



## **WORKING TOGETHER FOR A HEALTHY DULUTH:** 2016 Community Health Needs Assessment



To facilitate true collaboration among health care systems, public health, human services and the nonprofit sector in our community, a joint community health needs assessment process was developed and conducted within Duluth, Minnesota. These organizations have aligned their resources, skills, expertise and interests to collaborate towards a healthier Duluth.

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# ACKNOWLEDGEMENTS

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## LEAD ORGANIZATIONS ON THE ASSESSMENT

**St. Mary's Medical Center and Essentia Health-Duluth** are part of Essentia Health, a nonprofit, integrated health system caring for patients in Minnesota, Wisconsin, North Dakota and Idaho. Headquartered in Duluth, Minn., Essentia Health combines the strengths and talents of 14,000 employees, who serve our patients and communities through the mission of being called to make a healthy difference in people's lives.

**St. Luke's**, a comprehensive regional healthcare system, offers a comprehensive continuum of care serving the 17-county region of northeastern Minnesota, northwestern Wisconsin and the Upper Peninsula of Michigan. The system includes St. Luke's Hospital in Duluth, Minnesota; Lake View Hospital and Clinic in Two Harbors, Minnesota; 14 primary and 23 specialty clinics; six urgent care locations and one retail express care clinic.

**St. Louis County Public Health and Human Services** provides services in the areas of Adults, Children & Families, Disabilities, Elderly, Financial Assistance and Public Health. The Public Health Division consists of a team of nurses and educators who focus on protecting and improving the health and safety of families, communities and larger populations. St. Louis County Public Health promotes healthy lifestyles, and focuses on areas such as injury protection, prevention and detection of infectious diseases, and disease research.

**The Carlton–Cook–Lake–St. Louis Community Health Board (CHB)** will enhance collaborative efforts among member counties and community partners to strengthen public health in the region and the state to achieve optimal health for all. Working together to assess and address public health issues, strengthen local public health as well provide fiscal and programmatic administrative oversight with the goal of increasing effectiveness.

**Healthy Northland** seeks to improve the quality of life and health of all people in the seven counties of Northeastern Minnesota: Aitkin, Itasca, Koochiching, Carlton, Cook, Lake and St. Louis. It is a collaboration of Community Health Boards with the help of the Minnesota Department of Health's Statewide Health Improvement Program. Our staff and partners work in schools, workplaces, communities and health care on healthy eating, active living, tobacco-free living and breastfeeding initiatives, with a specific focus on health equity, policy, systems, and environmental change initiatives.

**Generations Health Care Initiatives** is private foundation that "engages the community to improve health for all, especially the underserved." It serves as a backbone organization to several health improvement initiatives in the greater Duluth area. Generations' current priorities are: connecting health and communities, access to care, and providing leadership for broader health improvement.

**Zeitgeist Center for Arts & Community** practices the art of growing a connected, healthy community empowered to create and thrive. We understand creativity and collaboration are linked, and use both as the seeds that inspire and nourish our efforts. A healthy community means people feel connected to

their culture without the divisions or prejudices that often separate us. It means the air and water are clean, and the residents' whole spectrum of wellness is accounted for. It means people aren't just getting by, but are participating in a vibrancy that makes community life worth living.

## Essentia Health at a Glance



### **ESSENTIA HEALTH: HERE WITH YOU**

At Essentia, our mission and values guide us every day. Together, we deliver on our promise to be here with our patients and members of our communities from the beginning to the end of life, both in our facilities and where they live, work and play. As a Catholic facility sponsored by the Benedictine Sisters of the St. Scholastica Monastery, St. Mary's Medical Center promotes Christ's ministry of holistic healing for all human life with special concern for the poor and powerless.

#### **Mission**

We are called to make a healthy difference in people's lives.

#### **Vision**

Essentia Health will be a national leader in providing high quality, cost effective, integrated health care services.

#### **Values**

- Quality
- Hospitality
- Respect
- Justice
- Stewardship
- Teamwork

#### **Belief Statements**

- Our highest priority is the people we serve.
- We believe that the highest quality health care requires a regard for both the soul and science of healing and a focus on continuous improvement.
- We believe in the synergy of sponsorship among faith-based and secular organizations.
- We believe in the value of integrated health care services.
- We believe in having a meaningful presence in the communities we serve.

### **Caring for our Community**

Our commitment to community health and wellness goes well beyond the work of the Community Health Needs Assessment. Through donations of funds, along with employees' time and talents, Essentia Health invests in a variety of programs and outreach efforts. Across the organization, we support community coalitions, housing, food shelves, mental health, congregational outreach, community infrastructure, public health, education, safety and other nonprofit organizations. These investments are designed to promote better health, help lessen inequities in our communities, improve access to health care and strengthen relationships with those we serve.



## ST. LUKE'S

St. Luke's is dedicated to improving the health of the communities it serves. St. Luke's will continue to seek opportunities to have the greatest impact in our community with the resources available to our hospital system. We will continue to support those efforts of community-based organizations whose goals and activities are compatible with our own mission, vision and values and the identified health priorities of our community.

### Mission

The Patient Above All Else

### Vision Statement

To be the provider and partner of choice for the region.

### Values

These values provide the foundation for our culture as we pursue our Mission and Vision:

- The patient comes first
- Quality is our expectation
- People make it happen
- Everyone is treated with respect

**PROGRESS TO DATE ON 2013 COMMUNITY HEALTH NEEDS ASSESSMENT**

The 2013 Community Health Needs Assessment for both Essentia Health-Duluth and Essentia Health-St. Mary's Medical Center included these top priorities:

<b>Priority 1</b>	Obesity, physical inactivity and poor nutrition as risk factors for chronic diseases, such as type 2 diabetes
<b>Priority 2</b>	Tobacco use, primary prevention/cessation
<b>Priority 3</b>	Reduction of excessive/binge drinking

A full progress report on actions taken to date and their impact can be found in Appendix A.

The 2013 Community Health Needs Assessment for St. Luke's included these top priorities:

<b>Priority 1</b>	Obesity, physical activity, and nutrition
<b>Priority 2</b>	Alcohol and drug use
<b>Priority 3</b>	Access to preventative care and screenings

A full progress report on actions taken to date and their impact can be found in Appendix B.



## **2016 COMMUNITY HEALTH NEEDS ASSESSMENT**

### **OBJECTIVES**

In conducting the 2016 Community Health Needs Assessment, Essentia Health and St. Luke's Hospital have collaborated with community partners to work towards a healthy Duluth and embrace these guiding principles:

- *Seek to create and sustain a united approach to improving health and wellness in our community and surrounding area;*
- *Seek collaboration towards solutions with multiple stakeholders (e.g. schools, work sites, medical centers, public health) to improve engagement and commitment focused on improving community health; and*
- *Seek to prioritize evidence-based efforts around the greatest community good that can be achieved through our available resources.*

The goals of the 2016 Community Health Needs Assessment were to:

1. Assess the health needs, disparities, assets and forces of change in the hospitals' shared service area.
2. Prioritize health needs based on community input and feedback.
3. Design a collective impact-based implementation strategy focusing on a multi-sector collaborative approach.
4. Engage community partners and stakeholders in all aspects of the Community Health Needs Assessment process.

### **ASSESSMENT PARTNERS**

The Community Health Needs Assessment (CHNA) was conducted in collaboration and partnership by Essentia Health-Duluth, Essentia Health- St. Mary's Medical Center, St. Luke's Hospital, the Carlton-Cook-Lake-St. Louis Counties Community Health Board and St. Louis County Public Health. Assessment partners also included stakeholders from community organizations working to improve health outcomes and reduce inequities including Generations Healthcare Initiatives and the Zeitgeist Center for Arts and Community. These partners assisted in developing the community-centered process, focus groups and community dialogues as well as prioritizing community needs. They also will help build the implementation plan through a collective impact model.

All three hospitals also partnered with Generations Healthcare Initiatives and a large number of other stakeholders across Northeast Minnesota and Northwest Wisconsin to conduct the Bridge to Health Survey to provide local and regional data utilized in this needs assessment.

## **PROCESS OVERVIEW**

In 2015, Essentia Health, St. Luke's Hospital, St. Louis County Public Health and the Community Health Board committed to conducting a joint assessment in order to align resources, strengths and best serve our community. This collaborative process was further strengthened by the involvement of Generations Healthcare Initiatives and the Zeitgeist Center for Arts and Community. This process was designed to:

- Incorporate community surveys and existing public data.
- Directly engage community stakeholders.
- Collaborate with local public health, other healthcare providers and local non-profits in the health sector.

The collaborative community health needs assessment was conducted in four stages: assessment, prioritization, design and finalization. Throughout each phase of the assessment process, a collaborative community assessment team was asked to review the data, prioritization and results of community focus groups to maximize the relevance of the assessment. This group included representation from Essentia Health-St. Mary's Medical Center, Essentia Health-Duluth, St. Luke's Hospital, St. Louis County Public Health and Human Services, the Carlton-Cook-Lake-St. Louis Community Health Board and non-profit organizations that work with underserved communities.

For Essentia Health-Duluth and Essentia Health-St. Mary's Medical Center, the process began in April 2015 and was completed in May 2016 with the final presentation of the Community Health Needs Assessment for St. Mary's Medical Center being presented and approved by hospital leadership and the Board of Directors on May 25, 2016. The East Region Board of Directors accepted and approved this report on June 8, 2016. This report was also presented and approved by the Essentia Health-Duluth Board of Directors on June 9, 2016.

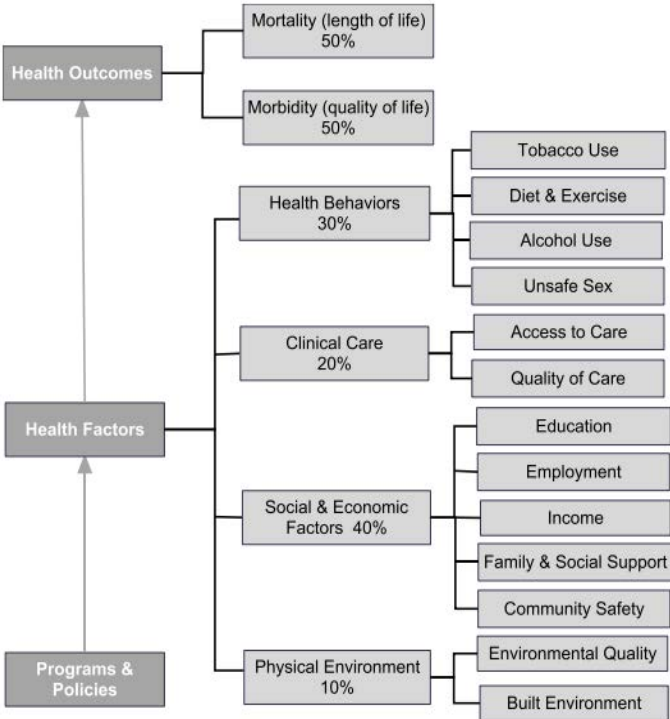
St. Luke's started the process in January 2016 and completed it in May 2016. The Community Health Needs Assessment will be presented to St. Luke's executive team and the Board of Directors on June 27, 2016.

