2011

Ramsey County's Children

Selected Indicators of Well-Being

Program Planning and Evaluation
Saint Paul – Ramsey County Public Health
June, 2012

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PREFACE AND READER'S GUIDE

Saint Paul – Ramsey County Public Health (SPRCPH) supports healthy families building healthy communities and is charged with ensuring quality public health services and maternal and child health programs throughout the county. SPRCPH fulfills these responsibilities, in part, by collecting and analyzing timely, topical information that identifies health priorities and trends that can be addressed through program interventions and capacity building.

SPRCPH is pleased to present *Ramsey County's Children: Selected Indicators of Well-Being, 2011*. To reflect the ever-changing, increasingly diverse population and its characteristics, *Ramsey County's Children* selectively highlights emerging issues and trends in children's health.

This data book was developed by SPRCPH to provide readers with an easy-to-use collection of current and historical data on some of the most pressing health challenges facing children, their families, and their communities. The organization of this book follows the outline of the federal publication *America's Children: Key National Indicators of Well-Being (http://childstats.gov/)* which is published yearly by the Federal Interagency Forum on Child and Family Statistics. *Ramsey County's Children* is intended to be a reference for policymakers and program managers at the local level to identify and clarify issues affecting the health of children. In these pages, readers will find a profile of children's health from a variety of data sources. Whenever possible, local data was used throughout this book. Regional, state or national data were used if local data was not collected or sources could not be easily accessed.

Ramsey County's Children: Selected Indicators of Well-Being, 2011 is available online through the Ramsey County Web site www.co.ramsey.mn.us/ph. The text and graphs in *Ramsey County's Children: Selected Indicators of Well-Being, 2011* are not copyrighted; the photographs are the property of Ramsey County and may not be duplicated. With that exception, readers are free to duplicate and use any of the information contained in this publication. Please provide any feedback on this trend book to the Planning and Evaluation team:

Planning and Evaluation
Family Health Section
Saint Paul – Ramsey County Public Health
90 W. Plato Blvd.
St. Paul, MN 55107
Phone: 651-266-2400
Fax: 651-266-2432
Online: www.co.ramsey.mn.us/ph

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KEY FINDINGS

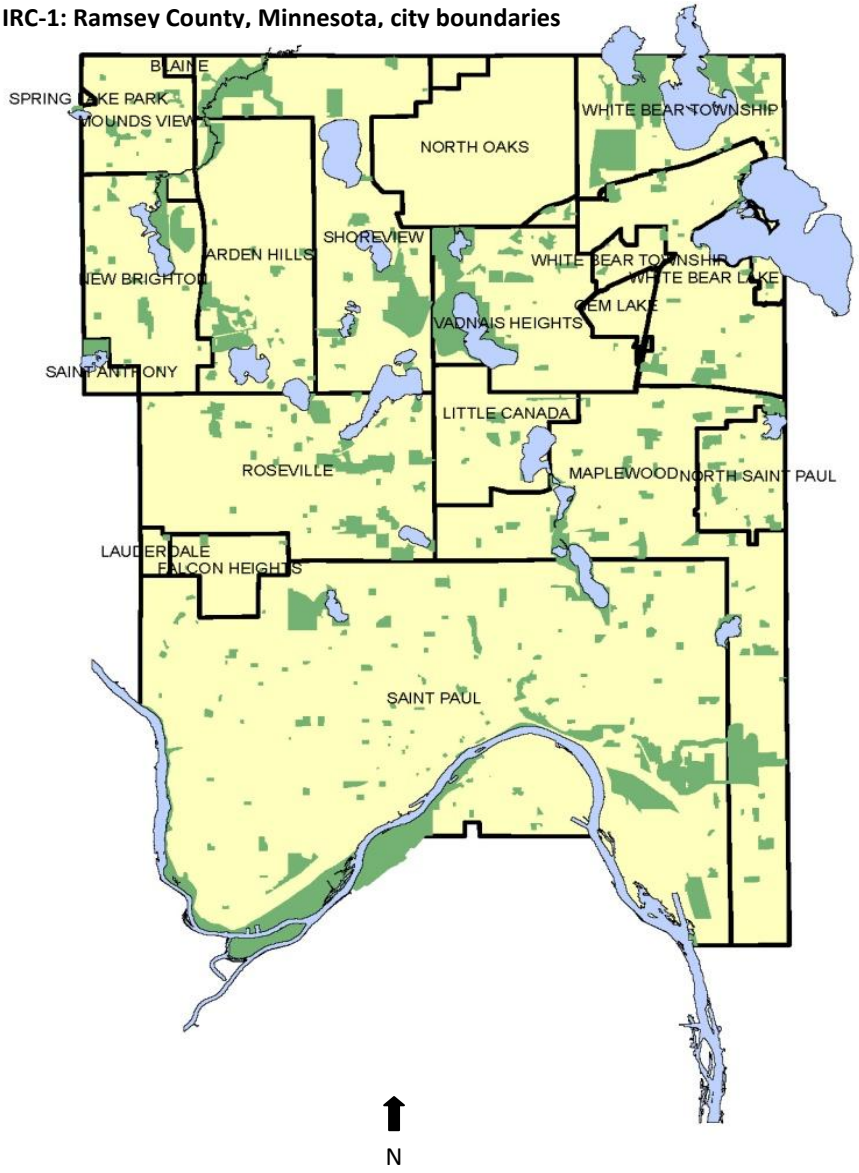
- About one-quarter of Ramsey County residents are children under 18. Children in Ramsey County are more racially diverse than older residents-only 42% of children under age 5 are White and over 80% of residents 50and older are White.
- Births to teens have fallen overall in recent years but continue to be disproportionately high for teens of color.
- Ramsey County has the highest rate of children in out-of home placements of the 11 county metro area.
- Family violence continues to be disproportionately experienced by children of color with some of the highest rates experienced by Hispanic girls.
- Ramsey County has the highest number of refugee arrivals in all of Minnesota and the % of foreign born residents continues to increase. Most new arrivals are from Burma where St. Paul is home to the largest population of Karen (from Burma) outside of Southeast Asia.
- The recession has brought about significant changes with Ramsey experiencing increases in homelessness, persistently high unemployment rates, dramatic increases in use of food support, food shelves, and marked increases in reliance of citizens on publicly-funded health programs.
- Injuries to children caused by assault have slowly decreased since 2008 for all age groups.
- Ramsey's childhood immunization lags statewide rates for all types of vaccinations.
- A combination of factors suggest that Hispanic/Latino children in Ramsey County are experiencing multiple stressors with disproportionate use of alcohol, tobacco, marijuana, and high rates of suicidal thoughts among Hispanic/Latino girls.
- The rate of Chlamydia infections among teens is increasing.
- Asthma hospitalizations are decreasing.
- Infant mortality is falling overall, but the highest rates are still observed for Black and Hispanic infants.
- The number of self-inflicted injuries and deaths increased slightly in 2010.
- Premature births have decreased overall and by 2009, rates were becoming more similar across racial and ethnic groups.
- There is no local data for many of the child well-being indicators (actual incidence and prevalence of mental disorders, the health needs of Ramsey County's LGBT youth, additional environmental health data, and foster care stability).

INTRODUCTION TO RAMSEY COUNTY

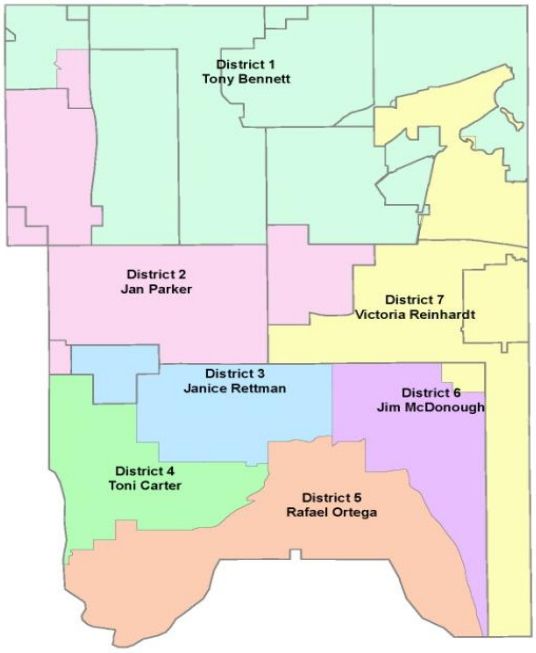
Ramsey County, Minnesota, was established by the territorial legislature of Minnesota in 1949, nine years before Minnesota became a state and was named for Alexander Ramsey, the first governor of the Minnesota territory. Ramsey County is located at the bend of the Mississippi River, which forms a portion of its southern border. The City of Saint Paul, the county seat and the capital of Minnesota, is one of 19 cities located in the county's borders. The County encompasses 207 square miles with 81 lakes and numerous parks and trails.

Ramsey County is home to all or parts of 19 cities (**Figure IRC-1**):
Arden Hills, Blaine (part), Falcon Heights, Gem Lake, Lauderdale, Little Canada, Maplewood, Mounds View, New Brighton, North Oaks, North St. Paul, Roseville, Saint Anthony (part), Saint Paul, Shoreview, Spring Lake Park (part), Vadnais Heights, White Bear Lake (part) and White Bear Township.

Figure IRC-1: Ramsey County, Minnesota, city boundaries



A seven-member Board of Commissioners elected by district for staggered four-year terms governs Ramsey County. County Commissioners are responsible for authorizing resolutions, adopting the annual budget, appointing committees, hiring a County Manager, and serving as the legislatively mandated Community Health Board (CHB). The County Manager is responsible for carrying out the policies and resolutions of the Board of Commissioners, for overseeing the day-to-day operations of the County, and for appointing the heads of the County's departments.



In 1990, Ramsey County citizens voted to become the first Home Rule Charter County in Minnesota. Adopted in 1992, the Charter means the people assume more control on the local level over the County and the policies it makes.

Minnesota Statute 145A, or the *Local Public Health Act*, outlines the shared public health responsibilities of the state and local governments in Minnesota and establishes accountability for funding on statewide initiatives, provides guidelines for assessment and planning, requires documented progress toward the achievement of statewide goals, and assigns oversight of the statewide system to the commissioner of health.

The community health board (CHB) is the legally recognized governing body for local public health in Minnesota. It is the only governmental entity eligible for funding under the Local Public Health Act grant. CHBs work in partnership with the Minnesota Department of Health to prevent disease, protect against environmental hazards, promote healthy behaviors and healthy communities, respond to disasters, ensure access to health services, and assure an adequate local public health infrastructure. CHBs have statutory responsibility under the Local Public Health Act and must address and implement the essential local public health activities.

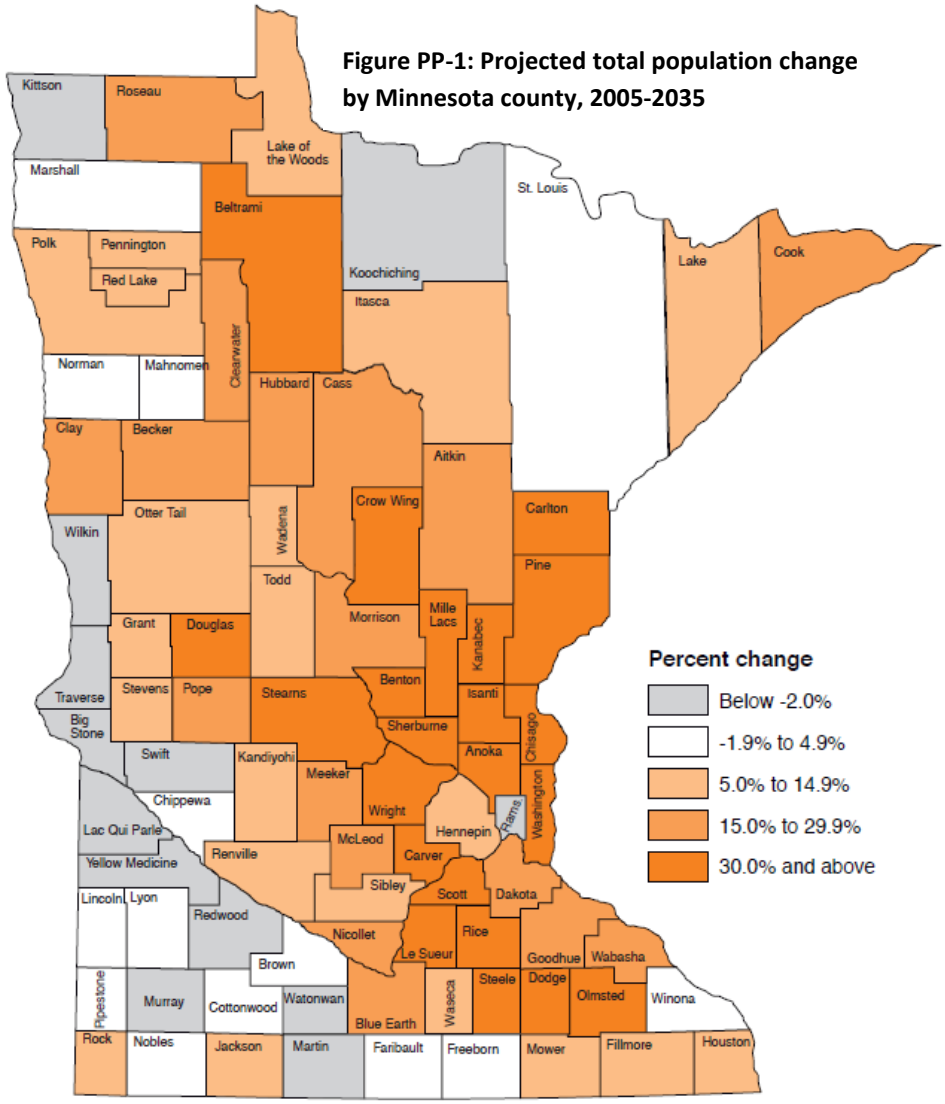
POPULATION PROJECTIONS

Demographic characteristics have important implications for the overall health and prosperity of Ramsey County. As the population ages, more and more of the county's resources will be dedicated to declining health and health care, making it more important than ever to find ways to minimize and prevent these costs. As the Baby-Boom generation exits the workforce all segments of the remaining workforce must maintain good health to sustain the economic productivity that supports Ramsey County's high standard of living.

Between 2005 and 2035 the number of Minnesotans over age 65 will more than double. By contrast, the population under age 65 will grow only by 10 percent. As a result, the age composition of all parts of the state, including Ramsey County, will be much older in 2035. Population projections are that these age groups will change in important ways:

- 14 years and under ⬇ 6%
- 15 to 24 years ⬇ 3%
- 25 to 44 years ⬇ 14%
- 45 to 64 years ⬇ 22%
- 65 to 84 years ⬆ 55%
- 85 years and above ⬆ 52%

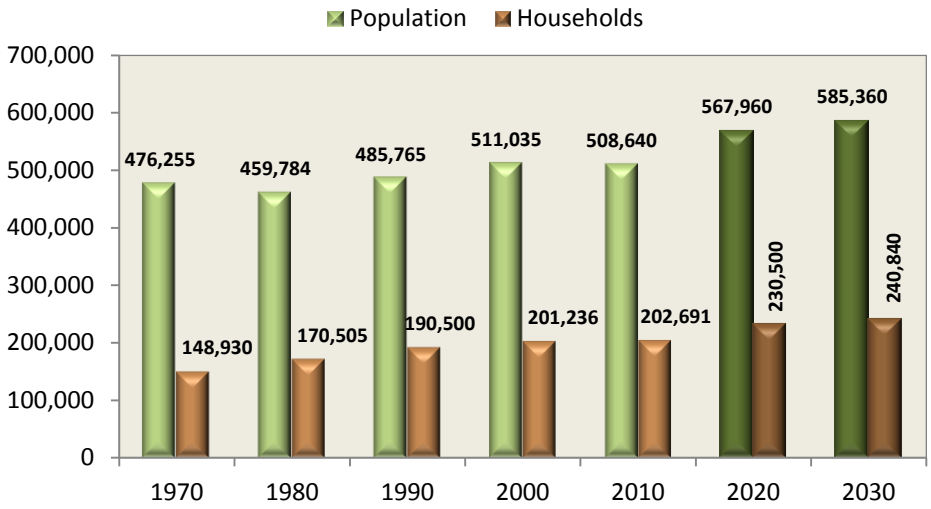
Figure PP-1: Projected total population change by Minnesota county, 2005-2035



Source: Minnesota State Demographic Center, Center for Rural Policy and Development

The population age 19 and under is projected to remain the highest in the Twin Cities suburbs. However, some rural counties are also projected to have a comparatively higher percentage of young people, most likely due to the presence of a college or university or a large minority population.

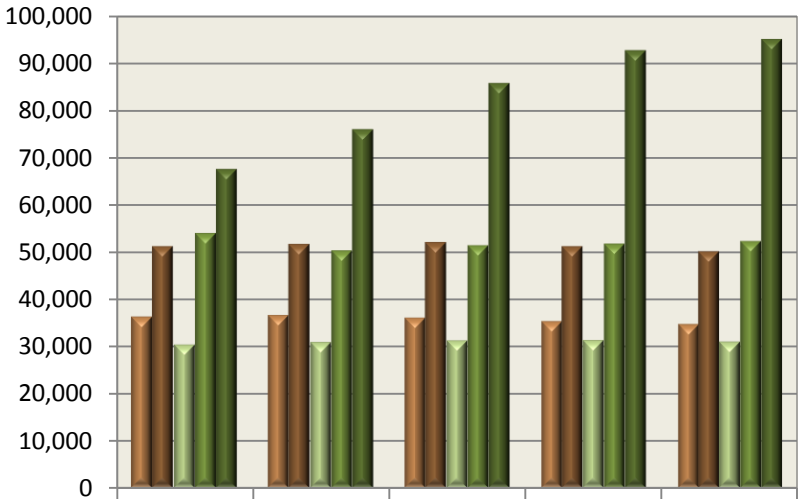
Figure PP-2: Number of Residents and households
Ramsey County, MN, 1970 - 2030



Between 2010 and 2035, Ramsey County is projected to have a 19% increase in population and 15% increase in number of households.

Source: U.S. Decennial Census, Metropolitan Council Forecasts 2010

Figure PP-3: Population projections
by selected age group, Ramsey County, MN, 2015-2035



	2015	2020	2025	2030	2035
0 to 4 yrs	36,129	36,480	35,941	35,181	34,610
5 to 12 yrs	51,119	51,590	52,049	51,111	50,061
13 to 17 yrs	30,237	30,756	31,133	31,217	30,878
18 to 24 yrs	53,863	50,154	51,296	51,603	52,136
65 yrs and older	67,520	75,910	85,700	92,620	95,000

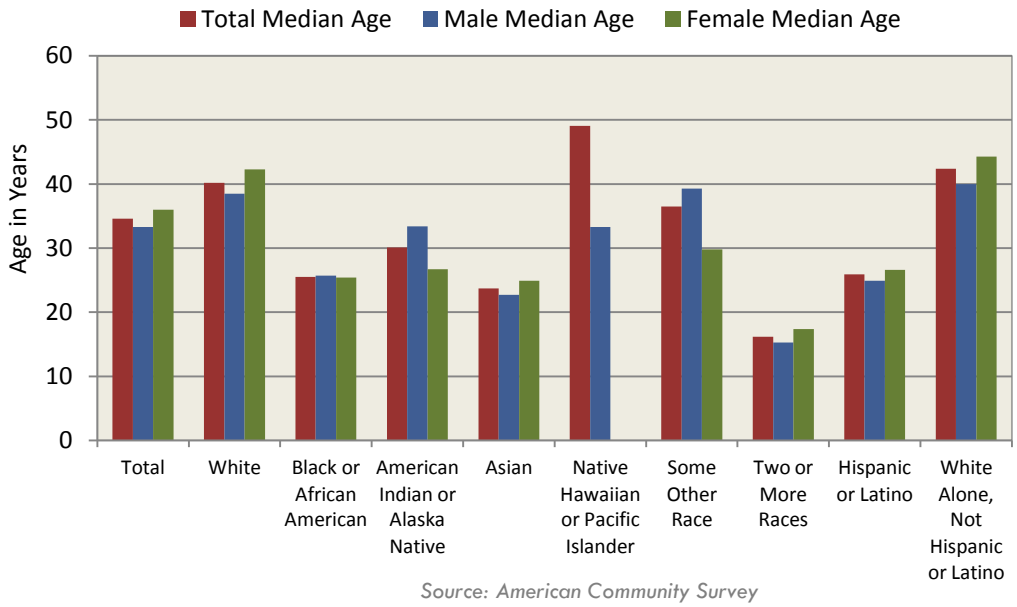
Ramsey County's fastest growing age group is residents 65 years and older.

Source: U.S. Census Bureau, modified by State Demographic Center in April 2007
http://www.demography.state.mn.us/projections.html

RACE/ETHNICITY AND AGE

The median age in Ramsey County varies by race with Native Hawaiian/Pacific Islanders having the highest median age of 49 years and mixed race males having the lowest median age of 15 years.

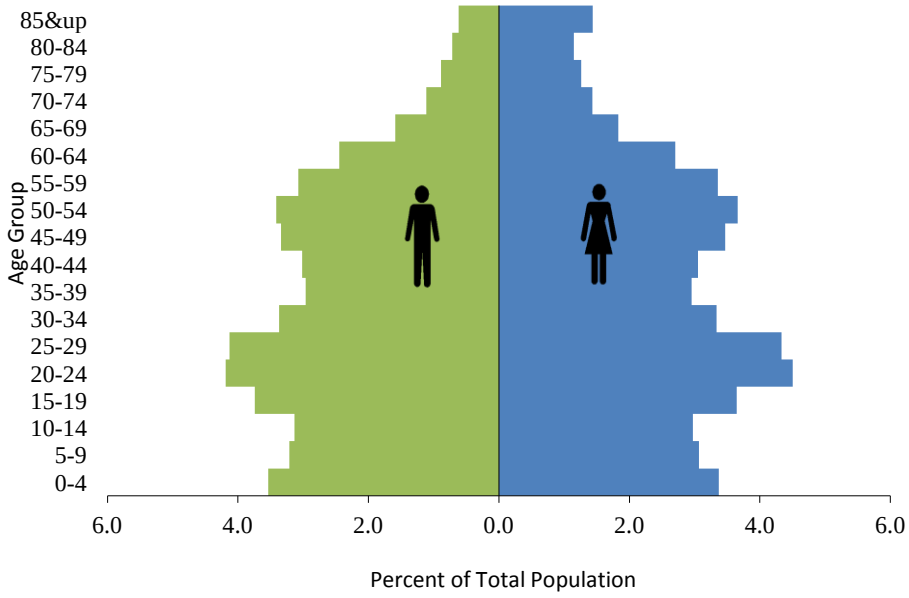
Figure REA-1: Median age by race and ethnicity, Ramsey County, MN, 2010



Source: American Community Survey

With the exception of Native Hawaiian/Pacific Islanders, Whites were older than all other racial/ethnic groups in 2010.

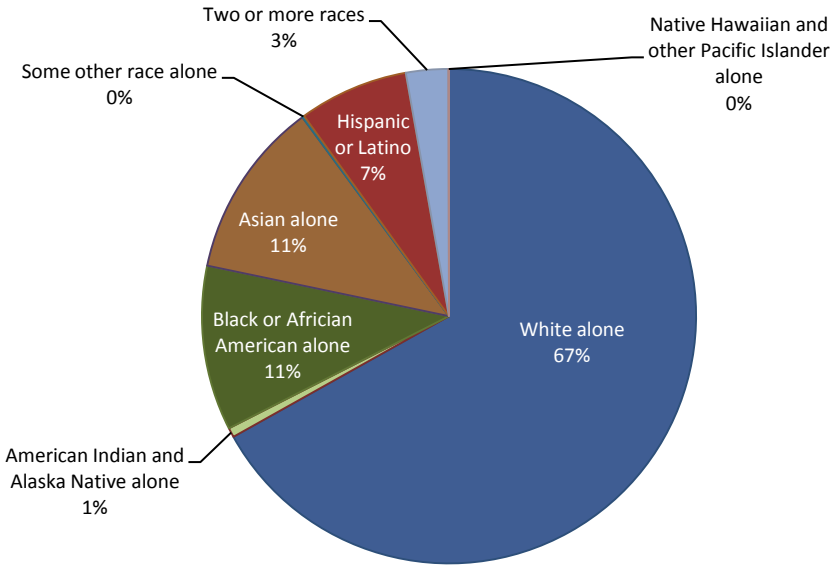
Figure REA-2: Population by age group and gender, Ramsey County, MN, 2010



Source: U.S. Decennial Census

The Twin Cities region is rapidly becoming more diverse. As recently as 1990, less than 10 percent of our region was made up of persons of color, including African Americans, American Indians, Asian Americans, and Latinos. By 2000, people of color made up 17 percent of our population, and today, 1 in 3 (33%) residents in the Twin Cities is a person of color. Of the 508,640 residents that live in Ramsey County, 23% are under 18 years old. The largest minority populations are African American (11%) and Asian (11.7%). About 7.2% of residents have Hispanic or Latino ethnic background. Seventeen percent of people ages 5 years and older in Ramsey County live in homes where a language other than English is spoken.

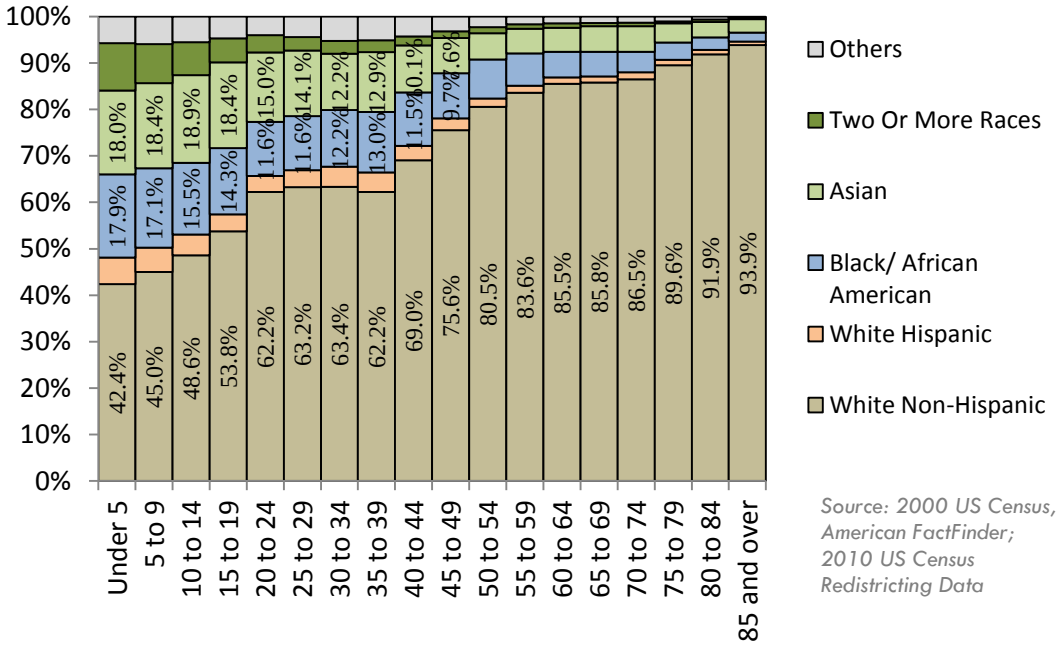
Figure REA-3: Percent of population by race and ethnicity, Ramsey County, MN, 2010



Source: U.S. Decennial Census

Older Ramsey County residents are predominately White, reflecting the county's demographic history, while younger residents are more diverse.

Figure REA-4: Percent of population within age group by race, Ramsey County, MN, 2010



Source: 2000 US Census, American FactFinder; 2010 US Census Redistricting Data

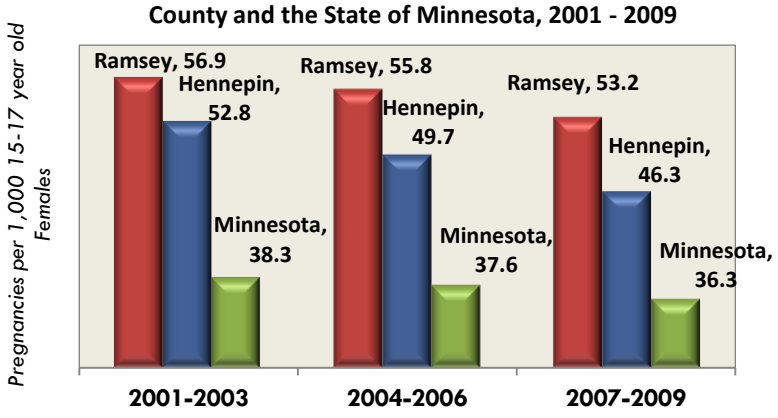
1 FAMILY AND SOCIAL ENVIRONMENT

ADOLESCENT BIRTHS

Compared to children born to older mothers, children born to teen mothers are more likely to grow up in a single-parent family, to have less educated and less securely employed parents, and live in poverty. In addition, children of adolescent parents are more likely than children of older parents, to have lower intellectual and academic achievement, lower educational expectations, and more behavioral disorders.[1] Teen mothers are more likely than older mothers to need the support of public assistance.

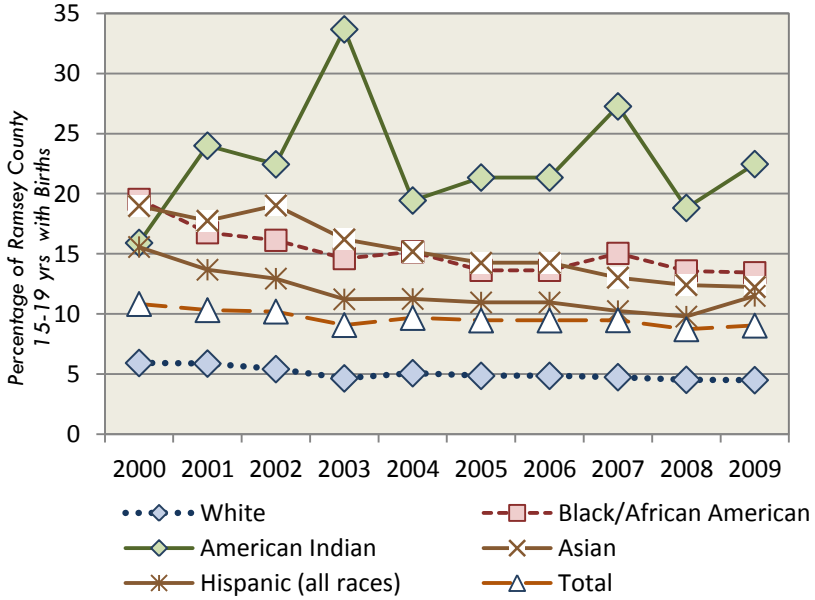
The reasons why adolescents become pregnant and become parents are complex, but research indicates that teens are less likely to become pregnant when certain assets are present in their lives. These include close and positive connections with caring adults, life opportunities and goals, contraceptive use, and success in school.[2]

Figure AB-1: Pregnancy rates , Ramsey and Hennepin County and the State of Minnesota, 2001 - 2009



Source: Minnesota Department of Health

Figure AB-2: Teen births (ages 15-19yrs) by race/ethnicity, Ramsey County, MN, 2000-2009



Source: Minnesota Department of Health Ramsey County Birth Certificate Data

Ramsey County: Persistent Racial Disparity in Teen Birth Rates

Overall, the percentage of Ramsey County teens giving birth is decreasing (Figure AB-1).

However, teens of color continue to have births at higher rates than White teens.

In 2009, Black/African American, Asian and Hispanic teens in Ramsey County made up 40% of the teen population (Figure AB-2), but accounted for 65% of teen births.

Source: American Community Survey

[1] *Suellentrop, K. (2010). The Odyssey Years: Preventing Teen Pregnancy Among Older Teens. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.*

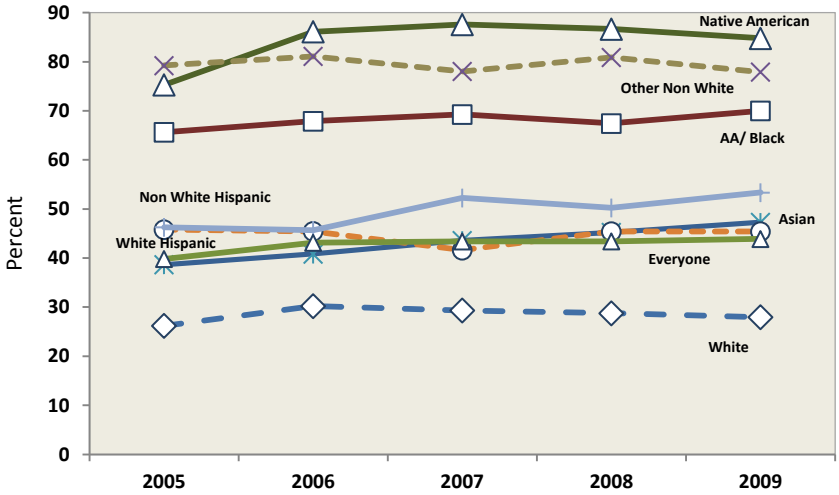
[2] *Kirby, D. & Lepore, G. (2007). Sexual Risk & Protective Factors Affecting Teen Sexual Behavior, Pregnancy, Childbearing and Sexually Transmitted Disease: Which Are Important? Which Can You Change? The National Campaign to Prevent Teen and Unplanned Pregnancy.*

Births to Unmarried Women

Increases in births to unmarried women are among the many changes in Ramsey County that have affected family structure and the economic security of children. Not all children who are born to single mothers are worse off economically but if a mother is poor and lacks economic or social support, it can affect a child's well-being.

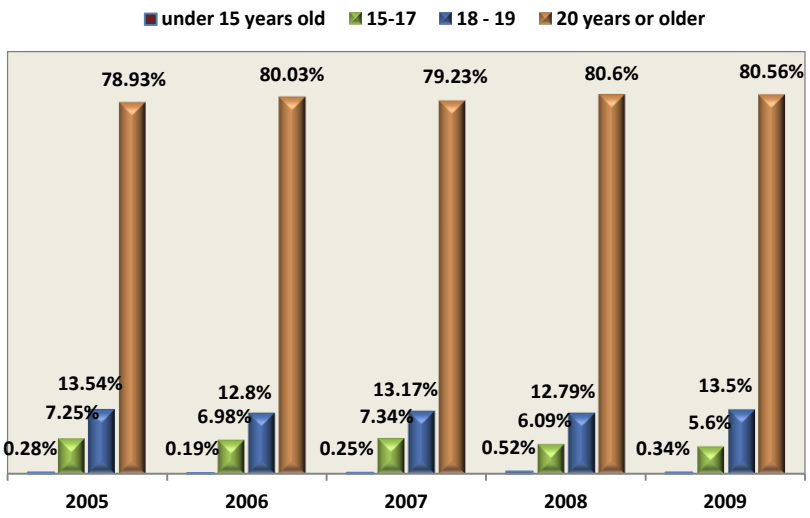
Nationally, the number of children born to unmarried women has been increasing since 2002 with nearly four out of ten U.S. births being to unmarried women.[1] In Ramsey County, a large disparity exists between White and Non-White unmarried mothers.

Figure BUW-1: Percentage of children born to unmarried women by mother's race/ethnicity, Ramsey County, MN, 2005 - 2009



Source: Minnesota Department of Health

Figure BUW-2: Percentage of children born to unmarried mothers by mother's age, Ramsey County, MN, 2005 - 2009



Source: Minnesota Department of Health

Children born to unmarried mothers are at higher risk for poor birth outcomes than children born to married women.[1] *These complications include:*

- *Low birth weight*
- *Preterm birth*
- *Infant mortality*
- *Limited social resources*
- *Poverty*

The majority of births to unmarried mothers were to women older than 20 years old.

[1] *Ventura, S.J. (2009). Changing Patterns of Nonmarital Childbearing in the United States. National Center for Health Statistics Brief No.18. U.S. Department of Health and Human Services, Center for Disease Control and Prevention.*

CHILD CARE

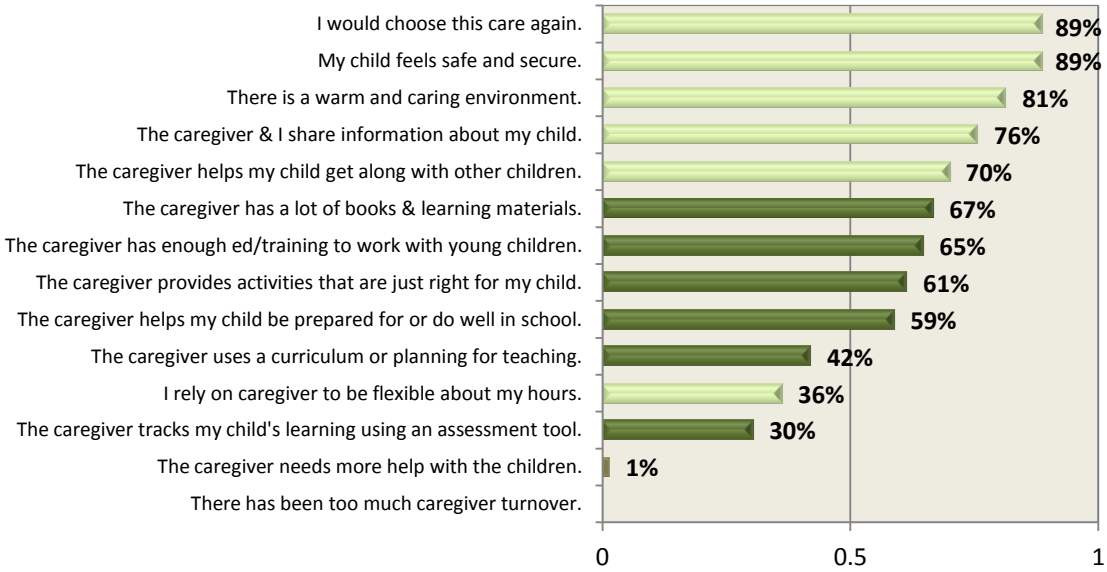
Child care can be an important indirect determinant of health for multiple reasons. Young children spend a considerable amount of their childhood in non-parental care and although this is true for the children of women who do and do not work outside of the home, Minnesota mothers consistently have one of the highest employment rates in the nation.

High quality early care and education is highly correlated with better social and emotional development and school readiness in young children.[1,2] For older, school-aged children, quality care includes homework support that helps students stay on track with school work and boosts school attendance. Teens who participate in engaging after-school programming tend to skip school less and have lower rates of juvenile crime involvement.[3] Finally, reliable and flexible child care arrangements facilitate employment, and parents with care that they can rely on and trust tend to be better employees.[4]

RAMSEY COUNTY PARENTS REPORT THAT THEIR CHILD CARE ARRANGEMENTS HAVE FEWER SCHOOL READINESS ATTRIBUTES

School readiness attributes (the dark green bars, Figure CC-1) are those that support learning and preparation for school. The light green bars are other attributes that are important to parents and children but that are not specific to early learning experience.

Figure CC-1: Attributes of child care arrangements that parents report are "always true", Ramsey County 2009



Source: Wilder Research Child Care Use Survey

outcomes for low-income children in pre-kindergarten programs. Early Childhood Research Quarterly, 25(2), 166-176.

[2] Moodie-Dyer,A. (2011). A policy analysis of child care subsidies: Increasing quality, access, and affordability. Children & Schools, 33(1), 37-45.

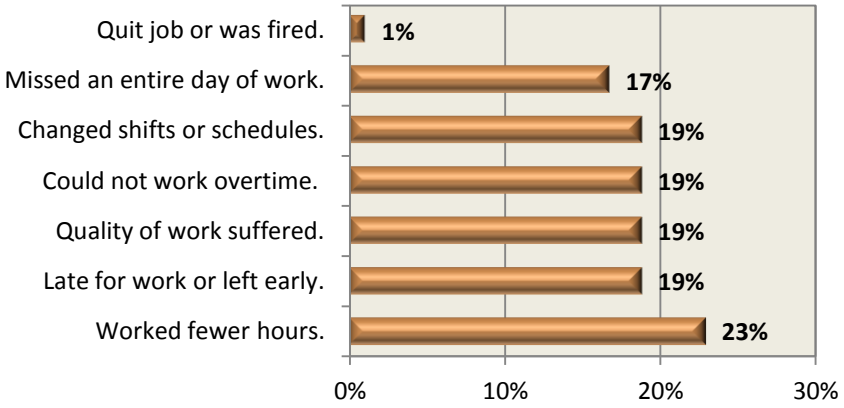
[3] www.FightCrime.org.

[4] Lemke, R.J., Witte, A.D., Queralt, M., & Witt, R. (2000). Child care and the welfare to work transition. National Bureau of Economic Research, Inc. Working paper, 7583. Cambridge, MA.

Every five years Wilder Research completes a statewide survey of child care patterns through their *Child Care Use* in Minnesota study.[5] This is one of the most comprehensive, periodic examinations of the child care patterns of families with young children in the nation. The survey examines a representative, statewide sample of families for type of child care used, parental perceptions of care quality, and the impact of cost on families. The cost of child care is influential in the type of care parents purchase for their children. Parents do not always use the type of care they prefer.

The Ramsey County sub-set of parents responding to the statewide *Child Care Use* survey is not representative of the county as a whole (the total number of respondents is too small). Therefore, the selected data shown below should only be considered a glimpse of some of the child care experiences of families in Ramsey County.

Figure CC-2: In the past six months, family child care arrangements affected the following (N = 96), Ramsey County, 2009



Source: Wilder Research Child Care Use Survey

The most common child care problems reported by Ramsey County parents were related to work schedules (e.g., leaving early, schedule changes, fewer hours worked, etc.).

Ramsey County parents can obtain information about child care providers in their areas from a resource and referral (R&R) network.[6] R&R agencies provide information on licensed child care providers based on criteria that parents specify (e.g. non-smoking homes, homes without pets, etc.). During fiscal year 2011, there were 121 licensed family child care homes in Ramsey County, 88 licensed centers, 66 school-aged care programs, and a total of 67 preschool programs. The R&R agency served over 3,000 families, 16% of whom were low income.

R&R agencies are also responsible for training child care providers to provide the best possible care, including readying children for school. During FY2011, Ramsey's R&R agency provided nearly 5,000 training sessions to over 1,500 providers.[6]

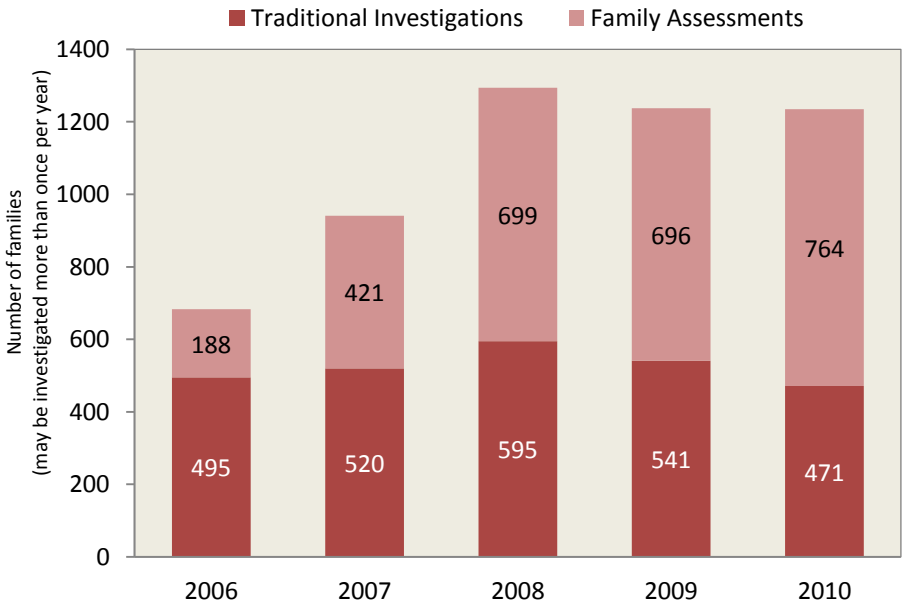
[5] Chase, R., & Valorose, J. (2010). Child Care Use in Minnesota. Wilder Research, St. Paul, MN. Retrieved from: www.wilder.org/download.0.html?report=2350.
[6] ThinkSmall.org (formerly Resources for Child Caring).

CHILD MALTREATMENT

Child maltreatment includes physical, sexual, and psychological abuse, as well as neglect (including medical neglect). Maltreatment is associated with a number of negative outcomes for children, including lower school achievement, juvenile delinquency, substance abuse, and mental health problems.[1] The most common form of child maltreatment is neglect. Neglect is most common in families under stress and can be a result of maternal withdrawal and hopelessness.[2] Over the last ten years, reports of child neglect or maltreatment in Minnesota have been triaged through a process called Family Assessment (FA)[3] that offers more service-oriented supports to families if their situations are not severe. FA is one of a number of national and international strategies aimed at preventing families from entering the child welfare system who really do not need nor benefit from intensive investigative services. FA usually includes services such as chemical dependency counseling or parenting classes and is intended to focus on family strengths. FA affects how many families now enter the traditional child welfare system.

Between 2006 and 2010 Ramsey County, like the rest of the state, has seen an increase in the number of child maltreatment assessments that are addressed via FA rather than traditional investigations. Each year since 2006, over half of accepted maltreatment reports in Ramsey County were referred to the Family Assessment program. Conversely, under half were referred for Traditional child protection investigations.

Figure CM-1: Number of families in investigations/ assessments, Ramsey County, MN, 2006-2010



Source: Ramsey County Community Human Services Annual Report, 2010

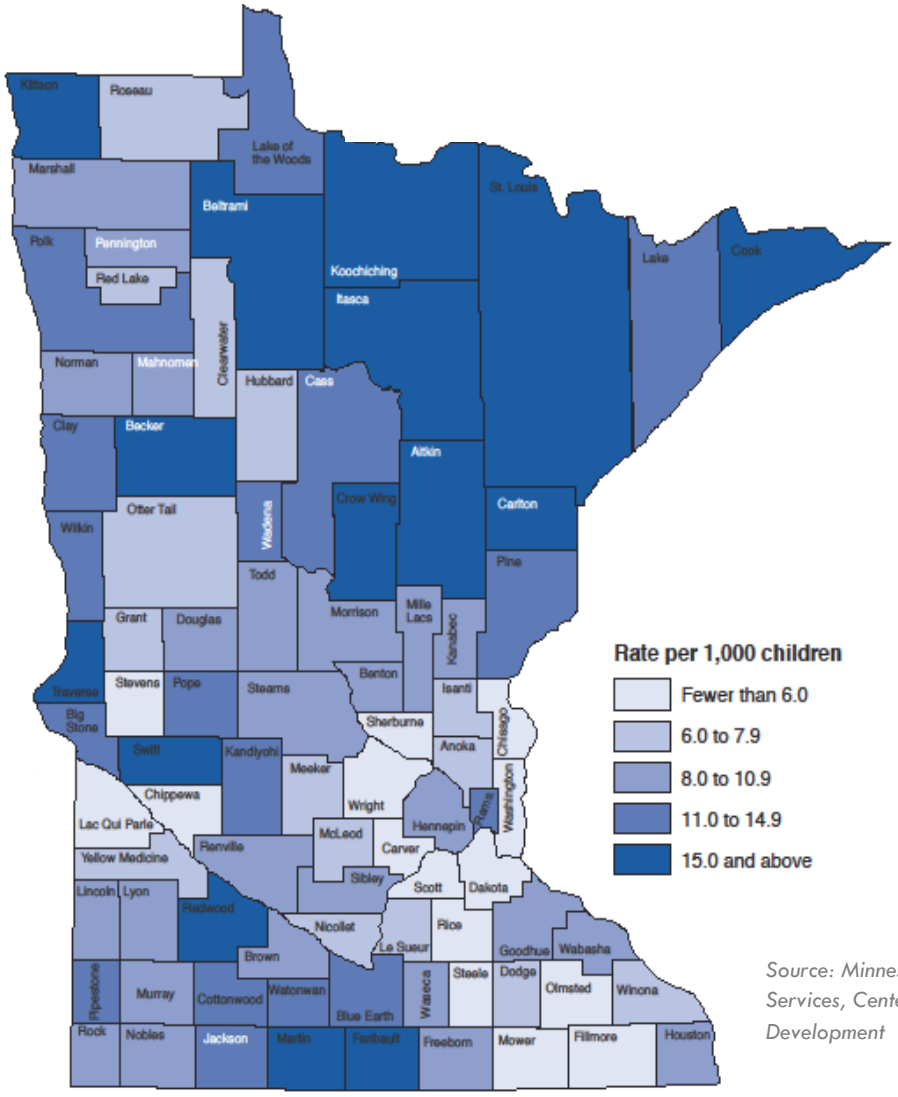
The intake phone line for Children's Services in Ramsey County receives more than 20,000 calls a year. As a result of those calls in 2010, over 3,100 children were identified as victims or minor members of a family where maltreatment or neglect had been alleged.

