Community Health Implementation Strategy

ASPIRUS HEALTH

2025-2028

ASPIRUS IRON RIVER HOSPITAL & CLINICS
1400 W Ice Lake Rd., Iron River, MI 49935

ASPIRUS IRONWOOD HOSPITAL & CLINICS
N 10561 Grand View Lane, Ironwood, MI 49938

ASPIRUS KEWEENAW HOSPITAL & CLINICS
205 Osceola St., Laurium, MI 49913

Acknowledgements

The Aspirus hospitals and clinics in and around Iron River, Ironwood and Laurium are grateful to the community stakeholders who participated in the listening sessions in Spring 2025. This plan begins from that point, and we are continuing to connect.

The plan coincides with the expansion of Aspirus Health's system-level strategies with tailored local flair. Being able to offer strategies that have built-in infrastructure is a way to build early momentum. The three-year timespan of the plan will bring more opportunities for strengthening the communities we serve.

We look forward to building new and enhancing current community relationships as part of improving people's health.

Respectfully,
Natalie Seaber, President – Michigan Region

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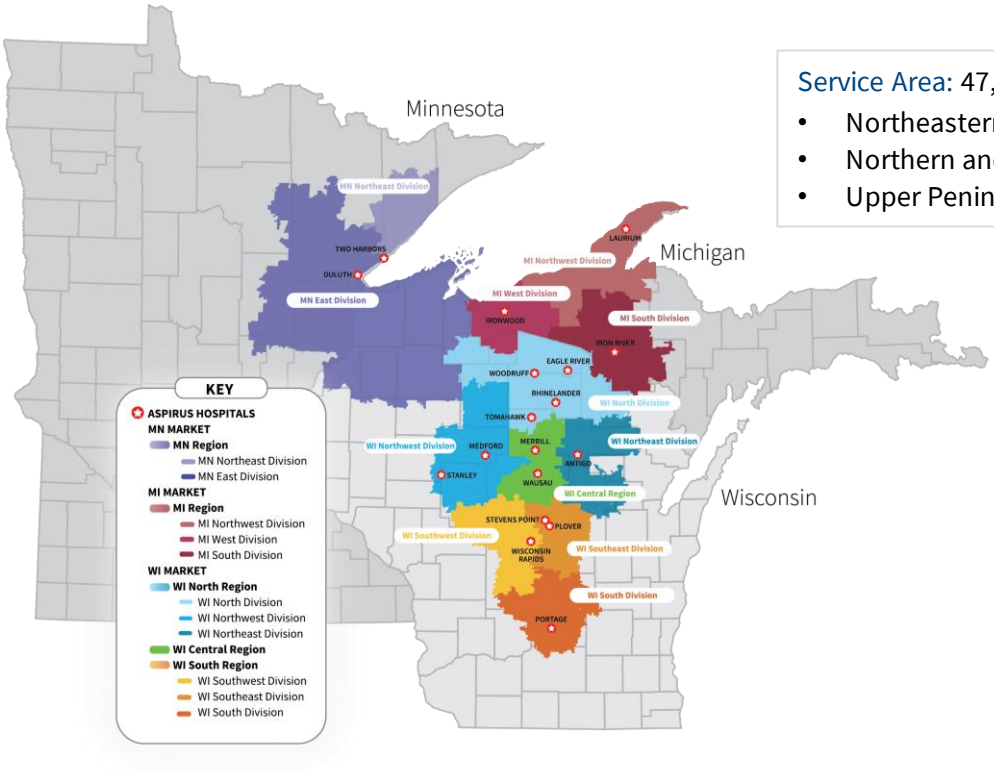
Profiles for Aspirus Health and Aspirus Ironwood, Aspirus Iron River and Aspirus Keweenaw Hospitals

Aspirus Health

Aspirus Health is a nonprofit, community-directed health system based in Wausau, Wisconsin, serving northeastern Minnesota, northern and central Wisconsin and the Upper Peninsula of Michigan. The health system operates 18 hospitals and 130 outpatient locations with nearly 14,000 team members, including 1,300 employed physicians and advanced practice clinicians. Learn more at aspirus.org.



