHB shall seek public input or consider the recommendations of the community health services advisory committee and consider the ten essential public health services.
2. Appoint, employ, or contract with a medical consultant.
3. Meet personnel requirements established for the CHS Administrator and the Medical Consultant.
4. Ensure that community health services are accessible to all persons on the basis of need.
5. Notify the commissioner in writing every five years of the statewide outcomes and local priorities that the board will address.
6. Work toward the Healthy People 2010 goals to reduce the state's percentage of low birth weight infants.
7. Provide the commissioner with annual information necessary to evaluate progress toward selected statewide outcomes and to meet federal reporting requirements.
8. Submit an annual report documenting progress toward the achievement of statewide outcomes and local priorities.
9. Consider the income and expenditures required to meet local public health priorities and statewide outcomes in levying taxes.

A Community Health Board may:

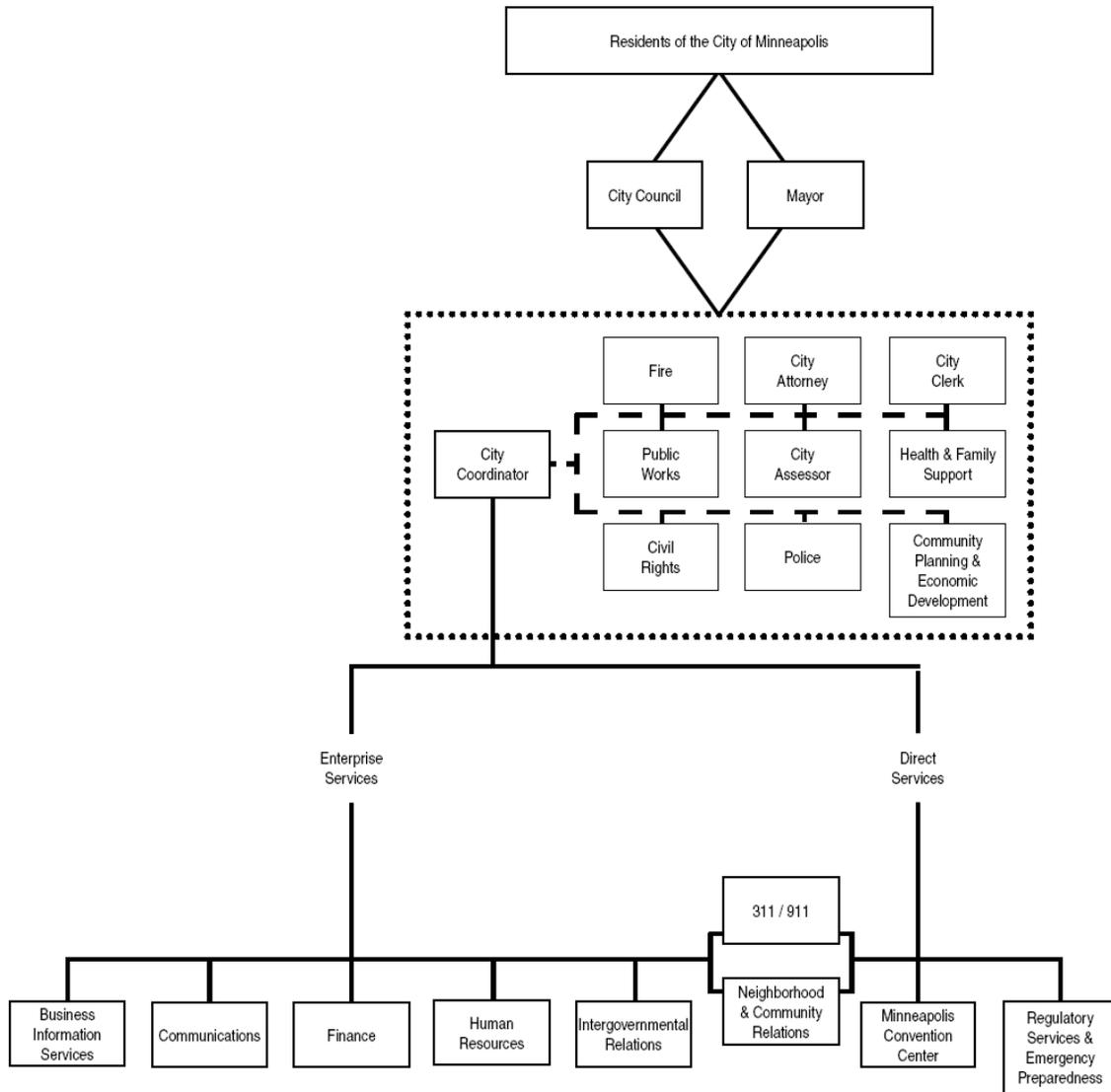
1. Appoint a Community Health Advisory Committee.
2. Recommend local ordinances to a county board or city council.
3. Appoint a member to the State Community Health Services Advisory Committee.
4. Use Local Public Health Act monies to address local public health priorities.

Minnesota Statutes 145A.03–145A.10

City of Minneapolis

City Coordinator

Organizational Chart



City of Minneapolis - Introduction

2009 Council Revised Budget

City Council 2011

350 South 5th Street, Room 307 - Minneapolis, MN 55415-1383
 Minneapolis Web site: www.ci.minneapolis.mn.us

Ward # Office	Council Member Council Office Associate Council Member Aide	673-	Ward # Office	Council Member Council Office Associate Council Member Aide	673-
1 Office Q	Kevin Reich Lisa Brock Shannon McDonough	x2201 x7920 x2003	8 Office C	Elizabeth Glidden Jennifer White Andrea Jenkins	x2208 x7114 x3569
2 Office L	Cam Gordon Nancy Olsen Robin Garwood	x2202 x7142 x3654	9 Office D	Gary Schiff Suzanne Murphy Heidi Hoffman	x2209 x7145 x3196
3 Office P	Diane Hofstede Vacant Peter Ebnet	x2203 x7146 x3142	10 Office O	Meg Tuthill Breanna Patsch Leslie Foreman	x2210 x7169 x3197
4 Office G	Barbara Johnson Audrey Rolfig Sara Goodnough	x2204 x7930 x3313	11 Office N	John Quincy Mary Petersen-am/ Barb Anderson-pm Kim Keller	x2211 x7143 x7147 x3314
5 Office B	Don Samuels Monique Cuff Steve Hogan	x2205 x7140 x3198	12 Office K	Sandy Colvin Roy Dawn Snow Loren Olson	x2212 x7138 x2378
6 Office E	Robert Lilligren Connie Kiser Nimco Ahmed	x2206 x7139 x3315	13 Office M	Betsy Hodges Mary Petersen-am /Barb Anderson-pm Ben Hecker	x2213 x7143 x7147 x3199
7 Office F	Lisa Goodman Ruth Hamann Weakly Doug Kress	x2207 x7144 x3195		City Council FAX Henn. Cty. Security MBC Operations EMERGENCY	x3940 9-348-5111 9-596-9512 9-911

City Clerk 2011

Administration	City Clerk: Casey Carl Assistant City Clerk: Tina Sanz Program Asst: Julie Meintsma Accountant: Diane Weigelt FAX	X3765 x2225 x3358 x3265 x3812	Records Management	Casey Carl Bob McCune Marsha Haagenon Tower	x3765 x3282 x3139 x3140
Committee Coordinators	Jackie Hanson (REE, PS&H) Irene Kasper (CD, Audit) Peggy Menshek (Charter, TPW, Claims) Anne Roth (Exec Cmte, WM/B, Elections) Anissa Hollingshead (ZP,COW, IGR)	x2046 x2219 x2287 x3130 x2296	Council Information	[Supervisor Admin Svc.] Sybil McMillan Colleen Peltier Anita Roby Tim Schwarz	x2225 x3135 x3947 x2654 x3136
Elections	Director: Vacant General Information Dani Connors-Smith (polls) Carol Strong (Judges, SEI) Judy Schwartau (web, training) [Elections Technician] Warehouse FAX	X3874 9-311 x3857 x3870 x3858 x3874 331-2446 x2756	Copy/Mail Room/ Data Operations	Supervisor Roger Williams John Maki Sheila Kretzmann Les DeCoteau Chris Johnson Jim Midthun FAX	x2570 x2354 x2354 x2354 x2354 x3302 x2376

M/Clerks/Common/Rosters,OrgChart,Oaths/2011/Roster Council-Clerk

Revisions contact: cityclerk@ci.minneapolis.mn.us

Revised: 01/13/2011 jkm

♥ = City Holiday

2011 COMMITTEE CALENDAR

💰 = City Pay Day

■ = City Council Meeting
9:30 am

■ = Claims
1:30 pm

■ = CoW
10:00 am

■ = CD
1:30 pm

■ = PS&H
1:30 pm

■ = RE&E
1:30 pm

■ = T&PW
9:30 am

■ = W&M
1:30 pm

■ = Z&P
9:30 am

■ = Audit
9:30 am

■ = Executive
9:30 am

■ = Off Week

JANUARY						
SUN	MON	TUE	WED	THU	FRI	SAT
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NOVEMBER						
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DECEMBER						
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18	19	20	21	22	23	24
25	♥26	27	28	29	30	31

✦ Meeting time rescheduled

*Last Updated 11/19/2010

City of Minneapolis
councilcommitteecoordinators@ci.minneapolis.mn.us



Vision

Health, equity, and well-being for all people in their communities

Mission

To promote health equity in Minneapolis and meet the unique needs of our urban population by providing leadership and fostering partnerships.

