Recommendations from the Blue Ribbon Panel on Public Health in Minneapolis

Prepared By Halleland Health Consulting
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About the Blue Ribbon Panel on Public Health in Minneapolis

Elected officials in the City of Minneapolis and Hennepin County, faced with tough choices about allocation of resources, raised the question of whether it is good public policy to maintain two different public health departments serving Minneapolis. *Would the merger of Minneapolis' Department of Health and Family Support and Hennepin County's Community Health Department result in greater efficiency and better service to Minneapolis residents?* To help answer this question, the Hennepin County Board of Commissioners and the Minneapolis City Council adopted resolutions to establish the Blue Ribbon Panel on Public Health in Minneapolis in the summer of 2003 (see Appendix A). The City's resolution prescribed a membership comprised of city residents, and health, human services and community leaders, reflecting the ethnic and cultural diversity of Minneapolis. Their charge was to make recommendations regarding structure, accountability, funding and governance of the health systems of Minneapolis.

Members of the Blue Ribbon Panel

Mary Ann Blade
Chief Executive Officer
Minnesota Visiting Nurse Agency

Doug Davis
Senior Citizen Community Activist from Northeast Minneapolis

Sharon Day
Executive Director
Indigenous Peoples Task Force

Sharon Henry-Blythe
Executive Director
Greater Minneapolis Daycare Association & Chair of the Minneapolis Public School Board of Education

Kinshasha Kambui
Community Aide to Mayor R.T. Rybak
City of Minneapolis

Jim Koppel
Executive Director
Children's Defense Fund of Minnesota

Jan Malcolm
Program Officer
Robert Wood Johnson Foundation and
Former Commissioner of the Minnesota Department of Health

Christopher Reif
Family Physician
Hennepin County Medical Center Family Practice & Chair of the Hennepin County Community Health Advisory Committee

Stella Sola
Bilingual-Bicultural Nutritionist & Doula Lactation Counselor
Family Center Community Doula Program

Edward Ehlinger
Director and Chief Health Officer
University of Minnesota
Boynton Health Services

Cha Lee
Executive Director
Southeast Asian Community Council

Marnie Wells
Chief Program Officer
Camp Fire USA Minnesota Council & Co-Chair of the Minneapolis Public Health Advisory Committee

Huda Farah
Molecular Biologist
Public Health Indicator Alliance for Early Childhood Professional

Tony Looking Elk
President
Urban Coalition & Co-Chair of Metropolitan Urban Indian Directors

John Williams
Dentist
Board Member, Children's Dental Services & Chair of the North Minneapolis Health Advisory Committee

The Panel was convened and co-chaired by Minneapolis Council Member Natalie Johnson Lee and Hennepin County Commissioner Gail Dorfman. Michael Scandrett and Deanna Mills of Halleland Health Consulting were retained to facilitate the Panel's deliberations and prepare its report.

The Panel members met five times in the fall of 2003. First, they began by reviewing background information about public health models and surveyed what national and international experts considered to be the "best practices" in urban public health. Second, they developed a set of principles to guide them as they discussed public health policy for Minneapolis (see Appendix B). Then, the members looked at the research and data on the public health needs of Minneapolis residents. Finally, they examined the two public health departments -- their resources, competencies and current activities – and tackled the core question of whether the current two-department structure is the best one. Their recommendations make up the body of this report, and a summary of the Panel's deliberations and other written materials appear in the Appendices.

City and County public health department staff provided administrative support, technical expertise and information about the City and County departments as requested by panel members. A special thanks is extended to Ken Dahl, Gretchen Musicant, Ellie Ulrich Zuehlke, and Shada Buyobe Hammond of the City of Minneapolis Department of Health and Family Support, and Todd Monson and Diane Loeffler of the Hennepin County Community Health Department. This report contains the recommendations of the Panel, which do not necessarily reflect the views of City and County public health department staff or elected officials who co-chaired this panel.

EXECUTIVE SUMMARY

We appreciate our elected officials' concerns about assuring effective and efficient public health in Minneapolis in the face of current fiscal constraints. We, too, are concerned that the cutbacks in public money will be deeply felt in the community and will further widen the disparities that exist in health status and access to health care.

From our perspective, this presents an urgent call to action for our community to work more strategically on a shared urban health agenda. Promoting health in an urban area is a dynamic process that requires full community involvement. Despite the recent successes in reducing the infant mortality rate, increasing immunizations, decreasing teen pregnancies and early sexual activity, to name a few, the data also reveals that Minneapolis' public health needs are actually increasing! In summarizing the views of her fellow panel members, Jan Malcolm, Program Officer at the Robert Wood Johnson Foundation and former Commissioner of the Minnesota Department of Health stated,

> At the end of the day, we need more focus on public health and more output from the public health systems, not less. The recommendations ought to be how best to produce more of the most important public health interventions given limited resources.

Today, the data we reviewed shows that the key public health issues facing Minneapolis residents include:

Growing at-risk populations who experience health disparities. With a substantive increase of immigrants and refugees, one in three Minneapolis residents represent an ethnic or racial group other than Caucasian. These groups of people experience worse health than their white counterparts on several measures. Subsequently, there is a disproportionate burden of health problems for Minneapolis residents.

Concentrated areas of pervasive and persistent poverty. One in six Minneapolis residents lives in poverty. Poverty is one of the greatest risk factors for poor health.

Student performance lagging behind the statewide average. The graduation rate of the Minneapolis Public Schools is 43 percent, just a little over half the rate statewide of 78 percent. Well documented research has shown that the more educated person tends to be healthier.

Risk of bioterrorism and emerging infectious diseases in densely populated areas. There is a critical need for overall community planning and preparations for emergencies, as became evident following the September 11 terrorist attacks.

Growing risk of outbreaks of infectious diseases and their effect on vulnerable populations. Seemingly "resolved" health issues such as tuberculosis have come back

to life with new arrivals to Minneapolis; 15 percent of Minneapolis residents are foreign-born. Preparations to control highly infectious diseases is critical.

Growing number of uninsured people. One in nine residents lacks health insurance; double that of the state rate.

Given what is now known about the overwhelming impact of social, environment and economic determinants on health status, these and many other factors affecting health and well being are interconnected and can vary significantly among Minneapolis neighborhoods and groups of city residents.

We believe the elected officials and staffs of the two public health departments are in key positions of leadership to call the community into organized action to tackle the most pressing public health issues in Minneapolis.

RECOMMENDATIONS FROM THE BLUE RIBBON PANEL ON PUBLIC HEALTH IN MINNEAPOLIS

To fulfill our charge, we carefully examined the key question raised by elected officials of whether it is good public policy to maintain two different public health departments serving Minneapolis. We ultimately concluded that merger is *not* in the best interest of Minneapolis residents at this time, but we believe significant improvements *can* be made in the way the two departments work with each other and community partners.

Fundamental concepts. The following fundamental concepts that formed our recommendations are:

- **This is a time of major change.** Today's challenging financial picture forces elected officials to make difficult choices with reduced public funds. Business as usual is not an option. New and forward-thinking approaches are called for leading to overall, systemic changes in both public health agencies and but how they work with community partners. We concluded it will take not only efficiency, but innovation to meet the City's growing public health needs with dwindling budgets.

- **Public health is a core business function of government.** Government has a responsibility to protect citizens from injury, illness and disease, and to support health improvement. It is not a discretionary activity that can be dispensed with when money is tight. The mission of public health is *"to fulfill society's interest in assuring conditions in which people can be healthy."* The importance of this societal interest cannot be overstated. Unhealthy children cannot learn. Unhealthy workers cannot contribute to a thriving economy. Sick and injured residents require more medical attention at a higher cost to the community and government. Unhealthy social conditions are a drag on the economic vitality and quality of life of Minneapolis. They also drive up costs in other areas of government spending such

as public education and criminal justice. A major cause of the current government budget crisis is rapidly rising health care costs. We are paying the price today for failing to devote enough attention in the past to assuring better health by addressing the conditions in our communities that result in illness and injury. Public health is a solution to fiscal woes rather than a drain on the public coffers.

- **Public health's central goal is to improve the health of populations.** The central goal of public health is to identify the particular *conditions* that cause illness and injury in the City, and work to change these conditions so the *entire population* is healthier. It is important to distinguish the public health role from the role of the medical care system, which treats *individual cases* of illness and injury. Public health activities prevent epidemics and injuries, protect against environmental hazards, promote healthy behaviors, and assure that residents have access to health care, and when necessary provide medical care where no services exist or where specialized treatment is needed. It is tempting to view public health as something that can be turned over to the private health care market and the not-for-profit and voluntary sectors, but there is no substitute for a robust public health system with the authority and capacity to protect and promote the health of Minneapolis residents.

Expected Outcomes. The following outcomes can be expected from our recommendations:

- **A unified voice for urban health** from elected officials and public health leaders in Minneapolis and Hennepin County.

- **A web of community partnerships** promoting accountability for and ownership of a shared urban health agenda.

- **Targeted, strategic investments** to improve the health of Minneapolis residents most in need.

- **Improved communication and operations** to support more effective and sustainable outcomes of core public health activities.

We encourage adoption of the following recommendations in order to continue to protect and promote the health of Minneapolis residents.

Recommendation #1 . . . *The City and County Public Health Departments Should Not Be Merged.*

We believe the merger of the two departments will leave Minneapolis with a diminished capacity to serve our public health needs. Each department has a distinct set of skills, relationships and tools that are valuable to the community; their respective strategies complement rather than compete with or duplicate the other. These departments would not be able to continue their key strategic directions without each continuing to do what it does. Merger would also result in less money for public health in Minneapolis. The City has the ability to leverage additional funding from other sources to increase the impact of each local dollar. For each dollar that the City puts up, an additional $2.61 is leveraged for Minneapolis residents. Finally, we found that the City public health department is of value to other city departments and to elected officials because the City department maintains close ties to community groups, communities of color, new immigrant populations and many others.

Recommendation #2 . . . *Establish Accountability for a Shared Urban Health Agenda.*

The City and County, together, need to establish a clear and focused public health agenda that is based on the unique health needs of an urban community. Priorities that are shared by the two departments should be addressed through a common community agenda. The common agenda should then be pursued with a coordinated strategy that takes advantage of the diverse skills, relationships and voices of the City and County as well as community partners. Our immediate interest is in seeing Minneapolis and Hennepin County, develop a shared agenda, but this issue does not stop at the river. At some future point, this urban health agenda should be expanded to St. Paul/Ramsey as well. It is also worth considering advocating for the creation of a Minnesota urban health advisory committee to the Minnesota Department of Health.

Look beyond traditional public health. The health of our urban community is strongly influenced by conditions that require interventions in areas not usually thought of as public health. For example, the childhood obesity epidemic cannot be contained if urban children do not have safe places to exercise, their families cannot easily buy healthy food in their neighborhood, and a shortage of affordable housing makes it difficult to have a stable home life. The urban health agenda should address social, behavioral and environmental conditions affecting health.

A shared agenda as a way of doing business. The process of identifying a shared urban health agenda should be institutionalized as a way of doing business for the City and County. The urban health agenda must be developed in close partnership with communities, nonprofit agencies, grassroots groups, and other partners.

An agenda that maximizes external and internal partnerships. Government acting alone can never effectively address all public health needs of Minneapolis, even in times of abundance. Community partners and resources are vital to the overall public health infrastructure. City and County departments can seize this window of opportunity for transformational change and work in close partnership with community organizations and nonprofit agencies to push forward community engagement in public health issues through collaboration.

Recommendation #3 . . . *Set Public Health Priorities Based on Expected Outcomes in Relation to the Amount Invested.*

Most current research on the social and economic determinants of health proves that public health can be a solution to fiscal woes, rather than a drain on government coffers. Public health strategies produce quantifiable economic payoffs by reducing health care costs, reducing burdens on criminal justice, corrections and education institutions, and improving worker productivity. If greater public health investments had been made in the past – for example, to prevent smoking or head off the obesity epidemic – the current budget crisis would be milder. Priorities should be carefully chosen based on the likelihood the investment will produce results. Great care is also needed so that the biggest long-term impacts aren't the first to be cut because the results don't show up in the next budget period.

Recommendation #4 . . . *Improve and Formalize Working Relationships Between the City and County Public Health Departments.*

While merger would diminish a resulting agency's capacity to continue the same level of service, structural and operational changes will produce a more effective and efficient partnership between the two departments. Changes are needed in how the

two departments work together so that their respective strengths can be combined in an efficient, focused and strategic way. These changes will not result in cost savings, but will enable the departments to accomplish more with available resources.

Inter-governmental agreement. Communication channels and expectations should be established to assure that appropriate communication and coordination becomes a way of doing business. These should be formalized in an agreement between the two departments.

