Community Health Needs Assessment

2025-2028

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Acknowledgements

The Aspirus Upper Peninsula Hospitals extend our deepest gratitude to the many community members and stakeholders who took part in the March 2024 listening sessions. Your voices, experiences, and ideas are essential in shaping the path forward for the health and well-being of our region.

We are also thankful to the Western Upper Peninsula Health Department for facilitating the community survey and helping us gather meaningful insights. Together, these efforts reflect the power of collaboration and our shared commitment to building a healthier future.

This report captures a moment in time – but it is only the beginning. What comes next is a shared responsibility: transforming community input into action. We are committed to continuing this journey hand-in-hand with you, our partners, to address the needs identified and create lasting impact for the residents of the Western Upper Peninsula.

Thank you for your partnership and dedication to the health of our communities.

Respectfully,
Sherry Bunten, Interim President – Michigan Region

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Executive Summary

Aspirus Iron River Hospital, Aspirus Ironwood Hospital and Aspirus Keweenaw Hospital conducted a community health needs assessment from late 2024 through Spring 2025. The assessment included:

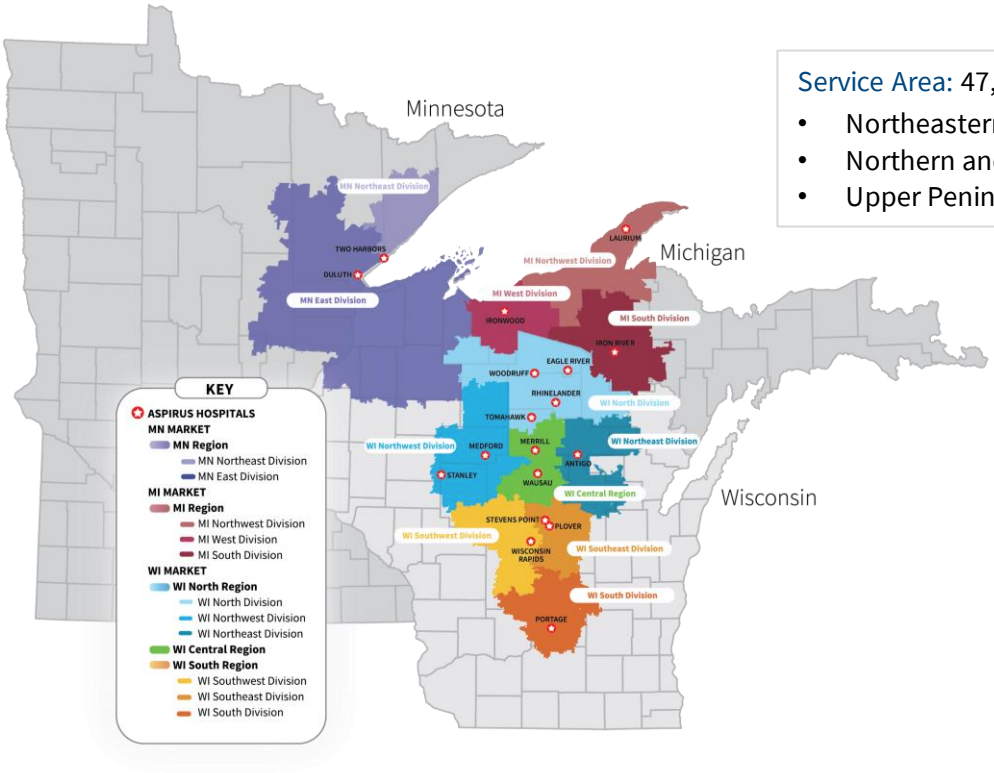
- The compilation of two kinds of data:
    - Community input. Community input was gathered through two virtual community stakeholder input sessions.
    - Health status data. Data on the health of the community was obtained primarily from the County Health Rankings and Roadmaps and the Wisconsin Department of Health Services.
- The review of data through the lens of multiple criteria (e.g., prevalence of the issue, internal infrastructure).
- A prioritization process that considered community input, health status data and criteria.
- The selection of a set of priorities the hospital is committed to formally pursuing over the next three years.

The three hospitals will be developing a plan to address **access to care** and **mental health**. As strategies are developed to address these issues, the hospital will be cognizant of the social drivers of health that contribute to these issues.

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 Iron River Hospital and Clinics is committed to providing local access with high quality health care and has the opportunity to keep care local and strengthen access to primary and specialty care.

Among the services provided to residents of Iron County and the UP include inpatient hospital care, a 24/7 emergency department, surgical services, imaging, laboratory, pharmacy and outpatient therapies. Aspirus also offers home care and hospice programs in the UP.

Aspirus Ironwood Hospital and Clinics

Aspirus Ironwood Hospital and Clinics is committed to providing local access with high quality health care and has the opportunity to keep care local and strengthen access to primary and specialty care.

Among the services provided to residents of Gogebic County and the UP include inpatient hospital care, a 24/7 emergency department, surgical services, imaging, laboratory, pharmacy and outpatient therapies. Aspirus also offers home care and hospice programs in the UP.

Aspirus Keweenaw Hospital and Clinics

Aspirus Keweenaw Hospital and Clinics in Laurium is committed to providing local access with high quality health care and has the opportunity to keep care local and strengthen access to primary and specialty care.

Among the services provided to residents of the Keweenaw Peninsula and the UP include inpatient hospital care, a 24/7 emergency department, surgical services, imaging, laboratory, pharmacy and outpatient therapies. Aspirus Keweenaw Fitness Center is a medically based community fitness facility. Aspirus also offers home care and hospice programs in the UP.

About the Community Health Needs Assessment

For Aspirus, the Community Health Needs Assessment (CHNA) 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. Conducting a CHNA is an opportunity to understand what health issues are important to community members. Community resources, partnerships and opportunities for improvement can also be identified, forming a foundation from which strategies can be implemented.

Definition / Purpose of a CHNA

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. The momentum from the assessment can support cross-sector collaboration that: 1) leverages existing assets in the community creating the opportunity for broader impact, 2) avoids unnecessary duplication of programs or services thereby maximizing the uses of resources, and 3) increases the capacity of community members to engage in civil dialogue and collaborative problem solving to position the community to build on and sustain health improvement activities.

Compliance

The completion of a needs assessment 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

Community Served and Demographics

Our Community

The hospitals' service area includes Gogebic, Houghton, Keweenaw, Iron and Ontonagon Counties. For the purposes of the Community Health Needs Assessment, the "community" is defined as these five counties because: (a) most population-level data are available at the county level and (b) this is the primary service area of the Aspirus hospitals and clinics.

All five counties are designated Health Professional Shortage Areas (HPSA) for dental (population-based HPSA) and primary care (geographic-based HPSA). Gogebic, Houghton and Keweenaw Counties are designated high need HPSAs for mental health (geographic HPSAs), and Iron and Ontonagon Counties are designated HPSAs for mental health (geographic-based HPSA). All five counties are designated Medically Underserved Areas (MUA).

Demographics

Gogebic, Houghton, Keweenaw, Iron and Ontonagon Counties are all in the Upper Peninsula of Michigan. The area is rural. The region covers 5128 square miles, with 13.9 people per square mile and an overall population of 71,234 people. The table below outlines some of the basic demographics and related descriptors of the counties' population compared to Michigan.

Compared to Michigan, these five counties have a higher percentage or proportion of individuals:	**Compared to Michigan, these five counties have a lower percentage or proportion of individuals:**
Who are White (alone)	Who are African American
Who are Veterans	Who are Asian
With a disability (all except Houghton Co.)	Who are Hispanic
Over age 65 (except Houghton County)	Under age 18
Who are high school graduates	
Without healthcare coverage (except Ontonagon County)	

Compared to Michigan, the counties have a:

- Higher median age (except Houghton County)
- Lower median household income
- Lower proportion of households where a language other than English is the primary language

Compared to Michigan, the counties vary in the percentage of the population:

- With Bachelor's degrees
- In poverty

Demographics of a community help with understanding changes in the population, economy, social and housing infrastructure.[2] Knowing who is part of the community and what their strengths and challenges are contributes to a stronger assessment and plan. See Appendix A for additional information.

Process and Methods Used – Models and Frameworks

Aspirus' community health improvement approach is based on national research and models. This helps provide consistency and opportunities for alignment as we work across the health system and in our communities.

