

Streamlining Grant Funding for Minnesota's Public Health System



**A report of the State Community Health Services Advisory Committee
Streamline Grants Administration Work Group**

December 2000

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Streamline Grants Administration Work Group Background and Membership

Charge

The work group was charged to:

Explore and recommend methods to achieve maximum efficiency and flexibility in Minnesota Department of Health (MDH) grants to Community Health Boards (CHBs) while assuring that all administrative requirements are met and the MDH has the information it needs to demonstrate state-level accountability and continuous quality improvement. This may include:

- reviewing existing grant programs and administrative requirements;
- looking at alternative administrative approaches, including a review of models from other states;
- recommending administrative and policy changes to streamline the process of awarding and monitoring grants to CHBs, consistent with the MDH vision and guiding principles for funding public health activities;
- identifying longer-range strategies to ensure adequate, stable funding for CHBs for public health activities; and
- recommending other efforts to carry out these strategies.

Process

The work group met five times to define problems with the current grant processes and seek solutions to the identified problems. The work group divided their charge into three categories – financing the community health services (CHS) system, administrative streamlining, and improving accountability.

Work group members agreed that immediate efficiencies could be achieved by streamlining the administrative requirements of grants, but to attain real reform there must be changes in the way the CHS system is funded and held accountable for outcomes. Therefore, the work group proposed an advocacy plan to inform policymakers about the impact of their funding decisions. Work group members agreed that administrative streamlining and advocacy efforts should begin in parallel, with the understanding that some recommendations will be implemented more quickly than others. The work group also agreed that improving the grant process would require ongoing discussions between local staff, state staff, and elected officials.

In June of 2000, the work group forwarded preliminary recommendations to the Commissioner of Health to be considered during the development of MDH budget priorities for the upcoming legislative session. Those recommendations presented a philosophical background for effectively financing the CHS system and are incorporated into this final report. In subsequent meetings, the work group developed and prioritized ideas for administrative simplification of the grant process and began discussions about improving accountability for grant funds.

Membership

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Cindy Borgen
Ryan Church
Gayle Hallin
Diane Loeffler
Pati Maier
Mary Manning
Dean Massett
Brenda Menier
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Anoka County CHB
MDH - Tobacco Prevention and Control Section
MDH - Community Health Services Division
MDH - Commissioner's Office
Hennepin County CHB
MDH - Family Health Division
MDH - Disease Prevention and Control Division
Goodhue County CHB
Polk County CHB
Wright County CHB
Carlton-Cook-Lake-St. Louis CHB
MDH - Family Health Division
MDH - Community Health Services Division
Kandiyohi County CHB
Kanabec-Pine CHB
Olmsted County CHB
Clay-Wilkin CHB

Staff

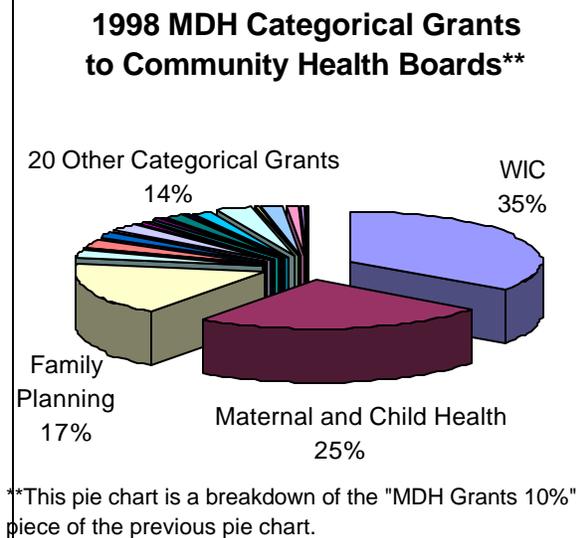
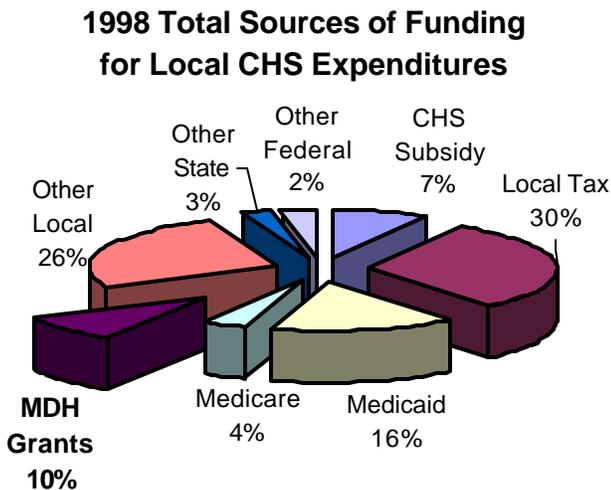
Julie Ring

MDH - Community Health Services Division

Current Grant Funding: What Is the Problem?

Fragmented Funding

Minnesota's local CHS system is funded by a patchwork of local, state, and federal funds. Many sources of relatively flexible funding have eroded and more narrowly focused, competitive grants have proliferated in recent years, further exacerbating the fragmented funding structure for local CHS activities. During the last decade, the percentage of categorical grant dollars provided to local CHBs from the MDH has remained fairly stable at ten percent of total expenditures. However, the *number* of grants that make up that ten percent has increased significantly during that same time period. Thus, categorical grant funding as a proportion of total local public health expenditures has remained steady, but the amount of work related to applying for and administering these grants has increased, and funding is less stable overall. (See Appendix A for a list of MDH grants to CHBs.)



There are a number of explanations for this shift from flexible to categorical funding, including:

- Local tax support, the most flexible source of funding for CHBs, has eroded in many parts of the state as mandated programs in other areas of county government (e.g., jail construction, correctional health, out-of-home placement) have consumed more and more local tax dollars. Conversely, in some parts of

the state, county boards may have been willing to provide additional funding for CHS activities, but they have been unable to raise additional funds due to local tax levy limits. Levy limits have recently expired, but it is too soon to determine what impact this will have on local tax funding for CHS activities.

