Health and Family Support

December 6, 2011

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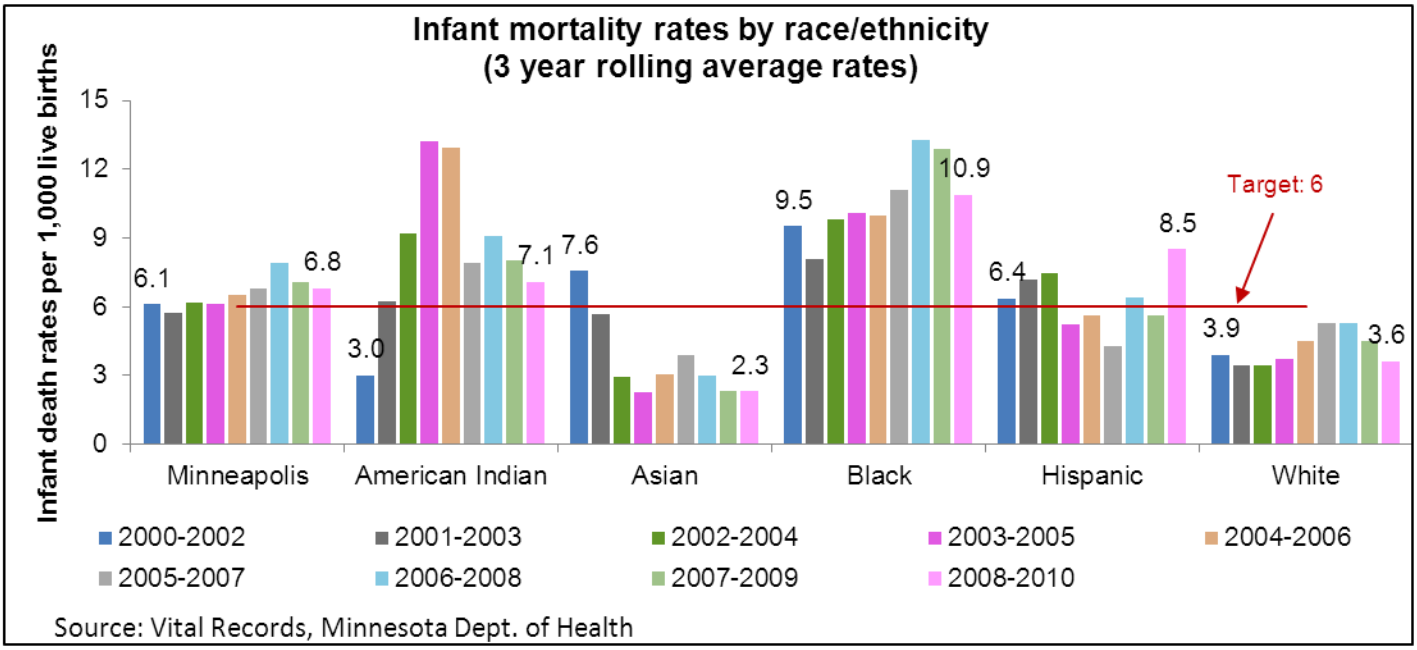


Infant Mortality

Why is this a priority?

Infant mortality is an important measure of community health because it reflects a broad range of factors that are associated with the health and well-being of pregnant women and infants.

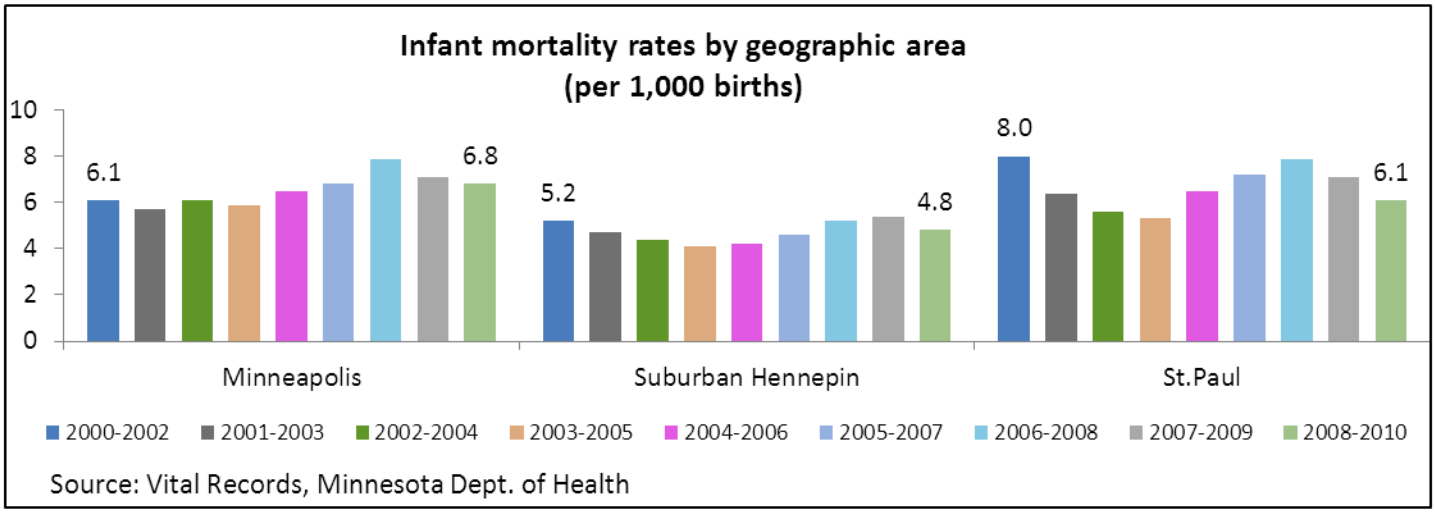
What strategies are you using to achieve the targets?

Over the past year, we have reassessed program activities through Twin Cities Healthy Start, recognizing the need to integrate the program more with other department and community-based programs and to ensure sustainability of program services if federal funding diminishes over time, as expected. Specifically, we have:

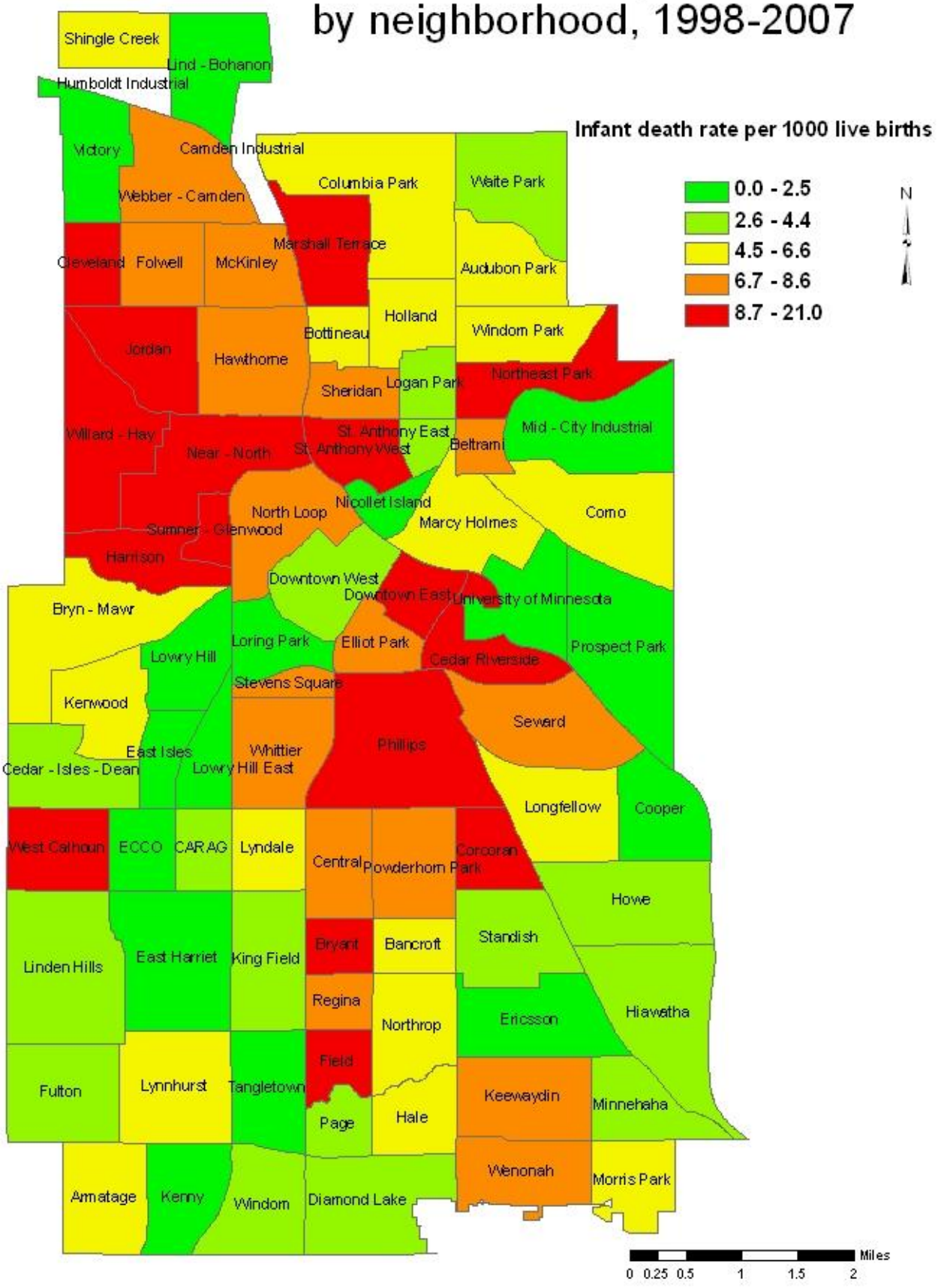
- Strengthened and developed new partnerships with health care and social services organizations to provide perinatal services to high-risk pregnant women.
- Screened 746 high-risk pregnant women in communities that have high rates of infant deaths.
- Provided case management services to 340 high-risk pregnant women who are at risk of having poor birth outcomes.
- Completed 619 public health nurse home visits to high-risk pregnant teens and teen moms.
- Conducted comprehensive prenatal education classes on topics such as the importance of safe sleep environments for infants, dangers associated with secondhand smoke, alcohol and drug use, importance of taking folic acid during pregnancy, childbirth education, nutrition, family planning, and the benefits of breast feeding.

