HEALTH HAPPENS IN HEALTHY COMMUNITIES

Pilot City Health Center

Access to Healthcare •
Heritage Cultural
Celebration • Education
and Training • Strong,
Healthy Relationships &
Families • Quality
Housing • Economic
Vitality • Youth Activities
& Recreation • Spiritual
Health & Opportunities •
Safety & Cleanliness •
Civic Engagement &
Volunteerism

North Minneapolis Health Advisory Committee
FINAL REPORT – April 2004
North Minneapolis Health Advisory Committee
Final Report — April 2004

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Dear Hennepin County Board of Commissioners and other interested stakeholders:

The report of the North Minneapolis Health Advisory Committee clearly shows that health status and outcomes are not equal across City neighborhoods. The report documents disparities in health that rob the North Minneapolis community of the potential vibrancy of citizens and cost the government, communities and individuals an inordinate amount of time and resources. Although there are many programs Countywide addressing health disparities issues, it is not clear to the Committee that measurable progress is being made or that the resources directed at the issues are being used in a coordinated and cost effective manner.

Hennepin County devotes so much of its resources to health care for low income people and people of color; it is in all of our best interests to promote a well-designed, coordinated approach.

We have entitled our report, "Health Happens in Healthy Communities," because of the irrefutable reality that true health can only happen in healthy communities. Good health is not a simple matter of taking more vitamins or seeing health professionals on a regular basis. Health, and healthy communities, are a highly interdependent mix of access to health care, civic engagement, spirituality, economic vitality, quality housing, safe neighborhoods, strong families, education, cultural celebration and more. It requires vigilant and multifaceted efforts to create and sustain it.

In November 2000, Mark Stenglein and the Hennepin County Board of Commissioners created the North Minneapolis Health Advisory Committee to look at the health needs of residents of North Minneapolis. The charge of the Committee was to:

1. Identify the health needs of North Minneapolis residents
2. Examine the health care delivery systems for residents of North Minneapolis
3. Examine how changes in access to care, environment and behavior can improve health status
4. Engage the North Minneapolis community in a dialogue to improve the health and wellness of community residents

The Committee has thoroughly researched and scrutinized the issues and it was time well spent. We have engaged the community, analyzed the facts, debated the solutions and envisioned our dreams. We spent considerable time conducting a stakeholder analysis, holding community forums, familiarizing ourselves with current research and refining ideas in committee meetings. The North Minneapolis Advisory Committee defined a Healthy Community as:
A place in which people of all ages, races and income levels live in a clean and safe environment; where there is a diverse and vibrant economy as well as educational, recreational and culture activities; where citizens and government share power; where cultural and historical heritage is celebrated and promoted; and where people experience physical and mental wholeness and well-being that allows them to develop to their greatest potential and participate fully in society.

We have produced a series of recommendations and corresponding action steps to help achieve this definition of a healthy community. We are recommending the creation of a Countywide health and wellness public/private partnership; a redesign of health care delivery; an asset-based approach to community development and an emphasis on individual action and responsibility. We have selected five focus areas for this work: cardiovascular disease, including stroke; diabetes; sexual health; access to health care; and healthy behavior.

We are pleased with our result and grateful for the opportunity to have served. Our report is designed to help you as well as other policymakers, community leaders, health care providers, insurers and the residents themselves to take action in addressing the problems of unsound health in North Minneapolis and elsewhere. It emphasizes both ownership and leadership at the community and individual levels. There is a strong need for a public/private partnership. We also realize that the solution ultimately comes down to a very individual level. North Minneapolis residents must become more informed and proactive in their own health care and claim responsibility for their actions.

In closing, I would like to express my appreciation to the County Board for creating the Committee, to all the former and current members who contributed so much, to the Hennepin County Community Health Department for running the Committee in its first two years, to Pilot City Health Center and Gary Cunningham for their leadership and to the many individuals and organizations who contributed. I would also like to give a special thanks to Pam Cosby, Project Manager, who did a stellar job of shepherding the process.

We have before us the opportunity to do something to truly create healthy communities. I hope the Board will act soon to endorse the report and its recommendations and action steps. I look forward to seeing the many positive things that can grow out of our work and thank you again for your trust and commitment.

Sincerely,

John M. Williams, DDS
Chair, North Minneapolis Health Advisory Committee
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Imagining a Healthy Community

What are people doing? What do you see? What sounds do you hear? How do people look? What is going on? How does it feel? What is present? What is happening in the life of a child, a teenager, an adult, an elder?*

There are coffee shops, parks with fountains, delis with food from around the world, ice cream shops, front porches, and storefronts with people living above them. There are concerts in the parks and live theater. Libraries, community education, adult education, arts and cultural activities provide multiple learning opportunities. People have jobs with livable wages and careers with opportunities for growth. Social networks support family and community. There are high levels of civic involvement with neighborhood groups. North Minneapolis feels friendly and hopeful.

We see people having conversations, smiling and not yelling and people holding their heads high. People of all ages, shapes, sizes and colors are walking, biking, riding and skating.

People feel safe; they are visible, supportive and know each other. They are unafraid. Their needs are met locally with moderate prices and services and products which are of good quality. People have access to health care regardless of ability to pay and take advantage of available health programs.

Elders feel safe and valued. Adults take care of family, home and environment. They create healthy relationships and supportive family living places.

Teenagers have a positive focus on the future so they have a reason to not self-destruct. There are high graduation rates.

Kids are outside playing. They have a childhood. They worry about "kid stuff" and not adult stuff.

There is the sound of laughter. People take the time to listen; they see and reflect one another's strength. They help one another and take responsibility for themselves and their community.

They inspire hope in each other.

They whisper dreams in young people's ears.

* These questions were asked of the North Minneapolis Health Care Advisory Committee. The following vision was created by members at their December 2003 meeting.
Executive Summary

Moving forward with the recommendations of the North Minneapolis Health Advisory Committee will go a long way toward eliminating health disparities and building healthy communities.
Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.¹ And health happens in healthy communities. The 70,000 people who call North Minneapolis home want their own health as well as a healthy community. The reality, however, is that for many, both health and a healthy community are elusive. The people of North Minneapolis experience health outcomes that are worse than for most other areas of the State and County. Their life expectancy is less, infant mortality is higher and they are more likely to suffer from diabetes, high blood pressure, cardiovascular disease and stroke, HIV/AIDS and other sexually transmitted infections. The community has more poverty, fewer jobs and fewer desirable places and spaces than other parts of the City and County.

In November 2000, Commissioner Mark Stenglein, along with his colleagues on the Hennepin County Board, created the North Minneapolis Health Advisory Committee (NMHAC) to look at the health needs of residents of North Minneapolis. The Committee found that there has been an increased awareness and emphasis on health and health disparities among researchers, policy makers and health care providers in recent years. There have been thorough surveys with intentional over-sampling of people of color and American Indians; task-forces, commissions and workgroups; grants and projects; conferences and articles. Much of this work is at the national or Statewide level, but there is also a considerable amount of activity at the local level. Yet, in the words of one Committee member from the County Health Department, “there has been more done to admire the problem than to do anything about it.” The Committee is ready for this next step; we are ready to do something about it.

We believe the following steps needs to be taken:

1. The creation of a common agenda and common goals among all stakeholders
2. Improved stewardship of public resources and a way to track outcomes and better understand whether the considerable investment of resources is yielding intended results
3. A health delivery system which is community driven and which promotes involvement, engagement and ownership, and which better meets the needs of all people, including those with few resources, limited English, cultural barriers, mental health issues or physical barriers
4. A recognition that health happens in healthy communities and the corresponding interest in, and support for, whole community development.

Past and current attempts, no matter how well-intended, have failed to understand, and therefore speak to the importance of building the kinds of relationships and social and economic networks needed to address health disparities in a holistic way. Therefore, it is time to rethink, reframe, and redefine these issues, and

move our focus from deficits, gaps and disparities, to communal wholeness, health, wellness, strengths, possibilities and hope. This calls for challenging and interrupting the status quo. We need to move from a system focused on processes and services to one focused on people and outcomes that meet and exceed the expectations and needs of the community and its diverse residents. In keeping with this framework, we offer four high-level or big-picture recommendations with corresponding specific action steps.

Recommendations

1. Leverage resources through a Hennepin County health and wellness public/private partnership

2. Redesign North Minneapolis health care delivery

3. Identify the assets of the community and build on them

4. Inspire and support individual action as a critical component of success

These recommendations will guide the County as a whole and provide a comprehensive overlay of how the "pieces of the puzzle" all fit together. Within this overlay, there is room and a need for more focused and specific action items tailored to the most pressing health issues identified by the Committee. These include the following five focus areas: cardiovascular disease, including stroke; diabetes; sexual health; access to health care; and healthy behavior. The Committee believes that a few specific action steps within each area, as opposed to more and less specific items, will be easier to implement and more effective in delivering results. With this in mind, the Committee suggests action steps around these five focus areas:

Cardiovascular disease, including stroke

✓ Collaborate with the Fremont Community Health Services and adapt and expand their stroke screening tool to reach more residents

✓ Partner with the schools, parks and others to tackle childhood obesity in Minneapolis

✓ Increase exercise options for North Minneapolis residents

✓ Use one-to-one peer outreach workers (also known as Community Health Workers)

Diabetes

✓ Expand the Pilot City Collaborative Diabetes Model

✓ Develop and implement a comprehensive plan to address food choices and availability in North Minneapolis

✓ Develop a health promotion and
education nutrition/food campaign that can be conducted in tandem with the availability of healthier food choices

✓ Use one-to-one peer outreach workers

**Sexual health**

✓ Coordinate and expand teen pregnancy prevention efforts

✓ Continue to endorse and support previously Board approved health recommendations from the African American Men Project Final Report

✓ Change attitudes and improve knowledge about HIV/AIDS

✓ Use one-to-one peer outreach workers

**Access to health care**

✓ Increase the number of people with health insurance and access to health service providers

✓ Improve services to immigrants and refugees

✓ Increase the numbers of health care service providers who reflect the demographics of the population

✓ Use one-to-one peer outreach workers

**Healthy behavior**

✓ Develop social marketing campaigns to support the messages on cardiovascular health, diabetes and sexual health that emphasize the individual’s role in health

✓ Work with faith communities to help individuals make more healthy lifestyle choices

✓ Partner with the University of Minnesota Academic Health Center, which includes the Medical School, the School of Public Health, the School of Nursing and the Center for Spirituality and Healing

Health happens in healthy communities. And while there are existing efforts underway to improve North Minneapolis in general and the health of North Minneapolis in particular, these efforts are fragmented. The County and the community must be willing and able to provide the ownership and leadership to coordinate efforts, align resources, and build trust and coalitions. Moving forward with the recommendations of the North Minneapolis Health Advisory Committee will go a long way toward eliminating health disparities and building healthy communities.
HEALTH AND WELLNESS IMPLEMENTATION PLAN

HENNEPIN COUNTY HEALTH AND WELLNESS PUBLIC/PRIVATE PARTNERSHIP
Years 1, 2 and 3
- Establish partnership
- Create common goals and agenda
- Oversee implementation of NMHAC action steps in the focus areas:
  - ✓ Cardiovascular disease, including stroke
  - ✓ Diabetes
  - ✓ Sexual health
  - ✓ Access to health care
  - ✓ Healthy behavior
- Review best practices
- Track funding streams and outcomes
- Assess outcomes of “Eliminating Health Disparities Initiatives”
- Create a Health Disparities Community Indicators Report

NORTH MINNEAPOLIS HEALTH CARE DELIVERY SYSTEM REDESIGN
Years 1, 2 and 3
- Identify strategic goals, objectives and outcomes
- Create and implement performance measures
- Integrate health and human services delivery
- Realign funding streams, resources, programs and policies
- Integrate and decentralize services
  - ✓ Diversify staff and management roles
  - ✓ Focus on community and customer
- Promote the use of health impact assessments to identify the health impacts of broader policies

IDENTIFY AND BUILD ON COMMUNITY ASSETS
Years 2 and 3
- Learn and use Asset Based Community Development
- Identify community assets
- Build upon assets to create positive community and improve community conditions including education, employment, housing and transportation

INSPIRE AND SUPPORT INDIVIDUAL RESPONSIBILITY AND ACTION
Years 2 and 3
- Create community norms for healthy behavior
- Establish forums for healthy community
- Encourage individual responsibility
The Issue of Health in North Minneapolis

The tremendous disparities between the health of people of color, American Indians and whites have been well researched and documented both nationally and in Minnesota. Nowhere in Hennepin County are these disparities more prevalent than in North Minneapolis.
Health – Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

—The World Health Organization

Healthy Community – A place in which people of all ages, races and income levels live in a clean and safe environment; where there is a diverse and vibrant economy as well as educational, recreational and cultural activities; where citizens and government share power; where cultural and historical heritage is celebrated and promoted; and where people experience physical and mental wholeness and well-being that allows them to develop to their greatest potential and participate fully in society.

