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# Children's Minnesota 2016 Community Health Needs Assessment

## Data Summary Packet

*A review of data compiled for the Children's Hospitals  
and Clinics of Minnesota*

Prepared by: Wilder Research

# Background

Children's Hospitals and Clinics of Minnesota (Children's Minnesota) and all other not-for-profit hospitals are federally-required to complete a Community Health Needs Assessment (CHNA) every three years. The assessment process is intended to help hospitals understand and respond to the health concerns of the communities they serve. Multiple strategies were used in this CHNA to identify the health needs, strengths, and assets of children and families: (a) reviews of secondary (existing) data sources, (b) analysis and mapping of Children's Minnesota patient data, (c) interviews with community stakeholders, (d) an online survey of Children's Minnesota providers, (e) discussion groups with Children's Minnesota staff (e.g., social workers, interpreters), and (f) written discussion boards that prompted children and families to describe health. This document includes the seven data summaries highlighting the information gathered during the CHNA process.

Children's Minnesota sees the CHNA requirement as an opportunity to work in partnership with community stakeholders in a more intentional way. As a result, they convened a Community Advisory Committee (CAC) to guide the assessment process. The CAC drew on the information gathered during the CHNA, as well as their own personal experiences and expertise, to identify the health priorities they felt would be most important for Children's Minnesota to work to address to improve child health and well-being. A description of this process and the priority health topics selected through the CHNA process is included in a separate document, the *2016 Children's Minnesota Community Health Needs Assessment Final Report*.

# Contents

## **1. Demographic Trends and Social Determinants of Health**

*Includes information from the American Community Survey and other secondary data sources to describe child demographic trends in the 7-county Twin Cities metro region and to describe how social determinants impact the health and well-being of children and families.*

## **2. Characteristics of Patients Served**

*Uses mapping to identify the neighborhoods where Children’s Minnesota reaches large numbers of patients and includes the community definition used to define the geographic scope of this assessment.*

## **3. Early Childhood Health**

*Highlights current data from multiple secondary data sources and recent trends on a range of health-related topics impacting young children age birth–5.*

## **4. School-Age Youth Health**

*Highlights current data from multiple secondary data sources and recent trends on a range of health-related topics impacting school-age children age 6–18.*

## **5. Community Descriptions of Child Health**

*Visually presents responses to the prompt “Kids that are healthy: \_\_\_\_\_” used to gather feedback from children and families at two Children’s Minnesota clinics and at local events.*

## **6. Community Stakeholder Perspectives on Child Health**

*Presents key themes from 43 interviews conducted with community stakeholders that focused on child health needs, the impact of social determinants and trauma on health, and family and community assets that support health.*

## **7. Clinician Perspectives on Child Health**

*Summarizes results from a survey administered to Children’s Minnesota clinicians and discussion groups with Children’s Minnesota staff focused on child health needs, the impact of social determinants and trauma on health, and family and community assets that support health.*

# Acknowledgments

There are many people who gave of their time to help guide this assessment process, to share their experience and expertise, and to elevate the strengths, assets, concerns, and priorities of children and families living in the Twin Cities metro region. Wilder Research and Children's Minnesota appreciate the time and insight of the following individuals who served on the Community Advisory Committee (CAC):

Betsy Sohn*	Hope Community, Inc.
Cardina Esparza*	Wilder Foundation
Deby Ziesmer*	YWCA
Dianne Haulcy*	Think Small
Elisa Iha	Minneapolis Public Schools
Francisco Segovia*	Pillsbury United Communities - Waite House
Hodan Guled	Somali Health Solutions
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Jackie Perez	Think Small
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Sarah Berger	Neighborhood House
Stephanie Graves*	Minneapolis Health Department
Úrsula Reynoso*	Aquí Para Ti -- HCMC

CAC members with an asterisk (\*) by their name also participated in an interview about community health assets, needs, and priorities (see below).

We would also like to thank the following community stakeholders who took time to speak to the health assets, needs, and priorities of the communities they are part of or serve through their individual leadership or organization's services:

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Bharti Wahi	Children's Defense Fund
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Councilmember Abdi Warsame	Minneapolis City Council
Councilmember Rebecca Noecker	St. Paul City Council
Crystal Windschitl	Phillips West Neighborhood Organization
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Rebeka Ndosi----- Formerly at Nexus Community Partners

We appreciate the time that Children’s Minnesota clinicians and staff to share their experiences and perspectives by completing the online survey or participating in discussion groups. The following staff members also contributed to this report by conducting interviews, gathering and analyzing data, facilitating discussions, and preparing interim documents:

- Children’s Minnesota: Elham Ashkar, Jessica Block, Katie Rojas-Jahn, Lisa Skjefte, Kelly Wolfe, and Anna Youngerman
- Wilder Research and Wilder Center for Communities: Steven Aviles, Anna Bartholomay, Jennifer Bohlke, Sindy Morales Garcia, Kirsten Johnson, Heather Loch, Nick Stuber, Thao Vang, and Ellen Wolter

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# Demographic Trends and Social Determinants of Health

*A summary prepared for the Children's Hospitals and Clinics of  
Minnesota 2016 Community Health Needs Assessment*

Prepared by: Melanie Ferris

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# Introduction

Health is strongly influenced by the conditions in which people are born, live, learn, work, play, worship, and age. These conditions, also called social determinants of health, have a greater influence on health than health care services.<sup>1</sup> They influence the availability of resources in neighborhoods, the way residents interact with one another, and the environmental conditions of indoor and outdoor spaces. These factors can limit or increase opportunities for health and well-being, ultimately influencing health and health behavior. Social determinants of health are shaped by structures, decisions, and policies that influence how money, power, and resources are distributed. Inequities result when policies and systems that were designed to advantage affluent, and often white, residents negatively impact groups of people, often people of color and lower-income residents. Policies that disproportionately impact people of color may not mention race explicitly. Inequities can also result when the full impacts of policies are not considered and if people most likely to be impacted by a proposed policy have limited influence or are excluded from decisions that impact health and well-being.

Given the close relationship between race, place, and health, Children's Hospitals and Clinics of Minnesota (Children's Minnesota) decided to use a racial equity lens in its Community Health Needs Assessment (CHNA) process. As a result, the assessment moves beyond identifying the most prevalent diseases and conditions currently impacting the health of children to recognizing the underlying factors that impact health and that must be addressed in order to eliminate the pervasive health inequities that currently exist in Minnesota.

<sup>1</sup> Schroeder, S. (2007). We can do better – Improving the health of the American People. *New England Journal of Medicine*, 357: 1221-1228.

## Community definition

Children's Minnesota has a broad reach; in 2015 the hospitals served children from all Minnesota counties and 66 percent of the counties in the four neighboring states (Iowa, North Dakota, South Dakota, and Wisconsin). However, a majority of these children live in the seven-county Twin Cities metro region. For the purposes of this CHNA, Children's Minnesota has adopted the following definition to describe the community it serves:

The community served by Children's Minnesota includes children of all ages (prenatal – 17 years) who live in the seven-county Twin Cities region: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties.

The assessment will also place additional emphasis on learning about the health needs, assets, and priorities of children and families living in the following neighborhoods where: a) high densities of Children's Minnesota patients live; and b) where children and families experience disproportionate burden of inequitable social, economic, and environmental conditions:

- In Minneapolis: Phillips and Powderhorn
- In Saint Paul: West Side, Frogtown/Thomas-Dale, and Dayton's Bluff

This summary describes current conditions influencing the health and well-being of children, starting with a description of the demographic characteristics of children who live in the Twin Cities region and then offering a more detailed look at social determinants that influence health: income and wealth accumulation; housing and residential segregation; educational attainment; and access to resources.

### ***Demographic characteristics at a glance***

Over 700,000 children (age 0-17) who currently live in the seven-county Twin Cities region are included using this definition of community. There are high-level differences between counties. Ramsey and Hennepin counties are home to the largest number of children and most racially and ethnically diverse populations (Figure 1). In Ramsey County, a majority of the population (55%) are children of color. In all other counties, white, non-Hispanic children comprise the majority of the population. Throughout the region, a relatively small percentage of children (up to 8 percent) were born in countries outside of the United States. However, many of these children are first-generation immigrants. Larger percentages of children (8-32%) live in households where a language other than English is the primary language. This summary will explore changes in these demographic trends over time and highlight data describing how social determinants are impacting health in these cultural communities.

#### **1. Demographic characteristics of children, by county**

	<b>Anoka</b>	<b>Carver</b>	<b>Dakota</b>	<b>Hennepin</b>	<b>Ramsey</b>	<b>Scott</b>	<b>Washington</b>
Number of children (age 0-17)	83,082	27,001	102,491	261,905	120,032	39,381	62,517
Race/ethnicity <sup>a</sup>							
American Indian	1%	1%	<1%	1%	1%	1%	**
Asian (Southeast) <sup>b</sup>	2%	2%	2%	4%	15%	2%	3%
Asian (other)	2%	3%	3%	4%	5%	3%	4%
Black – U.S. born	6%	2%	6%	16%	14%	2%	4%
Black – foreign born	1%	**	1%	2%	1%	**	<1%
White, non-Hispanic	75%	81%	72%	55%	45%	81%	77%
Two or more races	8%	6%	7%	9%	9%	6%	6%
Another race/ethnicity	2%	2%	4%	4%	2%	2%	1%
Hispanic/Latino	6%	6%	10%	12%	12%	6%	6%

Sources. Integrated Use Microdata Series (IPUMS), 2010-14, American Community Survey 5-year estimates (2010-14), Minnesota Department of Education (2013-14)

Note. Data are suppressed (\*\*) in counties where reliable estimates cannot be calculated.

<sup>a</sup> Carver and Scott counties were combined in order to calculate reliable race/ethnicity and nativity estimates.

<sup>b</sup> The Southeast Asian category includes those who identified their race as Asian and reported belonging to any of the following ancestry groups: Burmese, Cambodian, Filipino, Hmong, Indonesian, Laotian, Malaysian, Thai, Taiwanese, or Vietnamese. The category Asian (other) includes those who identified their race as Asian but did not report belonging to the ancestry groups listed previously.

## 1. Demographic characteristics of children, by county

	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington
<b>Nativity<sup>a</sup></b>							
Born outside of the U.S.	3%	2%	3%	6%	8%	2%	3%
<b>Language<sup>c</sup></b>							
Percentage of students whose primary household language other than English	15%	8%	15%	22%	32%	8%	19%

Sources. Integrated Use Microdata Series (IPUMS), 2010-14, American Community Survey 5-year estimates (2010-14), Minnesota Department of Education (2013-14)

Note. Data are suppressed (\*\*) in counties where reliable estimates cannot be calculated.

<sup>a</sup> Carver and Scott counties were combined in order to calculate reliable race/ethnicity and nativity estimates.

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<sup>c</sup> The most common household languages (spoken by at least 1,000 students) include: English, Spanish, Hmong, Somali, Vietnamese, Karen, Chinese/Mandarin, Russian, Arabic, Oromo, Amharic, Khmer, Laotian.

### About the data presented

The demographic data presented in this summary are largely from the American Community Survey (ACS). This survey is administered by the United States Census Bureau to a sample of residents and weighted in order to calculate estimates for the population. Throughout this summary, the most detailed data available are presented. However, there are limitations in the degree to which race and ethnicity data can be disaggregated while still providing reliable estimates at a more local (county or neighborhood) level or in counties where relatively few people of the same racial or ethnic community live. Therefore, in some tables, estimates are suppressed because there are not enough residents of a racial or ethnic community to calculate a reliable estimate. Most ACS data reported in this summary cite a date range (e.g., 2010-14) rather than a single year; the U.S. Census Bureau uses averaged data from a 5-year period to calculate the most reliable estimates possible.

We recognize that there are many different cultural communities that fall within each race/ethnicity category, as well as diversity in experience and perspective within each cultural community. Most secondary data sources report estimates based on responses provided by a sample of community residents. Often, potential disparities are reported using very broad cultural or socioeconomic categories, which does not capture the diversity of opinions and experiences of residents. The data provided in this summary are a starting point to better understand factors that contribute to health and well-being in the Twin Cities metro.

However, there are limitations in the data available. The race and ethnicity categories used in this report are intended to be more detailed and reflective of the backgrounds of residents who live in the Twin Cities metro, but are imperfect. Further, reported differences between populations reflect the varied experiences of residents, including the many ways that immigration, housing, education, employment, and other policies have impacted specific racial and ethnic groups.

Finally, although this summary presents the data available as individual topics, it is critical to recognize that these issues are often linked, having been established and reinforced through policies, practices, and social norms that routinely disadvantage some groups of people or geographic areas while benefitting others.

# Population profile

**The seven-county Twin Cities region is growing in population and increasing in racial and ethnic diversity.** Since 1990, both the number of children and cultural diversity of children and families have increased in all counties and these trends are expected to continue. Population changes may have implications for how Children’s Minnesota provides services, hires its workforce, or develops partnerships with community organizations in order to provide affordable, high-quality, culturally responsive care in an increasingly diverse region.

## Demographic trends

Since 1990, the most notable increases in population have been among children who are Hispanic/Latino, black with foreign-born parents, and described as multiracial (Figure 2). The trends listed below may not reflect the population changes in each of the many different cultural groups that fall within each race and ethnicity category.

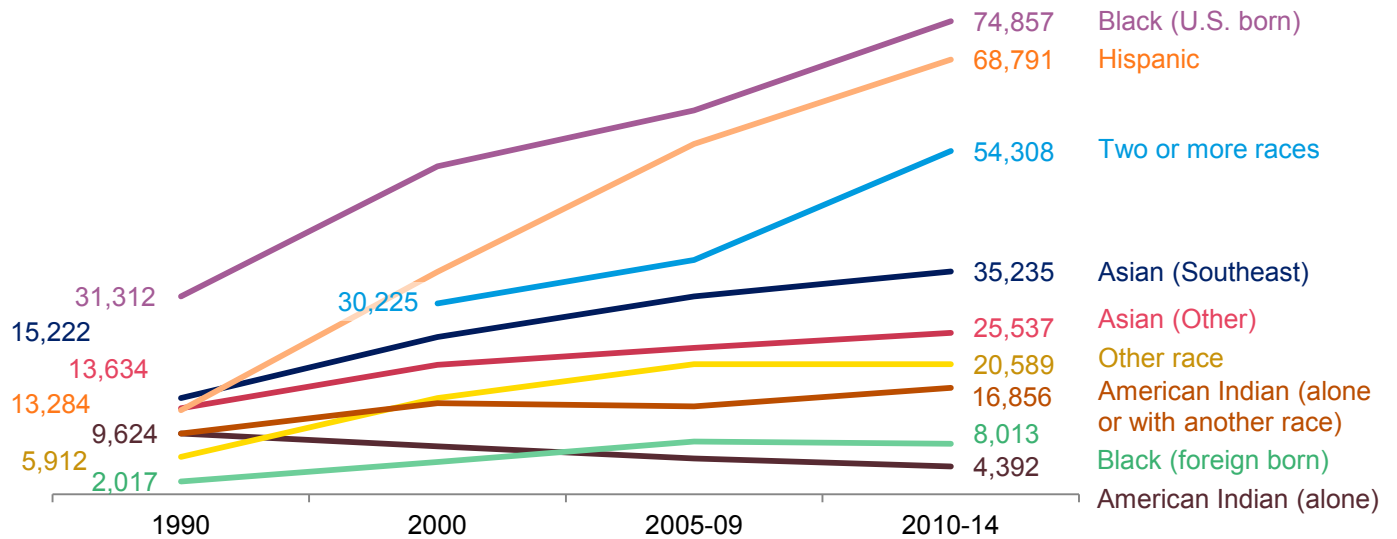
- The number of Hispanic/Latino children is more than five times larger today than it was in 1990. There are now over 68,000 children in the Twin Cities region who are Hispanic/Latino, comprising about 10 percent of the population.
- Among the nearly 83,000 African American or black children living in the Twin Cities, most (90%) were born in the United States. The number of foreign-born black children has increased from approximately 2,000 in 1990 to 8,000 today. However, this doesn’t fully capture changes resulting from a growing immigrant and refugee population; nearly 40 percent of black children have at least one parent born outside of the United States.
- The number of Southeast Asian<sup>2</sup> children living in the Twin Cities has doubled since 1990, from approximately 15,000 to over 35,000 today. The number of Asian children of other ethnicities is somewhat smaller and has experienced less growth (from approximately 14,000 in 1990 to nearly 26,000 children today).
- A growing number of children are multiracial. Currently, over 54,000 children are included in this category, nearly double the number from 2000 when the U.S. Census began to use this race category. The majority of children included in this category today are white and black (47%) and white and Asian (26%).

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<sup>2</sup> The “Southeast Asian” category includes those who identified their race as “Asian” and reported belonging to any of the following ancestry groups: Burmese, Cambodian, Filipino, Hmong, Indonesian, Laotian, Malaysian, Thai, Taiwanese, or Vietnamese.

- Population trends for American Indian children tell two different stories, depending on how race is defined. The estimated number of children identified as American Indian alone decreased from approximately 9,600 in 1990 to nearly 4,400 two decades later. This trend may be the result of families migrating from the Twin Cities to tribal land and greater Minnesota. It may also be explained by the growing number of children identified as American Indian alone or in combination with another race, which has increased in the population from approximately 14,000 in 2000 to nearly 17,000 today. Neither definition of race fully captures the number of children who are enrolled in a tribe, which has important implications for the policies that impact, and the resources available to, children and families.

## 2. Changes in the number of children of color over time, Twin Cities metro region



Source: Integrated Use Microdata Series (IPUMS)

Notes: The “two or more races” category was not used by the United States Census before 2000. The Southeast Asian category includes those who identified their race as Asian and reported belonging to any of the following ancestry groups: Burmese, Cambodian, Filipino, Hmong, Indonesian, Laotian, Malaysian, Thai, Taiwanese, or Vietnamese. The category Asian (other) includes those who identified their race as Asian but did not report belonging to the ancestry groups listed previously.

Additional analysis of American Indian data from the U.S. Census in 2000 and 2010 showed that while there was a decrease in the number of children who identified as American Indian only during that timeframe, the number of children whose race was identified as American Indian and another race increased from approximately 14,000 to nearly 17,000.

## Immigrant and refugee status

### **The Twin Cities is also home to a growing number of immigrants and refugees.**

While Minnesota has proportionally fewer immigrants than the United States as a whole (8% compared with 13% nationally), the state's foreign-born population is increasing faster than the national average. About 428,000 residents are foreign born, with approximately 80 percent of these residents living in the Twin Cities region. Overall, nearly 1 in 6 children (age 0-19) have at least one immigrant parent and, among our state's youngest children (age 0-4), nearly 1 in every 5 is a child of an immigrant.<sup>3</sup> The largest numbers of immigrants and refugees come from the following countries: Mexico, India, Somalia, Vietnam, Thailand (including Hmong refugees), China, Korea, Ethiopia, and Liberia. World events and immigration policies have influenced when various cultural communities have come to Minnesota. Karen refugees, fleeing the Burmese civil war, are among the newest populations to immigrate to Minnesota in larger numbers.

## Languages spoken at home

**At a county level, up to one-third of school-age children live in a household where a language other than English is spoken as the primary language.** These percentages are higher in the region's most diverse school districts. Nearly half (46%) of children enrolled in the Saint Paul Public Schools District speak a primary language other than English in their household, as do 32 percent of children enrolled in Minneapolis Public Schools.<sup>4</sup> In this district, over 1,000 students speak each of the following languages: English, Spanish, Hmong, Somali, Vietnamese, Karen, Mandarin Chinese, Russian, Arabic, Oromo, Amharic, and Khmer. Hennepin County, the largest of the seven counties in the region, has the largest number of children who speak languages other than English in their homes (Figure 3).

Although a number of school-age children speak languages other than English in their homes, most children (91-98%) speak English "very well." There are not good measures available that describe the degree to which institutions, schools, and other organizations have the linguistic and cultural capacity to meet the needs of all children and families.

<sup>3</sup> Integrated Use Microdata Series (IPUMS), 2010

<sup>4</sup> Minnesota Department of Education. 2014-15. Retrieved from <http://w20.education.state.mn.us/MDEAnalytics/Data.jsp>

### 3. Primary language spoken in household by children enrolled in school

	Enrolled students with language other than English as primary language spoken at home		Number of languages spoken by children enrolled in school	Percent of children (age 5-17) who speak English less than “very well”
	N	%	N	%
Anoka	9,246	15%	129	3%
Carver	1,302	8%	55	3%
Dakota	10,565	15%	121	3%
Hennepin	31,342	22%	154	6%
Ramsey	23,248	32%	133	9%
Scott	2,666	12%	90	4%
Washington	2,972	8%	86	2%

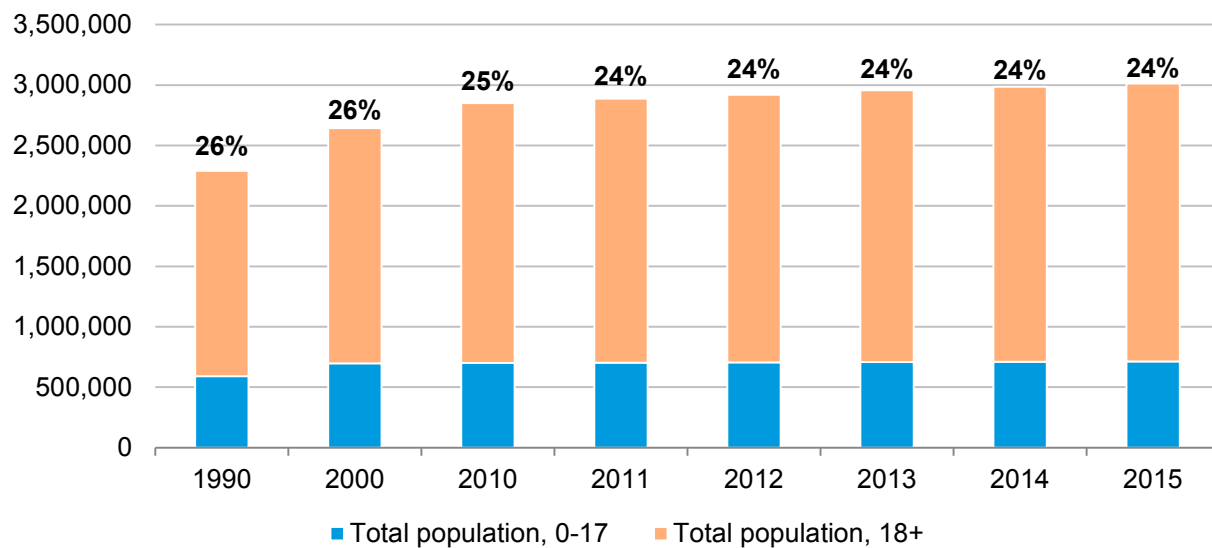
Sources: Minnesota Department of Education, American Community Survey 5-year estimates

### Children as a proportion of the population

**Although the number of children living in the Twin Cities metro has increased since 1990, children comprise a decreasing share of the overall population.** In 2015, nearly 714,000 children age 0-18 lived in the Twin Cities region, comprising nearly one-quarter of the overall population (Figure 4). Although the number of children living in the metro has continued to increase, the rate of growth is not as high as it had been prior to the 2008 recession. At the same time that there have been fewer births, the number of adults age 65 and older has been and will continue to increase dramatically as the baby boomer generation ages. As a result of these demographic shifts, within the next decade, the number of adults age 65 and older will be greater than the number of children living in the Twin Cities metro (Figure 5). This demographic change has the potential to influence how resources and funding are allocated at the state and local level.

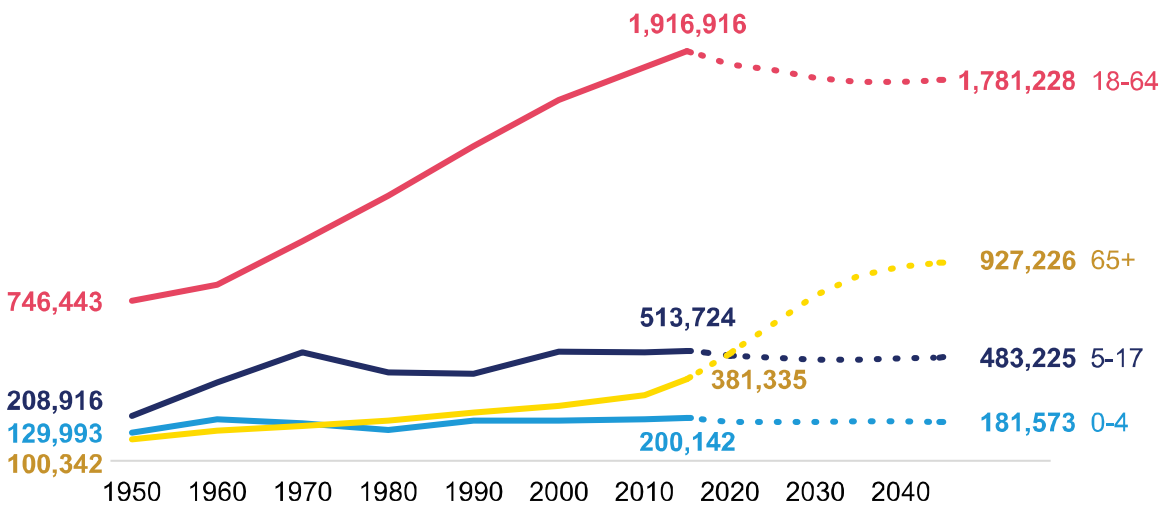


#### 4. Number and percentage of children living in the Twin Cities metro



Source: U.S. Census Bureau, Decennial Census and Population Estimates

#### 5. Projected changes in the population of children and other age groups in the Twin Cities metro



Sources: Minnesota State Demographic Center; U.S. Census Bureau, Decennial Census and Population Estimates.  
Retrieved from Minnesota Compass ([www.mncompass.org](http://www.mncompass.org))

# Income and wealth

Across a range of measures, data from the Twin Cities metro show health outcomes for children living in more affluent households are better than those for children in lower income households. Family income and wealth impact child health and well-being in multiple ways, influencing access to resources (e.g., safe housing, nutritious foods, clean water and air) and levels of stress.

## Wealth accumulation

**One of the key factors resulting in racial income disparities are differences in the accumulation of wealth.** Home ownership is the primary mechanism for wealth accumulation in the United States. A recent national study<sup>5</sup> found that Latino and black households own an average of six and seven times less wealth (\$98,000 and \$85,000, respectively) than white households (\$656,000). The lingering effects of discriminatory housing policies and a number of other practices (e.g., employment discrimination, racial discrimination in the criminal justice system, and unequal access to education opportunities) are major drivers of disparities in homeownership and household wealth. While local data on wealth were not gathered as part of this assessment, the same types of policies cited in the study have been in place in Minnesota and the Twin Cities region, disproportionately impacting people of color.

## Household income, poverty

**Nationally, over the past 25 years, the percentage of children who experience poverty increased while poverty rates among adults age 65 and older has steadily decreased.**<sup>6</sup> The three main reasons cited as explanations for this trend are: decreased real value of wages, particularly among workers with lower levels of education; a decrease in the real value of benefits families receive from public programs, such as welfare and Temporary Assistance for Needy Families (TANF) aid; and an increase in the number of single-parent, female-led households.<sup>7</sup>

**Over 200,000 children in the Twin Cities metro live in households with incomes at or near poverty levels.** Since 2000, the percentage of children living in lower-income

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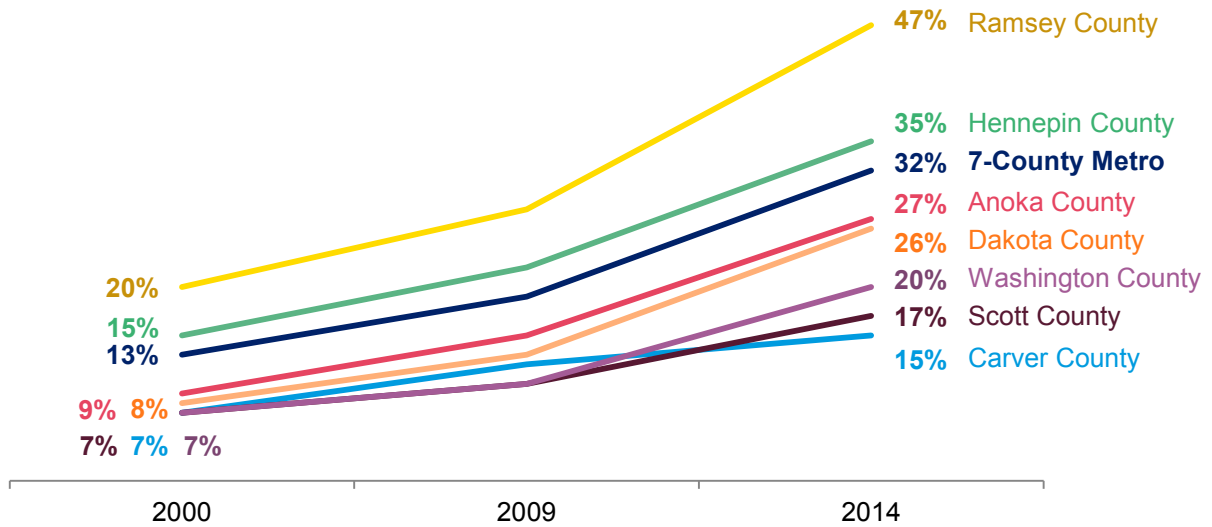
<sup>5</sup> CFED & Institute for Policy Studies. (2016). The ever-growing gap: Without change, African-American and Latino families won't match white wealth for centuries. Retrieved from: [www.IPS-dc.org](http://www.IPS-dc.org). Due to data limitations, Asian and American Indian households were not included in this study.

<sup>6</sup> Wood, D. (2003). Effect of child and family poverty on child health in the United States. *Pediatrics*, 112 (3).

<sup>7</sup> *ibid*

households<sup>8</sup> has more than doubled (Figure 6). Nearly half (47%) of children living in Ramsey County and 32 percent of children in Hennepin County live in lower-income households, with Minneapolis and Saint Paul having the highest child poverty rates. The county rates are two to three times higher than in Carver County, the most affluent county in the region, where 15 percent of children live in lower-income households.

**6. Changes in the percentage of children living in lower-income households over time, by county**



Sources. U.S. Census Bureau, American Community Survey 5-year estimates (2000, 2005-09, 2010-14)

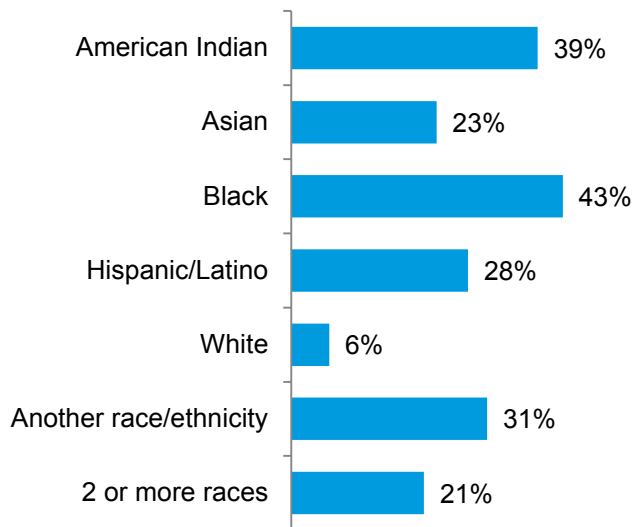
Notes. “Lower-income households” refers to households with an annual income at or below 200% of the Federal Poverty Level (200% FPL), \$48,500 for a family of four in 2015. This is the threshold used in eligibility guidelines for some state benefit programs.

<sup>8</sup> “Lower-income households” refers to households with an annual income at or below 200% of the Federal Poverty Level (200% FPL). The FPL does take household size into consideration; 200% FPL was \$48,500 for a family of four in 2015. This is the threshold used in eligibility guidelines for some state benefit programs.

**Racial disparities in income levels are evident; black and American Indian children are more likely to live in lower-income households and to experience poverty.** Forty-three percent of black children and a slightly smaller percentage of American Indian children (39%) live in households with incomes at or below the Federal Poverty Level<sup>9</sup> (Figure 7). In addition, over 20 percent of Asian (23%) and Hispanic/Latino (28%) children live in lower-income households. Although over 24,000 white children live in lower-income households, they comprise a much smaller percentage of the overall population (6%).

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**7. Percentage of children in the Twin Cities region living at or below 100% FPL by race/ethnicity, 2014**



Source. American Community Survey, 5-year estimates (2010-2014)

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<sup>9</sup> For a family of four, 100% FPL in 2015 was \$24,250.

The same disparities hold true when looking at data for each of the seven Twin Cities metro counties (Figure 8). Across all counties with data available, the percentage of American Indian and black children who live in lower-income households is at least five times higher than white, non-Hispanic children (the racial group with the lowest percentage of children living in lower-income households).

### 8. Percentage of children in each county living at or below 100% FPL, by race/ethnicity

	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington
American Indian	42%	**	**	43%	49%	30%	**
Asian	7%	**	14%	17%	37%	**	8%
Black	33%	**	35%	47%	47%	31%	21%
Hispanic/Latino	19%	18%	29%	28%	33%	26%	17%
White (non-Hispanic)	7%	3%	5%	5%	7%	4%	5%
Another race/ethnicity	22%	**	38%	29%	35%	44%	**
Two or more races	19%	**	16%	21%	32%	9%	14%
All children	10%	4%	11%	17%	25%	7%	7%

Source. American Community Survey, 5-year estimates (2010-2014)

Notes. Data are suppressed (\*\*) in counties where racial/ethnic groups are too small to calculate reliable estimates.