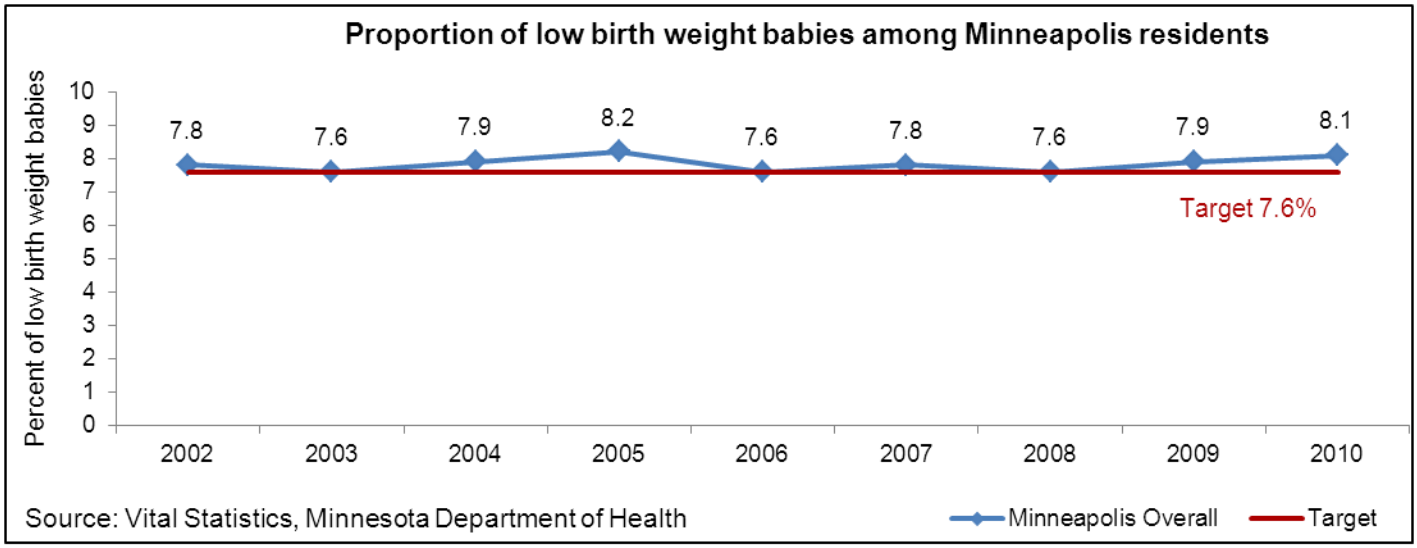
What resources are needed to carry out this strategy?

We currently receive $925,000 in funding from the federal Health Resources and Services Administration for the Twin Cities Healthy Start program. Maternal Child Health funding also addresses the needs of pregnant teens and teen mothers. TANF funding provides home visits through the Nurse Family Partnership. Additional funding for home visiting services would help efforts to reduce infant mortality.


Infant mortality rates by geographic area
(per 1,000 births)
10
8
6
4
2
0
6.1
6.8
5.2
4.8
8.0
6.1
Minneapolis
Suburban Hennepin
St.Paul
2000-2002
2001-2003
2002-2004
2003-2005
2004-2006
2005-2007
2006-2008
2007-2009
2008-2010
Source: Vital Records, Minnesota Dept. of Health

Infant mortality rates by neighborhood, 1998-2007





Low Birth Weight

Why is this a priority?

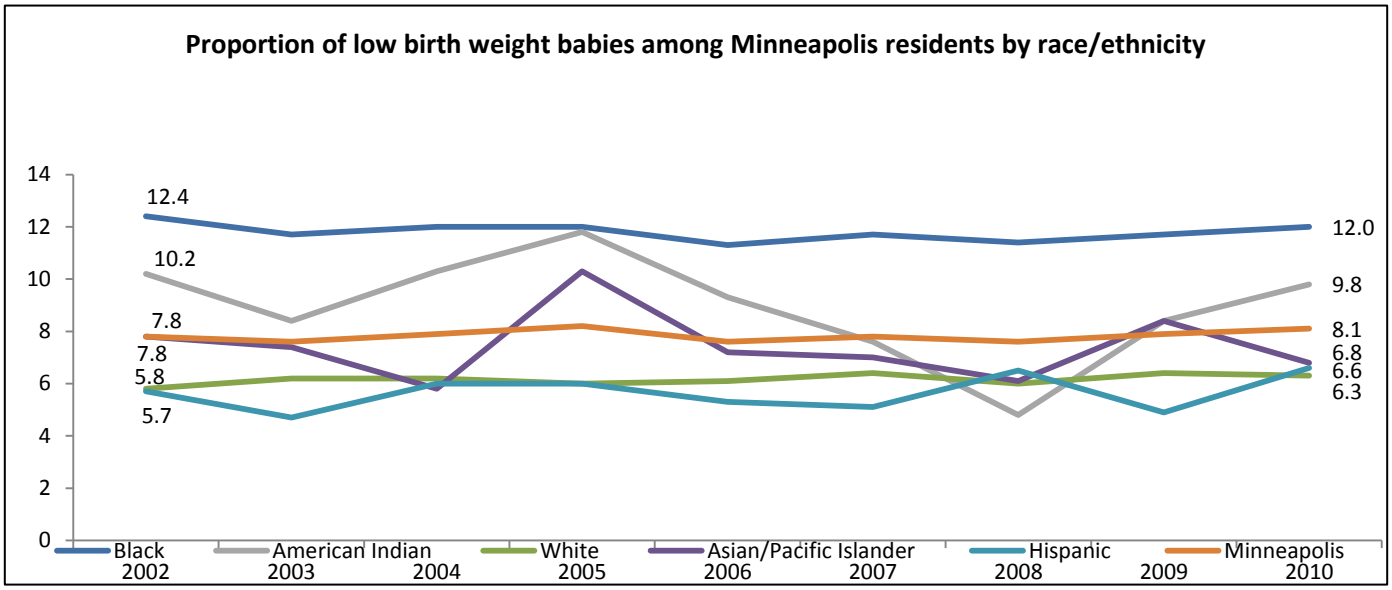
Low birth weight is risk factor for infant mortality and is strongly associated with developmental problems in childhood. Premature births account for a large proportion of low birth weights.

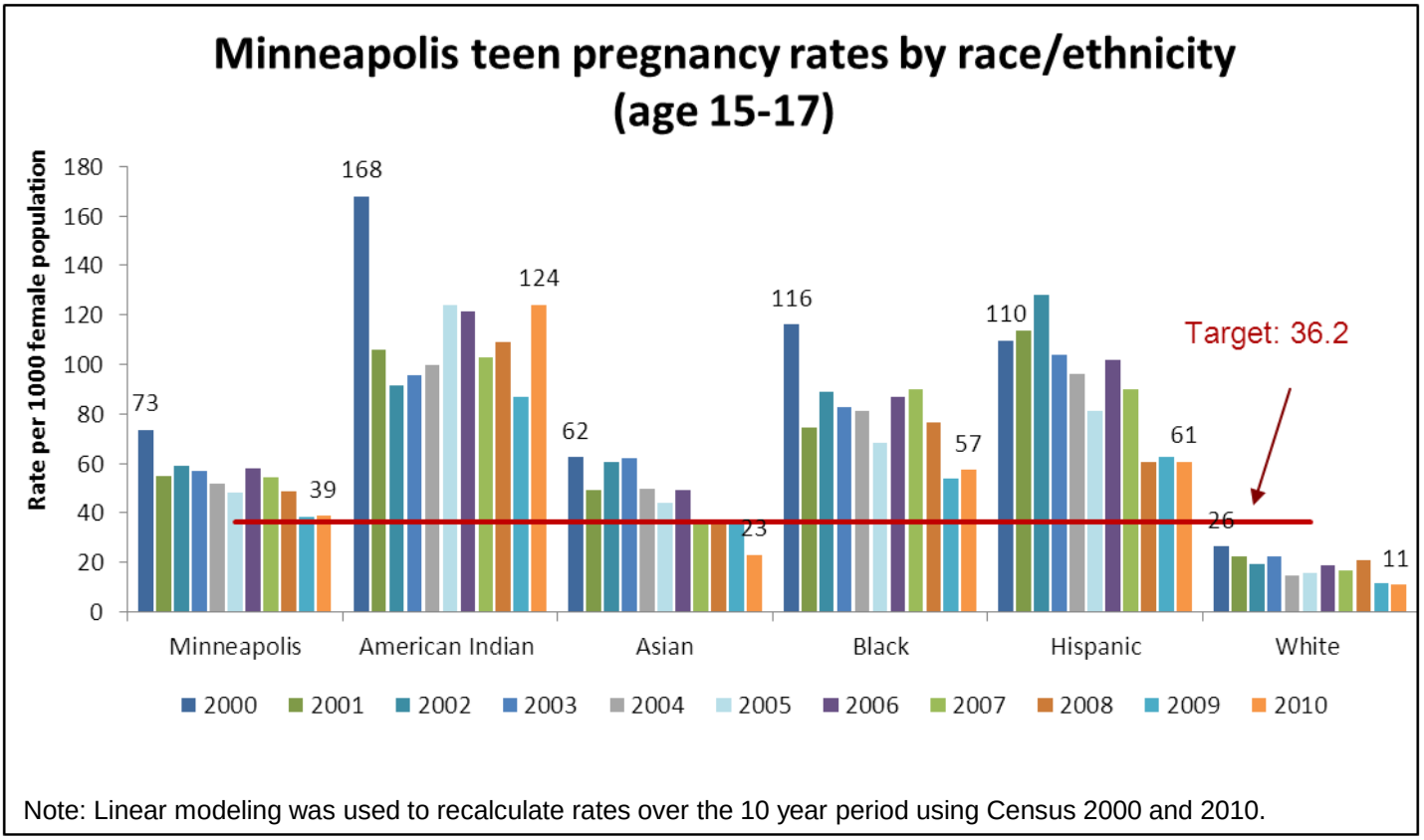
What strategy are you using to achieve the targets?

