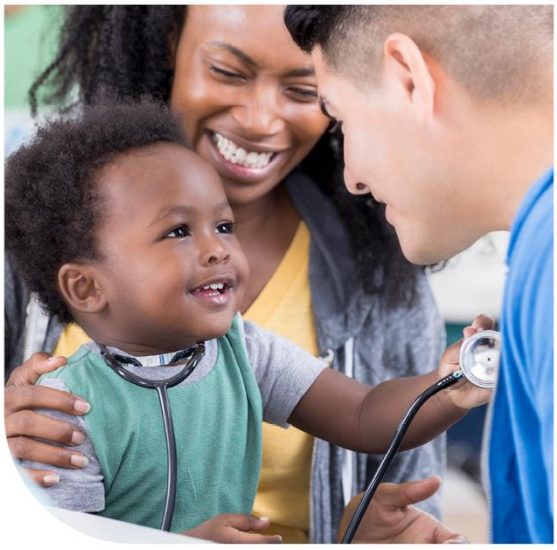
Hennepin County
Public Health



Community Health Assessment

2024-2028

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Acknowledgments

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Hennepin Healthcare

Annex Teen Clinic

NorthPoint Health & Wellness

Northwest Family Resource Collaborative

CAPI, Inc.

The Aliveness Project

Age Friendly Hennepin

Pillsbury United Communities

COPAL

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About this report

Hennepin County Public Health prepares a comprehensive assessment of the health of its residents every five years. The report is available on the Hennepin County website at: www.hennepin.us/publichealthdata

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Director's letter

Thank you for your interest in Hennepin County's 2025 Community Health Assessment. Every five years, Hennepin County Public Health works to identify assets and challenges affecting the health and well-being of our community. This process — called a community health assessment (CHA) — helps us understand priority issues our communities face. This allows us to develop and implement strategies for action that advance race and health equity through disparity reduction efforts, improve community well-being, and offer programs and services that help our residents be healthy. More information on the disparity reduction domains can be found on the county's website.

Our process and findings

Over the course of 18 months, we completed the qualitative and quantitative assessments. The community health assessment included an in-depth and broad review of data topics. These included measures of social and environmental factors that contribute to the health of our communities. Equally important, the assessment included a range of conversations with county and community partners and youth mental health professionals. The assessment also included findings from local health systems' needs assessments and the county's community engagement activities. Across all community inputs, we identified 30 themes across 10 health domains. These included:

- Overarching themes, such as racism and COVID-19
- Physical surroundings
- Access to basic needs
- Safety and violence
- Connectivity and social isolation
- Barriers to health care
- Quality of care for all
- Maternal and child health
- Chronic diseases
- Mental health
- Substance use

These themes were presented to community members, who voted to prioritize mental health, social isolation, substance use disorder, access to basic needs, and barriers to health care for Hennepin County Public Health's future work.

Our commitment and next steps

Hennepin County Public Health and our partners — the Community Health Improvement Plan — will use the assessment in its process of identifying two priority areas of focus and formulate strategic health goals for five years to come. Hennepin County Public Health will focus on these priorities with the goal of improving the health of all residents by addressing the social and environmental factors that affect their health and to advance race and health equity.

The Community Health Assessment and the identified health priorities are shared with the Community Health Improvement Plan partners, a joint effort of Hennepin County, Minneapolis, and Bloomington-Edina-Richfield health departments. This committee will engage and involve community in our health improvement processes, as well as co-design a path forward to improve health for all.

Sara Hollie, MPH
Hennepin County Public Health Director

Executive summary

The Hennepin County Community Health Assessment (CHA) is a summary of the health and well-being of Hennepin County residents, and the social and environmental conditions that affect their health. This assessment aims to build a holistic picture of health, identify emerging trends, and recognize health inequities, using diverse data and information sources. The CHA supports prioritization of health issues for the Community Health Improvement Plan (CHIP), which develops activities to improve priority health issues across the county. The CHA also contributes to Hennepin County Public Health's accreditation for the Public Health Accreditation Board (PHAB). The CHA is produced every five years.

This assessment recognizes that health is affected by nested layers of factors. The CHA analysis is partitioned into three layers: systems of power, privilege and oppression (or root causes), social determinants of health, and health behaviors and outcomes.

Systems of power, privilege and oppression (root causes)

Root causes are long-standing cultural or institutional structures, historical factors, or large-scale recent events, that impact the health and well-being of whole communities. Some root causes identified through this assessment include:

- The COVID-19 pandemic continues to impact residents, through issues such as increased medical mistrust and social isolation, and less use of primary care.
- Racism is a long-term society-wide issue that impacts health opportunities and outcomes for racially and ethnically diverse populations.
- High levels of cost inflation in recent years have increased residents' insecurity in attaining basic needs.
- Social and physical environmental qualities that promote health are not equally distributed across Hennepin County, and safety is a concern.
- There are gaps in providing culturally appropriate and holistic health care for all.

Positive and protective community factors include:

- Community members want access to services, are willing to trust, show-up and build.
- Older populations are looking for opportunities to actively participate.
- Public health workers see policy changes such as universal free breakfast and lunch in schools, driver's licenses without citizenship, and decriminalization of drug paraphernalia as opportunities to improve health.
- Some organizations are investing in racial and health equity approaches, and conversations are occurring.

Social determinants of health (SDoH)

The conditions of residents' everyday lives shape opportunities to live and grow, which in turn affect health outcomes. Because there are disparities in opportunities to thrive, there are disparities in health and well-being. Challenging SDoH trends include:

- 1 in 10 adults report experiencing food insecurity.
- Renters' eviction numbers in 2023 were double that of 2019 pre-pandemic numbers.
- Growth in the unhoused population is driven by families who are losing housing.
- 1 in 10 adults report usually or always feeling isolated.
- More than half of adults that wanted mental health care delayed seeking care. Respondents reported that accessing mental health care was especially difficult.
- Transportation, language, technology, and lack of trust are common barriers to attaining health care, in addition to insurance and cost barriers.

However, some SDoH indicators are improving:

- The percent of residents without health insurance is slowly decreasing over time, though disparities remain in health insurance access.
- Unemployment is low and has returned to levels before the COVID-19 pandemic.
- High school graduation rates have increased steadily in the last 10 years, and disparities in graduation rates have narrowed.

Health behaviors and outcomes

There have been improvements and setbacks in residents' health. Some indicators that are worsening include:

- More adults are reporting their general health as fair or poor, and there are significant disparities in this indicator.
- African American and American Indian residents are more likely to die prematurely (Years of Potential Life Lost indicator).
- One in 3 adults want to seek help from a mental health professional.
- Students are reporting more mental health problems. Girls and LGBTQ+ identified students are more likely to report mental health problems.
- Childhood immunization rates have decreased since the COVID-19 pandemic.
- Opioid-related deaths increased in 2020 and have remained high since; this issue disproportionally impacts some communities.
- Accidents, including drug overdoses, have emerged as a top cause of premature death.
- Sexually transmitted infection rates have increased in the last decade.
- Significant disparities remain in maternal and infant health and mortality.

Notable strengths or improvements or in residents' health include:

- Teen birth rates have declined.
- Three in 4 adults, and 4 in 5 youth, have recently visited the dentist, exceeding the U.S. rate.
- Adult tobacco use has declined over 20 years and is at an all-time low.

- Adult alcohol hospitalizations have declined over the last 5 years, although many young adults engage in heavy or binge drinking.
- Youth alcohol, cannabis, and tobacco use is declining. E-cigarette use also has declined since 2019.

Introduction

What is a community health assessment?

The Community Health Assessment (CHA) serves as a foundational document in implementing the Hennepin County Public Health mission to "improve the health of all county residents by addressing social and environmental factors that impact their health and offering programs and services that help them be healthy." As a vital function of public health, the CHA assesses the health status of the population and supports identifying and understanding the root causes of health problems in our community. It shows us which health concerns are most common, finds new health trends, and helps describe their impact on the lives of residents. This assessment also explores links between social and environmental factors that influence the health of county residents.

Health equity is a Hennepin County Public Health value, which is reflected throughout the body of this assessment. While we know that our community in Minnesota typically ranks highly in overall health, there are significant disparities in our communities' abilities to achieve good health. In many ways, health disparities by race in Minnesota and Hennepin County are among the worst in the country. In this assessment, health trends are analyzed by racial and ethnic group, when possible, given available data sources. Showing health inequities by race and ethnicity is an important step toward addressing the impact of race and racism on health in Hennepin County.

A main goal of this assessment is identifying populations at highest risk or with the greatest need to prioritize work to improve health and reduce disparities. Our general process in this work was to document the status of a health behavior or outcome, explore trends over time, and consider different demographic dimensions through which populations' health might be impacted. Status is determined through a combination of quantitative and qualitative approaches. Health outcomes were investigated by age, life stage, sexual orientation, gender identity, and race or ethnicity, as well as social determinants of health, such as income, education, and geography. This assessment is built on an understanding of disease causation and risk that may be experienced differently among diverse communities, leading to disparate outcomes. Marginalized populations, including racially and ethnically diverse populations, sexual and gender minority communities, and others, are significantly more likely to experience negative health outcomes per this assessment.

This assessment defines health as a product of multiple levels of influences, accounting for social, environmental and structural influences on individual-level health behaviors and outcomes. As such, nearly 40% of this health assessment describes the status of root cause and social determinants of indicators throughout Hennepin County that are understood to impact opportunities for health. Additional context is added through information about recent policy changes and community reported strengths, assets and networks that impact residents' health.

The CHA is produced every five years to update our understanding of residents' health in Hennepin County. The assessment is intended to be available and understandable to all professionals and residents interested in the current state of health in Hennepin County. The information in this assessment is used by the Community Health Improvement Plan to determine health priorities, and related activities and goals to address those priorities, that will guide the work of Hennepin County health for the next five years.

Approach

Hennepin County staff led the formation of a CHA Steering Committee to guide to assessment of the current state of health in Hennepin County while including diverse voices and sharing power with the community, especially the most marginalized, ultimately enabling the community members to live their most healthful lives. Recruitment for the steering committee members started with invitations to our local health department colleagues, health system partners with whom we had existing relationships and CHIP steering committee members. The CHA Steering Committee met monthly from December 2023 until February 2025. The steering committee also helped refine the following value statement that guided the CHA process:

- Inclusiveness: We respect all people and create equitable opportunities for diverse people and perspectives to be involved in the CHA process
- Transparency: We will be open and clear with our partners and the broader community about the CHA process, findings, and related decisions
- Continued improvement: We iteratively assess, reflect, and enhance CHA processes and results to support HCPH in achieving the best possible health outcomes for our community

The committee selected the Mobilizing for Actions through Planning and Partnerships (MAPP 2.0) framework, created by the National Association of County and City Health Officials (NACCHO) as a guide to the CHA process and concepts. MAPP 2.0 specifies both a Community Context Assessment (CCA) approach to capture qualitative perspectives of residents on community health, and a Community Status Assessment (CSA) approach for identifying and analyzing quantitative health indicators, to determine status, trends, and disparities. In the remainder of this CHA, we refer to these two components simply as the qualitative or quantitative assessment.

Hennepin County staff used the qualitative assessment to frame the 2025 Hennepin County CHA for two reasons. First, the qualitative information generated from this CHA process, as well as the critical insights it can provide concerning quantitative data, are a unique contribution of CHA work relative to health indicator dashboards, which are now widely in use at Hennepin County and updated more frequently. Second, the qualitative information reflects the health observations, attitudes, values, and priorities from a community perspective and experience, which we wish to center. This CHA begins with an overview summary of qualitative findings. Specific themes and additional insights are found in relevant quantitative data sections

throughout to provide a holistic picture of health. Thirty themes were identified as priorities through the qualitative assessment.

Four qualitative projects were completed to round out the qualitative assessment:

1) *Key informant interviews of county and community partners.* A semi-structured interview tool was developed based on MAPP 2.0 guidance, with questions on environment, policy, safety, community strengths and resources, social determinants of health, and health behaviors and outcomes. Fourteen interviews were completed, representing 15 Hennepin County and community partners. Themes were generated from the analysis. Results were reviewed by the CHA Steering Committee.
2) *Key informant interviews on youth mental health.* Youth mental health was deemed a likely public health priority at the initiation of the CHA process. Health systems providers were interviewed to identify priorities, challenges and opportunities concerning youth mental health. Three interviews were conducted, and content analysis was completed.
3) *Review of Community Health Needs Assessments (CHNA) of Hennepin County health systems.* Publicly available health systems' CHNAs were collected and reviewed for information regarding needs, barriers, successes and priorities as communicated by residents through community engagement efforts. Six CHNAs were analyzed using content analysis.
4) *Review of Hennepin County Public Health community engagement inventory.* Record review of community engagement documentation generated by Hennepin County public health programs was conducted. Fourteen programs provided publicly sharable records from 23 evaluation projects for the analysis. Content was analyzed for emerging common concerns, gaps in health care, and preferences among residents.

Quantitative data indicators were sought for four areas of analysis, per MAPP 2.0 guidance: 1) systems of power, privilege and oppression, 2) social determinants of health, 3) health behaviors and outcomes, and 4) demographics. Indicators were identified in

Hennepin County recognizes that health is impacted by multiple levels of inputs: the individual, their family and community, the local environment, and society wide practices and narratives. MAPP 2.0 breaks these layers of impact into three categories, which we follow in this assessment to create a holistic picture of health and understand potential for improved health:

Systems of Power, Privilege, and Oppression: Represent the root causes, or structural drivers, of inequity, including policies, practices, programs of institutions, narratives, and norms that contribute to adverse outcomes and conditions for communities.

Social Determinants of Health (SDoH): The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Health Behaviors and Health Outcomes: Health behaviors are actions people take that affect their health. Health outcomes, such as diagnoses and deaths, represent how healthy a community is right now.

two successive rounds. In the first round, a large list of possible indicators was created from record, literature and media review, and MAPP 2.0 suggestion; the large list was reduced to 71 indicators by CHA working group and steering committee review. Next, themes from the qualitative assessment identified additional topics for consideration for which supporting quantitative data was sought. A total of 129 quantitative indicators are used in this CHA.

Data use and limitations

Hennepin County collects self-reported resident health data through the SHAPE survey; however, all other data sources in this document are from outside of Hennepin County. The data sources from outside our jurisdiction may reflect some methods and choices beyond our control.

Regardless of source, every data analysis has limitations. Among them, any single piece of data does not tell the entire story, and multiple pieces of information, including qualitative context, can help build a better understanding. Data can help inform decisions and develop priorities, but data are not the only factor that influences decision-making. Finally, data analysis that shows a relationship between two variables are associations, and do not tell us about causation.

This assessment reflects data current as of January 2025. In keeping with the framework of foundational public health capabilities, however, we continue to update data for assessment and surveillance, performance management, and data-informed decision-making throughout Hennepin County Public Health. Data management, processing, and reporting are continually improved through data modernization. These efforts received a significant boost through American Rescue Plan Act (ARPA) funds allocated through Board Action Request (BAR) 21-0381. This funding expanded public health staffing including creating the public health informatics unit along with technical support and resources. This work aligned with an enterprise-wide focus on data modernization supported by ARPA funds allocated by BAR 21-0340. The Hennepin County public health data provides an inventory of the ever-growing public-facing data available for public health, health care, and community partners.

About demographic categories in data

Race and ethnicity data, and sexual orientation and gender identity data, are collected via various sources including self-reported information in medical records and survey responses, by next of kin report in birth and death records, among others. Demographic categories in any data collection process may not reflect the full range of identities or experiences, and data sources differ in use of categories.

In this assessment, comparisons by race and ethnicity are made using broad race and ethnicity categories based on limited options for self-identification in data sources and surveys. Data available from these sources cannot reflect the differences among ethnic groups and nationalities within the broad race and ethnicity categories. It is important to report data by race

and ethnicity to reflect the diversity of the population in Hennepin County. This has been able to show some indicative health inequities associated with race and ethnicity It is also important to note that the data does not tell the whole story given limitations.

SHAPE 2022 collected gender identity data using a 2-part self-report question, the first with options for nonbinary, male, and female, and the second with options for transgender identity. Sexual orientation data from SHAPE 2022 is presented as LGBQ+ (lesbian or gay, bisexual or pansexual, queer, questioning or something else) while sexual orientation data from the Minnesota Student Survey (MSS) is presented as LGBTQ+ (lesbian, gay, bisexual, transgender, queer, questioning) to reflect survey response options. In some data sources, gender classification options were limited to a binary sex model (male and female) and may not accurately reflect a respondent's gender identity. Where possible, data was reported by sexual orientation and gender identity to highlight inequities, not to indicate that being cisgender or heterosexual is the standard.

Crude (actual) rates and age-adjusted rates

This assessment uses both crude or actual rates and age-adjusted rates, depending on the data being analyzed. Crude rates reflect actual occurrence or commonness of a characteristic in the population. They are good for planners who want to know the size of the need of the population. Age-adjusted rates are used when two or more populations are being considered, and the populations' data are statistically adjusted to have the same age structure, so that the groups are comparable. Age-adjusted rates allow accurate comparison of groups, and for example, show health inequities, but they do not tell us the actual rates. Depending on how skewed the actual population is by age (e.g., very young or very old), age-adjusted rates can differ substantially from crude rates, and they should not be compared. In this assessment, when age-adjustment is used, the data are adjusted to 2000 U.S. Census data as a standard population.

Data sources

Each data source used has its own limitations as well, which restrict how data can be interpreted or what they might indicate. Below are brief descriptions and limitations specific to main data sources used in this assessment.

Minnesota Student Survey (MSS)

The Minnesota Student Survey (MSS) is one of the longest running youth surveys in the nation. A triennial survey that began in 1989, the survey is an anonymous statewide school-based survey conducted to gain insights into the world of students and their experiences, given to students in grades 5, 8, 9 and 11. The survey asks students about their activities, opinions, behaviors, and experiences. Students respond to questions on school climate, bullying, out-of-

school activities, health and nutrition, emotional and mental health, relationships, substance use and more. Questions about sexual behaviors are asked only of 9th and 11th grade students.

Some limitations of the MSS include:

- Variable response rate by district and grade
- Trend data set only includes districts participating in every year of trend analysis
- Minneapolis Public Schools not represented due to inconsistent participation over time
- Data are self-reported and subject to recall bias

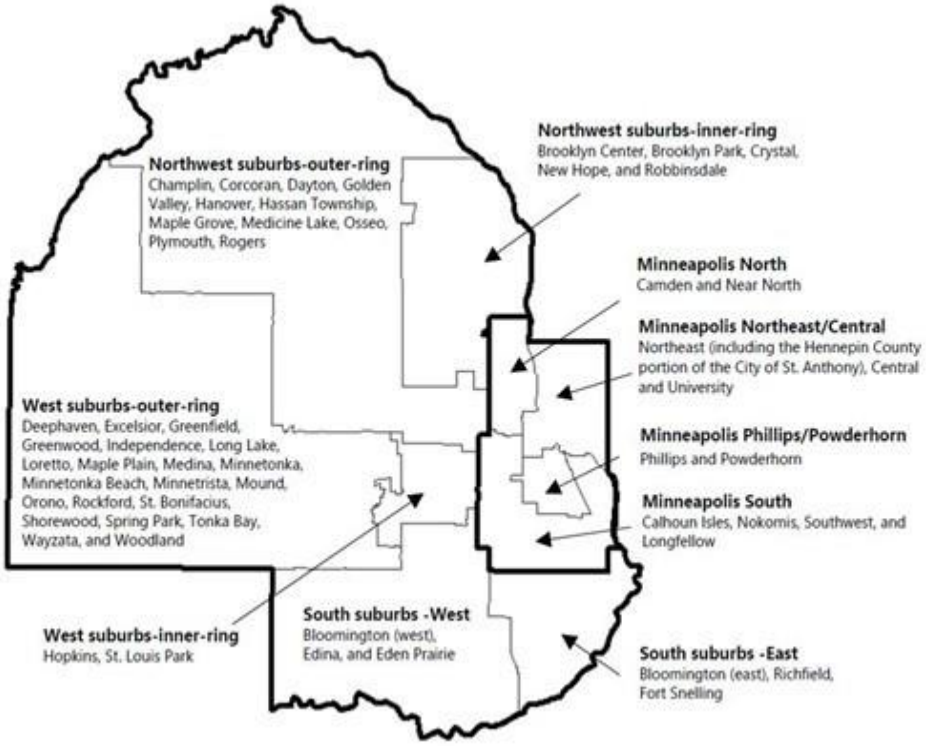
Survey of the Health of All the Population and the Environment (SHAPE)

The 2022 Survey of the Health of All the Population and the Environment, or SHAPE 2022, is the latest implementation in a series of surveys collecting information on the health of Hennepin County residents and the factors that affect their health across a broad range of topics. SHAPE results help us understand how healthy residents are, examine differences in health among different communities, and understand how social factors such as income, education, and housing stability affect health. SHAPE was initiated in 1998, and has repeated the effort every four years since, including data collection iterations in 2002, 2006, 2010, 2014, and 2018.

The SHAPE survey includes race and ethnicity subgroups when there are sufficient responses. For these graphs, Southeast Asian are people who indicated they are Hmong, Cambodian, Laotian, Thai, Vietnamese or Burmese. U.S.-born Black and foreign-born Black are based on responses to the question, "were you born in the United States?" An inclusive definition of American Indian or Alaska Native was used that included those who self-identified as such or checked the response in combination with one other race. Hispanic or Latino/a ethnicity included all respondents who checked Hispanic or Latino/a, excluding those included in the American Indian or Alaska Native group. Some limitations of SHAPE 2022 include:

- Low response rate (22.6%), and non-response bias affect the ability to generalize
- Respondents with limited English proficiency were under-represented
- Small sample sizes limit ability to report some crosstabs
- Data are self-reported and subject to recall bias
- Results are only generalizable to county adults who live in households with a residential address
- Results are subject to respondent self-selection bias in both the mail and in-person data collection methods

The SHAPE 2022 survey reported data for 10 geographic areas. Data for the city of Minneapolis, all suburban Hennepin County areas, and three suburban divisions are included.



U.S. Census and the American Community Survey (ACS)

The U.S. Census is conducted every 10 years and is the most accurate count of the population. The American Community Survey (ACS) is an ongoing survey that provides vital information on a yearly basis about our nation and its people. ACS estimates are available as 1-year and 5-year estimates. This assessment uses ACS 5-year estimates (2017 – 2021) to create population denominators for births and deaths vital statistics data to calculate rates and percentages. When age-adjusting was used, the population was standardized to the 2000 U.S. Census population. Limitations of these data include:

Census

- Data only includes individuals who earned wages in the U.S.
- Short form only, basic demographics only

American Community Survey

- Estimates, not actual counts such as with census

- One-year and 5-year estimates are available and used appropriately throughout this assessment. Five-year estimates are more accurate than one-year estimates, and available at the census tract level, but less timely
- Margin of error increases as geographic unit decreases in size (i.e., tract versus county)

Minnesota Vital Statistics

The Minnesota Vital Statistics System (MVSS) is a part of the Minnesota Center for Health Statistics (MCHS) at the Minnesota Department of Health. The MVSS compiles statistical data on all births, deaths, infant deaths, and fetal deaths of Minnesota residents. These data are provided to MVSS by the Office of Vital Records, the state entity responsible for registering the facts of birth and death in Minnesota using information submitted by hospitals, clinics, or medical examiners. Limitations of these data include:

Birth records

- Medical record extraction for some elements is inconsistent
- Race and ethnicity categories inadequate
- Race and ethnicity category changes over time, which makes reporting trends challenging

Death records

- Race and ethnicity reported by other than decedent
- Cause of death could be influenced by death reporting practices of certifiers

Health Trends Across Communities (HTAC)

The Health Trends Across Communities (HTAC) project offers a unique and valuable source of information on a range of chronic, behavioral, and mental health conditions in Minnesota. HTAC provides trends in prevalence data for high-priority health conditions across the state and information by patient characteristics. Some limitations of HTAC include:

- The 11 largest health systems in Minnesota participate in HTAC. Information represents health care for over 90% of Minnesotans. However, not all health systems and health services in the state participate in HTAC and provide summary information.
- The reports only include people who received health care at one of the participating health systems within a certain timeframe.
- For some conditions, the reporting relies on people disclosing certain health behaviors, such as substance use.
- Clinical information is collected by health systems mainly for billing or patient care, not for community health.

- Data are influenced by human practices, such as provider practices in diagnosing and documenting in electronic health records (EHR) records, errors or incomplete information in EHR, especially when it is not required. These factors could lead to issues with quality.
- EHR data currently does not give us detailed information on ethnicity, gender identity, health behaviors, and social and environmental factors that affect health.

Minnesota Electronic Health Record (MN ERH) Consortium

The EHR Consortium includes hospitalization data for opioids and other substances. The CHA reports data that are not age-adjusted and calculated rates from ACS 1-year estimates.

Additional data sources

- Behavioral Risk Factor Surveillance System, Minnesota data 2022
- Center for Disease Control and Prevention WONDER datasets
- Hennepin County Who We Serve Dashboard
- Johns Hopkins Center for Gun Violence Solutions
- Minnesota Department of Education, graduation rates
- Minnesota Department of Employment and Economic Development (MNDEED), unemployment statistics
- Minnesota Department of Health Violent Death Reporting System
- Minnesota Department of Health, Minnesota Center for Health Statistics, youth tobacco
- Minnesota Department of Human Services Aging Data Profiles
- Minnesota Department of Health Refugee Health Statistics
- Minnesota Hospital Discharge Data (MNHDD)
- Minnesota Immunization Information Connection (MIIC)
- Minnesota State Demographic Center Projections data and report (May 2024)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) data
- U.S. Bureau of Labor Statistics Occupation and Wage Statistics, Consumer Price Index
- U.S. Centers for Disease Control and Prevention
- U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
- U.S. Department of Housing and Urban Development, HUD Exchange, Homelessness Assistance, Continuum of Care (CoC) Homeless Populations and Subpopulations Reports.

Community partners and assets

There are numerous school districts, cities, coalitions and agencies throughout Hennepin County working to address health issues and health equity. The following list describes some of the closest partnerships in Hennepin County Public Health, with specific efforts to reduce health disparities and inequities.

American Lung Association
Annex Teen Clinic
Association for Nonsmokers - Minnesota
CAPI USA
Division of Indian Work
East Side Neighborhood Services, Inc.
Family Tree Clinic
Hennepin Healthcare System, Inc.
Indigenous Peoples Task Force
Loaves and Fishes Too
Lowry Hill East Neighborhood Association
Minnesota Breastfeeding Coalition
Native American Community Clinic
Neighborhood HealthSource
North Memorial Health Care
NorthPoint Health & Wellness Center, Inc.
Open Arms of Minnesota
Pillsbury United Communities
Planned Parenthood Minnesota, North Dakota, South Dakota
Second Harvest Heartland
Southside Community Health Services, Inc.

Qualitative summary findings

The COVID-19 pandemic was a top force of change theme, even though we are now five years since the pandemic start. Respondents discussed pandemic effects in 2024 as indirect and long-term. Respondents believed that the pandemic worsened social determinants of health and outcomes for those that were already facing challenges. Preventive and chronic disease care were disrupted during the initial years of the pandemic, and gaps remain in getting back to pre-pandemic levels of routine care. Early in the pandemic response, there were policies and funding that supported residents, but some of those resources have expired. Health care staff experienced burn out and left during the pandemic, and staffing challenges remain and affect capacity for health care delivery.

> Quote: [Some] people were able to go to their cabins versus communities of color are now in a two-bedroom apartment and they're supposed to help their kids with school. And a lot of service jobs went away. So now you have unemployment, and I don't even know how to teach my kid. And then I need assistance with my rent. [...] When we started trying to do things, what they said was normal, normal was abnormal, but we kept saying, oh, we wanna get back to normal. It was abnormal. Yet we did nothing to provide therapy or conversations around COVID.

County and community respondents also identified additional forces of change that were equally as important. Respondents shared that the murder of George Floyd, concerns about police aggression, and the social unrest of the summer of 2020 are still impacting individual and community safety and feelings of safety. Economic inflation, which was at a decades-long peak in 2023, has affected household purchasing capacity and increased insecurity for some residents. Increases in immigration, notably from Latin America, has resulted in an increased need in resources to support newly arrived residents. Finally, policy changes — both positive and challenging — continue to influence health in Hennepin County. National level policies on abortion access and LGBTQIA+ health care access have made Minnesota a destination for care, increasing demand at relevant Minnesota health providers. In 2023, Minnesota decriminalized possession of drug paraphernalia, a change that many see as positive that improves outcomes for residents. Other notable policy changes are mentioned in relevant sections of the CHA indicators.

Quote: We just got the ability to hand out safe smoking supplies last fall. Previously that was considered drug paraphernalia under state statute, and so we weren't able to hand that out. [...] So now we can handle it safe, which is a big public health win ...

Long-term and ongoing root causes that impact residents' health was also identified. Racism exists, in both direct and systemic forms, and affects all levels of social determinants of health and health outcomes. Health system CHNAs especially emphasized the health implications of structural racism. Additionally, Minnesota has some of the best outdoor environments for recreation and socialization, but there is a disparity in access to safe environments that contribute to good health. Living environments are impacted at multiple levels, from climate change implications to local investments in creating green spaces and maintaining public safety.

Quote: I know we wanna have jogging trails and bike trails and it'd be great to have those things, but in our minds, we're not feeling safe. So that's where I don't know how we're gonna get to it, but it's a battle in our minds about what is deemed safe.

This assessment pointed to gaps in health care delivery approaches. Health care might better serve residents through improved cultural appropriateness and responsiveness in service delivery, and more representative providers and staff. Respondents suggested that care could include more use of empathetic and trauma-informed approaches, and integration of non-medical approaches, such as doulas, midwives, dance circles, and body-based interventions. Additionally, mobile medical approaches that meet people where they are, might help reach more patients. There are unmet needs and not enough resources beyond acute care, regarding mental health, sobriety units, and shelters, and in some cases, there is an over-reliance on emergency room care because there are not enough long-term care in-patient facilities. Health care delivery is too often stretched, and programs that are not designed to meet certain needs are nonetheless stretched to address them, such as mental health needs. Although there are many challenges, respondents observe that more conversations are occurring about these topics.

Quote: There's also a need for broader access to mental health services, also mental services that are culturally relevant. [...] not every person or culture wants a sit and talk with, you know, sit down and talk face to face. Some benefit from movement. We have connected with an agency called Races to Gratis a couple months ago and they incorporate movement and spirituality if wanted for their Spanish speaking clients and then it is also talk, but sometimes it's dance as an expression of your feelings.

County and community respondents, as well as health systems' Community Health Needs Assessments (CHNAs), reported that health and human services could address structures that lead to gaps in service access. Some residents have multiple basic and health needs, and providing support and improving health for these residents, and serving their whole families, is challenging with current structures. Such residents might benefit from increased opportunities to access multiple health and human services in a single location or visit, with increased linkages across programs and resources, and reduced bureaucracy. Patient and service navigators can also support residents' access to and understanding of services. Respondents shared that the most common barriers to health care access for residents were lack of insurance and cost of services, language barriers, technology and internet access barriers, and fear and lack of trust in health systems, which can be related to personal or historical events, and racism and discrimination.

Quote: The other most obvious [concern] is substance use. We're a harm reduction facility. We meet people where they are, and oftentimes where they are is not conducive to follow through on the bureaucratic side of things, people are moving around a lot, living out of their car. They might not have a permanent or mailing address, so it makes it very tricky to actually help people in a real way without having their hierarchy of needs filled.

Quote: Another barrier, of course, is health insurance. We're able to serve people regardless of what their financial situations are, and language we're trying to address as well. Those are all barriers we're trying to address, but there's not enough of us to do it for everyone. The demand is greater than our ability to respond.

Respondents valued identifying and addressing social determinants of health before, or alongside, addressing health outcomes. Respondents emphasized specific social determinants of health that, in recent years, are most strongly impacting residents' health. Residents face transportation challenges, and need options that are useable, timely, and feel safe; this impacts all people but especially youth and older adults. There is a gap in available spaces for socialization and recreation, especially outdoor spaces, to maintain health. Finally, findings emphasized the growing need to address social isolation among residents, which contributes to decreased well-being and mental health.

Quote: It's something that we ask all of our patients when they're pregnant: You know who's with you? Who do you live with? Who can you call for help? Who can watch your kids or in the middle of the night when something is going on with your baby and you don't know what's going on? Who do you call? And it seems like all of our patients, their answer is no one, I have no one.

Health outcomes relating to chronic disease, mental health, and maternal and child health were identified as priorities by respondents. Respondents felt they observed strong health inequities in perinatal and infant outcomes, as well as in chronic disease rates. Increased concerns about mental health mirror trends in social isolation, which is likely a contributing factor. County and community respondents, as well as youth mental health respondents, shared that there are unique barriers to accessing mental health care, including knowledge in how to find a provider and stigma in seeking help among some communities. Youth mental health and well-being was a concern frequently raised, and respondents shared that youths' top health concerns were related to social and emotional needs. There are often not sufficient resources to support youth in social, emotional, and mental health needs, and more needs to be learned about the mental health and well-being needs of LGBTQ+ youth. Youth are looking for "third spaces" for social opportunities beyond school and home, and relationships with adults that they can trust.

Quote: In the community that I work with (youth and schools), the number one issue in the last five years is youth mental health. Excessive rates of mental health with anxiety, depression, suicide ideation all increased in the last five years.

County and community respondents shared that communities have many strengths and resources that support health. Community members are willing to trust, show up and build. Residents, including youth, want access to and use of resources. Older populations are seeking opportunities to actively participate in community and have wisdom to share. Community members are motivated by prospects for community ownership. Communities are diverse and have strong existing social networks among organizations. Community organizations sometimes provide meeting spaces that allow for socialization and programming, benefiting entire communities. Respondents observed growth in some areas of adult health, in mental health and school programming efforts, and investments in racial and health equity approaches in institutions.

Quote: If NorthPoint makes a call [to community members], they are able and willing to show up [for community].

Notes on data indicators

The CHA report contains data visualizations of quantitative data to support the qualitative themes. The tables and graphs include data from many sources. In some cases, special notations are used to indicate additional information about the data presented.

Data suppression and reliability

Data suppression rules are applied if a data count is too small to produce a reliable estimate or may violate confidentiality. Suppression criteria differ by data source, and are set by the institutions that manage the dataset:

- For all data sources, when a count or rate is equal to zero, it is reported.
- For Hennepin County maternal and child health, opioids, and vital statistics birth and mortality data, estimates are suppressed for a numerator that is <10, or denominator <30.
- For Hennepin County sexual health and infectious disease epidemiology data, the data suppression rule applies for a numerator <5, or denominator <30.
- HTAC data is suppressed when the numerator count is <12.
- MSS data is suppressed if the numerator <5 or denominator <20.
- SHAPE data is suppressed if the numerator <30 or the denominator <100.

† Indicates that a data count is below a suppression threshold and has been suppressed.

In some cases when there is a low data count, but the data are above the criterion for suppression, data are reported, but the estimate's reliability will be flagged accordingly, using the following symbols:

- ***** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.
- **^** Percentage does not meet criteria for statistical reliability, use with extreme caution RSE >50%.

Commonly used acronyms or terms

Throughout the CHA there are some commonly used acronyms or terms.

FPL: The federal poverty level (FPL) is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter, and other necessities. In the United States, this level is determined by the Department of Health and Human Services.

NH: Refers to Non-Hispanic or Latino/a race or ethnicity.

HP 2030: Refers to the U.S. Department of Health and Human Services Healthy People 2030 Objectives.

Systems of power, privilege, and oppression indicators

Root causes are long-standing cultural or institutional structures, historical factors, or large-scale recent events, that impact the health and well-being of whole communities. Our analysis looked at racism, discrimination, health systems structures, the COVID-19 pandemic, recent economic trends, safety, neighborhoods and environment to build a holistic picture of health in Hennepin

Theme: Racism exists and affects all levels of social determinants of health and health outcomes

Assessment respondents described racism as affecting health in many ways, through individual discrimination, structures in institutions, lack of feelings of safety, lack of representation, and the legacy of historical events. However, many noted that in recent years some institutions are working to address racism and health equity. There is no single indicator on the effects of racism on health. Many social determinates of health and health outcomes indicators reveal racial inequities in health and are found throughout the body of this assessment.

Theme: Communities are still recovering from the COVID-19 pandemic

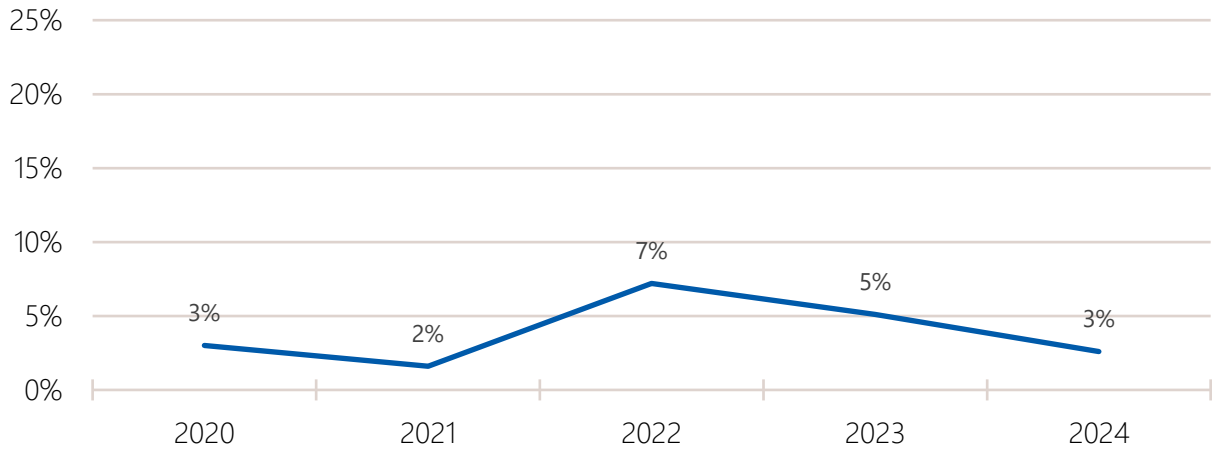
COVID-19 was a major cause of illness and death in Hennepin County during the pandemic. American Indian or Alaska Native (34 per 10,000) and Black or African American (14 per 10,000) were more likely to die from COVID-19 compared to the county average age-adjusted rate (6 per 10,000) (Vital Statistics, Deaths, 2020–2021). The assessment identified many ongoing impacts of the COVID-19 pandemic, many of which are supported by data. These include:

- Ongoing mistrust in medical systems
- Increased spread of health misinformation
- Increased social isolation
- Less use of primary care, such as youth vaccinations
- Less participation in group health programs, and some programs not reinstated
- Increase in mental health concerns, and insufficient support and resources for mental health, especially for youth
- Increased difficulty in medical staffing due to professionals leaving during the pandemic

Theme: Inflation in recent years has led to tighter household budgets, impacting housing and food security

In 2022, financial inflation was unusually high, at rates not experienced for over four decades. Respondents report that recent cost increases have tightened household budgets, making it harder for families to afford necessities like housing, food, medical care, gas, and baby items. As a result, more people face housing and food insecurity or skip medical care and other essential purchases.

Figure 1: Percent change in 12-month Consumer Price Index for All Urban Consumers (CPI-U) estimates for Minneapolis-St. Paul-Bloomington area, 2020-2024



Source: U.S. Bureau of Labor Statistics

Individual discrimination

Discrimination is psychologically harmful and can bar people from accessing needed resources [1, 2]. Discrimination can have long-term health effects, including worsened physical and mental health outcomes. Discrimination can be understood as structural, relating to institutional processes that can limit opportunities and access, or individual, wherein someone is treated differently in a negative way, based on their characteristics.

The 2022 SHAPE survey assessed the frequency of individual discrimination with two separate questions, one regarding race, ethnicity, religion, or immigration status, and the second regarding sexual orientation and gender identity. Respondents who reported they did not feel accepted due to their characteristics "at least once a month" were classified as experiencing frequent discrimination.

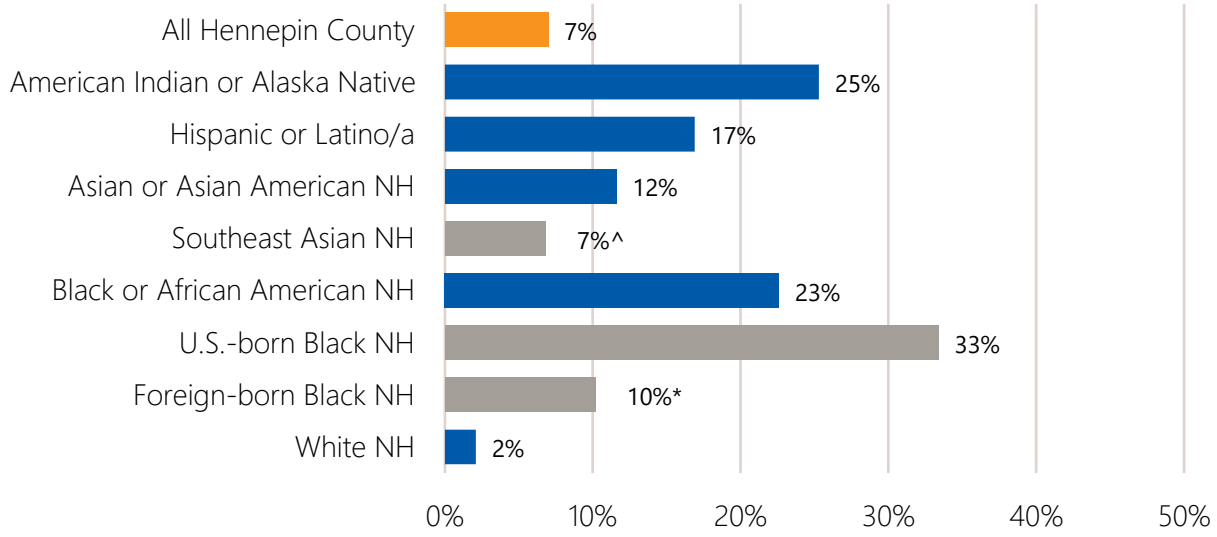
- A third of U.S.-born Black (33%) and a quarter of American Indian or Alaska Native (25%) adults felt discriminated against frequently due to their race, ethnicity, religion, or

immigration status. These rates are more than triple the overall rate of Hennepin County (7%) (Figure 2).

- The rates are higher for those with lower educational attainment and income (Figure 3).
- Individuals identifying as nonbinary (38%), transgender (50%), queer (35%), lesbian or gay (27%) were much more likely to experience frequent discrimination due to their sexual orientation or gender identity compared to the county average (4%) (Figures 4 and 5).

The 2022 Minnesota Student Survey (MSS) assessed students' experiences of bullying due to race, religion, sex/gender, gender expression, sexuality, disability, weight, or appearance. Ninth graders reported that appearance (23%), size or weight (20%), and gender expression (17%), were the most common characteristics that led to bullying (Figure 6). In this same assessment, LGBTQ+ students reported being bullied at up to 1.5 times the rate of youth who are not LGBTQ+ (MSS 2022).

Figure 2: Percent of adults reporting frequent discrimination based on race, ethnicity, religion, or immigration status by race/ethnicity, 2022

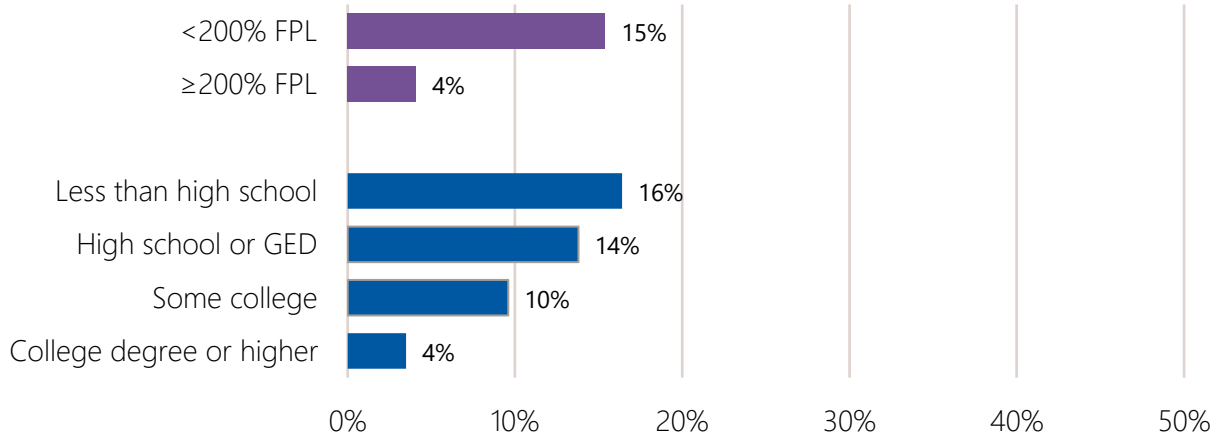


Source: SHAPE; NH is non-Hispanic ethnicity

***** *Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

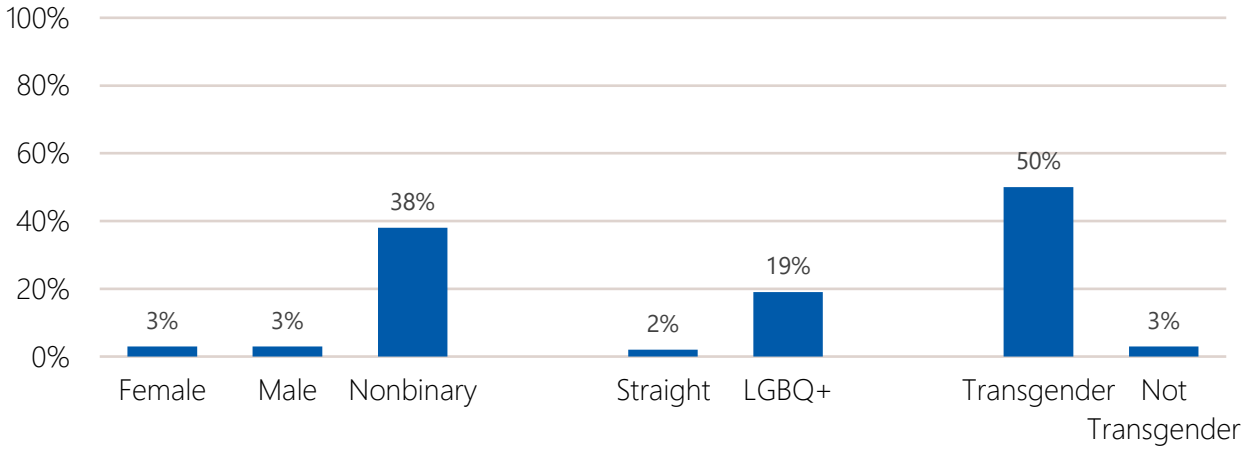
^ *Percentage does not meet criteria for statistical reliability, use with extreme caution RSE >50%.*

Figure 3: Percent of adults reporting frequent discrimination based on race, ethnicity, religion, or immigration status by income and education level, 2022



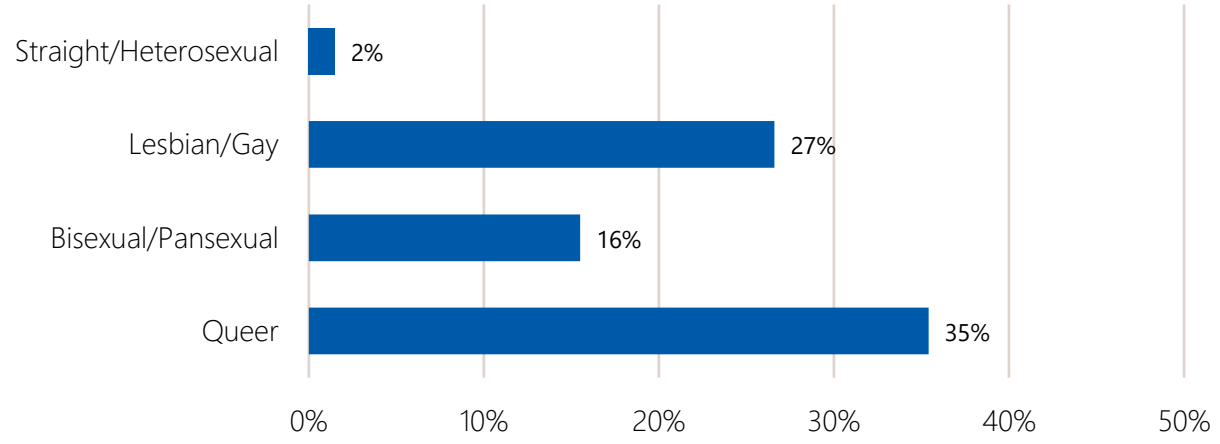
Source: SHAPE; FPL is Federal Poverty Level

Figure 4: Percent of adults reporting frequent discrimination based on sexual orientation or gender identity, 2022



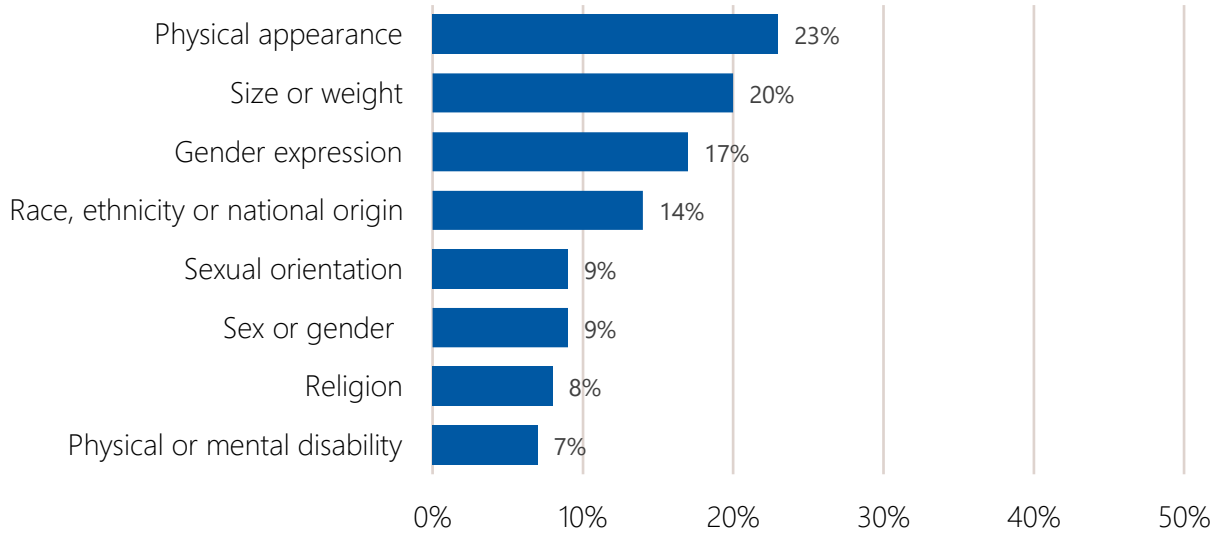
Source: SHAPE

Figure 5: Percent of adults reporting frequent discrimination based on sexual orientation or gender identity, 2022



Source: SHAPE

Figure 6: Percent of 9th grade students reporting bullying due to race, religion, sex/gender, gender expression, sexuality, disability, weight, or appearance, 2022



Source: MSS, Hennepin County

Safety, environment, and neighborhood

Neighborhood characteristics that affect health include physical environment qualities, like air pollution and green space, and social environment qualities, like social connectedness or crime [3, 4]. The neighborhoods people live in can impact their mental health, physical and psychological safety, level of physical activity, and environmental exposures. If residents believe

their neighborhood is unsafe or of poor quality, they are less likely to spend time enjoying and benefiting from the outdoor spaces and social opportunities around their homes.

Theme: There are gaps in addressing neighborhood and school safety concerns

Respondents described a connection between safety, stress and mental health, particularly affecting racially and ethnically diverse communities. They noted that perceptions of safety have decreased, with an increased security presence contributing to anxiety. Gun violence is seen as a leading cause of youth deaths, highlighting the need for school safety and violence prevention programs.

Theme: There is a disparity in access to environmental attributes that contribute to good health

Theme: There are disparities in access to socialization and recreation spaces that are safe, especially outdoor spaces

Respondents shared that neighborhood safety limits access to physical activity and recreation for some communities. Some residents are expressing increasing safety concerns at home, in neighborhoods, at schools, and during transportation. Respondents described some urban areas and neighborhoods around high rises as food deserts, where affordable, healthy food is hard to find. Safe routes to schools are needed for youth. Community centers and organizations are seen as important resources and safe spaces to support health, as they offer valuable resources like group health programs and spaces to gather. Community members view local ownership of shared spaces positively.

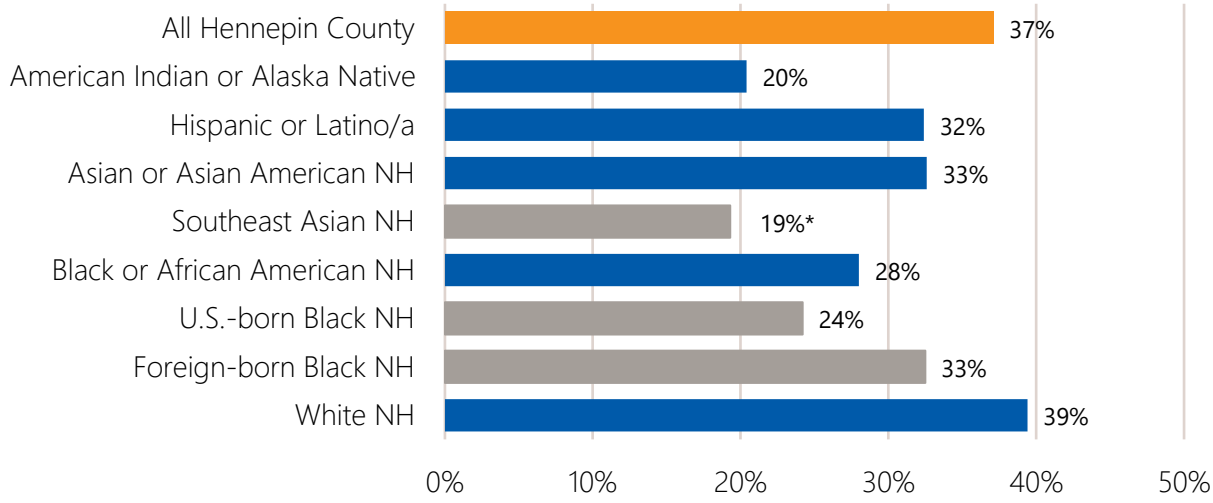
Feelings of safety

In 2022, about one-third (37%) of Hennepin County adults considered their neighborhood very safe from crime. However, perception of safety varied widely by geography with areas as low as 8% in the Camden and Near North communities in Minneapolis to 64% in the western outer-ring suburbs (SHAPE 2022). There were disparities among racially and ethnically diverse communities in perceptions of neighborhood safety, with American Indian or Alaska Native, Southeast Asian, and U.S.-born Black respondents less likely to say their neighborhood was very safe from crime (Figure 7). Adults with lower incomes and less than a high school education were less likely to feel their neighborhood was very safe from crime compared to adults with higher income and those with college degree or higher education (Figure 8).

Across Hennepin County, a high percent of students (8th, 9th, and 11th graders) reported they felt safe in the places they live and go to school (Figure 9). However, the perception of safety at school declined among youth from 93% in 2016 to 89% in 2022 (Figure 10). There is some

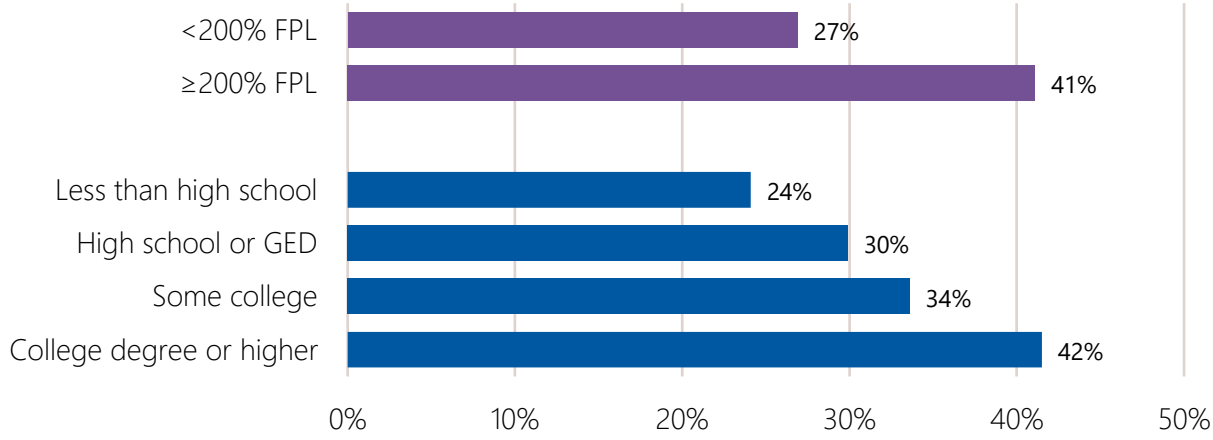
disparity in perception of safety at school by race or ethnic group, with a lower percent of American Indian or Alaska Native and Black or African American students reporting feeling safe at school (Figure 11).

Figure 7: Percent of adults reporting their neighborhood is very safe from crime by race/ethnicity, 2022



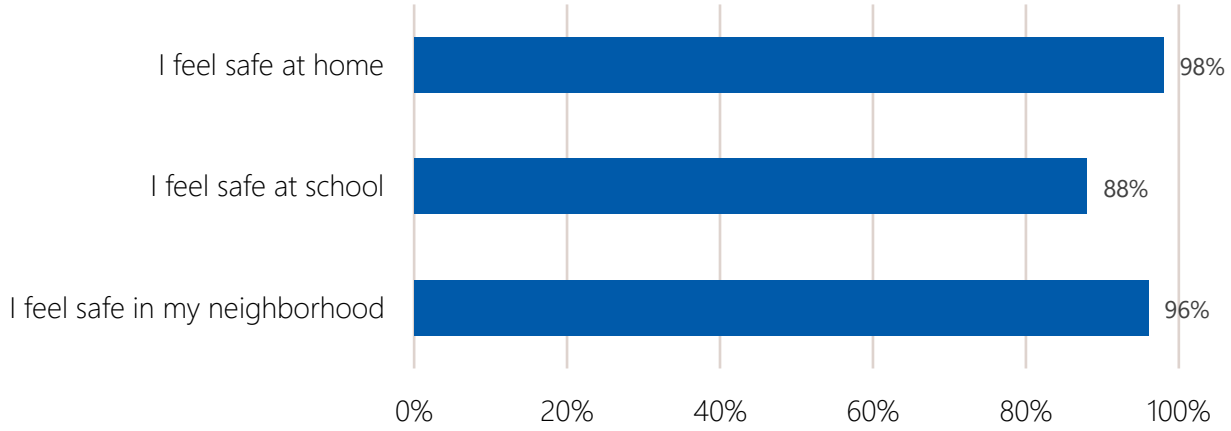
Source: SHAPE; NH is non-Hispanic ethnicity
** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

Figure 8: Percent of adults reporting their neighborhood is very safe from crime by income and education level, 2022



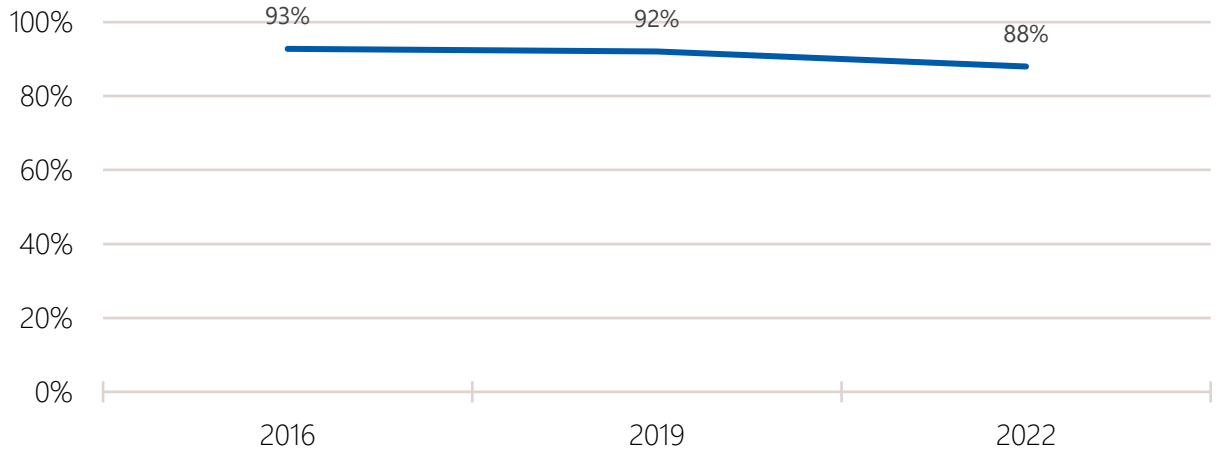
Source: SHAPE; FPL is Federal Poverty Level

Figure 9: Percent of students reporting they feel safe at home, school, and in their neighborhood (8th, 9th, and 11th graders), 2022



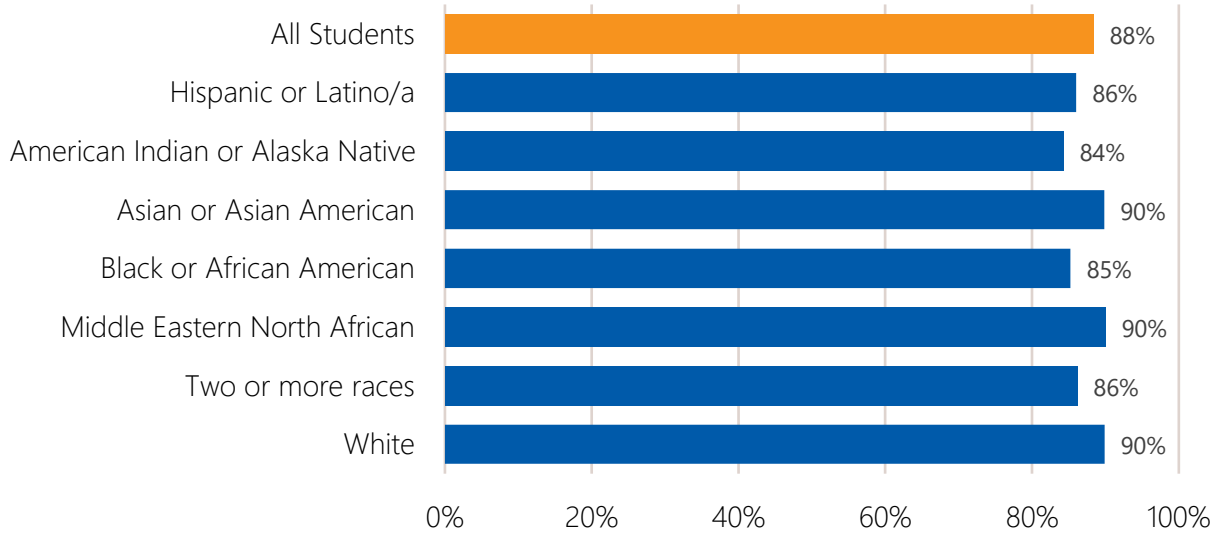
Source: MSS, Hennepin County

Figure 10: Percent of students reporting they feel safe at school (8th, 9th, and 11th graders), 2022



Source: MSS, Hennepin County

Figure 11: Percent of students reporting they feel safe at school (8th, 9th, and 11th graders) by race/ethnicity, 2022

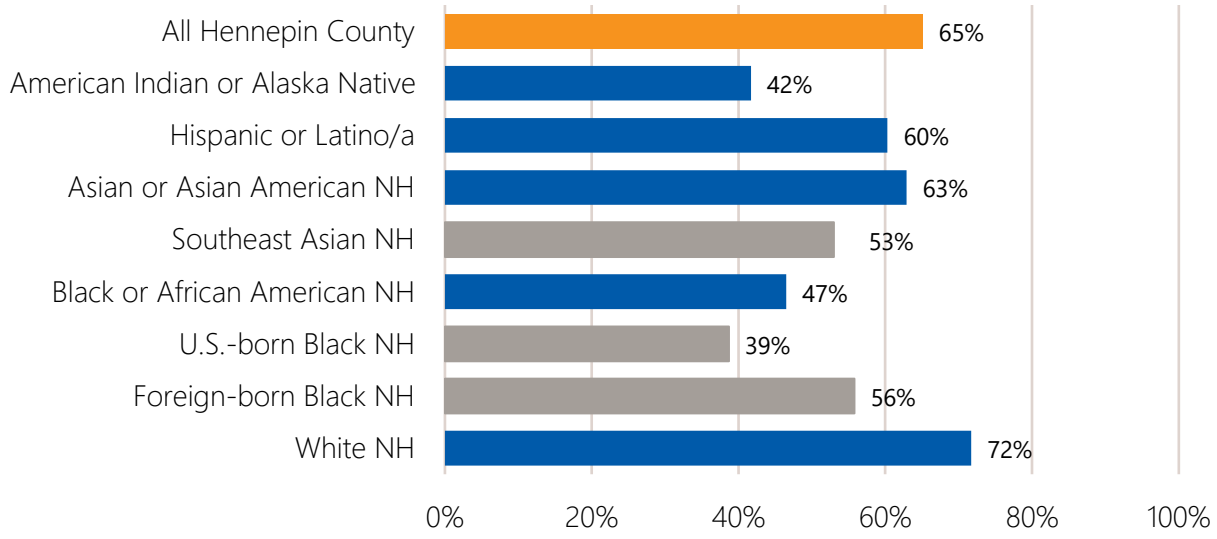


Source: MSS, Hennepin County

Access to safe parks and trails

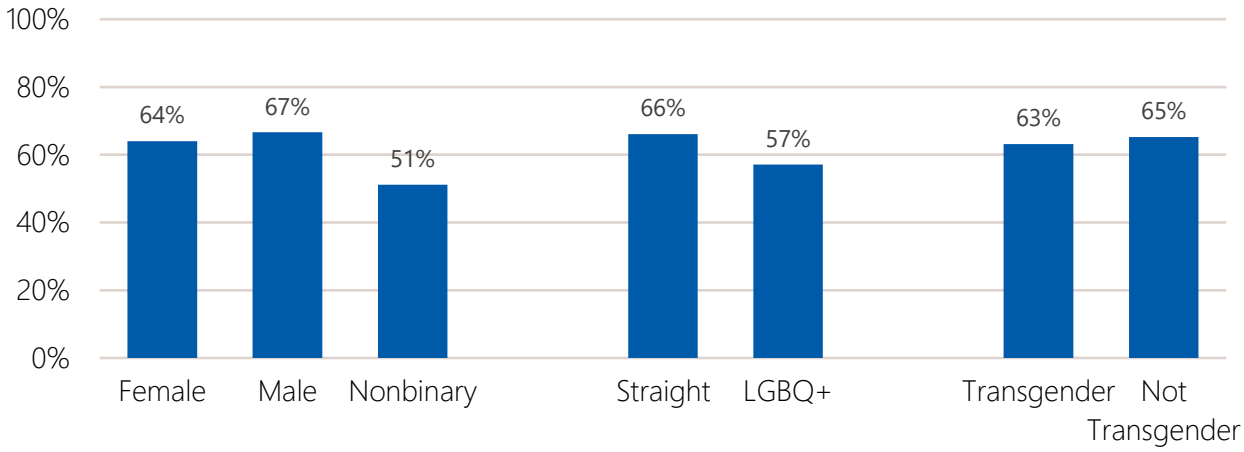
In Hennepin County, 65% of people strongly agree they have access to safe parks or trails for biking or walking (Figure 12). There was geographic variation of the perception of access, with 72% of adults in suburban areas strongly agreeing compared to 53% in urban areas of Minneapolis (SHAPE 2022). There was also variation by race or ethnicity, with only 42% of American Indian or Alaska Natives, 53% of Southeast Asians, 39% of U.S.-born Black residents, and 56% of foreign-born Black residents strongly agreeing (Figure 12). There was slight variation by sexual orientation and gender identity (Figure 13) and more variation by education and income (Figure 14).

