Community Health Needs Assessment and Implementation Plan 2017-2019

Healthier Together
Pierce County
St. Croix County

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

Executive Summary

Healthier Together Pierce and St. Croix Counties (Healthier Together) is a community coalition working to create and maintain healthy communities and provide a strategic framework for local health-improvement activities. This report describes the current community health needs assessment (CHNA) process and results for Healthier Together in Western Wisconsin. Healthier Together initiatives have focused on bringing people together from across the two counties to identify and address a variety of health priorities.

Under the auspices of Healthier Together, four hospitals and two health departments (Hudson Hospital & Clinic, River Falls Area Hospital, Western Wisconsin Health, Westfields Hospital & Clinic, Pierce County Public Health and St. Croix County Public Health) lead the planning and implementation of an organized, two-county, community-based approach for creating and maintaining healthy communities.

This effort included: (1) completion of a CHNA to systematically identify and analyze health priorities in the community, and (2) development of a plan to address these priorities as a coalition and in partnership with others. Through this process, Healthier Together engaged with community stakeholders to better understand the health needs of the communities it serves, identified internal and external resources for health promotion and created an implementation plan that leverages those resources to improve community health.

In late 2015, community members, community organizations, public health and hospital/health system staff participated in a process that identified the following priority areas for community health in the communities served by Healthier Together:

1. Mental health
2. Obesity/overweight
3. Alcohol abuse

In 2016, staff solicited community input, assessed existing resources and developed a community health improvement plan for 2017–2019 in order to address these priorities. This implementation plan includes the following goals, each of which is supported by multiple strategies and will be implemented through a variety of activities monitored for progress and outcomes over time.

Mental health goal:

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

Obesity/overweight goal:

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

Alcohol abuse goal:

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

Introduction

The mission of Healthier Together is to create and maintain healthy communities. Healthier Together conducted a community health needs assessment (CHNA) to systematically identify and analyze health priorities in the community and then developed a community health improvement plan in response to those priorities. The Internal Revenue Service provides guidelines for hospitals in this process as part of meeting obligations under the Patient Protection and Affordable Care Act, which requires 501(c)(3) non-profit hospitals to conduct an assessment at least every three years. While not related to ACA requirements, the state of Wisconsin also requires that public health departments conduct assessments "regularly." In 2015, the four hospitals and two public health departments in the Pierce and St. Croix county region agreed on a shared timeline. They plan to conduct a joint assessment every three years.

Through this process, Healthier Together aims to:

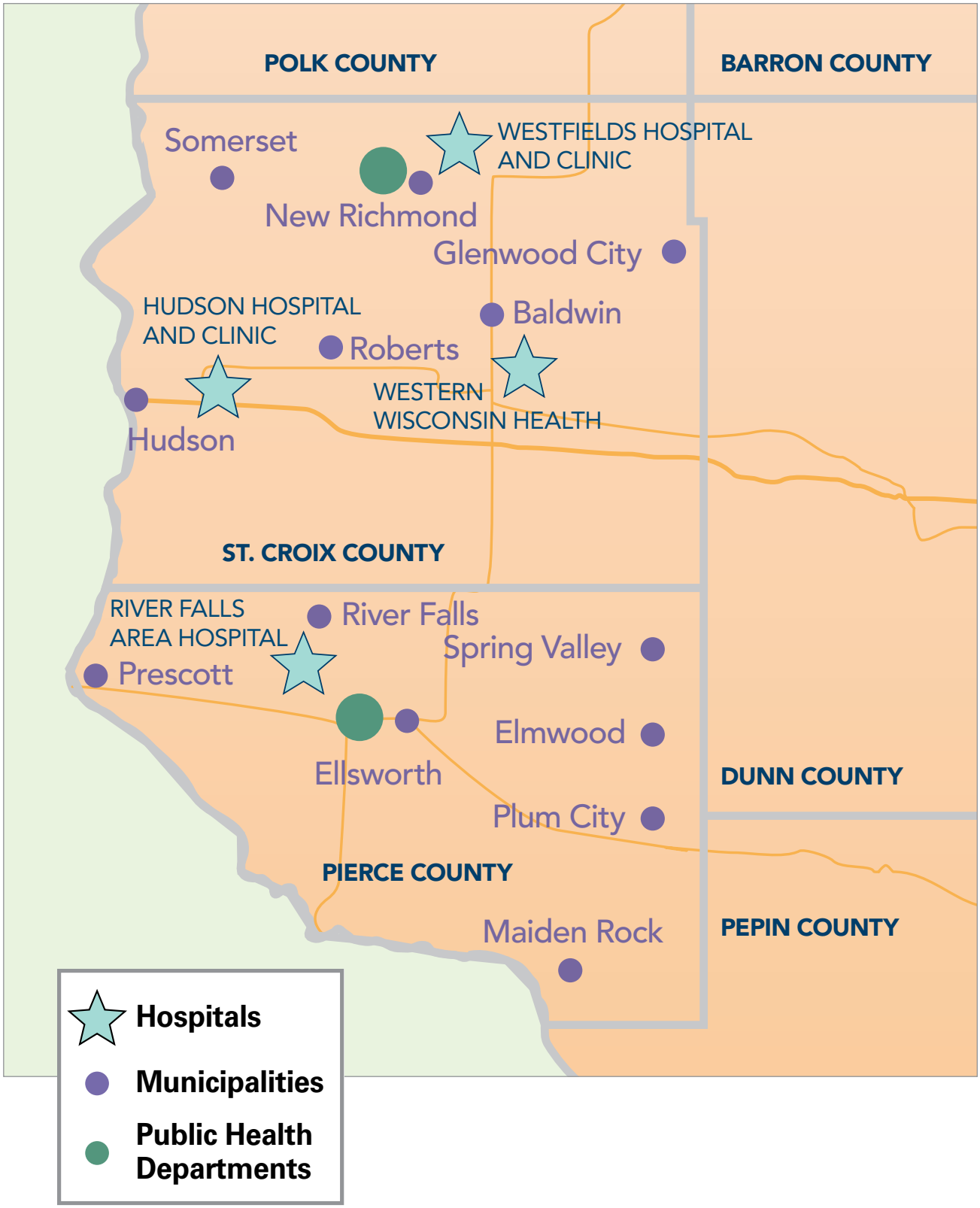
- Better understand the health status and needs of the communities it serves by considering the most recent health and demographic data as well as gathering direct input from community members.
- Gather perspectives from individuals representing the interests of the community, including those who have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

The purpose of this report is to share the current assessment of community health needs most relevant to the communities served by Healthier Together and its community health improvement plan to address these needs in 2017–2019. This report also highlights activities conducted during 2014–2016 to address needs identified in the previous 2013 assessment.

Healthier Together Description

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

Healthier Together Service Area



Member descriptions

Hudson Hospital & Clinic

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

River Falls Area Hospital

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

Western Wisconsin Health

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

Westfields Hospital & Clinic

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

Pierce County Public Health

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

St. Croix County Public Health

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

Community served and demographics

The focus of inquiry for this CHNA was Pierce and St. Croix Counties—two rural communities located in Western Wisconsin. According to the U.S. Census Bureau, a total of 128,402 (40,889 Pierce/87,513 St. Croix) residents live in the 1,295.73 square mile area occupied by the two counties. The area's population density, estimated at 99.1 persons per-square-mile (71.3 Pierce/121.2 St. Croix), is greater than the national average. The following key indicators provide a brief overview of the region. Additional information about Pierce and St. Croix County can be found through the U.S. Census Bureau.

Table. Key indicators for two-county region and Pierce and St. Croix counties

Selected Indicator	Two-County Region	Pierce County	St. Croix County
POPULATION			
Median income*	N/A	$61,613	$70,313
Residents in households with income below poverty line°	6.8%	10.8%	4.9%
Median age*	N/A	35 years	37 years
Residents under age 18**	25.0%	21.0%	25.8%
Residents age 65 or older**	12.8%	13.1%	12.7%
Residents with limited English proficiency•	0.9%	0.8%	0.9%
Foreign born residents*	1.7%	1.9%	1.3%
RACE AND ETHNICITY*			
White alone	96.3	96.6%	96.2%
Black or African American alone	.74%	0.6%	0.8%
Asian alone	1%	0.9%	1.1%
Hispanic or Latino	2.2%	2.0%	2.3%
HEALTH INDICATORS			
Residents reporting do not have a regular doctor‡	16.7%	21.3%	13.7%
Ratio of mental health providers to residents†	1548:1	1,011:1	2,157:1
Estimated adults drinking excessively‡	29.6%	31.9%	28.4%
Residents who are overweight or obese‡	61%	65.6%	58.7%
Residents reporting poor general health‡	9.6%	11.2%	8.7%

