



2025 Community Health Needs Assessment & 2026-2028 Community Health Implementation Plan

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Executive Summary

At a time where our communities face extraordinary challenges, being conscientious, strategic, and efficacious with our resources is critical to the survival of healthcare and to the communities we serve. By identifying the leading health concerns, disparities in care, and the social drivers of health impacting our neighbors, we can create powerful partnerships within our community, prioritize impactful interventions, and allocate our resources responsibly.

The Community Health Needs Assessment (CHNA) is not only a report, but a call to action on behalf of the communities we serve. Responsible stewardship starts with understanding the real needs of the people we serve and ensuring our interventions are informed, intentional, and impactful.

METHODOLOGY

The CHNA examined the health of North Memorial Health's (NMH) consolidated service area (CSA) which is comprised of 75% of the inpatient population at both North Memorial Health – Robbinsdale Hospital (North – Robbinsdale Hospital) and North Memorial Health – Maple Grove Hospital (North – Maple Grove Hospital). It includes 31 zip codes, 18+ cities, and 7 school districts located partially or fully within the CSA.

Quantitative data was collected and examined from key sources including North Memorial Health's databases, the Hennepin County Survey of the Health of All the Population and the Environment (SHAPE), the Minnesota Student Survey (MSS), national health indexes, Healthy People 2030, and data provided by the Minnesota Department of Health and Hennepin County Public Health.

Five Data Briefs were compiled from the data sources above and presented to the Community Engagement Advisory Team (CEAT), which consists of leaders from community organizations and team members from North Memorial Health. The five Data Brief topics were:

1. Sociodemographic Factors, Basic Needs, General Health
2. Chronic Disease, Physical Activity and Nutrition
3. Communicable Disease, Environmental Health, Oral Health
4. Maternal and Child Health, Injury, Violence and Safety
5. Mental Health and Well-Being, Substance Use

Members from CEAT scored 82 Key Health Indicators (KHIs) from these topics based on size, seriousness, availability of interventions, disparities and whether we are meeting a health goal. Based on KHI scores and CEAT conversations, four critical health issues were identified to move forward in the qualitative phase of the process. The issues were:

- Chronic Disease
- Health Access and Quality
- Maternal and Child Health
- Mental Health

A Data Walk was held in June 2025 for community members to review data and share insights on community needs, discuss impacts, and offer potential interventions. Community members ranked their top four most important health needs to address. This data was presented to CEAT to narrow down into three critical issues. The three health priorities that are the focus of our Community Health Implementation Plan (CHIP) are to work with community members and patients to:

1. Establish care with a primary care provider and/or health clinic
2. Understand and navigate the healthcare system
3. Prevent, detect, and manage chronic diseases

The CHIP is a blueprint for action to address community needs identified through North Memorial Health's CHNA process. Each priority has multiple strategies and actions to be implemented over the next three years from 2026 to 2028. Detailed strategies can be found in the 2026-2028 Community Health Priorities section of the 2025 CHNA.

Priority 1: Increase community members who establish care with a primary care provider and/or health clinic.

Objective 1: Enhance the ability of patients and community members to connect to and receive regular medical care from a primary care provider and/or a health clinic.

Priority 2: Help community members understand and navigate the healthcare system.

Objective 1: Improve access to care by minimizing geographic barriers and reducing disparities in access.

Objective 2: Increase baseline understanding of the healthcare delivery system so patients and community members can receive the care they need when, where, and how they need it.

Priority 3: Prevent, detect, and manage chronic diseases.

Objective 1: Promote community awareness on the need for annual exams, preventive health screenings, and immunizations.

Objective 2: Engage those with chronic diseases early and often through chronic disease self-management classes and support groups.

Objective 3: Provide evidence-based outpatient care for chronic disease patients, including timely screenings for cancer, diabetes, hypertension, and mental health.

North Memorial Health's 2025 CHNA and 2026-2028 CHIP were approved by North Memorial Health's Board of Trustees on December 11, 2025. The Community Health Needs Assessment meets all the federal requirements of the Patient Protection and Affordable Care Act (ACA) and the Internal Revenue Service (IRS) requirements. In accordance with federal regulations, the CHNA and CHIP are available to the public on North Memorial Health's website. Paper copies are available through North Memorial Health's Diversity, Equity, and Inclusion and Community Health Program.

Letter from the CEO

Dear North Memorial Health Community,

With deep gratitude, I share the results of North Memorial Health's 2025 Community Health Needs Assessment (CHNA). This comprehensive report celebrates our community's strengths and shines a light on the challenges we must address together to improve health for all.

Guided by the CHNA, our 2026–2028 Community Health Implementation Plan (CHIP) sets a clear path for the next three years. The CHIP focuses on three priorities:

- Helping individuals establish care with a primary provider or clinic
- Empowering people to confidently navigate the healthcare system
- Preventing, detecting, and managing chronic diseases

These priorities are grounded in rigorous data analysis and shaped by the voices of our community. Their input ensures our work targets the most urgent needs and reflects what matters most to those we serve.

Achieving meaningful change will require strong partnerships—across our healthcare system, with local governments, nonprofits, health agencies, and, most importantly, with you. Together, we can build a healthier future.

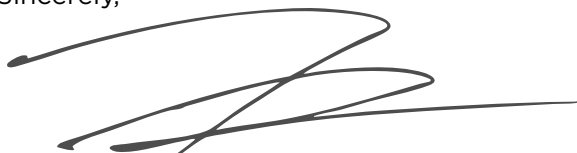
At North Memorial Health, our mission is to empower every patient to achieve their best health. Our vision—“Together, health care the way it ought to be”—is more than words; it's our commitment in action. This dedication is central to our 5x5 Strategic Plan and reflects our investment in the well-being, stability, and vitality of our communities.

Our values—advocating courageously, rallying together, respecting uniqueness, and creating impact—guide us every day. We strive to make a lasting difference in the lives of those we serve.

I extend heartfelt thanks to our Community Engagement Advisory Team for their dedication and insight, and to our public health epidemiologist partners for providing critical, local data. Your collaboration has laid the foundation for transformative progress.

Let's build on this momentum—together—and create lasting impact for years to come.

Sincerely,

A handwritten signature in black ink, appearing to read 'Trevor Sawallish', with a long horizontal line extending to the right.

Trevor Sawallish, CEO
North Memorial Health

Acknowledgments

The 2025 CHNA and the 2026-2028 CHIP is a result of contributions from many individuals and organizations. The 2025 CHNA was led by North Memorial Health's Carrie McLachlan, Senior Community Health Specialist, in partnership with Sam Elliott, an MPH Intern on the project. We also appreciated the guidance and creativity of Susan DeSimone, a consultant to the project. Thank you to Paul James, Marketing Strategist at North Memorial Health, for running sociodemographic data and compiling specialized maps for the CHNA. Thank you to the staff at Hennepin County Public Health and the Minnesota Department of Health who responded to a wide range of data requests specific to our consolidated service area, including Komal Mehratra, LJ Panas, Neeti Sethi, Marie Maslowski, Urban Landreman, Stefan Gingerich, and public health intern Erika Guenther.

We could not have completed this assessment without the contributions of the North Memorial Health's Community Engagement Advisory Team (CEAT) who reviewed and scored key health indicator data and selected the priority issues for action. Their participation in conversations about the data, sharing stories about patients and community members they serve, and insights into the health status of our communities helped highlight the issues in our region.

CEAT TEAM

(Current as of the October 2025 CEAT Meeting)

- Todd Archbold, *PrairieCare*
- Kevalin Aulandez, *Minneapolis Health Department*
- Kelly Becker, *City of Brooklyn Park*
- (Open), *Hennepin County Public Health*
- Telina Fleming, *Broadway Family Medicine*
- Patrick Foley, *Robbinsdale Police Department*
- Phillip Gray, *Hennepin County Community Outreach, Robbinsdale PD*
- Rachel Harris, *Northwest Family Resource Collaborative*
- Steve Knutson, *Neighborhood HealthSource*
- Holly Leppanen, *Annex Teen Clinic*
- Jill Lesne, *Osseo School District*
- Heidi Nelson, *City of Maple Grove*
- Marea Perry, *Secrets2Truth*
- Giannina Posner, *Three Rivers Park District*
- Tim Sandvick, *City of Robbinsdale*
- Molly Schlieff, *Broadway Family Medicine*
- Filisha Thor, *Broadway Family Medicine*
- LaTrese VanBuren, *Broadway Family Medicine*
- Angela Watts, *NorthPoint Health & Wellness Center*
- Eric Werner, *Maple Grove Police Department*
- Nina Wolf, *New Hope YMCA*
- Sam Elliott, *North Memorial Health*
- Bjorn Gunnerud, *North Memorial Health*
- Linnea Huinker, *North Memorial Health*
- Patty Johnson, *North Memorial Health*
- Shirley Kern, *North Memorial Health*
- Jessi Kingston, *North Memorial Health*
- Carrie McLachlan, *North Memorial Health*
- Mike Opat, *North Memorial Health*
- Melanie Smalley, *North Memorial Health*

About North Memorial Health

North Memorial Health is a comprehensive healthcare system that includes North – Robbinsdale Hospital and North – Maple Grove Hospital. Other entities in the system include 24 owned or affiliated clinics, and one of the largest ground and air medical transportation services in the country. With 1,058 physicians on the medical staff and 615 Advanced Practice Providers, North Memorial Health’s 6,000+ team members serve over 55,000 patients monthly.

North Memorial Health began with the establishment of North – Robbinsdale Hospital, founded as a community hospital in 1954 in Robbinsdale, Minnesota. While North Memorial Health’s roots lie in local, neighborhood-based health care, the hospital is one of four Level I Trauma Centers in the state.

It is a 353-bed tertiary hospital (518 licensed beds) and provides emergency and Level I trauma care, family birth center, cardiovascular services, oncology, stroke, acute psychiatric, and rehabilitation services. The Robbinsdale campus also includes a state-of-the-art breast cancer center, a heart health and vascular center, and other specialty services. North – Robbinsdale Hospital maintains strong connections with Minneapolis’ North Side neighborhoods and northwestern suburbs, including Brooklyn Center, Brooklyn Park, Crystal, Golden Valley, New Hope, and Robbinsdale.

Built in 2009, North – Maple Grove Hospital is the #1 hospital for births in Minnesota. The 130-bed hospital provides labor, delivery and postpartum services, a Level III NICU, pediatrics, general surgery, and intensive care services. Services also include urgent care, heart and vascular clinics, and a sleep center.

SERVING OUR COMMUNITY IN 2024



NORTH MEMORIAL HEALTH’S MISSION, VISION AND VALUES

North Memorial Health’s mission is “empowering our patients to achieve their best health” aligned with the vision of “Together, health care the way it ought to be.” North Memorial Health is committed to changing healthcare by delivering unmatched patient service, empowering our patients throughout the Twin Cities to lead their healthiest lives, and improving the health of our communities. Everyone should have the resources, knowledge, and tools necessary to make informed decisions regarding their own health. To this end, we strive to provide access to information through education, employees such as patient navigators and care coordinators, education and outreach, and transparency in care. We recognize that health is influenced by many factors both inside and outside the healthcare system.

In 2024, we committed to new values and a new 5-year strategic plan. Our values and our plan help ground us and are a guide for our current and future work.

5x5 5 Years.
5 Strategies.



VISION

Together, healthcare the way it ought to be.

MISSION

Empowering our patients to achieve their best health.

OUR VALUES

To provide the best care for our patients, their loved ones and each other, we will:

- Advocate**
Courageously
- Rally**
Together
- Respect**
Uniqueness
- Create**
Impact

Community Health Needs Assessment Model and Process

INTRODUCTION

The Patient Care and Affordable Care Act of 2010 requires that all 501(c)(3) hospitals conduct a community health needs assessment (CHNA) to meet the U.S. Department of Treasury and Internal Revenue Service (IRS) rules. The purpose of conducting CHNAs is to identify and analyze the health needs of the community and develop community health implementation plans (CHIP) to address priority health issues. North Memorial Health conducted its first CHNA in 2012 and adopted their first CHIP in 2013.

North Memorial Health conducted our fifth Community Health Needs Assessment in 2025. Both quantitative and qualitative data were analyzed by hospital staff and members of North Memorial Health's Community Engagement Advisory Team (CEAT).

By examining social determinants and other community risk factors such as basic needs (housing, food, language barriers), the CHNA covers health in its broadest sense. Efforts were made to identify health disparities and populations at greater risk of poor health. The CHNA is a key document leading to more in-depth analysis of the top issues. The work culminates in the development of a CHIP to address North Memorial Health's priority health issues.

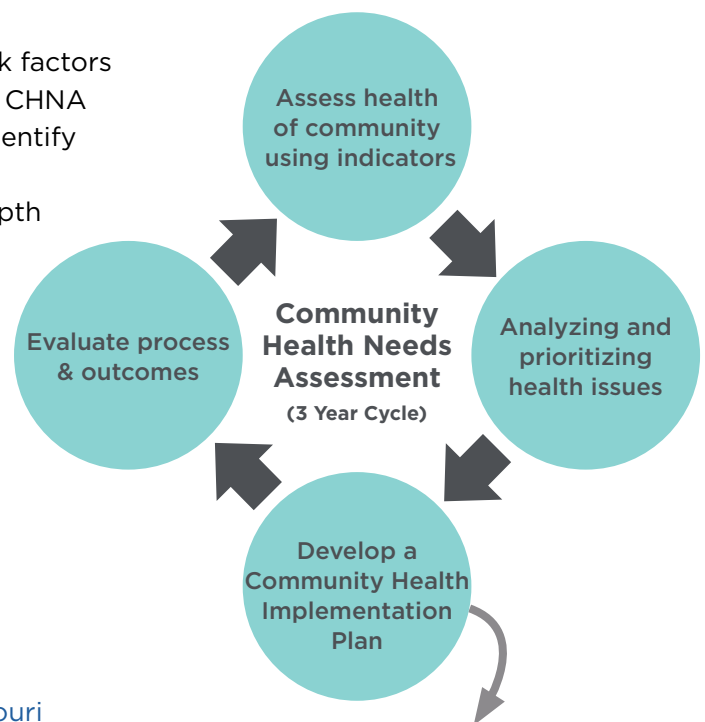
We do this work in partnership with numerous community partners. Our hope is that the CHNA will not only help identify top health issues in the service area but that the data can also assist civic leaders, community members, and non-profit organizations in their health planning, as well.

MODEL

We use a Community Health model adapted from the [Missouri Department of Health Community Health Assessment Resource Team \(CHART\) Model](#) and the [Institute of Medicine's CHIP Model \(1997\)](#). The framework consists of four phases:

1. Assessing the health of the community using both quantitative and qualitative data
2. Analyzing and prioritizing health issues
3. Developing and implementing a CHIP, and
4. Evaluating the process and outcomes.

This cycle repeats every three years. The first two steps are accomplished in the CHNA. Data for CHNAs come from quantitative and qualitative data sources such as health surveys that gather information on the health of youths and



Community Health Implementation Plan (CHIP)

With community partners:

1. Explore subpopulation data, including disparities
2. Identify gaps/barriers
3. Identify effective interventions
4. Inventory resources
5. Develop improvement strategies
6. Develop indicator set
7. Identify accountability

adults in the community. Primary data collection was completed by intentionally engaging with community members and organizations to identify and understand significant health needs in the community and seek input on addressing gaps and barriers so community members can lead healthy lives.

PROCESS

The CHNA examined the health of our consolidated service area (CSA), which is comprised of 75% of the inpatient population at both North - Robbinsdale Hospital and North - Maple Grove Hospital. See page 14 for more details on our CSA.

QUANTITATIVE RESEARCH

Quantitative data from the CSA was examined and 5 Data Briefs were compiled and presented to the Community Engagement Advisory Team (CEAT), which consists of community leaders from the CSA and team members from North Memorial Health. The five Data Brief topics were:

1. Sociodemographic Factors, Basic Needs, General Health
2. Chronic Disease, Physical Activity and Nutrition
3. Communicable Disease, Environmental Health, Oral Health
4. Maternal and Child Health, Injury, Violence and Safety
5. Mental Health and Well-Being, Substance Use

Members from CEAT individually scored 82 Key Health Indicators (KHIs) from these topics based on size, seriousness, availability of effective community or clinical interventions that could be used to improve the health issue, and whether we are meeting health goals, often Healthy People 2030 population health goals. Scores for each KHI were compiled and critical health issues were identified to move forward into the qualitative phase, they were:

- Chronic Disease
- Health Access and Quality
- Maternal and Child Health
- Mental Health



QUALITATIVE RESEARCH

Most of the qualitative data for the CHNA was collected during a Data Walk held with the community. North Memorial Health contracted with Susan DeSimone, Inc. to facilitate the Data Walk in 2025. Susan has over 24 years experience in qualitative research in a variety of areas. Large posters were created for each of the identified topics and presented at the event to community members who engaged with each other and Data Walk facilitators to discuss impact, offer potential interventions, and gather insights. Community members ranked their top four most important health needs. Data Walk details are included in the Appendix.

Findings

Data collected from the Data Walk was presented to CEAT to narrow down the most important health needs into three priorities and discuss potential interventions. After insight and engagement with CEAT, three health priorities were selected that are the focus of North Memorial Health's CHIP. They are to help our community members, patients and their families:

1. Establish care with a primary care provider and/or health clinic
2. Understand and navigate the healthcare system
3. Prevent, detect, and manage chronic diseases

PRIMARY DATA SOURCES

The Annie E. Casey Foundation Kids Count Data Center

The Kids Count Data Center has been a trusted source of data on children, youth and families since 1990. It has indicator data at national, state, county, and city levels.

<https://datacenter.aecf.org/#:~:text=Annie%20E.%20Casey%20Foundation%27s%20KIDS%20COUNTt>

Child Opportunity Index (COI)

The COI is a composite index measured at the census tract level that captures neighborhood resources and conditions that matter for children's healthy development in a single metric. The COI focuses on contemporary features of neighborhoods that are affecting children. It is based on 29 indicators spanning three domains: education, health and environment, and social and economic.

Child Opportunity Index database <https://www.diversitydatakids.org/child-opportunity-index>

Community Resiliency Estimates (CRE)

The CRE are produced using information on individuals and households from the American Community Survey (ACS), the Census Bureau's Population Estimates Program (PEP), as well as publicly available health condition rates from the National Health Interview Survey (NHIS). The CRE for Equity dataset provides social vulnerability and equity information about the nation, states, counties, and census tracts.

U.S. Census, Community Resiliency Interactive Tool, 2019. <https://www.census.gov/programs-surveys/community-resilience-estimates/data/tools.html>

Hennepin County Public Health, SHAPE 2022, Adult Data Book, Survey of the Health of All the Population and the Environment, Minneapolis, MN, June 5, 2023

Much of the adult health data comes from Hennepin County's 2022 Adult [Survey of the Health of All the Population and the Environment \(SHAPE\) survey](#). SHAPE surveys report on data in ten areas. For North Memorial Health's CHNA, data is reported from three geographic areas including Minneapolis North (Camden and Near North), Northwest suburbs-inner ring (Brooklyn Center, Brooklyn Park, Crystal, New Hope, and Robbinsdale) and Northwest suburbs-outer ring (Champlin, Corcoran, Dayton, Golden Valley, Hanover, Hassan Township, Maple Grove, Medicine Lake, Osseo, Plymouth, and Rogers). For brevity, data from the SHAPE survey will be noted as Minneapolis, Inner Suburbs, and Outer Suburbs.

Maptitude 2024, Caliper Corporation, Inc.

MAPTITUDE 2024 is a commercial GIS product from Caliper Inc. used by North Memorial Health to understand the population of the region we serve. Most Maptitude data is a blend of one-year and five-year American Community Survey (ACS) and U.S. Census data, and their own estimates. Maptitude five-year data estimates currently use 2020 Census and 2022 American Community Survey demographics.

Hospital data comes from North Memorial Health's data systems and is reported for all patients in the year(s) noted.

Minnesota Department of Health and Hennepin County Public Health

Minnesota Department of Health and Hennepin County Public Health also provided data on the health of populations in the consolidated service area. Some examples of data they provided include data on suicides, births, deaths, and immunization status.

Minnesota Student Survey 2022

[The Minnesota Student Survey \(MSS\)](#) is conducted every three years for students in grades 5, 7, 9, and 11. Data on youth in the consolidated service area will be reported separately for Anoka-Hennepin School District and Minneapolis School District (two of Minnesota's largest districts). Data from other school districts in the consolidated service area will be combined and reported on as CSA student data. These districts include Brooklyn Center, Hopkins, Osseo, Robbinsdale, and Wayzata.

Social Vulnerability Index (SVI)

The SVI uses 15 U.S. Census variables to develop an index for government and other non-profit agencies to identify communities that will most likely need support before, during, and after hazardous events including natural disasters or disease outbreaks. Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry/Geospatial Research, Analysis, and Services Program. CDC/ATSDR Social Vulnerability Index 2020 Database, Minnesota. https://www.atsdr.cdc.gov/place-health/php/svi/svi-data-documentation-download.html?CDC_AAref_Val=https://www.atsdr.cdc.gov/placeandhealth/svi/data-documentation_download.html

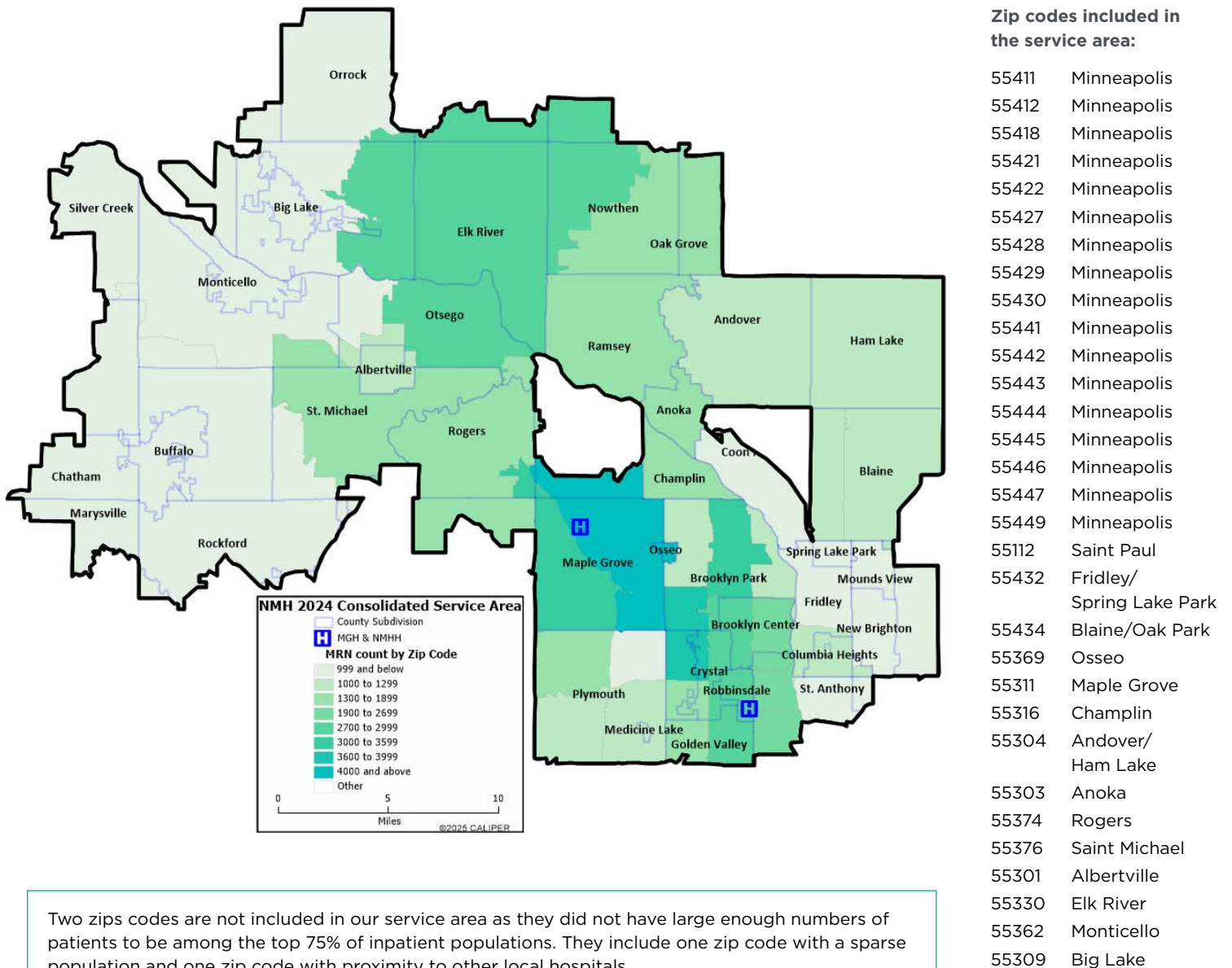
LIMITATIONS

The CHNA utilizes a wide-range of data sources to develop a comprehensive picture about the health of the community North Memorial Health serves. We explored health disparities within our population and sought input from diverse members of our community, as much as possible. There are, however, a number of limitations that impact various data sources, including:

- Time frames varied from data source to data source.
- The geographies of data varied depending on the data source (CSA, county, SHAPE geographic region, school districts).
- Some data sources did not have racial/ethnic data, specific to our CSA, e.g. the Minnesota Student Survey, or group data into larger categories (such as “Black”, “Hispanic”, “Asian”) which do not allow us to distinguish among ethnic groups or nationalities within categories. Many sources do not distinguish between those born in the United States or another country.
- Due to small numbers in either events and/or availability of race and/or ethnicity data in varying geographies, it is difficult to assess some health disparities and variances in rates. In some cases, this CHNA uses number of events to describe the health issue being reported on (e.g. infant deaths, unintentional injuries).
- North – Robbinsdale Hospital and North – Maple Grove Hospital data is based on Epic electronic health records, which only reflects the health of those seeking services from North Memorial Health facilities.
- Qualitative data is reflective of Data Walk participants and their individual experiences, but we recognize such stories and experiences are all part of the larger narrative about the health of our communities. Such data often does not reflect root causes and or provide insight into contributing factors, all important when assessing the health of communities.
- The SHAPE 2022 had a number of limitations including:
 - Low response rate (22.6%) and small sample sizes within categories, e.g. transgender and some race categories, limit the ability to generalize or crosstab data in smaller populations.
 - Respondents with limited English proficiency were under-represented.
 - Survey data was self-reported and is subject to recall bias by participants.
 - Results are subject to respondent self-selection bias and also only generalizable to Hennepin County adults who live in households with a residential address.

CONSOLIDATED SERVICE AREA

The CHNA reports on the health of people who live within the geographic boundaries of North Memorial Health’s consolidated service area. The area selected for data analysis includes the zip codes of the top 75% of North Memorial Health’s inpatient populations (North – Robbinsdale Hospital and North – Maple Grove Hospital) in the year 2023. The service area includes 31 zip codes, 18+ cities, and 7 school districts located partially or fully within the service area. Because the service area has changed from previous CHNAs, direct comparison to past CHNAs is not possible. Our goal is to report on baseline data for the entire consolidated service area as there is significant overlap of patients served by both hospitals. However, there is much variation between zip codes included in the consolidated service area. When possible, data was reviewed by zip codes and smaller geographies which are facing more health issues and/or health disparities.



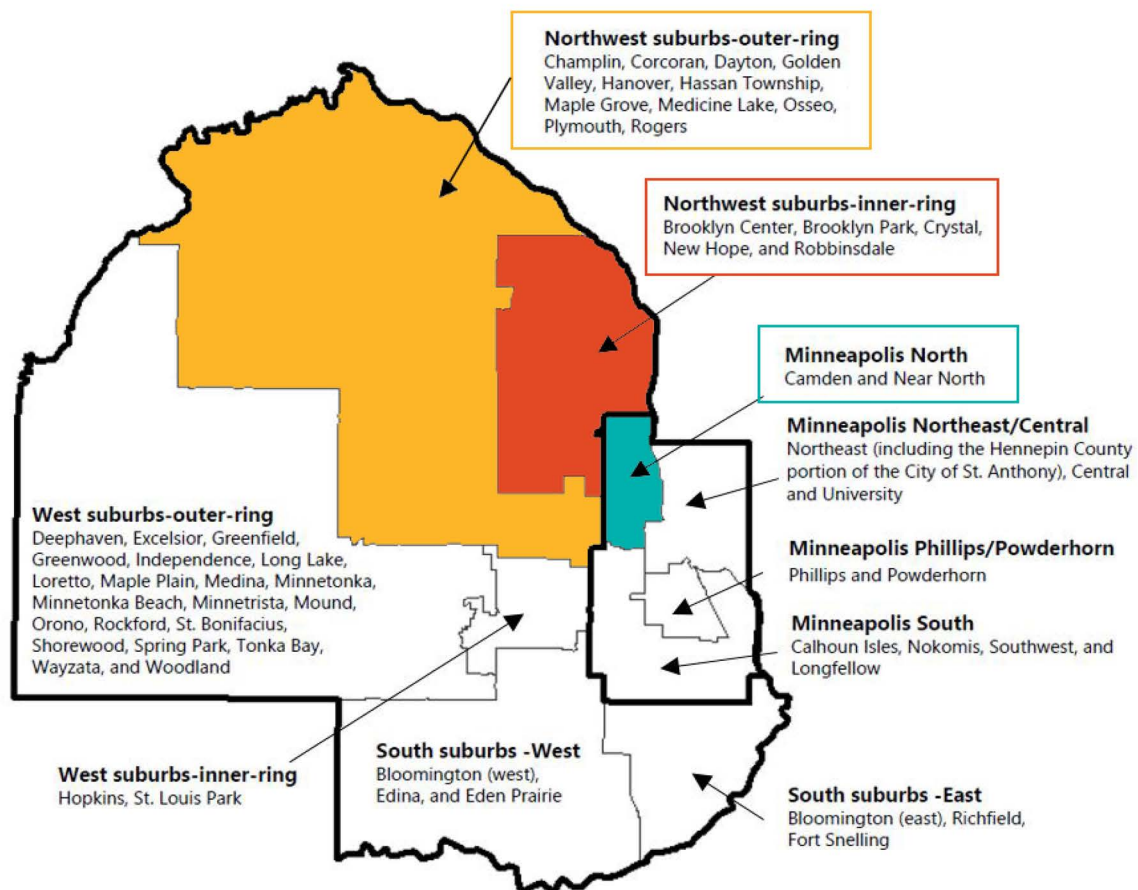
Two zip codes are not included in our service area as they did not have large enough numbers of patients to be among the top 75% of inpatient populations. They include one zip code with a sparse population and one zip code with proximity to other local hospitals.

Regional Reporting Geographies

Throughout the CHNA we report on data from two regional surveys (Hennepin County SHAPE and Minnesota Student Survey). Adult data is reported for three geographic regions including Minneapolis-North, Northwest suburbs-inner ring, and Northwest suburbs-outer ring. These geographies are noted as Minneapolis, Inner Suburbs and Outer Suburbs. Please see the map below for the areas included in this assessment.

Data on youth health comes from the Minnesota Student Survey and is reported on for the Minneapolis School District, Anoka-Hennepin School District, and a Consolidated School Area (CSA) that includes data from Brooklyn Center, Hopkins, Osseo, Robbinsdale, and Wayzata School Districts.

Geographic reporting areas in Hennepin County for the SHAPE 2022 Adult Data Book



Sociodemographic Data

INTRODUCTION

Sociodemographic data is used to describe the population within the consolidated service area. Such data includes demographic information about age, gender, race and ethnicity, income, unemployment, poverty, composition of households, and education levels. Data is reported on for the consolidated service area, with several indicators at the hospital service area, school district levels, or city levels.

Most of the sociodemographic data was not scored by CEAT as it describes population characteristics and not health outcomes. There are some key health indicators which can be changed and have Healthy People 2030 goals, which were included for scoring.

POPULATION

The population of the consolidated service area is 941,487 people. The population consists of 466,407 males and 475,081 females. The total population consists of 25.3% children and youth ages 0-19, 61.3% adults ages 20-64, and 13.4% adults ages 65+. It is estimated that the population will grow to 1,057,662 people by 2030, growing by about 11.3% from 2025 population estimates.

