

**A Race to Close
the Disproportionate
COVID-19 Death Rates
in Minnesota's
Asian Community**

This report is written for policy makers, healthcare providers and systems, and community leaders to provide insights and recommendations that can immediately improve on-going efforts to address COVID-19 infections, prevent further deaths, and ensure that future prevention strategies are responsive and relevant when serving Asian Minnesotans. This report uses preliminary data on COVID-19 mortality rates among Asian Minnesotans. It draws attention to the disproportionate number of COVID-19 mortality rates among Hmong, Karen, and Karenni residents to demonstrate the critical importance of data disaggregation.

Introduction

The COVID-19 pandemic is negatively and disproportionately impacting Asian Minnesotans who have higher rates of infection and mortality. When data is disaggregated, the Hmong, Karen and Karenni are more impacted than other Asian ethnic groups.¹ This trend is consistent and persistent among various Asian ethnic communities. It highlights the need for further disaggregated data to help develop more relevant and targeted strategies to reduce the racial and ethnic COVID-19 health disparities.

This report includes 2020 COVID-19 mortality rates in the Minnesota Asian population, discusses social and environmental factors, and explores recommendations on how to close health disparities experienced by unique Asian cultural groups in Minnesota. Additionally, a number of community resources and information from the Department of Health's Office of Vital Records (OVR) death certificate data on Hmong, Karen, and Karenni deaths are used.

1. Death Certificate dataset. Minnesota Department of Health Office of Vital Records. (2020, March 15). <https://www.health.state.mn.us/people/vitalrecords/death.html>



BACKGROUND

According to the most recent American Community Survey, the Asian population makes up 5.1% of Minnesota's total population.² Minnesota's Asian population differs from the rest of the country, with Southeast Asians making up the largest portion of the Asian population.³ The Hmong ethnic group is the largest Asian group, estimated to be 81,966, with 95% of Hmong Minnesotans living in the Twin Cities metro area.⁴ Minnesota also has the largest Karen community, with more than 17,000 Karen people, the newest refugee community from Asia, and also home to more than 2,000 refugees from other ethnic groups from Burma, including the Karenni and Mon.⁵

Importance

Overall Asian Minnesotans make up **5% of the population**, yet they represent **6% of all COVID-19 hospitalizations** and **8% of COVID-19 ICU cases**.⁶ This data is even more glaring when we disaggregate the information at the local level.

Despite the identifiable diversity within the Asian American community, Minnesota continues to combine all Asian Americans as one monolithic community. Asian Americans can trace their lineage to over 50 countries and speak more than 100 different languages.⁷ This broad diversity results in marked differences between education, English language fluency, economic class, immigration status etc. that has directly impacted the communities' access to health insurance.⁸ Just using the larger category of 'Asian' has created inaccurate assumptions, untargeted responses, and furthered generalizations about the true impact of COVID-19.⁹ Because the current COVID-19 infection and mortality data available to the public is only cumulative data or aggregated data, it fails to point out the health disparities that exist within different ethnicities in the Asian population.

2. ACS Demographic and Housing Estimates. United States Census Bureau. (2020). https://data.census.gov/cedsci/table?q=ACSDP1Y2019_DP05+Minnesota&q=0400000US27&tid=ACSDP1Y2019_DP05&hidePreview=true.

3. ACS Demographic and Housing Estimates. United States Census Bureau. (2020). https://data.census.gov/cedsci/table?q=ACSDP1Y2019_DP05+Minnesota&q=0400000US27&tid=ACSDP1Y2019_DP05&hidePreview=true.

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5. About. Karen Organization of Minnesota. (2020, January 7). <https://www.mnkaren.org/about/>.

6. Data by Race/Ethnicity. Minnesota COVID-19 Response. (n.d.). <https://mn.gov/covid19/data/data-by-race-ethnicity/index.jsp>.

7. APIAHF. (2021, March 4). <https://www.apiahf.org/>.

8. APIAHF. (2021, March 4). <https://www.apiahf.org/>.

9. APIAHF. (2021, March 4). <https://www.apiahf.org/>.

Understanding The Community & Environmental Situation

The following information highlights the Minnesota Department of Health's Office of Vital Records (OVR) death certificate data on Hmong, Karen, and Karenni deaths caused by COVID-19 between March 2020 through December 2020. The Hmong, Karen and Karenni communities' total mortality rate resulting from COVID-19 is more likely higher and beyond what can be shown in this dataset.