Assessment and planning. Both departments should continuously share information and coordinate planning processes in order to produce a joint, coordinated plan for addressing shared urban public health priorities, and to assure that the activities of the different departments do not create conflict or confusion.

Develop a formalized process for defining the roles and responsibilities. The staff and elected leaders for the two departments should work together to develop a process and criteria for continuously redefining the departments' respective roles in meeting Minneapolis public health needs. The process should be formalized so that it will not be disrupted in the event of changes in staff or elected leadership.

Partnership models. The strategic partnership should be tailored to each particular public health issue and strategy. We recommend the following categories as a tool for defining roles and responsibilities:

- Activities undertaken independently by the two departments.
- Shared activities divided according to political or geographic boundaries.
- Shared activities with different leadership roles for each department.
- Shared activities with one lead department and one supporting department.

Voices of urban public health. It is important that there be strong and consistent messages for urban public health, especially in today's environment of growing health concerns and competing fiscal priorities. The City and County should support a shared urban health agenda with compelling messages and advocacy.

RECOMMENDATIONS FROM THE BLUE RIBBON PANEL ON PUBLIC HEALTH IN MINNEAPOLIS

Thank you for the opportunity to present these recommendations on public health in Minneapolis. Although difficult in these times, we welcomed the opportunity to carry out the charge as stated in the City's resolution:

> " ..to assess the health and human development delivery systems of Minneapolis and develop recommendations to the Mayor and City Council of Minneapolis and Hennepin County Board of Commissioners regarding structure, accountability, funding and governance."

We appreciate the elected officials' concerns about assuring effective and efficient public health in Minneapolis in the face of current fiscal constraints. We, too, are concerned about cutbacks in public money at a time when our urban public health needs are growing. The cutbacks will be deeply felt in the community and will further widen the disparities that exist in health status and access to health care. To fulfill our charge, we looked for ways to improve the efficiency and effectiveness of the two public health departments serving Minneapolis. We concluded that significant improvements *can* be made; however, there is no silver bullet. Our recommendations will not begin to fully offset the reduced public health capacity that has resulted from budget reductions.

> *"Together, create an Urban Health Agenda. Tackle the greatest public health issues in Minneapolis - those of the health disparities experienced by some racial and ethnic people and those that exist because of poverty. Central to this agenda will be linking the greater community with the City and County governments. In order to put this plan of action in place, public health services need restructuring to magnify their effectiveness."*
>
> - Dr. Chris Reif
> Panel Member

We carefully examined the key question raised by elected officials of whether it is good public policy to maintain two different public health departments serving Minneapolis. Ultimately, we concluded the merger of the Minneapolis Department of Health and Family Support with Hennepin County Community Health Department is *not* in the best interest of Minneapolis residents at this time. Given current public health issues combined with the current fiscal constraints, we *did* conclude that targeted improvements can be made in the way the two departments work with each

other, within their respective governmental bodies, and with community partners. Our recommendations identify promising opportunities to improve both the efficiency and the effectiveness of all our combined efforts as an urban community to improve the health of the population.

Our recommendations cannot be implemented over night. A planful evolution to implementing our recommendations is necessary. Effective change takes time and our recommendations require changes within the City and County government systems, as well as sustained efforts to maximize the community's engagement in the public health.

> *"The challenge to improving health is long term and sustained and requires continued investments as multiple distinctions expose themselves through a true healing process."*
>
> - Tony Looking Elk
> Panel Member

Expected Outcomes. The expected outcomes from our recommended plan of action are:

- **A unified voice for urban health** from elected officials and public health leaders in Minneapolis and Hennepin County.

- **Targeted, strategic investments** to improve the health of Minneapolis residents most in need.

- **Formalized work processes and structures** to support more effective and sustainable outcomes of public health activities.

- **A web of community partnership** promoting accountability for and ownership of a shared urban health agenda.

Findings. A few key principles and research findings provided the foundation for our recommendations:

- **This is a time of major change.** Today's challenging financial picture is today's reality forces elected officials to make difficult choices with reduced public funds. Business as usual is not an option. New and forward-thinking approaches are called for leading to overall, systemic changes in both the public agencies and how they work with community partners. We concluded that it will take not only efficiency, but innovation to meet the City's growing public health needs with dwindling budgets. In summarizing the views of her fellow panel members, Jan Malcolm, Program Officer at the Robert Wood Johnson Foundation and former Commissioner of the Minnesota Department of Health, stated, *"At the end of the day, we need more focus on public health and more output from the public health system, not less. The recommendations ought to be how best to produce more of the most important public health interventions given limited resources."*

- **Public health needs in Minneapolis are growing.** The data we reviewed identified the unique needs of Minneapolis residents, compared to other parts of

the metropolitan area and the State of Minnesota. Clearly, Minneapolis as an urban area faces special challenges due to high concentrations of at-risk populations, poverty and other factors. Despite the recent successes of public health in reducing the infant mortality rate, increasing immunizations, decreasing teen pregnancies and early sexual activity, reducing smoking among youth, the data also reveals that Minneapolis' public health needs are actually increasing! The number of at-risk populations is growing, the risk of bio-terrorism and infectious disease outbreaks is increasing, and the number of uninsured residents is going up.

- **Public health is a core business function of government.** Government has a responsibility to protect citizens from injury, illness and disease, and to support health improvement. It is not a discretionary activity that can be dispensed with when money is tight. The mission of public health is *"to fulfill society's interest in assuring conditions in which people can be healthy."* The importance of this societal interest cannot be overstated. Unhealthy children cannot learn. Unhealthy workers cannot contribute to a thriving economy. Sick and injured residents require more medical attention at a higher cost to the community and government. Unhealthy social conditions are a drag on the economic vitality and quality of life of Minneapolis. They also drive up costs in other areas of government spending such as public education and criminal justice. A major cause of the current government budget crisis is rapidly rising health care costs. We are paying the price for failing to devote enough attention in the past to assuring better health by addressing the conditions in our communities that result in illness and injury. Public health is a solution to fiscal woes rather than a drain on the public coffers.

- **Public health's central goal is to improve the health of populations.** The central goal of public health is to identify the particular *conditions* that cause illness and injury in the City, and work to change these conditions so that the *entire population* is healthier. It is important to distinguish the public health role from the role of the medical care system, which treats *individual cases* of illness and injury after they occur. Public health activities prevent epidemics and injuries, protect against environmental hazards, promote healthy behaviors, and assure that residents have access to health care; and when necessary it provides medical care where none exists or specialized treatment is needed. It is tempting to view public health as something that can be turned over to the private health care market and the not-for-profit and voluntary sectors, but there is no substitute for a robust public health system with the authority and capacity to protect and promote the health of Minneapolis residents.

We encourage adoption of the following recommendations in order to continue to protect and promote the health of Minneapolis residents.

RECOMMENDATION #1: THE CITY AND COUNTY PUBLIC HEALTH DEPARTMENTS SHOULD NOT BE MERGED.

We believe that the merger of the two departments will leave Minneapolis with a diminished capacity to serve our public health needs. The two departments are not twins. Each department has a distinct set of skills, relationships and tools that are valuable to the community. Over time, these two departments have consistently, but informally, worked to assure that their respective strategies complement rather than compete with or duplicate the other's, as shown below.

Hennepin County public health "Only" activities	Minneapolis public health "Only" activities
• Assured Care • Baby Tracks • Child and Teen Check Up Outreach Services • Early Childhood Development (Follow Along and 348-TOTS*) • Health Care for the Homeless* • Health Promotion Programs • Immunization Services* • Infectious Disease Surveillance and Control* • Perinatal Hepatitis B • Prevention Coalition Support • Public Health STD/HIV and TB Clinics • Ryan White HIV/AIDS Services • Services to the Elderly and Persons with Disabilities • Vital Records • Women, Infants and Children (WIC)* ** These programs receive some financial support from the City's public health department.*	• American Indian Community Advocate • Community-Assisted Policy Development • Community-Based Research • Healthy Start • Multicultural Services • New Families Center • Public Health Laboratory • School-Based Clinics • Senior Ombudsman • Skyway Senior Center • Tenant/Landlord Services • Weed and Seed
Partnerships between City and County public health departments	**Shared activities between Minneapolis public health and other County departments**
• Emergency Preparedness • Lead – Outreach, Education, Epidemiology • Population Based Research Surveys • TANF Home Visiting • Teen Parent Connection • Way to Grow	• Curfew Truancy Center • Domestic Abuse • Income Tax Services • Lead Abatement

The two departments have a good understanding of their respective skills and assets. Each gave us examples of areas where they have forged effective partnerships in the past. However, in our discussions, it was difficult for the staff to explain the rationale for the current division of roles and responsibilities, to clearly articulate the manner in which they communicate, and decide when and how to work together, how financial resources are used in complementary ways, and how public health policy is formed together.

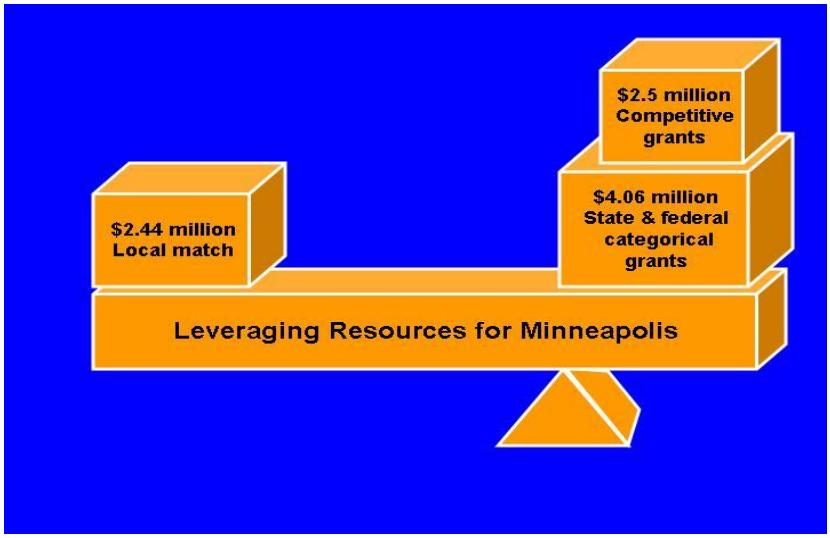
Unfortunately, it also appears to be the case that elected officials of the City and County do not systematically communicate or coordinate around the core public health functions for the City of Minneapolis. Changes are needed in how the two departments are directed to work together so their respective strengths can be combined in an efficient, focused and strategic way. These changes will not result in cost savings, but will enable the departments to accomplish more with available resources.

One plus one equals more than two. These two departments represent a synergistic relationship – remove one and the other will weaken, but when working side by side, their strengths are enhanced. An example of this relationship is shown in the generation and use of public health data. The County generates a comprehensive system for tracking disease trends and producing a wealth of data for needs assessment, while the City works closely with promising new or small community-based organizations to use data to increase their effectiveness or to design or evaluate programs to serve the specific needs of particular populations in the City.

These departments would not be able to continue their key strategic directions without the other continuing to do what it does. The Hennepin County Community Health Department is a powerhouse of solid epidemiological study, which provides a strong foundation for public health policy and strategy direction not only for itself, but also for Minneapolis and the many other cities within the County. The Minneapolis Department of Health and Family Support enjoys a hard-won reputation for minimal bureaucracy and maximum personal connection with community leaders and projects over time. With community engagement as a key public health strategy, this attribute is essential for implementing our recommendations.

Leveraging additional resources for public health from other levels of government. The two departments should not be merged because each department can access and leverage financial resources beyond their respective government bodies.

In particular, for each dollar the City provides, an additional $2.61 is leveraged for Minneapolis residents!



Key points if the City were to close the doors of its public health department are:

- Funds specifically granted to the Minneapolis public health department as a qualifying local public health board would likely be transferred to Hennepin County as they could meet the state match requirements and earn the state Local Public Health Grant allocations for both Minneapolis and Hennepin.

- Additional resources presently secured by the City's public health department to address specific urban challenges would be in jeopardy.

- With cutbacks at the County, it is difficult to imagine that the Hennepin County Board of Commissioners could make property tax funds available to replace lost city property tax investments.

Leveraging additional resources for public health in the community is very significant. Newman Associates surveyed five of the key community partners of the City and County health departments in June 2003. The report indicated that although the City and County funds by no means constitute large portions of any of their budgets, the funds serve as evidence to private funders that their programs are considered key parts of the public health infrastructure. Private funders are much more likely to provide financial contributions when local governments are part of the funding formula.

Additionally, several of the other City-County funded community organizations leverage grassroots-community volunteers to carry out much needed relationship-based activities in the neighborhoods. The financial impact of community volunteerism is very hard to quantify, but we know it is *priceless* to our overall community fabric.