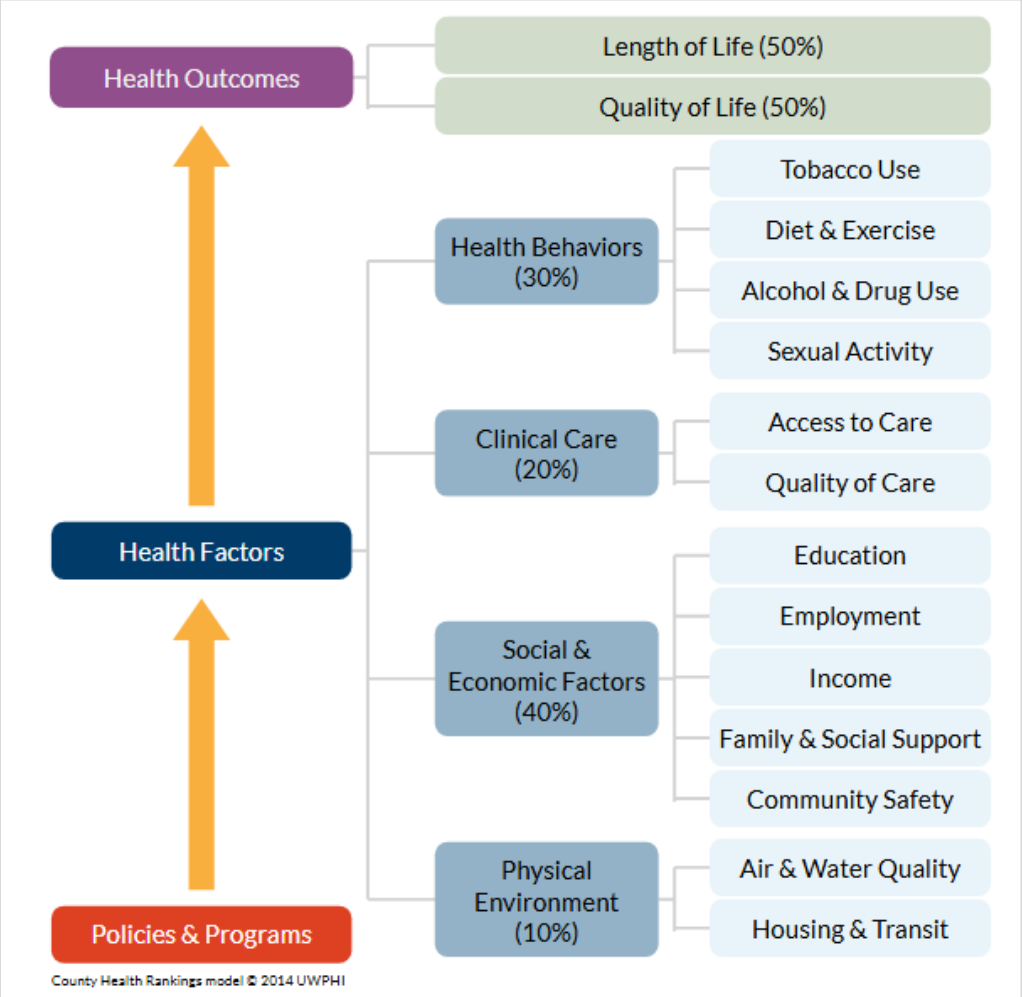
- For organizing data, Aspirus uses the County Health Rankings and Roadmaps Model. The model accounts for clinical, social, economic, behavioral and environmental factors that impact health.
- Aspirus recognizes that the factors affecting health are complex. The Bay Area Regional Health Inequities Initiative (BARHII) model helps represent those forces, as well as opportunities to intervene.
- A third model helps describe the difference between health equality and health equity.
- Lastly, Aspirus uses the Action Cycle from the County Health Rankings and Roadmaps . The Action Cycle describes how to conduct a community health needs assessment as well as community health improvement initiatives.

There are many other comparable models, which can be found in the Appendix B.

[2] Dan Veroff, University of Wisconsin-Madison, Division of Extension, Organizational and Leadership Development. What you can learn about your community from demographics.

Understanding Data: County Health Rankings Model

The County Health Rankings and Roadmaps Determinants of Health model was developed by the University of Wisconsin Population Health Institute (UWPHI). The Determinants of Health model (below) has three components – health outcomes, health factors and policies and programs. The County Health Rankings and Roadmaps (with funding from the Robert Wood Johnson Foundation) provides publicly available data within this framework for every county and state in the United States. For Aspirus, the health status data and much of the community input are organized in this framework.

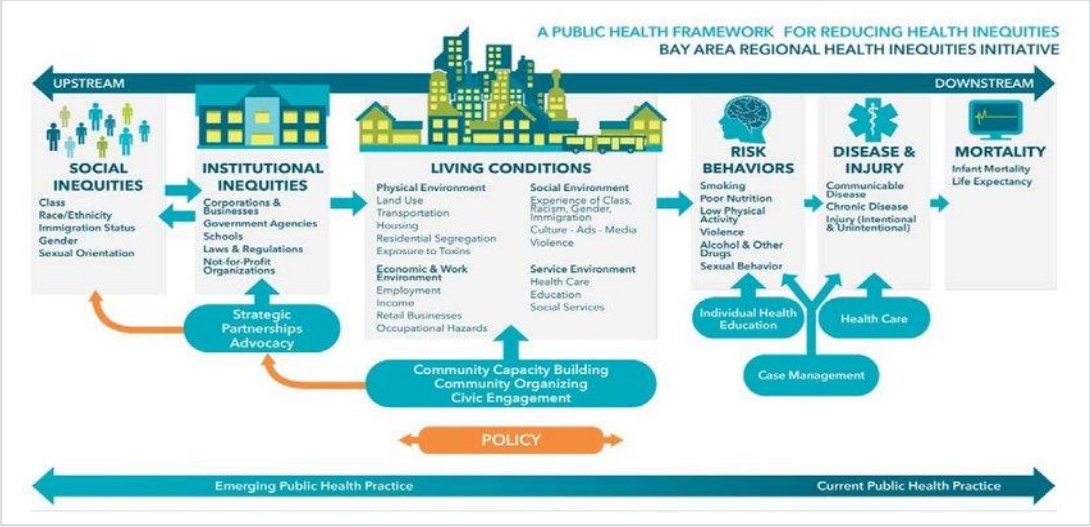


Understanding Equity, Inequities and Complex Factors

As shown in the County Health Rankings Model above, there are many factors that affect health. Those factors are, in turn, affected by policies, systems and environmental factors. For example:

- Pricing and taxation on cigarettes impact smoking levels.
- Zoning regulations impact how close or far a community is from a toxic waste dump.
- Stop signs, stop lights, school zones and roundabouts guide traffic patterns (and consequently the likelihood of accidents and injuries).

A model developed by the Bay Area Regional Health Inequities Initiative (BARHII) shows how those factors intersect.



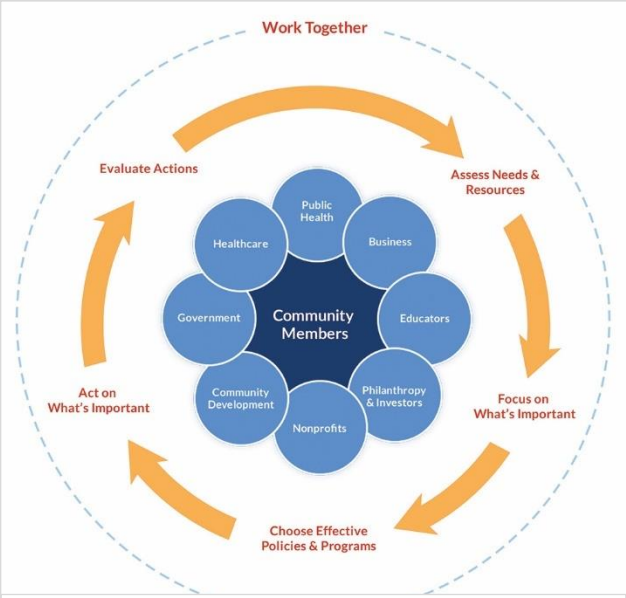
Another model helps explain the importance of recognizing that sometimes a one-size-fits-all solution does not work. The Robert Wood Johnson Foundation provided this health equity 'bicycle' model. If a person wants to go on a bicycle ride with their friends and family, each person needs a different bicycle solution to enjoy the ride. This parallels the work in health equity. Knowing what solutions work best for which people helps focus the provision of the appropriate resources.

Because of complex factors and forces, and the importance of individuals and communities getting what they need to be healthy, Aspirus is focused on strategies that impact everyone positively as well as strategies that disproportionately affect those who are most vulnerable to disease or illness.

Understanding the Process: Action Cycle

The Action Cycle (from the County Health Rankings and Roadmaps) outlines, at a very high level, the overall community health assessment and improvement process:

- Assessing needs and resources
- Focusing on what's important (i.e., prioritizing)
- Choosing effective policies and programs (i.e., planning)
- Acting on what's important (i.e., implementing)
- Evaluating actions
- Effectively communicating and collaborating with partners



https://www.countyhealthrankings.org/resources/take-action-cycle

Process and Methods Used – Applied

Aspirus Iron River, Aspirus Ironwood and Aspirus Keweenaw gathered community input and compiled data to learn more about what is important to the community.