The Way We Work

- We build on our urban community's cultural diversity, wisdom, strengths, and resilience.
- We support individual health within the context of families and communities across the lifespan.
- To achieve health equity, we invest in the social and physical environments of our residents.
- We bring people and resources together to achieve our common health goals.
- Sound research and promising strategies inform our activities and decisions.
- We promote health as the interconnection of physical, mental, social, and spiritual well-being.

Much of our work is done through partnerships with community agencies. The Minnesota Visiting Nurse Agency provides Public Health Nursing for Minneapolis Residents through a contract with Health and Family Support. We also have a contract with the Neighborhood Health Care Network to help subsidize the cost of care for uninsured patients in community clinics.

Some of the major initiatives and programs we oversee include:

- Healthy Start – a program to decrease the infant mortality rate in African American and American Indian families
 - The School Based Clinics which we operate in 6 Minneapolis high schools
 - We are responsible for assuring that Minneapolis is prepared to address the health related issues of man made and natural emergencies
 - We have a number of initiatives directed at changing the system and policy environment so that Minneapolis residents have easier healthy choices and obesity and exposure to tobacco are decreased.
 - We are addressing Youth violence as a Preventable public health issue and have partnered with HCMC to institute new protocols in the Er for any young person admitted because of a violent injury.
-



MDHFS Goals 2011 - 2015

Strong Urban Public Health Infrastructure

- City and community prepared for emergencies – now and in the future
- Health care safety net for everyone who needs it
- Staff Diverse, engaged, skilled

Healthy Weight Through Active Living and Healthy Eating

- Affordable and accessible healthy choices for all ages and abilities
- Opportunities to grow, prepare and distribute food locally
- Communities informed and engaged for healthy environments

Healthy Sexuality and Relationships

- Prevent teen pregnancy
- Sexually Transmitted Infections/HIV rates declining

Thriving and Violence Free Youth

- Communities engaged in parenting & mentoring youth
- Invest in activities that promote skills, strengths & contributions of youth
- Re-engaging disengaged youth

A Healthy Start to Life and Learning

- Healthy homes – lead and smoke-free
- Thriving babies
- School-ready children

**CITY OF MINNEAPOLIS
HEALTH AND FAMILY SUPPORT
2010-2014 BUSINESS PLAN**

SEPTEMBER 2010

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WHO ARE WE?

VISION

Health, equity and well-being for all people in their communities

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- We build on our urban community's cultural diversity, wisdom, strengths, and resilience.
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- We bring people and resources together to achieve our common health goals.
- Sound research and promising strategies inform our activities and decisions.
- We promote health as the interconnection of physical, mental, social, and spiritual well-being.

IN ADDITION OUR WORK REFLECTS THE CITY VALUES

- Strong, strategic relationships
- Engagement and empowerment
- Results-driven
- Informed decision-making
- Transparency and accountability
- Ethical and respectful behavior
- Inclusive and diverse.
- Sustainability and stewardship

BUSINESS LINE DESCRIPTIONS

A. Promote health; healthy residents, communities, and environments

A major responsibility of a local public health agency is health promotion. In Minneapolis, we believe that community engagement and partnerships are critical to success in this area. We seek out representatives of diverse communities to elicit their unique perspectives and build on their strengths to improve community health. We involve families, youth, and seniors in decisions that affect their well-being. Special projects target key phases across the lifespan. For example: A long-term partnership with area clinics and social service agencies aims to improve the health of babies and mothers by promoting early entry into prenatal care and providing targeted health education and care coordination services up to two years after the baby's birth. Other programs aim to reduce youth violence and promote healthy development by providing mentors and offering out-of-school time activities to youth and assistance to parents of teens. School-based clinics provide nutritional counseling, mental health and reproductive health services to high school students. A senior center reduces social isolation and engages older residents in activities that promote and maintain health.

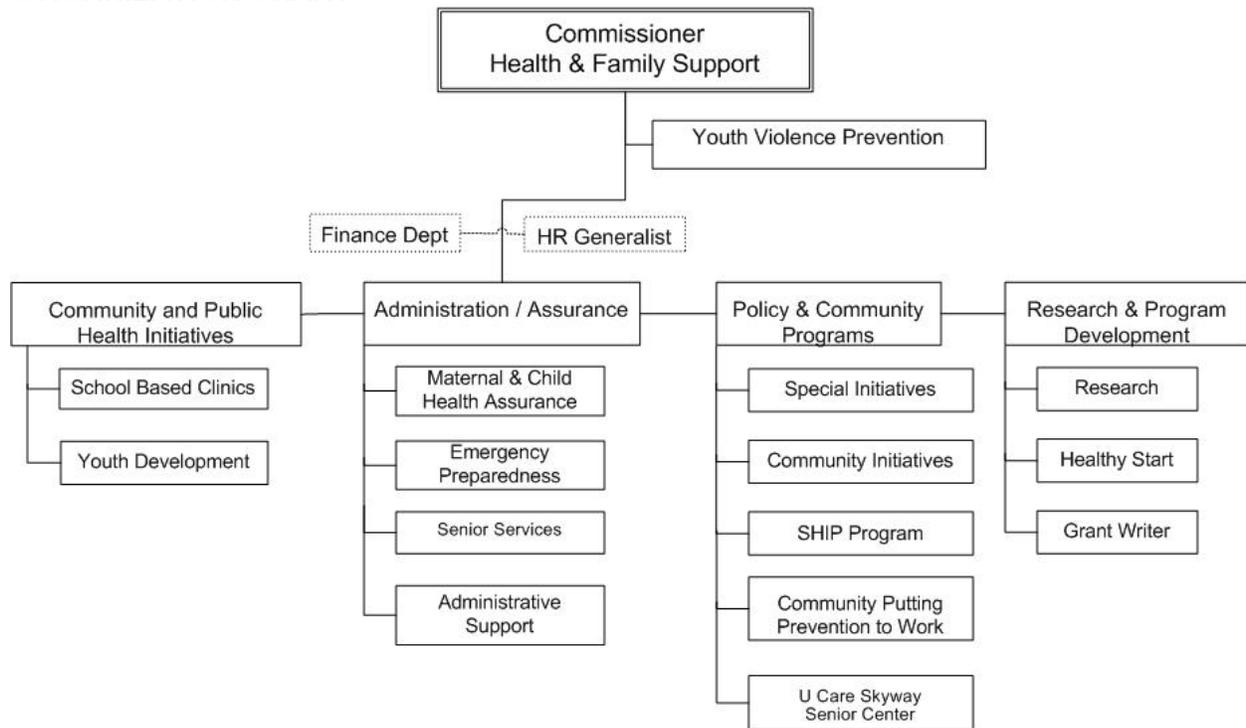
B. Address factors affecting health: social conditions and physical environment

Individual health is highly dependent on the environments in which individuals live and work, and this is most apparent in urban environments, where population density and mobility are higher and poverty is more concentrated. We work with community agencies to promote lead- and smoke-free homes and ensure physical safety for infants and toddlers in their homes and child care centers. To promote healthy weight through easier access to physical activity options and more nutritious foods, we work with City departments, schools, child care centers, and worksites to create healthier environments through policy changes. We also support place-based interventions, such as the Allina Backyard Initiative and the Northside Achievement Zone which aim to create broad collaborations to institute change at multiple levels to address a variety of goals simultaneously.

C. Protect the Public's health: disease prevention and control and emergency preparedness

Preventing and controlling infectious diseases is vital to community health. Pandemic influenza is an example of a situation that requires combined expertise in infectious disease control and emergency preparedness. We address our responsibilities through partnerships with Hennepin County, community clinics, and other community agencies. We identify populations at highest risk of specific diseases, such as sexually transmitted infections, and work with knowledgeable community members to develop targeted strategies that meet the unique needs of specific groups. As an urban public health agency, we focus on populations that require messages and intervention tailored to their particular needs, whether due to language differences, cultural norms, social isolation, or history of traumatic experiences.

ORGANIZATION CHART



WHAT DO WE WANT TO ACHIEVE?

DEPARTMENT GOALS, OBJECTIVES AND MEASURES (ALIGNED WITH CITY GOALS)-

City Goal	City Strategic Direction	Department Goal	Objective	Measure
A Safe Place To Call Home A City that Works	City employees high-performing, engaged and empowered	Strong Urban Public Health Infrastructure	City and community prepared for emergencies – now and in the future	Staff trained to basic awareness level within 3 months of hire. Branch Director positions trained to knowledge level within 6 months of designation. Staff designated for Command and Section Chiefs positions trained to proficiency level within one year of designation, and prior to assignment in a response . For each leadership position, maintain at least three deep staff trained.
A Safe Place to Call Home			Health care safety net for everyone who needs it	% of those who needed health care but delayed or didn't get it due to cost or no insurance
A City That Works	City employees high-performing, engaged and empowered		Diverse, engaged, and skilled staff	Department's staff diversity represents the racial/ethnic/cultural minority groups in the City. Staff's sense of recognition for outstanding service.

