RIVER FALLS AREA HOSPITAL
PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Community Health Needs Assessment and Implementation Plan 2014–2016

Pierce County health department

Allina Health
RIVER FALLS AREA HOSPITAL

WESTERN WISCONSIN

Assessment Summary

The Pierce County community health needs assessment (CHNA) was conducted in conjunction with River Falls Area Hospital and the Pierce County Public Health Department using the input from community members, community organizations, internal stakeholders from the public health department, and internal stakeholders at River Falls Area Hospital. These partners assisted in the determination of community health improvement priorities and the development of the implementation plan.

River Falls Area Hospital partnered with Wilder Research, a branch of the Amherst H. Wilder Foundation, to conduct community health dialogues in the Western Wisconsin region. Wilder Research developed the dialogue plan and materials, provided technical assistance related to recruitment strategies, facilitated the dialogues with the assistance of table hosts from River Falls Area Hospital and the Pierce County Public Health Department, and synthesized the information into a report.

The Pierce County Public Health Department received funding through the Wisconsin Nutrition, Physical Activity, and Obesity Program to implement the CHANGE (Community Health Assessment aNd Group Evaluation) assessment to gain an understanding of Pierce County's needs and assets relating to physical activity and nutrition. The CHANGE tool, developed by CDC's Healthy Communities Program, helped organize information on indicators related to policies and environments that support healthy eating, active living, and chronic disease management. CHANGE "action members" include representatives from the Pierce County Public Health Department, River Falls Area Hospital, River Falls Medical Clinic, Ellsworth School District, UW–River Falls, UW–Extension, Chippewa Valley Technical College/ UW–Eau Claire Interns, and the Allina Health Healthy Community Partnerships.

See Appendix A for details on the CHNA partners. All appendices can be found on the Allina Health website (**allinahealth.org**).

LEAD PARTIES ON THE ASSESSMENT

Heather Logelin, director, Foundation and Community Engagement, River Falls Area Hospital

Amy Hess, public health nutritionist, Pierce County Public Health Department

Sue Galoff, director and health officer, Pierce County Public Health Department

Melissa Hutchison, manager, Community Benefit, System Office, Allina Health

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John Salisbury, student intern, System Office, Allina Health

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2012 River Falls Area Hospital Benchmarks

Licensed Hospital Beds
25

Employees
270

Medical Staff
174

Volunteer Auxiliary Members
113

Babies Delivered
212

Emergency Department Visits
5,709

Infusion Therapy Visits
2,722

Sleep Studies
29

Patient Meals Served
10,904

Pounds of Patient Linens Laundered
197,356

Inpatient surgeries
461

Outpatient Surgeries
1,322

Inpatient Admissions
1,135

Lab tests
51,770

Radiology Procedures
23,442

Charity Care Patients
322

Uncompensated Care
$2.63

Wellness Center Visits
24,982

About River Falls Area Hospital

1629 East Division Street
River Falls, WI 54022

River Falls Area Hospital, founded in 1939, has evolved from a small city hospital to a larger regional hospital. River Falls Area Hospital is a part of Allina Health, a not-for-profit health system dedicated to the prevention and treatment of illness through its family of clinics, hospitals, care services and community health improvement efforts in Minnesota and western Wisconsin.
The River Falls health care campus includes the River Falls Area Hospital, River Falls Medical Clinic, a number of specialty provider partners and the Kinnic Health & Rehab Facility.

The current campus opened in September of 1992 and operates 25 beds as a critical access hospital. River Falls Hospital has more than 250 employees and 156 doctors on staff.

The focus of the hospital, clinic and specialty partners is to deliver exceptional health care, support services and preventive care – putting the patient first in everything. The health center provides an integrated personalized approach to patient care, where hospital staff, doctors, clinic staff, long-term care and rehabilitation/wellness services is provided in unison.

River Falls Area 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. One of the hospital's most visible and extensive efforts has been the creation and ongoing support of a free medical clinic to provide primary care to uninsured and underinsured residents of Pierce and St. Croix Counties. Other examples of work to improve community health include a falls prevention program for local seniors; a concussion prevention and management program; a summer strengthening program to prevent injuries in local student athletes; a community-based CPR/AED training program; and the Allina Health "Healthy Communities Partnership" worksite wellness initiative.

AFFILIATED CLINICS:

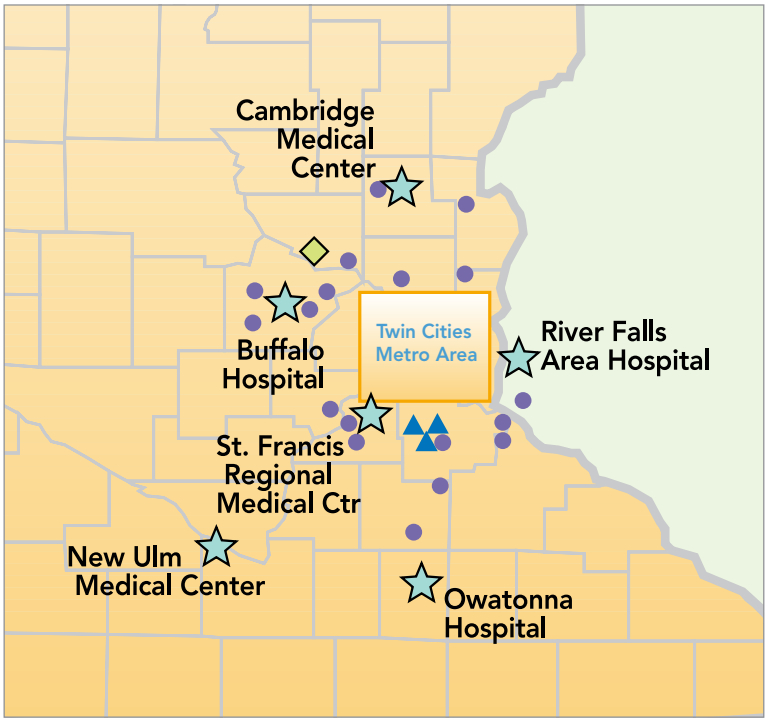
- River Falls, Ellsworth and Spring Valley Medical Clinics
  rfmc.org
- Allina Medical Clinic – Prescott
  allinahealth.org/ahs/medicalservices.nsf/page/AMC_Prescott

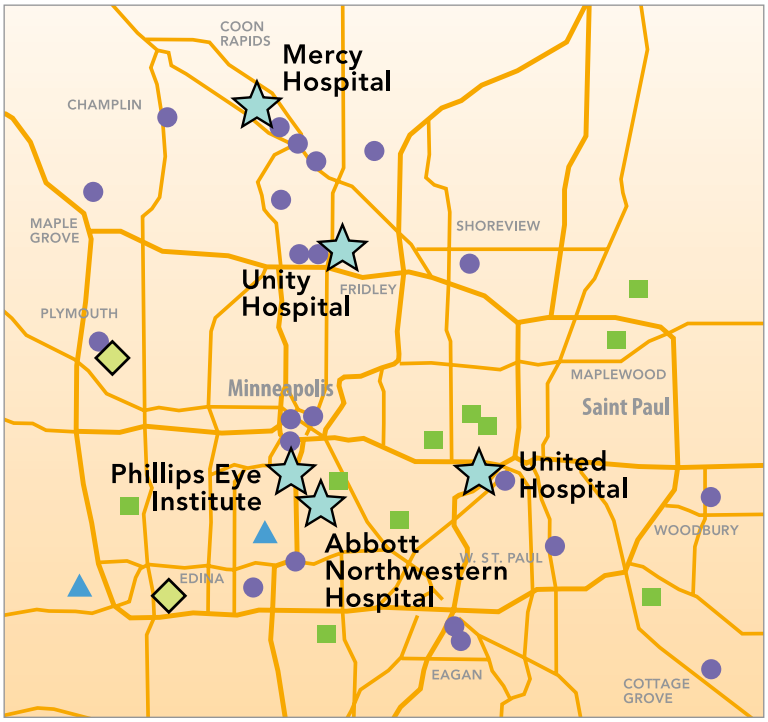
Allina Health and River Falls Area Hospital Service Area

River Falls Area Hospital is part of Allina Health, a not-for-profit health system of clinics, hospitals and other health and wellness services, providing care throughout Minnesota and western Wisconsin.

Allina Health cares for patients and members of its communities from beginning to end-of-life through:

- 90+ clinics
- 11 hospitals
- 14 pharmacies
- specialty medical services, including hospice care, oxygen and home medical equipment and emergency medical transportation
- community health improvement efforts



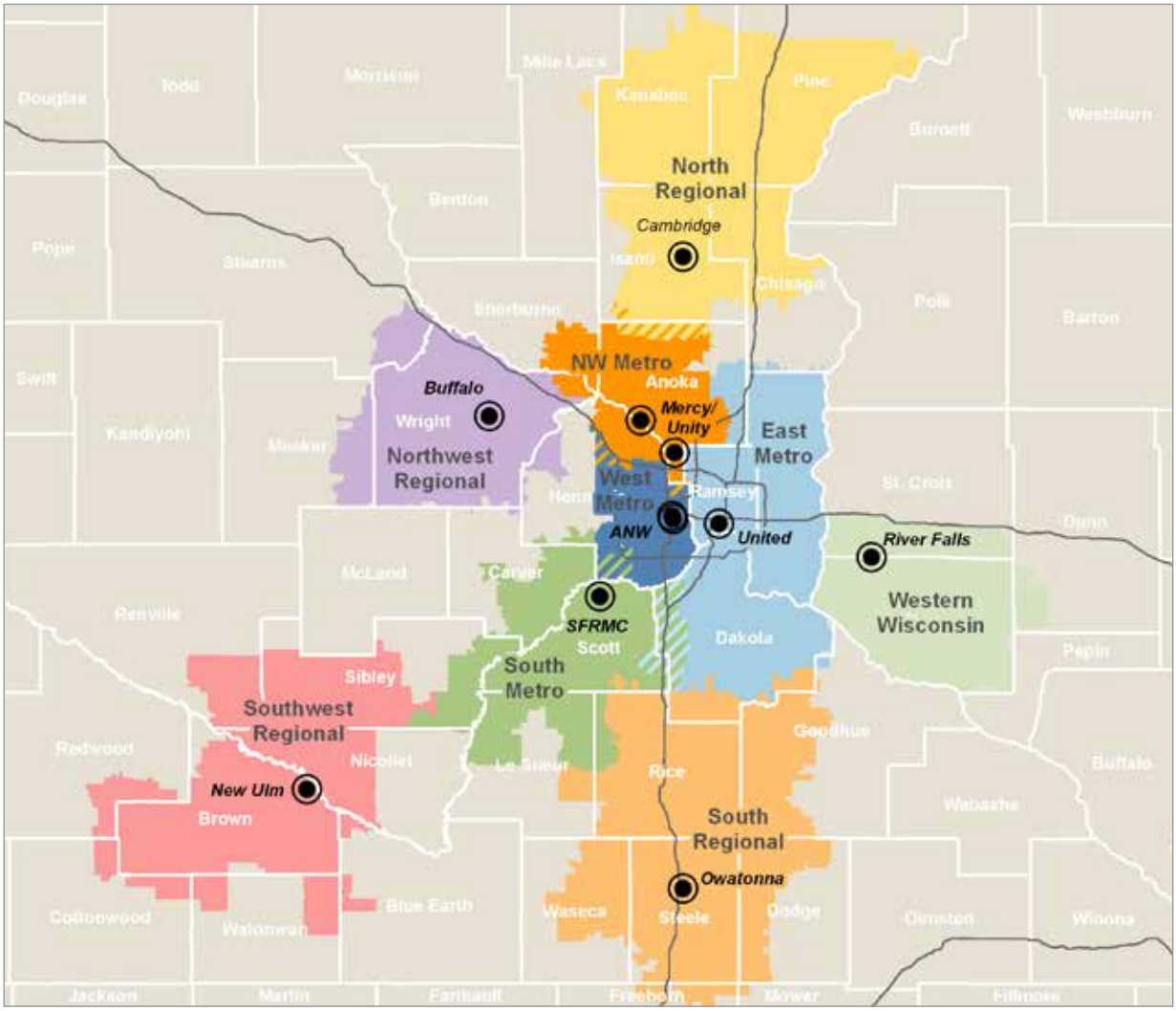


- Allina Health Hospital
- Allina Health Ambulatory Care Center
- Allina Medical Clinic
- Aspen Medical Group
- Quello Clinic

Description of Community Served by River Falls Area Hospital

For the purposes of community benefit and engagement, Allina Health divides its service area into nine regions.

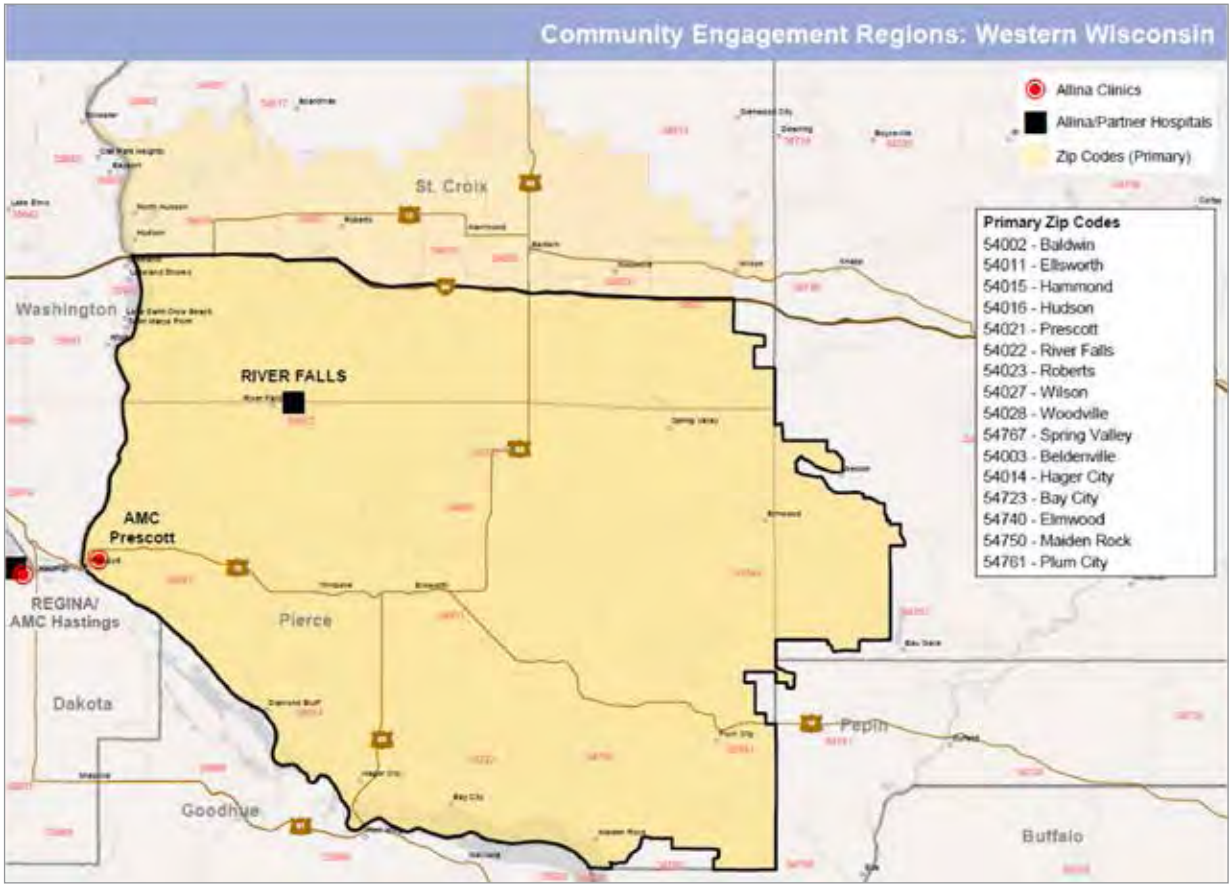
FIGURE 1: COMMUNITY BENEFIT & ENGAGEMENT REGIONAL MAP



The region associated with River Falls Area Hospital is known as the Western Wisconsin Region and primarily serves Pierce County and Southern St. Croix County in Wisconsin. For the Western Wisconsin Region Community Health Needs Assessment (CHNA), the focus of inquiry was Pierce County.

The focus was narrowed to Pierce County because this county comprises the bulk of River Falls Area Hospital's service area. Also, St. Croix County had recently completed a separate health needs assessment, engaging all four hospitals located in the county, including River Falls Area Hospital. In contrast, Pierce County was just about to launch its health needs assessment, and there are no hospitals located in Pierce County. (River Falls Area Hospital is located in St. Croix County, sits on the border of the two counties, in a city that is divided by the county line.) This assessment was therefore led in collaboration with the Pierce County Public Health Department.

FIGURE 2: WESTERN WISCONSIN REGION MAP



About Pierce County Public Health Department

Pierce County Office Building
412 West Kinne Street
Ellsworth, WI 54011

River Falls Health Office
174 South Riverwalk
River Falls, WI 54022

It is the mission at Pierce County Public Health to assure the health of the public, prevent disease and injury, promote healthy behaviors and protect against environmental hazards.

PIERCE COUNTY COMMUNITY COLLABORATIONS AND COALITIONS

- Breastfeeding Coalition
- CARES (Creating a Responsive and Effective System)
- Healthy Eating, Active Living (HEAL) Community Health Initiative
- Hunger Prevention Council
- Pierce/St. Croix Immunization Coalition
- Pierce County Partnership for Youth
- Partnership for Family Teaming
- Success by Six
- UW-River Falls Sexual Assault Coalition
- Western Wisconsin Working for Tobacco-free Living

PIERCE COUNTY PUBLIC HEALTH PRIORITIES

- Communicable Disease Prevention & Control
- Environmental Health
- Inspection & Licensing
- Injury Prevention
- Women, Infants, & Children (WIC) Nutrition Program
- Prenatal Care Coordination (PNCC)
- Birth to Three Program
- Reproductive Health
- Community Health Assessment and Planning
- Home Healthcare

According the 2013 County Health Rankings, Pierce County residents are among the healthiest in the state. Wisconsin's top healthiest counties are Ozaukee, Kewaunee, St. Croix, Pierce, and Door. Even with our high rankings, we still have much work to do with a 26% adult obesity rate. Pierce County is the scenic gateway to Western Wisconsin. It is home to more than 40,000 residents, good schools including the University of Wisconsin – River Falls, and some of the most productive farms in the state. For the sportsman, boating on the beautiful St. Croix River is an unforgettable experience with the confluence of the Mississippi and the St. Croix rivers being located in Prescott, WI. Further East, World Class trout fishing is enjoyed on the Kinnickinnic, Trembel, and Rush rivers.

Most measures of economic well-being are better in Pierce County than the comparable Wisconsin averages. Median household income is higher, SNAP usage is lower, and unemployment rates are lower.

US CENSUS BUREAU 2007-2001 DATA:

- Median household income: $61,443
  Wisconsin: **$52,374**
- Persons below poverty level: 10.5%
  Wisconsin: **12.0%**
- High School graduate or higher (ages 25+): 93.4%
  Wisconsin: **89.8%**
- Bachelor's degree or higher (ages 25+): 26.6%
  Wisconsin: **26.0%**

Assessment Process

The Allina Health System Office CHNA Team developed a template plan for the 11 hospitals within the system. This plan was based on a set of best practices for community health assessment developed by the Catholic Health Association with the purpose of identifying two to three regional priority areas to focus on for FY 2014–2016. The process was designed to rely on existing public data, directly engage community stakeholders and collaborate with local public health and other health providers. From there, each hospital was responsible for adapting and carrying out the plan within their regions. The Western Wisconsin Region Community Engagement Lead guided the effort for River Falls Area Hospital in collaboration with leadership from the Pierce County Public Health Department.

The assessment was conducted in three stages: data review and setting priorities, community health dialogues, and action planning. The process began in April of 2012 with the development of the plan and was completed in August 2013 with the final presentation of the assessment and action plan to the Pierce County Board of Health, the Community Engagement Committee of the River Falls Area Hospital's Board of Trustees, and the River Falls Area Hospital Board of Trustees. The following is a description of the assessment steps and timeline.

PHASE 1 — DATA REVIEW AND PRIORITY-SETTING

MAY – JULY 2012

DATA COLLECTION

Compiled existing county-level public health data, developed regional data packets, invited internal and external stakeholders to data review and issue prioritization meetings

SEPTEMBER 2012

DATA REVIEW

Reviewed data packets with stakeholders, selected initial list of regional health-related needs and priorities, identified additional data needs

OCTOBER 2012

ISSUE PRIORITIZATION

Reviewed revised data packet and completed formal prioritization process with stakeholders

PHASE 2 — COMMUNITY HEALTH DIALOGUES

JANUARY – MARCH 2013

DATA COLLECTION

Conducted community health dialogues and CHANGE assessment related to priority areas identified in the data review and prioritization process

APRIL 2013

REPORT PRODUCTION

Developed report of findings from needs assessment and community dialogues

PHASE 3 — ACTION PLANNING

APRIL – JUNE 2013

IMPLEMENTATION/PLAN

Internal and external stakeholders reviewed report and developed strategies to address health needs

AUGUST – DECEMBER 2013

APPROVAL

Presented implementation plans to local boards/committees/leaders for approval (August 2013) and sent to Allina Health Board of Directors for final approval (December 2013)

Data Review and Priority-Setting

The first phase in the process was to review data in order to determine two to three regional priority areas. Best practices for community health needs assessments state that this process begins with a systematic look at data related to the health of community members. This allows stakeholders to both understand the demographic profile of the community and compare and contrast the effect of health-related issues on the overall well-being of the community. The data review process then allows the stakeholders to make data-driven decisions about the priority areas.

Data Collection and Review

For this phase in the process, the process leads did not collect primary data, but instead compiled existing public health data to create a set of indicators specific to health in Pierce County. Stakeholders were given this set of indicators, which they reviewed prior to and during meetings, to gain a sense of current health needs. These data sets included:

WISCONSIN PUBLIC HEALTH COUNTY PROFILES

(http://www.dhs.wisconsin.gov/localdata/pubhlthprofiles.htm)

These county profiles, which describe the characteristics of individual counties, their economic development region, statewide and the nation. Each report contains data on:

- Demographics: age, gender, race and foreign born
- Socio-economic status: income, education and occupation
- Health status: birth rate and morbidity

These data provided standard set of indicators to review across our service area. For a full list of the indicators used, see Appendix B.

COUNTY HEALTH RANKINGS

The County Health Rankings (http://www.countyhealthrankings.org/) rank the health of nearly every county in the nation and show that much of what affects health occurs outside of the doctor's office. The County Health Rankings confirm the critical role that factors such as education, jobs, income and environment play in how healthy people are and how long they live.

Published by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, the Rankings help counties understand what influences how healthy residents are and how long they will live. The Rankings look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, access to healthier foods, air pollution levels, income, and rates of smoking, obesity and teen births. The Rankings, based on the latest data publically available, provided assessment stakeholders information on the overall health of Pierce County and comparison data for other counties in the state. See Appendix C for 2012 County Health Rankings data for Pierce County

The stakeholder group also reviewed the most recent community health improvement plans for both Saint Croix and Pierce County (See Appendices D and E).

Based on the review of data over the course of these meetings, the community health assessment group identified thirteen issues to be considered in the next step of the prioritization process.

1. Access to health care
2. Alcohol
3. Chronic disease
4. Drug use
5. Elder care
6. Falls prevention
7. Mental health
8. Healthy foods
9. Motor vehicle safety
10. Obesity
11. Physical inactivity
12. Safety/violence
13. Tobacco

Prioritization Process

In order to systematically select priorities, the community health assessment group used two approaches: the Hanlon Method and group discussion questions. These were chosen to allow participants to assign a numeric value to each priority issue, but also to ensure that participants engaged in a deeper discussion about how each issue fit within the mission and role of both the hospital and the local public health department.

THE HANLON METHOD

The Hanlon Method is a prioritization process which objectively takes into consideration explicitly defined criteria and feasibility factors. The Hanlon Method is used when the desired outcome is an objective list of health priorities based on baseline data and numerical values. For a more detailed description of this process see Appendix F. The method has three major objectives:

- to allow decision-makers to identify explicit factors to be considered in setting priorities
- to organize the factors into groups that are weighted relative to each other
- to allow the factors to be modified as needed and scored individually.

The Hanlon Method ranks health-related issues based on three criteria:

Component A = Size of the problem

Component B = Seriousness of the problem

Component C = Estimated effectiveness of the solution

Each possible priority is given a numerical score for each component and combined to provide a composite numerical score for each priority. (See Appendix G for full list of health issues and ranked scores.)

DISCUSSION QUESTIONS

Participants were asked to consider the numerical rankings for each issue along with the following questions in choosing their final two to three priority issues. This allowed stakeholders the chance to consider health issues that may have a great impact on their community, but fell short of the top three identified in the ranking method. These questions were based on a set of questions which are commonly used in conjunction to Hanlon-based prioritization work (http://www.naccho.org/topics/infrastructure/CHAIP/upload/Final-Issue-Prioritization-Resource-Sheet.pdf):

- Does work on this issue fit within our mission? Does this fit within work we're already doing?
- What is our role? Leader, partner or supporter? What are the opportunities for collaboration?
- What's the economic impact of the issue? What's the cost to address the problem? What are the costs associated with not doing anything?
- Will the community accept and support our efforts on this issue?
- Does work on this issue provide an opportunity to address the health needs of vulnerable populations? Can we impact barriers to health for groups around this issue?
- Are there legal implications involved in addressing the health issue? (e.g., HIPAA)

Notes from this discussion can be found in Appendix H.

The stakeholder group also received and reviewed "Framing CHNA's in the Context of Healthcare Equity," a document providing background and recommendations regarding consideration of healthcare inequities throughout the CHNA process. (see Appendix I). This report was to be used as a resource when considering the needs of vulnerable populations in the region.

Priority Health Needs for 2014–2016

Upon completion of the prioritization process, stakeholders determined the following two community health priority needs:

1. Physical activity

Physical activity received the highest score in the Hanlon Prioritization Process. The stakeholders identified physical activity as the top priority due the fact that interventions targeting physical activity have a wide range of effects on other important issues, such as mental health, obesity and chronic disease. Also, River Falls Area Hospital, as part of Allina Health, has a history of creating effective programs which address this program in specific population, such as Health-Powered Kids, which encourages physical movement and activity among grade-school aged children. Stakeholders were specifically interested in how River Falls Area Hospital, the Pierce County Public Health Department and other community partners could address barriers to physical activity, such as environmental factors that prevent walking and biking, motivation, socioeconomic factors and cultural barriers.

2. Healthy foods

Healthy Foods received the third-highest score in the Hanlon Prioritization Process. Obesity was the second-highest scoring priority, and stakeholders felt that focusing on both physical activity and healthy foods would also allow the community to address issues related to obesity. The stakeholders felt that this issue fits well with the mission of both River Falls Area Hospital and the Pierce County Public Health Department. Stakeholders also felt that as one of the largest health care providers in the community, River Falls Area Hospital is in a unique position to effective address this issue.

Also considered was the ability to work with existing health improvement efforts in the community, such as the Healthy Communities Partnership, an Allina Health worksite wellness program focused on nutrition, exercise, smoking and alcohol. Stakeholders also identified a high level of perceived readiness around issues of nutrition and physical activity, and also a need to increase awareness regarding the cost/burden to society, which will create not only a personal urgency but also community-level urgency.

Finally, all the priority health needs were chosen based on the ability of River Falls Area Hospital, the Pierce County Public Health Department and other community partners to collaborate, utilize assets and implement interventions beyond clinical services in addressing these needs in the community.

IDENTIFIED HEALTH NEEDS NOT SELECTED AS PRIORITIES

Obesity: Obesity was not chosen as a priority because stakeholders felt that obesity is a symptom of poor nutrition and inadequate physical activity, and that River Falls Area Hospital and Pierce County Public Health should focus on the behaviors rather than the disease. Choosing physical activity and healthy eating as priorities would, by proxy, address the issue of obesity

Alcohol: Alcohol was not chosen due to its low prioritization score and because stakeholders felt that there would probably be the most resistance to a focus on alcohol consumption, with the exception of readiness for work on impaired driving and youth consumption. Stakeholders also noted that University of Wisconsin-River Falls has done some policy and enforcement work around binge drinking and that at a forum held in October for legislative candidates, a question was raised about increasing the beer tax, and no candidate was willing to get behind that idea.

Motor vehicle safety: Motor Vehicle Safety was not chosen due to its low prioritization score and stakeholders identified that the Pierce County Sheriff's Department already leads a group working on motor vehicle safety issues.

Tobacco: Tobacco was not chosen due to its low prioritization score and the fact that stakeholders identified two organizations already working on this issue in the community. Pierce County Partnership for Youth is engaged on issues related to alcohol and other drugs and, to some extent, tobacco, and The Western Wisconsin Working for Tobacco-Free Living (W3TFL) coalition is working to prevent, reduce exposure to and eliminate the use of tobacco products through policy work, education and informational and service efforts.

Falls prevention and chronic disease: Falls Prevention and Chronic disease were not chosen due to low prioritization scores and the fact that the focus on healthy eating and physical activity will also have an effect on those two issues.

Mental health: Mental health was not chosen because of the low prioritization score, which stakeholder felt was probably a reflection of the immensity of the issue and the lack of resources to address it effectively in the community.

Access to health care, drug use, elder care, safety/violence: These four issues received the lowest scores in the prioritization process.

Community Health Dialogues

In spring 2013, River Falls Area Hospital held a series of meetings designed to solicit feedback from the community on how River Falls Area Hospital could most effectively address the selected priority issues. These dialogues were facilitated by a community partner and contractor, Wilder Research. The community dialogues were an opportunity for River Falls Area Hospital to hear from a broader group of community members, identify ideas and strategies to respond to the priority issues and inform the action-planning phase of the needs assessment.

Invitations were sent via email or in-person by River Falls Area Hospital's Community Engagement lead to community members including representatives from education, local government, religious, social service and other nonprofit organizations in the community. There was intentional outreach to representatives from the medically underserved, low income and minority populations and populations with chronic disease conditions to ensure vulnerable populations were included. All potential participants were told that their feedback was important in representing the many roles they might play in the community: as a worker, neighbor and citizen. A total of 43 people participated in the two community health dialogues in the Western Wisconsin Region.

KEY QUESTIONS

Participants were asked to answer the following questions:

1. What is the impact of each issue in your community?
2. What should be done to address each issue in your community?
3. What is the role for River Falls Area Hospital, as part of Allina Health, in addressing this issue in your community?

KEY FINDINGS

Physical activity: Dialogue participants felt that River Falls Area Hospital, as part of Allina Health, could help address physical activity in the community by expanding access to or creation of more exercise and physical health opportunities and developing community partnerships focused on exercise and physical activity. Participants specifically noted:

- Supporting the construction of sidewalks and bike trails; providing bike helmets and safety instruction
- Assisting in the development of onsite fitness rooms and donating "retired" fitness equipment to businesses
- Sponsoring community-wide health efforts, for example: "Can we achieve a goal of 90 percent of the community walking x number of steps per day?"
- Developing a class like "couch potato to 5k to encourage those out of shape to get fit.

Nutrition: Dialogue participants felt that River Falls Area Hospital, as part of Allina Health, could help address nutrition through increasing education and awareness (particularly by partnering with schools and businesses), creating classes focused on cooking and nutrition, and increasing the access and availability of nutritious food. Participants specifically recommended:

- Developing a "tool box" of educational materials and displays regarding nutrition that can be shared with local businesses
- Offering educational classes or presentations for parents who cook for their family or young single adults
- Supporting healthy nutrition options such as farmers market, farm to school initiatives, and Community Supported Agriculture
- Providing business with resources to guide wellness programs; collaborating with businesses around health competitions
- Working with employers to create wellness programs for their worksites.

For a full copy of the report see Appendix J.

CHANGE Assessment

In addition to the Wilder-lead dialogues, the Pierce County Public Health Department received funding through the Wisconsin Nutrition, Physical Activity, and Obesity Program to implement the the CHANGE (Community Health Assessment aNd Group Evaluation) assessment to gain an understanding of Pierce County's needs and assets relating to physical activity and nutrition. The CHANGE tool, developed by CDC's Healthy Communities Program, helped organize information on indicators related to policies and environments that support healthy eating, active living, and chronic disease management. CHANGE "action members" include representatives from the Pierce County Public Health Department, River Falls Area Hospital, River Falls Medical Clinic, Ellsworth School District, UW–River Falls, UW–Extension, Chippewa Valley Technical College/UW–Eau Claire Interns, and the Allina Health Healthy Community Partnerships.

Over twenty key informant interviews were conducted in the school, healthcare, community/organization, and worksite sectors. For every sector, a second method of data collection was used to assess such as focus groups, surveys, and onsite observation. Photo documentation, mapping, and walkability audits were methods used to capture the story and to verify interview discussions.

KEY FINDINGS

The CHANGE assessment results show the need for more work on community partnerships and coalitions focused on Nutrition and Physical Activity. Health promotion programs, chronic disease assessments, and education are needed in the school and worksite areas. Furthermore, both the Community-At-Large and Community Organizations/Institutions assessments showed a lack of availability of healthy foods and/or beverages (vending, meetings, events, and/or restaurants). Breastfeeding awareness and promotion is another area revealed in the assessment to continue to support for good nutrition. Lastly, environmental and policy indicators for physical activity were identified in the worksite sector. Assessment indicators linked to this were providing break times for employees to be physically active, providing safe areas outside to walk or be physically active, and providing bicycle parking (rack/shelter).

For a full discussion of findings from the CHANGE process see appendix K.

Community Assets Inventory

With learnings from the community health dialogues and the action-planning phase, staff from River Falls Area Hospital and the Pierce County Public Health Department developed an inventory of existing programs and services within the region related to the priority areas identified in the needs assessment. The inventory included the location of the program (hospital, clinic or community) as well as the target population and community partners. The purpose of the inventory was to identify:

- Gaps in services and opportunities for new work
- Where and with whom there is a lot of work already being done
- Opportunities for partnership and/or collaboration.

See Appendix L for full inventory of hospital and community-based programs.

Action Planning

The final phase of the CHNA process was to develop the implementation plan for River Falls Area Hospital and Pierce County. The implementation plan is a set of actions that the hospital will take to respond to the needs identified through the community health needs assessment process. River Falls Area Hospital and Pierce County Public Health convened three meetings to develop the implementation plan for FY 2014–2016.

Action planning was informed by the findings both from the Wilder-led dialogues and CHANGE PROCESS.

ACTION PLANNING HAD THREE PHASES:

1. Choosing key goals, objectives and indicators related to the priority issues.
2. Selecting evidence-based strategies and programs to address the issues.
3. Assigning roles and partners for implementing each strategy.

Part 1: Choosing key goals and objectives

Following best practices for community health improvement planning, as outlined by the CDC, objectives for the implantation plan were evaluated using SMART criteria:

SMART Objectives are:

1. **Specific:** Objectives should provide the "who" and "what." Use only one action verb, because objectives with more than one verb imply that more than one activity or behavior is being measured. Remember, the greater the specificity, the greater the measurability.
2. **Measurable:** The focus is on "how much" change is expected. Objectives should quantify the amount of change expected. The objective provides a reference point from which a change in the target population can clearly be measured (e.g., over the next 12 months).
3. **Achievable:** Objectives should be attainable within a given time frame and with available community resources.
4. **Realistic:** Objectives are most useful when they accurately address the scope of the problem and action steps that can be implemented within a specific time frame. Also, make sure the objective addresses the scope of the health issue and proposes reasonable next steps.
5. **Time-phased:** Objectives should provide a time frame indicating when the objective will be measured or a time by which the objective will be met. Including a time frame in the objectives helps to plan and evaluate the strategy.

Stakeholders also looked at Healthiest Wisconsin 2020 for a set of indicators that reflected overall trends related to the priority issues. These indicators will not be used to evaluate the programs, but rather provide a framework for discussion of the issue in the community.

Part 2: Selecting evidence-based strategies

When looking at strategies to address priority issues, River Falls Area Hospital and Pierce County Public Health looked to meeting Community Anti-Drug Coalitions of America's (CADCA) "Defining the Seven Strategies for Community Change" in order to ensure that strategies were chosen that could address the issues from multiple perspectives. For more information on CADCA's strategies see appendix M.

These strategies are:

1. Providing information
2. Enhancing skills
3. Providing support
4. Enhancing access/reducing barriers
5. Changing consequences
6. Physical design
7. Modifying/changing policies

In order to choose evidence-based strategies, River Falls Area Hospital and Pierce County Public Health first created a matrix which summarized existing programs in the community that addressed the priority issues and then looked at the site 'What Works for Health (http://www.countyhealthrankings.org/roadmaps/what-works-for-health) to choose scientifically-based strategies that would address the priority issues in the community.

Implementation Plan

The implementation plan is a 3-year plan depicting the overall work that River Falls Area Hospital, the Pierce County Public Health Department and other community partners plan to do to address its priority issues in the community. Yearly work plans will be developed to provide detailed actions, accountabilities, evaluation measures and timelines. Copies of these detailed work plans can be requested from River Falls Area Hospital and/or the Pierce County Public Health Department.

