Community Health Needs Assessment

2025-2028

ASPIRUS St. LUKE'S HOSPITAL & CLINICS

915 East First Street

Duluth, MN 55805

Acknowledgements

Improving our community's health is a collaborative effort. Aspirus St. Luke's Hospital is fortunate to have strong relationships with Essentia Health. Essentia's leadership in conducting a survey of over one thousand community members provides a robust set of data and insights for our work. We extend our gratitude to the many community members who took the time to respond to the survey. We deeply appreciate working collaboratively as part of our mission to heal people, promote health and strengthen communities.

This report provides a foundation for a community health improvement plan to address these important issues. We look forward to continued collaboration to create a healthier Duluth for all.

Respectfully,

Nick Van Deelen, MD
Senior Vice President and President, CMO
Minnesota Region
Aspirus Health

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Executive Summary

Aspirus St. Luke's Hospital and Essentia Health conducted a community health needs assessment from Summer 2024 through Spring 2025. The assessment included:

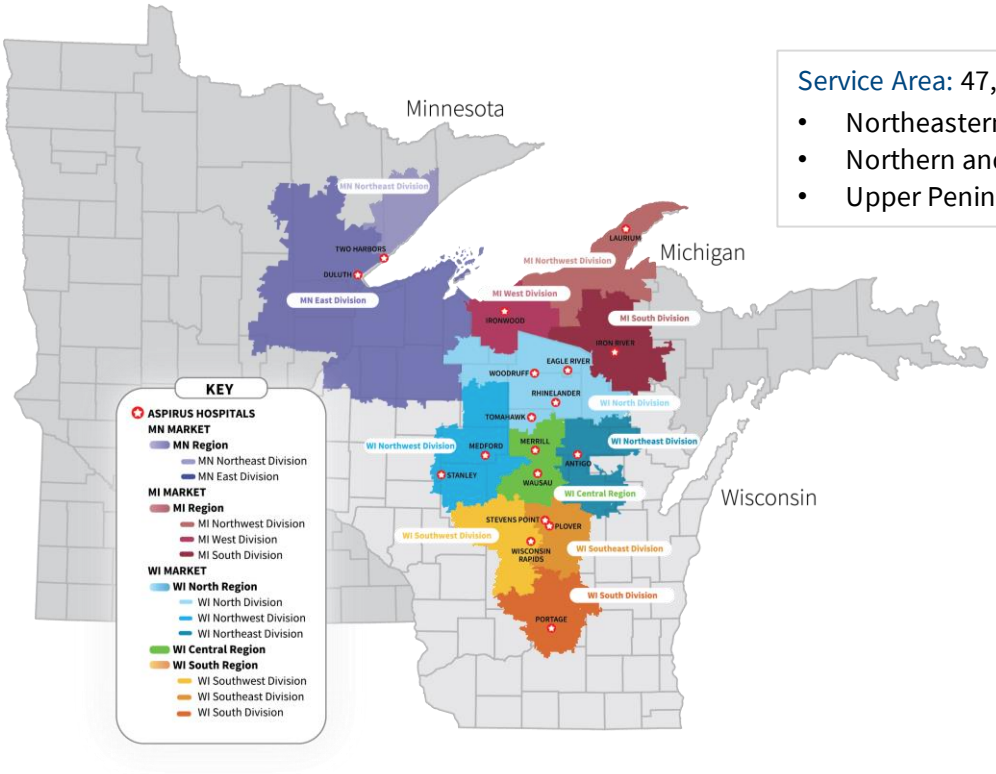
- Leadership from Essentia Health
- The compilation of two kinds of data:
    - Community input: Input was gathered through a community survey.
    - Health status data: Data on the health of the community was obtained primarily from the U.S. Census Bureau, County Health Rankings and Roadmaps and Essentia Health's local utilization data of www.weareresourceful.org.
- The review of data through the lens of multiple criteria (e.g., population affected, importance/urgency).
- 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.

Aspirus St. Luke's Hospital will develop a plan to address the priorities of housing, food security/nutrition, and social drivers of health.

Aspirus Health and Aspirus St. Luke's Hospital Profile

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 St. Luke's Hospital

Aspirus St. Luke's Hospital in Duluth 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. It serves as one of two tertiary care centers for the Aspirus Health system. Among the services provided to residents of St. Louis County and the North Shore 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 northeastern Minnesota.

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.

In Minnesota, non-profit hospitals are also guided by State Statute Sec. 144.6985. The statute has a number of requirements, including public reporting, the identification of three priority areas and the incorporation of evidence-based practices and evaluation measures.

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

Community Served and Demographics

Our Community

The hospital's primary service area is the City of Duluth. The hospital also serves individuals from St. Louis County and the surrounding areas. There are seven hospitals in the county (including Aspirus St. Luke's) and two hospitals in Duluth.

St. Louis County and/or portions of St. Louis County are designated Health Professional Shortage Areas (HPSA) for dental (population-based HPSA), primary care (geographic-based and population-based HPSA) and mental health (population-based HPSA). A portion of St. Louis County is also a designated Medically Underserved Area (MUA).

The City of Duluth is a designated Health Professional Shortage Areas (HPSA) for dental (population-based HPSA as part of St. Louis County), primary care (population-based HPSA) and mental health (population-based HPSA as part of St. Louis County). The City of Duluth is also a designated Medically Underserved Area (MUA).

For the purposes of our Community Health Needs Assessment, we have defined our "community" as the City of Duluth because (a) of the close alignment with community partners serving the residents of Duluth; (b) Duluth is an urban center and the remainder of the county is rural (which can result in different responses and scales of responses).

Demographics

The City of Duluth (along with the City of Superior, Wisconsin) is a metropolitan area. It covers 71.7 square miles, with 1223 people per square mile and an overall population of 87,000 people. The table below outlines some of the basic demographics and related descriptors of the City of Duluth's population compared to Minnesota.

Compared to Minnesota, the City of Duluth has a higher percentage or proportion of individuals:	Compared to Minnesota, the City of Duluth has a lower percentage or proportion of individuals:
Over age 65	Under age 18
Who are White (alone)	Who are African American (alone)
With a bachelor's degree or higher	Who are Asian (alone)
Who have a disability	Who are Hispanic or Latino
Who are in poverty	Who are Veterans
Using public insurance	

Compared to Minnesota, the City of Duluth also has a:

- Lower median age
- Lower median household income
- Higher percentage of high school graduates
- Comparable percentage of people of two or more races
- Comparable percentage of people without healthcare coverage

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 demographic information.

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

Process and Methods Used – Models and Frameworks

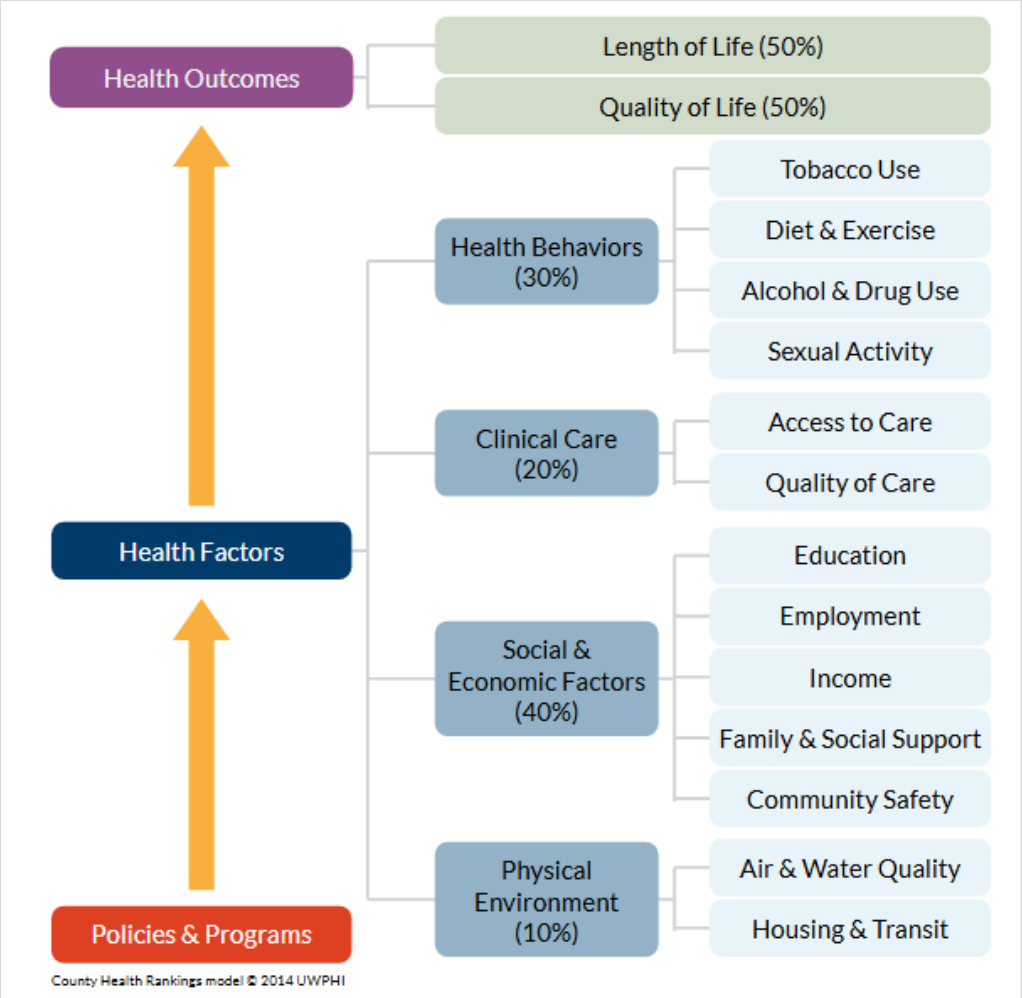
Aspirus' community health improvement approach is based on national research and models. This helps provide consistency and opportunities for alignment as we work across the health system and in our communities.

- 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 Appendix B.