Sources:

* U.S. Census Bureau, American Community Survey (ACS), 2010-2014, 5-year estimates

** U.S. Census Bureau's Decennial Census, 2015

° Small Area Income and Poverty Estimates, 2014

• U.S. Census Bureau, ACS, 2009-2013, 5-year estimates

† County Health Rankings, 2015

‡ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006–2012 or 2011–2012

Evaluation of 2014–2016 Implementation Plans

In 2013, entities in Pierce and St. Croix Counties conducted separate needs assessments and developed separate implementation plans for each county. Since that time, the hospitals and public health departments in the two-county region have joined to form Healthier Together Pierce and St. Croix Counties, and will be conducting a single needs assessment and implementation plan going forward. The goals and progress from the 2014–16 Community Health Needs Assessment for each county are listed below.

Pierce County:

Goal 1: Increase physical activity through changes to the environment, policy, and community support.

River Falls Area Hospital (RFAH) provided charitable contributions to a number of organizations in the community to support health education and opportunities for physical activity. These include a Neighborhood Health Connection Grant that was given to the Ellsworth Senior Center to start a walking program, a $1,600 contribution to purchase new trail signs for Kinnickinnic State Park and other contributions to organizations working on nutrition, physical activity and/or mental wellness. Through the Healthy Communities Partnership, wellness assessments, education and coaching sessions were held at worksites in the community. In 2014, 505 people received wellness assessments and 287 received assessments in 2015. Additionally, over 200 people participated in education and/or coaching sessions in 2014, and over 150 participated in 2015. To increase physical activity in schools, at least one of the WI Department of Public Instruction's Active Schools-Core 4+ strategies was implemented in all but one school district in the county.

Finally, public health and hospital staff engaged local policymakers on topics to make non-motorized commuting more safe and accessible. This led to identification of a dangerous highway crossing in Ellsworth and the installation of proper signage, as well as the prevention of a total repeal of the Complete Streets policy at the state level.

Goal 2. Healthy Eating: Increase the consumption of fruits and vegetables. Decrease consumption of sugar-sweetened beverages and other less-nutritious food. Increase breastfeeding.

In 2014, cooking classes were launched at RFAH. These classes have continued to grow in popularity, and most classes in 2015 were full and had a waiting list. A worksite wellness workshop series was also developed, which included presentations on healthy vending and the benefits of breastfeeding. As a result of this and other outreach work, five local businesses updated or added a breast feeding/pumping policy to their employee manual and/or made changes to their facility to better accommodate employees wishing to pump at work. The hospital's "Baby Café" program has also been growing, and continues to provide one-on-one support and breastfeeding education for new and expectant mothers.

Additionally, work is being done to increase healthy food options for low income families. Incentives for SNAP participants continue to be offered at the River Falls Farmers Market with support from the Allina Health Charitable Contributions program. A team of representatives from hospitals, public health departments, UW-Extension and other partners in Pierce and St. Croix counties participated in the Healthy Wisconsin Leadership Institute's (HWLI) Community Teams Program, with a focus on food insecurity. The relationships, resources and skills developed during the year-

long program will be an asset as the region continues to respond to issues of poor nutrition and food insecurity.

St Croix County:

Goal 1. Improve nutrition of St. Croix County residents by increasing access to healthy foods and supporting sustained breastfeeding.

The Healthy Foods Task Force has been working towards the goal of improving nutrition of residents by increasing access to healthy foods and supporting sustained breastfeeding. Task force members have worked with the Five Loaves Food Pantry to identify improvements that will increase fruit and vegetable access among clients. The implementation of these improvements is currently postponed while the Five Loaves Food Pantry is looking for a new location. Additionally, several task force members are participating in the Healthy Wisconsin Leadership Institute/ Community Teams Program. Initially this group was planning to work on increasing fruit and vegetable access at the food shelf, but the project has shifted to food insecurity. The task force is also collaborating with area hospitals and working with area schools to implement healthy options for celebrations, fundraisers and student rewards. Lastly, task force members worked on activities that lay a foundation for an ongoing worksite breastfeeding support.