City Goal	City Strategic Direction	Department Goal	Objective	Measure
Livable Communities, Healthy Lives A City That Works	Active lifestyles: walkable, bikeable, swimmable and healthy choices are easy and economical Shared democracy empowers residents as valued partners	Healthy weight through active living and healthy eating	Affordable and accessible healthy choices for all ages and abilities	Percent of adult population at healthy weight Percent of children and adults physically active at recommended levels. Percent of obese or overweight adults who saw a health care provider in the past year who received weight loss advice from their provider
Eco-Focused	Locally grown food available and chosen		Opportunities to grow, prepare and distribute food locally	Homegrown Sustainability Indicator (under development)
Livable Communities, Healthy Lives	Healthy choices are easy and economical		Communities expect healthier environments	Percent of childcare programs implementing at least 50% of best practices related to food and physical activity.
Many People, One Minneapolis A Safe Place to Call Home	Teen pregnancy a thing of the past Youth ... in school, involved, inspired and connected to an adult	Healthy sexuality and relationships	Prevent teen pregnancy	Teen pregnancy rate by race, and age
Many People, One Minneapolis	Teen pregnancy a thing of the past	Sexual	y transmitted Infections/HIV rates declining	STI rate by race, age and community.
A Safe Place To Call Home	Youth . . . in school, involved, inspired and connected to an adult	Thriving and Violence Free Youth		Number of homicides among Minneapolis residents under 18 and 18 -24 years old Number of hospital- based reports of assault-related injury among Minneapolis residents under 18 and 18-24 years old Juveniles involved in violent crime as arrestees or suspects
A Safe Place To Call Home	Youth . . . in school, involved, inspired and connected to an adult		Communities engaged in parenting & mentoring youth	MPS students reporting someone in their family helps them with homework
A Safe Place To Call Home Jobs and Economical Vitality	Youth . . . in school, involved, inspired and connected to an adult Guns, gangs, graffiti gone Teens prepared with career and life skills		Invest in activities that promote skills, strengths & contributions of youth and re-engage disengaged youth	Minneapolis Public School (MPS) student participation in after school activities MPS students who feel safe at home Percent of students identified through Juvenile Supervision Center with no current school affiliations that successfully reenroll in school /educational program.
Sustain	gains against violent crime.		Expand capacity to address youth violence	Funds leveraged to implement Blueprint activities.

City Goal	City Strategic Direction	Department Goal	Objective	Measure
Eco-Focused Many People, One Minneapolis A Safe Place to Call Home	Tots school ready, teen on course Healthy Home, Welcoming Neighborhoods	A Healthy Start to Life and Learning	Healthy homes – lead and smoke-free	Percent of children 9-36 months old tested for lead poisoning and number of children under age 6 who test positive Number of rental properties (10 or more units) with building-wide smoke-free policies Children under 6 with lead poisoning
Many People, One Minneapolis			Thriving babies	Infant mortality rate by race
Many People, One Minneapolis	Tots school-ready, teens on course	School-read	y children	Children annually receiving health and developmental screening by age 3

The Department has a secondary role in three City Strategic Directions that are not reflected in the chart above:

- Collaborative and caring communities help prevent crime;
- Seniors stay and talents tapped; and
- New arrivals welcomed, diversity embraced.

There are no specific tactics described to address these strategic directions, rather they are a reflection of the way the Department works and are imbedded in the descriptions of the Department's business lines as well.

MEASURES, DATA AND TARGETS TABLE

Measure Name	2004 Data	2005 Data	2006	2007	2008	2009	2010 Target	2014 Target
Staff trained for public health emergencies - basic awareness level within 3 months of hire (100, 200, 700)							100%	100%
Percent of those who needed health care but delayed or didn't get it due to cost or no insurance			58%	NA	NA	NA	58%	25%
Percentage of population at healthy weight as defined by Body Mass Index among adults age 18 years and older			44.0	49.0	49.0	NA	52.1%	55%
Percent of children and adults meeting recommended physical activity levels			Adults 55%	Children 38%	Adults 62%	Children 35%	Children: 36% Adults: 64%	Children 50% Adults 70%
Percent of obese or overweight adults who saw a health care provider in the past year who received weight loss advice from their provider			25.8%	NA	NA	NA	30%	40%
Percent of Minneapolis child care programs implementing at 50% or more of best practices related to food and physical activity							32%	40%
Teen pregnancy rate defined as number of teen pregnancies per 1000 population aged 15-17 years.	49.9	45.1	53.3	49.4	43.5	34.0	46.0 Healthy People 2010	30.0
For whites (non-Hispanic)	13.6	13.6	15.7	13.6	16.6	8.9	15.0	8.5
For Blacks (non-Hispanic)	80.0	66.8	84.2	86.8	73.6	51.6	46.0	46.0
For American Indians	87.6	98.5	91.2	73.0	73.0	54.7	46.0	46.0
For Asian/Pacific Islanders	45.2	37.2	39.8	29.2	27.9	26.6	25.0	23.0
For Hispanics	109.6	100.2	130.4	119.1	83.2	88.8	46.0	46.0

Measure Name	2004 Data	2005 Data	2006	2007	2008	2009	2010 Target	2014 Target
STI rate defined as Gonorrhea rate per 100,000 people	264.3	313.9	312.6	311.0	264.2	175.9	161.0	161.0
For whites (non-Hispanic)	90.8	101.2	72.8	78.2	76.1	61.5	70.0	60.0
For Blacks (non-Hispanic)	791.6	931.3	1065.2	1088.8	956.4	584.1	161.0	161.0
For American Indians	286.1	481.2	507.2	403.2	208.1	156.1	161.0	150.0
For Asian/Pacific Islanders	34.3	64.4	42.9	30.1	60.1	25.8	60.0	30.0
For Hispanics	209.1	140.5	178.2	174.8	109.7	89.1	161.0	100.0
Number of homicide deaths among individuals aged 18-24 years in Minneapolis	17	15	16	13	11	6	0	0
Hospital based reports of assault-related injury under 18 years old	447	518	475	421	381	355	362	330
Hospital based reports of assault-related injury under 18 - 24 years old	976	1151	1231	1067	1108	1202	1000	750
Juveniles involved in violent crime as arrestees or suspects (smaller number is arrests)			293	257	182	176	NA	NA
			1272	950	710	618		
Student participation in after-school activities (8 th graders)			55%	54%	55%	52%	58%	69%
Students reporting someone in their family helps them with homework (8 th grade)			57.1%	57.65	57.1%	56.45%	58%	65%
Percent of students who feel safe in school			87%	87%	85%	87%	90%	92%
Percent of students identified through JSC with no current school affiliation that enroll in school							Measure is under development	Measure is under development
Funds leveraged to implement Youth Violence Prevention Blueprint activities							Approx. \$9 million in City funds	Tracking method being developed
Percentage of children 9-36 months old screened for lead poisoning	61%	71%	69%	72%	74%	66%	74%	85%
Children under 6 screening with lead poisoning	384	374	351	282	217	170	136	100
Percent of Minneapolis rental properties (10 or more units) with building-wide smoke-free policies							2010 baseline: .4% (24/5989 properties)	25%
Infant mortality defined as number of deaths in the first year of life per 1000 live births	6.2	6.1	6.5	6.8	7.9	7.1	4.5	4.5
	('02-'04)	('03-'05)	('04-'06)	('05-'07)	('06-'08)	('07-'09)		
For whites (non-Hispanic)	3.4	3.7	4.5	5.3	5.3		4.5	4.5
For Blacks (non-Hispanic)	9.6	10.1	10.0	11.1	13.3		12.9	4.5
For American Indians	9.2	13.2	12.9	7.9	9.1		8.0	4.5
For Asian/Pacific Islanders	2.9	2.3	3.0	3.9	3.0		2.3	3.0
For Hispanics	7.5	5.2	5.6	4.3	6.4		5.6	4.5
Number of 3-year-olds screened by Minneapolis Public Schools			837	828	989	1000	1,000	1,200

TACTICS AND DEPARTMENT INITIATIVES (ALIGNED WITH DEPARTMENT GOALS AND OBJECTIVES)