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 this assessment process, the health status data and evidence-based strategies were obtained from the County Health Rankings resources.

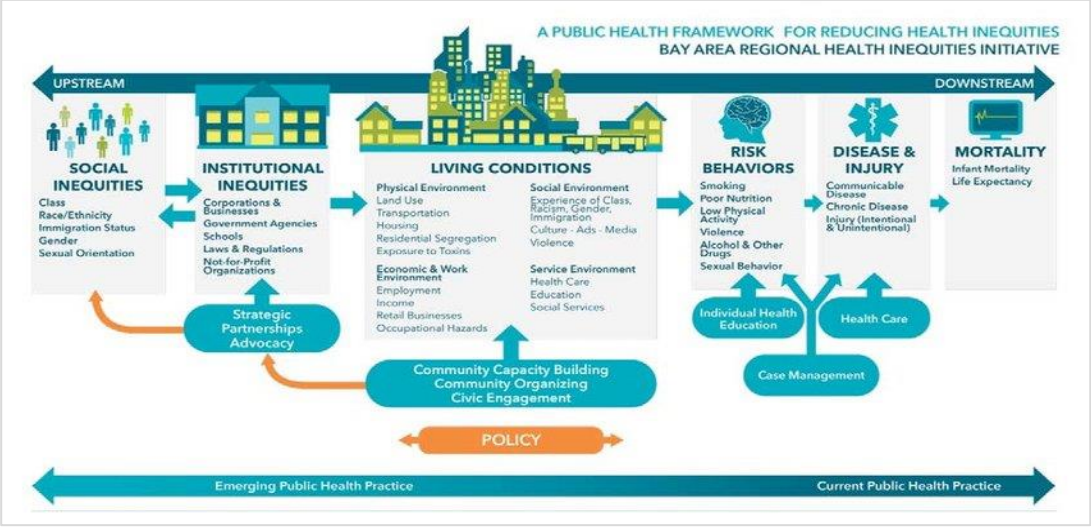


Understanding Equity, Inequities and Complex Factors

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

- Pricing and taxation on cigarettes impacts 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 and conditions intersect.



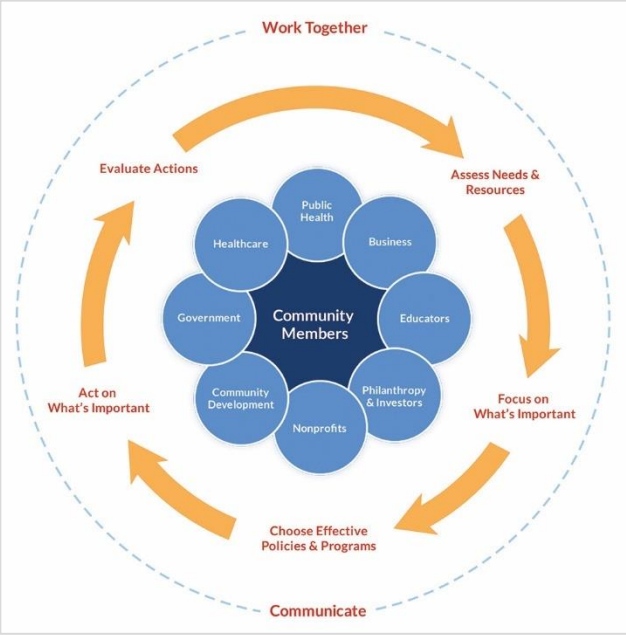
Another model helps explain the importance of recognizing that sometimes a one-size-fits-all solution does not work. The Robert Wood Johnson Foundation provided this health equity 'bicycle' model. If a person wants to go on a bicycle ride with their friends and family, each person needs a different bicycle 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 St. Luke's worked with Essentia Health-St. Mary's Medical Center and Essentia Health-Duluth (Miller-Dwan) to gather community input and compile data to learn more about what is important to the community.

A substantial portion of this *Process and Methods Used – Applied* section and the corresponding appendices is excerpted and adapted with permission from the Essentia Health-St. Mary's Medical Center and Essentia Health-Duluth (Miller-Dwan) CHNA report.

The 2024-2025 CHNA development process included seven phases:

1. June-July: Preparation
2. August-September: Data Collection
3. October: Needs Area Selection
4. November-February: Action Plan Development
5. March: Document Development
6. April-May: Adoption
7. June: Distribution

An advisory committee of Aspirus St. Luke's and Essentia Health leaders met periodically to inform the process. Please see Appendix C for a list of advisory committee members.

Collaborators and / or Consultants

In this, the fourth generation of the Duluth CHNA, Essentia Health was the lead coordinating entity. Essentia led the survey development and distribution, developed a prioritization rubric and helped assure an advisory committee process that provided periodic input and opportunities for Aspirus and Essentia leaders. No consultants or vendors were utilized.

Community Input

Community Survey – Distribution

Duluth community members provided their voice regarding community health needs through a community survey. 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.

The survey was administered online during the months of August and September in 2024. This survey asked respondents to provide their perspectives about community conditions related to health and about the level of urgency for the healthcare systems to respond to these issues. Aspirus St. Luke's and Essentia Health promoted the survey through email marketing within community networks, including through dissemination to email lists managed by partner organizations. Please see Appendix D for the distribution list.

Community Survey – Results

The survey captured responses from 1,117 area residents. The table below summarizes the survey respondents' ratings of a number of issues on a 1-5 scale. The top (i.e., most challenging or important) issues are listed first.

In response to a question about the respondents' ability to access services or experiences, the most challenging (in order) were:	*In response to a question about the importance of Aspirus St. Luke's and Essentia Health to start or continue to help people in the next 1 to 3 years, the most important (in order) were:*
• Find childcare • Find housing • Access mental health care • Have a livable income • Access dental care • Have means of transportation • Feel community connection • Eat healthy foods • Gain employment • Access primary health care	• Access mental health care • Access primary health care • Receive recommended vaccinations • Access dental care • Have a livable income • Eat healthy foods • Avoid unsafe drug use • Be physically active • Find childcare • Gain employment

The complete results from the community survey can be found in Appendix E.

Input Received on the Last CHNA

No known public input on the previous CHNA was received.

Health Status Data / Outside Data

In addition to gathering input directly from community members, the process included the compilation of outside data that is reflective of the overall population's health status. Secondary data to inform the CHNA was compiled by Essentia Health and came primarily from three sources: 1) the U.S. Census Bureau, which provides a consistent data source to assess conditions on a population level; 2) County Health Rankings, which curates health data across multiple secondary sources; and 3) Essentia Health, which collects data about social needs of patients through a screening questionnaire across its health system service area.

Secondary data were compiled in categories reflective of the *What Works for Health* database of evidence-based practices. *What Works for Health* is a platform on the County Health Rankings and Roadmaps website that provides communities with potential strategies to address community health issues; strategy descriptions include the level of evidence, impact on disparities and examples. The alignment of data with potential strategies provides a path to implementation.

The health status data can be found in Appendix F.

Community Needs and Prioritization Process

To identify the healthcare systems' priority community health needs, Essentia Health's Community Health Department led the development and application of a prioritization matrix to quantify the need and feasibility of addressing each potential community health need area. The applied matrix was shared with the advisory committee and discussed.

A substantial portion of this *Community Needs and Prioritization Process* section and the corresponding appendices is excerpted and adapted with permission from the Essentia Duluth CHNA report.

Using the *What Works for Health* platform on the County Health Rankings and Roadmaps website, the process began with the following list of potential community health need areas:

- Income
- Employment
- Childcare
- Education
- Primary Health Care Access
- Dental Care Access
- Mental Health Care Access
- Vaccination
- Housing
- Transportation
- Community Safety
- Family Support
- Community Support
- Alcohol Use
- Drug Use
- Nutrition
- Exercise
- Sexual Activity
- Tobacco Use

Each of these potential community health need areas was then analyzed with five weighted categories:

- **Feasibility of Impact:** This factor considers whether the healthcare systems can affect beneficial change for this topic area, based on scientifically supported community interventions available and the healthcare systems' ability to implement these interventions.
- **Population Affected:** This factor represents the prevalence of the health issue or condition.
- **Data Trend:** This factor looks at the history and forecast of the data.
- **Community Perception:** This factor asks residents to rate the difficulty level of participating in healthy actions in their area, as reported on the community survey.
- **Urgency to Act:** This factor asks residents to rate the level of urgency in responding to community conditions that impact health, as reported on the community survey.
- **Social Needs:** This factor considers the need for any given health area identified by data from Essentia's Resourceful/Find Help in the past year. It awards bonus points toward the total score of categories as follows: 0.20 extra points awarded for each of the top three most searched categories on Resourceful in the hospital's home county.

A detailed description of the prioritization criteria/rubric is in Appendix G and the resulting analysis is in Appendix H.

The rubric results were brought to the hospitals' advisory committee for review in October 2024. The advisory committee also reviewed the data collection and prioritization methodologies. Subsequent to the advisory committee review and recommendation, the Aspirus St. Luke's Executive Team reviewed and supported the top issues at their April 14, 2025 meeting.

