Community health needs assessment

2013

Prepared for Children's Hospitals and Clinics of Minnesota by Verité Healthcare Consulting, LLC

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Introduction to the CHNA process

Children's Hospitals and Clinics of Minnesota[1] (Children's) undertook the following Community Health Needs Assessment (CHNA) to better understand the health needs in local communities and to inform an effective implementation strategy to address the priority needs. This CHNA also responds to community benefit regulatory requirements.

Federal regulations require that tax-exempt hospitals provide and report community benefits to demonstrate that they merit exemption from taxation. As specified in the instructions to IRS Form 990, Schedule H, community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs.

Community benefit activities or programs seek to achieve certain objectives, including:

- improving access to health services,
- enhancing public health,
- advancing increased general knowledge, and
- relief of a government burden to improve health.[2]

To be reported as a community benefit, community need for the activity or program must be established. Conducting a CHNA is one method for establishing the community need.

The 2010 Patient Protection and Affordable Care Act (PPACA) requires each tax-exempt hospital to "conduct a [CHNA] every three years and adopt an implementation strategy to meet the community health needs identified through such assessment."[3]

CHNAs seek to identify priority health status and access issues for particular geographic areas and populations by focusing on the following questions:

- ***Who*** in the community is most vulnerable in terms of health status or access to care?
- ***What*** are the unique health status and/or access needs for these populations?
- ***Where*** do these people live in the community?
- ***Why*** are these problems present?

Priority needs are identified regardless of a hospital's ability to address such needs; hospitals are not required to address all the needs identified in the CHNA. The question of ***how*** the organization can best use its limited resources to respond to priority needs will be addressed in a separate document.

This assessment considers multiple data sources regarding the health needs of the community served by Children's, including secondary data, assessments prepared by other organizations in recent years, and primary data derived from interviews with persons who represent the broad interests of the community, including those with expertise in public health.

1 Children's Hospitals and Clinics of Minnesota operates two hospital campuses, located in Minneapolis and St. Paul, which are licensed as a single hospital facility. Throughout the report, the campuses are referred to as one hospital.
2 Instructions for IRS Form 990, Schedule H, 2012.
3 Patient Protection and Affordable Care Act.

The following topics and data are assessed in this report:

- Demographics, e.g., numbers and locations of vulnerable children;
- Economic issues that affect children, e.g., poverty and unemployment rates, and impacts of state or local budget changes;
- Community issues, e.g., homelessness, housing, environmental concerns, crime, and availability of social services;
- Health status indicators, e.g. morbidity rates for various diseases and conditions, and mortality rates for leading causes of death;
- Health access indicators, e.g., uninsurance rates, discharges for ambulatory care sensitive conditions (ACSC), and use of emergency departments for non-emergent care;
- Health disparities indicators; and
- Availability of healthcare facilities and resources.

The assessment identifies a prioritized list of community health needs. Children's will prepare an Implementation Strategy that responds to the issues identified in this assessment.

Executive summary

Children's is one of the largest freestanding pediatric health care systems in the U.S., with hospitals in St. Paul and Minneapolis as well as 12 clinic sites and a number of ambulatory locations in the surrounding suburbs. Children's is a statewide and regional resource, providing a broad spectrum of pediatric services throughout the Upper Midwest.

For purposes of having a clearly defined geographic boundary and consistency with accepted approaches to CHNAs, this assessment focuses on the needs of the seven-county area surrounding the Minneapolis and St. Paul hospital campuses. Throughout the assessment, the community being assessed will be described as the "immediate community," composed of 42 ZIP codes in five school districts around the Children's hospital campuses . The "broader community" is comprised of the seven-county metro area.

The broader community benchmarks favorably on a number of health indicators compared to national and Minnesota averages. However, there are health status and access problems and this assessment seeks to identify the most pressing issues regarding the wellbeing of children.

Social and economic factors, including income, education, race and/or ethnicity, and local environment play a significant role in a child's health. Among children, racial and ethnic minorities, and those with complex needs are more likely to lack the social and economic resources necessary to maintain optimal health. Such inequalities can create barriers to access (to health services, employment, quality education, healthy food, housing, and other necessities and opportunities) and thus contribute to poor health. Analysis of primary and secondary data reveals problematic health disparities in both the immediate and broader community.

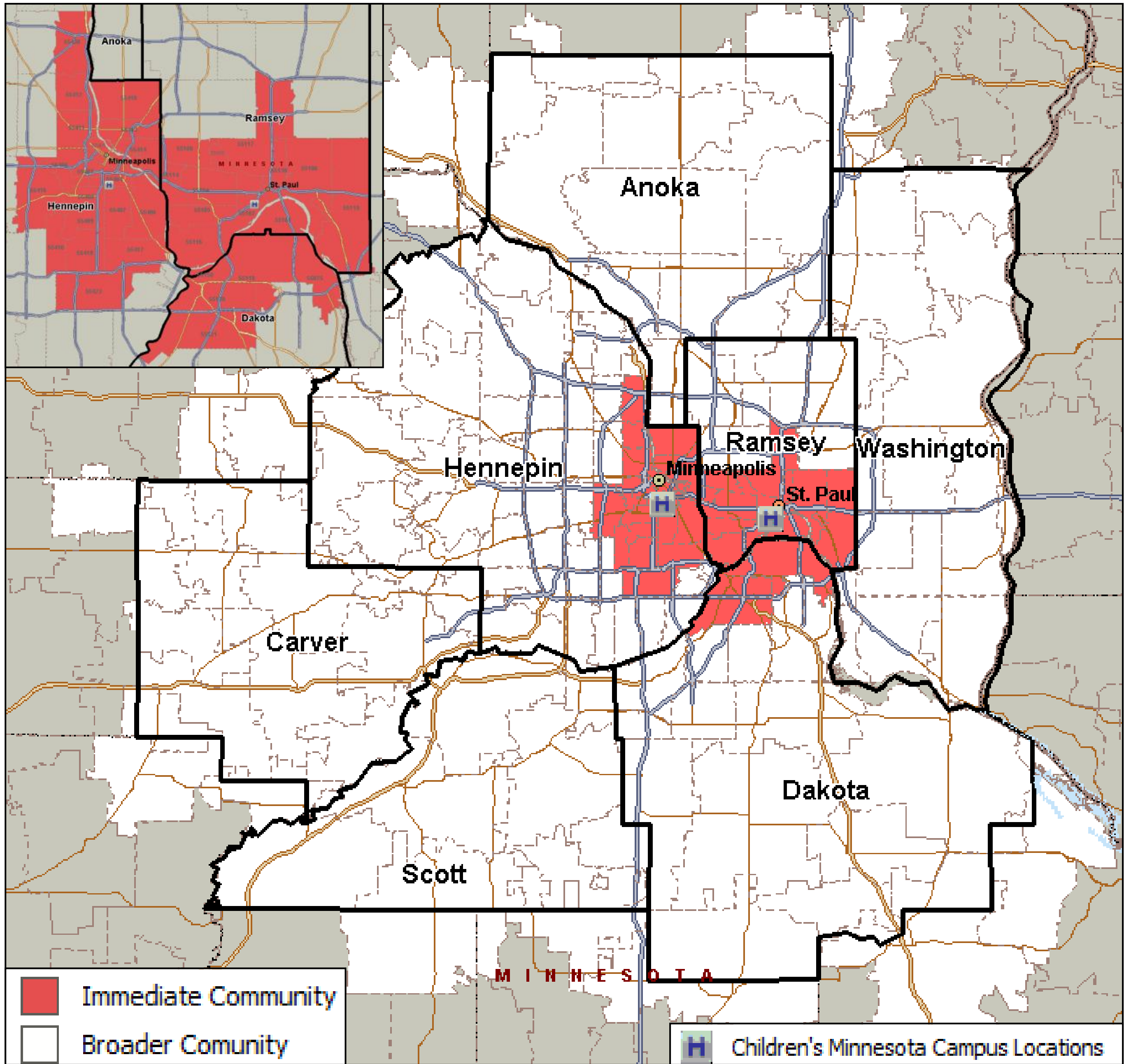
Geographically, the greatest socio-economic need and poorest health status is found in Minneapolis and St. Paul and certain low-income, less populous areas on the outer edge of the broader community.

The following is a brief portrait of community health in the seven county metro area.

Children's community by the numbers

- 42 ZIP codes in the immediate community in five school districts: Minneapolis, St. Paul, South St. Paul, Richfield, and West St. Paul—Mendota Heights—Eagan
- Broader community encompasses seven counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington
- Estimated pediatric population (2011): 192,325
- 6.9% of total hospital discharges within this area were for pediatric ambulatory care sensitive conditions
- Projected population change (2011-2016):
  - Growth of 3.2% overall; 4.0% decrease in 15-17 population
- Significant poverty in Hennepin and Ramsey counties
- Growing diversity:
  - Rapidly growing Asian, Black, and Hispanic or Latino populations
  - 19% non-White in 2011; 21% non-White by 2016

The community served by Children's



Demographics

The pediatric population is growing, especially in Minneapolis and St. Paul and the surrounding suburbs. The population also is increasingly diverse, with particularly high growth expected in the Hispanic or Latino population. Minneapolis-St. Paul, surrounding suburbs, and the northern portions of Dakota and Scott counties are currently home to relatively high proportions of racial and ethnic minority populations.

Those same locations report comparatively high percentages of linguistic isolation and low educational achievement. These factors can contribute to poverty, health care access barriers and poor health throughout a child's life.

Economics

Overall, the broader community has enjoyed lower unemployment rates than the U.S. and Minnesota averages. However, Hennepin and Ramsey counties report comparatively high rates of poverty. In all seven counties, child poverty rates are higher than those of the total population. Low-income households, students eligible for free and reduced-price lunch, and discharges for Medicaid (proxy measures of poverty) are most prevalent in areas proximate to the hospital.

Hennepin and Ramsey counties also report rates higher than the state average of homeless children and families, uninsured children, and violent and property crime.

Anoka County also exhibits comparatively high rates of crime, and, while not above the state average, the county ranks just behind Hennepin and Ramsey counties for rates of poverty, unemployment, homelessness, and uninsured youth.

The cost of living in the broader community is comparatively high and often accompanied by long wait times for housing assistance. The cost of child care is also more of a burden for low-income families. Increasingly, people are being forced to choose between meeting basic needs, such as food and housing, or obtaining health care.

State budget reductions in Minnesota over the past decade have affected health and human service providers. These reductions affect children and youth services, mental health programs and services, and health and social services departments.

Social factors

Language and cultural barriers between patients and providers, differing cultural expectations of behavior, concerns about immigration status, social stigma, and the complexity of navigating the health system prevent some residents from seeking timely and appropriate health services for themselves and their children.

Education about health and health care is also a pressing need. Many parents throughout the community need support in the form of health education, basic life skills training, techniques for providing guidance and discipline to adolescents, and assistance translating health care knowledge into behavioral changes.

There is hesitancy among the adolescent population to seek sexual and reproductive services due to fear of social repercussions from family and/or peer groups. Continued attention needs to be paid to access to these services by appropriate providers.

For families and caregivers of children with complex needs, conducting the activities of daily life can feel overwhelming and some families express a feeling of isolation. Greater awareness and empathy is needed from the wider community as well as assistance with daily caregiving, social and emotional needs, and the logistics of traveling to the hospital for medical services.

Behavioral factors

Among older students, alcohol and drug abuse is prevalent. Poor diet, lack of exercise, and incomplete immunizations were concerns for youth of all ages.

Low-income families and children in the community typically have poorer diets, limited physical activity and higher rates of smoking and substance abuse than higher-income families–resulting in higher rates of chronic diseases like diabetes, obesity, and cardiovascular issues.

Anoka, Hennepin, and Ramsey counties demonstrate higher rates of teen pregnancy than Minnesota overall. Additionally, women in Hennepin and Scott counties are not accessing prenatal care at optimal rates which may lead to poor health outcomes for infants.

Mortality and morbidity

Unintentional injury and perinatal conditions are the leading causes of death for youth (ages 0-24) in the state. In the seven-county area, unintentional injury and suicide are the most prevalent types of pediatric injury mortality. Disparities exist between rates of non-White and White infant mortality and low birth weight infants.

Poor mental health and chronic diseases are also issues for youth and adults across the community but are particularly problematic for low-income and homeless residents.
Asthma and allergies are issues for the pediatric population and for the providers and schools that serve them. In general, more children in the broader community served by Children's report having asthma than the statewide average.

Hennepin and Ramsey counties demonstrate high rates of communicable diseases, especially sexually transmitted diseases and tuberculosis. Dakota County demonstrates high rates of pertussis.

Local environment

Children in Hennepin and Ramsey counties are at greater risk of living in a poor physical environment by experiencing unsafe neighborhoods, inadequate infrastructure to support activities (e.g. parks, walking areas), and food deserts with a lack of access to healthy foods. Additionally, children Hennepin and Ramsey counties experience comparatively high rates of abuse and neglect.

Care access and delivery

Health system complexity, lack of care integration across providers, regulatory and administrative burdens, and payment reductions result in frustration for both patients and providers. Cost, lack of insurance, and a lack of providers accepting Medicaid create signficiant barriers to accessing primary, mental, and dental care for children.

The community has a variety of resources striving to meet the needs of patients that experience access barriers. Children's is a safety net provider, with Medicaid accounting for an average of 42 percent of patients seen. Thirty-nine Federally Qualified Health Centers (FQHCs) in Hennepin

and Ramsey counties and one in Washington County serve medically underserved areas and populations.

Twin Cities area residents face barriers to accessing care as demonstrated by the presence of federally-designated Medically Underserved Areas or Populations (MUA/MUPs) and Health Professional Shortage Areas (HPSAs) in Hennepin and Ramsey counties. Anoka, Washington, and Scott counties also contain HPSA facilities and populations.

Even with these resources, insufficient Medicaid acceptance is a particular issue for mental and dental care. These same issues and additional factors related to the level of understanding about the health care system contribute to overuse of the emergency room for non-emergent conditions.

Of total discharges at Children's, seven percent are for ambulatory care sensitive conditions (ACSC), which are those conditions that are potentially preventable if patients were accessing primary care resources at optimal rates. The most common conditions are: asthma, urinary tract infection, perforated appendix, and diabetes short-term complications.

Community-wide priority needs

Poor health status can result from a complex interaction of challenging social, economic, environmental and behavioral factors combined with a lack of access to care. Addressing these "root" causes is an important step to improve a community's quality of life and reduce mortality and morbidity.

This document explores these factors in order to develop a list of priority health needs. All primary and secondary data presented in the Appendix of this report were analyzed and findings were ranked to determine the priority issues. The table that follows describes results of the ranking process. The needs are listed in alphabetical order.

Access to care
Cultural and linguistic barriers affect access to care A lack of culturally competent health services, stigma associated with a diagnosis, work demands, language barriers, and fear of judgment for accepting services prevent residents from seeking timely and appropriate care.
Vulnerable populations lack sufficient access to care Low-income and minority populations have difficulty accessing health care services, insurance and specialists due to cost. Safety net providers are struggling with growing demand for services, inadequate provider payment rates and insufficient capacity. Many providers, especially for mental and dental health, do not accept Medicaid patients.
Maternal and child health
Prevalent infant health risk factors and disparities exist, particularly in Hennepin and Ramsey counties Mothers in Ramsey county are not accessing prenatal care at optimal rates. Hennepin and Ramsey counties reported comparatively high rates of teen pregnancy. Non-White populations in Hennepin and Ramsey counties exhibited high infant mortality rates compared to the White population.
Mental health
Poor mental health and lack of access to pediatric mental and behavioral health services is present Additional, comprehensive mental health services are needed to address the needs of children and families, particularly low-income, uninsured/underinsured residents and Medicaid beneficiaries. Depression among youth and adults and PTSD among refugee groups are prevalent in the community.
Morbidity and mortality
Diet, exercise, environment, and insufficient knowledge contribute to obesity Poor diet, lack of exercise, insufficient access to nutritious food and safe recreational spaces, and lack of knowledge about healthy food choices and preparation contribute to issues with obesity.
Youth suffer from asthma at high rates Improved management of asthma is needed for youth in the community.
Social and economic factors
Families/caregivers of children with complex needs lack sufficient support These families require assistance for daily caregiving and meeting the social and emotional needs of the entire family. Fostering greater awareness and empathy from the wider community around special needs would alleviate feelings of isolation. These families also need logistical and economic support for recurrent travel to the hospital for medical services.

Appendix

Methodology

Analytic methods

This Appendix begins by identifying the community served by Children's. Findings based on various quantitative analyses regarding health needs in those areas are discussed, followed by a review of health assessments conducted by other organizations in recent years.

The Appendix then presents information obtained from interviews with stakeholders who represent the broad interests of the community, including public health officials and experts, and Children's-affiliated clinicians, administrators, and staff. Interviews were conducted in the fall of 2012.

Identifying priority community health needs involves benchmarking and trend analysis. Statistics for several health status and health access indicators were analyzed and compared to state-wide and national benchmarks or goals. The assessment considers multiple data sources, including indicators from local, state, and federal agencies. Including multiple data sources and stakeholder views is important when assessing the level of consensus that exists regarding community health needs. If alternative data sources including interviews support similar conclusions, then confidence is increased regarding the most problematic health needs in a community.

Prioritization process and criteria

Verité applied a ranking methodology to help prioritize the community health needs identified by the assessment. Verité listed the identified health issues and assigned to each a severity score based on the extent to which indicators exceeded Minnesota or U.S. averages. An average severity score was calculated for each category of data (secondary data, previous assessments, and interviews) to account for the number of sources that measured each health issue. These averages were assigned a weight: 45 percent, 10 percent, and 45 percent, respectively. A final score was calculated by summing the weighted averages. The methodology takes into account severity scores for each health issue and the number of sources that measure each issue.

Information gaps

No information gaps have affected Children's ability to reach reasonable conclusions regarding priority community health needs.

Collaborating organizations

Children's did not establish a formal collaboration with other organizations for this assessment.

Definition of community assessed

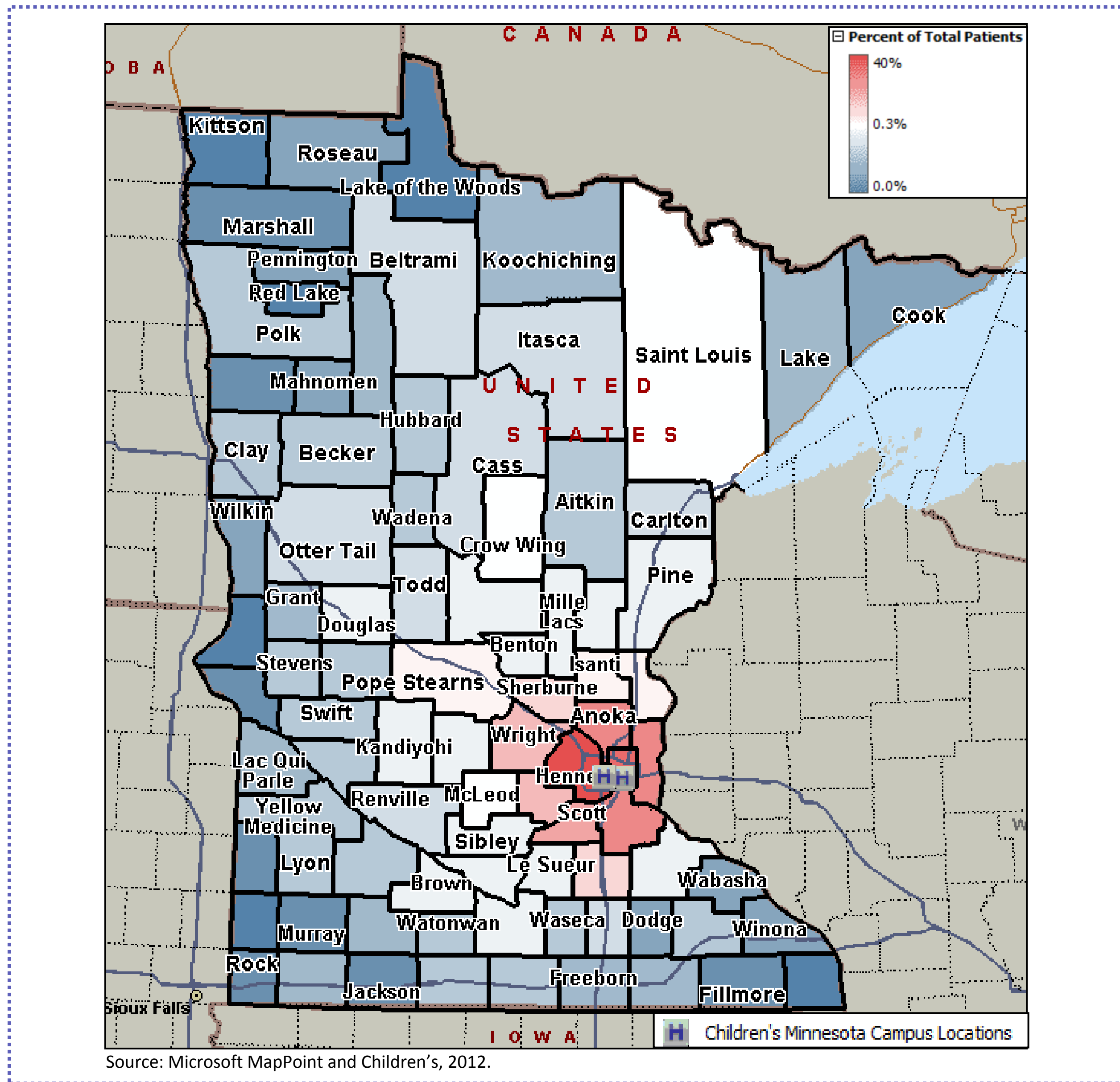
This section identifies the community assessed by Children's.

Children's is one of the largest freestanding pediatric health care systems in the U.S., with hospitals in St. Paul and Minneapolis and four outpatient sites in the surrounding suburbs. In addition to providing a broad spectrum of pediatric services to its local community, Children's is a statewide resouce and referral center for pediatric care across the upper Midwest.

- The hospital's cancer and blood disorders program is one of the largest in the region, caring for more than 55 percent of children diagnosed with cancer and blood disorders in Minnesota.
- Children's has the largest high-risk neonatal referral center in the region and the fourth-largest in the U.S., with more than 2,000 neonatal admissions in 2012. Children's is a primary referral center for other NICUs in the region.Thirty-five percent of the hospital's neonatal admissions are low birth weight or very low birth weight infants. In 2012, neonatal patients came to Children's from ten states and 58 Minnesota counties.
- The Minnesota Sudden Infant Death Center at Children's is a statewide program that provides information, counseling, and support to anyone experiencing a sudden and unexpected infant death from any cause. The center continues to be Minnesota's resource for information on Sudden Infant Death Syndrome (SIDS) and SIDS risk reduction.

Exhibit 1 illustrates the statewide reach of Children's. Unique patients from every county in the state were served through services including inpatient discharges, emergency department visits, and outpatient care.

Exhibit 1: Statewide Unique Patients Served, 2011



Source: Microsoft MapPoint and Children's, 2012.

Although Children's provides services to children throughout Minnesota, this assessment focuses on the needs of the local geographic community served by the hospital. Verité relied on the seven-county metro area as the broader community and an immediate community surrounding each hospital campus for the hospital.

Children's immediate community is comprised of 42 ZIP codes in five local school districts, Minneapolis, St. Paul, South St. Paul, Richfield, and West St. Paul – Mendota Heights – Eagan (**Exhibits 2A**). The broader community encompasses seven counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington (**Exhibit 2B)**. Children's is comprised of two campuses: Children's – Minneapolis in ZIP code 55404 and Children's – St. Paul in ZIP code 55102.

Exhibit 2A: Pediatric Population, 2011

School District	ZIP Code	Population Aged 0-17	Percent of Total Population
Minneapolis	55401	428	0.1%
	55402	17	0.0%
	55403	947	0.1%
	55404	6,252	0.8%
	55405	3,283	0.4%
	55406	6,489	0.9%
	55407	10,040	1.4%
	55408	5,758	0.8%
	55409	2,560	0.3%
	55410	3,946	0.5%
	55411	11,477	1.6%
	55412	7,383	1.0%
	55413	2,195	0.3%
	55414	2,436	0.3%
	55415	133	0.0%
	55416	5,374	0.7%
	55417	5,549	0.8%
	55418	6,099	0.8%
	55419	6,151	0.8%
	55430	5,402	0.7%
	55454	1,515	0.2%
	55455	7	0.0%
	55458	-	0.0%
	Subtotal	**93,441**	**12.7%**
St. Paul	55101	437	0.1%
	55102	3,223	0.4%
	55103	4,410	0.6%
	55104	10,989	1.5%
	55105	5,044	0.7%
	55106	16,158	2.2%
	55107	4,638	0.6%
	55108	2,797	0.4%
	55114	421	0.1%
	55116	4,634	0.6%
	55117	10,326	1.4%
	55119	10,034	1.4%
	55130	6,206	0.8%
	Subtotal	**79,317**	**10.8%**
West St. Paul - Mendota Heights - Eagan	55118	5,475	0.7%
	55120	1,164	0.2%
	55121	1,739	0.2%
	55150	-	0.0%
	Subtotal	**8,378**	**1.1%**
Richfield	55423	**6,683**	**0.9%**
South St. Paul	55075	**4,506**	**0.6%**
Immediate Community Total		**192,325**	**26.1%**
Broader Community Total		**736,874**	**100.0%**

Source: Thomson Reuters via Children's, 2012.

The pediatric population from the five school districts in the immediate community accounts for 26% of the total community population

Exhibit 2B: Pediatric Population, 2011

County	Population Aged 0-17	Percent of Total Pediatric Population
Anoka	96,312	13.1%
Carver	27,914	3.8%
Dakota	112,252	15.2%
Hennepin	274,108	37.2%
Ramsey	119,893	16.3%
Scott	41,247	5.6%
Washington	65,148	8.8%
Total	**736,874**	**100.0%**

Source: Thomson Reuters via Children's, 2012.

Of the seven counties in the broader community, Carver County is the least populous, accounting for 4% of the pediatric population

In 2012, the Children's broader community had a pediatric population (those younger than 18) of approximately 736,800 persons[4]. Approximately 37 percent of the population resided in Hennepin County, followed by 16 percent in Ramsey County and 15 percent in Dakota County (**Exhibit 2B**).

The immediate community definition was confirmed by examining the geographic origin of Children's inpatients and emergency department encounters. In 2011, 39 percent of inpatient discharges and 60 percent of emergency department visits originated from the immediate community. In the broader community, approximately 30 percent of the hospital's inpatients originated from Hennepin County, followed by 17 percent from Ramsey County and 11 percent from Dakota County. Collectively, the seven counties accounted for 76 percent of the hospital's inpatient discharges.

In 2011, approximately 85 percent of Children's emergency department visits originated from Hennepin, Ramsey, and Dakota counties; 95 percent originated from the broader community (**Exhibit 3A and 3B**).

4 The data in Exhibit 2 considers the pediatric population to be those residents aged 0-17. However, elsewhere in the report, the pediatric population is sometimes considered to be those residents aged 0-19 due to data limitations.

Exhibit 3A: Inpatient Discharges and Emergency Department Visits, 2011

School District	ZIP Code	Percent of Discharges	Percent of ED Visits
Minneapolis	55401	0.1%	0.1%
	55402	0.0%	0.0%
	55403	0.1%	0.4%
	55404	1.9%	4.4%
	55405	0.6%	0.8%
	55406	1.0%	1.8%
	55407	2.7%	6.2%
	55408	1.4%	3.2%
	55409	0.7%	1.0%
	55410	0.6%	0.6%
	55411	2.0%	2.6%
	55412	1.2%	1.1%
	55413	0.4%	0.7%
	55414	0.3%	0.5%
	55415	0.1%	0.2%
	55416	0.7%	0.6%
	55417	1.0%	1.2%
	55418	1.0%	1.6%
	55419	0.8%	1.2%
	55430	0.1%	0.9%
	55454	0.3%	0.8%
	55455	0.0%	0.0%
	55458	0.0%	0.0%
	Subtotal	**17.8%**	**29.7%**
St. Paul	55101	0.1%	0.4%
	55102	0.6%	1.3%
	55103	0.8%	1.7%
	55104	2.2%	3.7%
	55105	0.7%	0.8%
	55106	3.6%	5.3%
	55107	0.9%	2.2%
	55108	0.6%	0.4%
	55114	0.1%	0.1%
	55116	0.7%	1.2%
	55117	2.7%	3.3%
	55119	2.1%	2.5%
	55130	1.4%	1.9%
	Subtotal	**16.4%**	**24.7%**
West St. Paul - Mendota Heights -Eagan	55118	1.5%	2.0%
	55120	0.2%	0.1%
	55121	0.3%	0.3%
	55150	0.0%	0.0%
	Subtotal	**2.0%**	**2.4%**
Richfield	55423	**1.2%**	**1.8%**
South St. Paul	55075	**1.0%**	**1.3%**
Immediate Community Total		**38.5%**	**59.8%**
Broader Community Total		**3,548**	**52,752**

Source: Children's, 2012.

The five school districts in the immediate community represented 39% of Children's inpatient discharges and 60% of all emergency room visits in 2011

Exhibit 3B: Inpatient Discharges and Emergency Department Visits, 2011

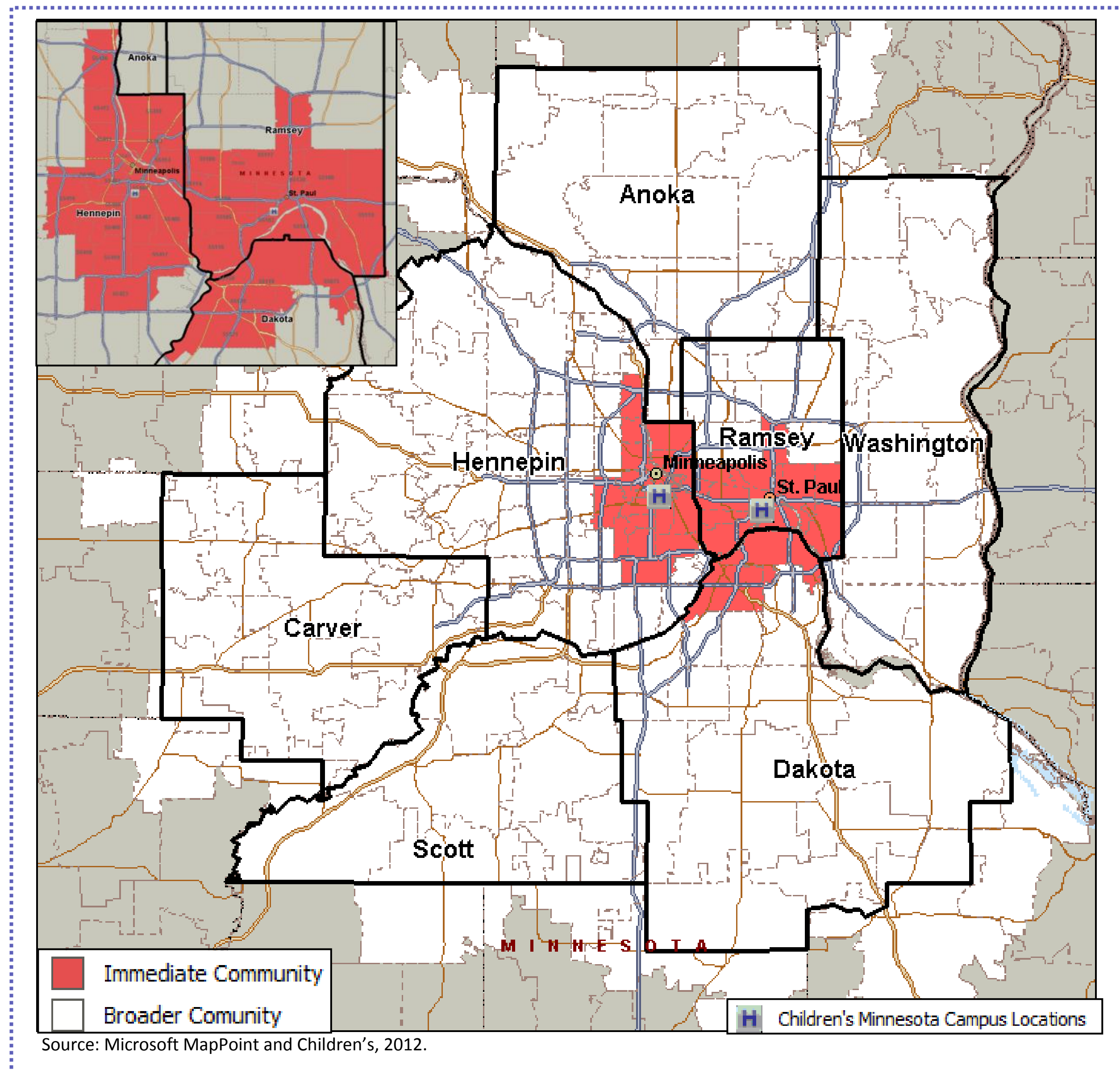
County	Percent of Discharges	Percent of ED Visits
Anoka	6.8%	4.0%
Carver	2.2%	0.6%
Dakota	10.6%	10.4%
Hennepin	30.0%	44.3%
Ramsey	17.2%	30.0%
Scott	2.4%	1.0%
Washington	6.5%	4.9%
Broader Community Total	**75.6%**	**95.2%**
Other Areas	**24.4%**	**4.8%**
All Discharges	**12,175**	**88,302**

Source: Children's, 2012.