Department Goal	Objective	Tactics
Strong Urban Public Health Infrastructure	City and community prepared for emergencies – now and in the future	Assure a workforce trained to the level of expected role responsibility for timely response to decrease morbidity and mortality.
		Assure the capability to communicate effectively with other responders, including other City departments, and diverse populations.
		Maintain formalized regional relationships (local public health, EMS, hospitals and emergency management) which streamline coordination, planning and response.
		Foster a culture of preparedness and maintain strong formalized relationships with community partners, and especially with at-risk populations.
	Health care safety net for everyone who needs it	Support school-based clinic, community clinic, and public health nursing services to provide medical and dental care for the uninsured.
		Assure the quality of health care safety net services.
Diverse, engaged, skilled staff	Maintain the department as a welcoming place of employment that is reflective of the diversity of the City. Activities include broad recruitment of candidates for all positions, employee professional development plans to support advancement within the department and within their profession, and implementing the recommendations coming out of the employee survey.	
Healthy Weight through Active Living and Healthy Eating	Affordable and accessible healthy choices for all ages and abilities	Create a referral system of clinic and community based resources addressing physical activity, nutrition and tobacco use.
		Institute policies and practices to create healthy food environments in multiple settings: childcare, school, worksite and community (parks, farmer’s markets, convenience stores, multi-unit housing facilities, etc.). This includes working with MPS, the Parks, MPHA, Public works, Human Resources, and the MBC.
		Promote active living by increasing access to the following: biking and walking supports, safe and accessible recreational settings for families, active playtime for children in schools and childcare settings, and active transportation to worksites and schools. This includes working with Public Works, Parks, CPED, MPS, Human Resources, MPHA, and the Downtown TMO.
	Opportunities to grow, prepare and distribute food locally	Coordinate Homegrown Minneapolis (HGM) and implement department assigned recommendations in HGM report (EBT and market bucks at Farmers Markets, community food preservation and distribution, the creation of a policy framework for urban agriculture, creation of garden cluster model). This involves working with CPED and Public Works.
	Communities expect healthier environments	Implement Movement to Change media campaign in consultation with Communications and NCR.
		Provide technical assistance and support in over 200 settings (schools, worksites, community organizations and health care clinics) to improve their policies and practices regarding chronic disease prevention. This includes formalized relationships with MPS and charter and alternative schools.
		Conduct events and other community engagement strategies with residents of multi-unit housing properties, neighborhood residents and parents of child care and school-age children to increase their understanding and support of environmental change strategies. This includes working with Communications, NRC, MPHA, and PICA Head Start.
Healthy Sexuality and Relationships	Prevent teen pregnancy	Work with MPS to assure that youth are provided age appropriate and accurate education and counseling regarding their sexual and reproductive health.
		Assure access to confidential, adolescent friendly responsive health care and contraception.
		Assure that teen parents are connected to school to prevent subsequent pregnancies.
		Collaborate with youth serving agencies including the libraries and parks to engage youth in positive opportunities for growth and development.

Department Goal	Objective	Tactics
Sexual	y Transmitted Infections/HIV rates declining	Provide outreach to youth in innovative and culturally relevant ways to ensure they receive evidence-based STI prevention education and confidential counseling.
		Assure access to low-cost STI screening, testing and treatment resources.
		Monitor and disseminate STI incidence and prevention information to partners/community via outreach, reports and /or trainings.
Thriving and Violence Free Youth	Communities engaged in parenting & mentoring youth	Foster the development of voluntary and culturally appropriate parent support education and skill building projects focused on parents of teens.
		Assure there is a trusted adult in the life of every youth in Minneapolis by supporting the mentoring community to recruit, train, and place mentors.
	All youth have the necessary tools, skills, and opportunities to successfully transition into adulthood and Re-engaging disengaged youth	Invest in activities that promote skills, strengths & contributions of youth including working with CPED related to youth employment programming.
		Invest in programs and opportunities to identify and engage disconnected youth, e.g. adjudicated youth, homeless, gang affiliated.
Expand the capacity to address youth violence	Leverage partnerships and resources to ensure the full implementation and sustainability of the Blueprint for Action framework.	
A Healthy Start to Life and Learning	Healthy homes- lead- and smoke-free	Continue to work with clinics, health plans, and community-based partners to increase screening of young children for lead poisoning.
		Increase educational calls made to families with children whose blood lead levels put them at risk.
		Continue to promote smoke free policies on a voluntary basis in public housing units.
		Increase community outreach and education around lead poisoning and environmental tobacco smoke and other hazards in the home, by continuing to expand connections between community-based organizations and the public.
Thriving	babies	Educate health care and social service providers about the 2010 change in the prenatal substance use reporting law and how to respond to alcohol and marijuana users who continue to use during pregnancy.
		Educate community members, including advocates and elders about the 2010 change in the prenatal substance use reporting law in order to encourage women to seek prenatal care in the first trimester.
		Provide enhanced psychosocial screening and case coordination services to women at higher risk for infant mortality and assess their impact on birth, maternal, and infant health outcomes.
		Provide community-based education to increase awareness of safe infant sleep practices and environments.
School-read	y children	Provide funding to the Minneapolis Public Schools and 348-TOTS to increase preschool screening. Participate on an interagency steering committee to ensure adherence to preschool screening and follow-up protocols.
		Assure school readiness services for at risk families, including support to provide parent and child education, childhood stimulation activities, positive parent engagement, connections to community resources.
		Assure that at risk children entering the Minneapolis Public Schools through the Family Connection Center are immunized.

WHAT RESOURCES ARE WE GOING TO USE? (FINANCE PLAN, WORKFORCE PLAN, EQUIPMENT AND SPACE PLAN AND TECHNOLOGY PLAN)

Finance Plan

Assessing Financial Patterns

In response to general fund reductions during the last five years the Department has reduced and realigned services including: closure of the Public Health Laboratory that had operated for over 100 years; reduction of administrative support staff, elimination of a city-sponsored tax preparation service for low income adults and seniors; and relocation of the Senior Ombudsman's Office.

Grant Funding

The Department stays abreast of needs and trends in the public health field and in Minneapolis communities to determine department priorities. A major source of resources to address priority issues and needs has been through a pattern of successes with competitive grant awards. Grant awards have exceeded the \$2M/year Results Minneapolis target annually since 2004 and in 2011 grant funding is projected to exceed \$3.5 million. The Department has successfully managed grant funded activities and positions which are developed specific to the funding source and are eliminated when funding ends.

There are two primary current challenges with grant funding:

- 1) Concern about the effects of the proposed city cost allocation plan for grants and a higher allocated rate for Health and Family Support than for any other department;
- 2) Having significant numbers of grant funded/restricted staff reduces their availability to help in successfully competing for new grants and responding to emerging city priorities. This may also affect the Department's ability to meet the full spectrum of its statutorily required essential functions if relying too heavily on grant funding without an adequate flexible core funding source. This essential core funding source is the state Local Public Health Fund and the required local match.

A pending future challenge is the potential requirement to obtain public health certification. Nationally, a certification process is being tested and refined and will be officially launched in 2011 or 2012. The process could take upwards of a year for a local public health agency to complete in order to qualify. Eventually local health departments may need to be certified to be competitive in applying for grants.

Ensuring a Public Health Infrastructure

The City must meet state statutory requirements for a 75% match (minimum \$2.2 million annually) in order to receive state Local Public Health funds. Achieving this local match may be increasingly difficult in the face of financial pressures on local government budgets. Top executives at the Centers for Disease Control and Prevention in Atlanta have recently stated that their highest concern for the nation's public health is the precarious financial position of state and local health departments.

Public Health Partnership with Hennepin County

The Department has had long-standing contractual partnerships with Hennepin County in the areas of WIC, emergency preparedness, preschool screening, lead poisoning prevention, the Juvenile Supervision Center, infectious disease investigations, and health care for homeless women and children. Working with the County on some issues has been challenging due to: frequent realignment of services to address their span of service delivery responsibilities; the large geographic area served spanning rural, suburban and inner city; and a population ranging from the wealthiest to poorest residents in the state. The County's frequent changes in its model for public health include combining and realigning services which results in changes in

the assignment of key public health staff which results in difficulty in identifying public health leadership and strategies within a larger human services department. This has left the Department responsible for keeping initiatives moving (e.g. Teen Parent Connection, Juvenile Supervision Center) and has necessitated bringing newly assigned county staff up to speed regularly.

Management of Internal Service Costs

Significant department effort has gone into reducing internal service costs:

- BIS costs through a copier/printer reduction project and careful monitoring of our computer inventory;
- Space costs by closing the laboratory and consolidating senior services with the rest of the department; and
- Liability costs reduced through training and following safe practices.

Challenges remain as BIS costs rise and more services are discontinued (e.g. support for smart phones), and additional costs are shifted to the department.

Creative Reallocation

A 2010 report by the Minnesota Department of Health, *Blueprint for Successful Local Health Departments*, was developed to determine the factors positively associated with local public health performance.

- The report found that the optimal size for a local public health agency is serving a jurisdiction that is between 50,000 and 500,000 in population. The Minneapolis Department of Health and Family Support serves a population that is approximately 380,000. According to the report findings, Minneapolis is appropriately sized to have a well functioning local health department. The current jurisdictional population for which Hennepin County public health is responsible (everything in Hennepin County except the cities of Minneapolis, Bloomington, Edina and Richfield) exceeds that recommended population range at 600,000.
- The other consistent predictor of performance is spending per capita, and particularly local per capita spending. The local match requirement for receiving state Local Public Health funds is a critical component of assuring an effective local health department.

In 2010 the Department conducted community meetings to assess community priorities. Input from these meetings helped to shape the Department's goals. In general the community input supported a continuation of the direction set in the previous 5 year business plan with an explicit emphasis on community engagement.