- The MDH has proposed narrowly categorical grant programs to address specific health concerns. In many cases, state budget constraints did not provide the level of funding that would allow grant programs to be implemented statewide, so demonstration or pilot projects were funded on a competitive basis. The hope was that the demonstration project would succeed and lead to additional funding to implement the program statewide. Unfortunately, this rarely happened.
- Congress and the Minnesota Legislature have often funded *competitive* grants instead of formula-based block grants because of the same budgetary pressures. Legislators and congressional representatives have initiated competitive grant programs when they felt it would be impossible to secure adequate funds for a statewide or nationwide program. There is also a belief by funders that a competitive process allows the best projects to “rise to the top” and get funded. In recent years, this practice has been further influenced by a belief that local governments may not be the most effective delivery system for some grant programs. This has increased the number of grant programs in which CHBs have to compete against their local partners (i.e., non-profits, collaboratives) for grant dollars.
- Congress and the Minnesota Legislature have preferred to fund *categorical* grant programs rather than block grants with the belief that specific issues brought before them would be “lost” in block grants. This method of funding allows elected officials to track issues in which they have specific interest, but makes it difficult for CHBs to target funding to locally identified needs.

The result of this patchwork of funding is that locally identified needs go unfunded as local agencies “follow the dollars” and focus on those activities that can be funded through available grants. Short-term, competitive grants also foster an unstable funding base for public health efforts, forcing local agencies to develop programs knowing that there may be no funding for those programs in coming years.

Administrative Inefficiency

A significant result of fragmented public health funding is that an increasing amount of time is spent on administration of programs rather than on actual program activities. Each grant program has its own application, program development and reporting requirements, which complicates grant management for CHBs.

The fragmented funding structure lends itself to the development of a wide variety of grant program requirements. These requirements come from numerous sources, including federal or state legislation, federal or state agency interpretation of legislation, federal and state grant management policies and local agency policies. When each grant must be managed in a slightly different way due to these varying requirements, the amount of time spent on administrative activities becomes unduly burdensome.

Unstable grant funding also creates complexity in staff management, as many staff positions are hired on a short-term, part time, or contract basis. In addition to creating an administrative burden, this instability makes it

difficult to recruit qualified staff, because potential staff are hesitant to accept grant-funded positions that may expire after a short time. Also, because grants are often small, single staff positions are funded by numerous grants. For example, one maternal and child health staff might be funded through as many as seven grants, including maternal and child health special projects (MCHSP), targeted home visiting, family planning special project, prenatal substance abuse prevention project, child and teen checkup outreach, follow along program, and universal home visiting. In addition, these grant funds are often supplemented by a variety of local funds. This requires program staff, as well as agency administrative staff, to understand the intricacies of individual funding sources so that activities are billed to the appropriate grant program.

Outdated Accountability Measures

Traditional accountability measures for grants have been based on detailed financial and program reporting. These reports tend to focus on how dollars are spent rather than the outcomes achieved. Collection of this type of data is uncoordinated throughout the MDH, therefore numerous grant programs may be asking for the same information in slightly different ways. Furthermore, many grant programs are still collecting data that is “nice to know” but not required for the evaluation of the grantee’s performance.

Perhaps most importantly, the public and elected officials have begun to ask what outcomes grant programs produce, but very few programs include performance or outcome measures. As the CHS system attempts to convince policymakers to move toward more flexible funding, being able to show the results of grant programs will become even more important. However, performance measurement in public health is a complex endeavor for several reasons. First, grant programs are often designed to change behavior to affect health status outcomes, and health status outcomes may not be seen for many years. Second, because of the numerous factors that affect behavior, it is difficult to draw a direct line between grant activities and outcomes. Finally, success in public health often means the *prevention* of a disease or behavior and it is difficult to measure the absence of disease or behavior.

Future Grant Funding: Effectively Financing Minnesota's CHS System

Current Reform Efforts

Despite the shift toward competitive and narrowly-focused categorical grants, public health organizations recognize that these mechanisms do not produce the best public health programs. This section outlines a variety of advocacy and reform efforts underway at all levels of government.

Effective Financing

A number of groups have lobbied the federal government to streamline its funding processes. The Public Health Leadership Society Think Tank has recommended that the Health Research and Services Administration streamline the way it provides grant funding to state health departments.¹ In Minnesota this would impact the way that the state provides a number of grant programs to local entities. In addition, the National Association of County and City Health Officials has long supported streamlining federal grants, as evidenced as far back as their 1991 Resolution 91-05 calling for better coordination of federal grants with local needs.

In October of 2000, Congress unanimously passed the "Public Health Threats and Emergencies Act of 2000." This federal legislation includes the first-ever authorization of new federal funding designated for public health *infrastructure*, rather than specific categorical programs. However, appropriations are not yet attached to this legislation.

Within Minnesota, the Local Public Health Association (LPHA) has long advocated for the streamlining of state grants to local agencies. This issue has been highlighted for several years in the LPHA legislative platform.

In 1997, the MDH developed the report *MDH Vision for Funding Public Health Activities* (see Appendix B) to guide MDH staff in developing new grant programs. This report highlights the MDH's commitment to pursue "stable and discretionary funding to maintain a strong and stable public health system."² MDH staff used this report, along with initial recommendations from this work group, in developing budget proposals for the 2001-2002 biennial budget.

Tax reform is expected to be a major issue during the 2001 Minnesota legislative session. It is unclear what shape this issue will take, but changes in local tax capacity may impact the availability of local funds for local public health activities.

¹Public Health Leadership Society Think Tank, Center for Health Leadership, Public Health Institute, "Eliminating Health Disparities: A Practice Based Review," October 1999, p. 11.

