2020-2022

Community Health Needs Assessment and Implementation Plan

Healthier Together

Pierce County

St. Croix County

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EXECUTIVE SUMMARY

Healthier Together Pierce & St. Croix Counties (Healthier Together) is a community coalition working to create and maintain healthy communities and provide a strategic framework for local health improvement activities. This report describes the Community Health Needs Assessment (CHNA) process, culminating in a Community Health Improvement Plan (CHIP) for 2020-2022.

In 2018 and 2019, Hudson Hospital & Clinic, River Falls Area Hospital, Western Wisconsin Health, Westfields Hospital & Clinic, Pierce County Public Health, St. Croix County Public Health, and the United Way of St. Croix Valley lead the planning and implementation of a two-county, community-based approach for creating and maintaining healthy communities. This is the second community health needs assessment and plan developed by these partners under the auspices of Healthier Together.

This effort included: (1) completion of a CHNA to systematically identify and analyze health priorities in the community, and (2) development of a CHIP to address these priorities as a coalition and in partnership with others. The Healthier Together Leadership Team collaboratively developed a process based on the Mobilizing for Action through Planning and Partnerships (MAPP) framework. Through this process, Healthier Together engaged with community stakeholders to better understand the root causes of health issues in our communities, identified internal and external resources for health promotion and created an implementation plan that leverages those resources to improve community health.

In late 2018, community members, community organizations, public health and hospital/health system representatives participated in an issue prioritization process that identified substance use disorder and mental health as priority areas impacting the health of the communities served by Healthier Together.

In 2019, staff solicited community and stakeholder input, assessed existing strategies and resources and developed a CHIP for 2020-2022 in order to address these priorities. This implementation plan includes the following goals, each of which is supported by multiple strategies and will be implemented through a variety of activities monitored for progress and outcomes over time.

Mental Health:

- Increase healthy coping skills and stress reduction strategies
- Support coordination of mental health care services between schools, providers, and counties
- Increase services that promote family stability

Substance Use Disorder:

- Increase coordinated youth prevention work, providing education, healthy activities and resilience training
- Increase early intervention, education and prevention services related to substance use in the community
- Advocate for policies that increase access to substance use treatment

MISSION

The mission of Healthier Together is to create and maintain healthy communities.

INTRODUCTION

The mission of Healthier Together is to create and maintain healthy communities. Healthier Together conducts a Community Health Needs Assessment (CHNA) to systematically identify and analyze health priorities in the community and then develops a Community Health Improvement Plan (CHIP) in response to those priorities every three years.

Through this process, Healthier Together aims to:

- Better understand the health status and needs of the communities we serve by considering the most recent health and demographic data as well as gathering direct input from community members.
- Gather perspectives from individuals representing the interests of the community, including those who have knowledge or expertise in public health and those who are more likely to experience health inequities,
- Identify community resources and organizations that Healthier Together can partner with and support in the priority areas for that community.
- Create a strategic implementation plan based on information gathered through the needs assessment.

The purpose of this report is to share the current assessment of community health needs most relevant to the communities served by Healthier Together and its community health improvement plan to address these needs in 2020-2022. This report also highlights activities conducted during 2017-2019 to address needs identified in the previous 2016 assessment.

HEALTHIER TOGETHER DESCRIPTION

Healthier Together is a community coalition working to create and maintain healthy communities and provide a strategic framework for local health improvement activities. Healthier Together initiatives have focused on bringing people together from across the two counties to identify and address a variety of health priorities.

HEALTHIER TOGETHER EXECUTIVE TEAM MEMBERS

Hudson Hospital & Clinic

Hudson Memorial Hospital was established in 1953 in Hudson, WI. In 2008, Hudson Hospital joined HealthPartners Family of Care and changed its name to Hudson Hospital & Clinic. The hospital is a regional partner of The Cancer Center of Western Wisconsin and is nationally and internationally recognized for its quality of care. With a mission "To improve health and well-being in partnership with our members, patients and community," Hudson Hospital & Clinic is dedicated to collaborative efforts in community health improvement.

Pierce County Public Health

Pierce County Public Health is a Level III Health Department founded in 1943 and accredited by the Public Health Accreditation Board (PHAB) in March 2015. Its mission is to "nurture healthy behaviors, prevent disease and injury, and protect against environmental health hazards". It fulfills this mission via involvement in numerous community collaborations and coalitions, including the Goodhue Wabasha Pierce Counties Breastfeeding Coalition, Pierce St. Croix County CARES, the St. Croix Valley Immunization Coalition, Partnership for Family Teaming, United Way Success By 6 and the UW-River Falls Sexual Assault Coalition, among others.

HEALTHIER TOGETHER SERVICE AREA

River Falls Area Hospital

River Falls Area Hospital, founded in 1939, is a part of Allina Health, a not-for-profit health system dedicated to the prevention and treatment of illness. The River Falls healthcare campus includes the River Falls Area Hospital, Allina Health River Falls Clinic, a number of specialty provider partners and the Kinnic Health & Rehab Facility. Its focus is to deliver exceptional health care, support services and preventive care—putting the patient first in everything. The hospital also has a long history of working to improve health in the community it serves through programs and services that respond to the health needs of the community.

St. Croix County Public Health

St. Croix County Public Health is a Level III Health Department founded in 1936 in response to a statewide tuberculosis crisis. The public health department became part of St. Croix County Health and Human Services in 1994 and achieved national PHAB accreditation in September 2014. Its mission is "to protect and promote health, prevent disease and injury and empower communities to live healthier lifestyles". To fulfill its mission, St. Croix County Public Health takes a lead role in community health assessment and improvement planning and is involved in numerous community programs and coalitions.

Western Wisconsin Health

Western Wisconsin Health, formerly Baldwin Area Medical Center, was established in 1936. Located in Baldwin, WI, its mission is to "Build a Healthier Tomorrow… Together" by providing health and wellness services in a sustainable environment. Its facility is designed using sustainable materials and offers comprehensive health and wellness services. Western Wisconsin Health is a critical access hospital and rural health clinic providing acute care, chronic health condition services, and is also committed to promoting community health and wellness through numerous community-based programs and services.

Westfields Hospital & Clinic

Westfields Hospital & Clinic, originally known as Holy Family Hospital, opened its doors in New Richmond, WI in 1950. In 2006, the hospital joined HealthPartners Family of Care, but remains a separate entity with its own governing board. Westfields' motto, "To improve health and well-being in partnership with our members, patients and community" far extends its walls. With a special emphasis on preventive medicine, the hospital's focus is on the personal care of family members. It is committed to the community and devoted to helping each patient become the healthiest person possible.

United Way St. Croix Valley

United Way St. Croix Valley has been a trusted partner assisting in addressing community needs for more than 25 years. Our mission is "to unite communities, focus resources and inspire people to measurably improve lives in Western Wisconsin". UWSCV works in St. Croix, Pierce, Polk, Washburn and Burnett counties providing support to local nonprofits financially as well as through local coalitions and programs and direct service programing. UWSCV direct service programs address hunger, early childhood education, mental health supports and the new 211 St. Croix Valley Community Resource Center.