Physical activity

GOAL: Increase physical activity through changes to the environment, policy, and community support

INDICATORS

- Percent of adults engaging in recommended levels of physical activity
- Percentage of high school students who meet federal standards for physical activity

STRATEGIES

1. **Providing Information**
   - Increasing community awareness of opportunities for physical activity and exercise
2. **Enhancing Skills**
   - Starting walking classes, programs and clubs
3. **Providing Support**
   - Continue to provide financial support to local organizations that promote physical activity through the Allina Health charitable contributions program
4. **Enhancing Access/Reducing Barriers**
   - No strategies selected
5. **Changing Consequences**
   - Implementing and supporting worksite wellness incentives
6. **Physical design**
   - Improve trail signage in community parks and recreation areas
7. **Modifying/Changing Policies**
   - Engaging local policy makers on the importance of physical activity
   - Establishing a county-wide school physical education and health committee

Healthy Eating

GOALS: Increase the consumption of fruits and vegetables and decrease consumption of sugar-sweetened beverages and other less nutritious food. Increased breastfeeding was also selected as a key goal.

INDICATORS

- Percentage of adults eating at least five servings of fruits and vegetables daily
- Percentage of high schools that do not sell candy, high-fat snacks or soda and juice that is not 100% juice
- Percentage of Pierce County WIC infants ever breastfed

STRATEGIES

1. **Providing Information**
   - Reduce use of trans-fats in local restaurants
   - Provide information about the benefits of breastfeeding to new and expectant mothers
2. **Enhancing Skills**
   - Starting cooking classes and nutritional education programs
3. **Providing Support**
   - Continue to provide financial support to local organizations that promote healthy eating through the Allina Health charitable contributions program
4. **Enhancing Access/Reducing Barriers**
   - Establish new and support existing community gardens
   - Implement labeling of healthy choices at local restaurants
5. **Changing Consequences**
   - Provide farmers market incentives for FoodShare and WIC participants
   - Promote and support healthy vending at worksites
6. **Physical design**
   - None selected
7. **Modifying/Changing Policies**
   - Promote and support healthy vending at schools
   - Promote and support worksite policies that support breastfeeding

Conclusion

River Falls Area Hospital, a not-for profit hospital, and the Pierce County Public Health Department are dedicated to improving the health of the communities they serve. This implementation plan is intended to show that the hospital and public health department will partner with and support community and clinical programs that positively impact the identified health needs in 2014–2016. In addition, the hospital will participate in system-wide efforts, as part of Allina Health, that support and impact community health. There are other ways in which River Falls Area Hospital and the Pierce County Public Health Department will indirectly address these priority issues along with other needs, through the provision of charity care, support of Medicare and Medicaid programs, discounts to the uninsured, among others. Altogether, River Falls Area Hospital and the Pierce County Public Health Department will continue to engage with the community to ensure that the work in the plan is relevant and effective and to modify accordingly.

Pierce County health department

Pierce County Office Building
412 West Kinne Street
Ellsworth, WI 54011

co.pierce.wi.us

Allina Health
RIVER FALLS AREA HOSPITAL

1629 East Division Street
River Falls, WI 54022
715-307-6000

riverfallsareahospital.com

RIVER FALLS AREA HOSPITAL
PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Appendix A

Community Partners

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
RIVER FALLS
AREA HOSPITAL

Meeting 1: 08/21/2012 Location, River Falls Hospital
Stage: Data Review Guests:

Katie Bartko, Pierce County Public Health
Sue Galoff, Pierce County Public Health
Greg Goblirsch, MD, River Falls Medical Clinic
Amy Hess, Pierce County Public Health
Melissa Hutchison, Allina Health
Mary Johnson, River Falls Area Hospital
Melissa Kosse, First National Bank of River Falls
Steve Leitch, Leitch Insurance
Heather Logelin, River Falls Area Hospital
David Miller, River Falls Area Hospital
Beth Nelson, River Falls Area Hospital
Kristen Novak, River Falls Area Hospital
Ken Osowski, First National Bank of River Falls
Cathy Quinlivan, St. Croix Valley YMCA
Alice Reilly-Myklebust, University of Wisconsin – River Falls
John Salisbury, Allina Health
Lori Severson, River Falls Area Hospital
Pat Sura, MD, River Falls Medical Clinic
David Woeste, MD, Retired
Glenda Zielski, Retired

Meeting 2: 10/30/2012 Location, River Falls Hospital
Stage: Data Review and Prioritization

Sue Galoff, Pierce County Public Health
Greg Goblirsch, MD, River Falls Medical Clinic
Amy Hess, Pierce County Public Health
Sandy Johnson, Hope Lutheran Church
Melissa Kosse, First National Bank of River Falls
Steve Leitch, Leitch Insurance
Heather Logelin, River Falls Area Hospital
Chris Myers, First Congregational Church
Beth Nelson, River Falls Area Hospital
Kristen Novak, River Falls Area Hospital
Cathy Quinlivan, Hudson YMCA
Alice Reilly-Myklebust, University of Wisconsin – River Falls
Pat Sura, MD, River Falls Medical Clinic

Meeting 3: 12/04/2012 Location, River Falls Hospital
Stage: Prioritization and Selection of Final list of Priorities

Katie Bartko, Pierce County Public Health
Breanna Burmeister, Hudson YMCA
Sue Galoff, Pierce County Public Health
Greg Goblirsch, MD, River Falls Medical Clinic

Amy Hess, Pierce County Public Health
Kali Higgins, Allina Health
Mary Johnson, River Falls Area Hospital
Melissa Kosse, First National Bank of River Falls
Steve Leitch, Leitch Insurance
Heather Logelin, River Falls Area Hospital
David Miller, River Falls Area Hospital
Beth Nelson, River Falls Area Hospital
Brandi Poellinger, Allina Health
Alice Reilly-Myklebust, University of Wisconsin – River Falls
Pat Sura, MD, River Falls Medical Clinic
David Woeste, MD, Retired

RIVER FALLS AREA HOSPITAL
PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Appendix B

Full List of Indicators

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
RIVER FALLS
AREA HOSPITAL

County- Leading Health Indicators

People and Place

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Pierce	Saint Croix
People and Place	1. Total population	WICHP	5,686,990	41,020	84,350
People and Place	2. Population by age and sex	WICHP	Table I	Table I	
People and Place	3. Number of females aged 15-44	WICHP	1,097,590	9,330	16,520
People and Place	4. Number of births	WICHP	68,376	425	1,119
People and Place	5. Birth rate	WICHP	12	10.4	13.3
People and Place	6. Total population by race and ethnicity	WICHP	Table II	Table II	Table II

Opportunity for Health

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Pierce	St.Croix
Opportunity for Health	7. Four year high school graduation rate	WCHR	86%	95%	95%
Opportunity for Health	8. 2010 Unemployed rate - annual average	WICHP	8.3%	6.8%	7.3%
Opportunity for Health	9. Median HH Income (2009)	WICHP	$49,994	$56,006	$67,049
Opportunity for Health	10. Percent of people 0-17 years living in poverty	WICHP	16.7%	8.8%	7.6%
Opportunity for Health	11. Percent of all ages living in poverty	WICHP	12.4%	10.1%	6.3%
Opportunity for Health	12. Percent of people of all ages living at or below 200% of poverty	WFHS	24%	19%	11%
Opportunity for Health	13.Percent of births to unmarried mothers	WICHP	37%	29%	22%
Opportunity for Health	14. Percent of birth cohort tested with elevated blood lead levels	WICLPP	2.2%	.36%	.53%
Opportunity for Health	15.Ratio of physicians to population	WCHR	744:1	1,058:1	1,130:1
Opportunity for Health	16. Percent currently uninsured	WFHS	6%	7%	3%

Healthy Living

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Pierce	St. Croix
Healthy Living	17. Percent of births by race/ethnicity of mother	WICHP	Table III	Table III	Table III
Healthy Living	18. Percent of mothers who identified as smokers	WICHP	13%	9%	8%
Healthy Living	19. Percent of births to unmarried mothers	WICHP	37%	29%	22%
Healthy Living/Opportunity for Health	20. Percent of mothers who initiated prenatal care in the 1st trimester	WICHP	84 %	85%	87%
Healthy Living	21. Percent of birth born low birth weight, less than 2,500 grams (singleton births)	WICHP	7%	4.7%	6.1%
Healthy Living	22. Number of infant deaths/rate	WICHP	393/5.7	2	7
Healthy Living	23. Percent of adults who are excessive drinkers (binge+ heavy)	WBRFS	24%	27%	31%
Healthy Living	24. Percent of adults who are current smokers	WBRFS	19%	17%	19%
Healthy Living	25. Colorectal cancer screening	WBRFS	69%		
Healthy Living	26. Breast cancer screening	WBRFS	80%		
Healthy Living	27. Percent of children in grades k-12 up to date with immunizations (vaccine series)	WICHP	96.6%	98.3%	99.3%

Chronic Diseases and Conditions

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Pierce	St. Croix
Chronic Dis. and Cond.	28. Percent of adults who are obese according to BMI	WBRFS	27%	25.8%	27.9%
Chronic Dis. and Cond.	29. Leading causes of death - age adjusted rates per 100,000 (e.g. cancer, heart disease, stroke)	WICHP	Table IV	Table IV	Table IV
Chronic Dis. and Cond.	30. Cancer incidence per 100,000 (all cancer types combined, age adjusted rate per 100,000)	WICHP	503.1	192.1	225.2
Chronic Dis. and Cond.	31. Breast cancer incidence (age adjusted rate per 100,000)	WICHP	136.4	63.6	39.7
Chronic Dis. and Cond.	32. Diabetes prevalence	WBRFS	7%	7.2%	7%

Infectious Disease

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Pierce	St. Croix
Infectious Disease	33. STD numbers (e.g. chlamydia, gonorrhea)	WICHP	Table V	Table V	Table V
Infectious Disease	34. Number of tuberculosis cases	WICHP	71	<5	<5
Infectious Disease	35. Vector borne diseases (e.g. Lyme disease, West Nile virus)	WICHP	Table VI	Table VI	Table VI

Injury and Violence

Statewide Health Assessment Theme Name	Indicator	Original Source	State-wide	Pierce	St. Croix
Injury and Violence	36. Unintentional injury death - age adjusted rate per 100,000	WISH	43	14	29
Injury and Violence	37. Percent of motor vehicle injuries and deaths that are related to alcohol	WICHP	8.5%/39.1%	15%/66%	8.7%/16%
Injury and Violence	38. Suicide deaths/rate (per 100,000)	WICHP	789/14	7/n.a.	13/n.a.

TABLE I

State-wide

Age Group	Female	Male	Total
0-14	539,080	563,910	1,102,990
15-17	114,820	121,680	236,510
18-19	79,580	83,120	162,700
20-24	189,660	196,900	386,550
25-44	713,530	733,830	1,447,360
45-64	788,010	785,550	1,573,560
65-84	358,840	299,970	658,810
85+	81,060	37,450	118,510
Total	**2,864,590**	**2,822,400**	**5,686,990**

Pierce

Age Group	Female	Male	Total
0-14	3,630	3,880	7,510
15-17	800	860	1,650
18-19	1,300	880	2,180
20-24	2,470	2,190	4,660
25-44	4,760	5,000	9,760
45-64	5,350	5,630	10,970
65-84	1,890	1,790	3,680
85+	400	200	610
Total	**20,600**	**20,242**	**41,020**

Saint Croix

Age Group	Female	Male	Total
0-14	9,460	9,810	19,270
15-17	1,750	1,870	3,620

18-19	830	910	1,750
20-24	1,900	2,020	3,920
25-44	12,040	12,140	24,180
45-64	11,470	11,680	23,140
65-84	3,870	3,440	7,310
85+	810	350	1,169
Total	**42,130**	**42,220**	**84,350**

TABLE II

Total population by race and ethnicity	**White**	**Black/ African American**	**Amer. Indian/ Alaskan Native**	**Asian/ Pacific Islander**	**Hispanic/ Latino (any race)**
WI	4,782,830	376,460	54,090	137,540	336,060
Pierce	39,570	310	150	360	620
St. Croix	80,550	740	310	1,050	1,690

TABLE III

Percent of births by race/ethnicity of mother	**White**	**African American**	**American Indian**	**Asian**	**Latina**	**Other/ Unknown**
WI	74	10	2	4	10	<.5
Pierce	94	1	1	1	2	0
St. Croix	95	1	<.5	2	2	0

TABLE IV

Leading causes of death - age adjusted rates per 100,000 (e.g. cancer, heart disease, stroke)	Heart Disease	Cancer	Stroke
WI	195	198	46
Pierce	154	122	n/a
St. Croix	146	142	43

TABLE V

STD numbers,	Chlamydia	Gonorrhea	Syphilis - All Stages	HIV
WI	23,000	5,074	183	376
Pierce	57	0	0	
St. Croix	119	10	0	

TABLE VI

Vector borne diseases	**Campylo-bacteriosis**	**Giardiasis**	**Lyme Disease**	**Human Anaplasmosis**	**Pertussiss**	**Salmo-nellosis**	**Shigellosis**
WI	1,385	627	2,518	124	296	846	71
Pierce	14	<5	30	<5	<5	<5	<5
St. Croix	15	6	54	0	<5	9	0

Sources:

2010 US Census (Census)
Wisconsin Department of Health Services 2010 County Health Profiles- WICHP
Childhood Lead Poisoning Prevention Program 2007- WICLPP
Wisconsin Family Health Survey - WFHS
Wisconsin Behavioral Risk Factor Survey- WBRFS
Wisconsin Interactive Statistics on Health –WISH
Wisconsin County Health Rankings- WCHR

RIVER FALLS AREA HOSPITAL
PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Appendix C

Wisconsin County Health Rankings

Community Health Needs Assessment and Implementation Plan 2014–2016

Allina Health
RIVER FALLS AREA HOSPITAL

County Health Rankings & Roadmaps

A Healthier Nation, County by County

2012 *Rankings*

Wisconsin

Robert Wood Johnson Foundation

UNIVERSITY OF WISCONSIN

Population Health Institute

Translating Research into Policy and Practice

Introduction

Where we live matters to our health. The health of a community depends on many different factors, including the environment, education and jobs, access to and quality of healthcare, and individual behaviors. We can improve a community's health by implementing effective policies and programs. For example, people who live in communities with smoke-free laws are less likely to smoke or to be exposed to second-hand smoke, which reduces lung cancer risk. In addition, people who live in communities with safe and accessible park and recreation space are more likely to exercise, which reduces heart disease risk.

However, health varies greatly across communities, with some places being much healthier than others. And, until now, there has been no standard method to illustrate what we know about what makes people sick or healthy or a central resource to identify what we can do to create healthier places to live, learn, work and play.

We know that much of what influences our health happens outside of the doctor's office – in our schools, workplaces and neighborhoods. The *County Health Rankings & Roadmaps* program provides information on the overall health of your community and provides the tools necessary to create community-based, evidence-informed solutions. Ranking the health of nearly every county across the nation, the *County Health Rankings* illustrate **what we know** when it comes to what is making communities sick or healthy. The *County Health Roadmaps* show **what we can do** to create healthier places to live, learn, work and play. The Robert Wood Johnson Foundation collaborates with the University of Wisconsin Population Health Institute to bring this groundbreaking program to counties and states across the nation.

The *County Health Rankings & Roadmaps* program includes the *County Health Rankings* project, launched in 2010, and the newer *Roadmaps* project that mobilizes local communities, national partners and leaders across all sectors to improve health. The program is based on this model of population health improvement:

In this model, health outcomes are measures that describe the current health status of a county. These health outcomes are influenced by a set of health factors. Counties can improve health outcomes by addressing all health factors with effective, evidence-informed policies and programs.

Everyone has a stake in community health. We all need to work together to find solutions. The *County Health Rankings & Roadmaps* serve as both a call to action and a needed tool in this effort.

Guide to Our Web Site

To compile the *Rankings*, we selected measures that reflect important aspects of population health that can be improved and are available at the county level across the nation. Visit www.countyhealthrankings.org to learn more.

To get started and see data, enter your county or state name in the search box. Click on the name of a county or measure to see more details. You can: Compare Counties; Download data for your state; Print one or more county snapshots; or Share information with others via Facebook, Twitter, or Google+. To understand our methods, click on Learn about the Data and Methods. To learn about steps that you can take to improve health in your community, click on the *Roadmaps* tab. The *Roadmaps to Health* Action Center provides tools and resources to help groups working together to create healthier places. The Opportunities section provides information on funding, recognition, and partnership opportunities. The Connections section helps you learn what others are doing.

County Health Roadmaps

The *Rankings* illustrate **what we know** when it comes to making people sick or healthy. The *County Health Rankings* confirm the critical role that factors such as education, jobs, income and the environment play in how healthy people are and how long we live.

This report introduces the *County Health Roadmaps*, a new partnership that mobilizes local communities, national partners and leaders across all sectors to improve health. The *County Health Roadmaps* show **what we can do** to create healthier places to live, learn, work and play. The Robert Wood Johnson Foundation collaborates with the University of Wisconsin Population Health Institute to bring this groundbreaking project to cities, counties and states across the nation.

The *Roadmaps* project includes grants to local coalitions and partnerships among policymakers, business, education, public health, health care, and community organizations; grants to national organizations working to improve health; recognition of communities whose promising efforts have led to better health; and customized technical assistance on strategies to improve health.

***Roadmaps to Health* Community Grants**
The *Roadmaps to Health* Community Grants provide funding for 2 years to state and local efforts among policymakers, business, education, healthcare, public health and community organizations working to create positive policy or systems changes that address the social and economic factors that influence the health of people in their community.

***Roadmaps to Health* Partner Grants**
The Robert Wood Johnson Foundation is awarding *Roadmaps to Health* Partner Grants to national organizations that are experienced at engaging local partners and leaders and are able to deliver high-quality training and technical assistance, and committed to making communities healthier places to live, learn, work and play. Partner grantees increase awareness about the *County Health Rankings & Roadmaps* to their members, affiliates and allies. The first Partner Grant was awarded to United Way Worldwide (UWW) in July 2011.

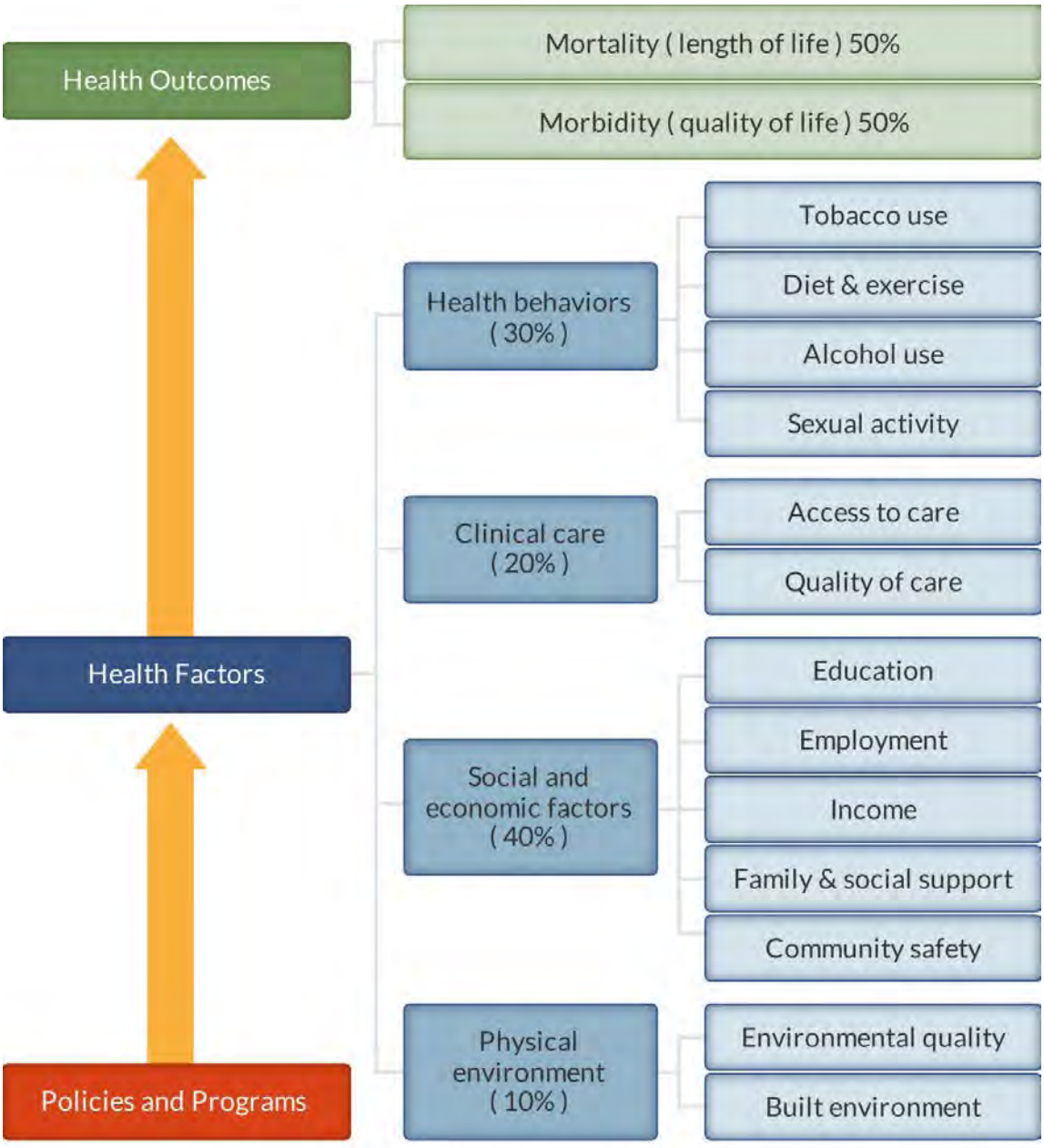
***Roadmaps to Health* Prize**
The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute will award *Roadmaps to Health* Prizes of $25,000 to up to six communities that are working to become healthier places to live, learn, work and play. The *Roadmaps to Health* Prize is intended not only to honor successful efforts, but also to inspire and stimulate similar activities in other U.S. communities.

***Roadmaps to Health* Action Center**
The *Roadmaps to Health* Action Center, based at the University of Wisconsin Population Health Institute, provides tools and resources to help groups working to make their communities healthier places. The new Action Center will provide guidance on developing strategies and advocacy efforts to advance pro-health policies, offer opportunities for ongoing learning, and in the summer of 2012, host a searchable database of evidence-informed policies and programs focused on health improvement. Experts provide customized consultation to local communities who have demonstrated the willingness and capacity to address factors that we know influence how healthy a person is, such as education, income and family connectedness.

County Health Rankings

The 2012 *County Health Rankings* report ranks Wisconsin counties according to their summary measures of **health outcomes** and **health factors**. Counties also receive a rank for mortality, morbidity, health behaviors, clinical care, social and economic factors, and the physical environment. The figure below depicts the structure of the *Rankings* model; those having high ranks (e.g., 1 or 2) are estimated to be the "healthiest."

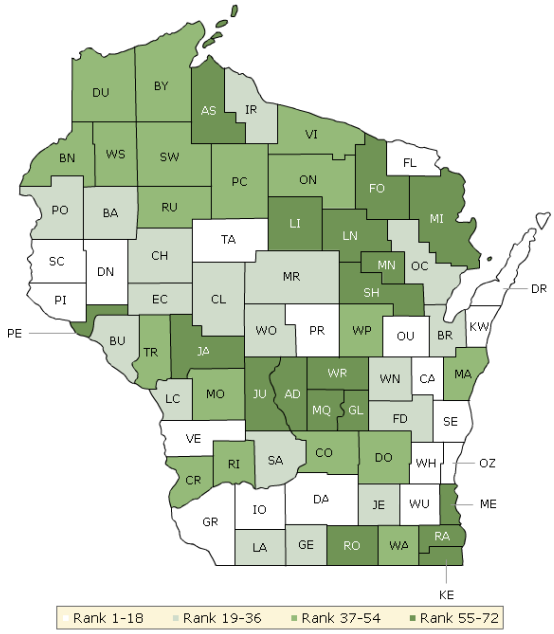
Our summary **health outcomes** rankings are based on an equal weighting of mortality and morbidity measures. The summary **health factors** rankings are based on weighted scores of four types of factors: behavioral, clinical, social and economic, and environmental. The weights for the factors (shown in parentheses in the figure) are based upon a review of the literature and expert input, but represent just one way of combining these factors.



County Health Rankings model ©2012 UWPHI

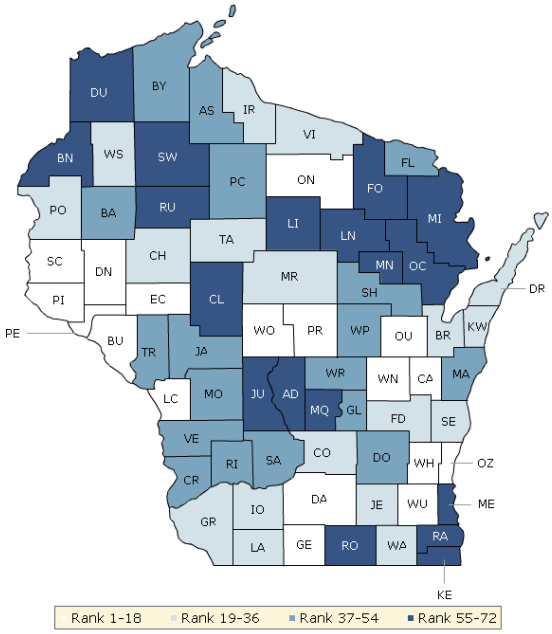
The maps on this page and the next display Wisconsin's counties divided into groups by health rank. Maps help locate the healthiest and least healthy counties in the state. The lighter colors indicate better performance in the respective summary rankings. The green map shows the distribution of summary health outcomes. The blue displays the distribution of the summary rank for health factors.

HEALTH OUTCOMES



County	Rank	County	Rank	County	Rank	County	Rank
Adams	69	Florence	15	Marathon	24	Rusk	52
Ashland	59	Fond du Lac	35	Marinette	62	Sauk	36
Barron	34	Forest	67	Marquette	71	Sawyer	51
Bayfield	47	Grant	17	Menominee	72	Shawano	60
Brown	29	Green	20	Milwaukee	70	Sheboygan	18
Buffalo	26	Green Lake	61	Monroe	48	St. Croix	1
Burnett	45	Iowa	4	Oconto	25	Taylor	3
Calumet	14	Iron	28	Oneida	50	Trempealeau	46
Chippewa	31	Jackson	68	Outagamie	16	Vernon	5
Clark	32	Jefferson	33	Ozaukee	2	Vilas	37
Columbia	40	Juneau	65	Pepin	55	Walworth	38
Crawford	44	Kenosha	64	Pierce	8	Washburn	42
Dane	11	Kewaunee	10	Polk	30	Washington	6
Dodge	39	La Crosse	23	Portage	12	Waukesha	7
Door	9	Lafayette	21	Price	49	Waupaca	54
Douglas	53	Langlade	66	Racine	63	Waushara	56
Dunn	13	Lincoln	57	Richland	43	Winnebago	27
Eau Claire	19	Manitowoc	41	Rock	58	Wood	22

HEALTH FACTORS



County	Rank	County	Rank	County	Rank	County	Rank
Adams	70	Florence	38	Marathon	29	Rusk	56
Ashland	42	Fond du Lac	33	Marinette	61	Sauk	37
Barron	41	Forest	66	Marquette	64	Sawyer	65
Bayfield	47	Grant	30	Menominee	72	Shawano	54
Brown	23	Green	12	Milwaukee	71	Sheboygan	19
Buffalo	16	Green Lake	43	Monroe	51	St. Croix	9
Burnett	62	Iowa	20	Oconto	55	Taylor	31
Calumet	10	Iron	27	Oneida	18	Trempealeau	40
Chippewa	32	Jackson	48	Outagamie	13	Vernon	44
Clark	63	Jefferson	34	Ozaukee	1	Vilas	25
Columbia	35	Juneau	69	Pepin	14	Walworth	26
Crawford	46	Kenosha	60	Pierce	5	Washburn	36
Dane	3	Kewaunee	22	Polk	24	Washington	6
Dodge	45	La Crosse	4	Portage	7	Waukesha	2
Door	21	Lafayette	28	Price	39	Waupaca	50
Douglas	58	Langlade	59	Racine	68	Waushara	53
Dunn	15	Lincoln	57	Richland	52	Winnebago	17
Eau Claire	11	Manitowoc	49	Rock	67	Wood	8

Summary Health Outcomes & Health Factors Rankings

Counties receive two summary ranks:

- Health Outcomes
- Health Factors

Each of these ranks represents a weighted summary of a number of measures.

Health outcomes represent how healthy a county is while health factors represent what influences the health of the county.

Rank	Health Outcomes	Rank	Health Factors
1	St. Croix	1	Ozaukee
2	Ozaukee	2	Waukesha
3	Taylor	3	Dane
4	Iowa	4	La Crosse
5	Vernon	5	Pierce
6	Washington	6	Washington
7	Waukesha	7	Portage
8	Pierce	8	Wood
9	Door	9	St. Croix
10	Kewaunee	10	Calumet
11	Dane	11	Eau Claire
12	Portage	12	Green
13	Dunn	13	Outagamie
14	Calumet	14	Pepin
15	Florence	15	Dunn
16	Outagamie	16	Buffalo
17	Grant	17	Winnebago
18	Sheboygan	18	Oneida
19	Eau Claire	19	Sheboygan
20	Green	20	Iowa
21	Lafayette	21	Door
22	Wood	22	Kewaunee
23	La Crosse	23	Brown
24	Marathon	24	Polk
25	Oconto	25	Vilas
26	Buffalo	26	Walworth
27	Winnebago	27	Iron
28	Iron	28	Lafayette
29	Brown	29	Marathon
30	Polk	30	Grant
31	Chippewa	31	Taylor
32	Clark	32	Chippewa
33	Jefferson	33	Fond du Lac
34	Barron	34	Jefferson
35	Fond du Lac	35	Columbia
36	Sauk	36	Washburn
37	Vilas	37	Sauk
38	Walworth	38	Florence
39	Dodge	39	Price
40	Columbia	40	Trempealeau
41	Manitowoc	41	Barron
42	Washburn	42	Ashland

Rank	Health Outcomes	Rank	Health Factors
43	Richland	43	Green Lake
44	Crawford	44	Vernon
45	Burnett	45	Dodge
46	Trempealeau	46	Crawford
47	Bayfield	47	Bayfield
48	Monroe	48	Jackson
49	Price	49	Manitowoc
50	Oneida	50	Waupaca
51	Sawyer	51	Monroe
52	Rusk	52	Richland
53	Douglas	53	Waushara
54	Waupaca	54	Shawano
55	Pepin	55	Oconto
56	Waushara	56	Rusk
57	Lincoln	57	Lincoln
58	Rock	58	Douglas
59	Ashland	59	Langlade
60	Shawano	60	Kenosha
61	Green Lake	61	Marinette
62	Marinette	62	Burnett
63	Racine	63	Clark
64	Kenosha	64	Marquette
65	Juneau	65	Sawyer
66	Langlade	66	Forest
67	Forest	67	Rock
68	Jackson	68	Racine
69	Adams	69	Juneau
70	Milwaukee	70	Adams
71	Marquette	71	Milwaukee
72	Menominee	72	Menominee

2012 *County Health Rankings*: Measures, Data Sources, and Years of Data

	Measure	Data Source	Years of Data
HEALTH OUTCOMES			
Mortality	Premature death	National Center for Health Statistics	2006-2008
Morbidity	Poor or fair health	Behavioral Risk Factor Surveillance System	2004-2010
	Poor physical health days	Behavioral Risk Factor Surveillance System	2004-2010
	Poor mental health days	Behavioral Risk Factor Surveillance System	2004-2010
	Low birthweight	National Center for Health Statistics	2002-2008
HEALTH FACTORS			
HEALTH BEHAVIORS			
Tobacco Use	Adult smoking	Behavioral Risk Factor Surveillance System	2004-2010
Diet and Exercise	Adult obesity	National Center for Chronic Disease Prevention and Health Promotion	2009
	Physical inactivity	National Center for Chronic Disease Prevention and Health Promotion	2009
Alcohol Use	Excessive drinking	Behavioral Risk Factor Surveillance System	2004-2010
	Motor vehicle crash death rate	National Center for Health Statistics	2002-2008
Sexual Activity	Sexually transmitted infections	National Center for Hepatitis, HIV, STD and TB Prevention	2009
	Teen birth rate	National Center for Health Statistics	2002-2008
CLINICAL CARE			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2009
	Primary care physicians	Health Resources & Services Administration	2009
Quality of Care	Preventable hospital stays	Medicare/Dartmouth Institute	2009
	Diabetic screening	Medicare/Dartmouth Institute	2009
	Mammography screening	Medicare/Dartmouth Institute	2009
SOCIAL AND ECONOMIC FACTORS			
Education	High school graduation	National Center for Education Statistics and state-specific sources[1]	2008-2010
	Some college	American Community Survey	2006-2010
Employment	Unemployment	Bureau of Labor Statistics	2010
Income	Children in poverty	Small Area Income and Poverty Estimates	2010
Family and Social Support	Inadequate social support	Behavioral Risk Factor Surveillance System	2006-2010
	Children in single-parent households	American Community Survey	2006-2010
Community Safety	Violent crime rate[2]	Federal Bureau of Investigation	2007-2009
PHYSICAL ENVIRONMENT			
Environmental Quality[3]	Air pollution-particulate matter days	U.S. Environmental Protection Agency	2007
	Air pollution-ozone days	U.S. Environmental Protection Agency	2007
Built Environment	Access to recreational facilities	Census County Business Patterns	2009
	Limited access to healthy foods[4]	U.S. Department of Agriculture	2006
	Fast food restaurants	Census County Business Patterns	2009

[1] NCES used for AK, AL, AR, CA, CT, FL, HI, ID, KY, MT, ND, NJ, OK, SD and TN

[2] State data source for IL.

[3] Not available for AK and HI.

[4] Access to Healthy Foods (2009) from Census Zip Code Business Patterns for AK and HI.

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Suggested citation: University of Wisconsin Population Health Institute. *County Health Rankings 2012.*

County Health Rankings & Roadmaps

A Healthier Nation, County by County

countyhealthrankings.org

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RIVER FALLS AREA HOSPITAL
PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Appendix D

St. Croix County CHIP

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
RIVER FALLS
AREA HOSPITAL

Community Health Improvement Plan

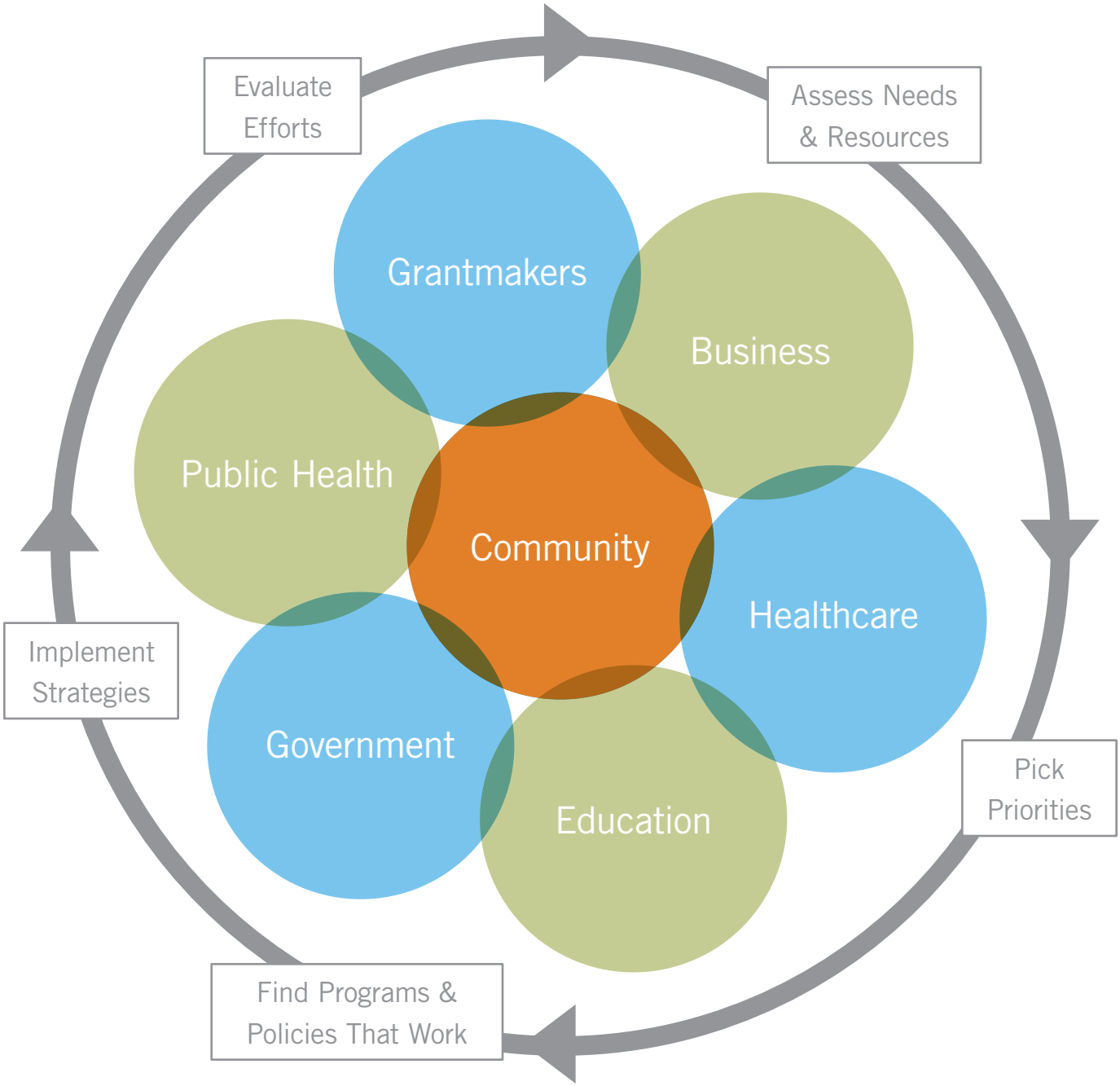
2009 – 2014

Healthier Together

St. Croix County

TAKE ACTION

Work Together



University of Wisconsin Population Health Institute. *County Health Rankings 2011*. Accessible at www.countyhealthrankings.org

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EXECUTIVE SUMMARY

St. Croix County (Wisconsin) is a pretty healthy place to live — No. 2 (out of 72 counties in the state). That's according to the most recent County Health Rankings report (Robert Wood Johnson Foundation). Both the 2010 and 2011 reports were welcome news for those within the county who strive to improve the health of local residents.