A resource to City officials and departments. We also concluded that the existence of a City public health department is of particular value to other city departments and to elected officials. Because the City department maintains close ties to community groups, communities of color, new immigrant populations and others, it serves as a valuable resource to other City departments seeking opportunities to communicate with or work with particular populations in the City.

RECOMMENDATION #2: ESTABLISH ACCOUNTABILITY FOR A SHARED URBAN HEALTH AGENDA.

We believe that the City and County, together, need to establish a clear and focused public health agenda that is based on the unique health needs of an urban community. It is appropriate that the City and County each have some unique public health priorities and activities, but those priorities that are shared should be addressed through a common community agenda. The common agenda should then be pursued with a coordinated strategy that takes advantage of the diverse skills, relationships and voices of the City and County, as well as community partners.

We call this an "urban health agenda" because public health needs do not line up precisely with political, geographic or even neighborhood boundaries. There are multiple overlapping communities in Hennepin County and Minneapolis that share common needs and conditions inherent in any metropolitan area. Our immediate interest is in seeing the City and County develop a shared agenda, but this issue does not stop at the river. At some future point, this urban health agenda should be expanded to St. Paul/Ramsey. Ironically, it was noted during our discussion that there exists a *Rural* Health Advisory Committee for the State but there is no similar *Urban* Health Advisory Council. We think it is worth considering organizing an effort of all of the urban public health organizations to advocate together establishing such an advisory council to give voice to the unique needs of urban people of the State.

Key aspects of the urban health agenda include the following:

An agenda that integrates community values. Values of the community must be considered when making policy and program decisions. Public health programs and policies should incorporate these values by implementing a variety of approaches that respect diverse values, beliefs and cultures in the community (see Appendix B). Blue Ribbon Panel member Stella Sola, a Bilingual-Bicultural Nutritionist at the Family Community Center stated, *"City and County officials need to welcome community leaders to discuss issues and trust their collective wisdom, they know their people, they are aware of their needs. But being nice is not enough; respect is what people truly want."*

Likewise, it is important to engage in partnerships with the voices of the more organized community stakeholders because they reflect a community's readiness and capacity to move forward on a health improvement strategy. It is equally important to implement community engagement strategies where no organized voices exist but some high health priority needs are evident. This makes good sense by economic, health and ethical standards.

An agenda based on greatest needs and effective strategies. The essence of public health is using accurate information gathered from epidemiological studies and community assessments to determine need, and then using proven and promising strategies to meet those needs. However, urban public health activities have not always accurately reflected the areas of greatest need nor implemented the most effective methods. This imbalance must be upended. This is not intended to place blame with the current departments. Often programs are driven by available funding streams or mandates imposed by other levels of government and sometimes by political pressure from special interest groups outside of the departments' control. Many recent and proven strategies based on research of how social determinants affect health need to be implemented and the means must be found to do this. Creative community organizations have put in place effective programs that work, but have never had the resources to put the program through the rigors of applied research methodology. This is fertile ground for cutting edge public health innovations.

> *"It is not sufficient to sit back and wait for specific needs to emerge. It is necessary to try to find out what the unmet needs are. Too many people, especially Senior Citizens, will not verbalize their needs; often they deliberately conceal them. So step one is to do some neighborhood surveys."*
>
> – Doug Davis
> Panel Member

An agenda that considers social, behavioral, and environmental conditions that impact health and well-being. The health of our urban community is strongly influenced by conditions that require interventions in areas not usually thought of as public health. For example, the childhood obesity epidemic cannot be contained if urban children do not have safe places to exercise, their families cannot easily buy healthy food in their neighborhood, and a shortage of affordable housing makes it difficult to have a stable home life. It is important to go as far "upstream" as possible to work on strategies that can positively impact multiple problems, multiple risk factors, and multiple determinants simultaneously.

A shared agenda as a way of doing business. The process of identifying a shared urban health agenda should be institutionalized as a way of doing business for the City and County. The departments need to develop an ongoing plan to hold *joint public health advisory committee activities* that would routinely provide guidance in:

- shaping how the departments should set public health priorities for Minneapolis,
- identifying specific priority areas where the two departments will work together,
- determining how best to work with community partners in a more coordinated, efficient and effective way.

An agenda that maximizes external and internal partnerships. Government acting alone can never effectively address all public health needs of Minneapolis, even in times of abundance. Community partners and resources are vital to the overall public health infrastructure. Multiple public health services are provided directly by the City or County and by community organizations. The urban health agenda must be developed in close partnership with these communities, nonprofit agencies and other partners. Government should not do what the community or other organizations can do, but government needs to draw these organizations and services into an overall collaborative plan.

> "Certainly partnerships and collaborations are important but we need to get below the surface of those terms and identify more precisely who does what, and who changes what. The public health agencies need to partner very closely with other departments within the local government like education, safety, housing, economic development etc. to assure the greatest leverage of strategies and resources working on common concerns."
>
> -- Jan Malcolm
> Panel Member

There is also a public health role to assist in building community capacity to eliminate gaps in services and to have those services delivered where they can have the most impact at the least expense. Other community partners include private sector business leaders and major organizations with a vested interest in public health, such as the Minneapolis Public Schools. The engagement of such large institutions as the University of Minnesota could certainly add another dimension of community engagement and expertise.

In recognition of the factors that can profoundly affect the health of a community, the public health departments should involve internal partners within the City and County government, as well in setting the urban health agenda. The reorganized Human Services Department in Hennepin County and the new Community Planning and Economic Development Department in Minneapolis are key examples of opportunities to work with other "internal" partners.

An agenda with accountability measures. *Public health has the responsibility to promote the well-being of all people within the community and especially provide special assistance for those who are at highest risk of poor health outcomes and have the fewest resources. Work on behalf of these people needs to be undertaken in close partnership with the best possible use of the unique skills, competencies and relationships of the City and County departments but equally important, with community partners. Blue Ribbon Panel member Mary Ann Blade, CEO of the Metropolitan Visiting Nurses Agency, reflected on accountability measures in this manner,* "If the public health departments together actively engaged in identifying results that they want to see, worked with their own staffs and community agencies to develop a way to measure achievement, formally evaluate and base funding on results, we would see dollars flowing to areas that are most helpful to families."

Today there is heightened awareness in the community of changing roles of government due to a number of factors, financial constraints being only one. City and County departments can seize this window of opportunity for transformational change and work in close partnership with community organizations and nonprofit agencies to push forward community engagement in public health issues through collaboration.

RECOMMENDATION #3: SET PUBLIC HEALTH PRIORITIES BASED ON EXPECTED OUTCOMES IN RELATION TO THE AMOUNT INVESTED.

We believe that if the City and County public health departments quantify the expected short and long term financial outcomes of their activities, the benefits will outweigh the expenditures. This is easier said than done. But the most current research on the social and economic determinants of health proves that public health can be a *solution* to fiscal woes, rather than a drain on government coffers.

Public health strategies produce quantifiable economic payoffs by reducing health care costs, reducing burdens on criminal justice, corrections and education institutions, and improving worker productivity. A recent study conducted by Art Rolnick, an Economist at the Minneapolis Federal Reserve Bank, shows that an investment in early childhood programs will significantly boost the quality of the work force 20 years down the road and produce exceptional gains for the economic well-being of the State. Thus, great care is needed so that the biggest long-term impacts aren't the first to be cut because the results don't show up in the next budget period.

Venture capitalist mindset. We are convinced that if greater public health investments had been made in the past – for example, to prevent smoking or head off the obesity epidemic – the current budget crisis would be much milder. Opportunities for investment in public health should be evaluated with the mindset of a venture capitalist; that is by considering the potential of today's investment for producing significant, quantifiable benefits in the future. Priorities should be carefully chosen based on the likelihood the investment will produce results. Public health investments often provide some of the biggest cost savings or biggest return long-term.

When elected officials establish public health priorities, it is important to think broadly on determining investments. Blue Ribbon Panel member Tony Looking Elk, President of the Urban Coalition and Co-Chair of the Metropolitan Urban Indian Directors, has an enlightening perspective on this concept, *"If there has been a common theme in the relationship of American Indians within the City of Minneapolis, it has been racism. What does racism do? It not only disenfranchises, but it creates lower expectations. If we need ten dollars, we will settle for a dollar and create under-invested programs that ultimately under-invest in people. Then people wonder why we can't succeed. We strive not for good health but functional health. We have the highest per-visit cost to Hennepin County Medical Center than any other group. We come in sicker because we have accepted exclusion to the point where we expect to suffer to the point of collapse."*

Short-term gains, too. Although investment in public health has long-term benefits, the short-term gains are equally important. A key example is public health's ongoing monitoring and provision of immunizations against communicable diseases. The most evident threat currently facing Minneapolis is the dramatic rise of tuberculosis, easily prevented but extremely expensive to treat if not controlled. Likewise, when eligibility for publicly-funded health insurance is cut, people have no health insurance and then they lack access to care in their communities; their health conditions do get worse fairly immediately and the local public hospital's emergency room becomes quickly overburdened as a direct result. The reduction in one area of government spending causes an increase in another area. What health dollars have then been saved?

The City and County public health departments can strive to define and quantify the outcomes of their activities and concentrate on those that are most likely to produce a benefit whose value outweighs the amount of the investment. Strategies to engage other areas of government in public health improvement and disease prevention programs can also create synergy to impact overall government expenditures. Whether through directly funding public health-related programs or addressing the social determinants of health, numerous short-term and less expensive investments made now will pay off in big returns -- or reduction of large expenses -- down the road.

RECOMMENDATION #4: IMPROVE & FORMALIZE WORKING RELATIONSHIPS BETWEEN THE CITY AND COUNTY PUBLIC HEALTH DEPARTMENTS.

Merger would likely diminish the resulting agency's capacity to continue the same level of specialized attention to the unique needs of Minneapolis-based nonprofits and grassroots community groups; however, this does not mean that we believe the current public health system is as good as it can be. On the contrary -- we believe several key changes will produce a more effective and efficient partnership between the two departments and between the elected officials.

Inter-governmental agreement. Regular communication and coordination between elected officials and the staffs of the two departments is essential. Formalized channels and expectations should be established to assure that appropriate communication and coordination becomes a way of doing business. To ensure this critical success factor, any number of formal agreements may be considered: memoranda of understanding, joint powers agreements, official committees, and mutual reporting. The important thing is not so much the type of agreement, but that both parties support and implement the agreement appropriately.

Assessment and planning. High on the list for coordination are public health assessments and planning for Minneapolis. Both bodies should continuously share information and coordinate planning processes in order to produce a joint, coordinated plan for addressing shared urban public health priorities, and to assure that the activities of the different departments do not create conflict or confusion.

Develop a formalized process for defining the roles and responsibilities of each departments. We see many additional opportunities for more strategic collaboration. Therefore, we recommend the staff and elected leaders for the two departments work together to develop a process and criteria for redefining the departments' respective roles in meeting Minneapolis public health needs. The division of roles ought to reflect the unique skills and competencies of the City and County departments, taking advantage of each department's ability to tap into different revenue sources and political constituencies to achieve common goals. The process should be formalized so that it will not be disrupted in the event of changes in staff or elected leadership. The process and criteria, and the resulting division of labor, should be easy to explain to community partners and the public.

Partnership models. A cookie cutter approach should not be used to divide up roles and responsibilities. The strategic partnership should be tailored to each particular public health issue and strategy. We recommend that the two departments consider the following categories as a tool for defining roles and responsibilities:

- Activities undertaken independently by the two departments.
- Shared activities divided according to political or geographic boundaries.
- Shared activities with different lead roles for each department.
- Shared activities with one lead department and one supporting department.

Regardless of which model is chosen for a particular public health activity, the two departments need to communicate regularly and should never compete with each other or undertake activities in ways that create confusion about the roles of either.

Voices of urban public health. It is important that there be strong and consistent messages for urban public health. This is especially critical in today's environment of growing health concerns and competing fiscal priorities. The City and County need to support mutually compelling messages and advocacy. A united front on urban health issues conveys a stronger message through multiple voices. When talking about advocacy and public awareness, a chorus is more effective than a soloist, but the chorus needs to sing together. When the largest city in Minnesota combines forces with the largest county in Minnesota, and all of their community partners join in, a louder voice and a greater impact for urban public health needs will result.

CONCLUSION

We believe that these recommendations will guide appropriate County Board and City Council governing actions when officially adopted by the respective government bodies. No specific change to existing governance structures are recommended at this time, although several were discussed. Blue Ribbon Panel member Dr. Ed Ehlinger stated that it would be ideal if, "…*the City Council and County Board develop a collaborative working agreement on public health priorities and a consensus understanding about the public goals of each geo-political unit."* We also strongly support the current County and City public health advisory committees coming together on a routine basis to discuss the urban health agenda as discussed in our fourth recommendation.

Final Messages from the Panel. As a way to provide some more qualitative information to our elected officials regarding City and County governance, here are some key messages from a few of the members of the Blue Ribbon Panel.