Population	North - MG	North - RH	Consolidated
Male	49.0%	49.7%	49.1%
18+	36.7%	37.4%	36.8%
65+	6.0%	6.1%	6.0%
Female	50.6%	50.2%	50.5%
18+	38.0%	38.0%	37.9%
65+	7.5%	7.5%	7.4%

Age 0-19	27.3%	26.6%	27.4%
Age 20 to 24	5.1%	5.5%	5.2%
Age 25-34	27.5%	29.2%	28.4%
Age 45-64	26.5%	25.1%	25.7%
Age 65+	13.5%	13.6%	13.4%

Source: Maptitude

RACE AND ETHNICITY

The consolidated service area is more racially and ethnically diverse compared to previous CHNAs, even considering a larger service area that includes more suburbs which typically have less diverse populations.

Race/Ethnicity	2012 CHNA NMH	2025 CHNA N-RH	2025 CHNA N-MGH	2025 Consolidated Service Area
White	76.2%	70.8%	75.5%	72.1%
Black	9.6%	13.7%	10.7%	12.8%
Asian and/or Pacific Islander	5.9%	7.2%	6.9%	7.2%
American Indian/Alaska Native/All Other*	3.3%	3.2%	2.2%	2.9%
Hispanic	5.1%	5.8%	4.6%	5.6%
2+ Races	N/A	5.1%	4.6%	5.0%

*To compare to 2012 data, AI/AN plus all other were combined

HOUSEHOLD COMPOSITION

The consolidated service area has 350,700 households. These households include 121,272 (34.6%) with at least one child under age 18 living in the home and 89,529 households (25.5%) with at least one person over age 65 living in the home.

Household Income

The median household income in the service area was \$91,381. Income levels vary widely in the service area from a low median income of \$49,917 in north Minneapolis to a high median income of \$160,416 in Plymouth.

Poverty

In the consolidated service area, 8.3% of all people are below the federal poverty level. This includes 6.1% of all families with 8.7% of families with children under the age of 18. In the North – Robbinsdale Hospital region, these numbers are 7% all people and 10.1% of families, while in the North – Maple Grove Hospital region the percentages are 4.5% of all people and 6.7% of all families. The U.S. Health and Human Services sets the federal poverty level (FPL) for all contiguous 48 states, Puerto Rico, the District of Columbia, and all U.S. territories. In the lower 48 states the 2022 FPL was set at \$13,590 for a household of 1; \$18,310 for a household of 2; \$23,030 for a household of 3; and \$27,750 for a household of 4. The data shows that poverty is more common among certain groups, particularly female head-of-households with children. Single parent families make up 12.5% (44,000 households or one in eight) in North Memorial Health’s consolidated service area. Nine zip codes in our CSA have poverty rates above 10%, they include 55411, 55412, 55418, 55421, 55428, 55429, 55430, 55432, and 55443.

ALICE Report for our region

The United Way of Minnesota publishes an annual ALICE Report. ALICE stands for Asset Limited, Income Constrained, Employed — households that earn above the Federal Poverty Level but cannot afford the basic cost of living in their county. Despite struggling to make ends meet, ALICE households often do not qualify for public assistance. The numbers below include households in poverty and ALICE households combined who do not have enough income to cover basic household costs.

City	Total households	% below ALICE threshold
Brooklyn Center	11,294	43%
Brooklyn Park	29,603	38%
Crystal	9381	36%
Dayton	2744	20%
Maple Grove	57,106	22%
Minneapolis	185,674	43%
New Hope	9120	46%
Plymouth	32,727	23%
Robbinsdale	6480	39%

The HP2030 goal is to reduce the portion of people living in poverty to 8.0%. We are not meeting this goal for many people in the area and for families with children in the Robbinsdale region.

We are meeting this goal in the Maple Grove region.

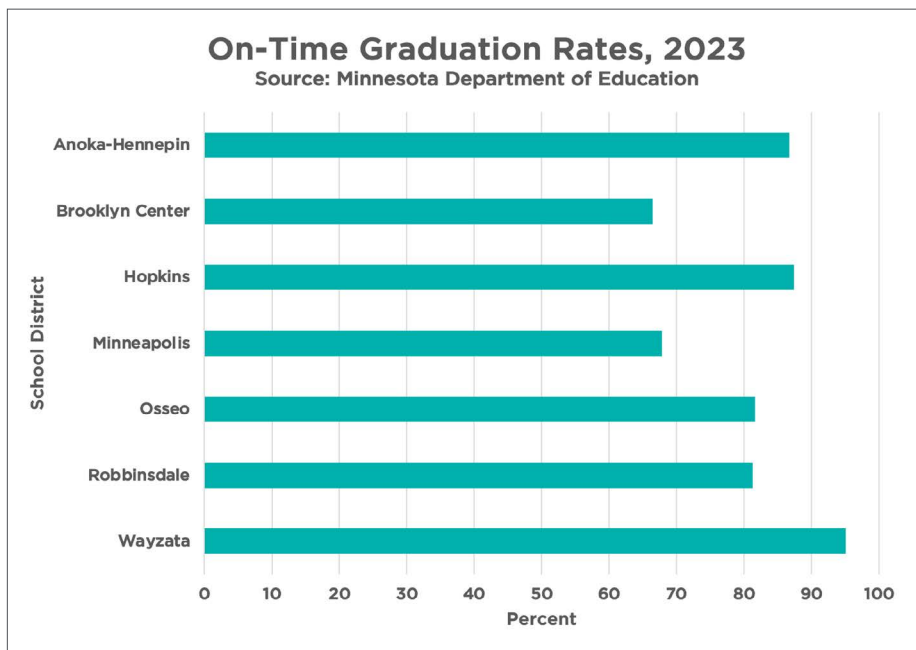
Unemployment

The latest unemployment data for the service area showed the unemployment rate to be 3.6% for all civilians age 19+ who are in the labor force. There are disparities in unemployment rates by zip code with zip codes 55411 and 55412 (Minneapolis), 55429 (Brooklyn Center) and 55434 (Blaine) having unemployment rates above 5%.

We are meeting the HP2030 goal of 75% of working-age people, ages 16-64, to be employed.

Graduation Rates by School District

The chart below shows on-time (4-year) graduation rate for public high schools in the service area. We defer to Hennepin County data for on-time graduation rates by race and gender. There are many graduation rate disparities by race throughout Minnesota. In 2020, the Minnesota Department of Education set a goal to reach a four-year adjusted cohort graduation rate of 90% with no student group below 85%.



The HP2030 goal is that 90.7% of students graduate on time. The Wayzata School District is the only district in our region meeting this goal.

Adult Education Level

Most (94.6%) adults age 25 or over in the service area have graduated from high school or earned a high school graduation equivalency. Of these, 27.7% also have a bachelor's degree or higher.

COMMUNITY RESILIENCY ESTIMATES (CRE)

Community resilience is the capacity of individuals and households within a community to absorb, endure, and recover from the impacts of a disaster. The Community Resilience Estimates (CRE) are experimental estimates that create aggregate scores from 10 social and economic risk factors at the census tract level. The U.S. Census uses this measure as a proxy to identify neighborhoods at higher risk of poor health outcomes and inequity to achieve an average standard of health. Risk factors included in the CRE are:

- Income to Poverty Ratio
- Single or Zero Caregiver Household
- Crowding
- Communication Barrier
- Households Without Full-Time, Year-Round Employment
- Disability
- No Health Insurance
- Age 65+
- No Vehicle Access
- No Broadband Internet Access

SOCIAL VULNERABILITY INDEX (SVI)

The CDC/ATSDR's Social Vulnerability Index (SVI) uses 15 U.S. Census variables to help government and other non-profit agencies identify communities that may need support before, during, or after disasters. Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss.

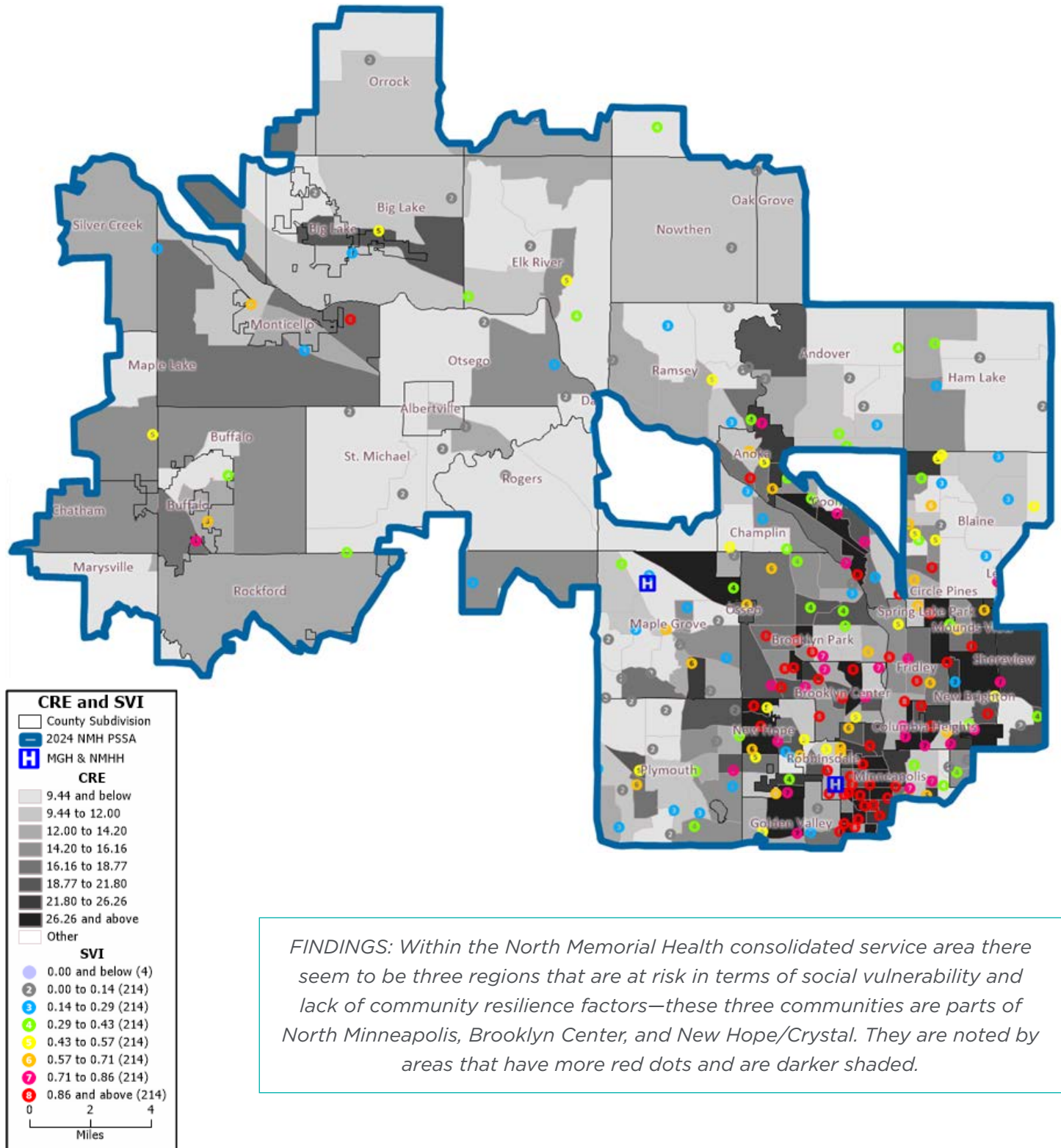
The Social Vulnerability Index uses metrics in four areas to show percentile of scores against one another. The four areas are socioeconomic status, household composition and disability, minority status and language, and housing type and transportation. The variables used in each of the four areas are shown in the Overall Vulnerability chart.

When SVI is added to the North Memorial Health consolidated service area map, it is easy to see the highest scores overlap the CRE on various census tracts.

Overall Vulnerability

Socioeconomic Status	Below poverty
	Unemployed
	Income
	No high school diploma
Household Composition & Disability	Age 65 or older
	Age 17 or younger
	Civilian with a disability
	Single-parent households
Minority Status & Language	Minority
	Speaks English "Less than well"
Housing Type & Transportation	Multi-Unit structures
	Mobile homes
	Crowding
	No vehicle
	Group quarters

North Memorial Health Service Area: Zoomed-in perspective of both CRE and SVI



FINDINGS: Within the North Memorial Health consolidated service area there seem to be three regions that are at risk in terms of social vulnerability and lack of community resilience factors—these three communities are parts of North Minneapolis, Brooklyn Center, and New Hope/Crystal. They are noted by areas that have more red dots and are darker shaded.

Basic Needs

INTRODUCTION

This section focuses on the basic needs everyone requires to be healthy, which includes access to affordable housing and food. Additional key indicators, such as nutrition and child health data, are explored in the Maternal and Child Health section, but are reported below in the overall Child Opportunity Index (COI) score as a metric of basic needs.

More Details About the Child Opportunity Index

The Child Opportunity Index (COI) is published by diversitydatakids.org housed at The Heller School for Social Policy and Management at Brandeis University. Developed in 2014, in collaboration with the Kirwan Institute for the Study of Race and Ethnicity at Ohio State University, the COI measures and maps the quality of resources and conditions that matter for children to develop in healthy ways in the neighborhoods where they live. The COI is also a tool intended to spark conversations about unequal access to opportunity and to spur actions to increase equity. The data is based on diversitydatakids core question on whether all children—regardless of where they live or their race and ethnicity—have a fair chance of experiencing neighborhood conditions that help them thrive. The COI for the zip codes in the North Memorial Health service area vary, however, most zip codes are rated to have high and very high overall COI scores. The zip codes with COI scores that are very low are 55411, 55412, 55428, 55429, 55430, 55421, and 55432.

HOUSING COSTS

One way to measure housing costs is to calculate gross rent or mortgage payments as a percent of a household's income. In the consolidated service area, 25.1% of the population is spending greater than 30% of their income on gross rent or mortgages, ranging from 23.75% in the North - Maple Grove Hospital area to 26.3% in the North - Robbinsdale Hospital area.

In 2017-2021, in Hennepin County, there were 118,105 (56.7%) households with children spending more than 30% of their income on housing (renters and homeowners). Of these, 19,109 (8.2%) spend more than 50% of their income on their mortgage (Source: *Kids Count*).

The HP2030 goal is to reduce the proportion of families spending greater than 30% of their income on housing to 25.5%.

We are meeting that goal.

Unhoused Adults and Youth

The Minnesota Student Survey asked youth if they had experienced homelessness in the past month. In our region, 3.4% of 9th graders in the consolidated school districts, 5.4% of 9th graders in Anoka-Hennepin School District, and 4.3% of 9th graders in the Minneapolis School District had experienced homelessness. According to the McKinney Vento federal definition, “homeless children and youths” are individuals who lack a fixed, regular, and adequate nighttime residence. There are 6.5% of all children and youth in our consolidated service area that meet this definition.

The 2022 SHAPE asked adults if they had stayed in someone else's house, shelter, outside or someplace not intended as a place to live in the past year. While many respondents answered never (95% Inner Suburbs, and 98.4% Outer Suburbs), only 83.5% of Minneapolis residents responded never.

FOOD SECURITY

Adult

Having access to and the ability to purchase food is an important component to health and well-being. When asked if they worried in the past 12 months if food would run out before they had money to buy more, 29.8% of Minneapolis residents reported they often or sometimes worried, which compares to 14.7% Inner Suburb residents and 4.6% Outer Suburb residents. These rates are lower than in 2018.

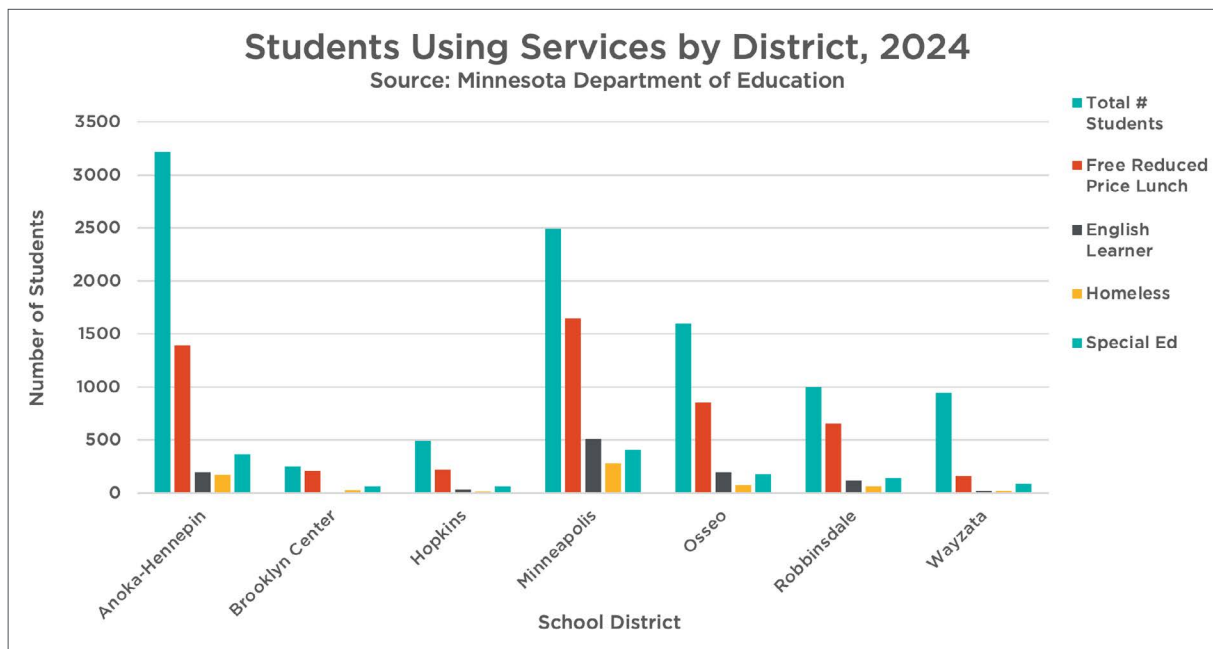
Youth

The Minnesota Student Survey asked a new question in 2022 called Food EcoDistress. They asked students if they had experienced food insecurity in the past 30 days. Among 9th grade responses, 20.7% of Minneapolis students had, 3.7% of Anoka-Hennepin students had, and 2.6% of students in the consolidated school districts had.

The HP2030 goal is that only 6% of households are food insecure.

We are only meeting this goal in the Outer Suburbs and not in many households with children in them.

A little more than half (51.5%) of students in the consolidated service area get free or reduced-price lunch (FRPL) at school. The Minneapolis School District has the most students utilizing the FRPL program, followed by Anoka-Hennepin, with Osseo and Robbinsdale also having large percentages of students accessing the program. Students utilizing the FRPL program are often used as a proxy for students who experience food insecurity.



Kids Count also notes that in Hennepin County in 2022 there were 534,186 households that visited food shelves, this compares to 382,544 in 2019, a 39.6% increase. This is a non-unique number, meaning that some households are counted more than once. The average number of children receiving supplemental nutrition assistance program (SNAP) benefits per month was 33,458 in 2022, down from 44,178 in 2021. This does not necessarily mean food insecurity has decreased as it might be due to eligibility criteria changes or SNAP resource changes.

General Health

INTRODUCTION

The term “general health” refers to the health status of the population as a whole. It can be assessed by analyzing health outcomes of the population including birth, death, and disability rates. Death is examined by looking at ages of death, leading causes of death, and death in relation to years of potential life lost (YPLL). The population’s self-reported general health status is also examined.

BIRTHS

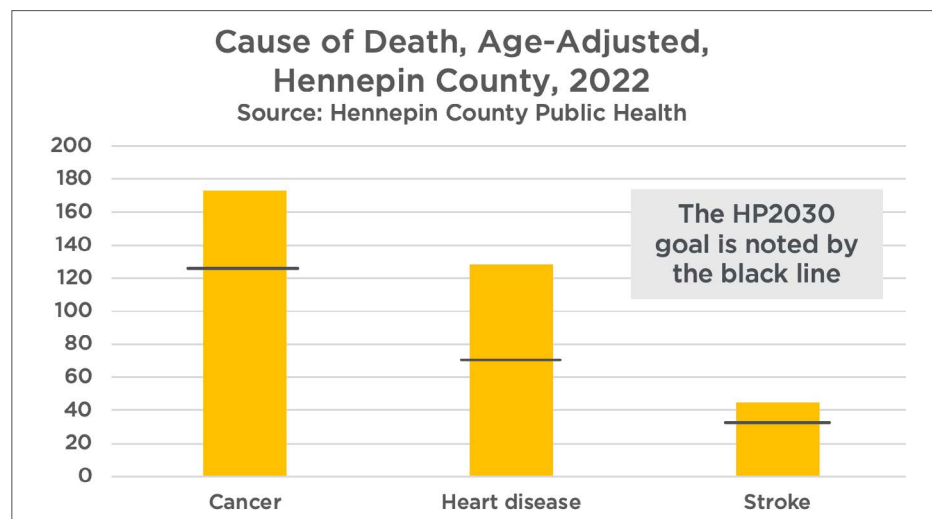
In 2023 there were 5,011 births in the North Memorial Health consolidated service area. Three out of four births were to women who lived in ten zip codes: 55369 (Osseo), 55446 (Plymouth), 55443, 55429, and 55428 (Brooklyn Center, Brooklyn Park, Crystal), 55311 (Maple Grove), 55422 (Robbinsdale), 55430 (Minneapolis, Brooklyn Center, Brooklyn Park), 55427 (Golden Valley, New Hope, Crystal), and 55316 (Champlin). (Provisional data, provided by Hennepin County Public Health).

DEATHS

By Age

In 2021, there were 9,813 deaths in the zip codes included in the CSA, compared to 8,987 deaths in 2019. COVID-19 was probably a confounding factor in the increased rates of death. The following charts note deaths by age as well as leading causes of death in the consolidated service area zip codes. Almost 1 in 3 (30.4%) deaths were people less than 65 years old.

Ages	# of deaths
0-4	91
5-14	20
15-24	133
25-34	281
35-44	377
45-54	853
55-64	1,229
65-74	1,818
75-84	2,181
85+	3,148
Total	9,813



*The HP2030 goal for cancer death rates is 122.7 per 100,000.
The HP2030 goal for heart disease death rates is 71.1 per 100,000.
The HP2030 goal for stroke death rates is 33.4 per 100,000.*

We are not meeting any of these.

Cause of Death by Number and Years of Potential Life Lost

Years of potential life lost is a summary measure of premature mortality, providing an explicit way of weighting deaths occurring at younger ages, which may be preventable. The calculation of Years of Potential Life Lost (YPLL) involved summing up deaths occurring at each age and multiplying this with the number of remaining years to live up to a selected age limit. Our leading causes of death that have the highest impact on YPLL are cancer, heart disease, unintentional injuries, Alzheimer's disease, stroke (cerebrovascular disease), and chronic lower respiratory disease.

There are many disparities in cause of death but race/ethnicity is a factor that seems to be correlated to higher numbers of years of potential life lost.

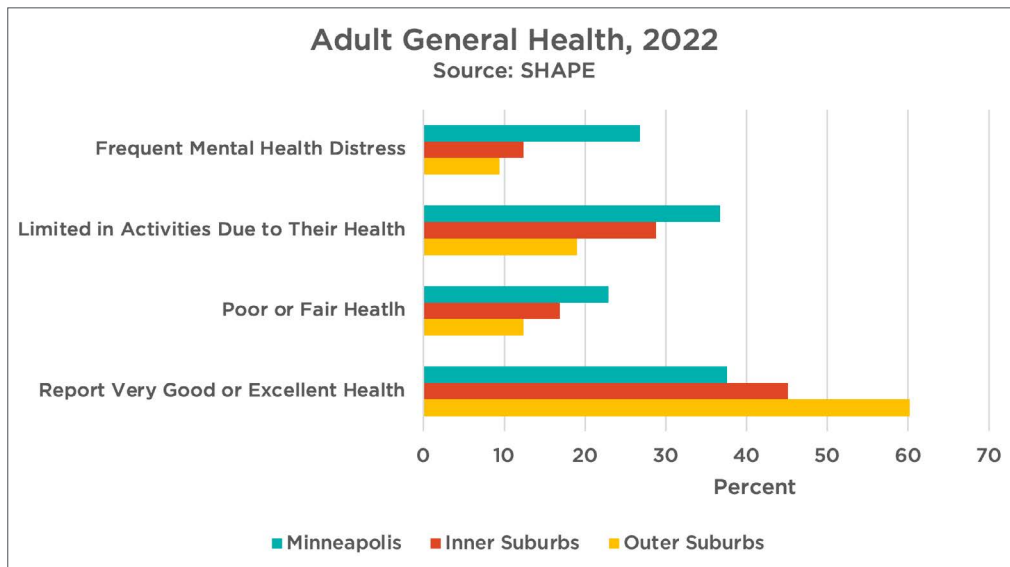
Years of Potential Life Lost (Age 65) by Race/Ethnicity Hennepin County Residents, 2021

Source: Hennepin County Public Health

Race/Ethnicity	# of deaths	Average Years Potential Life Lost
American Indian/Alaska Native	138	14.3
Asian/Pacific Islander	348	6.4
Black/African American	1144	12.0
White	7811	2.7
Hispanic	173	16.6
Other (Non-Hispanic)	12	15.9
Two or More (Non-Hispanic)	89	18.9
Unknown/Missing	98	13.7
Total	9,813	4.6

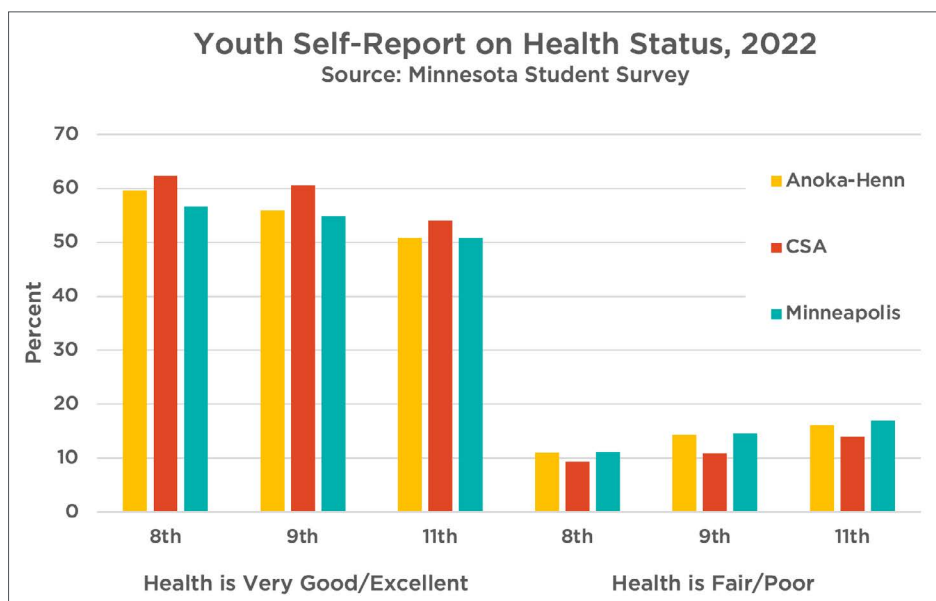
ADULT SELF-REPORT ON HEALTH

Overall, more adults are reporting better health when compared to SHAPE data from 2019. We are noting this in those who report their health is very good or excellent, and fewer adults who are limited in their activities due to their health. In Minneapolis we see higher rates of people reporting poor/fair health, limitations in their activities due to their health, and experiencing frequent mental health distress. There are disparities in persons who identify as American Indian/Alaska Native, SE Asian, Hispanic, Black-US born, transgender, low-income, have a HS degree or less, speak a language other than English at home, economically distressed, and/or mental health distressed.



YOUTH SELF-REPORT ON HEALTH

Among youth, the data is fairly consistent across school districts. Almost 60% of our 8th graders report being in very good or excellent health, however, this number falls to about 50% of 11th graders.



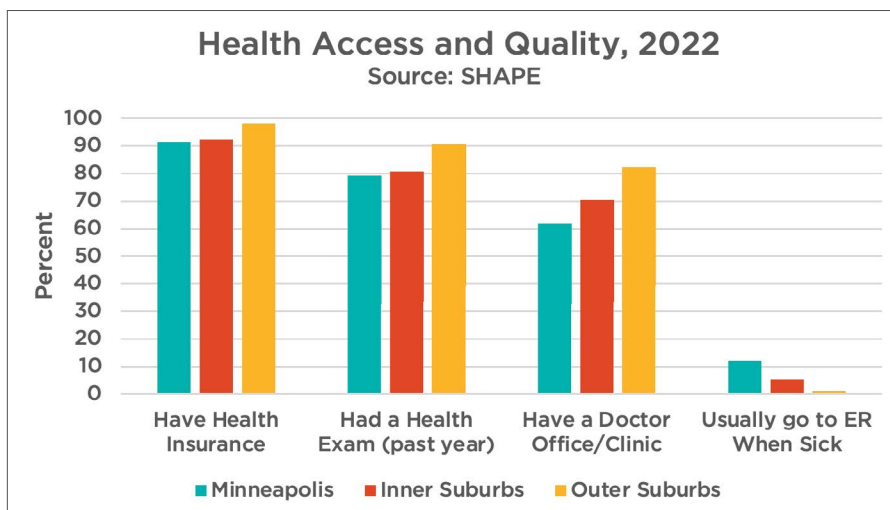
Health Access and Quality

INTRODUCTION

Access to comprehensive, quality health care services is key to achieving health equity and for increasing the quality of life for everyone. Insurance coverage and having access to care can influence an individual's overall physical, mental, and social health, prevention of disease and disability, identification and treatment of health conditions, preventable death, life expectancy, and quality of life.

Health Insurance Status

While the majority of respondents in our region have health insurance, there are differences by region from a high of 98% in the Outer Suburbs to a low of 91% in North Minneapolis. There are disparities by ethnicity (38.8% of SHAPE respondents who are uninsured are Hispanic), Black-Foreign born, persons who identify as transgender, HS/GED education or less, economically distressed, mental health distressed, or speak a language other than English in the home.



We are meeting the HP2030 goal of 92.1% of the population having health insurance in the Outer Suburbs and are very close in the other regions.

Health Exam in the Past Year

Throughout the CSA, most adults (between 79-91%) had a health exam in the year prior to 2022. Ideally, all adults would have an exam on an annual basis. Such exams enable primary care physicians (PCPs) to order age-appropriate health screenings and vaccinations, diagnose or track health conditions such as hypertension and diabetes, and offer prevention and wellness resources. We are reporting on data that was collected during the COVID-19 pandemic. Due to COVID-19, many people put off their annual health exam and health screenings.

There were disparate populations who did not have a health exam in the year before the SHAPE survey, including adults who identify as Hispanic, SE Asian, and Black-Foreign born. Additionally, the data shows higher percentages of individuals who are younger than 44 years and/or do not have a high school education, did not have a health exam in the past year.

Have a Doctor's Office or Health Clinic

It is important to have a doctor's office or health clinic to go to when a person needs care. They usually get treated earlier, recover faster, and have better health outcomes. Having a primary care physician (PCP) is important for maintaining health and preventing chronic diseases. PCPs can develop long-term relationships with patients and coordinate care across health care providers. When an individual has a PCP, they are more likely to receive recommended health screenings, vaccinations, and their doctor or clinic knows their medical history and status.

HP2030 has a baseline goal that 84% of the population has a primary healthcare provider. In the CSA we are not reaching this goal.

According to SHAPE, the majority of adults in the region have a doctor's office or health clinic to go to when they need care. It varies by region, ranging from a high of 82.4% in the Outer Suburbs to a low of 61.7% in Minneapolis. There are disparities in people who identify as American Indian/Alaska Native, SE Asian, Black-US born, Hispanic, low-income, HS/GED or less, and/or economically distressed.

Use of Emergency Rooms when Sick or Need Care

For people who do not have a primary care physician, the emergency room is often where they go when sick, 12% of Minneapolis adults participating in SHAPE reported going to the ER when they are sick or need care. This compares to 1.2% of Outer Suburb adults who go to the ER when they are sick or need care.

