Creating a Path to Better Health

2017 COMMUNITY HEALTH IMPROVEMENT PLAN

Forest County | Oneida County | Vilas County

Forest, Oneida and Vilas Counties' Community Health Improvement Plan

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Forest, Oneida and Vilas Counties' Community Health Improvement Plan

Introduction

As a core function of public health, local agencies have been participating in an ongoing process to improve the health of the community though a formal process commonly known as a community health assessment. The community health assessment helps to identify and measure health problems in the community through data collection, analysis and input from community stakeholders and members. After the assessment is completed, a community health improvement plan is developed which typically lasts five years. The plan is based from the priority health areas identified during the assessment process.

As a new initiative, the counties of Forest, Oneida and Vilas collaborated with with Ministry Health Care, including; Ministry Eagle River Memorial Hospital, Ministry Saint Mary's Hospital and Howard Young Medical Center, to complete this process as an effort to create a larger collective impact since many community agencies and organizations serve populations in each of the three counties.

Community Health Improvement Process

The process used for both the community assessment and improvement planning process was an adaptation from the County Health Rankings and Roadmaps, Wisconsin's Guidebook on Improving the Health of Local Communities. The guidebook is based on a continual improvement process with the following core steps: (1) Work together and communicate, (2) Assess needs and resources, (3) Focus on what's important, (4) Choose effective policies and programs, (5) Act on what's important and (6) Evaluate actions. This process has been conducted over the course of the last year in combination with state and local partners. The following information outlines each step taken including the inputs, outputs, successes and challenges experienced, if available.

Step 1: Formation of the Steering Committee

The steering committee was formed through representation from all three counties, the UW-Extension office and Ministry Health Care. During certain stages of the community health assessment and improvement planning process, specialists from certain sectors were asked to join and contribute their skills and expertise. The committee met bi-monthly throughout the entire process and will continue to meet to oversee implementation, monitor progress and address challenges as they arise.

Step 2: Assessing the Health of the Community

The community health assessment (CHA) process allows community stakeholders and members to gain a better understanding of the health concerns and needs of the area. The method in which the data was collected and analyzed matched the state plan, Healthiest Wisconsin 2020. The twelve health focus areas and nine infrastructure areas guided the development of the CHA. Both primary and secondary data sources were used along with input from a community survey. Once this information was compiled, it was formally presented to the community during a Data-in-a-Day event and through multiple media outlets. The data was also presented during community forums, focus groups and interviews.

Step 3: Selecting Priorities

Selecting priority areas occurred during the Data-in-a-Day event, which all three counties' community partners and local agencies were invited to attend. After reviewing the data, attendees were given the opportunity to share their thoughts on the information presented, along with identifying assets and resources in the community. This occurred during three facilitated break-out sessions using brainstorming and nominal group technique. At the end of the day, each participant was given the opportunity to select the health priorities of greatest concern to focus on for the next three to five years. If community stakeholders were not prepared to make a decision at the end of the day, a brief survey was distributed to all participants at a later date to identify the health priority areas.

To assure that multiple demographic groups were given the opportunity to provide feedback, small focus groups and interviews with pre-identified community members were conducted. At these meetings, key data points were reviewed and then followed-up with an opportunity to provide input on the strengths and weaknesses of the community along with selecting priority health areas. For a copy of the full report, which includes data for all health areas, identified assets and weakness, and other findings, please visit any of the three participating counties' health department websites. The final results, after all selection activities were complete are:

1. **Alcohol and Other Drug Abuse**
2. **Mental Health**
3. **Chronic Disease**

Timeline

- **May 2015** *Steering Committee Formed*
- **May 2015** *Begin Assessment-Data Collection*
- **September 2015** *Health Survey Developed*
- **October 2015** *Community Survey Launched*
- **December 2015** *Community Survey Closed*
- **December201** *Community-5 wide Data Forum*
- **March 2016** *Focus Groups and Interviews Conducted*
- **April 2015** *Community Health Assessment Released*
- **May 2016** *Community and Coalition Feedback on CHA*
- **April 2016** *Health Priority Areas Finalized*
- **July 2015** *Community Forums held to Draft Goals & Objectives*
- **August 2016** *Planning Committee & Coalitions Finalize Goals & Objectives*
- **September 2016** *Potential Stategies drafted*

Next Steps.....
Start Work Plan Development and Coalition Training

Step 4: Develop Goals and Objectives

Once the health priorities were selected, the planning committee held community forums for each priority area with stakeholders and experts in each related field. During each priority health area session specific to one of the three priority health areas, the participants were given a summary of the health assessment findings, brief education on goal development and a chance to share ideas. The education focused on the difference between goals, objectives and strategies along with guidance on how to choose effective, evidence-based programming. In an effort to align the improvement plan with Healthiest Wisconsin 2020 and Healthy People 2020, objectives from these plans were discussed as to their relationship to the chosen priority health areas.

To ensure everyone in the room had a voice and all potential ideas were presented, a number of quality improvement tools were utilized. First, a brainstorming session was held where participants were able to verbalize or write down their ideas and thoughts. Once all ideas were collected and presented to the group, multi-voting was used to select the final goals.

After each community forum, the planning committee reviewed the potential goals discussed and drafted objectives related to each of the goals selected. The objectives were selected based on feedback from the community forum and the SWOT (strengths, weaknesses, opportunities and threats) analysis conducted during the health assessment. Each objective was written with the "SMART" model in mind. The rough draft was then presented to the coalitions in the area for final feedback and revisions.

Step 5: Identifying Potential Strategies

After goals and objectives were finalized, the planning committee, along with input from the area coalitions, researched evidence-based strategies that could be implemented or strengthened in the community. In the following sections, each priority area is highlighted with the goals, objectives and potential strategies. A number of strategies were identified to give flexibility to the area coalitions and to take into consideration that each county may be at a different starting point. The list is not inclusive but rather should be used as a starting point; additional strategies could be implemented based on future findings or new research. A resource bank is provided in the Resources and Tools section that provides additional evidence-based programming and strategies if needed. Finally, to increase the collective impact and create sustainable change throughout all three counties, one strategy will be identified that all three counties will work on.

Step 6: Work Plan Development

After the selection of the goals and objectives, annual work plans outlining selected strategies will be developed by area coalitions with guidance from the community health improvement planning committee. A work plan will be created for each of the three health priority areas: chronic disease, AODA and mental health with a focus on the overarching themes of health equity, health across the lifespan and access to care. The work plans for the overarching themes will be created and maintained by the CHIP steering committee.

Due to the complexity of community change and using evidence-based programming, the planning committee will assist the coalitions with resources and training to ensure implementation is successful. An annual training on evidence-based programming will be offered in the area for all coalition members to attend. In addition, templates of work plans and other necessary tools will be provided. A copy of the templates can be found in the Resources and Tools section for coalitions and organizations.

Community Coalition Templates for Successful Implementation of Evidence-Based Strategies

Community Health Assessment Review

The community health assessment was a year-long process that included representation from multiple agencies including the Forest, Oneida and Vilas County Health Departments, Ministry Health Care and the University of Wisconsin-Extension Office. The assessment process used was an adaptation from the County Health Rankings and Roadmaps, Wisconsin's Guidebook on Improving the Health of Local Communities. The data was analyzed focusing on the priority areas of Healthiest Wisconsin 2020 and the underlying themes of health equity, access to care and health across the lifespan. All efforts were made to provide community members an equal opportunity to provide input using multiple approaches that include surveys, focus groups, forums and key- informant interviews. Special efforts were made to reach the under-served population in the area and the community partners and stakeholders who work with this population. The following snapshot highlights key data points about the community's demographics and health. The data presented combines Forest, Oneida and Vilas counties together. For individual county level data or the complete assessment, please see the 2016 Community Health Assessment on either Forest, Oneida or Vilas Counties' Health Department Websites.

Our Community Make-up

Certain populations tend to experience adverse health outcomes or have different health needs based on demographics. Key populations that can be at risk and should be monitored include the following:

Aging Population

1 in 4 are over the age of 65.

Tracking the population of individuals age 65 or older is important because this population has unique health needs which should be considered separately from other age groups.

Higher Education Attainment

28%

Only 28% of the adult population have some form of higher education.

This indicator is important because educational attainment has been linked to positive health outcomes. Also higher levels of education may increase health literacy and the ability for individuals to make informed health decisions.

Poverty Rate

1 in 7 community members live in poverty.

Living in poverty creates barriers for achieving optimal health. Examples include limited access to health services, healthy food, and other necessities that contribute to health status.

Our Health Snapshot

Maternal Smoking

26%

of pregnant women reported smoking at some time during their pregnancy, which is well above the state average of 14.1%.