Service Area: 47,517 square miles

- Northeastern Minnesota
- Northern and Central Wisconsin
- Upper Peninsula of Michigan

Aspirus Iron River Hospital and Clinics, Aspirus Ironwood Hospital and Clinics, and Aspirus Keweenaw Hospital and Clinics

Aspirus supports three hospitals and multiple clinics in the Upper Peninsula of Michigan. Aspirus Iron River Hospital is in Iron River; Aspirus Ironwood Hospital is in Ironwood; Aspirus Keweenaw Hospital is in Larium. All of the hospitals and clinics are committed to providing local access to high quality health care. Among the services provided to residents of the Upper Peninsula are: inpatient hospital care, 24/7 emergency departments, surgical services, imaging, laboratory, pharmacy, and outpatient therapies. Aspirus Keweenaw offers sleep services and a fitness center with medically-based community fitness programs. Aspirus Ironwood offers senior wellness programming. Aspirus also offers home care and hospice programs in the UP.

About the Implementation Strategy

For Aspirus, the community health needs assessment (CHNA), and the corresponding implementation strategy (IS) is one way to live our mission – to heal people, promote health and strengthen communities – and reach our vision – being a catalyst for creating healthy, thriving communities.

Definition / Purpose of a CHNA and Implementation Strategy

A CHNA is "a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize, plan and act upon unmet community needs."[1] The value of the CHNA lies not only in the findings but also in the process itself, which is a powerful avenue for collaboration and potential impact. An implementation strategy is "the hospital's plan for addressing community health needs, including health needs prioritized in the CHNA and through other means".[2]

Compliance

The completion of a needs assessment – and a corresponding implementation strategy – is a requirement for both hospitals and health departments. For non-profit hospitals, the requirement originated with the Patient Protection and Affordable Care Act (ACA). The IRS Code, Section 501(r)(3) outlines the specific requirements, including having the final, approved report posted on a public website. Additionally, CHNA and Implementation Strategy activities are annually reported to the IRS.

[1] Catholic Health Association of the United States, https://www.chausa.org

[2] Catholic Health Association of the United States, *A Guide for Planning & Reporting Community Benefit*

Final Prioritized Needs

Over the next three years, the Aspirus hospitals in Michigan will formally address the following issues through their community health needs assessment and corresponding implementation strategy:

- Mental health
- Access to care

Needs Not Selected

Aspirus Iron River, Aspirus Ironwood and Aspirus Keweenaw are not addressing the following needs for the following reasons:

- Substance use. Substance use was the third-highest rated priority area in the community meeting, and Aspirus has limited capacity to lead community-level efforts in this area. The hospitals will continue to address substance use through treatment and referrals, as well as system-level strategies (e.g., recovery coaches).
- Chronic disease. Chronic disease was the fourth-highest rated priority area in the community meeting, and Aspirus has limited capacity to lead community-level efforts in this area. The hospitals will continue to address chronic disease through treatment and referrals, as well as system-level strategies (e.g., fruit and vegetable prescription program).

General Approach to Implementation

For its community health improvement efforts, Aspirus Health is using the following approaches:

- *Results-based accountability*. Aspirus Health is applying the results-based accountability (RBA)[3] framework to its implementation plans. RBA focuses on both population-level accountability as well as program-level accountability. The descriptions below are outlined in the RBA framework.
- *Continuum of care*. Aspirus Health is approaching complex community health issues from multiple levels, as outlined by the Institute of Medicine (IOM):[4]
    - Upstream prevention (also known as promotion): Strategies that are designed to "create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services."[5] Examples of upstream conditions include housing, community safety, education/learning, a living wage/income and more.
    - Prevention: Strategies that are designed to "prevent or reduce the risk of developing a behavioral health problem…."[6]
    - Treatment: Strategies that are designed for individuals "diagnosed with a substance use or other behavioral health disorder."[7]

A description of the plans to address the needs, prefaced by data and community input gathered in the assessment, are on the next pages. The plans:

- Are described at a general level; plans with more specificity will be created annually.
- Reflect intended efforts; circumstances may affect the completion of the efforts.
- May be modified over the course of time.
- Include program evaluation measures in the "performance indicators" section of the table.