Leveraging General Funds and Other City Investments

The Department will continue to leverage general fund support to bring in additional funds focused on addressing the priority health needs of the City. Because the social and physical environments that people live in have been shown to have a very significant impact on the health of populations, the Department needs to work collaboratively with other city departments to leverage city resources for greatest health impact. Leadership by the Department serves as a catalyst to maximize the positive health aspects of city initiatives in the community. The Department will continue its practice of seeking funding to support the work of other city departments that is closely connected to health improvement efforts.

Assuring the Public's Health

Assuring the public's health requires both an ability to work "upstream" to prevent health problems and to also respond to new community issues and needs. This requires a core department infrastructure that is flexible and able to capitalize on broad relationships to identify emerging health needs and gaps in services as well as potential assets to leverage in addressing those needs. This assurance role is broader than what the department is able to provide in services or fund others to do. It includes that ability to continually be alert to changes

and to work with others in the community to meet unmet needs. Readiness to respond to emergencies is one essential component of this role that requires ongoing planning, opportunities to train and drill staff, and the ability to help community partners prepare for the unexpected.

Contingency Plans

Scenario A: Significant reduction in the Department’s general fund allocation would result in cuts in funding to community activities such as after school programs, public health nursing visits, medical and dental services to uninsured, domestic violence services, and school readiness. The Department operates a lean system, and more reductions would cut to the bone these key community services. Even though the Department is continually looking for ways to strategically align funds so that the community is better positioned to compete for outside finding, there is little chance that funding gaps made by department cuts would be filled by other funding sources.

Scenario B: The loss of significant grant projects such as the State Health Improvement Program would result in the elimination of staff positions, and the need to assess opportunities to maintain key upstream activities with other funding sources.

Scenario C: The elimination of CDBG Public Service funding that is currently competitively awarded to community agencies (\$400,000) would end department support of community services in the areas of teen pregnancy prevention, youth violence prevention, and senior services. The Department would continue to look for funding opportunities in these areas and, if possible, would pass some of that funding to community agencies.

City of Minneapolis Department of Health and Family Support Financial Plan									
	2008 Actual	2009 Actual	2010 Current	2010 Projected	2011 Budget	2012 Forecast	2013 Forecast	2014 Forecast	2015 Forecast
Revenues:									
General Fund	4,083	4,463	3,320	3,320	3,335	3,445	3,559	3,681	3,834
Federal Fund									
Competitive grants (Gang, Lead, HS, PPRSVS, CPPW)	1,225	2,066	2,266	2,479	2,736	1,075	0,925	0,463	
Categorical grants (EP, TANF, MCH)	3,096	2,240	2,085	2,688	2,235	2,235	2,235	2,235	2,235
Total	4,321	4,306	4,351	5,167	4,971	3,310	3,160	2,698	2,235
CDBG Fund	1,676	1,430	1,049	1,049	1,049	1,049	1,049	1,049	1,049
State/Other Fund									
Competitive grants (SHIP)	0	0,687	1,000	0,824	0,895	0	0	0	0
Categorical grants (LPH, MFF, CTC, Pt Rev)	3,374	3,461	3,597	3,78	3,487	3,487	3,487	3,487	3,487
Total	3,374	4,148	4,597	4,60	4,382	3,487	3,487	3,487	3,487
Total for Revenue	13,454	14,347	13,317	14,136	13,737	11,291	11,255	10,915	10,605
Expenditures:									
General Fund									
Personnel	1,237,918	1,688,201	880,337	880,337	866,175	903,499	933,396	965,411	1,005,572
Contracts	2,541,253	2,503,019	2,447,015	2,447,015	2,235,588	2,299,300	2,375,384	2,456,860	2,559,065
Operating	303,827	272,122	193,020	193,020	233,120	241,782	249,783	258,350	269,097
Total	4,082,998	4,463,342	3,320,372	3,320,372	3,334,883	3,444,581	3,558,562	3,680,621	3,833,735
Federal Fund									
Personnel	1,273,963	1,335,504	1,165,348	1,126,516	1,267,865	1,099,850	1,045,777	896,476	779,465
Contracts	3,086,102	3,305,691	3,185,652	4,040,484	3,703,135	2,210,150	2,114,223	1,801,524	1,455,535
Total	4,360,065	4,641,195	4,351,000	5,167,000	4,971,000	3,310,000	3,160,000	2,698,000	2,235,000
CDBG Fund									
Personnel	345,072	258,505	229,647	273,396	238,072	244,024	250,125	256,378	262,786
Contracts	1,085,121	864,143	819,353	1,033,842	810,928	804,976	798,875	792,622	786,214
Total	1,430,193	1,122,648	1,049,000	1,307,238	1,049,000	1,049,000	1,049,000	1,049,000	1,049,000
State/Other Fund									
Personnel	2,038,327	1,995,499	3,351,600	2,971,507	3,022,334	2,678,453	2,674,631	2,645,818	2,711,964
Contracts	1,397,853	1,729,934	1,245,450	1,677,915	1,359,666	808,966	812,807	841,561	775,301
Total	3,436,180	3,725,433	4,597,050	4,649,422	4,382,000	3,487,419	3,487,438	3,487,379	3,487,265
Total for Expenditures	13,309,434	13,952,618	13,317,422	14,444,032	13,736,883	11,291,000	11,255,000	10,915,000	10,605,000
Difference	144,566	1,814,382	-	1,240,968	-	-	(0)	0	0

The financial plan (above) was developed based on the known terms of current grants. It does not reflect grants that may be awarded in the future – even those grants that would be considered a continuation of existing efforts.

Workforce Plan

The Department operates a leaner and more efficient program than many local health departments. Both management and professional staff wear multiple hats and perform multiple jobs. The primary challenge is continuing to effectively manage short to long term grant funded positions to ensure sources of funding to support them in meeting department goals, and also ensuring an engaged, skilled, and more diverse workforce.

In response to employee surveys, the department is focusing on employee recognition and inclusiveness, timely annual employee evaluations, training for supervisors and team leaders in staff development, and diversity in recruiting and hiring.

Equipment and Space Plan

Equipment Needs: None anticipated (computers for electronic health records purchased in 2010).

Space: No additional space needs in city owned facilities. All department staff have been consolidated in the main office except for the School Based Clinic (SBC) sites and the U-Care Skyway Senior Center.

- SBC: The department will continued to work with Minneapolis Public Schools on improving SBC clinic space at the six high school sites, including applying for federal funding for capital improvements in 2011.
- Senior Center: Services will be maintained as long as external funding is available to support the program/site. The physical location of the center in the Target Building, a “box” in the rear of the facility, limits opportunities to expand services as funding may be available through grants. Over the next 5 years other downtown options may emerge. The Department will explore other space options as they become available.
- Juvenile Supervision Center: The Juvenile Supervision Center in City Hall is a collaborative project with the police department, and is located within the MPD space allocation. Upgrades to the space to expand capacity are scheduled for early 2011.

Technology Resource Plan

From the Department’s perspective, the technology priority is the establishment and maintenance of electronic health records for the School Based Clinic program to comply with federal and state mandates. Services are provided through external partners, with support from BIS and City Attorney’s Office staff around issues of electronic security and data practices.