Suicide

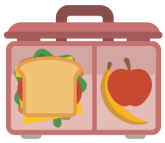
14%

of adolescences reported having seriously considered suicide in the past 12 months. The three counties also have a high mortality rate due to suicide compared to the state average.

Teen Birth Rate

30.5

per 1,000 females between the ages 15-19, an important indicator because teen mothers usually have a unique set of needs both socially and financially.



Free and Reduced Lunch

47%

of children are eligible for free or reduced lunch at school. This indicator helps to measure the vulnerable population footprint in the community.

Prescription Pain Medication

Community members in the area stated that prescription drug abuse is a common problem.

Income and Health

The community survey showed a direct correlation between income and health in the community.

People who reported making under $20,000 reported the following about their health:

- Lack of trust and money were the main reason for not seeing a doctor when sick.
- Concern about their own mental health or a friend's mental health increased compared to all other incomes.
- Lack of money was the main reason for not seeing a dentist annually.
- The availability of transportation was the main concern in overall health improvement.

25% of people making under $34,999 reported using a community food program.

Strengths of the Community

Collaboration between agencies and organizations within the community.

Established programming and coalitions.

Increased knowledge and educational programs.

Challenges in the Community

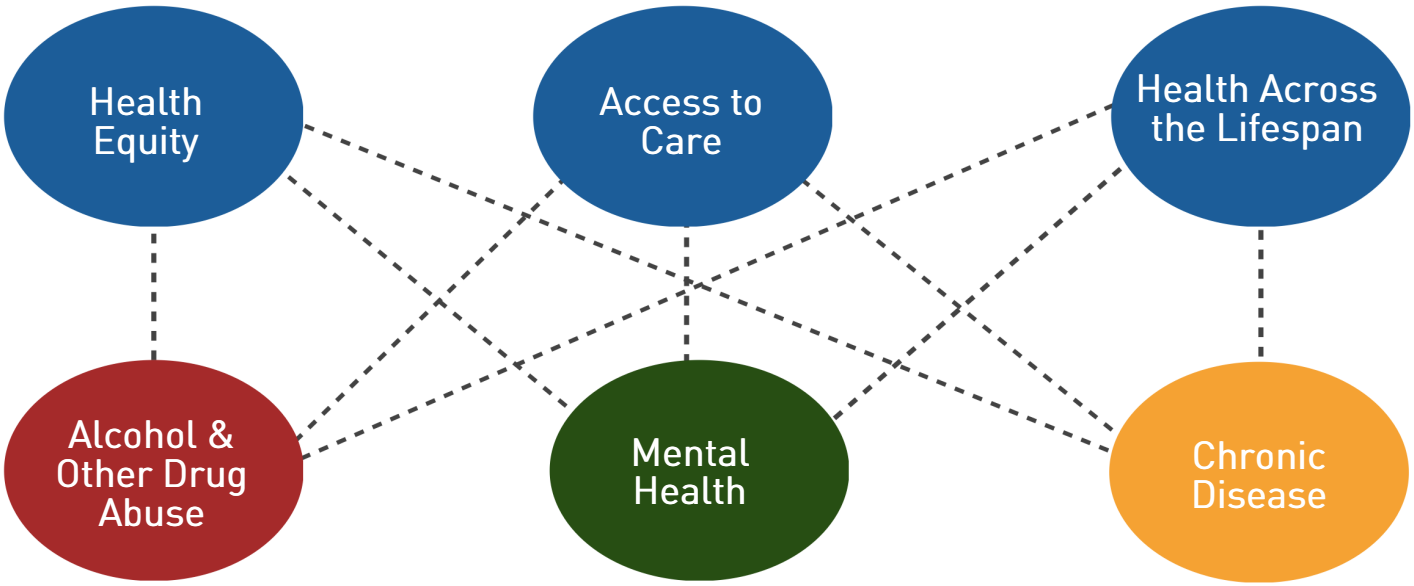
Lack of transportation.

Lack of providers across a number of disciplines.

Lack of resources including funding, services, support groups, and community classes.

2017-2020 CHIP Priority Areas

The next section outlines the vision for the priority areas selected for Forest, Oneida and Vilas Counties. As previously mentioned, the three health priority areas for the 2017-2020 CHIP are: AODA, Mental Health and Chronic Disease. These priority areas were selected through both community input and data analysis. During this process cross-cutting themes were identified that expand beyond just one health priority area, but affect all aspects of health. For this reason, three overarching themes were selected to be priority areas as well. These themes include: Health Across the Lifespan, Health Equity and Access to Care. The following section outlines in detail why each overarching theme and health priority area was selected and a plan for improvement.



Understanding Goals, Objectives, and Strategies

The CHIP is organized to reflect broad goals, measurable objectives and strategies used to address each overarching and health priority area. The goals were developed using best practices and modeled after the community change pyramid. The pyramid involves a goal directed at each level: policy, infrastructure and programmatic change.

In addition, goals were developed in this fashion to promote sustained action within the community. The goals in the CHIP plan will be shared among all three counties and monitored by the long-term indicators noted on the first page of each section. The same will hold true for the objectives, which were written with the SMART model in mind. The indicator that will be used to monitor each objective is included in each section and selected to represent short or medium-term change. Example strategies are also provided for each objective. More guidance on selecting evidence-based strategies are included on the following page and in the Resources and Tools Section.

Guide to Strategy Examples

For each priority area, strategy examples are provided as a potential starting point for coalitions. These lists are not inclusive and more examples and resources can be found in the Resources and Tools Section. Each strategy has been identified by which sector it impacts (community, school, older adults, or health care), the level of evidence behind each strategy, and whether or not it is likely to impact health disparities. The legend below describes what each indicator represents.

Health Equity Impact Indicators

Likely to impact health disparities

Sector Indicators

School-based

Aging adults

Community

Health care

Evidence- Based Indicators

Evidence-based

Some evidence

Expert opinion

Coalitions and Workplan Devleopment - How to use the CHIP

CHIP implementation will largely be charged to coalitions within the three counties that will address each health priority area (AODA, Mental Health, Chronic Disease). The workplans developed annually by these coalitions will contain action steps to address the CHIP goals as well as address the following:

A detailed timeline for implementation of each strategy selected to address goals and objectives

Identify the lead organization for each initiative and individuals or other organizations that will be responsible for implementation

Incorporate strategies used to address the overarching priorities

Follow the CADCA (Community Anti-Drug Coalitions of America) workplan design

Workplans for addressing the overarching priority areas (Health Across the Lifespan, Health Equity, Access to Care) will be developed and implemented by the CHIP steering committee. These work plans will include community-wide initiatives that cross all health priority areas and compliment the initiatives of each coalition.

Monitoring and Sustainability

Monitoring implementation of the CHIP will be will kept in a separate document tracking changes at the individual county level. Monitoring of each indicator will be done on an annual basis unless otherwise noted due to data collection limitations. All findings will be shared with the community in a yearly report. With continuous data monitoring and the selection of goals that mirror the standard of community change (policy, infrastructure and programming) will help to increase the sustainability of the 2017 CHIP initiatives.

Overarching Priority Areas

When improving the health of the community, underlying themes emerge that move beyond just the selected health focus areas. Optimal health is also linked to a wide variety of factors, including risky behaviors, where you live, work, learn and play, education attainment, and income. A community should consider the aforementioned factors when encouraging positive changes to achieve a greater impact on each resident and the community's overall health. Coalitions will select strategies that focus on the three top priority areas. The strategies that are chosen by area coalitions in Oneida, Vilas and Forest Counties will have three overarching goals: (1) Health across the Lifespan, (2) Health Equity and Social Determinants of Health, and (3) Access to Care.

Health Across the Lifespan

Healthy Choices at a Young Age

16% of Wisconsin students get the recommended amount of vegetables a day

78% of Wisconsin students reported drinking soda days before this survey

23% of Wisconsin students watch 3+ hours of TV on average

72% of children have received all the recommended immunizations by age 2

Proactive Cancer and Disease Prevention

Only 62% of the community over the age of 50 have had a colon cancer screening

47% of individuals over the age of 65 have had a flu shot in the past year

Managing and Living with Disease

14% of adults report having fair or poor health

Focusing on health across the lifespan means that strategies will touch the lives of community members at every stage of life, infancy through death. The CHIP steering committee, coalitions and workgroups in Oneida, Vilas and Forest Counties will work to improve the quality of life at every stage by implementing policy, systems and environmental changes in their communities.

Goals and Objectives

Goal 1: Implement strategies of the CHIP focusing on community members of all ages

Objective: By December 31, 2020 one new or existing strategy will be implemented, strengthened, or expanded from each health priority area focusing on each group; youth, community, and the aging.