Premature births are disproportionately high among African American women, and cumulative stress over a lifetime resulting from poverty, discrimination, unsafe neighborhoods, and other factors play a role. We have conducted a series of focus groups with pregnant women and new mothers to better understand their stress and emotional distress, and elicit their perspectives on what types of services or activities they would find beneficial. Because of their preference for peer support groups, we are funding the Consumer/Survivor Network of Minnesota to train peer facilitators and offer Wellness Action Recovery Groups to assist women in developing their own plans to improve their mental well-being and to provide them with peer support.

What resources are needed to carry out this strategy?

The same resources that address infant mortality address this measure.





Note: Linear modeling was used to recalculate rates over the 10 year period using Census 2000 and 2010.

Teen pregnancy

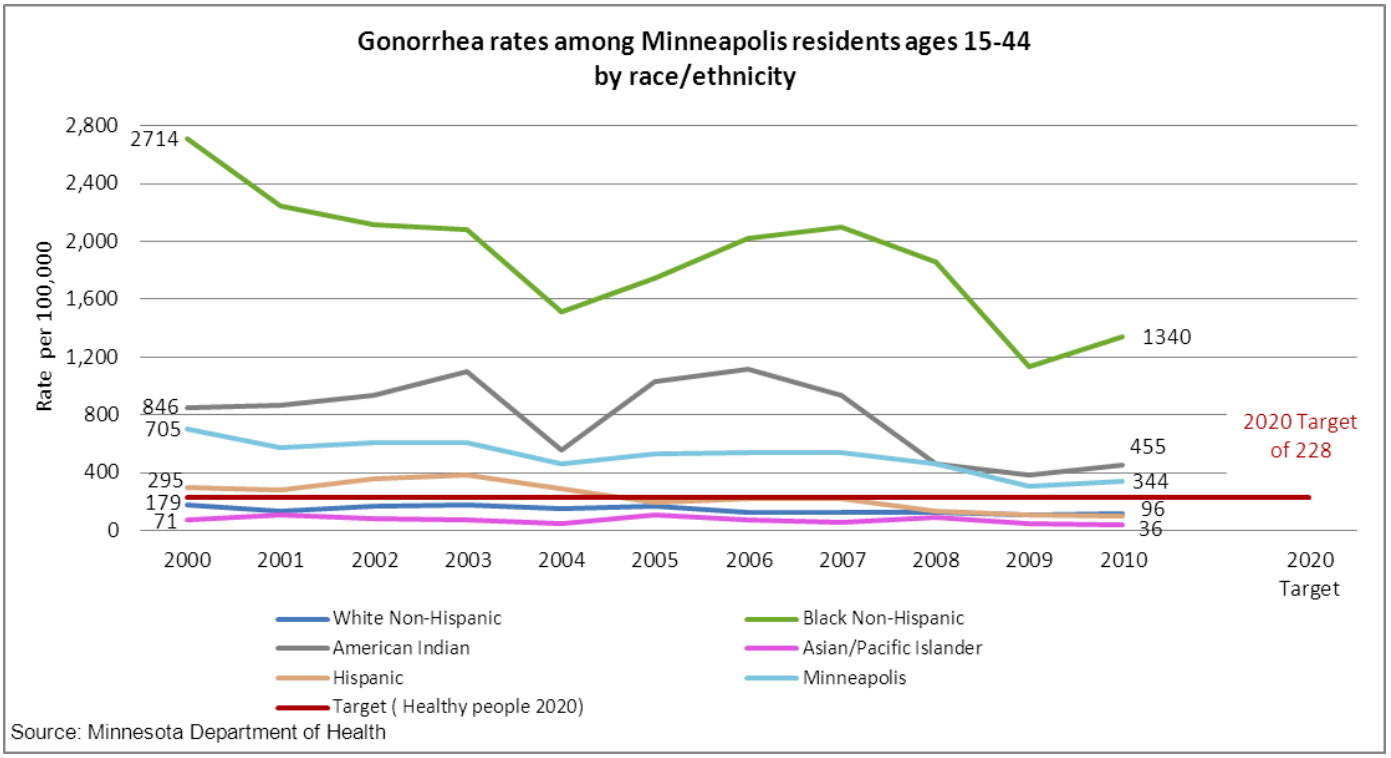
Why is this measure important?

Teen pregnancy poses risks to the short- and long-term health and well-being of teens and their children and also increases the likelihood that mothers will not complete high school and their children will be raised in poverty. The children of teen mothers are at higher risk for being born underweight and are more likely to exhibit behavioral problems than children of older mothers.

What strategies are you using to achieve the targets?

Although the measure focuses on girls aged 15 to 17 years, teen pregnancy prevention efforts target all teens aged 19 and younger and prevention of subsequent pregnancies to teens who are already mothers. Toward this end, we have:

- Promoted and funded culturally specific teen pregnancy prevention initiatives with a goal of reducing disproportionately high teen pregnancy rates among American Indians, Hispanics, and African Americans.
- Ensured that all students who visit our School Based Clinics receive sexual health screening, and STD testing and treatment.
- Promoted medically accurate sex education in public schools with emphasis on improving access to evidence-based sexuality education to students in grades 6-8.
- Provided 619 public health nurse home visits to high-risk pregnant teens and teen moms.
- Reduced the incidence of subsequent pregnancies by connecting teen parents with health, education and parenting resources to ensure that they have the tools they need to raise healthy children.
- Encouraged community collaboration and coordinated services delivery for pregnant and parenting teens through participation and co-sponsorship of the Hennepin County Teen Parent Connection.



Linear modeling was used to recalculate rates over the 10 year period using Census 2000 and 2010.

Gonorrhea

Why is this measure important?

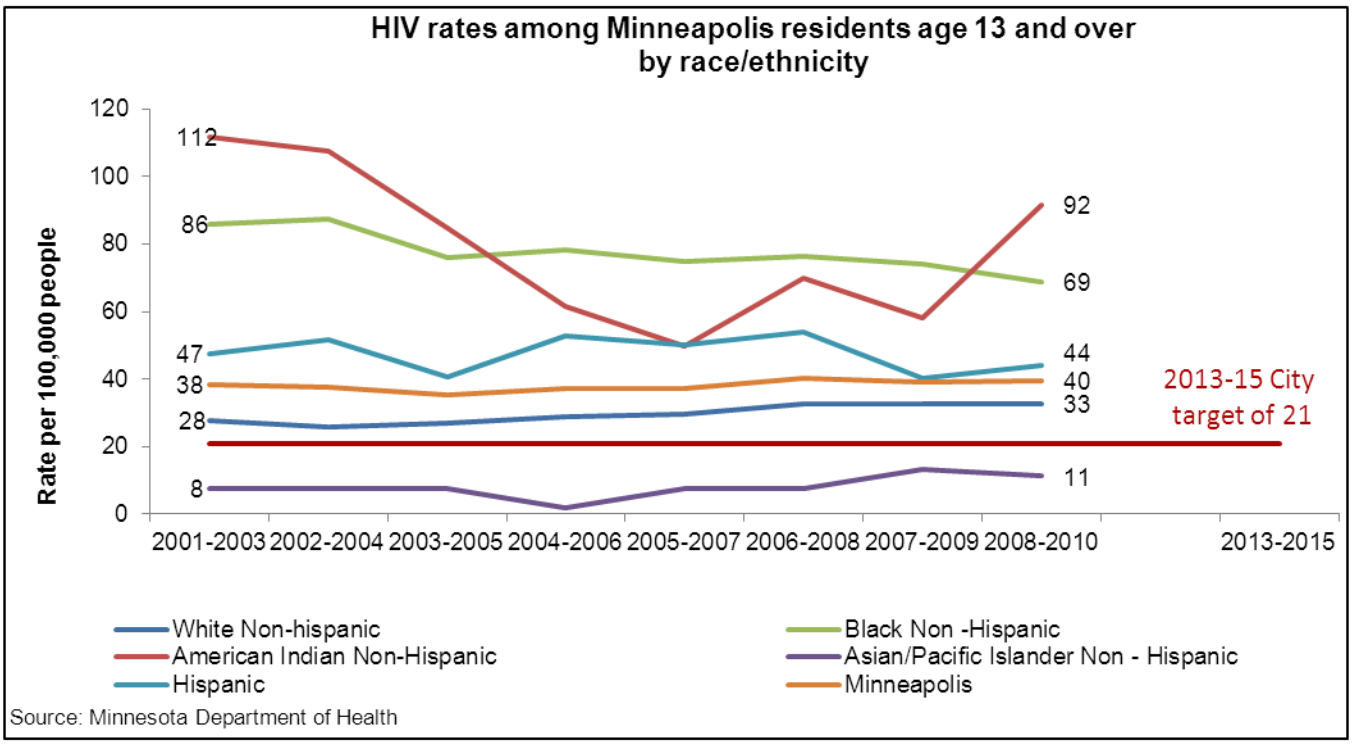
Gonorrhea is one of the most commonly reported sexually transmitted diseases (STDs) in the city and elsewhere. Left untreated, gonorrhea may cause pelvic inflammatory disease among women and may lead to infertility among women and men. As many as half of those infected experience no symptoms, and may unknowingly pass the disease to partners. Gonorrhea predominantly affects young people between the ages of 15 and 24, and has a disproportionate effect on people of color and low-income populations.

What strategies are you using to achieve the targets?

Two important strategies to combat gonorrhea are comprehensive sex education for young people and increasing screening of at-risk populations. Sexual health curricula that address both abstinence and contraception are effective in delaying sexual debut and increasing safe-sex practices and need to be universally available. In addition, targeted screening programs are needed to identify and treat the disease among high-risk populations. STD screening must be accessible, confidential and affordable.