Since June 2008, members of ***Healthier Together*** – *St. Croix County* (formerly St. Croix County Community Health Improvement Process (CHIP), have worked together to better understand current and future health care needs of St. Croix County. This process of assessing, prioritizing and addressing health needs in the region is facilitated by Hudson Hospital & Clinics and St. Croix County Public Health. It is a strategic, county-wide, community-based approach for creating and maintaining healthy communities. A steering committee of 20+ members representing diverse organizations from across the county provides oversight and guidance. Together they work to better align efforts among community partners and create a more strategic framework for local health improvement activities.

From the 2009 county-wide community needs assessment (*Executive Summary* and *Full Report* can be found at www.hudsonhospital.org/community), the top 5 health priorities were identified for the purpose of educating and mobilizing area organizations, planning actions to improve public health and quality of life, and garnering resources for health improvement initiatives. A community forum and multiple workshops were held in 2010 to share assessment findings and continue dialogue about possible root causes of troubling statistics.

Top 5 Health Priorities

- Access to Primary and Preventive Health Services
- Overweight, Obesity, and Lack of Physical Activity
- Adequate and Appropriate Nutrition
- Alcohol and Other Substance Use and Addiction
- Tobacco Use and Exposure

Over the past year, five task forces and over 100 community members have been involved in *Action*, *Implementation* and *Evaluation* planning to move St. Croix County's community health improvement process forward. The Plan, described within, represents the collective work of many dedicated individuals who have worked to find creative ways to improve health across the county. It is our hope that you will take a moment to review and find an area or topic of interest and ask yourself — *how can I help*?

Karen Hansen
Marketing & Community Relations
Co-facilitator
Hudson Hospital & Clinics

Wendy Kramer
Health Officer
Co-facilitator
St. Croix County Public Health

ACKNOWLEDGEMENTS

Special thanks to the many dedicated members of ***Healthier Together*** – *St. Croix County* who contributed to the development of this community health improvement Plan:

Steering Committee

- **Suzanne Ballantyne**, MSW, LCSW, Social Services, Westfields Hospital
- **Doug Briggs**, Chief, Somerset Police Department
- **Sandy Bruckner**, RN (Retired), Clinical Services Manager, Hudson Physicians – WWMA
- **John Coughlin**, Executive Director, United Way St. Croix Valley
- **Patty Draxler**, Executive Director, Family Resource Center St. Croix Valley, Inc.
- **Karen Hansen**, Manager, Marketing & Community Relations, Hudson Hospital & Clinics, Co-facilitator – ***Healthier Together***
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- **Vincent Hunt**, MD (Retired), Community Member
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- **Ruth Lehmann**, RD, CD, WIC Program, St. Croix County Public Health
- **Heather Logelin**, Executive Director, Foundation & Community Engagement, River Falls Area Hospital
- **Richard (Buzz) Marzolf**, Board Member, St. Croix County Board of Supervisors
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- **Deb Rasmussen**, Board Member, St. Croix County Department of Health & Human Services
- **Sharon Reyzer**, PHN, Prenatal Care Coordinator, St. Croix County Public Health
- **Robert (Bob) Simmons, Jr.**, CEO, Armor Healthcare, LLC
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- **Peter Van Dusartz III**, Manager, Programs for Change, Hudson Hospital & Clinics
- **Jim Zanto**, Public Health Educator, Division of Public Health, Eau Claire/Western Regional Office

New Members in 2011

- **Patty McGrath**, Executive Director, St. Croix Valley YMCA, River Falls Area YMCA
- **Cory McIntyre**, Director, Student Services, Hudson School District
- **Jean Needham**, President & CEO, Westfields Hospital

continued

◄ TASK FORCE CHAMPIONS/WORK GROUP LEADS

L to R: (front) Jean Weiler, Jill Best, Linda Robertson, Sue Lindberg, Terri Green; *(back)* Tonya Love, Ryan Purfeerst, Doug Briggs, Geralyn Karl.

Not pictured: Lisa Ramsay, MD, Erika Schendel, and Kathy Huston.

STEERING COMMITTEE ►

L to R: (front) Joan Simpson, Alison Page, Wendy Kramer, Deb Rasmussen, Karen Hansen, Patty Draxler, *New members* – Patty McGrath, Jean Needham; *(back)* Teresa Kvam, Buzz Marzolf, Heather Logelin, Ruth Lehmann, John Coughlin, Doug Briggs, Peter Van Dusartz, and Fred Johnson.

Not pictured: Suzanne Ballantyne, Vincent and Mary Kay Hunt, Sharon Reyzer, Bob Simmons, Jim Zanto and *New member*: Cory McIntyre.

Task Force Champions/ Work Group Members

Access to Primary and Preventive Health Services

TASK FORCE CHAMPIONS

- **Sue Lindberg**, PHN, St. Croix County Public Health
- **Linda Robertson**, RN, MPH (Retired), Community Member

WORK GROUP MEMBERS

Medical Care

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- **Wendy Kramer**, BSN, RN, Health Officer, St. Croix County Public Health
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- **Stephanie Stark**, West CAP/Health Literacy

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- **John Clymer**, Community Member
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- **Julie Lesher**, DDS, Dentistry on Vine
- **Sue Lindberg**, PHN, St. Croix County Public Health
- **Kitty Rhoades**, State Representative, Wisconsin State Assembly

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- **Sandy Bruckner,** RN (Retired), Clinical Services Manager, Hudson Physicians – WWMA
- **Dave Graebner**, VP, Western Wisconsin Services, HealthPartners
- **Lori Grambow**, RN, Clinical Services Manager, Hudson Physicians – WWMA

Overweight, Obesity and Lack of Physical Activity

TASK FORCE CHAMPIONS

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WORK GROUP MEMBERS

Nutrition

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continued

Adequate & Appropriate Nutrition

TASK FORCE CHAMPIONS

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- **Mary Lestrud**, Nutrition Coordinator, UW-Extension Office
- **Dolly Qualls**, (Retired Educator), Community Member
- **Barbara Richardson**, Former Community Member, Friend to Hudson Hospital & Clinics

Alcohol and Other Substance Use and Addiction

TASK FORCE CHAMPION

- **Doug Briggs**, Chief, Somerset Police Department

WORK GROUP MEMBERS

- **Steve Kirt**, BH/AODA Clinical Services Supervisor, St. Croix County
- **Dana Krahenbuhl**, AODA Coordinator, Hudson School District
- **Yvonne Larsen**, Community Relations, Youth Action Hudson
- **Mark Richert**, Chief, North Hudson Police Department
- **Peter Van Dusartz III**, Manager, Programs for Change, Hudson Hospital & Clinics
- **Family Life Educator**, UW-Extension Office
- **St. Croix County Substance Abuse Committee**
- **St. Croix County Prevention**
- **St. Croix County Underage Drinking Coalition**
- **Youth Service Bureau (YSB) AODA**

Tobacco Use and Exposure

TASK FORCE CHAMPIONS

- **Geralyn Karl**, Public Health Educator, St. Croix County Public Health
- **Tonya Love**, RT, Cardiopulmonary Care, Hudson Hospital & Clinics

WORK GROUP MEMBERS

- **Mark Aumann**, Congressional Aide, Office of U.S. Representative Ron Kind
- **Kellie Burrows**, Community Relations, American Cancer Society
- **Barbara Nelson**, Community Member
- **Sue Simonet**, RN, Hudson Physicians – WWMA

Other organizations and individuals to whom we owe thanks:

- **Richard L. Brown**, MD, MPH, Family Physician; School of Medicine and Public Health, University of Wisconsin – Madison, Clinical Director, Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) – SBIRT Program (*Screening, Brief Intervention, and Referral-to-Treatment*).
- **Tricia Christiansen**, Owner, Christiansen Creative
- **Elizabeth (Lieske) Giese**, RN, MSPH, Western Regional Office Director, Wisconsin Division of Public Health
- **Thomas E. Kottke**, MD, MSPH, Cardiologist, Hudson Hospital & Clinics; Medical Research Director for Evidence-based Health, HealthPartners; Epidemiologist; Health Services Researcher, HealthPartners Research Foundation; and consultant, UW Population Health Institute.
- **Nicholaas P. Pronk**, PhD, FACSM, Vice President and Health Science Officer, JourneyWell, HealthPartners; and Senior Research Investigator, HealthPartners Research Foundation

CONTINUED COLLABORATION

The benefits of participating in this process together are many. The operative word is "together". Collaboration helps communities improve their capacity to improve policies, draw attention to public health issues, and develop partnerships that can be applied in other areas.

The process is intended to be a group initiative rather than an individual endeavor. ***Healthier Together*** – *St. Croix County* emphasizes a community-building approach where organizations and individuals are engaged to participate in their own improvement initiatives. It's important that members are affected by, interested in, and/or have the capacity to impact the issue.

Collaboration also reduces isolation and working in silos. Working together increases program reach and impact. Through in-the-trenches teamwork, members build mutual trust and benefit from each other's expertise in the process. It is this group's goal to successfully leverage resources and address broad community health concerns, so as to have the greatest potential for improving health outcomes.

"For the Family Resource Center of St. Croix Valley, collaboration is critical as economic challenges pose hardships for families and public funding cuts for public health programs that serve such families continue. Funding cuts impact nonprofit organizations, just like ours. The Family Resource Center partners with governmental agencies to serve families. When public funding is cut, the burden to serve families continues yet the funding responsibility falls to the nonprofit sector — or in this case to us. This growing demand for programs and services creates waiting lists and in turn frustration for families in need.

Community partnerships, like those within **Healthier Together** – St. Croix County, *allow for the sharing of knowledge, expertise and resources so as to maximize impact and touch the lives of the greatest number of people."*

Patty Draxler, Executive Director
Family Resource Center
St. Croix Valley, Inc.

BUILDING CAPACITY

A community with capacity turns plans into results.

Every community that is trying to change its current condition starts from a different place, with different problems and different opportunities. All communities and community groups have capacity in some measure, and are capable of developing more. They can increase their ability to build community, to grow with opportunities, and to confront threats to the community's health and vitality.[1]

The three essential ingredients of community capacity — commitment, resources, and skills — are developed through effort and will, initiative and leadership and are used to build on community strengths and address community problems and opportunities. Communities that have the ways and means to undertake challenges demonstrate "capacity." Capacity is required to develop a healthier community.

The purpose of community capacity building is to enable people in a community to work together, make well-considered and collaborative decisions, develop a vision and strategy for the future, create local solutions for local problems, and act over time to make these real. **This process takes time.**

Healthier Together – *St. Croix County* facilitators intentionally and strategically worked to develop the group's capacity to build a healthy community through large group meetings, 1:1 meet-n-greets to determine "best fit", community presentations, continued networking and the offering of numerous educational opportunities and workshop trainings outlined in the following timeline.

Throughout the community health improvement process, the facilitators noticed signs that the group could make good decisions and had a common understanding of what it means to build a healthy community. Healthy attributes such as optimism, problem solving, consensus building, consideration for broad public interests, collaboration, tolerance and respect, trust, ability to challenge ideas, listening, sharing power, and "We can do it!" attitude emerged.

TIMELINE OF EVENTS

2008

- **Steering Committee Formation** (June)
- **Patrick Remington, MD, MPH, Director, UW Population Health Institute**
  Spoke on the use of *County Health Rankings* — specifically for St. Croix County — to help steering committee members better understand the relationship between health factors and health outcomes.
- **Photovoice® – *Using Photography to Hear the Voices of Mothers Raising Children in St. Croix County*** (qualitative research). Mothers with cameras were asked to capture images representing *Community Asset*, *Community Barrier/Need* and *Parenting Strategy/Reflection* in one of three topic areas.
  * To learn more visit www.hudsonhospital.org/community/show/96-community-health-improvement

2009

- **Community Needs Assessment**
  Healthiest Wisconsin 2010, the state public health plan, provided the framework for St. Croix County's community needs assessment conducted. Various types of research and activities were used to inform decisions and help determine the county's top 5 health priorities for the years 2009 – 2014 including: Photovoice®; *Use Your Voice* county-wide survey; and secondary research — steering committee review of quantitative data, including *County Health Rankings*.

2010

- **Mobilize for Action (January)**
  Reconvened steering committee to review findings of community needs assessment and discuss next steps for sharing information.
- **Community Forum/Workshops/Leadership Orientation/Task Force Work**
  Presentations (lecture, case studies, and small group activities) by content experts were invaluable to the process and instrumental in educating steering committee members, task force champions and engaging community stakeholders.
  - **Community Forum (February)**
    "If you bring the appropriate people together in constructive ways with good information, they will create authentic visions and strategies for addressing the shared concerns of the organization or community."

    David Chrislip and Carl Larson, Collaborative Leadership

    Results of the community needs assessment were presented to over 110 community stakeholders: Overview of St. Croix County community health improvement process; importance of collaboration; and introduction to community health actions. Information was used to make stakeholders aware of health-related concerns and mobilize them for action.

continued

2010 (continued)

- Key note: *Community Health Actions* (Nico Pronk, PhD)
- Letter: *Determinants of Health* (Tom Kottke, MD, MSPH, Cardiologist)

- **Workshop #1 (March)**
  "Never doubt that a small group of committed citizens can change the world; indeed it is the only thing that ever has!"

  Margaret Mead

  Initiated strategic planning — task force assembly and orientation to expectations and framework. Purpose was to connect people (75+ participants), ideas and resources and to further engage participants at a community level. Introduced *Healthy Wisconsin Leadership Institute* Community Health Improvement Toolkit (Root Cause Analysis Worksheet, Intervention Planning Matrix, Action and Evaluation Plan).

  - Key note: *Case Studies in Community Health* (Nico Pronk, PhD)
  - Training: Toolkit Introduction & Application (Lieske Giese, RN, MSPH)

- **Workshop #2 (April)**
  "I am of the opinion that my life belongs to the community, and as long as I live it is my privilege to do for it whatever I can."

  George Bernard Shaw

  Discussed leadership model/roles and responsibilities (Task Force Champion/Work Group Lead)

  - Training: Root Cause Analysis (direct and indirect contributing factors), Intervention Planning & Prioritization Exercise, Action and Evaluation Plan Examples (Lieske Giese, RN, MSPH)

- **Leadership Orientation (April)**
  Orientation for those who expressed interest in a leadership role; whether steering committee member, task force champion or work group lead. Revisited community health improvement process framework, leadership expectations, and *Roles & Responsibilities* form.

  - Special Presentation: *The Social Entrepreneur's Approach to Public Health: Changing Society's Performance Capacity* (Michael Kretz, MD)

- **Task Force Work (June 2010 – April 2011)**
  Each Task Force developed a community health improvement plan — goals, objectives, activities and measurable outcomes for respective health priority (independent task force work moving problems to solutions). Presented updates to steering committee as requested.

- **Special Presentation (July)**
  Screening, Brief Intervention and Referral to Treatment (SBIRT) Program (Richard Brown, MD)
  Overview/Program Feasibility/Grant Funding for St. Croix County

2010 (continued)

- **Special Presentation (September)**
  Hudson Physicians – *SBIRT Program Consideration/Grant Proposal*

- **Legislative In-district Meeting (December)**
  Steering Committee members/Task Force Champions met with Representative-Elect Dean Knudson to educate and inform him about the CHIP initiative and the work being done, specifically tobacco prevention and control efforts in his district. Updates included key messages, impact statements and demonstrated need for funding.

2011

- **Legislative Breakfast (February)**
  Quarterly event hosted by St. Croix Co. Department of Health & Human Services. Wendy Kramer and Karen Hansen attended. Updated attending legislators about *Community Health Improvement Process* (CHIP) for St. Croix County. Heard updates from Polk, Burnett, Dunn and Pierce counties as well.

- **Food for Thought Film Festival (February)**
  The Ethics of Eating (The Phipps Center for the Arts)
  Event support — displays included Photovoice exhibit and CHIP initiative materials.

- **Brand Identity (March)**
  Creation of new name and logo for "CHIP" that represents its mission and its members within — a collaboration of community partners (***Healthier Together*** – *St. Croix County*)

- ***Healthier Together* Leadership and Sustainability (April)**
  (Explore transition from planning model to implementation model and means of sustainability).

- **Task Force Plan Review/Steering Committee Final Recommendations (April/May)**

- **Master Report/Plan Roll-Up (May/June)**

2011 – 2013

- **Implement Community Health Improvement Plans (June)**
  Release ***Healthier Together*** – *St. Croix County* Master Report/Plan. Task forces begin implementation.

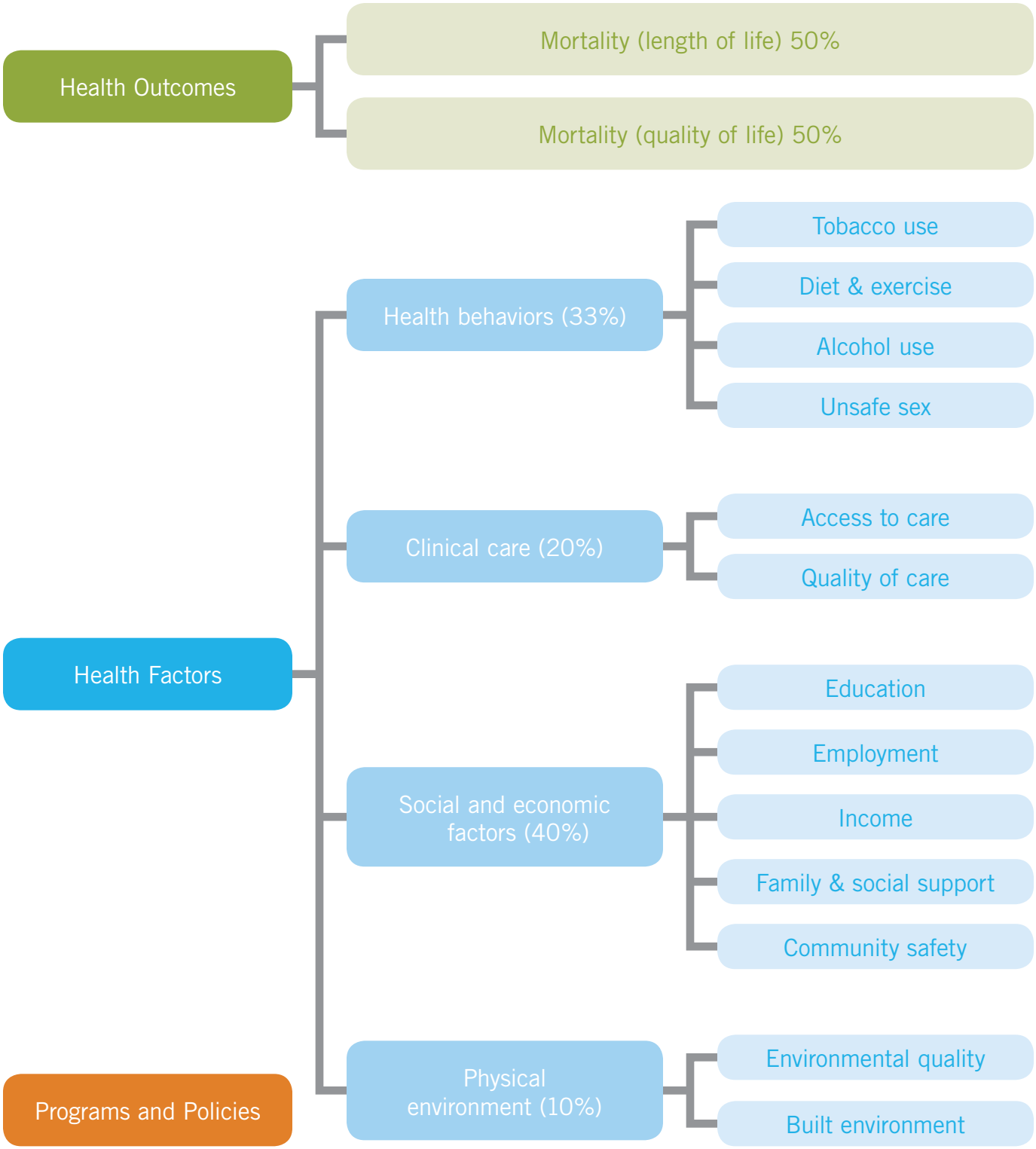
2012 – 2014

- Track health indicators over time to determine effectiveness of interventions and assess impact (annual evaluation). Promote Plan successes and modify individual plans needing improvement.

2014

- Begin reassessment of community needs in compliance with various reporting requirements (move from 5-Year to 3-Year reporting cycle).

COUNTY HEALTH RANKINGS: MODEL



University of Wisconsin Population Health Institute. *County Health Rankings 2011*. Accessible at www.countyhealthrankings.org

COUNTY HEALTH RANKINGS

From 2003 – 2009, the University of Wisconsin Population Health Institute released *County Health Rankings*, a report that ranked the overall health of all Wisconsin counties. The report took a broad look at community health across the state.

In 2010 and 2011, with the help of the Robert Wood Johnson Foundation, they were able to rank the overall health of nearly every county in all 50 states using a standardized method to measure how healthy people are and how long they live. The reports released continue to confirm the critical role that factors such as education, jobs, income and environment play in determining community health. Where we live matters and there is more to health than health care.

For St. Croix County, the release of *County Health Rankings 2010* came at the perfect time. The strengths and weaknesses identified in the report validated the findings (health priorities) recently identified in the county community needs assessment. The similarity in both reports helped the county focus on areas where public health efforts were lacking, as addressed in this Plan.

Why Rank?

The reason for ranking county health is to serve as a call to action for communities to:

- Understand the health problems in their community
- Get more people involved in building a healthier community
- Recognize that much of what influences our health happens outside the doctor's office

The *Rankings* is an improvement tool which allows counties to compare their overall health in relation to other counties in their state, and compare performance on specific health factors against national benchmarks. Counties are able to see where they are doing well and where changes are needed to improve health.

Health Factors and Health Outcomes

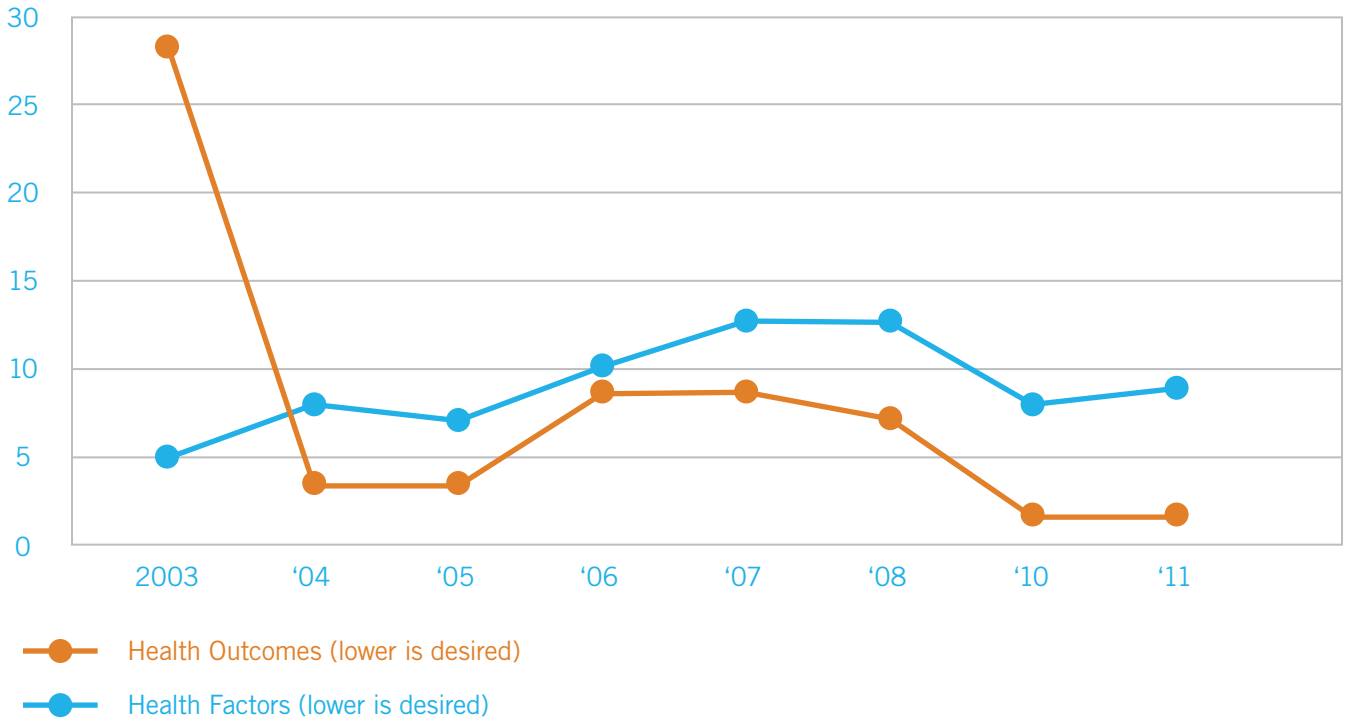
Both are used to determine how healthy a community is. *Health factors* represent what influences the health of a county "tomorrow" and include four types: health behaviors, clinical care, social and economic factors, and the physical environment. In turn, these factors are based on several measures (see *County Health Rankings* Model), many of which ***Healthier Together*** has addressed in this Plan — tobacco use, diet and exercise, alcohol use, access to care, quality of care, family and social support, and built environment. **In 2011, St. Croix County ranked #9 (out of 72 counties) in Health Factors, a slight decrease from the previous year (#8).** See *County Health Rankings* graphs — page 14.

Health outcomes represent "today's health" — how healthy a county currently is by measuring: how long people live (mortality) and how healthy people feel (morbidity). **In 2011, St. Croix County ranked #2 (out of 72 counties) in Health Outcomes, as it did in 2010.**

Because programs and policies implemented at the local, state and federal levels impact a variety of health factors, which in turn determine health outcomes, it is important to find evidence-based programs and policies that work, implement strategies for change and evaluate efforts.

COUNTY HEALTH RANKINGS: ST. CROIX COUNTY

Measure	2003	'04	'05	'06	'07	'08	'10	'11
TOTAL WISCONSIN COUNTIES	**72**	**72**	**72**	**73**	**73**	**73**	**72**	**72**
HEALTH OUTCOMES	**28**	**4**	**4**	**9**	**9**	**7**	**2**	**2**
Mortality	30	5	8	13	6	3	3	4
Morbidity	26	9	9	11	21	18	11	4
HEALTH FACTORS	**5**	**8**	**7**	**10**	**13**	**13**	**8**	**9**
Health Behaviors	13	28	50	44	38	37	15	17
Clinical Care	62	54	38	24	24	26	55	49
Social & Economic Factors	4	6	6	4	7	6	3	3
Physical Environment	6	29	30	20	56	62	38	39



ST CROIX COUNTY SNAPSHOT

By every picture of mortality (length of life) and morbidity (how healthy people feel), St. Croix County presents as a place where people tend to live well and live long. In fact, it is the second healthiest county in the state, according to results published in the recent *2011 County Health Rankings*. This message resonates well with those living in or relocating to western Wisconsin. St. Croix County's population grew by 34 percent in the first decade of the 21st century and is currently the fastest growing county in the state.

Plenty to be proud of

The county has many strengths that support healthy communities including a highly educated population — 73% of adults, ages 25 – 44, have some post-secondary education; residents with resources making it easier to stay healthy (median household income of $69,682 as compared to state median of $52,103); high immunization coverage; low rate of uninsured adults; and fewer poor mental health days per month reported.[2] People generally feel good.

Room for improvement

Even top-scoring counties in the state have areas related to health that need improvement, and St. Croix County is no exception. *County Health Rankings* was just one tool used to identify those areas needing attention. When compared to state averages, St. Croix County fares worse in binge drinking; ratio of residents to primary care providers; preventable hospital stays; access to healthy foods; prevalence of obesity; and low per capita public health funding to address these needs.

Finding solutions

We are all responsible for assuring that our communities are healthy places to live, learn, work and play. ***Healthier Together*** – *St. Croix County* is ready to take on these challenges and implement solutions. Are you?

2011 ST CROIX COUNTY, WISCONSIN

	St. Croix County	Error Margin	National Benchmark*	Wisconsin	Rank (of 72)
HEALTH OUTCOMES					**2**
Mortality					4
Premature death	4,633	4,116–5,150	5,564	6,230	
Morbidity					4
Poor or fair health	9%	7–13%	10%	12%	
Poor physical health days	2.7	1.9–3.4	2.6	3.2	
Poor mental health days	1.9	1.4–2.4	2.3	3.0	
Low birthweight	5.6%	5.1–6.1%	6.0%	6.8%	
HEALTH FACTORS					**9**
Health Behaviors					17
Adult smoking	18%	14–23%	15%	21%	
Adult obesity	28%	23–32%	25%	28%	
Excessive drinking	29%	23–36%	8%	25%	
Motor vehicle crash death rate	17	13–20	12	15	
Sexually transmitted infections	106		83	375	
Teen birth rate	16	14–18	22	32	
Clinical Care					49
Uninsured adults	11%	8–13%	13%	11%	
Primary care providers	1,130:1		631:1	744:1	
Preventable hospital stays	80	74–85	52	61	
Diabetic screening	85%	70–99%	89%	89%	
Mammography screening	74%	61–87%	74%	71%	
Social & Economic Factors					3
High school graduation	100%		92%	89%	
Some college	73%		68%	63%	
Unemployment	8.0%	7.7–8.2%	5.3%	8.5%	
Children in poverty	6%	5–8%	11%	14%	
Inadequate social support	12%	8–18%	14%	17%	
Single-parent households	20%		20%	29%	
Violent crime rate	76		100	283	
Physical Environment					39
Air pollution-particulate matter days	3		0	5	
Air pollution-ozone days	1		0	1	
Access to healthy foods	55%		92%	59%	
Access to recreational facilities	13		17	12	

* 90th percentile, i.e., only 10% are better
Note: Blank values reflect unreliable or missing data
www.countyhealthrankings.org/wisconsin/st-croix

* Data supplied on behalf of state ▶
Note: Blank values reflect unreliable or missing data
www.countyhealthrankings.org/node/3238/other-measures

2011 ST CROIX COUNTY, WISCONSIN

	St. Croix County	Wisconsin
DEMOGRAPHICS		
Population	83,351	5,654,774
% below 18 years of age	26%	23%
% 65 and older	10%	13%
% African American	1%	6%
% American Indian and Alaskan Native	0%	1%
% Asian	1%	2%
% Native Hawaiian/Other Pacific Islander	0%	0%
% Hispanic	1%	5%
% not proficient in English	1%	3%
% Females	50%	50%
% Rural	57%	32%
HEALTH OUTCOMES		
% diabetic	7%	7%
HIV prevalence rate	35	
HEALTH BEHAVIORS		
Binge drinking	28%	23%
Physical inactivity	19%	23%
*Smoking during pregnancy	9%	14%
*Motor vehicle crash occupancy rate	30	46
*Motor vehicle crash-related ER visits (onroad)	373	687
*Motor vehicle crash-related ER visits (offroad)	108	85
HEALTH CARE		
Mental health providers	82,487:0	8,437:1
*No recent dental visit	27%	25%
*Did not get needed health care	2%	2%
SOCIAL & ECONOMIC FACTORS		
Median household income	$69,682	$52,103
% with high housing costs	34%	33%
% of children eligible for free lunch	11%	32%
% illiterate	4.5%	7.3%
PHYSICAL ENVIRONMENT		
Liquor store density	17.0	7.0
% of labor force that drives alone to work	82%	80%
*Lead poisoned children	0%	2%
*Municipal water	42%	71%
*Contaminants in municipal water	0%	31%

PLAN OVERVIEW

The ***Healthier Together*** – *St. Croix County* Community Health Improvement Plan was designed by community stakeholders and partners who are putting it into action. In it, are defined specific goals for each of the five identified health priorities, individual tactics that will help achieve these goals, and leaders and partners who can make them happen.

While the Plan does not address every weakness and strength outlined in the community needs assessment, it does serve as a roadmap, and provides sufficient details to map a clear course of direction over the course of the current Plan cycle (2009 – 2014).

Approach

Healthier Together's approach was to develop intervention strategies that:

- best address identified health needs
- focus on improving health factors and health outcomes in St. Croix County
- engage a network of multidisciplinary, multisectoral stakeholders at all levels
- use data to identify and measure health impact
- increase program reach and impact county-wide (through replication of models created)
- concentrate on local area solutions that communities can benefit from
- support programs or policies recommended in both the Wisconsin and national health plans
- do more than educate about healthy lifestyles — initiate change strategies that require participants to "do" and empower residents to make the right decisions
- are realistic given the time and resources available

The success of each goal is based on outcome measurement to track community progress and project impact. Each goal has an assigned task force, and for some, additional work groups who worked together to develop coordinated Action and Evaluation plans. The task forces, with support and guidance from the steering committee, are ready to begin the *Implementation Phase* of the community health improvement process.

Tracking Results

Evaluation will remain important throughout the remainder of the 5-year Plan cycle (December 31, 2013) so that progress toward Plan goals is meaningful and measurable. Continual plan updates will occur based on feedback from task force members. Lessons learned from what's been done (what worked — what didn't) will help guide future actions. Evaluation will also help to inform key decision makers and help answer the important questions as to whether the right strategies were implemented and the desired impact achieved.

ACCESS TO PRIMARY AND PREVENTIVE HEALTH SERVICES – WHY ADDRESS?

- From 2004 – 2007, public coverage rose faster in St. Croix County than throughout the rest of the state, attributable, at least in part, to the fact that the percent of low-income people increased in St. Croix County while it dropped statewide.
- In the 2010 *County Health Rankings* report, issued by the Wisconsin Institute on Population Health, St. Croix County fared relatively poorly in the measure related to provision of health care services to those in need of (44 out of 72 counties), despite the high levels of insurance coverage.

Primary Care Providers	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
(Rate per 100,000 population)	2010	109	182	134
(Ratio of population to primary care providers)	2011	1,130:1	631:1	744:1

Uninsured Adults	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
(Percent of population age 65 without health insurance)	2010	10%	9%	10%
	2011	11%	13%	11%

- Access to oral health continues to be a major concern. Ironically, as more and more children are added to state programs, the number of providers willing to accept patients served by these programs remains inadequate.

No Recent Dental Visit	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
(Percent of population age 2+ – no dental visit past year)	2010	27%	20%	25%
	2011	27%		25%

- While the Wisconsin Parity Act went into effect April 30, 2010 and provides people living with mental illnesses and addiction disorders full benefits to receive the care they need, there still remain barriers — both for providers and consumers, limiting access to mental health care.

Mental Health Providers	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
(Ratio of population to mental health providers)	2010	N/A	N/A	N/A
	2011	82,487:0		8,437:1

- As health care costs spiral out of control, inpatient hospital stays for chronic or acute conditions that could have been handled on an outpatient basis continue to be an area of concern and opportunity for cost savings. Proper outpatient care could have prevented hospital stays for conditions such as diabetes, dehydration and certain heart conditions and infection.

Preventable Hospital Stays	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
(Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees)	2010	83	51	63
	2011	80	52	61

ACCESS TO PRIMARY AND PREVENTIVE HEALTH SERVICES – GOALS

Access to Medical Care Services

Goal: Expand free or reduced cost medical care to indigent (uninsured or underinsured) residents of St. Croix County and neighboring counties.

- **Objective 1**: By March 1, 2011, 20% of physicians practicing in St. Croix County will respond to an online survey to determine interest in providing care for indigent residents of St. Croix County and preferred model of care

- Survey tool (electronic) was created and pre-survey letter written explaining reason for survey and differentiation between Community Health Center and Health Care Network. Survey results used to create a list of potential provider volunteers for a Health Care Network. ***Looking for providers to sit on Steering Committee or assist with initiative.**

- **Objective 2**: By August 31, 2011, information and data will be collected to identify three health care delivery models that serve indigent residents and determine feasibility for St. Croix County. (Models: Free Clinic, Health Care Network and Community Health Center)

- Explored state and federal guidelines for various health care delivery models and assessed Emergency Room usage in St. Croix County — how many low income and uninsured patients accessed care through the ER? Investigated various models and proposed locations being considered.