Strategy Examples

Increase communication with local community stakeholders, partners and members within each target age group to assess needs and access points

Monitor CHIP implementation strategies across all community coalitions and encourage communication across all coalitions

Health Equity

Education

Only 32% of residents 25 years or older have an associate's degree or higher

8% of the population in Forest, Oneida and Vilas Counties have no high school diploma

Income

As income increases, residents are more likely to report higher levels of overall health

Residents making under $20,000 reported being concerned about their mental health more than any other group

33% of residents have very high housing costs, which is costs greater or equal to 30% of their income

Other Factors

47% of school-aged children are eligible for free or reduced lunch prices

13% of residents in the area are worried about where their next meal may come from

Health Equity is providing equal access to opportunities for individuals to achieve optimal health despite race, ethnicity, gender or socioeconomic status. According to the University of Wisconsin Population Health Institute, 40% of factors that influence health are social and economic. Local coalitions working on the priority areas of AODA, Mental Health and Chronic Disease will focus on creating policies, systems and environmental change to close the gaps in access to healthy opportunities. These initiatives will allow all people in Forest, Oneida and Vilas County the opportunity to have a better quality of life regardless of where they live, work, learn and play.

Goals and Objectives

Goal 1: Increase Health Literacy

Objective: By December 31, 2020, one new or existing strategy will be implemented, strengthened, or expanded to increase the dissemination or use of evidence-based health literacy practices and interventions.

Strategy Examples

Strengthen partnerships with local libraries and other organizations in the community

Increase education of health literacy and warning signs of low health literacy with partners

Goal 2: Improve Health Considerations in Policy Development

Objective: By December 31, 2020, one new or existing strategy will be implemented, strengthened, or expanded to increase health consideration during policy development to eliminate health disparities.

Strategy Examples

Increase education on the social determinants of health and their effects on health

Access to Care

Providers

Primary Care
1 provider per 1,000 community members

Mental Health
1 provider per 570 community members

Oral Health
1 provider per 1,350 community members

Services

Only 62% of adults over the age of 50 reported having a colonoscopy

Only 72% of children are up-to-date on their immunizations

22% of community members have not seen a dentist in the past year

Barriers

Uninsured:
Adults: 12%
Children: 7%

18% of community members do not have a primary care provider

The community is considered a health professional shortage area

As evident above, the Northwoods area does have a number of primary care, dental, and mental health providers but also serves as a hub for surrounding communities. However, the inadequacy of care is evident when looking at the number of community members who lack recommended preventive services. This trend is only magnified as individual income and education levels decline. This is due to a number of reasons; one being lack of adequate health insurance. High premium costs and not being offered insurance at work was the number one response to why community members lack health insurance. Other barriers contributing to lack of access include transportation, long wait times, and fear or lack of trust in medical providers.

Goals and Objectives

Goal 1: Strengthen Data Collection

Objective: By December 31, 2020 identify two data collection tools to be utilized annually to assess access to care in Forest, Oneida and Vilas counties.

Strategy Examples

Create a local, primary data source

Work with local providers and health care facilities to establish indicators to assess access to care

Goal 2: Reduce the Barriers to Health Care Services

Objective: By December 31, 2020 one new or existing strategy will be implemented, strengthened, or expanded to increase access to reliable transportation in the counties of Forest, Oneida and Vilas.

Strategy Examples

Encourage healthy community design

Increase access to affordable, public transportation

Priority Area: Alcohol & Drug Abuse

Substance abuse—involving drugs, alcohol, or both—is associated with a range of destructive social conditions, including family disruptions, financial problems, lost productivity, failure in school, domestic violence, child abuse, and crime. Moreover, both social attitudes and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. The cost of excessive alcohol use in Forest, Vilas and Oneida Counties combined is over $66 million, an average of $1027 per resident. Substance abuse contributes to a number of negative health outcomes including the following: cardiovascular conditions, pregnancy complications, sexually transmitted infections, and HIV/AIDS.

AODA Snapshot

Number of Residents per Liquor License

There is one liquor license per 120 residents

Adult Binge Drinking

1 in 5 Adults Engage in Binge Drinking in the Area

Adolescents who initiate alcohol use before the age of 13

1 in 5 Adolescents Begin Drinking Before the Age of 13

What you can do to make a difference.....

Individuals and Communities	Stakeholders and Organizations	
Don't Drink and Drive-appoint a designated driver	Participate in media campaigns	Enforce current laws
Keep medications in a safe place and dispose of them properly	Advocate for safe ride home programs	Support policy change
Do not provide alcohol to underage adults or children	Implement screening programs	Participate in local coalitions
Reduce alcohol consumption at public events	Train bartenders about responsible serving	Offer employee assistance programs

Long-term Outcome Indicators

Create a community free of AODA burdens through the reduction of use

The data below combines averages for Forest. Oneida and Vilas Counties. For county-specific data, please visit any of the above counties' health department websites to view the Community Health Assessment.

Number of Drug Use Violations

This indicator helps to monitor drug use in the area and targets preventive measures if needed

Current: 299 Target: 250

Adult Binge Drinking Rate

This indicator is important because it illustrates future health problems and a need for services

Current: 22.5% Target: 15%

Alcohol Use Violations Underage Drinking

This indicator is important because early use of alcohol can be a precurser to abuse later in life

Current: 142 Target: 0

Wisconsin Department of Justice, 2015
County Health Rankings, 2015
Age adjusted heart disease mortality rate per 100,000 persons(DHS WISH, 2009-2013)

Forest Oneida Vilas

GOAL 1 Strengthen data on AODA in Forest, Oneida, and Vilas Counties.

Obtaining reliable and accurate data on alcohol and other drug use is challenging for local communities. Issues with community members reporting accurately because of stigma or judgment and fear of repercussions with law enforcement are all contributing factors. When organizations in the communities collaborate, better data can be obtained.

Objectives

1. By December 31, 2020, two data collection tools will be identified and utilized biennially (every two years) on alcohol and other drug use throughout Forest, Oneida, and Vilas counties.

Short-term Indicator

Number of tools used to track and monitor data

Strategy Examples

Youth Risk Behavior Survey (YRBS)

Tri-Ethnic Youth Survey

Community Surveys

Department on Aging data systems

Additional examples are found in the Resources & Tools Section

Impacting Health Equity

Various subpopulations face elevated levels of mental and substance use disorders and experience higher rates of suicide, poverty, domestic violence, childhood and historical trauma, as well as involvement in the foster care and criminal justice systems. Historically, these diverse populations tend to have less access to care, lower or disrupted service use, and poorer behavioral health outcomes. These disparities may be related to factors such as a lack of access to health care, the need for a diverse health care workforce, a lack of information, and the need for culturally and linguistically competent care and programs. (SAMHSA)

Several biological, social, environmental, psychological, and genetic factors are associated with substance abuse. These factors can include gender, race and ethnicity, age, income level, educational attainment, and sexual orientation. (HP2020)

GOAL 2 Increase access to AODA services and programs in Forest, Oneida and Vilas Counties.

Access to AODA treatment remains a growing issue for the area. The community survey showed this is specially true for low-income residents. Some identified reasons for the lack of access include an inability to locate providers, insurance coverage and transportation to appointments.

Objectives

1. Identify and share current AODA services and programs in each county and develop a plan to update at least annually by December 31, 2020.

Strategy Examples

Utilize 211

Create and maintain electronic database

Explore apps

Brochures, website, social media

Short-term Indicator An updated community AODA resource guide

2. By December 31, 2020, one new or existing strategy will be implemented, strengthened or expanded upon to address gaps in AODA services.

Short-term Indicator

Increase in evidence-based programming in the community that supports access to mental health services

Strategy Exmaples

Standardized referral systems

Wellness courts

Prevention and management of alcohol problems in older adults

Wrap around services- drug endangered children, Coordinated Service Teams

Additional examples are found in the Resources & Tools Section

Using Policies to Reduce the Burden of AODA Issues

Policies at the local, state and federal level affect individual and population health. For example, increasing taxes on tobacco sales can improve population health by reducing the number of people using tobacco products.

GOAL 3 Decrease alcohol and drug abuse in Forest, Oneida and Vilas Counties.

The hope of this community health improvement plan is to allow the residents of the community to live happy and prosperous lives free of alcohol and drug abuse. To achieve this vision, services need to be expanded, awareness increased and communities working together towards one collective vision.

Objectives

1. By August 30, 2020, implement one policy to impact alcohol and drug use in Forest, Oneida and Vilas Counties.

Strategy Examples

Social host ordinances

Public alcohol availability restrictions

Enforcement of underage drinking laws- alcohol compliance checks

School review of Human Growth and Development Curriculum per state statute.

2. By August 30, 2020, one new or existing strategy will be implemented, strengthened or expanded upon to decrease alcohol and drug abuse in each sector.