[3] Clear Impact, https://clearimpact.com/results-based-accountability/
[4] Center for the Application of Prevention Technologies Fact Sheet, https://www.mass.gov/doc/samhsa-behavioral-health-continuum-of-care-overview-9232019/download
[5] Ibid
[6] Ibid
[7] Ibid

Mental Health

Why is it Important?

More than 1 in 5 adults in the United States (59.3 million people in 2022) has a mental illness.[1] Mental health and physical health are closely related, with a correlation between some physical chronic illnesses and poor mental health.[2] Some risk factors include lack of access to education, income, employment and housing; adverse childhood experiences (ACEs); social isolation; drug or alcohol use.[2] Untreated mental health issues can contribute to issues such as family conflicts, problems with drugs or alcohol, weakened immune system, some chronic diseases and more.[3]

Sources: (1) National Institute of Mental Health, https://www.nimh.nih.gov/health/statistics/mental-illness. Accessed on 2/20/2025. (2) Centers for Disease Control and Prevention, https://www.cdc.gov/mental-health/about/index.html. Accessed on 2/20/2025. (3) Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968. Accessed on 2/20/2025.

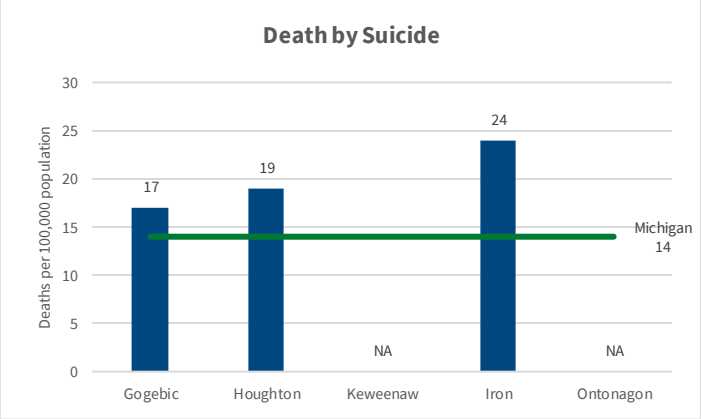
Disparities and Inequities

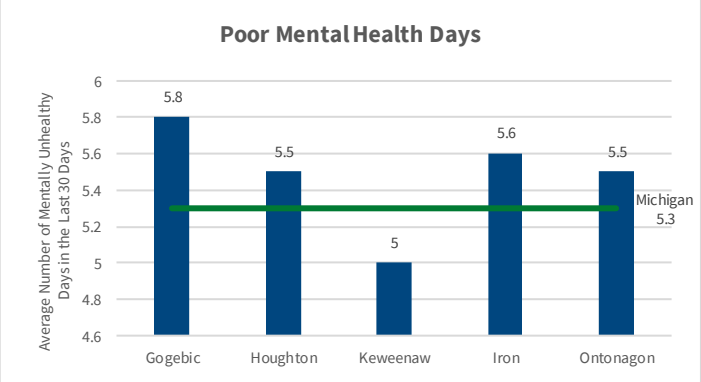
Disparities and inequities can show where interventions would be most beneficial.

