

Community Health Needs Assessment

DECEMBER 2025

Children's[®]
MINNESOTA

The Kid Experts[®]

In partnership with:



**Collective
Action Lab**[®]



WILDER

Letter from the CEO

Dear community member,

At Children's Minnesota, our mission is simple but powerful: we want every child to live a healthier life. To make this happen, providing great care in our hospitals and clinics is essential but not enough. We need to listen to our families and communities, and truly understand what each child needs to be healthy — not just when they're sick, but every day, in every part of their lives.

That's why, every three years, we complete a Community Health Needs Assessment (CHNA). This effort is special because it helps us learn directly from the people we serve. We talk with parents, caregivers, young people and community organizations. We ask questions like:

- What makes it hard for families to get health care?
- What helps them feel supported?
- Where do they go for help, and what's missing?

We do this because we know that health is shaped by so much more than what happens in the doctor's office. In fact, research shows that 80% of what affects children's health happens in their community and the conditions in which they are born, live, learn and play.

We take this work very seriously, because children's health is at stake. Our team partners with the community and listens carefully to what families say. We use what we learn to make real changes in how and where we deliver care, so every child and family receives equitable care and gets their needs met in a safe and welcoming environment. The CHNA is not just a requirement we have to meet; it's a promise we make to our community. We are working hand in hand with families, so all children can thrive.

The 2025 CHNA is the result of many conversations and a lot of hard work. We reviewed our last assessment, gathered new information from families and organizations, and looked closely at data about our community's health. We learned about the barriers families face, what's working well and where there are gaps. We're committed to listening and collaborating because together, we can build a healthier future for every child.

Thank you for being our partner in this important work. As you read this report, I hope you see how much we value the voices and experiences of our community members.

Together, we can make a difference.

Sincerely,

A handwritten signature in black ink that reads "Emily Chapman" followed by a horizontal line and the number "140".

Emily Chapman, MD
President and CEO
Children's Minnesota



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Letter from CEO

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Acknowledgements

There are many people who gave their time to help guide this assessment process, to share their experience and expertise, and to elevate the strengths, assets, concerns and priorities of children and families living in the Twin Cities metro region.

Community Advisory Committee

Children's Minnesota, Collective Action Lab and Wilder Research appreciate the time and insight of the Children's Minnesota Community Advisory Council which informed the design and approach to this assessment.

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Native American Community Clinic

Pacer Center

QueerSpace Collective/Transforming Families MN

YWCA St. Paul

Parents/caregivers and youth

We extend our gratitude to the parents/caregivers and youth who gave their time to participate in community conversations, sharing their experiences and perspectives on the health needs, assets and priorities of the communities they identify with.

Community organizations

We also thank the community organization leaders that shared their perspectives in a large group forum and individual interviews, highlighting the needs, assets and priorities of the communities they serve.

Vietnamese Social Services

Child Care Aware MN

African American

Leadership Forum

Minneapolis Public Health

Department

Collective Action Lab + Wilder

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All graphic illustrations are original artwork of Andres reflecting themes raised during community member discussion sessions.

Children's Minnesota staff

We want to acknowledge the contributions of Children's Minnesota providers and staff who volunteered their time to share their perspectives on patient, family and community needs. Their insights will inform the implementation strategy Children's Minnesota will develop in response to this assessment.

In addition to partners mentioned above, we also acknowledge our ongoing partnerships and discussions with community organizations and state and local public health agencies that make the Community Health Needs Assessment process possible. We are grateful for their insights and collaboration.

Introduction

Through the Affordable Care Act (ACA), all not-for-profit hospitals are federally required to conduct a community health needs assessment (CHNA) that identifies the health needs and priorities of the communities they serve and responsive steps that the hospital will take to address those needs. Legislation passed in Minnesota in 2024 contains similar requirements for triennial CHNAs from not-for-profit hospitals in the state.

Source: Minnesota Statutes 2024 144.6985 Subdivision 1. “Community Health Needs Assessment”



This report shares the results of the 2025 Children’s Minnesota assessment process in which community members and other stakeholders identified priority needs they believe are most important to address. A subsequent report will include an implementation strategy that describes specific actions Children’s Minnesota will take during the next three years to address these priority needs.

Not-for-profit hospitals have leeway regarding how they approach community health needs assessments. Children’s Minnesota continues its commitment to approach these assessments expansively as they are critical to identifying and understanding the needs of the community, especially as they relate to health equity and social conditions that contribute to health outcomes.

Additionally, Children’s Minnesota sees these assessments as a key tool for building relationships with individual community members and organizations. These relationships inform and help shape children and families’ experiences both inside and outside of the walls of our hospitals and clinics.

For this reason, the Children’s Minnesota 2025 community health needs assessment reached more broadly into community by directly engaging nearly two hundred community members and other stakeholders in a variety of ways. This deeper engagement resulted in enriching and inspiring learnings that will guide Children’s Minnesota’s actions, partnerships and strategies into the future.

Mission, vision and values

At Children’s Minnesota, our **mission** is to champion the health needs of children and families. We are committed to improving children’s health by providing the highest-quality, family-centered care, advanced through research and education.

Our vision

Our vision is to be every family’s essential partner in raising healthier children — not only during illnesses or injuries, but throughout childhood. As the health care industry faces a time of unprecedented change, we will continue our dedication to delivering an experience unlike any other, making access to health care easier and working with the community in innovative ways.

Our values

These values guide the way we engage with each other, our patients and our communities:

- **Kids first.** We’re inspired by children — we channel their optimism, resiliency, courage and curiosity into everything we do.
- **Listen, really listen.** Each person has a story to tell. We listen with compassion, ask meaningful questions and build relationships with individuals and communities.
- **Own outcomes.** We are 200% accountable for providing extraordinary service. Tireless in our pursuit of excellence, we never stop learning or improving.
- **Join together.** We are all caregivers. And, we are stronger when teamed with our patients, families, community and one another. Super teams trump superheroes.
- **Be remarkable.** We are innovators, reimagining health care and going beyond what’s expected. After all, kids are counting on us.

Children’s Minnesota community

Children’s Minnesota is one of the largest pediatric health systems in the United States and the only health system in Minnesota to provide care exclusively to children, from before birth through young adulthood. An independent and not-for-profit system since 1924, Children’s Minnesota is one system serving kids throughout the Upper Midwest at two freestanding hospitals, nine primary care clinics (Minneapolis, St. Paul, Brooklyn Park, Hugo, Maple Grove, Plymouth, Rogers, St. Louis Park and West St. Paul), multiple specialty clinics and seven rehabilitation sites. The network has more than 60 pediatric specialties to provide health and virtual care services to children with a range of needs.

Children’s Minnesota serves a large geographic area and diverse patient population. In 2024, Children’s Minnesota cared for more than 167,500 patients through its hospitals, primary and specialty care clinics and in home services. These patients represented all counties in Minnesota and 63 percent of the counties in the four neighboring states. At its hospital locations alone, there were nearly 86,500 emergency department visits and approximately 14,000 hospitalizations in 2024.

Children’s Minnesota is committed to having the CHNA process guide ongoing partnerships with communities to improve health. While the CHNA is intended to help understand strengths, needs and priorities of all children in the region, it is also an opportunity to identify specific neighborhoods and communities where the organization is best positioned to support local efforts to improve health. Most of the children served by Children’s Minnesota live in the seven-county Twin Cities metro region. Analysis of de-identified patient data shows that the two hospitals serve a culturally, linguistically and socioeconomically diverse patient population reflecting demographic trends across counties and the state. This assessment used the same definition of community* developed from past CHNAs process to understand community needs and inform action.



*Children’s Minnesota definition of community

Children’s Minnesota has a broad reach; however, a majority of children served live in the seven-county Twin Cities metro region. Children’s Minnesota will continue to use the following definition for the purposes for this CHNA:

The community served includes more than 731,000 children (0–17 years) who live in the seven-county Twin Cities region — Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties.

The assessment also placed emphasis on learning about the health needs, assets and priorities of children and families living in the following neighborhoods where: a) a high percentage of children are patients at Children’s Minnesota facilities; and b) children and families experience disproportionate burden of inequitable social, economic and environmental conditions:

- **In Minneapolis:** Phillips and Powderhorn neighborhoods
- **In St. Paul:** West Side, West Seventh and Summit-University neighborhoods



Broader community context

Minnesota: Growing and diversifying

Children’s Minnesota hospitals and clinics are located within the seven-county Twin Cities metropolitan area, serving children and families from across the state and the upper Midwest region. The Twin Cities area is Minnesota’s economic, cultural and political center and it continues to grow in size and diversity. The communities that call Minnesota home have built a robust life here and continue to shape and contribute to the area’s culture, economy and political landscape.

Recent public policy shifts at the federal and state level influence the overall health of our communities. Children’s Minnesota works closely with partners to assess the impact of these changes and advocate on behalf of patients, families and communities we serve.

The community is also working to heal after a series of mass shootings, including one that occurred at Annunciation Church and School in Minneapolis in August 2025. The event has sparked a renewed conversation around gun violence prevention at the state and local level.

About the Children's Minnesota patient population

Who receives care from Children's Minnesota

Children's Minnesota serves children of all ages and from many cultures across Minnesota and neighboring states. While most of the patients served are infants to age 17, Children's Minnesota provides care and services to young adults as they complete treatment for specific health issues.

In 2024, interpreter services were provided for more than 129,000 visits, in 75 different languages, but most commonly the languages of Spanish, Somali, Karen and Hmong.

Patients receive care for a wide range of health concerns. The most common diagnoses in 2024 were acute respiratory illness, dehydration, slow feeding newborn, constipation and anxiety disorder.

In 2024, over 60,000 individual children received emergency department services and nearly 14,500 were admitted to the hospital. Patient data from the two hospitals combined show that children who receive emergency department services tend to be toddlers and school-age children, while infants are more likely to be admitted to the hospital (Figure 1). A more culturally and socioeconomically diverse patient population received emergency department services than those admitted for inpatient hospital care.

In 2024, more than half of patients who received emergency department and/or inpatient hospital services were considered lower income. Because measures of household income and economic status are not routinely collected for all patients, this assessment uses enrollment in Medicaid as a proxy measure for lower-income households. In all, 55% of patients who received emergency department services in 2024, and 52% of patients who received inpatient hospital services, had Medicaid as their primary source of insurance (Table 1).

FIGURE 1. Characteristics of patients served in 2024: Hospitals

DEMOGRAPHICS	EMERGENCY DEPARTMENT ^a (N=60,159)		INPATIENT HOSPITALIZATION ^a (N=14,474)	
	N	%	N	%
AGE				
<1	9,504	15%	4,486	30%
1–2	7,551	12%	1,515	10%
3–4	9,595	15%	1,703	12%
5–6	8,002	13%	1,195	8%
7–12	15,970	25%	2,568	17%
13–18	11,172	18%	2,999	20%
19+	1,059	2%	272	2%
RACE/ETHNICITY				
American Indian/ Alaska Native	467	1%	147	1%
African	600	1%	122	1%
African American/Black	14,640	24%	2,419	17%
Asian	4,174	7%	865	6%
Hispanic/Latino	3,585	6%	274	2%
Middle Eastern	172	0%	34	0%
Native Hawaiian/ Pacific Islander	90	0%	19	0%
White/Caucasian	21,553	36%	7,551	52%
Other	4,503	8%	779	5%
More than one race	4,810	8%	1,199	8%
Unknown	1,209	2%	129	1%
Declined	4,255	7%	922	6%
Missing	7	0%		
PREFERRED HOUSEHOLD LANGUAGE				
English	48,876	81%	12,864	89%
Spanish	5,448	9%	599	4%
Somali	2,932	5%	430	3%
Additional languages ^a	2,903	5%	581	4%
SOCIOECONOMIC STATUS				
Proxy: Medicaid as primary insurance	33,776	55%	7,619	52%

Source: Children’s Minnesota Hospitals and Clinics (2024).

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

^a Additional languages identified (spoken by less than 1% of patients) included: Oromo, Karen, Amharic, Arabic, Nepali and Vietnamese.