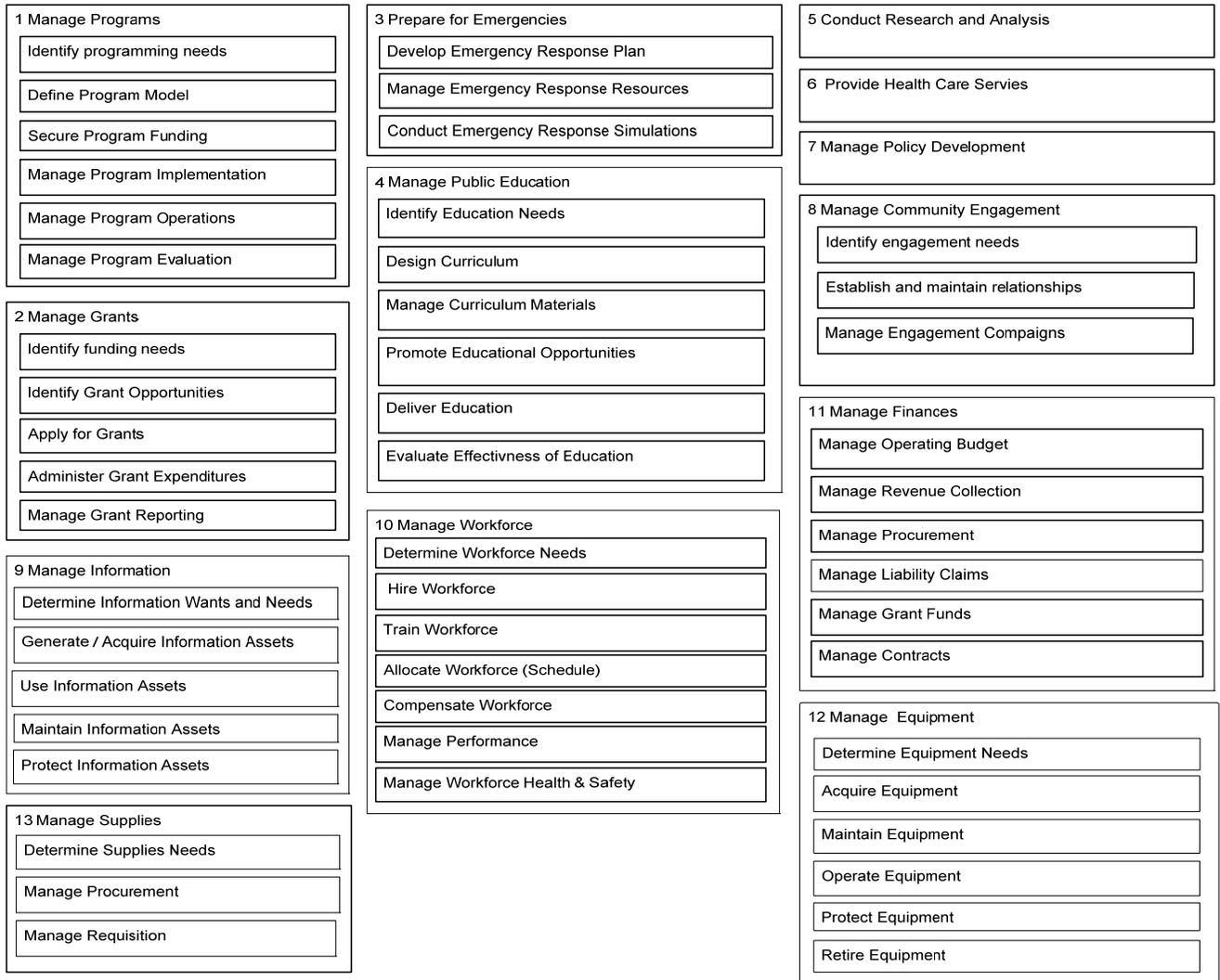
This plan will capture the current state of the business technology used by the Department, including lifecycle status of current business solutions as a driver for technology change. It also will forecast future technology needs around two questions: 1) Is anything changing about what is required to support current business capabilities? 2) Is anything changing that will drive addition of new business capabilities (and new technology solutions)?

1. Department Technology Overview

1.1. Business Capabilities

This section illustrates the business capabilities supported by information services and information-technology solutions. This view shows Levels 1 and 2 of the Assessor business capabilities model. See *Health & Family Support Detailed Business Capabilities Model* for more information.¹

¹ Detailed Business Capabilities models will be available in first quarter 2011.



Capability	Description
<i>Core Capabilities</i>	
1.	Manage Programs
2.	Manage Grants
3.	Prepare for Emergencies
4.	Manage Public Education
5.	Conduct Research and Analysis
6.	Provide Health Care Services
7.	Manage Policy Development
8.	Manage Community Engagement
<i>Supporting Capabilities</i>	
9.	Manage Information
10.	Manage Workforce
11.	Manage Finances
12.	Manage Equipment
13.	Manage Supplies

1.2. Applications/Solutions List

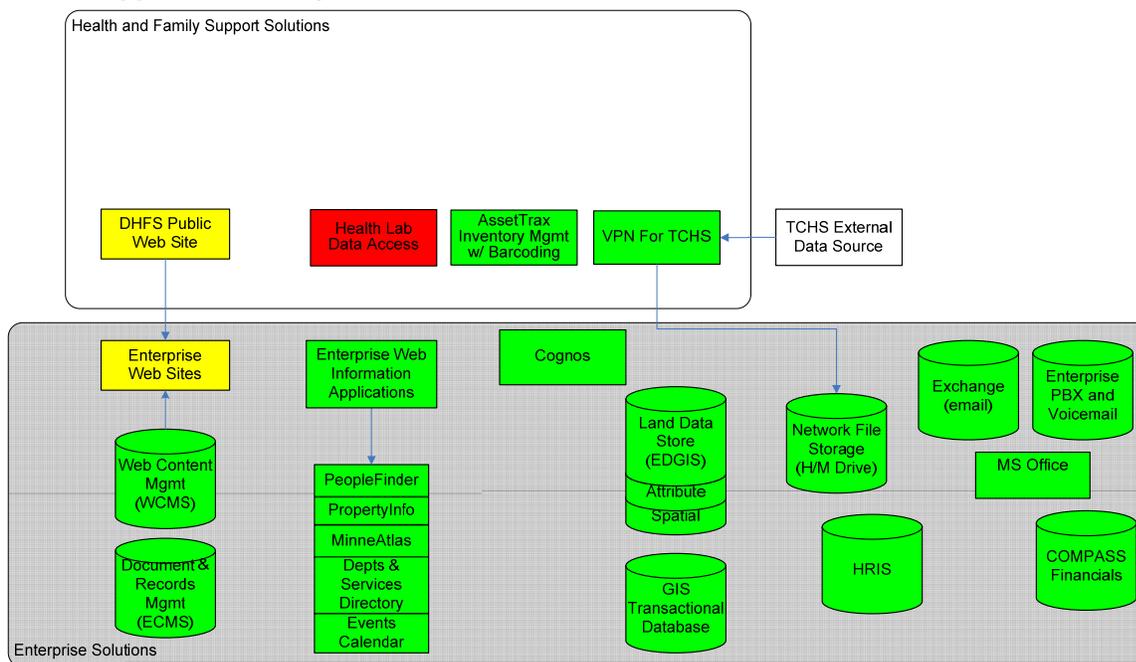
Solution/Service	Description	Funding Scope	Capabilities Supported
Health Lab Data Access	Software for accessing records in the health lab, which was closed in 2009.	HFS 9	
VPN for TCHS	BIS infrastructure solution to allow MHS staff to connect to remote site at TCHS to download data.	HFS 1,	9
AssetTrax	Stand-alone inventory management system (not in the network) for managing emergency medical supplies. Includes bar coding system.	HFS 2,	13
DHFS Public Websites	Public web content regarding HFS programs and services.	Enterprise	1-9

1.3. Information (Data Sets) List

Data Set	Description	Stewardship	Capabilities
Healthlab	Health Lab data – legacy data record of analyses performed on behalf of law-enforcement.	HFS 9	

2. Technology Change Drivers

2.1. Application Lifecycle Drivers



2.2. Application / Status Narrative

Application	Status	Rationale	Projects
Health Lab	Red	Health Lab has been closed. Data is only needed in read-only mode	n/a
VPN Tunnel for TCHS vendor	Green	When City moves to Cisco SSL VPN, we should check to see if we can download vendor without the use of current VPN tunnel	
DHFS Public Websites	Yellow	Content management system upgrade will require all public websites to be reconfigured in 2011. Part of the Oracle (a.k.a. Stellent) upgrade project.	BIS-Oracle-Stellent-Upgrade-880F8672

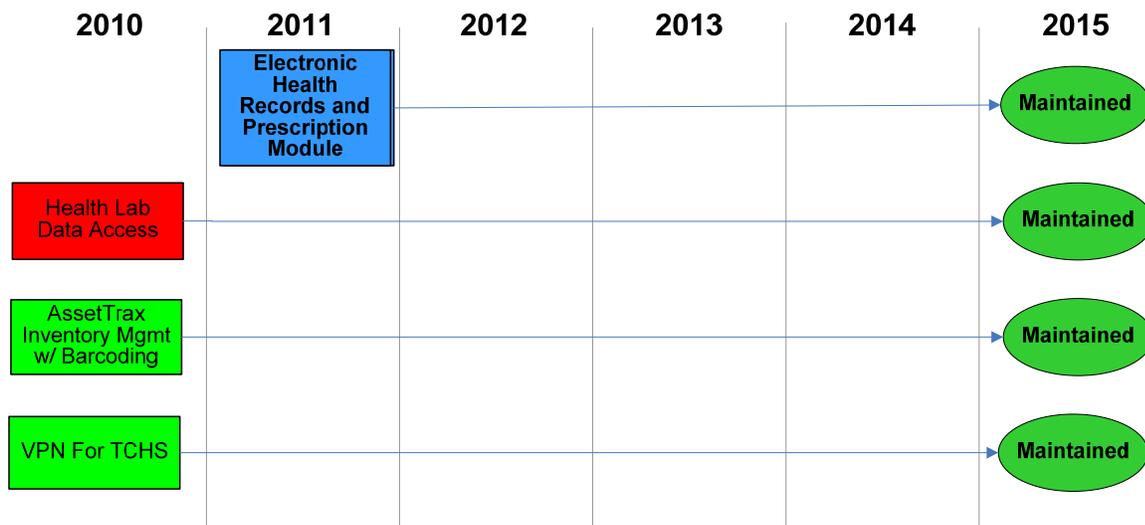
2.3. Business Change Drivers

2.3.1. Business Drivers- Capabilities - Solutions Impact List

Driver	Solution	Capabilities Impact	Projects
Federal mandate to move from paper to electronic health records by 2015	HFS working with Stratis Health on solution	6, 9 Be compliant with Federal regulations and security standards Streamlined information access.	Electronic Records Management System
Federal mandate to move to electronic prescriptions by 2011	Same product referenced above will provide services for this business need.	6, 9 Be compliant with Federal regulations and security standards Streamlined information access.	Electronic Records Management System
Need to be able to send electronic program data securely to other agencies	Currently have workaround of keeping data separate from personal identification	9 Protect information assets	
Need to be able to track/manage program data internally	Currently use Access on department M: drive – this is sufficient for now	9 Manage information.	