Final Prioritized Needs

Over the next three years, Aspirus St. Luke's will formally address the following issues through its community health needs assessment and corresponding implementation strategy:

- Housing
- Food Security / Nutrition
- Social Drivers of Health

Needs Not Selected

Some significant needs were identified through a community survey. For the survey question "… how important is it for Aspirus St. Luke's and Essentia to start or continue to help people….?" the responses with the strongest ratings were:

- Access mental health care
- Access primary health care
- Receive recommended vaccinations
- Access to dental care

Using the results of the survey as well as additional criteria (e.g., feasibility of impact, data trend and more), the following issues rose to the top:

- Housing
- Vaccination
- Exercise
- Nutrition
- Transportation
- Community Safety

Aspirus St. Luke's is not addressing the undermentioned needs for the following reasons:

- Access to Care (mental, medical and dental) and Vaccinations – Access to care and vaccinations were not selected as formal priorities because maintaining high quality care and improving access to care is already the core business Aspirus implements to live our mission – to heal people, promote health and strengthen communities.
- Exercise – Aspirus St. Luke's supports several initiatives in the community, including school-based athletic training and community-based outpatient rehabilitation programs (e.g., at an assisted living). Aspirus St. Luke's has invested in renovations that improve the on-site spaces for exercise opportunities for patients and employees. Aspirus provides an employee wellness program, including an on-campus fitness center.
- Transportation – Although transportation is not a formal priority, it is consistently addressed through the work of the Aspirus Care Coordination team, prompted by the social needs screening. Additionally, Aspirus St. Luke's continues to engage with policymakers regarding opportunities to increase access to transportation in rural areas.
- Community Safety – Aspirus is committed to being a community partner at the table to contribute to solutions. As a Level II Trauma Center, the hospital provides community safety programming (e.g., falls prevention, Stop the Bleed). The hospital has ongoing partnerships with the Community Intervention Group, as well as with local law enforcement and EMS.

Aspirus St. Luke's recognizes that mental and social well-being and substance use (both priorities from the previous CHNA cycle) continue to be important areas of needed improvement in Duluth. Aspirus St. Luke's will address mental and social well-being through its clinical services as well as community-focused efforts.

Although Aspirus may not be leading initiatives in these areas, Aspirus is committed to being a community partner at the table to contribute to solutions. One way Aspirus will contribute is by screening for health-related social needs. Aspirus monitors the results of screening and uses the FindHelp platform to refer patients. Over time, data will be analyzed and incorporated into the CHNA in identifying top health priorities and corresponding strategies.

Healthcare Facilities and Community Resources

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

Housing

Why is it Important?

Safe, high-quality housing is the foundation for our individual and collective physical and mental health. The condition of housing affects our health, as does its stability and affordability. When housing is free from toxins such as mold and lead paint, we have better health. When it is affordable, we have more resources to pay for medical care, healthy food and utility bills.[1]

Housing instability encompasses a number of challenges, such as having trouble paying rent, overcrowding, moving frequently, or spending the bulk of household income on housing. These experiences may negatively affect physical health and make it harder to access health care.[2]

Homeownership is lower for individuals who are Black or Hispanic compared to individuals who are White. This disparity has persisted for decades and impacts generational wealth.[3]

Sources: (1) Verbatim from the County Health Rankings and Roadmaps website https://www.countyhealthrankings.org/health-data/community-conditions/physical-environment/housing-and-transportation?. Accessed on 3/25/2025. (2) Verbatim from the Healthy People 2030 website https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability. Accessed on 3/25/2025. (3) U.S. Department of the Treasury website https://home.treasury.gov/news/featured-stories/racial-differences-in-economic-security-housing Accessed on 3/23/2025.

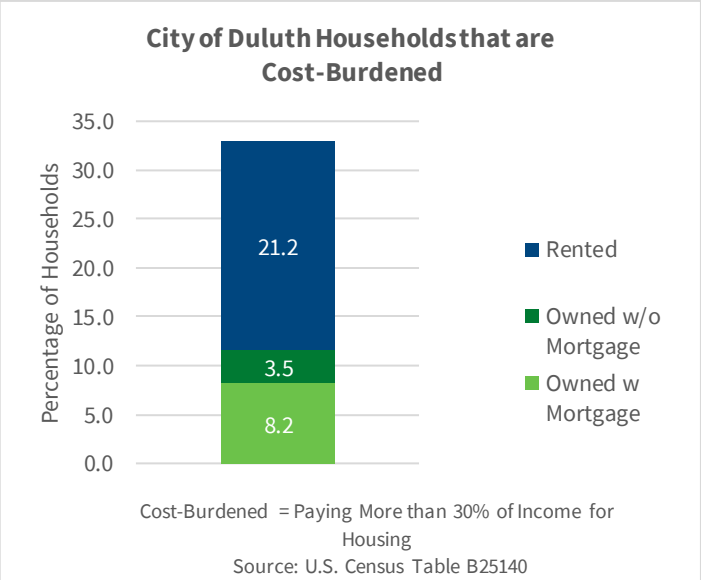
Disparities and Inequities

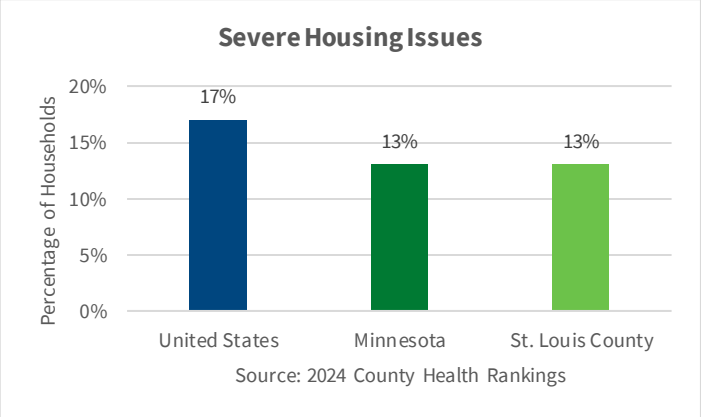
Disparities and inequities can show where interventions would be most beneficial.

- Households are considered to be cost burdened if they spend more than 30 percent of their income on housing and severely cost burdened if they spend more than 50 percent of their income on housing. Cost-burdened households have little left over each month to spend on other necessities such as food, clothing, utilities, and health care. Black and Hispanic households are almost twice as likely as White households to be cost burdened.[1]
- Children who move frequently are more likely to have chronic conditions and poor physical health.[1]
- People who have spent time in prison may be discriminated against by potential landlords, lose eligibility for public housing, and struggle to maintain stable housing.[1]

Sources: (1) Verbatim from the Healthy People 2030 website https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability. Accessed on 3/25/2025.

Data Highlights





Community Perceptions & Challenges

The Fall 2024 community survey asked how respondents would rate their ability to … ? The rating scale was Very Easy [1], Easy [2], Neutral [3], Hard [4], or Very Hard [5]. The most challenging issues were:

1. Find childcare, 3.97 Average
2. Find housing, 3.92 Average
3. Access mental health care, 3.46 Average
4. Have a livable income, 3.38 Average

Food Security and Nutrition

Why is it Important?

Food insecurity is defined as a household-level economic and social condition of limited or uncertain access to adequate food. In 2020, 13.8 million households were food insecure at some time during the year. Food insecurity does not necessarily cause hunger, but hunger is a possible outcome of food insecurity.[1]

Employment, disability status, neighborhood conditions, physical access to food, and lack of transportation can all impact food security.[2]

Sources: (1) Verbatim from the Healthy People 2030 website https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity. Accessed on 3/25/2025. Accessed on 3/25/2025. (2) Healthy People 2030 website https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity. Accessed on 3/25/2025.

Disparities and Inequities

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

- Neighborhood conditions may affect physical access to food. For example, people living in some urban areas, rural areas, and low-income neighborhoods may have limited access to full-service supermarkets or grocery stores.
- Predominantly Black and Hispanic neighborhoods may have fewer full-service supermarkets than predominantly White and non-Hispanic neighborhoods.
- Convenience stores may have higher food prices, lower-quality foods, and less variety of foods than supermarkets or grocery stores.
- Access to healthy foods is also affected by lack of transportation and long distances between residences and supermarkets or grocery stores.
- Food-insecure children may also be at an increased risk for a variety of negative health outcomes, including obesity. They also face a higher risk of developmental problems compared with food-secure children. In addition, reduced frequency, quality, variety, and quantity of consumed foods may have a negative effect on children's mental health.

Sources: (1) Verbatim from the Healthy People 2030 website https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity. Accessed on 3/25/2025. Accessed on 3/25/2025.

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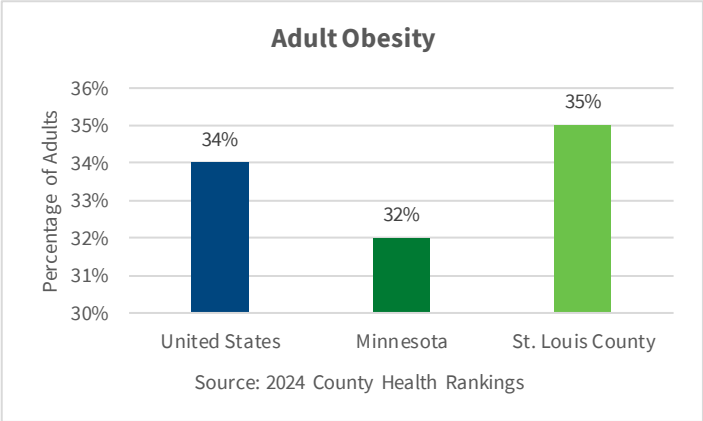
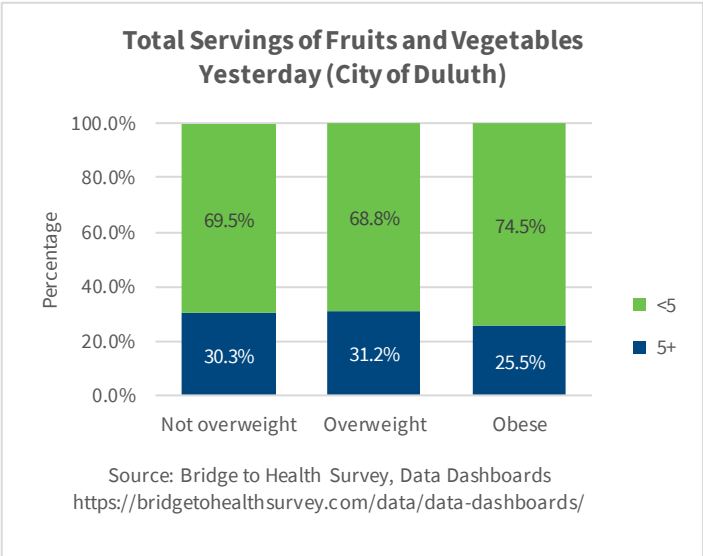


Source: 2024 County Health Rankings



Source: Bridge to Health Survey, Data Dashboards https://bridgetohealthsurvey.com/data/data-dashboards/

- In St. Louis County, about 9% of people do not have a reliable source of food. (2024 County Health Rankings and Roadmaps)

Community Perceptions & Challenges

Results from the community survey showed that *eating healthy food* was rated:

- 8th of 19 in terms of their ability to achieve or succeed in accessing different services and experiences.
- 6th of 19 in terms of how important it was for Aspirus St. Luke's and Essentia Health, in the next 1 to 3 years, to start or continue to help people with the issue.