The seven-county area accounts for 76% of all Children's inpatient discharges and 95% of all emergency room visits

Exhibit 4 presents the ZIP codes and counties that comprise Children's broader community and highlights the hospital's immediate community. Zip codes are indicated by dotted lines.

Exhibit 4: Children's Community



Source: Microsoft MapPoint and Children's, 2012.

Secondary data assessment

This section assesses secondary data regarding health needs in the community served by Children's.

Key insights: ***Demographics***	» The majority of hospital patients live in Hennepin, Ramsey, and Dakota counties. » The community population is growing, especially in the suburban and exurban areas of the Twin Cities. » The population is increasingly diverse, with particularly high growth expected in the Hispanic or Latino population. Racial and ethnic minority groups are more likely to lack social and economic resources, resulting in health disparities and unique health and social service needs. Minneapolis and St. Paul, surrounding suburbs, and the northern portions of Dakota and Scott counties are currently the most diverse. - These same locations report comparatively high percentages of linguistic isolation, which can contribute to low health literacy and barriers to accessing care, and low educational achievement, which often is linked with poverty and poor health.

Demographics

Pediatric population

Population change plays a determining role in the types of health and social services needed by communities. Overall, the pediatric population (those younger than 18) living in the broader community is expected to increase 3.2 percent between 2011 and 2016 (**Exhibit 5**).

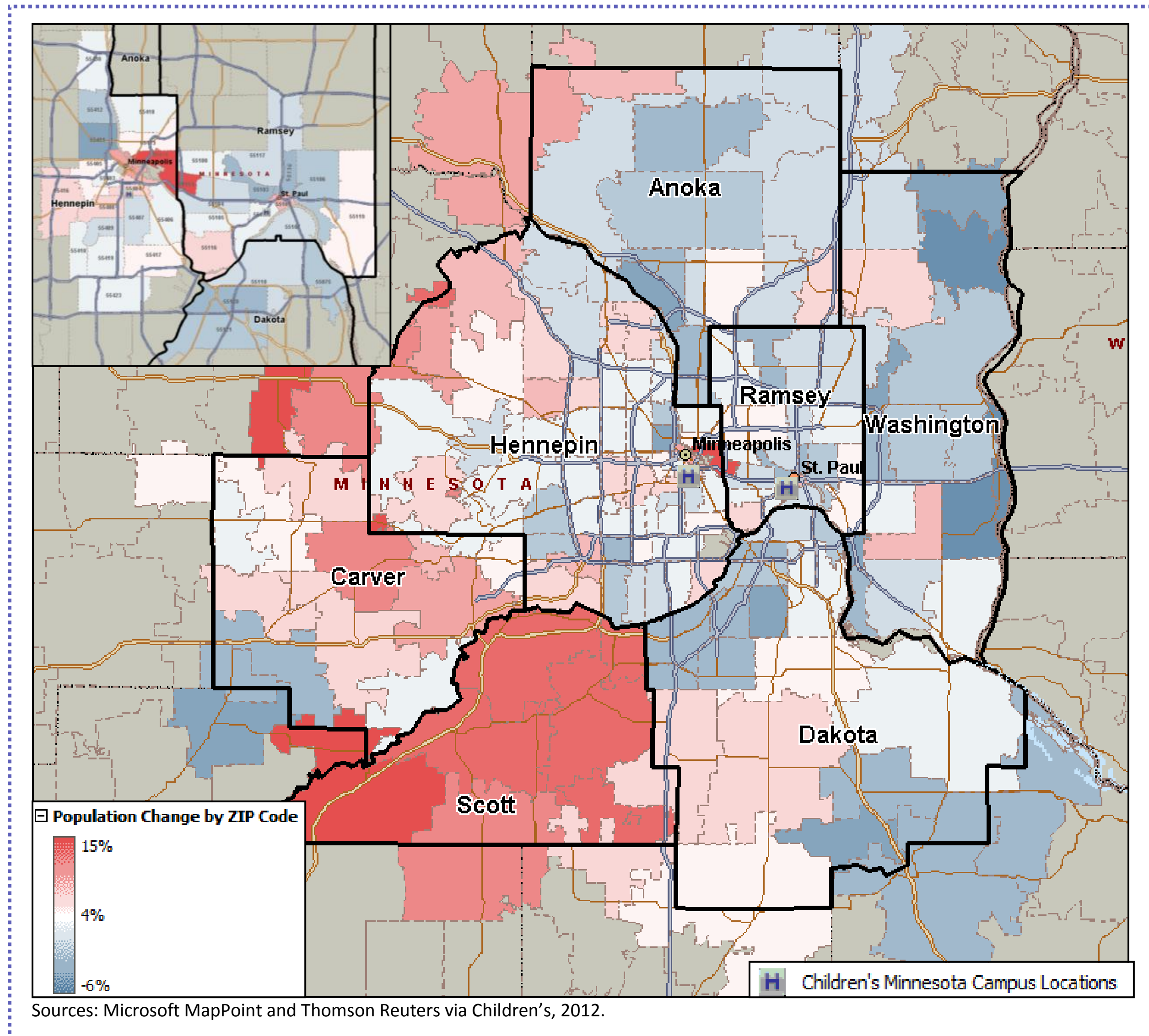
Exhibit 5: Percent Change in Pediatric Population by County and Age in the Broader Community, 2011-2016

County	Population Cohort				
	0-5	5-9	10-14	15-17	Total 0-17
2011 Population					
Anoka	26.9%	27.1%	28.0%	17.9%	96,312
Carver	26.4%	27.3%	29.0%	17.3%	27,914
Dakota	27.5%	27.1%	27.4%	18.1%	112,252
Hennepin	30.2%	28.1%	25.5%	16.3%	274,108
Ramsey	30.4%	27.9%	25.1%	16.6%	119,893
Scott	29.0%	28.0%	27.0%	16.0%	41,247
Washington	25.9%	27.0%	28.5%	18.6%	65,148
Total	**28.8%**	**27.6%**	**26.5%**	**17.0%**	**736,874**
2016 Population					
Anoka	27.8%	27.1%	27.3%	17.8%	97,686
Carver	27.0%	26.1%	28.7%	18.3%	29,884
Dakota	28.2%	27.3%	26.9%	17.6%	114,040
Hennepin	29.3%	28.7%	26.8%	15.2%	284,087
Ramsey	29.9%	28.8%	26.6%	14.7%	121,875
Scott	28.7%	27.6%	26.8%	16.8%	46,571
Washington	27.2%	26.3%	27.4%	19.1%	65,906
Total	**28.7%**	**27.9%**	**27.0%**	**16.4%**	**760,049**
Percent Change 2011-2016					
Anoka	4.7%	1.5%	-1.3%	0.5%	1.4%
Carver	9.5%	2.2%	6.1%	12.7%	7.1%
Dakota	4.2%	2.5%	-0.1%	-1.2%	1.6%
Hennepin	0.8%	5.8%	9.0%	-3.2%	3.6%
Ramsey	-0.1%	5.0%	7.5%	-9.7%	1.7%
Scott	11.9%	11.3%	12.1%	18.8%	12.9%
Washington	6.2%	-1.2%	-2.7%	3.5%	1.2%
Total	**3.0%**	**4.2%**	**4.9%**	**-1.0%**	**3.2%**

Source: Thomson Reuters via Children's, 2012.

Projected pediatric population growth varies by ZIP code. Although Hennepin County has the highest percentage of the population 17 years of age and under, projected growth is concentrated in Scott and Carver counties **(Exhibit 6)**.

Exhibit 6: Pediatric Population Change by ZIP Code, 2011-2016



Sources: Microsoft MapPoint and Thomson Reuters via Children's, 2012.

Race and ethnicity

In 2011, over 80 percent of the broader community's population was White. Non-White populations are expected to grow faster than White populations in the broader community. In Hennepin and Ramsey counties, the White population is expected to decrease. The Asian/Pacific Islander population is expected to increase by 14 percent (**Exhibit 7**). The growing diversity of the community is important to recognize given that health disparities and the need to enhance cultural competency of health care providers. (Note that Hispanic or Latino ethnicity is reported separately from race. Persons of Hispanic or Latino origin may be from any racial group. **Exhibit 10** provides data regarding ethnicity).

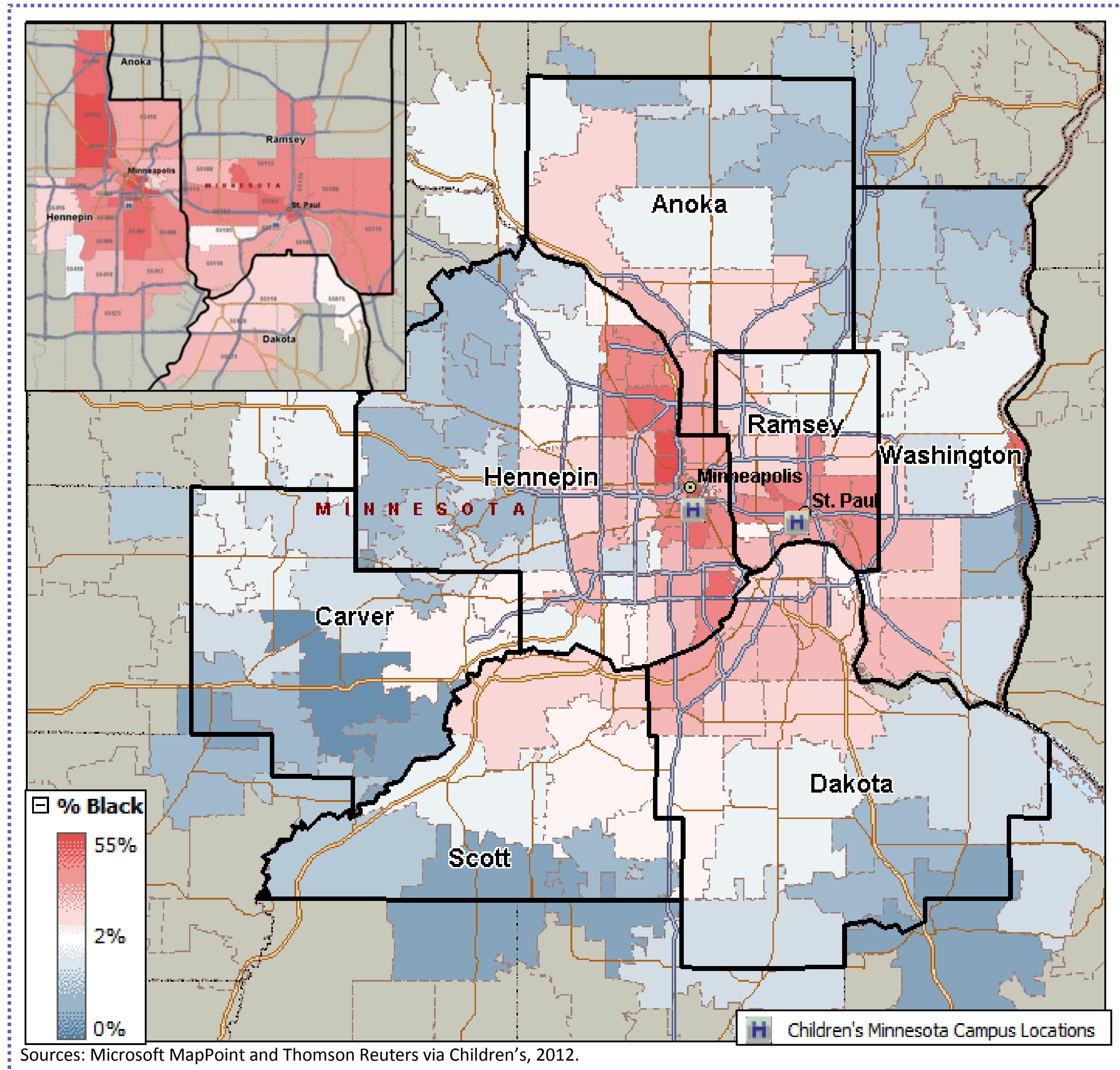
Exhibit 7: Distribution of Population by Race in the Broader Community, 2011-2016

	Racial Cohort						
County	White	Black	American Indian & Alaska Native	Asian/ Pacific Islander	2+ Races	Other	Total
2011 Population							
Anoka	88.3%	3.8%	0.7%	3.8%	2.3%	1.1%	377,356
Carver	92.8%	1.6%	0.3%	2.5%	1.4%	1.4%	97,717
Dakota	86.6%	4.2%	0.5%	4.3%	2.4%	2.0%	440,421
Hennepin	76.7%	10.1%	1.0%	5.8%	3.1%	3.2%	1,190,617
Ramsey	73.9%	9.4%	0.9%	9.5%	3.3%	3.1%	513,092
Scott	87.4%	2.5%	0.7%	5.7%	1.8%	1.9%	141,624
Washington	88.1%	3.3%	0.5%	5.1%	2.1%	0.9%	246,106
Total	**81.1%**	**7.1%**	**0.8%**	**5.8%**	**2.8%**	**2.4%**	**3,006,933**
2016 Population							
Anoka	85.9%	4.7%	0.7%	4.7%	2.6%	1.3%	397,394
Carver	91.3%	2.1%	0.3%	3.0%	1.6%	1.6%	108,011
Dakota	84.3%	5.0%	0.6%	4.9%	2.8%	2.4%	460,898
Hennepin	74.9%	10.7%	1.1%	6.2%	3.4%	3.7%	1,209,353
Ramsey	72.2%	10.2%	0.9%	9.9%	3.5%	3.3%	510,111
Scott	84.4%	3.2%	0.7%	7.3%	2.1%	2.2%	161,743
Washington	85.6%	4.0%	0.5%	6.5%	2.4%	1.0%	261,742
Total	**79.2%**	**7.8%**	**0.8%**	**6.4%**	**3.0%**	**2.8%**	**3,109,252**
Percent Change 2011-2016							
Anoka	2.4%	32.7%	8.1%	31.1%	19.1%	24.5%	5.3%
Carver	8.8%	43.3%	30.7%	30.3%	30.4%	29.0%	10.5%
Dakota	1.9%	27.1%	17.3%	20.3%	18.4%	21.7%	4.6%
Hennepin	-0.8%	7.3%	3.6%	9.2%	9.6%	17.9%	1.6%
Ramsey	-2.8%	7.8%	2.9%	2.8%	5.0%	8.5%	-0.6%
Scott	10.4%	47.2%	13.0%	46.4%	32.3%	32.5%	14.2%
Washington	3.4%	28.1%	13.9%	33.8%	22.3%	21.4%	6.4%
Total	**1.1%**	**12.5%**	**6.5%**	**14.2%**	**12.6%**	**17.5%**	**3.4%**

Source: Thomson Reuters via Children's, 2012.

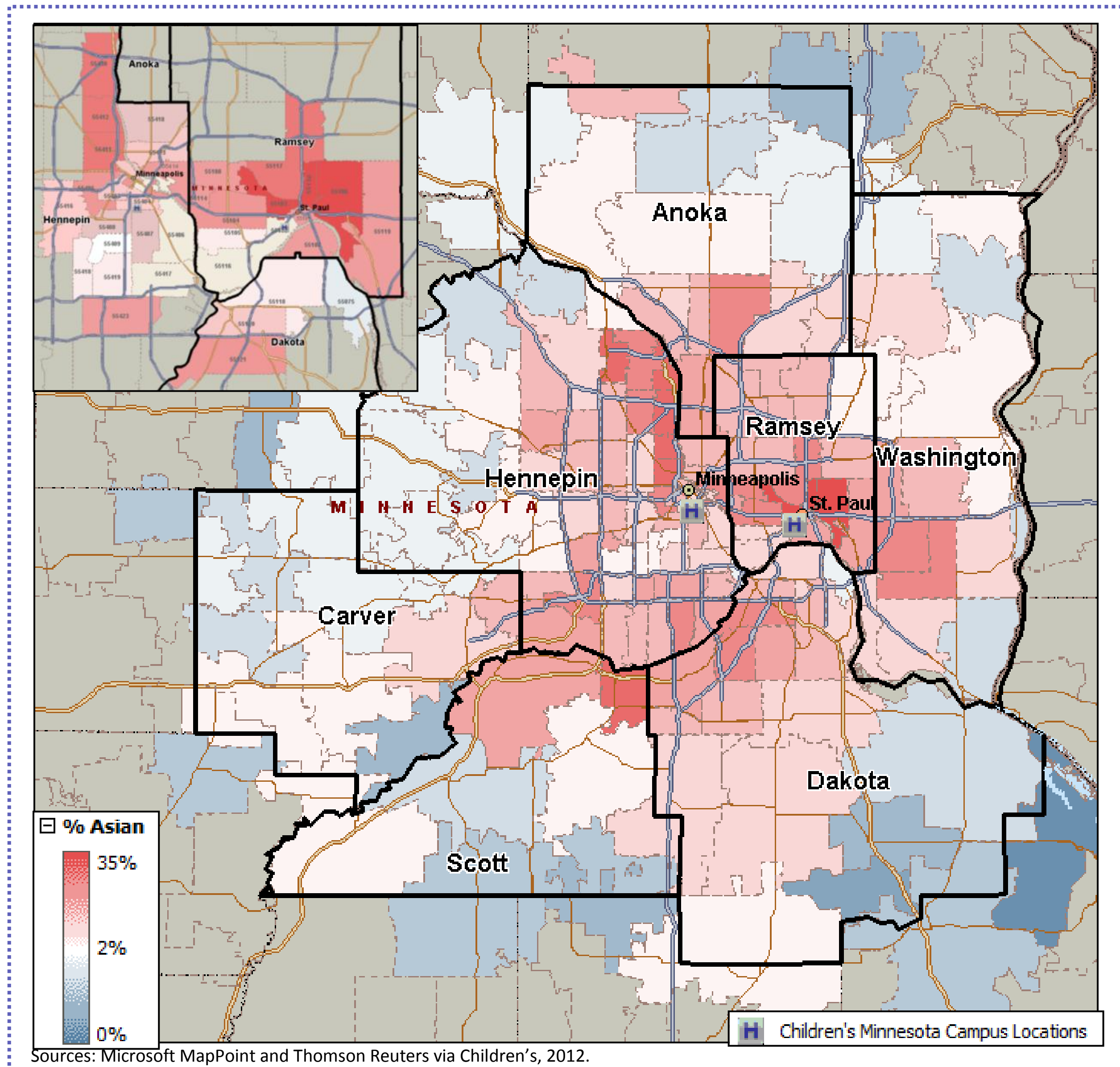
Non-White populations are concentrated in Hennepin and Ramsey counties; these counties had the highest percentage of Black residents. Ramsey, Scott, Washington, and Hennepin counties had the highest percentages of Asian/Pacific Islander residents in 2011 (**Exhibits 8 and 9**).

Exhibit 8: Areas with Highest Concentration of Black Residents, 2011



Sources: Microsoft MapPoint and Thomson Reuters via Children's, 2012.

Exhibit 9: Areas with Highest Concentration of Asian/Pacific Islander Residents, 2011



Sources: Microsoft MapPoint and Thomson Reuters via Children's, 2012.

Projections indicate that the Hispanic or Latino community population is expected to increase more rapidly than the non-Hispanic or Latino population. In terms of overall percent change, the broader community is projected to experience growth in the Hispanic or Latino population of approximately 19 percent between 2011 and 2016 (**Exhibit 10**).

Exhibit 10: Distribution of Population by Ethnicity in the Broader Community, 2011-2016

County	Ethnic Cohort		
	Hispanic or Latino	Non-Hispanic or Latino	Total
2011 Population			
Anoka	3.0%	97.0%	377,356
Carver	4.1%	95.9%	97,717
Dakota	5.0%	95.0%	440,421
Hennepin	6.6%	93.4%	1,190,617
Ramsey	6.7%	93.3%	513,092
Scott	4.1%	95.9%	141,624
Washington	3.0%	97.0%	246,106
Total	**5.4%**	**94.6%**	**3,006,933**
2016 Population			
Anoka	3.6%	96.4%	397,394
Carver	4.8%	95.2%	108,011
Dakota	5.8%	94.2%	460,898
Hennepin	7.7%	92.3%	1,209,353
Ramsey	7.4%	92.6%	510,111
Scott	4.8%	95.2%	161,743
Washington	3.5%	96.5%	261,742
Total	**6.2%**	**93.8%**	**3,109,252**
Percent Change 2011-2016			
Anoka	26.5%	4.6%	5.3%
Carver	29.4%	9.7%	10.5%
Dakota	22.8%	3.7%	4.6%
Hennepin	19.0%	0.3%	1.6%
Ramsey	9.0%	-1.3%	-0.6%
Scott	33.1%	13.4%	14.2%
Washington	23.3%	5.8%	6.4%
Total	**18.9%**	**2.5%**	**3.4%**

Source: Thomson Reuters via Children's, 2012.

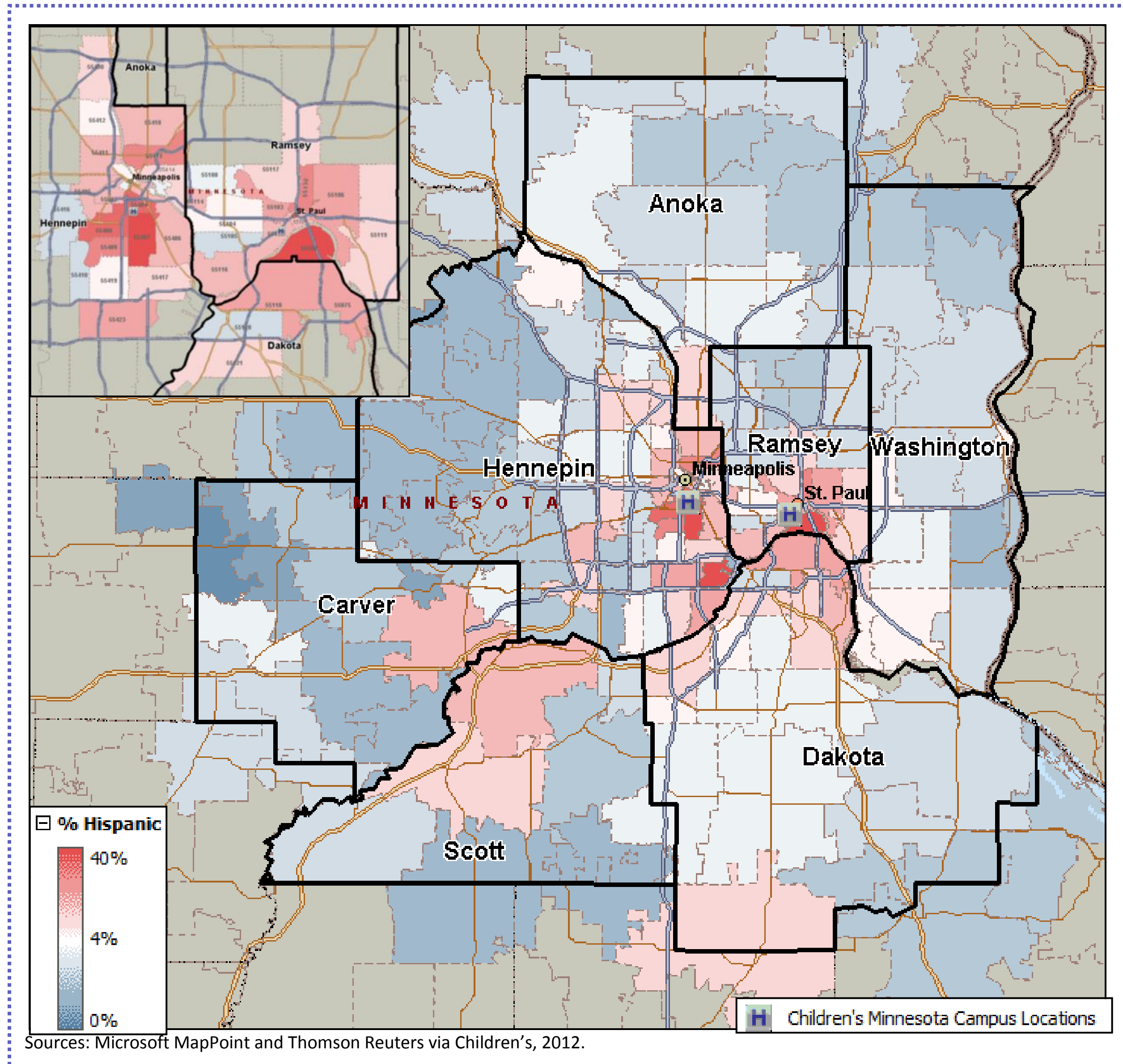
The Hispanic or Latino population is projected to increase more than 20%in five counties: Anoka, Carver, Dakota, Scott, and Washington

...

The non-Hispanic population is projected to decrease in Ramsey County

Exhibit 11 illustrates the concentration of Hispanic or Latino residents in the Children's broader community. Hispanic or Latino communities are highly concentrated in Hennepin, Ramsey, and Dakota counties. At 33 percent, Scott County is projected to experience the highest growth in the Hispanic or Latino population.

Exhibit 11: Areas with Highest Concentration of Hispanic or Latino Residents, 2011



Sources: Microsoft MapPoint and Thomson Reuters via Children's, 2012.

Other demographic information

Additional demographic characteristics are presented in **Exhibit 12**.

» In 2010, Washington County had a higher percentage of disabled pediatric residents than Minnesota and national averages.

» All counties, with the exception of Ramsey, had a higher high school graduation rate than the Minnesota and national average. Ramsey County had the highest percentage of non-graduates at 10.4 percent.

» Hennepin, Ramsey, and Scott counties had higher percentages of linguistically isolated individuals than the Minnesota average. Linguistic isolation is defined as the population aged 5 and older who speak a language other than English at home and who speak English less than "very well."

Exhibit 12: Prevalence of Demographic Indicators and Variation from Minnesota in the Broader Community, 2010

County	Aged 0-17 With Any Disability	Aged 25+ No High School Graduation	Aged 5+ Linguistically Isolated
Anoka	3.8%	5.5%	3.3%
Carver	2.8%	3.7%	N/A
Dakota	3.8%	5.1%	4.1%
Hennepin	3.6%	7.9%	6.9%
Ramsey	3.8%	10.4%	9.5%
Scott	1.8%	6.1%	4.8%
Washington	4.6%	4.0%	3.2%
Minnesota	**3.7%**	**8.2%**	**4.2%**
U.S.	**4.0%**	**14.4%**	**8.7%**

Source: U.S. Census Bureau, 2012.

Hennepin, Ramsey, and Scott counties all reported a greater rate of linguistic isolation than the Minnesota average

Hennepin and Ramsey counties reported the lowest percentages of students who speak English at home. Both counties have a significant number of Spanish speakers; Ramsey County reports that 14.4 percent of its households speak Hmong at home (**Exhibit 13**).

Exhibit 13: Primary Language of Students in the Broader Community, School Year 2011

Primary Language	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington	Minnesota
English	86.3%	92.6%	87.7%	79.0%	68.8%	88.9%	91.8%	**87.3%**
Hmong	2.2%	0.1%	0.4%	2.8%	14.4%	0.0%	3.4%	**2.4%**
Karen	0.0%	0.0%	0.0%	0.0%	1.8%	0.0%	0.0%	**0.2%**
Russian	0.7%	0.3%	0.5%	0.5%	0.2%	1.3%	0.2%	**0.3%**
Somali	0.9%	0.3%	1.5%	3.8%	2.7%	0.6%	0.1%	**1.6%**
Spanish	3.7%	4.5%	5.3%	8.4%	6.8%	4.3%	1.3%	**4.7%**
Vietnamese	0.9%	0.4%	0.9%	0.7%	0.8%	1.2%	0.3%	**0.5%**
Other	5.2%	1.9%	3.8%	4.8%	4.6%	3.7%	2.9%	**3.0%**
Total Enrollments	**62,336**	**15,769**	**71,996**	**156,124**	**83,806**	**21,992**	**39,246**	**825,077**

Source: Minnesota Department of Education, 2012.

Exhibit 14 demonstrates the high school dropout rate in each county by race and ethnicity as reported by the Minnesota Department of Education. American Indians/Alaska Natives had the

highest dropout rates in three of the four counties for which their demographic figures were reported; Ramsey County had the highest dropout rate at 20.5 percent. Hispanic or Latino students also reported high dropout rates; Hennepin County's 15.9 percent dropout rate was significantly higher than Minnesota's average. All counties reported higher rates of students receiving free or reduced-price lunch dropping out than students not receiving free or reduced-price lunch. Overall, Hennepin and Ramsey counties reported higher dropout rates than Minnesota's average.