Data presented in other recent reports can provide further insight into the economic circumstances impacting the health and well-being of children. The Minnesota State Demographic Center<sup>10</sup> estimated the number of residents living at or near federal poverty levels for 17 cultural communities, including American Indian tribes and multiple ethnic groups and nationalities. While the report has limitations, this analysis helps illustrate a few important points:

- Differences in socioeconomic status vary widely across cultural communities. These differences reflect the varied experiences of people who today call Minnesota home, including how groups have been impacted by historical events and many different types of policies, including immigration policy (Figure 9).
- There are wide differences in experiences of cultural groups often reported together within a single race category (e.g., Chinese and Hmong residents grouped together in a single Asian race category).

<sup>10</sup> Minnesota State Demographic Center. (2016). *The economic status of Minnesotans: A chartbook with data for 17 cultural groups*. Retrieved from: [https://mn.gov/admin/assets/the-economic-status-of-minnesotans-chartbook-msdc-jan2016-post\\_tcm36-219454.pdf](https://mn.gov/admin/assets/the-economic-status-of-minnesotans-chartbook-msdc-jan2016-post_tcm36-219454.pdf)

- Nearly 350,000 white residents experience poverty, more than any other cultural group, but this comprises only 8 percent of the white population overall.

**9. Number and percentage of people (all ages) living in lower-income households in Minnesota, by cultural group, 2014**

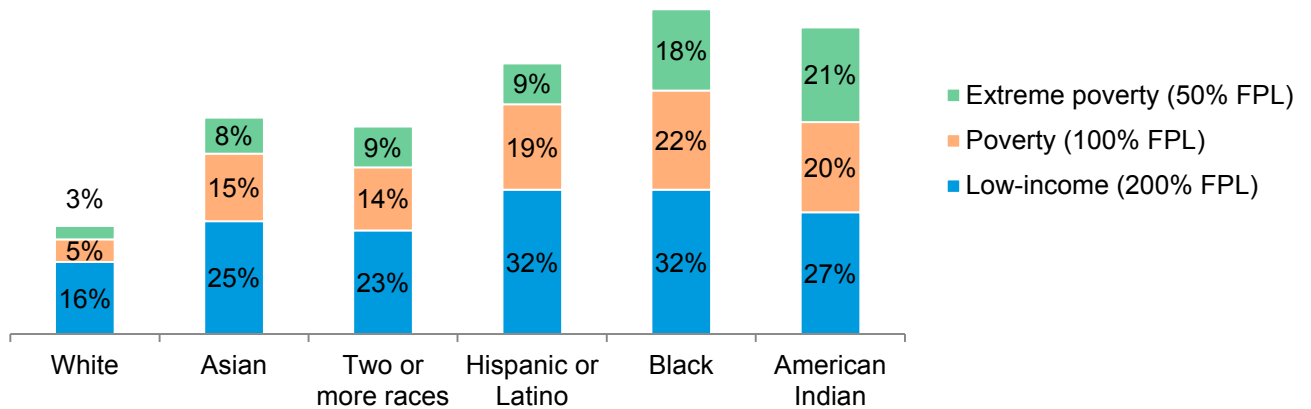
<b>Cultural group</b>	<b>Number living below 100% FPL (% of population)</b>	<b>Number living between 100% and 200% FPL (% of population)</b>
Somali	26,400 (57%)	11,700 (26%)
Ojibwe	12,200 (38%)	8,400 (26%)
African American	72,800 (35%)	51,500 (25%)
Ethiopian	5,900 (35%)	3,600 (21%)
Dakota	1,800 (30%)	1,300 (22%)
Hmong	17,700 (27%)	22,300 (34%)
Mexican	47,100 (26%)	57,200 (32%)
Liberian	2,800 (21%)	4,500 (33%)
Puerto Rican	2,600 (21%)	1,600 (13%)
Vietnamese	4,300 (15%)	5,100 (17%)
Lao	1,500 (12%)	3,300 (27%)
Russian	1,200 (12%)	2,000 (21%)
Chinese	2,600 (9%)	3,700 (13%)
Korean	1,900 (9%)	3,400 (15%)
White	346,800 (8%)	578,300 (13%)
Filipino	1,000 (7%)	1,900 (14%)
Asian Indian	2,700 (6%)	4,000 (9%)
All Minnesotans	594,400 (11%)	809,000 (15%)

Source. Minnesota State Demographic Center (2016)

Notes. Estimates in this report were calculated from responses to the American Community Survey; data limitations do not allow for reliable regional- or county-level estimates.

Every year, the Children’s Defense Fund compiles data describing the health and well-being of children. The 2015 Minnesota Kids Count report looked at levels of poverty for children in Minnesota, highlighting the percentage of children who live in extreme poverty (at or below 50% FPL, or an annual income of just over \$12,000 for a family of four). Their analysis shows that, while children of all race and ethnic groups experience extreme poverty, black (18%) and American Indian (21%) children experience extreme poverty at a much higher rate than children of other race and ethnic groups (3-9%; Figure 10).

### 10. Levels of child poverty by race and ethnicity in Minnesota, 2013



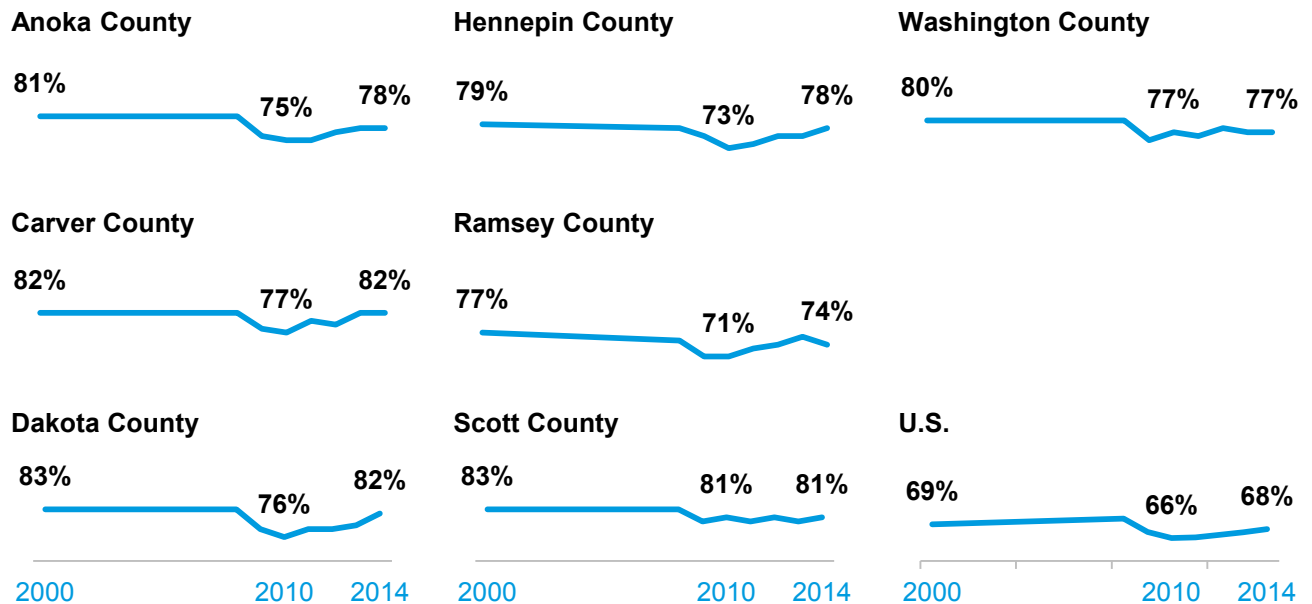
Source. Children’s Defense Fund-Minnesota. Kids Count Data Book. Retrieved from: <http://www.cdf-mn.org/includes/2015-minnesota-kids-count.pdf>

Notes. The 2015 Kids Count report uses the most updated data available. Analysis of rates was completed by the Population Reference Bureau using data from the U.S. Census Bureau, 2013 American Community Survey. In order to calculate reliable estimates, 3-year pooled data (2011-13) were used to calculate poverty levels for American Indian children. All other racial/ethnic group estimates are based on 2013 (1-year) data.

## Employment

**Employment is the primary driver of household income.** In most Twin Cities counties, employment levels have not fully rebounded after the 2008 recession (Figure 11). During the recession, the proportion of adults working dropped to the lowest levels in Hennepin and Ramsey counties (73% and 71%, respectively) and is still below 75 percent in Ramsey County today. Despite a slower recovery in some parts of the region, the proportion of working adults is higher in the Twin Cities region (78%) than the national average (68% in 2014).

### 11. Proportion of adults (age 16-64) working, by county



Sources. U.S. Census Bureau, Decennial Census and American Community Survey. Retrieved from Minnesota Compass ([www.mncompass.org](http://www.mncompass.org)).

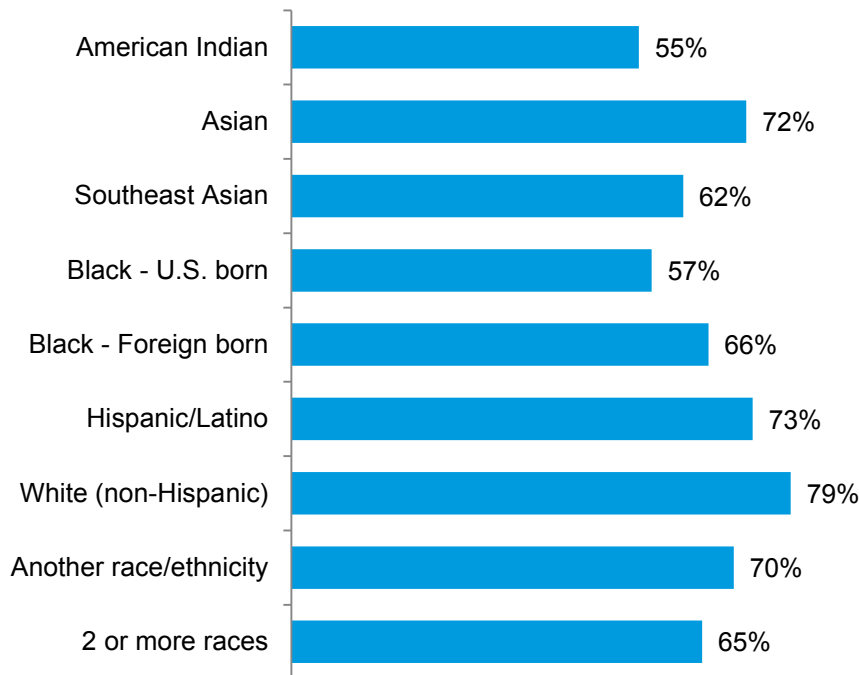
Notes. People are considered “working” if they are self-employed, working for a family business, or working for others. The percentage of adults working considers all adults (16-64) not living in an institutionalized setting (e.g., prison, residential group home), including adults not actively looking for work or who have otherwise left the labor force.

**There are significant racial disparities in employment.** Only 55 percent of American Indian and 57 percent of black (U.S.-born) adults in the Twin Cities were working in 2014 (Figure 12). This is nearly 20 percentage points lower than among white adults, the racial group with the highest proportion of working adults (73%). It should be noted that these data do not provide insight into job quality; adults categorized as working may not be earning high enough wages to provide for their families.



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## 12. Proportion of Twin Cities adults (age 16-64) working, by race/ethnicity



Source. Integrated Use Microdata Series (IPUMS), 2010-12. Retrieved from Minnesota Compass ([www.mncompass.org](http://www.mncompass.org)).

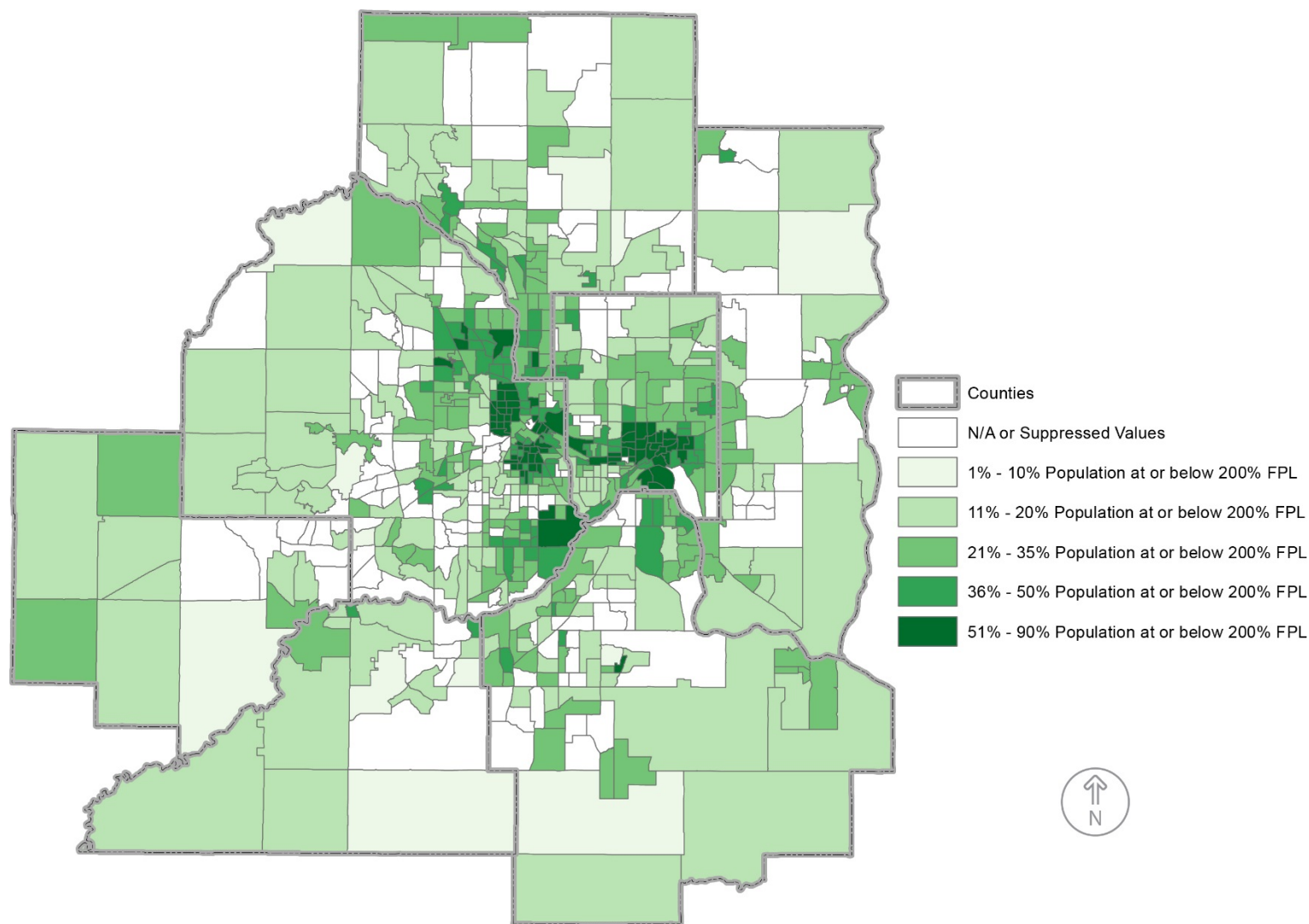
Notes. People are considered “working” if they are self-employed, working for a family business, or working for others. The percentage of adults working considers all adults (16-64) not living in an institutionalized setting (e.g., prison, residential group home), including adults not actively looking for work or who have otherwise left the labor force.

The Southeast Asian category includes those who identified their race as Asian and reported belonging to any of the following ancestry groups: Burmese, Cambodian, Filipino, Hmong, Indonesian, Laotian, Malaysian, Thai, Taiwanese, or Vietnamese. The category Asian (other) includes those who identified their race as Asian but did not report belonging to the ancestry groups listed previously.

### Neighborhoods of concentrated poverty

In neighborhoods of concentrated poverty, resources that support health and wellness are often limited, making it more difficult for residents to make choices that promote health. In the Twin Cities metro region, most of the neighborhoods where over half of residents live in lower-income households are in the central cities of Minneapolis and Saint Paul, including the neighborhoods included in the definition of community being used in this CHNA (Figure 13). In the five Minneapolis and Saint Paul neighborhoods identified as neighborhoods of focus by Children’s Minnesota in this CHNA process, at least two-thirds of children (age 0-17) are living in lower-income households.

### 13. Percentage of children (age 0-17) living in lower-income households, by census tract



Source. American Community Survey 5-year estimates (2010-14)

Notes. "Lower-income households" refers to households with an annual income at or below 200% of the Federal Poverty Level (200% FPL), \$48,500 for a family of four in 2015.

# Housing and residential segregation

## Homeownership

Homeownership is a key step, though not a guarantee, to successful wealth accumulation, particularly for lower-income families.<sup>11</sup> However, for many decades, policies restricted people of color from owning homes or choosing the neighborhoods where they would like to live. In the Twin Cities metro, the lasting impacts of discriminatory housing practices can be seen today by comparing “redlined” districts established decades ago to current areas of concentrated poverty (Figure 14). Redlining refers to a set of practices established by the Federal Housing Administration (FHA), other government agencies, and private banks to label neighborhoods based on their perceived credit risk. Mortgage loan applications were regularly approved for (predominantly white) people living in suburban areas or other neighborhoods with high credit ratings, and denied for residents living in areas identified as “declining” neighborhoods, often areas with many residents of color. As a result of these policies, households of color received just 2 percent of the FHA loans made between 1934 and 1968.<sup>12</sup> Without homeownership, lower-income residents have very few options to increase wealth, reducing financial stability and contributing to intergenerational poverty.

**As a result of historical redlining policies and disparities in income, access to credit, and other forms of structural racism, there is a significant**

**homeownership gap today.** In the Twin Cities, less than one-quarter of black residents own their own homes. Homeownership rates are higher among Hispanic/Latino (37%), American Indian (39%), Southeast Asian (49%), and all other Asian (59%) residents, but still are much lower than the homeownership rate for white, non-Hispanic (76%) adults.<sup>13</sup>

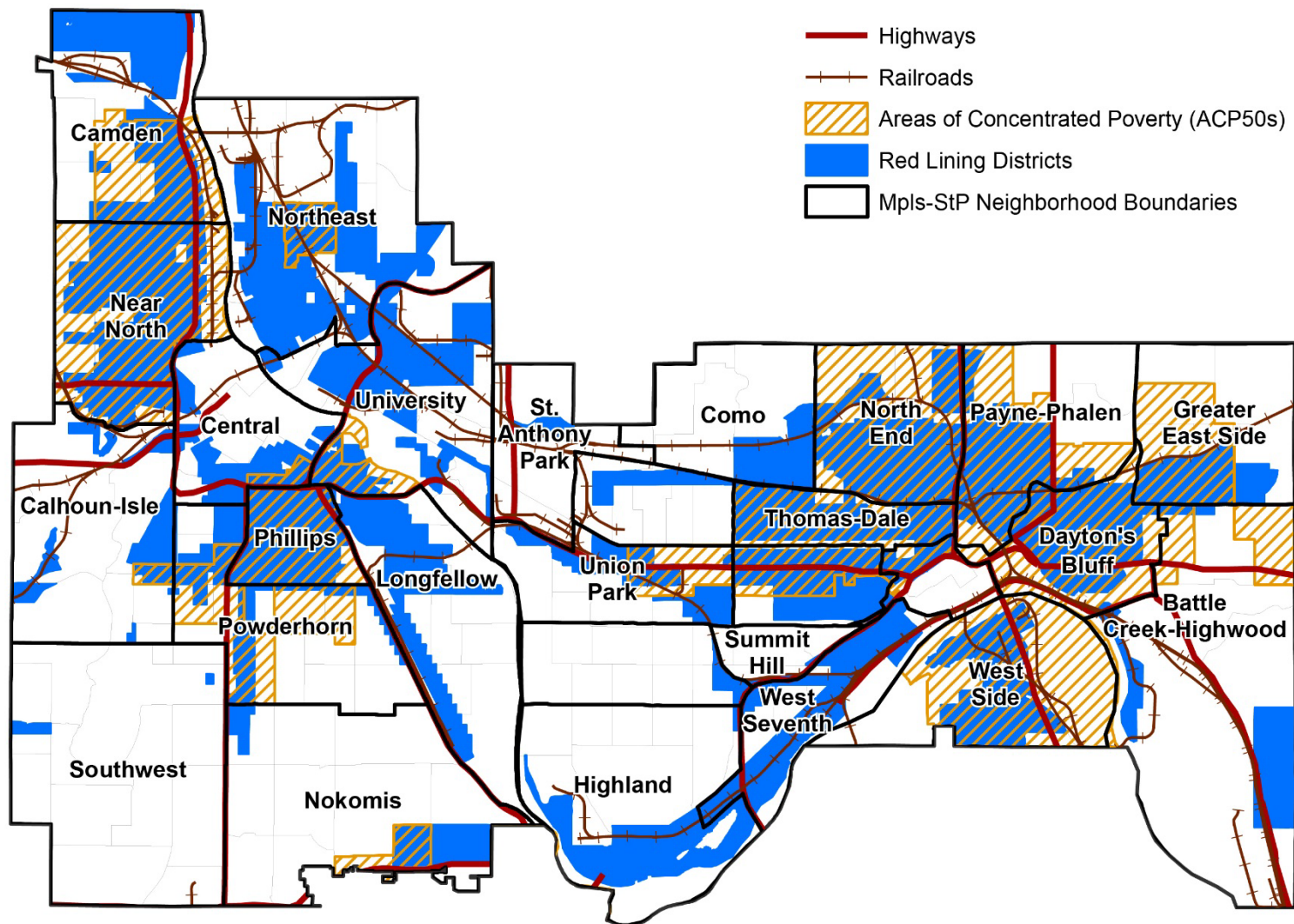
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<sup>11</sup> Boehm, T. & Schlottmann, A. (2004). *Wealth accumulation and homeownership: Evidence for low-income households*. Retrieved from the U.S. Department of Housing and Urban Development website: <https://www.huduser.gov/portal/Publications/pdf/WealthAccumulationAndHomeownership.pdf>

<sup>12</sup> Asante-Muhammed, D., Collins, C., Hoxie, J., & Nieves, E. (2016). *The ever-growing gap: Without change African-American and Latino families won't match white wealth for centuries*. Retrieved from the Corporation for Enterprise Development website: [http://cfed.org/policy/federal/The\\_Ever\\_Growing\\_Gap-CFED\\_IPS-Final.pdf](http://cfed.org/policy/federal/The_Ever_Growing_Gap-CFED_IPS-Final.pdf)

<sup>13</sup> Homeownership rates are categorized by the racial/ethnic group of the householder. The data presented are from the Integrated Public Use Microdata Series for the Twin Cities region (2010-12). Retrieved from: <http://www.mncompass.org/housing/homeownership-gap#7-5599-d>

14. Past housing policies and current areas of concentrated poverty in Minneapolis and Saint Paul: Redlining district maps



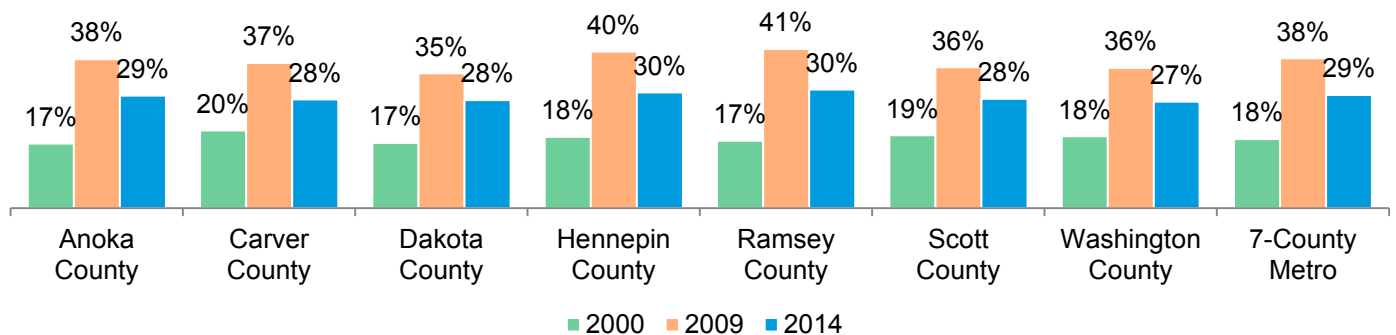
Minnesota Geospatial Information Office. Produced by Wilder Research

Although the Civil Rights Act of 1968 banned the practice of redlining, there is evidence that discriminatory practices have continued. A 2014 report by the Institute on Metropolitan Opportunity<sup>14</sup> showed how recent discriminatory mortgage lending practices in the Twin Cities have contributed to home foreclosures and loss of wealth that disproportionately impact communities of color. Their report showed that people from lower-income neighborhoods and people of color were more likely to receive subprime loans, the type of lending that resulted in so many home foreclosures during the market collapse.

## Housing stability

When families need to spend a large amount of their income on housing, it can impact their ability to pay for other basic needs. A household is considered housing cost-burdened when 30 percent or more of its monthly gross income is dedicated to housing expenses, including rent or mortgage payments, taxes, and utilities. In all Twin Cities counties, the percentage of cost-burdened households increased dramatically from 2000 to 2009, a reflection of the rapid growth and collapse of the housing market during that time, and changes in monthly income due to job loss during the recession. In 2009, at least one-third of households were cost-burdened in each of the seven counties in the region (Figure 15). There were fewer cost-burdened households in 2014 (27 to 30% of homeowners), which is due, in part, to some people selling or losing their homes.

### 15. Percentage of cost-burdened households over time, by county



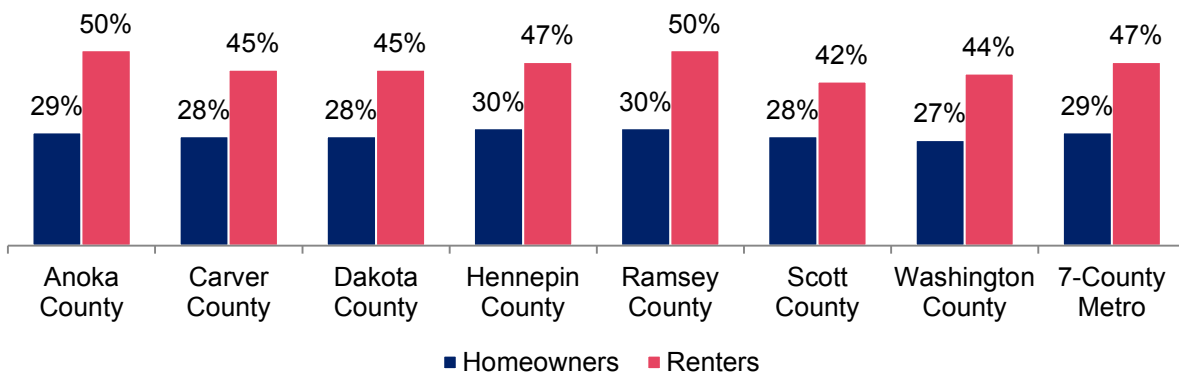
Sources: U.S. Decennial Census, American Community Survey 5-year estimates (2005-09, 2010-14)

In 2014, just over 355,000 households lived in rental properties, including apartments and rental homes. In all Twin Cities metro counties, at least 40 percent of households that rent

<sup>14</sup> Institute on Metropolitan Opportunity. (2014). *Twin Cities in crisis: Unequal treatment of communities of color in mortgage lending*. Retrieved from the University of Minnesota Law School website: <http://www1.law.umn.edu/uploads/ef/be/efbe0b8fda7508c925b74c7add571f41/IMO-Twin-Cities-Lending-Report-2014-Final.pdf>

were cost-burdened, and renters were more likely than homeowners to be spending at least 30 percent of their income on housing costs (Figure 16).

## 16. Percentage of cost-burdened households, homeowners and renters (2014)



Sources. U.S. Decennial Census, American Community Survey 5-year estimates (2005-09, 2010-14)

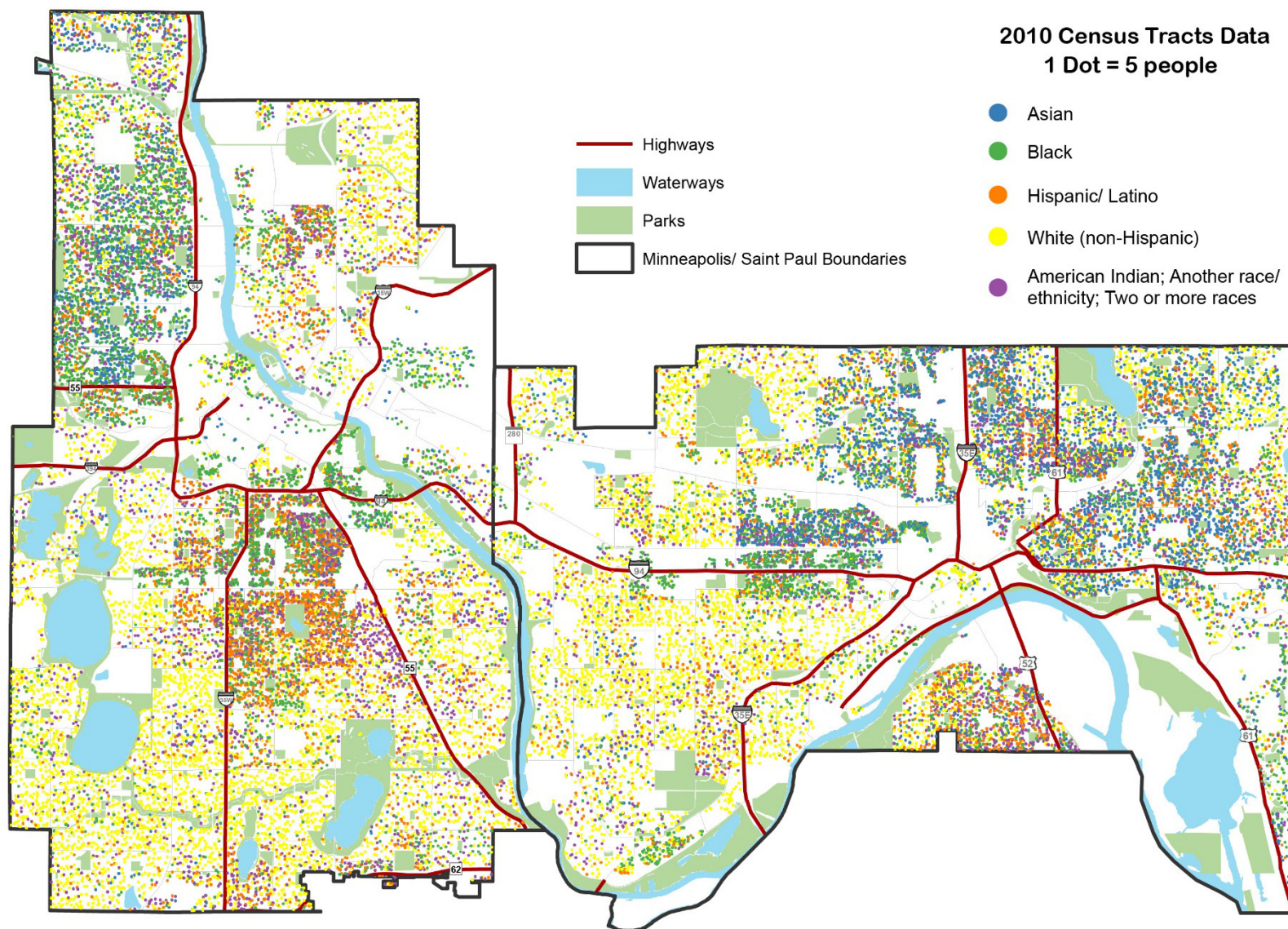
## Residential segregation

**Mapping of Twin Cities metro residents by race and ethnicity shows that although the region is becoming increasingly culturally diverse, few neighborhoods are racially integrated** (Figure 17). (See appendix figures A2-A7 for additional maps by racial/ethnic groups.) A recent report by the Institute on Metropolitan Opportunity<sup>15</sup> looks in depth at how housing and education policies have reinforced neighborhood segregation. The authors identify a number of key governmental decisions and policy initiatives that have increased or reinforced segregation, including policies that have increased affordable housing goals for Minneapolis and Saint Paul while decreasing these goals in more affluent, majority-white suburbs, and revisions to the state's school desegregation rules. Another recent study from University of Minnesota<sup>16</sup> pointed out that racially concentrated areas of affluence (RCAA) in cities may lead to lower empathy among white residents, potentially inhibiting policies and other efforts that would aim to reduce citywide or regional racial inequalities. While it is not within the scope of this assessment to examine the extent to which specific policies have contributed to residential segregation, these brief examples illustrate how policy decisions can have long-lasting impacts that reinforce segregation and disparities in health.

<sup>15</sup> Institute on Metropolitan Opportunity. (2015). *Why are the Twin Cities so segregated?* Retrieved from the University of Minnesota Law School website: <https://www1.law.umn.edu/uploads/ed/00/ed00c05a000fffeb881655f2e02e9f29/Why-Are-the-Twin-Cities-So-Segregated-2-26-15.pdf>

<sup>16</sup> Goetz, Damiano, & Hicks. (2015). Retrieved from: [http://www.lincolinst.edu/docs/979/1839\\_8%20Edward%20Goetz.pdf](http://www.lincolinst.edu/docs/979/1839_8%20Edward%20Goetz.pdf)

## 17. Racial dot map of children (age 0-17) living in Minneapolis and Saint Paul



Source. American Community Survey 5-year estimates (2010-14)

Note. Three race categories (American Indian, Another race/ethnicity, and Two or more races) were combined into a single group because reliable estimates could not be calculated for any of the categories alone.