Figure 12: Percent of adults reporting they strongly agree that people in their neighborhood have access to safe parks or trails for biking or walking by race/ethnicity, 2022



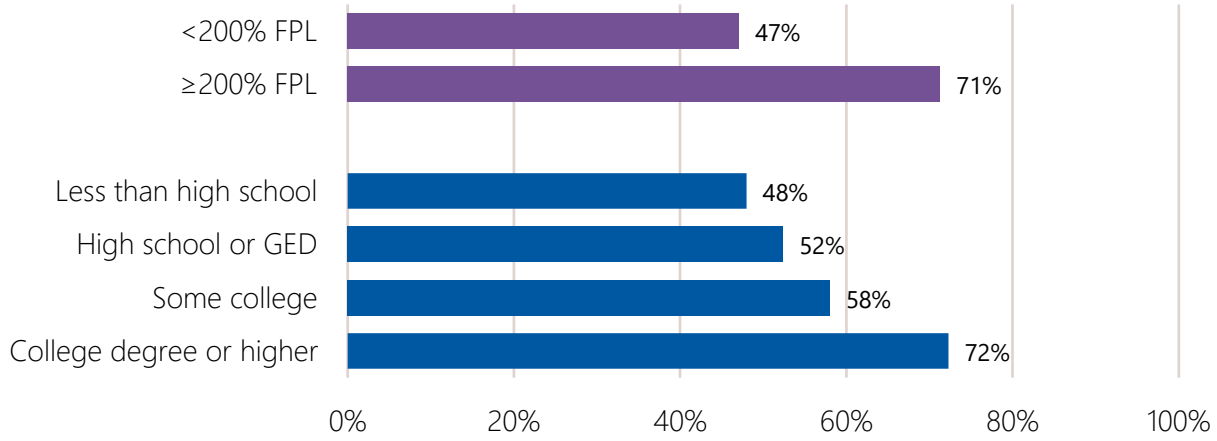
Source: SHAPE; NH is non-Hispanic ethnicity

Figure 13: Percent of adults reporting people in their neighborhood have access to safe parks or trails for biking or walking by sexual orientation and gender identity, 2022



Source: SHAPE

Figure 14: Percent of adults reporting people in their neighborhood have access to safe parks or trails for biking or walking by income and education level, 2022



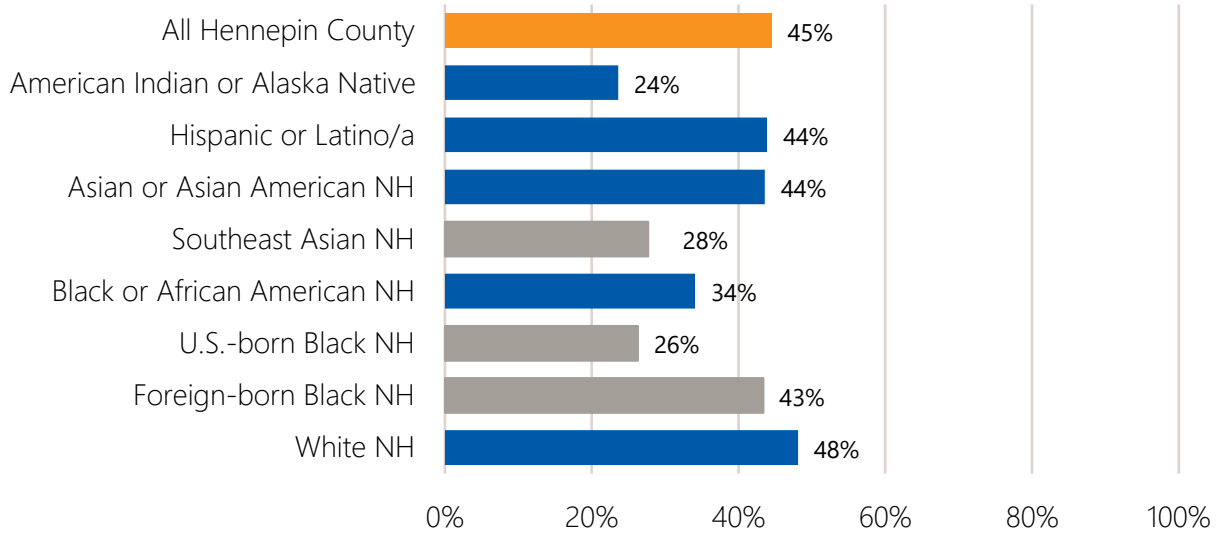
Source: SHAPE; FPL is Federal Poverty Level

Neighborhood and families

Fewer than half of adults in Hennepin County (45%) strongly agreed that their neighborhood is a good place to raise children (SHAPE 2022). This percent declined since 2018, when over half of respondents strongly agreed (56%) (SHAPE 2018).

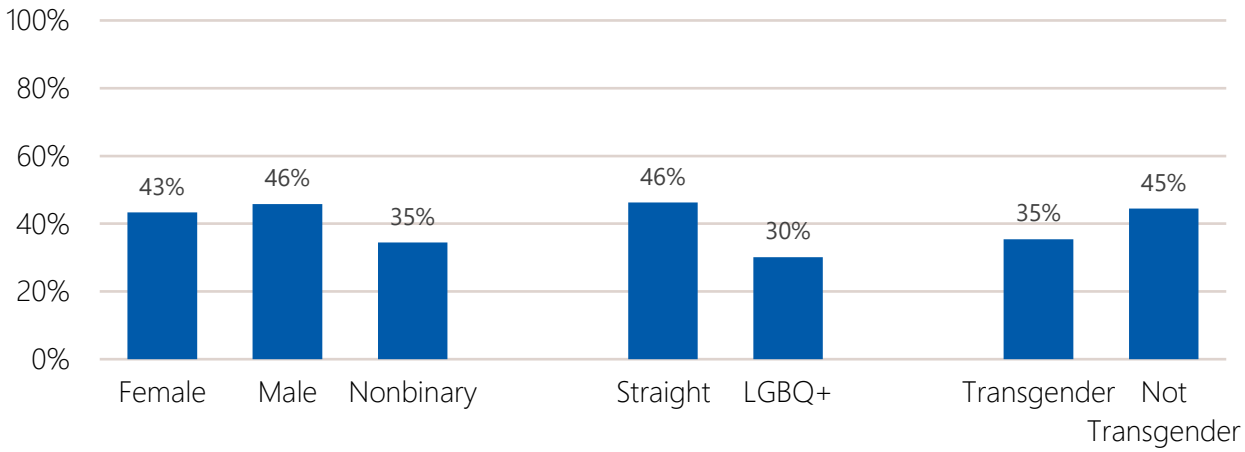
- The percent varies geographically across the county with the lowest percent in the Minneapolis Camden and Near North areas (17%) and highest in the west outer suburbs (67%) (SHAPE 2022).
- The perception also varied by race or ethnicity with American Indian or Alaska Native (24%), Southeast Asian (28%), and U.S.-born Black or African American (26%) adults less likely to strongly agree that their neighborhood is a good place to raise children (Figure 15).
- In addition, LGBQ+ (30%) and transgender adults (35%) and adults with lower household incomes compared to higher incomes (32% vs. 49%) were less likely to strongly agree (Figures 16 and 17).

Figure 15: Percent of adults reporting they strongly agree their community is a good place to raise children by race/ethnicity, 2022



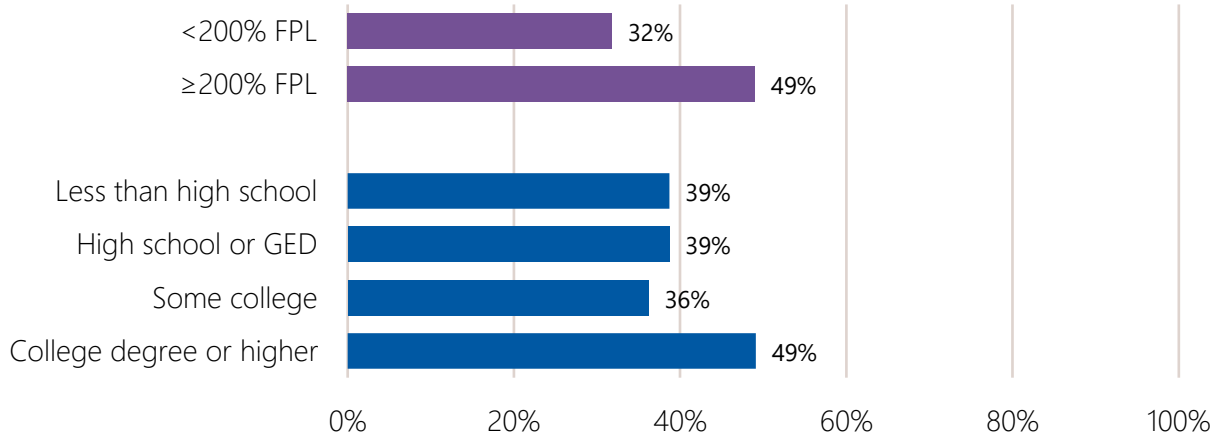
Source: SHAPE; NH is non-Hispanic ethnicity

Figure 16: Percent of adults reporting their community is a good place to raise children by sexual orientation and gender identity, 2022



Source: SHAPE

Figure 17: Percent of adults reporting their community is a good place to raise children by income and education level, 2022

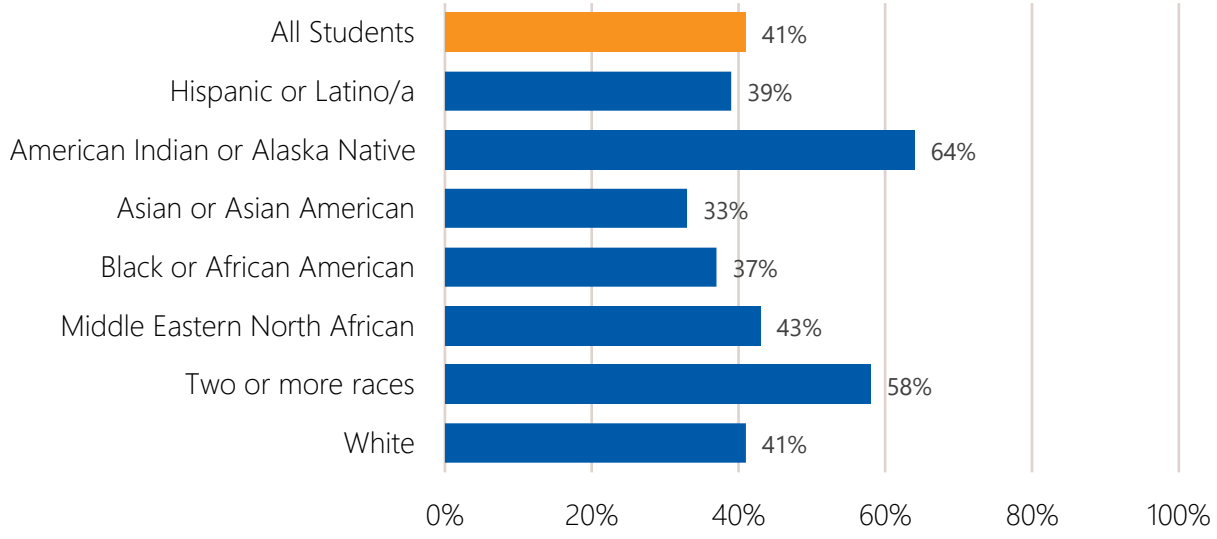


Source: SHAPE; FPL is Federal Poverty Level

Adverse Childhood Experiences

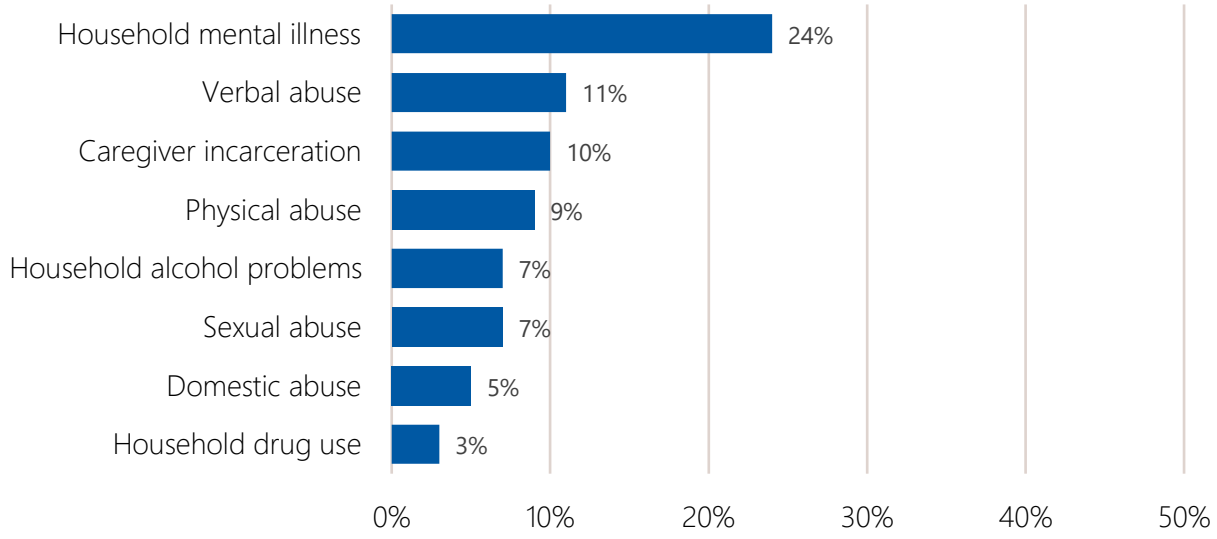
Adverse Childhood Experiences (ACEs) are stressful or traumatic experiences a young person may encounter before they turn 18 years old [5]. Preventing ACEs can reduce negative outcomes and health conditions later in life. In Hennepin County, 41% of 8th, 9th, and 11th grade students reported experiencing at least one ACE (Figure 18). The most reported ACE was household mental illness (Figure 19).

Figure 18: Percent of students reporting at least one ACE (8th, 9th, and 11th graders) by race/ethnicity, 2022



Source: MSS, Hennepin County

Figure 19: Percent of students reporting Adverse Childhood Experiences (ACEs) (8th, 9th, and 11th graders), 2022



Source: MSS, Hennepin County

Health systems

Health systems approaches and structures can influence how accessible, or effective health services are and without careful consideration some structures may be unfairly limiting or excluding to some communities [6]. Health system structures are broader than barriers to health care access (more on barriers under Social Determinants of Health, Health Care Access, page 46), including the style in which services are provided. The assessment identified several themes on health systems structures and how they might be improved to better serve all residents.

Health care systems in the county have identified similar themes in their respective service areas and have set priorities to better meet their communities' needs as described in CHNA reports. If structural changes to the human and health care service delivery are sought, additional indicators and data collection about institutional qualities may be important to create, implement, and track at the county level. In addition, to the health systems structures mentioned here, specific heath care access barriers are described in the social determinants of health section (page 45).

Theme: There are not enough or appropriate resources for helping those most in need beyond acute care

Respondents described insufficient resources for health needs beyond acute care for unhoused populations and individuals requiring inpatient mental health or substance use care. This issue affects youth and adults. For youth, emergency room boarding is a crisis resulting from limited pediatric inpatient beds and too few longer-term care resources. There is an overreliance on emergency rooms for health care needs, even as emergency room care is not equipped to provide all types of care or longer-term care. Non-medical, empathetic, and affirming care options are seen as part of the solution.

- In 2024, 13% of unhoused people did not have shelter (HUD, CoC).
- 64% of Minnesotans seeking acute behavioral health care in emergency rooms could not be transferred to inpatient facilities due to a lack of available beds, with 45% of these cases involving Hennepin County residents [59].
- American Indian or Alaska Native (18%), Hispanic or Latino/a (13%), and Black or African American (13%) individuals are more likely to use emergency rooms for health needs than the county average (4%) (SHAPE 2022). More information about the usual place of health care can be found on page 47.

Theme: Non-medical approaches to maternal health are needed to improve birth outcomes in the perinatal time

Respondents shared that non-medical approaches — such as using midwives and doulas — can improve health and well-being in maternal and child health, particularly during pregnancy and birth. These approaches are seen as promising for addressing racial and ethnic disparities in infant and maternal outcomes during the perinatal period. As of May 2023, 180 nurse midwives were employed in the Twin Cities area (U.S. Bureau of Labor Statistics).

Theme: Some residents face multiple health and social determinant of health needs, requiring support from multiple services, and finding a means to improve their health and well-being is challenging

Respondents shared challenges in improving health and well-being when residents had multiple and complex needs, including basic life needs and acute or long-term health care needs. There is a lack of capacity to connect residents to multiple resources in one place, and service programs are often stretched to address needs beyond their scope.

- Between 2021 and 2023, Hennepin County Health and Human Services served 655,006 residents, with 40% using two or more services. American Indian or Alaska Native residents (46%), Black or African American residents (57%), and residents identifying as two or more races (70%) were more likely to use two or more services (see HC Who We Serve Dashboard).

Theme: There is an increasing need for capacity to serve Hispanic or Latino/a Spanish-speaking populations

Respondents saw an increase in Hispanic or Latino/a community members seeking health care, partly due to a larger influx of immigrants from Central and South America. To better serve this growing population, leaders emphasized the need for more translation services, particularly in Spanish, to reduce language barriers to health care.

Between 2021 and 2023, Hennepin County Health and Human Services served 655,006 residents, with 40% using two or more services. American Indian or Alaska Native residents (46%), Black or African American residents (57%), and residents identifying as two or more races (70%) were more likely to use two or more services (see HC Who We Serve Dashboard).

Access to culturally responsive care includes programs and services offered in a resident's preferred language. In Hennepin County, an estimated 18% of the population 5 years old and over spoke a language other than English at home in 2022. Of the many languages spoken in the home, the largest language group was Spanish (58,702). Other languages more widely used across the county were Amharic, Somali, or other Afro-Asiatic languages (47,021); Hmong (17,220); Vietnamese (9,369); Yoruba, Twi, Igbo, or other languages of Western Africa (9,226); Chinese (7,446); and Russian (5,693), among others (ACS 1-YR, 2022). See the full list in Appendix B.

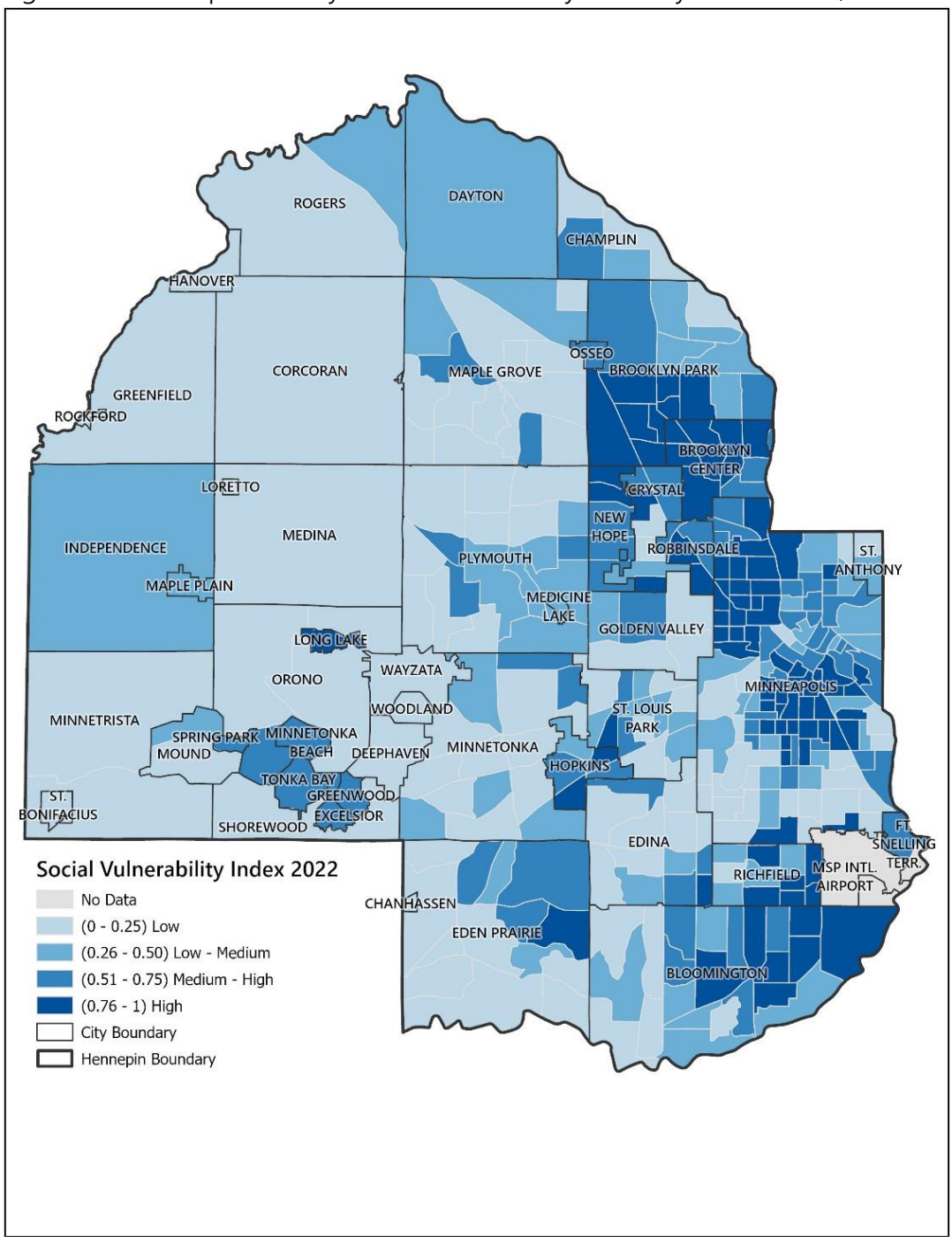
Social determinants of health indicators

The conditions of residents' everyday life shape opportunities to live and grow, which in turn impact quality of life and health outcomes [7]. Because there are disparities in opportunities to thrive, there are disparities in well-being and health. This assessment uncovered themes on health access barriers, and looked at social determinants of health, indicators of health care access, economic opportunity, access to basic needs like housing and food, and social connection. The assessment also looked at the social vulnerability index, an aggregate measure of many social determinants of health measures that provides an overall rating of community vulnerability to health and well-being challenges for every census tract in Hennepin County.

Social Vulnerability Index (SVI)

The Social Vulnerability Index indicates the relative vulnerability of every U.S. census tract to hazards, disasters and stressors [8]. Each tract receives a ranking for 16 factors within four themes including socioeconomic status, household characteristics, racial and ethnic group, and housing and type of transportation. The analysis suggests that there are disparities in the abilities of neighborhoods to absorb challenges, which can impact the health of residents. Areas of high social vulnerability were concentrated in northern and southern first ring suburbs, such as Brooklyn Center, Brooklyn Park and Richfield, as well as North Minneapolis and portions of south Minneapolis (Figure 20).

Figure 20: Hennepin County Social Vulnerability Index by census tract, 2018-2022



Source: U.S. CDC

Health care access

Health care access barriers can affect health by limiting, delaying, or blocking access to health services, which can impact prevention, diagnosis and treatment [9, 10]. Barriers lead to health inequities when they disproportionally affect some populations. Health care access barriers can

be measured by health insurance rates, delays in or avoidance of care or fulfilling prescriptions, and by usual place of care, such that increased use of emergency room care can indicate lack of access to primary care or delays in care until a health issue has become critical. The most common health care barriers described by respondents were (described in six themes):

- **Cost and/or lack of insurance**
- **Fear and lack of trust in health systems or providers**
- **Language and lack of translators**
- **Technology and internet access**
- **Transportation insecurity**
- **Bureaucracy and the need for service navigation**

The cost of health care services and lack of insurance were the top barriers to health care as described by assessment respondents. The impact of medical costs has increased alongside worries about household budgets and financial inflation. Fear and lack of trust in health care systems and providers can also prevent people from seeking care. Distrust can stem from personal experiences or historical events, often relating to racism or discrimination based on other personal characteristics. Some residents fear that accessing services will initiate involvement of other authorities.

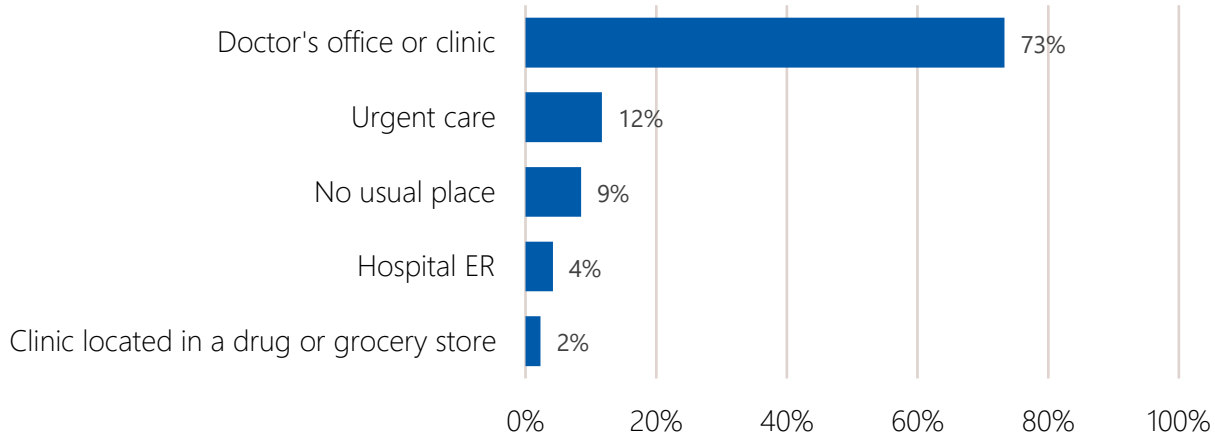
Access to and knowledge of health technology, as well as access to timely, reliable and safe transportation, were other common barriers to health care. Youth and older adults are most greatly impacted by transportation barriers, and public services are limited in the suburbs. Respondents discussed a need for improved translation services across many organizations in Hennepin County. Current services can fall short, particularly in specialized settings like birthing centers, where support is needed around the clock. Finally, respondents shared the need to help residents connect to health and human services, by using navigators to link people to care, providing knowledge about services, and facilitating warm handoffs. Streamlining services and reducing paperwork could also help.

- As of May 2023, there are 560 community health workers or patient navigators working the Twin Cities metro area (U.S. Bureau of Labor Statistics).

Usual place of care

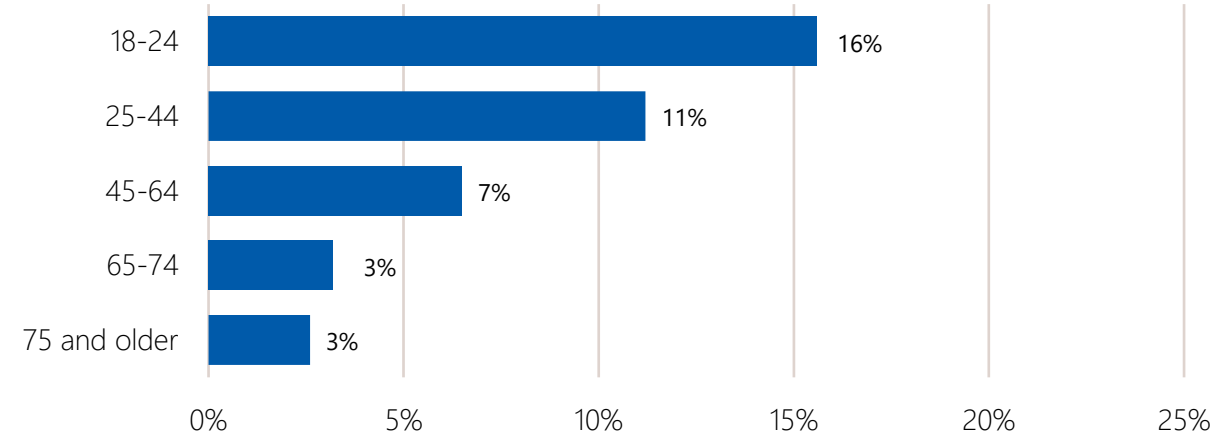
Patients with a usual provider or site of care experience reduced barriers to care because of familiarity and support through provider reminders and education, and usual providers are most relevant for uptake of preventive care [11, 12]. In 2022, 9% of adults in Hennepin County reported having no usual place of care (Figure 21). Disparities are present for younger adults or those who did not graduate from high school (Figures 22 and 23).

Figure 21: Percent of adults by usual place of medical care, 2022



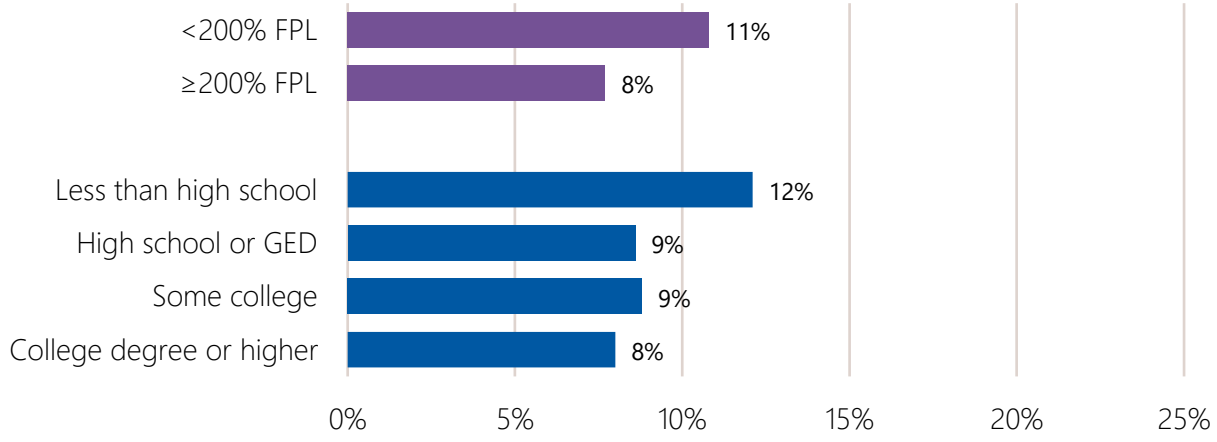
Source: SHAPE

Figure 22: Percent of adults reporting no usual place of medical care by age, 2022



Source: SHAPE

Figure 23: Percent of adults reporting no usual place of medical care by income and education level, 2022



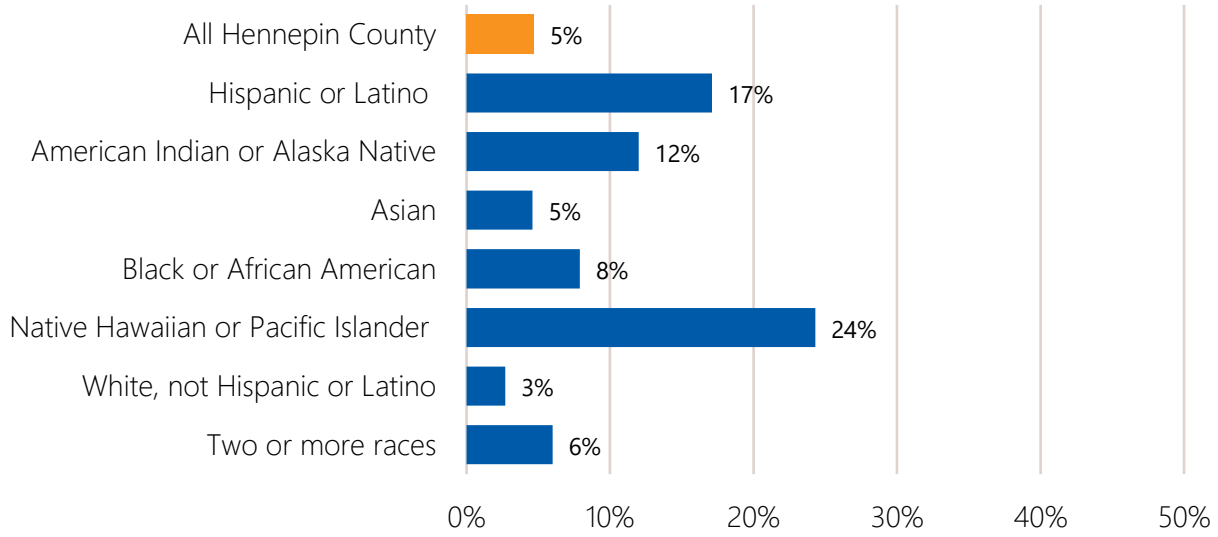
Source: SHAPE; FPL is Federal Poverty Level

Health insurance coverage

An objective of the federal Healthy People 2030 is to increase the proportion of people with health insurance to 92.4%. In Hennepin County adults, only 5% reported they lacked health insurance, however, the percent of adults without insurance was higher among Hispanic or Latino/a (17%), American Indian or Alaska Native (12%), and Black or African American (8%) residents (Figure 24). Uninsured rates appear high for Native Hawaiian or Pacific Islander residents (24%), yet this data should be interpreted with caution as it is based on a small sample size.

- In the SHAPE survey, 61% of adults reported having private insurance, while 34% reported using public insurance including Medicare (SHAPE 2022).
- The percent of public insurance enrollment was higher for lower income residents (66%) compared to higher (22%) (SHAPE 2022).
- A higher percent of residents who were not a U.S. citizen (19%), had less than a high school educational level (18%) or were unemployed (17%) did not have insurance (ACS 5-YR, 2018-2022).

Figure 24: Percent of population without insurance by race/ethnicity, 2018-2022



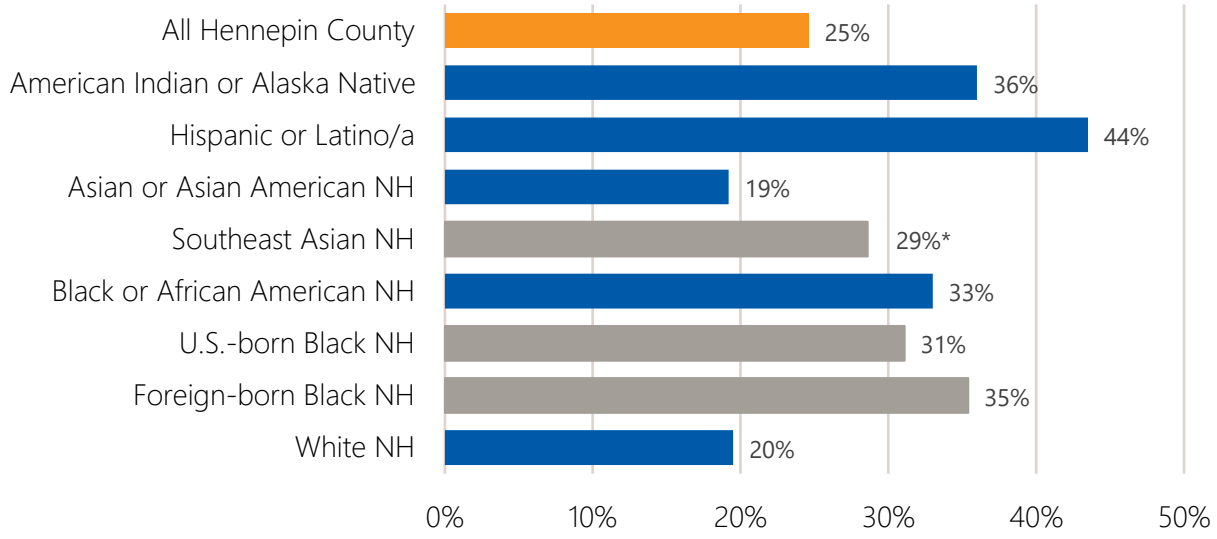
Source: American Community Survey 5-year estimates

Delayed care

Among residents who needed medical care in the past year (63%), nearly one-quarter (25%) delayed getting care, and nearly half (48%) cited delaying care because of cost or lack of insurance (SHAPE 2022).

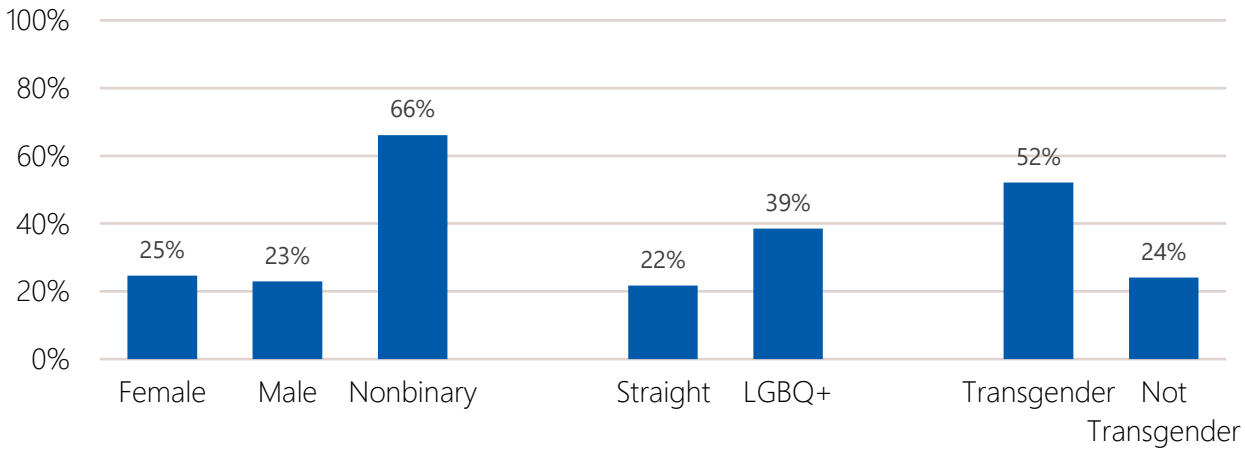
- Of those who needed medical care, American Indian or Alaska Native (36%), Black or African American (33%), and Hispanic or Latino/a (44%) residents were more likely to report delaying care compared to the county average (25%) (Figure 25).
- Adults who identify as LGBQ+ (39%) or transgender (52%) were more likely to delay medical care compared to people who do not identify as LGBQ+ or transgender, among those who needed care (Figure 26).

Figure 25: Percent of adults reporting delayed getting medical care in the past year (among those who needed care) by race/ethnicity, 2022



Source: SHAPE; NH is non-Hispanic ethnicity
***** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

Figure 26: Percent of adults reporting delayed getting medical care (among those who needed care) by gender identity and sexual orientation, 2022



Source: SHAPE

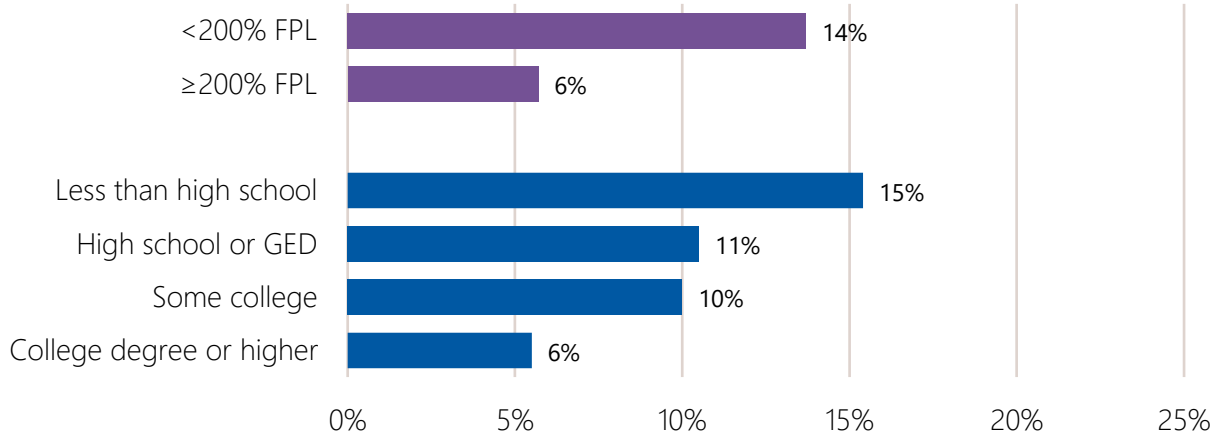
Delayed prescription fulfillment

High prescription drug costs and difficulty affording medication has led many people to forgo or ration their prescriptions. Delaying refills, skipping doses, or stopping necessary prescription medications can worsen health conditions or result in hospitalization. The federal Healthy

People 2030 has set an objective to reduce the proportion of people who can't get prescription medicines when they need them to 6.3%.

- In Hennepin County nearly 8% of adults who take prescription medications reported delaying refills, skipping doses, taking a smaller amount, or not filling a prescription, because of cost (SHAPE 2022).
- The likelihood of having difficulty paying for a prescription medication decreased as income and educational attainment increased (Figure 27).

Figure 27: Percent of adults reporting skipped, took smaller amounts of, or did not fill a prescription because of cost (among those who were prescribed medication) in the past year by income and education level, 2022



Source: SHAPE; FPL is Federal Poverty Level

Delayed mental health care

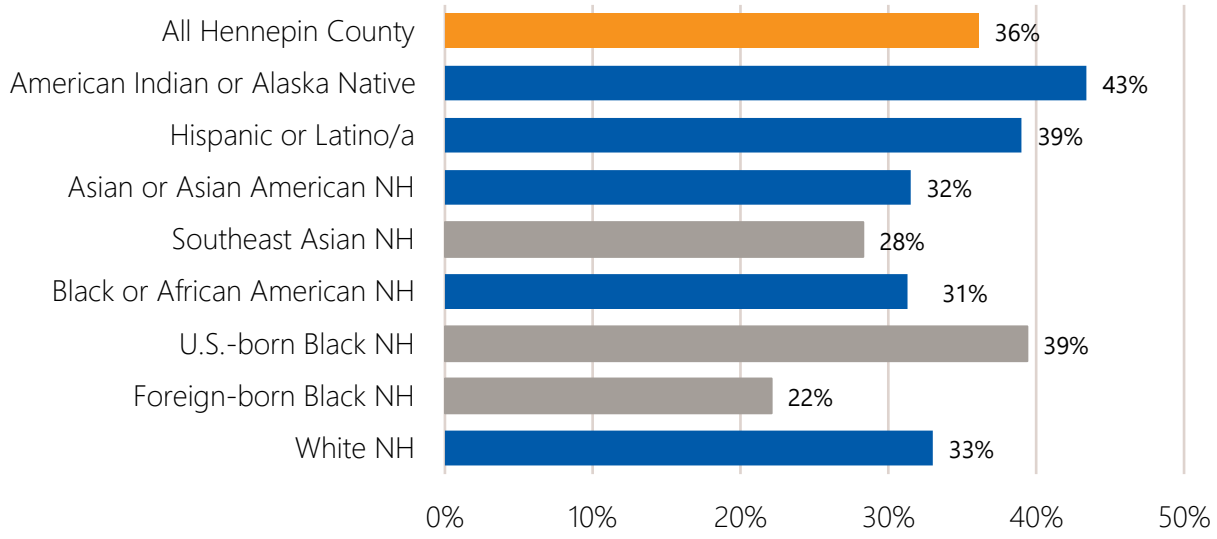
There are barriers unique to accessing mental health care, and this assessment considered themes and data to understand residents' barriers to this specific health need. Delaying mental health care can cause an individual unnecessary psychological suffering. The longer individuals postpone mental health care, the more likely their concerns will escalate to crisis or suicide.

Theme: There are barriers to accessing needed mental health services

Respondents shared that mental health care is hard to access because of lack of insurance and difficulty and uncertainty of finding providers. There is a need for more culturally appropriate practices and providers, including counselors who understand historical trauma. Additionally, providers who can address barriers to mental health care and reduce the stigma around seeking help are needed. Respondents also shared that programs not specifically focused on mental health are still playing a key role in meeting the mental health needs of the community. Stigma, high cost of services, and difficulty accessing qualified mental health professionals contribute to delays in receiving mental health care.

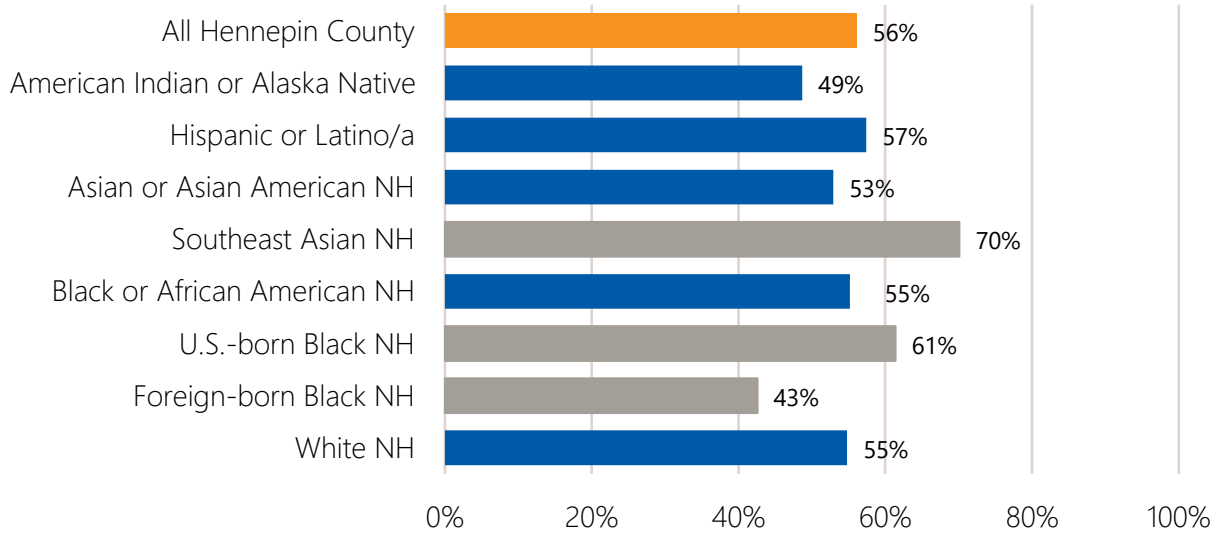
- Over 1 in 3 adults (36%) reported there was a time when they "wanted to talk with or seek help from a health professional about stress, depression, a problem with emotions, excessive worrying, or troubling thoughts" (Figure 28). Mental health care needs were higher among young adults, people who identify as LGBQ+ or transgender, and people with lower incomes (SHAPE 2022).
- For adults who reported wanting to see a health professional for mental health concerns, over half (56%) delayed or did not get the care they needed (Figure 29).
- The most common reason for delaying or deferring mental health care was not knowing where or how to get help (39%) (Figure 30).
- Five percent of adults in Hennepin County reported delaying mental health care in past 12 months because they could not find a provider who spoke their language or understood their culture (Figure 30). This was a barrier for 13% of those who speak a language other than English in the home and 11% of those who were born outside the U.S. (SHAPE 2022).
- Younger adults delayed getting mental health care at higher percents than older groups (Figure 31).
- The percent of those who needed mental health care, but delayed getting care was similar across income and education (Figure 32), and sexual orientation or gender identity (Figure 33).

Figure 28: Percent of adults reporting needed mental health care by race/ethnicity, 2022



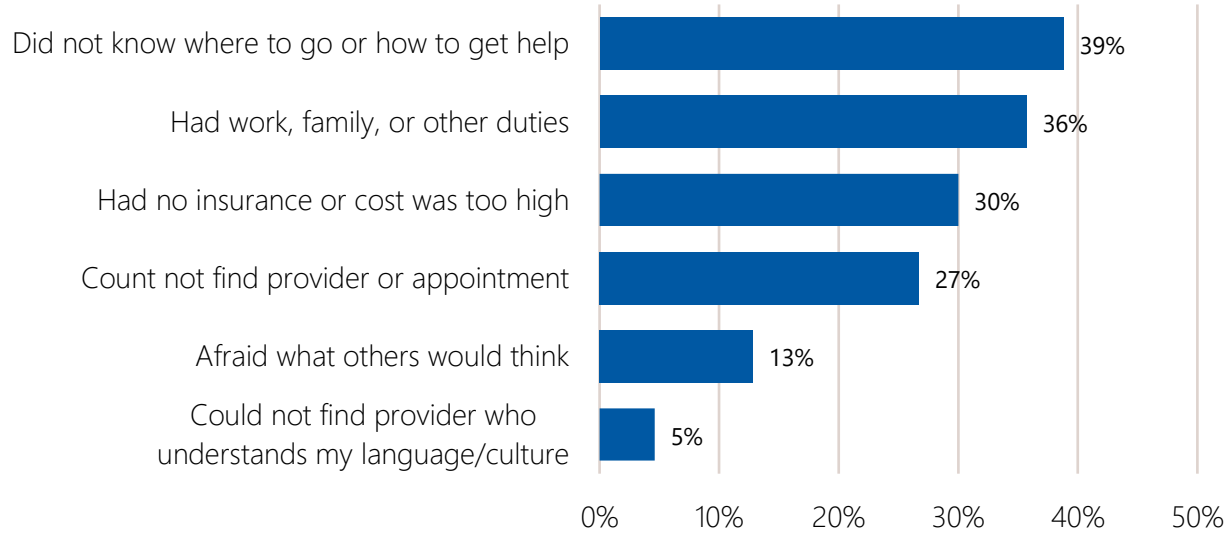
Source: SHAPE; NH is non-Hispanic ethnicity

Figure 29: Percent of adults reporting delayed needed mental health care by race/ethnicity (among those who needed care), 2022



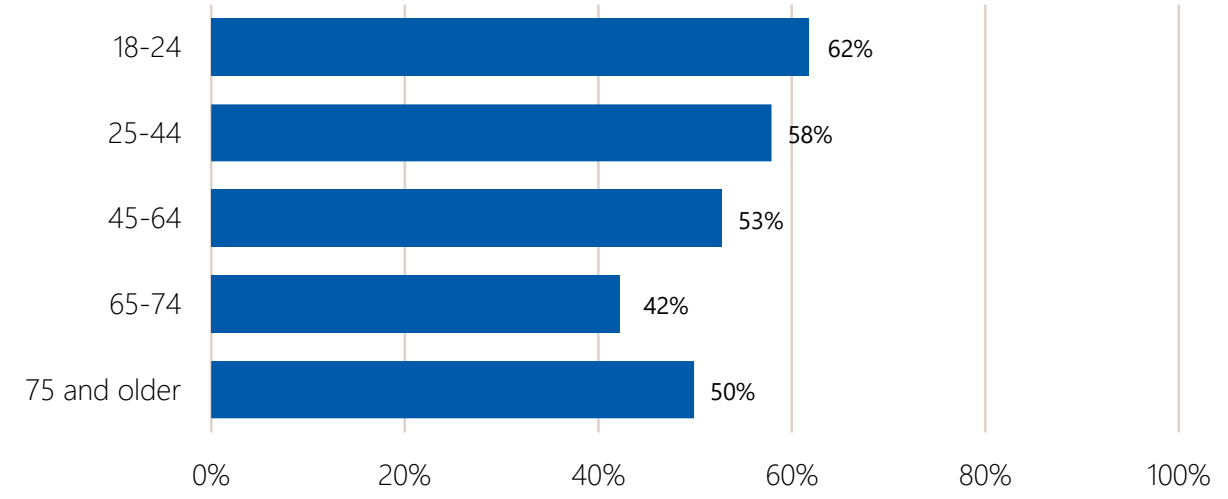
Source: SHAPE; NH is non-Hispanic ethnicity

Figure 30: Frequency (by percent) of specific barriers to care as reported by adults who needed mental health care, 2022



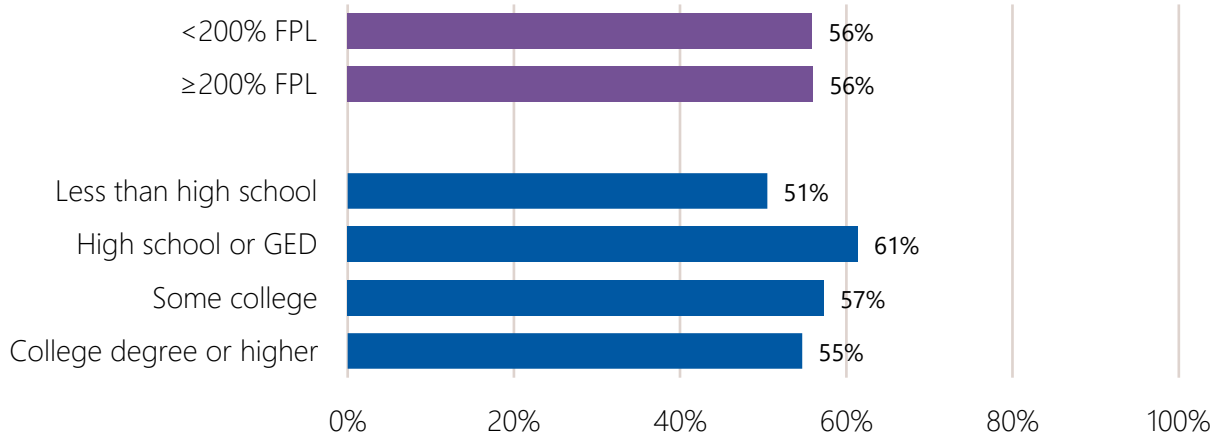
Source: SHAPE

Figure 31: Percent of adults reporting delayed getting needed mental health care by age (among those who needed care), 2022



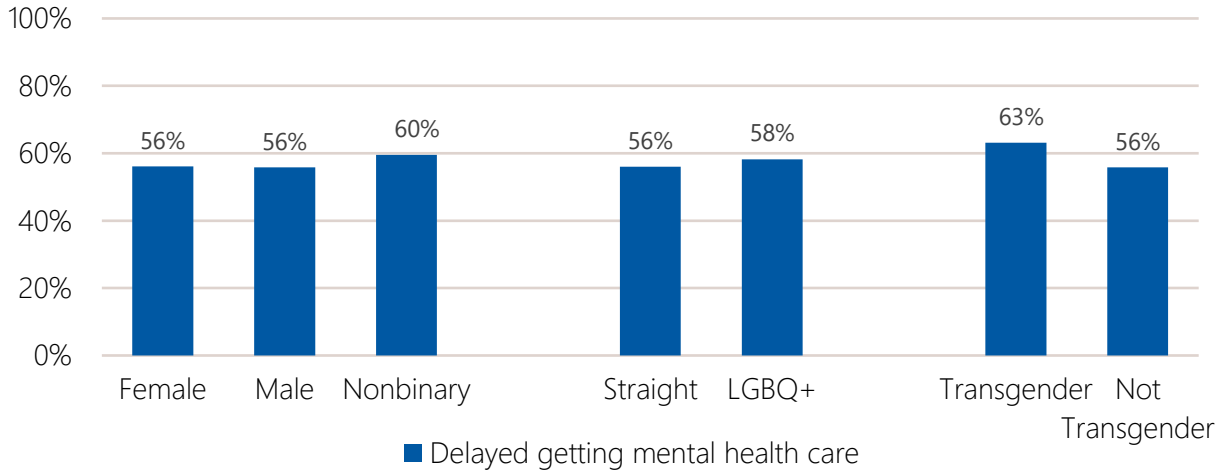
Source: SHAPE

Figure 32: Percent of adults reporting getting needed mental health care by income and education level (among those who needed care), 2022



Source: SHAPE; FPL is Federal Poverty Level

Figure 33: Percent of adults reporting delayed needed mental health care by gender identity and sexual orientation (among those who needed care), 2022



Source: SHAPE

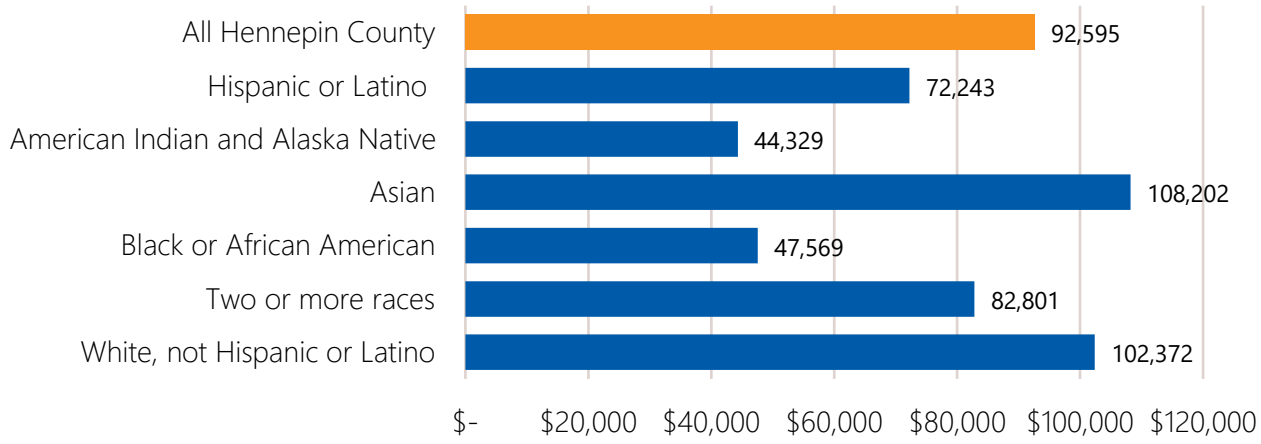
Income and employment

Income, often related to employment, is strongly related to health, so those with higher incomes experience better health outcomes and longer lives than those with lower incomes [13, 14]. These outcomes are related to wealthier residents' access to health care and insurance, ability to afford healthier lifestyles and access to safer neighborhoods, and reduced stress from greater

stability. Throughout this assessment, health behaviors and outcomes are often examined by income (comparing residents with income <200 Federal Poverty Level (FPL) to residents with income ≥200 FPL) (page 57), revealing many disparities correlated with wealth, especially chronic conditions outcomes. Income, and the related measures of poverty rates and reported economic distress, show population and geographic disparities.

- The Hennepin County unemployment rate was at 3% in 2017, rose to 7% in 2020, and has returned down to 3% in 2023 (Minnesota DEED).
- The median income for full-time work for women ($65,623) was lower than that of men ($78,388) (ACS 5-YR, 2018-2022).
- American Indian or Alaska Native residents and Black or African American residents had significantly lower household incomes compared to the county average (Figure 34).

Figure 34: Median household income by race/ethnicity, 2018-2022



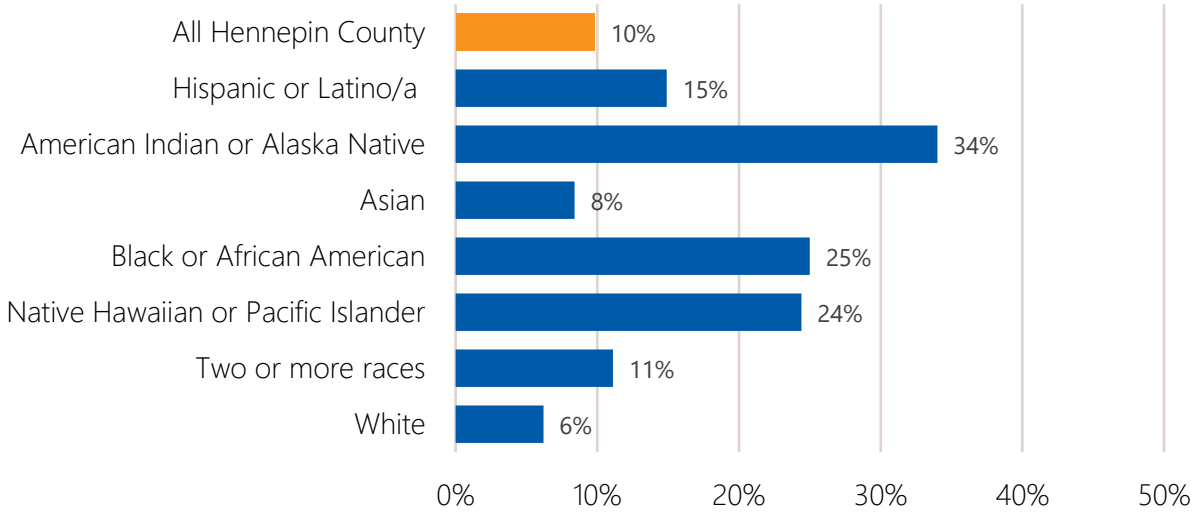
Source: American Community Survey 5-year estimates

Poverty

Poverty refers to a low level of income that is insufficient to buy basic needs [15]. The federal government tracks poverty via the Federal Poverty Level (FPL) measure, which accounts for income, family size, and inflation. In 2024, 100% of the FPL was $15,060 for one person, and $31,200 for a family of four [16]. Poverty can result in part from unequal economic opportunities, and in turn, can lead to downstream disparities in health outcomes. Children are disproportionally represented among the impoverished, which can lead to life-long decreases in health and well-being and challenging generational effects in health and opportunity. The federal Healthy People 2030 has set an objective to reduce the proportion of people living in poverty to 8% [17].