Emergency rooms are vitally important for providing care in case of emergencies and when other care is not available. Individuals often use emergency rooms for care, especially if they lack insurance or do not have an established primary care provider. The data shows that lower percentages of adults living in Minneapolis have a usual source of care and also have higher rates of utilization of emergency rooms.

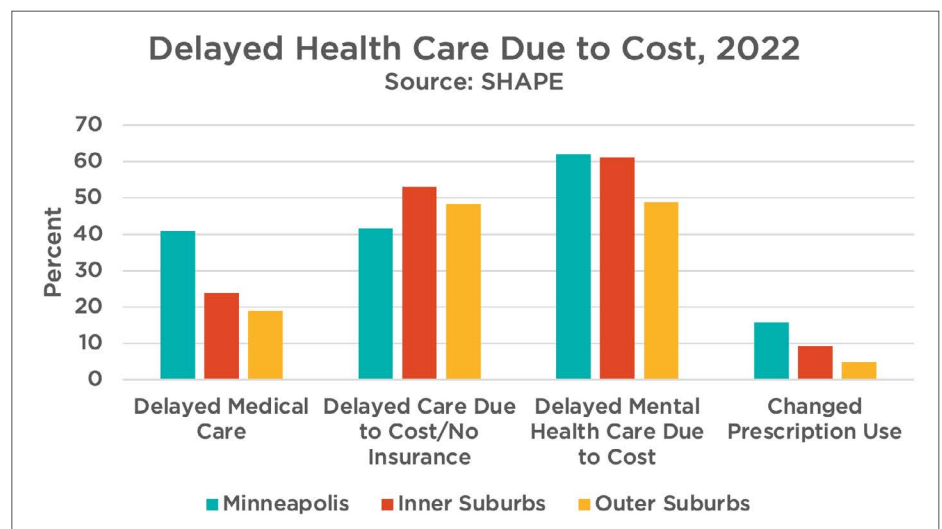
Additionally, using the emergency room when sick or needing care was reported by higher percentages of persons who identify as American Indian/Alaska Native, Black-US born, Hispanic, low-income, have a HS/GED or less, and are economically distressed.

DELAYED CARE

This section includes data on persons who delayed care due to the cost of care and/or lack of health insurance. This chart notes four key health indicators in which people delayed getting care for a medical or mental health condition.

Delayed Medical Care Due to Cost

The majority of adults who delayed getting medical care (ranging from 19-41%) reported it was due to cost



or lack of insurance. Rates of delaying care due to cost were high in all regions including Minneapolis (42%), and the Inner Suburbs (53%), and the Outer Suburbs (48%).

The population reporting this most frequently were adults ages 18-64, Hispanic, Asian, and economically distressed. Disparities were also noted in populations who identify as non-binary, transgender, and/or LGBTQ+.

Delayed Care for a Mental Health Concern

SHAPE asks adults whether they had delayed seeking care for stress/depression/problem with emotions/excessive worrying/troubling thoughts due to the cost of such care or lack of insurance. In 2022, between 29-47% adults wanted to seek help for a mental health concern. Of those, more than half (49-62%) reported they had delayed or not received such care due to cost.

Delaying care for a mental health concern was reported by higher percentages of individuals who identify as adults ages 18-44, Hispanic, SE Asian, non-binary, transgender, and/or LGBTQ+.

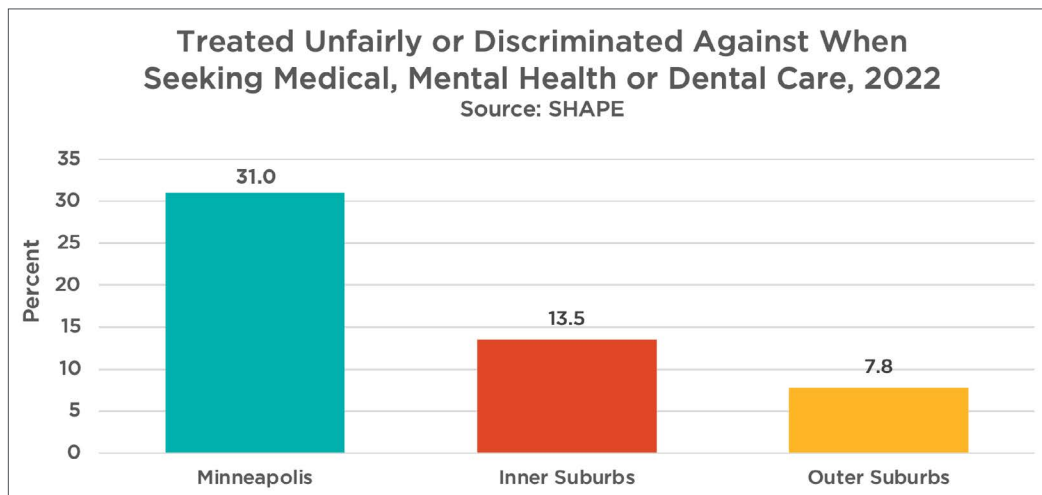
Adults who Changed Prescription Use Due to Cost

Sixteen percent (16%) in the Minneapolis region reported skipping doses of a prescription, taking smaller amounts, or not filling a prescription due to cost. This compares to 9% in the Inner Suburbs and 5% in the Outer Suburbs.

Populations most at risk for not taking their prescriptions as prescribed due to cost include adults who identify as Hispanic, American Indian/Alaska Native, Black-US born, or experience economic distress.

Adults who Report Treated Unfairly or Discriminated Against when Seeking Care

A number of adults reported being treated unfairly or discriminated against when they sought health care. This includes 31% of adults in Minneapolis, 13.5% of adults in the Inner Suburbs and 7.8% of adults in the Outer Suburbs. There are many disparities noted by respondents including those who are American Indian/Alaska Native, Hispanic, Black, transgender, low-income, economically distressed, HS/GED or less than a college degree, speak a language other than English in the home, and/or report frequent mental distress.



Chronic Disease

INTRODUCTION

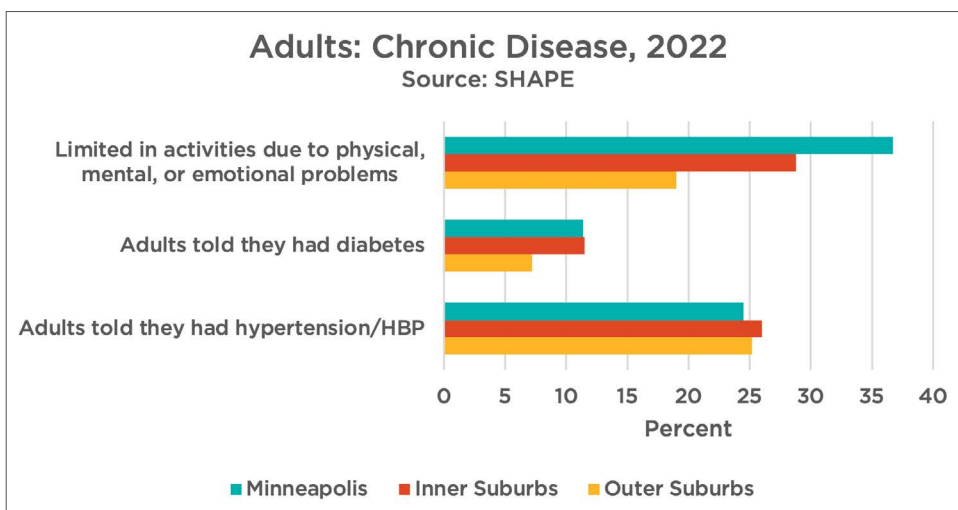
Chronic diseases are conditions that can be controlled but not cured. These include conditions like asthma, diabetes, and heart disease. Lifestyle factors such as diet, physical activity levels, and smoking can all impact chronic conditions. Early intervention is vital in treating chronic disease successfully. Timely screenings such as colonoscopies, mammograms and pap tests are necessary to keep populations healthy and be able to detect and treat cancer and other diseases at early stages.

Since our last CHNA, we have initiated several strategies to increase mammograms among Black women who live within 8 miles of our Robbinsdale Breast Center. In 2024, we identified 420 Black women in the service area of our Robbinsdale Hospital who were overdue for breast cancer screenings (BCS). To address this, we hired a Community Health Worker (CHW) with the goal of engaging these women in their care and increasing screening rates. By May 2025, 195 women had been screened, 7 needed further tests, and four were diagnosed with breast cancer and referred to our cancer center for treatment. The project’s success can be directly attributed to the efforts of our CHW, also a Black woman, to connect with patients within their own community. She has established relationships in local schools, salons, and more. Through these conversations and focus groups with patients and staff, we have identified key barriers to care and opportunities for improvement at all phases of the breast cancer journey—screening, diagnosis, treatment, and recovery. We also have increased outreach and education at local health fairs and other events focused on the importance of breast cancer screenings, reaching more than 1,200 people in 2024.

CHRONIC DISEASE RATES AMONG ADULTS

Adults with Hypertension or High Blood Pressure (HBP)

High blood pressure, or hypertension, is a fairly common disease, with 29.9% of U.S. residents reporting in 2017 that a doctor had, at some point in their lives, told them that they had high blood pressure. Our rates are similar ranging from 25.2% in the Outer Suburbs to 26% in the Inner Suburbs to 24.5% in Minneapolis. There are disparities in hypertension rates in adults that are over age 65, identify as American Indian/Alaska Native, Black-US born, low-income, and low education levels.



The HP2030 goal for HBP is that less than 27.7% of adults have hypertension. We are meeting this goal in all regions.

Adults with Diabetes

Adults diagnosed with diabetes are at an increased risk of early death. Complications like heart disease and kidney disease are among the leading causes of death in people with diabetes. Improving diabetes treatments can help reduce the risk of these complications and lower the death rate in people with diabetes.

Adult rates in our region range from low of 7.2% in the Outer Suburbs to a high of 11.5% in the Inner Suburbs. Disparities exist in adults over age 65, Black-US born, American Indian/Alaska Native, low-income, and/or lower education levels.

The HP2030 goal is to reduce deaths from diabetes (per 100,000, age-adjusted) to 66.6. We are meeting the HP2030 goal.

Adults Limited in Activities Due to Their Health

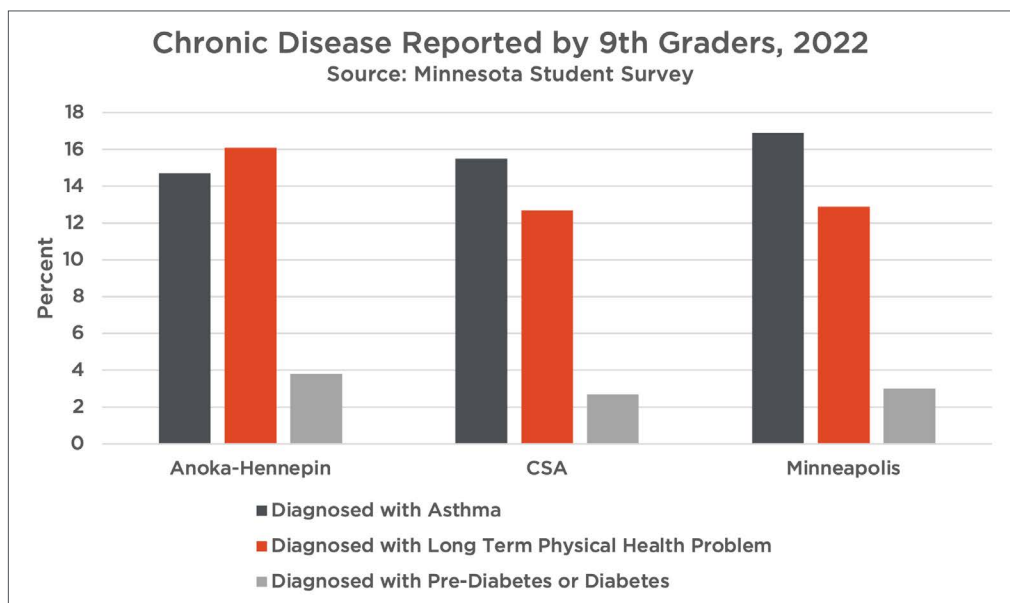
Activity limitation refers to a long-term reduction in a person’s ability to perform their usual activities, including caring for themselves, working, remembering, or any other activity that a person cannot participate in because of a physical, mental, or emotional problem. Adults reporting that they are limited in activities include 37% of Minneapolis adults, 29% of Inner Suburb adults, and 19% of Outer Suburb adults. There are disparities in persons over age 65, American Indian/Alaska Native, Black-US born, non-binary, transgender, LGBTQ+, low-income, have less than a college degree, experience economic distress, and/or frequent mental distress.

CHRONIC DISEASE RATES AMONG YOUTH

Youth With Chronic Health Conditions

Between 13% and 16% of youth report they have a long-term physical health condition such as asthma, diabetes, or cancer. Youth who have been diagnosed with pre-diabetes or diabetes ranges between 2.7-3.8% in all our school districts.

Asthma is a leading chronic disease among children, accounting for many lost days at school and numerous visits to the hospital. It can be triggered by allergens (dust, pollen, mold), cigarette smoking, air pollution, including that from wildfires, weather changes, exercise, and infections, like a cold or flu. The percentages of youth who report they have been diagnosed with asthma are fairly similar throughout our school districts ranging from 14.7% to 16.9%.



Physical Activity and Nutrition

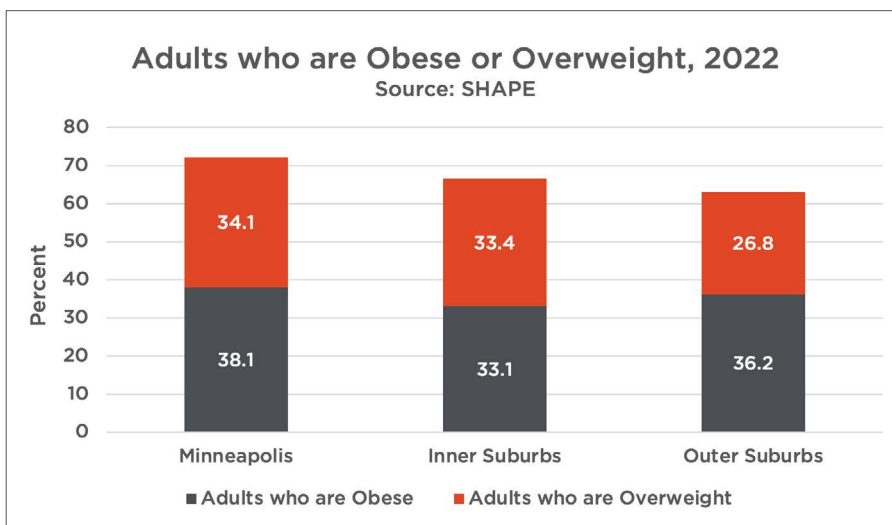
INTRODUCTION

Physical activity, combined with a diet rich in fruits and vegetables, are known to prevent chronic disease. Maintaining a healthy weight, promoting healthy habits, and collaborating with partners to create policies and communities that make healthy choices a way of life is key to community health improvement. It is the mission of North Memorial Health to empower our patients to achieve their best health. Encouraging healthy behaviors, such as increasing physical activity and healthy eating, are two ways to help accomplish that goal.

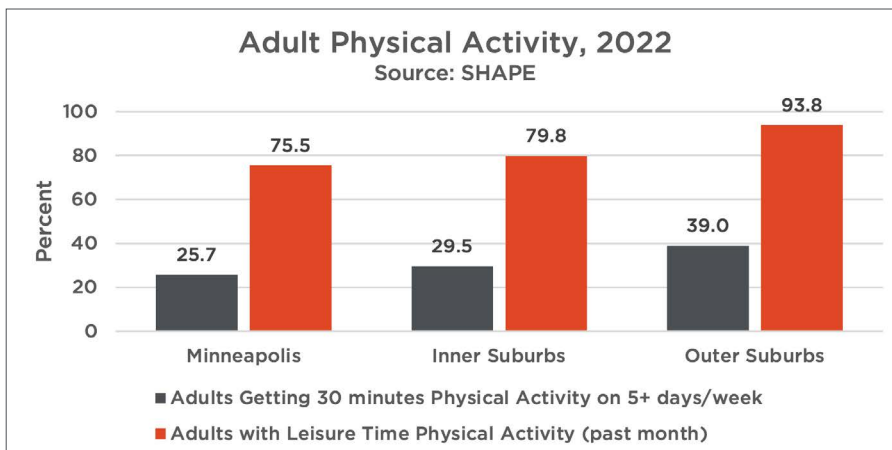
ADULT WEIGHT AND PHYSICAL ACTIVITY

Adults Who are Obese or Overweight

Height and weight are self-reported in the SHAPE survey. The percentage of adults who are overweight or obese ranges from a low of 59.9% in the Outer Suburbs to a high of 72.2% in Minneapolis. There are disparities in populations who are older, identify as Black, American Indian/Alaska Native, Hispanic, transgender, low-income, economically distressed, and/or have a HS/GED or less.



We are meeting the HP2030 goal in both the Inner and Outer Suburbs, which is for less than 36% of adults to be obese. We are not meeting this goal in Minneapolis.



While not an exact match, HP2030 has a goal of increasing the proportion of adults who do enough aerobic and muscle-strengthening activity to 28.4%. We are not meeting this goal in Minneapolis.

Adults Not Participating in Leisure Physical Activity

SHAPE asks adults whether they had participated in any physical activity or exercise in the past 30 days such as walking, running, gardening, sports, or other types of exercise. Our rates of adults *not* participating in any physical leisure time activities are low, ranging from 6.2% in the Outer Suburbs to 24.5% of adults in Minneapolis. There are disparities in American Indian/Alaska Native, Hispanic, Black, low-income, less than college degree, economically distressed, and/or mental health distressed.

Adults Not Meeting Moderate or Vigorous Physical Activity

Adults need a mix of activities to stay healthy. SHAPE asks adults how many days in the average week do they get at least 30 minutes of physical activity or exercise. It is recommended that adults get at least 150 minutes per week of heart-pumping exercise. Our rates show between 26%-40% of adults are meeting this goal.

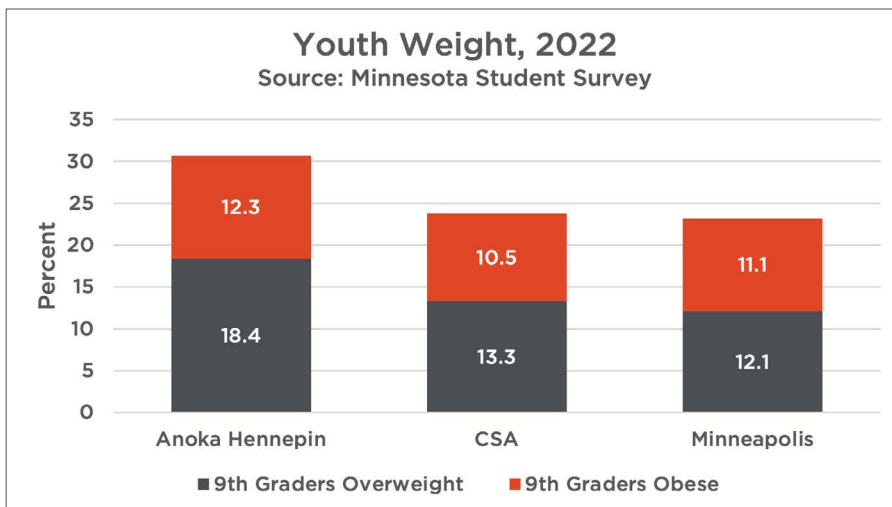
Adults report in SHAPE on whether they engaged in moderate leisure time physical activity (causes light sweating or a slight increase in breathing or heart rate) 0-7 days per week or engaged in vigorous leisure time activity (causes heavy sweating or a large increase in breathing or heart rate) 0-7 days per week.

There are disparities in levels of physical activity in adults who identify as ages 18-44, non-binary, transgender, LGBTQ+, Hispanic, Black, SE Asian, low-income, have less than a HS/GED, are economically distressed, and/or have frequent mental distress.

YOUTH WEIGHT AND PHYSICAL ACTIVITY

Percent of 9th Graders Classified as Overweight or Obese

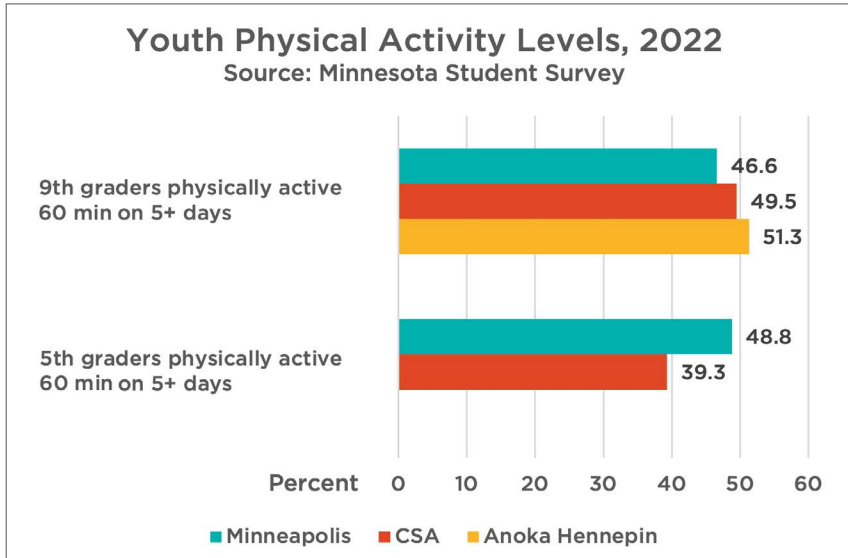
Between 23-31% of 9th grade youth were classified as overweight or obese. All of our school districts are meeting the HP2030 goal with obesity rates ranging from 10.5-12.3%.



The HP2030 goal is to reduce the proportion of children and adolescents with obesity to 15.5%. We are meeting this goal.

Youth Physical Activity Levels

Children and youth need at least 60 minutes of physical activity a day. Physical activity improves heart, muscle, bone, and mental health in children. Strategies at the community and family level — and in schools and childcare centers — can promote physical activity in children and youth.



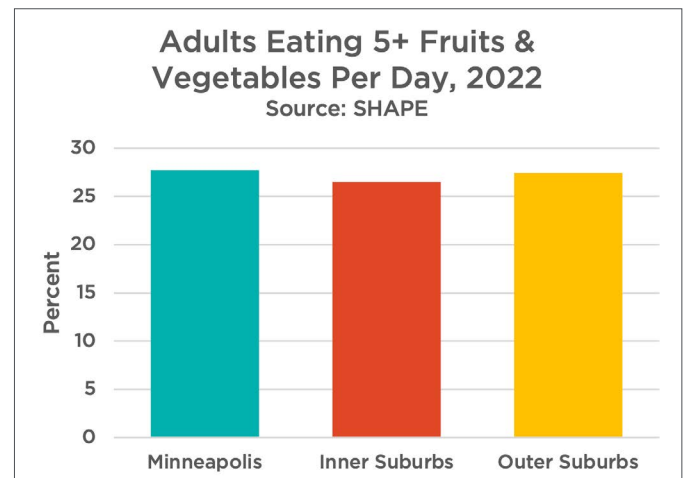
*HP2030 has a goal to increase the proportion of children who meet the current aerobic physical activity guidelines to 30.4%.
Our youth are meeting this goal.*

Due to varying data, the chart above notes the physical activity levels of some 5th graders (Anoka-Hennepin and the CSA) and 9th graders (Anoka-Hennepin, Minneapolis, CSA). The data show youth who were physically active for 60 minutes or more on at least 5 days in the last week. The CSA data shows that persons who identify as male were more physically active than persons who identify as female (54.2% versus 42.4%).

NUTRITION

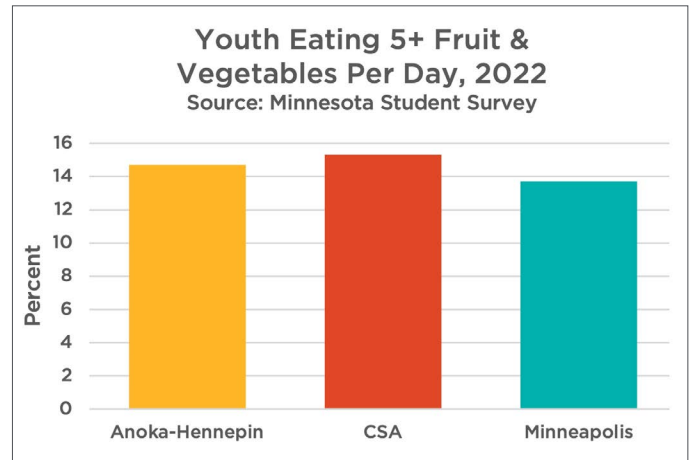
Adult Consumption of Fruits and Vegetables

Adult consumption of 5 servings or more a day of fruit and vegetables is similar throughout the CSA. Adults who identify as non-binary, transgender, low-income, economically distressed, and/or have frequent mental health distress eat less fruits and vegetables. There are racial disparities in American Indian/Alaska Native, Hispanic, Black-Foreign-born, and SE Asian.



Youth Consumption of Fruits and Vegetables

Fruit and vegetable consumption are recommended as key parts of a healthy diet and are linked to lower risks for many diseases. Most people in the United States do not eat enough recommended servings of fruit or vegetables. The chart shows the small percentages of youth who are eating the recommended 5+ fruits and vegetables a day. Evidence suggests that nutrition counseling, school and workplace-based programs and policies can help people eat more fruit and vegetables.



Communicable Disease

INTRODUCTION

Many people in the United States get sick and die from communicable diseases each year. A communicable disease is spread from one person (or other source) to another person through a variety of ways that include contact with blood and bodily fluids, breathing in an airborne virus, eating food or drinking water that is contaminated, or being bitten by an animal or insect. Some examples of communicable diseases include influenza, measles, hepatitis A, B and C, E-coli, salmonella, and other food-borne illnesses.

Minnesota law mandates that healthcare providers and laboratories report over 87 diseases or conditions to their local health department. Health departments can then rapidly deploy strategies to reduce the spread of the disease such as identifying the source of outbreaks, initiating interventions such as immunization clinics or quarantine programs, and alerting the public to seek medical care if they show symptoms of the disease so they can be diagnosed and treated quicker, increasing the likelihood of successful treatment.

Recent years have seen increases in various communicable diseases including COVID-19, infections like *C. diff* (*Clostridioides difficile*) and MRSA (Methicillin-resistant *Staphylococcus aureus*), and sexually transmitted infections. Many communicable diseases are preventable through vaccination and other prevention strategies. Some diseases, such as hepatitis C, cannot be prevented by vaccines but early diagnosis and treatment can help improve health outcomes. In 2022 there were 265 newly diagnosed cases of hepatitis C in Hennepin County, bringing the total to 9272 persons living with hepatitis C in the county.

It is important that children and at-risk adults get vaccinated for diseases like measles, pertussis, flu, and hepatitis A and B. By increasing vaccination rates, communicable disease rates can be reduced. For example, adolescents need the HPV (human papillomavirus) vaccine, older adults need vaccines to help prevent pneumonia, and most everyone age 6 months and older needs a yearly flu vaccine. Communication about the importance of vaccines, sending vaccination reminders, and making it easy to get vaccines all help increase immunization rates. In 2024 there were 51 measles cases total in Hennepin County (45 of these were associated with one measles outbreak). We also had 44 cases of tuberculosis reported in 2022, both vaccine-preventable diseases.

Certainly, the COVID-19 pandemic highlighted the threat communicable diseases are to human life, world economies, and disruptions to societal institutions. While we will always be under threat of emerging new viruses, it is important to prevent communicable diseases as much as possible through effective immunization and preventive health measures.

HP2030 has many objectives that pertain to vaccinations, with many either in development or the Centers for Disease Control (CDC) is collecting baseline data. These goals are high-priority public health issues that have evidence-based interventions to address them. As a healthcare system, our clinical providers are vital in making sure their patients are up-to-date on their immunizations, They also provide preventive health information about possible risky health behaviors and advise on safe methods to protect against communicable disease.

IMMUNIZATION DATA

Data was obtained from the Minnesota Department of Health (MDH) on the vaccination status of populations in North Memorial Health’s consolidated service area. We report on immunization rates of young children, adolescents, and adults (highlighting ages 65+) for flu and COVID-19.

Here are what each immunization acronym stands for:

- DTaP (Diphtheria, Tetanus, and Pertussis)
- MMR (Measles, Mumps, Rubella)
- Hib series (Haemophilus Influenzae type b),
- Hep B (Hepatitis B)
- Varicella (Chicken pox)
- PCV (Pneumococcal Conjugate)
- HPV1+: Human Papillomavirus
- MenACW4: Meningococcal
- Tdap (Tetanus, Diphtheria, Pertussis): One dose after age 7

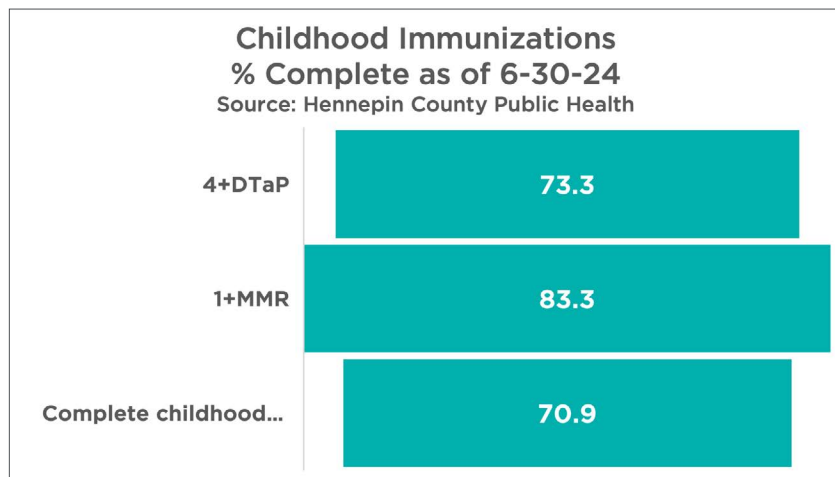
Child: Data is reported for infants and young children who have received 4+ DTaP, 1+ MMR, and completed childhood series immunization rates (4+ DTaP, 3+ Polio, 1+ MMR, complete Hib series, 3+ Hep B, 1+ varicella, and complete PCV) by consolidated zip codes for those born 1/1/2021-12/31/2021. Data is as of 10/7/2024, with vaccination status as of 6/30/2024.

Adolescent: Data is reported for adolescents who have been received 1+ HPV, complete HPV, 1+ MenACWY, MenACWY booster, and adolescent series (complete HPV, 1+ Tdap, 1+ MenACW4) immunization rates by consolidated zip codes for those born 1/1/2008-12/31/2010. Data is as of 10/7/2024, with vaccination status as of 6/30/2024.

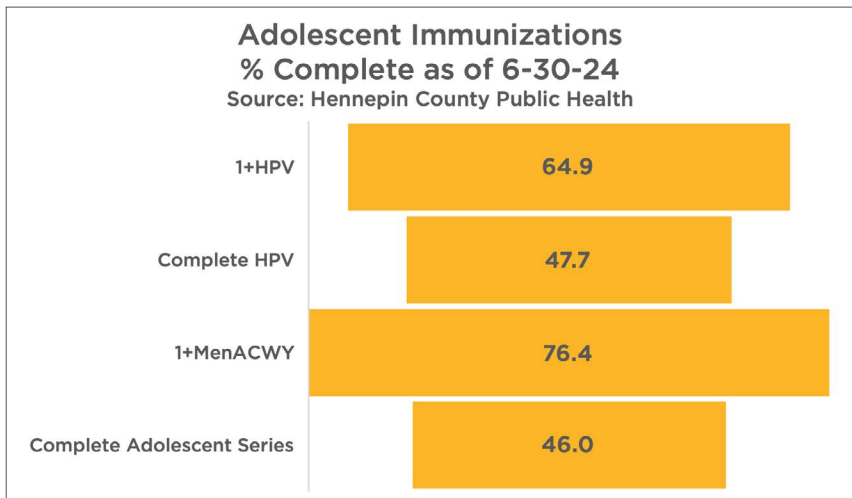
Adults: Data is reported for the 2023-24 season (7/1/2023-6/30/2024) by examining flu and COVID-19 vaccination rates by consolidated zip codes for adults and adults age 65+. Data is current as of 10/7/2024, with age as of 10/1/2023.

