Community Health Implementation Strategy

2025-2028

ASPIRUS St. LUKE'S HOSPITAL & CLINICS

915 East First Street

Duluth, MN 55805

Acknowledgements

Aspirus St. Luke's Hospital is excited to share this Implementation Strategy with the community. This plan was developed in Spring 2025 in collaboration with Essentia Health. We anticipate leading some local efforts as well as being a strong supporter of other efforts. These issues are complex and will require persistent partnerships. We look forward to continued collaboration to create a healthier Duluth for all.

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

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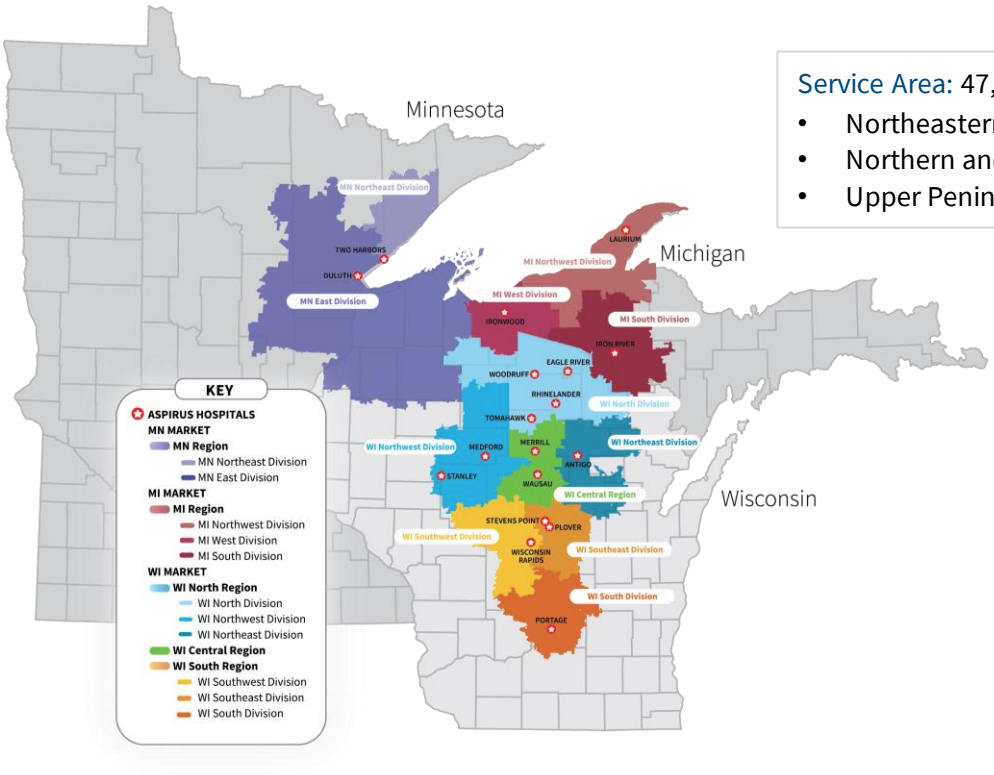
Aspirus Health and Aspirus St. Luke's Hospital Profile

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 Implementation Strategy

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

Definition / Purpose of a CHNA and Implementation Strategy

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

Compliance

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

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

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

Prioritized Significant 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 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 following 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.

General Approach to Implementation

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

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

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

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

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

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.