Exhibit 14: Dropout Rate within 4 Years by Cohort in the Broader Community, School Year 2011

Student Cohort	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington	Minnesota
Race/Ethnicity								
American Indian/ Alaskan Native	13.9%	N/A	4.7%	16.7%	20.5%	N/A	N/A	**18.8%**
Asian/Pacific Islander	2.2%	N/A	3.7%	3.7%	4.9%	6.1%	2.5%	**4.3%**
Black, Not Hispanic or Latino	7.0%	N/A	7.6%	9.2%	8.3%	2.3%	2.1%	**8.7%**
White, Not Hispanic or Latino	3.0%	2.9%	2.2%	2.7%	6.5%	2.6%	1.3%	**3.3%**
Hispanic or Latino	9.4%	14.5%	11.0%	15.9%	9.9%	13.4%	2.6%	**13.5%**
Low-Income								
Free or Reduced-Priced Lunch	8.5%	11.7%	10.8%	10.6%	9.3%	10.4%	6.1%	**10.1%**
Sex								
Male	4.3%	5.3%	4.2%	6.3%	7.8%	3.2%	2.1%	**5.6%**
Female	3.3%	3.0%	2.3%	4.8%	5.9%	3.9%	0.9%	**3.9%**
All Students	**3.8%**	**4.1%**	**3.3%**	**5.5%**	**6.9%**	**3.5%**	**1.5%**	**4.8%**

Source: Minnesota Department of Education, 2012.

Economic indicators

The following types of economic indicators with implications for health were assessed: (1) people in poverty, (2) household income, (3) unemployment rates, (4) homelessness, (5) crime, (6) State of Minnesota budget cuts, (7) utilization of government assistance programs, and (8) insurance status.

Key insights: Economic Indicators

» Poverty creates barriers to access (to health services, quality education, healthy food, housing, and other basic needs and opportunities) that contribute to poor health status. The immediate community demonstrates the greatest socio-economic need, followed by Anoka County.

- Children have a higher poverty rate than the total population; Hennepin and Ramsey counties have rates higher than state averages. These counties also have more uninsured children than the state average.
- Low-income households, students eligible for free and reduced lunch, and discharges for Medicaid/PMAP (proxy measures of poverty) are most prevalent in the immediate community.
- Cost of living in the area is high, often with long wait times for housing assistance.
- The more urban counties (Hennepin and Ramsey) report comparatively high rates of child homelessness as well as violent and property crime.

» Unemployment rates decreased between 2011 and 2012 and were lower than state and national averages.

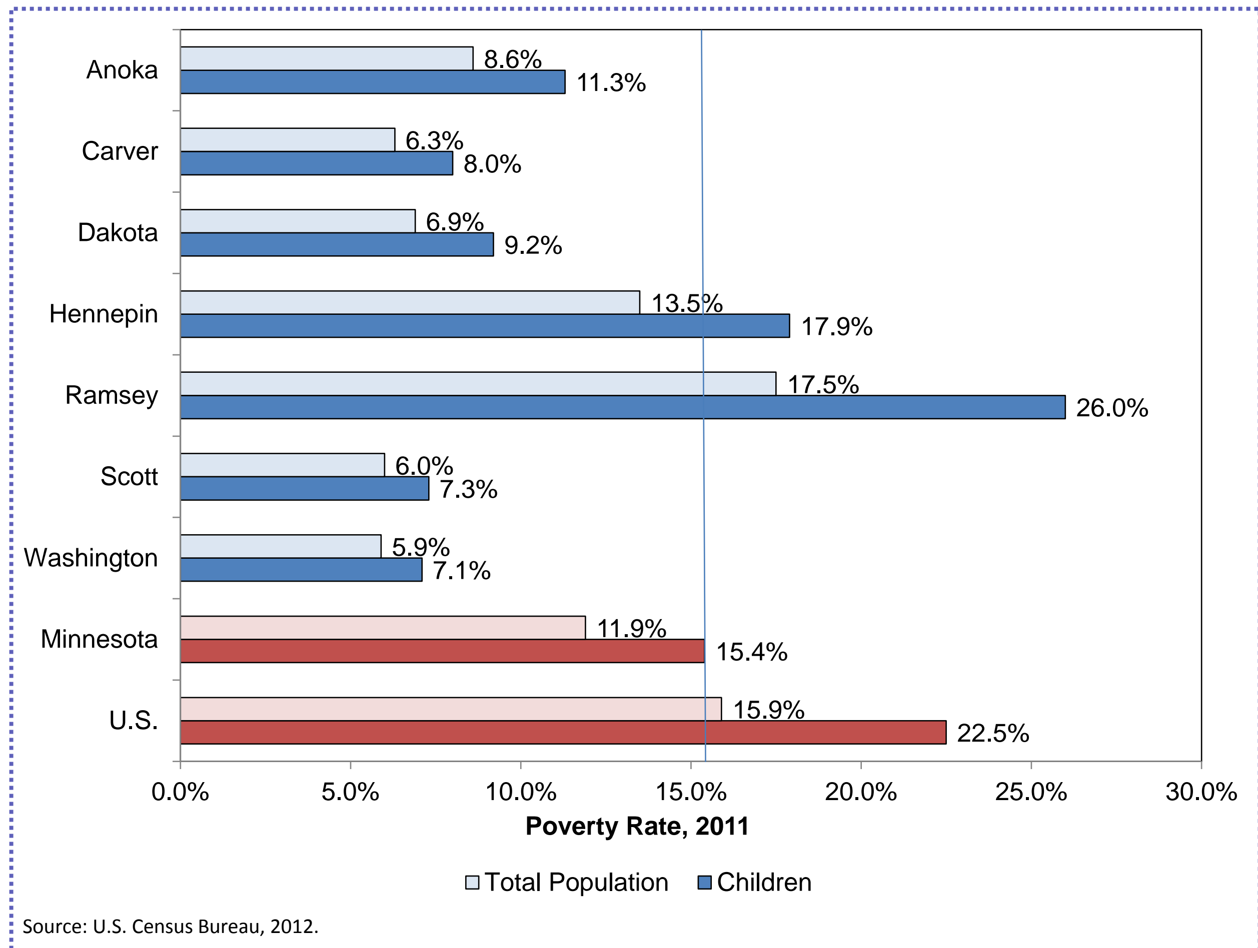
» Anoka County exhibits rates of rape and larceny above the state average.

» Health and human services programs, including Medicaid, mental health programs and managed care organizations faced budget cuts.

People in poverty

Many health needs are associated with poverty. According to the U.S. Census, about 16 percent of people in the U.S. and about 12 percent of people in Minnesota lived in poverty in 2011. The poverty rate for children was 23 percent nationally and 15 percent in Minnesota. Ramsey County reported an overall poverty rate that was higher than both the Minnesota and national averages. Hennepin County's total poverty rate was higher than the Minnesota average. In all counties, children had a higher poverty rate than the adult population. Hennepin and Ramsey counties also reported poverty rates for the pediatric population that compare unfavorably to state and national averages (**Exhibit 15**).

Exhibit 15: Poverty Rates, 2011



Source: U.S. Census Bureau, 2012.

Household income

In the Children's broader community in 2011, approximately 15 percent of all households had incomes below $25,000, an approximation of the federal poverty level (FPL) for a family of four; 38 percent had incomes less than $50,000, an approximation of 200 percent of the FPL for a family of four. FPL is used by many agencies and organizations to assess household needs for low-income assistance programs. Ramsey and Anoka counties exhibited the lowest average household income. The immediate community had the highest rates of households with incomes less than $25,000 (**Exhibits 16A and 16B**).

Exhibit 16A: Percent Low-Income Households in the Immediate Community, 2011

School District	ZIP Code	Number of Households 2011	Average Household Income	Percent Less Than $25,000	Percent Less Than $50,000
Minneapolis	55401	3,972	78,231	22.2%	44.7%
	55402	274	57,646	35.0%	59.5%
	55403	10,436	61,678	35.3%	64.8%
	55404	12,360	33,180	50.0%	80.7%
	55405	7,617	72,003	25.5%	55.3%
	55406	15,148	59,263	21.3%	52.4%
	55407	13,754	54,431	24.6%	56.2%
	55408	15,249	56,033	26.0%	61.5%
	55409	5,046	70,213	17.4%	45.2%
	55410	8,934	97,566	9.8%	29.6%
	55411	8,966	41,279	39.0%	71.9%
	55412	8,389	53,902	24.0%	56.7%
	55413	5,860	52,712	33.0%	60.2%
	55414	10,473	46,739	41.9%	70.1%
	55415	1,378	59,496	33.1%	58.3%
	55416	14,958	88,282	13.2%	37.9%
	55417	11,191	73,629	13.0%	39.2%
	55418	13,341	57,770	22.3%	53.1%
	55419	11,435	100,551	10.7%	29.8%
	55430	7,949	53,755	22.3%	54.7%
	55454	2,681	25,349	68.4%	86.6%
	55455	164	20,488	75.6%	93.9%
	55458	-	-	0.0%	0.0%
	Subtotal	**189,575**	**59,736**	**25.7%**	**54.4%**
St. Paul	55101	3,322	49,960	36.1%	67.2%
	55102	9,248	56,337	27.8%	58.3%
	55103	4,608	41,372	38.6%	69.7%
	55104	17,565	58,830	26.9%	55.6%
	55105	11,519	90,552	13.7%	37.4%
	55106	17,855	47,662	28.4%	63.3%
	55107	5,339	51,655	26.3%	56.2%
	55108	6,217	65,466	23.8%	52.3%
	55114	1,240	47,692	36.9%	62.7%
	55116	11,431	73,634	23.0%	47.4%
	55117	15,653	54,299	25.9%	57.2%
	55119	15,561	63,660	20.9%	48.6%
	55130	5,520	44,057	34.3%	66.6%
	Subtotal	**125,078**	**57,321**	**25.7%**	**55.1%**
West St. Paul - Mendota Heights - Eagan	55118	12,169	77,256	20.3%	45.2%
	55120	1,870	106,230	7.2%	21.7%
	55121	3,240	70,655	11.8%	40.7%
	55150	-	-	0.0%	0.0%
	Subtotal	**17,279**	**84,714**	**17.3%**	**41.8%**
Richfield	55423	**14,770**	**61,892**	**19.4%**	**49.7%**
South St. Paul	55075	**8,079**	**60,299**	**18.4%**	**47.7%**
Immediate Community Total		**354,781**	**64,792**	**24.9%**	**53.7%**
Broader Community Total		**1,171,108**	**82,405**	**15.1%**	**38.3%**

Source: Thomson Reuters via Children's, 2012.

Exhibit 16B: Percent Low-Income Households in the Broader Community, 2011

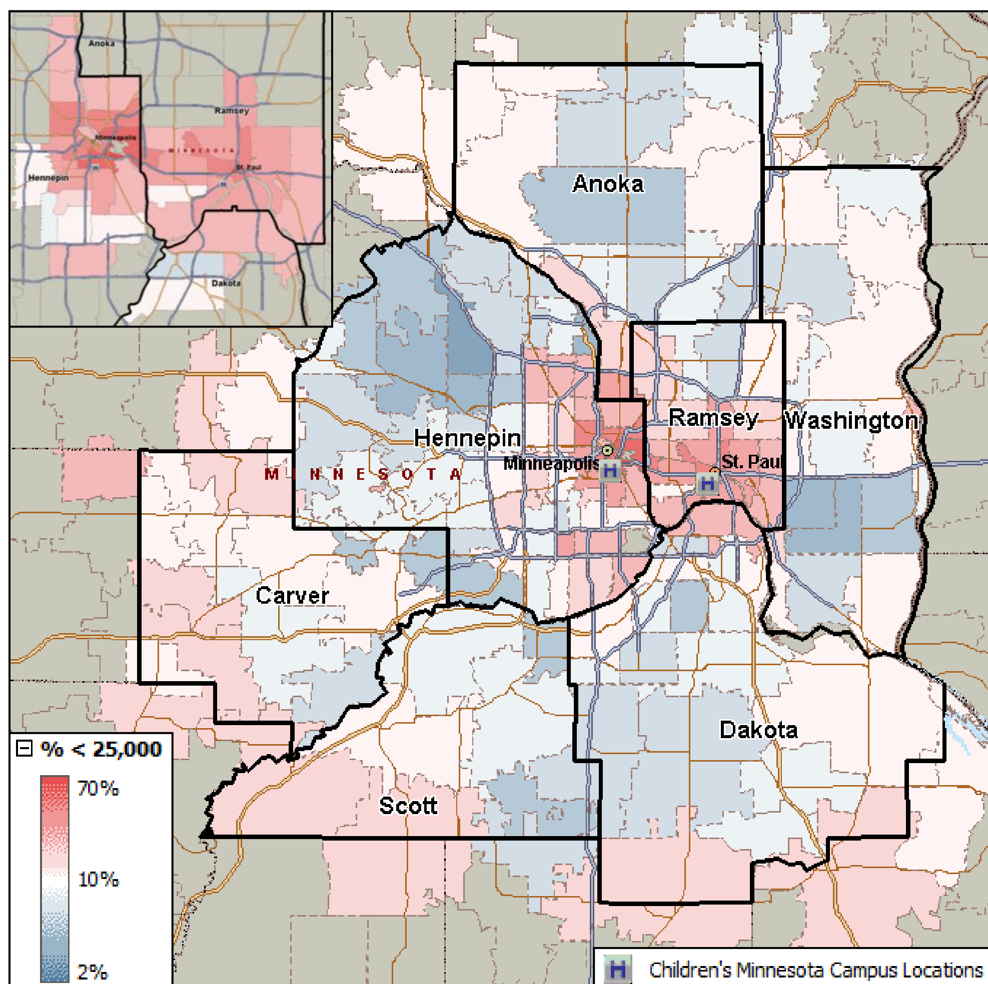
County	Number of Households 2011	Average Household Income	Percent Less Than $25,000	Percent Less Than $50,000
Anoka	138,569	75,585	12.0%	34.2%
Carver	34,444	81,222	11.3%	30.5%
Dakota	164,703	83,949	10.6%	31.7%
Hennepin	490,230	84,909	17.0%	41.2%
Ramsey	203,262	65,989	21.1%	48.5%
Scott	49,346	89,914	9.3%	26.1%
Washington	90,554	92,444	8.9%	27.3%
Total	**1,171,108**	**82,405**	**15.1%**	**38.3%**

Source: Thomson Reuters via Children's, 2012.

Ramsey County reported the highest rates of households with income less than $25,000 and $50,000

The highest proportions of households with incomes under $25,000 in 2011 were located in the Minneapolis and St. Paul school districts (**Exhibit 17**).

Exhibit 17: Households with Incomes Less than $25,000 by ZIP code, 2011

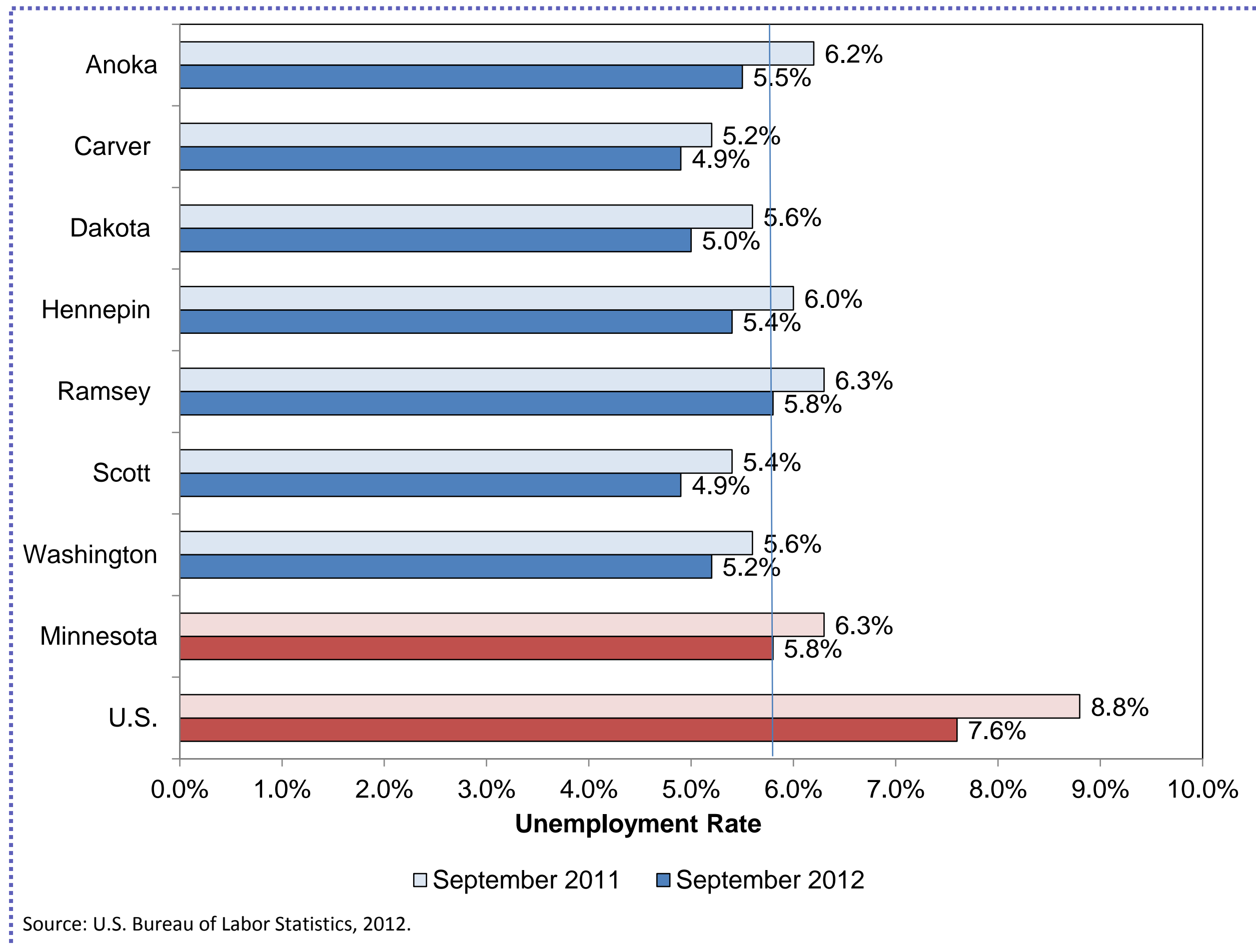


Sources: Microsoft MapPoint and Thomson Reuters via Children's 2012

Unemployment rates

High unemployment rates are associated with high numbers of uninsured people due to the lack of employer-based insurance. All counties reported unemployment rates in 2011 and 2012 that were lower than or equal to the Minnesota average (**Exhibit 18**).

Exhibit 18: Unemployment Rates, 2011-2012



Source: U.S. Bureau of Labor Statistics, 2012.

Homelessness

Since 1991, Wilder Research has conducted a triennial survey of the homeless population throughout Minnesota. Hennepin County reported the greatest rate of homeless children, while Ramsey County reported the greatest rate of homeless families (**Exhibit 19)**. Hennepin and Ramsey were the only counties to report rates of homelessness greater than the Minnesota average. Carver and Scott counties reported the lowest rates of homelessness in the broader community.

Exhibit 19: Homelessness Rates in the Broader Community, 2009

County	Number		Rate per 100,000	
	Children	Families	Children	Families
Anoka	134	70	40.7	165.5
Carver/Scott*	34	18	15.6	54.0
Dakota	148	80	37.3	150.5
Hennepin	1,356	659	118.3	497.1
Ramsey	490	279	96.7	498.9
Washington	49	24	20.8	74.6
Minnesota	**3,251**	**1675**	**61.6**	**262.8**

Hennepin County reported a child homelessness rate double the Minnesota average

Source: Wilder Research 2009 Minnesota homeless study (compiled in 2011) and U.S. Census Bureau: American Community Survey 5 Year Estimates, 2007-2011.
* Data for Carver and Scott counties were combined in the original source.

Crime

The Minnesota Department of Public Safety's Bureau of Criminal Apprehension reports data on violent and property crime in Minnesota from county police departments that participate in its Uniform Crime Reporting (UCR) Program. Hennepin and Ramsey counties reported higher rates of violent and property crime than the Minnesota average in 2011. Within the broader community, Ramsey County reported the highest rates of violent and property crime (**Exhibit 20**).

Exhibit 20: Violent Crime Rates in the Broader Community, 2011

County	Crime Rates Per 100,000 Population									
	Violent Crime				Property Crime					
	Murder	Rape	Robbery	Aggravated Assault	Burglary	Larceny	Motor Vehicle Theft	Arson	Violent Crime Total	Property Crime Total
Anoka	1	44	32	84	405	2,635	107	12	163	3,162
Carver	1	15	9	39	176	893	23	7	66	1101
Dakota	0	25	25	99	296	1,754	71	7	149	2131
Hennepin	3	51	172	190	699	2,463	214	18	416	3,394
Ramsey	2	44	139	248	817	2,465	462	27	434	3,773
Scott	0	29	12	63	261	1,570	55	12	110	1,974
Washington	1	14	13	40	342	1,870	103	7	70	2,324
Minnesota	**1**	**39**	**63**	**120**	**47**	**1,897**	**149**	**12**	**224**	**2,533**

Key	
Better than MN	
0%-50% worse than MN	
50% to 75% worse than MN	
>75% worse than MN	

Source: Minnesota Department of Public Safety Uniform Crime Report, 2011.

Exhibit 21 reports pediatric arrest rates by county from 2007 to 2009, the most recent years available from the Minnesota Bureau of Criminal Apprehension. Four of the seven counties in the Children's broader community reported higher rates of arrests for serious crimes than the state average in 2009.

Exhibit 21: Children Aged 10-17 Arrested for Serious Crimes* in the Broader Community, 2007-2009

County	Number			Rate** per 1,000 Children 10-17		
	2007	2008	2009	2007	2008	2009
Anoka	865	855	830	21.3	21.3	21.2
Carver	133	103	190	11.5	8.8	15.6
Dakota	869	947	958	17.8	19.7	20.6
Hennepin	3,188	3,293	3,257	27.6	29.0	30.1
Ramsey	982	1,752	1596	17.9	32.7	32.9
Scott	138	157	195	8.7	9.7	12.0
Washington	424	412	309	14.9	14.6	10.8
Minnesota	**10,895**	**11,847**	**11,351**	**19.1**	**21.1**	**20.5**

Source: Minnesota Bureau of Criminal Apprehension via Minnesota Department of Health, 2011.

*Children aged 10-17 arrested for Part I crimes: murder, rape, robbery, aggravated assault, burglary, larceny, vehicle theft, and arson. Not all children arrested for serious crimes committed these crimes, and some children are not arrested for crimes that they actually committed.

**Rates may be low because of the inclusion of children in the younger age ranges and the inclusion of females, both of whom have fewer arrests.

The impact of budget cuts in Minnesota

The recent recession had major implications for employment and for the availability of state and county resources devoted to health, public health, and social services. In previous budget cycles, Minnesota significantly reduced funding appropriated to these services. Funding reductions included Medicaid reimbursement rates cuts to hospitals and providers, dramatic decreases in public health initiatives such as the Statewide Health Improvement Program (SHIP), reductions in Emergency Medical Assistance (EMA), and cuts to mental health services.

For the first time in several budget cycles, the 2013 legislative session did not result in cuts or reductions to health and human services. In fact, many programs previously cut were restored to near pre-2011 levels, including funding for medical education training, SHIP, personal care attendant services and EMA. Investments were also made in mental health, particularly school-based mental health services and reimbursement for mental health providers. In addition, Minnesota enacted legislation creating its own state based health insurance exchange and basic health plan, expanding health insurance coverage to an additional 87,000 Minnesotans.

Utilization of government assistance programs

Federal, state, and local governments provide assistance programs for low-income individuals and families. These programs include vouchers that subsidize housings costs, free and reduced-price lunches at public schools through the National School Lunch Program, the Supplemental Nutrition Assistance Program (SNAP), Medical Assistance and MinnesotaCare, and Temporary Assistance for Needy Families (TANF). Minnesota refers to SNAP as Food Support and TANF as the Minnesota Family Investment Program (MFIP).

Housing certificates and vouchers allow residents who meet certain eligibility criteria to receive monthly housing assistance under Section 8 of the Housing Act of 1937. Under that program,

subsidies of rental and mortgage costs help make housing more affordable. Residents who apply for these certificates and vouchers may be placed on a waiting list before funds become available. Anoka, Carver, Hennepin, Ramsey, and Washington counties all reported average months on the waiting list for Section 8 housing certificates and vouchers that were greater than both the Minnesota and U.S. averages. Average household federal contributions for all seven counties in the broader community were higher than the U.S. and Minnesota averages (**Exhibit 22**).

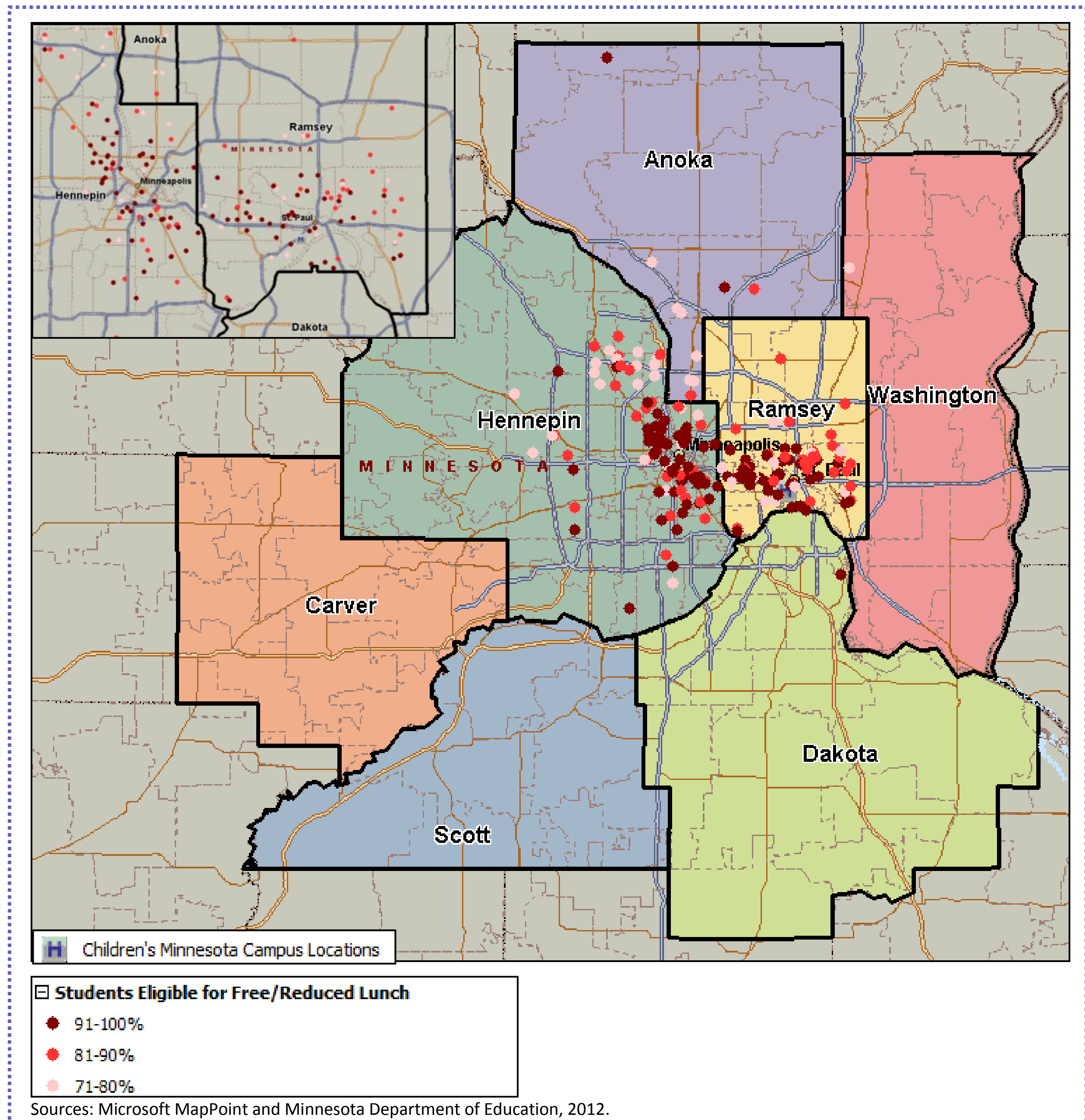
Exhibit 22: Waiting Time for Section 8 Housing Certificates and Vouchers in the Broader Community, 2009

County	Number of Participating Households	Spending per Unit per Month		Average Months on Waiting List
		Average Household Contribution	Average Federal Contribution	
Anoka	1,390	$ 379	$ 663	25
Carver	154	$ 384	$ 620	22
Dakota	2,547	$ 390	$ 588	6
Hennepin	8,865	$ 365	$ 712	17
Ramsey	5,349	$ 314	$ 683	15
Scott	315	$ 405	$ 741	5
Washington	460	$ 429	$ 638	19
Minnesota	**30,543**	**$ 330**	**$ 560**	**12**
U.S.	**2,040,801**	**$ 319**	**$ 580**	**9**

Source: U.S. Department of Housing and Urban Development, 2012.

Schools participating in the National School Lunch Program are eligible to receive financial assistance from the USDA to provide free or reduced-cost meals to low-income students. Schools with 40 percent or more of their student body receiving free or reduced-cost meals are eligible for school-wide Title I funding, designed to ensure that students meet grade-level proficiency standards. In the Children's broader community, 270 schools had greater than 70 percent of the student body eligible for free or reduced-cost lunches (**Exhibit 23**). These schools are primarily located proximate to the hospital campuses, in the immediate community.

Exhibit 23: Public Schools with Over 70% of Students Eligible for Free or Reduced Price Lunches, School Year 2011-2012



Sources: Microsoft MapPoint and Minnesota Department of Education, 2012.

Exhibit 24 shows the percent of the total population enrolled in the Minnesota Food Assistance Program (also known as Food Support). This program is offered as part of the U.S. Department of Health and Human Services Supplemental Nutrition Assistance Program (SNAP) and provides financial assistance to eligible low-income and no-income families with dependent children. Minnesota's Food Support program also provides support for certain noncitizens over the age of 50 who are not covered by SNAP.5 From 2006 to 2011, children have exhibited the fastest growth in enrollment, increasing by 150 percent.6

Exhibit 24: Minnesota Food Assistance Program Enrollment in the Broader Community, 2011

County	Percent of Enrollees that are Children	Total Enrollees
Anoka	43.5%	23,390
Carver	46.0%	3,172
Dakota	47.0%	21,511
Hennepin	36.4%	108,054
Ramsey	40.1%	64,070
Scott	50.0%	5,960
Washington	44.7%	9,736
Minnesota	**40.7%**	**448,362**

Source: Minnesota Department of Human Services, 2012.

Anoka, Carver, Dakota, Scott, and Washington counties reported a higher percent of Food Support enrollees who are children than the Minnesota average

Exhibit 25 shows the percent of enrollees in Medical Assistance and MinnesotaCare who are children and families in each county. Medical Assistance (MA) is Minnesota's Medicaid program, which currently provides coverage for 733,000 Minnesotans up to approximately 100 percent of the federal poverty level (FPL). MinnesotaCare currently covers an additional 129,000 Minnesotans who do not have employer-sponsored insurance but do not meet the income requirements for MA.7 Anoka County had the greatest proportion of Medicaid enrollees who were children and families, at 70.6 percent; children and families made up the greatest proportion of MinnesotaCare enrollees in Scott County, at 71.5 percent.