Strategy Examples

Multi-component community interventions against alcohol impaired driving

Group-based parenting programs- building resiliency

Universal school-based programs: alcohol misuse and impaired driving

Additional examples are found in the Resources & Tools Section

Short-term Indicator Increase in the number of policies impacting alcohol and drug use

Short-term Indicator Increase in evidence-based programming in the community that decrease alcohol and drug abuse

Impacting Health Across the Lifespan

Substance abuse remains a serious concern for Americans of all ages. 15% of Wisconsin high school students reported using alcohol before the age of 13. Research has shown that early initiation is an important precursor to abuse later in life. Adult use of alcohol can be an issue too. Wisconsin is the second leading state in binge drinking with a rate of 23%. (WI DHS, 2013). Furthermore, adults dependent on alcohol report higher rates of illicit drug use and non-medical use of prescription drugs compared with the general population. (HP 2020) Substance abuse in the elderly populations can also become a problem due to many factors such as living in isolation, depression or dementia. As people age the effects of alcohol on the body can change, putting that person at greater risk.

Priority Area: Mental Health

Mental and emotional well-being is essential to overall health. Positive mental health allows people to realize their full potential, cope with the stresses of life, work productively, and make meaningful contributions to their communities (National Prevention Council, 2010). Developing emotional well-being from the earliest stages of life helps build a foundation for overall health and well-being.

Mental Health Snapshot

Mental Health Services

1 in 5 received some type of mental health service in 2013.

Source: Mental Health and Substance Abuse Services and Programs Provided by WI Counties and Regions, 2015

What you can do to make a difference.....

Individuals and Communities

Encourage children and youth to participate in extracurricular and out-of-school activities

Build strong, positive relationships with family and friends

Become more involved in their community (e.g., mentor or tutor youth, join a faith or spiritual community)

Work to make sure children feel comfortable talking about problems such as bullying and get help if needed

Stakeholders and Organizations

Support child and youth development programs, especially those that include youth with mental, emotional, and behavioral problems

Provide space and organized activities that encourage social connectedness for all people

Train key community members to identify the signs of depression and suicide and refer people to resources

Expand access to mental health services and improve linkages between mental health, substance abuse, disability, and other social services

Long-term Outcome Indicators

Reduce the burden of mental health by strengthening community systems

The data below combines averages for Forest. Oneida and Vilas Counties. For county-specific data, please visit any of the above counties' health department websites to view the Community Health Assessment.

Strengthen Data

Identify data sources that provide information on what is happening locally in all ages

Access to Consistent Data Annually to Review and Assess

Suicide

Suicide can act as an indicator to track the mental health status of the population. The burden of suicide in the area is much greater than that of the rest of the state.

16.0

TARGET: 10.2

The current age-adjusted suicide rate is 16 per 100,000, the goal is to decrease this rate to 10.2 per 100,000 residents

Access to Care

Access to care encompasses a number of things, such as the number of providers and community programs. Increasing access to care can help to decrease the mental health burden in the area.

12

TARGET: 15

Currently, there are 12 community programs to address mental health, the goal is to increase community programs to 15

Community Commons, 2015
WI DHS Community Mental Health Program Certification Directory

GOAL 1 Strengthen data on mental health in Forest, Oneida, and Vilas counties.

Access to mental health data is not only a challenge for local communities but also nationwide. Many barriers to collecting reliable mental health data exist. Some issues include increased stigma and lack of participation in surveys addressing mental health issues and the complexity surrounding mental health, which makes it hard to measure and transfer into statistics. These barriers are magnified at the local level.

Objective

1. By December 31, 2020, one data collection tool related to mental health will be identified and utilized throughout Forest, Oneida and Vilas Counties.

Strategy Examples

Youth Risk Behavior Survey

Department of Aging data systems

Community survey

Additional examples are found in the Resources & Tools Section

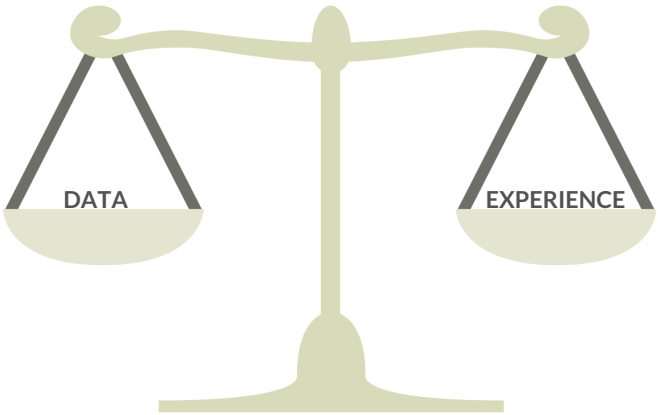
Impacting Health Across the Lifespan

Mental health disorders are a concern for people of all ages, from early childhood through old age. Positive mental health at all ages, allows a person to reach his or her full potential, cope with stresses of life, work productively and have meaningful relationships with others.

Short-term Indicator

Number of tools used to track and monitor data

Balancing making data-informed decisions with community experience and known assets within political and social contexts



GOAL 2

Increase the number of mental health access points to expand the availability of mental health services to Forest, Oneida, and Vilas Counties.

Access to mental health services remains a growing issue for this area. For a large portion of the population living in the northwoods, access to any type of mental health services is inadequate or completely nonexistent. Some identified reasons for the lack of access include the inability to locate providers, stigma, lack of insurance, and denial of a problem that prevents people from seeking treatment.

Objective

1. By December 31, 2020, one new or existing strategy will be implemented, strengthened, or expanded upon to expand the availability of mental health services throughout Forest, Oneida and Vilas Counties.

Strategy Examples

Families and Schools Together-FAST

Facilitate social connectedness and community engagement across the lifespan.

Additional examples are found in the Resources & Tools Section

Mental health benefits legislation

Telemedicine

Behavioral health primary care integration

Increasing Access to Care to Decrease Disparities

Several factors have been linked to mental health, including race and ethnicity, gender, age, income level, education level, sexual orientation, and geographic location. Other social conditions—such as interpersonal, family, community dynamics, housing quality, social support, employment opportunities, and work and school conditions—can also influence mental health risk and outcomes, both positively and negatively. (Healthy People 2020).

Short-term Indicator

Increase in evidence-based programming in the community that supports access to mental health services.

GOAL 3 Decrease Suicide and Depression in Forest, Oneida, and Vilas Counties.

In alignment with the state of Wisconsin's vision of preventing suicide, the area hopes to make a strong commitment to increase the effectiveness of systems and programming that prevent suicide. Currently, suicide is a huge burden and is the 11th leading cause of death and the 2nd leading cause of death when stratified by deaths due to injury. (WI Suicide Prevention Strategy, 2015).

Objective

1. By December 31, 2020, one new or existing strategy will be implemented, strengthened or expanded upon to increase the availability of mental health services throughout Forest, Oneida and Vilas Counties.

Short-term Indicator Rates of Suicide

Strategy Examples

Youth peer mentoring (Sources of Strength)

Trauma-informed approaches to community building

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

Zero Suicide

Additional examples are found in the Resources & Tools Section

Policies to End Health Inequity

Since the range of risks to mental health is wide, responses to them need to be multi-layered and multi-sectoral. Addressing gaps in the community through policies, such as changing regulations for mental health insurance coverage or to increase access to mental health services, is a key to improving and maintaining the mental health of all.

Priority Area: Chronic Disease Prevention and Management

Chronic Disease Snapshot

Adult Tobacco Use

1 in 5 adults use tobacco products

Overweight or Obese

4 in 10 adults are either overweight or obese

Premature Deaths

6 in 100 die prematurely due to chronic diseases

Chronic diseases are defined as illnesses that last a long time, often cannot be cured and most likely result in disabilities later in life (Healthiest Wisconsin, 2020). Prevention starts at a young age through the promotion of a healthy diet and physical activity. Chronic diseases are among the most preventable diseases when risk factors such as tobacco smoking, excessive alcohol use, physical inactivity and an unhealthy diet are minimized.

During the last three years, great strides to improve the overall health and well-being of the community through chronic disease prevention efforts have been made. However, still only 23% of adults reported consuming at least 5 servings of fruits and vegetables daily, and 1 in 5 are not participating in regular physical activity.

What you can do to make a difference.....

Individuals and Communities

Reduce risk factors and aim for a healthy weight through diet and exercise

Speak to your doctor about preventive services or managment of an existing chronic diease

Know your numbers (blood pressure, cholesterol, blood sugar)

Stakeholders and Organizations

Become an active member of the chronic disease coalition in your area

Become a leader and work to advance efforts in the community

Push for health in the workplace

Support healthy school initiatives and other community programs

Long-term Outcome Measures

Reduce the burden of chronic disease in the community by decreasing long term indicators to reflect national averages

The data below combines averages for Forest, Oneida and Vilas Counties. For county-specific data, please visit any of the above counties' health department websites to view the Community Health Assessment.