Collaborators and / or Consultants

Aspirus conducted the needs assessment. The Western U.P. Health Department disseminated a community survey in Fall 2024, however the final results were not available for incorporation into this assessment. No paid consultants or vendors were utilized.

Community Input

Residents of the Upper Peninsula, as well as neighboring Wisconsin counties, provided their voices to the community health needs through listening sessions. A concerted effort was made to ensure that the individuals and organizations represented the needs and perspectives of: 1) public health practice; 2) individuals who are medically underserved, have low income, or are considered among the minority populations served by the hospital; and 3) the broader community at large and those who represent the broad interests and needs of the community served.

Key Stakeholder Listening Sessions

To gather community input, Aspirus invited over 50 key stakeholder organizations to participate in one of two listening sessions. (See Appendix C for a list of organizations.) Both listening sessions had the same content and structure and both were held in March 2025.

Aspirus prepared and shared materials in advance of the meeting, including:

- An internally-prioritized list of the top four health issues to discuss
    - This list included a rationale with criteria
- Discussion questions
    - For which issues is there current community momentum (e.g., effective strategies)? What does the momentum look like?
    - Where are there gaps that the hospital and clinics might be able to contribute to addressing?
    - Are there any emerging trends or other important information that is missing?
- Additional secondary data

The internally-prioritized list of the top four health issues was:

- Mental health
- Substance use
- Chronic disease
- Access to care

The identification of those issues was the result of a review of information across multiple criteria:

- Demographics and related measures
- Prevalence of the issue
- Internal infrastructure
- Current hospital priority area
- Community survey priority area (most recently available from 2021)

A table outlining the issues and criteria can be found in Appendix D.

Approximately 50 community stakeholders (excluding Aspirus staff) participated in the meetings.

Qualitative input was documented, including where there is momentum (and things are improving) and where there are gaps (that are of concern).

In addition, the participants provided quantitative input through a short poll. The results were:

- Mental health (23 votes)
- Access to care (15 votes)
- Substance use (7 votes)
- Chronic disease (4 votes)
- Other (2 votes)

See Appendix E for qualitative and quantitative results.

Input Received on the Last CHNA

No known input on the previous CHNA was received.

Health Status Data / Outside Data

In addition to gathering input directly from community members, Aspirus compiled outside data reflective of the overall population's health status. These 'health status data' are gathered by credible local, state and national governmental and non-governmental entities and published/shared.

Reflective of the University of Wisconsin Population Health Institute (UWPHI) model, the data were grouped in the following categories:

- Health outcomes
- Health behaviors
- Clinical care
- Social and economic factors
- Physical environment

A summary of the health status data and corresponding sources can be found in Appendix F.

Community Needs and Prioritization Process

Multiple steps led to the prioritization of **mental health** and **access to care**:

- Identifying four internally-prioritized health issues through the review of data and the lens of criteria:
    - Demographics and related measures
    - Prevalence of the issue
    - Internal infrastructure
    - Current hospital priority area
    - Community survey priority area (most recently available from 2021)
- Compiling secondary data
- Providing qualitative and quantitative opportunities for community input:
    - Current context was shared by community partners
    - Mental health and access to care were top issues
    - Additional concerns were identified
- Aspirus Community Health team recommending the prioritized issues to administrative leadership

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).

A brief overview of the top issues is on the next pages.

Healthcare Facilities and Community Resources

A brief description of health care and other organizations available to address community needs is in Appendix G.

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.

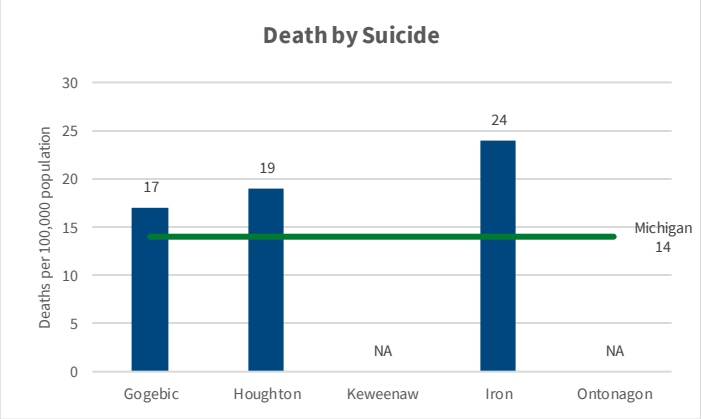
Disparities and Inequities

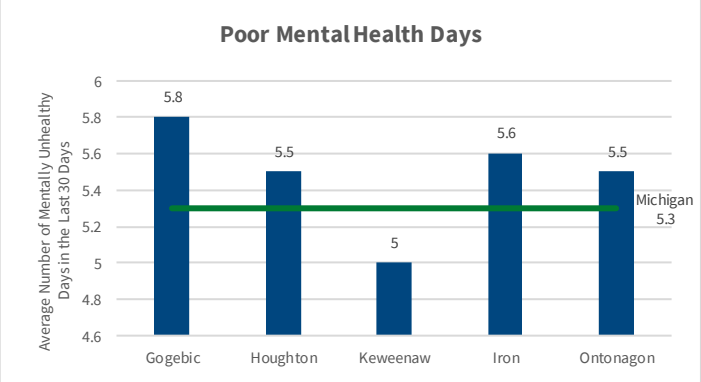
Disparities and inequities can show where interventions would be most beneficial.

- 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.

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.

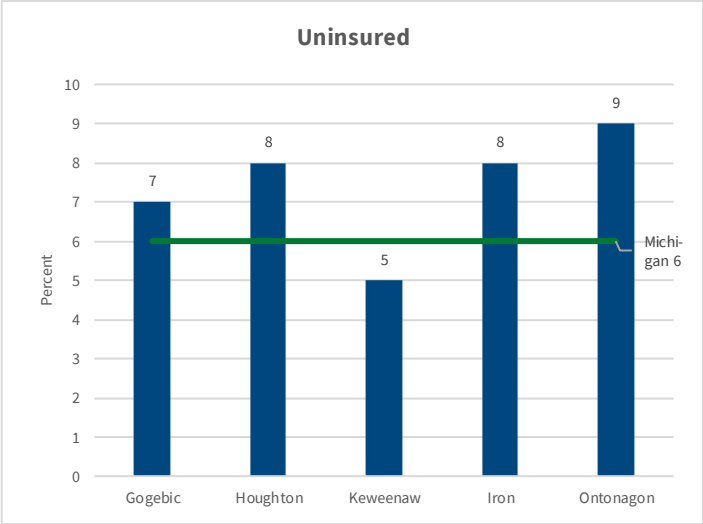
Disparities and Inequities

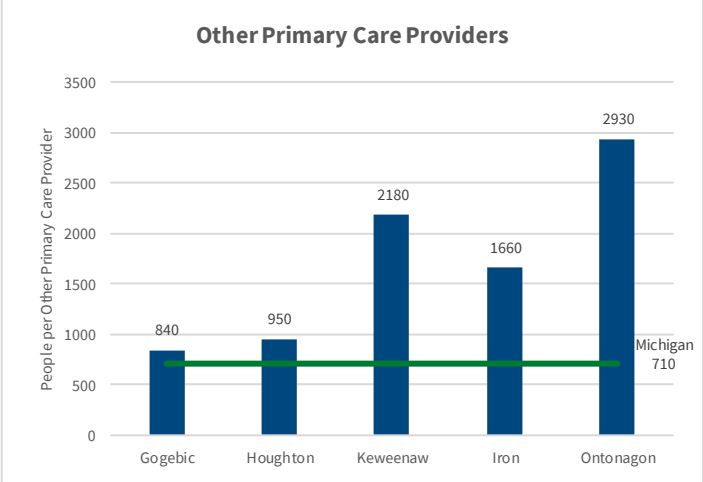
Disparities and inequities can show where interventions would be most beneficial.

- 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.

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. A number of related strategies/approaches are being implemented within the system:

- Connecting patients with food and other basic needs resources (through FindHelp.org)
- Fruit and vegetable prescription program

As appropriate, Aspirus staff will be participating in coalitions and community-level efforts to address other health-related social needs (e.g., transportation, housing).

Evaluation of Impact from the Previous CHNA Implementation Strategy

The Aspirus Michigan hospitals' priority health issues from the previous CHNA included:

- Substance use
- Mental health
- Chronic disease

A summary of the impact of efforts to address those needs is included in Appendix H.

Approval by the Hospital Board

The CHNA report was reviewed and approved by the Aspirus Iron River, Aspirus Ironwood and Aspirus Keweenaw Board of Directors on May 19, 2025.