—The North Minneapolis Health Advisory Committee

The tremendous disparities between the health of people of color, American Indians and whites have been well researched and documented both nationally and in Minnesota.\(^2\) Nowhere in Hennepin County are these disparities more prevalent than in North Minneapolis.\(^3\) These health disparities rob the community of the potential vibrancy of citizens, exacerbate conditions of impoverishment and cost the government, communities and individuals an inordinate amount of time and resources.

Healthy citizens cannot exist without healthy communities. This report is a documentation of the work we, the North Minneapolis Health Advisory Committee, have been doing to more fully understand the complexities of health disparities on the North Side and to develop a vision of what a truly healthy community looks like.

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2 These disparities have existed for many years but recent data collection and analysis have quantified the extent of the problem. See Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Institute of Medicine, 2002; 1997 Populations of Color in Minnesota – Health Status Report, Minnesota Department of Health; Closing the Gap: A Public Health Report on Health Disparities, Metro Minority Health Assessment Project, March 2001; Eliminating Health Disparities Initiative: 2003 Report to the Legislature, Minnesota Department of Health, January 15, 2003.

3 For the purposes of this report, we define North Minneapolis to include the Near North and Camden communities of Minneapolis (generally the 55411 and 55412 zip code areas).
like. It is no coincidence that on other indicators of well-being such as income levels, educational attainment, crime rates, recreational offerings, and even restaurant choices, the North Minneapolis area often comes up short. People live in poverty, good jobs are scarce, the schools are failing children, violence is endemic, and there are few safe and healthy places to eat, shop or recreate. It is no wonder that people’s health is suffering.

Now is the time for a different approach, one that is shaped and directed by community voices, one that inspires sustained, authentic partnerships and accountability among key stakeholders, one that ensures sound stewardship of County resources, and one that is able to inform progress toward a wide range of carefully selected healthy outcomes that encompasses more than just the absence of disease.
HEALTH DISPARITIES IN NORTH MINNEAPOLIS

People in North Minneapolis are dying who do not need to die. People are struggling to live with health conditions that they should not have. Opportunities for individuals and the communities in which they live to develop to their full potential are being lost.
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People in North Minneapolis are dying who do not need to die. People are struggling to live with health conditions that they should not have. Opportunities for individuals and the communities in which they live to develop to their full potential are being lost.

The greatest health disparities in North Minneapolis are differences in health status that exists between racial and ethnic groups. Populations of color and American Indians die younger and have higher rates of infant mortality, greater incidences of diabetes, heart disease, cancer and sexually transmitted diseases including HIV/AIDS, more teen pregnancies and overall poorer health than whites.¹

We know that, in part, an individual's health status is the result of individual behavior and choices. We also know that many other factors, including race, gender, geographic location and economic situation play a huge part in people's health outcomes, even in the midst of some of the best health care in the world and often despite the desires of people to make healthy choices. Choosing a healthy option, be it reproductive health care or nutritious food, is only possible if the options are present and attainable.

For many in North Minneapolis, the choices simply are not available in any kind of coordinated or coherent fashion.

My husband died a few years ago and I can't drive anymore. I live in a senior high-rise, and they have some shuttles so that I can get out and go shopping or to the clinic. I have high blood pressure, and I am trying to eat better, but my doctor says it is still too high. I have to take a lot of pills. I am supposed to walk and get some exercise, but I don't feel safe. I am worried sick about my grandson. When I was in my house, he'd stay on and off with me. Lately he is getting into trouble at school and at home. I keep looking at the boys on the corner and hoping I don't see him.*

*The stories that appear throughout this report in the text boxes are composites created from the focus groups, conversations and meetings held by the Committee.

⁴ According to the U.S. Centers for Disease Control and Prevention, health disparities are largely connected to environmental conditions, social and economic factors, and health behaviors. The issues contributing to health disparities are threefold:
1. The social and economic environment, including levels of poverty, racial and economic conditions, social networks, social organization and political organization;
2. The physical environment, including quality of air and water, housing conditions, public safety, and transportation to resources and opportunities and
3. The access to and quality of services, including health care and access to other public and private services and opportunities.

Reducing Health Disparities Through a Focus on Communities, A Policy Link Report, 2002 at www.policylink.org/pdfs/HealthDisparities.pdf. The Institute of Medicine concludes that even when you control for all these factors listed by the Center for Disease Control, there is still a sizeable disparity in health, which they attribute to unequal treatment and unconscious discrimination. See Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Institute of Medicine, 2002.
People in the Near North and Camden communities have health outcomes worse than suburban areas and many other communities in Minneapolis.

- More than 20 percent of the people in Camden and 26 percent of the people in Near North report that they are obese. In comparison, less than 17 percent of the people in Minneapolis and Hennepin County report that they are obese.\(^5\)

- More than 7 percent of the people in Camden and Near North report that they have been diagnosed with diabetes. In Minneapolis and Hennepin County, this figure is about 5 percent.\(^6\)

- The rate of detected Gonorrhea infections per 100,000 people is 454 in Camden and 1,195 in Near North. In comparison, the rate for Minneapolis is 373 and the rate for Hennepin County is 169. This means the rate is seven times higher in Near North than in the County as a whole.\(^7\)

- The rate of detected Chlamydia infections per 100,000 people is 814 in Camden and 1,690 in Near North. In comparison, the rate is 616 for Minneapolis and 311 for Hennepin County.\(^8\)

- The detected HIV/AIDS rate per 100,000 people is 277 in Camden and 502 in Near North. This compares to a County rate of 94 per 100,000.\(^9\)

- About 19 percent of the babies born in Camden and 25 percent of the babies born in Near North are born to a teenage mother. In the entire City of Minneapolis, about 13 percent of the babies born have a teenage mother and about 8 percent of the babies in all of Hennepin County are born to a teenage mother.\(^10\)

- The infant mortality rate is 9.7 per 1,000 live births in Camden and 9.2 in Near North, compared to 6.7 in Minneapolis as a whole and 6.2 in Hennepin County.\(^11\)

These maps show the higher rates of teen pregnancy and sexually transmitted diseases in the urban core areas of the

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5 SHAPE 2002: Geographic Databook, Survey of the Health of Adults, the Population and the Environment, March 2003. SHAPE is a collaborative effort of the Hennepin County Community Health Department, the Minneapolis Department of Health and Family Support and the Bloomington Division of Health.

6 SHAPE 2002.

7 Minnesota Department of Health, STD and HIV Section, 2003; 2001 Hennepin County Community Indicators.

8 Ibid.

9 Ibid.


11 City of Minneapolis, State of the City Report, 2002; Minnesota Department of Health 2002 County Health Tables, Natality. For more information on health disparities in North Minneapolis, see Appendix II.
Diabetes Incidence

Percentage who had been told that they have diabetes, by geographic area
- 2.8%-3.6%
- 3.7%-4.8%
- 4.9%-5.5%
- 5.6%-7.4%

Minneapolis Communities and the Cities of Bloomington, Brooklyn Center, Brooklyn Park, Edina, Osseo and Richfield

Source: SHAPE 2002

Physical Activity Levels

Percentage who get 30 minutes of moderate physical activity five or more days during an average week, by geographic area
- 2.8%-3.6%
- 3.7%-4.8%
- 4.9%-5.5%
- 5.6%-7.4%

Minneapolis Communities and the Cities of Bloomington, Brooklyn Center, Brooklyn Park, Edina, Osseo and Richfield

Source: SHAPE 2002
County. But they also show that the diabetes incidence and reduced levels of exercise are not isolated to the urban areas. It is important to note that the incidence of diabetes and other diseases is not necessarily correlated with the outcomes; for instance, while they might have lower incidences of diabetes in North Minneapolis than in suburban Hennepin County, people of color also have higher negative outcomes, such as amputation of a limb.

Additionally, North Minneapolis lags behind the County as a whole and almost all other Minneapolis neighborhoods, in

I left after I had the last big fight with my mom about her drinking and that idiot boyfriend of hers. I was tired of waking up and finding him there and coming home and he would still be there – and he had not done a thing all day. They drank all the time. He was just using my mom and she was just letting it happen. I stayed with my friend for a while; her mom was cool with it. Lots of times we would just go hang out places. I met this guy – he was older – and he was pretty nice to us. We’d go to his place and chill. He bought me food and clothes and drugs. I started staying at his place most of the time. But when I got pregnant, he told me I had to leave. I bounced around a bit, staying with people I met. It was not too bad; I had some good times but I wanted a place of my own. I found this shelter and stayed there for a while until they kicked me out. They said I was selling drugs. I don’t really go to the doctor for the baby. I think I will when it gets closer to the time.
terms of life expectancy. Near North has the shortest life expectancy of all neighborhoods with the exception of men residing in the Phillips neighborhood of South Minneapolis.\textsuperscript{12}

There are a variety of factors which likely come into play in determining the life expectancies of residents living in individual neighborhoods. However, research suggests that at least part of this difference is due to differences in education and income and some of it is due to unequal treatment by race. A recent article in the New England Journal of Medicine concluded that targeting high quality, equal care for hypertension, HIV, trauma and diabetes would have the greatest effect on the racial disparities in mortality.\textsuperscript{13}

\begin{center}
\begin{figure}
\centering
\includegraphics[width=\textwidth]{life_expectancy_chart.png}
\caption{Life Expectancy at Birth by Community 1997-2001}
\end{figure}
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\textsuperscript{12} Hennepin County Health Department, 2003. Life expectancy is a statistical measurement of current mortality. Life expectancy at birth is defined as the average number of years a newborn in a particular area or population group can be expected to live if it experiences the current age-specific mortality rates of that particular area or population group throughout its entire lifetime. It is not a prediction of how long babies born will survive, but it is a useful and easily understood summary measurement of the current mortality experience of that population. Life expectancy of a particular area or population is greatly influenced by the number of premature deaths occurring in the area or group. For example, areas with higher infant mortality rates will have lower life expectancy rates, or areas with higher rates of intentional or unintentional injury deaths to young adults will have lower life expectancy rates. In addition, external factors such as the residential features of the area will affect the analysis of life expectancy rates for very small geographic areas. For example, concentrations of nursing homes or other housing options that result in the shifting of unhealthy persons into a geographic area will have a negative impact on life expectancy rates. For this analysis, five years of resident deaths (1997 - 2001) were aggregated in order to have a sufficient number to produce reliable life expectancy rates. Age- and gender-specific deaths rates were computed using the 2000 population counts for each community.