[1] Alink, L., Kim, J., Cicchetti, D., Rogosch, F. (2012). Longitudinal associations among child maltreatment, social functioning, and cortisol regulation. Developmental Psychology, 48(1), 224-236.
[2] Lescheid, A., Chido, D., Whitehead, P.C., Hurley, D. (2005). The relationship between maternal depression and child outcomes in a child welfare sample: implications for treatment and policy. Child & Family Social Work, 10(4), 281-291.
[3] Minnesota Department of Human Services, Family Assessment Response: Reaching out to support families. http://www.dhs.state.mn.us/.

CHILDREN IN OUT-OF-HOME PLACEMENT (FOSTER CARE)

Children thrive when they grow up in loving, stable, healthy homes with families that have what they need to safely care for them. When children experience some forms of abuse, neglect, or crisis, they may be placed out of their original homes for safety. A placement may be temporary (just a few days) or longer-term while families get the help they need to be able to be reunited. Out-of-home placement refers to children who experience one or more days in a placement setting outside of their original home during the calendar year. The most common types of reasons for placement include: neglect, parent drug abuse, parent alcohol abuse, abandonment, inadequate housing, parent incarceration and child behaviors.

Figure FC-1: Children in out-of-home placements, Minnesota, 2010



Source: Minnesota Department of Human Services, Center for Rural Policy and Development

Not all children in out-of-home placements were taken out of their original home because of child maltreatment. In 2010, 844 children in Ramsey County were in placements under the supervision of child protection. Other Ramsey County programs responsible for the majority of non-child protection placements were Delinquency (506 children), and Permanent Connections (468 children).

There is a disproportionate representation of children by race and ethnicity in the public child welfare system. The greatest disproportion is experienced by American Indian and African American children who are in out-of-home placements at higher rates compared to their representation in Minnesota's child population.

Table FC-2: Children in out-of-home placement, Ramsey County, MN, 2005-2009

	Number	Rate (per 1,000 children)
2005	1906	16
2006	1967	16
2007	1944	14.9
2008	1820	14.9
2009	1620	13.9
2010	1666	12.6

Source: Minnesota Department of Human Services, Minnesota's Child Welfare Report (annual) and Ramsey County Community Human Services. Definitions: Children who spent time in foster care, group homes, emergency shelter or residential treatment facilities during the year, including those formally placed with relatives.

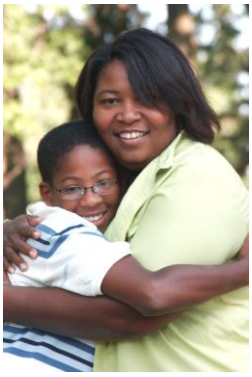
In 2010, Ramsey County's out of home placement rate dropped to 12.6 per 1,000 children, the lowest in five years, but Ramsey County's rate still remains the highest rate among all metro area counties.

Table FC-3: Out-of-home placements by area and setting, Ramsey County, MN, 2010

Area Responsible for Placement	Total	Shelter	Foster Home	Other
Child Protection	844 (41%)	473	340	31
Permanent Connections	468 (23%)	34	353	81
Delinquency	506 (25%)	246	10	250
Children's Mental Health	206 (10%)	76	45	85
Other	29 (1%)	2	3	24
Total	2053	831	751	471

Source: Ramsey County Community Human Services Annual Report, 2010
Each individual placement is counted once so a child with multiple placements is counted more than once.

FAMILY STRUCTURE AND CHILDREN'S LIVING ARRANGEMENTS

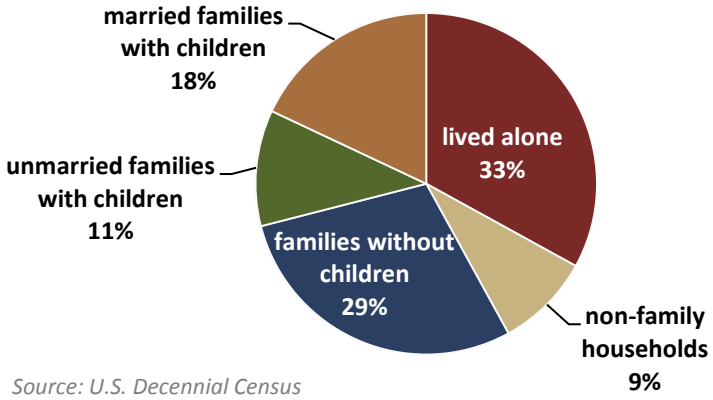


Family structure and stability impact children through the availability of emotional and financial resources. Loving families come in many different forms, but whatever the structure, all children deserve safe, permanent and nurturing environments. Many children lack the active support of two parents, grandparents, and other relatives, who often care for children when parents can't.

The 2001-2007 National Health Interview Survey found that children living with two parents are less likely than other children to be in fair or poor health. They are also less likely to have learning disabilities, attention deficit hyperactivity disorder, to lack health insurance, to have had multiple emergency room visits, to go without needed prescription medication due to lack of affordability, and to have gone without dental care.[1]

Children living in single-parent families have higher rates of poor health; yet, when compared with children living in other nonnuclear families, children in single-parent families exhibit similar rates in health status, access to care, and emotional or behavioral difficulties.[2]

Figure FMS-1: Household structure, Ramsey County, MN, 2010

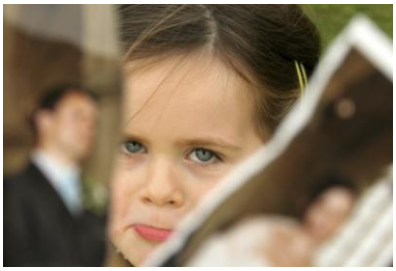


Source: U.S. Decennial Census

[1] *Family Structure and Children's Health in the United States: Findings From the National Health Interview Survey, 2001–2007 by Debra L. Blackwell, Ph.D., Division of Health Interview Statistics.*

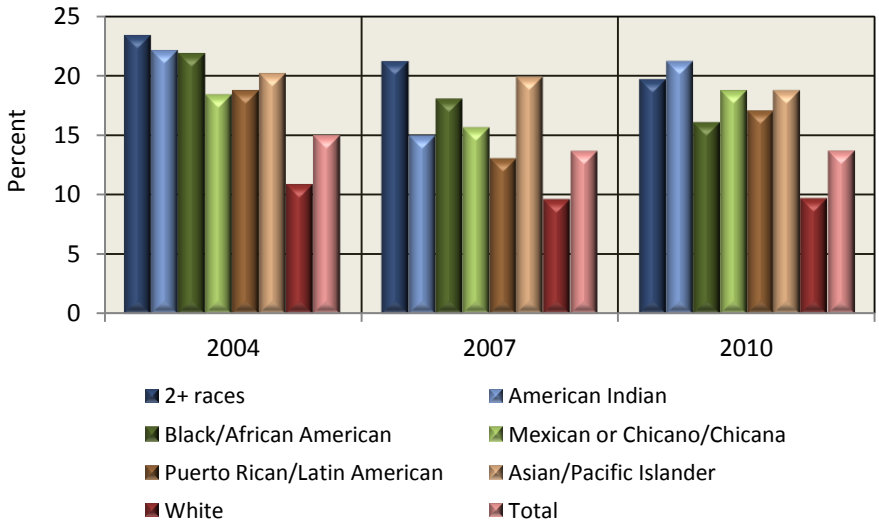
[2] *Ibid.*

FAMILY VIOLENCE



Children exposed to violence between parents or intimate partners are at increased risk of many of the same adverse mental health outcomes associated with childhood victimization itself. The fear, anxiety and elevated stress that students experience as a result of a violent school atmosphere have serious psychological health consequences. Stress related to feeling unsafe in one's neighborhood can have adverse health effects throughout life, and may even influence subsequent generations through genetic changes. Research from large national longitudinal studies such as the Adverse Childhood Experiences (ACE) study[1] have shown the strong link between violence and shortened lifespan and serious, chronic health conditions in adulthood.

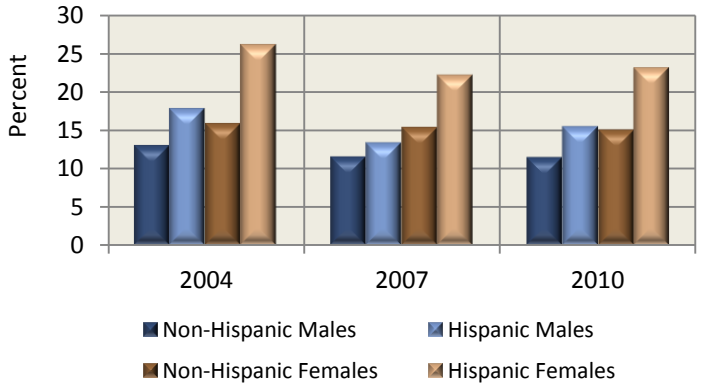
Figure FV-1: Percentage of 6th, 9th, and 12th graders reporting family violence by race, Ramsey County, MN, selected years



Source: Minnesota Student Survey

Children of color in Ramsey County report more family violence than White children.

Figure FV-2: Percentage of 6th, 9th and 12th graders reporting family violence by Hispanic ethnicity, Ramsey County, MN, selected years



Source: Minnesota Student Survey

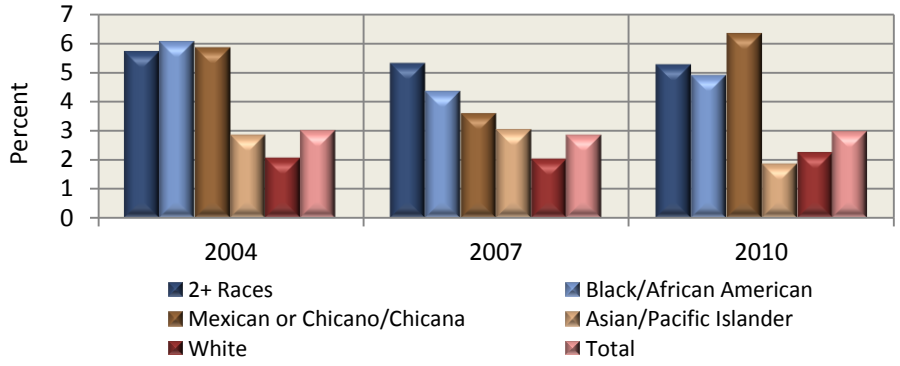
Hispanic females report the highest rates of family violence.

[1] *Centers for Disease Control and Prevention. Adverse Childhood Experiences (ACE) Study. Retrieved from: http://www.cdc.gov/ace/index.htm*

SEXUAL ABUSE AND CHILDREN

Children who suffer sexual abuse trauma can develop serious and costly forms of psychological, physical and emotional consequences. Through appropriate services, some children are able to recover from past sexual abuse. The strongest predictor of a child's recovery from past sexual abuse is high-functioning and supportive mothers and families.[2]

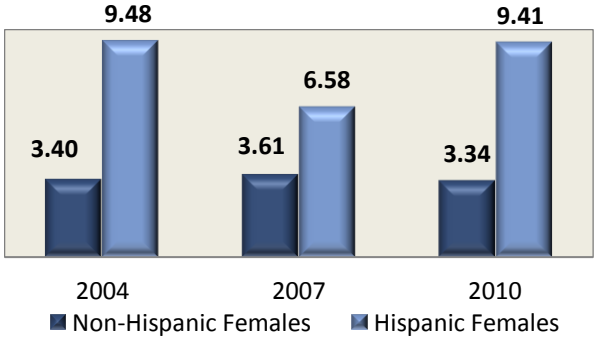
Figure FV-3: Percentage of 6th, 9th and 12th graders reporting family sexual abuse by race, Ramsey County, MN, selected years



Source: Minnesota Student Survey

Children of color report family sexual abuse at higher rates than White children.

Figure FV-4: Percentage of 6th, 9th and 12th graders reporting family sexual abuse by Hispanic Ethnicity, Ramsey County, MN, selected years



Source: Minnesota Student Survey

Hispanic females report the highest rates of sexual abuse.

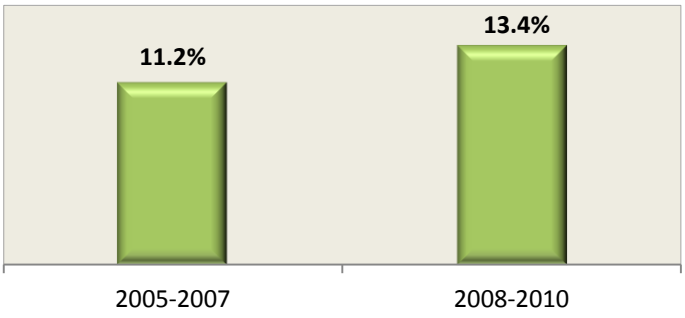
[2] Ibid.

FOREIGN BORN

Minnesota's diversity is increasing primarily through immigration. The state attracts a wide range of immigrants and refugees from other parts of the U.S. and from other countries, who move here to attend school, start businesses, work in Minnesota industries, and join family members. The diversity within racial and ethnic categories (especially from Asia and Africa) presents nearly as many challenges as diversity within the whole population: for example, at least 19 different countries are represented among Asian immigrants to Minnesota. In Ramsey County, the majority of new residents have come from Burma.

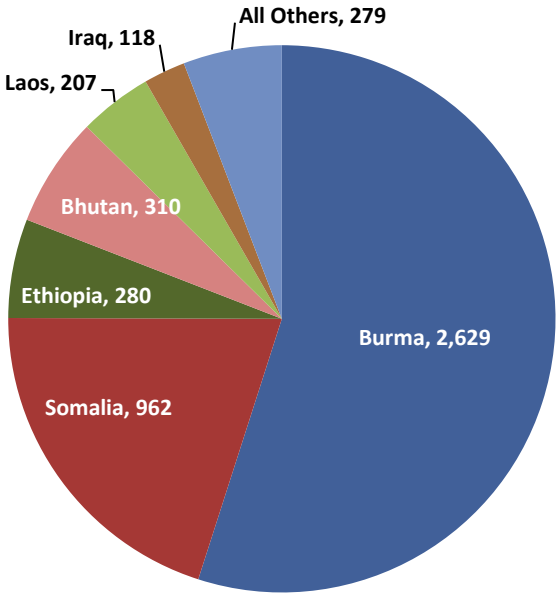
RAMSEY COUNTY: HOME TO IMMIGRANTS AND REFUGEES

Figure FB-1: Percentage of foreign-born residents, Ramsey County, MN, 2005-2010



Source: American Community Survey

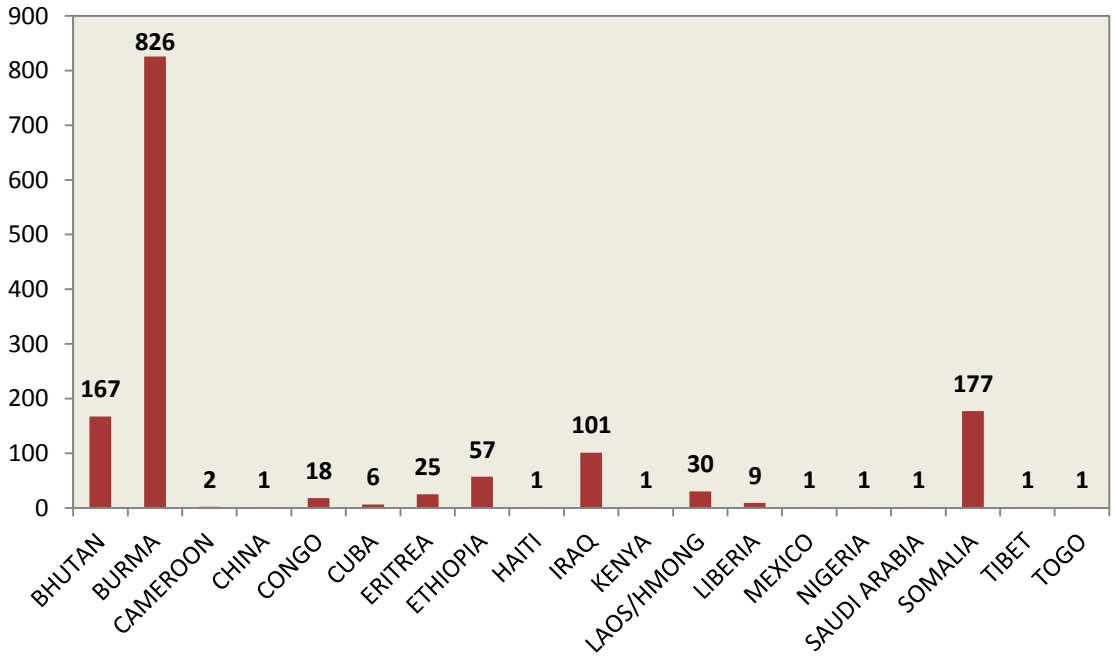
Figure FB-2: Primary refugee* arrivals to Ramsey County by country of origin, 2006-2010



Source: Minnesota Department of Health Refugee Health Program
** Primary refugee includes "Primary Refugee", "Asylee", "Parolee", "Amerasian", "Victim of Trafficking".*

Over half of new refugees arriving to Ramsey County in the past five years are from Burma. 20% are from Somalia; 6% from Ethiopia and 6% from Bhutan.

Figure FB-3: Primary refugee arrivals by country of origin, Ramsey County, 2010



Source: Minnesota Department of Health Refugee Health Program

The Karen: Ramsey County's Newest Residents

The Karen (pronounced Ka-REN) are the indigenous ethnic minority in the mountainous regions of Burma and Thailand, where they constitute the second largest ethnic group in each country. They are persecuted by the Burmese military junta, who conduct acts of genocide against the Karen people in Burma and in refugee camps in Thailand. Many Karen families who flee Burma and Thailand have settled in Saint Paul. Currently, Saint Paul is home to the largest population of Karen outside of south-east Asia.

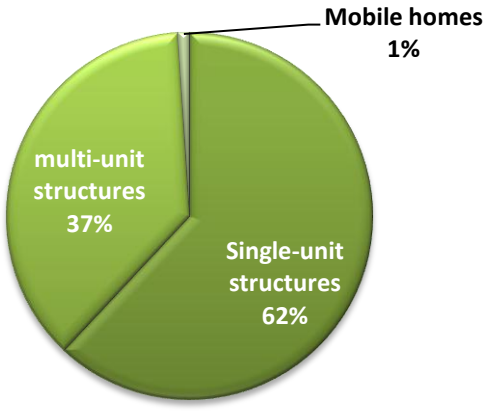
HOUSING

Where we live is at the core of our daily lives. For most Americans, home represents a place of safety, security, shelter, and where families come together. Housing costs generally represent a family's greatest single expenditure, and, for homeowners, their most significant source of wealth. Housing is often one of the top two to three expenses in a family's budget.[1] Given its importance, it is not surprising that factors related to housing have the potential to help, or harm our health in major ways.

Good health depends in part on having homes that are safe and free from physical hazards. When adequate housing protects individuals and families from harmful exposures and provides them with a sense of privacy, security, stability and control, it can contribute to health. In contrast, poor quality and inadequate housing contributes to health problems such as infectious and chronic diseases, stress, injuries and poor childhood development.[2]

In 2005-2009, Ramsey County had a total of 215,000 housing units, 6 percent of which were vacant. Among total housing units, 62 percent were in single-unit structures, 37 percent were in multi-unit structures, and one percent were mobile homes. Thirteen percent of housing units were built since 1990.

Figure HSG-1: Types of housing units in Ramsey County, MN, 2005-2009



Source: American Community Survey, 2010

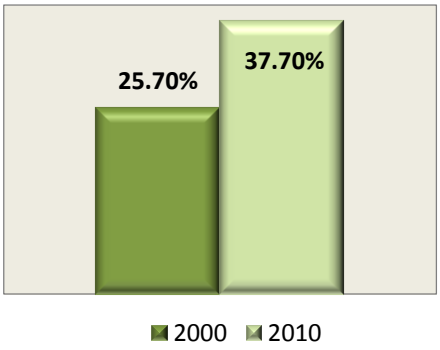
In 2005-2009, Ramsey County had 201,000 occupied housing units - 129,000 (64 percent) owner occupied and 72,000 (36 percent) renter occupied. Three percent of households did not have land-line telephone service and 11 percent did not have access to a car, truck, or van for private use. Multi vehicle households were common. Thirty-seven percent had two vehicles and another 14 percent had three or more. The average household size was 2.4 people.

In 2005-2009, 82 percent of individuals, age 1 and up in Ramsey County had resided in the same home for at least one year. Nine percent had moved during the past year from another residence in the same county, 5 percent from another county in the same state, 2 percent from another state, and 1 percent from abroad.

[1] *Housing Affordability in Ramsey County. Minnesota Housing Partnership. 2010*
[2] *Robert Wood Johnson Foundation's Vulnerable Populations Portfolio, Retrieved from: www.rwjf.org/vulnerablepopulations.*

Housing is un-affordable (or cost-burdened) when costs exceed 30% of household income. About 38% of households in Ramsey County were cost-burdened in 2010, up from 26% in the previous decade.[3] In 2010, about 61% of Ramsey County households owned their home and 39% were renters.[4] With the foreclosure crisis, rental is becoming increasingly important. Statewide, home ownership rates have fallen to 73%, a significant drop since peaking at 76% in 2006.[5]

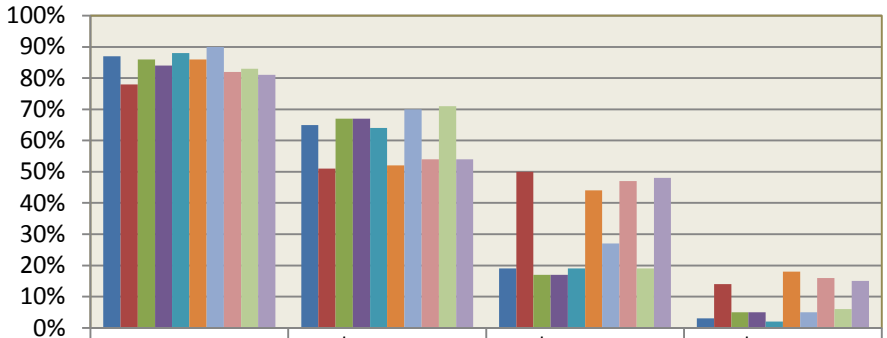
Figure HSG-2: Percentage of households paying more than 30% of income for monthly housing costs, Ramsey County, MN, 2000 and 2010



Source: American Community Survey

Residents at all income levels experience housing cost-burden. However, higher proportions of lower-income families struggle with unaffordable housing. In 2010, 90% of homeowners earning less than $20,000 were in unaffordable housing, compared with 5% of homeowners earning $50,000 or more.

Figure HSG-3: Percentage of renters and homeowners paying more than 30% of their income for housing, Ramsey County, MN, 2006-2011



	Less than $19,999	$20,000 - $34,999	$35,000 - $49,999	$50,000 and over
2006/2007 Renters	87%	65%	19%	3%
2006/2007 Homeowners	78%	51%	50%	14%
2008 Renters	86%	67%	17%	5%
2008 Homeowners	84%	67%	17%	5%
2009 Renters	88%	64%	19%	2%
2009 Homeowners	86%	52%	44%	18%
2010 Renters	90%	70%	27%	5%
2010 Homeowners	82%	54%	47%	16%
2011 Renters	83%	71%	19%	6%
2011 Homeowners	81%	54%	48%	15%

Source: Minnesota Housing Partnership, Ramsey County Profile

[3] *Housing Affordability in Ramsey County. Minnesota Housing Partnership, 2011.*
[4] *U.S. Census 2010*
[5] *U.S. Census 2010 and American Community Survey, 2006.*

HOMELESSNESS

Homelessness is especially traumatic for children. Studies of homeless children show that they have more trouble developing healthy relationships and more difficulty staying on track in school. [1] Homeless children experience a number of mental health and overall negative health outcomes related to the stresses of their living arrangements.[2] Homeless youth who have involvement with foster care are highly likely to suffer from mental illness such as depression.[3] Homeless parents have high rates of chronic physical and mental illness, as well as low employment and wages and many mothers are homeless as a result of domestic violence. Long-term studies show that homeless children are more likely than other children to be homeless again as adults, and that young adulthood is a particularly risky time of life for them.

Every three years since 1991, Wilder Research has conducted a statewide survey of people without permanent housing. Their recent report released in May, 2011 showed that the number of homeless children and families increased dramatically in 2010 after steady decreases between 2003 and 2006.[4]

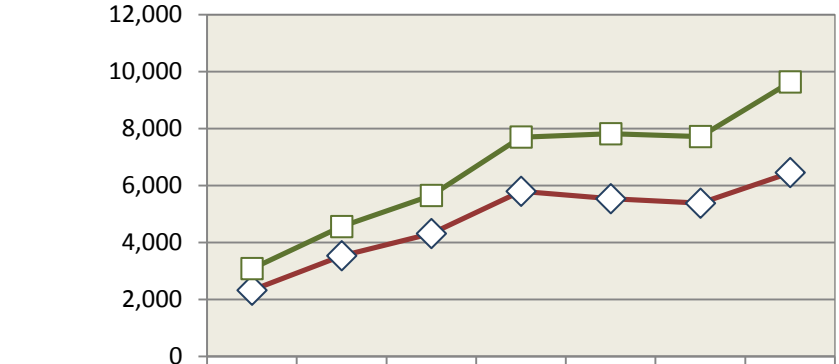
Homeless families in Minnesota are now at their highest levels since 1991.

On any given night in Minnesota, Wilder estimates that 3,900 children are homeless and with their parents. An additional 550 youth age 17 or younger are estimated to be homeless and on their own ("unaccompanied youth"), for a total of nearly 4,500 children. Over the course of a full year, Wilder estimates that about 14,120 children with their parents and 4,800 unaccompanied minor youth are homeless. Many of these individuals are homeless for just a short time and are not captured in a single-night survey.[5]

Homeless families and children comprise the fastest-growing segment of homeless people in Minnesota since the statewide homeless survey began in 1991.[6] At 3,251, the number of children in 2009 is more than three times the number (889 homeless children) found in 1991. These findings are consistent with national studies that also show faster growth in the number of homeless families than among homeless single adults. Using conservative calculations based on studies done elsewhere, Wilder estimates that another 24,000 to 34,800 children and youth were doubling up, or staying temporarily with family or friends because they had nowhere else to live in 2010. The total estimated number of children, including those in shelters, in unsheltered locations, and doubled-up or in other temporary arrangements in Minnesota on any given night is 29,000 to 39,000. Fifty-two percent of homeless children were age 5 or younger (including 9% who were less than 1 year old). Thirty-three percent were age 6-12, and 16 percent were 13-17.

[1] *Gerwitz, A., Hart-Shegos, E., Medhanie, A. (2008). Psychosocial status of homeless children and youth in family supportive housing. American Behavioral Scientist, 51(6), 810-823.*
[2] *Buckner, J. (2008). Understanding the impact of homelessness on children: Challenges and future research directions. American Behavioral Scientist, 51(6), 721-736.*
[3] *White, C. R., Gallegos, A. H. O'Brien, K., Weisberg, S., Pecora, P. J., Medina, R. (2011). The relationship between homelessness and mental health among alumni of foster care: Results from the Casey Young Adult Survey. Journal of Public Child Welfare, 5(4), 369-389.*
[4] *Homelessness in 2009: Results of the Wilder Statewide Survey. Retrieved from: http://www.wilder.org/homeless2009.0.html.*
[5] *Ibid.*
[6] *Ibid.*

Figure HLS-1: Number of persons experiencing homelessness, Twin Cities and Minnesota, selected years



	1991	1994	1997	2000	2003	2006	2009
Twin Cities	2,319	3,530	4,309	5,791	5,532	5,374	6,449
State of MN	3,079	4,553	5,645	7,696	7,811	7,713	9,630

Source: Wilder Compass

The Twin Cities increase in homelessness is similar to state and national trends.

HOUSING CRISIS RESPONSE: RAMSEY COUNTY'S FIRST RESPONDER

Ramsey County Housing Crisis Response provides services to Ramsey County families, single adults and unaccompanied youth who are homeless or in imminent risk of becoming homeless. Over the past two years

- 9,300 calls were received from families, and
- 12,543 calls were received from single adults.

There are inadequate resources to address housing crises. Only 1 out of 4 families, and only 1 in 12 youth that seek emergency shelter are able to be served.[7]

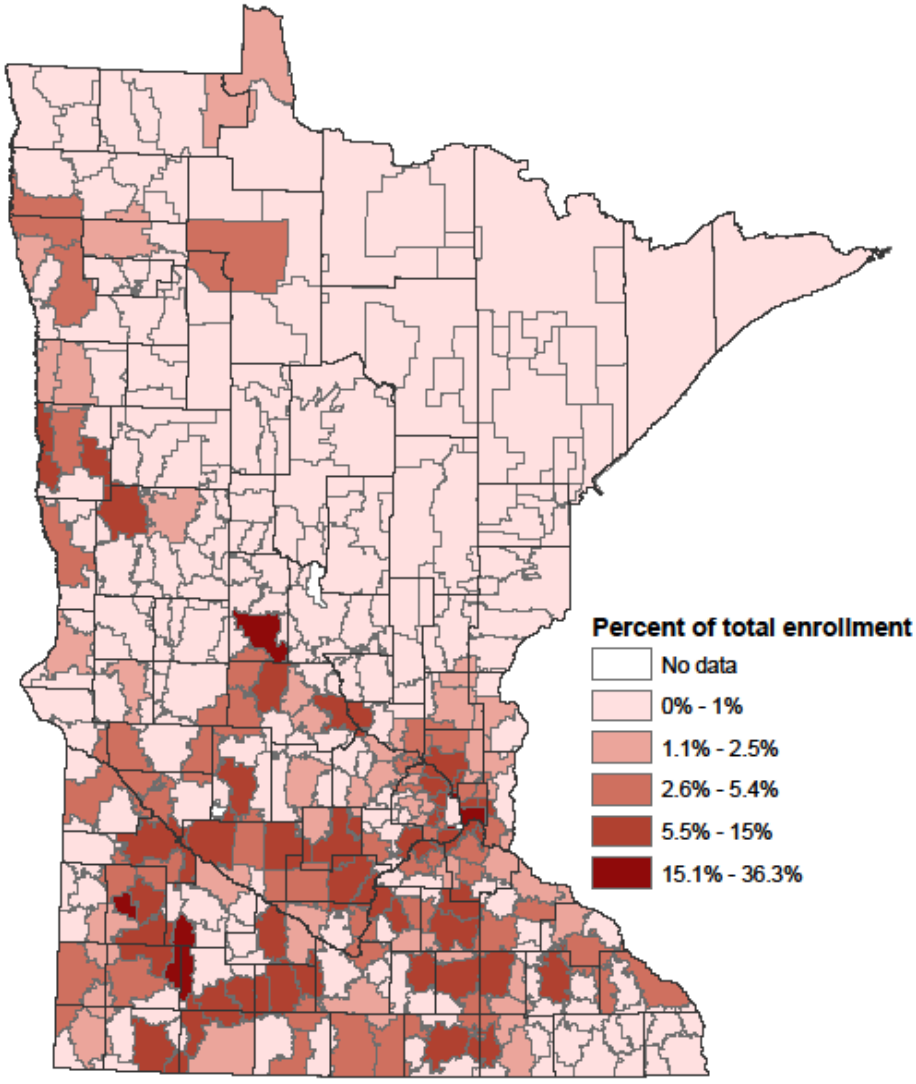
Between 2006 and 2010, the number of reported homeless students in Ramsey County doubled to 1,996. There has been a 200% increase in homeless children in Ramsey County suburbs.

[7] Heading Home Ramsey

LANGUAGE SPOKEN AT HOME

The primary language spoken in the home is not a direct indication of immigrant status; however, it suggests the degree to which students or their parents may be recent immigrants. English home language adoption takes 1-3 generations and some families always choose to speak another language other than English at home. Understanding home language also provides information on students' likelihood of having to navigate the education system through two or more languages. Data on primary language spoken in the home is collected annually by Minnesota public schools. Survey data are kept separate from all other education data so that students cannot be identified.

Figure LSH-1: Limited English proficiency of students in Minnesota, by district, 2010-2011

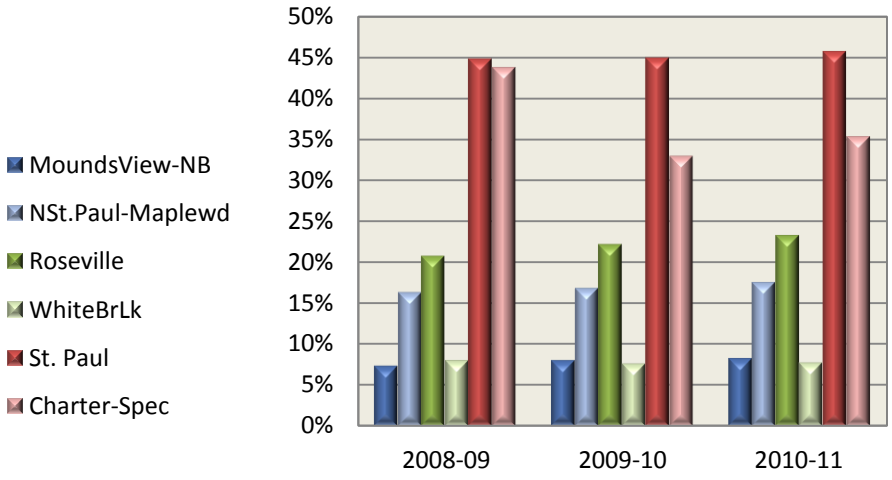


Source: Minnesota Department of Education

Proportions shown in Figure LSH-2 are for the percent of students in each Ramsey County school district whose primary home language is a language other than English, for three academic years. The Charter-Specialty district includes charter schools throughout Ramsey County, along with specialty schools such as schools for the deaf, blind, and integration districts.

The proportion of students whose families speak a language other than English at home is increasing in most districts but has always been highest in Saint Paul Public Schools.

Figure LSH-2: Percentage of students with non-English primary home language, Ramsey County, MN, 2008-2011



Source: Minnesota Department of Education data and analytics: https://education.state.mn.us/MDEAnalytics/Data.jsp

The most common non- English primary home languages spoken by Ramsey County school children are:

- *Spanish*
- *Hmong*
- *Vietnamese*
- *Burmese*
- *Chinese*
- *Somali*

LESBIAN, GAY, BISEXUAL, TRANSGENDER (LGBT)

LGBT individuals are represented among all races, ethnicities, religions, and social classes. Sexual orientation and gender identity questions are rarely included on most national, state, or local surveys, making it difficult to estimate the number of LGBT individuals and their health needs. For many, the acronym LGBT reflects a community of individuals who, in some way, are attracted to members of the same sex. However, many people fail to realize that the "T" in the acronym does not relate to sexual attraction at all; rather, it refers to a person's sense of gender (referred to as gender identity).[1]

Research shows that lesbian, gay, bisexual, and transgender (LGBT) individuals suffer disproportionately from a number of health ailments.

Research suggests that LGBT individuals face health disparities linked to social stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBT persons has been associated with high rates of psychiatric disorders, substance abuse, and suicide. Experiences of violence and victimization are frequent for LGBT individuals, and have long-lasting effects on the individual and the community. Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals.[2]

Accurate estimates of the gay, lesbian, bisexual and transgender (LGBT) persons in Ramsey County are unavailable. However the SHAPE 2002 study[3] conducted in Hennepin County found that 4% of males and 2% of females identified as LGBT.

Top Health Issues for Lesbians[1]

- Heart Disease
- Cancers
- Fitness
- Obesity
- Injury/violence
- Mental health
- Suicide
- Substance abuse

Top Health Issues for Bisexuals[1]

- Heart Disease
- Cancer
- Obesity
- Injury and Violence
- lack of health screenings
- Sexual Health
- Mental Health
- Suicide
- Alcohol Abuse
- Smoking

Top Health Issues for Gay Men[1]

- Heart disease
- Cancer
- Injury and violence
- Fitness and body image
- Mental health
- Suicide
- Substance Abuse
- HIV/AIDS
- Syphilis
- Human Papillomavirus (HPV)
- Hepatitis

Top Health Issues for Transgender People[1]

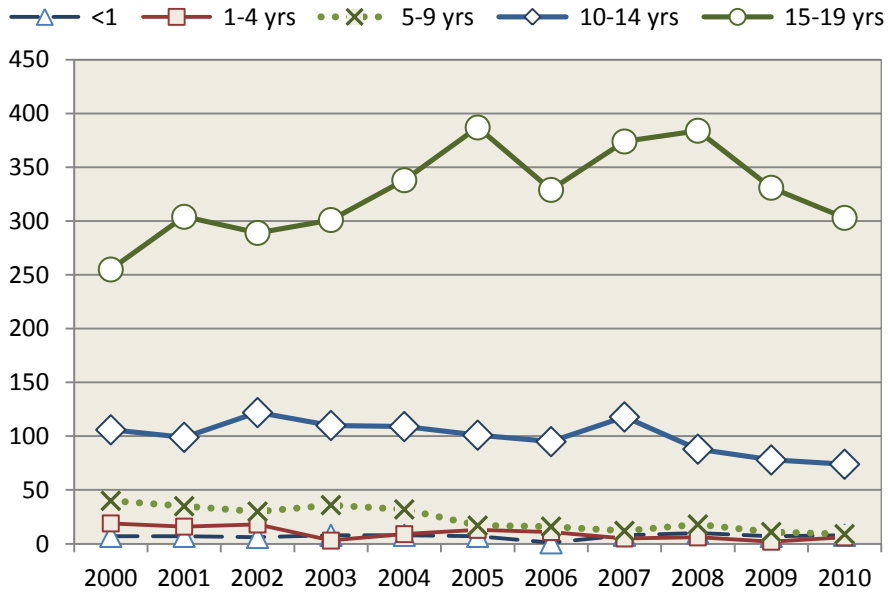
- Injury and violence
- Suicide
- Mental Health
- Substance Abuse
- HIV/AIDS
- Sexually Transmitted Infections

[1] Substance Abuse and Mental Health Services Administration, Top Health Issues for LGBT Populations Information & Resource Kit. HHS Publication No. (SMA) 12-4684. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.
[2] Gruskin EP, Greenwood GL, Matevia M, Pollack LM, Bye LL. Disparities in Smoking Between the Lesbian, Gay, and Bisexual Population and the General Population in California. Am J Public Health. 2007; 97:1496–1502.
[3] Hennepin County Community Health Department and Bloomington Division of Public Health. SHAPE 2002: A Preview, Survey of the Health of Adults, the Population and the Environment. Minneapolis, Minnesota, January 2003.

YOUTH VICTIMS OF VIOLENT CRIMES

Children and youth are the unfortunate victims of family stress, dysfunction and disordered communities. This victimization takes the form of injuries, assaults and even rapes. Children that suffer emotional, sexual or physical abuse are more likely to become perpetrators of crime themselves.[1]

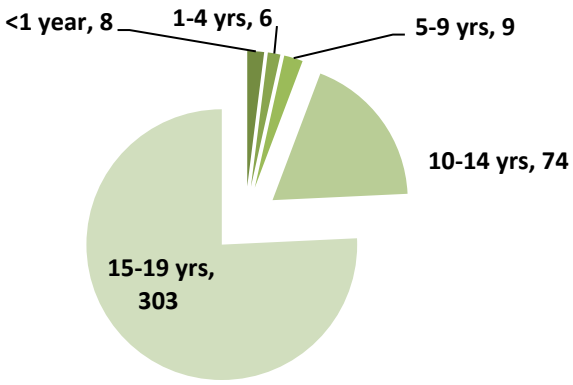
Figure YVC-1: Number of assaults (fatal and non-fatal) to children that resulted in an emergency room treatment or hospitalization, Ramsey County, MN, 2000-2010



Assault injuries in children and teens have decreased since 2008. Ramsey County youth ages 15-19 are assaulted three times more often than younger children.

Source: Minnesota Department of Health, MIDAS System

Figure YVC-2: Number of non-fatal assaults to children by age group, Ramsey County, MN, 2010

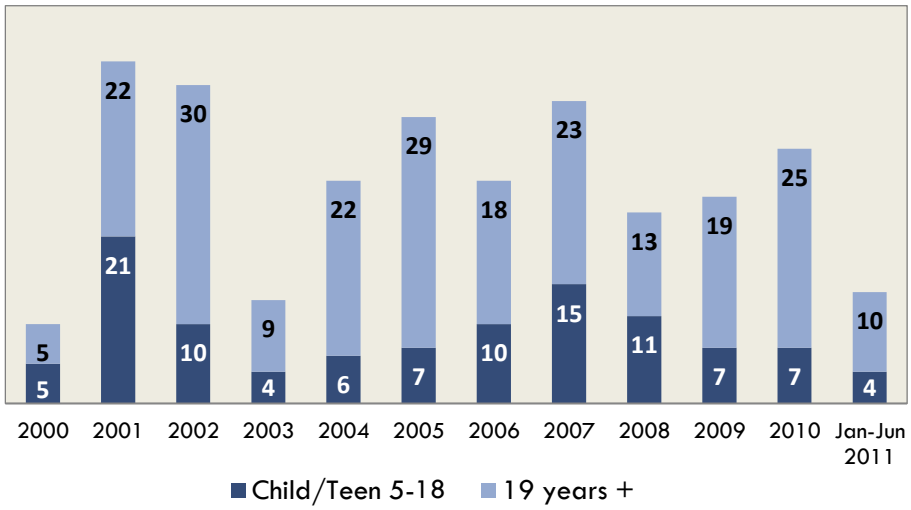


Source: Minnesota Department of Health, MIDAS System

[1] U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, The Research, Development and Evaluation Agency of the U.S. Department of Justice. Impact of Child Abuse and Maltreatment on Delinquency, Arrest and Victimization. Retrieved from: http://www.nij.gov/nij/topics/crime/child-abuse/impact-on-arrest-victimization.htm#note3.

[2] State of Minnesota department of Public Safety Uniform Crime Report 2010. Bureau of Criminal Apprehension and Minnesota Criminal Justice Information Services. Retrieved from: https://dps.mn.gov.

Figure YVC-3: Number of rapes resulting in ER treatment or hospitalization, by age group, Ramsey County, MN, 2000-2011



Source: Minnesota Department of Health Injury and Violence Prevention Unit, MIDAS System

Children and youth are also victims of sexual assault, although the majority of rapes happen to adults age 19 and over.

In 2010, there were a total of 240 rape offenses in Ramsey County.[2]

Child victims of sexual assault are three to five times more likely to suffer from post traumatic stress disorder, substance abuse, repeat assaults, or be perpetrators themselves.[1]

2 ECONOMIC CIRCUMSTANCES

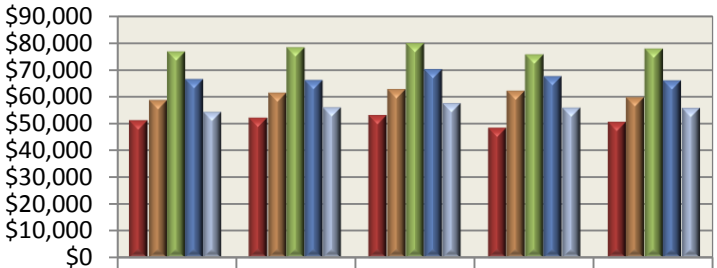
Family Income
Food Insecurity
Poverty

FAMILY INCOME

Families with wealth and resources enjoy better health.[1] Wealth enables families to access high-quality health care, good schools, decent housing, and safe neighborhoods. Families with wealth are able to enjoy leisure time, allowing them opportunities to strengthen social bonds with family, friends and their community. Compared to families with fewer resources, economically secure families have lower levels of stress thus more ability to nurture the health of their families.

The current Recession has worsened the economic circumstances of many Ramsey County residents. In addition, the Twin Cities is home to the highest unemployment disparity between White and Black job seekers in the nation.[2]

Figure FMI-1: Median income, Ramsey County, MN and surrounding communities, 2006 - 2010

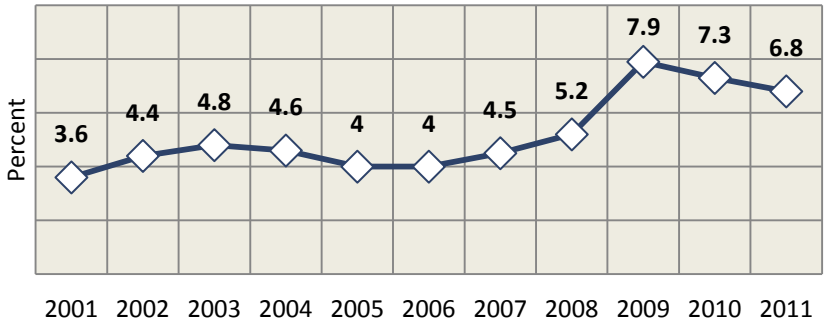


	2006	2007	2008	2009	2010
Ramsey	$50,813	$51,803	$52,762	$48,008	$50,224
Hennepin	$58,275	$60,943	$62,275	$61,651	$59,252
Washington	$76,563	$78,113	$79,670	$75,421	$77,591
Anoka	$66,271	$65,832	$69,981	$67,349	$65,732
MN	$54,022	$55,664	$57,318	$55,621	$55,422

Source: Small Area and Poverty Estimate, US Census Bureau

Ramsey County has the lowest median income of the surrounding communities and the state.

Figure FMI-2: Annual unemployment rate, Ramsey County, MN, 2001-2011



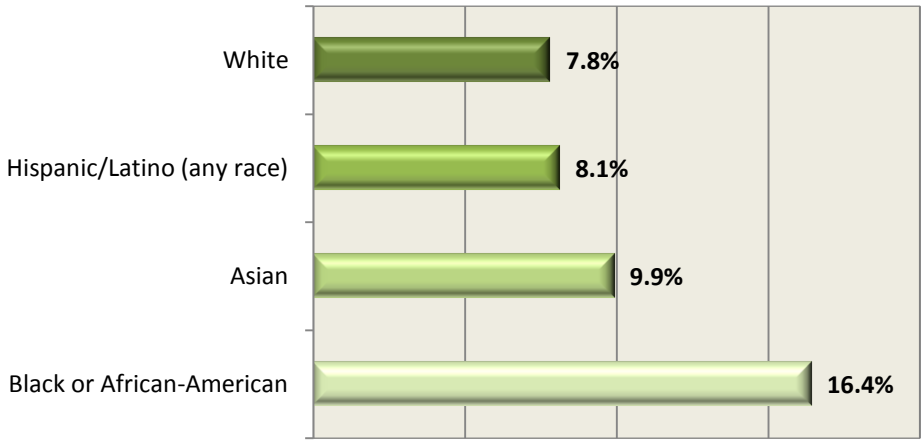
Source: Local Area Unemployment Statistics, Minnesota Department of Employment and Economic Development, Metropolitan Council Community Profile

The recent unemployment rate peaked at 7.9% in Ramsey County in 2009, yet still remains the highest rate in over 20 years.

