

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

**SEPTEMBER 2010**

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## **WHO ARE WE?**

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### **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.

### **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.

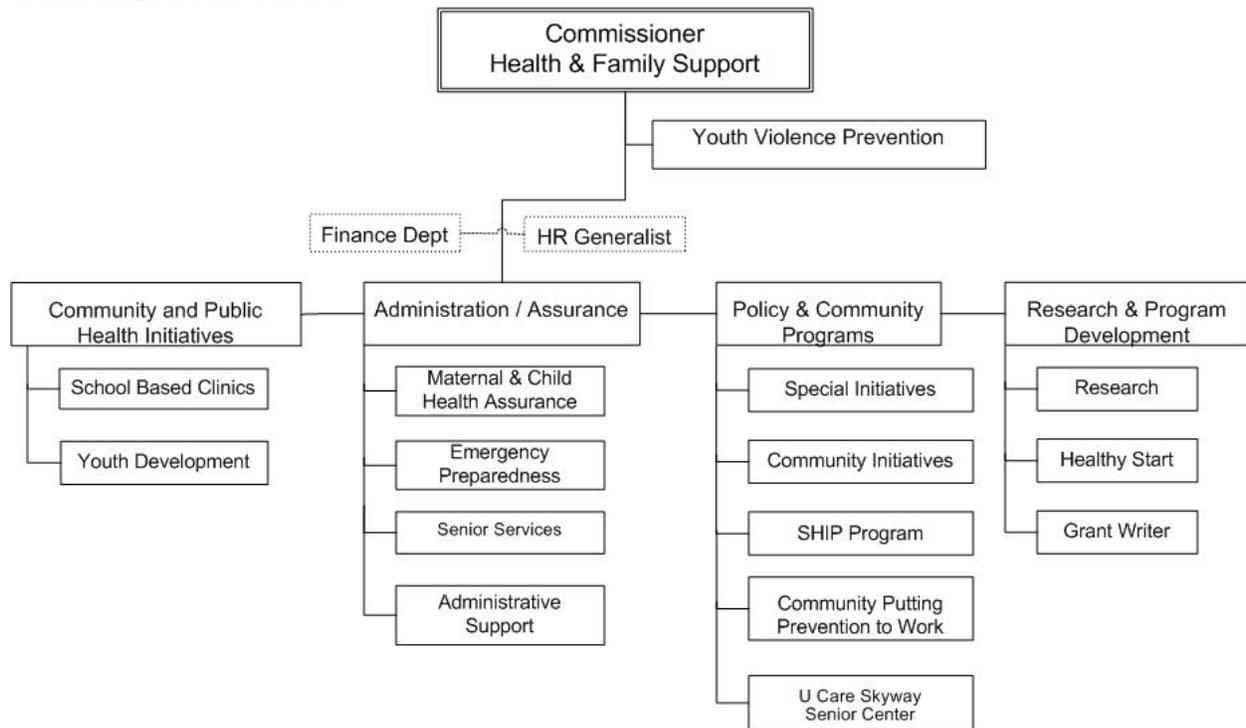
### **B. Address factors affecting health: social conditions and physical environment**

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<br>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.<br>Staff designated for Command and Section Chiefs positions trained to proficiency level within one year of designation, and prior to assignment in a response .<br><br>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.<br><br>Staff's sense of recognition for outstanding service.  |

