

**COMMUNITY HEALTH SERVICES
PLAN UPDATE
FOR 2002-2003**



**MINNEAPOLIS DEPARTMENT OF
HEALTH AND FAMILY SUPPORT**

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MINNEAPOLIS DEPARTMENT OF HEALTH AND FAMILY SUPPORT

COMMUNITY HEALTH SERVICES PROGRAM PLAN UPDATE SUMMARY 2002 - 2003

Background

The Minnesota Community Health Services (CHS) Act of 1976 (later renamed the Local Public Health Act) established a public health infrastructure based on a state and local partnership. The Act allowed the state to provide funds to local governments to assess community health needs, and plan and deliver services to address those needs. The Act requires local Community Health Services Boards to prepare and submit CHS plans to the State Commissioner of Health every four years and a CHS Plan Update two years into each plan cycle. This document is the plan update.

The CHS Plan has two major components: the community assessment and the program plan. The purposes of the assessment are to identify actual and potential health problems in the community, determine the community's capacity and resources to respond to the identified problems, and establish priorities for working on the identified problems. The program plan describes the various actions and activities which exist or will be developed in response to the public health problems identified in the community of 1999 and addressed the 2000-2003 time frame. This Plan Update provides a status report on the objectives and methods submitted in the 2000-2003 CHS Plan, identifies changes in program activities, and identifies new efforts.

Community input for the 2002-2003 CHS Plan Update was obtained through various mechanisms from people interested in and knowledgeable about public health issues. Throughout 2000-2001, community members/stakeholders participated in steering committees, focus groups, and task forces to develop community action in response to assessment data. Some specific examples include:

CHAMP forum

May 30, 2001, attended by 100 agency and community members.

Senior Forums

Six forums were held between March and May, 2001, attended by almost 200 community members in the 1st, 3rd, 10th, 12th, and 13th wards.

Minority Health Assessment Project Community Forums

About 100 community members attended six forums (including one specifically for immigrants and refugees) in October and November, 2000.

Twin Cities Health Start Project

There is on-going community input for the project through an 80 member consortium and African American and American Indian Advisory committees, which advise the Executive Committee on issues which are specific to each community related to infant mortality.

Reports on numerous public health issues were distributed and discussed at community forums and workshops. In addition, the Minneapolis Public Health Advisory Committee addresses issues related to existing and emerging public health issues.

A public hearing on the Plan update was held on June 19, 2001.

Community Assessment

The community assessment submitted with the original 2000-2003 CHS Plan provides comprehensive data on the health status and needs of Minneapolis residents. This information has not been updated for the 2002-2003 Plan Update. Reports on assessment and other program activities completed after submission of the original plan have been included as attachments to the Plan Update (for submission to the Minnesota Department of Health). Additional copies are available through the Department of Health & Family Support.

These documents include:

- Minneapolis Seniors Speak Out Summer 2001
- Preliminary Report Senior Housing in Minneapolis: Background & Recommendations
- Closing the Gap: (A Public Health Report on Health Disparities) (Report on Immigrant & Refugee Health of the Twin Cities)
- Closing the Gap: (A Public Health Report on Health Disparities) (Summary & Recommendations of the Twin Cities Metro)
- Closing the Gap: (A Public Health Report on Health Disparities) (Date Report of the Twin Cities Metro)
- Faith Communities & Public Health: Partners For Healthier Communities
- The Minneapolis Lead Hazard Reduction Network: (A Summary Report May 2001)
- Lead Hazard Control: A Comprehensive Plan
- Initial Findings from CHAMP (Child Health Assessment & Monitoring Project) Draft 2001
- Minneapolis Birth Data 1997-1999
- Summary & Update of the Initiative on Youth Access to Alcohol in Minneapolis
- Supporting our Community (Annual Report 2000)
- KidStat Databook
- KidStat Neighborhood Factbook - CHAMP (Northside Neighborhood)
- KidStat Neighborhood Factbook - CHAMP (Southside Neighborhood)
- Executive Summary CHAMP
- Alcohol Use in Minneapolis
- Aiming For A Safe City (Reducing Gun Tragedies in Minneapolis)
- Health Check, Minneapolis Lead Poisoning
- You Can Prevent Lead Poisoning: Healthy Homes Healthy Families Healthy Communities (A Strategic Action Plan to Address Childhood Lead Poisoning)
- Welcoming New Arrivals to Minneapolis: Issues and Recommendations

- Healthy Start Proposal Abstract 2002-2005
- Examining the Organization of Perinatal Service Systems in Hennepin and Ramsey Counties
- Aiming for a Safe City
- Binge Drinking in Minneapolis: Understanding the Problem and Possible Solutions

Program Plan

The Minneapolis Department of Health and Family Support has identified four strategic directions to address in 2002 – 2003:

- **Improve Community Health**
By expanding Healthy Start, implementing recommendations from the Perinatal Care, Minority Health, and CHAMP reports; improving dissemination of research to the community to support policy and programs; developing a business plan for school based clinics; expanding services to seniors; faith based initiatives.
- **Eliminate Health Disparities**
By working with community partners to enhance the well being of the Minneapolis community by calling attention to health disparities and other social and economic circumstances that limit the ability of Minneapolis residents to improve their quality of life. The department will examine and report disparities and work with partners and other stakeholders to develop strategies and actions that address these conditions.
- **Support and Welcome New Arrivals**
By working with other governmental, community-based, and culturally based organizations to implement the recommendations from the New Arrivals report.
- **Developing a Healthy Workforce**
By identifying the factors that inhibit individual and family economic stability, as well as those factors that sustain individuals and families. The department will work with policy makers and community programs to assure effective job training and employment opportunities for Minneapolis residents in need.

The CHS Program Plan is formatted around five populations and/or program categories that are linked to the Department's strategic directions. These organizing categories are:

- Family planning, prenatal care, birth outcomes, and children 0-5 years old
- School age children and youth
- Community health
- Social health, disparities, and access
- Institutional relationships

Some of the objectives and related activities have been modified from the original plan due to new assessment information, program evaluation information, altered priority direction, and available funding. Considerable effort has been expended in all program categories with resultant progress toward objective attainment.

Plan Update Format

The Plan Update builds upon and revises the 2000-2003 CHS Program Plan. Statements regarding the status of objectives and methods are provided when applicable. When changes have been made to a previously existing objective or method, the old language is ~~struck out~~ and new language is underlined to illustrate the changes made. New material is also underlined.

COMMUNITY HEALTH SERVICES PROGRAM PLAN UPDATE: 2002-2003

FAMILY PLANNING, PRENATAL CARE, BIRTH OUTCOMES, AND CHILDREN 0-5 YEARS OLD

- I. Problem Statement(s)
 - A. Minneapolis compares less favorably to the state of Minnesota on major birth indicators such as teen pregnancy and births, births to unmarried women, and women who did not receive adequate prenatal care.
 - B. Infant mortality in Minneapolis is higher than the Year 2000 goal, especially for American Indian and African American women. This is due to complex factors including inadequate prenatal care, fragmentation of women's health care, not identifying pregnancy risk factors, and lack of provider cultural competence.
 - C. Preschool children are not being fully immunized against vaccine-preventable diseases.
 - D. Families are at risk for economic and emotional stress due to unintended pregnancy.

