



Community Health Assessment 2020

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Revised 2020*

Report contents

Minneapolis assessments

Section 1: Health status indicators

Section 2: Local Public Health System

Section 3: Forces of change

Section 4: Themes and strengths

Community Health Assessment findings



Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

**Thank you very much to the
Minneapolis
Community Health Assessment
Advisory Committee!**

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Datasources

Vital statistics as reported through the Minnesota Department of Health

American Community Survey data 2013 – 2017

Minnesota Hospital Association data

Survey results from Forces of Change survey, collected by MHD

Health themes and strengths focus groups and interviews, collected by MHD

We used the WHO ICD10 system for diagnosis and disease classification

<https://www.who.int/classifications/classification-of-diseases>

MAPP2.0

We used the process outlined in the MAPP 2.0 process to complete our CHA.



Section 1: Minneapolis Health Status Indicators





Indicators include:

Minneapolis city profile

Minneapolis population characteristics

- Race/ethnicity, Languages at home, Foreign born residents
- Disability
- Poverty
- Cost-burdened and rentals vs homeownership
- Households
- Educational attainment
- Workforce
- Workforce industries and location
- Transportation

Health status

- Asthma
- Births
- Deaths
- Mental health
- Opioids
- STI/HIV

Minneapolis city profile



Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

The land Minneapolis is on was originally Dakota land (name mni = water), located at the point where the Minnesota River joins the Mississippi River called Bdote in Dakota language.

Minneapolis is a comparatively young city, with about 71% of our residents between the ages of 18 and 64. Other cities for comparison (St Paul – 64.9, Duluth – 66.8, Rochester – 61.7, Mankato – 71.9, MN compass (2013 – 2017)). Total population growth has been steady over the last decade, with the latest estimates at 425,403 (2018, ACS). Forecasts predict that with similar growth over the next decade, we may attain a population of 439,100 and 459,200 by 2040.

Geographically, Minneapolis includes 12 lakes, 3 ponds, 5 unnamed wetlands are located within the city limits, small and shallow enough to be covered by ice in the winter (6% of total city is covered in water).

Minneapolis-based Fortune 500 companies include Target, US Bankcorp, Xcel Energy, Ameriprise Financial, and Thrivent Financial for Lutherans. Minneapolis-based Fortune 1000 companies include PepsiAmericas, Valspar, and Donaldson Company.

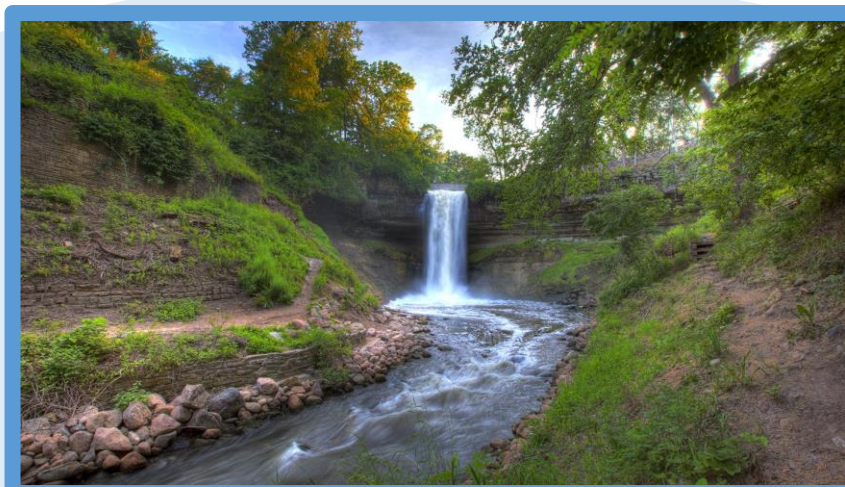


Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

Minneapolis city profile

The area of the city is 54.9 square miles, divided administratively into 11 communities and 87 neighborhoods. The city is located within Hennepin County, a large and populous county that

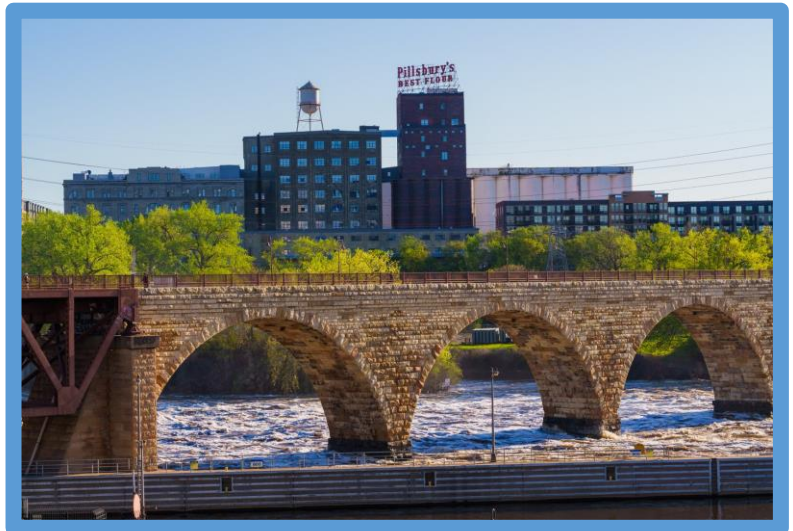
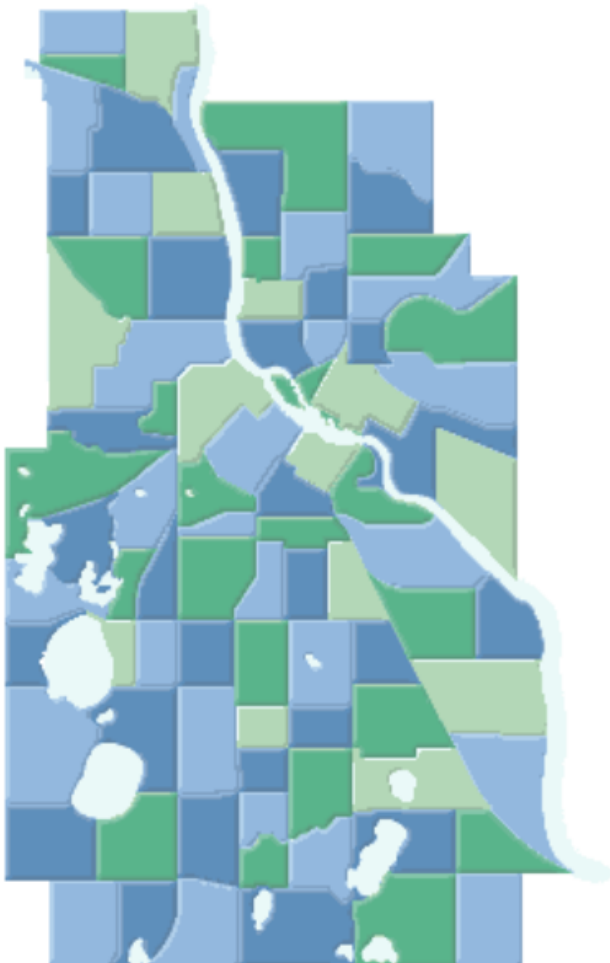


Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

stretches from rural Rogers in the north to wealthy lake communities like Minnetonka in the west. The Minneapolis city center is just south of 45 degrees north latitude – and just east of Wirth Parkway is a plaque that marks a point on the 45th parallel! Minneapolis is the birthplace of the American Indian Movement, and the Minneapolis Sound, made famous by Prince.



- Armatage
- Audubon Park
- Bancroft
- Beltrami
- Bottineau
- Bryant
- Bryn Mawr
- Cedar-Riverside
- Cedar-Isles-Dean
- Central
- Cleveland
- Columbia Park
- Corcoran
- Downtown East, West
- East Bde Maka Ska
- East Harriet
- East Isles
- East Phillips
- Elliot Park
- Field, Regina, Northrop
- Folwell
- Fulton
- Hale, Page, Diamond Lake
- Harrison
- Hawthorne
- Holland
- Jordan
- Kenny
- Kenwood
- Kingfield
- Lind-Bohanon
- Linden Hills
- Logan Park
- Longfellow
- Loring Park
- Lowry Hill
- Lowry Hill East
- Lyndale
- Lynnhurst
- Marcy-Holmes
- Marshall Terrace
- McKinley
- Midtown Phillips
- Near North, Willard-Hay
- Nicollet Island/East Bank
- Nokomis East
- North Loop
- Northeast Park
- Phillips West
- Powderhorn Park
- Prospect Park
- Seward
- Sheridan
- Shingle Creek
- South Uptown
- Southeast Como
- St. Anthony East
- St. Anthony West
- Standish Ericsson
- Stevens Square
- Sumner-Glenwood
- Tangletown
- Ventura Village
- Victory
- Waite Park
- Webber-Camden
- West Maka Ska
- Whittier
- Windom
- Windom Park

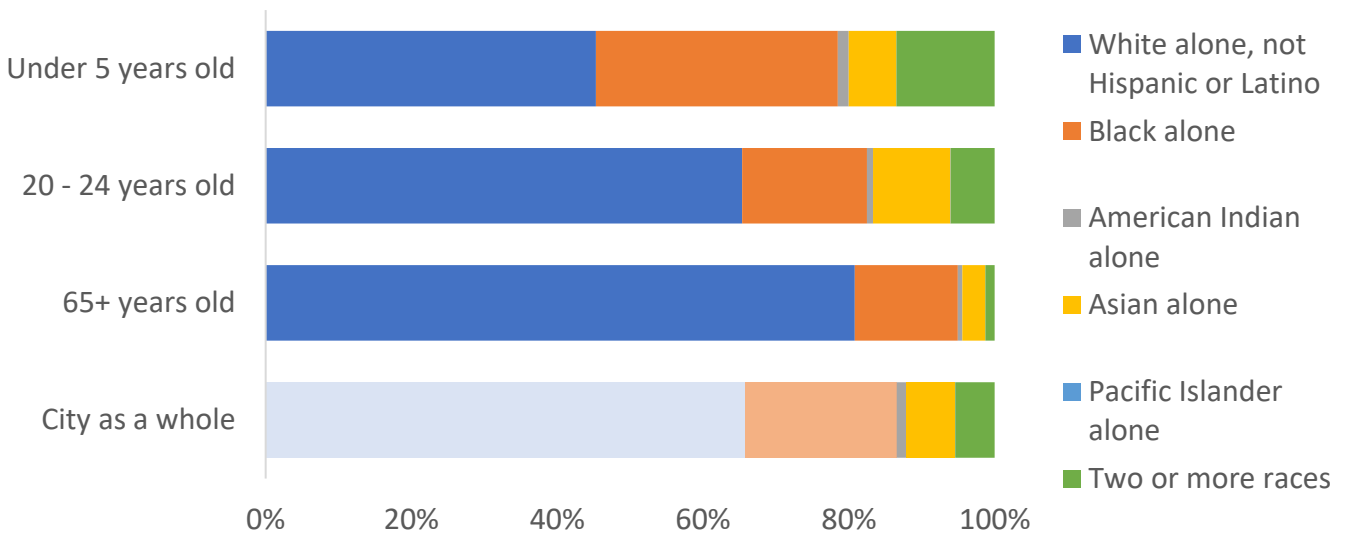
Minneapolis population characteristics:

Race/ethnicity, birth location, and languages spoken at home

Minneapolis is vibrant and bustling city, home to distinct communities with their own goals and visions for their health. Although many outside of the city stereotype Minnesotans as white and Scandinavian, this young city identifies increasingly as non-white with every generation.

This underlines the urgency of racial equity and anti-racism work as foundational to health in the city.

Race by age group



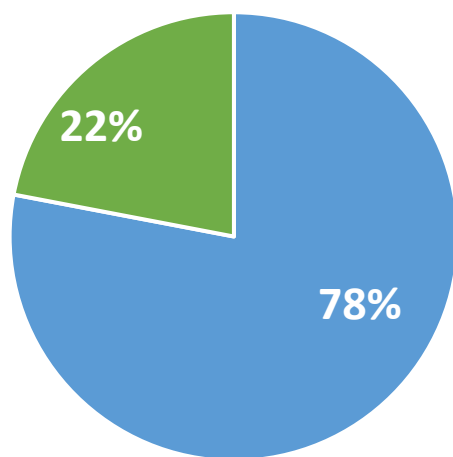
ACS 2013 - 2017

Race/ethnicity	Under 5 years old	20 – 24 years old	65+ years old	City as a whole
White alone, not Hispanic or Latino	10,819	24,420	29,814	246,351
Black alone	7,932	6,390	5,223	77,778
American Indian alone	355	311	227	5,086
Asian alone	1,563	3,975	1,156	24,892
Pacific Islander alone	0	6	0	79
Two or more races	3,221	2,255	479	20,218
Hispanic or Latino	4,489	3,539	877	40,147

ACS 2013 - 2017

Over one-fifth of Minneapolis households speak a language other than English at home and about 10% of individuals in Minneapolis speak English less than “very well.” About 16% of Minneapolis residents were born in another country.

Languages spoken at home



■ English only ■ Other than English

ACS 2013 - 2017

About 16% of Minneapolis residents were born in another country.

Minneapolis population characteristics:

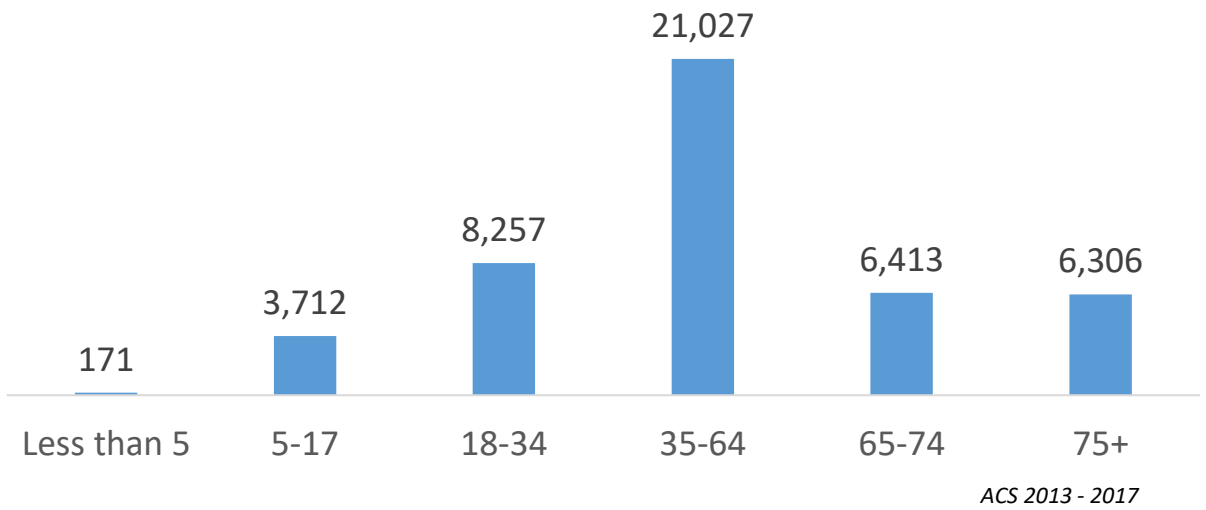
Disability

About 112 people per 1,000 Minneapolis residents live with a disability.

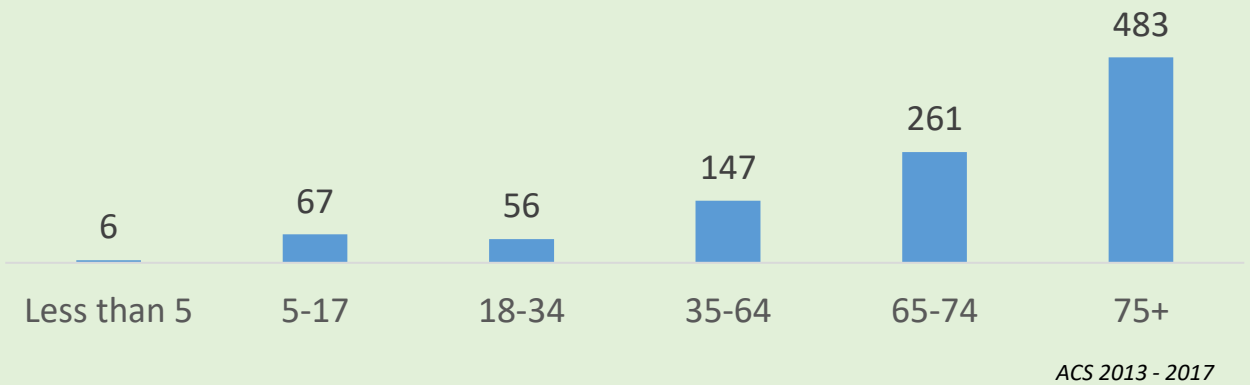
About 34% of adults over 65 live with a disability.

Overall, 11% of Minneapolis residents live with a disability.