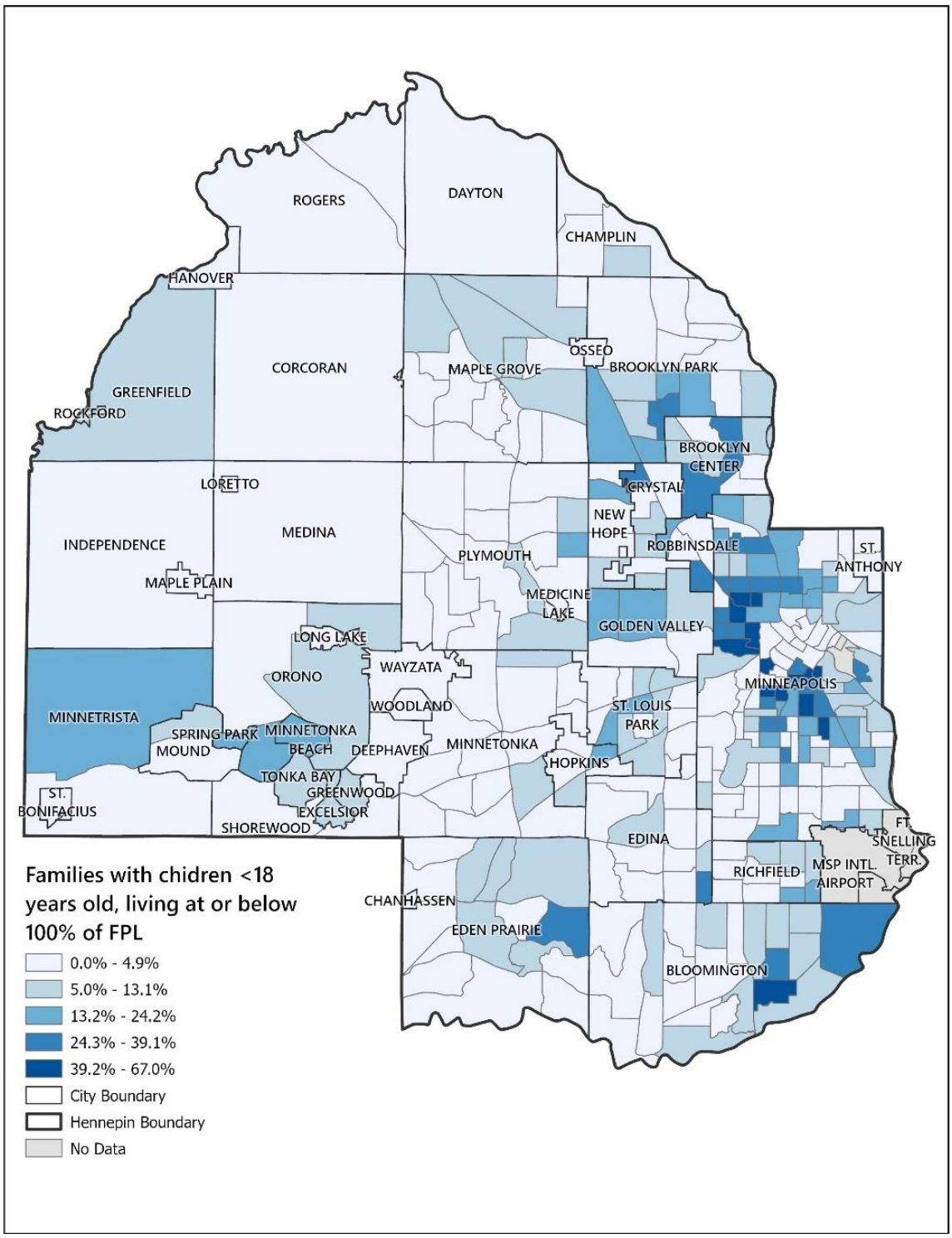
- From 2018 to 2022, nearly one in 10 (10%) Hennepin County residents, 11% of children (under 18), and 8% of seniors (65 and over) in the county were living below the poverty line (ACS 5-YR, 2018-2022).
- Racially and ethnically diverse populations were more likely to experience poverty compared to the county average (Figure 35).
- There are geographic concentrations of poverty, with higher concentration of residents with low incomes in Minneapolis and the first ring suburbs such as Brooklyn Center, Brooklyn Park, Richfield, Hopkins and areas of Bloomington, New Hope and St. Louis Park in comparison to the outer ring suburbs (Figure 36).

Figure 35: Percent of individuals living under 100% of the Federal Poverty Level, 2018-2022



Source: American Community Survey 5-year estimates

Figure 36: Percent of families with children less than 18 years old, living at or below 100% of the Federal Poverty Level by census tract, 2018-2022



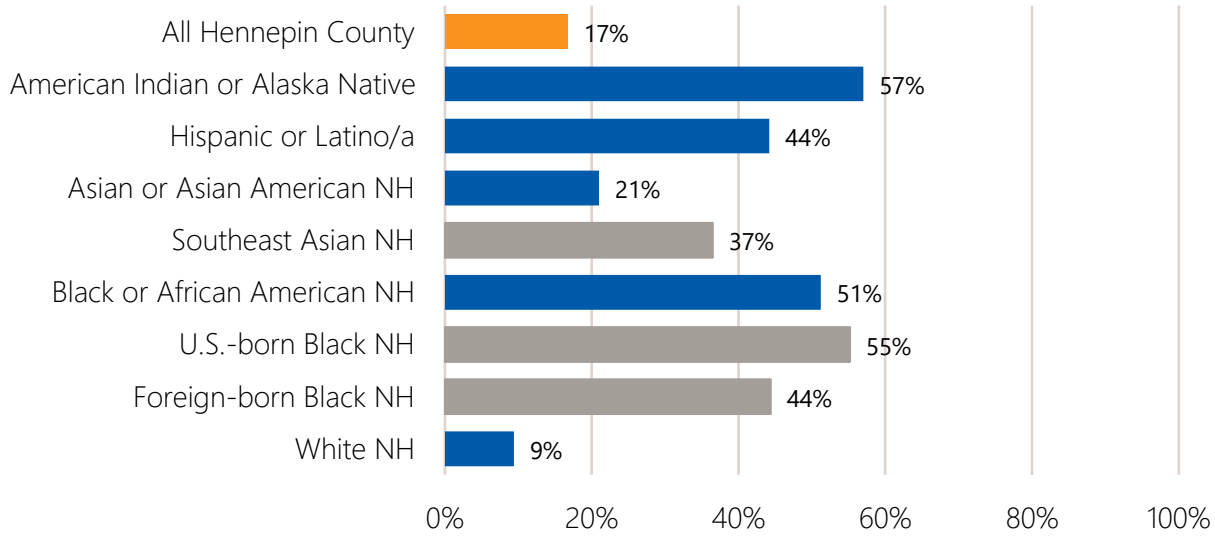
Source: American Community Survey 5-year estimates; FPL means Federal Poverty Level

Economic distress

The SHAPE survey measures economic distress as a summary measure of five SHAPE questions regarding food insecurity, hunger, housing insecurity, being unhoused, and transportation insecurity. The measure captures strain or inability in attaining basic life needs.

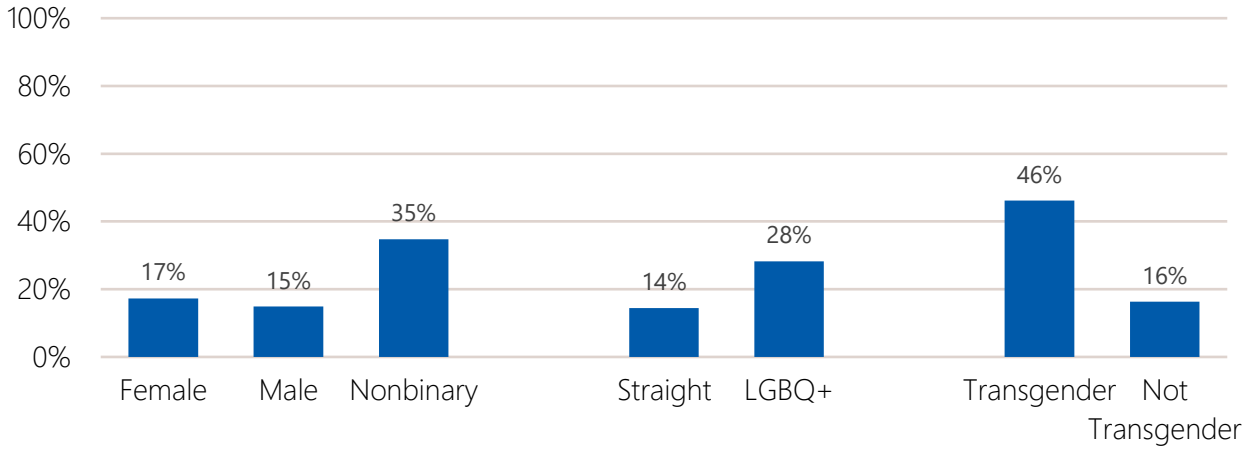
- Economic distress is disproportionally high among racially and ethnically diverse populations in Hennepin County, as well as nonbinary, LGBQ+, and transgender residents compared to the county average (Figures 37 and 38).
- Young residents and residents with less than a college degree were more likely to experience economic distress (Figure 39).

Figure 37: Percent of adults reporting economic distress during the past 12 months by race/ethnicity, 2022



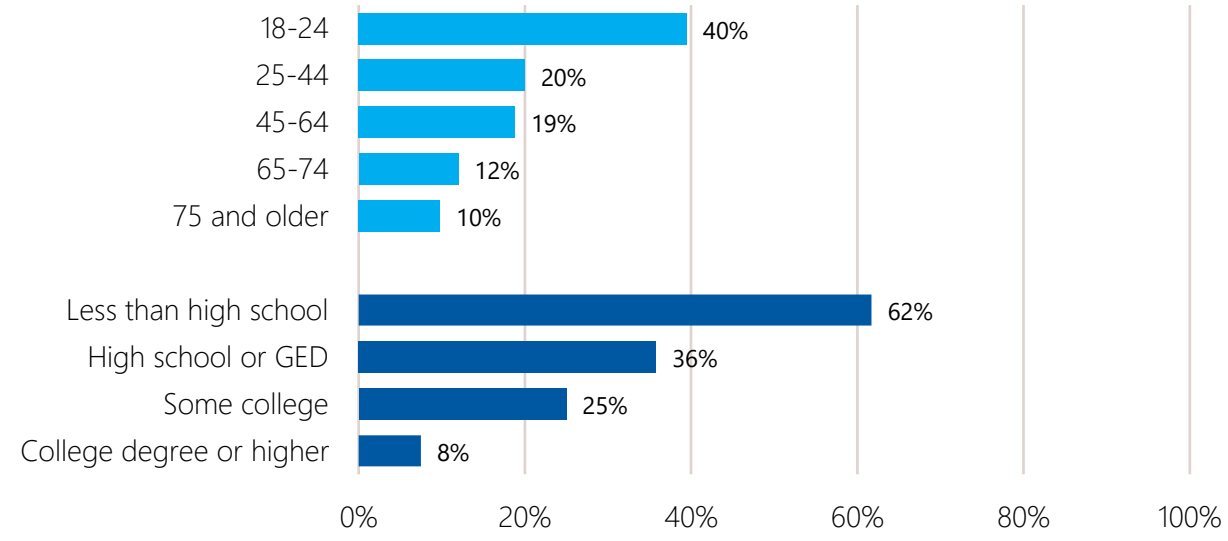
Source: SHAPE; NH is *non-Hispanic ethnicity*

Figure 38: Percent of adults reporting economic distress during the past 12 months by gender identity and sexual orientation, 2022



Source: SHAPE

Figure 39: Percent of adults reporting economic distress during the past 12 months by age and education, 2022



Source: SHAPE

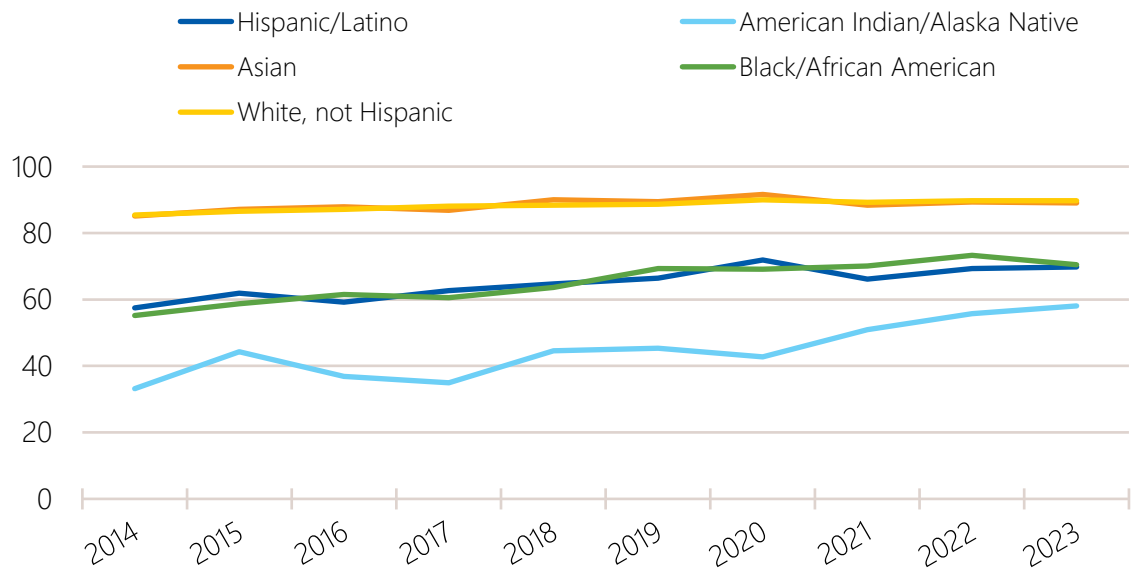
Education

Educational attainment is casually related to income and employment, and all three qualities are strongly associated with health outcomes [18]. People with a higher level of education tend to have greater socioeconomic resources for a healthy lifestyle, better health access, and more

security in ability to live and work in environments with the resources and physical surroundings that support healthy living.

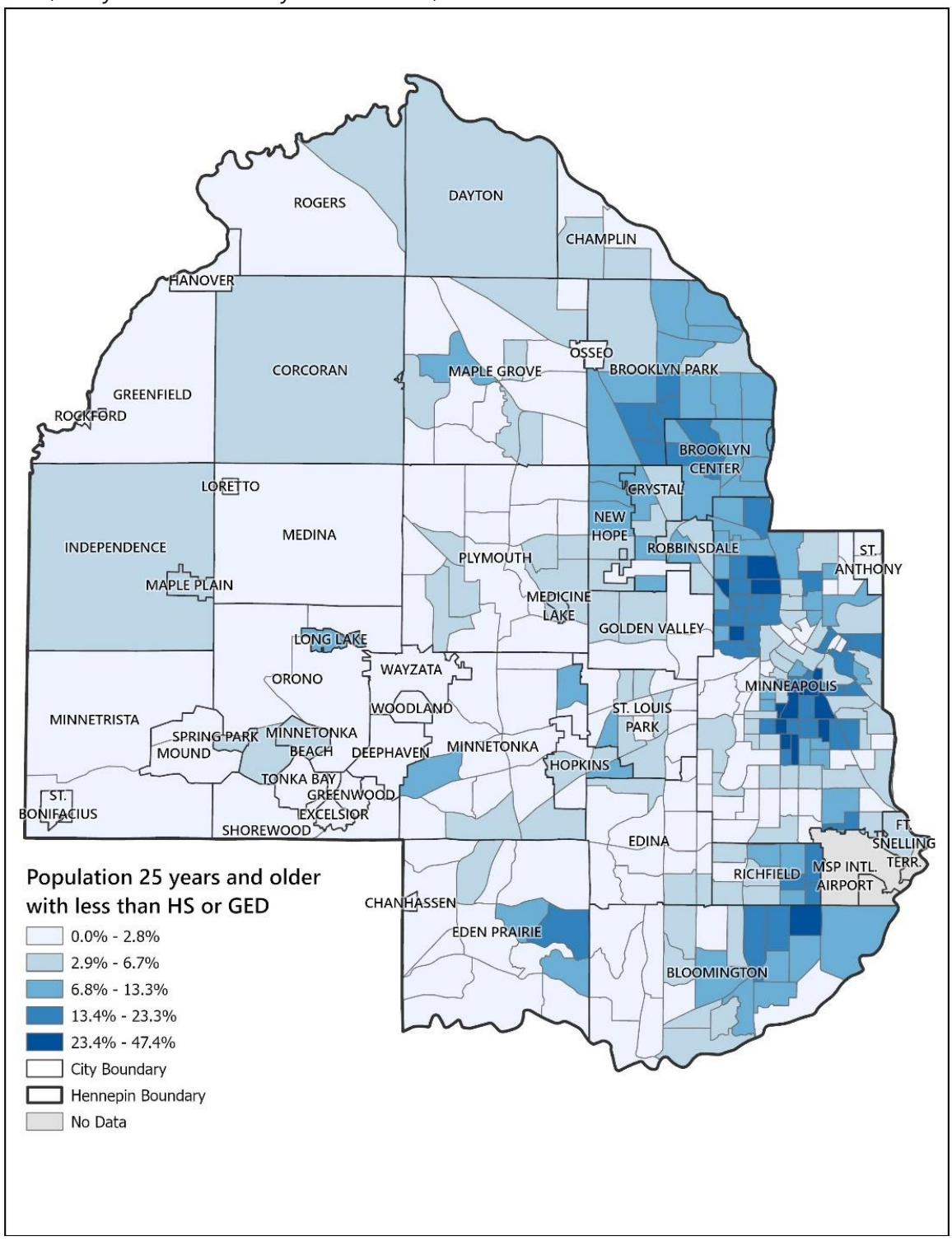
- During the 2022-2023 school year, 82% of Hennepin County high school students graduated within four years. Although graduation rates improved for all racial and ethnic groups, disparities persisted for Hispanic or Latino/a, American Indian or Alaska Native, and Black or African American students in Hennepin County (Figure 40).
- High school students who were eligible for free/reduced priced meals (70%) and students who experienced homelessness (49%) were less likely to graduate in four years compared to the overall rate (Minnesota Department of Education).
- There were geographic concentrations of lower educational attainment, with a larger percent of residents 25-years or older with less than a high school diploma in North Minneapolis, parts of south Minneapolis, Richfield, Bloomington, and north first ring suburbs, such as Brooklyn Park (Figure 41).
- Half (53%) of Hennepin County adults ages 25 and had a bachelor's degree. White and Asian adults were more than twice as likely to have a bachelor's degree compared to American Indian or Alaska Native, Black or African American, or Hispanic or Latino/a adults (Figure 42).

Figure 40: Percent of students graduating high school in four years by race/ethnicity, 2014-2023



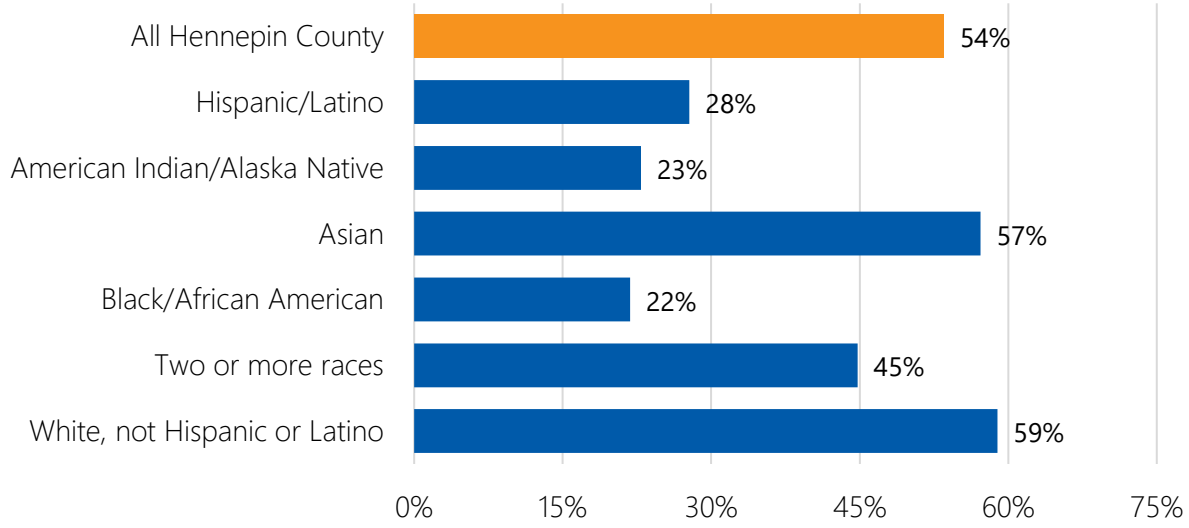
Source: Minnesota Department of Education Graduation Indicators, Hennepin County

Figure 41: Percent of the population that has not graduated high school or obtained a GED, 25-years or older by census tract, 2018-2022



Source: American Community Survey 5-year estimates

Figure 42: Percent of population 25-years and older with a bachelor's degree or higher by race/ethnicity, 2018-2022



Source: American Community Survey 5-year estimates

Attaining basic needs

Basic needs, or physiological needs, refer to things needed for survival, such as food, clean water, and shelter from the outside world. This assessment looks at both food and housing insecurity, when maintaining access to these resources is not stable, and the absence of these resources altogether, such as hunger and being unhoused. When basic needs are not met, other health and well-being behaviors — like provider visits — may not be a priority or possible to carry out [19]. Specifically, food insecurity is associated with negative health outcomes in children, such as obesity, developmental challenges, and poorer mental health [20]. Housing insecurity is known to have broad impacts on health, including reduced social connection, psychological trauma because of sudden life disruptions when housing is lost, higher rates of chronic disease and poor physical health, and higher rates of premature death [21].

Theme: Residents need equitable access to affordable, nutritious food

Respondents shared that rising food costs have increased demand at food shelves, especially for culturally preferred items. Food insecurity creates stress for families, with youth experiencing heightened insecurity during summer and school breaks. Addressing youth food insecurity is critical for them to benefit from other services and programs.

Theme: There is a lack of stable, affordable housing and an increase in housing insecurity

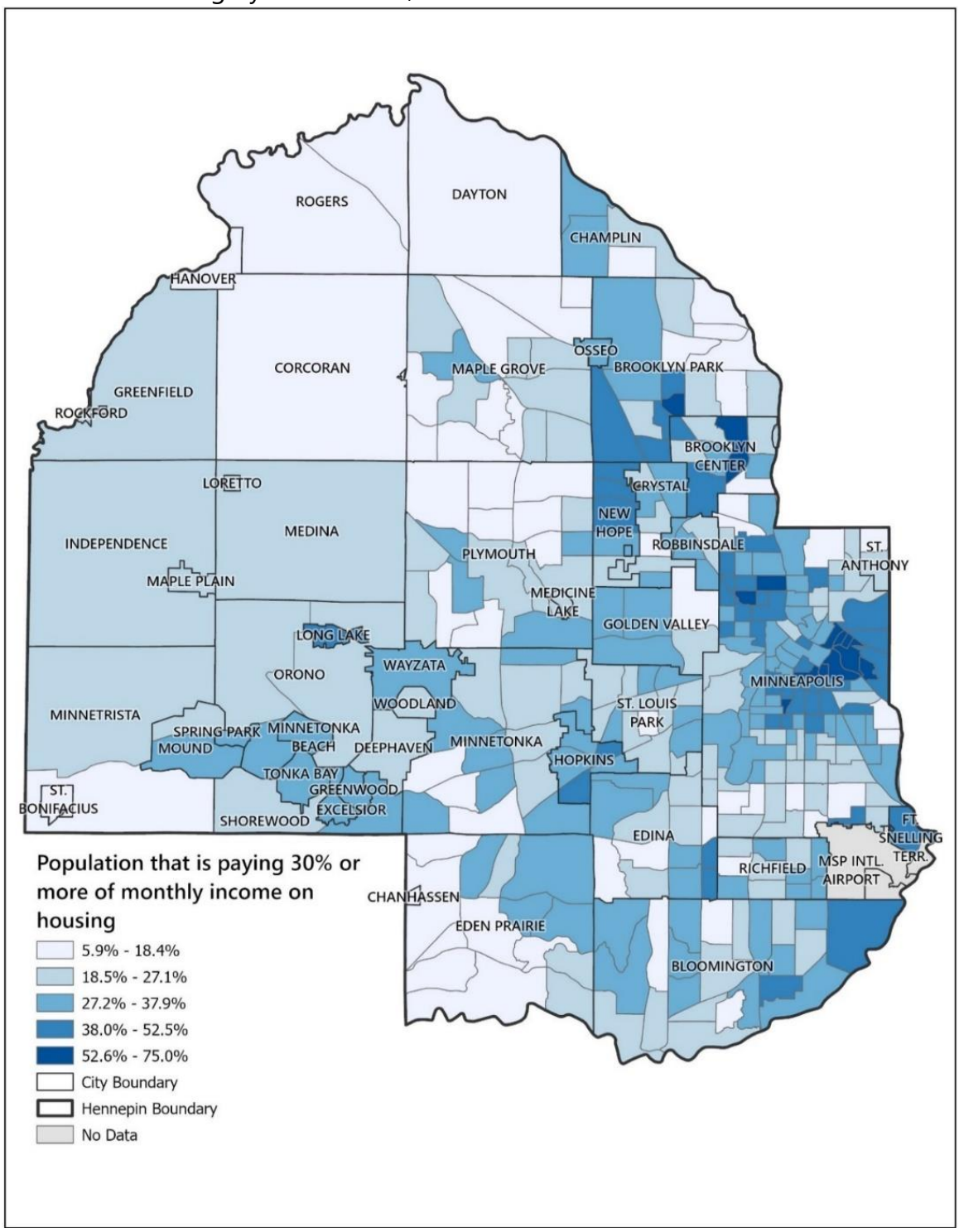
Respondents said that barriers to housing, and support programs need to be reduced. Housing programs are overwhelmed. Unhoused individuals — particularly older adults — are at-risk for communicable diseases in shared living spaces and have reduced access to preventive care and ability to manage chronic conditions. Contributing factors include the end of the eviction moratorium, reduced pandemic-era supports, inflation in food and fuel costs, and an increase in newly arrived households unable to access legal employment or benefits.

Housing cost-burdened

Individuals or families who pay more than 30% of their income towards housing are considered housing cost-burdened. This burden may result in difficulty affording necessities such as food, clothing, transportation, and medical care.

- There was a higher concentration of people who are housing cost-burdened living in Minneapolis and first ring suburbs such as Brooklyn Center, Brooklyn Park, Richfield, Hopkins, Bloomington, New Hope, and St. Louis Park in comparison to the outer ring suburbs (Figure 43).

Figure 43: Percent of the population that is paying 30 percent or more of monthly income on housing by census tract, 2018-2022



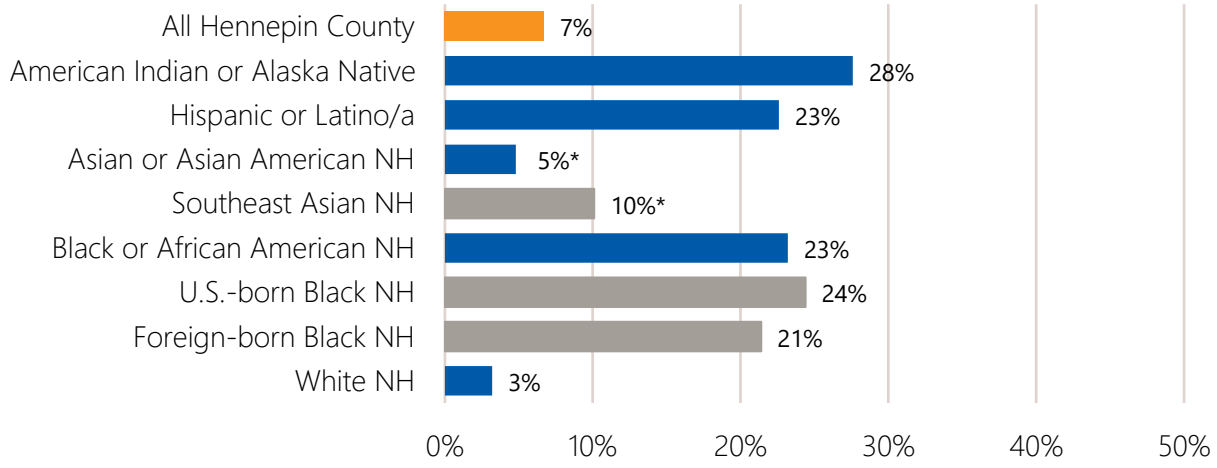
Source: American Community Survey 5-year estimates

Housing insecurity

In the 2022 SHAPE survey, a measure of housing insecurity is the percent of people who missed or delayed a rent or mortgage payment in the past year.

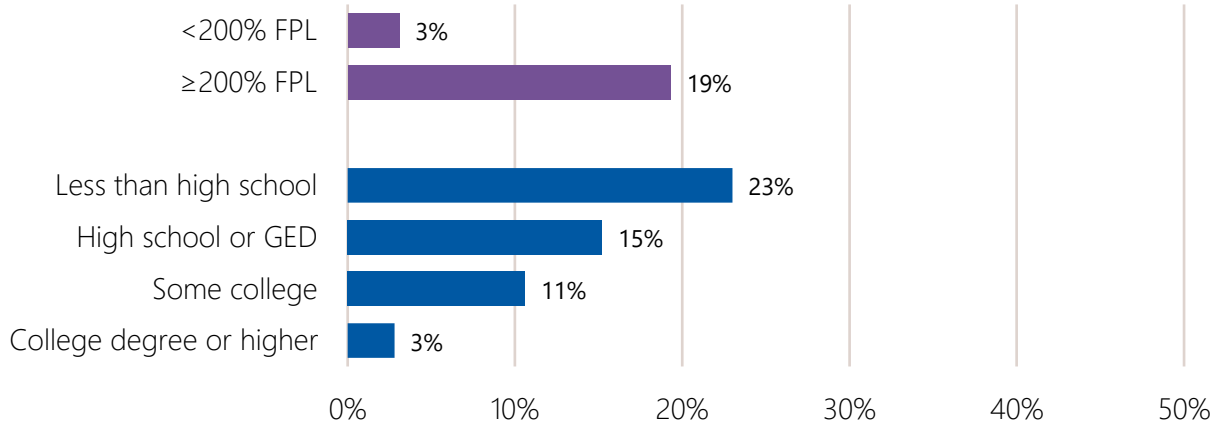
- In 2022, 7% of Hennepin County adults reported experiencing housing insecurity, but the percent varied geographically, with 10% in Minneapolis compared to 5% in suburban Hennepin County (SHAPE 2022).
- Racial disparities within housing were evident. Nearly a quarter of American Indian or Alaska Native adults (28%), U.S.-born Black adults (24%), and Hispanic or Latino/a adults (23%) reported experiencing housing insecurity in the past year (Figure 43).
- Adults who identify as LGBQ+ (12%) or transgender (21%) were more likely to experience housing insecurity (SHAPE 2022).
- Adults with less than a high school education were seven times as likely to experience housing insecurity (23%) as adults with a college degree or higher (3%) (Figure 44).

Figure 43: Percent of adults reporting missed or delayed rent or mortgage due to finances the past 12 months by race/ethnicity, 2022



Source: SHAPE; NH is non-Hispanic ethnicity
***** *Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

Figure 44: Percent of adults reporting missed or delayed rent or mortgage due to finances the past 12 months by income and education level, 2022



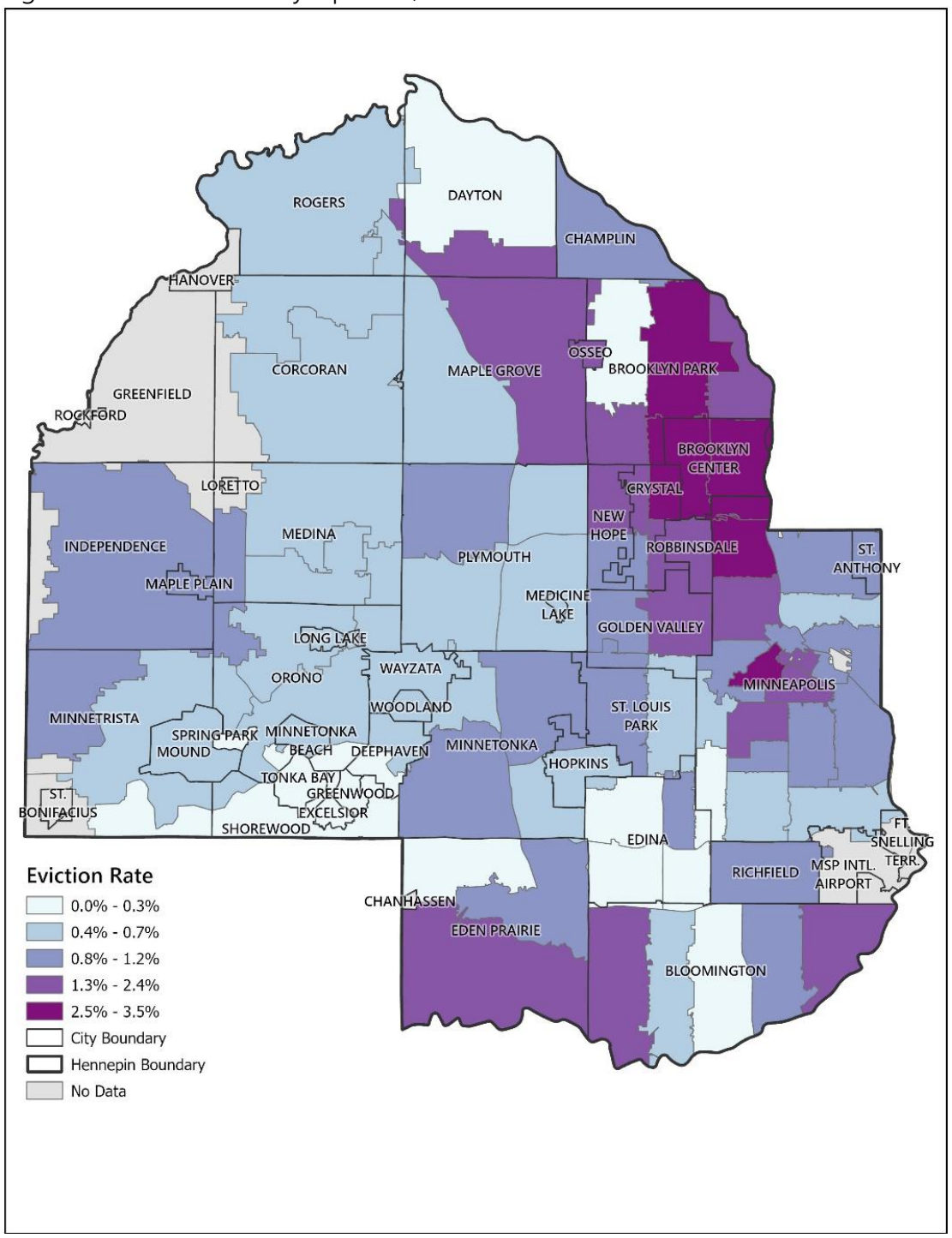
Source: SHAPE; FPL is Federal Poverty Level

Evictions

Evictions are when a person or family is expelled from a property, and there are many reasons for eviction but inability to pay rent is a common cause. In response to the pandemic, a federal eviction moratorium for cases involving non-payment of rent was implemented on September 2020 by the U.S. Centers for Disease Control and Prevention (CDC), to reduce the spread of COVID-19 and bring housing insecurity relief to residents that were economically impacted by the pandemic [22]. The U.S. Supreme Court rejected the case to continue the CDC's eviction moratorium, and the policy ended August 26, 2021. Minnesota state enacted executive orders covering June 30, 2021, to June 1, 2022, to phase out the eviction moratorium practices, and during this time evictions were still possible, but more support and opportunity was provided to renters.

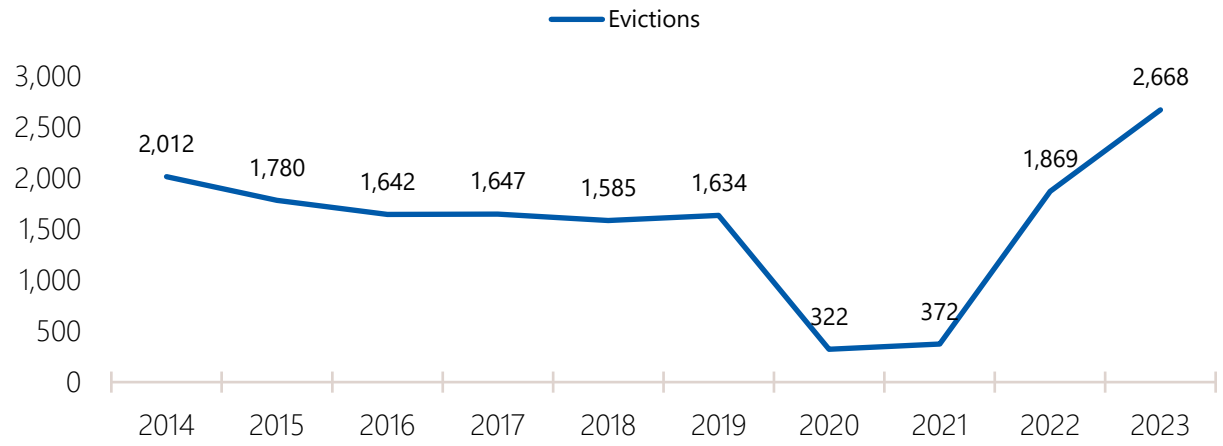
- Long term data (2014 – 2022) of evictions show geographic disparities in eviction occurrence, with a greater number occurring in central and North Minneapolis, and first ring northern suburbs, such as Brooklyn Park, Crystal, and Brooklyn Center (Figure 45).
- The Hennepin County eviction count for 2023, 2,700 evictions, far exceeded the pandemic era and pre-pandemic counts for the previous decade (Figure 46).

Figure 45: Eviction rate by zip code, 2014-2022



Source: Hennepin County

Figure 46: Number of housing evictions, 2014-2022



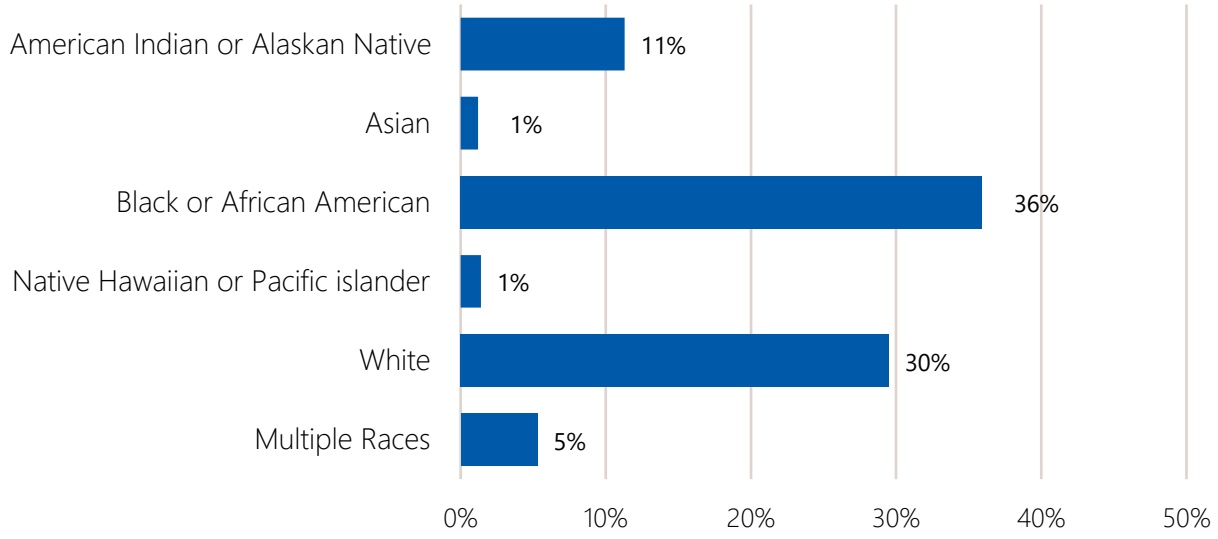
Source: Hennepin County

Unhoused persons

Unhoused persons and families include those in emergency shelter, transitional housing, and those without any shelter. Recent years have seen an increased count of unhoused persons and need for shelter. Several causes factored into the increased demand, including the end of the eviction moratorium, the winding down of pandemic-era supports for low-income households, inflation affecting prices of basic needs, and an increase in households newly arrived in Hennepin County without recourse to legal employment or benefits.

- The overall increase in unhoused persons was driven by a spike in families that became unhoused. Unhoused families increased by 79% from 2022 to 2023, and by 30% from 2023 to 2024 (HUD CoC).
- As a result of Hennepin County's shelter-all policy for families, more than 98% of families were in shelter or transitional housing and avoided unsheltered homelessness (HUD, CoC).
- American Indian or Alaska Native, Black or African American, and Hispanic or Latino/a people were disproportionally represented among the unhoused population based on a Point in Time Count in January 2024 (Figure 47).

Figure 47: Percent of people unhoused by race/ethnicity on January 25, 2024



Source: Hennepin County Point in Time Count Estimates, 2024
**Hispanic category is not mutually exclusive*

Food insecurity

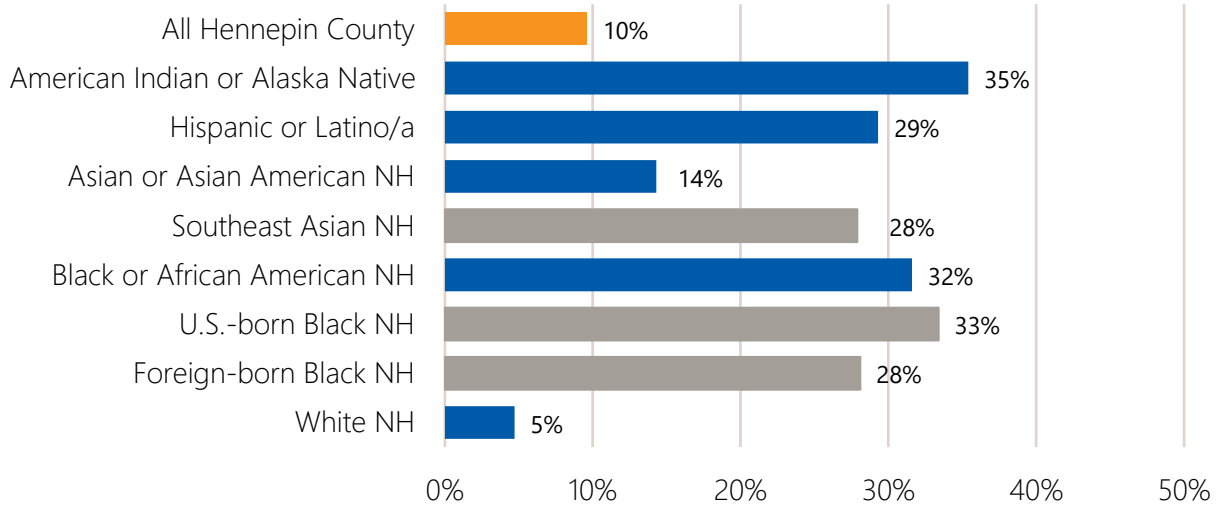
Food insecurity is when conditions limit or make uncertain access to adequate food [20]. Low food security can refer to either a reduced quality diet or disrupted eating patterns, or hunger. The SHAPE 2022 survey defined food insecurity as adults worrying often or sometimes that food would run out before there was money to buy more. The survey defined hunger as often or sometimes reporting the food in the household did not last and that there was no money to buy more. The Minnesota Student Survey asked students about hunger by asking whether they had to skip meals because their family did not have enough money to buy food.

There is reason to believe that child hunger is decreasing in Minnesota. In July 2023, the Free School Meals for Kids Program, passed by the Minnesota Legislature in spring 2023, came into effect, providing free breakfast and lunch to any child enrolled in a qualifying school [23]. Early data suggest that breakfast participation increased by 40% and lunch participation increased by 15% across Minnesota.

- In Hennepin County, one in 10 adults (10%) reported food insecurity. This percent varied by geography, with nearly a third (30%) of adults in North Minneapolis reporting food insecurity compared to only 4% in the Suburban South-West areas (SHAPE 2022).
- Nearly one in three American Indian or Alaska Native (35%), Black or African American (32%), and Hispanic (29%) adults reported food insecurity, as well as residents with low-income (32%) and less than a high school education (43%) (Figures 48 and 49).

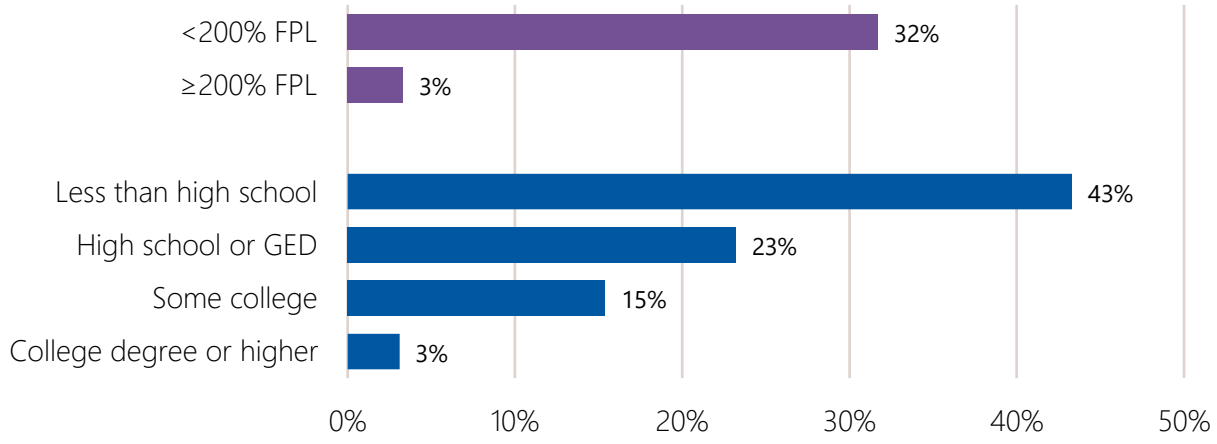
- The percent of adults reporting hunger was higher among American Indian or Alaskan Native (31%), Black or African American (31%), and Hispanic or Latino/a (20%) residents, compared to the county average (7%) (Figure 50). The percent was also higher among residents with a lower income (25%), and those with a less than a high school degree (38%) (Figure 51).
- Experiencing food insecurity in the past 30 days was reported by 3% of adolescents (8th, 9th, and 11th graders) (MSS 2022).

Figure 48: Percent of adults reporting they often/sometimes worry that food in the household would run out before there was money to buy more by race/ethnicity, 2022



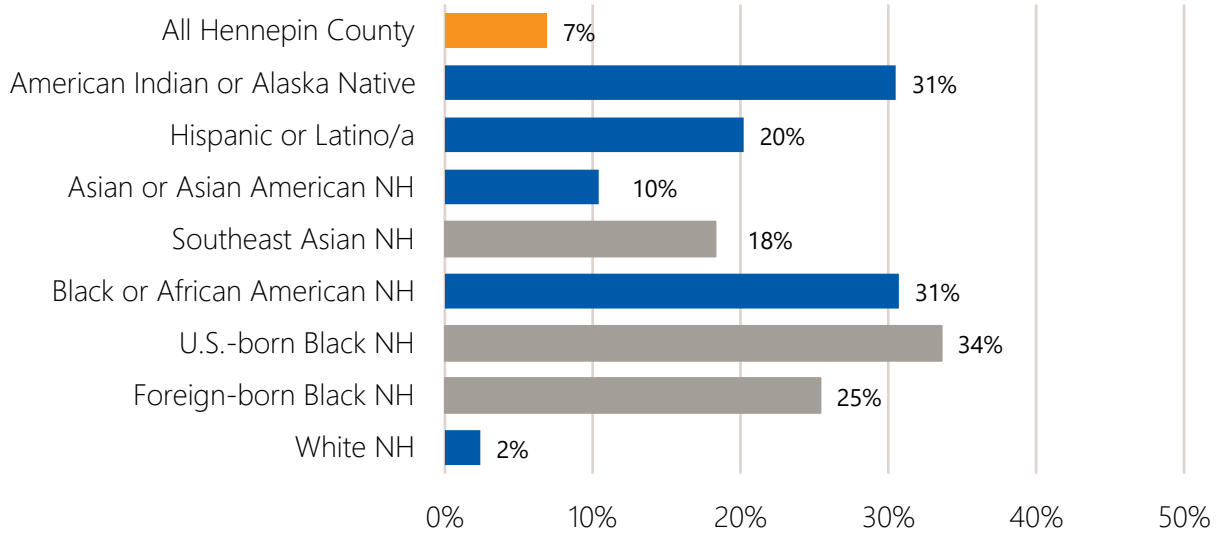
Source: SHAPE; NH is non-Hispanic ethnicity

Figure 49: Percent of adults reporting they often/sometimes worry that food in the household would run out before there was money to buy more by income and education level, 2022



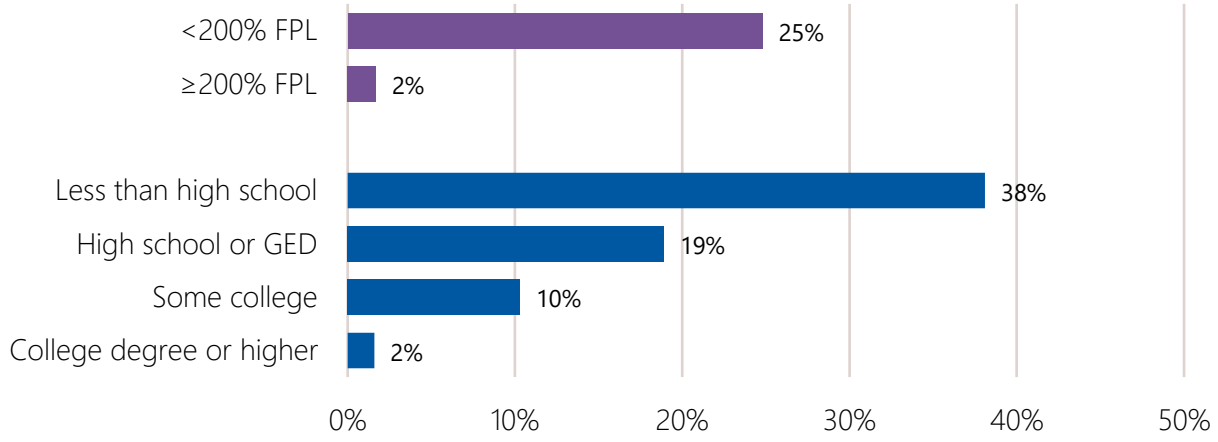
Source: SHAPE; FPL is Federal Poverty Level

Figure 50: Percent of adults reporting often/sometimes food in the household did not last and there was not money to get more by race/ethnicity, 2022



Source: SHAPE; NH is non-Hispanic ethnicity

Figure 51: Percent of adults reporting often/sometimes food in the household did not last and there was not money to get more by income and education level, 2022



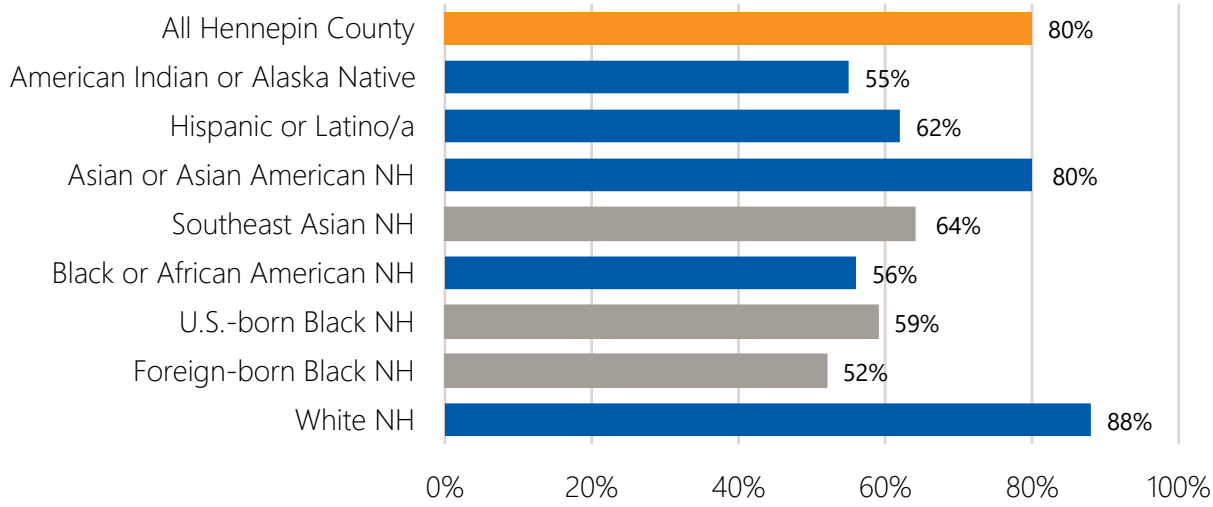
Source: SHAPE; FPL is Federal Poverty Level

Access to food

The degree of local access to fruits and vegetables and affordable cultural foods can contribute to levels of food insecurity. In Minneapolis, 70% of residents reported that accessing fruits and vegetables in their local area was very easy, while the percent was higher at 85% for residents in suburban areas of the county. However, there was geographic variation, such as in Minneapolis areas of Camden and Near North, only 53% reported it easy to find fruits and vegetables. There was variation in access by race or ethnicity (Figure 52), income, and education (Figure 53).

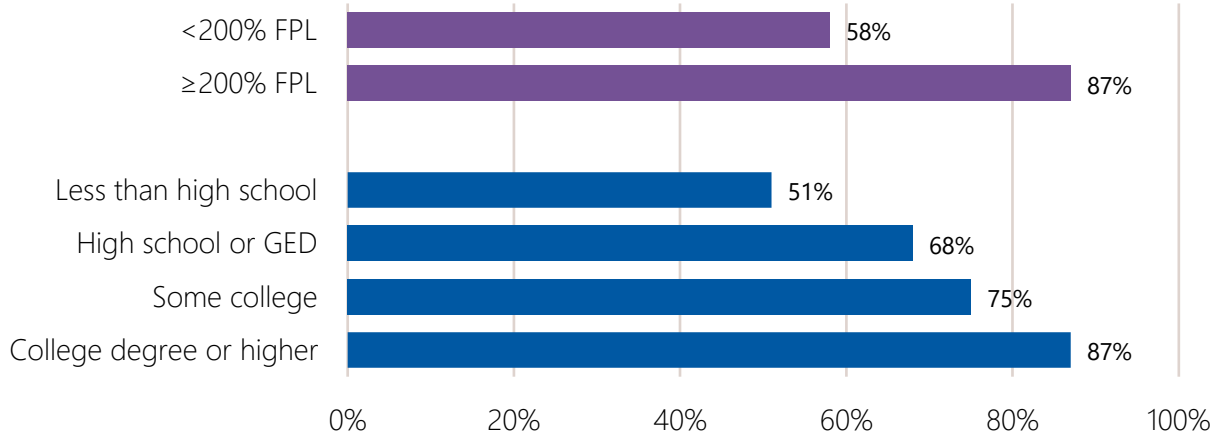
Access to affordable cultural food followed a similar pattern geographically, as well as by race or ethnicity, income, and education (Figures 54 and 55).

Figure 52: Percent of adults reporting that it is very easy to get fruit and vegetables in the local area by race/ethnicity, 2022



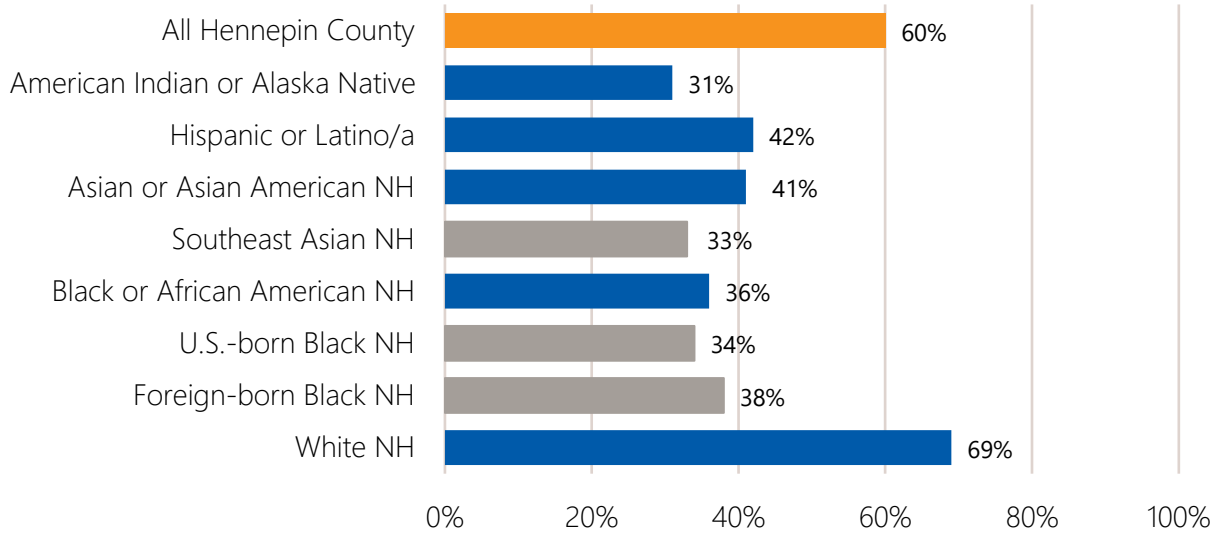
Source: SHAPE; NH is non-Hispanic ethnicity

Figure 53: Percent of adults reporting that it is very easy to get fruit and vegetables in the local area by income and education level, 2022



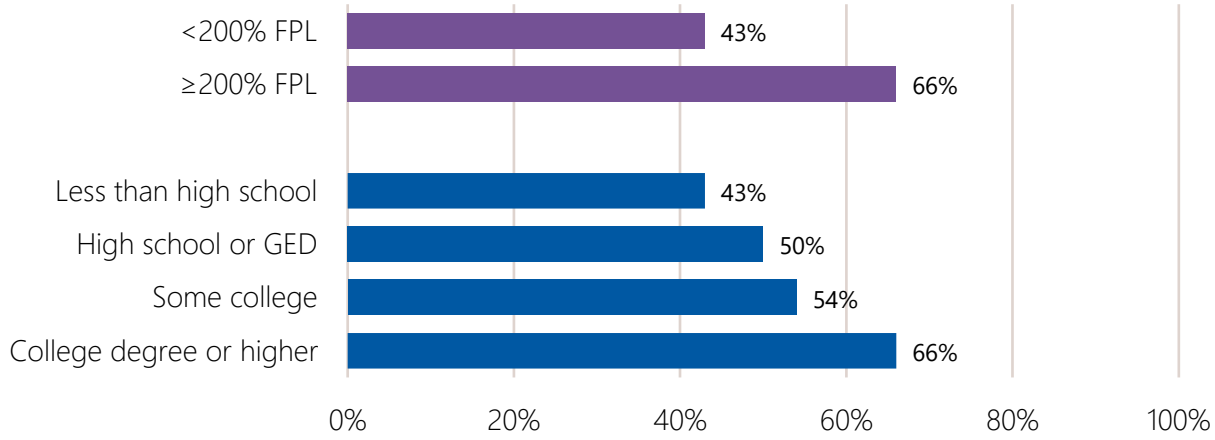
Source: SHAPE; FPL is Federal Poverty Level

Figure 54: Percent of adults reporting it is very easy to get food that reflects their culture and is affordable in the local area by race/ethnicity, 2022



Source: SHAPE; NH is non-Hispanic ethnicity

Figure 55: Percent of adults reporting it is very easy to get food that reflects their culture and is affordable in the local area by income and education level, 2022



Source: SHAPE; FPL is Federal Poverty Level

Connection

Increasing social isolation and loneliness is a national trend, and the U.S. Surgeon General announced an advisory statement on the national epidemic of loneliness in May 2022 [24]. Social connectivity has direct effects on our psychological well-being, as relationships can bring meaning and happiness, and decreased occurrence of mental health issues. Low social connectivity can also impact our physical health, increasing the risk of chronic disease and premature death. Wider community or civic engagement is also known to improve community

and individual health, such that more involved individuals are more likely to report a status of good health [25]. Research on community-wide connections and health is still developing. In this assessment, we looked at information on personal social connection, as well as factors that allow people to connect with their broader communities, including voting, transportation access, and internet access. Social connection emerged as an important theme in the qualitative findings.

Theme: Social isolation is an epidemic, affecting people across the lifespan and in multiple communities

Many informants stressed the need for programs that support social connection in communities. The COVID-19 pandemic caused a decline in participation in in-person support and activity groups. Respondents highlighted the link between social connection and mental well-being, noting that older adults, youth, new parents, and racially and ethnically diverse communities are particularly affected by social isolation.

Theme: Youth need adults they can trust

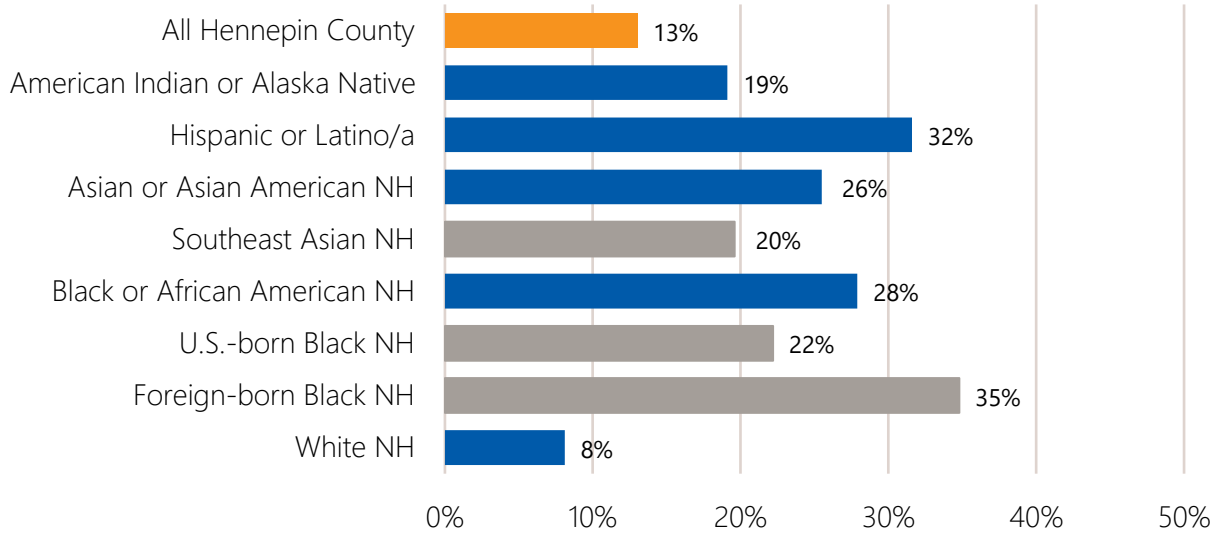
Respondents shared that youth need adults they can trust, rely on, and who understand them. Many youth health concerns are tied to social and emotional skills gaps. Adult relationships are crucial for growth and help, especially when family members lack these qualities. Trusted adults in the community, like teachers, can fill this role, but their actions may not always align with youth needs. Additionally, not all community connections are positive. While youth often turn to peers for support, peers may not be equipped to provide the help needed in all cases.

Adult social connection

The 2022 SHAPE survey asks respondents about how often they get social and emotional support from any source, such as family, friends, neighbors, and/or coworkers.