- II. Healthy Minnesotan 2004 Goals
 - A. (2) Improve birth outcomes and early childhood development.
 - B. (3) Reduce unintended pregnancy.
 - C. (9) Reduce infectious disease.

- III. Healthy Minnesotan 2004 Objectives
 - A. (2.1) Reduce to no more than 5.0 per 1000 live births the infant mortality rate.
 - B. (9.5) Ensure that at least 90 percent of infants in all geographic areas, racial and ethnic groups, and socio-economic strata will receive age-appropriate immunizations against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, Hib disease, and hepatitis B; and at least 60 percent receive immunizations for varicella within two months of the recommended age as measured by population-based surveys.
 - C. (3.1) Reduce the proportion of all pregnancies that are unintended.

- IV. Program Plan:
 - A. Child Health Assessment and Monitoring Project (CHAMP)
This is a major initiative for the MDHFS.
 1. Objectives
 - a. ~~By 2001, conduct a survey of the health of Minneapolis children aged 6-24 months, analyze data, and create recommendations for population health improvements. Preliminary findings will be produced by March, 2000. Subsequent findings/reports will be published during the balance of 2000 through 2002. Survey Completed in 2000.~~
 - b. ~~Depending on study findings, develop recommendations and action plans for improvements in children's health with public and private decisionmakers by 2001.~~

c. By January 2002, conduct community forums to relay CHAMP Survey findings and facilitate development of recommendations/action plans. Meet with Council members. Do educational sessions with community groups such as ECFE(Early Childhood Education)

2. Method

- a. ~~Conduct a survey of parents with children aged 6-24 months about their children's health, parent involvement, day care, assets of the parents and community, the child's learning environment, housing, income, and use of government and community services by early 2000. Survey Completed. Three databooks produced; initial findings Report, and initial recommendations completed in 2001.~~
- b. Meet with professionals and providers to incorporate recommendations.

V. Ongoing Activities

A. Immunizations: MDHFS will promote immunization of preschool children through:

1. ~~Participating in the development of~~ Continue support for the metropolitan-wide Immunization Registry which combines a contract with Hennepin County's registry (ImmulinK) and public and private providers in the seven county metro area for the purpose of tracking immunizations.
2. Cooperating with and providing funding to Neighborhood Health Care Network to promote immunizations.

B. Family Planning: Continue providing Maternal and Child Health Special Project funding to community clinics to address reproductive health, pregnancy testing, family planning, and counseling. ~~Continue working with MDH on a statewide work group to address family planning funding for the next two years.~~ Provide advocacy for sustaining state and other funding from family planning services.

C. Prenatal care and birth outcomes: Continue activities to implement Project LID (Lower Infant Deaths) recommendations for enhancing the survival of infants (See LID report). Continue providing Maternal and Child Health Special Project funding to community clinics for prenatal care. Seek additional grants to fund initiatives for prenatal care for underserved populations. Because populations in poverty are at increased risk for infant mortality, MDHFS will address this through our major initiative in attaining and sustaining self-sufficiency. Two major activities resulting from Project LID recommendations are the Twin Cities Healthy Start Project (TCHS) and a study to examine the organization of perinatal service systems in Hennepin and Ramsey Counties.

1. Healthy Start: MDHFS, in collaboration with St. Paul-Ramsey Department of Public Health and often community partners, was awarded funding through the Maternal and Child Health Bureau of the US Department of Health and Human Services to implement a Twin

Cities Healthy Start Project (TCHS) in 1999. This initiative focuses on enhancing community systems of maternal and infant care and works with communities to address medical, behavioral, social service, and cultural needs of women and infants. The goals of TCHS are to: 1) utilize a consortium of stakeholders in the community to discuss, plan, and provide activities and training that strengthen and empower perinatal health in the African American and Native American communities in Minneapolis and St. Paul; 2) assure that seamless and unduplicated services from multiple providers meet family needs in a respectful and culturally appropriate manner that promotes family strengths and self-care capabilities; 3) identify and enroll perinatal health care consumers in community health services; 4) provide respectful and culturally appropriate education that promotes healthy perinatal beliefs and self-care; and 5) provide holistic, respectful, and culturally appropriate community clinic service that can be replicated throughout the Minneapolis and St. Paul perinatal system. From January 2000 through December 2000, TCHS enrolled 409 women and 232 infants in project activities. Ninety-six percent (96%) of enrollees were persons of color and fifty-one percent (51%) were pregnant at the time of enrollment. A proposal has been submitted and funded at \$925,000 per year for four years to sustain this project through 2005.

2. Perinatal Service System Examination: In response to findings and recommendations of Project LID, the Minnesota Council of Health Plans' Community Health information on perinatal health care systems. To address this concern, MDHFS and the Minnesota Department of Health collaborated to conduct an investigation of perinatal care system functions in Hennepin and Ramsey Counties. The purpose of the investigation was to gather information regarding the capacity of the current perinatal care system to deliver comprehensive support services to pregnant women and to support the healthy development of infants. Throughout 2000, surveys were conducted among community health care centers, public health nurse agencies, hospitals, and managed health care organizations. The survey elicited information on mission, philosophy and scope of practice, community and system level activities, client level activities, and financial and capacity issues. A major finding of the investigation is that the current perinatal system lacks the system integration necessary to address the multiple needs of high risk families in the Twin Cities metro area. During 2002-2003, MDHFS will work with providers, reimbursement organizations, and other public and private agencies concerned with perinatal health care to address the service system gaps identified in the investigation. One initiative already in progress is funding a public health nurse through MVNA to provide outreach and liaison with Minneapolis community clinics, particularly those actively involved in the TCHS project. This will increase the opportunities for pregnant women to receive needed services both through the clinics and via home visits.

D. Ongoing research activities: MDHFS Research Unit will continue to collect, analyze, and report vital statistics and other information on the health of Minneapolis residents.

- E. Ongoing policy activities
 - 1. MDHFS will join with other stakeholders in advocating for expanding the Basic Sliding Fee Child Care program.
 - 2. Support increased availability of noncompetitive statewide funding to provide a continuum of community-based prevention and early intervention activities that promote healthy birth outcomes, optimal child health, and prevent maltreatment.

VI. Contracts, Grants, Administrative Agreements

- A. Metro Immunization Registry
- B. Hennepin County Community Health Department
- C. Children's Dental Services
- D. Way to Grow
- E. Neighborhood Health Care Network
- F. Headstart
- G. 348-TOTS through Hennepin County Community Health Department
- H. Greater Minneapolis Council of Churches, Division of Indian Work
- I. Greater Minneapolis Day Care Association
- J. Minnesota Visiting Nurses Agency
- K. Maternal and Child Health Special Program (MCHSP) competitive contracts in 2000-01 (new contracts to be awarded for 2002-03):
 - 1. Uptown Community Clinic
 - 2. Family Medical Center
 - 3. Southside Community Clinic
 - 4. Fremont Community Clinic
 - 5. Community University Health Care Clinic (CUHCC)
 - 6. Planned Parenthood
 - 7. Minnesota Indian Women's Resource Center
 - 8. Teen Age Medical Services
 - 9. Greater Minneapolis Council of Churches, Division of Indian Work
 - 10. Minneapolis Public Schools, Health Related Services
 - 11. Neighborhood Health Care Network
 - 12. Plymouth Christian Youth Center
 - 13. Southside Community Clinic
 - 14. Youth Coordinating Board, Way to Grow

VII. Community Resources

- A. Many of the organizations working on these health issues are represented in the list of contracts. Since MDHFS provides very little direct service, our links to these agencies is through funding. Also, we have worked together on joint projects, involved these agencies in any initiatives around birth outcomes and children's health, and provided consultation and training. Other agencies we work with in this content area are St. Paul/Ramsey County Public Health Department, Bloomington Health Department, and the Minnesota SIDS Center.