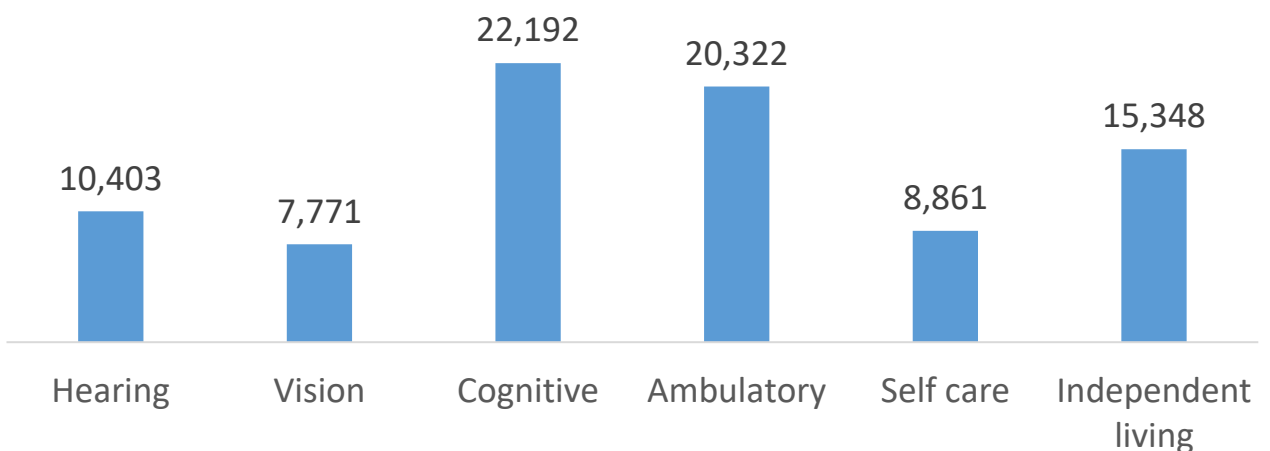
Count of residents living with a disability by age group



Rate of people living with a disability per 1,000 residents, by age group



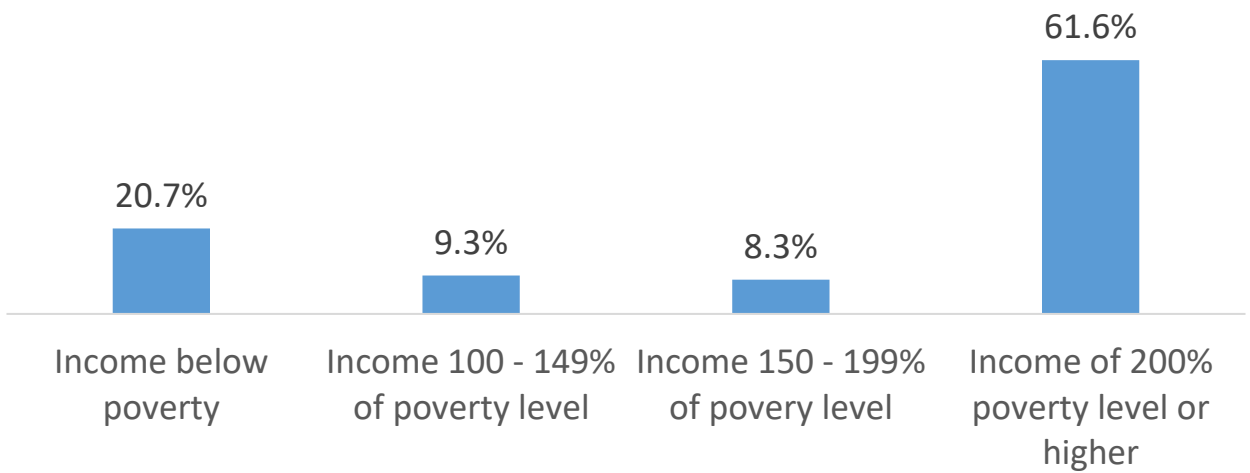
Count of residents with different types of disabilities



Minneapolis population characteristics:

Poverty

Percent of Minneapolis residents living in poverty



ACS 2013 - 2017

Poverty level refers to the level of income above which it is possible to achieve a reasonable standard of living and below which it is not. It is the minimum amount of income required by a family for food, clothing, transportation, shelter, and other necessities. This is also frequently a number used to determine eligibility for certain medical or government assistance.

The number changes because it is calculated using number of household members, so it is higher for people with more children and lower for smaller families, which makes sense because it costs more to feed more people.

A household is defined as people who live together under one roof and buy food together. Below is the 2023 Federal Poverty guidelines.

Number of people in the household	2023 federal poverty line (100% of the federal poverty guideline)	150% of the federal poverty guideline (1.5 x guideline)	200% of the federal poverty guideline (2 x guideline)
One	\$14,580	\$21,870	\$29,160
Two	\$19,720	\$29,580	\$39,440
Three	\$24,860	\$37,290	\$49,720
Four	\$30,000	\$45,000	\$60,000
Five	\$35,140	\$52,710	\$70,280
Six	\$40,280	\$60,420	\$80,560
Seven	\$45,420	\$68,130	\$90,840
Eight*	\$50,560	\$75,840	\$101,120

*For more than eight people, add \$5,140 for each additional person

Minneapolis population characteristics:

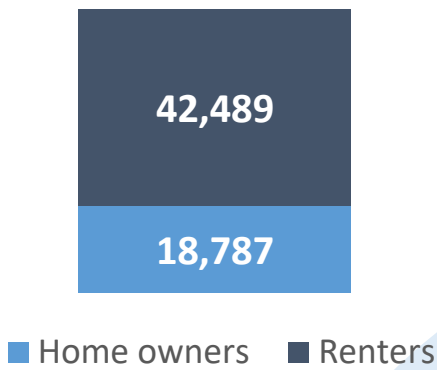
Cost-burdened households

In Minneapolis, the median rent paid is \$941

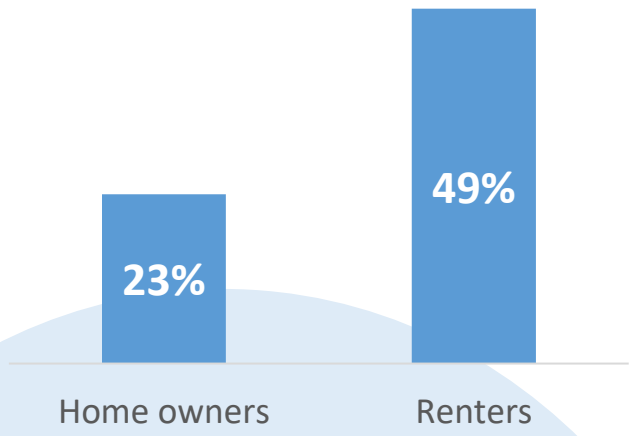
36% of all households in Minneapolis are cost-burdened.

A household is cost-burdened when it spends more than 30% of its income on rent and utilities.

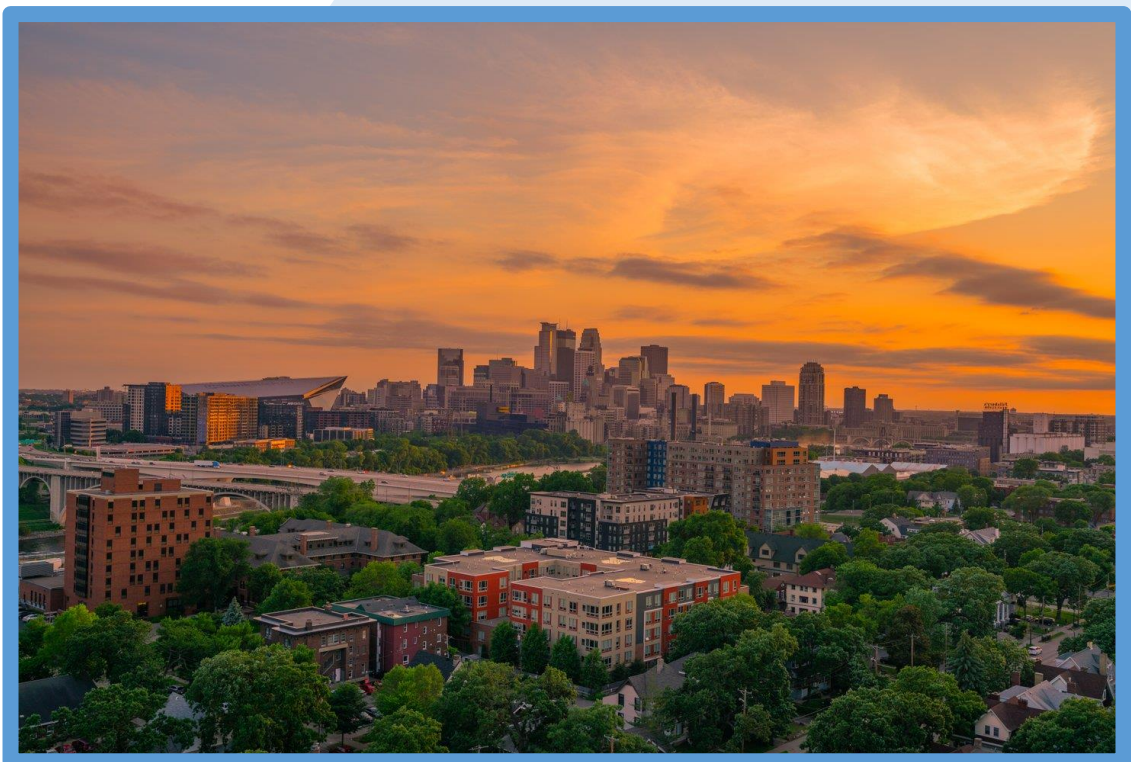
Count of cost-burdened households in Minneapolis



Percent of cost-burdened households by ownership



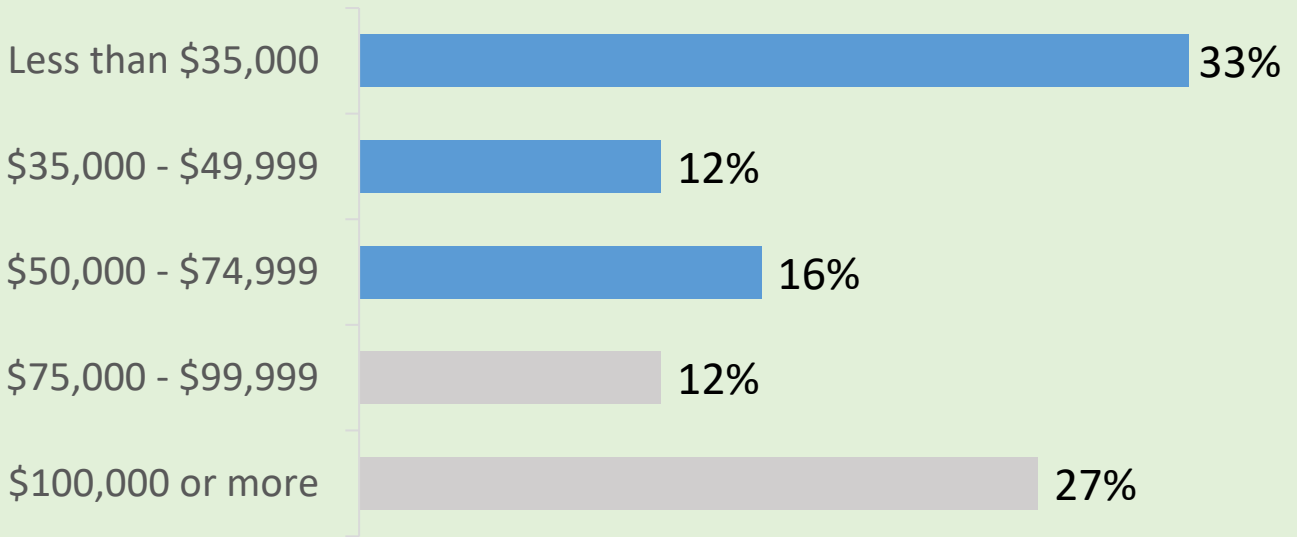
ACS 2013 - 2017



Minneapolis population characteristics:

Households

Households by income (2017 dollars)



Median household income (2017 dollars)

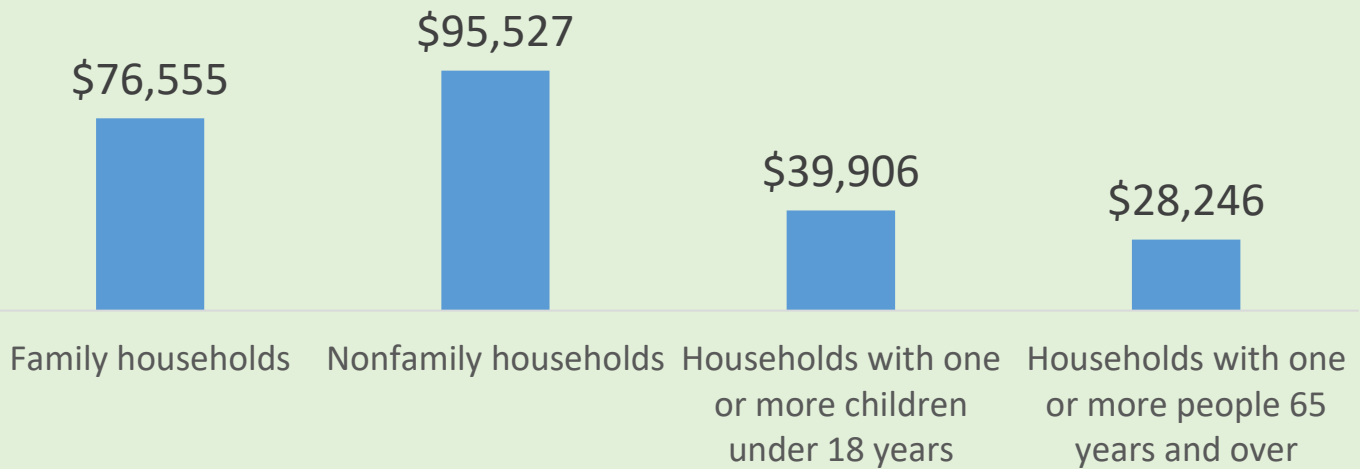
\$55,720

Median household income, householder age 65+

\$36,416

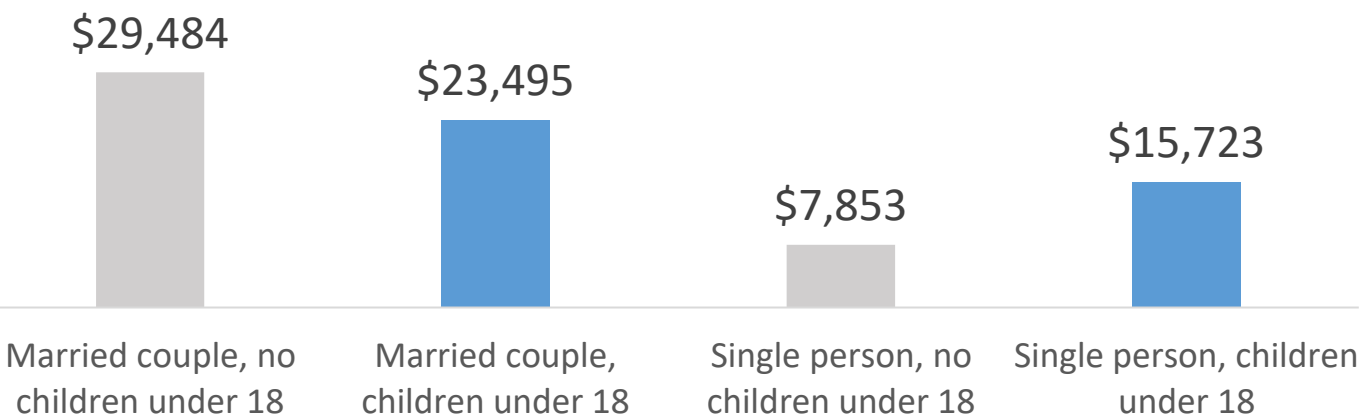
ACS 2013 - 2017

Households by composition



ACS 2013 - 2017

Households by children under 18 years old

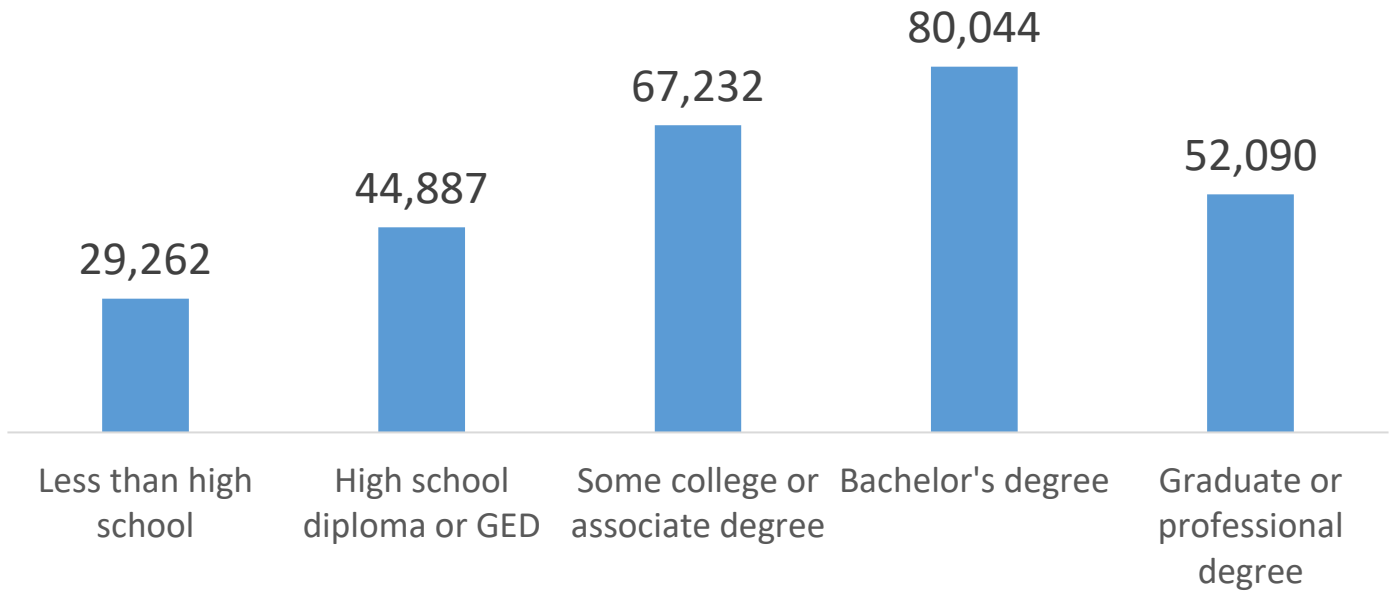


ACS 2013 - 2017

Minneapolis population characteristics:

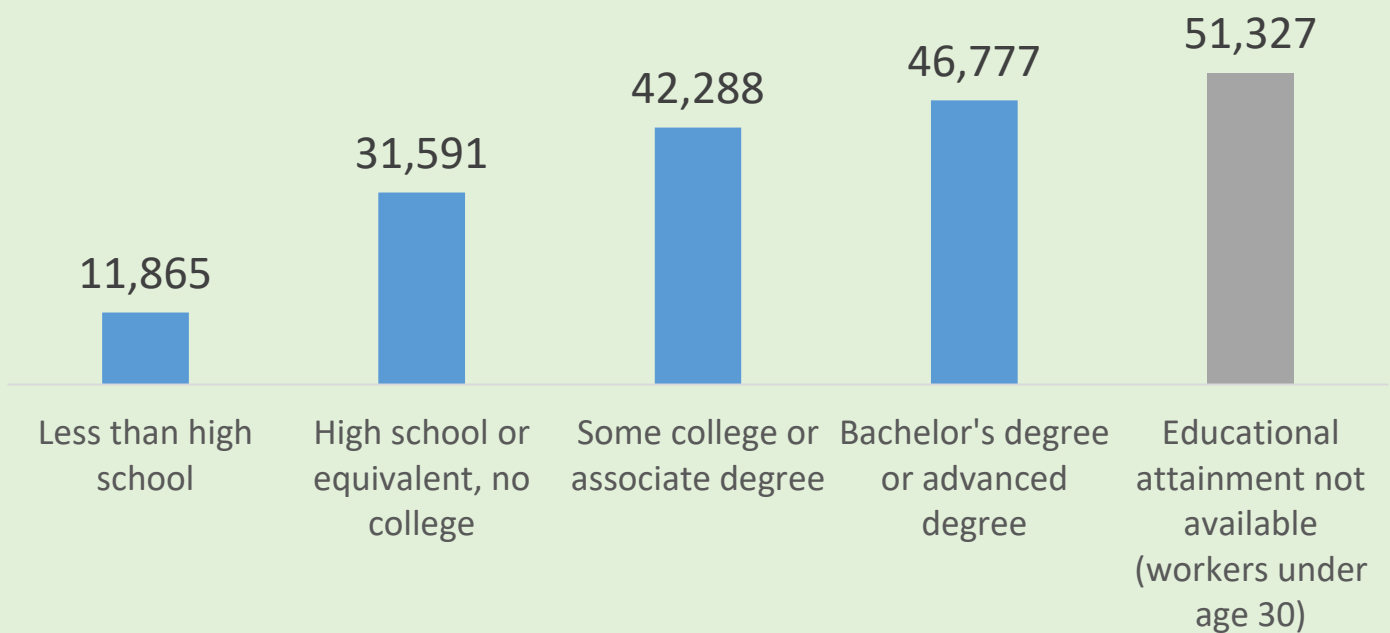
Educational attainment

Count of Minneapolis residents age 25 years and older by educational attainment



ACS 2013 - 2017

Count of workers who are Minneapolis residents, by educational attainment



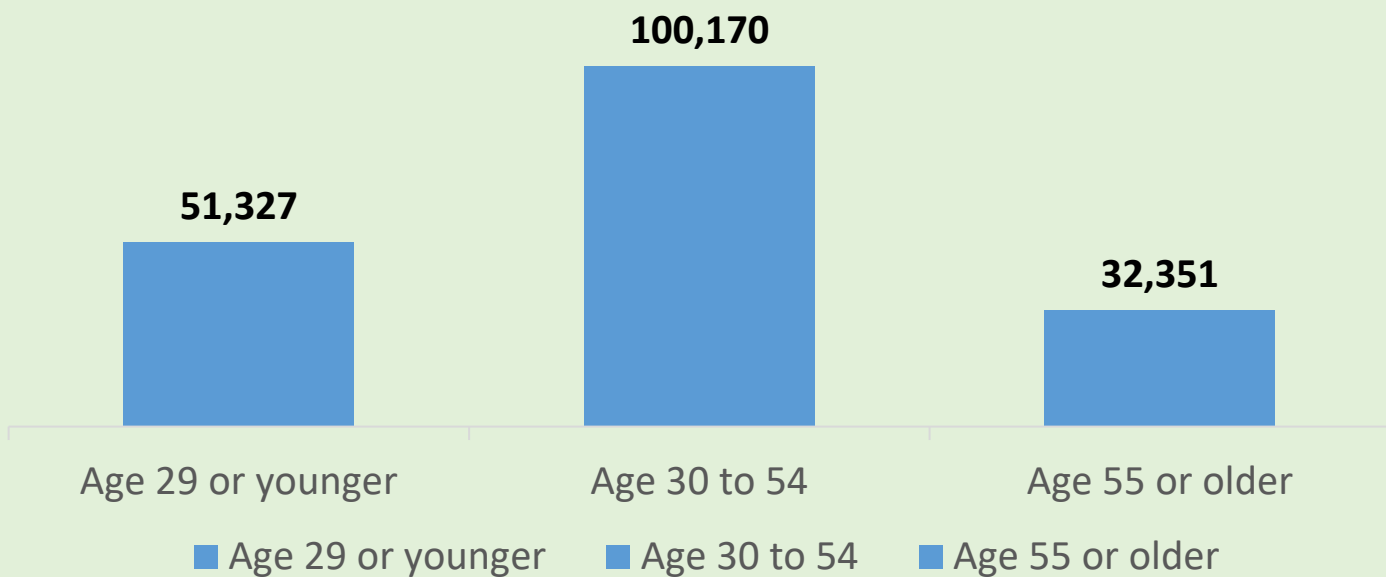
ACS 2013 - 2017

Minneapolis population characteristics:

Workforce

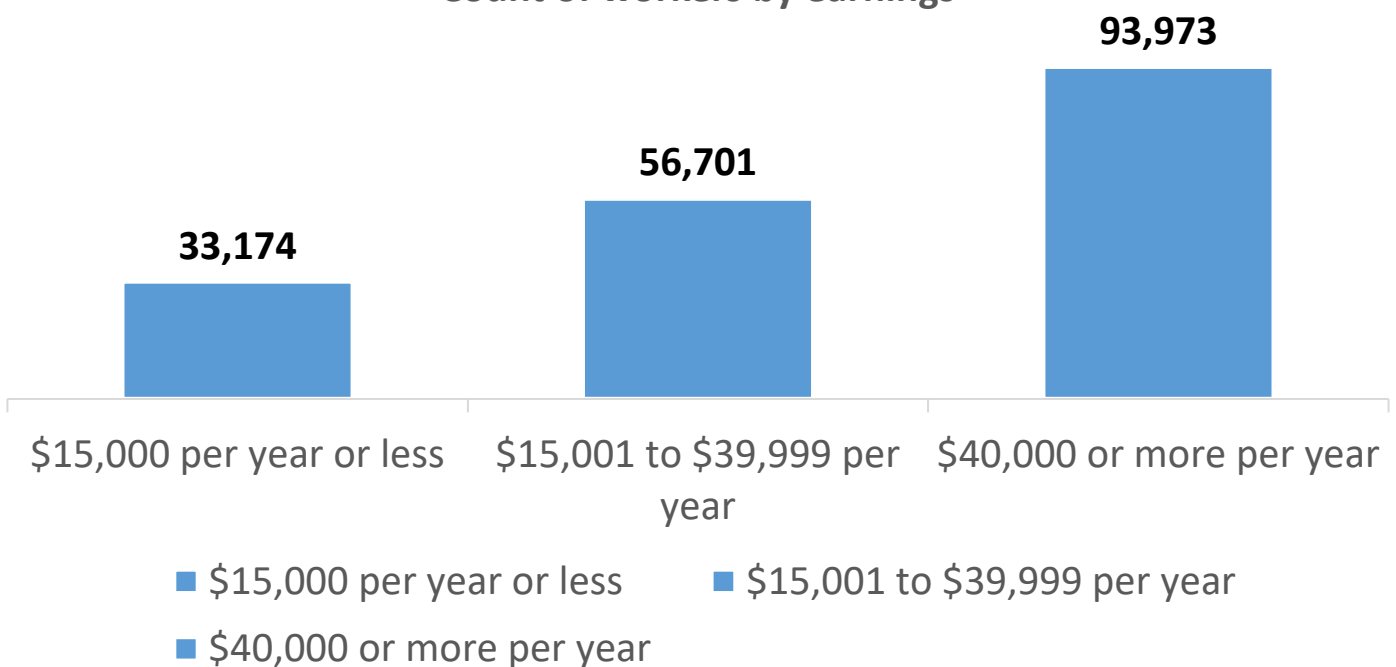
Unemployment in Minneapolis is 5.9% (among the civilian labor force that is unemployed).
77.4% of working adults are employed.

Count of workers by age group



ACS 2013 - 2017

Count of workers by earnings



ACS 2013 - 2017

Minneapolis population characteristics:

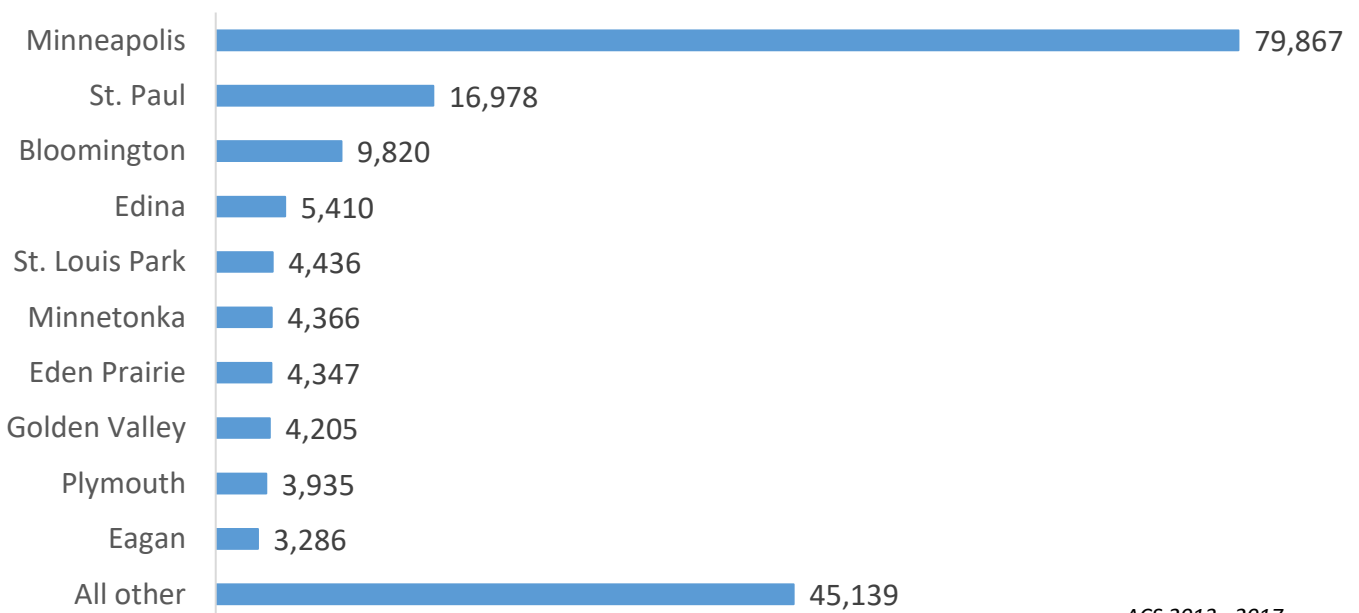
Workforce industries and settings

Count of workers living in Minneapolis by industry of employment



ACS 2013 - 2017

Count of workers living in Minneapolis by employment location



ACS 2013 - 2017

Minneapolis population characteristics:

Transportation

Traffic injuries and fatalities occur in Minneapolis at a rate of 114.5 per 10,000 residents.



Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

Count of Minneapolis residents by transportation to work

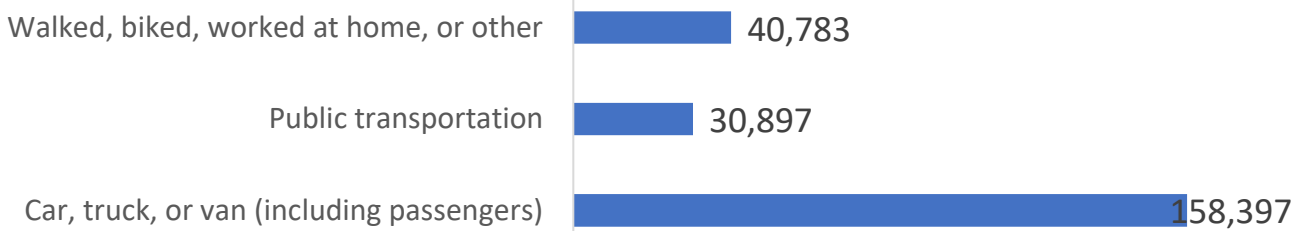
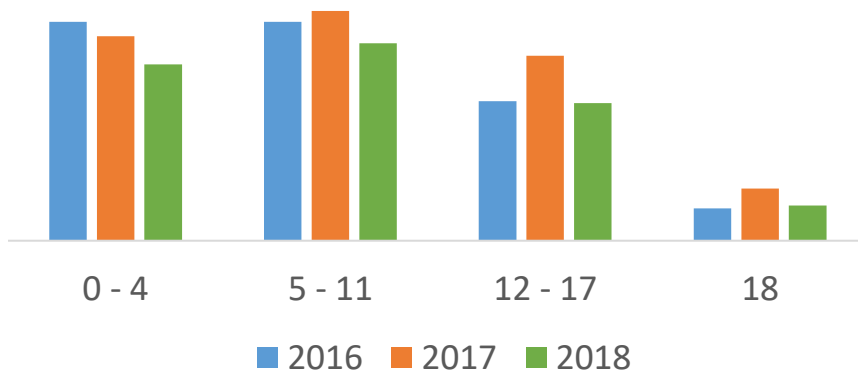


Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

Asthma:

Emergency department visits and deaths

Asthma emergency department visits among Minneapolis youth



Asthma emergency department visits			
Age groups	2016	2017	2018
0 - 4	1,178	1,100	950
5 - 11	1,179	1,236	1,062
12 - 17	751	995	740
18	174	282	190
19 and over	11,072	13,682	12,306
Totals	14,354	17,295	15,248

Minnesota Hospital Association data

Asthma-related death									
	Year of death								Total
	2011	2012	2013	2014	2015	2016	2017	2018	
Juvenile, age 10-17	0	0	0	0	1	0	0	0	1
Young adult, age 18-24	0	0	0	1	0	0	0	0	1
Adult, age 25 and over	4	5	4	6	5	3	0	7	34

Asthma as contributing cause of death									
	Year of death								Total
	2011	2012	2013	2014	2015	2016	2017	2018	
Child, age 1-9	0	0	0	1	0	0	0	0	1
Juvenile, age 10-17	0	0	0	0	1	2	0	0	3
Young adult, age 18-24	0	1	0	2	0	0	1	0	4
Adult, age 25 and over	17	23	23	38	26	24	25	24	200

Death records, updated 11/6/2019

Asthma:

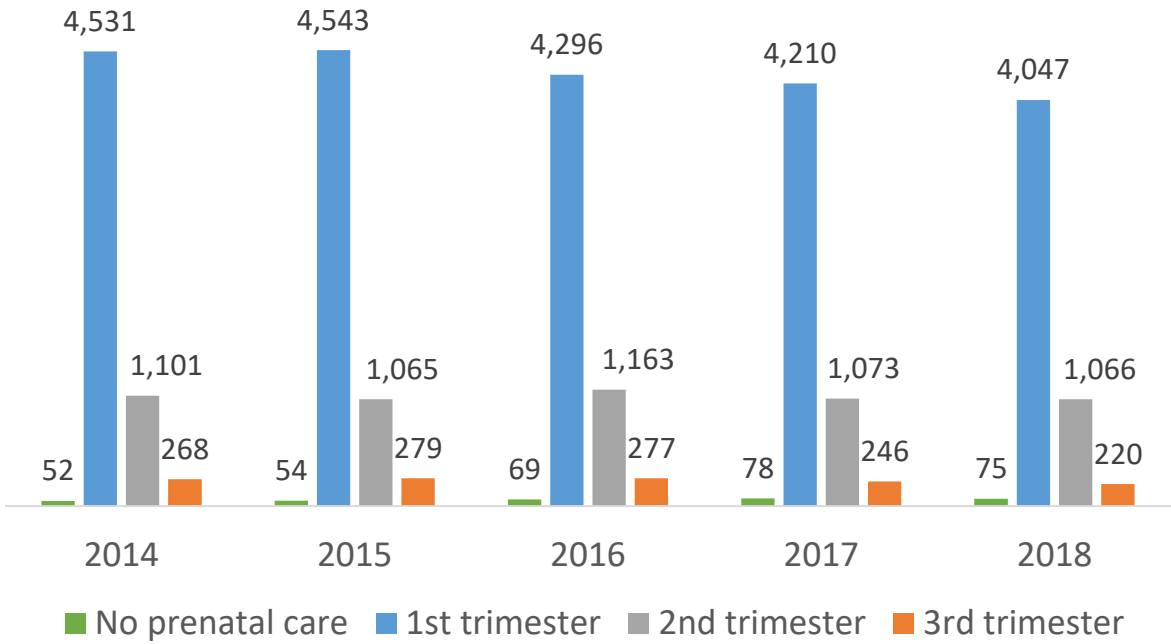
Emergency department visits and deaths

Asthma emergency visits among residents younger than 19 years, by zip code				
	2016	2017	2018	Total
55401	9	17	7	33
55402	2	2	0	4
55403	57	52	43	152
55404	308	314	289	911
55405	93	90	71	254
55406	154	157	115	426
55407	408	318	300	1026
55408	198	190	148	536
55409	47	61	45	153
55410	40	52	40	132
55411	687	949	742	2378
55412	415	537	357	1309
55413	54	40	49	143
55414	70	43	42	155
55415	49	57	56	162
55416	60	56	40	156
55417	118	110	102	330
55418	153	110	99	362
55419	84	97	102	283
55430	198	267	224	689
55454	76	90	71	237
55455	2	2	0	4
55487	0	2	0	2

Birth data:

Mother received prenatal care

Mother's receipt of prenatal care (age >14) by year of birth



Mother's receipt of prenatal care (age >14)					
	2014	2015	2016	2017	2018
No prenatal care	52	54	69	78	75
1st trimester	4531	4543	4296	4210	4047
2nd trimester	1101	1065	1163	1073	1066
3rd trimester	268	279	277	246	220
Total	5952	5941	5805	5607	5408

Data from MDH, analysis by MHD, Updated: 11/06/2019

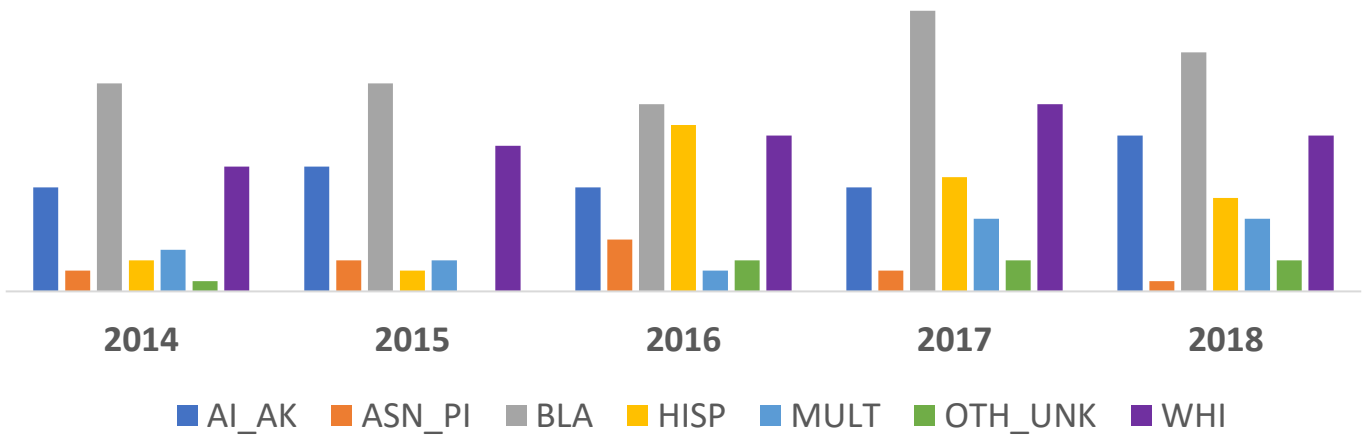


Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

Birth data:

Mother received prenatal care by race/ethnicity

Mothers who received no prenatal care by race/ethnicity, count

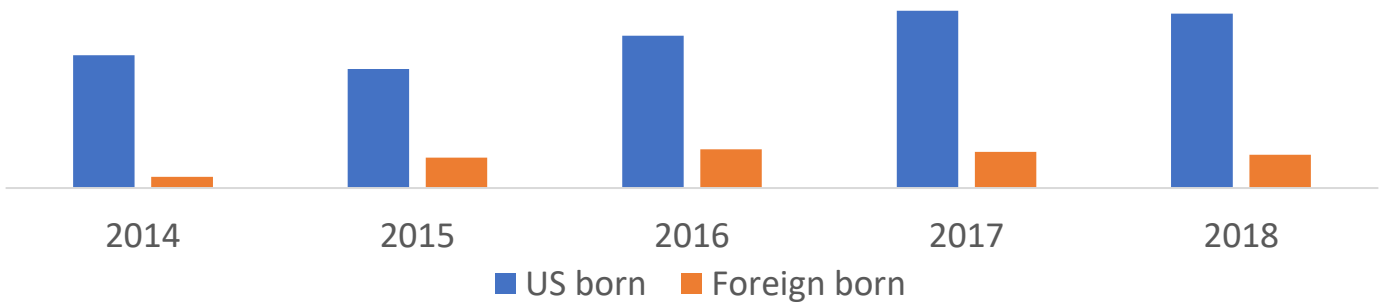


Mother's receipt of prenatal care by race (count)		2014	2015	2016	2017	2018
No prenatal care	Not provided	18	0	0	0	2
	AI_AK	10	12	10	10	15
	ASN_PI	2	3	5	2	1
	BLA	20	20	18	27	23
	HISP	3	2	16	11	9
	MULT	4	3	2	7	7
	OTH_UNK	1	0	3	3	3
	WHI	12	14	15	18	15
1st trimester	Not provided	0	0	0	82	91
	AI_AK	58	53	44	42	33
	ASN_PI	319	327	287	282	302
	BLA	1141	1167	1084	1064	1013
	HISP	547	553	506	377	323
	MULT	134	156	165	140	133
	OTH_UNK	33	51	32	36	22
	WHI	2,299	2,236	2,178	2,186	2,128
2nd trimester	Not provided	0	0	0	31	24
	AI_AK	36	25	34	28	27
	ASN_PI	109	89	109	89	80
	BLA	445	446	480	468	481
	HISP	147	129	153	121	134
	MULT	37	52	41	41	44
	OTH_UNK	13	15	8	8	10
	WHI	314	309	338	286	266
3rd trimester	Not provided	0	0	0	8	5
	AI_AK	12	14	15	14	8
	ASN_PI	15	23	19	16	11
	BLA	128	136	125	126	121
	HISP	29	28	41	25	20
	MULT	13	12	14	7	10
	OTH_UNK	3	2	2	4	2
	WHI	68	64	61	46	43

Birth data:

Mother received prenatal care by nativity

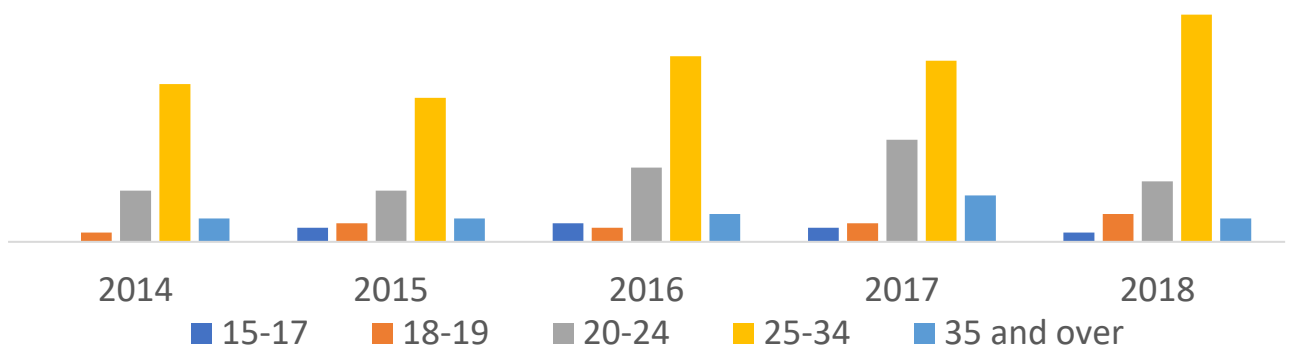
Mothers who received no prenatal care by nativity, count



Mother's receipt of prenatal care by nativity (count)		2014	2015	2016	2017	2018
No prenatal care	US born	48	43	55	64	63
	Foreign born	4	11	14	13	12
1st trimester	US born	3225	3180	3069	3030	2935
	Foreign born	1301	1362	1224	1178	1111
2nd trimester	US born	647	615	680	614	608
	Foreign born	452	449	482	458	456
3rd trimester	US born	157	156	139	131	118
	Foreign born	110	123	137	114	101

Data from MDH, analysis by MHD, Updated: 11/06/2019

Mothers who did not receive prenatal care by age, count



Mother's receipt of prenatal care by age, (count)		2014	2015	2016	2017	2018
No prenatal care	15-17	0	3	4	3	2
	18-19	2	4	3	4	6
	20-24	11	11	16	22	13
	25-34	34	31	40	39	49
	35 and over	5	5	6	10	5
1st trimester	15-17	55	34	36	32	20
	18-19	114	103	103	90	77
	20-24	579	581	470	443	398
	25-34	2820	2827	2572	2590	2435
	35 and over	963	998	1115	1055	1117
2nd trimester	15-17	26	22	22	19	24
	18-19	63	45	43	38	37
	20-24	204	212	191	181	158
	25-34	627	578	661	591	595
	35 and over	181	208	246	244	252
3rd trimester	15-17	6	11	6	4	2
	18-19	9	10	9	14	7
	20-24	58	53	61	44	49
	25-34	154	151	157	130	121
	35 and over	41	54	44	54	41

Data from MDH, analysis by MHD, Updated: 11/06/2019

Birth data:
Low birth weight

Minneapolis low birth weight (all births)					
	2014	2015	2016	2017	2018
Not LBW, >=2500 grams	5,623	5,571	5,446	5,210	5,050
LBW, <2500 grams	470	489	476	504	442

Data from MDH, analysis by MHD, Updated: 11/06/2019

Minneapolis low birth weight by race (all births)						
		2014	2015	2016	2017	2018
Not LBW, >=2500 grams	AI_AK	109	100	95	86	81
	ASN_PI	413	422	393	369	359
	BLA	1,595	1,609	1,568	1,509	1,462
	HISP	698	674	647	491	458
	MULT	177	208	204	178	175
	OTH_UNK	48	69	40	53	39
	WHI	2,583	2,489	2,499	2,406	2,355
LBW, <2500 grams	AI_AK	16	16	17	14	10
	ASN_PI	43	27	29	25	41
	BLA	181	199	162	204	188
	HISP	41	49	74	51	36
	MULT	15	21	23	25	19
	OTH_UNK	7	3	7	10	2
	WHI	167	174	164	168	140

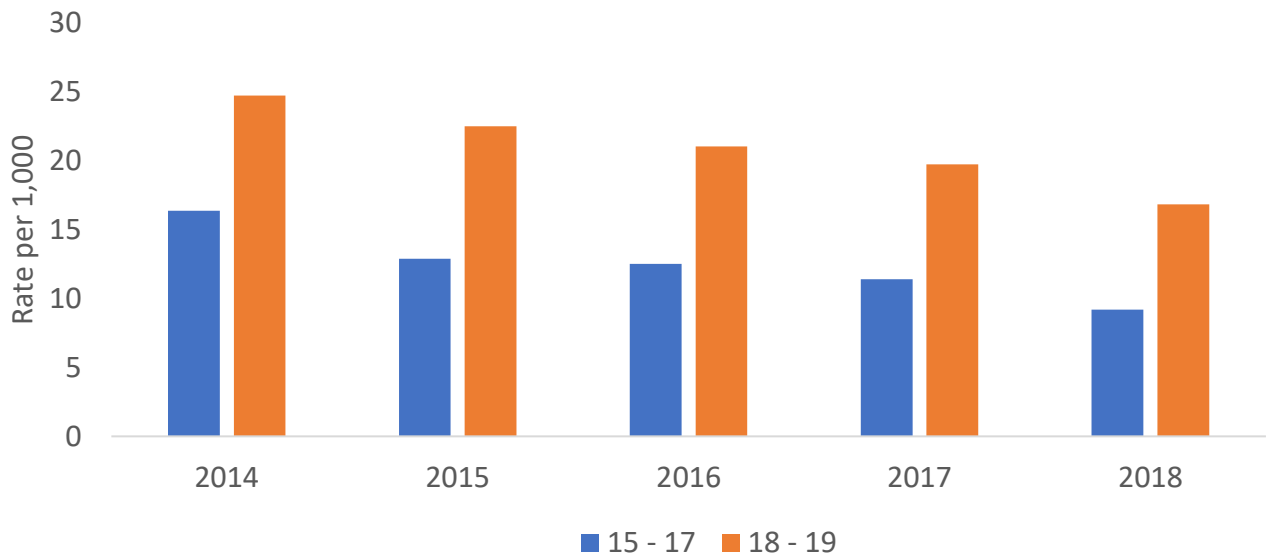
Data from MDH, analysis by MHD, Updated: 11/06/2019

Minneapolis low birth weight by nativity (all births)						
		2014	2015	2016	2017	2018
Not LBW, >=2500 grams	US born	3,836	3,697	3,685	3,532	3,458
	Foreign born	1,780	1,872	1,756	1,673	1,587
LBW, <2500 grams	US born	340	383	356	376	326
	Foreign born	129	105	118	128	116