Conclusion

Thank you to all the community members who provided thoughts, input and constructive feedback. The Aspirus hospitals will continue to work with community partners to address the health issues important to the region.

Appendices

Appendix A: Demographics and Related Descriptors

The table below outlines some of the demographic characteristics of the counties Aspirus serves in the Upper Peninsula of Michigan.

	Michigan	Gogebic County	Houghton County	Keweenaw County	Iron County	Ontonagon County
Population	10,077,331	14,380	37,361	2,046	11,631	5,816
Population per square mile	178.0	13.0	37	3.8	10.0	4.4
Age <18	21.0%	16.4%	19.9%	14.8%	17.4%	11.6%
Age 65+	19.3%	28.8%	17.7%	36.0%	30.9%	37.8%
Median age	40.5	51.3	32.3	56.7	53.2	59.4
White alone	73.9%	90.8%	91.3%	95.5%	94.0%	94.1%
Black or African American alone	13.7%	<1%	<1%	<1%	<1%	<1%
American Indian and Alaska Native alone	0.6%	3.6%	<1%	<1%	<1%	1.1%
Asian alone	3.3%	<1%	2.3%	0%	<1%	<1%
Two or more races	6.3%	4.3%	4.4%	3.5%	4.2%	4.1%
Hispanic or Latino	5.6%	1.5%	1.8%	1.3%	1.8%	1.2%
Language other than English spoken at home	10.5%	2.5%	6.8%	3.0%	2.0%	1.7%
High school graduate or higher	92.1%	95.8%	94.5%	97.5%	93.4%	94.1%
Bachelor's Degree or Higher	32.7%	21.9%	36.6%	43.6%	20.6%	16.7%
Individuals who are veterans	5.6%	10.6%	6.8%	17.0%	10.5%	14.5%
Individuals with disabilities	14.7%	18.3%	11.3%	14.8%	21.7%	20.8%
Persons in poverty	13.5%	15.0%	15.9%	8.7%	16.9%	12.6%
Median household income	$69,183	$49,672	$56,573	$53,893	$53,614	$51,844
Percent without healthcare coverage	4.5%	6.1%	6.0%	7.6%	4.7%	4.1%
Percent using public insurance (Medicaid, Medicare, veterans' benefits, etc.)	40.0%	57.4%	37.1%	53.6%	55.2%	60.7%

Sources:

MI: Michigan - Census Bureau Profile and corresponding tables accessed on January 27, 2025

MI: S2704: Public Health Insurance ... - Census Bureau Table accessed on January 27, 2025

Counties:

Census Bureau Profiles Results and corresponding county profiles and tables, accessed on January 27, 2025 and March 5, 2025

Census Tables:

S1501 Educational Attainment

P8 Race and P9 Ethnicity

Appendix B: Frameworks and Models of Factors that Impact Health and Health Equity

Aspirus strives to include research, evidence and best practices into its community health improvement work. This appendix includes some frameworks and models that show the intersection between health and a variety of factors.

Model Type: Contributors to Health and Illness

Title / Name	Source
Social Ecological Model of Health	Wisconsin Department of Health Services https://www.dhs.wisconsin.gov/publications/p03361.pdf
Mental Health and Well-Being: A Socio-Ecological Model	University of Minnesota https://mch.umn.edu/sem/ and https://drive.google.com/file/d/14p1GfTVwbDU96TmkPr0zmP2iJENEIXsk/view
Social Drivers of Health	Midwest Kidney Network https://www.midwestkidneynetwork.org/equity-in-healthcare/social-drivers-of-health-sdoh
Social Determinants of Health	Healthy People 2030 U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://health.gov/healthypeople/objectives-and-data/social-determinants-health
Social Determinants of Health	Beckers Hospital Review
Vital Conditions for Health and Well-Being	National Association of Community Health Centers and the Rippel Foundation https://www.nachc.org/resource/vital-conditions-for-health-and-well-being/ and https://rippel.org/vital-conditions/
Societal Factors that Influence Health: A Framework for Hospitals	American Hospital Association (2024) https://www.aha.org/societalfactors and SocietalFactorsFramework_Fall2024.pdf
Impact of Social Determinants of Health	American Hospital Association (2018) https://www.aha.org/landing-page/addressing-social-determinants-health-presentation
Social Determinants and Social Needs: Moving Beyond Midstream	Brian Castrucci and John Auerbach in https://www.healthaffairs.org/content/forefront/meeting-individual-social-needs-falls-short-addressing-social-determinants-health
Social Determinants and Social Needs	National Academies https://nap.nationalacademies.org/read/25982/chapter/4#36

Model Type: Health Equity

Title / Name	Source
Equality and Equity (bicycles)	Robert Wood Johnson Foundation https://www.rwjf.org/en/insights/our-research/infographics/visualizing-health-equity.html
Framework for Reducing Health Inequities	Bay Area Regional Health Inequities Initiative (BARHII) https://barhii.org/framework

Model Type: Assessment, Planning and Implementation Process

Title / Name	Source
Action Cycle	County Health Rankings and Roadmaps https://www.countyhealthrankings.org/resources/take-action-cycle
Mobilizing for Action through Planning and Partnerships (MAPP)	National Association of County and City Health Officials (NACCHO) https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp
Community Health Assessment Toolkit	AHA Community Health Improvement [American Hospital Association (AHA) Community Health Improvement] https://www.healthycommunities.org/resources/community-health-assessment-toolkit

Model Type: Other

Title / Name	Source
Why Collect Standardized Data on Social Drivers of Health	National Association of Community Health Centers https://www.nachc.org/about-nachc/our-work/social-drivers-of-health/

Appendix C: Community Input – Listening Session Invitees

As part of the Aspirus Keweenaw, Aspirus Iron River and Aspirus Ironwood community health needs assessment process, two community listening sessions were conducted in early Spring 2025. Both listening sessions were the same. The list of invited stakeholders is below.

Agency	Sector
Western Upper Peninsula Health Department*	Public Health Agency
Phoenix House*	Substance Use
Salvation Army*	Housing, food, etc.
Keweenaw Community Foundation	Non-profit Foundation
Gogebic Sheriff's Department	Public Safety | Emergency Services
Houghton Housing Commission	Housing and Building
Laurium Housing Commission	Housing and Building
Omega House	Hospice and Palliative Care
City of Houghton	Local Government
City of Hancock	Local Government
UP Kids (foster children)*	Child and Family Services
Great Start Collaborative	Early Childhood and Family Services
Laurium Village	Local Government
Barbara Kettle Gundlach Shelter*	Domestic Violence and Victim Support
Lake Linden Village	Local Government
Copper County Intermediate School District	Education and Youth Development
Lake Linden Hubbell Schools	Education and Youth Development
Calumet Public Schools	Education and Youth Development
Hancock Public Schools	Education and Youth Development
Houghton Public Schools	Education and Youth Development
Gogebic County Medical Care Facility	Long Term Care and Rehabilitation Services
Canal View Houghton County	Long Term Care and Rehabilitation Services
Little Brothers Friends of the Elderly*	Aging and Social Support Services
Copper Shores Foundation	Non-profit Foundation
Ironwood Public Schools	Education and Youth Development
City of Ironwood	Local Government
City of Iron River	Local Government
Michigan Technological University	Education and Research

Keweenaw Chamber of Commerce	Community and Economic Development
Bessmer Public Schools	Education and Youth Development
Houghton County	Local Government
Keweenaw County	Local Government
Gogebic County	Local Government
Iron County	Local Government
Crystal Falls Village	Local Government
UPCAP*	Community and Economic Development
Michigan State University Extension	Education and Youth Development
Michigan Works	Community and Economic Development
Copper Country Mental Health	Behavioral Health and Social Services
UP Health System – Portage	Clinical and Hospital Care
Gogebic Range Health Foundation	Non-Profit Foundation
Baraga County	Local Government
Dial Help	Behavioral Health and Social Services
Gogebic County Intermediate School District	Education and Youth Development
Baraga County Memorial Hospital	Clinical and Hospital Care
Ontonagon Village	Local Government
Village of L'Anse	Local Government
BHK Child Development*	Education and Youth Development
Senior Meals	Senior Services
Unite Wellness	Behavioral Health and Social Services
Ontonagon County	Local Government
Upper Great Lake Family Health Center*	Clinical and Hospital Care
Lac View Desert Health Center	Clinical and Hospital Care

* Agencies that represent individuals who are medically underserved, have low income, or are considered among the minority populations served by the hospital.

Appendix D: Community Input – Preliminary Prioritization

The table below reflects the process and results of the internal prioritization process that was conducted prior to the community input session. The four areas were identified as top concerns given current data and the likelihood of hospital and clinic capacity. This information was included in the materials that were shared in advance of the community listening session. One benefit of this approach was providing community stakeholders with a focused opportunity for discussion without necessitating a substantial amount of time and energy.