Childhood and Adolescent Vaccinations

The following charts note childhood and adolescent immunization status. In 2022, we worked closely with Hennepin County public health staff to select immunization indicators to monitor, based on data availability, and use as a snapshot of the immunization status of our population. 2025 vaccination data is reported in aggregate for the CSA while noting zip codes with low vaccination rates.

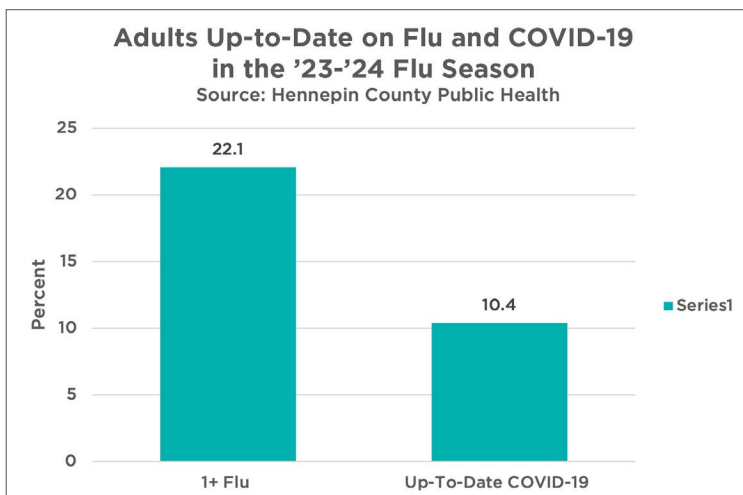


We are doing fairly well on childhood immunizations in the consolidated service area. Zip codes with <70% for 4+ DTaP and <73% 1+ MMR are 55411 and 55412. Three zip codes have 60% or less of their children complete on their childhood series, they include 55411, 55412, and 55421.



Rates of adolescent immunizations range from 46% (complete adolescent series) to 76.4% (1+ MenACWY), and there are disparities in the zip codes with low rates of adolescent immunization.

- 55411 and 55412 have low rates for all the adolescent immunizations we are tracking (1+ HPV and complete HPV, 1+ MenACWY, and complete adolescent series).
- 55362 has lower rates of complete HPV and adolescent series.
- 55441 and 55442 have lower rates of 1+ HPV, and 1+ MenACWY.
- 55429 has lower rates of youth completing the adolescent series.



There are a number of goals for childhood and adolescent immunizations, including:

- *The American Academy of Pediatrics has a goal to increase the percentage of children 24-35 months up-to-date with immunizations (vaccine series including DTaP, polio, MMR, Hib, Hep B, varicella, PCV, rotavirus, Hep A). We are at 70.9% for children within our CSA.*
- *Increase the coverage level of 4 doses of the DTaP vaccine in children by age 2 years to 90%. We are at 77.3%.*
- *Increase the proportion of adolescents who get recommended doses of the HPV vaccine to 80%, we are at 64.9% for 1+ HPV.*

There are several HP2030 goals around adult immunizations.

We are not meeting these goals even among our older adults.

They include:

- *Increase the proportion of adults ages 19 years or older who get recommended age-appropriate vaccines to 95%.*
- *Increase the proportion of people who get the flu vaccine every year to 70%.*

The majority of adults are not getting their annual flu vaccine or keeping up with the latest COVID-19 vaccine. Even among adults ages 65+, who are at greater risk for more severe disease, only about half of adults in this age range are up-to-date (UTD). Less than 40% of adults age 65+ living in zip codes 55411 and 55412 had an annual flu vaccine during the 23-'24 flu season. Additionally, less than 35% of adults age 65+ living in zip codes 55411, 55412, 55429, and 55430 were up-to-date with their COVID-19 vaccines during the '23-'24 season. Adults should also have a Tdap booster once every ten years, a pneumococcal vaccine after age 65, shingles vaccinations (2 doses after age 50), and a respiratory syncytial virus (RSV) vaccination after age 60.

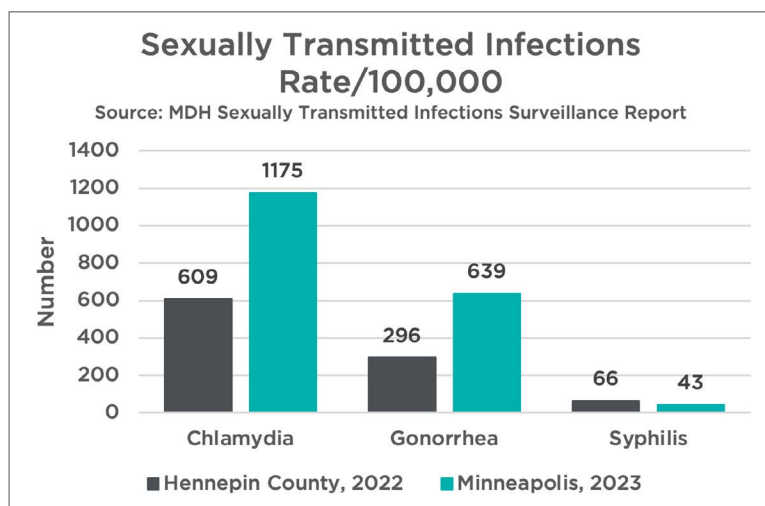
SEXUALLY TRANSMITTED INFECTIONS

The Twin Cities metropolitan area had 23,018 cases of sexually transmitted infections reported in 2023. These rates include 15,035 cases of chlamydia, 6,444 cases of gonorrhea, and 793 cases of syphilis (all kinds). Chlamydia and gonorrhea reached all-time highs in 2019 and syphilis in 2022. Cases are lower than in 2022 and slowly trending downward.

Minnesota's rate of congenital syphilis (passed along from a pregnant person to a baby) reached an all-time high in 2024 (n=29).

Congenital syphilis can cause miscarriages and stillbirths. Infants born with congenital syphilis may have severe health conditions including deformities, seizures, and/or anemia.

This chart shows the rate per 100,000 for each of these STIs for Hennepin County and Minneapolis, which has the highest rates for all STIs. Data shows that rates are particularly high among adolescents and young adults and residents in the Twin Cities. There are many disparities in each these STIs.



Key highlights from a 2023 Surveillance Report on STIs from the Minnesota Department of Health:

- From 2014-2023, the chlamydia rate increased by 4.3%. The rate of gonorrhea increased by 80%, syphilis has increased by 157%.
- Adolescent and young adults aged 15-24 years old continue to make up the majority of all chlamydia or gonorrhea cases at 54%.
- Syphilis has resurged in Minnesota over the past decade, with men who have sex with men (MSM) and those co-infected with HIV being especially impacted. However, the number of females impacted is near the record high for the last decade.
- People of color and those who identify as American Indian continue to be disproportionately affected by all STIs in Minnesota. Disparities in the rates of STIs are not explained by differences in sexual behavior, but are due to differences in health insurance coverage, employment status, and access to healthcare with preventive, screening, and treatment services.

SEXUALLY TRANSMITTED INFECTION DISPARITIES

Chlamydia

Chlamydia is the number one reported STI in the state of Minnesota. Youth and young adults ages 15-24 account for 59% of all chlamydia cases. Rates are highest among young females and Black, non-Hispanic, populations. While the number of cases among people who identify as White or Black is close, rates are highest among individuals who identify as Black, non-Hispanic, Hispanic, any race; and American Indian.

Gonorrhea

While gonorrhea rates have been trending downward, youth and young adults, ages 15-44, and people who identify as Black, non-Hispanic, American Indian, or Hispanic are disproportionately affected by gonorrhea.

HIV/AIDS

Despite relatively small numbers of cases, in 2023 we had 324 new cases of HIV/AIDS in Minnesota. Most new cases were among people who identify as White or Black. However, in 2023, Hispanic populations comprised 22% of newly diagnosed cases, compared to 14% the year before.

Syphilis

Males have the highest rates of syphilis in the state, however, in 2023, 30% of early syphilis cases were females, up from 10% in 2014. Adults ages 20-39 have the highest rates of syphilis. Most (38%) primary and secondary syphilis cases are Black, non-Hispanic, followed by White, non-Hispanic (36%) populations. There are still large disparities in the rates of syphilis. American Indian populations are 16.5 times higher, Black populations are 11.2 times higher, and Hispanic populations are 3.5 times higher compared to White populations to contract syphilis.

While we are not able to measure our data directly to HP2030 goals, HP2030 goals focused on sexually transmitted infections include:

- *Reduce the syphilis rate in females to 4.6 per 100,000 (we are not meeting at 5.1/100,000), our numbers peaked in 2022.*
- *Reduce congenital syphilis cases (our numbers are getting worse, with 29 cases in 2024).*

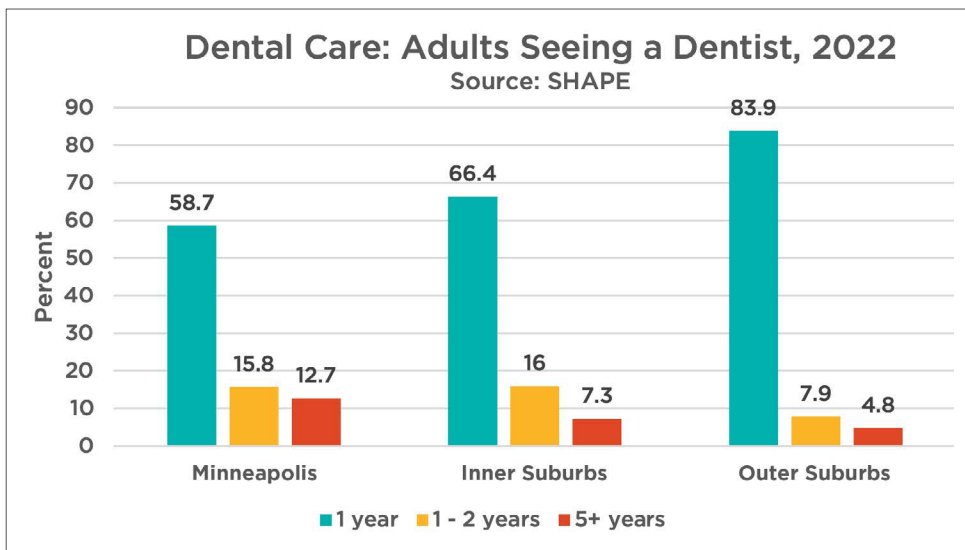
Oral Health

INTRODUCTION

Oral diseases cause pain and disability for millions of people in the United States, and some are linked to other diseases — like diabetes, heart disease, and stroke. Regular visits to the dentist can help prevent oral diseases and related problems, but many people, especially low-income families, do not complete preventive dental care. Strategies that make it easier for people to get dental care are critical for better oral health and overall health outcomes. Training non-dental providers to conduct oral screenings, talking to caregivers about oral health, and referring patients to dental care can help more children, adolescents, as well as adults, get regular, preventive oral health care.

Adult Dental Care

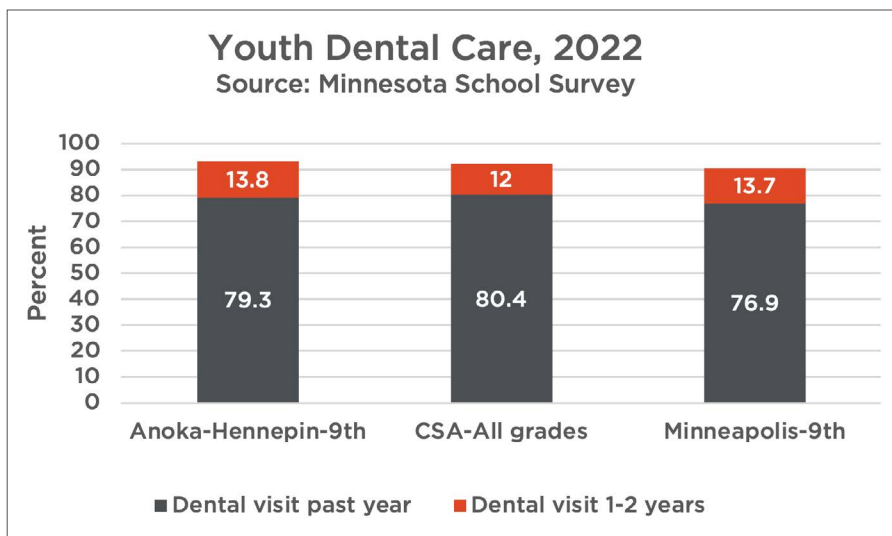
The chart below shows the percentage of adults who have visited the dentist or dental clinic for any reason within the past 2 years as well as those who have not been to a dentist in more than five years. There are disparities in Minneapolis, where 12.7% of Minneapolis adults had not been to a dentist in 5+ years. This has improved since 2019 (17.1%). There are also disparities among persons who identify as transgender and/or non-binary (numbers are small so data must be interpreted cautiously).



We are meeting the HP2030 goal to reduce the proportion of people who cannot get the dental care when they need it to less than 19.4%.

Youth Dental Care

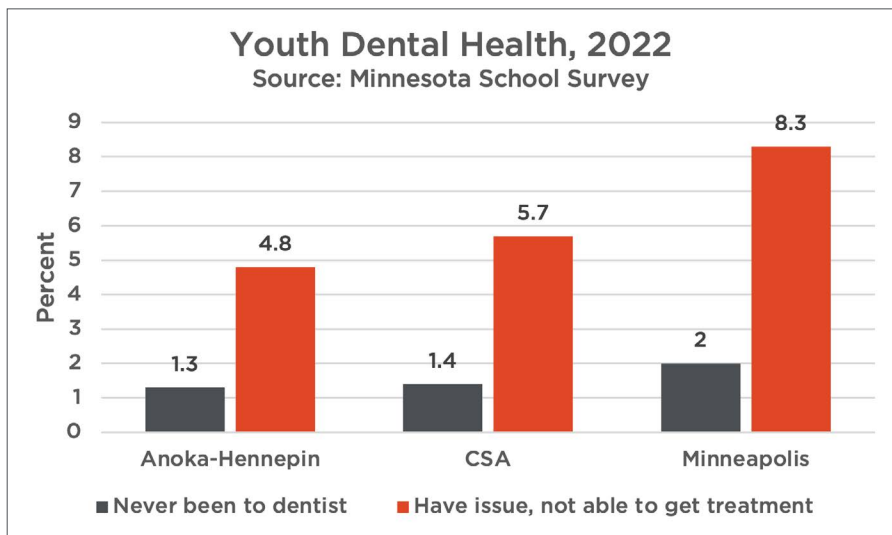
The first chart shows 9th grade youth who had seen a dentist for a check-up, exam, teeth cleaning, or other dental work in the past two years. The second chart shows 9th grade youth with unmet dental needs - either they had never been to a dentist or had a dental problem but said they were unable to seek dental treatment.



We are meeting the two HP2030 goals for children and youth:

Increase the percentage of low-income youth who have a preventive dental visit to 82.7%.

Reduce to 10.2% children and adolescents with active and untreated dental decay.



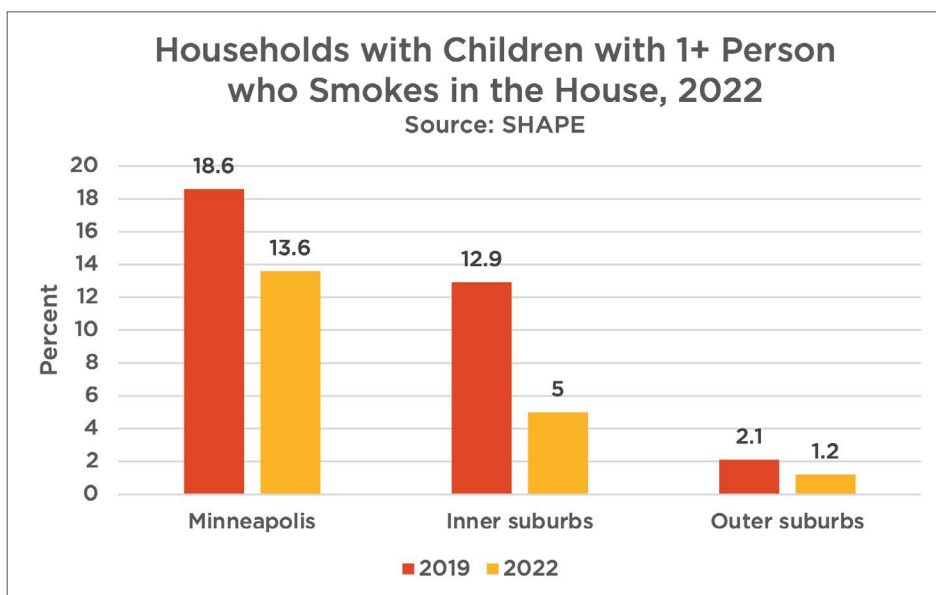
Environmental Health

INTRODUCTION

There are a number of environmental practices and policies that can help keep our populations safe. While not in the scope of the CHNA, there are several indicators we report on to raise awareness. Some communicable diseases that can be transmitted through unsafe water or food handling practices include campylobacteriosis (Hennepin County had 209 cases in 2022), Shiga toxin-producing E. coli (Minnesota had 698 cases in 2022), and salmonellosis (Hennepin County had 190 cases in 2022). Safe housing is also vitally important for preventing exposures to toxic agents, such as lead and radon.

Children and Youth in Smoke-Free Homes

Another environmental key health indicator of concern is households with children ages 0-17 where one or more persons regularly smoke in the home. Children exposed to tobacco smoke are more likely to develop severe health problems including sudden infant death syndrome, acute respiratory infections, ear problems, and severe asthma. We are happy to report that the rates of children in homes where someone smokes have gone down over time.



We are not meeting the HP2030 goal for 92.9% of homes with children to be smoke-free in Minneapolis, although we have reached that goal in the Inner and Outer Suburbs.

There are disparities among persons who identify as American Indian/Alaska Native, Black-US born, and/or have less than a college degree.

Air Quality

Minnesotans are experiencing a steady increase in seasonal smoke exposure from wildfires, triggering air quality alerts and heightening concerns about the health impacts of smoke and other air pollutants. Exposure to air pollution is linked to many health problems, including cancer, respiratory diseases, and heart disease. Poor air quality both inside and outside can lead to asthma complications and respiratory issues. Air pollution leads to heart and lung conditions and premature deaths, with the largest impacts in marginalized communities.

The Minnesota Pollution Control Agency reports on the number of days the Air Quality Index (AQI) exceeds 100. Air quality in the Twin Cities has been exceptionally good. Unfortunately, the impact of wildfires is affecting air quality. In the summer of 2021, Minnesota, air quality index reached record highs, with smoke in the air pushing the index level above 200 for the first time, leading to purple (201-300 AQI, “very unhealthy”) and maroon (301+ AQI, “hazardous”) color codes. In 2023 we also had poor air quality days due to wildfires as well as stagnant weather that present health risks for everyone, not just people who are sensitive to air quality.

Climate change is an emerging issue that is affecting health. Indicators around exposure and/or unsafe conditions due to extreme heat or cold are under development. HP2030 has a developmental objective around heat exposure (reduce heat-related morbidity and mortality). It is a high-priority public health issue that has evidence-based interventions to address it but does not yet have reliable baseline data. Once baseline data are available, this objective may be considered to become a core Healthy People 2030 objective, as well as one of ours.

In Minnesota’s largest cities, the highest estimated rates of death and disease related to air pollution were in communities with higher percentages of:

- low-income residents
- uninsured residents
- residents of color
- residents living with a disability

These communities often have higher rates of heart and lung conditions, driven by systemic racism, housing insecurity, discrimination in health care, and other social and economic factors. Existing health conditions make the communities more susceptible to poor air quality. Zip codes with the largest percentage of residents of color had more than five times the rate of asthma emergency room visits related to air pollution than areas with more White residents.

Life and Breath: Metro Report (updated 2022), <https://www.pca.state.mn.us/air/life-and-breath-report>

Maternal and Child Health

INTRODUCTION

Every year in the United States, thousands of infants die from causes like preterm birth, low birth weight, and sudden infant death syndrome. While we have seen great progress in decreasing the number of infant deaths, there are disparities by race/ethnicity, income, and geographic location. Ensuring access to equitable, high-quality care for mothers and babies can help reduce the rate of infant deaths.

Pregnant women who receive proper prenatal care and follow a healthy lifestyle are more likely to give birth to a healthy baby. Women’s health before, during, and after pregnancy can have a major impact on infants’ health and well-being. It is important for women to receive recommended health care services before and during their pregnancy, and to practice healthy behaviors during pregnancy. Getting good medical care and avoiding risky behaviors — like smoking or drinking alcohol — can improve health outcomes for infants.

Reducing the rates of low or high birth weight helps babies get the healthiest start possible. Preterm births (infants born before 37 weeks of gestation) are more common in some racial/ethnic groups. Babies both preterm or at low birth weights have a higher risk of infections, developmental problems, breathing problems, and even death. There are clinical and community-based interventions that can help promote healthy pregnancies and healthy babies.

Births

In 2023 there were 5,485 babies born at North – Maple Grove Hospital and North – Robbinsdale Hospital. This compares to 5,755 born in 2021 and 5,467 born in 2019.

Most (81.9%) pregnant women in Hennepin County received prenatal care during their first trimester. Early prenatal care is important because screenings can identify babies or mothers at risk for health problems. Healthcare providers can educate and prepare mothers for pregnancy and childbirth including advice about healthy nutrition and behaviors, such as abstaining from smoking. Smoking during pregnancy is associated with adverse health effects including premature births, certain birth defects, and infant death. There have been significant declines in the proportion of women smoking during pregnancy with 3.6% of babies born in Hennepin County to women who smoked during their pregnancy.

Around 10% (10.1%) of babies were preterm (< 37 weeks) and 7.4% of babies were considered low birth weight (<2500 g). One in five mothers (19.1%) participate in the Women, Infants and Children program which offers nutritional and breastfeeding support to new parents. The teen birth rate (births rates among mothers ages 15-19 years per 1,000) in Hennepin County continues to trend downward. In 2021 only 2.2% of births in Hennepin County were to teen mothers. In general, teen birth rates have been going down for the past ten years. The highest teen birth rates in the CSA (>5%) were in zip codes 55404, 55430, 55411, and 55412.

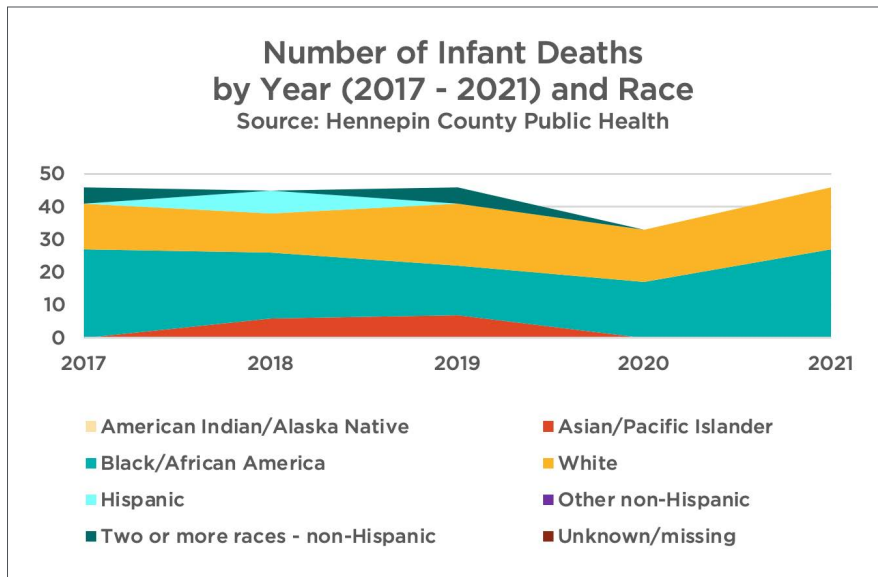
HP2030 has a goal to reduce pregnancies among adolescent females (aged 15-19) to 31.4 per 1,000. We are meeting that goal.

HP2030 has a goal to reduce the percentage of preterm births to 9.4%. We are not quite meeting this goal.

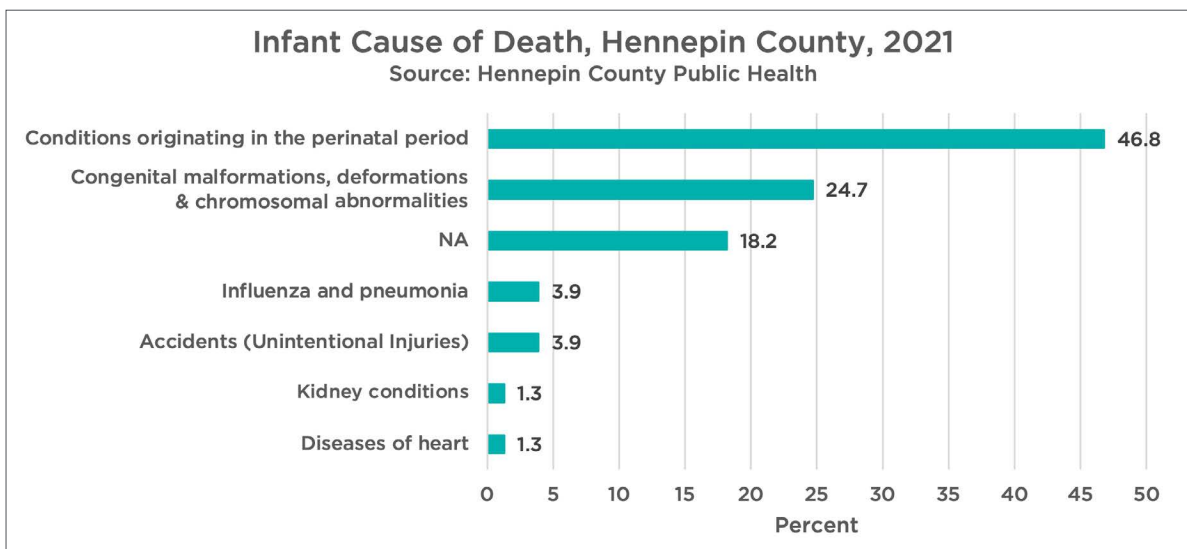
HP2030 has a goal to increase abstinence from smoking among pregnant women to 95.7%. We are meeting this goal.

Infant and Child Deaths

Infant mortality is an important indicator of a population’s health because it is associated with maternal health, quality and access to medical care, socioeconomic conditions, and public health practices. In 2021 there were 77 infant deaths (up to 1 year) and 55 child death (1-17 years) in Hennepin County. This is a rate of 5.3 infant deaths per 1000, and compares to a rate of 5.0 per 1000 in 2019. There are disparities in infant death rates by race and ethnicity with higher rates among Black, Hispanic, American Indian, and Asian populations when compared to White infant death rates. During the years 2017-2021, there were higher numbers of Black infant deaths compared to Whites every year except in 2019.



The following chart shows the cause of death among infants who died in 2021 in Hennepin County. The majority died from conditions originating in the perinatal period or congenital malformations, deformations, and chromosomal abnormalities. Other causes include influenza/pneumonia, accidents, and diseases of the heart.



Injury, Violence, and Safety

INTRODUCTION

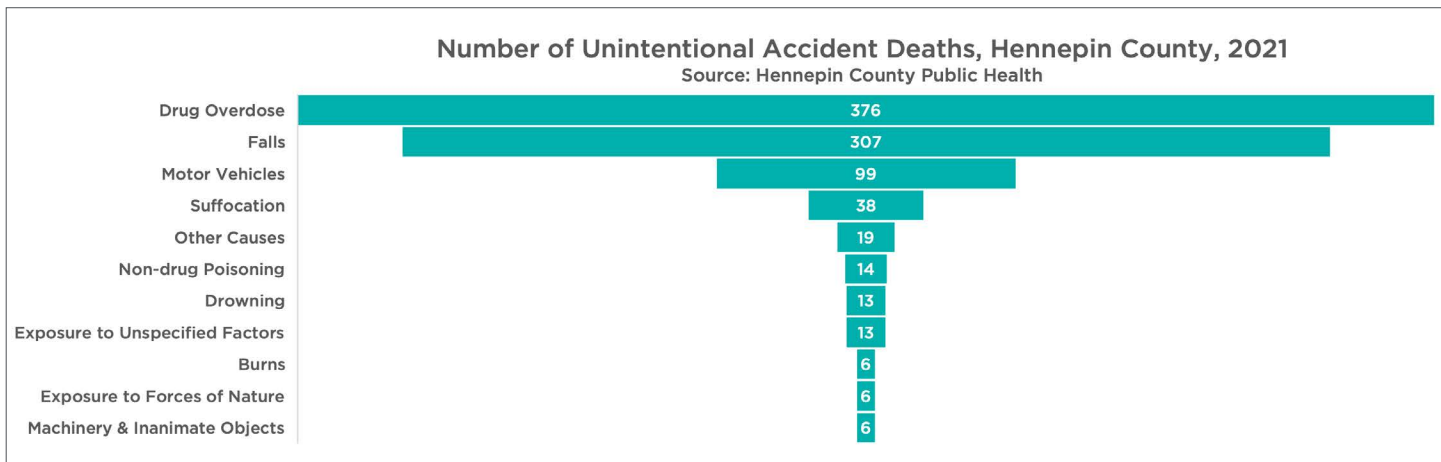
Injury includes events that are both unintentional as well as intentional, and can be both fatal and non-fatal. Injuries result in many visits to healthcare providers and hospitals. They include a wide range of types including burns, drownings, falls, firearm injuries (intentional and unintentional), motor vehicle crashes, and poisonings, to name a few. Injuries are often classified by intent of injury, such as unintentional (accidents, falls) or intentional injury (violence-related homicide/assault, suicide, intentional self-harm) or by the mechanism (cause) of injury, such as fall, fire, firearm, motor vehicle crash, poisoning, or suffocation.

Injuries are the leading cause of death and disability for people ages 1-44 in the United States and in our consolidated service area. Unintentional injuries are a leading cause of death and disability throughout the lifespan and a leading cause of premature death. Early death is both tragic and often preventable. There are many risk factors for injuries and there are many preventive health policies and practices that can be put into place to reduce the rate of injuries, especially unintentional ones.

UNINTENTIONAL INJURY AND DEATH

Lacking data specific to only North Memorial Health’s consolidated service area, the following data shows the impact of unintentional injuries in Hennepin County in 2021. Falls and drug overdoses (mostly with opioids present) were the leading causes of unintentional injury deaths. In 2022, more than 10,000 people in Hennepin County were hospitalized due to opioids, and 376 lives were lost to opioid-related overdoses. Fentanyl is involved in over 95% of opioid-related deaths in Hennepin County, and a major contributor to the rise in these deaths.

There are health disparities in unintentional injury rates. Among Black persons who died of unintentional injuries, 70% were due to poisoning compared to 28% of White persons. Among American Indian populations who died of unintentional injuries, almost all were due to poisonings as well. However, 42% of total drug overdoses were White, 34% were Black, 8% were American Indian/Alaska Native, 5.9% were two or more races, and 4.8% were Hispanic. Fall deaths were almost all White (94%).



Source: Provisional 2021 death records, Office of Vital Records, MDH. Analyzed by Hennepin County Public Health Assessment team, 2024. Data is considered provisional and subject to change upon receipt of final 2021 death file from MDH Center for Health Statistics.

Falls

Falls are one of the leading causes of unintentional injury deaths in Minnesota and Hennepin County. As noted above, 307 Hennepin County residents died as a result of a fall. The majority of fall injury deaths were among White residents (94%). People 65 years or older have a much higher rate of death caused by falls compared to all other ages. Falls are the leading chief complaint among patients seeking emergency care at North Memorial Health. Between the period 1/1/2019 and 5/2/2022 over 16,211 emergency encounters listed falls as the primary reason people sought care.