Data from MDH, analysis by MHD, Updated: 11/06/2019

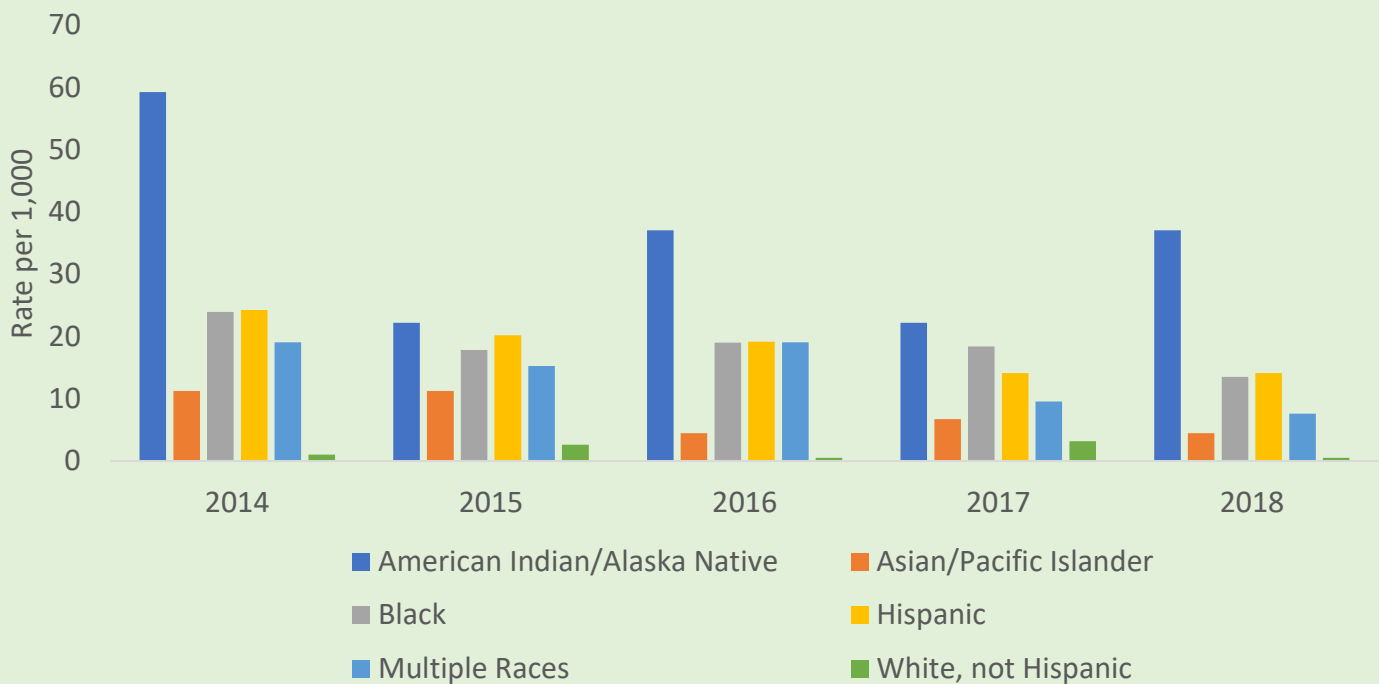
Birth data:
Births to teen mothers

Teen Birth Rate by Age Group and Year, Minneapolis, 2014 - 2018



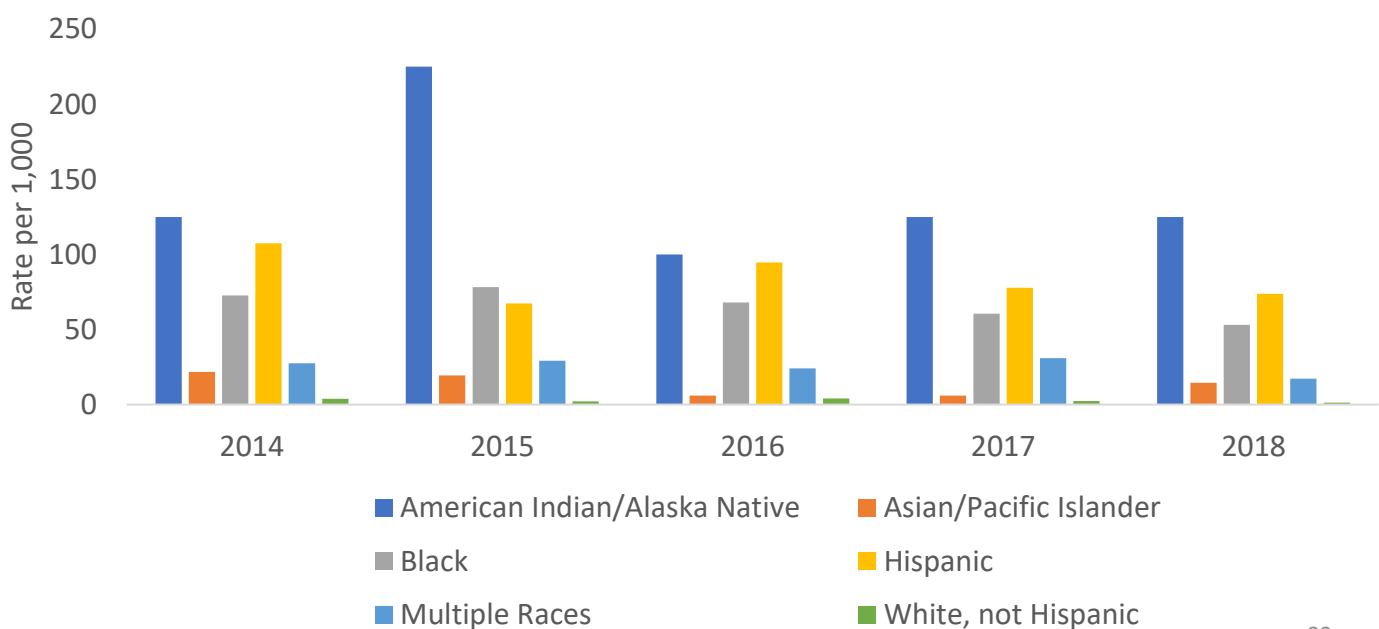
Data from MDH, analysis by MHD, Updated: 11/06/2019

Teen (15 - 17) Birth Rate by Race, Minneapolis, 2014 - 2018



Data from MDH, analysis by MHD, Updated: 11/06/2019

Teen (18 - 19) Birth Rate by Race, Minneapolis, 2014 - 2018



Data from MDH, analysis by MHD, Updated: 11/06/2019

Death Data

Leading Causes of Death - 2018

Cause of death		Count
All-cause		2,339
1	All cancer	469
2	Heart disease	362
3	Unintentional injury	234
4	Chronic lower respiratory disease	115
5	Cerebrovascular disease	110
6	Alzheimer's disease	81
7	Diabetes	78
8	Chronic liver disease and cirrhosis	61
9	Essential (primary) hypertension and hypertensive renal disease	56
10	Suicide	41

Data from MDH, analysis by MHD, Updated: 11/06/2019

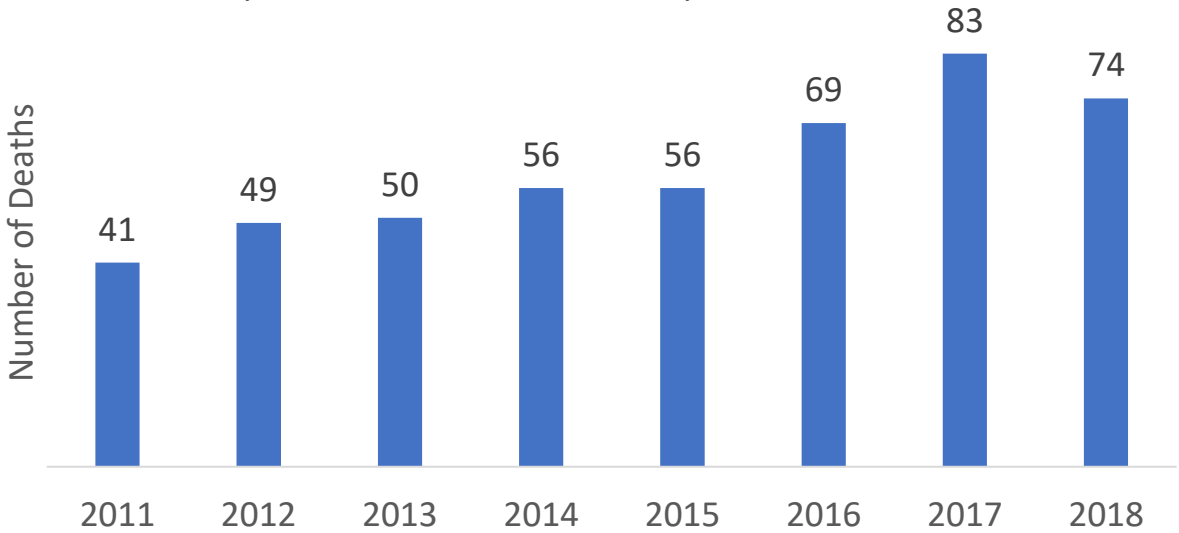
Leading Cause of Premature Death - 2018

Cause of premature death		Count
All-cause		815
1	All cancer	153
2	Unintentional injury	155
3	Heart disease	120
4	Chronic liver disease and cirrhosis	46
5	Suicide	39
6	Chronic lower respiratory disease	25
7	Diabetes	23
8	Cerebrovascular disease	23
9	Homicide	20
10	Influenza and pneumonia	11

Data from MDH, analysis by MHD, Updated: 11/06/2019

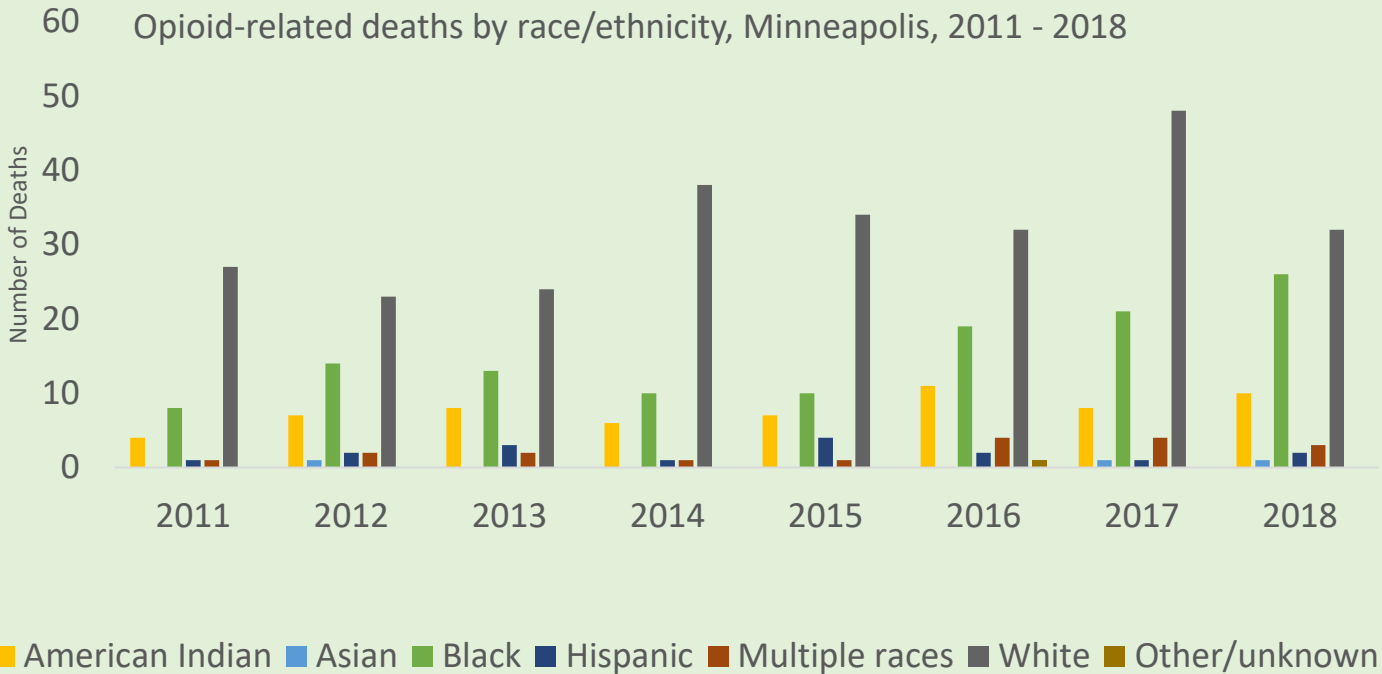
Opioids

Opioid-related deaths, Minneapolis, 2011 - 2018



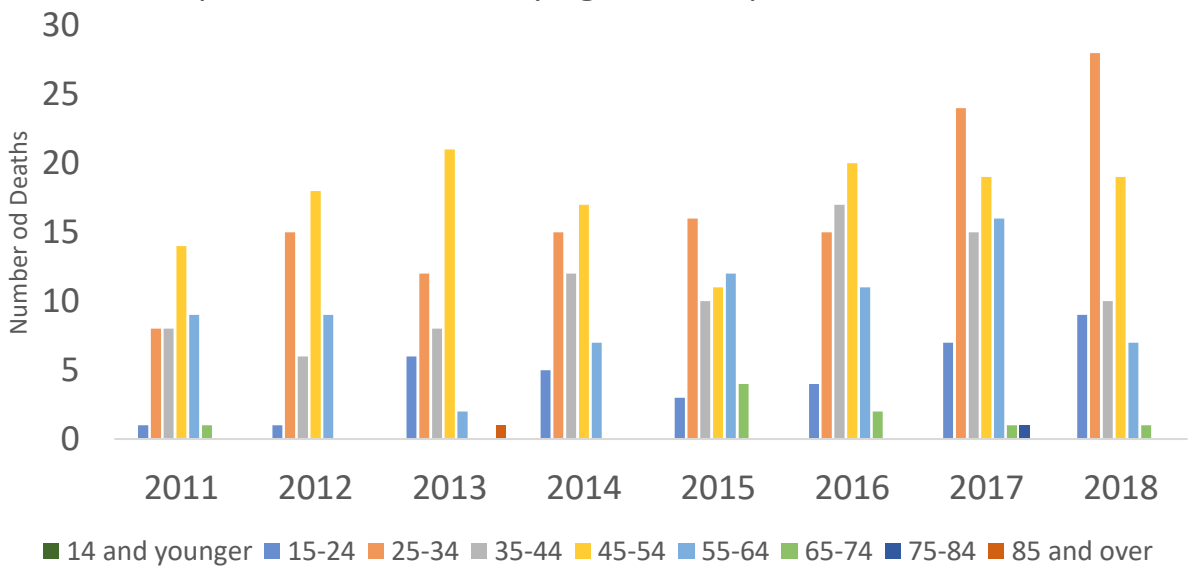
Data from MDH, analysis by MHD, Updated: 11/06/2019

Opioid-related deaths by race/ethnicity, Minneapolis, 2011 - 2018



Data from MDH, analysis by MHD, Updated: 11/06/2019

Opioid-related deaths by Age, Minneapolis, 2011 - 2018



Data from MDH, analysis by MHD, Updated: 11/06/2019

Mental health

Self-inflicted injuries hospital visits, inpatient and outpatient, Minneapolis

Self-inflicted injuries: non-poisoning				
	2016	2017	2018	Total
Self-inflicted injuries: non-poisoning	22	25	22	69
Self-inflicted injuries: poisoning, non-drug				
	2016	2017	2018	Total
Self-inflicted injuries: poisoning, non-drug	74	69	99	242
Self-inflicted injuries: poisoning, drug				
	2016	2017	2018	Total
Self-inflicted injuries: poisoning, drug	665	695	768	2,128

Data from MHA, analysis by MHD, Updated: September 2019

Mental health diagnosis among Emergency Department admissions				
	Year of discharge			
	2016	2017	2018	
Mental health as part of diagnosis (F90 - F99)	72,398	83,732	80,799	
Organic, including symptomatic, mental disorders, e.g. dementia. (F00 - F09)	2,963	3,201	3,335	
Mental and behavioral disorders due to psychoactive substance use. (F10 - F19)	52,381	63,205	58,848	
Schizophrenia, schizotypal and delusional disorders. (F20 - F29)	5,709	6,119	6,549	
Mood (affective) disorders. (F30 - F39)	19,772	20,889	22,455	
Neurotic, stress-related and somatoform disorders. (F40 - F48)	16,930	18,036	19,887	
Behavioral syndromes associated with physiological disturbances and physical factors. (F50 - F59)	587	668	815	
Disorders of adult personality and behavior. (F60 - F69)	2,648	3,170	3,183	
Intellectual disability. (F70 - F79)	554	566	638	
Disorders of psychological development. (F80 - F89)	649	699	818	
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence. (F90 - F98)	2,054	2,123	2,330	

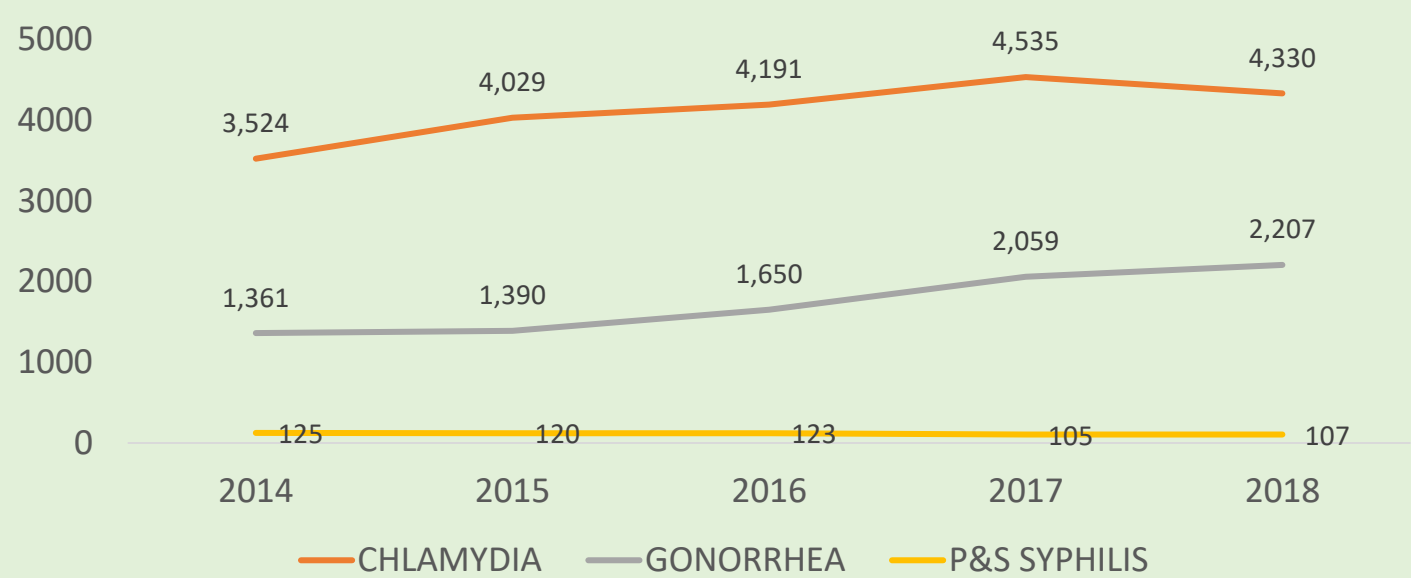
Data from MHA, analysis by MHD, Updated: September 2019