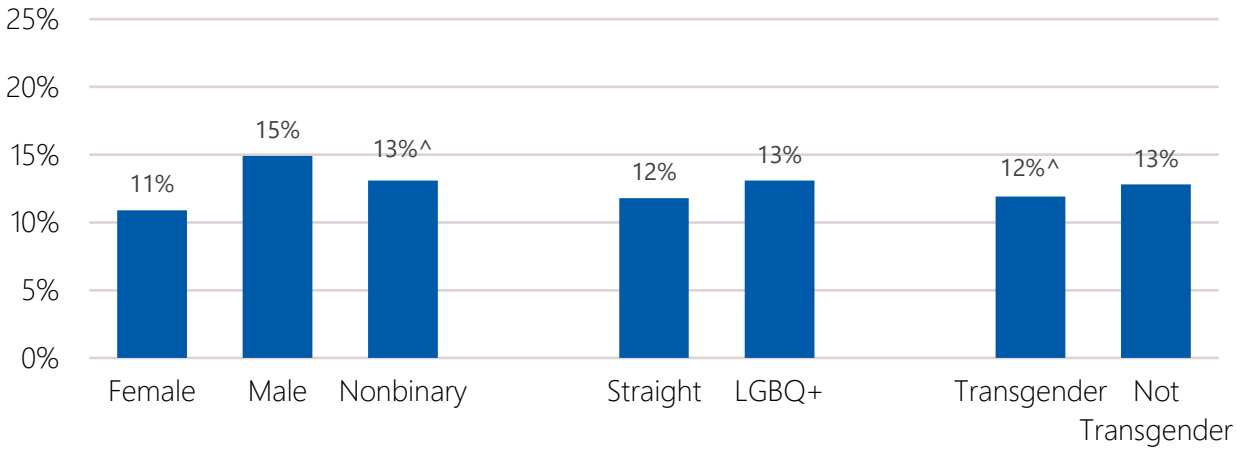
- In 2022, 13% of adults reported rarely or never getting the social and emotional support they need (Figure 56).
- There are disparities of getting needed social or emotional support by race or ethnicity with some over double that of the county overall (Figure 56).
- The likelihood of adults receiving the social and emotional support they need increased with income and educational attainment (Figure 57).
- About 10% of Hennepin County adults reported always or usually feeling isolated. U.S.-born Black or African American adults (25%), young adults (18%), LGBQ+ adults (21%), transgender adults (31%), and those experiencing economic distress (25%) all report isolation at nearly double or higher rates than the county overall (Figures 59-61).

Figure 56: Percent of adults reporting they rarely or never get the social and emotional support they need by race/ethnicity, 2022



Source: SHAPE; NH is non-Hispanic ethnicity

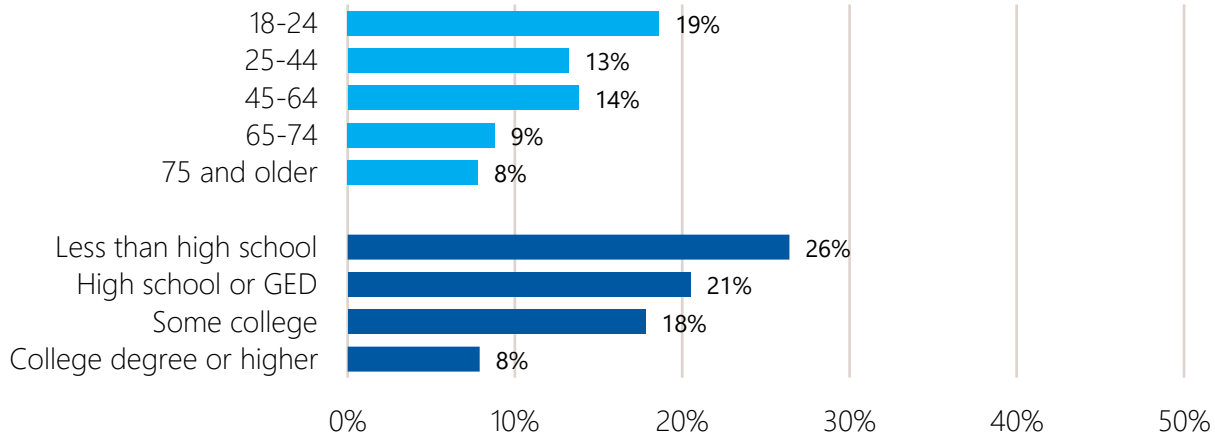
Figure 57: Percent of adults reporting they rarely or never get the social and emotional support they need by gender identity and sexual orientation, 2022



Source: SHAPE

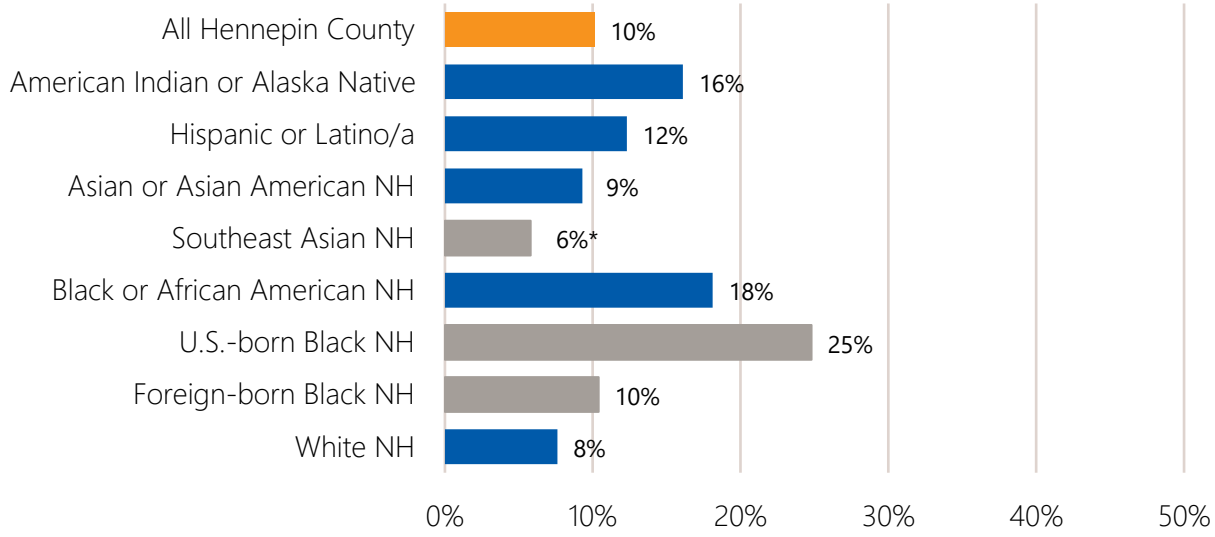
^ Percentage does not meet criteria for statistical reliability, use with extreme caution RSE >50%.

Figure 58: Percent of adults reporting they rarely or never get the social and emotional support they need by age and education, 2022



Source: SHAPE

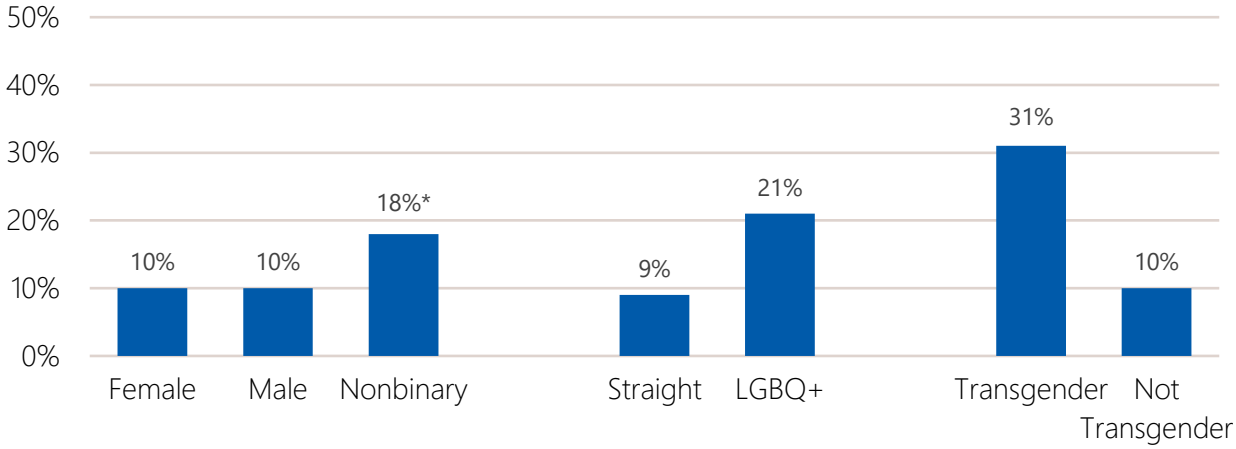
Figure 59: Percent of adults reporting they always or usually feel lonely or isolated from others by race/ethnicity, 2022



Source: SHAPE; NH is non-Hispanic ethnicity

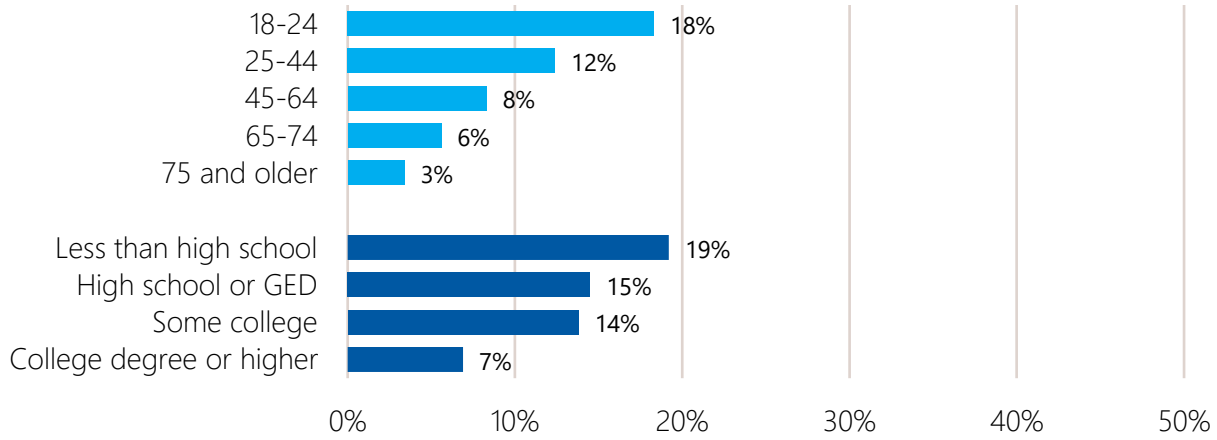
***** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

Figure 60: Percent of adults reporting they always or usually feel lonely or isolated from others by gender identity and sexual orientation, 2022



Source: SHAPE
***** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

Figure 61: Percent of adults reporting they always or usually feel lonely or isolated from others by, age and education, 2022



Source: SHAPE

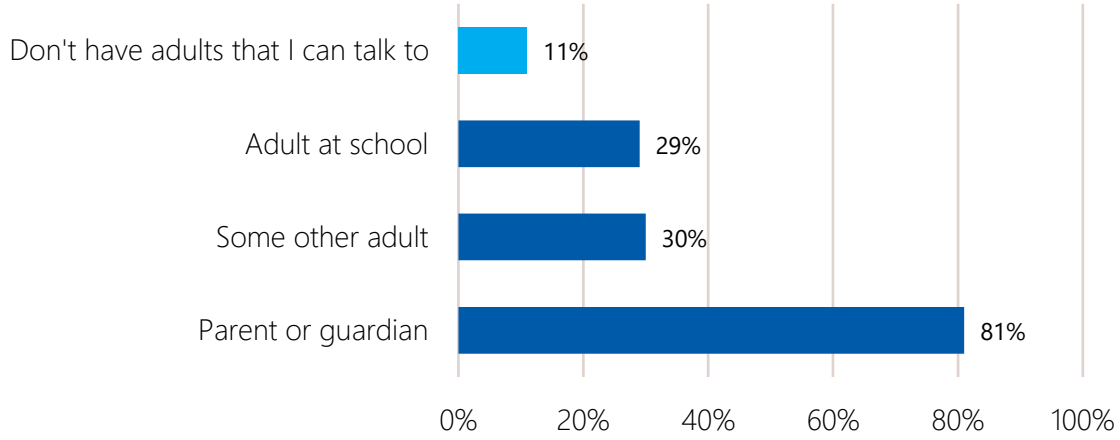
Students with a caring adult

Research demonstrates there are health benefits for adolescents who have a positive relationship with a non-parent adult [26]. Studies show adolescents who have a connection with a caring adult report less risky behaviors, lower tobacco use, and more positive mental health. The federal Healthy People 2030 has set a goal to increase the proportion of adolescents who have an adult they can talk to about serious problems to 82.9% [27].

- About one in 10 (11%) of Hennepin students (8th, 9th, and 11th graders) reported having no adults they can talk to (Figure 62).

- This issue was more common among American Indian or Alaska Native (21%), Black or African American (17%), and Hispanic or Latino/a (17%), and Middle Eastern or North African (17%) students (MSS 2022).

Figure 62: Percent of students reporting they can talk to adults about problems (8th, 9th, & 11th grade students) 2022



Source: MSS, Hennepin County

Civic engagement

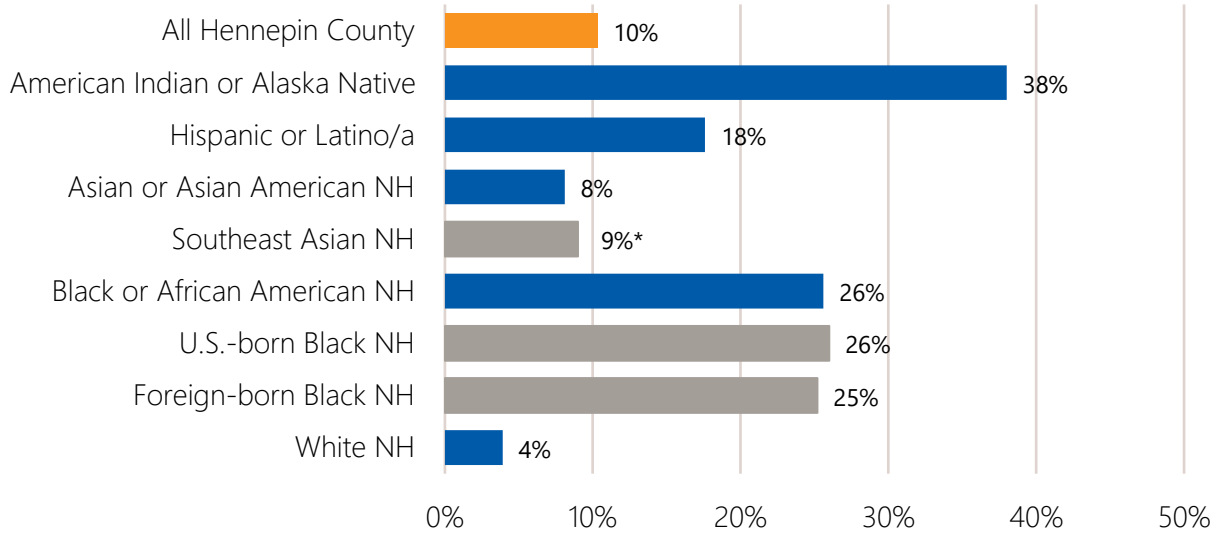
As of August 2024, there were 797,743 registered voters in Hennepin County. In 2020, voter turnout among citizens 18 years of age or older was 86%, which is higher than the statewide voter turnout of 80% (Office of the Minnesota Secretary of State).

Transportation

People rely on transportation to access goods and services and go to work or school. People experiencing transportation difficulties are less likely to access services and obtain basic needs, which can have a negative impact on many aspects of health.

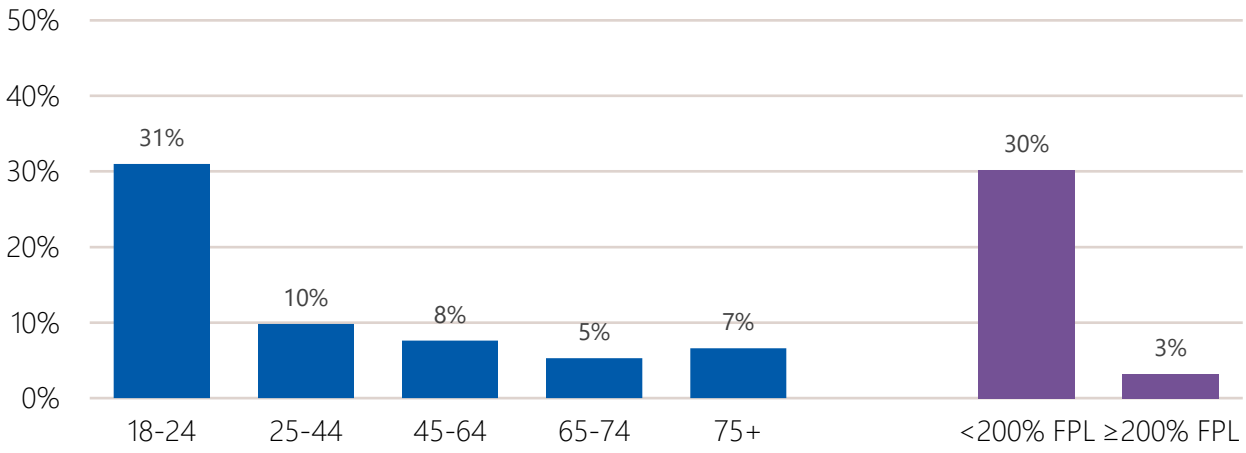
- American Indian or Alaska Native, Black or African American, and Hispanic or Latino/a residents were more likely to face transportation difficulties compared to other racial and ethnic groups (Figure 63).
- A lack of transportation was more commonly reported among younger adults and those with a lower income (Figure 64).
- The disparity in transportation access was also geographic. A higher percent of Minneapolis residents (7%) reported lack of transportation was often keeping them from getting places they needed to go compared to suburban Hennepin County residents (2%) (SHAPE 2022).

Figure 63: Percent of adults reporting they often/sometimes lacked transportation by race/ethnicity, 2022



Source: SHAPE; NH is non-Hispanic ethnicity
***** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

Figure 64: Percent of adults reporting they often/sometimes lacked transportation by age, 2022



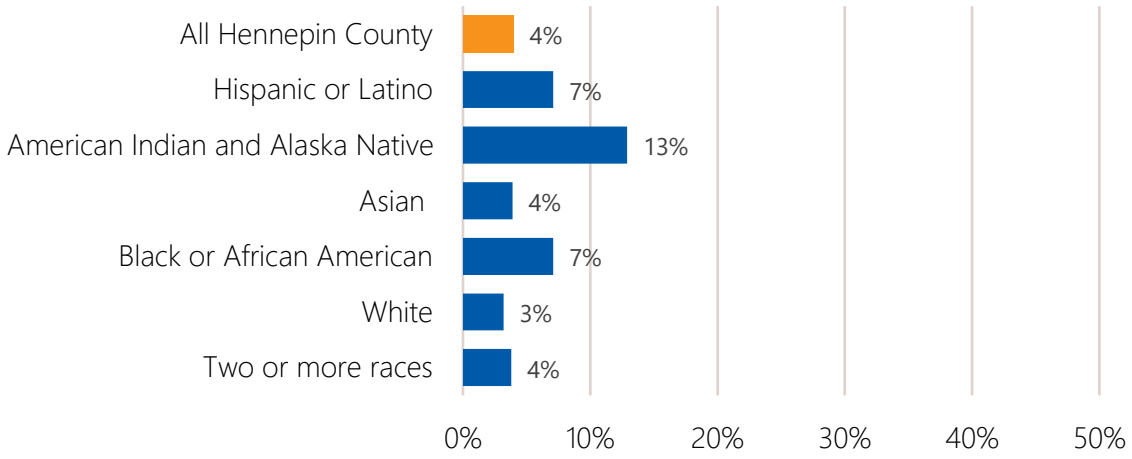
Source: SHAPE; FPL is Federal Poverty Level

Technology

Technology is a tool that can increase connectivity via social interaction, access to health information, and telemedicine options. In Hennepin County, 94% of households had a computer with a broadband internet subscription; however, there were some differences when looked at by age, race or ethnicity, employment status, or education level.

- Nearly one in 10 (9%) adults ages 65 and over did not have a computer in their household, and of those with a computer, 6% did not have an internet subscription (ACS 5-YR, 2018-2022).
- There was a disparity in connectivity to the internet by race or ethnicity. Compared to 4% of Hennepin County households overall, 13% of American Indian or Alaska Native, 7% of Black or African American, and 7% of Hispanic or Latino/a households did not have an internet subscription (Figure 65).
- Those with lower education also had less connectivity to the internet. Of those with less than a high school graduate or equivalency, 11% did not have an internet subscription, and 10% did not have a computer in the household. Of those with a college degree or higher, less than 2% lacked an internet subscription and less than 1% did not have a computer (ACS 5-YR, 2018-2022).

Figure 65: Hennepin County households with a computer but no internet subscription by race/ethnicity, 2018-2022



Source: American Community Survey 5-year estimates

Health behavior and outcomes indicators

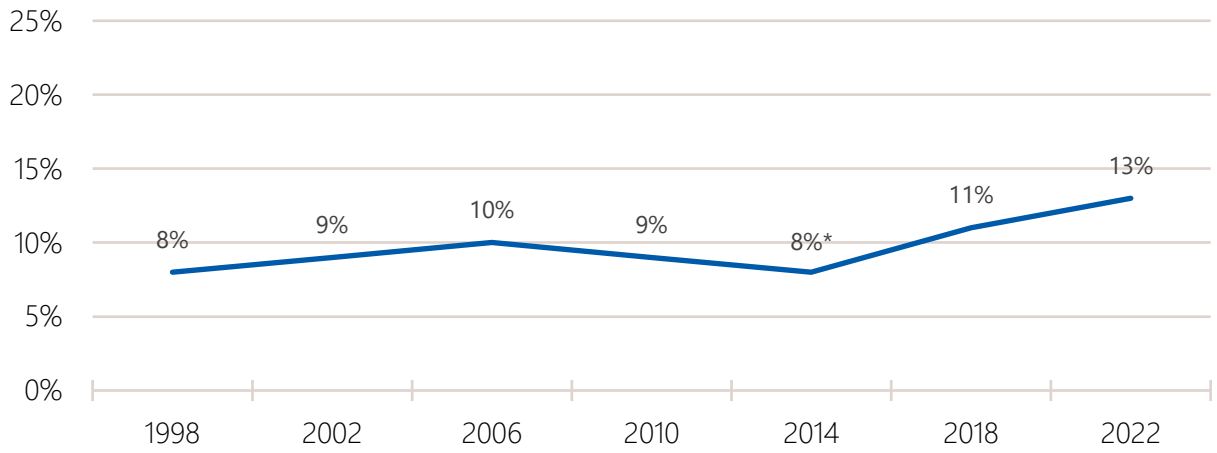
Overall health

Self-rated health reflects how an individual perceives their overall health. Although it is subjective, self-rated health helps predict future health care needs and mortality. Overall, in Hennepin County, the percent of adults reporting their health status was fair or poor increased from 8% in 1998 to 13% in 2022 (Figure 66).

- The rating of health status as fair or poor was more common for certain racial and ethnic groups. American Indian or Alaska Native (29%), Hispanic or Latino/a (29%), and U.S.-born Black (27%) residents reported over double the overall county percent (Figure 67).
- The percent also varied by gender identity and sexual orientation (Figure 68).

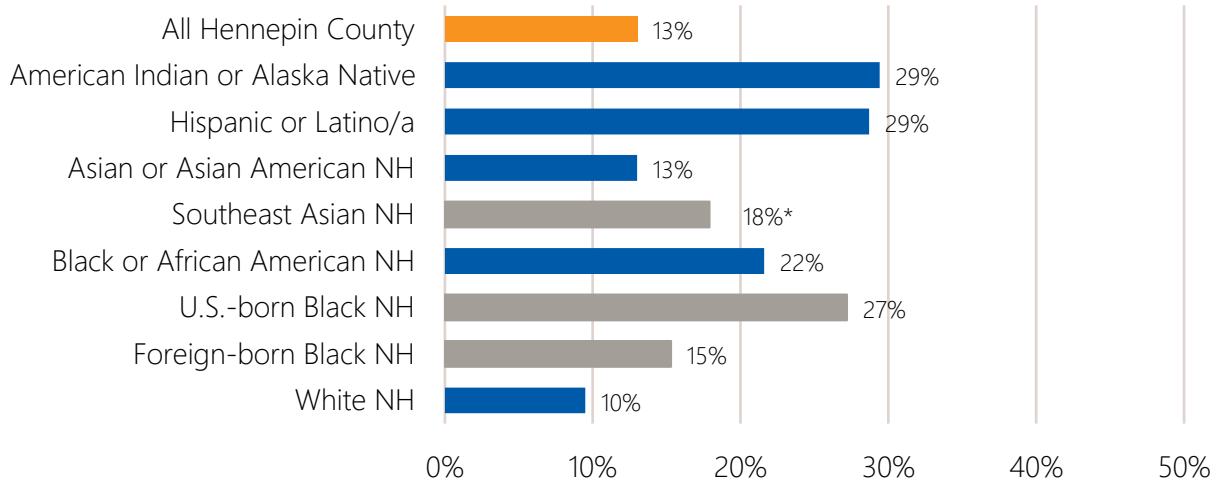
- Among youth attending public schools in the 8th, 9th, and 11th grades, 11% reported their health was fair or poor (Figure 69).
- One in 4 (25%) Hennepin County adults reported being limited in any activities because of physical, mental, or emotional problems. The percent was higher among American Indian or Alaska Native (43%) and U.S.-born Black (38%) residents (Figure 70).
- Activity limitation was also disproportionately higher by gender identity and sexual orientation, particularly for nonbinary (63%), LGBQ+ (38%), and Transgender (66%) adults (Figure 71).

Figure 66: Percent of adults reporting general health status as fair or poor, 1998-2022



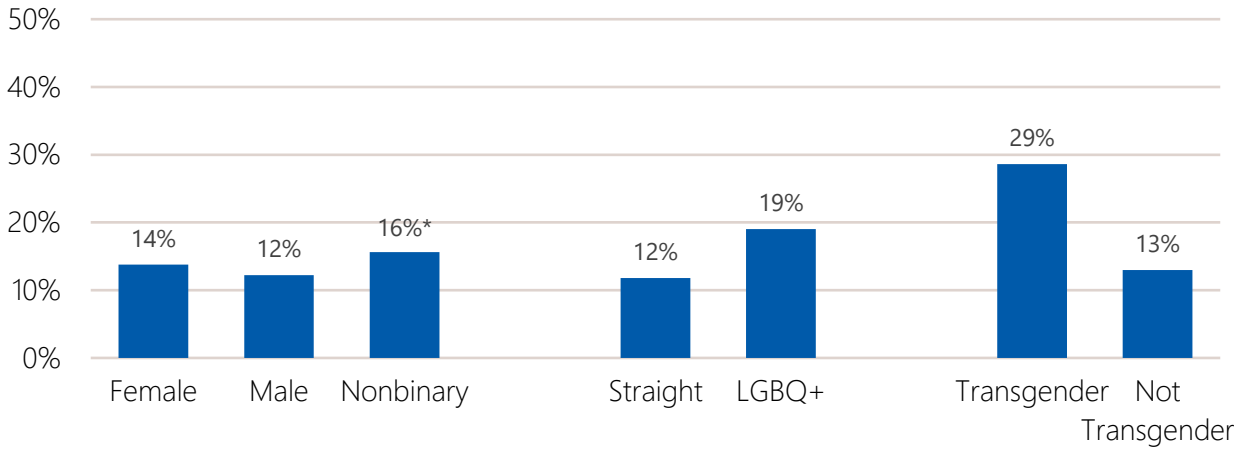
Source: SHAPE
** Results from 2014 survey limited to adults aged 25 and older*

Figure 67: Percent of adults reporting general health status as fair or poor by race/ethnicity, 2022



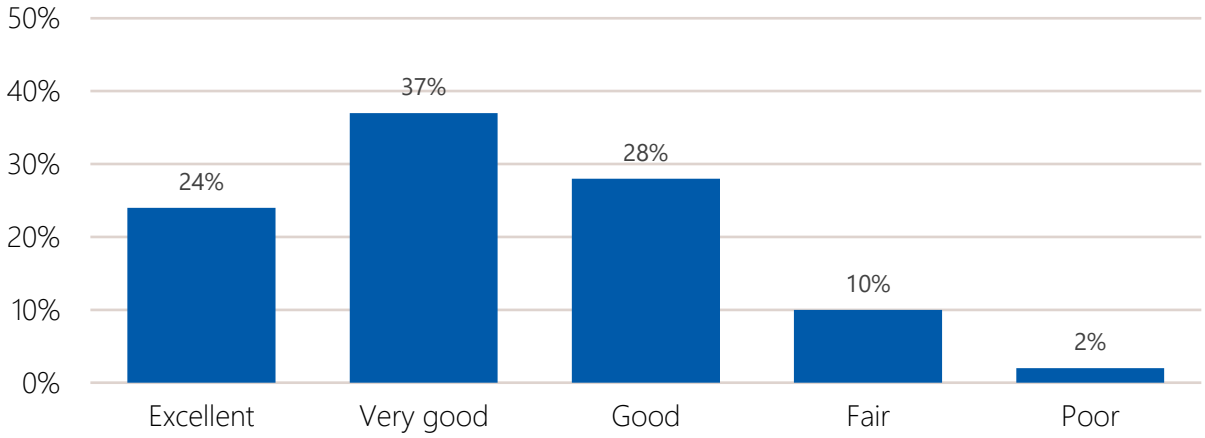
Source: SHAPE; NH is non-Hispanic ethnicity
***** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

Figure 68: Percent of adults reporting general health status as fair or poor by gender identity and sexual orientation, 2022



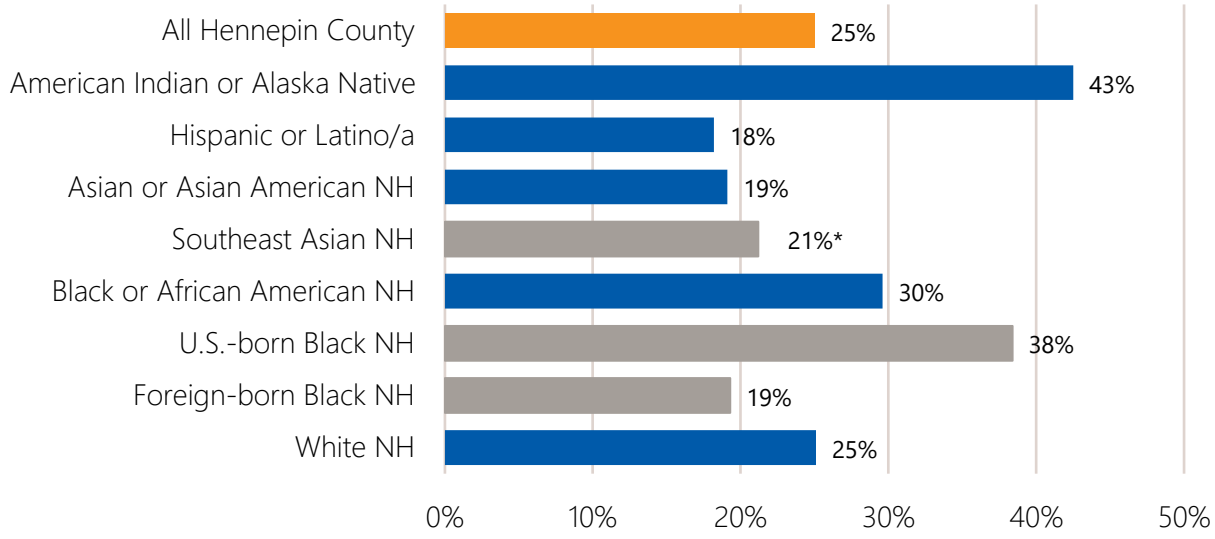
Source: SHAPE
** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

Figure 69: Percent of students reporting general health status (8th, 9th, and 11th graders), 2022



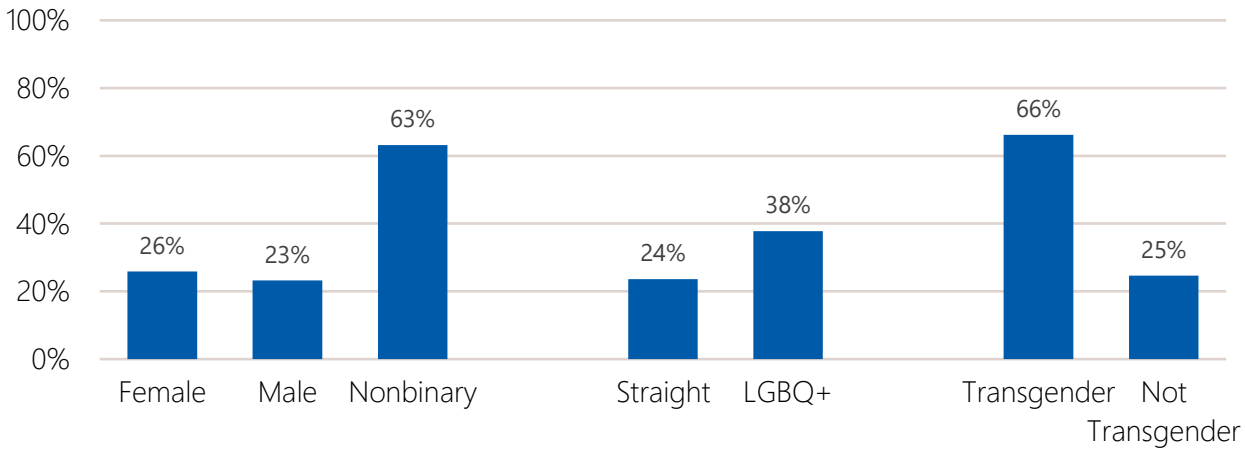
Source: MSS, Hennepin County

Figure 70: Percent of adults reporting being limited in any activities because of physical, mental, or emotional problems by race/ethnicity, 2022



Source: SHAPE; NH is non-Hispanic ethnicity
***** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

Figure 71: Percent of adults reporting being limited in any activities because of physical, mental, or emotional problems by gender identity or sexual orientation, 2022



Source: SHAPE

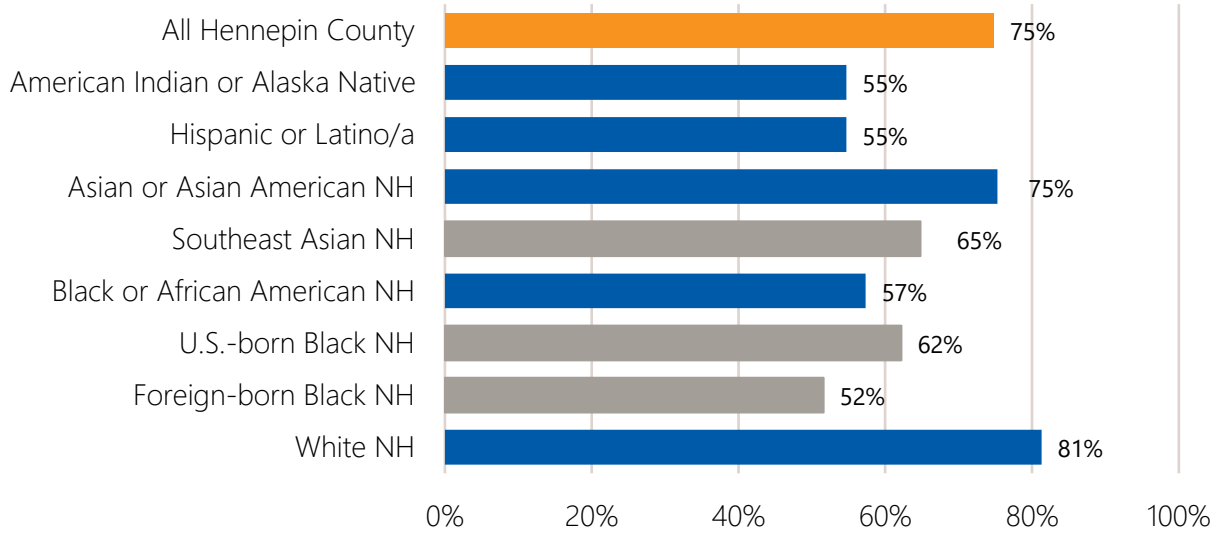
Oral health

Oral and dental health is an indicator of overall health and is important to general health and well-being. Oral health problems are often painful, costly, and can result in diminished quality of life. The federal Healthy People 2030 includes an objective to increase use of the oral health care system to 45% of children and adults [28]. In 2022, three-quarters (75%) of Hennepin County

adults reported that they visited a dentist or a dental clinic for dental care in the past year (SHAPE 2022).

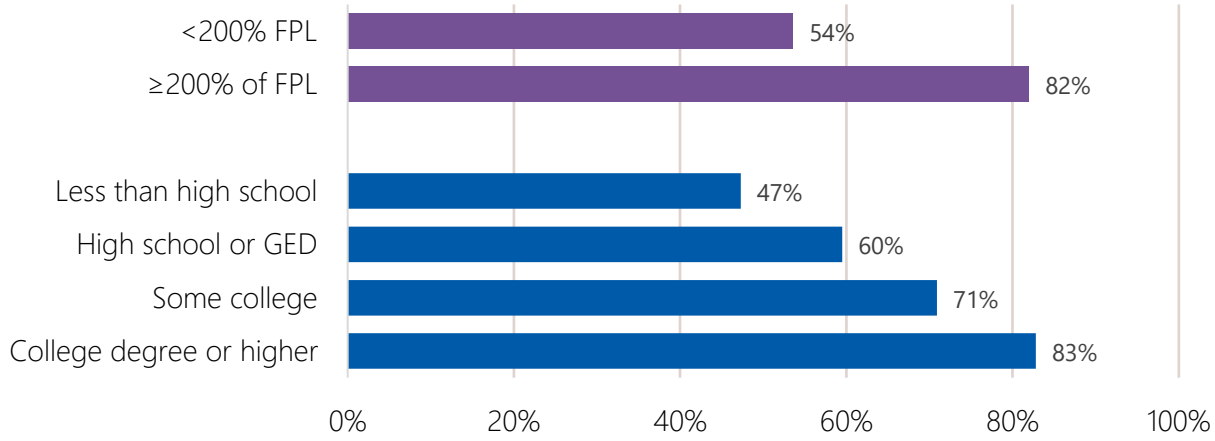
- American Indian or Alaska Native (55%), Hispanic or Latino/a (55%), and Black or African American (57%) adults were less likely to report visiting a dentist or dental clinic in the past year compared to the county overall (75%) (Figure 72).
- Residents living in Minneapolis (68%) were less likely to have received dental care in the past year compared to suburban Hennepin County residents (79%) (SHAPE 2022).
- Adults with lower income, lower educational attainment, or experiencing housing or transportation insecurity, were less likely to have had an annual dental visit in the past year compared to the county average (Figure 73 and SHAPE 2022).
- Among students (9th graders), 82% of male and 81% of female students received dental care in the last year while 12% received care 1-2 years prior, 5% more than 2 years ago, and 1% never for both genders (Figure 74).
- While 81% of students (8th, 9th, and 11th graders) reported having dental care in the past year, the percent varied by race and ethnicity with rates of 64% of American Indian, and 67% of Black or African American and Hispanic students (Figure 75).

Figure 72: Percent of adults reporting dental visit in the last year by race/ethnicity, 2022



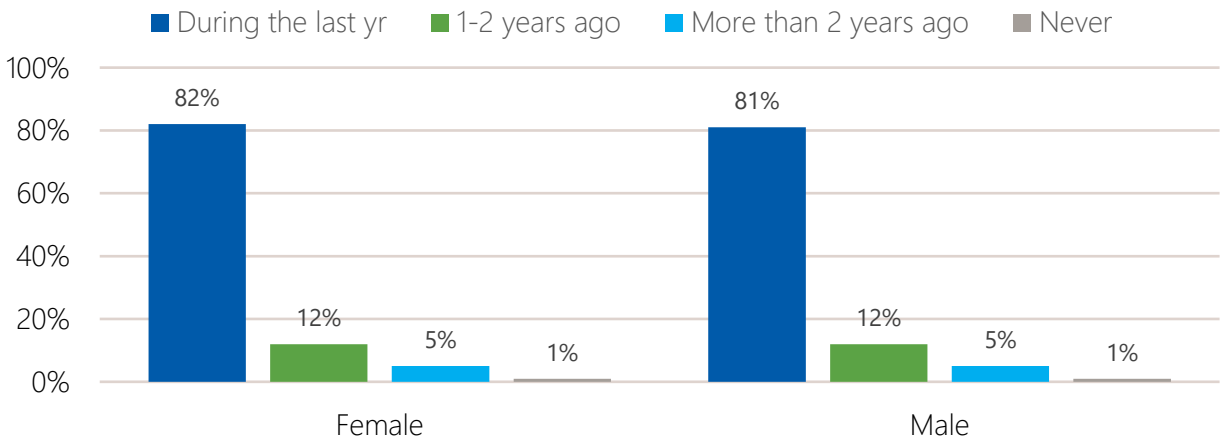
Source: SHAPE; NH is non-Hispanic ethnicity

Figure 73: Percent of adults reporting dental visit in the last year by income and education, 2022



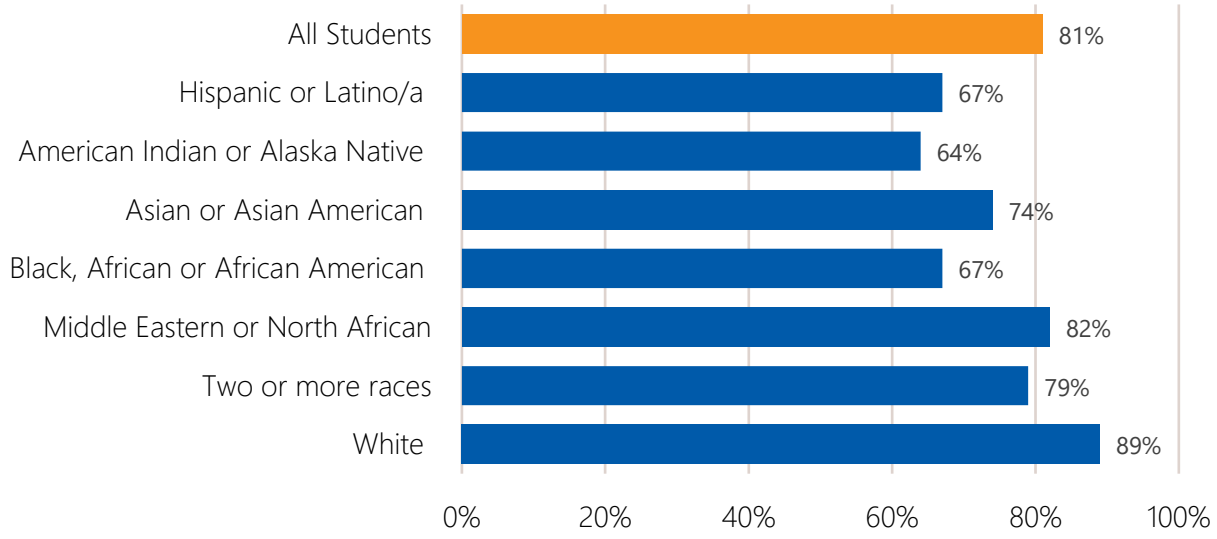
Source: SHAPE; FPL is Federal Poverty Level

Figure 74: Percent of 9th grade students that received dental care by gender, 2022



Source: MSS, Hennepin County

Figure 75: Percent of students that received dental care in the last year by race/ethnicity (8th, 9th, and 11th graders), 2022



Source: MSS, Hennepin County

Chronic disease

The CDC defines chronic diseases as conditions that last a year or more and require ongoing medical attention or limit activities of daily living. Most chronic diseases are caused by common risk factors of tobacco use, poor nutrition, lack of physical activity, and excessive alcohol use. Throughout the United States, chronic diseases are the leading cause of death and disability. The burden of chronic disease is experienced disproportionately by diverse racial and ethnic communities and low-income populations.

Theme: There are disparities in chronic disease and related risk factors

Respondents described disparities in chronic diseases outcomes and risk factors such as nutrition, physical activity, and wellness practices. The need for chronic disease awareness and care is especially high for the growing Hispanic or Latino/a community. (HTAC 2023; Vital Statistics 2017 – 2021)

- Cancer and heart disease were the leading causes of death in Hennepin County.
- American Indian or Alaska Native (11%) and U.S.-born Black or African American (8%) adults had high rates of Type 2 diabetes compared to the county overall (6%).
- Obesity — a risk factor for chronic illness — was more common among American Indian or Alaska Native adults (32%) compared to the county overall (24%).
- Heart disease death rates were rising among Hispanic and Latino/a populations, more than doubling from 2017 to 2021 (19 to 48 per 100,000, age-adjusted).

Theme: Preventative and chronic disease care are down

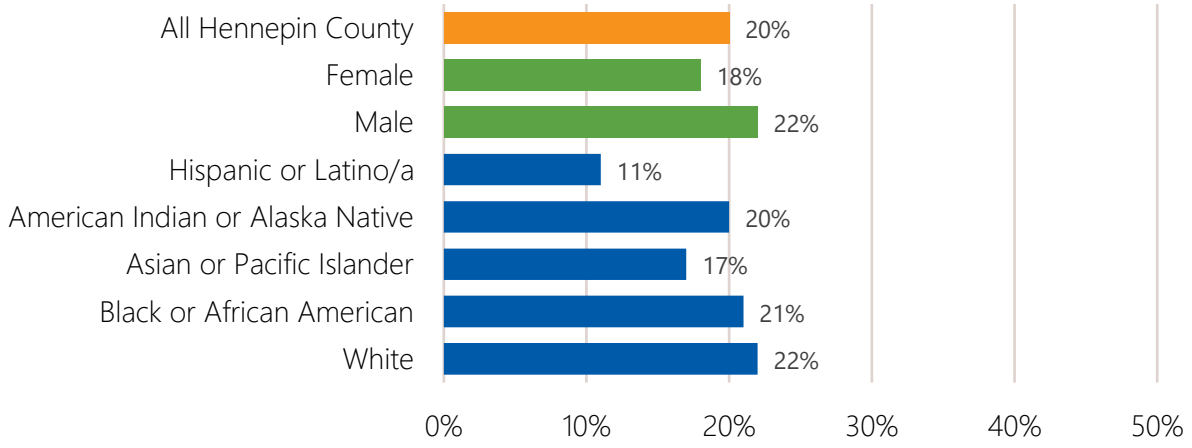
Respondents said that preventive and chronic disease care were deprioritized or not available during the COVID-19 pandemic and engaging in care has not fully recovered. Organizations are trying to increase preventive care use like immunizations, cancer screenings, and weight management. With fewer patients using care, there has been an uptick in issues like measles cases. There's a need for more awareness of prevention and patient navigation, particularly for those who are prediabetic or pre-hypertensive.

- One-fourth of adults (25%) who reported they needed medical care delayed or did not receive it. There were disparities among populations, with 44% of Hispanic or Latino/a and 36% of American Indian or Alaska Native adults reporting delayed care among those who needed care. Nearly half of those who delayed care said cost or lack of insurance was the reason (48%) (SHAPE 2022).

Cardiovascular health

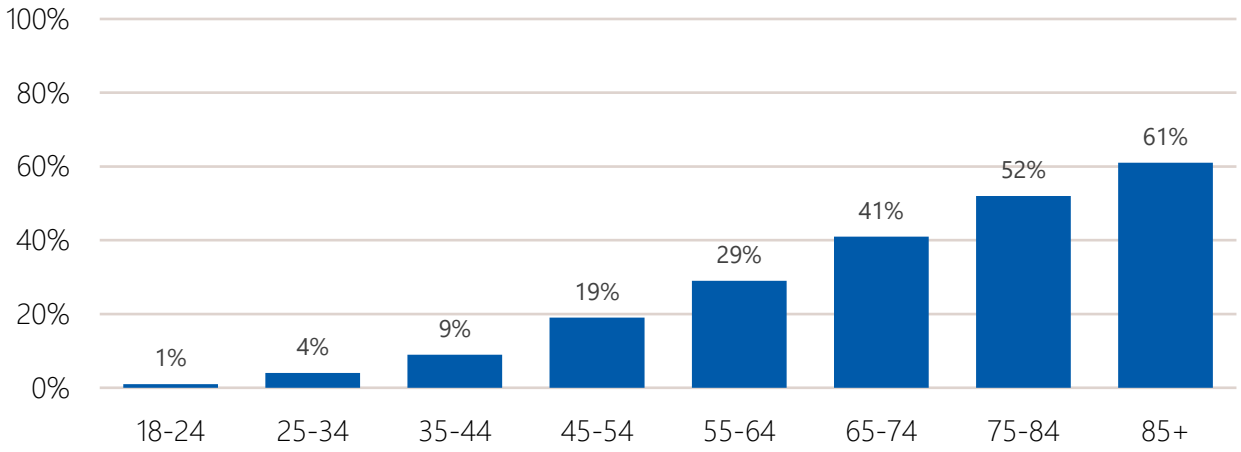
Cardiovascular diseases affect the heart and blood vessels. Common risk factors for cardiovascular diseases include high blood pressure, high cholesterol, smoking, lack of physical activity, poor nutrition, and excessive alcohol use. In 2023, 20% of Hennepin County adults were diagnosed with hypertension (Figure 76). The prevalence of hyptertension was highest among men and seniors ages 65 and older (Figure 77).

Figure 76: Hypertension prevalence (unadjusted) among adults (ages 18 and older) by race/ethnicity and gender, 2023



Source: Health Trends Across Communities (HTAC)

Figure 77: Hypertension prevalence (unadjusted) among adults (ages 18 and older), 2023



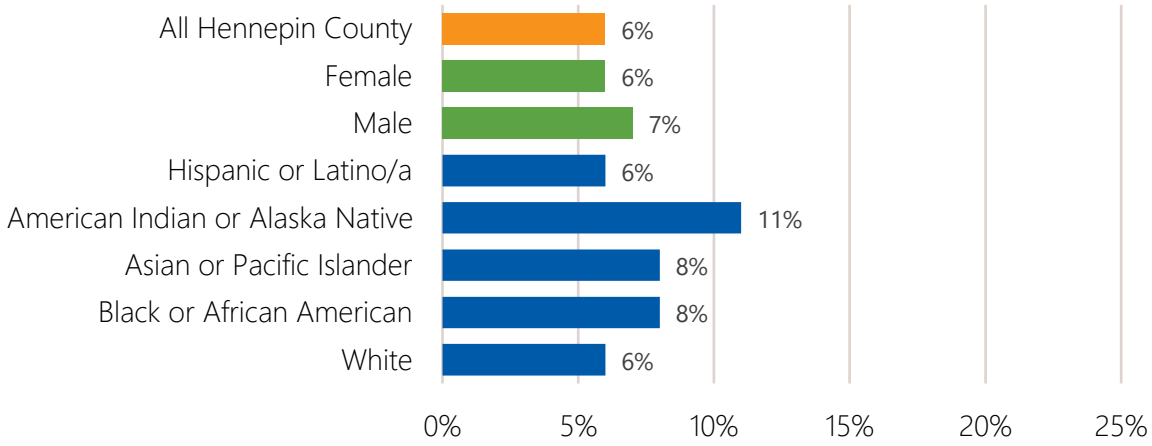
Source: Health Trends Across Communities (HTAC)

Diabetes

Diabetes is a chronic condition that affects how the body breaks down sugar. Over time diabetes can lead to health concerns such as nerve damage, heart disease, vision loss, and kidney disease. The most common type of diabetes, type II diabetes, is preventable. The risk of type 2 diabetes can be reduced with regular physical activity, healthful eating, and weight management.

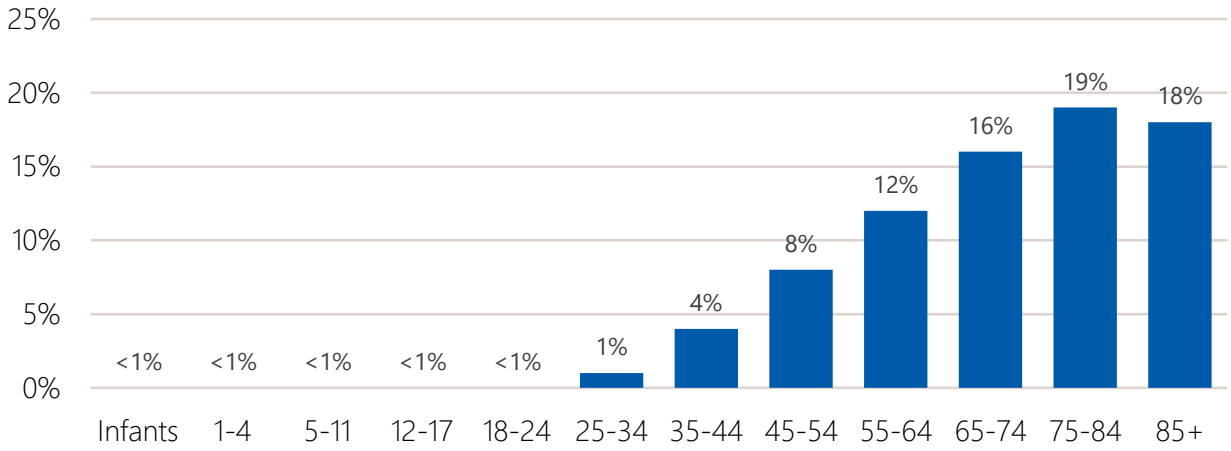
- In 2023, 6% of Hennepin County residents were diagnosed with type 2 diabetes (excluding gestational diabetes) (Figure 78).
- The prevalence was higher among American Indian or Alaska Native residents (11%), and increased with age, with the highest among 65-74 year olds (19%) (Figures 78 and 79).
- By self-report, 8% of adults were ever told by a health professional that they had diabetes (SHAPE 2022).
- A higher percent of those with less than a high school education (18%) and those with a household income less than 200% of the FPL (14%) reported they were told they had diabetes (SHAPE 2022).
- There was variation geographically, with a higher percent of diabetes reported in Northwest suburban areas of Brooklyn Center, Brooklyn Park, Crystal, New Hope and Robbinsdale (12%) and those in Minneapolis areas of Camden and Near North (11%) (SHAPE 2022).

Figure 78: Type 2 diabetes prevalence (unadjusted) by race/ethnicity and gender, 2023



Source: Health Trends Across Communities (HTAC)

Figure 79: Diabetes (type 2) prevalence by age group, 2023



Source: Health Trends Across Communities (HTAC)

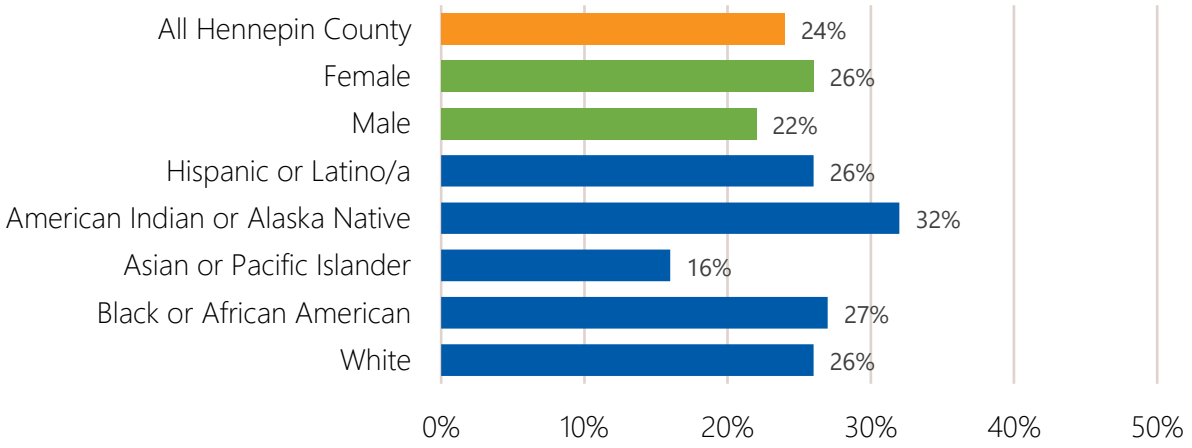
Obesity

Obesity is associated with poorer mental health, reduced quality of life and chronic diseases such as type 2 diabetes, cancer, heart disease, and stroke. Rates of obesity have been steadily climbing in the U.S. for the last two decades. The Hennepin County overall adult obesity prevalence was 24% (HTAC, 2023), below the federal Healthy People 2030 goal of 36% [29].

Weight status based on Body Mass Index (BMI) was also calculated from self-reported height and weight measurements by Hennepin County adults in the 2022 SHAPE survey. Overall, by self-report 39% of county adults had a healthy weight, 34% were overweight, and 25% were obese, which indicates that more than half of Hennepin County adults exceeded a healthy weight.

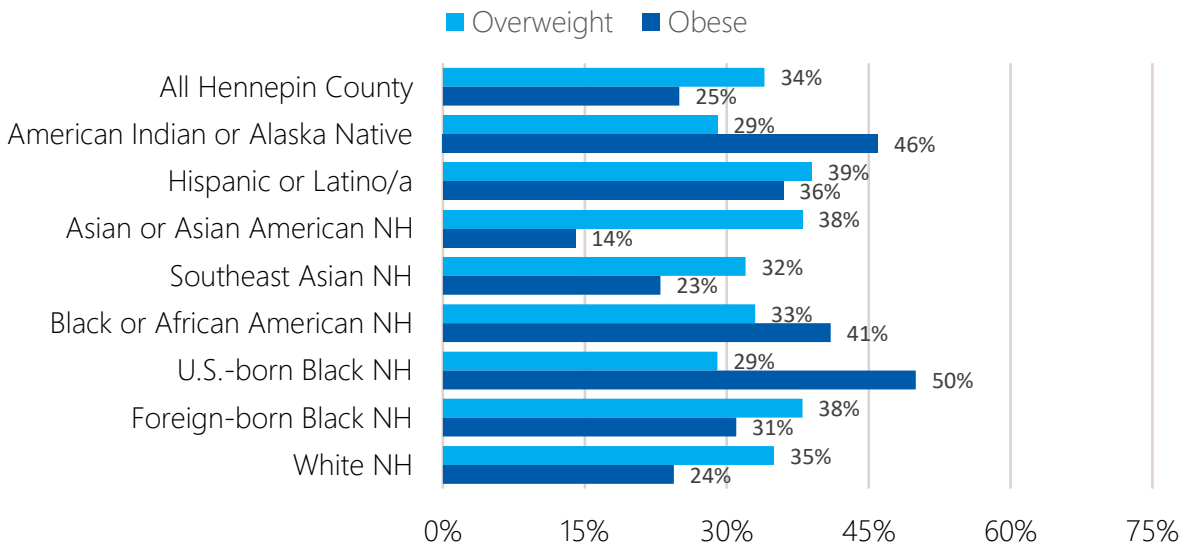
- As reported in HTAC, in 2023, the prevalence of obesity for all ages was highest among American Indian or Alaska Native (32%), and Black or African American (27%) residents compared to the Hennepin County average (24%) (Figure 80).
- SHAPE data show a similar disparity by race and ethnicity with overweight status and obesity (Figure 81).
- Weight status varied by gender with a higher percent of males (41%) reported being overweight as compared to females (28%) and nonbinary (27%) residents (Figure 82).
- A higher percent of females (28%) and nonbinary (34%) residents reported being obese compared to males (22%) (Figure 82).
- Obesity prevalence among Hennepin County children was 7% (5-11 years of age) and 12% in adolescents (12-17 years of age), lower than the federal Healthy People 2030 obesity prevalence goal of 15.5% for 2–19-year-olds (HTAC 2023) [30].
- By self-report in the MSS survey, 13% of students (8th, 9th, and 11th graders) were overweight and 10% obese (Figure 83).
- There were higher rates reported of overweight and obesity among American Indian or Alaska Native, Hispanic or Latino/a, Black or African American, and multi-racial students (9th, 10th, and 11th graders) (Figure 83).

Figure 80: Obesity prevalence (unadjusted) by race/ethnicity and gender, 2023



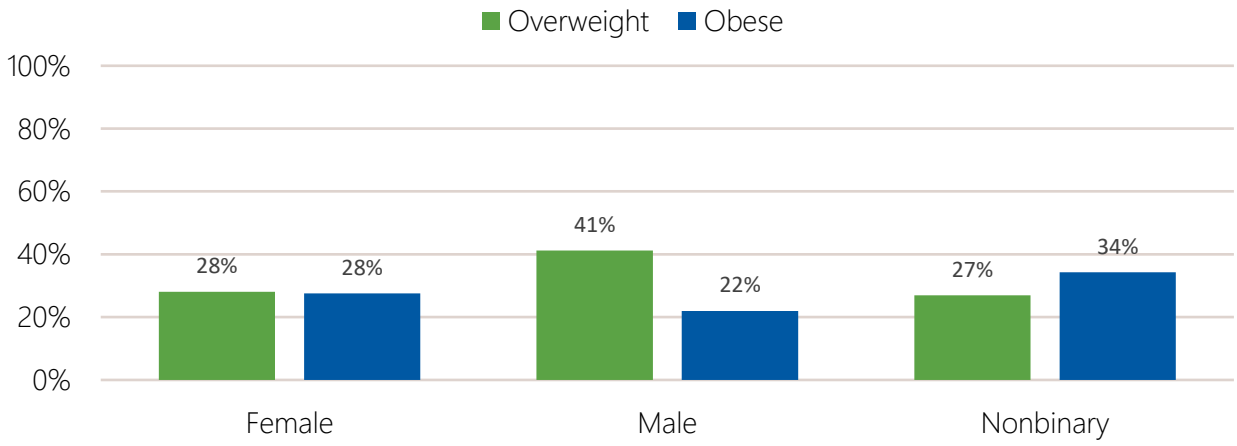
Source: Health Trends Across Communities (HTAC)

Figure 81: Percent of adults reporting weight status by race/ethnicity, 2022



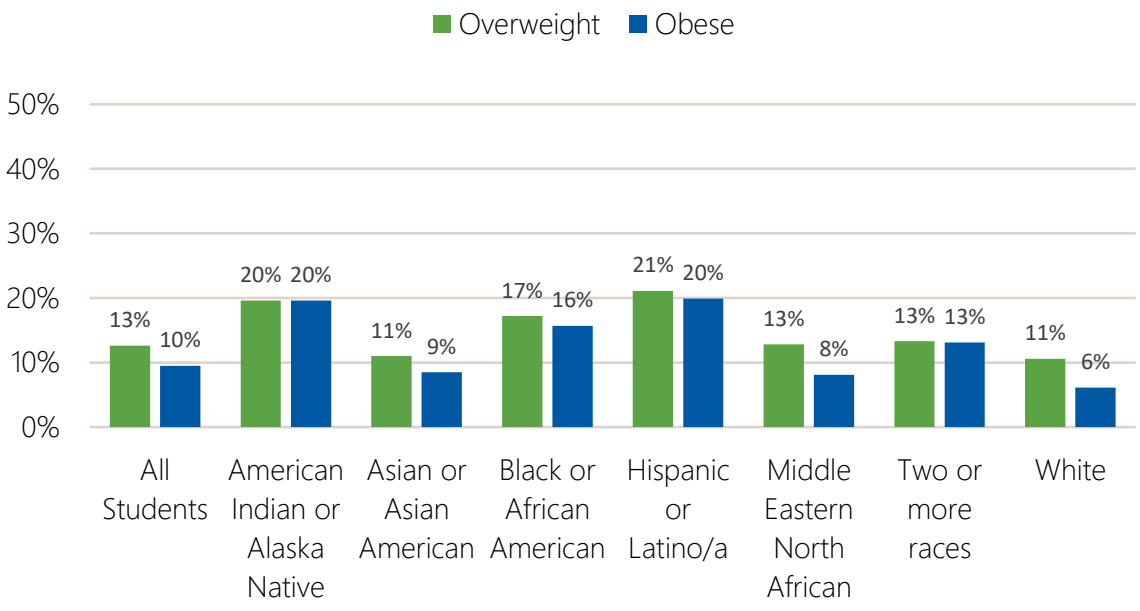
Source: SHAPE; NH is non-Hispanic ethnicity

Figure 82: Adult weight status by gender identity, 2022



Source: SHAPE

Figure 83: Youth weight status by race/ethnicity (8th, 9th, and 11th graders), 2022



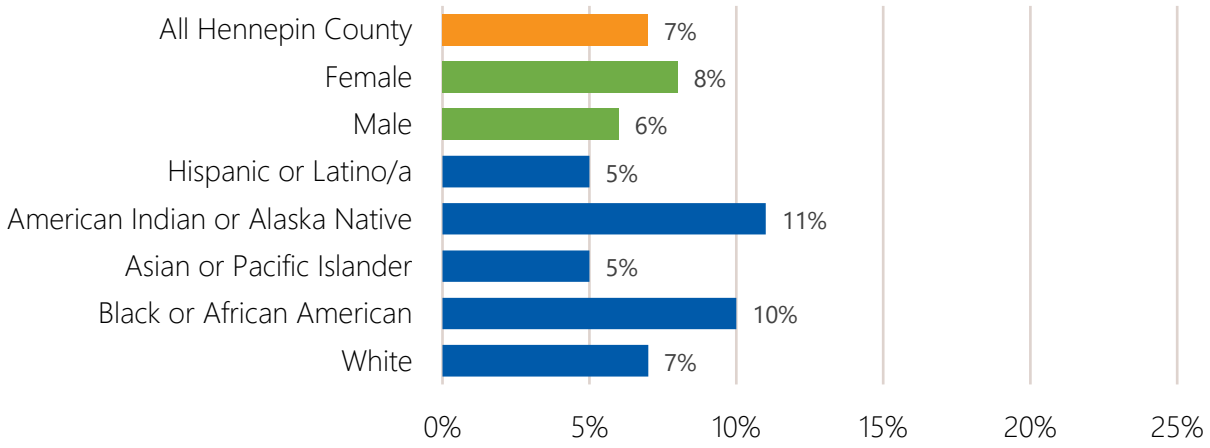
Source: MSS, Hennepin County

Asthma

Asthma is a treatable chronic lung disease sensitive to social determinants of health factors, such as access to quality housing, air quality, and regular access to prescriptions to control symptoms [31]. Uncontrolled asthma can result in missed work or school days, emergency room visits, hospitalization, or death. Statewide data show that higher rates of hospitalizations and emergency room visits among children within the seven-county metro are of special concern [32].