Children’s Minnesota primary care clinics located on the Minneapolis and St. Paul campuses reach a more culturally diverse patient population than the hospitals or clinics located in other parts of the Twin Cities metro. **At the Minneapolis clinic, 31% of children have a preferred household language other than English, and the same is true for 21% of children at the St. Paul clinic** (Table 2).

FIGURE 2. Characteristics of patients served in 2024: Minneapolis and St. Paul primary care clinics

DEMOGRAPHICS	MINNEAPOLIS (N=10,487)		ST. PAUL (N=5,878)	
	N	%	N	%
AGE				
<1	1,068	9%	587	9%
1–2	884	8%	498	8%
3–4	1,304	11%	728	11%
5–6	1,320	12%	713	11%
7–12	3,261	28%	1,835	29%
13–18	2,892	25%	1,620	25%
19+	734	6%	390	6%
RACE/ETHNICITY	N	%	N	%
African	156	1%	54	<1%
African American/Black	4,493	43%	1,980	34%
American Indian/ Alaskan Native	66	1%	45	1%
Asian	124	1%	295	4%
Hispanic/Latino	611	6%	390	16%
Middle Eastern	15	<1%	3	<1%
Native Hawaiian/ Pacific Islander	11	<1%	3	<1%
White	1,630	16%	1,499	29%
Other	2,168	21%	694	2%
More than one race	680	6%	640	7%
Biracial	1	<1%		
Unknown	129	1%	85	1%
Declined	399	4%	190	3%
PREFERRED HOUSEHOLD LANGUAGE	N	%	N	%
English	1,352	13%	4,652	79%
Spanish	1,811	17%	699	12%
Somali	7,185	69%	340	6%
Oromo	31	<1%	30	<1%
Amharic	19	<1%	38	<1%
Hmong	--*	--*	31	<1%
Karen	--*	--*	22	<1%
Additional languages ^a	85	<1%	66	1%

FIGURE 2 *continued*

DEMOGRAPHICS	MINNEAPOLIS (N=10,487)		ST. PAUL (N=5,878)	
SOCIOECONOMIC STATUS	N	%	N	%
Proxy: Medicaid as primary insurance	8,159	76%	3,850	64%

Source: Children’s Minnesota Hospitals and Clinics (2024)

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

* Values <10 are suppressed to protect patient confidentiality.

^a Additional languages identified (spoken by fewer than 10 patients) included: Acholi, Anuak, Arabic, Burmese, Dari French, Vietnamese, Hmong, ASL, Pashto, Afar, Ewe, Igbo, Karenni Lingala, Nepali, Romanian, Russian, Acholi, Dari, Karen, Korean, Portuguese, Swahili, Thai, Tigrinya, Serbian and Turkish.

Over three-fourths of the patients seen at the Minneapolis and St. Paul clinics live in lower-income households, as estimated by enrollment in Medicaid (76% and 64%, respectively). At the other Children’s Minnesota affiliated primary care clinics that number ranges between 15–36% (Table 3). And at the Children’s Minnesota specialty clinics it ranges from 42–45% (Table 4).

FIGURE 3. Characteristics of patients served in 2024: Suburban Twin Cities primary care clinics

	CHILDREN'S MINNESOTA		CHILDREN'S MINNESOTA PARTNERS IN PEDIATRICS					
	HUGO (N=4,381)	WEST ST. PAUL (N=3,554)	BROOKLYN PARK (N=6,692)	ST. LOUIS PARK (N=5,156)	MAPLE GROVE (N=16,046)	PLYMOUTH (N=4,674)	ROGERS (N=8,333)	MINNETONKA (N=2,530)
AGE	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
<1	362 (7%)	352 (9%)	591 (8%)	474 (8%)	1,596 (9%)	381 (8%)	791 (8%)	239 (9%)
1–2	393 (8%)	358 (9%)	571 (8%)	457 (8%)	1,450 (8%)	353 (7%)	717 (8%)	201 (8%)
3–4	572 (12%)	535 (13%)	913 (12%)	655 (12%)	2,218 (13%)	522 (11%)	1,087 (12%)	297 (12%)
5–6	623 (13%)	570 (14%)	824 (11%)	632 (11%)	2,130 (12%)	571 (12%)	1,102 (12%)	267 (10%)
7–12	1,557 (32%)	1,139 (28%)	2,095 (28%)	1,799 (32%)	5,456 (31%)	1,460 (30%)	2,921 (31%)	778 (30%)
13–18	1,134 (23%)	849 (21%)	1,877 (26%)	1,293 (23%)	3,854 (22%)	1,235 (25%)	2,213 (24%)	645 (25%)
19+	298 (6%)	194 (5%)	486 (7%)	322 (6%)	927 (5%)	422 (9%)	525 (6%)	149 (6%)
RACE/ETHNICITY	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
American Indian	--*	31 (1%)	48 (1%)	--*	--*	--*	--*	--*
Asian	157 (4%)	119 (3%)	794(12%)	177 (3%)	1140 (7%)	344 (7%)	201 (2%)	160 (6%)
Black/African American	106 (2%)	525 (15%)	1481 (22%)	557 (11%)	1243 (8%)	285 (6%)	228 (3%)	134 (5%)
Hispanic/Latino	27 (1%)	480 (14%)	118 (2%)	59 (1%)	209 (1%)	40 (1%)	55 (1%)	24(1%)
Native Hawaiian/ Pacific Islander	--*	--*	--*	--*	--*	--*	--*	--*
White/Caucasian	3657 (83%)	1351 (38%)	3010 (45%)	3554 (69%)	11062 69%)	3435 (73%)	6766 (81%)	1,876 (74%)
Other	81 (2%)	454 (13%)	308 (5%)	141 (3%)	436 (3%)	119 (3%)	121 (1%)	77 (3%)
Declined	214 (5%)	246 (7%)	336 (5%)	221 (4%)	760 (5%)	201 (4%)	513 (6%)	136 (5%)
Unknown	53 (2%)	20 (1%)	153 (2%)	109 (2%)	265 (2%)	59 (1%)	181 (2%)	30 (1%)

PREFERRED HOUSEHOLD LANGUAGE	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
English	4,325 (99%)	2,711 (76%)	6,229 (93%)	5,000 (97%)	15,386 (96%)	4,418 (97%)	8,020 (98%)	2,452 (97%)
Spanish	21 (<1%)	750 (1%)	122 (2%)	41 (<1%)	158 (1%)	14 (<1%)	32 (<1%)	15 (<1%)
Somali	--*	56 (2%)	97 (2%)	36 (<1%)	76 (<1%)	24 (<1%)	--*	16 (<1%)
Hmong	--*	--*	65 (1%)	--*	--*	--*	--*	--*
Vietnamese	--*	--*	19 (<1%)	--*	16 (<1%)	--*	--*	--*
Russian	--*	--*	--*	--*	46 (<1%)	12 (<1%)	12 (<1%)	--*
Chinese	--*	--*	--*	--*	20 (<1%)	--*	--*	--*
Japanese	--*	--*	--*	--*	14 (<1%)	--*	--*	--*
Hindi	--*	--*	--*	--*	13 (<1%)	--*	--*	--*
French	--*	--*	12 (<1%)	--*	12 (<1%)	--*	--*	--*
Arabic	--*	--*	--*	--*	10 (<1%)	--*	--*	--*
Additional languages ^a	21 (<1%)	29 (1%)	85 (1%)	67 (1%)	287 (2%)	106 (2%)	160 (2%)	47 (2%)
SOCIO-ECONOMIC STATUS	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Proxy: Medicaid as primary insurance	662 (15%)	2,051 (52%)	2,740 (36%)	890 (17%)	2,968 (18%)	1,002 (13%)	1,127 (13%)	

Source: Children's Minnesota Hospitals and Clinics (2024)

* Values <10 are suppressed to protect patient confidentiality.

^a Additional languages identified (spoken by fewer than 10 patients) included: Hmong, Nepali, Bengali, sign languages, Arabic, Kinyarwanda, Marathi, Somali, Oromo, Tigrinya, Burmese, Hmong, Karen, Tibetan, Ukrainian, Vietnamese, Amharic, Chinese, Mandingo, Laotian, German, Harari, Lao/Laotian, Mandarin, Thai, Wolof, Italian, Marathi, Tamil, Turkish, French, Russian, Korean, Japanese, Telugu, Indian, Kannada, Malayalam, Tagalog, Urdu, Hindi, Hmong, Philippine languages, Romanian, Moldavian, Moldovan, Telug, Finnish, Vidni, Hong, Portuguese, Telugu, Mongolian, Persian, Tajik and Turkmen.

FIGURE 4. Characteristics of patients served in 2024: Minneapolis and St. Paul specialty clinics

DEMOGRAPHICS	MINNEAPOLIS (N=60,159)		ST. PAUL (N=14,474)	
	N	%	N	%
AGE				
<1	4,503	11%	1,968	10%
1–2	3,002	7%	1,477	7%
3–4	4,508	11%	2,346	12%
5–6	4,266	10%	2,215	11%
7–12	9,849	24%	5,312	26%
13–18	10,978	27%	5,496	27%
19+	4,325	11%	1,318	7%
RACE/ETHNICITY	N	%	N	%
African	211	<1%	98	1%
African American/Black	4,410	11%	2,424	13%
American Indian/Alaskan Native	219	<1%	104	1%
Asian	1,611	4%	952	5%
Hispanic/Latino	413	1%	269	1%
Middle Eastern	76	<1%	30	<1%
Native Hawaiian/Pacific Islander	26	<1%	9	<1%
White	23,139	59%	11,001	58%
Other	1,934	5%	1,056	6%
More than one race	2,639	7%	1,559	8%
Unknown	2,634	7%	411	2%
Declined	1,888	5%	929	5%
Missing	7	0%		
PREFERRED HOUSEHOLD LANGUAGE	N	%	N	%
English	35,391	90%	17,420	92%
Spanish	1,243	3%	704	4%
Somali	823	2%	372	2%
Additional languages ^a	1,765	5%	352	2%
SOCIOECONOMIC STATUS	N	%	N	%
Proxy: Medicaid as primary insurance	16,636	42%	8,588	45%

Source: Children’s Minnesota Hospitals and Clinics (2024)

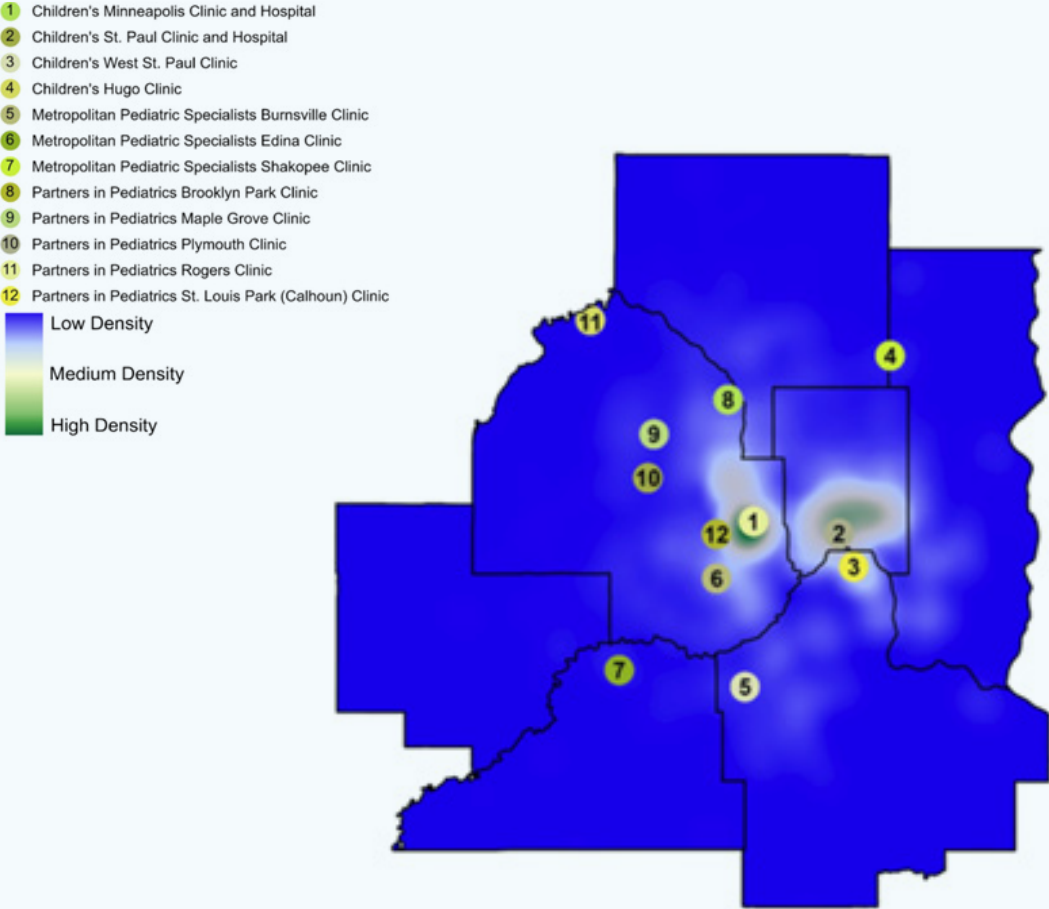
Note: Totals for race/ethnicity and language may exceed 100%, as more than one category may be selected. All race/ethnicity categories include foreign-born children.