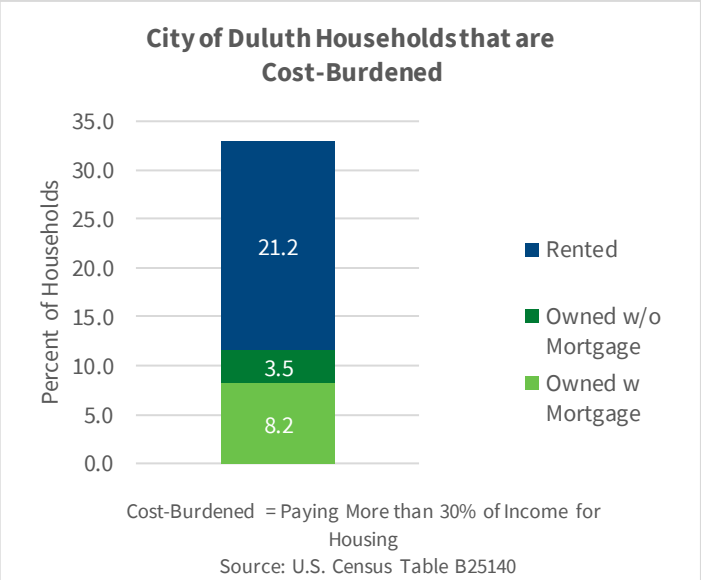
Disparities and Inequities

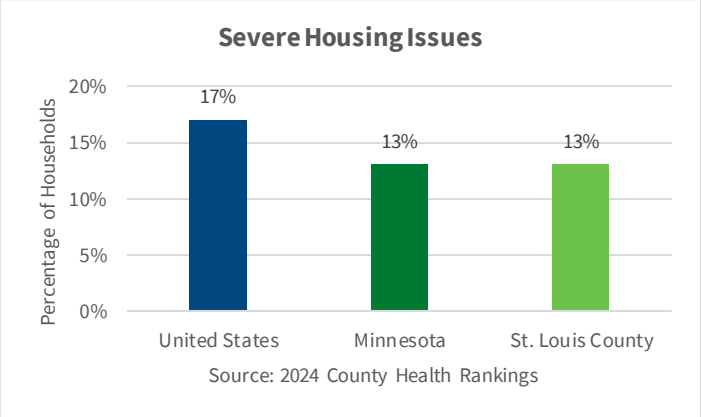
Disparities and inequities can show where interventions would be most beneficial.

- 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

Housing

Aspirus St. Luke's plans to address housing through the strategies below. Strategies are a combination of existing, proposed, internal-only, and collaborative efforts.

Program Accountability		Population Accountability	
Strategies	**Performance Measures**	**Indicators**	**Results**
Upstream Prevention (Promotion)			
• Advocacy for the availability of low income housing • Funding for local housing coalition or agency (CHUM) • Funding for local home rehabilitation and weatherization programs	• Funded program results	Indicators: • Percent of Duluth households that are cost-burdened • Percent of Duluth renters that are cost-burdened ○ Note: "Cost-burdened" is defined as the situation where 30% or more of a household income goes toward housing costs. *(Credit to and alignment with Essentia)*	All people residing in the City of Duluth have affordable housing. *(Credit to and alignment with Essentia)*
Prevention			
• Maintaining St. Francis apartments for older individuals who are unhoused (CHUM helps identify potential applicants) 32 units + 11 units • Provide resources to support patients who might be facing housing instability	• # of occupied apartments • # searches • # of referrals		
Treatment			
• Screening and referrals to community resources in an ED, inpatient and/or outpatient visit	• # of searches • # of referrals		

Potential Collaborative Partners	Aspirus Resources
• St. Louis County • Churches United in Ministry (CHUM) • Community non-profit housing-related organizations • True North Goodwill	• Funding opportunities through the Community Benefits program and grants • Staff time – resource identification (Aspirus Community Resources (FindHelp.org)) • Space – hosting meetings and community organizations (as requested). • Clinical services and related infrastructure – Aspirus provides Care Coordination that links to housing. Aspirus also provides the St. Francis apartments.

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.

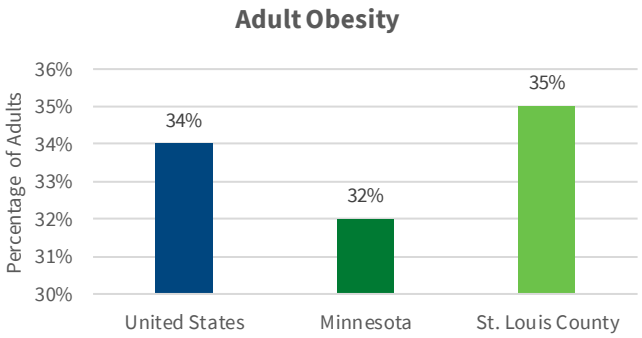
Disparities and Inequities

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

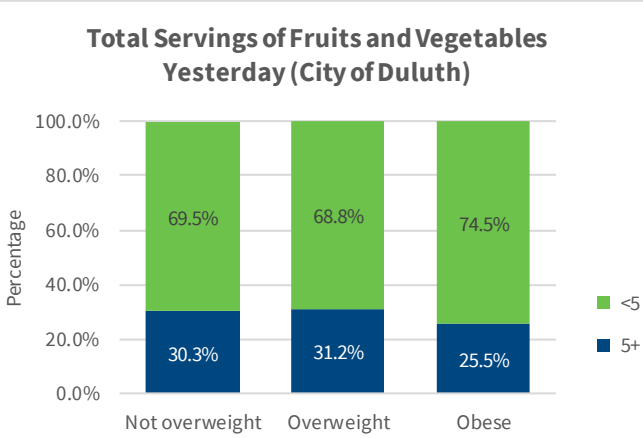
- Neighborhood conditions may affect physical access to food. For example, people living in some urban areas, rural areas, and low-income neighborhoods may have limited access to full-service supermarkets or grocery stores.
- Predominantly Black and Hispanic neighborhoods may have fewer full-service 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.