| City Goal   | City Strategic Direction   | Department Goal   | Objective   | Measure   |
|---|--|---|---|---|
| Livable Communities, Healthy Lives<br><br>A City That Works   | Active lifestyles: walkable, bikeable, swimmable and healthy choices are easy and economical<br><br>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<br><br>Percent of children and adults physically active at recommended levels.<br><br>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<br><br>A Safe Place to Call Home | Teen pregnancy a thing of the past<br><br>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   |   | Sexually 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<br><br>Number of hospital- based reports of assault-related injury among Minneapolis residents under 18 and 18-24 years old<br><br>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<br><br>Jobs and Economical Vitality | Youth . . . in school, involved, inspired and connected to an adult<br><br>Guns, gangs, graffiti gone<br><br>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<br><br>MPS students who feel safe at home<br><br>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<br><br>Many People, One Minneapolis<br><br>A Safe Place to Call Home | Tots school ready, teen on course<br><br>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<br><br>Number of rental properties (10 or more units) with building-wide smoke-free policies<br><br>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-ready 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%<br>Adults: 64% | Children 50%<br>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<br>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            | 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<br>1272    | 257<br>950     | 182<br>710     | 176<br>618     | NA                                      | NA                              |
| Student participation in after-school activities (8 <sup>th</sup> graders)                          |                |                | 55%            | 54%            | 55%            | 52%            | 58%                                     | 69%                             |
| Students reporting someone in their family helps them with homework (8 <sup>th</sup> 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<br>(02-04) | 6.1<br>(03-05) | 6.5<br>(04-06) | 6.8<br>(05-07) | 7.9<br>(06-08) | 7.1<br>(07-09) | 4.5                                     | 4.5                             |
| For whites (non-Hispanic)   | 3.4            | 3.7            | 4.5            | 5.3            | 5.3            | 4.5            | 4.5                                     | 4.5                             |
| For Blacks (non-Hispanic)   | 9.6            | 10.1           | 10.0           | 11.1           | 13.3           | 12.9           | 4.5                                     | 4.5                             |
| For American Indians  | 9.2            | 13.2           | 12.9           | 7.9            | 9.1            | 8.0            | 4.5                                     | 4.5                             |
| For Asian/Pacific Islanders   | 2.9            | 2.3            | 3.0            | 3.9            | 3.0            | 2.3            | 3.0                                     | 3.0                             |
| For Hispanics   | 7.5            | 5.2            | 5.6            | 4.3            | 6.4            | 5.6            | 4.5                                     | 4.5                             |
| Number of 3-year-olds screened by Minneapolis Public Schools  |                |                | 837            | 828            | 989            | 1000           | 1,000                                   | 1,200                           |