COMMUNITY SERVED

The focus of inquiry for this CHNA was Pierce and St. Croix Counties—two rural communities located in western Wisconsin. According to the U.S. Census Bureau, a total of 128,402 (41,226 Pierce/87,142 St. Croix) residents live in the 1,295.73 square mile area occupied by the two counties. The following key indicators provide a brief overview of the region. Additional information about Pierce and St. Croix County can be found through the U.S. Census Bureau

Table. Key indicators for Pierce and St. Croix counties		
Selected Indicator	**Pierce County**	**St. Croix County**
Population[5]		
Median income	$66,772	$77,768
Median age	36 years	38 years
Residents under age 18	21.1%	25.8%
Residents age 65 or older	13.2%	12.5%
Residents with limited English proficiency	1.7%	1.0%
Foreign born residents	1.8%	2.4%
Residents in households with income below poverty line[3]	10%	6%
Percent of Population Asset Limited, Income Constrained, Employed (ALICE)[3]	32%	25%
Residents living in food insecurity[4]	10%	7.8%
Children living in food insecurity[4]	15.3%	13.6%
Race and Ethnicity[2]		
White alone	95.9%	96%
Black or African American alone	0.8%	0.8%
Asian alone	1.2%	1.1%
Hispanic or Latino	2.1%	2.4%
Health Indicators[1]		
Ratio of primary care physicians to residents	2,170:1	1,960:1
Ratio of mental health providers to residents	2,460:1	780:1
Adults reporting binge or heavy drinking	28%	26%
Adults who are obese	29%	27%
Residents reporting poor or fair general health (age adjusted)	12%	12%

Sources:

[1] County Health Rankings, 2019

[2] US Census Bureau, Quick Facts, Population Estimates July 1, 2018.

[3] United Way St. Croix Valley ALICE Data

[4] U.S. Census Bureau, American Community Survey (ACS), 2012-2016, 5-year estimates

[5] U.S. Census Bureau, American Community Survey (ACS), 2013-2017, 5-year estimates

EVALUATION OF THE 2017–2019 COMMUNITY HEALTH IMPROVEMENT PLAN

In 2016, Healthier Together conducted the first bi-county community health assessment and improvement plan. This plan consisted of three priority areas: mental health, obesity and overweight, and alcohol abuse. Action teams for each priority area were formed to implement strategies identified during the planning process.

Improve mental health status of residents of Pierce and St. Croix counties

During 2017-2019, the Mental Health Action Team completed a number of activities to increase community awareness, reduce stigma and increase access to services.

The group implemented the Make It OK campaign to increase awareness about mental health issues and reduce stigma associated with mental illness. Since beginning the Make It Ok initiative in 2017, 365 ambassadors have been trained to provide presentations in the two-county region, and there have been more than 5,250 local touch points through outreach activities such as Make It Ok displays, presentations and events.

In order to increase access to mental health services, the team supported Mental Health First Aid Trainings in our communities. Just as CPR helps you assist an individual having a heart attack, Mental Health First Aid helps people assist someone experiencing a mental health or substance use-related crisis. Thirty trainers were trained to provide classes to the public, and 25 trainers continue teaching classes to date. Since 2017, 500 members of the public were trained in Mental Health First Aid in 50 classes. Survey results were positive for participants having increased knowledge about mental illness, appropriate response to people experiencing mental health crises, lowering stigma, and mental health resources. One attendee commented, "This has been an excellent course- empowering and informative. [It provides] excellent information. [The course] destigmatizes the conversation and offers us helpful tools. This is so important."

The team worked with local schools to understand what mental health services were available and what the schools needed. A survey of school districts was conducted in 2017 and results were shared in early 2018 with a group of area superintendents. As a result of the analysis of that survey, Healthier Together hosted a Youth Mental Health Collaboration meeting in October 2018 with 24 local school, county, and healthcare leaders present to identify root causes of mental health issues for youth and opportunities. Additionally, the team worked with two schools to implement programs that supported the development of resilience and coping skills in youth.

The team also helped create and disseminate a comprehensive inventory of mental health services and resources for residents of both counties. In addition, the group encouraged and supported investigating the possibility of bringing 211 under local management through our United Way St. Croix Valley office in Hudson, WI to gather more accurate local data and expanded resources related to mental health and other health and economic resources.

Decrease the percentage of the population that's overweight or obese in Pierce and St. Croix Counties

During 2017-2019, two action teams on food insecurity and physical activity implemented strategies to support healthy lifestyles throughout the counties.

The Food Insecurity Action Team worked to ensure healthy food was more accessible to residents and to strengthen the food support systems in our area by offering meetings for local food pantries and food assistance programs to collaborate.

Through existing and new partnerships, a number of projects were developed or enhanced. A new Food Share Outreach Specialist position assigned to our region enrolled 104 families in Pierce and St. Croix Counties into the SNAP program in 2018. This provided more than 54,100 meals for these families.

United Way St. Croix Valley (UWSCV) expanded offerings for healthy food to those in need by partnering with local farmers to add Community Supported Agriculture (CSA) shares of fresh, locally grown, produce for each pantry throughout the summer to their existing produce distributions; resulting in more than 6,000 pounds of additional produce distributed. UW Madison Extension supported the CSA shares by providing educational flyers that were included with CSA shares on the selecting, storing, prepping and cooking of veggies for pantry clients in both Spanish and English.

UWSCV piloted a mobile pantry in Deer Park, an underserved area of St. Croix County, and is currently serving an average of 35 households per month. UWSCV also facilitated meetings with seven school districts backpack programs to better understand their needs. This resulted in more than 3,800 healthy snack packs being included in weekend backpack programs for families and students. An unexpected result of the backpack program meetings was an ordering collaboration between two school districts to place joint food orders and reap the benefits of improved ordering efficiencies and cost savings; two other districts piloted summer backpack programs after hearing about successful models in other districts.

UW Madison Extension and Pierce County Public Health provided food pantries with assistance on how to improve the nutritional quality and safety of their food through promotion of the Safe and Healthy Pantries Project model.

University of Wisconsin-River Falls , Our Neighbors Place and other local partners brought Fare for All to River Falls. Fare for All provides monthly healthy food options in produce and meat packs at a low cost to all community members. An average of 28 families participated in the Fare for All program in the first nine months.

The Physical Activity Action Team worked with schools to increase use of Active School Core 4+ strategies, which are designed to increase physical activity. The team developed educational materials and resources to assist schools with implementing Core 4+ strategies, and assisted interested schools in updating their wellness policies to include Active Schools Core 4+ language. In 2017, Prescott's Malone Elementary School successfully revised their school wellness policy based on technical assistance from Healthier Together.

The Physical Activity Action Team also promoted National Walk to School Day through offering support the day of and developing a guide for schools wanting to participate. In 2018, over 1,700 students across the counties participated in this event. Bike to School Day was also promoted in 2019, with helmet giveaways given as prizes for participating schools within the two counties. The helmets included safety literature on how to ensure a helmet fits correctly and were a generous donation from River Falls Area Hospital (Allina Health).