To that end, specific actions we have undertaken include:

- Focus on communities experiencing increased rates of disease by continuing to fund the Seen on da Streets program, which provides clinic outreach, education, and testing services directed at African American males.
- Reducing barriers to clinical services by offering routine STD screening to all students using our School Based Clinics.
- Promoting medically accurate sex education in public schools with emphasis on improving access to evidence-based sexuality education to youth in grades 6-8.
- Encouraging coordination of efforts to address STDs among healthcare, public health, education, business, and policy leadership through participation in the Minnesota Chlamydia Partnership. Basic strategies of health promotion, education, screening and treatment are similar for both gonorrhea and chlamydia.

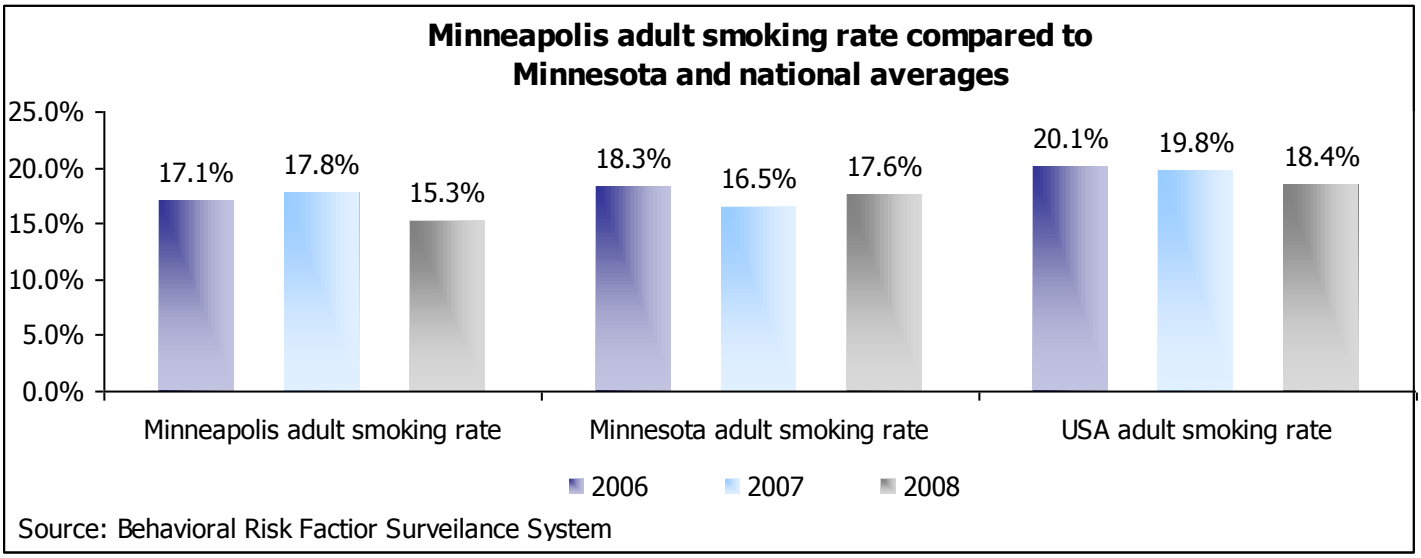


Linear modeling was used to recalculate rates over the 10 year period using Census 2000 and 2010.

HIV
Why is this measure important?

HIV (the virus that causes AIDS) has significant personal and medical consequences for infected individuals. The disease is more prevalent in Minneapolis than in other areas in Minnesota. Because people may be infected with HIV for a long time but still show no symptoms, aggressive screening of those at-risk is necessary to control the spread of HIV. According to the Centers for Disease Control, as many as 44% of those who are infected with HIV are unaware of their status. Among infected individuals, disease management with antiretroviral drugs is important to control the progression of the disease.

What strategies are you using to achieve the targets?
In order to reduce HIV infections, strategies must be tailored to affected populations, including men who have sex with men (MSM) and populations of color. Strategies that have been effective in addressing this disease include increasing awareness about the disease and its consequences, increasing screening, combating social stigma, and empowering individuals to make healthy sexual choices. Our staff attend the Hennepin County HIV Planning Council meetings and provide support to the Research and Evaluation Committee of the Council. We were also instrumental in the adoption of comprehensive sexual health education curriculum delivered through the Minneapolis Public Schools; this curriculum contains medically accurate information about HIV transmission and prevention.



Adult smoking

Why is this measure important?

Smoking was responsible for 5,121 adult deaths in Minnesota in 2007. Thousands more adults and children suffer from chronic illness such as cancer and asthma due to tobacco use or exposure to secondhand smoke. Tobacco use is a leading driver of preventable health care costs. In 2007, tobacco use was responsible for $2.87 billion in excess medical expenditures, a per capita expense of $554 for every man, woman and child in Minnesota, according to a Blue Cross and Blue Shield of Minnesota report.

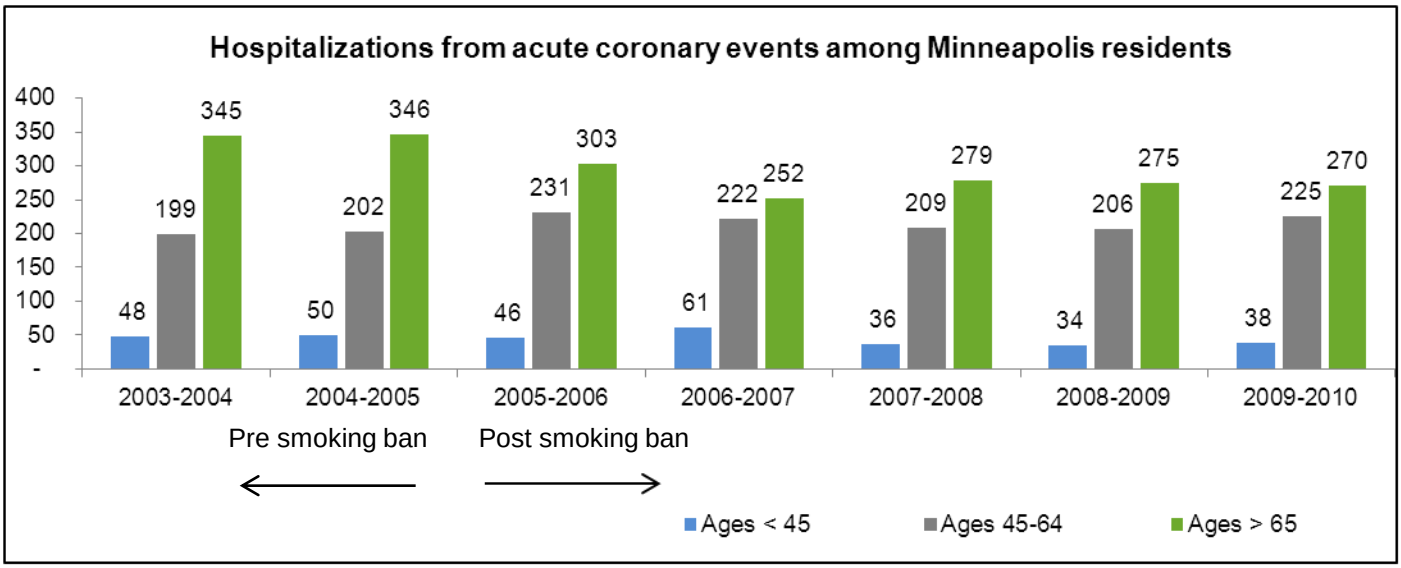
What strategies are you using to achieve the target?

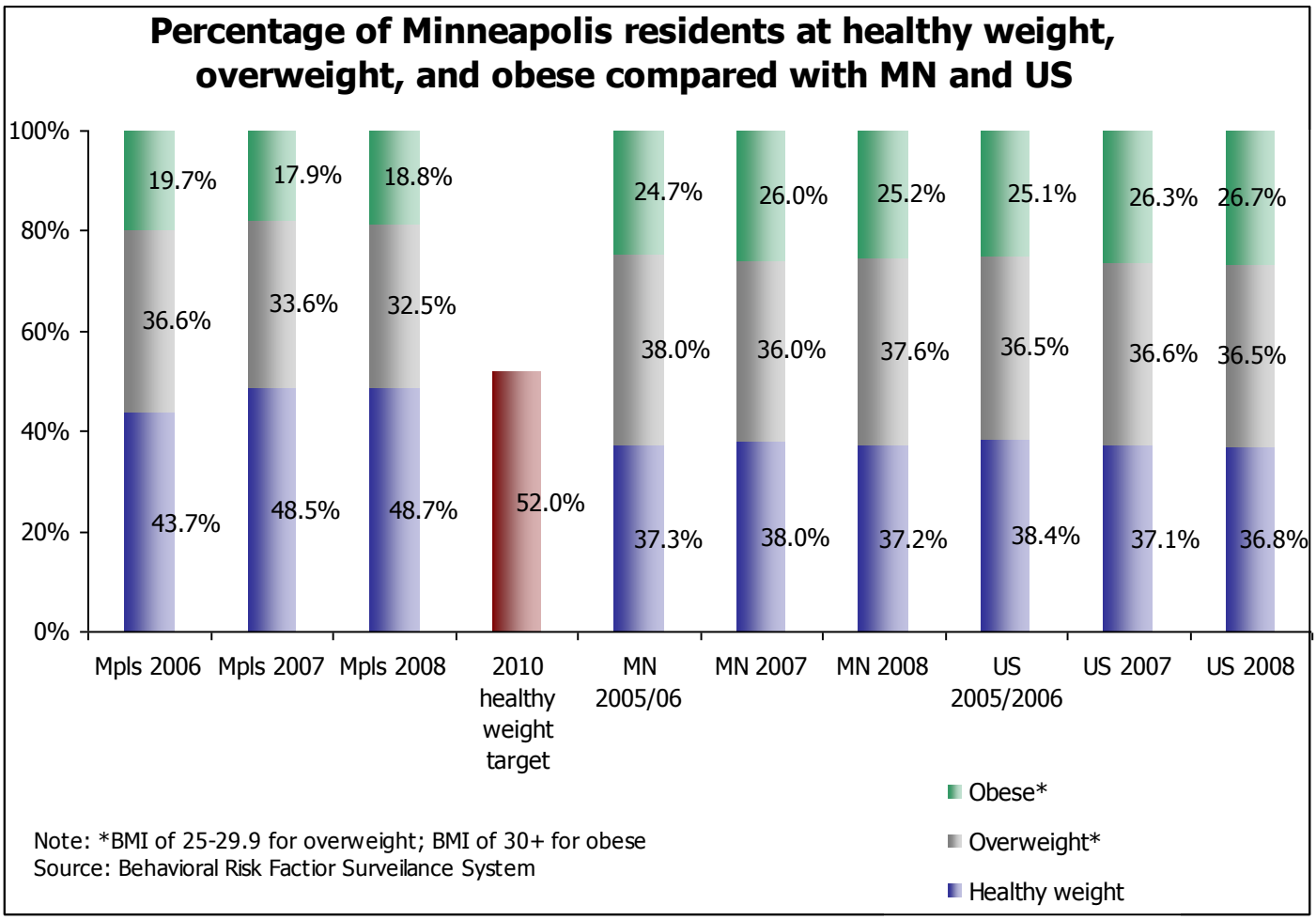
Restricting the places where people can smoke and increasing the cost of cigarettes are the most effective strategies for reducing tobacco use.