- The prevalence of asthma across all age groups was 7% in 2023. The percent was highest among American Indian or Alaska Native (11%) and Black or African American residents (10%) (Figure 84).
- In the SHAPE 2022 survey, 8% of county adults reported they currently had asthma. The percent of self-reported asthma was higher for those with less than a high school education (13%), a household income less than 200% of the FPL (10%), or in the youngest age group of adults 18-24 years old (11%) (SHAPE 2022).
- Residents living in urban areas of the county reported the highest percent of current asthma. In Minneapolis the percent was 9%, but higher at 13% in the Camden and Near North areas, compared to 7% reported across suburban areas (SHAPE 2022).

Figure 84: Asthma prevalence (unadjusted) by race/ethnicity and gender, 2023



Source: Health Trends Across Communities (HTAC)

Mental health

Mental health is a significant factor in overall well-being. For adults, chronic mental health issues may interfere with relationships, self-regard, and ability to engage in community or society. For children, chronic mental health, emotional, or behavioral problems can impact physical, mental, and social development with long-term consequences. This assessment looked at measures of frequent mental distress, anxiety and depression risk, and common mental health diagnoses to capture the status of adult mental health in Hennepin County. Measures of mental health among youth can be found on page 100. As stated previously, mental health — for adults and youth — was a top priority among assessment respondents.

Theme: Mental health problems are prevalent across communities

Respondents said mental health was a priority, particularly for youth, adults, older adults, unhoused individuals, maternal health, and racial and ethnically diverse communities. They noted that even programs not focused on mental health are addressing the mental health needs. Respondents shared that there was a need for more culturally congruent practices and practitioners, providers who understand historical trauma, and providers who can address barriers to mental health care and the stigma surrounding it.

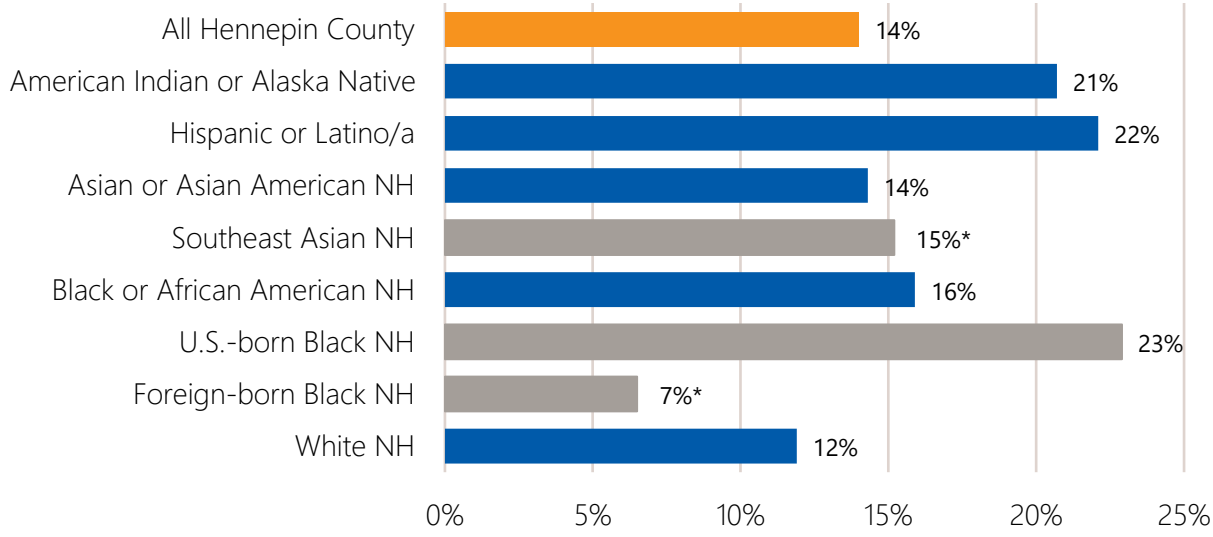
Frequent mental distress in adults

Frequent mental distress is one measure of overall mental well-being. In the SHAPE 2022 survey, frequent mental distress was defined as adults who reported their mental health, including

stress, depression, or a problem with emotions, was "not good" for 14 days or more of the last 30 days.

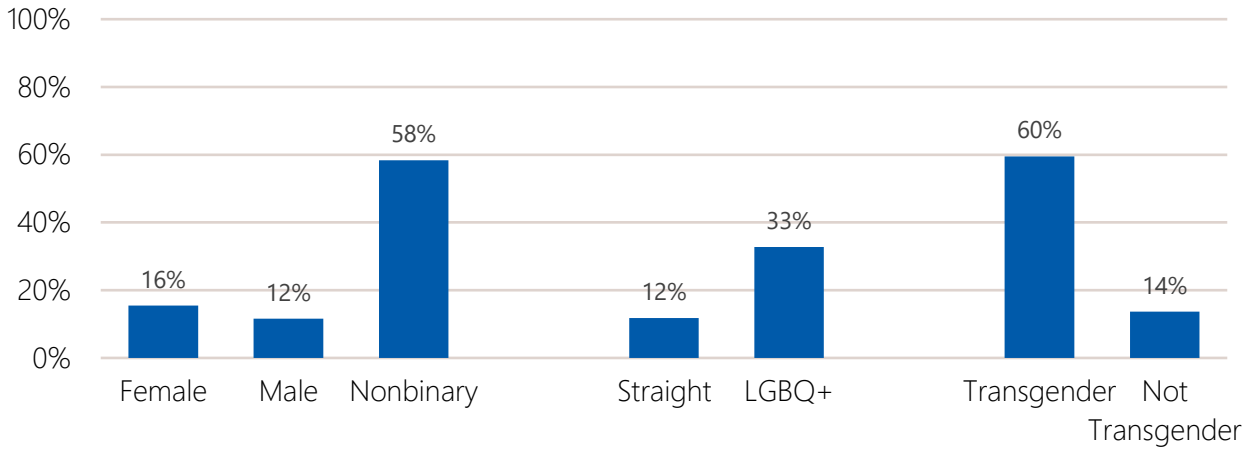
- In 2022, 14% of Hennepin County adults reported experiencing frequent mental distress (Figure 85). This percent doubled in the last twenty years (6% in 2002) (SHAPE 2002).
- American Indian or Alaska Native (21%), Hispanic or Latino/a (22%), and U.S.-born Black or African American populations (23%) were more likely to experience frequent mental distress compared to the county overall rate (14%) (Figure 85).
- The percent of nonbinary (58%), LGBQ+ (33%) and transgender (60%) adults reporting frequent mental was also higher than the county overall (Figure 86).
- The percent of reported frequent mental distress decreased with higher educational attainment, income, and age (Figures 87 and 88).

Figure 85: Percent of adults reporting frequent mental distress in the past 30 days by race/ethnicity, 2022



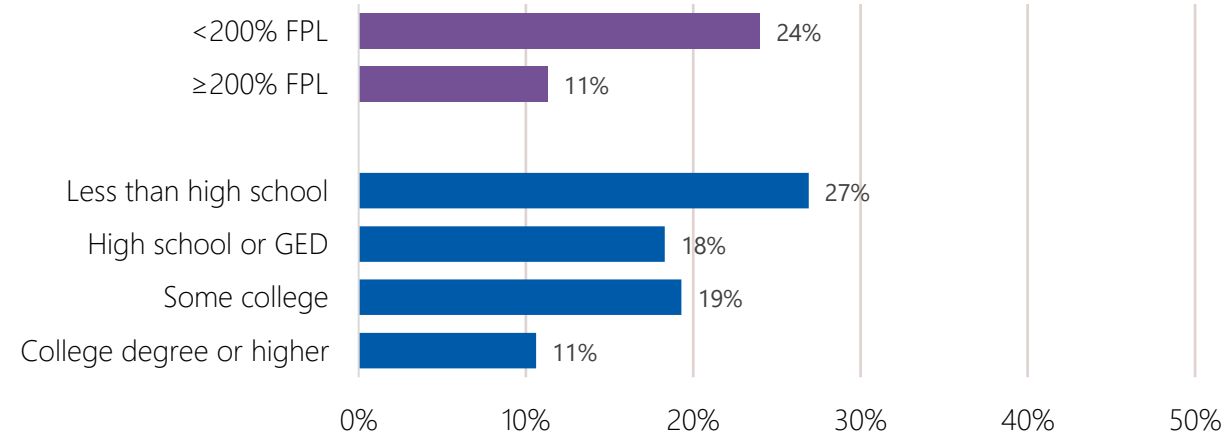
Source: SHAPE; NH is non-Hispanic ethnicity
** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

Figure 86: Percent of adults reporting frequent mental distress in the past 30 days by gender identity or sexual orientation, 2022



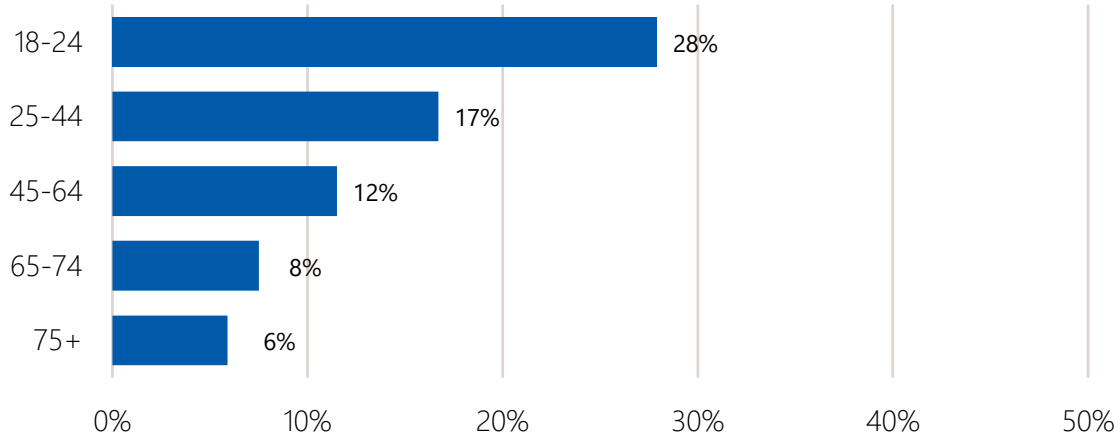
Source: SHAPE

Figure 87: Percent of adults reporting frequent mental distress in the past 30 days by income and education, 2022



Source: SHAPE; FPL is Federal Poverty Level

Figure 88: Percent of adults reporting frequent mental distress in the past 30 days by age, 2022



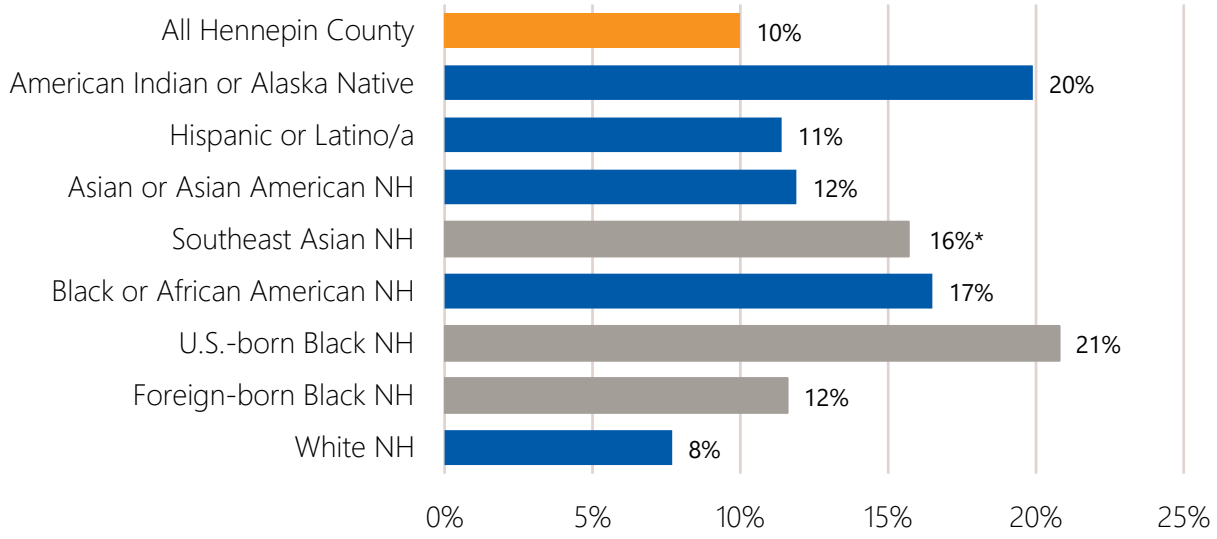
Source: SHAPE

Mental health risk and diagnosis in adults

In 2023, the most prevalent adult mental health conditions, as measured by clinical diagnoses, were anxiety (21%), followed by depression (17%), bipolar disorder (2%), and post-traumatic stress disorder (2%) (HTAC 2023). However, a significant portion of people with mental health concerns are not able to access care, and so the prevalence in the general population will be most likely be higher. In 2022, the SHAPE survey assessed the general adult population for anxiety and depression risk using the PHQ-4 questionnaire, and high risk is known to be strongly predictive of an anxiety or depression disorder [33].

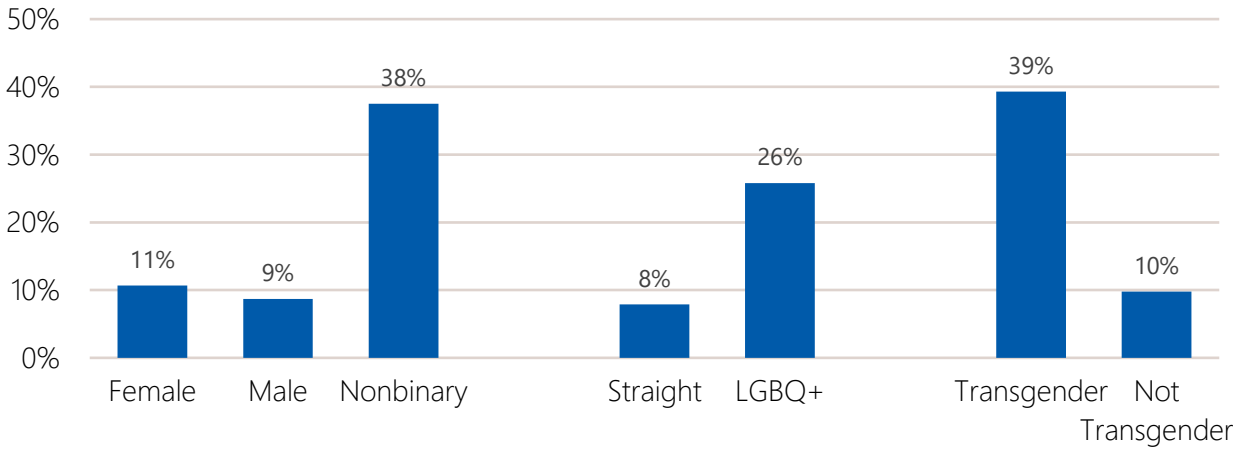
- In the SHAPE 2022 survey, 10% of Hennepin County residents were at high risk of depression and 14% were at high risk of an anxiety disorder (Figure 89).
- High risk of depression was disproportionately experienced among race and ethnic groups including American Indian and Alaska Native (20%) and U.S.-born Black or African American populations (21%) (Figure 89).
- The percent of nonbinary (38%), LGBQ+ (26%) and transgender (39%) adults reporting a high risk of depression was also higher than the county overall (Figure 90).
- High risk of depression was reported by a larger percent of adults with lower educational attainment, lower income, and younger age that the county average (Figures 91 and 92).
- High risk of anxiety showed similar demographic patterns to high risk of depression, with slightly higher prevalence. Young adults (27%), American Indian or Alaska Native adults (25%), as well as LGBQ+ (32%), transgender (54%), and nonbinary (39%) adults were more likely to be high risk for an anxiety disorder (SHAPE 2022).

Figure 89: Percent of adults reporting a high risk of depression during the past 2 weeks by race/ethnicity, 2022



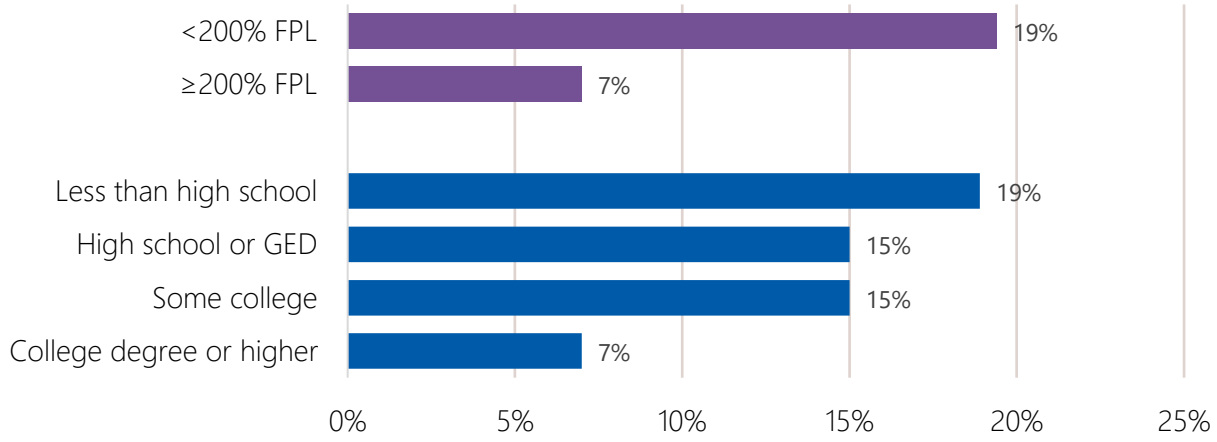
Source: SHAPE; NH is non-Hispanic ethnicity
***** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

Figure 90: Percent of adults reporting a high risk of depression during the past 2 weeks by gender identity and sexual orientation, 2022



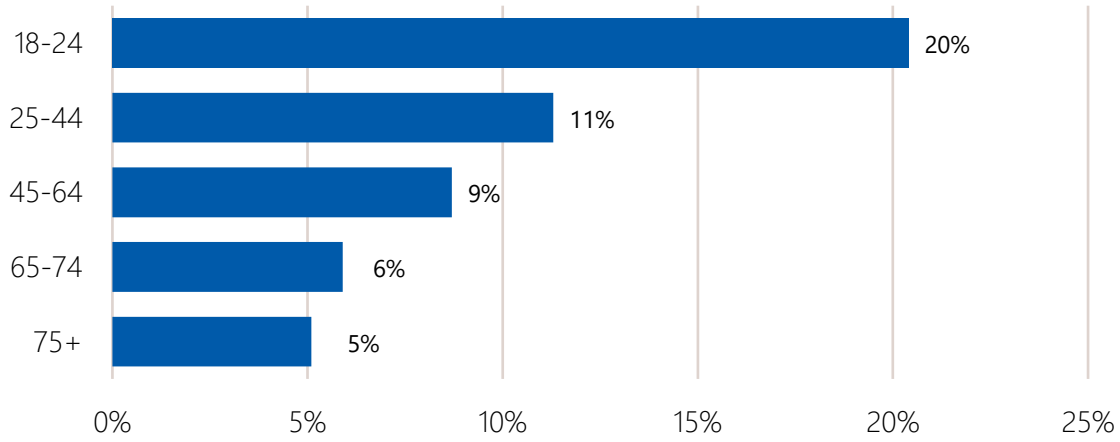
Source: SHAPE

Figure 91: Percent of adults reporting a high risk of depression during the past 2 weeks by income and education, 2022



Source: SHAPE; FPL is Federal Poverty Level

Figure 92: Percent of adults reporting a high risk of depression during the past 2 weeks by age, 2022



Source: SHAPE

Youth mental health

The status and context assessment aligned to show that youth mental health is a top health concern in Hennepin County. In the 2022 Minnesota Student Survey, students reported an unprecedented degree of mental health problems, with the highest percentage of students reporting mental health issues since the survey began in 1989. A contributing force of change was the COVID-19 pandemic, which created an interplay of many factors that has led to a crisis in long-term mental health problems [34].

Theme: Youth mental health problems are rising

Respondents shared that youth mental health is the top concern in schools, and the issue continues to grow. Organizations are developing strategies to address youth mental health needs while recognizing youth's strengths, including their innovation, interest in health, and persistence in addressing their needs.

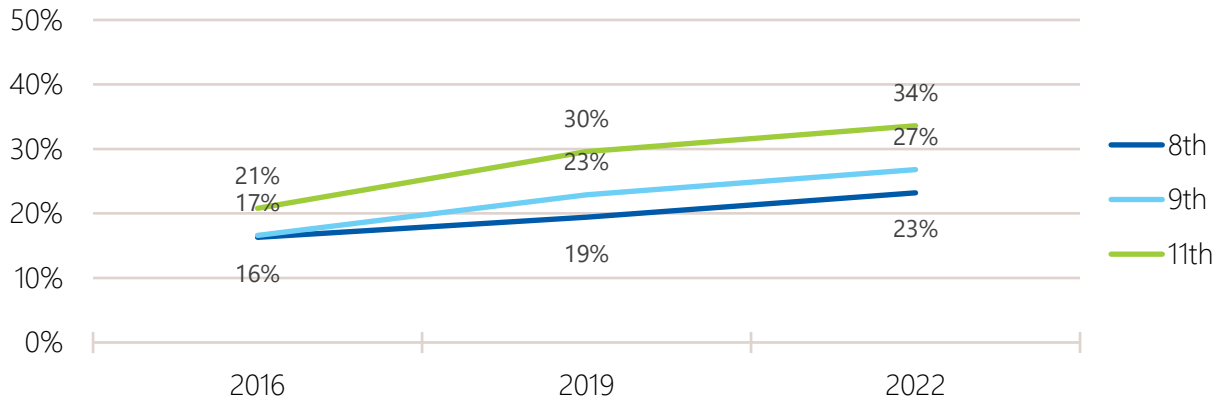
Theme: There is a need to better support LGBTQ+ youth in areas of mental health and substance use, and a better understanding of how to support them

Respondents shared that the LGBTQ+ population in schools is growing, and there is a need to develop better approaches to support them. They also pointed out that data on gender identity and suicide often lacks representation of non-cisgender youth, which can obscure the specific needs of LGBTQ+ youth.

Youth mental health indicators show that:

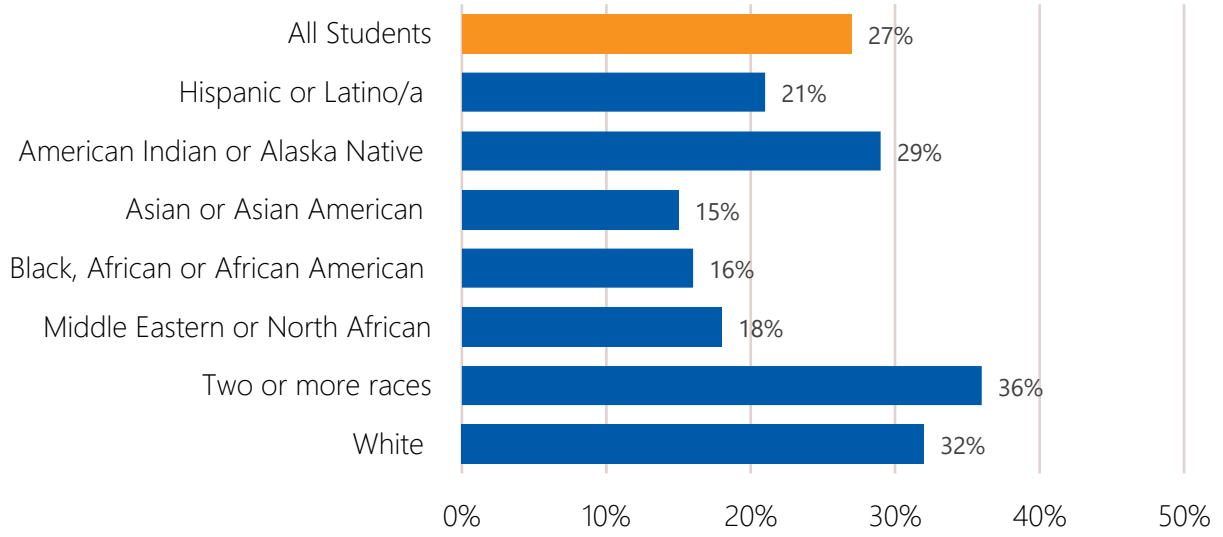
- In Hennepin County, the most prevalent diagnosis for a mental health condition for children was anxiety (6%), followed by depression (3%) (HTAC 2023).
- Youth mental health, behavioral, or emotional problems have steadily increased since 2016. For example, 27% of 9th graders reported mental health issues in 2022, up from 17% in 2016 (Figure 93).
- Long-term (6 months or more) mental, behavioral, or emotional problems were reported by 27% of all students (8^{th}, 9^{th}, and 11^{th} graders), with a higher percent among multi-racial (36%), and White (32%) students (Figure 94).
- Girls reported mental health problems at more than twice the rate of boys across 8^{th}, 9^{th}, and 11^{th} grades (37% versus 16% in 9^{th} graders) (Figure 95).
- LGBQ+ youth reported a higher risk of depression (40%) and anxiety (48%) compared to straight and cisgender students (18% and 22%) (MSS 2022).
- A large percent of gender expansive students (transgender, nonbinary, or additional identity) students also reported a higher risk of depression (52%) and anxiety (61%) (MSS 2022).
- From 2019 to 2022, the percent of students reporting ever having suicidal thoughts increased slightly across all grades (Figure 96).
- Suicide ideation measured by students that reported they had ever seriously considered attempting suicide (8^{th}, 9^{th}, and 11^{th} graders) increased from 19% in 2016 and 20% in 2020, to 21% in 2022 (Figure 96).
- In 2022, one out of four female students (28%) and nearly half of LGBTQ+ students (44%) reported having seriously considered suicide (Figure 97).

Figure 93: Percent of students reporting long-term mental health, behavioral or emotional problems (8th, 9th, and 11th graders), 2016-2022



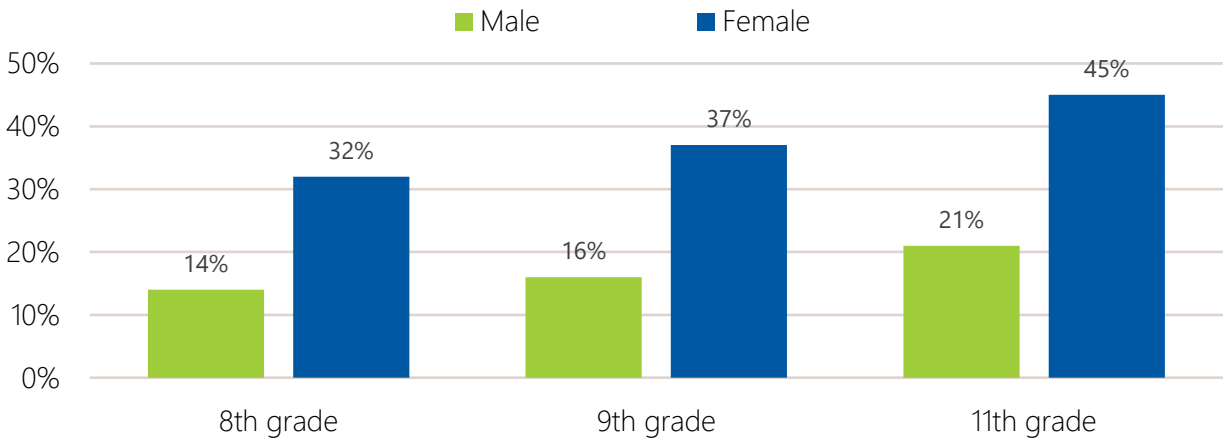
Source: MSS, Hennepin County

Figure 94: Percent of students reporting long-term mental health, behavioral or emotional problems by race/ethnicity (8th, 9th, and 11th graders), 2022



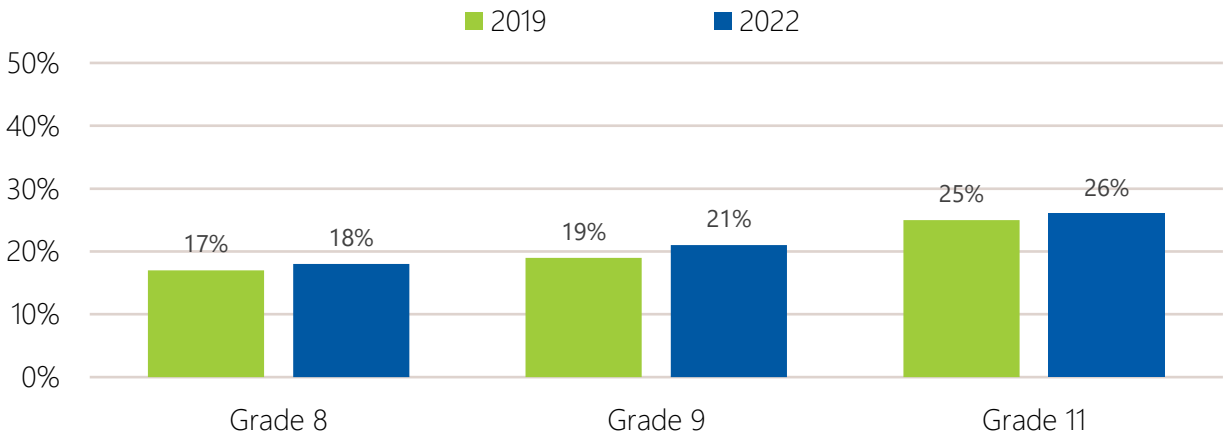
Source: MSS, Hennepin County

Figure 95: Percent of students reporting long-term mental health, behavioral or emotional problems by gender (8th, 9th, and 11th graders), 2022



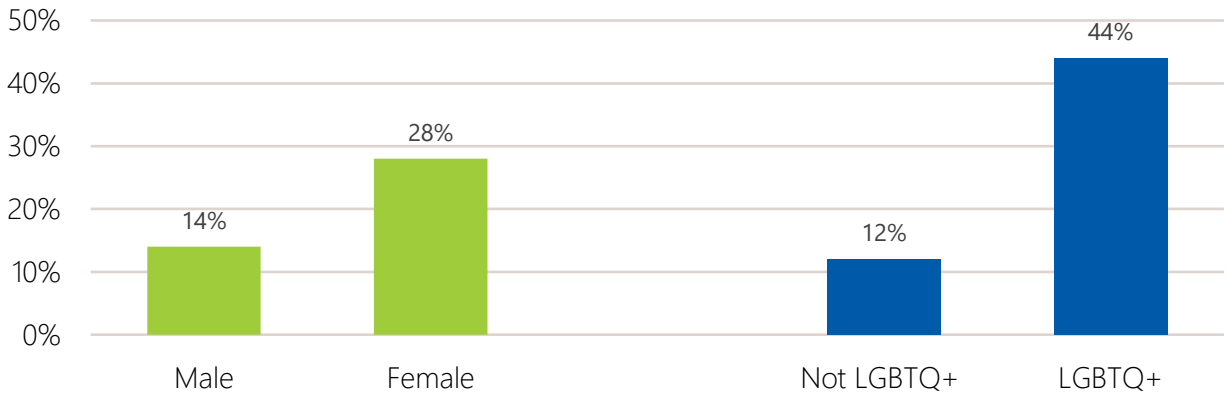
Source: MSS, Hennepin County

Figure 96: Percent of students reporting ever seriously considered attempting suicide (8th, 9th, and 11th graders) 2019, 2022



Source: MSS, Hennepin County

Figure 97: Percent of students reporting ever seriously considered attempting suicide by gender and LGBTQ+ identity (8th, 9th, and 11th graders) 2022



Source: MSS, Hennepin County

Sexual health

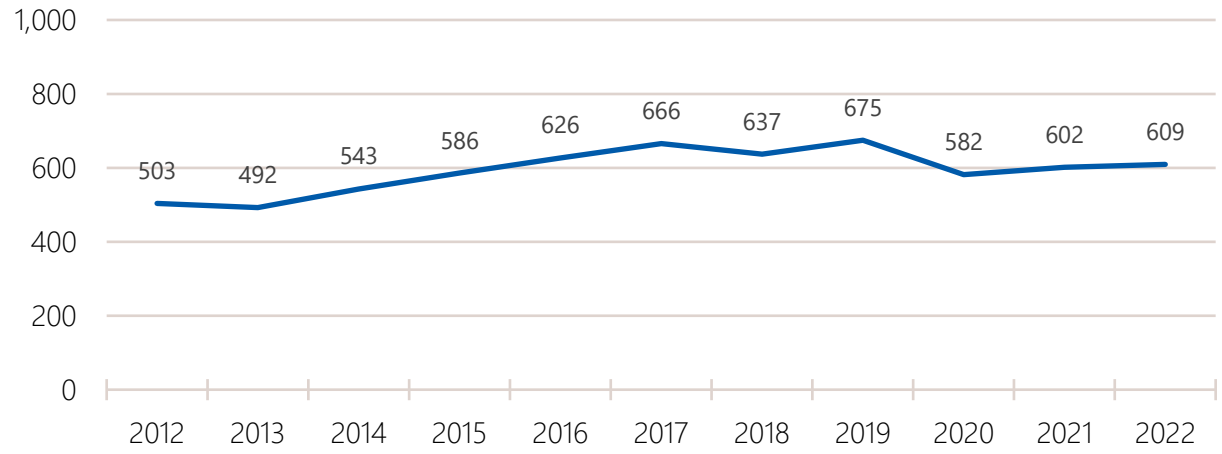
Sexual health can include reproductive health and family planning, relationship safety, and sexually transmitted infections (STIs). Improving sexual health often focuses on prevention and early detection through education and access to care and resources. This assessment considered STI rates as indicators of communities' sexual health (teenage pregnancy is covered under Maternal and Child Health, page 133. Nationally, STIs have greatly increased in recent years, peaking in 2021 [35], and Hennepin County reflects these trends in some STI rates. The majority of STIs are spread through sexual activity, but some are transmitted through additional pathways, such as infected blood (i.e., HIV), or from mothers to their infants during pregnancy, birth, or breast feeding or chest feeding.

Chlamydia

Chlamydia is the most common STI in Minnesota. It can also have long-term health implications if left untreated. For females, chlamydia can cause pelvic inflammatory disease (PID), which may cause infertility, chronic pelvic pain, or tubal pregnancy. Males with untreated chlamydia typically develop urethral infections, and in rare cases, become sterile.

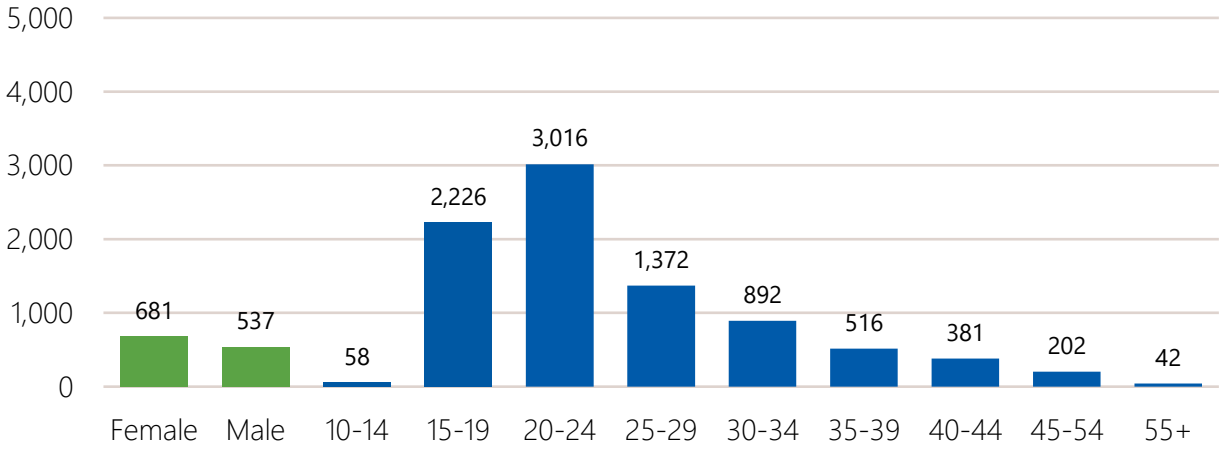
- The rate of chlamydia infection increased from 2012 to 2022 by approximately 100 cases per 100,000 (Figure 98).
- In 2022, the chlamydia infection rate for females was higher than for males (681 cases compared to 537 cases per 100,000 population) (Figure 99).
- Sexually active adolescents (ages 15-19) and young adults (ages 20-24) had the highest rates of chlamydia infections (Figure 99).
- Chlamydia infection was disproportionately found in American Indian or Alaska Native, Black or African American, and Hispanic or Latino/a and populations (Figure 100).

Figure 98: Chlamydia infection rate (per 100,000) in Hennepin County (2012-2022)



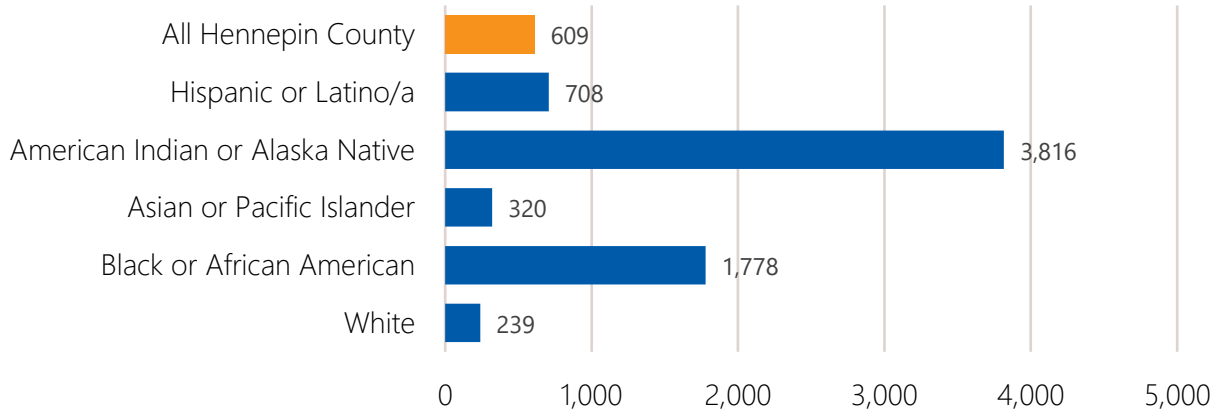
Source: HCPH epidemiology

Figure 99: Chlamydia infection rate (per 100,000) by gender and age, 2022



Source: HCPH epidemiology

Figure 100: Chlamydia infection rate (per 100,000) by race/ethnicity, 2022



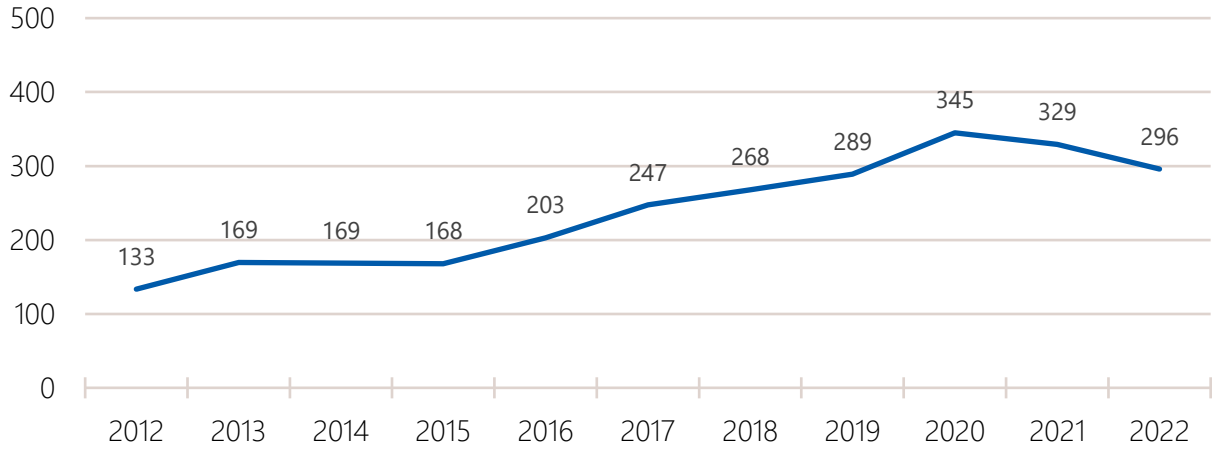
Source: HCPH epidemiology

Gonorrhea

Gonorrhea is another treatable STI that can have long-term health implications if left untreated. Gonorrhea infections may be missed because many people do not show symptoms. Untreated gonorrhea in males can cause epididymitis (a painful condition affecting the testes) and in females it can cause pelvic inflammatory disease (PID). These conditions can lead to infertility.

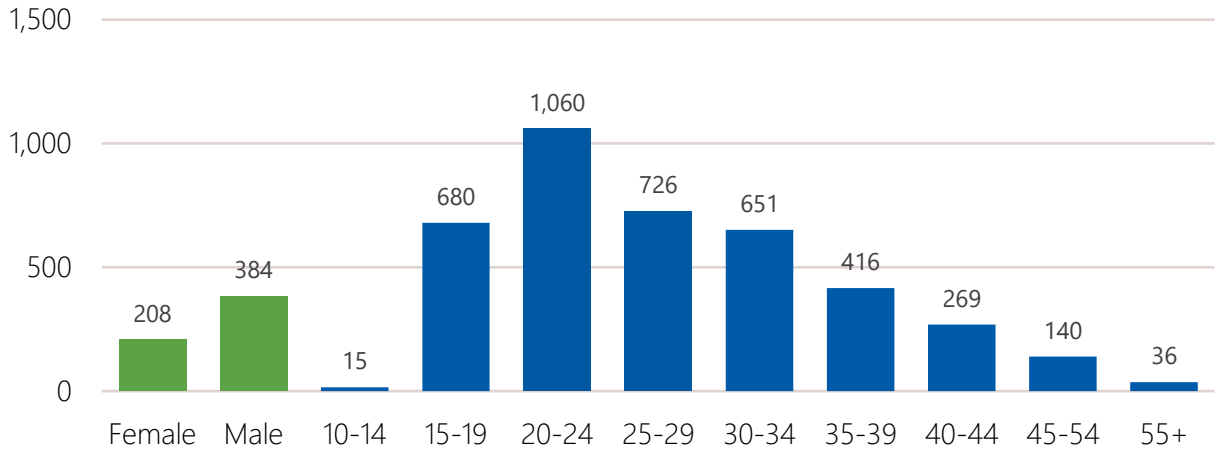
- The rate of gonorrhea infection more than doubled from 2012 to 2022 (Figure 101).
- In 2022, the gonorrhea rate was higher for males than females (384 cases compared to 208 cases per 100,000 population) (Figure 102).
- Young adults (ages 20-24) had the highest rate of gonorrhea infections (Figure 102).
- The gonorrhea infection rate was disproportionately higher in American Indian or Alaska Native and Black or African American populations (Figure 103).

Figure 101: Gonorrhea infection rate (per 100,000) in Hennepin County (2012-2022)



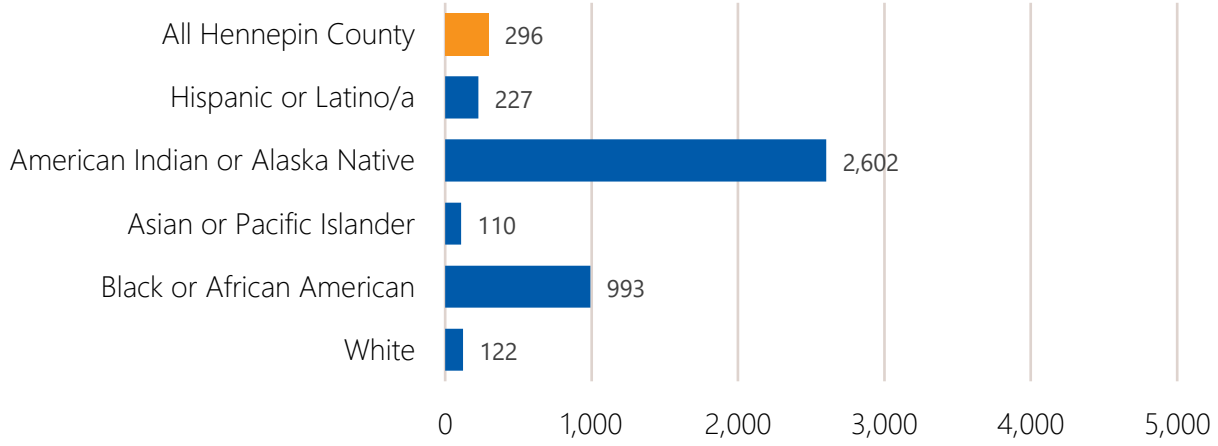
Source: HCPH epidemiology

Figure 102: Gonorrhea infection rate (per 100,000) by gender and age, 2022



Source: HCPH epidemiology

Figure 103: Gonorrhea infection rate (per 100,000) by race/ethnicity, 2022



Source: HCPH epidemiology

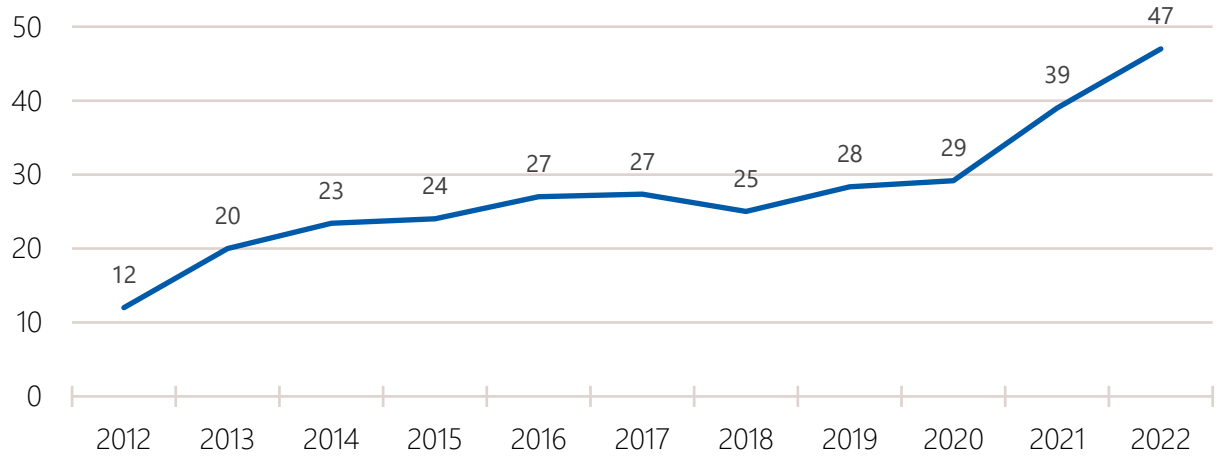
Syphilis

The symptoms of syphilis emerge in stages. Early-stage syphilis is either primary stage, as a single sore, or secondary stage, which is characterized by a rash. Late-stage syphilis may progress to organ damage, brain or nerve problems, and even death. Although treatable, syphilis continues to persist because people may not recognize the symptoms or attribute their condition to other causes.

- From 2012 to 2022, the infection rate of early-stage syphilis increased from 12 to 47 cases per 100,000 (Figure 104).

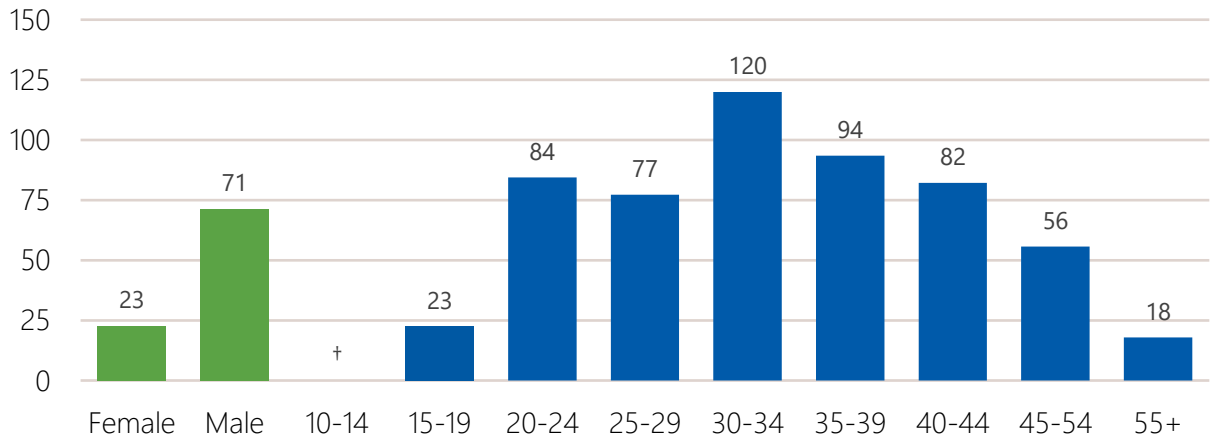
- In 2022, the early-stage syphilis (primary and secondary stages) infection rate was higher for males than females (71 cases compared to 23 cases per 100,000 population) (Figure 105).
- Adults ages 30-34 had the highest infection rate of early-stage syphilis infections (Figure 105).
- The infection rate of early-stage syphilis was disproportionately higher in American Indian or Alaska Native and Black or African American populations (Figure 106).

Figure 104: Early-stage syphilis infection rate (per 100,000) in Hennepin County (2012-2022)



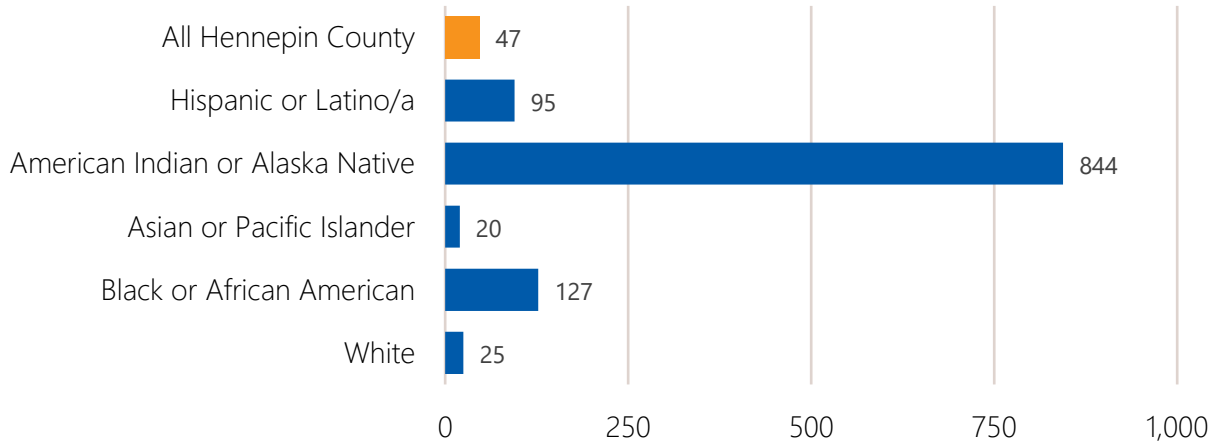
Source: HCPH epidemiology

Figure 105: Early-stage syphilis infection rate (per 100,000) by gender and age, 2022



Source: HCPH epidemiology
† Indicates that a data count is below a suppression threshold and has been suppressed.

Figure 106: Early-stage syphilis infection rate (per 100,000) by race/ethnicity, 2022



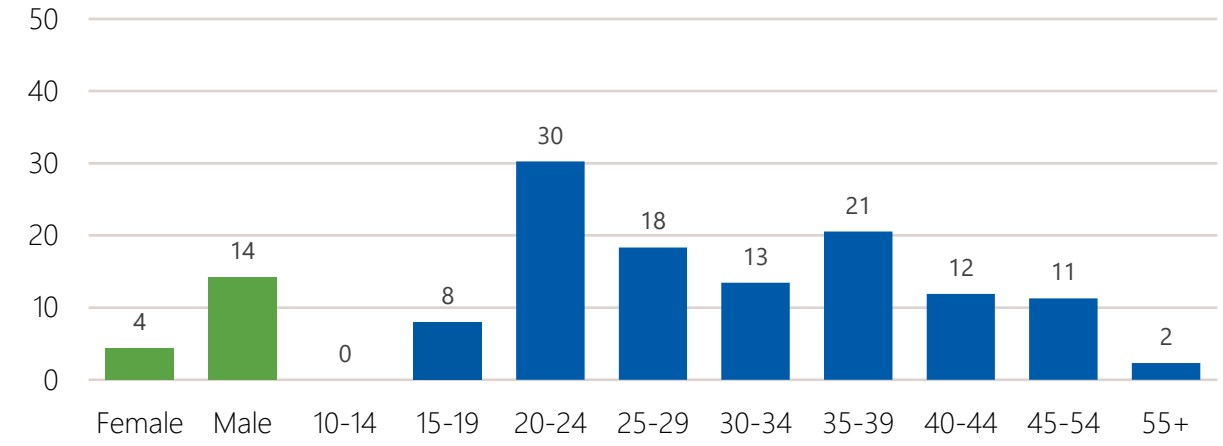
Source: HCPH epidemiology

HIV/AIDS

Human immunodeficiency virus (HIV) infects the cells of the immune system, weakening the body's ability to fight other infections or diseases. The most advanced stage of HIV infection is acquired immunodeficiency syndrome (AIDS). Without proper medical treatment, AIDS is a fatal condition. While there is still no cure for HIV, treatment allows people living with HIV to live longer, healthier lives. Prevention, education and health access are important to addressing HIV infection rates.

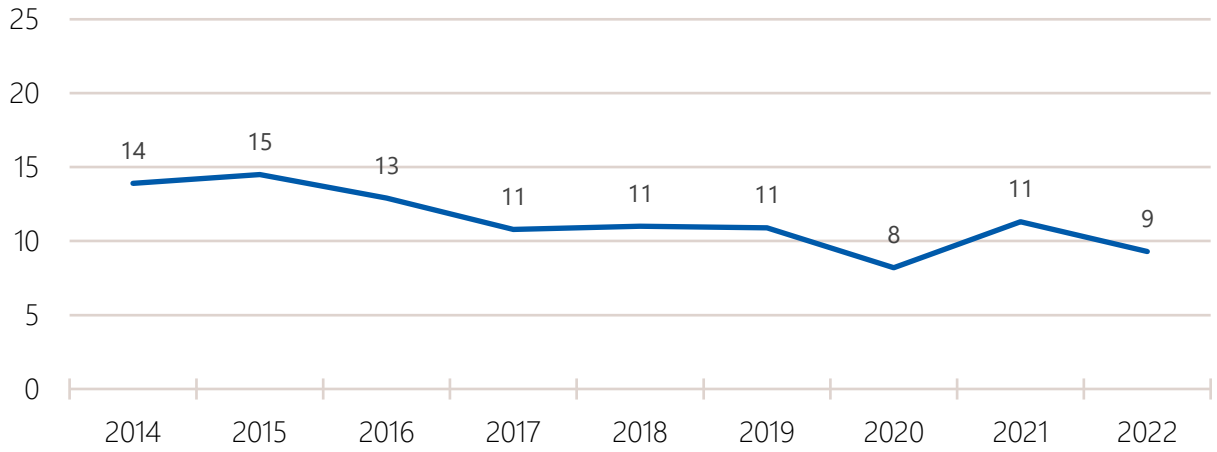
- In 2022, there were 118 newly diagnosed HIV infections in Hennepin County. New HIV infections were highest among men and younger adults ages 20-24 (Figure 107).
- The rate of new HIV infection has declined since 2014 (Figure 108).
- Men who have sex with men (MSM) have accounted for most new cases of HIV since 2014. In 2022, 53% of cases were among MSM (Hennepin County Public Health Epidemiology).
- The HIV prevalence rate increased slightly from 2014 to 2022 (Figure 109).
- HIV prevalence was highest among those 50 years and older (Figure 110). Part of this continued increase from 2014 has been because people with HIV are living longer.
- HIV infections have remained disproportionately prevalent in American Indian or Alaska Native, Black or African American, and Hispanic or Latino/a populations (Figure 111).

Figure 107: New HIV infection rate (per 100,000) by gender and age, 2022



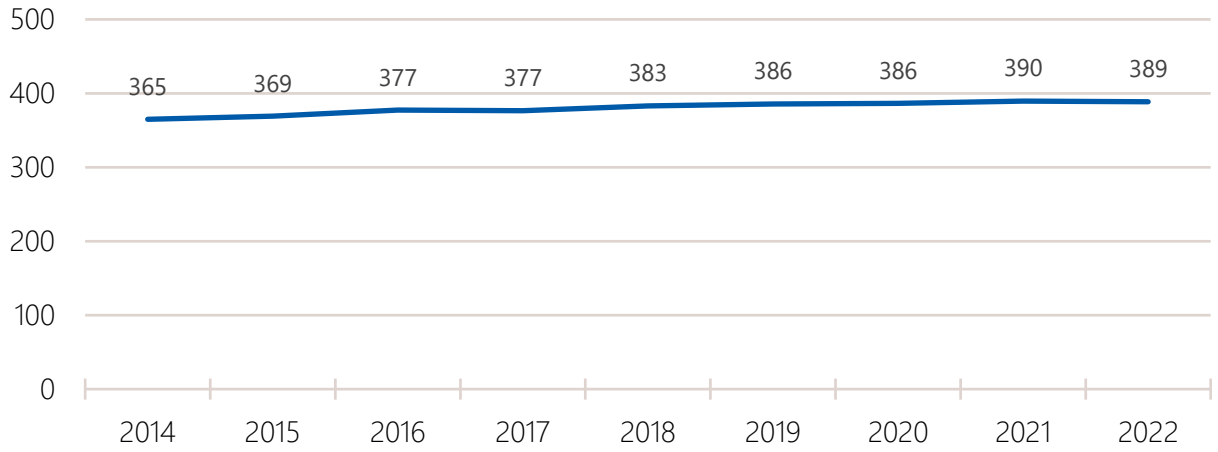
Source: HCPH epidemiology

Figure 108: New HIV infection rate (per 100,000) in Hennepin County (2014-2022)



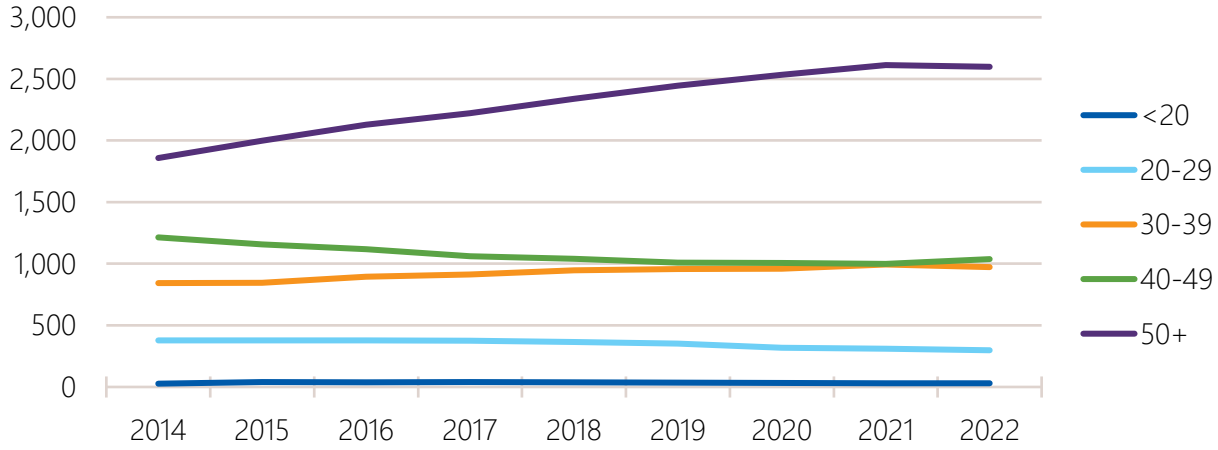
Source: HCPH epidemiology

Figure 109: HIV infection prevalence rate (per 100,000) in Hennepin County (2014-2022)



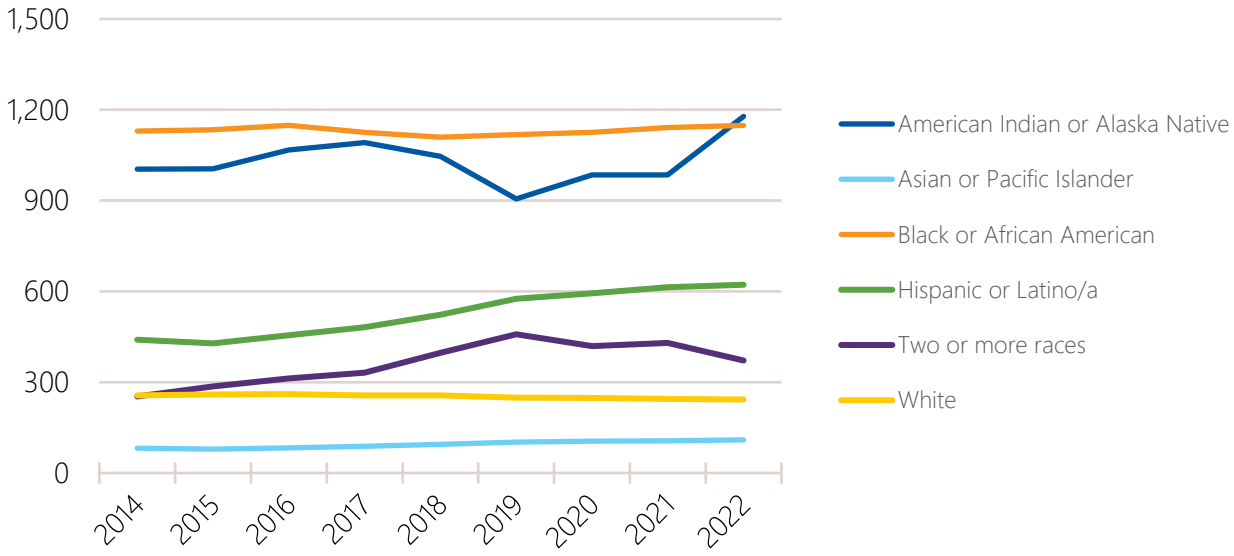
Source: HCPH epidemiology

Figure 110: HIV infection prevalence (count) by age group (2014-2022)



Source: HCPH epidemiology

Figure 111: HIV infection prevalence rate (per 100,000) population by race/ethnicity (2014-2022)



Source: HCPH epidemiology

Substance use

There have been many recent changes in Minnesota law related to substance use [36]. The possession of drug paraphernalia is no longer criminal, even if that item contains residual amounts of substances. Syringes are no longer considered drug paraphernalia, and pharmacies can dispense syringes without a prescription. These changes allow more harm reduction approaches to substance use. Finally, in 2021 and 2023, laws passed that allow the legal adult use of tetrahydrocannabinol (THC) and other cannabis products (respectively), with legal retail of cannabis being implanted in 2024.