> *Based on the assessment of the community including its culture, diversity, financial and health status of families, and health care resources, the government can be the architect to assure care is delivered to its constituents.*
>
> - Mary Ann Blade

> *There have been multiple efforts historically that promote the improvement of the overall health of people and communities and yet, communities like the American Indian continue to suffer. When does belief wane and mistrust develop? At what point does the definition of "we" mean "not us"? How do you change the face of public health to provide at a minimum some level of symbolism that American Indians belong in a decision making capacity and not in safe, distant "advisory" role? What in this city suggests American Indians belong? Remove the basic need organization and there is little to nothing to show of our place here. Symbolism suggests who belongs, who has control and ultimately a sense of power. If there are no active reminders of American Indians then there are no triggers to create inclusion in any movements.*
>
> - Tony Looking Elk

> *Too often we overlook the impact that conflicting local policy decisions have on children. It is our responsibility to measure, communicate and respond to these decisions as they impact the lives of children and their families.*
>
> - Jim Koppel

Minneapolis has a unique mix of people with different backgrounds, racial, economic, social and religious. We have both American Indian and African American who have a great history in this county and have their own unique health challenges. We have the Somalis, Oromo, Ethiopians and other Africans, Asian and Hispanic communities, and the White Americans from different cultures too. On the other hand we have a large gay and lesbian community who need special health care attention. We have newcomers from refugee camps that come with infectious diseases and health conditions that need immediate attention. We should not exclude the great number of American and foreign students attending the Universities and other colleges with their own health needs.

- Huda Farah

When people know that they are different and do not feel welcome, they do not feel that they belong to a community. The homeless people are not only the ones without a shelter; they [immigrants] are also the ones that do not feel that this is "home" now. This is a public health need that is unique to immigrants, newcomers and people from other cultures, that certainly has not been met.

- Stella Sola

Stay dedicated to the core mission of public health to serve all the people in Minneapolis but particularly the underserved. Promote healthy people, healthy families, healthy communities and healthy environments though compassionate care, education and prevention.

- Dr. John Williams

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APPENDICES

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APPENDIX A

RESOLUTION 2003R-217
By Johnson Lee

Authorizing establishment of a panel of community leaders and residents to assess the health and human development delivery systems of Minneapolis and develop recommendations to the Mayor, Minneapolis City Council and Hennepin County Board regarding structure, accountability, funding and governance; and Adopting Guiding Principles to address the health and human development needs of City residents as a framework to guide the work of the aforementioned panel.

Whereas, the Mayor and Minneapolis City Council have approved a 2003 City of Minneapolis Human Development Goal to ensure a healthy, safe city and enhance community engagement; and

Whereas, City of Minneapolis and Hennepin County leaders have exercised good stewardship by periodically reviewing and adapting the structure and governance and financing of the health and human services delivery systems in a manner which best reflects the needs, interests and well being of its residents; and

Whereas, City of Minneapolis and Hennepin County leaders recognize the severe challenges placed upon local governments as a result of the national recession and the federal and State budget deficits; and

Whereas, the Minneapolis City Council, as the Board of Health for the City of Minneapolis, is authorized (MN Stat.145A.03 subdivision 1) to determine the City's powers and duties as a board of health;

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

That a panel of residents, health and human services and community leaders shall be impaneled to examine the present delivery systems and forward recommendations for consideration to the Mayor, Minneapolis City Council and Hennepin County Board regarding the structure, governance and financing of said delivery system.

Be It Further Resolved that the panel members shall be selected through the consensus of the Mayor, the Chair of the City Council's Health & Human Services Committee, and the Hennepin County Board member responsible for oversight of the Hennepin County Community Health Department.

Be It Further Resolved that the panel membership shall be limited to twelve (12), to include: the Mayor or his designee, one member of the Minneapolis City Council, one Hennepin County Commissioner, a representative of the Minneapolis Public Schools, three (3) representatives of organizations that have worked with both the City of Minneapolis and Hennepin County, and five (5) leaders from the health and human services area. The membership of the panel shall reflect the ethnic and the cultural diversity of Minneapolis.

Be It Further Resolved that the Minneapolis Department of Health & Family Support, with support of the City Coordinator's Office and the appropriate Hennepin County staff, shall be responsible for providing staff support to the panel.

Be It Further Resolved that the panel use the following principles to guide the analysis about the best way to structure government services to meet the health and human development needs of City residents:

Focus on the beneficiaries. The needs of the people who live in Minneapolis are foremost. Decisions and activities must help children and adults live better, healthier, and safer lives. We must eliminate the disparities between racial/ethnic and income groups in health and opportunities for development.

Listen and respond to community voices. Government must respect and benefit from the knowledge, abilities, and inventiveness of ordinary citizens, community leaders, and community agency staff who confront problems and overcome obstacles daily. Productive and sustained partnerships are the only way to ensure that the people who live and work in the City identify needs, craft solutions, and target limited resources. Partnerships must capitalize on the rich diversity that our urban environment offers.

Demand a focus on the uniqueness of the urban environment. Planning must take into account the effects on resident health of concentrated poverty, unemployment, discrimination, and crime; dense and older housing; industrial neighborhoods; and mobility of residents. Planning must also address the needs of new arrivals and people with varied cultures, traditions, and languages.

Provide leadership. Leadership must inspire innovation, community engagement, and the commitment to do better. Government leaders need to remain accountable to City residents and must be willing to engage in difficult and controversial issues. Leaders must be willing to take a stand on behalf of addressing reproductive health issues and the rights of adolescents to seek necessary care in a safe and confidential environment.

Promote entrepreneurship. Creative government activities are needed to bring more resources of all kinds into the City to strengthen community agencies and service providers and to address priority needs.

Require efficiency and effectiveness. Government roles should be complementary and clearly articulated. Local government should not do what the community can do. Government resources should be leveraged to ensure the best return on public investments. Use research to inform decisions, evaluate activities, and identify next steps.

Use data to drive action: Information about community needs and health outcomes must guide the use of human and financial resources. Data needs to be used to engage communities in helping to generate solutions. Reports and studies need to lead to action with measurable benefits to City residents.

Be It Further Resolved that the panel shall present preliminary findings to the Health & Human Services Committee and the Mayor by August 11, 2003, with a final report to be submitted to the Committee and Mayor no later than October 27, 2003.

Adopted 5/16/03.
Absent - Colvin Roy.

Agenda No 11E

RESOLUTION NO. 03-6-417

The following Resolution was offered by Commissioner Dorfman, seconded by Commissioner Koblick:

WHEREAS, City of Minneapolis and Hennepin County leaders have exercised good stewardship by periodically reviewing and adapting the structure and governance of the health and human services delivery systems in a manner which best reflects the needs, interests and well being of its residents; and

WHEREAS, City of Minneapolis and Hennepin County leaders recognize the severe challenges placed upon local governments as a result of the national recession and the federal and state budget deficits; and

WHEREAS, the Minneapolis City Council on May 16, 2003, adopted a resolution which seeks County participation in reexamining the public health service delivery system for Minneapolis residents; therefore

BE IT RESOLVED, that a joint city/county working group be established to review current public health delivery systems and develop recommendations for improvements in the structure, accountability, funding and governance of public health services within the City of Minneapolis; and

BE IT FURTHER RESOLVED, that the working group members will be jointly appointed by the Minneapolis City Council and the Hennepin County Board of Commissioners and that membership will be limited to twelve (12) to include: the Mayor of Minneapolis or his designee, the chair of the Health and Human Services Committee of the Minneapolis City Council, the chair of the Community Health and MHP Committee of the Hennepin County Board, a representative of the Minneapolis Public Schools, the chairs of the Minneapolis and Hennepin County Community Health Services Advisory Committees, three (3) representatives of organizations that have worked with both the City and the County and three (3) leaders in the health and human services area; and

BE IT FURTHER RESOLVED, that preliminary recommendations to the Minneapolis City Council and Hennepin County Board be made by August 11th, 2003, with a final report submitted no later than October 27th, 2003.

The Question was on the adoption of the Resolution and there were 7 YEAS and 0 NAYS, as follows:

COUNTY OF HENNEPIN BOARD OF COUNTY COMMISSIONERS	YEA	NAY	OTHER
Mark Stenglein	X		
Gail Dorfman	X		
Peter McLaughlin	X		
Randy Johnson	X		
Linda Koblick	X		
Penny Steele	X		
Michael Opat, Chair	X		

RESOLUTION ADOPTED ON 06/24/03

ATTEST: _____
Clerk of the County Board

APPENDIX B

"BLUE RIBBON PANEL'S PUBLIC HEALTH VALUES"

Value 1: Effective public health strategies must consider social, behavioral, and environmental conditions that impact health and well-being.

The conditions that most affect the health of many Minneapolis residents are often areas not usually thought of as public health. Given the underlying causes of poor health, some of the most powerful ways to improve health across whole communities of people, not just one at a time, may include conditions such as safe and lead-free housing, affordable day care, living wage employment and effective education. Less tangible, but very real health predictors such as supporting connections to the community, friends and family, developing trusting and respectful community relationships, and taking on significant social issues such as racism should also remain in the mix of public health approaches. It is well known that where poverty is the most concentrated and the social disparities most extreme, the health challenges are the greatest. Strategies that blend both social and health strategies are likely the most effective.

Value 2: A comprehensive approach to public health assessment is critical for today's health concerns.

Health disparities i.e., differences in health status between racial and ethnic groups and between those who live in poverty and those who don't, is one of many key issues for Minneapolis residents where there is not yet adequate research data to build effective strategies. Qualitative needs–based assessment and innovative programs can be used to support early public health strategy. Outcome data on innovative programs that have been implemented needs greater distribution.

Value 3: It is important to continue the prevention measures of public health, especially in the times of reduced budgets.

When making decisions about how to invest public health dollars, it is important to consider the expected short and long term return on investment across the entire City and for all levels of government, including savings in welfare and health care programs, the criminal justice system, and the schools, to name a few. Great care is needed so that the biggest long-term impacts aren't the first to be cut because the results don't show up in the current or next budget period. Especially in the prevention areas, the short-term gain from a cut is often a big long-term cost. Strategies to engage other areas of government in public health improvement and disease prevention programs will create synergy to impact overall government expenditures.

Value 4: Public health has the responsibility to promote the well-being of all people within the community and provide special assistance for those who are at highest risk of poor health outcomes.

Values of the community must be considered when making policy and program decisions. Public health programs and policies should incorporate these values by implementing a variety of approaches that respect diverse values, beliefs and cultures in the community. This makes good sense by economic, health and ethical standards.

Community engagement is one of the most effective health promotion and prevention methods. It is important to engage in partnerships with the voices of the more organized community stakeholders because it reflects a community's readiness and capacity to move forward on a health improvement strategy. It is equally important to implement community engagement strategies where no organized voices exist but some high health priority needs are evident through comprehensive assessments.

Value 5: An effective public health system must be coordinated and connected.

Limited tax revenue means that every public health dollar must be spent as efficiently as possible and targeted where it will do the most good. The existence of two public health agencies serving the same community raises the potential of overlap in services and inefficient use of resources. However, it also can be viewed as an advantage when 1) a coordinated strategy leverages the unique competencies of both bodies of government, and 2) it produces better public health outcomes than one agency acting alone.

Others in the community also have a vested interest in providing public health services in Minneapolis. It is also imperative to assess all the health resources available within the community to maximize the health benefit. There are community organizations that can leverage additional dollars and provide expertise not readily available or cost effective within government itself. It would be wise not only to maximize City and County government efficiencies but also to maximize efficient and effective community providers. Community organizations, which function in this capacity, need to be connected or they lose their commitment to the City and County's health goals.

A focus on what needs to be done in Minneapolis organizations in the next five years will best target, limited resources. When looking at the roles of the City and County's public health departments, each department's capacity (i.e., both resources and competencies) to undertake particular public health activities as well as be accountable for the results should be examined. The City and County can best direct their resources to contribute, individually and together with community partners, to meeting needs of the citizens and community stakeholders. City and County staff can serve as navigators within their own units of government to address the social conditions of health.

Value 6: Joining voices for common public health concerns in Minneapolis is essential in today's environment of significant health issues and fiscal constraints.

Each public health department needs to coordinate leadership to send a united message to community officials and others in leadership positions. Overlaps between the City and County public health advocacy are a good strategy if they are intentional and based on shared advocacy to leverage the power of the City and the County together.

Value 7: Public health is a core business function of government that must protect the public from injury, illness and disease, and support health improvement.

It is tempting to view public health as something that can be turned over to the private market or to the not-for-profit and voluntary sectors. However, there is no substitute for a robust public health system with the authority and capacity to protect the health of the public from injury, illness and disease, and promote the development of programs and activities that improve the health of its citizens. This must remain a core business function of government. Local government is in the best position to quickly and accurately assess problems and implement solutions.