\textsuperscript{13} Contribution of Major Diseases to Disparities in Mortality, New England Journal of Medicine, Volume 347, no. 20, November 14, 2002.
The Significance of Health Disparities for Hennepin County

Over $1 billion is spent each year in Hennepin County to provide health services and deal with the consequences of health disparities.¹⁴

¹⁴ Hennepin County, www.co.hennepin.mn.us/pa/factsheets/HealthCareAssistanceFS.htm; State of Minnesota, www.dhs.state.mn.us/FMO/ReportsForecasts/FamilySelfSufficiencyHealthCare.pdf. This amount was calculated by dividing the state net annual payments by the average monthly enrollees (Tables 13, 14 and 15 from the Reports and Forecast document) and multiplying by the actual number of enrollees for Hennepin County.
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The simple and straightforward answer to the question of why health disparities matter for Hennepin County is because of the costs incurred by the County, other levels of government and the residents. These costs are not easily quantifiable. They include actual financial expenditures as well as the opportunity costs associated with citizens who are prevented from developing to their full potential and living their lives fully. They include the intangible costs of having citizens distrustful of available services as well as the frustrations of well-meaning professionals aware that they are not able to have the impact they know they could.

Over $1 billion is spent each year in Hennepin County to provide health services and deal with the consequences of health disparities. The public cost (which is shared between federal, state and local governments) of providing Hennepin County residents with public health insurance coverage through Medical Assistance, General Assistance Medical Assistance and MinnesotaCare was more than $1.1 billion for fiscal year 2001. The cost of uncompensated care, which is generally provided to people who lack either public or private insurance, for budget year 2003, was $53 million dollars. Although this represents spending for the County as a whole, people in North Minneapolis are more likely to receive public health coverage or require uncompensated care, so they disproportionately account for this public spending.

While we have no data specific to North Minneapolis, we do know that the costs for treating and responding to the health issues identified by the Committee are staggering. Hennepin County spends $4.6 million each month on MFIP grants for families headed by a mother who gave birth as a teenager. The cost of AIDS drugs can run from $10,000 to $20,000 per year per individual. And while these drugs are expensive, studies show that they can save money and increase lifespan. The total national annual economic cost of diabetes in 2002 was $132 billion, or one out of every 10 health care dollars spent in the United States.
In Minnesota, the estimated annual costs of diabetes-related medical care, lost productivity and premature morbidity is $2 billion.\(^{22}\)

Costs also increase when patients use the emergency room as their primary care provider. This is common among the uninsured, recent immigrants who do not understand the western system of health care and individuals who do not have a trusting relationship with a health care provider. The average charge for an emergency room visit is considerably more than an outpatient clinic visit. For example, on average, in 1999 a visit to Hennepin County Medical Center's Emergency Department by an 18- to 30-year old African American man resulted in charges that were $113 more than for a typical outpatient visit.\(^{23}\)

We all know that health care costs continue to rise and are increasingly difficult to contain. It is time to try to change the things that we know the system is not currently handling well and to focus on prevention, health promotion, the elimination of disparities and the creation of healthy communities.

---

I guess I have been living on the “down low” for a while. Maybe ten years or so. It was hard to tell my girlfriend that I was positive. I have not told her that I have been having sex with other men. I don’t really think I am gay; it is just what I do. We don’t use condoms; she has never really asked me to. She’s using birth control, so we don’t worry about her getting pregnant.

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\(^{21}\) Direct medical expenditures totaled $92 billion. Indirect expenditures resulting from lost workdays, restricted activity days, mortality and permanent disability due to diabetes totaled $39.8 billion. Cardiovascular disease is the most costly complication of diabetes, accounting for more than $17.6 billion of the $92 billion annual direct medical costs for diabetes in 2002. In 2002, diabetes accounted for a loss of nearly 88 million disability days. Diabetes caused 176,000 cases of permanent disability, at a cost of $7.5 billion. [www.diabetes.org/info/facts/facts_costs.jsp](http://www.diabetes.org/info/facts/facts_costs.jsp); [care.diabetesjournals.org/cgi/content/full/26/3/917](http://care.diabetesjournals.org/cgi/content/full/26/3/917).


CREATING THE
North Minneapolis
Health Advisory Committee

WHEREAS: according to recent studies and data collected by various health agencies, residents of north Minneapolis suffer from a variety of health conditions to a much greater degree than most other residents of Hennepin County; and

WHEREAS: the Hennepin County Board envisions a future where individuals and families are healthy and well; and

WHEREAS: there is a need to better assess and improve the overall health status in north Minneapolis; and

WHEREAS: this need for assessment requires a process for developing policy recommendations to submit to the County Board;

BE IT RESOLVED, that the Hennepin County Board of Commissioners does hereby declare its desire to establish the Hennepin County North Minneapolis Health Advisory Committee...

24 Hennepin County Resolution No. 00-11-813RI, November 15, 2000.
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In November 2000, Hennepin County Commissioner Mark Stenglelin, along with his colleagues on the County Board, created the North Minneapolis Health Advisory Committee (NMHAC) to look at the health needs of residents of North Minneapolis. The charge of the Committee was to:

1. Identify the health needs of North Minneapolis residents

2. Examine the health care delivery systems for residents of North Minneapolis

3. Examine how changes in access to care, environment and behavior can improve health status

4. Engage the North Minneapolis community in a dialogue to improve the health and wellness of community residents

The Committee was asked to report periodically to the Hennepin County Board with regard to its findings, strategies and progress. The Committee includes eight at-large members, six consumers, six County/City representatives and a chair appointed by the Second District Commissioner. The Committee met monthly and presented information to the County Board in April 2002, and submitted preliminary recommendations to Commissioner Stenglelin in August 2002.
The Work of the North Minneapolis Health Advisory Committee

Through this process, two very significant correlations emerged. First, the analysis illustrated that those stakeholders with the most interest in the issue of a high standard of health and quality health care for the community have the least power. Conversely, those with the most power who are most directly associated with the provision of health care often do not know how they can have an impact on health outcomes or are unsure of how their actions can affect their own interests. Another critical finding demonstrated that the primary flow of influence goes from agencies with high power but low interest to those with high interest but low power.
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Research on Needs and Delivery Systems

Initially, we looked at what was going on in relation to health in North Minneapolis. We found causal factors contributing to the severity of health disparities, including poor diet, lack of exercise, smoking and alcohol/drug use. Compounding these factors were education levels, available jobs and economic status, high rates of incarceration, the abundance of liquor stores, poverty, lack of access to healthy foods, lack of affordable housing and cultural beliefs.

There are a plethora of organizations and individuals working in some health related capacity in North Minneapolis and Hennepin County. We found, however, that their work was fragmented and disconnected. In some cases services are duplicative and in other cases there are clear gaps in service delivery. There is little information with regard to successful models or outcomes. The concept of public stewardship over money spent is not prevalent. Even the structure of the local health efforts within the County and in the City of Minneapolis, with their sometimes overlapping and sometimes separate jurisdictional responsibilities, contributes to this fragmentation. Hennepin County Public Health is delivered by three separate entities: Hennepin (which includes Suburban Hennepin exclusive of Bloomington, Richfield and Edina); Bloomington, Richfield and Edina (which serves those respective cities); and Minneapolis (which includes the City proper.) Within the various community-based organizations, and even within the public entities, there is no common agenda or prioritization beyond a general commitment to focus on health disparities.

When I knew that it was time for the baby to come, I called my neighbor who spoke some English. She called my clinic and they told me to go to the hospital. I had planned to see my healer and get some herbs to help the baby, but there was no time. My neighbor stayed with my other children while my husband took me to the hospital. It took a long time for the interpreter to come. Everything was very noisy and confusing. There were so many people. I was in much pain. I told the interpreter that I did not want any medicine, but he told the doctor it was okay with me. I was very angry, but they would not listen to me. I knew I needed some special herbs to help the baby. The medicine they gave me made me very sick. I cried and screamed. I don’t remember much of the baby’s birth. I will not go back to the hospital.
**Countywide issues and efforts**

It became clear to the Committee that by focusing on just North Minneapolis, we were likely missing some critical pieces. For one thing, the population we are concerned with is highly mobile. School data, which provides a good proxy for mobility, indicates that in one year there were "22,000 transactions, meaning students enrolled and withdrew from our schools at amazing levels." We know from additional research done by the University of Minnesota that many of the people living in the most disadvantaged parts of the community are extremely mobile; they may live in North Minneapolis at some point in the year but also frequently move across the City. We concluded that those who are experiencing negative health outcomes are also those who are most likely to be the recipients of government social services. The maps of health outcomes (see pages 15 and 16) look very similar to those documenting social service use, on the following page, and highlight the connections between place and outcomes.

There is a need to look at the entire City, and even the entire County, to fully understand the scope of the issues as well as the complexities of the solutions. Many of the issues contributing to the health disparities of North Minneapolis residents are systemic issues that extend beyond the jurisdictional boundaries of North Minneapolis. Therefore, the solutions must be found by looking at the County as a whole, and not just isolating a part of North Minneapolis. As an example, the separation of people by race and income in our County is not just a random happening but the result of both legal and de facto segregation that arose during the 1940s and 50s. We believe we need to tie the health issues of North Minneapolis to these macro level systems and issues in order to fully and effectively address them.

The Hennepin County Community Health Department has been focusing attention, through detailed research, dedicated staff resources and community conferences, on getting a better understanding of the County's health disparity issues. In 2002, the Hennepin County Community Health Department, in collaboration with the Minneapolis Department of Health and Family Support and the Bloomington Division of Health, conducted the SHAPE 2002 survey, the second in the series of SHAPE surveys (the first was conducted in 1998). SHAPE (Survey of the Health of Adults, the Population and the Environment) is a health surveillance project that monitors the health of adults in Hennepin County. The project uses a holistic perspective — taking a comprehensive look at the health status, behaviors and health care practices of residents, as well as other social and


Hennepin County Social Service Clients, 1999

Density of Hennepin County social service clients* per square mile, 1999


28 Hennepin County Adult Services Department clients (1999), Children and Family Services Department clients (1999) and Economic Assistance Department Public Assistance clients (December 1999; does not include clients receiving only child support services). Clients were not unduplicated between departments.
environmental factors that influence their health.

One of the objectives of the SHAPE 2002 survey was to fill the racial and ethnic data gap identified in the 2001 Twin Cities Metro Minority Health Assessment Project report, “Closing the Gap: A Public Health Report on Health Disparities.” The SHAPE 2002 survey was designed and implemented to report on six racial/ethnic groups: American Indians, Southeast Asians, U.S.-born Blacks, African-born Blacks, Hispanic/Latinos and Whites. The data were collected primarily through phone surveys, supplemented by in-person surveys. Culturally appropriate questions and interview methods were used to support the focus on racial and ethnic data. Members from the various racial and ethnic communities were actively involved in the project's development, implementation and analysis. In addition to English, interviews were conducted in four other languages; Spanish, Somali, Hmong and Vietnamese. Of the 9,959 survey respondents, 2,794 respondents were people of color or American Indian.

The 2002 survey findings provide a detailed baseline of local racial and ethnic health disparities, published in a series of SHAPE reports, including: “SHAPE 2002: a Preview,” “SHAPE 2002: Racial and Ethnic Data Book,” and “23 Community Health Services Assessment Fact Sheets.”29 The County has also held two relatively recent health disparities "summits." The first, “Hennepin County Health Safety-Net Summit: Zero Disparities and 100% Access: How do We Get There?” was held in December 2001 and attended by 275 people. The second summit, “Hennepin County Health Disparities Summit Partners in Action: Closing the Gaps,” included almost 500 participants.

Finally, the County is participating in a City-County blue ribbon panel on public health. Although the panel is finalizing its recommendations, which will be out in the early part of 2004, one most likely recommendation is the development of an “urban health agenda.” An urban health agenda focuses on both the vitality within the communities of a city, as well as identifying the broader public health issues to address disparities and increase wellness. Based on our work to date, we would support such an “urban” approach.

In the end, notwithstanding the efforts that have been made to understand health disparities and the priority the issue has been given within the County, we feel that there has been little progress or planning to address the issues either Countywide or in specific communities. Again, it is our hope that this report will motivate progress from data collection to action.