²*MDH Vision for Funding Public Health Activities*, Minnesota Department of Health, 1997, p. 3.

Administration Simplification

The Governor's State Agencies Focused on Effectiveness (SAFE) Council created a subcommittee of state agency staff to review grant processes used by Minnesota state agencies. The subcommittee goals included the following:

- streamlined application, administrative, and reporting requirements;
- uniform application (or set) for similar programs;
- expanded use of electronic applications and reporting; and
- demonstrated interagency coordination in application and reporting requirements.

The subcommittee developed a list of recommendations for streamlining processes across state agencies. However, the MDH already employs most of the recommended processes, so this project will have less impact on grants from the MDH than on grants from other state agencies.

The preliminary advice of this work group has already sparked administrative changes in the MDH's grant process. For example, the MDH has attempted to centrally collect items from CHBs such as signature resolutions and other legal documentation to assure that local staff are not asked to submit this information for each individual MDH grant. The MDH grant managers' group has also begun standardizing requests for proposals (RFPs) and applications.

Improved Accountability

The MDH has attempted to improve accountability measures related to grant funds. The agency has focused its efforts in two areas – outcome measurement and data coordination.

A highly visible outcome measure was initiated in the tobacco endowment legislation in 2000. The legislation authorizing the new tobacco grants and youth risk behavior grants requires a thirty percent reduction in teen smoking rates in five years. This rate is based on the *Minnesota Public Health Improvement Goals*. The MDH and CHBs will partner to achieve this outcome by implementing appropriate programs at each level of government. The grants allocated to local agencies include outcome measures designed to lead to a thirty percent statewide reduction of teen smoking. While each CHB is not individually responsible for the thirty percent reduction as part of its grant contract, there is a sense of shared accountability to achieve this outcome.

Other MDH grant programs also include outcome measures, although they are usually limited to achieving certain levels of service, rather than the improved health status that is expected to accompany those services. For example, the Women, Infants and Children (WIC) grant funding is largely driven by the local agency's ability to meet caseload goals.

The CHS system has long relied upon population health data to track the impact of programs on health outcomes and to target programs to populations with the most need. For two consecutive legislative sessions the MDH proposed, and LPHA endorsed, the creation of a "state/local public health information system." This system would coordinate public health data from across the state and across the MDH to facilitate the better

use of data in designing and evaluating programs. Despite the fact that this proposal was not funded, state and local officials continue to work together to achieve the goals set out in the initiative.

The CHS annual reporting system, created more than ten years ago, currently collects data about activities and expenditures of CHBs as outlined in Minnesota Rule 4736.0090. This system has the potential to serve as a foundation for more coordinated data collection, but in its current form is inadequate, both in content and technologically. The system has the potential to serve as a basic method of accountability for the CHS system, but it must first be updated to focus on current public health activities and expenditures. It could then evolve to integrate the collection of outcome measures related to local CHS plans.

Principles for Effective Financing

Effectively financing Minnesota's CHS system requires a combination of factors including implementing appropriate funding mechanisms, easing administrative requirements, and improving accountability measures.

The work group developed the following principles to serve as the foundation for its recommendations. These principles support the *MDH Vision for Funding Public Health Activities* developed in 1997. They are the following:

1. *Financing the CHS system requires a mix of funding, including:*
 - *stable, ongoing funding for basic operations and locally identified priorities;*
 - *stable, ongoing funding to address broad program areas; and*
 - *discrete funding to address specific needs and to explore innovative ideas.*
2. *All of these types of funding must be coordinated so that outcomes are emphasized and the CHS system is efficiently run and adequately financed over the long term.*
3. *Accountability for funds is necessary to ensure the overall effectiveness of the CHS system in meeting the goals of funders.*

Recommendations

The work group developed recommendations to address three topic areas – effective financing, administrative simplification, and improved accountability. The work group recommends that work begin on all of these recommendations immediately, but understands that some of the recommendations will take longer to implement than others. Wherever possible, the work group included time lines within each recommendation. Where specific time lines are not included, the work group recommends that the Commissioner work with partners in LPHA and the State CHS Advisory Committee to develop specific work plans.

The work group anticipates that most of the financing recommendations will involve multi-year efforts, because they require a shift in policy. However, most of the administrative items should be addressed within one year, although the sheer number of items will require that the MDH devote specific resources to this project for it to succeed. Improving accountability through outcome measurement will require more research and discussions, although the work group did include recommendations related to streamlining reporting and other current accountability measures.

The work group strongly encourages the Commissioner to designate staff to further develop and implement these recommendations.

Recommendations for Effective Financing

1. *Inform congressional representatives and legislators about the impact of their funding choices.*

Policymakers have traditionally funded competitive, narrowly categorical grants due to budgetary constraints and the belief that they produce better programs and better results. The MDH and the LPHA should work together to inform policymakers about the difficulties created by funding the CHS system with these types of grants. In 2001, the MDH and the LPHA should implement an advocacy plan that clearly articulates the problems presented by competitive and narrowly categorical funding and includes realistic alternatives to these types of grants. The advocacy plan should contain talking points that state and local staff can use in discussions with elected officials, as well as a list of options and opportunities for presenting this information.

2. *Establish stable block grant funding for the CHS system to minimize the need for categorical grants.*

The CHS system needs stable, ongoing funding for basic public health programs that are identified as statewide priorities. Block grants should be flexible enough for CHBs to address the particular *piece* of

the issue that is of highest priority in their area. For example, a “disease prevention and control” block grant could be used to address immunization needs in one community and disaster planning in another community.

The current method of grant funding fosters an unstable base for financing local public health activities. The majority of MDH grants to CHBs are small, competitive, narrowly categorical, and/or short-term grants. Only two ongoing, broad-based grant programs exist (the MCHSP grant and the youth risk behavior grant). The only truly flexible grant funding is the CHS Subsidy, which accounts for 35% percent of total MDH grant funding to CHBs, but less than 8% of total local expenditures³. To achieve stability, funding needs to shift from the numerous unstable grants to broader block grants, and, ideally, additional funding for the CHS Subsidy. Competitive, narrowly categorical grants are not designed to provide a stable public health infrastructure, nor are they flexible enough to address locally identified health problems. The flexibility to focus on local needs and results must be our first priority for funding.