3. Technology Solution Roadmap

3.1. Applications / Solutions Roadmap



3.2. Technology Projects List

Project	Description	Start Year	End Year	Projected Cost	Funding Status
Electronic Health Records and Electronic Prescriptions			2011	50K	HFS to use grant money

4. Glossary

Business Capability Modeling	This is a methodology BIS is adopting to help make sure that the City's technology planning is aligned to the specific needs and strategies in each department and to the shared needs and strategies of the enterprise. A business capability models <i>what</i> work a business function does. It is different from a business process, which describes procedurally <i>how</i> work is done.
Application	For purposes of this document an application describes a specific software product that has been acquired or built and implemented as part of a solution
Solution	For purposes of this document, a solution describes one or more applications and/or services that have been implemented to enable a business capability.

5. BIS Technology Assessment Rating Key

Following conditions have been used by BIS to assign Technology Assessment Rating to applications/solutions.

Green	Strategic / Available (has a life of at least 3 years with continued enhancements and maintenance)
	Product, technology or application is available and proven for enterprise use. It is well-architected and it is the default choice for core enterprise functionality. It is the strategic choice and will continue to be enhanced for the intended business purpose. Production use is encouraged. There is full institutional support.
Yellow	Has less than 3-years expected life:
	Evaluating
	Product, technology or application is being evaluated. This includes research, proof of concept, and pilot. Production use requires an approved exception. Minimal institutional support – primary support provided by the sponsoring project/area.
	Maintained
	Product, technology or application is being maintained, but is being considered for replacement, refactoring ² or retirement. Production use allowed for existing services, including additional purchases to meet capacity requirements. New usage requires an approved exception. There is full institutional support.
Red	Sunsetting
	Product, technology, or application has been identified for sunseting. It could be nearing the end of life by vendor, it may be poorly architected, or it may no longer meet business needs. New production use is not acceptable. There is limited and reducing institutional support.
	Unavailable
	Product, technology or application is either:
	1. Retired – Production use is not acceptable. There is no institutional support.
	2. Unacceptable – Production use is not acceptable. It never existed in the environment and has been identified as not suitable for CoM. There is no institutional support.
	3. Limited Production Use – It has been approved for limited use in a specific area as an exception. Production use requires an approved exception. Minimal institutional support – primary support provided by the sponsoring project/area

The department will assess the new Remote Access/Telework options for applicability to department needs.

² Refactoring is when a software product is substantially redesigned for a new platform or code base and redeployed without necessarily changing or enhancing the business functionality it provides.

APPENDIX A

Planning and engagement activities leading up to business plan development

Environmental Scan

To prepare for Department goal setting staff from across the department collected and reviewed the following information:

- Results Minneapolis and Sustainability Indicators and lifespan information by neighborhood
- “Where we Are” materials
- Health and Family Support “Strategies for accomplishing our work” document
- Analysis of where we are currently investing our financial resources
- Healthy People 2020
- Analysis of potential impact of Health Care reform
- Public Health work/priorities in other urban areas
- RWJ Urban Health Initiative
- National Association of County and City Health Officers information and materials

Staff input

Meetings were held with staff including an all-staff meeting in March to review outcomes data and to get input on priorities in the goal and strategy setting process. Staff teams were created to develop tactics and measures for Department Goals and Objectives.

Community input

In the business plan development process the Department built on the existing community-based work underway and also convened additional community meeting specific to the development of new goals.

Over the last several years the Department has engaged with the community in a broad range of health areas. Community engagement has been a foundational component of the following efforts:

- The Multicultural Storytelling process that led to 6 cross-cutting recommendations and has evolved into a new process for community engagement.
- Homegrown Minneapolis which engaged over 100 community members has led to a multi-year, multi-department initiative to strengthen access to locally grown food
- The Youth Violence Prevention Blueprint was developed over several years collaboratively with community members. Its 34 recommendations are being implemented across departments in the City in collaboration with many community organizations and other units of local government.

Additionally within the last few years the Department has conducted focus group and surveys with program participant and other members of the public to gather input on our programs and key health issues. These include:

- School Based clinic parents and youth
- Focus groups for Steps to a Healthier Minneapolis about healthy eating and exercise
- Healthy Start pregnant and parenting women about use of prenatal care services

Two community meetings were held – one each in North and South Minneapolis to review current health outcomes and gather input about priorities and goals for the Department.

Community participants expressed general agreement with the 2007-2011 Department Goals. Most comments focused on the way that the community would like to see health issues approached. This led to the development of “The way we work” which expanded on a previous document titled “Strategies for accomplishing our work”.

The Public Health Advisory Committee also reviewed health outcomes and gave input to the department on the 2010-2014 goals.

The Public Safety and Health City Council Committee received information about current health outcomes and provided input to the department goal setting process.

COUNCIL ACTION

COMMITTEE: H+HS
DATE OF COUNCIL MEETING: 8-5-05
DATE OF PUBLICATION: 8-13-05

As seen in Finance & Commerce:

Description:

Public Health Advisory Committee

Request new resolution to update the responsibilities and composition of the ~~MOHHS~~ PHAC.

The **HEALTH & HUMAN SERVICES** Committee submitted the following report:
H&HS - Your Committee, having under consideration the roles and responsibilities of the Public Health Advisory Committee, now recommends passage of the accompanying Resolutions:

a. Rescinding Resolution 76R-089 entitled "Establishing a Public Health Advisory Committee for the Minneapolis Health Department to review and make recommendations regarding Health Department programs", passed March 26, 1976.

b. Approving and adopting a consolidated and amended resolution defining the role, function, size, composition and organization of the Public Health Advisory Committee for the Minneapolis Department of Health & Family Support.

Adopted 8/5/05.

Resolution 2005R-437, rescinding Resolution 76R-089 entitled "Establishing a Public Health Advisory Committee for the Minneapolis Health Department to review and make recommendations regarding Health Department programs", passed March 26, 1976, was adopted 8/5/05 by the City Council. A complete copy of this resolution is available for public inspection in the office of the City Clerk.

The following is the complete text of the unpublished summarized resolution.

RESOLUTION 2005R-437

By Johnson Lee

Rescinding Resolution 76R-089 entitled "Establishing a Public Health Advisory Committee for the Minneapolis Health Department to review and make recommendations regarding Health Department programs", passed March 26, 1976.

Resolved by The City Council of The City of Minneapolis:
That the above-entitled Resolution be and is hereby rescinded.
Adopted 8/5/05.

Resolution 2005R-438, approving and adopting a consolidated and amended resolution defining the role, function, size, composition and organization of the Public Health Advisory Committee for the Minneapolis Department of Health & Family Support, was adopted 8/5/05 by the City Council. A complete copy of this resolution is available for public inspection in the office of the City Clerk.



PHAC Training Manual

PHAC

Resolution Reestablishing the PHAC



Resolution of the City of Minneapolis: Reestablishing the role and composition of the Public Health Advisory Committee

Approved by Council on May 14, 2010

Whereas, the Public Health Advisory Committee, a standing advisory committee to the Minneapolis Department of Health & Family Support and the Minneapolis City Council, has been in existence through resolution since 1976 in accordance with the provisions of the Community Health Services Act (Minn. Laws 1976, Ch. 9); and

Whereas, changes to the public health system at the state and local levels necessitate that the responsibilities and composition of the Public Health Advisory Committee be updated to allow the committee to most effectively serve the City of Minneapolis;

Whereas, the City Council values the efforts of the Public Health Advisory Committee to provide public health related advice which is representative of and takes into account the viewpoints, concerns and interests of the diverse Minneapolis community;

Whereas, The City of Minneapolis finds the continued existence of the Public Health Advisory Committee benefits the citizens of the City;

Now, Therefore, Be It Resolved by The City Council of The City of Minneapolis:

That the Public Health Advisory Committee (PHAC) for the Minneapolis Department of Health & Family Support has the following responsibilities and composition:

A. Role of the PHAC

The role of the PHAC is to advise the City Council and the Department on policy matters affecting the health of Minneapolis residents, and to serve as liaisons between the City and the community in addressing health concerns. In this role PHAC shall make every effort to ensure that the concerns represented reflect the diverse viewpoints and interests of the Minneapolis community.