**Assessment Process**

**PHASE 1: ASSESSMENT**

The first phase in the process included the collection and review of data in order to provide stakeholders with a systematic review of the health of the community members. This process fosters a deeper understanding of the demographics and health status of the Duluth area as compared to the rest of the region, state and nation. This process also was designed to assist stakeholders in focusing on data-driven opportunities for improvement in the identified priorities.

Throughout this assessment, it was imperative to view the health needs of the community through the lens of the social determinants of health. The social conditions in which we live, work and play have more of an impact on our life expectancy and total health than the medical care we receive. The model by the University of Wisconsin Population Health Institute, Figure 1, estimates that social and economic factors may have a larger impact (40%) than either clinical care (20%) or individual behavior (30%). The themes in this assessment directly reflect the community’s definition of health as it relates to their whole lives, not the medical care they receive within our healthcare system.



Source: University of Wisconsin Health Institute ([www.countyhealthrankings.org](http://www.countyhealthrankings.org))

FIGURE 1

**DESCRIPTION OF COMMUNITY SERVED BY ESSENTIA HEALTH-ST. MARY’S MEDICAL CENTER, ESSENTIA HEALTH-DULUTH AND ST. LUKE’S HOSPITAL**

Throughout the assessment and implementation strategy for the Community Health Needs Assessment a special emphasis is placed on populations facing the highest disparities in health outcomes.

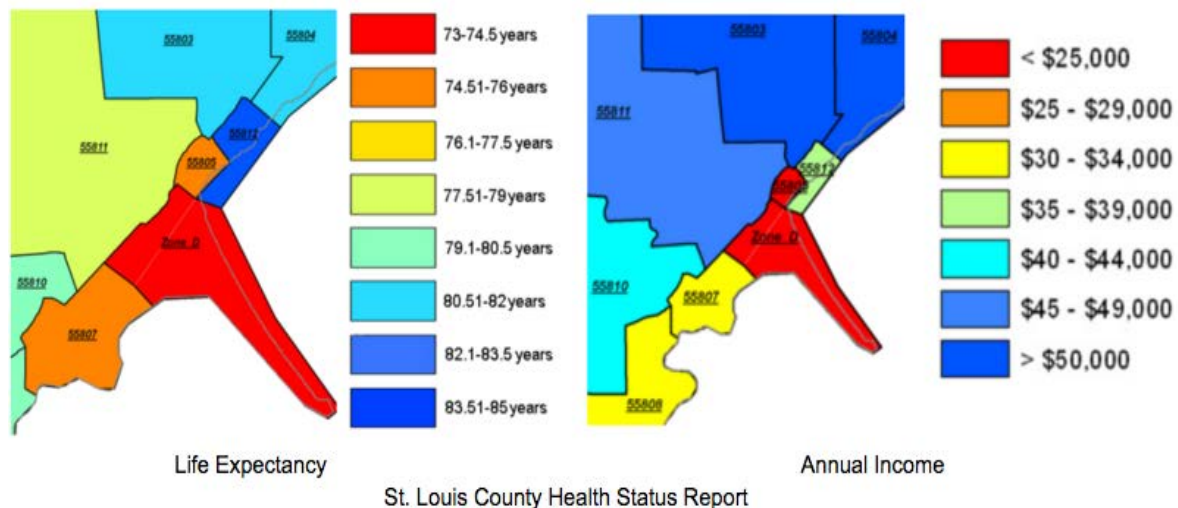
Although all three hospitals serve the entire Duluth/Superior area and beyond, for the purpose of the community health needs assessment the community served has been defined as the city of Duluth. This specifically includes Duluth, Minnesota ZIP codes 55802, 55803, 55804, 55805, 55806, 55807, 55808, 55810, 55811 and 55812. It is identical to the Duluth area as defined in the 2015 St. Louis County Health Status Report.

<b>Population Characteristics</b>		
	<b>Duluth</b>	<b>Minnesota</b>
Population	86,265	5,303,925
Median household income	\$43,518	\$60,828
Persons in poverty	22.7%	11.5%
High School Graduate (or GED)	93.0%	92.3%
Persons 65 years and over	13.8%	12.9%
Female persons	51.0%	50.4%
Persons white alone	90.4%	85.3%
Persons black or African American alone	2.3%	5.2%
Persons American Indian or Alaska Native alone	2.5%	1.1%
Data Source: U.S. Census Bureau, Quick Facts (based on 2010 Census)		

It is necessary to look at the stark disparities that exist between neighborhoods. It has been said, as based on the social determinants of health, that one’s ZIP code is more important than one’s genetic code as a predictor of health and life expectancy and that rings true in Duluth.

This is clearly illustrated in findings from the 2012 St. Louis County Health Status Report<sup>1</sup> relevant to the community served include:

- Projected life expectancy varies between ZIP codes in Duluth by 11.2 years.
- ZIP codes with the lowest median household income (under \$25,000 in ZIP code 55805) have the lowest projected life expectancy at 74.47 as compared to those with the highest median household income (over \$50,000 in ZIP Code 55803) who have the highest projected life expectancy at 81.43.
- The chronic stress experienced by people of color in Duluth has negatively impacted their projected life expectancy, lowering it by 4.32 years compared to the white population.



Poverty, education, age and race are all factors contributing to the inequitable health outcomes in Duluth. According to the Minnesota Department of Health’s (MDH) White Paper on Income and Health, “Poverty in Minnesota is not evenly distributed across racial/ethnic groups, ages or educational levels. Poverty is concentrated among populations of color, children, people with less education, female-headed households and rural Minnesotans<sup>2</sup>.”

People in Minnesota with lower incomes are more likely to:

- Have an infant die in the first year of life
- Report that their health is fair or poor
- Report having diabetes
- Report having seriously considered attempting suicide

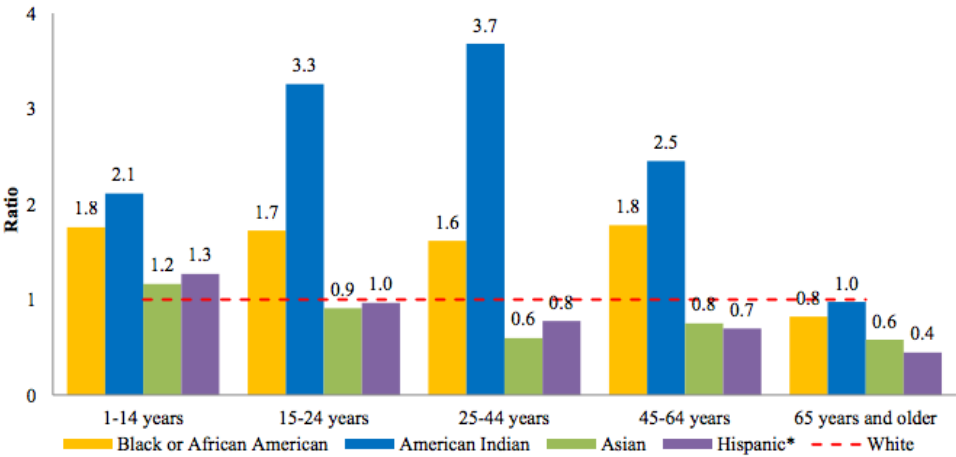
<sup>1</sup> 2012 St. Louis County Health Status Report, <http://www.stlouiscountymn.gov/portals/0/library/government/reports-n-publications/phhs/SLC-Health-Status-Report.pdf>

<sup>2</sup> Minnesota Department of Health, White Paper on Income and Health, March 3, 2014 <http://www.health.state.mn.us/divs/opa/2014incomeandhealth.pdf>

With Duluth’s higher density population of American Indians, it is crucial to consider the health needs of the American Indian population. As reported by the Indian Health Service<sup>3</sup>, “The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.

- Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of American Indian and Alaska Native deaths (2007-2009).
- American Indians and Alaska Natives born today have a life expectancy that is 4.4 years less than the all-races population (73.7 years to 78.1 years, respectively).
- American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.”

Additional information on the health disparities faced by minority populations in Duluth has been incorporated into this assessment. According to the Minnesota Department of Health’s “Advancing Health Equity” report<sup>4</sup> to the legislators on February 1, 2014: “American Indians and African-Americans in Minnesota experience substantially higher mortality rates at earlier ages.”<sup>5</sup>



\* Hispanic may be any race.

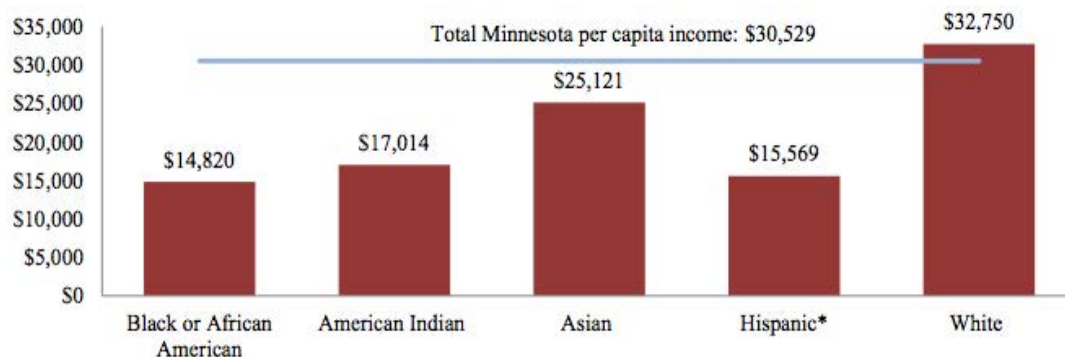
<sup>3</sup> U.S. Department of Health and Human Services, Indian Health Service, Indian Health Disparities <https://www.ihs.gov/newsroom/factsheets/disparities/>

<sup>4</sup> [http://www.health.state.mn.us/divs/chs/healthequity/ahc\\_leg\\_report\\_020414.pdf](http://www.health.state.mn.us/divs/chs/healthequity/ahc_leg_report_020414.pdf)

<sup>5</sup> Mortality disparity ratio is calculated by dividing the rate for a given population by the White rate. Source: MDH, Center for Health Statistics.

The disparities faced by minority populations in Duluth go far beyond their life expectancy and health status. Equity based on ZIP code and race remains a prominent theme in Duluth. The Minnesota Education Report Card highlights the significant disparity in graduation rates based on socio-economic background and race. In 2015, the four-year graduation rate for Duluth Public High Schools was 77.5% overall, but only 56.4% for students who qualified for free or reduced-price lunches. Racial discrepancies are even more severe: only 32% of Native Americans and 47.2% of black students graduated on time<sup>6</sup>.

The MDH “Advancing Health Equity” report to the legislators also cites that, “African-American, American Indian and Hispanic/Latino populations have household incomes that are almost half that of Asian and white populations.” This is clearly illustrated in this graph depicting the per capita income of Minnesota residents from the past 12 months in 2012<sup>7</sup>.



\* Can be any race.