Data Highlights



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.

Food Security / Nutrition

Aspirus St. Luke's plans to address food security through the strategies below. Strategies are a combination of existing, proposed, internal-only, and collaborative efforts.

Program Accountability		Population Accountability	
Strategies	**Performance Measures**	**Indicators**	**Results**
Prevention			
• Food gleaning (in partnership with Second Harvest) • Hydroponic garden • Conduct education and outreach activities (e.g., dietician articles) • Support existing farmers market programs with funding and/or volunteerism	• # of pounds of food • # of active hydroponic gardens • # of outreach articles and/or activities in the community • # of people served through funded farmers market programs • Funded program results	Indicators: • Percent of Duluth adults who are obese • Percent of Duluth adults who eat 5+ servings of fruits or vegetables per day • Percent of Duluth adults who worry about food running out sometimes or often *(Credit to and alignment with Essentia)*	All people residing in the City of Duluth consume a nutritious diet. *(Credit to and alignment with Essentia)*
Treatment			
• Fruit and vegetable prescription program (FVRx) • Screening and referrals to community resources in an ED, inpatient and/or outpatient visit	• # of vouchers given to patients • % of vouchers redeemed at the farmers markets • # searches • # referrals		

Collaborative Partners	Aspirus Resources
• Community Action Duluth • Second Harvest • Local food pantries • Churches United in Ministry (CHUM)	• Funding opportunities through the Community Benefits program and grants • Staff time – resource identification (Aspirus Community Resources (FindHelp.org)) and information-sharing (e.g., educational information) • Space – hosting meetings and community organizations (as requested). • Clinical services and related infrastructure – Aspirus provides Care Coordination that links to food resources. Aspirus hosts a number of on-site micro-food pantries for patients. Aspirus also partners with Second Harvest to repurpose untouched food.

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

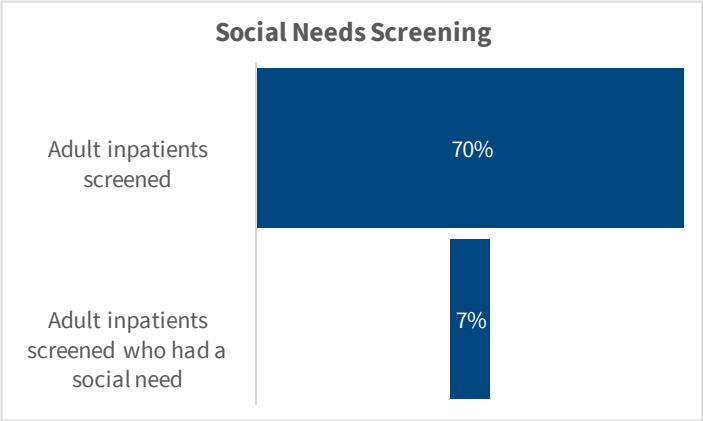
Disparities and Inequities

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 of Health

Aspirus St. Luke's plans to address social drivers of health through the strategies below. Strategies are a combination of existing, proposed, internal-only, and collaborative efforts.

Program Accountability		Population Accountability	
Strategies	**Performance Measures**	**Indicators**	**Results**
Upstream Prevention (Promotion)			
• Participation in the Transportation Coalition (includes MN Dept of Transportation and DHS and others) • Advocacy		• Percent of Aspirus St. Luke's Health patients screened for unmet social needs • Percent of Aspirus St. Luke's Health patients with unmet social needs *(Credit to and alignment with Essentia)*	People have access to the community support and resources they need to be healthy. *(Credit to and alignment with Essentia)*
Prevention			
• Community funding for local needs	• Funded program results		
Treatment			
• Fruit and vegetable prescription program (FVRx) • Screening and referrals to community resources in an ED, inpatient and/or outpatient visit	• # of vouchers given to patients • % of vouchers redeemed at the farmers markets • # of searches • # of referrals		

Collaborative Partners	Aspirus Resources
• Many community organizations that are available through the FindHelp platform (e.g., Second Stork, CHUM, Community Action Duluth, United Way, Senior Linkage Line, Safe Haven) • St. Louis County	• Funding opportunities through the Community Benefits program and grants. The Foundation has a 'Small Things' request process. • Staff time – resource identification (Aspirus Community Resources (FindHelp.org)) • Space – hosting meetings and community organizations (as requested). • Clinical services and related infrastructure – Aspirus Care Coordination helps coordinate addressing patients' social and economic needs (e.g., food, transportation). Aspirus contracts with Elevate for assistance with Medicaid applications.

Approval by the Hospital Board

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

Conclusion

Aspirus St. Luke's Hospital is looking forward to continuing its community and collaborative efforts.

aspirus.org

April 2025