VIII. MDH Assistance

- A. Continue to receive MDH support and consultation for infant mortality projects, including funds for infant mortality policy and implementation activities.
- B. ~~Complete state led initiative to set policies and standards to minimize infant mortality.~~
- C. Leadership and funding from MDH for Metro Area and statewide immunization registries.

IX. MDHFS Program Contact: Janet Howard, (612) 673-3735

SCHOOL-AGE CHILDREN AND YOUTH

- I. Problem Statement(s)
 - A. Although national studies have found that teenage pregnancy rates declined 8% from 1991 to 1995, the Minneapolis teenage pregnancy rate has remained constant. Also, the percentage of births to women under 20 has remained constant at 14.5%.
 - B. Adolescents are at high risk for a constellation of health concerns including STDs, unintended pregnancy, accidents, alcohol and tobacco abuse, suicide, and homicide.
 - C. There are high rates of STDs in Minneapolis, particularly among women, adolescents, communities of color, and particular geographic communities. African American women are at greatest risk.
 - D. Asthma is a serious chronic condition, affecting significant numbers of school children, as well as Minneapolis adult residents.
 - E. School children's needs in such areas as immunizations, communicable diseases, chronic health problems, social and emotional health, and special health needs will not improve without innovative partnerships among the school system, public health agencies, and the private healthcare system.

- II. Healthy Minnesotan 2004 Goals
 - A. (3) Reduce unintended pregnancies.
 - B. (4) Promote health for all children, adolescents, and their families.
 - C. (9) Reduce infectious disease.

- III. Healthy Minnesotan 2004 Objectives
 - A. (1.1 & 1.3) Decrease the percentage of adolescents who smoke cigarettes and/or use spit tobacco.
 - B. (1.7) Reduce from 37 to 30 percent the proportion of high school seniors who have used alcohol at least once a month for the past 12 months. Reduce from 20 to 14 percent the proportion of ninth-grade students who have used alcohol at least once a month for the past 12 months.
 - C. (3.4) Reduce adolescent pregnancy rates as follows: from 27.5 pregnancies per 1000 women aged 15-17 (1996) to no more than 26.9 per 1000 women aged 15-17; and from 77.3 pregnancies per 1000 women aged 18-19 (1996) to no more than 76.7 per 1000 women aged 18-19.
 - D. (3.6) Increase from 44 to 50 percent the proportion of sexually active sixth graders who always use birth control. Increase from 59 to 64 percent the proportion of sexually active twelfth graders who always use birth control.
 - E. (4.14) Promote positive adolescent development through increasing (by 25 percent from 1995 levels) the percentage of high school students who talk to their parents about problems they are having; state positive feelings about school; state that they have received most of their information about sex from their parents, school, teachers or

counselors; state school personnel care about them; and state their parents care about them.

- F. (4.20) Increase the number of school-based and school-linked health clinics providing primary care and mental health services for adolescents.
- G. (12.13) Reduce asthma morbidity (as measured by a reduction in asthma hospitalization).
- H. (12.15) Begin collecting Minneapolis-specific (originally, Minnesota-specific) data on asthma incidence, prevalence, and severity.
- I. Reduce from 52 cases per 100,000 people to no more than 40 cases per 100,000 people the overall incidence of gonorrhea.
- J. (4.26) Reduce from 145 to no more than 100 cases per 100,000 people the overall prevalence of chlamydia infection.

III. Program Plan:

A. ~~School Health Data~~

~~This is a major initiative for MDHFS.~~

1. ~~Objectives~~

- a. ~~Cooperate with the Minneapolis Public Schools and other community stakeholders to determine the best way to develop a surveillance system for student health data by 2003.~~
- b. ~~As a first step, identify gaps and barriers to implementing the most effective system for developing a student health surveillance system by 2001.~~

2. ~~Methods~~

- a. ~~Assess the current data collection system maintained by the Minneapolis Public Schools Health Related Services program.~~
- b. ~~Assess the health and human service stakeholders' interest and capacity to collect school-age health data.~~

A. Asthma Management

This a major initiative for MDHFS.

1. Objectives

- a. ~~Assist the Minneapolis Public Schools in developing and implementing a comprehensive asthma management initiative by 2003 in cooperation with the American Lung Association and the Healthy Learners Board.~~
- b. Assist the Healthy Learners Board to develop policies for schools, medical providers, and communities for coordinated management of asthma.

2. Methods

- a. Cooperate with the School Health Data project in collecting and analyzing data on students with asthma.
- b. Establish a Systems Management Committee composed of representatives from the Minneapolis Public Schools, American Lung Association, Healthy Learners Board, medical providers, and community members to meet and set comprehensive asthma management policies. A

system Management Committee was established and a study related to asthma management in intervention and control schools was completed in 2000. Asthma management policies, including training for teachers and school health workers, will be implemented by 2003. Through our support of the Healthy Learners Board a youth organizer is being placed at North High School.

B. Social and Emotional Health

This is a major initiative for MDHFS.

1. Objectives

- a. Assist the Minneapolis Public Schools, in cooperation with the Healthy Learners Board, in developing and implementing a comprehensive initiative by 2003 to address the significant social and emotional health needs of students. Work with Youth Coordinating Board, Mpls. Public Schools, Konopka Institute, and Center for 4 H Youth Development to enhance capacity of community youth workers by developing training opportunities in youth development.
- b. Strengthen the capacity of the School Based Clinic Program to meet the current overwhelming social and emotional needs of students served by the program.

1. Methods

- a. Assess the current data collection system to determine capacity to collect data related to social and emotional needs.
- b. Increase social service staff in School Based Clinics from 2.5 FTE to 4.0 FTE social workers. Social Service Staff increased to 4.0 FTE.

c. Youth Risk Behavior

Youth Risk Behavior endowments appropriated by the 1999 Minnesota legislature enabled local public health agencies to establish initiatives that address a broad range of youth risk behaviors. The MDHFS analyzed available data, and elicited participation of internal staff, the Public Health Advisory Committee, and other community groups to determine use for these endowment funds.

1. Objective:

- a. Reduce sexual behavior that leads to pregnancy, HIV, and STIs among youth.

2. Methods:

- a. Support implementation of the Life Skills Training curriculum and related teacher training for all 6, 7, and 8th grade students in Minneapolis Public middle schools.
- b. Support existing efforts of community agencies that promote healthy sexual behaviors among Minneapolis youth.

c. Tobacco Use

Tobacco prevention endowments appropriated by the 1999 Minnesota legislature enabled the MDHFS, in partnership with Hennepin County Community Health Department, Northwest Hennepin Health and Human Services Council, and the Bloomington Division of Public Health to develop the Communities Targeted Tobacco project. Added 1.0 FTE to this project.