- We have been promoting passage of smoke-free building policies at Minneapolis Public Housing properties and 9 other privately-owned, publicly-subsidized properties, with the potential to affect 8,144 residents.
- We helped 9 health care clinics that provide 560,000 patient visits annually to develop systems for identifying and counseling patients who smoke and referring them to community-based support such as QuitPlan and other cessation resources.

What resources have been used to carry out these strategies?

	2008	2009	2010	2011
State		$90,216	$260,662	$65,670
Federal	$64,568	$20,130		


Hospitalizations from acute coronary events among Minneapolis residents
400
350
300
250
200
150
100
50
-
48
199
345
50
202
346
46
231
303
61
222
252
36
209
279
34
206
275
38
225
270
2003-2004
2004-2005
2005-2006
2006-2007
2007-2008
2008-2009
2009-2010
Pre smoking ban
Post smoking ban
Ages < 45
Ages 45-64
Ages > 65



Adult Healthy Weight

Why is this measure important?

Obesity is one of the most common causes of chronic diseases such as diabetes and heart disease, which are more prevalent among low-income populations. These costly, preventable illnesses reduce quality of life and cause disability and premature death.

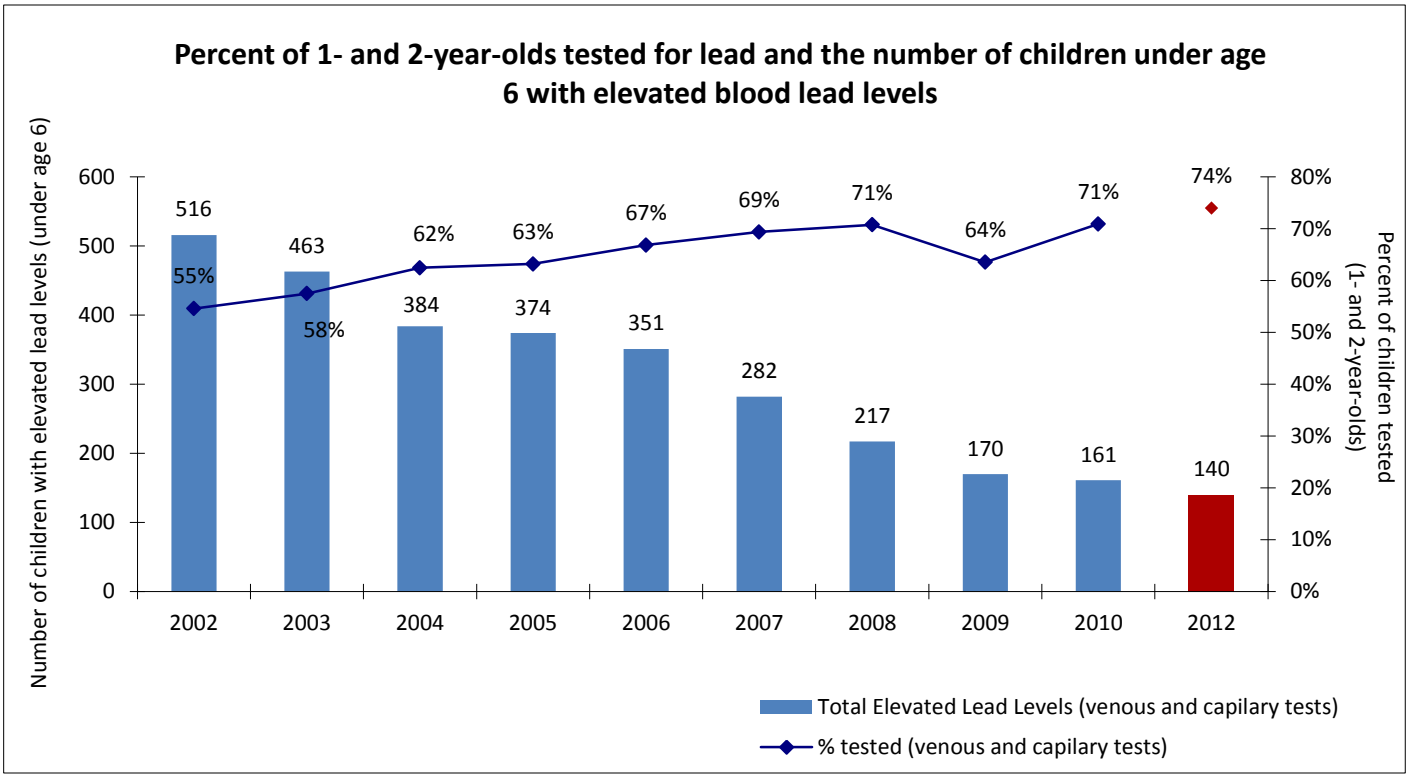
What strategies are you using to achieve the target?

Healthy eating and physical activity are the best strategies for achieving healthy weight. We created healthier environments in 225 settings. Some accomplishments include:

- Improved clinic al care for obese and overweight patients at 9 clinics
- Expanded residents' ability to grow and access healthy food through Homegrown Minneapolis initiatives, including helping 6 farmers markets accept Electronic Benefits Transfer (food support) and helping hundreds of residents in generating an additional $90,411 in sales for vendors.
- Improved physical activity and nutrition policies and practices at 50% of child care programs and 9 PICA Head Start sites, Minneapolis Public Schools and 20 charter and alternative schools.
- Expanded support for biking and walking in North Minneapolis through expansion of Nice Ride, a social awareness campaign, signage and a bike-walk community center.

What resources have been used to carry out these strategies?

	2008	2009	2010	2011
State		$595,955	$1,423,897	$982,030
Federal	$581,115	$181,086	$933,303	$1,110,466



Note: Linear modeling was used to recalculate rates over the 10 year period using Census 2000 and 2010.

Child lead poisoning

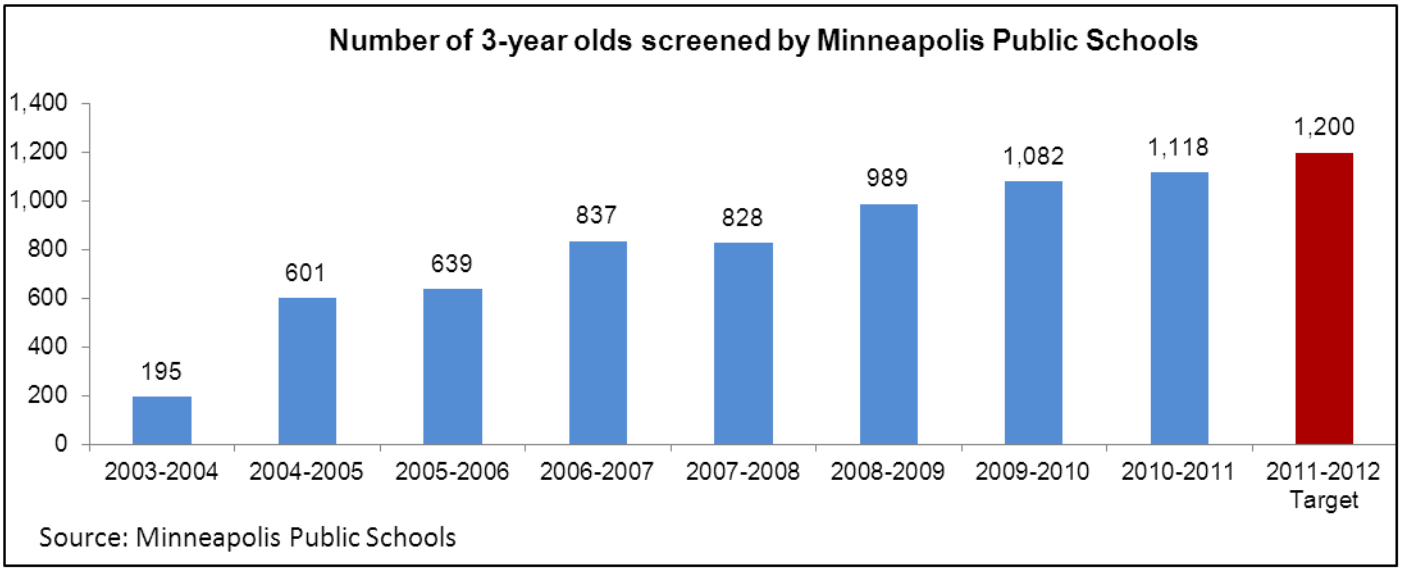
Why is this measure important?

An elevated blood lead level (a venous test result of 10 micrograms per deciliter or higher) in a child has significant and irreversible impacts, including learning disabilities, decreased IQ, decreased growth, hyperactivity, hearing impairment, brain damage and, at very high levels, death.