5Minnesota Department of Human Services. (2012, 26 November). The Minnesota Food Assistance Program. Retrieved 2012, from
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_017791
6Minnesota Department of Human Services. (2012, August). Characteristics of People and Cases on the Supplemental Nutrition Assistance Program December 2011. Retrieved 2012, from
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_149063
7 Minnesota Department of Human Services(2012, October). Minnesota Health Care Programs. Retrieved 2012, from https://edocs.dhs.state.mn.us/lfserver/public/DHS-3182-ENG

Exhibit 25: Medicaid and Minnesota Care Average Monthly Enrollment in the Broader Community, 2011

County	Percent of County Enrollees that are Children and Families	
	Medical Assistance	MinnesotaCare
Anoka	70.6%	61.5%
Carver	65.7%	64.5%
Dakota	67.6%	66.0%
Hennepin	61.1%	55.7%
Ramsey	66.7%	59.3%
Scott	69.3%	71.5%
Washington	67.5%	66.3%
Minnesota	**65.5%**	**60.6%**

Source: Minnesota Department of Human Services, 2012.

Anoka County reported the highest percent of children and families as enrollees in Medical Assistance

Exhibit 26 shows the percent of the total pediatric population in each county that is enrolled in the Minnesota Family Investment Program (MFIP). MFIP combines cash and food support for eligible low-income and no-income families. MFIP functions as part of the federal Temporary Assistance for Needy Families program (TANF). Ramsey County had the greatest percent of children enrolled in MFIP, at 1.6 percent.

Exhibit 26: Children Enrolled in MFIP in the Broader Community, 2011

County	Percent of Children Enrolled in MFIP
Anoka	0.6%
Carver	0.1%
Dakota	0.4%
Hennepin	1.3%
Ramsey	1.6%
Scott	0.3%
Washington	0.3%
Minnesota	**0.8%**

Source: Minnesota Department of Human Services, 2012.

Hennepin and Ramsey counties both reported higher percentages of children enrolled in MFIP than the state average

Insurance status

Exhibit 27 indicates that, in 2011, a higher percentage of residents and children in Hennepin and Ramsey counties were uninsured than the Minnesota average.

Exhibit 27: Uninsured Population by Age Cohort in the Broader Community, 2011

County	Percent Uninsured	
	Total Population	Population 0-17
Anoka	8.9%	6.5%
Carver	6.1%	3.8%
Dakota	6.7%	6.0%
Hennepin	10.4%	7.1%
Ramsey	10.7%	6.9%
Scott	8.4%	5.5%
Washington	6.0%	4.0%
Minnesota	**9.1%**	**6.6%**
U.S.	**15.5%**	**8.0%**

Source: U.S. Census Bureau, 2012.

Hennepin and Ramsey counties both reported higher pediatric uninsured populations than the Minnesota average

Exhibit 28A and 28B portray the distribution of community-wide discharges in the immediate community and broader community by payer.

Exhibit 28A: Discharges in the Immediate Community by Payer, 2011

School District	Zip Code	Discharges	Commercial/ Self-Pay	Medicaid / PMAP	Medicare	Other	Private
Minneapolis	55401	11	9.1%	9.1%	0.0%	0.0%	81.8%
	55402	-	0.0%	0.0%	0.0%	0.0%	0.0%
	55403	12	8.3%	50.0%	0.0%	0.0%	41.7%
	55404	171	0.6%	81.3%	0.0%	0.0%	18.1%
	55405	57	0.0%	71.9%	0.0%	0.0%	28.1%
	55406	94	1.1%	55.3%	0.0%	2.1%	41.5%
	55407	247	3.6%	76.1%	0.0%	0.0%	20.2%
	55408	129	1.6%	90.7%	0.0%	0.0%	7.8%
	55409	61	0.0%	65.6%	0.0%	0.0%	34.4%
	55410	55	0.0%	18.2%	0.0%	1.8%	80.0%
	55411	187	0.5%	84.5%	0.0%	0.5%	14.4%
	55412	115	0.0%	73.9%	0.0%	1.7%	24.3%
	55413	37	0.0%	78.4%	0.0%	0.0%	21.6%
	55414	27	0.0%	59.3%	0.0%	0.0%	40.7%
	55415	10	0.0%	100.0%	0.0%	0.0%	0.0%
	55416	67	0.0%	16.4%	0.0%	3.0%	80.6%
	55417	95	3.2%	31.6%	0.0%	1.1%	64.2%
	55418	90	1.1%	52.2%	0.0%	0.0%	46.7%
	55419	76	3.9%	35.5%	0.0%	0.0%	60.5%
	55430	65	0.0%	81.5%	0.0%	0.0%	18.5%
	55454	32	0.0%	93.8%	0.0%	0.0%	6.3%
	55455	2	0.0%	100.0%	0.0%	0.0%	0.0%
	55458	1	0.0%	100.0%	0.0%	0.0%	0.0%
	Subtotal	**1,641**	**1.4%**	**66.6%**	**0.0%**	**0.5%**	**31.4%**
St. Paul	55101	13	0.0%	92.3%	0.0%	0.0%	7.7%
	55102	57	1.8%	63.2%	0.0%	0.0%	35.1%
	55103	72	1.4%	80.6%	0.0%	0.0%	18.1%
	55104	200	0.0%	70.0%	0.0%	0.0%	30.0%
	55105	69	2.9%	18.8%	0.0%	0.0%	78.3%
	55106	331	1.2%	71.0%	0.0%	0.3%	27.5%
	55107	85	2.4%	69.4%	0.0%	0.0%	28.2%
	55108	56	1.8%	48.2%	0.0%	1.8%	48.2%
	55114	5	0.0%	20.0%	0.0%	0.0%	80.0%
	55116	63	1.6%	46.0%	0.0%	1.6%	50.8%
	55117	248	0.8%	69.0%	0.0%	0.4%	29.8%
	55119	189	1.6%	54.0%	0.0%	1.1%	43.4%
	55130	126	0.8%	84.1%	0.0%	0.0%	15.1%
	Subtotal	**1,514**	**1.2%**	**65.3%**	**0.0%**	**0.4%**	**33.1%**
West St. Paul - Mendota Heights - Eagan	55118	141	2.1%	58.2%	0.0%	0.0%	39.7%
	55120	14	0.0%	14.3%	0.0%	0.0%	85.7%
	55121	30	0.0%	20.0%	0.0%	0.0%	80.0%
	55150	-	0.0%	0.0%	0.0%	0.0%	0.0%
	Subtotal	**185**	**1.6%**	**48.6%**	**0.0%**	**0.0%**	**49.7%**
Richfield	55423	114	**0.0%**	**64.0%**	**0.0%**	**0.0%**	**36.0%**
South St. Paul	55075	94	**0.0%**	**46.8%**	**0.0%**	**1.1%**	**52.1%**
Immediate Community Total		**3,548**	**1.2%**	**64.5%**	**0.0%**	**0.5%**	**33.8%**
Broader Community Total		**9,205**	**1.0%**	**44.8%**	**0.2%**	**0.7%**	**53.3%**

Source: Children's, 2012.

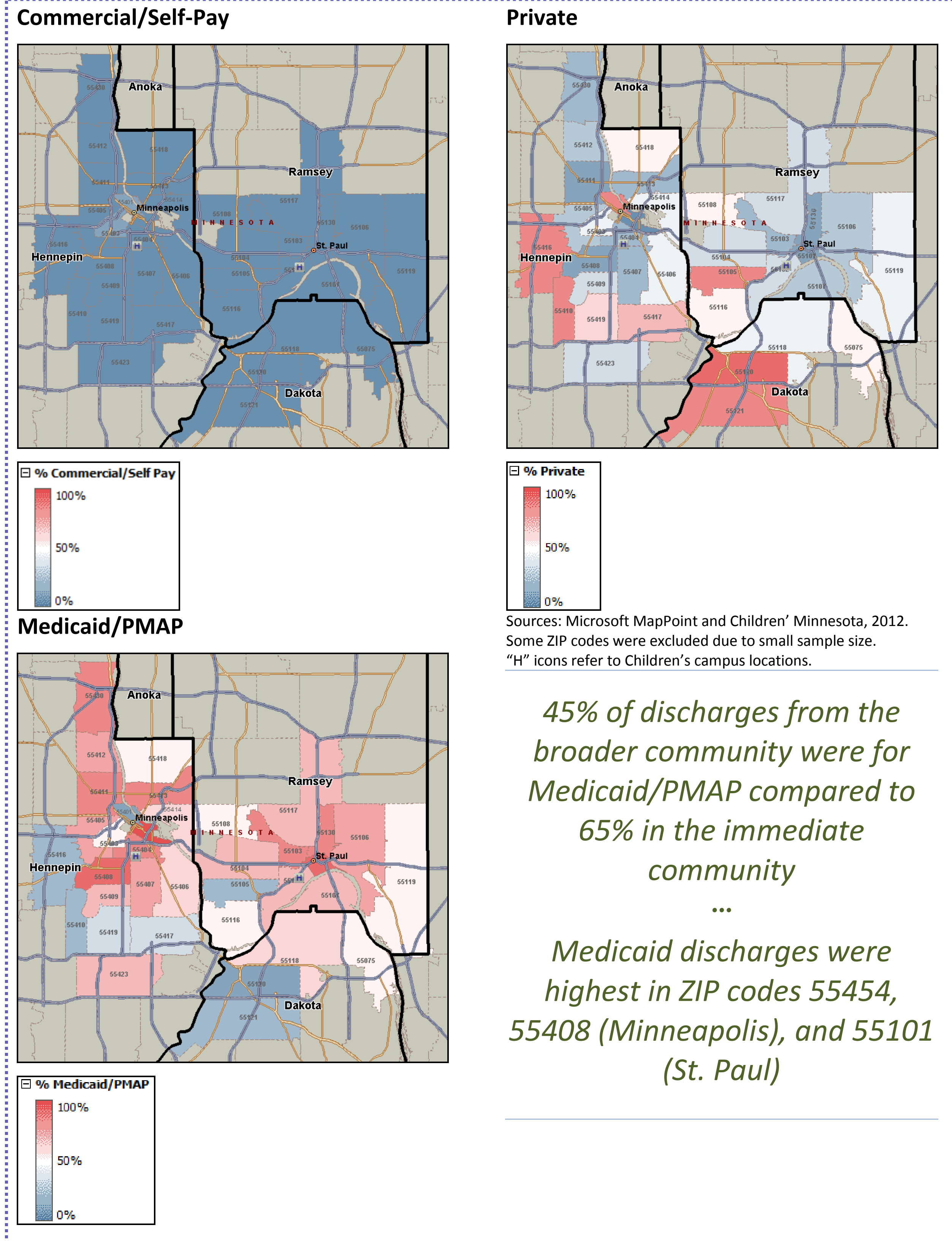
Exhibit 28B: Discharges in the Broader Community by Payer, 2011

County	Discharges	Commercial / Self-Pay	Medicaid / PMAP	Medicare	Other	Private
Anoka	830	0.7%	38.8%	0.0%	0.8%	59.6%
Carver	262	1.1%	20.6%	5.3%	0.8%	72.1%
Dakota	1,287	0.9%	36.0%	0.0%	1.2%	61.9%
Hennepin	3,649	1.1%	50.1%	0.1%	0.5%	48.3%
Ramsey	2,091	1.1%	57.5%	0.0%	0.3%	41.0%
Scott	296	2.0%	23.3%	0.0%	1.4%	73.3%
Washington	790	0.8%	23.5%	0.0%	1.3%	74.4%
Total	**9,205**	**1.0%**	**44.8%**	**0.2%**	**0.7%**	**53.3%**

Source: Children's, 2012.

The percentage of Medicaid discharges was higher in the immediate community than in the broader community as a whole. In the immediate community, Medicaid discharges were highest in the Minneapolis, St. Paul, and Richfield school districts**.** Commercial/Self-Pay discharges were prevalent in ZIP codes 55407 and 55417 in the Minneapolis school district **(Exhibit 29)**.

Exhibit 29: Discharges by Payer and ZIP Code in the Immediate Community, 2011



County-level health status and access indicators

The following secondary data sources have been used to examine county-level health status and access to care indicators in the community served by Children's: (1) County Health Rankings, (2) Community Health Status Indicators Project, (3) Minnesota Department of Health, (4) Minnesota Student Survey, and (5) Minnesota Department of Human Services.

Key insights: ***County-Level Indicators***

- On average, Hennepin, and Ramsey counties benchmark poorly on the greatest number of indicators.
- Anoka, Hennepin, and Ramsey counties demonstrate comparatively high rates of teen pregnancy.
- Poor community safety, poor built environment, and higher rates of abuse and neglect create negative physical surroundings for children in Hennepin and Ramsey counties.
- The majority of pediatric injury mortalities in the community are due to unintentional injury and suicide.
- Hennepin and Ramsey counties demonstrate high rates of communicable diseases, in particular sexually transmitted diseases and tuberculosis. Dakota County demonstrates high rates of pertussis.
- Approximately 50-60 percent of children aged 24-35 months have completed the recommended series of immunizations.
- Disparities between non-White and White infant mortality and out-of-home care rates are present.
- Women in Hennepin and Scott counties are not accessing prenatal care at optimal rates.
- Among older students, alcohol and drug abuse are prevalent.
- Many students reported having asthma and engaging in 11 or more hours of screen time per week.

County Health Rankings

County Health Rankings, a collaborative project between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, ranks each county within each state in terms of health factors and health outcomes. The health outcomes measure is a composite based on mortality and morbidity statistics. The health factors measure is a composite of several variables known to affect health outcomes: health behaviors, clinical care, social and economic factors, and physical environment. Although the health factors and health outcomes data measured in *County Health Rankings* are not specific to children, it is meaningful to assess the social/familial, economic, behavioral, and environmental context in which children live; often children do not have the agency to alter the factors that affect their health and wellbeing.

County Health Rankings is updated annually. *County Health Rankings 2012* relies on data from 2002 to 2010, with most data originating in 2006 to 2009. *County Health Rankings 2011* relies on

data from 2001 to 2009, with most data originating in 2006 to 2008. In 2011, *County Health Rankings* was able to rank 85 of Minnesota's 87 counties. In 2012, *County Health Rankings* ranked 84 counties.

Exhibits 30A and 30B provide a summary analysis of the rankings for the seven counties in the community served by Children's. Rankings for Minnesota were divided into quartiles to indicate how each county ranks versus others in the State. **Exhibits 30A and 30B** illustrate the quartile into which each area fell by indicator in the 2012 edition, and also illustrates whether an area's ranking worsened or improved from 2011. For example, in the 2012 edition, Anoka County was in the bottom half (63rd out of 84) of Minnesota counties for the overall rate of morbidity; its ranking in 2012 fell for this indicator compared to the 2011 edition.

Exhibit 30A: County-Level Health Status and Access Indicators

Indicator	Anoka	Rank Change 2011 to 2012	Carver	Rank Change 2011 to 2012	Dakota	Rank Change 2011 to 2012
Health Outcomes	↓	34 to 38		5 to 2		17 to 8
Mortality		21 to 20		1 to 1		12 to 3
Morbidity	↓	61 to 63		14 to 12	↓	33 to 39
Health Factors	↓	36 to 51		2 to 2	↓	6 to 8
Health Behaviors		71 to 68		6 to 6		14 to 9
Tobacco Use	↓	66 to 67	↓	10 to 19	↓	21 to 29
Diet and Exercise*		N/A		N/A		N/A
Alcohol Use	↓	23 to 26	↓	17 to 34		13 to 7
Sexual Activity		58 to 57		6 to 6	↓	46 to 54
Clinical Care	↓	25 to 47		6 to 4		18 to 17
Access to Care	↓	11 to 25		5 to 3		20 to 16
Quality of Care	↓	55 to 71	↓	16 to 39		26 to 26
Social & Economic Factors	↓	29 to 34		2 to 1	↓	8 to 11
Education	↓	46 to 47		5 to 5	↓	7 to 11
Employment		50 to 48		29 to 28	↓	24 to 34
Income	↓	7 to 9		2 to 1	↓	4 to 6
Family and Social Support		49 to 42		2 to 2		53 to 39
Community Safety	↓	53 to 74		25 to 6		35 to 27
Physical Environment	↓	16 to 59	↓	34 to 36	↓	41 to 66
Environmental Quality		1 to 1		1 to 1		67 to 65
Built Environment*	↓	N/A	↓	N/A	↓	N/A

Source: *County Health Rankings*, 2011 and 2012.
*The 2012 edition of *County Health Rankings* used different data sources for the "Diet and Exercise" and "Built Environment" indicators than the 2011 edition. Therefore, it is not possible to draw comparisons between years for these indicators.

Key	
2012 County Ranking 1-42	
2012 County Ranking 43-63	
2012 County Ranking 64-84/85**	
Ranks Not Comparable Between 2011 and 2012	N/A
Rank Decreased from 2011 to 2012	↓

**In 2011, CHR was able to rank 85 of Minnesota's 87 counties. In 2012, CHR ranked 84 counties.

Exhibit 30B: County-Level Health Status and Access Indicators

Indicator	Hennepin	Rank Change 2011 to 2012	Ramsey	Rank Change 2011 to 2012	Scott	Rank Change 2011 to 2012	Washington	Rank Change 2011 to 2012
Health Outcomes	↓	48 to 52	↓	59 to 61	↓	6 to 10		11 to 7
Mortality		39 to 39		55 to 55		12 to 12		9 to 7
Morbidity		70 to 69	↓	71 to 72		33 to 28	↓	19 to 32
Health Factors	↓	5 to 30	↓	32 to 69		6 to 5		3 to 3
Health Behaviors	↓	1 to 4	↓	15 to 16		14 to 5	↓	3 to 7
Tobacco Use	↓	20 to 28	↓	29 to 55	↓	21 to 24	↓	23 to 33
Diet and Exercise*		N/A		N/A		N/A	↓	N/A
Alcohol Use		10 to 9		7 to 6	↓	13 to 43	↓	11 to 14
Sexual Activity		81 to 80		85 to 83		46 to 21	↓	17 to 20
Clinical Care	↓	4 to 5	↓	9 to 20	↓	18 to 21		2 to 2
Access to Care	↓	4 to 7	↓	7 to 22		20 to 8		3 to 2
Quality of Care		20 to 13		23 to 22	↓	26 to 46	↓	10 to 11
Social & Economic Factors	↓	59 to 75	↓	72 to 80		8 to 3		3 to 2
Education	↓	30 to 52	↓	42 to 64		7 to 7		3 to 1
Employment	↓	25 to 28	↓	36 to 42	↓	24 to 34	↓	25 to 28
Income	↓	41 to 66	↓	77 to 80		4 to 2	↓	1 to 3
Family and Social Support	↓	72 to 76		80 to 80		53 to 3	↓	16 to 17
Community Safety	↓	82 to 84	↓	81 to 83	↓	35 to 41	↓	25 to 28
Physical Environment	↓	6 to 35	↓	25 to 67	↓	41 to 45	↓	77 to 80
Environmental Quality		1 to 1		67 to 65		67 to 1		83 to 82
Built Environment*		N/A		N/A		N/A		N/A

Source: *County Health Rankings* 2011 and 2012.

*The 2012 edition of *County Health Rankings* used different data sources for the "Diet and Exercise" and "Built Environment" indicators than the 2011 edition. Therefore, it is not possible to draw comparisons between years for these indicators.

Key	
2012 County Ranking 1-42	
2012 County Ranking 43-63	
2012 County Ranking 64-84/85**	
Ranks Not Comparable Between 2011 and 2012	N/A
Rank Decreased from 2011 to 2012	↓

**In 2011, CHR was able to rank 85 of Minnesota's 87 counties. In 2012, CHR ranked 84 counties.

For the Children's broader community, the indicators that most frequently ranked in the bottom one-half of Minnesota counties include sexual activity8 and built environment.[9]
Ramsey County had the highest number of unfavorable indicators, ranking in the bottom one-half of Minnesota areas on the following: Mortality, morbidity, health factors, tobacco use, sexual activity,[10] education, income, family and social support, community safety,[11] environmental quality,[12] and built environment.

Community Health Status Indicators Project

The *Community Health Status Indicators* (CHSI) Project, provided by the U.S. Department of Health and Human Services, compares many health status and access indicators to both the median rates in the U.S. and to rates in "peer counties" across the U.S.

Counties are considered "peers" if they share common characteristics such as population size, poverty rate, average age, and population density. **Exhibit 31** highlights the analysis of CHSI health status indicators. Cells in the table are shaded if, on that indicator, a county compared unfavorably both to the U.S. as a whole and to the group of specified peer communities. Although not all of the data measured by CHSI are specific to children, the selected indicators may affect the health and wellbeing of children either directly or indirectly.

8 A composite measure that examines the chlamydia rate per 100,000 population and the teen birth rate per 1,000 females ages 15 to 19.
9 A measure that examines the percent of the population without easy access to food, the number of fast food restaurants, and the availability of recreational facilities.
10 A composite measure that examines the chlamydia rate per 100,000 population and the teen birth rate per 1,000 females ages 15 to 19.
11 A measure that examines the violent crime rate per 100,000 population.
12 A composite measure that examines the number of air pollution-particulate matter days and air pollution-ozone days.

Exhibit 31: Unfavorable Health Status Indicators

Indicator	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington
Low Birth Weight Infants							
Very Low Birth Weight Infants							
Premature Births							
No Care in First Trimester							
Births to Women under 18							
Births to Women age 40-54*							
Births to Unmarried Women							
Infant Mortality							
Hispanic Infant Mortality							
White non Hispanic Infant Mortality							
Black non Hispanic Infant Mortality							
Neonatal Infant Mortality							
Post-neonatal Infant Mortality							
Homicide							
Suicide							
Motor Vehicle Injuries							
Unintentional Injury							

Key	
Better than U.S	
0%-50% worse than U.S.	
50% to 75% worse than U.S.	
>75% worse than U.S.	

Source: The *Community Health Status Indicators* Project, 2010.

* The Community Health Status Indicators Project considers a high number of births to women age 40-54 to be an unfavorable health outcome. Caution should be used when interpreting this indicator; women may be choosing to delay having children to pursue career or educational goals.

Overall, the Children's broader community compared relatively favorably for most health indicators. Ramsey County compared unfavorably on three indicators, followed by Dakota County with two. Births to women age 40-54 compared unfavorably in five of seven areas.

Minnesota Department of Health

The Minnesota Department of Health (MDH) maintains a publicly-available data warehouse that includes indicators regarding a number of health issues. **Exhibits 32-40** provide information on pediatric injury mortality rates, motor vehicle safety indicators, the potential life lost due to leading causes of death, morbidity rates of various reportable diseases, vaccination rates, and maternal and child health indicators.

In 2010, unintentional injury and perinatal conditions were the leading causes of death for youth in the state and in the community served by Children's. **Exhibit 32** reports injury mortalities for residents younger than age 20 by county in 2010. Washington County reported a higher proportion of pediatric injury mortality than the state average for three injury types. Anoka, Hennepin, and Ramsey counties reported higher proportions of pediatric injury mortality than Minnesota for two injury types. In the broader community, the majority of injury deaths were due to unintentional injury or suicide.

Exhibit 32: Pediatric Injury Mortality by Cause in the Broader Community, 2010

Injury Type	Injury Mortalities Ages 0-19							
	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington	Minnesota
Number of Injury Mortalities								
Unintentional	11	1	8	24	5	1	2	**132**
Homicide	1	0	0	11	7	0	1	**29**
Suicide	5	3	1	6	5	3	5	**45**
Falls	0	0	0	0	0	0	0	**2**
Motor	4	1	4	4	0	1	0	**59**
Pedestrian	2	0	1	1	1	0	1	**9**
Percent of Injury Mortalities								
Unintentional	47.8%	20.0%	57.1%	52.2%	27.8%	20.0%	22.2%	**47.8%**
Homicide	4.3%	0.0%	0.0%	23.9%	38.9%	0.0%	11.1%	**10.5%**
Suicide	21.7%	60.0%	7.1%	13.0%	27.8%	60.0%	55.6%	**16.3%**
Falls	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.7%**
Motor	17.4%	20.0%	28.6%	8.7%	0.0%	20.0%	0.0%	**21.4%**
Pedestrian	8.7%	0.0%	7.1%	2.2%	5.6%	0.0%	11.1%	**3.3%**

Source: Minnesota Department of Health, 2011.

Exhibit 33 demonstrates the prevalence of teen car occupant fatalities by county. Carver, Dakota, Ramsey, and Washington counties all reported higher percentages of teen vehicle occupant fatalities than the state average. Carver, Ramsey, and Washington counties reported a higher prevalence of teen fatalities in which the teen was not wearing a seat belt than the Minnesota average.

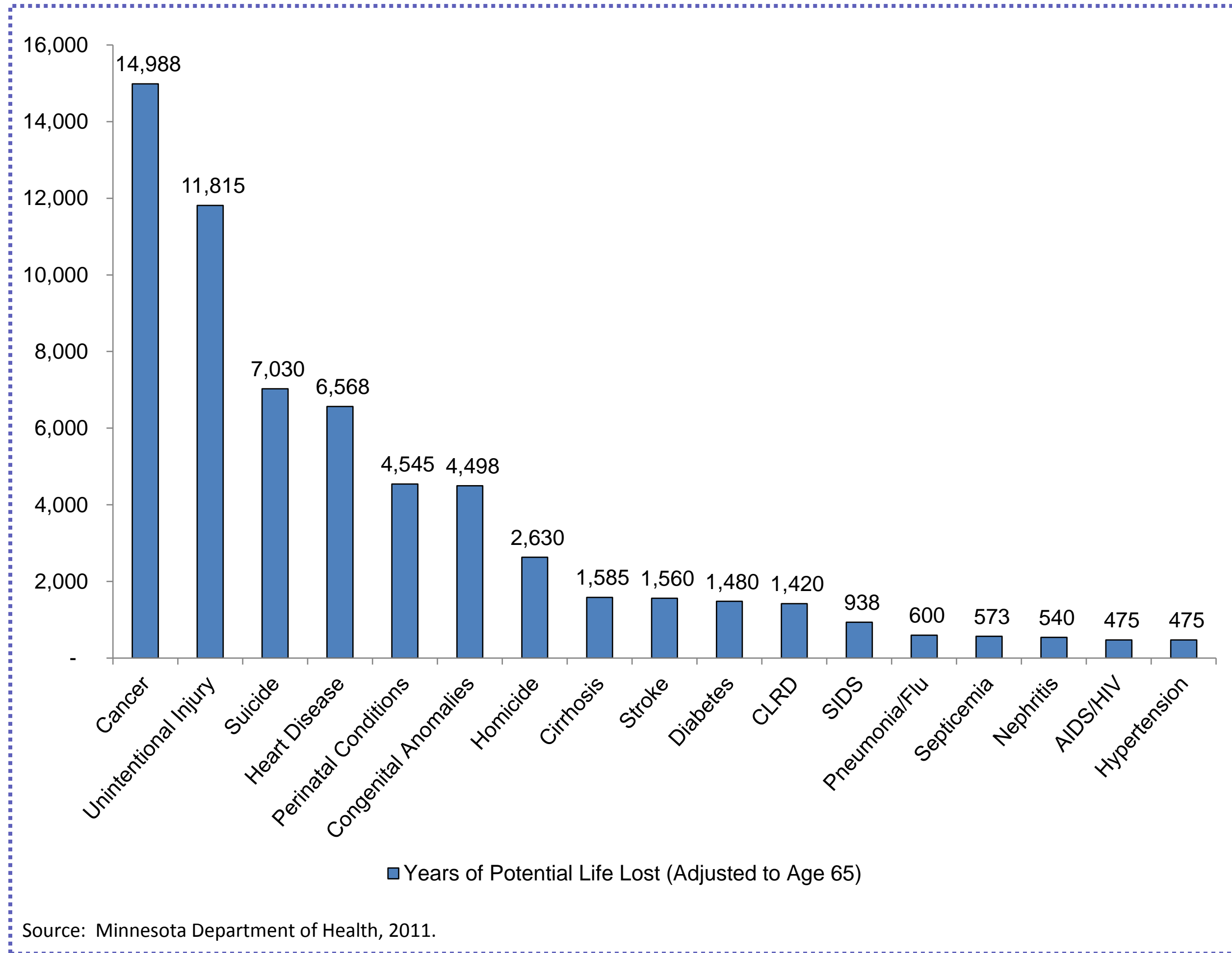
Exhibit 33: Motor Vehicle Safety Indicators in the Broader Community, 2011

County	Total Motor Vehicle Fatalities	Total Vehicle Occupant Fatalities	Teen Vehicle Occupant Fatalities Percent of Total Vehicle Occupant Fatalities	Teen Unbelted Vehicle Occupant Fatalities Percent of Total Vehicle Occupant Fatalities
Anoka	11	8	0.0%	0.0%
Carver	6	5	20.0%	20.0%
Dakota	16	6	16.7%	0.0%
Hennepin	45	27	3.7%	3.7%
Ramsey	14	5	20.0%	20.0%
Scott	9	7	0.0%	0.0%
Washington	6	3	33.3%	33.3%
Minnesota	**368**	**271**	**13.3%**	**8.9%**

Source: Minnesota Department of Public Safety, Office of Traffic Safety, June 2012.

Years of potential life lost (YPLL) is a measure of premature death calculated by subtracting the age of death from a standard life expectancy estimate (a conservative estimate of age 65 was used in this analysis). **Exhibit 34** examines the years of potential life lost (YPLL) by cause of death in the broader community. Cancer, unintentional injury, suicide, heart disease, and perinatal conditions cost the community the most years of life.

Exhibit 34: Years of Potential Life Lost by Cause in the Broader Community, 2010



Source: Minnesota Department of Health, 2011.

Exhibit 35 examines disease morbidity rates by county and compares them to the state average. Ramsey County compared unfavorably to the state average in eight of the twelve diseases followed by Hennepin County with six. Both counties exhibited high rates of sexually transmitted diseases.

Exhibit 35: Reported Disease Morbidity in the Broader Community, 2010

Disease	Rates per 100,000 population							
	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington	Minnesota
Pertussis	13.9	24.2	33.6	20.3	17.7	N/A	21.8	**21.5**
Campylo-bacteriosis13	11.5	N/A	15.6	15.4	19.5	N/A	13.0	**19.0**
Giardiasis14	6.6	N/A	7.8	12.2	38.9	N/A	10.5	**16.0**
Lyme Disease	32.9	N/A	17.3	14.5	16.7	N/A	29.0	**24.4**
Human Anaplasmosis15	10.3	N/A	N/A	6.0	8.7	N/A	N/A	**13.6**
Salmonellosis16	10.0	N/A	13.0	13.1	19.5	N/A	10.9	**13.1**
Shigellosis17	N/A	N/A	N/A	2.5	N/A	N/A	N/A	**1.2**
Tuberculosis	0.9	N/A	N/A	5.8	6.7	N/A	N/A	**2.5**
Chlamydia	275.1	95.6	238.1	454.9	487.8	157.8	163.8	**288.4**
Gonorrhea	26.3	N/A	22.3	93.1	66.6	N/A	12.6	**40.0**
Syphilis - All Stages	6.0	N/A	N/A	18.5	8.3	N/A	N/A	**6.5**
HIV	N/A	N/A	N/A	15.2	10.8	N/A	N/A	**6.2**

Key	
Better than MN	
0%-50% worse than MN	
50% to 75% worse than MN	
>75% worse than MN	

Sources: Minnesota Department of Health, 2011.
*Certain rates are not reported due to insufficient sample size. Rates were calculated using U.S. Census 2010 demographic estimates.

Exhibit 36 displays the percent of children between the ages of two and three who have received a series of age-appropriate vaccinations by county in the Children's service area. Every county reported lower rates of Hepatitis B vaccination than the state average. Ramsey reported the smallest percentage children who had received their complete series of vaccine doses at 47.5 percent; Carver reported the greatest percentage at 60.5 percent.