^a Additional languages identified (spoken by less than 1% of patients) included: Amharic, Arabic, French, Hmong, Karen and Oromo.

Many Children’s Minnesota emergency department and primary care clinic patients live in close proximity to the health care clinic facilities that provide these services.

The majority of these patients live in the seven-county Twin Cities metro. Many of the children who received acute care services from the emergency department in 2024 lived in close proximity to the two hospital campuses in south Minneapolis and downtown St. Paul (Figure 5).

FIGURE 5. Areas of high patient density: Children’s Minnesota emergency departments



Source: Children’s Minnesota mapping and analysis by Wilder Research using 2020 census tracts.

Notes: The most recent residence was selected for each child who had at least one visit at a Children’s Minnesota emergency department between January 1, 2024, and December 31, 2024. 60,159 unique patients are represented in this map. Emergency departments are located at the Minneapolis and St. Paul hospital campuses (1 and 2 on the map).

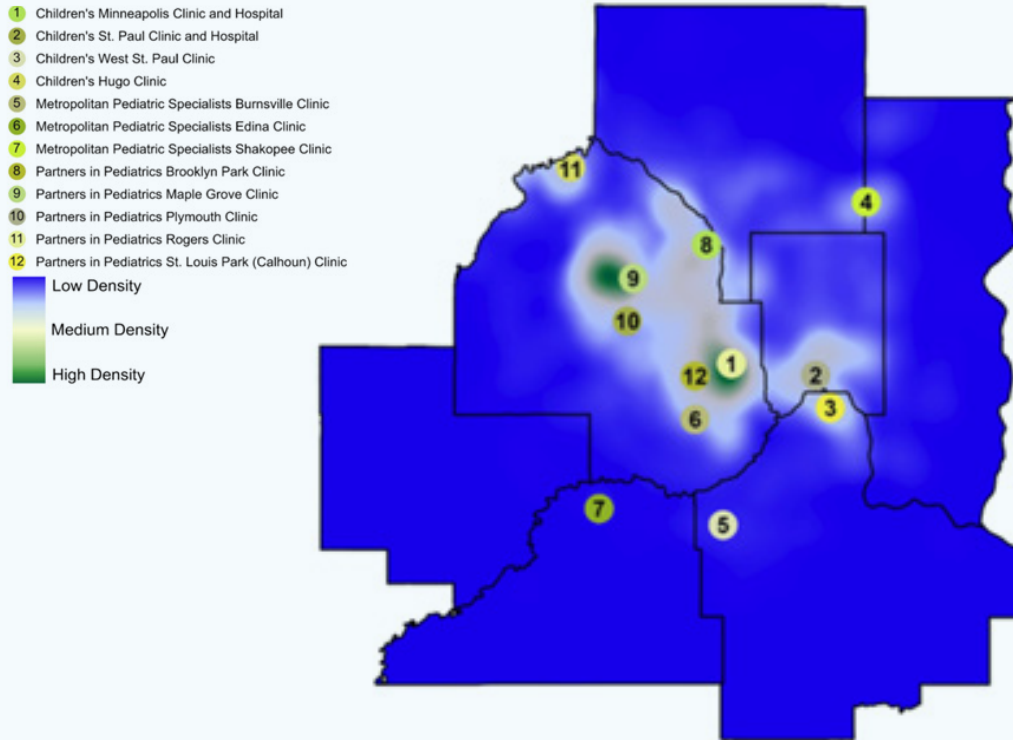
The nine primary care clinics affiliated with the Children’s Minnesota system also provided preventive and acute care services to children who lived in Minneapolis and St. Paul in 2024, as well as suburban communities located nearby (Figure 6).

Looking more closely within the metro area, there are specific Minneapolis and St. Paul neighborhoods where a high percentage of children receive services from Children’s Minnesota.

Figure 7 presents the percentage of children in each metro neighborhood who received some type of care from Children’s in 2024 across emergency departments, hospitals, primary care clinics and specialty clinics taken together.

In both the West Side and West Seventh neighborhoods of St. Paul, 40.1% or more of children receive care from Children’s Minnesota. In the St. Paul neighborhoods of Summit-University, Downtown and Saint Anthony Park, along with the Minneapolis neighborhoods of Phillips, Powderhorn, Central and Calhoun-Isle, between 30.1% and 40.1% of children are patients at Children’s Minnesota.

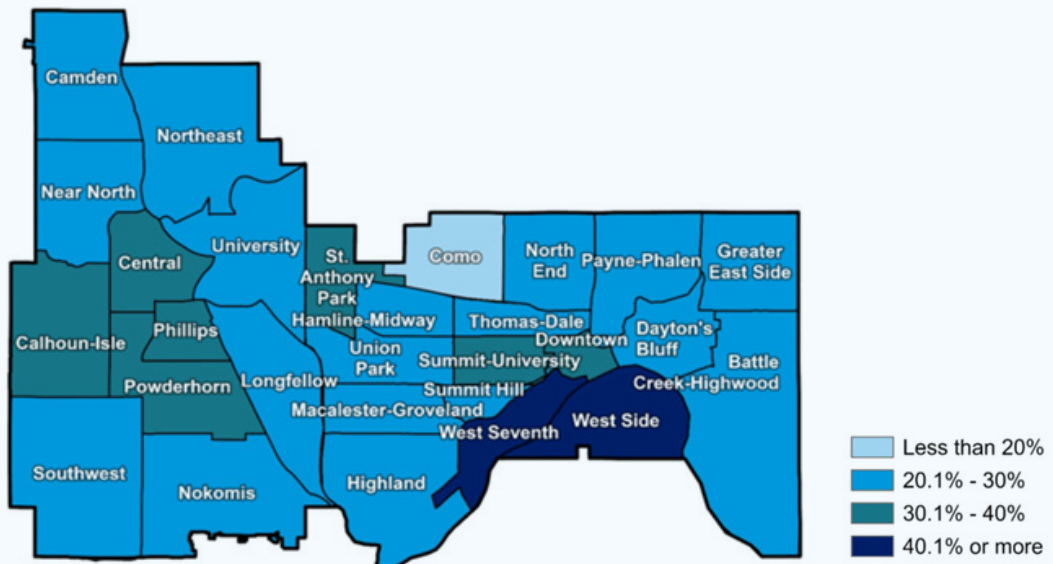
**FIGURE 6. Areas of high patient density in the seven-county metro area:
Children’s Minnesota primary care clinics**



Source: Children’s Minnesota mapping and analysis by Wilder Research using 2020 census tracts.

Notes: The most recent residence was selected for each child who had at least one visit at a Children’s Minnesota primary care clinic between January 1, 2024, and December 31, 2024. 65,201 unique patients are represented in this map. Children’s Minnesota primary care clinics are located across the Twin Cities metro and include clinics located at the Minneapolis and St. Paul hospital campuses (1 and 2 on the map). Patients who were seen only at one or more of the Metropolitan Pediatric Specialists clinics (located in Burnsville, Edina and Shakopee) are not included in the map.

FIGURE 7. Percentage of children (0–17) in Minneapolis and St. Paul neighborhoods reached by all Children’s Minnesota facilities



Source: 2020 Census (P.L. 94-171 Redistricting data). Children’s Minnesota administrative data. Wilder Research calculations.

Assessment process overview

The previous CHNA Children’s Minnesota conducted in 2022 identified six priority health needs: structural racism, health disparities, economic opportunity and income, mental health, access to resources and community safety. The 2023–2025 CHNA Implementation Strategy developed in response to these priorities, guided the work of the Children’s Minnesota Collective for Community Health as well as the work of the broader organization, creating opportunities to build upon current initiatives and expand efforts to invest in community solutions and partnerships.

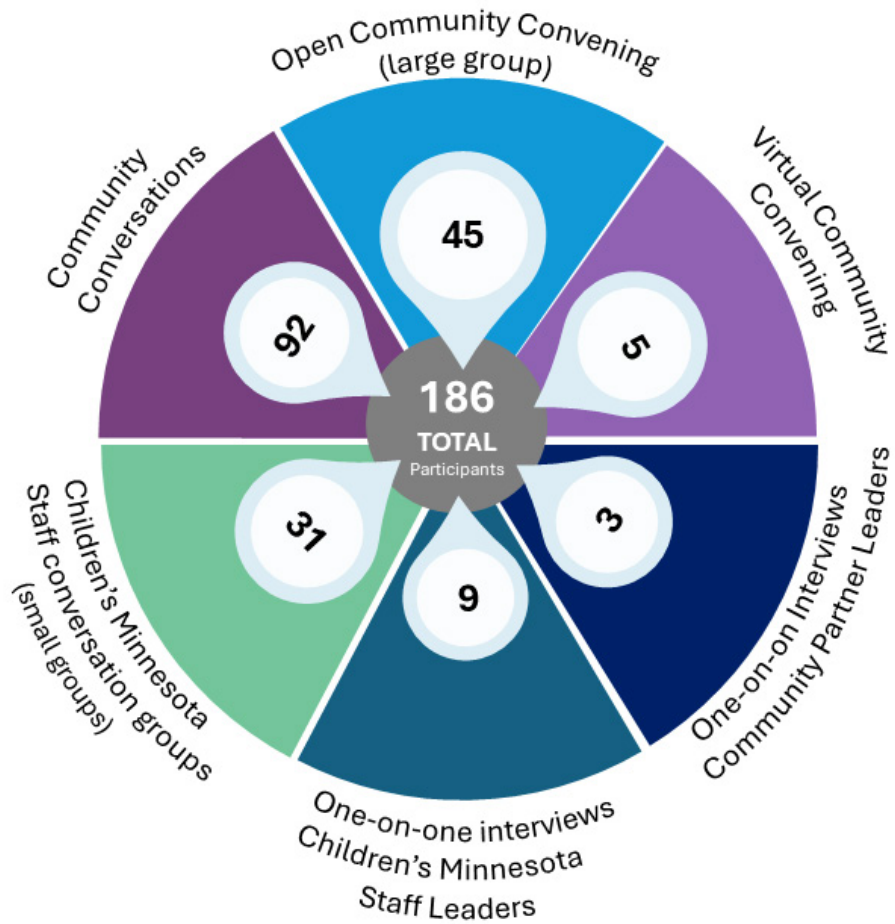
The priorities identified in 2022 provided the foundational framing for the 2025 CHNA, which emphasized deepening the organization’s understanding of community members’ experiences through expanded community member engagement. To this end, Children’s Minnesota, Collective Action Lab and Wilder Research undertook the following process:

- Partnered with the Children’s Minnesota Community Advisory Council, which informed the assessment design and primary data collection process and hosted several community conversations.
- Conducted a review of the 2022 CHNA report.
- Conducted primary data collection with parents and caregivers and youth; community-based organizations that represent community groups most impacted by health and social inequities; and parents and caregivers of families with medically complex children.
- Conducted secondary data analysis on community demographics and health indicators, some of which were informed by the community engagement conversations.