The same report also focuses on additional social determinants of health as related to health equity and health outcomes, including housing. When looking at our built environment as related to the social determinants of health, housing is a key factor. It is known that older housing in particular can present multiple threats to health, including lead-based paint, lead solder in plumbing and in the soil, mold, and asbestos. Because of affordability, Minnesota’s low-income families often live in older housing, both as renters and as owners. Specifically in Duluth, according to the City of Duluth’s Housing Indicator Report<sup>8</sup>, “The U.S. Department of Housing and Urban Development (HUD) determines housing to be affordable when costs for housing are no more than 30% of a household’s gross income (i.e. before taxes and deductions are removed). A household in Duluth would then need to make approximately \$42,040 annually to afford a \$153,504 home – the 2014 average value of an owner-occupied single family home in Duluth. The average wage in Duluth for 2014 was \$40,560, which would equate to a \$147,650 dwelling unit.

<sup>6</sup> Minnesota Education Report Card, [http://rc.education.state.mn.us/#graduation/orgId--10709000000\\_groupType--district\\_graduationYearRate--4\\_categories--all%7CamIndian%7Cblack%7CFRP\\_p--3](http://rc.education.state.mn.us/#graduation/orgId--10709000000_groupType--district_graduationYearRate--4_categories--all%7CamIndian%7Cblack%7CFRP_p--3), April 2016

<sup>7</sup> Source: 2012 Census ACS 1 year, B19301 (race alone)

<sup>8</sup> City of Duluth 2014 Housing Indicator Report, <http://www.duluthmn.gov/media/348599/City-of-Duluth-2014-Housing-Indicator-Report.pdf>, April 2016

- Households that are in the Extremely Low Income (30% or less of area median income) bracket, based on paying 30% of income towards housing, cannot afford anything other than an efficiency unit in Duluth.
- Households that are at or below 50% of area median income cannot afford a 2+ bedroom house to purchase but can afford a 2-bedroom unit to rent.
- Households that are near the 80% of area median income can afford to purchase or rent 2- and 3-bedroom homes in Duluth.”

Residents cite transportation, cost and access due to scheduling constraints as the primary barriers to care in Duluth.

Limitations exist in reviewing health outcomes of specific sub-populations (low-income, people of color, Native Americans) due to the region’s rural nature and the data for populations smaller than county level frequently being unavailable or of limited value. Therefore, much of the assessment data are presented at the county and state level to ensure stability of the estimates. When available, ZIP code or U.S. Census tract level data will supplement the county-level information to provide a deeper understanding of the health needs of the community.

#### **Data Collection and Review**

The collaborative did not directly collect primary data, but partnered with many other stakeholders on the regional 2015 Bridge to Health Survey. The hospitals worked together to collect, review and evaluate existing public health data to support key indicators focused on aspects of health, wellness and the social determinants of health. These datasets included information from:

#### **United States Census Bureau**

This dataset provided internal and external stakeholders with the basic demographics of Duluth. Data utilized included:

- Demographic breakdown of Duluth: age, gender, race
- Socio-economic status: income, education

#### **Minnesota County-Level Indicators for Community Health Assessment**

This Minnesota Department of Health dataset consists of data related to multiple indicators from several MDH sources to assist local health departments and community health boards with their community health assessments and community health improvement planning processes. These datasets are a standard set of indicators to compare across the Arrowhead Region of Minnesota. Data was reviewed from:

- Minnesota Student Survey Selected Single Year Results
- 2011 Minnesota County Health Tables
- 1991-2010 Minnesota Vital Statistics State, County and CHB Trends
- Minnesota Public Health Data Access

#### **CDC Behavioral Risk Factor Surveillance System (BRFSS)**



This dataset provided an opportunity for comparison of the health outcomes and health status in Duluth from local surveys to state and national averages for the same questions.

### **Carlton-Cook-Lake-St. Louis County Community Health Board Community Health Improvement Plan (CHIP)**

In 2012, the Carlton-Cook-Lake-St. Louis County Community Health Board gathered diverse data sources and conducted community assessment meetings, which included prioritization, to shape a shared vision for a healthy region. This collaborative effort identified priority areas needing attention across the Community Health Board's geographical region and built a foundation for future collaborative work amongst community partners. The Community Health Improvement Plan serves as a guide for Carlton-Cook-Lake-St. Louis County Community Health Board on how local health boards, hospitals, health plans, clinics and other community organizations will focus and align their work to improve the health of the population and communities they jointly serve. Priorities identified through this process included:

1. Obesity
2. Mental Health

The Carlton-Cook-Lake-St. Louis County Community Health Board CHIP also includes an additional focus on health inequity and the opportunities to work with communities experiencing greater health inequity as related to the higher burden of both obesity and mental health issues. The 2012 CHIP can be found in Appendix C.

### **2015 Bridge to Health Survey**

Based on the 2015 Bridge to Health Survey<sup>9</sup>, families living at 200% of poverty or less have a self-reported lower perceived health status, report higher rates of mental health problems, report a higher incidence of rarely to never getting the social and emotional support they need, have higher obesity rates, eat less fruits and vegetables, exercise less, have higher tobacco use rates and often worry that food would run out.

Additional highlights from the 2015 Bridge to Health Survey specific to Duluth can be found in Appendix D.

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<sup>9</sup> Kjos, S.A., Kinney, A.M., Finch, M.D., Peterson, J.M., *Bridge to Health Collaborative (2015). Bridge to Health Survey 2015: Northeastern Minnesota and Northwestern Wisconsin Regional Health Status Survey*. April 2016.

The following table of indicators represents the specific health needs of the community:

<b>Condition or outcome</b>	<b>Indicator</b>	<b>Bridge to Health Survey Result (2015)</b>	<b>Minnesota (Years of Data)</b>	<b>National (Years of Data)</b>
Obesity	% obese according to BMI from self-reported height and weight	27.5%	25.5% (2013 BRFSS)	29.4% (2013 BRFSS)
Tobacco use	% reporting smoking $\geq$ 100 cigarettes and currently smoking	15.4%	18.0% (2013 BRFSS)	19.0% (2013 BRFSS)
Physical activity	% that meet either moderate or vigorous physical activity guidelines of $\geq$ 5 days/week of $\geq$ 30 min. moderate OR $\geq$ 3 days/week of $\geq$ 20 min. vigorous	37.7% Moderate 27.7% Vigorous	52.7% (2013 BRFSS)	50.8% (2013 BRFSS)
Diet	% consuming $\geq$ 5 servings/day of fruits and vegetables combined	82.7%	21.9% (2009 BRFSS)	23.4% (2009 BRFSS)
Mental health	Average number of mentally unhealthy days reported in past 30 days	4.6	2.9 (2013 BRFSS)	3.7 (2013 BRFSS)
Physical health	% reporting fair OR poor health	14.6%	12.4% (2013)	16.7% (2013)
Alcohol use	% reporting either binge OR heavy drinking	35.4% Binge	21.6% Binge 7.1% Heavy Drinking (2013 BRFSS)	17.4% Binge 6.2% Heavy Drinking (2013)

## **Other Input**

Additionally, results of the Vision Duluth 2015 report and the Duluth Vision and Agenda for Racial Equity were reviewed in detail to ensure the voices and feedback from women, people of color, people living in poverty, people leaving incarceration, teachers and labor leaders were heard and reflected through the needs assessment process. The Vision Duluth 2015 report can be found in Appendix E and the Agenda for Racial Equity can be found in Appendix F. Both of these highlight input of the underserved, low-income and minority populations in Duluth. The Agenda for Racial Equity specifically highlights healthy communities as a focus area including:

- An increase in community-wide health
- An increase in access to healthy foods

## **Written Comments from 2013 Community Health Needs Assessment**

Essentia Health-Duluth, Essentia Health-St. Mary's Medical Center and St. Luke's Hospital did not receive any comments on their previous Community Health Needs Assessment. Any comments would have been taken into consideration in the development of this report.

## **Current Community Health Assets in Duluth**

Duluth is a community with a vibrant array of work taking place in regards to improving our community's health. The implementation plan developed collaboratively will center on the opportunity for partnership with existing work already being done by organizations in our community.

The [interactive map](#) on Healthy Northland<sup>10</sup> provides an opportunity for review of other assets, including opportunities for recreation, physical activity, healthy food, tobacco-free living resources and overall health and wellness resources. A continued partnership with Healthy Northland and the coalitions they work with is vital in addressing the needs of our community's health. The resources outlined in this asset map highlight the existing resources within the community that are available to respond to the health needs of the community. Additionally, healthcare organizations within Duluth include St. Luke's Hospital and clinics, Essentia Health hospitals and clinics, Lake Superior Community Health Center, St. Louis County Public Health and Human Services. Additional partners and stakeholders will be added to this list as the implementation plan is developed to address community priorities.

In designing the implementation strategy for this report, further analysis will be done of existing internal and external resources to improve the health of the community.

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<sup>10</sup> Healthy Northland, [http://www.healthynorthland.org/index\\_split.aspx?w=424&r=/index\\_simple.aspx?id=32~pv=78~pvq=subdivision\\_name=%27Duluth%27~pvc=5000~rnd=zGLa3&l=/active\\_arrowhead/menu\\_panel.aspx^cal=26~p\\_op=11~tow=12](http://www.healthynorthland.org/index_split.aspx?w=424&r=/index_simple.aspx?id=32~pv=78~pvq=subdivision_name=%27Duluth%27~pvc=5000~rnd=zGLa3&l=/active_arrowhead/menu_panel.aspx^cal=26~p_op=11~tow=12), April 2016.

## PHASE 2: PRIORITIZATION

The assessment follows an iterative process that uses data from a wide range of sources and then solicits feedback from a broad group of stakeholders. The process began with a comprehensive review of local demographic and health data to identify health status, health disparities and inequities that contribute to poorer health outcomes. This included a review of the data available for common risk factors that contribute to poor health, including obesity, physical inactivity and tobacco use.

The data showed that across multiple measures of health, wellness, and disease prevalence, our residents of color and residents with lower levels of income have poorer health outcomes. Therefore, a health equity focus is needed to ensure that any strategies developed to improve the health and well-being of all patients are also effective in reducing health inequities between populations based on race, income and place.

The collaboration placed a heavy emphasis on taking into account the input from persons who represent the broad interests of the community, specifically individuals from low-income, medically underserved or minority populations and those with a special knowledge or expertise in public health. The collaboration conducted focus groups in community locations at various times of the day throughout the months of March and April 2016. A total of 12 focus groups were held with more than 300 total participants. A full list of organizations represented at the community focus groups can be found in Appendix G.

Participants at the focus groups were presented with background details on the social determinants of health and information from the 2015 Bridge to Health Survey. They were asked to share their feedback on these questions:

- *What makes you feel healthy in your neighborhood?*
- *What is working for health in Duluth?*
- *What is not working for health in Duluth?*

Participants were then asked to share what they believed were the top three biggest challenges to achieving health in Duluth by writing them on post-it notes. These topics were then placed on a wall within the room and grouped into common themes (e.g. obesity, mental health, access to dental care). Participants were then asked to prioritize using the dot-voting method based on these criteria:

- *What is most important to the community?*
- *What will have the greatest burden on the community if the problem is not addressed?*
- *What impacts certain subgroups/populations more than others?*

A focus group was held with 35 staff members from St. Louis County Public Health and Human Services in order to ensure strong representation from those with knowledge or expertise of public health in our community. Additionally, focus groups were held with teachers, students, community members and targeted outreach that included invitations to members of low-income and minority communities.