Value 8: Assurance means making sure that necessary services are being provided, not only by the health departments but also by other agencies in the community.

Community partners are vital to the overall public health infrastructure. Multiple public health services are provided directly by the City or County to residents of Minneapolis and/or by community organizations. Government should not do what the community or other organization can do. There is a public health role to assist in building community capacity to eliminate gaps in services and to have those services delivered where they can have the most impact at the least expense.

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APPENDIX C

"SUMMARY OF THE BLUE RIBBON PANEL'S DELIBERATIONS"

Standards of Practice for Public Health

Public health defines its work through a mission, three core functions, six key activities, and ten essential services. It is presented here as set forth by the *Public Health Functions Steering Committees, Public Health in America,* July 1995.

The Mission of Public Health is to Fulfill Society's Interest in Assuring Conditions in Which People Can be Healthy.

Three Core Functions

- *Assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities.*
- *Formulating public policy in collaboration with community and government leaders, designed to solve identified local and national health problems and priorities.*
- *Assurance that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the effectiveness of that care.*

Six Key Activities

- *Prevent epidemics and the spread of disease.*
- *Protect against environmental hazards.*
- *Prevent injuries.*
- *Promote and encourage healthy behaviors.*
- *Respond to disasters and assist communities in recovery.*
- *Assure the quality and accessibility of health services.*

Ten Essential Services

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

This approach is presented to the industry, by the industry in its own language. This "public health speak" results in a lack of understanding and a distinct lack of appreciation of the contributions that public health provides to a community. According to a 1999 national survey, when asked, "What do you [individual citizens] think public health means?," less than half surveyed correctly identified public health as either "protecting the population from disease" or "policies and programs that promote healthy living conditions for everyone." *(Public Opinion about Public Health – United States, 1999. Morbidity and Mortality Weekly Report 49(12): 258-260.)*

Public Health or Medicine

Another common misunderstanding results from confusion between public health practice and medical practice. Two distinctions are most notable. First, public health takes a population approach to improving health rather than the more familiar health care where a doctor treats an individual patient one-on-one for a specific disease or injury. While people might recognize that a public health department conducts restaurant inspections, not many are aware that public health specialists monitor health conditions, conduct and act on community-wide health assessments, and make sure health care is accessible to everyone. Everyday realities such as fluoride in the drinking water, mandatory seat belt use, and the warning on cigarette packages are the direct result of public health efforts.

Second, because doctors treat individual patients one-on-one for a specific illness, disease or injury, patients need medical care only part of the time. Public health professionals, on the other hand, monitor and diagnose the health concerns of the entire community and promote healthy practices and behaviors to assure populations stay healthy. Thus, communities need public health all of the time in order to stay healthy. Further distinctions are in the table on the following page.

Although these distinctions articulate the unique practices of each, it is also important to note that the roles of public health and medicine only have limited effectiveness standing alone. Each is a piece in the entire health system and both are necessary and must work together. For example, public health could spend a great deal of time and money in the community promoting early prenatal care; however, if there is no medical clinic to provide it, the effort may be futile. Likewise, a physician caring for an elderly person with limited income will depend on the public health nurse to make home visits to check up on not only medical aspects of the care, but also the social aspects.

In some cases, public health departments must operate medical clinics because the community lacks services or because specialized care is needed that no one in the community can or will provide. In Minneapolis, the Hennepin County Community Health Department operates the Health Assessment and Promotion Clinic with a strong emphasis on preventing the transmission of infectious diseases, and the Red Door Clinic, which offers highly confidential services for sexually transmitted infections. The Minneapolis Department of Health and Family Support operates clinics in the Minneapolis Public High Schools.

Public Health *(left column)* Compared to Medicine *(right column)* ***Public Health Functions Steering Committees, Public Health in America. July 1995.***	
Primary focus on population	Primary focus on individual
Public services ethic, tempered by concerns for the individual	Person services ethic, conditioned by awareness of social responsibilities
Emphasis on prevention, health promotion for the whole community	Emphasis on diagnosis and treatment, care for the whole patient
Public health paradigm employs a spectrum of interventions aimed at the environment, human behavior, and lifestyle and medical care	Medical paradigm places predominant emphasis on medical care
Multiple professional identities with diffuse public image	Well-established professional identities with sharp public image
Variable certification of specialists beyond professional public health degree	Uniform system for certifying specialists beyond professional medical degree
Lines of specialization organized, for example, by: • Analytical method (epidemiology) • Setting and population (occupational health) • Substantive health problem (nutrition) • Skills in assessment, policy development and assurances	Lines of specialization organized, for example by: • Organ system (cardiology) • Patient group (pediatrics) • Etiology, pathophysicology based (oncology, infectious disease) • Technical skill (radiology)
Biologic sciences central, stimulated by major threats to health of population; move between laboratory and field	Biologic sciences central, stimulated by needs of patients; move between laboratory and bedside
Numeric sciences an essential feature of analysis and training	Numeric sciences increasing in prominence, through still a relatively minor part of training
Social sciences are an integral part of public health education	Social sciences tend to be an elective part of medical education
Clinical sciences peripheral to professional training	Clinical sciences an essential part of professional training

State of Public Health Affairs in Minneapolis

Historical Perspective

The Minneapolis' public health department came into being, fully 111 years prior to the establishment of Hennepin County's public health department. In 1867, the City's public health services, now the Minneapolis Department of Health and Family Support, at one time owned Hennepin County Medical Center, formerly known as Minneapolis General Hospital.

Before Hennepin County established its public health department in 1978, it convened a 30-plus member panel to explore the feasibility of this development with the assistance of the Minneapolis' public health department. It was determined that public health services in the whole of Hennepin County were highly fragmented and varied greatly among its cities. The passing of the Minnesota Community Health Services Act in 1976 allowed both City and County health boards to receive a state subsidy to perform work, helped to close the deal for the creation of the Hennepin County Community Health Department.

The County's public health position is assured because Minnesota's public health system is fundamentally county-based across its 87 counties, and many cities within Hennepin County would otherwise lack any public health services. It is important to note that within Hennepin County, three other cities—Bloomington, Edina, and Richfield—determined they also had reason to establish a joint public health board. Likewise, although there are 87 counties in Minnesota, many rural counties have joined together to form a single public health department. There are 50 Boards of Health in Minnesota receiving community health service funds from the State health department. The beauty of Minnesota's public health system is that the laws encourage local or regional efforts to improve the well being of the citizenry.

While 60 percent of public health systems across the U.S. are also county-based, it is common that many large cities in the country find it essential to maintain a city public health department to focus on the unique needs of its distinctly urban citizenry *(Local Public Health Agency Infrastructure: A Chartbook. National Association of County and City Health Officials, 2002).* However, the need for a Minneapolis public health agency has been called into question several times. This is the third time in the past 17 years that the City of Minneapolis and Hennepin County have explored the possibility of combining and thus eliminating the Minneapolis Department of Health and Family Support. This is also the third time both bodies and many community leaders have reaffirmed the importance of each department's existence and re-identified the strengths of each, as well as the areas of interdependence with each other and the people they serve. Although on the surface the existence of two health departments usually appear duplicative, it was again realized that overlap—when intentional and coordinated—is a strength and is anything but excess when it comes to critical public health issues.

In 1986, only eight years after Hennepin County's public health department came about, tough budget times caused the City Council to consider consolidating the City

and County public health functions. A collaborative study was undertaken between the two entities to explore the possibility. After lengthy discussion and study, however, the City Council determined that the City would not save much in the way of General Fund dollars, but it would lose its power to influence public health services in Minneapolis. Further, because there wasn't much overlap between the two departments, not much efficiency would be realized by a consolidation.

In 1993, the consolidation question was posed again, partly due to another financial crunch and also because there was political pressure to "get out" of the direct provision of medical services that others in the community also provided. While the consolidation concept was dispensed with in much the same way as it had been the last time, the direct services issue remained. As a result, the City's public health department dramatically downsized its direct clinical services in 1996, resulting in many service contracts with community partners. All the maternal and child health clinics were closed but the Minneapolis Department of Health and Family Support continues to operate school clinics in six Minneapolis Public High Schools.

Public Health Today

The Minneapolis Department of Health and Family Support currently has 83 formal community partnerships and countless informal community relationships. *(Minneapolis Department of Health and Family Support, Annual Report 2002)* This high level of collaboration is largely due to the Department's 1996 change in strategic direction, which has resulted in a hard-won reputation for minimal bureaucracy and maximum personal connection with community leaders and projects over time. The history of these City-community relationships has resulted in trust primarily fostered by the department's motto that *…we need not and should not do what the community can do for itself.* The Department reflects the way that municipal government works. Closer to ground level, the department has developed expertise in relationship building with diverse communities. It has the capacity to bring the community viewpoint to the table in assessing and defining issues, prioritizing investments and designing solutions that reflect the complexity of urban issues and acknowledge the unique needs and skills of its residents. In short, what the Minneapolis public health department has built would take enormous dedication and time to rebuild, should its doors be closed.

The Hennepin County Community Health Department, on the other hand, embodies the core science of public health. It is known throughout the state as a "power house" of solid epidemiological study, which results in implementation of strong data-driven public health policy and strategy. Hennepin County Community Health Department's strategic plans define implementation of the core public health functions of assessment, policy and assurance, and their programs support this direction. In fact, the Minneapolis Department of Health and Family Support as a public health department would likely not be able to continue to do what it does without the County's public health department doing what it does. These two departments represent a synergistic relationship—remove one and the other will weaken—which becomes both an advantage and challenge to the everyday operations of the two departments.

Assessment

Generally, the County focuses on large population health studies done often at a low enough level to inform and guide responses and actions. Larger scale projects often involve partnership with other public health agencies including Minneapolis. The City targets its assessments on key urban issues that have been set forth publicly, e.g. new arrivals or adolescent health services, to gain clearer insights into the underlying factors of key urban health issues. Both departments, individually use locally developed and researched data from others to identify issues, identify best practices and track progress in reducing health problems. Specifically, the Minneapolis Department of Health focuses on evaluation at the community program level.

Policy

Both City and County staff conduct policy analysis and provide information to guide the development of their respective elected leadership's public policy priorities and the differing focus of their interests. Additionally, they work collaboratively on many issues and support each other when the opportunities arise.

Assurance

Both departments help to assure that people have access to health services. The City and the County both have contracts with community providers for sliding fee health services and public health nursing services. In these instances the departments work together on the larger contracts to streamline the bureaucracy by developing consistent reporting requirements and outcome measures. The City and the County also operate clinics that provide direct clinical services. As noted above, the City operates the school clinics in six Minneapolis Public Schools high schools. The County public health department operates the Health Assessment and Promotion clinic and the Red Door clinic. Other parts of Hennepin County provide an enormous amount of direct clinical services, e.g. Hennepin County Medical Center and Pilot City Health Center. In another area of assurance, many City and County departments are working together on making preparations for emergencies; the public health departments are just two members of the collaboration. The police, emergency medical services, firefighters, non-profit organizations and the hospital are among the other partners.

The following table shows the results of a survey of specific programs where there is little overlap between the two departments. The lack of overlap shows the results of previous efforts to assure that the departments do not duplicate services.

Hennepin County public health "Only" activities	Minneapolis public health "Only" Activities
• Assured Care • Baby Tracks • Child and Teen Check Up Outreach Services • Early Childhood Development (Follow Along and 348-TOTS*) • Health Care for the Homeless* • Health Promotion Programs • Immunization Services* • Infectious Disease Surveillance and Control* • Perinatal Hepatitis B • Prevention Coalition Support • Public Health STD/HIV and TB Clinics • Ryan White HIV/AIDS Services • Services to the Elderly and Persons with Disabilities • Vital Records • Women, Infants and Children (WIC)* ** These programs receive some financial support from the City's public health department.*	• American Indian Community Advocate • Community-Assisted Policy Development • Community-Based Research • Healthy Start • Multicultural Services • New Families Center • Public Health Laboratory • School-Based Clinics • Senior Ombudsman • Skyway Senior Center • Tenant/Landlord Services • Weed and Seed
Partnerships between City and County public health departments	**Shared activities between Minneapolis public health and other County departments**
• Emergency Preparedness • Lead – Outreach, Education, Epidemiology • Population Based Research Surveys • TANF Home Visiting • Teen Parent Connection • Way to Grow	• Curfew Truancy Center • Domestic Abuse • Income Tax Services • Lead Abatement

As Hennepin County is in the process of reorganizing its health and human services during panel deliberations, the distinctions between the partnerships with Hennepin County Community Health/Other County departments (lower two quadrants) and the City may be characterized differently in the future.