Social Drivers of Health

Why is it Important?

Social drivers of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH refers to community-level factors. They are sometimes called "social determinants of health." (Adapted from CDC Healthy People 2030)[1] Examples of SDOH include economic stability, access to quality education and health care, and the neighborhood and built environment.[1]

Sources: (1) Nearly verbatim from Centers for Medicare and Medicaid Services website https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs. Accessed on 3/25/2025

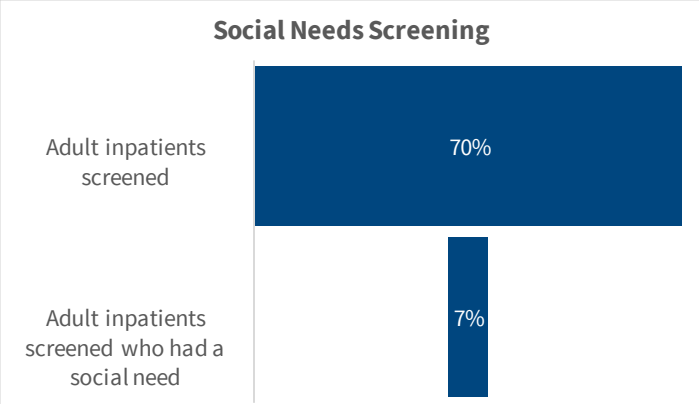
Disparities and Inequities

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

- Unmet social needs, environmental factors, and barriers to accessing health care contribute to worse health outcomes for people with lower incomes. For example, people with limited finances may have more difficulty obtaining health insurance or paying for expensive procedures and medications. In addition, neighborhood factors, such as limited access to healthy foods and higher instances of violence, can affect health by influencing health behaviors and stress.[1]
- Across the lifespan, residents of impoverished communities are at increased risk for mental illness, chronic disease, higher mortality, and lower life expectancy.[1]
- Children make up the largest age group of those experiencing poverty. Childhood poverty is associated with developmental delays, toxic stress, chronic illness, and nutritional deficits. Individuals who experience childhood poverty are more likely to experience poverty into adulthood, which contributes to generational cycles of poverty. In addition to lasting effects of childhood poverty, adults living in poverty are at a higher risk of adverse health effects from obesity, smoking, substance use, and chronic stress.[1]

Sources: (1) Verbatim from Healthy People 2030 website https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty. Accessed on 3/25/2025.

Data Highlights



Aspirus St. Luke's Social Drivers of Health Inpatient Screening data from Strata; 2024.

Additional Data

- Percentage of individuals under the age of 18 who are in poverty: 14% for St. Louis County; 11% for Minnesota.
- Percentage of individuals ages 25 or over who have a high school degree or equivalent: 95% for St. Louis County; 94% for Minnesota.

Source: County Health Rankings and Roadmaps

Community Perceptions & Challenges

The Fall 2024 community survey asked how respondents would rate their ability to … ? The rating scale was Very Easy [1], Easy [2], Neutral [3], Hard [4], or Very Hard [5]. The most challenging issues (top 13) were:

1. Find childcare, 3.97 Average
2. Find housing, 3.92 Average
3. Access mental health care, 3.46 Average
4. Have a livable income, 3.38 Average
5. Access dental care, 2.94 Average
6. Have means of transportation, 2.84 Average
7. Feel community connection, 2.72 Average
8. Eat healthy foods, 2.71 Average
9. Gain employment, 2.67 Average
10. Access primary health care, 2.49 Average
11. Avoid injury and/or violence, 2.44 Average
12. Feel family support, 2.43 Average
13. Get an education, 2.40 Average

Social Drivers and Health 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 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.

As appropriate, Aspirus St. Luke's Hospital staff will participate in internal efforts (e.g., quality improvement) as well as community efforts (e.g., coalitions and programs) to address health related social needs (e.g., transportation).

Evaluation of Impact from the Previous CHNA Implementation Strategy

Aspirus St. Luke's priority health issues from the previous CHNA included:

- Substance Use
- Mental and Social Wellbeing
- Food Access

A description of the impact of efforts to address those needs is included in Appendix J.

Approval by the Hospital Board

The CHNA report was reviewed and approved by the Aspirus St. Luke's Board of Directors on April 21, 2025.

Conclusion

Thank you to all the community members who provided input as part of the process. Aspirus St. Luke's Hospital will continue to work with its partners to address the health issues important to the community.

Appendices

Appendix A: Demographics and Related Descriptors

The table below outlines some of the demographic characteristics of the City of Duluth, St. Louis County and the State of Minnesota.

	City of Duluth	St. Louis County	Minnesota
Population	87,693	200,231	5,706,494
Age <18	16.0%	18.3%	22.6%
Age 65+	18.6%	22.0%	17.9%
Median age	37.0	41.7	39.1
White alone	85.0%	88.6%	77.5%
Black or African American alone	3.6%	2.1%	7.0%
American Indian and Alaska Native alone	2.6%	2.3%	1.2%
Asian alone	1.6%	1.0%	5.2%
Two or more races	6.5%	5.5%	6.1%
Hispanic or Latino	2.5%	1.8%	6.1%
Language other than English spoken at home	Not available	3.4%	12.5%
High school graduate or higher	95.8%	95.6%	94.3%
Bachelor's Degree or Higher	44.4%	33.6%	40.0%
Individuals who are veterans	4.8%	6.5%	5.7%
Individuals with disabilities	15.7%	16.1%	11.8%
Persons in poverty	17.7%	13.3%	9.3%
Median household income	$61,163	$67,269	$85,086
Percent without healthcare coverage	4.6%	3.4%	4.2%
Percent using public insurance (Medicaid, Medicare, veterans' benefits, etc.)	37.7%	41.7%	35.1%

Sources:
MN: American Community Survey table, ACS 5-Year Estimate S2704 - Census Bureau Tables Accessed January 28 and 31, 2025.
MN: Minnesota -- Census Bureau Profile and corresponding tables Minnesota - Census Bureau Profile Accessed January 28 and 31, 2025 and March 25, 2025.

Census Tables:
S1501 Educational Attainment
P8 Race and P9 Ethnicity
Profiles

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: Advisory Committee

An advisory committee of Aspirus St. Luke's and Essentia Health leaders met periodically from Summer 2024 through Spring 2025 to inform the assessment process. The individuals on the advisory committee were:

- Katherine Becker, Aspirus St. Luke's Vice President of Corporate Compliance
- Sarah Beversdorf, Aspirus Health Community Benefit and Community Health Improvement Manager
- Kelly Crandall, Aspirus St. Luke's Clinic Manager
- Penny Danger-Fye, Aspirus St. Luke's Pediatric Care Coordinator
- Russell Habermann, Essentia Health Community Health Program Manager
- Karly Horn, Essentia Health Wellness Program Manager
- Stacey Jutila, Essentia Health Chaplaincy Services Director
- Maggie Kayfes, Aspirus St. Luke's Ambulatory Quality Partner
- Jenna Kowaleski, Aspirus St. Luke's Marketing Specialist
- Tamm Kritzer, Essentia Health Senior Vice President of Operations
- Emily Kuenstler, Essentia Health Community Health Director
- Tonya Loken, Essentia Health Community Relations Director
- Christine Mitchell, Essentia Health Cancer Center Program Manager
- Allison Nicolson, Essentia Health Injury Prevention Specialist
- Kala Pedersen, Essentia Health Community Relations Program Manager
- Bret Reuter, Essentia Health Mission Integration Director
- Anna Solem, Aspirus St. Luke's Director of Case Management
- Kayla Witzman, Aspirus St. Luke's Clinic Manager

Appendix D: Community Input – Community Survey Distribution

As part of the Aspirus St. Luke's community health needs assessment process, a community survey was conducted in Fall 2024. The survey was developed and distributed by Aspirus St. Luke's and Essentia Health. The healthcare systems sought input directly from community members (e.g., at events) and also by asking community organizations to share the survey.

The table below, provided by Essentia Health, includes the list of community organizations that the healthcare partners planned to and then did reach out to for survey distribution.