	Mental Health	Substance Use	Chronic Disease	Access to Care
Demographics and Related Measures	- Higher proportion of veterans (who can be affected by mental health issues)		- Higher proportion of older individuals	- Worse insurance coverage - Higher rates of public insurance -- The U.P. is a health professional shortage area for primary care, dental care and mental health care
Prevalence of the Issue	- Worse suicide rate - Worse or similar levels of frequent mental distress	- Worse or similar rates of overdose-related deaths - Worse rates of overdose-related emergency healthcare visits - Similar or better levels of binge drinking	- Worse rates of smoking, physical inactivity - Between 10 and 14 percent of the people in the five counties are food insecure	- Worse proportions of providers to population
Internal Infrastructure	- Current Aspirus system-level community health priority area	- Current system-level community health priority area - Medication-assisted treatment availability	- Current system-level priority area (diabetes care)	- Transportation is an issue for patients leaving the hospital
Current Hospital Priority Area	Yes	Yes	Yes	No
Survey Priority Area	- MH provider was a top-4 concern in 2021	- Drugs was a top-4 concern in 2017 and 2021	--	- Cost of health insurance was the top issue in 2017 and 2021
Other	--	--	- Upper Peninsula Community Health Needs Assessment (2021) identified the impact of an aging population as a key theme	- Worse rates of flu vaccine

Notes: "Worse than" or "Better than" compares the counties with Michigan. Those comparisons are in general; there may be some variability between the counties.

Appendix E: Community Input – Listening Session Qualitative and Quantitative Input

As part of the Aspirus Keweenaw, Aspirus Iron River and Aspirus Ironwood community health needs assessment process, two community listening sessions were conducted in early Spring 2025. Both listening sessions were the same. Aspirus shared materials in advance and provided data during the meeting. For each of four health issues – mental health, substance use, chronic disease and access to care – the attendees were asked to comment on the following questions:

- For which issues is there current community *momentum* (e.g., effective strategies)? What does the momentum look like?
- Where are there *gaps* that the hospital and clinics might be able to contribute to addressing?
- Are there any *emerging trends* or other important information that is missing?

Participants were also asked to raise additional health issues or topics that had not otherwise been addressed during the session.

Highlights from the discussions are below.

Mental Health

Community Momentum	Gaps
• Emergency department to inpatient beds is improving • Law enforcement use of iPads at crises to reduce emergency department visits • Crisis services available • Copper Country Mental Health will be getting a psychiatrist • Unite Mental Health and Wellness is a new non-profit that is growing • There is an increase in private providers that Copper Country Mental Health is referring to	• Post-inpatient safe and healthy living space • Insurance coverage • Decreasing in-school funding for mental health awareness and services • Someone to help navigate insurance, financial assistance • High levels of youth depressive symptoms

Substance Use

Community Momentum	Gaps
• Healthy Connections program (Salvation Army and health department) for individuals trying to say sober and clean	• Decrease in prevention funding (NorthCare); 18-42% cut in prevention services • Challenges with recruitment and retention of addiction counselors, social workers and other substance use-related disciplines • Great Lakes Recovery no longer has local offices; outpatient services are no longer available in Hancock • High levels of youth substance use (especially alcohol) and being in a vehicle with someone who is under the influence of alcohol • Workforce development; trying to help those in recovery get employed is very difficult

Chronic Disease

Community Momentum	Gaps
• Aspirus' Pathway to Diabetes program • Local community health workers are available to help address chronic disease • Aspirus' FVRx Program and the area Food is Medicine program • SDOH screening	• Skilled nursing facilities are full or not accepting • Larger regional and tertiary hospitals are at capacity • Smoking cessation promotion

Access to Care

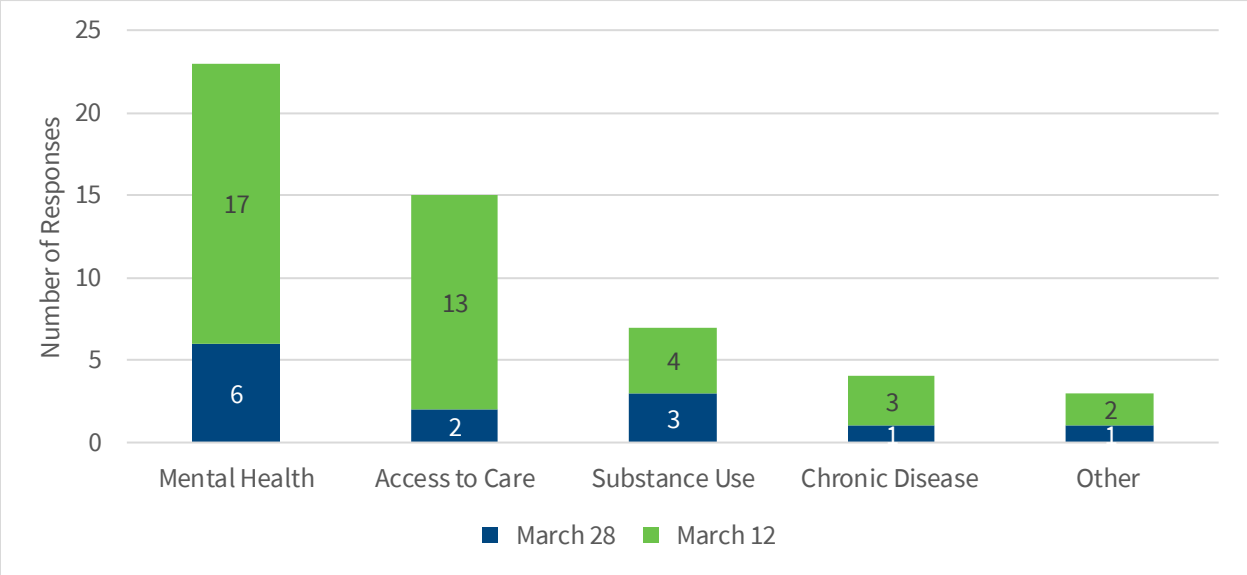
Community Momentum	Gaps

• Ontonagon extended care hours
• Tele-cardiology services (reducing the need for transfers)
• Veterans Affairs hospital is an asset
	• Closure of Ontonagon Hospital and the loss of 24/7 care; result is traveling 35-50 miles and return transportation can be a barrier
	• Providers leaving a local practice results in patients wanting to follow that provider
	• High co-pays can result in avoiding visits
	• High turnover and new staff are not aware of what's available out in the community.
	• Transportation (esp. older individuals)
	  ◦ Patients missing follow up appts
	  ◦ Emergency department and inpatient discharge delays

Other

Negative Momentum or State	Negative Momentum or State
• Housing • Childcare • Financial literacy • Grief support • Domestic violence – risks and vulnerabilities for the adults and the children	• Availability of dental care • Child developmental delays and [challenging] behaviors in the classroom • Care collaboration for students with special needs • Social emotional consultation from Copper Country Mental Health is limited to individuals with Medicaid; not enough referrals (including from primary care providers, schools and neonatal intensive care units)

The result of the community listening session polling on the top issues is below.



Appendix F: Health Status Data and Sources (Outside Data)

The tables below provide an overview of how Gogebic, Houghton, Keweenaw, Iron and Ontonagon Counties compare to Michigan on measures of health. Citations for the data are included. Please note: County rates that are better than state rates may still be at an unacceptable level.

HEALTH OUTCOMES										
Measure	**Description**	**Year(s)**	**Top Performers**	**US Overall**	**MI**	**Gogebic**	**Houghton**	**Keweenaw**	**Iron**	**Ontonagon**
Premature Death*	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	2019-2021	6,000	8,000	8,500	9300	6500	NA	11300	NA
Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	2021	13%	14%	15%	16%	15%	12%	17%	16%
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	2021	3.1	3.3	3.6	3.9	3.8	3.2	4.0	3.9
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	2021	4.4	4.8	5.3	5.8	5.5	5.0	5.6	5.5
Low Birthweight*	Percentage of live births with low birthweight (< 2,500 grams).	2016-2022	6%	8%	9%	7%	6%	NA	10%	12%
Life Expectancy*	Average number of years people are expected to live.	2019-2021	NA	77.6	76.6	76.6	78.0	77.0	74.6	75.4
Premature Age-Adjusted Mortality*	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	2019-2021	NA	390	410	440	370	400	490	450
Child Mortality*	Number of deaths among residents under age 20 per 100,000 population.	2018-2021	NA	50	50	NA	50	NA	NA	NA
Infant Mortality*	Number of infant deaths (within 1 year) per 1,000 live births.	2015-2021	NA	6	6	NA	NA	NA	NA	NA
Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	2021	NA	10%	11%	12%	11%	10%	12%	12%
Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	2021	NA	15%	16%	18%	17%	16%	18%	18%
Diabetes Prevalence	Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted).	2021	NA	10%	9%	9%	9%	8%	9%	9%
HIV Prevalence+	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	2021	NA	382	203	47	50	NA	108	NA

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

Source:

- 2024 County Health Rankings and Roadmaps website. Accessed September 15, 2024 and February 2, 2025.