Nearly two hundred community stakeholders were engaged in a variety of ways shown here.





Assessment learning categories

To deepen understanding and inform responsive implementation activities, the CHNA data collection and analysis process included the following steps:



1. Define good health and positive health care experiences.

Before exploring priority health needs, the assessment process sought input from parents, caregivers, youth, community-based organizations and Children’s Minnesota staff and providers regarding what good health and positive health experiences look, sound and feel like. From these perspectives:

- **Good health** encompassed a continuum of mental, physical, social, relational and spiritual well-being; and
- **Positive health care experiences** included having access to safe supportive spaces and feeling heard and validated by providers who are culturally and trauma responsive, good communicators and problem solvers.

These discussions provided a foundation for subsequent steps in the assessment process, including identifying obstacles to good health experiences, which informed later conversations about priority health needs and gaps.

“ youth participant:

I think being healthy is like being fulfilled as a whole and like being well-rounded in all areas. Like having good mental health, having good physical health, having good communication skills... being able to maintain relationships and stuff.

GOOD HEALTH



“ parent/caregiver:

Like the doctor took time to explain health information in a way that was understandable. I'm not a medical professional, but the doctor like explained things in a very simple basic way. And then also respect, like coming into a health care center facility, feeling like you're, you're respected as like a human being.

POSITIVE EXPERIENCE



“ community partner:

I think everything starts with conversations and community conversation is so powerful because one family having the experience will share, will be our own ambassador, to enhance that engagement. And, with that engagement, it becomes more. Some of those will turn into opportunity and, you know, mutual benefits that centering families and children and I think aligning our missions together have all of us share the commitment to improve health equity.

GOOD HEALTH

“ parent/caregiver:

We wanted a pediatrician who did gender affirming care and understood that and was proactive about it. And so just seeing that change of energy and priority was important for us...it felt like the whole team was rooting for me, like the admin at the front and the doctor got it to us and it felt really supportive for like all of those urgent details things and the quality of care and attention that, the staff was giving to us.

POSITIVE EXPERIENCE



“ parent/caregiver:

I felt validated with what was going on. I had an ideal, but I just couldn't pinpoint what it was until after the doctor, you know, really listen to my concern and referred me somewhere and then just validated, you know, that this kid needs help.

POSITIVE EXPERIENCE

2. Identify/affirm priority health needs.

The priority health needs identified in 2022 provided the starting point for the 2025 health needs identification. Community members were asked to review and expand upon the 2022 priority health needs and identify any new priorities that should be added.

The priorities are listed and defined below:

Structural racism

Structural racism^a refers to the ways in which the policies, practices and systems of organizations and institutions routinely advantage White populations while disadvantaging people of color and American Indians.

Health disparities

Health disparities^b are preventable differences in health outcomes caused by inequitable and unjust distribution of resources, opportunities and power.

Economic opportunity + income

Economic opportunity and income are the factors that ensure families can access and obtain financial resources that support the well-being of children and the community.

Mental health

Mental health refers to the critical need for children, youth and families to have equitable access to a full spectrum of culturally responsive mental health services throughout their life, in both medical and community-based settings.

Access to resources

Access to resources is the ability to have equitable access to culturally responsive health care services, as well as social supports that all people need to survive and thrive, including food, housing, transportation and education.

Community safety

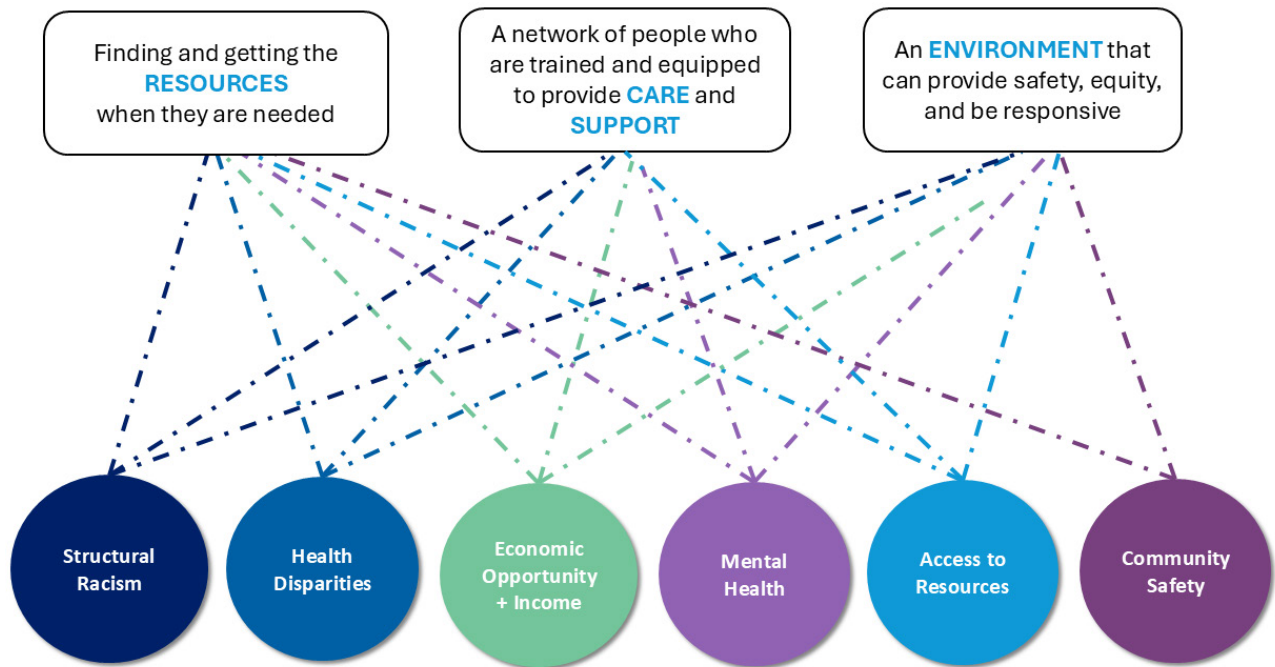
Community safety is the opportunity for children and families to feel safe at home, at school and in the broader community.

^a The Aspen Institute. (n.d.). Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis.

^b Centers for Disease Control and Prevention. (2008). Community Health and Program Services (CHAPS): Health disparities among racial/ethnic populations. U.S. Department of Health and Human Services.

3. Highlight cross-cutting assessment results.

The first iteration of input and feedback from community members was organized and summarized under the six priority health needs listed above. In a facilitated review of the community input, the Children’s Minnesota Advisory Council and Children’s Minnesota leaders noticed three recurring themes that cut across the six priority health needs. These cross-cutting themes were used to organize and prioritize the assessment results as shown here.



CROSS-CUTTING THEME:

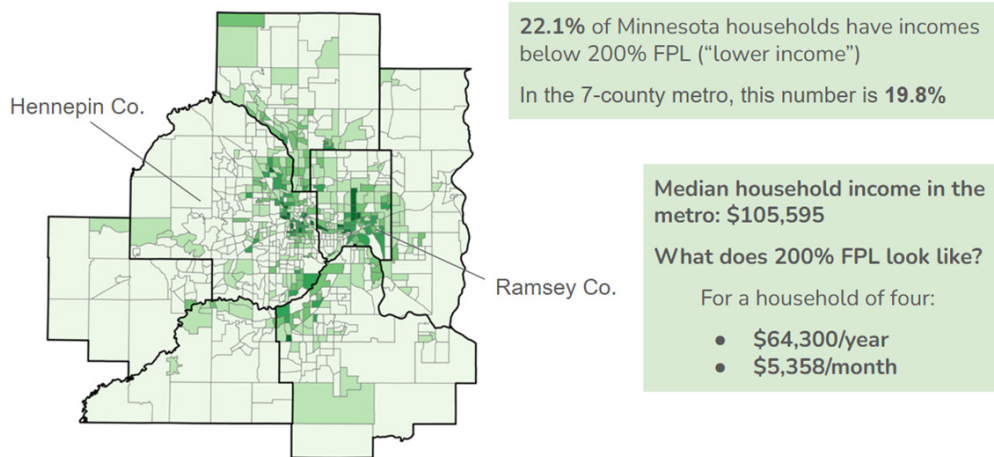
Finding, affording and getting resources when they are needed

Health is multifaceted and does not stand in isolation. Consistent with what surfaced in the “what is good health” conversations, people need resources outside of health care to support their health and well-being such as money, nutritious food, housing, education, transportation, employment, therapy and cultural support. This requires that resources not only exist, but that people can afford, find and use them. Barriers to paying for, finding and using needed resources was a recurring theme across all six priority need areas and are discussed further.

Being able to afford resources is key.

Finding and accessing resources is significantly more difficult for families who have low incomes, and Children’s Minnesota serves a region in which more than 20 percent of families are low income.

Context: The Metro Area’s Lower-Income (<200% FPL) Families



Source: 2019-2023 American Community Survey

Inequitable wealth distribution disproportionately impacts people who are Black or African American, American Indian, Latino, Asian and persons of color, immigrants and refugees, in the Twin Cities seven-county metro area. The rate of poverty (<100% FPL) is at or below 6% among White (non-Hispanic) children in every metro county, averaging 3.3% across the metro. In contrast, the rate among Black children is as high as 34% in Scott County and averages 19% across counties — a 15.7 percentage point difference. (Table 5)

Table 5. Percent of metro-area children (0-17) below 100% of poverty and between 100% and 200% of poverty, by county (2019-2023)

Race/Ethnicity	Anoka		Carver		Dakota		Hennepin		Ramsey	
	< 100% FPL	101% - 200% FPL	< 100% FPL	101% - 200% FPL	< 100% FPL	101% - 200% FPL	< 100% FPL	101% - 200% FPL	< 100% FPL	101% - 200% FPL
American Indian	5%	24%	21%	0%	13%	18%	37%	25%	36%	56%
Asian	5%	25%	0%	2%	2%	13%	6%	18%	24%	35%
Black	21%	34%	0%	21%	16%	22%	28%	31%	32%	29%
Hispanic/Latino	3%	29%	8%	24%	12%	36%	16%	23%	12%	37%
Two or more races	5%	19%	0%	17%	5%	26%	9%	15%	12%	25%
White (non-Hispanic)	6%	11%	3%	5%	3%	6%	3%	4%	4%	10%

Source: U.S. Census Bureau. 2019-2023 American Community Survey. Analysis by Wilder Research.

The income distribution across cultural groups throughout the state shows similar patterns (Table 6). In total, 9% of Minnesota children live in households with incomes below 100% FPL. Among White children this rate is 5%, compared to an average of 15% across all other cultural groups. Among cultural groups that are not White, poverty rates reach a high of 42% among Somali children, followed by 35% among Burmese children and 24% among Ecuadorian children.

FIGURE 8. Percent of children (age 0–17) in lower-income households, by cultural group

CULTURAL GROUP	CHILDREN AGE 0–17 LIVING BELOW 100% FPL		CHILDREN AGE 0-17 LIVING BETWEEN 100%–200% OF FPL	
	N	%	N	%
Somali	15,796	42%	12,422	33%
Burmese	2,457	35%	1,171	16%
Ethiopian	2,439	14%	6,756	39%
Liberian	2,022	22%	3,136	35%
Salvadoran	434	5%	2,604	31%
AfricanAmerican	18,406	19%	27,299	28%
Mexican	12,489	14%	25,991	30%
Guatemalan	1,238	15%	2,189	27%
Hmong	4,497	12%	13,635	36%
Puerto Rican	787	9%	1,486	18%
Native American	10,827	17%	15,703	24%
Kenyan	1,551	17%	1,944	21%
Nigerian	380	7%	1,187	22%
Filipino	253	3%	1,351	18%
White	43,593	5%	99,069	12%
Chinese	866	8%	742	7%
Korean	389	4%	833	8%
Vietnamese	938	10%	1,381	15%
Asian Indian	505	3%	762	5%
Ecuadorian	1,850	24%	2,281	29%
All Minnesota children	117,606	9%	218,242	17%

Source: U.S. Census Bureau. 2019-2023 American Community Survey. Analysis by Wilder Research

Finding and using resources often requires navigation.