Organization	Representing medically underserved, low-income, or minority community	Representing state, local, tribal or governmental public health	Survey Distribution
23rd Veteran	Yes	No	Yes
Access North	Yes	No	Yes
AgeWell Arrowhead	Yes	No	Yes
American Indian Community Housing Organization	Yes	No	Yes
Arc Northland	Yes	No	Yes
Arrowhead Area Agency on Aging	Yes	No	Yes
Aspirus St. Luke's	No	No	Yes
Bob Tavani House for Medical Respite	Yes	No	Yes
Boys and Girls Clubs of the Northland	No	No	Yes
Carlton Cook Lake St. Louis Community Health Board	No	Yes	Yes
Chum	Yes	No	Yes
City of Duluth	No	No	No
Community Action Duluth	Yes	No	Yes
Damiano Center	Yes	No	Yes
DAV Minnesota	Yes	No	Yes
Duluth Aging Support	Yes	No	Yes
Duluth Area Family YMCA	No	No	Yes
Duluth Community Garden Program	No	No	No
Duluth Community Schools Collaborative	No	No	Yes
Duluth Farmers Market	No	No	No
Duluth Fire Department	No	No	Yes
Duluth NAACP	Yes	No	Yes
Duluth Police Department	No	No	Yes
Duluth Public Schools	No	No	No
Duluth Tenants Union	Yes	No	Yes
Ecolibrium3	No	No	No
Family Freedom Center	Yes	No	Yes
Family Rise Together	Yes	No	Yes
Fond du Lac Health and Human Services	Yes	Yes	Yes
Generations Healthcare Initiatives	Yes	No	Yes
Head of the Lakes United Way	No	No	Yes
Health Equity Northland	Yes	No	Yes
Human Development Center	No	No	Yes
Justice North	Yes	No	No
Lake Superior Community Health Center	Yes	No	Yes
Lighthouse Center for Vital Living	Yes	No	Yes
Lutheran Social Service of MN	Yes	No	Yes

Neighborhood Youth Services	Yes	No	Yes
One Roof Community Housing	Yes	No	No
PAVSA	No	No	Yes
Safe Haven	No	No	Yes
Second Harvest	Yes	No	Yes
SOAR Career Solutions	No	No	Yes
St. Louis County Public Health	No	Yes	Yes
St. Louis County Veterans Service Office	Yes	No	Yes
The Salvation Army	Yes	No	Yes
Trans Northland	Yes	No	Yes
Twin Ports APIDA Collective	Yes	No	Yes
UDAC	Yes	No	Yes
UMD Multicultural Center	Yes	No	Yes
Union Gospel Mission	Yes	No	Yes
University of Minnesota Extension SNAP-Ed	Yes	No	Yes
YWCA	No	No	Yes
Zeitgeist Center for Arts and Community	No	No	Yes

Appendix E: Community Input – Community Survey Results

The community survey results were compiled by Essentia Health and are shared here with their permission.

Number of Respondents = 1,117 (inclusive of the City of Duluth as well as neighboring zip codes)

Demographics

1. What is the ZIP code of your main residence?
    - 55811: 185 Respondents, 17%
    - 55804: 184 Respondents, 16%
    - 55803: 163 Respondents, 15%
    - 55805: 91 Respondents, 8%
    - 55806: 84 Respondents, 8%
    - 55807: 78 Respondents, 7%
    - 55812: 62 Respondents, 6%
    - 55810: 49 Respondents, 4%
    - 54880: 46 Respondents, 4%
    - 55808: 36 Respondents, 3%
    - 55802: 19 Respondents, 2%
    - 55616: 18 Respondents, 2%
    - 55733: 16 Respondents, 1%
    - Other: 74 Respondents, 7%
    - No Response: 12 Respondents, 1%
2. What is your age?
    - Under 5 years: 1 Respondent, 0.09%
    - 5 to 9 years: 0 Respondents, 0%
    - 10 to 14 years: 5 Respondents, 0.4%
    - 15 to 19 years: 6 Respondents, 0.5%
    - 20 to 24 years: 51 Respondents, 5%
    - 25 to 29 years: 79 Respondents, 7%
    - 30 to 34 years: 128 Respondents, 11%
    - 35 to 39 years: 177 Respondents, 16%
    - 40 to 44 years: 188 Respondents, 17%
    - 45 to 49 years: 141 Respondents, 13%
    - 50 to 54 years: 116 Respondents, 10%
    - 55 to 59 years: 69 Respondents, 6%
    - 60 to 64 years: 74 Respondents, 7%
    - 65 to 69 years: 39 Respondents, 3%

- 70 to 74 years: 21 Respondents, 2%
- 75 to 79 years: 12 Respondents, 1%
- 80 to 84 years: 7 Respondents, 0.6%
- 85 years and over: 1 Respondent, 0.09%
- No Response: 2 Respondents, 0.2%

3. What is your gender identity?
    - Cisgender Female: 911 Respondents, 82%
    - Cisgender Male: 152 Respondents, 14%
    - Non-binary: 8 Respondents, 0.7%
    - Gender Fluid: 6 Respondents, 0.5%
    - Transgender Female: 5 Respondents, 0.4%
    - Two-Spirit: 3 Respondents, 0.3%
    - Transgender Male: 2 Respondents, 0.2%
    - Other: 2 Respondents, 0.2%
    - No Response: 28 Respondents, 3%

4. What is your race?
    - White or Caucasian: 1,049 Respondents, 94%
    - American Indian or Alaska Native: 39 Respondents, 3%
    - Black or African American: 22 Respondents, 2%
    - Asian: 18 Respondents, 2%
    - Native Hawaiian or Other Pacific Islander: 3 Respondents, 0.3%
    - Middle Eastern or North African: 1 Respondent, 0.09%
    - Some other race: 20 Respondents, 2%

5. Are you of Hispanic, Latino/Latina/Latine, or Spanish origin?
    - Yes: 20 Respondents, 2%
    - No: 1,076 Respondents, 96%
    - No Response: 21 Respondents, 2%

6. What is your individual annual income?
    - Less than $10,000: 41 Respondents, 4%
    - $10,000-$14,999: 30 Respondents, 3%
    - $15,000-$24,999: 51 Respondents, 5%
    - $25,000-$34,999: 85 Respondents, 8%
    - $35,000-$49,999: 153 Respondents, 14%
    - $50,000-$74,999: 268 Respondents, 24%
    - $75,000-$99,999: 203 Respondents, 18%
    - $100,000-$149,999: 150 Respondents, 13%
    - $150,000-$199,999: 38 Respondents, 3%
    - $200,000 or more: 67 Respondents, 6%
    - No Response: 31 Respondents, 3%

Community Conditions

7. In the city of Duluth, how would you rate the ability to… ? (Each option is provided with an average score of all responses based on the following scoring: Very Easy [1], Easy [2], Neutral [3], Hard [4], or Very Hard [5].)

    1. Find childcare, 3.97 Average
    2. Find housing, 3.92 Average
    3. Access mental health care, 3.46 Average
    4. Have a livable income, 3.38 Average
    5. Access dental care, 2.94 Average
    6. Have means of transportation, 2.84 Average
    7. Feel community connection, 2.72 Average
    8. Eat healthy foods, 2.71 Average
    9. Gain employment, 2.67 Average
    10. Access primary health care, 2.49 Average
    11. Avoid injury and/or violence, 2.44 Average
    12. Feel family support, 2.43 Average
    13. Get an education, 2.40 Average
    14. Avoid excessive alcohol use, 2.32 Average
    15. Avoid unsafe drug use, 2.11 Average
    16. Be physically active, 2.08 Average
    17. Avoid tobacco use, 2.01 Average
    18. Receive recommended vaccinations, 1.98 Average
    19. Avoid unsafe sexual activity, 1.93 Average

8. Review the community conditions above where you answered “hard” or “very hard”. In your opinion, what makes these actions hard to do in Duluth?

    - Answers to this question include personal details about community members and are not available to the public.

Community Urgency

9. In the city of Duluth in the next 1 to 3 years, how important is it for Aspirus St. Luke's and Essentia Health to start or continue to help people… ? (Each option is provided with an average score of all responses based on the following scoring: Very Unimportant [1], Unimportant [2], Neutral [3], Important [4], or Very Important [5].)

    1. Access mental health care, 4.68 Average
    2. Access primary health care, 4.54 Average
    3. Receive recommended vaccinations, 4.28 Average
    4. Access dental care, 4.22 Average
    5. Have a livable income, 4.20 Average
    6. Eat healthy foods, 4.19 Average
    7. Avoid unsafe drug use, 4.16 Average
    8. Be physically active, 4.12 Average
    9. Find childcare, 4.06 Average
    10. Gain employment, 4.03 Average
    11. Avoid injury and/or violence, 4.01 Average
    12. Avoid excessive alcohol use, 4.01 Average
    13. Avoid tobacco use, 4.01 Average
    14. Avoid unsafe sexual activity, 4.00 Average
    15. Feel community connection, 3.90 Average
    16. Find housing, 3.89 Average
    17. Get an education, 3.73 Average
    18. Have means of transportation, 3.73 Average
    19. Feel family support, 3.69 Average

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

The table below was compiled by Essentia Health and is shared here with their permission. The data framework is centered around the What Works for Health section of the County Health Rankings and Roadmaps website. The corresponding data were also obtained from the County Health Rankings & Roadmaps website and reflect St. Louis County and the State of Minnesota.

Category	Measure	Description	St. Louis County	State of Minnesota	Source
Outcomes	Death Before Age 75 (Per 100,000 People)	Years of potential life lost before age 75 per 100,000 population (age-adjusted)	7,800	6,100	CDC WONDER 2019-2021
Outcomes	Poor or Fair Health Rate	Percentage of adults reporting fair or poor health (age-adjusted)	14%	12%	Behavioral Risk Factor Surveillance System 2021
Outcomes	Poor Physical Health Days Per Month	Average number of physically unhealthy days reported in past 30 days (age-adjusted)	3.2	2.7	Behavioral Risk Factor Surveillance System 2021
Outcomes	Poor Mental Health Days Per Month	Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	5.1	4.3	Behavioral Risk Factor Surveillance System 2021
Outcomes	Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams)	7%	7%	National Center for Health Statistics - Natality Files 2016-2022
Income	Child Poverty Rate	Percentage of people under age 18 in poverty	14%	11%	Small Area Income and Poverty Estimates 2022
Income	Income Inequality (Ratio of Household Income at 80th Percentile to Household Income at 20th Percentile)	Ratio of household income at the 80th percentile to income at the 20th percentile	4.6	4.3	American Community Survey 5-Year Estimates 2018-2022
Employment	Unemployment Rate	Percentage of population ages 16 and older unemployed but seeking work	3.3%	2.7%	Bureau of Labor Statistics 2022