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

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### **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<br>Department of Health and Family Support<br>Financial Plan |                   |                   |                   |                   |                   |                   |                   |                   |                   |
|--|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
|  | 2008 Actual       | 2009 Actual       | 2010 Current      | 2010 Projected    | 2011 Budget       | 2012 Forecast     | 2013 Forecast     | 2014 Forecast     | 2015 Forecast     |
| <b>Revenues:</b>   |                   |                   |                   |                   |                   |                   |                   |                   |                   |
| General Fund   | 4,083             | 4,463             | 3,320             | 3,320             | 3,335             | 3,445             | 3,559             | 3,681             | 3,834             |
| <b>Federal Fund</b>  |                   |                   |                   |                   |                   |                   |                   |                   |                   |
| 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             |
| <b>Total</b>   | <b>4,321</b>      | <b>4,306</b>      | <b>4,351</b>      | <b>5,167</b>      | <b>4,971</b>      | <b>3,310</b>      | <b>3,160</b>      | <b>2,698</b>      | <b>2,235</b>      |
| CDBG Fund  | 1,676             | 1,430             | 1,049             | 1,049             | 1,049             | 1,049             | 1,049             | 1,049             | 1,049             |
| <b>State/Other Fund</b>  |                   |                   |                   |                   |                   |                   |                   |                   |                   |
| 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             |
| <b>Total</b>   | <b>3,374</b>      | <b>4,148</b>      | <b>4,597</b>      | <b>4,60</b>       | <b>4,382</b>      | <b>3,487</b>      | <b>3,487</b>      | <b>3,487</b>      | <b>3,487</b>      |
| <b>Total for Revenue</b>   | <b>13,454</b>     | <b>14,347</b>     | <b>13,317</b>     | <b>14,136</b>     | <b>13,737</b>     | <b>11,291</b>     | <b>11,255</b>     | <b>10,915</b>     | <b>10,605</b>     |
| <b>Expenditures:</b>   |                   |                   |                   |                   |                   |                   |                   |                   |                   |
| <b>General Fund</b>  |                   |                   |                   |                   |                   |                   |                   |                   |                   |
| Personnel  | 1,237,916         | 1,688,201         | 680,337           | 680,337           | 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           |
| <b>Total</b>   | <b>4,082,996</b>  | <b>4,463,342</b>  | <b>3,320,372</b>  | <b>3,320,372</b>  | <b>3,334,883</b>  | <b>3,444,581</b>  | <b>3,558,562</b>  | <b>3,680,621</b>  | <b>3,833,735</b>  |
| <b>Federal Fund</b>  |                   |                   |                   |                   |                   |                   |                   |                   |                   |
| 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         |
| <b>Total</b>   | <b>4,360,065</b>  | <b>4,641,195</b>  | <b>4,351,000</b>  | <b>5,167,000</b>  | <b>4,971,000</b>  | <b>3,310,000</b>  | <b>3,160,000</b>  | <b>2,698,000</b>  | <b>2,235,000</b>  |
| <b>CDBG Fund</b>   |                   |                   |                   |                   |                   |                   |                   |                   |                   |
| 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           |
| <b>Total</b>   | <b>1,430,193</b>  | <b>1,122,648</b>  | <b>1,049,000</b>  | <b>1,307,238</b>  | <b>1,049,000</b>  | <b>1,049,000</b>  | <b>1,049,000</b>  | <b>1,049,000</b>  | <b>1,049,000</b>  |
| <b>State/Other Fund</b>  |                   |                   |                   |                   |                   |                   |                   |                   |                   |
| 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           |
| <b>Total</b>   | <b>3,436,180</b>  | <b>3,725,433</b>  | <b>4,597,050</b>  | <b>4,649,422</b>  | <b>4,382,000</b>  | <b>3,487,419</b>  | <b>3,487,438</b>  | <b>3,487,379</b>  | <b>3,487,265</b>  |
| <b>Total for Expenditures</b>  | <b>13,309,434</b> | <b>13,952,618</b> | <b>13,317,422</b> | <b>14,444,032</b> | <b>13,736,883</b> | <b>11,291,000</b> | <b>11,255,000</b> | <b>10,915,000</b> | <b>10,605,000</b> |
| <b>Difference</b>  | <b>144,566</b>    | <b>1,814,382</b>  | <b>-</b>          | <b>1,240,968</b>  | <b>-</b>          | <b>-</b>          | <b>(0)</b>        | <b>0</b>          | <b>0</b>          |

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)?