1. Objective:

a. Reduce tobacco use among youth ages 12 –17 years by 30 percent by the year 2005.

2. Methods:

a. Throughout 2001- 2002, contract with community organizations that serve youth to initiate activities that reduce youth exposure to second hand smoke, reduce youth access to tobacco products, promote comprehensive school-based tobacco prevention efforts, and provide linkages to cessation resources that focus on youth.

b. Throughout 2001-2002, provide oversight and resource support to the Communities Targeting Tobacco project in Minneapolis.

V. Ongoing Activities

- A. School-Based Clinics (SBC): MDHFS will ~~continue to~~ operate school-based clinics in five high schools and ~~four~~ one alternative site to provide sports physicals, immunizations, pregnancy and STD testing, and family planning exams/education/contraceptives. Staff will continue to assist students in getting medical homes outside SBCs. A large part of SBC work is dealing with social and emotional problems of students. Individual and group counseling and referrals are provided by clinic staff, which includes ~~2.5~~ 4.0 full time social workers. SBC staff continues to collect data for patient care and composite data for community and policy makers. Also, staff management continues to assess and develop sound ways to finance student health services. By the end of 2001, the Department will have initiated a billing system via contractual arrangements with HMO service providers. (UCARE Minnesota, MHP, and Medica and DHS) A business plan reflective of environmental changes is being developed and will include internal and external interviews.
- B. Youth access to alcohol and tobacco: Continue to work with the Minneapolis Police Department to institutionalize compliance checks on beverage alcohol retailers. Provide representation to the Hennepin County Community Prevention Coalition and the University of Minnesota Alcohol, Tobacco, and other Drugs Task Force to support and enhance their youth prevention efforts in Minneapolis. Federal grant funds provided through the Minnesota Department of Public Safety enabled MDHFS to enhance efforts to decrease youth access to alcohol by supporting (1) an increase in the number of alcohol compliance checks, (2) update of an alcohol retailer manual, (previously produced by MDHFS),and (3) training for Minneapolis peer

educators regarding links between alcohol use and risk behaviors among youth. Continue work with the City's Licensing Department on efforts to reduce youth access to tobacco.

- C. School-age immunizations: Continue to work with Metro Immunization Registry. Cooperate with Minneapolis Public Schools' "No Shots, No School" campaign, the ~~Welcome Center~~ The New Family Center, and the Metro Immunization Registry, general initiatives through Health Related Services to promote immunizations. Immunizations will be given through the School Based Clinics as appropriate. (The New Shots, No School campaign received statewide recognition from MDH and DCFL.
- D. Ongoing research activities: Continue to monitor teen pregnancy rates, STD rates, and other behavioral risk factors drawn from vital statistics in Minneapolis. Support the enhancement of the School Clinic data collection system. ~~As well as development of Minneapolis Public School's data collection system.~~ Report key findings to policy makers and program administrators.
- E. Ongoing policy activities
 - 1. Continue to support policy and legislative initiatives that enhance the health of adolescents in such areas as medical services, STDs, alcohol, tobacco, family planning, and teen parents.
 - 2. Work with stakeholders to ensure that minor consent continues for reproductive health care, chemical dependency counseling, and some mental health services.
 - 3. Participate in A Call To Action collaborative activities to address adolescent pregnancy and the prevalence of STDs among adolescents and young adults.

VI. Contracts, Grants, Administrative Agreements

- A. Minneapolis Public Schools
 - 1. Health Related Services: Maternal and Child Health Special Projects
 - 2. Welcome Center/New Family Center
 - 3. School-Based Clinic related contracts:
 - a. Plymouth Christian Youth Center
 - b. Teenage Medical Services
 - c. Jill Leverone, Psychologist
 - d. Pilot City Health Center
 - e. Hennepin County Nutrition Services/WIC
 - f. Incompass
 - g. Hennepin Faculty Associates
- B. Metropolitan Health Plan, UCare Minnesota, Medica
- C. Children's Dental Services
- D. Minneapolis Youth Diversion: Project Offstreets
- E. Youth Coordinating Board/ Phat Summer, City of Minneapolis
- F. Minneapolis Urban League/Curfew Truancy
- G. Youth Employment and Training/Job Readiness
 - 1. American Indian OIC
 - 2. Employment Action Center-Youth MFIP & Youth Hired

3. Loring-Nicollet-Bethlehem Community Center
4. Jump Start
5. Minneapolis Urban League
6. Pillsbury Neighborhood Services
7. Youth Trust

VI. Community Resources: Many of the organizations working on these health issues are represented in the list of contracts. MDHFS still provides direct services through the school based clinics, but many of our links to these agencies is through funding. Also, we have worked together on joint projects, involved these agencies in any initiatives around school age children and youth, and provided consultation and training. These agencies will be invited to work with MDHFS in developing the major new initiatives in this area.

VIII. MDH Assistance

~~A. Technical assistance from the Center for Health Statistics on surveillance data for school age populations.~~

B. There is a need for more comprehensive state-generated data on children's asthma and mental health problems, as well as general surveillance information on school aged children

IX. MDHFS Program Contact: Gretchen Musicant, (612) 673-3955

COMMUNITY HEALTH

- I. Problem Statement(s)
 - A. Homicide is the leading cause of death for Minneapolis youth and young adults between the ages of 15 and 24. A high proportion of those victims (aged 12-22) are victims of gun violence.
 - B. Minnesota data reflects an over-representation of certain populations in individual categories of violence, including rates of homicide for children under one, African American males aged 15-44, American Indian males aged 25-44, as well as the rates of maltreatment of children with disabilities and of African American children.
 - C. Family violence, composed of child maltreatment, as well as domestic and intimate partner violence, is by far the most prevalent form of violence in Minnesota.
 - D. There are high rates of STDs in Minneapolis, particularly among women, adolescents, communities of color, and particular geographic communities. African American women are at greatest risk.
 - E. There is a lack of a continuum of coordinated services to meet the needs of seniors to maintain an independent and healthy lifestyle.

- II. Healthy Minnesotan 2004 Goals
 - A. (6) Promote a violence-free society.
 - B. (9) Reduce infectious disease.
 - C. (10) Promote the well being of the elderly, those with disability, disease and /or chronic illness.
 - D. (11) Reduce exposure to environmental health hazards.

- III. Healthy Minnesotan 2004 Objectives
 - A. (6.3) Reduce by 15 percent child maltreatment in Minnesota.
 - B. (6.4) Reduce by 15 percent domestic and intimate partner violence in Minnesota.
 - C. (6.6) Reduce by 15 percent youth violence in Minnesota.
 - D. (9.17) Ensure that by the year 2004, at least 90 percent of newly arrived refugees in Minnesota receive a domestic refugee health assessment.
 - E. (10.1) Increase years of healthy life (as measured by quality-adjusted life years) by two years.
 - F. (10.2) Increase the number of communities that offer elderly persons a full continuum of care.

- IV. Program Plan:
 - A. Health and welfare of new arrivals

This is one of MDHFS' top three priorities.