31%

Obesity Rate

This indictor is important because excess weight may indicate an unhealthy lifestyle and can lead to further health issues

TARGET: 27.5%

191

Cancer Incidence Rate

This indicator is important because cancer is the leading cause of death in Wisconsin and the United States

TARGET: 175

550.4

Heart Disease Mortality Rate

This indicator is important because heart disease is the 2nd leading cause of death only behind cancer in Wisconsin

TARGET: 455

Percentage of adults over the age of 20 with a BMI over 30 (CDC, 2013)
Age-adjusted rate for all invasive cancers per 100,000 persons (DHS WISH, 2009-2013)
Age-adjusted heart disease mortality rate per 100,000 persons(DHS WISH, 2009-2013)

GOAL 1

Evidence-based programming will be selected to promote chronic disease prevention and management.

Chronic disease risk factors are often developed early in life such as: smoking, physical inactivity and an unhealthy diet. Using evidence-based programming can help to reverse these learned behaviors and prevent them from developing in today's youth. By focusing on prevention of chronic disease risk factors, the burden in the community can be reduced.

Impacting Health Across the Lifespan

Promoting chronic disease prevention and management across the lifespan will lead to community members living long healthy lives, which can positively affect our communities and economy.

With improved health:

Children are less likely to miss school, leading to better opportunities for learning

Adults are more likely to be productive and be at work more days

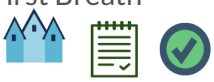
Seniors can keep their independence and remain in their own homes

Objectives

1. By December 31, 2020, decrease tobacco use by 5%.

Strategy Examples

First Breath



Policy development - OTP product placement

Street Smarts

Short-term Indicator

Percent of adults using tobacco products

Additional examples are found in the Resources & Tools Section

2. By December 31, 2020, increase the number of evidence-based programs that support healthy nutrition throughout Forest, Oneida and Vilas Counties.

Strategy Exmaples

Point of decision prompts

Break time for nursing mothers

Farm to school programs

Short-term Indicator

Increase in evidence-based programming in the community that supports healthy nutrition

3. By December 31, 2020, increase the number of evidence-based programs that support physical activity throughout Forest, Oneida and Vilas Counties

Strategy Examples

Work-site wellness programs

Programming for older adults

Physical education minutes in schools

Short-term Indicator

Increase in evidence-based programming in the community that supports physical activity

Additional examples are found in the Resources & Tools Section

GOAL 2

Built environments that support chronic disease prevention and management will be established.

Creating communities that support a safe and healthy place for all residents to work, live and play is critical in the prevention of chronic diseases. Building a community that supports and reinforces healthy behaviors will lead to sustainable change.

Objectives

1. By December 31, 2020, one new or existing environmental strategy will be implemented, strengthened, or expanded upon to support physical activity throughout Forest, Oneida and Vilas Counties.

Strategy Examples

Streetscape design

Bike and pedestrian master plans

Walking school bus

Short-term Indicator

Increases access to exercise opportunities

2. By December 31, 2020, one new or existing environmental strategy will be implemented, strengthened, or expanded upon to support nutrition throughout Forest, Oneida and Vilas Counties.

Strategy Examples

Community gardens (day-cares, schools, nursing homes and schools)

Farmers markets and stands

Health food initiatives in food banks

Short-term Indicator

Decreased rate in reported food insecurity rates

Additional examples are found in the Resources & Tools Section

Impacting Health Equity

The environment consists of everything around us that shapes where we live, work and play. These factors play a large role in both individual and community health. By providing a safe, clean and healthy environment for all, people may thrive and live happy, healthy lives. By addressing barriers in the community such as transportation, access to healthy fruits and vegetables and access to physical activity, everyone can be given the equal opportunity to obtain optimal health free of chronic diseases.

GOAL 3

Policies that promote chronic disease prevention and management.

Developing policies that shape the community to promote healthy lifestyle choices can have the biggest impact on chronic disease prevention and management. Policy work includes passing laws or ordinances at the government or organizational level, which includes local businesses and schools. Policies can greatly influence how we live our day to day lives and the choices we make.

Using Policies to End Health Inequity

Health in all policies is a movement to incorporate making health considerations when developing or reviewing policies. Health is affected by a number of factors beyond what you eat and the medical care you receive. Health can also be affected by the world around you, or the determinants of health, which include social factors, physical environment and economic opportunities.

Social Factors:
Violence
Leadership
Political Influence
Social Support

Physical Environment:
Transportation
Safety
Environmental Quality
Access to Recreational Facilities

Economic Opportunities:
Income
Employment
Education
Housing

Objectives

1. By December 31, 2020, increase the number of policies that support improved nutrition.

Strategy Examples	Short-term Indicator
Business for breastfeeding	Increased number of polices supporting healthy nutrition initiatives
Junk food tax	
School nutrition policies	

2. By December 31, 2020, increase the number of policies that support increased physical activity.

Strategy Examples	Short-term Indicator
Worksite policies	Increased number of polices supporting physical activity in the community
Physical activity school policies	
Zoning regulations for land use policies	

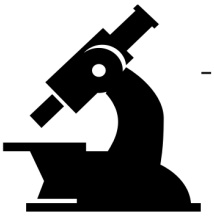
Additional examples are found in the Resources & Tools Section

Other Health Priority Areas

The remaining health focus areas listed below were not selected as the top issues for Forest, Oneida and Vilas Counties' Community Health Improvement Plan but still play a large role in the overall health of the community. Certain focus areas, such as Adequate Appropriate and Safe Food and Nutrition, Physical Activity, and Tobacco Use and Exposure, are naturally intertwined with the chosen focus areas (Alcohol and Other Drug Use, Mental Health, and Chronic Disease) so were not chosen to stand alone. Other focus areas, such as Communicable Disease Prevention and Control, Environmental and Occupational Health, Healthy Human Growth and Development, Injury and Violence Prevention and Oral Health are part of public health and other agencies' framework.

Communicable Disease

Communicable diseases (infectious diseases) are illnesses caused by bacteria, viruses, fungi or parasites. Organisms that are communicable may be transmitted through contact with an infected person, bites from insects or animals, or contact with a contaminated surface or object, such as a doorknob. Communicable disease prevention and control is the cornerstone of public health. Advancements in clean water, refrigeration, and the development of safe, effective vaccines have greatly decreased such threats; however, common diseases still cause outbreaks and new communicable diseases still emerge.



Community Data

1. Over 50% of adults over the age of 65 have had at least one pneumococcal shot

2. 46% of community members reported having done some type of emergency preparedness planning in the past year

Community Strategies

1. Continue emergency preparedness planning

2. Continue promoting disease prevention and surveillance to prevent outbreaks

3. Continue to promote vaccines including both childhood and adult

Environmental & Occupational Health

Environmental and occupational health includes the broad and diverse group of regulatory and educational programs and services needed in every Wisconsin community to prevent, identify and reduce illnesses and injuries resulting from hazards in the natural, built and work environments. More and more clear associations and linkages are emerging to demonstrate the ways human health is affected by the environments where people live and work.

Community Data

1. High rates of ER visits for asthma compared to the state average

2. Giairda is the most common food-borne or water-borne disease in the area.

Community Strategies

1. Continue to provide food and safety licensing and inspection program

2. Increase community knowledge about safe living environments

Healthy Growth & Development

Healthy growth and development requires family-centered, community-based, culturally-competent coordinated care and support throughout the life course during preconception and prenatal periods, infancy, childhood, adolescence and adulthood. Healthy growth and development in early life have a profound effect on health across the lifespan. Research studies over the past decade demonstrated the link between early life events and adult chronic diseases and found that babies born at lower birth weights have an increased risk of developing heart disease, diabetes and high blood pressure in later life. Infants with poor birth outcomes begin life with multiple risk factors that may prevent them from reaching their full health.

Community Data

1. Only 72% of children under two have received all their required immunizations

2. Decreasing rates in the number of females receiving prenatal care in the first trimester

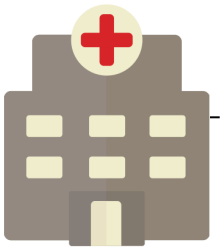
Community Strategies

1. Continue to provide programs to strengthen families

2. Promote the importance of receiving early prenatal care

Injury and Violence Prevention

Injury and violence encompasses a broad array of topics. Unintentional injuries are often referred to as accidents despite being highly preventable. Examples include falls, drowning, motor vehicle crashes, suffocation and poisoning. Intentional injuries include those that were purposely inflicted with the intent to injure or kill someone (including self). Intentional injuries often involve a violent act. Examples include homicide, child maltreatment, sexual assault, bullying and suicide. Injuries and violence are not discriminatory; they occur in all ages, races and socioeconomic classes. However, we do know that some groups are affected more severely.