The community focus groups provided the opportunity for more than 300 community members, business leaders, healthcare professionals, public health professionals, minority groups, teachers and community-based organizations to share their input on the overarching health needs of the community. The Community Health Needs Assessment collaboration compiled the feedback to discussion questions and the results of prioritization and reviewed to determine if the needs that emerged aligned with the mission of the two healthcare systems and came within their resources. The needs were prioritized as follows:

1. Mental Health
2. Alcohol, tobacco and other drugs
3. Socio-economic disparities based on race and neighborhood
4. Obesity, including lack of access to healthy foods and physical inactivity

While the focus groups and community input did not place obesity (or factors leading to obesity) in the top three, instead the community prioritized aspects of obesity including lack of access to healthy foods within the top 10. The hospitals all had prioritized obesity as a top need in the community with the previous Community Health Needs Assessment and felt the work was only beginning to address obesity, physical inactivity and poor nutrition. Thus, the hospitals prioritized this as a need to continue to address, based on data and community conversations. Essentia Health-Duluth, Essentia Health-St. Mary's Medical Center and St. Luke's Hospital all plan to adopt the top four priorities from this collaborative Community Health Needs Assessment.

Each priority area has multiple aspects in which the hospitals will work with community partners and stakeholders to collaborate to address. By adopting a collective impact model to improve overall health and wellness in our community, not all issues will be directly addressed by the hospitals, but through a multi-sector coalition-based approach.

While it was a common theme and frequently discussed topic at the community focus groups, based on resources available and lack of expertise in the area, the needs that the hospitals will not be addressing includes:

1. Access to dental care

This collaborative effort will work to bring visibility to this issue and share findings with local subject matter experts.

### **PHASE 3: DESIGN OF STRATEGY AND IMPLEMENTATION PLAN**

The hospitals will work together to design an implementation strategy with internal stakeholders as well as external partners and stakeholders who represent the existing healthcare facilities and resources within the community that are available to respond to the health needs of the community as identified in this assessment. This implementation strategy will be reviewed and approved by each hospital's board of directors prior to November 15, 2016.

Essentia Health-Duluth and Essentia Health-St. Mary's Medical Center have incorporated Community Health and Wellness into the FY 2016-2018 System Strategic Plan under "Building Healthy Communities." The system has also outlined an allocation of resources available to each hospital as a percentage of net revenue less bad debt to address the priorities set forth in the Community Health Needs Assessments.

St. Luke's continually reviews how the organization's resources are best allocated to address the priorities identified in the Community Health Needs Assessment.

### **CONCLUSION**

As part of nonprofit health systems, Essentia Health-Duluth, Essentia Health-St. Mary's Medical Center and St. Luke's are committed to improving the health of our community. This needs assessment and implementation plan illustrate the importance of collaboration between our hospitals and our community partners. By working collaboratively, we can have a positive impact on the identified health needs of our community during each hospital's individual Fiscal Years 2017-2019. There are other ways in which the hospitals will indirectly address local health needs, including the provision of charity care, the support of Medicare and Medicaid programs, discounts to the uninsured and others.

Over the next three years, this collaboration will continue to work with the community to ensure that this implementation plan is relevant and effective and to make modifications as needed.

## APPENDIX A

**Essentia Health-Duluth and Essentia Health-St. Mary's Medical Center  
Progress to Date on 2013 Community Health Needs Assessment**

**2013 Community Health Needs Assessment Implementation Plan Progress Report**  
**Essentia Health-Duluth and Esentia Health-St. Mary's Medical Center**  
**Duluth, Minnesota**  
**April 21, 2016**

Priority Area	Obesity, physical inactivity and poor nutrition as risk factors for chronic diseases such as Type 2 diabetes.
Target Population	Adults, ages 18 and over, who are currently prediabetic or possess risk factors for developing Type 2 diabetes
Goal	Reduce body weight and increase physical activity in program participants, thereby reducing their risk for Type 2 diabetes.

<b>Performance Measures</b>
<ul style="list-style-type: none"> <li>● Participants will lose weight; program goal is 5-7% of body weight. <ul style="list-style-type: none"> <li>○ Baseline and post-course (1 year) weight will be tracked</li> </ul> </li> <li>● Participants will increase physical activity; program goal is 150 minutes/week. <ul style="list-style-type: none"> <li>○ Baseline* and post-course (1 year) progress for physical activity minutes will be tracked.</li> </ul> </li> </ul>
Objective 1: Implementation of a community-wide intervention, the National Diabetes Prevention Program (NDPP), to address the hospital facility's highest priority health need as identified by the 2013 Community Health Needs Assessment.
<p>Accomplishments to Date:</p> <ul style="list-style-type: none"> <li>● 66 participants have completed the program.</li> <li>● The average weight-loss by participants was 9.63 pounds, which translates to a 4.47% decrease in body weight.</li> <li>● Participants reported an average of 185.5 minutes/week of physical activity at the completion of the program. This is an increase of 41.5 minutes/week or 28.82% increase in physical activity.</li> <li>● 26 lifestyle coaches were trained by Essentia Health's master trainer in the Duluth area in 2014-2015.</li> <li>● An additional 20 community lifestyle coaches in the Duluth area were trained by the Minnesota Department of Health in 2015-2016.</li> </ul>

\*Physical activity minutes are tracked beginning at week #7 of the NDPP.





Essentia Health-St. Mary's Medical Center and Essentia Health-Duluth continue to work collaboratively with community partners in their efforts to offer a community-wide NDPP. Both hospitals also have continued their partnership with the Duluth YMCA to offer the program its locations in different Duluth neighborhoods. Additionally, both Essentia Health hospitals have partnered with Healthy Northland, the YMCA and St. Louis County Public Health to create an even more robust offering of the NDPP. Essentia Health-Duluth and Essentia Health-St. Mary's Medical Center worked with internal marketing and population care management to identify all current Essentia Health patients in the Twin Ports area who would qualify for the program as a prediabetic based on the patient's A1C, BMI, family history or history of gestational diabetes. With physician support, a letter was sent to these individuals encouraging them to enroll in an upcoming program. Targeted outreach and program offerings are now focused in low-income neighborhoods (e.g. Lincoln Park) experiencing larger disparities in health outcomes.

### ***Additional Achievements***

#### **Obesity, physical inactivity and poor nutrition as risk factors for chronic diseases such as Type 2 diabetes**

Essentia Health-St. Mary's Medical Center and Essentia Health-Duluth have partnered with Community Action Duluth and Seeds of Success to provide an EBT match program at the Lincoln Park Farmers Market for the 2016 growing season. This will allow families who use SNAP/EBT at the farmers market to receive matching dollars up to \$10 for healthy and fresh produce. It is anticipated that around 85 families will utilize this match program in 2016.

#### **Tobacco Use – Primary Prevention/Cessation**

Essentia Health-St. Mary's Medical Center and Essentia Health-Duluth sponsored the [Mayo Clinic Tobacco Treatment Specialist Certification Program](#) in March 2016 in order to increase the capacity of the communities served by Essentia Health to support residents and patients on their tobacco-cessation journey. This included training 20 Essentia Health staff across the healthcare system as well as six community partners specific to the Duluth area who work with college-aged young adults, medically underserved and/or low-income populations.

#### **Reduction of Excessive/Binge Drinking**

While Essentia Health-St. Mary's Medical Center and Essentia Health-Duluth have not specifically focused on this priority, as a result of the Community Health Needs Assessment, the hospitals have been at the table with the [Tri Campus Coalition](#) and are an active partner and lead organization in the [Driving for Safe Communities Coalition](#). Essentia Health-St. Mary's Medical Center and Essentia Health-Duluth work to provide community education on the dangers of distracted driving through events geared towards young drivers. The hospitals are also involved in the safe ride program with local restaurant and bar owners.

## **Access to Healthcare**

Essentia Health-St. Mary's Medical Center and Essentia Health-Duluth were key community partners in the process and now implementation of the Minnesota Accountable Communities for Health grant. This two-year grant, totaling \$369,000, targets the Myers Wilkins Elementary School children and families in the neighborhood surrounding the school. The program is focused on bringing health services, including dental and mental health services, to the community school. It also includes a community health worker and a public health nurse on site to directly interact with families and children. Generations Healthcare Initiatives, a nonprofit Duluth organization, serves as the fiscal agent. This initiative will serve as a model for other community partnerships and opportunities between Essentia Health, St. Luke's, public health, the school district and others. More information can be found at <http://www.togetherforhealthatmyers-wilkins.com/>

## **Promoting Community Health**

Essentia Health-Duluth and Essentia Health-St. Mary's Medical Center collaboratively sponsored both the 2015 and 2016 Bus-Bike-Walk Month, a one-of-a-kind month-long event to promote health and wellness through the use of people-powered modes of transportation. This includes promotion amongst Essentia Health employees, an audit of the Essentia Health campuses in Duluth to make them friendlier for employees to use active modes of transportation to commute to work.

Essentia Health-Duluth and Essentia Health-St. Mary's Medical Center also partner with Grandma's Marathon Inc. to conduct the Fit-n-Fun middle school assemblies to discuss the importance of physical activity and wellness. In April 2015, these assemblies included guest speaker and Olympic Gold Medalist Dan O'Brien speaking to area middle-school children.

## **Immunizations**

Essentia Health-St. Mary's Medical Center and Essentia Health-Duluth are both well represented at family community health events/fairs throughout the service area. These events promote both childhood immunizations and well-child checks.

# APPENDIX B

St. Luke's Hospital

Progress to Date on 2013 Community Health Needs Assessment

**Community Health Needs Assessment Implementation Plan Progress Report**

St. Luke’s Hospital  
 Duluth, Minnesota  
 May, 2016

<b>Priority Area</b>	<b>Access to Preventative Care and Screenings</b>
<b>Target Population</b>	St. Luke’s market area
<b>Goal</b>	Improve care coordination

<b>Performance Measures</b>	
<ul style="list-style-type: none"> <li>● Addition of Care Coordinators to help patients identified as high risk to navigate the healthcare continuum.</li> <li>● Improve rates of patients that experience coordination gaps.</li> <li>● Develop community asset database in partnership with local community agencies to support care coordination referrals.</li> <li>● Combine Community Health Needs Assessment oversight and management in this initiative.</li> </ul>	

<b>Priority Area</b>	<b>Obesity, Physical Activity and Nutrition</b>
<b>Target Population</b>	St. Luke’s market area and employees
<b>Goal</b>	Educate community on benefits of physical activity and proper nutrition.