STI Diagnosis, Minneapolis, 2014 - 2018

Year	CHLAMYDIA	GONORRHEA	P&S SYPHILIS
2014	3,524	1,361	125
2015	4,029	1,390	120
2016	4,191	1,650	123
2017	4,535	2,059	105
2018	4,330	2,207	107

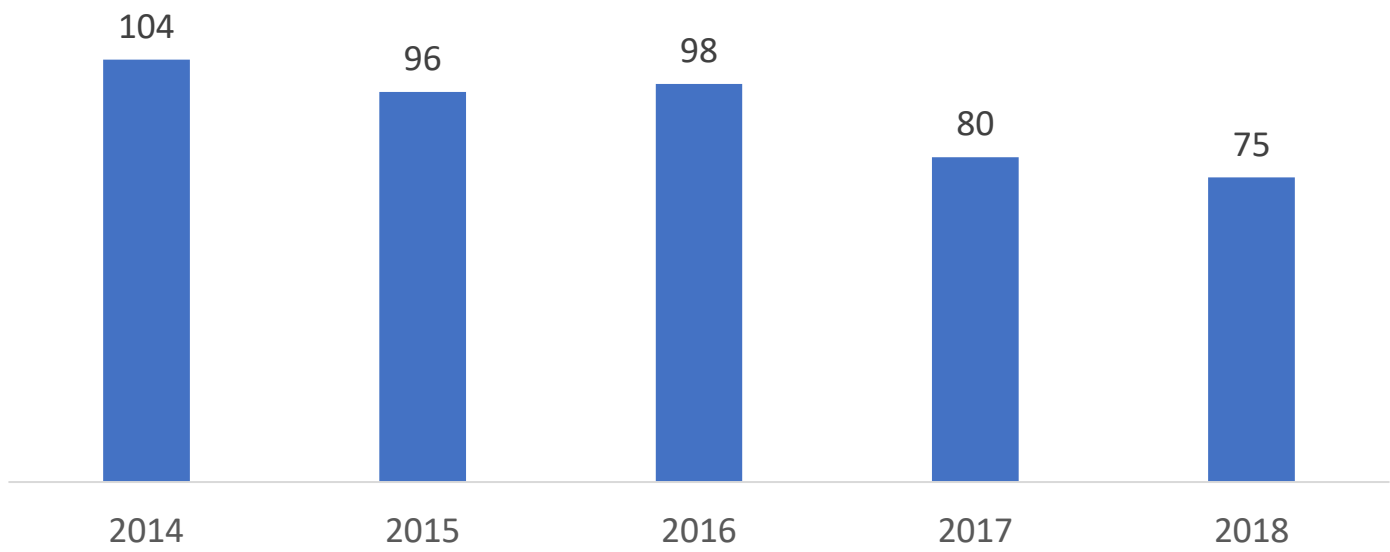
Data from MDH, analysis by MHD, Updated: July 2019

STI Diagnosis, Minneapolis, 2014 - 2018



Data from MDH, analysis by MHD, Updated: July 2019

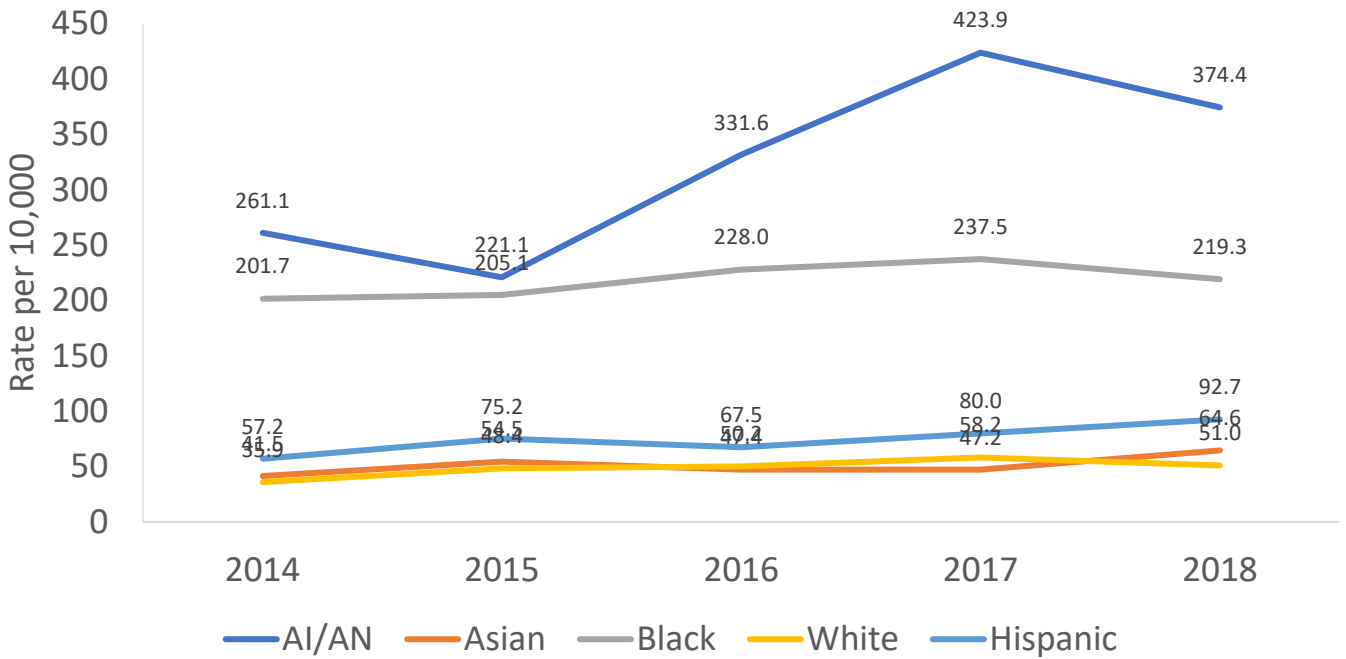
New HIV Infections, Minneapolis, 2014 - 2018



Data from MDH, analysis by MHD, Updated: July 2019

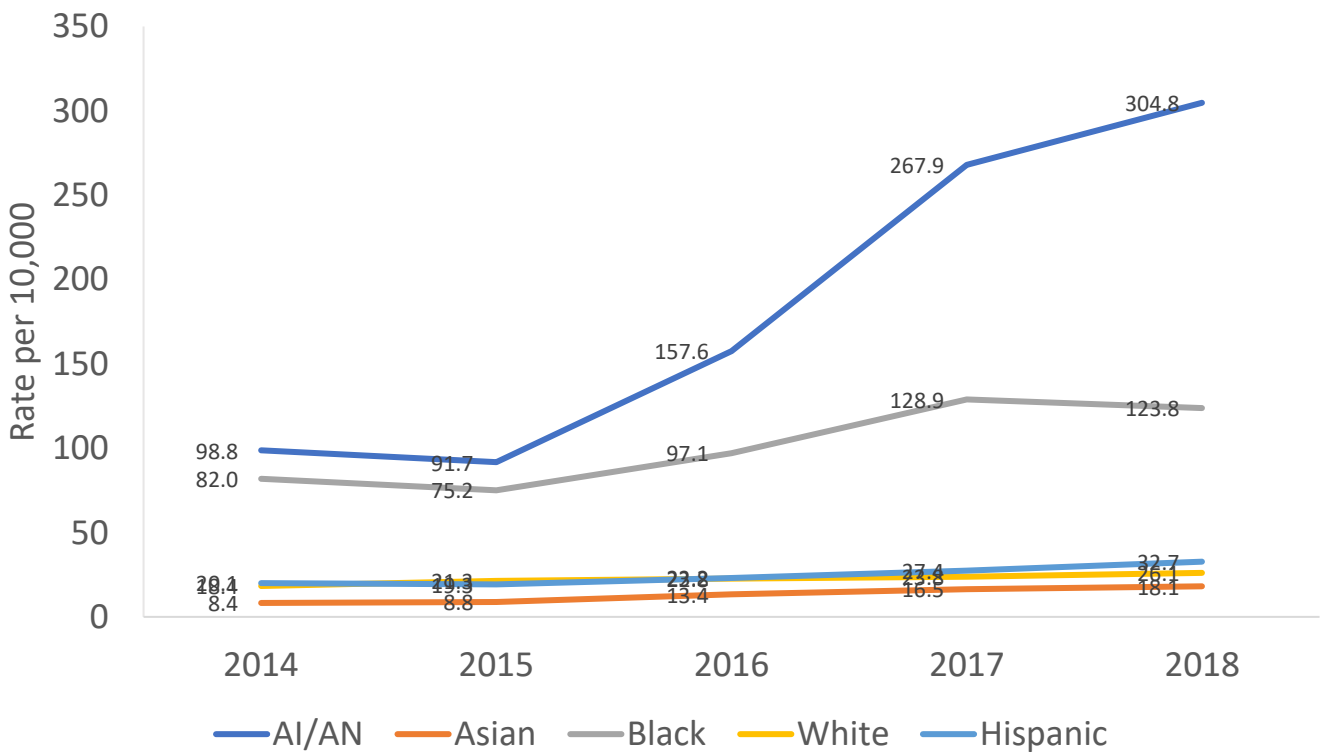
STI – Chlamydia & Gonorrhea

Chlamydia Rates by Race/Ethnicity, Minneapolis, 2014 - 2018



Data from MDH, analysis by MHD, Updated: July 2019

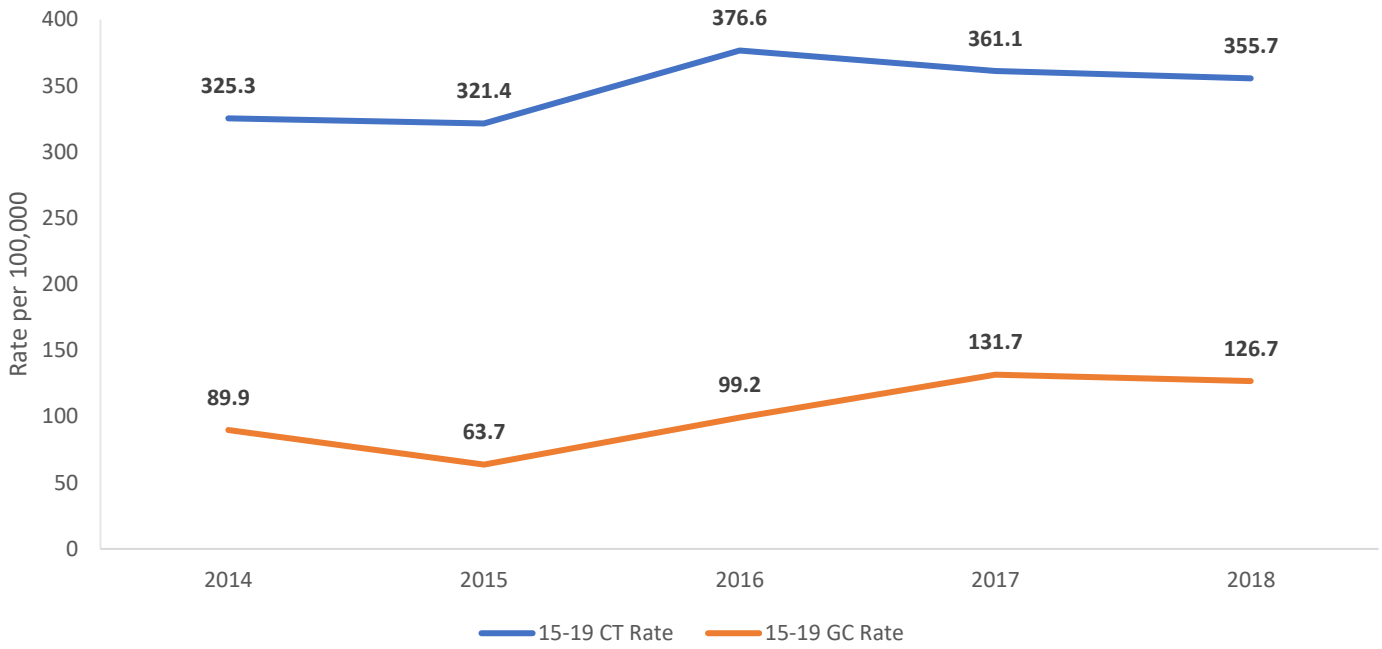
Gonorrhea Rates by Race/Ethnicity, Minneapolis, 2014 - 2018



Data from MDH, analysis by MHD, Updated: July 2019

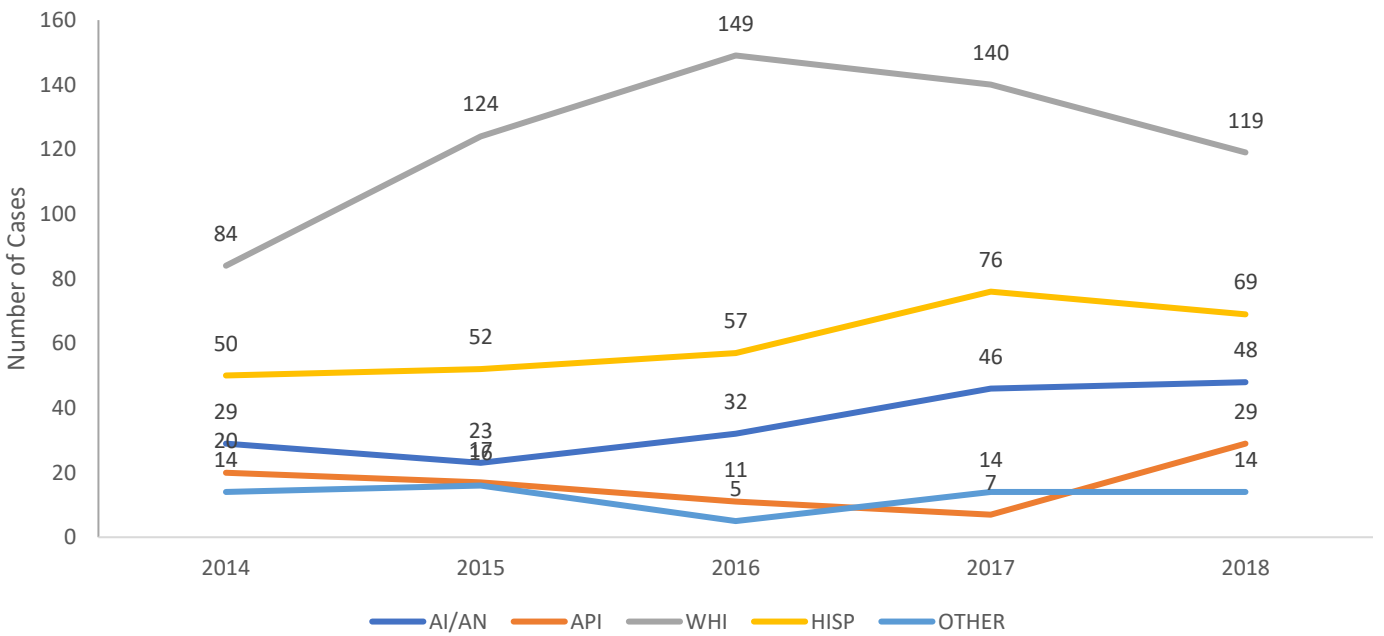
STI – Chlamydia & Gonorrhea

CT and GC rates among 15 - 19 year olds, Minneapolis, 2014 - 2018



Data from MDH, analysis by MHD, Updated: July 2019

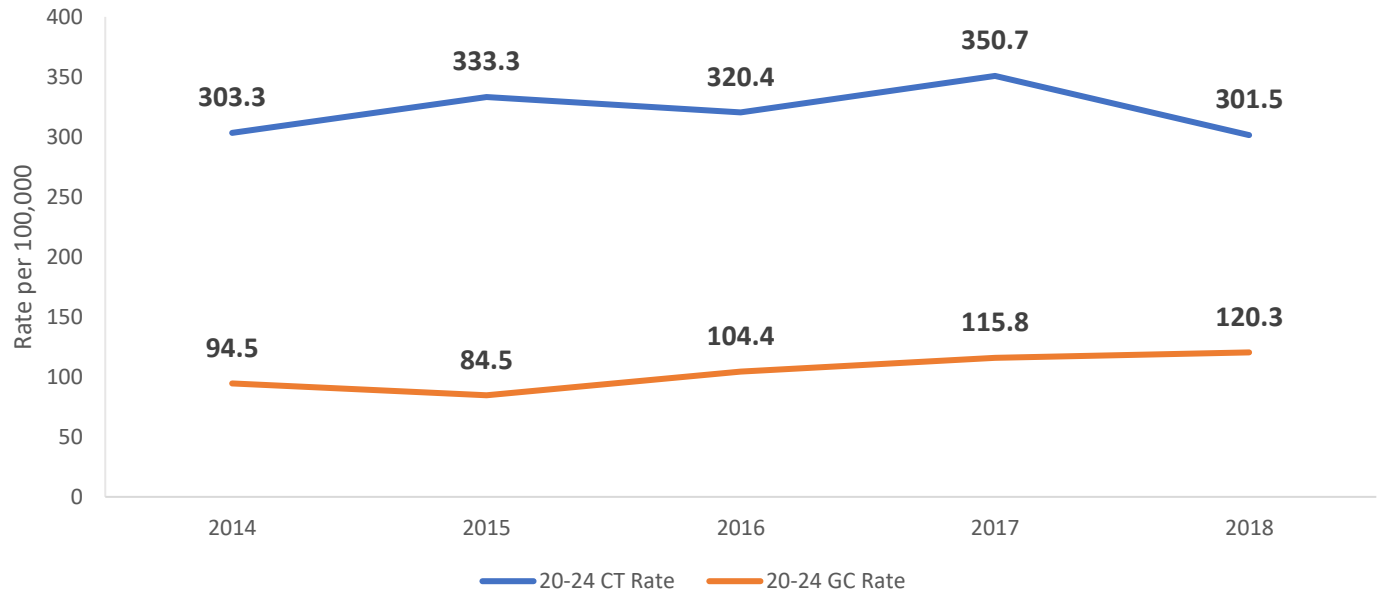
CT cases among 15 - 19 year olds by race, Minneapolis, 2014 - 2018