There are community and hospital-based health interventions that can help prevent falls. Some community-based interventions include exercise programs that strengthen core strength and balance. North Memorial Health offers “Stepping On” classes several times a year for patients and community members at risk of falling. “Stepping On” is a 7-week evidence-based program that reduces the risk of falls for people living at home who have experienced a fall or are concerned about falling. It has been proven to reduce falls in older people living in the community by 31%.

Another is home inspection programs offered to older home owners that can help them correct structural items around their homes that may lead to a fall, ranging from simple actions like reducing the use of throw rugs, minimizing clutter in hallways and walkways, to more complex actions such as building ramps over curbs. NMH’s Community Paramedics often follow up with NMH patients to help them reduce the risk of falls in their homes.

Poisoning Mortality

One of the leading, and growing, contributors to premature death is drug overdose deaths. The United States, including Minnesota, is experiencing an epidemic of drug overdose deaths. Since 2000, the rate of drug overdose deaths has increased by 137% nationwide. Opioids contribute largely to drug overdose deaths; since 2000, there has been a 200% increase in deaths involving opioids (opioid pain relievers and heroin). The majority of unintentional deaths in Hennepin County were due to opioid overdoses (42%). Much of the increase in opioid overdose deaths is due to the presence of fentanyl or opioids and methamphetamines being used together. Fentanyl is a synthetic opioid that is about 50 times as potent as heroin. Fentanyl is cheap to manufacture, often mixed with other opioid drugs, and many people who use drugs are not aware of the exact composition of the substance they are using. Others use fentanyl intentionally because of its potency.

HP2030 Goal is to reduce fall-related deaths among older adults (age 65 and above) to 63.4 per 100,000.

We are not meeting this goal.

Highlight: Working to Reduce Overdose Deaths

North is proud of our overdose harm reduction interventions which have been implemented within our system. In 2021, we launched the distribution of Detera medication disposal bags through hospital pharmacies to promote the safe and environmentally responsible disposal of unused medications. These pouches deactivate pills, patches, liquids, creams, and films, allowing for safe disposal in household trash while reducing the risk of accidental overdose and environmental harm.

Additional harm-reduction efforts include the availability of fentanyl test kits, which allow individuals to check opioid drugs for the presence of fentanyl. Naloxone, a life-saving medication that can reverse opioid overdoses, is also available. Both resources are provided free-of-charge at the Security Desks of the North-Robbinsdale Hospital Emergency Department and the North-Maple Grove Hospital Emergency Care Center.

There are interventions that can be used to stop drug overdoses. Some of them include interventions aimed at distributing naloxone to reverse opioid overdoses, increasing access to medication assisted treatment (MAT) for people with substance use disorder, and encouraging safe disposal of medications. Other evidence-based harm reduction strategies such as fentanyl test strips, safety planning, and access to safe supplies are vitally important in reducing drug-related overdose deaths.

Motor Vehicle Crashes

Over time, with increased safety features on cars, graduated licensure programs for new drivers, and safer roads and walkways, vehicle crash deaths from have been reduced. Motor vehicle crashes still remain a primary unintentional injury, however, resulting in much injury and pain. The zip code with the highest motor vehicle crash death rate was 55411. Between the period 1/1/2019 and 5/2/2022 there were 8805 emergency encounters with a motor vehicle crash as a primary visit reason.

HP2030 has a goal to reduce deaths from motor vehicle crashes to 10.1 per 100,000.

We are meeting this goal at 7.8/100,000 in Hennepin County.

Drownings

Swimming, boating and other forms of water recreation are among Minnesota residents’ most popular pastimes. Sometimes, these activities can be dangerous or fatal. In 2024, Hennepin County had 18 residents die from drowning. Preventing drowning requires multiple strategies. Isolation fencing of swimming pools is well-established as a method to reduce drowning in pools. Studies also show that wearing a life jacket and swimming lessons also reduce the risk of drowning.

INTENTIONAL INJURIES

Intentional injuries are where harm was intended, such as assaults, homicides, and suicides. Violence is a leading cause of injury and death, especially among youth and young adults. Violent crime rates vary throughout the consolidated service area and increased during the pandemic. They are starting to decrease but but still are not as low as 2018-2019. Most local police and sheriff’s departments report the number of violent crimes to the Federal Bureau of Investigation’s (FBI).

Even though suicide is considered an intentional injury, we will report on suicides and other self-harm behaviors in the following section on Mental Health & Well-Being.

In 2021, there were 133 firearm related deaths in Hennepin County. Over half (57%) were homicides, and 41% were suicides. Almost all firearm deaths in Hennepin County were people identified as either White or Black. The majority of homicide deaths by firearm were people who are Black while the majority of suicide deaths by firearm were people who were White. The remaining were accidental, legal interventions, or undetermined intent.

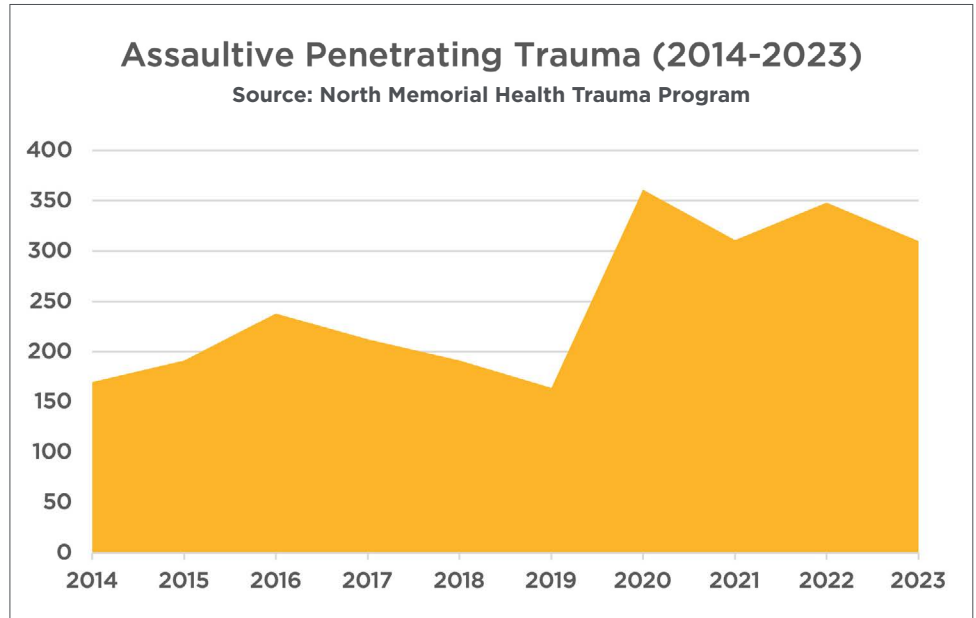
Causes of Death, Firearms – 2021		
Source: Hennepin County Public Health		
Race	Assault (homicide)	Intentional self-harm (suicide)
American Indian/Alaska Native alone	*	0
Asian/Pacific Islander alone	0	*
Black/African American alone	57	*
White alone	7	37
Hispanic	*	*
Unknown/missing	*	0
TOTAL	76	54

* Suppressed due to small n's

Penetrating Trauma

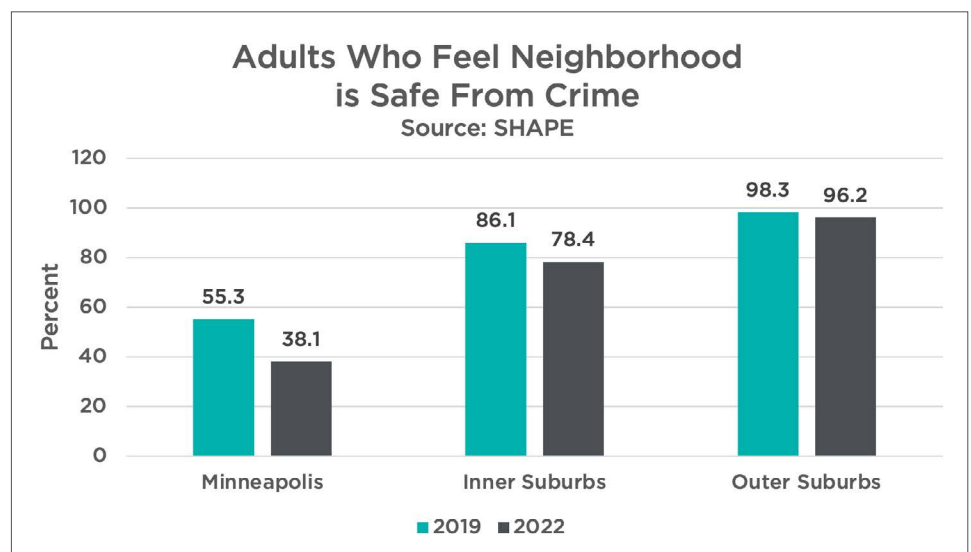
North - Robbinsdale Hospital is a Level 1 Trauma Center. Level 1 Trauma Centers are required to have immediately available all resources to stabilize and definitively treat even the most complex traumatic injuries. Penetrating trauma injuries are a broad category for trauma mechanism (blunt vs. penetrating). Assaultive penetrating trauma is what people might consider 'violent injury.' Assaultive penetrating trauma is an injury caused by something piercing or entering the victim that is intentionally caused by another person.

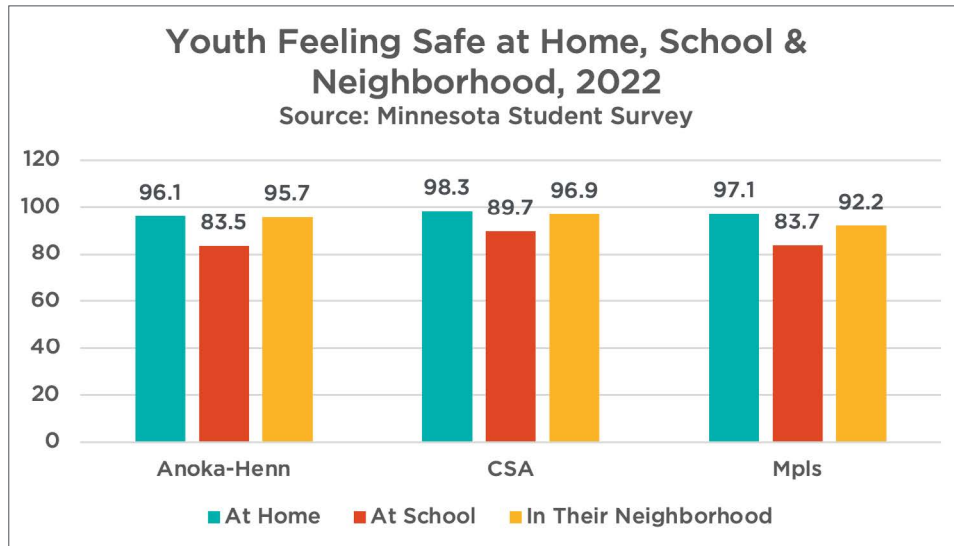
This injury category includes gunshot wounds and stabbings, not physical assault with fists or a blunt object. It does not include unintentional injuries (falling on a sharp object) nor self-inflicted injuries. North - Robbinsdale Hospital closely tracks penetrating trauma data and is working in partnership with other hospitals to try to reduce violence in our communities.



COMMUNITY SAFETY

Most people desire to feel safe in their neighborhoods, places of employment, schools, and homes. Even though violent crime rates had gone up in 2020-2021, in 2022 the majority of residents in the consolidated service area feel safe in their neighborhoods, schools, and homes. However, Minneapolis has lower rates of adults who feel their neighborhood is safe from crime, and both Minneapolis and Anoka-Hennepin youth feel less safe at school compared to other CSA school districts. The following data shows adults who consider their neighborhood as very or somewhat safe and youth who feel safe in their neighborhood, school, and home.

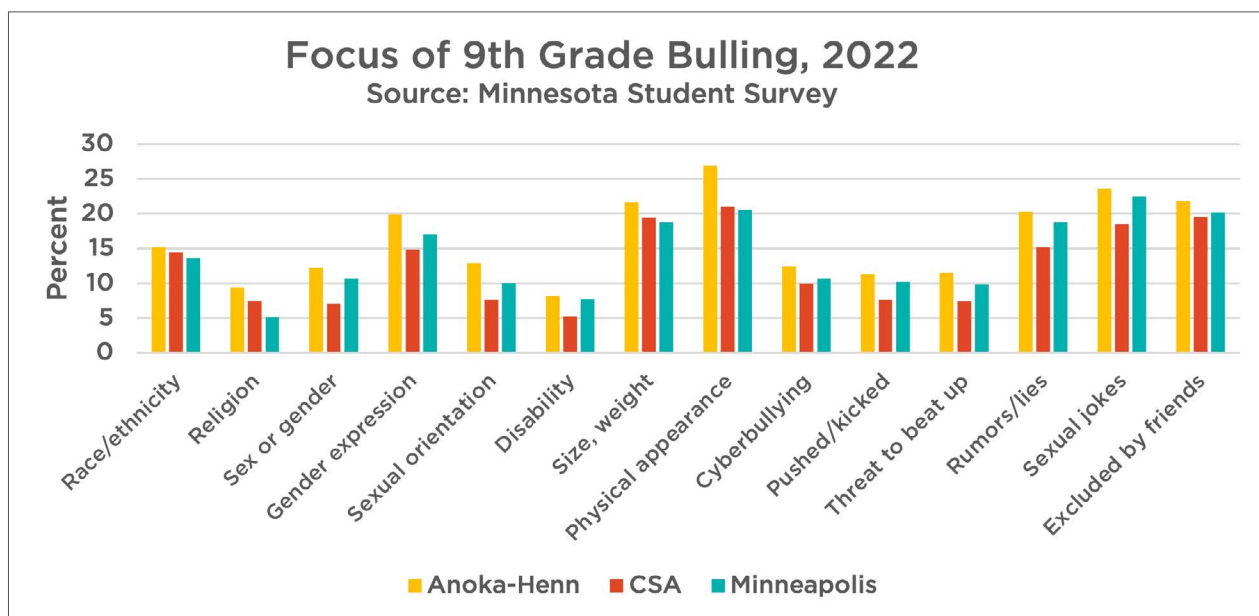




Bullying

While the majority of students attending schools in North Memorial Health’s service area report feeling safe at school, there are still many students who report feeling unsafe at school due to bullying behaviors. The Minnesota Student Survey asks many questions about bullying and the reasons for bullying. The following chart shows the percentages of students who report being bullied one time a week or more for a number of reasons.

The primary reasons for bullying in all the school districts in the region are due to a person’s physical appearance, their size, and/or obesity. Research shows that the establishment of strong anti-bullying policies and enforcement by school officials has the potential to prevent bullying.



Mental Health and Well-Being

INTRODUCTION

Psychological, physical, and mental health are all intricately connected and contribute to a person's overall health and well-being. In fact, about half of all people in the United States will be diagnosed with a mental health disorder at some point in their lifetime.¹ Of those that were diagnosed, only half are estimated get the treatment they need.² Mental health is a large umbrella term that covers a variety of diagnoses, a range of spectrums, of impact, and different care and treatment needs.

People of all ages and racial/ethnic groups are affected by mental health, but some populations are disproportionately affected more than others. Minority groups have increased rates of psychological symptoms that impair functioning, decreased access to mental health services, delay mental health care more often, receive worse quality of care, and are more likely to terminate care early, as compared to White counterparts.³ Additionally, rates of suicide deaths and drug overdose deaths are increasing at faster rates for people of color as compared to White populations.⁴

Mental health conditions can affect a person's ability to eat healthy, be physically active, and choose healthy behaviors, thus impacting their physical health. For those with chronic diseases such as diabetes, cancer, and heart disease, having a co-occurring mental health disorder can lead to poor medication compliance, lack of follow-up care, and worse health outcomes. There is substantial evidence showing a link between mental health disorders, those with chronic diseases, and worse health outcomes, especially for those that have co-occurring mental health disorders and chronic diseases. For example, those who have diabetes and symptoms of depression have a 46% increased risk of dying from any cause as compared to those with diabetes who do not have symptoms of depression.⁵

Not only does mental health impact chronic disease outcomes, but chronic diseases also impact mental health outcomes. Americans with diabetes are 2 to 3 times more likely to develop depression as those without diabetes, yet only 25%-50% are diagnosed with depression and treated.⁵ When patients are diagnosed with chronic health conditions, they are referred to many medical specialists but often not a mental health specialist as part of their treatment plan. Furthermore, people with chronic health conditions often find it harder to get treatment for mental disorders and have more health-related appointments and medications to manage, all increasing the complexity of their care and potentially impacting their mental health and well-being. Additionally, many people have co-occurring mental health conditions and substance use disorders which can further complicate diagnosis and treatment options.

Healthy People 2030 (HP2030) focuses on the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. Their Mental Health and Mental Disorders objectives aim to improve health and quality of life for people affected by these conditions.

¹Centers for Disease Control and Prevention. (2018). Mental Health: Data and Publications. Retrieved from https://www.cdc.gov/mentalhealth/data_publications/index.html

²National Institutes of Mental Health. (2018). Statistics. Retrieved from <https://www.nimh.nih.gov/health/statistics/index.shtml>

³(McGuire, T. G., & Miranda, J. (2008). Racial and Ethnic Disparities in Mental Health Care: Evidence and Policy Implications. *Health Affairs (Project Hope)*, 27(2), 393-403. <https://doi.org/10.1377/hlthaff.27.2.393>

⁴Panchal, N., Saunders, H., & Published, N. N. (2022, September 22). Five Key Findings on Mental Health and Substance Use Disorders by Race/Ethnicity. KFF. <https://www.kff.org/mental-health/issue-brief/five-key-findings-on-mental-health-and-substance-use-disorders-by-race-ethnicity/>

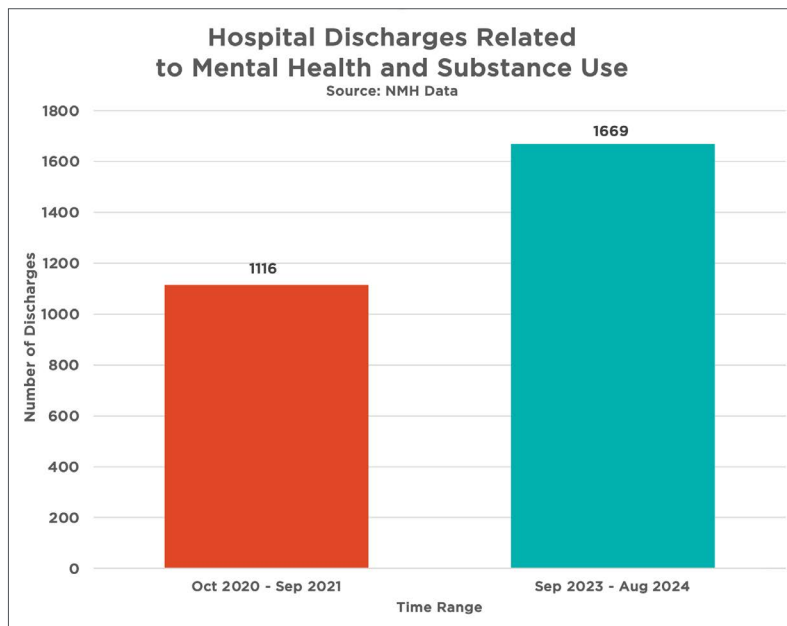
⁵Fernandez, G. (2021, December 16). The Intersection of Mental Health and Chronic Disease | Johns Hopkins | Bloomberg School of Public Health. <https://publichealth.jhu.edu/2021/the-intersection-of-mental-health-and-chronic-disease>

North Memorial Health: Hospitalizations for Mental Health and/or Substance Use Conditions

In the span of one-year (09/01/23 - 08/31/24), North Memorial Health had a total of 1,669 inpatient discharges related to mental health and substance use: 37.1% (619) inpatient discharges related to psychiatry, 34.3% (572) discharges related to chemical (substance) dependency, and 28.6% (478) discharges related to the effects and consequences of substance use (e.g. alcohol-related hepatitis or toxic effects of drugs). 70.1% or (434) of patients discharged with psychiatry diagnoses were due to psychoses.

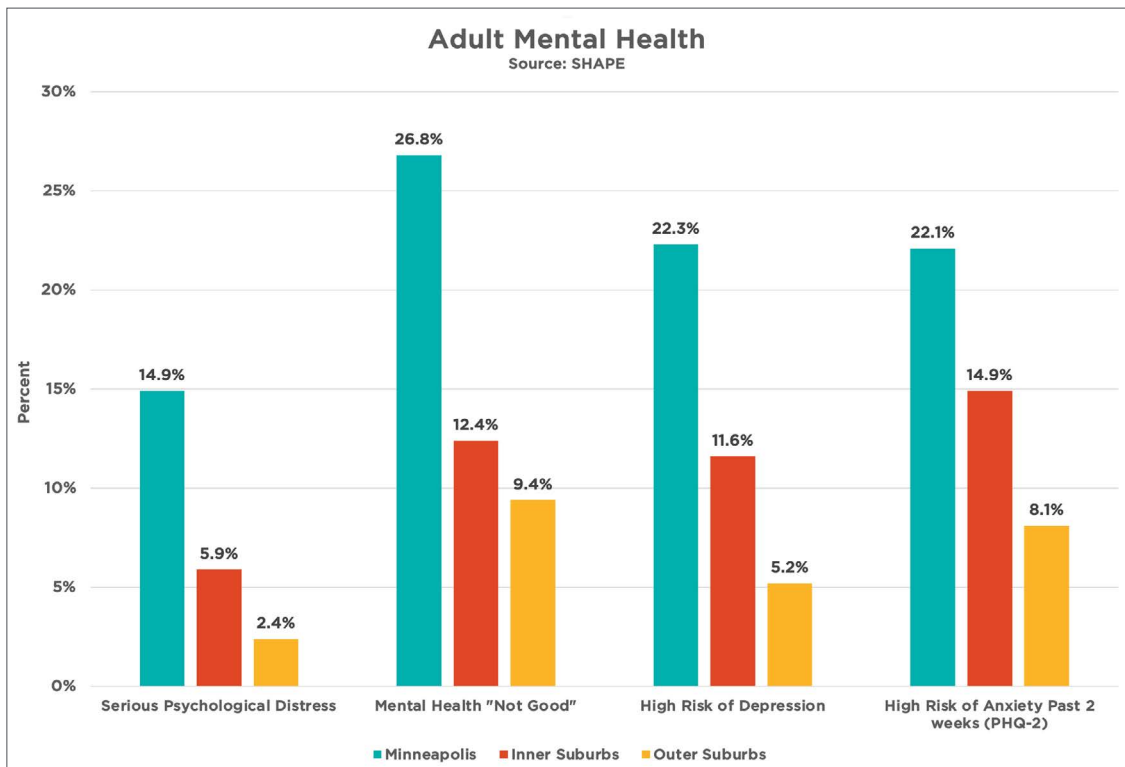
88.1% (1,470) were discharged from North - Robbinsdale Hospital with the remaining 11.9% (199) from North - Maple Grove Hospital. At the time of this report, it was not possible to determine the ages of persons discharged, the gender, and whether there were higher rates for different races/ethnicities.

In the 2022 CHNA, there were 1,116 discharges from North - Robbinsdale Hospital and North - Maple Grove Hospital in a one-year period between 10/01/2020 and 9/31/21 for the same three DRGs listed above. Since the previous 2022 CHNA and this one, we have seen 553 more inpatient discharges related to mental health and substance abuse, a 49.6% increase.



ADULT MENTAL HEALTH

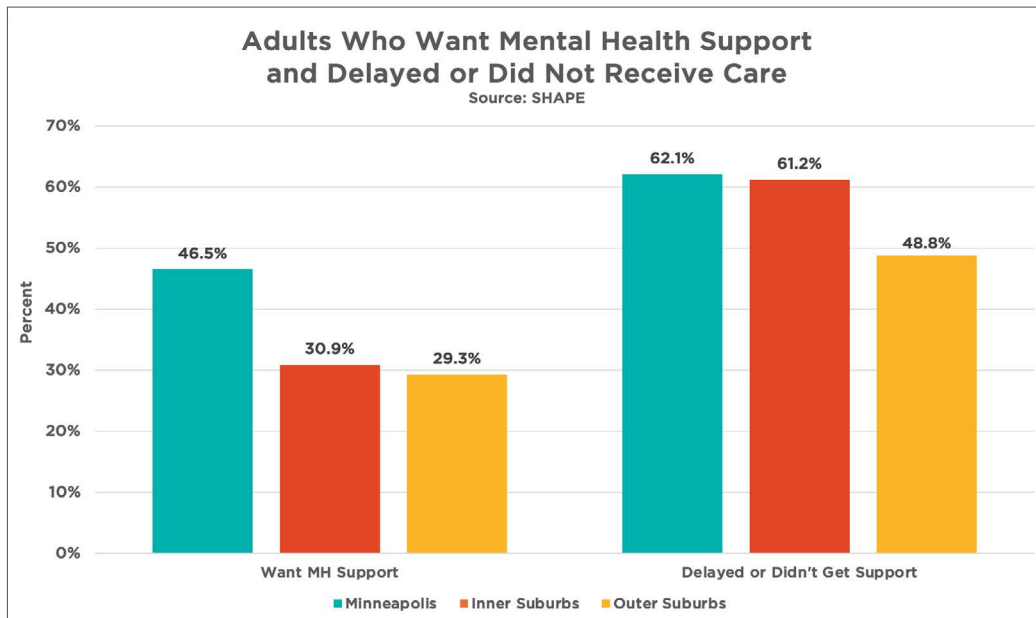
The primary data source on adult mental health and substance use for our CSA comes from the 2022 Adult Survey of the Health of All the Population and the Environment (SHAPE 2022). The following chart shows: 1) the percentage of adults who reported their mental health was not good for 14 or more days during the past 30 days; 2) adults who were at a high risk of depression based on their PHQ2 score; 3) adults who were at a high risk of anxiety based on their PHQ2 score; and 4) the percentage of adults reporting feeling serious psychological distress/anxiety.



- Disparities in adults who report their mental health is not good include those who identify as Black-US born, American Indian/Alaska Native, Hispanic or Latinx, non-binary, transgender, LGBTQ+, low-income, have less than a college degree, and those who experiencing economic distress.
- For adults at high risk for depression or anxiety during the past two weeks, those who identify as transgender, non-binary, LGBTQ+, American Indian/Alaska Native, Black-US born, low-income, less than a college degree, and those experiencing economic distress had the most amount of disparities as compared to those who did not identify in any of these categories.
- The disparities in adults with serious psychological distress are among adults who identify as non-binary, transgender, LGBTQ+, American Indian/Alaska Native, Black-US born, low-income, have less than a college degree, and those experiencing economic distress.

Adult Mental Health Support

Anywhere from more than 1 in 4 (29.3%) of adults in the Outer Suburbs to almost half (46.5%) of Minneapolis adults wanted mental health support. Of those that wanted support, almost half of adults (48.8%) in the Outer Suburbs and almost two out of three adults in Minneapolis (62.1%) and the Inner Suburbs (61.2%) delayed or did not receive support for their mental health.



For adults who wanted to seek help for a mental health issue, there are disparities among those who identify as American Indian/Alaska Native, non-binary, transgender, LGBTQ+, and those who experience economic distress as compared to those outside of these identities.

There were minimal disparities between different races and ethnicities, ages, gender, sexuality, income level, economic distress, English as a second language, and educational attainment for adults who wanted to seek support but delayed or did not receive support. Across the board, almost half or more of adults in every demographic of our community wanted mental health support but did not receive it.

YOUTH MENTAL HEALTH

Nationally, there have been drastic increases in depressive symptoms, feeling hopeless, emergency department visits for mental health, rates of anxiety, suicidal ideation, and deaths by suicide for our youth over the last decade. The Surgeon General’s Advisory on Youth Mental Health (2021) lists key data on youth mental health including¹:

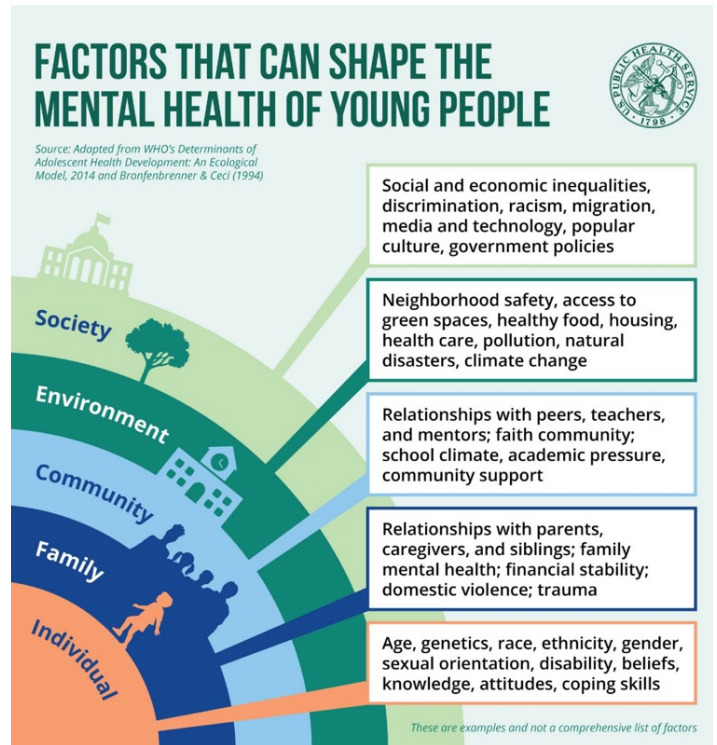
- 40% increase in high school students with persistent feelings of hopelessness or sadness (2009-2019)
- 28% increase in emergency department visits for depression, anxiety, and behavior (2011-2015)
- 36% increase in youth seriously considering attempting suicide (2009-2019)
- 57% increase in suicide rates for youth ages 10-24 (2007-2018)

¹U.S. Surgeon General’s Advisory on Protecting Youth Mental Health, 2021, [youth.gov/carousel/us-surgeon-generals-advisory-protecting-youth-mental-health](https://www.youth.gov/carousel/us-surgeon-generals-advisory-protecting-youth-mental-health).

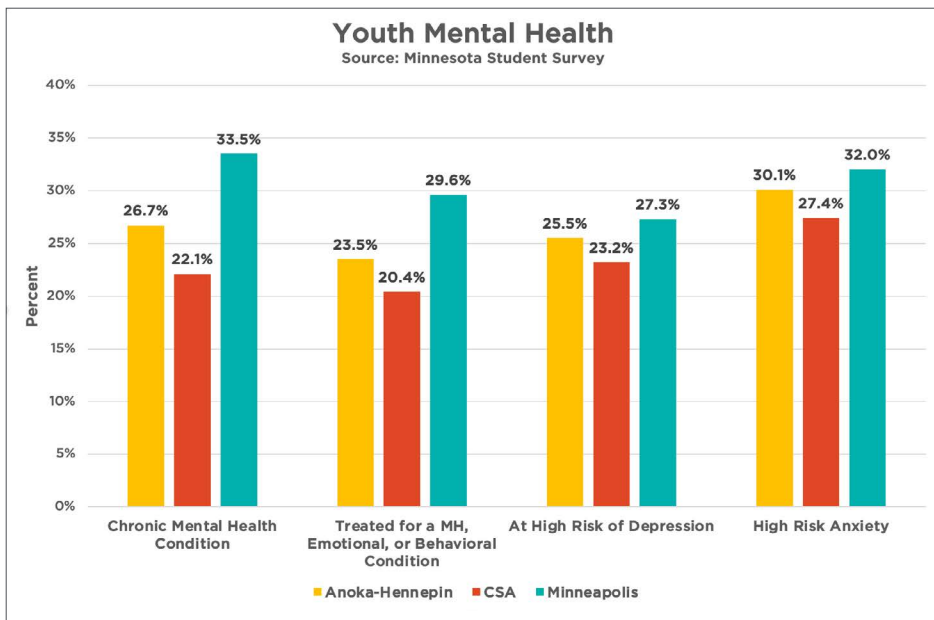
The Surgeon General declared a mental health crisis for the 2021 report listed above due to the increasing rates of mental health concerns and lack of access for youth requiring care.

Data specifically for our community was collected through the 2022 Minnesota Student Survey and the Youth Risk Behavior Survey. It should be noted that data was not available on race/ethnicity, household income, English as a second language, gender, or sexual orientation to examine disparities amongst different demographics of youth in our community.