13 Diarrheal illness caused by bacteria, often food-borne.
14 Parasitic disease affecting the digestive tract.
15 Tick-borne disease.
16 Infection caused by the bacteria salmonella.
17 Fecal-orally transmitted bacterial infection of the intestines.

Exhibit 36: Children Aged 24-35 Months* With Recommended Vaccinations in the Broader Community, 2011

MIIC Immunizations**	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington	Minnesota
DTaP18	70.3%	79.7%	71.5%	71.5%	63.3%	76.3%	69.2%	**72.0%**
Polio	82.8%	89.0%	84.5%	84.2%	77.4%	87.7%	80.0%	**85.6%**
MMR19	86.1%	88.8%	84.9%	83.7%	83.1%	87.7%	88.4%	**86.0%**
Hib20	80.9%	85.2%	80.7%	78.0%	74.7%	84.0%	80.4%	**79.7%**
Hepatitis B	79.1%	79.5%	77.2%	75.7%	73.3%	75.7%	75.6%	**79.6%**
Varicella	84.8%	87.0%	83.6%	83.3%	81.2%	86.5%	86.8%	**84.3%**
Pneumococcal	78.8%	87.1%	78.8%	78.0%	72.6%	83.3%	77.3%	**80.0%**
Rotavirus	68.1%	75.0%	68.0%	65.7%	58.1%	75.8%	65.7%	**64.6%**
Hepatitis A	59.9%	52.1%	58.8%	53.5%	52.2%	60.3%	61.0%	**51.8%**
Complete Vaccine Series Doses21	55.3%	60.5%	53.6%	52.3%	47.5%	56.9%	54.5%	**55.7%**
24-35 Mo Population with 2+ Shots in MIIC	4,443	1,150	5,369	15,977	7,533	2,025	2,987	**70,453**

Source: Minnesota Department of Health, 2011

**Children that were born July 2008 through June 2009. Analyzed August 2011.

* Data present immunizations among children aged 24-35 months with 2 or more non-influenza shots in the Minnesota Immunization Information Connection (MIIC) registry. MIIC percentages are affected by provider participation in the voluntary registry, management of children who have moved or gone elsewhere, and border-state data exchange, which is currently limited to Wisconsin. Percentages are likely lower than the actual percent of children receiving the vaccinations due to these limitations

Exhibit 37 displays infant mortality by race and ethnicity in the broader community. Rates were not age-adjusted; rates also were not calculated if they represented fewer than 20 mortalities. Ramsey County reported rates of infant mortality for Blacks, Asians, and Pacific Islanders which were greater than the Minnesota average. The entire community reported infant mortality incidence below the state's average rate.

Exhibit 37: Infant Mortality Rates by Race and Ethnicity in the Broader Community, 2008-2010

Racial and Ethnic Cohort	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington	Minnesota
White	11.3	N/A	1.5	6.7	9.3	N/A	0.3	**13.4**
Black	N/A	N/A	N/A	43.9	67.9	N/A	N/A	**65.2**
American Indian	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**65.9**
Asian/Pacific Islander	N/A	N/A	N/A	13.7	33.8	N/A	N/A	**27.6**
Other/Unknown	N/A	N/A	N/A	26.9	N/A	N/A	N/A	**31.1**
Hispanic or Latino*	N/A	N/A	N/A	24.3	N/A	N/A	N/A	**38.7**
Total Population	**12.3**	**N**	**2.0**	**12.6**	**17.0**	**3.6**	**0.4**	**17.9**

Source: Minnesota Department of Health, 2010 Health Statistics Annual Summary, and U.S. Census.

*Hispanic or Latino ethnicity is reported separately from race. Persons of Hispanic or Latino origin may be from any racial group.

Rates are per 100,000 population.

18 Diphtheria, tetanus, and pertussis.

19 Measles, mumps, and rubella.

20 Haemophilus influenzae type b.

21 Children with all DTaP, Polio, MMR, Hib, HepB, Varicella, and PCV doses.

Exhibit 38 displays each county's teen pregnancy rate, broken out into age cohorts. Hennepin and Ramsey counties reported higher rates of teen pregnancy between the ages of 15 and 17 than the Minnesota average. Anoka, Hennepin, and Ramsey counties reported higher rates of teen pregnancy between the ages of 18 and 19 than the state average.

Exhibit 38: Teen Pregnancy Rates in the Broader Community, 2008-2010

Age Cohort	Rates per 100,000 Teens							
	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington	Minnesota
15-17	13.5	6.9	11.2	21.1	27.6	9.2	8.6	**16.0**
18-19	61.2	35.9	56.0	71.1	74.3	53.6	45.0	**58.1**
Total (15-19)	**29.8**	**15.9**	**26.1**	**41.5**	**49.0**	**22.8**	**20.4**	**33.2**

Key	
Better than MN	
0-50% worse than MN	
50-75% worse than MN	
Greater than 75% worse than MN	

Source: Minnesota Department of Health and the U.S. Census, 2011.

Exhibits 39A and 39B examine health indicators for children and mothers in the broader community. Ramsey County reported three indicators whose incidence was more than 50 percent worse than Minnesota's average.

Exhibit 39A: Selected Maternal and Child Health Indicators in the Broader Community, 2010

Indicator	Anoka	Carver	Dakota	Hennepin	Minnesota
Births to Unmarried Mothers	30.9%	15.0%	28.0%	33.7%	**33.1%**
Births with No Father on Birth Certificate	7.1%	4.0%	8.1%	10.5%	**9.3%**
Mothers Smoked during Pregnancy	9.4%	3.1%	6.4%	5.1%	**10.0%**
Preterm Births	8.3%	6.4%	7.0%	8.2%	**8.1%**
Low Weight Births	4.4%	4.4%	4.4%	5.4%	**4.8%**
Very Low Birth Weight Births, 2008-2010	0.8%	0.8%	0.8%	1.0%	**0.8%**
Prenatal Care Received in 1st Trimester	87.0%	93.0%	85.9%	86.7%	**86.3%**
*Adequate or Better Prenatal Care	81.0%	86.7%	80.7%	81.4%	**80.0%**
*Intermediate Prenatal Care	15.9%	12.2%	16.6%	15.5%	**16.9%**
*Inadequate or No Prenatal Care	3.1%	1.2%	2.7%	3.0%	**3.1%**

Source: Minnesota Department of Health, 2011.
* GINDEX: A prenatal care index determined by combining measures of the month or trimester prenatal care began, the number of prenatal visits, and the gestational age of the infant/fetus at the time of birth. Adequacy of prenatal care is determined by combining measures of the month or trimester prenatal care began, the number of prenatal visits and the gestational age of the fetus at the time of birth. The GINDEX includes gestational age of over 36 weeks and the number of prenatal visits exceeding nine to impute adequacy of prenatal care.
Adequate or Better: Prenatal care started in the 1st trimester and the woman had an adequate number of visits.
Intermediate: Prenatal care started in the 1st or 2nd trimester and the woman had an intermediate range of visits.
Inadequate or None: No prenatal care or the prenatal care started in the 3rd trimester or the woman had an inadequate range of visits, regardless of when prenatal care began.

Key	
Better than MN	
0-50% worse than MN	
50-75% worse than MN	
Greater than 75% worse than MN	

Exhibit 39B: Selected Maternal and Child Health Indicators in the Broader Community, 2010

Indicator	Ramsey	Scott	Washington	Minnesota
Births to Unmarried Mothers	44.4%	19.6%	24.0%	**33.1%**
Births with No Father on Birth Certificate	15.4%	5.0%	6.5%	**9.3%**
Mothers Smoked during Pregnancy	9.6%	4.1%	7.4%	**10.0%**
Preterm Births	8.9%	7.0%	8.0%	**8.1%**
Low Weight Births	5.8%	3.7%	4.6%	**4.8%**
Very Low Birth Weight Births, 2008-2010	1.0%	0.6%	0.7%	**0.8%**
Prenatal Care Received in 1st Trimester	76.4%	89.5%	91.4%	**86.3%**
*Adequate or Better Prenatal Care	69.2%	74.6%	86.7%	**80.0%**
*Intermediate Prenatal Care	26.1%	22.0%	12.2%	**16.9%**
*Inadequate or No Prenatal Care	4.7%	3.4%	1.1%	**3.1%**

Source: Minnesota Department of Health, 2011.
* GINDEX: A prenatal care index determined by combining measures of the month or trimester prenatal care began, the number of prenatal visits, and the gestational age of the infant/fetus at the time of birth. Adequacy of prenatal care is determined by combining measures of the month or trimester prenatal care began, the number of prenatal visits and the gestational age of the fetus at the time of birth. The GINDEX includes gestational age of over 36 weeks and the number of prenatal visits exceeding nine to impute adequacy of prenatal care.
Adequate or Better: Prenatal care started in the 1st trimester and the woman had an adequate number of visits.
Intermediate: Prenatal care started in the 1st or 2nd trimester and the woman had an intermediate range of visits.
Inadequate or None: No prenatal care or the prenatal care started in the 3rd trimester or the woman had an inadequate range of visits, regardless of when prenatal care began.

Key	
Better than MN	
0-50% worse than MN	
50-75% worse than MN	
Greater than 75% worse than MN	

The Women, Infants and Children's (WIC) program, administered by the U.S. Department of Agriculture, provides assistance for families at or below 185 percent of poverty. **Exhibit 40** presents obesity and breastfeeding data gathered from Minnesota WIC participants. Of Ramsey County WIC participants, almost 66.5 percent of children ages 2 through 5 had ever been breastfed compared to 73.7 percent in Minnesota and 80.3 percent in Dakota County. Hennepin and Ramsey counties also had higher percentages of obese children than the Minnesota average.

Exhibit 40: Minnesota Women, Infants and Children (WIC) Selected Indicators from CDC's Pediatric and Pregnancy Nutrition Surveillance System in the Broader Community, 2008-2010*

County	2010 WIC Participants**	Children 2-5 years			Women (Pre-pregnancy) Overweight or Obese
		Overweight	Obese	Ever Breastfed	
Anoka	10,647	15.8%	11.5%	71.2%	52.3%
Carver	1,706	11.9%	9.3%	78.9%	53.4%
Dakota	10,765	15.8%	12.9%	80.3%	53.4%
Hennepin	47,252	16.7%	14.2%	77.3%	54.1%
Ramsey	31,274	17.6%	14.6%	66.5%	50.8%
Scott	3,481	13.9%	11.8%	79.9%	52.4%
Washington	5,656	17.9%	10.8%	77.2%	52.6%
Minnesota	**230,110**	**16.7%**	**13.1%**	**73.7%**	**54.2%**

Source: Pediatric Nutrition Surveillance System and Pregnancy Nutrition Surveillance System via Minnesota Department of Health, 2011.
*WIC participants are not a representative sample of the total population
**The total number of pregnant, post-partum and nursing women, infants and children less than 5 years of age who received WIC vouchers. County level data are determined by combining unduplicated participants of all clinics within a county's boundaries. State total does not equal the sum of the counties because participants may move counties during the year.

Minnesota Student Survey

A survey of students in 6th, 9th, and 12th grades, administered by the Minnesota Department of Education, gathers data on demographics, family and relationships, health status issues, mental health indicators, and various health risk behaviors including substance abuse, diet and exercise, and sexual activity. Eighty-eight percent of the school districts in the state participated in the 2010 survey.

Exhibits 41A-41C compare various indicators for the seven counties in the community served by Children's to state averages at each grade level. Indicators are shaded light grey if they are 0-25 percent worse than the state, medium grey if 25-50 percent worse, and dark grey if greater than 50 percent worse than Minnesota. On average, students from Anoka and Ramsey counties reported the greatest number of unfavorable indicators. Four indicators were greater than 50 percent worse than the Minnesota average; the percent of 9th and 12th grade students in Ramsey County eligible for free and reduced-price lunch and the percent of 9th grade students in Anoka County and 12th grade students in Scott County that reported using drugs other than marijuana in the past month. Reported drug use for older students was comparatively high across several counties.

Among 6th grade students, screen time and asthma were issues in four or more counties. These issues carry over into 9th and 12th grade as well. Mental and behavioral health problems as well as drug use become more prevalent in older age groups. In 12th grade, binge drinking and domestic physical abuse compared unfavorably to Minnesota in five of the seven counties.

Exhibit 41A: 6th Grade Indicators and Variation from Minnesota, 2010

Category	Indicator	Anoka	Carver	Dakota	Hennepin	Ramsay	Scott	Washington	Minnesota
Participants	Total Participants(N)	3,745	1,006	4,733	8,383	3,904	1,430	2,359	**46,7**
Access to Care	Physical Exam in Past Year	64.5%	61.0%	62.5%	66.5%	61.0%	60.0%	57.0%	**58.0**
Health Behaviors	11+ Hours TV Time per Week	20.0%	18.5%	17.0%	16.5%	16.5%	13.5%	15.0%	**17.0**
	11+ Hours Video Game Time Per Week	12.5%	8.5%	11.0%	14.0%	11.5%	8.5%	9.0%	**10.5**
	11+ Hours Internet Time per Week	11.0%	7.5%	9.5%	10.0%	10.5%	8.0%	8.0%	**9.0**
	Exercise 30 Minutes 5+ Days Per Week	40.0%	56.0%	49.0%	46.0%	43.0%	54.0%	52.5%	**48.0**
	4+ Servings of Fruits and Vegetables Yesterday	37.5%	39.5%	40.0%	42.5%	39.0%	35.0%	42.5%	**39.0**
	Always Wear Seatbelt	73.0%	77.0%	75.0%	75.0%	71.0%	74.5%	76.0%	**72.0**
	Tobacco Use in Past Month	2.5%	1.0%	1.5%	2.5%	3.0%	1.0%	2.0%	**2.5**
	Binge Drinking in Past Year*	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0**
	Alcohol Use in Past Year	9.0%	5.0%	6.0%	7.5%	8.5%	4.5%	8.0%	**8.0**
	Driving While Impaired in Past Year	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**
	Ever Ride With Impaired Driver	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**
	Marijuana Use in Past Month	1.0%	0.0%	0.0%	1.0%	1.0%	0.0%	0.5%	**1.0**
	Use of Drugs Other Than Marijuana in Past Month	1.0%	1.0%	0.5%	1.0%	1.0%	0.5%	1.0%	**1.0**
	Ever Had Sex	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**
	Do Not "Always" Use Any Birth Control Method	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**
Health Status	Asthma	16.0%	16.0%	15.5%	17.5%	17.0%	13.5%	14.0%	**15.0**
	Overweight or Obese	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**
Mental and Behavioral Health	Mental/Emotional Problem Lasting 12+ Months	8.5%	5.5%	7.0%	7.0%	7.5%	6.5%	7.0%	**7.5**
	Often Unhappy, Depressed, or Tearful	7.0%	6.0%	6.0%	7.5%	9.0%	7.5%	6.5%	**8.0**
	Depression**	11.0%	6.5%	10.0%	12.0%	13.0%	10.5%	10.5%	**11.5**
	Ever Hurt Oneself On Purpose	14.5%	9.0%	11.5%	13.5%	15.5%	10.0%	13.0%	**13.0**
	Attempted Suicide	3.5%	1.0%	3.0%	4.5%	4.5%	2.5%	3.5%	**3.5**
Social and Economic Factors	Free or Reduced Lunch	30.0%	22.5%	26.5%	35.0%	47.5%	22.5%	20.0%	**32.5**
	Feel Safe in Neighborhood	92.0%	96.0%	92.5%	90.5%	92.5%	94.5%	84.0%	**91.0**
	Bullied in Last Month	49.5%	52.0%	52.5%	52.5%	50.5%	55.0%	53.5%	**53.5**
	Suffered Domestic Physical Abuse	13.0%	9.0%	12.0%	12.0%	14.0%	11.0%	12.0%	**12.0**
	Suffered Sexual Abuse	4.5%	3.0%	3.5%	4.0%	4.0%	3.5%	4.0%	**4.0**

Source: Minnesota Department of Health, 2012.
*Typically drank 5 or more drinks at a time and drank on 10 or more occasions during the past year
** In last 30 days have you felt so discouraged or hopeless that you wondered if anything was worthwhile?

Exhibit 41B: 9th Grade Indicators and Variation from Minnesota, 2010

Category	Indicator	Anoka	Carver	Dakota	Hennepin	Ramsay	Scott	Washington	Minnesota
Participants	Total Participants (N)	3,698	1,056	4,541	8,466	4,401	1,415	2,478	**47,3**
Access to Care	Physical Exam in Past Year	55.5%	56.5%	56.0%	63.0%	57.0%	50.0%	48.0%	**49.5**
Health Behaviors	11+ Hours TV Time per Week	21.0%	20.0%	20.0%	19.0%	19.5%	18.5%	20.0%	**20.0**
	11+ Hours Video Game Time Per Week	15.0%	11.5%	13.5%	17.0%	11.5%	14.0%	13.0%	**12.5**
	11+ Hours Internet Time per Week	16.5%	14.0%	14.5%	16.0%	17.0%	16.0%	15.5%	**15.5**
	Exercise 30 Minutes 5+ Days Per Week	51.0%	61.0%	56.0%	56.0%	47.5%	62.0%	59.0%	**56.5**
	4+ Servings of Fruits and Vegetables Yesterday	32.0%	42.5%	38.5%	38.5%	34.5%	34.0%	36.5%	**36.0**
	Always Wear Seatbelt	68.0%	65.5%	71.0%	70.5%	65.5%	66.5%	71.0%	**65.5**
	Tobacco Use in Past Month	13.5%	11.5%	11.5%	9.5%	13.5%	13.0%	12.5%	**13.0**
	Binge Drinking in Past Year*	2.5%	2.5%	2.0%	2.0%	3.0%	3.5%	2.5%	**2.5**
	Alcohol Use in Past Year	33.5%	26.5%	30.0%	26.5%	32.5%	34.5%	33.5%	**33.0**
	Driving While Impaired in Past Year	3.5%	2.5%	3.0%	2.0%	5.0%	3.5%	3.5%	**4.0**
	Ever Ride With Impaired Driver	18.0%	14.0%	13.5%	14.0%	18.0%	18.5%	14.5%	**16.5**
	Marijuana Use in Past Month	11.0%	10.0%	9.0%	10.5%	13.5%	11.5%	10.0%	**10.0**
	Use of Drugs Other Than Marijuana in Past Month	6.0%	5.0%	3.5%	3.5%	4.0%	4.0%	4.0%	**3.5**
	Ever Had Sex	21.5%	16.5%	17.5%	19.0%	21.5%	18.5%	18.0%	**20.0**
	Do Not "Always" Use Any Birth Control Method	68.0%	66.0%	62.5%	61.5%	64.5%	60.5%	60.5%	**63.5**
Health Status	Asthma	19.0%	19.0%	17.5%	20.0%	17.5%	18.0%	18.5%	**17.5**
	Overweight or Obese	23.5%	17.5%	19.0%	20.0%	24.5%	21.5%	17.5%	**22.0**
Mental and Behavioral Health	Mental/Emotional Problem Lasting 12+ Months	11.5%	9.0%	11.0%	9.5%	11.5%	11.5%	10.0%	**10.5**
	Often Unhappy, Depressed, or Tearful	9.0%	6.0%	7.5%	7.5%	9.5%	8.0%	6.0%	**8.0**
	Depression**	15.5%	10.5%	13.5%	13.5%	15.0%	13.0%	12.0%	**13.5**
	Ever Hurt Oneself On Purpose	19.0%	14.5%	18.5%	15.5%	19.5%	19.0%	15.5%	**17.5**
	Attempted Suicide	7.0%	5.5%	6.5%	5.5%	7.5%	6.0%	5.5%	**6.5**
Social and Economic Factors	Free or Reduced Lunch	27.0%	13.5%	19.5%	29.5%	43.5%	16.0%	13.0%	**27.5**
	Feel Safe in Neighborhood	93.0%	97.5%	95.0%	93.0%	91.0%	92.5%	87.5%	**93.5**
	Bullied in Last Month	35.0%	42.0%	37.0%	33.5%	35.0%	40.0%	32.5%	**38.0**
	Suffered Domestic Physical Abuse	11.5%	9.5%	10.0%	10.0%	12.0%	9.0%	8.5%	**10.0**
	Suffered Sexual Abuse	6.5%	4.0%	5.0%	5.0%	5.5%	5.0%	4.0%	**5.5**

Source: Minnesota Department of Health, 2012.
*Typically drank 5 or more drinks at a time and drank on 10 or more occasions during the past year
** In last 30 days have you felt so discouraged or hopeless that you wondered if anything was worthwhile?

Exhibit 41C: 12th Grade Indicators and Variation from Minnesota, 2010

Category	Indicator	Anoka	Carver	Dakota	Hennepin	Ramsay	Scott	Washington	Minnesota
Participants	Total Participants(N)	2,621	655	3,541	7,088	3,267	908	1,714	**36,7**
Access to Care	Physical Exam in Past Year	48.5%	46.5%	50.5%	54.5%	50.0%	45.0%	45.0%	**46.0**
Health Behaviors	11+ Hours TV Time per Week	18.5%	17.5%	18.0%	18.0%	17.5%	18.5%	14.5%	**18.0**
	11+ Hours Video Game Time Per Week	11.5%	9.0%	10.0%	14.5%	10.0%	11.0%	10.5%	**10.5**
	11+ Hours Internet Time per Week	15.0%	17.0%	14.0%	15.5%	16.5%	13.5%	13.5%	**14.5**
	Exercise 30 Minutes 5+ Days Per Week	38.5%	43.0%	46.5%	42.5%	41.5%	44.0%	48.5%	**44.0**
	4+ Servings of Fruits and Vegetables Yesterday	32.0%	41.5%	36.5%	38.5%	35.0%	34.0%	38.0%	**34.5**
	Always Wear Seatbelt	73.5%	71.0%	74.5%	77.0%	74.5%	70.0%	78.0%	**69.0**
	Tobacco Use in Past Month	29.0%	36.5%	33.0%	27.0%	28.0%	36.0%	30.0%	**31.5**
	Binge Drinking in Past Year**	11.0%	16.5%	14.5%	12.0%	10.0%	16.0%	14.5%	**13.5**
	Alcohol Use in Past Year	52.0%	54.0%	59.0%	54.0%	52.0%	61.5%	59.0%	**56.5**
	Driving While Impaired in Past Year	17.0%	21.0%	19.5%	17.0%	17.0%	19.0%	18.5%	**18.5**
	Ever Ride With Impaired Driver	29.5%	33.5%	35.0%	33.0%	34.0%	33.0%	33.5%	**33.0**
	Marijuana Use in Past Month	21.0%	20.5%	23.5%	24.0%	21.0%	22.5%	23.0%	**21.0**
	Use of Drugs Other Than Marijuana in Past Month	7.0%	5.5%	7.5%	6.0%	7.5%	9.5%	5.5%	**5.5**
	Ever Had Sex	49.5%	46.5%	52.0%	46.0%	47.0%	50.0%	42.0%	**50.5**
	Do Not "Always" Use Any Birth Control Method	39.0%	39.0%	38.5%	37.5%	42.5%	37.5%	30.0%	**38.5**
Health Status	Asthma	18.5%	20.0%	19.0%	21.0%	17.0%	16.0%	19.0%	**18.0**
	Overweight or Obese	22.0%	15.5%	19.5%	19.0%	22.0%	20.5%	17.0%	**21.0**
Mental and Behavioral Health	Mental/Emotional Problem Lasting 12+ Months	13.0%	11.0%	13.0%	11.5%	11.5%	12.0%	11.0%	**11.5**
	Often Unhappy, Depressed, or Tearful	6.0%	5.5%	5.0%	6.5%	6.5%	6.0%	4.5%	**6.0**
	Depression*	13.0%	10.5%	11.0%	12.5%	14.0%	12.0%	9.0%	**11.0**
	Ever Hurt Oneself On Purpose	19.0%	14.5%	17.5%	15.5%	17.0%	20.0%	13.5%	**17.5**
	Attempted Suicide	7.5%	6.5%	6.5%	7.0%	7.0%	7.5%	6.0%	**7.5**
Social and Economic Factors	Free or Reduced Lunch	21.5%	12.0%	13.5%	25.5%	36.0%	13.5%	9.5%	**22.5**
	Feel Safe in Neighborhood	94.5%	95.5%	95.5%	93.5%	92.0%	94.0%	92.0%	**95.0**
	Bullied in Last Month	25.0%	27.5%	26.0%	23.5%	26.0%	30.5%	23.0%	**25.0**
	Suffered Domestic Physical Abuse	9.0%	6.5%	8.5%	7.5%	9.5%	8.5%	8.5%	**8.0**
	Suffered Sexual Abuse	6.0%	5.5%	4.5%	5.0%	6.5%	6.0%	4.0%	**5.5**

Source: Minnesota Department of Health, 2012.
*Typically drank 5 or more drinks at a time and drank on 10 or more occasions during the past year
** In last 30 days have you felt so discouraged or hopeless that you wondered if anything was worthwhile?

Minnesota Department of Human Services

Exhibits 42, 43, and 44 relate data from the Minnesota Department of Human Services' yearly child welfare report. **Exhibit 42** shows the child maltreatment rate by county in 2011. The chart also shows the percent of child maltreatment cases in 2011 which recurred from 2010. Hennepin and Ramsey counties both reported higher rates of child maltreatment than the Minnesota average. Hennepin, Washington, and Carver counties had higher percent recurrence of maltreatment in their populations than the state average.

Exhibit 42: Confirmed Child Maltreatment Rates in the Broader Community, 2011

County	Maltreatment Rate per 1,000 Children	Percent of Maltreatment Cases Which Recurred in 12 Months
Anoka	2.2	3.1%
Carver	1.9	7.9%
Dakota	2.9	6.2%
Hennepin	4.7	10.7%
Ramsey	3.8	3.7%
Scott	1.7	2.4%
Washington	1.6	10.5%
Minnesota	**3.5**	**6.6%**

Source: Minnesota Department of Human Services 2011 Minnesota Child Welfare Report, 2012.

Exhibit 43 demonstrates the rate of abuse per type in each county. A child may have been abused in multiple ways, which would result in each abuse being recorded separately in the chart. Hennepin County reported higher rates of non-medical neglect and sexual abuse than the Minnesota average; Ramsey County reported higher rates of non-medical neglect and physical abuse.

Exhibit 43: Confirmed Child Maltreatment Rates by Type in the Broader Community, 2011

	Rates per 1,000 Children							
Maltreatment Type	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington	Minnesota
Neglect (non-medical)	1.4	1.3	1.9	3.9	2.6	1.2	1.1	**2.5**
Physical abuse	0.4	0.2	0.5	0.7	1.0	0.3	0.2	**0.7**
Sexual abuse	0.5	0.4	0.7	0.9	0.6	0.2	0.4	**0.7**
Mental injury	0.0	0.1	0.0	0.0	0.0	0.0	0.0	**0.0**
Medical neglect	0.0	0.0	0.0	0.1	0.0	0.0	0.0	**0.0**
Total	**2.2**	**2.0**	**3.0**	**5.0**	**3.9**	**1.7**	**1.7**	**3.6**

Source: Minnesota Department of Human Services 2011 Minnesota Child Welfare Report and U.S. Census Bureau: American Community Survey 5 Year Estimates 2007-2011, 2012.

Exhibit 44 displays the rate of children in out-of-home care by race in each locality. Native American children experienced the greatest rate of out-of-home care in six of seven counties. White children were the least likely to live in out-of-home care. Hennepin and Ramsey counties had the greatest rates of children not living at home, and their rates were above Minnesota's average.

Exhibit 44: Children in Out-Of-Home Care by Race and Ethnicity in the Broader Community, 2011

Racial/Ethnic Cohort	Rates per 1,000 Children							
	Anoka	Carver	Dakota	Hennepin	Ramsey	Scott	Washington	Minnesota
Black	14.3	31.7	9.1	24.5	38.3	12.6	7.5	**27.2**
Native American	25.1	0.0	13.3	91.7	67.0	38.6	110.6	**89.4**
Asian/Pacific Islander	0.0	0.0	0.0	4.0	7.1	0.0	0.0	**4.4**
White	4.0	3.3	2.7	3.0	7.1	2.3	2.6	**5.6**
Two or More Races	22.3	22.9	8.9	22.4	17.0	9.9	4.6	**19.3**
Hispanic or Latino*	6.9	6.7	4.2	10.3	13.5	2.9	2.7	**11.5**
Total	**5.6**	**4.3**	**3.4**	**9.1**	**13.0**	**3.1**	**3.0**	**8.9**

Source: Minnesota Department of Human Services 2012 Minnesota Child Welfare Report and U.S. Census Bureau: American Community Survey 5 Year Estimates 2007-2011, 2012.

* Hispanic or Latino ethnicity is reported separately from race. Persons of Hispanic or Latino origin may be from any racial group.

Ambulatory care sensitive conditions

This section examines the frequency of discharges for ACSC throughout the community and at the hospital.

Key insights: ***Ambulatory Care Sensitive Conditions***	» ACSCs are conditions which might have been prevented if the patient had accessed primary care at optimal rates. Uninsured patients have higher levels of these discharges. High numbers of ACSC discharges may indicate the lack of access to or utilization of primary care services. » Asthma, urinary tract infection, perforated appendix, and diabetes short-term complications are the most frequent discharges for ACSC from Children's.

The methodologies for quantifying discharges for ACSC have been well-tested for more than a decade. The methodologies quantify inpatient admissions for diabetes, perforated appendixes, chronic obstructive pulmonary disease (COPD), hypertension, congestive heart failure, dehydration, bacterial pneumonia, urinary tract infection, asthma, and other conditions that, in theory, could have been prevented if adequate ambulatory (primary) care resources were available and accessed by those patients.22

Disproportionately large numbers of discharges for ACSC indicate potential problems with the availability or accessibility of ambulatory care services. The Agency for Healthcare Research and Quality (AHRQ), part of the U.S. Department of Health and Human Services, publishes software and methodologies for assessing discharges for ACSC. The AHRQ software was applied to analyze the prevalence of discharges for ACSC in geographic areas served by Children's.

The ACSC analysis provides a single indicator of potential health problems - allowing comparisons to be made reliably across geographic areas and hospital facilities. This analysis also allows demonstrating a possible "return on investment" from interventions that reduce admissions (for example, for uninsured or Medicaid patients) through better access to ambulatory care resources.

22 See: http://www.ahrq.gov/data/hcup/factbk5 for more information on this methodology.

County-level analysis

Disproportionately large numbers of discharges for ACSC indicate potential problems with the availability or accessibility of ambulatory (primary) care services. **Exhibit 45** indicates how many hospital discharges from the seven counties in the Children's broader community were found to be for ACSCs by payer and by area.

Exhibit 45: Children's Discharges for ACSC in the Broader Community by Payer, 2011

County	Medicare*	Private	Commercial/Self-Pay*	Medicaid/PMAP	Other*	Total
Anoka	100.0%	7.1%	0.0%	7.4%	14.3%	7.3%
Carver	0.0%	5.7%	0.0%	5.8%	0.0%	5.4%
Dakota	0.0%	6.7%	16.7%	8.0%	25.0%	7.5%
Hennepin	0.0%	7.8%	12.5%	9.9%	5.6%	8.9%
Ramsey	0.0%	6.0%	9.1%	9.8%	0.0%	8.2%
Scott	0.0%	3.7%	0.0%	6.1%	0.0%	4.3%
Washington	0.0%	6.3%	16.7%	7.3%	25.0%	6.9%
Total	**5.9%**	**6.9%**	**10.5%**	**9.2%**	**12.7%**	**8.0%**

Source: Verité analysis of data from Children's, using AHRQ software, 2012.