- **Objective 2A**: By March 31, 2013, a Health Care Network (HCN) will be implemented in St. Croix County to serve indigent residents.

- As a result of provider survey feedback and preliminary findings (feasibility, funding, etc.), the Health Care Network model looks most promising. Meet with local hospital CEOs, Clinic Administrators, and interested providers to discuss in detail and assess interest.

Goal: Connect indigent residents of St. Croix County with the resources they need to be happy.

- **Objective 3:** By December 31, 2013, Public Health will partner with at least two health care providers in St. Croix County to provide a preventive screening service based on community needs assessment results.

- Team will evaluate recognized sources of preventive care, conduct a gap analysis to identify existing services vs. needed services, and select and provide for our communities. Consumer education about preventive health screenings available and recommended screening measures will be important.

- **Objective 4:** By June 30, 2013, create a county-wide online resource directory to inform communities of resources available and link users to appropriate primary and preventive medical care services.

- Sub-committee (including task force appointee) will be formed to research and create an online resource directory.

- **Objective 5:** By December 31, 2011, a new website will be launched to promote ***Healthier Together*** initiative and the five identified health priorities.

- Website is communication portal for ***Healthier Together*** initiative (community resource for education, updates, event calendar, health engagement, volunteer opportunities, etc.)

ACCESS TO PRIMARY AND PREVENTIVE HEALTH SERVICES – GOALS

Access to Mental Health Services

Goal: Improve the understanding of the barriers and gaps related to access of Mental Health Services in St. Croix County from both a community resource and consumer perspective.

- **Objective 1:** By February 28, 2011, a minimum of 158 key community resources will be surveyed regarding barriers and gaps related to access of Mental Health Services in St. Croix County and results analyzed.

- In effort to better understand county-wide mental health services access issues, task force work group developed survey tools including online survey questionnaire, email distribution lists, and script explaining reason for request. Results analyzed and gap analysis done to identify key barriers and gaps

- **Objective 2:** By September 30, 2011, a minimum of 100 consumers will be surveyed regarding barriers and gaps related to access of Mental Health Services in St. Croix County and results analyzed.

- Survey tool (paper) created and distributed to counseling services willing to administer the survey to their patients. Additional phone survey work to be done with point staff (access and referral) to determine why *potential customers* have not accessed mental health services.

- **Objective 3:** By July 31, 2012, an analysis of key barriers and gaps identified by both community resources and consumers will be completed and strategies for change developed.

- Comparison of similarities and differences between community resources and consumers with the intent of recommending ways to change or remove barriers and fill gaps. New *Action, Implementation and Evaluation* plans will be created at that time specific to and in support of selected strategies.

- **Objective 4:** By June 30, 2013, create a county-wide online resource directory to inform communities of resources available and link users to appropriate primary and preventive health services that support mental health.

- Sub-committee (including task force appointee) will be formed to research and create an online resource directory.

- **Objective 5:** By December 31, 2011, a new website will be launched to promote ***Healthier Together*** initiative and the five identified health priorities.

- Website is communication portal for ***Healthier Together*** initiative (community resource for education, updates, event calendar, health engagement, volunteer opportunities, etc.)

ACCESS TO PRIMARY AND PREVENTIVE HEALTH SERVICES – GOALS

Access to Oral Health Services

Goal: To achieve optimal dental health and access to dental care for all residents of St. Croix County.

- **Objective 1**: By August 31, 2010, at least three preventive oral health programs will be evaluated and findings documented.

- In effort to better understand county-wide dental needs, task force work group researched current county programs, past efforts, industry standards, and legislative involvement regarding dental access issues.

- **Objective 2**: By August 31, 2011, all dentists in St. Croix County will be surveyed to identify key barriers and gaps prohibiting dental service delivery to underserved communities and results analyzed and shared.

- Survey tool, cover letter and link to online survey were created and survey was administered. Group has completed gap analysis and is ready to share results with all dentists to further determine interest in dental access opportunities.

- **Objective 3**: By March 31, 2013, 5% of dentists in St. Croix County will participate in an established Health Care Network serving indigent (uninsured/underinsured) residents.

- Group is looking to engage interested St. Croix County dentists in discussions about this care delivery model in alignment with Medical Care Access work group efforts.

- **Objective 4:** By July 1, 2012, six school districts in St. Croix County will be assessed to determine appropriateness and viability of a school-based fluoride program and next steps initiated for those interested.

- Work to be done is to help determine whether evidence and data support school-based fluoride programs (whether Swish and/or Varnish) in individual county school districts and to assess interest in various program offerings.

- **Objective 4A:** By December 31, 2013, 30% of children in grades K – 6 in one or more school districts in St. Croix County will receive at least one Fluoride Varnish treatment during the school year.

- Goal is to increase eligible student participation rates through collaboration in service delivery (school district reps, public health staff, Chippewa Valley Technical College (CVTC) dental students and staff, etc.)

- **Objective 5:** By June 30, 2012, officials in at least four local municipalities in St. Croix County without fluoridated water will receive information about the benefits to residents of municipal water fluoridation.

- Activities are meant to educate and inform key municipality officials about the benefits of fluoridated water. This initiative focuses on policy and procedural changes. ***Group is looking for local dental input and willingness to attend local government meetings to affect change.**

- **Objective 5A:** By December 31, 2013, one non-fluoridated municipality in St. Croix County will implement water fluoridation.

- Goal is to secure commitment from at least one municipality and to work together to draft an *Action*, *Implementation* and *Evaluation* Plan to aid process.

- **Objective 6:** By June 30, 2013, create a county-wide online resource directory to inform communities of resources available and link users to appropriate primary and preventive health services that support oral health.

- Sub-committee (including task force appointee) will be formed to research and create an online resource directory.

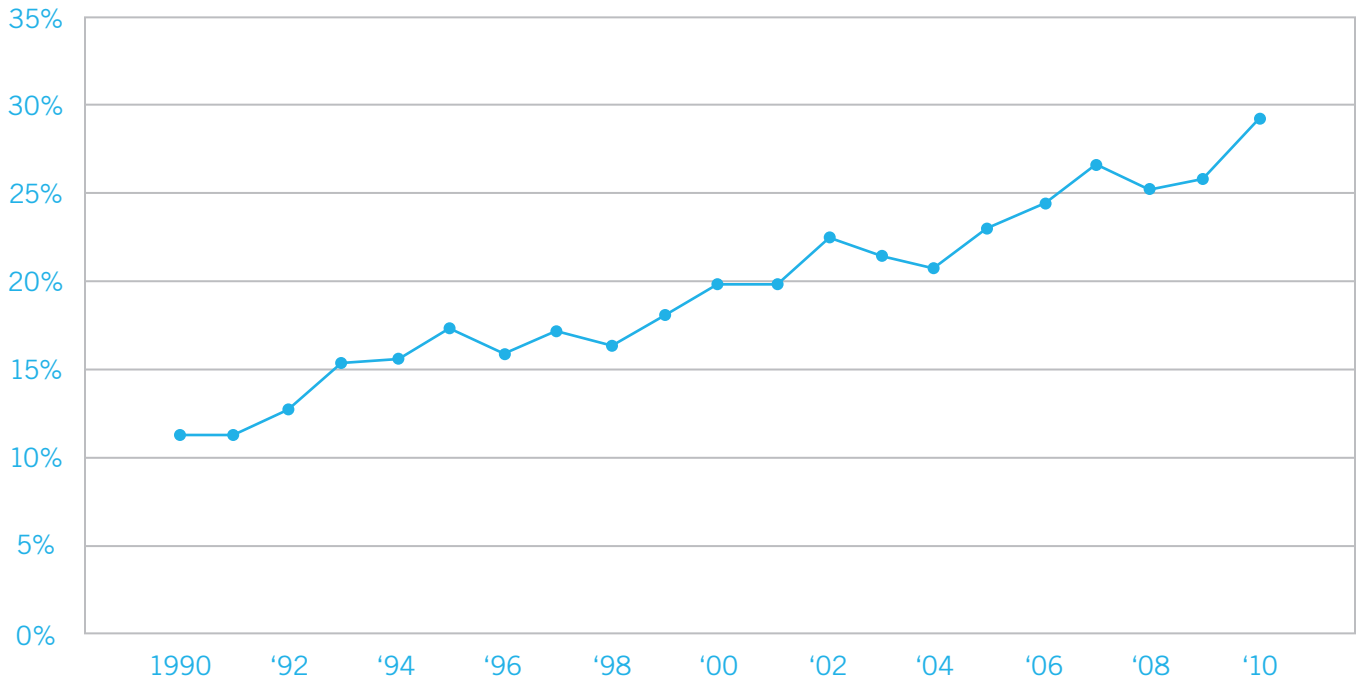
- **Objective 7:** By December 31, 2011, a new website will be launched to promote ***Healthier Together*** initiative and the five identified health priorities.

- Website is communication portal for ***Healthier Together*** initiative (community resource for education, updates, event calendar, health engagement, volunteer opportunities, etc.)

OVERWEIGHT, OBESITY, AND LACK OF PHYSICAL ACTIVITY – WHY ADDRESS?

- Obesity continues to be one of the fastest growing health issues in our nation and America is spending billions in direct health care costs associated with poor diet and physical inactivity.
- "Obesity and tobacco use are top contributors to a variety of diseases and other leading causes of premature death and disability. We cannot avoid these critical public and personal health battles. We must work with multiple stakeholders and our public health partners to develop comprehensive solutions to solve this problem."
  (Georges C. Benjamin, M.D., executive director of the American Public Health Association)
- Obesity increases the risk for health conditions such as coronary heart disease, type two diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gall bladder disease, sleep apnea and respiratory problems, and osteoarthritis.
- Across the nation, obesity rates are increasing, in fact, at a more rapid rate in Wisconsin, and in St. Croix County.

Adult Obesity	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
(Percent of adults that	2010	26%	24%	25%
report a BMI >= 30)	2011	28%	25%	28%



Obesity has increased 132 percent from 11.6 percent of the population in the 1990 Edition *America's Health Rankings®* to 26.9 percent in the 2010 Edition; meaning today, more than one in four Americans are considered obese.

OVERWEIGHT, OBESITY AND LACK OF PHYSICAL ACTIVITY – GOALS

Goal: Through *Healthier Together* contribute to an increase in the percent of children, adolescents and adults in St. Croix County classified as healthy weight and physically active.

- **Objective 1**: By September 30, 2012, three school districts in St. Croix County will implement a physical activity and nutrition program for children in grades K – 6.

- Through partial grant funding received May 2011 from the St. Croix Valley Foundation, three school districts (Hudson, New Richmond and Somerset) and their Community Ed representatives will begin a 1-year pilot program this fall offering an after school and/or Saturday morning program to children K – 6 not in organized sports. ***Volunteers needed to assist with a variety of seasonal sports-related activities and connect youth to the outdoors.**

- **Objective 2**: By September 30, 2013, at least one additional school district in St. Croix County will implement a *Farm to School* program.

- Goal is to connect schools with interested Community Supported Agriculture (CSAs), a popular way for consumers to buy local, seasonal food directly from a farmer. This arrangement is beneficial for both parties, even the kids, who typically favor food from "their" farm — even veggies they've never been known to eat. ***Looking for work group members and interested CSAs/farmers to help advance this program.**

- **Objective 3**: By May 31, 2013, at least four new ***Healthier Together*** community gardens will be established and maintained by organizations willing to foster participation within.

- A garden sub-committee was formed (new members welcome) who developed a community garden model (template) which is easily replicable for interested businesses and organizations joining the initiative. Plan metrics are included to ensure objective is meaningful and measurable. Pilot garden created: *Community Garden – Hudson Hospital & Clinics*. Forty-four plots planted this spring. ***Additional plots available. Topic experts wanted for community gardener education and training programs, as well as, those interested in youth gardening.**

- **Objective 4:** By June 30, 2013, create a county-wide online resource directory to inform communities of resources available that support optimal lifestyle behaviors.

- Sub-committee (including task force appointee) will be formed to research and create an online resource directory.

- **Objective 5:** By December 31, 2011, a new website will be launched to promote ***Healthier Together*** initiative and the five identified health priorities.

- Website is communication portal for ***Healthier Together*** initiative (community resource for education, updates, event calendar, health engagement, volunteer opportunities, etc.)

ADEQUATE AND APPROPRIATE NUTRITION – WHY ADDRESS?

In response to the St. Croix County community needs assessment completed in 2009, the task force is addressing some of the identified health priority issues outlined in the *CHIP Executive Summary*:

- **Percentage of residents eating adequate amounts of fruits and vegetables** – nearly 80% of residents in St. Croix County report eating insufficient amounts.
- **Rate of growth of participation in the Free and Reduced Lunch Program** – in 2006, St. Croix County reported 14.72% of children were enrolled in the program as compared to statewide average of 32%.
- **Rate of growth for the Food Share Program (Food Stamps)** – according to a report released in November 2009, only 64% of eligible individuals in Wisconsin were enrolled in program.
- **Increase rise in Food Insecurity** – in 2008, 17 million households (14.6 percent) across the nation were food insecure and had difficulty putting food on the table. While Wisconsin showed lower than average food insecurity during this period, WIC food insecurity figures for St. Croix County point to a likely population health disparity — the "working poor".
- **Access to Healthy Foods** – studies have linked physical environment (built environment) to consumption of healthy food and overall health outcomes.

Access to Healthy Foods	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
(Percent of zip codes in a county with a healthy food outlet including grocery stores and produce stands/ farmers markets)	2010	55%	63%	46%
	2011	55%	92%	59%

- Based on *America's Health Rankings 2010* (a long-running annual report on national health), Wisconsin dropped from 11th place overall in 2009 to 18th place in 2010. The state ranked 7th when the annual rankings began in 1990. This includes poverty as well as access to food.
- Our action plan reflects current legislation — *The Healthy, Hunger-Free Kids Act of 2010* authorizing funding for federal school meals and child nutrition programs and increased access to healthy food for low-income children.

Impact our work has or we anticipate it will have:

Addressing these issues will assist the county in *increasing access* for those in need; *ensuring adequate nutrition* to the increased number of residents needing food assistance; and *ensuring that the food is appropriate* to support healthy eating within a budget.

ADEQUATE AND APPROPRIATE NUTRITION – GOALS

Goal: Increase consumption of fruit and vegetables by residents of St. Croix County.

- **Objective 1**: By August 31, 2012, one or more targeted school districts will enroll and participate in an intervention program to increase student participation in free/reduced lunch program by 5%.

! Efforts are underway to increase eligible student enrollment and participation in program in school districts with lowest participation rates. Initiative provides opportunity for targeted interventions with students including increased consumption of fruits and vegetables.

- **Objective 2**: By December 31, 2013, St. Croix County will decrease the percentage of insufficient fruit and vegetable intake from 79.6% to 77.2% (Wisconsin average) or lower, through increased nutrition education and access to area food resources.

! Revised and updated *Community Food Resource Directory* will be made available as a resource. Surveys will be administered to assess foods available/taken by clients at local food shelves and another, to assess food shelf staffing needs, facility and other resource issues. Goal is to increase the availability, accessibility and distribution of fruits and vegetables.

- **Objective 3**: By December 31, 2013, increase utilization of farmers markets by 20% and increase utilization of WIC vouchers at farmers markets by 20%.

! A marketing plan will be created to increase awareness of farmers markets in St. Croix County and help promote WIC voucher usage at farmers markets. Campaigns will be targeted to specific populations who might benefit most.

! Objective also includes implementation of a plan to offer Electronic Benefit Transfer (EBT) at farmers markets and outreach and training for market vendors.

- **Objective 4**: By December 31, 2013, newsletter readership and participation rates for proposed community projects, classes, and demos (created to help increase knowledge and skills needed to prepare easy, affordable, nutritious meals according to nutrition guidelines) will increase by 25%.

! Development of newsletter "Food Sense" with distribution to targeted populations, outreach strategies for food shelves to include provision for recipes, cooking demos, samples, etc. and engagement of county-wide representatives (hospital, school, nutritionists, etc.) to advocate for and work collaboratively for community education.

- **Objective 5:** By June 30, 2013, create a county-wide online resource directory to inform communities of resources available that support adequate and appropriate nutrition.

! Sub-committee (including task force appointee) will be formed to research and create an online resource directory.

- **Objective 6:** By December 31, 2011, a new website will be launched to promote ***Healthier Together*** initiative and the five identified health priorities.

! Website is communication portal for ***Healthier Together*** initiative (community resource for education, updates, event calendar, health engagement, volunteer opportunities, etc.)

ALCOHOL AND OTHER SUBSTANCE USE AND ADDICTION – WHY ADDRESS?

- Excessive drinking is a risk factor for a number of adverse health outcomes such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
- Wisconsin is a national leader of heavy and high-risk drinking and drug abuse.
- Substance abuse is the fourth leading cause of death in Wisconsin.
- St. Croix County is among the top 10 counties in Wisconsin with the highest rates of binge drinking.

Binge Drinking	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
(Percent of adults that report binge drinking in the last 30 days)	2010	27%	16%	23%
	2011	28%	—	23%
Excessive Drinking (Binge + heavy drinking)	2011	29%	8%	25%

- St. Croix County high school students report a slightly higher use than their peers statewide with regard to binge drinking before age 13 and sniffing/inhaling glue, aerosols, paints, or sprays.
- The physical environment (built environment) plays a role in alcohol consumption and overall health outcomes.

Liquor Store Density	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
(Number of stores per 10,000)	2010	1.9	—	0.8
(Number of stores per 100,000 population)	2011	17.0	—	7.0

- While St. Croix County alcohol-related car crashes and related deaths are down since 2000, the number of adults arrested for *Operating While Intoxicated* has increased dramatically.
- A strong correlation between excessive drinking and alcohol-impaired driving exists, with approximately 17,000 Americans killed each year in alcohol-related motor vehicle crashes.

Motor Vehicle Crash	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
Death Rate	2010	16	12	16
(Crash rate per 100,000 population)	2011	17	12	15

Motor Vehicle Crash-Related	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
ER Visits (off road)	2010	109	74	90
(Visits per 100,000 population)	2011	108	—	85

ALCOHOL AND OTHER SUBSTANCE USE AND ADDICTION – GOALS

Goal: Reduce, to the greatest extent possible, the factors that contribute to alcohol abuse.

- **Objective 1**: By December 31, 2013, reduce Citations for Underage Possession of Alcohol by 20%.

! Efforts are underway to increase compliance of laws involving alcohol sales points and accessibility of alcohol by underage persons. Initiative includes vendor education program and employee training.

- **Objective 2**: By December 31, 2013, one or more *Screening, Brief Intervention, and Referral to Treatment (SBIRT)* programs will be implemented in a St. Croix County hospital or clinic.

! Program provides for screening of all patients for alcohol, drug and tobacco problems and brief intervention including follow-up and outcome measures. Referral to other treatment services when appropriate. Opportunity to help individuals before crisis situation or chronic health conditions develop.

- **Objective 2A**: By September 30, 2011, determine baseline utilization rates for screenings, brief interventions, and referrals to treatment services as provided through SBIRT program.

! Using SBIRT generated outcome data from Baldwin Area Medical Center, assess whether there was an increase in the number of people receiving screening, treatment, etc. for alcohol, drug and tobacco abuse. Data results will show effect of screening, early detection, and prevention services on behavior change, if any.

- **Objective 3:** By December 31, 2013, 25% more adolescents and their families will receive Alcohol and Other Drug Abuse (AODA) treatment services that incorporate a family component.

! Task force is developing and implementing a Matrix Based Treatment Program for adolescents and their families, with the goal of increased family participation.

- **Objective 4:** By June 1, 2013, one additional St. Croix County community will participate in the *Parents Who Host Lose the Most* campaign.

! Purpose of campaign is to educate parents and community members about the consequences of underage drinking. ***Students and businesses and organizations will be needed to help promote the campaign in selected community.**

- **Objective 5:** By December 31, 2013, decrease elementary and secondary level alcohol and drug incidences by 10%.

! Activities to help accomplish this include the building of a comprehensive K–12 evidence-based AODA curriculum and interventions in all St. Croix County schools. Hope is that there will be an increase in student self-reporting, reduction in risk behaviors, and decrease in student substance use.

- **Objective 6:** By June 30, 2013, create a county-wide online resource directory to inform communities of resources available to help with alcohol and other substance use and addiction.

! Sub-committee (including task force appointee) will be formed to research and create an online resource directory.

- **Objective 7:** By December 31, 2011, a new website will be launched to promote ***Healthier Together*** initiative and the five identified health priorities.

! Website is communication portal for ***Healthier Together*** initiative (community resource for education, updates, event calendar, health engagement, volunteer opportunities, etc.)

TOBACCO USE AND EXPOSURE – WHY ADDRESS?

- More than 915,000 Wisconsinites still smoke cigarettes.[3]

Adult Smoking	**Year**	**St. Croix Co.**	**Benchmark**	**Wisconsin**
(Percent of adults that report smoking at least 100 cigarettes and currently smoke)	2010	21%	16%	21%
	2011	18%	15%	21%

- 6,900 Wisconsin kids (under 18) become new smokers each year.[4]
- Tobacco is still the #1 cause of preventable death. Nearly 7,000 Wisconsin adults die each year from their own smoking.[5]
- Cigarette smoking is identified as a cause in multiple diseases including various cancers, cardiovascular disease, respiratory conditions, low birth weight, and other adverse health outcomes.
- We all pay — annual health care costs in Wisconsin directly caused by smoking total $2.8 billion.[6]
- For each smoker who quits, Wisconsin saves $1,623 in Medicaid and other health care costs.[7]
- Program funding is at an all-time low. Wisconsin invests only 10% of the amount recommended by the Centers for Disease Control.[8]
- Program funding cuts resulted in a reduction in the number of tobacco prevention and control programs across the state, a reduction in the number of compliance checks done, as well as cessation counseling services for smokers.
- Youth smokeless tobacco use is on the rise in Wisconsin.[9] Candy flavorings and bright colors make smokeless products extremely appealing to young people.
- The health consequences of smokeless tobacco use include oral, throat and pancreatic cancer, tooth loss, gum disease, and increased risk of heart disease, heart attack and stroke.[10]
- In the 2010 *State of Tobacco Control Report* released by the American Lung Association, Wisconsin received an "F" for tobacco control funding, an "A" for implementing the new Smoke Free Air law, a "B" for our sales tax on cigarettes and chew, and an "F" for cessation services.

TOBACCO USE AND EXPOSURE – GOALS

Goal: Support for Wisconsin Tobacco Prevention and Control Program, Policies and Laws, and Cessation Services.

- **Objective 1**: By December 31, 2013, 90% of businesses possessing a license to sell tobacco will be in compliance with the "sales to minors" law.

- Increase awareness and support for the *WI Wins Program* and the sales to minors law in hopes of decreasing sales of tobacco to minors and decreased youth tobacco initiation and use.

- **Objective 2**: By December 31, 2013, increase support of, and compliance with, the 2010 Wisconsin Smoke Free Air Law by 20%.

- Efforts to educate business community, law enforcement, judges, key stakeholders, the public, and other identified groups about the law, so as to increase support for and compliance and enforcement of law, as well as increase number of people protected from secondhand smoke.

- **Objective 3**: By December 31, 2013, there will be a 30% increase in affordable, accessible and appropriate cessation programs/services offered and utilized by St. Croix County residents wanting to quit tobacco.

- Plan to mobilize identified community partners to address current services, need for services, best practices for implementation of services, promotion of services, and outcome of services. Goal is to increase number of organizations offering cessation services and decrease number of individuals who use tobacco.

- **Objective 4**: By December 31, 2013, there will be a 20% increase in funding for the *Tobacco Prevention and Control* program in Wisconsin.

- Educate key stakeholders on the impact of an adequately funded and sustainable program through state budget allocations, in-district and town hall meetings, candidate forums, legislative events, and media outlets. Work to leverage resources to comprehensively address identified needs.

- **Objective 5:** By June 30, 2013, create a county-wide online resource directory to inform communities of resources available that support smoking cessation.

- Sub-committee (including task force appointee) will be formed to research and create an online resource directory.

- **Objective 6:** By December 31, 2011, a new website will be launched to promote ***Healthier Together*** initiative and the five identified health priorities.

- Website is communication portal for ***Healthier Together*** initiative (community resource for education, updates, event calendar, health engagement, volunteer opportunities, etc.)

USING THE PLAN

Despite St. Croix County's general "good health," there is still room for improvement. Each of us can play an important role in community health improvement whether in our homes, schools, workplaces, churches, or in our communities. Encouraging and supporting healthy behaviors from the start is so much easier than altering unhealthy habits. Below are some simple strategies[11], ways to use the County Health Rankings and this Plan, to improve the health of your community:

Employers

- Use the Plan to improve the health of your employees and your community in which you work
- Understand priority health issues that affect the health of your community
- Use objectives to talk with employees about health issues that affect their well-being, productivity, and health care costs
- Develop worksite wellness programs

Educators

- Because life-long habits are often developed in childhood, understand you are key partners in improving the long-term health of a community
- Use Plan to integrate prevention into education — across the continuum — starting from the earliest ages
- Align Plan and school district Wellness Policy (collaborative efforts to support Plan — leadership, wellness team, teachers, parents and students)
- Identify youth opportunities within each plan and offer to get involved

Government Officials

- Identify the barriers to good health in your communities, and mobilize community leaders to take action — investing in programs and policy changes that help residents lead healthier lives

Health Care Professionals

- Use Plan to remove barriers and create solutions for identified health priorities
- Offer your time and expertise to local improvement efforts (Health Care Network, committee member, content resource, etc.)
- Offer patients relevant counseling, education, and other preventive services in alignment with identified St. Croix County health needs

State and Local Public Health Professionals

- Use the Plan to improve population health
- Understand how Wisconsin and St. Croix County compare with the U.S. population as a whole
- Learn about key issues that are important to address on a national level — align efforts locally to support

Faith-based Organizations

- Talk with parishioners/members about the importance of overall wellness (mind, body and spirit) and local community health improvement initiatives that support wellness
- Identify Plan opportunities that your organization or individual members can help support and encourage participation (i.e. community garden, food pantry initiatives, Farm to School program, etc.)

Community Residents

- Use plan to improve the health of your community
- Understand how health issues are changing in your community over time
- Use information to talk with community leaders about those health issues important to you
- Get involved — join a task force, volunteer your time or expertise for an event or activity, or financially help support initiatives planned

HEALTHIER TOGETHER

Because community health improvement is a shared responsibility among us all, everyone is invited to join the efforts of ***Healthier Together*** – *St. Croix County*. The Community Health Improvement Plan (2009–2014), including detailed task force *Action*, *Implementation* and *Evaluation* plans, is available online at www.hudsonhospital.org/community or www.co.saint-croix.wi.us/publichealth for review.

For more information, to request a copy of the Plan, to schedule a ***Healthier Together*** representative to speak at your organization, or if you are interested in participating in any of the Plan initiatives, please contact:

Karen Hansen, Co-facilitator
Hudson Hospital & Clinics
(715) 531-6056
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(715) 246-8363
wendyk@co.saint-croix.wi.us

COMING SOON!
Healthier Together – *St. Croix County* website
December 2011!

ENDNOTES

1 *Measuring Community Capacity Building*, Tools for Practice. Aspen Institute/Rural Economic Policy Program, Version 3-96.

2 University of Wisconsin Population Health Institute. *County Health Rankings 2011.*

3, 5, 6 *Burden of Tobacco in Wisconsin*, 2010.

4 Campaign for Tobacco-Free Kids, *Toll of Tobacco in Wisconsin*, 2009.

7 University of Wisconsin Center for Tobacco Research and Intervention. *Quit Line Fact Sheet*, 2010.

8 Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs*, 2007.

9 Campaign for Tobacco-Free Kids. *The Danger from Dissolvable Tobacco and Other Smokeless Tobacco Products*, 2010.

10 American Cancer Society. *Smokeless Tobacco*, 2010.

11 County Health Rankings *Mobilizing Action Toward Community Health.* Available at www.countyhealthrankings.org/print/take-action

Healthier Together

St. Croix County

RIVER FALLS AREA HOSPITAL
PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Appendix E

Pierce County CHIP

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
RIVER FALLS
AREA HOSPITAL

2008-2012

Community Health Improvement Plan

Access to Health Care

- Including Medical, Dental, and Mental Health Services

Overweight & Obesity

- Lack of Physical Activity
- Inadequate Fruit and Vegetable Intake

Alcohol Issues

- Underage Drinking
- Binge Drinking

Pierce County

Public Health Department

How Do We Build A Healthier Pierce County?

- ☑ Involve Pierce County citizens
- ☑ Assess needs and priorities
- ☑ Prepare a guide for community action
- ☑ Share this guide with colleagues, friends, and policy makers
- ☑ Invite the community to take action

By Working Together!

Executive Summary

The Pierce County Community Health Improvement Process (CHIP) began in October of 2007 with leadership from the Health Department and a community steering committee comprised of local representatives from the River Falls Area Hospital, River Falls Area Hospital Foundation, Elmwood Ambulance Service, United Way St. Croix Valley, Plum City Care Center, Pierce County Human Services, Ellsworth Medical Clinic, UW-River Falls Student Health and Counseling, English Lutheran Church, and the Pierce County Board of Health. The Mobilizing for Action through Planning and Partnerships (MAPP) process was chosen as a framework for the assessment. The State Health Plan priorities and the Essential Public Health Services provided additional direction.

The first of the four MAPP assessments, the Local Public Health System Assessment, was conducted at a December 2007 meeting to determine the activities, competencies, and capacities of our local public health system. Although many strengths of our local system were identified, additional coordination and activities are needed to:

1. Develop policies and plans that support individual and community health efforts
2. Link people to needed personal health services
3. Assure the provision of health care when otherwise unavailable
4. Research new insights and innovative solutions to health problems

The remaining three MAPP assessments, the Forces of Change Assessment, a Community Themes and Strengths Survey, and Community Health Status data review were completed during 2008 through a combination of steering committee meetings and a community survey. Common themes provided the basis for establishing the three health priorities of ***access to care, overweight and obesity, and alcohol issues***. Presentations to share assessment results and create awareness of the issues were conducted at various local organization meetings. Representatives from a wide variety of community organizations participated in a December 2008 action planning meeting to begin the implementation phase of the project. Best practices were identified while workgroups set short and long-term goals and strategies to address these issues.

The identified health priorities will be the focus of action planning to improve the health of Pierce County residents for the next five years.

It is recognized that the coordinated, collaborative efforts of many organizations in the community are necessary to significantly impact these complex health issues. Currently, there are minimal activities aimed at addressing these priorities, thus additional resources will be needed to implement effective health improvement initiatives in Pierce County.

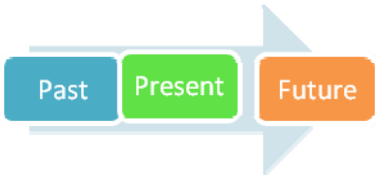
Purpose

There are several reasons for doing a community needs assessment:

- Wisconsin State Statute HFS 140.04 requires that each local health department complete a community health assessment and participate in a new local health improvement plan every 5 years.
- To provide updated information on the county's population health status by following the Wisconsin Statute Chapter 251.05.
- To create a process which encourages the community and residents to provide input into identifying the needs of the community and the availability of local resources.

History

In the past, the health priorities identified by Pierce County Health Needs Assessments have been useful guides in which to frame community goals and services.



In 1992, the Year 2000 Citizens Advisory Committee Report identified that access to health care, especially for adolescents and those with chronic disease, as well as access to dental care were needs. In addition, it inspired the group to focus on education and prevention in areas of communicable disease, chronic disease, injury prevention, parenting and environmental health.

The 1998 Assessment Protocol for Excellence in Public Health Composite Report identified five priority areas. Those areas included adolescent alcohol use and its effects, lack of food security, lack of access to health care services, lack of awareness of community resources, and tobacco use by youth and pregnant women.

By 2002, the Community Needs Assessment Priorities & Progress group identified that overall community wellness and disease prevention was a need.

This identification led to the formation of the Healthy Eating Active Living (HEAL) coalition.

Identified Needs

Access to Health Care
'92, '98, '02
Access to Dental Care
'92, '02
Alcohol Use
'98
Wellness
'02

Access to Dental Care/Health Care was another need of the community. Success in this area is being achieved by the formation of the Pierce County Dental Health Clinic and the Free Clinic of Pierce & St. Croix Counties.

After identification of tobacco issues in our community, the Pierce/St. Croix Tobacco Coalition took the lead in encouraging policy changes throughout the county.

Following a nation-wide drive for improvements in emergency response preparedness, the Public Health Preparedness Program was developed locally.

With demand on home care resources increasing, Pierce County Public Health and Home Care was tasked to advocate for additional funding and grants to help fund this vital and successful program.

Negative community health trends have been identified in recent years that are complex and challenging for the community. A spectrum of interested participants/stake holders needs to be involved to successfully address the resolution of these problems. By building on the successes of the past community assessments and action plans, all involved will help to steer the community in a healthier direction.

Process

To thoroughly and accurately assess the needs of the Pierce County community, the steering committee utilized the Wisconsin State Health Plan Priorities, the Ten Essential Public Health Services, and the Mobilizing for Action through Planning and Partnerships Assessment (MAPP).

MAPP, a strategic planning tool from the National Association of City County Health Offices was chosen to help guide the process. This guide assisted the group to perform four types of assessments to produce the final product.

1. **Local Public Health System Assessment**
   What is currently being done to address health issues by the health system partners?
2. **Forces of Change Assessment**
   What are the changes occurring in the community that could pose threats or provide opportunities?
3. **Community Themes and Strengths Assessment**
   What are the perceptions of the community members when asked about the health of their community?
4. **Community Health Status Assessment**
   What data is available to assess the health status of the community?

The PURPLE text on the following pages highlights trends across the four assessments indicating the priorities identified by the steering group and community data obtained. Interestingly, they support one another…

1. Local Public Health System Assessment

The first of the four MAPP assessments was conducted at a December 2007 steering committee meeting to determine the activities, competencies and capacities of our local public health system. The 10 Essential Services of Public Health and current activities occurring in Pierce County were examined. Strengths of our local system were identified as well as targeted goals for each area.

Essential Services being done well:

- Identify and investigate health problems & health hazards in the community
- Inform, educate and empower people about health issues
- Assure a competent public health and personal health care workforce

Goal: *Maintain current level and effort*

Essential Service being done well:

- Mobilize community partnerships to identify and solve health issues

Goal: *Refocus some resources to higher priority activities*

Essential Services requiring improvement:

- Monitor health status to identify community health problems
- Enforce laws & regulations that protect health and ensure safety
- Evaluate effectiveness, accessibility and quality of personal & population-based health services

10 Essential Services of Public Health

- *Monitor Health Status*
- *Identify, Investigate, Control and Prevent Disease/Injury*
- *Inform, Educate and Empower the Public*
- *Promote Community Partnerships*
- *Develop Policies and Plans*
- *Enforce Public Health Laws and Regulations*
- *Link People to Health Services*
- *Maintain a Competent Public Health Workforce*
- *Evaluate and Improve Programs and Services*
- *Research*

Goal: *Increased coordination among partners*

Essential Services requiring improvement:

- Develop policies & plans that support individual and community health efforts
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable

- Research new insights and innovative solutions to health problems

***Goal**: Increase activities in these areas*

In summary, additional coordination and activities are needed to develop policies and plans that support individual and community health efforts, link people to needed personal health services, and research new insights and innovative solutions to health problems within our community.

Initiatives that are currently supporting these targeted areas include the Immunization Coalition, Tobacco Coalition, School District Wellness plans, UWRF Tobacco & Alcohol Prevention, Women, Infant and Children Supplemental Nutrition Program (WIC), Pierce County Health Department Dental Program, WI BadgerCare, Prenatal Care Coordination, First Breath, Pierce County Reproductive Health services, Free Clinic of Pierce and St. Croix Counties, Food Shelves, Meals on Wheels, Salvation Army, Turning Point for Victims of Domestic and Sexual Violence, River Falls Partnership for Youth, Parish Nursing, First Call for Help, School Health, Sexual Assault Response Team (SART), Impact Program RFMC (Improving patient outcomes), Psychiatrist on staff at the River Falls Medical Clinic, Safe Routes to School Grants, New Electronic Data System for EMS, and Wisconsin Electronic Communicable Disease Reporting System (WEDSS).

2. Forces of Change Assessment

Throughout 2008, the remaining aspects of the MAPP process were completed. A group of community experts conducted a brainstorming session that focused on the forces of change within our community. The goal was to determine what is occurring or might occur that affects the health of the community. Additionally, the goal was to identify what specific threats or opportunities are generated by these occurrences. The following identified forces of change are listed in no particular order:

3. Community Themes and Strengths Assessment

There were 2 key questions to be answered: First, "What is the perception of quality of life in the community?" Second, "What assets in the community can be used to improve community health?"

A survey was prepared and distributed throughout Pierce County via e-mail, Pierce County's website and on hard copies to community groups including churches, schools, and senior meal sites. 296 community members responded. The results below indicate what the community members found "most important".