- In the U.S., young adults (ages 18-25) have higher levels of any mental illness compared to adults 26-49 and over 50 years old.[1]
- Individuals in marginalized groups are more likely to have poor mental health.[2]
- The likelihood of depression decreases as education levels increase.[4]
- Depression is higher for women compared to men.[3]
- The suicide rate for men is four times the rate for women.[4]
- Over 50 percent of the students who identified in each of the following groups reported having anxiety: LGB; with disabilities; with food insecurity; with low grades; who are Hispanic; who have a multi-racial background.[5]

Sources: (1) National Institute of Mental Health, https://www.nimh.nih.gov/health/statistics/mental-illness. Accessed on 2/20/2025. (2) Macintyre, A., Ferris, D., Gonçalves, B.et al. What has economics got to do with it? The impact of socioeconomic factors on mental health and the case for collective action. Palgrave Commun4, 10(2018). https://doi.org/10.1057/s41599-018-0063-2. (3) Centers for Disease Control and Prevention, https://www.cdc.gov/mmwr/volumes/72/wr/mm7224a1.htm. Accessed on 2/21/2025. (4) National Institute of Mental Health, https://www.nimh.nih.gov/health/statistics/suicide#part_2557. Accessed on 2/21/2025. (5) Wisconsin Youth Risk Behavior Survey Summary Report (2021), Summary Report: 2021 Wisconsin Youth Risk Behavior Survey. Accessed on 2/21/2025.

Data Highlights





Source: 2024 County Health Rankings

Community Perceptions and Challenges

- Mental health was the top issue identified by community members in the listening sessions.
- Community stakeholders identified momentum: emergency department transfers to inpatient beds is improving; law enforcement's use of iPads in crisis situations is reducing visits to the emergency department; crisis services are available.
- Community stakeholders identified gaps: insurance coverage; decreasing in-school funding for mental health awareness and services; high levels of youth depressive symptoms.

Mental Health

One or more of the hospitals plan to address access to care through the strategies below. Strategies might be completed with funding, dedicated staff time and/or coalition participation. Additional information on which hospital anticipates completing which strategy can be found in the addendum.

Program Accountability		Population Accountability	
Strategies	**Performance Measures**	**Indicators**	**Results**
Prevention			
• Participate in local community coalitions • Support mental health and suicide prevention trainings and efforts (e.g., Question, Persuade, Refer; MH First Aid, reduced access to lethal means) • Conduct an environmental scan of school districts' mental health-related efforts and respond • Explore Community Health Worker (CHW) opportunities and respond	• # of trainings or programs • # of training or program participants • Training or program evaluation results • CHW pilot project results and next steps	• Decrease the suicide rate (baselines are between 17 and 24 deaths per 100,000 population for the five counties (2017-2021)) • Decrease the average number of poor mental health days in the last 30 days (baselines are between 5.0 and 5.8 days for the five counties (2021)) • Increase youth resilience • Decrease youth depression • Decrease youth anxiety • Increase in the number of tele-behavioral health visits	Community members have equal opportunities for mental well-being
Treatment			
• Provide tele-behavioral health services • Support recovery coaches and/or peer support (e.g., funding for Phoenix House)	• # of participants		

Collaborative Partners	Aspirus Resources
• Phoenix House • Northern Michigan University • Western Upper Peninsula and Dickinson-Iron District Health Departments • Copper Country, Gogebic-Ontonagon, and Dickinson-Iron Intermediate School Districts • Community Mental Health Agencies	• Funding through Aspirus Community Benefit Funding – particularly for Phoenix House • Staff time – coalition participation, suicide reduction efforts, environmental scan, CHW efforts, resource identification • Space – hosting support groups and meetings • Clinical services and related infrastructure – providing direct mental health care; using FindHelp to connect patients to community resources

Access to Care

Why is it Important?

High quality clinical care is accessible, timely, safe, effective and affordable, providing the right care for the right person at the right time. Clinical care should also respect and value patients' unique cultural beliefs, practices and values. Access to it can protect and improve physical, social and mental health. Health insurance helps individuals and families access care but does not guarantee it; providers need to be both available, in relatively close proximity to patients and offer affordable care.[1]

Primary care providers offer a usual source of care, early detection and treatment of disease, chronic disease management, and preventive care. Patients with a usual source of care are more likely to receive recommended preventive services such as flu shots, blood pressure screenings, and cancer screenings. However, disparities in access to primary care exist, and many people face barriers that decrease access to services and increase the risk of poor health outcomes. Some of these obstacles include lack of health insurance, language-related barriers, disabilities, inability to take time off work to attend appointments, geographic and transportation-related barriers, and a shortage of primary care providers.[2]

Sources: (1) The paragraph is verbatim from https://www.countyhealthrankings.org/health-data/community-conditions/health-infrastructure/clinical-care (2) This paragraph is verbatim from https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care.