Community Data

1. Falls are the number one reason community members visit the ER

2. High rates of motor vehicle fatalities in the area compared to the state of Wisconsin rates

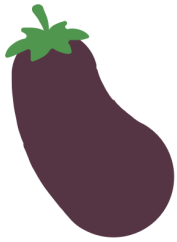
Community Strategies

1. Strengthen partnerships and support efforts of other agencies

2. Continue Child Death Review Teams in the area

Nutrition and Healthy Foods

As established in the U.S. Dietary Guidelines, good nutrition includes meeting nutrient recommendations yet keeping calories under control. It includes safe handling, preparation, serving and storage of foods and beverages. It also includes ready and appropriate access to nutritious foods throughout the year for all individuals and families in Wisconsin communities. Any nutrition policy is good health policy. Healthy eating is a staple for a good life. Adequate and appropriate nutrition is a cornerstone to prevent chronic disease and promote vibrant health.



Community Data

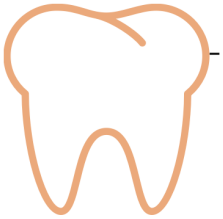
1. High food insecurity rates in children
2. Community members rarely eat enough fruits and vegetables because of cost and availability

Community Strategies

1. Increase and support breastfeeding-friendly practices
2. Continue garden-based nutrition activities through LEAN

Oral Health

Oral health is integral to general health, and people cannot be healthy without good oral health. Good oral health means being free of mouth pain, tooth decay, tooth loss, oral and throat cancer, oral sores, birth defects, gum (periodontal) disease and other diseases that affect the mouth and surrounding structures. Many systemic diseases may initially start with and be identified through oral symptoms.



Community Data

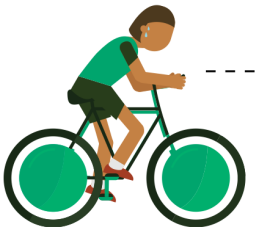
1. Many community members lack dental insurance or the cost of care is too expensive
2. The area is considered a federally-designated health professional storage area, however safety net clinics are located in Forest, Oneida and Vilas County

Community Strategies

1. Continue to support the Northwoods Dental Project
2. Increase access to dental care for all across the lifespan

Physical Activity

Physical activity means any bodily activity that enhances or maintains physical fitness and overall health. Public health strategies focus on environmental and policy changes (e.g., active community environment initiatives, urban planning, safety enforcement, trails and sidewalks) to reach large sections of the population. The health benefits of physical activity have been studied extensively. Physical activity is a preventive factor for premature death and a number of chronic diseases.



Community Data

1. 1 in 3 adults are considered obese in the area
2. 50% of community members reported using area walking trails regularly

Community Strategies

1. Increase access to affordable, low cost physical activity
2. Promote biking and walking-friendly communities

Reproductive & Sexual Health

Reproductive and sexual health includes the factors that affect the physical, emotional, mental and social well-being related to reproduction and sexuality across the lifespan and is a core component of individual and community public health. Supportive community attitudes toward healthy sexuality, positive social and economic environments, and constructive public policies are as important as access to education and services in fostering reproductive and sexual health. Supportive community attitudes recognize that sexuality is normal. Unintended pregnancies and sexually transmitted diseases, including HIV infections, result in tremendous health and economic consequences for individuals and society.

Community Data

1. High teen birth rates compared to the state average of Wisconsin

2. High rates of chlamydia in the area

Community Strategies

1. Promote the importance of reproductive health throughout the entire lifespan

2. Promote preventable health screenings

Tobacco Use & Exposure

Eliminating tobacco use and exposure means improving health by preventing tobacco abuse, promoting tobacco dependence treatment, protecting all people from exposure to secondhand smoke, and identifying and eliminating tobacco-related disparities. This is accomplished by partnering with state and local leaders to implement a research-based comprehensive tobacco prevention and control plan. Tobacco continues to be a devastating health and economic burden on Wisconsin. Each year, 8,000 people in Wisconsin die from tobacco-related illnesses. Tobacco use is the single most preventable cause of death and disease in the United States.

Community Data

1. High rate of retailers selling tobacco to minors

2. About 21% of the community members in the area use tobacco products.

Community Strategies

1. Work to develop policies that limit tobacco exposure and expand to include OTP

2. Continue to strengthen the tobacco-free coalition and the work being done in the community

Forest, Oneida and Vilas Counties' Community Health Improvement Plan

CHIP Committee and Collaborating Partners

A thank you is extended to all who worked tirelessly on improving health within the community. Completing an assessment and improvement plan of this scope could not occur without the assistance of many individuals. Forest, Oneida and Vilas County Health Departments along with Ministry Health Care acknowledge the assistance of the Division of Public Health Northern Region, UW-Extension office and individuals who took time from their busy schedules to participate in the community needs assessment and in the development of the Community Health Improvement Plan.

Community Health Improvement Planning Committee

Jill Krueger	*Forest County Health Department*
Linda Conlon	*Oneida County Health Department*
Gina Egan	*Vilas County Health Department*
Julie Hladky	*Ministry Health Care*
Sara Richie	*UW - Extension - Oneida County*
Laurel Dreger	*Vilas County Health Department*
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Collaborating Partners

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Dawn Gapko
Sue Kirby
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Kadie Montgomery
Jason Pertile
Cory Dart
Jenny Felty

Other Participating Organizations

LEAN Coalition
AODA Coalition
CAN Coalition
Mental Health Inter-agency Coalition
Nicolet College
ADRC of Forest, Oneida and Vilas Counties
UW- Extension
YMCA of the Northwoods
Northland Pines School District
Office on Aging; Forest, Oneida and Vilas Counties
Community Coalition of Forest County
Northwoods United Way
Positive Alternatives Coalition
Northwoods Coalition North Region
Marshfield Clinic

Forest, Oneida and Vilas Counties' Community Health Improvement Plan

For the Coalition Resources and Tools section, please visit any one of the three counties' websites:

http://forestcountypublichealth.org/

http://oneidacountypublichealth.org/

http://www.vilaspublichealth.com/

Coalition Resources & Tools

Overarching Goals

Health across the Lifespan

Goal 1: Implement strategies of the CHIP focusing on residents of all ages

Objective: By December 31, 2020, one new or existing strategy will be implemented, strengthened or expanded on from each health priority area focusing on each priority group- youth, middle age or community and the aging.

Health Equity and Socioeconomic and Educational Determinants

Goal 1: Increase Health Literacy

Objective: By December 31, 2020, one new or existing strategy will be implemented, strengthened or expanded on that will increase the dissemination or use of evidence-based health literacy practices and interventions.

Goal 2: Improve Health Considerations in Policy Development

Objective: By December 31, 2020, one new or existing strategy will be implemented, strengthened or expanded on to increase health consideration during policy development to eliminate health disparities.

Access to Care

Goal 1: Strengthen Data Collection

Objective: By December 31, 2020, identify two data collection tools to be utilized annually to assess access to care in Forest, Oneida and Vilas counties.

Goal 2: Reduce the Barriers to Health Care Services

Objective: By December 30, 2020, one new or existing strategy will be implemented, strengthened or expanded on to increase access to reliable transportation in the counties of Forest, Oneida and Vilas.

Alcohol and Other Drug Abuse

Goal 1: Strengthen data on AODA in Forest, Oneida, and Vilas counties.

Objective: By December 31, 2020, two data collection tools will be identified and utilized biennially (every two years) on alcohol, and other drug use throughout Forest, Oneida, and Vilas counties.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Youth Risk Behavior Survey	School-based		Likely
Community Survey	Community		Likely
Tri-Ethnic Youth Survey	Community		Likely
Department of Aging Data Systems	Older adults		Likely

Goal 2: Increase access to AODA services and programs in Forest, Oneida and Vilas Counties.

Objective: Identify and share current AODA services and programs in each county and develop a plan to update at least annually by December 31, 2020.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Utilize 211	Community		
Create and maintain electronic database	Community		
Brochures, Website, social media	Community		
Explore Apps	Community		

Objective: By December 31, 2020, one new or existing strategy will be implemented, strengthened or expanded upon to address gaps in AODA services.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Alcohol screening and brief intervention	School-based & Health care	Scientifically supported	No impact likely
Standardized referral systems	Health care		
Strengthen Teen Courts/Restorative Justice programs	School-based & Community		
Families and Schools Together – FAST	School-based	Scientifically supported	Likely
Early childhood home visitation programs	Community	Scientifically supported	Likely
Functional Family Therapy – FFT	Community	Scientifically supported	No impact likely
Wellness Courts (Drug Courts)	School-based	Scientifically supported	No impact likely
Wrap around services: drug endangered children, Coordinated Service Teams	Community	Some evidence	Likely
Brief Intervention and Treatment for Elders	Older adults	Scientifically supported	
Prevention and Management of Alcohol Problems in Older Adults	Older adults	Scientifically supported	

Goal 3: Decrease alcohol and drug abuse in Forest, Oneida and Vilas counties.