*Caution should be used when interpreting these data due to small sample size (less than 20 total discharges).

The table indicates that in 2011, 8.0 percent of discharges were for ACSCs. Patients from the "other" payer group (neither private, self-pay, Medicaid, Medicare, nor PMAP) had the highest proportion of discharges for ACSC, followed by commercial/self-pay patients.

Hospital-level analysis

In 2011, 6.9 percent of Children's total discharges were for ACSCs. **Exhibit 46** indicates that Children's discharges for ACSC were most concentrated in four conditions: asthma, urinary tract infection, perforated appendix, and diabetes short-term complications.

Exhibit 46: Discharges for ACSC by Condition, 2011

Condition	0-4	5-9	10-14	15-17	18-34	Grand Total
Pediatric asthma	41.8%	32.3%	19.5%	6.4%	0.0%	359
Pediatric urinary tract infection	54.0%	27.0%	10.9%	8.0%	0.0%	174
Pediatric perforated appendix	18.2%	31.1%	41.7%	9.1%	0.0%	132
Pediatric diabetes short-term complications	0.0%	17.9%	54.7%	27.4%	0.0%	106
Pediatric gastroenteritis	73.5%	23.5%	2.9%	0.0%	0.0%	34
Dehydration	0.0%	0.0%	0.0%	0.0%	100.0%	10
Bacterial pneumonia	0.0%	0.0%	0.0%	0.0%	100.0%	9
Urinary tract infection	0.0%	0.0%	0.0%	0.0%	100.0%	4
Hospital acquired vascular catheter related infections	0.0%	0.0%	0.0%	0.0%	100.0%	3
Uncontrolled diabetes	0.0%	0.0%	0.0%	0.0%	100.0%	2
Accidental puncture or laceration	0.0%	0.0%	0.0%	0.0%	100.0%	1
Asthma in younger adults	0.0%	0.0%	0.0%	0.0%	100.0%	1
Congestive heart failure	0.0%	0.0%	0.0%	0.0%	100.0%	1
Diabetes long-term complication	0.0%	0.0%	0.0%	0.0%	100.0%	1
Diabetes short-term complication	0.0%	0.0%	0.0%	0.0%	100.0%	1
Iatrogenic pneumothorax	0.0%	0.0%	0.0%	0.0%	100.0%	1
Total	**34.9%**	**27.5%**	**24.2%**	**9.3%**	**4.1%**	**839**

Source: Verité analysis of discharge data from the Children's using AHRQ software, 2012.

ZIP code and census tract-level health status and access indicators

The following secondary data sources have been used to examine ZIP code and census tract-level health status and access to care indicators in the Children's broader community: (1) Dignity Health's Community Need Index, and (2) U.S. Department of Agriculture.

Key insights: ***ZIP Code and Census Tract-Level Indicators***	» Based on a composite measure of socio-economic need (Dignity Health's *Community Needs Index*), the immediate community contains ZIP codes scoring as medium-high or high need. » Eighty-six census tracts surrounding the Twin Cities area are classified as food deserts, low-income areas with low access to healthy food.

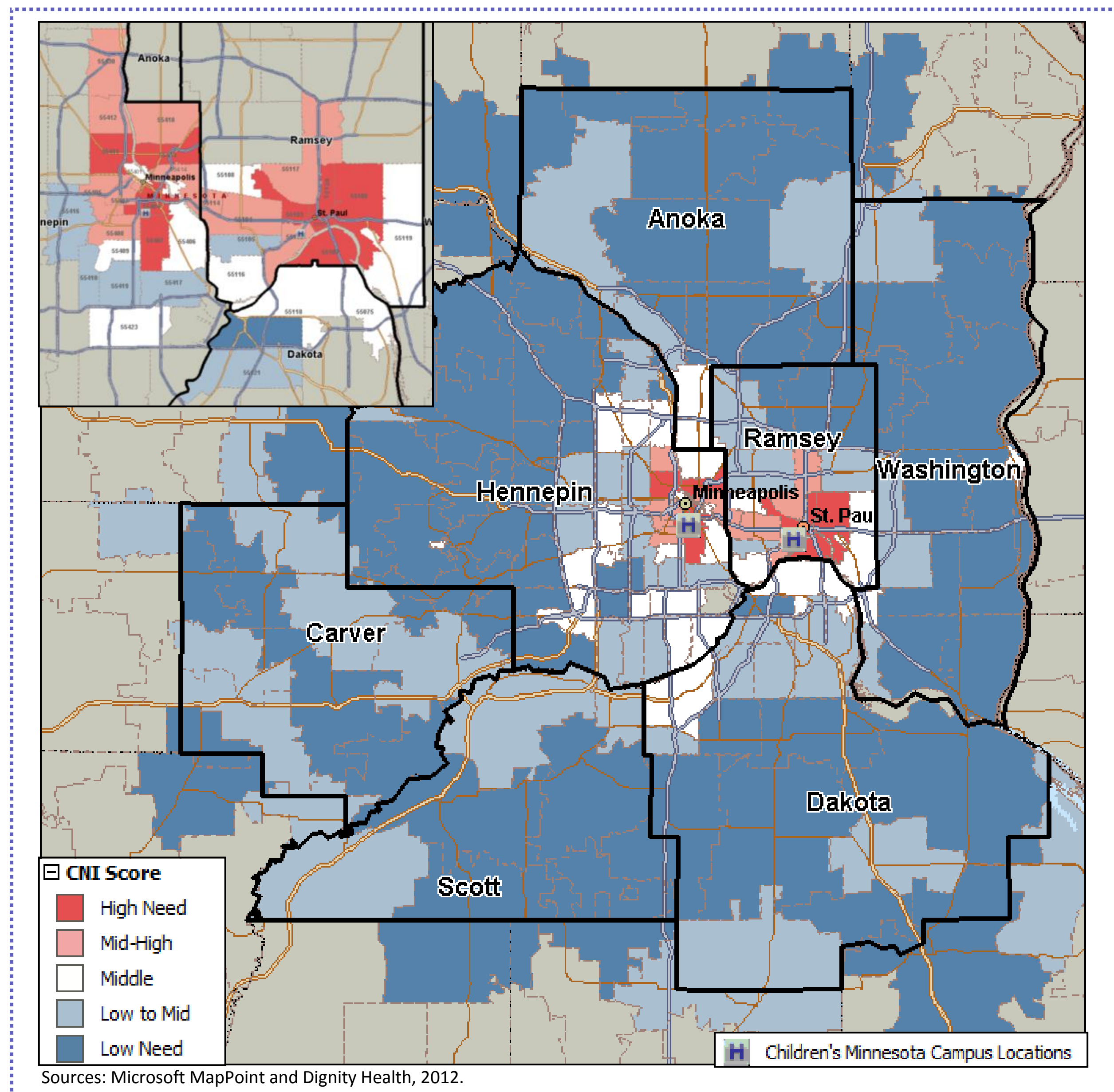
Dignity Health Community Needs Index

Dignity Health, a hospital system based in California, developed the *Community Needs Index,* a standardized index that measures barriers to healthcare access by county and ZIP code. The index is based on five social and economic indicators:

- » The percentage of elderly, children, and single parents living in poverty;
- » The percentage of adults over the age of 25 with limited English proficiency, and the percentage of the population that is non-White;
- » The percentage of the population without high school diplomas;
- » The percentage of uninsured and unemployed residents, and;
- » The percentage of the population renting houses.

The *Community Needs Index* represents a score based on these indicators, assigned to each ZIP code. Scores range from "Lowest Need" (1.0-1.7), to "Highest Need" (4.2-5.0). Although not all of the data measured by the *Community Needs Index* are specific to children, the selected indicators may affect the health and wellbeing of children either directly or indirectly. **Exhibit 47** presents the *Community Needs Index* (CNI) score of each ZIP code in the Children's broader community. Minneapolis (ZIP codes 55404, 55411, and 55454) and St. Paul (ZIP code 55103) exhibit the highest need score at 5.0.

Exhibit 47: Community Needs Index Score by ZIP Code



Sources: Microsoft MapPoint and Dignity Health, 2012.

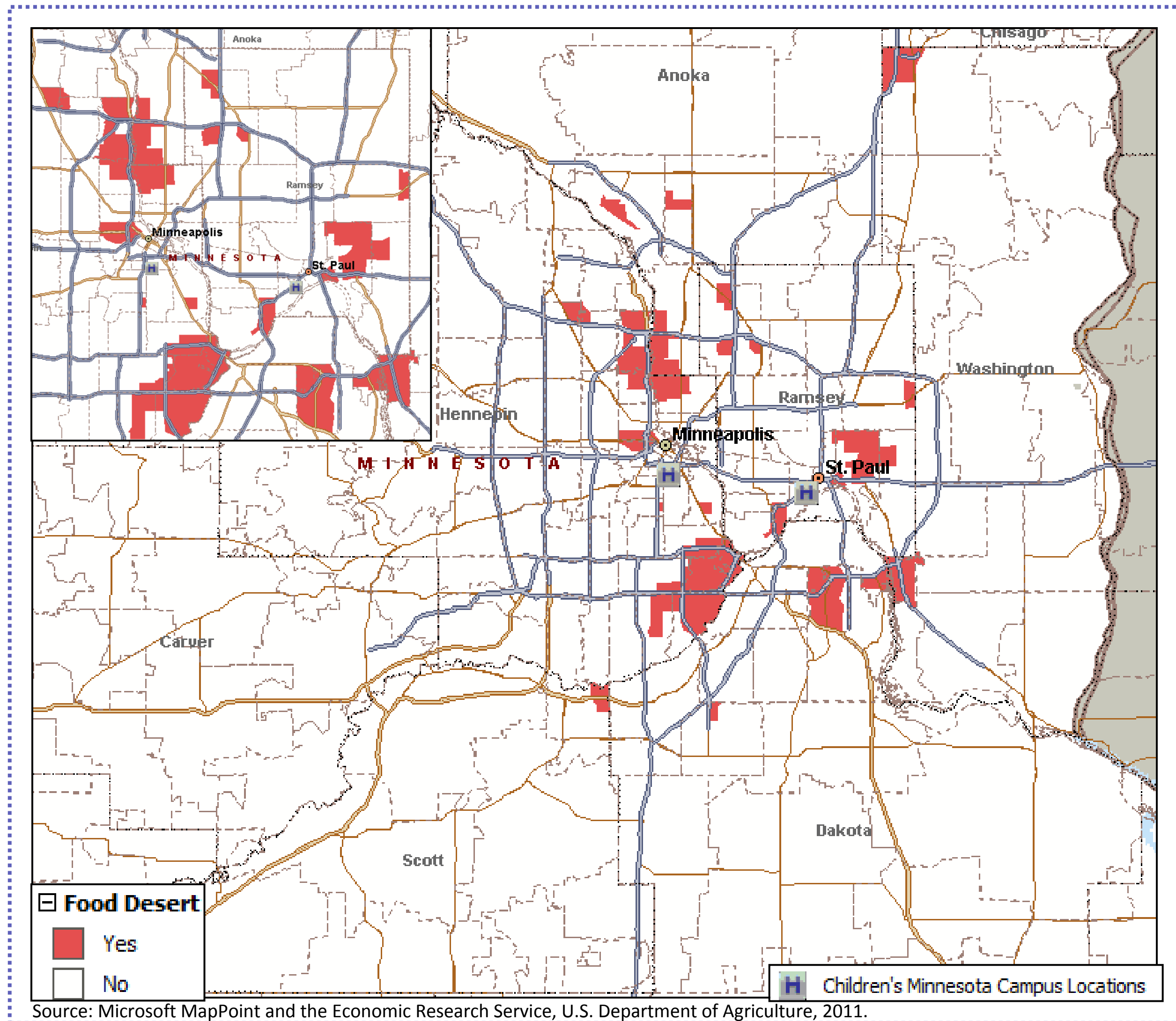
Food deserts

The U.S. Department of Agriculture's Economic Research Service estimates the number of people in each census tract that live "more than 1 mile from a supermarket or large grocery store in urban areas and more than 10 miles from a supermarket or large grocery store in rural areas."[23] Several government-led initiatives aim to increase the availability of nutritious and affordable foods to people living in these food deserts. **Exhibit 48** indicates the location of identified food deserts in the Children's broader community.

23 Economic Research Service (ERS). (n.d.). Food Desert Locator. U.S. Department of Agriculture. Retrieved 2012, from http://www.ers.usda.gov/data-products/food-desert-locator.aspx

Eighty-six census tracts in the broader community were determined to be food deserts. The majority of the food deserts were located near Minneapolis and St. Paul.

Exhibit 48: Food Deserts by Census Tract



Source: Microsoft MapPoint and the Economic Research Service, U.S. Department of Agriculture, 2011.

Although rates of food insecurity are some of the lowest in the U.S., 16.7 percent of Minnesota's children were food insecure in 2010. Food insecurity is not directly related to poverty. In many cases, residents with incomes greater than 185 percent of FPL are food insecure, especially in unemployed or underemployed households, areas with a high cost of living, and in families with high medical bills.[24]

24 Feeding America. (2012). Map the Meal Gap: Child Food Insecurity 2012. Retrieved 2012, from http://feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap/~/media/Files/a-map-2010/2010-MMG-Child-Executive-Summary-FINAL.ashx

Overview of the health and social services landscape

This section first examines geographic areas and populations in the community with barriers to accessing care due to medical underservice or a shortage of health professionals as well as individual facilities similarly lacking sufficient health professionals.

Second, this section summarizes the various assets and resources available to improve and maintain the health of the community.

Key insights: ***Health and Social Services Landscape***

- The Twin Cities area faces barriers to accessing care as demonstrated by the presence of federally-designated Medically Underserved Areas or Populations (MUA/MUPs) and Health Professional Shortage Areas (HPSAs).
- Anoka, Washington, and Scott counties also contain facilities and areas with a shortage of health professionals.
- The Shakopee Mdewakanton Sioux Community in Scott County is designated as a primary medical, dental, and mental health professional shortage area due to economic and/or cultural/linguistic barriers to receiving primary care.
- 39 FQHCs in Hennepin and Ramsey counties and one in Washington County serve HPSAs, MUAs, and MUPs.
- Each county contains one or more hospitals, health and human services departments, and other agencies striving to meet health needs.

Medically Underserved Areas and Populations

The Health Resources and Services Administration (HRSA) has calculated an Index of Medical Underservice (IMU) score for communities across the U.S. The IMU score calculation includes the ratio of primary medical care physicians per 1,000 persons, the infant mortality rate, the percentage of the population with incomes below the poverty level, and the percentage of the population greater than age 64. IMU scores range from zero to 100 where 100 represents the least underserved and zero represents the most underserved.[25]

Any area or population receiving an IMU score of 62.0 or less qualifies for Medically Underserved Area (MUA) or Medically Underserved Population (MUP) designation. Federally Qualified Health Centers (FQHCs) may be established to serve MUAs and MUPs. Populations receiving MUP designation include groups within a geographic area with economic barriers or cultural and/or linguistic access barriers to receiving primary care. When a population group does not qualify for MUP status based on the IMU score, Public Law 99-280 allows MUP designation if "unusual local conditions which are a barrier to access to or the availability of personal health services exist

25 U.S. Health Resources and Services Administration. (n.d.) Guidelines for Medically Underserved Area and Population Designation. Retrieved 2012, from http://bhpr.hrsa.gov/shortage/muaps/index.html.

and are documented, and if such a designation is recommended by the chief executive officer and local officials of the State where the requested population resides."[26]

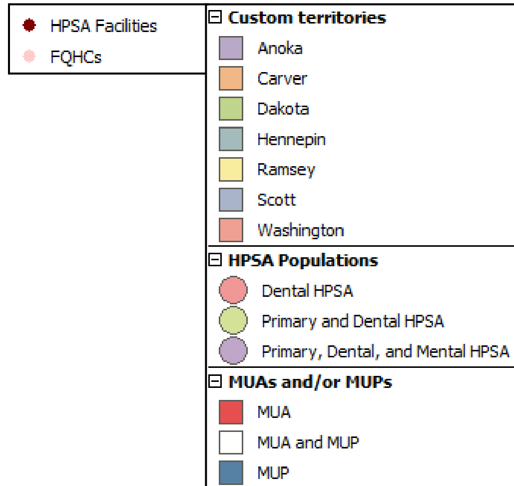
Exhibit 49 shows areas designated by HRSA as medically underserved. Hennepin and Ramsey counties both contain MUAs; Ramsey County also contains an MUP.

26 Ibid.

Insert Exhibit 49: Location of Federally Designated Areas in the Broader Community, 2012

Children's Minnesota Campus Locations

Sources: Microsoft MapPoint and HRSA, 2012.



The broader community contains MUAs and MUPs as well as HPSA populations and facilities

…

The majority of these designations are located near Minneapolis and St. Paul

Health Professional Shortage Areas

An area can receive a federal Health Professional Shortage Area (HPSA) designation if a shortage of primary care, dental care, or mental health care professionals is found to be present.

In addition to areas and populations that can be designated as HPSAs, a facility can receive federal HPSA designation and a resultant, additional Medicare payment if it provides primary medical care services to an area or population group identified as having inadequate access to primary care, dental, or mental health professionals and service capacity.

HPSAs can be: "(1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility."[27]

Many populations in the Children's broader community are designated as HPSAs (**Exhibit 49**). The Shakopee Mdewakanton Sioux Community in Scott County is designated as a primary medical care, dental, and mental health HPSA. In Hennepin County, the low-income populations in North and Northeast Minneapolis are designated as primary medical care and dental HPSAs. The low-income populations of Central Minneapolis, Central St. Paul, and Riverview/St. Paul also are designated as dental HPSAs.

Description of other facilities and resources within the community

The Children's broader community contains a variety of resources that are available to meet the health needs identified in this CHNA. These resources include facilities designated as HPSAs, hospitals, FQHCs, health professionals, and other agencies and organizations.

In addition to the populations designated as HPSAs, several facilities in the Children's broader community are designated as HPSAs (**Exhibit 50**).

27 U.S. Health Resources and Services Administration, Bureau of Health Professionals. (n.d.). Health Professional Shortage Area Designation Criteria. Retrieved 2012, from http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/index.html

Exhibit 50: HPSA Facilities in the Broader Community, 2012

County	Name	Type of Facility	Type of HPSA
Anoka	Anoka Metro Regional Treatment Center	State Mental Hospital	Mental Health
	Minnesota Correctional Facility - Lino Lakes	Correctional Facility	Primary Medical Care, Dental, Mental Health
Hennepin	Axis Community Health	Federally Qualified Health Center Look A Like	Primary Medical Care, Dental, Mental Health
	Cedar Riverside People's Center	Comprehensive Health Center	Primary Medical Care, Dental, Mental Health
	Community University Health Care Center	Comprehensive Health Center	Primary Medical Care, Dental, Mental Health
	Fremont Community Health	Comprehensive Health Center	Primary Medical Care, Dental, Mental Health
	Hennepin County Health Care for the Homeless	Comprehensive Health Center	Primary Medical Care, Dental, Mental Health
	Hennepin County Medical Center	Other Facility	Primary Medical Care
	Indian Health Board	Comprehensive Health Center	Primary Medical Care, Dental, Mental Health
	Native American Community Clinic	Comprehensive Health Center	Primary Medical Care, Dental, Mental Health
	Northpoint Health and Wellness Center	Comprehensive Health Center	Primary Medical Care, Dental, Mental Health
	Southside Community	Comprehensive Health Center	Primary Medical Care, Dental, Mental Health
	University of Minnesota Community Health Care	Comprehensive Health Center	Dental
Ramsey	Model Cities Health Center	Comprehensive Health Center	Primary Medical Care, Dental, Mental Health
	United Family Practice Health Center	Federally Qualified Health Center Look A Like	Primary Medical Care and Dental
	Westside Community Health Center	Comprehensive Health Center	Primary Medical Care, Dental, Mental Health
Scott	Minnesota Correctional Facility - Shakopee	Correctional Facility	Primary Medical Care, Dental, Mental Health
Washington	Minnesota Correctional Facility - Stillwater	Correctional Facility	Primary Medical Care and Mental Health
	Minnesota Correctional Facility Oak Park Heights	Correctional Facility	Mental Health

Source: HRSA, 2012.

Each county contains at least one hospital facility (**Exhibit 51**).

Exhibit 51: Information on Hospitals in the Broader Community, 2011

County	Facility Name	ZIP Code
Anoka	Mercy Hospital	55433
	Unity Hospital	55432
Carver	Ridgeview Medical Center	55387
Dakota	Fairview Ridges Hospital	55337
	Northfield Hospital	55057
	Regina Medical Center	55033
Hennepin	Abbott Northwestern Hospital	55407
	Children's Hospital & Clinics Minneapolis	55404
	Fairview Southdale Hospital	55435
	Hennepin County Medical Center	55415
	Maple Grove Hospital	55369
	North Memorial Medical Center	55422
	Park Nicollet Methodist Hospital	55440
	Phillips Eye Institute	55404
	Regency Hospital Of Minneapolis LLC	55422
	Shriners Hospital For Children	55414
	University Of Minnesota Medical Center	55454
Ramsey	Children's Hospital & Clinics of Minnesota	55102
	Gillette Children's Specialty Hospital	55101
	HealthEast Bethesda Hospital	55103
	HealthEast St. John's Hospital	55109
	HealthEast St. Joseph's Hospital	55102
	Regions Hospital	55101
	United Hospital Inc.	55102
Scott	MCHS - New Prague	56071
	St Francis Regional Medical Center	55379
Washington	HealthEast Woodwinds Hospital	55125
	Lakeview Memorial Hospital	55082

Source: Minnesota Department of Human Services, 2012, and the CMS Impact File, 2012.

Federally Qualified Health Centers (FQHCs) were created by Congress to promote access to ambulatory care in areas designated as "medically underserved." These clinics receive cost-based reimbursement for Medicare and many also receive grant funding under Section 330 of the Public Health Service Act. FQHCs also receive a prospective payment rate for Medicaid services based on reasonable costs.

There are 40 FQHCs located in the seven counties within the community served by Children's; 27 in Hennepin County, 12 in Ramsey County, and one in Washington County (**Exhibit 52**). Seven of these FQHCs also are HPSAs.

Exhibit 52: FQHCs in the Broader Community, 2012

County	Facility Name	ZIP Code
Hennepin	Branch III Health Care For Homeless	55404
	Cedar Riverside People's Center	55454
	Central Avenue Clinic	55418
	Community-University Health Care Center	55404
	Family Dental Of South Minneapolis	55406
	Fremont Clinic	55412
	Hennepin County Public Health Clinic	55415
	Heritage Seniors Clinic	55405
	Indian Health Board Of Minneapolis, Inc.	55404
	Mary's Place	55405
	Native American Community Clinic Dental Services	55405
	Native American Community Clinic Counseling Services	55405
	Northpoint Health And Wellness	55411
	Our Savior's Shelter-Homeless Shelter	55404
	People Serving People	55415
	People's Center Teenage Medical Services	55454
	Plymouth Christian Youth Center	55411
	Salvation Army Harbor Lights	55403
	Secure Waiting	55403
	Sharing & Caring Hands	55405
	Sheridan Women & Children's Clinic	55413
	Simpson Shelter	55408
	Southside Dental Clinic & Mobile Dental Van	55409
	St. Stephen's Shelter	55404
	Universal Medical Services, Inc. / Axis Medical Center	55404
	Vision Clinic	55406
	Youthlink	55403
Ramsey	Dorothy Day Clinic	55102
	East Side Family Clinic	55106
	Family Services Center	55109
	Helping Hand Dental Clinic	55102
	McDonough Homes Clinic	55117
	Open Cities Health Center, Inc.	55117
	Open Cities North End Clinic	55117
	Union Gospel Mission	55101
	United Family Medicine	55102
	United Family Medicine at Sibley Plaza	55116
	West Side Dental Clinic	55107
	Westside Community Health Services, Inc.	55107
Washington	St Croix Family Medical Clinic	55082

Source: HRSA, 2012.

Exhibit 53 presents the rates of primary care physicians, mental health providers, and dentists per 100,000 population. Provider rates are roughly half the Minnesota average for mental health providers in Anoka County and for dentists in Carver County.

Exhibit 53: Health Professionals Rates per 100,000 Population in the Broader Community

County	Primary Care Physicians*		Mental Health Providers*		Practicing Dentists*	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Anoka	192	57.6	121	36.3	131	39.4
Carver	83	89.6	44	47.5	32	34.4
Dakota	282	70.1	254	63.2	227	57.0
Hennepin	1,492	127.7	1,586	135.7	869	74.5
Ramsey	651	126.5	680	132.1	481	94.4
Scott	84	63.4	66	49.8	50	37.3
Washington	270	111.9	149	61.8	144	61.6
Minnesota	**5,280****	**98.8**	**3,848****	**72.0**	**3,249**	**61.4**

Source: HRSA's Area Resource File, 2011, and Minnesota Department of Health, 2011.
*Primary care physician data is from 2011, dentist data is from 2010, and mental health provider data is from 2007.
**Numbers of health professionals in Minnesota calculated by Verité.

As of 2012, a range of other agencies and organizations are available in each county to assist in meeting health needs, including county health departments and human services departments. Some of these include:

» Local health departments and human and social services departments, and related clinics:

  - Anoka County Human Services Department
    http://www.co.anoka.mn.us/departments/human_serv/index.htm
  - Anoka County Department of Community Health and Environmental Services
    http://www.co.anoka.mn.us/v2_dept/ches/index.asp
  - Carver County Community Social Services Department
    http://www.co.carver.mn.us/departments/CSS/index.asp
  - Carver County Public Health and Environmental Division
    http://www.co.carver.mn.us/departments/PH/index.asp
  - Dakota County Health and Family Services:
    http://www.co.dakota.mn.us/HealthFamily/Pages/default.aspx
  - Hennepin County Human Services and Public Health Department
    http://hennepin.us/hsphd
  - Ramsey County Community Human Services Department
    http://www.co.ramsey.mn.us/hs/index.htm
  - St. Paul - Ramsey County Public Health Department
    http://www.co.ramsey.mn.us/ph/
  - Scott County Public Health Department
    http://www.co.scott.mn.us/HelpingPeopleHealth/PublicHealth/Pages/PublicHealth.aspx
  - Washington County Community Services Department
    http://www.co.washington.mn.us/index.aspx?nid=469

- Washington County Public Health and Environment Department http://www.co.washington.mn.us/index.aspx?NID=471

» School districts in the seven-county community.

» Free clinics in Hennepin, Ramsey, and Washington counties.

» Organizations that focus on mental health, including:
  - Anoka County Children's Mental Health Unit
  - Children's Mental Health Local Advisory Council of Dakota County
  - Hennepin County Children's Mental Health Collaborative
  - Hennepin County Mental Health Advisory Council (HCMHAC)
  - Mental Health Association of Minnesota
  - Mental Health Consortium of Carver County
  - National Alliance on Mental Illness of Minnesota (NAMI Minnesota)
  - Ramsey County Children's Mental Health Collaborative
  - St. Paul-Ramsey County Mental Health Board
  - Scott County Mental Health Advisory Council
  - Washington County Mental Health and Advisory Recovery Board

» Organizations that focus on dental health, including:
  - Neighborhood Health Care Network in St. Paul
  - Children's Dental Clinics in Scott County
  - Children's Dental Services
  - Ronald McDonald Care Mobile Dental Clinic
  - Dakota Smiles, a mobile dental program for children.

Additionally, lists of available resources have been compiled by community foundations, clinics, and health departments and can be found at the following websites:

» 2012 Health Resources Directory for Diverse Cultural Communities

» http://www.health.state.mn.us/divs/idepc/refugee/directory.html

» Anoka County Resources for Building Better Lives http://www.co.anoka.mn.us/v2_dept/cmhs/childrens/pdf/ResourceGuide2012.pdf

» Anoka County Resource Guide for Seniors

» http://ww2.anokacounty.us/v4_seniors/documents/SeniorServicesWebsiteDirectory.pdf

» Dakota County Resource Guide

» http://www.positivelyminnesota.com/JobSeekers/WorkForce_Centers/Dakota_County_West/Resource_Guides/Dakota_County_Resource_Guide.pdf

» Dental Clinics in the Anoka County Area

» http://www.partnershipforbetterhealthanokacounty.com/vertical/Sites/%7B2E3DFA25-04F4-46C7-BDDB-02D52D6104DC%7D/uploads/%7B29E960B2-4B8D-4300-A377-731688A79DBB%7D.PDF

- Hennepin County Directory of Free or Sliding Fee Mental Health Clinics http://www.hennepin.us/portal/site/HennepinUS/menuitem.b1ab75471750e40fa01dfb47ccf06498/?vgnextoid=49e2e5d0820a3210VgnVCM10000049114689RCRD
- Scott County List of Low-Cost Dental Clinics
- http://www.co.scott.mn.us/HelpingPeopleHealth/PublicHealth/Forms/low%20cost%20dental%20clinics%20website.pdf
- Scott County List of Sliding Fee and Low-Cost Medical Clinics http://www.co.scott.mn.us/HelpingPeopleHealth/PublicHealth/Forms/Sliding%20fee%20and%20Low%20Cost%20Medical%20Clinics%20website.pdf

Findings of other recent community health needs assessments

Verité also considered the findings of other needs assessments published since 2007. Twenty such assessments have been conducted in the Children's area and are publicly available. Summary findings from these assessments are provided below, with the most recent presented first.

Key insights: ***Other Recent CHNAs***	» Common themes among other recent needs assessments conducted in the area include: - Abuse of alcohol among adults and older children, - Poor mental health, - Insufficient exercise among youth, - Prevalence of chronic diseases, particularly diabetes and obesity among adults, and asthma among children, - Low birth weight infants for the non-White population, and - Disparities in access to and affordability of care. » Vulnerable populations such as racial and ethnic minorities, low-income and homeless populations, and those with special needs generally face greater barriers to health compared to other cohorts. The above assessments found that these groups have greater difficulty accessing health care and insurance due to cost. The cost of child care is also more of a burden for these families. Increasingly, people are being forced to choose between meeting basic needs, such as food and housing, or obtaining health care. » Local needs assessments also show that social and economic disadvantages create disparities in health status for vulnerable populations in the community. Low-income families and children typically have poorer diets, limited physical activity, and higher rates of smoking and substance abuse – resulting in higher rates of chronic diseases like diabetes, obesity, and cardiovascular issues. Chronic disease and mental illness are particularly prevalent among homeless youth and adults. Non-White populations exhibit higher rates of low birth weight infants.

Hennepin County Human Services and Public Health Department, et al., 2012

Five local community health boards, together with community partners, collaborated in the creation of a Community Health Improvement Plan for Hennepin County. Participating health boards represented the cities of Minneapolis, Richfield, Edina and Bloomington, as well as Hennepin County as a whole.28 The group drew on various secondary data sources, including the SHAPE survey (summarized below), Minneapolis Department of Health and Family Support, *Results Minneapolis,* Bloomington Public Health, Minnesota Department of Health, *Minnesota Student Survey, Healthy People 2020*, Minnesota Department of Education, Centers for Disease Control and the Census Bureau.