1 out of 3 (33.5%) Minneapolis students report having a chronic mental health condition as compared to 1 out of 4 (26.7%) students in Anoka-Hennepin and 1 out of 5 (22.1%) students in the CSA. Students in Minneapolis also have higher rates of being at high-risk for depression and anxiety when compared to students in Anoka-Hennepin and the rest of our CSA. However, it should be noted that around 1 in 4 students has a mental health condition in our community, regardless of their location in Anoka-Hennepin, Minneapolis, or our CSA.

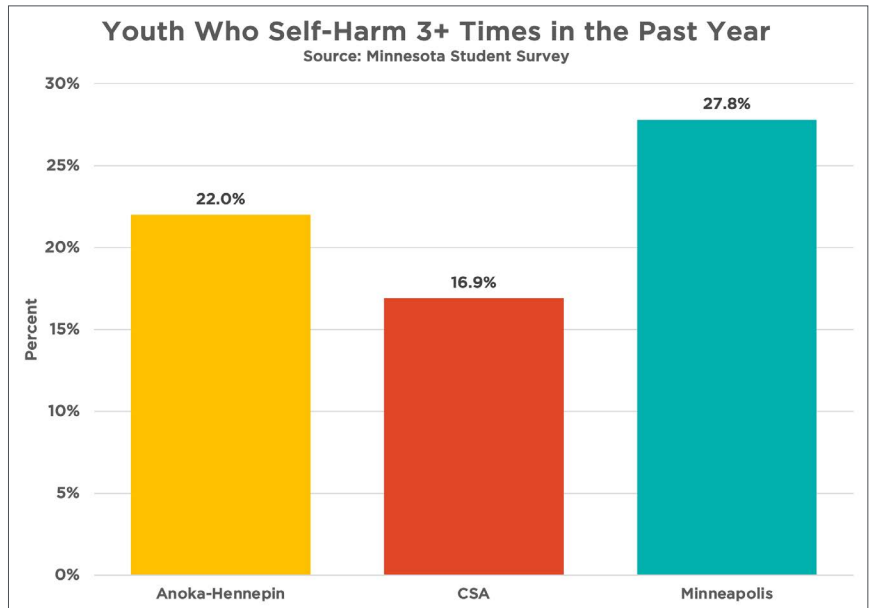


This figure comes from the Surgeon General's Advisory on Protecting Youth Mental Health (2021) and shows the five distinct categories that affect youth's mental health including individual, familial, community, environment, and societal factors.



Youth Self-Harm

The *Journal of Pediatric Health Care* defines nonsuicidal self-injury (NSSI) as “the deliberate infliction of damage, pain or both to one’s own body tissue without the intention of suicide¹.” This can include behaviors like cutting, burning, biting, or scratching themselves and estimated to affect 7%-14% of youth at least once. The onset of NSSI typically starts around 11-15 years old and occurs most often in those aged 14 to 24 years old¹. Many youth cite engaging in NSSI to relieve anxiety or stress, to punish themselves, or as a way to avoid dissociation or feel numb.



The Minnesota Student Survey asks students if they have engaged in any self-harming behaviors within the past year. More than 1 in 5 (22.0%) students in Anoka-Hennepin school districts, almost 1 in 6 students (16.9%) in our CSA, and more than 1 in 4 students (27.8%) in the Minneapolis School District report self-harming at least three or more times within the past year.

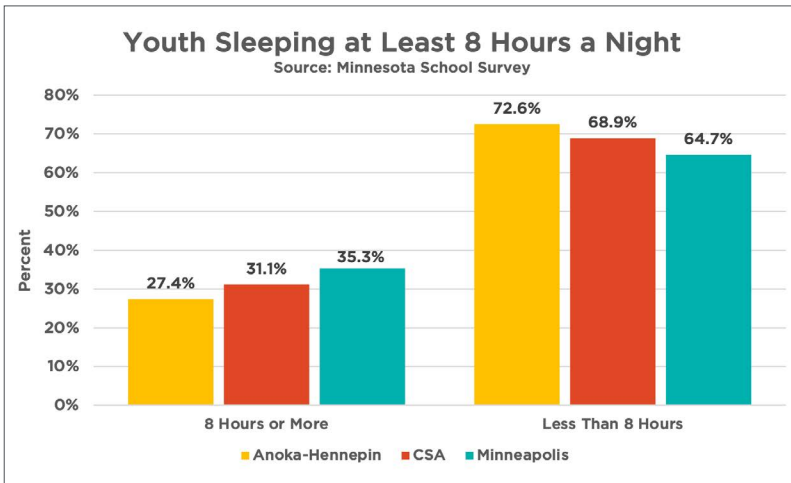
¹Hornor, G. (2016). Nonsuicidal Self-Injury. *Journal of Pediatric Health Care*, 30(3), 261-267. <https://doi.org/10.1016/j.pedhc.2015.06.012>

YOUTH SLEEP

There is ample evidence showing an association between the quantity and quality of sleep and mental health for youth. A lack in quantity and quality of sleep predisposes youth to emotional dysregulation, mood disorders, depression, anxiety, substance use, risk-taking behaviors, and suicide¹. Additionally, the development of mental health conditions impacts sleep and increases the frequency of sleep disturbances, ultimately impacting mental health, resulting in unhealthy sleep patterns. There is a strong association between sleep and mental health, especially for youth.

In our community, about 2 out of 3 students (64.7% in Minneapolis to 72.6% in Anoka-Hennepin) do not sleep at least 8 hours every night, thus increasing their risk of mental health conditions.

However, Minneapolis students had the lowest rates of less than 8 hours of sleep a day (64.7%) but the highest rates of chronic mental health conditions (33.5%), being at high risk of depression (27.3%), being at high risk for anxiety (32.0%), and reporting self-harm at least three times in the past month (27.8%). Furthermore, Anoka-Hennepin students had the highest percentage of students sleeping less than 8 hours a night (72.6%), second highest rates of chronic mental health conditions (26.7%), being at high risk for depression (25.5%), being at high risk for anxiety (30.1%), having the highest rates of seriously considering suicide (25.4%), and the lowest rates of attempting suicide (3.5%), as compared to students in different areas of our CSA. There are additional factors to consider when examining youth mental health such as individual, familial, community, environmental, and societal factors mentioned on the previous page.



HP2030 notes that youth getting adequate sleep is getting worse. Their goal is to increase the proportion of youth getting adequate sleep to 27.4% by 2030. We are meeting this goal.

Uccella, S., Cordani, R., Salfi, F., Gorgoni, M., Scarpelli, S., Gemignani, A., Geoffroy, P. A., De Gennaro, L., Palagini, L., Ferrara, M., & Nobili, L. (2023). Sleep Deprivation and Insomnia in Adolescence: Implications for Mental Health. *Brain Sciences*, 13(4), 569. <https://doi.org/10.3390/brainsci13040569>

ADVERSE CHILDHOOD EXPERIENCES (ACES)

Adverse Childhood Experiences (ACEs) are potentially traumatic events that happen to an individual aged 0 to 17 years old including experiencing violence at home or in the community, neglect or abuse by a parent or caregiver, substance use in the home, a parent or guardian with mental health conditions, or a parent or guardian who is incarcerated¹. This list is not all-inclusive as there are many potentially traumatic events that could occur.

ACEs are quite common! Almost 2 out of 3 (64%) US adults have at least 1 adverse childhood experience in their lifetime and almost 1 out of 6 (17.3%) of US adults have four or more ACEs¹. However, not all individuals are at the same risk of developing ACEs. Individuals who are female, American Indian or Alaska Native, Black², Hispanic², and those unable to work or unemployed have the highest rates of ACEs¹.

ACEs have a dose-dependent relationship with health outcomes in that the more adverse childhood experiences someone has, the higher their risk of mental health conditions such as depression or anxiety, substance use (including alcohol), obesity,

ADDRESS IT TODAY. PREVENT IT TOMORROW.

We can reduce the generational impact of adverse childhood experiences (ACEs), overdose, and suicide.

URGENT IN EVERY COMMUNITY	RELATED TO EACH OTHER	PREVENTABLE IF WE ACT NOW
<p>ACEs, overdose, and suicide are critical and growing public health challenges.</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>5+</p> <p>of the 10 leading causes of death are associated with ACEs¹</p> </div> <div style="text-align: center;"> <p>35%</p> <p>increase in suicide rates²</p> <p>— 1999 - 2018 →</p> </div> </div> <div style="text-align: center; margin-top: 10px;"> <p>6x</p> <p>increase in opioid overdose deaths³</p> <p>— 1999 - 2018 →</p> </div>	<p>ACEs, overdose, and suicide have generational impact since preventing or addressing any one of these issues...</p> <p>... decreases the risk of the others both now and for the next generation.</p>	<p>Aligning policies and programs—and building on community strengths—can prevent ACEs, overdose, and suicide.</p> <div style="display: grid; grid-template-columns: 1fr 1fr; gap: 10px;"> <div style="text-align: center;"> <p>Engage People as change agents in their communities</p> </div> <div style="text-align: center;"> <p>Increase Understanding of the shared root causes</p> </div> <div style="text-align: center;"> <p>Ensure Equity in policies, programs, and services</p> </div> <div style="text-align: center;"> <p>Invest in Research to better understand what works</p> </div> </div>
<p>PREVENTION BENEFITS US ALL Preventing ACEs, overdose, and suicide has wide-ranging benefits.</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>Increased Economic Productivity</p> </div> <div style="text-align: center;"> <p>Lower Healthcare Costs</p> </div> <div style="text-align: center;"> <p>More Effective Programs and Services</p> </div> <div style="text-align: center;"> <p>Longer Life Span</p> </div> </div>		
<p><small>¹ https://www.cdc.gov/vitalsigns/aces/index.html ² https://www.cdc.gov/nchs/products/databriefs/db362.htm ³ https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf</small></p> <p style="text-align: center;">www.cdc.gov/injury</p> <div style="display: flex; justify-content: flex-end; align-items: center; gap: 20px;"> </div>		

heart disease, diabetes, cancer, other chronic health conditions, sexually transmitted infections, teenage pregnancy, risky behaviors and social determinants that impact their health, smoking, suicide, and ultimately, mortality. ACEs are also associated with decreased rates of educational attainment, financial stability, and job opportunities while increasing rates of incarceration and violence.

According to the Centers of Disease Control and Prevention, preventing ACEs could have¹:

- Prevented 1.9 million cases of heart disease
- Avoided 21 million cases of depression
- Reduced suicide attempts among high school students by 89%
- Decreased prescription medication misuse by 84%
- Lessened persistent feelings of sadness or hopelessness by 66%
- Saved \$748 billion annually in healthcare expenses in the US

Preventing ACEs has monumental impacts on our community members and our healthcare system.

¹CDC. (2025, January 31). About Adverse Childhood Experiences. Adverse Childhood Experiences (ACEs). <https://www.cdc.gov/aces/about/index.html>

²Zhang, X, and Monnat, SM. Racial/ethnic differences in clusters of adverse childhood experience and associations with adolescent mental health. SSM – Population Health, 16 December 2021, accessed Jan 2025.

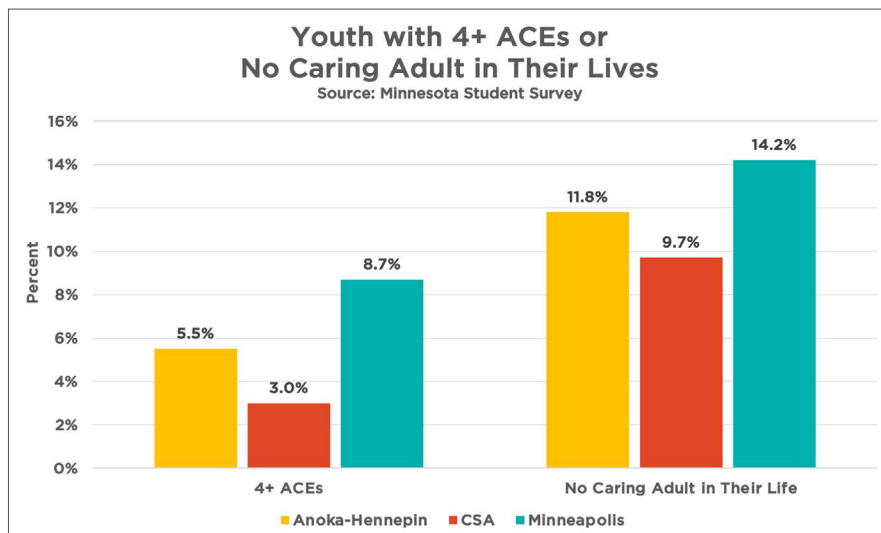
Youth with ACEs

No information is available on adults with ACEs for our specific CSA or for the state of Minnesota. However, national rates of ACEs among adults are summarized above.

For youth in our community, 1 out of 12 (8.7%) of Minneapolis students had at least four or more adverse childhood experiences, increasing their risk of life-long health impacts, chronic disease, and worsening economic outcomes (e.g., educational attainment or job opportunities) in our community.¹

1 out of 18 (5.5%) Anoka-Hennepin students and 1 out of 33 students in our CSA had 4+ ACEs. Students in Minneapolis had almost triple the rate of 4+ ACEs as compared to other students in our CSA (excluding Anoka-Hennepin students).

One of the ways to combat adverse childhood experiences is by increasing the amount of positive childhood experiences (PCEs). PCEs can be increased through a relationship with an adult who takes genuine interest in a child/youth, models healthy communication and emotional regulation, and supports them. PCEs also



*CSA data may not be accurate as a portion of CSA student respondents were missing.

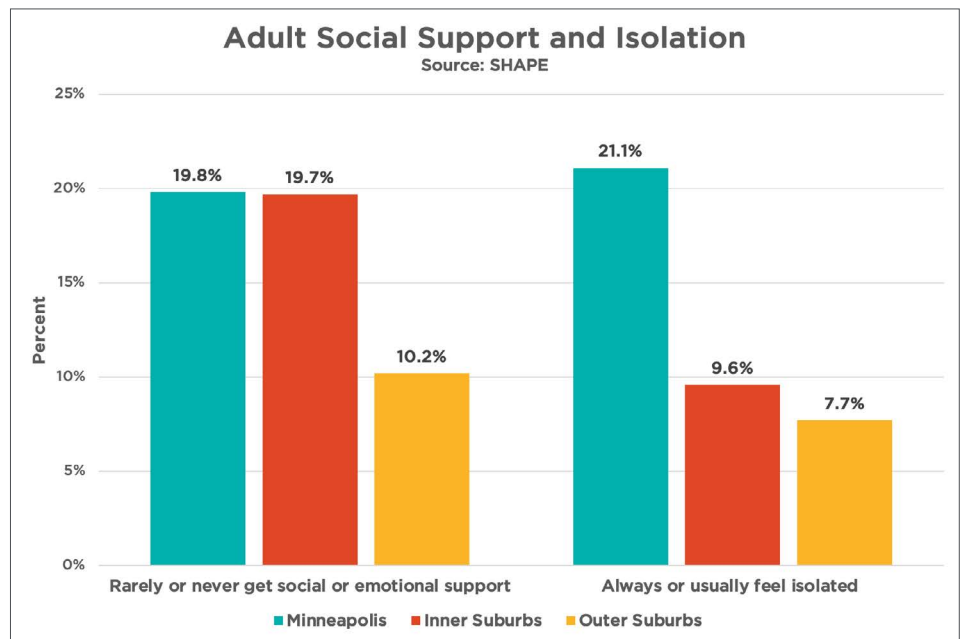
have a dose-dependent relationship in that the higher the number of PCEs, the less impactful ACEs are, and health and economic outcomes increase¹.

Youth without a caring adult in their lives to contribute PCEs are at highest risk of ACEs and their impacts. Minneapolis students had the highest rate of ACEs in our community (8.7%) and also had the highest rate of not having a caring adult in their lives (14.2%). In fact, 1 out of 7 Minneapolis students reported not having a single caring adult in their lives as compared to 1 in 9 (11.9%) Anoka-Hennepin students and 1 in 10 (9.7%) of students in our remaining CSA.

¹Aware, A. C. E. (2021, June 4). ACE Aware NL. Www.Aceaware.Nl. <https://aceaware.nl/en/2021/06/04/positive-childhood-experiences-building-resilience-and-mitigating-toxic-stress-through-safety-and-connection-2/>

SOCIAL AND EMOTIONAL SUPPORT

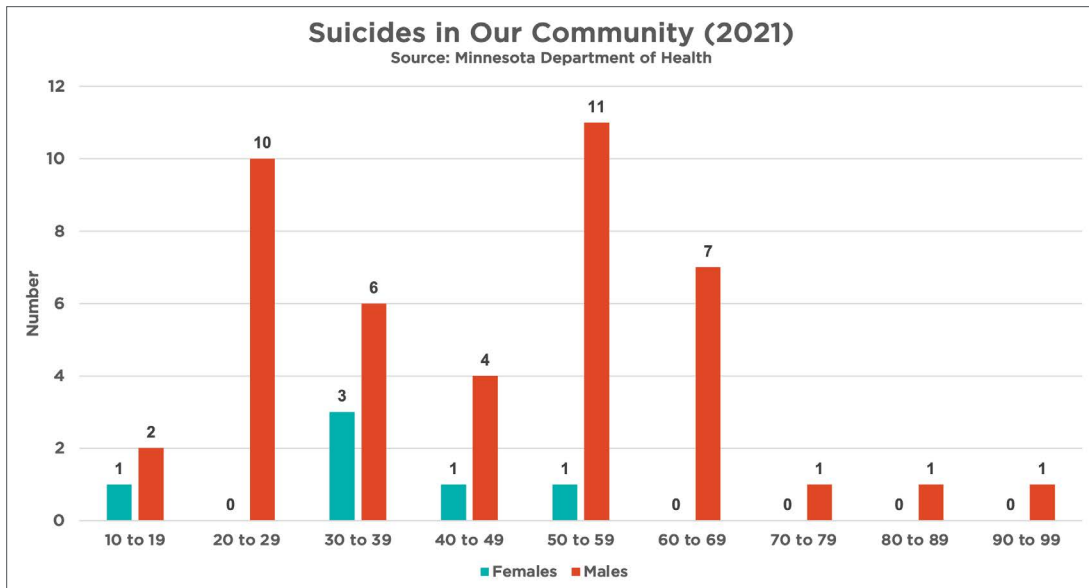
There is strong and ample evidence showing the connection between social and emotional support, isolation, mental health, and overall health outcomes. In our community almost 1 out of 5 adults in Minneapolis (19.8%) and the Inner Suburbs (19.7%) felt they rarely or never got the social or emotional support they needed, as compared to 1 in 10 (10.2%) of adults in the Outer Suburbs. The populations who felt like they received the least amount of social and emotional support were populations who were ages 18-24 years old, American Indian/Alaska Native, Hispanic, Asian, Black, low-income, had a high school degree or less, speak a another language other than English at home most of the time, and those who experienced economic distress.



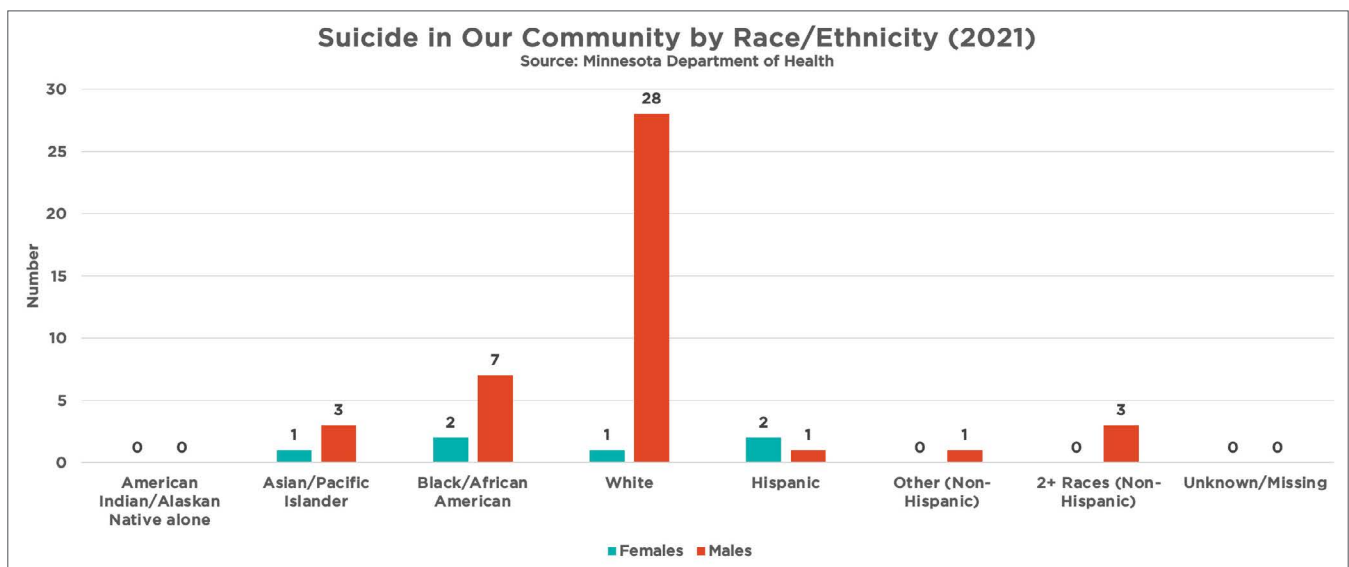
Equal percentages of respondents in the Minneapolis and Inner Suburbs of our CSA felt they never received social or emotional support. More than twice as many Minneapolis respondents (21.1%) said they always or usually felt lonely, as compared to 9.6% in the Inner Suburbs and 7.7% in the Outer Suburbs. The populations that felt the most isolated were ages 45 and older, Black-Foreign born, heterosexual, had less than a high school degree, and primarily speak a language other than English at home.

SUICIDE DATA

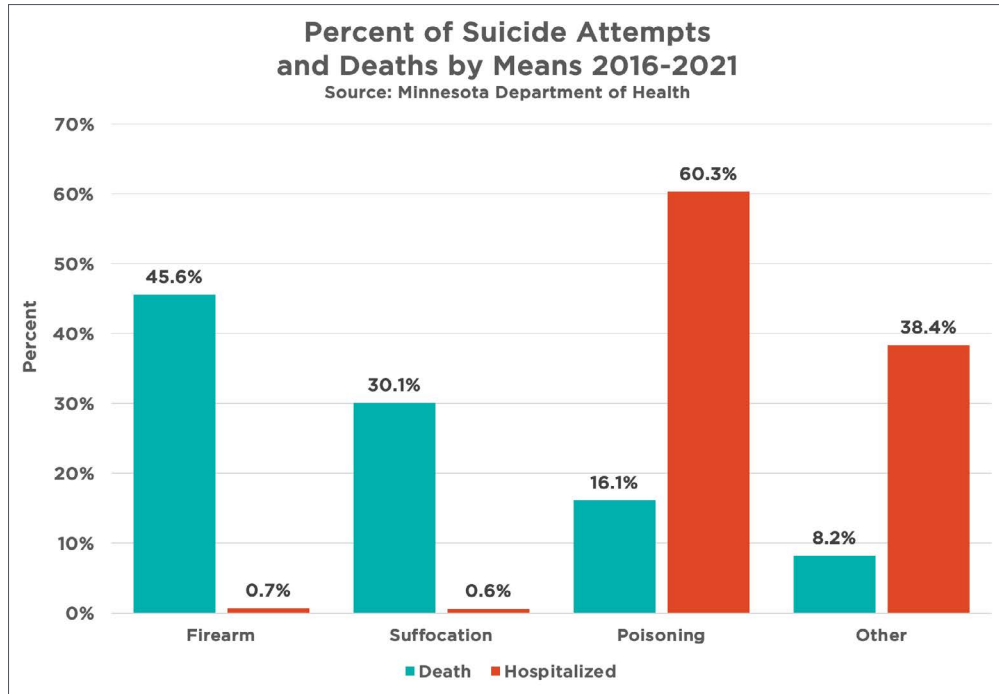
The most recent data we have on suicide is from the Minnesota Department of Health for 2021. Data was shared about gender and age. In our CSA in 2021, 87.8% of suicide deaths were male as compared to 12.2% of females. Males had the most suicide deaths at ages 50-59 followed by 20-29. Females had the most suicide deaths in the ages of 30-39. The Minnesota Department of Health estimates that approximately 80% of all suicide deaths in Minnesota involve men¹.



Regarding race and ethnicity, 59.2% of suicide deaths in our CSA were White individuals with 28 out of 29 being White males.



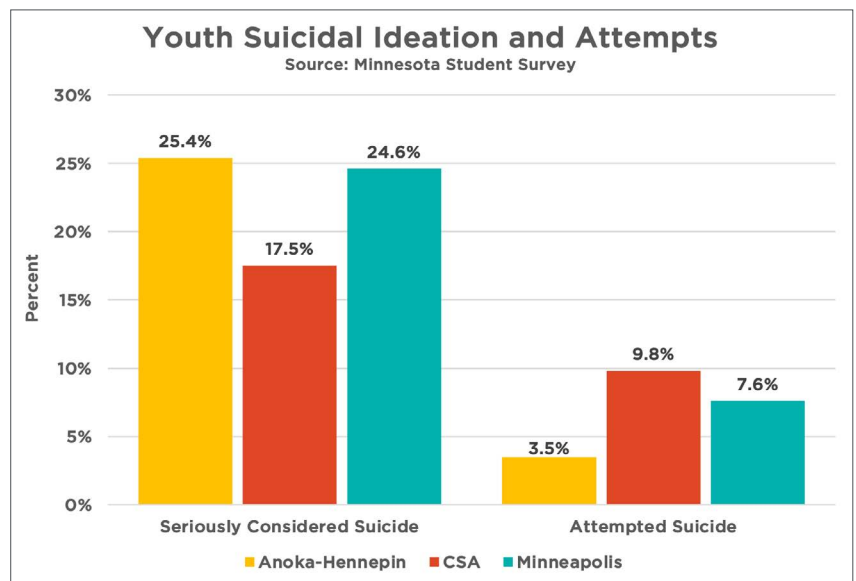
The highest suicide fatality rates in Minnesota are from those who use firearms (45.6%), followed by suffocation (30.1%), and poisoning (16.1%). Males often choose more lethal means such as using a firearm whereas females tend to have higher rates of nonfatal suicide attempts¹. According to MDH, White males account for around 80% of all suicide deaths involving firearms in all of Minnesota.



¹Preventable deaths by suicide declined in 2023—MN Dept. Of Health. (n.d.). Retrieved February 4, 2025, from <https://www.health.state.mn.us/news/pressrel/2024/suicide073124.html>

Youth Suicide

According to data from the Minnesota Student Survey, approximately 1 out of 4 students in Anoka-Hennepin (25.4%) and Minneapolis (24.6%) and more than 1 in 6 students in our CSA (17.5%) seriously considered suicide. Interestingly, it was the rest of the CSA who had the highest percentage of youth who attempted suicide at almost 1 out of 10 (9.8%) of students. Although Anoka-Hennepin and Minneapolis, had higher percentages of youth who seriously considered suicide, they had lower rates of youth who attempted suicide at 3.5% (Anoka-Hennepin) and 7.6% (Minneapolis).



Substance Use

INTRODUCTION

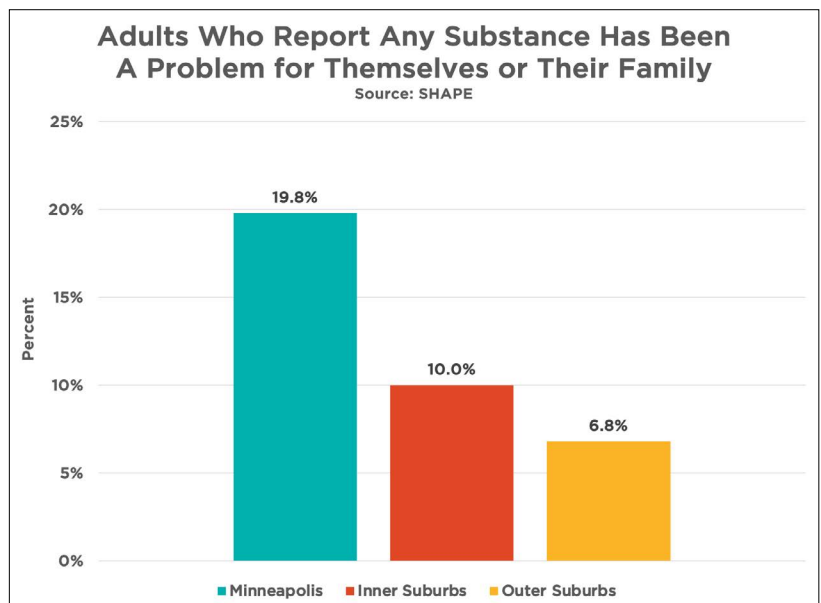
Like mental health, substance use disorders have a variety of types, range of spectrums, and evidenced-based treatments. Substances could refer to alcohol, cannabis, hallucinogens (e.g., psilocybin, LSD, ecstasy, Ketamine), inhalants, opioids, sedatives, stimulants, tobacco, and many other substances. Additionally, some individuals use prescription drugs in ways other than that for which they were prescribed, which is considered substance misuse and contributes to many leading causes of death including cancer, heart disease, and stroke, and increases a person's risk for both intentional and unintentional injury. Substance use and misuse can also impact a person's education, employment, family, and social relationships.

Substance use disorder (SUD) is the persistent use of drugs despite adverse consequences and harm. Substance use can result in a wide range of mental/emotional, physical, and behavioral impacts and problems, including chronic guilt, an inability to reduce or stop consuming the substance(s) despite repeated attempts or wanting to, engaging in risky behavior (e.g., driving while intoxicated, risky sexual behavior), physiological withdrawal symptoms, and increased mortality. Symptoms can range from moderate to severe, with addiction being the most severe form of SUDs.

More than 46 million (16.5% of the US population) people in the United States ages 12 and older had a substance use disorder in 2021.¹ Only 6% (or <2.8 million) of those with a SUD ever receive treatment for their SUD in their lifetime.

In our community, almost 1 out of 5 (19.8%) of Minneapolis adults reported at least one substance (alcohol, marijuana, opioids, or other) was a problem for either themselves or their family. This compares to rates of 1 in 10 in the Inner Suburbs and almost 1 in 15 (6.8%) in the Outer Suburbs who felt one of these substances was a problem.

Strategies to prevent drug and alcohol use at the school, family, and community level are key to reducing substance use disorders and improving health in our community.



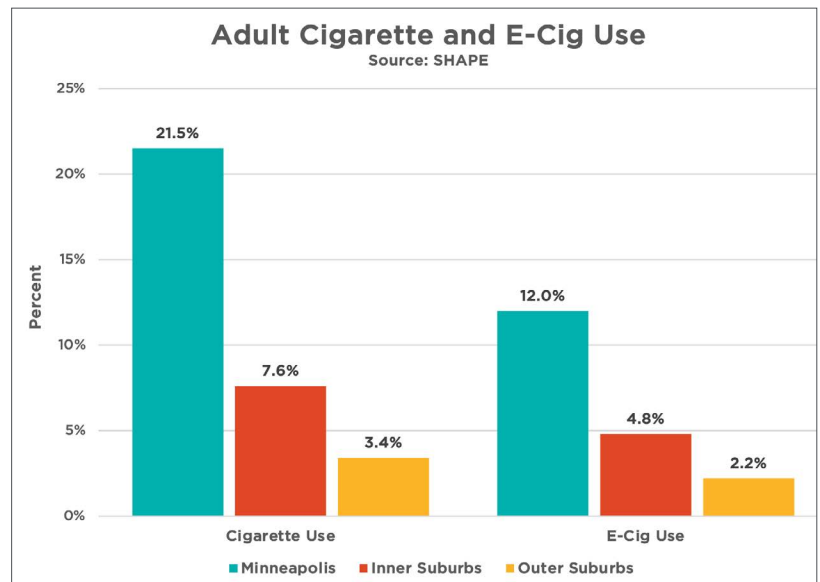
¹Survey: Most Americans with substance use disorders don't receive treatment | AHA News. (2023, January 6). American Hospital Association. <https://www.aha.org/news/headline/2023-01-06-survey-most-americans-substance-use-disorders-dont-receive-treatment>

TOBACCO USE

Tobacco use can have many health consequences such as an increased risk of chronic respiratory diseases, cancers, heart disease, high blood pressure, the risk of stroke, and more. In fact, the CDC estimates that smoking and secondhand smoke causes over 480,000 deaths annually and is the leading cause of preventable death in the United States¹. Over the last few years there has been a reduction in both adult and youth smoking cigarettes. However, there has been an increase in e-cigarette use, which is still considered tobacco use, by both groups as well.