Community members shared that to effectively find and get resources, they need navigation support. Navigation includes connecting to someone who understands the process and necessary steps to get needed resources and can help families walk through those steps.

Parents/Caregivers shared that even knowing what to ask, how to ask it, getting connected and knowing who to trust are fundamental challenges. Finding resources can sometimes seem impossible when a family is managing multiple health conditions along with other needs. Parents/caregivers also spoke to how challenging it is when something new and unfamiliar is diagnosed or discovered. Specific navigation needs that surfaced from the assessment are described below:

- **Low-cost support programs for lower-income households and multilingual/multicultural families.** Families expressed limited awareness of available resources for low-cost community or government support programs.
- **Community/cultural resource lists, outreach and peer support.** People expressed the need for more information that specifically addresses the needs of children/youth regarding homelessness, substance abuse, social and support groups; and parents/caregivers, such as parenting, legal services, housing, childcare and substance abuse.
- **Complex paperwork and processes.** Parents/Caregivers specifically mentioned becoming overwhelmed and not understanding the paperwork and processes required to access financial assistance and school services (e.g., Individual Education Plans (IEPs)). Even more complexity is added when family members/guardians are addressing these issues while also working through legal and/or custody issues within kinship foster care or adoption proceedings.
- **Familiar, high quality and affordable foods for new immigrant and refugee families to Minnesota.** Many families are adjusting to new types of food and need support in accessing high quality organic foods, fruits and vegetables, especially while adjusting to the reality of higher costs and difficulty sourcing the foods that they are accustomed to eating.
- **Mental health services.** Community members noted the difficulty of finding and getting services from providers that fit the needs of their kids, have hours outside of standard work and school schedules, and who remain in their insurance provider network. They also expressed the need for expanded services in the areas of death and grieving, complex care/disabilities, decision-making about kids, and early intervention and assessment.

CONTEXT:

Housing resource access is critical given homelessness rates in the metro area.

- 48.0% of renters in the metro area and 19.0% of homeowners are spending 30% or more of their income on housing — making them “cost-burdened.”
- The most common cause of homelessness in Minnesota is a lack of affordable housing.
- 80% of homeless youth in Minnesota in 2023 were minors with their parents.
- Certain groups of youth are disproportionately affected: 25% of homeless youth in the metro identify as LGBTQIA+.
- A disproportionate number of youth who are Black/African American, American Indian or Alaska Native, Hispanic or Latino/a/x, or who report multiple racial or ethnic identities, are experiencing homelessness in the Twin Cities.

For example, while 10% of metro area residents are Black or African American, 57% of homeless youth in the metro are Black or African American.

Source: Wilder Research. 2024. “2023 Minnesota Homeless Study: Detailed Data.” mnhomeless.org/results/detailed-data

“parent/caregiver:

I think what affects me the most is the lack of variety in fruits, such as, let's say, blackberry, passion fruit, guava, very little is available. I mean, fruits that we used to consume daily and turn into juice. During my pregnancy here, I craved all the foods from my home country and I tried hard to find them. Even when I arrived in New York I found a restaurant where they sold passion fruit juice, they also stuffed them, things like that. I ate everything there because, I mean, you don't always find your own food and mostly fruits. And the products that are natural are very expensive, so obviously we can't afford them.

CONTEXT:

Access to food support is important because food insecurity is high in Minnesota.

Nearly one in five Minnesotans (19%) has some level of food insecurity. A substantial portion of households (13%) report use of resources such as food shelves, community meals and SNAP to meet their needs.

Households where the **primary language is not English** and households where at least one member identifies as **Black or American Indian** report consistently higher rates of hunger.

Sources: U.S. Census Bureau. 2019-2023 American Community Survey through Minnesota Compass.

Kinoglu, S., and Spitzfaden, K. Second Harvest Heartland. 2025 "The State of Food Security in Minnesota." wilder.org/wilder_research/second-harvest-heartland-the-state-of-food-security-in-minnesota

“ **parent/caregiver:**

We are very lost when it comes to dealing with insurance, how much we need to pay, how much the insurance covers. And there's another problem, which is that we get medical attention and then every month we keep getting bills. And every month we keep getting bills and more bills and more bills. We're even getting bills from last year and bills for things that have already been paid. So, we don't even know how much we really need to pay. We have made calls complaining about how much we need to pay, or why they are charging us so much, but there is no clarity, that is, there is no clarity about how much we really owe.

- **Transitions from youth to adult health care systems.** Parents/Caregivers expressed the need for care continuity for their older children, especially those who are medically complex, who will be transitioning to adult care systems, including continued access to providers to help manage their health conditions, medications and provide mental health support.
- **Health care.** Community members identified a diversity of needs for navigating and accessing health care, which are outlined below:
 - **Insurance policies and benefits.** Community members expressed the need for an orientation and explanation of their insurance policy coverage, including which providers are available to them and the full spectrum of care available including specialists and complementary therapies. They also want help understanding the insurance claims process, their share of costs and what the insurer covers, especially for specific conditions, diagnoses, tests and services. They want to know how billing and the payment process works and how to transition from one policy to another or how to manage transitions if they move from one county to another. They also want guidance on how to talk with benefit representatives. Finally, they expressed a need for support in choosing a primary clinic in their insurance network.
 - **Replacing a provider when they switch clinics and systems.** Community members shared that it would be helpful to have support in making successful provider replacement decisions when providers leave their insurance network; this is extremely disruptive to care and they cannot change their insurance plan until the annual enrollment period.
 - **Appointment locations and options.** Community members expressed a need for appointment times that allow busy families to get appointments at needed times that do not require long travel distances. They also expressed a need for shorter wait lists for specialty care and services. Multilingual community members also expressed a need for support in making appointments.

- **Longer appointments.** Community members want longer appointments to build deeper relationships with providers so that the provider can get to know the child and family and help them connect to resources.
- **Finding providers for services that are difficult to source.** Community members need support in finding providers for dental care, care for services not covered by government insurance programs, kids who require additional accommodations for routine appointments and complex medical diagnoses. In Greater Minnesota, families requested more support for getting routine physical health monitoring, in-network specialty referrals and transportation to medical appointments.
- **Social determinants of health screening.** Community members expressed a need for more consistency in social determinants of health screening and responsive follow up for locating resources like grocery stores with healthy foods, affordable childcare close to home, gender affirming schools, legal assistance, resources for youth homelessness and substance abuse, financial support for childcare and housing and transportation.

A promising solution: School-based mental health services

A recent University of Minnesota study found that School-Based Mental Health (SBMH) programs improved student access to mental health services in Hennepin County by 8% and reduced the attempted suicide rate by 15%. SBMH programs, which place licensed mental health clinicians who work for mental health agencies directly in schools, are especially important for children from underserved communities, for whom SBMH is their primary source of mental health care. 50% of children who receive SBMH have never used mental health services before, and 45% have a major mental health concern. The annual cost of the SBMH program studied was approximately \$117 per student, covered by grant funds and health insurance from students with coverage.

Sources: McDill, V. November 28, 2023. "School-based mental health services can improve the well-being of children and adolescents." University of Minnesota School of Public Health News. sph.umn.edu/news/school-based-mental-health-services-can-improve-the-well-being-of-children-and-adolescents.

Goberstein, E., Zainullina, I., Sojourner, A., & M. Sander. (2023). "Effects of School-Based Mental Health Services on Youth Outcomes." Journal of Human Resources 60(5): 1222-1270. jhr.uwpress.org/content/early/2023/10/02/jhr.1222-12703R2.

“ parent/caregiver:

Even if you do get the testing done, and then it's like, okay, now what do I do? I have the diagnosis, right? But yes, now where do I go now what do I do? Right? Because my, trans kiddo was also autistic and, he got his diagnosis a couple years ago and we're still trying to figure out like all of the right resources to help him. And, and for him, school has been really, really, really challenging and, so hard, you know, and tired of it three years later. So it's not only like the limitations of finding the resources, getting the testing, but then where do you go from there the Resources after. And like how do you find 'em? Where do you go? You know, I mean at, at least I am like a parent who will dig into and, and find, re try to find resources, but I'm like, what if I was a parent who didn't really know how to dig for resources or look for options or, you know, you're just kind of out there?

CROSS-CUTTING THEME:

Having a network of people who are trained and equipped to provide care and support

Community members shared that the people who provide health care or community services significantly impact their experiences and outcomes. Community members most value providers and staff who foster responsive, whole-person centered care and support, an affirming culture, and who are well-trained and culturally congruent.

- **Responsive, whole-person centered care and support.**

Approaches that have made a positive difference for parents/caregivers and kids include:

- Welcoming and accommodating institutional practices such as a diversity of space, stimuli and noise accommodations.
- Trauma-informed and other adaptive approaches that build trust and positive interactions.
- Cultural and gender affirming practices and approaches.
- Providers who help people feel comfortable, ease anxieties and fear and who take time to understand their patients' preferences, family routines and home and community environments.



“ youth participant:

If they start a job that they should be culturally aware and also trying to make you feel more comfortable rather than going about asking here and there how you doing, just checking on medicine.

- **Affirming organizational culture.** Community members emphasized the importance of an institutional culture that consistently implements and integrates affirming practices at all levels of service delivery. Affirming practices include meeting people where and as they are without judgment, assumptions or bias; investing time to build relationships with and understand people's needs; and being familiar with resources that are responsive to each person's unique needs.

- **Well-trained and knowledgeable providers.**

Providers who are trained and comfortable in working with a wide variety of backgrounds, lived experiences, cultures and care needs is essential to meeting the needs and expectations. The assessment emphasized the following areas for provider training and knowledge.

- **Cultural humility.** Many parents/caregivers acknowledged that they expected to be engaged with providers and professionals that offer support without assumptions of race, bias and stereotypes (e.g., judgments beyond race including clothing, or their physical appearance), while also affirming (multiple) identities, family composition and parent/guardianship.
- **Relationship building skills.** Parents/caregivers emphasized the need for providers to be equipped to help families feel comfortable and connected when receiving support and care, to check on their needs and preferences and ask whether they understand information the provider is sharing.
- **Transparency, empathy and respect.** Unclear, limited, terse or unfeeling communication was perceived by parents/caregivers and kids as disrespectful and harmful. They felt that providers should be equipped to present information transparently yet empathetically. This included sharing a variety of treatment options and explaining why they were recommending certain tests/procedures and doing so in ways that are understandable to a person without medical training.

- **Cultural congruency.** The assessment emphasized that beyond having access to well-trained providers, it is also critical to be supported by people who reflect, deeply understand and/or are from one’s own community. Congruency needs span a range of areas including race and ethnicity, sexual orientation, gender identity — this was especially true for trans-identifying kids and disability — including autism and neurodivergence. Cultural congruency also included language support provided by multilingual speakers who prioritize privacy/comfort, consistency, cultural context and effective communication both in person and virtually.

Concern among community members about having health care providers that reflect their cultural identities is borne out by statewide health care workforce data from the Minnesota Department of Health (MDH). The MDH data in Table 7 show that among all providers taken together and among physicians, physician assistants (PAs), advance practice registered nurses (APRNs) and registered nurses (RNs) examined separately:

- 75% of workers or more identify as White.
- Among all providers, the second largest category is Black or African American at 4.1%.
- South Asians make up the second largest category of physicians at 5.9%,
- Southeast Asians are the second largest category of PAs at 1.9%,
- Black or African American is the second largest category for both APRNs at 4.7%, and RNs at 4.5%

Source: Minnesota Department of Health. March 2024. Minnesota’s Licensed Health Care Workforce Data. Data Dashboard. health.state.mn.us/data/workforce/hcwdash

“ parent/caregiver:

I see a nurse practitioner and I just love her. She spends a lot of time with me. She makes sure I have all my questions answered that I have and she will look into something if she don’t know the answer and she’ll get back to me. I really, really, um, I’m glad to have her right now. She’ll spend like 35 minutes with me, you know, answering every question.