 1. Objectives
 - a. Assess needs, and create recommendations and policies to guide development of effective programs at MDHFS and the City of Minneapolis to meet the needs of new arrivals. Completed survey of City Departments and preparation of report (Welcoming New Arrivals to

Minneapolis: Issues and Recommendations. Fully implement recommendations by 2002.

- b. ~~Determine changes needed for the City of Minneapolis to develop procedures that meet the needs of those with limited English-speaking abilities.~~
- c. ~~In cooperation with other stakeholders, develop~~ Promote the development of Minnesota standards for certification of medical language interpreters.

2. Methods

- a. Sponsor a collaborative with internal and external stakeholders to assess current activities and service gaps, as well as develop recommendations and policies.
- b. ~~Research current literature and key service providers on definitions of immigrants, differences in services based on definitions, existing regulations, current services, strategies, and resources.~~
- c. Collaborate Maintain collaboration with Minneapolis Public Schools, Hennepin County, and others with the ~~Welcome Center~~ The New Families Center to provide an early connection with limited English-speaking families to help them access services.
- d. ~~Work with Interpreter Standards Task Force to Provide advocacy for development of standards for medical interpretation certification.~~
- e. Develop and operate for at least one year a New Arrivals program within City government that will support internal improvements in service delivery for new arrivals and development of relationships in new arrival communities. Evaluate effectiveness.

B. Domestic Abuse

~~This is one of MDHFS' top three priorities.~~

1. Objectives

- a. ~~Develop consistent and effective policies and coordination among City Departments, as well as the County and other community organizations working with domestic abuse.~~
- b. ~~Assure a strong working relationship between the Police Department and MDHFS in working on domestic abuse issues.~~
- a. Throughout 2002-2003, continue coordination with other City Departments and community organizations to address issues related to domestic abuse in Minneapolis.
- b. Throughout 2002 – 2003 provide advocacy and support for adequate community resources to provide assessment and intervention services for individuals/families experiencing or at risk for experiencing domestic abuse.

2. Methods

- a. ~~Sponsor a collaborative with internal and external stakeholders to assess current activities and service gaps, as well as develop recommendations and policies.~~
- b. ~~Assess the cost and extent of domestic abuse, as well as the relationship between child maltreatment and domestic abuse.~~
- c. ~~Meet with Police Department to strengthen working relationship.~~
- a. Sustain coordination activities with the Minneapolis Police Department and City Attorney's office.
- b. Contract with the Domestic Abuse Project and Harriet Tubman Center to provide services to victims of domestic abuse, and support liaison services between MVNA and Harriet Tubman.

C. Seniors

This is a major initiative for MDHFS.

1. Program objectives

- a. ~~By 2001, establish a multi-jurisdictional Senior Coordinating Board comprised of elected officials from the City of Minneapolis, Hennepin County, and the State of Minnesota to advocate for visionary public policy and programs that help older adults maintain a high quality of life in Minneapolis.~~
- b. ~~Restructure the City of Minneapolis' Senior Advisory Council from its current configuration to a 23 member Committee with Minneapolis senior citizens from each of the 13 wards and ten representatives from organizations that provide services to older adults. This Senior Advisory Committee will act as a community resource and recommend policy issues for the Senior Coordinating Board to address.~~

Although considerable effort was expended in the year 2000 to create a multijurisdictional Senior Coordinating Board, the formation of a Senior Board was not approved by all involved jurisdictions.

- a. By 2002, MDHFS will establish a mechanism to facilitate communication between Minneapolis City Council members and senior citizen constituents.

2. Methods

- a. ~~Provide staff support for the development of the Senior Coordinating Board, including researching legal, political, and social issues. Determine need for legislative action to form the joint powers board and develop a budget and a formula for contributions by each of the participants.~~
- b. ~~Determine the ongoing role of MDHFS with the Senior Coordinating Board, particularly in regards to the activities of the Senior Citizen Ombudsman Program.~~

- ~~e. The Senior Advisory Committee will continue to enhance communication among service providers and inform older adults and their families about available services.~~
- a. Based on the needs identified through senior forums and a survey done in 2001, develop contracts for services targeting the most vulnerable and isolated seniors. The objectives of the contracts are to reduce social isolation and help seniors remain safely in their homes.
- b. Throughout 2002 –2003, MDHFS staff will coordinate efforts with the Senior Ombudsman Program to further delineate and address issues/concerns of Minneapolis seniors.
- c. Through 2002-2003, MDHFS will work with the business community and elected officials to establish a senior drop-in center at the Target Store scheduled to open in Oct, 2001.
- d. MDHFS is meeting with MCDA, NRP, Mpls. Public Housing, and Hennepin County to look at more options for senior housing.

D. Housing & Health Initiative

~~This is a major initiative of MDHFS.~~

- 1. Program objectives
 - a. ~~Develop~~ Explore initiatives that addresses the concrete relationship between housing and family health and well being.
 - b. After research, adopt policy initiatives that will inform and advocate for housing that promotes family health and well being.
- 2. Methods
 - a. Review and summarize existing studies and data sources that identify concrete linkages between housing and family health and well being, with particular attention to the issues of lead and asthma.
~~Include housing and health data in coordinating the Child Health Assessment and Monitoring Project (CHAMP).~~

E. Community Well-being

- a. Throughout 2002-2003, MDHFS will coordinate efforts of the Weed and Seed Program. Weed and Seed is a collaborative federal, state, and city initiative focused in three geographic areas in Minneapolis. Efforts of the initiative address community restoration, community policing, and provision of a safe haven for community residents.
- b. Throughout 2002-2003, MDHFS will participate in a Faith Based Project to address 2-4 selected issues/concerns identified among selected congregations in Minneapolis faith institutions. The selected issues/concerns will be identified from a survey conducted among faith leaders

and congregation participants in 2000-2001.
Development of action steps to address the
issues/concerns will be a collaborative effort among
MDHFS, faith leaders, congregation participants, and
community agencies with expertise in the areas identified.

~~E. Chemical Misuse Program~~

~~This is a major MDHFS initiative.~~

~~1. Objectives~~

- ~~a. Develop appropriate and effective public health response
to drug problems in the City of Minneapolis.~~
- ~~b. Bring group of internal and external stakeholders together
to study research findings and develop recommendations for
a citywide public health response to drug use issues. Task
completed.~~

~~2. Methods~~

- ~~a. Research existing sources of data such as the Substance
Abuse Monitoring System (SAMS), the Minnesota Student
Survey (MSS), and METP client data for current drug use
patterns in Minneapolis.~~
- ~~c. Create a methamphetamine users survey, administer survey, and analyze
data. Survey completed in 2000. Trainings were completed on
methamphetamine in 1999-2000 for Mpls. health teachers and other staff,
Mpls. alternative school staff, and Hennepin County community prevention
forum and distributed 50 Hazelden videos on methamphetamine.~~

VI. Ongoing Programs

- A. Housing Services: This program provides information to landlords and tenants in the City of Minneapolis about rental rights and housing issues. Housing advocates counsel clients on residential rental issues, provide education on rental rights, act as an information and referral service on housing issues, and help tenants and landlords prepare for housing and conciliation court.
- B. Survey of the Health of Adults, the Population, and the Environment (SHAPE): MDHFS will continue to analyze data, write and disseminate reports on health behavior of Minneapolis residents to community stakeholders, policy-makers, health program planners, and the public. ~~MDHFS will be consulting with community stakeholders on the feasibility of conducting a second SHAPE survey and comparing those results with the original SHAPE findings.~~ By 2002, complete SHAPE II in collaboration with Hennepin County.
- C. The "Stay Alive" program was developed in 1998 after Minneapolis-based research highlighted the need for youth violence prevention. Research identified that 60 percent of arrestees and suspects were 14-24 years of age. The Stay Alive program developed league basketball for 17-25 year-old African American and American Indian males during the summer months in three high-risk neighborhoods of Minneapolis. The program is coordinated by MDHFS, Ghetto Basketball League (GBL), Harriet Tubman Center, and Twin Cities Healthy Nations. The

program will continue to offer organized basketball and community cookouts, as well as education about jobs, training, life enhancement skills, rites of manhood, and cultural history. Explore transition of program to community based partner.