Community sharing event and stakeholder analysis

To gather more information about what was happening, the Committee also held a community sharing event at North Star Elementary School. We targeted those who work with the community: community leaders, community-based organizations, the faith community and other health professionals. In addition to sharing information from the work of the Committee, the purpose of the event was to invite public participation in a series of dialogs on creating a community committed to health promotion.

To further assist us in understanding some of the obstacles confronting the health and health care delivery problems in the North Minneapolis community, we commissioned Professor John Bryson and Karen Lokkesmoe from the Humphrey Institute of Public Affairs at the University of Minnesota to conduct a stakeholder analysis. This process helped to uncover some of the hidden power differentials that impede policy and strategy decisions in addressing health disparities. By doing so, the stakeholder analysis demonstrated how the differing stakeholders—those people and organizations that have an interest in, are affected by or have power and influence over the health and health care of the community—are interrelated and how these relationships are influenced by the direction and flow of power.

There are numerous stakeholders who have a role to play in the health of the people of North Minneapolis. They include:

- Nonprofits and other community-based organizations, such as The City Inc., Minneapolis Urban League, Stairstep Foundation, African American AIDS Task Force and Turning Point (all agencies doing health care related work in North Minneapolis)
- Community clinics including Pilot City Health Center and Fremont Community Health Services
- Private health care providers
- Hennepin County Medical Center and other local hospitals
- Minnesota health associations
- Hennepin County Community Health Department
- City of Minneapolis Department of Health and Family Support
- For profit and nonprofit health care providers and HMOs—e.g. Metropolitan Health Plan, Health Partners, Medica, Blue Cross, etc.
- U.S. Department of Health and Human Services, Bureau of Primary Health Care
- Minnesota Department of Human Services
- Minnesota Department of Health – Community Health Services
- Minnesota Department of Health – Office of Minority and Cultural Affairs
- Other City departments and programs including the Neighborhood Revitalization Program, the Police Department, the Public Housing Authority and Community Planning and Economic Development
- Business community – people who
market and sell, or don't market and sell, goods and services
- Hennepin County Commissioners
- Schools and faith-based organizations
- The residents of North Minneapolis

All of these stakeholders are doing certain things, or not doing certain things, that impact the health of the North Minneapolis community. However, these actions are largely fragmented. A great deal of resources, both financial and human, has been channeled into the North Side to meet these challenges, with little success. Fragmented programs and services, often created with limited community input, seem to be more concerned with maintaining the current systems than with making significant positive change in the health and well-being of the communities affected by the health disparities.

Through this process, two very significant correlations emerged. First, the analysis illustrated that those stakeholders with the most interest in the issue of a high standard of health and quality health care for the community have the least power. Conversely, those with the most power who are most directly associated with the provision of health care often do not know how they can have an impact on health outcomes or are unsure of how their actions can affect their own interests. Another critical finding demonstrated that the primary flow of influence goes from agencies with high power but low interest to those with high interest but low power. Overall, the stakeholder analysis identified strong linkages and networks that are present among people and groups working on

more positive health outcomes. The analysis revealed four themes for action:

1. Stronger alliances are needed among key stakeholders
2. North Minneapolis residents must become more proactive in their own health care
3. Agencies with the power to influence health disparities must become aware that it is in their own self interest to align with others to work on these issues
4. Institutionalized policies and procedures that perpetuate disparities in health outcomes must be actively challenged

(See Appendix I for more information about the stakeholder analysis.)

**One example: teen sexual health**

The rate of teen pregnancy on the Northside is one of the more troubling statistics in the health disparities picture. There are many programs working to prevent teen pregnancy (both first and subsequent births to teens) including the new Teen Parent Connection, the Alternative School (the Hub) for teen mothers, The City Inc., Call to Action, ENABL, Healthy Start and the Broadway Community School. These programs appear to be having some impact and the number of teen births in the Near North dropped by 22 percent between 1992 and 2001.\(^{30}\) A Hormonal Family Planning Program at North High School, operated in partnership with Pilot City Health Center, resulted in only one unplanned

\(^{30}\) Data provided by the City of Minneapolis Health Department, November 2003.
pregnancy out of the 105 participants. A smaller effort, the Adolescent Parent Program, yielded no repeat or second pregnancies among its 20 participants.31

Nonetheless, the teen birth rate remains high, at 24 percent for the period covering 1999-2001, and is higher than in other areas of the County.32 Between 1992 and 1999, every year 10 percent of Black girls ages 15-19 in Hennepin County give birth, compared to only 1.3 percent of white girls.33 A screen of 200 North High students found that a troubling 30 percent of them tested positive for sexually transmitted infections.34

Specific focus and findings

After analyzing the disparities of opportunities for health, the often disconnected initiatives and the data specific to disparate health outcomes, we chose to focus our efforts on selected individual areas of health: cardiovascular disease (which includes stroke), diabetes and sexual health, as well as access to health care and healthy behavior.

Based on several years of study, research and dialogue, we found that the current approach suffers from four common ailments:

1. A lack of common goals and agendas among policy makers and service providers, even though they serve the same population
2. No easily accessible tracking of specific results and efforts and no system to measure disparities by race/ethnicity
3. Recipients of services are faced with a maze of difficult to understand health programs and practices which confound even the healthiest participants but which often are insurmountable for those with few resources, limited English, mental health issues or physical barriers
4. Little recognition that health can only happen in healthy communities

Past and current attempts, no matter how well-intended, have failed to understand and therefore speak to the importance of building the kinds of relationships and social networks needed to address health disparities in a holistic way.

32 Ibid.
33 Hennepin County, www.co.hennepin.mn.us/chpcsi/hp/information%2Dstats/disparities/overview%5Ffrom%5F2001%5Fhealth%5Fsummit.htm.
34 Conversation with Ann Sweeney, Northside High School Clinic, December 2003.
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A New Framework: From Disparity and Fragmentation to Hope and Healthy Community

All stakeholders, particularly those identified by the stakeholder analysis, must be compelled to view health and the idea of healthy communities, not in isolation but rather from a holistic and whole systems perspective, one that truly acknowledges, embraces and practices the axiom that the whole is greater than the sum of the parts.
It is therefore time to rethink, reframe and redefine these issues, moving from a focus on deficits, gaps and disparities, to focus on communal wholeness, health, wellness, strengths, possibilities and hope. This calls for challenging and interrupting the status quo, to move from a system focused on processes and services to one focused on people and outcomes that meet and exceed the expectations and needs of the community and its diverse residents.

The stakeholder analysis identified several areas of “common good” or interests which had the most support among all the stakeholders. They include: improving the quality of life; having an effective educational system; supporting a safe environment; having a vital economy; having healthy individuals, families and communities; being fiscally responsible; fostering respect and appreciation for all cultures; leaving a legacy; having a good reputation; supporting sustainability; reducing government; and increasing social justice and social equity. Identifying assets and targeting resources to focus on these areas in pursuit of the common good are potential pathways to a healthy community. An Asset Based Community Development (ABCD) process, which focuses on a community’s capacities and abilities, rather than deficiencies, could help identify the strengths and assets of the community and how those strengths can be leveraged to create the healthy community that people desire and deserve.35

We recognize that there are multiple communities within the community of North Minneapolis. Each community has its own stories of hope, courage, resilience and success. It therefore becomes critical to find a menu of ways to share these life-giving stories of

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health - O.E. hæl_ “wholeness, a being whole, sound or well,” from hal (see whole).

holy - O.E. halig “holy,” from P.Gmc. *khailagas (cf. O.N. heilagr, Ger. heilig, Goth. hailags “holy”), adopted at conversion for L. sanctus. Primary (pre-Christian) meaning is not impossible to determine, but it was probably “that must be preserved whole or intact, that cannot be transgressed or violated,” and connected with O.E. hal (see whole) and O.H.G. hild “health, happiness, good luck.”

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35 See www.northwestern.edu/IPR/abcd.html.
wholeness and success and to find ways to expand the learning opportunities. For example:

- The nonprofit Frazier Foundation operates “Diamonds in the Rough,” a program to create academic and economic opportunities for inner-city young women athletes. Young women are assisted in developing effective support systems and job-readiness skills. Their All Star Game and Celebrity Shootout showcases basketball players; 92 percent of eligible participants have received either an academic or athletic scholarship.

- Within the American Indian community, more focus is being brought to bear on the importance of social gatherings to celebrate life cycle events, such as a baby naming. These social gatherings allow for inter-generational connections and reclaiming of cultural and spiritual beliefs and practices and help to begin to rebuild a sense of community wholeness and health and a reconnection to heritage and spiritual well-being. There is a growing focus on creating community wellness based on core values of “beliefs, belonging and becoming.”

- The Cultural Wellness Center, in the Powderhorn neighborhood, is a model worth considering with some communities on the North Side. This model focuses on the cultural and relational context of health and wellness within the African-American, Latino and American Indian populations. Understanding that each racial and ethnic group has their own core values and vision around health and wellness, it then works from a foundation of cultural attributes to build wellness.

- The La Creche Early Childhood Center, in collaboration with Way to Grow’s Northside Family Connection, connects families with needed and existing community resources. Through home visitation, one-on-one support and group activities, families get important early childhood development service.

- C.H.A.S.E. (Creating Healthy and Safe Environments) and the Child Abuse Prevention Council of Hennepin County train neighborhood and government agencies, as well as the general public, to support and nurture at-risk families and children. Their annual “Blue Ribbon” child abuse campaign raises awareness and provides practical ways to prevent child abuse and neglect.

- The Plymouth Christian Youth Center provides high school students who would otherwise be unlikely to enroll in a physical education class a chance to participate in a twice weekly exercise program. Yoga, Pilates, stretching and low-impact aerobics encourage young people to move their bodies and improve their health. This is combined with individualized nutrition education and counseling for even more impact.

- The “Step To It” Northside Walking Club meets every Saturday morning and walks together for two miles. The club targets seniors but people of all ages can join in the walk. All walkers
receive a t-shirt, passes to the Y and a pedometer. Some serious socializing happens every week, in addition to healthy exercise. Step To It is sponsored by several government agencies focused on health, neighborhood development and crime prevention, a testament to the multiple goals a simple walk through the neighborhood can achieve.

All stakeholders, particularly those identified by the stakeholder analysis, must be compelled to view health and the idea of healthy communities, not in isolation but rather from a holistic and whole systems perspective, one that truly acknowledges, embraces and practices the axiom that the whole is greater than the sum of the parts. Research conducted with women and girls in North Minneapolis revealed their deep convictions of the spiritual aspects of health. A whole and healthy Northside Community is comprised of many parts; each of which contributes to the health of the community:

36 "The Experience of Women and Girls of Color in North Minneapolis as it relates to the Interplay of Health, Well Being and Racism," A Community Based Action Research Project conducted by the College of Saint Catherine and the Community Center of Excellence in Women's Health at Pilot City Health Center, Hennepin County, Minnesota, 2003.
The task of building a healthy Northside Community calls for developing stronger social networks and bonds and deeper relationships and interconnectivity. For this to happen the County and all key stakeholders must:

- Move from a focus on disparities to focus on strengths, successes and assets of individuals, families, neighborhoods and community.

- Move from a focus on programs to focus on community (individual, family, neighbor and community at large) expectations, needs and their resolutions.

- Move from the mechanistic idea that health is about the absence of disease and pain to one of individual and community assets—that health is a result of assets and the means to develop greater assets within oneself, one’s family and one’s community.

- Move from services outside the neighborhoods and community to place-based services, e.g. promotoras (lay health workers at such places as barbershops, hair salons, places of worship, etc.). Models can be found in Detroit and Denver and within many non-governmental organizations that train community health workers in developing countries and in refugee situations.