<b>Performance Measures</b>	
<ul style="list-style-type: none"> <li>● Community education provided by clinical dietitians.</li> <li>● Sponsoring a variety of various community athletic events.</li> <li>● Offering Fitbits to St. Luke’s employees to encourage physical activity.</li> <li>● Combine Community Health Needs Assessment oversight and management in this initiative.</li> </ul>	

<b>Priority Area</b>	<b>Alcohol and Drug Use</b>
<b>Target Population</b>	St. Luke's market area
<b>Goal</b>	Address alcohol and drug use

<b>Performance Measures</b>
<ul style="list-style-type: none"> <li>● Naloxone study on drug use conducted by Whiteside Institute for Clinical Research.</li> <li>● Provide tobacco cessation counseling through primary care clinics.</li> <li>● Promote drug-use tapering.</li> <li>● Monitoring emergency department visits to identify drug seekers.</li> <li>● Community education.</li> <li>● Combine Community Health Needs Assessment oversight and management in this initiative.</li> </ul>

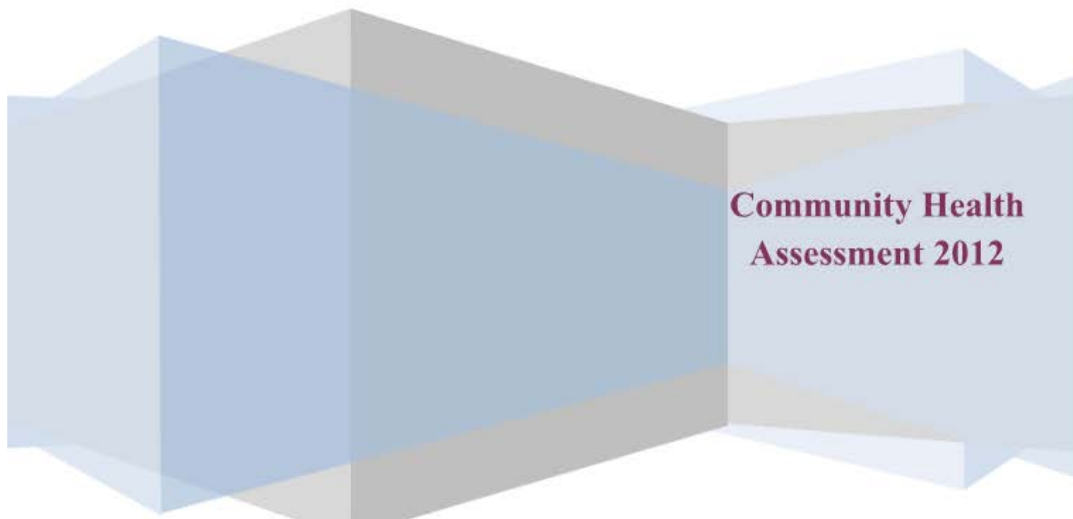
## APPENDIX C

**2012 Carlton-Cook-Lake-St. Louis County  
Community Health Improvement Plan**



**Public Health**  
Prevent. Promote. Protect.

**Carlton-Cook-Lake-St. Louis  
Community Health Board  
(CCLStL CHB)**





## Overview:

The Minnesota County-level Indicators for Community Health Assessment is a listing of indicators across multiple public health categories and from various data sources. This list of indicators has been gathered together to assist Minnesota's community health boards (CHB) in their community health assessment and community health improvement planning processes.

### **Community Health Assessment is:**

1. Collecting, analyzing and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health; and
2. The systematic collection and analysis of data in order to provide a basis for decision making.

A thorough and valid Community Health Assessment is a customary practice and core function of public health, and also is a national standard for all public health departments. Since the passage of the Local Public Health Act in 1976, Minnesota CHBs have been required to engage in a community health improvement process, beginning with a Community Health Assessment. As part of Minnesota's Local Public Health Assessment and Planning process, every Minnesota CHB must submit its Ten Most Important Community Health Issues (based on the Community Health Assessment) to the Minnesota Department of Health (MDH) by **February 15, 2015**.

### **Phase 1: Initial Planning Meetings**

An initial planning committee comprised of Sue Erzar, AIK CHB, Jenny Peterson, Generations Healthcare Initiative, Julie Myhre, CCLStL CHB, Marie Margitan, MDH Nurse Consultant completed a cross walk between MDH Statewide Assessment and the MDH's basic set of indicators (compiled by Epidemiologists Kinney and Edelman) and assembled an initial set of data indicators.

The core planning committee continued to meet throughout the summer providing direction to a student intern who inputted data sets into an excel document.

In early September, a diverse set of stakeholders met to review the initial set of data indicators as well as suggest additional data sets:

Facilitators: Jenny Peterson, Marie Margitan, Julie Myhre and Annie Harala.

Attendees: Integrity Health; Barb Westberg, Essentia; JoAnn Hoag, St. Luke's; Mavis Breehm, Lake Superior Community Health Center; Amy Westbrook, MDH; Guy Peterson, St. Louis County; Michelle MacDonald, St. Louis County; Terri Allen, Carlton County; Michelle Backes-Fogelberg; Carol Berg, UCare.

### **Key Data Sources included:**

- Bridge to Health (2000, 2005, 2010)
- Minnesota Student Survey (2004, 2007, 2010)
- Minnesota Department of Health Statistics
- Minnesota Department of Human Services
- Census

The Data Profile was organized into sections similar to the format used by the Minnesota Department of Health in its MN Statewide Health Assessment - 2012:

\*People and Place  
\*Healthy Living

\*Opportunity for Health  
\* Injuries and Violence

\* Chronic Disease and Conditions

## **Phase 2: Opinion Survey September – November 2012**

Over 1,000 residents completed a convenience sample opinion survey either online link or by paper. Questions were taken from surveys developed by Ann Kinney, Epidemiologist at the Minnesota Department of Health. The purpose of the survey was to provide a snapshot of the community's perceptions and opinions regarding health issues which would not only engage additional people in the assessment process but also help inform the prioritization process. Data profile is available on the CHB's website at [www.communityhealthboard.org](http://www.communityhealthboard.org) under "Health Data" tab.

## **Phase 3: Community Assessment Meetings - Fall 2012**

Community meetings were held throughout the fall in locations across the four counties. Facilitators for these meetings: Jenny Peterson, Marie Margitan and Julie Myhre

The guiding principles of the assessment process and community meeting were as follows:

- Data-driven from respected sources
- Input from diverse stakeholders participate
- Locally driven
- Assessment would meet requirements (public health, hospitals, etc.)
- Diverse view and opinions welcomed
- Serve as a catalyst for individual and collaborative efforts

The community assessment meetings all followed the same format:

A total of three rounds of initial prioritization occurred in the following areas:

- \* "People and Place" and "Healthy Living"
- \* "Opportunity for Health" and "Injuries and Violence"
- \* Chronic Disease and Conditions

Followed by small group discussion

Resulting in the small group identification of initial set of prioritized issues for each section

The group also reviewed results from each county's collated opinion surveys to help inform the prioritization process.

A final prioritization process occurred at the end of the meeting where participants were given a number of dots to vote with on their top priority health issues. They were asked to consider the following:

- What issue can we best impact?
- Is there energy around the issue?
- Will addressing the issue improve the health of all?

This final prioritization process provided a ranking of the health issues with their corresponding votes. By the end of the meeting, the top 10 health issues for each meeting were identified.

## **County Based Meeting: Dates and Stakeholder Attendance**

County based meetings were held across the four counties and included input from a broad and diverse stakeholder group including representatives from healthcare, social services, community agencies, education, public health, tribal reservations, faith communities, county advisory committee members, policy makers, etc.

## **Phase 4: Health Priorities**

Health Issues Refined

Presentation of Top 10 Health Issues to Community Health Board

### **Obesity**

There are increased rates of overweight and obesity among adults and children. Obesity leads to long term health issues (e.g. heart disease, diabetes, arthritis, etc.). In the CHB area, 49.5 % of the people are considered obese or overweight (BTH). The percentage of Cook and Lake 12<sup>th</sup> graders who are overweight almost doubled from 2007 to 2010 (MSS).

### **Mental Health**

There are increased rates of untreated or undiagnosed mental health issues (e.g. anxiety, depression, stress) being reported by both youth and adults. In 2010, 14% of ninth grade students had suicidal thoughts and 3% of ninth grade students attempted suicide (MSS). In the CHB area 17.4% of the people reported that they delayed seeking mental health care due to cost (BTH).

### **Alcohol, Tobacco & Drug Use**

There are high rates of alcohol, tobacco, and marijuana use in youth and high rates of binge drinking in adults and adolescents. In the previous 30 days, 44% of twelfth grade students in the CHB area used alcohol and 22% of St. Louis County adults use tobacco. In the CHB area 13.9% of the people are current smokers (MSS).

### **Poverty**

Poverty has a negative impact on health (e.g. poor diet, substance use, lack of access to health care, higher stress, lack of exercise, etc.) Single parent homes are at an even greater risk to live in poverty. In Northeastern Minnesota, people with income of  $\leq 200\%$  of poverty reported a higher incidence of obesity, depression, and food insecurity (BTH).

### **Priority: Adolescent Sexual Activity**

Sexual activity among teens continues to be a concern. According the MSS, there is an increasing number of youth engaged in sexual activity with decreased use of preventive methods. In the CHB area 59% of twelfth graders have had sexual intercourse. Among those sexually active, 40% do not use birth control (MSS).

### **Access to Dental Care**

There is limited access to dental care for low income adults and children, even if covered by a MN Health Care Program. In the CHB area 61.3% either delayed or did not receive dental care because it cost too much and 42.5% stated they delayed or did not receive dental care because they did not have insurance (BTH).

### **Uninsured & Underinsured**

Both adults and children reported that a lack of insurance or being underinsured was the reason they delayed seeking care when needed. There is also a lack of information related to the availability of health services and options for payment of those services. In the CHB area 8.1% of the people are currently uninsured (BTH).

### **Lack of Preventive Services**

Adults and children are not getting preventative screenings and immunizations. In the CHB area (2010) 29.9% adults have never had a colon screening and 13.3% have never had a cholesterol screening. In addition, 10.2% of women have never had a mammogram (BTH). Reported participation rates for complete child and teen checkups were in 2009- 72%, 2010- 73% and 2011- 70% (DHS).

### **Lack of Physical Activity**

Adults and adolescents are less active than recommended for optimal health. Higher participation levels of physical activity are needed to impact overall health. In 2010, 29.5% of the adults in the CHB area reported they participated in vigorous activity 3 or more times per week and 42.3% in moderate activity 5 days a week (BTH). In 2010, the percentages of adolescents who reported as physically active for at least 30 minutes on at least 5 of the last 7 days were 6<sup>th</sup> - 47%, 9<sup>th</sup> graders- 57% and 12<sup>th</sup> graders- 46% (MSS).

### **Food Insecurity**

Increased rates for food assistance and support programs indicate food insecurity which results in a negative impact on overall health. Food insecurity limits access to healthy foods. In the CHB area 7.6% of BTH respondents reported they had used the food shelf. In addition, 39.3% of students were eligible for free or reduced lunch (MSS).