[1] *Robert Wood Johnson Foundation. (2011). Issue Brief Series: Exploring the Social Determinants of Health Income, Wealth and Health. Retrieved from: www.rwjf.org/vulnerablepopulations.*

[2] *Blue Ribbon Commission. (2011). Everybody In: A Report to Reduce Racial Employment Disparities in the Ramsey County Metropolitan Area. Retrieved from: http://www.rcwib.org/boardmembers/BRC/BRCReport.pdf.*

Figure FMI-3: Unemployment by race/ethnicity, Ramsey County, MN, 2010



Source: American Community Survey

The Twin Cities has one of the largest employment disparities between Blacks and Whites in the nation.

The Twin Cities has one of the largest employment disparities between Blacks and Whites in the nation.

The Blue Ribbon Commission Report[2], a study of the unemployment disparity in Ramsey County, offered the following findings about the disparity:

- Employment disparities are closely tied to the educational disparity, which disproportionately affect youth from racial, ethnic and cultural communities
- Employment disparities are the result of discriminatory practices
- Economic cycles also affect racial employment disparities

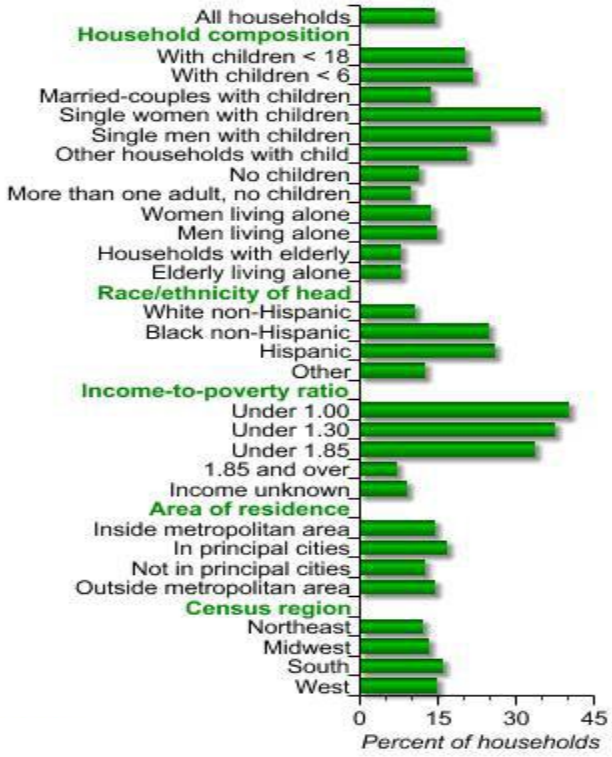
FOOD INSECURITY

Food security is defined as having access at all times to enough nutritionally adequate and safe foods to lead a healthy active lifestyle.[1] About 17.2 million U.S. children (23 percent of all children) lived in households that were classified as food insecure at times in 2009, up from 17% of children in 2007.[2] About 988,000 of these children (1.3 percent of all children) lived in households classified as having very low food security among children.

Food insecurity has a variety of direct and indirect health effects. Research suggests that toddlers are more susceptible to short-term negative developmental outcomes if they live with a food insecure adult [3] and school-aged children experiencing food insecurity exhibit more emotional and behavioral problems compared to children who are not food insecure.[4]

Figure FI-1

Prevalence of food insecurity, U.S. 2010



Source: Calculated by ERS using data from the December 2010 Current Population Survey Food Security Supplement.

[1] *Anderson, S.A. (Ed.). (1990). Core indicators of nutritional state for difficult-to-sample populations. Journal of Nutrition 120(11S), 1557–1600.*

[2] *Nord, M., Coleman-Jensen, A., Andrews, M., and Carlson, S. (2010). Household food security in the United States, 2009 (Economic Research Report 108). Washington, DC: U.S. Department of Agriculture, Economic Research Service. http://www.ers.usda.gov/Publications/ERR108.*

[3] *Hernandez, D.C., Jacknowitz, A. (2009). Transient, but not persistent, adult food insecurity influences toddler development. Journal of Nutrition, 139(8), 1517-1524.*

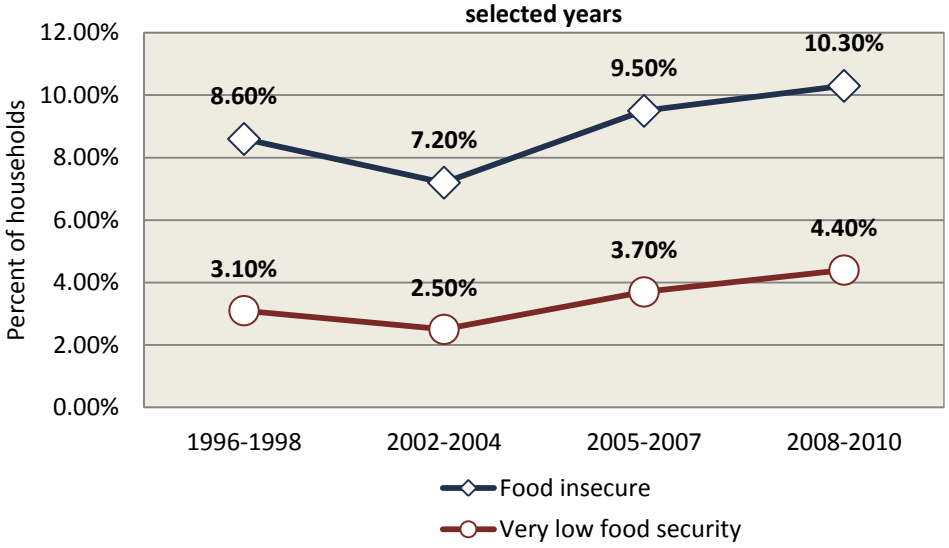
[4] *Belsky, D.W., Moffit, T.E., Arseneault, L., Melchior, M., & Caspi, A. (2010). Context and sequelae of food insecurity in children's development. American Journal of Epidemiology, 172(7), 809-818.*

The prevalence of food insecurity varies considerably among household types. Some groups with rates of food insecurity higher than the national average (14.5 percent) were

- *Households with incomes below the Federal poverty line—$22,113 for a family of four in 2010—(40.2 percent).*
- *Households with children, headed by a single woman (35.1 percent).*
- *Households with children, headed by a single man (25.4 percent).*
- *Black households (25.1 percent).*
- *Hispanic households (26.2 percent).*

Source: *http://www.ers.usda.gov/Publications/ERR108*

Figure FI-2: Food insecurity in Minnesota , three year averages, selected years



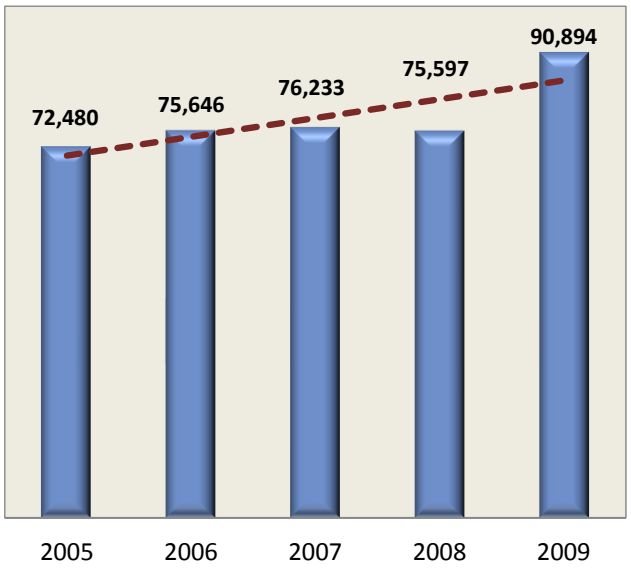
Source: U.S. Department of Agriculture, Economic Research

Federal programs can provide essential help to low-income families and children in obtaining food and income support. The Supplemental Nutrition Assistance Program (SNAP), formally the Federal Food Stamp Program helps low-income individuals and families purchase food. Food shelves and WIC provide needed food to low income families.

Figure FI-3: Average number of cases receiving food support each month, Ramsey County, MN, 2005-2010

Source: Ramsey County Community Human Services Annual Report, 2010

Figure FI-4: Number of children who visited food shelves by year, Ramsey County, MN, 2005-2009



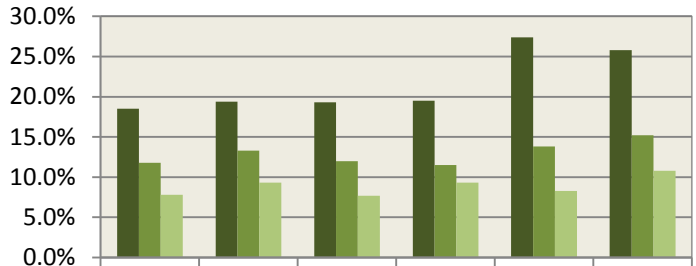
Source: MN KIDS COUNT

POVERTY

Over 15 million children in the United States (21 percent of children under age 18) are growing up in poverty. When children in low-income families living at the edge of poverty (incomes up to twice the official poverty level) are included, they account for 44 percent (31.9 million) of our nation's children.[1] Even though most low-income parents work, many are unable to provide economic security for their children. They worry daily about how to pay their bills, put food on the table and afford needed medical care. A growing body of research is demonstrating that children who are raised in families experiencing chronic stress created by poverty are a much higher risk of significant and long-term deficits in health.[2] In Ramsey County, one in four children under the age of 18 lived in poverty in 2010.

The demand for food support, cash assistance, and medical assistance in Ramsey County is unprecedented due to the poor economy. Those caseloads at the end of the year in 2010 numbered over 54,000 and over 62,000 cases are expected in 2012 and 2013.[3]

Figure PV-1: Percentage of residents living in poverty by age group, Ramsey County, MN, 2005-2010



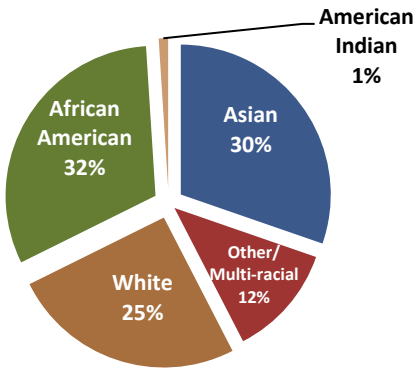
	2005	2006	2007	2008	2009	2010
Children (under 18 years old)	18.5%	19.4%	19.3%	19.5%	27.4%	25.8%
Adults (18 to 64 years old)	11.8%	13.3%	12.0%	11.5%	13.8%	15.2%
Elderly (65 years and older)	7.8%	9.3%	7.7%	9.3%	8.3%	10.8%

Source: American Community Survey

Children in Ramsey County are more likely to live in poverty than any other age group.

In 2010, 12.2% of Ramsey County families were living below the Federal Poverty line; that's 50% higher than the Minnesota state-wide rate of 8%.

Figure PV-2: Percentage of children living in poverty by race, Ramsey County, MN, 2010

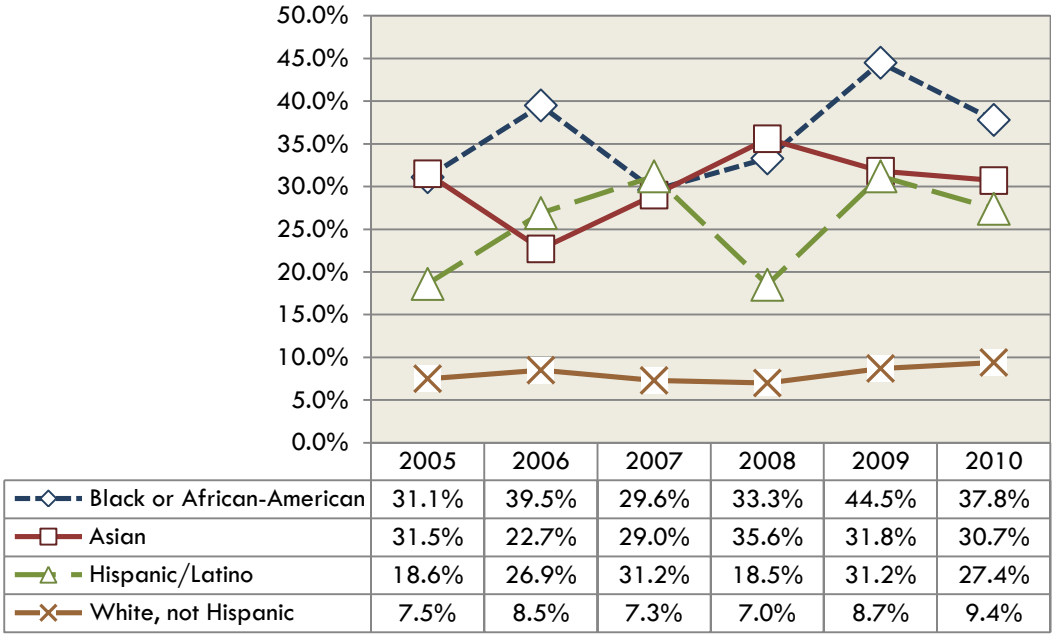


Source: American Community Survey, Ramsey County Community Human Services.
16% of children living in poverty are of Hispanic ethnicity.

While children of color are 54% of the County population, they comprise 75% of all the children who are living in poverty in Ramsey County.

[1] *Basic Facts about Low-Income Children, 2010: Children under 18. Retrieved from: http://www.nccp.org/publications/pub_1049.html*
[2] *Robert Wood Johnson Foundation. 2011. Exploring the social determinants of health, How social factors shape health, The Role of Stress. Retrieved from: http://www.rwjf.org/files/research/sdohstressandhealththissue20110324.pdf.*
[3] *Ramsey County Community Human Services. (2011). County Budget Volumes. Retrieved from: http://www.co.ramsey.mn.us/ba/operating_budget.htm.*

Figure PV-3: Percentage of residents living in poverty by race/ethnicity, Ramsey County, MN, 2005 - 2010

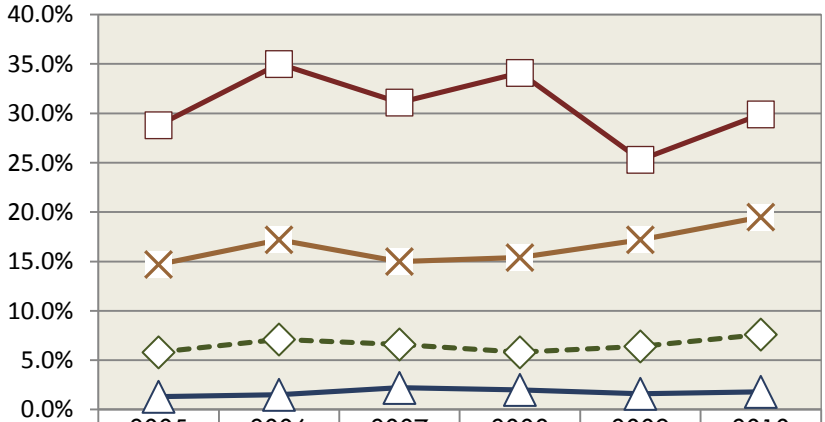


	2005	2006	2007	2008	2009	2010
Black or African-American	31.1%	39.5%	29.6%	33.3%	44.5%	37.8%
Asian	31.5%	22.7%	29.0%	35.6%	31.8%	30.7%
Hispanic/Latino	18.6%	26.9%	31.2%	18.5%	31.2%	27.4%
White, not Hispanic	7.5%	8.5%	7.3%	7.0%	8.7%	9.4%

Source: American Community Survey

People of Color in Ramsey County continue to have higher rates of poverty than Whites.

Figure PV-4: Percentage of residents living in poverty by employment status, Ramsey County, MN, 2005-2010

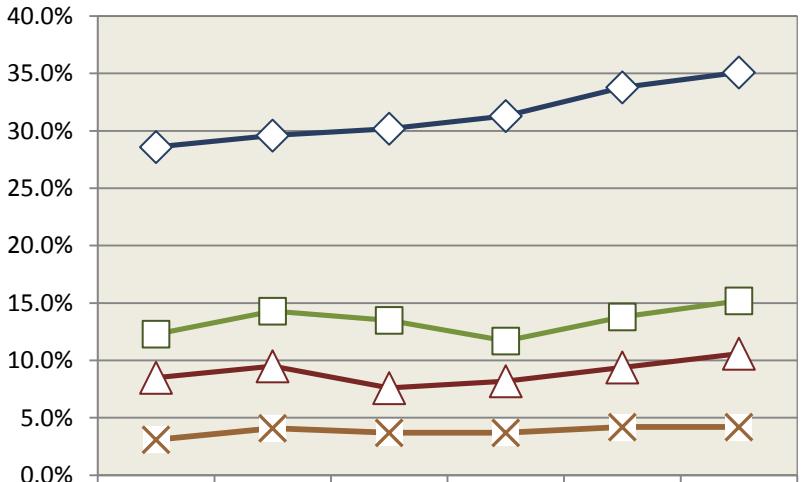


	2005	2006	2007	2008	2009	2010
Employed	5.8%	7.1%	6.6%	5.8%	6.4%	7.6%
Unemployed	28.8%	35.0%	31.1%	34.1%	25.3%	29.9%
Worked full-time	1.3%	1.5%	2.2%	2.0%	1.6%	1.8%
Worked Part-Time	14.7%	17.2%	15.0%	15.4%	17.2%	19.5%

Source: American Community Survey

Even many employed residents live in poverty.

Figure PV-5: Percentage of residents living in poverty by educational attainment, Ramsey County, MN, 2005-2010

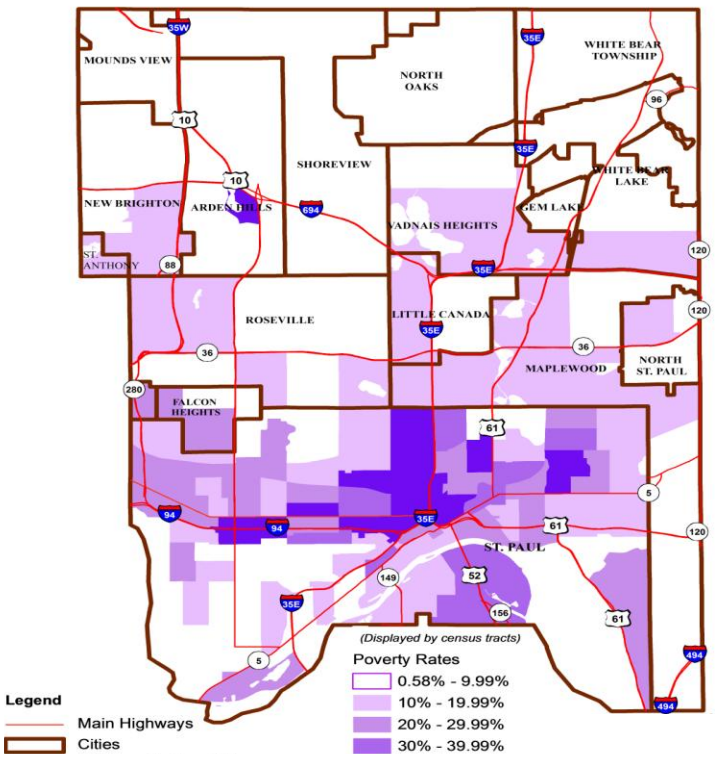


	2005	2006	2007	2008	2009	2010
Less than High School	28.6%	29.6%	30.2%	31.3%	33.8%	35.1%
High School Graduate	12.3%	14.3%	13.5%	11.7%	13.8%	15.2%
Some College, Associate's Degree	8.5%	9.5%	7.6%	8.2%	9.4%	10.6%
Bachelor's Degree or Higher	3.1%	4.1%	3.7%	3.7%	4.2%	4.2%

Source: American Community Survey

Education, which is strongly correlated with employment status, increases a resident's likelihood of earning a living wage.

Figure PV-6: Poverty rates for individuals by neighborhood, Ramsey County, MN, 2006-2010



Source: American Community Survey
Map created by Ramsey County Community Human Services

The majority of poor people live in the City of Saint Paul, although increasingly poverty is reaching suburban communities.

3 HEALTH CARE

Health Insurance Coverage
Immunization
Oral Health
Utilization of Health Care

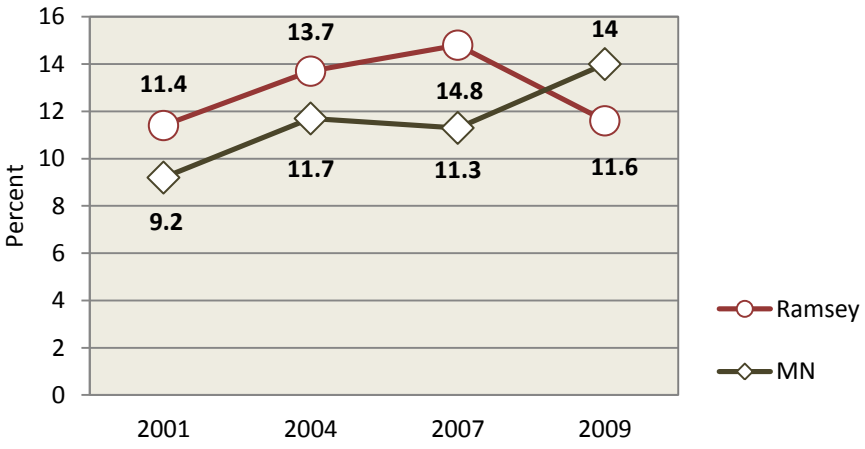
HEALTH INSURANCE COVERAGE

Children and families without medical insurance are more likely to lack a usual source of medical care, such as a primary care provider, and are more likely to skip routine medical care due to costs, increasing their risk for serious and disabling health conditions.[1] When they do access health services, they are often burdened with large medical bills and out-of-pocket expenses. The uninsured are more likely than the insured to experience a host of negative health outcomes including stroke, cancer, heart failure, diabetes, heart attack, hypertension, and trauma.[2] The Healthy People 2020 Objective for the United States is that 100% of all people have medical insurance, an increase from 83.2 percent in 2008.[3]

Table HI-1: Percent uninsured at some point in year	2009
Ramsey County	11.6% (+/-1.1%)
St. Paul	13.6% (+/-1.3%)
State of Minnesota	14% (+/-0.2%)

Source: University of MN School of Public Health and the Minnesota Department of Health Economics Program 2009 MN Health Access Survey

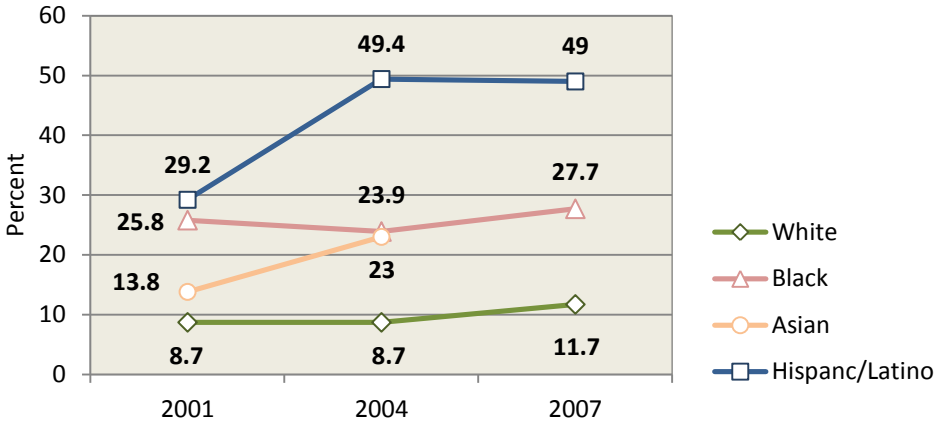
Figure HI-2: Percentage uninsured at some point in year, Ramsey County and Minnesota, selected years



Source: University of MN School of Public Health and the Minnesota Department of Health Economics Program 2009 MN Health Access Survey

[1] *Starfield B, Shi L. The medical home, access to care, and insurance. Pediatrics. 2004;113(5 suppl):1493-8.*
[2] *Robert Wood Johnson (2009). America's Uninsured Crisis: Consequences for Health and Healthcare, Report Brie. Retrieved from: http://www.iom.edu/Reports/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care.aspx.*
[3] *Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=1.*

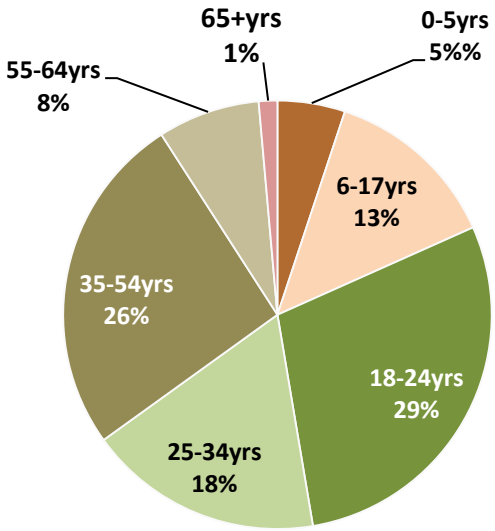
Figure HI-3: Percentage uninsured at some point in year by race/ethnicity, Ramsey County, MN, selected years



Source: University of MN School of Public Health and the Minnesota Department of Health Economics Program 2009 MN Health Access Survey

Almost half of Hispanic/Latinos in Ramsey County were uninsured at some point in time in 2007, the year in which the most recent race data is available.

Figure HI-4: Twin Cities uninsured at some point in time, by age, 2009



Source: University of MN School of Public Health and the Minnesota Department of Health Economics Program 2009 MN Health Access Survey

Children with health insurance, whether public or private, are more likely than children without insurance to have a regular and accessible source of health care.

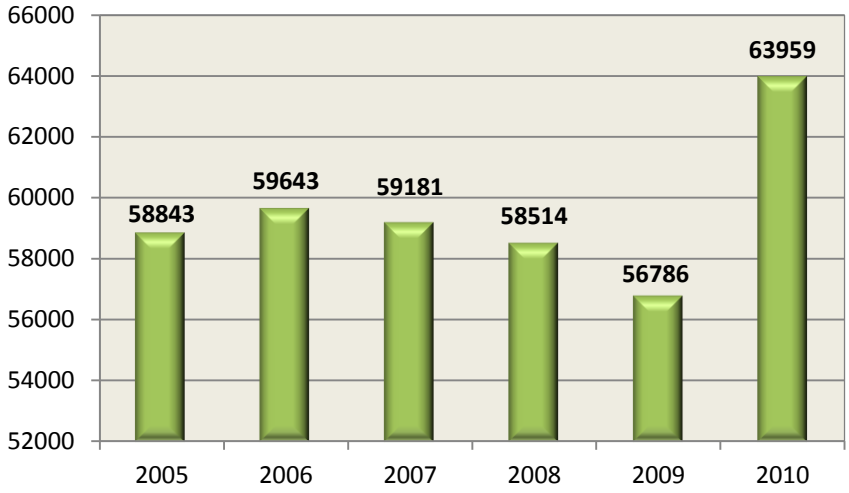
The uninsured individual in the Twin Cities is more likely to be male, in their early 20s, white, single, and without a college education.

Table HI-5: Demographic characteristics of the uninsured, Twin Cities, selected years

	Twin Cities Uninsured	
	2007	2009
Gender		
Male	50.6%	62.0%
Female	49.4%	38.0%
Age		
0 to 5	5.0%	5.1%
6 to 17	15.7%	13.2%
18 to 24	21.4%	29.0%
25 to 34	20.2%	17.7%
35 to 54	32.6%	25.8%
55 to 64	5.0%	7.7%
65+	0.1%	1.4%
Race/Ethnicity[1]		
White	69.3%	67.1%
Black	20.5%	18.8%
American Indian	2.8%	3.3%
Asian	4.6%	2.8%
Hispanic/Latino	12.7%	15.8%
US Born[2]		
US Born	83.4%	78.4%
Not US Born	16.6%	21.6%
Family Income, as % of Poverty (2 categories)		
0 to 200%	44.7%	48.6%
201%+	55.3%	51.4%
Marital Status[3]		
Married	32.1%	27.7%
Not Married	67.9%	72.3%
Education (3 categories)[4]		
High school graduate or less	53.9%	48.4%
Some college/tech school	32.5%	30.3%
College graduate & higher	13.6%	21.3%
Health Status (3 categories)		
Excellent/Very Good	53.6%	54.2%
Good	29.2%	28.2%
Fair/Poor	17.2%	17.6%

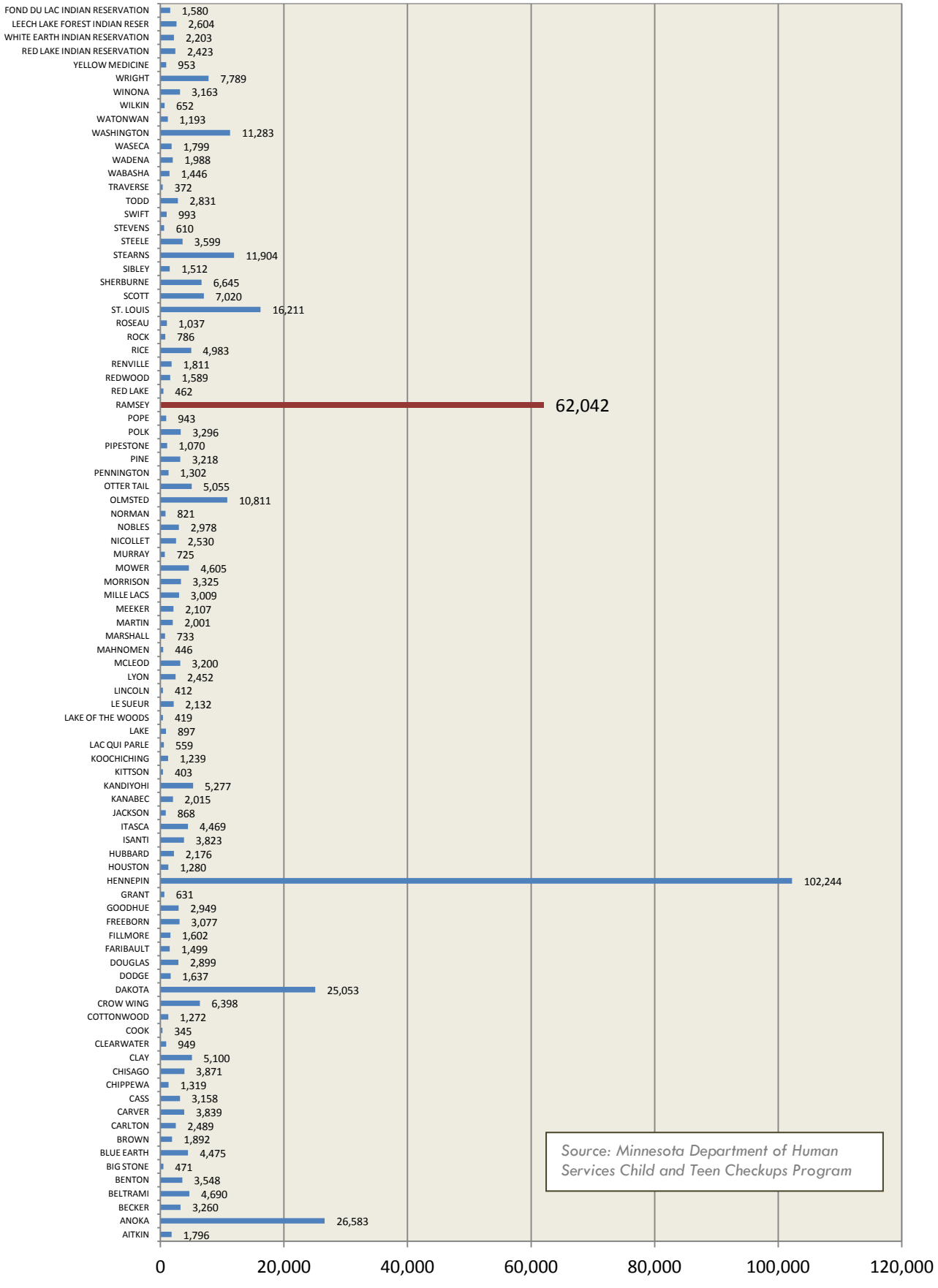
Source: MINNESOTA DEPARTMENT OF HEALTH Health Economics Program and University of Minnesota School of Public Health, Minnesota Health Access Surveys.
[1] Distribution may add to more than 100% since individuals were able to choose more than one race/ethnicity.
[2] Reported for individuals 3 years and older.
[3] Reported for individuals 18 and older.
[4] For children refers to parent.
Twin Cities is the seven county Twin Cities Metropolitan Area.
Greater Minnesota is the area outside the seven county Twin Cities Metropolitan Area.
-- Last updated 01/12/2011

Figure HI-6: Total number of children under age 21 enrolled in publically funded health insurance, Ramsey County, MN 2005-2010



Source: St. Paul-Ramsey County Public Health Child and Teen Checkkups Program

Figure HI-7: Number of children enrolled for at least 90 days in publically funded health insurance, by Minnesota county, 2010

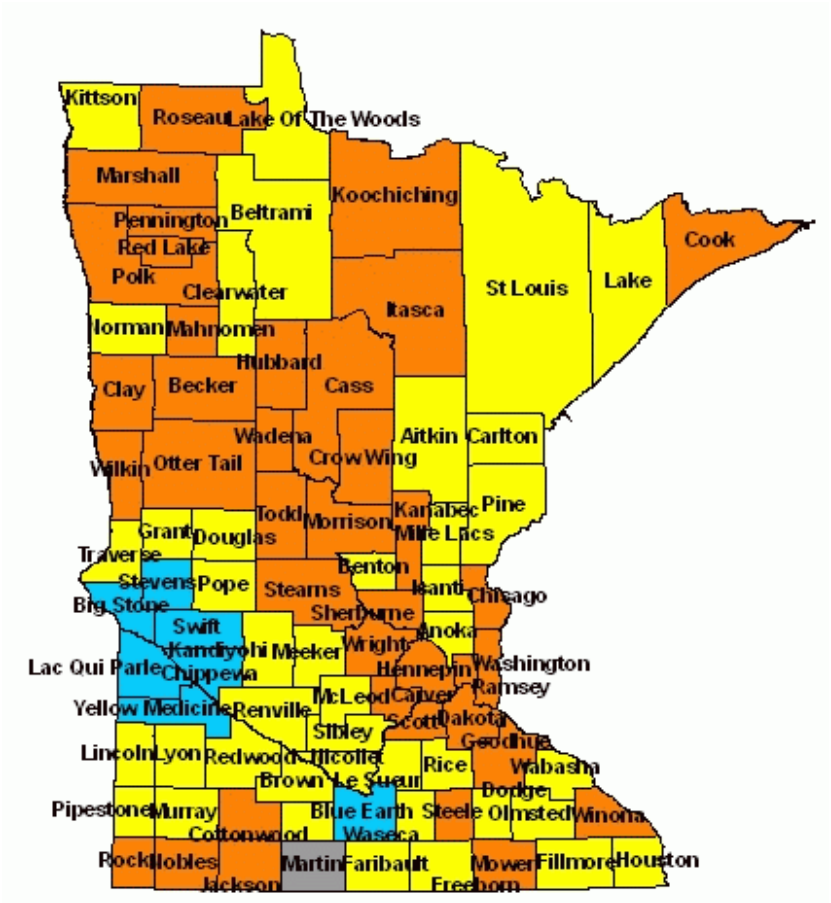


IMMUNIZATIONS

Data on vaccination coverage (the rate at which a given population has been vaccinated against disease) are used to identify groups at risk of vaccine-preventable diseases, to monitor vaccination coverage progress, and to evaluate the effectiveness of programs designed to increase vaccinations.

Despite progress, approximately 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases, according to the Centers for Disease Control and Prevention (CDC).[1] Communities with pockets of unvaccinated and under-vaccinated populations are at increased risk for outbreaks of vaccine-preventable diseases. The emergence of new or replacement strains of vaccine-preventable disease can result in a significant increase in serious illnesses and death in communities.

Figure IMZ-1: Percent of Minnesota children age 24-35 months up-to-date on the following recommended vaccine series: 4+ DTaP, 3+ polio, 1+ MMR, Completed Hib, 3+ Hep B, 1+ varicella, and Completed Prevnar, by county, 2011



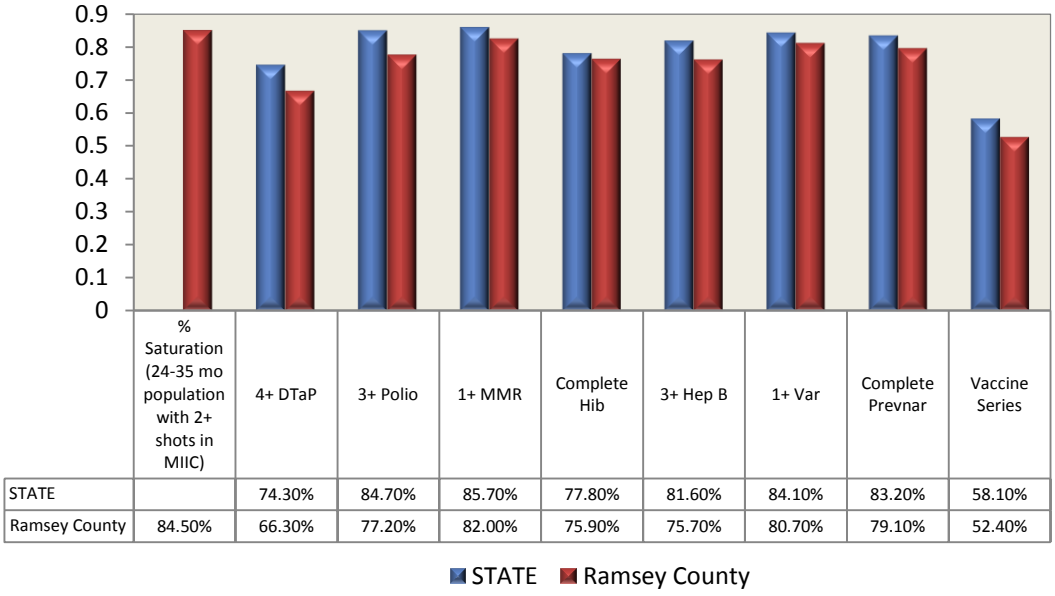
Orange 60-79% **Yellow 30-59%**
Light Blue 90-100% **Dark Blue 80-89%**

Data as of January 1, 2011, for children with two or more non-influenza shots in MIIC. Sixty days allowed for data to be in the registry.

Source: Minnesota Department of Health Immunization Program (4/11)

[1] *Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23#.*

Figure IMZ-2: Childhood immunization coverage
Minnesota and Ramsey County, January 2011



	% Saturation (24-35 mo population with 2+ shots in MIIC)	4+ DTaP	3+ Polio	1+ MMR	Complete Hib	3+ Hep B	1+ Var	Complete Prevnar	Vaccine Series
STATE		74.30%	84.70%	85.70%	77.80%	81.60%	84.10%	83.20%	58.10%
Ramsey County	84.50%	66.30%	77.20%	82.00%	75.90%	75.70%	80.70%	79.10%	52.40%

Ramsey County's childhood immunization rates lag the state by a few percentage points for all types of vaccinations.

Percent of children age 24-35 months up to date with a vaccine series and individual vaccines. Data as of January 1, 2011 for children with two or more non-influenza shots in the Minnesota Immunization Information Connection (MIIC) immunization registry. Analyzed April 2011

Source: Minnesota Department of Health Immunization Program

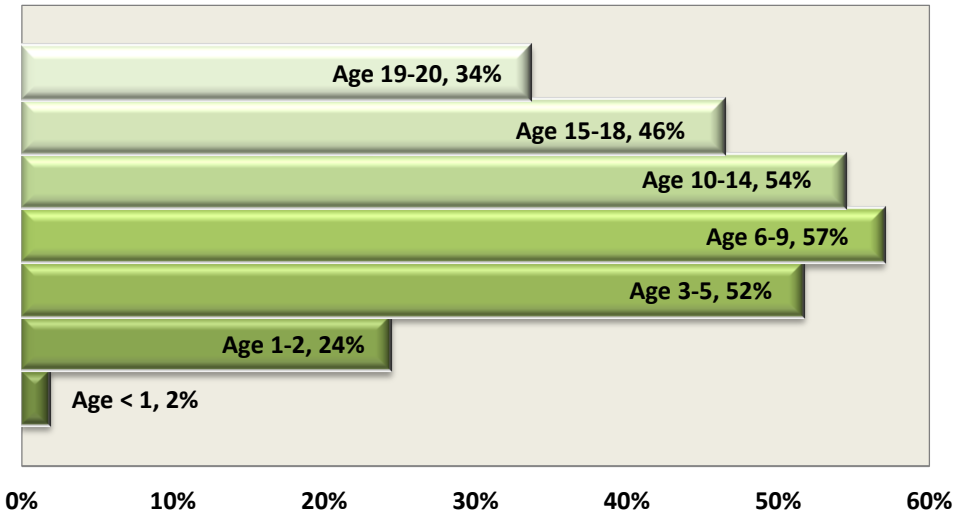
ORAL HEALTH

Dental care is the most common unmet treatment need in children. Low-income children have more untreated dental disease than more affluent children who tend to obtain care on a regular periodic basis.[1] Reasons for this disparity include the fact that low-income children are more likely to experience dental disease and typically access care on an episodic or urgent basis when decayed teeth cause pain or swelling. NHANES III, the most recent national survey, found that nearly 80 percent of the decayed teeth of poor two to five year olds and 40-50 percent of the decayed permanent and primary teeth in 6-14 year olds were unfilled (untreated).[2]

The consequences of severe, untreated dental disease and poor oral health in millions of American children are evident in many dimensions. Untreated dental disease can lead to pain, infection and destruction of teeth and surrounding tissues with associated dysfunction. Untreated tooth decay may lead to delayed overall development of young children affected with severe forms of the disease. Dental diseases have been shown to be associated with systemic health conditions. Socially, affected children have problems with school attendance and performance, and are often stigmatized because of their appearance. Potential consequences to the health system as a result of poor dental health care include: frequent visits to emergency departments (often without definitive resolution of the presenting problem); hospital admissions; and treatment provided in operating rooms for conditions that are either largely preventable or amenable to less costly care had they been treated earlier.[3]

Tens of millions of children have dental coverage through either private insurance or a public program such as Medical Assistance or MinnesotaCare. Unfortunately, for many children, this does not translate into actual care.

Figure OH-1: Percentage of children on publically funded health insurance (Medical Assistance and MinnesotaCare) who received any type of dental service, Ramsey County, MN, 2010

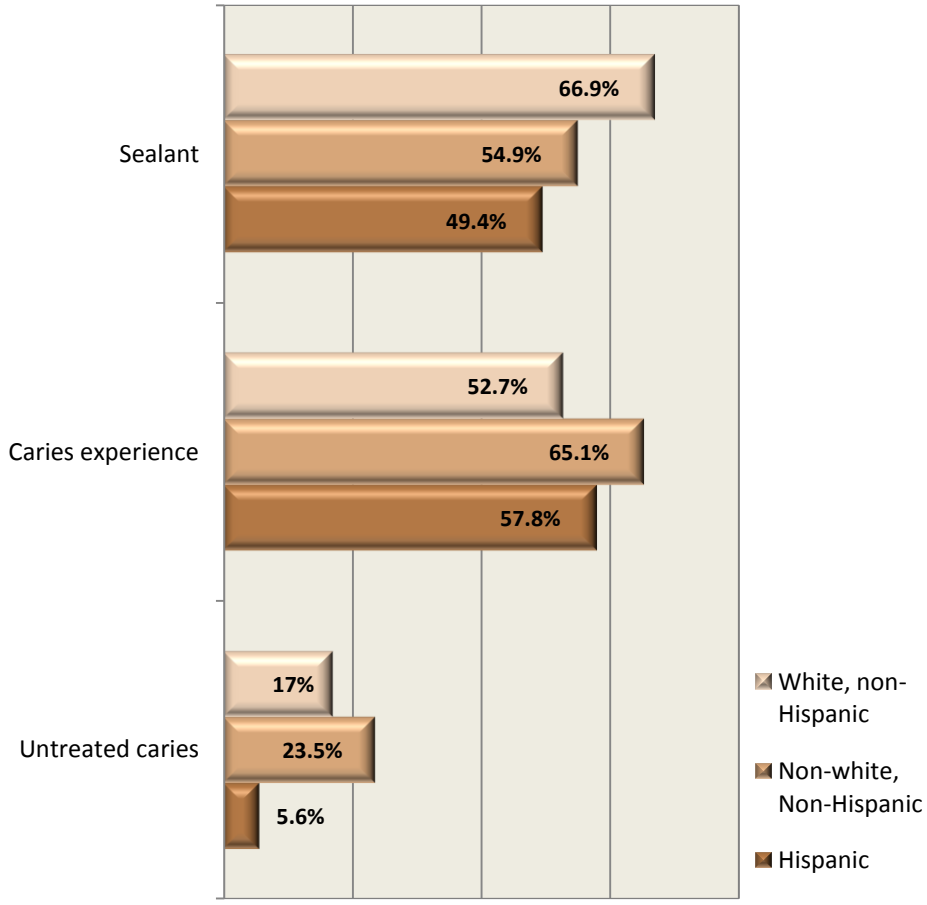


Source: Saint Paul - Ramsey County Public Health Child and Teen Checkups Program

The American Academy of Pediatric Dentistry recommends that all children be seen by a dentist following the eruption of their first tooth, OR no later than 12 months of age.

[1] *Centers for Disease Control and Prevention. (2012). National Health and Nutrition Examination Survey (NHANES III). Retrieved on 2/8/2012 from http://www.cdc.gov/nchs/nhanes/nh3data.htm*
[2] *Ibid.*
[3] *Ibid.*

Figure OH-2: Oral health status by race, Minnesota, 2010



Source: Minnesota Department of Health Oral Health Program

Children's dental care is about more than simple cavities. One in seven elementary school children ages 6-12 years suffers from a toothache, which can affect a child's concentration, school attendance and academic achievement.

Dental problems can lead to lifelong health challenges, and difficulties finding and holding a job. Some oral infections can be life-threatening.

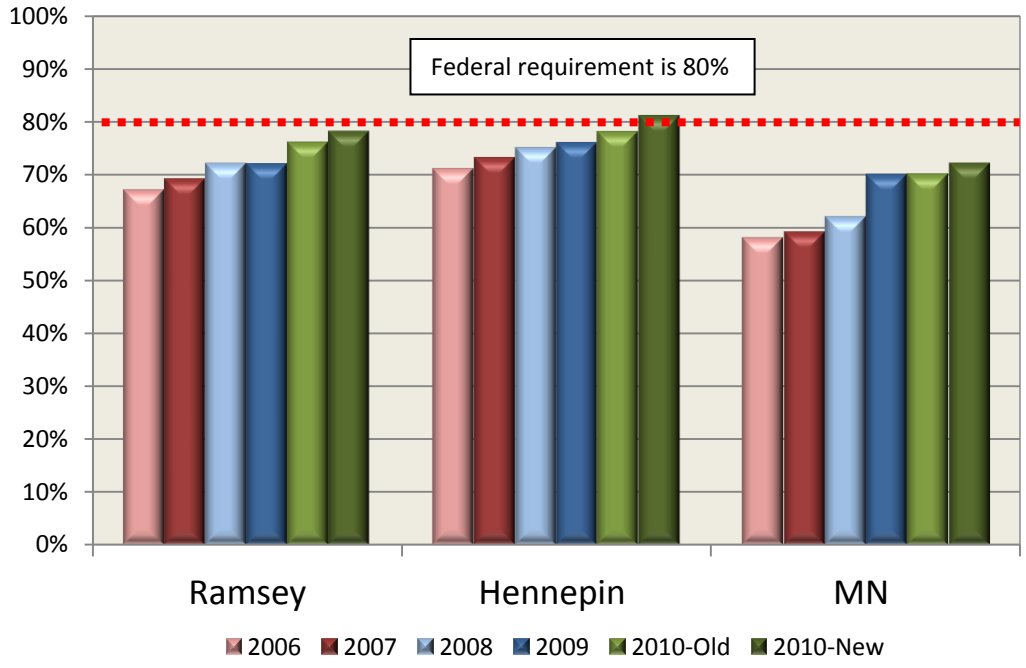
UTILIZATION OF HEALTH CARE

The health of children depends in part on their access to health services. Health care for children includes physical examination, preventive care, health education, observations, screenings, immunizations, and sick care. Having a usual source of care, or a health care home, a particular person or place a child goes to for sick and preventive care, makes pediatric care more likely.[1] The Healthy People objective for the U.S. is to increase the proportion of persons with a usual primary care provider from 76.3 percent (2007) to 83.9percent by 2020.[2]

The federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program (called Child and Teen Checkups in Minnesota) is the child health component of Medicaid. EPSDT programs are required in every state and are designed to improve the health of low-income children by connecting families and children to appropriate and necessary pediatric services.