Legislators will always be interested in issues that are important to their constituents. State and local staff should work together to harness that enthusiasm and channel it to broader funding mechanisms. Rather than creating narrowly focused categorical grants to address “hot topics,” those “hot topics” should form the basis for block grants. Using the above example again, if immunization remains an issue of high interest, the momentum it creates can be used to propose funding for a disease prevention and control block grant that might include immunization as one area of focus.

To be considered “stable,” block grants should be distributed based on a formula rather than competitively. A “base” or “floor” should always be included so that all CHBs receive a minimal amount of funds to implement an effective program.

3. *Establish a moratorium on requesting new competitive, narrowly categorical grant programs for CHBs and consolidate existing grant programs into broad-based block grants.*

The work group understands the complexity of combining existing grant programs. Therefore, the work group’s primary short term recommendation is that no **new** competitive, narrowly categorical grants programs for CHBs be created. Instead, new grant programs should be integrated into existing grant programs, either by use of an existing formula distribution process (the CHS Subsidy formula, the MCHSP grant formula⁴, or the youth risk behavior grant formula) or by adding additional funds and activities to another existing grant program.

Over the long term, consolidating existing grants into block grants will reduce the administrative burden of grant programs while continuing to fund activities that are already taking place at the local level.

³ The \$19.1 million CHS Subsidy includes the \$5 million of core functions funding appropriated by the Minnesota Legislature in 1997.

⁴ If the MCHSP formula is used as a vehicle for future funding, the *new* formula developed in 1998 by the MCHSP Distribution Formula Work Group of the Maternal and Child Health Advisory Task Force should first be implemented.

Block grants must be created that are broad enough to encompass a wide variety of existing grants. These block grants should be driven by local CHS needs assessments and MDH data. The work group understands that it is politically difficult to consolidate existing grant programs, because each program has a constituency group that does not want to see their program lost in a larger block grant. However, to achieve real reform in grant funding, reducing the overall number of competitive, narrowly categorical grants is necessary.

4. *Request an ongoing inflationary adjustment to the CHS Subsidy.*

To be considered “stable funding,” grant dollars must reflect the actual costs of programs over time. If funding remains constant over time, the real value declines. The CHS Subsidy has benefitted from several increases since its inception; however, without regular inflationary increases, the CHS system is forced to go back to the Legislature every few years and ask for large increases. Rather than continue this piecemeal approach, the Commissioner should request that an inflationary adjustment be built into the CHS Subsidy. If the CHS Subsidy had been adjusted for inflation each year since 1982 the value of the CHS Subsidy in 2001 would be \$22.7 million instead of \$19.1 million.⁵

Recommendations for Administrative Simplification

5. *Streamline the administrative requirements of MDH grant programs.*

An immediate way to reduce the burden of the numerous MDH grant programs is to reduce the administrative requirements related to each program. The work group recommends that each grant program review the information requested at each stage of the grant process and eliminate all information that is not absolutely necessary. The work group also recommends that the administrative requirements related to MDH grants be consistent across all grant programs.

The work group believes that this administrative simplification should be an immediate priority for the MDH. The MDH should devote staff specifically to this effort to ensure that this recommendation is implemented within one year. Staff directing this effort must have the authority to make decisions that will impact all MDH grant programs.

Specific tasks, as prioritized by the work group, include the following:

- Develop a “master contract” that would incorporate all grants. *This would be the master legal document, and each grant program would attach a “program description” that would list the duties and budget for that grant.*

⁵Although the CHS Subsidy was implemented in 1977, 1982 was the first year that it was distributed statewide.

- Incorporate all MDH grant programs into the “Combined Notice of Availability” RFP. *Several MDH grant program RFP’s are currently combined into this notice. The MDH should work toward including all grant programs in this notice.*
- Develop consistent reporting. *This may include making data definitions (age groupings, activities, etc.) more consistent, coordinating reporting time lines, reducing reporting duplication, etc.*
- Develop a consistent application format.
- Develop a consistent invoice.
- “Cluster” grant time lines throughout the year, so that applications and reports for related programs are due at the same time (e.g., tobacco and youth risk behavior).

6. *The MDH should improve communication related to grants.*

Inconsistent communication exacerbates the administrative burden of grants. If the MDH communicated more effectively about grants it would relieve the pressure caused by misperception and unclear expectations. The work group believes that this recommendation should be implemented in 2001 in conjunction with the previous administrative simplification recommendation.

- Utilize more electronic communication. *The MDH should implement procedures for placing notices of RFP’s, RFP documents, grant applications, invoice forms, reporting forms, and other grant documents on the MDH website. The MDH should also explore methods for local agencies to submit documents electronically.*
- Streamline external communication. *The MDH should develop a consistent method of keeping CHBs and others informed of potential new funding sources, funding mechanisms and expectations related to grants.*
- Improve internal MDH communication related to grants. *MDH grant managers should be informed of MDH policies and procedures related to grants through ongoing communication and education. It is important for MDH grant managers to understand the role that their programs play in the larger picture of the CHS system so that they can better understand the impact of their decisions.*

Recommendations for Improved Accountability

7. *Pursue outcome measurement as a preferred method of accountability.*

The work group recommends that further discussions take place about grant programs outcome measurement. While the work group raised this topic as an important part of reforming the grant

process, it was not discussed thoroughly enough to create specific recommendations. The work group is intrigued by Wisconsin's new outcome-based grant program that blends funding from several different federal grants and would like Minnesota to explore this model further.