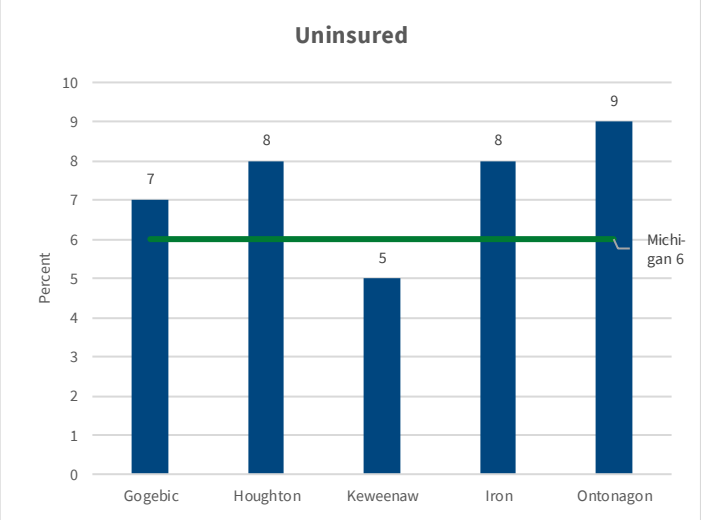
Disparities and Inequities

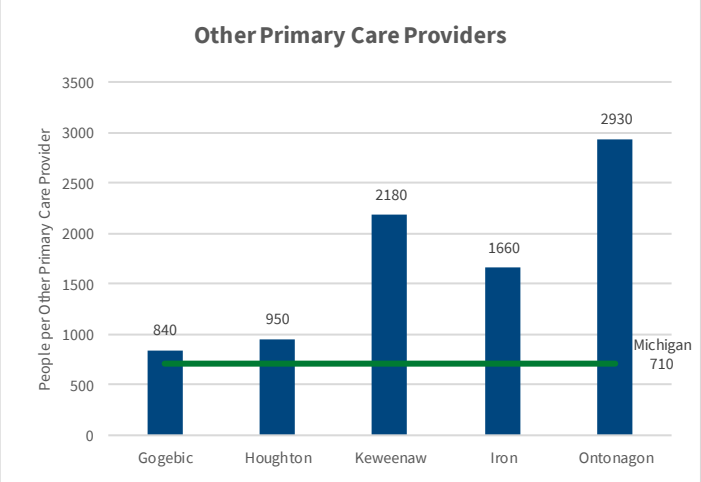
Disparities and inequities can show where interventions would be most beneficial.

- Not having healthcare insurance is associated with not having preventive care and not receiving services for major health conditions and chronic diseases. With less outpatient care, individuals are more likely to be hospitalized for avoidable care and experience overall health declines.[1]
- Compared to higher-income Americans, low-income people face greater barriers to accessing medical care. They are less likely to have health insurance, receive new drugs and technologies, and have ready access to primary and specialty care. Low-income workers are more likely to be employed by organizations that do not offer health benefits.[2]

Sources: (1) https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/ (2) Excerpted verbatim from https://www.healthaffairs.org/content/briefs/health-income-poverty-we-could-help

Data Highlights





Source: 2024 County Health Rankings

Community Perceptions and Challenges

- Access to care was the second-highest issue identified by community members in the listening sessions.
- Community stakeholders identified gaps: high co-pays; the closure of the Ontonagon Hospital; provider turnover; transportation.