- Move from lack of reliable data to collecting and sharing data that tracks progress toward goals and enables changes to better achieve desired results.

- Move from disjointed services, efforts and initiatives within County departments and community agencies to an integrated and coordinated service delivery model of seamless, customer-focused services and partnerships.
**Principles Used to Develop Recommendations**

As recommendations were being developed, we used the following fundamental underlying principles to guide the process:

- Reach agreement about what is meant by a healthy community.

- Consider strength-based, asset-building approaches. Seek to discover and illuminate the stories of wellness, pride and success within the individuals, families, social networks, neighborhoods and communities of the people of the North Side—and beyond the geographical boundaries.

- Leverage the different experiences within the North Side communities, the County departments, the health care providers, health insurance companies, education professionals, community agencies and others to foster commitments to raising the level of the social capital of the people in North Minneapolis.

- Explore the inclusion of complimentary and alternative health care modalities, including traditional healing practices of various ethnic groups.

- Consider how to connect and bridge neighborhoods and individual communities to the greater community while preserving each community’s uniqueness.

- Consider how the idea of power and privilege affects the current constructs and how to rewrite the rules that govern the current structures and systems.
Next Steps

Ownership and leadership are certainly abstract concepts, yet ownership and leadership can take very concrete forms.
These recommendations are presented with the belief that their adoption and implementation will contribute to a healthier North Minneapolis community and a healthier Hennepin County. The overarching theme of these recommendations is that the Board of Commissioners and Hennepin County need to demonstrate ownership and provide inspiring leadership with regard to creating healthy communities. Hand in hand with this theme, however, is the corresponding message that the community needs to provide equivalent levels of ownership and innovative leadership.

**Ownership and Leadership**

- Ownership at the community level means that the community needs to build alliances across different groups for the good of the community. Ownership also means coming together to galvanize a collective voice and actively engage in conversation and action with the County to jointly create health and wellness amidst and among the diversity of communities.

- Community leadership means recognizing that some poor health is the result of unhealthy behavior and then creating community norms and expectations for healthy behavior.

Ownership and leadership are certainly abstract concepts, yet ownership and leadership can take very concrete forms. For example, both the County and the community have leadership roles to take on with regard to their use of social marketing to induce certain behaviors such as smoking cessation. Both the County and the communities can and should take leadership and produce appropriate campaigns; the County can produce and pay for social marketing materials to be used on the sides of buses, for example, and the community can broadcast public service announcements on KMOJ and ban smoking at community gatherings.
Recommendations

There are four recommendations which have emerged from the analysis and discussion of healthy community creation. These four recommendations are "big-picture," broad scale actions which, if taken, will provide a comprehensive framework for the more specific action steps.
There are four recommendations which have emerged from the analysis and discussion of healthy community creation. These four recommendations are “big-picture,” broad scale actions which, if taken, will provide a comprehensive framework for the more specific action steps. These recommendations are:

1. Leverage resources through a Hennepin County health and wellness public/private partnership

Three themes emerged from the stakeholder analysis: a call for stronger and more positive alliances among crucial stakeholders; an observation that agencies with the power to influence health disparities must become aware that it is in their interest to align with others to work on these issues; and a challenge to institutionalized policies and procedures that perpetuate disparities in health outcomes. The goal of a Countywide health and wellness public/private partnership is to forge these alliances and focus on a common agenda and work toward the common good.

We recommend that the County Commissioners take a leadership role in convening a Hennepin County health and wellness public/private partnership. The charge of the health and wellness partnership is multifold and includes:

• Identifying the necessary public, nonprofit and private partners

• Convening and coalescing around common goals and agendas and coordinating with other health disparities work

• Overseeing the implementation of recommendations from the North Minneapolis Health Advisory Committee as approved by the County Board

• Tracking the various funding streams; knowing where the money is coming from, where it is going and whether it is getting the desired results

• Ensuring ongoing evaluation mechanisms

• Becoming a learning community; reviewing best practices, understanding existing data and requesting research to fill in any gaps

• Understanding the outcomes generated by current “Eliminating Health Disparities Initiatives” grants

The partnership should be comprised of leadership from the County, the City of Minneapolis, the State (including a representative from the Department of Health’s Eliminating Health Disparities Initiative), educational systems, hospitals (HCMC and North Memorial in particular), health care providers and insurers, housing and economic development agencies, the media, business leaders, the faith community and community members. The Minnesota Council on Health Plans is currently involved with many health disparities projects and has indicated a willingness to participate in such a partnership. There are certainly other organizations that would be equally willing to come to the table and focus on

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37 The Minnesota Council of Health Plans represents eight nonprofit health care organizations and includes Medica Health Plan, Blue Cross Blue Shield, Health Partners, UCare and the Metropolitan Health Plan. See www.mnhealthplans.org/index.htm.
creating a common agenda and working toward the common good. Convening a group of senior leadership from across sectors gives credibility to and sets the tone for the partnership. The leadership group will, in turn, determine the strategic direction, common agenda and the framework of the partnership, and thus authorize their individual organizations to join together in implementing the goals of the partnership.

We understand that there have been a number of attempts, both large and small, at collaborative efforts. Many of these, despite the best of intentions, have left individuals and groups skeptical of yet another collaborative effort. Yet we believe that in order for real change to occur in this area of public health, all key stakeholders must come together to work through their differences, leave their individual agendas at the door and co-create a common vision and agenda that addresses clinical health, public health and community development issues. Formal engagement of community participation is essential to the success of building healthy communities. Too often past attempts have included little if any authentic listening to community needs and expectations. For the partnership to be successful, partnering with formal and informal community leaders is necessary. Some of the current members of the North Minneapolis Health Advisory Committee may move onto the partnership to ensure a community presence, voice and continuity.

We also understand that the scope of a Countywide partnership goes beyond just the North Minneapolis area, but it is our belief that this is required in order to effectuate any real change. Unless we tie North Minneapolis to larger spheres of influence we risk marginalizing North Minneapolis. Systemic change requires broader investment in order to have longevity and impact. Creating healthy communities necessitates the involvement of cross-sector participation, the identification of resources and the establishment of trust between and among the stakeholders. The County can and should provide the leadership to make this happen.

2. Redesign North Minneapolis health care delivery

We recommend that the Board of Commissioners lead inter-governmental efforts to redesign and re-align health care delivery in North Minneapolis. If we really want to have healthy communities, there must be systems-wide changes; the current delivery system and approach to health does not work and is a poor example of public stewardship of tax dollars. With the current system, it is nearly impossible to determine what results are being purchased from specific efforts. A redesign means a fundamental change in the way things are done, an interruption of the standard practices and policies that have been in place for years and a renewed commitment to meet the needs of the people.

There are four primary aspects of this systems redesign:

1. Any redesign needs to identify the strategic goals, objectives and outcomes and re-align stakeholders,
funding streams and other resources, as well as policies and programs, to be consistent with the identified goals, objectives and outcomes. In order for this to happen, all those who have an interest need to be strongly committed to cooperation, openness and collaboration.

2. To more effectively meet the unique needs of North Minneapolis residents, services need to be integrated and provided in a one-stop shop or “hub.” North Minneapolis has attracted a sizable number of human and social service organizations. The breadth of the services offered impacts a number of quality of life issues. Despite the multitude of organizations charged with improving the health and economic status of disadvantaged communities, disparities continue to exist. A more organized and comprehensive approach to service delivery has a better likelihood of addressing long-term issues of health disparities and poverty, while developing the social capacity for creating a healthy, vibrant and robust community. Pilot City Health Center and Pilot City Neighborhood Services are the most obvious selection for this “hub creation” and the Committee supports efforts to redesign and integrate existing services.

3. Any service delivery system is vastly improved when the strategic direction and goals are determined by what is most valuable to the customers. Thus, the redesigned system must be customer and community driven.

4. A decentralized delivery system allows for more integration and customer choice. Decentralization also drives down decision-making to front line workers who are the most in touch with the community and the needs of the community. Decentralization relies upon increased community involvement and the building of an infrastructure right in the neighborhoods that need the services. It recognizes that “one size does not fit all” and allows each community to develop its own approach, within the context of the common goals and objectives. This community involvement grants authority as well as responsibility and accountability at the community/local level.

In order for this redesign, integration and decentralization to happen, the following are needed:

• Effective mechanisms for real and sustained community input and involvement. This will improve the chances that the system is truly customer-focused and can transform the relationship between governmental “experts” and resident clients from an “us” and “them” framework to a more equal partnership.

• An increase in the diversity of staff and management in leadership roles.

• County measures of performance, including the Balanced Scorecard, need to measure both health and health disparities among all populations and neighborhoods. The County Community Health
Department’s Health Disparities Community Indicators Report Card will be an important part of this work.

- Emphasis on cooperation and assistance between County and City departments.

- A focus on collaboration, customer service and quality work that serves the people of the County, particularly those most needing County services.

- The measurement and subsequent publication of the cultural competence of health care providers.³⁸

- Identification and response to the large disparity of opportunities for healthy food, recreation, safe streets, decent housing and jobs in North Minneapolis.

- Integration of Eastern, traditional and alternative medical and spiritual practices into mainstream medical service delivery.

- More comprehensive and usable data that tracks, measures and evaluates progress toward specific health and wellness outcomes and indicators for both individuals and the community. These will be determined after strategic goals and objectives are set with community input.

### 3. Identify community assets and build on them

It is important to help the community identify, and the County understand, the assets of the community and how they can best be harnessed to create positive, lasting change toward health and wellness. The process of identifying these assets will be affirming and strengthening. Building upon them will further reinforce and develop those community strengths and create a greater sense of possibilities and hope. These assets can be leveraged to address the changes that are needed. There are lots of incredible things and people in North Minneapolis—the key is to help uncover them and spread the message. There are also people and organizations skilled at using this positive approach to change. The Office of Minority and Multicultural Health within the Minnesota Department of Health has been delivering specific training on how to do Asset Based Community Development and would be willing to do more training for those who are interested.³⁹

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³⁸ *There are proxies that have been used to measure cultural competence. For example, the time to measure treatment for pain is sometimes used to demonstrate health care providers’ unconscious prejudice or bias. The Institute of Medicine has other specific recommendations.*

³⁹ *Asset Based Community Development (ABCD) is but one approach to looking at issues through a positive, rather than a negative lens. See also the work of Professor Joseph L. White who focuses on positive aspects of African American psychology as opposed to deficits; and the organizational development method known as "Appreciative Inquiry."*
4. **Inspire and support individual action as a critical component of success**

The stakeholder analysis also recommended that North Minneapolis residents must become more proactive in their own health care. Individual action—on the part of a single Commissioner or a teenager in Near North—is critical. Individual action is the building block of collective action. Individuals need to be motivated and supported in their efforts to stop smoking, control their weight, increase physical activity, engage in responsible sex; abstain from drugs; limit alcohol; and commit to preventative care. People need to own their unhealthy behavior and vow to change it, as well as create community norms for collective behavior. Parents need to teach their children; both with words and their actions. Friends and neighbors need to confront each other on activities which endanger the health of an individual or the community. We need engagement on a community level, in a very systematic way, to inspire people to know that they have a right to be healthy. Each and every person has the responsibility to make their choices and raise their voices.
Action Steps for Building a Healthy Northside Community

The County and the community must be willing and able to provide the ownership and leadership to coordinate efforts, align resources and build trust and coalitions. Moving forward with the recommendations of the North Minneapolis Health Advisory Committee will go a long way toward transforming health disparities into healthy communities.
The recommendations presented above will guide the County and provide a comprehensive overlay of how the “pieces of the puzzle” all fit together. Within this overlay, there is room and a need for more focused and specific action items tailored to the most pressing health issues identified by the Committee. These include the following five areas: cardiovascular disease, including stroke; diabetes; sexual health; access to health care and healthy behavior. The Committee believes that a few specific recommendations within each area, as opposed to more and less specific recommendations, will be easier to implement and more effective in delivering results. With this in mind, the Committee suggests the following:

**Cardiovascular disease, including stroke**

✓ **Collaborate with the Fremont Community Health Services and adapt and expand their stroke screening tool to reach more residents**

Fremont Community Health Services worked with a suburban-based cardiologist with regard to a screening tool he had developed to identify people at risk of stroke and provide prevention services. They worked together to adapt the screening tool for use in the North Minneapolis community. Using an Eliminating Health Disparities Initiative Grant from the State, they worked with the cardiologist and nursing staff from the clinic to adapt the tool and take it out into the community. They are using the tool in places where people naturally congregate such as beauty salons, barbershops and coffee shops. They have further refined the tool to make it more user friendly and adaptable to the diverse communities served by the clinic. Results of the screening are positive and deserve further consideration and flexible replication.