8. *Continue to pursue funding for a state/local public health information system.*

During the past two legislative sessions the MDH, with the support of LPHA, has proposed funding a "state/local public health information system." This system would coordinate public health data from across the state and across the MDH to facilitate the effective use of data in designing and evaluating programs. The MDH should continue to consider this effort a priority and pursue methods of achieving it.

9. *Continue to hold MDH staff accountable for implementing the ideas in the MDH Vision for Funding Public Health Activities.*

The work group was pleased that MDH staff were asked to use the *MDH Vision for Funding Public Health Activities* when developing legislative initiatives during the past year. The work group also suggests that when the MDH funds community agencies other than CHBs, MDH staff consult and confer with CHB staff to do the following:

- Determine the appropriate role for the CHB when the MDH provides grants to other local entities. CHBs are responsible for coordinating and integrating health services in their community, and for protecting and promoting the health status of their population. CHBs can better perform that role if they are aware of the other projects in their communities that are being funded. CHBs can then collaborate with these partners and help ensure that their projects are integrated with the work of the CHB.
- Determine the approach the MDH will use to hold the grantee accountable and explore the role the CHB might play in helping assure the best possible results from the grant program. •

MDH Grants to Community Health Boards

11/28/00

Name of Grant (Contact Person)	Annual Amount	Funding Basis	Source	Restrictions to Spending Flexibility (Source*)	Major Grant Requirements (Source*)
CHS Subsidy (Julie Ring)	\$19.1 million	Formula/ non-competitive	State General Fund	<ul style="list-style-type: none"> Ⓒ CHS program areas and administration (State Statute) 	<ul style="list-style-type: none"> Ⓒ Community health advisory committee Ⓒ Medical consultant Ⓒ CHS administrator Ⓒ Community health plan (4 years w/ two-year update) Ⓒ Local match (100%) (State Statute and Rules)
WIC (Betsy Clarke)	\$11.7 million (Administrative funds only)	Formula/ non-competitive	Federal USDA and state funds	<ul style="list-style-type: none"> Ⓒ Supplemental nutrition program, provides nutrition education, health assessments, referrals, and vouchers for supplemental foods Ⓒ Serves pregnant, breast feeding, and postpartum women, infants, children to age 5 Ⓒ Eligibility based on medical/nutritional needs and income eligibility for MA (275-280% of poverty for pregnant women and children up to age 2) or 185% of poverty (Federal) 	<ul style="list-style-type: none"> • Nutrition and breast-feeding services • Management of caseload Ⓒ Fiscal management of grant Ⓒ Nutrition education plan Ⓒ Outreach (Federal)

MDH Grants to Community Health Boards

Appendix A

11/28/00

Name of Grant (Contact Person)	Annual Amount	Funding Basis	Source	Restrictions to Spending Flexibility (Source*)	Major Grant Requirements (Source*)
Maternal and Child Health Special Projects (MCHSP) Block Grant (Ron Campbell)	\$7.4 million	Formula/ non-competitive	Federal & State General Fund	<ul style="list-style-type: none"> Ⓒ 3 priority areas with fourth allowed if first three addressed (State Statute) • “grandfathered” projects are to be continued Ⓒ 30% for preventive and primary care for children and 30% for children with special health needs (Federal) 	<ul style="list-style-type: none"> Ⓒ Local match (25%) Ⓒ Provide opportunity for others to sub-grant Ⓒ Target to low income and high risk (State Statute)
Youth Risk Behavior (Gretchen Griffin)	\$2.3 million (SFY2001) \$2.9 million (estimate for SFY2002)	Formula/ non-competitive	State Tobacco Endowments	Funds will be distributed to Community Health Boards for local health promotion and protection activities for local health initiatives other than tobacco prevention aimed at high risk health behaviors among youth. (State)	Funds will be used to create statewide social and physical environments that reduce risk behaviors among youth, age 12-18, and support the health and well-being of youth. Targeted Risk Behaviors include: alcohol and other drug use; sexual behaviors that result in pregnancy, HIV and STDs; violence; suicide; physical inactivity; unhealthy dietary behaviors. (State)
TANF Home Visiting (Jill Briggs)	\$7.0 million	Formula/ non-competitive	State	Promotes health and self-sufficiency for some of Minnesota's most vulnerable families. Offers home visits by a public health nurse and trained home visitors.	Eligible families are those with: <ul style="list-style-type: none"> • incomes at or below 200% of poverty with a minor child or a pregnant woman and who are citizens or qualified non-citizen; • currently enrolled on the federally funded MFIP; or • minor parent(s) and their child who are residing with a parent or legal guardian or who meets the exemptions under 42USC 608(a)(5).

MDH Grants to Community Health Boards

Appendix A

11/28/00

Name of Grant (Contact Person)	Annual Amount	Funding Basis	Source	Restrictions to Spending Flexibility (Source*)	Major Grant Requirements (Source*)
Health Alert Network (Myrlah Olson)	\$431,000	Formula/ non-competitive	Federal	<ul style="list-style-type: none"> • Must be used for connectivity, hardware, software, training, and planning to enable local public health agencies to communicate via email and the Internet. (Federal grant) 	<ul style="list-style-type: none"> • Identify three HAN contact people who check email frequently • Identify a distance learning coordinator • Produce a public health annex to the county emergency management plan. (MDH)
Tobacco-Free Communities for Children (Randy Kirkendall)	\$500,000	Formula/ non-competitive	State General Fund	Formula grants to CHBs to reduce youth tobacco use.	
Perinatal Hepatitis B Prevention (Margo Roddy)	\$200,000	Formula/ non-competitive (selected agencies)	Federal	<ul style="list-style-type: none"> • Outreach and follow-up to families of newborns where mother is positive for hepatitis B (Federal) 	<ul style="list-style-type: none"> • Limited to counties with greatest number of HBV-positive births. (State policy) • Follow-up protocol specified (Federal and state)
Refugee Health (Ann O'Fallon)	45,000	Formula/ non-competitive (selected agencies)	Federal	<ul style="list-style-type: none"> • Coordinate initial refugee health assessments and follow-up services (Federal) 	<ul style="list-style-type: none"> • Limited to counties which received >500 new refugee arrivals in previous year (MDH)
Immunization Registries (Bill Brand)	\$318,000	Non-competitive (Selected registries)	BlueCross Foundation; federal immunization	Restricted to regional immunization registries (Blues/MDH)	Achieve project-specific objectives, usually around advancing the registry one or more steps toward full functionality.
5 A Day Power Plus (Fran Doring)	\$334,000	Non-competitive	Federal	Must be used to increase fruit and vegetable consumption among elementary school students.	