Strategic health issues identified include:

» Maternal and child health; nutrition, obesity and physical activity; social and emotional wellbeing; health care access; and social conditions that impact health.

Fairview Health Services, 2012

Fairview Health Services, a hospital system based in Minneapolis, collaborated with each of their six facilities to conduct a community health needs assessment and adopt implementation strategies in 2012.29 Within the Fairview system, the University of Minnesota Amplatz Children's Hospital, located on the University of Minnesota Medical Center Fairview campus, provides specialized pediatric care to the community. The hospital used discharge data from 2008-2010, Dignity Health's Community Need Index, and data from focus groups, interviews, and surveys to assess needs for the broader Minneapolis area.

Findings include:

» Mental health, heart disease, diabetes, low birth weight infants and infant mortality, and the need for health information, education, and cultural competency emerged as top themes from the assessment.

» The facility's top hospitalizations for the total population resulted from pneumonia, blood poisoning, and osteoarthritis.

» The area's leading causes of death were for cancer, heart diseases, and mental disorders. Hospitalizations for mental health and deaths related to mental disorders were both higher than Minnesota averages.

» For the pediatric population, top hospitalizations were for pneumonia, dehydration, and asthma. Leading causes of death for this population include birth defects, SIDS, and homicide, all of which compared poorly to state averages.

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28 Hennepin County Human Services and Public Health Department, et al. (2012). 2012 – 2015 Community Health Improvement Plan for Hennepin County Residents. Retrieved 2013, from http://www.hennepin.us/portal/site/HennepinUS/menuitem.b1ab75471750e40fa01dfb47ccf06498/?vgnextoid=8a010eb64666b310VVgnVC10000099fe4689RCRD

29 Fairview Health Services. (2012). University of Minnesota medical Center Community Health Needs Assessment (CHNA) Implementation Plan. Retrieved 2012, from http://www.fairview.org/About/Communitycommitment/HealthNeedsAssessments/index.htm

Kids Count Minnesota and Children's Defense Fund, 2012

The assessment conducted by Children's Defense Fund and Kids Count Minnesota30 analyzed the health of children in the 11 Economic Development Regions (EDRs or Regions) of Minnesota. Region 11 represented the seven counties in the Minneapolis-St. Paul metro area: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. Findings were primarily from years 2009 to 2011.

Findings are as follows:

- About 22 percent of children in Region 11 received SNAP assistance in 2011, one of the highest percentages in the state.
- The rate of children arrested for a serious crime in 2010 was nearly four times higher in Region 11 than in the lowest rate in the state.
- Eleven percent of children in Region 11 had limited English proficiency skills, compared to seven percent in the whole state in 2011.
- About 5.8 percent of children in Region 11 did not have health insurance, compared to a state average of 6.7 percent.

The Minneapolis Foundation and Wilder Research, 2012

The assessment[31] analyzes changes to the 25 social, educational, and economic indicators selected by The Minneapolis Foundation and Wilder Research in 2010 for the OneMinneapolis dashboard. The report provides, for each indicator, the most current available data and examines racial and ethnic differences, when available. Although many indicators improved or remained the same, racial and ethnic disparities are still prevalent.

Findings include:

Education / Children and Youth

- The percent of students graduating on time worsened; additionally, graduation rates were highest for White residents, at 68 percent, and lowest for American Indian residents, at 17 percent.
- Only 57 percent Hmong-speaking kindergarteners and 38 percent of Spanish-speaking kindergartners were ready for school compared to 83 percent of English-speaking kindergartners. White residents outperformed non-White residents on kindergarten readiness, 3rd grade reading proficiency, and 5th grade math proficiency.
- There are large gaps between enrollment of White and non-White high school students in post-secondary education. While about 68 percent of all students enrolled in post-secondary education, 31 percent of American Indian residents enrolled compared to 77 percent of White residents.

Economic Vitality

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30 Children's Defense Fund – Minnesota. (2012). Minnesota Kids Count 2012: Children Across Minnesota. Retrieved 2012, from http://www.cdf-mn.org/sites/2012_publications/kc/minnesota-kids-count-2012.pdf

31 The Minneapolis Foundation and Wilder Research. (2012). oneMinneapolis 2012 Community Indicators Report. Retrieved 2013, from http://www.wilder.org/Wilder-Research/Publications/Studies/oneMinneapolis/oneMinneapolis%202012%20Community%20Indicators%20Report.pdf

- The share of low-income households with affordable housing in 2008-2010 was 21 percent, a 42 percent decrease from 1999. Asian and Hispanic or Latino residents living in low-income households are least likely to have affordable housing.
- A single female is the head of household in 68 percent of the Minneapolis families that face poverty.
- Non-White and foreign-born residents are more likely to be in poverty than White residents.

Justice and Equality

- 27 percent of Minneapolis youth were arrested for a serious crime, a higher rate than in previous years. Black residents were more often arrested for serious crimes than White and Asian residents. Black residents make up 29 percent of the Minneapolis population but 65 percent of the arrests.
- Non-White residents earning less than 200 percent of the federal poverty level reported experiencing the most situations in which they felt unaccepted due to their race, ethnicity, or culture.

St. Paul – Ramsey County Public Health, Family Health Section, 2012

The Family Health Section of St. Paul-Ramsey County Public Health32 created and issued a teen survey on reasons for and reasons deterring visits to the doctor, as well as general demographic trends in the data.

Findings include:

- In the last year, about 81 percent of teens reported visiting a doctor in a clinic.
- Thirty-six percent of respondents stated lack of health insurance as the main reason for not visiting a doctor in the last year. Another predominant reason for not visiting the doctor was feeling uncomfortable with the doctor.

Washington County Community Services, 2011

Results from a survey by Washington County Community Services and Wilder Research33 demonstrated the need for child care in Washington County and the state. In the 2009 survey, 1,209 families with at least one child under age 12 in their household were randomly selected to participate.

Some of the findings include:

- Among children that received child care, only 25 percent attended child care full time, as compared to 75 percent who received part time care.
- Low-income families tended to pay about 20 percent of their income on child care, which was double the portion of what higher income families paid.

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32 St. Paul-Ramsey County Public Health, Family Health Section. (2012, January). Access and Use of Medical Care: A Survey of Teen's Perspectives. Retrieved 2012, from http://www.co.ramsey.mn.us/NR/rdonlyres/EDC9A91A-F7A3-4CA2-8D8C-9DB650FE8F0D/26817/access_and_use_of_medica_care_teen_study.pdf

33 Washington County Community Services Child Care Licensing Program. (2011, September/October). Washington County Child Care Statistics in Minnesota. Caring and Sharing Newsletter. Retrieved 2012, from http://www.co.washington.mn.us/Archive.aspx?AMID=74

- About every 1 in 5 children in Minnesota had a special need that impacted their quality of child care.
- Non-White parents, parents of children with special needs, and low-income parents were twice as likely to be affected by the cost of child care compared to parents not in these categories.

Wilder Research, 2011

Wilder Research completed a study34 about the homeless population in the seven-county Minneapolis-St. Paul metro area and in Greater Minnesota in 2009. A total of 220 homeless parents in the state (with 349 children) were interviewed, 66 of whom (with 109 children) were in the metro area.

Findings are as follows:

- Single adult females were the head of nearly 80 percent of homeless sheltered families and 62 percent of homeless unsheltered families.
- Similar to past rates, 13 percent of homeless parents reported that one or more of their children had a chronic or severe illness.
- Of the unsheltered homeless parents:
    - Nineteen percent reported trouble accessing needed dental care for their children;
    - Twenty percent said their children had skipped meals in the past month; and
    - Fourteen percent reported they had been unable to obtain needed health care for children in the past year.
- About 49 percent of homeless parents stated that they (the parent) were told by a health provider or professional that they had a serious mental health disorder.
- Homeless parents reported an inability to obtain needed health care:
    - Three percent of parents were unable to provide or obtain mental health care for their children; and
    - Parents in the metro area had fewer difficulties obtaining care, at nine percent, compared to parents in Greater Minnesota, at 17 percent.

Hennepin County Human Services and Public Health Department and Statewide Health Improvement Program (SHIP), 2011

Hennepin County Human Services and Public Health Department and Statewide Health Improvement Program (SHIP) produced a report titled *SHAPE 2010-Child Data Book,*35 portraying data from the SHAPE 2010 Child Survey.

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34 Wilder Research. (2011, May). 2009 Minnesota Homeless Study: Homeless Children and their Families. Retrieved 2012, from http://www.wilder.org/Wilder-Research/Publications/Studies/Homelessness%20in%20Minnesota,%202009%20Study/Homeless%20Children%20and%20Their%20Families,%20Full%20Report.pdf

35Hennepin County Human Services and Public Health Department. (2011, April). SHAPE 2010 – Child Survey Data Book. Retrieved 2012, from http://www.hennepin.us/files/HennepinUS/HSPHD/Public%20Health%20Protection/Assessment/SHAPE/2010/ChildDataBook2010Full_200110719.pdf

Findings are as follows:

- Overall Health and Chronic Conditions:
    - About two percent of Hennepin County parents stated their children had serious physical, behavioral, or developmental conditions that limited their ability to attend school regularly.
    - About 15 percent of Hennepin County parents took their children to the emergency room due to an asthma attack. Of those children (old enough to attend an educational institution), 23 percent were in pre-kindergarten or kindergarten, 12 percent were in first through third grades, 13 percent were in fourth through 6th grades, and 14 percent were in 7th through 12th grades.
    - The rates of children with ADD/ADHD in Hennepin County (10 percent) and depression (nine percent) were lower than the Minneapolis averages at 12 percent and 10 percent, respectively.
- Weight, Nutrition, and Physical Activity:
    - About 17.2 percent of children surveyed from low-income households did not have any servings of vegetables daily, compared to 12.6 percent of children from households not classified as low-income.
    - About 73.5 percent of Hennepin County's residents stated that the schools involved children in enough physical activity; low-income families felt less secure about their children's physical activity levels than those not classified as low-income.
    - Regular smoking around children was present in 11 percent of low-income households as compared to 2.5 percent of higher-income households in Hennepin County.
    - Drug use prevention was discussed by 65 percent of families who were not low-income in Hennepin County, as compared to only 60 percent of low-income families.
    - About 79.1 percent of Hennepin County children ate the standard servings of fruit (2 or more servings), compared to 74.9 percent of low-income children.
    - About 48.1 percent of children in Hennepin County had zero servings of sweetened drinks, compared to 34.5 percent of low-income children.
- Child Care and Health Insurance Coverage:
    - The percentage of families receiving childcare from someone not related to the child was much lower for low-income families, at 28 percent, than higher income families, at 51 percent.
    - About 88.8 percent of children aged 17 or younger receive care from a medical home, compared to 80 percent of low-income children.
    - About 60.6 percent of children in Hennepin County saw the same doctor more than once, compared to 46.7 percent of low-income children.

Dakota County Public Health Department, 2011

The Dakota County Public Health Department completed a set of community health profiles36 of data from 2000 to 2010. This analysis described health outcomes, changes, and behaviors in the population.

The following are findings from the study:

- Alcohol and Drug Use by Youth:
  - Dakota County experienced a decrease in frequent drinking among 9th and 12th graders from 2004 to 2010.
  - Of all motor vehicle injuries in Dakota County, seven percent were alcohol-related, compared to 38.5 percent of motor vehicle fatalities that were alcohol-related. There were steady decreases in alcohol-related fatalities and injuries between 2000 and 2009.
  - In 2009, the sale or possession of marijuana comprised eighty-one percent of narcotics arrests.
- Chronic Disease:
  - Between 2008 and 2009, the highest rate of asthma was among children ages 0 to 4, consisting of 529 hospitalizations and 1,925 emergency room visits.
- Maternal and Child Health:
  - About six percent of mothers were smokers during pregnancy, an increase from 2006.
  - Unintended pregnancies were reported among 37 percent of women in 2008.
  - In 2010, 86 percent of mothers received prenatal care in their first trimester.
- Mental Health:
  - Attempted suicide or premeditated feelings of suicide decreased for students from 2004 to 2010, but suicide and unintentional injuries were still the leading causes of death, as their rates increased between 1998 and 2009.
- Nutrition and Physical Activity:
  - The percent of six month old babies in 2010 who were still breastfed was similar to the state at 31 percent but lower than the Healthy People 2010 goal of 50 percent.
  - The percentage of 9th grade students who wanted to lose weight (59 percent in 2010) decreased 21 percentage points, while the percentage of 12th graders who wanted to lose weight (62 percent in 2010) decreased 14 percentage points between 2004 and 2010.
- Smoking:
  - Dakota County 9th graders reported primarily accessing cigarettes from friends, at a rate of 55 percent in 2010.

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36 Dakota County Public Health Department. (2011-2012). Dakota County Community Health Assessment and Planning: Community Health Profiles. Retrieved 2012, from http://www.co.dakota.mn.us/Government/publiccommittees/CHA/Pages/profiles.aspx

- The number of students in Dakota County who reported smoking decreased from 1998 to 2010.

Minnesota Department of Health – Community and Family Health Division, 2010

The Minnesota Department of Health's Community and Family Health Division37 worked on the Maternal and Child Health Services Title 5 Block Grant, analyzing the past performance of the state of Minnesota and creating priorities for 2011 through 2015. It also provided trends and impacts on health outcomes of mothers, infants, children, and youth with special healthcare needs.

Findings for Minnesota include:

- Binge drinking was an issue for 6.6 percent of mothers during their first trimester of pregnancy, and for 5.6 percent during their last trimester.
- About 16 percent of pregnant women in Minnesota reported smoking during their pregnancy.
- Unintentional pregnancies were highest among Black (47.4 percent) and Hispanic or Latino populations (45.9 percent). These pregnancies were lowest among Whites (33.6 percent).
- Immunization records in 2008 showed that approximately 91 percent of all children were properly and age-appropriately immunized, an increase from the 2004 immunization rate of 85 percent.
- The pregnancy rate and birth rate for women between the ages of 15 and 19 decreased between 1997 and 2008.
- In 2008, the population of children with special health care needs was about 14.4 percent, slightly higher than the national average of 13.9 percent.

Blue Cross and Blue Shield Foundation of Minnesota and Wilder Research, 2010

Wilder Research and the Blue Cross and Blue Shield of Minnesota Foundation commissioned a report in October 201038 to examine links between socioeconomic status and health outcomes for the Twin Cities seven county region (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington). They also released a supplement to the report which provided additional data and analyses.39 Secondary data from the Minnesota Department of Health and geographic mapping patterns were used to provide analysis.

Some of the findings include:

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37 Minnesota Department of Health, Community and Family Health Division. (2010, July). Minnesota 2010 Needs Assessment: Maternal and Child Health Services Title V Block Grant. Retrieved 2012, from http://www.health.state.mn.us/divs/cfh/na/documents/MN2010NeedsAssessment.pdf

38Blue Cross and Blue Shield of Minnesota Foundation and Wilder Research. (2010, October).The Unequal Distribution of Health in the Twin Cities. Retrieved 2012, from http://www.wilder.org/Wilder-Research/Publications/Pages/default.aspx

39Blue Cross and Blue Shield of Minnesota Foundation and Wilder Research. (2010, October). Revealing Socioeconomic Factors that Influence Your Health: Supplement to the Unequal Distribution of Health in the Twin Cities Report. Retrieved 2012, from http://www.bcbsmnfoundation.org/objects/Publications/F9789_web%20-%20Wilder%20companion%20piece.pdf

- The mortality rate for the seven county area was highest for American Indians (about eight percent) and Blacks (about seven percent). American Indians and Blacks also had the highest rates for obesity, diabetes, and infants with low birth weights.
- The mortality rate for non-White residents was nearly 60 percent higher than for those who were White.
- While about four percent of Whites had babies with low birth weights, seven percent of non-Whites had the same outcome.
- Every additional $10,000 of household income earned in an area correlated with a one-year increase in life expectancy for that area's population. High income areas had children with life expectancies that were up to eight years higher than children in lower-income areas.
- The report noted that more than half of a person's health outcomes were impacted by the following factors: income, education, race, and residence.

Wilder Research, 2010

Wilder Research provided a report40 for Hennepin County Children's Research Collaborative on health needs, particularly mental health needs, of children and teens in schools and community programs of Hennepin County in 2010. The report used data collected from two online surveys with mental health service providers and collaborative stakeholders in Hennepin County, interviews with mental health system leaders, and a 90-minute focus group with parents/caregivers in the county who cared for a child receiving mental health services.

Findings include:

- Nearly 70 percent of the Hennepin County mental health unit was male, with the majority of the population being Black (43 percent) and White (42 percent).
- More than 80 percent of youth receiving targeted case management help were covered through a public health insurance plan in 2008.
- Student to school counselor ratios in Minnesota were some of the lowest in the nation, at 800:1, compared to the national average of 488:1 students in 2007.
- About 83 percent of survey respondents felt that the system serving youth with mental health issues was "somewhat effective."

Wilder Research, 2010

Wilder Research analyzed the availability of mental health services for the Hmong Community in Ramsey County and assessed barriers to accessing these services. The report[41] is a compilation of surveys, interviews, and secondary data collection from U.S. Census data for the years 2006-2008.

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40 Wilder Research. (2010, January). Hennepin County Children's Health Collaborative: System of Care Assessment. Retrieved 2012, from http://www.wilder.org/Wilder-Research/Publications/Studies/Hennepin%20County%20Children%27s%20Mental%20Health%20Collaborative/System%20of%20Care%20Assessment.pdf

41 Wilder Research. (2010, June). Hmong Mental Health Assessment- An Assessment of mental health needs and services in the Hmong Community in Ramsey County. Retrieved 2013, from http://www.wilder.org/Wilder-Research/Publications/Studies/Hmong%20Mental%20Health%20-%20An%20Assessment%20of%20Mental%20Health%20Needs%20and%20Services%20for%20the%20Hmong%20Community%20in%20Ramsey%20County/Mental%20Health%20Needs%20and%20Services%20for%20the%20Hmong%20Community%20in%20Ramsey%20County,%20Full%20Report.pdf

Findings include:

- The Hmong community accounted for about five percent of Ramsey County's population, but nearly half of the Hmong population in Ramsey County was under the age of 18 years.
- In Ramsey County, about 40 percent of the Hmong community was not in the labor force, compared to 31 percent of the general population.
- In St. Paul, the average household income for the Hmong community was $45,300, compared to the average household income of $62,559.
- In St. Paul, nearly 11 percent of the Hmong community was receiving government assistance, compared to about 5 percent of the overall population.
- Between 2009 and 2010, about 90 percent of students who stated Hmong was their primary language were enrolled in the free or reduced-price lunch program although these students comprised only 25 percent of the entire student population.
- Between 2009 and 2010, about 12 percent of the Hmong community received special education classes.
- Hmong community members expressed a preference for traditional practices and support services compared to more Western forms of care.
- More acculturated and educated Hmong members in the community were the most likely to seek care for mental health issues.
- During 2008 and 2009, nearly half of the individuals using the Southeast Asian Services within Wilder's Children and Family Services were from the Hmong community.

Carver County Public Health Department Data Resource Center, 2009

The Data Resource Center of Carver County Public Health Department completed a data profile42 of residents' behaviors between 2003 and 2009 that discussed findings in multiple categories.

Findings are as follows:

- Health Behaviors:
    - In 2007, about 13.7 percent of 9th graders and 31.5 percent of 12th graders reported binge drinking.
    - Between 2003 and 2006, the number of minor consumption citations increased from about 150 to 250.
    - The percentage of physically inactive students (those who do not exercise for 30 minutes or more a day, on five or more days) increased 6.2 percent for 9th graders, 9.8 percent for 6th graders, and 13 percent for 12th graders between 1998 and 2007.
- Overall Health:

42 Carver County Public Health Department. (2009, July). Carver County Public Health Data Profile. Retrieved 2012, from http://www.co.carver.mn.us/departments/PH/data/local_public_health_assessment_planning.asp

- Chronic disease, poor oral health, lack of prenatal care, and mental health problems were among the major health issues in Carver County.

» Infectious Disease:

- Between 2007 and 2008, cases of pertussis increased from three to 36.

Carver County Public Health Department, 2009

Carver County Public Health Department administered a biannual survey43 in 2008. Out of 42 public and private schools in the community, 32 schools responded. By examining the services provided by school nurses to elementary, middle, and high school students, health needs of students were identified.

Survey findings are as follows:

» Among students, the predominant health condition present was asthma, at a rate of 78.4 per 1,000 students (or 39 students per school), followed by ADD/ADHD at a rate of 59.2 per 1,000 students (or 31 students per school).

» Hearing referral rates were highest among high school students at 13.9 per 1,000 children and lowest among middle school students at 8.7 per 1,000 children.

» Vision referral rates were highest among elementary school students at a rate of 56.1 per 1,000 children and lowest among high school students at a rate of 25.8 per 1,000 children.

» Regularly scheduled medications for asthma or other chronic conditions were provided to eight students per day, on average, but some schools had up to twenty-eight students per day receiving this treatment.

Anoka County Government Center and Community Health and Environmental Services Department, 2009

The Community Health and Environmental Services Department44 of the Anoka County Government Center discussed findings and health trends in Anoka County from 2000 to 2010, though findings concerning children were primarily from 2003 to 2012.

Findings about youth include:

» In 2007, 36 percent of children were considered overweight, while 26 percent were classified as obese, comparable to the statewide percentages.

» An estimated 15 percent of adults exhibited binge drinking behavior in 2007, higher than state averages, but the behavior has trended downward since 1997.

» Twenty-six percent of 12th graders reported binge drinking, compared to 12 percent of 9th graders.

» Eighty-five percent of Anoka children received age-appropriate immunizations.

43 Carver County Public Health Department. (2009, May). Survey of Nursing Services in Carver County Schools. Retrieved 2012, from http://www.co.carver.mn.us/departments/PH/docs/School_Nurse_Survey_Results_from_07_08_School_Year.pdf

44 Anoka County Government Center, Community Health & Environmental Services Department. (2009, October). Anoka County Community Health Assessment Report 2010-2014. Retrieved 2012, from http://www.co.anoka.mn.us/v2_dept/ches/documents/Community%20Health%20Assessment%20Report%202010-2014.pdf

Dakota County Human Services Advisory Committee, 2008

Information on autism and its impact on children and adults in Dakota County were provided in a report45 by the Dakota County Human Services Committee in 2008. Data sources included school districts and the Dakota County Social Services Department.

Findings include:

- » Between 2002 and 2006, the number of autistic children (0 to 21 years old) served through Special Education departments increased by 117 percent, from 514 to 1,117, across eight local school districts within Dakota County.
- » School districts saw increases in the detection of children with autism by 116 percent between 1997 and 2006.
- » Within the Dakota County Developmental Disabilities (DD) Section, only 17 percent of individuals with autism in this region received services.

Washington County Department of Public Health and Environment, 2008

An assessment by the Washington County Department of Public Health and Environment discussed trends46 in Washington County between 2000 and 2008. Using an online health survey, youth environmental survey, senior citizens survey, focus groups, and interviews, this report was compiled during November 2007 and February 2008 and included responses by more than 1,370 individuals.

Findings include:

- » The percent of premature births decreased from 8.6 percent to 7.6 percent in the county between 2004 and 2006.
- » Births to unmarried women increased from 20.2 percent in 2004 to 22.2 percent in 2006.
- » The number of cases of Lyme disease increased from 51 in 2004 to 64 in 2007.
- » Looking at physicians per 10,000 people, Washington County had a greater number (14.9) than Scott County (8.8) and Dakota County (10), while it had fewer physicians than Hennepin County (37.6), Anoka County (16.2), and Ramsey County (28.6).
- » The number of dentists per 10,000 population was higher for Washington County (6.6) than Scott County (3.3), Carver County (2.9), Dakota County (5.7), and Anoka County (4.9), while the number of dentists was lower than in Ramsey County (6.8) and Hennepin County (7.5).
- » In Washington County, 15 percent of children enrolled in the WIC program were at risk for being overweight, compared to 13 percent statewide; however, the percent of overweight children enrolled in WIC decreased from 12.2 percent to 9.3 percent between 2003 and 2007.
- » The percent of children in 6th grade eating five or more servings of vegetables decreased from 1998 (23.2 percent) through 2007 (21.1 percent). In comparison, the percent of

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45 Dakota Human Services Advisory Committee. (2008, October). Report on Autism Spectrum Disorder in Dakota County. Retrieved 2012, from
http://www.co.dakota.mn.us/NR/rdonlyres/00002638/nijqpkmligwuukgksnwfaqmfnxnbzwde/1008FinalAutismReport.pdf
46 Washington County Department of Public Health and Environment. (2008). Washington County Community Health Assessment 2008. Retrieved 2012, from http://washco.stage.clockwork.net/_asset/tmgk3m/PHE-08CHA.pdf

individuals consuming the dietary guideline in 9th grade and 12th grade increased from 17.2 percent in 1998 to 20 percent in 2007 and 12.2 percent in 1998 to 15.7 percent in 2007, respectively.

- The leading causes of hospitalizations were as follows:
  - Injury and poisoning (19.2 percent) for ages 5 through 14; and
  - Mental disorders (25.9 percent) for ages 15 through 19.
- In 2002, approximately 22 percent of Washington County's population reported problems with "acute drinking," defined as drinking more than 5 drinks on one occasion, compared to 18 percent in 2006.
- Cigarette smoking declined from 2002 and 2006, decreasing from 22.3 percent to 18.9 percent.

Wilder Research, 2008

Wilder Research analyzed the availability of affordable housing services in the East Metro Area, which includes: Anoka, Dakota, Ramsey, and Washington counties. Needs for housing services are analyzed by jurisdiction, household size, senior households, and income level. Households defined as low-income have incomes at or below 60 percent of the region's Median Family Income (MFI), which is $80,900; whereas households defined as very low-income have incomes at or below 30 percent of the MFI. The report[47] uses secondary data from the U.S. Census, the State Demographer, and the Metropolitan Council to provide projections and trends.

Findings include:

- St. Paul had the highest actual and projected low-income and cost-burdened households in 2000 and 2010, at 31 and 30 percent, respectively. Projections suggest a decrease in the percentage to 27 percent by 2020. Washington County had the lowest percent of cost-burdened households, at 11 percent, for the years 2000 and 2010, but this is projected to increase to 13 percent by 2020.
- St. Paul was projected to consist of 35 percent of very low-income households by 2010. The town is projected to gain another 16 percent of very low-income households between 2010 and 2020. The greatest increase projected in very low-income households was in Dakota County, at 29 percent between 2010 and 2020.
- The greatest number of cost-burdened, very low-income senior households was projected to be in St. Paul (6,032 households) compared to Washington County, with the lowest projected number (2,975 households).
- By 2020, Dakota County is projected to have the greatest number of cost-burdened, very low-income households, or nearly 8,395 households. Washington County is projected to have the least, at 4,665 households.
- The sheltered homeless population increased around 10 percent between 2000 and 2006 and the prevalence of mental illness in the homeless population rose 16 percentage points. The proportion of homeless that were ex-offenders increased 11 percentage points.

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47 Wilder Research. (2008, July). East Metro Housing Need: Projections of low-income and cost-burdened households by 2010 and 2010. Retrieved 2013, from http://www.wilder.org/Wilder-Research/Publications/Studies/East%20Metro%20Housing%20Needs/East%20Metro%20Housing%20Need%20-%20Projections%20of%20Low-income%20and%20Cost-burdened%20Households%20by%202010%20and%202020,%20Full%20Report.pdf

» About 25 percent of the homeless population entering shelters in Ramsey County were considered "long term homeless populations." Of the nearly 2,000 shelters across the East Metro region, 80 percent of the current capacity for providing shelter, transitional housing, beds, and resources was used in Ramsey County in 2006.

St. Paul-Ramsey County Department of Public Health, 2007

This assessment48 began in the fall of 2007 by St. Paul-Ramsey County Department of Public Health. The assessment presented responses from a survey of 575 participants, meetings with Community Health Advisory Committee experts, and public health related secondary data. Findings include:

- Alcohol and Drug Use:
  - Ramsey County experienced 4.1 alcohol related vehicle crashes for every 100 motor-vehicle crashes that occurred in the county, down from 5.1 in 2002, and lower than the state average of 5.3 in 2004.
  - Approximately 5 percent of 9th through 12th graders reported using methamphetamines in the past year, a decrease from 2001.
  - Between 2003 and 2004, about 18.8 percent of children between the ages of 6 and 11 were overweight. In comparison, 17.4 percent of adolescents between the ages of 12 and 19 were overweight.
- Infectious Disease:
  - The rate of new HIV diagnoses was 10.8 per 100,000 individuals for Ramsey County in 2005, higher than that of the state, at 6.2 per 100,000 individuals.
  - The rate of AIDS was higher for males than females, though recently the male AIDS cases have trended down while female cases of AIDS have risen.
  - The Black population has higher rates of HIV/AIDS than the White population.
- Children, Youth, and Families:
  - The percent of low birth weight babies in Ramsey County, at 5.8 percent in 2005, was higher than the state average of 4.9 percent.
  - The percent of mothers who did not smoke during pregnancy increased from 89.4 percent of mothers in 2001 to 92.5 percent in 2005, compared to the state figures of 88.8 and 90.5 percent, respectively.
  - Roughly 12.4 percent of women who had no prenatal care or had prenatal care only during their third trimester had low birth weight babies, as compared to 6.9 and 8.3 percent of those who received prenatal care in their first or second trimester, respectively.
  - The Women, Infants, and Children Program (WIC) catered to a diverse population in Ramsey County in 2006, with 28 percent of participants being Asian, 27 percent Black, 20 percent Hispanic or Latino, and 18 percent White.
  - WIC children were more likely to be overweight compared to children in the rest of the state in every year from 2004 through 2006.
- Child Care:

48 St. Paul-Ramsey County Department of Public Health. (2007.) Community Health Assessment. Retrieved 2012, from http://www.co.ramsey.mn.us/ph/docs/chs_full_document_2007.pdf

- The average cost of child care decreased as age increased; the cost for children two years of age and younger was $5,700, compared to the cost of child care for children between 10 and 12 years, which was only $3,300.
- The percent of income spent on child care was much higher for those of lower income brackets, as families earning under $20,000 paid 28 percent of their income on child care, as compared to families earning $75,000 or more, who spent seven percent of income on child care.

Secondary data indicators of concern

This assessment analyzed secondary data regarding demographics, social and economic factors, health behaviors, physical environment, care delivery, morbidity, and mortality. **Exhibits 54-56** present the indicators that appeared most unfavorable in the community served by Children's when compared to national, state, or local benchmarks. Further details and discussion regarding these indicators can be found in previous sections.