The Child and Teen Checkups (C&TC) program's mission is to find and treat health conditions among enrollees of public healthcare plans, ages 0 - 21. C&TC measures progress towards goals through tracking participation rates. Participation rates are calculated by dividing the number of children engaged in the program over the total number of eligible children. In 2010 the participation rate calculation changed to take the mobility of families into account, only counting children who had been eligible in the county 90 days or more in the denominator. Participation calculation rate differences explain the upward increase in participation for 2010. Participation rates are also monitored for children in foster care.

Figure UTZ-1: Child and Teen Checkups participation rate for children under age 21, Ramsey, Hennepin Counties and Minnesota, 2006-2010



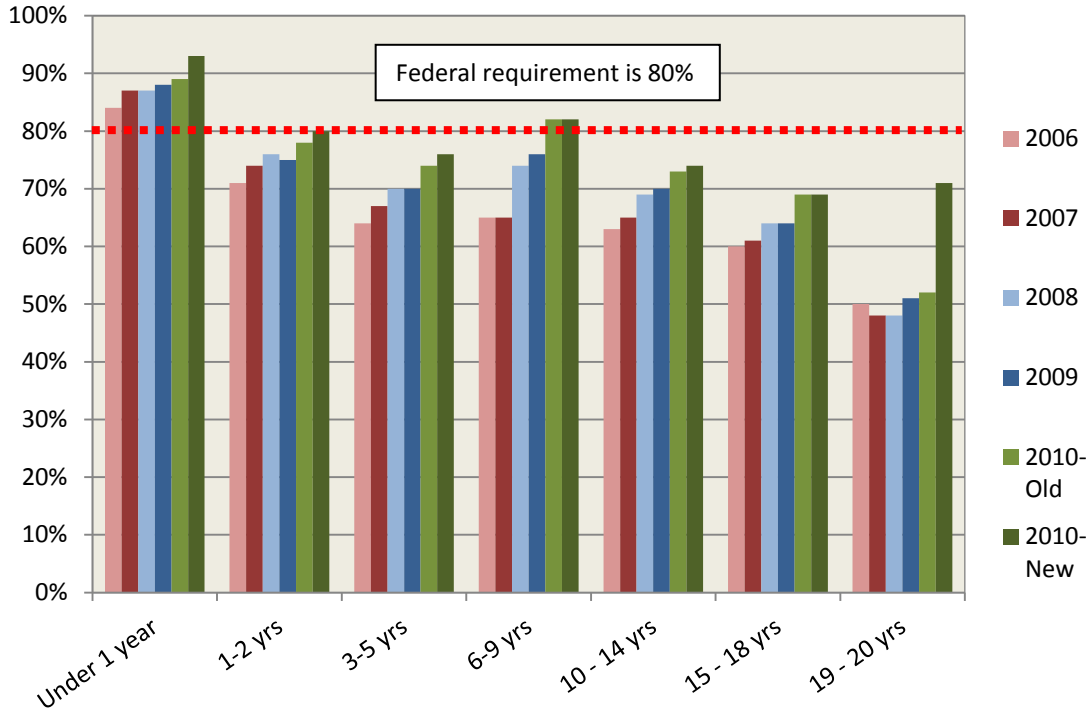
The overall C&TC participation rate in Ramsey County increased from 67% in 2006 to 78% in 2010, falling just below the federal requirement of 80%.

Source: Saint Paul -Ramsey County Public Health C&TC Program

[1] *De Maeseneer JM, De Prins L, Gosset C, et al. Provider continuity in family medicine: Does it make a difference for total health care costs? Ann Fam Med. 2003;1:144-8.*

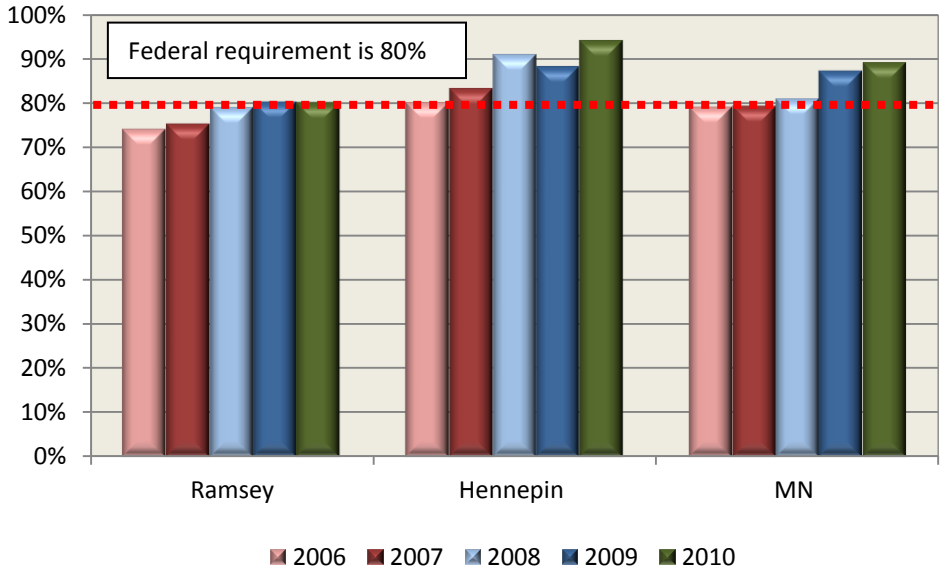
[2] *Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=1.*

Figure UTZ-2: Child and Teen Checkups participation rate for children under age 21 by age group, Ramsey County, MN, 2006-2010



Source: Saint Paul -Ramsey County Public Health C&TC Program

Figure UTZ-3: Child and Teen Checkups participation rate for children under age 21 in foster care, Ramsey County, MN 2006-2010



Source: Saint Paul -Ramsey County Public Health C&TC Program

The foster care participation rate in Ramsey County increased from 74% in 2006 to 80% in 2010, now meeting the federal requirement.

4 PHYSICAL ENVIRONMENT AND SAFETY

Child and Adolescent Injury and Mortality
Drinking Water Quality
Healthy Homes
Lead in the Blood of Children
Outdoor Air Quality
Secondhand Smoke

CHILD AND ADOLESCENT INJURY AND MORTALITY

Although injury and death rates have declined over the past two decades in the U.S., unintentional injuries remain the leading cause of death for children ages 1-4 years and 5-14 years. Nonfatal injuries continue to be important causes of child morbidity, disability and reduced quality of life.

THE UNITED STATES HAS A HIGHER CHILD MORTALITY RATE THAN MOST OTHER OECD (Organization for Economic Co-operation and Development) MEMBER COUNTRIES.

Child mortality (deaths at 1–19 years of age) varies considerably across countries. The U.S. child mortality rate (32.7 per 100,000 children) was the second highest among the member countries of Organization for Economic Co-operation and Development (OECD). Rates for other OECD countries ranged from 14.8 per 100,000 children in Luxembourg (average annual 2003–2005) to 34.6 per 100,000 children in Portugal (average annual 2001–2003).[1]

Child mortality rates exclude infants because most neonatal and post neonatal deaths are due to different causes than those for children and adolescents. Unintentional injuries (accidents) are the leading cause of death among children in the United States and Europe.[2,3] Among 1–4 year olds, motor-vehicle accidents were the leading cause of unintentional injury death in the United States, whereas drownings are the most common cause of unintentional injury death in Europe.[4] Motor-vehicle injuries are the leading cause of unintentional injury deaths among older children in both the United States and Europe. Among the other top causes of death in the United States and Europe are birth defects, homicide, cancer, and heart disease. Among adolescents (15–24 years of age), suicide is a leading cause of death.

***Injuries** (unintentional and intentional) **are the number one killer** of children, youth, and young adults. **Injuries are not the result of accidents.** They are predictable and preventable. **Injuries are expensive.** They are the leading cause of hospital treatment.*

[1] *Child well-being [online]. OECD StatExtracts. Organisation for Economic Co-operation and Development. Available from: http://stats.oecd.org/Index.aspx.*
[2] *Xu JQ, Kochanek KD, Murphy SL, Tejada-Vera B. Deaths: Final data for 2007. National vital statistics reports; vol 58 no 19. Hyattsville, MD: NCHS; 2010. Available from: http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf.*
[3] *Sethi D, Towner E, Vicenten J, Segui-Gomez M, Racioppi F. European report on child injury prevention. Copenhagen: World Health Organization; 2008. Available from: http://www.euro.who.int/__data/assets/pdf_file/0003/83757/ E92049.pdf.*
[4] *Ibid.*

Figure CIM-1

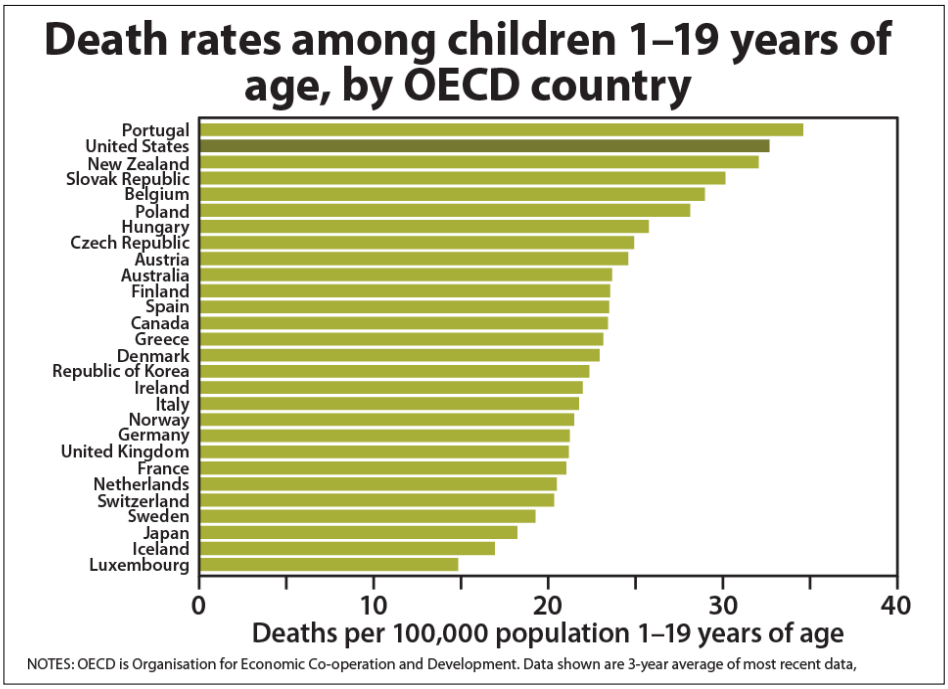
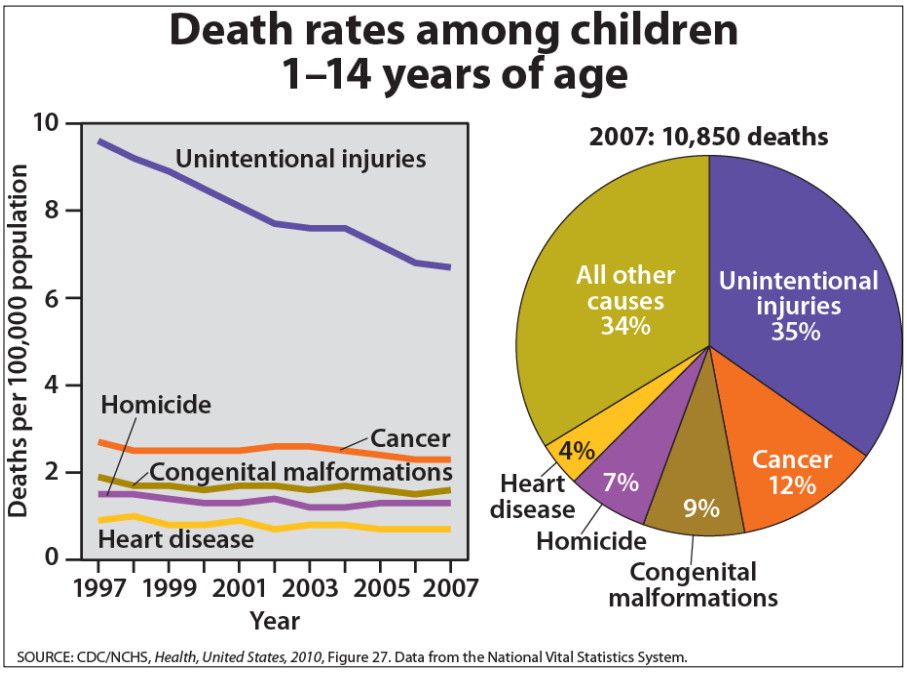
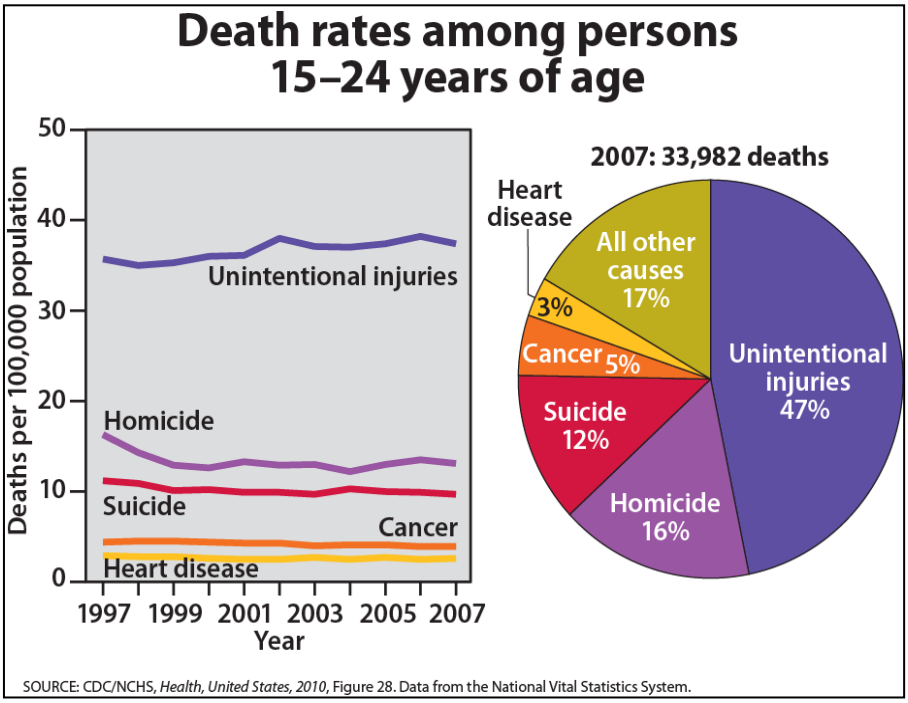


Figure CIM-2



The death rate among U.S. children 1–14 years of age decreased 22% from 1997 to 2007.

Figure CIM-3



SOURCE: CDC/NCHS, *Health, United States, 2010*, Figure 28. Data from the National Vital Statistics System.

Death rates from unintentional injuries—the leading cause of death for persons 15–24 years of age in the U.S. increased 5% between 1997 and 2007.

MINNESOTA'S CHILDREN

In Minnesota, injury causes more deaths among children and young people than disease. Unintentional injury continues to be among the leading causes of death throughout the lifetime of Minnesotans.

In addition to those who die, many Minnesotans are affected by unintentional injuries, sometimes for many years. They are unable to perform normal activities, or are permanently disabled as a result of injury. Different racial and ethnic groups are affected differently by injury.[5]

The rate of death from unintentional injuries in Minnesota is three times greater for American Indians and two times greater for African Americans than it is for Whites.[5]

[5] *Minnesota Department of Health, Injury and Violence Prevention Publications*

Table CIM-4: Ten leading causes of nonfatal emergency department-treated injury by age group, Minnesota, 2000-2009

Rank	<1 year	1-4	5-9	10-14	15-19	20-24
1	Fall	Fall	Fall	Struck by or against	Struck by or against	Fall
2	Struck by or against	Struck by or against	Struck by or against	Fall	Fall	Fall
3	Foreign body entering eye/orifice	Foreign body entering eye/orifice	Cut/pierce	Cut/pierce	MV traffic-occupant	Cut/pierce
4	Hot object/substance	Cut/pierce	Pedal cyclist/other	Overexertion	Overexertion	MV traffic-occupant
5	Unspecified	Bites and stings	Bites and stings	Pedal cyclist/other	Overexertion	Overexertion
6	Cut/pierce	Caught in-between objects	Foreign body entering eye/orifice	Bites/stings	**Struck by or against**	**Struck by or against**
7	Poisoning	Overexertion	Caught in-between objects	MV traffic-occupant	Unspecified	Unspecified
8	Bites and stings	Unspecified	Overexertion	Caught in-between objects	Bites and stings	Bites and stings
9	Overexertion	Hot object/substance	MV traffic-occupant	Unspecified	Caught in-between objects	Foreign body entering eye/orifice
10	Caught in-between objects	Poisoning	Unspecified	Foreign body entering eye/orifice	Pedal cyclist-other	Caught in-between objects

Source: Minnesota Department of Health
Includes nonfatal, unduplicated Minnesota resident injury events treated in emergency departments of acute care Minnesota hospitals. Includes any listed injury meeting the Safe States consensus definition for hospital discharge data injury surveillance.

Unintentional **Assaultive**

Table CIM-5: Ten leading causes of nonfatal hospitalized injury by age group, Minnesota, 2000-2009

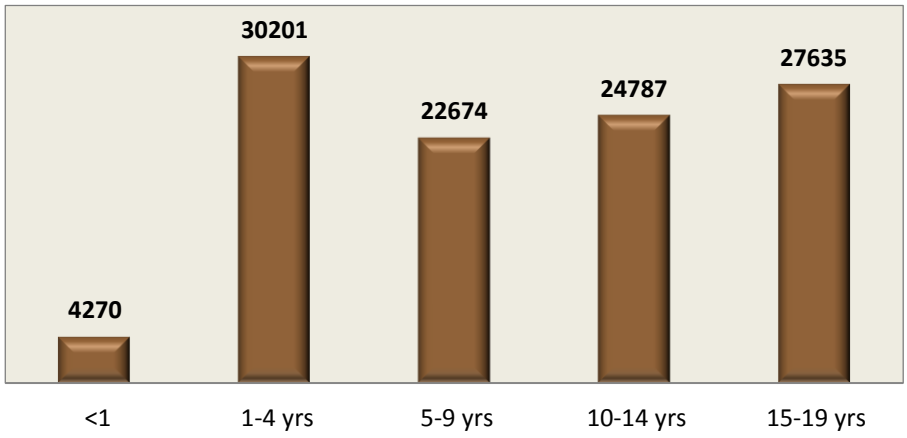
Rank	<1 year	1-4	5-9	10-14	15-19	20-24
1	Fall	Fall	Fall	Fall	Poisoning	Poisoning
2	Foreign body entering eye/orifice	Poisoning	Struck by or against	Struck by or against	MV traffic-occupant	MV traffic-occupant
3	Suffocation	Hot object/substance	Pedal cyclist-other	Poisoning	Fall	Fall
4	Unspecified	Struck by or against	MV traffic-occupant	Pedal cyclist-other	Struck by or against	Cut/pierce
5	Poisoning	Bites and stings	Bites and stings	Cut/pierce	Cut/pierce	Struck by or against
6	Hot object/substance	Foreign body entering eye/orifice	MV traffic-pedestrian	MV traffic-occupant	Poisoning	Poisoning
7	**Battering/ maltreatment**	Suffocation	Cut/pierce	ATV rider	**Struck by or against**	Struck by or against
8	**Unspecified**	MV traffic-occupant	Poisoning	Poisoning	Unspecified	Cut/pierce
9	Other injury	Unspecified	Transport-other	Transport-other	ATV rider	MV traffic-motorcyclist
10	Struck by or against	MV traffic-pedestrian	Foreign body entering eye/orifice	Unspecified	**Firearm**	unspecified

Source: Minnesota Department of Health
Includes nonfatal, unduplicated Minnesota resident injury events admitted as inpatients to acute care Minnesota hospitals. Includes any listed injury meeting the Safe States consensus definition for hospital discharge data injury surveillance.

Unintentional **Self-inflicted** **Assaultive**

RAMSEY COUNTY'S CHILDREN

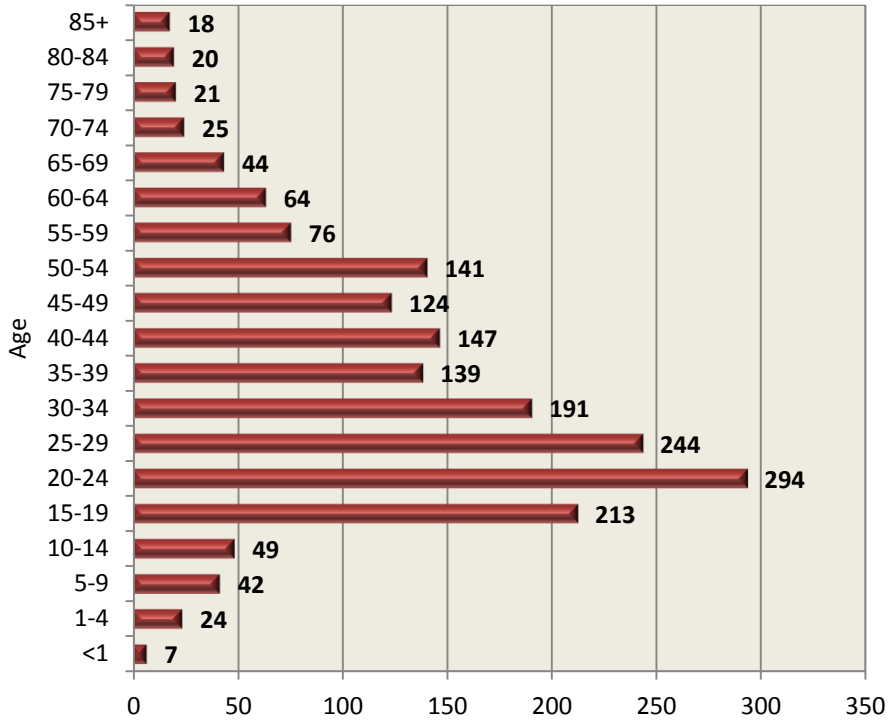
Figure CIM-6: Number of unintentional, non-fatal injuries (hospitalizations and emergency department visits) in children by age group, Ramsey County, MN, 2000-2010



Source: Minnesota Department of Health, MIDAS System

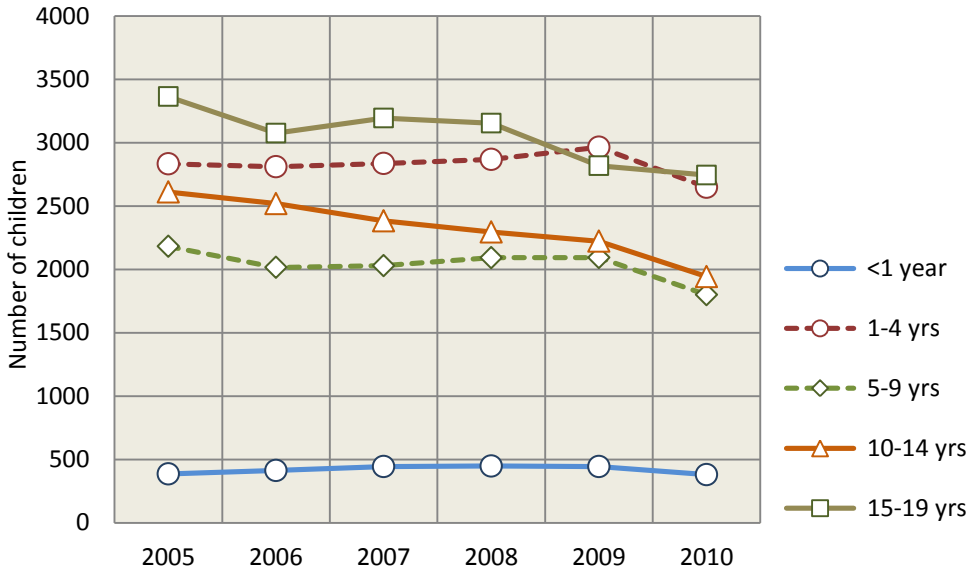
Most unintentional injuries that result in an emergency department visit or hospitalization occur in children 1-4 years old in Ramsey County.

Figure CIM-7: Number of motor vehicle injuries and fatalities by age group, Ramsey County, MN, 2010



Source: Minnesota Department of Health, MIDAS System

Figure CIM-8: Number of injuries in children (all types, fatal and non-fatal), Ramsey County, MN, 2005-2010



Source: Minnesota Department of Health, MIDAS System

The number of injuries and fatalities per year in Ramsey County children is steadily declining among all age groups.

DRINKING WATER QUALITY

In urban and suburban areas, much of the land surface is covered by buildings and pavement, inhibiting the drainage of rainwater and snowmelt. Most developed areas rely on storm drains to carry large amounts of runoff from roofs and paved areas to nearby waterways. Storm water runoff carries pollutants such as oil, dirt, chemicals, and lawn fertilizers directly to streams and rivers, where they taint water quality. To protect surface water quality and groundwater resources, urban development should be designed and built to minimize runoff. Common pollutants include:

- Sediment
- Oil, grease, and toxic chemicals from motor vehicles
- Pesticides and nutrients from lawns and gardens
- Viruses, bacteria, and nutrients from pet waste and failing septic systems
- Road salts
- Heavy metals from roof shingles, motor vehicles, and other sources
- Thermal pollution from dark impervious surfaces such as streets and rooftops

These pollutants harm fish and wildlife populations, kill native vegetation, foul drinking water supplies, and make recreational areas unsafe and unpleasant.

Contaminants in surface and ground waters that serve as sources of drinking water vary and may cause a range of negative health effects in children, including acute diseases such as gastrointestinal illness, developmental effects such as learning disorders, and serious long-term illnesses such as cancer. The Environmental Protection Agency (EPA) sets drinking water standards intended to protect people against adverse health effects. These standards currently include Maximum Contaminant Levels (MCLs) and mandate water treatment technique requirements for over 90 chemical, radiological, and microbiological contaminants. One way to gain insight into children's potential exposure to drinking water contaminants is to look at community water system compliance with these standards. EPA's drinking water regulations require public water systems, including community water systems, to monitor compliance with Federal health-based standards and to treat their water if needed.

The Healthy People objective for the U.S. is to increase the proportion of persons served by community water systems who receive a supply of drinking water that meets the regulations of the Safe Drinking Water Act from 89 percent in 2005 to 91 percent by 2020.[1]

The Minnesota Department of Health is responsible for enforcing the federal Safe Drinking Water Act and safeguarding the quality of drinking water in our state. This includes the responsibility of regulating approximately 7,100 public water supply systems statewide. This figure includes 961 community systems, which provide drinking water to people in their places of residence. The community systems include 727 municipal systems, serving towns or cities.[2]

[1] *Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=12.*
[2] *Safe Drinking Water in Minnesota: A Summary of Drinking Water Protection Activities in Minnesota for 2010. Issued May 2011. Minnesota Department of Health. Retrieved from: http://www.health.state.mn.us/divs/eh/water/com/dwar/report10.html*

The Minnesota Environmental Quality Board (EQB) has adopted the *2010 Minnesota Water Plan*, a comprehensive long-range water resources plan for the state that presents a vision for achieving sustainable water management and ensuring healthy ecosystems.[3]

In St. Paul, no contaminants were detected at levels that violated federal drinking water standards in 2010

Table DW-1: 2010 Saint Paul Regional Water Services results of monitoring conducted on drinking water (City of St. Paul), 2010

Detected Substance	Meets Standards ?	Amount Detected**	Allowed (MCL)	MCLG	Typical Source of Substance	Type	Monitoring Location
Trihalomethanes	YES	Average: 31.81 Ramge: 20.9 – 28.72	80	0	Disinfection By-Product	R	Distribution System
Nitrate as Nitrogen (ppm)	YES	0.56	10	10	Fertilizer, sewer, natural deposits	R	Treatment Plant
Haloacetic Acids (HAA5) (ppb)	YES	Average: 14.09 Range: 19.5 – 20.6	60	0	Disinfection by-product	R	Distribution System
Fluoride (ppm)	YES	Average: 0.97 Range: 0.88 – 1.1	4	4	State mandated dental health additive, fertilizer, aluminum factory discharge	R	Distribution System
Chlorine (ppm)	YES	Average: 2.55 Range: 2.39 – 2.76	4MRDL	4 MRDLG	Microbe control additive	R	Distribution System
Lead (ppb)	YES	11.6* (3 of 50 sites over AL)	Action level: 15	0	Corrosion of home plumbing	R	Customers' Tap
Copper (ppm)	YES	0.05* (0 of 50 sites over AL)	Action level: 1.3	1.3	Corrosion of home plumbing	R	Customers' Tap
Turbidity (NTU)	YES	Max 0.104 Average 0.032 (limit met 100%)	TT	NA	Soil runoff	R	Treatment Plant
Sodium (ppm) (10/22/09)	YES	17.0	200 HRL	NR	natural deposits	NR	Treatment Plant
Sulfate (ppm)	YES	21.2	250 HRL	NR	natural deposits	NR	Treatment Plant

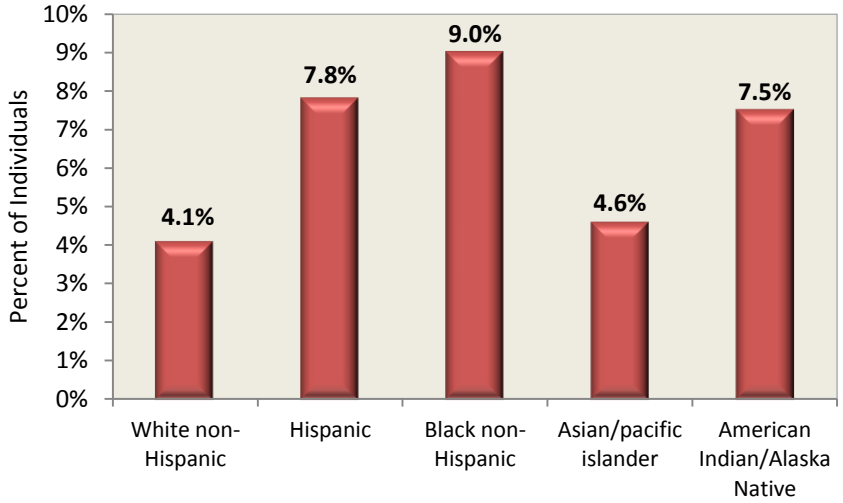
Source: Saint Paul Regional Water Services Water Quality Report 2011; www.stpaul.gov/water

[3] *Minnesota Environmental Quality Board. 2010 Minnesota Water Plan. Retrieved from: www.eqb.state.mn.us.*

HEALTHY HOMES

No environment is more influential on health than the home. While many low-income families have health insurance, many live in substandard housing. A variety of health-related hazards are disproportionately found in low-income housing, including excess moisture or mold, allergens, poor indoor air quality, structural deficiencies and lead contamination.[1]

Figure HH-1: Percentage of individuals living in inadequate housing*, U.S. 2009



Inadequate housing rates are highest among Blacks, Hispanics, and American Indian/Alaska Natives in the U.S.

Source: American Housing Survey, U.S. Census Bureau

*Inadequate housing: moderate or severe deficiencies in plumbing, heating, electricity, or upkeep, or a combination of these.

Most people spend at least half of every day inside their home.[2]

Some homes may expose children to:

- Indoor air pollution
- Inadequate heating and sanitation
- Structural problems
- Electrical and fire hazards
- Lead-based paint hazards

[1] National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011. Retrieved from: http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf.
[2] Surgeon General's Call to Action on Healthy Homes. http://www.surgeongeneral.gov/topics/healthyhomes/index.html.

Data compiled by the Minnesota Department of Health show that these housing-based hazards can have a significant impact on health and wellness:[3]

- One in three Minnesota homes has high levels of radon and there is no area of the state that has a low radon exposure potential. Radon exposure increases the risk for lung cancer of Minnesota residents.
- In 2010, 617 Minnesota children younger than six years old had an elevated blood lead level.
- Over 100,000 falls statewide were reported to the Minnesota Injury Data Access System in 2009, the CDC estimates that about half of falls reported each year occur in the home.
- Between 2002 – 2008, 131 Minnesotans died from unintentional exposure to carbon monoxide (CO).

In 2011, the state of Minnesota received funding from the Centers for Disease Control and Prevention (CDC) for healthy homes programmatic activities.[4,5]

Seven principles of a healthy home:

- *Dry*
- *Clean*
- *Well-ventilated*
- *Pest-free*
- *Contaminant-free*
- *Safe*
- *Maintained*

[3]*Minnesota Department of Health, Minnesota Environmental Public Health Tracking http://www.health.state.mn.us/divs/hpcd/tracking/index.html.*
[4]*Centers for Disease Control and Prevention, Healthy Homes. http://www.cdc.gov/HealthyHomes/programs/mn.htm.*
[5]*U.S. Department of Housing and Urban Development, Healthy Homes Program Guidance Manual. http://portal.hud.gov/hudportal/HUD?mode=disppage&id=HHGUIDANCEMANUAL.*

LEAD IN THE BLOOD OF CHILDREN

Lead poisoning remains one of the most common environmental health threats to children. There are many sources of lead, such as soil contaminated from accumulated runoff of leaded gasoline, lead dust accidentally brought home from parents' workplaces and hobby areas, imported candies, traditional healing remedies, pottery, and toys. However, deteriorated lead paint in homes is the primary source of lead exposure for U.S. children.[1]

Children less than six years old, are most vulnerable to lead's toxicity due to their growing bodies, nutritional needs, mouthing behavior and spending time on the floor. Pregnant women and the developing fetus are also at risk because lead easily passes through the placenta to the fetus, and the changing nutritional needs of the mother cause release of lead stored in bone.

The Centers for Disease Control and Prevention (CDC) considers children and pregnant women to have elevated blood lead levels (EBLLs) if their blood test results are greater than or equal to 10 micrograms of lead per deciliter whole blood (µg/dL).

Table LD-1: Childhood lead poisoning, percent tested, Ramsey County, MN, 2006-2008 birth years

	# tested	Total births	% tested	# EBLLs*	% EBLLs*	% children < age 5 in poverty	% pre-1950 housing	% 1950-1979 housing
Minnesota	299347	487198	61.4	2651	0.89	10.4	27.1	6.6
Ramsey County	36815	51924	70.9	675	1.83	15.7	35.2	2.5

Source: Minnesota Public Health Data Access, Minnesota Department of Health

*EBLL = Elevated Blood Lead Levels.

Certain populations of children are at increased risk of lead poisoning. For example, low-income children are more likely to live in older homes that are in poor condition and live in urban areas that may contain lead-contaminated soils. Refugees and immigrants are also at increased risk because they are likely to have lead exposure in their home countries, may have poor nutritional status, and may live in substandard housing once in the U.S.

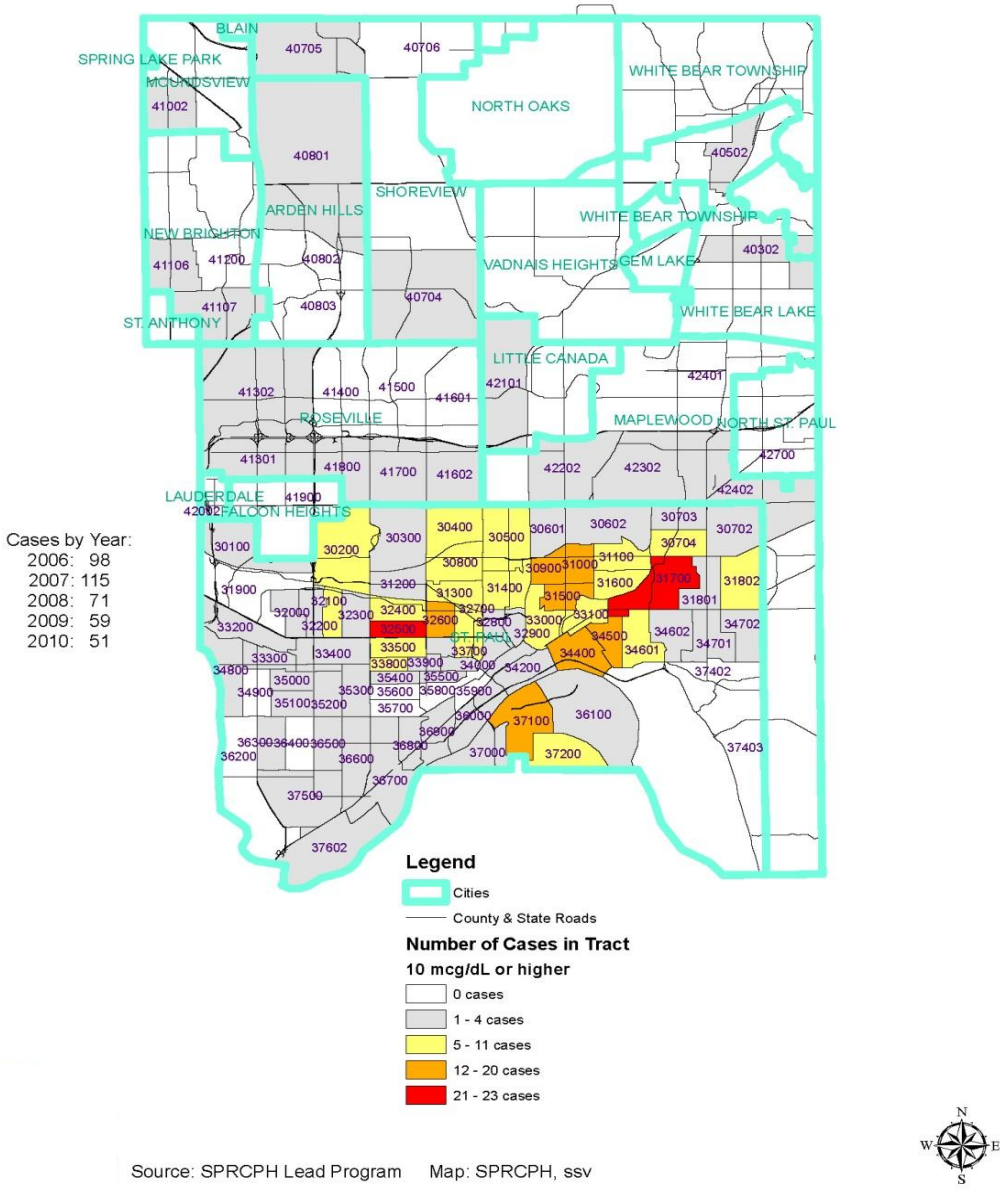
Recognizing and treating lead poisoning is difficult. Elevated levels of lead in the first years of life may not produce symptoms until children enter school and display learning difficulties, low IQ, or behavior problems. At that point it is too late for prevention of lead poisoning and the effects are likely to be permanent.

[1] *Federal Interagency Forum on Child and Family Statistics (2011). America's Children: Key national Indicators of Well-Being, 2011. Lead in the Blood of Children. Retrieved from: http://www.childstats.gov/americaschildren/phenviro4.asp.*

Minnesota statute 144.9504 mandates environmental interventions for venous blood lead levels of 15 µg/dL or greater in children less than six years old. For levels of 10 µg/dL or greater, local public health nurses work with families to identify potential exposure routes and reduce elevated lead levels. For most children and adults with lead poisoning, identification and elimination of the source of lead is the main treatment.

Figure LD-2

Lead Cases 10 mcg/dL or Higher, 2006-2010
Ramsey County Children Under 6 Years



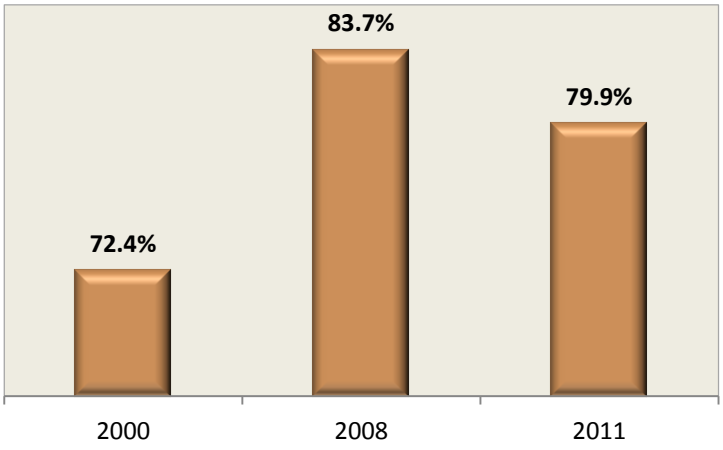
Source: SPRCPH Lead Program Map: SPRCPH, ssv

OUTDOOR AIR QUALITY

Children are at increased risk for suffering adverse health effects from breathing low quality air. Children typically spend more time outdoors than adults and have greater exposure to outdoor air. The health impacts of poor air quality for children include asthma exacerbations, asthma hospitalizations and decreased lung function.[1] Children with cardiac problems are especially susceptible to the effects of poor air quality.[2] These health problems in children are often translated into increased school absences and higher rates of healthcare utilization.

Poor air quality has far reaching health impacts. Studies in other countries have shown associations between air pollution and post neonatal infant mortality, possibly sudden infant death syndrome, low birth weight and preterm birth.[3] The Healthy People objective for the U.S. is to reduce the days the Air Quality Index exceeds 100 from 11 days in 2008 to 10 days by 2020.[4]

Figure OAQ-1: Percentage of days the air quality index was "Good", Ramsey County, MN, selected years



Source: Minnesota Compass, Wilder Research

The Air Quality Index measures five main pollutants regulated by the 1990 Clean Air Act. Days are rated as "Good," "Moderate," "Unhealthy for Sensitive Groups," or "Unhealthy" based upon the amount of pollutants in the air.

Source: Twin Cities Compass, Wilder Research

Air quality in Ramsey County declined in 2011, after a significant improvement in 2008.

[1] Committee on Environmental Health. (2004). American Academy of Pediatrics Policy Statement. Ambient Air Pollution: Health Hazards to Children. Pediatrics, 114:1699.
[2] Ibid.
[3] Ibid.
[4] Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=12.

SECONDHAND SMOKE

Reducing exposure to secondhand hand smoke is one of the major components of a comprehensive strategy to reduce the damage caused by tobacco use. The latest scientific evidence estimates that about 3,000 adult non-smokers die of lung cancer and an additional 46,000 die of coronary heart disease each year due to secondhand smoke exposure. An estimated 430 babies die each year of sudden infant death syndrome related to secondhand smoke. Breathing secondhand smoke can cause health problems in children, such as increased severity of asthma attacks, respiratory illnesses, chronic cough, bronchitis and middle ear problems.[1]9 In October of 2007, the Freedom to Breathe Act was passed, prohibiting smoking in all Minnesota workplaces, including bars and restaurants. A 2009 University of Minnesota study[2] found that the law is already reducing health risks. Other studies have shown that antismoking bans improve air quality without harming business in bars and restaurants.[1,3] Secondhand smoke exposure in Minnesota significantly declined after the law took effect although progress in reducing exposure has slowed since 2008.[4]

HEALTH EFFECTS OF SECONDHAND SMOKE IN CHILDREN[5]

- Because their bodies are developing, infants and young children are especially vulnerable to the poisons in secondhand smoke.
- Both babies whose mothers smoke while pregnant and babies who are exposed to secondhand smoke after birth are more likely to die from sudden infant death syndrome (SIDS) than babies who are not exposed to cigarette smoke.
- Mothers who are exposed to secondhand smoke while pregnant are more likely to have lower birth weight babies.
- Babies whose mothers smoke while pregnant or who are exposed to secondhand smoke after birth have weaker lungs than other babies.
- Secondhand smoke exposure causes acute lower respiratory infections such as bronchitis and pneumonia in infants and young children.
- Secondhand smoke exposure causes children who already have asthma to experience more frequent and severe attacks.
- Secondhand smoke exposure causes respiratory symptoms, including cough, phlegm, wheezing, and breathlessness, among school-aged children.
- Children exposed to secondhand smoke are at increased risk for ear infections and are more likely to need an operation to insert ear tubes for drainage.

After just four hours in a casino where smoking is permitted, Minnesota nonsmokers showed 112% more lung-cancer-causing chemicals in their bodies than normal, and 456 % more nicotine.[1]

[1] *U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta, GA. U.S. Department of Health and HumanServices, Centers for Disease Control and Prevention; 2006. California Environmental Protection Agency. Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant. Part B: Health Effects.Sacramento CA. 2005.*

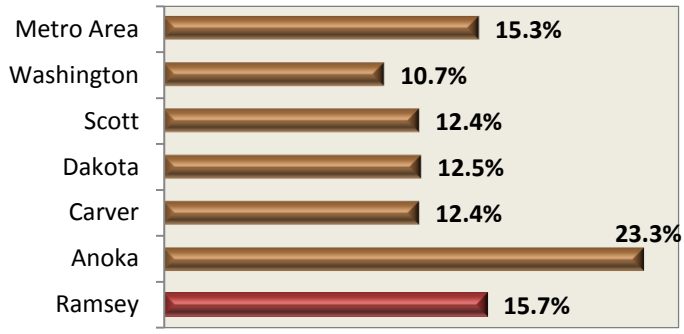
[2] *Waters, H., Foldes, S., Alesci, N., & Samet, J. (2009). The economic impact of exposure to secondhand smoke in Minnesota. American Journal of Public Health, 99(4), 754-759.*

[3] *Twombly, R. (2004). Where there's no smoke: Popular smoke-free laws curbing active, passive smoking. Journal of the National Cancer Institute, 96(14), 1058-1060.*

[4] *Teens and Tobacco in Minnesota, 2011 Update: Results from the Minnesota Youth Tobacco and Asthma Survey. Minnesota Department of Health Division of Health Policy, Center for Health Statistics. December 2011.*

[5] *Office of the Surgeon General, U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure of Tobacco Smoke: A Report of the Surgeon General. 2006. Retrieved from: http://www.surgeongeneral.gov/library/secondhandsmoke/index.html.*

Figure SHS-1: Percentage of adults who currently smoke, selected counties, MN, 2010



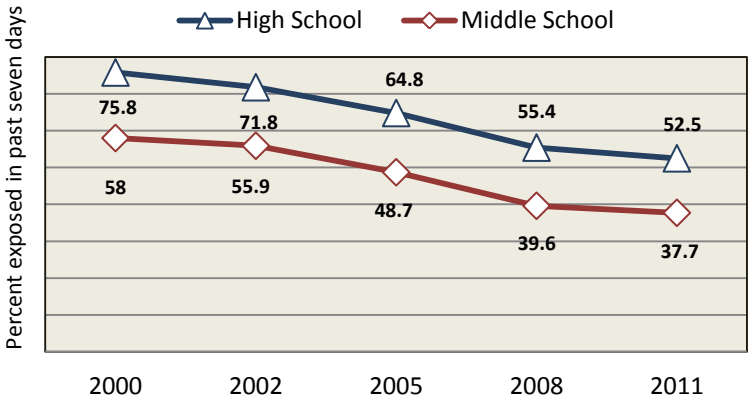
Source: Metro Health Survey January 2011

Ramsey County's adult smoking rate is just slightly higher than the metro area's rate.