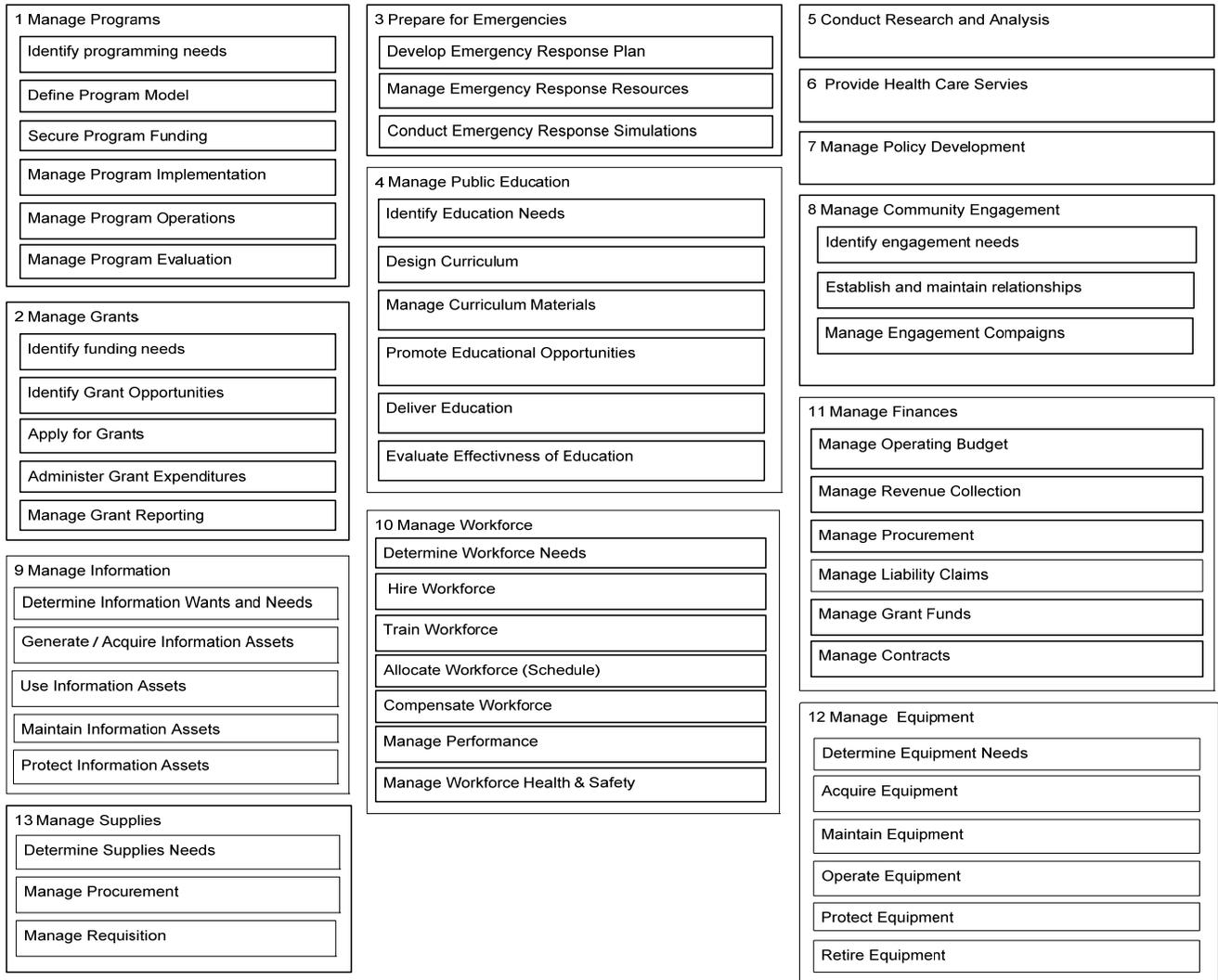
### **1. Department Technology Overview**

#### **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.<sup>1</sup>

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<sup>1</sup> 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

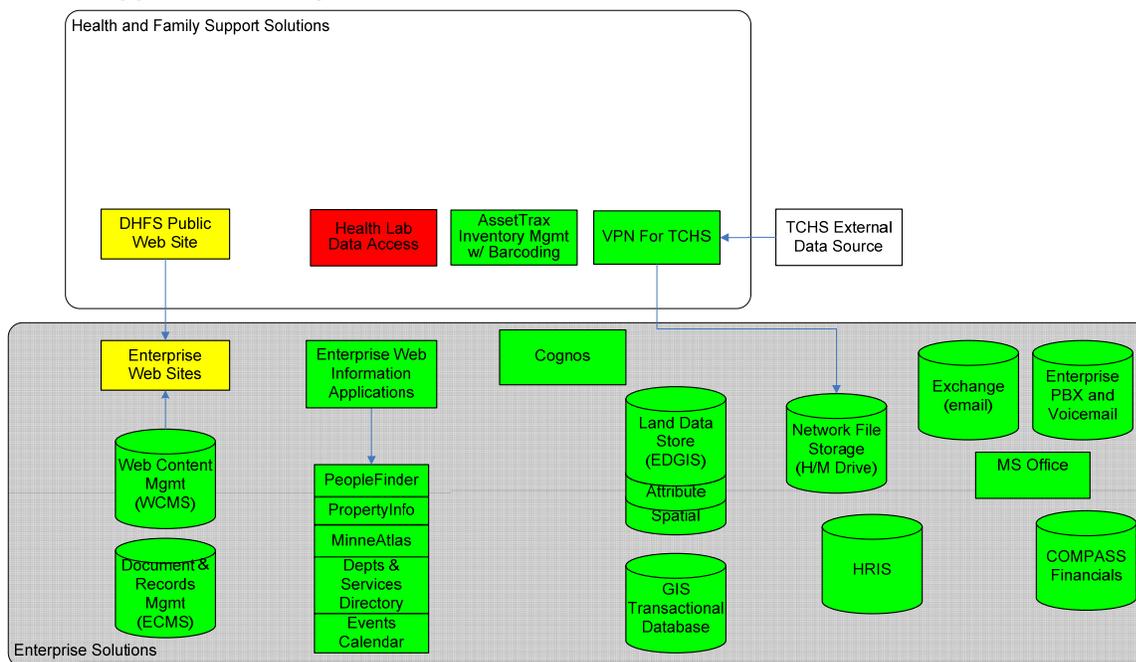
| Solution/Service       | Description   | Funding Scope | Capabilities Supported |
|------------------------|---|---------------|------------------------|
| Health Lab Data Access | Software for accessing records in the health lab, which was closed in 2009.   | HFS           | 9                      |
| 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 |