What strategies are you using to achieve the targets?

Reaching the screening target requires coordinated efforts with the state health department, clinical providers, and health plans, as well as community resources to address lead hazards once elevated lead levels are detected. Eliminating lead poisoning requires broad-based community and government efforts to remediate lead hazards in homes prior to poisonings. We work with Regulatory Services and Community Planning and Economic Development, along with a variety of other stakeholders, to achieve the targets. Our activities include:

- Coordinating grant funding from Hennepin County to provide community-based lead education through CLEARCorps USA, Southeast Asian Community Council, and Sustainable Resources Center. Services include community education and blood lead screening events, in-home lead and healthy homes education visits, lead dust wipe sampling of homes, and referrals to remediation programs.
- Providing outreach to clinics and medical providers, and calling families with lead-exposed children to inform them of available resources for in-home education and for remediation grant funds.
- Convening the Lead Testing Task Force to focus on tracking lead testing rates and targeting outreach efforts to areas and populations most in-need.
- Participating in the Minneapolis Green and Healthy Homes Initiative to coordinate the City's lead and other healthy homes activities, including applying for related grant funding when available.



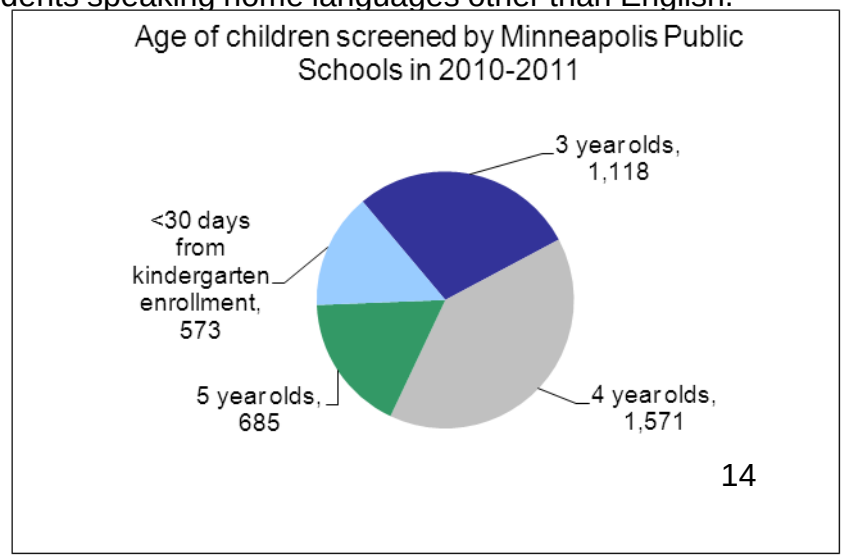
Screening by Age 3

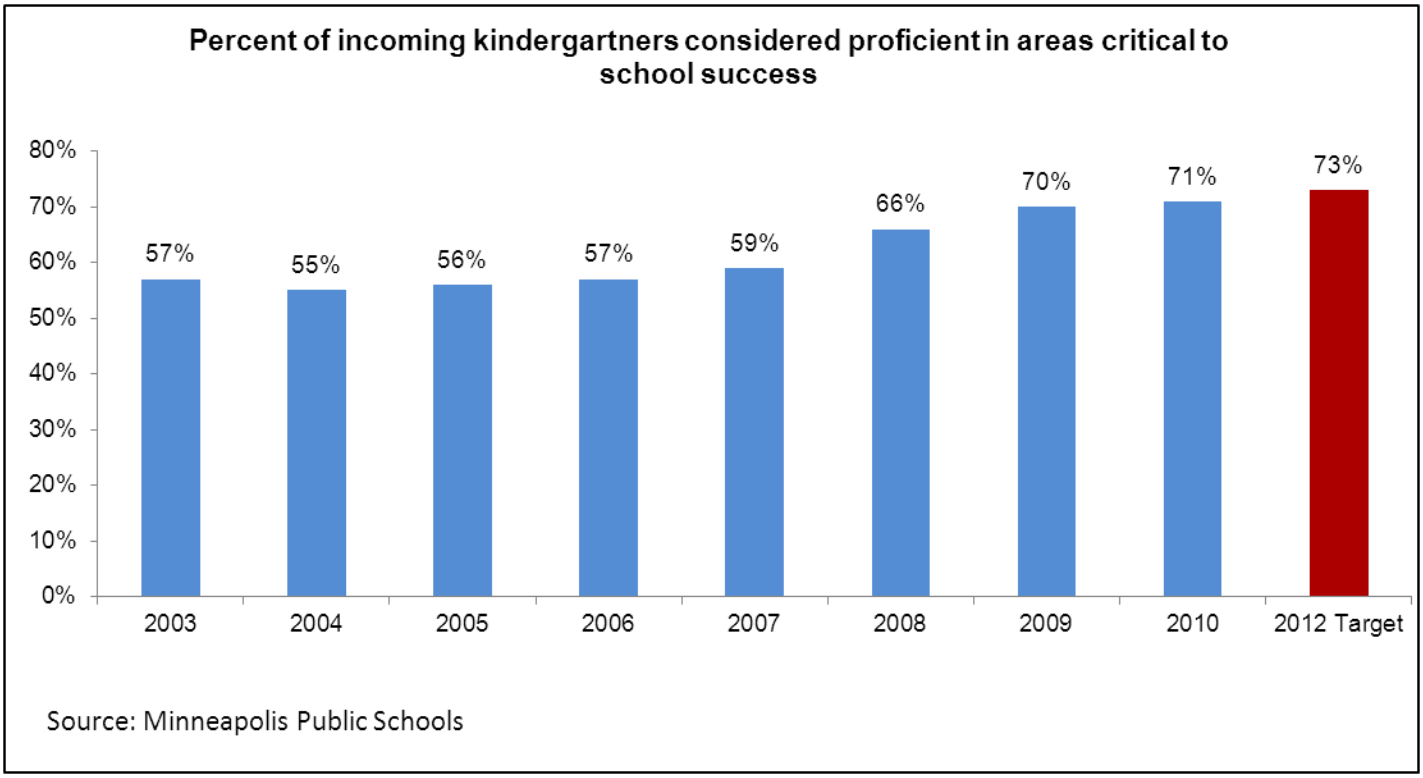
Why is this measure important?

Research shows earlier childhood interventions produce more positive outcomes for children because they identify physical health, mental health, and developmental problems that can be addressed before children enter kindergarten. Early services can reduce the likelihood that the identified issues will impede learning.

What strategies are you using to achieve the target?

- We partnered with Minneapolis Public Schools and 348-TOTS to provide early childhood screening ; 947 children were referred to 348-TOTS in the first half of 2011.
- We collaborated with WIC program sites, community clinics, child care centers, and the Minnesota Visiting Nurse Association to identify 3-year-olds who needed screening.
- We worked with the Minnesota Organization on Fetal Alcohol Syndrome and Minneapolis Public Schools to improve identification of children who may have been exposed to alcohol prenatally; 38 children were identified by mid-year.
- We participated as a Regional member of the new Region 11 Interagency Early Intervention Committee.
- We increased the number of English Language Learners who were screened and served. In the first 6 months of 2011, 365 ELL children were screened. During the 2010-11 school year, early childhood services served 469 Spanish-speaking students, 198 Somali-speaking students, 155 Hmong-speaking students, and 95 students speaking home languages other than English.
- Through a partnership with Way to Grow 89 children were referred for early childhood screening.
- We helped Head Start to develop a new process to share early childhood screening information.