Although cannabis use among students has declined (19% in 2013 to 12% in 2022 among 11th graders), more than half (64%) of 11th graders perceive little or no risk from cannabis use. The impacts for youth from legalized adult cannabis use in 2024 remain unknown.

Theme: Youth substance use issues are related to unsafe use of legal drugs (for adults), lack of knowledge of harms, and increased access in recent years

Respondents working with youth identified challenges related to substance use, particularly cannabis and vaping. Key concerns included:

- Reduced perception of substance harms
- Increased access, potentially linked to policy changes
- More concentrated substances, contributing to rising poisonings

Theme: Use of opioids and fentanyl is prevalent among specific adult populations that have many health needs and is associated with particularly poor health outcomes that can affect entire communities.

Respondents shared that opioid and other substance use is a significant public health challenge that intersect with other concerns. For instance, a respondent shared that 24% of unhoused adults report substance use disorder, and their substance use-related death rate is 10 times higher than the general population. There are intertwined epidemics of HIV, hepatitis C, and substance use.

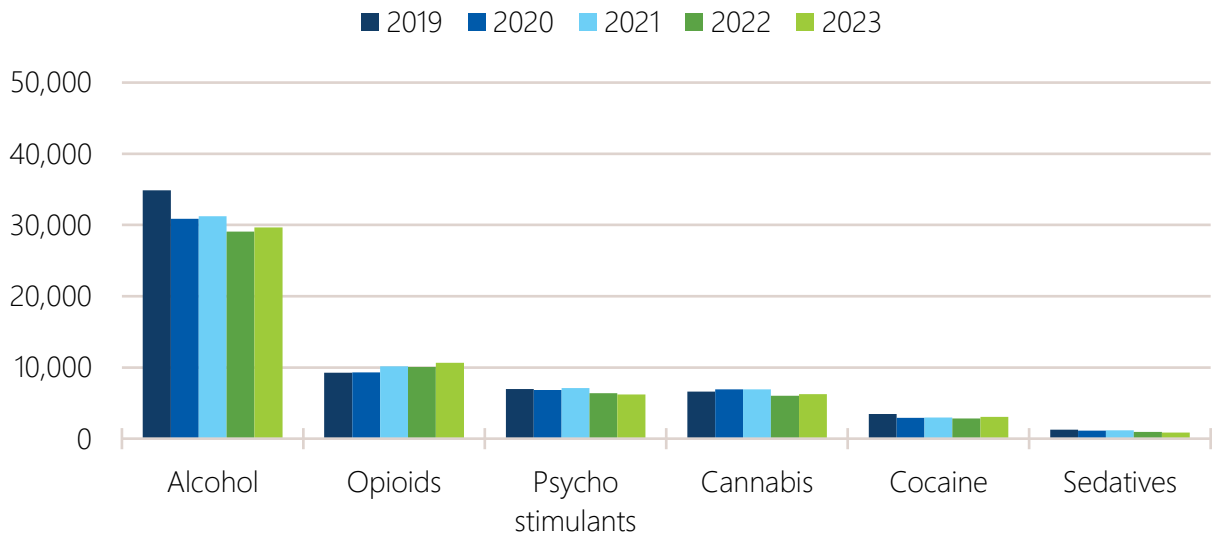
- Emergency and hospital visits involving opioids have also reached an all-time high in 2023 (Opioid-related deaths dashboard)

Substance use among adults

While alcohol is still the most common substance involved in health care visits, there has been decreasing trend in recent year (Figure 112). Additionally, a greater proportion of opioid visits are for non-fatal overdose visits compared to alcohol and other substances (Figure 113).
The SHAPE survey provides an indication of the overall burden of substance use in the county with a question that asks, "in the last 12 months, have any of the following been a problem for you or your family (alcohol, marijuana, opioids, or other drugs)?"

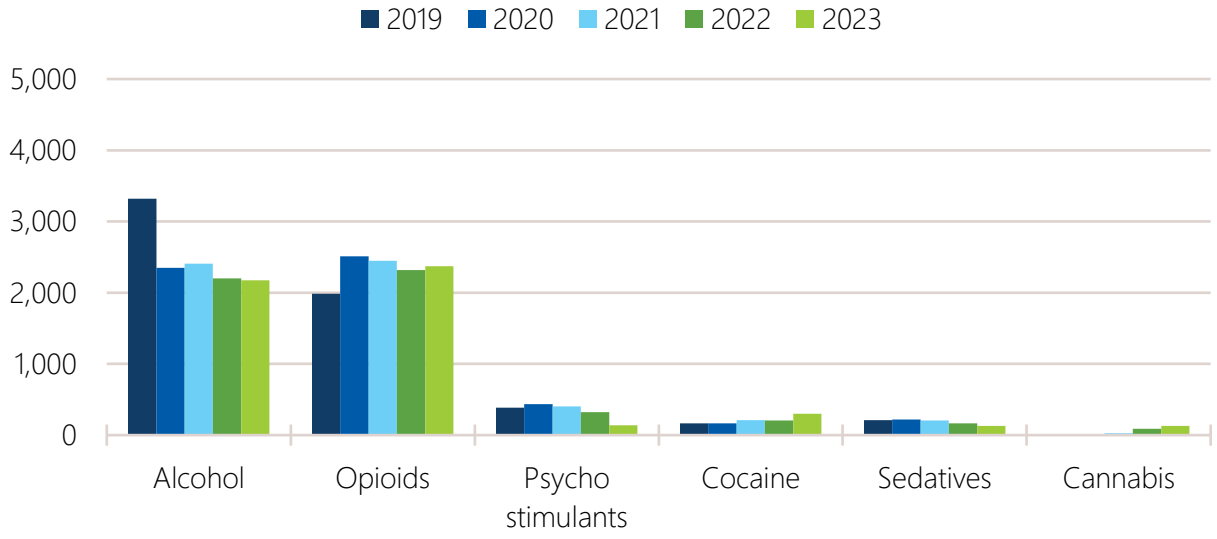
- One in 10 (10%) Hennepin County adults reported there had been a substance use problem (alcohol, marijuana, opioids, or other drugs) for them or their family in the past year (Figure 114).
- The percent of substance use problems in the family was highest among American Indian or Alaska Native (38%) and U.S.-born Black (17%) adults (Figure 114).
- There was a higher percent of substance use problems in the family reported by nonbinary (25%), LGBQ+ (19%), and transgender (20%) adults in the county (Figure 115).

Figure 112: Substance-related visits (including non-fatal overdoses) at hospitals and emergency departments in Hennepin County, 2019-2023



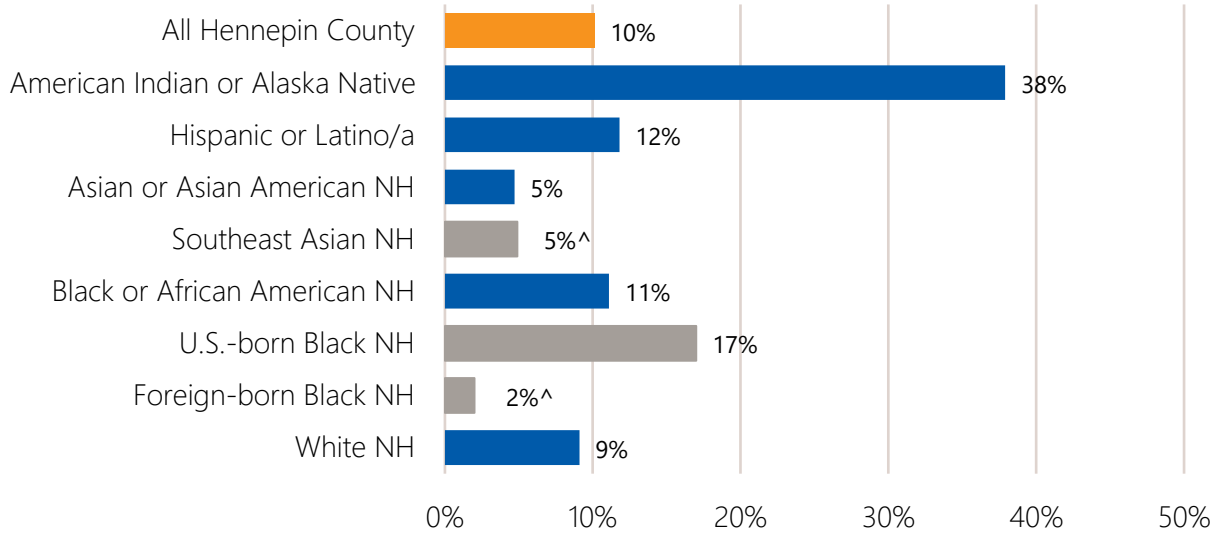
Source: Minnesota Electronic Health Record (MN EHR) Consortium

Figure 113: Substance-related non-fatal overdose visits at hospitals and emergency departments in Hennepin County, 2019-2023



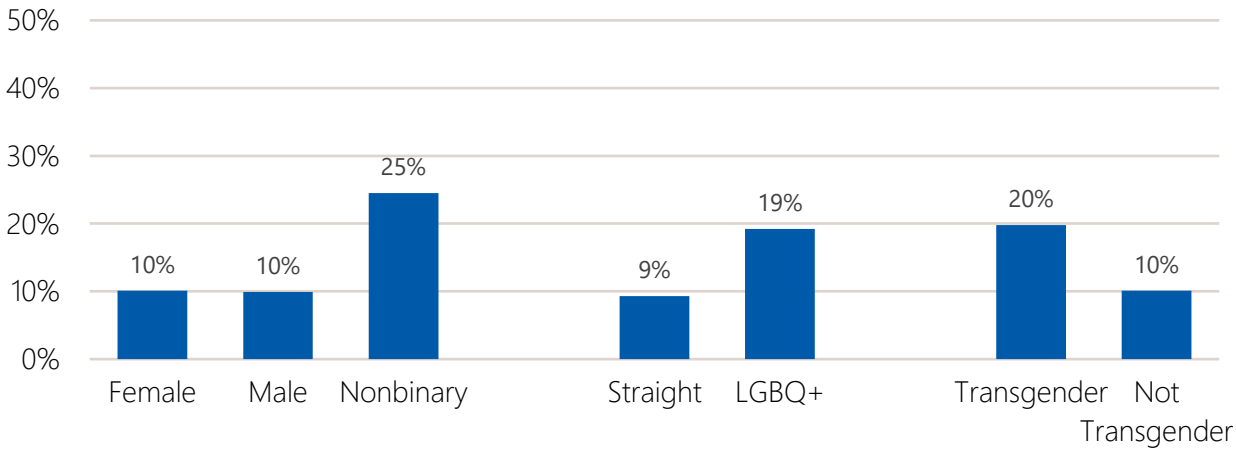
Source: Minnesota Electronic Health Record (MN EHR) Consortium

Figure 114: Percent of adults reporting drug or alcohol problems in the family by race/ethnicity, 2022



Source: SHAPE; NH is non-Hispanic ethnicity
^ Percentage does not meet criteria for statistical reliability, use with extreme caution RSE >50%.

Figure 115: Percent of adults reporting drug or alcohol problems in the family by gender identity and sexual orientation, 2022



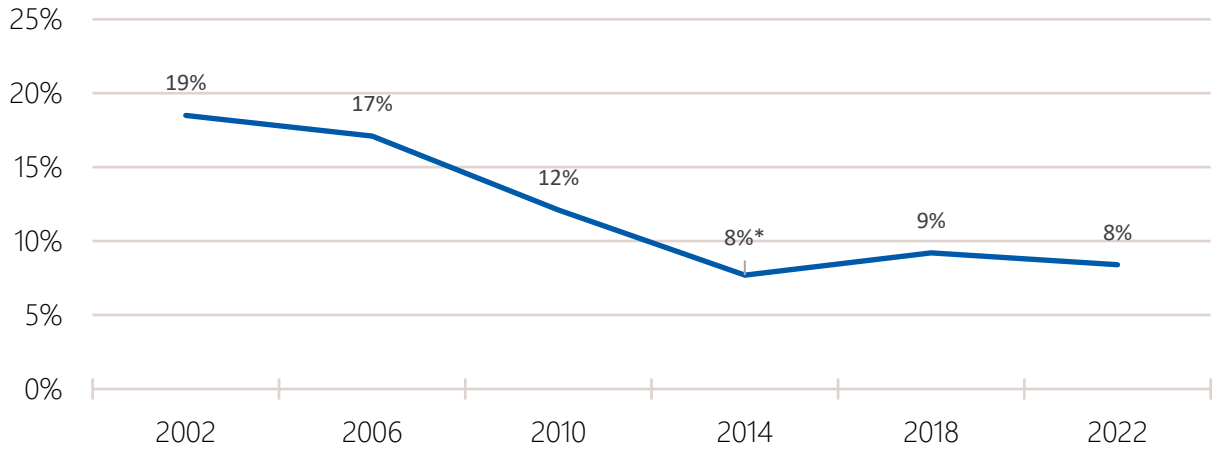
Source: SHAPE

Tobacco use

Commercial tobacco use is still the largest preventable cause of death, disability, and disease in the United States [37]. Smoking is linked to heart disease, stroke, and other chronic lung diseases, such as chronic obstructive pulmonary disease, and cancers, including 80-90% of lung cancer cases. The federal Healthy People 2030 target is to reduce current cigarette smoking percentage in adults to 6.1% [38].

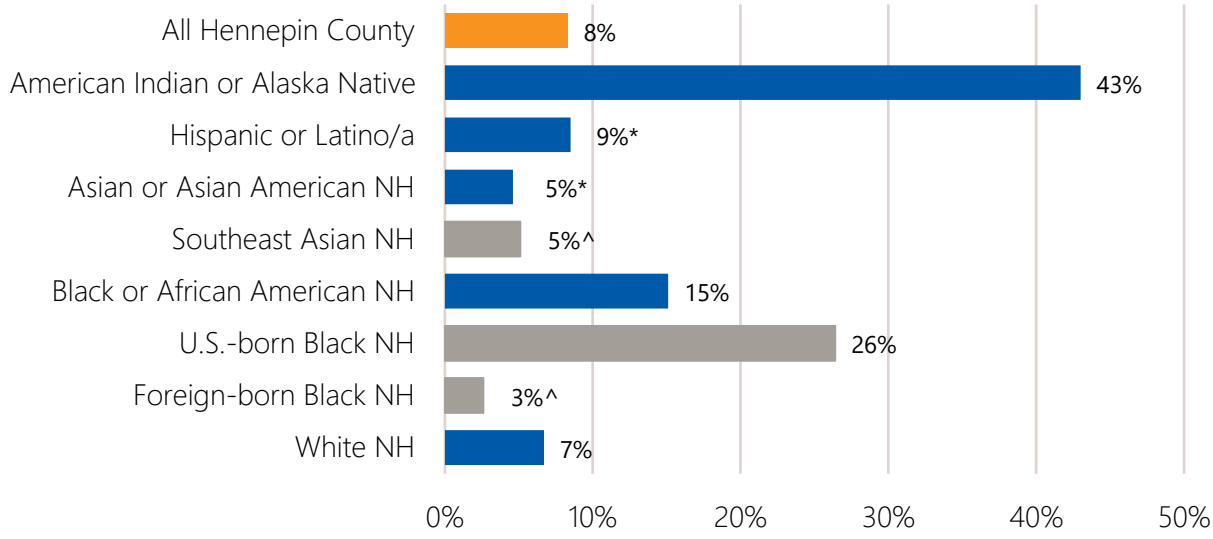
- In 2022, 8% of Hennepin County adults reported being a current smoker, which is lower than the rate for adults in Minnesota (13%) (BRFSS, 2022). The rate has decreased steadily in the last 20 years from 19% in 2002 (Figure 116).
- Smoking rates were higher among American Indian or Alaska Native (43%) and U.S.-born Black adults (26%) than the county overall (Figure 117).
- Smoking rates varied slightly by gender and sexual orientation with a higher percent of male (10%) and LGBQ+ (11%) respondents reporting current smoking (Figure 118).
- Most U.S.-born Black current smokers smoked menthol cigarettes (77%) (SHAPE 2022).
- There were disparities in current smoking percents by income and education. Of adults with a lower household income level, 18% were current smokers compared to 5% with higher income. Similar differences were seen by education level, with 20% of adults with less than a high school education currently smoking (20%) compared to adults with a college degree or higher (3%) (Figure 119).

Figure 116: Percent of adults reporting current cigarette use, 2002-2022



*Source: SHAPE * Results from 2014 survey limited to adults ages 25 and older*

Figure 117: Percent of adults reporting they currently smoke every day or some days by race/ethnicity, 2022

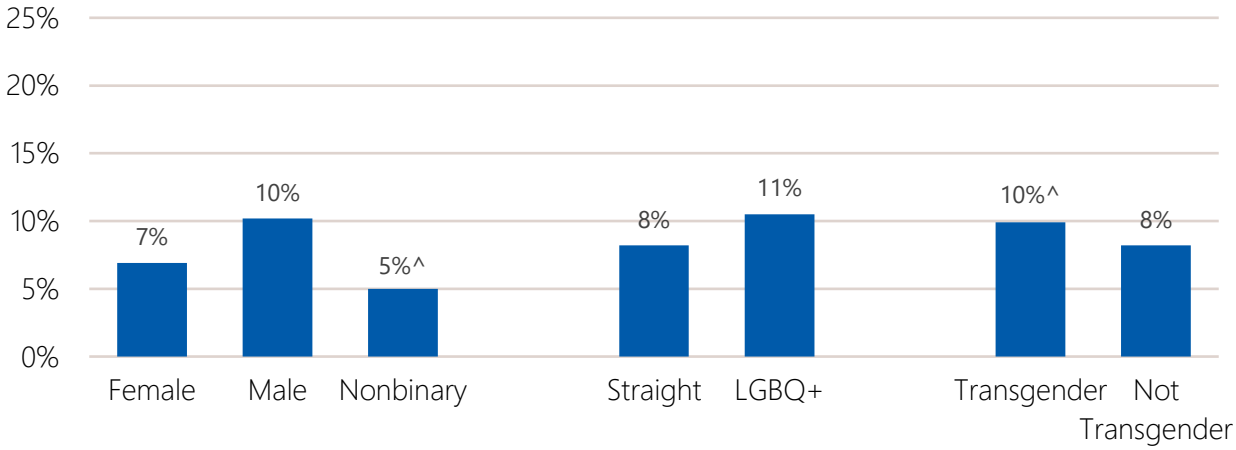


Source: SHAPE; NH is non-Hispanic ethnicity

***** *Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

^ *Percentage does not meet criteria for statistical reliability, use with extreme caution RSE >50%.*

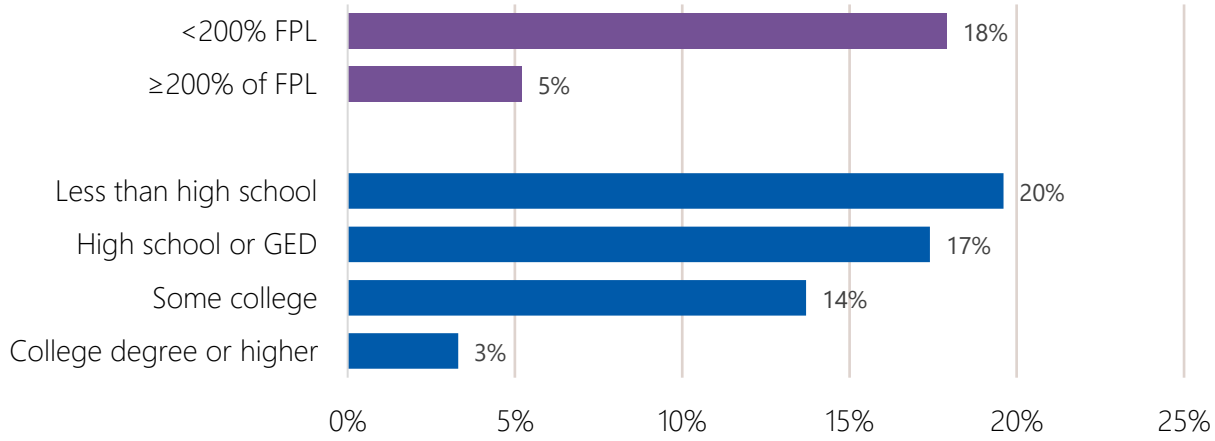
Figure 118: Percent of adults reporting they currently smoke every day or some days by gender identity, 2022



Source: SHAPE

^ *Percentage does not meet criteria for statistical reliability, use with extreme caution RSE >50%.*

Figure 119: Percent of adults reporting current cigarette use by income and education, 2022



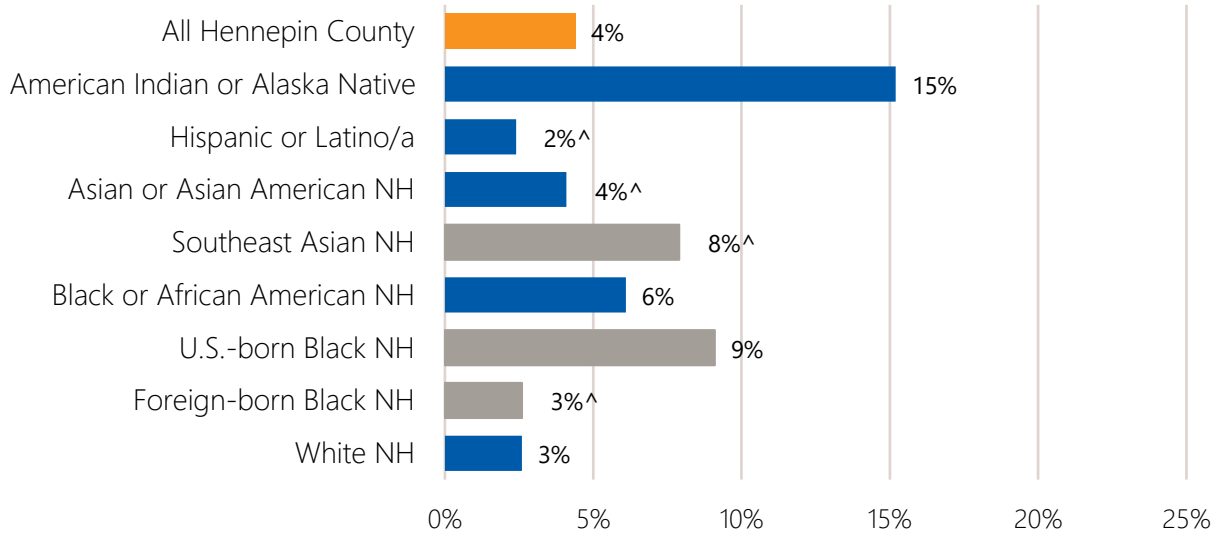
Source: SHAPE; FPL is Federal Poverty Level

Electronic cigarette use

Electronic cigarettes (e-cigarettes) gained popularity in recent years. Nearly all e-cigarettes contain nicotine, a highly addictive substance that can harm developing brains. The aerosol produced from e-cigarettes contains additional harmful substances such as ultrafine particles, heavy metals, and other cancer-causing chemicals.

- In 2022, 4% of adults in Hennepin County reported current use of e-cigarettes. E-cigarette percents were higher among American Indian or Alaska Native or Alaska Native (15%) and U.S.-born Black adults (9%) (Figure 120).
- Although some estimates were less reliable, nonbinary, LGBQ+, and transgender adults reported higher rates of e-cigarette use (Figure 121).
- Younger adults reported over double the rate of e-cigarette use compared to older age groups (Figure 122).

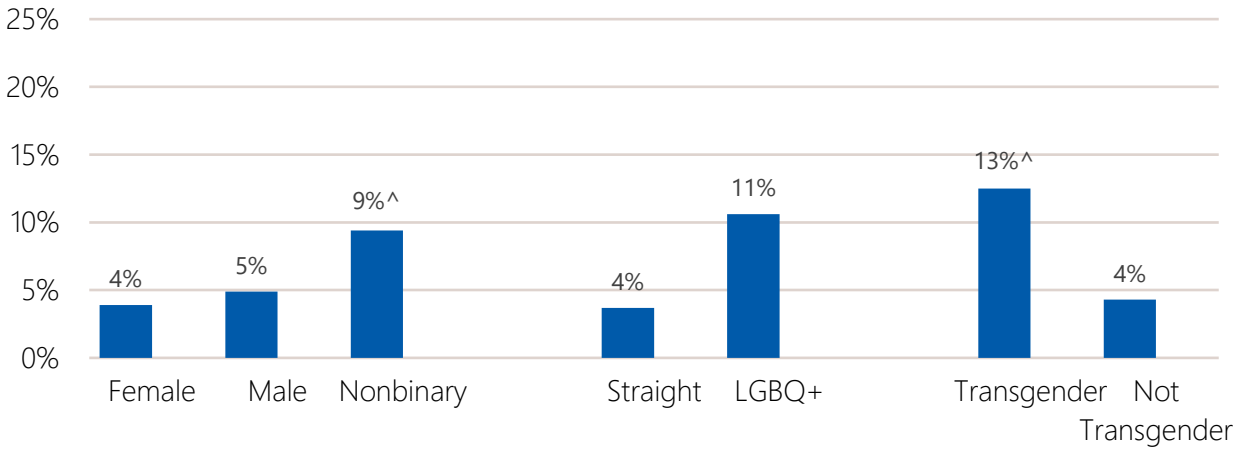
Figure 120: Percent of adults reporting current e-cigarette use by race/ethnicity, 2022



Source: SHAPE; NH is non-Hispanic ethnicity

^ Percentage does not meet criteria for statistical reliability, use with extreme caution RSE >50%.

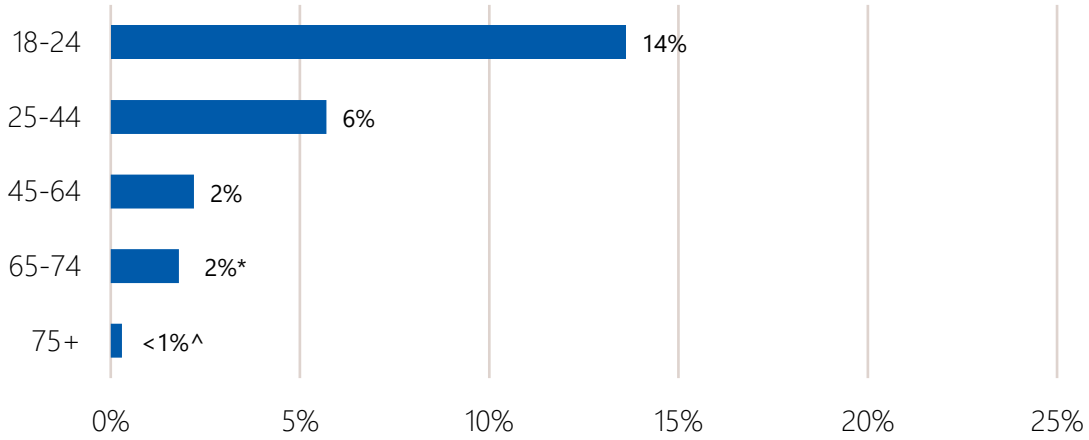
Figure 121: Percent of adults reporting current e-cigarette use by gender identity, 2022



Source: SHAPE

^ Percentage does not meet criteria for statistical reliability, use with extreme caution RSE >50%.

Figure 122: Percent of adults reporting current e-cigarette use by age, 2022



Source: SHAPE

***** *Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

^ *Percentage does not meet criteria for statistical reliability, use with extreme caution RSE >50%.*

Youth tobacco use

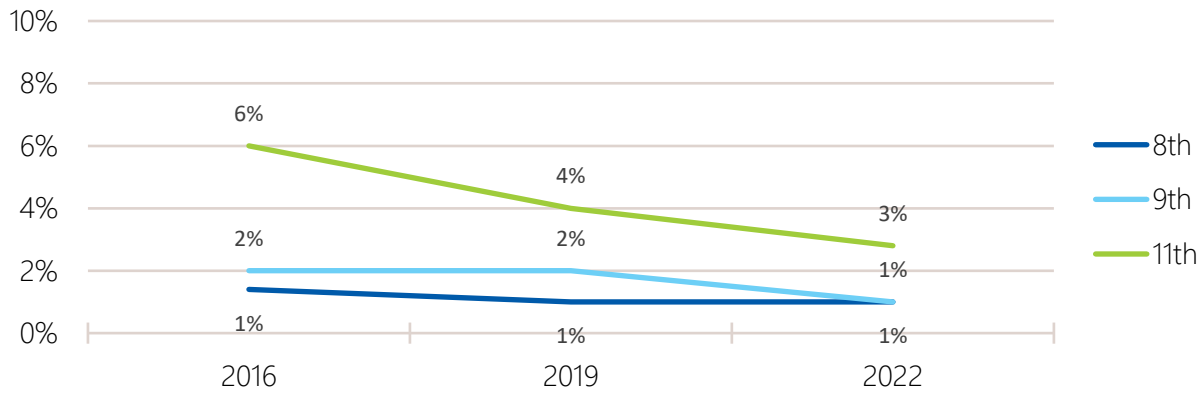
The use of conventional tobacco products has declined among Minnesota high school students since 2000 [39]. In 2023, less than 5% of high school students in Minnesota reported current use of tobacco products (cigarettes, cigars, and smokeless tobacco). However, as the use of conventional tobacco products lost favor among youth, the use of e-cigarettes increased in 2017 and then declined in Minnesota more recently. Hennepin County trends mirror state-level trends. The federal Healthy People 2030 goal for adolescent tobacco use is 11.3% [40].

Flavored commercial tobacco products are appealing to youth. In 2023, 76% of Minnesota students reported the first product they experimented with was flavored (Minnesota Youth Tobacco Survey). In Hennepin County among the students (8th, 9th, and 11th graders) reporting tobacco use, over three-quarters (77%) used flavored tobacco. This percent is above the federal Healthy People 2030 goal of reducing the use of flavored tobacco products in adolescents who use tobacco to 73.2% [41].

- In Hennepin County, the percent of 8th, 9th, and 11th graders reporting cigarette use has decreased since 2016 (Figure 123).
- In 2022, 2% of 8th, 9th, and 11th graders students reported current tobacco use (cigarette, cigar/cigarillos/little cigars, chewing tobacco/snuff or dip) but there was variation among racial or ethnic groups (Figure 124).
- E-cigarette use peaked in 2019 but decreased in 2022 (Figure 125). Overall, 6% of students reported using e-cigarettes or vaping in 2022 (MSS 2022).
- The percent of students (8th, 9th, and 11th graders) that reported current tobacco product use (cigarettes, smokeless tobacco, e-cigarettes, vaping, or hookah/water pipe, etc.) was 7%. However, there was variation by race and ethnicity (Figure 126).

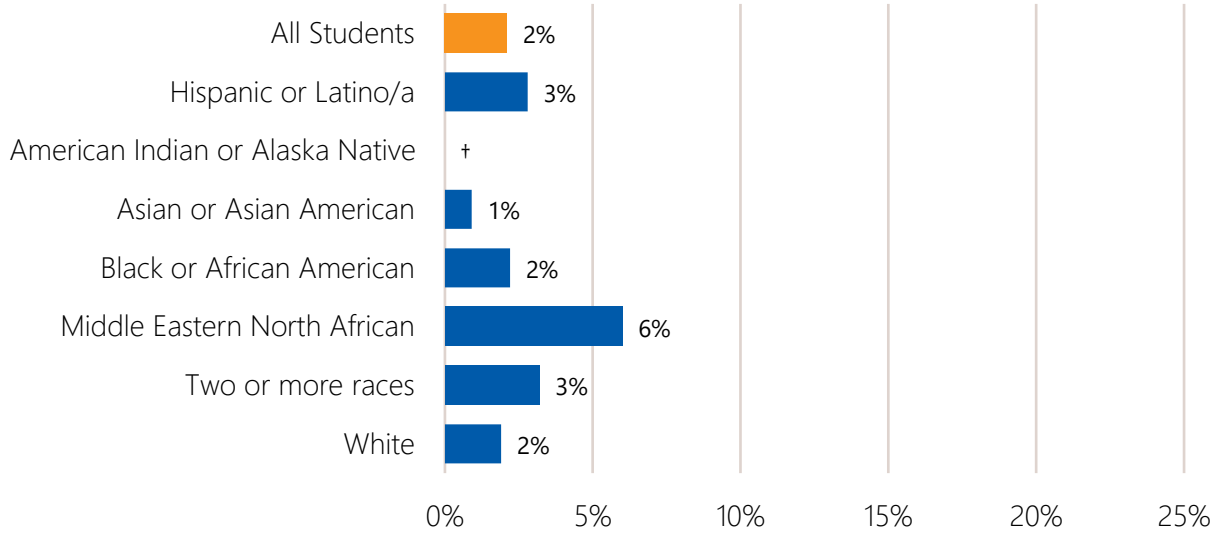
- Among the students who reported current tobacco products use, 77% used flavored tobacco (Figure 127).

Figure 123: Percent of students reporting current cigarette use (8th, 9th, and 11th graders), 2016-2022



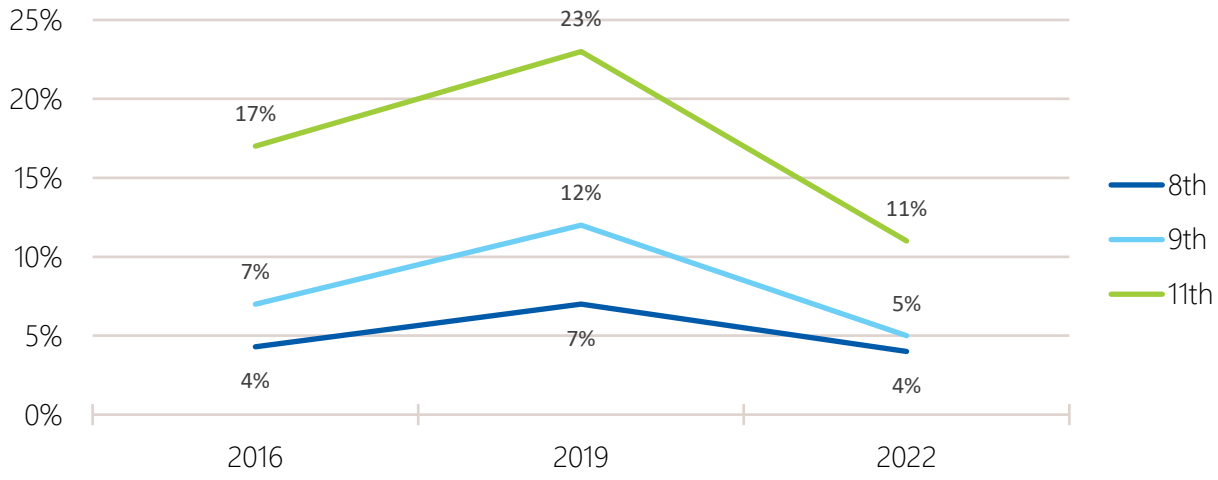
Source: MSS, Hennepin County

Figure 124: Percent of students reporting current tobacco use (cigarette, cigar/cigarillos/little cigars, chewing tobacco/snuff or dip) (8th, 9th, and 11th graders) by race/ethnicity, 2022



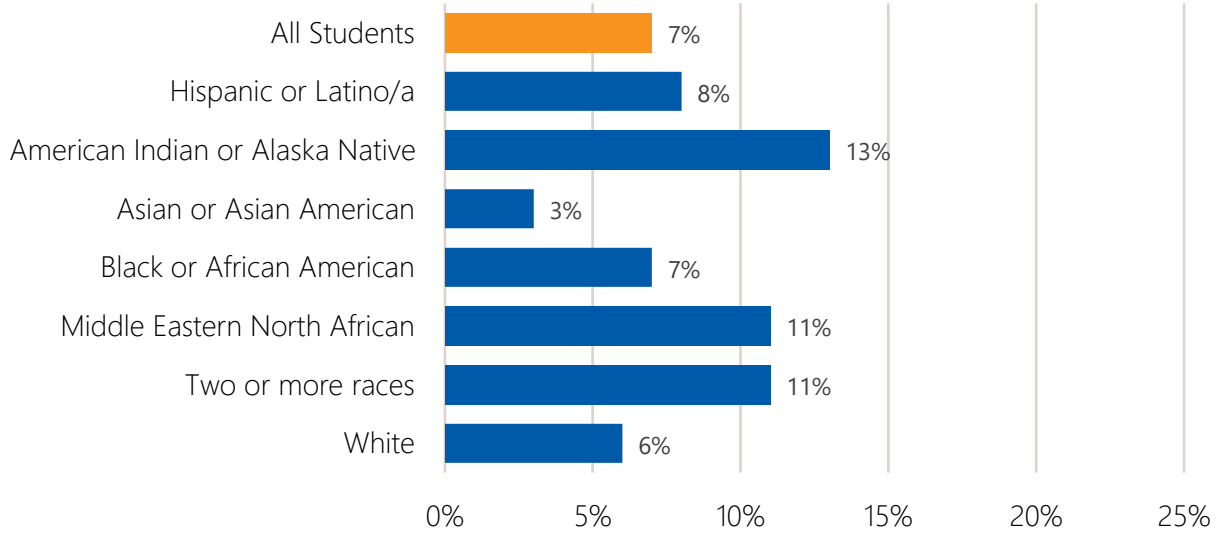
Source: MSS, Hennepin County
† Indicates that a data count is below a suppression threshold and has been suppressed.

Figure 125: Percent of students reporting current e-cigarette or vape use (8th, 9th, and 11th graders), 2022



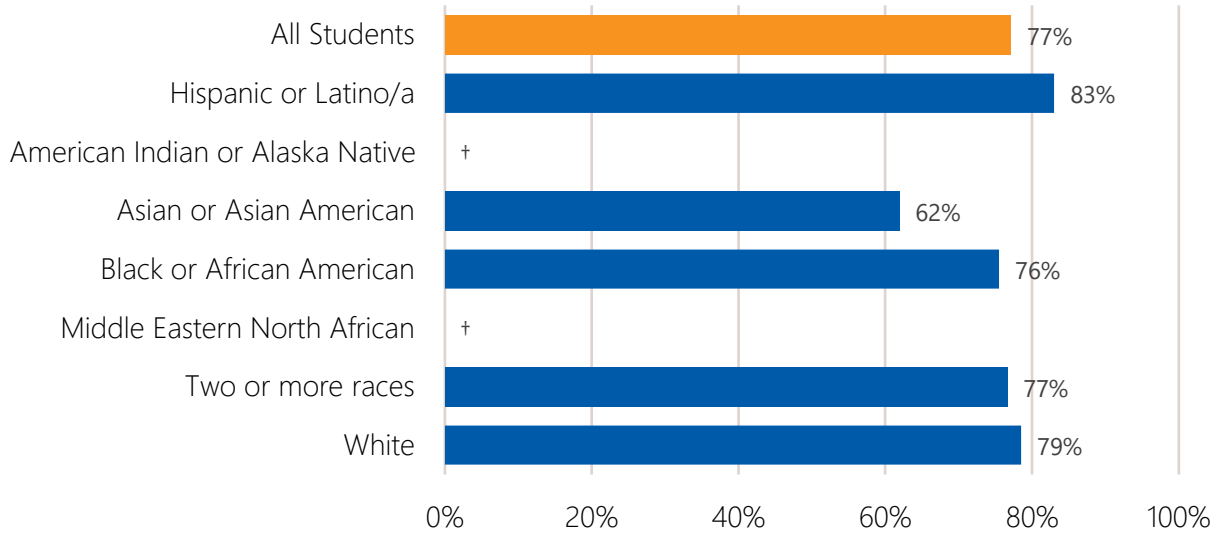
Source: MSS, Hennepin County

Figure 126: Percent of students reporting current tobacco product use, including e-cigarettes, vaping, or hookah/water pipe, in the past 30 days (8th, 9th, and 11th graders) by race/ethnicity, 2022



Source: MSS, Hennepin County

Figure 127: Percent of students reporting flavored tobacco use (among those who used tobacco in past 30 days) by race/ethnicity (8th, 9th, and 11th graders), 2022



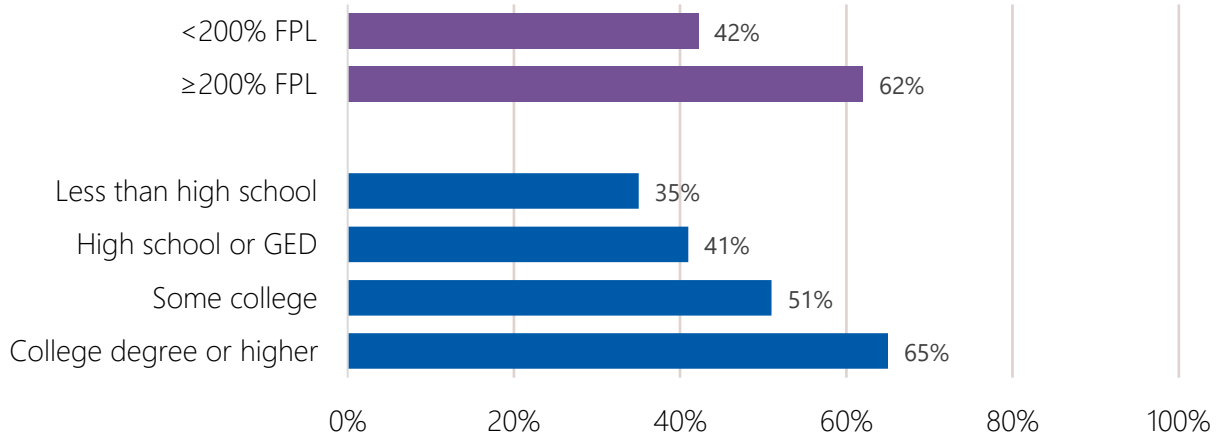
Source: MSS, Hennepin County
† Indicates that a data count is below a suppression threshold and has been suppressed.

Alcohol use

In 2022, over half of (57%) Hennepin County adults reported heavy or binge alcohol consumption (SHAPE 2022). Heavy drinking is defined as consuming more than one drink (for females) or two drinks (for males) per day on average during the past 30 days. Binge drinking is defined as consuming four or more drinks for females, or five drinks or more for males at least once in the past 30 days. In the SHAPE survey, the amount of reported alcohol use varied by income, education, age, race and ethnicity, and gender, sexual orientation, or transgender identity.

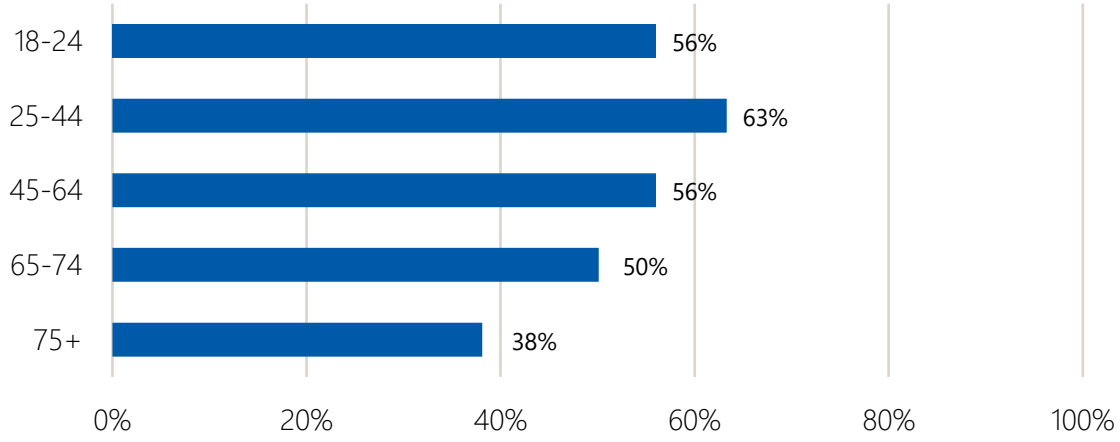
- Adults who have higher income and higher education reported disproportionately high rates of heavy or binge drinking compared to their counterparts (Figure 128).
- By age group, the highest percent of heavy or binge drinking was reported by 25–44-year-olds (63%) (Figure 129).

Figure 128: Percent of adults reporting they engaged in heavy or binge drinking by income and education, 2022



Source: SHAPE; FPL is Federal Poverty Level

Figure 129: Percent of adults reporting they engaged in heavy or binge drinking by age, 2022



Source: SHAPE

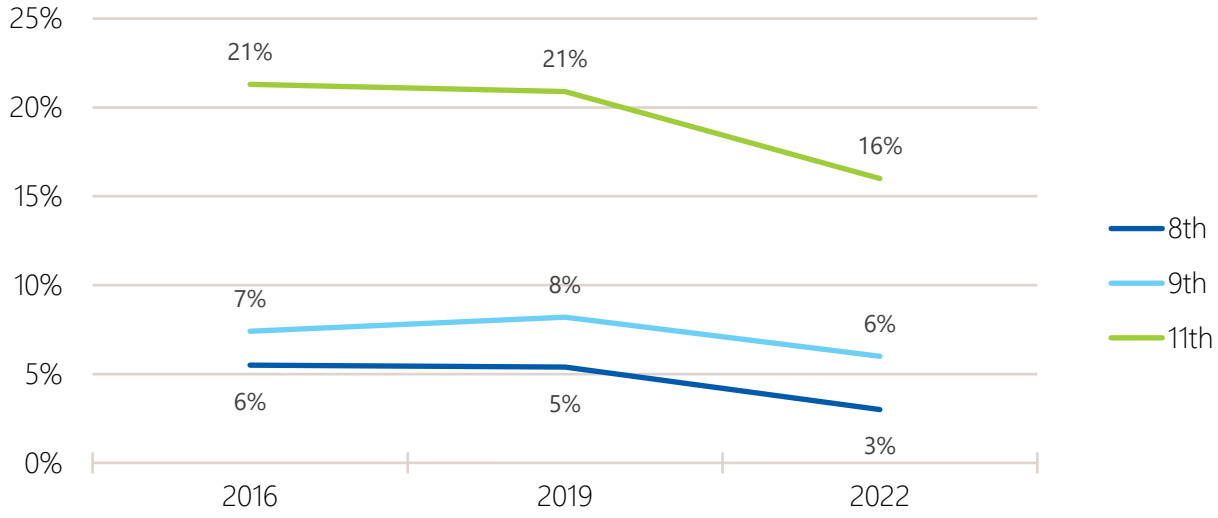
Youth alcohol use

Youth who drink alcohol are at risk of academic, social, legal, physical, and emotional problems. Youth who binge drink are at risk of experiencing problems related to drinking more than youth who drink alcohol but do not binge drink. The federal Healthy People 2030 goal is to reduce the proportion of adolsecents who drank alcohol in the past month to 6.3% [42].

- Adolescent alcohol use decreased from 2016 to 2022 (Figure 130).
- In 2022, 8% of Hennepin County youth (8th, 9th, and 11th graders) reported using alcohol at least once during the past 30 days (MSS 2022).

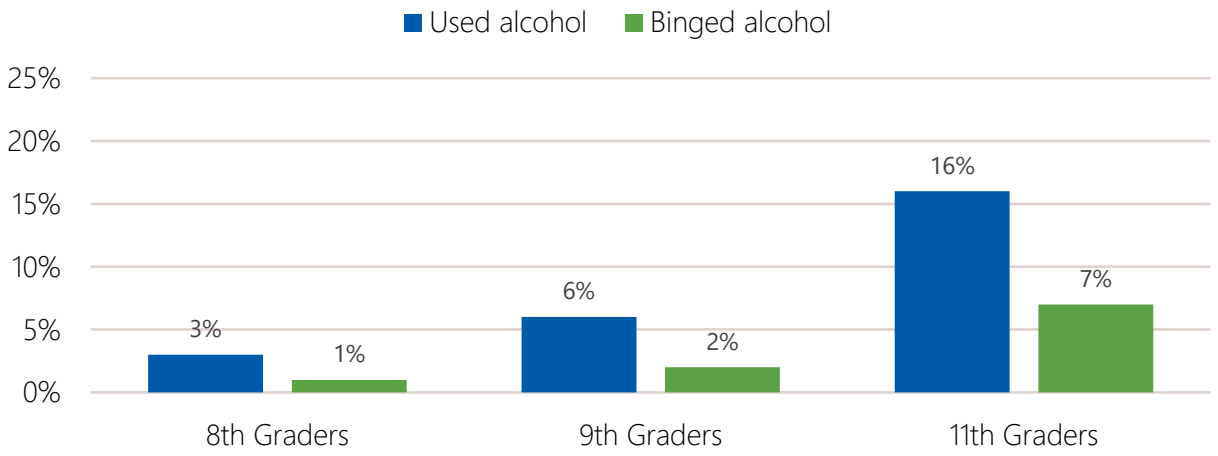
- Binge drinking in the past 30 days was reported by 3% of Hennepin County students, a decline from 4% in 2019 and 5% in 2016 (Minnesota Student Survey 2022).
- Alcohol use increased significantly from 9th to 11th grades. 11ths graders were 2.5 time more likely to report current alcohol use, 3 times more likely to report binge drinking (Figure 131).

Figure 130: Percent of students reporting current alcohol drinking (8th, 9th, and 11th graders), 2016-2022



Source: MSS, Hennepin County

Figure 131: Percent of students reporting current alcohol drinking and binge drinking (8th, 9th, and 11th graders), 2016-2022



Source: MSS, Hennepin County

Cannabis use

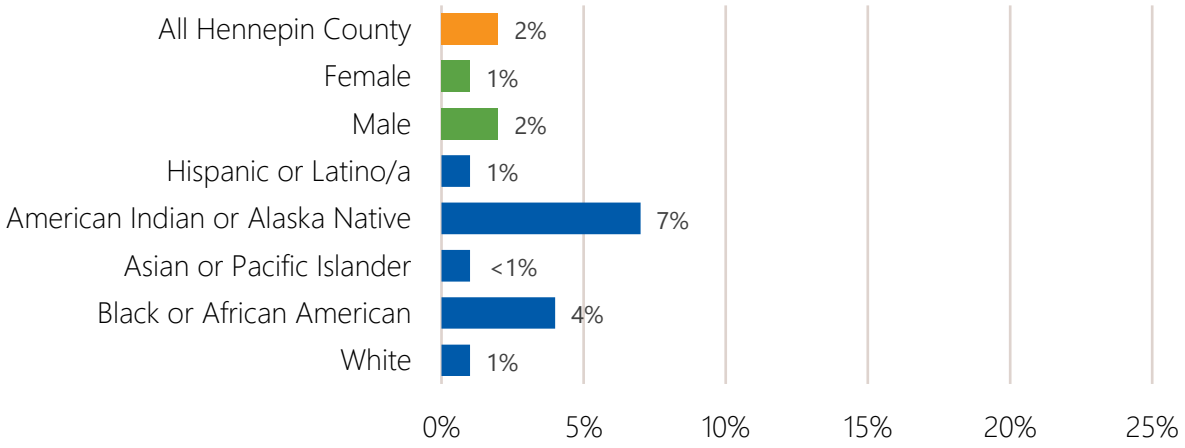
Cannabis is the most commonly used drug in the United States with an estimated 61.9 million users in 2022 [43]. Although it is legal in some states, it remains illegal at the federal level. Cannabis refers to the dried leaves, flowers, stems, and seeds of the cannabis plant. The plant has many different chemical compounds, including tetrahydrocannabinol (THC), which has intoxicating, mind altering effects. Hemp and marijuana are both cannabis plants that contain THC.

In July 2022, Minnesota passed legislation legalizing the sale of edibles that contain up to 5 milligrams of hemp-derived THC per serving, with a limit of 50 milligrams per package [44]. In July 2023, Gov. Tim Walz signed an expansive cannabis legalization bill into law. Beginning August 1, 2023, adults 21 years of age and older may possess up to 2 ounces of cannabis flower, no more than 8 grams of cannabis concentrates, and up to a total of 800 milligrams of THC edible cannabis products in public. Additionally, the law permits possession of up to 2 pounds of marijuana in the home.

New legislation and popularity of marijuana use poses risks for misuse among adolescents. Cannabis-related data highlighted in this assessment pre-date the legislation change in 2022.

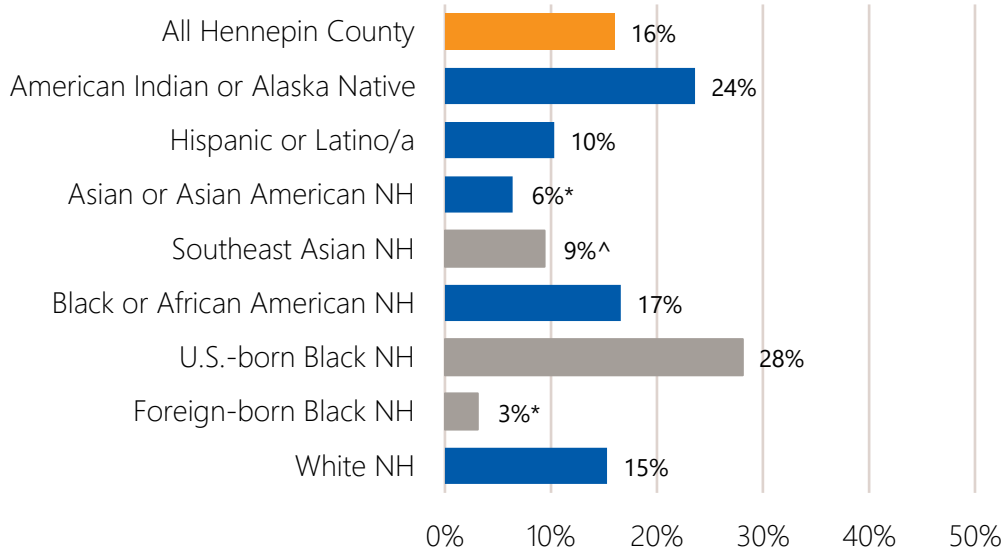
- Two percent of Hennepin County adults were diagnosed with cannabis use at a medical visit in 2023 (Figure 132).
- Marijuana product use was reported at a higher rate by U.S.-born Black (28%) and American Indian or Alaska Native (24%) adults than the overall rate in Hennepin County (16%) (Figure 133).
- Nonbinary (42%), LGBQ+ (33%), and transgender adults (37%) reported using marijuana products at over double the rate of the county overall (16%) (Figure 134).

Figure 132: Prevalence of cannabis use diagnosis at a medical visit (unadjusted) among adults (ages 18-85+) by gender and race/ethnicity, 2023



Source: Health Trends Across Communities (HTAC); <1 is less than one

Figure 133: Percent of adults reporting marijuana or products containing THC use in the past 30 days by race/ethnicity, 2022

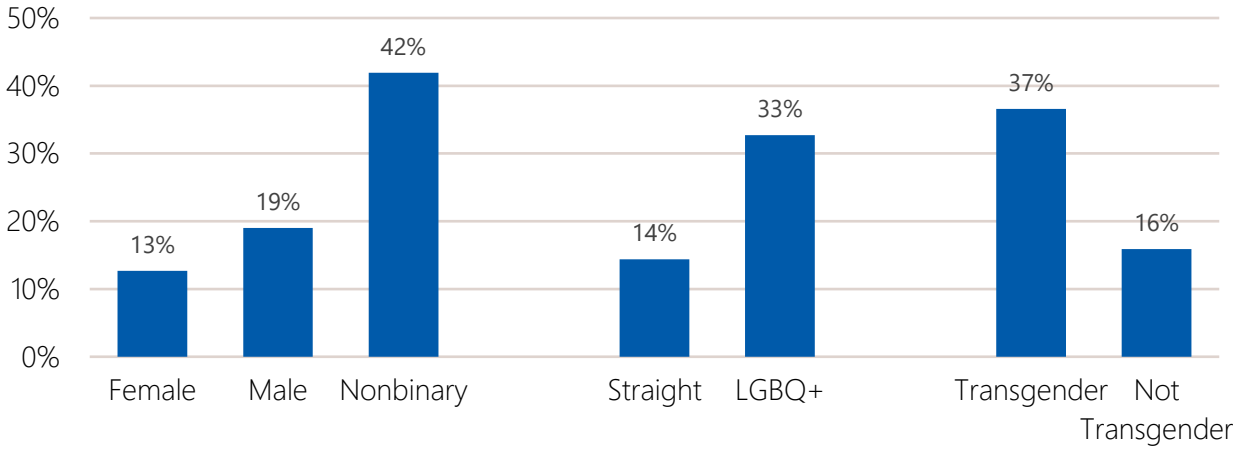


Source: SHAPE; NH is non-Hispanic ethnicity

** Percentage is potentially unreliable, use with caution. Relative Standard Error (RSE) ≥30% and ≤50%.*

^ Percentage does not meet criteria for statistical reliability, use with extreme caution RSE >50%.

Figure 134: Percent of adults reporting marijuana or products containing THC use in the past 30 days by gender identity and sexual orientation, 2022



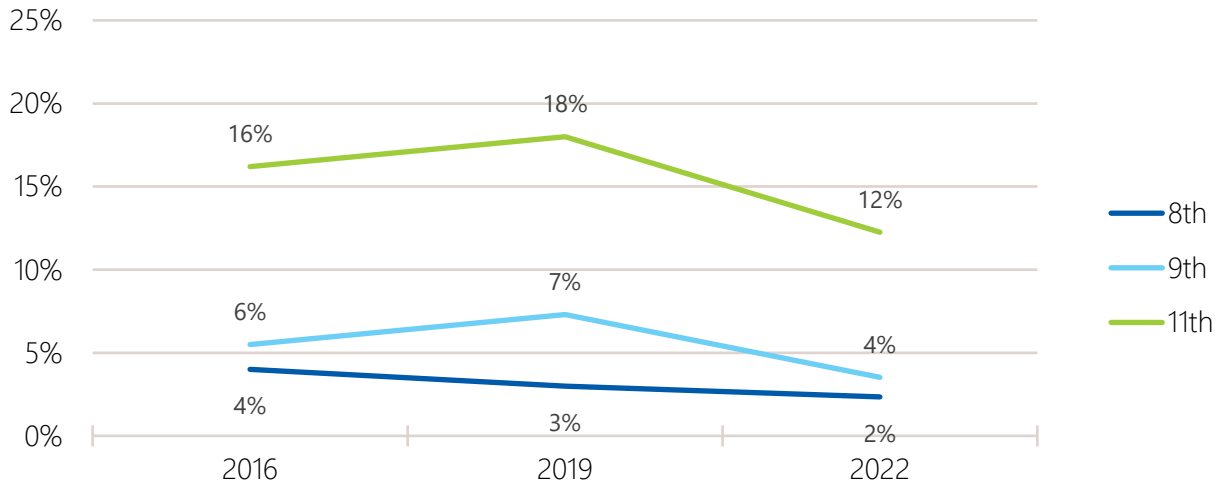
Source: SHAPE

Youth cannabis use

Cannabis use has declined among Hennepin County youth (8th, 9th, and 11th graders) attending public schools since 2016 (Figure 135). Current cannabis use was reported by 16% of 11th graders in 2016 compared to 12% in 2022. Across 9th, 10th and 11th graders, 6% of students reported current cannabis use and 8% reported using cannabis in the past year, but there was

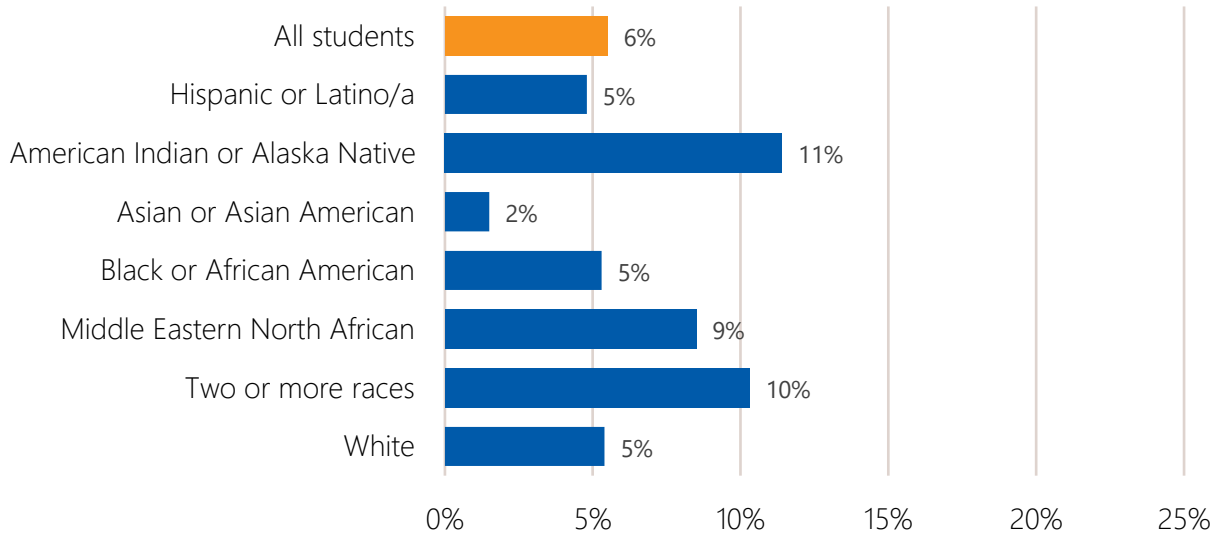
some variation by race and ethnicity in 2022 (Figures 136 and 137). The overall percent is close to the federal Healthy People 2030 goal to reduce the proportion of adolescents who used marijuana in the past month to 5.8% [45]. Of concern is the percent of LGBTQ+ youth that reported cannabis use, as well as reported use of cigarettes, vapes, alcohol, marijuana, and illicit or prescription drugs at up to 2x the rate of youth who are not LGBTQ+ (MSS 2022).