- D. Senior Ombudsman Services will continue to provide consultation, information and assistance to City senior citizens. The program provides information, tax assistance, home visits, and a written guide to senior services.
- E. The American Indian Advocacy program will continue to create and maintain an open channel of communication between the Minneapolis American Indian community and the City of Minneapolis. The goal is to make City services more relevant and accessible, and to increase understanding by City officials and staff of issues in the Indian community. Also, the program will continue to serve as a liaison between the Indian community and City Hall by answering questions, resolving problems, and directing American Indians to the appropriate City department for assistance.
- F. Environmental health: Although the Environmental Health program is not organizationally part of MDHFS, staff continue to cooperate on health issues. The Environmental Health Division of the City's Regulatory Services, protects the public from foodborne illness by enforcing Minneapolis, state, and federal laws through inspections, licensing, investigations, education, and certification of food workers. The Division began using the Hazard Analysis Critical Control Points inspections in 1997. The Lead Abatement Program ~~continues to identify contaminated housing and affected children, and remedy the situation through referrals and abatement activities.~~ has developed a plan to eradicate lead poisoning by 2010 through a four element process: (1) increase screening for children under six years; (2) decrease household lead; (3) train contractors involved in lead abatement procedures; and (4) conduct housing tests. Next steps to achieve this plan will be identification of funding sources. Throughout 2001-2002, MDHFS and Environmental Health will collaborate to utilize improved methods for ongoing evaluation of the quality of city beaches and lakes.
- G. Ongoing policy activity: Oppose legislation that would increase the availability and prevalence of handguns in Minneapolis.

VII. Contracts

- A. Neighborhood Health Care Network (ImmulinK and 489-CARE line)
- B. Minnesota Aids Project
- C. Minneapolis Youth Diversion Project
- D. Hennepin County Community Health Department: Disease Prevention and Control and ImmulinK
- E. Cindy Kallstrom, Health Education Consultant
- F. Minnesota Visiting Nurses Agency
- G. Domestic Abuse Project
- H. Harriet Tubman Center

- I. Volunteers of America, previously Minneapolis Age and Opportunity Center
- J. Legal Aid Society
- K. Southeast Seniors: A Living at Home Block Nurse Program
- L. Longfellow/Seward Healthy Seniors
- M. Nokomis Healthy Seniors

VIII. Community Contacts

Many of the organizations working on these health issues are represented in the list of contracts. MDHFS does not provide direct services in this area, so many of our links to these agencies are through funding. Also, we have worked together on joint projects, involved these agencies in any initiatives around community health, and provided consultation and training. These agencies will be invited to participate in developing our major new initiatives in community. Hopefully, many of them will participate in developing these programs.

IX. MDH assistance

- A. Conduct and/or research outcome-based studies on violence prevention.
- ~~B. Provide data on quality-adjusted life years by county and major cities such as Minneapolis.~~
- C. Continued research on effective legal tools for changing drug, ~~and~~ alcohol, and tobacco and other use norms, i.e. compliance checks.

X. MDHFS Contact: Patty Bowler, (612) 673-3009

SOCIAL HEALTH, DISPARITIES, AND ACCESS TO SERVICES

- I. Problem Statement(s)
 - A. Over 20% of Minneapolis residents are without medical insurance sometime during the year.
 - B. Health disparities exist in the African American community in such areas as homicide, infant mortality, adequate prenatal care, STDs, and cancer deaths.
 - C. Health disparities exist in the American Indian community in areas such as homicide, infant mortality, adequate prenatal care, STDs, and cancer deaths.
 - D. Populations of color are less likely than whites to have private or public insurance.
 - E. Lower income residents tend to have worse physical and mental health than higher income adult residents do.
 - F. Poverty among children in Minneapolis increases their risk for developmental delays, physical and mental health problems, and intentional and unintentional injury.

- II. Healthy Minnesotan 2004 Goals
 - A. (15) Assure access to and improve the quality of health services
 - B. (17) Eliminate the disparities in health outcomes and the health profile of populations of color.
 - C. (18) Foster the understanding and promotion of social conditions that support health.

- III. Healthy Minnesotan 2004 Objectives
 - A. (15.1) Achieve 100 % health care coverage, including preventive services, for all Minnesotans.
 - B. (15.4) Increase to 100% the percentage of Minnesota's population that has a regular source of care.
 - C. (15.5) Increase the cultural competency of all health care professionals within the health care delivery system to ensure that culturally appropriate, quality care is available to all Minnesotans.
 - D. (15.6) Decrease the number of Minnesotans who forgo needed health care services because of transportation or distance problems.
 - E. (15.7) Develop mechanisms and systems to aid consumers' understanding and practical ability to utilize health care delivery systems appropriately within Minnesota.
 - F. (17.25) Strengthen the capacity of the health care system to improve the health status of populations of color.
 - G. (18.1) Review and summarize existing studies and data sources that identify concrete linkages between social conditions and health.
 - H. (18.4) Discuss the impact of social conditions that contribute to poor health in terms of their organization's sphere of influence.
 - I. (18.5) Collaborate with community efforts to improve social conditions that affect health.

IV. Program Plan:

A. Individual and family stability and self-sufficiency

This is one of three top priority initiatives for MDHFS.

1. Objectives

- a. Develop and implement policies and programs that increase and maintain individual and family stability and self-sufficiency in the City of Minneapolis.
- b. Integrate MDHFS activities in the areas of public health, employment and training, and human services to move toward more coordinated services and referrals among health, employment, and other agencies.
- c. Working with welfare and employment services, monitor what happens to health and social status after welfare recipients reach their limit of benefits.

2. Methods

- a. Research specific conditions and services that promote individual and family stability and self-sufficiency, including private conditions and resources, as well as public programs and policies.
- b. Produce a report using SHAPE data examining health status and individual and community income levels.
- c. Throughout 2002-2003, participate with Hennepin County Community Health Department and Minnesota Visiting Nurse Agency with implementation of the TANF Public Health Nurse Home Visiting Initiative. Goals of this initiative are to improve the health and well being of children and families and to promote family self-sufficiency. In Hennepin County two target populations for the initiative are pregnant and/or parenting adolescents and MFIP recipients who are not making progress toward self-sufficiency. MDHFS staff serve in a advisory capacity with the initiative and will collaborate with Hennepin County Community Health Department to provide initiative services for pregnant and/or parenting adolescents who attend schools served by the MDHFS School Based Clinic Program.
- d. The Alliance for Families and Children Public Health Task Force is contracting with MDHFS to act as fiscal agent for a home visiting project for pregnant and parenting teens in the Latino community who are not covered by TANF home visiting Funds.