MDH Grants to Community Health Boards

Appendix A

11/28/00

Name of Grant (Contact Person)	Annual Amount	Funding Basis	Source	Restrictions to Spending Flexibility (Source*)	Major Grant Requirements (Source*)
TB Control Program (Wendy Mills)	\$85,000	Non-competitive (selected counties based on TB data)	Federal	TB outreach services only, cannot be used for medications or clinical services. (Federal)	Provide TB outreach with emphasis on culturally specific services (also includes transportation to clinic). The goal is to provide complete and timely follow-up and treatment of people with active TB and people who are in need of screening because of exposure to active TB.
Minority Health Assessment (Lou Fuller)	\$400,000	Non-competitive	State	Grants to Community Health Boards to conduct a health needs assessment specific to populations of color. (State Statute)	Requires use of an ad hoc advisory committee reflecting people of color and use of CHS planning guidelines. (State Statute)
Native American Infant Mortality Reduction (Cheryl Fogarty)	\$ 120,000	Non-competitive (Defined criteria: •size of reservation •number of children born)	General Fund	Infant, fetal, and maternal death studies (State Statute)	<p>☐ Create local fetal-infant death review projects to:</p> <ul style="list-style-type: none"> • establish death reporting, family referral, and data collection systems • use standardized data collection forms and protocols <p>☐ Data management and data privacy</p> <p>☐ Nurse visits</p> <p>(State Statute)</p>
Indoor Radon Grant (Georg Fischer)	\$190,000	Non-competitive (selected agencies)	Federal	Support objectives of the EPA State Indoor Radon Grant to promote radon-resistant new construction, encourage testing and mitigation in conjunction with real estate transactions, promote testing and mitigation in schools, and promote the development of indoor air coalitions.	The EPA identifies priorities for the funding to the state. MDH then identifies our own priorities within the larger framework of the federal priority list. MDH is generally flexible.

MDH Grants to Community Health Boards

11/28/00

Name of Grant (Contact Person)	Annual Amount	Funding Basis	Source	Restrictions to Spending Flexibility (Source*)	Major Grant Requirements (Source*)
Minnesota Breast and Cervical Cancer Control Program (MBCCCP) (Shelly Madigan)	\$2.1 million	New sites—competitive; Existing—renewal	Federal and General Fund	<ul style="list-style-type: none"> • Breast and cervical cancer screening, outreach and education (Federal) 	<ul style="list-style-type: none"> C FDA-certified mammography facility (Federal) C CLIA-certified lab (Federal) C Accept Medicare rates (Federal) C Standardized data collection forms (MDH) C Patient tracking/follow-up systems (Federal) C Biannual meetings with MDH (MDH) C annual site visit (MDH)
Local Tobacco Endowment Grants (Randy Kirkendall)	\$3.45 million	Competitive w/in regions	State Tobacco Endowments	Population based prevention targeting 12-17 year olds (State statute)	Partners must include public health, schools and law enforcement. (MDH)
Family Planning (Ron Campbell)	\$4.9 million	Competitive within regions; needs-based regional formula	State General Fund	C Pre-pregnancy family planning services in six areas (State Statute)	<ul style="list-style-type: none"> C Minimum standards in up to six program areas C Application requirements (State Statute and Rules)
Burn Prevention (Mark Kinde)	\$38,000	Competitive	Federal CDC	Used for community smoke detector installation program	Community served has high fire-death rate; remote or inner city areas collaborate w/local fire department and other community based organizations
Fire/Fall Injuries in Older Adults	\$18,000	Competitive	Federal	Reduce fire and fall injuries for seniors by eliminating home and community hazards.	

MDH Grants to Community Health Boards

Appendix A

11/28/00

Name of Grant (Contact Person)	Annual Amount	Funding Basis	Source	Restrictions to Spending Flexibility (Source*)	Major Grant Requirements (Source*)
Indian Health (Sheila Brunelle)	\$177,000	Competitive	State General Fund	<ul style="list-style-type: none"> ⊆ Health services to American Indians who reside off reservations ⊆ Limited to Community Health Boards (State Statute) 	<ul style="list-style-type: none"> ⊆ Application must be part of community health plan (State Statute)
Migrant Health (Sheila Brunelle)	\$104,000	Competitive	State General Fund	<ul style="list-style-type: none"> ⊆ Health services for migrant farm workers and their families in areas where significant numbers of migrants are located (State Statute) 	<ul style="list-style-type: none"> • Preference given to statewide services • Available to cities, counties, or combinations thereof, and non-profit corporations (State Statute)
Commodity Supplemental Food Program (CSFP)	\$417,000	Competitive	Federal	Provide nutrition information and supplemental foods.	