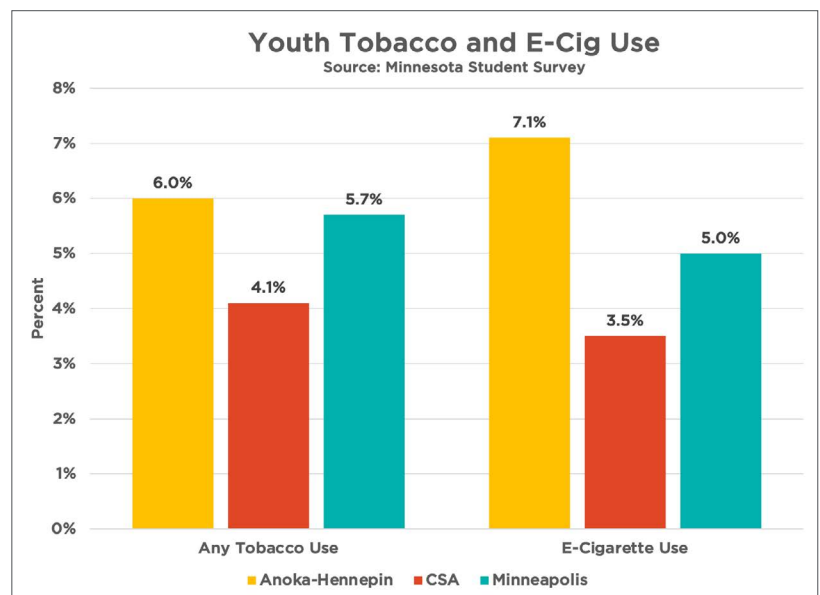
Adult Tobacco Use

Minneapolis adults had almost triple the percentage of adults that used traditional cigarettes or e-cig use (21.5% and 12.0%, respectively) when compared to other areas of our community. Furthermore, cigarette smoking and e-cig use doubled for the Inner Suburbs compared to the Outer Suburbs. Tobacco use was highest among individuals who are American Indian or Alaska Native, Black-US born, low-income, do not have a college degree, who experience economic distress, and who experience mental distress.



Youth Tobacco Use

For youth, tobacco and e-cigarette use is highest in the Anoka-Hennepin area (6.0% and 7.1%, respectively). This is in contrast to the adults in the Outer Suburbs who used tobacco the least often (3.4% and 2.2%). No information is available on race, income, or other demographics to examine for disparities in our student populations.



¹CDC. (2025, January 6). Cigarette Smoking. Smoking and Tobacco Use. <https://www.cdc.gov/tobacco/about/index.html>

*HP2030 has a baseline goal to reduce current e-cigarette use among youth to 10.5%.
We are meeting this goal in all school districts.*

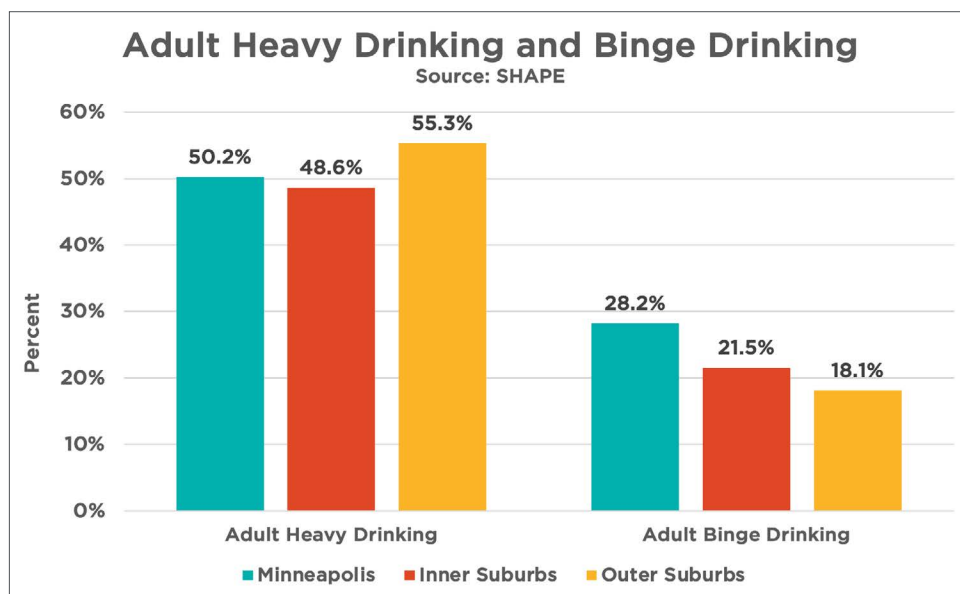
ALCOHOL USE

Alcohol is the most frequently misused substance nationally and causes more injury and fatalities than any other drug or substance¹. In fact, in 2022, alcohol accounted for almost one third (32%) of all driving fatalities and alcohol use disorder accounts for approximately 1 in 4 deaths by suicide¹. Furthermore, drinking too much alcohol can cause serious, lifelong health problems including stroke, cancer, and cirrhosis. People with alcohol use disorder are also more likely to get sick and less able to fight off infections.

Adult Alcohol Use

Alcohol misuse can be classified as heavy drinking or binge drinking. Heavy drinking is defined as one or more drinks on average per day for women or two or more drinks per day for men. Binge drinking is defined as 4 drinks on a single occasion, within two hours for women, and 5 drinks on a single occasion, within two hours, for men. SHAPE asks respondents about their use of alcohol in the past 30 days. About 50% of all adults in our CSA report heavy drinking in the last 30 days with the highest being in the Outer Suburbs (55.3%). Heavy drinking was highest among those aged 25-44 (60.5%), White (59.9%), Hispanic (52.2%), American Indian or Alaska Native (46.0%), females (63.4%), 200+% above the Federal Poverty Level (60.4%), and those with some college or higher.

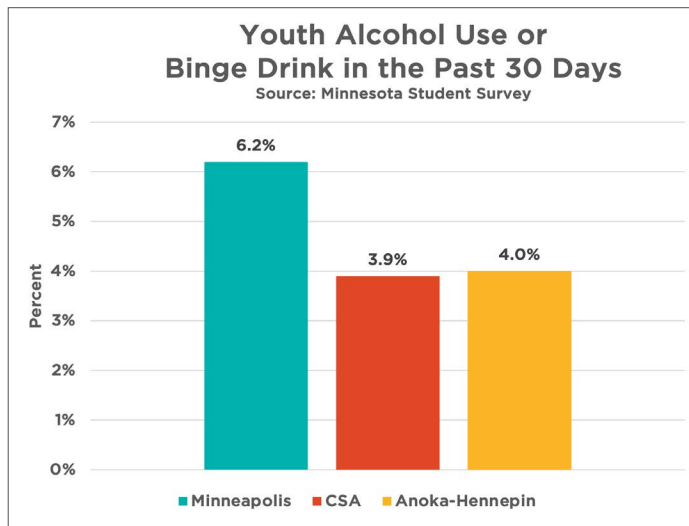
Minneapolis adults report the highest percentage of binge drinking at 28.2% as compared to the Outer Suburbs where 18.1% of adults report binge drinking. The highest rates of binge drinking occur in individuals aged 25-44 (33.4%), and those who identify as either American Indian or Alaska Native (28.4%), or Hispanic (26.6%).



¹Alcohol-Related Emergencies and Deaths in the United States | National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2024, November). <https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics-z/alcohol-facts-and-statistics/alcohol-related-emergencies-and-deaths-united-states>

Youth Alcohol Use

In our community, Minneapolis students reported the highest percentage of alcohol use and binge drinking within the last 30 days at 6.2% or about 1 out of 16 students as compared to CSA and Anoka-Hennepin at about 4% or 1 out of every 25 students.



HP2030 has the goal of decreasing youth alcohol use and binge drinking to 8.4%. We are meeting this goal for all areas in our community.

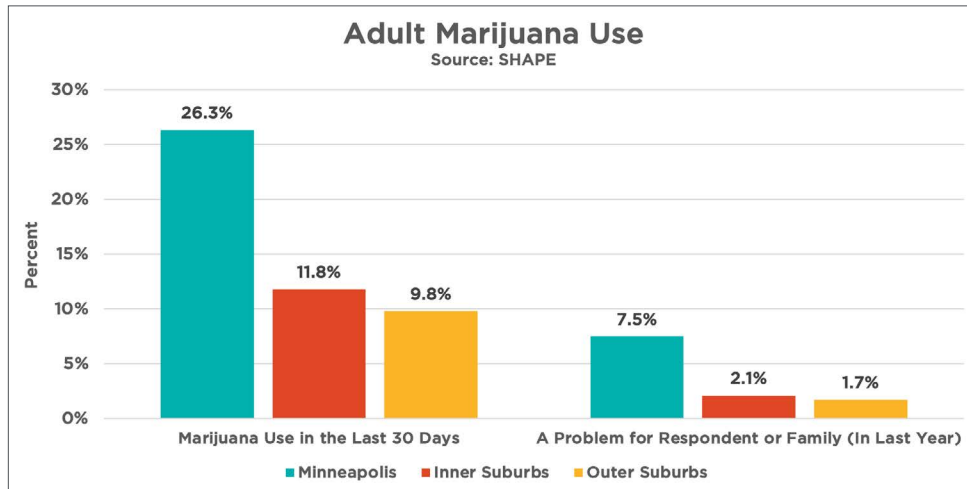
MARIJUANA USE

Marijuana, also known as cannabis, prevalence has been increasing in years since it was legalized in varying degrees across the US. Although there is a common misconception that marijuana use is not addictive, approximately 1 in 10 people who use marijuana become addicted and several more experience marijuana use disorder¹. Chronic marijuana use has been shown to lead to an increased risk of head, neck, and throat cancers, chronic respiratory diseases, stroke, abnormal heart rhythms, heart attacks, and gastrointestinal issues².

Adult Marijuana Use

In Minneapolis, more than 1 in 4 adults (26.3%) have used marijuana in the last 30 days and about 1 in 13 adults (7.5%) said that marijuana was a problem for themselves or their family within the last year. For the rest of our community, approximately 1 in 10 adults (~10%) has used marijuana in the last 30 days and around 1 in 50 adults (~2%) stated that marijuana was a problem for their family. According to the 2022 SHAPE survey, individuals who had the largest rates of marijuana use were ages 18-44 years old, Black-US born, non-binary, transgender, LGBTQ+, spoke English as their primary language, experiencing economic distress, or reporting frequent mental illness. There were minimal differences in adult marijuana use for educational attainment levels and income levels.

Though marijuana use was more prevalent for our community in ages 18-44, it should be noted that the National Institute on Drug Abuse found that adults 50+ years of age had the “largest increase in cannabis use compared to any other age group, with the greatest increase among those 65 years or older”. With marijuana more readily accessible, use has become more frequent across multiple ages and demographics.

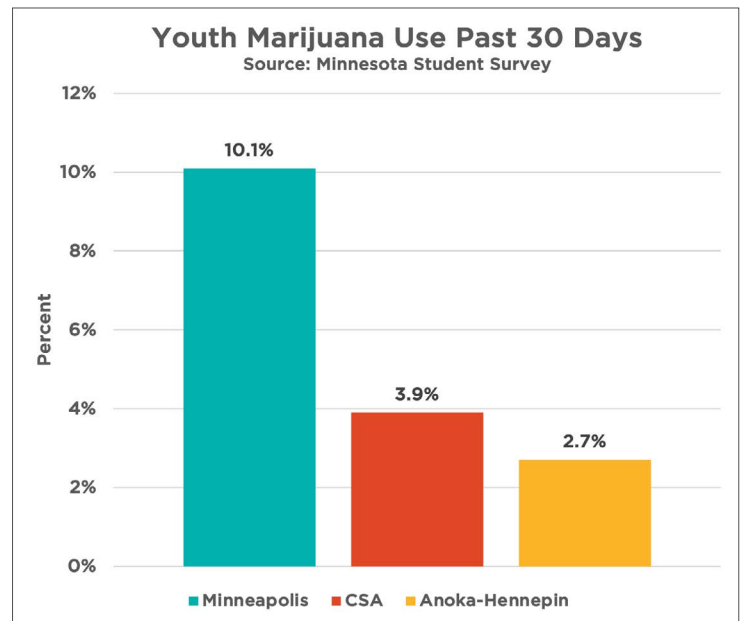


¹SAMHSA Fact Sheet “Learn About Marijuana Risks” Know the Risks of Marijuana | SAMHSA, accessed May 16, 2022.

²Abuse, N. I. on D. (2024, September 24). Cannabis (Marijuana) | National Institute on Drug Abuse (NIDA). <https://nida.nih.gov/research-topics/cannabis-marijuana>

Youth Marijuana Use

As stated above, approximately 1 in 10 people who use marijuana will become addicted but when someone starts using marijuana before 18 years of age, approximately 1 in 6 become addicted to it, almost doubling the chances of addiction¹. Youth who use marijuana frequently or heavily have an increased risk of memory impairment, decreased processing speed, impaired academic functioning, developing psychosis and other mental health conditions, which impact educational attainment, employment, and income later in life². Minneapolis students used marijuana at more than twice the rate than our CSA or Anoka-Hennepin students did (10.1%, 3.9%, 2.7%, respectively). No information was available on disparities among youth who use marijuana.



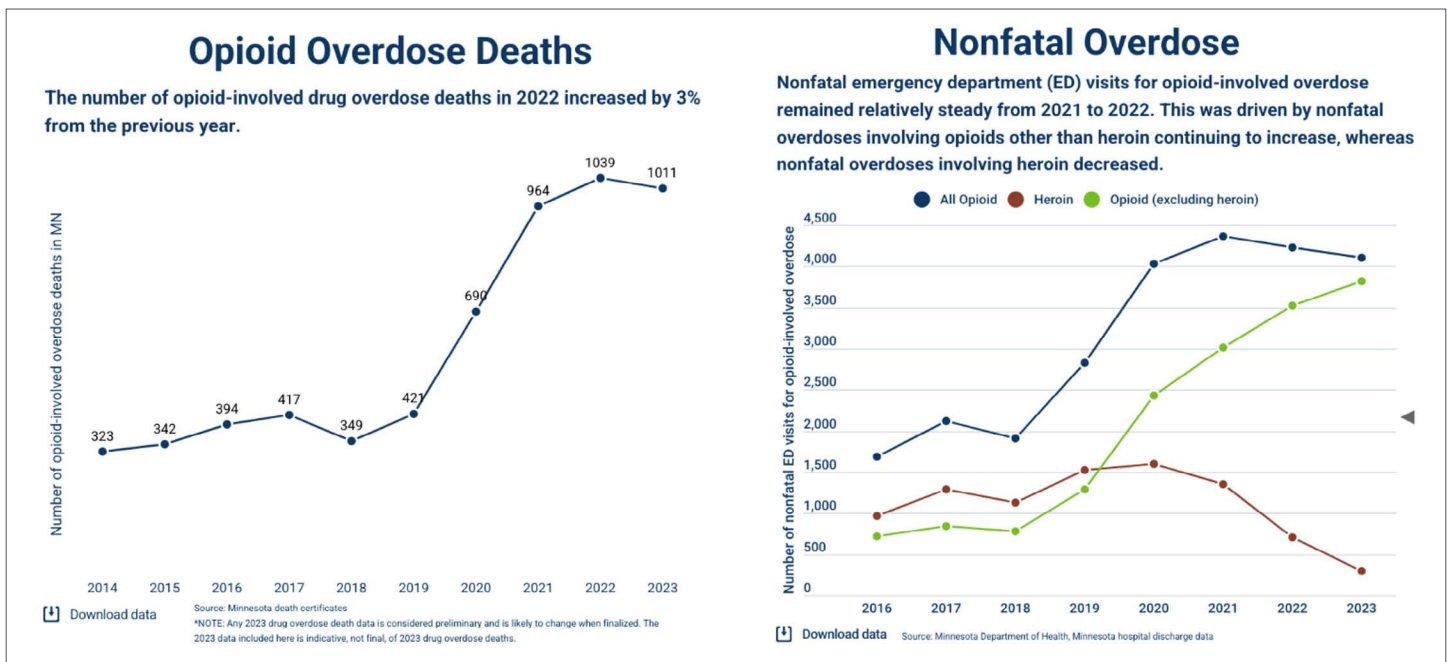
¹SAMHSA Fact Sheet “Learn About Marijuana Risks” Know the Risks of Marijuana | SAMHSA, accessed May 16, 2022.

²Abuse, N. I. on D. (2024, September 24). Cannabis (Marijuana) | National Institute on Drug Abuse (NIDA). <https://nida.nih.gov/research-topics/cannabis-marijuana>

HP2030 has a baseline goal to reduce the proportion of adolescents who used marijuana in the past month to 5.8%. We are not meeting that goal in the Minneapolis school district.

OPIOID USE

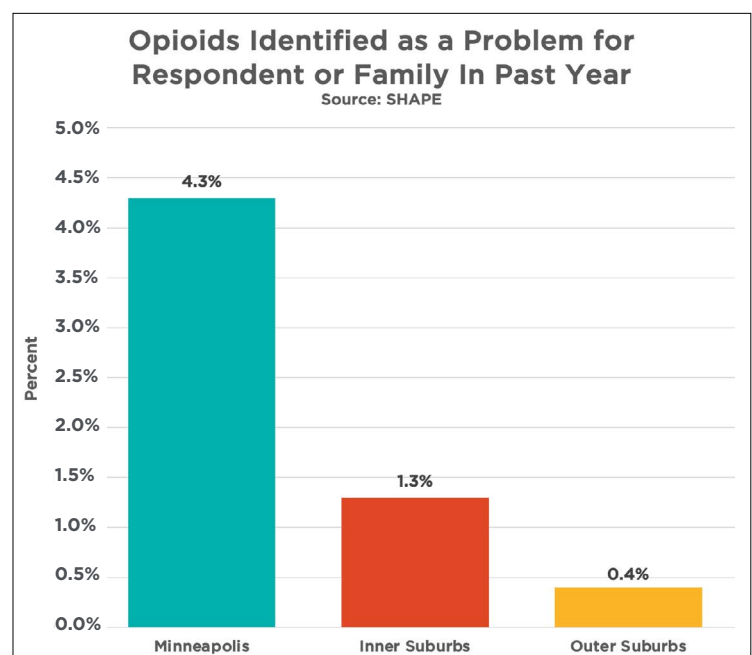
Opioid overdose deaths decreased 3% between 2022 and 2023 in Minnesota but continue to remain at almost triple the rate from before 2019¹. The large increase in opioid overdose deaths since 2019 was thought to be partially due to COVID-19, social isolation causing people to use opioids alone and overdose alone, and the increased prevalence of Fentanyl in opioids.



Adult Opioid Use

According to the Minnesota Department of Health, emergency department visits have remained steady from 2021 to 2022 but have still been elevated after 2018. In 2022, 2 out of 3 (67.8%) people who experienced nonfatal opioid overdoses were male. Persons aged 25-34 also had the greatest number of nonfatal opioid overdose as compared to any other age group.

There is only one question on the 2022 SHAPE specifically asking about opioid use in adults, which inquires if a respondent believed that opioid use was a problem for themselves or their family. 4.3% of Minneapolis respondents felt that opioids were a problem for themselves or their family members, as compared to Inner Suburbs (1.3%) and Outer Suburbs (0.4%). However, SHAPE identified that the sample sizes were not large enough to make inferences about the suburbs.



¹Drug Overdose Dashboard—MN Dept. Of Health. (n.d.). Retrieved February 5, 2025, from <https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html>

Youth Opioid Use

The 2022 MSS does not ask students about their opioid use. The Minnesota Department of Health reports that the percent of 8th and 9th graders who reported inappropriate use of pain medications has continued to increase for the past decade (from 0.8% in 2013 to 5.2% in 2022 for 8th graders; 1.8% to 4.4% of 9th graders). The percentage of 11th graders who report misusing pain medications decreased from 4.8% (2016) to 3.1% (2019) and remained the same in 2022.

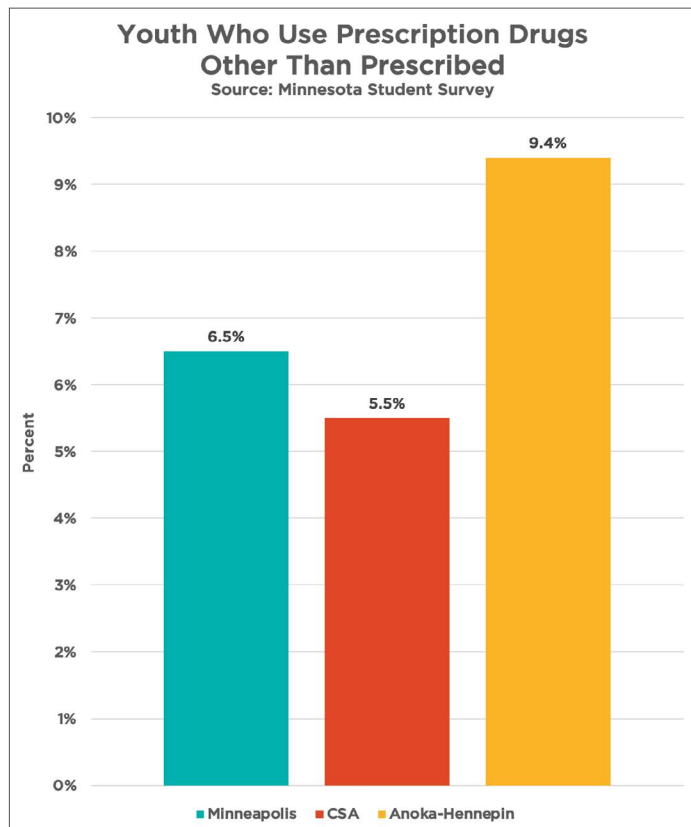
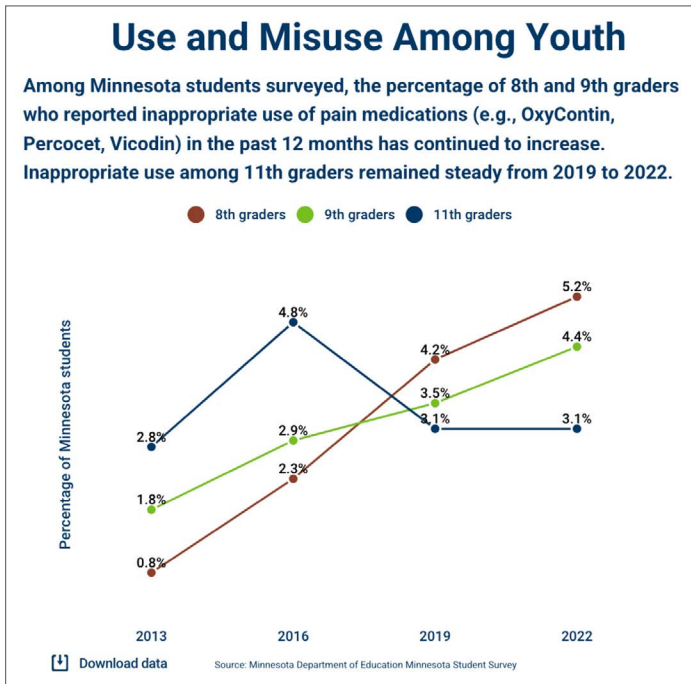
North Memorial Health Opioid Work

North Memorial Health continues to combat the opioid epidemic by partnering with departments such as their Community Paramedic Program to meet with a patient in the community, give them naloxone (or Narcan)—the lifesaving reversal medication for someone who overdoses on opioids— at no cost, and teach them and their supports how to use it.

¹Drug Overdose Dashboard—MN Dept. Of Health. (n.d.). Retrieved February 5, 2025, from <https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html>

YOUTH USING PRESCRIPTION DRUGS

Prescription misuse is using a medication differently than was prescribed or by a different person than who it was prescribed for. Students in the Anoka-Hennepin school districts reported the highest rate of prescription drug misuse at about 1 out of 11 students (9.4%) as compared to about 1 in 15 (6.5%) of Minneapolis students and 1 in 18 (5.5%) of students in the CSA. HP2030 does not presently have a goal on this. No information or data is available to assess for disparities.



Review of Findings

QUANTITATIVE FINDINGS

CEAT Members scored 82 key health indicators on five criteria: Size, Seriousness, Effective Interventions, Disparities and Meeting a Health Goal (See the Appendix for the scoresheet CEAT members used). CEAT members were asked to analyze key health indicators at a generalized level for the five criteria. Health issues that were deemed critical were explored further through the qualitative phase of our CHNA and more specific quantitative data was provided as priority issues were selected.

Doing Well

Health issues were listed as doing well by CEAT members if they had a score of 13-14 when health goal scores were included and 10-12 when health goals were not available or included.

Basic Needs

- Unemployment is low

Safe and Healthy Communities

- Youth feel safe and supported at school, home, and in their neighborhood
- Youth with a caring adult
- Adults feel neighborhood is safe from crime
- Good air quality

Youth and Adult General Health

- Youth health is excellent or very good
- Youth are physically active
- Youth get enough sleep
- Adult and youth oral health

Maternal Health

- Low teen birth rates
- Pregnant women not smoking

Substance Use

- Youth not smoking or vaping
- Youth not using alcohol

Unintentional Injury

- Motor vehicle crash mortality

Critical Health Issues

Health issues were deemed critical by CEAT members if they had a score of ≥ 17.4 when health goal scores were included and ≥ 15 when health goals were not available or included.

Health Access and Quality

- Adults who have a doctor's office or health clinic to go to when they need care
- Adults delaying medical care due to cost of lack of insurance
- Treated disrespectfully or discriminated against by health care providers

Chronic Disease

- Heart disease, cancer, and stroke mortality

Basic Needs

- Food insecurity for both adults and youth
- Adult fruit and vegetable consumption

Communicable Disease

- Sexually transmitted infection rates
- Adults up-to-date on immunizations

Maternal and Child Health

- Rate of infant deaths per 1,000 live births

Substance Use

- Heavy alcohol use in adults
- Tobacco use in adults
- Percent of households with children 0-17 where at least one person smokes

Mental Health

- Adults delaying care for a mental health concern due to cost of lack of insurance
- Adults reporting poor mental health for 14+ days
- Adults at risk for depression
- Adults who wanted help for a mental health problem

Disparities

There were many health disparities in the data that was examined. A definition of health disparities and a table of disparities can be found in the appendix.

QUALITATIVE RESEARCH

At the Data Walk, participants voted for what they believed are the more critical health issues for North Memorial Health to address. Of the four topics areas, Health System received 32 votes, followed by Chronic Disease (31), Mental Health (30), and Maternal and Child Health (15).

Common themes appeared across all four health topics including:

- Access to and usage of a primary care provider
- Finding providers who look like our community members, understand their culture, who speak their native language, and/or that they can trust
- Awareness and education surrounding health and chronic disease
- Identifying and flagging important health needs and why they matter
- Availability of preventative screenings in the community
- Help navigating the healthcare system and being referred to appropriate care

Data and information from the Data Walk was brought back to the CEAT to discuss further and prioritize the needs of the community with the capabilities of North Memorial Health. Mental Health and Maternal and Child Health were both eliminated as two health priority topic areas for different reasons. Mental health was significant to our community, but the identified needs did not match with North Memorial Health's capacity and resources which limited our ability to impact mental health. Maternal and Child health was not seen as a significant priority by Data Walk participants, having 50% or less votes compared to other critical health issues. However, CEAT acknowledged that both mental health and maternal and child health benefit from a focus on primary care, navigating the health care system, and preventative care.

Health System and Chronic Disease health priorities were often seen as related to each other by both community members and CEAT members. For example, prevention, early intervention, and screening for chronic diseases often happens with primary care providers. If there is limited access to primary care, chronic disease management can be delayed, require more aggressive intervention, or neglected entirely by patients.

2026-2028 Community Health Priorities

DEVELOPMENT AND ADOPTION OF THE COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP)

Community Health employees researched and provided evidence-based or promising practices to address the three priority issues. Many of the strategies were identified from inventories or best-practice clearinghouses such as *The Community Guide to Preventive Health Services*, *the RWJF Community Health Rankings-What Works for Health and Action Center*, *HP2030 Goals and Objectives-Evidence-Based Resources*, *The Community Toolbox: Database of Best Practices*, *CDC's Community Health Navigator*, *Substance Abuse and Mental Health Services Administration's Evidence-Based Practices Resource Center*, and the *American Hospital Association's Association for Community Health Improvement's Reducing Healthcare Disparities Resources*.

Strategies were selected based on research on evidence-based practices that could make a difference in our priority health areas. With limited resources, we have narrowed down our strategies to those that North Memorial Health has some resources and capabilities to address. Additionally, we are focusing on areas in which we believe we can obtain additional funding (e.g., grants) and/or that are narrow enough to measure the impact of our work.

Working closely with the CEAT, community partners, and community members, a CHIP has been developed that outlines strategies for addressing the priority health issues. The following tables list the three priority issues, objectives, and strategies to address the issues, along with current partners, resources needed, initial metrics for measuring progress on each strategy, responsible program(s), and a high-level timeframe for completing the strategy.

CHIP PRIORITIES: 2026-2028 OVERVIEW

To improve community health outcomes, we are committed to supporting community members, including patients and their families, in three priority health areas which are:

Priority 1: Establish Care with a Primary Care Provider and/or Health Clinic

Rationale: Access to a primary care provider (PCP) is essential for preventive care, early diagnosis, and chronic disease management. Individuals with a PCP are more likely to receive routine screenings, immunizations, and timely treatment, resulting in better health outcomes and reduced reliance on urgent care and emergency services. PCPs are very good at chronic condition management and provide continuity of care, which leads to better medication adherence and fewer complications. Long-term relationships with a PCP fosters trust, which improves communication and treatment adherence resulting in better health outcomes and earlier diagnosis of health issues.

Expected Impact: Connecting patients and community members to a PCP or clinic will promote earlier diagnosis, reduce emergency department usage, and improve overall health—especially among populations who are uninsured, underinsured, or delaying care due to cost.

Key Data:

- **More than one in three (38%)** of North Minneapolis adults lack a regular source of care; **12%** use the ER when sick.
- **19-41%** of adults delay care due to cost or lack of insurance, with disparities among younger adults, Hispanic, Asian, economically distressed, and LGBTQ+ populations.

- Disparities in access are highest among American Indian/Alaska Native, Southeast Asian, Black-US-born, Hispanic, low-income, and less-educated groups.
- **31%** of Minneapolis adults report discrimination in healthcare settings, with higher rates among marginalized populations.
- Preventive care gaps: Less than **40%** of adults 65+ in zip codes 55411 and 55412 received a flu shot in 2023–24; fewer than **35%** were up-to-date on COVID-19 vaccinations in key zip codes.
- Recommended vaccines include Tdap (every 10 years), pneumococcal (65+), shingles (50+), and RSV (60+).

Community Feedback:

- Improve access to multilingual, easy-to-understand health information.
- There is a need to connect individuals to appropriate care resources.
- Reduce wait times for primary and urgent care.