Three most important factors for a "healthy community"

1. Low Crime/Safe Neighborhoods
2. Good place to raise children
3. Ability to get health care (medical & dental)

Three most important "health problems" in Pierce County

1. Overweight and obesity
2. Lack of available healthcare (medical and dental)
3. Mental Health problems

The most important "risky behaviors" in Pierce County

1. Alcohol abuse
2. Illegal drug use
3. Underage drinking
4. Lack of physical activity

Community Survey Results

Are you satisfied with the quality of life in our community?
Average rating 3.86

Are you satisfied with the health care system in the community?
Average rating 3.29

Is this community a good place to raise children?
Average rating 3.94

Is this community a good place to grow old?
Average rating 3.56

Is there economic opportunity in the community?
Average rating 2.68

Is the community a safe place to live?
Average rating 3.97

Are there networks of support for individuals and families during times of stress and need?
Average rating 3.53

Do all individuals and groups have the opportunity to contribute and participate in the community's quality of life?
Average rating 3.42

Do all residents perceive that they, individually and collectively, can make the community a better place to live?
Average rating 3.12

All questions are rated on a 1-5 scale (1 least positive - 5 most positive)

The results indicate that while the residents do not find there to be strong economic opportunity, it is an overall safe place to raise their children and to grow old. They seem overall satisfied with their lives, yet could see improvement in the health care system and community involvement. Community respondents have identified similar risk behaviors and health problems as the steering committee.

4. Community Health Status Assessment

The most recent data from a variety of sources including the Wisconsin County Rankings, the US Census and the Wisconsin WISH Data System was reviewed to determine community health status, quality of life, and risk factors.

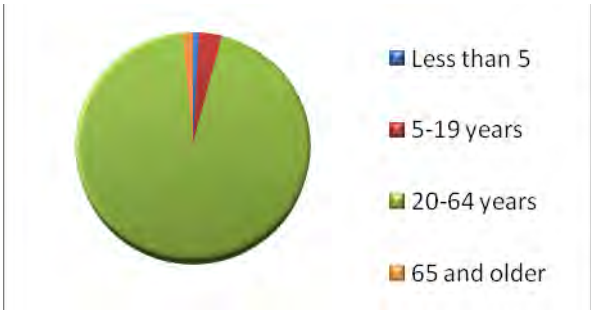
Demographics

Recent decades have shown growth in Pierce County. The growth was 43.3 % from 1970 to 2005. An additional 11% growth is projected to occur by 2020 to a population of 42,655. The growth is expected to occur in the currently more populated areas of the western municipalities of River Falls and Prescott. Eastern and southern areas will likely experience declines in population. This shift in population may have an implication on how the services to the county are delivered. There may be more need in areas that are less populated.

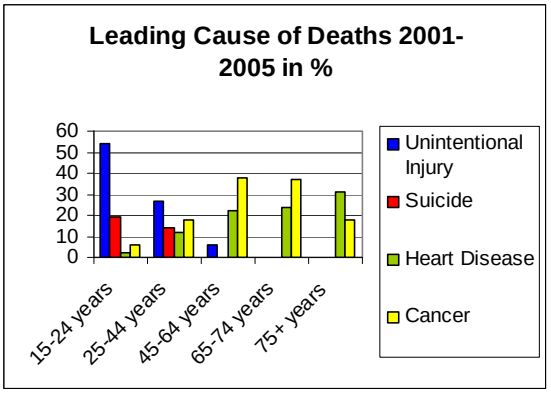
Pierce County Township and Municipalities

The most recent population data from 2006-2008 indicated that the population for the county was 39,856.

Population Distribution



Source: US Census Bureau



Source: WI resident death certificates, WDHFS

One of the most comprehensive sources of demographic and population information is the University of Wisconsin Population Health Institute County Health Rankings. The 2008 Snapshot was a vital source of information for this assessment. Please see the next page for the 2008 Pierce County Health Snapshot. It may be accessed on line at http://uwphi.pophealth.wisc.edu/pha/wchr/2008/snapshots/pierce.pdf

PIERCE

2008 County Health Snapshot

Wisconsin County Health Rankings
UW Population Health Institute

TRENDS IN RANKINGS	2004	2005	2006	2007	2008
Health Outcomes	13	13	36	12	11
Health Determinants	6	5	9	8	8

	Pierce County	Error margin	Best county in WI	Wisconsin value	Rank
HEALTH OUTCOMES					11
Mortality: Years of potential life lost (YPLL)/100,000 population	4,807	± 125	4,020	5,979	8
General health status: % of people reporting fair/poor health	10.6%	± 2.7	6.6%	13.2%	13
HEALTH DETERMINANTS					8
HEALTH CARE					61
No health insurance (%)	8.9%	± 3.4	2.8%	7.4%	43
Did not receive needed health care (%)	4.6%	± 2.4	0.0%	2.2%	70
No dentist visit in past year (%)	30.3%	± 5.2	17.1%	25.4%	44
Poor diabetic care: Score based on % of diabetics without recommended care	42		36	50	11
No biennial mammography (%)	28.9%		18.9%	29.0%	29
Poor inpatient care: Score based on % of patients without recommended care	59		36	50	60
HEALTH BEHAVIORS					18
Cigarette smoking (%)	17.0%	± 4.5	12.3%	20.9%	12
Smoking during pregnancy (%)	12.1%		6.5%	14.1%	12
Physical inactivity (%)	37.5%	± 8.9	23.5%	44.5%	9
Obesity (%)	25.6%	± 5.3	17.0%	24.1%	41
Insufficient fruit and vegetable intake (%)	80.8%	± 5.6	64.0%	77.2%	53
Binge drinking (%)	25.6%	± 5.2	10.3%	23.2%	53
Motor vehicle crash rate: No. of people involved in a crash/1,000 population	38.3		20.6	41.4	25
Motor vehicle crash-related ER visits (onroad)/100,000 population	310	± 32	110	712	5
Motor vehicle crash-related ER visits (offroad)/100,000 population	104	± 18	38	91	25
Teen birth rate/1,000 births	11.2	± 2.3	8.8	30.9	3
Sexually transmitted disease rate/100,000 population	155	± 44	52	498	24
SOCIOECONOMIC FACTORS					4
High school noncompletion: % of students not graduating as expected	4.9%		0.0%	10.4%	17
No high school diploma: % of people age 25+ without a high school diploma	10.4%	± 1	7.8%	14.9%	6
Unemployment (%)	4.4%		3.5%	4.9%	12
Children in poverty (%)	5.6%	± 1.3	3.0%	12.4%	6
Divorce (%)	7.1%	± 0.7	6.7%	9.0%	5
Single parent households (%)	7.0%	± 1	5.3%	8.2%	36
PHYSICAL ENVIRONMENT					43
Air quality risk: Score based on measures from EPA and DNR	47		39	60	40
Nitrates in water: Estimated % of population exposed to excess nitrate levels	57.5%		0.0%	40.7%	56
Housing with increased lead risk: % of pre-1950s housing stock	31.6%	± 1.8	8.2%	31.1%	34
Lead poisoned children: % screened testing positive for lead poisoning	0.4%	± 0.5	0.0%	2.2%	15
Radon risk: % of homes screened with elevated radon levels	12.8%		1.9%	12.0%	52
Method of commuting: % of workforce that drives alone to work	75.1%		68.7%	79.5%	25

*NR = Not Ranked

After reviewing a large volume of data for Pierce County in comparison to Wisconsin, the following strengths and challenges were identified. Some of the highlights identified were:

Strengths:

- Lower number of children living in poverty
- Less divorce
- Clean air (low particulate matter and ozone level)
- Low number of lead poisoned children
- Fewer women smoking during pregnancy
- Higher number of high school graduates
- Fewer teen births
- Fewer motor vehicle related ER visits

Challenges

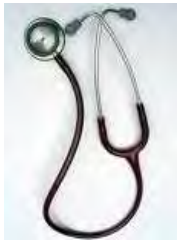
- Low fruit/vegetable consumption
- Obesity
- Radon risk
- Nitrates in water
- No health insurance
- Did not receive needed health care
- No dental visits in past year
- Mental health professional shortage area throughout county
- Binge drinking

Determining Health Priorities

The four areas of the MAPP process were cross-referenced and some common themes were identified. These were used to establish the determinants of health for Pierce County. Determinants of health are all of the factors that combine together to influence health status throughout all stages of life. These factors include income, social status, social support networks, education, literacy, housing, transportation, employment/working conditions, personal health practices, coping skills, healthy child development, genetics, health services, gender and culture. In general, numerous determinants contribute to the overall health priorities of a community. In this community assessment the three overriding health priorities identified for Pierce County are access to care, overweight and obesity, and alcohol issues.

Public Health Priority Issues and Strategies:

Issue One: Access to Health Care; including medical, dental, and mental health services



Based on the collectively gathered data, Access to Health Care was determined to be a high priority issue. There were many specific contributing factors:

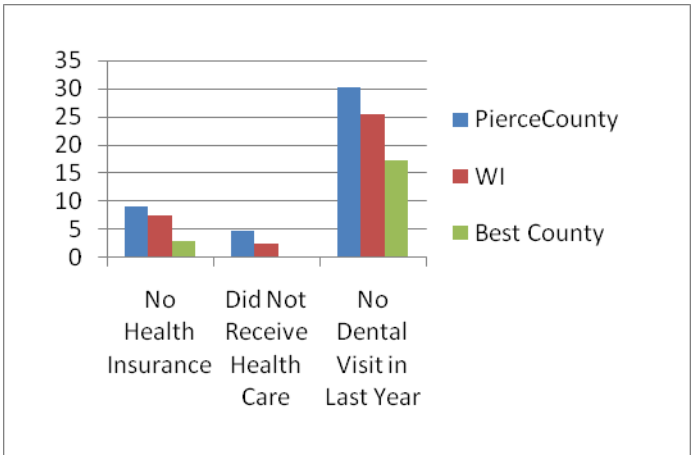
- Rising burden of the lack of health insurance
- Limited access to mental health care
- The need to develop policies and plans that support individual and community health efforts
- The need to link people to needed personal health services and assure the provision of health care when otherwise unavailable
- The need for additional coalitions to address health issues
- Lack of available health, dental and mental health care

Typically residents who lack adequate health insurance and/or a consistent medical provider and who face other barriers often encounter greater difficulty in obtaining preventative health services and continuity of care.

Initial Action Steps

Initially, two public health nurses attended the HealthWatch Wiscosin Annual meeting in Madison in February 2009. They gained information regarding how to serve as an advocate for clients as well as information on forming local coalitions. Staff visited the Dunn County HealthWatch Coalition to see if that format would be replicable in Pierce County. They meet regularly with a very broad group to discuss access to care issues.

In April 2009, a meeting regarding access to care was held at River Falls Area Hospital. The meeting focused on changes coming to the BadgerCare program. Another activity related to this priority area was the update of the Public Health professional resource guide. The guide was distributed to community partners.



2008 County Health Snapshot

Progress Summary

In early 2010, grants were written and obtained to expand school based dental service for low income elementary students in Pierce County. Implementation of these grants has begun.

Community partners have communicated with department staff that they would like to see some access to care activities that would involve both Pierce and St. Croix County. In June 2010, a public health nurse attended an access to care meeting regarding dental in St. Croix County. Their program is in the fledgling stages and the PHN offered to provide some technical assistance. They have other groups that are meeting to address billing issues related to access to care and another group looking at medical access in general. Staff will continue to monitor activities of these groups, but none of the three are a direct fit for needs identified by the CHIPS process in Pierce County.

Linking to Healthiest Wisconsin 2020

The Pierce County CHIP priority of Access to Care encompasses access to medical, dental, and mental health services. These areas are all mentioned in Healthiest Wisconsin 2020. To ensure the health of families, everyone needs access to affordable and high quality health services. Focus areas of the health plan include creating a medical home to improve coordinated care; improving access to dental care especially for families covered by BadgerCare; and reaching out to the approximately 20 percent of the population that struggle with mental health problems.

2020 Objectives

1. By 2020, assure all residents have affordable access to comprehensive, patient-centered health services that are safe, effective, affordable, timely, coordinated, and navigable.

2. By 2020, assure access to ongoing oral health education and comprehensive prevention, screening, early intervention, and treatment of dental disease in order to promote healthy behaviors and improve and maintain oral health.

3. By 2020, assure appropriate access to effective and adequate oral health delivery systems, utilizing a diverse and adequate workforce, for populations of differing races, ethnicities, sexual identities and orientations, gender identities, and educational or economic status and those with disabilities.

2020 Indicators

1. Proportion of people with health insurance (National Health Interview Survey and Wisconsin Family Health Survey).

2005-2007 Baseline: 88% of people in Pierce County had insurance the entire year. (Local Data on Poverty Status and Health insurance coverage in Wisconsin, Pierce County, 2005-2007)

2. Proportion of BadgerCare enrollees with at least one dental claim in a year (Division of Health Care Access and Accountability).

2009 Baseline: 25.1% of Pierce County Medicaid recipients received a dental service in 2009.

3. Percent of schools with school-based dental screening/sealant programs (Department of Public Instruction and SEALS).

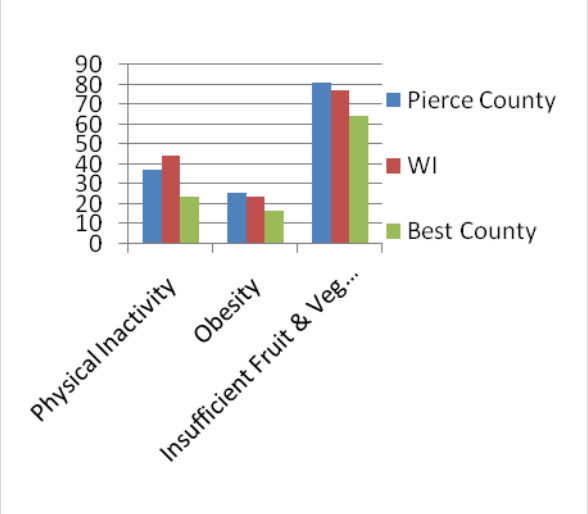
2009-2010 School Year Baseline: Five of nine (55%) Pierce County public elementary schools (including three River Falls schools) have a sealant program.

Public Health Priority Issues and Strategies:

Issue Two: Overweight and Obesity due to lack of physical activity and inadequate fruit and vegetable intake

Obesity is a serious national problem that may contribute to the complicating factors of a number of chronic diseases. This is a problem that affects all ages of our population. Our results indicate that this is an issue for our community due to the factors/determinants identified:

- Overweight and obesity rates
- Lack of physical activity
- Low fruit and vegetable consumption



2008 County Health Snapshot

Initial Action Steps

The Health Eating Active Living Coalition of Pierce County (HEAL), a collaborative community organization with Health Department leadership, is focusing on projects to address the identified overweight/obesity issues.

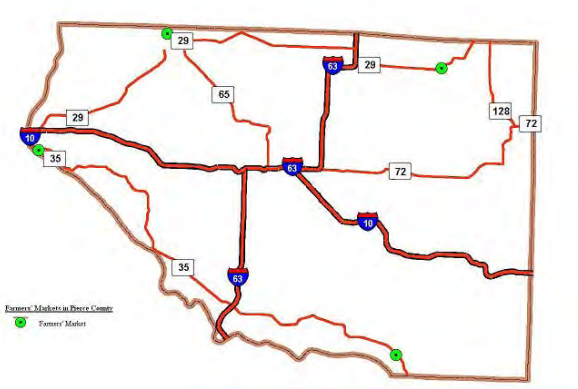
A HEAL gardening subcommittee was formed to evaluate gardening activities as a means of addressing both lack of physical activity and low fruit and vegetable intake in Pierce County

The HEAL coalition submitted a grant proposal in July 2009 for local implementation of the Wisconsin Nutrition and Physical Activity State Plan. If funded, the Wisconsin Fresh Fruit and Vegetable Audit Tool would be used to conduct an audit of the availability of fruits and vegetables in the county. An action plan will be developed and implemented based on audit results.

Progress Summary

In 2009 a strategic plan was developed by the HEAL coalition. This plan focuses on fruit and vegetable consumption. A fruit and vegetable audit of Pierce County was conducted by the coalition in 2009. At the same time, a perceptions survey was also conducted with Pierce County residents. The results of these two assessments were used to develop a logic model targeting strengthening the farmers' market infrastructure in Pierce County and to apply for several different funding sources in 2010.

Farmers' Markets in Pierce County Identified in 2009 Fruit and Vegetable Audit.



Linking to Healthiest Wisconsin 2020

The HEAL coalition's activities directly mirror the 2020 Health Improvement Plans' objectives relating to increasing access to nutritious foods.

2020 Objectives

1. By 2020, people in Wisconsin will eat more nutritious foods and drink more nutritious beverages through increased access to fruits and vegetables, decreased access to sugar-sweetened beverages and other less nutritious foods, and supported, sustained breastfeeding.

2. By 2020, all people in Wisconsin will have ready access to sufficient nutritious, high-quality, affordable foods and beverages.

3. By 2020, increase physical activity for all through changes in facilities, community design, and policies.

2020 Indicators

1. Number of farmers' markets per 100,000 population (State Indicator Report on Fruits and Vegetables, CDC).

2010 Baseline: In the 2010 county health rankings, 36% of zip codes in Pierce County have access to a healthy food outlet compared with 46% of zip codes for WI and a target value of 63%. In 2010 Pierce County has 2.5 farmers' markets per 100,000 compared to a state value of 3.5.

2. Proportion of Wisconsin farmers' markets that accept payment from Electronic Benefit Transfer (EBT) and Women, Infants and Children (WIC) Farmers' Market Nutrition Program Coupons (State Indicator Report on Fruits and Vegetables, CDC).

2010 Baseline: In 2010, there are no Pierce County farmers' markets that accept EBT and three that accept WIC vouchers.

3. Proportion of high school students who meet federal physical activity guidelines for aerobic physical activity and muscle-strengthening (Youth Risk Behavior Survey).

2009 Baseline: Ellsworth School District Physical Education Minutes/Week

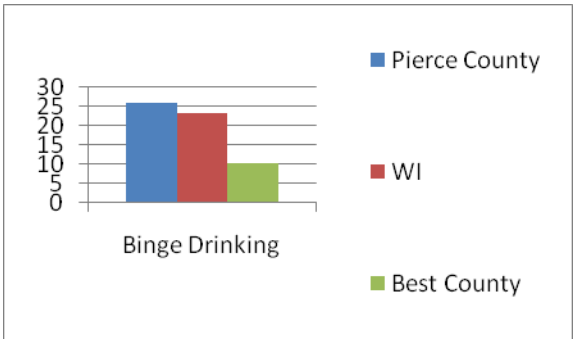
Elementary: 112.5 minutes/week (150 recommended); Middle School 117.5 minutes/week (225 recommended); High School 90 minutes/day for one quarter only (225/wk recommended)

Public Health Priority Issues and Strategies:

Issue Three: Alcohol Issues related to Underage Drinking and Binge Drinking

Often, patterns related to the use of alcohol are started when a person is still in school. The community response indicated these perceptions of risk factors:

- Alcohol abuse
- Underage drinking
- Illegal Drug Abuse



Percent of persons reporting binge drinking--2008 County Health Snapshot

Initial Action Steps

Historically, strategies to reduce alcohol abuse and underage drinking in the community have been initiated by the local schools. The River Falls District Alcohol, Tobacco and other Drugs (ATOD) Committee started in the late 80's including representatives from the schools, University of River Falls, Pierce County Public Health, Pierce County Human Services, local law enforcement and other youth serving agencies. This committee provided the foundation for conducting student ATOD surveys, writing and implementing WI Alcohol and other Drug Abuse (AODA) Grants and collaborating to support and encourage alcohol, tobacco and other drug prevention.

The River Falls Partnership for Youth (formerly River Falls District AODA Committee) received a five-year Drug Free Community Support grant in 2002. This led to the growth and transformation of the Partnership, transitioning from a school-based ATOD committee to a broader community base for prevention and protection. The partnership has successfully implemented several grants involving evidence-based strategies to decrease underage drinking and its consequences.

Progress Summary

Discussions began in 2009 to explore the expansion of this group to serve the entire county and address this health priority.

In 2009, the River Falls Partnership for Youth was able to obtain a grant to pilot the underage drinking prevention program *Parents Who Host Lose the Most*. This campaign was a local success. Discussion is in progress to expand the program countywide.

In the spring of 2010 the River Falls Partnership for Youth (RFPFY) participated in discussions, followed by strategic planning to initiate the growth and expansion of the coalition, resulting in the beginnings of the Pierce County Partnership for Youth 2010 (PCPFY). As of fall 2010 a strategic plan and goals have emerged.

Linking to Healthiest Wisconsin 2020

The Health Improvement Plan links with the 2020 Plan by applying evidence-based strategies to decrease underage drinking and its consequences through local partnerships and collaborating with community organizations involved with alcohol prevention activities.

2020 Objectives

1. By 2020, reduce unhealthy and risky alcohol and other drug use by changing attitudes, knowledge, and policies, and by supporting services for prevention, screening, intervention, treatment and recovery.

2. By 2020, assure access to culturally appropriate and comprehensive prevention, intervention, treatment, recovery support and ancillary services for underserved and socially disadvantaged populations who are at higher risk for unhealthy and risky alcohol and other drug use.

3. By 2020, reduce the disparities in unhealthy and risky alcohol and other drug use among populations of differing races, ethnicities, sexual identities and orientation, gender identities, and educational or economic status.

2020 Indicators

1. State and local rates and rankings of selected youth and adult behaviors related to unhealthy and risky alcohol and other drug use (Wisconsin Department of Health Services, Behavioral Risk Factor Survey; Wisconsin Department of Public Instruction, Youth Risk Behavior Survey; National Survey on Drug Use and Health).

Baseline: In 2007, Wisconsin high school student's rate of current alcohol use (49%) was the highest among all states while the binge drinking rate (32%) was the third highest in the nation. Data specific to Pierce County high school students is not yet available. Among adults in 2006, Wisconsin rated highest for binge drinking (24%), current alcohol use (69%), and heavy drinking (8%) in the nation. From 2002-2008 the adult binge drinking rate for Pierce County was 26%.

2. Proportion of counties with local capacity to provide alcohol and other drug abuse prevention, intervention (including criminal justice diversion), treatment, recovery support and ancillary services across all revenue streams for underserved and socially disadvantaged populations.

2010 Baseline: There are two programs providing alcohol and drug abuse prevention, intervention and treatment in Pierce County: Pierce County Human Services and Wisconsin Probation and Parole.

3. Unhealthy and risky alcohol and other drug use by race, ethnicity, sexual identity and orientation, gender identity, and educational or economic status (Wisconsin Department of Health Services, Behavioral Risk Factor Survey; National Survey on Drug Use and Health)

2004-2006 Baseline: Among Wisconsin racial/ethnic groups, white adults reported the highest current alcohol use (69%), followed by Hispanics (67%), American Indians (65%), Asians (57%) and African Americans (48%). No data available for gender, educational or economic status. No data specific to Pierce County is available.

Resources for Effective Action

As individuals, families, and organizations within the Pierce County community join forces to address the priority health issues, choosing effective strategies for action is of critical importance. The following websites are provided as a resource to guide the use of evidence-based and/or promising practices when designing programs.

What Works for Health website:

http://whatworksforhealth.wisc.edu

The Center for Disease Control and Prevention Community Guide website:

http://www.thecommunityguide.org/index.html

Nutrition, Physical Activity and Obesity Prevention Program:

http://www.dhs.wisconsin.gov/health/physicalactivity/index.htm

Team Nutrition:
http://www.fns.usda.gov/tn/Default.htm

ABC for Health-Healthwatch Coalition website:

http://www.healthwatchwisconsin.org/

Action for Healthy Kids website:

http://www.actionforhealthykids.org/resources/

Wisconsin State Health Plan:

Healthiest Wisconsin 2020

"It takes the work of many to improve and protect the health of all"

Website:
http://www.dhs.wisconsin.gov/hw2020/

Get Involved!

Are you or a member of your organization interested in making a difference in the health of the Pierce County community? Consider joining the collaborative efforts to address the health priorities identified in this plan. Involvement of a broad base of community members is essential to improving the health of Pierce County citizens!

Healthy Eating Active Living Coalition (HEAL)

Contact: Katie Bartko, RD 715-273-6755

Access to Health Care

Contact: Lisa Raethke, PHN 715-273-6755

Pierce County Partnership for Youth

Contact: Kayla Buck, CSAC 715-273-6766

Acknowledgements

The Pierce County Health Department along with the Pierce County Board of Health would like to acknowledge all those who participated and contributed in the Community Health Improvement Process. While the mission of the Pierce County Public Health Department is to assure the health of the public, it cannot work alone to improve the overall health of the community.

Local representatives from all public stakeholders, business, education, government, health, faith groups, and community health care providers were essential throughout this process.

Steering Committee

Ann Claflin - Elmwood Ambulance Service

Pastor Lauryl Stockness - English Lutheran Church

Heather Logelin - River Falls Area Hospital Foundation

Ben Plunkett - Pierce Co. Board of Health

Dr. Richard Purdy - Pierce Co. Board of Health

Tammy Kincaid - Pierce Co. Human Services

Amy Fetzer - Plum City Care Center

Dr. Keri Lijewski– River Falls Medical Clinic-Ellsworth

John Coughlin - United Way St. Croix Valley

Alice Reilly-Myklebust - UW-RF Student Health & Counseling

Action Planning Participants

Joan Lantz – Ellsworth Care Center

Eric Ladwig – Ellsworth Police Dept.

Bill Brookshaw – Ellsworth Ambulance Service

Kim Thompson – Pierce Co. Human Services

Kurt Helmrick – River Falls Medical Clinic-Ellsworth

Lori Zierl – UW Extension

Gary Brown – Pierce Co. Emergency Management

Bonnie Scheel – River Falls School District

Missy Mathieson – Spring Valley HealthCare Center

Angela Veek – River Falls Area Hospital

Karen Swenson – River Falls Area Hospital

Jennifer Loesch – River Falls Area Hospital

Shauna Knott – River Falls Area Hospital

Holly Mitchell – River Falls EMS

Mike Knoll – Pierce Co. Sheriff Dept.

Mark Luebker – Plum City Schools

Joyce Karlstad – English Lutheran Church

Jenny Legaspij – Chippewa Valley Red Cross

Elaine Schultz – Pierce Co. Human Services

Betsy Byker – Family Resource Center of St Croix Valley

Blake Fry – University of Wisconsin River Falls

Dena Casey – Fairview Clinic - Ellsworth

Mary Zimmerman – Ellsworth School District

Thank you to Brandi Raverty, RN, and MSN graduate student who assisted in designing and writing the Community Health Improvement Plan document.

This document is available at the Pierce County web site in Public Health under publications in Needs Assessment.

http://www.co.pierce.wi.us/Public%20Health/PH_index.htm

RIVER FALLS AREA HOSPITAL
PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Appendix F

Hanlon Process

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
RIVER FALLS
AREA HOSPITAL

First Things First: Prioritizing Health Problems

Introduction

Despite the many accomplishments of local public health, we continue to see emerging population-wide health threats as we forge ahead into to the 21st Century. We are in an economic climate where LHD personnel are facing dire budget cutbacks while simultaneously dealing with issues like H1N1, chronic diseases, and natural disasters. Because LHDs are the backbone of the public health system, the recent movement to establish a national system of accountability for governmental health agencies is particularly timely. The Public Health Accreditation Board (PHAB) is developing a voluntary national accreditation program which is grounded in continuous quality improvement. As LHDs work toward meeting accreditation standards and implementing quality improvement efforts, they are faced with an infinite number of competing health issues to address, while keeping in mind several external considerations such as urgency, cost, impact and feasibility, to name just a few. Fortunately, a number of prioritization methods specifically designed to assist agencies with this very challenge have been developed and widely used in a range of industries including public health. When faced with these tough decisions, employing a defined prioritization technique can provide a structured mechanism for objectively ranking issues and making decisions, while at the same time gathering input from agency-wide staff and taking into consideration all facets of the competing health issues.

This document serves as a guide and provides five widely used options for prioritization including guidance on which technique best fits the needs of your agency, step-by-step instructions for implementation, and practical examples.

Getting Started

Prior to the implementation of any prioritization process, preliminary preparations are necessary to ensure the most appropriate and democratic selection of priority health issues:[i]

1. **Community assessment** – Conducting assessments will determine the current status and detect gaps to focus on as potential priority areas. LHDs engaging in the Public Health Accreditation Board (PHAB) accreditation process must conduct a *community* health assessment (CHA) as a prerequisite for eligibility. A CHA provides data on the overall health of a community and uncovers target priority areas where a population may have increased risk for poor health outcomes.
2. **Agency self-assessment -** As part of the national accreditation process, LHDs must use the PHAB *agency* self-assessment tool to evaluate agency performance against nationally recognized standards. Post-assessment, LHDs can analyze their results and determine strengths and areas for improvement to address through continuous quality improvement efforts. Prioritization methods can be used to help select areas for improvement from a CHA or PHAB self-assessment.
3. **Clarify objectives and processes –** Before beginning the process, LHD leadership must ensure that all team members have a clear understanding of the goals and objectives along with the chosen prioritization process.
4. **Establish criteria -** Selection of appropriate prioritization criteria on which to judge the merit of potential focus areas is important to avoid selection based on bias or hidden agendas and ensure that everyone is 'on the same page.' **Table 1.1** below identifies criteria commonly used in prioritization processes:

Table 1.1: Commonly Used Prioritization Criteria[ii]

Criteria to Identify Priority Problem	Criteria to Identify Intervention for Problem
• Cost and/or return on investment • Availability of solutions • Impact of problem • Availability of resources (staff, time, money, equipment) to solve problem • Urgency of solving problem (H1N1 or air pollution) • Size of problem (e.g. # of individuals affected)	• Expertise to implement solution • Return on investment • Effectiveness of solution • Ease of implementation/maintenance • Potential negative consequences • Legal considerations • Impact on systems or health • Feasibility of intervention

Prioritization in Practice

The following section highlights five prioritization methods:

1. Multi-voting Technique
2. Strategy Grids
3. Nominal Group Technique
4. The Hanlon Method
5. Prioritization Matrix

Each sub-section includes step-by-step instructions on implementation followed by examples illustrating practical application. It is important to remember that no right or wrong method of prioritization exists. Although the provided examples in this document are useful in gaining an understanding of how to use prioritization techniques, they are not meant to be prescriptive but rather, should be tailored to the needs of individual agencies. Additional information on prioritization processes can be found in the Assessment Protocol for Excellence in Public Health (APEX*PH*).

Multi-voting Technique [iii]

Multi-voting is typically used when a long list of health problems or issues must be narrowed down to a top few. Outcomes of Multi-voting are appealing as this process allows a health problem which may not be a top priority of any individual but is favored by all, to rise to the top. In contrast, a straight voting technique would mask the popularity of this type of health problem making it more difficult to reach a consensus.

Step-by-Step Instructions:

1. **Round 1 vote –** Once a list of health problems has been established, each participant votes for their highest priority items. In this round, participants can vote for as many health problems as desired or, depending on the number of items on the list, a maximum number of votes per participant can be established.
2. **Update list** - Health problems with a vote count equivalent to half the number of participants voting remain on the list and all other health problems are eliminated (e.g. if 20 participants are voting, only health problems receiving 10 or more votes remain).
3. **Round 2 vote** – Each participant votes for their highest priority items of this condensed list. In this round, participants can vote a number of times equivalent to half the number of health problems on the list (e.g. if ten items remain on the list, each participant can cast five votes).

4. **Repeat** – Step 3 should be repeated until the list is narrowed down to the desired number of health priorities.

Multi-voting Example: The following example illustrates how an LHD used the Multi-voting technique to narrow down a list of ten health problems, identified by an agency self-assessment, to one priority focus area for a quality improvement (QI) project. **Table 2.1** illustrates the results of a three-round multi-voting process implemented by a group of 6 project directors using the following steps:

1. **Round-one vote** – On a note card, all participants anonymously voted for as many priority focus areas as desired.
2. **Update list** – All votes were tallied and the six health indicators receiving three or more votes were posted for the group to view.
3. **Round-two vote** – All participants voted up to three times for the remaining health indicators.
4. **Update list** – All votes were re-tallied and the three health indicators receiving less three or more votes were posted for the group to view.
5. **Round-three vote** - All participants voted up to two times and the only item with three or more votes, "Effective Media Strategy," was the chosen focus area for a QI project.

Table 2.1: Three-Round Multi-voting Example
Jane Doe County Health Department wanted to prioritize one health problem to address with funds from a small grant. They began with a list of 12 health problems, which they identified through standards and measures where they scored poorly on PHAB's self-assessment tool. The director convened the management team and implemented the multi-voting method to select the priority area.

Health Indicator	Round 1 Vote	Round 2 Vote	Round 3 Vote
~~Collect and maintain reliable, comparable, and valid data~~	√√√	√√	
Evaluate public health processes, programs, and interventions.	√√√√√	√√√√	√√√√√
~~Maintain competent public health workforce~~	√√		
~~Implement quality improvement of public health processes, programs, and interventions~~	√√√√	√√	
~~Analyze public health data to identify health problems~~	√√		
~~Conduct timely investigations of health problems in coordination with other governmental agencies and key stakeholders~~	√√		
~~Develop and implement a strategic plan~~	√√√√√	√√√√	√√
~~Provide information on public health issues and functions through multiple methods to a variety of audiences~~	√√		
~~Identify and use evidence-based and promising practices~~	√√		
~~Conduct and monitor enforcement activities for which the agency has the authority~~	√		
~~Conduct a comprehensive planning process resulting in a community health improvement plan~~	√√√√√	√√√√	√√
~~Identify and implement strategies to improve access~~	√√√	√√	

~~to healthcare services~~			

Red = Round 1 Elimination Green = Round 2 Elimination Blue = Round 3 Elimination

Strategy Grids [iv]

Strategy grids facilitate agencies in refocusing efforts by shifting emphasis towards addressing problems that will yield the greatest results. This tool is particularly useful when agencies are limited in capacity and want to focus on areas that provide 'the biggest bang for the buck.' Rather than viewing this challenge through a lens of diminished quality in services, strategy grids can provide a mechanism to take a thoughtful approach to achieving maximum results with limited resources. This tool may assist in transitioning from brainstorming with a large number of options to a more focused plan of action.

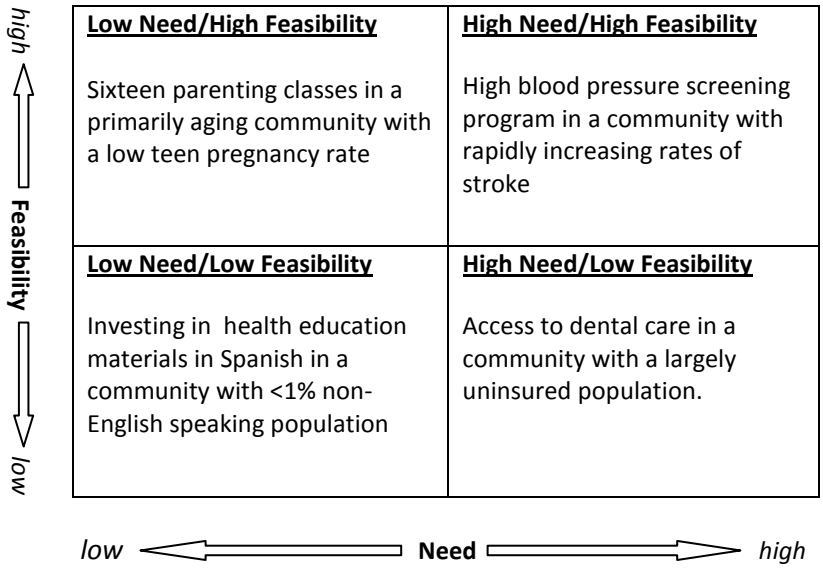
The strategy grid below provides an example of an LHD's effort to refocus efforts towards programs that will feasibly result in the greatest impact. Refer to the example strategy grid below while working through the step-by-step instructions.

Step-by-Step Instructions:

1. **Select criteria** – Choose *two* broad criteria that are currently most relevant to the agency (e.g. 'importance/urgency,' 'cost/impact,' 'need/feasibility,' etc.). Competing activities, projects or programs will be evaluated against how well this set of criteria is met. The example strategy grid below uses 'Need' and 'Feasibility' as the criteria.
2. **Create a grid** – Set up a grid with four quadrants and assign one broad criteria to each axis. Create arrows on the axes to indicate 'high' or 'low,' as shown below.
3. **Label quadrants** – Based on the axes, label each quadrant as either 'High Need/High Feasibility,' 'High Need/Low Impact,' 'Low Need/High Feasibility,' 'Low Need/Low Feasibility.'
4. **Categorize & Prioritize -** Place competing activities, projects, or programs in the appropriate quadrant based on the quadrant labels. The example below depicts 'Need' and 'Feasibility' as the criteria and items have been prioritized as follows:

    - *High Need/High Feasibility* – With high demand and high return on investment, these are the highest priority items and should be given sufficient resources to maintain and continuously improve.
    - *Low Need/High Feasibility* – Often politically important and difficult to eliminate, these items may need to be re-designed to reduce investment while maintaining impact.
    - *High Need/Low Feasibility* – These are long term projects which have a great deal of potential but will require significant investment. Focusing on too many of these items can overwhelm an agency.
    - *Low Need/Low Feasibility* – With minimal return on investment, these are the lowest priority items and should be phased out allowing for resources to be reallocated to higher priority items.