MDH Grants to Community Health Boards

Appendix A

11/28/00

Name of Grant (Contact Person)	Annual Amount	Funding Basis	Source	Restrictions to Spending Flexibility (Source*)	Major Grant Requirements (Source*)
Targeted Home Visiting (Barbara Palmer)	\$378,000	Competitive	State General Fund	<ul style="list-style-type: none"> Ⓒ Home visits to prevent child abuse and neglect, and to promote positive parenting, resiliency in children and a healthy beginning for every child. (State Statute)	<ul style="list-style-type: none"> • Contact families at birth of child to provide information and offer home visits • Conduct a screening process to determine family's need for additional support • Use of common risk assessment tool, the AAPI • Coordinate with other local home visiting programs especially those offered by school districts • Provide at least 40 hours' training for staff Ⓒ Demonstrate strong collaborative linkages Ⓒ Standardized data collection forms and statewide program evaluation (MDH)
Minnesota Healthy Beginnings (Junie Svenson)	\$666,000 (already allocated through 2003)	Competitive	State General Fund	<ul style="list-style-type: none"> • Universally offered home visits to strengthen families and promote positive parenting and healthy child development. (State Statute)	<ul style="list-style-type: none"> • Coordinate coalition for program oversight and direction, for resource coordination and to minimize service duplication • Offer home visits to all families prenatally or as soon after birth as possible • Provide information, support and referrals to community resources based on family interests and needs • Participate in uniform evaluation (State Statute, MHB Steering Committee, MDH)
Diabetes Control (Martha Roberts)	\$142,000	Competitive	Federal	<ul style="list-style-type: none"> Ⓒ Community-based diabetes control interventions (Federal)	<ul style="list-style-type: none"> Ⓒ Two-day workshop Ⓒ Community assessment Ⓒ Community strategic plan (Federal)

MDH Grants to Community Health Boards

Appendix A

11/28/00

Name of Grant (Contact Person)	Annual Amount	Funding Basis	Source	Restrictions to Spending Flexibility (Source*)	Major Grant Requirements (Source*)
HCAF-Community Health Grants (Mark Schoenbaum)	\$250,000	Competitive	State	Grants for planning, establishing, and operating community health centers through the Minnesota community health center program. Grant recipients shall develop and implement a strategy that allows them to become self-sufficient and qualify for other supplemental funding and enhanced reimbursement.	Grantees must: <ul style="list-style-type: none"> • be located in a rural shortage area that is a medically underserved, federal health professional shortage, or governor designated shortage area; • represent or propose the formation of a nonprofit corporation with local resident governance, or be a governmental or tribal entity; and • for an application for an operating expense grant, demonstrate that expenses exceed revenues or demonstrate other extreme need that cannot be met from other sources.
Fetal Alcohol Syndrome (FAS) (Elisabeth Atherly)	\$850,000	Competitive	State General Fund	Community organizations and coalitions collaborate on FAS prevention and intervention strategies and activities. At least one grant for transition skills and services for individuals with FAS and FAE.	Prevention or intervention with individuals who have FAS or FAE
Minnesota Education Now, Babies Later (MN ENBL) (Gabriel McNeal)	\$500,000	Competitive	State General Fund and State Special Revenue Fund	Must follow requirements in MS§ 145.9255	Program targeted to youth 12-14 and their communities. Must provide community organizing activities including use of the Postponing Sexual Involvement Curricula. Must participate in statewide media campaign, trainings, and evaluation.

MDH Grants to Community Health Boards

Appendix A

11/28/00

Name of Grant (Contact Person)	Annual Amount	Funding Basis	Source	Restrictions to Spending Flexibility (Source*)	Major Grant Requirements (Source*)
MN Abstinence Education (Sarah Smith)	\$350,000	1998-99 competitive; possible three year extension	Federal Welfare Reform Law; Section 510 of Title V of the Social Security Act	Must follow requirements of Minnesota's Approved State Abstinence Education Plan	Program targeted to youth 14 and under; must provide community organizing activities including use of up three approved curricula. Must participate in statewide media campaign, trainings, and evaluation.
Lead Safe Housing (Dan Locher)	\$25,000	Competitive	State General Fund	Funds must be spent to provide lead safe housing to families with at-risk children less than 6 years old; \$ may be used for rent and relocation	Local public health agency must have retained jurisdiction for conducting lead inspections in homes of children with elevated blood lead levels, as defined by statute.

* Federal = federal requirements; State Statute = Minnesota law; State Rules = rules developed by state agency in response to MN law; MDH = MDH grant requirements not based on statute or rule

MDH Vision for Funding Public Health Activities

Preamble

The 1995 report, *Building a Solid Foundation for Health: A Report on Public Health System Development*, recommended that MDH “identify state policy barriers to local government flexibility in using state categorical grant funds to perform core public health functions.” This recommendation arose from an analysis by the State Community Health Services Advisory Committee of the financial resources that would be required to support Community Health Boards in performing core governmental public health functions in the future. The analysis found that, while the amount of funding available to the CHS system at that time was nearly equal to the amount needed to address core functions, many of the funds were categorical and thus not necessarily available for core function activities.

In addition, the various ways in which MDH awards grants to Community Health Boards and other community organizations has sometimes resulted in confusion regarding the purpose of the grant programs and in questions about MDH’s commitment to the state-local public health partnership. The MDH grant managers group discussed this issue, assembled background information on the type and number of grants to Community Health Boards, and recommended to the MDH Agency Management Team (AMT) that a vision and principles be developed to guide both the application for state and federal funds and the distribution of these funds in the future. Based on this information, the AMT authorized a cross-divisional team to develop this vision and these principles and report back to AMT.

The vision and principles were intended to build on and complement the Department’s overall Vision Statement and Guiding Principles, finalized in October 1996. The funding vision provides additional detail on how many of the Guiding Principles — particularly those related to setting priorities and focusing resources, building partnerships, and stewardship of public resources — can be carried out with respect to funding public health activities.

After approving the funding vision and principles, the AMT then charged the Grants Managers Group to identify specific strategies for implementing these principles during calendar year 1998 and evaluating their impact on how grants are administered by MDH.

MDH Vision for Funding Public Health Activities

MDH Vision Statement

“The Minnesota Department of Health will be a leader on behalf of the public’s health, with the capacity to anticipate and meet the health needs of all Minnesotans in an ever-changing world. In this environment, our priorities will be developed collaboratively, will guide our program activities, and will be achieved through partnerships and shared leadership.”