C. Health care access and system delivery

1. Objective

- a. MDHFS will continue to support the New Families Center, A cooperative venture between MDHFS, Mpls. Public Schools, and the Children's Defense Fund. The New Families Center, housed at Four Winds School, reaches

out to students and their Families for whom there are language and cultural barriers.

One of MDHFS' major initiatives.

1. ~~Objectives~~

- a. ~~By 2002 finish a health access needs assessment, develop and implement a health care access strategy, and evaluate activities. Analyze populations experiencing difficulty with health care access, as well as system difficulties in providing access.~~
- b. ~~Develop a Health Care Access Community Collaborative to develop and implement a health care access strategic plan.~~
- c. ~~Depending upon assessment's findings and recommendations, advocate for improvements in policy and programmatic activities that will improve health care access.~~

2. ~~Methods~~

- a. When students register for school at the New Families Center, Language and health assessments are given, immunizations when needed, and social workers and outreach workers counsel families on how to access health insurance and medical care.
- a. ~~A full-time CDC Prevention Specialist assigned to MDHFS for two years will provide leadership for the project.~~
- b. ~~Prevention Specialist will organize and staff a Health Care Access Community Collaborative to help accomplish the needs assessment, as well as develop a policy and programmatic project plan based on the findings of the assessment. Representation will be from such groups as the Minneapolis Public Schools, Hennepin County, MDH, MDHS, the Neighborhood Health Care Network, the Minnesota Legislature, and other community health agencies.~~
- c. ~~Prevention Specialist and Collaborative will write an implementation plan that defines actions steps and organizational responsibilities for members of the collaborative and other community stakeholders.~~
- d. ~~Though final content of the plan would depend upon assessment's findings and recommendations of the Collaborative, the plan could include such activities as:
 - 1) ~~Incorporating collaborative recommendations into the programmatic functions of various stakeholders,~~
 - 2) ~~Designing and conducting public information campaigns targeting consumers,~~
 - 3) ~~Advocating for improving health care access through presentations of the assessment's findings and recommendations to various groups, such as the Minneapolis City Council, Minnesota Council of Health~~~~

- Plans, State Departments of Health and Human Service, and private health systems and insurers,
- 4) ~~Identifying and supporting legislative proposals that further the Collaborative's recommendations.~~
 - e. ~~The Commissioner of Health and Family Support will chair a statewide committee on uncompensated care. Statewide committee convened and report issued.~~
 - f. ~~Collaborate with Children's Defense Fund to pilot access activities at the Minneapolis Public School's Welcome Center.~~

Although the specific objectives and methods delineated to improve health care access were not implemented, MDHFS staff expended considerable energy with committees and community efforts to improve access to appropriate health care for Minneapolis residents. Throughout 2002-2003, MDHFS will focus on health care access and service delivery through the TANF Home Visiting initiative, Healthy Start, new arrival programming, the Senior Ombudsman Program, contractual arrangements with community agencies, and the Faith Based Project. In addition, Department staff will continue to serve in an advisory/consultative capacity with community groups addressing issues related to access and utilization of appropriate health services including advocacy for implementation of recommendations resulting from the minority Health Assessment Project.

Throughout 2000-01, MDHFS provided direction for Minority Health Assessment Project. This project was a collaborative effort among the nine Community Health Service agencies in the seven county metro area to conduct a health assessment and develop recommendations for improving the health of populations of color in the metro area. Recommendations arising from this assessment involve actions related to: (1) addressing health disparities; (2) working outside of traditional public health roles to address the social and economic determinants of health; (3) increasing the participation and leadership of people of color in health professions; (4) educating community leaders and the public regarding the benefits of reducing health disparities; (5) increasing the quality and availability of spoken-language interpreter services in health and social service settings; (6) combating discrimination; and (7) improving racial/ethnic information in health data.

V. Ongoing Activities

A. Minneapolis Employment and Training Program (METP)

1. The goal of METP is to assist disadvantaged and dislocated adults and youths in preparing to enter private sector employment. METP will continue to manage state, federal, and locally funded employment and training services via contracts with private and nonprofit organizations, as well as provide direct

services. METP will continue to work with programs for youth, dislocated workers, Minnesota Family Investment Program clients, older employees, and disadvantaged adults. Services provided include job readiness assessment, training, counseling, placement, and work-based learning. METP has a rigorous evaluation system that measures job placement success, job retention, as well as compliance and success of contract agencies.

- B. Ongoing research activities
 - 1. METP does surveillance of the labor market situation and trends in the Metro Area.
- C. Ongoing policy activities
 - 1. At the Legislature, advocate for continuance and strong funding for MNCare, as well as simplification of the program (especially the program forms).
 - 2. Monitor PMAP enrollees in Minneapolis to ensure they are getting medical and support services they need.
 - 3. Advocate for a strong safety net for uninsured and underinsured residents in Minneapolis, including the continued financial viability of the community clinics.

VI. Contracts, Grants, and Administrative Agreements

- A. Employment and Training:
 - 1. Catholic Charities
 - 2. Center for Asians & Pacific Islanders
 - 3. Church of St. Stephens
 - 4. Eastside Neighborhood Services
 - 5. Exodus Community Development Corporation
 - 6. Employment Action Center
 - 7. CLUES
 - 8. Hennepin County WERC
 - 9. Freeport West
 - 10. HIRED
 - 11. Powderhorn/Phillips Wellness Center
 - 12. Hmong American Partnership
 - 13. Indian Chamber of Commerce
 - 14. Jewish Vocational Services
 - 15. Pillsbury United Communities
 - 16. Goodwill/Easter Seals
 - 17. Phillips Job Bank
 - 18. Greater Minneapolis Council of Churches
 - 19. Person to Person
 - 20. Minneapolis Urban League
 - 21. Minnesota Department of Economic Security
 - 22. University of Minnesota Extension
 - 23. Lao Family Community
 - 24. Urban Hope Ministries
 - 25. Project For Pride in Living
 - 26. American Indian OIC

27. Southeast Asian Refugee Community Home
 28. Anishinabe Council of Job Developers
 29. LifeTrack Resources
 30. Phillips Community Development Corporation
 31. Resident Management Corporation.
 32. Lutheran Social Services
 33. Rise, Inc.
 34. Youth Trust
 35. Summit Academy OIC
 36. Twin Cities Rise
 37. Women Venture
 38. Hmong American Mutual Assistance Association
 39. Loring- Nicollet- Bethlehem Community Center
- B. Access to Health Services contracts
1. Neighborhood Health Care Network and individual clinics
 2. Children's Dental Services
 3. Minnesota Visiting Nurses Agency

VII. Community Resources

- A. Many of the organizations working on these health issues are represented in the list of contracts. MDHFS does not provide direct service in this area, so many of our links to these agencies are through funding. Also, we have worked together on joint projects, involved these agencies in community health initiatives, and provided consultation and training. These agencies will be invited to participate in developing our major new initiatives in health access. Hopefully, many of them will participate in developing these programs.
- B. Additional agencies we will work with include:
1. Hennepin County Community Health Department
 2. Hennepin County Economic Assistance
 3. Minneapolis Public Schools
 4. Minnesota Department of Health
 5. Minnesota Department of Human Services
 6. Minnesota health plans
 7. Minnesota State Legislature
 8. Neighborhood Health Care Network
 9. St. Mary's Clinics
 10. Children's Defense Fund

VIII. MDH Assistance

- A. Active participation on our health care access collaborative.
- B. Minnesota Department of Health, Department of Human Services (DHS), and community partners research and monitor relationship between health and welfare status, particularly finding out what happens when recipients finish eligibility for welfare benefits.
- C. In cooperation with DHS, evaluate Medical Assistance financing and reimbursement levels, as well as simplification of Minnesota Care application forms.