Relationship Between the State and Local Public Health Agencies

During the Panel's meetings, information was presented about the State's recently revised Community Health Services Act (see Appendix F). The Act was amended in significant ways during the 2003 legislative session, which in turn affects the functions of local public health departments. Two main changes were made. First, the Minnesota Commissioner of Health, in consultation with the State Community Health Advisory Committee, is required to establish statewide outcomes for local public health grant funds allocated to community health boards in five areas: Chronic Disease Prevention and Health Promotion; Communicable Diseases; Environmental Health; Family Health; and Emergency Preparedness. This change reflects a fundamental switch

from viewing Minnesota primarily as a community-based public health system, to a more uniform system of core minimum services with greater attention to outcomes defined at a statewide level. In addition to this change, the many other grants provided to local boards of health were combined into one grant called the Local Public Health Grant. It is important to note that this consolidation of grants also included a 29 percent cut in funds to local boards of health.

In order for all local boards of health in Minnesota to continue receiving Local Public Health Grants from the State Department of Health in 2005 and beyond, local community health boards must establish local public health priorities based on an assessment of community health needs and assets. A mechanism must be established by which the community health board will address these priorities to achieve the required statewide outcomes, all within the limits of available funding.

Public Health Issues and Strategies

Today, the key public health issues facing Minneapolis residents include:

- *Growing at-risk populations that experience health disparities.* With a substantive increase of immigrants and refugees, one in three Minneapolis residents are persons of color or American Indians. These populations experience worse health than their white counterparts on several measures. Subsequently, there is a disproportionate burden of health problems in Minneapolis.

- *Concentrated areas of pervasive and persistent poverty*. One in six Minneapolis residents lives in poverty. Poverty is one of the greatest risk factors for poor health.

- *Student performance lagging behind the statewide average*. The graduation rate of the Minneapolis Public Schools is 43 percent, just a little over half the rate statewide of 78 percent. Well documented research has shown that the more educated person tends to be healthier.

- *Risk of bioterrorism and emerging infectious diseases in densely populated areas.* There is a critical need for overall community planning and preparations for emergencies, as became evident following the September 11 terrorist attacks.

- G*rowing risk of outbreaks of infectious diseases and their effect on vulnerable populations*. Seemingly "resolved" health issues such as tuberculosis have come back to life with new arrivals to Minneapolis. Fifteen percent of Minneapolis residents are foreign-born. Preparation to control highly infectious diseases is critical.

- *Growing number of uninsured people*. One in nine residents lacks health insurance, double that of the state rate.

Promoting health in an urban area is a dynamic process. Every day more health issues come to the public's attention such as the current focus on the obesity epidemic or the long-standing issues of tobacco use. Given what public health professionals now know about the overwhelming impact of social, environment and economic determinants on health status, City residents face a wide variety of interconnected issues that will vary significantly among neighborhoods. A multifaceted community approach, rather than singular focus on particular issues, is necessary: well-being relates to poverty relates to safety relates to jobs relates to housing relates to smoking relates to teen pregnancy relates to family connectedness relates to school performance relates to … and the list goes on. The City and the County must conduct continued and diligent community assessments—and research—to protect citizens' health and provide the greatest opportunities for citizens to improve their own well-being.

Revenue and Expenditures of the Two Departments

The panel was presented with an in depth view of each department's financial structure and key investments.

The 2002 annual budget for the Hennepin County Community Health Department was approximately $60 million. A goodly share, $45 million is spent for people residing in Minneapolis. This is due to the concentration of certain problems within the urban core and because money for services "follows" the person in need of it, most often a person with limited income. Upon further analysis of this $45 million, approximately $32 million is spent on home and community-based services for seniors and persons with disabilities. The remaining approximately $13 million is spent on: disease prevention and control ($7 million), family health ($5 million), health promotion ($620,000), and environmental health ($15,000)(see Appendix E).

The projected annual budget for 2004 for the Minneapolis Department of Health and Family Support is $14 million. Of this, approximately $4 million is spent on clinical and home-based health services, $3 million for early childhood services, $2.5 million for other activities: Policy and Advocacy Division, research, emergency preparedness, contract administration and department overhead. $2.5 million is spent on direct services such as the public health laboratory and the school-based clinics, $1 million for community services: domestic abuse, Legal Aid, Minnesota Aids Project, Immunlink, disease surveillance, etc. The balance of investments includes: $355,000 for senior citizens, $332,000 for health education, $300,000 for school health services, and $205,000 for school age youth(see Appendix D).

To be a viable public health entity, a local unit of government must put up a local match in order to secure state and federal public health dollars that can be allocated to a particular community. Based upon the current formula, Minneapolis qualifies for $3.5 million dollars of federal and state public health dollars. In order to get those funds the City must ante up $2.4 million in local match. In addition, as a qualifying public health agency, the City qualifies for an additional $500,000 in TANF dollars. Another way to look at this would be to say that for each dollar the City contributes, an additional $1.67 comes to Minneapolis residents, or conversely, for every $1.00 that the City investment falls below $2.4 million, it loses $1.67. These resources combined with

Community Development Block Grant funds managed by the Minneapolis Department of Health and Family Support creates the infrastructure that secures an additional $2.5 million in other federal, state and foundation grants, based on competitive grants secured through August 2003. Taken to that level, each dollar brings in $2.61.

Matching funds, leveraging issues and aggressive pursuit of competitive grants aside, a current "level of effort" perspective must also be pursued. It is assumed Hennepin County could meet the necessary match requirement. But the framing question is:

> *If the City of Minneapolis sticks with its present 5-year plan to remove the Department of Health and Family Support from the General Fund will Hennepin County increase its level of effort on behalf of Minneapolis residents in the same amount to compensate for the loss of the City investment in health?*

It is difficult to imagine that Hennepin County would make property tax funds available to replace lost City property tax investments but that would ultimately be decided by the Hennepin County Board of Commissioners. Because of its extensive commitment to a wide range of health programming, Hennepin County would likely be able to meet the state match requirements and earn the state Local Public Health Grant allocations for both Minneapolis and Hennepin County if there was a merger. Both Minneapolis and Hennepin County have a history of seeking out other sources of funds that would be appropriate for public health services.

All local public health agencies sustained major cuts in state funding for 2003 and 2004. The base of the local public health grant was cut 29 percent and as a result both the City and the County have had to make significant adjustments in services, staffing and programming in order to accommodate the reduced resources. In addition, the state is engaged in a process of defining essential public health services that will be expected to be funded by each local agency out of its state grant. This process will require ongoing budget and service discussions between the City and the County.

The Federal Community Development Block Grant dollars, which fund "bricks and mortar" development are given directly to the City. Fifteen percent of these funds may be directed toward non-bricks and mortar public service activities that allow spending on a wide array of supportive health and human services. This percentage represents approximately $2.2 million flowing through the City's health department. If the City's health department were no longer in existence: Would the City lose its capacity to manage those resources effectively? Would the City be likely to transfer these dollars to Hennepin County?

Key points are: 1) An important strategic piece of the health delivery system in Minneapolis would be unraveled should the City health department close its doors; 2) Other funds specifically granted to Minneapolis as a qualifying local public health board would likely be transferred to Hennepin County and beyond the decision making purview of City leaders; 3) Additional resources presently secured on behalf of residents to address specific urban challenges would be in jeopardy; and 4) With cutbacks

pending at the County, the under-investment in the public health infrastructure could be nearing a potential crisis to the health protection of Minneapolis citizens.

It is clear that essential public health services in the City would be significantly compromised by the City's closing the Minneapolis Department.

Organizational Restructuring Affecting Future Public Health Effectiveness

Staff briefed the Panel about current organization changes affecting the two departments that could, in the future, affect public health services. The most significant change in Minneapolis is that the Employment Training program, formerly run by the Minneapolis Department of Health and Family Support has now been moved under the newly created Community Planning and Economic Development department. Although this represented a loss to the Minneapolis Department of Health and Family Support in terms of shared efficiencies (e.g., costs for space and clerical support), it does open a door to develop more integrated strategies and relationships to work with the more abundant and varied resources of the Community Planning and Economic Development department, positively affecting focus on the social and economic determinants of health. This is consistent with the goal of both organizations to participate in partnerships to address disparities and promote strong, healthy families and communities.

The Hennepin County Community Health Department recently moved under the newly re-organized human services department within the County. The new department model will preserve a strong public health identity while using a multi-disciplinary and shared approach to serving clients. The Hennepin County Community Health Department's integration into a larger organization that focuses on issues exacerbated by poverty will provide multiple opportunities to apply public health strategies to social determinants of health.

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APPENDIX D

Minneapolis Department of Health and Family Support: 2003 Investments			
MDHFS Service Contracts	**Description**	**Service Level Description**	**Total Funds**
Health Contracts			
Clinical and Home-Based Health Services			
Neighborhood Healthcare Network	Safety-net medical/dental services to low income/uninsured Minneapolis residents through five community clinics, and central intake through the 489-CARE line.	6,500 medical and dental visits	
Planned Parenthood	Culturally appropriate community education on reproductive health for African American and Latino residents of Minneapolis.	2,000 served	
Public Health Nursing Minnesota Visiting Nurse Agency	Public Health home visiting for low income/high risk uninsured families, including: 1) pregnant and postpartum women and children with complex social problems, 2) developmentally delayed, chronically ill children of adolescent mothers at risk for abuse or neglect, or high lead blood levels, 3) families who are at risk for violence whose parenting is affected by mental illness or impaired cognitive functioning, 4) services to refugees families. TANF and Alliance Home Visits and other services to TANF families, pregnant and parenting teens, and eligible undocumented families.	4,647 clients served in 16,583 visits 1,541 TANF/Alliance visits	
Children's Dental Services	Provides acute and preventive dental services to low income children through 11 Head Start and selected Minneapolis School sites.	900 dental visits	
Maternal & Child Special Projects	Maternal & Child services to low income, uninsured, and high risk families through eight community agencies	5,177 women & children served	
		Clinical and Home-Based Health Services	**$4,333,625**

School Health Services	Description	Service Level Description	Total Funds
MDHFS School Based Clinic Service Contracts	Contracted services: physician, nutritionist, pharmaceuticals, billing, and clinical supervision for social services staff.		
Pilot City Health Center and Teen Age Medical Services	Support for School Based Clinic services at North and Southwest High Schools.		
Minneapolis Public Schools (New Family Center)	Part of a cooperative initiative with Minneapolis Schools, the Children's Defense Fund and the Healthy Learners Board. Funding supports coordination activities surrounding immunizations and health care access. Targeted are new arrivals to Minneapolis, primarily immigrants and refugees.	400 families served 800 children served 2,000 immunizations administered	
		School Health Services	**$296,000**

Health Education	Description	Service Level Description	Total Funds
Health Education Contractual Services	Health promotion, consultation, materials, within context of MDHFS Strategic Directions as determined by MDHFS management team.		
Uptown Community Clinic	Safety-net health services to low income and uninsured Minneapolis residents. Supports nurse for midwife clinic/community and clinic health education.	Service coordination to 80 prenatal clients 1,720 nurse health education visits	
Indian Health Board of Minneapolis	Clinic and community health education services to American Indian residents.	2,500 residents served	
Youth Risk Behavior Projects	Contracts with eight community agencies to reduce sexual behaviors in adolescents that lead to pregnancy, HIV, and sexually transmitted diseases.	3,000 served	
		Health Education	**$332,000**

Early Childhood	Description	Service Level Description	Total Funds
Hennepin County - 348-TOTS	Early identification, screening and outreach to children from birth to three years old. Developmental screening and service coordination for identified high-risk children 0-5 years of age.	500 children aged 0-3 years served	
Minneapolis Public Schools	Outreach and pre-school screening services for 3-5-year-olds for early identification of children needing special education or other services to address developmental delays and other conditions that affect their ability to learn.	430 children screened	
Youth Coordinating Board (Way to Grow-School Readiness)	Promotes school readiness of Minneapolis children by coordinating comprehensive community-based services that support and assist parents in meeting the developmental needs of their children from conception through age six.	509 pregnant women served 1,500 families received school readiness services	
Youth Coordinating Board (Way to Grow-Health)	Public health nursing services for Way to Grow families.	163 identified high-risk pregnant women served 515 children served	
Minnesota Visiting Nurse Agency	Capacity building for day care centers in public health/safety. Provides consultations to Minneapolis day care centers and to legally licensed and legally unlicensed family day care homes to promote safe and healthy childcare environments.	109 centers served 122 family child care homes served 5,200 children affected	
Greater Minneapolis Day Care Association	Loan renovation program. Loans to family day care homes and centers so facilities can meet state childcare guidelines and improve services to children and their families. Coordinated Child Development. Partially subsidized childcare to low and moderate income families.	32 facilities supported 78 families served	
Parents in Community Action/Head Start	Provides full Head Start services for very low income 3-5-year-old children.	15 children served	
Twin Cities Healthy Start	An infant mortality reduction and positive birth outcome project that funds a network of programs throughout Minneapolis and St. Paul targeting at-risk families in the African American and American Indian communities.	300 families served pregnant/parenting mothers and infants	
		Early Childhood	**$2,684,012**