In the spring of 2019, the Physical Activity Action Team reached out to libraries in the two counties to see if there was interest in participating in a nature parks packs program (library backpack program). This is an idea that came from the library in New Richmond, which has themed backpacks (e.g. bird watching, geocaching, hiking, etc.) that can be checked out by kids and families to take to parks. Every library within the two counties expressed interest in having this program at their site. In the fall of 2019, the Physical Action Team secured funding from Allina Health to purchase the backpacks and themed contents. Towards the end of 2019, funding and/or sourcing of park passes (county and/or state) is being sought to help reduce financial barriers to park access.

Reduce alcohol abuse among residents of Pierce and St. Croix counties

The Alcohol Action Team aimed to decrease both adult and youth alcohol use through changes to policy, systems and environment. In order to reduce underage drinking, the team conducted a public information campaign through a local paper about the dangers of overconsumption. Assessments to gauge a community's readiness for policy change around alcohol were conducted in both River Falls and Hudson. The group also conducted an inventory of ordinances in both Hudson and the City of River Falls related to alcohol policies. Results of the inventory were shared with community decision-makers in River Falls.

2020-2022 COMMUNITY HEALTH NEEDS ASSESSMENT METHODOLOGY AND TIMELINE

Healthier Together designed a process that engaged both community members and stakeholders, and took a wide variety of data sources into account. Because Healthier Together conducts an assessment and new plan every three years to follow IRS requirements, Healthier Together's Leadership Team decided to limit stakeholder issue prioritization to the top five health issues from the results of the community survey rather than considering all health issues for prioritization. Limiting the options for prioritization prevented priorities from shifting too fast for the action teams to do meaningful work.

Timing	Steps	Stakeholders Consulted
June-July 2018	**Initial Planning** The initial planning process included a brief training/refresher on the MAPP process, a SWOT analysis of the CHNA process from three years ago, and the formation of a data team.	Healthier Together Leadership Team
July-December 2018	**Data Gathering and Analysis** The data team started their data review process by gathering secondary, quantitative indicators by health issue area. The data team aimed to find local, frequently updated data for the dashboard (Appendix C). The data team intends to update this dashboard annually. The data team then redesigned the survey from three years ago and distributed the survey to communities. The survey remained mostly the same from the version three years ago to allow comparisons. The survey was available in Spanish and English and available in paper and electronic versions (Appendix A). The data team analyzed the survey results and put them into a presentation (Appendix B). Lastly, the data team updated the data packet from three years ago to provide to stakeholders during the prioritization process (Appendix E).	Community members, Healthier Together Leadership Team
December 2018	**Issue Prioritization and Root Cause Analysis** Community leaders from a variety of sectors throughout the counties gathered for a workshop to review data results, prioritize health issues and discuss root causes of top health issues.	Community leaders
January-April 2019	**Key Community Input on Top Issues** The Healthier Together Leadership Team worked with a consultant to conduct focus groups with key community members identified during the root cause discussion in December. The groups helped narrow down the priority areas into more manageable focus areas by ranking potential goal statements. The focus group participants were also asked about root causes of top health issues.	Community members: farmers, youth, mental health providers, youth service providers, those in recovery from substance use or mental health disorders and people 60 and over.
May-July 2019	**Implementation Planning** Based on feedback from the focus groups and stakeholders, an action team was formed for each priority area. These action teams were provided with resources for researching evidence-based practices and were asked to suggest potential strategies. Strategies were then prioritized using a feasibility and impact matrix.	Healthier Together wide membership
July-October 2019	**Report Preparation and Approval** The initial report draft was shared with Healthier Together Leadership Team members for feedback. Final approval was sought from each local board.	Healthier Together Leadership Team
October-December 2019	**Activity Planning for 2020** Action teams conducted activity-level planning for the year 2020 for each selected strategy. Activity planning will occur annually.	Healthier Together wide membership

DATA GATHERING AND ANALYSIS

Data of many different types and from many sources were considered during the assessment process. The team started with secondary, quantitative data organized by health topic area. This was followed up with a comprehensive community survey to gather primary data on the perspectives of community members. Later in the process following issue prioritization, focus groups were conducted with key groups to better understand the root causes of important health issues.

SECONDARY DATA DASHBOARD

The Healthier Together Leadership Team formed a sub-group to research data points on key health issues to compile into a dashboard. The group prioritized indicators that were local, frequently updated, easily interpreted by the public, and available in both counties. Data on the following topics was included in the data dashboard (Appendix C):

- Nutrition, Physical Activity, and Obesity
- Chronic Disease
- Drug Use
- Alcohol Use
- Mental Health
- Access to Care
- Economic Opportunity
- Maternal and Child Health
- Environmental Health

This dashboard will be updated annually and is available to the public online. Analysis of this secondary data revealed a few key observations:

- Proper diet appears to be a more common problem than physical activity. 1 in 5 adults reported no leisure activity, but 3 in 4 adults do not eat enough fruits or vegetables.
- Residents of Pierce and St. Croix Counties have lower rates of avoidable heart disease and stroke deaths than the state as a whole.
- Methamphetamines are a serious issue in both counties. Crime lab submissions for methamphetamines peaked in 2014 and 2015, but about 45 cases were still submitted in St. Croix in 2018. Opioid dispensing rates per 100 persons remain well below the state average in both counties.
- Alcohol continues to be a health, law enforcement and economic issue in both counties. About 1 in 4 adults report binge or heavy drinking. Female students are more likely to report drinking in the past 30 days compared to their male counterparts. There were more alcohol-related arrests in Pierce County compared to St. Croix County, despite Pierce having half the population of St. Croix County.
- About 6,000 adults in Pierce County and 12,180 adults in St. Croix County suffer from a mental illness. High school girls were more likely to report feeling sad or hopeless almost every day for two or more weeks compared to their male counterparts. Suicides in St. Croix County remained stagnant from 2012-2015, but suicides in Pierce declined during that period.
- Access to care is a problem in both counties, which are primarily rural. Both counties have fewer primary care doctors, dentists and mental health providers per residents than the state average. Pierce County has fewer providers than St. Croix in every category, and has no hospital within its borders.
- While poverty levels are relatively small in both counties (10% in Pierce and 6% in St. Croix), a significant portion of residents in both counties are Asset Limited, Income Constrained and Employed (35% in Pierce and 25% in St. Croix). More adults and children in Pierce County suffer from food insecurity compared to St. Croix, though the difference is not a large one.

- Although the percent of infants born with low birth weight is relatively low in both counties, smoking rates among Pierce County pregnant women (22%) remain high and immunization rates for two-year-olds in St. Croix County (65% up to date) remain low.
- Environmental health remains an area of great public interest in both counties. St. Croix county fairs worse than the state average and Pierce in key environmental health indicators such as in nitrate concentrations in public water supplies, fluoridation, and Lyme disease rates. Both counties have over twice the state rates for Lyme disease.