Data from MDH, analysis by MHD, Updated: July 2019

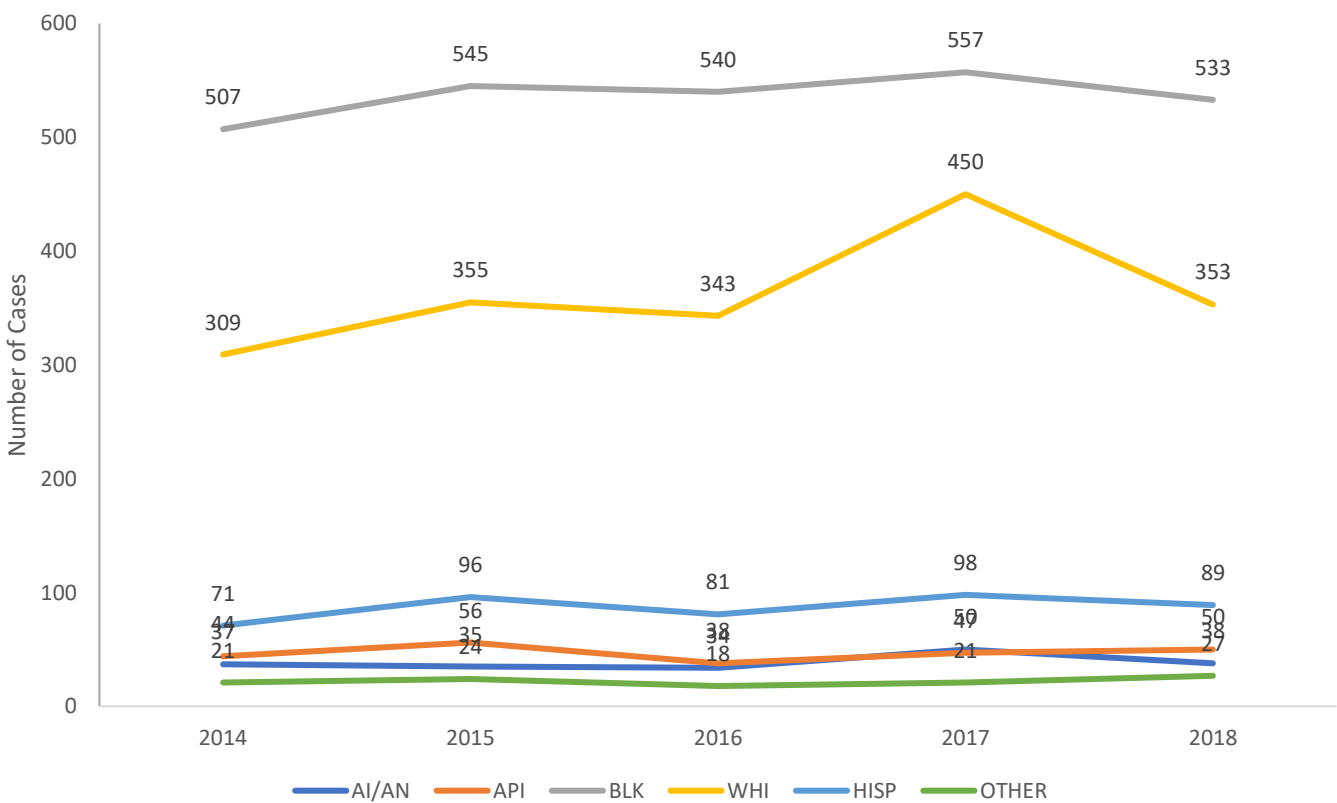
STI – Chlamydia & Gonorrhea

Young Adult CT and GC rates, Minneapolis, 2014 - 2018



Data from MDH, analysis by MHD, Updated: July 2019

CT cases among 20-24 Year olds by Race, Minneapolis, 2014 - 2018



Data from MDH, analysis by MHD, Updated: July 2019



Section 2: Minneapolis Local Public Health System Assessment



Local public health system assessment: *Question, methods, and participants*

Assessment question:

Based on feedback from staff, how well are we performing the foundational public health capabilities?



Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

Methods/Participants:

We held one-hour guided discussions to assess at what level the health department performs the model standards.

We recruited staff members through leadership, looking for people on a variety of teams, serving at a variety of levels

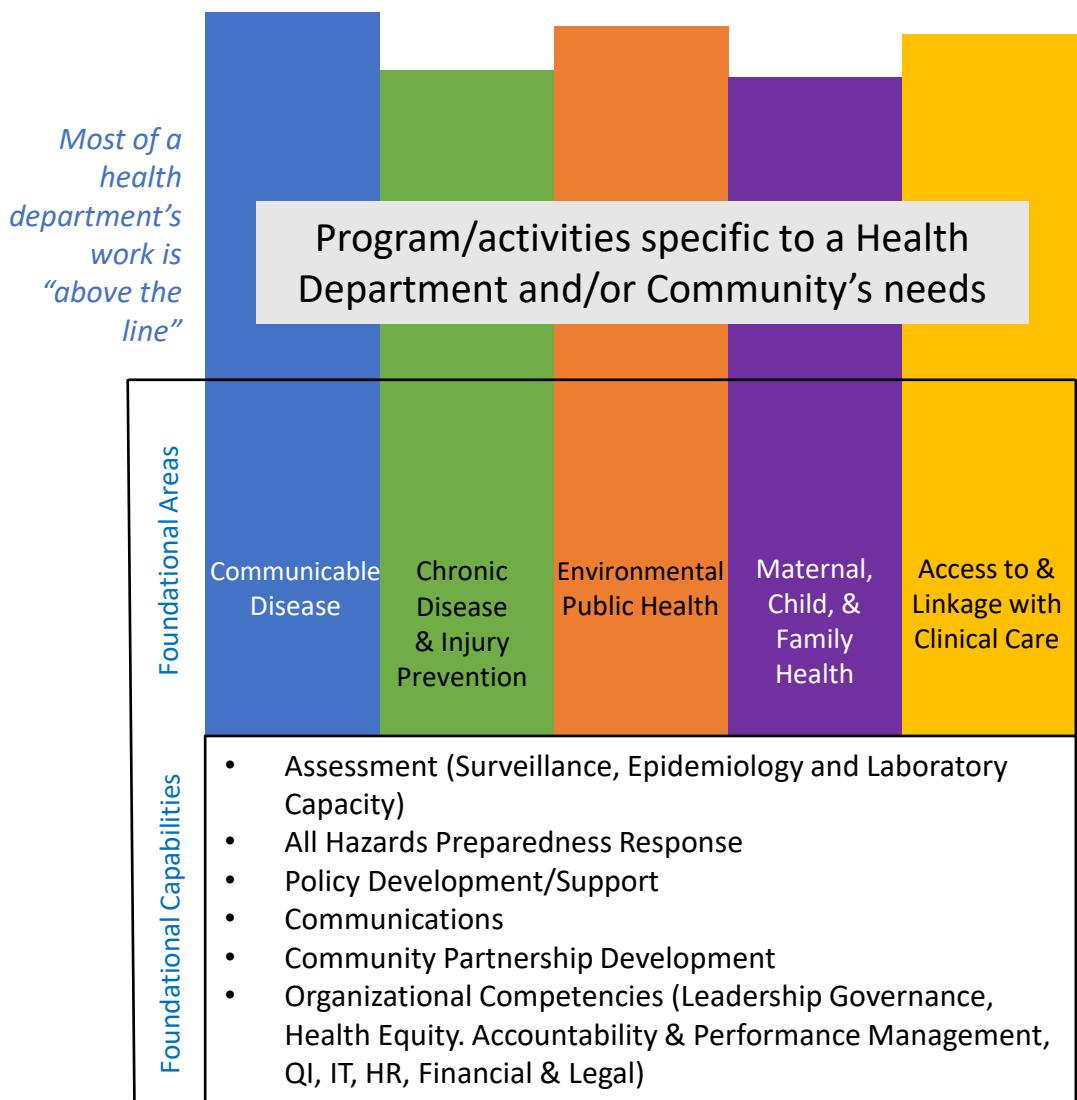
- This approach responded to feedback from accreditation interviews recommending involving multiple levels of staff in self-assessment activities

After the discussions, we sent a follow-up survey asking for participants' top three and bottom three priority model standards.

This process was adapted the National Public Health Performance Standards Program Local Public Health System Performance Assessment Instrument v2.0, published by the Centers for Disease Control and Prevention

Local public health system assessment: *Our model*

Foundational Public Health Services



Our model relates our work to a **minimum package of public health services** including foundational capabilities (FCs) and an array of basic programs no health department can be without, now known as foundational areas (FAs).

Local public health system assessment: *Priorities*

Two separate groups of staff were asked to prioritize the areas of public health performance that we would be examining in detail.

Interestingly, the priorities did not completely align, which possibly reflects the department structure, as regulatory staff have higher representation in the group of Directors, Managers, and Supervisors than the staff more aligned towards health education and promotion.

#1

Staff, Directors/Managers/Supervisors:
Community Partnerships

#2

Staff:
Health Education
and Promotion

Directors/Managers/Supervisors:
Enforcement of Laws,
Regulations, and Ordinances

#3

Staff, Directors/Managers/Supervisors:
Investigation and Response to Public Health
Threats and Emergencies

Local public health system assessment: *Quality improvement opportunities*

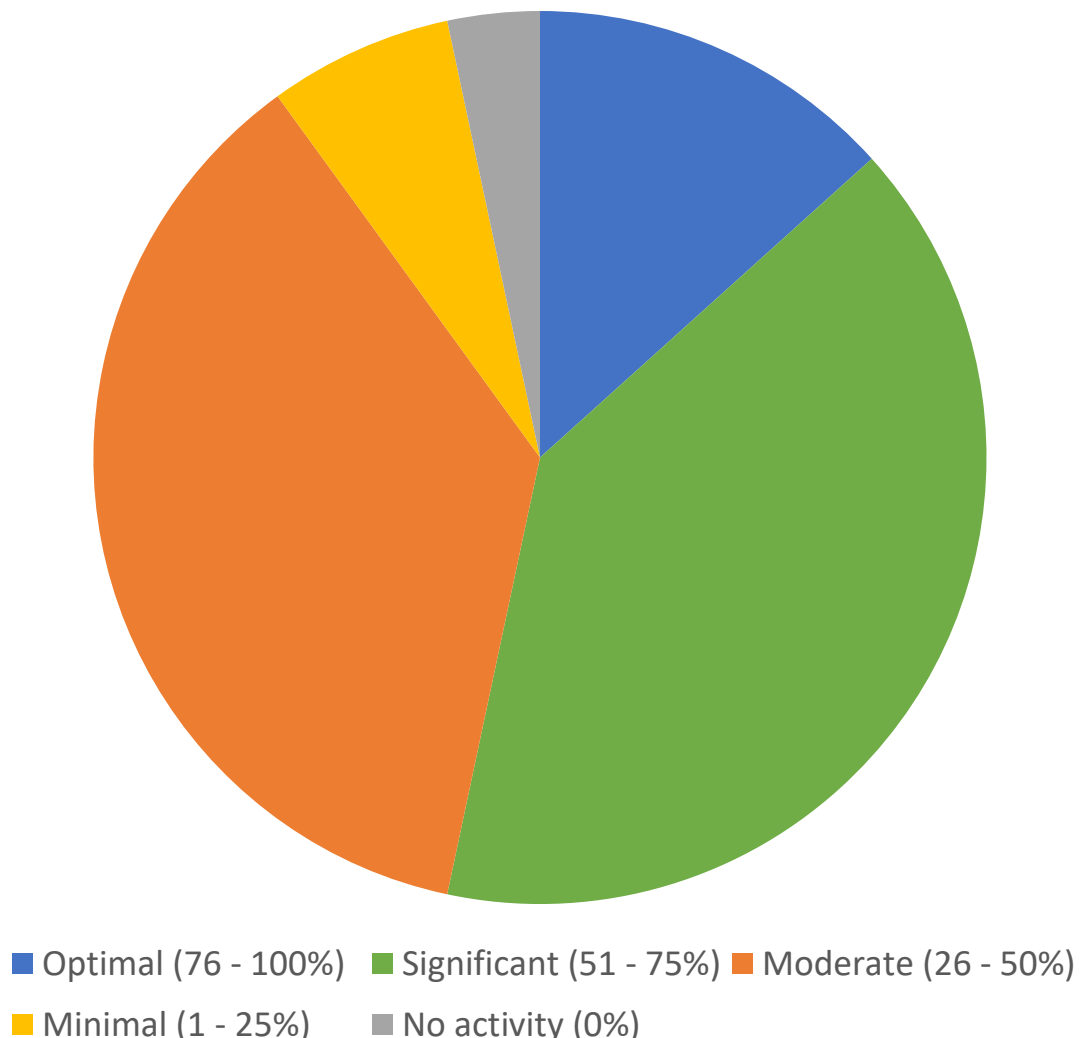
Discussions with staff focused on evaluation of the department's efforts to meet the public health model standards as outlined in the NPHPSP Local Public Health System Performance Assessment Instrument v2.0.

Over half of the standards were assessed as optimal or significant levels of activity, and around 37% were assessed as moderate. Only 10% were assessed at minimal or no activity.

The assessment was done from a Quality Improvement perspective, and it was important to let staff know that this wasn't for a grant, wasn't to make ourselves look good, but to seek to understand what we could improve.

Staff grappled with decisions about rate the whole department high and then acknowledge some teams are behind or rate the whole department and acknowledge that some of the teams are ahead of the department.

Number of model standard performance scores within each category



Local public health system assessment: *Lessons learned*

Conclusions:

MHD staff had insightful reflections on the work of the department to consistently meet the best practices of a local public health system.

Despite this, staff had concerns about how external partnerships with other governmental entities contribute to the efficacy of the local public health system or potentially undermine our work.

Lessons learned:

Staff wanted to be engaged and wondered if the Directors and Managers group was interested in their feedback. Department leadership should consider ways to meaningfully use staff input about the work of the health department.

Directors and staff had different perspectives on the priorities of the work of the local public health system. This is worth further exploration, including the reasons for the disconnect as well as ways that the Directors and Managers seek and receive feedback in safe ways for staff.



Section 3: Minneapolis Forces of Change Assessment



Forces of change assessment: *Question, methods, and participants*

Assessment question:

According to public health professionals, what is occurring that affects the health of our community?



Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

Methods:

1. We formed a survey based on a previous 2017 Forces of Change assessment from the Center for Community Health and took the results of the 2017 assessment to generate 15 broad issues that influence community health in Minneapolis
3. We created specific sub-issues for each of the 15 broad issues
4. We created a survey mechanism that asked respondents to select their top influential broad issues and then to rank their respective sub-issues by level of influence, then allowed space for respondents to provide additional comments about issues and sub-issues that were not originally included
6. We worked with a community advisory board to create a list of 36 organizations and then invited those organizations to participate in our survey and we identified our top 5 Forces of Change with the results of respondent's top issues, sub-issues, and additional comments

Participants:

The survey was fully completed by 54 individuals, and partially completed by an additional 10 individuals.