School Age Youth	Description	Service Level Description	Total Funds
Youth Link	HIV prevention, high-risk homeless youth. Provides targeted outreach, education, intervention and counseling services to homeless and sexually exploited youth who are at risk of HIV infection, or who are already infected with HIV.	Direct outreach to 1,200 youth	
Suicide Prevention Project	The development and implementation of a multicultural training of "gatekeepers" for alternative school students to respond to signs of suicidal risk.	Risk assessments of 200 youth	
Curfew Truancy Center/Minneapolis Urban League	A joint powers agreement between the City, County, and Minneapolis Public Schools to provide services through the Urban League.	2800 youth served	
Achieve! Minneapolis (Youth Trust)	Promote, facilitate, implement and evaluate school partnership programming in Minneapolis Public Schools. Manage projects in 15 school/business partnerships that include e-mentoring, workplace tutoring and career portfolios.	15 school partnership projects	
		School Age Youth	**$204,500**

Community Services	Description	Service Level Description	Total Funds
Domestic Abuse Project	Provides intervention and advocacy services to domestic abuse victims, including children. Provides assistance with negotiating the court system and social service networks. Assists with securing and coordinating basic needs services to ensure the safety of the victims.	390 served	
Tubman Family Alliance	Support for victims of domestic violence with emergency shelter and advocacy in court.	107 sheltered	
Legal Aid	Provides legal services related to housing to low income families as well as technical support to the City's housing advocates.	205 served	
Minnesota AIDS Project	Provides outreach and education on HIV prevention and risk reduction behaviors among at risk City residents.	9,500 education contacts	
ImmuLink/Hennepin County	Operational support for the metro-wide Immunization registry.		
Disease Surveillance & Control/Hennepin County	The County provides disease prevention and control services, including surveillance, case investigation and management, and outbreak response.		
Emergency Preparedness/ Hennepin County	In partnership with the City, develop and implement an all hazards public health emergency plan.		
Weed & Seed	Provides crime prevention and community enhancement services in the Phillips and Northside communities.		
		Community Services	**$1,251,000**

Senior Citizens	Description	Service Level Description	Total Funds
Minnesota Visiting Nurse Agency (MVNA)	Provides home health care and therapeutic services for low-income, uninsured, and high risk seniors age 60 and over.	845 clients served 25,899 visits	
Neighborhood Health Care Network	Primary medical and dental services to low income seniors.	250 clinic visits	
Pilot City Neighborhood Services and Greater Minneapolis Council of Churches	Provide chore services to low income seniors.	300 seniors served	
Volunteers of America	Provide chore, homemaking, transportation, and legal services to low income seniors to help them remain in their homes and maintain independent living.	550 seniors served	
Block Nurse Programs: S.E. Seniors, Nokomis Healthy Seniors, Longfellow/Seward	Provides home health services, health education and consultation, to assist seniors in staying in their own homes and maintaining independence.	356 seniors served	
		Senior Citizens	**$354,000**

TOTAL: Service Contracts - MDHFS	**$9,455,137**

MDHFS In-House Operations			
Direct Services	**Description**	**Service Level Description**	**Total Funds**
School Based Clinics	Salary/fringe benefits for staff and non-contractual operations support for six safety-net clinics for adolescents. Clinics provide family planning, sports physicals, health care screening/referral and social services to Minneapolis students. 20 FTE	2,000 youth served (All clinics and all funding sources)	
Multi-Cultural Services	Makes services offered by the City of Minneapolis accessible to residents who speak limited English. This includes bilingual assistance for Latino and Somali residents with City-related issues. Works with City departments on cultural competency issues and to streamline City services and processes to improve accessibility. Develops and maintains positive working relationships with immigrant and refugee community-based organizations. 4 FTE	3,310 direct client encounters Serve all City departments Strengthen City's community outreach capacity	
Senior Ombudsman	Salary/fringe benefits for 2 FTE and operations for Senior Ombudsman Office: Includes constituent services, social work interventions, management of income tax preparation service for low-income and senior residents. Oversight of Skyway Senior Center. Staffs Senior Citizen Advisory Committee and Minneapolis Advisory Committee on People with Disabilities. 3 FTE	7,000 senior contacts 8,500 residents assisted with taxes 18,000 visits per year 2,200 volunteer hours 4,500 program and class attendees	
New Family Center	The New Family Center provides services to families with language and cultural barriers who have students enrolling in the Minneapolis Public Schools. These services include immunizations, assistance with accessing health insurance, and referral for health and other social services as needed by the families. 4 FTE	400 families served 800 children served 2,000 immunizations administered	

Direct Services	Description	Service Level Description	Total Funds
Public Health Laboratory	7.5 FTE lab staff and operations budget to perform clinical, environmental and chemical (e.g. medical, lead, food and drug testing for law enforcement) laboratory testing to support City departments, and maintain City public health capacity.	Recover 80-90% of general fund investment through revenue	
		Direct Services	**$2,673,039**

MDHFS Other In-House Activities			
Direct Services	Description	Service Level Description	Total Funds
Community Initiatives	Share of operating costs for Community Initiatives Division: supplies, transportation, and staff development. Contractual and consultant services for special projects. Includes Housing Advocates, American Indian Advocate, Skyway Senior Center and Weed & Seed staff. 6 FTE		
Policy & Advocacy	Provision of the core public health function of Policy & Advocacy, with division costs for personnel and other expenses. 5.75 FTE		
Research	Provision of the core public health function of assessment, including research, reporting, and project evaluation. 6.0 FTE		
Special Projects	Operating costs for the Public Health Initiatives division, including personnel costs, supplies, and other expenses. Includes in-house expenses for TANF, Emergency Preparedness, and Healthy Start. 4 FTE		
Contract Administration/Assurance	Provision of the core public health function of assurance, including contract management and public health compliance activities, as well as accounting services. 4.5 FTE		
		Other In-House Activities	**$2,750,140**

SUMMARY OF MDHFS INVESTMENTS	
Total MDHFS: Service Contracts	**$9,455,137**
Total MDHFS: Direct Services	**$2,673,039**
Total MDHFS: Other In-House Activities	**$2,750,140**
TOTAL: MDHFS 2003 Investments	**$14,878,316**

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APPENDIX E

PUBLIC HEALTH SERVICES PROVIDED TO MINNEAPOLIS RESIDENTS BY HENNEPIN COUNTY COMMUNITY HEALTH DEPARTMENT 2002

Service / Program	Percent of County's Program Provided to Mpls Residents (Approximate)	Total Program Costs for Services Provided to Mpls Residents in 2002 (Approximate)	MDHFS Funding Toward Program Costs in 2002 (Approximate)
FAMILY HEALTH			
348-TOTS	100%	$344,300	$113,000
Assured Care	66%	$80,400	0
Child and Teen Check-ups	59%	$700,800	0
Community Clinics (Medical and Dental Services • Nutrition Services (Simply Good Eating) • Indian Health Grant (IHB and CUHCC) • Children's Dental (Children's Dental Services) • Medical Services (CRPC, CUHCC, FCHS, HIS, NIP, SCHS) • Adolescent Health (TAMS, Annex, WSTC) • Teen Pregnancy Prevention (MCH-SP Grants)	63%	$780,000	0
Family Contracts (domestic violence prevention)	53%	$457,800	0
Family Home Visiting (TANF funding)	56%	$691,500	0
Family Planning Services	34%	$9,800	0
Follow-Along	60%	$56,800	0
Public Health Nursing (MWNA)	70%	$285,900	0
School Nutrition	66%	$19,700	0
Way to Grow	100%	$260,000	0
WCH Administration	34%	$193,300	0
WIC	66%	$1,515,500	
Subtotal		**$5,395,800**	**$113,000**
HOME HEALTH			
Home and community-based services for seniors and persons with disabilities	49%	$32,667,000	0
ENVIRONMENTAL HEALTH			
Children's Environmental Health	25%	$15,000	0
Licensing and inspection of food, beverage, lodging, body art, swimming pools and camps	0%	0	0
Subtotal		**$15,000**	**$0**

DISEASE PREVENTION AND CONTROL			
Baby Tracks (Immunization tracking and intervention for children from birth-24 months of age)	84%	$273,000	0
Epidemiology Infectious Disease Surveillance and Control	40%	$124,600	$100,000
Health Care for the Homeless	100%	$1,109,600	$88,800
HIV Prevention Services	70%	$203,000	0
Immunization Registry	26% of total 47% Hennepin County Records	$252,600	$150,000
Perinatal Hepatitis B Control	49%	$48,800	0
Prevention, Diagnosis, Treatment and Control for Sexually Transmitted Infection	70%	$1,127,500	0
Public Health Emergency Preparedness	40%	$406,000	$257,300
Public Health Nuisances	0%	0	0
Public Immunization Clinics	57%	$94,100	0
Refugee Health Screening (Infectious disease control)	38%	$150,000	0
Ryan White HIV/AIDS Services (Title I & II)	50%	$2,139,000	
Tuberculosis Prevention, Diagnosis, Treatment and Control	63%	$1,071,000	0
Subtotal		**$6,999,200**	**$596,100**

HEALTH PROMOTION			
North Minneapolis Health Advisory Committee	100%	$75,000	0
Parent Messages Campaign	70%	$105,000	0
Rainbow Terrace & Parker Skyview “5 A Day” Project	100%	$40,000	0
School Health Promotion	30%	$200,000	0
Step To It Northside	100%	$25,000	0
Worksite Health Promotion	40%	$175,000	0
Subtotal		**$620,000**	**$0**

GRAND TOTAL		**$45,697,000**	**$709,100**

APPENDIX F

"REGULATORY ANALYSIS OF MINNESOTA'S LAWS REGARDING LOCAL PUBLIC HEALTH"

Establishing Local Public Health Boards

The governing body of a city or county is responsible for acting as a board of health, or it may establish a board of health and assign the powers and duties of a board of health to that newly established board. Minn. Stat. § 145A.03, subd. 1(a) (2002). Along the same lines, a city council may ask a county or joint power board of health to act as the board of health for the city's jurisdiction. Minn. Stat. § 145A.03, subd. 1(b) (2002). However, a county board or city council may not form a board of health if there is already a community health board operating within the jurisdiction of that county board or city council, unless there is a joint powers agreement or delegation agreement in place between the parties. Minn. Stat. § 145A.03, subd. 1(c) (2002).

Cities and/or counties may join together to form joint powers boards of health. For example, a county may establish a joint board of health by agreement with one or more contiguous counties, or a city may establish a joint board of health with one or more contiguous cities in the same county, or a city may establish a joint board of health with the county or counties within which it is located. The agreements must be established according to the requirements outlined in Minnesota Statutes § 471.59, which pertains to joint exercise of power between multiple governmental units. Minn. Stat. § 145A.03, subd. 2 (2002).

Once a city or county forms a board of health, that board of health must have at least five members, one of whom must be elected by the members as chair and one as vice-chair. The chair, or in the chair's absence, the vice-chair, must preside at meetings of the board of health and sign or authorize an agent to sign contracts and other documents requiring signature on behalf of the board of health. Minn. Stat. § 145A.03, subd. 4 (2002). In addition, a board of health must hold meetings at least twice a year and as determined by its rules of procedure. The board must adopt written procedures for transacting business and must keep a public record of its transactions, findings, and determinations. Members may receive a per diem plus travel and other eligible expenses while engaged in official duties. Minn. Stat. § 145A.03, subd. 5 (2002).

After establishing a joint powers board of heath, a county or city may withdraw from the joint powers board of health by resolution of its governing body not less than one year after the effective date of the initial joint powers agreement. The withdrawing county or city must notify the Commissioner and the other parties to the agreement at least one year before the beginning of the calendar year in which withdrawal takes effect. Minn. Stat. § 145A.03, subd. 3 (2002).

Powers and Duties of Board of Health

A county or multi-county board of health has the powers and duties of a board of health for all territory within its jurisdiction that is not under the jurisdiction of a city board of health. Under the general supervision of the Commissioner, the board of heath shall enforce laws, regulations, and ordinances relating to its powers and duties as a board of health within its jurisdictional area. Minn. Stat. § 145A.04, subd. 1 (2002).

According to state law, a board of health **must** engage in the following activities:

- Appoint, employ, or contract with a person or persons to act on its behalf. The board shall notify the Commissioner of the agent's name, address, and phone number where the agent may be reached between board meetings and submit a copy of the resolution authorizing the agent to act on the board's behalf.
- Make investigations and reports and obey instructions on the control of communicable diseases as the Commissioner may direct under section 144.12, 145A.06, subdivision 2, or 145A.07. Boards of health must cooperate so far as practicable to act together to prevent and control epidemic diseases.
- Participate in the removal and abatement of public health nuisances. For example, if a threat to the public health such as a public health nuisance, source of filth, or cause of sickness is found on any property, the board of health or its agent shall order the owner or occupant of the property to remove or abate the threat within a time specified in the notice but not longer than ten days.