## Homelessness

### **In Minnesota, children represent 35 percent of the overall homeless population.**

Housing instability, unemployment, and poverty can lead to short-term or chronic homelessness. Every three years, Wilder Research conducts a study where volunteers across the state interview as many individuals experiencing homelessness as possible on a single night, including people in shelters, temporary housing, and in non-shelter locations such as encampments and drop-in service sites. In 2015, the study found that 3,509 children were homeless. This count likely underestimates the number of children and youth experiencing homelessness since many homeless youth stay outside the shelter system, living temporarily with friends or staying in places not intended for habitation. The number of homeless children decreased 7 percent between 2012 and 2015. However, the percentage of unaccompanied minors (age 17 and under) who were homeless increased 46 percent during the same time period (Figure 18).

#### **18. Changes in Minnesota youth experiencing homelessness over time, 2009-2015**

	<b>2009 study</b>	<b>2012 study</b>	<b>2015 study</b>	<b>% change (2012-2015)</b>
Children (17 and under) with parents	3,251	3,546	3,296	-7%
Unaccompanied minors (17 and under)	227	146	213	+46%
Young adults (18-21)	1,041	1,005	779	-22%
Adults (22-54)	4,585	4,708	4,108	-13%
Older adults (55 and older)	526	777	843	+8%

Source. Wilder Research, 2015 Homeless Study Detailed Data. Retrieved from: <http://mnhomeless.org/minnesota-homeless-study/detailed-data.php>



# Educational attainment

Educational attainment is another important predictor of overall health and is closely related to other social determinants of health. Individuals without a high school diploma have greater difficulty finding a high-paying job and accessing resources that support health and well-being. When children do not receive a high-quality education, they enter adulthood at a disadvantage. Racial disparities in educational outcomes perpetuate inequities in employment, income, housing, and health.

## **Minnesota has some of the worst educational disparities in the nation.**

Graduation rates in Minnesota are among the worst nationwide for Hispanic/Latino (63%), black (60%), and American Indian (51%) students.<sup>17</sup> While there is still room for improvement, graduation rates are much higher among white students (86%) in Minnesota.

Overall graduation rates are more than 10 percentage points lower in Ramsey (73%) and Hennepin (75%) counties than other counties in the seven-county Twin Cities region. The same patterns in racial disparities, where Hispanic/Latino, black, and American Indian students graduate at much lower rates than Asian and white non-Hispanic students, persist across all counties (Figure 19). Individual school districts and the Minnesota Department of Education (MDE) have plans in place to help improve graduation rates and reduce this gap. MDE aims to increase the overall four-year graduation rate to 90 percent by 2020, with no groups lower than 85 percent. While graduation rates have been improving for all racial and ethnic groups, current rates still fall short of this goal.

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## 19. Graduation rates by race/ethnicity, by county (2013-14)

	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington
American Indian	61%	**	75%	38%	41%	67%	60%
Asian	85%	88%	87%	84%	78%	82%	94%
Hispanic/Latino	68%	56%	68%	57%	63%	65%	80%
Black, non-Hispanic	61%	69%	73%	55%	62%	65%	85%
White, non-Hispanic	83%	94%	90%	85%	78%	89%	90%
All students	80%	91%	87%	75%	73%	86%	90%

Source. Minnesota Department of Education

Notes. This high-level reporting cannot capture successful efforts of schools within each county to reduce this educational disparity. Data are suppressed (\*\*) when there are fewer than 10 students in a racial/ethnic group.

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<sup>17</sup> National Center for Education Statistics. (2016). *Public High School Graduation Rates*. Retrieved from: [http://nces.ed.gov/programs/coe/indicator\\_coi.asp](http://nces.ed.gov/programs/coe/indicator_coi.asp)

**Multiple factors that begin at birth and occur throughout childhood contribute to disparities in graduation rates.** Access to high-quality early learning opportunities, for example, help children start kindergarten ready to learn. In Minnesota, Early Head Start, Head Start, and School Readiness are the public programs available to help young children develop skills to be successful in school. Recent efforts have focused on increasing opportunities for early childhood learning. Parent Aware Ratings help families identify the best quality child care and early education opportunities. In 2016, new state funding was allocated to some school districts and charter schools interested in establishing voluntary pre-kindergarten programs. Early childhood screening helps identify health and developmental concerns early so that children can receive necessary services and supports. (See the “Early Childhood Data Summary” for measures of Head Start enrollment and participation in other public programs that support early childhood development.)

While this summary focuses on graduation rates as a primary measure of educational achievement, multiple factors contribute to these disparities. Student educational achievement is also impacted by the school environment, including discipline and suspension policies; family characteristics, including parents’ educational attainment; the presence of caring adults in a child’s life; and neighborhood characteristics.

# Access to resources and supports

There are a number of resources and systems that support the health and well-being of children. Vibrant and healthy neighborhoods have a range of assets to support child health and development, including green spaces and parks where children can play and exercise, places to purchase healthy and affordable food, water and air free of pollution, and high-quality schools. These neighborhood assets and other types of resources need to be available, accessible, and welcoming to community residents. This section of the report highlights just a few of the many resources children and families access to support health.

## *Healthy food*

Food deserts are defined by the United States Department of Agriculture (USDA) as “low-income census tracts where a significant share of the population is more than 1 mile (urban) or 10 miles (rural) from a supermarket.” This measure only shows areas with low access to supermarkets; the measure assumes that high-quality, affordable food are available at all supermarkets and does not capture access to fresh foods available through other types of outlets (e.g., farmers markets or convenience stores that sell high-quality fresh produce). Census tracts identified as food deserts using the USDA Food Access Research Atlas<sup>18</sup> are located in Minneapolis and Saint Paul; suburban cities including Brooklyn Center, New Hope, South Saint Paul, and Maplewood; and more rural areas, including areas in Carver and Dakota counties.

## *Health care*

**Residents in Hennepin and Ramsey counties face significant barriers accessing health care.** Medically underserved areas (MUAs) are federally designated geographic areas where residents are underserved based on four criteria: ratio of primary care physicians to residents, infant mortality rate, percentage of residents living below the poverty level, and the percentage of the population age 65 and over. In the Twin Cities metro, all medically underserved areas are located in Hennepin and Ramsey counties: the Rice-Phalen, Thomas-Dale, Dayton’s Bluff, and Summit-Dale neighborhoods in Saint Paul and the Phillips, Northeast, Northside, and Cedar-Riverside neighborhoods in Minneapolis.

The American Indian population in Saint Paul is also designated as a medically underserved population (MUP), meaning that it is considered a population with economic, cultural, or linguistic barriers that limit access to primary medical care services. While this designation is one way to identify groups with limited access to health care, additional information from

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<sup>18</sup> Retrieved from: [www.ers.usda.gov/data-products/food-access-research-atlas](http://www.ers.usda.gov/data-products/food-access-research-atlas)

community residents and stakeholders is needed to fully understand what contributes to these difficulties accessing services.

### ***Health care insurance***

**The majority of children living in the Twin Cities have access to health care insurance.** In 2014, after the Affordable Care Act (ACA) was passed, just 3 percent of children (age 0-17) lacked insurance, a decrease from 6 percent of the population in 2010.<sup>19</sup> While health care insurance does not ensure access to services, the ACA required insurance plans to include expanded coverage for preventive care. This measure does not consider the quality of the health care plan; children who are covered by high deductible plans or coverage that includes only the minimum requirements may have inadequate coverage for their individual health care needs.

### ***Other factors***

This summary focused on a number of factors that can influence the health and well-being of children and families, but is not exhaustive. Data limitations, including the lack of availability or specificity, make it difficult to explore a number of important topics, including: transportation options; school environment and quality; public safety; social norms and attitudes, such as racism; exposure to mass media and emerging technology; housing quality; exposure to pollution or toxic substances; and the availability of culturally appropriate services.

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<sup>19</sup> U.S. Census Bureau, American Community Survey (2010-2014). Retrieved from Minnesota Compass: <http://www.mncompass.org/health/health-care-coverage#7-7152-g>

# Appendix

## A1. Demographic characteristics of children living in key neighborhoods served by Children's Minnesota (2015)

	Phillips (Minneapolis)	Powderhorn (Minneapolis)	West Side (Saint Paul)	Thomas-Dale (Saint Paul)	Dayton's Bluff (Saint Paul)
Number of children (age 0-17)	6,724	12,816	4,491	5,082	5,535
Percentage served by Children's MN	46%	35%	30%	28%	26%
Race					
African American/Black	46%	25%	23%	33%	16%
American Indian	9%	2%	**	2%	**
Asian/Pacific Islander	**	**	9%	40%	36%
Caucasian/White	22%	46%	35%	10%	25%
Two or more races	**	13%	11%	14%	12%
Other race <sup>a</sup>	2%	13%	20%	3%	**
Ethnicity					
Hispanic <sup>b</sup>	32%	41%	37%	9%	9%
Nativity					
Born outside of U.S.	14%	8%	8%	13%	10%
Socioeconomic status					
Percentage of children living in poverty (age 0-17)	83%	68%	70%	78%	68%
Percentage of children living in poverty (Under age 5)	82%	65%	77%	82%	68%
Employment rate (working-age adults)	57%	76%	71%	61%	64%
Cost-burdened households	54%	43%	44%	49%	45%

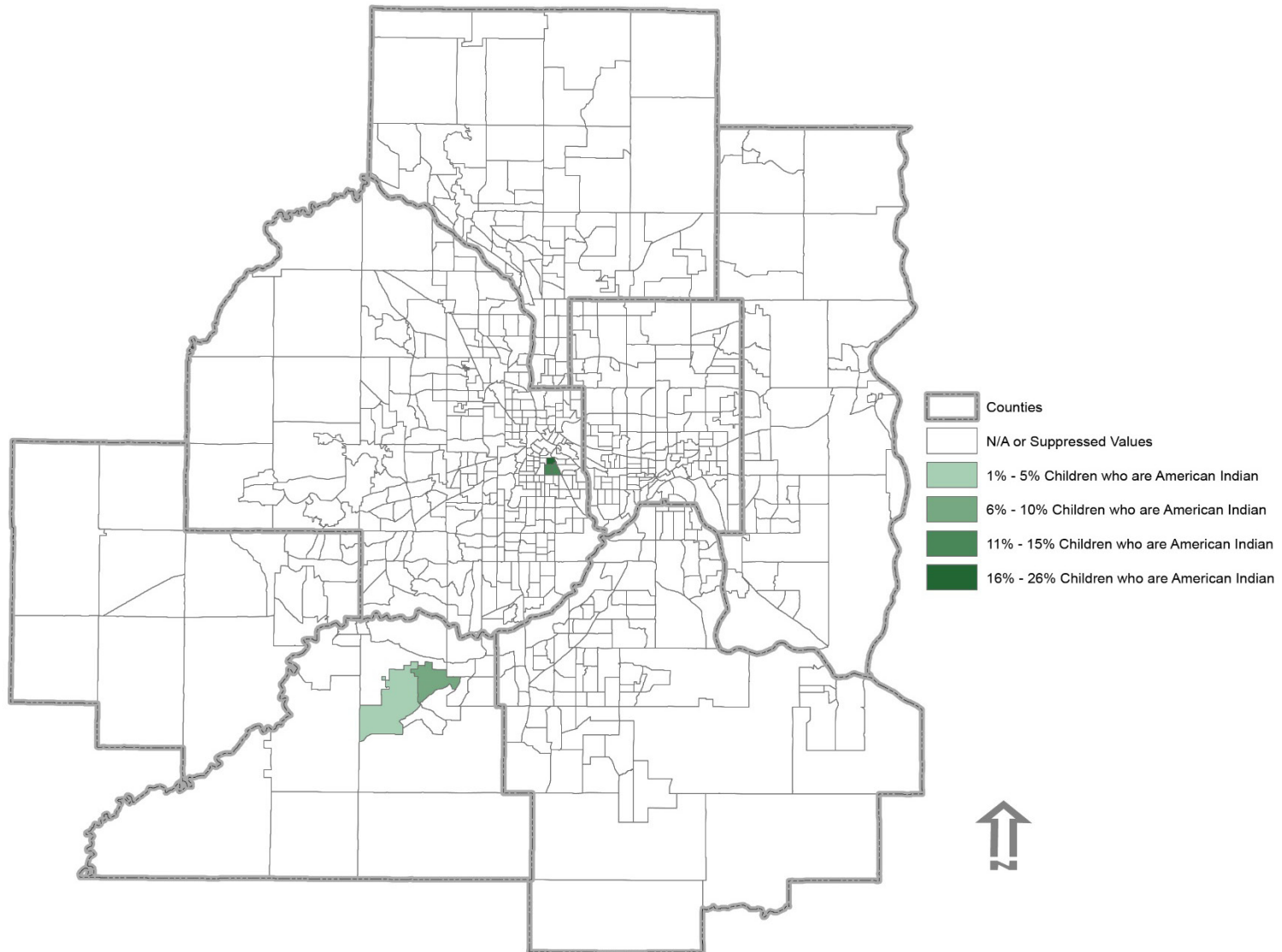
Source. American Community Survey, 5-year pooled estimate (2010-14)

\*\* = Due to small numbers, reliable estimates cannot be calculated.

<sup>a</sup> "Other" race often includes, but is not limited to, people who identify as Hispanic/Latino.

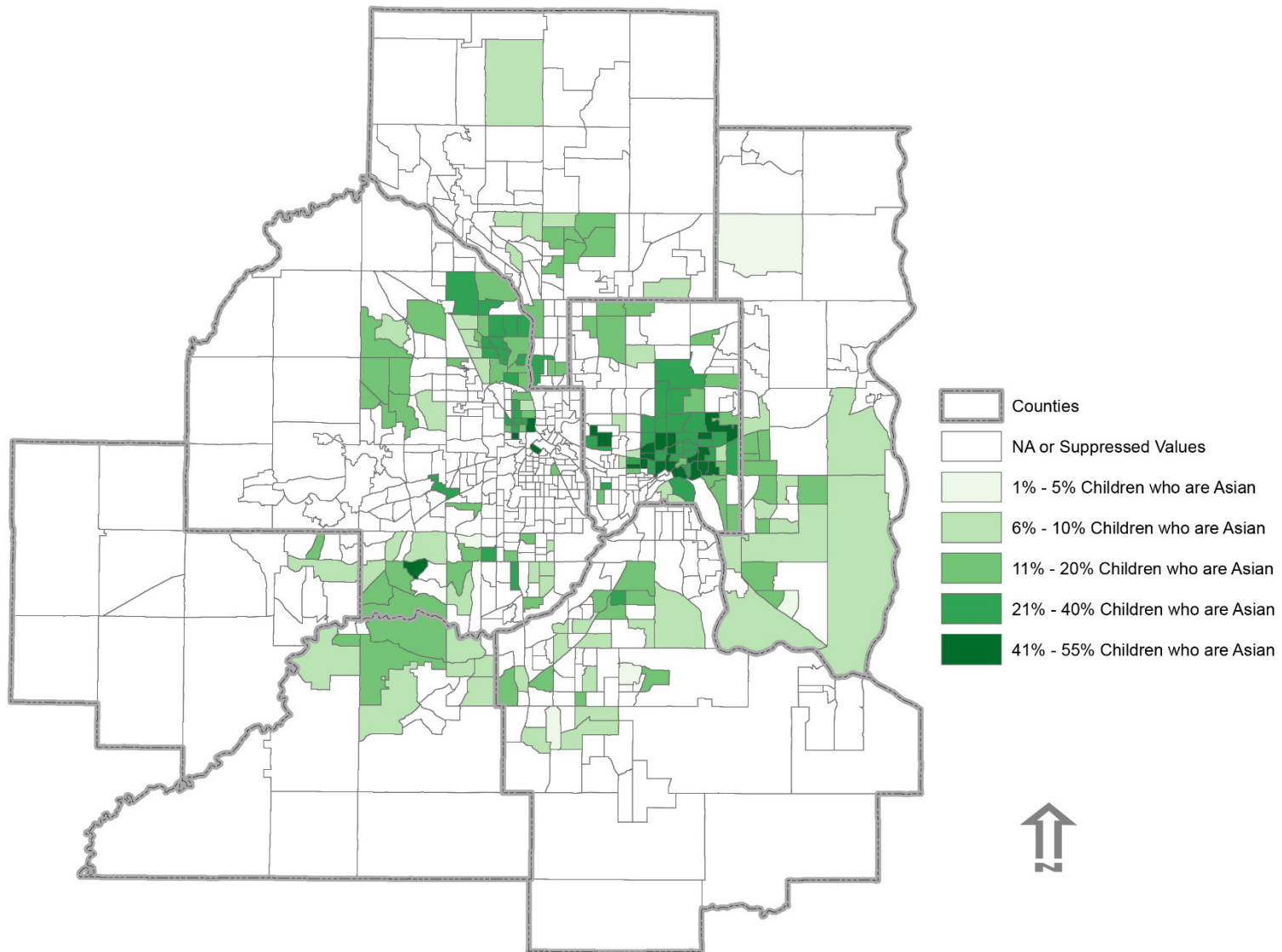
<sup>b</sup> The American Community Survey asks about race and ethnicity separately. Children identified as Hispanic are also represented in one of the race categories presented in this table.

## A2. Percentage of children who are American Indian, by census tract



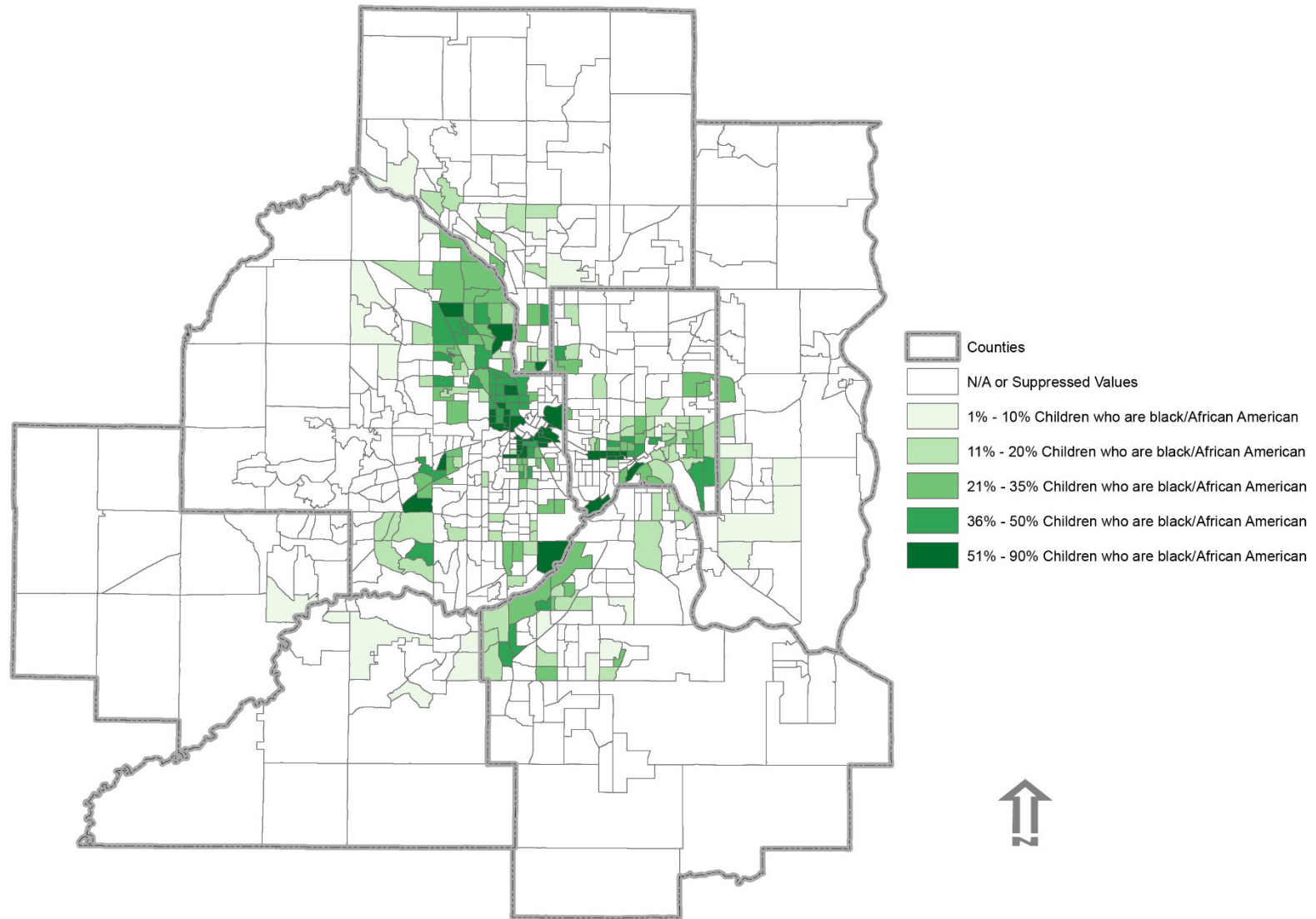
Source. American Community Survey 5-year estimates (2010-14)

### A3. Percentage of children who are Asian, by census tract



Source. American Community Survey 5-year estimates (2010-14)

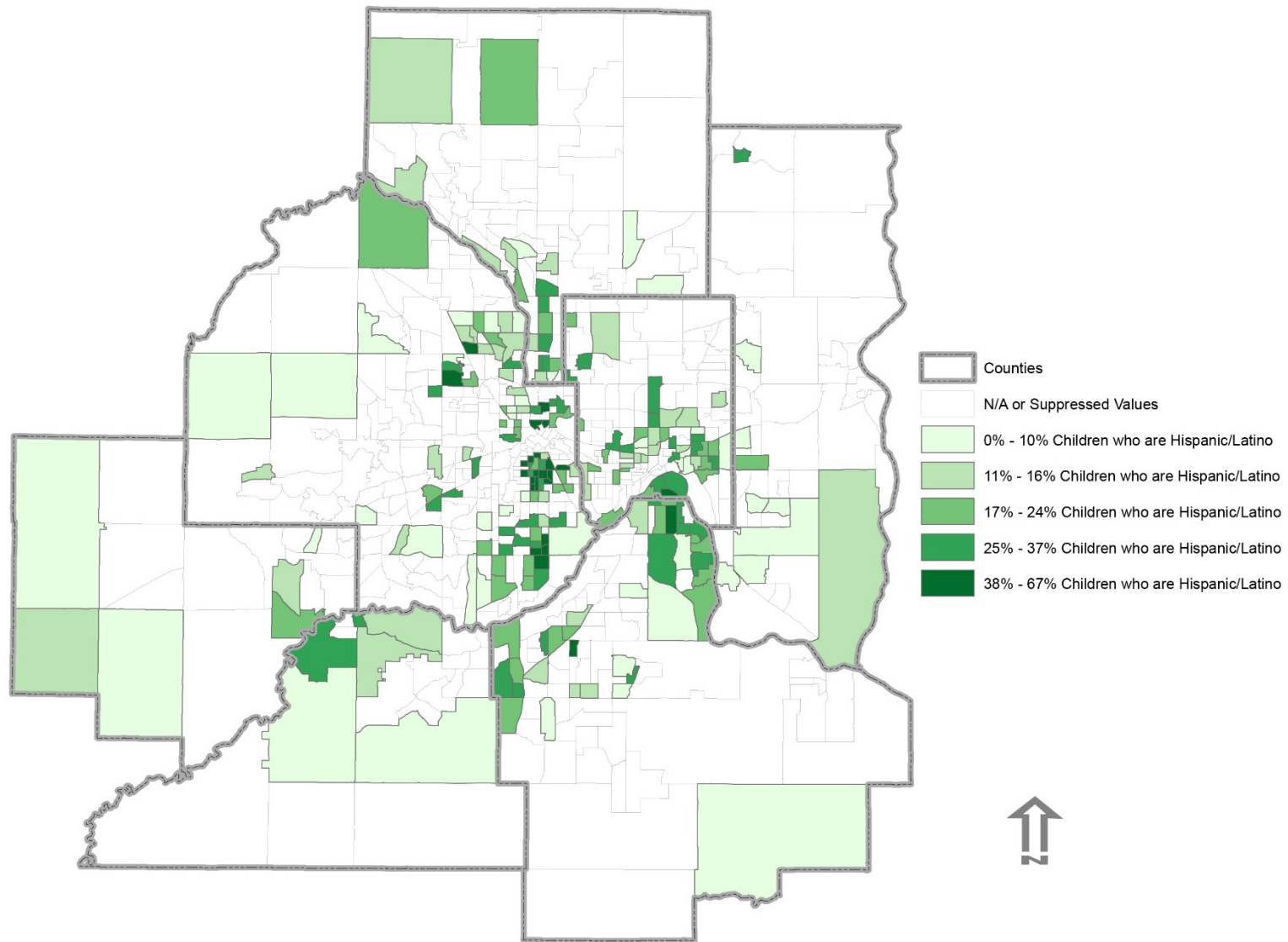
#### A4. Percentage of children who are black/African American, by census tract



Source. American Community Survey 5-year estimates (2010-14)

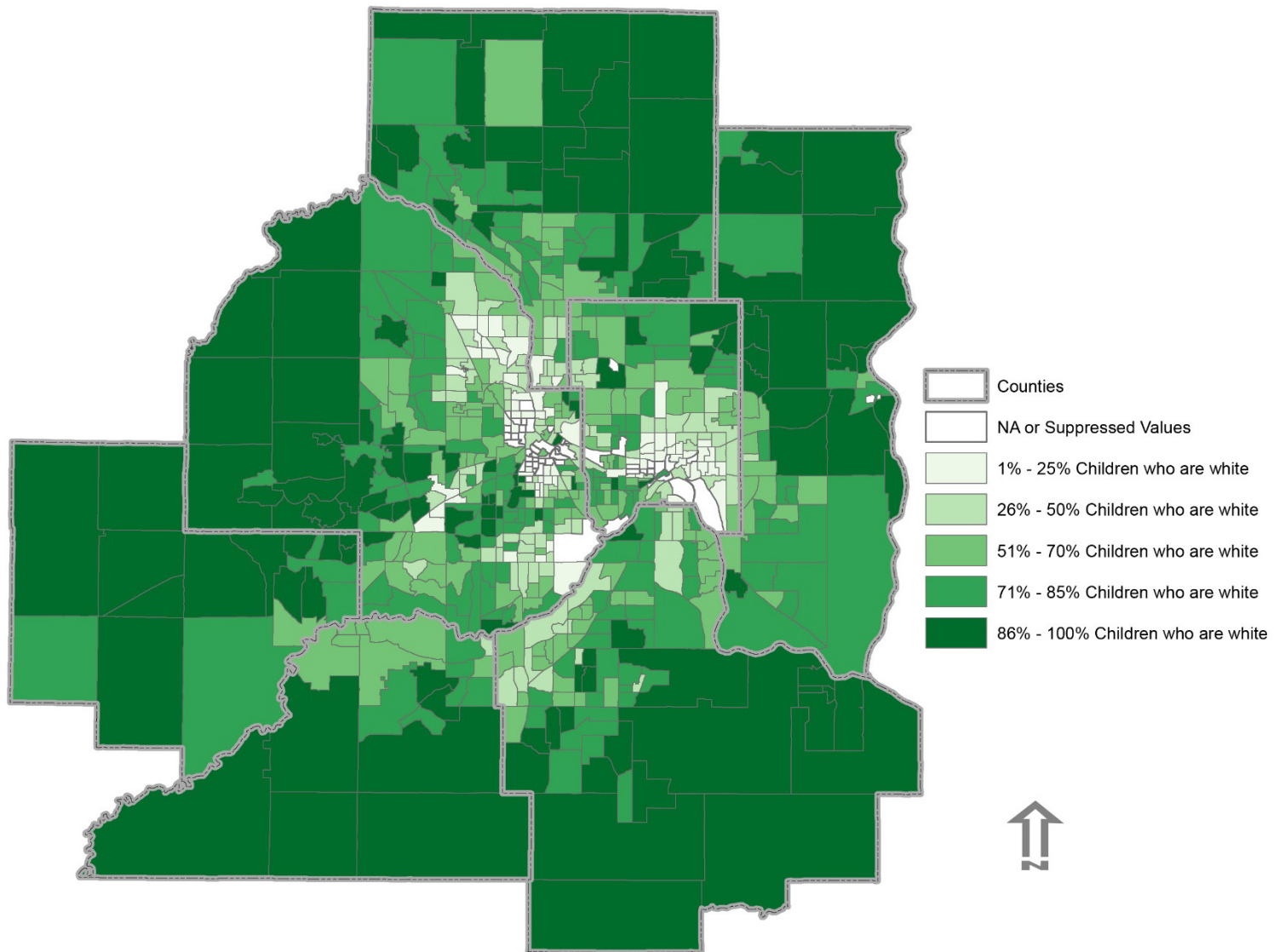


## A5. Percentage of children who are Hispanic/Latino, by census tract



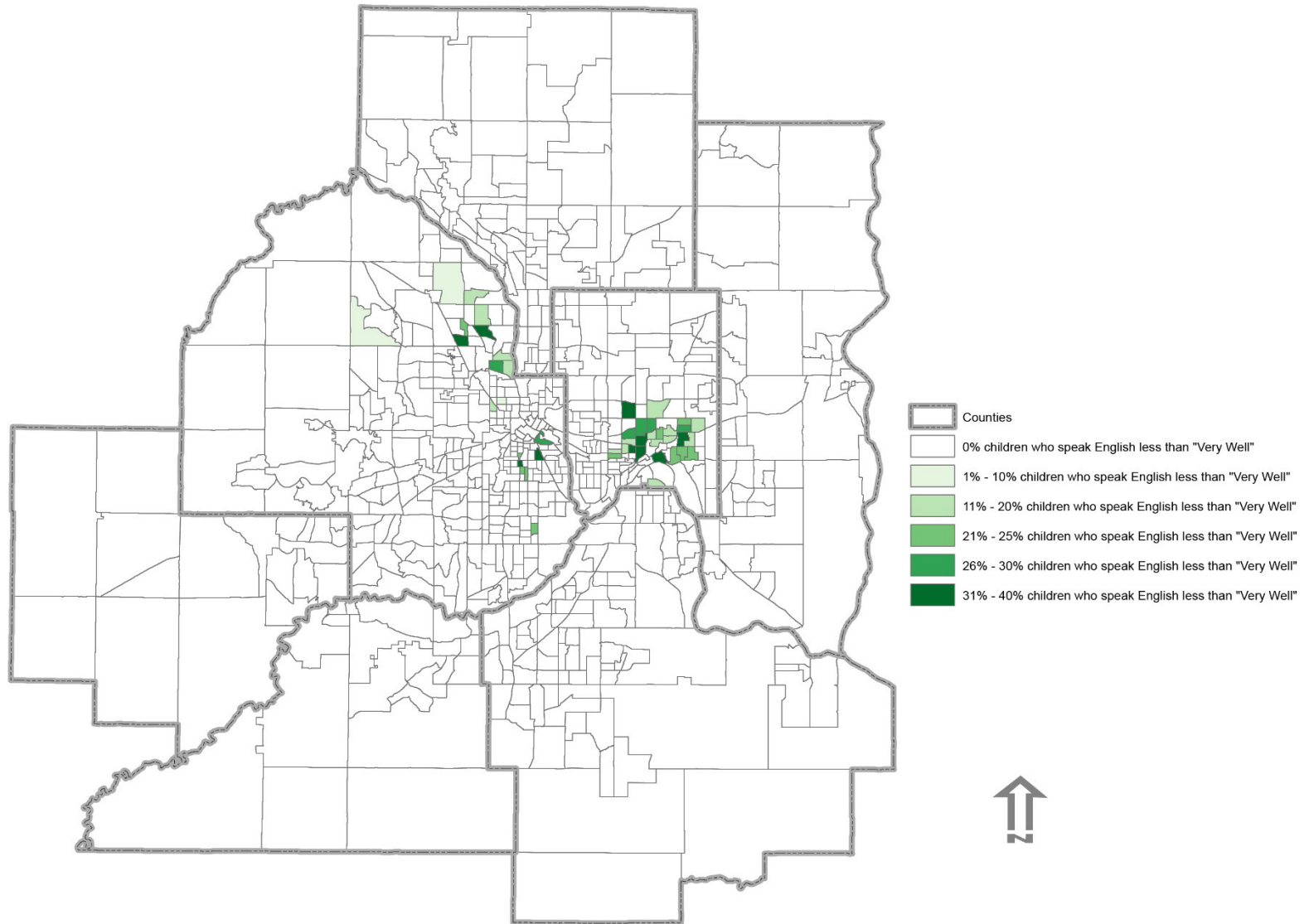
Source. American Community Survey 5-year estimates (2010-14)

**A6. Percentage of children who are white, by census tract**



Source. American Community Survey 5-year estimates (2010-14)

**A7. Percentage of children who speak English less than “very well”, by census tract**



Source. American Community Survey 5-year estimates (2010-14)

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# Characteristics of Patients Served

*A summary prepared for the Children's Hospitals and Clinics of  
Minnesota 2016 Community Health Needs Assessment*

Prepared by: Melanie Ferris

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# Background

Children's Hospital and Clinics of Minnesota (Children's Minnesota) is a network of two hospitals, 12 primary and specialty care clinics, and six rehabilitation sites that serves children before birth and into young adulthood. The two hospital campuses are located in Minneapolis and Saint Paul. A primary care clinic is located in each of these two cities, and other primary care clinics are located in Twin Cities suburbs (Brooklyn Park, Burnsville, Edina, Hugo, Maple Grove, Plymouth, Rogers, Shakopee, St. Louis Park, and West St. Paul). The network has more than 60 pediatric specialties to provide health services to children with a range of health needs.

This summary describes the demographic characteristics of patients served by Children's Minnesota during 2015 and summarizes how that information was used to define the community that will be the focus for this Community Health Needs Assessment (CHNA) process.