Category	Measure	Description	St. Louis County	State of Minnesota	Source
Child Care	Child Care Cost Burden	Child care costs for a household with two children as a percent of median household income	36%	30%	The Living Wage Institute Small Area Income and Poverty Estimates 2022-2023
Child Care	Child Care Centers	Number of child care centers per 1,000 population under 5 years old	8	6	Homeland Infrastructure Foundation-Level Data (HIFLD) 2010-2022
Education	High School Completion Rate	Percentage of adults ages 25 and over with a high school diploma or equivalent	95%	94%	American Community Survey 5-Year Estimates 2018-2022
Education	Post-Secondary Education Rate	Percentage of adults ages 25-44 with some post-secondary education	77%	76%	American Community Survey 5-Year Estimates 2018-2022
Primary Health Care Access	Uninsured Rate	Percentage of population under age 65 without health insurance	5%	5%	Small Area Health Insurance Estimates 2021
Primary Health Care Access	Mammography Screening Rate	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening	45%	52%	Mapping Medicare Disparities Tool 2021
Primary Health Care Access	Patient to Primary Care Physician Ratio	Ratio of population to primary care physicians	810:1	1,130:1	Area Health Resource File/American Medical Association 2021
Dental Care Access	Patient to Dentist Ratio	Ratio of population to dentists	1,020:1	1,290:1	Area Health Resource File/National Provider Identifier Downloadable File 2022
Mental Health Care Access	Patient to Mental Health Provider Ratio	Ratio of population to mental health providers	290:1	300:1	CMS, National Provider Identification 2023

Housing	Severe Housing Problems (Overcrowding, High Cost, Lack of Kitchen/Plumbing) Rate	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities	13%	13%	Comprehensive Housing Affordability Strategy (CHAS) 2016-2020
Transportation	Driving Alone to Work Rate	Percentage of the workforce that drives alone to work	77%	72%	American Community Survey 5-Year Estimates 2018-2022
Transportation	Long Commute – Driving Alone Rate	Among workers who commute in their car alone, the percentage that commute more than 30 minutes	20%	30%	American Community Survey 5-Year Estimates 2018-2022
Community Safety	Preventable Hospital Stays (Per 100,000 Medicare Enrollees)	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	4,064	2,225	Mapping Medicare Disparities Tool 2021
Community Safety	Injury Deaths (Per 100,000 People)	Number of deaths due to injury per 100,000 population	95	73	National Center for Health Statistics - Mortality Files 2017-2021
Family Support	Children in Single-Parent Households Rate	Percentage of children that live in a household headed by a single parent	23%	20%	American Community Survey 5-Year Estimates 2018-2022
Community Support	Membership Organizations (Per 10,000 People)	Number of membership associations per 10,000 population	14.7	12.4	County Business Patterns 2021
Alcohol Use	Excessive Drinking Rate	Percentage of adults reporting binge or heavy drinking (age-adjusted)	21%	21%	Behavioral Risk Factor Surveillance System 2021
Alcohol Use	Alcohol-Impaired Driving Deaths Rate	Percentage of driving deaths with alcohol involvement	40%	30%	Fatality Analysis Reporting System 2017-2021
Drug Use	Drug Overdose Deaths (Per 100,000 People)	Number of drug poisoning deaths per 100,000 population	28	19	National Center for Health Statistics – Mortality Files 2019-2021

Nutrition	Food Environment Index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best)	8.1	9.1	USDA Food Environment Atlas 2019-2021
Nutrition/Exercise	Adult Obesity Rate	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)	35%	32%	Behavioral Risk Factor Surveillance System 2021
Exercise	Physical Inactivity Rate	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted)	22%	20%	Behavioral Risk Factor Surveillance System 2021
Exercise	Access to Park/Recreation Rate	Percentage of population with adequate access to locations for physical activity	81%	86%	ArcGIS Living Atlas 2020, 2022, 2023
Sexual Activity	Chlamydia Infection Rate (Per 100,000 People)	Number of newly diagnosed chlamydia cases per 100,000 population	391.6	395.5	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention 2021
Sexual Activity	Teen Births (Per 1,000 Females)	Number of births per 1,000 female population ages 15-19	11	10	National Center for Health Statistics - Natality Files 2016-2022
Tobacco Use	Adult Smoking Rate	Percentage of adults who are current smokers (age-adjusted)	18%	14%	Behavioral Risk Factor Surveillance System 2021

Additional Data Utilized as Part of the Prioritization Process

The following report details social needs self-reported by Essentia Health patients residing within the home county of Essentia Health-St. Mary's Medical Center and Essentia Health-Duluth (Miller-Dwan) during FY24. Social Needs Screenings are administered to all patients upon hospital admission and during primary care and pediatric appointments. Approximately 60% of patients choose to complete the screening.

While the data below reflect Essentia Health and were used as part of the prioritization process, Aspirus St. Luke's has similar data.

Category	Measure	Description	Duluth Hospitals and Clinics	Source
Income	Utility Strain	Percentage of patients who have had the electric, gas, oil, or water company threaten to shut off services in their home in the past 12 months.	1.8%	Essentia Health patients who completed the Social Needs Screening tool during clinic visit or hospital admission (2024).
Housing	Housing Affordability	Percentage of patients who have not been able to pay their mortgage or rent on time in the past 12 months.	3.8%	Essentia Health patients who completed the Social Needs Screening tool during clinic visit or hospital admission (2024).
Housing	Housing Insecurity	Percentage of patients who have not had a steady place to sleep or slept in a shelter in the past 12 months.	1.3%	Essentia Health patients who completed the Social Needs Screening tool during clinic visit or hospital admission (2024).
Transportation	Medical Transport	Percentage of patients who lacked transportation to medical appointments or for getting medications in the past 12 months.	3.6%	Essentia Health patients who completed the Social Needs Screening tool during clinic visit or hospital admission (2024).
Transportation	Non-Medical Transport	Percentage of patient who lacked transportation to get to meetings, work, or getting things needed for daily living in the past 12 months.	3.3%	Essentia Health patients who completed the Social Needs Screening tool during clinic visit or hospital admission (2024).
Nutrition	Food Worry	Percentage of patients who worried about running out of food before they got money to buy more in the past 12 months	6.7%	Essentia Health patients who completed the Social Needs Screening tool during clinic visit or hospital admission (2024).
Nutrition	Food Insecurity	Percentage of patients who ran out of food before they had money to buy more in the past 12 months.	5.6%	Essentia Health patients who completed the Social Needs Screening tool during clinic visit or hospital admission (2024).

Additional Data Utilized as Part of the Prioritization Process

Essentia Health also hosts a free community resource guide called Resourceful that lists free and reduced-cost social service programs in the community. This tool is embedded in Essentia Health's electronic medical records, allowing healthcare providers to refer patients to listed programs, and is accessible for public use. During FY24, the top three most searched categories on Resourceful for the home county of Essentia Health-St. Mary's Medical Center and Essentia Health-Duluth (Miller-Dwan) were:

1. Housing (2,261 searches)
2. Nutrition (1,615 searches)
3. Health Care Access (1,614 searches)

While the data above reflect Essentia Health and were used as part of the prioritization process, Aspirus St. Luke's has similar data.

Appendix G: Prioritization Rubric

To identify the healthcare systems' priority community health needs, Essentia Health's Community Health Department created and applied a prioritization matrix to quantify the need and feasibility of addressing each potential community health need area. Aspirus St. Luke's recognizes Essentia's leadership in this area and is sharing the information below with Essentia's permission.

Using the *What Works for Health* platform on the County Health Rankings and Roadmaps website, the process began with the following list of potential community health need areas:

- Income
- Employment
- Childcare
- Education
- Primary Health Care Access
- Dental Care Access
- Mental Health Care Access
- Vaccination
- Housing
- Transportation
- Community Safety
- Family Support
- Community Support
- Alcohol Use
- Drug Use
- Nutrition
- Exercise
- Sexual Activity
- Tobacco Use

Each of these potential community health need areas was then analyzed with five weighted categories to determine its priority on a scale from one to five, with higher scores reflecting a greater need and a higher feasibility of the healthcare systems effectively responding to that community need. The five weighted categories and their scoring system are outlined below.

Feasibility of Impact: This factor considers whether the health systems can affect beneficial change for this topic area, based on scientifically supported community interventions available and the health systems' ability to implement these interventions. It accounts for 30% of the score and is completed as follows:

- How many scientifically supported strategies are there for this issue?
  - 1 = No scientifically supported strategies
  - 2 = One scientifically supported strategy
  - 3 = Two scientifically supported strategies
  - 4 = Three to 10 scientifically supported strategies
  - 5 = More than 10 scientifically supported strategies

Population Affected: This factor represents the prevalence of the health issue or condition. It accounts for 30% of the score and is completed as follows:

- What portion of the population is affected by the problem?
    - 1 = Minimal amount of the population is affected (0-9%)
    - 2 = Sporadic amount of the population is affected (10-29%)
    - 3 = Moderate amount of the population is affected (30-69%)
    - 4 = Most of the population is affected (70-89%)
    - 5 = Nearly all or all of the population is affected (90-100%)

Data Trend: This factor looks at the history and forecast of the data. It accounts for 20% of the score and is completed as follows:

- What do recent data trends demonstrate about the issue?
    - 1 = Major Right Direction Movement (6+% Change)
    - 2 = Minor Right Direction Movement (1-5% Change)
    - 3 = No Significant Movement (<1% Change)
    - 4 = Minor Wrong Direction Movement (1-5% Change)
    - 5 = Major Wrong Direction Movement (6+% Change)

Community Perception: This factor asks residents to rate the difficulty level of participating in healthy actions in their area, as reported on the healthcare systems' community survey. It accounts for 10% of the score and will be derived from the average of responses provided for each health needs area category in the community survey. The numeric coding of these numbers is outlined below.

- In your area, how would you rate the ability to (Healthy Action)?
    - 1 = Very Easy
    - 2 = Easy
    - 3 = Neutral
    - 4 = Hard
    - 5 = Very Hard

Urgency to Act: This factor asks residents to rate the level of urgency in responding to community conditions that impact health, as reported on the healthcare systems' community survey. It accounts for 10% of the score and will be derived from the average of responses provided for each health needs area category in the community survey. The numeric coding of these numbers is outlined below.