COMMUNITY SURVEY

Primary data was collected via an online and paper survey August-September 2018. The survey was handed out at county fairs, via church and civic email lists, clinic waiting rooms, and to county and hospital employees living within the counties. The survey was translated into Spanish and was available in the paper version. The survey was roughly the same as the survey distributed three years ago to allow for easy historical comparison.

A total of 1,072 people completed the survey. 34% of them were from Pierce and 66% were from St. Croix, which is roughly in line with their population proportions. 80% of the respondents were female and 97% were white. The majority of respondents were 25-64 years old. All income brackets were represented, but many respondents were from households making $50K-$99K a year.

Community members in both counties agreed that the top three community strengths were "Good place to raise children," "Good schools," and "Good place to live." The top three remained consistent with 2015 results.

Community members in both counties strongly ranked drug abuse and mental health as the top community concerns. Pierce residents ranked alcohol use as third, while St. Croix residents ranked obesity/overweight as third. The results differed from the 2015 survey results. Mental health was ranked as top three by only 28% of participants in 2015 versus 45% in 2018. Obesity/overweight was ranked as top three by 36% of participants in 2015 but only 28% in 2018.

Another swing in the data came in a question about health equity. In 2015, the majority (59%) of respondents through health resources were equal for all regardless of race, income, gender and age. In 2018, only 47% of respondents agreed with this statement.

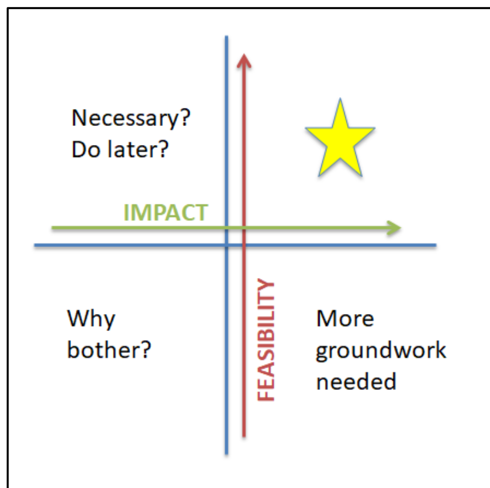
A summary of survey results can be found in Appendix B.

ISSUE PRIORITIZATION AND ROOT CAUSE ANALYSIS

Approximately 50 stakeholders from a variety of organizations representing many sectors attended a workshop in December to view results of secondary and primary data analysis and prioritize health issues for Healthier Together's next Community Health Improvement Plan.

After sharing a data presentation, stakeholders were asked to use a feasibility/impact matrix to rank each health priority from -5 to 5 for both feasibility and impact. Feasibility was defined as the ability for Healthier Together, with existing members, resources, funding and knowledge, to work on this issue. Impact was defined as the corresponding change in morbidity and mortality that would be experienced by our residents, particularly the most vulnerable, if progress was made on this issue. The rating work was done in three small groups. The results were discussed and averaged.

Averages		
Priority Area	**Feasibility Score**	**Impact Score**
Drug Abuse	0.33	3.67
Mental Health	2.67	4.17
Obesity/Overweight	1.67	1.67
Alcohol Abuse	-2.00	2.67
Ability to Get Healthcare	-2.67	3.33



The larger group discussed the results of the scoring. The group decided that pursuing the top three priorities areas, which all scored positively for both feasibility and impact, was sensible. In the same small groups, stakeholders were also asked to discuss which groups in our communities are disproportionally impacted by the top three health issues. Groups cited seniors, youth, those in jail or just out of jail, people with disabilities, people with mental illness or substance use issues, staff at institutions providing direct services and people living in poverty.

Lastly, participants were asked to reorganize into small groups by the three top priorities (mental health, drug abuse and obesity/overweight). Each of these groups was asked to develop a problem statement and conduct a root cause analysis of economic, social, environmental, and policy/systems causes for the problem. The goal of this exercise was to better understand the social determinates of health impacting each issue area.

Results of the health equity and root cause discussions were used for two purposes; to identify focus groups and to inform the implementation planning process to focus on root causes of poor health.

For the group focusing on mental health, root causes of poor mental health discussed included social issues such as intergenerational stress, isolation, increased use of social media, and lack of healthy coping skills. Economic factors such as inequitable wages, stress on farmers, and lack of providers in the area. Policy issues such as lack of access to child care and transportation and high costs of healthcare.

For the group focusing on obesity and overweight, root causes discussed included social issues such as social norms around food as reward/celebration. Environmental issues such as lack of affordable housing near healthy food, food deserts, lack of livable wage jobs and increasing debt. Policy issues such as lack of emphasis on places to be physically active in city planning.

For the group focusing on substance use disorder, root causes of substance use discussed included social issues such as social acceptance of drug use, lack of alternatives for pain management, generational poverty, lack of living wage jobs and affordable housing in the area, social isolation in bedroom communities, and increased bullying in schools. Environmental issues such as lack of transportation options, our proximity to drug trafficking routes, and lack of transitional housing. Economic issues such as income disparity, and policy issues such as lack of coordination among service providers and lack of detox facilities.

Agencies represented at this meeting included:

- St. Croix Central Community Education
- Hudson Hospital & Clinics
- Pierce County Aging and Disability Resource Center
- St. Bridget Catholic Church
- St Croix County Health and Human Services

- Hudson YMCA
- United Way St. Croix Valley
- New Richmond School District
- River Falls School District
- Family Resource Center St. Croix Valley
- Pierce County Public Health
- River Falls Area Ambulance Service
- St. Croix and Pierce County Farm Bureau
- WestCAP
- OEM Fabricators
- Westfields Hospital & Clinic Foundation
- UW Extension
- Gethsemane Lutheran Church
- Pierce County Sheriff's Office
- New Richmond Chamber
- Westfields Hospital & Clinics
- Pierce County Administrative Coordinator
- Baldwin-Woodville School District
- United Way St. Croix Valley
- Our Neighbors Place
- Western Wisconsin Health
- Second Harvest Heartland
- St. Croix Valley Foundation
- Pierce County Human Services
- Western Credit Union (New Richmond)
- Allina Health River Falls Area Hospital
- Ellsworth School District
- Prescott School District
- Work Force Resource
- Hudson School District
- River Falls Police Department
- District 10 State Senator's office representative
- Ellsworth Cooperative Creamery

Following the stakeholder meeting, the Healthier Together Executive Team met to review the results of the exercise with stakeholders. Because many of the root causes of obesity aligned with mental health root causes, the Executive Team decided to combine those wanting to work on obesity issues into a subgroup under the Mental Health Action Team. This move was designed to increase the sustainability of administration of the action teams.

FINAL PRIORITIES

Through this process, two priorities were identified for action in 2020-2022:

1. **Mental health (MH)**
2. **Substance use disorder (SUD)**

KEY COMMUNITY INPUT ON TOP PRIORITIES

After issues were prioritized, focus groups were conducted with populations identified by stakeholders as being information-rich and/or being at higher risk for poor health outcomes. Focus groups included farmers, people over 60, youth, people in recovery from mental health or substance use disorders, providers and people who work with youth. Members of these focus groups ranked goal areas within the priority areas to help Healthier Together narrow our focus within the wide areas of substance use and mental health. Results of the goal area ranking process can be found in Appendix D.