Strategy Grid



Nominal Group Technique [v]

The Nominal Group Technique (NGT) has been widely used in public health as a mechanism for prioritizing health problems through group input and information exchange. **This method is useful in the early phases of prioritization when there exists a need to generate a lot of ideas in a short amount of time and when input from multiple individuals must be taken into consideration.** Often, the Multi-voting Technique is used in conjunction with NGT whereby NGT can be used to brainstorm ideas and create a broad list of possibilities and Multi-voting can be used to narrow down the list to pinpoint the top priorities. One of the greatest advantages of using this technique is that it is a democratic process allowing for equal say among all participants, regardless of position in the agency or community.

Step-by-Step Instructions:

1. **Establish group structure –** Establish a group of, ideally, 6-20 people to participate in the NGT process and designate a moderator to take the lead in implementing the process. The moderator should clarify the objective and the process.
2. **Silent brainstorming –** The moderator should state the subject of the brainstorming and instruct the group to silently generate ideas and list them on a sheet of paper.
3. **Generate list in round-robin fashion –** The moderator should solicit one idea from each participant and list them on a flip chart for the group to view. This process should be repeated until all ideas and recommendations are listed.

4. **Simplify & clarify –**The moderator then reads aloud each item in sequence and the group responds with feedback on how to condense or group items. Participants also provide clarification for any items that others find unclear.
5. **Group discussion –** The moderator facilitates a group discussion on how well each listed item measures up to the criteria that was determined by the team prior to the NGT process.
6. **Anonymous ranking –** On a note card**,** all participants silently rank each listed health problems on a scale from 1 to 10 (can be altered based on needs of agency) and the moderator collects, tallies, and calculates total scores.
7. **Repeat if desired –** Once the results are displayed, the group can vote to repeat the process if items on the list receive tied scores or if the results need to be narrowed down further.

John Doe County Health Department: Nominal Group Technique Example

The John Doe County Health Department (JDCHD) implemented NGT to choose one priority focus area for a QI project. In an effort to remain objective, the process was facilitated by an external consultant and the decision making team was a large group of 27 program and division managers and staff from throughout the agency. The goal of the exercise was to identify a focus area for a QI project based on the following criteria: 1) areas of weakness determined by agency self-assessment results; 2) the degree to which the health department is used for a particular service; and 3) the level of impact the health department can make to bring forth an improvement. In preparation for the exercise, the group was also provided with a detailed report of findings from the agency self-assessment to read prior to the decision-making process. From this point, the following steps were followed to identify a primary focus area for improvement:

1. **Silent brainstorming –** Two weeks in advance of the meeting**,** team members were provided with results of the self-assessment for review and to individually brainstorm ideas on which health issues should be the focus of a QI project.
2. **Generate list –** At the start of the meeting, the facilitator collected potential health issues from all group members, one by one, and recorded them on a flip chart. The list was simplified by combining and grouping similar items, resulting in the 6 potential health indicators shown in **Table 3.1**.
3. **Group discussion –** The facilitator led a discussion where everyone was given the opportunity to provide input on how each of the 6 priorities measured up against the criteria previously established.
4. **Anonymous voting –** Following the meeting**,** all group members individually completed an on-line ranking for their top three choices by assigning a number of 1-3 next to each option, with 1 being the last choice and 3 being the first choice.
5. **Calculate priority score –** The total priority scores were calculated by adding scores given by every group member for each item on the list **Table 3.1** shows a compilation of the rankings from the 27 group members with improved communication and coordination between divisions and programs within the health department as the top priority:

Table 3.1: Count of Staff Responses to QI Focus Areas

Priority Health Indicator	1st Choice Score = 3	2nd Choice Score = 2	3rd Choice Score = 1	Total Score
Improve communication and coordination between divisions and programs within health	4	6	6	30

department				
Engage policymakers and community to support health department initiatives	1	6	3	18
Promote understanding of public health in general and health department as an organization among stakeholders (may include internal and external stakeholders)	3	1	6	17
Better utilize data and best practices to inform health department program decisions and to generate community support and understanding of the health department's role and contribution to public health	2	4	6	20
Establish a health department presence and recognition at a level comparable to other major City departments	4	5	5	27

The Hanlon Method [vi]

Developed by J.J. Hanlon, the *Hanlon Method for Prioritizing Health Problems* is a well respected technique which objectively takes into consideration explicitly defined criteria and feasibility factors. **Though a complex method, the Hanlon Method is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values**.

Step-by-Step Instructions:

1. **Rate against specified criteria** – Once a list of health problems has been identified, on a scale from zero through ten, rate each health problem on the following criteria: *size of health problem, magnitude of health problem, and effectiveness of potential interventions*. It is important to remember that this step requires the collection of baseline data from the community such as from a community health assessment. **Table 4.1** illustrates an example numerical rating system for rating health problems against the criteria.

Table 4.1

The Hanlon Method: Sample Criteria Rating			
Rating	**Size of Health Problem** *(% of population w/health problem)*	**Seriousness of Health Problem**	**Effectiveness of Interventions**
9 or 10	>25% (STDs)	Very serious (e.g. HIV/AIDS)	80% - 100% effective (e.g. vaccination program)
7 or 8	10% - 24.9%	Relatively Serious	60% - 80% effective
5 or 6	1% - 9.9%	Serious	40% - 60% effective
3 or 4	.1% - .9%	Moderately Serious	20% - 40% effective
1 or 2	.01% - .09%	Relatively Not Serious	5% - 20% effective
0	< .01% (Meningococcal Meningitis)	Not Serious (teen acne)	<5% effective (access to care)
Guiding considerations when ranking health problems against the 3 criteria	• Size of health problem should be based on baseline data collected from the individual community.	• Does it require immediate attention? • Is there public demand? • What is the economic impact? • What is the impact on	• Determine upper and low measures for effectiveness and rate health problems relative to those limits. • For more information on assessing effectiveness of

		quality of life? • Is there a high hospitalization rate?	interventions, visit http://www.communityguide.org to view CDC's Guide to *Community Preventive Services.*

**Note: The scales in Table 1 are arbitrary models of how numerical scales are established and are not based on real epidemiological data; LHDs should establish scales that are appropriate for the community being served.*

2. **Apply the 'PEARL' test** - Once health problems have been rated by criteria, use the 'PEARL' Test, to screen out health problems based on the following feasibility factors:

    - **P**ropriety – Is a program for the health problem suitable?
    - **E**conomics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
    - **A**cceptability – Will a community accept the program? Is it wanted?
    - **R**esources – Is funding available or potentially available for a program?
    - **L**egality – Do current laws allow program activities to be implemented?

    Eliminate any health problems which receive an answer of "No" to any of the above factors or proceed with corrective action to ensure that potential health priorities meet all five of the feasibility factors.

3. **Calculate priority scores** – Based on the three criteria rankings assigned to each health problem in Step 1 of the Hanlon Method, calculate the priority scores using the following formula:

    D = [A + (2 x B)] x C
    Where: D = Priority Score
    A = Size of health problem ranking
    B = Seriousness of health problem ranking
    C = Effectiveness of intervention ranking

    **Note: Seriousness of health problem is multiplied by two because according to the Hanlon technique, it is weighted as being twice as important as size of health problem.*

4. **Rank the health problems** – Based on the priority scores calculated in Step 3 of the Hanlon Method, assign ranks to the health problems with the highest priority score receiving a rank of '1,' the next high priority score receiving a rank of '2,' and so on.

<u>McLean County Health Department - The Hanlon Method Example:</u>
As a part of the Illinois Project for Local Assessment of Needs (IPLAN), a community health assessment and planning process, the McLean County Health Department (MCHD) used the Hanlon Method to prioritize health problems in the community. After determining the top eight health problems from the community health assessment data, MCHD used the Hanlon Method to establish the top three focus areas the agency should address. The following steps were taken to implement the prioritization process:

1. **Rate against specified criteria** – To rate each health problem, MCHD used the following considerations for each Hanlon criterion. **Table 3.2** illustrates the top three of the eight health problems and corresponding ratings for each criterion.
    - *Size of the problem* – the percentage of the population with the problem, with an emphasis on the percentage of the population at risk for the problem
    - *Seriousness of the problem* – morbidity rates, mortality rates, economic loss, and the degree to which there is an urgency for intervention
    - *Effectiveness of the intervention* – the degree to which an intervention is available to address the health problem

2. **Apply the 'PEARL' test –** After long discussion, all eight health problems passed the 'PEARL' test as the interventions for each problem were judged to be proper, economical, acceptable, feasible based on available resources, and legal.

3. **Calculate the priority scores –** Priority scores were calculated by plugging in the ratings from Columns A through B into the formula in Column D. The calculations of the top three priority scores are illustrated in **Table 3.2**

Table 4.2: MCHD Hanlon Priority Scoring

Health Problem	A Size	B Seriousness	C Effectiveness of Intervention	D Priority Score (A + 2B)C	Rank
Cancer	8	10	6	168	3
Cerebrovascular Disease	7	9	7	175	2
Heart Disease	10	10	7	210	1

Livingston County Department of Health - The 'PEARL' Test Example:

Often, the 'PEARL' component is pulled out of the Hanlon Method and applied on its own or used in conjunction with other prioritization techniques. The following example illustrates how the Livingston County Department of Health (LCDOH) in New York applied the "PEARL" test to assist in the selection of a QI project in preparation for accreditation.

The LCDOH accreditation team was comprised of the agency's center directors and supervising staff and the process was facilitated by an external consultant to ensure objectivity and minimization of bias. Initially, the team completed a scoring matrix to identify areas of weakness and came up with the following focus areas: *engaging in research, connectedness to universities, strategic planning,* and *development and maintenance of an effective performance appraisal system*. Once the team reached a consensus on these potential focus areas, a 'process of elimination' tactic was employed by utilizing the 'PEARL' Test. The facilitator led the group through a discussion allowing all team members to provide input on how well each focus area measured up to the 'PEARL' feasibility criteria. Upon consideration of the criteria, LCDOH initially eliminated engagement in research and connectedness to universities because the group felt that, at that time, any time or resources put into these issues would yield minimal results. Additional focus areas were also eliminated until, ultimately, the group agreed that improving and maintaining an effective performance appraisal system passed all 'PEARL' criteria. Since the previous system lacked basic core competencies, as a part of a QI project, LCDOH went on to

develop a new performance appraisal system which incorporated eight fundamental core competencies which all staff are expected to meet. The new system was tested and changes were made based on feedback provided from the staff. In an effort to continually improve the system, each center is developing more specific competencies for particular job titles.

Prioritization Matrix [iv]

A prioritization matrix is one of the more commonly used tools for prioritization and is ideal when health problems are considered against a large number of criteria or when an agency is restricted to focusing on only one priority health issue. Although decision matrices are more complex than alternative methods, they provide a visual method for prioritizing and account for criteria with varying degrees of importance.

Step-by-Step Instructions:

The following steps outline the procedure for applying a prioritization matrix to prioritize health issues. While working through each step, refer to **Table 4.1** below for a visual representation:

Table 5.1: Example Prioritization Matrix

	Criterion 1 (Rating X Weight)	Criterion 2 (Rating X Weight)	Criterion 3 (Rating X Weight)	Priority Score
Health Problem A	2 X 0.5 = 1	1 X .25 = .25	3 X .25 = .75	2
Health Problem B	3 X 0.5 = 1.5	2 X .25 = 0.5	2 X .25 = 0.5	2.5
Health Problem C	1 X 0.5 = 0.5	1 X .25 = .25	1 X .25 = .25	1

1. **Create a matrix –** List all health issues vertically down the y-axis (vertical axis) of the matrix and all the criteria horizontally across the x-axis of the matrix so that each row is represented by a health issue and each column is represented by a criterion. Include an additional column for the priority score.
2. **Rate against specified criteria –** Fill in cells of the matrix by rating each health issue against each criterion which should have been established by the team prior to beginning this process. An example of a rating scale can include the following:

   3 = criterion met well
   2 = criterion met
   1 = criterion not met

3. **Weight the criteria –** If each criterion has a differing level of importance, account for the variations by assigning weights to each criterion. For example, if 'Criterion 1' is twice as important as 'Criterion 2' and 'Criterion 3,' the weight of 'Criterion 1' could be .5 and the weight of 'Criterion 2' and 'Criterion 3' could be .25. Multiply the rating established in Step 2 with the weight of the criteria in each cell of the matrix. If the chosen criteria all have an equal level of importance, this step can be skipped.
4. **Calculate priority scores –** Once the cells of the matrix have been filled, calculate the final priority score for each health problem by adding the scores across the row. Assign ranks to the health problems with the highest priority score receiving a rank of '1.'

Lawrence-Douglas County Health Department: Example Prioritization Matrix

Prior to beginning the prioritization process, Lawrence-Douglas County Health Department (LDCHD) developed a decision-making team which was comprised of ten people including directors and coordinators from throughout the department. Next, upon completion of an agency self-assessment, LDCHD identified areas of weakness and created a list of three potential health indicators to improve upon, along with five criteria found to be most relevant in pinpointing which health indicator will prove to have the greatest impact on the needs of Lawrence-Douglas County. Once these variables were determined, the groundwork was in place and LDCHD was ready to use a prioritization matrix to weigh the identified health indicators against each criterion to make a final decision on a focus area for a QI project. The following steps were used to implement the process:

1. **Create a matrix** – LDCHD used the prioritization matrix shown in **Table 4.2**, with the chosen health indicators listed on the Y-axis and each criterion listed across the X-axis:

Table 5.2: LDCHD Prioritization Matrix

	Evaluative Criteria					
Proposed Area for Improvement Based on LHD Self-Assessment	Linkage to Strategic Vision (.25)	Do we need to improve this area? (.25)	What chance is there that changes we put into place will make a difference? (.5)	Likelihood of completion within the timeframe we have (.5)	Importance to Customer (customer is the one who would benefit; could be patient or community) (.75)	**Total Score**
Media strategy & Communications to raise public health awareness	3 X (.25)	4 X (.25)	4 X (.5)	3 X (.5)	3 X (.75)	**7.5**
Work within network of stakeholders to gather and share data and information	2 X (.25)	3 X (.25)	2 X (.5)	1 X (.5)	1 X (.75)	**3.5**
Continuously develop current information on health issues that affect the community	4 X (.25)	2 X (.25)	3 X (.5)	1 X (.5)	2 X (.75)	**5**

**Note: The numerical rankings in Table 3.1 are meant to serve as an example and do not reflect the actual rankings from LDCHD's prioritization process.*

2. **Rank each health indicator against criteria** – Each member of the decision-making team was given this prioritization matrix and asked to fill it out individually based on the following rating scale:

   4 = High priority
   3 = Moderate priority
   2 = Low priority
   1 = Not priority

   After completing the matrix, each team member individually discussed with the facilitators of the process the reasoning behind how the health indicators were rated.

3. **Weight the criteria –** Although LDCHD weighted each criterion equally, (i.e. each criterion was assigned a multiplier of 1) the numbers in red provide an arbitrary example of how an agency

could assign weights to the criteria based on perceived importance. In this example, with multipliers of .5, 'Likelihood of making a difference' and 'Completion within timeframe' are weighted as twice as important as 'Linkage to strategic vision' and 'Need for improvement,' with multipliers of .25. With a multiplier of .75, 'Importance to customer' is weighted as three times as important.

4. **Calculate priority scores –** Final priority scores are calculated by adding the weighted scores across the row and recording it in the 'Total Score' column. Since LDCHD had the team complete multiple matrices, the total scores for each health indicator were added together to determine the final priority scores. With 'Media Strategies' receiving the highest priority score of 7.5, it was assigned a rank of '1' and identified as the highest priority health indicator.

Conclusion

In a world with a growing number of health concerns, scarce resources, budget cuts, and conflicting opinions, it is very easy to lose sight of the ultimate goal - improving health outcomes. Often times these external forces drive the decision making process within a health department and make determining where to focus resources and time challenging. Prioritization techniques provide a structured approach to analyze health problems and solutions, relative to all criteria and considerations, and focus on those that will prove to have the greatest impact on the overall health of a community.

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Appendices

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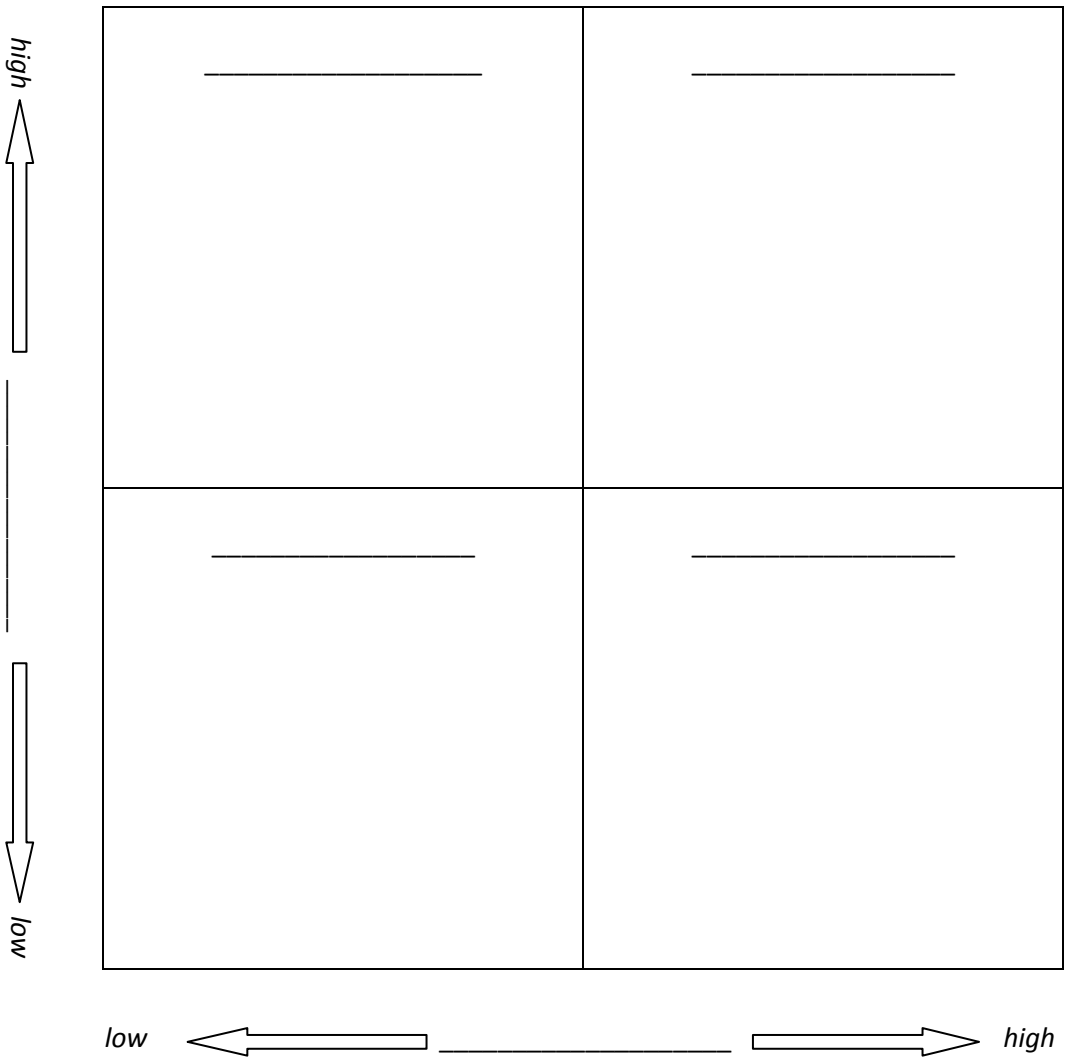
3 Round Multi-voting Template

Health Indicator	Round 1 Vote	Round 2 Vote	Round 3 Vote

Instructions:

1. Fill in items to be prioritized under the 'Health Indicator' column
2. Tally votes for each round of voting in the respective column

Strategy Grid



Instructions:

1. Fill in the blank spaces on each axis with the desired criteria
2. Label each quadrant according to the axes
3. Place competing programs/activities into the appropriate quadrant

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Hanlon Method Worksheet

Health Indicator	A Size	B Seriousness	C Effectiveness of Intervention	D Priority Score (A + 2B)C	Rank

Instructions:

1. Fill in items to be prioritized under the 'Health Indicator' column.
2. Fill in the 'A,' 'B,' and 'C' columns with the assigned ratings for each health indicator with respect to the three criteria.
3. Calculate the priority score using the formula in column 'D.'
4. Rank the health indicators with the highest priority score receiving a rank of '1.'

Prioritization Matrix

Health Indicator	_____	_____	_____	Priority Score

Instructions:

1. Fill in items to be prioritized under the 'Health Indicator' column.
2. Fill in the blank spaces in columns 2, 3 and 4 with the chosen criteria.
3. Fill in the ranks for each health indicator under the appropriate criteria.
4. Calculate the priority score by adding the rankings in each row.

[i] Health People 2010 Toolkit. Setting Health Priorities and Establishing Objectives. Available at http://www.healthypeople.gov/State/toolkit/priorities.htm. Accessed February 9, 2009.

[ii] Public Health Foundation. Priority Setting Matrix. Available at http://www.phf.org/infrastructure/priority-matrix.pdf. Accessed February 9, 2010

[iii] American Society for Quality. Evaluation and Decision Making Tools: Multi-voting. Available at http://www.asq.org/learn-about-quality/decision-making-tools/overview/mutivoting.html. Accessed December 2, 2009.

[iv] Duttweiler, M. 2007. *Priority Setting Tools: Selected Background and Information and Techniques*. Cornell Cooperative Extension.

[v] American Society of Quality. Idea Creation Tools: Nominal Group Technique. Available at http://www.asq.org/learn-about-quality/idea-creation-tools/overview/nominal-group.html. Accessed December 2, 2009.

[vi] National Association of County and City Health Officials. 1996. Assessment Protocol for Excellence in Public Health: Appendix E.

RIVER FALLS AREA HOSPITAL
PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Appendix G

Prioritization List

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
RIVER FALLS
AREA HOSPITAL

Rank	Priority	Score
1	Physical Inactivity	203
2	Obesity	197
3	Healthy Foods	184
4	Alcohol	161
5	Motor Vehicle Safety	138
6	Tobacco	137
7	Falls Prevention	127
8	Chronic Disease	123
9	Mental Health	122
10	Access	89
12	Drug Use	77
12	Elder Care	76
13	Safety/Violence	70

RIVER FALLS AREA HOSPITAL
PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Appendix H

Justification Notes

Community Health Needs Assessment
and Implementation Plan 2014–2016

Allina Health
RIVER FALLS
AREA HOSPITAL

Allina Health - Western Wisconsin

COMMUNITY HEALTH NEEDS ASSESSMENT

Stakeholder Meeting #3
Tuesday, December 4, 2012
9:30-11:00 am
River Falls Area Hospital

Present:
Katie Bartko, Pierce County Public Health
Breanna Burmeister, Hudson YMCA
Sue Galoff, Pierce County Public Health
Greg Goblirsch, MD, River Falls Medical Clinic
Amy Hess, Pierce County Public Health
Mary Johnson, River Falls Area Hospital
Melissa Kosse, First National Bank of River Falls
Steve Leitch, Leitch Insurance
Heather Logelin, River Falls Area Hospital
David Miller, River Falls Area Hospital
Beth Nelson, River Falls Area Hospital
Alice Reilly-Myklebust, University of Wisconsin – River Falls
Pat Sura, MD, River Falls Medical Clinic
David Woeste, MD, Retired

Guests:
Brandi Poellinger
Kali Higgins

Heather Logelin welcomed participants and introduced Breanna Burmeister, Aquatics Director, Hudson YMCA. Breanna is replacing Cathy Quinlivan, who has taken a position as director at the Midway YMCA. Heather also introduced Healthy Communities Partnership staff Brandi Poellinger (program ambassador) and Kali Higgins (wellness care guide), who were present as guests and will start their new positions on Friday, December 14.

BACKGROUND INFORMATION: CHNA, HEALTHIEST WI 2020, CHANGE GRANT

Logelin provided a brief overview of the CHNA process and reminded participants that our charge for this meeting was to select the 2-3 priority health issues on which we will focus for 2012-2014. Community dialogues in early 2013 will gather feedback on these 2-3 issues from a broad cross-section of the county, after which we will develop our action plan for 2014-2016. The plan will go to the hospital board of trustees in August and to the Allina Health board of trustees in September.

Sue Galoff provided a brief overview of the Healthiest Wisconsin 2020 plan, developed by the Wisconsin Department of Health Services, Division of Public Health, to support the national Healthy People 2020 plan. The Healthiest Wisconsin 2020 plan includes twelve focus areas, including – not surprisingly – nearly all of the health issues identified through our prioritization process. Each of these focus areas has a detailed work plan, complete with objectives and action plans, and we should consider the opportunity to leverage opportunities to connect with this work and leverage related resources. More information on both plans is available online at http://www.healthypeople.gov and http://www.dhs.wisconsin.gov/hw2020/index.htm.

Amy Hess provided a brief overview of the CHANGE (Community Health Assessment and Group Evaluation) grant recently awarded to Pierce County. The CHANGE tool will help Pierce County "gather and organize information on indicators related to built and social environments that support healthy

eating, active living, tobacco-free living, and chronic disease management." The timing of this grant will enable us to use the tool to gather information that will inform the CHNA process and planning for 2014-2016. More information on the CHANGE tool is available online at http://www.cdc.gov/healthycommunitiesprogram/tools/change.htm.

CHOOSING 2-3 PRIORITY HEALTH ISSUES FOR PIERCE COUNTY

Logelin launched the discussion with a review of the rankings generated at the group's last meeting:

Rank	Priority	Score
1	Physical Inactivity	203
2	Obesity	197
3	Healthy Foods	184
4	Alcohol	161
5	Motor Vehicle Safety	138
6	Tobacco	137
7	Falls Prevention	127
8	Chronic Disease	123
9	Mental Health	122
10	Access	89
12	Drug Use	77
12	Elder Care	76
13	Safety/Violence	70

Discussion focused on the top four ranked issues. Discussion points included:

- Obesity is really a symptom of poor nutrition and inadequate physical activity; we should focus on the behaviors rather than the disease.
- There is an interconnectedness between many of these issues – for instance, obesity, nutrition, exercise, alcohol, smoking, and mental health.
- There is an opportunity to tie the CHNA action plan for 2014-2016 into the work of the Healthy Communities Partnership, which will have a strong presence in River falls for 2013-2015, with a focus on nutrition, exercise, smoking and alcohol.
- When thinking about interventions, we should consider engineering, education and enforcement. It would be ideally if we would have action steps related to all three for each of the priority areas. Work on engineering and enforcement may provide an opportunity to focus on policy changes that will have a positive impact on health.
- When asked why mental health ranked so low, group members indicated that it was probably a reflection of the immensity of the issue and the lack of resources to address it.
- We need to have a focus. There are many people competing for time and energy we need to get people's attention and create a critical mass. It would be ideally if we could identify a strategy – walking, for instance – and develop a campaign to get groups across the county excited about being part of the movement. People want to have fun and see immediate benefits. Don't focus on the fact that walking will prevent heart disease 10 years from now, focus on the fact that it will make you feel better today. Heather encouraged participants to watch the video at http://www.youtube.com/watch?v=aUaInS6HIGo titled "23-1/2 Hours: What is the single best thing we can do for our health?"
- Thinking about cost of intervention, physical activity is likely the lowest, nutrition likely the highest.

- Thinking about community readiness, there would probably be the most resistance to a focus on alcohol consumption, with the exception of readiness for work on impaired driving and youth consumption. Alice Reilly-Myklebust noted that UW-RF has done some policy and enforcement work around binge drinking. Sue Galoff noted that at a forum held in October for legislative candidates, a question was raised about increasing the beer tax, and no candidate was willing to get behind that idea.
- There is a high level of perceived readiness around issues of nutrition and physical activity, but we also want to increase awareness regarding the cost/burden to society. That will help create not only a personal urgency but also community-level urgency.
- By focusing on physical activity, we will also impact senior falls and chronic disease.
- Regarding health disparities, the discussion focused primarily on low-income households with minimum-wage workers who may work multiple jobs and be uninsured. One program currently reaching some of these families is the backpack program in most local schools; we could consider partnering with them to reach this population.

There are existing groups working on many of these issues.

- The Pierce County Healthy Eating, Active Living Coalition is focused on nutrition and physical activity, but has had a difficult time engaging the broader community.
- The Pierce County Partnership for Youth is engaged on issues related to alcohol and other drugs and, to some extent, tobacco.
- The Western Wisconsin Working for Tobacco-Free Living (W3TFL) coalition http://www.w3tfl.org/ is working to prevent, reduce exposure to, and eliminate the use of tobacco products through policy work, education and informational/service efforts.
- The Pierce and St. Crioix County SHARES group provides a forum for mental health and health care providers to meet and share information and resources.
- The Pierce County Sheriff's Department leads a group working on motor vehicle safety issues.

The group then reached consensus that the two priority issues for 2014-2016 will be physical activity and healthy foods.

Regarding the community dialogues in early 2013, we want to ensure representation from:

Schools
Universities
Churches
YMCA/Health Clubs
Larger Employers
Grocers
Food Shelves
Farmers Markets
Service Clubs (Rotary, Lions, Kiwanis, etc.)

Engaging members of service clubs could be an effective way to bring people to the table who are there not because of their profession, but because they are members of the community who care about our future.

- Submitted by Heather Logelin, Community Engagement Director, Western Wisconsin

RIVER FALLS AREA HOSPITAL
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Appendix I

Framing CHNA Health Disparities

Community Health Needs Assessment and Implementation Plan 2014–2016

Allina Health
RIVER FALLS AREA HOSPITAL

Framing CHNA's in the Context of Healthcare Equity

"A prerequisite to improving health and reducing inequities is to consider and address social determinants of health, namely the social and physical environments in which people are born, live, learn, work, play, worship and age." (American Public Health Association et al, 2012)

What are health disparities?
Health disparities, or the unequal distribution and prevalence of illness, chronic disease, and death, are ubiquitous at a national, state and local level. Health disparities are connected to a myriad of historical, social, behavioral, environmental and biological factors. An individual's health (physical, mental, emotional, social, cultural and spiritual) is uniquely shaped by a number of factors, including (but not limited to):

- Lifestyle
- Behaviors
- Family History
- Cultural History/Heritage
- Values and Beliefs
- Hopes and Fears
- Life Experience
- Level of Education
- Neighborhood
- Spiritual Beliefs/Practices
- Cultural Group
- Gender
- Language
- Employment Status/Occupation
- Sexual Orientation
- Relationship Status
- Disability Status
- Social, Economic and Environmental Circumstance

An individual's health can be promoted or constrained by these factors, placing specific patients and populations at greater risk for chronic disease and suboptimal health.

What are health*care* disparities?
The care that patients access and receive in the hospital, clinic, community and household setting is also a factor in health disparities. Evidence of disparities within the health care setting has been documented. For example,

- the 2003 Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* highlighted racial and ethnic disparities in access to care and also disparities in quality of care for those who had access (IOM, 2012), and
- the most recent *National Healthcare Disparities Report* documents socioeconomic, racial/ethnic and age disparities for a large percentage of quality of care measures they assessed (AHRQ, 2011).

What are a few examples of disparities?
National Level
Health disparities have persisted over time, where minority racial groups such as African Americans and American Indians have higher mortality rates compared to whites (IOM, 2012). Examples include:

- gaps in heart disease and cancer mortality rates between African Americans and whites (even though these mortality rates have declined in both groups, the gap between both racial groups still exists),
- a considerable gap in diabetes-related mortality rates has been present between American Indians and whites since the 1950s, and

- disparities in mortality rates for both African Americans and American Indians compared to whites exist at all age levels (across the life span).

Health disparities have also been documented where racial and ethnic minorities "experience an earlier onset and a greater severity of negative health outcomes" (IOM, 2012). Examples include:

- breast cancer outcomes,
- major depression outcomes, and
- and first birth neonatal mortality.

State Level

Statewide, there are racial/ethnic disparities in the number and magnitude of select health indicators, especially for African Americans and American Indians (MDH, 2009a; MDH, 2009b). Examples include:

- increased incidence of select STDs (HIV, gonorrhea, chlamydia),
- pregnancy and birth disparities (prenatal care, low birth weight, teen births, infant mortality),
- select chronic disease mortality (diabetes, heart disease, cancer, chronic lower respiratory disease), and
- stroke, mortality rates, and homicide.

Disparities are also present among Hispanics, especially with select STDs incidence, pregnancy and birth disparities, and diabetes mortality rates (MDH, 2009a; MDH, 2009b). All of the mentioned racial/ethnic minorities also have higher rates of uninsurance compared to Whites (MDH, 2009b). Evidence also suggests significant disparities for specific health indicators when comparing urban versus rural populations (MDH, 2011). Examples include:

- higher diabetes, stroke, heart disease, pneumonia and influenza mortality rates are some examples of disparities in rural populations compared to urban populations, and
- higher uninsurance, smoking, obesity, and suicide rates and reporting of "fair" or "poor" health are also examples of disparities in rural communities.

Metro Area

In the Metro Area, a study by Wilder Research in 2010 commissioned by the Blue Cross and Blue Shield of Minnesota Foundation identified unequal distribution of health in the Twin Cities based on median area income, education, race and neighborhood conditions (Helmstetter et al, 2010). For example, the report highlights disparities in health outcomes for American Indians residing in the Twin Cities Metro Area, indicating American Indians in the metro area have: the lowest life expectancy (61 years) compared to Asians (83 years) and whites (81 years); the highest mortality rate (3.5 times higher than whites); and the highest diabetes rate (18%) compared with the overall average for Hennepin County (6%).

Hennepin County

In Hennepin County, according to a Survey of the Health of All the Population and the Environment (SHAPE), lesbian, gay, bisexual, and transgender (LGBT) persons have much higher prevalence of poor mental health, including frequent mental distress, depression, anxiety or panic attack, serious psychological distress, and any psychological distress. Smoking, binge drinking, and heavy alcohol use are also higher among LGBTs compared to non-LGBT adults. Rates of LGBTs who currently lack health insurance, or who were not insured at least part of the past year were almost twice as high as those who are not LGBT. Disparities within the healthcare setting are also apparent: "[c]ompared to their non-LGBT peers, LGBT residents are more likely to report experiencing discrimination while seeking health care, have unmet medical care needs and unmet mental health care needs" (SHAPE, 2012).

Allina Health

At Allina Health, preliminary research is beginning to suggest disparities in care and outcomes. For example:

- an internal study by Pamela Jo Johnson, MPH, PhD and her cohorts identified significant disparities in hospital admission rates for potentially-avoidable hospital care for Ambulatory Care Sensitive Conditions (ACSC), especially for chronic conditions. Overall, 10% of 2010 hospital admissions at Abbott Northwestern Hospital were due to diabetes complications and significant disparities by race/ethnicity were noted. Specifically, 36% of Hispanic admissions, 20% of American Indian admissions, and 15% of Black admissions were due to diabetes, compared with only 8% of White admissions (Johnson et al, 2012), and

- preliminary analysis of 2010 optimal diabetes control data from Allina clinics 2010 data by Jennifer Joseph, MPH, and her cohorts show substantial disparities in optimal status by race/ethnicity. Only 37% of Blacks and 37% of American Indians achieved optimal control status compared with 51% of non-Hispanic whites. Analysis indicates that Blacks and American Indians have significantly higher odds of sub-optimal diabetes control compared to non-Hispanic whites (Joseph et al, 2012).

These examples indicate that opportunities may exist for enhanced clinical care and self-management support for chronic disease for some populations to reduce potentially-avoidable hospital care and to improve optimal control of chronic disease, such as diabetes.

What are healthcare systems doing to eliminate healthcare disparities?

Many healthcare systems, including Allina, are working to identify and understand disparities in care and outcomes and to develop and implement evidence-based solutions to promote healthcare equity. Healthcare equity is a key component of our national and local healthcare agenda (U.S. Department of Health and Human Services, 2012; National Prevention Council, 2011). In addition, health equity is inherently related to care quality, and equitable care is one of the six aims for quality improvement identified by the IOM in their groundbreaking report *Crossing the Quality Chasm* (IOM, 2001). Healthcare equity initiatives are expected to:

Improve:

- Quality of Care
- Patient Outcomes
- Patient Safety
- Patient Experience/Satisfaction

Reduce:

- Potentially Preventable Events
- Potentially Preventable Hospital Care
- Readmissions
- Medical Errors
- Overall Healthcare Costs

Identifying Healthcare Disparities within the Hospital and Clinic Setting

Recent improvements in health information technology (HIT) and electronic medical records are helping healthcare systems identify disparities in care, utilization, and outcomes. For example, leading agencies and institutions (such as the National Quality Forum, the Department of Health and Human Services, the IOM, the Joint Commission, the Health Policy Institute, and Minnesota Community Measurement) recommend stratifying hospital quality data/measures by race, ethnicity, and language data to determine whether there are differences in quality of care for different populations. This information can be used to inform specific quality improvement initiatives to reduce disparities and improve outcomes.