This is the first time Children's Minnesota has used patient data in its CHNA to identify the geographic areas where many of its patients live as well as the health needs and assets of current patients. The maps included in this summary help visualize neighborhoods where large number of patients live. However, there were challenges using existing patient data to describe child health and well-being. Although individual patient records include child and family health needs and concerns, this information is not often captured in a format that can be easily extracted and analyzed. This makes it difficult to determine how common various health concerns are among the entire Children's Minnesota patient population. Additional information describing other factors that influence health (e.g., socioeconomic factors, social support) are not readily available through Children's Minnesota electronic health record data. Homelessness or housing instability, recent divorce or incarceration of a parent, participation in extracurricular activities, and support from caring adults are just a few examples of the many factors that can impact the health and well-being of children. Although providers may be aware of family needs, strengths, and priorities, this information is not documented in a way that can be easily retrieved from Children's Minnesota electronic health record (EHR) systems. Adding fields in the EHR and encouraging consistent tracking of key measures may be important ways for Children's Minnesota to better assess patient needs and strengths, as well as to monitor the impact of its efforts to improve health.

# Who receives care from Children's Minnesota?

In 2015, Children's Minnesota cared for 133,082 individual patients at their two hospitals.<sup>1</sup> Children's Minnesota sees patients from all across Minnesota and more than 65 percent of the counties in the four surrounding states. Most of the children who receive care from Children's Minnesota live in the seven-county Twin Cities metro region. In addition, there were nearly 450,000 outpatient clinic visits at Children's Minnesota primary care clinics (266,504 visits), specialty clinics (96,218 visits), and rehabilitation clinics (83,227 visits).

## Demographic characteristics of Children's Minnesota patients

**Children's Minnesota serves children of all ages and cultures.** While most of the children served are infants to age 17, Children's Minnesota provides prenatal care and services to some young adults as they complete treatment for specific health issues. English, Spanish, Somali, and Hmong are the most common languages spoken by Children's Minnesota patients. Interpreter services were provided for nearly 85,000 visits and in 64 different languages during 2015.

**Patients receive care from Children's Minnesota for a wide range of health concerns.** The most common reasons for hospital visits in 2015 were treatment of acute respiratory illnesses (acute bronchiolitis and bacterial pneumonia), chemotherapy, and care following a pre-term birth.

**In 2015, over 55,000 children received emergency department services and over 11,000 were admitted to the hospital.** Patient data from the two hospitals combined shows that children who receive emergency department services tend to be school-age children or teenage youth, while infants and toddlers are more likely to be admitted to the hospital (Figure 1). A more culturally and socioeconomically diverse patient population received emergency department services than those admitted for inpatient hospital care. Because measures of household income and poverty status are not routinely collected for all patients, this assessment uses enrollment in Medicaid as a proxy measure for lower-income households. A majority of patients (64% of emergency department and 54% of inpatient hospital patients) had Medicaid as their primary source of insurance.

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<sup>1</sup> Data provided by Children's Hospitals and Clinics of Minnesota (2015)

## 1. Characteristics of patients served in 2015: Hospitals

County	Emergency visits (N=55,209) <sup>a</sup>		Inpatient hospitalizations (N=11,902) <sup>a</sup>	
	N	%	N	%
<b>Age</b>				
<1	1,209	2%	1,744	15%
1-2	6,656	12%	3,165	26%
3-4	12,720	23%	1,786	15%
5-6	8,062	15%	917	8%
7-12	15,948	29%	1,921	16%
13-18	8,814	16%	1,971	16%
19+	1,800	3%	516	4%
<b>Race/ethnicity</b>				
American Indian	742	1%	171	2%
Asian	3,067	6%	717	6%
Black/African American	16,941	33%	1,944	17%
Hispanic/Latino	8,128	16%	651	6%
Native Hawaiian/Pacific Islander	122	<1%	24	<1%
White/Caucasian	18,569	36%	6,836	61%
More than one race	3,218	6%	958	9%
Other	807	2%	71	1%
Declined	2,912	6%	586	5%
Unknown	329	1%	135	1%
<b>Preferred household language<sup>a</sup></b>				
English	41,940	76%	10,665	89%
Spanish	5,881	11%	374	3%
Somali	4,829	8%	399	3%
Additional languages <sup>b</sup>	2,539	5%	497	4%
<b>Socioeconomic status</b>				
Proxy: Medicaid as primary insurance	35,176	64%	6,392	54%

Source. Children's Hospitals and Clinics (2015).

Note. Due to rounding, totals may not equal 100%. Totals for race/ethnicity exceed 100%, as more than one category may be selected.

<sup>a</sup>Children's Minnesota reports these as the total number of unique patients served. Because of differences in data systems used to gather and report patient information the N varies somewhat across the demographic categories.

<sup>b</sup>Additional languages identified (spoken by less than 1% of patients) included: Hmong, Oromo, Karen, Amharic, Arabic, and Vietnamese.



**Children’s Minnesota primary care clinics located on the Minneapolis and Saint Paul campuses reach a more culturally diverse patient population than the hospitals or clinics located in other parts of the Twin Cities metro.** At the Minneapolis clinic, 42 percent of children need an interpreter at the visit because the child or caregiver speaks a language other than English (Figure 2). Fewer children (21%) need interpreter services at the Saint Paul clinic. Over half of the patients seen at the Minneapolis and Saint Paul clinics live in lower-income households, as estimated by enrollment in Medicaid (73% and 59%, respectively). This is a much larger percentage of patients than at the other Children’s Minnesota affiliated primary care clinics (3-22%) (Figure 3).

**These comparisons by hospital and clinic location illustrate why Children’s Minnesota needs to consider the factors that influence health differently at each of its sites.** For example, while interpreter services and culturally appropriate care is a critical component for high quality care at all of its locations, the demand for these supports is much higher at health care facilities located in Minneapolis and Saint Paul. Similarly, lower-income families may need additional help getting financial support in order to access community and medical services that support health.

## 2. Characteristics of patients served in 2015: Minneapolis and Saint Paul primary care clinics

	Minneapolis campus (N=11,926)		Saint Paul campus (N=8,448)	
	N	%	N	%
<b>Age</b>				
<1	1,237	10%	649	8%
1-2	2,089	18%	1,254	15%
3-4	1,922	16%	1,344	16%
5-6	1,225	10%	963	11%
7-12	2,902	24%	2,298	27%
13-18	2,093	18%	1,608	19%
19+	458	4%	332	4%
<b>Race/ethnicity</b>				
American Indian	158	1%	123	2%
Asian	233	2%	413	5%
Black/African American	5,284	44%	2,887	34%
Hispanic/Latino	2,975	25%	1,504	18%
Native Hawaiian/Pacific Islander	54	<1%	27	<1%
White/Caucasian	2,392	20%	2,829	33%
Other	512	4%	178	2%
Declined	469	4%	467	5%
Unknown	18	<1%	20	<1%
<b>Nativity</b>				
Born in the United States	9,864	83%	7,041	83%
Born outside of the United States	556	5%	166	2%
Unknown	1,506	13%	1,241	15%
<b>Preferred household language <sup>a</sup></b>				
English	6,904	58%	6,660	79%
Spanish	2,461	21%	989	12%
Somali	2,367	20%	523	6%
Additional languages spoken <sup>b</sup>	176	1%	235	3%
Unknown	26	<1%	64	1%
<b>Socioeconomic status</b>				
Proxy: Medicaid as primary insurance	8,724	73%	5,026	59%

Source. Children's Hospitals and Clinics (2015)

Note. Totals for race/ethnicity exceed 100%, as more than one category may be selected. All race/ethnicity categories include foreign-born children.

<sup>a</sup> These percentages are based on a slightly larger N because of the data systems used by Children's Minnesota to collect and report language data.

<sup>b</sup> Additional languages identified (spoken by less than 1% of patients) included: Hmong, Oromo, Amharic, Arabic, and Vietnamese.

### 3. Characteristics of patients served in 2015: Primary care clinics suburban Twin Cities locations

	Children's Hugo Clinic (N=12,924) <sup>a</sup>	Children's West St. Paul Clinic (N=8,643) <sup>a</sup>	Partners in Peds – Brooklyn Park (N=8,162) <sup>a</sup>	Partners in Peds – Calhoun (N=5,768) <sup>a</sup>	Partners in Peds – Maple Grove (N=18,307) <sup>a</sup>	Partners in Peds – Plymouth (N=7,027) <sup>a</sup>	Partners in Peds – Rogers (N=8,556) <sup>a</sup>
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
<b>Age</b>							
<1	2,145 (17%)	767 (9%)	1,397 (17%)	1,224 (21%)	3,295 (18%)	1,246 (18%)	1,585 (19%)
1-2	1,550 (12%)	642 (7%)	819 (10%)	695 (12%)	2,103 (11%)	812 (12%)	975 (11%)
3-4	1,374 (11%)	920 (11%)	869 (11%)	710 (12%)	2,252 (12%)	735 (10%)	1,043 (12%)
5-6	1,181 (9%)	963 (11%)	810 (10%)	542 (9%)	1,869 (10%)	604 (9%)	874 (10%)
7-12	3,108 (24%)	2,107 (24%)	2,048 (25%)	1,256 (22%)	4,282 (23%)	1,669 (24%)	2,124 (25%)
13-18	2,847 (22%)	2,567 (30%)	1,616 (20%)	900 (16%)	3,103 (17%)	1,451 (21%)	1,441 (17%)
19+	717 (6%)	912 (11%)	602 (7%)	441 (8%)	1,400 (8%)	510 (7%)	514 (6%)
<b>Socioeconomic status</b>							
Proxy: Medicaid as primary insurance	397 (3%)	864 (10%)	1,779 (22%)	818 (14%)	1,832 (10%)	640 (9%)	755 (9%)
<b>Race/ethnicity</b>							
	Race/ethnicity data are not available						
<b>Language</b>							
	Language was not captured for >90% of patients			English is the primary language spoken by families served; other languages spoken include Hmong, Spanish, Vietnamese, Chinese, Harari, Hindi, Somali, Russian, and French; the most prevalent languages spoken cannot be calculated because of missing data			

Source. Children's Hospitals and Clinics (2015)

<sup>a</sup>Children's Minnesota reports these as the total number of unique patients served. Because of differences in data systems used to gather and report patient information the N varies somewhat across the demographic categories.

# How is “community” defined in this CHNA process?

Federal IRS regulations give hospitals considerable flexibility in how they define the community it serves. Hospitals are encouraged to take all facts and circumstances under consideration to define the community it serves, including the target geographic area, target populations (e.g., children), and specialty areas.

The community can include both current patients and community residents likely to be served by the hospital. However, hospitals cannot define community in a way that excludes medically underserved, low-income, or minority populations who live in the geographic area the hospital serves. In addition, the hospital must consider the needs of all who receive care without regard to insurance status or eligibility for assistance.

With these regulations in mind, and using the process described in subsequent sections of this summary, Children’s Minnesota has adopted the following definition of community for this CHNA process:

## Children’s Minnesota Community Definition

The community served by Children’s Minnesota includes children of all ages (prenatal – 17 years) who live in the seven-county Twin Cities region: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties.

The assessment will also place additional emphasis on learning about the health needs, assets, and priorities of children and families living in the following neighborhoods where: a) high densities of Children’s Minnesota patients live; and b) where children and families experience disproportionate burden because of inequitable social, economic, and environmental conditions:

- In Minneapolis: Phillips and Powderhorn
- In Saint Paul: West Side, Frogtown/ Thomas-Dale, and Dayton’s Bluff

## Neighborhoods reached by Children’s Minnesota

Children’s Minnesota is interested in having the CHNA process support ongoing efforts to work in partnership with communities to improve health. That means that while the CHNA is intended to help understand strengths, needs, and priorities of all children in the region, it is also an opportunity to identify the specific neighborhoods and communities where Children’s Minnesota may be best able to support local efforts to improve health. Mapping was used to identify the specific neighborhoods where large numbers of children served by Children’s Minnesota live in concentrated areas, referred to as areas of high patient density.<sup>2</sup> These maps were created using a de-identified file of patient addresses for children who received services from Children’s Minnesota hospital emergency departments, inpatient units, and primary care clinics. The maps use color gradients, rather than individual dots or points, to show areas where large numbers of patients live without compromising patient privacy.

### What is “patient density?”

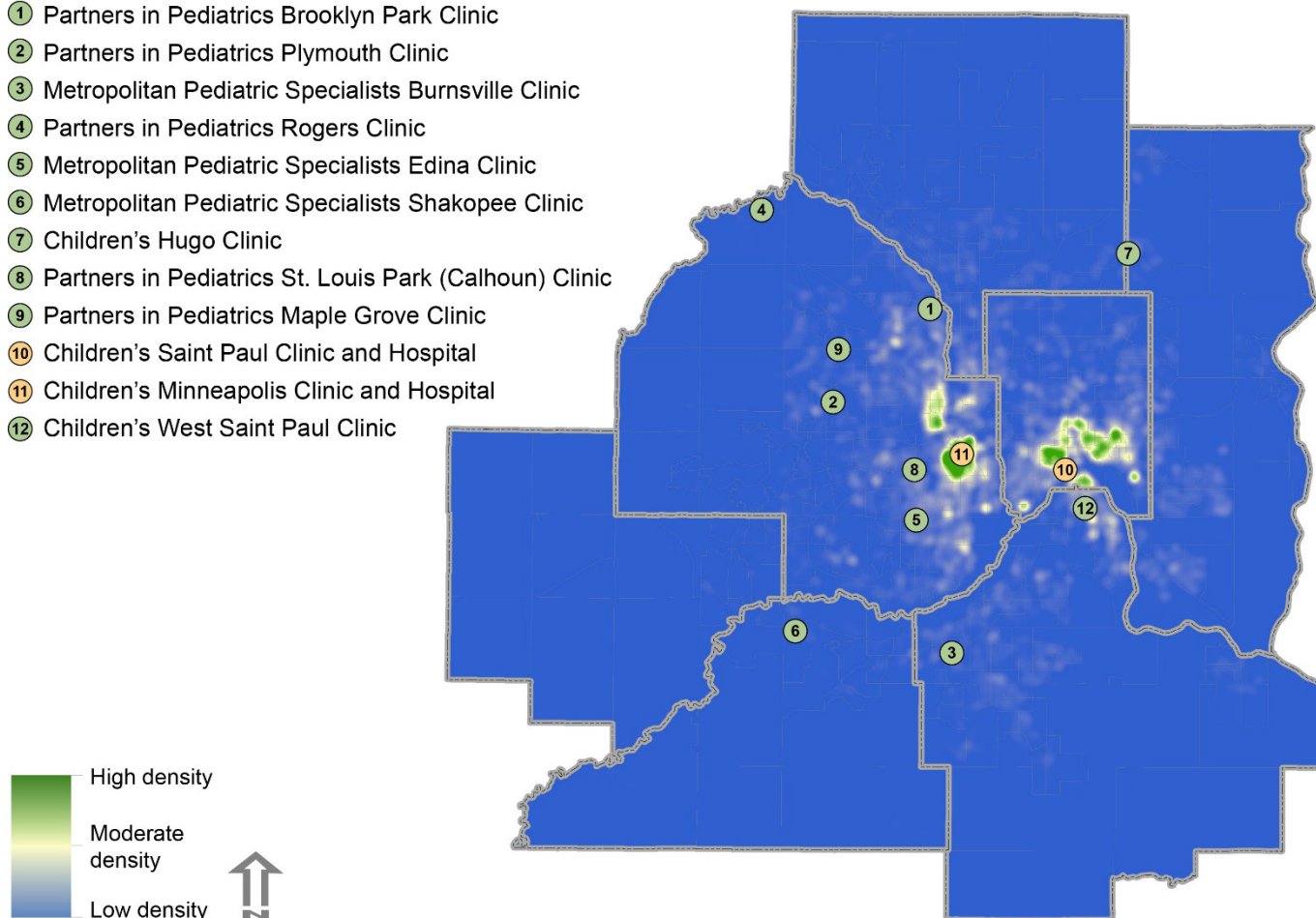
Patient density is a relative measure of how close Children’s Minnesota patients live to one another. In the following maps, areas of high patient density are shown using a color gradient with green indicating high-density areas and blue indicating low-density areas. This measurement helps identify areas where Children’s Minnesota serves a relatively large number of patients living in a small geographic area.

**Many of Children’s Minnesota emergency department and primary care clinic patients live in close proximity to health care facilities that provide these services.** The majority of patients live in the seven-county Twin Cities metro, a region of over 3 million residents including more than 700,000 children age 17 and younger. Many of the children who received acute care services from the emergency department lived in close proximity to the two hospital campuses in south Minneapolis and downtown Saint Paul (Figure 4). The 12 clinics affiliated with the Children’s Minnesota system also provided preventative and acute care services to children who live in Minneapolis and Saint Paul, as well as suburban communities located near pediatric primary care clinics in Brooklyn Park, Maple Grove, Plymouth, and Rogers (Figure 5).

<sup>2</sup> Differences in patient density are calculated in ArcGIS software using a spatial statistics method known as Getis-Ord Gi. Each patient address is assigned a z-score based on the distance between that individual and other nearby patients. It identifies areas where there are higher densities of patients than you might expect if patients’ residences were evenly spaced throughout an area. This approach helps reduce bias that occurs when basing analyses on areas of different geographic size, like census tracts, or using quintiles or other defined breaks.

#### 4. Children served by Children’s Minnesota emergency departments: Areas of high patient density (2015)

- ① Partners in Pediatrics Brooklyn Park Clinic
- ② Partners in Pediatrics Plymouth Clinic
- ③ Metropolitan Pediatric Specialists Burnsville Clinic
- ④ Partners in Pediatrics Rogers Clinic
- ⑤ Metropolitan Pediatric Specialists Edina Clinic
- ⑥ Metropolitan Pediatric Specialists Shakopee Clinic
- ⑦ Children’s Hugo Clinic
- ⑧ Partners in Pediatrics St. Louis Park (Calhoun) Clinic
- ⑨ Partners in Pediatrics Maple Grove Clinic
- ⑩ Children’s Saint Paul Clinic and Hospital
- ⑪ Children’s Minneapolis Clinic and Hospital
- ⑫ Children’s West Saint Paul Clinic

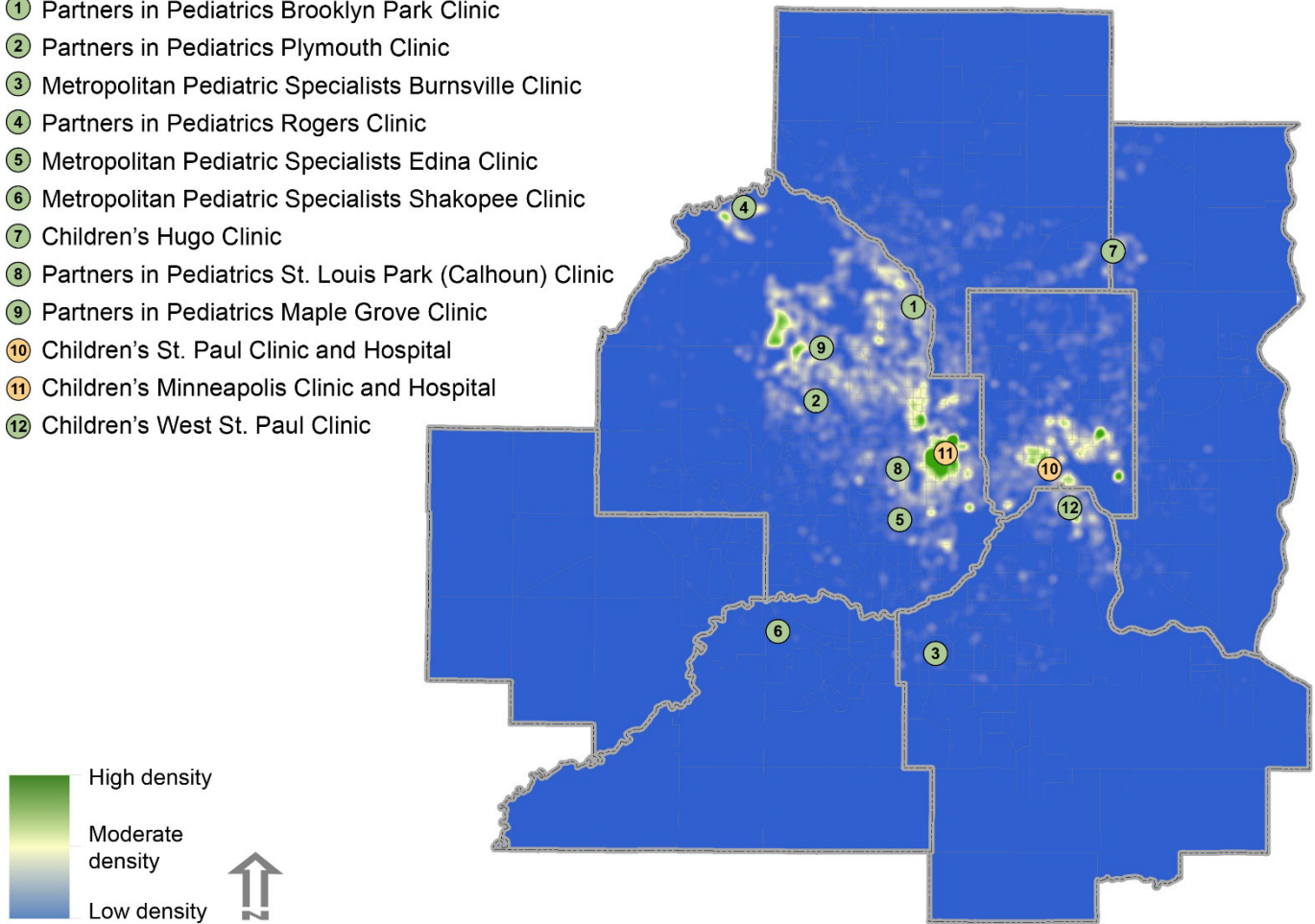


Source. Children’s Minnesota. Mapping and analysis by Wilder Research using 2010 census tracts.

Notes. The most recent residence was selected for each child who had at least one visit at Children’s Minnesota emergency departments between January 1, 2015 and December 31, 2015. 53,910 unique patients are represented in this map. Emergency departments are located at the Minneapolis and Saint Paul hospital campuses (10 and 11 on the map).

**5. Children served by Children’s primary care clinics (12 locations): Areas of high patient density (2015)**

- ① Partners in Pediatrics Brooklyn Park Clinic
- ② Partners in Pediatrics Plymouth Clinic
- ③ Metropolitan Pediatric Specialists Burnsville Clinic
- ④ Partners in Pediatrics Rogers Clinic
- ⑤ Metropolitan Pediatric Specialists Edina Clinic
- ⑥ Metropolitan Pediatric Specialists Shakopee Clinic
- ⑦ Children’s Hugo Clinic
- ⑧ Partners in Pediatrics St. Louis Park (Calhoun) Clinic
- ⑨ Partners in Pediatrics Maple Grove Clinic
- ⑩ Children’s St. Paul Clinic and Hospital
- ⑪ Children’s Minneapolis Clinic and Hospital
- ⑫ Children’s West St. Paul Clinic

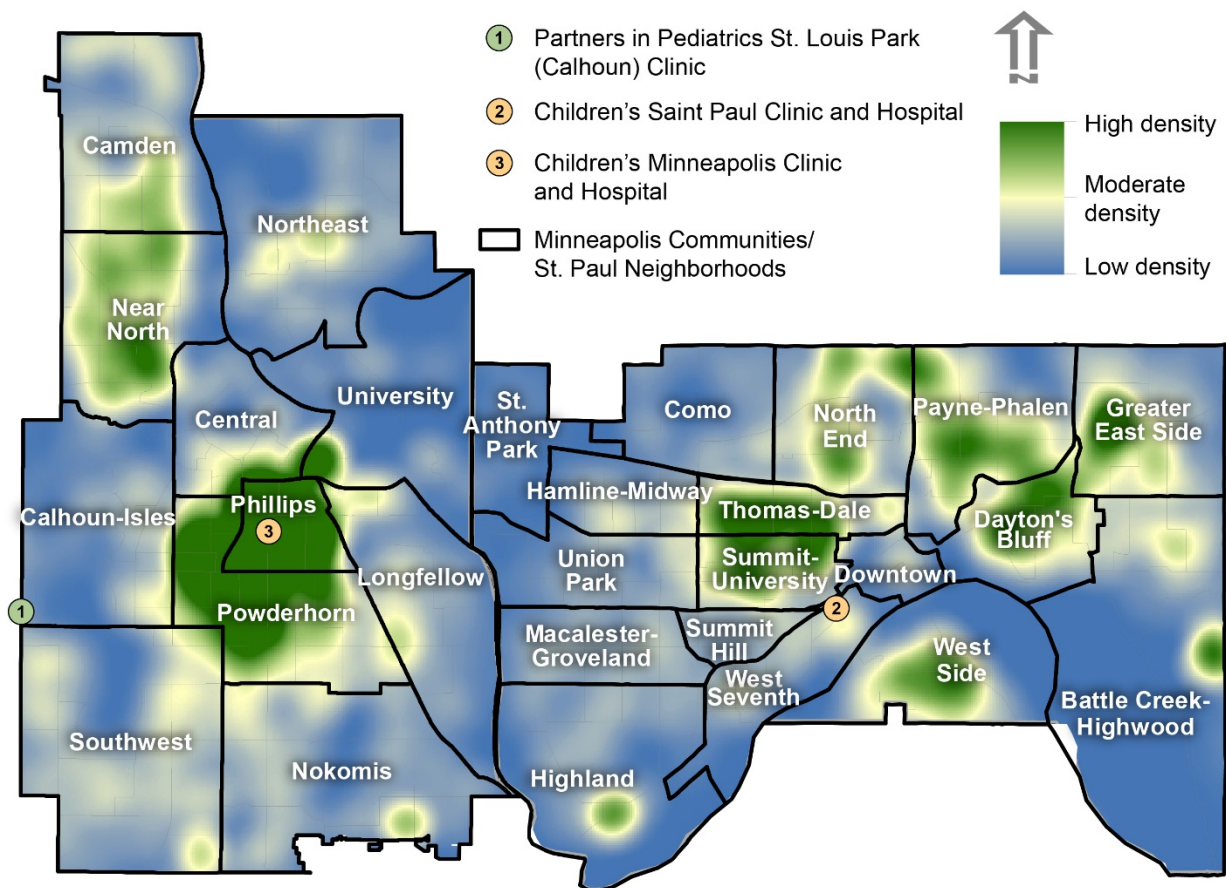


Source. Children’s Minnesota. Mapping and analysis by Wilder Research using 2010 census tracts.

Notes. The most recent residence was selected for each child who had at least one visit at a Children’s Minnesota primary care clinic between January 1, 2015 and December 31, 2015. 49,713 unique patients are represented in this map. Children’s Minnesota primary care clinics are located across the Twin Cities metro, and include clinics located at the Minneapolis and Saint Paul hospital campuses (10 and 11 on the map). Patients who were seen only at one or more of the Metropolitan Pediatric Specialists clinics (located in Burnsville, Edina, and Shakopee) are not included in this map.

**There are specific Minneapolis and Saint Paul neighborhoods, particularly lower-income areas of the two cities, where there is a high density of children who receive services from Children’s Minnesota.** Relatively large numbers of children who receive services (emergency department, inpatient hospital, or primary care) from Children’s Minnesota live in the Powderhorn, Phillips, and Near North neighborhoods of Minneapolis and Dayton’s Bluff, North End, Payne-Phalen, Thomas-Dale, and West Side neighborhoods of Saint Paul (Figure 6). Small areas in the Highland and Battle Creek neighborhoods in Saint Paul stand out as areas of high patient density because of concentrated affordable housing options in those areas; however, Children’s Minnesota serves relatively few children living in other parts of those neighborhoods.

**6. Children served in Children’s Minnesota emergency departments, inpatient hospital units, and pediatric primary care clinics: Areas of high patient density (2015)**



Source. Children's Minnesota. Analyzed by Wilder Research using 2010 census tracts.

Notes. The most recent residence was selected for each child who had at least one visit at Children’s Minnesota emergency departments or primary care clinics, or had an inpatient hospital stay between January 1, 2015 and December 31, 2015. 37,694 unique patients are represented in this map. Emergency departments are located at the Minneapolis and Saint Paul hospital campuses (10 and 11 on the map).



**Children’s Minnesota has a significant reach in some communities, serving at least one-quarter of children living in those neighborhoods.** Nearly half of the children who live in the Phillips neighborhood in Minneapolis received some type of care from Children’s Minnesota in 2015 (Figure 7). In addition, more than one-quarter of children received services from Children’s Minnesota in the following neighborhoods: Powderhorn (35%), West Side (30%), Thomas-Dale (28%), and Dayton’s Bluff (26%).

## 7. Percentage of children reached in Minneapolis and Saint Paul neighborhoods (2015)

Neighborhood (city)	Number served	Percentage of population (age 0-17) reached
Phillips (Minneapolis)	3,079	46%
Powderhorn (Minneapolis)	4,460	35%
West Side (Saint Paul)	1,366	30%
Thomas-Dale (Saint Paul)	1,419	28%
Dayton’s Bluff (Saint Paul)	1,440	26%

### Characteristics of key neighborhoods served by Children’s Minnesota

As described in the *Social Determinants of Health* summary, neighborhood socioeconomic conditions can have a significant impact on health. Community resources, such as parks and grocery stores, are often less available in lower-income neighborhoods or provide services that are unaffordable or inaccessible to families. In addition, families living in lower-income households can experience high levels of stress due to a range of challenges, including poor quality housing or housing instability and difficulty affording high quality food and necessary services.

**In neighborhoods where Children’s Minnesota has a notable reach, over two-thirds of children are living in low-income households.**<sup>3</sup> Employment rates for working-age adults (age 16-64) are also lower in these neighborhoods (57%-76%) than for the Twin Cities region overall (78%) (Figure 8). Affordable housing is an issue among many residents in these neighborhoods; approximately half (43%-54%) live in cost-burdened households where at least 30 percent of the family’s gross income is dedicated to housing costs.

**While these neighborhoods are all culturally diverse, they are home to residents from different cultural communities.** None of the five neighborhoods has a majority racial/ethnic group that is shared by at least half of children (Figure 8). In Saint Paul, many of the children living in the Thomas-Dale and Dayton’s Bluff neighborhoods are Asian while African American or white residents comprise the largest racial groups in the two Minneapolis

<sup>3</sup> “Low-income households” are defined as households earning less than 200% of the Federal Poverty Guidelines (\$48,500 for a family of four in 2015).

neighborhoods. Roughly one-third or more of children in the Phillips (32%), West Side (37%), and Powderhorn (41%) neighborhoods are Hispanic/Latino. The percentage of children born outside of the United States also varies by neighborhood, ranging from 8 to 14 percent. These differences are important to remember throughout the assessment process, as cultural values and beliefs influence priorities around health and wellness, influence health behavior, and inform the changes residents hope to see within their communities.

## 8. Demographic characteristics of children living in key neighborhoods served by Children’s Minnesota (2015)

	Phillips (Minneapolis)	Powderhorn (Minneapolis)	West Side (Saint Paul)	Thomas-Dale (Saint Paul)	Dayton’s Bluff (Saint Paul)
Number of children (age 0-17)	6,724	12,816	4,491	5,082	5,535
Percentage served by Children’s MN	46%	35%	30%	28%	26%
Race					
African American/Black	46%	25%	23%	33%	16%
American Indian	9%	2%	**	2%	**
Asian/Pacific Islander	**	**	9%	40%	36%
Caucasian/White	22%	46%	35%	10%	25%
Two or more races	**	13%	11%	14%	12%
Other race <sup>a</sup>	2%	13%	20%	3%	**
Ethnicity					
Hispanic <sup>b</sup>	32%	41%	37%	9%	9%
Nativity					
Born outside of U.S.	14%	8%	8%	13%	10%
Socioeconomic status					
Percentage of children living in lower-income households <sup>c</sup> (age 0-17)	83%	68%	70%	78%	68%
Percentage of children living in lower-income households <sup>c</sup> (Under age 5)	82%	65%	77%	82%	68%
Employment rate (working-age adults)	57%	76%	71%	61%	64%
Cost-burdened households	54%	43%	44%	49%	45%

Source. American Community Survey, 5-year pooled estimate (2010-14)

\*\* = Due to small numbers, reliable estimates cannot be calculated.

<sup>a</sup>“Other” race often includes, but is not limited to, people who identify as Hispanic/Latino.

<sup>b</sup>The American Community Survey asks about race and ethnicity separately. Children identified as Hispanic are also represented in one of the race categories presented in this table.

<sup>c</sup>“Lower-income households” refer to households with an annual income at or below 200% of the Federal Poverty Level (approximately \$48,000 for a family of 4).

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# Early Childhood Health

*A summary prepared for the Children's Hospitals and Clinics of Minnesota 2016 Community Health Needs Assessment*

Prepared by: Melanie Ferris

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# Background

This document highlights data describing the health needs and priorities for young children living in the 7-county Twin Cities metro region, from prenatal through age 5. The information cited in the document includes the most recent data available, broken out in as much detail as possible (e.g., most local geography available, most detailed race/ethnicity categories). Potential health disparities observable through these available data sources are noted throughout; however, these sources of information have a number of limitations that, if not taken into account, can lead to an inaccurate interpretation and oversimplification of the health status of young children in the Twin Cities.

## Considerations for interpreting the data presented

Most secondary data sources report estimates based on responses provided by a sample of community residents. Often, potential disparities are reported using very broad cultural or socioeconomic categories and, alone, the data do not capture the diversity of opinions and experiences of residents. The data provided in this summary are a starting point to identify community strengths and flag concerns or disparities. Data sources cited in this report define and report race and ethnicity differently. As a result, there are variations in the race and ethnicity categories used throughout this summary.