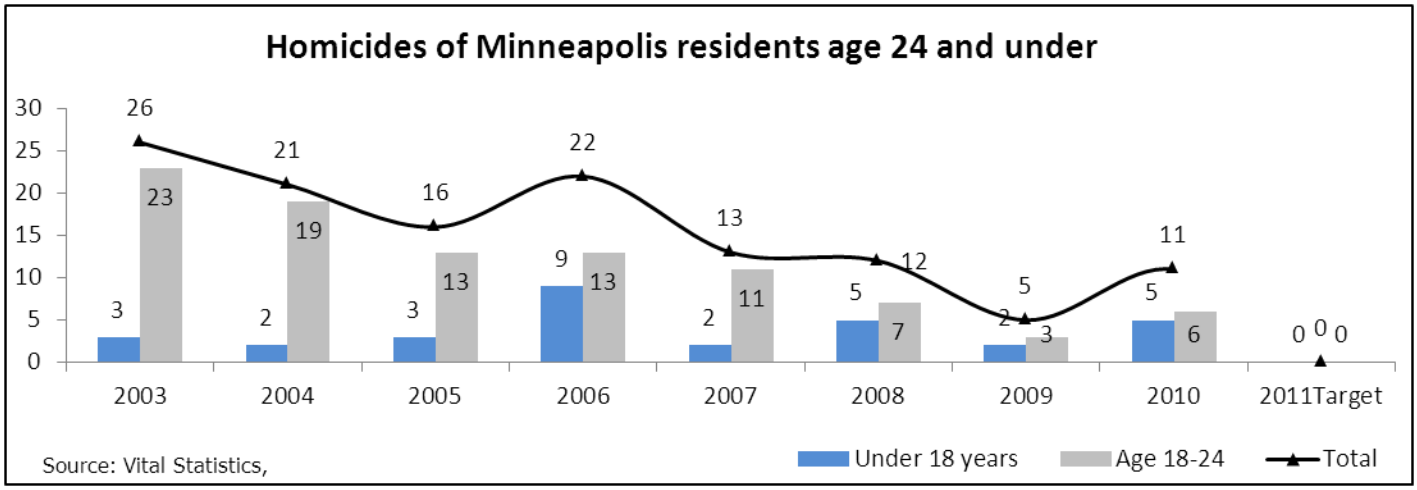
Kindergarten Readiness

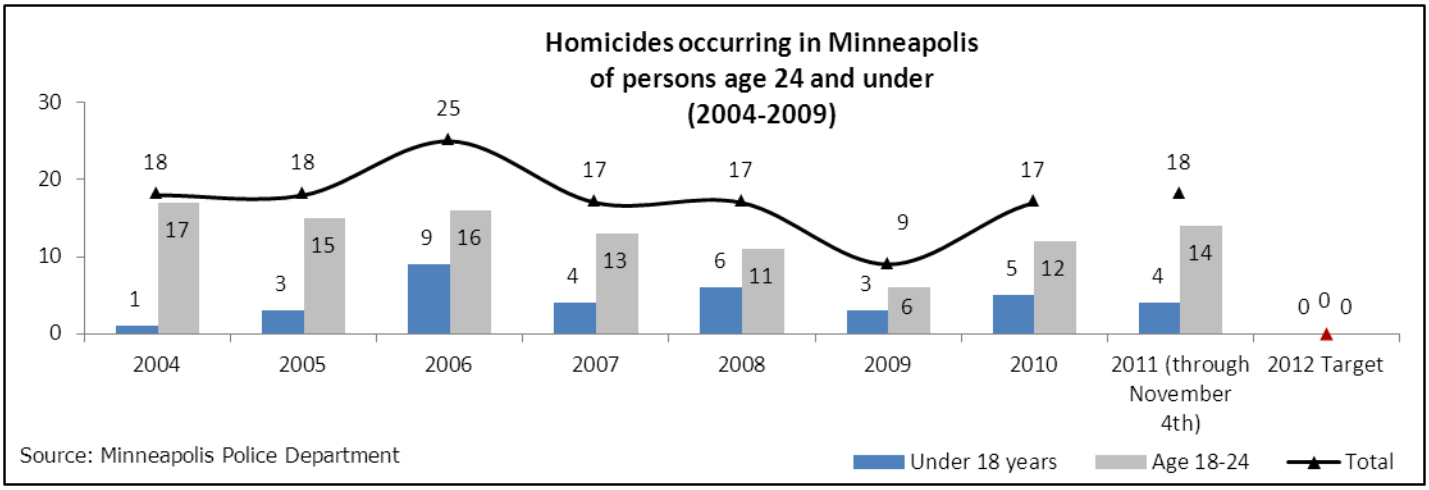
Why is this measure important?

School readiness is important because children who lag behind their peers in learning skills in the early grades often fail to catch up later; many become discouraged and eventually drop out of school. The Beginning Kindergarten Assessment is closely aligned with academic success.

What strategies are you using to achieve this goal?

- During the 2010-11 school year, we partnered with Minneapolis Public Schools and Hennepin County to ensure Minneapolis preschool children were screened prior to entering kindergarten.
- We targeted outreach to communities of color and English language learners. Special efforts targeted two underserved populations, African Americans and American Indians. These activities include;
  - Working with North side Achievement Zone (NAZ) project to ensure at risk children are being screened in north Minneapolis.
  - Providing community early childhood screenings.
  - Providing culturally appropriate screening services.
  - Strengthening partnerships with Head Start, Way to Grow, and early childhood centers in the Phillips neighborhood.





Homicides of person age 24 and younger

Why is this measure important?

Life lost at a young age is tragic. Death from violence has a traumatic impact on the entire community and frequently leads to retaliation resulting in more fatalities.

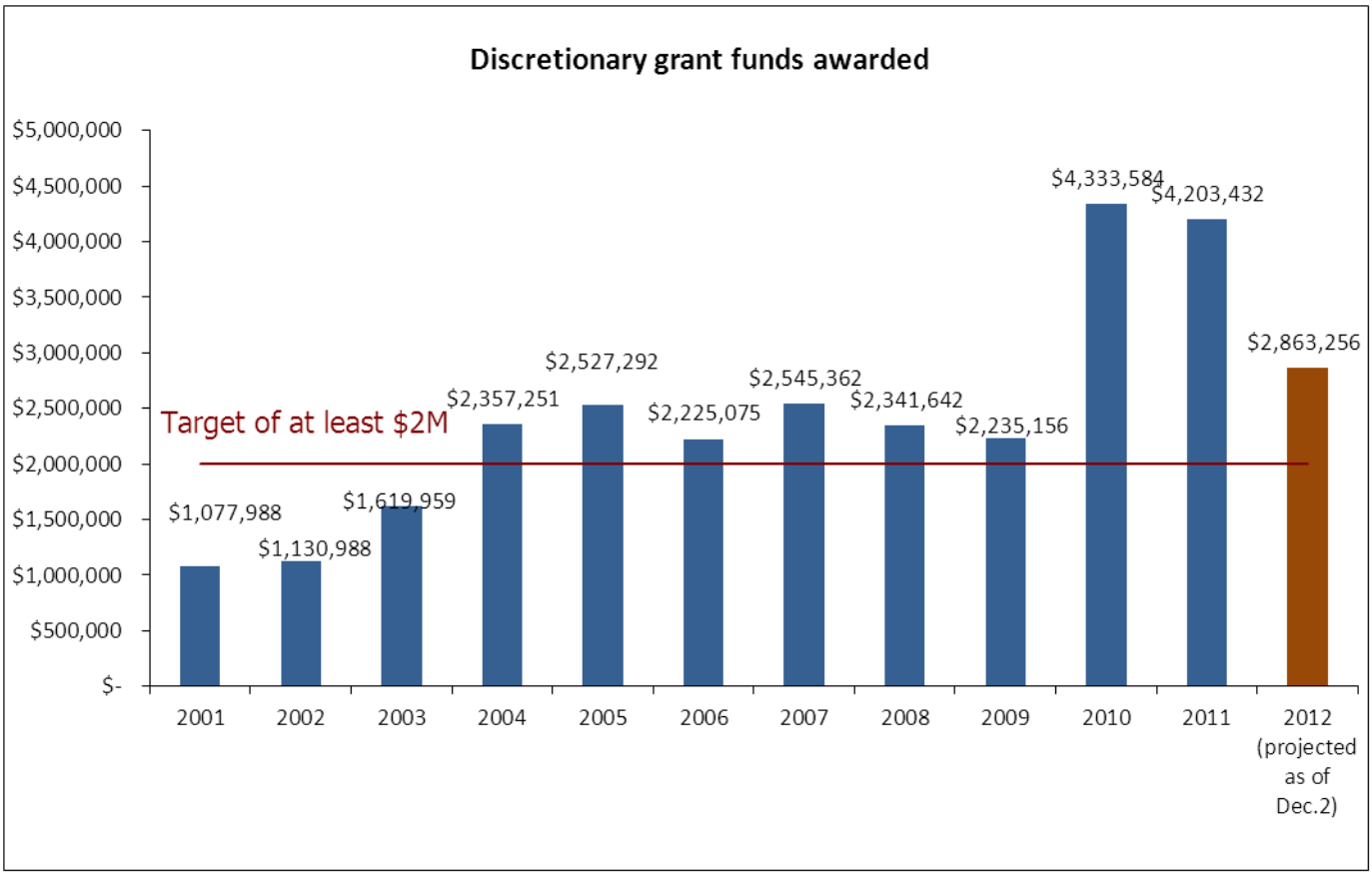
What will it take to make progress?

Our efforts at reducing homicide among young people are based on the strategies outlined in the *Blueprint for Action: Preventing Youth Violence in Minneapolis*. North4 is a collaboration with CPED and employs 30 young people who self-identify as gang-affiliated. Minneapolis BUILD implements a structured curriculum to steer young people away from gangs and will reach 40 Beacons-program students at Nellie Stone Johnson and 80 young people reentering the community from juvenile detention. BUILD outreach workers have contacted 913 at-risk young people. Both North4 and Minneapolis BUILD predominantly recruit and connect with young people from Folwell, Hawthorne, Jordan and McKinley neighborhoods that have had a disproportionate number of homicides. A hospital-based protocol to connect victims of assault-related injuries to community-based services for follow-up is being expanded to an additional hospital, and a new community outreach component is being developed for the two trauma hospitals that serve Minneapolis. A new pilot of post-homicide Community Response was initiated this past summer in North Minneapolis with a plan to expand citywide in 2012. Group listening sessions were held and resources provided for families and friends following two youth homicides.

Homicides in the age group 17 and under by race /ethnicity during 2003-2010								
Race/ethnicity	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
White Non-Hispanic	0	0	0	3	0	0	0	0
Black Non-Hispanic	2	2	2	6	2	5	1	4
American Indian	0	0	0	0	0	0	1	1
Asian/Pacific Islander	1	0	1	0	0	0	0	0
Hispanic	0	0	0	0	0	0	0	0
Minneapolis Total	3	2	3	9	2	5	2	5

Homicides in the age group 18 through 24 by race /ethnicity during 2003-2010								
Race/ethnicity	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
White Non-Hispanic	4	1	0	1	2	2	0	1
Black Non-Hispanic	10	14	7	7	7	5	2	5
American Indian	4	2	4	0	0	0	0	0
Asian/Pacific Islander	1	1	2	3	2	0	1	0
Hispanic	4	1	0	2	0	0	0	0
Minneapolis Total	23	19	13	13	11	7	3	6

Source: Minnesota Department of Health



Discretionary Grant Funds

Why is this measure important?