NUMBER OF DEATHS

According to OVR, there were 5,803 COVID-19 confirmed deaths in Minnesota between March 2020 to December 2020. Of this, approximately 86% were White, 5% Black, 4% Asian and Native Pacific Islanders, 3% Hispanic, and 1% American Indian.¹⁰

When the data on COVID-19 deaths in the Asian community are disaggregated by Asian ethnic groups, 110 of the 223 (49%) COVID-19 deaths were from the Hmong community. Overall, the data showed total mortality in the Hmong community increased over 50% from 2019, indicating a substantial increase in deaths overall – but 81% of this increase was attributable to confirmed COVID-19 cases.

COVID-19 DEATHS IN THE ASIAN COMMUNITY

110 of the 223 COVID deaths were from the Hmong community



LEADING CAUSE OF DEATH

While other infectious and chronic diseases continue to impact the health and lives of Minnesotans, COVID-19 was the leading cause of death in Hmong, Karen, and Karenni communities in 2020 at 29% compared to 11% in White Minnesotans.¹¹

AGE OF DEATH

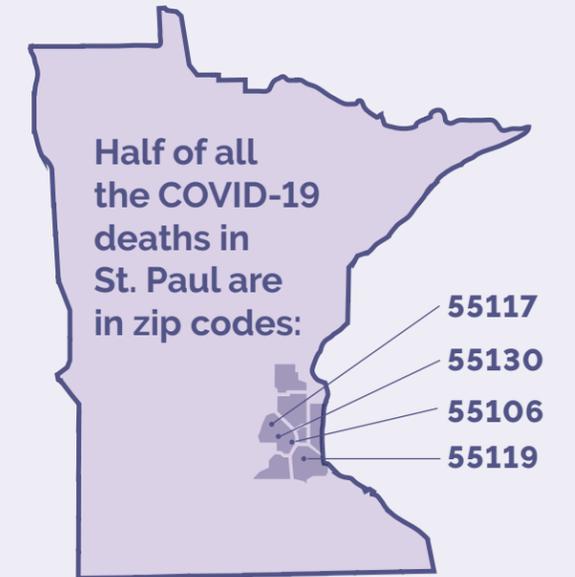
The proportion of Hmong Minnesotan deaths between the ages of 20-79 exceeds that of White Minnesotans, respectively:

AGE	HMONG	WHITE
24-34	3%	0%
35-49	8%	1%
50-64	30%	6%
65-79	35%	26%

Although people ages 65 years and older are at increased risk of severe health complications or death related to COVID-19,¹² OVR data shows that Hmong Minnesotans of young and middle ages are also at increased risk.

GEOGRAPHY OF DEATHS

The top three cities with the most Hmong, Karen, and Karenni COVID-19 deaths are **St. Paul (63%)**, **Minneapolis (6%)**, and **Maplewood (4%)**.



These cities are located in the seven metro counties where the largest concentrations of Hmong and Karen populations live.

OCCUPATION

The top five occupations listed most frequently on Hmong, Karen and Karenni death certificates with COVID-19 as the leading cause of death were:

1. Farmer (17%)
2. Retired (15%)
3. Unknown (14%)
4. Homemaker (9%)
5. Machine Operator (3%)

Notably, farmers and machine operators are categorized as essential workers to keep supply chains open¹³; this makes them more susceptible to contracting COVID-19 due to the types of jobs they hold. In these work environments, employees must be in closer proximity to one another. Additionally, there are more communal-based practices in these communities, which contributed to the spread of COVID-19. It should be noted 14% of the occupations are listed as unknown.

10. Death Certificate dataset. Minnesota Department of Health Office of Vital Records. (2020, March 15). <https://www.health.state.mn.us/people/vitalrecords/death.html>

11. Death Certificate dataset. Minnesota Department of Health Office of Vital Records. (2020, March 15). <https://www.health.state.mn.us/people/vitalrecords/death.html>

12. Older Adults and COVID-19. CDC. (2021). <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html>

13. Interim List of Categories of Essential Workers Mapped to Standardized Industry Codes and Titles. CDC. (2021). <https://www.cdc.gov/vaccines/covid-19/categories-essential-workers.html>

Vulnerability Analysis

There are a number of social and environmental factors which contribute to the increased vulnerability of Southeast Asian groups. The identified medical conditions, such as cancer and diabetes, that increase the risk of COVID-19 severity from the Centers for Disease Control and Prevention¹⁴ are more prevalent among the Hmong population compared to other Asian ethnic groups.¹⁵ This further supports the COVID-19 mortality data, and further exemplifies the misleading nature of data when Asian ethnic groups are lumped together.