B. PHAC Functions

The Public Health Advisory Committee has responsibility for the following functions:

1. To advise the City Council regarding: a) policy matters affecting health of Minneapolis residents, and b) general roles and functions of the Department of Health and Family Support.
 2. To review the proposed priorities of the Department of Health and Family Support and make recommendations to the City Council;
 3. To consider complaints and views expressed by residents affecting delivery of public health services in Minneapolis, forward those concerns, and make recommendations
-



PHAC Training Manual

PHAC

Resolution Reestablishing the PHAC

as necessary to the City Council and/or the Department of Health and Family Support;

C. Size and Composition

The composition of the Public Health Advisory shall reflect the diverse interests and perspectives of the Minneapolis community. It is the expectation that all parties responsible for the recruitment, recommendations to and approval of members shall make every effort to ensure this diversity.

The PHAC will have up to twenty (20) members composed of fourteen (14) Resident Members and up to six (6) Other Representative Members. Members will not be compensated for service on the PHAC.

1. Resident Member appointments.

The fourteen (14) Resident Members will be selected by having each of the thirteen (13) City Council Members appoint one (1) Residential Member who lives or works in their respective wards, and one (1) Residential Member who lives or works in the City of Minneapolis shall be appointed by the Mayor. These Resident Member appointments and terms are subject to Minneapolis Code of Ordinances Title 2 Chapter 14.180. No public hearing is required for Resident Member appointments.

2. Other Representative Member appointments.

- a. The 6 Other Representative Members will be appointed by the City Council by requesting the following organizations to submit one (1) nominee representing their interests:
 - The Minneapolis Public Schools, Student Support and Related Services;
 - Hennepin County Human Services and Public Health
 - The University of Minnesota School of Public Health
- b. The PHAC shall recommend up to three (3) at large nominees to the City Council for appointment.
- c. In addition, two (2) representatives from the Minneapolis Health and Human Services Leadership Group, one (1) from the Urban Health Professional Advisory Committee and one (1) from the Urban Health Agenda Community Advisory Committee, shall serve in an ex-officio non-voting capacity.

The Other Representative Member appointments pursuant to this subsection C.2. shall be not be made pursuant to the open appointments process of Minneapolis Code of Ordinances Title 2 Chapter 14.180 and no public hearing is required for these appointments.



D. Organization, Term, Meeting Frequency

1. Continuity of membership will be assured by having an approximately equal number of terms expire each year.
2. All terms will be two years and no member will serve more than three consecutive terms.
3. The PHAC will elect a chairperson and vice-chairperson or co-chairs,
4. The PHAC shall establish its own operating rules and procedures and meeting schedule, provided that it meets at least six times each year to conduct its business.
5. Eight (8) members shall constitute a quorum.

E. Relationships between the PHAC, City Council and the Department of Health and Family Support

- (1) The City Council is the Board of Health and makes final decisions regarding policy and programs of the Department of Health and Family Support. The City Council's health-related Committee shall review and decide upon Department of Health and Family Support matters prior to final action by the City Council.
 - (2) PHAC members are expected to communicate regularly with their respective appointing authority.
 - (3) The PHAC is an advisory committee to the City Council and the Department of Health and Family Support.
 - (4) The Department of Health and Family Support is responsible for providing staff assistance to the PHAC to carry out its advisory functions.
 - (5) It is expected that the Department of Health and Family Support will give significant weight to the recommendations of PHAC. On those occasions when the Department cannot incorporate these recommendations into its policy and program operations, the Commissioner will provide explanation.
 - (6) The Department of Health and Family Support staff will present department business to the health-related Committee. Such staff presentations shall include an explanation of how such activities fit within the framework of the priorities as approved by the PHAC.
 - (7) While prime responsibility for presenting PHAC views rests with the Department of Health and Family Support staff, the PHAC may elect to designate its members to directly explain PHAC views to the health-related Committee.
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PHAC Training Manual

PHAC

Description of Committee and Positions



PHAC Overview

I. Description

The Public Health Advisory Committee (PHAC) is a 20-member advisory committee for the Minneapolis Department of Health & Family Support (MDHFS) and the City Council. The role of the PHAC is to advise the Council and the Department on policy matters affecting the health of Minneapolis residents, and to serve as liaisons between the City and the community in addressing health concerns. In this role PHAC shall make every effort to ensure that the concerns represented reflect the diverse viewpoints and interests of the Minneapolis community.

II. Function Responsibilities

- a. To advise the City Council regarding:
 - i. Policy matters affecting health of Minneapolis residents
 - ii. General roles and functions of the Department of Health and Family Support.
- b. To review the proposed priorities of the Department of Health and Family Support and make recommendations to the City Council;
- c. To consider complaints and views expressed by residents affecting delivery of public health services in Minneapolis, forward those concerns, and make recommendations as necessary to the City Council and/or the Department of Health and Family Support;



Committee Composition and Appointing Authority

It is the clear intent that the composition of the PHAC reflects the diverse interests and perspectives of the Minneapolis community. It is the expectation that all parties responsible for the recruitment, recommendations to and approval of members shall make every effort to ensure the realization of this intent.

The PHAC has up to 20 voting members composed of 14 residents and up to 6 other representatives.

I. Residents

- a. 13 Council Members shall appoint one resident from their respective wards
- b. One resident representative shall be appointed by the Mayor
- c. Appointments are confirmed by the full Council

II. Organization Representatives

6 representatives will be appointed by the City Council by requesting the following organizations to submit one (1) nominee representing their interests

- a. The Minneapolis Public Schools, Health Related Services
 - b. Hennepin County Human Services and Public Health
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PHAC Training Manual

PHAC

Description of Committee and Positions

- c. The University of Minnesota, School of Public Health
- d. At Large appointees to be recommended by the PHAC to ensure that the membership reflects the diversity of the Minneapolis community.

III. Ex-officio Non-voting Representatives

In addition, two representatives from the Minneapolis Health and Human Services Leadership Group shall serve in an ex-officio non-voting capacity.

- a. one (1) from the Urban Health Professional Advisory Committee
- b. one (1) from the Urban Health Agenda Community Advisory Committee



Membership Terms & Duties

I. Terms

- a. Member terms are two years in length, with approximately half the terms expiring each year. Members may serve up to three consecutive terms.
- b. Anniversary dates are recognized as January 1st, regardless of actual appointment date.
- c. Three unexcused absences from regular meetings may result in termination of membership.

II. Duties

- a. Members are responsible for attending all regularly scheduled PHAC meetings, which are generally held on the fourth Tuesday of the month, from 6:00 to 8:00 p.m. in various community locations.
- b. In addition, subcommittees are occasionally formed for special purposes for which members are asked to volunteer.
- c. In carrying out the functions previously listed, members may be reviewing, discussing, modifying and deciding upon staff-prepared documents, or engaging in the original preparation of such documents. In addition to meeting times, members should be prepared to spend some time reading and reviewing committee documents in order to be prepared for discussion and development of recommendations.



Minutes

Please review the past meeting minutes at <http://www.ci.minneapolis.mn.us/dhfs/agendas-minutes.asp>



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PHAC

Meeting Attendance Rules & Procedures



Attendance Overview

Adopted 02/07/1977

On several occasions, committee members have expressed concern about the meeting attendance rate of some members. In accepting the appointment to the PHAC, each member by oath accepts the responsibility of carrying out the PHAC functions specified in the City Council resolution and for attending meetings scheduled to conduct committee business. The committee has, however, never established any rules or procedures governing individual member participation. Accordingly, staff recommends the following procedures about meeting attendance for consideration by the PHAC:



Committee Meeting Attendance Procedures

- I. Each member is expected to attend regularly scheduled meetings of the full PHAC. If not able to attend a meeting, a member is expected to inform the Health Department in advance. Such notification will constitute an excused absence.
- II. Members failing to attend two consecutive meetings without an excused absence will be contacted by staff to determine any problems and to encourage future attendance.
- III. Members failing to attend three consecutive meetings without an excused absence will be sent a letter by the Chairperson. The letter will encourage attendance, inquire about the member's ability and interest in continuing to serve on the committee, and state that failure to attend the next meeting will initiate termination proceedings.
- IV. If a member fails to attend four consecutive meetings without an excused absence, a letter from the Chairperson will be sent to the appointing person or group. The letter will describe the failure to attend meetings and request that another person be appointed to the committee.
- V. Members with frequent excused absences **will** be contacted by staff or the Chairperson regarding their interest and ability to continue to participate on the committee.



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PHAC
 Membership as of 3/21/11



PHAC Membership

Ward	Seat	Committee Member
1	Reich	Gavin Watt
2	Gordon	Robin Kay Schow
3	Hofstede	Vacant
4	Johnson	Vacant
5	Samuels	Vacant
6	Lilligren	Vacant
7	Goodman	Karen Soderberg
8	Glidden	Debra Jacoway
9	Schiff	John Schrom
10	Tuthill	Lizz Hutchinson
11	Quincy	Robert Burdick
12	Roy Colvin	Vacant
13	Hodges	Vacant
	Mayor's Representative	Clarence Jones
	Minneapolis Public Schools	Julie Young-Burns
	Hennepin County Human Services and Public Health Department	Renee Gust
	U of M School of Public Health	TBD
	Member at Large	Samira Dini
	Member at Large	Vacant
	Member at Large	Douglas Limon
	Urban Health Professional Advisory Committee	Revolving
	Urban Health Agenda Community Advisory Committee Representative	Revolving