Eliminating Healthcare Disparities within the Hospital and Clinic Setting

Central to the goal of eliminating disparities *within* healthcare setting are 1) knowing the unique physical, mental, emotional, social, cultural and spiritual needs of each patient we serve, 2) being aware of the unique resources and barriers to healing that are present in each patient's path to optimal healing and optimal health, and 3) engaging patients as active collaborators in the care of their health. Initiatives in data collection/analysis, patient-centered care, culturally-and linguistically appropriate services, patient engagement, patient-provider communication and shared-decision making are examples of ways that Allina is working toward this goal. In addition, there are a number of evidence-based strategies available to promote healthcare equity within healthcare settings, such as:

- Culturally-Responsive Care
- Cultural Competence Training for Providers
- Interpreter Services (for patients with a primary language other than English)
- Community Health Workers and Promotoras
- Innovative HIT Tools
- Patient-Centered Care
- Patient-Centered Communication
- Bilingual Staff
- Data Collection & Analysis
- Care Management
- Care Navigators
- Coordinated Care
- Prevention and Wellness Initiatives
- Advanced Care Teams
- Meaningful Use
- Patient Materials/Signage in Multiple Languages
- Workforce Diversity

How can Allina's Community Engagement Programs and Projects Such as the CHNA Reduce Disparities?

Allina's community engagement, community benefit, charitable contributions, community health improvement, and public policy initiatives are critical vehicles for reducing disparities and promoting healthcare equity. Since most barriers and resources to health are present within the contexts where patient's carry out their daily lives, the ability to eliminate health disparities from within the walls of hospitals and clinics is limited; conversely, the capacity to capture insights from patient voices and develop solutions within patients and their communities is almost limitless. The IOM, in their groundbreaking report *Unequal Treatment*, explain that racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life (IOM, 2003). So, as Allina works to meet the needs the physical, mental, emotional, social, cultural and spiritual needs of our patients, we have to understand and collaboratively care for our patients in the context of the homes, schools, neighborhoods, communities, and environments where our patients carry out their daily lives.

- For example, community-based efforts, multi-factorial approaches, and HIT are the 'new frontier' for reducing disparities in diabetes, according to leaders in disparities reduction who summarized the latest research in on this topic (Betancourt et al, 2012). What could this mean for Allina? Dialogue and research with patients, providers and community leaders about obstacles to optimal diabetes control at the personal, community, system and policy level may help Allina understand why standard care alone is not successful for some patients/populations. These insights and perspectives could be used to 1) inform quality improvement initiatives in diabetes clinical care delivery, 2) facilitate collaborative bridges between the medical care that is delivered in the clinic setting with additional self-care that is being fostered in the community setting, and 3) improve diabetes control in patients/populations for whom standard care alone is not successful.

Community Health Needs Assessments (CHNA's), as mandated under section 9007 of the Patient Protection and Affordable Care Act and outlined in IRS policy 2011-52, are especially promising for

understanding the specific needs of our patients and informing solutions through patient-centered dialogue in the broader context of the communities we serve. CHNA's will help Allina begin to understand 1) the barriers and resources to health and unmet medical needs of the community, 2) identify actionable opportunities, and 3) implement a community benefit implementation strategy to respond to such needs. To reduce disparities, it is important that Allina understand the needs of our communities overall, and understand the *specific needs of specific patients and populations* within the overall community. In this way, CHNA's present an opportunity for hospitals to maximize community health impact and reduce health disparities by considering social determinants of health and creating strategies to address health inequities (American Public Health Association et al., 2012; Crossley, 2012). CHNA's can be a critical tool to inform prevention, health promotion, quality improvement and healthcare equity initiatives because such assessments "can be considered alongside clinical, utilization, financial and other data to help craft health improvement solutions that take into account both the individual's health and the community context in which they live" (Bilton, 2011; Bilton, 2012).

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RIVER FALLS AREA HOSPITAL

PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Appendix J

Community Dialogue Report

Community Health Needs Assessment and Implementation Plan 2014–2016

Allina Health

RIVER FALLS AREA HOSPITAL

ALLINA HEALTH COMMUNITY DIALOGUE

WESTERN WISCONSIN

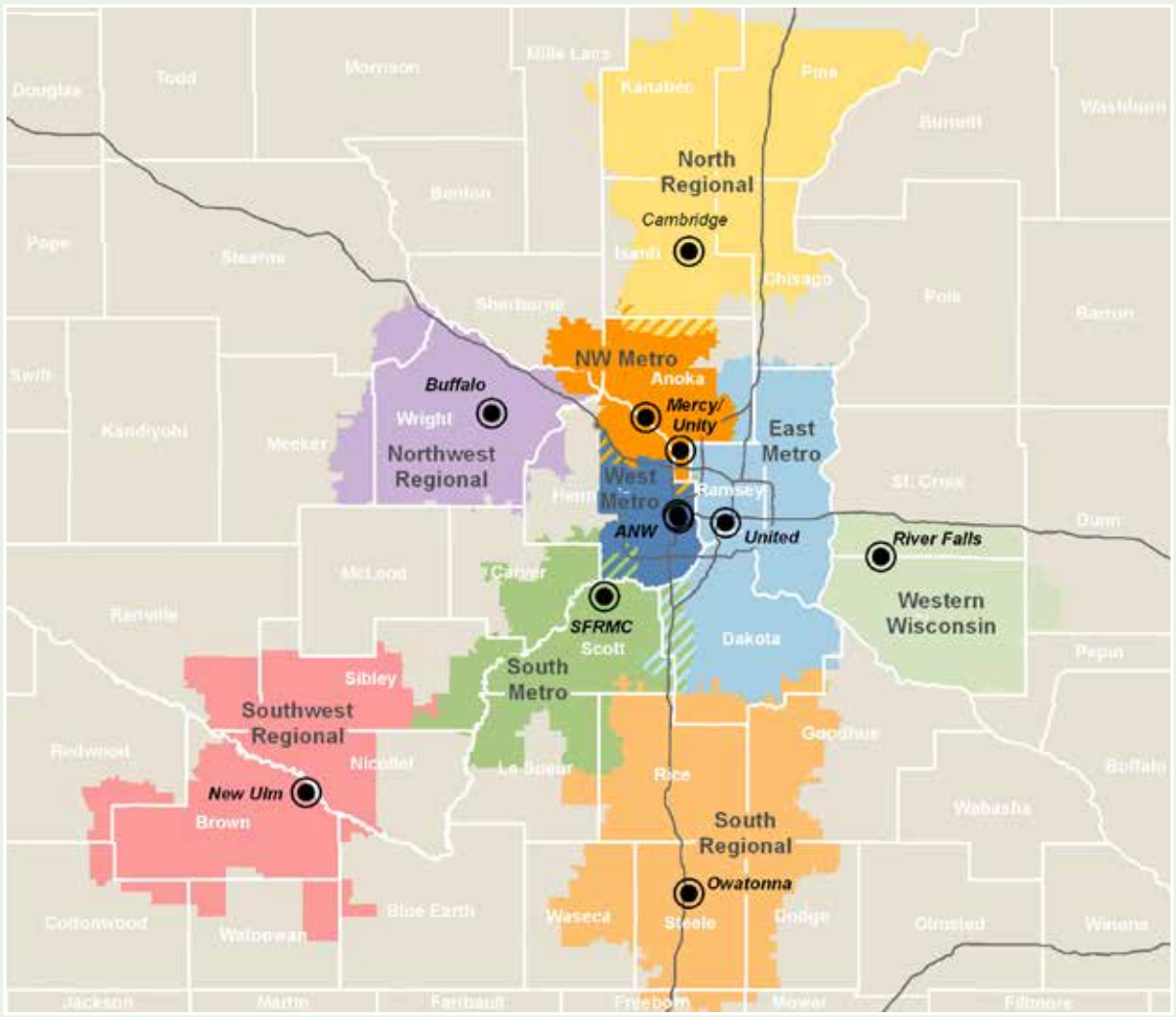
MARCH 2013

Allina Health

Improving health in our community

Allina Health is dedicated to the prevention and treatment of illness and enhancing the greater health of individuals, families and communities throughout Minnesota and western Wisconsin.

Allina Health Community Benefit & Engagement Regional Map



Introduction

Allina Health is a not-for-profit organization of clinics, hospitals and other health and wellness services that cares about improving the health of all communities in its service area of Minnesota and Western Wisconsin. Allina Health divides its service area into nine community engagement regions, each with a regional Community Engagement Lead dedicated to working with community partners to develop specific, local plans based on community needs.

To identify and respond to the community needs present in its service area, Allina Health recently conducted a community health needs assessment at an Allina Health hospital in each of the nine community engagement regions.

The needs assessment at River Falls Area Hospital, part of the Western Wisconsin Region, identified two priority health issues to focus on from 2014–2016 (see **allinahealth.org** for the full community health needs assessment report). They included:

- NUTRITION,
- AND PHYSICAL ACTIVITY.

As a part of the process, the hospital hosted two community health dialogues with leaders and residents from the region to hear from a broader group of community members, identify ideas and strategies to respond to the priority issues and inform the action-planning phase of the needs assessment. A total of forty-three people participated.

This summary highlights the findings from the 2013 dialogues in the Western Wisconsin Region, which includes River Falls Area Hospital.

In February 2013, River Falls Area Hospital and Allina Health convened two Community Dialogues in Western Wisconsin.

Participants were asked to share their knowledge about the local health concerns that are most pressing among residents and their ideas about what works and what needs to be done to improve health in their community. Participants engaged in a World Café or participatory dialogue facilitated by members of Wilder Center for Communities. Participants moved through different rounds of conversation focused on nutrition and physical activity.

The following summarizes key themes identified through analysis of individual discussion guides, completed by participants prior to engaging in the dialogue. In addition, where possible, themes from the dialogues are also included in the analysis. The information presented in this summary reflects the perspectives of a relatively small number of community members, and may not fully convey the diversity of experiences and opinions of residents who live in Western Wisconsin. Allina Health believes the community members included in the dialogues conveyed useful information and insight, and they continually seek to develop an understanding of the diverse experiences and opinions of community residents.

COMMUNITY DIALOGUE PARTICIPANTS

River Falls (February 18)

Eighteen community members participated in the February 18 community dialogue held in River Falls. Efforts were made to recruit participants who were local business owners. Participants were almost equally split between 25-44 and 45-64 years of age. They reported living in a diversity of communities, including small towns, rural areas, and large towns or cities. Half of the participants indicated representing the hospitality, retail, manufacturing, and construction industries. Many participants citied an expertise in health topics such as physical activity and nutrition. Various participants noted working with and/or representing adults (25-64), parents of children, and white residents.

River Falls (February 28)

Twenty-five community members participated in the February 28 community dialogue held in River Falls. Efforts were made to recruit older adults as participants, 55 or older. A majority of the participants were between 45-64 years of age and reported living in a small town. Over three quarters of participants noted being retired or unemployed. Nearly half of the participants did not report an area of expertise in a health topic. Of those who did indicate an expertise, many identified nutrition and physical activity. Several participants cited working withand/or representing senior citizens and white residents.

Community impact

NUTRITION

Participants were asked to reflect on how nutrition impacts people in their community. Several participants pointed out that there is a large presence of fast food restaurants in their community providing cheap, unhealthy food. They indicated that residents often choose the fast food options because of limited time and busy schedules, a lack of knowledge about nutrition or how to prepare meals, and the high cost of purchasing healthier food. Some participants noted that the consumption of unhealthy foods can lead to obesity and chronic health conditions. Several participants referenced many local community assets that serve to promote or provide healthy food options, such as community gardens, farmers markets, the Whole Earth cooperative, and newly developed cooking classes led by dieticians at Family Fresh grocery market.

PHYSICAL ACTIVITY

Participants were asked to reflect on how physical activity impacts people in their community. Participants reported that people in their community do not engage in physical activity due to a lethargic attitude, a lack of time, or reduced access to exercise opportunities. Participants also cited barriers to exercise and physical activity such as the closing of an exercise facility and a limited number of walking and bike paths. Many participants highlighted the assets in the local community such as access to exercise facilities, neighborhood parks, walking trails, and an active community of families who exercise. Some acknowledged that exercise and physical activity opportunities could be better publicized and shared with the public.

Addressing health concerns in the community

NUTRITION

Participants were asked to reflect on what should be done to address nutrition. They focused on creating more education and awareness regarding nutrition and increased access to and availability of nutritious food (particularly for local schools). In terms of education and awareness, participants suggested:

- Developing community reminders focused on what food is in season and its impact on health
- Hosting healthy meals classes after work hours or on weekends for families

Regarding increased access to and availability of nutritious food, participants recommended:

- Increasing options for purchasing healthier foods such as farmers markets or offering more organic food at grocery stores
- Having the school lunch program buy local, fresh foods

PHYSICAL ACTIVITY

Participants were asked to reflect on what should be done to address physical activity. They called for increased education and awareness about physical activity, expanded access to or creation of more exercise and physical health opportunities, and a greater focus on the intersection between physical activity and local infrastructure. To increase education and awareness, participants suggested a community-wide campaign emphasizing the benefits of physical activity and health. In terms of expanded access to and creation of exercise and physical health opportunities, participants mentioned:

- Incentivizing people to be healthy by offering people a monetary incentive to go to the gym or take a nutrition class
- Attracting a fitness facility that offers group classes
- Expanding opportunities for the Silver Sneaker program

Regarding physical activity and local infrastructure, participants suggested:

- Developing walking and biking trails; declaring the community a "biking town or walking/ pedestrian town"

How Allina Health can help address health concerns

NUTRITION

Participants were asked to reflect on how Allina Health could help address nutrition. They reported that Allina Health could help address nutrition through increasing education and awareness (particularly by partnering with schools and businesses), creating classes focused on cooking and nutrition, and increasing the access and availability of nutritious food. Participants specifically recommended:

- Developing a "tool box" of educational materials and displays regarding nutrition that can be shared with local businesses
- Offering educational classes or presentations for parents who cook for their family or young single adults
- Supporting healthy nutrition options such as farmers market, farm to school initiatives, and Community Supported Agriculture
- Providing business with resources to guide wellness programs; collaborating with businesses around health competitions
- Working with employers to create wellness programs for their worksites

PHYSICAL ACTIVITY

Participants were asked to reflect on how Allina Health could help address physical activity. They shared that Allina Health could help address physical activity by expanding access to or creation of more exercise and physical health opportunities and developing community partnerships focused on exercise and physical activity. Participants specifically noted:

- Supporting the construction of sidewalks and bike trails; providing bike helmets and safety instruction.
- Assisting in the development of onsite fitness rooms and donating "retired" fitness equipment to businesses
- Sponsoring community-wide health efforts, for example: "Can we achieve a goal of 90% of the community walking x number of steps per day?"
- Developing a class like "couch potato to 5k to encourage those out of shape to get fit"

Conclusion

The community dialogues were an opportunity for River Falls Area Hospital to hear from a broader group of community members and identify ideas and strategies to respond to the priority issues to inform the action-planning phase of the needs assessment, and ultimately the action plan for River Falls Area Hospital for FY 2014–2016.

Intersecting social, economic, and cultural barriers impact the health of the community, and by conducting community dialogues, Allina Health gained insight into how to support the community, building on the existing assets, and engage more people in defining the problems, and coming up with appropriate solutions.

Allina Health

allinahealth.org

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PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Appendix K

CHANGE Summary

Community Health Needs Assessment
and Implementation Plan 2014–2016

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Creating a Culture of Healthy Living

CDC's Healthy Communities Program

CHANGE summary

Introduction

Pierce County HEAL (Healthy Eating Active Living) coalition implemented the CHANGE (Community Health Assessment aNd Group Evaluation) to gain an understanding of Pierce County's needs and assets relating to physical activity and nutrition. The CHANGE tool, developed by CDC's Healthy Communities Program assisted our team to organize information on indicators related to policies and environments that support healthy eating, active living, and chronic disease management. Our CHANGE/HEAL "action members" include representatives from the Pierce County Public Health Department, River Falls Hospital, River Falls Clinic, Ellsworth School District, UW- Extension, Chippewa Valley Technical College/UW-Eau Claire Interns, and Healthy Community Partnership Grantees.

Methods

Our team consisted of ten "action" members that collected data for the CHANGE tool. Over twenty key informant interviews were conducted in the school, healthcare, community/organization, and worksite sectors. For every sector, a second method of data collection was used to assess such as focus groups, surveys, and onsite observation. Photo documentation, mapping, and walkability audits were methods used to capture the story and to verify interview discussions.

Agency Overview

The CHANGE tool summary provides a citizen's perspective; therefore is invaluable in determining Pierce County's Community Health Improvement Plan. The assessments completed provided a score (percentage of implementation) for policy and environment in areas of physical activity, nutrition, chronic disease, and leadership. All scores were entered into the summary statements for each sector and then into the master sector data grid. The sector data grid gives an overview of the current areas where policies and environment can be improved for healthier outcomes.

Results

The Sector Data Grid shows that the two areas that ranked with the greatest needs are in the worksite and school sectors, both in the chronic disease management and leadership category (scoring with 0-20% of assessment indicators implemented). The next area of priority is the community-at-large and community organization/institution sector in the category of nutrition (scoring with 21-41% of assessment indicators implemented). Worksite scored the same percentage level (21-40% implemented) in the area of physical activity.

Summary and Conclusion

Worksite Health Indicators that scored 0-21%

Chronic Disease:

- Provide routine screenings, follow up counseling and education to employees to help address chronic diseases and related risk factors
- Provide paid time off to attend health promotion programs or classes
- Provide access to chronic disease self-management programs

Leadership:

- Participate in the public policy process to highlight the need for community changes to address chronic diseases and related risk factors
- Have a wellness committee/coordinator
- Participate in community coalitions and partnerships
- Reimburse employees for preventive health or wellness activities

Summary and Conclusion, continued

School Health Indicators that scored 0-21%

Chronic Disease:

- Provide chronic disease self-management education to individuals identified with chronic conditions or diseases

Leadership:

- Participate in community coalitions and partnerships
- Participate in the public policy process to highlight the need for community changes to address chronic diseases and related risk factors

Community-at-Large Health Indicators that scored 21-40%

Nutrition:

- Adopt strategies to encourage food retailers to provide healthy food and beverages
- Connect locally grown food to local restaurants and food venues
- Promote the purchase of fruits and vegetables at local restaurants and food venues (signage, product placement, pricing strategies)
- Institute healthy food and beverage options at local restaurants and food venues
- Institute nutritional labeling at local restaurant and food venues
- Ban local restaurants and retail food establishments from cooking with trans fats
- Adapt strategies to recruit grocery stores in underserved areas

Community Organization/Institution Health Indicators that scored 21-40%

Nutrition:

- Institute healthy food and beverage options in vending machines
- Institute healthy food and beverage options at institution sponsored meetings and events
- Institute healthy food and beverage options in onsite cafeteria and food venues
- Institute pricing strategies that encourage the purchase of healthy food and beverage options
- Ban marketing of less than healthy foods and beverages onsite
- Provide a comfortable, private space for women to nurse or pump to support and encourage patrons' ability to breastfeed

Healthcare Health Indicators that scored 21-40%

Leadership:

- Participate in community coalitions and partnerships
- Participate in the public policy process to highlight the need for community changes to address chronic diseases and related risk factors

Worksite Health Indicators that scored 21-40%

Physical Activity:

- Provide flexible work arrangements or break times for employees to engage in physical activity
- Encourage non-motorized commutes to work
- Support clubs or groups to encourage physical activity among employees
- Provide a safe area outside to walk or be physically active
- Designate a walking path on or near building property
- Provide access to onsite fitness center, gymnasium, or physical activity class
- Provide a changing room or locker room with showers
- Provide bicycle parking (bike rack, shelter) for employees
- Implement activity breaks for meeting that are longer than one hour
- Provide direct support for supporting community-wide physical activity opportunities

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Appendix L

Community Assets Inventory

Community Health Needs Assessment
and Implementation Plan 2014–2016

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Healthy Communities Partnership

Your Guide to Healthy and Active Living

Allina Health

RIVER FALLS AREA HOSPITAL

Your Guide to Healthy and Active Living

First edition

Developed by Allina Health.

Allina Health System Patient Education
ISBN 1-931876-36-3

The publisher believes that information in this manual was accurate at the time the manual was published. However, because of the rapidly changing state of scientific and medical knowledge, some of the facts and recommendations in the manual may be out-of-date by the time you read it. Your health care provider is the best source for current information and medical advice in your particular situation.

Disclaimer

This publication is for general information only and is not intended to provide specific advice or recommendations for any individual. The information it contains cannot be used to diagnose medical conditions or prescribe treatment. The information provided is designed to support, not replace, the relationship that exists between a patient and his/her existing physician. For specific information about your health condition, please contact your health care provider.

Allina Health
RIVER FALLS AREA HOSPITAL

Acknowledgments

The first edition of "Your Guide to Healthy and Active Living" was edited and produced by Allina Health's Patient Education Department.

Table of Contents

Chapter 1:
Welcome

In This Chapter:

- Welcome to the Healthy Communities Partnership (HCP) Worksite Wellness Program

Chapter 1:
Welcome to the Healthy Communities Partnership (HCP) Worksite Wellness Program

Tip

As a participant in this program, you can choose to go to education classes to:

- learn about healthful eating and local foods
- share ideas for how to live an active lifestyle
- gain support from others
- talk about community resources to help you in your efforts.

More Information

For more information about the HCP Worksite Wellness Program, please contact Brandi Poellinger, program coordinator, at 715-307-6084 or brandi.poellinger@allina.com.

Congratulations! You have just taken an important step toward improving your overall health and wellness. By participating in the Healthy Communities Partnership (HCP) Worksite Wellness Program you now have many useful resources to help you achieve your goals.

Your first step is to take an online health assessment. This will ask you some basic questions about your health. Then, you will learn what your "numbers" are by having your heart rate, blood glucose, blood pressure, cholesterol and body mass index (BMI) measured. Turn to chapter 2 on page 11 to learn more about how knowing your numbers can help you move toward better health in the future.

Next, you will be scheduled to talk with a wellness coach about your health. He or she will help you set goals to either maintain or improve your lifestyle. You will continue having one-on-one coaching sessions as you are in the program. Your wellness coach will be there to support and encourage you, and connect you with helpful community resources.

You will be scheduled to do these steps once each year for the next 3 years. This will help you to stay on track and achieve your goals.

Chapter 2:
Know Your Numbers

In This Chapter:

- Introduction
- Heart Rate
- Blood Glucose
- Blood Pressure
- Cholesterol
- HDL ("Good") Cholesterol
- LDL ("Bad") Cholesterol
- Triglycerides
- Body Mass Index (BMI)
- Worksheet: Your Numbers

Chapter 2:
Know Your Numbers

Introduction

Knowing your numbers today will help you to move toward better health in the future.

It's a hot summer day and you're biking along a beautiful state trail. You'd like to stop for some water and a short rest in the shade. Should you turn your bike around to go back to the last rest stop you passed or continue ahead, hoping to see another? If you were in this situation, it would be helpful for you to look at a trail map to figure out the distance to the next rest stop.

The first step in the Healthy Communities Partnership (HCP) Worksite Wellness Program is to "know your numbers." Your numbers include your:

- heart rate
- blood glucose
- blood pressure
- cholesterol
  - — total cholesterol
  - — HDL ("good") cholesterol
  - — LDL ("bad") cholesterol
  - — triglycerides
- body mass index (BMI).

Knowing these numbers is similar to using a trail map. Just like needing to know where the rest stops are located to move in the right direction, knowing your numbers will help you to achieve your wellness goals and move toward better health.

Heart Rate

Your heart rate lets you know how fast your heart is beating. Every time your heart beats it pumps blood into your arteries. This action causes a pulse that you can feel when you put your finger near the artery. Your pulse rate counts the number of heartbeats per minute. In general, the more your heart beats, the harder your heart is working.

Did You Know?

Your heart beats about 60 to 100 times each minute.

Blood Glucose

After you eat, food is turned into glucose (blood sugar) that is used by your cells for fuel. If your blood glucose is too high for too long, it can cause damage to your body. This can put you at a higher risk for developing diabetes in the future.

Blood Glucose Levels (fasting)	
Normal	less than 100 mg/dL
Prediabetes	100 to 125 mg/dL
Diabetes	126 mg/dL or higher on two occasions

Blood Pressure

You may have high blood pressure (hypertension) and not even know it. Often there are no signs or symptoms of this dangerous condition.

Did You Know?

According to the American Heart Association, **nearly 1 in 3 American adults** has high blood pressure.

High blood pressure puts stress on your blood vessel walls and can lead to:

- heart attack
- heart failure
- stroke
- kidney failure.

You should have your blood pressure checked often. Your blood pressure is checked with two numbers. The top number (systolic) shows the pressure in your arteries when your heart beats. The bottom (diastolic) shows the pressure in your arteries when your heart rests. A typical blood pressure reading is 120/80.

Blood Pressure for Adults: General Guidelines		
	Top number (systolic)	**Bottom number (diastolic)**
Normal	less than 120	less than 80
Prehypertension (not yet high blood pressure)	120 to 139	80 to 89
Hypertension	more than 139	more than 89

Salmon cooked with parsley.

Tip

Try cooking with herbs and spices instead of reaching for the salt shaker. Some good flavoring options include:

- **garlic:** chicken breast or potatoes
- **basil:** eggs or broccoli
- **oregano:** squash or pork tenderloin
- **basil:** turkey breast or peas
- **parsley:** tomatoes or salmon.

How to control or lower high blood pressure

You need to treat high blood pressure. If you don't, you could have a heart attack or stroke. Although high blood pressure cannot be cured, it can be managed.

Here are some things you can do to control or lower your blood pressure:

- lower the sodium in your diet
- get regular exercise
- decrease the amount of alcohol you drink
- stop smoking
- take medicine to lower your blood pressure.

Cholesterol

Cholesterol is a fat-like substance in your blood. Your body makes some cholesterol to help it function properly. You may also get cholesterol from some of the foods you eat.

When your blood cholesterol level is too high, the cholesterol builds up on the walls of your arteries. Over time, this can lead to a heart attack or stroke.

You can have your cholesterol level checked by having a blood test. Your results will tell you your:

- total cholesterol
- HDL ("good") cholesterol
- LDL ("bad") cholesterol
- triglycerides
- total cholesterol/HDL ratio.

Cholesterol Goals (fasting)		
Total cholesterol	less than 200 mg/dL	"Desirable" level that puts you at lower risk for heart disease. A cholesterol level of 200 mg/dL or greater increases your risk.
HDL ("good") cholesterol	greater than 40 mg/dL	HDL of 40 mg/dL and higher is recommended to protect you against heart disease. (For women, an HDL goal of 50 mg/dL should be considered.)
LDL ("bad") cholesterol*	less than 130 mg/dL	"Optimal" level that is considered to protect you against heart disease.
Triglycerides	less than 150 mg/dL	"Desirable" level that puts you at lower risk for heart disease.
Total cholesterol/HDL ratio	less than 4.5	

***LDL less than 100 mg/dL is recommended if you have diabetes. LDL less than 70 mg/dL is recommended if you have both diabetes and heart disease or if you have had a heart attack or a stroke.**

HDL ("Good") Cholesterol

HDL cholesterol is known as the "good" cholesterol. This helps to get rid of extra cholesterol from your blood and tissues. Higher levels of HDL may prevent or reverse blood vessel problems.

The National Cholesterol Education Program guidelines for HDL cholesterol levels are:

- 40 mg/dL or higher for men
- 50 mg/dL or higher for women.

How to increase your HDL

- Lose weight if you are overweight.
- Stop smoking if you smoke.
- Exercise more.

Did You Know?

If you smoke, quitting can help to raise your HDL ("good") cholesterol. The benefits of quitting happen right away and continue many years later:

- **24 hours:** Your chance of a heart attack decreases.
- **1 year:** Your chance of heart disease is cut in half.
- **10 years:** Your risk of stroke and heart disease is the same as a non-smoker's risk.

LDL ("Bad") Cholesterol

LDL cholesterol is known as the "bad" cholesterol. When too much LDL builds up on your artery walls, plaque forms and blocks blood flow in vessels leading to your heart, legs and brain. This can cause heart disease, peripheral vascular disease and stroke.

The National Cholesterol Education Program guidelines for LDL cholesterol levels are:

- optimal: less than 100 mg/dL
- near optimal: 100 to 129 mg/dL
- borderline high: 130 to 159 mg/dL
- high: 160 to 189 mg/dL
- very high: 190 mg/dL and higher.

How to decrease your LDL

- Lose weight if you are overweight.
- Lower the saturated fat in your diet.
- Lower the cholesterol in your diet.
- Add more fiber to your diet.

Beans are an excellent source of cholesterol-lowering fiber. Try adding beans in to your next pot of soup, casserole or rice dish to fit more fiber into your diet.

Triglycerides

A blueberry muffin may seem like a healthful food but most are oversized and high in carbohydrates, sugar and saturated fat. Eating a lot of these types of foods can lead to high levels of triglycerides in your blood.

Triglycerides are a type of fat carried through the bloodstream. Triglycerides are found in fat from foods or made in your body from carbohydrates. Unused calories from food are turned into triglycerides and stored in fat cells.

The National Cholesterol Education Program guidelines for triglyceride levels are:

- normal: less than 150 mg/dL
- borderline high: 150 to 199 mg/dL
- high: 200 to 499 mg/dL
- very high: more than 500 mg/dL.

High levels of triglycerides

Triglycerides and cholesterol move through your blood in packages known as lipoproteins.

Triglycerides often have high levels of low density (known as LDL or "bad") cholesterol and low levels of high density (known as HDL or "good") cholesterol. This can cause a buildup of plaque (fatty deposits) in blood vessels.

High levels of triglycerides, known as hypertriglyceridemia, put you at risk for:

- heart disease
- stroke
- pancreatitis, an inflammation of the pancreas. (The pancreas helps you digest food and releases hormones that help your body use glucose.)

Hypertriglyceridemia may occur with diabetes or certain medicines.

Body Mass Index (BMI)

The body mass index (BMI) is a measure of body fat based on height and weight. It's a mathematical formula that calculates your risk of obesity.

Did You Know?

The BMI chart may not be accurate for people who have a muscular build or for older people who have lost muscle mass.

The numbers on the BMI are grouped into four categories:

- less than 18.5 — underweight
- 18.5 to 24.9 — normal weight
- 25 to 29.9 — overweight
- 30 or more — obese.

If you are obese, you are at risk for diabetes, high blood pressure, heart disease, stroke, arthritis, respiratory disorders, high cholesterol and other health disorders.

Use the charts on the next two pages to find your BMI.

- Find your height in the far left column.
- Follow the line to the right until you reach your weight.
- Follow this column up to read your BMI.

	healthy weight 19 to 24						overweight 25 to 29					obese 30 to 39					
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
Height	**Weight (pounds)**																
4′ 10″	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
4′ 11″	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
5 feet	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179
5′ 1″	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
5′ 2″	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191
5′ 3″	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197
5′ 4″	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
5′ 5″	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
5′ 6″	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
5′ 7″	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
5′ 8″	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
5′ 9″	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
5′ 10″	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243
5′ 11″	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
6 feet	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258
6′ 1″	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265
6′ 2″	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
6′ 3″	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
6′ 4″	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287

 Source: National Institutes of Health

	obese 30 to 39				very obese 40 to 52												
BMI	36	37	38	39	40	41	42	42	44	45	46	47	48	49	50	51	52
Height	**Weight (pounds)**																
4′ 10″	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248
4′ 11″	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257
5 feet	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266
5′ 1″	190	195	201	206	211	217	222	227	232	238	243	248	255	259	264	269	275
5′ 2″	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284
5′ 3″	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293
5′ 4″	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302
5′ 5″	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312
5′ 6″	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322
5′ 7″	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331
5′ 8″	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341
5′ 9″	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351
5′ 10″	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362
5′ 11″	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372
6 feet	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383
6′ 1″	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393
6′ 2″	280	287	285	303	311	319	326	334	342	350	358	365	373	381	389	396	404
6′ 3″	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415
6′ 4″	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426

Source: National Institutes of Health

Your Numbers

Each participant in the HCP Worksite Wellness Program will be scheduled for a health screening once each year for the next 3 years. This will help you to "know your numbers." After each screening write the date of your screening and your results in the chart below. You may bring this chart with you to your next appointment or use it to track your progress at home.

	Date _____	Date _____	Date _____	Date _____
Pulse				
Blood glucose				
Blood pressure				
Total cholesterol				
HDL				
LDL				
Triglycerides				
BMI				

Notes: _____

_____

_____

_____

_____

_____

_____

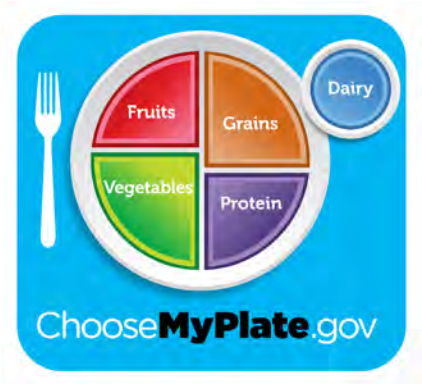
Chapter 3:
Nutrition

In This Chapter:

- General Information
- Amount of Each Food Group Needed Each Day
- Fruit Group
- Vegetable Group
- Dairy Group
- Grain Group
- Protein Group
- Understanding Fats

Chapter 3: Nutrition

General Information



The nutrition information in this section is from choosemyplate.gov.

Good nutrition is essential for a healthy body. Eating well-balanced meals will help you feel your best. According to the United States Department of Agriculture, a healthful diet is one that:

- focuses on fruit, vegetables, whole grains, and fat-free or low-fat milk
- includes lean meats, poultry, fish, beans, eggs and nuts
- is low in saturated fats, trans fats, cholesterol, sodium and added sugars.

For complete information, go to choosemyplate.gov. The website contains tips and resources, foods to eat more and less of, and nutrition information for women who are pregnant or breastfeeding, children, and people who want to lose weight.

In general:

- Eat smaller portion sizes.
- Make half of your grains whole.
- Make half of your plate vegetables and fruits.
- Drink fat-free or low-fat milk.
- Eat lean proteins.

Amount of Each Food Group Needed Each Day

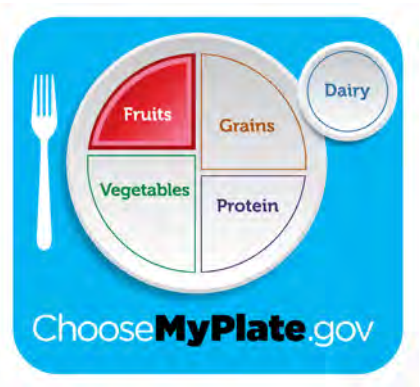
Use the chart below to find how much of each food group you need to eat each day.

	Age	Fruit*	Vegetables*	Protein*	Dairy	Grains*
Children	2 to 3 years	1 cup	1 cup	2 ounces	2 cups	1 ½ ounces
	4 to 8 years	1 to 1 ½ cups	1½ cups	4 ounces	2 ½ cups	2 ½ ounces
Girls	9 to 13 years	1 ½ cups	2 cups	5 ounces	3 cups	3 ounces
	14 to 18 years	1 ½ cups	2½ cups	5 ounces	3 cups	3 ounces
Boys	9 to 13 years	1 ½ cups	2½ cups	5 ounces	3 cups	3 ounces
	14 to 18 years	2 cups	3 cups	6 ½ ounces	3 cups	4 ounces
Women	19 to 30 years	2 cups	2½ cups	5 ½ ounces	3 cups	3 ounces
	31 to 50 years	1 ½ cups	2½ cups	5 ounces	3 cups	3 ounces
	51+ years	1 ½ cups	2 cups	5 ounces	3 cups	3 ounces
Men	19 to 30 years	2 cups	3 cups	6 ½ ounces	3 cups	4 ounces
	31 to 50 years	2 cups	3 cups	6 ounces	3 cups	3 ½ ounces
	51+ years	2 cups	2½ cups	5 ½ ounces	3 cups	3 ounces

Source: choosemyplate.gov

***The amounts listed for these food groups are appropriate for people who get less than 30 minutes of moderate physical activity a day. If you are more physically active, you may need to eat more than the amount listed above.**

Fruit Group



Any fruit or 100 percent fruit juice is included in this group. Fruits may be fresh, frozen, canned or dried.

Benefits of eating fruits

Most fruits are low in fat, sodium and calories. They do not have cholesterol. Fruits are rich in potassium, fiber, vitamin C and folate (folic acid).

Eating a diet rich in fruits may:

- reduce your risk for type 2 diabetes, stroke, heart disease and obesity
- help protect against certain cancers
- lower blood pressure
- help you manage your weight (helps keep you feeling "full" longer)
- help lower your cholesterol.

Tip

Add more color to your diet! Try to eat fruits of all different colors for your body to be its healthiest.

What is one serving?

One cup of fruit is equal to:

- ½ cup of dried fruit
- 1 large banana (8 to 9 inches long)
- 32 seedless grapes
- about 8 large strawberries
- 1 large peach or 2 halves, canned
- 1 medium pear
- 1 large orange
- 1 small apple.

Amounts needed each day

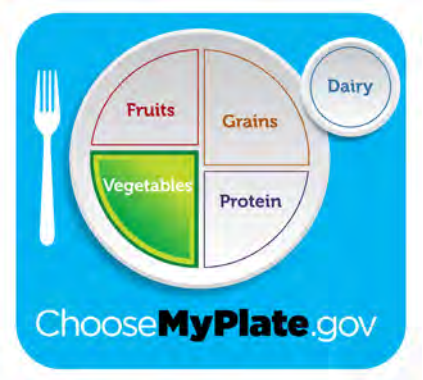
The following recommendations are for adults who get less than 30 minutes of moderate physical activity a day.