HEALTH FACTORS										
HEALTH BEHAVIORS										
Measure	**Description**	**Year(s)**	**Top Performers**	**US Overall**	**MI**	**Gogebic**	**Houghton**	**Keweenaw**	**Iron**	**Ontonagon**
Adult Smoking	Percentage of adults who are current smokers (age-adjusted).	2021	14%	15%	18%	21%	19%	15%	21%	21%
Adult Obesity	Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted).	2021	32%	34%	35%	34%	35%	33%	35%	39%
Food Environment Index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	2019 & 2021	8.9	7.7	7.2	7.7	7.8	8.0	7.3	6.6
Physical Inactivity	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted).	2021	20%	23%	22%	24%	23%	18%	25%	24%
Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity.	2023, 2022 & 2020	90%	84%	86%	87%	77%	77%	82%	60%
Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	2021	13%	18%	19%	15%	20%	16%	15%	14%
Alcohol-Impaired Driving Deaths	Percentage of driving deaths with alcohol involvement.	2017-2021	10%	26%	30%	14%	17%	100%	29%	67%
Overdose-related deaths	Rate per 100,000 population	2021 2022 2023	NA	NA	Btwn 6.5 & 8.3	30.3	8.1	NA	22.9	NA
Overdose-related emergency healthcare visits	Rate per 100,000 population	2023	NA	NA	Btwn 66.5 & 72.8	335.2	210.6	NA	249.2	238.8
Alcohol-induced deaths	Rate per 100,000 population	2021 2022 2023	NA	NA	14.2	NA	NA	NA	NA	NA
Sexually Transmitted Infections+	Number of newly diagnosed chlamydia cases per 100,000 population.	2021	151.7	495.5	452.4	236.8	160.8	NA	223.5	136.3
Teen Births*	Number of births per 1,000 female population ages 15-19.	2016-2022	9	17	15	16	11	NA	22	NA
Food Insecurity	Percentage of population who lack adequate access to food.	2021	NA	10%	12%	13%	12%	10%	14%	14%
Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	2019	NA	6%	6%	5%	5%	7%	6%	13%
Drug Overdose Deaths*	Number of drug poisoning deaths per 100,000 population.	2019-2021	NA	27	27	NA	NA	NA	NA	NA
Insufficient Sleep	Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted).	2020	NA	33%	36%	35%	33%	32%	35%	36%

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

Source:

- 2024 County Health Rankings and Roadmaps website. Accessed September 15, 2024 and February 2, 2025.

CLINICAL CARE										
Measure	**Description**	**Year(s)**	**Top Performers**	**US Overall**	**MI**	**Gogebic**	**Houghton**	**Keweenaw**	**Iron**	**Ontonagon**
Uninsured	Percentage of population under age 65 without health insurance.	2021	6%	10%	6%	7%	8%	5%	8%	9%
Primary Care Physicians	Ratio of population to primary care physicians.	2021	1,030:1	1,330:1	1280:1	1200:1	1440:1	NA	1450:1	2930:1
Dentists	Ratio of population to dentists.	2022	1,180:1	1,360:1	1250:1	2050:1	1370:1	2180:0	2910:1	1950:1
Mental Health Providers	Ratio of population to mental health providers.	2023	230:1	320:1	300:1	460:1	450:1	2180:1	890:1	2930:1
Preventable Hospital Stays*	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	2021	1,558	2,681	3,246	1479	1722	1589	2017	972
Mammography Screening*	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening.	2021	52%	43%	44%	45%	46%	43%	52%	42%
Flu Vaccinations*	Percentage of fee-for-service (FFS) Medicare enrollees who had an annual flu vaccination.	2021	53%	46%	45%	33%	29%	26%	28%	25%
Uninsured Adults	Percentage of adults under age 65 without health insurance.	2021	NA	12%	7%	8%	9%	5%	9%	9%
Uninsured Children	Percentage of children under age 19 without health insurance.	2021	NA	5%	3%	4%	4%	3%	5%	6%
Other Primary Care Providers	Ratio of population to primary care providersother than physicians.	2023	NA	760:1	710:1	840:1	950:1	2180:1	1660:1	2930:1

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

Source:

- 2024 County Health Rankings and Roadmaps website. Accessed September 15, 2024 and February 2, 2025.

SOCIAL & ECONOMIC FACTORS										
Measure	**Description**	**Year(s)**	**Top Performers**	**US Overall**	**MI**	**Gogebic**	**Houghton**	**Keweenaw**	**Iron**	**Ontonagon**
High School Completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	2018-2022	94%	89%	92%	96%	94%	98%	93%	94%
Some College	Percentage of adults ages 25-44 with some post-secondary education.	2018-2022	74%	68%	68%	62%	71%	56%	54%	52%
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	2022	2.3%	3.7%	4.2%	5.2%	4.8%	6.1%	6.0%	7.5%
Children in Poverty*	Percentage of people under age 18 in poverty.	2022 & 2018-2022	10%	16%	18%	24%	13%	16%	21%	23%
Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	2018-2022	3.7	4.9	4.6	4.8	5.3	3.9	4.4	3.8
Children in Single-Parent Households	Percentage of children that live in a household headed by a single parent.	2018-2022	13%	25%	25%	19%	15%	29%	37%	12%
Social Associations	Number of membership associations per 10,000 population.	2021	18.0	9.1	9.5	12.5	11.5	NA	11.2	11.9
Injury Deaths*	Number of deaths due to injury per 100,000 population.	2017-2021	64	80	84	87	71	104	114	121
High School Graduation+	Percentage of ninth-grade cohort that graduates in four years.	2020-2021	NA	86%	82%	NA	83%	NA	NA	NA
Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	2018-2022	NA	7%	7%	NA	5%	NA	NA	NA
Reading Scores*+	Average grade level performance for 3rd graders on English Language Arts standardized tests.	2018	NA	3.1	3.0	2.9	3.5	NA	3.1	2.6
Math Scores*+	Average grade level performance for 3rd graders on math standardized tests.	2018	NA	3.0	2.8	3.0	3.4	NA	2.9	2.8
School Segregation	The extent to which students within different race and ethnicity groups are unevenly distributed across schools when compared with the racial and ethnic composition of the local population. The index ranges from 0 to 1 with lower values representing a school composition that approximates race and ethnicity distributions in the student populations within the county, and higher values representing more segregation.	2022-2023	NA	0.24	0.34	0.24	0.12	NA	0.03	NA

Measure	Description	Year(s)	Top Performers	US Overall	MI	Gogebic	Houghton	Keweenaw	Iron	Ontonagon
School Funding Adequacy+	The average gap in dollars between actual and required spending per pupil among public school districts. Required spending is an estimate of dollars needed to achieve U.S. average test scores in each district.	2021	NA	$634	($2,474)	($3,394)	$433	NA	($1,087)	($5,342)
Gender Pay Gap	Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as	2018-2022	NA	0.81	0.78	0.78	0.75	1.14	0.78	0.82
Median Household Income*	The income where half of households in a county earn more and half of households earn less.	2022 & 2018-2022	NA	$74,800	$66,900	$50,100	$55,600	$57,100	$54,100	$45,700
Living Wage	The hourly wage needed to cover basic household expenses plus all relevant taxes for a household of one adult and two children.	2023	NA	NA	$46.33	$40.66	$43.37	$44.54	$41.12	$42.06
Children Eligible for Free or Reduced Price Lunch+	Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.	2021-2022	NA	51%	51%	62%	45%	77%	63%	60%
Residential Segregation - Black/White	Index of dissimilarity where higher values indicate greater residential segregation between Black and white county residents.	2018-2022	NA	63	73	53	78	NA	NA	NA
Child Care Cost Burden	Child care costs for a household with two children as a percent of median household income.	2023 & 2022	NA	27%	32%	32%	37%	33%	31%	36%
Child Care Centers	Number of child care centers per 1,000 population under 5 years old.	2010-2022	NA	7	9	10	11	NA	12	7
Homicides*	Number of deaths due to homicide per 100,000 population.	2015-2021	NA	6	7	NA	NA	NA	NA	NA
Suicides*	Number of deaths due to suicide per 100,000 population (age-adjusted).	2017-2021	NA	14	14	17	19	NA	24	NA
Firearm Fatalities*	Number of deaths due to firearms per 100,000 population.	2017-2021	NA	13	13	NA	10	NA	NA	NA
Motor Vehicle Crash Deaths*	Number of motor vehicle crash deaths per 100,000 population.	2015-2021	NA	12	10	12	7	NA	19	NA
Juvenile Arrests+	Rate of delinquency cases per 1,000 juveniles.	2021	NA	NA	19	39	17	NA	36	NA
Voter Turnout+	Percentage of citizen population aged 18 or older who voted in the 2020 U.S. Presidential election.	2020 & 2016-2020	NA	67.9%	73.6%	67.0%	67.3%	87.7%	73.6%	74.6%