Focus Group Population	Organizational Partners	Number of Participants
Farmers	St. Croix County Farm Bureau Pierce County Farm Bureau	8
People Over the Age of 60	Aging and Disability Resource Center, Spring Valley-Seniors Staying Put	8
People in Recovery from Mental Health Disorders	National Alliance on Mental Illness (NAMI)	8
People in Recovery from Substance Use Disorders	County Behavioral Health Program	2
Substance Use Disorder Treatment Providers	County Behavioral Health Program	4
Youth	Youth Action Hudson	3
Professionals Working with Youth	Youth Mental Health Collaboration, Schools, Hospitals	28

Focus group members were also asked about the root causes of mental health and substance use in our communities. The following themes were identified during these discussions:

The importance of feeling appreciated

- Over and over, focus group members talked about how not feeling appreciated or cared for contributes to mental health and substance use issues. Farmers don't feel appreciated because they aren't paid a decent wage for their work. Seniors can feel forgotten. Youth can feel overlooked and under-appreciated. People said it is important to have others who believe in them, care about them, and appreciate them.

Difficulty in asking for help

- Whether it is youth or adults, we heard that people with substance use disorder (SUD) or mental health issues (MH) don't want to ask for help. They feel the stigma associated with these issues. Seniors who are isolated don't want to be a burden. Farmers are private; they don't want to talk about feelings or finances. Even people in recovery, who had previously sought help, said they were ashamed when they relapsed and resisted asking for help because they didn't want others to know.

The importance of teaching people to recognize the signs and symptoms

- Participants rated these goals the highest:
- Early intervention, education and prevention related to substance use in the community.
- Increase coping skills and stress reduction strategies for all.
- They said these goals could help everyone but suggested focusing on parents, teachers, and youth. For farmers they suggested partnering with other organizations and for

seniors they suggested a more one to one approach, through friends and volunteers helping others.

- Lack of funding and resources continues to be an issue.
- Providers and people in recovery said there is a severe lack of affordable care for treating MH and SUD. Both counties lack providers and treatment options. The state as a whole lacks inpatient beds and treatment facilities. Our hospitals often aren't well-equipped to deal with MH or SUD crises. There are long wait times for treatment after discharge. There aren't enough counselors in our schools to deal with non-school issues.

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLANNING

The Healthier Together Leadership Team collaboratively developed an implementation planning process loosely based on the Mobilizing for Action through Planning and Partnerships (MAPP) framework. Because this process is conducted every three years, a full MAPP process was determined not to be feasible. The modified process consisted of five phases:

Phase	Activities
1: Evaluation of Current Strategies and Goal Brainstorm	Decide whether to adapt, expand or abandon current strategies in the 2017-2019 plan. Propose narrower areas within the priority area in the form of goals based on root cause activity.
2: Finalize Goals and Scan Environment	Finalize goal areas based on focus group feedback and ranking activity. *If the groups want to explore new strategies*, use a structured approach to look at gaps in the prevention continuum.
3: Research	Identify new strategies to fit gaps in the prevention continuum.
4: Agree on New Strategies	Prioritize new ideas based on impact and feasibility.
5: Activity Planning	Using goals and strategies already selected, brainstorm and select intermediate measures and activities, along with timelines and responsibilities. Action teams were asked to consider how each strategy might be tailored to take health equity into consideration.

The planning process resulted in a community health improvement plan with the following structure:

- **Priority:** The area of public health we aim to improve
    - **Goal**: The broad area within priority we wish to focus on
- **Strategy**: The overall intervention
    - **Measure**: A progress or intermediate measure we use to demonstrate success
    - **Activity**: The specific actions that will be taken to complete the strategy

COMMUNITY HEALTH IMPROVEMENT PLAN

The existing mental health action team, along with the physical activity and food insecurity action teams, went through this process as one team. A new substance use disorder action team formed and combined with existing members of the alcohol action team to go through this process. Strategies listed here are initial and will be reviewed and adjusted throughout the three-year plan based on continuous evaluation. Strategies included in the plan focus on prevention and early intervention.

WHY FOCUS ON PREVENTION?

Clinical interventions focus on treating someone who is already sick. The efforts of Healthier Together go farther "upstream" and center on prevention and early intervention. This can be primary prevention - intervening before health effect occurs, or secondary prevention - screening to identify health issues early before serious health consequences take place.

Prevention is difficult work. It requires an understanding of the conditions in which people are born, live, work and play. These conditions are called the "social determinants of health" and include things like income, social status, housing, education, physical environment and access to health care. In Healthier Together's work, it is also critical to examine the risk factors for mental health as mental health conditions and substance abuse are often intertwined.

When done right, prevention is powerful: improving community conditions improves the health of populations, not just individuals. Tackling such big issues requires partners from different sectors to come together to create community conditions that support the health of all people.

Priority Area: Mental Health

Population Health Outcomes:

Number of suicides (baseline is 1 in Pierce, 10 in St. Croix)[1]

Proportion of high school students who report feeling sad or hopeless (1 in 3 for girls, 1 in 5 for boys)[2]

Goal 1: Increase healthy coping skills and stress reduction strategies

Initial strategies include:

- Implementing activities that connect kids to nature
- Promoting the Hopeline
- Providing Dementia Friends and Dementia Live Trainings
- Exploring Bounce Back program components
- Supporting implementation of Taking Care of You courses

Goal 2: Support coordination of mental health care services between schools, providers, and counties

Initial strategies include:

- Continuing Youth Mental Health Collaboration Meetings
- Continuing promotion and support of Make It OK, Mental Health First Aid and school-based resilience programming
- Seeking funding and pilot schools for universal emotional health screenings
- Exploring the use of social-emotional screening tools to providers and schools for children under the age of three

Goal 3: Increase services that promote family stability

Initial strategies include:

- Supporting the roll out and strategic growth of United Way of St. Croix Valley 211
- Searching for funding and a pilot community for a built environment assessment
- Supporting healthy food initiatives in food pantries
- Searching for funding and a pilot community for a built environment assessment
- Supporting healthy food initiatives in food pantries

[1] Wisconsin Vital Records, 2015 data
[2] Centers for Disease Control and Prevention, 2016 Youth Risk Behavior Survey

Priority Area: Substance Use Disorder

Population Health Outcomes:

- Proportion of adults who report binge or heavy drinking (baseline 1 in 4)[3]
- Proportion of high school students who report vaping in the past 30 days (no baseline available)[4]

Goal 1: Advocate for policies that increase access to substance use treatment
Initial strategies include:

- Advocating for Medicaid expansion
- Advocating for first responders and appropriate community members to carry Narcan

Goal 2: Increase early intervention, education and prevention services related to substance use in the community
Initial strategies include:

- Supporting youth alcohol compliance checks and conducting retailer education
- Conducting a scan of substance use screenings being used in the community
- Continuing to identify opportunities to change alcohol ordinances
- Marketing WI Addiction Recovery Help Line through 211
- Educating the community on proper drug storage and disposal
- Coordinating biannual meetings for substance use/mental health providers

Goal 3: Increase coordinated youth prevention work, providing education, healthy activities and resilience training
Initial strategies include:

- Implementing SAMSHA's "Talk. They Hear You." Campaign
- Marketing the DITCHJUUL text service to teens and adults who vape
- Exploring implementation of CATCH My Breath™ in schools and other community settings
- Exploring drug impairment training for education professionals
- Exploring how Healthier Together can support local SADD chapters

RESOURCE COMMITMENTS

Healthier Together, through its member organizations, will commit both financial and in-kind resources during 2020–2022 to ensure effective implementation of its planned activities to meet the goals identified. Resources may include specific programs and services, technical assistance, advocacy efforts, charitable contributions and employee volunteerism offered by individual organizations and staff time devoted to collaborations with others to advance collective work.