Perceptions, Rules and Opinions about Secondhand Smoke[6]

- Over 90 percent of students agree that secondhand smoke is harmful.
- Among high school students, 79.7 percent report that smoking is never allowed inside their home and 64.0 percent report that smoking is never allowed in the vehicle they drive or ride in the most.
- Current smokers are much less likely than non-smokers to have smoke-free rules in their homes and vehicles.
- Support for public and private smoke-free rules is very high. Nearly 90 percent of middle school students believe that smoking should never be allowed inside their homes, in their vehicles, at workplaces, and in indoor public places. Support by high school students ranges from 70.9 percent for smoke-free rules in vehicles to 84.4 percent for smoke-free rules in indoor public places.

Figure SHS-2: Percentage of students exposed to secondhand smoke in past seven days, MN, selected years



Source Minnesota Deaprtment of Health Center for Health Statistics

[6]*Teens and Tobacco in Minnesota, 2011 Update: Results from the Minnesota Youth Tobacco and Asthma Survey. Minnesota Department of Health Division of Health Policy, Center for Health Statistics. December 2011.*

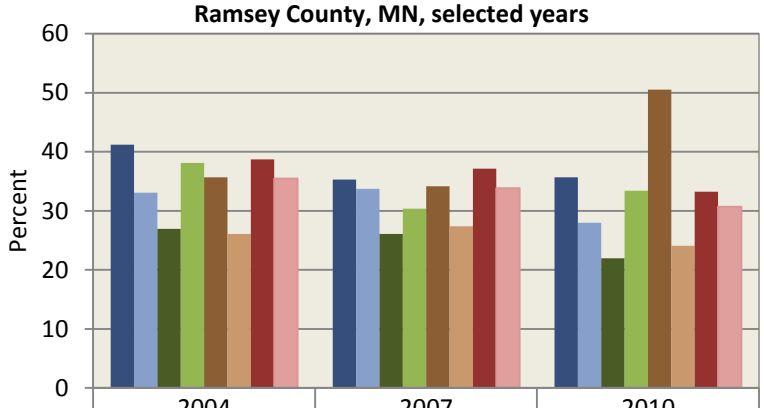
5 BEHAVIOR

ALCOHOL USE

The use and abuse of alcohol by adolescents causes problems that are pervasive and have significant effects on health and adolescent development. Alcohol use contributes to chronic disease, injuries, violence, unsafe sexual behavior, unplanned pregnancy, decreased productivity, social and family disruption, lack of educational attainment and other problems.[1] Use also leads to numerous societal costs including increased health care costs, insurance costs (medical, home and auto) and law enforcement, judiciary and corrections costs.[2] Alcohol and other drug use impacts adolescent brain development.[3]

Underage drinking is prevalent[4,5] and represents an important risk factor for risky sexual behavior,[6] injury and mortality during adolescence.[7,8]

Figure AU-1: Percentage of 6th, 9th, 12th graders who had alcoholic beverages during the past year by race/ethnicity, Ramsey County, MN, selected years



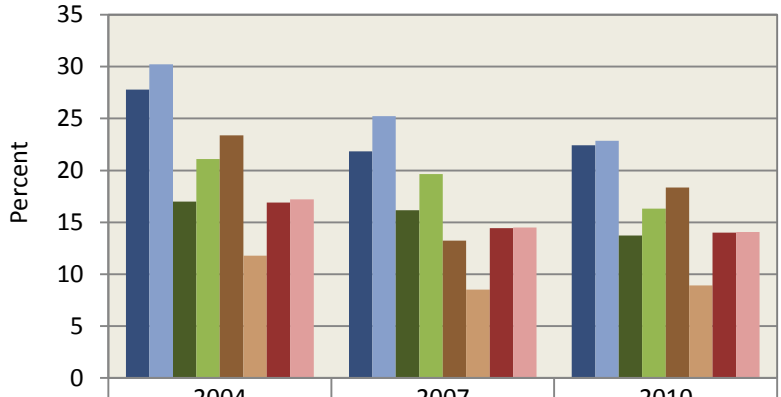
	2004	2007	2010
2+ races	41.19	35.28	35.65
American Indian	33.08	33.71	28
Black/African American	26.94	26.08	21.93
Mexican or Chicano/Chicana	38.13	30.36	33.41
Puerto Rican/Latin American	35.65	34.17	50.52
Asian/Pacific Islander	26.06	27.38	24.09
White	38.7	37.14	33.23
Total	35.47	33.83	30.66

Source: Minnesota Student Survey

Alcohol use among Mexican or Chicano/ Chicana and Puerto Rican/Latin American children is increasing in Ramsey County.

[1] Minnesota Department of Health Fact Sheet. Title V (MCH) Block Grant Children and Adolescents: Alcohol and Drug Use. September 2009.
[2] Ibid.
[3] Breyer J, Winters KC. Adolescent brain development implications for drug use prevention. Center for Substance Abuse Research Department of Psychiatry, University of Minnesota & Mentor USA, 2005.
[4] Johnston LD, O'Malley PM, Bachman JG, et al. Monitoring the Future national results on adolescent drug use: Overview of key findings, 2010. Ann Arbor: Institute for Social Research, The University of Michigan, 2011:77.
[5] Windle M. Alcohol Use Among Adolescents. Thousand Oaks: Sage, 1999.
[6] Fergusson DM, Lynskey MT. Alcohol misuse and adolescent sexual behaviors and risk taking. Pediatrics 1996;98:91e6.
[7] Ellickson PL, Tucker JS, Klein DJ. Ten-year prospective study of public health problems associated with early drinking. Pediatrics 2003;111:949e55.
[8] National Highway Traffic Safety Administration (NHTSA). Traffic Safety Facts: Alcohol. Traffic Safety Facts: Crash Stats. Washington DC: U.S. Department of Transportation, 2006.

Figure AU-2: Percentage of 6th, 9th, 12th graders reporting alcohol use by a family member caused family, health, job or legal problems by race/ethnicity, Ramsey County, MN, selected years



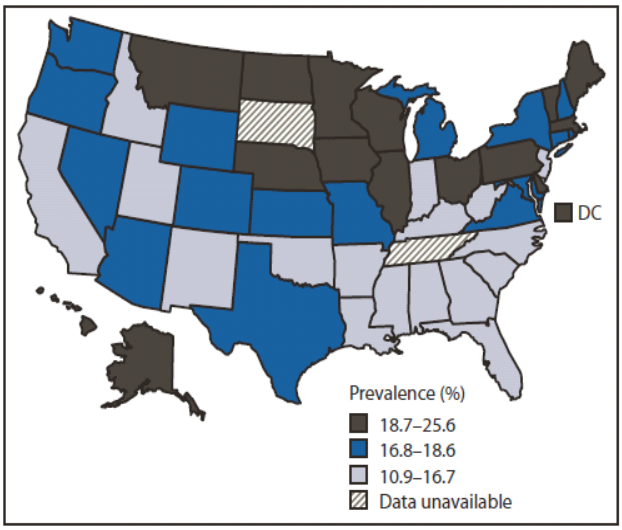
	2004	2007	2010
2+ races	27.79	21.84	22.42
American Indian	30.22	25.24	22.86
Black/African American	16.99	16.16	13.73
Mexican or Chicano/Chicana	21.1	19.66	16.32
Puerto Rican/Latin American	23.39	13.22	18.35
Asian/Pacific Islander	11.79	8.51	8.91
White	16.89	14.45	13.99
Total	17.22	14.51	14.06

Source: Minnesota Student Survey

Alcohol use in Ramsey County families is decreasing in many communities. Exceptions are Puerto Rican/Latin American and two or more race families, for whom use is increasing.

Binge drinking is reported by one in six U.S. adults, and those who binge drink tend to do so frequently and with high intensity. In a recent study reported by the CDC[9], the overall national prevalence of binge drinking was 17.1%. Among binge drinkers, the frequency of binge drinking was 4.4 episodes per month, and the intensity was 7.9 drinks on occasion.

FIGURE AU-3: Prevalence of binge drinking among adults, 2010

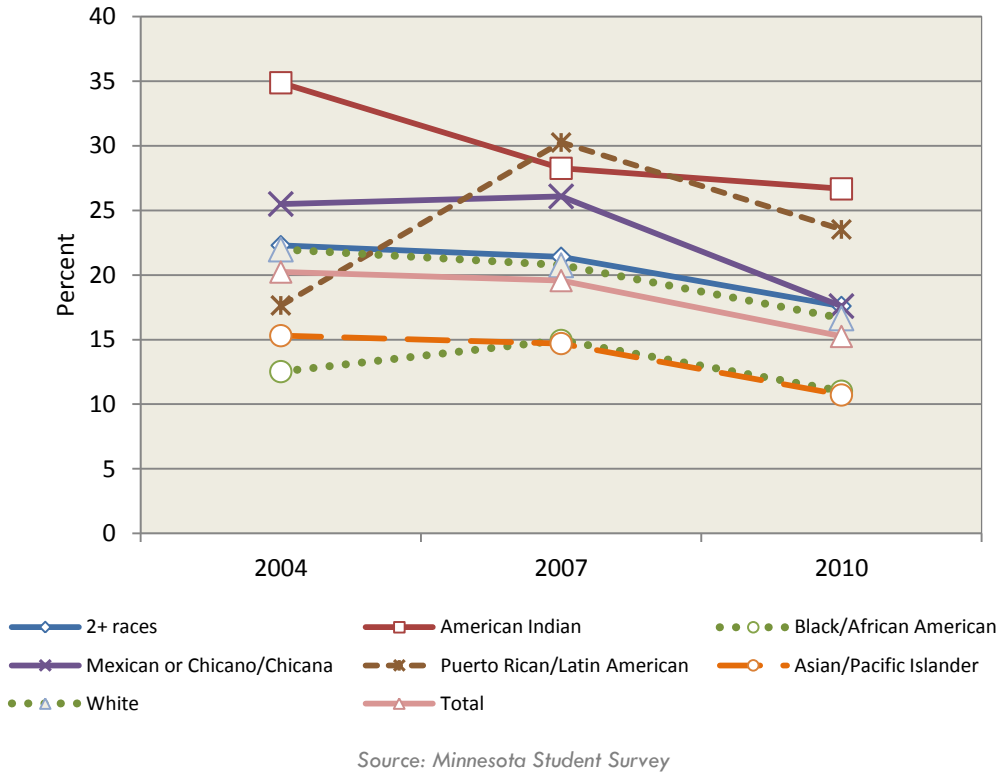


Source: Behavioral Risk Factor Surveillance System combined landline and cellular telephone developmental dataset, United States, 2010

Binge drinking prevalence (28.2%) and intensity (9.3 drinks) were highest among persons aged 18–24 years in the Midwest.

[9] Vital Signs: Binge Drinking Prevalence, Frequency, and Intensity Among Adults – United States, 2010, Weekly January 13, 2012/61(01); 14-19. Retrieved from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a4.htm?s_cid=mm6101a4_w.

Figure AU-4: Percentage of 6th, 9th, and 12th graders reporting binge drinking during past two weeks by race/ethnicity, Ramsey County, MN, selected years



Source: Minnesota Student Survey

Drinking and driving remains a serious problem in Minnesota and across the nation. Predictably, there is a strong positive relationship between alcohol use and crash severity. That is, as crash severity increases, alcohol is more likely to have been a factor in the crash. In 2010 in Minnesota, 6% of minor injuries, 11% of moderate injuries, 24% of severe injuries, and 32% of deaths were alcohol-related. In all, 131 people died and 2,485 people were injured in crashes classified as alcohol-related.[10]

[10] *Minnesota Impaired Driving Facts 2010. Office of Traffic Safety, Minnesota Department of Public Safety. 2011. Retrieved from: https://dps.mn.gov/divisions/ots/reports-statistics/Pages/impaired-driving-facts.aspx*

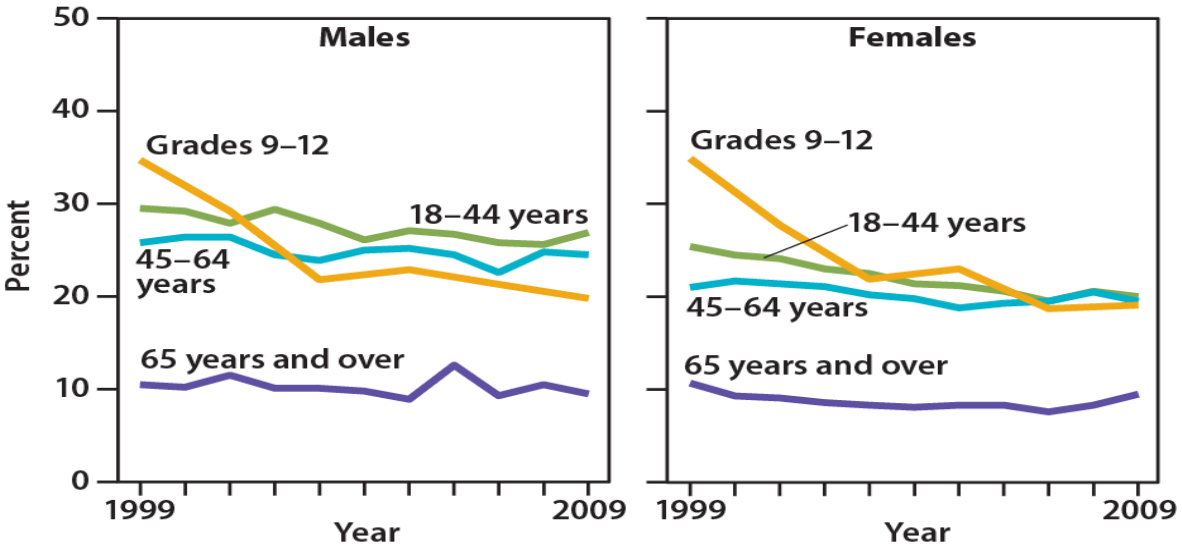
CIGARETTE SMOKING

Cigarette smoking is one of the most widely understood causes of disease. Preventing smoking among young people is critical to ending the epidemic of tobacco use. Since the first Surgeon General's report on youth in 1994, the basis for concern about smoking during adolescence and young adulthood has expanded beyond the immediate health consequences for the young smoker to a deeper understanding of the implications for health across the life span from early use of tobacco.[1] Cigarette smoking remains the leading cause of preventable death in the United States, accounting for approximately 443,000 deaths, or about 1 of every 5 deaths, in the United States each year.[2]

Nearly all tobacco use begins during youth and young adulthood. These young individuals progress from smoking occasionally to smoking every day. Each day across the United States over 3,800 youth under 18 years of age start smoking. Although much progress has been made, today nearly one in four high school seniors and one in three young adults under age 26 smoke.[3]

Although it is not legal to smoke until age eighteen, tobacco use begins early. The average age of starting to smoke is thirteen. Smokers are not a cross section of the teen population. Generally, youth who smoke share one or more of the following characteristics: lower levels of school achievement; fewer skills to resist pressure to use tobacco; friends and family who use tobacco; lower self-images; are less likely to have plans for continuing their education; are more likely to use other drugs including alcohol; and are more likely to have other encounters with law enforcement.[4]

Figure CS-1: Percentage of U.S. smokers, selected age groups, by gender, 1999-2009



SOURCE: CDC/NCHS, *Health, United States, 2010*, Figure 11. Data from the National Health Interview Survey (for adults) and the Youth Risk Behavior Survey (for grades 9–12).

[1] *U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012.*

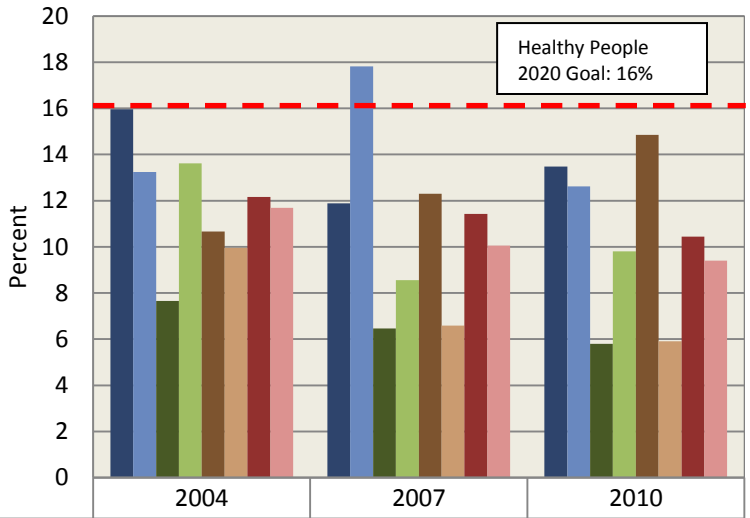
[2] *Ibid.*

[3] *Ibid.*

[4] *The Association for Non-Smokers-Minnesota. (1998) Teens and Tobacco: A community handbook for developing youth diversion/tobacco awareness program. Retrieved from: http://www.ansrmn.org/resources/youth-access.*

Recent research indicates that the Midwest has some of the highest smoking rates in the nation (23% compared to 21% in the South and 16% in the West) and that the nation's progress towards reducing smoking rates seems to have stalled.[5]

Figure CS-2: Percentage of 6th, 9th and 12th graders that reported smoking cigarettes during the past 30 days by race, Ramsey County, MN, selected years



	2004	2007	2010
2+ races	15.96	11.88	13.48
American Indian	13.24	17.82	12.62
Black/African American	7.65	6.46	5.79
Mexican or Chicano/Chicana	13.62	8.56	9.8
Puerto Rican/Latin American	10.66	12.3	14.85
Asian/Pacific Islander	9.95	6.59	5.91
White	12.16	11.42	10.44
Total	11.69	10.06	9.4

Source: Minnesota Student Survey

In Ramsey County, Puerto Rican/Latin American and children of two or more races are smoking at higher rates than in previous years. Child smoking rates in 2010 declined to below the Healthy People 2020 goal of 16%.

YOUTH ACCESS TO TOBACCO

In 1997, the Minnesota Legislature passed a powerful bill to restrict youth access to tobacco. The Ramsey Tobacco Coalition (RTC) has been working since then to reduce the harm caused by tobacco in Ramsey County and is a leader in reducing youth access to tobacco, enforcing tobacco-free school ground policies, adopting tobacco-free park policies, adopting tobacco-free policies for youth clubs and youth-serving agencies, and adopting smoke-free workplace laws in Ramsey County and St. Paul.[6]

[5] *Ibid.*

[6] *The Association for Non-Smokers-Minnesota. Retrieved from: http://www.ansrmn.org/programs/ramsey-tobacco-coalition.*

TOBACCO ADVERTISING AIMED AT AFRICAN AMERICANS

Point-of-sale tobacco advertising data were collected by the Association for Nonsmokers—Minnesota (ANSR) staff as part of the Ramsey Tobacco Coalition.[7] The point-of-sale advertising and promotion environment was assessed in all of the licensed tobacco vendors in Ramsey County and in the cities of South St. Paul and West St. Paul by trained data collectors. Research found that tobacco ads in Ramsey County are clustered in poor, African American neighborhoods.

EMERGING ISSUES[8]:

Hookah is a waterpipe used to smoke tobacco and is growing in popularity in the Twin Cities particularly among older teens and college students. Hookah is usually smoked in social settings in lounges or bars run much like a café.

Dissolvable tobacco products: These products dissolve when placed in the mouth, releasing nicotine. Users do no need to spit when using this product. Snus is a smokeless, spitless tobacco product that came into the market in Minnesota in 2008. Small pouches filled with tobacco are placed between the gum and lip where nicotine can be absorbed.

Camel Crush is a "customizable" cigarette. There is a small blue bead in the filter that a smoker can squeeze to release menthol flavoring into the cigarette. In this way, smokers can switch from a regular cigarette to a menthol cigarette with the simple squeeze of the filter. Menthol cigarettes are most popular with youth and African Americans.

Little filtered cigars: These little "cigars" are really just cheap cigarettes. They look and feel like cigarettes with one exception, they have a small amount of tobacco in the rolling paper. They are, therefore, able to be called cigars and can avoid cigarette taxes. As a result, these products are extremely inexpensive. These products are likely appealing to youth and low-income people as these groups are price sensitive.

E-cigarettes are electronic nicotine delivery devices. These devices do not contain any tobacco. Users inhale a nicotine infused vapor. Not much is known about the health impact of these devices. A number of companies manufacture e-cigarettes. As of 2010, Minnesota law prohibits the sale of e-cigarettes to minors.

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[7] The Association for Nonsmokers-Minnesota (ANSR-MN) conducted this research with funding from the Robert Wood Johnson Foundation (PI: Rachel Widome, PhD) and the Minnesota Department of Health Office of Tobacco Prevention and Control. Ramsey Tobacco Coalition. (2007). Point-of-Sale Tobacco Advertising Assessment: Preliminary Findings from Ramsey County, West St. Paul, and South St. Paul. Retrieved from: http://www.ansrmn.org/programs/ramsey-tobacco-coalition.

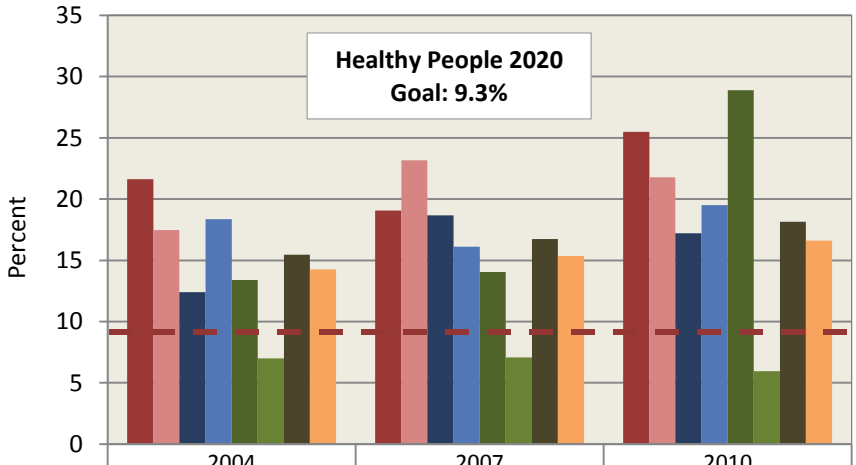
[8] Ramsey Tobacco Coalition New Tobacco Products fact sheet. 10/20/2010. Retrieved from: http://www.ansrmn.org.

ILLICIT DRUG USE

Research shows that by age 14, 35% of youth have engaged in some form of illicit (illegal) drug use and by the end of high school, more than 50% will have tried at least one illicit drug.[1] Teens who begin using illicit drugs before the age of 15 are more likely to develop a lifelong dependence on illegal substances.[2] Youth with emotional/behavioral problems are more likely to use illicit drugs. In most cases, mental illness precedes substance use, particularly among adolescents. In addition, adolescence is a difficult developmental period for many young people and some turn to substances as a way to self-medicate and cope with social pressures.[3]

Rates of marijuana use by youth and young adults are on the rise and fewer youth perceive great risk from smoking marijuana once or twice a week.[4]

Figure IDU-1: Percentage of 6th, 9th and 12th graders that report using marijuana during the past year, Ramsey County, MN, selected years



	2004	2007	2010
2+ races	21.63	19.05	25.49
American Indian	17.46	23.16	21.78
Black/African American	12.4	18.66	17.21
Mexican or Chicano/Chicana	18.36	16.12	19.51
Puerto Rican/Latin American	13.39	14.05	28.87
Asian/Pacific Islander	7	7.08	5.95
White	15.47	16.73	18.14
Total	14.26	15.35	16.6

Source: Minnesota Student Survey

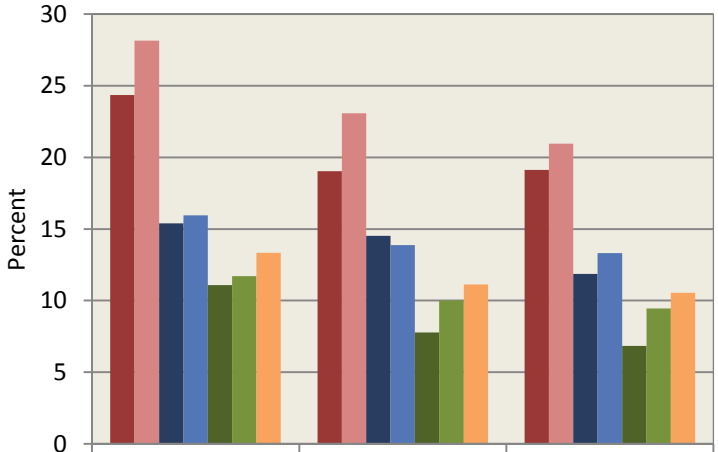
Currently in the U.S., 10% of youth 12-17 years report using illicit drugs in the previous 30 days.

The Healthy People 2020 goal is that no more than 9.3% of youth use illicit drugs.

[1] *Anthony,J.C.,&Petronis,K.R. (1995). Early onset drug use and risk of later drug problems. Drug and Alcohol Dependence, 40(1),9-15.*
[2] *Ibid.*
[3] *Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (1999) The Relationship Between Mental Health and Substance Abuse Among Adolescents. OAS Analytic Series #9, DHHS Publication No. (SMA) 99-3286.*
[4] *Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Trends and Program Directions in Substance Abuse Prevention, Vol VIII, 2002-2009: Key Findings. 2011; 8.*

Six million children (9 percent) in the U.S. live with at least one parent who abuses alcohol or other drugs.[5] Children of parents with substance use disorders are more likely to experience abuse (physical, sexual, or emotional) or neglect and are more likely to be placed in foster care.[6]

Figure IDU-2: Percentage of 6th, 9th and 12th graders reporting drug use by a family member caused family, health, job or legal problems by race/ethnicity, Ramsey County, MN, selected years



	2004	2007	2010
2+ races	24.35	19.03	19.13
American Indian	28.15	23.08	20.95
Black/African American	15.4	14.52	11.87
Mexican or Chicano/Chicana	15.94	13.88	13.32
Asian/Pacific Islander	11.08	7.77	6.85
White	11.71	10	9.46
Total	13.34	11.12	10.55

Source: Minnesota Student Survey

Adolescents with parents that use substances are more likely to use substances themselves. Some risk factors that increase the likelihood of adolescent substance abuse are parental attitudes about substance use and parental role-modeling.

Protective factors include two parent family structure, parental supervision, perception of parental concern and strong child-parent bonds.[2]

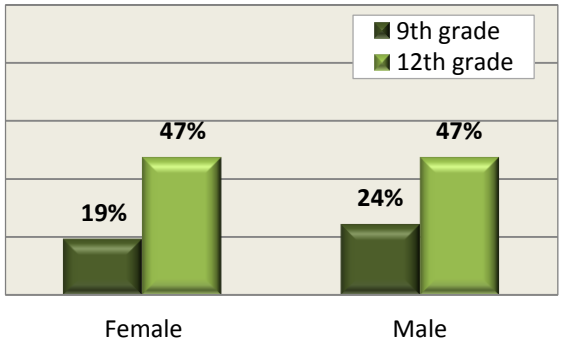
[5] *Office of Applied Studies, Children living with substance-abusing or substance-dependent parents, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2003. Retrieved from: http://www.DrugAbuseStatistics.samhsa.gov.*

[6] *National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011. Retrieved from: http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf.*

Sexual Activity

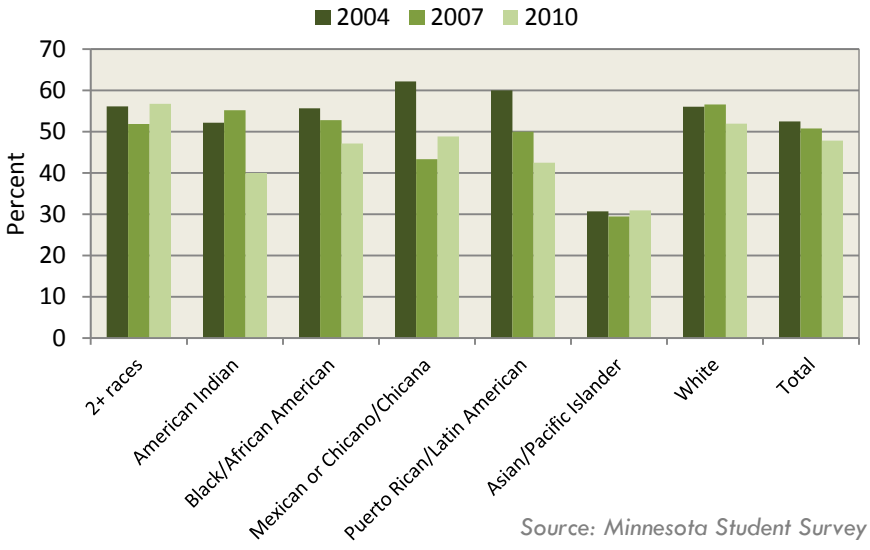
On average, American young people have sex for the first time at age 17.[1] Youth who engage in early sexual activity are at risk of contracting sexually transmitted infections and having an unintended pregnancy. While the sexual activity of American teens is comparable to that of their European counterparts, American teens are less likely to use contraceptives and have higher teen pregnancy rates.[2] Sexual activity among adolescents is increasing. Twenty percent of Minnesota 9th graders and 50% of 12th graders report having sex. The percent of sexually active 9th and 12th graders increased by 8.1% and 3.1%, respectively, from 2007 to 2010.

Figure SXA-1: Percentage of Ramsey County 9th and 12th graders who report having had sex, 2010



Source: Minnesota Student Survey

SXA-2: Percentage of 6th, 9th and 12th graders that report using a condom during intercourse last time (sexually active children only) by race/ethnicity, Ramsey County, MN, selected years



Source: Minnesota Student Survey

In 2010, the percentage of sexually active students reporting condom use decreased for all groups except 2+race, Mexican/Chicano, and Asian/Pacific Islander students.

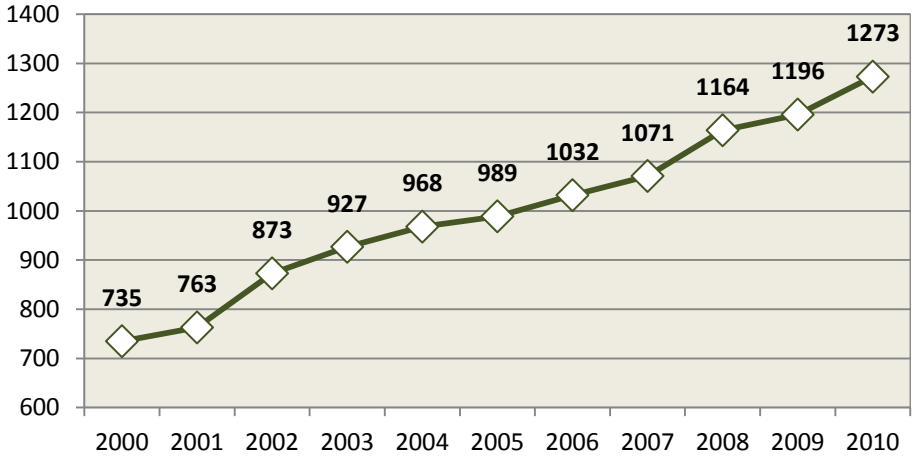
[1] http://www.guttmacher.org/pubs/FB-ATSRH.html
[2] Ibid.

Table SXA-3: Sexually transmitted infection rates (age 15-19 per 100,000 population), 2010

	Ramsey County	*Minnesota*
Chlamydia rate	2373	1273
Gonorrhea rate	272	164

Source: Minnesota Department of Health

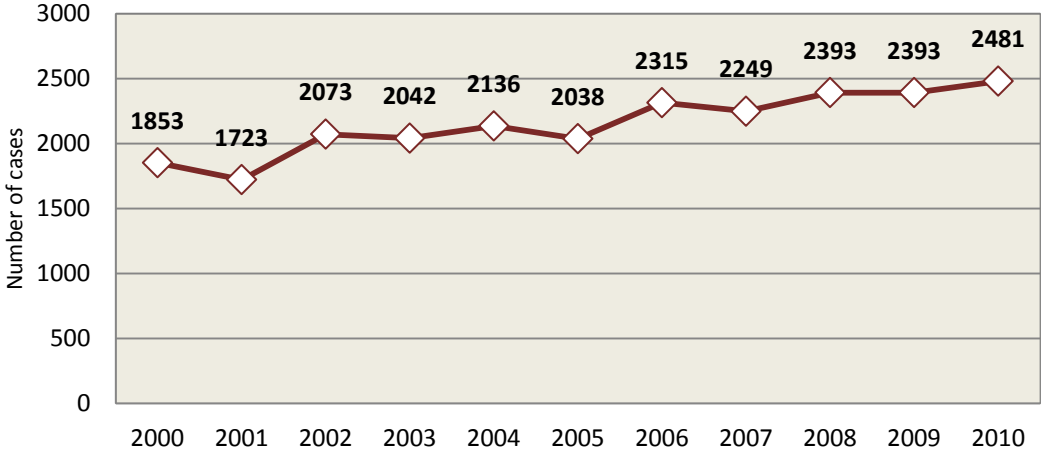
Figure SXA-4: Chlamydia rates (age 15-19 per 100,000 population), Minnesota, 2000-2010



Source: Minnesota Department of Health

According to the Minnesota Department of Health, even though they account for only 7% of the population in Minnesota, adolescents aged 15-19 accounted for 31% of chlamydia and 29% of gonorrhea cases in 2010.

Figure SXA-5: Number of reported cases of chlamydia, Ramsey County, MN, 2000-2010



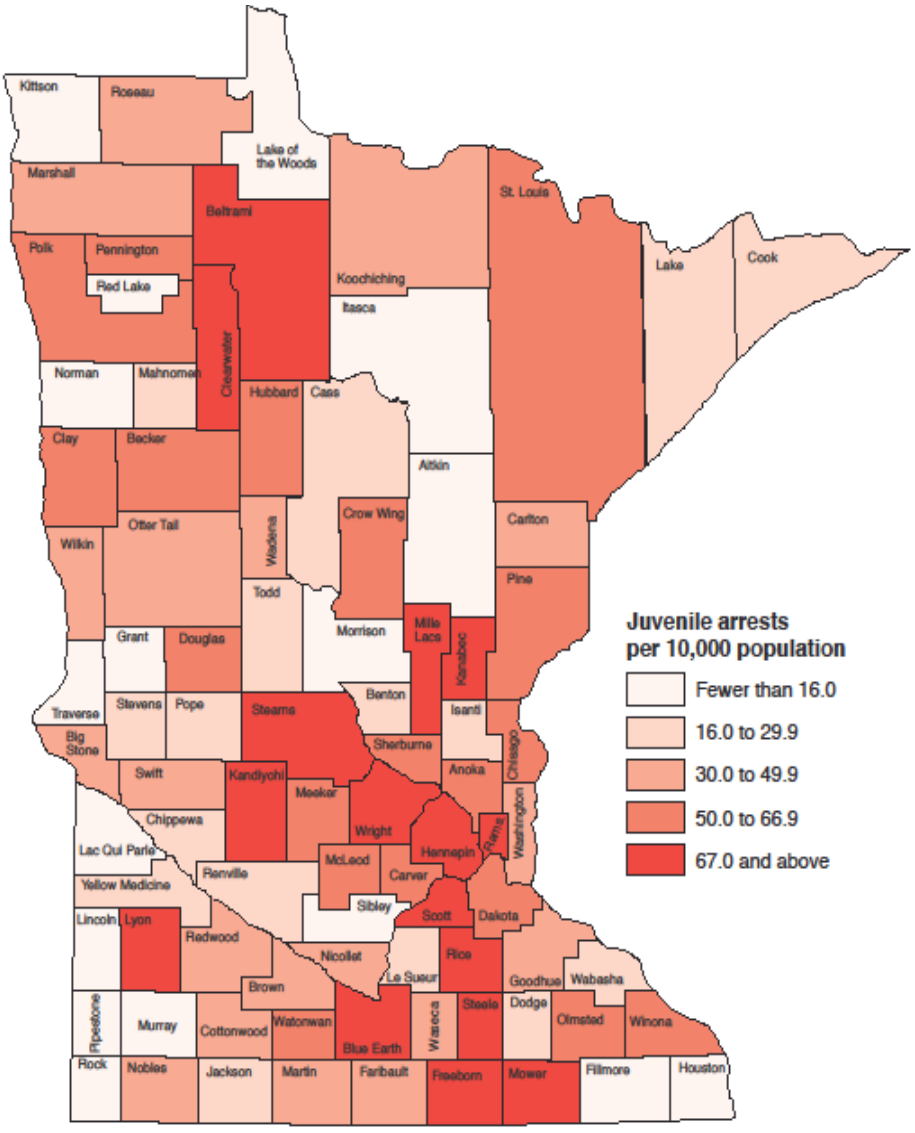
Source: Saint-Paul-Ramsey County Public Health, Preventative Health Section

Children and adolescents 19 years and under made up 36.7% of Chlamydia cases in 2010 in Ramsey County.

YOUTH PERPETRATORS OF CRIMES

The reasons why young people gravitate towards crime are complex and involve factors including individual personality/mental health issues, family culture, peer influence, and community/neighborhood disorganization. When these factors are dysfunctional, a young person is more likely to turn towards crime. Similarly, when these factors are healthy, they can be deterrents from engaging in violent or criminal behavior.[1]

Figure YPC-1: Juvenile arrests by county, Minnesota, 2010



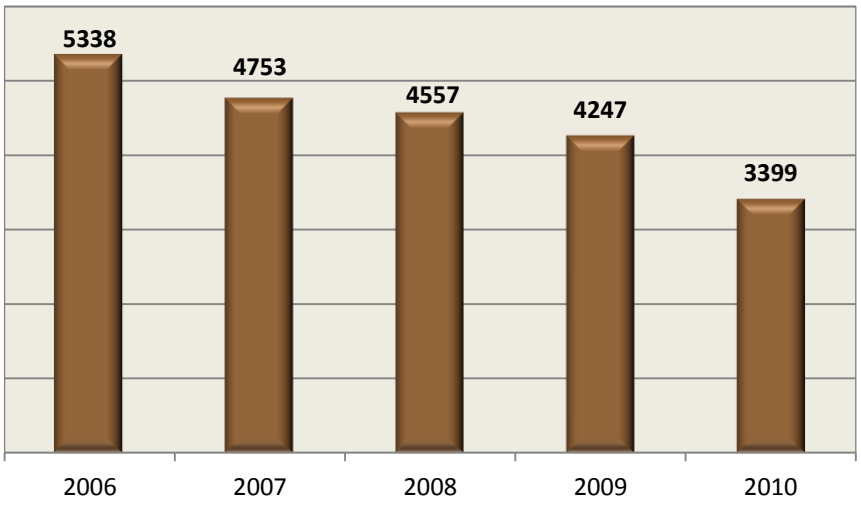
Source: Minnesota Bureau of Criminal Apprehension, Criminal Justice Information Systems, Center for Rural Policy and Development

The U.S. Health People objective is to decrease the rate of minor and young adult perpetration of violent crimes from 44.4 per 10,000 population aged 10-24 years in 2008 to 39.9 per 10,000 population by 2020.

Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=2.

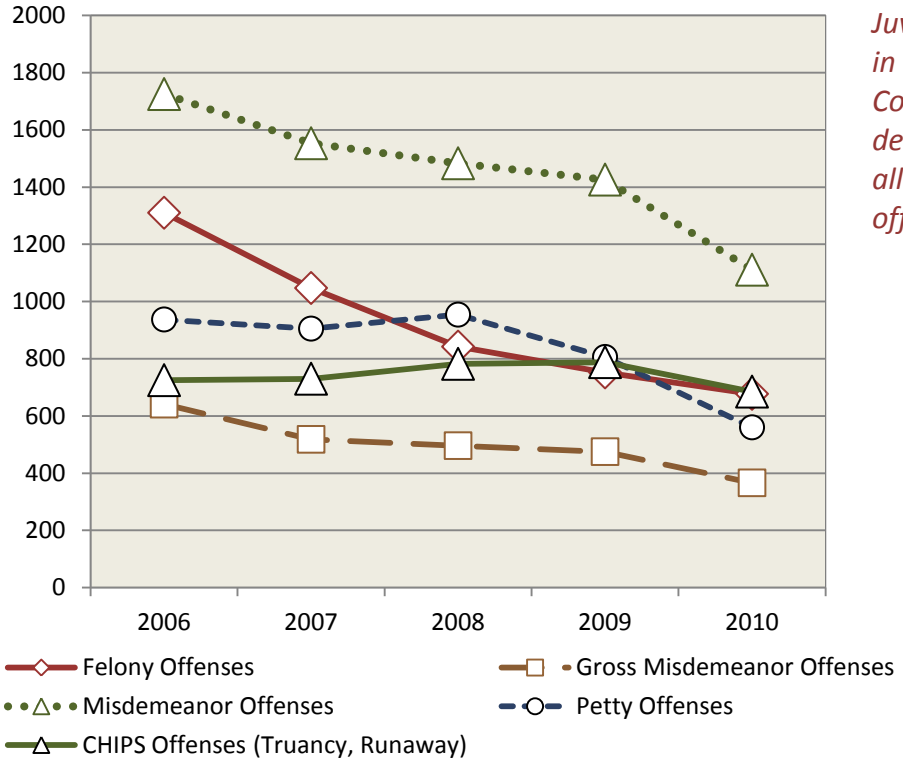
[1] *U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. (2000, April). Predictors of Youth Violence. Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/179065.pdf.*

Figure YPC-2: Number of juvenile offenses, Ramsey County, MN, 2006-2010



Source: Ramsey County Community Corrections, Juvenile Division, 2011

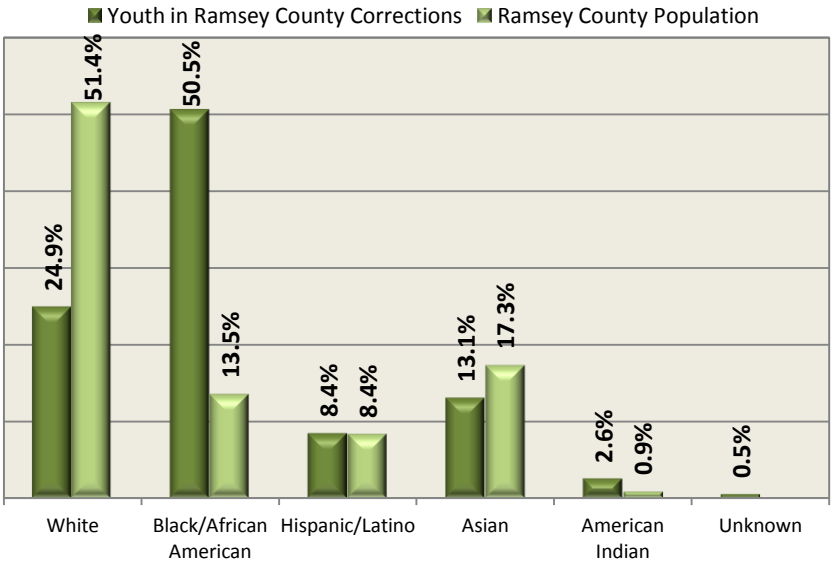
Figure YPC-3: Number of juvenile offenses by severity of the crime, Ramsey County, MN, 2006-2010



Juvenile crime in Ramsey County is decreasing for all types of offenses.

Source: Ramsey County Community Corrections, Juvenile Division, 2011

Figure YPC-4: Percentage of youth in the juvenile corrections system compared to youth in the population, by race/ethnicity, Ramsey County, MN, 2010



Source: Ramsey County Community Corrections, Juvenile Division, 2011and American Community Survey

In 2010, African-Americans ages 15 to 19 made up only 14% of the County's total population, yet 50% of the youth in Ramsey County Juvenile Corrections.

RAMSEY COUNTY'S JUVENILE DETENTION ALTERNATIVES INITIATIVE: ELIMINATING DISPARITIES

The Ramsey County Juvenile Detention Alternatives Initiative (JDAI) reduces the over-reliance on secure detention of juveniles, and seeks to eliminate racial, ethnic, and gender disparities in the juvenile justice system. Adopted in 2005 by the Ramsey County Board of Commissioners, JDAI is a nationally recognized approach with a proven record of reducing unnecessary reliance on secure detention in a wide range of jurisdictions. Ramsey County is engaged in a multi-year effort to safely minimize populations in its juvenile correctional facilities through fairer, better informed system policies and practices.

Between 2005 (pre-JDAI) and the end of 2011, Ramsey County experienced over 70% reductions in its overall detention admissions and over 60% reductions for youth of color.

Data from the 2010 Minnesota Student Survey support the need for gender responsive services for girls in the juvenile justice system. Gender-responsive programming acknowledges girls' unique pathways into the juvenile justice system; high prevalence of physical and sexual victimization among girls; underlying reasons for girls' chemical use; and that girls have mental and emotional health issues related to depression, anxiety and post-traumatic stress disorder at rates significantly higher than boys.[2]

[2] *Dept of Public Safety, Girls in MN Correctional Facilities. (2011). Retrieved from: https://dps.mn.gov/divisions/ooc/news-releases/Pages/Differences-Between-Girls-and-Boys-in-Minnesota-Correctional-Facilities-Highlighted-in-Report.aspx*

6 EDUCATION

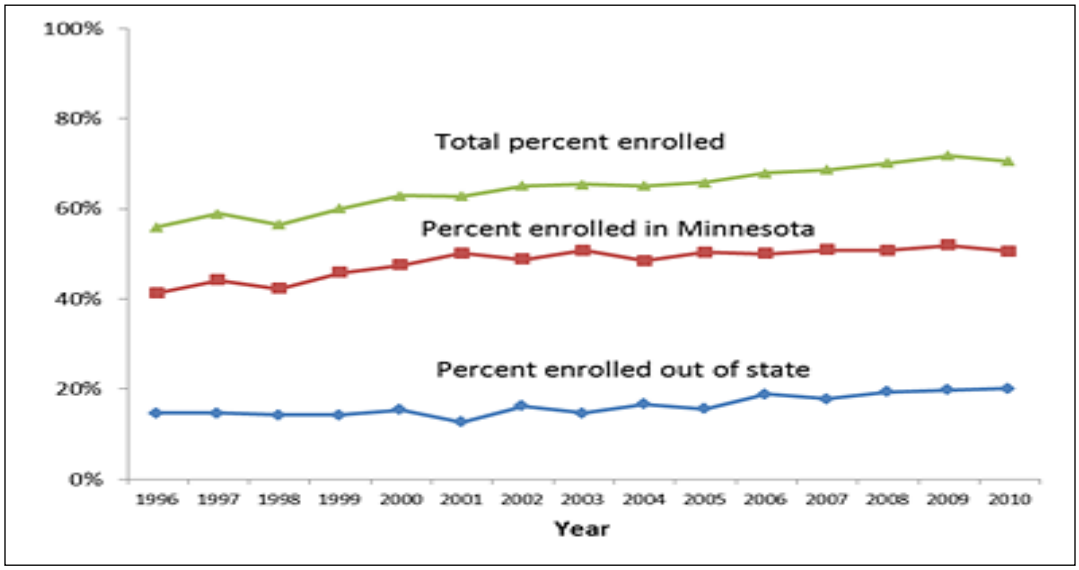
College Enrollment
Family Reading to Young Children
High School Academic Course Taking
High School Completion
Mathematics and Reading Achievement
School Attendance
Youth Neither Enrolled in School Nor Working

COLLEGE ENROLLMENT

Earning a college degree significantly enhances an individual's lifetime earnings potential. There are also benefits to the broader community through increased tax contributions from higher salaries.[1] Lifetime earnings potential is particularly significant for specific subpopulations that have had historically poor education outcomes such as some Hispanic and Latino students.[2]

Seventy-one percent of Minnesota's 2010 high school graduating class attended a postsecondary institution the following fall. Among all graduates, 51% percent attended a Minnesota institution, 20% attended institutions out of state, and 29% did not enroll directly in college after high school.