✓ **Partner with the schools and the parks and others to tackle childhood obesity in Minneapolis**

Obesity is heavily correlated with cardiovascular disease as well as diabetes. Obesity is increasing in the general population but disproportionately so among communities of color and American Indians. The County has already gathered some of the relevant data in a recent report entitled “Eat. Play. Learn.” This report, published in June of 2003, documents the status of physical activity and food environments in Hennepin County schools and provides some new ideas to improve children’s health. Selected community organizations, including Plymouth Christian Youth Center, have recognized the importance of addressing obesity in children and are designing programs to address the problem. Coordinating and expanding these efforts by partnering

40 www.co.hennepin.mn.us/commhlth/services/hprom/calendarlinkspdfs/PANReport.pdf.
with the schools and parks would ensure that more children benefit. Going into adulthood with their weight under control is a great gift we could give our children.

✓ Increase exercise options for North Minneapolis residents

There are a variety of things that can and should be done to increase exercise options for North Minneapolis, including continued expansion of the Plymouth Avenue Walkway/Bikeway; support for and expansion of walking clubs and basketball leagues; community gardens and the building of some exercise facilities (such as private or non-profits like Lifetime Fitness or YMCAs). Creative

Imagine this: "The Northside R & R – Register and Run!"

Join with other Northside residents on a Saturday morning in mid-October to register to vote and run or walk a 5K race through the Parkway and closed-off North Minneapolis city streets. The Run is sponsored by local businesses and large health organizations. Multicultural music, entertainment and food is available after the race. Meaningful health information and screening are also provided. It is cool to wear your R & R T-shirt all year.

✓ Use one-to-one peer outreach workers

Over and over again, the Committee heard from people and read in the research that a key to health delivery is in relationships that are mutually respectful, trusting and caring. For many in North Minneapolis, conventional health care service delivery does not meet their needs. Many people are literally afraid of going to the doctor; afraid that they will not be understood, afraid that they might get bad news or treatment that they don’t want, even afraid of disrobing.

We recommend using successful models for one-to-one and small group peer outreach workers (often referred to as community health workers, "CHW" or Promotores de Salud,) to develop a cadre of culturally competent people who are known and trusted for their ability to directly reach residents and convey accurate and critical information.

Community health workers connect people who have traditionally lacked access to adequate health care with providers. They generally work in non-traditional locations such as beauty salons, barbershops, coffee shops and clan leaders’ homes. They meet community residents where they naturally and comfortably gather, addressing one or more health topics at a time.
Community Health Workers:
- Strengthen already existing community network ties
- Live in the communities in which they work, understand what is meaningful to those communities and communicate in the language of the people
- Recognize and incorporate cultural buffers
- Build partnerships with formal health care delivery systems to connect people with the services they need
- Educate providers about the community’s health needs and the cultural relevancy of interventions
- Help reduce health care and personal costs as they help improve outcomes for community members
- Provide culturally appropriate and accessible health education and information
- Build individual and community capacity

I like going to Mai’s health promotion group. She is one of several Hmong community health workers in our community. She helps us understand the very different ways of American culture, government (like asking for Medical Assistance) and medicine. She sometimes uses drawings to explain what certain medical practices are and what some of the medicines and tests do. We don’t have words for these things — like antibiotics — in our language because they did not exist in Laos. She also helps us see when our own healing practices are most helpful and when we need to see a western doctor.

I learn so much from Mai, from how to cook different foods that help lower my husband’s blood pressure to how to be involved in my children’s education. Back in Laos, we looked to the teacher to help sculpt and mold the morals of our children. Until we had community health workers like Mai, we didn’t fully understand that American teachers don’t do that; that in America, it is our job as parents, along with our church or spiritual leaders, to do so.
According to the U.S. Centers for Disease Control and Prevention, using community health workers in health intervention programs is “improving health care access, prenatal care, pregnancy and birth outcomes, client health status, health and screening related behaviors as well as reduced health care costs.”

For example:
- A six-month self-management program for patients with chronic disease who worked with lay health instructors resulted in improved health behaviors, improved health status and fewer hospitalizations compared with usual care.
- 44 clients with diabetes in St. Louis, Missouri, who accepted a home health aide to support their self-care for 18 months showed improved glycemic control, improved attendance at eye and diabetes clinic visits and fewer emergency room visits compared with a control group.
- Hispanic clients who were assigned to a CHW intervention group were more likely than those who were not to complete their diabetes education programs.
- More than 100 Spanish-speaking persons using peer educators demonstrated improved diabetes education and self-care.

**Diabetes**

✓ Expand the Pilot City Health Center Collaborative Diabetes Model

Pilot City currently has a collaborative diabetes model that is generating exciting results for diabetics and their families. It involves tightly coordinated case management and collaboration between the different health providers for each individual. Support groups, frequent visits, testing and monitoring of patient status and a data tracking system allow for oversight and correction of health conditions at an early stage and are key components of this model.

✓ Develop and implement a comprehensive plan to address food choices and availability in North Minneapolis

Both diabetes and cardiovascular health are affected by diet. The old adage many of us learned in school, “you are what you eat,” remains an important cornerstone of health. Many in North Minneapolis are unable to choose affordable, healthy food. There are too many fast food restaurants and convenience stores and not enough low-cost grocery stores or restaurants offering...

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42 Lorig et al. 1999.
43 Hopper, Miller, Birge, & Swift 1984.
healthy food. Food shelves and even school lunches offer food that does not directly improve health. The County and others should document the food choices available, identify gaps and again engage in creative partnerships to woo the kinds of businesses that are more likely to contribute to affordable and healthy eating.

✓ Develop a health promotion and education nutrition/food campaign that can be conducted in tandem with the availability of healthier food choices

Whether it is fried chicken, mole, fry bread, or mangoes with sticky rice, all cultures elevate food to an art form and an important and defining feature of community and belonging. This campaign obviously needs to be culturally sensitive and relevant and responsive to the roles that food plays in cultures and the different traditions of the Northside. The link between income and food choices also needs to be understood and incorporated.

✓ Utilize one-to-one peer outreach workers

The same concepts and model discussed above apply here.

Sexual Health

✓ Coordinate and expand teen pregnancy prevention efforts

There is a need to better coordinate and align the existing efforts to more effectively address the complex issues surrounding teen pregnancy. The Minnesota Organization for Adolescent Pregnancy, Parenting and Prevention (MOAPPP), a preeminent state-based nonprofit dedicated to understanding teen pregnancy, has developed a model they call the "Teen Pregnancy Puzzle" which contains the components that research has shown are critical for reducing teen pregnancy. It is interesting to note that MOAPPP's approach is not dissimilar to the Committee's "puzzle pieces" of a healthy community and serves to underscore that these issues are complex, require multi-faceted approaches and will not be solved by simple and singular responses.

The Committee recommends that the existing teen pregnancy service providers, the Teen Parent Connection, local health agencies and other community based organizations work together to create a comprehensive plan for teen pregnancy prevention in North Minneapolis which addresses each of these twelve "puzzle pieces."
 Continuing to endorse and support previously Board approved health recommendations from the African American Men Project Final Report

The African American Men Project Final Report contains a variety of recommendations focused on improving the health of young African American men. They include increasing the number of men who have physicals and a relationship with a primary care doctor (and thereby reducing the numbers of emergency room visits), aggressive street outreach for HIV testing and assessments, innovations in chemical dependency outreach, fostering mental health awareness and establishing a comprehensive response to domestic violence. The African American Men Final Project Report also specifically discusses the many challenges faced by men who are incarcerated and those who return to the community after serving their time.

The health and other needs of these ex-offenders must be included in any comprehensive plan. These efforts will only improve as the number of organizations and individuals come on board. The Committee recommends coordinating and complementary efforts.

 Change attitudes and improve knowledge about HIV/AIDS

The face of AIDS is increasingly one of people of color. African American women, in particular, are becoming infected at alarming rates. Community advocates working on HIV/AIDS issues know that with a true prioritization on prevention,
increased information and reduced stigma, infection rates could be decreased. The Committee believes efforts need to focus on three areas: improving condom usage, increasing testing and improving access to care. Community health workers should be deployed to breakdown the barriers that many communities of color have about HIV/AIDS. In the words of one activist: “AIDS is not a gay person’s disease; it is an every person’s disease.” There are organizations focusing on HIV/AIDS; their efforts need to be better coordinated with those going on in North Minneapolis. The work of the Department of Health, in particular, needs to become more integrated into the community. Innovative work is being conducted by the Balm in Gilead, a national non-profit which has established, and continues to develop, educational and training programs specifically to meet the needs of churches and mosques that strive to become centers for HIV/AIDS ministry, education and compassion. A partnership should be created to bring work such as the Balm in Gilead’s to Hennepin County.

Access to Health Care

✓ Increase the number of people with health insurance and access to health service providers

Research shows that not only do people with health insurance live longer, healthier lives, but they also have higher earnings and are able to increase their education level. Increasing the numbers of people of color and American Indians covered by insurance would likely reduce health differences that exist between racial and ethnic groups and white Minnesotans.

A recent survey by the Minnesota Department of Health found that two-thirds of uninsured Minnesotans are eligible for private or public coverage but are not enrolled. Approximately three-fourths of the uninsured are employed and 76 percent of those working uninsured people work more than 30 hours a week. More than 90 percent of children without insurance are eligible for health insurance programs, but are just not enrolled. One common problem discussed by almost every group in the survey was a lack of information about available health insurance programs. There are a variety of ways in which information can be shared. For instance, the Minnesota Children’s Defense Fund has developed a new web tool designed to increase awareness about a variety of safety net programs including public health coverage. Additional innovative approaches, such as this new web tool, should be developed.

46 See www.balmingilead.org.
48 www.cyfc.umn.edu/coveringallfamilies/.
The Committee recommends efforts to increase and improve the provision of accurate, accessible information about health insurance and access to providers.

✓ Improve services to immigrants and refugees

Persons who have recently arrived in the United States, as well as second and third generations of immigrants and refugees, present challenges to the conventional “system” of health and human service delivery. They struggle with issues of language, cultural differences, fear of prosecution or deportation by the INS and additional burdens. The Committee recommends that a concerted effort be made to improve access and services to these populations through the provision of culturally competent health care, translation services, “safe” zones for undocumented people and a better understanding of the enormous difficulties many of these people face in surviving and thriving in this society.

✓ Increase the numbers of health care service providers who are demographically reflective of the population

A recent research project looking at the experience of women and girls of color in North Minneapolis stated one of its findings quite simply. It reads: “Participants stated they want to walk into a clinic or hospital and see providers who look like them.” The Committee believes that it is important to recruit, train and hire diverse health care and related staff. One idea for doing this is a variation on the military model of education with its subsequent expectation of service. People of color and American Indians could be recruited and sent to various health care educational institutions. Their tuition would be paid for and in turn, they would be expected to work for a specified period of time in one of the public urban health care settings. This model would have multiple benefits including community economic development, increased educational levels, improved customer service and better health outcomes. This is but one way in which the diversity of health workers can be enhanced.