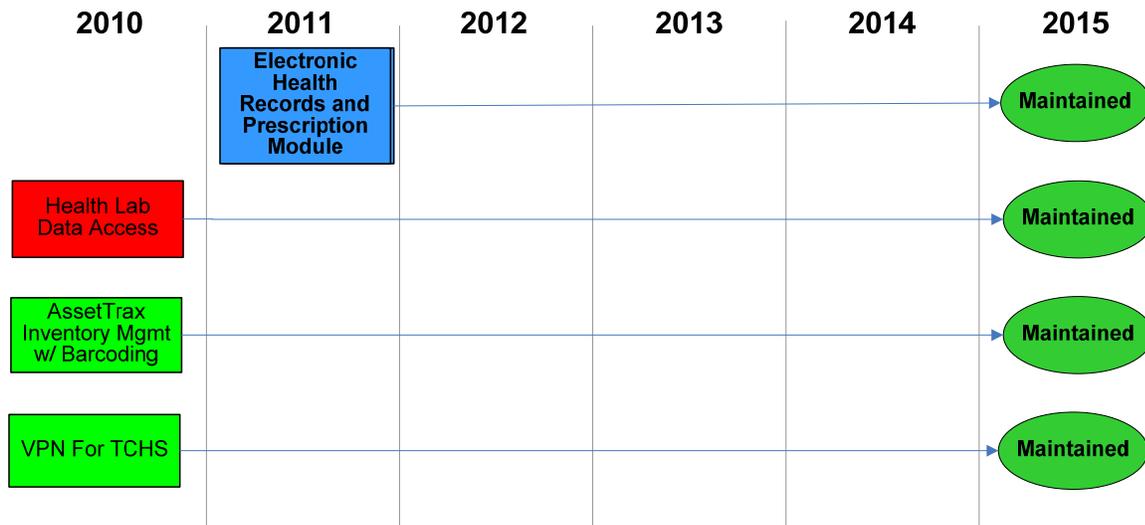
### 2.3. Business Change Drivers

#### 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<br>Be compliant with Federal regulations and security standards<br>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<br>Be compliant with Federal regulations and security standards<br>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<br>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<br>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  | <b>Strategic / Available (has a life of at least 3 years with continued enhancements and maintenance)</b>   |
|        | 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:  |
|        | <b>Evaluating</b>   |
|        | 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.   |
|        | <b>Maintained</b>   |
|        | Product, technology or application is being maintained, but is being considered for replacement, refactoring <sup>2</sup> 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    | <b>Sunsetting</b>   |
|        | 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.   |
|        | <b>Unavailable</b>  |
|        | Product, technology or application is either: <ol style="list-style-type: none"> <li>1. Retired – Production use is not acceptable. There is no institutional support.</li> <li>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.</li> <li>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</li> </ol> |

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

<sup>2</sup> 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.

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