EVALUATION OF STRATEGIES

Throughout the implementation phase, both population-level and progress measures will be tracked to document progress toward meeting goals and objectives and make adjustments to the implementation plan as needed. Each strategy will be evaluated annually during a data review and group discussion, which will result in changes to the CHIP as appropriate.

[3] Behavioral Risk Factor Surveillance System, 2016 data
[4] Centers for Disease Control and Prevention, Youth Risk Behavior Survey

HOSPITAL/SYSTEM ORGANIZATIONAL PRIORITIES

Besides the work conducted as Healthier Together, hospitals or health care systems represented on the Healthier Together Executive Team have individual activities related to the improvement of population health. Each hospital or system's priorities outside of their Healthier Together work are included in this document per IRS requirements.

ALLINA HEALTH SYSTEM PRIORITIES

To support local CHNA efforts, Allina Health identifies community health needs consistent across its entire system and identifies systemwide initiatives with which to address these needs. By developing systemwide initiatives, Allina Health ensures efficient use of resources across its service area and provides hospitals with programs they can adapt to meet their community's unique needs. Thus, as part of developing its implementation plan, River Falls Hospital staff met in February and April 2019 with leaders from each of Allina Health's nine community engagement regions to discuss the results of each hospital's data review, prioritization and community input processes. Together, they identified mental health, including substance use, as a priority need in all Allina Health geographies. Additionally, all communities identified social determinants of health, particularly access to healthy food and stable housing, as key factors contributing to health. Obesity caused by physical inactivity and poor nutrition was identified as a priority need in most Allina Health communities.

Based on this process, Allina Health will pursue the following system-wide priorities in 2020-2022:

- **Mental health and substance use**
- **Social determinants of health**
- **Healthy eating and active living**

Below are the system wide goals and strategies that River Falls Hospital will pursue. Though obesity was not identified as a priority in the Healthier Together community, River Falls will address Allina Health's healthy eating and active living priority through its social determinants of health-work, particularly increasing access to healthy food. When implementing activities, consideration is given to how these activities can best support historically underserved communities and reduce health disparities

Mental Health and Substance Use

Goal 1: Increase resilience and healthy coping skills in our communities

Goal 2: Reduce barriers to mental health and substance use services for people in our communities.

Strategies:

- Increase resilience among school-age youth.
- Increase social connectedness and community-wide resilience efforts.
- Decrease stigma associated with seeking help for mental health and substance use conditions, with a particular focus on the experiences of racial and ethnic minorities and other historically underserved communities.
- Increase support of policy and advocacy efforts aimed at improving access to adolescent mental health and substance use services.

Activities:

- Offer Change to Chill programming in at least one Pierce or St. Croix County high school each year and continue to support current Change to Chill schools as requested.
- Enhance and promote Health Powered Kids mental health and wellness programming to Pierce and St. Croix County schools.
- Support grassroots community-based programs around resilience efforts, including social-connectedness.
- Enhance mental health and substance use stigma elimination programming in the Change to Chill program.

- Promote stigma elimination education and messaging in May and October.
- Support and advocate for policies aimed at increasing number of and accessibility to mental health and substance use services.

Social Determinants of Health

Goal: Reduce social barriers to health for Allina Health patients and communities.

Strategies:

- Implement a sustainable, effective model to systematically identify and support patients in addressing their health-related social needs.
- Implement a sustainable network of trusted community partners who are able to support our patients in addressing their health-related social needs.
- Increase support of policy and advocacy efforts aimed at improving social conditions related to health.
- Improve access to healthy food in our communities.

Activities:

- Support the successful implementation and evaluation of the Accountable Health Communities model at participating sites.
- Champion development of and support transition to an Allina Health system-wide strategy and care model to identify and address the health-related social needs of our patients.
- Implement a process to identify key community partners and support their sustainability through financial contributions, exploration of reimbursement models, employee volunteerism and policy advocacy.
- In partnership with Allina Health and community stakeholders, design and implement a process to facilitate tracked referrals to connect patients to community resources.
- Participate in and support community coalitions aimed at improving access to transportation, housing and food, including connecting Allina Health resources, expertise and data to these groups as appropriate.
- Work with community organizations to improve access to healthy food in the communities we serve through grant-making, charitable contributions, employee volunteer opportunities and innovative community partnerships.

HUDSON HOSPITAL & CLINIC PRIORITIES

HealthPartners collaborated across six hospitals within its family of care for the Community Health Needs Assessment (CHNA). Each hospital engaged with local public health partners, local health organizations and community members for input on community assets and resources as well as primary and secondary data. HealthPartners hospitals used a thorough, facilitated large and small group process to reach consensus on top priorities. The CHNA Team considered the criteria described above as well as community input data in these discussions. The five priorities are of equal importance and are presented in alphabetical order:

- **Access to care**
- **Access to health**
- **Mental health and well-being**
- **Nutrition and physical activity**
- **Substance abuse.**

Priority: Access to Care

Definition: Access to care refers to having equitable access to appropriate, convenient and affordable health care. This includes factors such as proximity to care, access to providers, cost, insurance coverage, and medical transportation, care coordination within the health care system and cultural sensitivity and responsiveness.

Goal: Help our organization achieve its full potential by ensuring that every person who touches our organization feels welcomed, included, and valued.

Strategies:

- Develop the equity and inclusion acumen of our people.
- Build a diverse recruitment, development and retention strategy.
- Continue our work to support learning and development for Leaders and Non-leaders.

Goal: Improve access to care that is appropriate, affordable, and convenient.

Strategies:

- Advance consumer friendly initiatives to make our care easy to navigate and affordable
- Evaluate and adapt system capacity and design to meet patient needs.
- Educate communities about advanced care planning.
- Explore alternative care delivery methods.

Priority: Access to Health

Definition: Access to health refers to the social and environmental conditions that directly and indirectly affect people's health, such as housing, income, employment, education and more. These factors, also referred to as social determinants of health, disproportionately impact low income communities and communities of color.

Goal: Strengthen existing and explore new community partnerships to address social determinants of health.

Strategies:

- Standardize hunger screening and referral process with community partners.
- Develop and deepen community partnerships to address social determinants in our efforts to eliminate health disparities (transportation, housing, food, etc.).