Figure 135: Percent of students reporting current cannabis use (8th, 9th, and 11th graders), 2016-2022



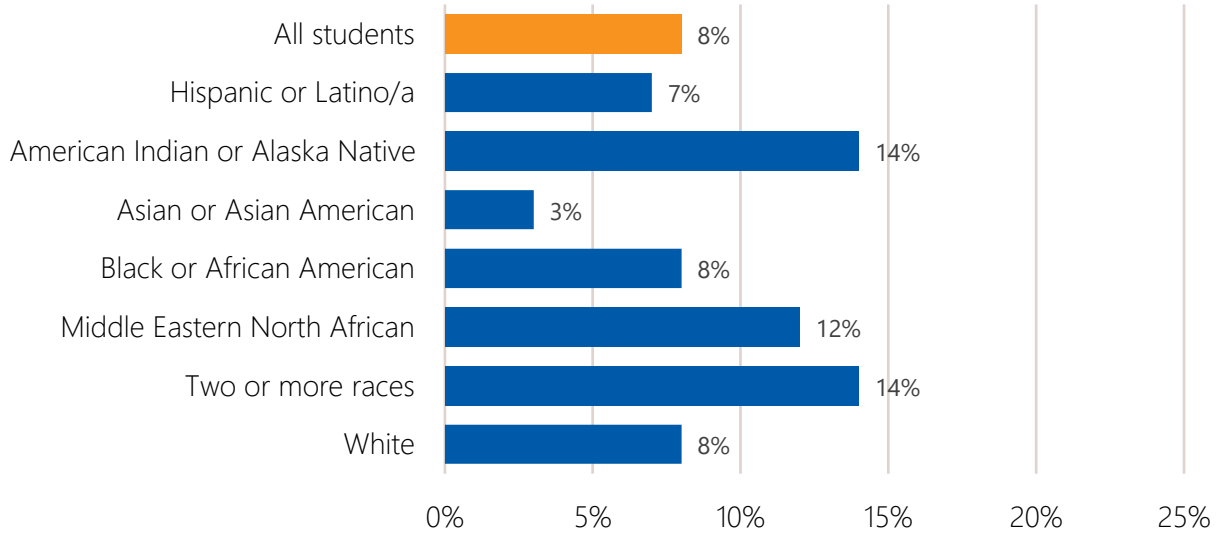
Source: MSS, Hennepin County

Figure 136: Percent of students reporting current cannabis use by race/ethnicity (8th, 9th, and 11th graders), 2022



Source: MSS, Hennepin County

Figure 137: Percent of students reporting cannabis use at least once in the past year by race/ethnicity (8th, 9th, and 11th graders), 2022



Source: MSS, Hennepin County

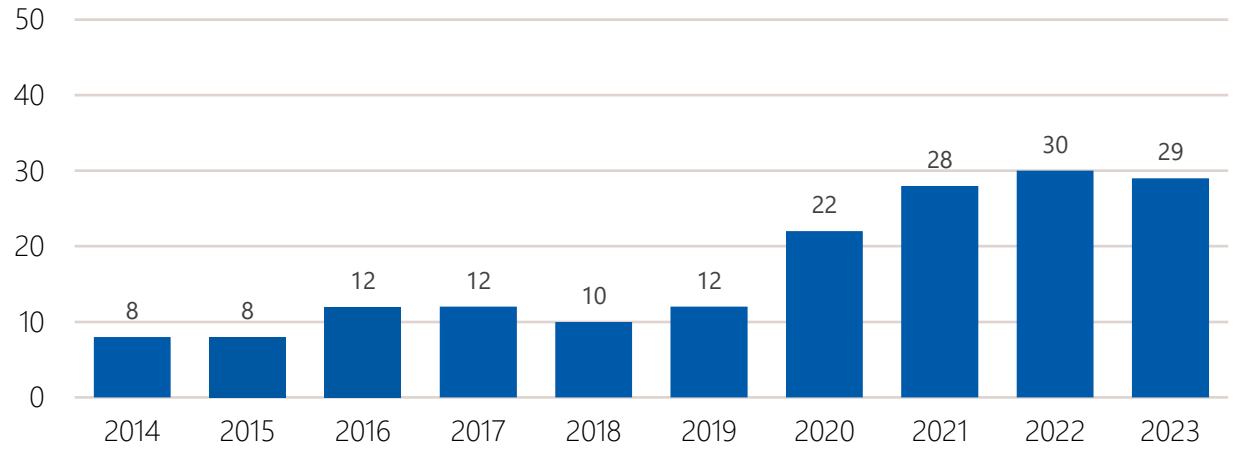
Opioid use

In 2022, there were more than 10,000 emergency room or hospital visits that involved opioids, and more than 2,000 visits for non-fatal overdoses in Hennepin County (Substance involved emergency and hospital visits in Hennepin County dashboard). The federal Healthy People 2030 has set objectives to reduce drug overdose deaths to 20.7 per 100,000 and overdose deaths involving opioids to 13.1 per 100,000 [46]. In 2023, the opioid related death rate in Hennepin County was 29 per 100,000 (Figure 138).

Synthetic opioids (such as fentanyl) are increasingly involved in drug-related deaths among residents, with up to 95% of opioid-related deaths involving fentanyl in 2022 (Figure 139). Non-fatal overdoses, hospitalizations, injuries, and trauma are additional harms related to opioid use.

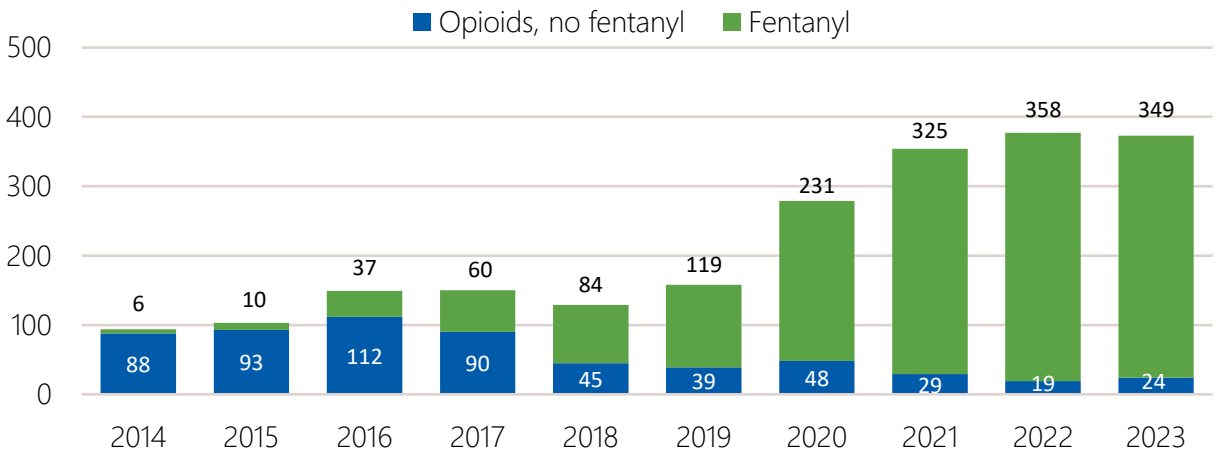
In Minnesota, social determinants of health have prevented racial or ethnic groups from having equal access to the resources needed to be healthy. Certain groups are affected by opioids disproportionately, leading to health inequities that result in overdose and death disparities [47]. In 2023, American Indian or Alaska Native and Black or African American adults experienced a disproportionality high rate of opioid-related deaths and hospitalizations compared to the other racial and ethnic groups (Figures 140 and 141). The largest numbers of opioid-related deaths occurred in males, Black or African Americans, and white populations in 2023 (Figure 142).

Figure 138: Annual opioid-related death rate per 100,000, 2014-2023



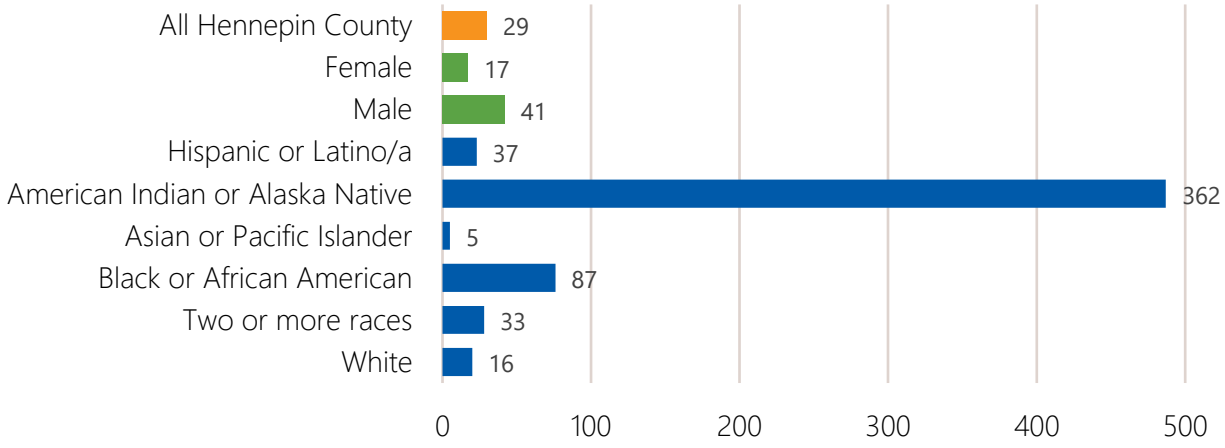
Source: Minnesota Vital Statistics, Hennepin County death records

Figure 139: Opioid deaths involving fentanyl in Hennepin County, 2014-2023



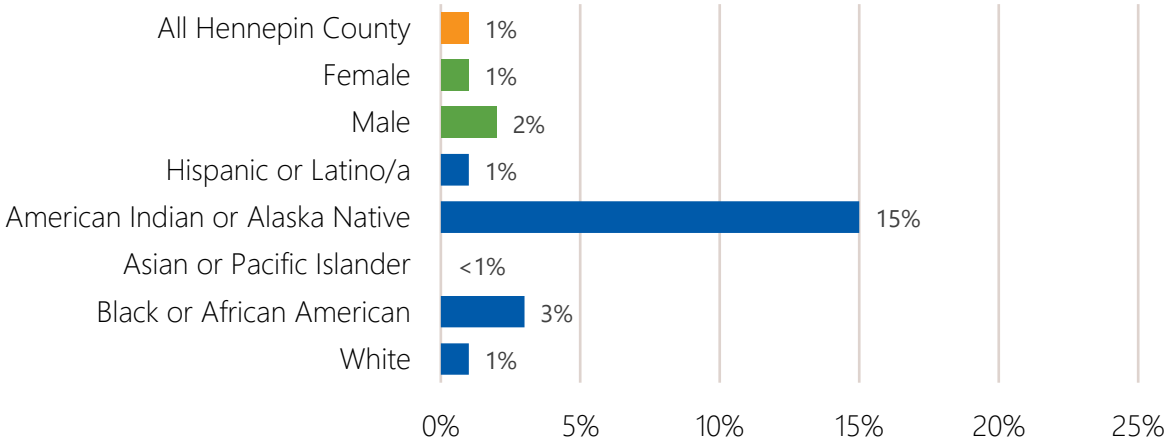
Source: Minnesota Vital Statistics, Hennepin County death records

Figure 140: Opioid-related death rate per 100,000 population (unadjusted) by gender and race/ethnicity, 2023



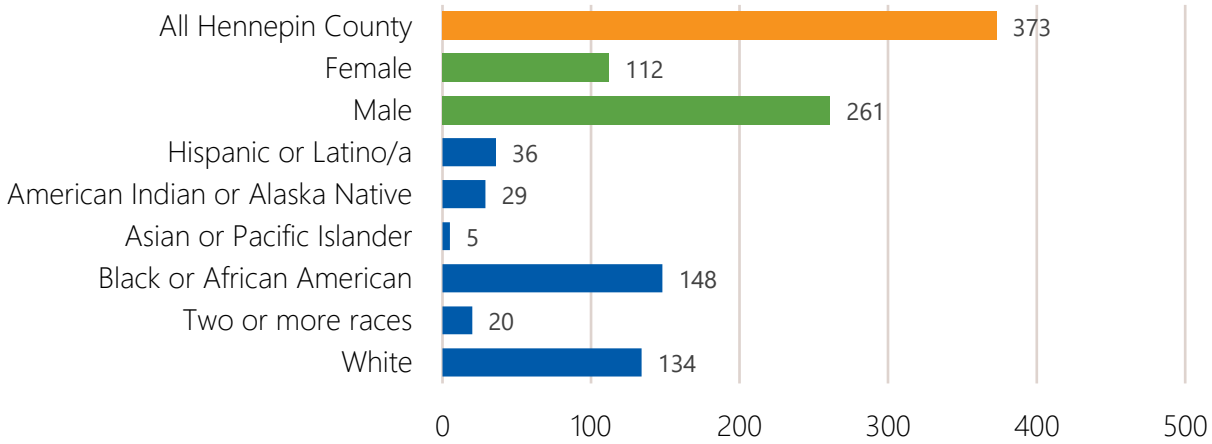
Source: Minnesota Vital Statistics, Hennepin County death records

Figure 141: Prevalence of opioid use medical visit diagnosis (unadjusted) among adults (ages 18 and older) by race/ethnicity and gender, 2023



Source: Health Trends Across Communities (HTAC); <1 is less than one

Figure 142: Opioid-related deaths by gender and race/ethnicity, 2023



Source: Minnesota Vital Statistics, Hennepin County death records

Maternal and child health

Infant and maternal morality

Theme: Maternal and infant outcomes are disparate for racial and ethnically diverse populations

Respondents reported significant racial and ethnic disparities in maternal and child health outcomes in Hennepin County. They emphasized the need for multi-program support and suggested that innovative care models, such as doulas, culturally appropriate care, and mobile in-home services, could help improve these outcomes. Updated, county-specific data on maternal mortality is needed.

Infant mortality is the death of an infant within the first year of life. Infant mortality not only impacts families, but the communities they live in. Because infants are among the county's most vulnerable residents, infant mortality is an important indicator of population health. Improving the health and well-being of mothers, infants, and children continues to be a crucial area of focus in public health. Not only does their well-being determine the health of the next generation, but it can also help predict future public health challenges and disparities. Hennepin County has nearly reached the federal Healthy People 2030 target goal to decrease the infant death rate to 5 per 1,000 live births [60].

- According to 2021 Hennepin County death records, 78 babies died before their first birthday. This represents 53 babies per 10,000 born, which is like the national rate (54 per 10,000 births) [61] (Figure 143).
- In the five-year period from 2017-2021, infant mortality showed disparate outcomes by race and ethnicity with a greater infant mortality rate for American Indian or Alaska Native (163 per 10,000 births) and Black or African American (94 per 10,000 births) people compared to Hennepin County overall (48 per 10,000) (HC Vital Statistics Death Records 2017 – 2021).
- The annual death rate of Black or African American people by perinatal condition (1 per 10,000) was three times higher than that of Hennepin County overall (0.3 per 10,000) (HC Vital Statistics Death Records 2017 – 2021).
- As of 2019, the Minnesota maternal mortality rate was 8.9 per 100,000 births, with American Indian or Alaska Native and African American communities having higher rates [62].

Early and adequate prenatal care

Prenatal care helps keep pregnant people and their babies healthy. Receiving regular medical care during pregnancy reduces the risk of pregnancy and birth complications. The earlier prenatal care is started during pregnancy, the lower the risk of birth complications. Prenatal care

starting in the first trimester of pregnancy is ideal; people who do not receive prenatal care until their third trimester, or who do not receive any care prior to delivery, are at risk for birth complications.

- In 2021, 82% of pregnant people in Hennepin County received early and adequate prenatal care (Figure 144). This is near the federal Healthy People 2030 target, which aims for at least 80.5% of pregnant people receiving early and adequate prenatal care.
- American Indian or Alaska Native people who are pregnant were the least likely (48%) to receive early and adequate prenatal care compared to other racial and ethnic groups. Black or African American (67%) and Hispanic (69%) people who are pregnant were the second and third least likely, respectively (Figure 144).

Low birth weight births

Birth weight is an indicator of infant mortality and development. Babies born weighing less than 5.5 pounds are considered low birth weight. Low birth weight is associated with infant mortality, developmental difficulties, and higher rates of non-communicable diseases such as diabetes and hypertension later in life.

- In 2021, 8% of all babies born in Hennepin County were low birthweight (Figure 145). Infants born to Black or African American mothers (132 per 1,000 live births) were at highest risk of being low birthweight in 2021 (Figure 145). The disparity in low birth weight births by race and ethnicity has persisted over the five-year period from 2017-2021 (Figure 146).

Preterm birth

Babies born before 37 weeks of gestation are considered preterm and premature. Preterm babies are at higher risk of developing illness, feeding/digestive problems, intellectual or developmental delays and even death. The federal Healthy People 2030 target aims to reduce preterm births to 9.4% [48].

- In 2021, 10% of all births in Hennepin County were delivered preterm (Figure 147) slightly higher than the federal Healthy People 2030 target.
- Babies born to American Indian or Alaska Native mothers (15%) were most likely to be preterm, followed by babies born to Black or African American (13%) (Figure 147).
- The disparity in preterm births by race and ethnicity has persisted over the five-year period from 2017-2021 (Figure 148).

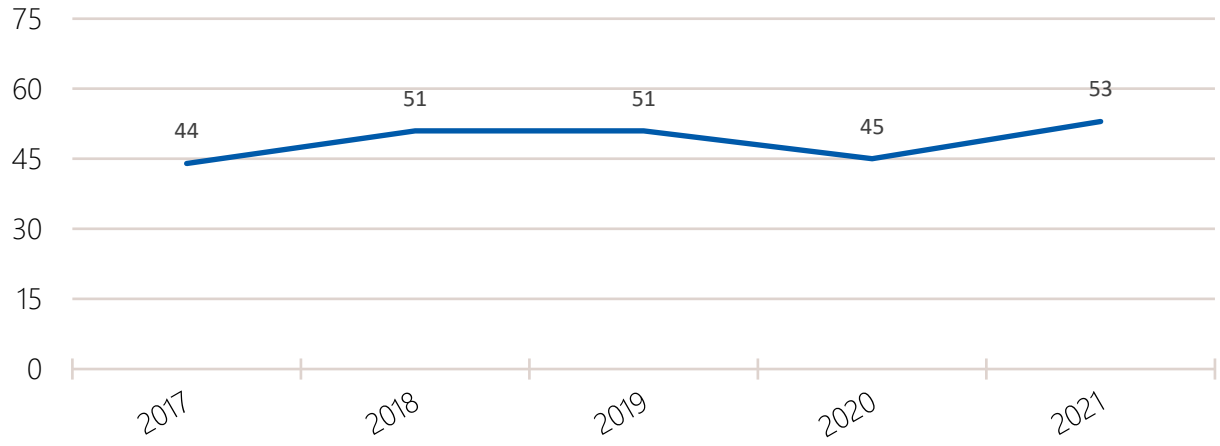
Maternal age

Giving birth or being pregnant during the teen years can result in significant social, health, and economic burden for the parents, their children, and their communities. Children of teenage parents are more likely to become teenage parents themselves, experience health issues,

perform poorly in school, and be incarcerated as an adolescent. The federal Healthy People 2030 goal is to reduce pregnancies in adolescents ages 15-19 to 31.4 per 1,000 [49].

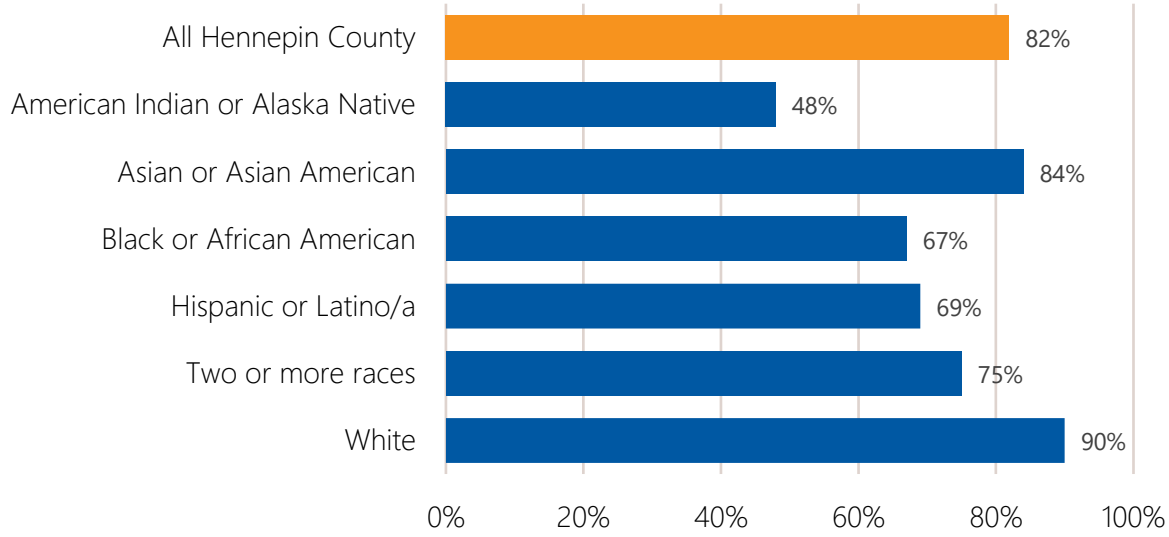
- According to 2021 Hennepin County birth data, there were 322 births, or 2% of all births (14,655 births) in Hennepin County were to mothers ages 15 to 19.
- The teen birth rate was 8 per 1,000 (Figure 149).
- Disparities remain in the rates of teen births for some racial and ethnic groups, especially American Indian or Alaska Native, Black or African American, and Hispanic or Latino/a mothers (Figure 150).

Figure 143: Infant mortality annual deaths per 10,000 births from all causes, 2017-2021



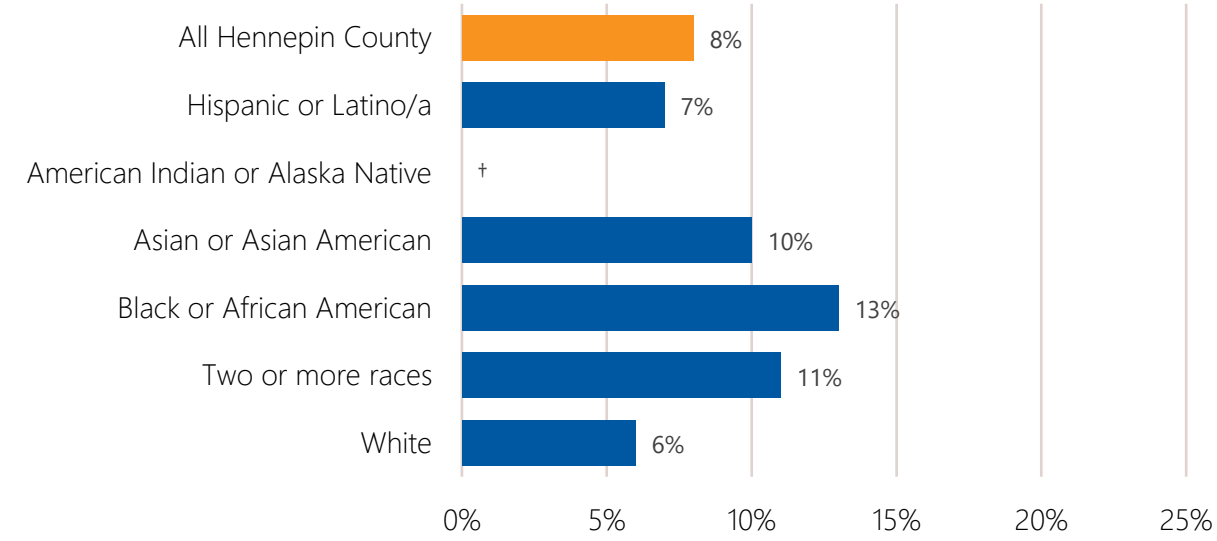
Source: Minnesota Vital Statistics, Hennepin County death records

Figure 144: Percent of mothers who received early (first trimester) prenatal care by mother's demographics, 2021



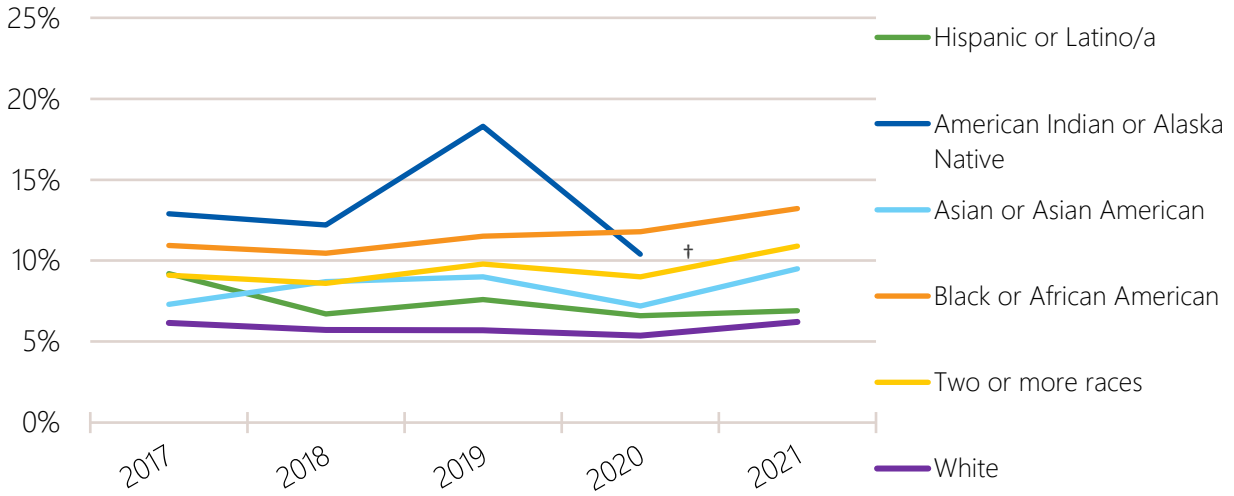
Source: Minnesota Vital Statistics, Hennepin County birth records

Figure 145: Percent of low weight births by mother's race or ethnicity, 2021



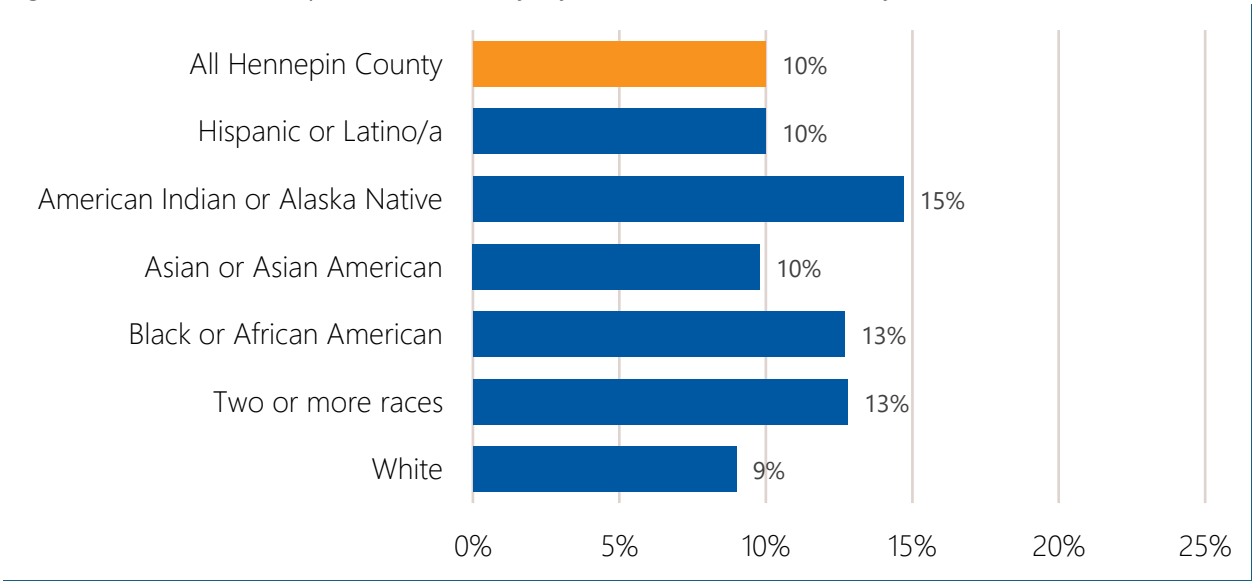
Source: Minnesota Vital Statistics, Hennepin County birth records
† Indicates that a data count is below a suppression threshold and has been suppressed.

Figure 146: Percent of low weight births by mother's race or ethnicity, 2017-2021



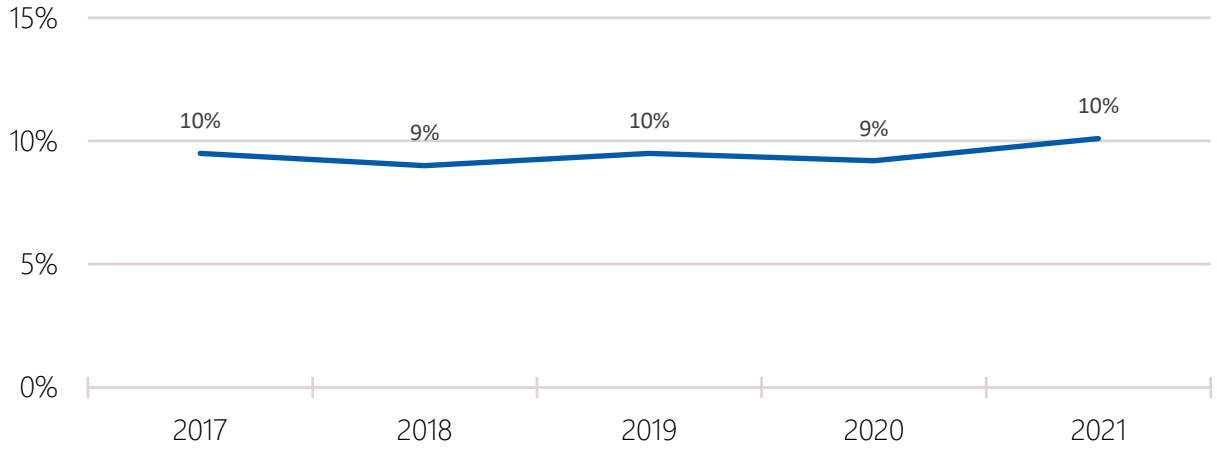
Source: Minnesota Vital Statistics, Hennepin County birth records
† Indicates that a data count is below a suppression threshold and has been suppressed.

Figure 147: Percent of preterm delivery by mother's race/ethnicity, 2021



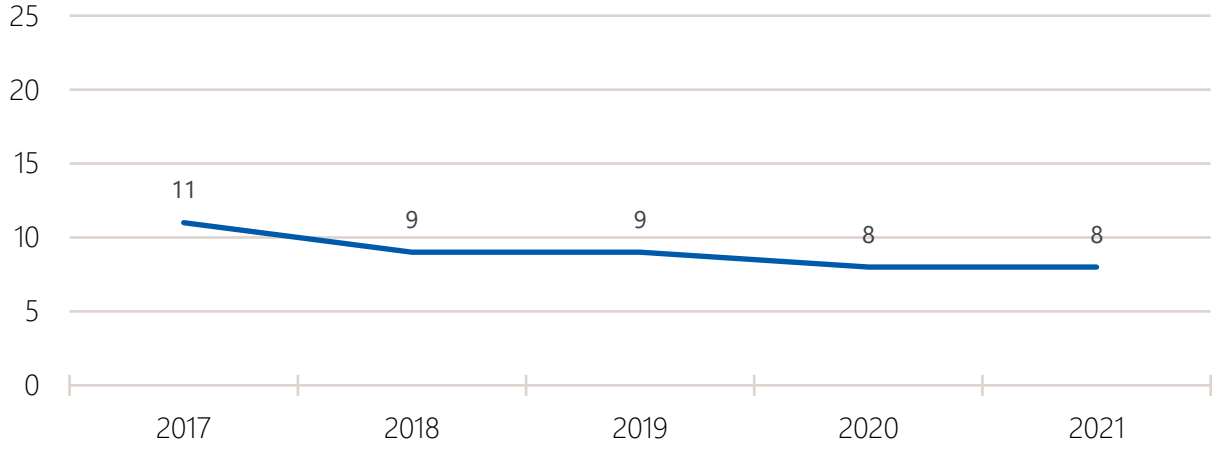
Source: Minnesota Vital Statistics, Hennepin County birth records

Figure 148: Percent preterm delivery in Hennepin County, 2017-2021



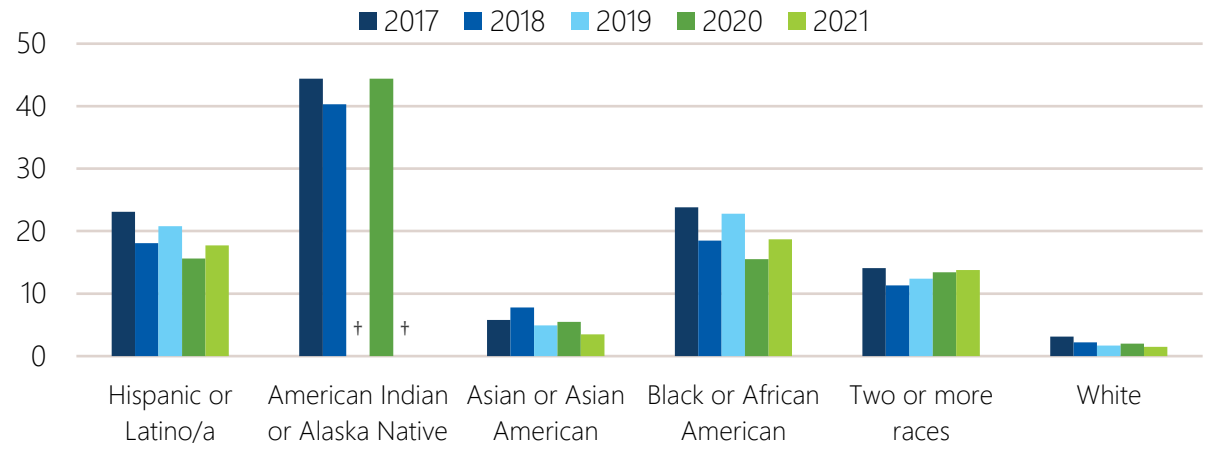
Source: Minnesota Vital Statistics, Hennepin County birth records

Figure 149: Birthrate (per 1,000) for mothers 15-19 years, 2017-2021



Source: Minnesota Vital Statistics, Hennepin County birth records

Figure 150: Birthrate (per 1,000) for mothers 15-19 years by race/ethnicity, 2017-2021

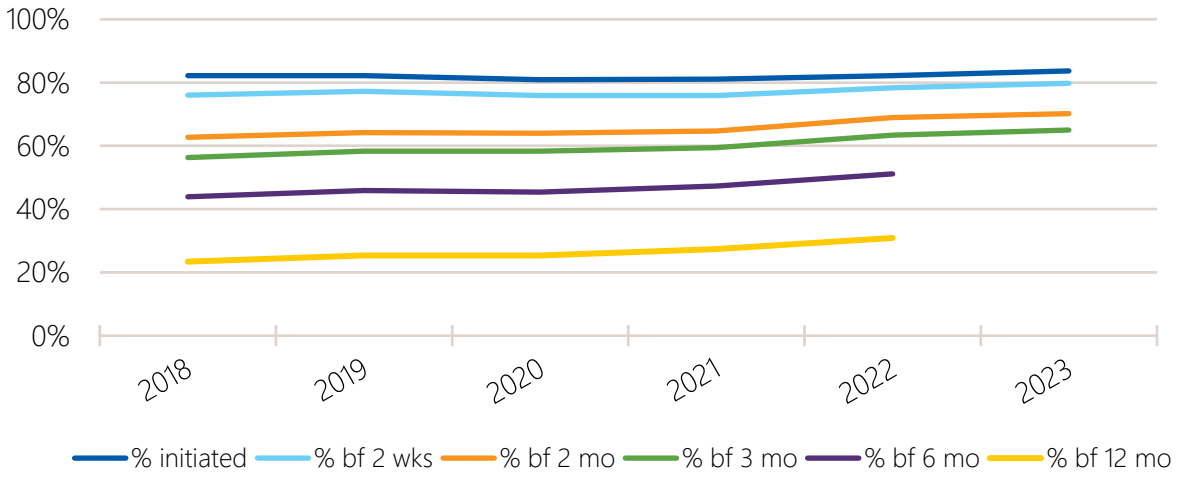


Source: Minnesota Vital Statistics, Hennepin County birth records
† Indicates that a data count is below a suppression threshold and has been suppressed.

Breastfeeding initiation

Breastfeeding or chest feeding is the best source of nutrition for most infants. The American Academy of Pediatrics recommends breastfeeding for the first 6 months of infancy. Both infants and the birthing parent can benefit from breastfeeding. Infants who are breastfed have reduced risks of asthma, obesity, type 2 diabetes, ear infections, and other conditions. Parents who breastfeed are at lower risk for high blood pressure, type 2 diabetes, ovarian cancer, and breast cancer. The Hennepin County Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides breastfeeding and chest feeding support to new and expectant parents and tracks breast feeding initiation and duration (Figure 151).

Figure 151: Percent of WIC participants breast feeding, 2018-2023



Source: Minnesota WIC; bf is breast feeding

Vaccination

Vaccines help keep children healthy. Preventable disease outbreaks can happen when children in the community do not receive the recommended vaccines. A higher rate of vaccine coverage indicates a greater level of community protection.

By 2 years of age, all children are recommended to have received the complete vaccine series, known as the "431331 series."

- 4 doses of diphtheria-tetanus-pertussis (DTaP)
- 3 doses of polio
- 1 dose of measles-mumps-rubella (MMR)
- 3 doses of Hepatitis B
- 3 doses of Haemophilus Influenza, type B (Hib)
- 1 dose of Varicella vaccine

Since 2019, the coverage rate for children ages 24-35 months with a completed the "431331 series" has declined (Tables 1 and 2). In 2023, only 59% of children completed the series, the lowest rate in the previous five-year period (Table 1). Hennepin County's coverage rate has remained slightly lower than Minnesota overall (Figure 152). As mentioned earlier in the report, immunization rates have declined, possibly due to the COVID-19 pandemic and its aftereffects.

Table 1: Percent of children, ages 24-35 months, that completed the "431331 series" 2016-2023

Complete "431331" series	HC%	MN%
2019	68%	69%
2020	68%	70%
2021	62%	63%
2022	60%	63%
2023	59%	63%

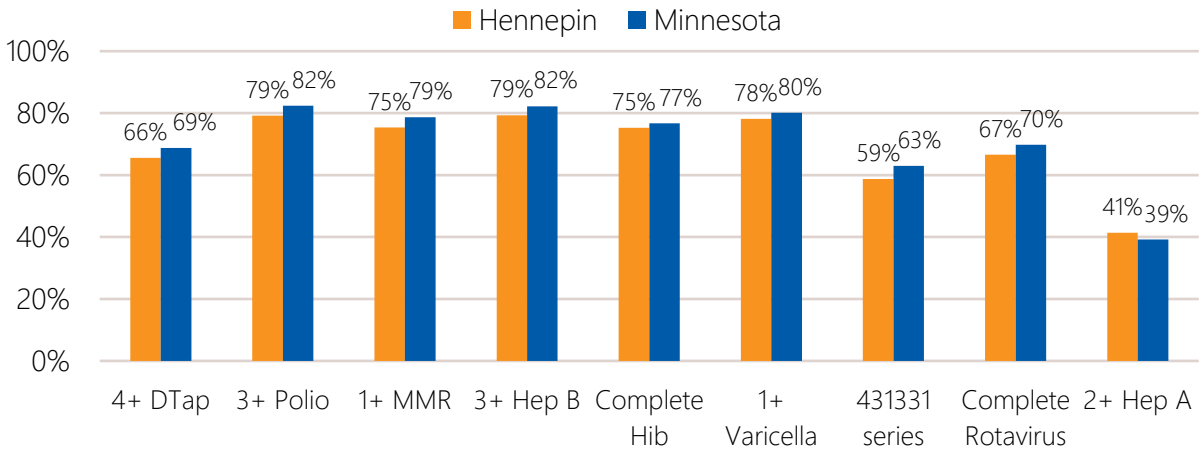
Source: MIIC (Minnesota Public Health Data Access queries)

Table 2: Percent of vaccination coverage among 24-35 month-olds in Hennepin County, 2019-2023

Vaccine	2019	2020	2021	2022	2023
4+ Dtap	74%	74%	70%	68%	66%
3+ Polio	86%	86%	84%	82%	79%
1+ MMR	82%	82%	78%	76%	75%
3+ Hep B	86%	85%	84%	83%	79%
Complete Hib	82%	82%	78%	77%	75%
1+ Varicella	86%	85%	80%	80%	78%
431331 series	68%	68%	62%	60%	59%
Complete rotavirus	74%	76%	76%	71%	67%
2+ Hep A	48%	47%	44%	44%	41%

Source: MIIC (Minnesota Public Health Data Access queries

Figure 152: Percent of vaccination coverage among 24-35 month-olds in Minnesota and Hennepin County, 2023



Source: Minnesota Immunization Information Connection (MIIC)

Injury and mortality

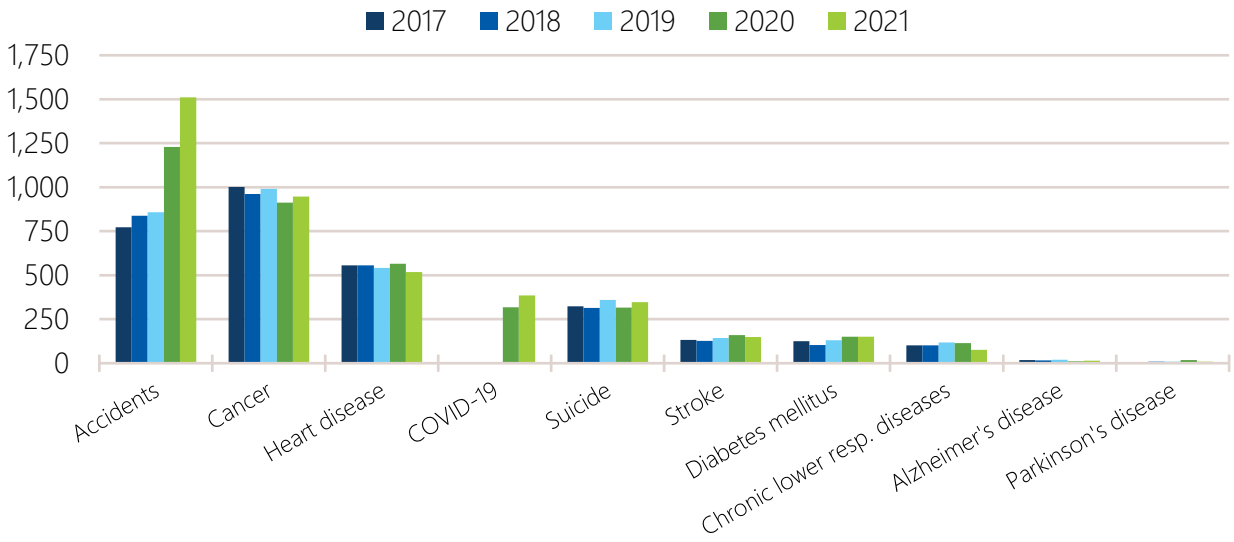
A notable indicator is Years of Potential Life Lost (YPLL), which is an estimate of how many years of life a person would have lived if they hadn't died prematurely, an average of which can be calculated for a population. YPLL by cause of death can indicate health issues to prioritize and address preventable premature deaths. YPLL can also be a good summary indicator to visualize inequities in overall health and length of life.

- YPLL shows racial and ethnic disparities in Hennepin County, with American Indian (352 per 1,000) and Black or African American (127 per 1,000) communities experiencing more

YPLL compared to other racial and ethnic groups (Vital Statistics, Death summary dashboard, 2017 – 2021).

- In 2020 and 2021, accidents became the source of the highest YPLL. Accidents are injuries that were not deliberately intended. Accidents include unintentional overdoses, contributing to this increase in YPLL (Figure 153).

Figure 153: Years of potential life lost (YPLL) by leading causes of death rates per 100,000 population, 2017-2021



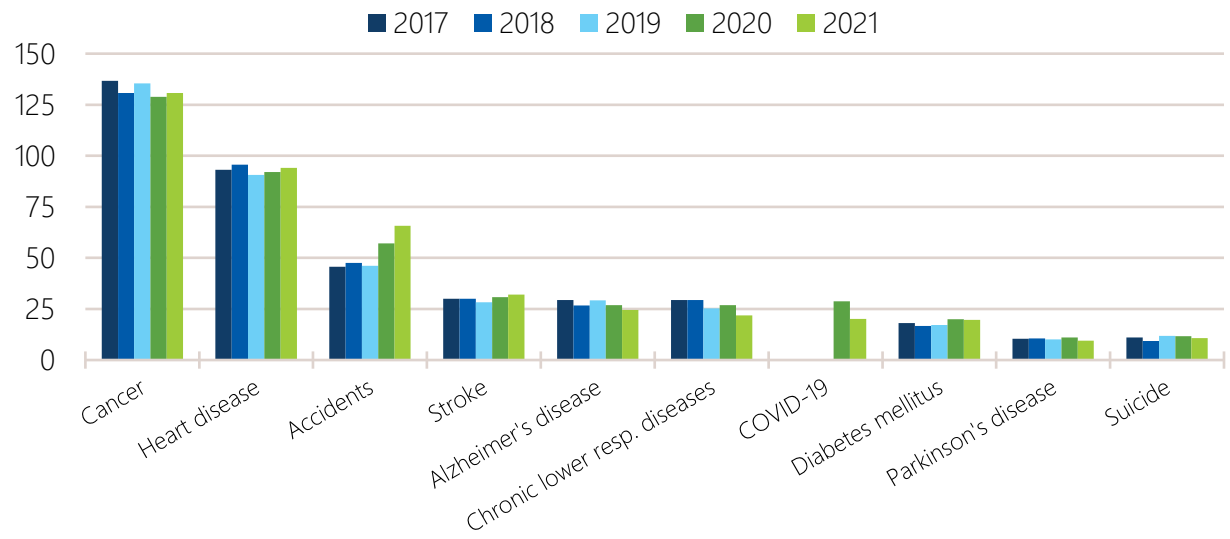
Source: Minnesota Vital Statistics, Hennepin County death records

Chronic disease deaths

Chronic diseases are the leading cause of illness, disability, and death in America. Most chronic diseases are related to a short list of risk factors: smoking, poor nutrition, physical inactivity, and excessive alcohol use. When chronic conditions are not adequately managed or controlled, it is more likely that people with those conditions will develop serious health issues that lead to death. Throughout the United States, chronic diseases are the leading causes of death and disability. The burden of chronic disease is experienced disproportionately by race, ethnicity, income, and education.

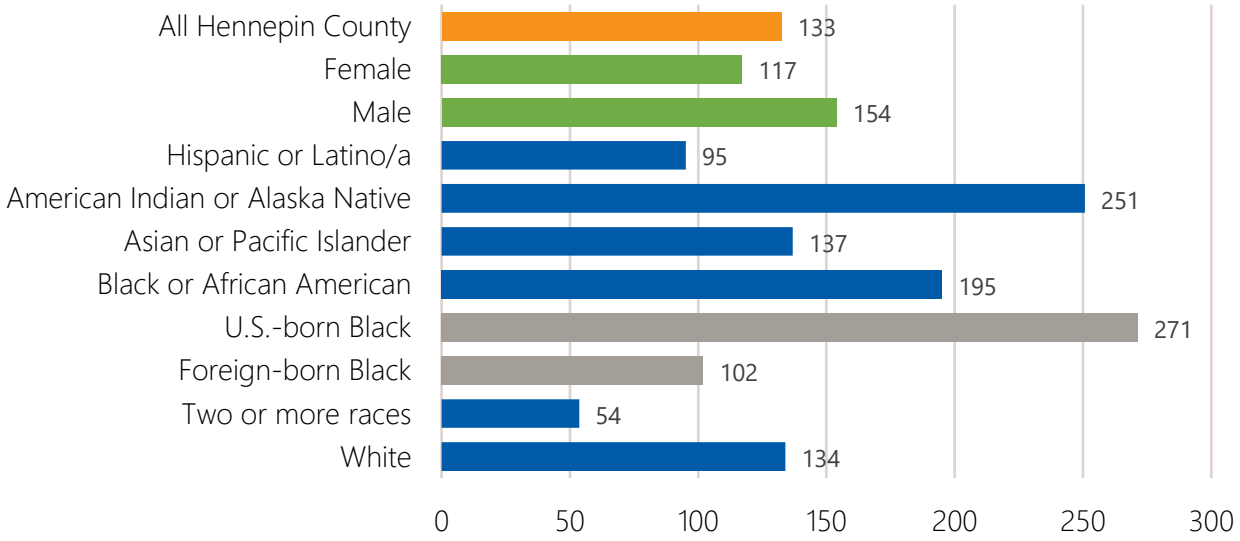
Cancer has remained the leading cause of death in Hennepin County since 2000, followed by heart diseases and accidents (Figure 154). The leading causes of death are similar across racial and ethnic groups, though the overall burden is disproportionate (Minnesota Vital Statistics death records) (Figures 155 and 156). The federal Healthy People 2030 has set objectives to lower the overall cancer death rate to 122.7 per 100,000, coronary heart disease deaths to 71.1 per 100,000 and stroke deaths to 33.4 per 100,000 population [50, 51] .

Figure 154: Leading causes of death rates per 100,000 population, 2017-2021 (age-adjusted)



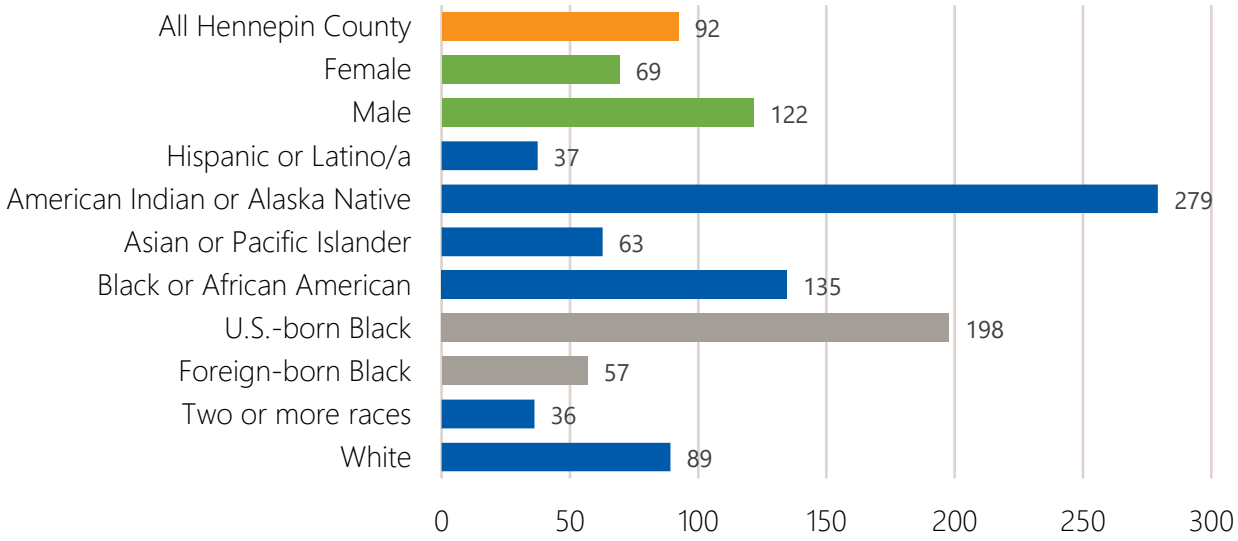
Source: Minnesota Vital Statistics, Hennepin County death records

Figure 155: Cancer death rate per 100,000 population by gender and race/ethnicity, 2017-2021 (5-year average, age-adjusted)



Source: Minnesota Vital Statistics, Hennepin County death records

Figure 156: Heart disease death rate per 100,000 population by gender and race/ethnicity, 2017-2021 (5-year average, age-adjusted)

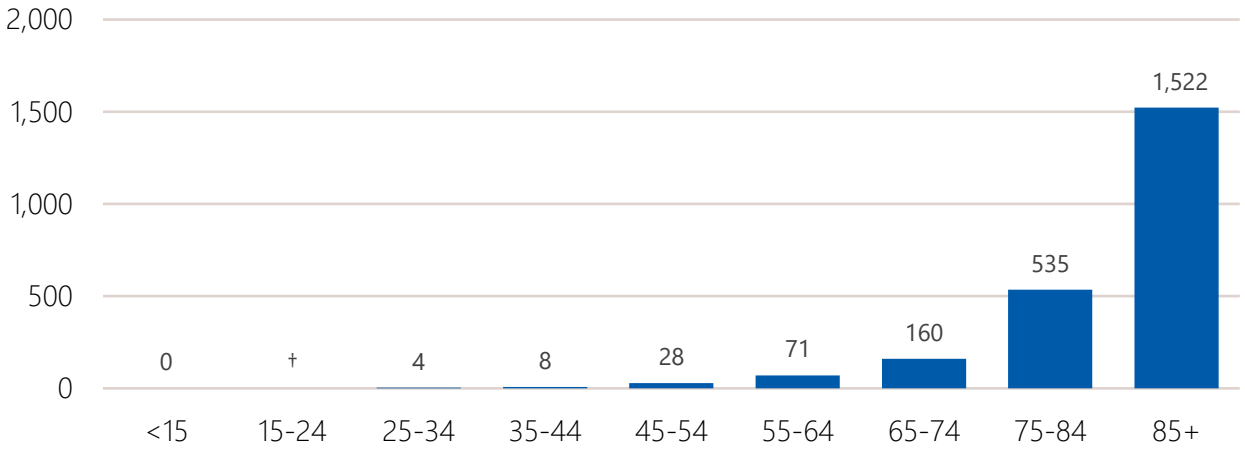


Source: Minnesota Vital Statistics, Hennepin County death records

COVID-19 deaths

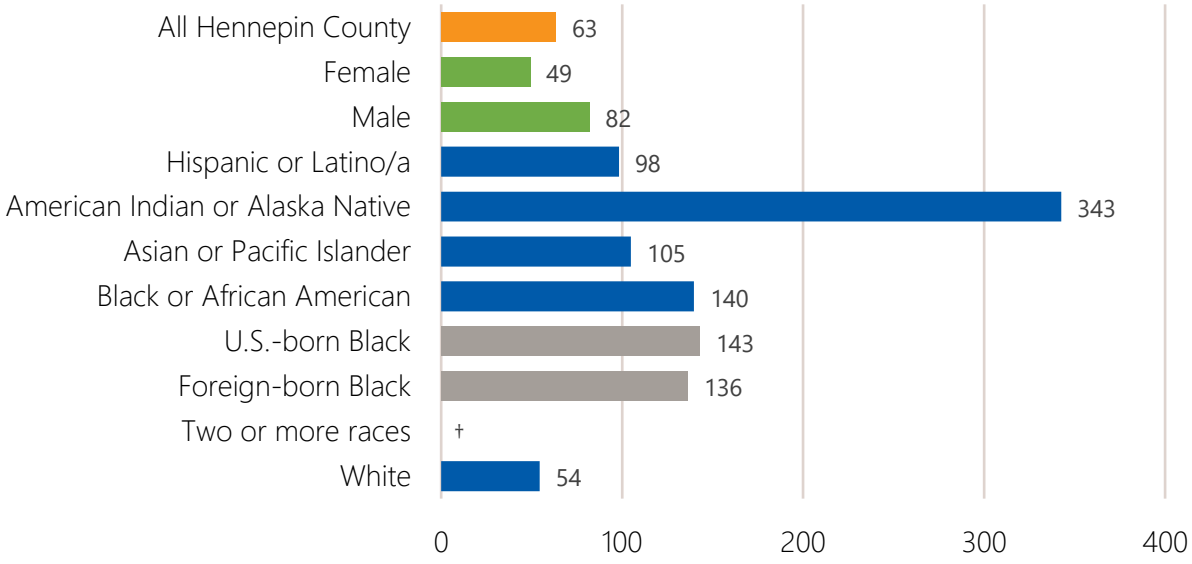
COVID-19 is a disease caused by a coronavirus that passes easily from one person to another. COVID-19 affects a person's nose and throat and can sometimes affect a person's lungs and can make it hard to breathe normally. Some people can get very sick and die, while most have mild or moderate symptoms and get better without going to a clinic or into a hospital. Older adults and people of any age who have certain medical conditions, such as diabetes or asthma, might be at higher risk of getting severely sick or dying from COVID-19 (Figure 157). From 2020-2021 the overall death rate for Hennepin County was 63 per 100,000 (age-adjusted), but it varied greatly by race and ethnicity (Figure 158).

Figure 157: COVID-19 death rate per 100,000 population by age, 2020-2021 (2-year average, age-specific rates)



Source: Minnesota Vital Statistics, Hennepin County death records
† Indicates that a data count is below a suppression threshold and has been suppressed.

Figure 158: COVID-19 death rate per 100,000 population by race/ethnicity and gender, 2020-2021 (2-year average, age-adjusted)



Source: Minnesota Vital Statistics, Hennepin County death records
† Indicates that a data count is below a suppression threshold and has been suppressed.

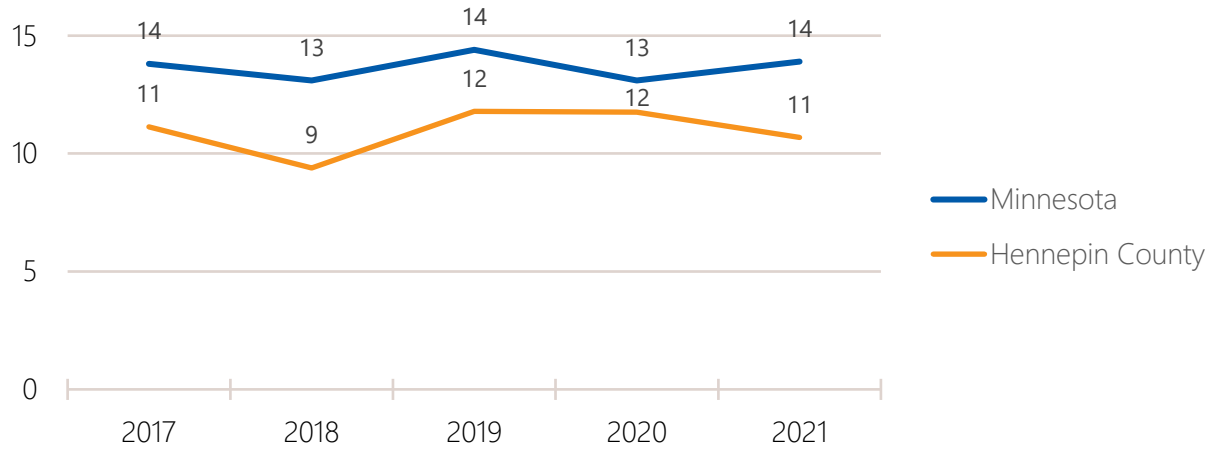
Suicide deaths

As of 2021, suicide was one of the leading causes of death for adults in Hennepin County (using age-adjusted data). A suicide attempt is when a person harms themselves with the intent to end

their life, but they do not die because of their actions. Many more people survive than die from suicide attempts, but they often have serious injuries. Suicide attempts do not always result in a physical injury. The federal Healthy People 2030 objectives include reducing the suicide rate to 12.9 per 100,000 [52].

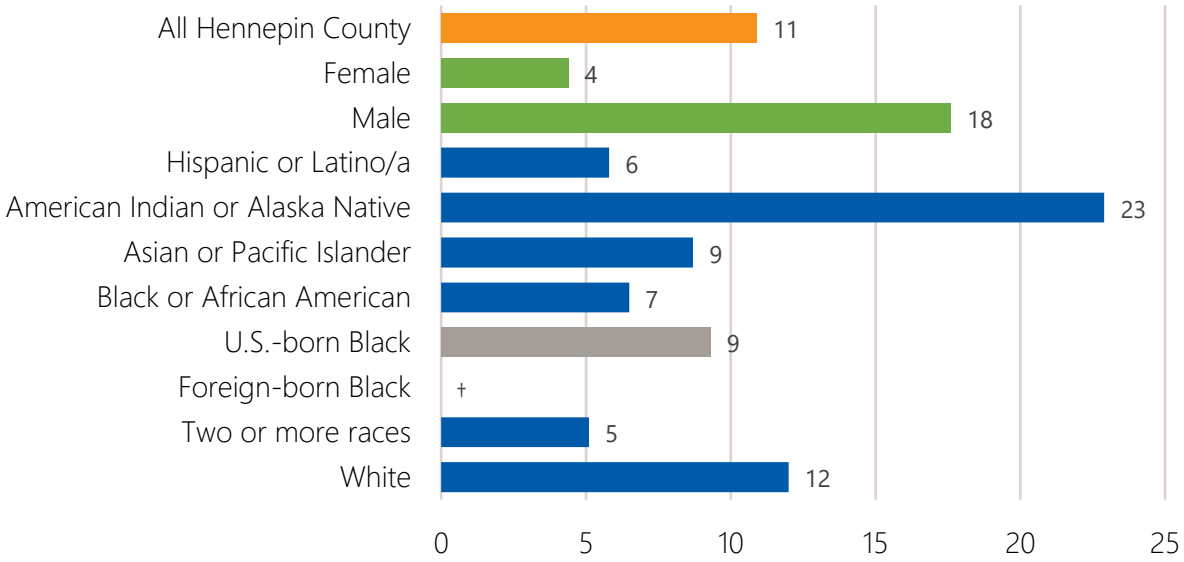
- From 2017 to 2021, the suicide rate in Hennepin County fluctuated between 9 to 12 deaths per 100,000 population (Figure 159).
- The age-adjusted suicide rate in Hennepin County was lower than overall Minnesota (Figure 159).
- Suicide rates were higher for males compared to females. Females tend to consider and attempt suicide at higher rates than males, but males are more likely to die by suicide (Minnesota Vital Statistics death records) (Figure 160).

Figure 159: Suicide death rate (per 100,000) in Hennepin County and Minnesota, 2017-2021 (age-adjusted)



Source: Minnesota Vital Statistics, Hennepin County and Minnesota death records

Figure 160: Suicide death rate per 100,000 population by race/ethnicity and gender, 2017-2021 (5-year average, age-adjusted)



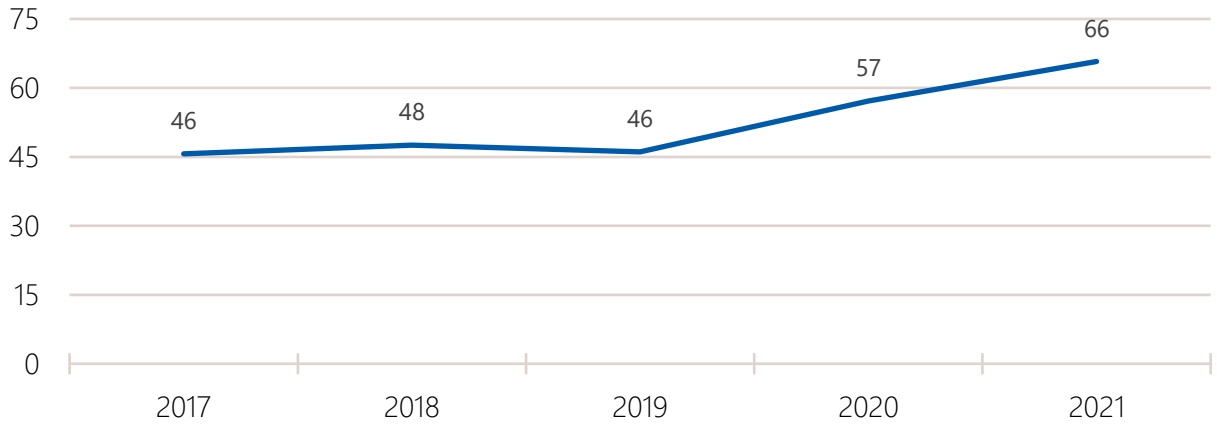
Source: Minnesota Vital Statistics, Hennepin County death records
† Indicates that a data count is below a suppression threshold and has been suppressed.

Unintentional injuries and deaths

Unintentional injury or accidents are a leading cause of death nationwide. In Hennepin County, unintentional injuries are continuing to increase (Figure 161). The federal Healthy People 2030 has set an objective to reduce unintentional injury deaths to 43.2 per 100,000 population [53].

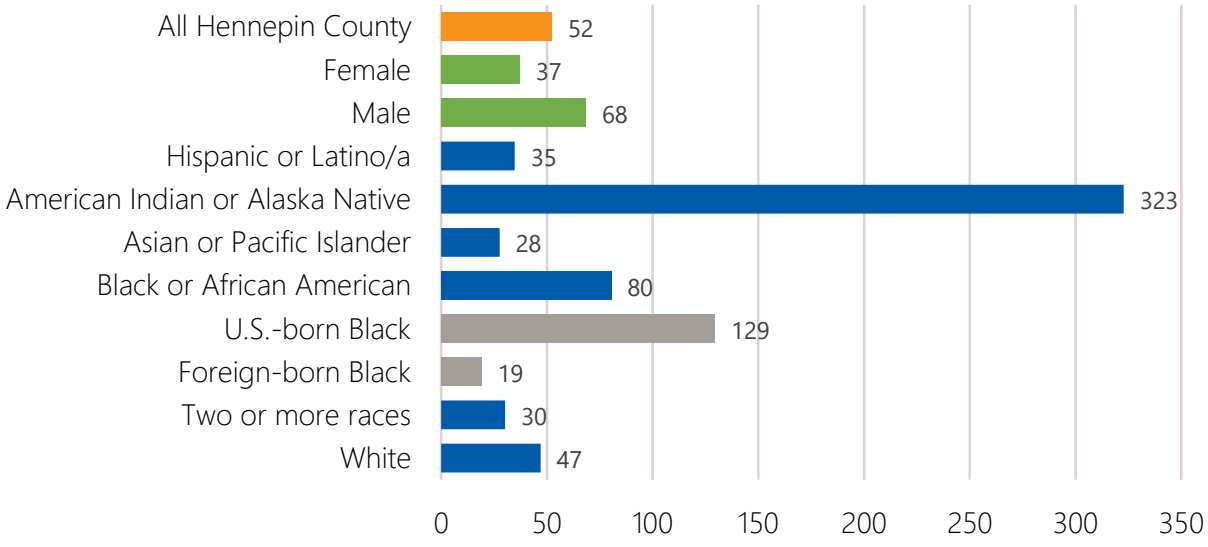
- American Indian or Alaska Native and U.S.-born Black residents died from unintentional injuries at a disproportionately high rate compared to residents from other racial and ethnic groups (Figure 162).
- Males and those who are White account for the larger numbers of accidental (unintentional injury) from 2017-2021 (annual average) (Figure 163).
- The increase was largely driven by drug-related poisoning (overdoses). Poisonings disproportionately affected young and middle-aged adults, American Indian or Alaska Native and Black or African American communities. Falls affected a higher proportion of older adults (Figure 164).