IX. MDHFS Program Contact: Becky McIntosh, (612) 673-2884

INSTITUTIONAL WORKING RELATIONSHIPS

- I. Problem Statement(s)
 - A. Develop more effective ongoing work relationships with community stakeholders when developing, implementing, monitoring, and evaluating public health initiatives and programs.

- II. Healthy Minnesotan 2004 Goal
 - A. (16) Ensure an effective local and state government public health system.

- III. Healthy Minnesotan 2004 Objectives
 - A. (16.6) MDH and MDHFS, in partnership with health care research institutions, higher education institutions, and others, will identify priority public health surveillance, information, research, and evaluation needs, and will develop plans to address them.
 - B. (16.9) MDH and MDHFS information systems will provide a means to collect information about indicators to assess their performance of essential public health services.
 - C. (16.14) MDH and MDHFS will have, or participate in the development of, a response plan for disease outbreaks and natural and human-made disasters

- IV. Program Plan:
 - A. Public Health Initiatives
An MDHFS major initiative.
 1. Objective
 - a. Significantly increase the capacity of MDHFS to undertake priority public health initiatives outlined in this plan, and to respond to emerging public health needs in a timely manner in coordination with key stakeholders
 2. Method
 - a. ~~By early 2000, have staff in place with primary responsibilities for leading initiatives.~~ Completed.

 - B. Contract Administration
An MDHFS major initiative.
 1. Objectives
 - a. ~~Create~~ Maintain an integrated, comprehensive contract system focused on outcomes and performance measures in 2002-2003.
 - b. Ensure all contracts between MDHFS and service contractors are developed in accordance with relevant Laws and regulations, and in compliance with multiple funding sources.

- c. Ensure contracts are processed in a timely manner so that 90% are fully executed prior to contract start date in 2002 and 2003.
 - d. Ensure administrative expenses are less than 10% of available contract funds.
2. Methods
- a. Develop and implement a performance management effectiveness system. Completed with on-going activities.
 - b. ~~Develop~~ Continue development of improved performance measures, particularly for the largest contracts, in collaboration with Hennepin County.
 - c. An annual contract monitoring site visit will be made for at least 30% of health contracts.
 - d. Contract managers will conduct quarterly compliance reviews using upgraded monitoring tools.
 - e. By early 2002, evaluate the effectiveness of the largest contracts, and make any recommendations for changes in allocations to the City Council.
 - f. Throughout 2002-2003, identify strategies to increase the availability and diversity of public health workers.

V. Ongoing Programs

- A. Public Health Laboratory: MDHFS Public Health Laboratory provides clinical, environmental, and drug testing for City departments, Hennepin County, State agencies, the public, and law enforcement agencies throughout the Metropolitan Area.
- B. Ongoing policy activities: Research and advocate for more secure funding for community-based health services such as community clinics and school based clinics. Continue to collaborate with other community stakeholders in the private and public sector to develop more effective programs, funding, and policy initiatives to address the health care needs of the citizens of Minneapolis.
- C. Participate in on-going discussions with other public and private health entities to plan and execute emergency procedures for disease outbreaks, as well as other natural and human-made disasters. In 2001 the department completed a review of Roles and Responsibilities for Public Health Emergencies in the City of Minneapolis, which is also included in the public health annex of the Minneapolis Emergency Operations Plan; to be reviewed annually. Based on the bioterrorism plan developed as part of the Metropolitan Medical Response System planning process, work with Hennepin County and others in 2002 on the development of a bioterrorism plan for Minneapolis/Hennepin County. On an on-going basis, work with Hennepin County as appropriate in addressing infectious disease concerns in Minneapolis, interventions as needed, and in annual review and update of emergency preparedness plans.

- VII. Contracts, Grants, and Administrative Agreements
 - A. Hennepin County Medical Center (for medical direction as needed)
 - B. Mary Hourigan, Consultant
 - C. Minnesota Department of Health (for lab consultation)
 - D. Parenteau Graves Communications, marketing and public relations consultants

- VIII. Community Resources

First, in creating a better system to monitor and evaluate contracts, all 150 entities we have contracts with are potential resources. The groups have been listed throughout the CHS plan under the appropriate program areas. The second major group of resources are all the other local, county, state, and federal entities we work with in carrying out our public health responsibilities. Finally, as we carry out new and emerging public health initiatives, we have multiple relationships with community stakeholders. Many of these are contractees and others are other groups mentioned throughout the Plan.

- IX. MDH Assistance
 - A. Simplify the grant funding processes for local health departments, and provide additional funds for public health initiatives.
 - B. Increased input by local health departments into MDH decisions and planning.

- X. MDHFS Program Contact: Becky McIntosh, (612) 673-2884

VII. Evaluation of CHS Plan Update 2002 – 2003

Evaluation of both process and outcomes of a project are critical, yet difficult. Process evaluation can help determine program resources needed to carry out a program, while outcome evaluation helps us know which interventions really work. The Minneapolis Department of Health and Family Support is vitally interested in doing both process and outcome evaluations for our programs and initiatives.

Many MDHFS programs are provided through contracts granted to community organizations to carry out program goals and objectives. In fact, MDHFS has over 400 contracts with more than 75 agencies in contrast to two direct service programs, the School-Based Clinics and the Public Health Laboratory. Contracted programs present different evaluation challenges than direct service programs. When program objectives are carried out by another agency, gathering process information and outcome data can be difficult.

Contract management evaluation

One of the major initiatives described in the section of the plan, "Institutional Relationships," discussed MDHFS' development of a contract management system based on outcomes and performance measures. MDHFS will continue to expand its capacity to gather better process data, as well as outcome data. Based on those program objectives, MDHFS will evaluate:

1. Maintain and continue to enhance an integrated and comprehensive contract system focused on outcomes and performance measures during 2002-03.
2. Continued efforts on enhanced performance measures for the largest contracts for contract years 2002-03.
3. Processing of contracts in a timely manner, so that 90% are fully executed prior to contract start date in 2002-03.
4. Conducting monitoring site visits for at least 30% of contracts annually.
5. Conducting quarterly compliance reviews by contract managers using upgraded monitoring tools.

Other evaluations

MDHFS will be evaluating activities and outcomes for other priority areas such as health disparities (including the Healthy Start project), New Arrivals, youth tobacco prevention, youth risk behavior

Other programs will continue to collect process information, and where appropriate, carry out more extensive evaluations alone or with community partners.