FIGURE 9. Health care workforce in Minnesota by race and ethnicity

RACE/ETHNICITY	ALL PROVIDERS (N=268,795)	PHYSICIANS (N=28,373)	PAs (N=4,461)	APRNs (N=12,674)	RNs (N=121,438)
African	2.1%	1.9%	0.7%	3.0%	2.5%
American Indian/ Alaska Native	1.2%	1.0%	0.4%	0.9%	1.1%
Another race	1.6%	2.9%	1.5%	1.7%	1.4%
Asian (Other)	1.7%	4.2%	1.3%	1.0%	1.1%
Asian (South Asian)	1.4%	5.9%	0.7%	0.6%	0.5%
Asian (Southeast Asian)	2.9%	5.2%	1.9%	1.7%	2.5%
Black/African American	4.1%	3.2%	1.4%	4.7%	4.5%
Hispanic/Latin	2.4%	3.3%	1.5%	1.5%	2.0%
Middle Eastern/ North African	0.7%	2.8%	0.4%	0.3%	0.2%
White	85.7%	74.9%	92.9%	87.4%	87.2%

Source: Minnesota Department of Health. March 2024. Minnesota’s Licensed Health Care Workforce Data. Data Dashboard. health.state.mn.us/data/workforce/hcwdash

“ parent/caregiver:

You know, my daughter doesn’t want to sit and talk with a white person. They can’t identify like the one therapist she had. ‘Mom, she don’t know what I’m talking about.’ If we had more resources, you know, providers that were of color who the student can identify with and the families can identify with. So it was a cultural thing. I believe if we had more providers that look like us, you know, it would benefit us more.

With respect to language specifically, state licensure data show that Minnesota’s health care workforce offers a mix of skills.

- In all, 17.1% of providers speak at least one language in addition to English, with the five most common of these languages being Spanish (36.9%), Arabic (6.4%), Hmong (6.0%), Hindi (5.8%) and Somali (5.2%).
- Among physicians, 22.1% speak at least one language in addition to English. The 5 most common of these are: Spanish (37.3%), Hindi (11.3%), Arabic (9.7%), Chinese (6.9%) and Urdu (6.1%).

Source: Minnesota Department of Health. March 2024. Minnesota’s Licensed Health Care Workforce Data. Data Dashboard. health.state.mn.us/data/workforce/hcwdash

Cultural congruency is intimately connected with structural racism in healthcare systems, largely due to the fact that such systems were originally designed by and for people living within a White, mainstream culture. Individuals outside of that culture may need more assistance in understanding and using a system that wasn't designed with them in mind. Without providers who share similar lived experience, patients may experience barriers to effective care and support.

Community members shared numerous examples of how African Americans, American Indians and communities of color, including immigrant and refugee communities, did not receive needed resources and/or felt alienated from the health care system because of their race, culture, sexual orientation, gender identity and/or language. Community members recommended that health care systems can prevent or at least defend against such inequities by investing in and growing a workforce that better reflects the diversity of communities they serve.

“ youth participant:

Being, like young, and trying to find somebody that is, like, close to your age that understands you. 'cause personally I have a hard time communicating with people older than me, like adult wise. 'cause if I feel like I'm not being heard or I feel misunderstood, I will say and like, it's hard for me to, like, find a lot of people that understand me physically, mentally, emotionally. I have had therapists but I stopped going because I just felt like it's like only me understands what I'm going through.

CROSS-CUTTING THEME:

Safe, equitable and responsive environments

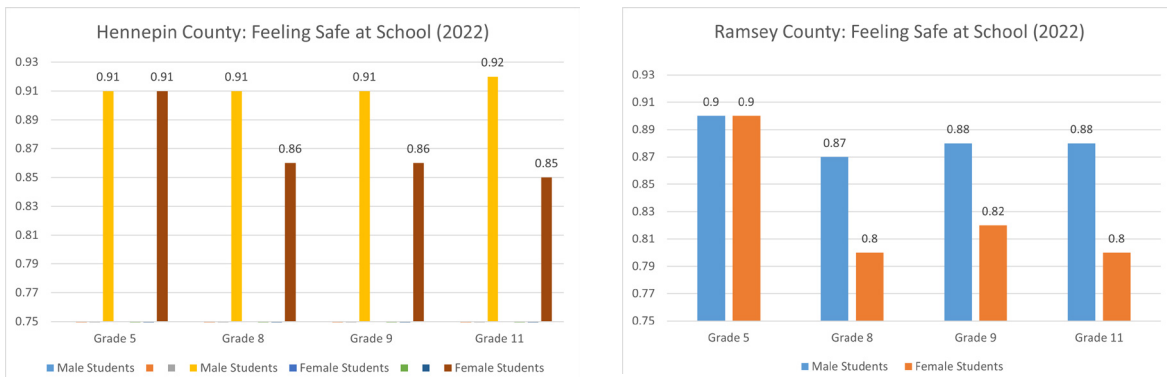
Community members shared information about environmental challenges they face and the needs that result from those challenges. They recommended that systems address the needs by assuring safe public and community spaces, strengthening relationships between health care and community resources, investing in educational and employment opportunities, providing solutions for people facing systemic barriers to housing, exploring new care models that center families and kids rather than the health system, and fostering connections that advance needed policy change. These are described in more detail below.

- Invest in community spaces that are safe for kids and foster connections. The importance of safe spaces for children, especially where they learn, play and socialize together, is especially salient given the recent violence at Annunciation Catholic Church and School in Minneapolis. The Minnesota Department of Education data analyzed by the Minnesota Star Tribune show that safety threats at Minnesota schools have increased dramatically since 2020. For example, nearly 200 firearms have been found in Minnesota schools since the 2021–2022 academic year, which is nearly three times as many as were found in the school years spanning 2017–2020.

Source: Klecker and Hargarten. October 21, 2025. "Minnesota schools reporting sharp increase in number of guns confiscated from students." Minnesota Star Tribune



While younger children generally feel safe at school, data from Ramsey and Hennepin counties show that after fifth grade feelings of safety decline.



Source: Minnesota Department of Education. 2022. "Minnesota Student Survey: Data Reports and Analytics." Minnesota Student Survey Tables, 2013–2022." public.education.mn.gov/MDEAnalytics/DataTopic.jsp?TOPICID=11

In this context, community members expressed a growing need for safe spaces in community for children. Parents/Caregivers and kids desire affinity-based gathering places so that children who have similar needs, identities, or conditions/diagnoses can participate in activities and groups and feel supported. Additionally, parents/caregivers who live in areas where there are high concentrations of drug use or homeless populations felt it was especially important to have safe recreational spaces in their neighborhoods.

- Deepen connections between healthcare and social care resources.** Community members expressed a need for better information sharing between communities, healthcare and social care supports and resources. For example, healthcare systems could participate in and/or host community events, including cultural events, where attendees could build relationships and trust and share and learn about resources and information available to children and families. A second example is to build stronger referral relationships and infrastructure that simplifies processes and applications for getting resources and prevents having to tell one’s story over and over when seeking resources. This might require new public policy that catalyzes standardized policies and procedures and better connections and coordination across systems that children and families use.
- Connect with community organizations about employment and educational opportunities.** Community members suggested participating in education and job fairs and other information exchanges so that communities of color and younger people interested in the healthcare field would know about opportunities. Job fairs could also help parents learn about employment resources and opportunities.
- Explore system solutions for families who face systemic barriers to housing.** Community members expressed a need and hope for healthcare systems to participate in coalitions exploring new housing models designed for intergenerational and kinship living and collaborating to address addiction and domestic violence, including offering outreach and support from peers and professionals for unhoused people, substance and addiction and cleanup of drug use areas.

“parent/caregiver:

Community organizations could come in and do presentations to doctors about what kind of supports they can offer families more efficiently. And doctors might actually (I don’t think they always know what they’re referring to) have heard [community organization] does this and they refer, but then it doesn’t really fit the needs of the family. So doing like reverse where you have community groups coming into the hospital.

- **Provide supportive services for multilingual families.** Community members suggested offering support to multilingual families regarding care, accessing providers and systems (e.g., insurance coverage, billing, etc.).
- **Explore models that simplify access and center families and kids.** Community members of color described how difficult it is to navigate so many systems and want a system where they can be assigned to a “One-Stop Service” model for families that offers one provider/team that they know and has proactive resource supports. CLUES, a community organization that serves the Spanish speaking community in the metro area, has such a model. The Native American Community Clinic (NAAC) has a central location that focuses on health, wellness and dental services and has referral relationships with other proximate resources such as substance abuse programs. Cultural community members also expressed a need for partnership models that support culturally specific and grounded wellness centers and services, including cultural ceremony.



Next steps

The Children’s Minnesota 2025 Community Health Needs Assessment engaged nearly two hundred community members and other stakeholders in a variety of ways. The assessment process and results will guide Children’s Minnesota’s actions, partnerships and strategies moving forward. In the next few months Children’s Minnesota will take the following steps to develop an implementation strategy in response to the assessment:

- Convene the Children’s Community Advisory Council, organizational partners, community stakeholders and internal staff to identify implementation strategies that will be used to address the three focus areas identified in this assessment.
- Develop an evaluation plan to monitor the status and impact of the implementation strategy.
- Establish a communications strategy to update community partners, Children’s staff and the public on what was learned in this assessment.
- Present the final implementation strategy to the Children’s Minnesota Board of Directors and make the documents available to assessment participants, community stakeholders and the public.

Children’s Minnesota plans to continue our efforts to engage community members in our broader work and to maintain and develop new partnerships.

For more information about the 2025 Community Health Needs Assessment, visit childrensmn.org/chna.

Questions? Contact Children’s Minnesota at community@childrensmn.org.

APPENDIX A:

Assessment methodology

Guiding questions

For this assessment, Children’s Minnesota was especially interested in exploring the following questions:

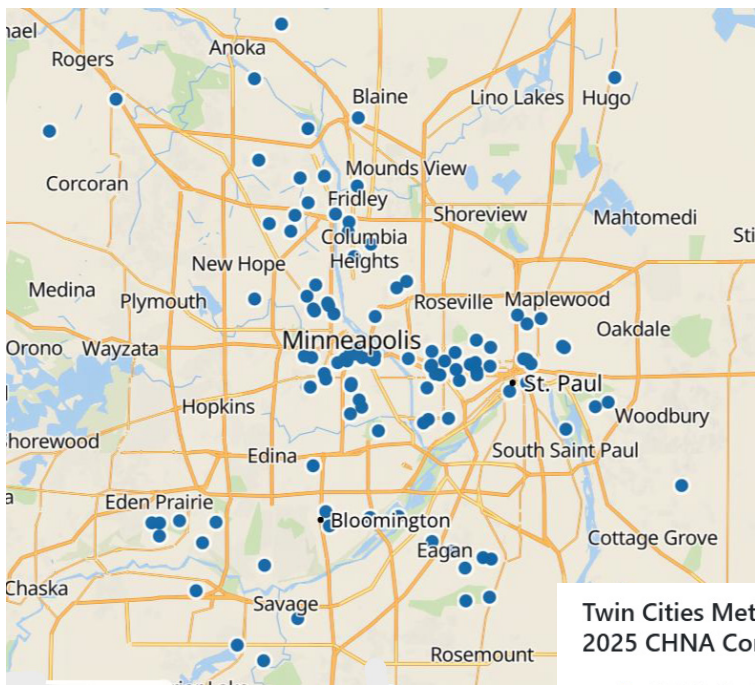
- What are the barriers children and families face when accessing health care?
 - What are those things that make a positive difference in their health care experience?
- What is working well to improve the health of children and families in our communities?
 - How can Children’s Minnesota support these existing community health innovations?
- Where are the resource gaps and assets for families and children in the community related to social determinants of health or social supports that help address the gaps?