MDH Finance Vision and Principles

In carrying out our mission and vision, we work with our internal and external partners to focus resources on established statewide priorities. We do this by:

- ~ providing leadership in the development of statewide health priorities to encourage efforts to improve the health of Minnesotans. These priorities will be based on an assessment of the health status of the Minnesota population;
- ~ using these priorities to set agency goals, allocate resources within the department, and identify resource needs;
- ~ sharing our resources, including funding and technical expertise, with our partners to build and maintain their capacity to be partners in protecting the public’s health;
- ~ encouraging collaboration and strong relationships, and sharing resources where appropriate, with all of our internal and external partners; and
- ~ practicing sound stewardship in the use of public resources.

Applying the Funding Vision and Principles

Seeking Funding

- ~ We will develop internal agency goals and focus resources to achieve these goals, acting in our unique capacity and within the framework of the statewide health priorities.
- ~ We will evaluate new funding opportunities for consistency with agency priorities and goals.
 - *If requested, Section Managers will be responsible for demonstrating to their respective Division Director and Assistant Commissioner how a proposed MDH grant application relates to statewide priorities and/or agency goals, or why it is otherwise critical for MDH to apply for the funding.**

Funding for Community Health Boards

- ~ Community Health Boards are our local governmental partner, and we share with them unique responsibilities for public health.
- ~ We are committed to seeking stable and discretionary funding to maintain a strong and stable public health system. This does not imply that CHBs are necessarily the only eligible applicant for categorical grants from MDH.
- ~ Such ongoing funding is necessary for Community Health Boards to achieve their statutory responsibility of coordinating and integrating health services in the community, and conducting comprehensive community health assessment and planning.
 - *Public health is responsible for population-based assessment of community health needs, and for identifying roles—for others and for public health—in addressing those needs.*
 - *Emerging public health priorities are generally more population-based than individual-based. These population-based services require skills in areas like community organizing, media relations, risk communication, coalition building, marketing, population-based needs assessment and data interpretation, being an information resource/expert to providers and the public, and serving as an advocate for at-risk families and individuals. However, funding for such population-based services is not as stable or available as fee-for-service funding has been historically.*
- ~ Many of the resources that come to MDH are categorical; that is, they are designated by the state Legislature or federal government for a specific health problem or problems. While such funds are used to address specific health problems, they may also serve to strengthen the governmental public health infrastructure.
- ~ Our categorical grant programs to Community Health Boards will be designed and administered with the overall intent of increasing state and local capacity to effectively carry out the core public health functions. *This means that:*
 - *all categorical grants contribute to building the skills, knowledge and technical ability necessary for state and local public health staff;*
 - *greater consistency exists in how grant dollars support core public health functions;*
and
 - *greater consistency exists in how we provide technical support.*
- ~ There are times when it may be appropriate to award categorical grants only to Community Health Boards. In deciding whether only Community Health Boards are eligible for categorical grants, we will consider the following questions (taken as a whole, not singly):
 - Can the funds stimulate and support CHBs in gaining greater expertise in core function activities which could then translate to other program/problem areas (e.g. surveillance, community organizing, collaboration with health plans or providers)?
 - Are the problems or needs statewide and is a statewide system needed to address these problems?
 - Does the program/problem fall within the unique responsibilities of governmental public health?
 - Is the program/problem most effectively addressed through a population-based approach?

Funding Other Partners

- ~ There are situations when MDH will award categorical grants to organizations other than CHBs, such as community-based organizations and other governmental entities. In deciding whether to directly fund these types of organizations, we will use the following considerations (taken as a whole, not singly):
 - Do these organizations have unique access to or credibility with special populations?
 - Do these organizations have unique expertise or experience?
 - Does communication with CHBs indicate that there would not be statewide interest in participating this grant program?
 - Does another system other than CHBs already exist? Is there a public health benefit in funding the CHB system which could be potentially duplicative?

Categorical Funding

- ~ We are committed to creating maximum administrative ease and consistency among our categorical grants. We realize that time spent in preparing applications and reports is time not devoted to achieving the goals of the grant.
- ~ We will distribute categorical grants on a non-competitive and formula basis whenever possible. In choosing whether a grant will be competitive or non-competitive, formula or non-formula, and statewide or targeted, we will consider the following questions (taken as a whole, not singly):
 - Is the problem prevalent statewide?
 - Is there interest among many eligible applicants?
 - Do we have sufficient funds for a formula?
 - Are there geographic-specific data to target funding based on need?
 - Can we learn about an applicant's current capacity and level of readiness in a way other than a competitive application?

Accountability

- ~ We strive to be a responsible steward of public resources. As such, we will assure that public health activities supported by funds we administer result in measurable improvements in health outcomes.
 - ~ We are committed to advancing our capacity, and the capacity of our partners, to accurately assess health needs and measure health outcomes.
 - ~ We will assure that our grant programs are implemented in a way that the health problems of people of color are being appropriately addressed.
 - ~ We will keep categorical grant and other funding requirements to the minimum needed to assure accountability for the funds we oversee.
-

Appendix B

By applying our finance vision and principles, we intend to achieve the following:

- ~ Increased focusing of MDH resources on statewide priorities and agency goals, established with our partners.
- ~ Increased use of statewide priorities and agency goals to drive MDH funding requests and grant applications.
- ~ Stable funding for Community Health Boards statewide.
- ~ Enhanced capacity of the state and local public health workforce to carry out all three core functions.
- ~ Increased non-competitive categorical grants that use data to equitably distribute funding.
- ~ Greater administrative consistency among grants and reduced administrative complexity.
- ~ Clearer criteria for when MDH funds organizations other than Community Health Boards.
- ~ Enhanced methods for assuring accountability of funds and assessing health impacts and other outcomes of grant programs. •

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