Figure: CE-1: College participation rates of Minnesota high school graduates, fall 1996 to 2010

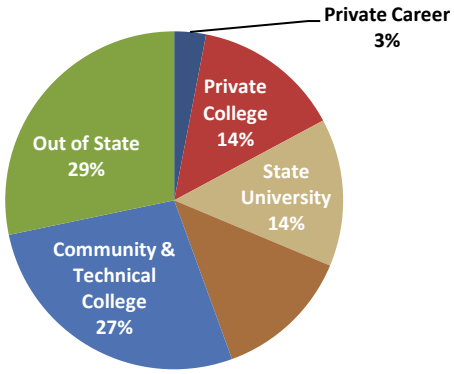


Source: Minnesota Office of Higher Education (for Minnesota institutions); U.S. Department of Education, Enrollment Survey (for out of state)

[1] *Trostel, P. (2010). The fiscal impacts of college attainment. Research in Higher Education, 51(3), 220-247.*

[2] *Robles, B. (2009). Exploring the wealth returns to Latino higher educational attainment: estimates of work-life earnings profiles. Journal of Hispanic Higher Education, 8(1), 5-22. College enrollment rates are referred to as college participation. College participation rates are defined as the number of high school graduates who enroll in a postsecondary education institution the fall after high school graduation. Participation rates are calculated by dividing the number of Minnesota high school graduates by the number who attended a Minnesota postsecondary institution the fall following their year of high school graduation. The Office of Higher Education's student enrollment record database contains data on students' year of high school graduation, state of residence, and high school attended. New entering students, defined as not having previously attended a postsecondary institution, except while a secondary student, are used in calculating participation rates.*

Figure CE-2: Type of college,Minnesota high school graduates, 2010

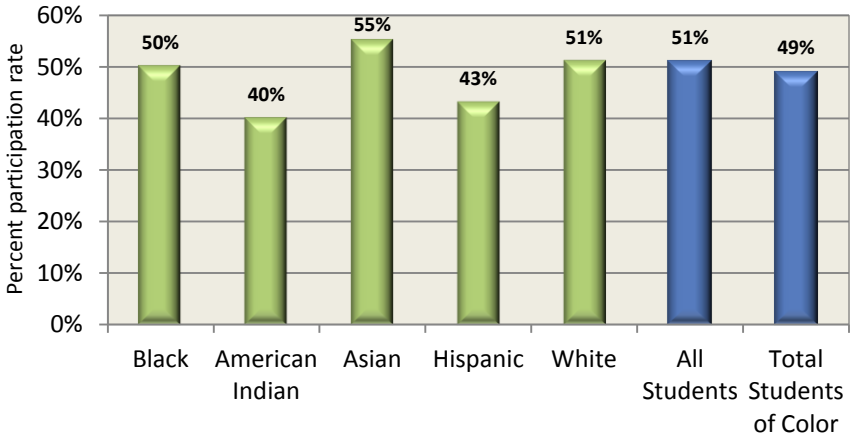


Source: Minnesota Office of Higher Education (for MN institutions); U.S. Department of Education Enrollemnt Survey (for out of state)

In 2010, there were 63,781 high school graduates in Minnesota. A majority of graduates chose to enroll in a Minnesota college.

Participation rates by race and ethnicity are available only for students attending Minnesota institutions, so a complete picture of college participation of Minnesota's high school graduates by race and ethnicity is not available.

Figure CE-3: Five year average college participation rates of Minnesota high school graduates who enrolled in a Minnesota postsecondary institution by race, fall 2006-2010



Source: Minnesota Office of Higher Education

While college participation rates for various racial and ethnic populations can vary by several percentage points from year to year, Asian high school graduates typically enroll in Minnesota postsecondary institutions at rates higher than other populations.

MINNESOTA COMPARES WELL WITH COLLEGE PARTICIPATION RATES NATIONALLY

Table CE-4: Percentage of high school graduates going directly to college in Minnesota and nationally, selected years

Top 3 States 2004		Top 3 States 2006		Top 3 States 2008	
South Dakota	68.8%	Mississippi*	76.1%	Mississippi*	77.4%
New York	67.9%	New York	74.4%	Massachusetts	74.6%
North Dakota	67.6%	North Dakota	72.3%	New York	74.2%
Minnesota (5th)	65.3%	Minnesota (9th)	68.4%	Minnesota (8th)	69.2%
Nation	55.7%	Nation	61.6%	Nation	63.3%

**Note: Mississippi has one of the lowest high school graduation rates in the nation, ranking 46th at 59.5 percent. It may rank first in college going due to the likelihood that the small percent who do graduate are more likely to enroll in college. Mississippi has the highest percent of its college students enrolled in 2-year institutions than other states.*

Source: Postsecondary Education Opportunity

FAMILY READING TO CHILDREN

Reading to young children is a critical step in improving academic outcomes and closing achievement gaps. Reading to young children promotes language and literacy development and, longer-term, boosts achievement in reading comprehension and overall success in school. The percentage of young children read to daily by a family member is one indicator of how well young children are being prepared for school.[1]

By the age of two, children who are read to regularly display greater language comprehension, larger vocabularies and higher cognitive skills than their peers who were not read to. Being read to also aids in the socio-emotional development of young children giving them the skills to become independent readers and to transition successfully from infancy to toddlerhood.[2]

In the U.S., 62% of high socioeconomic status (SES) kindergartners are read to every day by their parents, compared to 36 percent of kindergartners in the lowest SES group. White and Asian-American children who live with two parents, and children with mothers with higher education levels are more likely to have a parent read to them daily compared to their counterparts who were Black or Hispanic, lived with one parent, or had mothers with lower educational levels. By age 4, the average child in a professional family hears about 20 million more words than the average child in a working-class family, and about 35 million more words than children in low-income families.[2,3,4]

The Healthy People objective is to increase the proportion of parents who read to their young child age 0-5 years from 47.8 percent in 2007 to 52.6 percent by 2020.[5]

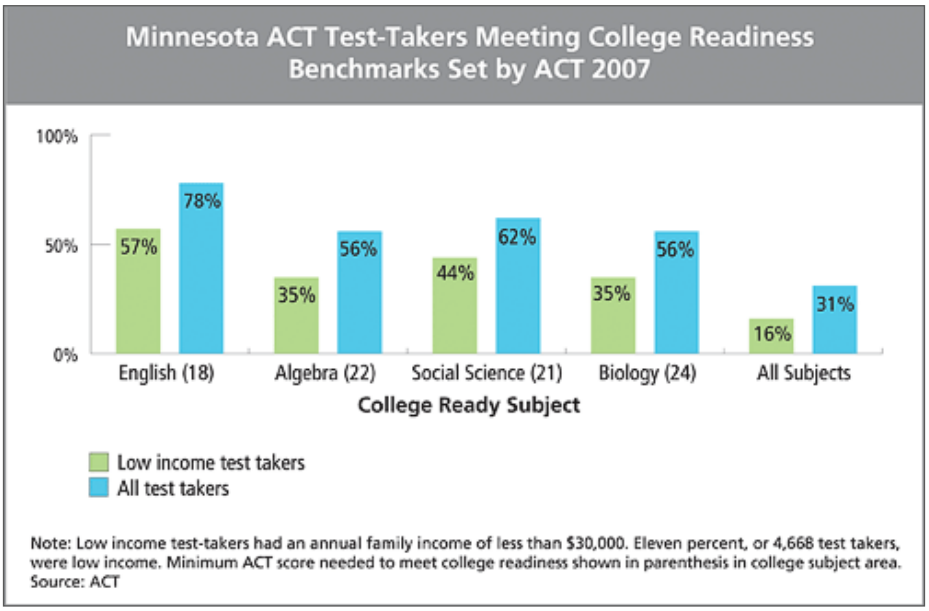
[1] *Weigel, D., Martin, S.S., & Bennett, K. K. (2006). Contributions of the home literacy environment to preschool-aged children's emerging literacy and language skills. Early Childhood Development & Care, 176(3/4), 357-378.*
[2] *http://www.childtrendsdatabank.org/indicators/5ReadingtoYoungChildren.cfm.*
[3] *Hammer, C.S., Farkas, G., Maczuga, S. (2010). The language and literacy development of Head Start children: A study using the Family and Child Experiences Survey database. Language, Speech & Hearing, 41(1), 70-83.*
[4] *Rodriguez, E. T., Tamis-LeMonda, C., Spellman, M. E., Pan, B.A., Raikes, H., Lugo-Gil, J., & Luze, G. (2009). The formative role of home literacy experiences across the first three years of life in children from low-income families. Journal of Applied Developmental Psychology, 30(6), 677-694.*
[5] *Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=10.*

HIGH SCHOOL COURSE TAKING

Disparities persist in the academic achievement among high school students. As Minnesota grows increasingly more diverse, effectively addressing achievement gaps becomes an urgent moral and economic imperative. Seventy-two percent of Minnesota high school graduates in 2011 took the Minnesota's Comprehensive Assessment. On average, low-income students and students who are Black, American Indian or Hispanic posted dramatically lower-than-average scores on the assessment as well as the ACT college entrance exam.[1] Minnesota's average composite ACT score of 22.9 was the highest in the nation among the 27 states in which more than half the college-bound students took the test in 2011. Minnesota has led the nation in average composite ACT scores for seven consecutive years. College preparatory classes taken in high school are positively correlated with high ACT test scores.

Students completing more rigorous courses in core academic subjects in high school consistently score higher on standardized tests and college entrance assessments. These students are more likely to participate and succeed in college. Two exam results illustrate the academic strengths and weaknesses of Minnesota high school students: the Minnesota Comprehensive Assessments and the ACT exam.

Figure HSCT-1:



[1] *ACT, College Board, Minnesota Department of Education, Minnesota Office of Higher Education http://www.ohe.state.mn.us/mPg.cfm?pageID=792.*

Table HSCT-2:

Minnesota ACT Test-Takers Meeting College Readiness Benchmarks Set by ACT by Race/Ethnicity 2008

	ACT Percent College Ready by ACT Score in:				
	English Composition: score of 18 or higher in English	Social Science: score of 21 or higher in reading	College Algebra score of 22 or higher in math	Biology: score of 24 or higher in science	All Four Subject Areas
All students	77%	64%	56%	40%	32%
American Indian	64%	58%	38%	23%	18%
Asian	55%	41%	41%	25%	19%
Black	38%	26%	16%	9%	5%
Hispanic	59%	50%	34%	22%	17%
White	81%	67%	59%	42%	34%

Note: The data in this table are from 2008 whereas the chart above presents 2007 ACT data.
Source: ACT

All Minnesota high school students have opportunities to prepare for college by challenging themselves with college-level courses in high school.[2] Students may:

- Enroll in the College Board's Advanced Placement courses either at their local high school or online.
- Enroll in classes at local colleges through the Minnesota Postsecondary Enrollment Options (PSEO) program.
- Enroll in "college in the schools" or other concurrent enrollment classes at their high school (these classes are part of the PSEO alternative to attending a college).
- Enroll in the International Baccalaureate curriculum at participating high schools.

Approximately 20 percent of Minnesota high school seniors earn college credits by the time they graduate from high school.

Eight percent, or 2,592 students who graduated from a Minnesota high school during 2006-07 and enrolled in a Minnesota postsecondary institution in fall 2007, had earned enough college credits through one or more of the above activities to have a college class standing of sophomore or higher upon admission.

College Remediation

A number of Minnesota high school graduates take remedial coursework once in college. A recent report[3] highlights developmental and remedial course work of recent Minnesota high school graduates:

- 40 percent of Minnesota's recent public high school graduates who enrolled in public higher education in the state have taken at least one developmental or remedial course within two years after graduation.
- Most students take only one remedial course.
- Math is the weakest area.
- Students who take developmental courses are increasingly concentrated in the two-year colleges.

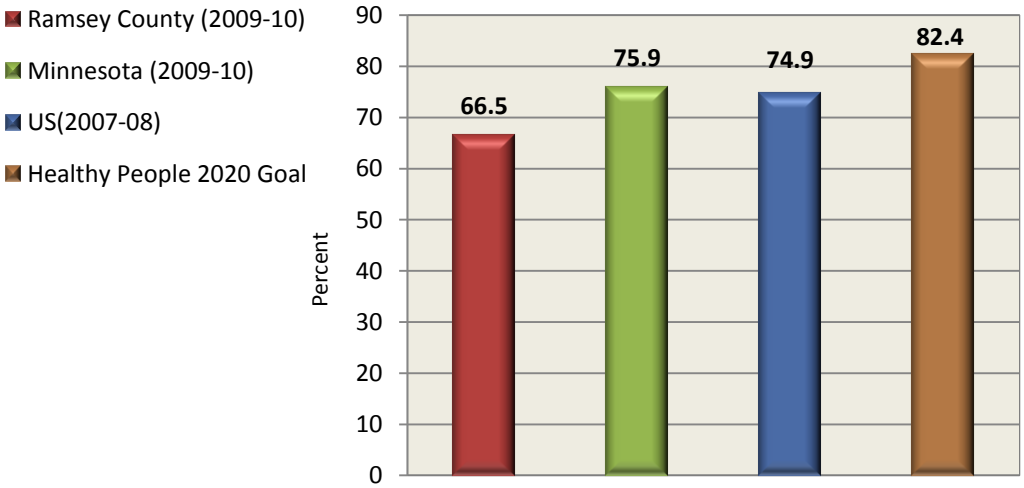
[2] *Getting Prepared: A 2010 Report on Recent High School Graduates Who Took Developmental/Remedial Courses State-Level Summary and High School Summary January 2011 Minnesota State Colleges and Universities http://www.mnscu.edu/media/publications/index.html.*
[3] *Ibid.*

HIGH SCHOOL COMPLETION

Earning a high school diploma or its equivalent indicates that a person has acquired the basic reading, writing, and mathematics skills needed for most forms of employment. In 2007, 89 percent of persons aged 18 to 24 years old had completed high school in the United States.[1]

Ramsey County lags behind Minnesota and the United States in terms of the percent of students who graduated with a regular diploma in 2007-08, 4 years after starting 9th grade. The Healthy People 2020 goal is 82.4% in recognition of the strong correlation between education attainment and health, something that has also been recognized by the international Organization for Economic Cooperation and Development (OECD).[2]

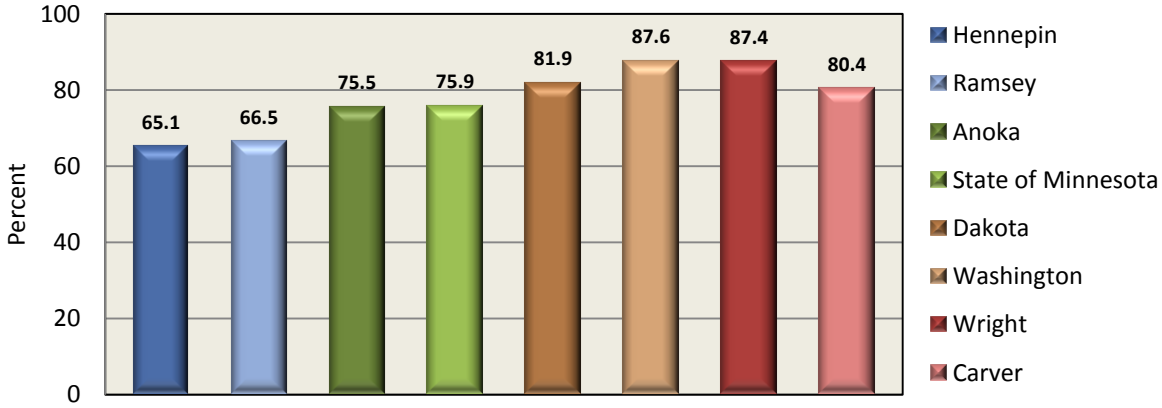
Figure HSC-1: On-time four-year graduation rate, Ramsey County, MN, 2010



Source: Minnesota Department of Education, MN KIDS COUNT

Four-year high school graduation rates for all students are just under 60% in St. Paul. Suburban districts tend to be above 70%.

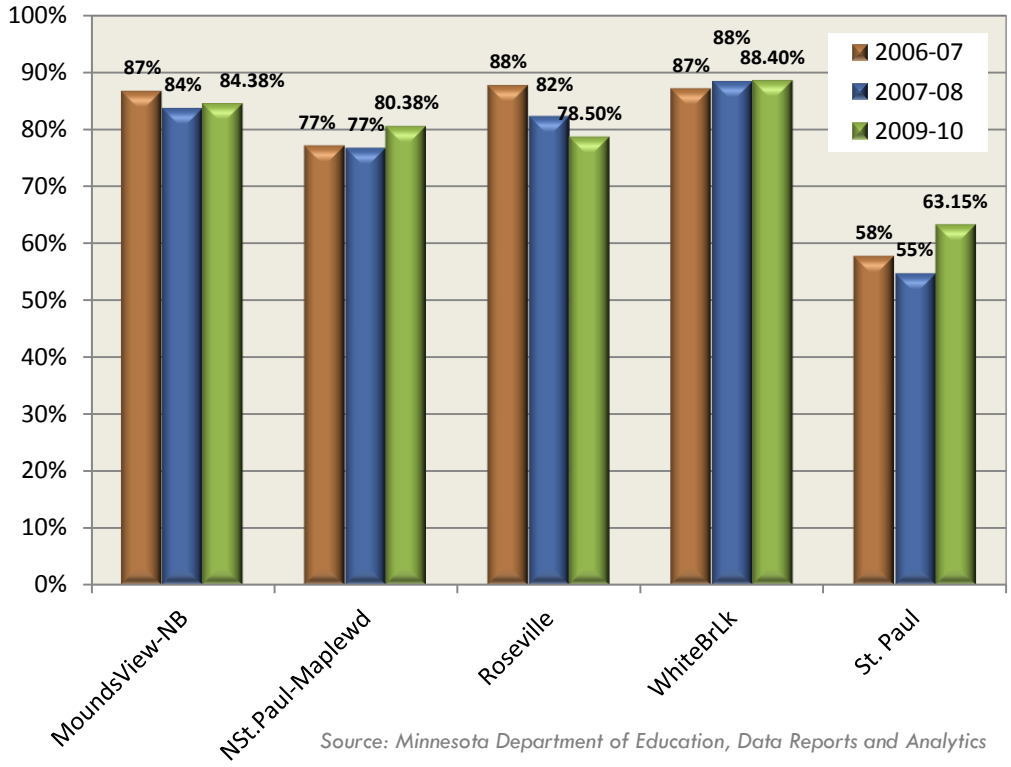
Figure HSC-2: On-time four-year graduation rate, selected counties, MN, 2010



Source: Minnesota Department of Education

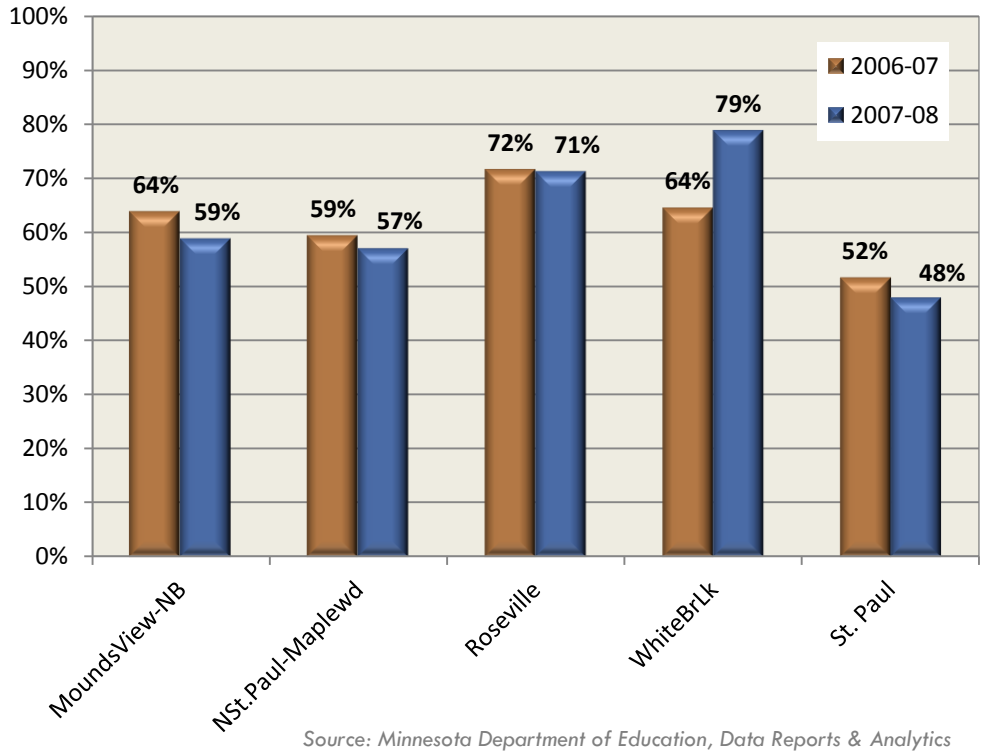
[1] Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=11.
[2] Siddiqi, A., Kawachi, I., Berkman, L., Hertzman, C., & Subramanian, S.V. (2012). Education determines a nation's health, but what determines educational outcomes? A cross-national comparative analysis. Journal of Public Health Policy, 33(1), 1-15.

Figure HSC-3: On-time graduation rate by school district, Ramsey County, MN 2006-2010



Source: Minnesota Department of Education, Data Reports and Analytics

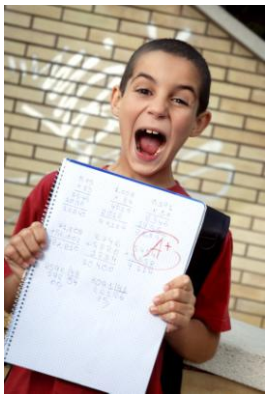
Figure HSC-4: On-time graduation for students who receive free and reduced school lunches by district, Ramsey County, MN, 2006-2008



Source: Minnesota Department of Education, Data Reports & Analytics

Students eligible for Free & Reduced Lunches are from families whose incomes are below 185% of the Federal Poverty Guidelines. These students are more likely to be students of color but since the Recession, many more children are eligible for the program than in recent years.

MATH AND READING ACHIEVEMENT



The extent and content of students' knowledge as well as their ability to think, learn, and communicate affect their likelihood of becoming productive adults and active citizens. Mathematics and reading achievement test scores are important measures of students' skills in these subject areas and good indicators of overall achievement in school.[1]

Results from a new study of student achievement for the high-school graduating class of 2011 show that U.S.students rank 32nd among industrialized nations in proficiency in math and 17th in reading.[2] Comparing students' math achievement across states, the study finds the highest performing state to be Massachusetts. Minnesota is among the top ten performing states.

The statewide results of Minnesota public high school students in 2008 indicate 71 percent were meeting the minimum competency standards set by the Minnesota Department of Education in reading and 34 percent in math. Gaps in math were especially acute for low-income students and students of color.

Figure MRA-1:

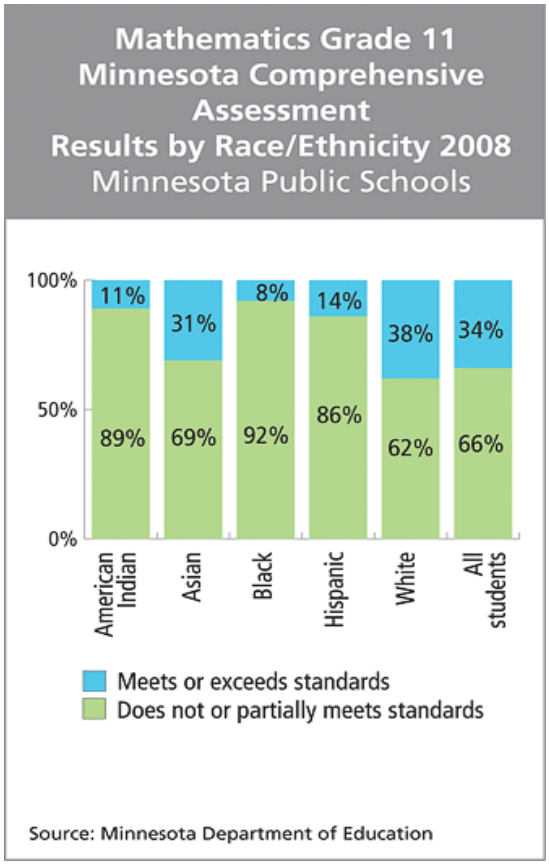
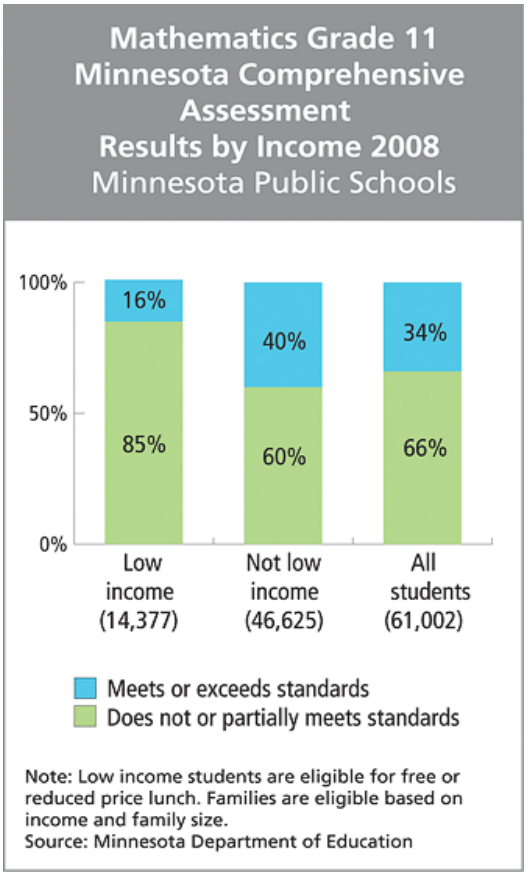


Figure MRA-2:



[1] *Federal Agency Forum on Child and Family Statistics (2011).* America's Children: Key National Indicators of Well-Being, 2011, Mathematics and Reading Achievement. Retrieved from: *http://www.childstats.gov/americaschildren/edu2.asp.*

[2] *Paul E. Peterson, Ludger Woessmann, Eric A. Hanushek, Carlos X. Lastra-Anadón. (2011). Globally Challenged: Are U. S. Students Ready to Compete? The latest on each state's international standing in math and reading. Retrieved from http://www.hks.harvard.edu/pepg/PDF/Papers/PEPG11-03_GloballyChallenged.pdf.*

MINNESOTA COMPREHENSIVE ASSESSMENTS

Minnesota Comprehensive Assessments measure student progress toward Minnesota's academic standards for K-12 education. All public school students in grades three through eight take reading and mathematics assessments. Students in grade 10 take reading assessments and students in grade 11 take mathematics assessments.

Table MRA-3: MN Assessments 3rd grade reading and 11th grade math	**Most recent year**
Percent meeting or exceeding standards in 3rd grade reading	
Ramsey County	66.4% (2011)
St. Paul	57.4% (2010)
State of Minnesota	76.3% (2010)
Percent meeting or exceeding standards in 11th grade math	
Ramsey County	41.2% (2011)
St. Paul	27.2% (2010)
State of Minnesota	43.3% (2010)

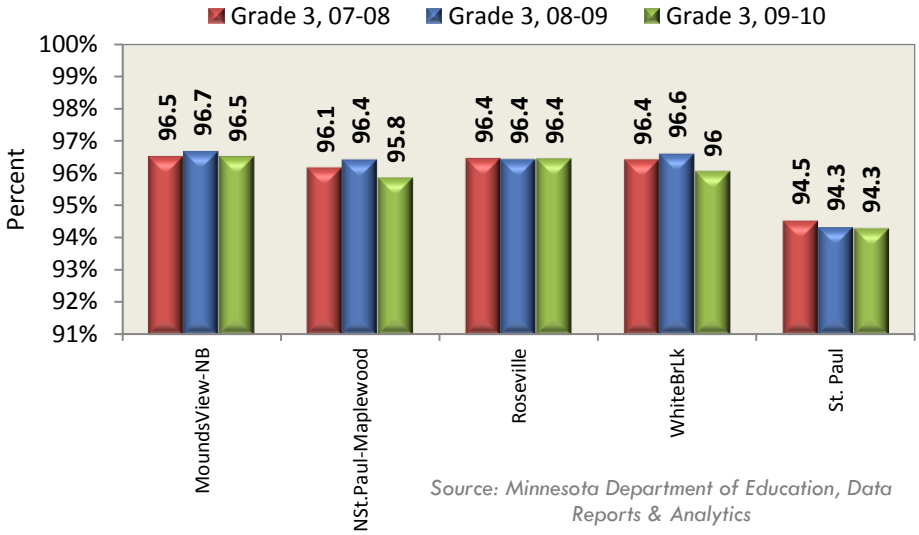
Source: Minnesota Department of Education

Overall, Ramsey County students' performance on state assessments is 2-9% lower other students in Minnesota.

SCHOOL ATTENDANCE

School attendance is a critical measure of student engagement for all grade levels, but research shows that three grade levels are of particular importance: 3rd, 6th, and 9th grade.[1] Research shows that graduation can be accurately predicted by school attendance in the earliest grades (between first and third grades).[2] Third grade is also the first year in which standardized testing is undertaken for most subjects in Minnesota schools and is the grade by which students should be reading well. Sixth grade is an important middle school year for all teens and ninth grade is a key transition year to high school. In particular, students who are struggling in school have an increased likelihood of dropping out in 9th grade.[3]

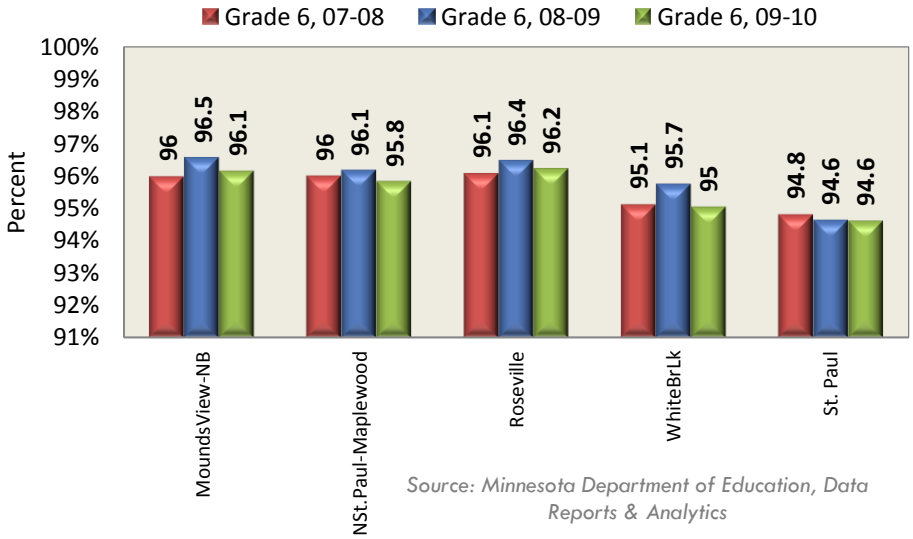
Figure SCH-1: Grade 3 attendance rate by district, Ramsey County, MN, 2007-2010



Source: Minnesota Department of Education, Data Reports & Analytics

While attendance remains fairly stable county-wide in 3rd and 6th grades, attendance rates are increasing for 9th graders in three out of five Ramsey County districts.

Figure SCH-2: Grade 6 attendance rate by district, Ramsey County, MN, 2007-2010



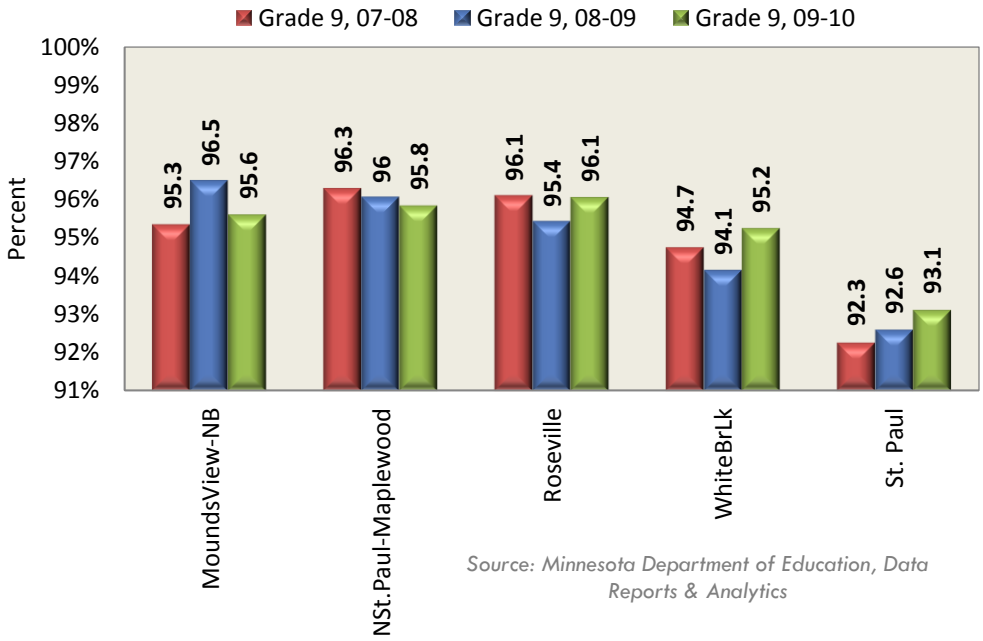
Source: Minnesota Department of Education, Data Reports & Analytics

[1] *E.M. Allensworth, J.Q. Easton, What Matters for Staying On-Track and Graduating in the Chicago Public High Schools. University of Chicago, 2007; C. D. Jerald, Identifying Potential Dropouts: Key Lessons for Building an Early-Warning Data System: A Dual Agenda of High Standards and High Graduation Rates, white paper prepared for Staying the Course: High Standards and Improved Graduation Rates, a joint project of Achieve and Jobs for the Future, funded by Carnegie Corporation of New York (2006).*

[2] *Ibid.*

[3] *Ibid.*

Figure SCH-3: Grade 9 attendance rate by district, Ramsey County, MN, 2007-2010

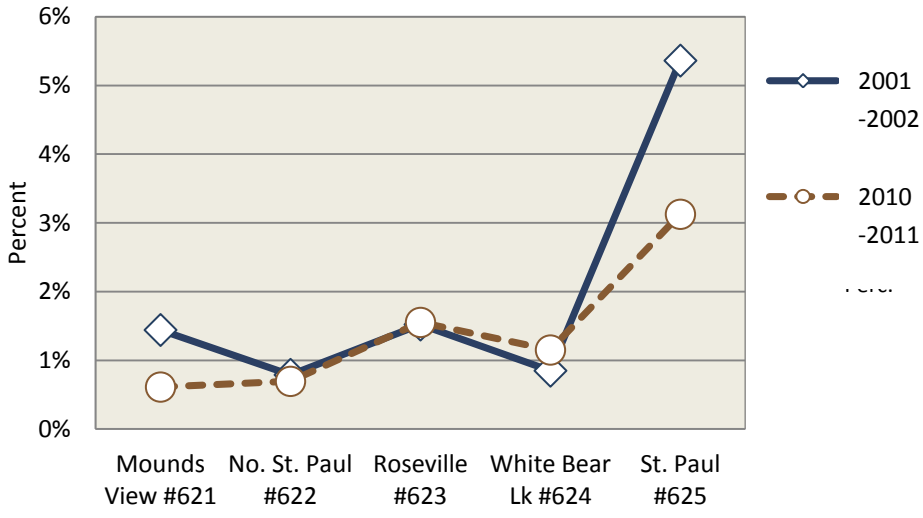


Source: Minnesota Department of Education, Data Reports & Analytics

Since 1995, the Ramsey County Attorney's Truancy Intervention Program (TIP) has worked in collaboration with schools to address the problem of truancy in Ramsey County for all students age 12-17. TIP provides a mechanism for schools to report truancy and quickly address the problem of excessive school absences. Early identification and intervention with at-risk youth has been the hallmark of the Truancy Intervention Program. It is well established that improved attendance leads to improving academic achievement and an increase in school completion rates.[4]

- Since TIP was established, more than 31,000 students from 150 schools have been referred to the program; 1,293 students were referred in the 2009-2010 school year.
- During the 2009-2010 school year 76% of Saint Paul students in the program improved their attendance.
- Filings for truancy petitions have dropped approximately 50% since TIP started.

Figure SCH-4: Percentage TIP referrals as a percentage of total enrollment by district, Ramsey County, MN, 2001-2002 and 2010-2011



Source: Ramsey County Attorney's Office, 2011

Truancy has decreased in all school districts except Roseville and White Bear over the last decade. The greatest increase in regular school attendance is in the St. Paul Public Schools.

[4] Retrieved from: http://www.co.ramsey.mn.us/Attorney/TIPOverview.htm

Table SCH-5: Selected characteristics of students, Ramsey County, MN 2006-2010

Education (Prekindergarten to 12th Grade)	2006-07	2007-08	2008-09	2009-10
Total Enrollment	84,471	83,815	83,710	84,542
Students Eligible for Free or Reduced Meals (Percent)	49.5	50.5	50.8	54.0
Students with Limited English Proficiency (Percent)	23.4	22.0	23.5	21.5
Students Receiving Special Education (Percent)	14.9	15.1	15.3	15.7

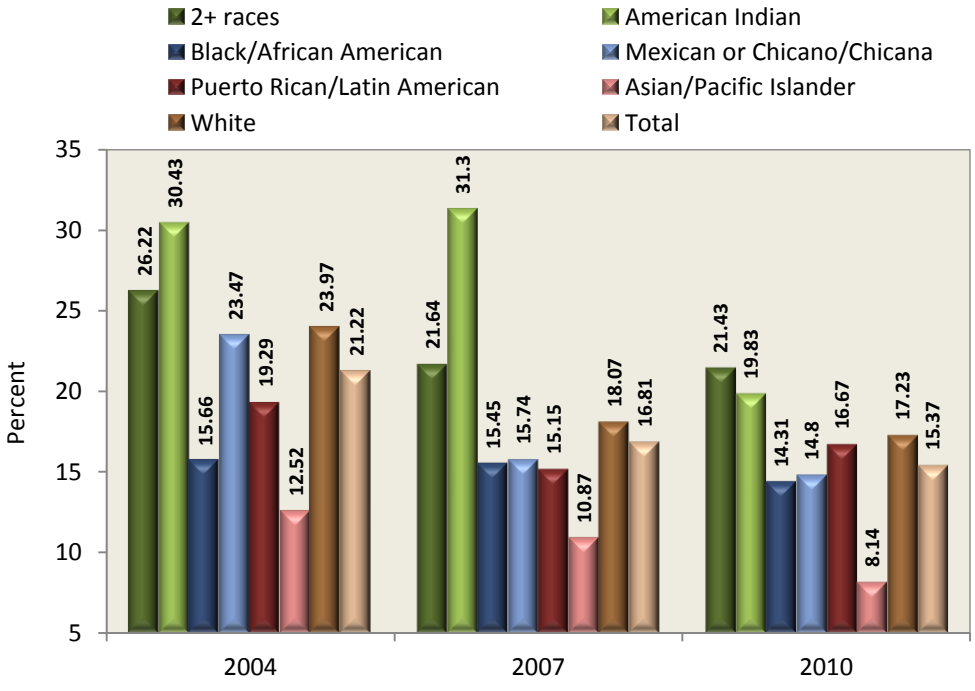
Source: Minnesota Department of Education

Over half of Ramsey County students receive free or reduced lunch

One in every five students in Ramsey County has limited English proficiency.

One in every six students receives special education services.

Figure SCH-6: Percentage of 6th, 9th and 12th graders that report not liking or hating school by race/ethnicity, Ramsey County, MN, 2004 - 2010



Source: Minnesota Student Survey

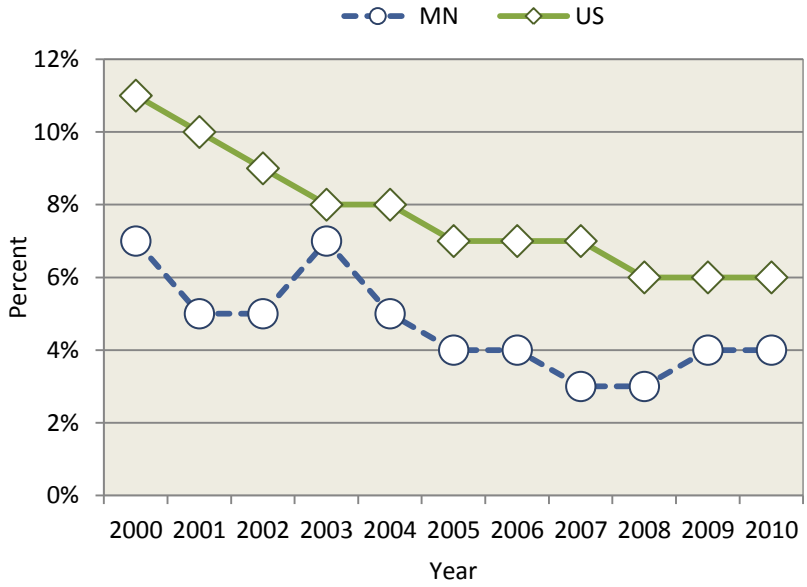
Even though school attachment in Ramsey County is improving, 20% of American Indian and mixed race students still report not liking or hating school.

YOUTH NEITHER ENROLLED IN SCHOOL NOR WORKING ("DISENGAGED YOUTH")

Youth ages 16-19 years who are neither in school nor working are detached from activities that play an important role in the developmental transition from adolescence to adulthood. Such detachment, particularly if it lasts for several years, decreases a youth's opportunities to build a work history or complete education that contribute to future employability and earnings potential.

Four percent of Minnesota teens, ages 16-19 yrs, were not in high school or working in 2009-10.

Figure YNE-1: Percentage of teens 16-19 years not working and not in high school, Minnesota and US, 2000-2010



Source: Population Reference Bureau, analysis of data from U.S. Census Bureau, American Community Survey

Minnesota's rate of disengaged youth is consistently lower than the national rate but any loss of youth potential represents costs to communities later on in remedial education (GED programs) and the development of employment skills.

7 HEALTH

ASTHMA

Asthma is a chronic disease that impairs normal breathing and is one of the most common chronic diseases in the United States. Asthma is an increasing concern in Minnesota and across the country because of rising incidence rates, especially in children. Asthma disproportionately impacts children, females, African-Americans, and people with low incomes. A meta-analysis of studies of the effects of asthma on children shows that although children with asthma tend to miss more days of school than children without, they tend to perform equally well academically.[1] Over the life-course, however, there is some evidence that children from deprived areas tended to miss more school than their more well-off peers and adults who had asthma as a child may experience economic disadvantage in life. This may also be due to the fact that asthma disproportionately affects poor children.[2]

Each year, asthma costs the U.S. about $3,300 per person (with asthma) in medical expenses, missed school and work days, and early deaths.[3] Nine percent of Minnesota children (age 0-17) have been diagnosed with asthma at some point in their lives and one in 16 children currently has asthma.[4] Black children are more likely to have asthma (17 percent) than Hispanic children (8 percent) or non-Hispanic white children (8 percent). Environmental factors (e.g., pests, mold and pollen, tobacco or wood smoke, indoor and outdoor air pollution) exacerbate asthma.

In the table ASM-1 below, a student is defined as having current asthma if he or she has ever been diagnosed with asthma *and* has had asthma-like symptoms in the past 12 months. About one in eight Minnesota students (11.8% in middle school; 12.9% in high school) meet the criteria for current asthma. Rates for current asthma are the same for males and females in middle school, while females have higher rates than males in high school.[5]

Table ASM-1: Percentage of Minnesota students with current asthma, by gender, 2011

	Middle school			High School		
	Female	**Male**	**Total**	**Female**	**Male**	**Total**
Percent with current asthma-has been diagnosed in lifetime and reports symptoms in past 12 months*	11.9%	11.6%	11.8%	14.3%	11.5%	12.9%

Source: Minnesota Department of Health Center for Health Statistics, 2011 Minnesota Youth Tobacco and Asthma Survey
**The survey questions are: "Has a doctor or nurse ever told you or your parents that you have asthma?" and "During the past 12 months, have you had wheezing, tightness in your chest, or other symptoms of asthma?"*

[1] *Milton, B., Whitehead, M., Holland, P., & Hamilton, V. (2004). The social and economic consequences of childhood asthma across the life course: a systematic review. Child: Care, Health & Development, 30(6), 711-728.*

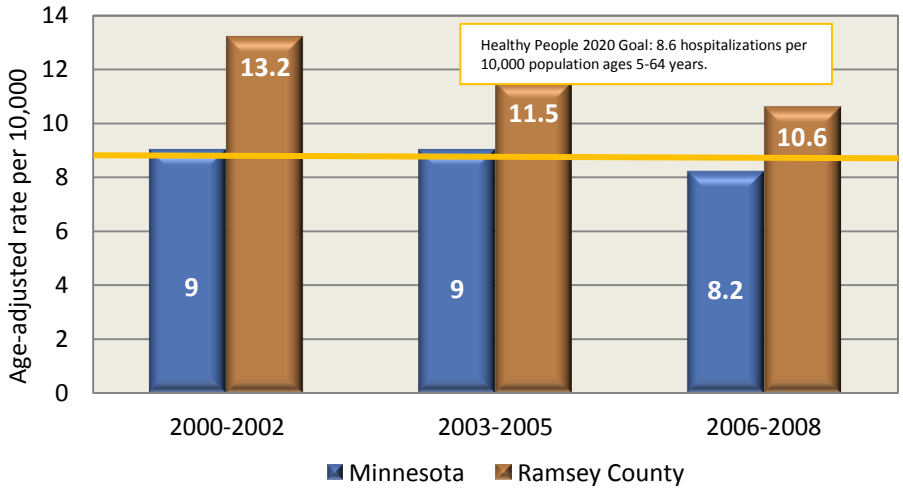
[2] *Ibid.*

[3] *National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.*

[4] *National Survey of Children's Health, 2007. http://www.nschdata.org.*

[5] *Teens and Tobacco in Minnesota, 2011 Update: Results from the Minnesota Youth Tobacco and Asthma Survey. Minnesota Department of Health Division of Health Policy, Center for Health Statistics. December 2011.*

Figure ASM-2: Rate of asthma hospitalizations, Ramsey County and Minnesota, 2000-2008



Source: Minnesota Department of Health Public Health Data Access

In Minnesota, the rates of hospitalizations and emergency department visits for asthma are highest for children under 5 years old and residents of the Minneapolis-St. Paul metropolitan area.

Source: Minnesota Hospital Association, 2009

DIET QUALITY

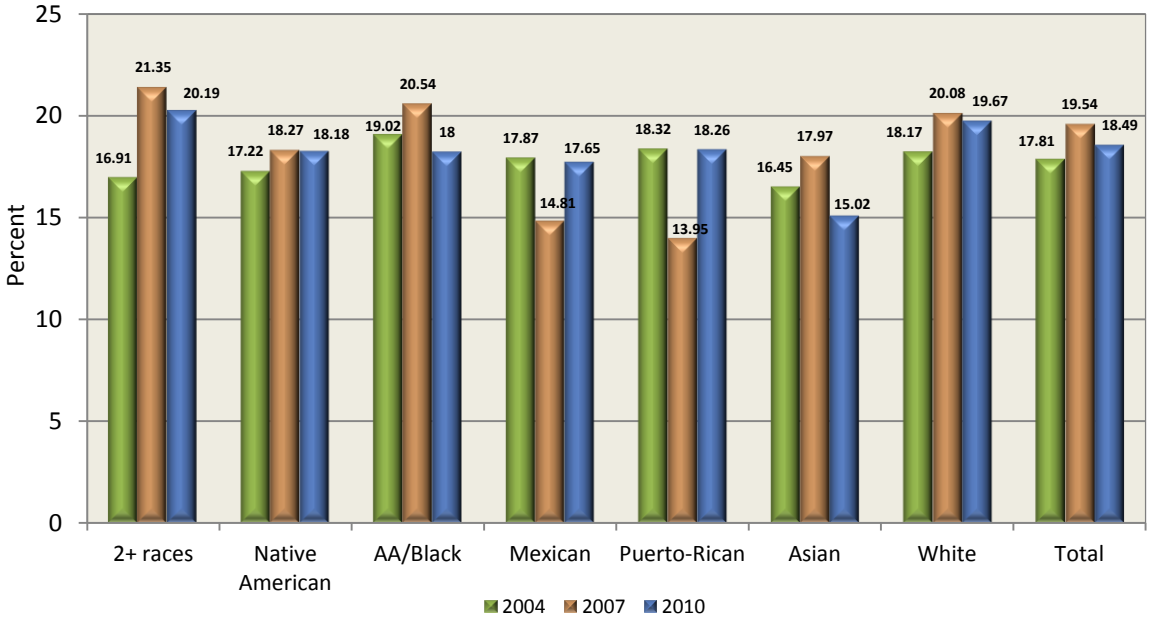
Poor eating patterns in childhood are major contributors to childhood obesity and contribute to chronic diseases starting in childhood. Diseases such as type 2 diabetes and those that emerge throughout the life cycle, such as cardiovascular disease, are directly linked to poor eating. The Healthy Eating Index-2005[1] is a dietary assessment tool measuring how well diets meet the recommendations of USDA's food guidance system.