Minn. Stat. § 145A.04 (2002).

According to state law, a board of health **may** participate in the following activities:

- Establish a health department or other administrative agency and may employ persons as necessary to carry out its duties.[1]
- Acquire and hold in the name of the county or city the lands, buildings, and equipment necessary for the purposes of carrying out its responsibilities and duties, by any lawful means, including gifts, purchase, lease, or transfer of custodial control.
- Accept gifts, grants, and subsidies from any lawful source, apply for and accept state and federal funds, and request and accept local tax funds.
- Establish and collect reasonable fees for performing its duties and providing community health services.[2]

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[1] Except where prohibited by law, employees of the board of health may act as its agents. Employees of the board of health are subject to any personnel administration rules adopted by a city council or county board forming the board of health unless the employees of the board are within the scope of a statewide personnel administration system. The board of health may appoint, employ, or contract with a medical consultant to receive appropriate medical advice and direction. Minn. Stat. § 145A.04, subd. 3 (2002).

[2] With the exception of licensing and inspection activities, access to community health services provided by or on contract with the board of health must not be denied to an individual or family because of inability to pay. Minn. Stat. § 145A.04, subd. 4 (2002).

- Contract to provide, receive, or ensure provision of services, in order to improve efficiency, quality, and effectiveness, avoid unnecessary duplication, and gain cost advantages.
- Enter a building, conveyance, or place where contagion, infection, filth, or other source or cause of preventable disease exists or is reasonably suspected, to enforce public health laws, ordinances or rules.
- Bring an action in the court of appropriate jurisdiction to enjoin a violation of statute, rule, or ordinance that the board has power to enforce, or to enjoin as a public health nuisance any activity or failure to act that adversely affects the public health.

Minn. Stat. § 145A.04 (2002).

Powers of a County Board

A county board, which is defined as a county board of Commissioners, may adopt ordinances for all or a part of its jurisdiction to regulate actual or potential threats to the public health, unless the ordinances are preempted by, in conflict with, or less restrictive than standards in state law or rule. A county board may also adopt ordinances to address the following types of public health concerns:

• Animal control	• Regulation of offensive trade[3]
• Control of unwholesome substances	• Control of public health nuisances
• Waste regulation	• Curfew
• Water regulation	• Enforcement of powers delegated by the Commissioner

Minn. Stat. § 145A.05 (2002).

Duties of the Commissioner of Health

The Commissioner of Health has the power to supervise local enforcement. In the absence of provision for a board of health, the Commissioner may appoint three or more persons to act as a board until one is established. The Commissioner may fix their compensation, which the county or city must pay. The Commissioner by written order may require any two or more boards of health to act together to prevent or control epidemic diseases. If a board fails to comply with section 145A.04, subd. 6, the Commissioner may employ medical and other help necessary to control communicable disease at the expense of the board of health involved. If the Commissioner has reason to believe that the provisions of this chapter have been violated, the Commissioner shall inform the attorney general and submit information to support the belief. The attorney general shall institute proceedings to enforce the provisions of this chapter or shall

[3] Offensive trades are defined as a trade or employment that is hurtful to inhabitants within any county, city or town, dangerous to public health, injurious to neighboring property, or from which offensive odors arise.

direct the county attorney to institute proceedings. Minn. Stat. § 145A.06, subd. 2 (2002).

The Commissioner is responsible for helping and advising local boards of health that ask for the Commissioner's assistance in developing, administering, and carrying out public health services and programs. Minn. Stat. § 145A.06, subd. 4 (2002).

The Commissioner of Health may enter into an agreement with any board of health to delegate all or part of the licensing, inspection, reporting and enforcement duties authorized under certain provisions of state law. Similarly, a board of health may authorize a township board, city council, or county board within its jurisdiction to establish a board of health and delegate to the board of health by agreement its powers or duties. Such agreements to delegate powers and duties of a board of health must be approved by the Commissioner and must contain the required terms outlined in Minn. Stat. § 145A.07, subd. 3 (2002).

Establishing Community Health Boards

The general purpose of establishing community health boards is to develop and maintain an integrated system of community health services under local administration and within a system of state guidelines and standards. Minn. Stat. § 145A.09, subd. 1 (2002). In order to be eligible to form a community health board, a board of health must include within its jurisdiction a population of 30,000 or more persons or be composed of three or more contiguous counties. Minn. Stat. § 145A.09, subd. 3 (2002).

Community health boards are eligible for a community health subsidy. Minn. Stat. § 145A.09, subd. 2 (2002). A city that received a community health services subsidy and that meets the requirements of a community health board is eligible for a community health subsidy. Minn. Stat. § 145A.09, subd. 4 (2002). A new state law explains the funding formula for community health boards, as well as the local match procedure for such local public health grants. Minn. Stat. § 145A.131 (2003).

Similarly, a county board or a joint powers board of health that establishes a community health board and has or establishes an operational human services board under the Minnesota laws pertaining to human services (Minnesota Statutes Chapter 402) must assign the powers and duties of a community health board to the human services board. Minn. Stat. § 145A.09, subd. 5 (2002).

Advisory Committees

Minnesota established a state community health advisory committee to advise, consult with, and make recommendations to the Commissioner on the development, maintenance, funding, and evaluation of community health services. Each community health board may appoint a member to serve on the committee. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. Members or their alternates may reimbursed for travel and

other necessary expenses while engaged in their official duties. Minn. Stat. § 145A.10, subd. 10(a) (2002).

The city councils or county boards that have established or are members of a community health board may appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board. Minn. Stat. § 145A.10, subd. 10(b) (2002).

Community Health Boards Powers and Duties

A community health board has the powers and duties of a board of health, as well as the general responsibility for development and maintenance of an integrated system of community health services. Minn. Stat. § 145A.10, subd. 1 (2002).

Minnesota law requires a community health board to participate in the following activities:

- Appoint, employ, or contract with a medical consultant to ensure appropriate medical advice and direction for the board of health and assist the board and its staff in the coordination of community health services with local medical care and other health services.
- Ensure that community health services are accessible to all persons on the basis of need. No one shall be denied services because of race, color, sex, age, language, religion, nationality, inability to pay, political persuasion, or place of residence.

Minn. Stat. § 145A.10 (2002).

In addition, community health boards must establish local public health priorities based on an assessment of community health needs and assets; and determine the mechanism by which the community health board will address the local public health priorities established and achieve the statewide outcomes established, within the limits of available funding. The community health board shall seek public input or consider the recommendations of the community health advisory committee and the certain essential public health services. Minn. Stat. § 145A.10, subd. 5(a) (2002).

By February 1, 2005, and every five years thereafter, each community health board that receives a local public health grant shall notify the Commissioner in writing of the statewide outcomes established that the board will address and the established local priorities that the board will address. Minn. Stat. § 145A.10, subd. 5(a) (2002).

Finally, each community health board receiving a local public health grant must submit an annual report to the Commissioner documenting progress toward the achievement of statewide outcomes and the established local public health priorities, suing reporting standards and procedures established by the Commissioner. Minn. Stat. § 145A.10, subd. 5(a) (2002).

Minnesota law provides that a community health board may, at its discretion, recommend local ordinances pertaining to community health services to any county board or city council within its jurisdiction and advise the Commissioner on matters relating to public health that require assistance from the state, or that may be of more than local interest.

Powers and Duties of City and County Relative to Subsidies

In addition to the powers and duties described above, a city council or county board that has formed or is a member of a community health board has the following additional the powers and duties:

- In levying authorized taxes, a city council or county board that has formed or is a member of a community health board must consider the income and expenditures required to meet the objectives of the local public health priorities and statewide outcomes for its area.
- A city council or county board may by ordinance adopt and enforce minimum standards for services provided, as long as such ordinance does not conflict with state law or with more stringent standards established either by rule of an agency of state government or by the provisions of the charter or ordinances of any city.

Minn. Stat. § 145A.11 (2002).

Powers and Duties of the Commissioner of Health to Subsidies

The Commissioner must assist community health boards in the development, administration, and implementation of community health services. This assistance may consist of but is not limited to: (1) informational resources, consultation, and training to help community health boards plan, develop, integrate, provide and evaluate community health services; and (2) administrative and program guidelines and standards, developed with the advice of the state community health advisory committee. Minn. Stat. § 145A.12, subd. 1 (2002).

The Commissioner, in consultation with the State Community Health Advisory Committee, shall establish statewide outcomes for local public health grant funds allocated to community health boards between January 1, 2004 and December 31, 2005. Minn. Stat. § 145A.12, subd. 7 (2003). At least one statewide outcome must be established in each of the following public health areas:

- Preventing disease;
- Protecting against environmental hazards;
- Preventing injuries;
- Promoting health behavior;
- Responding to disasters; and,
- Ensuring access to health services.

Minn. Stat. § 145A.12, subd. 7(b) (2003).

By December 31, 2004, and every five years thereafter, the Commissioner, in consultation with the State Community Heath Advisory Committee, and the Maternal and Child Health Advisory Task Force, shall develop statewide outcomes for the local public health grant based on state and local assessment data regarding the health of Minnesota residents, the essential public health services and current Minnesota public health goals. Minn. Stat. § 145A.12, subd. 7(e) (2003).

Until January 1, 2004, the Commissioner of Health shall distribute a subsidy for the operations of community health boards organized and operating under Minnesota law. The formula for such subsidies is described in detail by statute. Minn. Stat. § 145A.13, subd. 1 (2002). Until January 1, 2004, each community health board that receives a subsidy shall provide local matching money equal to that subsidy during the year for which the subsidy is made, subject to certain provisions. Minn. Stat. § 145A.13, subd. 2 (2002).

Grants

The Local Public Health Act allows the Commissioner of Health to make special grants, such as migrant health grants, and Indian health grants, to cities, counties, groups of cities or counties, or nonprofit corporations to establish operated or subsidize clinic facilities and services. Minn. Stat. § 145A.14 (2002). In addition, the community health board may establish a community-based health promotion team made up of certain community representatives. Minn. Stat. § 145A.14 (2002).

The Act also includes provisions to establish and expand a variety of home visiting programs designed to prevent child abuse and neglect, and reduce juvenile delinquency by promoting positive parents, resiliency in children and a healthy beginning for children by providing early intervention services of families in need. Minn. Stat. §§ 145A.15 through 145A.17 (2002).

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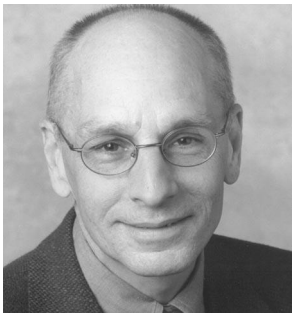
About The Authors



Michael Scandrett, J.D. has been a trusted advisor and policy analyst for Minnesota's health care leaders and policy makers for 25 years. He was an influential force in the formation of nearly all of Minnesota's major public policies and reforms in health care, from managed care regulation to the MinnesotaCare program for the uninsured, from health care quality measurement to long-term care reimbursement policies. On the private side, he has helped organizations and coalitions launch successful, innovative programs in such challenging and unwieldy areas as community-wide quality measurement, managed care for persons with disabilities, and violence prevention. Both attorney and consultant, he is often called upon to bring his critical thinking to bear on complex legal, policy, and regulatory challenges to help fashion solutions that are both politically acceptable and administratively feasible, but which also produce measurable results. Michael received his law degree from the University of Minnesota Law School.

Deanna Mills, M.P.H. is an expert in community health, and has over 25 years' experience in building coalitions based on a broad and inclusive concept of community health to address complex health and social problems. Most recently in July of 2003, the Business Journal acknowledged Deanna as one of "25 Women Change Makers." Her passion has become reality through such projects as the Healthy Learners Board, which collaborates to give disadvantaged children the extra help they need to begin the school day alert and ready to learn. As an adjunct faculty member at the University of Minnesota, her involvement in the Community Health Intersection Program placed her at the keynote's podium in Hong Kong and again in Budapest, reporting the program's progress and successes. As Executive Director of Fremont Community Health Services, she directed all aspects of a multi-million dollar nonprofit community health center for low-income patients. She received her Master of Public Health degree from the University of Minnesota.

Contact Information:
Halleland Health Consulting
600 Pillsbury Center South
220 South Sixth Street
Minneapolis, MN 55402-4501
www.halleland.com
612/338-1838

Deanna's direct contact information: dmills@halleland.com or 612/204-4106
Michael's direct contract information: mscandrett@halleland.com or 612/573-2923

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