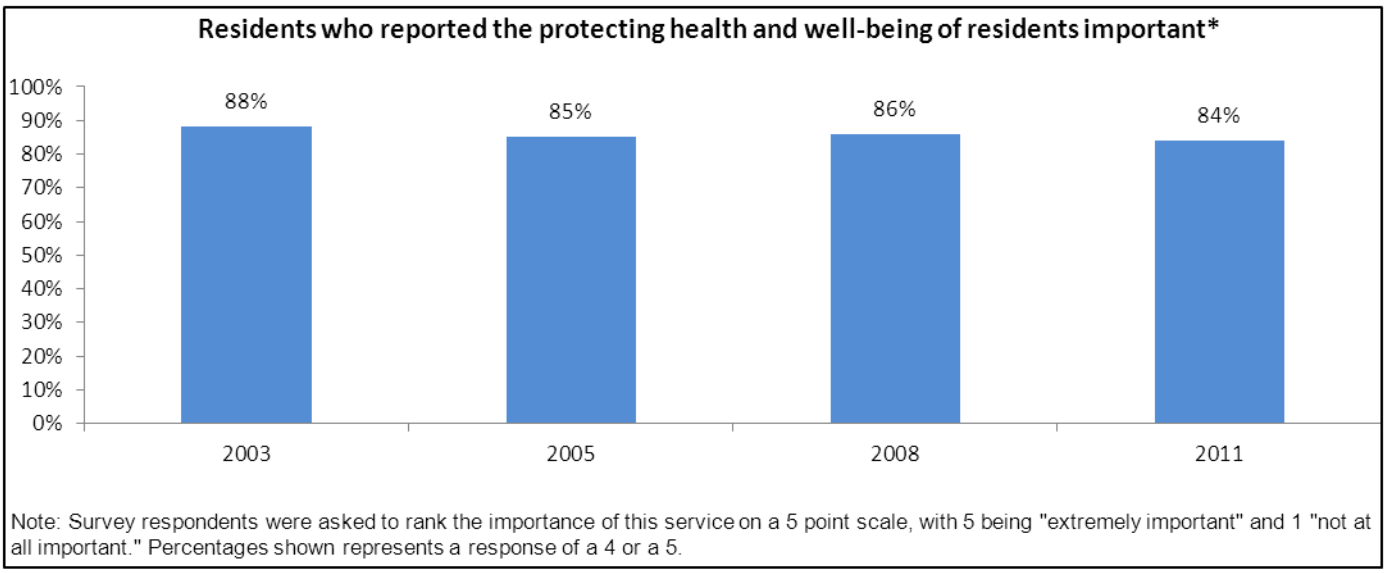
Our funding from the city general fund and state block grants has remained stagnant or decreased over recent years. At the same time, the demand for local public health services has increased, due to higher rates of poverty, housing instability, and lack of health insurance, combined with diminishing support for community-based organizations from other government agencies and foundations. Racial and socioeconomic health disparities persist. Our ability to obtain government and foundation grants is critical to making progress toward city and department goals.

What will it take to achieve this target?

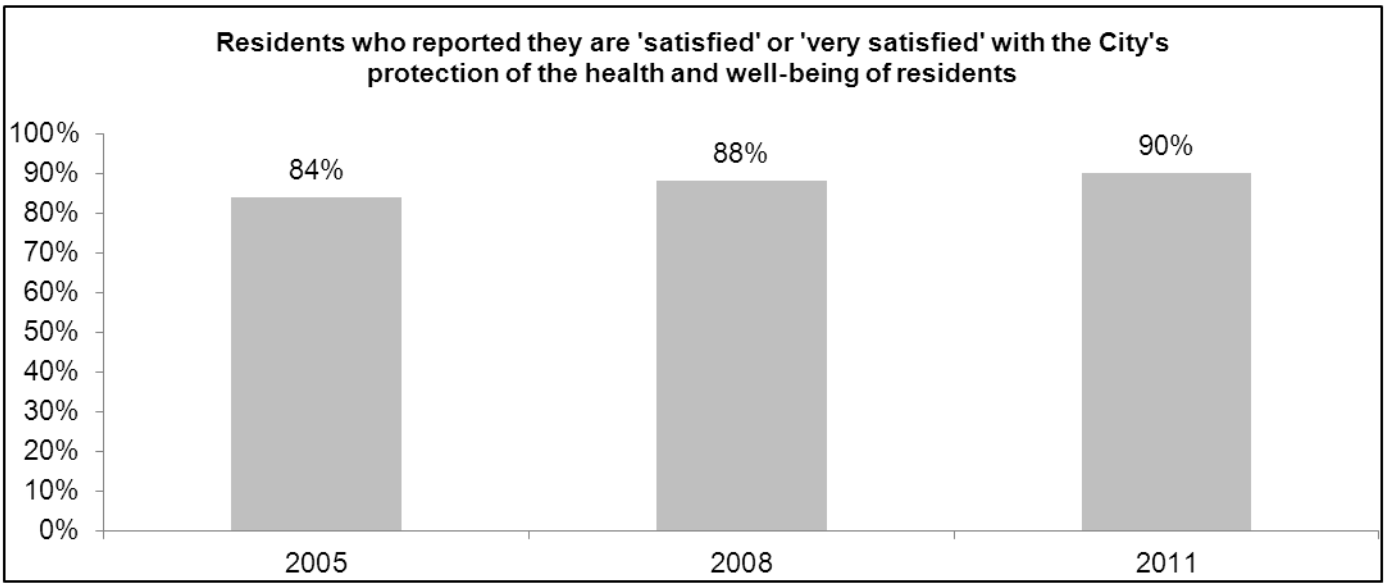
Grant opportunities are becoming scarcer while competition for grant awards is increasing. Strategies to improve our competitiveness for grant awards include working with Inter-Governmental Relations to identify funding opportunities, developing strong partnerships with other public health and community-based agencies on grant applications, and dedicating more staff time to designing projects and writing grant applications.

The Health Department anticipates completing 2011 with a total of $4.2 million in active discretionary grants. While this total is likely to decrease in 2012, more than $2.8 million has been secured for 2012 as of December 2, 2011, exceeding our target for 9 consecutive years.

Appendix

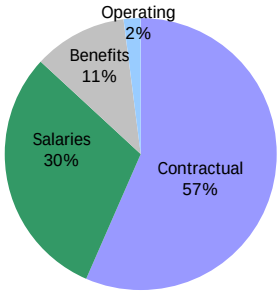


Note: Survey respondents were asked to rank the importance of this service on a 5 point scale, with 5 being "extremely important" and 1 "not at all important." Percentages shown represents a response of a 4 or a 5.

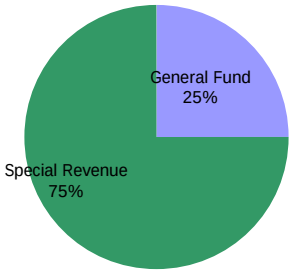


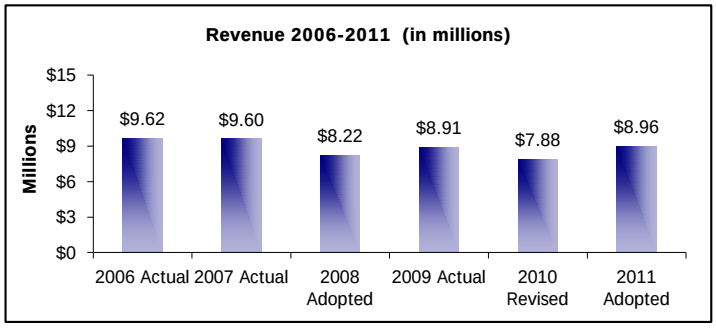
Management Dashboard: Health and Family Support

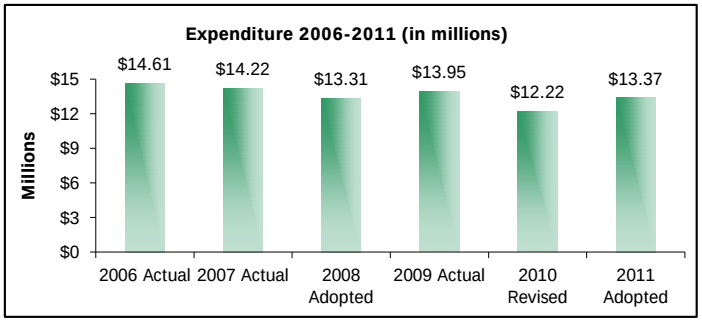
2011 Expenditures by Type: $13.37 million



2011 Expenditures by Fund: $13.37 million







Loss Prevention Data					
Year	2006	2007	2008	2009	2010
Workers Comp	$682	$1,070	$122	$3,612	$4,142
Liability Claims	$0	$0	$0	$0	$340

Average Sick Days Taken per Employee					
Year	2006	2007	2008	2009	2010
Days	9.5	8.6	7.4	8.3	7.9

Workforce Demographics		
Year end	12/31/03	12/31/10
% Female	82%	88%
% Employee of Color	27%	44%
# of Employees	60	60

Note: See back for detailed workforce analysis

Overtime Costs					
Year	2006	2007	2008	2009	2010
Hours	59.5	39.5	35.0	110.3	40.8
Cost	$1,692	$1,066	$1,053	$3,046	$1,097

Employee Turnover and Savings					
Year end	2006	2007	2008	2009	2010
Turnover	14%	13%	11%	25%	14%
Savings	$431,184	$456,220	$590,162	-	-
% of Total Budget	3.4%	3.4%	4.3%	-	-

Positions Vacancies					
Year end	2006	2007	2008	2009	2010
Percent of Total	4%	9%	6%	14%	5%

Performance Reviews Past Due in HRIS	
As of 12/01/11	76%

Retirement Projections											
Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Number	0	0	2	1	0	0	1	2	1	1	1

Notes:

Average Sick Days taken per Employee

A) Based on the payroll calendar year not the calendar year.
B) Does not include employees who were in a suspended ("S") Pay Status at the end of a given payroll year.
C) Includes employees who are in a paid ("P") Leave of Absence status and an unpaid Leave of Absence status ("L").

Overtime Costs

A) OT amount - Fiscol. Reconciled with CRS and Data ware house queries.
B) Hours - based on HRIS management reports with payroll data

Workforce Demographics

A) Includes employee counts at year's end for 2003 and 2007.
B) Only includes active FT regular employees.

Employee Turnover and Savings

A) Turnover Savings= $Budgeted (personnel) - $Actual (personnel)

Position Vacancies

A) Includes only budgeted positions.

Retirement Projections

A) The projected time an employee is eligible to retire is based on service time in HRIS. For employees who received pension service credit in other organizations, the actual year of retirement eligibility may be sooner than the projections show.

Workforce Analysis
1 of 8 categories indicates under-utilization:
- Service Maintenance 2 incumbents POC = 0.0% Available workforce = 20.0%

Goal: If any deficiency exists in HFS, it would be that the department is heavily female. Of the 65 total FTEs only 9 are male. Emphasis to be placed on creating a diverse workforce that is culturally and technologically competent and who are highly engaged in their work environment and relationships.