Goal 2. Improve oral health of children and participants in the St. Croix County school backpack program.

The Oral Health Task Force focused on improving the oral health of children participating in the St. Croix County School Backpack Program. With the support of donations from all area hospitals, dental care kits that included a toothbrush, timer, fluoridated toothpaste and dental floss were distributed to all children in the Backpack Program. Educational materials in a newsletter and evaluation cards were also included.

In the returned surveys, parents indicated that frequency and length of brushing time increased among children who received the kits. Parents were also provided with information about resources including a list of dentists who see children in their area. Several positive comments from parents/guardians were received.

Goal 3. Improve the physical activity of St. Croix County residents by increasing awareness of and providing opportunities for physical activity.

The Physical Activity Task Force realized several major accomplishments over the past year in St. Croix County. After-school physical activity opportunities were offered three times per year in all school districts in the county with one district beginning open gym times for families. The promotion of a county-wide Walk to School Day was a success. For this event, each district and private school in St. Croix County received a tool kit and small incentive tokens. There was good participation in all but one school district. A "traveling trophy" was presented to the school with the highest percentage of participation. Guides to continue daily activity after the event were provided to all school districts.

Other accomplishments included implementing active-classroom initiatives including incorporating "brain breaks" into the school day. Also, three task force members participated in the St. Croix County Bike and Ped (pedestrian) Plan Advisory Team, and task force members assisted in several school assessments to obtain baseline pedometer data for the implementation of the Core 4+ strategies in schools.

2015-2016 CHNA Process and Timeline

Healthier Together designed a process that engaged community stakeholders throughout and included both review of existing secondary data and collection of primary data through an online survey and community dialogues.

Staff of each organization provided leadership for the process designed to identify unique needs and develop localized action plans, while also identifying common themes for action systemwide.

TIMING	STEPS
July–September 2015	ESTABLISH PLANNING TEAMS and COLLECT DATA Staff identify and invite stakeholder groups for each hospital; share initial results from 2014–2016 implementation plan. Develop and distribute guidance and data packets and schedule local stakeholder meetings.
October–January 2016	REVIEW DATA and PRIORITIZE ISSUES Review data with stakeholders and complete formal prioritization process, using Hanlon method. Review prioritized issues and summarize themes for the system.
February 2016	DESIGN COMMUNITY INPUT Identify specific methods and audiences for community input on strategies, work with vendor to design process and questions/topics, and recruit participants.
March–June 2016	GATHER COMMUNITY INPUT and DEVELOP IMPLEMENTATION PLAN Conduct focus groups or community health dialogues to solicit action and implementation ideas related to priority areas. Local teams develop action plan, metrics and resource inventory.
July–September 2016	PREPARE REPORTS and SEEK INTERNAL SUPPORT/APPROVAL Share results and action plans with key stakeholders systemwide. Present plans to local boards/committees/leaders for approval.
October–December 2016	SEEK FINAL APPROVAL Staff present plans to Board of Directors for final approvals as needed.

Data Review and Issue Prioritization

Data Collection

Healthier Together used the most recent secondary data available via the CHNA toolkit—a web-based platform hosted by Community Commons—as well as additional state and local data resources available for St. Croix and Pierce counties such as the Youth Risk Behavior Surveillance System. Data for Wisconsin and the United States were also provided for comparison and context. The data included approximately 75 indicators relating to demographics, social and economic factors, health behaviors, physical environment, health conditions and healthcare access.

Primary data was collected via online and paper community health surveys. In September, 2015, a total of 1341 residents of Pierce (n = 536) and St. Croix County (n = 805) completed this survey. Individuals were invited to participate in-person and via email, news releases, partner websites and fliers. Special efforts were made to reach out to at-risk populations.