# Key health indicators

Early childhood is a critical period in a child’s healthy development, setting the stage for lifelong learning and long-term health and quality of life. Young children (age 0-5) are generally healthy but are at risk for some conditions, including developmental and behavioral disorders, child maltreatment, asthma and other chronic conditions, obesity, dental cavities, and unintentional injuries.<sup>1</sup> This summary presents prenatal indicators, as well as some measures of health and access to resources for young children and their families. It should be noted that there is little information available that describes the family and community strengths that support the health and well-being of young children.

## Prenatal and birth indicators

Healthy childhood development begins during pregnancy. A total of 39,650 babies were born in the Twin Cities metro region in 2014. About 40 percent of these births were in Hennepin County (Figure 1). The birth rate in the 7-county region is fairly close to the statewide average (12.8 births per 1,000 population). Overall birth rates in Minnesota have declined considerably since the 1960s when the birth rate peaked at 26.2 births per 1,000 population; this shift is thought to be largely due to economic changes and women waiting longer to become pregnant.<sup>2</sup>

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### 1. Infant births, by county (2014)

County	Number of births	Birth rate (births per 1,000 population)
Anoka	4,223	12.4
Carver	1,125	11.8
Dakota	5,148	12.6
Hennepin	16,584	13.8
Ramsey	7,833	14.9
Scott	1,880	13.7
Washington	2,857	11.6
Minnesota	69,183	12.8

Source: Minnesota Department of Health (MDH), County Health Tables – Natality

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<sup>1</sup> *Healthy People 2020. Early and Middle Childhood.* Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/early-and-middle-childhood>

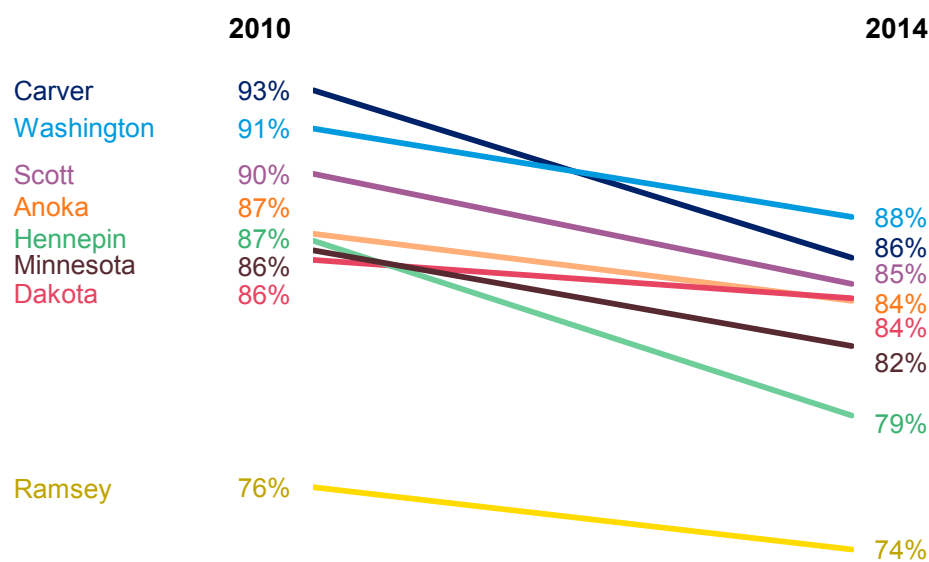
<sup>2</sup> Minnesota State Demographic Center. (2014). *Minnesota births yet to rebound to pre-recession level.* Retrieved from [https://mn.gov/admin/assets/mn-births-yet-to-rebound-to-prerecession-level-popnotes-nov2014\\_tcm36-219637.pdf](https://mn.gov/admin/assets/mn-births-yet-to-rebound-to-prerecession-level-popnotes-nov2014_tcm36-219637.pdf)

## Prenatal care

Women who do not receive adequate prenatal care are less likely to receive important components of preventive care, such as early identification of health conditions that can impact pregnancy, and more likely to experience a poor birth outcome, such as a premature birth or low birth weight.

**Across the 7-county metro, as well as statewide, the percentage of women who receive this care has decreased since 2010.** The percentage of women who receive prenatal care in the first trimester of pregnancy ranges from 74 percent in Ramsey County to 88 percent in Washington County (Figure 2). In 2014, Hennepin and Ramsey county rates of prenatal care in the first trimester were lower than the statewide average. Prenatal care provided by doulas may not be tracked and included in this indicator and may account for at least some of this trend.

### 2. Percentage of women who receive prenatal care in the first trimester, by county (2010, 2014)



Source: Minnesota Department of Health (MDH), County Health Tables - Natality

**Over the past 20 years, there have been significant improvements in the percentage of African American, Asian, and Hispanic/Latino women who receive adequate care during pregnancy.** In 1989-1993, 1 in 5 American Indian, Asian, and black women received inadequate prenatal care, as defined by the Minnesota Department of Health (see table notes). While access to adequate prenatal care has improved for most cultural communities, 21 percent of American Indian mothers continue to receive inadequate prenatal care during pregnancy (Figure 3).



### 3. Inadequate prenatal care among mothers in Minnesota, by race/ethnicity (1989-2014)

Race/ethnicity of mother	1989-93	2003-07	2010-14
American Indian	27%	16%	21%
Asian	21%	5%	6%
Black	20%	8%	8%
Hispanic/Latino	15%	7%	5%
White	3%	2%	3%

Source: Minnesota Department of Health (MDH), 2015. Populations of color health update: birth and death statistics

Notes: MDH measures adequate prenatal care using a composite index called the GINDEX. This measure takes multiple factors into account, including: the month/trimester that prenatal care began, the number of prenatal care visits, and the gestational age of the infant at the time of birth.

### *Low birthweight*

Low birthweight babies weigh less than 2,500 grams (approximately 5 ½ pounds) at birth. These babies are at greater risk for health problems, particularly during their first year of life, and are also more likely to have developmental complications, which can lead to longer-term difficulties with school performance and other outcomes. Teen mothers, especially those younger than 15, and mothers in poorer health are more likely to give birth to a low birthweight baby, but any premature birth can result in low birth weight.

**In 2014, over 4,000 infants were born at low birthweight in Minnesota.** Infants born to African American (8%), Hispanic/Latino (7%), American Indian (6%), and Asian (6%) mothers were more likely to be born with low birthweight than infants born to white, non-Hispanic mothers (4%) (Figure 4). Socioeconomic status and other factors that contribute to the health of mothers likely contribute to these disparities. The percentage of low birthweight babies born to African American mothers has decreased dramatically, from nearly 12 percent 25 years ago to 8 percent today.<sup>3</sup> Little change has occurred among other cultural groups.

<sup>3</sup> Minnesota Department of Health. (2015). *Populations of color health update: Birth and death statistics*. Retrieved from: <http://www.health.state.mn.us/divs/chs/raceethn/POC/POCUpdate2015.pdf>

#### 4. Low-weight births in Minnesota, by race/ethnicity (2014)

Race/ethnicity of mother	Total births	Percent low-weight births (all births)	Percent low-weight births (singleton)
African American/Black	7,334	9%	8%
American Indian	1,083	7%	6%
Asian/Pacific Islander	5,106	8%	6%
Hispanic/Latino	4,346	7%	7%
Unknown race/ethnicity	413	8%	8%
White, non-Hispanic	48,102	6%	4%

Source: Minnesota Department of Health (MDH), County Health Tables – Natality

Notes: Low weight births are more common among multiples (i.e., twins, triplets), so data are shown for all births (multiples and singletons) and singleton births alone.

### *Infant mortality*

There are a number of factors associated with infant mortality (defined as the death of an infant less than one year of age), including low birthweight, preterm birth, lack of adequate prenatal care, substance use, and access to care. There has been a steady decrease in the rate of infant deaths over time in Minnesota and across all Twin Cities metro counties (Figure 5). Ideally, no infant deaths should occur. Healthy People 2020 established a national goal to reduce the number of infant deaths to no more than 6 per 1,000 births; all counties now meet this national benchmark. Ramsey County fell short of this target in 2004-08.

#### 5. Number of infant deaths, by county (2004-2013)

County	Infant mortality rate (deaths per 1,000 births)		Number of infant deaths	
	2004-08	2009-13	2004-08	2009-13
Anoka	4.9	4.7	108	98
Carver <sup>a</sup>	**	4.4	20	25
Dakota	4.5	3.7	125	96
Hennepin	5.7	4.8	475	392
Ramsey	6.8	5.6	257	212
Scott	4.6	3.2	49	31
Washington	4.9	4.0	71	56
Minnesota	5.2	4.8	1,891	1,659

Source: Minnesota Department of Health (MDH), MN Public Health Data Access Portal. Retrieved from: <https://apps.health.state.mn.us/mndata/reproductive>

<sup>a</sup> Because of the small number of overall births and infant deaths, the infant birth rate for Carver County is suppressed (\*\*). While the number of infant deaths is higher in 2009-13, this observed change should be interpreted with caution, as the numbers are too small to determine whether the change is reflective of a larger trend.

**Infant mortality rates continue to be twice as high for American Indian and black infants, compared to Asian and white, non-Hispanic infants.** Across all race and ethnicity categories, infant mortality rates are lower today than in 1995-99, just before the Minnesota Department of Health began a concerted effort to improve this outcome via its Eliminating Health Disparities Initiative. The most dramatic reductions have been among American Indian and black, non-Hispanic communities (Figure 6). However, racial disparities in infant mortality rates still persist, and some cultural groups continue to fall short of meeting the national Healthy People 2020 target. While still meeting the national target, infant mortality rates among Hispanic infants have increased slightly from 2004-08. While reasons for this change are not clear, disparities in some of the factors that support a healthy pregnancy (e.g., access to adequate prenatal care) and social determinants (e.g., poverty) that impact the health of mothers likely contribute to racial disparities in infant mortality rates.

## 6. Infant mortality rates by race/ethnicity of mother, Minnesota (1995-2013)

Race/ethnicity	1995-1999 <sup>a</sup>	2004-08	2009-2013
American Indian, non-Hispanic	13.5	10.6	9.3
Asian, non-Hispanic	7.1	5.0	4.4
Black, non-Hispanic	13.2	10.8	8.5
Hispanic/Latino, any race	7.0	4.4	5.2
White, non-Hispanic	5.5	4.5	4.1
Another race/unknown <sup>a</sup>	N/A	8.2	**

Sources: Minnesota Department of Health. (2009). Disparities in infant mortality. Retrieved from: <http://www.health.state.mn.us/divs/chs/infantmortality/infantmortality09.pdf> ; Minnesota Department of Health, MN Public Health Data Access Portal. Retrieved from: <https://apps.health.state.mn.us/mndata/reproductive>

<sup>a</sup>Because of the small number of overall births and infant deaths, the infant mortality rate for babies born to women of another or unknown race is suppressed (\*\*). Race and ethnicity for this report (1995-99) considered race and ethnicity separately. For example, an infant death to a mother described as both Hispanic/Latino and American Indian would be included in the calculation for both rows of data. These historical data are included to provide greater context to how trends have changed over time. The race/ethnicity categories listed in the table reflect how the data from the Minnesota Public Health Data Access Portal is presented.

## Early childhood indicators

There are multiple systems and supports in place to help parents and caregivers support the health and well-being of young children (age 0-5). Regular pediatric appointments are recommended for young children to screen for potential health concerns and to receive preventive care, including vaccinations. These early visits with providers are opportunities to screen for developmental concerns and for caregivers to learn information about how to support their child's health and development. There are also a number of public programs in place that help caregivers with lower income levels access resources to support the development of young children. However, there are relatively few sources of information in place that

describe the health and wellness of young children, particularly the family strengths and community assets in place that support their health and overall development. This section of the summary includes measures of early childhood health before focusing on various social determinants of health that can influence health and wellness.

## ***Measures of health***

### **Immunizations**

**The majority (92-95%) of young children are up to date on two or more immunizations** (Figure 7). The Minnesota Department of Health recommends that children receive vaccinations before age 3 to prevent a range of diseases, including hepatitis A and B, polio, measles, mumps, rubella, whooping cough, chicken pox, and tetanus. While most infants have received at least two vaccinations, the number of children with the full immunization schedule completed is much lower, ranging from 52 percent in Ramsey County to 74 percent in Carver County. Immunizations may be missed if children have difficulty accessing health care services or if caregivers refuse vaccinations for their child.

#### **7. Young children (24-35 months) up to date on recommended vaccines (2012)**

<b>County</b>	<b>Percent of children with 2+ immunization shots</b>	<b>Percent of children with immunization schedule completed</b>
Anoka	95%	56%
Carver	95%	74%
Dakota	92%	61%
Hennepin	92%	60%
Ramsey	93%	52%
Scott	94%	67%
Washington	94%	55%
Minnesota	94%	62%

Source: Minnesota Department of Health (MDH). County Health Tables – Morbidity tables

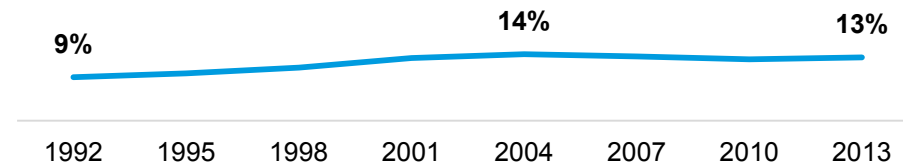
### **Obesity**

Obesity information is gathered consistently for children enrolled in the Women, Infant, and Child (WIC) program, which helps lower-income children and families have better access to healthy foods and nutrition information. There is not a source of data to determine obesity rates for all children in the Twin Cities metro region.

**The percentage of young children (age 2-5) who are obese is approximately 50 percent higher today than in the early 1990s.** In 2013, 13 percent of children enrolled

in the program were identified as obese, an increase from 9 percent in 1992 (Figure 8). Although the rate of obesity has leveled off since 2000, there has not been a consistent reduction. Obesity rates today are somewhat higher in Ramsey County (14%) than in Hennepin (12%), Washington (12%), Dakota (12%), and Anoka (11%) counties. Only two counties meet the Healthy People 2020 obesity rate target of 9.6 percent: Carver (5%) and Scott (9.5%) counties.

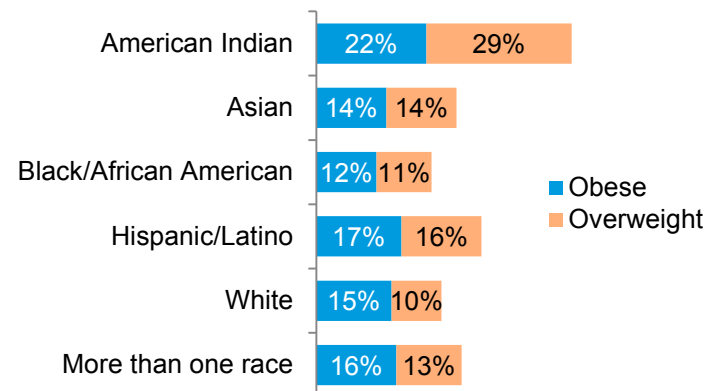
### 8. Changes in obesity rates among WIC-enrolled children (age 2-5) in Minnesota over time



Source: Minnesota Department of Health (MDH). MN Public Health Data Access Portal

**Rates of obesity among young children enrolled in WIC is lowest among black children.** Obesity rates are somewhat higher among Asian (14%), white (15%), and Hispanic/Latino (17%) children (Figure 9). Obesity rates are nearly twice as high among American Indian children compared to Black/African American children, the racial group with lowest obesity rate.

### 9. Obesity rates among WIC-enrolled children (age 2-5) in Minnesota, by race/ethnicity (2014)



Source: Minnesota Department of Health (MDH). MN Public Health Data Access Portal

### Unintentional injuries

Safety in the home and in other settings is important for the healthy development of young children, as the main cause of serious health problems and death for young children are unintentional injuries. According to the Minnesota Department of Health, drowning and accidental poisoning are two of the leading causes of these preventable deaths for young children.

## ***Adverse Childhood Experiences (ACEs)***

There is a growing understanding that negative experiences in childhood have implications for both child and adult health outcomes. Adverse childhood experiences, or ACEs, refer to a set of issues including abuse, neglect, caregiver mental illness, caregiver incarceration, and divorce that studies have shown to have long-term negative impacts on health.<sup>4</sup> While there are not sources of data available that describe the number of children currently impacted by these events in most areas, child maltreatment and foster care records are available for this young age group. (See the “School-age health status summary” for additional information on ACEs, including disparities.)

Child maltreatment can include physical, emotional, and sexual abuse, as well as neglect by a parent or caregiver. Children under age 5 are more likely to experience neglect than older children and are at greatest risk for injury and death from abuse. Maltreatment reports by county in this summary include both family investigations and assessments,<sup>5</sup> as well as facility investigations. The rate of maltreatment reports involving young children is higher than or equal to the statewide average in Hennepin (28 per 1,000 children) and Anoka (25 per 1,000 children) counties (Figure 10).

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### **10. Rate of child maltreatment reports (children under age 5), 2013**

<b>Rate of children under age 5 with filed maltreatment report during the past year (per 1,000 children)</b>	
Anoka	25
Carver	18
Dakota	15
Hennepin	28
Ramsey	17
Scott	19
Washington	13
Minnesota	25

Source: Chase et. al. (2015). *Minnesota early childhood risk & reach report*. Retrieved from Wilder Research website: <https://www.wilder.org/Wilder-Research/Publications/Studies/Minnesota%20Early%20Childhood%20Risk%20and%20Reach/Key%20Indicators%20of%20Early%20Childhood%20Development%20in%20Minnesota,%20County%20by%20County,%20Full%20Report.pdf>

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<sup>4</sup> For more information about ACEs in Minnesota and their impacts, see the Minnesota Department of Health website: <http://www.health.state.mn.us/divs/cfh/program/ace/>

<sup>5</sup> A family assessment is completed when social services staff accepts a report about a child’s safety, but there are not threats of immediate and serious harm. A family investigation is completed by social services when a child is in immediate or severe danger or when a family refuses to work with social services staff to ensure a child is safe.

Where there are significant concerns about the child’s safety or the ability of the family to meet the child’s needs, children may be temporarily placed in foster care. The removal of a child from their caregiver and home, as well as the instability of placements after a child enters the child welfare system, can be very stressful for children, lead to gaps in care, and exacerbate existing health and mental health conditions. In the Twin Cities metro, the rate of foster care placement for young children was higher in Ramsey County (8.8 per 1,000) than the statewide average (8.3 per 1,000) (Figure 11).

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### 11. Rate of child foster care placements (children under 6), 2013

Children under age 6 in foster care (per 1,000 children)	
Anoka	5.7
Carver	3.8
Dakota	2.6
Hennepin	7.5
Ramsey	8.8
Scott	1.4
Washington	2.1
Minnesota	8.3

Source: Chase et. al. (2015). Minnesota early childhood risk & reach report. Retrieved from Wilder Research website:  
<https://www.wilder.org/Wilder-Research/Publications/Studies/Minnesota%20Early%20Childhood%20Risk%20and%20Reach/Key%20Indicators%20of%20Early%20Childhood%20Development%20in%20Minnesota,%20County%20by%20County,%20Full%20Report.pdf>

## Access to resources

As described in the “Demographics and Social Determinants of Health” summary, a number of factors influence the health and well-being of children and contribute to disparities. Issues including chronic poverty, housing instability, and homelessness can lead to stress and poor health outcomes and contribute to disparities. There are a number of public programs in place aimed to support the health and well-being of children, particularly children in lower-income household and neighborhoods. However, **many of the children and families eligible for these programs that support child health and wellness do not receive these resources** (Figure 12, see page 12 for a description of these programs). Differences in enrollment by county can be the result of a number of factors, including disparities in who is reached through each county’s outreach approach. There are many reasons families may choose not to participate in these programs, but these topics were not explored in this assessment.

### 12. Percentage of eligible children enrolled in selected programs that support early childhood health and development, 2013

	Women, Infant, and Children (WIC)	Family Home Visiting Program	Minnesota Family Investment Program (MFIP)	Child Care Assistance Program (CCAP)	Early Childhood Screening	Head Start/Early Head Start
Anoka	63%	6%	65%	15%	36%	27%
Carver	45%	19%	27%	11%	38%	8%
Dakota	60%	2%	44%	14%	48%	10%
Hennepin	68%	10%	65%	16%	25%	18%
Ramsey	82%	11%	65%	13%	22%	15%
Scott	65%	11%	46%	19%	39%	28%
Washington	57%	8%	35%	11%	38%	13%

Source: Chase et. al. (2015). *Minnesota early childhood risk & reach report*. Retrieved from Wilder Research website: <https://www.wilder.org/Wilder-Research/Publications/Studies/Minnesota%20Early%20Childhood%20Risk%20and%20Reach/Key%20Indicators%20of%20Early%20Childhood%20Development%20in%20Minnesota,%20County%20by%20County,%20Full%20Report.pdf>



## Brief description of public programs and resources available to young children

- **The Women, Infant, and Children (WIC) program** provides pregnant women, as well as new mothers and their children, with nutrition education, breastfeeding support and information, nutritious food, and referrals to health and social services. Participation in the WIC program in Minnesota has consistently been high; in 2013 (the most recent data available) Minnesota participation rates were 2<sup>nd</sup> highest in the nation, with 71 percent of women eligible for WIC enrolled in the program.
- **The Family Home Visiting Program** works with families with lower incomes (at or below 185% of federal poverty guidelines) who are experiencing other stressful situations, including poverty, past alcohol or drug use, or a history of abuse or neglect. In-home visits are provided by public health nurses or other trained staff and are intended to support healthy parent-child relationships and healthy child development.
- **The Minnesota Family Investment Program (MFIP)** supports low-income families (at or below 125% of the federal poverty level) with children. Parents are supported through cash and food assistance, as well as employment services.
- **The Child Care Assistance Program (CCAP)** subsidies are available to working parents eligible for MFIP or from lower-income households to help cover the costs of childcare. In some counties there are wait lists because there is more demand for CCAP subsidies than funding available.
- **Early Childhood Screening** is available to all children beginning at age 3 to evaluate their physical, verbal, cognitive, and social-emotional development. State law requires screening to be completed within 30 days of enrollment to kindergarten.
- **Head Start and Early Head Start** are available to children with low household incomes, special health needs, or other specific circumstances, such as homelessness. These programs provide young children (6 weeks to 5 years old) with services that support all aspects of child development and health.

Adapted from Chase et. al. (2015). Minnesota early childhood risk & reach report. Retrieved from Wilder Research website <https://www.wilder.org/Wilder-Research/Publications/Studies/Minnesota%20Early%20Childhood%20Risk%20and%20Reach/Key%20Indicators%20of%20Early%20Childhood%20Development%20in%20Minnesota,%20County%20by%20County,%20Full%20Report.pdf>

# Additional information

## Other data sources

Children’s Defense Fund – Minnesota. Each year, the Children’s Defense Fund – Minnesota works with the Annie E. Casey Foundation to release the Minnesota KIDS COUNT data book, which includes measures that track the well-being of children. The reports offer high level state and county measures that highlight needs and strengths of children. While the state-level report provides disaggregated data by race and ethnicity, the county-level measures look at important indicators of well-being for all children.

*Available from: <http://www.cdf-mn.org/programs/minnesota-kids-count>.*

Children’s Minnesota, Early Childhood Development: In-Depth Stakeholder Interview Results Report. In 2014, Children’s Minnesota conducted interviews from community-based organizations, state agencies, and public school systems to assess the health needs of children in underserved communities. The following health needs emerged as important key themes from the series of interviews: a) a need for prenatal and early childhood (age 0-3) health interventions; b) lack of access to basic needs, including housing insecurity; c) well-child visits are an optimal time for interventions; d) prevailing attitudes shaping trust/distrust of health care providers; and e) a lack of pediatric mental health (social-emotional development) services. *Interview results made available for the CHNA by Children’s Minnesota.*

Voices and Choices for Children: Recommendations for the Wellbeing of Families of Color and American Indian Families in Minnesota. The recommendations included in this 2015 report draw from a review of resources developed by culturally rooted organizations and institutions that serve communities of color and American Indian communities and informed by participants in two convenings. Themes from the report highlight: a) the importance of people of color and American Indians having an active and sustained voice in setting agendas, designing programs, and providing services that affect the wellbeing of children and their families; b) the need for alignment of services across departments to increase accessibility and reduce requirements; c) recommendations for a racial and equity impact analysis of current state programs and future policies to determine if they weaken families and communities; and d) suggestions for state agencies to contract with community-based organizations to design and deliver programs. The report recommendations and results from the literature review may be a helpful resource to Children’s Minnesota as it considers implementation strategies that foster community strengths and advance racial equity.

*Available at: <http://startearlyfundersmn.org/wp-content/uploads/2015/12/2015-Voices-and-Choices-Literature-Review.pdf>*

## Relevant public health efforts

Local public health departments in the Twin Cities region also conduct regular assessments of community health (all ages) to identify health priorities and inform their efforts to improve health. Wilder Research reviewed the most recent Community Health Improvement Plan (CHIP) reports completed by local public health departments and identified the goals directly related to health and wellness of young children (Figure 13). These may offer initial opportunities for collaboration. Through a series of community stakeholder interviews and ongoing outreach and engagement with community partners, Children’s Minnesota will also be identifying additional opportunities for collaboration and partnership identified by these local organizations and residents as most important to their community.

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### 13. Relevant public health goals to improve the health of young children

Local public health department(s)	Years	Goal
Dakota County	2014-18	Reduce the percentage of preschool children who are obese
Hennepin County; Cities of Bloomington, Edina, Richfield; City of Minneapolis	2012-15	Increase child readiness for school
Saint Paul/Ramsey County	2014-18	Reduce the percentage of children (age 0-18) living in poverty
Scott County	2015-19	Increase access and availability of fruits, vegetables, and physical activity options for children (age 0-5) Increase screening of children (age 0-3) for developmental concerns

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# School-Age Youth Health

*A summary prepared for the Children's Hospitals and Clinics of Minnesota 2016 Community Health Needs Assessment*

Prepared by: Melanie Ferris

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# Introduction

As part of Children’s Hospitals and Clinics of Minnesota’s (Children’s Minnesota) community health needs assessment (CHNA) process, a review of secondary data sources was completed to describe the current health status and emerging issues of children living in the Twin Cities. This document highlights data describing the health needs and priorities for school-age children and adolescents, age 6 to 18, living in the 7-county Twin Cities metro region. The information cited includes the most recent data available, broken out in as much detail as possible (e.g., most local geography available, most detailed race/ethnicity categories). Potential health disparities observable through these available data sources are noted throughout.

The Community Advisory Committee will play a key role in interpreting the information presented, drawing on their expertise to provide broader context to the data and identify questions that need to be addressed in order to help Children’s Minnesota take actions that align with the concerns and priorities of community residents. In addition, discussions with Children’s staff and providers, community stakeholders, and community residents that will be held as part of the assessment will be integrated into final reporting materials and help provide us with a more comprehensive and nuanced understanding of the health assets and concerns impacting children.

## Considerations for interpreting the data presented

Most secondary data sources report estimates based on responses provided by a sample of community residents. Often, potential disparities are reported using very broad cultural or socioeconomic categories and, alone, the data do not capture the diversity of opinions and experiences of residents. The data provided in this summary are a starting point to identify community strengths and flag concerns or disparities. Data sources cited in this report define and report race and ethnicity differently. As a result, there are variations in the race and ethnicity categories used throughout this summary.

The Minnesota Student Survey (MSS) is cited frequently in this summary, as it includes questions that consider child health and well-being holistically. The MSS is administered every 3 years to students in selected grades throughout the state; individual survey items and grade levels of students asked to participate have changed over time. This summary includes data from 2013 (the most recent survey results available). Results from the ninth grade survey are presented because all MSS items are asked of these young adolescents and the response rate for students at this grade level is higher than for older students. Two important limitations should be noted when interpreting information from this data source:

- Minneapolis Public Schools (Hennepin County) and Chanhassen Public Schools (Carver County) decided to opt out of the MSS in 2013. Data from these two counties are included in the summary, but should be interpreted with caution as they exclude the opinions and experiences of large numbers of students.
- In 2013, the survey was available only in English. Schools and districts with students who were not proficient in English were asked to provide accommodations for students to take the survey. In schools that could not develop translations or provide interpreters, the survey results may not adequately reflect the opinions and experiences of students who receive English Learner (EL) services.
- Because Minneapolis Public Schools students (a district where nearly two-thirds of students are youth of color) and potentially some English Learner students were not included, this summary does not report responses by race and ethnicity at the county level. Where available, other sources of data or statewide information are used to identify potential disparities in factors that influence health and well-being.

Results from the 2016 MSS are expected to be released soon and may be available in time to inform potential implementation strategies.

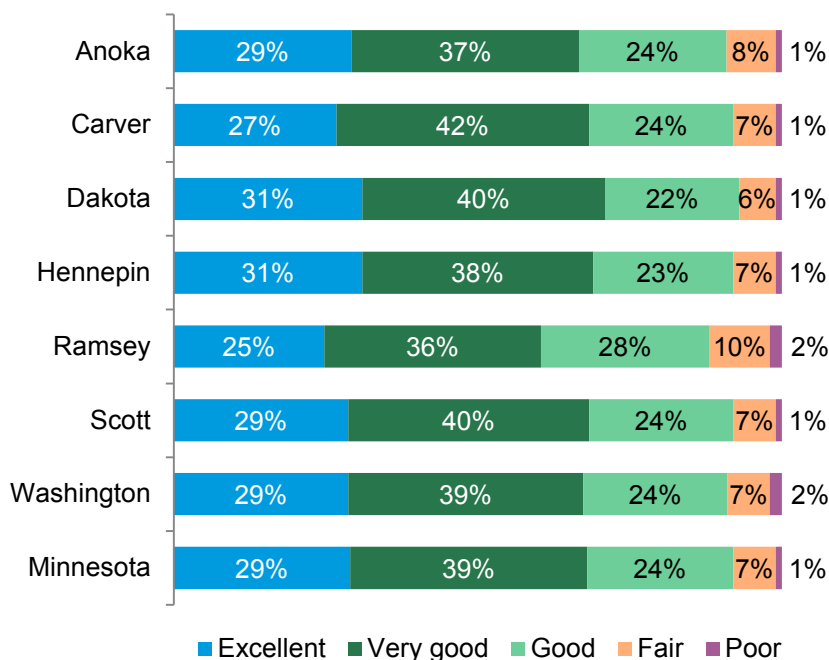


# Key health indicators

## Overall health and well-being

**Over 60 percent of ninth-grade students in each of the Twin Cities metro counties rate their overall health as “very good” or “excellent”** (Figure 1). Overall health ratings are similar across the 7-county metro and comparable to the statewide average (68%). Self-reported health status is considered a good indicator of actual overall health and well-being.

### 1. Self-reported overall health by ninth-graders (2013)



Source. Minnesota Student Survey, 2013

**More than 60 percent of ninth-grade students in the Twin Cities region are optimistic about their future, build friendships with others, and feel valued and appreciated by others.** However, there is a notable difference in self-confidence between males and females; 80 percent of ninth-grade male students report they “often” or “almost always” agree that they feel good about themselves, compared with 57 percent of female students (Figure 2). This is consistent with studies that look at changes in self-esteem across the lifespan. On average, self-esteem is relatively high in childhood and drops during adolescence

(particularly for girls) before rising again in adulthood.<sup>1</sup> Differences in body satisfaction are one of the main factors that contribute to gender differences in self-esteem in adolescence.<sup>2</sup>

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## 2. Measures of well-being among ninth-graders, by gender (2013)

Percentage of students who “often” or “almost always” agree with each item:



Source. Minnesota Student Survey, 2013

Note. The following question is used for each of the items listed in the figure: “In general, how does each of the following statements describe you.”

**A majority of youth feel they can talk to a parent about their problems.** Across all counties, most students feel they can talk to their mother (78-87%) or father (55-77%) at least “some of the time” about problems they are having.<sup>3</sup> In all counties, female students were less likely than male students to report being comfortable talking to their fathers. A number of students reported they did not have fathers in their lives; across the region, 6 to 12 percent of students reported their father was not around, compared to up to 3 percent of students who reported their mother was not around.

**A majority of ninth-grade students feel they have other caring adults in their lives.** Positive connections to non-family adults are also important to the health and well-being of youth. More than half (55-61% across counties) of ninth-grade students felt that a religious or spiritual leader, teacher or other school staff, or other adult in the community cared about them

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<sup>1</sup> Robins, R. W., & Trzesniewski, K. H. (2005). *Self-esteem development across the lifespan*. *Current Directions in Psychological Science*, 14(3): 158-162.

<sup>2</sup> Gentile, B., Grabe, S., Dolan-Pascoe, B., Twenge, J. M., Wells, B. E., & Maitino, A. (2009). *Gender differences in domain-specific self-esteem: A meta-analysis*. *Review of General Psychology*, 13(1): 34-45.

<sup>3</sup> Minnesota Department of Health: 2013 Minnesota Student Survey County tables

“very much” or “quite a bit” (Figure 3). Fewer students have connections to caring non-family adults in the community than adults in school or faith settings.

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### 3. Percentage of ninth-grade students who feel non-family adults in their lives care about them “very much” or “quite a bit” (2013)

County	%
Anoka	55%
Carver	61%
Dakota	59%
Hennepin	61%
Ramsey	56%
Scott	56%
Washington	57%
<b>Minnesota</b>	<b>57%</b>

Source. Minnesota Student Survey, 2013

Notes. Percentages are based on student respondents who said they feel one or more of the following groups of adults in the community cares about them “quite a bit” or “very much:” teachers and other adults at school, religious or spiritual leaders, or other adults in the community. Responses about caring adults who are parents or other relatives of the student are not included.