**In attendance:**

**Lake County – September 24, 2012**

Lakeview Memorial Hospital:	JoAnn Hoag
Lakeview Clinic Manager:	Brad Alm
Lake Superior Community Education Director:	Chris Langenbrunner
Lake County Medical Consultant:	Dr. Leppink
Lake County Commissioner	Dr. Tom Clifford
Lake County Human Services Director	Vickie Thompson
Lake County Public Health Supervisor	Michelle Backes-Fogelberg
Lake County Public Health Advisory Committee member:	Nancy Christenson
Two Harbors Area Partners Director:	Kristen Cruikshank
Lake County SHIP Coordinator:	Forrest Johnson

**Cook County – October 22, 2012**

Cook County North Shore Hospital and Care Center – Administrator:	Kimber Wraalstad
North Shore Hospital Board:	Tom Spence
Sawtooth Mountain Clinic:	Rita Plourde
Cook County PH & HS:	Sue Futterer, Joni Kristenson, Grace Buschard, Allison Heeren
Cook County PH & HS Advisory Committee:	Diane Pearson
Cook Co Rep on Community Health Board:	Diane Pearson
Cook County Community Center and Extension Service:	Diane Booth
Care Partners:	Kay Olson
North Shore Health Care Foundation:	Karl Hansen
Cook County Board of Commissioners:	Sue Hakes

**St. Louis County – Northern Site (Mountain Iron) October 26, 2012**

Fairview Range Hospital	David Hohl
Northern St. Louis Family Services Collaborative:	Edie Carr
Salvation Army:	Debbie Stahl
AEOA Planning:	Lorrie Janatopulos
AEOA HeadStart:	Chuck Neil
Laurentian Clinic:	Todd Scaia
Virginia Medical Center:	Michelle Flemming
Ely Community Member:	Wendy Nelson
Ely Community Resource Agency:	Julie Hingel
School Nurse:	Wendy Newcomb
St. Louis County Public Health:	Guy Peterson
St. Louis Co. PH & HS Advisory Committee Member:	Tony Cuso
Cook Hospital:	Mike Holmes
St. Luke's	Todd Scaia
Essentia Health-Northern Pines:	Cindy Loe
Essentia Health – Virginia:	Dan Milbridge

### Carlton County – November 5, 2012

Community Memorial Hospital:	Rick Bruer and Nancy Taggert
Mercy Hospital:	Jason Douglas
Carlton County PH & HS:	Dave Lee, Terri Allen, Pam Brumfeldt, Joanne Erspamer, Meghann Condit
Carlton Co. Children & Family Services Collaborative:	Donna Lekander
Veteran's Services Director:	Duane Brownie
Public Health Advisory Committee:	Loren Bergstedt
PH Advis Committee and CHB Board:	Barb Little
Carlton County Volunteer Services	Jill Hatfield
Villa Vista Nursing Home & Moose Lake School Board:	Julie Peterson
Carlton County Human Services Advisory Board:	Jerry Pederson
Sunnyside Nursing Home:	Wendy Lonetto
Fond du Lac College:	Mary Monsen
Residents from Cromwell:	Liz Thom
Fond du Lac Reservation:	Nate Sandman
U of M Extension Nutrition Program:	Janet Adkins

### St. Louis County – Southern Site (Duluth) – November 7, 2012

Lake Superior College - Nursing Program:	
Arrowhead Parish Nurse Association:	Pam Franklin
Essentia:	Dr. Tim Zager and Dr. Nancy Beery
Essentia:	Barb Westberg
American Lung Association:	Jill Rogers
Integrity Health:	Bruce Penner
Lake Superior Healthcare Center:	Mavis Beehm, Dr. Jacob Prunuske
Area Agency on Aging:	Catherine Sampson
Community Action Duluth:	Angie Miller
Institute for Sustainable Futures:	Jamie Harvie
St. Luke's Hospital:	Dr. Mary Boylan
CHUM Agency:	Shari Flesness
LISC Director:	Pam Kramer
Gloria Dei Lutheran Church:	Patti Maguire
United Way:	Emily Way
UMD Medical School:	Dr. Jacob Prunuske
Ely Bloomenson Hospital:	Nancy Andrea

#### Phase 5: Next Steps

- Complete an environmental scan identifying current activities, community partners and gaps in services.
- Develop a Community Improvement Plan to address the top prioritized health issue.

The CHB will develop a collective four County Community Health Improvement Plan to address the top health issues.

## APPENDIX D

**Highlighted Duluth Minnesota data  
from the 2015 Bridge to Health Survey**

All data shared in this appendix is specific to Duluth, Minnesota, from the 2015 Bridge to Health Survey. Full results of the Bridge to Health Survey for both the region and Duluth can be found at <http://www.bridgetohealthsurvey.org/index.php/reports/81-bridge-to-health-reports/2015-reports/92-2015-bridge-to-health-survey-results>

### Perceived Health Status

Statum	Poverty Status	Perceived Health Status								Total
		Excellent		Very good		Good		Fair or poor		
		#	%	#	%	#	%	#	%	
Duluth	200% or Less	29.5	15.3	47.0	24.4	85.8	44.5	30.3	15.7	192.6
	More than 200%	91.9	31.5	125.1	42.9	59.3	20.3	15.6	5.3	291.9

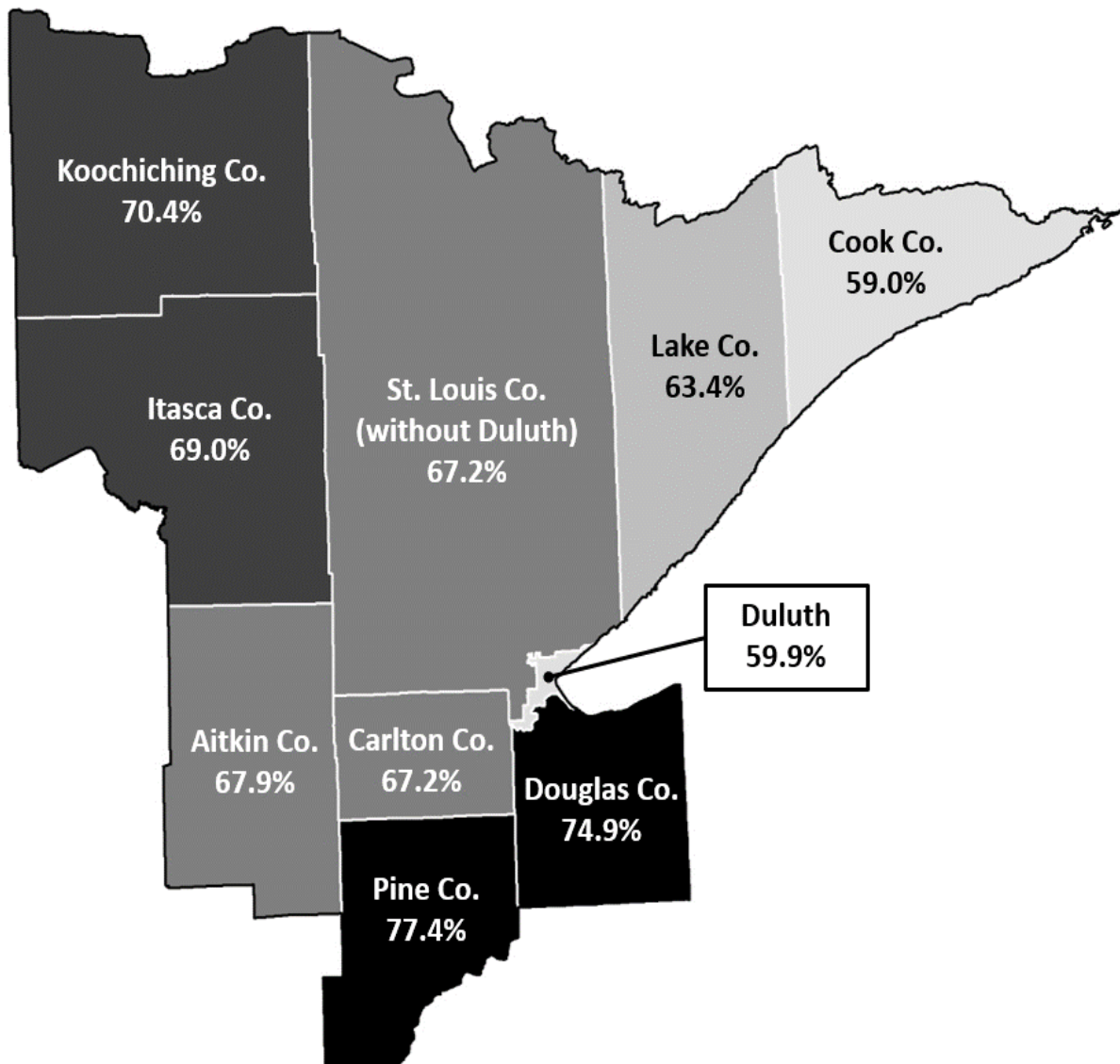
### Poor Mental Health Days

Statum	Poverty Status	Days of Poor Mental Health in Last 30										Total
		0		1-9		10-19		20-29		All 30		
		#	%	#	%	#	%	#	%	#	%	
Duluth	200% or Less	98.0	54.7	54.6	30.5	13.8	7.7	10.0	5.6	2.9	1.6	179
	More than 200%	138.7	49.4	96.8	34.5	25.9	9.2	5.5	2.0	14.0	5.0	281
	Total											460



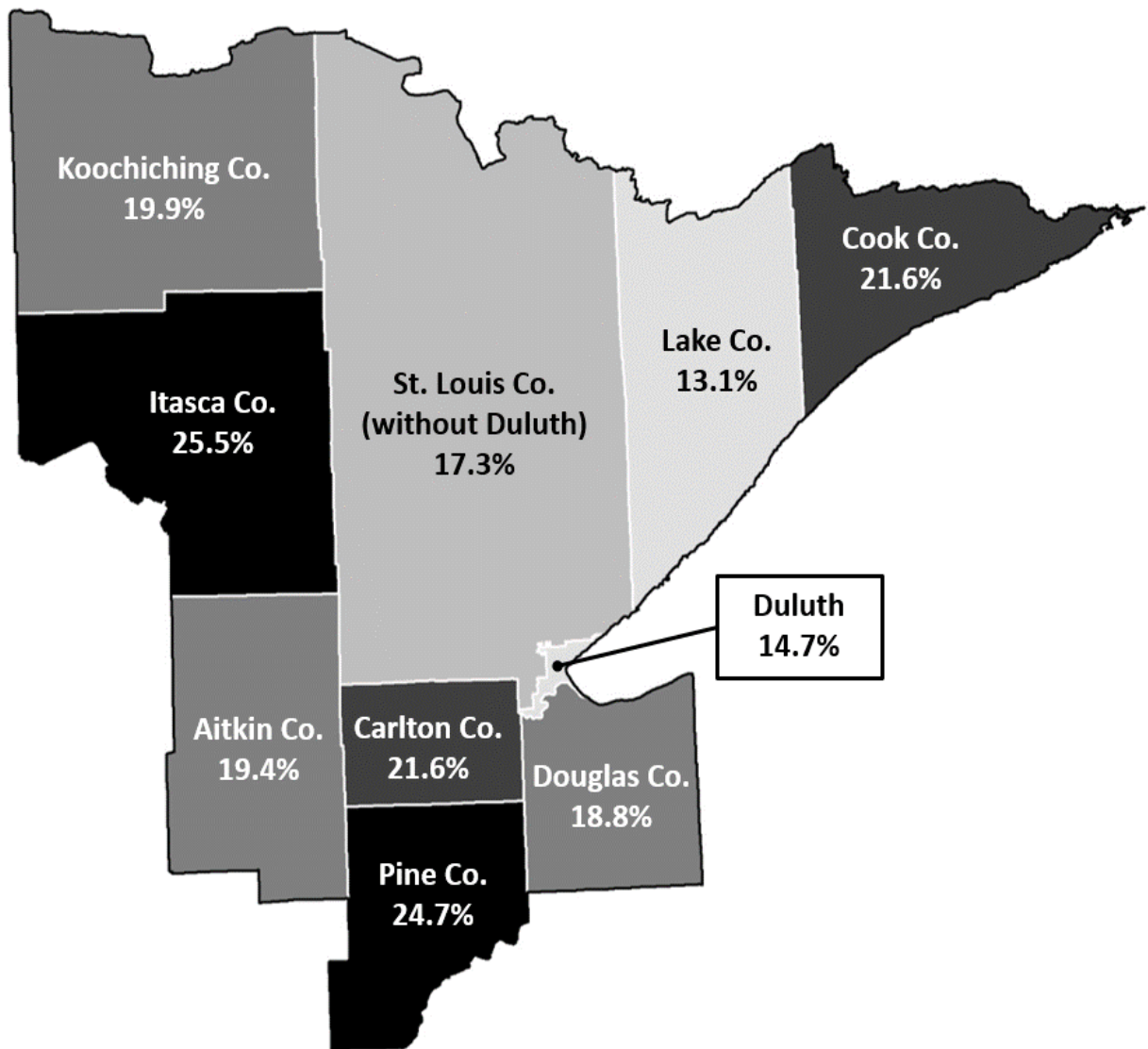
**Overweight/Obese**

Statum	Poverty Status	% Overweight + Obese
Duluth	200% or Less	59.4
	More than 200%	59.6