Healthy Behavior

✓ Develop social marketing campaigns to support the messages developed from the work on cardiovascular health, diabetes and sexual health that emphasize the individual’s role in health

Social marketing campaigns are one tool that can be used to bring about lasting change in individual and collective behavior. The Committee recommends that a variety of culturally specific social marketing efforts be used to support the implementation work discussed above. The Committee also recommends that “success stories” of individuals, families and social networks are shared broadly so that people can see how others in their community are thriving. Social marketing can be a sophisticated, widespread endeavor but can also be the simple inclusion of stories in neighborhood papers, church newsletters and

community web pages. A new local publication, "Know Your Health," a multicultural health magazine and the County's new cable program "A Public Health Journal" are great places to spotlight stories and messages.

✓ Work with faith communities to help individuals make choices towards more healthy lifestyles

The faith community is in a unique position to motivate, encourage and actually inspire behavior. The faith community has a rich history of connecting values to action. Moreover, many people feel most comfortable and safe in their spiritual home. Ministers and other religious leaders, parish nurses and other faith leaders are currently organizing and collaborating around pressing social issues. Some churches have started operating HIV ministries. The Committee recommends coordinating efforts between health providers, public health advocates and the faith community so that concrete health information, screening and promotion can most effectively be added to the agenda of the faith community. This coordination could range from changing post-service luncheons from high fat foods to more healthy options to counseling parishioners to seek blood testing and engage in safe and respectful relationships to conducting Ora Quick/Rapid HIV tests on-site.

✓ Partner with the University of Minnesota Academic Health Center, which includes the Medical School, the School of Public Health, the School of Nursing and the Center for Spirituality and Healing

The University of Minnesota Medical School provides training to many of the physicians who ultimately practice medicine in Minnesota. The School of Public Health also graduates students who become the next generation of leaders in the work to improve the health of the population. The innovative Center for Spirituality and Healing focuses on integrative medicine and brings together biomedical, complementary, cross-cultural and spiritual care and it would be a natural avenue for partnership. Working with the University to include health disparities work in the curriculum, developing research proposals and engaging these experts to help solve the more vexing aspects of disparate health outcomes is a smart way to leverage taxpayer investment in our premier public educational institution. This work could ultimately lead to a better understanding of the role of individual behavior and choices on health outcomes.

Health happens in healthy communities. And while there are existing efforts underway to improve North Minneapolis in general and the health of North Minneapolis residents in particular, these efforts are fragmented and uncoordinated. The County and the community must be willing and able to provide the ownership and leadership to coordinate efforts, align resources and build trust and coalitions. Moving forward with the recommendations of the North Minneapolis Health Advisory Committee will go a long way toward transforming health disparities into healthy communities.
HEALTH AND WELLNESS IMPLEMENTATION PLAN

HENNEPIN COUNTY HEALTH AND WELLNESS PUBLIC/PRIVATE PARTNERSHIP
Years 1, 2 and 3
- Establish partnership
- Create common goals and agenda
- Oversee implementation of NMHAC action steps in the focus areas:
  ✓ Cardiovascular disease, including stroke
  ✓ Diabetes
  ✓ Sexual health
  ✓ Access to health care
  ✓ Healthy behavior
- Review best practices
- Track funding streams and outcomes
- Assess outcomes of “Eliminating Health Disparities Initiatives”
- Create a Health Disparities Community Indicators Report

NORTH MINNEAPOLIS HEALTH CARE DELIVERY SYSTEM REDESIGN
Years 1, 2 and 3
- Identify strategic goals, objectives and outcomes
- Create and implement performance measures
- Integrate health and human services delivery
- Realign funding streams, resources, programs and policies
- Integrate and decentralize services
  ✓ Diversify staff and management roles
  ✓ Focus on community and customer
- Promote the use of health impact assessments to identify the health impacts of broader policies

IDENTIFY AND BUILD ON COMMUNITY ASSETS
Years 2 and 3
- Learn and use Asset Based Community Development
- Identify community assets
- Build upon assets to create positive community and improve community conditions including education, employment, housing and transportation

INSPIRE AND SUPPORT INDIVIDUAL RESPONSIBILITY AND ACTION
Years 2 and 3
- Create community norms for healthy behavior
- Establish forums for healthy community
- Encourage individual responsibility
APPENDIX I
A Stakeholder Analysis of Health Disparities In North Minneapolis

Synopsis
August, 2003

Commissioned by:
The North Minneapolis Health Advisory Committee and Pilot City Health Center
What is stakeholder analysis?

Stakeholder analysis is a process used by researchers to understand complicated problems and issues. Stakeholders are people and organizations that have an interest in an issue, are affected by an issue, or have power and influence with regard to an issue. The analysis shows how the stakeholders and the goals of the various stakeholders are related and the directions that power and interest flow among them.

Why did the North Minneapolis Health Advisory Committee (NMHAC) commission a stakeholder analysis?

The NMHAC, with members chosen for their variety of backgrounds and experience, spent a good deal of time learning, exchanging points of view and examining the issues of health disparities. It became clear that the issues were very complicated and involved a lot of people, organizations and fields (health, government, faith communities and so on). The Committee wants to produce recommendations that are both realistic and a road map that shows each stakeholder what its role must be in the elimination of health disparities. Therefore, the Committee commissioned the staff at the Humphrey Institute of Public Policy at the University of Minnesota to conduct a stakeholder analysis as a foundation for their strategic recommendations.

How was the stakeholder analysis done?

Five techniques were used:
- A power vs. interest grid
- A stakeholder influence diagram
- A bases of power/direction of interest diagram for key stakeholders
- Finding the common good and structuring a winning argument
- Tapping individual stakeholder interest to pursue the common good

What did the analysis find?

In the power vs. interest grid, stakeholders were identified and listed according to how much interest they have in equal health outcomes and then by how much power they have to influence the outcomes. The analysis shows that those with the most interest have the least power. It also showed that those with the most power and who are most directly associated with the provision of health care are not those with an interest in addressing the issue of health disparities.

The stakeholder influence diagram shows that the primary flow of influence is from agencies with high power but low interest in health disparities to those with high interest but low power. It also shows that there are strong linkages and networks among those already working on health outcomes. The researchers felt that this was hopeful; if a convincing argument that eliminating health disparities was in everyone’s interest could be made, and good plans for action could be created, the pathways and networks to carry out the plans were in place.

The stakeholders identified as most central to the network of those involved in health outcomes (in order of most central to least central):
- Nonprofit organizations
• Community clinics
• Private healthcare providers
• HCMC
• Local hospitals
• North Minneapolis residents
• Minnesota health associations
• Hennepin County Community Health Department
• Insurance industry
• HMOs
• DHS (Minnesota Department of Human Services)
• MDH (Minnesota Department of Health)
• County Commissioners

The bases of power/directions of interest diagram shows that each stakeholder has multiple concerns and bases of power.

The analyses of individual stakeholders were then combined into an exercise called finding the common good and the structure of a winning argument. (See page 74.) This involved finding the interests which had the most support among the stakeholders. These interests are:

• Improving the quality of life
• Having an effective educational system
• Supporting a safe environment
• Having a vital economic environment
• Having healthy individuals, families and communities
• Being fiscally responsible
• Fostering respect and appreciation of all cultures
• Leaving a legacy
• Having a good reputation
• Supporting sustainability
• Reducing government

• Increasing social justice and social equity, that is, reducing racism

To create a winning argument, the NMHAC should frame the argument in the context of these common interests.

How can stakeholders be mobilized through these common interests to take actions that would eliminate health disparities? Tapping individual interests in pursuit of the common good is a way of asking how an individual’s interests can be used to create actions for the common good; in this case eliminating health disparities.

What does this mean for the NMHAC?

Public policy action happens when problems are clearly identified, when good ideas worth implementing have been suggested, and when there is the political will to implement them. The problem before us is that millions of dollars are being spent on costly healthcare policies that are having a poor effect on communities of color. Methods of healthcare delivery are either not equal or not equally effective in communities of color compared to white communities of similar social-economic and educational status.

If policies, programs or projects are put forward that address those common interests and will have a positive impact on health outcomes in a cost-effective way, they stand a good chance of being implemented.
Health disparities impact everyone and thus are a public policy issue. The impacts include:

- Cost of healthcare because of the use of emergency rooms rather than regular health care
- Increases in the cost of health insurance
- Work force issues like absences because of illness
- Increases in illness related to crime, abuse and addiction

The analysis reveals four themes for action:

- Stronger alliances are needed among key stakeholders
- North Minneapolis residents must become more proactive in their own health care
- Agencies with the power to influence health disparities must become aware that it is in their own self interest to align with others to work on these issues
- Institutionalized policies and procedures that perpetuate disparities in health outcomes must be actively challenged

The work of the NMHAC is to identify policies and programs that address the problem and create a winning argument for implementing them, using the common interests identified by stakeholder analysis.
Finding the common good and the structure of a winning argument — North Minneapolis Health Advisory Committee
APPENDIX II

Northside Health and Wellness

Gary L. Cunningham
Stacey Rude
June 19, 2003

For more information contact Stacey Rude at 612-302-4840 or stacey.rude@co.hennepin.mn.us
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Perinatal Health

The Near North community has the highest rate of babies born with low birth weight (less than 5.5 lbs.) in Minneapolis. This may be due, in part, to a lower rate of early prenatal care in this community. Less than two-thirds (63.6%) of women in Near North get prenatal care in the first trimester of pregnancy. In the Camden community, 72% of women get prenatal care in the first trimester.

Source: City of Minneapolis, State of the City Report, 2002; 2002 Hennepin County Indicators.

The infant mortality rate in both of these communities is also higher than most other communities in Minneapolis, with Camden having the highest rate in the City. Only Powderhorn has an infant mortality rate similar to these two communities (9.3).

Source: City of Minneapolis, State of the City Report, 2002; Minnesota Department of Health 2002 County Health Tables, Natality.
Pediatric Health

While more than three-quarters of 2-year-olds in Hennepin County are up-to-date on childhood immunizations, only 58% of 2-year-olds in Near North and 64% in Camden are up-to-date.

Source: City of Minneapolis, State of the City Report, 2002; Minnesota Department of Health at www.health.state.mn.us/div/dpc/adps/retrosurvey/retro02htm.

Adolescent Health

Over one-quarter of the babies born in the Near North community and nearly 20% of those born in the Camden community are born to a teenage mother. Near North has the highest percentage of births to teens in Minneapolis; this rate is more than three times what it is for Hennepin County, as a whole.

**Adult Health**

Adults in the Near North and Camden communities struggle with many chronic conditions. SHAPE 2002 findings show that about 7% of people in both communities report that they are diabetic and nearly one-quarter have high blood pressure.

In part, these conditions stem from high rates of obesity (26.4% in Near North and 20.3% in Camden are considered obese) and lack of exercise (18.0% of Near North and 14.2% of Camden residents say they get zero 30-minute periods of moderate exercise per week). In addition nearly 30% of Near North residents and one-quarter of Camden residents report that they currently smoke.

*Source:* Hennepin County Community Health Department, SHAPE, 2002.
The Chlamydia and Gonorrhea rates in Near North are about 3 times higher than what they are for Minneapolis, as a whole. Camden's rates are also higher than the City averages.

The rate of people living with HIV/AIDS in Near North is substantially higher than for the State, as a whole. The majority of African Americans with HIV/AIDS in Minnesota live in the 55411 ZIP code (in Near North.)
Cities Comparisons

Nine major U.S. cities were selected to compare their demographic characteristics with those of Camden, Near North and Minneapolis. Minneapolis, as a whole, often looks comparable to or better-off than many other cities. However, specifically focusing on Near North and Camden reveals that these two communities are often faring worse than other major U.S. cities.