## Adverse Childhood Experiences (ACEs)

There is a growing understanding that negative experiences in childhood have implications for both child and adult health outcomes. Adverse childhood experiences, or ACEs, refer to a set of issues that studies have shown have long-term negative impacts on health. These include: abuse, neglect, caregiver mental illness, caregiver incarceration, and divorce.<sup>4</sup> In 2013, some ACE questions were added to the Minnesota Student Survey. This section of the summary draws from statewide analyses of MSS data completed by the Minnesota Department of Health and SUMN (Substance Use in Minnesota)<sup>5</sup> to describe how often youth experience ACEs, how ACEs impact youth well-being, and how family and community strengths can reduce the negative impacts of ACEs. Their analyses include Minnesota students in grades 5, 8, 9, and 11 who completed the Minnesota Student Survey in 2013.

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<sup>4</sup> For more information about ACEs in Minnesota and their impacts, see the Minnesota Department of Health website: <http://www.health.state.mn.us/divs/cfh/program/ace/>

<sup>5</sup> SUMN (Substance Use in Minnesota) provides data on over 100 indicators related to alcohol, tobacco, and other drug use ([www.sumn.org](http://www.sumn.org)). It is a project of the Minnesota State Epidemiological Outcomes Workgroup, a collaborative effort across multiple state agencies and EpiMachine, LLC, and includes representatives from state agencies, coalitions, and other local organizations. Data in this summary were reported in a presentation given by Melissa Adofson (EpiMachine, LLC) and are used with permission.

## ***Description and prevalence***

ACEs are negative, sometimes traumatic, experiences that occur before age 18. Studies have shown that the impacts of ACEs are cumulative, meaning negative long-term impacts are more likely when children have had more of these negative experiences.

The seven ACEs items included in the MSS are: incarceration of parent/caregiver; living with someone who drinks too much alcohol; living with someone who uses illegal drugs or abuses prescription drugs; verbal abuse; physical abuse; household domestic abuse; and sexual abuse.

- **A majority of Minnesota children (64%) have not experienced any of these ACEs.** Fewer students have experienced one (18%), two (9%), three (5%), or four or more (4%) ACEs. Girls were somewhat more likely to experience one or more ACEs than boys (38% and 33%, respectively).
- **Fifteen percent of students experienced a parent or caregiver being incarcerated at some point in their life.** Parental incarceration was the most commonly reported ACE.
- **At least 10 percent of children had experienced verbal abuse (14%), physical abuse (12%), or household alcohol problems (10%).** Fewer children experienced household drug use (6%) or sexual abuse (5%).
- **There are notable racial disparities in ACEs.** It was more likely for students who identified themselves as American Indian (62%), multi-racial (54%), Hispanic/Latino (50%), and black or African-born (48%) to experience one or more ACE than students identified as Asian (39%) or white (31%). Parental incarceration is one key factor contributing to these racial disparities. American Indian, black, Hispanic/Latino, and multi-race students were two to three times more likely to report having an incarcerated parent than Asian American or white students.<sup>6</sup> Multiple factors contribute to these disparities: patrolling and policing practices that contribute to disparities in arrests, sentencing guidelines that disproportionately impact people of color, and difficulty obtaining employment after incarceration (which can lead to higher rates of recidivism).

## ***Impacts on health and well-being***

The first research studying the impact of ACEs found that there is a relationship between the number of ACEs experienced in childhood and increased risk of a number of poor outcomes in adulthood, including: alcoholism, drug use, mental health issues (e.g., depression), chronic diseases (e.g., heart disease, liver disease), higher risk sexual activity, poor academic/work

<sup>6</sup> Minnesota Department of Health. Minnesota Student Survey statewide tables. Retrieved from: <http://www.health.state.mn.us/divs/chs/mss/statewidetables/>

performance, and lower quality of life.<sup>7</sup> A recent MDH report found the same patterns in Minnesota; adults who experienced multiple ACEs in childhood are more likely to report their own health as “fair” or “poor,” to use tobacco products and overuse alcohol, and to be diagnosed with depression or anxiety.<sup>8</sup> The study also found that adults who experienced five or more ACEs were more likely to be unemployed and feel financial stress.

While the initial study focused on ACEs impacting health outcomes in adulthood, ACEs have more immediate impact on youth health and well-being. When ACEs occur, particularly if they occur repeatedly or over long periods of time, children experience toxic stress which can impact brain development, influencing behavior, learning, relationships, memory, and overall health. In Minnesota, for example, youth who have more ACEs are more likely to report mental health concerns and use alcohol, marijuana, and prescription drugs.<sup>9</sup>

ACEs are an important, but not exhaustive, list of factors that can lead to poor health outcomes. For example, chronic poverty and its impacts on housing, food security, and access to resources, can lead to chronic stress and poor health. Children and families who come to the United States as immigrants and refugees experience stress as they learn about living in a new culture and interacting with new systems. This is in addition to the chronic stress that some families experienced in their home country. Structural racism, experiences of direct racism or discrimination, and historical trauma are also experiences that impact people of color and American Indians, but these topics are not asked about in surveys that are used to describe ACEs and their impacts.

### ***Factors that reduce ACE impacts***

Although ACEs can have profound short- and long-term impacts on health and well-being, community and familial strengths and assets can offset the negative impacts of ACEs. Nurturing relationships, connections with supportive and caring adults, ensuring basic needs are met, and nurturing the social emotional development of children are all examples of protective factors that can reduce the negative impacts of ACEs. SUMN’s analyses of MSS data showed that strong families and communities minimize the impacts of ACEs in Minnesota:

- Among students with two or more ACEs, students who can talk to their mother or father about problems and students who feel their parents care about them were approximately two times less likely to report suicide ideation in the past year.

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<sup>7</sup> Centers for Disease Control and Prevention (CDC). For more information, see: <https://www.cdc.gov/violenceprevention/acestudy/about.html>

<sup>8</sup> Minnesota Department of Health. (2013). Adverse childhood experiences in Minnesota. Retrieved from: <http://www.health.state.mn.us/divs/cfh/program/ace/content/document/pdf/acereport.pdf>

<sup>9</sup> SUMN: Analysis of 2013 MSS data

- Regardless of the number of ACEs, students who feel adults in the community care about them are 8 to 15 percentage points less likely to report significant problems with anxiety than students who do not feel they have that support.

In an ideal world, no child would experience abuse, neglect, and other traumatizing events. While working to prevent ACEs from occurring, it is important to help teachers, health care providers, and others who work closely with children increase their understanding of ACEs and how these events can impact development and child behavior (a trauma-informed approach), as well as to support efforts that foster community and family strengths and assets.

## Academic achievement

There is a strong association between education and health. Adults with higher levels of education tend to have lower rates of most acute and chronic illnesses and have higher levels of functioning as they age. There are multiple factors that contribute to this relationship: people with higher levels of education are more likely to have higher-paying jobs; less likely to live in poverty; and less likely to smoke, to drink heavily, or to be overweight or obese (all factors that contribute to chronic disease). Graduating from high school is an important step that supports overall health and wellness into adulthood.

### *Graduation rates*

The high school graduation rate is one of many measures that can be used to describe youth academic achievement. This assessment does not include information on other measures of academic achievement and student experiences in school, such as standardized test scores in reading and math, school suspensions and disciplinary action, school climate (i.e., how the school environment and culture supports students), and the availability of in-school resources. However, it should be noted that all of these factors impact school success and likelihood of graduation, and can contribute to disparities in graduation rates.

**Statewide, less than two-thirds of American Indian, Hispanic/Latino, and black students graduate from high school** (Figure 4). There are notable disparities in this measure of academic achievement; graduation rates are much higher among Asian (82%) and white (86%) students. Disparities in graduation rates are found in Minneapolis Public Schools (MPS) and Saint Paul Public Schools (SPPS), the school districts where Children’s Minnesota’s two hospital campuses are located. Graduation rates for MPS students are lower than the statewide average for some racial and ethnic groups.

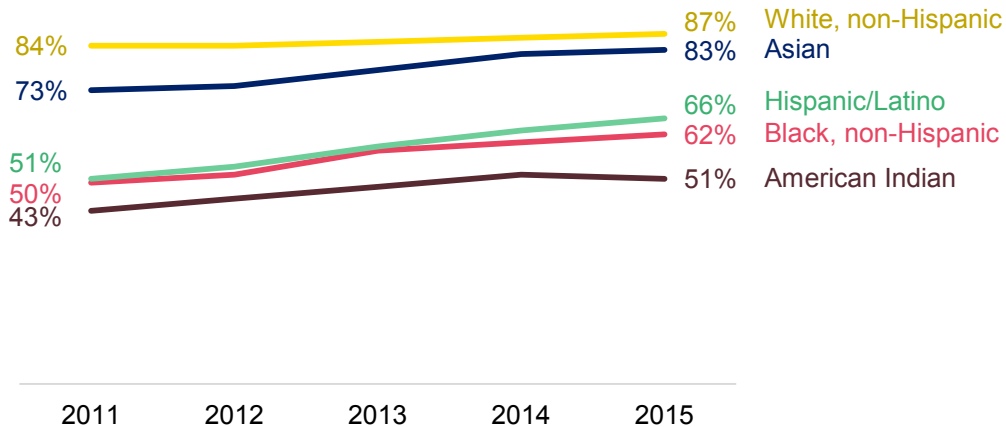
#### 4. Graduation rates by race/ethnicity, statewide and selected districts (2014-15)

Race/Ethnicity	Minnesota	Minneapolis Public Schools	Saint Paul Public Schools
American Indian/Alaskan Native	51%	36%	52%
Asian/Pacific Islander	82%	80%	76%
Hispanic	63%	57%	72%
Black, not of Hispanic origin	60%	52%	70%
White, not of Hispanic origin	86%	82%	83%
All students	81%	64%	75%

Source. Minnesota Department of Education, Minnesota Report Card

Over the past five years, graduation rates have consistently improved for all racial and ethnic groups except American Indian students, where there was a small decline in 2015 (Figure 5). While this trend is moving in a positive direction, it will still take a number of years before disparities in graduation rates can be eliminated unless the pace of change increases dramatically.

#### 5. Statewide trends in graduation rate, by race/ethnicity (2011-15)



Source. Minnesota Department of Education, Minnesota Report Card

There are a number of factors, both within and extending beyond schools, that contribute to racial disparities in academic achievement. A recent report prepared by the Minnesota Education Equity Partnership calls out the need to address broader issues of “segregation and integration, the intersections of race and economic class, and white dominance in K-12 and teacher education” to understand and change the opportunity gaps that impact students and families.<sup>10</sup>

## Health insurance

**An estimated 22,000 children (age 0-18) in the Twin Cities region do not have health insurance.** The percentage of children without health insurance has decreased from 6 percent of children in 2011 to 3 percent in 2015. Just over 10,000 of these children live in Hennepin County.<sup>11</sup> The affordability and level of coverage for children who have health insurance is not known; children covered by high deductible health care plans, for example, or high co-pays may be underinsured. While health insurance helps many families afford services that support health and well-being, multiple studies, including one conducted by Children’s Minnesota on emergency department use,<sup>12</sup> have demonstrated that a number of additional factors also impact access to health care services.

## Physical health

### *Premature death*

**The three leading causes of premature death among youth in the 7-county metro area are unintentional injuries, suicide, and cancer (Figure 6).** Nationally, the most common types of unintentional injuries for youth and young adults (age 5-24) are traffic accidents, poisoning, drowning, and firearm injuries.<sup>13</sup> In Minnesota and nationally, unintentional injuries are closely followed by suicide as leading causes of death for adolescents and young adults (age 15-24), highlighting mental health and community violence as important areas of concern.

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<sup>10</sup> Hamilton, J. L., Spies, P., Godinez, J., & Mariani, C. (2016). *State of students of color and American Indian students report*. Retrieved from: <http://mnneep.org/wp-content/uploads/2016/04/SOSOCAI-Report-2016.pdf>

<sup>11</sup> Minnesota Department of Health. Public Health Data Portal. Retrieved from: <https://apps.health.state.mn.us/mndat>

<sup>12</sup> See the “other data sources” section of this summary for more information about the study conducted by Children’s on factors influencing frequent emergency department use.

<sup>13</sup> National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2014). *10 leading causes of injury deaths by age group highlighting unintentional injury deaths, United States – 2014*. Retrieved from: [http://www.cdc.gov/injury/images/lc-charts/leading\\_causes\\_of\\_injury\\_deaths\\_unintentional\\_injury\\_2014\\_1040w740h.gif](http://www.cdc.gov/injury/images/lc-charts/leading_causes_of_injury_deaths_unintentional_injury_2014_1040w740h.gif)



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## 6. Leading causes of death by age in 7-County Metro, (2013)

	Number of child deaths	
	Age 5-14	Age 15-24
Unintentional injury	16	61
Suicide	4	43
Cancer	5	14
Heart disease	3	9
Chronic lower respiratory disease	5	2
Diabetes	0	2
Stroke	1	1
Septicemia	0	2
Pneumonia and influenza	1	0
Nephritis	0	1
Benign Neoplasms	0	1

Source. Minnesota Department of Health, County Health Tables

### *Health conditions*

School-age children are generally healthy. Therefore, this section of the summary focuses on two conditions that can be managed or prevented by changes in behavior or environment: asthma and diabetes.

#### **Asthma**

Across the seven counties in the metro region, 15 to 19 percent of ninth-grade students have been told they have asthma.<sup>14</sup> Asthma is one of the leading causes of absenteeism from school. A number of factors can trigger an asthma episode, including air pollution, exposure to allergens, exercise, tobacco smoke, and chemical irritants. The rate of asthma-related hospitalizations is higher in Minneapolis and Saint Paul than in other parts of the metro region, particularly in the downtown areas of each city and nearby neighborhoods (Near North and Phillips neighborhoods in Minneapolis, Summit-University neighborhood in Saint Paul).<sup>15</sup>

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<sup>14</sup> Minnesota Student Survey, 2013

<sup>15</sup> Minnesota Department of Health. Asthma hospitalizations (2009-2013) [Interactive map]. Retrieved from MN Public Health Data Access: <https://apps.health.state.mn.us/mndata/webmap/asthma.html>

## Diabetes and contributing factors

In the 7-county metro region, approximately 1 percent of ninth-grade students have been told they have diabetes.<sup>16</sup> This may be an underestimate of the prevalence of the disease; members of the Community Advisory Committee felt that diabetes was a growing concern among youth in the communities they serve. A much larger percentage of students have an increased risk of developing diabetes because of their weight or health behaviors. Approximately one-quarter of Minnesota ninth-grade students are overweight or obese, with Ramsey County having the largest percentage of youth who are defined as obese (Figure 7). The percentage of students who are overweight or obese changed little from 2010, staying the same or changing by one percentage point, depending on the county.

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### 7. Weight status of Minnesota ninth-graders (2013)

County	Not overweight	Overweight	Obese
Anoka	78%	14%	9%
Carver	83%	11%	6%
Dakota	81%	12%	8%
Hennepin	80%	13%	8%
Ramsey	75%	15%	11%
Scott	79%	14%	8%
Washington	79%	13%	8%
Minnesota	77%	14%	9%

Source. Minnesota Student Survey, 2013

Note. 2013 data do not include students from Minneapolis Public Schools (Hennepin County) or Chanhassen Public Schools (Carver County); data from these counties should be interpreted with caution. Weight status was based on body mass index (BMI) calculated using students' self-reported height and weight.

**Relatively few ninth-grade students meet recommended guidelines for physical activity and healthy eating.** The Centers for Disease Control and Prevention (CDC) *Physical Activity Guidelines for Americans* recommends that children age 6 to 17 should be physically active for at least 60 minutes each day. Only 1 in 5 children in the state meet the physical activity recommendations. In its food pyramid, the United States Department of Agriculture (USDA) recommends that school-age children consume at least two servings of fruit and three servings of vegetables a day. Approximately three to four times as many ninth-grade students consume the recommended number of fruit servings each day, compared to those who consume the recommended number of vegetable servings (Figure 8). A number of factors contribute to how easily students can be physically active and follow a healthy diet, including

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<sup>16</sup> Minnesota Student Survey, 2013

the availability and affordability of resources that support health, and comfort or experience with exercise and meal preparation.

## 8. Percentage of ninth-grade students who meet recommended physical activity and healthy eating guidelines

County	60 minutes of physical activity daily	2 or more servings of fruit daily	3 or more servings of vegetables daily
Anoka	20%	27%	8%
Carver	21%	31%	7%
Dakota	21%	31%	9%
Hennepin	18%	34%	10%
Ramsey	17%	30%	12%
Scott	17%	27%	9%
Washington	19%	28%	9%
Minnesota	20%	27%	9%

Source. Minnesota Student Survey, 2013

## Mental health

**Thirteen percent of ninth-grade students in Minnesota reported having a long-term mental health, behavioral, or emotional problem** (Figure 9). This is in line with national studies that estimate 13 percent of youth (age 8-15) have experienced a mental health disorder in the past 12 months.<sup>17</sup> The percentage of people who will experience poor mental health at some point in their lifetime is higher; just over 20 percent of people will experience a serious mental health disorder that impacts functioning in their lifetime. Although national studies show there is no difference in lifetime prevalence for mental health disorders by gender, among ninth-grade students in Minnesota, females are more likely to report a mental health concern than males (15% compared to 10%, respectively).

**At least 10 percent of youth reported having a long-term mental health, behavioral, or emotional problem in all Twin Cities metro counties.** The percentage of students reporting a mental health problem has stayed about the same between 2010 and 2013 (Figure 9). Results from the College Student Health Survey conducted by the University of Minnesota showed 33 percent of students reported having a mental health diagnosis in their lifetime, compared to 25 percent of students in 2007.<sup>18</sup> This observed

<sup>17</sup> National Institute of Mental Health. (2010). Any disorder among children. Retrieved from: <http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml>

<sup>18</sup> University of Minnesota. (2015). 2015 college student health survey report: Health and health-related behaviors: University of Minnesota-Twin Cities students. Retrieved from: [http://www.bhs.umn.edu/surveys/survey-results/2015/UofMTwinCities\\_CSRSReport\\_2015.pdf](http://www.bhs.umn.edu/surveys/survey-results/2015/UofMTwinCities_CSRSReport_2015.pdf)

increase may not be a change in actual prevalence; reduced stigma around mental illness may make youth more willing to discuss problems they are experiencing and seek treatment.

## 9. Percentage of ninth-graders reporting long-term mental health, behavioral, or emotional problems (2010 and 2013)

County	2010	2013
Anoka	12%	12%
Carver	9%	10%
Dakota	11%	13%
Hennepin	10%	13%
Ramsey	12%	13%
Scott	12%	11%
Washington	10%	13%
Minnesota	11%	13%

Source. Minnesota Student Survey, 2013

**Statewide, the percentage of ninth-grade students who have had suicidal thoughts has steadily decreased since 1998**, when Minnesota Student Survey data were first gathered on the topic. Among students, suicidal thoughts are more common among females than males.<sup>19</sup> Although the trend showing reductions in suicidal thoughts and attempts is promising, suicide continues to be the second leading cause of death among youth and young adults (age 15-24). The number of suicides among this age group has decreased over time, which the Minnesota Department of Health attributes to targeted prevention efforts. (In contrast, suicide among adults in Minnesota, particularly among young white men age 25 to 34, has been increasing.)

## Youth health behavior indicators

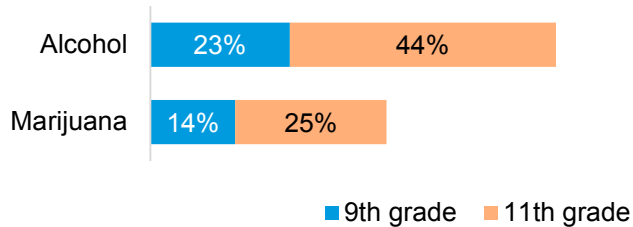
### *Substance abuse*

**Alcohol, marijuana, and prescription drugs were used by less than one-quarter of students.** In 2013, 44 percent of 11<sup>th</sup> grade students reported using alcohol at least once during the past year and fewer (25%) used marijuana (Figure 10). Ninth grade students were less likely to have used alcohol or marijuana. In contrast, there was little difference in the

<sup>19</sup> Minnesota Departments of Education, Health, Human Services, & Public Safety. (2010). Minnesota Student Survey 1992-2010 trends. Retrieved from: <http://www.health.state.mn.us/divs/chs/mss/trendreports/msstrendreport2010.pdf>

percentage of 9<sup>th</sup> and 11<sup>th</sup> grade students who reported misusing a prescription drug in the past 30 days (6% and 7%, respectively).<sup>20</sup>

## 10. Percentage of students that used alcohol or marijuana during the past year



Source. Minnesota Student Survey, 2013

**The percentage of students who reported having alcoholic beverages at least once in the past year has declined greatly over time.** In 1992, nearly two-thirds (64%) of 9<sup>th</sup> grade students in Minnesota reported using alcohol in the past year, compared to 23 percent in 2013.<sup>21</sup> Both males and females have followed similar downward trend in rates of alcohol consumption. However, the data consistently show a slightly higher percentage of females than males drinking alcohol in the past year and past 30 days.

## *Sexual activity*

### **Teen pregnancy**

**In Minnesota, the teen pregnancy rate has steadily decreased since 1990** (Figure 11). In 2013, there were 1,004 births to teenagers age 15-17 and nearly three times as many births (n=2,874) to teenagers age 18-19. The same trend has occurred nationally, likely due to teenagers waiting longer before becoming sexually active and the increased use of more effective contraceptive methods.<sup>22</sup> However, American Indian, Hispanic/Latina, and black teenagers are more than three times as likely to become pregnant than white teenagers, the racial group with the lowest teen pregnancy rate (Figure 12).

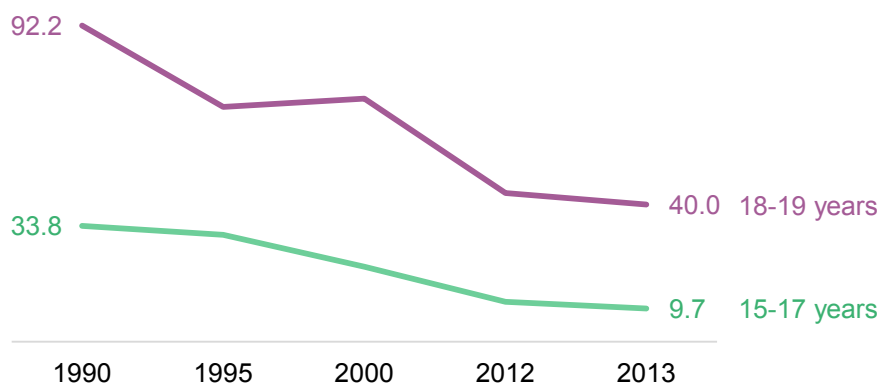
<sup>20</sup> The MSS asks students about how often, in the past 30 days, they have used prescription drugs that were not prescribed to them. This item on prescription drug misuse was first added to the survey in 2013. There is not a question comparable to the alcohol and marijuana survey items that asks about any misuse during the past year.

<sup>21</sup> Minnesota Departments of Education, Health, Human Services, & Public Safety. (2013). Minnesota Student Survey 1992-2013 trends. Retrieved from: <http://www.health.state.mn.us/divs/chs/mss/trendreports/msstrendreport2013.pdf>

<sup>22</sup> Farris, J., & Regan, E. (2015). 2015 Minnesota adolescent sexual health report. Retrieved from: <http://www.pediatrics.umn.edu/sites/pediatrics.umn.edu/files/2015ashr.pdf>

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## 11. Changes in teen pregnancy rates, statewide (1990-2013)

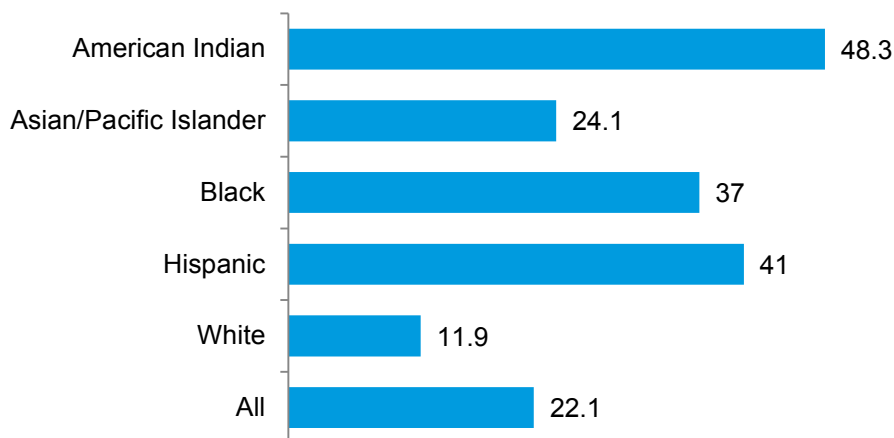


Source. Farris, J., & Regan, E. (2015). *2015 Minnesota adolescent sexual health report*. Retrieved from: <http://www.pediatrics.umn.edu/sites/pediatrics.umn.edu/files/2015ashr.pdf>

Note. The teen pregnancy rate is the number of pregnancies to a specific age group per 1,000 female population of the specific age group.

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## 12. Teen pregnancy rates (statewide), age 15-19, by race/ethnicity (2013)



Source. Farris, J., & Regan, E. (2015). *2015 Minnesota adolescent sexual health report*. Retrieved from: <http://www.pediatrics.umn.edu/sites/pediatrics.umn.edu/files/2015ashr.pdf>

Note. The teen pregnancy rate is the number of pregnancies to a specific age group per 1,000 female population of the specific age group.

**Among teenagers age 15-19, pregnancy rates in Ramsey County are nearly twice as high as the statewide average** (Figure 13). Teen pregnancy rates in Hennepin County are also higher than the statewide average. The counties with the highest teen pregnancy rates are the most racially and ethnically diverse counties; the observed differences between counties are due to racial disparities in teen pregnancy rates.

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### 13. Teen pregnancy rates, by county (2010-2012)

<b>County</b>	<b>15-17 years</b>	<b>18-19 years</b>	<b>15-19 years</b>
Ramsey	21.7	62.2	40.7
Hennepin	16.7	55.2	32.4
Anoka	10.2	48.3	23.4
Dakota	8.2	44.8	20.3
Scott	8.6	39.4	18.0
Washington	6.9	35.8	16.2
Carver	5.5	27.3	12.5
<b>Minnesota</b>	<b>12.6</b>	<b>47.8</b>	<b>27.0</b>

Source. Minnesota Department of Health, County Health Tables (2013 natality table)

Note. The teen pregnancy rate is the number of pregnancies to a specific age group per 1,000 female population of the specific age group. Because of the relatively small numbers of births in some Minnesota counties, pooled data over a 3-year period (2010-12) were used to calculate more reliable rates.

### Sexually transmitted infections

Adolescents and young adults (age 15-24) accounted for 66 percent of chlamydia and 51 percent of gonorrhea cases reported in Minnesota in 2014.<sup>23</sup> High rates of STIs among this age group are likely the result of limited access to prevention services and lack of comfort seeking services, including concerns about confidentiality.<sup>24</sup>

The chlamydia incidence rate for adolescents (age 15-19) increased 51 percent between 2007 and 2014 (from 1,071 to 1,402 adolescents infected per 100,000 population). Gonorrhea incidence rates have fluctuated over the same time period, and are now slightly lower than in 2007 (218, compared with 229 adolescents infected per 100,000 population). For both of these STIs, the majority of infections are reported in Hennepin and Ramsey counties. STIs are more common among black, American Indian, and Hispanic/Latino adolescents than among Asian or white youth.<sup>25</sup>

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<sup>23</sup> Minnesota Department of Health. Annual summary: 2014 Minnesota sexually transmitted disease statistics. Retrieved from: <http://www.health.state.mn.us/divs/idepc/dtopics/stds/stats/2014/stdstats2014.html#2a>

<sup>24</sup> Centers for Disease Control and Prevention. (2014). Sexually transmitted disease surveillance 2013. Retrieved from: <http://www.cdc.gov/std/stats13/surv2013-print.pdf>

<sup>25</sup> Farris, J., & Regan, E. (2015). 2015 Minnesota adolescent sexual health report. Retrieved from: <http://www.pediatrics.umn.edu/sites/pediatrics.umn.edu/files/2015ashr.pdf>

# Additional information

## Other data sources

**Children’s Minnesota. *Results from conversations with families about emergency department use.*** In 2015, Children’s Minnesota staff reached out to caregivers to participate in conversations to understand the reasons surrounding the use of emergency department services. The participating caregivers had children who were seen multiple times in the emergency department, including children who received minor illness care in the emergency department services (not in the clinic). The experiences shared by caregivers, and data compiled from the emergency department, helped Children’s Minnesota challenge existing assumptions about who seeks emergency department care, when they seek it, and for what reasons. The feedback from caregivers showed that a number of factors can increase or reduce accessibility, such as the cost of parking, the ability for multiple siblings to be seen together, the availability of same-day appointments, and the types of transportation used by the family. The study helped Children’s Minnesota identify practices and policies that inadvertently posed challenges to families seeking care in clinic settings. *Study results made available for the CHNA by Children’s Minnesota.*

**Hope Community. *Feed the roots: A Hope Community listening project report.*** In 2013, Hope Community organized a Food Justice Leadership Team made up of community members and organizers interested in food and health. The Team facilitated 20 listening sessions and conducted surveys to hear the opinions and feedback of 415 community residents in the Phillips neighborhood of Minneapolis. The report highlights residents’ experiences with food, provides historical context to the policies and systems that have shaped the local food environment, and summarizes the many solutions and calls to action made by community residents. Available from:

[http://www.hope-community.org/sites/default/files/HOPE%20Feed\\_The\\_Roots\\_web2.pdf](http://www.hope-community.org/sites/default/files/HOPE%20Feed_The_Roots_web2.pdf)

**Minnesota Education Equity Partnership. *State of students of color and American Indian students report.*** This 2016 report provides a comprehensive description of the factors that have contributed to inequities in educational outcomes, including a brief history of key changes in state and national education policy, and data from multiple sources highlighting racial disparities in academic outcomes. The report offers questions for consideration and recommendations to address the issues leading to inequitable academic outcomes for students of color and American Indian students. Available from:

<http://mneep.org/wp-content/uploads/2016/04/SOSOCAI-Report-2016.pdf>



**Rainbow Health Initiative. *Invisible youth: The health of lesbian, gay, bisexual, and questioning (LGBQ) adolescents in Minnesota.*** The Minnesota Student Survey (MSS) first included a question about sexual identity in 2013. This report, published in 2015, reports findings from the survey to describe the health and experiences of LGBQ students. Results from the survey show approximately 6 percent of 9th and 11<sup>th</sup> grade students identify as lesbian, gay, bisexual, or questioning. The data consistently show that LGBQ students had poorer educational and health/mental health outcomes than straight students. LGBQ students were also more likely than straight students to have experienced physical and sexual abuse and harassment from their peers, as well as have concerns about their own safety. LGBQ students were also more likely to use tobacco, alcohol, and other drugs, compared to straight students. The report includes a number of recommendations to increase awareness about issues impacting LGBQ students and learn about factors that can influence positive outcomes.

Available from:

[http://www.rainbowhealth.org/files/1714/4561/9488/Oct\\_23\\_MSS\\_Report.pdf](http://www.rainbowhealth.org/files/1714/4561/9488/Oct_23_MSS_Report.pdf)

**Star Tribune. *Indian kids in foster crisis.*** The Star Tribune published a series of articles exploring reasons that Minnesota has placed more American Indian children in foster care than any other state in the nation. The series explores bias in child protection reporting and sentencing guidelines that disproportionately impact American Indian children. The articles quote tribal leaders who note that placing so many children in foster care perpetuates cycles of poverty, neglect, drug and alcohol abuse, and mental illness. Available from:

<http://www.startribune.com/part-1-why-does-minnesota-have-so-many-american-indian-kids-in-foster-care/389309792/#1>

## Relevant public health efforts

Local public health departments in the Twin Cities region also conduct regular assessments of community health (all ages) to identify health priorities and inform their efforts to improve health. In a review of the most recent Community Health Improvement Plan (CHIP) reports completed by Wilder Research, the following goals, directly related to health and wellness of young children, were identified (Figure 14). These may offer initial opportunities for collaboration. Through a series of community stakeholder interviews and ongoing outreach and engagement with community partners, Children's Minnesota will also be identifying additional opportunities for collaboration and partnership identified by these local organizations and residents as most important to their community.

#### 14. Relevant public health goals to improve the health of school-age children and adolescents

Local public health department(s)	Years	Goal
Anoka County	2015-19	<p>Decrease tobacco, alcohol, and other drug use among teens and young adults, especially abuse of prescription medication and illegal drugs</p> <p>Address violence and safety for all ages*</p> <p>Reduce obesity across all age groups*</p>
Carver County	2015	Reduce underage alcohol consumption among students by changing the idea that it is simply a “rite of passage”
Dakota County	2014-18	<p>Reduce the percentage of preschool children who are obese</p> <p>Reduce the percentage of youth who attempted suicide in the past year; Increase the percentage of youth who receive treatment for mental distress</p>
Hennepin County; Cities of Bloomington, Edina, Richfield; City of Minneapolis	2012-15	<p>Increase regular physical activity and proper nutrition through improvements to the physical environment</p> <p>Increase community and social connectedness*</p>
Saint Paul/Ramsey County	2014-18	<p>Reduce the percentage of children (age 0-18) living in poverty</p> <p>Increase the percentage of high school students who graduate within 4 years</p> <p>Increase the percentage of ninth-graders who: a) eat 5+ fruit/vegetable servings each day; b) get moderate physical activity for at least 20 minutes 5 or more days a week</p> <p>Decrease the percentage of obese ninth-graders</p> <p>Decrease the percentage of Hispanic females reporting suicidal ideation</p> <p>Decrease the percentage of: a) ninth-graders who have been bullied; b) female students who have been “hit, hurt, or threatened” by someone they are dating; c) students of color who have ever been “hit hard or often”</p>
Scott County	2015-19	Increase access and availability of fruits, vegetables, and physical activity options for school-age children
Washington County	2014	<p>Increase the prevalence of youth who: a) eat the recommended number of servings of fruits and vegetables and b) meet guidelines for moderate physical activity</p> <p>Reduce the number of 12<sup>th</sup>-graders (under age 18) who smoke</p> <p>Reduce suicide attempts among ninth-grade students</p> <p>Increase portion of youth who experience social and emotional support from adults at school</p>

Note. Items with an asterisk (\*) have an unspecified age target or include adults as priority populations.