### Smoking Status

Statum	Poverty Status	% Current Smoker
Duluth	200% or Less	26.1
	More than 200%	7.8



# APPENDIX E

## Vision Duluth 2015: Final Report



**Vision Duluth is grounded with the people who came together to talk about what is possible for Duluth and how we make it happen.**

Vision Duluth partners Chum, TakeAction Minnesota, SOAR Career Solutions, PAVSA, YWCA Duluth, AICHO, Community Action Duluth, Education Minnesota, & Duluth Central Labor Body reached 8,000 individuals through emails, conversations, meetings, and social media.

196 individuals filled out an on-line survey about their Vision for Duluth

We hosted 8 facilitated conversations with 82 women, people of color, people living in poverty, individuals leaving incarceration, teachers, labor leaders.... representing a diversity of neighborhoods.

We knocked on 810 doors and had 256 conversations with neighbors in Spirit Valley, Denfeld, Lincoln Park and Park Point.

---

**The city as it is, the city as we want it to be, and how we get there.**

**The city people want** has jobs that pay living wages with benefits and transportation to get to jobs. Housing that is affordable and accessible for all. Resources and consideration of needs that are spread equitably from West to East Duluth. With safe & free recreation activities for youth. Where our urban green spaces are protected and our elected officials work with all people to implement good policy.

*"I see so much enthusiasm around the importance of equal opportunities for everyone and the fact that we continue to protect and build our outdoor amenities."*

**The barriers that stand in the way are** racism, lack of focus on affordable housing with too much focus on market rate housing development, low wage jobs without benefits, gap in transportation between jobs and housing, geographic divide, drugs and violence.

*"While some people in Duluth are doing better economically there are still far too many Duluthians struggling to make ends meet at low-paying service jobs without benefits. That needs to change. We ALL need to do better."*

**How we get there** is by working together as individuals and organizations, with genuinely bold and progressive elected officials, who work with those impacted by decisions, to tackle issues through policy solutions. To move beyond talking points to what will make life easier for people.

*"Hear the voices of the people, especially in regards to listening to the needs in our community, especially those living in poverty. Then create a strategic plan where these voices are engaged in helping with the issues/solution and moving forward."*

---

*"Duluth is a wonderful big/small town for its middle and upper class citizens. We have access to a variety of restaurants, entertainments, and outdoor activities. I would like to see these opportunities made available for our low income neighbors."*

*"Living wage is top priority!"*

*"The opportunity gap for people of color; lack of commitment by local systems to engage stakeholders in meaningful ways."*

*"The focus on gentrification and tourism at the expense of living wage jobs and affordable housing."*

*"People can't afford housing, jobs aren't paying enough, and there is a huge disparity east the west."*

*"Ensuring local democratic control of resources will be an issue as outside interests realize that Duluth is a great investment."*

*"While some people in Duluth are doing better economically there are still far too many Duluthians struggling to make ends meet at low-paying service jobs without benefits. That needs to change. We ALL need to do better."*

*"I see so much enthusiasm around the importance of equal opportunities for everyone and the fact that we continue to protect and build our outdoor amenities."*

*"The sense that it is not a fading rust-belt shadow of civilization, but has new energy and seems to be reinventing itself."*

*"Community size allows for social change."*

*"We are reaching a critical mass to change from 'no' to 'yes we can'."*

*"Let's get to the root of the problem and act on it!"*

*"If all organizations get together and put their ideas together and come up with a way to put things in to into action we can then begin creating change within the community."*

*"Be progressive. Have an agenda. Take risks."*

*"Filter decisions, 'does it improve the health of the community or decrease it'."*

*"Identify issues in each neighborhood and organize people in their neighborhoods."*

*"I want elected officials that are committed to considering how budgets and policy decision affect the lives of our low-income neighborhoods."*

*"Hear the voices of the people, especially in regards to listening to the needs in our community, especially those living in poverty. Then create a strategic plan where these voices are engaged in helping with the issues/solution and moving forward."*

*"Mobilize the general public around a common vision and set of strategies."*



# APPENDIX F

**Voices for Racial Justice:  
2016 Vision and Agenda for Racial Equity**

2016

# A Vision and Agenda for Racial Equity in OUR DULUTH



Education equity for our children • Safe and affordable housing • Respect and accountability in policing • Political representation • Leadership in schools, government, and business • Living wage jobs • Respect of our cultures in public spaces • Access to health care • Recreation opportunities for all of us • Access to healthy food for everyone



**VOICES FOR  
RACIAL JUSTICE**

ORGANIZING | ADVOCACY | POLICY



This is the vision for OUR DULUTH, one where racial and cultural equity resides not just in dreams, but in reality. OUR DULUTH is a community where we all belong and thrive. How can we get there, especially when people of color and Indigenous people in Duluth now face racial disparities in education, employment, housing, health, and safety, as well as severe political and cultural underrepresentation of our communities?

Overcoming these disparities requires a deep and honest conversation about this community's history and its current reality of structural racism. And we must move beyond conversation toward powerful solutions and urgent action to realize the vision for OUR DULUTH. We who experience these disparities know what it will take to move toward this vision.

Together, we are building the power to dismantle the systems that keep our communities from experiencing Duluth as we all should. We call on OUR DULUTH to stand together, allowing for our voices to define the barriers, highlight our assets, and lead for change.

**These principles should guide us:**

**Acknowledge the truth of structural racism in our community.**

Commit to understanding the impact on American Indians, people of color, and all people in Duluth.

**Recognize the assets of our communities,** including our deep experience and knowledge, our resilience, and our cultures and histories. Honor these as an equal part of the story of Duluth.

**Commit to an explicit racial equity lens on all of our community decisions,** whether in budgeting and investment, policymaking, or changes in practice.

**Make space for our voices at decision making tables,** especially where decisions are being made that affect our communities, whether in education, housing, employment, or other opportunities. We are experts in the barriers that we face, and we have the solutions for breaking them down.

## Levels of Racism

Racial justice strategies recognize that racism is present in all aspects of our society, that it is embedded in institutions, and that it can often be an unintentional result of policies and practices. Knowing the level of racism we are confronting allows for targeted solutions that can help avoid the unintentional consequences of worsening disparities through colorblind policy making.

**Individual or Internalized Racism:** racism within individuals, through personal attitudes, thoughts, and internalized oppression (feeling inadequate because of your race). Solutions focus on changing individual attitudes through conversation, groups, and other educational opportunities.

**Interpersonal Racism:** racism between individuals resulting in bigotry and bias. Solutions should include diversity training, building cultural awareness, and developing relationships.

**Institutional Racism:** racism within and between institutions which results in discriminatory treatment, unequal treatment, and disparate outcomes. Solutions to mitigate institutional racism must focus on change in policies and practices focused on equity, as well as demanding accountability for disparities.

**Structural Racism:** racism that permeates through society through history, culture, and systemic inequality. Solutions must expose historical roots, assumptions, and biases and lead to racial justice movement building that connects issues and systems that are part of the fabric of structural racism.

## Education Equity

High school graduation rates for students of color have gone up just slightly in the last year to 47 percent and dropped dramatically from 49 to 32 percent for American Indian students. We know education is vital to stopping cycles of incarceration and poverty. We believe that all of our students must be able to succeed in and graduate high school. OUR DULUTH must:

### **Offer education for all of us.**

- Provide culturally informed third party advocacy, mediation, and conflict resolution.
- Re-assess the role of school resource officers.
- Improve access to driver's education.
- Take action to improve parent and community involvement in schools.
- Work with our communities to improve cultural relevance of learning.

### **Reflect our communities in its teachers and school board members.**

- The school board should be made up of members who reflect our families.
- Schools must commit to recruiting and retaining teachers who reflect the populations they serve.
- To move toward teachers and board members reflecting our communities fully, create a process that allows communities to be involved in hiring teachers.

### **Expand opportunities for continuing education.**

- Students of color, American Indian and under-resourced high school graduates should qualify for higher education application fee waivers.
- All schools in the area should be working directly with admissions units to recruit underrepresented students.
- Post-secondary institutions should create avenues to more affordable education, such as off-campus work study options.

## Political Representation and Power

In our last election more people of color and American Indians ran for elected office than ever before, but none won their race. Neighborhoods with the highest poverty rates in Duluth have some of the lowest voter turnout, not reaching over 55 percent. OUR DULUTH must foster leadership at all levels.

### **Appoint members of boards and commissions to better reflect all of Duluth.**

- Meetings should be held at accessible times and locations, and facilitation must be culturally and linguistically appropriate.
- Training, incentives, or possible compensation should be provided to make participation possible.
- Make appointments of people of color and American Indians to the nine vacant seats on the human rights commission a priority.

**Represent us in elected offices.**

- Develop more equitable endorsement processes for people running for election.
- Explore supporting underrepresented leaders in running for public office through alternative campaign finance strategies at the local level, including public finance and democracy vouchers that allow voters to contribute public dollars to candidates of their choosing.
- Elected officials and leaders should develop deep relationships with our community, and have ongoing dialogue on how they will commit to closing gaps and advancing racial equity.

**Overcome barriers to voting.**

- Work in partnership with community organizations to build stronger civic engagement and overcome the barriers to voting.
- The city of Duluth should commit to get out the vote campaigns specific to communities of color and low-wealth communities.

## Employment and Economic Opportunity

The unemployment rate in Duluth is about 20 percent for people of color and American Indian people, much higher than the rate for whites, at about 7.5 percent. The median income for people of color in Duluth is \$19,844. For American Indian households median income is just \$16,875. This compares to a median income of over \$45,000 for white households. OUR DULUTH must:

**Make the connection.**

- Invest in developing Employment Navigators from communities experiencing high unemployment to connect their communities to jobs.
- Commit to reassessing hiring practices within the city and increase hiring of people of color and American Indians for city jobs.
- Work with large employers in the community to increase racial diversity of the workforce.