Objective: By December 31, 2020, one new or existing strategy will be implemented, strengthened or expanded upon to decrease alcohol and drug abuse in each sector.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Mass media campaigns against underage drinking and binge drinking	School-based	Expert opinion	Likely to increase disparities
Mentoring programs: delinquency	School-based	Scientifically supported	Likely
Universal school-based programs: alcohol misuse and impaired driving	School-based	Some evidence	No impact likely
Prescription drug monitoring programs	Health care	Some evidence	Likely to increase disparities
Proper drug disposal programs	Community	Expert opinion	No impact likely
Multi-component community interventions against alcohol-impaired driving	Community	Scientifically supported	No impact likely
Early childhood home visitation programs	Community	Scientifically supported	Likely
Group-based parenting programs to build resiliency	Community	Scientifically supported	Likely
Naloxone access	Health care	Some evidence	Likely

Objective: By December 31, 2020, implement one policy to impact alcohol and drug use in Forest, Oneida and Vilas Counties.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Social Host ordinances	Community	Expert opinion	No impact likely
Public alcohol availability restrictions	Community	Expert opinion	
Alcohol outlet density	Community	Scientifically supported	No impact likely
Alcohol excise tax	Community	Scientifically supported	No impact likely
Enforcement of underage drinking laws- Alcohol Compliance Checks	Community	Scientifically supported	
Tobacco and other products-ordinances or laws	Community	Scientifically supported	Likely
School review of Human Growth and Development Curriculum per state statute	School-based		

Mental Health

Goal 1: Strengthen data on mental health in Forest, Oneida and Vilas counties

Objective: By December 31, 2020, one data collection tool related to mental health will be identified throughout Forest, Oneida and Vilas counties.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Youth Risk Behavior Survey	School-based		
Community Survey	Community		
Behavioral Risk Factor Surveillance System	Community		
Department of Aging Data Systems	Older adults		

Goal 2: Increase the number of mental health access points to expand the availability of mental health services.

Objective: By December 31, 2020, one new or existing strategy will be implemented, strengthened, or expanded upon to expand the availability of mental health services throughout Forest, Oneida and Vilas counties.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Families and Schools Together-FAST	School-based	Scientifically supported	Likely
Early childhood home visiting programs	Community	Scientifically supported	Likely
Text-message based health interventions	Health care	Some evidence	
Mental health benefits legislation	Community	Scientifically supported	Likely
Healthy Families America-HFA	Community	Some evidence	Likely
Strengthening Families	Community		

Facilitate social connectedness and community engagement across the lifespan	Community		
Telemedicine	Health care	Scientifically supported	Likely
Telemental health	Health care	Some evidence	Likely
Behavioral health primary care integration	Health care	Scientifically supported	Likely
Cell-phone based support programs	Health care	Some evidence	No impact likely
Functional Family Therapy-FFT	Community	Scientifically supported	No Impact likely

Goal 3: Decrease suicide and depression in Forest, Oneida and Vilas Counties.

Objective: By December 31, 2020, one new or existing strategy will be implemented, strengthened or expanded upon to expand the availability of mental health services throughout Forest, Oneida and Vilas counties.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Trauma-informed approaches to community building	Community	Scientifically supported	Likely
Activity programs for older adults	Older adults	Scientifically supported	Likely
Screening tools	Health care	Some evidence	
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	Older adults	Scientifically supported	Likely
Zero Suicide	Health care	Scientifically supported	Likely
Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)	Older adults	Scientifically supported	No Impact likely

Community arts program	Community	Some evidence	Likely
Community centers	Community	Expert opinion	
Intergenerational programs/communities	Community	Expert opinion	
Intergenerational communities	Community	Scientifically supported	No impact likely
Promote positive early childhood development, including positive parenting and violence-free homes	Community	Some evidence	Likely
Youth peer mentoring	School-based	Scientifically supported	Likely
Outdoor experiential education & wilderness therapy	Community	Some evidence	No impact likely

Chronic Disease

Goal 1: Evidence-based programming will be selected to promote chronic disease prevention and management.

Objective: By December 31, 2020, decrease tobacco use by 3%.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
WI Wins	Community		
First Breath	Community	Scientifically supported	
Policy development (product placement and OTP)	Community	Some evidence	No impact likely
CEASE program	Community		
Strengthening Families	Community		
Enforce preexisting laws	Community		
Street Smarts	School-based		

Objective: By December 31, 2020, one new or existing strategy will be implemented, strengthened or expanded programs that support physical activity.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Worksite wellness programs	Community		
Programming for older adults	Older adults	Scientifically supported	No impact likely
Community fitness programs	Community	Scientifically supported	
Prescriptions for physical activity	Health care	Scientifically supported	No impact likely
Physical education minutes in schools	School-based	Scientifically supported	No impact likely

Objective: By December 31, 2020 , one new or existing strategy will be implemented, strengthened or expanded programs that support healthy nutrition.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Point of decision prompts or other grocery store programs	Community	Some evidence	No impact likely
Farm to School programs	School-based	Some evidence	No impact likely
Breastfeeding Childcare Centers and other initiatives	Community	Scientifically supported	Likely
Nutrition prescriptions	Health care	Expert opinion	No impact likely

Goal 2: Built environments that support chronic disease prevention and management will be established.

Objective: By December 31, 2020, one new or existing environmental strategy will be implemented, strengthened or expanded programs that support physical activity.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Walking school bus	School-based	Scientifically supported	No impact likely
Safe routes to school	School-based	Scientifically supported	No impact likely
Bike and pedestrian master plans	Community	Some evidence	No impact likely
Streetscape design	Community	Scientifically supported	No impact likely
Green space and parks	Community	Some evidence	Likely

Objective: By December 31, 2020, one new or existing environmental strategy will be implemented, strengthened or expanded programs that support improved nutrition.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
Community gardens (daycares, schools, and nursing homes)	Community/ School-based	Some evidence	No impact likely
Access to farmers markets and stands access	Community	Some evidence	No impact likely
Healthy food initiatives in food banks	Community	Some evidence	Likely
Community Kitchens	Community	Expert opinion	No impact likely

Goal 3: Policies that promote chronic disease prevention and management.

Objective: By December 31st, 2020, increase the number of policies that support improved nutrition.

Strategy Examples

Strategy	Focus	Evidence	Health Equity Impact
School nutrition policies	School-based	Scientifically supported	Likely
Business Case for breastfeeding	Community	Scientifically supported	Likely
Vending machine Tax	Community	Some evidence	Likely
Sugar-sweetened beverage tax	Community	Some evidence	Likely

Objective: By December 31, 2020, increase the number of policies that support increased physical activity.