Of the survey respondents, most (78%) were female. Respondents' income varied greatly—34 percent of respondents' income was $50,000–$99,999; 21 percent $25,000–$49,999; and 20 percent $100,000–149,999. The remaining respondents' income was either less than $25,000 (14%) or greater than $150,000 (11%). Most respondents (42%) were age 32–54 years, though 20 percent were age 20–34 years and 20 percent 55–64 years. Almost all of respondents (96%) identified as white/Caucasian.

When asked about their county's top three strengths, the most common responses were that the area is a good place to raise children, has good schools, is a good place to live and has low crime and safe neighborhoods. When asked about their county's top three health concerns, the most common responses were drug use, obesity/overweight, mental health and alcohol abuse.

Data review and issue prioritization

Approximately 65 stakeholders representing broad interests of the community attended at least one of three meetings between November 2015 and January 2016 to review and discuss the above data and identify three priority health issues. Agencies represented at these meetings include:

- Baldwin Farmers Market
- Chippewa Valley Technical College
- Ellsworth Area Ambulance Service
- Ellsworth Community School District
- Ellsworth Cooperative Creamery
- Ellsworth Police Department
- Family Resource Center St. Croix Valley
- Friends of Willow River and Kinnickinnic State Parks
- Gethsemane Lutheran Church
- Grow to Share
- Hudson Hospital & Clinic
- Hudson School District
- Hudson YMCA
- Hunger Prevention Council of Pierce County
- Local Food Partnership
- New Richmond Farmers Market
- OEM Fabricators
- Our Neighbors Place
- Pierce and St. Croix County AODAs
- Pierce County Economic Development
- Pierce County Economic Support
- Pierce County Public Health Board and Staff
- Plum City School District
- River Falls Area Ambulance Service
- River Falls Area Hospital

- River Falls School District
- Salvation Army-Grace Place
- Somerset School District
- Spring Valley Health Care Services
- St. Bridget Catholic Church
- Pierce and St. Croix County ADRCs
- St. Croix Central School District
- St. Croix County EDC
- St. Croix County Health and Human Services Board and Staff
- St. Croix County Sheriff's Office
- St. Croix Valley Habitat for Humanity
- Turningpoint
- United Way St. Croix Valley
- University of Wisconsin Extension
- University of Wisconsin-River Falls
- Vibrant Health Family Clinics
- WestCAP
- Western Wisconsin Health
- Westfields Hospital & Clinic
- Wisconsin Indianhead Technical College
- Wisconsin State Senate

The review process included a formal prioritization process known as the Hanlon method, which includes ranking health priorities based on three primary criteria: the size of the problem, including projection of future trends; the seriousness of the problem, including disparate health burdens within the population; and the effectiveness and feasibility of interventions on the part of health care.

Final priorities

Through this process, three priorities were identified for action in 2017–2019:

1. **Mental health**
2. **Obesity/overweight**
3. **Alcohol abuse**

Needs identified but not included in the CHNA:

Other prioritized health issues identified through the process but not included among the top three priorities include housing, dental care and diabetes. Healthier Together plans to address diabetes prevention in part with its work on obesity/overweight prevention, but did not feel that there was significant enough need in the community for it to be among the top three. Housing and dental care were both identified as needs that existing partnerships in the community can or will address.

Community Input

Once priority issues were identified with the stakeholders, Healthier Together solicited broad feedback from the community on the appropriateness of the identified priority areas as well as how Healthier Together could most effectively address the needs. Community input was primarily gathered via community dialogues and focus groups (with an online survey option if interested persons could not attend).

Community dialogue/focus group descriptions

Healthier Together partnered with The Improve Group to design, plan and facilitate community health dialogues and focus groups between March and April 2016. The dialogues were open to all members of the community. The community health dialogues were facilitated by The Improve Group and used a World Café methodology. Participants had a chance to engage in discussion about all topics during three, 20-minute rounds. Participants were asked to share their vision for health in the community, clarify aspects of the priority health areas that are most important to address and discuss opportunities for Healthier Together to support community health.

Key questions Healthier Together sought to answer through the discussions were as follows:

- Does the community concur with/confirm our top priorities for the region?
- What specific aspect or components of the broad priorities should Healthier Together work to improve?
- What strategies and partnerships should Healthier Together implement in order to address the priorities?