Priority 1: Increase community members who establish care with a primary care provider and/or health clinic

Objective	Strategies	Timeline	Metrics	Responsible Program(s)
Enhance the ability of patients and community members to connect to and receive regular medical care from a primary care provider or a health clinic.	Develop outreach materials, including videos, highlighting the importance of having a PCP/health clinic for care.	Years 1 & 2	# of outreach materials and videos	Community Health, Care Management, Marketing/Communications
	Educate about the importance and benefits of having a primary care provider/health clinic through community events and community presentations, with a focus on communities with high rates of people without a usual source of care.	Years 1-3	# and types of community events and presentations	Community Health, CHWs
	Tailor outreach materials in English and other languages, if possible, prioritizing SE Asian and Spanish languages.	Years 1 & 2	# of outreach materials including those in other languages	Community Health, Marketing/Communications
	Navigate high users of emergency departments, patients at high risk of readmission, and people with chronic conditions to primary care providers and specialists.	Years 1-3	# of patients referred	Care Management, Community Paramedics

Priority Populations: North/NE Minneapolis, AI/AN, SE Asian, Black-US born, Hispanic, low-income, HS/GED or less, economically distressed.

Resources Needed: Funding for outreach materials, videos, and translation costs

Internal Partners: Care Management, Population Health, specialty services, Emergency Departments, Community Health Workers (CHWs), Patient Navigators, Community Paramedics, Community Health

External Partners: Neighborhood HealthSource, Broadway Family Medicine, Non-profits serving new Americans, schools, social service agencies

Priority 2: Understand and Navigate the Healthcare System

Rationale: Health literacy empowers individuals to make informed decisions about care, insurance, and costs. Understanding how to access services and manage coverage reduces inappropriate ER use and improves care coordination.

Expected Impact: Educating community members on healthcare navigation will lead to more appropriate service utilization and better financial preparedness.

Key Data:

- **12%** of Minneapolis adults use the ER when sick, compared to **1.2%** in Outer Suburbs.
- ER usage is higher among American Indian/Alaska Native, Black-US-born, Hispanic, low-income, and less-educated individuals.

Community Feedback:

- The system is complex and difficult to navigate.
- Patients need support in establishing care and obtaining referrals beyond primary care.

Priority 2: Help community members understand and navigate the healthcare system				
Objective	Strategies	Timeline	Metrics	Responsible Program(s)
Improve access to care by minimizing geographic barriers, and reducing disparities in access	Consolidate community information on health care barriers, gaps, and challenges in obtaining regular primary care and preventive health, make recommendations for system improvements.	Years 1 & 2	Report on barriers and gaps in healthcare access in our region, # of recommendations	Community Health, Care Management
	Collaborate with local partners to address barriers and gaps in healthcare access that limit community members' ability to access existing resources.	Years 1 & 2	# of meetings with community partners	Community Health, CEAT
	Operationalize reminders for routine check-ups/wellness care/preventive care, such as optimizing Epic for North Memorial Health patients and preventive care reminders at community events.	Years 1-3	# of community events with a prevention outreach focus	Community Health, Care Management

Increase baseline understanding of the healthcare delivery system so patients and community members can receive the care they need when, where, and how they need it.	Develop outreach materials on how to navigate the healthcare system, translate into other languages, as resources allow.	Years 1-3	# of outreach materials including those in other languages	Community Health
	Utilize community care management and community paramedic team members to help community members/patients understand the health care system so they can use it effectively.	Years 1-3	# of patients served	Care Management, Community Paramedics
	Partner with other healthcare organizations to develop and share outreach materials.	Years 1 & 2	# of organizations partnered with	Community Health
	Develop webpages to health system navigation tools such as "Newcomer Education for Wellness"	Years 2 & 3	# of new webpages and navigation tools developed	Community Health, Population Health

Priority Populations: North Minneapolis, persons who speak English as a second language, with a focus on Hmong, Vietnamese, and Spanish speaking populations; high rates of uninsurance among our Hispanic population.

Resources Needed: Funding for outreach materials, videos, and translation costs

Partners: Non-profits serving Hispanic/Latinx populations, Non-profits serving SE Asian populations

Priority 3: Prevent, Detect, and Manage Chronic Diseases

Rationale: Chronic conditions such as diabetes, heart disease, and asthma require ongoing management. Early detection through screenings and lab tests, combined with lifestyle interventions, can significantly improve outcomes.

Expected Impact: Expanding access to preventive care and chronic disease education will reduce disease burden and improve early diagnosis and disease management.

Key Data:

- Cancer and heart disease are leading causes of death in the service area.
- Disparities in premature death are highest among American Indian/Alaska Native, Black, Hispanic, and multiracial populations.
- **One in four adults** have high blood pressure; disparities exist among older adults, American Indian/Alaska Native, Black-US-born, low-income, and less-educated groups.
- **7.2-11.5%** of adults have been diagnosed with diabetes, with similar disparities.

Community Feedback:

- Increase education on chronic disease prevention and management.

Priority 3: Prevent, detect, and manage chronic diseases

Objective	Strategies	Timeline	Metrics	Responsible Program(s)
Promote community awareness on the need for annual exams, preventive health screenings, and immunizations.	Increase screenings for breast cancer, colon cancer, heart disease, diabetes, and lung cancer.	Years 1-3	% of patients on time for health screenings	Community Health, Care Management, PCPs
	Outreach at community events, especially those in communities with higher rates of chronic disease.	Years 1-3	# of events	Community Health, Care Management
Engage those with chronic diseases early and often through chronic disease self-management classes and support groups.	Host and increase community participation in chronic disease self-management courses (Living Well with Chronic Disease, Living Well with Chronic Pain).	Years 1-3	# of classes and # of participants	Care Management
	Raise awareness about regional support groups (Heart, Stroke, Cancer).	Year 1	# of resources listed	Community Health
Provide evidence-based outpatient care for chronic disease patients, including timely screenings for cancer, diabetes, hypertension, and mental health.	Expand provider-patient strategies to help manage chronic conditions (text messaging for medication management and self-care strategies, better use of MyChart).	Years 1-3	# of new strategies	Care Management, PCPs
	Continue to grow North Memorial Health's Black Women and Breast Cancer Initiative in areas such as wayfinding, cultural competency, narrating care, and updated communications.	Years 1-3	Report on new interventions, communications	DEI, Community Health, CHW
	Expand outreach to heart health including current focus on Black and Indigenous women's heart health, utilize grant dollars to expand awareness, education, and support.	Years 1-3	# of patients and community members impacted	CHW, Care Management, Community Health
	Heart Disease/Hypertension: Work with Sage Plus to expand the number of patients who get A1C and lipid screenings	Years 1-3	# of patients screened for A1C and lipid levels	CHW, Care Management, Community Health
	Diabetes: Work with Sage Plus to expand the number of patients who get A1C screenings; explore and expand diabetes glucose monitoring.	Years 1-3	# of patients screened for A1C	DEI, Community Health, CHW

Priority Populations: American Indian/Alaskan Native, Black-US born, East Indian, Hispanic, Low income, low education.

Resources Needed: Funding to educational and outreach materials and community room rentals.

Partners: Neighborhood HealthSource, Broadway Family Medicine, non-profits serving new Americans, schools, social service agencies, Juniper, American Cancer Society, American Heart Association, New Hope YMCA, Age-Friendly Maple Grove, Minnesota Department of Health's Sage and Sage Plus programs, American Diabetes Association

UPDATE ON PREVIOUS CHNA PRIORITY HEALTH ISSUES

Over the past three years, North Memorial Health has actively implemented strategies outlined in the [2023–2025 Health Priorities](#), focusing on two key health priorities: **racial disparities in health** and **life-impacting traumas**.

Racial Disparities in Health

Significant efforts have been made to improve breast cancer screening, care, and treatment for Black women. This initiative was prioritized due to alarming disparities: although Black women have lower breast cancer incidence rates, they experience a 24% higher mortality rate compared to white non-Hispanic/Latina women in Minnesota. Many Black women are diagnosed at later, less treatable stages.

In 2023 a dedicated workgroup—primarily composed of Black women employed at North Memorial Health—was formed to improve breast health outcomes within the North Memorial Health system. Two team member training courses were conducted in 2023 by Race Forward, focusing on the application of Racial Equity Tools in decision-making and policy development. The Black Women and Breast Health Workgroup applied the tools and made a number of recommendations that led to culturally appropriate updates to website content, brochures, and educational materials.

Community engagement was central to this initiative. In 2023, 23 Black women toured North's Breast Center and provided feedback on space design, communication strategies, and cultural representation. They also recommended that patients are invited to tour the Breast Center prior to first mammograms if they desire.

In 2024, four community conversations were facilitated by the Cultural Wellness Center and Design by Melo, engaging approximately 100 Black women. The sessions focused on:

1. Understanding health disparities, particularly in breast health.
2. Designing empathetic and purposeful healthcare spaces.
3. Creating scripts for “narrating care” to train staff.
4. Exploring foundational experiences that shape attitudes toward breast health.

These sessions resulted in recommendations that can be used to inform improvements to breast health services, enhancing cultural relevance and accessibility.

Throughout 2023-2025, North Memorial Health participated in numerous community events promoting breast health, including Live Your Healthy Lyfe, Twin Cities Pride, golf tournaments, and city-based resource fairs. Outreach materials featured Black women and included educational exhibits illustrating breast health conditions, such as what breast cancer tumors feel like. Each year, outreach efforts reached over 1,200 individuals, including Black women and their families.

In early 2024, a Community Health Worker (CHW) was hired to support Black women behind on mammograms. Sharing the racial and cultural background of the target population, the CHW provided tailored interventions, including education, resource coordination, and follow-up care. Initial outreach targeted 360 Black women overdue for mammograms within an eight-mile radius of the North Memorial

Health Breast Center in Robbinsdale. Since February 2024, the CHW has contacted over 400 patients, resulting in 213 completed mammograms and several diagnoses requiring further care.

The CHW also collaborates with the care management team to address barriers such as insurance access, cultural beliefs, and transportation. Four patients were successfully enrolled in the Minnesota Department of Health’s SAGE Screening Program. Approximately 20% of patients reported transportation challenges, prompting efforts to identify additional resources. Additionally, the “Mammogram – What to Expect” brochure was translated into Somali to better serve Somali patients.

In recognition of this work, the Minnesota Hospital Association honored North Memorial Health in 2024 for its Black Women’s Breast Health Initiative, which aims to eliminate disparities in breast cancer screening and care.

Life-Impacting Traumas

In addressing the second health priority of Life-Impacting Traumas, North Memorial Health launched a Trauma-Informed Care (TIC) Workgroup in 2023. The goal was to guide the organization along the trauma-informed continuum: trauma-aware, trauma-sensitive, trauma-responsive, and result in NMH becoming a trauma-informed care organization. The TIC Workgroup, composed of thirteen multidisciplinary members, was a working group that provided oversight and guidance in implementing the strategies noted in the 2023-2025 CHIP.

Accomplishments include:

- Development of a strategic roadmap for organizational transformation, based on an Emerging Leader Program (ELP) project as noted later.
- Staff and community training on trauma’s impact on health and behavior.
- Emphasis on employee wellness to support caregivers.
- Creation of safe physical, social, and emotional environments.

A cornerstone of this work was the annual Trauma Symposium, held each fall in 2023 and 2024. These events raised awareness of trauma’s many forms—historical, collective, generational, and childhood ACEs—and promoted healing and resilience. Funded by North Memorial Foundation’s small grant program, the symposiums were offered free of charge, removing financial barriers to community-based health and wellness practitioners and other non-profits, who had noted this as a barrier during our 2022 CHNA community engagement work.

Key Achievements:

- **Community-Centered Design:** Events were shaped by BIPOC, immigrant, and underserved voices.
- **Personal Stories of Healing:** Keynote speakers shared lived experiences of trauma and recovery.
- **Education for Impact:** Attendees received actionable tools for trauma-informed care and self-care resources for people caring for traumatized patients/clients.
- **Safe Spaces for Healing:** Symposiums fostered emotionally and physically safe environments.

Symposium Highlights:

- **2023 Trauma Symposium:** “Cultivating Trauma-Informed Care through Growth, Healing, and Knowledge” (October 6, 2023). Keynote by Dr. Ryan Van Wyk. Attended by 122 individuals (62 NMH team members). Evaluation results: 97% satisfaction, 98% would apply what they learned in their job or in the community, and 96% would be interested in attending similar events in the future.

- **2024 Trauma Symposium:** “From Pain to Progress: Bringing Trauma-Informed Care to the Heart of Healing” (November 8, 2024). Featured Kathy Flaminio (MoveMindfully©) and Tonier Cain. Attended by 132 individuals (77 NMH team members). Evaluation results: 94% satisfaction, 98% would apply what they learned in their job or in the community, and 91% were interested in attending similar events in the future.

Three Emerging Leader Program cohorts contributed to trauma-informed care projects:

1. Developed a roadmap and recommendations for future efforts.
2. Created a self-assessment tool to evaluate organizational readiness (not implemented due to survey volume).
3. Supported planning and execution of the 2024 Trauma Symposium.

North Memorial Health remains committed to advancing equity and healing through community-driven, culturally responsive initiatives that address the root causes of health disparities and trauma.

Appendix

DISPARITIES

Disparity Definition: Due to changing demographics for each indicator, a simple definition was used to define disparities. We noted disparities if the stratified populations were more than 10% “worse off” than the healthiest group, which was most often White. For example, in the area of food security if White populations were 10% food insecure, all groups that were more than 20% food insecure were noted as having a disparity. Disparities were stratified by location, age, race, gender, sexual orientation, income, education, language, economic distress, and frequent mental health distress, depending on availability of data stratification from the data sources.

Location Disparities	
Minneapolis	Poverty levels; unemployment; high school graduation rates; food security (adults and youth); adults reporting very good or excellent health; adults with a health exam in the past year; adults with a doctor’s office or health clinic; adults who go to the ER when sick; adults not taking their prescriptions due to cost; adults treated unfairly or discriminated against when seeking care; adults limited in activities due to physical, mental, or emotional health; children not up-to-date on immunizations; adults not up-to-date on immunizations; sexually transmitted infection rates; percent of households with children 0-17 years where one person smokes; number of days the Air Quality Index exceeded 100; rate of infant deaths per 1,000 live births; motor vehicle crash mortality; assaultive penetrating trauma; adults and youth who feel their neighborhood is safe from crime; adults reporting poor mental health for 14+ days in a month; adults at risk for depression; adults at risk for anxiety; adults with serious psychological distress; adults wanting help for a mental health issue; adults feeling isolated; adult current cigarette use; adults who binge-drink alcohol; adult marijuana use; adult and youth opioid use
Inner Suburbs	Poverty levels; unemployment; high school graduation rates; adult food security; adults reporting very good or excellent health; adults with a health exam in the past year; adults delaying medical care due to cost or lack of insurance; rate of infant deaths per 1,000 live births; adults who feel their neighborhood is safe from crime
Outer Suburbs	None identified. The Outer Suburbs of our CSA often had the most advantageous health outcomes.

Age Disparities	
<18	Food security; children up-to-date on immunizations; percent of households with ages 0-17 where one person smokes; rate of infant deaths per 1,000 live births; youth who feel their neighborhood is safe from crime; youth opioid use
18-24	Adults with a health exam in the past year; adults with a doctor’s office or health clinic; adults delaying medical care due to cost or lack of insurance; adult fruit and vegetable consumption; adults who feel their neighborhood is safe from crime; adults reporting poor mental health for 14+ days in a month; adults at risk for depression; adults at risk for anxiety; adults with serious psychological distress; adults wanting help for a mental health issue; adults without social or emotional support; adults feeling isolated; adult current e-cigarette use; adults with heavy alcohol use; adults binge-drinking alcohol; adult marijuana use
25-44	Adults with a health exam in the past year; adults with a doctor’s office or health clinic; adults delaying medical care due to cost or lack of insurance; adults delaying care for a mental health concern due to cost or lack of insurance; adults who have been to the dentist in the last 1-2 years; adults who feel their neighborhood is safe from crime; adults reporting poor mental health for 14+ days in a month; adults at risk for anxiety; adults wanting help for a mental health issue; adult suicidal ideation, attempts, and death; adults with heavy alcohol use; adults binge-drinking alcohol; adult marijuana use; adult opioid use

45-64	Adults with a doctor's office or health clinic; adults delaying medical care due to cost or lack of insurance; adults delaying care for a mental health concern due to cost or lack of insurance; adults with hypertension/high blood pressure; adults who are overweight or obese; adults who have been to the dentist in the last 1-2 years; adults wanting help for a mental health issue; adult suicidal ideation, attempts, and death; adults with heavy alcohol use; adults binge-drinking alcohol; adult opioid use
65-74	Adults delaying medical care due to cost or lack of insurance; adults with hypertension/high blood pressure; adults with diabetes; adults limited in activities due to physical, mental, or emotional health; adults who are overweight or obese; adults who have been to the dentist in the last 1-2 years; falls mortality rate; adults with heavy alcohol use
75+	Adults reporting very good or excellent health; adults with hypertension/high blood pressure; adults with diabetes; adults limited in activities due to physical, mental, or emotional health; adults who are overweight or obese, adult fruit and vegetable consumption; adults who have been to the dentist in the last 1-2 years; falls mortality rate

Racial Disparities

American Indian or Alaskan Native	Adult food security; adults reporting very good or excellent health; adults with a doctor's office or health clinic; adults who go to the ER when sick; adults not taking their prescriptions as directed due to cost; adults treated unfairly or discriminated against when seeking health care; adults with hypertension/high blood pressure; adults with diabetes; adults limited in activities due to physical, mental, or emotional health; adults who are overweight or obese; adult fruit and vegetable consumption; sexually transmitted infection rates; percent of households with children 0-17 where one person smokes; number of days the Air Quality Index exceeded 100; rate of infant deaths per 1,000 live births; unintentional poisoning mortality; adults who feel their neighborhood is safe from crime; adults at risk for depression; adults at risk for anxiety; adults wanting help for a mental health issue; adults without social or emotional support; adults feeling isolated; adult current cigarette use; adult current e-cigarette use; adults with heavy alcohol use; adults binge-drinking alcohol; adult marijuana use
Hispanic/Latin(o/a/x)	Adults reporting very good or excellent health; adults with a health exam in the past year; adults with a doctor's office or health clinic; adults who go to the ER when sick; adults delaying medical care due to cost or lack of insurance; adults delaying care for a mental health concern due to cost or lack of insurance; adults not taking their prescriptions as directed due to cost; adults treated unfairly or discriminated against when seeking health care; adults who are overweight or obese; adult fruit and vegetable consumption; sexually transmitted infection rates; number of days the Air Quality Index exceeded 100; rate of infant deaths per 1,000 live births; adults without social or emotional support; adults with heavy alcohol use
Asian	Adults with a health exam in the past year; adults delaying medical care due to cost or lack of insurance; sexually transmitted infection rates; adults who have been to the dentist in the last 1-2 years; number of days where the Air Quality Index exceeded 100; rate of infant deaths per 1,000 live births; adults without social or emotional support
Southeast Asian	Adults reporting very good or excellent health; adults with a health exam in the past year; adults with a doctor's office or health clinic; adult fruit and vegetable consumption; number of days the Air Quality Index exceeded 100; adults who feel their neighborhood is safe from crime; adults without social or emotional support

African American/ Black (US-born)	Adult food security; cancer as a cause of death; adults reporting very good or excellent health; adults with a doctor's office or health clinic; adults who go to the ER when sick; adults not taking their prescriptions as directed due to cost; adults treated unfairly or discriminated against when seeking health care; adults with hypertension/high blood pressure; adults with diabetes; adults limited in activities due to physical, mental, or emotional health; adults who are overweight or obese; sexually transmitted infection rates; percent of households with children 0-17 where one person smokes; number of days where the Air Quality Index exceeded 100; rate of infant deaths per 1,000 live births; unintentional poisoning mortality; assaultive penetrating trauma; adults who feel their neighborhood is safe from crime; adults reporting poor mental health for 14+ days in a month; adults at risk for depression; adults at risk for anxiety; adults without social or emotional support; adults feeling isolated; adult suicidal ideation, attempts, or death; adult current cigarette use; adults with heavy alcohol use; adult marijuana use; adult opioid use
African American/ Black (foreign-born)	Adults with a health exam in the past year; adults treated unfairly or discriminated against when seeking health care; adults who are overweight or obese; adult fruit and vegetable consumption; sexually transmitted infection rates; number of days where the Air Quality Index exceeded 100; rate of infant deaths per 1,000 live births; unintentional poisoning mortality; assaultive penetrating trauma; adults without social or emotional support; adult suicidal ideation, attempts, or death; adult opioid use
White	Adults who are overweight or obese; adults who have been to the dentist in the last 1-2 years; falls mortality rate; adult suicidal ideation, attempts, or death; adults with heavy alcohol use; adult opioid use

Gender Disparities

Female	Poverty; adults wanting help for a mental health issue; adults with heavy alcohol use
Male	Adults who are overweight or obese; adult suicidal ideation, attempts, or death; adult opioid use
Non-Binary	Adults with a health exam in the past year; adults with a doctor's office or health clinic; adults delaying medical care due to cost or lack of insurance; adults delaying care for a mental health concern due to cost or lack of insurance; adults limited in activities due to physical, mental, or emotional health; adults who are overweight or obese; adult fruit and vegetable consumption; adults who feel their neighborhood is safe from crime; adults reporting poor mental health for 14+ days in a month; adults at risk for depression; adults at risk for anxiety; adults with serious psychological distress; adults wanting help for a mental health issue; adult marijuana use
Transgender	Adults reporting very good or excellent health; adults without health insurance; adults with a health exam in the past year; adults with a doctor's office or health clinic; adults delaying medical care due to cost or lack of insurance; adults delaying care for a mental health concern due to cost or lack of insurance; adults treated unfairly or discriminated against when seeking health care; adults limited in activities due to physical, mental, or emotional health; adults who are overweight or obese; adult fruit and vegetable consumption; adults who feel their neighborhood is safe from crime; adults reporting poor mental health for 14+ days in a month; adults at risk for depression; adults at risk for anxiety; adults with serious psychological distress; adults wanting help for a mental health issue; adults feeling isolated; adult current e-cigarette use; adult marijuana use

Sexual Orientation Disparities

Heterosexual (Straight)	Adults with hypertension/high blood pressure
LGBQ+	Adults delaying medical care due to cost or lack of insurance; adults delaying care for a mental health concern due to cost or lack of insurance; adults limited in activities due to physical, mental, or emotional health; adults who feel their neighborhood is safe from crime; adults reporting poor mental health 14+ days in a month; adults at risk for depression; adults at risk for anxiety; adults with serious psychological distress; adults wanting help for a mental health issue; adults feeling isolated; adult marijuana use

Income-Level Disparities

<200% Federal Poverty Line	Adult food security; adults reporting very good or excellent health; adults without health insurance; adults with a doctor's office or health clinic; adults who go to the ER when sick; adults treated unfairly or discriminated against when seeking care; adults limited in activities due to physical, mental, or emotional health; adults who are overweight or obese; number of days where Air Quality Index exceeded 100; adults who feel their neighborhood is safe from crime; adults reporting poor mental health 14+ days in a month; adults at risk for depression; adults at risk for anxiety; adults without social or emotional support; adults feeling isolated; adult current cigarette use
>200% Federal Poverty Level	Adults who have been to the dentist in the last 1-2 years; adults with heavy alcohol use

Education-Level Disparities

Did not graduate high school	Adult food security; adults reporting very good or excellent health; adults without health insurance; adults with a health exam in the past year; adults with a doctor's office or health clinic; adults who go to the ER when sick; adults delaying medical care due to cost or lack of insurance; adults treated unfairly or discriminated against when seeking health care; adults with hypertension/high blood pressure; adults with diabetes; adults limited in physical, mental, or emotional health; adults who are overweight or obese; adult fruit and vegetable consumption; percent of households with children 0-17 where one person smokes; adults feel their neighborhood is safe from crime; adults reporting poor mental health 14+ days in a month; adults at risk for depression; adults at risk for anxiety; adults with serious psychological distress; adults without social or emotional support; adults feeling isolated; adult current cigarette use
High school diploma or GED	Adults reporting very good or excellent health; adults with a doctor's office or health clinic; adults who go to the ER when sick; adults treated unfairly or discriminated against when seeking health care; adults with hypertension/high blood pressure; adults limited in activities due to physical, mental, or emotional health; adults who are overweight or obese; adult fruit and vegetable consumption; percent of households with children 0-17 where one person smokes; adults who feel their neighborhood is safe from crime; adults without social or emotional support; adult current cigarette use
Some college but no degree	Adults reporting very good or excellent health; adults delaying medical care due to cost or lack of insurance; adults delaying care for a mental health concern due to cost or lack of insurance; adults treated unfairly or discriminated against when seeking health care; adults with hypertension/high blood pressure; adults limited in activities due to physical, mental, or emotional health; adults who are overweight or obese; adult fruit and vegetable consumption; adult current cigarette use; adults with heavy alcohol use
College degree+	Adults delaying medical care due to cost or lack of insurance; adults who have been to the dentist in the last 1-2 years; adults with heavy drinking

Language Disparities

English	Adults who have been to the dentist in the last 1-2 years; adults with heavy alcohol use; adult marijuana use
English as a second language	Adults reporting very good or excellent health; adults without health insurance; adults treated unfairly or discriminated against when seeking health care; adults without social or emotional support

Economic Distress Disparities	
Experiencing economic distress	Adult food security; adults reporting very good or excellent health; adults without health insurance; adults with a doctor’s office or health clinic; adults who go to the ER when sick; adults delaying medical care due to cost or lack of insurance; adults not taking prescriptions as directed due to cost; adults treated unfairly or discriminated against when seeking care; adults limited in activities due to physical, mental, or emotional health; adults who are overweight or obese; adult fruit and vegetable consumption; number of days the Air Quality Index exceeded 100; adults who feel their neighborhood is safe from crime; adults reporting poor mental health 14+ days in a month; adults at risk for depression, adults at risk for anxiety; adults with serious psychological distress; adults wanting help for a mental health issue, adults without social or emotional support; adults feeling isolated; adult current cigarette use; adult marijuana use
Not experiencing economic distress	Adults who have been to the dentist in the last 1-2 years; adults with heavy alcohol use

Frequent Mental Distress Disparities	
Experiencing frequent mental distress	Adults reporting very good or excellent health; adults with a doctor’s office or health clinic; adults not taking their prescriptions as directed due to cost; adults treated unfairly or discriminated against when seeking health care; adults limited in activities due to physical, mental, or emotional health; adult fruit and vegetable consumption; adults who feel their neighborhood is safe from crime; adults reporting poor mental health 14+ days in a month; adults at risk for depression; adults at risk for anxiety; adults with serious psychological distress; adults wanting help for a mental health issue; adults without social or emotional support; adults feeling isolated; adult current cigarette use; adult marijuana use
Not experiencing frequent mental distress	None identified. Those without frequent mental distress often had the most advantageous health outcomes.

KEY HEALTH INDICATORS SCORING TABLE

Size Rating (Magnitude)	Seriousness	Effective Intervention (Best Practice)	Disparities	Meet Goal (HP2030, other)
Number of people affected by health condition/health issue in the North Memorial Health service area	Potential of a health condition and/or issue to result in serious disability or death	The availability of effective community-based or clinically-based health interventions/strategies	Differences in the health status of different groups of people, some groups of people have higher rates of disease, more deaths, and suffering, compared to others.	HP2030 establishes goals and objectives for many common health indicators; professional groups also establish goals for certain health indicators
0 = Do not know number affected by health condition/health issue	0 = Do not know the impact of this issue on our communities	0 = No known interventions to address this health issue/condition/behavior	0 = No known health disparities or health inequities	0 = No goal available or inconsistently meeting a goal
1 = Relatively few people affected by health condition/health issue	1 = Not life threatening or resulting in disability	1 = There are some strategies to address this issue but they have not been documented as promising or effective interventions	1 = There are health disparities or health inequities in 1-2 subgroups	1 = We are exceeding the HP2030 goal or another gold standard goal
2 = Limited or moderate numbers affected in a particular subgroup	2 = Not life threatening but sometimes results in disability			2 = We are just barely meeting the HP2030 goal
3 = Moderate numbers affected across the population	3 = Moderately life threatening with a strong chance of disability	3 = There are promising practices or interventions to address this issue	3 = There are health disparities or health inequities in 3-4 subgroups	3 = We are not meeting the HP2030 goal, but we are close
4 = Large numbers affected in subgroups	4 = Moderately life threatening with a strong chance of serious disability			4 = We are not meeting the HP2030 and have significant work until we meet the goal
5 = Large numbers affected across the population	5 = High likelihood of death or permanent disability	5 = There are proven, effective community-based or clinically-based interventions to address this issue	5 = There are disparities or health inequalities in many subgroups	5 = We are a long way from meeting the HP2030 goal

DATA WALK PROCESS

A Data Walk is an organized, interactive event where community members gather to share data, offer insight, and discuss a specific topic, typically lasting anywhere from two to four hours. They have been utilized over the last few decades to involve community members in topics from education to healthcare to developmental planning.

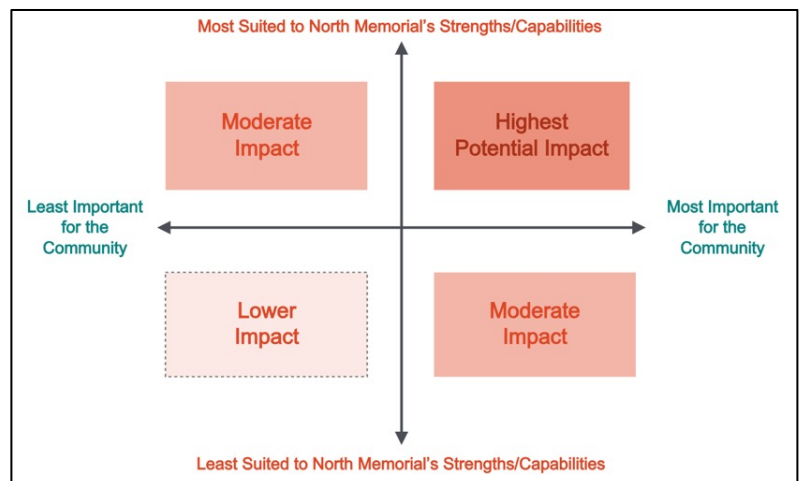
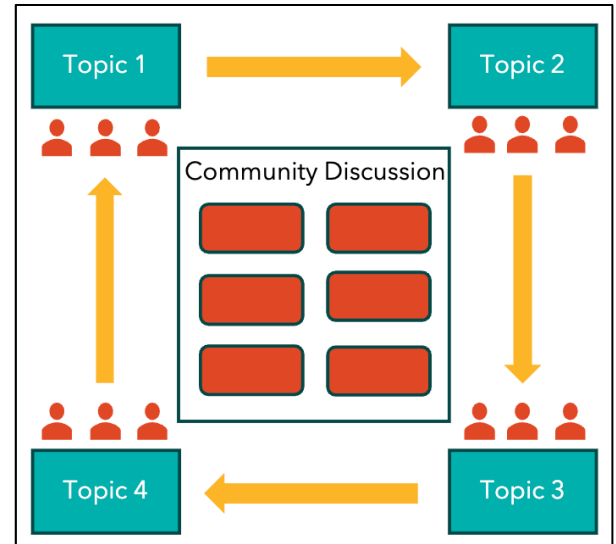
Our Data Walk had 33 participants consisting of community members, CEAT members, and North Memorial Health staff as facilitators and notetakers. Participants were divided into four groups with each group consisting of 7-9 participants. Each group spent 17-20 minutes at each topic: Health Access and Quality, Maternal and Child Health, Mental Health, and Chronic Disease.

Many community organizations were represented at the Data Walk including social services agencies, city government, elected officials (4), community collaboratives (2), parks and recreation organizations, advocacy organizations, small businesses, and community residents.

Participants were encouraged to write down interventions, challenges, and opportunities on sticky notes and place their insights on a matrix with the x-axis representing importance to the community and the y-axis representing how suited the intervention was to North Memorial Health’s capabilities. The health priorities in our CHNA and CHIP should align with what our communities need the most and with what North Memorial Health has the capabilities and resources to provide (represented in the matrix as the area with highest potential impact).

It was also noted that many participants were deeply engaged in the discussions at each topic and often deprioritized the process of writing on notes and placing them in the matrix in favor of the conversation. However, facilitators and notetakers captured the essence of the conversations and that data was shared back to the CEAT.

At the end of the Data Walk, participants were gathered together for a group discussion and voted for the most important health needs.





This report is available online at northmemorial.com/communityhealth or hard copies can be obtained from North Memorial Health's Community Health Program.