Primary research

The primary research was collected from across six different engagement types that engaged nearly 200 people:

- Seven community conversation groups (ranging from 8-22 people each) with specific identified populations: LGBTQ+, Native families, families focused on mental health, families with medically complex children and Multilingual families that speak Somali, Spanish and Hmong.
- An open community convening (large group) reviewed what was collected from the conversation groups to identify any gaps and add to assets and resources, attended by families and youth.
- A virtual community convening attended by organization and partners’ staff and leaders that support families and children
- Two Children’s Minnesota staff conversation groups (small groups) with staff from various departments within Children’s Minnesota.
- One-on-one interviews with Children’s Minnesota leaders.
- One-on-one interviews with community partner leaders.

Community conversation groups were hosted by organizations that served the identified populations. Outreach to participants was done using a combination of the hosting organization’s network, the Children’s Minnesota’s Community Advisory Council and CAL partnerships. Participants began each conversation with a meal, were provided childcare and received a gift card for their time.



Twin Cities Metro Area Distribution of 2025 CHNA Community Participants

● CHNA Participant

All participants were invited to complete a demographic survey that asked about the zip code they live in. The majority of parents/caregivers and youth lived in zip codes within the Twin Cities Metro area. There were a small number of participants from zip codes in Greater Minnesota as well. Of the participants who responded to the demographic survey, the highest zip code concentrations were in St. Paul, Minneapolis, Brooklyn Park, Eagan, Eden Prairie, Bloomington and Columbia Heights.

Secondary research

- Data sources such as the American Community Survey, the Minnesota Student Survey and the Minnesota Department of Health Public Health Data Access Portal were used to characterize demographics, health status and trends in the Children’s Minnesota community.
- Patient data from Children’s Minnesota were used to characterize patient demographics and service information across Children’s Minnesota facilities
- Children’s Minnesota administrative data and U.S. Census redistricting data were used to analyze patient density across the Twin Cities metro area as well as patient spread across neighborhoods in Minneapolis and St. Paul.
- Data from the 2023 Minnesota Homeless Study (Wilder Research), the State of Food Security in Minnesota (Second Harvest Heartland) and Minnesota Licensed Health Care Workforce Data (MDH) were used to provide context around the themes that surfaced from the primary data.
- Other sources include peer-reviewed research and media coverage of public health issues.

Prioritization process

The first iteration of input and feedback from community members was organized and summarized under the six priority health needs identified in the 2022 CHNA. In a facilitated review of the community input, the Children’s Minnesota Advisory Council and Children’s Minnesota leaders noticed three recurring themes that cut across the six priority health needs. They used these cross-cutting results to organize and prioritize the assessment results as shown here.

Current resources used by community members

To ensure that future work builds on resources and services that are currently serving community, community members engaged during the assessment were asked to identify resources they use, trust and value. The graphic shown here highlights only what was mentioned in primary data collection and while the list is not exhaustive, it will inform Children’s Minnesota’s effort to build on current strengths and resources.



APPENDIX B:

Aligning available resources to address assessment priorities

The following highlights resources and initiatives Children’s Minnesota will draw on to address the priorities and cross-cutting themes identified in this CHNA. Many of these initiatives are further described in Appendix C.

Finding and getting **resources** when they are needed

- Continued funding support for the Children’s Minnesota Community Connect and Healthcare Legal Partnership programs to address health-related social needs and ongoing development of cross-sector referral partnerships.
- Family resource centers in Minneapolis and St. Paul hospitals with information for families and food shelf access.
- A financial counseling team that partners with patient families with concerns related to medical expenses and walks them through the entire process of applying for Medical Assistance (MA), TEFRA, Children’s Minnesota financial assistance application for a discount, spend down and Emergency Medical Assistance.
- Ongoing public awareness and advocacy efforts focused on ensuring that children have access to health care through Medicaid, CHIP and other public programs.
- A spectrum of mental health services offered including behavioral health specialists in all of our primary care clinics and inpatient specialty care areas, outpatient mental health services, two partial hospitalization programs and an inpatient mental health unit.
- Continued implementation of the HealthySteps program in Children’s Minnesota primary care clinics.
- Children’s Minnesota is a member of the Mental Health Legislative Network and participates in meetings convened by the Minnesota Children’s Cabinet focused on addressing and identifying gaps in the spectrum of care for children’s mental health — including state leaders, county leaders, hospital staff and advocates.

A network of people who are trained and equipped to provide **care and support** for children and families, considering their culture, history and communication needs.

- A health equity team implementing community engagement strategies and clinical activities designed to reduce disparities.
- A multidisciplinary gender health program that provides compassionate and comprehensive care for transgender and gender diverse youth.
- A Clinic in the Classroom webinar education series where clinic experts from Children’s Minnesota provide ongoing continuing education programming for school nurses across the state.
- An equity and inclusion department focused on creating an inclusive culture at Children’s Minnesota that reflects the rich backgrounds of the communities we serve.

- Implementation and advancement of Respect and Dignity Safety Learning reports and tools for conducting root cause analyses using an equity lens.
- Inclusive leadership training and intercultural development training for leaders and teams.
- Employee resource groups (ERGs) are established at Children’s Minnesota and enhance inclusion and equity efforts and promote community enrichment and development for employees.
- Established relationships with local educational institutions and programs focused on equity and inclusion and creating a pipeline for health care careers.

An environment that can provide safety, equity and be responsive to a diverse population of children and families that need resources, support and care.

- Established partnerships with local and state officials to advance community safety initiatives in areas where our hospitals and clinics — and the patients and employees who rely on them — are located.
- The Midwest Children’s Resource Center which is a child advocacy center (CAC) and clinic within Children’s Minnesota that offers medical evaluations and case management in alleged child abuse cases, serious neglect and witness to violence.
- A trauma and injury prevention department that works in the community to provide information and educational resources to support caregivers in their efforts to keep their children safe in their homes and other environments.
- A large number of Minnesota health systems, including Children’s Minnesota, have declared gun violence a public health crisis. Children’s Minnesota continues to advocate at the state and local level to address gun violence which continues to be the number one cause of death in children nationwide.

APPENDIX C:

Progress since the 2022 CHNA

The 2022 CHNA identified six priorities that were the focus of the Children’s Minnesota 2023–2025 CHNA Implementation Strategy. These priority areas and a brief summary of the impact of the work done to address each area is described below. In addition to the programmatic efforts listed below, these priorities and those of the 2025 assessment will continue to guide the work of the organization and the Children’s Minnesota Collective for Community Health which aims to improve the health of children and families — both inside and outside of our hospitals and clinics — by working together with community partners, policymakers and other organizations.

PRIORITY HEALTH TOPIC:

Structural racism

Goal from 2023–2025 implementation strategy: Eliminate racism and resulting negative impacts on health by advancing health equity through changes in policies and practice, shifts in organizational culture and operations and greater collaboration with community partners.

Objectives:

- Identify and address policies, practices and systemic issues within the organization that contribute to structural racism.
- Further implement an equity impact lens into organizational goal setting, project planning and performance measures.
- Identify and address procedures, policies and practices that influence clinical health outcomes and perpetuate disparities at the point of care.

Operationalizing racial equity as a measure of quality and clinical excellence

- In partnership with the Value and Clinical Excellence Dept, the equity team continues to affirm equity and inclusion as a core element of Children’s value program including re-shaping the organization’s perspective on how and where to focus quality improvement efforts. Specific efforts include the implementation and advancement of Respect and Dignity Safety Learning Reports and tools for conducting root cause analyses through an equity lens.
- The Equity and Inclusion team at Children’s Minnesota consults on key components to service delivery within the care continuum.
- A specific “equity lens” tool has been implemented to enable leaders to identify biases and advance equity within their standard work. These include reviewing organizational policies and practices that could contribute to structural racism.

Changing the system to advance equity

A Children’s Minnesota surgery policy that required all hair braids to be removed prior to surgery was found to negatively and inequitably impact Black children, especially young Black girls. While this wasn’t the intent, the implementation of the policy resulted in Black children and their caretakers being emotionally traumatized when faced with the decision to remove their braids to access surgery.

Children's Minnesota's health equity team partnered with surgical staff and leaders in 2022 to conduct an internal audit and update the policy, eliminating the requirement for braids to be removed.

Intercultural development

- All new employees at Children's Minnesota are required to complete an equity and inclusion session as a part of the New Employee Orientation program. Over 1,200 new employees participated in 2024.
- The Children's Minnesota Equity and Inclusion team administers the Intercultural Development Inventory (IDI) to various departments within Children's Minnesota. In 2024, 166 IDI assessments were completed by Children's Minnesota staff. This assessment helps to gauge where a group of people as well as individuals are in navigating cultural differences. The IDI is also being administered externally through the Children's Health Network to individual clinics around the Twin Cities.
- The Equity and Inclusion (E&I) team is working cross-functionally with Human Resources and Organizational Learning and Development to conduct listening sessions across Children's Minnesota. These sessions are designed to gain a deeper understanding of the meaningfulness of the employee work experience in clinical and non-clinical areas. This information will be utilized to improve retention rates for diverse employees and to continue to advance an equitable, diverse and inclusive organization.
- Clinical departments continue to partner with the equity and inclusion team to develop educational opportunities for staff and leaders, build perspectives and skills around inclusion, the impact of microaggressions, identity, the difference between equity and equality, the Platinum Rule and other aspects of equity and inclusion.

Inclusive leadership cohort training

The Children's Minnesota Inclusive Leadership Cohort Program was launched in 2022 and was strategically designed to engage a diverse group of leaders through a 12-month immersive experience. The second iteration of the program began at the end of 2024 and integrates experiential learning, structured reflection and peer engagement to foster inclusive leadership competencies. Nearly 100 leaders have participated in the cohort training since its launch.

Education and advocacy on equitable and inclusive health care

- The Children's Minnesota Talking Pediatrics podcast includes a specific Equity Actions series hosted by the Children's Minnesota Chief Equity and Inclusion Officer. The series includes regular interviews with leaders from across the country to discuss issues related to health equity, workplace diversity and creating inclusive environments.
- In 2023, Children's Minnesota advocated in partnership with the Minnesota Business Coalition for Racial Equity to pass the CROWN Act in Minnesota, prohibiting racial discrimination based on natural hair texture and hair styles, such as locs, braids and twists.

Health disparities

Goal from 2023–2025 implementation strategy: Build internal capacity and work in partnership with the community to establish goals and implement strategies to significantly reduce targeted health disparities.

Objectives:

- Share available and reliable disaggregated data with the community, including health disparities in vaccination rates and asthma management.
- Work with community partners and patient families to co-create strategies and initiatives to address health disparities, engage them to regularly share progress, refine strategies and prioritize additional health disparities.

Children’s Minnesota health equity team

Children’s Minnesota health equity coaches provide coaching for staff when navigating clinical situations that can benefit from additional insight and support.

Health equity measurement and data collection

Data collection materials have been improved to gather and analyze race, ethnicity and language data that is truly representative of the communities we serve, giving Children’s Minnesota additional opportunities to partner and co-create solutions with those communities.

Partnering to advance health equity

- The Twin Cities metro area is home to a large urban American Indian population and that population experiences some of the highest health disparities. Children’s Minnesota continues to support the “First Gift” program, providing baby moccasins to expecting parents, in partnership with the Native American Community Clinic.
- In 2023 Children’s Minnesota engaged in discussions with Islamic scholars, other health care systems and community partners about the use of pasteurized donor human milk for babies when a mother’s milk is not available. This led to the issuing of a first of-its-kind fatwa or religious clarification from the Minnesota Islamic Council encouraging the practice.
- With support from a grant from the United Health Foundation, Children’s Minnesota engaged in mobile vaccination efforts designed to build relationships with schools and community partners and provide vaccine education and on site vaccination opportunities. Targeted outreach, focused on communities with lower vaccination rates, was supported with internal data collected by the health equity team. To date over 550 vaccines (flu, COVID and childhood vaccinations) have been administered through the Children’s Minnesota mobile clinic outreach program.
- The Children’s Minnesota Community Health Innovation Fund, launched in 2024, is an innovative partnership with Delta Dental of Minnesota Foundation, focused on supporting community-led initiatives to reduce pediatric health disparities across physical, dental and mental health. The fund partners with organizations that advance health equity and other health priorities for children and families identified through the Community Health Needs Assessment process.