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# Community Descriptions of Child Health

*A summary prepared for the Children's Hospitals and Clinics  
of Minnesota 2016 Community Health Needs Assessment*

Prepared by: Anna Bartholomay

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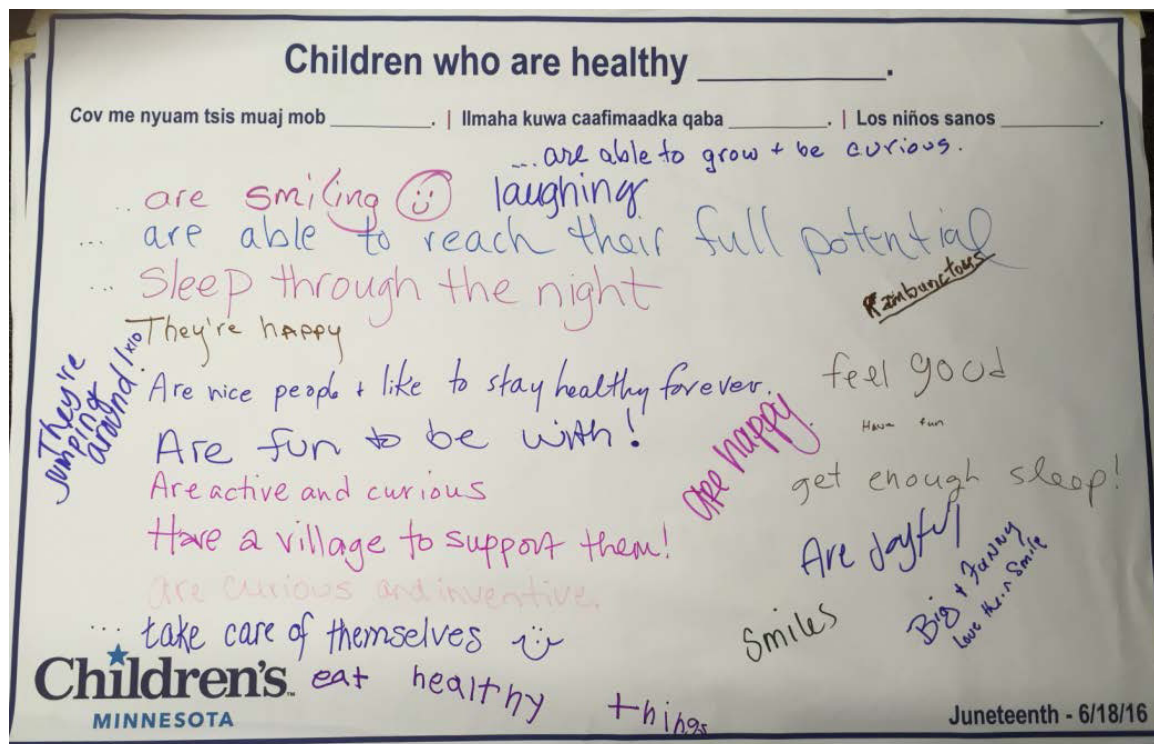
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# Background

Throughout the community health needs assessment (CHNA) process, Children’s Minnesota wanted to use a broad definition of health that reflected the values and highlighted the strengths and assets of the diverse community it serves. To hear from children and families, Children’s Minnesota posted discussion boards at community events as well as in the Children’s Minneapolis and St. Paul general pediatrics clinics. The discussion boards (see below) prompted children and families to finish the sentence:

**Children who are healthy \_\_\_\_\_.**

The prompt was written in multiple languages (English, Hmong, Somali and Spanish) and people were invited to answer the question in any language.



The responses provided by the more than 800 people who wrote comments at these locations were collected and entered into a spreadsheet by location. Responses from each event were uploaded into Tagul, an online word cloud generator to create the visuals included in this summary. The most frequent words are generally the largest, however, the algorithm used is designed to manipulate the size of the words to fill the space regardless of the frequency.

The comments shared at all events and locations showed that children and families described health holistically to include physical and mental health, connections with others, and

multiple aspects of development. Most of the comments focused on strengths and assets, rather than describing health as the absence of illness or other problems. This activity was not intended to result in a clear community definition of health or to look for differences in perspectives. It is a starting point for gathering community input and reaffirmed that by considering the multiple underlying factors that impact neighborhood conditions, family stability, and opportunities for healthy development, the CHNA process used by Children’s Minnesota were exploring a range of topics that aligned with how children and families think about health.

The discussion boards were posted at the following events and locations:

<b>Juneteenth</b>	Camden, Minneapolis	June 18, 2016
<b>Children’s – Minneapolis clinic</b>	Phillips, Minneapolis	July 2016
<b>Children’s – Saint Paul clinic</b>	Ford Road/West Seventh, Saint Paul	July 2016
<b>Somali Independence Day</b>	Powderhorn, Minneapolis	July 9, 2016
<b>Rondo Days Festival</b>	Thomas-Dale/Summit-University, Saint Paul	July 16, 2016
<b>Open Streets – East Lake</b>	Phillips/Powderhorn, Minneapolis	July 24, 2016
<b>SPPN Health Fair</b>	Thomas-Dale/Summit-University, Saint Paul	July 26, 2016
<b>Brian Coyle Health Fair</b>	Cedar-Riverside, Minneapolis	August 5, 2016
<b>Open Streets – Franklin</b>	Phillips, Minneapolis	August 21, 2016
<b>Minneapolis Urban League Family Day</b>	Near North, Minneapolis	August 29, 2016
<b>CLUES Health Fair</b>	Dayton’s Bluff, Minneapolis	September 10, 2016
<b>Native American Day Celebration</b>	Longfellow, Minneapolis	September 25, 2016
<b>Open Streets – University of Minnesota</b>	Cedar-Riverside, Minneapolis	October 1, 2016

Overall, responses were collected from more than 800 people throughout the summer.

# Word clouds

Responses shared at all events and clinics



# Juneteenth









# Somali Independence Day





# Open Streets – East Lake



















## Unique words and phrases from responses given at all events and locations



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# Community Stakeholder Perspectives on Child Health

*A summary prepared for the Children's Hospitals and Clinics of  
Minnesota 2016 Community Health Needs Assessment*

Prepared by: Anna Bartholomay & Melanie Ferris

DECEMBER 2016

**Wilder Research**  
Information. Insight. Impact.

**Children's**  
MINNESOTA

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# Background

Children's Hospitals and Clinics of Minnesota (Children's Minnesota) and all other not-for-profit hospitals are required to complete a Community Health Needs Assessment (CHNA) every three years. The assessment process is intended to help hospitals understand and respond to the health concerns of the communities they serve. Children's Minnesota sees the CHNA requirement as an opportunity to work in partnership with community stakeholders in a more intentional way.

As a component of their community health needs assessment, Children's Minnesota conducted interviews with stakeholders in the community to better understand the needs of children in the 7-county metro region. The purpose of the interviews were threefold; 1) to better understand the strengths and needs of children and ways that they can support their health and wellness, 2) to inform an implementation plan with strategies to guide how Children's Minnesota will respond to the health needs and priorities of community residents, and 3) to foster relationships with community partners for future collaborative work. The interviews are one of several strategies Children's Minnesota is using to learn about the health needs and priorities of children and families. The Community Advisory Committee convened by Children's Minnesota to guide this assessment process will play a critical role to help interpret the information presented and consider how it can inform Children's Minnesota's to support the health and wellbeing of children and families.

## Description of the community stakeholders interviewed

Children's Minnesota staff conducted interviews with 35 individuals selected by Children's Minnesota staff in addition to a group interview with Children's Minnesota's American Indian External Advisory Committee. The largest number of interviews was conducted with representatives from community-based or nonprofit organizations. Community stakeholders also represented local government agencies, public school districts, neighborhood associations, faith-based organizations, and community residents and advocates.

During the interview, the community stakeholders were asked to consider the needs of children of all ages and their families and to use a broad definition of health and wellness. Interview participants were most likely to describe the populations they serve as children and youth, families, low-income populations, people experiencing homelessness, and specific cultural communities, including Latino, East African (Somali, Ethiopian, Oromo), and American Indian. Stakeholders also talked more broadly about their experiences with immigrant and refugee communities.



The majority of those interviewed provide services in the Twin Cities metro area with very few providing services that extend to Twin Cities suburbs and greater Minnesota. Community stakeholders described working to improve health and wellness of children in the Twin Cities in a variety of ways, several of which target social determinants of health such as housing and education. Most commonly, interviewees said their organizations worked on issues related to education and awareness, housing, health care services (clinic-based), physical activity, economic opportunity, family services, mental health services, and community engagement.

## About the interviews and analysis approach

Children's Minnesota staff conducted the interviews to facilitate relationship-building with community partners. Interviews were conducted either in person or over the phone and lasted approximately 30-60 minutes. Community stakeholders were asked a series of questions about how they hear health being talked about in their community or among those served by their organization, what they perceive to be the top health needs of children, what they perceive as the most significant barriers to health, and emerging trends impacting the health and wellness of children. They were also asked who they feel has the most influence on the health of children, what strengths and assets support health and wellness in their communities, and how they have observed culture playing a role in the health and wellness of children. The community stakeholders were also asked to identify the steps that can be taken to improve the health of children and ways in which Children's Minnesota might partner with organizations to that end.

This summary highlights key themes from the interviews. These themes emerged from an analysis of the interview notes using grounded theory.<sup>1</sup> This summary is organized by interview question with related themes listed in order of how often they are mentioned. Statements in italics are taken from the interviews to illustrate key themes or unique perspectives.

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<sup>1</sup> Grounded theory is an approach for analyzing qualitative data (in this case, interview notes) that is flexible and involves repeated reviews of the information collected to develop codes and understand key concepts. With this approach, the codes and key themes emerge from the data rather than being developed in advance, based on an existing theory or assumptions about concepts likely to be addressed. In this analysis of interview notes, similar ideas or concepts were identified and given codes. Codes most frequently assigned were then identified as themes for each interview question. Unique ideas continued to be included in the analysis and are also reflected in this summary.

# Key themes

*NOTE: The quotes included in this summary have been minimally edited in some cases for clarity. Every effort was made to maintain the stakeholder's meaning.*

## Perspectives on health and wellness in community

The Community Advisory Committee recommended that Children's Minnesota approach the assessment process using a strengths-based and holistic approach to discuss health and wellbeing that reflects the language and interests of community residents. Community stakeholders were asked how people in their community talk about health and wellness.

### ■ Health is grounded in culture and shaped by experience

According to community stakeholders, members of their community talk about health and wellness in the context of their culture and in ways that highlight their community's unique experiences. Familiarity with preventive care, perceived stigma around mental health, expectations around childhood development, and past experiences with systems and institutions are all factors that influence if and when families seek support.

*Some people say that the root of good health and wellness comes from the internal systems of your body...My colleagues talk about having to first gain an understanding of how the family or the person is oriented toward health and wellness...and then they work from there.*

*People [in my community] really talk about isolation, loss of community, loss of culture and language, stress, fear, social paralysis.*

*We [Somali's] go to a doctor when we are sick...when we are very sick. We tend to wait and tolerate pain. That means that prevention and health maintenance...is a new concept that we need to understand and process it.*

### ■ Health is shaped by social, economic, and environmental conditions

Community residents also frequently talk about how social determinants of health impact the health and wellness of children. Interviewees mentioned access to parks, environmental injustice in neighborhoods with high rates of poverty, community safety, the availability of healthy food options, walkability in neighborhoods, and housing conditions.

### ■ Trauma and stress impact health and wellbeing

Due to challenging circumstances related to poverty, immigration, or a history of oppression, the impact of trauma, stress, and anxiety on health and wellness is a part of

community conversations around health. Multiple stakeholders spoke to the importance of providers recognizing the impacts of trauma in their interactions with children and families.

*There's also a significant awareness of widespread trauma that exists in so many communities... It really deals with historic and generational oppression that is only now being brought to the forefront as a causative factor for some of the present situations and living conditions of even children. That connection is crucial...And it's not just to be trauma-informed, it's about really healing the trauma and that's not what Western medicine as it exists now is focused on, but there are cultural practices that have always focused on how to clear and process and heal these things as they come up but they have been lost. Not because we have forgotten them but because they have been silenced and discredited.*

- **Overall functioning, a sense of belonging and spirituality are all part of a holistic understanding of health**

Community stakeholders felt that, overall, community members have a comprehensive understanding of health as more complex and nuanced than simply living without illness. One interviewee discussed a holistic view of health as feeling part of a community, feeling welcomed, knowing where they come from and who their community is, and having a sense of connectedness with their school community. Conversely, several stakeholders discussed how health in their community is not addressed proactively through preventive care, noting that health is not discussed until someone is sick.

*People view wellness different from health. And that wellness is much more important to them because it brings in physical, mental, spiritual: it brings in a whole mind/body perspective. I think the community is much more advanced in how they're talking about this than the medical profession.*

*Somalis see health from a perspective of "Bokal" or sick, it only raises their conscious when they cannot function to some extent...Health is never seen in the perspective of depression, isolation, fatigue. Health is only seen in the context of disease...that limits major functions.*

*There is a lot more consensus, I guess, among Latinos that the definition of health is beyond the idea of not being sick.*

## Most influential factors affecting health decisions and behaviors

Family, including extended family, was often identified as having the most influence on the health behavior of children and health decisions. However, there were some differences for specific populations or communities. Religious or spiritual leaders were noted as being particularly influential within the Hmong and Somali communities. Persons outside of the family were noted as most influential for children experiencing homelessness (e.g., case managers, school staff, therapists, and program managers). Other factors influencing the health of children included peers (particularly among older children), media, school staff, youth development programming (e.g., afterschool programming), social determinants of

health (e.g., education, economy, environment), medical providers and staff, and policies and institutional practices.

## Resources, assets, and strengths that support children's health

Community stakeholders were asked to identify the three most important resources, strengths, or assets they see families draw on to support the health and wellbeing of children. The assets most frequently identified were (in order of prevalence):

- **Relationships and informal support**, including community resources, and social connections and relationships with family, peers, religious community, and school community
- **Skills and attributes of individuals, families, and communities**, including creativity, resiliency, faith, and resourcefulness
- **Relationships with the medical community**, including providers, clinic staff, and community health workers
- **Culture**, including history and traditions, values, beliefs, and attitudes

The stakeholders were also asked about ways they observe culture playing an important role in the health and wellbeing of children and families. Community stakeholders talked about the essential role culture plays in the development of self-identity and having a sense of belonging. They talked about the need for providers to see health through a cultural lens and understand the cultural values and practices that communities hold. They noted that children benefit from programming that ties back to culture.

*Connecting to the culture and history of oneself...I think it's a healing thing to do...Learning oneself prepares one to better be able to engage in a community and a broader society and that creates a healthier community overall.*

*There's accountability when you say these people [ancestors] did this before you, so I could be here. And then forward. So if you look seven generations back and seven generations forward, what we do today is all related to that.*

*At the shelter specifically, that's through cooking, it's through food...We had a young man last year who did arts and we talked a lot about literature and seeing your image in books and poetry and spoken word. How do you express your experiences in ways that are powerful? I think culture for us is at the heart of what we do.*

*Self-determination and having staff that understand or approach their work with a positive youth development lens. Letting young people be useful, find their belonging and find their power. Once young people are able to own it for themselves that's when they really thrive.*

## Top children's health issues

Community stakeholders were asked to identify the top health issues for children. Many of the stakeholders identified issues in the following four areas: obesity, trauma, asthma, and homelessness or housing-related issues. These topics are described in more detail below. Other major health concerns identified by stakeholders included dental health, food allergies, lack of paid sick leave for caregivers, substance use, sexual health, access to health care, concerns about vaccinations, school success, and racism. Young girls' vulnerability to sexual violence and exploitation was a concern among stakeholders speaking to health issues in the American Indian community. Another stakeholder identified teen pregnancy and the lack of resources for pregnant and parenting young adults (age 18-23) as a major health concern for Latinas.

### ■ Obesity and diabetes

Community stakeholders identified obesity and diabetes as major children's health issues, often noting the importance of a healthy diet and nutrition. Some stakeholders described racial, ethnic, and socioeconomic disparities in the availability of health food options, while another noted they observed adolescent girls being less physically active than boys. Two stakeholders noted cultural differences made it difficult to work with young children to manage their diabetes symptoms. A number of stakeholders said that obesity and diabetes were increasing among the children who they work with.

*Obesity and child health as it relates to baseline fitness levels and screen time. It's also related to racial and ethnic disparities. The mere fact that there are entire swaths of Minneapolis that are a food desert is a big problem.*

*Those two things [diabetes and dental decay] seem to be very common and it most likely has to do with diet and with access to things [like food].*

### ■ Mental health

A number of stakeholders identified undiagnosed or untreated mental health issues as a major health concern, impacting how children interact with others at home, in school, and in the community. A number of community stakeholders described the impact of multiple forms of trauma on the mental health and wellbeing of children, with one noting that trauma is not distant when you consider children living under chaotic circumstances or experiencing trauma in their community. (The types of trauma listed included chronic poverty, abuse, historical trauma, domestic violence, breakdown of relationships, and chronic homelessness.) Some stakeholders described stress and trauma as ever-present in the lives of some children and families. A few stakeholders also highlighted the unmet mental health needs of a caregiver as a major health concern for children. Anxiety and

depression were two types of mental health issues identified by stakeholders, with one noting that these issues can lead to eating disorders.

*The constant, chronic stress that goes along with [racism, implicit bias, oppression] for people, experienced in every circumstance they are in, is a real thing. If you're feeling it at your job, and you're feeling it on the bus, and you're hearing it on the radio, and you're seeing it on the internet and on television and in movies, and you're hearing it from teachers at your child's school, it's everywhere – that sets up a condition where you can never rest, truly. Your nervous system is keyed up all the time... I don't know that people get that –we have children who are in a constant state of anxiety and stress...*

*In Latino kids [there] is anxiety with lack of documents and the idea that parents might not show up back home or the political environment that generates that level of anxiety. Even when people have documents there is a level of anxiety because of how mainstream society communicates about particular groups and how kids bring that in and how they express that in social settings...Mental illness is not seen as something that people want to deal with because it's still probably shameful to have mental issues.*

*Broadly, children's mental health [is an issue] and, along with that, learning issues, behavior issues, and the ability of kids to be successful in school. It's really a connection between kids' mental health and environment and how they're doing in school.*

## ■ Asthma

Asthma was identified as one of the top concerns for children. One interviewee discussed the prevalence of asthma in elementary school-aged African American children and another talked about asthma as a problem in their neighborhood due to people living in densely-populated, old buildings, highways that run through the neighborhood, and an absence of trees.

*In Saint Paul schools, about 11 percent of students have asthma, but we do have schools where there are pockets of increased asthma, where the rates are as high as 20 to 22 percent in a building.*

## ■ Housing stability

Lack of stable and safe housing was a recurring issue that community stakeholders saw as a key problem related to the health of children. One stakeholder noted the rise of homelessness among older youth as a key concern. Another noted that children in foster care experience housing instability through multiple placements.

*Homelessness for older kids, and reasons for homelessness, [including] abuse or non-acceptance of being transgender or LGBTQ [identity]...Issues for foster kids not being able to find homes.*

## Emerging trends

Many of the topics identified as major health concerns were also described as emerging health issues. A number of other concerning trends and emerging issues were identified, including: substance abuse, particularly the use of new drugs; increased violence and juvenile justice involvement among girls; increased number of children with complex medical conditions; and the impacts of social media on physical activity, bullying, and wellbeing. Some stakeholders identified positive trends: magnet schools that teach American Indian languages; growing efforts to support community leadership and capacity; awareness of long-term impact of environmental changes; increased awareness of trauma among young children (age 0-3); family-centered approaches; more collaborative efforts; and growing use of non-Western models of care.

More information on the emerging trends most commonly identified follows.

### ■ **Mental health**

Community stakeholders identified a number of emerging trends related to mental health. These include: unmet mental health needs contributing to homelessness, particularly among young adults; examples of more integrated mental and physical health care; and mobile therapists and other services to improve the accessibility of services. A few stakeholders also noted a growing recognition and understanding of trauma.

*[There is] a broad trend of starting to [have] less stigma about mental health in general along with more acceptance and understanding that mental health really is part of health.*

### ■ **Obesity and diabetes**

Some stakeholders noted that obesity trends were not improving and pointed to broader systemic issues as problems that contribute to this trend. A few stakeholders noted the availability of inexpensive junk food or the cost of health food as issues. One stakeholder noted that while juvenile diabetes was not highly common, it was difficult to help youth manage their health condition.

*The level of sugar intake is tremendous...junk food basically is a problem and there is not enough programming to help the community be aware of the effects that these things have. So parents are not understanding the effects that junk food has on the wellbeing of their children.*

### ■ **Stress and trauma**

Multiple stakeholders noted that trauma is not new, but they have seen a trend in the increased awareness of trauma and how it impacts brain development, and also more understanding of ways that organizations can use trauma-informed approaches. A

number of stakeholders also brought up concerns related to violence: gun violence; violence and juvenile justice involvement among girls; bullying among young children; and policy brutality.

*Children's ability to participate in school – there are so many aspects of health and wellness that can impact that. While we've known trauma has been around for centuries... [It's] the idea that there is a trauma-informed approach included in our lens of how we work with young people.*

## ■ **Increasing recognition of the role of culture in one's health**

A number of stakeholders felt that there was growing recognition among service providers that culture is a critical component of health. Community stakeholders discussed challenges related to improving health when there are diverse understandings of what it means to be healthy and how to become healthy.

*Non-western models of caring for ourselves...the trend is to talk more openly now about other practices like mindfulness, acupuncture, and other regular practices that people coming from other countries have done for centuries.*

*There is an emerging trend in our work not only recognizing culture, but really doing work that incorporates people's cultural experiences, beliefs, traditions and practices...Our work is both wanting to make room for distinctions between people based on culture, or gender, or experience, but ultimately focusing on what we have in common and acting out of a belief and set of experiences that say when we work together across our differences, that's when we have power.*

## Key barriers to health

Community stakeholders were asked to identify key barriers to children's health and wellbeing. The four barriers most often described included financial instability impacting individuals and neighborhoods, difficulty navigating systems and accessing resources, lack of culturally appropriate services, and limited access to high quality and affordable food. Additional barriers to health identified by stakeholders included: disproportionate criminal justice involvement (particularly among African American young men) and implications for future employment, environmental hazards, lack of understanding of mental health, family instability, and lack of connections to other caring adults. Multiple stakeholders identified cultural oppression and discrimination as barriers to health, with one stakeholder noting that the problem is an underlying belief that those oppressed are somehow responsible for their own oppression.

## ■ **Financial instability, lack of community investment**

The community stakeholders described a number of ways that poverty and financial instability impacted children and families. Unemployment and poverty were identified as



key concerns. Some stakeholders noted poor quality housing and limited housing options for large families as barriers to health.

*Social determinants of health, it's a big topic of course. [Within that] there is education, poverty, that people don't feel safe in their own neighborhood. The stress of living in a poor neighborhood is a lot.*

## ■ **Difficulty navigating complex systems, accessing resources**

According to community stakeholders, many of the community residents they serve do not receive support navigating the health care system or help to ensure they understand the health information given by their provider. Lack of health insurance was identified as a barrier to services and continuity of care. Although a number of stakeholders made specific comments about the health care system, interviewees talked about the lack of an investment to help families navigate a number of complex institutional systems (education, medical, financial, etc.)

*Every year, families on Medical Assistance have to reapply...It's a systems barrier that's complicated...A child may be scheduled for an appointment on Friday and on Monday they had insurance, but it's the first of the month on Wednesday and they re-verify and we find out that the paperwork didn't get done so they're waiting for services until the next month that we can help the family reapply for that insurance. What I see is that it is a huge barrier for children to get services.*

*For example when you go to the clinic and the hospitals, they only give you the pamphlet and the information and that's it, but they don't really explain.*

*Families don't necessarily know how to navigate the [health care] system...It's a complex system that's pretty difficult to navigate without someone always to do that with you...*

*When young people and families have to make a transition into a school community, either because they've moved or because they're new to the community, it's really hard to figure out what would help and how we could do it when there's not enough resources to build a bridge...so that it's not overwhelming, so that it doesn't feel confusing, so that parents that didn't have good school experiences themselves aren't triggered.*

## ■ **Cultural bias in organizations and institutions**

A number of stakeholders felt that health providers and educators lack the culturally specific knowledge necessary to best serve children and families. Stakeholders noted the need for more multilingual services and resources and a health care workforce that better represents the cultural diversity of the community. They also stressed the importance of a much deeper understanding of culture in health care settings and other institutions. The stakeholders also provided examples of ways that systemic racism and service-delivery approaches designed by and for a dominant culture create significant barriers for children and families, limiting access to services and negatively impacting interactions between community members and service providers and institutions.

*Education for professionals in cultural competency: how to work with kids, how to work with community – there is a lack of that everywhere, in all systems.*

*Most of our teachers don't even know how to address the issue of race and they are not equipped to do it.*

*By and large, the way we treat patients by having a structured setting where we invite people to come by appointment has been the same for a really long time...How can we design any of our systems to be more responsive to the evolving way that our families are living?*

## ■ **Lack of access to healthy food**

A few community stakeholders also talked specifically about the lack of access to healthy food due to cost and proximity to grocery stores or other healthy food outlets (e.g., farmers markets).

*A huge barrier is a cost of healthy foods and the time that's needed...For families when you've got all these things you're dealing with, that time factor is huge.*

*Lack of access to really nutritious food. I think we have enough food deserts here that it's unbelievable.*

## Trauma and its impacts on health

Community stakeholders were asked how they see traumatic experiences –including chronic stress, housing and financial insecurity, racism, and violent incidents—contributing to poor health among children and families. The stakeholders described ways that multiple forms of trauma impacted the wellbeing of children, both individually and community-wide. Multiple stakeholders noted that some communities experience trauma on a regular basis and in multiple ways, including through repeated acts of violence, the experience of chronic poverty, and instability resulting from multiple out of home placements. Multiple stakeholders spoke to the negative impacts resulting from historical or multigenerational trauma on the lives of children, particularly in American Indian and African American communities. A number of stakeholders also described the trauma that children and families experience through immigration, including through their interactions with systems and institutions that are poorly equipped to understand and appropriately respond to their concerns. One stakeholder noted that while many communities experience the same forms of trauma, the frequency of these experiences and the ways that trauma impacts the lives of children and families varies across cultures.

## ■ **Coping mechanisms**

Both healthy and unhealthy coping responses to traumatic experiences can have an impact on children's health. Examples of unhealthy coping responses given by

interviewees included the consumption of junk food, getting into unhealthy relationships, drug and alcohol use, and acting out (learned violence or attention seeking).

*It can be very overwhelming to think about how to cope with [chronic stress, unstable living situations] on a regular basis and so I think about the things people do to numb it or internalize it. When families choose to be active together, to try things that keep them more active, those also have been practices that ultimately help cope with all those things...I don't think we talk enough about how moving actually helps our body release toxins that build up and impact brain development, can impact our cortisol levels and anxiety levels, and breathing.*

## ■ **Impact of racism**

The impact of racism on children and families is apparent when looking at health disparities by race and geographic area. Stress, anger, and dehumanization due to societal and institutional racism were discussed as having a significant negative effect on the mental health of children and families.

*There is an assault on black bodies in that the stress on black folk in this neighborhood is so deep, and [there is] cyclical, generational issues and disinvestment in the black community... The degree and the magnitude of crisis manifest very visibly.*

*It's so systemic, it's everywhere. It's in the schools they go to, in their case workers...The racism is everywhere, institutional racism is the best way to describe it...They are treated different, they are dehumanized, their needs aren't met. That's why we need our advocates and we need the culture and we need all these different things because our people are treated poorly.*

*I am convinced that this [racism, poverty] has an effect on them physically: high blood pressure, diabetes and a number of health related issues.*

## ■ **Effects on learning and behavior**

Community stakeholders acknowledged that brain development is affected when traumatic experiences happen at an early age. Common results are negative behavior and impaired ability to learn. Often children are sent out of the classroom and are sent to detention facilities.

*I think that exposure to trauma and being re-traumatized with future experiences is one of the biggest things that impact both children's health and their success in school.*

## ■ **Lack of trust**

Multiple community stakeholders noted that the mistrust that is the result past negative experiences from systems and institutions leads to mistrust and caregivers then being less likely to access services for their children through these systems. One interviewee made this point specifically in relation to the American Indian community.

*Well if you think about institutions being unfriendly and causing stress, which happens a lot in our community, it doesn't really make you want to go seek out another institution or place.*

*It's a trust issue. Who do [families] trust to give them the right information?*

*Trust is the basis of relationships and relationships are the basis of getting anything done.*

## ■ Trauma due to immigration and refugee experience

Multiple community stakeholders gave examples of ways that concerns about a family member's legal immigration status or immigration experience contributing to stress and trauma. These issues were most often described in relation to the East African and Latino communities.

*A decision that people made to move, you know. America is a great country, getting the opportunity to come here is a very great one, but it comes with its own challenges. When you are new, don't speak the language, have many kids, don't have the support. All those are stressors. And we should not also forget they are coming already with the trauma of leaving their country, living in a refugee camp...*

*There are situations [when] the anxiety because of papers exists ... You are [treated as] less than a human being if you don't have a piece of paper that allows you to move within a society, and always being denied services because of that paper.*

## Moving forward

These community stakeholders brought unique perspectives about the health and wellbeing of children that reflected their experience working with specific cultural communities, in particular neighborhoods, or through key systems and institutions. Some spoke broadly to the needs of all children, while others focused their comments on the strengths, assets, and barriers facing children from a specific community. The interview questions asked stakeholders to speak directly about the impacts of trauma and the importance of culture in order to hear how Children's Minnesota and other institutions can foster the strengths and assets that exist within communities and address barriers to health and wellness. In multiple interviews, community stakeholders talked less about specific actions that organizations and institutions should take, but rather the importance of how the work is done. Disparities established and maintained through biased institutional policies and systemic racism will not be eliminated through the addition of a new program, but through changes in how institutions and systems fundamentally operate.

Community stakeholders were asked to identify one thing they think should be done and were asked, more specifically, how Children's Minnesota and their organization might partner to improve the health and wellness of children in the Twin Cities metro. Some of those interviewed talked about specific topics that should be addressed (i.e., mental health and trauma, obesity) and others talked about building relationships with community, providing

more information about Children’s Minnesota services to community members, and hiring staff that come from the cultural communities served at Children’s. Others mentioned systemic changes such as immigration reform, universal health care, and access to good education, health care, and food. One stakeholder noted that a problem in Minnesota is the time spent studying disparities and gaps between racial groups, rather than trying new things and trusting that communities will have the answers. Despite there being many different ideas for action, there were two key underlying themes that influence the way in which any future effort to support the health and wellbeing of children is approached:

- **Partnerships, collaboration, and information sharing**

Community stakeholders shared a variety of suggestions for how Children’s Minnesota might partner with their community or organization. Some suggestions included providing services and referrals; developing partnerships with schools, parks and recreation, clinics, and community organizations; and acting as an information resource in the neighborhoods they serve.

- **Community engagement and cultural understanding**

Several interviewees suggested Children’s Minnesota engage in community outreach by talking with family and care providers and hiring staff that represent the cultural communities served.

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# Clinician Perspectives on Child Health

*A summary prepared for the Children's Hospitals and Clinics of  
Minnesota 2016 Community Health Needs Assessment*

Prepared by: Wilder Research

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# Background and methods

As part of Children’s Hospitals and Clinics of Minnesota’s (“Children’s Minnesota”) Community Health Needs Assessment (CHNA), two different strategies were used to hear the perspectives of Children’s Minnesota clinicians and staff: an online survey administered to clinicians and discussion groups attended by a variety of staff. This summary includes key findings from both data collection strategies.

## About the clinician survey

The survey was sent to clinicians who work at the two hospital locations in Minneapolis and Saint Paul, nine of its affiliated primary care clinics (Brooklyn Park, Maple Grove, Minneapolis, Plymouth, Rogers, St. Louis Park, Saint Paul, Hugo, and West St. Paul), and specialty care clinics in the Twin Cities metro. The survey included questions about common health concerns among children and families they serve, barriers to health and wellness, and community assets, resources, and strengths. These survey results are one of multiple data collection strategies that Children’s Minnesota will use to better understand the health needs of community residents, community assets, barriers that influence health, and emerging health trends.

During June 2015, Wilder Research administered the online survey to clinicians using an individualized email invitation. Up to two reminders were sent via email, encouraging clinicians to participate. The survey was sent to 384 individuals and completed by 161, a response rate of 42 percent.<sup>1</sup> The overall response rate was higher than anticipated, suggesting high interest among clinicians in the assessment and in sharing what they learned through their experience working with children and families.

Children and families seeking care for an acute illness may talk to a clinician about very specific and time-sensitive needs during a medical appointment, but raise different concerns during an annual check-up with a primary care clinician or specialist treating a chronic condition. Because of these potential differences, some survey questions are also reported by practice setting (emergency department, inpatient hospital, primary care clinic, and specialty clinic).