Goal: Promote early child brain development.

Strategies:

- Incorporate early childhood resources into clinics and community.
- Sustain the Children's Health Initiative.
- Partner to connect families of infants and young children to community resources.

Goal: Promote sustainable operations to positively impact the community.

Strategies:

- Implement practices that utilize resources efficiently, minimize waste and engage stakeholders.
- Engage community to leverage strength and build relationships.
- Partner with local Green Teams to increase outreach and partnership.

Priority: Mental Health and Well-Being

Definition: Mental health and well-being refers to the interconnection between mental illness, mental health, mental well-being and the associated stigma. Poor mental health is associated with poor quality of life, higher rates of chronic disease and a shorter lifespan.

Goal: Reduce stigma surrounding mental illness.

Strategies:

- Expand and deepen Make It Ok anti-stigma campaign.
- Develop and deepen community partnerships to reduce stigma.

Goal: Increase access to education and resources around mental health and well-being.

Strategies:

- Offer HealthPartners online program for members, patients and employees
- Increase staff knowledge and awareness of mental health and wellbeing.
- Develop and deepen community partnerships to improve mental health and wellbeing (Healthier Together, etc.).

Goal: Improve access to mental health services.

Strategies:

- Improve access to mental health services for patients in crisis.
- Expand alternative care delivery methods.
- Increase internal and external awareness of existing services.

Priority: Nutrition and Physical Activity

Definition: Nutrition and physical activity refers to equitable access to nutrition, physical activity and food and feeding choices. Poor nutrition and physical inactivity are major contributors to obesity and chronic diseases such as diabetes, heart disease and stroke, which disproportionally impact low income communities and communities of color.

Goal: Promote and support physical activity.

Strategies:

- Support and engage communities and schools through PowerUp programs and partnerships.
- Deepen the impact of PowerUp to increase and measure community health improvement.
- Partner to provide free and low-cost physical activity opportunities.
- Partner to increase awareness of physical activity resources.

Goal: Promote and support better eating.

Strategies:

- Support and engage communities and schools through PowerUp programs and partnerships.
- Deepen the impact of PowerUp to increase and measure community health improvement.

Goal: Support and encourage healthy food and physical activity environment change.

Strategies:

- Develop and deepen community partnerships to create healthy communities (Restaurants, local government, schools, etc.).
- Support and positively influence policies that impact health and wellness.

Goal: Promote breastfeeding.

Strategies:

- Offer educational opportunities for women and families.

Priority: Substance Abuse

Definition: Substance abuse and addiction are the excessive use of substances including alcohol, tobacco, prescription drugs, opioids and other drugs in a manner that is harmful to health and well-being.

Goal: Reduce opioid prescriptions, doses, and patients meeting chronic opioid use criteria.

Strategies:

- Reduce the supply of opioids.
- Treat pain differently.
- Address addiction.
- Educate patients, families, staff and members.

Goal: Increase awareness and access of treatment for substance abuse (alcohol, tobacco, e-cigarettes, and drugs).

Strategies:

- Increase awareness of available resources
- Provider training
- Support Healthy Beginnings Program
- Educate patients, families, community and staff on substance abuse.
- Expand Substance Use Disorder treatment services.

Goal: Align efforts and collaborate with community partners.

Strategies:

- Partner with Healthier Together and County to explore alcohol policies and ordinances.

Goal: Reduce accidental poisoning and drug abuse.

Strategies:

- Offer free and environmentally-friendly medication collection at our hospitals and clinics for the community.
- Promote community prescription take-back locations and disposal bags.

WESTERN WISCONSIN HEALTH PRIORITIES

Western Wisconsin Health's strategic vision is to stay an independent organization, and partner with others to be:

- A Regional Leader in HEALTH AND WELLNESS
- The First Stop and Best Partner for ACUTE CARE SERVICES
- A leader in Exceptional, Holistic Management of CHRONIC DISEASE

The implementation plan for this strategic plan includes a focus on long term viability, increasing meaningful service offerings, and demonstrating value to our community, customers and payers which includes a focus on improving the overall health of the communities we serve. We adopt Healthier Together Pierce-St. Croix Counties Coalition CHIP in addition to our specific organization wide goals and strategies.

Western Wisconsin Health will pursue the following organization-wide community health priorities in 2020-2022:

- **Mental health**
- **Substance use disorder**

Priority: Mental Health

Goal 1: Increase resilience and healthy coping skills in our region.

Strategy 1: Increase resilience and coping skills among school-age youth.

Activities:

- Offer Resilience training programming to local schools.
- Offer mental health and wellness programming to local schools.

Strategy 2: Increase coping and resilience skills in all age groups.

Activities:

- Offer Mindfulness training classes, Resilience training classes, and other mental health or coping skill-based classes to the community.
- Provide comprehensive coping, resilience based, and healthy lifestyle classes to all Western Wisconsin Health staff.

Strategy 3: Increase affordable opportunities for community members to engage in an active lifestyle to improve mental health.

Activities:

- Build walking/biking trail on WWHealth campus to connect to Wintergreen Park in Baldwin.
- Increase fitness center and therapeutic pool variety of classes for all ages and abilities.

Goal 2: Increase access to mental health services in our region through increased collaboration with schools and community partners.

Strategy 1: Implement and expand school based mental health services in local schools.

Activities:

- Collaborate with Baldwin-Woodville and other local school districts to provide mental health services in schools.

Strategy 2: Hire additional Behavioral Health providers to ensure adequate access for outpatient services.

Activities:

- Hire licensed social worker to cover school based mental health services.
- Hire additional psychiatry support.
-

Goal 3: Increase wellness service offerings that promote family stability.

Strategy 1: Improve access to healthy food and improve food security in our community.

Activities:

- Expand Food Security screening questions to all departments at WWH.
- Sustain "We Care Bags" program and referral program for patients.

Strategy 2: Increase parenting support class opportunities.

Activities:

- Increase Parenting Support group meetings that include childcare.

- Collaborate with Family Resource Center for prenatal, birth center, and postpartum services.
- Offer "Realizing Resilience" classes for women's health patients.

Priority: Substance Use Disorder

Goal 1: Increase access to substance use disorder services in our region.

Strategy 1: Partner to provide substance use disorder outpatient services locally.

Activities:

- Offer outpatient substance use disorder individual and group visits.
- Support and advocate for policies aimed at improving access to and reimbursement for substance use disorder services.

Strategy 2: Increase outpatient service access for Integrative Health services.

Activities:

- Create affordable integrative health service packages for both preventative care and in conjunction with substance use treatment.

Goal 2: Increase early intervention, education and prevention services related to substance use in the community.

Strategy 1: Increase access to integrative and holistic services for pain management for inpatient and outpatient services to reduce the use of pain medications.

Activities:

- Expand acupuncture and other integrative services to ED and Surgery departments.
- Increase use of robotic surgery in effort to reduce post-surgical pain.