Measure	Description	Year(s)	Top Performers	US Overall	MI	Gogebic	Houghton	Keweenaw	Iron	Ontonagon
Census Participation	Percentage of all households that self-responded to the 2020 census (by internet, paper questionnaire or telephone).	2020	NA	65.2%	NA	49.7%	59.7%	33.1%	49.3%	43.6%
Falls (age 65+)	Percentage of adults age 65 and older who reported falling in the past 12 months	2020	NA	~25%	29.4%	NA	NA	NA	NA	NA
Falls Deaths (age 65+)	Age-adjusted falls death rate (per 100,000 older adults)	2021	NA	78.0	87.2	NA	NA	NA	NA	NA
Hospitalizations due to injury or poisoning, ages 65+	Rate per 10,000 population	2017-2021	NA	NA	263.7	142.3	218.0	128.7	169.0	121.4

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

Sources:

- 2024 County Health Rankings and Roadmaps website. Accessed September 15, 2024 and February 2, 2025.
- Centers for Disease Control and Prevention, Older Adults Falls Data. https://www.cdc.gov/falls/data-research/index.html
- Michigan Department of Health and Human Services, https://www.mdch.state.mi.us/osr/chi/hospdx/frame.html

PHYSICAL ENVIRONMENT										
Measure	**Description**	**Year(s)**	**Top Performers**	**US Overall**	**MI**	**Gogebic**	**Houghton**	**Keweenaw**	**Iron**	**Ontonagon**
Air Pollution - Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	2019	5.0	7.4	6.8	5.3	5.1	4.8	5.3	5.0
Drinking Water Violations+	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	2022	NA	NA	NA	No	No	No	No	No
Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	2016-2020	8%	17%	13%	10%	15%	11%	12%	11%
Driving Alone to Work*	Percentage of the workforce that drives alone to work.	2018-2022	70%	72%	77%	80%	65%	72%	80%	78%
Long Commute - Driving Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	2018-2022	17%	36%	33%	16%	12%	29%	23%	30%
Traffic Volume	Average traffic volume per meter of major roadways in the county.	2023	NA	108	108	38	66	1	14	2
Homeownership	Percentage of owner-occupied housing units.	2018-2022	NA	65%	72%	83%	69%	93%	84%	88%
Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing.	2018-2022	NA	14%	12%	10%	13%	10%	11%	9%
Broadband Access	Percentage of households with broadband internet connection.	2018-2022	NA	88%	88%	82%	85%	82%	77%	82%

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

Source:

- 2024 County Health Rankings and Roadmaps website. Accessed September 15, 2024 and February 2, 2025.

Special Populations and Disparities

Some communities are more likely to experience health disparities.

Individuals who are Hispanic: Individuals who are Hispanic, compared to non-Hispanic white individuals, are at higher risk for diabetes, asthma (Puerto Ricans), cervical cancer, liver disease and obesity.[3] Children who are Hispanic, compared to non-Hispanic white children, are more likely to suffer from infant mortality (Puerto Ricans), asthma (Puerto Ricans) and obesity. Children who are Hispanic are 34 percent more likely to attempt suicide as a high schooler.[4]

Individuals who are Native / Indigenous:

In the United States, the average lifespan for individuals who are Native American is approximately 5 years shorter than the national average.[5] Individuals who are Native American are three times more likely to die from diabetes complications, are six times more likely to die from alcoholism and were severely affected by COVID-19.[6] Poverty, historical trauma and ACEs (adverse childhood experiences) play a role in these disparities.[7]

Individuals who have disabilities:

People with disabilities experience significant health disparities, often facing poorer health outcomes and limited access to healthcare compared to their non-disabled peers. These disparities are not solely due to the disability itself but are also influenced by factors like limited access to education and employment, poverty, and inequities within the healthcare system.[8]

Individuals in Poverty:

Individuals experiencing poverty face significant health disparities, including higher rates of chronic diseases, lower life expectancy, and increased risks of preventable illnesses.[9] These disparities are often linked to factors like limited access to quality healthcare, nutritious food, and safe housing, as well as the negative effects of chronic stress and exposure to environmental hazards.[10]

[3] https://www.familiesusa.org/resources/latino-health-inequities-compared-to-non-hispanic-whites/
[4] https://www.familiesusa.org/resources/latino-health-inequities-compared-to-non-hispanic-whites/
[5] Ehrenpreis, Jamie E and Ehrenpreis, Eli D. A Historical Perspective of Healthcare Disparity and Infectious Disease in the Native American Population. Am J Med Sci. 2022 Apr; 363(4): 288-294.
[6] Ibid.
[7] Ibid.
[8] NACCHO, Addressing Health Disparities Among People with Disabilities, https://www.naccho.org/blog/articles/addressing-health-disparities-among-people-with-disabilities. Accessed January 6, 2025.
[9] Healthy People 2030, poverty, https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty
[10] Healthy People 2030, poverty, https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty

Individuals who are 65 and older:

Social isolation and loneliness are associated with a higher risk of dementia and other serious health problems in older adults — while having positive social relationships can help people live longer, healthier lives.[11] About 8 in 10 older adults struggle to use medical documents like forms or charts, which could make it harder for them to make well-informed health decisions.[12] Most older adults in the United States have at least one chronic health condition, making access to affordable, quality health care a priority.[13] However, factors like a lack of health care options in rural areas, high out-of-pocket costs, and transitions from private insurance to Medicare often complicate older adults' care.[14]

[11] Excerpted verbatim from: https://odphp.health.gov/our-work/national-health-initiatives/healthy-aging/social-determinants-health-and-older-adults

[12] Excerpted verbatim from: https://odphp.health.gov/our-work/national-health-initiatives/healthy-aging/social-determinants-health-and-older-adults

[13] Excerpted verbatim from: https://odphp.health.gov/our-work/national-health-initiatives/healthy-aging/social-determinants-health-and-older-adults

[14] Excerpted verbatim from: https://odphp.health.gov/our-work/national-health-initiatives/healthy-aging/social-determinants-health-and-older-adults

Appendix G: Healthcare Facilities and Community Resources

A subset of the healthcare and other resources in the community that can help address community health needs are in the table below. A more comprehensive set of resources can be found at findhelp.org or https://aspiruscommunity-resources.findhelp.com/, and then searching by zip code and program need/area.

Agency	Need/Resource
U.P. Health System – Hancock	Hospital/Healthcare
U.P. Health System - Houghton	Hospital/Healthcare
U.P. Health System – Lake Linden	Hospital/Healthcare
U.P. Health System- Ontonagon	Hospital/Healthcare
U.P. Health System – University Center	Hospital/Healthcare
U.P. Health System – Calumet	Hospital/Healthcare
St. Vincent De Paul	Durable Medical Equipment
Salvation Army	Durable Medical Equipment
Apothecary Home Medical Equipment	Durable Medical Equipment
Wright & Filippis, Inc.	Durable Medical Equipment
Great Lakes Home Medical	Durable Medical Equipment
Aspirus At Home	Nursing Services
Horizon Home Care	Nursing Services
Regional Hospice	Nursing Services
U.P. Area Agency on Aging	Nursing Services
Northern Michigan Home Health	Nursing Services
Dickinson County Home Health	Nursing Services
Mission Point at Hancock	Nursing Home/Rehab
Canal View – Houghton County	Nursing Home/Rehab
The Lighthouse of Hubbell	Nursing Home/Rehab
Golden Living Center	Nursing Home/ Rehab
Iron County Medical Care Facility	Nursing Home/Rehab
Iron River Care Center	Nursing Home/ Rehab
ManorCare MedBridge Rehab	Nursing Home/ Rehab
Nu-Roc Community Healthcare	Nursing Home/ Rehab
Portage Pointe	Nursing Home/ Rehab
Medicaid – MDHHS	Financial Assistance
Medicare – US Social Security Administration	Financial Assistance
Children's Special Health Services	Financial Assistance
Michigan Rehab Services	Financial Assistance
Medical Access Program	Financial Assistance