We contacted a list of 36 contacts at public health related community organizations, regional/local government departments, and healthcare clinics. An initial email was then sent to the 36 organizations, and they were asked to share the survey link with individuals within their organization that they thought could provide important information.

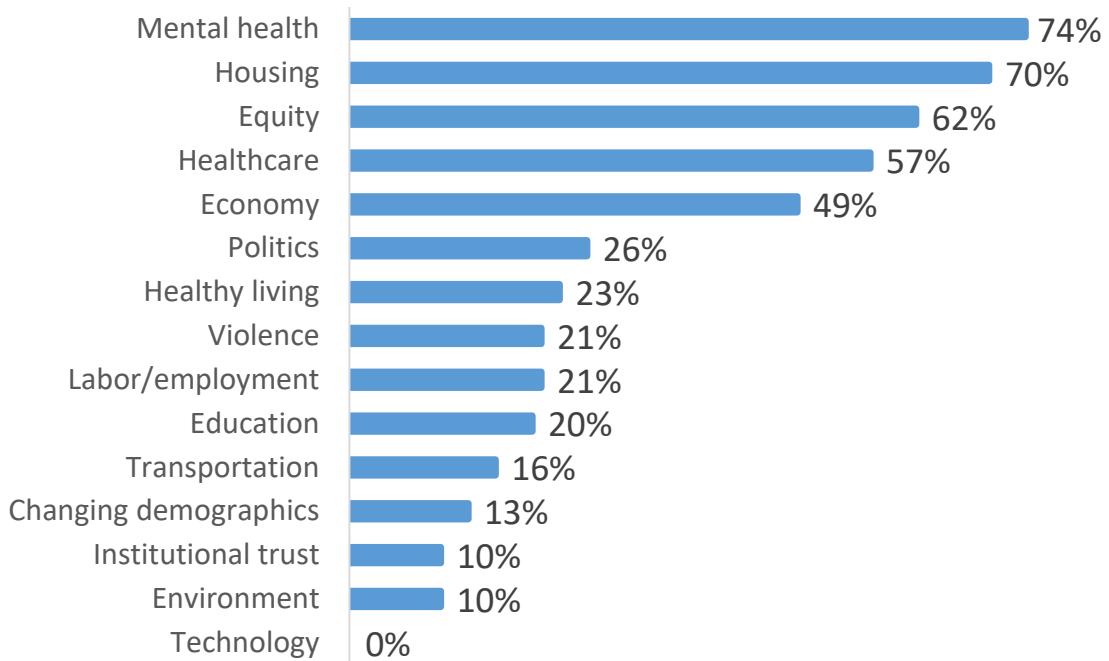
Because of this snowball sampling method there is no response rate.

Most participants were either aged 25 to 44 (45%) or 45 to 64 (43%). Eleven percent of respondents were over 65 years of age. The majority of respondents identified as female (70%), 20% as male, and 13% as gender non-conforming, genderqueer, or non-binary, and 6% as transgender. Seventy-two percent of individuals selected White as their race, 13% Black/African American, 6% American Indian/Alaskan Native, 6% multiracial, and 3% Asian/Pacific Islander. Forty-four percent of respondents belonged to a non-profit organization, healthcare (38%), and regional/local government (19%). Note that some demographic questions allowed for checking multiple boxes.

Forces of change assessment: *Findings*

Participants were asked to select issues from a list that they felt the Minneapolis Health Department should focus on.

The top three areas were mental health (74%), Housing (70%), and Equity (62%).



Next, participants were asked to rank sub-issues from highest to least importance.

In nearly every open-ended response, *equity* was mentioned.

	1 st (Highest priority)	2nd	3rd	4th	5th	6 th (Lowest priority)
Mental health	Access to mental health services and medication	Drug use/abuse	Social isolation	Depression	Alcoholism	Suicide
Housing	Affordable housing	Housing insecurity	Increasing homeless population	Rent increase	Gentrification	Lead levels
Inequity	Systematic racism	Incarceration	Historical/ intergenerational trauma	Gender pay gap	Slavery reparations	Public health jargon
Healthcare	Cost of insurance	Coverage	Culturally sensitive practices	Cost of medication	Accessible clinic location	Easy transportation to clinic
Economy	Income inequality	Wage stagnation	Increase in poverty	Funding/ resource availability	NA	NA

Forces of change assessment: *Lessons learned*

Conclusions:

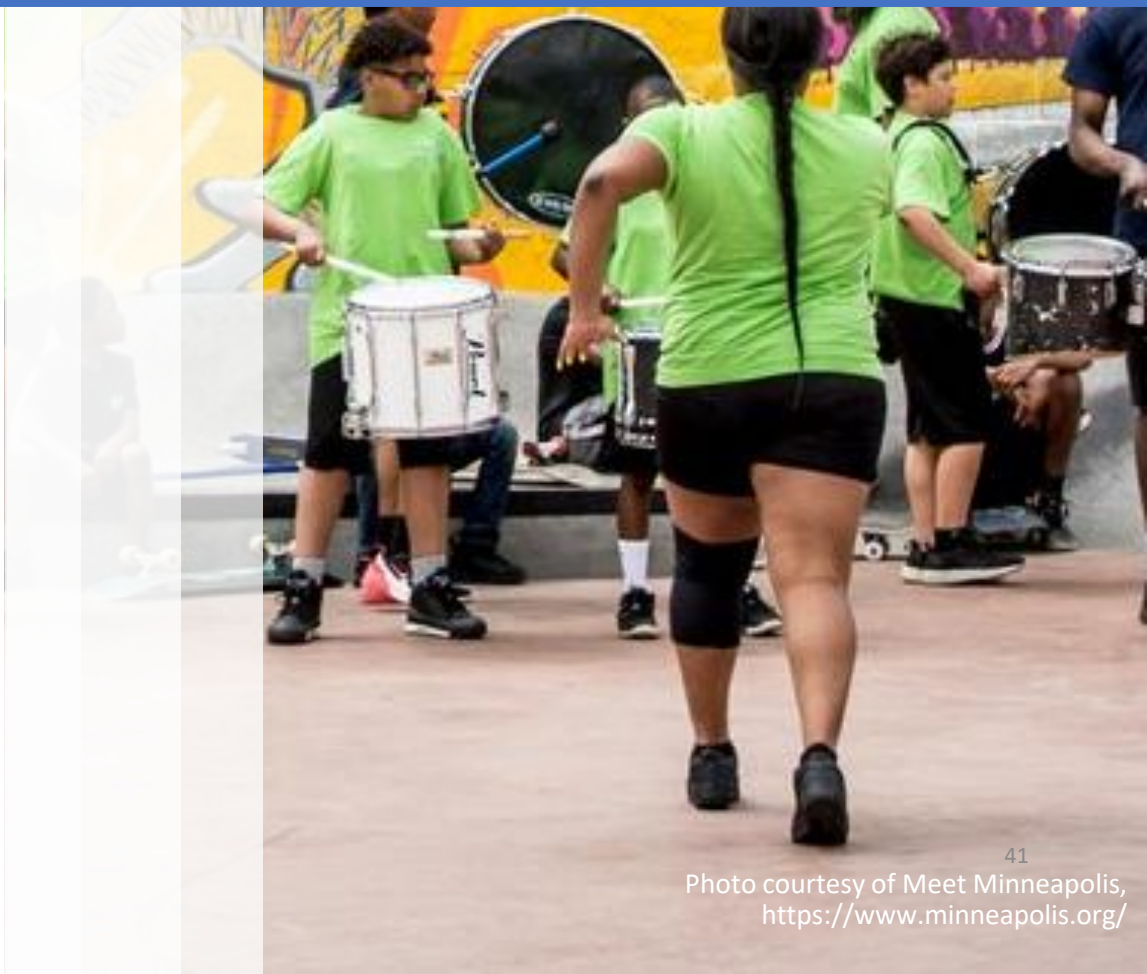
- Housing, mental health, equity, the economy, and healthcare were the top 5 issues of influence on public health in Minneapolis.
- While rankings of what was the top issue, the same 5 top issues were seen across government, healthcare, and non-profit respondents.
- Within each of the issues, specific areas were identified as areas of concern. For example, within housing, availability of affordable housing and the growth of the homeless population were identified as specific issues of concern

Lessons learned:

- Working with partner organizations was effective for requesting the information we were looking for.
- This remains a good opportunity for collaboration with other public health departments to ensure that we aren't over-surveying our partners, although we also need to maintain channels for feedback outside of the assessment cycle.



Section 4: Minneapolis Themes and Strengths Assessment



Themes and strengths assessment: *Question, methods, and participants*

Assessment question:

Based on conversations with community members, can we get an understanding of their health priorities for Minneapolis?

Methods:

Forty-four participants joined the Health Department's community conversations about health in Minneapolis from November 8, 2019 to January 13, 2020.

Community members were invited to these conversations through multiple avenues:

- Advertisement and recruitment through Health Department and Health Department community partners
- Advertisement on social media platforms, including Facebook, Twitter, and NextDoor
- Minneapolis city councilmembers were asked and encouraged to share information about the community events through their outreach methods
- Two community meetings were held at sites of long-time partnerships
 - Minneapolis Urban League, located on the Northside of Minneapolis, looking for representation of the Black/African-American community
 - Division of Indian Work, looking for representation of the Native/American Indian/Alaskan Native community.

Participants:

A total of 31 community members participated in community meetings, focus groups, and interviews. There were 2 focus groups offered to the larger Minneapolis community and 8 smaller focus groups and one on one interviews offered to the groups our community advisory board recommended.

Our community advisory board recommended that we reach out to partner and wished-for partner organizations including those focused on work with the following communities:

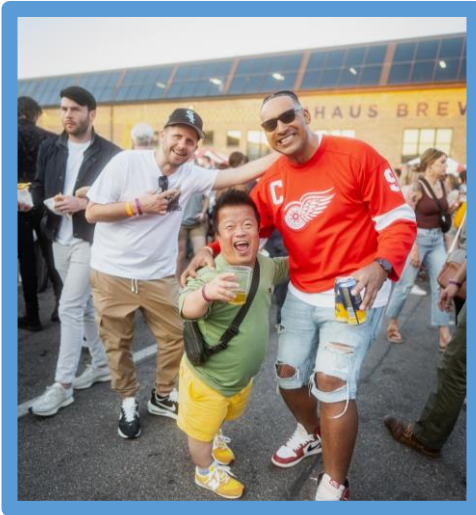
- Aging groups/senior groups
- Hispanic/Latino groups
- Lao groups
- LGBTQIA+ groups
- People living with disabilities
- Somali groups
- Veteran groups
- Vietnamese groups



Themes and strengths assessment: *Findings on perceptions of health*

Participants were asked to think about and share their answers to three questions:

- 1) What does a healthy life look like for you or your family?
- 2) What does a healthy community mean to you?
- 3) What good things are happening in the community?



Individuals and families feel healthy when they ...

- Are socially connected
- Have quality mental health
- Are physically active
- Eat healthy
- Accessibility needs are met

Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

Communities feel healthy when...

- Everyone has basic needs met, such as safety, food, shelter, and clean water
- Housing is accessible, safe, and meets needs for seniors, and connects generations
- Hospitals and clinics provide access to quality healthcare
- There is a sense of community and support
- There is quality transportation



Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

Themes and strengths assessment: *Findings on assets*

Existing community assets include...

- Community clubs, programs, events, and organizations that foster social connectedness
- Resources like quality public transit, solid biking infrastructure, health services, parks, and walking areas
- Sufficient ways and programs to access food



Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

Relating individuals, communities, and assets...

- Healthy community themes are so closely tied in with individual healthy living
- Aspects of social connectivity and accessibility were noted of highest frequency across all questions
- Most themes across all questions cover basic needs

Themes and strengths assessment: *Conclusions and lessons learned*

Conclusions:

Most of the priority findings are around basic needs. This continues to reinforce the overall CHA finding that poverty and racism dominate conversations about health in Minneapolis.

Despite the daunting task of addressing these nefarious persistent social ills, respondents highlighted connectedness and the vivacious culture in Minneapolis. Accessibility can be improved but was overall noted as an asset to Minneapolis.

Lessons learned:

Most of the individuals recruited were already engaged with the Health Department, so the results were likely biased.

While we approached this with open-ended questions and let the community drive the themes, to develop the thoughts offered into tighter recommendations, we may need to request more specific feedback based on local current events.



Minneapolis Community Health Assessment findings

ee. Everyone is welcome
visiting the **Minneapolis Institute of Art.**





Minneapolis Community Health Assessment findings

After completing the four assessments, it is clear that the social determinants of health are dominant in Minneapolis, especially the continued impacts of racism and poverty, as well as intergenerational trauma. These underpinnings create consistently predictable patterns in the city of disparate outcomes for our communities of color.

This is the major task of the Minneapolis Health Department. It is inarguable and of massive influence, and all work that MHD does must include intention around these dominant influences on health in Minneapolis.

That said, there is energy, engagement, and creativity also present in Minneapolis and the close relationships of staff and community have helped MHD and those working in community health to cope through other changes and challenges. We continue to have very positive health outcomes when looking at averages, and very large gaps when disaggregating data by race and ethnicity. By advocating for our population and jurisdiction, the Minneapolis Health Department can take on these significant challenges and continue our persistent work for the health of all the people who live, work, and play in Minneapolis.

Community Health Assessment: *Priority Health Issues*

The Minneapolis Health Department noted six priority health issues for our jurisdiction.

Within those six issues, our community health improvement plan partnership with our neighboring health boards.



Photo courtesy of Meet Minneapolis, <https://www.minneapolis.org/>

Minneapolis Health Department priority health issues:

Economic stability

Poverty

Employment

Food security

Housing stability

Homelessness

Mental health**

Neighborhood and built environment**

Quality of housing

Transportation access

Access to healthy foods

Neighborhood crime and safety

Social connectedness

Substance use: opioids

Heroin

Prescription

***Issues to be addressed in community health improvement plan*

Minneapolis

Community Health Assessment (CHA) process reflections

The Minneapolis Health Department (MHD) formed a CHA Advisory Committee for the purposes of guiding a CHA to capture Minneapolis-specific perspectives on community health.

We completed all four MAPP 2.0 assessments using mixed methods and combined efforts with the Hennepin County CHIP process as appropriate. Our goal in our assessments were to center and hold our community's perspectives in a way that would not be lost in the larger efforts.

Some of our lessons learned included:

We need to use our existing groups better. We appreciated our CHA Advisory Committee very much. That said, we have a lot of committees, groups, and boards that we already convene, and we could have used our Public Health Advisory Board (PHAB) to function as a CHA Advisory Committee since those individuals are appointed by the Community Health Board (our City Council) to represent all different parts of the city as well as several at-large members. This would save our partners time and effort. Additionally, the CHA Advisory Committee was not interested in intensive decision-making – they wanted to be informed of the results and have a chance to interpret them but felt like we could design and coordinate the operations related to the CHA without their involvement.

Our community is tired of being assessed. We need to find a way to build on past assessments and dig deeper or find a new way of advancing our understanding of how the community sees their health. Additionally, because of the number of hospitals, the county health department, and the state health department who all come knocking for information, we need to coordinate even better to shift the weight of the work off of our community and on to ourselves. The community tells us what they need in many different ways on timelines that work for them. We need to find ways to better capture this information on their schedule.

We need to firmly advocate for our jurisdiction. Although we love a good collaboration, we notice that when we report our indicators or try to capture our perspectives alongside the county, due to the size of the county and the very different characteristics of the populations that live within it, our Minneapolis priorities and voice are lost. We must have the space and support to serve our community using the relationships we have with them.

Minneapolis Community Health Assessment (CHA) limitations

The limitations of our CHA can be grouped into four general categories.

Data

We don't always have access to data at the granularity and disaggregation that we would like. Sometimes, that is due to how it is collected and sometimes, that is due to how it is shared. This is an ongoing conversation for us and while we have seen improvements in this area, we must continue to push for data to be available to us in ways that we can use to serve our community.

Reach

We have deep and steady relationships with some groups in the community with specific and known interests and limitations. We have not had the uptick and interaction of all the groups we would like to have to get the breadth we would like.

New indicators

Our community has identified new aspects of health and community that they want us to track and solve how to measure. Additionally, ever continuing scholarship has added to the ways that we can and should look at health equity and we will need to develop these indicators for our jurisdiction.

Partnerships

We haven't evaluated our partnerships across the department, consistently and rigorously. The partnerships very much influence our information and work - we need to improve how we assess and understand our own ecology.



Minneapolis

Health

*For any questions, please do not
hesitate to reach out to the
Minneapolis Health Department.*

*Assessment completed by
MHD Evaluation and Research Unit
Contact us at
research.health@minneapolismn.gov or
612.673.6065*

*People who are deaf or hard of hearing can use a relay
service to call 311 at 612-673-3000.*

TTY users call 612-263-6850.

Para asistencia 612-673-2700

Rau kev pab 612-673-2800

Hadii aad Caawimaad u baahantahay 612-673-3500.