Figure 161: Accident (unintentional injury) death rate per 100,000 in Hennepin County, 2017-2021 (age-adjusted)



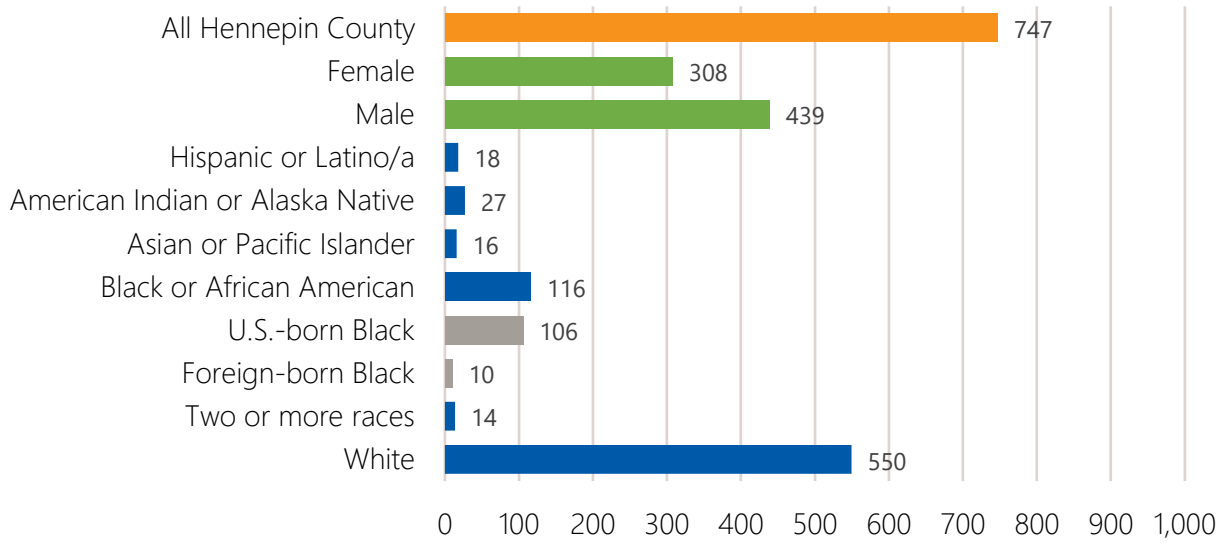
Source: Minnesota Vital Statistics, Hennepin County death records

Figure 162: Accident (unintentional injury) death rate per 100,000 population by gender and race/ethnicity, 2017-2021, (5-year average, age-adjusted)



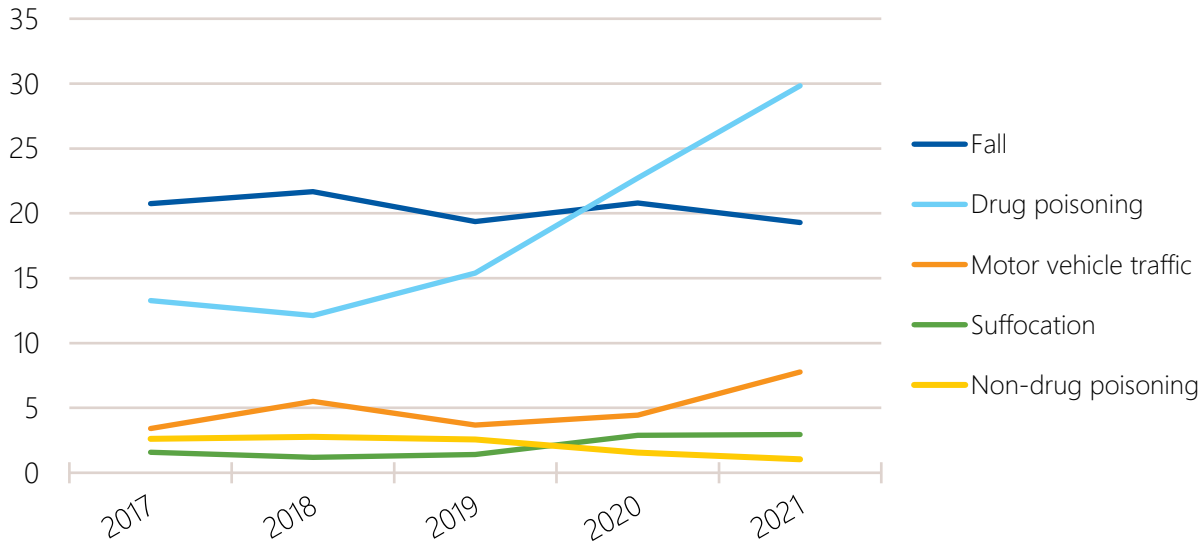
Source: Minnesota Vital Statistics, Hennepin County death records

Figure 163: Number of accidental (unintentional injury) deaths by gender and race/ethnicity, 2017-2021, (annual average)



Source: Minnesota Vital Statistics, Hennepin County death records

Figure 164: Accident (unintentional injury) death rate by type (per 100,000) in Hennepin County, 2017-2021 (age-adjusted)



Source: Minnesota Vital Statistics, Hennepin County death records

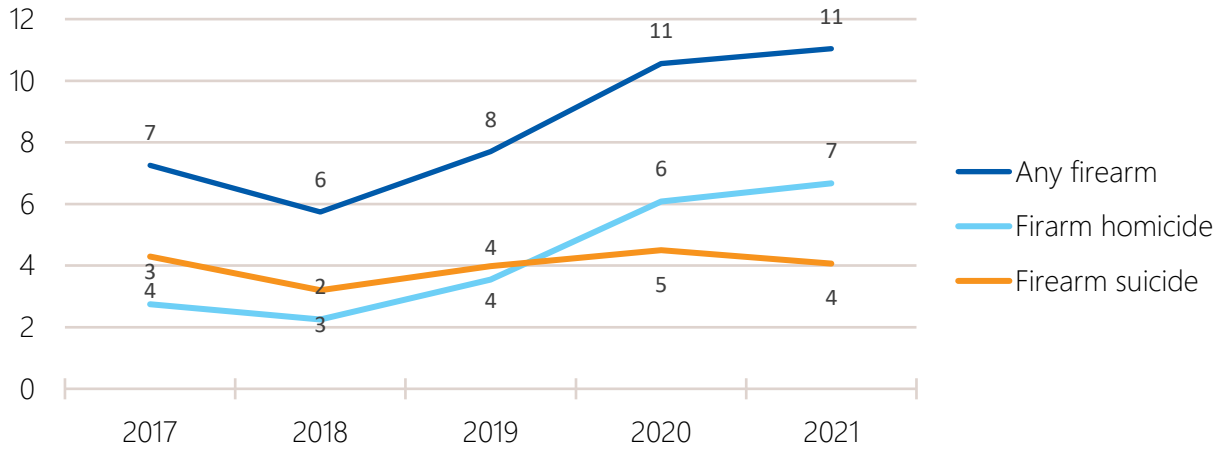
Violent deaths

Violent deaths resulting from intentional use of physical force are often directly associated with firearms [54, 55]. Nationally, deaths due to firearms increased by approximately 25% from 2015 to 2020 (CDC Wonder). Gun violence affects more than just victims and their families, friends,

and coworkers: It affects communities, through impacting residents' perception of safety and security and feelings of stress and anxiety. The federal Healthy People 2030 has set an objective to reduce firearm-related deaths to 10.7 per 100,000 population [56].

- The overall gun death rate in Minnesota increased by 26% from 2013 to 2022 [55].
- Since 2017, firearm homicides have increased while firearm suicides have remained stable. In 2021, 58% of firearm deaths in Hennepin County were homicides (Figure 165).
- In Hennepin County, most of all homicide deaths in 2021 involved a firearm (Figures 166 and 167).
- Firearm homicides disproportionately impact U.S.-born Black or African American (30 per 100,000) residents compared to the county average (7 per 100,000 residents, all age-adjusted rates, Minnesota Vital Statistics, Hennepin County death records).

Figure 165: Firearm death rate (per 100,000) in Hennepin County, 2017-2021 (age-adjusted)



Source: Minnesota Vital Statistics, Hennepin County death records

Figure 166: Suicide and homicide death rates (per 100,000) and firearm involvement in Hennepin County, 2017-2021 (age-adjusted)

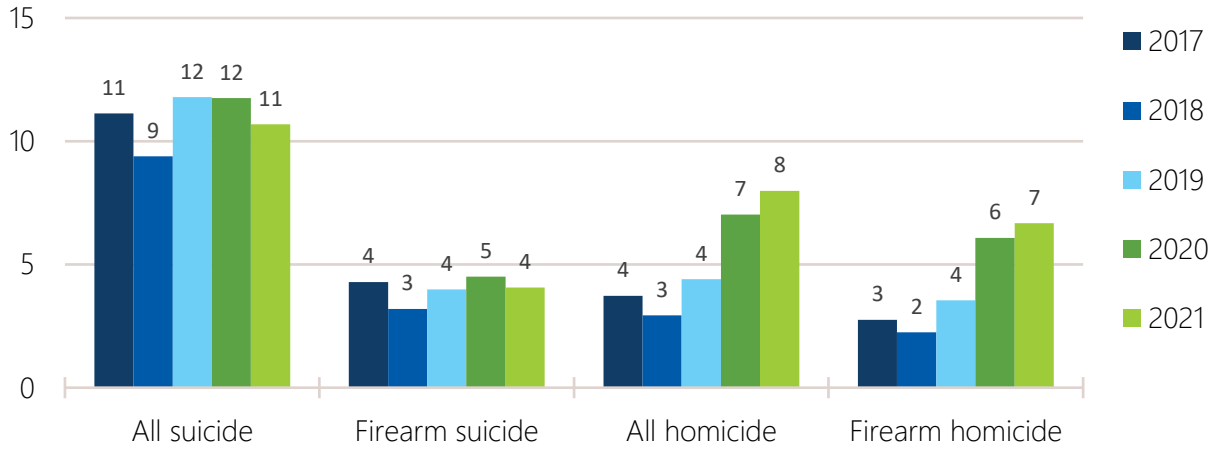
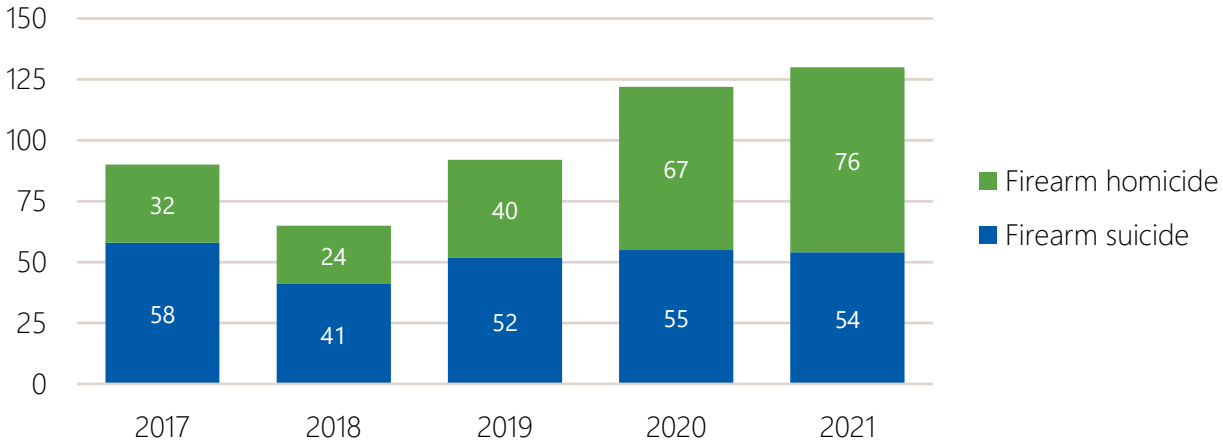


Figure 167: Firearm deaths (number) by type in Hennepin County, 2017-2021



Source: Minnesota Vital Statistics, Hennepin County death records

Appendices

A. County description and demographics

Hennepin County description and population trends

Hennepin County is in the western portion of the Twin Cities metropolitan area and shares borders with Anoka, Carver, Dakota, Ramsey, Scott, and Wright counties. Hennepin County is the most populated county in Minnesota. According to the American Community Survey for the years 2018-2022, Hennepin County had the following demographic characteristics:

- About 1.3 million people resided in the county, which was 22% of Minnesota's total population
- There were 529,029 households in the county with an average household size of 2.4 people. The census defines a household as all people that share a living unit, regardless of their relationships to each other.
- There were 299,267 families living in the county with an average family size of 3.1.
- Just over one-fourth of households included children under 18 years (27%).
- The county fertility rate was 52 per 1,000 women.
- 21% of residents were under the age of 18 and 15% were ages 65 or older.

The Hennepin County population increased over the 10 years from 1,210,720 in 2014 to 1,297,847 in 2023. Projections show Hennepin County will maintain its rank as the most populous county in Minnesota, but with a 5% decrease in the county's population by 2055 (Minnesota State Demographic Center).

Hennepin County demographics are predicted to change in the next 30 years. Racial and ethnic populations other than White and those that are two or more races are expected to make up a greater portion of the county's population (34% in 2025 to 41% by 2055). The aging population in Hennepin County is expected to grow significantly. Projections for 2055 show a 13% increase of the population 65-years and older and a 81% increase of population 85-years and older.

Race and ethnicity

Hennepin County is the most racially diverse county in Minnesota and has large populations of refugee, immigrant, and migrant people. The county's population by federal race and ethnicity grouping from 2018 to 2022 were 0.4% American Indian or Alaska Native or Alaskan Native, 7% Hispanic or Latino/a (of any race), 7% Asian alone, and 13% Black or African American alone, 67% White alone, and 5% two or more races (non-Hispanic or Latino/a) (Table A1). In addition, estimates show 8,500 people of Arab origin or ancestry, 73,853 people of Sub-Saharan African origin or ancestry, and 3,833 people of West Indian origin or ancestry lived in Hennepin County (ACS 5 YR, 2018-2022). The Minnesota State Demographic Center projections show the county's racial diversity continuing to increase over time (Table A2).

Table A1: Hennepin County demographic estimates 2018-2022

	Count	Percent
Hispanic	89,878	7%
Not Hispanic		
American Indian or Alaskan Native	5,687	0.4%
Asian alone	90,086	7%
Black or African American alone	167,289	13%
Native Hawaiian or Pacific Islander alone	262	0%
Some other race alone	8,485	0.7%
Two or more races	58,925	5%
White alone	850,175	67%

Source: American Community Survey 5-year estimates

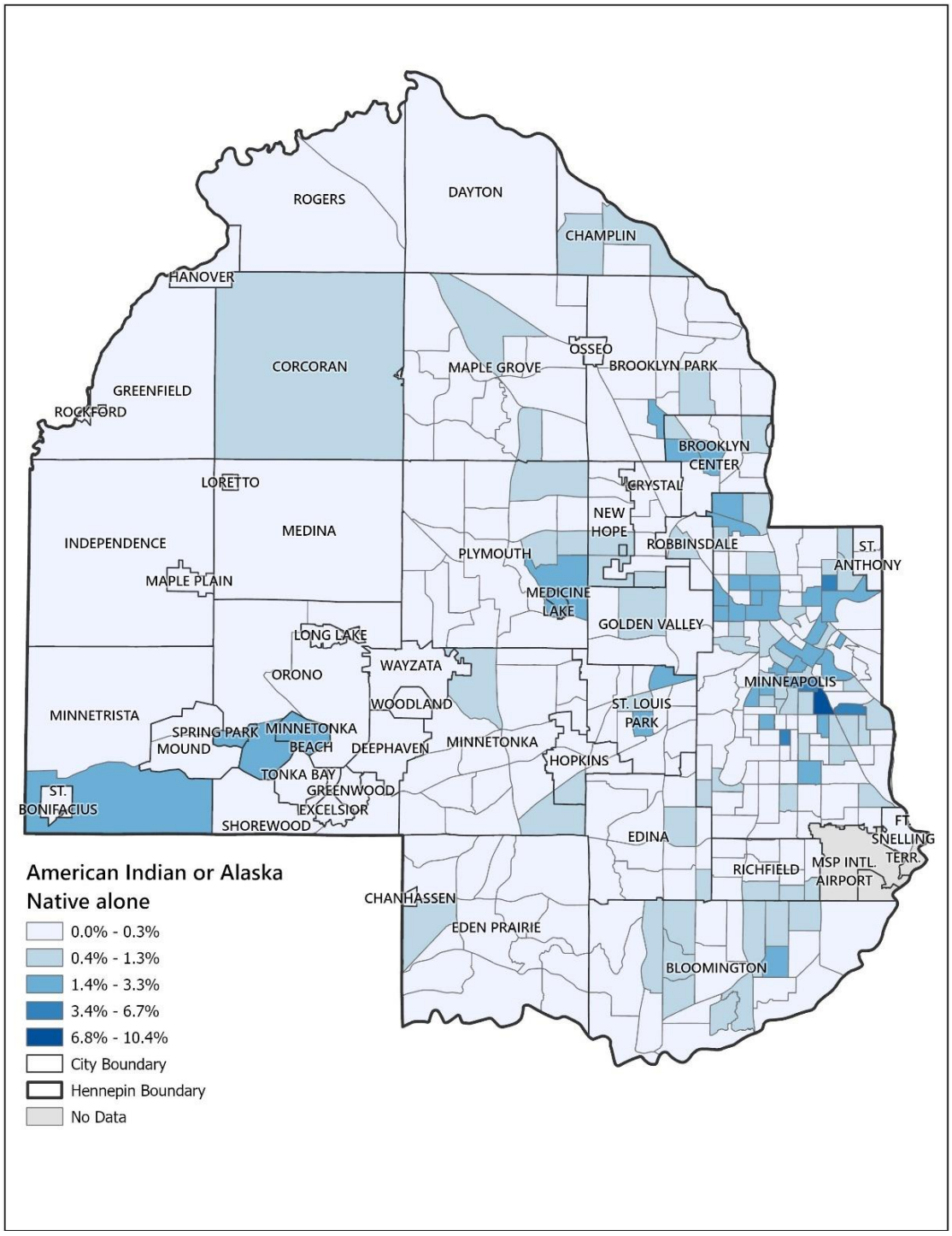
Table A2: The projected population numbers for Hennepin County from 2025 to 2055 vary by race and ethnicity.

	2025	2055
Hispanic	92,067	95,751
Not Hispanic		
American Indian or Alaskan Native	7,796	4,889
Asian	103,005	12,2161
Black or African American	187,721	224,629
Native Hawaiian or Pacific Islander	472	463
Two or more races	40,703	48,660
White	839,873	709,199

Source: Minnesota Demographers Office

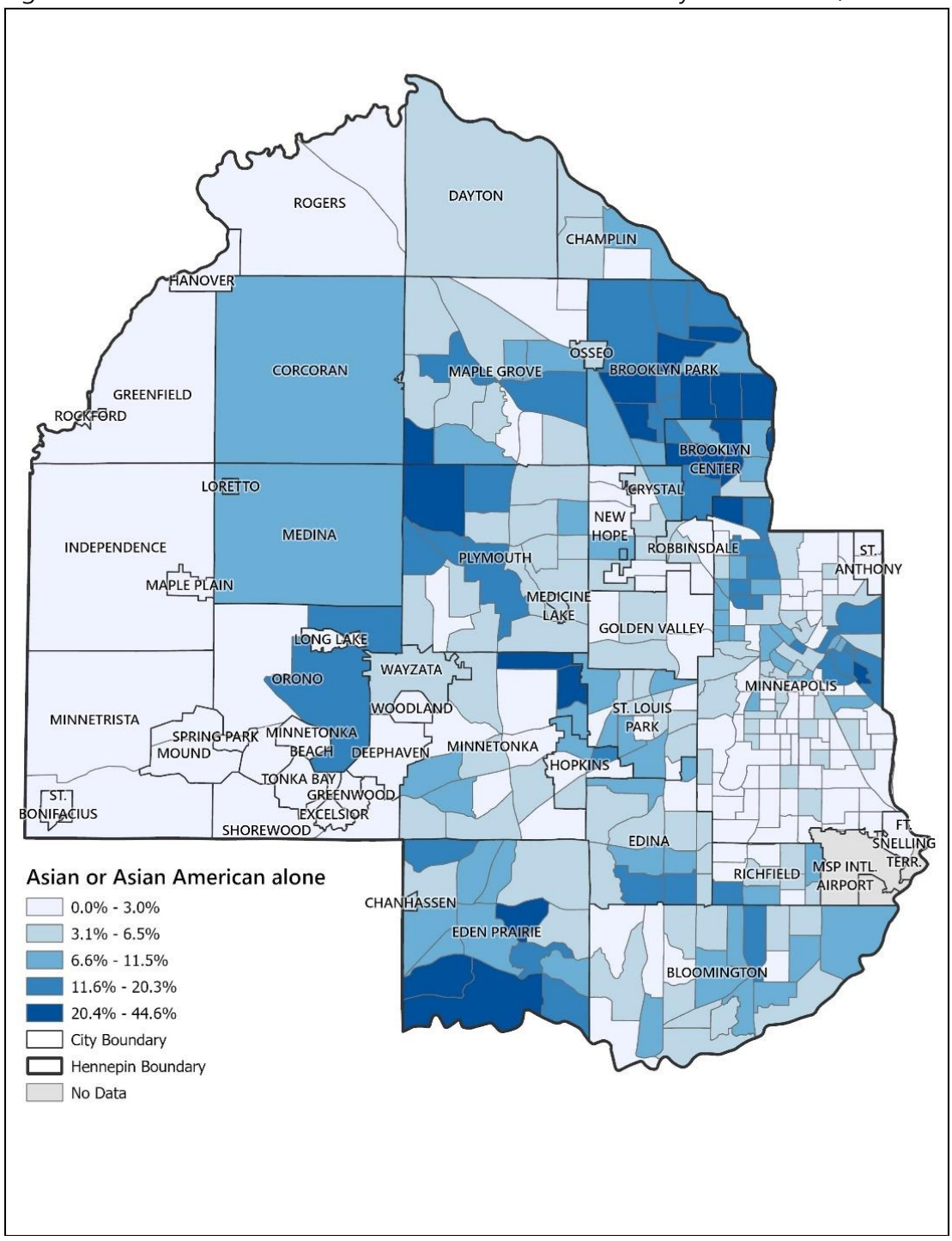
Racially and ethnically diverse populations are concentrated in portions of Minneapolis and a few inner ring suburbs, including Brooklyn Center, Saint Louis Park, and Richfield. Figures A1 through A7 show the geographic distribution of racial and ethnic groups across the county.

Figure A1: Percent of American Indian or Alaska Native residents by census tract, 2018-2022



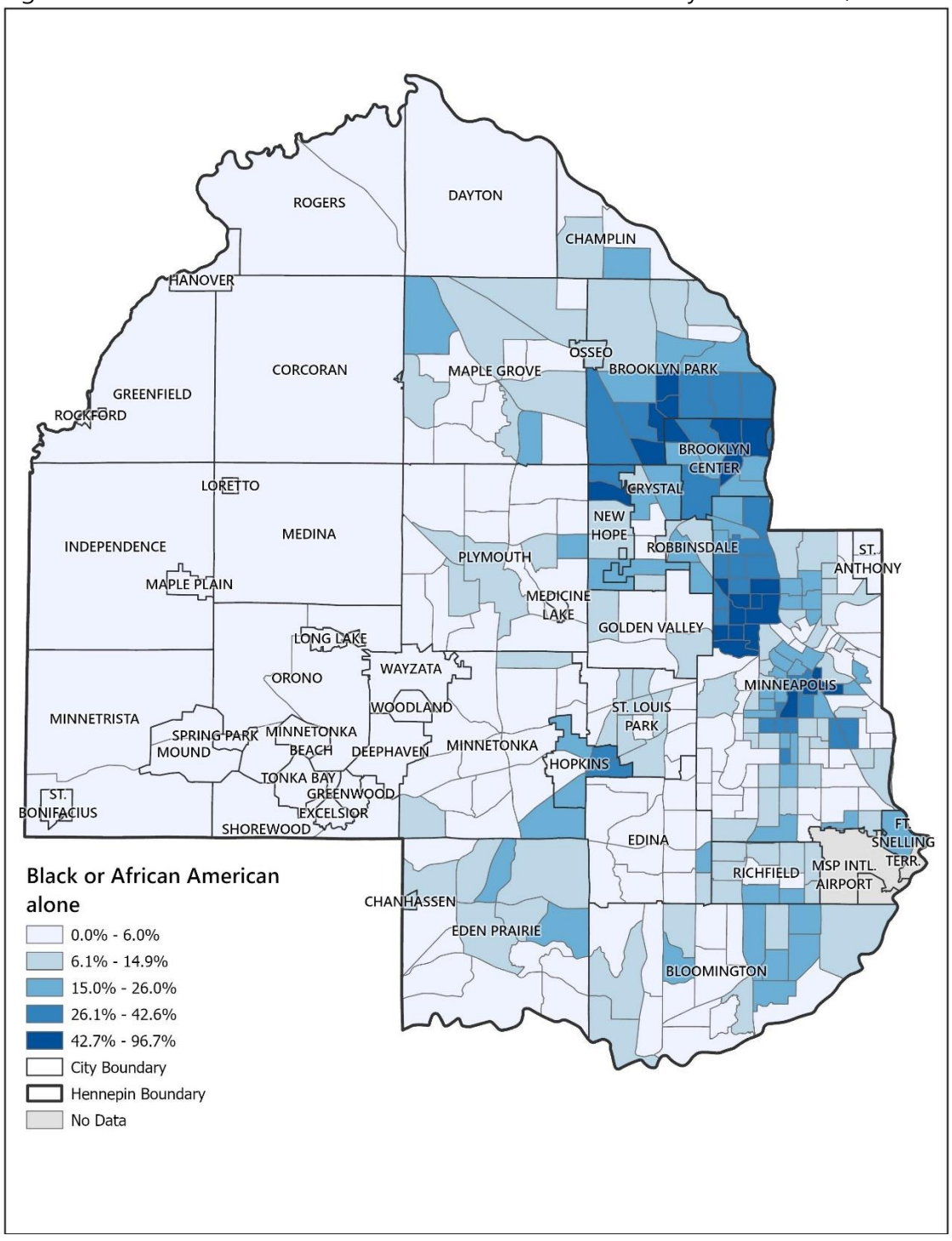
Source: American Community Survey 5-year estimates

Figure A2: Percent of Asian or Asian American residents by census tract, 2018-2022



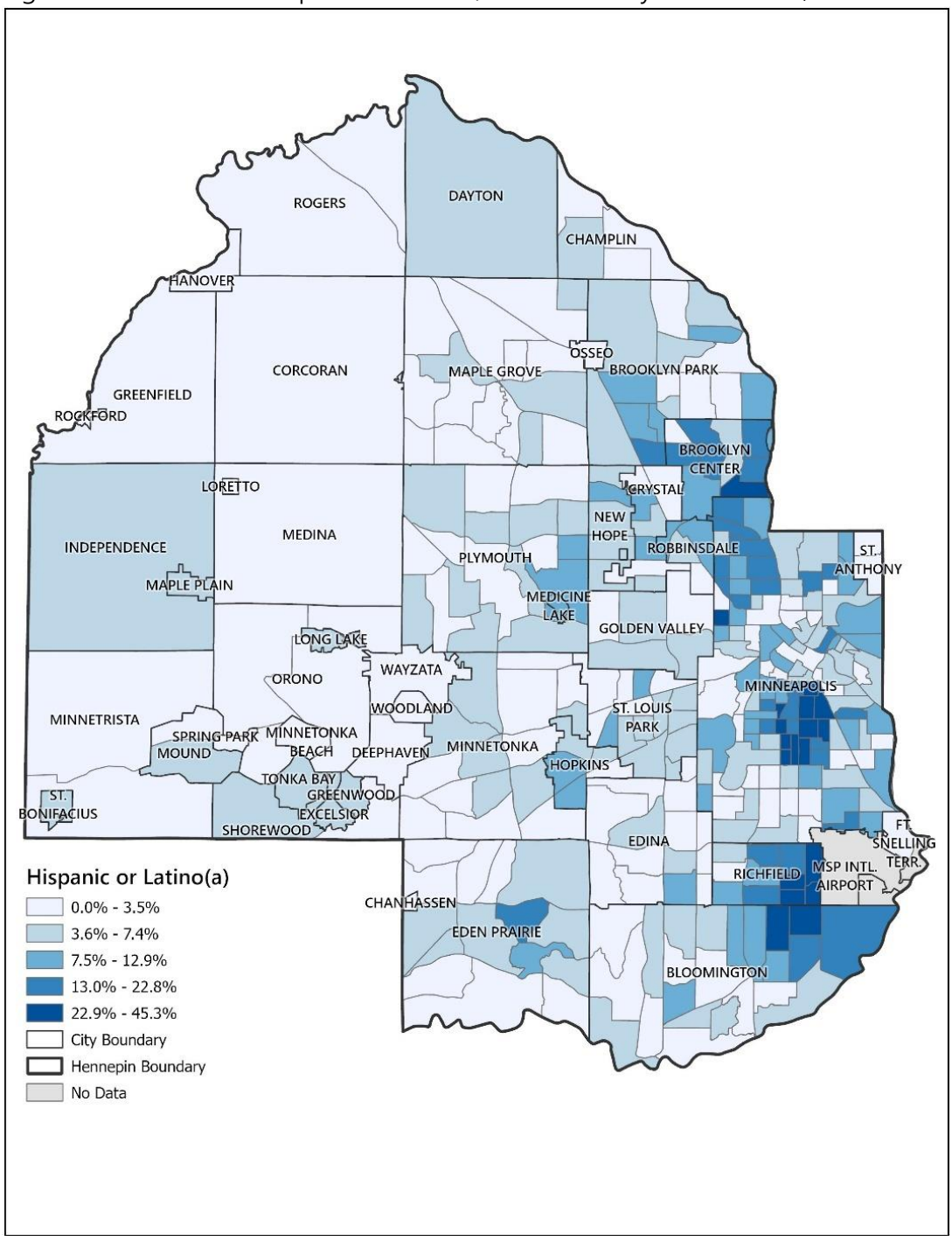
Source: American Community Survey 5-year estimates

Figure A3: Percent of Black or African American residents by census tract, 2018-2022



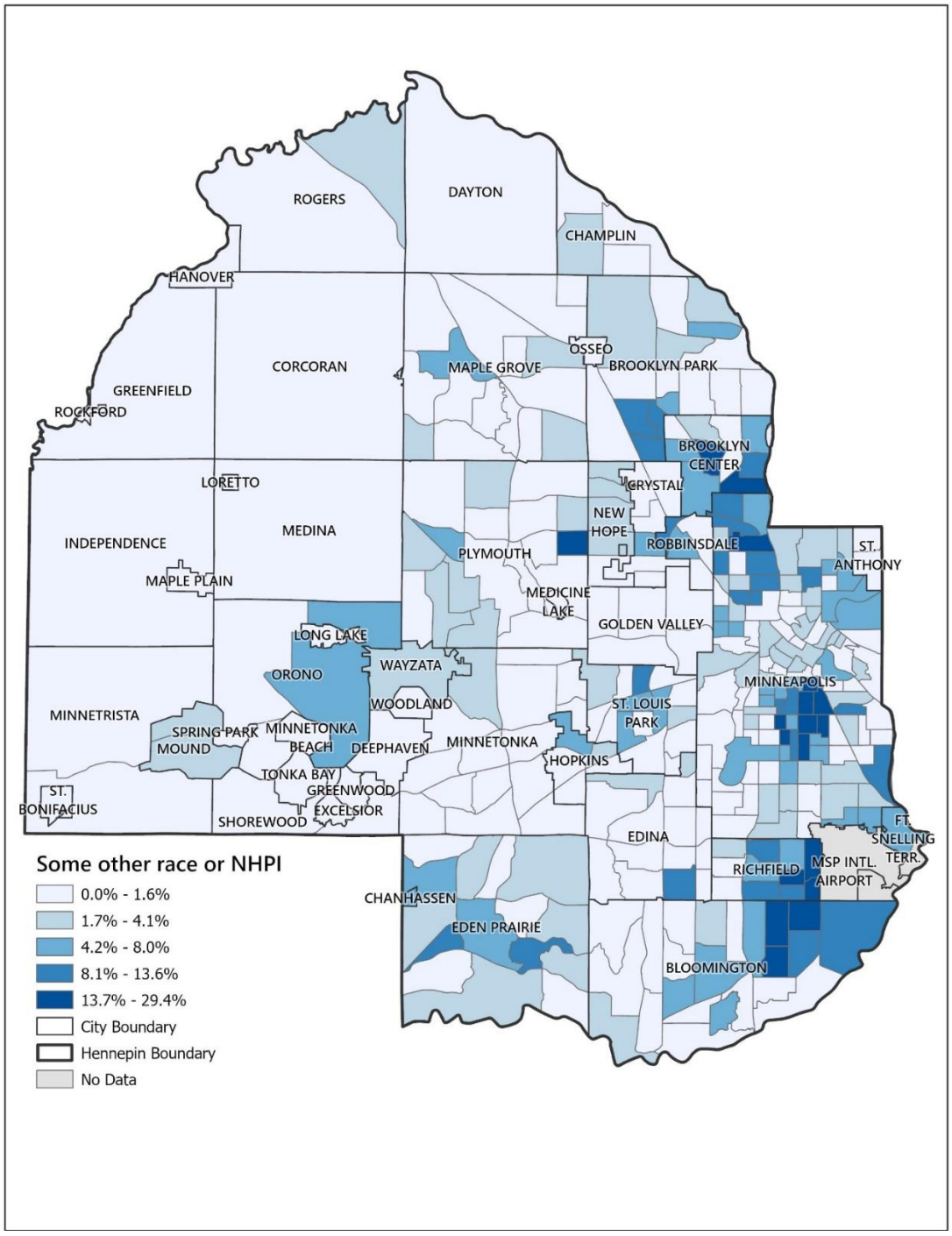
Source: American Community Survey 5-year estimates

Figure A4: Percent of Hispanic or Latino/a residents by census tract, 2018-2022



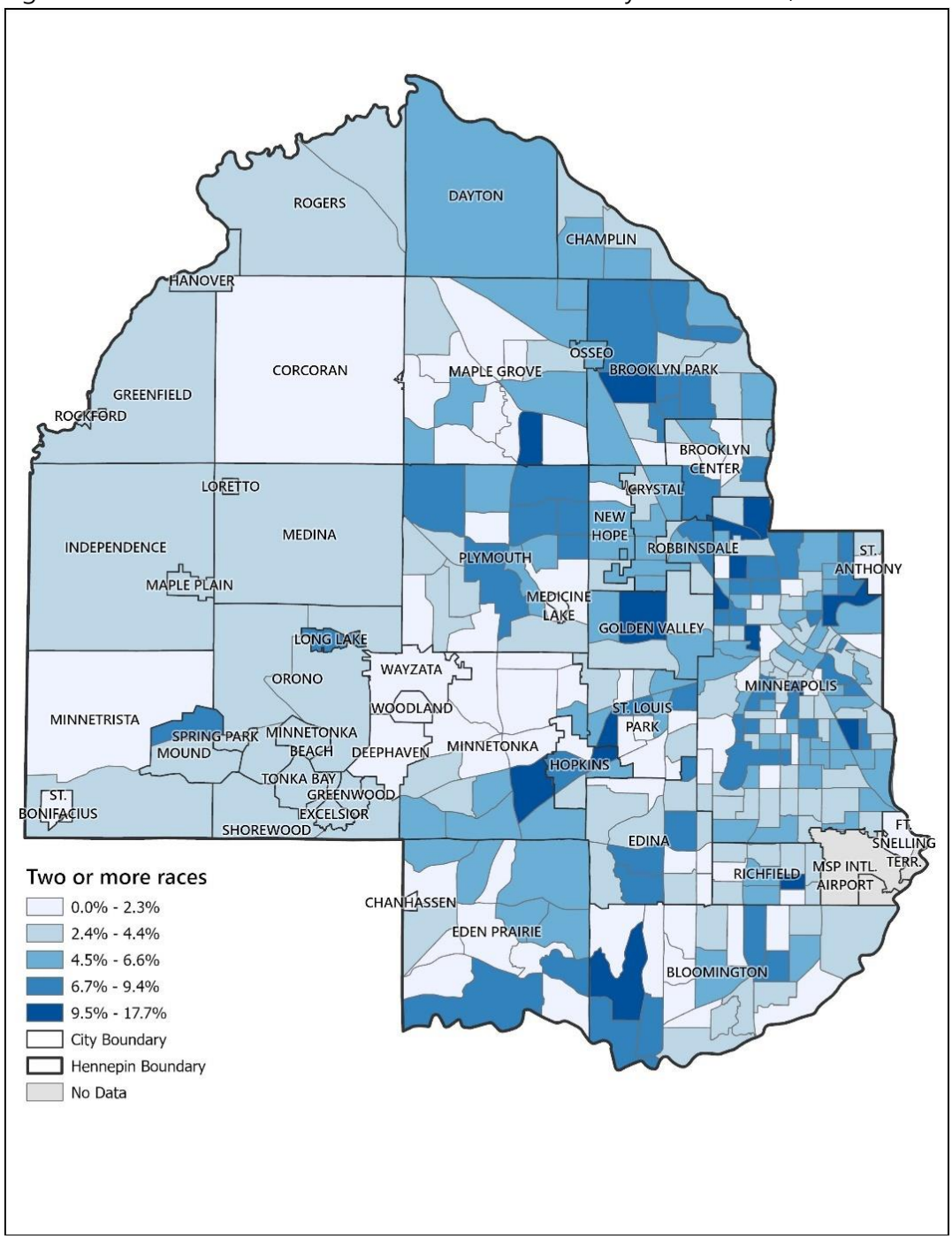
Source: American Community Survey 5-year estimates

Figure A5: Percent of Native Hawaiian and Pacific Islander residents by census tract, 2018-2022



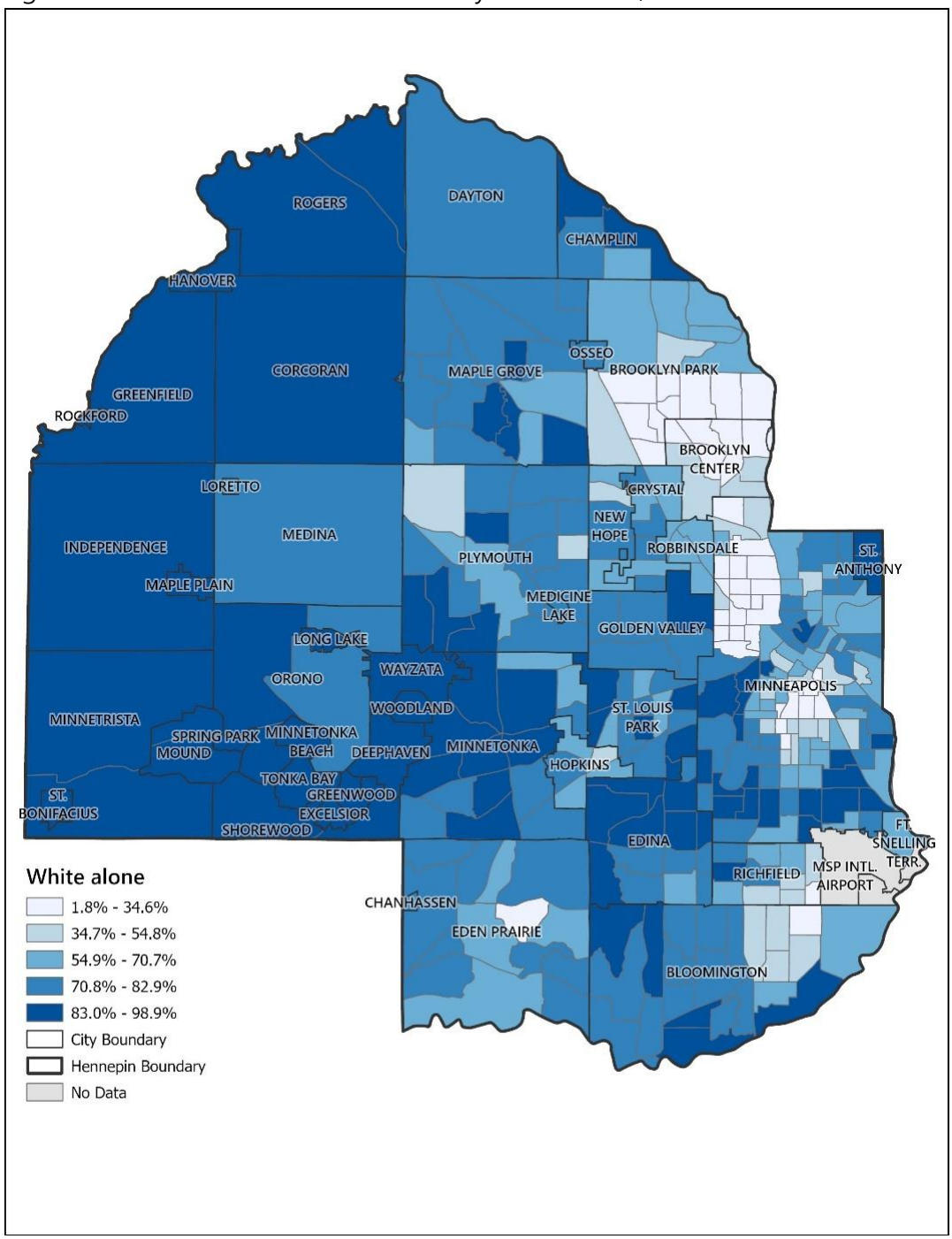
Source: American Community Survey 5-year estimates

Figure A6: Percent of residents two or more races by census tract, 2018-2022



Source: American Community Survey 5-year estimates

Figure A7: Percent of White residents by census tract, 2018-2022



Source: American Community Survey 5-year estimates

Immigration

Immigration brings diversity to Hennepin County. Between 2018-2022, Hennepin County had nearly 1.3 million residents. Of those, 174,102 (14%) had been born outside the United States. Of those born outside of the United States, 97,523 were foreign-born citizens, and 76,579 were foreign-born noncitizens. Most foreign-born residents were from Asia (58,756), followed by Africa (58,527), the Americas (39,801), Europe (16,503), Northern America (4,344), and Oceania (515) (ACS 5-YR, 2018-2022). In 2023, Hennepin County welcomed 1,123 refugees. Nearly half of all refugees in Hennepin County are Somali (Refugee Health Statistics, Minnesota Department of Health).

The "driver's license for all" law went into effect across Minnesota in October 2023 [57]. This law allows residents to obtain driver's licenses and identifications cards regardless of immigration or citizenship status. Assessment respondents shared that this change is viewed positively as more people can legally use personal transportation, which supports health, well-being, and employment.

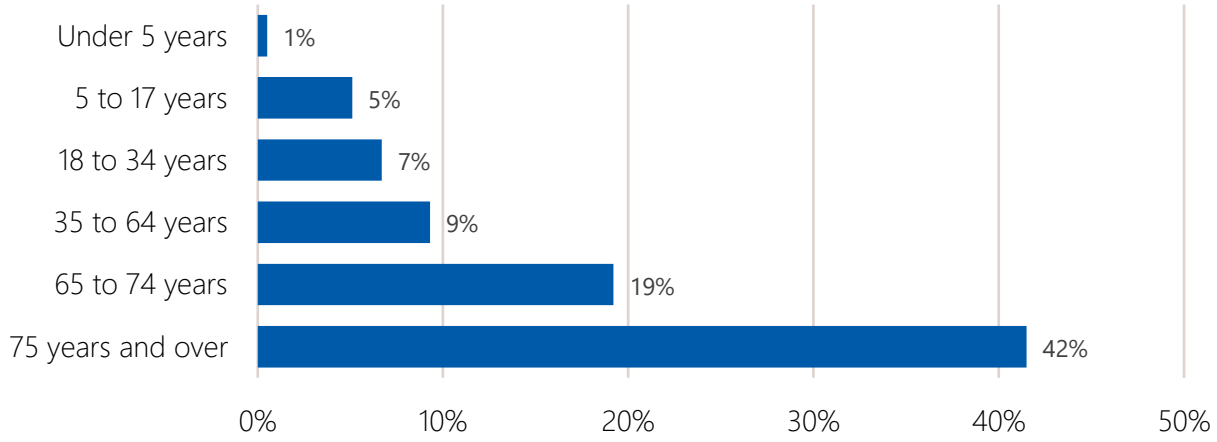
In 2022, an estimated 18% of the population ages 5 and older spoke a language other than English at home (214,170 out of 1,187,799). Of the many diverse languages spoken in the home, the largest language group was Spanish (58,702). Other languages more widely used across the county were Amharic, Somali, or other Afro-Asiatic languages (47,021); Hmong (17,220); Vietnamese (9,369); Yoruba, Twi, Igbo, or other languages of Western Africa (9,226); Chinese (7,446); and Russian (5,693), among others (American Community Survey 1-year, 2022). Appendix X lists the languages spoken in Hennepin County.

Disability

There is no universal definition of disability. The definition of disability used for data collection changes how people are included or left out. Because of the variability in data collection of disability status, different data sources produce different estimates. The American Community Survey's (ACS) definition of disability includes visual, hearing, cognitive, ambulatory, self-care, and independent living difficulty. This definition may exclude individuals with upper body disabilities or mental illness.

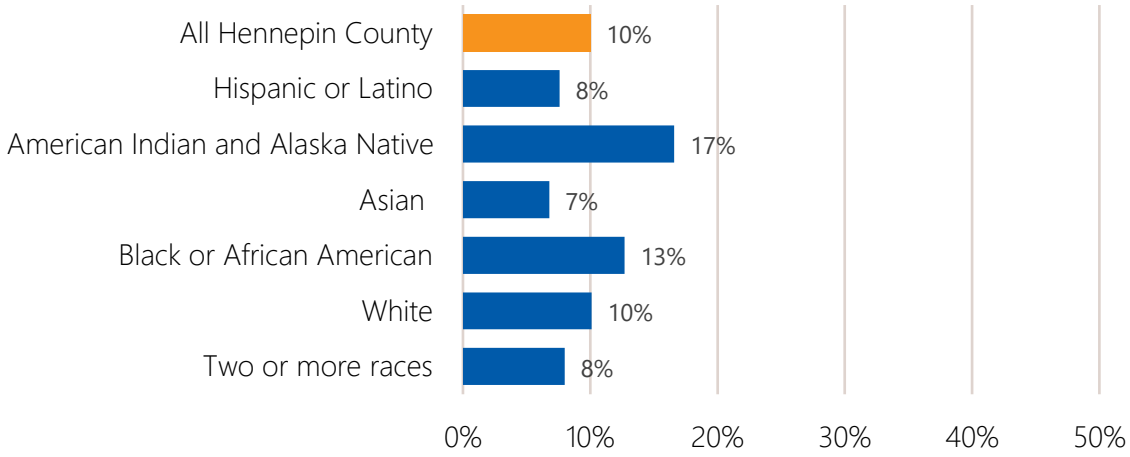
- Based on 5-year ACS data for 2022, one in 10 (10%) Hennepin County adults were living with a disability.
- Adults 75-years and older had the highest rates of disability in the county (42%) by age group (Figure A8). By race or ethnicity, American Indian or Alaska Native (17%) and Black or African American (13%) residents had the highest reported rates of disability (Figure A9).

Figure A8: Hennepin County residents with a disability by age, 2018-2022



Source: American Community Survey 5-year estimates

Figure A9: Hennepin County residents with a disability by race/ethnicity, 2018-2022



Source: American Community Survey 5-year estimates

B. Languages spoken at home

Table B1. Hennepin County, 2022 (American Community Survey 1-year estimate)

	2022 Hennepin County estimate
Total:	1,187,799
Speak only English	973,629
Spanish	58,702
Amharic, Somali, or other Afro-Asiatic languages	47,021
Hmong	17,220
Vietnamese	9,369
Yoruba, Twi, Igbo, or other languages of Western Africa	9,226
Chinese (incl. Mandarin, Cantonese)	7,446
French (incl. Cajun)	7,021
Russian	5,693
Hindi	4,337
Swahili or other languages of Central, Eastern, and Southern Africa	3,825
Telugu	3,562
German	3,332
Tamil	3,145
Thai, Lao, or other Tai-Kadai languages:	2,985
Arabic	2,748
Other languages of Asia	2,643
Persian (incl. Farsi, Dari)	2,460
Other Indo-European languages	2,420
Korean	2,219
Tagalog (incl. Filipino)	2,088
Bengali	2,086
Portuguese	2,051
Gujarati	1,583
Other Native languages of North America	1,261
Khmer	1,222
Nepali, Marathi, or other Indic languages	1,058
Ukrainian or other Slavic languages	1,033
Other and unspecified languages	885

Japanese	855
Urdu	789
Yiddish, Pennsylvania Dutch or other West Germanic languages	652
Punjabi	578
Hebrew	477
Serbo-Croatian	471
Malayalam, Kannada, or other Dravidian languages	466
Greek	339
Polish	272
Ilocano, Samoan, Hawaiian, or other Austronesian languages	264
Italian	199
Haitian	167
Navajo	0
Armenian	0

References

[1] Office of Disease Prevention and Health Promotion, "Literature Summaries: Discrimination," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/discrimination. [Accessed 8 January 2025].

[2] A. I. Vines, J. B. Ward, E. Cordoba and K. Black, "Perceived Racial/Ethnic Discrimination and Mental Health: a Review and Future Directions for Social Epidemiology," *Current Epidemiology Reports,* vol. 4, no. 2, pp. 156 - 165. doi: 10.1007/s40471-017-0106-z, 2017.

[3] Center for Disease Control and Prevention, "Neighborhood Characteristics," Division for Heart Disease and Stroke Prevention , 2023. [Online]. Available: https://www.cdc.gov/dhdsp/health_equity/neighborhood.htm. [Accessed 8 January 2025].

[4] A. V. Diez Roux, "Neighborhoods and Health: What Do We Know? What Should We Do?," *American Journal of Public Health,* vol. 106, no. 3, p. 430–431. doi: 10.2105/AJPH.2016.303064, 2016.

[5] Vital Signs, "Adverse childhood experiences (ACEs): preventing early trauma to improve adult health," Center for Disease Control and Prevention, 23 August 2021. [Online]. Available: https://www.cdc.gov/vitalsigns/aces/. [Accessed 17 January 2025].

[6] D. J. Chislom, D. A. Jerome, J. F. Figueroa, M. B. Lane-Fall, D. H. Roby, H. P. Rodriquez and A. N. Ortega, "Improving health equity through health care systems research," *Health Services Research,* vol. 58, no. 3, pp. 289–299. doi: 10.1111/1475-6773.14192, 2023.

[7] P. Braverman, S. Egerter and D. R. Williams, "The Social Determinants of Health: Coming of Age," *Annual Review of Public Health,* vol. 32, pp. 381- 398. doi.org/10.1146/annurev-publhealth-031210-101218, 2011.

[8] Agency for Toxic Substances and Disease Registry, "Social Vulnerability Index," Place and Health - Geospatial Research, Analysis, and Services Program, 2024. [Online]. Available: https://www.atsdr.cdc.gov/place-health/php/svi/index.html. [Accessed 8 January 2025].

[9] Office of Disease Prevention and Health Promotion, "Literature Summaries: Access to Health Services," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services. [Accessed 8 January 2025].

[10] K. Whetten, J. Leserman, R. Whetten, J. Ostermann, N. Thielman, M. Swartz and D. Stangi, "Exploring lack of trust in care providers and the government as a barrier to health service use," *American Journal of Public Health,* vol. 96, p. 716–721. doi:10.2105/AJPH.2005.063255, 2006.

[11] L. A. Blewett, P. J. Johnson, B. Lee and P. B. Scal, "When a Usual Source of Care and Usual Provider Matter: Adult Prevention and Screening Services," *Journal of General Internal Medicine,* vol. 23, no. 8, pp. 1354–1360. doi: 10.1007/s11606-008-0659-0, 2008.

[12] Office of Disease Prevention and Health Promotion, "Literature Summaries: Access to Primary Care," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care. [Accessed 8 January 2025].

[13] I. Karachi, N. Adler and W. Dow, "Money, schooling, and health: Mechanisms," *ANNALS OF THE NEW YORK ACADEMY OF SCIENCES,* vol. 1186, pp. 56 - 68. doi: 10.1111/j.1749-6632.2009.05340., 2010.

[14] D. Chokshi, "Income, Poverty, and Health Inequality," *Journal of the American Medical Association,* vol. 319, no. 13, pp. 1312-1313. doi:10.1001/jama.2018.2521, 2018.

[15] Office of Disease Prevention and Health Promotion, "Literature Summaries: Poverty," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty. [Accessed 8 January 2025].

[16] Office of the Assistant Secretary for Planning and Evaluation, "Povety Guidelines," US Dept of Health and Human Services, [Online]. Available: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines. [Accessed 24 January 2025].

[17] Office of Disease Prevention and Health Promotion, "Reduce the proportion of people living in poverty — SDOH-01," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01. [Accessed 24 January 2025].

[18] A. Zajacova and E. Lawrence, "The relationship between education and health: reducing disparities through a contextual approach," *Annual Reviews in Public Health,* vol. 39, pp. 273–289. doi: 10.1146/annurev-publhealth-031816-044628, 2018.

[19] M. Stahre, J. VanEenwyk, P. Siegel and R. Njai, "Housing Insecurity and the Association With Health Outcomes and Unhealthy Behaviors, Washington State, 2011," *Preventing Chronic Disease,* vol. 12, p. 140511. DOI: http://dx.doi.org/10.5888/pcd12.140511, 2015.

[20] Office of Disease Prevention and Health Promotion, "Literature Summaries: Food Insecurity," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity. [Accessed 9 January 2025].

[21] Office of Disease Prevention and Health Promotion, "Literatue Summaries: Housing Instability," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability. [Accessed 9 January 2025].

[22] R. M. Houghtaling, "Moratoriums, phase-outs, and zoom: Landlord-tenant actions in a covid world," MN 4th Judicial District Court, [Online]. Available: https://mn.gov/law-library/assets/Moratoriums%20Phase-outs%20%20Zoom%209%2022%2021_tcm1041-500264.pdf. [Accessed 23 January 2025].

[23] Minnesota Department of Education, "Free School Meals for Kids Program," [Online]. Available: https://education.mn.gov/MDE/dse/FNS/SNP/free/. [Accessed 23 January 2025].

[24] The U.S. Surgeon General's Advisory on the Health Effects of Social Connection and Community, "Our epidemic of loneliness and isolation," Office of the Surgeon General, https://www.hhs.gov/surgeongeneral/priorities/connection/index.html, 2023.

[25] C. Nelson, J. Sloan and A. Chandra, "Examining civic engagement links to health," Rand Corporation, www.rand.org/t/RR3163, 2019.

[26] Center for Disease Control and Prevention, "Adverse Childhood Experiences (ACEs): Risk and Protective Factors," 16 May 2024. [Online]. Available: https://www.cdc.gov/aces/risk-factors/index.html. [Accessed 24 January 2025].

[27] Office of Disease Prevention and Health Promotion, "Increase the proportion of adolescents who have an adult they can talk to about serious problems — AH-03," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/adolescents/increase-proportion-adolescents-who-have-adult-they-can-talk-about-serious-problems-ah-03. [Accessed 24 January 2025].

[28] Office of Disease Prevention and Health Promotion, "Increase use of the oral health care system — OH-08," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/health-care/increase-use-oral-health-care-system-oh-08. [Accessed 24 January 2025].

[29] Office of Disease Prevention and Health Promotion, "Reduce the proportion of adults with obesity — NWS-03," Healthy People 2030, [Online]. Available:

https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/overweight-and-obesity/reduce-proportion-adults-obesity-nws-03. [Accessed 24 January 2025].

[30] Office of Disease Prevention and Health Promotion, "Reduce the proportion of children and adolescents with obesity — NWS-04," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/overweight-and-obesity/reduce-proportion-children-and-adolescents-obesity-nws-04. [Accessed 24 January 2025].

[31] T. Grant, E. Corce and E. Matsui, "Asthma and social determinants of health," *Annals of Allergy, Asthma, and Immunology,* vol. 128, no. 1, pp. P5-11, DOI: 10.1016/j.anai.2021.10.002, 2022.

[32] Minnesota Department of Health, "Asthma in Minnesota," Minnesota Public Health Data Access, October 2023. [Online]. Available: https://data.web.health.state.mn.us/web/mndata/asthma. [Accessed 22 January 2025].

[33] K. Kroenke, R. Spitzer, J. B. Williams and B. Loew, "An ultra-brief screening scale for anxiety and depression: the PHQ-4," *Psychosomatics,* vol. 50, no. 6, pp. 613-21. doi: 10.1176/appi.psy.50.6.613, 2009.

[34] Minnesota Department of Health, "News Release: 2022 Minnesota Student Survey results released," Minnesota Department of Health, 30 Decemeber 2022. [Online]. Available: https://www.health.state.mn.us/news/pressrel/2022/stsurvey122322.html. [Accessed 22 January 2025].

[35] US Dept of Health and Human Services, "Sexually transmitted Infections (STIs)," Featured Topic Sites, [Online]. Available: https://www.hhs.gov/programs/topic-sites/sexually-transmitted-infections/index.html. [Accessed 23 January 2025].

[36] STD/HIV/TB Section, "Laws affecting people who use drugs," Minnesota Department of Health, 20 12 2023. [Online]. Available: https://www.health.state.mn.us/people/syringe/ssplaws.pdf. [Accessed 16 January 2025].

[37] American Lung Association, "10 of the Worst Diseases Smoking Causes," State of Tobacco Control, 7 June 2024. [Online]. Available: https://www.lung.org/research/sotc/by-the-numbers/10-worst-diseases-smoking-causes. [Accessed 24 January 2025].

[38] Office of Disease Prevention and Health Promotion, "Reduce current cigarette smoking in adults — TU-02," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/tobacco-use/reduce-current-cigarette-smoking-adults-tu-02. [Accessed 24 January 2025].

[39] S. R. Helgertz, "Teens and commercial tobacco in Minnseota: Highlights from the 2023 Minnesota Youth Tobaxxo Survey," Minnesota Center for Health Statistics, Minnesota Department of Health, May 2024. [Online]. Available: https://www.health.state.mn.us/data/mchs/surveys/tobacco/docs/teenscommercialtobacco2023.pdf. [Accessed 23 January 2025].

[40] Office of Disease Prevention and Health Promotion, "Reduce current tobacco use in adolescents — TU-04," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/tobacco-use/reduce-current-tobacco-use-adolescents-tu-04/data. [Accessed 24 January 2025].

[41] Office of Disease Prevention and Health Promotion, "Reduce current use of flavored tobacco products in adolescents who use tobacco — TU-09," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/tobacco-use/reduce-current-use-flavored-tobacco-products-adolescents-who-use-tobacco-tu-09. [Accessed 23 January 2025].

[42] Office of Disease Prevention and Health Promotion, "Reduce the proportion of adolescents who drank alcohol in the past month — SU-04," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use/reduce-proportion-adolescents-who-drank-alcohol-past-month-su-04. [Accessed 6 February 2025].

[43] Substance Abuse and Mental Health Services Adminstration, "Key substance use and mental health indicators in the Univted States: Results from the 2022 national survey on drug use and health," Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Adminstration, (HHS Publication No. PEP23-07-01-006, NSDUH Series H-58) 2023. [Online]. Available: https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf. [Accessed 24 January 2025].

[44] Minnesota Department of Health, "Cannabis use in Minnesota: Report to the Legislature," 1 January 2025. [Online]. Available: https://www.health.state.mn.us/data/mchs/pubs/cannabisuse2025.pdf. [Accessed 5 February 2025].

[45] Office of Disease Prevention and Health Promotion, "Reduce the proportion of adolescents who used marijuana in the past month — SU-06," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use/reduce-proportion-adolescents-who-used-marijuana-past-month-su-06. [Accessed 6 February 2025].

[46] Office of Disease Prevention and Health Promotion, "Drug and Alcohol Use: Goal reduce misuse of drugs and alcohol," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use. [Accessed 6 February 2025].

[47] Minnesota Department of Health, "Differences in rates of drug overdose deaths by race," Injury and Prevention Violence Section, 2019. [Online]. Available: https://www.health.state.mn.us/communities/opioids/documents/raceratedisparity2019prelimfinal.pdf. [Accessed 6 February 2025].

[48] Office of Disease Prevention and Health Promotion, "Reduce preterm births — MICH-07," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-preterm-births-mich-07. [Accessed 6 February 2025].

[49] Office of Disease Prevention and Health Promotion, "Reduce pregnancies in adolescents — FP-03," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning/reduce-pregnancies-adolescents-fp-03. [Accessed 6 February 2025].

[50] Office of Disease Prevention and Health Promotion, "Reduce the overall cancer death rate — C-01," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/cancer/reduce-overall-cancer-death-rate-c-01. [Accessed 7 February 2025].

[51] Office of Disease Prevention and Health Promotion, "Heart disease and stroke: Goal improve cardiovasculat health and reduce deaths for heart disease and stroke," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/heart-disease-and-stroke. [Accessed 7 February 2025].

[52] Office of Disease Prevention and Health Promotion, "Reduce the suicide rate — MHMD-01," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders/reduce-suicide-rate-mhmd-01. [Accessed 7 February 2025].

[53] Office of Disease Prevention and Health Promotion, "Reduce unintentional injury deaths — IVP-03," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/injury-prevention/reduce-unintentional-injury-deaths-ivp-03. [Accessed 7 February 2025].

[54] Injury and Violence Prevention, MDH, "Minnesota Violent Death Reporting System (MNVDRS) Dashboard," Minnesota Department of Health, 22 January 2025. [Online]. Available:

https://www.health.state.mn.us/communities/injury/midas/mnvdrs.html. [Accessed 23 January 2025].

[55] Center for Gun Violence Solutions, "State data: Minnesota," Johns Hopkins Bloomberg School of Public Health, [Online]. Available: https://publichealth.jhu.edu/center-for-gun-violence-solutions/minnesota. [Accessed 23 January 2025].

[56] Office of Disease Prevention and Health Promotion, "Reduce firearm-related deaths — IVP-13," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/violence-prevention/reduce-firearm-related-deaths-ivp-13. [Accessed 7 February 2025].

[57] Minnesota House of Representatives, "Driver's licenses will be accessible regardless of immigration status," Minnesota Legistlature, HF4*/SF27/CH13. [Online]. Available: https://www.house.mn.gov/NewLaws/story/2023/5520. [Accessed 16 January 2025].

[58] Office of Disease Prevention and Health Promotion, "Reduce bullying of lesbian, gay, or bisexual high school students — LGBT-05," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/lgbt/reduce-bullying-lesbian-gay-or-bisexual-high-school-students-lgbt-05. [Accessed 24 January 2025].

[59] Minnesota Department of Health, Wilder Research, "Transfer and discharge delays for behavioral health patients at Minnesota hospitals," 15 July 2024. [Online]. Available: https://www.health.state.mn.us/data/economics/docs/dischargedelays.pdf. [Accessed 24 January 2025].

[60] Office of Disease Prevention and Health Promotion, "Reduce the rate of infant deaths — MICH-02," Healthy People 2030, [Online]. Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/infants/reduce-rate-infant-deaths-mich-02. [Accessed 6 February 2025].

[61] US Dept of Health and Human Services, CDC, "Mortality in the United States, 2021," *NCHS Data Brief ,* vol. 456, p. https://www.cdc.gov/nchs/data/databriefs/db456.pdf, 2022.

[62] Minnesota Department of Health, "Minnesota Maternal Morality Update: Reporting for 2017 - 2019," *Child and Family Health Division,* no. https://www.health.state.mn.us/people/womeninfants/maternalmortality/maternalmortreport.pdf, 2024.

[63] Office of Disease Prevention and Health Promotion, "https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/cancer/reduce-overall-cancer-death-rate-c-01," Healthy People 2030, [Online].

Available: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/cancer/reduce-overall-cancer-death-rate-c-01. [Accessed 7 February 2025].