Diet quality scores of children would be improved by increasing the intake of vegetables, beans, fruits, and whole grains, and by decreasing the intake of saturated fat, sodium (salt), and the extra calories from saturated fats and added sugars.

In the U.S. in 2007–2008, the average diet quality score for all children met or exceeded the standards only for total grains. Only the youngest children (ages 2–5) met or exceeded the standards for total fruit, whole fruit, and milk. All other diet quality components failed to meet standards.

National studies of diet quality show that some sub-groups of Americans eat better than others. In a multi-state study of Head Start mothers, most mothers obtained more than 35% of their energy from fat. However, Hispanic American mothers averaged much higher fruit and vegetable consumption than any other ethnic or race group.[2] These findings were similar to an examination of grocery purchasing patterns in an urban setting in which Hispanics purchased a greater percentage of vegetables and fruits than other racial groups.[3]

Figure DQ-1: Percentage of 6th, 9th and 12th graders that reported eating 5 or more servings of fruits and vegetables a day by race, Ramsey County, MN, selected years



Source: Minnesota Student Survey

[1] *Retrieved from: http://www.cnpp.usda.gov/HealthyEatingIndex.htm.*

[2] *Hoerr, S., Tsuei, E., Liu, Y., Franklin, F., & Nicklas, T. (2008). Diet quality varies by race/ethnicity of Head Start mothers. Journal of the American Dietetic Association, 108(4), 651-659.*

[3] *Cullen, K., Baranowski, T., Watson, K., Nicklas, T., Fisher, J., O'Donnell, S., Baranowski, J., Islam, N., Missaghian, M. (2007). Journal of the American Dietic Association, 107(10), 1747-1752.*

Over 23 million people, including 6.5 million children, live in "food deserts" – neighborhoods that lack access to stores where affordable, healthy food is readily available (e.g., full-service supermarkets, grocery stores).[4] These communities commonly have an abundance of fast food restaurants and convenience stores that offer foods high in calories but low in nutritional value. There is a correlation between lack of access to supermarkets and diet-related disease.[5]

Areas with the fewest supermarkets in St. Paul include the neighborhoods of Thomas-Dale/Frogtown, Dayton's Bluff, North End, Summit-University and St. Anthony Park.

Minnesota has fewer supermarkets per capita than most states. Compared to national averages, Minnesota has 40 too few supermarkets. This shortage means that residents, particularly those in lower-income communities, face greater challenges finding fresh produce and the foods necessary to maintain a healthy diet.

The Food Trust conducted an extensive mapping study of Minnesota to identify communities with limited access to supermarkets and high areas of diet-related disease. They found that supermarkets in the Twin Cities are disproportionately located in higher-income communities.[6]

WIC (Women, Infants and Children) participants receive a health assessment, which includes measurement of height, weight, and hemoglobin, as well as evaluation of diet and health history. Based on the results of assessments, nutrition counseling is provided. Participants with higher risk conditions (failure to gain weight in pregnancy, underweight, low hemoglobin, overweight, etc.) are referred to their medical clinic and/or public health nurses as well as to WIC's high risk counselors for additional nutrition counseling.

WIC participants receive vouchers for nutritious foods, including fruits and vegetables, low fat milk, whole grain bread, brown rice, iron-rich cereals, eggs, and peanut butter. WIC offers referrals to services in the community, including medical care, home visiting nurses, Head Start, Early Childhood Family Education and many other programs. WIC also provides breast-feeding support and education. To be eligible, household income must fall within certain guidelines including family size and income to determine eligibility. Many people work and still qualify for WIC. Saint Paul - Ramsey County Public Health runs five WIC clinics, four in the city and one in New Brighton. All clinics have day and evening hours and are located on or near bus lines. In the last few months of 2011, Saint Paul - Ramsey County WIC served an average of 19,500 participants per month.

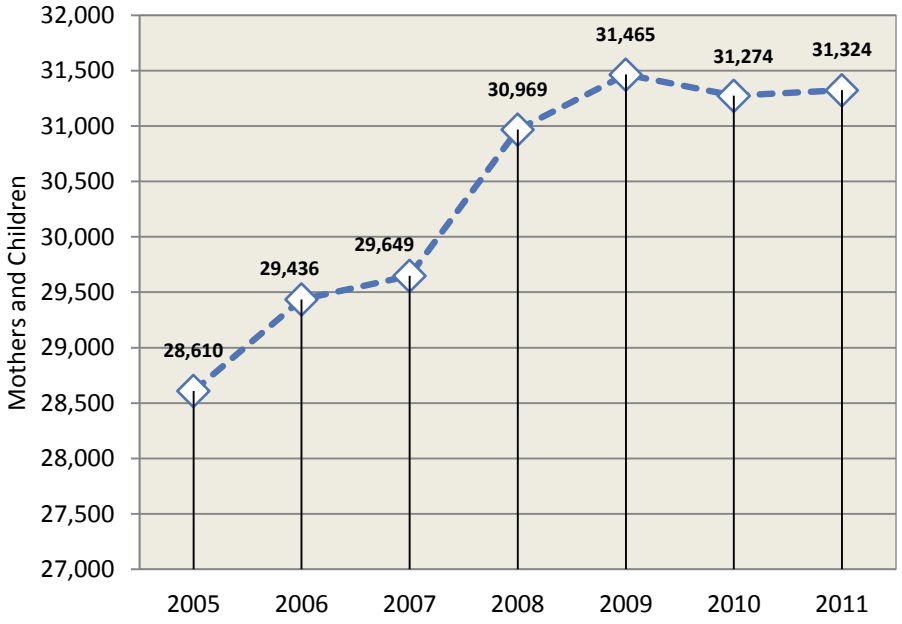
Slight reductions in the WIC caseload in recent years were due to a variety of factors, including a change in eligibility guidelines, declining birth rates, and the roll out of a new statewide computer system.

[4] *United States Department of Agriculture. Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences, United States Department of Agriculture, Economic Research Service, June 2009.*

[5] *Treuhaft, S. and Karpyn, A. (2010). The Grocery Gap: Who has Access to Healthy Food and Why it Matters. Oakland (CA): PolicyLink and the Food Trust.*

[6] *The Food Trust. (2011). Food for every child: The need for more supermarkets in Minnesota. Philadelphia, PA. www.thefoodtrust.org/.*

Figure DQ-2: Number of Ramsey County mothers and children receiving WIC, 2005-2011



Source: SPRCPH WIC Program

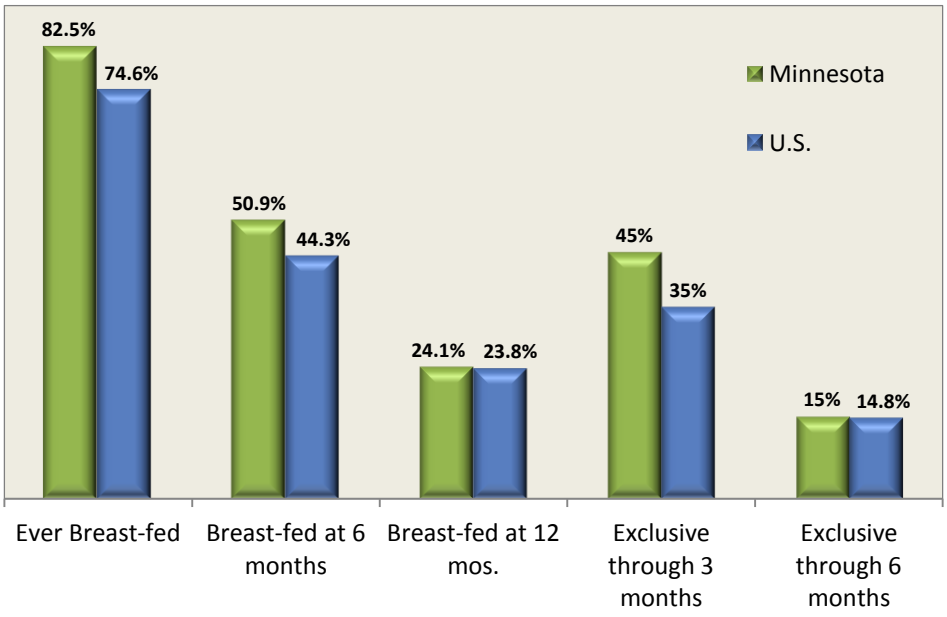
The period from 2008-2011 was marked by a reduction in the number of Minnesota mothers and children served by WIC. But while Minnesota's WIC participation fell by 8.244%, Ramsey County's WIC participation increased by 1.146% in this same period.

BREAST-FEEDING

Breast-feeding conveys important protective factors for infants, like boosting immune system response, and promotes maternal-child bonding. Babies who are breast–fed are less likely to become obese.[7] Although breast-feeding initiation rates have increased steadily since 1990 in the U.S., exclusive breast-feeding initiation rates have shown little or no increase over that same period. Similarly, 6 months after birth, the proportion of infants who are exclusively breast-fed has increased at a much slower rate than that of infants who receive mixed feedings.[8]

The American Academy of Pediatrics recommends breast-feeding for a year or more after birth.[9] Even though breast-feeding rates have not met that goal, Minnesota mothers breast-feed at a higher rate than mothers in the U.S. overall.

Figure DQ-3: Breast-feeding in Minnesota and the U.S., for children born in 2008



Source: CDC Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS) http://apps.nccd.cdc.gov/cPONDER/

Breastfeeding initiation in Minnesota is positively associated with prenatal participation in WIC. Mothers who participated in WIC for three or more months prenatally were more likely to breastfeed.[10]

[7] *National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.*
[8] *American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk. Pediatrics. Vol. 115 No. 2 February 2005, pp. 496-506. Retrieved from: http://aappolicy.aappublications.org/cgi/content/full/pediatrics%3B115/2/496.*
[9] *Ibid.*
[10] *Minnesota Department of Health WIC Program and CSFP. Breastfeeding in Minnesota's WIC Program. February 2012. Retrieved from: http://www.health.state.mn.us/divs/fh/wic/statistics/bffactsheet0312.pdf*

DISABILITY/ACTIVITY LIMITATION

In January 2011, the Centers for Disease Control & Prevention (CDC) released their Health Disparities and Inequalities Report.[1] Disability status was used for the first time as a measure in the report, recognizing that disability is a source of both health, and health care disparity. According to the report, disability includes impairments or limitations in activities or social participation as a result of an interaction between a person's environment and his or her health condition.

The CDC finds that persons with disabilities have greater disparity in health and socio-economic status including high school completion rates, living below the federal poverty level, and higher rates of chronic health conditions. Having a disability does not directly result in poor health outcomes. However, some disabilities complicate an individual's ability to access care, communicate effectively, or maintain healthy habits in the community. For instance, people living with certain intellectual disabilities and serious mental illness experience barriers to accessing substance abuse treatment when needed, and adults with developmental disabilities often struggle with the access, knowledge, and communication skills needed to access health care.[2,3] Overall, people with disabilities experience a host of negative health outcomes: they are disproportionately more likely to smoke, avoid physical exercise, and to be overweight. [4]

Approximately 59,000 American children between the ages of 5 - 17 (6.1% of this age group) have one or more disabilities. Difficulties with learning, remembering or concentrating accounted for most of the reported disabilities.

Table DA-1. Types of disabilities reported for children 5-17 years old, U.S., 2010

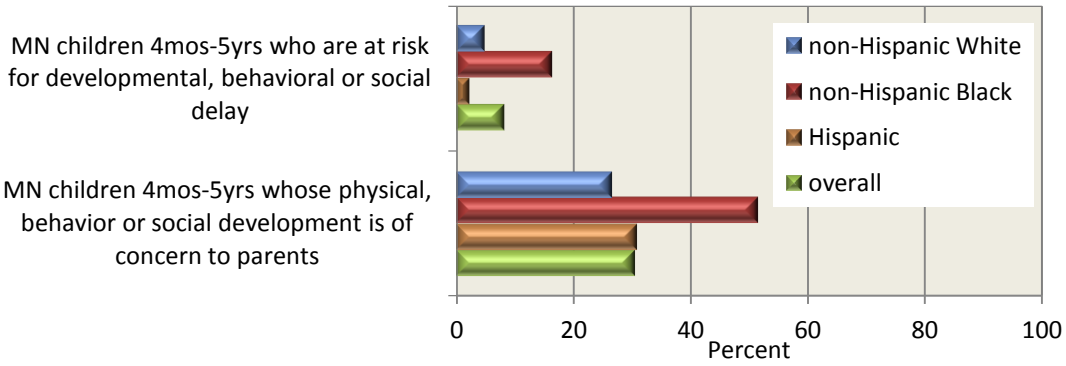
Percent with disability	
Blindness, deafness, severe vision or hearing impairment	**0.8%**
Difficulty with basic physical activities	**0.8%**
Difficulty learning, remembering, concentrating	**4.6%**
Difficulty with self care	**0.7%**
One or more disabilities	**6.1%**

Source: U.S. Census

Some disabilities present in young children very early while others take time to become evident. Children of color are disproportionately more likely to experience some form of disability.[5]

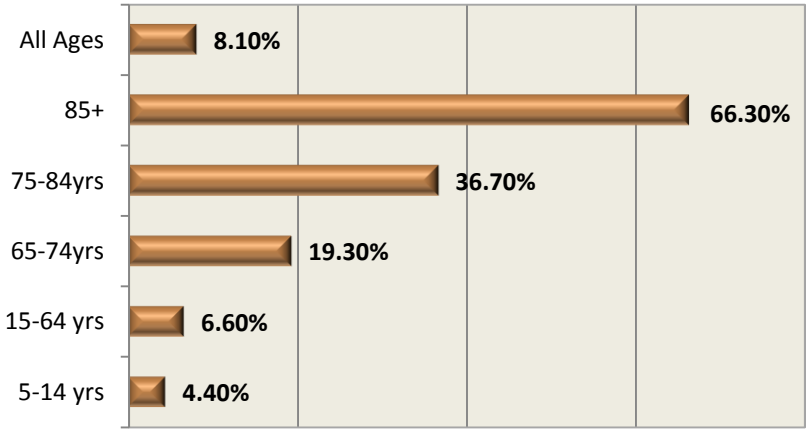
[1] *Centers for Disease Control and Prevention. Health Disparities and Inequalities Report-United States. MMWR 2011;60(Suppl).*
[2] *Slayter, E. (2010). Disparities in access to substance abuse treatment among people with intellectual disabilities and serious mental illness. Health & Social Work, 35(1), 49-60.*
[3] *Ward, R., Nichols, A., & Freedman, R. I. (2010). Uncovering health care inequalities among adults with intellectual and developmental disabilities. Health & Social Work, 35(4), 280-290.*
[4] *Iezzoni, I. (2011). Eliminating health and health care disparities among the growing population of people with disabilities. Health Affairs, 30(1), 1947-1954.*
[5] *MN report comparing results from the 2005/06 and 2009/10 national survey of children with special health care needs NS-CSHCN 2009/10. Child and adolescent health measurement initiative, Data Resource Center for Child and Adolescent Health. Retrieved from: www.childhealthdata.org*

Figure DA-2: Percentage of children who are at risk for delay or whose development is of concern to parents by race/ethnicity, Minnesota, 2007



Both children and adults can receive Social Security Insurance (SSI) payments when their disability interferes significantly with learning, employment or daily living. In 2010, 12,984 children received federally administered SSI payments.[6]

Figure DA-3: Percentage with a disability by age, Twin Cities 7-county region, 2008



Source: Compiled by MNCompass, from: Integrated Public Use Microdata Series from the U.S. Census Bureau, American Community Survey

[6] *Source: Social Security Administration, Supplemental Security Records*

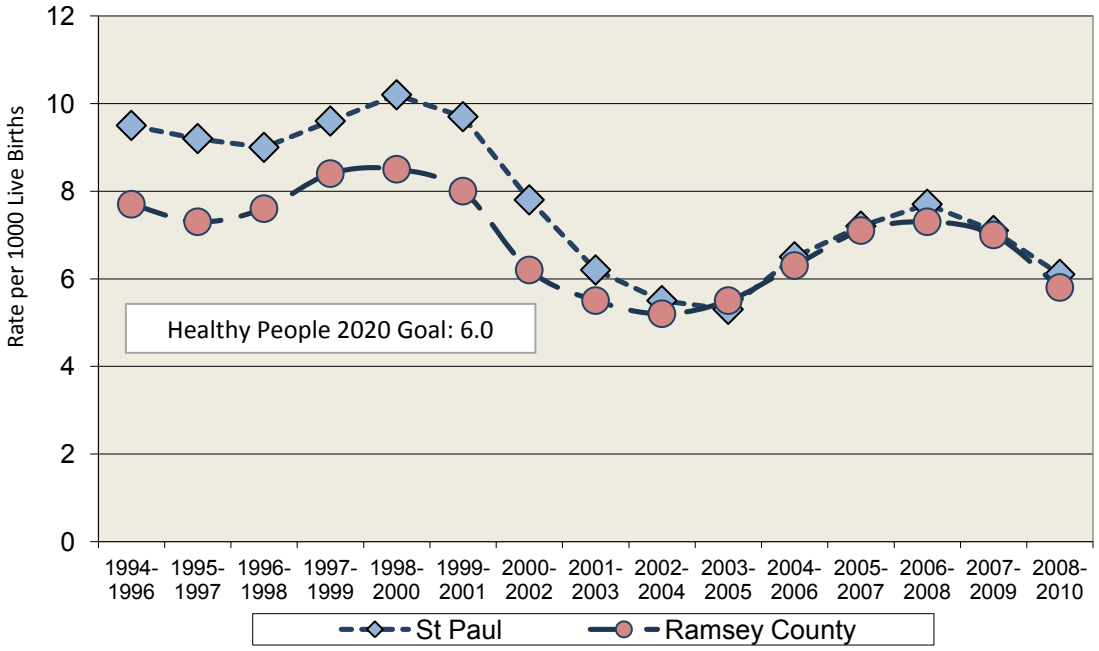
INFANT MORTALITY

Infant mortality is used to compare the health and well-being of populations across and within geographies and is a useful indicator of a geographic area's overall level of health or development. The estimated 2011 U.S. infant mortality rate is 6.06 infant deaths per 1,000 live births.[1] The 2010 preliminary infant mortality rate for black infants in the U.S. was 11.61 infant deaths per 1,000 live births, 2.2 times the rate for white infants.[2]

Minnesota consistently ranks among the states with the lowest infant mortality rates. Rates have declined for all racial and ethnic populations in Minnesota over the last 20 years. Nonetheless, significant disparities persist in mortality rates of African-American and American Indian infants, compared to all other population groups. The causes of infant mortality are not fully understood and vary by population: sleep-related causes, such as SIDS, are a primary source of infant deaths in the American Indian community, while prematurity is the leading cause of death among African-Americans. Birth defects are the main source of infant deaths in the Asian, Hispanic and white populations. Chronic stress, poverty, substance abuse, a lack of prenatal care, and a lack of access to health care all contribute to infant mortality.[3]

The 3-year average infant mortality rate for Ramsey County and Saint Paul during 2008-2010, has decreased after a period of increase in 2003-2005. The number of infant deaths is relatively low in any given year, which results in annual rates that fluctuate widely; therefore, three or five year averages give a more accurate picture of trends. The rates in St. Paul have been consistently higher than Ramsey County rates, but over the past five years that gap has narrowed.

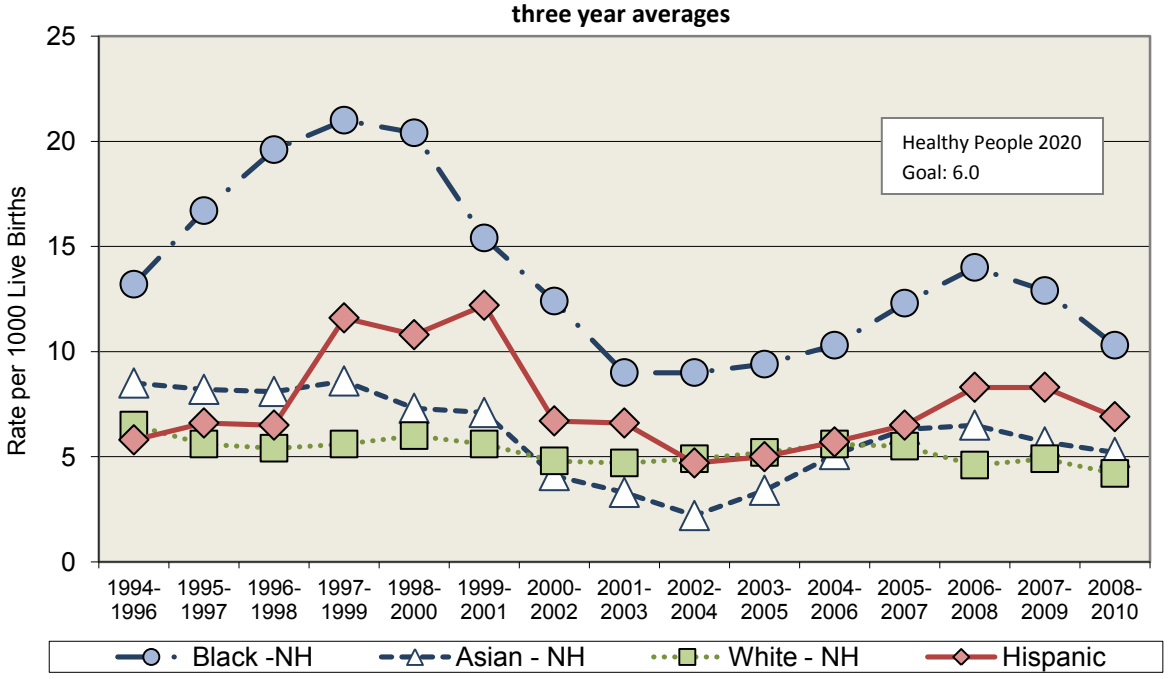
Figure IM-1: Infant mortality rate, Saint Paul and Ramsey County, 1994-2010 three year averages



Source: St. Paul-Ramsey County Public Health geocoded vital statistics database

[1] *CIA Factbook, 2011. Retrieved from: https://www.cia.gov/library/publications/the-world-factbook/geos/us.html.*
[2] *National Vital Statistics Report. Deaths: Preliminary Data for 2010, January 11, 2012. Vol. 60, No. 4. Retrieved from: http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf.*
[3] *Minnesota Department of Health, Minnesota Center for Health Statistics and Community & Family Health Division Maternal & Child Health Section. Disparities in Infant Mortality. January 2009.*

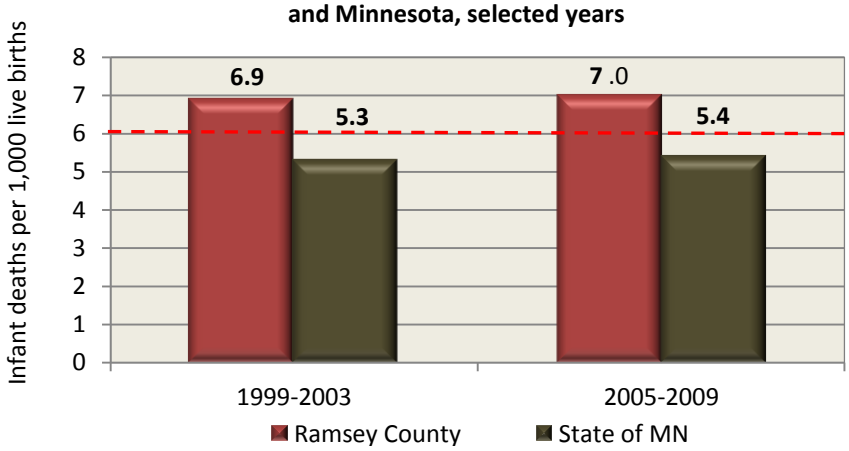
Figure IM-2: Infant mortality rate by race, Ramsey County, MN, 1994-2010 three year averages



Source: St. Paul-Ramsey County Public Health geocoded vital statistics database

The high infant mortality rate for Blacks and American Indian infants in Ramsey County reflects the national trend of disparity in health indicators between racial groups.

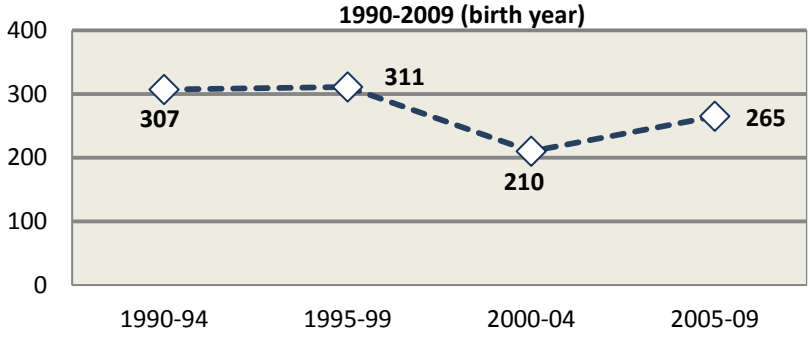
Figure IM-3: Infant deaths per 1,000 live births, Ramsey County and Minnesota, selected years



Source: Minnesota Department of Health, Center for Health Statistics

Infant mortality rates have remained steady for both Minnesota and Ramsey County over the last decade. But Ramsey County has not yet reached the Healthy People 2020 objective of 6.0 infant deaths per 1,000 live

Figure IM-4: Number of infant deaths,* Ramsey County, MN, 1990-2009 (birth year)



Source: Minnesota Department of Health, Center for Health Statistics

Source: Minnesota Department of Health, Center for Health Statistics
**Previous County Health tables from MDH reported infant deaths by year of death, the infant deaths in this figure are reported by year of birth.*

MENTAL HEALTH AND MENTAL DISORDERS

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to a child's well-being.[1] Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental illness is the term that refers collectively to all diagnosable mental disorders.[2] Mental disorders are among the most common causes of disability and are closely connected to physical health.[3]

One in five young people have one or more mental, emotional, or behavioral disorders at any given time. Among adults, half of all mental, emotional, or behavioral disorders were first diagnosed by age 14 and three-fourths by age 24.[4]

Many disorders have life-long effects that include high psychosocial and economic costs, not only for the young people, but also for their families, schools, and communities. The financial costs in terms of treatment services and lost productivity are estimated at $247 billion annually. Beyond the financial costs, mental, emotional, or behavioral disorders also interfere with young people's ability to accomplish age and culturally appropriate developmental tasks, such as establishing healthy interpersonal relationships, succeeding in school, and making their way in the workforce.[5]

Treatments for mental health problems are expensive and may not be available to all who need them. Recent findings in a report by the Minnesota Department of Human Services[6] indicate that more than two out of five students (46%) who were at risk of mental illness did not receive treatment during the past year. Minority students and students from low income households were less likely to get treatment than their counterparts.

Individuals with fewer resources are also more likely to report experiencing adverse childhood events and the health-damaging psychosocial effects of neighborhood violence or disorder, residential crowding, and struggles to meet daily challenges with inadequate resources.[7]

Children 17 years and under Receiving Public* Mental Health Services 2010	Total Clients *(unduplicated count of clients receiving any mental health service)*	Clients per 10,000 Capita *(unduplicated count of clients receiving any mental health service)*	Number of Clients *(number of unduplicated clients served for each 10,000 children in the county)*
Ramsey County	5,454	467	2,798

**To qualify as public mental health services, 25 percent or more of the cost of services is paid through state or county resources.*

Sources: MMIS Data Warehouse, August 2011, Community Mental Health Reporting System, August 2011, Estimates of Population 2009, US Census

Table MHMD-1: Number of children served in mental health case management and crisis line, Ramsey County, MN, 2006-2010

Services	2006	2007	2008	2009	2010
MH Case Management	708	726	635	567	582
Calls to Crisis Line	2691	2296	2830	2652	2492

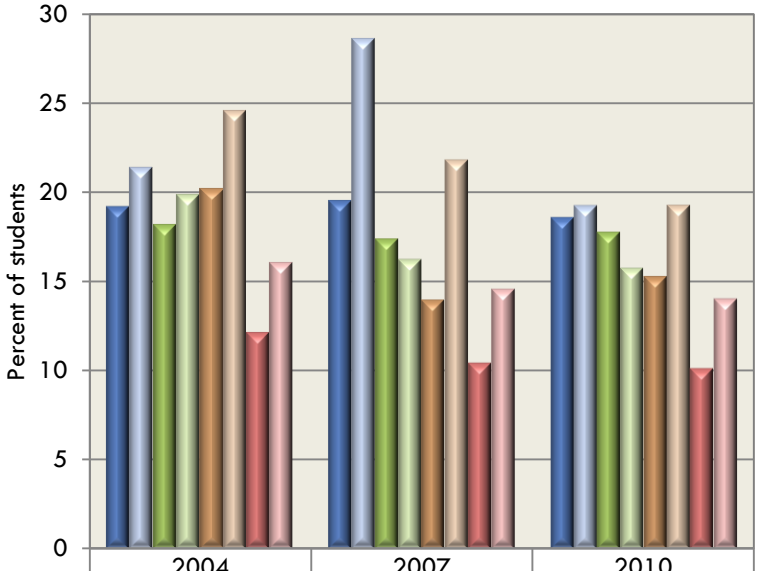
Source: Ramsey County Community Human Services Annual Report, 2010

By the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 percent to become one of the five most common causes of morbidity, mortality, and disability among U.S. children.

(World Health Organization)

[1] *Retrieved from: http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28.*
[2] *Ibid.*
[3] *Ibid.*
[4] *National Research Council. "Part I: Overview and Background."* Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. *Washington, DC: The National Academies Press, 2009.*
[5] *Ibid.*
[6] *Park, Eunkyung. Minnesota Department of Human Services Performance Measurement and Quality Improvement Division in cooperation with Children's Mental Health Division. Mental health problems and treatment receipt among youths in Minnesota: Data from 2007 Minnesota Student Survey. DHS-5491-ENG 6-08*
[7] *Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention.*

Figure MHMD-2: Percentage of 6th, 9th and 12th graders that felt extreme discouragement or hopelessness during the past 30 days, by race/ethnicity, Ramsey County, MN, selected years



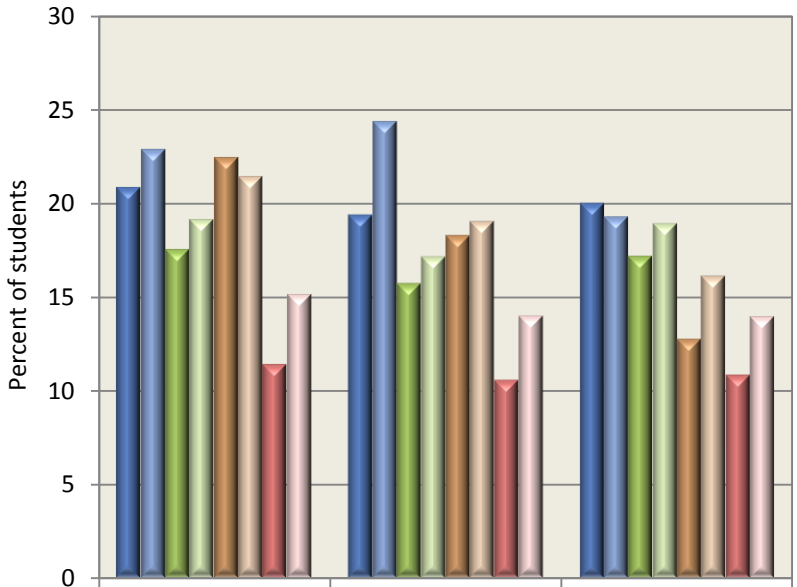
	2004	2007	2010
2+ races	19.14	19.48	18.54
American Indian	21.38	28.57	19.23
Black/African American	18.17	17.37	17.74
Mexican or Chicano/Chicana	19.83	16.19	15.72
Puerto Rican/Latin American	20.16	13.93	15.24
Asian/Pacific Islander	24.57	21.81	19.27
White	12.09	10.38	10.07
Total	16.02	14.52	13.98

Source: Minnesota Student Survey

In 2010, one in five Asian and American Indian 6th, 9th and 12th grade students in Ramsey County reported feeling extremely discouraged and hopeless in the past month.

Serious emotional disturbances (SEDs) affect up to 9 percent of all teenagers in America. This means that SEDs (diagnosable disorders in children and adolescents that severely disrupt daily functioning) affect about one in 15 teens or, on average, two students in every high school classroom.

Figure MHMD-3: Percentage of 6th, 9th and 12th graders who felt sad most or all of the time during the past 30 days, Ramsey County, MN, selected years



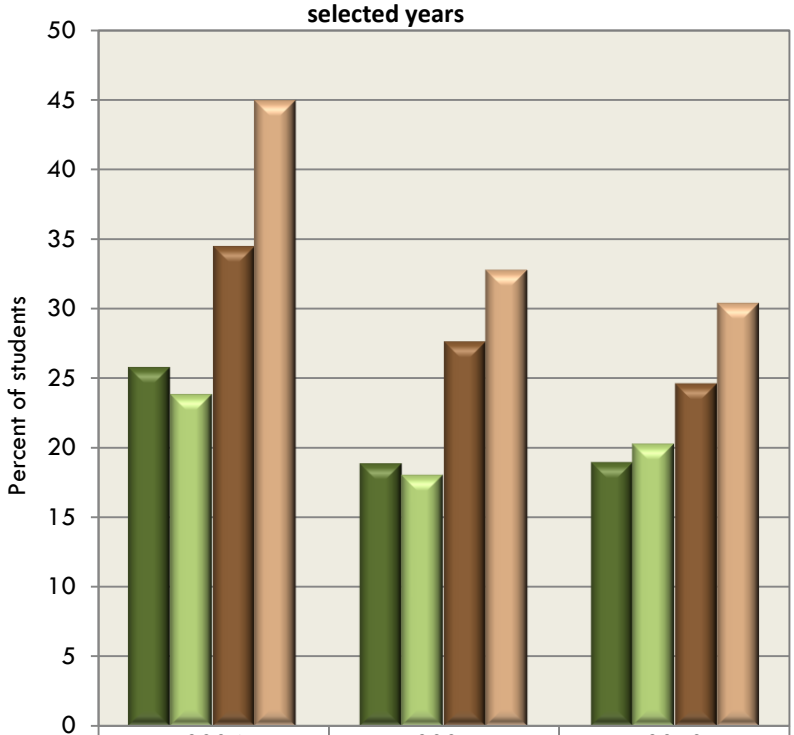
	2004	2007	2010
2+ races	20.86	19.39	20
American Indian	22.82	24.3	19.23
Black/African American	17.51	15.7	17.15
Mexican or Chicano/Chicana	19.11	17.13	18.88
Puerto Rican/Latin American	22.4	18.25	12.73
Asian/Pacific Islander	21.38	18.99	16.09
White	11.36	10.51	10.79
Total	15.12	13.96	13.94

Source: Minnesota Student Survey

14 % of 6th, 9th and 12th grade students in Ramsey County felt sad most or all of the time.

Mixed race and American Indian students had the highest rates of feeling sad during the past 30 days.

Figure MHMD-4: Percentage of 6th, 9th and 12th graders who reported having suicidal thoughts by Hispanic ethnicity, Ramsey County, MN, selected years



	2004	2007	2010
Non-Hispanic Males	25.74	18.84	18.92
Hispanic Males	23.76	17.98	20.23
Non-Hispanic Females	34.41	27.59	24.57
Hispanic Females	44.92	32.74	30.36

Source: Minnesota Student Survey

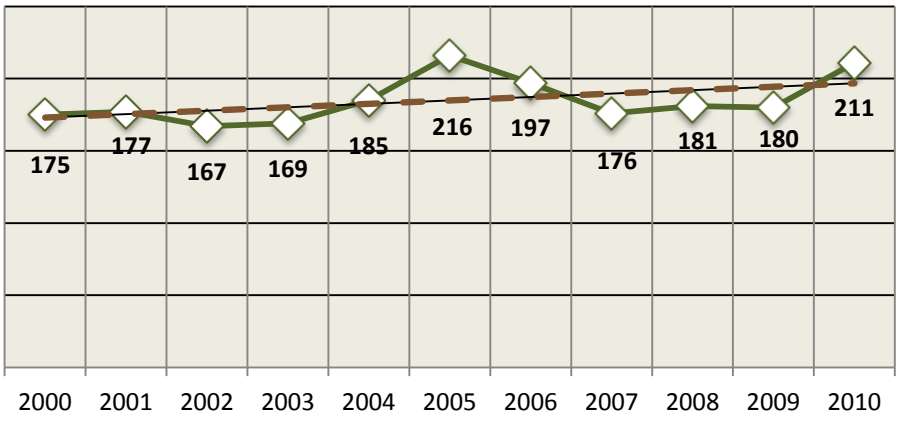
Over 30% of Hispanic 6th, 9th and 12th grade young women in Ramsey County reported having had suicide thoughts in 2010.

The reasons why Latina's contemplate suicide at higher rates than their peers is unclear. However, some stressors in the lives of these young women include[8]:

- Increased family responsibilities
- Developmental conflict with parents and/or family
- Issues of acculturation into American culture and the loss of culturally-influenced coping strategies and supports

[8] Zayas, L.H., Lester, R.J., Cabassa, L.J., Fortuna, L.R. (2005). Why do so many Latina teens attempt suicide? A conceptual model for research. American Journal of Orthopsychiatry, 75, 275-287.

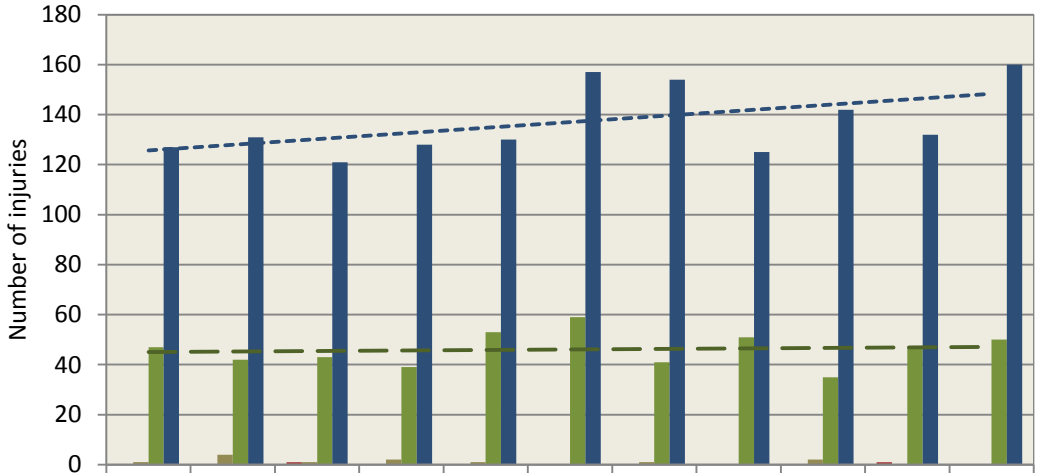
Figure MHMD-5: Number of self-inflicted injuries and deaths treated in emergency rooms or hospitals among children 0-19 years, Ramsey County, MN, 2000-2010



Source: Minnesota Department of Health, MIDAS System

Self-inflicted injuries and deaths have increased over the past decade in Ramsey County children especially among teens ages 15 to 19 years old.

Figure MHMD-6: Number of non-fatal self-inflicted injuries treated in emergency rooms or hospitals by age group, Ramsey County, MN, 2000-2010



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
1-4 yrs	0	0	1	0	0	0	0	0	0	1	0
5-9 yrs	1	4	1	2	1	0	1	0	2	0	0
10-14 yrs	47	42	43	39	53	59	41	51	35	47	50
15-19 yrs	127	131	121	128	130	157	154	125	142	132	160

Source: Minnesota Department of Health, MIDAS System

ESTIMATES OF PREVALENCE OF MENTAL HEALTH DISORDERS IN RAMSEY COUNTY CHILDREN

In any given year, it is estimated that one in five (20%) children from before birth to age 18 has a diagnosable mental illness.[9] One in ten youth (5%) has a serious mental health disorder that significantly impairs how they function at home, in school, or in the community.[10] A more recent study, the first representative survey of children in the United States, found that 13% of children ages 8 to 15 years had at least one psychiatric disorder during one year[11] and the prevalence of emotional/behavioral disturbance in children 0 to 5 years is in the range of 9.5% to 14%.[12]

Applying a range of 13% - 20% prevalence from the studies cited above to children under age 20 (135,628) in Ramsey County, (2010 Census), results in approximately **17,632 - 27,125** children affected by a mental health disorder (6,781 children with a serious mental health disorder that significantly impairs how they function).

In 2007, the Minnesota Department of Human Services estimated that 91,000 children statewide required treatment for emotional disturbances. This suggests that Ramsey County children needing treatment is **18,200 - 20,930** (20-23% of the state population).

Only half of the children in the U.S. with diagnosed disorders seek help for their symptoms and children with disruptive behavior (ADHD and Conduct Disorder) were most likely to seek treatment. Only a third of children with an anxiety disorder received services. The children with more severe symptoms were only slightly more likely to get help. [13]

A study of insurance claims in 2008 by the Minnesota Council of Health Plans found that among privately insured Minnesota children 0-20 years, 9% (or approximately **12,206** of Ramsey's children) had a mental health diagnosis and sought treatment.[14]

*The difference between the estimate of prevalence (federal study estimates of (**17,632- 27,125** or DHS estimate of **18,200-20,930**)) and the number of insured children with a diagnosis (**12,206** in 2008) suggests the magnitude of unmet need for mental health services among children in Ramsey County.*

Sub-groups and Benchmarks

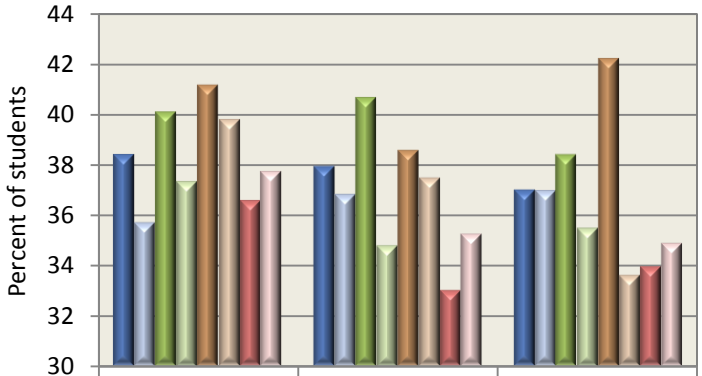
Understanding the prevalence of children with mental health problems is helpful, but alone does not inform policy or practice. Depending upon the specific question and objectives, additional measures and potential benchmarks for children can be identified.

The federal 2011 *America's Children* report[15] identifies mental health disorders by type and population, noting that 5% of children ages 4-17 had emotional and behavioral difficulties, and 8% of 12-17 year-olds had experienced a Major Depressive Episode in the last year. The 2010 Minnesota Student Survey results for Ramsey County 6th, 9th, and 12th graders revealed that both

[9] Department of Health and Human Services (US); Rockville (MD): Department of Health and Human Services. Mental health: a report of the Surgeon General. 1999.
[10] New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America. Final report_(DHHS Pub. No. SMA-03-3832). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
[11] Merikangas, K., He, J., Brody, D., Fisher, P., Bourdon, K., & Koretz, D. (2009). Prevalence and Treatment of Mental Disorders Among US Children in the 2001-2004 NHANES PEDIATRICS, 125 (1), 75-81.
[12] Brauner, Cheryl, Stephens, Cheryl. Estimating the Prevalence of Early Childhood Serious Emotional/Behavioral disorders: Challenges and Recommendations. Public Health Reports. May-June 2006. Volume 121.
[13] Ibid (12).
[14] Retrieved from: http://mnhealthplans.org/news/documents/MCHPMentalHealthReportfinal.pdf.
[15] America's Children: Key National Indicators of Well-Being, 2011. Retrieved from: http://www.childstats.gov/pdf/ac2011/ac_11.pdf

male and female students had experienced a mental health problem that had lasted at least 12 months: 7% & 8% (male and female); 10% and 13%; and 9% and 14%, respectively. These two examples focus upon specific age groups for whom specific policies and services may be targeted. Logical benchmarks for all Ramsey County children could include the proportion of all children with access to regular preventive care, mental health services, or school counselors and the proportion of children with mental health problems who actually receive care. Identification of this type of gap could lead to service delivery and outreach activities.

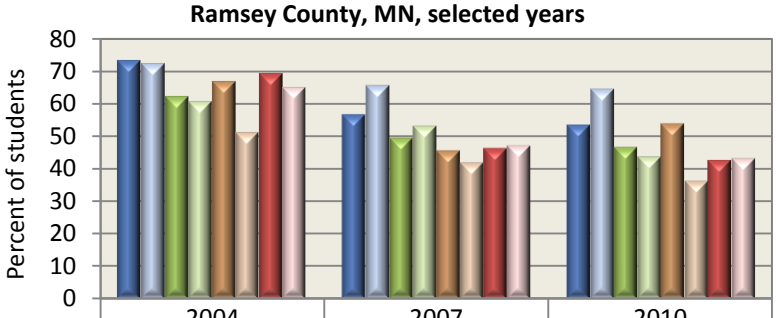
Figure MHMD-7: Percentage of 6th, 9th and 12th graders that report that *most* students in their school make fun of, or threaten, students of different races/backgrounds by race/ethnicity, Ramsey County, MN, selected years



	2004	2007	2010
2+ races	38.36	37.88	36.96
American Indian	35.67	36.79	36.94
Black/African American	40.08	40.64	38.38
Mexican or Chicano/Chicana	37.3	34.78	35.47
Puerto Rican/Latin American	41.18	38.58	42.24
Asian/Pacific Islander	39.78	37.46	33.61
White	36.58	33.01	33.95
Total	37.73	35.25	34.88

Source: Minnesota Student Survey

Figure MHMD-8: Percentage of 6th, 9th and 12th graders that report *ever* being bullied physically or emotionally by race/ethnicity, Ramsey County, MN, selected years



	2004	2007	2010
2+ races	73.08	56.5	53.37
American Indian	71.95	65.22	64.1
Black/African American	61.84	49.18	46.41
Mexican or Chicano/Chicana	60.41	52.87	43.5
Puerto Rican/Latin American	66.67	45.45	53.72
Asian/Pacific Islander	51.07	41.82	36.19
White	69.05	46.19	42.5
Total	65.07	47.17	43.18

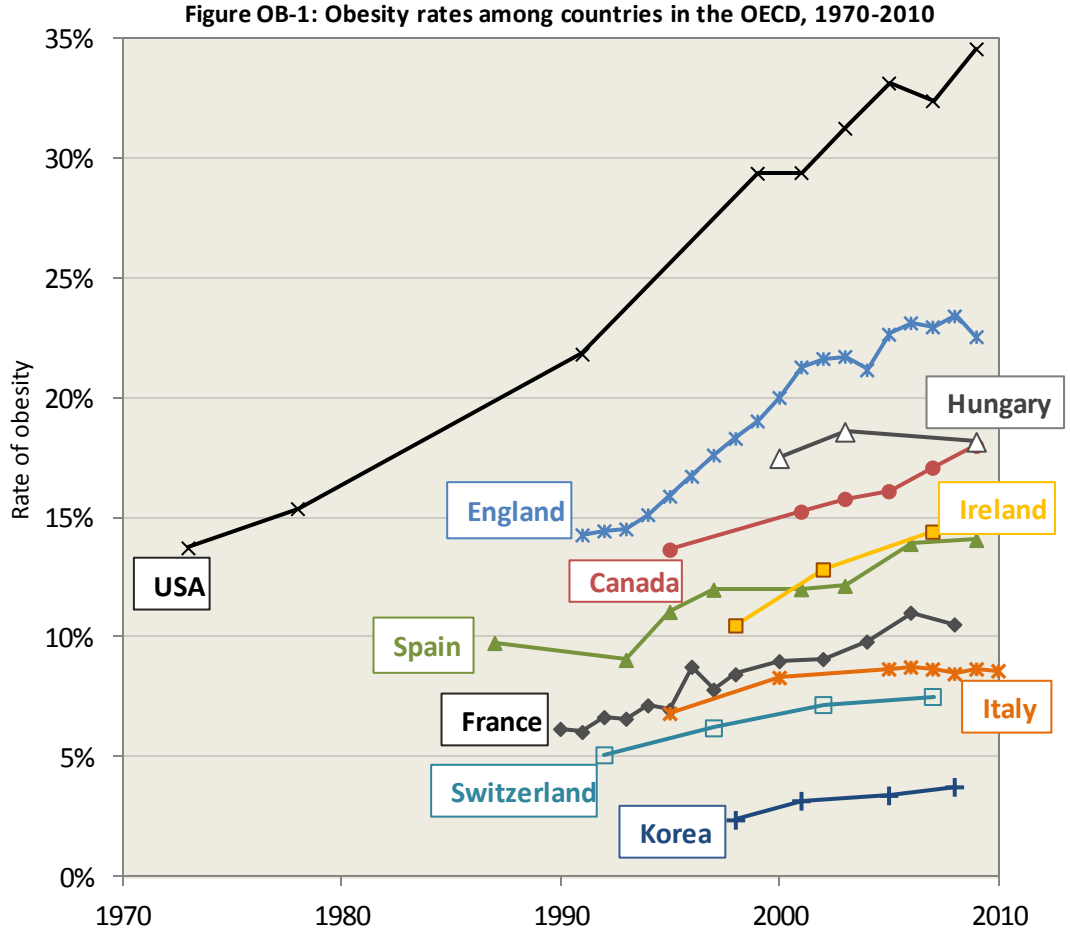
Source: Minnesota Student Survey

The majority of Ramsey County children continue to experience bullying (physical and/or emotional): American-Indian children report the highest rates of bullying.