- In your area in the next 1 to 3 years, how important is it for Essentia Health and Aspirus St. Luke's to start or continue to help people (Healthy Action)?
    - 1 = Very Unimportant
    - 2 = Unimportant
    - 3 = Neutral
    - 4 = Important
    - 5 = Very Important

Social Needs: This factor considers the need for any given health area identified by data from Resourceful/Find Help in the past year. It awards bonus points toward the total score of categories as follows:

- 0.20 extra points awarded for each of the top three most searched categories on Resourceful in the hospital's home county.

Appendix H: Prioritization Rubric Applied: Results

To identify the healthcare systems' priority community health needs, Essentia Health's Community Health Department created and applied a prioritization matrix to quantify the need and feasibility of addressing each potential community health need area. Aspirus St. Luke's recognizes Essentia's leadership in this area and is sharing the information below with Essentia's permission.

Scored out of five points, each potential community health need area is ranked in order below.

Topic	Feasibility of Impact	Population Affected	Data Trend	Community Perception	Urgency to Act	Social Needs	Weighted Score
Housing	4	3	4	3.92	3.89	0.2	3.88
Vaccination	4	3	3	1.98	4.28	0	3.75
Exercise	5	2	4	2.08	4.12	0	3.52
Nutrition	5	2	2	2.71	4.19	0.2	3.39
Transportation	4	2	4	2.84	3.73	0	3.26
Community Safety	4	2	4	2.44	4.01	0	3.24
Community Support	3	3	3	2.72	3.90	0	3.06
Education	5	1	1	2.40	3.73	0	2.61
Childcare	1	3	3	3.97	4.06	0	2.60
Primary Health Care Access	2	1	4	2.49	4.54	0.2	2.60
Tobacco Use	2	2	3	2.01	4.01	0	2.40
Sexual Activity	3	1	3	1.93	4.00	0	2.39
Drug Use	2	1	4	2.11	4.16	0	2.33
Employment	3	1	2	2.67	4.03	0	2.27
Income	1	2	2	3.38	4.20	0	2.06
Dental Care Access	2	1	2	2.94	4.22	0	2.02
Alcohol Use	2	1	2	2.32	4.01	0	1.93
Mental Health Care Access	1	1	2	3.46	4.68	0	1.81
Family Support	2	1	1	2.43	3.69	0	1.71

Appendix I: 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 www.weareresourceful.org and then searching by zip code and program need/area.

Agency	Need/Resource
St. Louis County Health Department	Multiple – Car seats, cribs, WIC program, Healthy Smiles, immunizations, Parents as Teachers, and more
Aspirus St. Luke's Behavioral Health	Counseling, recovery
CHUM	Shelter, Housing, Street Outreach, Food Shelf
Center for Alcohol & Drug Treatment-Duluth	Chemical Dependency
Damiano Center	Food shelf, soup kitchen, clothing, hygiene, skills training.
Ecolibrium3	Sustainable housing and food access
Essentia Health	Healthcare
Life House	Youth drop-in center, food access, shelter/housing, food access.
Safe Haven	Domestic Violence
Program for Aid to Victims of Sexual Assault (PAVSA)	Sexual Assault
Senior LinkAge Line	Aging and Disability Resource Center
Urgent Care Behavioral Health	Crisis Response, behavioral health, substance use, dental services.
One Roof Community Housing	Housing
Head of the Lakes Unite Way-211	Health and Human Services Resources
Recovery Alliance Duluth	Peer Recovery Support

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

In Spring 2024, St. Luke's Hospital became part of Aspirus Health. With this transition, Aspirus St. Luke's and the local community experienced changes in processes, relationships and other related impacts. Aspirus Health is working to strategically build strong, effective community health efforts that meet local needs as this transition continues.

The significant health priorities identified in Aspirus St. Luke's Hospital's 2023-2025 (most recent) CHNA and Implementation Strategy were **mental and social well-being**, **substance use** and **food insecurity**. A summary of the impact of efforts to address those needs is below. The summary reflects FY23 (January 1, 2023-December 31, 2023), FY24 (January 1, 2024-June 30, 2024) and a portion of the current (FY25) fiscal year (July 1, 2024-June 30, 2025). FY25 was incomplete at the time of this report's approval.

Aspirus St. Luke's took the following steps to address significant community health needs.

Overall Actions

- St. Luke's contributed financially to support Bridge to Health Survey occurring in 2025. This survey assesses key health indicators for adults in the Northeastern Minnesota and Northwestern Wisconsin region, where the primary population of Aspirus St. Luke's Community Health Needs Assessment (CHNA) efforts are located. Following completion of the survey, Aspirus St. Luke's will review the outcomes for applicable alignment and application to the implementation plans.
- St. Luke's Hospital developed and implemented social determinants of health screening within the inpatient hospital setting, with rollout in October 2023. With this project, education was provided to inpatient nursing and case management staff to review what social determinants of health are, how they impact our patient's lives, and the screening and referral process. The screening tool developed screens for domestic violence, abuse, neglect, in addition to housing insecurity, food insecurity, transportation access, and financial insecurity, including ability to support in home utilities. This screening process, if flagged positive on any of the elements, generates a consult to Case Management for intervention. With a transition from Meditech to Epic in April 2025, a more robust screening tool is being used. The screening results for calendar 2024 were as follows:
    - 70% of patients (n=4173) were screened, with 7% showing positive results:
        - *Transportation Needs: 4%*
        - *Utility Difficulties: 3%*
        - *Food Insecurity: 3%*
        - *Housing Instability: 1%*

- Access to transportation remains a significant barrier to healthcare services within the communities served by Aspirus St. Luke's Hospital. The hospital provides coverage for non-emergent medical transport (NEMT) services, including through FY25.
- The Director of Case Management has consistently worked with the Regional Rural Transportation Coalition to address the gap in Non-Emergent Medical Transportation in the region. Coalition efforts included data collection and advocacy. This collaborative work continues in FY25.
- Through May 2024, St. Luke's participated in Bridging Health Duluth, a local 'coalition of local organizations that have combined resources, skills and expertise to improve the health of all people in Duluth.' Participation included being on the steering committee and action teams.
- St. Luke's participated in a study in tandem with Minnesota Hospital Association to evaluate Inpatient Avoidable Days. The intent of the study was to determine the number of patient days at each hospital for patients who no longer met acute level of care, but were facing discharge barriers including lack of Medicaid funding for long term care, homelessness, and/or other complex barriers. The study process and results resulted in the hospital strengthening its avoidable day tracking process within the electronic medical record.

Mental and Social Wellbeing

- In FY23 and FY24, Aspirus St. Luke's facilitated several free support groups that help in promoting mental health:
    - The Director of Chaplaincy provided bereavement support to individuals who experienced the death of a loved one. The group met twice a month and it was open to anyone in the community.
    - Patients experiencing perinatal loss are provided with the Mending Hearts curriculum that was purchased through the St. Luke's Foundation. A monthly group is held, with between 3 and 10 participants. This program is available to community members who also have received care outside of Aspirus St. Luke's and is free of charge. Other community agencies participate, including Threesixty Therapy and Duluth Perinatal. This programming continues in FY25.
    - The Oncology Clinic social workers provide two free support groups including:
        - The General Cancer Support Group: This 90-minute cancer support group meets once a month and serves 8-12 patients per month. The focus is on social and coping support for their own or their loved one's cancer diagnosis. This support group is available free of charge to community members. This programming continues in FY25.
        - The Breast Cancer Support Group: This 90-minute cancer support group meets once a month. This support group is available free of charge to community members. This programming continues in FY25.

- In FY23 and FY24, Aspirus St. Luke's continued to grow its mental health services available to the community. To maintain adequate coverage of community needs, eight adult therapists, two child therapists, four adult psychologists, one child psychologist, one child psychiatrics, three adult psychiatrists and two adult psychiatric certified nurse practitioners are employed with the following projects.
    - Transcranial Magnetic Stimulation service has expanded. Transcranial Magnetic Stimulation is for those who experience refractory major depressive disorder, obsessive-compulsive disorder, in addition to other diagnoses when standard treatments have not worked.
    - The behavioral health clinic has participated in community diversity, equity and inclusion events including Trans Joy Fest and Duluth/Superior Pride, in addition to presenting to local college students on DEI.
    - The psychiatric team at Aspirus St. Luke's has spent considerable time and investment in developing an Esketamine program set to roll out in FY25 to provide further depression treatment options in the community.
- In FY23 and FY24, the St. Luke's pediatric clinic coordinated a backpack event and school supply drive for the pre-start-of-school Unity in the Community event. Donations were collected from St. Luke's employees and donated to area schools.
- In the interest of supporting patients served at Aspirus St. Luke's Hospital who may not have adequate clothing or other resources due to limited financial means, the hospital and clinics have a variety of programs.
    - In FY23, St. Luke's contributed $8,702 in new clothing items for patients including shoes and jackets; that funding carried over into FY24.
    - The Aspirus St. Luke's Clinic-Superior maintained a personal hygiene supply closet. In FY23 they served approximately 60 patients and in FY24 they served approximately 10 patients. This program continues in FY25.
    - In FY23 and FY24, Aspirus St. Luke's Oncology staff screened patients utilizing a distress thermometer and screening tool for measurement of patient distress. Based on these screenings, resources were provided through grant funded opportunities for gas cards, local hotel lodging support, grocery gift cars, chemotherapy supply bags and nutritional supplements for patients that are facing disparities in maintaining well-being and accessing care. This program continues in FY25.
- In FY23 and FY24, Aspirus St. Luke's Oncology staff maintained a wig room, including a supply of hats and scarves. Approximately five wigs are provided per week, which assists with improving the patients' overall wellbeing and coping with their diagnosis. This program continues in FY25.
- In FY23 and FY24, the Aspirus St. Luke's Rejuvenation Clinic aesthetician supported the Brave Faces program to promote appropriate skin care for patients undergoing oncology treatment. The

skin care supplies are foundation grant supported, but the class time is supported through staffing. The program had four classes in FY24 and eight in FY23.