Community dialogues were held in New Richmond, WI on March 31, 2016 and in River Falls, WI on April 7, 2016. A total of 48 community members attended, including representatives of local schools, government agencies, businesses, faith communities, health care organizations, non-profit organizations and advocacy groups. An online survey was also offered to people who could not attend the community dialogues but wanted to provide input on the assessment. Twelve people completed the survey in the corresponding zip codes for St. Croix and Pierce counties.

Pierce County Focus Groups		
Date	Location	Target Population
February 11, 2016	Rural Ellsworth Farm	Hispanic/Latino adults
February 19, 2016	Prescott Watertower Apartments	Seniors
February 23, 2016	Plum City High School	Youth
March 1, 2016	Elmwood Food Pantry	Persons who are low-income
St Croix County Focus Groups		
Date	Location	Target Population
February 17, 2016	Grace Place Homeless Shelter, New Richmond	Persons experiencing homelessness
February 22, 2016	The Bridge for Community Life, Hudson	Adults with developmental disabilities
March 9, 2016	Glenwood City Senior Center	Seniors
March 9, 2016	First Lutheran Church, New Richmond	Youth
March 24, 2016	Western Wisconsin Health	Latina adults

Findings from Community Dialogues/ Focus Groups

Mental Health

Vision for health

Participants envisioned a community in which people are more open to talking about mental health needs, there is decreased stigma and information about resources and treatment is readily available to the public. Mental health services are available in the schools to assist students with the challenges that they face, and services are offered at home or with transportation vouchers for those who cannot travel long distances. Other ideas for improving mental health care include creating a drop-in clinic, similar to an urgent care, where people who are in crisis can access walk-in services; reducing the financial barriers by providing more insurance options to pay for mental health care; increasing the number of providers in the community and offering more holistic care.

Existing strengths

Several groups are working in River Falls to improve mental health care. For example, National Alliance on Mental Illness (NAMI) is working to address mental health needs within the community. Veterans' Affairs provides some services for veterans and their families. The Family Resource Center St. Croix Valley provides screenings for postpartum depression. Several organizations work with specific age groups. For example, the YMCA in Hudson offers programming tailored for youth while the Aging and Disability Resource Centers in each county work with the aging population. There is also a mental health resource guide for St. Croix County that is available in many schools to use for mental health assessment and to make referrals. Additionally, there are programs in jails that provide mental health services for inmates.

Healthier Together role and opportunities

During the community dialogues, participants discussed ways Healthier Together could help address the priority area. Ideas that came out of the session include:

- Partner with schools to increase mental health services in schools.
- Create public service announcements to increase discussion about mental health topics.
- Create an up-to-date resource list of mental health services and providers.
- Increase collaboration with all providers so that health care services are not siloed.
- Provide alternative treatment options for mental health such as mindfulness training.
- Promote community- and family-building events that will strengthen social bonds.
- Facilitate easier access to mental health services.
- Recruit more mental health providers and develop a more state-of-the-art clinic.

Obesity/Overweight

Vision for health

Participants envisioned a future in which people in the community exercise together as a social activity. This includes people meeting outside and in gyms for exercise groups, increased peer support to be active and people choosing to walk or bike as a means of travel. Participants also envisioned more healthy food options, such as smaller and healthier portions at restaurants, fewer sugar-sweetened beverages in schools and increased access to healthy food through farmer's markets and community gardens. They also would like to see increased physical activity through the use of public trails and parks and more affordable gyms.

Existing strengths

There are several options that exist for people to engage in physical activity including the trail system, biking groups and open gyms. Healthy food options are available through the Whole Earth Co-op, community gardens and farmer's

markets. Additionally, educational efforts are taking place in schools to teach children about growing their own food and how to cook nutritious meals.

Healthier Together role and opportunities

During the community dialogues, participants discussed ways Healthier Together could help address the priority area. Ideas that came out of the session include:

- Promote healthy diet and exercise in schools.
- Provide additional community education around healthy lifestyles.
- Sponsor social activities that promote healthy eating and exercise.
- Partner with community groups that are working towards the goal of supporting healthy lifestyles.
- Make gyms and fitness centers affordable and accessible.
- Increase healthy food options in restaurants, social functions and grocery stores.
- Work on policy changes that will increase healthy lifestyles.