- **Women:**
  - — 19 to 30 years: 2 cups
  - — 31 to 51 + years: 1 ½ cups
- **Men:**
  - — 19 to 51 + years: 2 cups

Healthful Habit

Keep a basket of fresh fruit on your kitchen counter. Each time you need a snack, grab a piece of fruit!

Vegetable Group



Any vegetable or 100 percent vegetable juice is included in this group. Vegetables may be raw, cooked, fresh, frozen, canned or dried.

Benefits of eating vegetables

Most vegetables are low in fat and calories. Vegetables do not have cholesterol. Vegetables are a good source of potassium, fiber, and vitamins A and C.

- Eating a diet rich in vegetables may:
  - — reduce your risk for type 2 diabetes, stroke, heart disease and obesity
  - — help protect against certain cancers
  - — lower blood pressure
  - — help you manage your weight (helps keep you feeling "full" longer).
- Vitamin A in vegetables helps keep your eyes and skin healthy.
- Vitamin C in vegetables helps keep your teeth and gums healthy. It helps your body absorb iron, and helps your body heal from cuts and wounds.

What is one serving?

One cup of vegetables is equal to:

- 1 cup of raw or cooked vegetables or vegetable juice
- 2 cups of raw leafy greens.

Tip

Prepare your vegetables using different cooking methods. In the summer, you can put asparagus or corn on the grill. In the winter, place potatoes and carrots in the slow cooker with a lean cut of meat.

Amounts needed each day

The following recommendations are for adults who get less than 30 minutes of moderate physical activity a day.

- **Women:**
  - — 19 to 50 years: 2 ½ cups
  - — 51 + years: 2 cups
- **Men:**
  - — 19 to 50 years: 3 cups
  - — 51 + years: 2 ½ cups

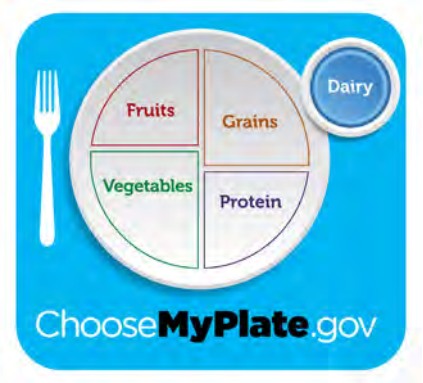
Pizza with added spinach, tomatoes, mushrooms and corn.

Healthful Habit

Eating salads isn't the only way to fit more vegetables into your diet. Be creative in your kitchen by trying the following.

- Grate up carrots or zucchini to put in meatloaf or turkey burgers.
- Puree cooked vegetables to add to sauces for pasta or casseroles.
- Put cooked broccoli or spinach into creamy dishes such as macaroni and cheese.
- Add mushrooms or peppers to your pizza.
- Bake grated zucchini or pumpkin puree into quick breads or muffins.

Dairy Group



Foods in the dairy group are those made from milk or fluid milk products. Foods in the dairy group contain calcium, potassium, vitamin D and protein. Most dairy group choices should be fat-free or low-fat.

Foods made from milk that have little to no calcium (such as cream cheese, cream and butter) are not part of this group.

Common choices in this group are:

- milk
- milk-based desserts (puddings, ice milk, frozen yogurt, ice cream)
- calcium-fortified soymilk
- cheese
- yogurt.

Tip

If you usually add milk to your coffee, ask for fat-free or low-fat milk.

Benefits of eating or drinking dairy products

Calcium in milk and milk products helps build and maintain bones and teeth. Foods in the dairy group also have potassium, vitamin D and protein.

Eating a diet rich in low-fat or fat-free dairy may:

- reduce your risk of osteoporosis (weak, brittle bones)
- reduce the risk for type 2 diabetes, stroke and heart disease.

Most milk group choices should be fat-free or low-fat. Many cheese, whole milk and products made from them are high in cholesterol. Limit the amount of these foods you eat.

Yogurt mixed with granola and fresh fruit.

What is one serving?

One cup of dairy is equal to:

- 1 cup of milk
- 1 cup (8 ounces) yogurt
- 1 ½ ounces of natural cheese
- 2 ounces of processed cheese
- ½ cup ricotta cheese
- 2 cups cottage cheese
- 1 cup pudding made with milk
- 1 ½ cups ice cream.

Amounts needed each day

The following recommendations are for adults who get less than 30 minutes of moderate physical activity a day.

Women:

- 19 to 51 + years: 3 cups

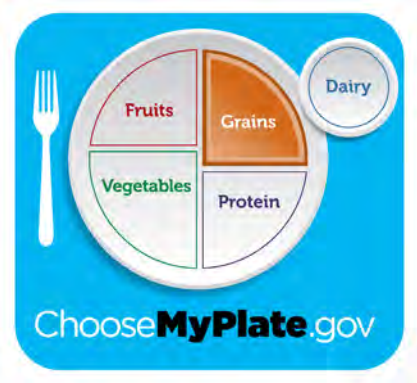
Men:

- 19 to 51 + years: 3 cups

Healthful Habit

Swap your bowl of ice cream for 1 cup of low-fat or fat-free yogurt. You can add fresh fruit and a small amount of nuts or healthful granola to add extra flavor and nutrition.

Grain Group



Grain products are made from wheat, rice, oats, cornmeal, barley or another cereal grain. Examples of foods in this group are bread, pasta, oatmeal, tortillas and grits.

Grains are split into two groups:

- **whole grains:**
  These contain the entire grain kernel (bran, germ and endosperm). The whole grains are rich in fiber, B vitamins and iron. Examples are whole-wheat flour, bulgur, oatmeal and brown rice. Make at least half of your grains whole grains.
- **refined grains:**
  These have gone through a process to remove the bran and germ. This gives the grains a fine texture but removes the fiber, iron and several B vitamins. Examples are white flour, white bread and white rice. Most refined grains are enriched. This means some B vitamins and iron are added back in after processing.

Tip

Use whole grains in mixed dishes. Try using barley in vegetable soups or stews and bulgur wheat in casseroles.

Benefits of eating whole grains

- Eating a diet rich in fiber may:
  - — reduce your risk of heart disease, obesity and type 2 diabetes
  - — help lower cholesterol levels
  - — reduce constipation
  - — help you manage your weight (helps keep you feeling “full” longer)
  - — help prevent neural tube defects during pregnancy.
- Whole grains contain fiber, many B vitamins (such as thiamin, riboflavin, niacin and folate) and minerals (such as iron and magnesium).
- The vitamins and minerals in whole grains help build red blood cells, build bones and release energy.

Cooked quinoa with raisins and walnuts.

What is one serving?

One ounce of grains is equal to:

- 1 slice of bread
- 1 cup of ready-to-eat cereal
- ½ cup cooked rice, pasta or cereal
- 5 whole-wheat crackers
- ½ English muffin
- 1 pancake (4 ½ inches in diameter)
- 3 cups popped popcorn
- 1 flour tortilla (6 inches in diameter).

Amounts needed each day

The following recommendations are for adults who get less than 30 minutes of moderate physical activity a day.

Women:

- 19 to 50 years: 6 ounces
- 51 + years: 5 ounces

Men:

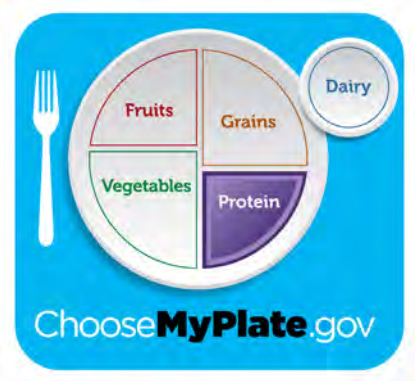
- 19 to 30 years: 8 ounces
- 31 to 50 years: 7 ounces
- 51 + years: 6 ounces

Healthful Habit

Oatmeal isn't your only whole-grain breakfast option. Try making the following to mix up your breakfast routine.

- Sprinkle raisins and almonds on top of cooked quinoa.
- Slice up a banana and sprinkle some cinnamon on cooked brown rice.
- Pair cream of buckwheat with a sliced apple and some almond butter.
- Put fresh berries and low-fat milk or yogurt over cooked barley.

Protein Group



All foods made from meat, poultry, seafood, beans and peas, eggs, processed soy products, nuts and seeds are included in the protein group. (Beans and peas are also in the vegetable group.)

Benefits of eating protein products

- Food in the protein group provides protein, B vitamins, vitamin E, iron, zinc and magnesium. These nutrients help keep bones, muscles, cartilage, skin and blood healthy. Iron is used to carry oxygen in the blood.
- Eating a diet rich in low-fat or lean proteins may reduce your risk of heart disease.
- Eat at least 8 ounces of seafood each week. Seafood is rich in omega-3 fatty acids, which helps protect your heart against heart disease.
  - — Follow any precautions if you have a shellfish allergy.
  - — If you are pregnant, read the Wisconsin Department of Natural Resources Statewide Safe Eating Guidelines. Visit dnr.wi.gov and type *eating fish* into the search box.
- Some meats and poultry are high in cholesterol or saturated fat. These foods can raise your blood cholesterol level. Limit the amount of these foods you eat: fatty cuts of beef, pork and lamb; regular ground beef; sausages, hot dogs and bacon; some luncheon meats (bologna and salami); duck; egg yolks; organ meats.

Tip

Unsalted almonds make a great high-protein snack! The United States Department of Agriculture recommends a serving size of 1 ounce, which is about 25 almonds.

What is one serving?

One ounce of food from the protein group is equal to:

- 1 ounce of meat, poultry or fish
- ¼ cup cooked beans
- 1 egg
- 1 tablespoon of peanut butter
- ½ ounce of nuts and seeds.

Have breakfast for dinner with an omelet stuffed with your favorite vegetables.

Amounts needed each day

Women:

- 19 to 30 years: 5 ½ ounces
- 31 to 51 + years: 5 ounces

Men:

- 19 to 30 years: 6 ½ ounces
- 31 to 50 years: 6 ounces
- 51 + years: 5 ½ ounces

Healthful Habit

Have one high-protein, meatless dinner each week. To do this, include at least one of the following high-protein foods in your meal:

- beans
- nuts
- seeds
- quinoa
- whole-grain noodles
- low-fat or fat-free milk or yogurt
- eggs
- peanut butter
- tofu.

Understanding Fats

Tip

You can make healthy substitutions in your recipes to reduce the amount of fat or switch the type of fat to a more healthful one. Instead of 1 cup of butter, you can substitute:

- ½ cup butter plus ½ cup fruit puree (applesauce or prune) in baked goods
- 1 cup canola oil in place of melted butter.

Different kinds of fat

Fats are an essential nutrient, but you only need small amounts each day. Total dietary fat is made up of saturated, polyunsaturated and monounsaturated fats.

- **Saturated fats** are found in animal products such as butter, cheese, whole milk, ice cream and fatty meats. They are also found in some vegetable products (coconut, palm and palm kernel oil).

  Saturated fats raise blood cholesterol more than anything else in your diet.
- **Polyunsaturated fats** can help lower cholesterol if you eat them instead of saturated fats. Polyunsaturated fats usually come from vegetable products such as corn, safflower, sunflower, soybean and sesame seed oils.
- **Monounsaturated fats**, in the right amounts, may lower your total cholesterol and LDL ("bad") cholesterol levels. Monounsaturated fats usually come from seeds or nuts such as avocado, olive, peanut and canola oils.
- **Omega-3 fatty acids** are polyunsaturated fats. They include ground flaxseed, flaxseed oil, soybean oil, canola oil, walnuts and fatty fish (such as salmon, mackerel, herring and trout). If your triglycerides are high, try to add these foods to your diet.
- **Trans fatty acids** result from a chemical process known as hydrogenation. Trans fats can raise LDL cholesterol levels and add to heart disease.

  Shortening, partially hydrogenated vegetable oil and hydrogenated vegetable oils are examples of trans fats. They also occur naturally in some foods such as meat and milk.

  — Read ingredient labels and buy items that have a recommended fat, such as canola or soybean oil.

  — Avoid foods that have hydrogenated vegetable oil, partially hydrogenated oil or shortening.

  — Choose foods that have as close to 0 grams trans fat as possible.

Chapter 4:
Local, Healthful Choices

In This Chapter:

- General Information
- Community Supported Agriculture (CSAs)
- Farmers Markets
- U-picks (Pick-your-own)
- Community Gardens

Chapter 4:
Local, Healthful Choices

General Information

How far did your carrot travel to get to your table?

More Information

Turn to the resource section on pages 59 to 79 to learn more about local foods in your community.

When you pick up a carrot at the grocery store, it most likely had to travel a long distance to get there. The further a food has to travel, the less fresh (and less nutritious) it is by the time you eat it.

In the local foods system, food doesn't have to travel long distances because farmers sell their products directly to you. Local foods can be sold through the following:

- Community Supported Agriculture (CSAs)
- farmers markets
- u-picks (pick-your-own).

Many communities also have a community garden. By participating in a community garden, YOU get to be the farmer!

Benefits of local foods

The local foods system creates supportive relationships by bringing together farmers and members of your community to promote eating foods grown closer to home. The local foods system also:

- saves money and resources
- helps to reduce pollution from farm chemicals which supports a healthier environment for future generations
- educates the public about fresh, local foods and how they are grown.

Community Supported Agriculture (CSAs)

Source: River Falls Grow to Share

Did You Know?

Many CSAs offer the option to buy a half share. A half share will usually be enough for two people.

Community Supported Agriculture (CSA) is a way for you to buy fresh, local foods directly from farmers.

You buy "shares" to receive a box, basket or bag of seasonal produce every 1 or 2 weeks throughout the farming season. Each share includes a variety of fresh vegetables, fruits and other farm products.

The following are benefits unique to CSAs.

- **Farmers:**
  - — get paid at the beginning of the season (instead of having all payments come in at harvest)
  - — are able to get direct feedback from the participants.
- **You:**
  - — have the opportunity to try a wide variety of fresh produce and local products that you may not otherwise buy
  - — save time by picking up a box rather than shopping for a variety of produce from a store.

Farmers Markets

A farmers market is an event for farmers to sell their products directly to you. Farmers markets often take place outdoors in public places such as parking lots or parks.

Tip

Take time to talk with the farmers at the markets. They can tell you how your food was grown and give you tips on how to prepare it at home.

The following are benefits unique to farmers markets.

- **Farmers:**
  - — build relationships with other farmers within their community
  - — are able to get direct feedback from returning customers
  - — have control over the quality of their products at the time of sale
  - — have the ability to offer a unique product to bring attention to their farm.
- **You:**
  - — have access to a wide variety of healthful, seasonal produce and local products in one location
  - — can enjoy other activities at the markets such as crafts and live music
  - — are often able to sample the produce before making your purchase(s).

Farmers sell their products directly to you at farmers markets.

U-picks (Pick-your-own)

Some farmers open up their field for you to pick your own fruits and vegetables. You can pick as much or as little as you want and when you are finished, take it to the farmer to pay. Common produce for u-picks include strawberries, raspberries, blueberries or pumpkins.

The following are benefits unique to u-picks.

- **Farmers:**
  - — save time by not having to pick or pack the produce before sale
  - — can bring attention to their business by inviting the public to come to their farm
  - — don't have leftover, unsold produce to hold in cold storage
  - — can run their business directly from their farm (no transportation costs).
- **You:**
  - — know when your produce was picked
  - — can choose your own produce
  - — pay a lower price because you pick the produce yourself
  - — learn how and where your food was grown.

Tip

Make sure you dress for the work you will be doing. Consider wearing or bringing the following:

- hat
- gardening gloves
- sunglasses
- long pants
- shirt with long sleeves
- an old pair of closed-toe shoes (such as an athletic shoe, hiking shoe or work boot).

You may also want to apply sunscreen or bug spray.

U-picks are a great option for those wanting to get the freshest fruits and vegetables available.

Community Gardens

A community garden is a shared space where members of your community can get together to plant and grow fruits, vegetables and flowers. The gardens can be in big cities, small towns or rural communities.

More Information

Turn to the resource section on pages 61 to 62 to learn more about:

- starting a community garden
- community gardens in your area
- community gardening clubs, classes and programs.

Benefits of community gardens

Community gardens:

- help build relationships
- make local, healthful foods more accessible
- provide an opportunity for recreation, physical activity and therapy
- add beauty to community spaces
- create opportunities for learning
- provide safe spaces for children and community members to play and socialize
- conserve natural resources
- preserve outdoor green spaces
- provide less expensive healthful foods by cutting out labor and transportation costs.

Source: River Falls Grow to Share

Chapter 5:
Physical Activity

In This Chapter:

- General Information
- Benefits of Physical Activity
- Kinds of Physical Activity

Chapter 5: Physical Activity

General Information

More Information

For more information about ways to get active in your community, turn to pages 73 to 75 in the resource section.

Physical activity is important for everyone. When you are physically active, your overall health and fitness improves and you reduce your risk of heart disease, diabetes and other conditions.

The amount of physical activity you need every day depends on your age, gender, height, weight and other factors. In general, the American Heart Association recommends:

- children get 60 minutes of moderate to vigorous physical activity each day
- adults should be moderately active for at least 30 minutes a day, most days of the week.

Daily physical activity doesn't have to be done all at once. You can break it into blocks of 10 minutes instead. The important thing is that you are moving your body and staying active!

One size does not fit all for physical activity. Try a variety of activities and choose the ones you enjoy most.

Benefits of Physical Activity

Tip

Start a routine. Set aside time for activity every day.

Physical activity has many benefits. In addition to helping build strong bones and muscles, regular physical activity can:

- reduce the risk for heart disease, diabetes, obesity, certain cancers and joint conditions
- reduce levels of anxiety and stress
- increase self-esteem
- help maintain a healthy weight
- help improve concentration
- help maintain good blood pressure and cholesterol levels.

Physical activity is good for the body and mind!

Kinds of Physical Activity

Important

Make sure you start slowly when starting a new kind of physical activity. As your body adjusts to moving more, you will be able to gradually increase your activity level.

There are three basic kinds of physical activity: aerobic activities, resistance/strength training, and balance and stretching.

- Aerobic activities speed your heart rate and breathing. It helps improve your heart and lung fitness. Examples include brisk walking, jogging and swimming.
- Resistance, strength training and weight-bearing activities help build and maintain bones and muscles. Examples include lifting weights and walking.
- Balance and stretching activities enhance your stability and flexibility. Examples include gently stretching, dancing, yoga and the martial arts.

Whichever activity you choose to do, make sure it's one you enjoy. If you look forward physical activity, you will be more likely to stick with it!

Practicing yoga can help to improve your stability and flexibility.

Chapter 6:
Stress Management

In This Chapter:

- General Information
- Signs of Stress
- What Stress Can Do
- What You Can Do

Chapter 6: Stress Management

General Information

Important

How you handle stress will have an effect on your body and emotional well-being. Stress can cause health problems if you don't learn how to deal with it.

Stress is your body's fight-or-flight response. You may feel energy surge through your body if you are in an emergency, or if you are worried or anxious about something.

Stress can be found at home, work, school or in traffic. A situation you find threatening may trigger stress. For example, you may feel stress in the following situations:

- a co-worker who gets a promotion you thought should have been yours
- divorce
- financial problems
- marriage
- job loss or change
- moving
- having a baby
- a disagreement with a child
- a serious illness within the family
- being stuck in traffic when you are running late
- standing in a long line at the grocery store with a fussy child.

Situations that cause you stress may not cause stress for others. It is helpful for you to learn which situations affect you the most so you can plan ahead and practice stress management.

Signs of Stress

People react to stress in different ways. There are some general signs of stress:

- constant fatigue (feeling tired)
- a change in eating habits
- an increase in the use of alcohol, tobacco or drugs
- a change in normal bowel or bladder habits
- aches or pains not caused by exercise
- a change in normal sleep patterns
- emotional upsets (anger, anxiety, depression).

What Stress Can Do

Stress can give you health problems or make a current problem worse. It can increase your breathing, heart rate and blood pressure. Feelings of anger may turn into chronic (long-lasting) irritation and feelings of fear may become anxiety. Long-term stress can cause:

- depression
- anxiety disorders
- ulcers
- high blood pressure
- phobias
- disturbed sleep patterns
- tension headaches.

Stress affects everyone but reactions to stress vary from person to person. You cannot make stress go away, but you can manage it.

More Information

Turn to pages 76 to 78 for stress management resources within your community.

What You Can Do

Tip

Effective stress management usually involves changing unhealthy habits, attitudes and behaviors into positive ones.

To manage stress, start by learning about yourself. What do you like? What do you hate? What calms you down? What stresses you out? Know that, and you're on your way to managing stress. You can use the following tips to manage your stress.

- Maintain good health habits. Eat well-balanced meals and avoid caffeine, alcohol and nicotine. A healthy body handles stress better.
- Get regular exercise. Physical activities often relieve the body of unnecessary tensions. Strenuous exercise is not necessary because even moderate exercise has health benefits.
- Get plenty of rest. Your body and mind need to "re-energize" each night. Most adults do not get enough sleep each night.
- Structure daily activities. Plan out your activities to make the best use of your time. Make sure to include personal time for yourself and do something you enjoy.
- Set realistic goals. Ask for help if you need it.
- Don't worry about things you can't change.
- Identify what causes you stress and avoid those situations if possible.
- Talk about stress. Talking with a close friend, spouse or doctor may help you relax.

Feeling stressed? You may need to take some time out of your day to rest. Most adults do not get enough sleep each night.

Chapter 7:
Resources

In This Chapter:

- Community Gardens
- Community Supported Agricultre (CSAs)
- Farmers Markets, Growers and U-picks
- Grocery and Nutrition
- Meat, Poultry and Fish
- Physical Activity
- Stress Management
- Additional Resources

Chapter 7: Resources

Community Gardens

River Falls Community Gardens

River Falls Hospital
1629 E. Division St.
River Falls, WI 54022
715-425-8434
email: katie_chaffee@yahoo.com

This gardening space has been donated by the River Falls Hospital. It is located north of the Care Center. Plots are available for rent.

River Falls Grow to Share Garden

Hoffman Park
Hanson Drive
River Falls, WI 54022
715-426-0826
email: growtoshare@gmail.com
website: growtoshare.org

This volunteer garden is owned by St. Bridget Catholic Church. Large amounts of produce such as corn and potatoes are grown. Most of the produce is donated.

= CSA

= Farmers Market

River Falls Rocky Branch Elementary School Garden

Tara Albores, volunteer coordinator
1415 N. Bartosh Ln.
River Falls, WI 54022
715-425-1819

This garden is tended by school children, parents and some school staff. All food produced is donated to a local food pantry. Volunteer opportunities are available.

Gardening Classes

Diana Alfuth, horticulture educator
University of Wisconsin-Extension, Plant & Earth Science
715-273-6781
email: diana.alfuth@ces.uwex.edu

If you have gardening questions or are interested in learning more about gardening, call or email Diana Alfuth to sign up for this class.

River Falls Gardening Club

River Falls Public Library
140 Union St.
River Falls, WI 54022
email: gardenclub@mannfarm.net

If you are interested in community gardening, join the River Falls Gardening Club. The club meets on the first Monday of every month at 7 p.m. (no meeting in January, July or August).

Community Supported Agriculture (CSAs)

Note

CSAs usually have an 18-week season but this can vary from year-to-year.

Farm Where Life is Good

Roger and Lara Anderson
N7971 747th St.
River Falls, WI 54022
715-426-7582
email: farmwlig@dishup.us
website: farmwlig.locallygrown.net

This farm offers a variety of produce and fruit. Participants receive a delivery every Wednesday during the season. In addition to CSA, the farm also runs an online market, works with local restaurants and donates extra produce locally.

SunRush Community Farm

Rainbow Barry
N8391 510th St.
Spring Valley, WI 54767
715-688-3112
website: sunrushfarm.com

SunRush CSA offers non-certified organic vegetables and herbs. Participants pick up their weekly produce box at the River Falls Tuesday Farmers Market.

Sweet Top Farm, LLC

Adam and Megan Greeson
P.O. Box 36
Hudson, WI 54016
507-923-6251
email: sweettopfarm@gmail.com
website: sweettopfarm.weebly.com

Sweet Top Farm offers sustainably grown, seasonably sweet vegetables to a drop site near you.

Farmers Markets, Growers and U-picks

Bella Collina Produce Farm

Betty Schultz
N7250 910th St.
River Falls, WI 54022
715-220-6308
email: bellacollina98@yahoo.com

Hours: June to October, by appointment only

Offers a variety of produce, including raspberries and plums.

Blue Ridge Growers Orchard and Nursery

246 Carlson Ln.
River Falls, WI 54022
715-425-8289
website: blueridgegrowers.net

Hours: July to August

This u-pick offers non-certified organic blueberries, raspberries, cherries (on occasion) and fruit preserves.

Cedar Hill Farm and Greenhouse

W10041 Hwy. 29
River Falls, WI 54022
715-426-1831
website: cedarhillfarmandgreenhouse.com

Hours: spring to fall, times vary

This farm stand offers fruit, a variety of vegetables and fall decorations. A kids' gardening club is also held once each month.

Garden Divas

N7789 State Rd. 65
River Falls, WI 54022
715-222-0436
email: gardendivas@pressenter.com

Hours: early spring to Christmas

U-pick: raspberries

You can also visit the local garden gift shop, take a class or browse funky to traditional garden art, pots and easy plants.

Golden Star Strawberries

W7246 870th Ave.
River Falls, WI 54022
715-220-8732

Hours: early summer, 8 to 11 a.m. and 3 to 7 p.m.

U-pick: strawberries

Kinnickinnic Natives

235 State Rd. 65
River Falls, WI 54022
715-425-7605
email: mbredah@hotmail.com
website: kinninatives.com

Hours: weekends during growing season

Grower: native plants selectively grown for St. Croix Valley

Kinnickinnic Natives is a family-owned nursery that grows a wide variety of plants. Native lady slippers are available.

Lebo's Bloomin' Berries

Mark and Carol Lebo
1784 County Rd. M
River Falls, WI 54022
715-684-4666

Hours: Opens around the third week of June. Please call for hours.

U-pick: : strawberries

Lebo's Bloomin' Berries also has pre-picked strawberries available for purchase.

Parker Creek Farms

Jay Kassera
1472 County Rd. J
River Falls, WI 54022
651-208-0304
email: jaykassera@comcast.net

Grower: produce, raspberries and blueberries for sale on-site

River Falls Farmers Market

Betty Schultz
Second and Locust St.
River Falls, WI 54022
715-220-6308
email: bellacollina98@yahoo.com

Hours: June 1 to Oct. 31, Tuesday 3 to 6 p.m., Saturday 8 a.m. to 12 p.m.

The River Falls Farmers Market offers a wide variety of fresh vegetables, honey, apples, berries, maple syrup, meats, annuals and perennials, vegetable and herb plants, pumpkins, and fall crops and decorations.

White Pine Berry Farm

Greg and Irma Zwald
1482 Oak Dr.
River Falls, WI 54022
715-222-4349
email: whitepineberryfarm@hotmail.com
website: whitepineberryfarm.com

Hours: late May to fall frost. Call for hours and pre-pick orders.

U-pick: variety of produce including strawberries, raspberries, currants, asparagus and rhubarb

White Pine Orchard

Keith Kozub
W7901 830th Ave.
River Falls, WI 54022
715-452-2248
website: whitepineorchard.com

Hours: September to October. Call for hours.

U-pick: apples

Fresh, unpasteurized cider is pressed weekly and available for purchase. Locally produced honey also available.

Grocery and Nutrition

Dicks Fresh Market

1121 S. Main St.
River Falls, WI 54022
715-426-5920
website: dicksfreshmarket.com

Family Fresh Market

303 S. Main St.
River Falls, WI 54022
715-425-7277
email: wellbalanced@familyfreshmarket.com
website: familyfreshmarket.com

Nutrition 4ever

1025 S. Main St., Ste. 400
River Falls, WI 54022
715-425-1319

Whole Earth Grocery Cooperative

126 S. Main St.
River Falls, WI 54022
715-425-7971
website: wholeearthgrocery.coop

If you or someone you know is struggling to put food on the table, please contact one of the community resources listed below.

Backpack Program

The Day Center
136 North Riverwalk
River Falls, WI 54022
715-426-9000
email: ourneighborsplace@gmail.com

With school staff recommendation, eligible students receive a backpack of nonperishable food on Friday. Available at some Pierce County Elementary Schools.

Food Share Program

Pierce County Human Services Department
715-273-6788
website: access.wisconsin.gov

The Food Share Program aims to end hunger, and improve nutrition and health. To qualify for food share, you must meet certain income and resource standards.

Free Community Meals

St. Bridget's Church
211 E. Division St.
River Falls, WI 54022
715-425-1870

A free meal of soup and bread is served every third Tuesday, from 5 to 6 p.m.

River Falls Community Food Pantry

222 N. Main St., P.O. Box 341
River Falls, WI 54022
715-425-6880
email:rfc.foodpantry@gmail.com
website: rfcfp.org

Salvation Army

715-425-8900

For emergency food needs, an operator can connect you with volunteers in your area.

School Breakfast and Lunch

715-425-1800

To qualify for reduced-price or free school meals, your family must meet certain household income standards.

Second & Fourth Tuesday Banquet

St. Bridget's Church
211 E. Division St.
River Falls, WI 54022
715-425-1870

A free meal is served every second and fourth Tuesday from 5 to 6 p.m.

This service is run by local volunteers from United Methodist, Ezekiel Lutheran, St. Bridget's, First Congregational, Luther Memorial, Hope Lutheran, River Falls H.S. FLBA, Order of Eastern Star (Kinnickinnic chapter) and Newman Center.

Senior Meal Sites and Home-delivered Meals

Pierce County Human Services Department
715-273-6780
website: co.pierce.wi.us

Midday meals offered daily to senior citizens at six sites in Pierce County. Meals can be delivered in each area to anyone who is unable to leave home without help.

Women, Infants and Children (WIC) Special Supplemental Food Program

Pierce County Health Department
715-273-6758

The WIC program is not connected to welfare. It is a supplemental food program for pregnant and nursing women, infants and children under age 5. WIC provides health screening, nutrition education and vouchers for specific foods and infant formulas. You must meet certain household income standards to qualify for WIC.

Wisconsin Nutrition Education Program (WNEP)

UW-Extension, Pierce County
715-273-6781
website: uwex.edu (type "WNEP" in the search box at top right and then click on *Wisconsin Nutrition Education Program)*

The WNEP provides community-based nutrition education programs to those who meet certain income standards.

Meat, Poultry and Fish

Gehl's Buffalo Hill Ranch

Mark and Kathy Gehl
7573 730th St.
River Falls, WI 54022
715-426-5566
email: buffalohillmeats@hughes.net
website: buffalohillmeats.com

Hours: Meat shop open daily. Please call ahead.

The meat shop is located directly on the farm. All buffalo have been naturally pasture-raised and have not received growth hormones, antibiotics or animal byproducts.

Grassroots Meat

Mark and Jean Moelter
1669 E. County Rd. M
River Falls, WI 54022
715-821-1975
website: moeltersgrassrootsmeat.com

Hours: Please call to place your order.

Grassroots Meat offers 100 percent grass-finished beef and pastured poultry. The Galloway cattle receive fresh grass and quality hay. Beef is sold in a variety of cuts and amounts.

Pure.Sun.Farm

Dan and Terri Pearson
524 County Rd. MM
River Falls, WI 54022
715-425-9488
email: pure.sun.farm@gmail.com

Hours: Please call for an appointment.

The Pure.Sun.Farm provides your family with wholesome, certified organic products. You can purchase pork, free range chickens and eggs.

Physical Activity

River Falls Area Hospital Wellness Center

1629 E. Division St.
River Falls, WI 54022
715-307-6060

Work out in a safe environment supported by health and fitness experts. Your membership includes:

- towel service
- locker rooms
- aerobic and strength equipment
- fitness trainers available during wellness center hours
- free wellness classes
- reduced rates on wellness events and programs.

Anytime Fitness

114 Spring St.
River Falls, WI 54022
715-425-0225

BodyRox Fitness Group, LLC

222 N. Main St.
River Falls, WI 54022
715-222-1111
email: info@bodyrox-fitness.com

Curves for Women

107 N. Main St.
River Falls, WI 54022
800-704-5908

Field of Dreams Indoor Sports & Batting Cages

265 Mounds View Dr.
River Falls, WI 54022
715-781-7081
website: rffieldofdreams.com

Glen Park Pool

355 Park St.
River Falls, WI 54022
715-425-0924

Hours: Please call for summer outdoor open swim hours, and class and birthday party information

Let's Dance!, LLC

Academy Building
211 N. Fremont, Studio 307
River Falls, WI 54022
website: msjenniferdance.com

Peek A Boo Boxing Gym

264 Troy St.
River Falls, WI 54022
715-220-0284
website: peek-a-booboxing.com

Red Twig Yoga & Gardens, LLC

N7799 County Rd. W.
River Falls, WI 54022
715-220-1185
website: redtwigyoga.com

River Falls City Parks & Recreation

222 Lewis St.
River Falls, WI 54022
715-425-0924
email: cdanke@rfcity.org
website: rfcity.org

Synergy Judo and Self Defense Systems

112 E. Walnut St.
River Falls, WI 54022
715-425-0333

Real Fit 6

212 N. Main St.
River Falls, WI 54022
651-216-5830
website: realfit6.com

Stress Management

Adulteen Counseling

117 E. Maple St.
River Falls, WI 54022
715-410-5822
email: brian@adulteencounseling.com
website: adulteencounseling.com

A Mother's Touch

109 N. Main St., Ste. B
River Falls, WI 54022
715-441-1080

AURYN Massage

421 N. Main St.
River Falls, WI 54022
651-307-0160
email: aurynmassage@gmail.com

Cleveland Family Chiropractic

112 E. Walnut St.
River Falls, WI 54022
715-425-0333
website: clevelandfamilychiro.com

Flowing Rivers Acupuncture, Inc.

1694 Commerce Ct.
River Falls, WI 54022
715-425-2677

Horizon Family Chiropractic

109 N. Main St., Ste. B
River Falls, WI 54022
715-426-4774
website: dchorizon.net

Kinni Valley Chiropractic Inc.

314 N. 2nd St., Ste. 200
River Falls, WI 54022
715-425-6100
website: kinnivalleychiro.com

Massage Concepts, LLC

109 N. Main St., Ste. B
River Falls, WI 54022
651-208-6551
email: info@massageconceptsllc.com
website: massageconceptsllc.com

McClelland Chiropractic and Wellness

1674 Commerce Ct.
River Falls, WI 54022
715-425-9439
website: riverfallsfamilychiro.com

Necessary Therapeutics

214 N. Main St.
River Falls, WI 54022
715-220-8754
email: necessarytherapeutics@gmail.com
website: necessarytherapeutics.com

Phoenix Counseling Services

216 N. Main St.
River Falls, WI 54022
715-629-1081

River Falls Chiropractic & Decompression

215 N. 2nd St., Ste. 201
River Falls, WI 54022
715-425-6665
website: rfchiro.com

Sunrise Healing Arts

River Falls, WI 54022
715-821-1892
website: sunrisehealingarts.com

Additional Resources

River Falls Area Hospital, part of Allina Health

1629 E. Division St.
River Falls, WI 54022
715-307-6000
email: riverfallsareahospital@allina.com
website: riverfallsareahospital.com

Adult Recreation Programming

715-425-0924
website: rfcity.org (click on *Parks and Recreation* on the left side bar, click on *Recreation* and then click on *Adult Recreation)*

School District of River Falls
River Falls High School, Community Education

818 Cemetery Rd.
River Falls, WI 54022
715-425-1830, ext. 1125

Free Clinic of Pierce and St. Croix Counties

1687 Division St.
River Falls, WI 54022
715-307-3948

River Falls Medical Clinic

1687 E. Division St.
River Falls, WI 54022
715-425-6701
email: sbluhm@rfmc.org
website: rfmc.org

RIVER FALLS
AREA HOSPITAL

ISBN 1-931876-36-3

gen-rfah-95731 (9/13)

RIVER FALLS AREA HOSPITAL
PIERCE COUNTY PUBLIC HEALTH DEPARTMENT

Appendix M

CADCA's Seven Strategies for Community Change

Community Health Needs Assessment and Implementation Plan 2014–2016

Allina Health
RIVER FALLS AREA HOSPITAL

CADCA's National Coalition Institute

Defining the Seven Strategies for Community Change

1. Providing Information – Educational presentations, workshops or seminars or other presentations of data (e.g., public announcements, brochures, dissemination, billboards, community meetings, forums, web-based communication).

2. Enhancing Skills – Workshops, seminars or other activities designed to increase the skills of participants, members and staff needed to achieve population level outcomes (e.g., training, technical assistance, distance learning, strategic planning retreats, curricula development).

3. Providing Support – Creating opportunities to support people to participate in activities that reduce risk or enhance protection (e.g., providing alternative activities, mentoring, referrals, support groups or clubs).

4. Enhancing Access/Reducing Barriers- Improving systems and processes to increase the ease, ability and opportunity to utilize those systems and services (e.g., assuring healthcare, childcare, transportation, housing, justice, education, safety, special needs, cultural and language sensitivity).

5. Changing Consequences (Incentives/Disincentives) – Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior (e.g., increasing public recognition for deserved behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges).

6. Physical Design – Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g., parks, landscapes, signage, lighting, outlet density).

7. Modifying/Changing Policies – Formal change in written procedures, by-laws, proclamations, rules or laws with written documentation and/or voting procedures (e.g., workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities and organizations).