Access to Care

One or more of the hospitals plan to address access to care through the strategies below. Strategies might be completed with funding, dedicated staff time and/or coalition participation. Additional information on which hospital anticipates completing which strategy can be found in the addendum.

Program Accountability		Population Accountability	
Strategies	**Performance Measures**	**Indicators**	**Results**
Upstream Prevention (Promotion)			
• Explore transportation models and respond	• SBAR or SWOT of current state and potential solutions • FindHelp closed-loop referrals for transportation		
Prevention			
• Explore Community Health Worker (CHW) opportunities and respond • Analyze SDoH data and respond with FindHelp-related strategies (e.g., closed-loop referrals)	• CHW pilot project results and next steps • SDoH screening rates • FindHelp utilization • FindHelp closed-loop referrals	• Increase in clinic visits • Increase in the hours the clinics are open • Increase in tele-medicine specialty visits • Improvement in Nourished Rx participant measures (e.g., food security, depression, etc.)	Community members have access to high quality primary and specialty care
Treatment			
• Provide tele-medicine for ambulatory specialty care • Provide Walk-in care • Provide home-delivered, medically-tailored food (Nourished Rx)	• Clinical strategy for extended clinic hours • # of Nourished Rx participants		

Collaborative Partners	Aspirus Resources
• Northern Michigan University • Western Upper Peninsula and Dickinson-Iron District Health Departments •	• Funding through Aspirus Community Benefit Funding • Staff time – coalition participation, CHW efforts, resource identification • Space – hosting support groups and meetings • Clinical services and related infrastructure – providing primary, specialty and home health care; using FindHelp to connect patients to community resources

Social Drivers and Equity

Research shows that social and economic factors (social drivers) are significant 'upstream' contributors to individuals' and communities' health outcomes. In clinical settings, Aspirus hospitals are gathering social drivers of health (SDOH) data as a way to understand how to tailor care to better meet the unique needs of each patient, leading to improved health equity and better health outcomes. Using aggregated patient-level social drivers data can assist in understanding the root causes of complex health issues to improve access to preventative and chronic care services. Linking patient level SDOH data and community level data can provide stronger clinical-community linkages to help connect healthcare providers, community organizations and public health agencies.

Aspirus is committed to recognizing and addressing health-related social needs as part of its overall community health improvement efforts. Several related strategies/approaches are being implemented within the hospital and clinics, including:

- Connecting patients with food resources
- Identifying resources for patient transportation needs
- Providing free home-delivery services for prescription medications

As appropriate, Aspirus staff may participate in other community-level efforts to address other healthcare and health-related social needs.

Approval by the Hospital Board

The implementation strategy report was reviewed and approved by the Aspirus Iron River, Aspirus Ironwood and Aspirus Keweenaw Board of Directors on November 5, 2025.

Conclusion

Thank you to all the community members who provided thoughts, input and constructive feedback throughout the process.

Addendum

The table below describes which hospital anticipates implementing which strategy in the next three years.

Priority/Strategy	Aspirus Iron River Hospital and Clinics	Aspirus Ironwood Hospital and Clinics	Aspirus Keweenaw Hospital and Clinics
Mental Health			
Coalition participation	Yes	Yes	Yes
Mental health and suicide prevention trainings	Yes	Yes	Yes
Reduce access to lethal means	Yes	Yes	Yes
Conduct an environmental scan of school districts' mental health-related efforts and respond	Yes	Yes	Yes
Explore Community Health Worker (CHW) opportunities	Yes	Yes	Yes
Tele-behavioral health services	Yes	Yes	Yes
Recovery coaches and/or peer support	TBD	TBD	Yes
Access to Care			
Explore transportation models and respond	Yes	Yes	Yes
Explore Community Health Worker (CHW) opportunities	Yes	Yes	Yes
Analyze SDoH data and respond with FindHelp-related strategies	Yes	Yes	Yes
Tele-medicine for ambulatory specialty care	Yes	Yes	Yes
Walk-in clinic	No	Yes	No
Nourished Rx	Yes	Yes	Yes

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October 2025