Alcohol Abuse

Vision for health

Participants envisioned a community in which there is affordable and accessible treatment options for those that are experiencing chemical addiction. This includes treatment centers as well as aftercare options for people after they complete treatment. In 2019, participants envisioned the existence of a resource guide that people can easily access to know where to go and who to call if they or someone they know is experiencing problems stemming from alcohol abuse. Participants recognize that there is a strong drinking culture in the region, but hope that in the future there are more community activities and ways to socialize that are not centered on drinking alcohol. They also recognized the value in educating youth early-on about the dangers of alcohol.

Existing strengths

Participants noted that many in the community are aware that there is a regional problem with alcohol addiction. Support groups that exist for people seeking treatment include Alcoholics Anonymous. Kinnic Falls Drug and Alcohol Abuse Services provides residential treatment options in River Falls. Veterans' services also provide resources for those seeking treatment, and programs exist within the correctional system to assist youth and adults who are struggling with chemical dependency.

Healthier Together role and opportunities

During the community dialogues, participants discussed ways Healthier Together could help address the priority area. Ideas that came out of the session include:

- Encourage healthy activities as an alternative to drinking.
- Use social media to promote services and resources that currently exist.
- Provide educational opportunities about chemical dependency and alcoholism.
- Partner with local government to enact policies around drinking.
- Eliminate activities that encourage binge drinking.
- Address chemical dependency early in life.
- Increase alignment between medical health care and chemical dependency treatment providers.
- Provide treatment opportunities that are close-by and age-appropriate.

Implementation Plan

Overview of process

After confirming the top three priorities with the community and gathering community ideas for action, Healthier Together developed an implementation plan based on the input. This plan outlines the set of actions that the coalition will take to respond to the identified community needs.

Following the community dialogues and focus groups, a core group of staff from the local health departments and area hospitals worked through email, phone and four in-person meetings to review and discuss the data and to draft goals and strategies for the 2017-2019 implementation plan. The three priorities and their respective goals and strategies were communicated to Healthier Together members and other interested community members at a meeting in July 2016. Action teams were then convened to develop specific objectives and evidence-based activities to support each of the goals during the three-year implementation phase.

The following implementation plan is a three-year plan depicting the overall work that Healthier Together will conduct to address the priority areas. Existing resources to address each issue are also listed so as to reduce duplication and identify possible partners. Detailed objectives including timelines and measures of success will be developed in detail by three workgroups, each dedicated to one priority area.

Priority 1: Mental health

Resources: In addition to the collective resources of Healthier Together, many partners exist in the community that have expertise in and work to support mental health, such as Pierce and St. Croix County Human Services, NAMI, Northwest Connections, Arbor Place, Positive Alternatives, Success by Six, Valley Co-op Behavioral Health Steering Committee, the Pierce-St. Croix CARES Coalition, Family Resource Center St. Croix Valley and the Free Counseling Center.

Goal: Improve the mental health status of residents of Pierce and St. Croix Counties.

Strategies:

1. Increase awareness about mental health issues and reduce the stigma of mental illness.
2. Increase access to mental health services.

Priority 2: Obesity/overweight

Resources: In addition to the collective resources of Healthier Together, many partners exist in the community that have expertise in and work to reduce obesity/overweight, such as the Hudson YMCA, local food pantries, the Hunger Prevention Council of Pierce County, the United Way St. Croix Valley Food Resource Center, Better Bites St. Croix Valley, school districts, local park and recreation departments, Catalyst Sports Medicine, Friends of Kinnickinnic and Willow River State Parks, WestCAP, UW-Extension and the St. Croix Bike and Pedestrian Trail Coalition.

Goal: Decrease the percentage of the population that is overweight or obese in Pierce and St. Croix counties.

Strategies:

1. Increase physical activity through changes to policy, systems, environment and community support.
2. Decrease food insecurity and improve nutrition through changes to policy, systems, environment and community support.