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<sup>1</sup> Because Children’s Minnesota did not have individual emails for clinicians who work at three primary care clinics (Metropolitan Pediatric Specialists in Burnsville, Edina, and Shakopee), an open link was sent to clinic managers at these sites and they were asked to invite staff at the clinic location to participate. There were not any clinicians who completed the survey at these clinic sites using the open link option. Because it is not certain that clinicians did receive an invitation to complete a survey using this method, they are not included in the overall response rate.



## About the staff discussion groups

A series of four discussion groups were convened with Children’s Minnesota staff in June 2016. Three groups were hosted in Minneapolis and one in Saint Paul. In total, 34 staff who hold roles as social workers, interpreters, service coordinators, community health workers, and other positions participated in the discussions (Figure 1). These staff, many of whom share the same cultural background as the families they serve, work closely with children and families to access community resources and address barriers to health. Because of the roles they play, these staff are uniquely positioned to understand the needs of the children and families served by Children’s Minnesota and the resources available in the Twin Cities metro region.

During the discussion, Children’s Minnesota staff were asked to describe the resources, supports, and assets that families draw on to support the health and well-being of children, barriers that make it difficult for children to be healthy, ways culture is used as a resource to support health and wellness, and the impact of chronic stress, housing and financial insecurity, racism, and trauma on health. Discussion participants also had opportunities to offer their thoughts about emerging trends impacting the health of children and suggestions about changes that could be made to improve the health and wellness of children in the Twin Cities metro.

All discussions were recorded and notes were taken at each discussion. The recordings were used to refine the notes after the discussion. The data from the discussions were analyzed for key themes. This summary highlights the key findings from the discussion groups, using a sample of anonymous comments to illustrate important concepts.

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### 1. Staff role of discussion participants (N=34)

Role	N	%
Social worker	13	38%
Interpreter	7	21%
Service coordinator	3	9%
Community health worker	2	6%
Nurse	2	6%
Other	7	21%

Note. Due to rounding, percentages may equal more than 100%.

# Limitations

The results from the clinician survey are from a point in time assessment. In addition, while the response rate was higher than anticipated, we do not know how well the clinicians who responded represent the diversity of background, experience, and perspectives of all staff. None of the clinicians who work at Metropolitan Pediatric Specialists primary care clinics in Burnsville, Edina, and Shakopee completed the survey.

All Children's Minnesota employees who held roles as social workers, care coordinators, community health workers, and other similar positions were invited to participate in one of the conversations. The staff who participated held a number of different roles and professional experiences. However, it is important to note that staff who participated in the discussions were selected through a convenience sample and may not fully represent the diverse perspectives and experiences of all Children's Minnesota staff. In addition, the participant impressions of community concerns and priorities are reflective of their experience working with children and their families, but may not accurately or comprehensively describe the lived experience of children and families of a specific cultural group.

The discussion groups were held with staff from the Minneapolis and Saint Paul clinics. Therefore, the perspectives of staff practicing at suburban primary care clinic locations (Burnsville, Brooklyn Park, Edina, Maple Grove, Plymouth, Shakopee, St. Louis Park, and Rogers) are under-represented. Topics that may be higher priorities for children and families in these suburban communities may be underrepresented in the summary.

# Clinician survey key findings

Key findings from the clinician survey are highlighted in this section of the report. The Appendix includes all data tables and the open-ended responses provided by survey respondents. Stakeholders reviewing this summary are encouraged to refer to the Appendix for more details about the barriers and community assets that influence health and clinicians' suggestions for changes to better support the health and well-being of children and families.

## Respondents' characteristics

Most respondents are experienced professionals who identified as female, white, and either a physician or nurse practitioner. However, because we do not have demographic information or other descriptive data for all clinicians, it is not known whether the survey respondents are a representative sample of all Children's Minnesota clinicians.

The survey respondents shared the following personal and professional characteristics:

- **Three-quarters of respondents (75%) identified as female.** Twenty-two percent identified as male.
- **Most respondents identified as white (87%).** Fewer identified as Asian (6%), black or African American (1%), Hispanic or Latino (1%), Hawaiian or Pacific Islander (1%), or as another race or ethnic group (1%). No respondents identified as African native or American Indian/Native American.
- **Most respondents identified as a physician (46%) or nurse practitioner (35%).** Fewer identified as a psychologist (11%), clinic manager (5%), advanced practice registered nurse (1%), or psychiatrist (1%).
- **A majority of respondents (66%) reported practicing medicine for 11 or more years.** Twenty-one percent indicated practicing for 1-5 years and 14 percent have been practicing 6-10 years.
- **A majority of respondents work in specialty clinic care (42%) or primary care (29%).** Just under one-third work in an emergency department (18%) or inpatient hospital (12%).
- **Just under half of respondents (45%) primarily practice in Minneapolis.** One-third (34%) practice in Saint Paul proper and 14 percent practice in suburban communities including West St. Paul. Six percent work in other locations.

- **Most respondents reported working with children and youth of multiple ages.** More than 80 percent of clinicians worked with adolescents (age 12-17; 93%), school-age children (age 6-11; 88%), and young children (age 0-5; 86%). Fewer indicated working with young adults (age 18 or older; 58%).

## Community assets, resources, and strengths

Roughly one-quarter (24%) of respondents reported that community and cultural resources (including health-promotion resources/services, formal/informal supports, and other community and cultural strengths) are “always or very often” part of their conversations with patients or caregivers about health and wellness. Over half (56%) indicated that they “sometimes” discuss community and cultural resources and 18 percent reported “rarely or never” talking about community and cultural resources with their patients.

Based on their conversations with patients and their families, respondents were asked to list up to three key community, cultural, or interpersonal resources that are critical for supporting the health and well-being of children. They noted the following:

- **Supportive community organization or groups.** Respondents noted several organizations and groups that work to support the health and well-being of children and their families such as Big Brothers Big Sisters, CLUES, the Courage Center, the Family Partnership, the PACER Center, Tubman, Vida Sana, YMCA, faith communities, libraries, community centers, and public resources such as WIC.
- **School, education, or child care resources.** Respondents highlighted the importance of good schools, affordable daycare, and resources to support education.
- **Health care and health resources, specifically in the areas of mental health and development.** Similar to other open-ended responses, respondents pointed out the need for increased access to health care, improved insurance coverage, and more mental health support and developmental screening.
- **Healthy food, physical activity resources, and transportation.** Respondents indicated that children and their families need increased access to affordable healthy food, physical activity resources (e.g., sports or weight loss programs), and transportation, especially for getting to medical appointments.
- **Family and parent support resources.** Respondents reported that family and connections with adults are important to the health of children. They noted a need for more resources and support groups or networks for parents.

- **Culturally responsive services.** Respondents underscored the importance of having culturally appropriate services and supports by ensuring access to interpreters, engaging social workers and therapists with specific cultural knowledge, having traditional medicines, and ensuring that clinicians have knowledge about common cultural beliefs and practices.

## Common health concerns

**Over three-quarters of respondents reported that mental health/social-emotional development, nutrition, overweight/obesity, disease management, sleep, and infectious diseases/acute illness are “frequently” or “sometimes” identified as major health concerns among patients or caregivers in their practice.** Looking more closely only at how often topics are “frequently” discussed is one way to further explore which health issues are most often brought to the attention of clinicians:

- Seven in ten (70%) indicated that mental health/social-emotional development is “frequently” identified as a major health concern.
- Over half reported that patients and caregivers “frequently” identified disease management (57%), nutrition/healthy eating (56%), and infectious diseases or acute illness (55%) as major health concerns.
- Just under half indicated that overweight/obesity (49%) and sleep (46%) are “frequently” identified as major health concerns.
- Fewer (15-16%) reported that dental care, alcohol/drug use, violence (assault, neglect), and reproductive health are “frequently” identified as major health concerns.

## *Comparisons by practice setting*

**A majority of respondents who primarily practice in specialty clinic care, primary care, an emergency department, or an inpatient hospital reported that mental health/social-emotional development is “frequently” identified as a major health concern among patients or caregivers.** However, there are differences in how often other types of health concerns are brought to the attention of clinicians in an emergency department or inpatient hospital compared with a primary or specialty clinic care setting. Most notably, respondents from primary or specialty clinic care were more likely to indicate that nutrition, overweight/obesity, and sleep are “frequently” identified as a major health concern compared to those who practice in an emergency department or inpatient hospital.

- **Mental health/social-emotional development:** Respondents who practice in specialty clinic care, primary care, emergency department, or inpatient hospital were all

likely to report (72%, 71%, 69%, and 56%, respectively) that mental health/social-emotional development is “frequently” identified as a major health concern.

- **Nutrition:** Respondents who practice in primary care or specialty clinic care were more likely to report (78% and 70%, respectively) that nutrition/healthy eating is “frequently” identified as a major health concern compared to those who practice in an inpatient hospital or emergency department (27% and 25%, respectively).
- **Overweight/obesity:** Respondents who practice in primary care or specialty clinic care were more likely to report (68% and 53%, respectively) that overweight/obesity is “frequently” identified as a major health concern compared to those who practice in an emergency department or inpatient hospital (48% and 20%, respectively).
- **Sleep:** Respondents who practice in specialty clinic care or in primary care were more likely to report (74% and 51%, respectively) that sleep is “frequently” mentioned as a major health concern compared to those who practice in an inpatient hospital or emergency department (14% and 9%, respectively).
- **Disease management:** Respondents who practice in an emergency department, inpatient hospital, or primary care were more likely to report (89%, 71%, and 60%, respectively) that disease management (asthma and diabetes) is “frequently” identified as a major health concern compared to those who practice in specialty clinic care (39%).
- **Infectious disease:** Respondents who practice in an emergency department, inpatient hospital, or primary care were more likely to report (96%, 80%, and 73%, respectively) that infectious disease/acute illness is “frequently” identified as a major health concern compared to those who practice in specialty clinic care (20%).
- **Alcohol/drug use:** Respondents who practice in an emergency department or inpatient hospital were more likely to report (27% and 21%, respectively) that alcohol/drug use is “frequently” mentioned as a major health concern compared to those who practice in specialty clinic care or in primary care (13% and 7%, respectively).
- **Dental care:** Respondents who practice in primary care were more likely to report (28%) that dental care is “frequently” mentioned as a major health concern compared to those who practice in an emergency department, specialty clinic care, or inpatient hospital (15%, 12%, and 8%, respectively).
- **Violence or safety:** Respondents who practice in an emergency department or inpatient hospital were more likely to report (27% and 20%, respectively) that violence or safety is “frequently” mentioned as a major health concern compared to those who practice in a specialty clinic care or primary care (15% and 13%, respectively).

- **Reproductive health:** Respondents who practice in primary care, specialty clinic care, or an inpatient hospital were more likely to report (20%, 15%, and 15%, respectively) that reproductive health is a major health concern compared to those who practice in an emergency department (8%).

### ***Other noted health concerns***

Additional patient concerns most often brought to the attention of clinicians included patients' challenges addressing their basic needs and accessing health care. Respondents noted poverty, lack of housing, and other issues that impact family stability, like toxic stress, as concerns that youth and caregivers brought to their attention during appointments. They also highlighted the cost of health care, limited insurance coverage, and lack of access to primary and mental health care and medication.

Other common concerns included academic struggles and cognitive development; specific mental health issues such as eating disorders, anxiety, and suicide; developmental issues; parenting skills and support; lack of health literacy and language barriers; dermatological issues; and chronic medical conditions and acute illness.

### **Emerging issues or trends impacting the health and well-being of children**

#### **The most commonly identified emerging trends or issues were related to mental health, barriers to accessing care, poor nutrition, and limited physical activity.**

Most respondents who identified mental health as a key trend or emerging issue described concerns about limited mental health services without providing specific details. Those who did provide more detailed responses mentioned limited mental health resources in terms of specific treatment services (e.g., diagnostic assessment and therapy, hospitalization, day treatment, and crisis stabilization) and staff capacity (e.g., psychiatry, behavioral health specialists, and psychologists). Some respondents noted the prevalence of specific mental health disorders such as maternal depression, eating disorders, anxiety, mood disorders, and suicidal thoughts. A few referenced development concerns and focused on early detection and assessment of developmental issues. Respondents also reported barriers to accessing primary and preventative care, such as cost, lack of insurance coverage, and issues with transportation. In addition, they highlighted obesity and overweight issues stemming from a lack of nutrition and physical activity. Some noted the importance of having more opportunities and spaces for exercise and play.

Other common issues or trends included the use of social media and technology and its impact on health, well-being, and social connections; the importance of fostering culturally responsive health care through multiculturalism, training, and education for clinicians; drug

use among parents and youth; a decrease in the rate of vaccinations and concerns among some parents regarding immunizations; lack of supportive family or parents; and poverty.

## Barriers to health and wellness

**Over one-third of respondents (35%) reported that barriers to health and wellness (including barriers to accessing health care services) are “always/very often” part of the conversation they have with patients or their caregivers.** Fifty-three percent indicated that they “sometimes” have a conversation about barriers and 9 percent reported that the “rarely/never” have a conversation about barriers impacting health.

**Of those who reported barriers, over three-quarters of respondents indicated that poverty, chronic stress, high health care costs, limited transportation, housing, and quality of living conditions are a “major” or “somewhat” of a barrier to the health and wellness of children based on conversations they have had with patients.**

- A majority reported that poverty (53%) and chronic stress (51%) are “major” barriers to the health and wellness of children.
- Over one-third indicated that high health care costs (48%), limited reliable transportation options (40%), and housing instability/difficulty accessing affordable housing (34%) are “major” barriers to the health and wellness of children.
- One-quarter or more reported that quality of living conditions (28%), trauma, including historical trauma (27%), and limited access to affordable, healthy foods in neighborhoods (25%) are “major” barriers to the health and wellness of children.
- Roughly 20 percent indicated that inadequate school resources/opportunities for quality education (23%), lack of health insurance (23%), limited employment options (20%), and racism, prejudice, hate, and discrimination (including both individual systemic/structural experiences; 20%) are “major” barriers to the health and wellness of children.
- Over 10 percent reported that limited access to parks, recreation centers, and other places to exercise (17%), crime and community violence (17%), and environmental conditions, including air quality (11%) are “major” barriers to the health and wellness of children.
- Few (4-5%) indicated that pedestrian and bicyclist safety, traffic safety, and neighborhood police presence were a “major” barrier; however, around one-third or more (31-45%) also reported not knowing or being unsure about these barriers.



**When asked to identify any additional issues that are major barriers to children’s health, the most commonly reported issues included access to care, family dynamics, and lack of language support and understanding of cultural differences among clinicians and staff.** Respondents shared that accessing services can be difficult for caregivers who are unable to take time off work to care for their children or have busy schedules. They also pointed out issues accessing primary, mental, and in-home care, including transportation challenges (e.g., parking is too expensive or busing takes too long). Some clinicians noted difficult family dynamics that impact engagement in the child’s health services, such as when parents are incarcerated or using drugs. In addition, respondents indicated that caregivers and children need services and supports provided in their preferred language. One respondent also noted that clinicians have unexamined white privilege and implicit biases. A few respondents highlighted that some parents have limited knowledge or understanding of medical conditions and health.

### ***Comparisons by practice setting***

**Based on the type of setting respondents primarily practice in, there are some notable differences regarding what they identified as “major” barriers to the health and wellness of children.** For example, those who practice in primary and specialty clinic care were more likely to report that poverty and chronic stress are “major barriers,” while those who practice in an inpatient hospital were more likely to report that transportation and housing are “major barriers.” High health care costs were reported as a “major barrier” more often among those who practice in specialty care or an inpatient hospital.

- **Poverty:** Respondents who practice in primary care, specialty clinic care, or an emergency department were more likely to report (60%, 58%, and 50%, respectively) that poverty is a “major barrier” to the health and wellness of children compared to those who practice in an inpatient hospital (42%).
- **Chronic stress:** Respondents who practice in specialty clinic care, primary care, or an inpatient hospital were more likely to report (63%, 58%, and 55%, respectively) that chronic stress is a “major barrier” to the health and wellness of children compared to those who practice in an emergency department (32%).
- **High health care costs:** Respondents who practice in specialty care or an inpatient hospital were more likely to report (59% and 50%, respectively) that high health care costs are a “major barrier” to the health and wellness of children compared to those who practice in primary care or an emergency department (43% and 36%, respectively).
- **Housing:** Respondents who practice in an inpatient hospital were more likely to report (50%) that housing instability/difficulty accessing affordable housing is a “major barrier”

to the health and wellness of children compared to those who practice in an emergency department or primary care or (38% each) or specialty clinic care (29%).

- **Transportation:** Respondents who practice in an inpatient hospital were more likely to report (67%) that limited reliable transportation options are a “major barrier” to the health and wellness of children compared to those who practice in an emergency department, primary care, or specialty clinic care (41%, 39%, and 33%, respectively).
- **Living conditions:** Respondents who practice in an inpatient hospital or primary care were more likely to report (42% and 36%, respectively) that quality of living conditions are a “major barrier” to the health and wellness of children compared to those who practice in an emergency department or specialty care clinic (29% and 21%, respectively).
- **Trauma:** Respondents who practice in specialty or primary care were more likely to report (38% and 30%, respectively) that trauma, including historical trauma, is a “major barrier” to the health and wellness of children compared to those who practice in an inpatient hospital or emergency department (18% and 10%, respectively).
- **Healthy food:** Respondents who practice in primary care, specialty clinic care, or an inpatient hospital were more likely to report (36%, 31%, and 27%, respectively) that limited access to affordable, healthy foods is a “major barrier” to the health and wellness of children compared to those who practice in an emergency department (6%).
- **Schools:** Respondents who practice in specialty or primary care were more likely to report (33% and 26%, respectively) that inadequate school resources/opportunities for quality education are a “major barrier” to the health and wellness of children compared to those who practice in an inpatient hospital or emergency department (13% and 7%, respectively).
- **Health insurance:** Respondents who practice in an inpatient hospital or specialty clinic care were more likely to report (33% and 28%, respectively) that lack of health insurance is a “major barrier” to the health and wellness of children compared to those who practice in primary care or an emergency department (19% each).
- **Racism:** Respondents who practice in an inpatient hospital, specialty clinic care, or primary care were more likely to report (40%, 27%, and 24%, respectively) that racism, prejudice, hate, discrimination (including both individual and systemic/structural experiences) is a “major barrier” to the health and wellness of children compared to those who practice in an emergency department (11%).

## Potential implementation strategies

Respondents were asked to share one change that they would like to see that would improve the health and wellness of children in the Twin Cities metro.

**When asked to share an idea for a change that could be made to improve the health and well-being of children, the most commonly noted suggestion related to mental health.** A number of clinicians wanted to see increased capacity and accessibility of mental health resources such as access to psychiatric care, day treatment and inpatient care, behavioral health specialists, psychologists, and clinicians with a trauma focus. Respondents also highlighted the need to improve school lunches and nutrition programs, strengthen partnerships between schools and Children’s Minnesota, and host dental and other health care services at schools. In addition, they noted a need for community centers with on-site health care clinicians, improved parent education about health, free options for children to get exercise, inexpensive transportation options for families, and stronger support for families following hospitalization to manage medication and care.

Respondents were also asked what community resources, assets, and strengths, if any, they would like to know more about in order to better support patients and their families. They want more information on:

- **Resources to assist people with different health and human service needs**, such as community health workers, patient family liaisons, physical activity options for children, obesity and nutrition programs, density care, respite care, and transition resources for young adults.
- **Mental health resources**, specifically psychiatric care, community psychology, early childhood development, early childhood and mental health resources for immigrants, and mental health facilities for adolescents.
- **Affordable options for supporting health and well-being**, for example, low-cost gyms or outdoor activities, free community resources that support children’s speech, language, and learning, affordable daycare, and subsidized transportation.
- **Parenting support**, such as parenting classes, support groups, and teaching parents specific skills or topics like cooking and sleep hygiene.
- **Resources to help children and families meet their basic needs**, particularly housing support, food assistance, and help with employment.

# Discussion group key themes

## How do families and patients describe what it means for children to feel healthy?

Children's Minnesota staff who took part in the discussions shared that they hear patients and families feel kids are healthy when they:

- Achieve academic success, function in school without being suspended, and engage in extra-curricular activities.
- Have access to affordable fresh fruit and vegetables.
- Experience safe neighborhoods.
- Have stable and connected families.
- Have parents or caregivers who understand how to access preventive care and how to meet the health needs of newborns.
- Do not have to see a health care clinician or take medicine to address an acute illness.

Some staff commented that assessments of health and well-being are highly influenced by a child's current health and contextualized by a family's cultural background and family values. For example, a staff member highlighted that Mexican and Latino families view a healthy baby as one that is chubby and that some mothers supplement breast milk with formula to ensure their baby gains weight. Staff also pointed out that good health or well-being for a child with chronic or special needs may mean stabilizing their condition or having them maximize their time at home with their family.

*Most parents just want to see their kids happy and healthy and being together.*

*Some of the families that I see, they want to get through the current crisis that they are in.*

*Some families that have kids that have chronic special needs, their idea of healthy is a lot different than the model Gerber baby.*

*Somali and Hmong families want [their kids] to be healthy, to eat, to be normal. They want the best for their child.*

*Generally what parents and grandparents think of is physical health. I don't think mental health is addressed.*

## What resources, supports, and assets do families use to support the health and well-being of their children?

**A number of respondents shared that many of the Latino, Somali, American Indian, and Hmong families who they work with rely on their community and relatives for support.** Several respondents said that family and community connections were important support systems among the Latino, Somali, American Indian, and Hmong families they support. Without family support, caregivers can struggle because many are working in lower wage jobs and cannot afford to purchase day care.<sup>2</sup> Respondents reported that across cultural communities, faith communities and cultural practices also play important roles in supporting the health and well-being of children. Two respondents noted that some members of the Latino community use traditional herbal medicines and healing techniques.

*In the Spanish community the family support is really strong.*

*With our Latino families, we have a mix of those who have extended family supports and some are isolated. There's a strong network in community with each other and that's a resource they use sometimes. They rely a lot on word of mouth and people's experience.*

*With American Indians, the family comes [to health appointments] and there's that family support. With Hispanic and Hmong there's also family support.*

*We try to connect people to places for preventive [support]. We connect them to libraries, gyms, community centers.*

*There are some families that have social support and some families are dependent on any assistance that [Children's Minnesota] can provide.*

**Respondents reported that many families they work with are unaware of, or have difficulty accessing, programs and services that support health.** Examples of these resources include: energy assistance, services available for children or family members with disabilities, asylum application assistance for refugees or immigrants, and preventive health care services. One respondent shared that for some families there are language barriers and challenges with literacy when families attempt to fill out paperwork or applications for public programs. Two respondents noted that it is difficult to connect families to resources and supports when their attention is focused on receiving treatment for acute illnesses or other health issues. Staff also work with Children's Minnesota social workers to help families connect to resources.

*When [families] are not accessing the community resources, they're making things work and using resources like their elders, other family members, or church. I do see some families who are isolated, but I also see some who know about more resources than I do.*

<sup>2</sup> This comment was made by a staff member who worked primarily with Latino families, but the observation may apply to other cultural communities.

## What key barriers make it difficult for children to be healthy?

Respondents noted a number of barriers that make it hard for children to be healthy. While barriers to health are very individualized and influenced by broader cultural, economic, and social factors, some of the commonly mentioned barriers included:

- **Immigration status.** Undocumented parents experience anxiety and other mental health issues that can make it difficult for them to care for their children.
- **Access to preventive or mental health care.** Some parents want to take their children for well- or sick-care visits but cannot get appointments at Children’s Minnesota clinics. One respondent pointed out that many clinics’ hours of operation do not fit the schedules of working parents who cannot leave work for their child’s appointment. Some parents are unaware of minute clinics and urgent care clinics that have longer hours and more flexible scheduling. Respondents also described a lack of mental health care services, an unclear process for referring children to mental health services, and that these services require a long wait.
- **Limited affordable transportation options.** The respondents noted challenges accessing transportation to attend medical appointments, particularly for parents who have multiple young children.
- **Lack of affordable housing.** Some families move frequently, which makes it difficult for them to access home health care or the Help Me Grow program. One respondent noted that securing affordable housing for members of the Latino community is particularly difficult, but time was not spent during the discussion to further explore this statement and ways that housing concerns may be similar or unique across cultural communities. Respondents also underscored the negative impact substandard housing has on children’s health, such as mold exacerbating asthma symptoms.
- **Limited information on healthy eating.** The respondents saw soda and sugary fruit juices as popular beverages among families they work with, particularly among Latino families. They noted that, when not consumed in moderation, these beverages can contribute to diabetes. Respondents in the Saint Paul discussion group suggested expanding access to Vida Sana, a Children’s Minnesota program focused on eating healthy and supporting wellness, as a way to address this barrier.
- **Lack of support for immigrants’ and refugees’ native language.** The respondents reported that Children’s Minnesota is limited in the language support it can provide to immigrants and refugees to help them access information about health or social support services.

- **Lack of public financial support.** The respondents felt that there is limited public support for families with a newborn, illness, or disability and lack of support for affordable day care.
- **Other systems barriers.** Some of the barriers identified are much broader system barriers. For example, one respondent noted that there are not services in place that help children (and their families) if they do not meet early intervention criteria. Another noted that clinicians will make an assumption that families can afford to buy the things recommended by the physician or that insurance will cover the things needed to support the child's health.

### How is culture used as a resource to support health and wellness?

Across all focus groups, respondents had difficulty identifying or sharing specific examples of how culture is used as a resource to support health. Instead, they shared ways that Children's Minnesota integrates culture into its work. This may reflect an opportunity for Children's Minnesota to work more closely with staff to help them understand how culture is an asset for health and wellness, and share examples of how culture is used by children and families.

#### *Engaging interpreters and cultural liaisons to work with children and families*

**Several respondents shared that Children's Minnesota has been able to support the health and wellness of children and families by having interpreters and cultural liaisons on staff.** One example offered during the discussion was of the American Indian Community Liaison, who helps connect families to clinicians and is a trusted contact for the community. One respondent felt that Spanish language interpreters are good at making families feel comfortable and helping increase their trust in the health care system. Cultural liaisons or interpreters can also explain the significance of certain prayers or spiritual practices to health care clinicians, helping them find ways to better bridge Western medicine and cultural beliefs. Another respondent observed that families feel more connected to the Children's Minnesota system when they are able to interact with other families who share the same cultural background, noting this has been particularly important for Karen families.

*I think over the last few years, we have had a liaison that has been helpful for us. We have interpreters who are helpful. Some families don't feel like they can share what is going on at home for one reason or another. They don't know if they can trust the health care system.*

*I think interpreters are helpful when they bridge the cultural gap. We do a lot of that, to the extent we are able. [Patients] get the interpretation services because when [they] don't have a voice in their own language, it is hard for them. They need to be heard in their own voices.*

*Part of culture is language and way of life. So, I think having people from [a patient's] own culture is important. We're seeing a lot more of dual roles of patient advocate and navigator, or service coordinator.*

## ***Expanding cultural knowledge among Children's Minnesota clinicians***

**Respondents noted that Children's Minnesota clinicians are deepening their understanding of cultural practices and beliefs to inform their practice.** One respondent felt that Children's Minnesota pediatricians make an effort to understand the cultures of the different groups they serve. Another respondent reported that when staff are admitting children for inpatient care, the nurse will ask if there are any culturally specific needs they have regarding receiving health care. The respondent felt that this practice should be extended to care at primary and specialty care clinics as well. Respondents also indicated that more could be done to support cultural groups and increase clinicians' knowledge. Some suggested strategies included hosting support or discussion groups for families of different cultural groups or having Children's Minnesota do a better job of documenting and sharing the experiences of different groups receiving care. One respondent shared that the Somali health resource group will provide peer education about health and cultural resources to aid Children's Minnesota staff in providing more culturally appropriate care.

*There is a need [for Children's Minnesota] to be more present in communities and meet people where they are at.*

*Families comes in with fear and anxiety. [We need] to take into account their culture [and where] they are coming from.*

*Our families are huge resources of cultural knowledge, and being a woman of European heritage, I'm disconnected from my own cultural group and that makes it hard for me to see how other people have these deep connections that likely influence how they view health.*

*Children's Minnesota makes a good faith effort to understand different populations. Our pediatricians have a higher level of interest and concern about the populations they serve than clinic staff.*

*We need to get to the point to where we step back and look at the families and cultures as a whole. Sometimes [Children's Minnesota staff] are afraid of the unknown.*

**Respondents also recognized that Children's Minnesota could be more culturally responsive and address racial disparities in serving patients.** Some respondents shared examples of personal interactions and observations to highlight a need for ongoing efforts in order for the organization to work effectively with all cultural communities and reduce disparities. A few respondents from the Saint Paul discussion felt that some Children's Minnesota clinicians display racially biased attitudes when they do not take the time to engage with interpreters or connect families to interpreters, instead expecting that patients should be able to speak English. One respondent from a Minneapolis discussion



highlighted an internal study done by Children’s Minnesota that found that children of color with long-bone fractures experienced longer wait times compared to white children.

## What is the impact of chronic stress, housing and financial insecurity, racism, and trauma on the health and wellness of children and families?

**Respondents highlighted that when families cannot meet their basic needs, their health and wellness suffers.** They reported that families who they work with experience a number of problems such as homelessness, limited access to food, lack of transportation, and chronic poverty. These pervasive issues can contribute to stress, impact physical and mental health, and act as barriers to families receiving health care. Another respondent mentioned that the inability of families to meet their basic needs is magnified for immigrants who are experiencing poverty, attempting to learn how the social service and health care systems function, and, if they are undocumented, are at risk of deportation. A few respondents also reported that some children and families experience trauma through domestic and sexual abuse and do not have access to the appropriate mental health care to address these issues. Other respondents underscored the need for greater support for parents who are experiencing issues that lead to their children being removed and placed in foster care.

*Deportation of family members. We have a lot of families where one or both parents are deported.*

*A lot of families I see have dealt with generations of trauma.*

*I see a lot of domestic violence and community violence that kids have been exposed to. It is difficult for families to deal with.*

*If [a patient] doesn’t know where [they’re] going to sleep tonight or if [they are] not going to have any food, chronic illness doesn’t matter.*

*It kind of goes into the social determinants of health. When you look at the home environment a [family] is in and realize that they need other help and other resources. We need to focus on what is causing the problem, which is not always medical.*

## What are some of the emerging trends impacting the health and wellness of children?

Respondents noted a number of emerging trends impacting the health and wellness of children. The most commonly mentioned trends included:

- **Increasing health information and care navigation resources available to families and parents.** Respondents underscored the need to work with families to help them understand the health needs and options for their children. One respondent felt that preventive care offers an important opportunity to work with families on deepening their understanding of prevention and the support Children’s Minnesota can

offer. Another respondent shared that it would be beneficial to give families an orientation to how Children's Minnesota functions and the role it can play in their lives.

- **Addressing mental health needs and limited availability of care.** Respondents reported that families are focusing more on mental health needs. One respondent felt that society is becoming more accepting of discussing and treating mental health. Respondents shared that while health insurance companies are increasingly covering mental health care, Children's Minnesota has a lack of inpatient services and psychiatric care.
- **Increasing coordination of care between health care systems and schools.** Respondents indicated that Children's Minnesota is starting to address the silos between schools, hospitals, and homes, and is focusing on strengthening coordination of care. One respondent noted that some schools have strong wraparound services and concentrate on early intervention, which is helping identify behavioral health issues.

Other trends identified by individual respondents included: a need for affordable transportation and housing options; increase in children's use of technology, which has led to a decrease in physical activity; more children exposed to drugs during the prenatal phase; limited access to primary care; lack of home care; and an increased focus on addressing obesity among clinicians and families.

## What changes would improve the health and wellness of children in the Twin Cities metro?

Respondents noted multiple changes to improve the health and wellness of children in the Twin Cities metro. The most commonly mentioned changes included:

- **Building on Children's Minnesota's involvement in the community.** Respondents highlighted that Children's Minnesota has the opportunity to work more closely with families and communities by supporting efforts such as urban gardening and focusing on building children's habits around healthy eating and physical activity. One respondent pointed out the positive role Children's Minnesota plays in Open Streets events and other local celebrations. Another respondent shared that Children's Minnesota could do a better job of engaging the community to build trust and connections.
- **Increasing connections to the cultural communities served by Children's Minnesota.** Respondents shared that Children's Minnesota should improve its outreach to families of color and integrate their voices into informing its work. One respondent felt that those in leadership positions and charged with making decisions that impact the Children's Minnesota system are not representative of the communities that are served. Another respondent identified the success of the American Indian Advisory Council, a

body that brings together Children’s Minnesota and American Indian leadership to discuss issues and how to improve Children’s Minnesota’s work.

- **Enhancing mental health care.** Respondents suggested improvements to mental health care including providing stabilization services (i.e., an in-home follow-up a few weeks after an assessment and intervention to check on a patient’s status), having “walk-in” services for mental health, reducing the waitlist for mental health services, and working more closely with community-based resources and organizations to support mental health.
- **Providing more education and support for parents and families.** Respondents reported that parents could benefit from more programs and groups that focus on the importance of children’s healthy eating and physical activity and support groups for parents who have children with special needs.

**Other changes individually identified by respondents include:**

- Having affordable extra-curricular activities available in the community.
- Increasing access to affordable housing.
- Increasing multi-lingual resources for families that do not speak English.
- Supporting the health of parents.
- Having more outpatient services available during evening times.
- Helping patients transition to adult clinicians and other providers when they turn 18.
- Making it easier for Children’s Minnesota staff to provide in-home care to families.
- Having more homecare nurses.
- Recruiting more Somali, African American, and Latino nurses.
- Supporting more collaboration within Children’s Minnesota, specifically across the hospital departments.
- Establishing more partnerships between Children’s Minnesota and crisis teams in the community.