Senior Nutrition Program	Food Assistance
Gogebic-Ontonagon Community Action Meals on Wheels	Food Assistance
Centerline Apartments	Senior Citizen Housing
Golden Horizon Apartments	Senior Citizen Housing
Laurium Housing Commission	Senior Citizen Housing
Park Ave Apartments	Senior Citizen Housing
Rustic Meadows	Senior Citizen Housing
Gardenview Assisted Living	Senior Citizen Housing
The Bluffs Senior Community	Senior Citizen Housing
City View	Senior Citizen Housing
Pleasant Valley Apartments	Senior Citizen Housing
Sunset Manor Apartments	Senior Citizen Housing
Spring Valley Apartments	Senior Citizen Housing
Apple Blossom	Senior Citizen Housing
Woodridge Apartments	Senior Citizen Housing
Barbara Kettle Gundlach Shelter Home	Abuse and/or Neglect
Dial Help, Inc	Abuse and/or Neglect
Adult & Children's Protective Services	Abuse and /or Neglect
Little Brother's Friends of the Elderly	Transportation
MDHHS	Transportation
DAV Van – Houghton County Vets	Transportation
B&B Wheelchair	Transportation
Hancock Public Transit	Transportation
Houghton Public Transit	Transportation
Community Action Bus Services	Transportation
On-Tran	Transportation
Copper Country Mental Health	Counselling Services
Life Outreach Center	Counselling Services
American Pregnancy Association	Counselling Services
Lutheran Social Services	Counselling Services
Western UP Assessment Services	Substance Abuse
Western U.P. Health Department	Substance Abuse
Phenix House, Inc	Substance Abuse
Pathways- NorthCare Network	Substance Abuse
New Day Treatment Center	Substance Abuse
Alcoholics Anonymous	Support Group
Diabetes Support Group	Support Group
Community Coalition for Grief and Bereavement	Support Group
Vulnerable Adult Services	Support Group

Little Brothers Friends of the Elderly	Support Group
Narcotics Anonymous	Support Group
Parent HELP Line	Support Group
Parkinson's Support Group	Support Group
Senior Helpline	Support Group
Cancer Support Group	Support Group
Great Lakes Recovery	Support Group

Appendix H: Evaluation of Impact from the Previous CHNA Implementation Strategy

Aspirus Health is working to strategically build strong, effective community health efforts that meet local needs. They have strengthened their community health efforts by implementing cross-organizational strategies along with local strategies. Cross-organizational strategies are implemented (as appropriate) locally but benefit from the expertise and structure available within the system. Descriptions below reflect both cross-organizational and local strategies. This work is done in the context of the ever-changing healthcare landscape as well as other economic pressures.

The significant health priorities identified in Aspirus Iron River, Aspirus Ironwood and Aspirus Keweenaw's 2022-2025 (most recent) CHNA and Implementation strategy were **substance use**, **mental health**, and **chronic disease**. The summary reflects FY23, FY24 and a portion of the current (FY25) fiscal year. FY25 was incomplete at the time of this report's approval.

Iron River

Substance Use

In FY23, FY24 and FY25, Aspirus Iron River Hospital and Clinics provided access to addiction-related treatment, including suboxone. The hospital and clinics also facilitated referrals to local non-profit behavioral health services organizations for patients with significant mental health and substance use issues.

Mental Health

In FY23, Aspirus Iron River Hospital staff participated in a parenting expo/fair, providing health and well-being information and materials to over 40 people.

The hospital and clinics also facilitated referrals to local non-profit behavioral health services organizations for patients with significant mental health and substance use issues.

Chronic Disease

In FY23 and FY24, Aspirus Iron River Hospital staff facilitated a monthly Diabetes Support Group. The group started in February 2023 and averages about five people per session.

In FY23, the hospital provided funding to the Michigan Transportation Connection to increase the accessibility of medical treatment and other services for Michigan residents. In FY23, the hospital also contributed funds to the Superior Health Foundation. The Superior Health Foundation's mission is 'to assist with unmet healthcare needs, with health education, and with programs and research on preventing illness and promoting health in the Upper Peninsula.'

In FY24, the hospital contributed in-kind time to the Iron Area Health Foundation and the Iron County School District's Color Run.

Ironwood

Substance Use

In FY23, FY24 and FY25, Aspirus Ironwood Hospital and Clinics provided access to addiction-related treatment, including suboxone. The hospital and clinics also facilitated referrals to local non-profit behavioral health services organizations for patients with significant mental health and substance use issues.

Mental Health

In FY24, Aspirus Ironwood provided funding to support media promotion around positive mental health, mental health awareness and suicide prevention. The hospital and clinics also facilitated referrals to local non-profit behavioral health services organizations for patients with significant mental health and substance use issues.

In FY23 and FY24, Aspirus Ironwood staff facilitated a monthly virtual Dementia Caregiver Support Group. Between 2 and 6 individuals participated in the meetings in FY23 and between 1 and 3 individuals participated in FY24.

Aspirus Ironwood Hospital conducts a Senior Wellness Program. The program is available to older adults with traditional Medicare Part B and an unresolved mental health need. A multi-disciplinary team provides ongoing support.

Chronic Disease

FY23 was the first year that Aspirus' Fruit and Vegetable Prescription Program (FVRx) was available in the Upper Peninsula region. A voucher is given to patients to purchase fruits and vegetables from local farmers. The program also provides nutrition information and access to recipes. During the 2024 season, over 700 vouchers were distributed across the system.

In FY23, the hospital provided time, expertise and healthy snacks for a series of ski lessons for second graders. Approximately 45 students were served. The hospital also financially supports multiple ski and run events throughout the year. In FY24, the hospital provided multiple nutrition-related presentations and services in the community, including to students.

The Senior Wellness Program (above) also supports older individuals maintaining their health.

Other

Aspirus Ironwood has a Certified Application Counselor who helps individuals seeking health care insurance access the insurance Marketplace. Over 40 people were served in FY23.

In FY23, the hospital donated time to gather products to give to the local domestic abuse shelter. Aspirus staff also provided time and expertise to a number of local boards and committees, including the Head Start Health Services Advisory Committee and the Sexual Assault Response Team. In FY24, Aspirus staff provided time and expertise to the Gogebic Range Health Foundation Board. Aspirus Ironwood provided in-kind resources to seniors at two health and wellness events in FY24.

Aspirus Ironwood is one of many Aspirus hospitals that provides Sexual Assault Nurse Examiner services.

In FY23, the hospital contributed funds to the Superior Health Foundation. The Superior Health Foundation's mission is 'to assist with unmet healthcare needs, with health education, and with programs and research on preventing illness and promoting health in the Upper Peninsula.' In FY24, the hospital provided funding for multiple ski events/programs.

Keweenaw

Substance Use

In FY23, FY24 and FY25, Aspirus Keweenaw and Clinics provided access to addiction-related treatment, including suboxone. The hospital and clinics also facilitated referrals to local non-profit behavioral health services organizations for patients with significant mental health and substance use issues.

In FY23, FY24 and FY25 (pending), the hospital provided five free fitness facility memberships for men who are in a substance use residential treatment facility. This enables the men and their counselor to be physically active as part of their recovery.

Mental Health

In FY23, the hospital contributed funding to Life Skills North. The funds focused on providing uninsured clients with access to parenting, anger management, grief and domestic violence classes.

The hospital and clinics also facilitated referrals to local non-profit behavioral health services organizations for patients with significant mental health and substance use issues.

Chronic Disease

In FY23 and FY24, a diabetes support group was held. The group met seven times in FY23 and met September 2023 – May 2024. Each meeting is an hour and is facilitated by a registered dietician at Keweenaw. The hospital also supports a number of fitness and wellness programs with in-kind time or funding. Those programs included an elementary school wellness event and a 5K race.

FY23 was the first year that Aspirus' Fruit and Vegetable Prescription Program (FVRx) was available in the Upper Peninsula region. A voucher is given to patients to purchase fruits and vegetables from local farmers. The program also provides nutrition information and access to recipes. During the 2024 season, over 700 vouchers were distributed across the system.

Other

In FY23, the hospital donated to a fundraiser for a food pantry and also to Little Brothers / Friends of the Elderly for transportation. Aspirus staff provide time and expertise to a number of local boards and committees, including the Head Start Advisory Board, foundation boards, and an emergency services board. Aspirus staff also participated in a local meeting about childcare.

In FY23, the hospital also contributed funds to the Superior Health Foundation. The Superior Health Foundation's mission is 'to assist with unmet healthcare needs, with health education, and with programs and research on preventing illness and promoting health in the Upper Peninsula.'

In FY24, Aspirus staff provide time and expertise to a number of local boards and committees, including the Michigan Works Workforce Development Board, Keweenaw Health Foundation Board, Mercy Emergency Services Board and others. Aspirus staff also contributed time to a babysitter training and bike-to-school day. Aspirus Keweenaw supports workforce development through career camps and other strategies.

In FY24, the hospital contributed funds to the Keweenaw Community Foundation. The Foundation's vision and mission is to see a thriving community by connecting the needs of the community with resources to collaboratively improve quality of life.

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aspirus.org

May 2025