Priority 3: Alcohol Abuse

Resources: In addition to the collective resources of Healthier Together, many partners exist in the community that have expertise in and work to reduce alcohol abuse, such as Alcoholics Anonymous, Alano, Pierce and St. Croix County AODA, Hudson Hospital & Clinic Programs for Change, Midwest Psychological Services, Burkwood Treatment Center, Kinnic Falls Alcohol and Drug Abuse Services, Arbor Place, Veterans Outreach and Recovery Program, the correctional system, Pierce County Partnership for Youth, St. Croix County Underage Drinking Coalition, and the University of Wisconsin-River Falls Student Health and Counseling Services.

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

Strategies:

1. Decrease youth alcohol use through changes to policy, systems, environment and community support.
2. Decrease adult alcohol abuse through changes to policy, systems, environment and community support.

Resource commitments

Healthier Together, through its member organizations will commit both financial and in-kind resources during 2017–2019 to ensure effective implementation of its planned activities to meet the goals and objectives identified. Resources may include specific programs and services, charitable contributions and employee volunteerism offered by individual organizations and staff time devoted to collaborations with others to advance collective work.

Evaluation of objectives

Throughout the implementation phase, specific metrics will be tracked to document progress toward meeting goals and objectives and make adjustments to the implementation plan as needed. Specific evaluation plans will be established or continued for programs and initiatives as appropriate. Monitoring of population-level metrics and systemwide metrics will also provide context for the health status of communities Healthier Together serves and the work of Healthier Together overall (see Appendix).

Acknowledgments

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

- Individual community members who offered their time and valuable insights;
- The Improve Group, who facilitated our community conversations;
- Partner organizations that met to review and prioritize data and develop implementation plans and the individuals who contributed their expertise and experience to ensure a thorough and effective outcome;
- Member organization's staff who provided knowledge, skills and leadership to bring the assessment and plan to fruition;
- Allina Health system office staff and interns who supported the process throughout, including Debra Ehret Miller, Christy Dechaine, Sarah Bergman, Brian Bottke and Axmed Siciid; and
- Members of the CHNA steering team, representing the four hospitals and two public health departments in the two-county region.

Conclusion

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

For questions about this plan or implementation progress, please contact a member of the CHNA steering team:

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

Appendix: Healthier Together Progress Indicators

Population Health Metrics

The following population-level indicators will be used to provide context and to monitor the region's status related to the identified priorities. Data will be analyzed at the county-level wherever possible.

Overweight/obesity		
Adult physical activity	Percentage of adults reporting no leisure time physical activity.	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)
Youth physical activity	Percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the seven days before the survey.	Wisconsin Youth Risk Behavior Survey (YRBS)
Adult fruit and vegetable consumption	Percentage of adults with inadequate fruit and vegetable consumption.	Behavioral Risk Factor Surveillance System (BRFSS)
Adult BMI	Percentage of adults with a Body mass Index (BMI) over 25.0 (overweight) or 30.0 (obese).	Centers for Disease Control and Prevention, NCCDPHP
Mental health		
Youth suicidal thoughts	Percent of students who seriously considered attempting suicide in the last 12 months.	YRBS
Youth depression	Percent of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activity.	YRBS
Adult mental distress	Average number of mentally unhealthy days reported in the past 30 days (age-adjusted).	BRFSS
Adverse childhood experiences	Percent of respondents reporting a score of 4 or more on adverse childhood events (ACE)	BRFSS
Mental Health crisis	Number of annual crisis calls to Northwest Connections	Wisconsin Department of Health Services
Suicide rate	Mortality rate from suicides	Wisconsin Department of Health Services, Vital Statistics

Alcohol abuse		
Youth drinking	Percentage of students who have had five or more drinks of alcohol in a row (binge drinking) during the past thirty days.	YRBS
Youth drinking	Percent of students who drank alcohol in the last 30 days.	YRBS
Youth drinking	Percent of students who drank alcohol (other than a few sips) for the first time before age 13.	YRBS
Youth drinking	Percent of students who feel their parents would think it is wrong of very wrong for them to drink alcohol at least twice per month.	YRBS
Adult alcohol abuse	Percentage of adults drinking excessively	BRFSS
Adult alcohol abuse	Number of alcohol-related hospitalizations and arrests	The Burden of Excessive Alcohol Use in Wisconsin, University of Wisconsin Population Health Institute

Healthier Together
Pierce County
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