OBESITY

Soaring obesity rates make the U.S. the fattest country in the OECD (Organization for Economic Co-operation and Development).[1] Overweight and obesity rates increased steadily since the 1980s in both men and women. The latest data show that the proportion of adults who are overweight increased further since the early 2000s.[2]

Figure OB-1: Obesity rates among countries in the OECD, 1970-2010



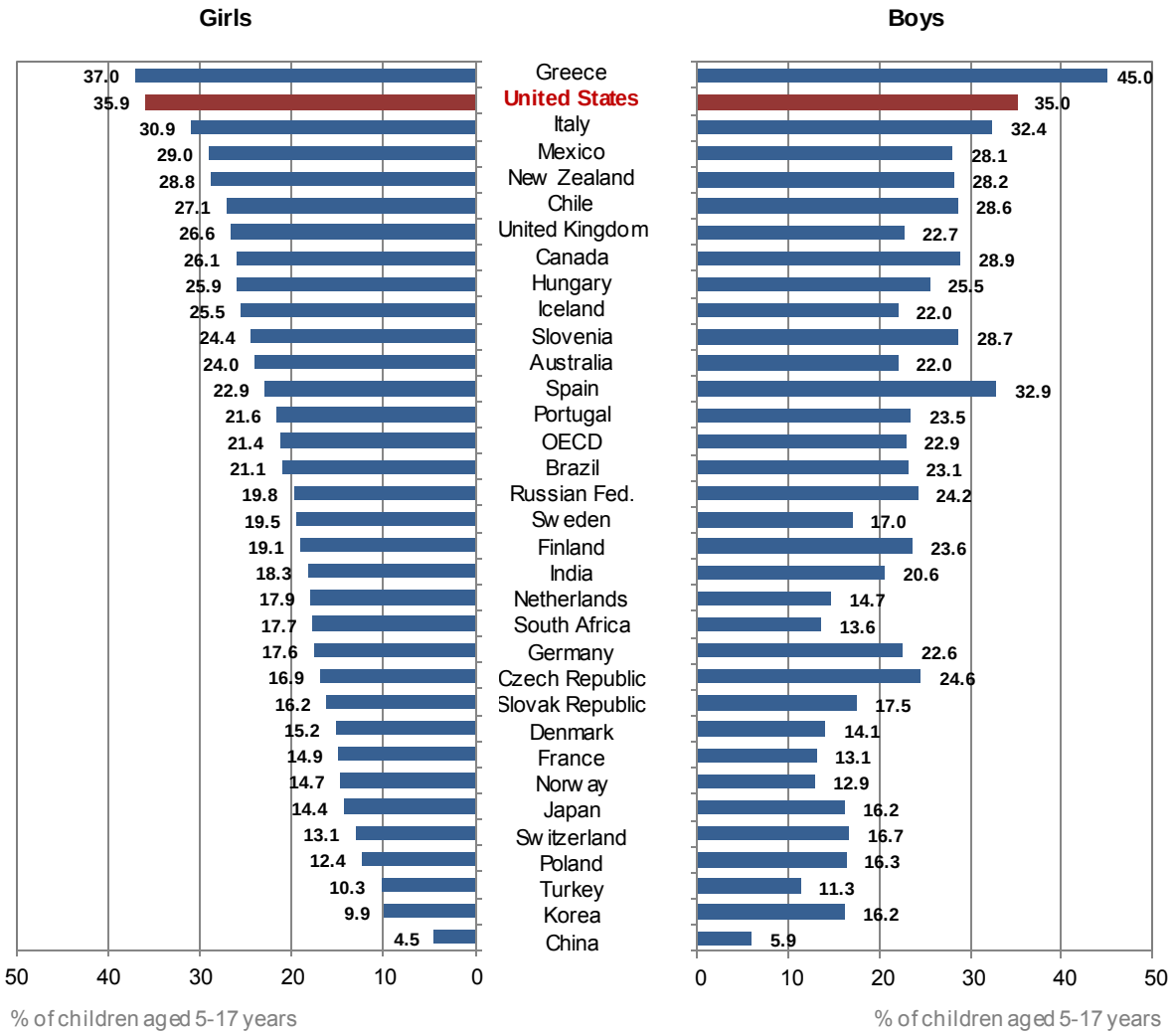
Source: NHANES data , and OECD estimates

[1] *OECD (Organization for Economic Co-operation and Development) origins date back to 1960, when 18 European countries plus the United States and Canada joined forces to create an organization dedicated to global development. Today, the 34 member countries are from North and South America, Europe and the Asia-Pacific region. The full list of member countries can be found on: http://www.oecd.org/pages/0,3417,en_36734052_36761800_1_1_1_1_1,00.html*

[2] *Healthy Choices, OECD Health Ministerial Meeting, 7-8 October 2010, OECD 2010 Retrieved from: http://www.oecd.org/dataoecd/14/13/46098333.pdf*

The prevalence of obesity among U.S. children changed relatively little from the early 1960's through 1980, however after 1980, it increased sharply and now over the past ten years rates have become relatively stable. Forty percent of American children are currently overweight. Of these, half are obese.[3] Obesity tied as one of the top two concerns of parents for American children, according to the fifth annual survey of the top health concerns for kids.[4]

Figure OB-2: Children aged 5-17 years who are overweight (including obese), OECD countries, 2011

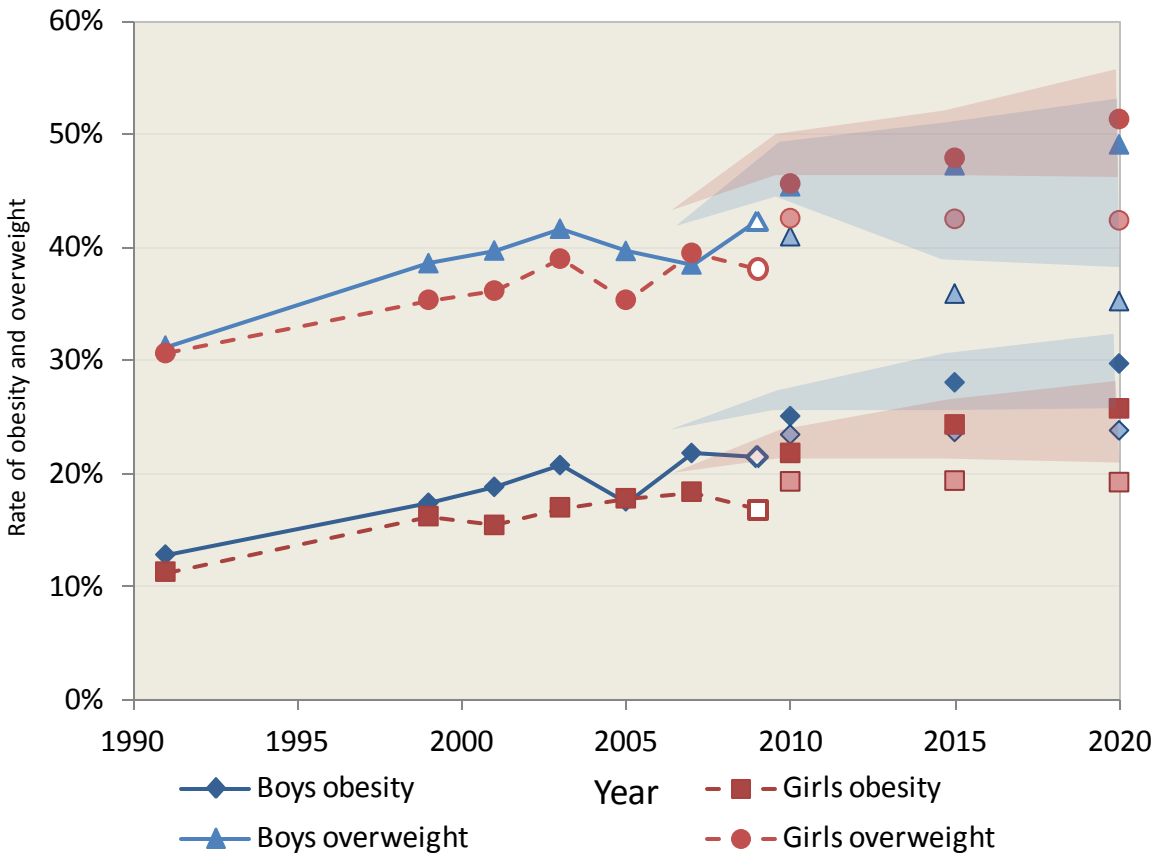


Source: International Association for the Study of Obesity (2011)

[3] *Flegal et al., 2012. Prevalence of Obesity and Trends in the Distribution of Body Mass Index Among US Adults, 1999-2010. JAMA, Published online January 17, 2012. Retrieved from: http://www.oecd.org/health/prevention.*

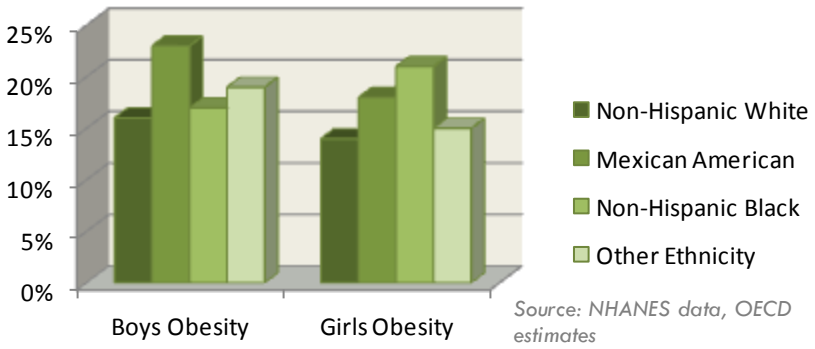
[4] *University of Michigan C.S. Mott Children's Hospital National Poll on Children's Health, May 2011.*

Figure OB-3: Rates of obesity and overweight in girls and boys, U.S. 1990-2020



Source: NHANES data, OECD estimates

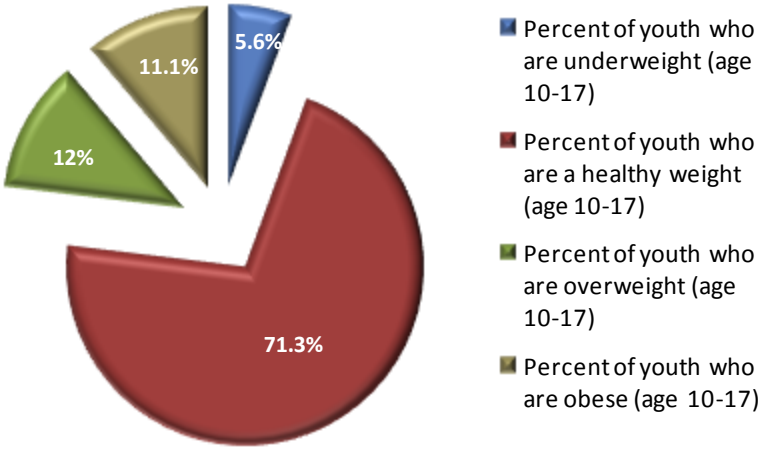
Figure OB-4: Percentage of children age 3-17 years who are obese by gender and race/ethnicity, U.S., 2011



Source: NHANES data, OECD estimates

In the U.S., Hispanic boys and African-American girls have the highest obesity rates. These two groups stand out with 50% higher obesity rates than white non-Hispanic boys and girls, respectively. Socio-economic disparities are larger in children than adults. Less well off children are up to 1.6 times more likely to be obese than children from higher income groups.[1]

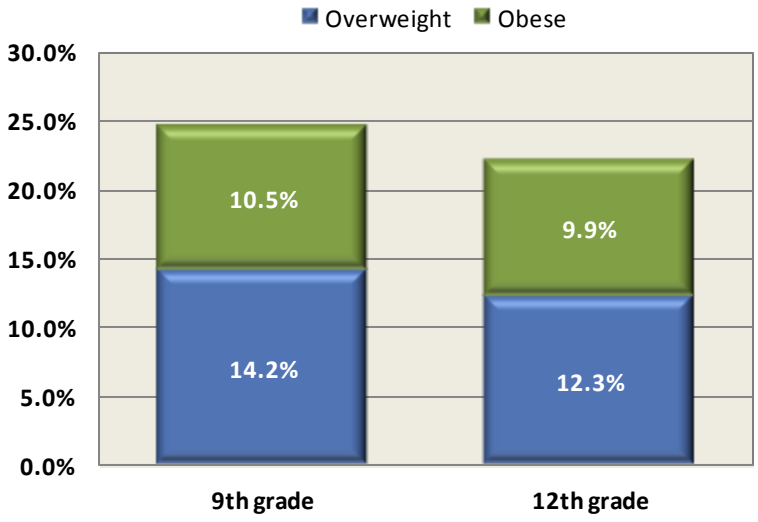
Figure OB-5: Percentage of children age 10-17 self reported weight status, Minnesota, 2007



Source: National Survey of Children's Health

The Healthy People 2020 goal is that no more than 14.6% of youth ages 2-19 are obese.

Figure OB-6: Percentage of 9th and 12th grade students overweight or obese based on self-report weight and height, Ramsey County, MN, 2010



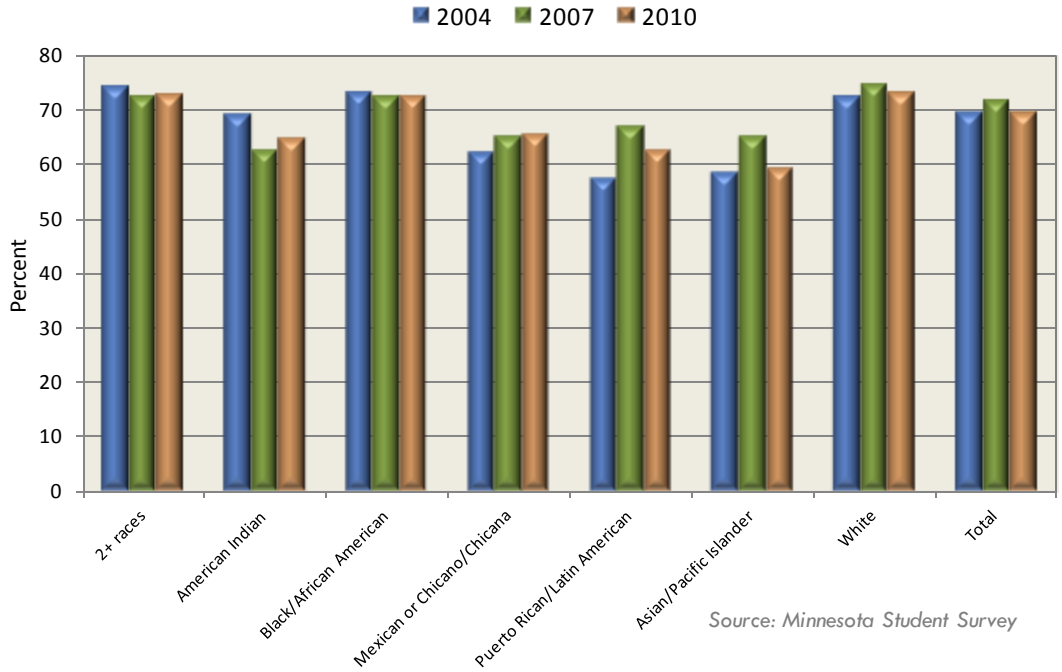
Source: Minnesota Student Survey

22% of Ramsey County 12th graders report being obese or overweight.

The effects of television viewing and other screen time activities—computers, video games, hand-held devices such as games, cell phones and computing devices—on adults, youth, the community and social norms is a subject of much interest, research and opinion. There is a positive relationship between obesity and the amount of television a person watches.[5,6]

In Minnesota, 5.8% of children ages 1-5 years engage in 4 of more hours of screen time per weekday. 6.2% of Minnesota children ages 6-17 years spend 4 or more hours looking at screens.[7] White children in Ramsey County watch the most TV.

Figure OB-7: Percentage of 6th, 9th and 12th grade students reporting over 2 hours of TV viewing per day by race/ethnicity, Ramsey County, MN, selected years



Source: Minnesota Student Survey

[5] Viner, R.M. and T.J. Cole. 2005. Television viewing in early childhood predicts adult body mass index. J Pediatr 147(4): 429-435.
[6] Hancox, R.J., B.J. Milne and R. Poulton. 2004. Association between child and adolescent television viewing and adult health: a longitudinal birth cohort study. Lancet 364: 257-62.
[7] 2007 National Survey of Children's Health. Data analysis provided by the Child and Adolescent Health Measurement Initiative, Data Resource Center. http://www.childhealthdata.org/

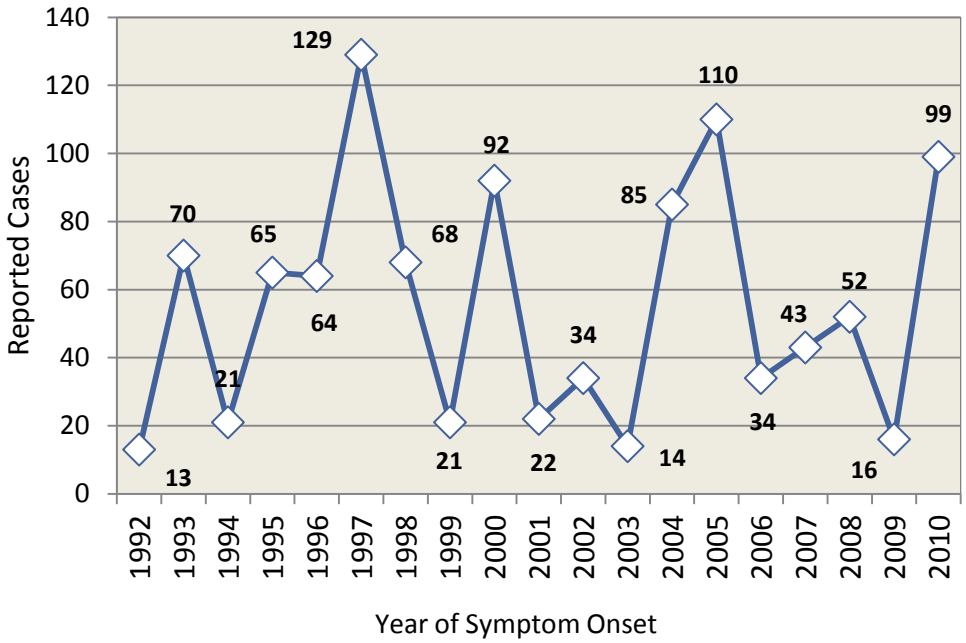
PERTUSSIS

Pertussis, or whooping cough, is a disease caused by bacteria that infects the lungs. Pertussis is spread through the air in droplets dispersed during coughing or sneezing. The best way to prevent pertussis is for all children to be fully vaccinated on time and for adolescents and adults to get a booster shot.

Anyone of any age can become infected with pertussis, but it can be a very severe disease for infants and young children. A child who is not fully immunized is at risk for pertussis. Although older children and adults generally do not become seriously ill with pertussis, they can spread it even though they may have very few symptoms.

Infants and small children are more vulnerable to this infection, often facing hospitalization and sometimes, death. One of the most common ways children become infected is from caregivers who have an active case.[1] Adolescents are frequently infected. One of the greatest challenges with pertussis is the very low awareness of the disease which aggravates already low vaccination rates in adults.[2]

Figure P-1: Number of reported pertussis cases, Ramsey County, MN, 1992-2010



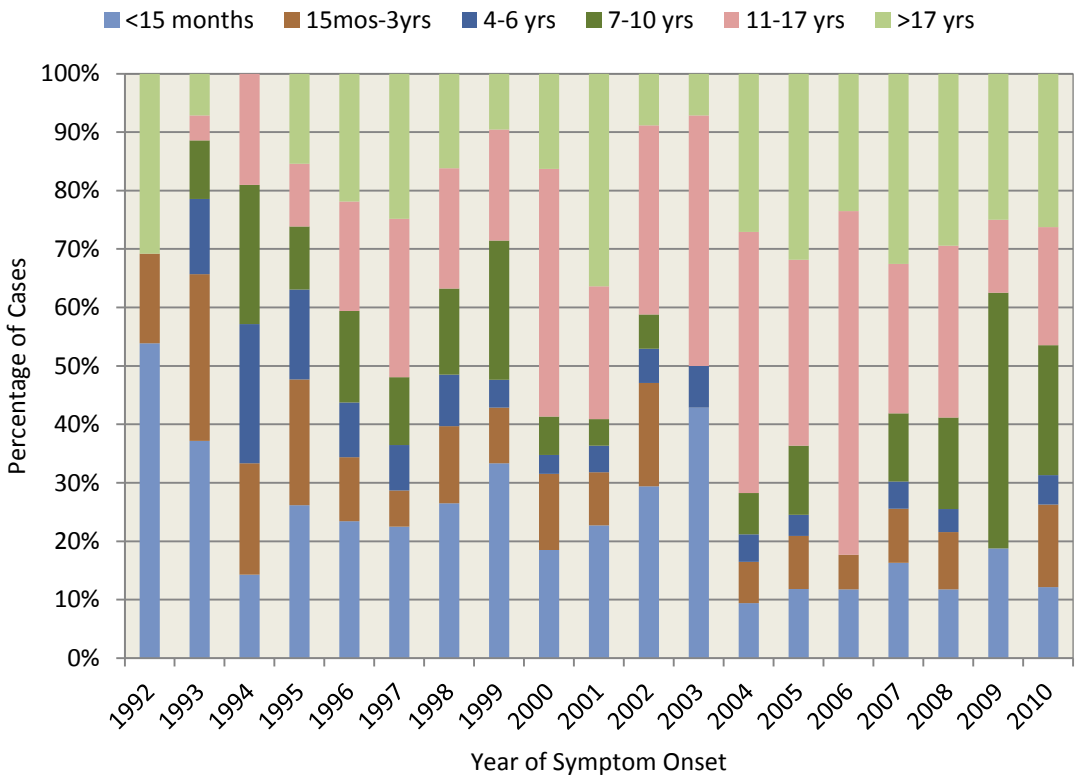
Source: Saint Paul - Ramsey County Public Health, Preventative Health Section

Overall rates of pertussis infection in Ramsey County fluctuate by year, but older children and adults have begun to comprise a larger proportion of all infected.

[1] *Cortese, M. M., Baughman, A.L., Brown, K., & Srivastava, P. (2007). The "new age" of pertussis prevention: New opportunities through adult vaccination. American Journal of Preventive Medicine, 32(3), 177-185.*

[2] *Hampton, T. (2008). Research reveals low immunization rates and vaccination awareness among adults. Journal of the American Medical Association, 299(9), 1007-1007.*

Figure P-2: Percentage of reported pertussis cases by age group, Ramsey County, MN, 1992-2010



Source: Saint Paul - Ramsey County Public Health, Preventative Health Section

Children and adolescents under 17 years of age made up 73% of Ramsey County pertussis cases in 2010.

PHYSICAL ACTIVITY

Physical activity has been shown to have significant positive health effects, including lowering the risk of chronic illness (heart disease, stroke, type 2 diabetes, high blood pressure, and certain cancers), preventing falls, avoiding weight gain, and reducing depression.[1] Since 1995, the Dietary Guidelines for Americans[2] have included advice on physical activity. In 2008, the U.S. Department of Health and Human Services released updated guidelines for aerobic activity and muscle-strengthening activities for Americans.[1]

Recent national estimates indicate that only about 18% of adolescents meet current physical activity recommendations[3] of 1 hour of physical activity a day.

Physical Activity Guidelines for Adolescents[3]

Children and adolescents should have 60 minutes (1 hour) or more of physical activity daily.

- **Aerobic:** 60 or more minutes a day of moderate or vigorous intensity aerobic physical activity. Vigorous-intensity physical activity on at least 3 days a week.
- **Muscle-strengthening:** As part of their 60 or more minutes of daily physical activity, children and adolescents should include muscle-strengthening physical activity on at least 3 days of the week.
- **Bone-strengthening:** As part of their 60 or more minutes of daily physical activity, children and adolescents should include bone-strengthening physical activity on at least 3 days of the week.

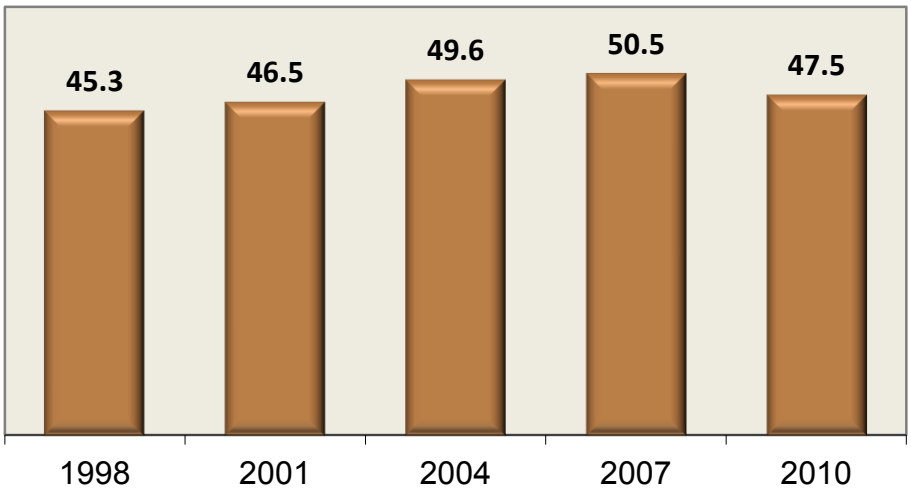
Figure PA-1: Percentage of 9th graders reporting vigorous physical activity 3 + times per week, Ramsey County, MN, selected years

Source: Minnesota Student Survey

Over half of Ramsey County 9th graders report engaging in vigorous activity for 20 minutes three or more times each week.

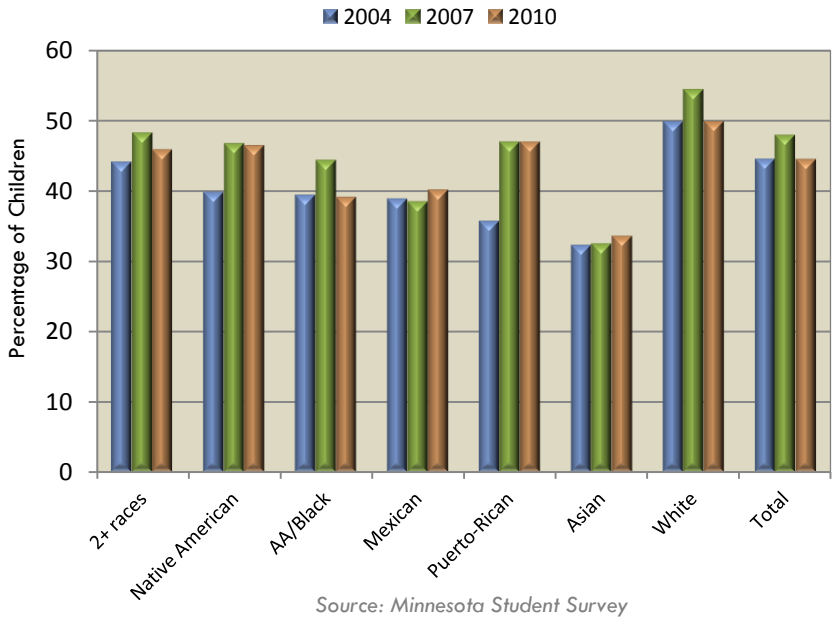
[1] *2008 Physical activity guidelines for Americans [online]. U.S. Department of Health and Human Services. Retrieved from: http://www.health.gov/paguidelines/default.aspx.*
[2] *Nutrition and your health: Dietary guidelines for Americans, 4th ed [online]. U.S. Department of Agriculture and U.S. Department of Health and Human Services. 1995. Retrieved from: http://www.cnpp.usda.gov/Publications/ DietaryGuidelines/1995/1995DGConsumerBrochure.pdf.*
[3] *Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. How much physical activity do children need? Retrieved from: http://www.cdc.gov/physicalactivity/everyone/guidelines/children.html.*

Figure PA-2: Percentage of 9th graders reporting moderate physical activity 5 or more times per week, Ramsey County, MN, selected years



Source: Minnesota Student Survey

Figure PA-3: Percentage of 6th, 9th and 12th graders that engaged in at least 30 minutes of exercise every day by race, Ramsey County, MN,selected years



Source: Minnesota Student Survey

Asian students are the least likely to engage in at least 30 minutes of exercise every day. White students are the most likely to engage in 30 minutes of exercise every day.

Preterm Birth and Low Birth Weight

Low birth weight (LBW) babies (less than 2500 grams or 5 lb. 8 oz.) are at higher risk for a range of poor health outcomes, including death before their first birthday.

Infants are at higher risk of being born with LBW if their mothers are young, not white, unmarried, smokers, or began prenatal care after the first trimester. If the mother's educational status is low for her age and if she is pregnant with twins, she also has a greater chance of having a LBW. Other factors, such as economic security and safety also affect birth outcomes.

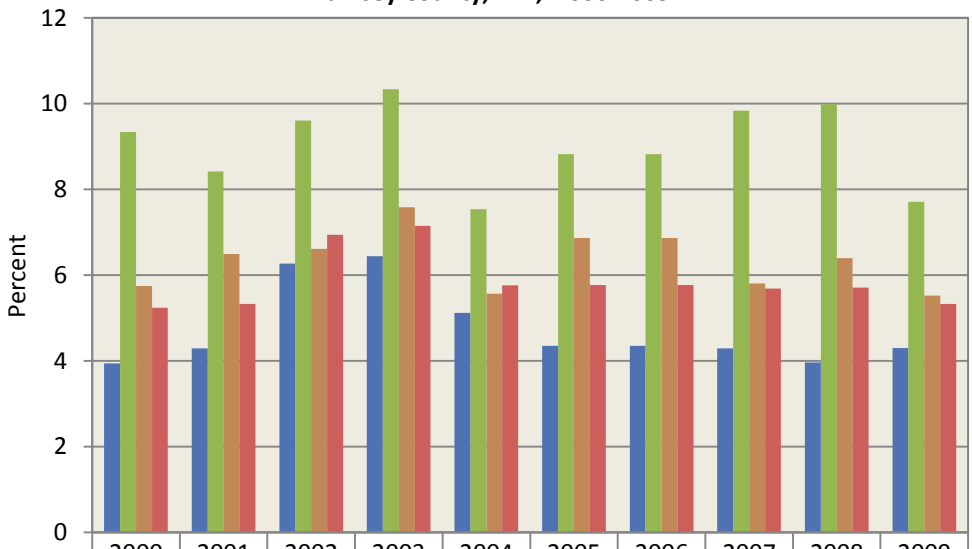
Table PB-1: Percent preterm and low birth weight, Ramsey County, MN, 2010

	Percent Preterm Births	Percent Low Birth Weight	Percent Very Low Birth Weight 2008-2010	Percent Small for Gestational Age
Minnesota	8.1%	4.8%	0.8%	3.1%
Ramsey	8.9%	5.8%	1.0%	4.3%

Source: Minnesota Department of Health, Center for Health Statistics

Ramsey County's low birth weight rate is higher than the State.

Figure PB-2: Percentage of mothers with low birth weight infants by race/ethnicity, Ramsey County, MN, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White	3.94	4.29	6.27	6.44	5.12	4.35	4.4	4.29	3.96	4.3
Black/African-American	9.34	8.42	9.61	10.34	7.54	8.82	8.8	9.84	9.99	7.7
Asian/Pacific Islander	5.75	6.49	6.61	7.58	5.57	6.87	6.9	5.81	6.4	5.5
Total	5.24	5.33	6.94	7.15	5.76	5.77	5.77	5.69	5.71	5.33

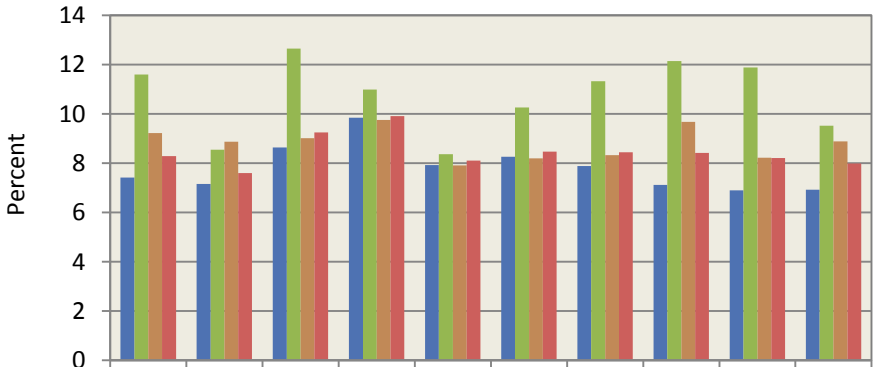
Source: Minnesota Department of Health, Birth Certificate Data

The percent of low birth weight births (<2500 grams or 5 lb. 8 oz.) varies widely by race in Ramsey County with Black women experiencing much higher rates than Whites, Asians, or Hispanic mothers.

The causes of premature/LBW births are not entirely known, but there is evidence showing an association with the following factors:[1,2,3]

- Smoking
- Alcohol consumption
- Low maternal body-mass index
- Maternal age
- Maternal race
- Limited maternal education
- Unmarried status
- Short interval between pregnancies
- Inadequate prenatal care
- Poverty
- Racial discrimination
- Stress
- Infection

Figure PB-3: Percentage of mothers with premature births by race/ethnicity, Ramsey County, MN, 2000-2009

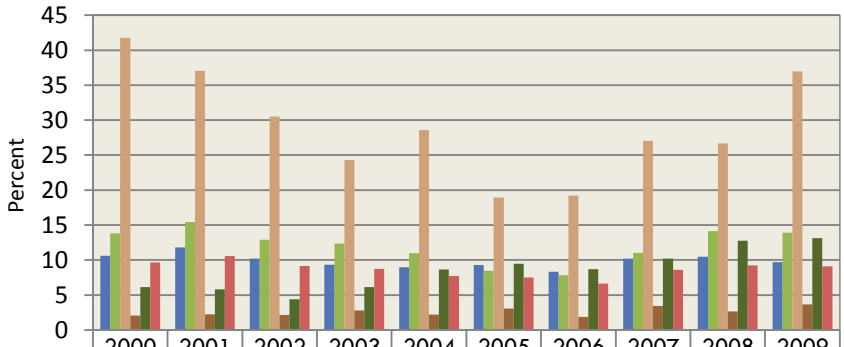


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White	7.41	7.16	8.64	9.84	7.92	8.26	7.88	7.12	6.9	6.92
Black/African-American	11.6	8.55	12.64	10.99	8.36	10.26	11.32	12.14	11.88	9.52
Asian/Pacific Islander	9.22	8.87	9.01	9.75	7.91	8.19	8.33	9.67	8.22	8.88
Total	8.28	7.6	9.25	9.91	8.1	8.46	8.44	8.42	8.21	7.98

Source: Minnesota Department of Health, Birth Certificate Data

[1] *Muglia, LJ. & Katz, M.J. (2010). The Enigma of Spontaneous Preterm Birth. New England Journal of Medicine, 362:6: 529-535.*
[2] *Lu, Michael et. al. (2003). Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective. Maternal and Child Health Journal, Vol.7, No.1:13-30.*
[3] *Centers for Disease Control and Prevention & US Department of Health and Human Services (2007). Preventing smoking and exposure to secondhand smoke before, during, and after pregnancy. Retrieved from: http://www.health.state.mn.us/divs/fh/mch/mortality/documents/CDCsmokingPGfactsheet.pdf*

Figure PB-4: Percentage of mothers that report smoking during pregnancy by mother's race/ethnicity, Ramsey County, MN, 2000 - 2009



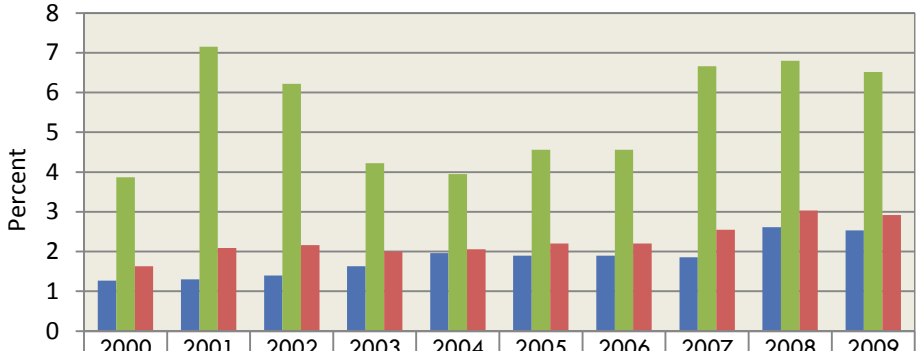
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White (non-hispanic)	10.6	11.79	10.21	9.33	8.94	9.28	8.34	10.19	10.47	9.69
Black/African American	13.83	15.41	12.88	12.34	10.96	8.48	7.84	11.01	14.14	13.92
Native American	41.77	37.04	30.53	24.27	28.57	18.92	19.19	27.03	26.67	36.96
Asian/Pacific Islander	2.04	2.25	2.16	2.8	2.18	3.08	1.87	3.42	2.63	3.64
Hispanic	6.12	5.8	4.38	6.11	8.65	9.45	8.67	10.2	12.76	13.11
Total	9.65	10.57	9.14	8.72	7.74	7.49	6.61	8.58	9.23	9.08

Source: Minnesota Department of Health, Birth Certificate Data

Smoking during pregnancy is the single most preventable cause of maternal and infant illness and death.[3]

In Ramsey County, Native American mothers have smoking rates during pregnancy almost three times higher than other mothers.

Figure PB-5: Percentage of mothers that report using drugs during pregnancy by mother's race/ethnicity, Ramsey County, MN, 2000-2009

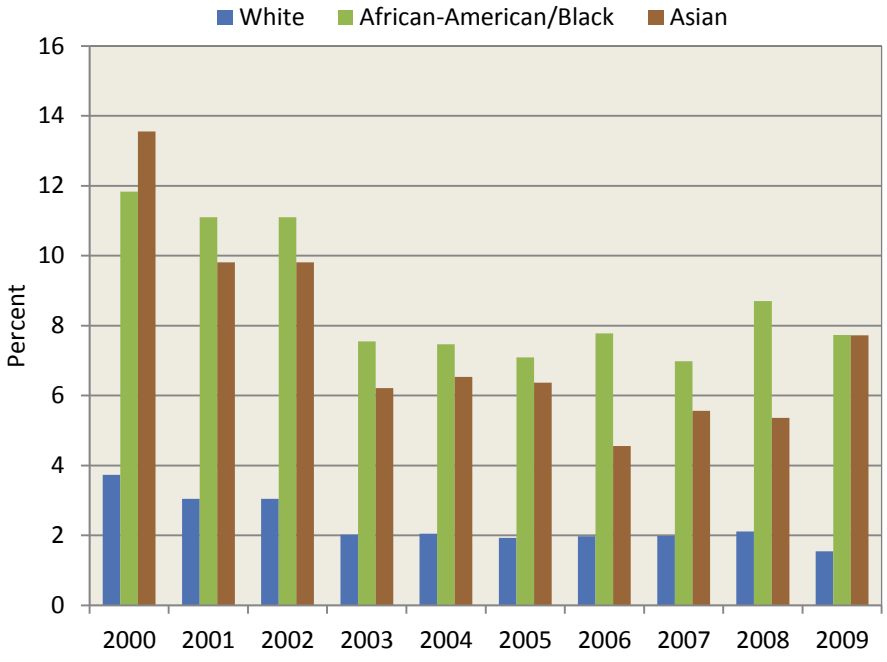


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White (non-hispanic)	1.27	1.3	1.4	1.63	1.96	1.9	1.9	1.86	2.61	2.53
Black/African-American	3.87	7.15	6.22	4.22	3.95	4.56	4.56	6.66	6.8	6.52
Total	1.63	2.09	2.16	2	2.06	2.2	2.2	2.55	3.03	2.92

Source: Minnesota Department of Health, Birth Certificate Data

Black/African American mothers report using drugs at higher rates than White mothers.

Figure PB-6: Percentage of mothers with inadequate or no prenatal care by race, Ramsey County, MN, 2000-2009



Source: Minnesota Department of Health, Birth Certificate Data

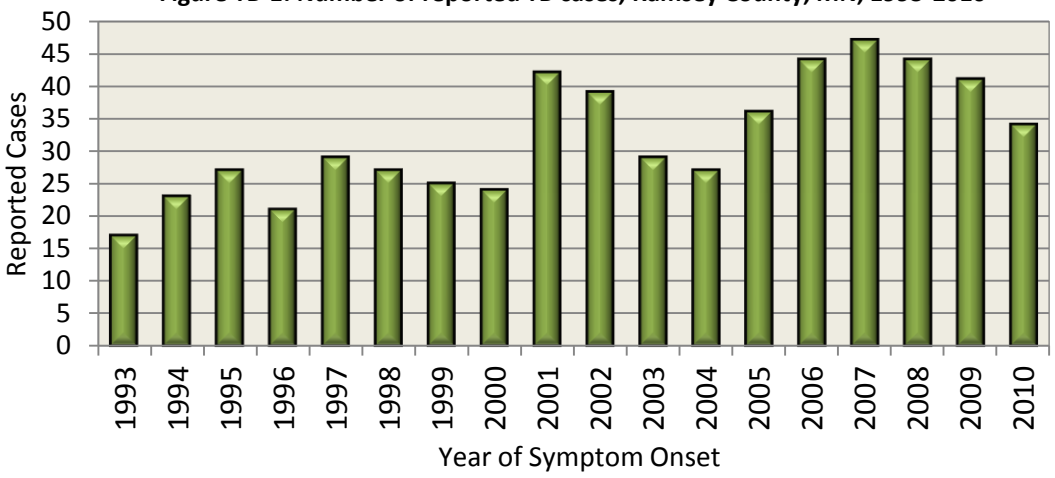
Women who access prenatal services receive some of the most important components of care to assure a healthy pregnancy, and prevent prematurity or LBW. White mothers have the highest rate of 1st trimester prenatal care.

TUBERCULOSIS

Cases of active or latent tuberculosis (TB) infection in children indicate that transmission of tuberculosis has recently occurred.[1] When a child is diagnosed with active TB, it means that someone close to them, almost always an adult, has active TB, and is probably transmitting the disease to others.

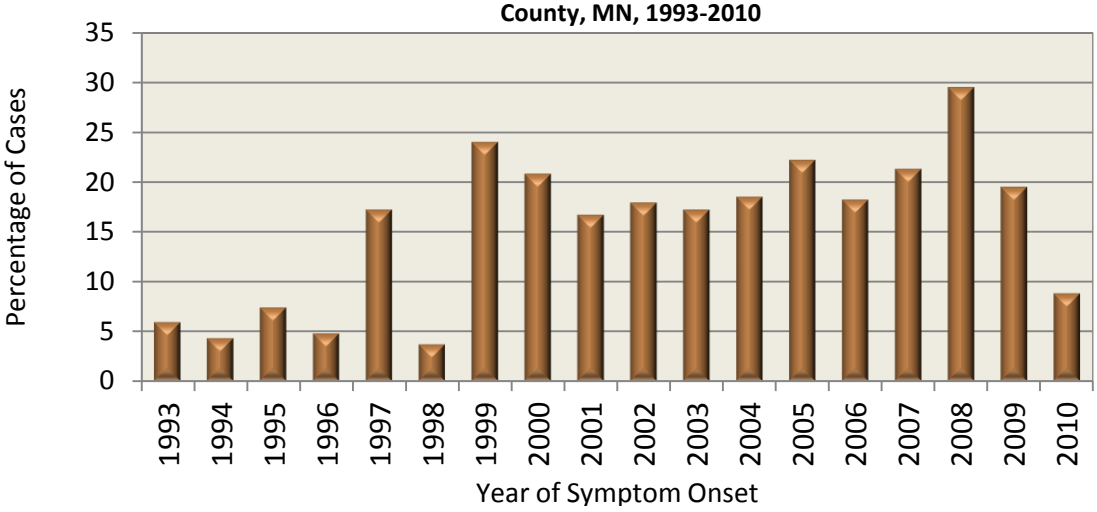
Early diagnosis and successful treatment of an infectious adult TB patient is the best way to protect children from becoming infected. Therefore a good TB control program, which will ensure early diagnosis and treatment of adults with infectious forms, is the best way to prevent infections in children. Diagnosis of tuberculosis in children is more difficult than in adults. Children are less likely to have obvious symptoms of TB and sputum samples are more difficult to collect. Unfortunately, the incidence of TB is increasing with a growing number of cases of multi-drug resistant strains of TB. In January of 2012, there were the first reports of a "totally drug-resistant" strain of TB in Mumbai, India, attributed primarily to the misuse of antibiotics.[2]

Figure TB-1: Number of reported TB cases, Ramsey County, MN, 1993-2010



Source: Saint Paul - Ramsey County Public Health Preventive Health

Figure TB-2: Percentage of TB cases that occurred in children under 19, Ramsey County, MN, 1993-2010



Source: Saint Paul – Ramsey County Public Health Preventive Health Section

Children and adolescents under 19 years made up 9% of TB cases in Ramsey County in 2010

[1] *American Thoracic Society, CDC and Infectious Disease Society of America. Treatment of Tuberculosis. Morbidity and Mortality Weekly Report. June 20, 2003; 52(RR-11).*

[2] *Loewenberg, S. (2012). India reports cases of totally drug-resistant tuberculosis. Lancet, 379(9812), 205-205.*

APPENDIX

Detailed List of Figures and Tables