![Percent of Families With Children Under 18 Headed by a Single Mother, 2000](image)


Over one-half of the families with children in Near North (and 37.7% in Camden) are headed by a single mother. These figures are comparable to cities such as Baltimore, Cleveland and St. Louis. In Minneapolis, about 35% of families with children are headed by a single mother.

An additional 10% of families with children in Near North are headed by a single father. This figure is higher than any of the other cities examined.
Nearly 15% of the families in Near North had annual incomes less than 50% of the poverty line in 1999. This figure is higher than any of the other U.S. cities. Camden's rate is lower than many other cities. About 40% of families in Near North have incomes more than 200% of the poverty line, which is substantially lower than any of the other cities.

These figures are likely to be different now, as the economy was much stronger in 1999 than it is today.
Nearly 30% of people over age 25 in Near North and 21% of those in Camden have less than a high school education. This is comparable to cities such as Baltimore, Cleveland and St. Louis.
# Health and Wellness in Camden, Near North, Minneapolis and Hennepin County

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<th></th>
<th>Camden</th>
<th>Near North</th>
<th>Minneapolis</th>
<th>Hennepin County</th>
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<td>52.5%</td>
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<td>Percent babies born to unmarried mothers</td>
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<td>LOW BIRTH WEIGHT (1998-2000)</td>
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<td>INFANT MORTALITY (1998-2000)</td>
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<td>INFANT DEATHS PER 1,000 LIVE BIRTHS</td>
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<td>LEAD (2000)</td>
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<td>Percent Screened for Lead</td>
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<td>Percent of 2-year olds with up-to-date immunizations**</td>
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<td>Percent babies born to teenage mothers</td>
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</tr>
<tr>
<td>SEXUALLY TRANSMITTED INFECTIONS PER 100,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhea***</td>
<td>454.3</td>
<td>1195.2</td>
<td>373.2</td>
<td>168.9</td>
</tr>
<tr>
<td>Chlamydia***</td>
<td>813.9</td>
<td>1690.0</td>
<td>615.8</td>
<td>311.0</td>
</tr>
<tr>
<td>HIV/AIDS**</td>
<td>276.7</td>
<td>502.0</td>
<td>N/A</td>
<td>93.3</td>
</tr>
<tr>
<td>DIABETES (SHAPE 2002)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Diabetic</td>
<td>7.4%</td>
<td>7.2%</td>
<td>5.0%</td>
<td>4.9%</td>
</tr>
<tr>
<td>CARDIOVASCULAR HEALTH (SHAPE 2002)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent with High Blood Pressure</td>
<td>22.9%</td>
<td>23.4%</td>
<td>16.5%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Percent Obese</td>
<td>20.3%</td>
<td>26.4%</td>
<td>16.6%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Percent Getting 0 days per week of 30 minutes of moderate exercise</td>
<td>14.2%</td>
<td>18.0%</td>
<td>13.9%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Percent who currently smoke</td>
<td>24.0%</td>
<td>29.4%</td>
<td>20.7%</td>
<td>18.5%</td>
</tr>
<tr>
<td><strong>WOMEN’S HEALTH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent ever had a mammogram (women 40+)</td>
<td>82.2%</td>
<td>84.1%</td>
<td>90.2%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Percent had a pap smear within last 3 years</td>
<td>81.8%</td>
<td>84.1%</td>
<td>85.4%</td>
<td>86.6%</td>
</tr>
<tr>
<td><strong>GERIATRIC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VACCINATIONS FOR SENIORS (SHAPE 2002)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent received a flu shot within past year (people 65+)</td>
<td>71.8%</td>
<td>67.5%</td>
<td>74.0%</td>
<td>80.1%</td>
</tr>
<tr>
<td><strong>DENTAL CARE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent visiting a dentist within past year (age 18-39)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(SHAPE 2002)</td>
<td>72.4%</td>
<td>61.8%</td>
<td>61.8%</td>
<td>72.6%</td>
</tr>
<tr>
<td><strong>HEALTH CARE ACCESS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent with health care coverage (SHAPE 2002)</td>
<td>91.7%</td>
<td>82.4%</td>
<td>88.8%</td>
<td>93.1%</td>
</tr>
</tbody>
</table>

** 55412 information used for Camden and 55411 for Near North
*** 1999 data used for Hennepin County total
# Demographic Characteristics: Camden, Near North, Minneapolis and Hennepin County and Nine U.S. Cities, U.S. Census 2000

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Camden</th>
<th>Near North</th>
<th>Minneapolis</th>
<th>Hennepin County</th>
<th>Atlanta</th>
<th>Baltimore</th>
<th>Cleveland</th>
<th>Denver</th>
<th>Miami</th>
<th>Portland</th>
<th>St. Louis</th>
<th>San Diego</th>
<th>Seattle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31,712</td>
<td>37,336</td>
<td>382,452</td>
<td>1,116,200</td>
<td>858,850</td>
<td>615,154</td>
<td>478,393</td>
<td>554,636</td>
<td>850,867</td>
<td>653,813</td>
<td>348,189</td>
<td>2,072,936</td>
<td>896,917</td>
</tr>
</tbody>
</table>

## Race/Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>African American</th>
<th>Asian</th>
<th>American Indian</th>
<th>2+ Races</th>
<th>Other Race</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50.7%</td>
<td>27.0%</td>
<td>12.0%</td>
<td>0.9%</td>
<td>5.5%</td>
<td>0.3%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

## Age

|               | Under 1 Year | 1-4 years | 5-9 years | 10-14 years | 15-17 years | 18-19 years | 20-29 years | 30-39 years | 40-49 years | 50-59 Years | 60-64 years | 65-69 years | 70-79 years | 80-84 years | 85+           |
|---------------|-------------|-----------|-----------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|---------------|
|               | 1.7%        | 6.4%      | 10.0%     | 10.1%       | 4.4%        | 2.9%        | 13.2%       | 17.3%       | 14.7%       | 7.8%        | 2.4%        | 1.9%        | 4.2%        | 1.7%        | 1.2%          |

## Marital Status for People Age 15+

<table>
<thead>
<tr>
<th></th>
<th>Never Married</th>
<th>Currently Married</th>
<th>Widowed</th>
<th>Divorced</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>39.3%</td>
<td>42.4%</td>
<td>5.8%</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

## Families with Children <18

<table>
<thead>
<tr>
<th></th>
<th>Married Couple</th>
<th>Single Father</th>
<th>Single Mother</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>54.0%</td>
<td>8.3%</td>
<td>37.7%</td>
</tr>
<tr>
<td></td>
<td>38.8%</td>
<td>10.6%</td>
<td>50.6%</td>
</tr>
<tr>
<td></td>
<td>56.6%</td>
<td>8.2%</td>
<td>35.2%</td>
</tr>
<tr>
<td></td>
<td>72.2%</td>
<td>6.0%</td>
<td>21.8%</td>
</tr>
<tr>
<td></td>
<td>50.0%</td>
<td>7.2%</td>
<td>42.8%</td>
</tr>
<tr>
<td></td>
<td>38.3%</td>
<td>8.4%</td>
<td>53.4%</td>
</tr>
<tr>
<td></td>
<td>40.3%</td>
<td>8.3%</td>
<td>51.4%</td>
</tr>
<tr>
<td></td>
<td>63.0%</td>
<td>8.9%</td>
<td>28.2%</td>
</tr>
<tr>
<td></td>
<td>55.8%</td>
<td>8.3%</td>
<td>50.3%</td>
</tr>
<tr>
<td></td>
<td>67.2%</td>
<td>8.9%</td>
<td>22.3%</td>
</tr>
<tr>
<td></td>
<td>40.8%</td>
<td>7.3%</td>
<td>23.6%</td>
</tr>
<tr>
<td>Population</td>
<td>Camden 31,712</td>
<td>Near North 37,336</td>
<td>Minneapolis 382,452</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------</td>
<td>-------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Less than High School</td>
<td>21.4%</td>
<td>29.3%</td>
<td>15.0%</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>31.0%</td>
<td>28.5%</td>
<td>20.7%</td>
</tr>
<tr>
<td>Some College</td>
<td>24.3%</td>
<td>22.0%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Associate’s Degree</td>
<td>6.6%</td>
<td>5.2%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>12.6%</td>
<td>10.3%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Graduate/ Professional Degree</td>
<td>4.1%</td>
<td>4.6%</td>
<td>13.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment Status for People Age 16+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
</tr>
<tr>
<td>Unemployed</td>
</tr>
<tr>
<td>Not in labor force</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Poverty Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under .50</td>
</tr>
<tr>
<td>.50 to .99</td>
</tr>
<tr>
<td>1.00 to 1.49</td>
</tr>
<tr>
<td>1.50 to 1.99</td>
</tr>
<tr>
<td>2.00 and over</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Housing Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owned</td>
</tr>
<tr>
<td>Rented</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language Spoken at Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
</tr>
<tr>
<td>Miao, Hmong</td>
</tr>
<tr>
<td>Spanish</td>
</tr>
<tr>
<td>African Languages</td>
</tr>
<tr>
<td>Laotian</td>
</tr>
<tr>
<td>European Languages</td>
</tr>
<tr>
<td>Other Asian Languages</td>
</tr>
<tr>
<td>Other Languages</td>
</tr>
</tbody>
</table>

Note: for purposes of this Census analysis, the Camden community includes Census tracts 1.01, 1.02, 3, 1002, 1004, 1007, 1008 and 1009. Near North includes 22, 27, 32, 33, 35.01, 35.02, 1013, 1014, 1015, 1016, 1020, 1021, 1023, 1028, 1029, 1034, 1041.
Hennepin County Board of Commissioners
Mike Opat, 1st District
Mark Stengele, 2nd District
Gail Dorfman, 3rd District
Peter McLaughlin, 4th District
Randy Johnson, 5th District
Linda Koblick, 6th District
Penny Steele, 7th District

County Administration
Sandra L. Vargas, County Administrator
Richard P. Johnson, Deputy County Administrator

North Minneapolis Health Advisory Committee Members
Current Members:
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Laura Au-Yeung, U of M Extension Service, At-large
Mark Brooks, Hennepin County Office of Health Policy and Service Integration
Cleora Brown, At-large
Gary L. Cunningham, Pilot City Health Center
Leahjean Dixon, Frazier Foundation, At-large
Charlnitta (Chi) Ellis, The City Inc., At-large
April Estes, Consumer
Dr. Farzaneh Kia, Northside Health & Family Resource Center, At-large
Amoke Kubat, At-large
Judith Leatham, Hennepin County Medical Center
Anne Long, Plymouth Christian Youth Center, At-large
Carla McMorris, Pilot City Health Center
Todd Monson, Hennepin County Community Health Department
Gretchen Musicant, Minneapolis Department of Health & Family Support
Walter Perkins, Hennepin County Children, Family & Adult Services
Dr. Margaret Dexheimer Pharris, College of Saint Catherine, At-large
Erika Shatz, Consumer
Aaron-Keith Stewart, Minneapolis Urban League, At-large
Rosalind Sullivan, Consumer
Dr. John Williams, Chair and Dental Practitioner

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Gary L. Cunningham, Director, Pilot City Health Center
Stacey Rude, Pilot City Health Center

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Meg Hargreaves and Sheldon Swaney, Hennepin County Community Health
David Doth and Gretchen Musicant, Minneapolis Department of Health and Family Support

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Laura Lipkin

Halleland Health Consulting
Deanna Mills

Indian Wellness Center
Justin Huenemann

Metropolitan Health Plans
David Johnson

Minnesota Council on Health Plans
Janny Brust

Pillsbury United Communities
Lee Pao Moua

Pilot City Health Center
Jacquelyn Coleman, Pilot City Health Center Healthy Start
Ann Sweeney, Pilot City Health Center North High School Based Clinic
Plymouth Christian Youth Center
Maureen Walsh

Stairstep Foundation
Helen Jackson

Turning Point
Yolanda Plunkett

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