According to the Coalition of Asian American Leaders (CAAL) *Redefining Wealth through Communal and Cultural Assets* Report, many Asian Minnesotans rely on resource-sharing to support themselves and their families.¹⁶ Some examples include formal care, pooling financial resources, living in multi-generational households, and providing and/or sharing housing.¹⁷ In particular, Hmong weddings and funerals are often long and expensive events that require extended families pooling together financial resources. Multi-generational households in the Karen and Karenni community¹⁸ have also created unique challenges during the pandemic.¹⁹ These have been focal points for preventing the spread of disease.²⁰

Racism towards the Asian population has only increased with COVID-19. Many Asian Americans have been targeted, threatened, and attacked.²¹ The MN Department of Human Rights implemented a Discrimination Helpline, but there is a high demand for additional support and resources. These acts of racism emphasize the dangers and inaccuracy of grouping together different ethnicities and labeling them in all as one category. The alarming rates of anti-Asian hate crimes reveal the lack of the general understanding and knowledge of the differences in histories, cultural values, and experiences within each Asian ethnic group. It should be known that racist acts toward Asian Americans is not new. The Chinese Exclusion Act in 1882 prevented Asian immigrants from immigrating to the United States.²² After the attack on Pearl Harbor in 1941, elevated levels of systemic racism increased targeting Asian immigrants throughout the country, with the hardest impact among Japanese Americans in Hawaii.²³ Beginning in 2020, we saw this through the negative impacts and connotations from the Trump Administration referring to COVID-19 as the "Chinese Virus".²⁴ Attacks are not only focused on the Chinese community, but all Asian ethnicities.

14. Certain Medical Conditions and Risk for Severe COVID-19 Illness. Centers for Disease Control and Prevention. (2020, December 23). https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fgroups-at-higher-risk.html.
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Recommendations



Scale up the collection and use of disaggregated data to understand COVID infections, vaccinations, and longer-term impact. Disaggregated data better captures the patterns within a subpopulation that may be hidden with aggregated data. This can be used to support COVID-19 program development, implementation, monitoring, and evaluation. A strong recommendation is to prioritize vaccinations of communities with high infection and mortality rates as you see reflected in this report. We know that health disparities are a result of the complex layer of racial, economic, educational and other social factors.²² This is apparent in terms of mortality rate when broken down by zip code. Before the COVID-19 pandemic, the evidence to support the relationship between life expectancies and zip codes was growing.²³ However, this pandemic has made it abundantly clear that preventable deaths as the result of COVID-19 disproportionately shortened the lives of communities made most vulnerable because of race, income, immigration status, age and other intersecting identities. Understanding that the long-term impact of COVID for those who have been infected are not fully known and future booster vaccinations will likely be required means having disaggregated data allows better targeted approaches to ensure equity that can truly successfully prevent death.



Provide language and technology access and cultural competence across the spectrum of healthcare. In Minnesota, there are 81,966 Hmong residents and 5,280 are aged 55 and older.²⁴ 37% of the Hmong population felt their English was less than "very well" and 50% live within 200% of the federal poverty guideline.²⁵ Healthcare system investments to address these realities should include increasing bilingual and bicultural staffing and programming to support the community in culturally competent ways. In addition, it is not enough to put a person who identifies as the cultural group into a position of power or authority, or to assume a person of the same cultural group can create linguistically and culturally appropriate services and programming alone. There needs to be a systematic response to close the gap in access, technology and cultural competence.



Direct resources to community-based groups and organizations to serve as providers, navigators, and bridgers for vulnerable communities. There are many culturally congruent organizations that are trusted and can be a critical partner in the rollout of COVID-19 programming. Working directly with organizations that know the specific challenges and strengths of that community while providing equitable resources based on the organization's needs can enhance relationship building and program outcomes. Again, this means working systematically across the spectrum of community members to have a representative group of individuals and organizations.



Ensure that recovery solutions and programs meet the needs of Asian Minnesotan communities and are inclusive of cultural practices and experiences. The voices of different Asian cultural groups must be present in all conversations and decisions related to recovery solutions and programming. Recovery solutions need to honor the shared and distinct identities within the Asian American community. This requires early engagement with each specific community, incorporation of their needs appropriately, implementation strategies in the community, and continued follow-up during and after programming for more equitable solutions and improved outcomes.



Provide support to address anti-Asian violence, discrimination and hate. Anti-Asian violence, discrimination, and hate crimes have exponentially increased since the start of the pandemic. Local public health in the Twin Cities has declared racism a public health threat.²⁶ Acts of anti-Asian racism, whether overt or covert, is detrimental to the physical, emotional, and mental health and well-being of the community. State and local funding need to be appropriated for violence prevention, trauma-informed care and resources offered to the Asian community and continued public education on racism and bystander intervention in all spaces of work, education, and healthcare.

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Conclusion

As the COVID-19 pandemic continues, the number of preventable deaths will increase at rates we cannot forecast. Use and access to disaggregated information would contribute to more targeted responses and better examination of issues that contribute to preventable deaths during this pandemic.²⁷ This report shows that disaggregated data exist and can be used to analyze the burden of disease in specific cultural communities and provide evidence for targeted resource allocation.

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