Providing gender affirming care

In 2019 Children’s Minnesota launched a first of its kind pediatric, multidisciplinary gender health program that provides compassionate and comprehensive care for transgender and gender diverse youth. The clinic was opened in response to the growing need for gender informed and gender affirming care. The LGBTQ+ population, particularly transgender and gender diverse patients, experience health disparities relative to access to care, insurance coverage and several other health outcomes. This program is part of an ongoing effort to reduce health disparities by ensuring that Children’s Minnesota provides care in an environment that is inclusive and gender affirming.

Children’s Minnesota Community Advisory Council

Children’s Minnesota launched the Community Advisory Council in June 2023 to help advise on strategies for health equity and community engagement. The council works collaboratively with Children’s Minnesota’s Collective for Community Health to ensure representation of diverse community voices.

As part of our mission to be every family’s partner in raising healthier kids, the council:

- Represents and advocates for the communities that Children’s Minnesota serves.
- Engages with the community, including children and families who use our health system to understand their needs.
- Supports the design of programs and projects that positively impact community health, including the development of the Children’s Minnesota Community Health Needs Assessment and the Community Health Innovation Fund grant program.
- Advises on Children’s Minnesota initiatives and strategies.
- Supports Children’s Minnesota in building partnerships and collaborations with community organizations.

PRIORITY HEALTH TOPIC:

Mental health

Goal from 2023–2025 implementation strategy: Identify opportunities for enhanced and more coordinated mental health support for children with an emphasis on early childhood services, early intervention and culturally informed care.

Objectives:

- Identify and develop specific services for at-risk children in early childhood.
- Explore opportunities to strategically address mental health disparities, implement trauma informed care and improve community safety.

Supporting mental health in primary care

- HealthySteps is an interdisciplinary program that promotes the healthy development of babies and toddlers by focusing on positive parenting, supportive resources and parent well-being. The program connects specialists with parents during well-child visits and is continuing to be implemented in the Children’s Minnesota Minneapolis primary care clinic. In 2024, more than 2,500 patients were served by the program. Based on guidance from national HealthySteps, Children’s

Minnesota moved to introduce the Survey of Well-Being of Young Children (SWBYC) in all primary care clinics. The survey is a comprehensive screening tool designed to assess the development and well-being of children under the age of five and is used by healthcare professionals to identify potential developmental or behavioral risks.

- Integrated behavioral health specialists operate in all Children’s Minnesota primary care clinics and inpatient specialty care areas.

Expanding access to mental health services

In 2023 Children’s Minnesota opened a second Partial Hospitalization Program in Roseville, MN. These day treatment programs are designed to meet each child’s emotional and behavioral needs through a combination of therapies during weekdays, with the patient returning home to their family on evenings and weekends.

Supporting families through partnership

- In 2023 with support from the United Health Foundation (UHF), Children’s Minnesota partnered with Phyllis Wheatley Community Center (PWCC) to offer a Parent-Child Interaction Therapy Group at PWCC. The goal of the group was to intervene early with parents of young children who were exhibiting challenges in their social, emotional and/or behavioral functioning and help to improve their functioning and facilitate long-term outcomes.
- The United Health Foundation also supported Children’s Minnesota’s efforts to continue to expand the Bridging program. There are currently two bridging therapists on the mental health team that work to bridge gaps of care for patients that move through the continuum of services Children’s Minnesota offers. UHF support enabled the program to add referrals to Bridging from the emergency department so that when children arrive at the emergency department in mental health crisis, but do not meet criteria for acute services, they can be referred to Bridging care. To date more than 50 referrals have come from the emergency department with Bridging therapists working to see those patients and make a closed loop referral to community programs.
- Children’s Minnesota and Washburn Center for Children continue to partner to support patient access to the Washburn Acute Response Model (WARM) program. The program is critical service for families following an emergency department or clinic visit for a young person experiencing a mental health crisis. Research shows that this kind of therapeutic support for youth makes it less likely to have another similar incident.

Advocating for kids’ access to mental health care

Children’s Minnesota continues to partner with coalitions and policy makers to advance policy and system wide solutions to support the mental health of children and end the crisis of patients stuck in hospitals waiting for community placement.

Economic opportunity and income

Goal from 2023–2025 implementation strategy: Invest in economic and employment opportunities for all the communities Children’s Minnesota serves.

Objectives:

- Increase investment of resources into local community businesses through supplier contracts and sponsorships
- Increase employment opportunities for the communities Children’s Minnesota serves, including patients and families themselves.
- Implement training, recruitment and retention strategies to achieve organizational work force diversity, equity and inclusion goals.
- Expand programs that help families access social supports and public benefits.

Investing in community business

- Children’s Minnesota is continuing to develop and implement a sustainable framework for supplier diversity. This framework is focused on intentionally engaging with community businesses that represent the communities Children’s Minnesota serves.
- Partnerships with Business Bridge, Women’s Business Development Center and the Black Chamber of Commerce have expanded Children’s Minnesota’s access to community vendors.

Pipeline for health care careers

- With support from a Department of Labor workforce grant, Children’s Minnesota has created a comprehensive scholarship program aimed at recruiting, training and retaining skilled professionals in high-need roles including Certified Registered Nurse Anesthetists (CRNAs), Maintenance Engineers and Respiratory Therapists (RTs).
- Children’s Minnesota has partnered with the People of Color Career Fair platform and it is utilized regularly by recruiters.
- Established in 2019, the Children’s Minnesota Summer Equity Internship Program provides opportunities for diverse high school and college students to learn and engage in areas that they potentially see as a future career opportunity. More than 100 students have completed the program since its launch.
- In 2024, Children’s Minnesota supported legislation to create an alternative pathway to social work licensure, which was a critical step toward creating a more equitable licensure process in Minnesota. This has supported a need to hire more social work professionals that represent the communities Children’s Minnesota serves and has led to more opportunities for social workers currently working at Children’s.
- Children’s Minnesota participates in the Minnesota Dual Training Pipeline grant program which enables the organization to provide paid on-the-job training and tuition support for specific clinical roles.
- Eight tuition discount partnerships have been established with universities to support Children’s Minnesota employees looking to further their education.

Continuous Medicaid eligibility for children in Minnesota

In 2023, Children’s Minnesota joined a number of organizations and coalitions in advocating for continuous Medicaid eligibility for children. The law that was passed ensures that Minnesota children supported by Medicaid will maintain consistent access to health care coverage throughout childhood.

PRIORITY HEALTH TOPIC:

Access to resources

Goal from 2023–2025 implementation strategy: Expand programming and partnerships that connect patients and families to essential resources to positively impact overall health, development and well-being.

Objectives:

- Expand screening and referrals for health related social needs to serve more patient populations.
- Build upon existing relationships and explore new partnerships to foster mutually beneficial collaborations with community-based organizations, schools and other key entities to streamline communication, service delivery and information sharing for patients and families.

Community Connect

- The Children’s Minnesota Community Connect program was launched in 2017 in our Minneapolis and St. Paul primary care clinics. In 2022, the program expanded to serve patient families at Children’s Minnesota’s West St. Paul and Brooklyn Park clinics.
- The program continues to screen families for unmet social needs and connects them with Resource Navigators. In 2024, a total of 1,640 families were able to meet with a navigator equipped to help them find responsive resources and support them with follow-up services.
- Community partnerships are the key to ensuring seamless referrals and access to resources.
- In 2024, Children’s Minnesota launched and implemented the FindHelp, a social health screening technology platform that allows staff to access a database of local services and directly connect with community-based organizations serving families in Minnesota.

Universal school meals

In 2023, as a part of the Hunger Free Schools Coalition, Children’s Minnesota advocated in support of universal school meals for Minnesota students, sharing with lawmakers the physical, mental and developmental health benefits of students having guaranteed access to meals in school.

Healthcare Legal Partnership

- Launched in 2017, the Children’s Minnesota Healthcare Legal Partnership (HLP) continues to support two attorneys based on the St. Paul and Minneapolis hospital campuses, along with a dedicated intake coordinator. These dedicated lawyers and staff collaborate with healthcare teams to identify, prevent and remedy health-harming factors that are rooted in legal problems.
- In 2024, the Healthcare Legal Partnership provided services in 218 cases across multiple legal issues including: housing, education, employment, benefits, family law and immigration.

Clinic in the Classroom

- The Clinic in the Classroom webinar series was launched in 2021 and supports school nurses across the state with content that is eligible for continuing education credits. In 2024 1,682 school health staff attended a live webinar or viewed the recording later for credit. The content was focused on mental health, eating disorders, concussions, nature exposure for kids, ADHD, supporting children with cancer, non-epileptic events and postural orthostatic tachycardia syndrome.
- Content for the series is informed by an advisory group that includes various school district health professionals, Children’s Minnesota providers and representatives from the state health department.

PRIORITY HEALTH TOPIC:

Community safety

Goal from 2023–2025 implementation strategy: Partner with local and state officials, health systems and community organizations to address gun violence in the community and ensure equitable, safe and secure environment for patients, families and employees.

Objectives

- Strengthen cross sector partnerships to enhance the capacity of community-based organizations to promote healthy youth development, improve safety and build stronger, resilient neighborhoods.
- Increase access to trauma services and culturally responsive substance use and mental health treatment for children, adolescents and their families.
- Train staff, clinicians and leadership about local trends and the role of health care in reducing violence, including how to screen and provide resources for patients and families.

Supporting safety and security through partnership

- Children’s Minnesota’s security team continues to engage a multidisciplinary advisory committee, including coordination with local officials to support an equitable, safe and secure environment for patients, their families and employees.
- Children’s Minnesota also meets regularly with local law enforcement and the Minneapolis Office of Community Safety to raise specific concerns and collaborate on solutions and planning related to emergency preparedness and community and staff needs.

Next Step partnership

In 2023, Children’s Minnesota began partnering with Next Step, a hospital-based violence intervention program that connects survivors of violent injury to resources and support, helping survivors and their families heal.

Trauma and injury prevention outreach in the community

- The Children’s Minnesota trauma and injury prevention team does regular outreach in the community, distributing safety equipment such as bike helmets, car seats and home safety items including cabinet and window locks.
- The trauma and injury prevention team also hosts regular child passenger safety trainings in multiple languages. In 2024 more than 100 Child Passenger Safety Technicians were trained.
- In 2024 the trauma and injury prevention team led two out of state classes for the Safe Travel for All Children curriculum, designed to assist families with children who have unique medical conditions that may prevent effective use of retail-available seats.

Gun violence prevention

- At the Minnesota State Capitol and at the local level, Children’s Minnesota continues to advocate in support of common-sense gun regulations, expanding access to mental health services and improving school safety.
- With philanthropic support, Children’s Minnesota has been able to more regularly distribute gun locks and lock boxes to patients and families who are seeking mental health support and would benefit from reduced access to lethal means.
- A study, led by a Children’s Minnesota physician researcher, focused on implementing a firearm screening program in Children’s Minnesota emergency departments. The purpose of the study was to determine the most effective screening language for firearm exposure and uptake of a secure storage device through a randomized controlled trial. It was found that open ended and non-judgmental language improves uptake of secure storage devices by caregivers.
- Staff education related to the Next Step program, the study mentioned above and other research continue to highlight the role that health care providers and systems can play in reducing violence.
- In 2024, former Children’s Minnesota President and CEO, Marc Gorelick, MD, released his new book, “Saving Our Kids: An ER Doc’s Common-Sense Solution to the Gun Crisis.” Since his retirement in 2025, Dr. Gorelick continues to be an advocate for addressing the public health crisis of gun violence through policy and systems change.



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