WESTFIELDS HOSPITAL PRIORITIES

HealthPartners collaborated across six hospitals within its family of care for the Community Health Needs Assessment (CHNA). Each hospital engaged with local public health partners, local health organizations and community members for input on community assets and resources as well as primary and secondary data. HealthPartners hospitals used a thorough, facilitated large and small group process to reach consensus on top priorities. The CHNA Team considered the criteria described above as well as community input data in these discussions. The five priorities are of equal importance and are presented in alphabetical order:

- **Access to care**
- **Access to health**
- **Mental health and well-being**
- **Nutrition and physical activity**
- **Substance abuse.**

Priority: Access To Care

Definition: Access to care refers to having equitable access to appropriate, convenient and affordable health care. This includes factors such as proximity to care, access to providers, cost, insurance coverage, and medical transportation, care coordination within the health care system and cultural sensitivity and responsiveness.

Goal: Help our organization achieve its full potential by ensuring that every person who touches our organization feels welcomed, included, and valued.

Strategies:

- Develop the equity and inclusion acumen of our people.
- Build a diverse recruitment, development and retention strategy.
- Continue our work to support learning and development for Leaders and Non-leaders.

Goal: Improve access to care that is appropriate, affordable, and convenient.

Strategies:

- Advance consumer friendly initiatives to make our care easy to navigate and affordable
- Evaluate and adapt system capacity and design to meet patient needs.
- Educate communities about advanced care planning.
- Explore alternative care delivery methods.

Priority: Access to Health

Definition: Access to health refers to the social and environmental conditions that directly and indirectly affect people's health, such as housing, income, employment, education and more. These factors, also referred to as social determinants of health, disproportionately impact low income communities and communities of color.

Goal: Strengthen existing and explore new community partnerships to address social determinants of health.

Strategies:

Standardize hunger screening and referral process with community partners.

- Develop and deepen community partnerships to address social determinants in our efforts to eliminate health disparities (transportation, housing, food, etc.).
- Explore opportunities for community giving and volunteerism.

Goal: Promote early child brain development.

Strategies:

- Incorporate early childhood resources into clinics and community.
- Sustain the Children's Health Initiative.
- Partner to connect families of infants and young children to community resources.

Goal: Promote sustainable operations to positively impact the community.

Strategies:

- Implement practices that utilize resources efficiently, minimize waste and engage stakeholders.
- Engage community to leverage strength and build relationships.
- Partner with local Green Teams to increase outreach and partnership.

Priority: Mental Health and Well-Being

Definition: Mental health and well-being refers to the interconnection between mental illness, mental health, mental well-being and the associated stigma. Poor mental health is associated with poor quality of life, higher rates of chronic disease and a shorter lifespan.

Goal: Reduce stigma surrounding mental illness.

Strategies:

- Expand and deepen Make It Ok anti-stigma campaign.
- Develop and deepen community partnerships to reduce stigma.

Goal: Increase access to education and resources around mental health and well-being.

Strategies:

- Offer HealthPartners online program for members, patients and employees
- Increase staff knowledge and awareness of mental health and wellbeing.
- Develop and deepen community partnerships to improve mental health and wellbeing (Healthier Together, CHAT, Living Well Together, etc.).

Goal: Improve access to mental health services.

Strategies:

- Improve access to mental health services for patients in crisis.
- Expand alternative care delivery methods.
- Increase internal and external awareness of existing services.
- Explore opportunities to increase mental and behavioral health resources in schools.

Priority: Nutrition and Physical Activity

Definition: Nutrition and physical activity refers to equitable access to nutrition, physical activity and food and feeding choices. Poor nutrition and physical inactivity are major contributors to obesity and chronic diseases such as diabetes, heart disease and stroke, which disproportionally impact low income communities and communities of color.

Goal: Promote and support physical activity.

Strategies:

- Support and engage communities and schools through PowerUp programs and partnerships.
- Deepen the impact of PowerUp to increase and measure community health improvement.
- Partner to provide free and low-cost physical activity opportunities.

- Partner to increase awareness of physical activity resources.
- Collaborate with community stakeholders in an effort to improve outdoor spaces and trails.

Goal: Promote and support better eating.

Strategies:

- Support and engage communities and schools through PowerUp programs and partnerships.
- Deepen the impact of PowerUp to increase and measure community health improvement.
- Expand community education offerings around better eating.

Goal: Support and encourage healthy food and physical activity environment change.

Strategies:

- Develop and deepen community partnerships to create healthy communities (Restaurants, local government, schools, etc.).
- Support and positively influence policies that impact health and wellness.

Goal: Promote breastfeeding.

Strategies:

- Offer educational opportunities for women and families.
- Explore baby-friendly hospital status.

Priority: Substance Abuse

Definition: Substance abuse and addiction are the excessive use of substances including alcohol, tobacco, prescription drugs, opioids and other drugs in a manner that is harmful to health and well-being.

Goal: Reduce opioid prescriptions, doses, and patients meeting chronic opioid use criteria.

Strategies:

- Reduce the supply of opioids.
- Treat pain differently.
- Address addiction.
- Educate patients, families, staff and members.

Goal: Increase awareness and access of treatment for substance abuse (alcohol, tobacco, e-cigarettes, and drugs).

Strategies:

- Increase awareness of available resources
- Provider training
- Support Healthy Beginnings Program
- Educate patients, families, community and staff on substance abuse.
- Expand Substance Use Disorder treatment services.

Goal: Align efforts and collaborate with community partners.

Strategies:

- Partner with Healthier Together and County to explore alcohol policies and ordinances.
- Partner with schools on substance abuse prevention and education

Goal: Reduce accidental poisoning and drug abuse.

Strategies:

- Offer free and environmentally-friendly medication collection at our hospitals and clinics for the community.
- Promote community prescription take-back locations and disposal bags.
- Keeping chemicals out of the environment.
- Prevent medication from being misused.
- Lower occurrence of overdose.

CONCLUSION

Healthier Together will work diligently to address the identified needs prioritized in this process by taking action on the goals and objectives outlined in this plan.

For questions about this plan or implementation progress, please contact a member of the Healthier Together Leadership Team:

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Copies of this plan can be downloaded from our website: healthier2gether.org.

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Healthier Together would like to thank many partners who made this assessment and plan possible:

- Individual community members who offered their time and valuable insights;
- Partner organizations that met to review and prioritize data and develop implementation plans and the individuals who contributed their expertise and experience to ensure a thorough and effective outcome;
- Member organization's staff who provided knowledge, skills and leadership to bring the assessment and plan to fruition;
- Members of the CHNA steering team, representing the four hospitals, United Way of St. Croix Valley, and two public health departments in the two-county region;
- Mary Anne Casey, PhD, and Richard Krueger, PhD, for assisting in focus group facilitation training and write-up.

APPENDICES

Appendices referenced in this document are available on Healthier Together's website: healthier2gether.org.

- Appendix A: Community Health Needs Assessment Survey
- Appendix B: Community Health Needs Assessment Survey Data
- Appendix C: Community Health Data Dashboard
- Appendix D: Focus Group Summary
- Appendix E: Analysis of Health Equity Data
- Appendix F: Assets and Resources

United Way
St. Croix Valley

WESTERN WISCONSIN HEALTH

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