Exhibit 54A: Secondary Data Indicators of Concern

Category	Indicator	Location	Community Value	Benchmark	Data Format	Benchmark Definition
Demographics	Growth in non-White populations 2013-2018	Community	6.5%-17.5%	1.1%	Percent	White population
	Growth in Hispanic population 2013-2018	Community	18.9%	2.5%	Percent	Non-Hispanic population
	Residents 5+ who are linguistically isolated	Hennepin	6.9%	4.2%	Percent	MN average
	Residents 5+ who are linguistically isolated	Ramsey	9.5%	4.2%	Percent	MN average
	Primary language of students: Hmong	Ramsey	14.4%	2.4%	Percent	MN average
	Primary language of students: Russian	Scott	1.3%	0.3%	Percent	MN average
	Primary language of students: Somali	Hennepin	3.8%	1.6%	Percent	MN average
	Primary language of students: Somali	Ramsey	2.7%	1.6%	Percent	MN average
	Primary language of students: Spanish	Dakota	5.3%	4.7%	Percent	MN average
	Primary language of students: Spanish	Hennepin	8.4%	4.7%	Percent	MN average
	Primary language of students: Spanish	Ramsey	6.8%	4.7%	Percent	MN average
Social and Economic Factors	Educational achievement	Ramsey	64	84	County rank	Number of counties
	Poverty rate: total population	Hennepin	13.5%	11.9%	Percent	MN average
	Poverty rate: total population	Ramsey	17.5%	11.9%	Percent	MN average
	Poverty rate: children	Hennepin	17.9%	15.4%	Percent	MN average
	Poverty rate: children	Ramsey	26.0%	15.4%	Percent	MN average
	Poverty	Hennepin	66	84	County rank	Number of counties
	Poverty	Ramsey	80	84	County rank	Number of counties
	Children enrolled in MFIP	Hennepin	1.3%	0.8%	Percent	MN average
	Children enrolled in MFIP	Ramsey	1.6%	0.8%	Percent	MN average
	Child homelessness	Hennepin	118.3	61.6	Rate per 100,000	MN average
	Child homelessness	Ramsey	96.7	61.6	Rate per 100,000	MN average
	Section 8 housing assistance wait time	Anoka	25	12	Months	MN average
	Section 8 housing assistance wait time	Carver	22	12	Months	MN average
	Section 8 housing assistance wait time	Hennepin	17	12	Months	MN average
	Section 8 housing assistance wait time	Ramsey	15	12	Months	MN average
	Section 8 housing assistance wait time	Washington	19	12	Months	MN average
	Students reporting free and reduced lunch (9th)	Ramsey	43.5%	27.5%	Percent	MN average
	Students reporting free and reduced lunch (12th)	Ramsey	36.0%	22.5%	Percent	MN average
	Family and social support	Hennepin	76	84	County rank	Number of counties
	Family and social support	Ramsey	80	84	County rank	Number of counties
	Teen pregnancy age 15-17	Ramsey	27.6	16.0	Rate per 100,000	MN average
	Births with no father on birth certificate	Ramsey	15.4%	9.3%	Percent	MN average

Source: Verité analysis of secondary data, 2012.

Exhibit 54B: Secondary Data Indicators of Concern

Category	Indicator	Location	Community Value	Benchmark	Data Format	Benchmark Definition
Health Behaviors	Student drug use other than marijuana (9th)	Anoka	6.0%	3.5%	Percent	MN average
	Student drug use other than marijuana (12th)	Scott	9.5%	5.5%	Percent	MN average
	Tobacco use	Anoka	67	84	County rank	Number of counties
	Unsafe sex	Hennepin	80	84	County rank	Number of counties
	Unsafe sex	Ramsey	83	84	County rank	Number of counties
	Intermediate prenatal care	Ramsey	26.1%	16.9%	Percent	MN average
	Inadequate or no prenatal care	Ramsey	4.7%	3.1%	Percent	MN average
Physical Environment	Environmental quality	Dakota	65	84	County rank	Number of counties
	Environmental quality	Ramsey	65	84	County rank	Number of counties
	Environmental quality	Washington	82	84	County rank	Number of counties
	Built environment	Anoka	72	84	County rank	Number of counties
	Violent crime	Hennepin	416	224	Rate per 100,000	MN average
	Violent crime	Ramsey	434	224	Rate per 100,000	MN average
	Community safety	Anoka	74	84	County rank	Number of counties
	Community safety	Hennepin	84	84	County rank	Number of counties
	Community safety	Ramsey	83	84	County rank	Number of counties
	Children arrested for serious crimes	Ramsey	32.9	20.5	Rate per1,000	MN average
Access to Care	Insufficient mental health providers	Anoka	36.3	72	Rate per 100,000	MN average
Morbidity	Morbidity rate	Hennepin	69	84	County rank	Number of counties
	Morbidity rate	Ramsey	72	84	County rank	Number of counties
Health Outcomes: Mortality	Teen unbelted vehicle fatality percent of total	Carver	20.0%	8.9%	Percent	MN average
	Teen unbelted vehicle fatality percent of total	Ramsey	20.0%	8.9%	Percent	MN average
	Teen unbelted vehicle fatality percent of total	Washington	33.3%	8.9%	Percent	MN average
	Child unintentional injury percent of total injury	Dakota	57.1%	47.8%	Percent	MN average
	Child unintentional injury percent of total injury	Hennepin	52.2%	47.8%	Percent	MN average
	Child homicide percent of total injury	Hennepin	23.9%	10.5%	Percent	MN average
	Child homicide percent of total injury	Ramsey	38.9%	10.5%	Percent	MN average
	Child suicide percent of total injury	Anoka	21.7%	16.3%	Percent	MN average
	Child suicide percent of total injury	Carver	60.0%	16.3%	Percent	MN average
	Child suicide percent of total injury	Ramsey	27.8%	16.3%	Percent	MN average
	Child suicide percent of total injury	Scott	60.0%	16.3%	Percent	MN average
	Child suicide percent of total injury	Washington	55.6%	16.3%	Percent	MN average
	Child motor vehicle fatality percent of total injury	Dakota	28.6%	21.4%	Percent	MN average

Source: Verité analysis of secondary data, 2012.

Disparities of concern

Vulnerable populations often lack the resources necessary to maintain optimal health. Health indicators highlighting racial and ethnic disparities that appeared most unfavorable in the community served by Children's are presented below (**Exhibit 55**).

Exhibit 55: Disparities of Concern

Category	Indicator	Location	Community Value	Benchmark	Data Format	Benchmark Definition
Social and Economic Factors	Dropout rate: White	Ramsey	6.5%	3.3%	Percent	MN average
	Dropout rate: American Indian/Alaska Native	Anoka	13.9%	3.0%	Percent	White population
	Dropout rate: American Indian/Alaska Native	Dakota	4.7%	2.2%	Percent	White population
	Dropout rate: American Indian/Alaska Native	Hennepin	16.7%	2.7%	Percent	White population
	Dropout rate: American Indian/Alaska Native	Ramsey	20.5%	6.5%	Percent	White population
	Dropout rate: Asian	Scott	6.1%	2.6%	Percent	White population
	Dropout rate: Asian	Washington	2.5%	1.3%	Percent	White population
	Dropout rate: Black	Anoka	7.0%	3.0%	Percent	White population
	Dropout rate: Black	Dakota	7.6%	2.2%	Percent	White population
	Dropout rate: Black	Hennepin	9.2%	2.7%	Percent	White population
	Dropout rate: Black	Ramsey	8.3%	6.5%	Percent	White population
	Dropout rate: Hispanic or Latino	Community	11.0%	3.0%	Percent	White population
Access to Care	Medically underserved populations (MUPs) (Native American Population)	St. Paul	Present	N/A	N/A	Present or not present - no benchmark
	Health professional shortage areas (HPSAs) (Native American Population)	Scott	Present	N/A	N/A	Present or not present - no benchmark
Health Outcomes: Mortality	Non-White infant mortality	Ramsey	33.8-67.9	9.3	Rate per 100,000	White population
	Non-White infant mortality	Hennepin	13.7-43.9	6.7	Rate per 100,000	White population

Source: Verité analysis of secondary data, 2012.

Geographic areas of concern

Certain geographic areas within the community served by Children's exhibited higher levels of need when compared to the community as a whole. Secondary data show that areas and populations proximate to Minneapolis and St. Paul had particularly high levels of financial hardship, risk for food insecurity, and barriers to accessing care (**Exhibit 56**).

Exhibit 56: Geographic Areas of Concern

Category	Indicator	Location	Community Value	Benchmark	Data Format	Benchmark Definition
Social and Economic Factors	Low-income households	Minneapolis School Dist	25.7%	15.1%	Percent	Children's community total
	Low-income households	St. Paul School Dist	25.7%	15.1%	Percent	Children's community total
	Medicaid discharges	Minneapolis School Dist	66.6%	44.8%	Percent	Children's community total
	Medicaid discharges	St. Paul School Dist	65.3%	44.8%	Percent	Children's community total
	Self-pay discharges	Scott	2.0%	1.0%	Percent	Children's community total
	High CNI scores	Minneapolis	4.2-5	5	CNI score	Worst score
	High CNI scores	St. Paul	4.2-5	5	CNI score	Worst score
Physical Environment	Food deserts	Minneapolis	Present	N/A	N/A	Present or not present - no benchmark
	Food deserts	St. Paul	Present	N/A	N/A	Present or not present - no benchmark
Access to Care	Medically underserved areas (MUAs)	Minneapolis	Present	N/A	N/A	Present or not present - no benchmark
	Medically underserved areas (MUAs)	St. Paul	Present	N/A	N/A	Present or not present - no benchmark
	Health professional shortage areas (HPSAs)	Hennepin	Present	N/A	N/A	Present or not present - no benchmark
	Health professional shortage areas (HPSAs)	Ramsey	Present	N/A	N/A	Present or not present - no benchmark

Source: Verité analysis of secondary data, 2012.

Primary data assessment

Community input was gathered through interviews. Findings from this primary data are presented below.

Key insights: ***Interviews***	» Poor mental health impacts the entire family and accessing treatment for these issues is difficult. » Many parents throughout the community need support in the form of health education, basic life skills training, techniques for providing guidance and discipline to adolescents, and assistance translating health care knowledge into behavioral changes. » Language and cultural barriers, citizenship/residency conditions, social stigma, fear, cost, and a lack of providers accepting Medicaid are major barriers to accessing primary, mental health, and dental care. » Adolescents needs access to confidential sexual and reproductive medical services. Many in this population hesitate to seek care due to fear of social repurcussions. » Diabetes, asthma, allergies, and obesity are chronic disease concerns of the pediatric population. » Health risk behaviors such as substance abuse, poor diet, lack of exercise, and incomplete immunizations are prevalent. » Families of children with complex needs require assistance with daily caregiving, social and emotional needs, and the logistics of traveling to the hospital for medical services. » Health system complexity, lack of integration across providers, regulatory and administrative burdens, and payment reductions result in frustration for both patients and providers. » Lack of insurance and lack of understanding of appropriate use leads to insufficient primary care utilization and overuse of the emergency room for non-emergent conditions.

Summary of interview findings

Interviews regarding health needs in the community served by Children's were conducted with 63 key informants, including external stakeholders (those not affiliated with Children's) and internal staff. The interviews provided input on a wide range of community health issues, including barriers to access to health services, changes in community population, prevalence of certain health conditions, social determinants of health, health disparities, and other topics. The interviews were guided by a structured interview guide, and interviewees were encouraged to identify and discuss all current and emerging issues affecting community health.

Verité staff summarized all interview comments and assessed the frequency with which community health issues were mentioned and also assessed informant views regarding the severity of each concern. The following issues are considered of greatest concern to community health, based on that assessment. Issues are ordered based on the frequency and intensity of responses:

Poor Mental and Behavioral Health. Issues relating to poor mental health are prevalent and increasing throughout the entire community, including depression, bullying, child abuse, anger management, anorexia, and seasonal adjustment disorder. The impact of mental of illness of parents/caregivers on the development and mental health of infants, children, and adolescents is also a concern. Other issues are more concentrated in subpopulations, notably Posttraumatic Stress Disorder (PTSD) in refugee groups.

These issues are exacerbated by a lack of integration between medical and mental health, insufficient insurance access and coverage, inadequate payment rates to attract and retain providers insufficient treatment capacity, insufficient language/culturally appropriate care, lack of participation in Medicaid/Medical Assistance by providers, difficulty of effective drug management, and lack of free/low-cost services, and travel for treatment out of the area. A fraction of referrals get treatment but even those services that are provided can be difficult to access. Skilled interpreters also may not be readily accessible and ineffective interventions may be prescribed due to misdiagnoses. Additionally, although a strong provider-patient relationship improves health outcomes, relationship strength varies between individual provider-patient encounters.

Effective treatment for these issues is hindered by stigma associated with diagnosis, cultural acceptance of symptoms of mental illness as normal, and unrealistic expectations for quick treatment of long-standing mental illnesses. Further, lack of formal training for first responders increases the likelihood that the result of mental health crises will be incarceration/detention rather than treatment.

Unsupported Parenting. Lack of parenting knowledge negatively impacts children despite the best intentions of parents/caregivers. This lack of parenting knowledge ranges from basic skills to more specialized skills, such as conflict resolution and supervision of older children/adolescents. The reluctance for parents/guardians to seek assistance due to perceptions of judgment, management of other issues, work demands, and lack of awareness that problems exist compounds this issue. In some families, an inverted parent-child relationship exists due to language or other barriers. As a result, parents may wait too long to seek parenting support. In some cases that can result in child abuse and/or interventions from the police/courts.

Parents/caregivers in the community may lack basic living skills, be unaware of available resources, and be unable to translate health care knowledge into behavioral changes. Patients

may be mistrusting and/or intimidated by the size of institutional facilities and confused by conflicting messages, such as food assistance options and nutrition counseling. Finally, individuals may not seek support due to misperceptions and fears, notably fears of the unknown, concerns about affordability, reluctance to ask for assistance, and fear for physical safety in traveling to different facilities.

Effective support for parents needs to be provided in a supportive, culturally appropriate manner which respects the role of parents/caregivers. Parents need to be engaged in open and honest dialogue, and provided materials that translate theory into readily applied practice, such as how to pack a school lunch.

Lack of Access and Barriers to Care. Enhanced access to care is needed for children/adolescents because of language, cultural and citizenship barriers, paperwork/documentation requirements, insufficient public transportation including for suburban/exurban populations, hours of operation, and the decreasing number of providers who accept Medical Assistance (MA). Interrupted insurance coverage is also a concern due to MA's recertification requirements and changing coverage from parents/caregivers. Lack of access to care is exacerbated by different cultural expectations of care and the complexity of the medical system. Navigation support is insufficient in the community. The lack of access and barriers to care is evidenced by the use of the ER for non-emergent conditions and insufficient utilization of preventive care.

Adolescent Needs. Adolescents have unmet needs for confidential access to medical services, especially those related to sexual and reproductive health, safety from/alternatives to violence, and interventions against substance abuse. For some adolescents, the need for confidentiality is significant due to potential repercussions of sexual activity from family members and violence by gang members. Issues of confidentiality are impacted by lack of independent financial resources, insurance documents that may disclose services received, misunderstandings concerning provider-patient confidentiality, and lack of available community services. Additionally, the transition between pediatric and adult services needs to be improved.

Substance Abuse. Interventions are needed to respond to abuse of alcohol, prescription drugs, and illegal drugs. In addition to the personal impact on users, providers within the community are challenged to provide services because of the mixing of different substances, varying strengths of illegal drugs, and the continual emergence of new substances. Problems are increased in households in which parents/caregivers do not secure prescribed medications.

Chronic Disease. Improved management of chronic disease, including diabetes, asthma, and allergies is needed, especially given increases in the severity and number of impacted individuals. Integration of services across the community, including schools, social workers, and nutritionists is lacking, as evidenced by scope of practice restrictions in schools that may delay treatment. Additionally, changes to the environmental factors that impact chronic disease, such as air particulates and parental stress levels, need to be addressed.

Obesity, Insufficient Activity, and Poor Nutrition. Children and adolescents lack sufficient activity and appropriate nutrition to maintain healthy body weights. The resulting obesity is endemic across all groups and regions in the area. Many issues compound the need for increased activity and improved nutrition, including environmental factors such as lack of access to healthy foods, ready access to unhealthy food, and insufficient options for safe, physical activity. Personal factors also increase obesity, including lack of knowledge about how to prepare healthy food option, overestimates of healthy portion sizes, misperceptions of health food options, and different cultural perceptions of healthy body weight.

Dental Needs. More access to dental services is needed by children and adolescents who are uninsured or underinsured, especially those individuals covered by MA. Dental care needs have increased due to increased consumption of non-fluorinated bottled water, limited MA acceptance by dentists, and resistance by some parents/guardians to accept free services due to fear of judgment.

Support for Caregivers/Families of Children with Complex Needs. Children's is a key resource for children in need of specialized medical care, drawing patients from the seven-county metro area and throughout the state. Families and caregivers of children with special needs report that conducting the activities of daily life can be overwhelming. These families require comprehensive support for daily caregiving and meeting the social and emotional needs of the entire family as well as greater awareness and empathy from the wider community. For families who live at distance from Children's, the logistics of recurring travel to the hospital for medical services are daunting as well as economically draining.

ER Use. There are numerous reasons that parents/caregivers choose to use ER services for non-emergency conditions, including concern for the safety of children, lack of knowledge about appropriate ER use, ease of receiving services, and lack of health insurance. Use of the ER increases after the first visit, regardless of the emergent status of the patient.

Provider Expectations. Providers, as key members of and stakeholders in the Children's community, are operating in a system with enhanced expectations for services, changing regulations, increased documentation requirements, and reductions in payments. The result is overwork, stress, and "compassion fatigue" by providers as evidenced by reduced volunteerism, lack of participation in MA, and difficulty in recruiting new practitioners. The time demands from high assigned caseloads make it difficult for providers throughout the continuum of care, including physicians, nurses, pharmacists, social workers, and community health workers, to work collaboratively in the provision of care. Additionally, financial pressures necessitate consolidation of providers into large systems yet some in the community assign negative qualities to these entities due to the resulting scale and scope.

Patient Dissatisfaction. The delivery and financing of services by entities has yielded a system in which navigation is difficult because of geographic distances and knowledge gaps. Patients are expected to manage their care yet lack system knowledge. Participants raised concerns about confronting phone trees when calling providers, interacting with stressed front line staff, and having to complete numerous detailed forms during periods of illness/injury. Further, patient populations assess the degree to which the community is inclusive or exclusive by representation of similar individuals on the entity boards, the local perspective of health services/insurance as a right or privilege, and the ease or difficulty in accessing services.

Changing Economy and Demographics. The population in the service area is becoming more diverse, with notable increases in Latino, Southeast Asian, and Somali populations. However, adjustments to provide culturally appropriate services lag behind and can result in misdiagnosis and ineffective treatment plans. Further, a set of common, cross-cultural expectations has not been developed, leading to friction from unmet expectations. Downturns in the economy and a shift to service jobs increased unmet needs due to declines in income and increases in uninsurance/underinsurance. Geographically, vulnerable populations are becoming more concentrated in Hennepin County.

Communicable Diseases and Injuries. Incomplete immunizations lead to preventable epidemics, such as whopping cough and influenza. Similarly, preventable injuries result from lack of or

misuse of safety equipment, such as absence of bicycle helmets, lack of car seats in taxis, and improper installation of car seats in private automobiles.

Information and Misinformation. Providing personal and community health information to individuals is challenging because this information is often complex. Simultaneously, the benefits of interventions and preventive activities are difficult to measure and communicate to the community and policy makers. Misinformation, such as the incorrect belief that vaccines cause disease, can be communicated and accepted rapidly.

Individuals providing community input

The 63 stakeholders were comprised of public health experts; individuals from health or other departments and agencies; leaders or representatives of medically underserved, low-income, and minority populations; and other community members **(Exhibits 57, 58, 59,** and **60**).

Public health experts

Individuals interviewed with special knowledge of or expertise in public health include (**Exhibit 57**):

Exhibit 57A: Public Health Experts Interviewed

Name	Title	Affiliation or Organization	Special Knowledge or Expertise
Rina McManus	Director	St. Paul Ramsey County Public Health	Rina McManus has over 40 years of experience in public health and safety issues. She led the Anoka County Community Health and Environmental Services Department for 20 years and has also been the Deputy Commissioner of the Minnesota Department of Public Safety and as a Nursing Director in St. Louis County.
SuzAnn Stenso-Velo	Planning Specialist	St. Paul Ramsey County Public Health	SuzAnn Stenso-Velo has worked in Ramsey County for 10 years. She is responsible for community health improvement plans and the accreditation process, with expertise in public health.
Bonnie Brueshoff, RN, PHN, MSN	Public Health Director	Dakota County Public Health Department	Bonnie Brueshoff manages and provides leadership for the Public Health Department in Dakota County. In the past, she has worked as Public Health Deputy Director and Supervisor for Dakota County and Apnea Home Monitoring Coordinator at Minneapolis Children's Medical Center.
Laurel Hoff	Director of Community Health and Environmental Services	Anoka County Community Health and Environmental Services Department	Laurel Hoff has been the Director of Community Health & Environmental Services and has served as Public Health Nursing Director, with expertise in nursing and health issues.
Marcee Shaugnessy	Public Health Department Manager	Carver County Public Health	Marcee Shaugnessy is the Public Health Department Manager and Alternate Appointment to the State Community Health Services Advisory Committee (SCHSAC) for Carver County.

Exhibit 57B: Public Health Experts Interviewed

Name	Title	Affiliation or Organization	Special Knowledge or Expertise
Ellen de Schwitzenberg	Family Health Director	Scott County Public Health	Ellen de Schwitzenberg has public health expertise through her job as the Family Health Director at Scott County Public Health.
Jennifer Deschaine	Director of Health and Public Services	Scott County Public Health	Jennifer Deschaine came to Scott County in June 2000. She has directed a number of initiatives, including leading Scott County's response to the 2009 H1N1 pandemic, assisting with the formation of the Meth Task Force, and working with the Shakopee Mdewakanton Sioux Community to establish the Mobile Health Clinics program.
Sue Hedlund	Deputy Director	Washington County Public Health and Environment	Sue Hedland is the Deputy Director of Public Health and the Environment in Washington County and is the Chair of the Health & Wellness Advisory Committee. She has also served as Program Manager of Washington County Public Health.
Gretchen Musicant	Commissioner	Minneapolis Department of Health and Family Support	Gretchen Musicant is the Commissioner of the Minneapolis Department of Health and Family Support and previously has served as the Director of Public Health Initiatives.
Karen Zeleznak, MPH	Director and Public Health Administrator	Bloomington Public Health	Karen Zeleznak has public health expertise through her role at Bloomington Public Health.
Molly Snuggerud, RN	Family Health Program Manager	Bloomington Public Health	Molly Snuggerud is a Family Health Program Manager at Bloomington. She also has public health experience working as a Prenatal Educator at Ridgeview Medical Center, and has been the Program Director of West Suburban Teen Clinic.
David Brummel	Public Health Improvement Coordinator	Hennepin County Human Services and Public Health Department	David Brummel is the Public Health Improvement Coordinator with Hennepin County Human Services and Public Health and also has served as the Community Health Program Supervisor.
Todd Monson	Public Health and Case Management Area Director	Hennepin County Human Services and Public Health Department	Todd Monson has expertise on a variety of public health issues including disabilities and senior issues.
Cheryl Burke	County Coordinator	St. Paul Ramsey County Public Health	Cheryl Burke works as the county coordinator for St. Paul Ramsey County Public Health.

Health or other departments or agencies

Several interviewees were from departments or agencies with current data or other information relevant to the health needs of the Children's community (**Exhibit 58**). This list excludes the public health experts identified in **Exhibit 57**.

Exhibit 58: Individuals from Health Departments or Agencies Interviewed

Name	Title	Affiliation or Organization
Scott Leitz	Assistant Commissioner	Minnesota Department of Human Services
Glenace Edwall, PhD, PsyD, LP, MPP	Director of the Children's Mental Health Division	Minnesota Department of Human Services

Community leaders and representatives

The following individuals were interviewed because they are leaders or representatives of medically underserved, low-income, and/or minority populations (**Exhibit 59**). This list excludes the public health experts identified in **Exhibit 57**.

Exhibit 59A: Community Leaders or Representatives Interviewed

Name	Title	Affiliation or Organization	Nature of Leadership Role
Shirlynn LaChapelle, RN	President	Minnesota Black Nurses Association	Shirlynn LaChapelle has experience with a minority population as President of the Minnesota Black Nurses Association.
Kathleen Tomlin	Vice President of Social Justice Advocacy	Catholic Charities of St. Paul and Minneapolis	Kathleen is the Vice President of Social Justice Advocacy and supervises the Office for Social Justice at Catholic Charities.
Mary Ann Sullivan, MSW, LISW	Vice President for Program Operations	Catholic Charities of St. Paul and Minneapolis	Mary Ann Sullivan has 30 years of experience in a leadership role with Catholic Charities. She has held various roles as a part of Family Services Division. She began her career as a psychiatric social worker at Middlesex State Hospital in Middletown, Connecticut.
Jose William Castellanos, MD, PhD	Senior Director of the Community Health Worker Services (at the time of interview)	Comunidades Latinos Unidos En Servicio (CLUES) DREGAN Project	At the time of the interview, Dr. Castellanos worked for CLUES, a culturally-sensitive research program for the Latino Community in Minnesota. As an emergency medicine physician, Dr. Castellanos has directed national and international public health community-based initiatives in health promotion and prevention.

Exhibit 59B: Community Leaders or Representatives Interviewed

Name	Title	Affiliation or Organization	Nature of Leadership Role
Patricia Harmon	Executive Director	Corner House	Patricia Harmon has been responsible for the overall management of the Center and continued development of programming in order to meet the mission of Corner House. Patricia has over 20 years of experience working in not-for-profit leadership, the majority of which has been in the field of child welfare.
Wendy Ringer	Family-to-Family Health Information Center Coordinator	PACER (**P**arent **A**dvocacy **C**oalition for **E**ducational **R**ights)	Wendy Ringer is the Family-to-Family Health Information Center Coordinator for PACER, an organization focused on children with disabilities.
Nora Slawik, MPA	Director of Education at Autism Society of Minnesota (AuSM)	Autism Society	Nora Slawik handles Autism Discovery programs, and group-specific autism training; her area of expertise is in autism and early childhood policy issues.
Matthew Flory	Director of Healthcare Partnerships	American Cancer Society	As the Minnesota Director of Healthcare Partnerships, Matthew Flory is responsible for increasing the rate of cancer screening through strategic collaborations and state and local agencies.
Gretchen Ambrosier	Vice President of Programs	Ronald McDonald House	Gretchen Ambrosier provides marketing and community relations support to the Ronald McDonald Care Mobile program. Gretchen has past work experience at the American Red Cross Twin Cities Chapter for nearly 5 years in multiple roles, including Community Programs and Outreach Manager. She has also worked as the Outreach Coordinator for Partners for Violence Prevention in St. Paul.
Tom Steinmetz, MA	Chief Operating Officer/Program Director	Washburn Center for Children	Tom has presented nationally and locally on treating child trauma and aggression, developing and sustaining school-based mental health services.
Elaine Cunningham	Outreach Director	Children's Defense Fund	Elaine Cunningham has been the Outreach Director for nearly 12 years at Children's Defense Fund.
Crystal (Trutnau) Windschitl	Executive Director	Phillips West Neighborhood Organization	Crystal (Trutnau) Windschitl is the Executive Director for the Philips West Neighborhood Organization, an organization focusing on development of the Phillips West neighborhood.
Kendall Munson	Family Resource Center Coordinator	Children's	Kendall Munson provides support for family planning programs and services to the community.

Exhibit 59C: Community Leaders or Representatives Interviewed

Name	Title	Affiliation or Organization	Nature of Leadership Role
Dealla Cahow	WIC Supervisor	Children's	Dealla Cahow provides training and support on breast feeding and nutrition education.
Lisa Buchal	Clinical Social Worker	Children's	Lisa Buchal provides services to all inpatient units and several outpatient units/clinics in the hospital.
Tessa Billman	Family Advisory Council Family Coordinator	Children's	The Family Advisory Council represents inpatient and outpatient experiences working collaboratively with staff to promote and enhance family-centered care and to improve the family and patient experiences. Tessa provides a supporting role in establishing programs for this objective.
David Teschler, RN	Clinic Manager	Native American Community Clinic	David Teschler is the Clinic Manager at the Native American Community Clinic, which provides medical, dental, counseling, and support services for the Native American Community, especially for underserved and underrepresented groups.
Leah Hebert	Executive Director	Open Arms of Minnesota	Leah Herbert is the Executive Director of Open Arms of Minnesota, which provides free meals to individuals in the community, especially those with HIV/AIDS, MS, ALS, breast cancer and more than 60 other diseases.

Persons representing the broad interests of the community

Exhibit 60: Other Interviewees Representing the Broad Interests of the Community

Name	Title	Affiliation or Organization
Carmen Teskey, MA, BSN, RN	Nursing Services Manager	Minneapolis Public Schools
Don Greeley	Officer	Minneapolis Police Department
Lucy Gerold	Officer	Minneapolis Police Department
Mark Blumberg	Officer	St. Paul Police Department
Kevin Miller	Medical Transport Director of Operations	Allina
Dan DeSmet	Regional Manager	North Memorial Hospital
Mary Yackley, RN, LSN, MA	Supervisor, Student Health and Wellness	St. Paul Public Schools
Erin Petersen	Coordinator, Family Safety Programs	Minnesota Safety Council
Luis Ramirez-Regalado	Program Coordinator, Strong, Fast, Fit	YWCA Minneapolis
Amy Ward	Manager, Health Care Initiative	Wilder Foundation
Elizabeth Peterson, PhD	Director of Research & Planning	Greater Twin Cities United Way
Stephanie Devitt	Public Affairs Consultant	The Bush Foundation
Gary Schiff	Councilmember	Minneapolis City Council
Gwen Riedl	Manager Organizational Development	Children's
Dave Brumbaugh	Vice President, Human Resources	Children's
John Chavers	HR Business Partner	Children's
Bobbie Carroll	Sr. Director of Patient Safety and Informatics	Children's
Julie Boman, MD	Staff Physician, Gen Pediatric Clinic	Children's
David Hirschman, MD	Trauma Co-Medical Director	Children's
Toneto Barry, MSN, RN	Patient Care Manager	Children's
Donald Brunnquell, PhD, LP	Director, Ethics	Children's
Pamela Gigi Chawla, MD	Medical Director, General Pediatrics Clinic, St. Paul (At time of interview)	Children's
Sheldon T Berkowitz, MD	Medical Director, General Pediatrics Clinic, Minneapolis	Children's
Erik Bjerke	Specialty Clinic Manager	Children's
Lisa Levy	Specialty Clinic Manager	Children's
Kim Flaata, RN	RN Clinic Supervisor	Children's
Dave Aughey, MD	Medical Director of Adolescent Health	Children's
Clark Smith, MD	Chief of Pediatrics	Children's
Lisa Fray	Assistant Clinical Manager	Children's

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About Verité Healthcare Consulting

Verité Healthcare Consulting, LLC (Verité) was founded in May 2006 and is located in Alexandria, Virginia. The firm serves as a national resource that helps hospitals conduct community health needs assessment and develop implementation strategies that address priority needs. The firm also helps hospital associations and policy makers with community benefit reporting, planning, program assessment, and policy and guidelines development. Verité is a recognized, national thought leader in community benefit and in the evolving expectations that tax-exempt healthcare organizations are being required to meet.

The CHNA prepared for Children's Hospitals and Clinics of Minnesota was directed by the firm's president and managed by a senior-level consultant. Associates and research analysts supported the work. The firm's president, as well as all senior-level consultants and associates, hold graduate degrees in relevant fields.

More information on the firm and its qualifications can be found at www.VeriteConsulting.com.

Verité Healthcare Consulting's work reflects fundamental concerns regarding the health of vulnerable people and the organizations that serve them

childrensMN.org/community