**Support new ideas.**

- Commit to funding entrepreneurial opportunities that launch new businesses owned by underrepresented communities and that create jobs in those communities.
- Make local government procurement and contracting intentionally inclusive of businesses owned by people of color and American Indians.
- Strengthen local businesses that are an important source of local jobs.

**Offer training that leads to jobs.**

- Co-create the training and education that leads to living wage jobs.
- Diversify the management of the workforce by race.
- Access state and federal funding for workforce development to be run by communities of color and American Indians.
- Increase the presence of workforce job training within communities of color and American Indian communities and in spaces that are welcoming for us.

## Housing and Homelessness

Despite making up about 15 percent of the population, people of color and American Indians are hugely overrepresented in our homeless population. The city and community of Duluth should commit to making sure that everyone has a safe and warm place to sleep each night. Because people of color and American Indians are disproportionately represented in the homeless population, as renters, and are overly rent-burdened, we often have little control over the safety of our homes. OUR DULUTH must:

### **Address homelessness in our communities.**

- Officially adopt a homeless bill of rights and make housing status a protected class.
- Commit city funding to culturally-specific housing and housing services.
- The local Housing Redevelopment Authority should review their exclusion policies to make housing more accessible for people with criminal records.
- Support all initiatives that come out of the St. Louis County annual Homes for All Summit.

### **Increase safe and affordable housing.**

- Continue to support accessible legal services that make tenants aware of their rights.
- Address unsafe, unsanitary housing and the risk of lead poisoning.
- Work to increase housing vacancy rates in Duluth and build affordable housing stock.
- Commit to genuine neighborhood choice for all citizens by identifying and securing affordable housing outside of low income neighborhoods, but also working to address disparities in historically disinvested neighborhoods.
- Work with lenders to develop programs that increase people of color and American Indian homeownership.

## Healthy Communities

In Duluth, life expectancy differs by 10 years between our healthiest and least healthy zip codes. Some Duluth neighborhoods and communities can be considered food deserts, with little access to fresh produce and other nutritious foods. Mental health concerns, and drug use are also problems that plague our communities, as are extremely high rates of Hepatitis C and HIV AIDs among people of color and American Indians. OUR DULUTH must:

### **Increase community-wide health.**

- Commit to ensuring that all Duluth citizens have access to affordable healthcare.
- Decrease zip code health and life expectancy disparities.
- Support earned sick time for all employees.

### **Increase access to healthy foods.**

- Support community-led collaboratives to eliminate food deserts such as the "Grocery Express" project.
- Support community gardens and public orchards.
- Provide education on growing food and healthy eating to minimize dependence on processed foods and commodities.

**Reduce harm.**

- Support harm reduction models such as syringe and needle exchange programs that emphasize treatment and services over incarceration..
- Commit to the creation of an emergency task force including those living with mental health issues, mental health care providers and law enforcement in order to identify and address solutions to gaps in mental health care services.

## Safe Communities

Women of color and American Indian women suffer all kinds of sexual violence, including domestic violence, sexual assault, and trafficking at significantly higher rates than the general population, with one in four women of color and one in three American Indian women experiencing some form of violence. People of color and American Indians also experience police stops and harassment at much higher rates than the general population, and at the same time only 14 people of color and American Indians serve in the Duluth Police Department. OUR DULUTH must:

**End domestic violence, sex trafficking, and other forms of sexual violence.**

- Support the earned safe time initiative.
- Offer culturally specific programming to address domestic violence.
- Trafficked women should be treated as victims, rather than perpetrators, and be offered appropriate services.
- Focus on supporting harsher punishment for sex-buyers.

**Make policing accountable.**

- Candidates for Duluth Police Chief and other positions should meet with people of color and American Indian people at a racial equity forum to hear our concerns and answer our questions.
- Support more community policing in every area of the city to improve police relationships with the communities they serve.
- Provide ongoing implicit bias and cultural training for police throughout their service.
- Encourage community members to take part in the Duluth Police Citizens' Academy.

**Build community.**

- Promote ongoing community events that support peace, camaraderie, and community connections.
- Engage young people and promote youth leadership throughout the city.

## Culture, Art, and Public Spaces

People of color and American Indians in Duluth long for culturally grounded arts centers that allow for authentic elevation of our history, voices, and vision. Opportunities for sculpture, murals, music, theater, and more bring vibrancy to Duluth and create a deeper sense of belonging. All of us will benefit from the richer cultural representation of diverse communities. OUR DULUTH must:

### See Us. Give us space to be us.

- The city of Duluth should only commission artists of color and native artists to produce art that is representative of us.
- The city of Duluth should support and promote an eclectic range of art where ALL the cultures of Duluth are well-represented.
- Commit city funding to develop and encourage cultural centers.
- Allow ceremony and peaceful gathering in all public spaces.
- Support the ongoing efforts by the Duluth Indigenous Commission to rename Gitchi Ode Akiing park in order to honor and acknowledge Indigenous history in Duluth.



OUR DULUTH is part of the Greater Visions MN project, a collaboration between Voices for Racial Justice and organizers living and working in Duluth who are leading their vision for a more equitable community.



**VOICES FOR  
RACIAL JUSTICE**

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## APPENDIX G

### Community Organizations Represented in Focus Groups

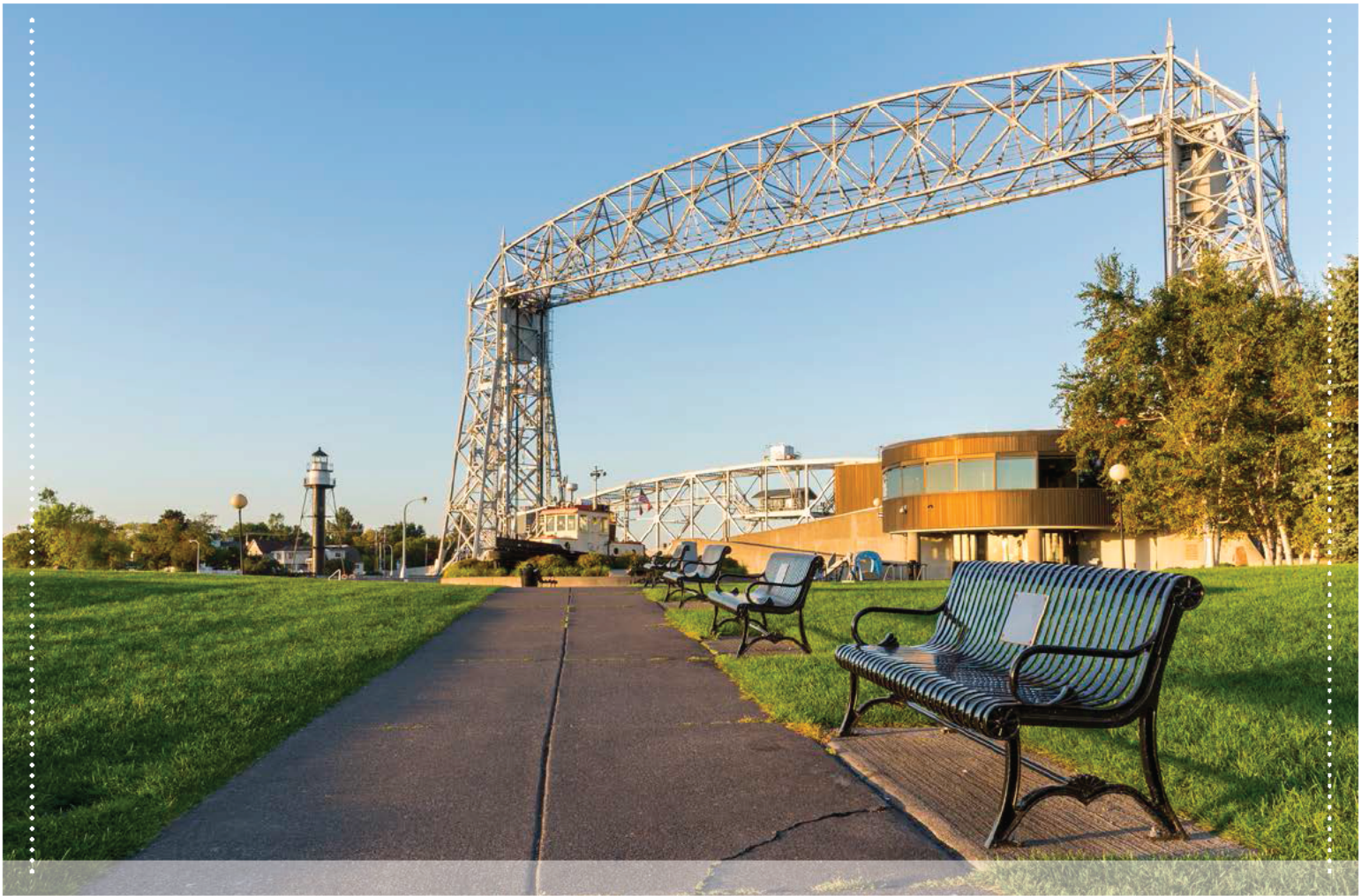
### Community Organizations Represented at March-April, 2016 Focus Groups\*

Organization Name	Area of Focus	Organization Name	Area of Focus
Duluth Public Schools	Youth	Essentia Health	Health care
CHUM	Low-income, homeless	St. Luke's Hospital	Health care
Fair Food Access	Low-income	Duluth LISC	Community Development
Community Action Duluth	Low-income, minority	Maurices	Business community member
FUSE Duluth	Young professionals	National Bank of Commerce	Business community member
Duluth News Tribune	Business community member	Greater Downtown Council	Business community member
Inn on Lake Superior	Business community member	Lake Superior Community Health Center	Health care, low-income
Western Lake Superior Sanitary District	Business community member	Myers-Wilkins Community School	Youth, low-income, minority
Kraus-Anderson	Business community member	St. Louis County Public Health and Human Services	Public health, human services
CF Design	Business community member	American Lung Association	Tobacco policy
LHB	Business community member	Peace Church	Diverse, faith-based congregation
Woodland Hills	Mental health, adolescents	St. Scholastica	College
Zeitgeist Center for Arts and Community	Community	Women of ELCA	Women of Lutheran faith
PAVSA (Program to Aid Victims of Sexual Violence)	Sexual assault victims	Protect Minnesota	Gun-safety advocates
CAIR	Public health, social services; Native Americans	Cross Cultural Alliance of Duluth	Racial minorities
All Nations Indigenous Center	Native Americans	Health & Wellness Table	Central hillside/Lincoln Park residents
Life House	Homeless and street youth	PS Rudie Clinic	Primary Care
AICHO (American Indian Community Housing Organization)	Native Americans	Institute for a Sustainable Future	Ecological health
Arrowhead Parish Nurse Association	Community		

\*Full rosters with names available upon request.

Additionally, community residents and students (high school and college) attended the majority of the focus groups, providing representation and input from the community at large.





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