- In FY23 and FY24, Aspirus St. Luke's staff maintained a resource list of both local and national crisis resources. They also maintained information on mental health treatment resources. This work continues in FY25.
- Community Education
    - On June 27, 2023, St. Luke's hosted a free community event covering the topic of *Navigating Cancer; Get to know the Team* with St. Luke's speakers including pharmacy, oncology physicians, oncology nurses, research staff, registered dieticians as well as occupational therapists.
    - On June 11, 2024, Aspirus St. Luke's hosted a free community event covering the topic of *Role of Genetics in Cancer Development and Treatment* with content specialists from Aspirus St. Luke's including an Oncologist, a pharmacist, and genetic counselor.
- Aspirus St. Luke's Hospital provided funding to the following organizations to aid in addressing mental and social well-being:
    - Northern Expressions Arts Collective Programming, YMCA Kids Club and Events, Chester Bowl Improvement Project, Movies in the Park and Sidewalk Days through the Greater Downtown Council, Young Athletes Foundation, Zeitgeist's Healthy Hillside Initiative, First Witness, SANE/PAVSA, Alzheimer's Walk, Rhubarb Festival and the Juneteenth event.
- In FY23, the Community Action Duluth Farmers Market asked St. Luke's to contribute time and kids activities at the local farmers market with the idea to have children spend more time completing these activities at the event, thereby building community. Bridging Health Duluth coordinated participation in this event with St. Luke's participating.
- In FY23, St. Luke's partnered with Safe Haven for ongoing employee education surrounding domestic partner violence. Aspirus St. Luke's provides both 211 United Way cards and Safe Haven business cards to those who flag positive for domestic partner violence on HITS screening (Hurt, Insult, Threaten, Scream, Strangle).

Mental and Social Wellbeing and Substance Use (overlapping programs/efforts)

- In November 2022, Aspirus St. Luke's took over the contract for Jail Medical Services at St. Louis County Jail and the North East Regional Correctional Center. The contract includes providing 24/7 on-site medical services as well as 40 hours of mental health services per week on site. In FY2024, Aspirus St. Luke's Hospital supported the community members incarcerated at the jail with one full time and one part time mental health professional to promote mental health stability and transition planning back into the community. This partnership has allowed for patients who previously would acutely psychiatrically decompensate to receive ongoing care in the jail, maintaining emotional and mental stability, and allowing for court ordered Jarvis medications to be administered at Aspirus St. Luke's Hospital Emergency Department under Jarvis order prior to decompensation. This partnership has reduced preventable hospital admissions for psychiatric illness. This partnership continues in FY25.
- In FY23 and FY24, St. Luke's Hospital participated in the Clarity Project, an interfacility community collaborative approach to develop a behavioral health urgent care within the City of Duluth. The Urgent Care Behavioral Health facility opened in FY24. Although the facility is focused primarily on crisis response and behavioral health services, they also provide direct access to detox services, comprehensive assessments to access treatment services for substance use disorders as well as Medication Assisted Therapy (MAT) for substance use disorder. Aspirus St. Luke's will continue collaborating in FY25 with the Urgent Care Behavioral Health to optimize patient throughput and referral to services.
- In FY23 and FY24, the St. Luke's Hospital Emergency Department Social Worker participated monthly in the Community Intervention Group (CIG). The CIG work focuses on providing social structure and supports for patients who experience high law enforcement, corrections, homelessness, and hospital recidivism to reduce risk, improve patient outcomes, and decrease criminalization of homelessness, mental health and substance use disorder. Participation continues in FY25.
- In FY23, St. Luke's Hospital participated in a 45-day study of Minnesota hospitals focusing on discharge delays for both inpatient and emergency department behavioral health patients. The results of the study were published July of 2024 and can be found here: https://www.health.state.mn.us/data/economics/docs/dischargedelays.pdf
- In FY24, the Director of Case Management participated in facilitated focus groups with a cross-sector group of agencies. The aim of the work was to identify gaps in behavioral health services, establish joint understanding of our infrastructure and inspire future strategy work to impact the behavioral health services within the community.

Substance Use

- In FY23 and FY24, two Aspirus St. Luke's staff members participated on a Wilderness Health-led collaboration with a goal of measuring, assessing, and reducing by 20% the negative outcomes of post-partum families with substance use disorder by promoting harm reduction and education around substance use disorder issues to staff and affected communities in Northeast Minnesota by June 2028.
- In FY23 and FY24, patients who demonstrate a positive screen for substance use and or alcohol abuse are provided with a Screening Brief Intervention and Referral to Treatment (SBIRT) intervention by acute care coordination. The goal is to provide risk reduction for those who are at risk for poor health outcomes related to their substance use, and or engage the patient in referral to treatment for those who have a high probability of a substance use disorder and or alcohol use disorder. This program continues in FY25.
- In FY23 and a portion of FY24, a St. Luke's staff member was the lead of an action team that facilitated programming for substance use recovery.
- In FY23 and FY24, Aspirus St. Luke's Staff maintained a resource list of substance use treatment resources that are reviewed and updated annually for patient dissemination. This program continues in FY25.
- In FY23, a pharmacist at St. Luke's obtained a community grant to purchase Narcan kits. These kits are provided in the St. Luke's Emergency Department to patients who themselves experience opioid use or live with those who experience opioid use. The State Opioid Response Grant that was pursued in tandem with Essentia Health had two focuses: to support and increase access to medication for opioid use disorder (MOUD) treatment and to create formal pathways to enhance transitions between emergency departments and other community entities. In addition to building internal capacity through buprenorphine waiver training and staff education, the grant enabled the department to purchase 180 2-dose packs of Narcan. In 2023, approximately 60 Narcan kits were provided and approximately 60 kits were provided in FY24. This program continues in FY25.
- In FY23, St. Luke's Hospital provided funding for Recovery Alliance Duluth's monthly meeting. This group focuses on providing peer recovery support to those experiencing substance use disorders.
- In FY23, Aspirus St. Luke's, through Bridging Health Duluth, was involved in the Community Solutions for Substance use and Recovery (CSSUR) coalition. The coalition aimed to reduce harm, increase safety, and support recovery through community-based solutions for those impacted by substance use. The coalition focused on stigma, advocacy and positive community support.

Food Security

- In FY23 and FY24, Aspirus St. Luke's supported the local community by providing food to the local Second Harvest Northland foodbank throughout the year from the Blue Waves Café, the cafeteria at Aspirus St. Luke's Hospital. In FY23, St. Luke's provided 711 pounds of food equating to 569 meals to be provided to the local community. In FY24, Aspirus St. Luke's provided 100 pounds of food equating to 80 meals to be provided to the local community. This program continues in FY25.
- St. Luke's continued to build a community approach to screening for food insecurity and connecting people facing food insecurity with resources. This included the growing utilization and effectiveness of www.weareresourceful.com in the acute and ambulatory setting.
    - In FY23 and FY24, Aspirus St. Luke's Pediatric Clinic screened patients for SDOH during patient visits to identify needs, offer services, supports and resources. In FY23, nine families were helped with 188 items in the food closet. In FY24, four families were helped with 69 items from the closet. This program continues in FY25.
    - In March 2024 a Care Closet was developed at Aspirus St. Luke's Duluth Obstetrics and Gynecology clinic. From March 2024 to the end of the fiscal year, 58 patients utilized the Care Closet. Care Closet access is provided by a positive screen on a patient's Social Drivers of Health screening form. This program continues in FY25.
    - In FY23 and FY24, the Oncology clinic provided grant funded grocery cards, in addition to nutritional supplements for patients experiencing food insecurity and/or risk for malnutrition during active cancer treatment. This program continues in FY25.
- In FY23, St. Luke's supported community-led partnerships that focus on culturally appropriate food access and education. Those included American Indian Community Housing Organization's (AICHO's) food sovereignty programs and events, the Giving Garden, and Freedom Farm. Also in FY23, in coordination with Community Action Duluth and Bridging Health Duluth, St. Luke's arranged family-friendly activities at the Harrison Park Farmers Market.
- In FY23, St. Luke's staff participated in the Duluth Farm to School Program, the Lincoln Park Middle School food shelf and the Laura MacArthur school food drive.
- FY23, 19 employees packed food boxes for families in need at Second Harvest Northland. Their time resulted in one thousand boxes of food being packed for distribution in the community.

A Note on Housing

Aspirus St. Luke's recognizes that stable housing impact health. The hospital has been involved in a number of housing-related initiatives.

- In FY23 and FY24, Aspirus St. Luke's continued to support housing for those who are experiencing long term homelessness and are of advanced age. Aspirus St. Luke's owns and maintains The St. Francis Apartments in collaboration with Chum (a non-profit human services agency) who provides support to the tenants. The program provides 32 units to people experiencing chronic homelessness who qualify for the Department of Housing and Urban Development's project-based permanent supportive housing subsidy voucher. The remaining 11 units are offered to those experiencing long-term homelessness who qualify for Housing with Support subsidies as per St. Louis County. This continues in FY25.
    - In 2023, St. Luke's Hospital provided a replacement washing machine to the facility, at a cost of $489, to provide ongoing access to laundry facilities.
- Aspirus St. Luke's financially supported the Chum Rhubarb Festival in FY24 (June 2024). All proceeds from the community festival support Chum's work to help those in need in Duluth who are homeless and/or facing poverty.
- In early FY24, Aspirus St. Luke's staff conducted a supplies drive for individuals who are unhoused. Fifty-nine boxes of needed items (e.g., hygiene products, handwarmers and more) were donated.
- In FY23 and FY24, an Aspirus St. Luke's Emergency Department social worker participated in a monthly meeting to facilitate community supports with the Health and Homelessness Committee. The Committee focuses on the support of the medical respite house which provides transitional support to patients who are experiencing medical fragility following acute hospitalization who would be at greatest risk for decompensation should they return to a homeless shelter. The hospital Case Management team works closely with this group to identify high risk patients appropriate for utilization of these free services. This continues in FY25.

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April 2025