Strategy Examples

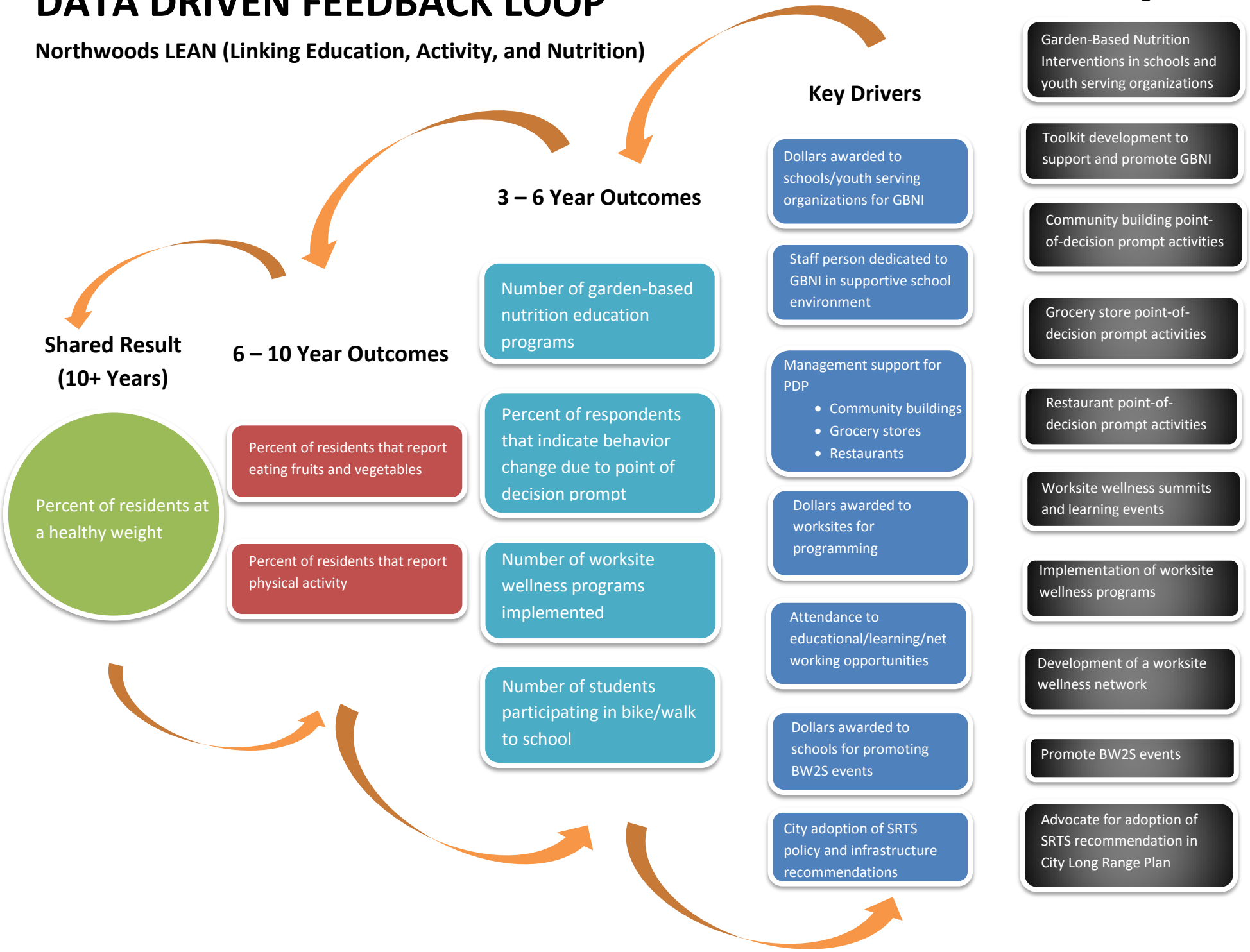
Strategy	Focus	Evidence	Health Equity Impact
Worksite policies	Community	Scientifically supported	
Physical activity school policies	School-based	Scientifically supported	
Zoning regulations for land use policies	Community	Scientifically supported	No impact likely

The following sites provide a wide variety of additional evidence –based strategies in not only the three priority areas but in all areas of health and community improvement.

- CDC Community Health Improvement Navigator
  - http://www.cdc.gov/CHInav/database/
- County Health rankings and Roadmaps: What Works for Health
  - http://www.countyhealthrankings.org/policies
- The Community Guide
  - http://thecommunityguide.org/index.html
- National Registry of Evidence-based Programs and Practices
  - http://www.samhsa.gov/nrepp
- What Works for Health: Policies and Program to Improve Wisconsin's Health
  - http://whatworksforhealth.wisc.edu/
- What Works for Health – Rural Specific Approaches
  - http://www.countyhealthrankings.org/node/35670

DATA DRIVEN FEEDBACK LOOP

Northwoods LEAN (Linking Education, Activity, and Nutrition)



CADCA Strategy	Local Campaign	Audience	Responsible Party	Timeline	Status	Evaluation Indicators	Funding Sources	Outcome
Providing Information								
Educational presentations, workshops or seminars or other presentations of data								
Providing Support								
Creating opportunities to support people to participate in activities that reduce risk or enhance protection								
Reducing Barriers/Enhancing Access								
Improving systems and processes to increase the ease, ability and opportunity to utilize those systems and services								
Changing Consequences								
Increasing or decreasing the probability of a specific behavior that reduces risk or enhances								

protection by altering the consequences for performing that behavior								
Enhancing Skills								
Workshops, seminars or other activities designed to increase the skills of participants, members and staff needed to achieve population level outcomes								
Providing Support								
Creating opportunities to support people to participate in activities that reduce risk or enhance protection								
Reducing Barriers/ Enhancing Access								
Improving systems and processes to increase the ease, ability and opportunity to utilize those systems and services								
Changing Consequences								

Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for								
Physical Design								
Changing the physical design or structure of the environment to reduce risk or enhance protection								
Changing Policy								
Formal change in written procedures, by-laws, proclamations, rules, or laws within written documentation and/or voting procedures								

Strategy	
Start Date – End Date:	
Overarching Goal(s)	
Objectives:	

Objective:					
Activities	**Timeframe**	**Person(s) Responsible**	**Resources Needed (Money, Staff, Volunteers, etc.)**	**Measures/Indicators of success**	**How you will measure success**

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Best Practices in Planning Community Health Improvement Initiatives

❖ **Involve subject matter experts and stakeholders – including those directly affected.**

❖ **Focus on prevention:**

- ➢ Do a root cause analysis to get upstream and see where there are opportunities to intervene and have an impact. Examples:
  - Maybe people are not physically active because there is not a free, safe location to do so in winter – so work with schools to make gyms available to the public in the evening.
  - Maybe older adults' depression is in part due to social isolation – so implement/support social activity programs for seniors.

- ➢ Target your efforts. Rather than trying to reach everyone in the community, focus on one group. Look at who is most affected by the problem/issue. A helpful resource:
  - Wisconsin Health Disparities Report details which subpopulations are most affected for all 12 health focus areas in the state health plan.

❖ **Find evidence-based strategies:**

We are more likely to achieve our goals when the strategies we choose have been shown to be evidence-based or "promising practices." Innovation can lead to exciting successes, but often the tried and true approach is more fruitful and cost-efficient. There are great resources for finding evidence-based strategies:

- What Works For Health
- SAMSA (Substance Abuse and Mental Health Services Administration)
- National Prevention Strategy

❖ **Establish measurable goals:**

- ➢ Be clear about what you what to accomplish; spell out what success will look like.
- ➢ Using a logic model can help to map out short term, medium term, and long-term goals.
- ➢ Create SMART objectives (Specific, Measurable, Achievable, Realistic, Time-Oriented)
- ➢ Track and report actual results at least annually.

Examples:

- By 12/31/19, decrease the percent of adults who drink excessively in this county from 22% to 20%.
- By 12/31/16, maintain at 80% the percent of QPR trainees who report an increased ability to recognize at risk individuals.
- By 12/31/17, increase the number of community sectors receiving QPR training session from 1 to 4.

❖ **Have a mix of approaches:**

Prevention strategies can range from one-on-one education to community-wide or statewide policy change. Individual education or awareness approaches are relatively easy to implement but will have less broad and lasting impact. Policy, system, and environmental change are the most powerful tools to change health outcomes in a community but they can take more time and be more difficult to achieve. A mix is ideal.

Individual education/awareness:

- Celebrate national nutrition month
- Implement a mass media campaign about alcohol
- Hold a health screening
- Hold free breastfeeding classes for new moms
- Distribute a mental health services resource guide

Policy, system or environmental change:

- Add fruits and vegetables to the a la carte options in schools
- Implement municipal policies to address alcohol misuse such as social host ordinance
- Implement a healthy bending machines policy to offer healthy snacks at affordable prices
- Implement the WHO 10 Steps to Successful Breastfeeding a become a Baby Friendly Hospital
- Implement telehealth mental health services.

Aligning Approaches and Spheres of Influence				
APPROACHES	**SPHERES OF INFLUENCE**			
	Individuals, Families, Social Networks	**Organizations & Institutions**	**Community (neighborhoods, municipalities, counties or state)**	**Social Determinants of Health**
Crosscutting Equity Considerations for all approaches and spheres of influence	• Are there communities experiencing inequities that need to be prioritized for efforts? • How is engagement and capacity building occurring with communities affected by inequity to shape efforts in the short and long term? • How are coalitions and alliances fostered to build power and convening groups and individuals for broader goals and impact? • How are structures, institutions, and policies that support/inhibit equity being addressed? • How are conditions of power being addressed?			
Programs Activities, including direct education, focused on increasing knowledge about health issues and/or promoting healthy behaviors or conditions.				
Systems Change Change that impacts social norms of an organization, institution, or system; may include a policy or environmental change strategy. Policies are often the driving force behind systems change.				
Environmental Change Physical aspects of the environment that support healthy or discourage unhealthy behaviors and conditions.				
Policy Policies, rules, ordinances and laws that support healthy practices, actions and behaviors.				
Structure Change	• What capacities do your coalitions and leaders need to grow to increase your impact? • How do the levels of influence interact to build healthy communities? • Is a health lens used to inform broad decision making decision-making? • To what extent to cross-sector collaboration occur (public, private, content specific)? • To what extent is a culture of health supported?			

Endorsement of the Plan

What Does the Endorsement Mean?

As an **individual** it means you are agreeing to support the three health focus areas and are willing to start actions and activities to improve your personal health and/or you are willing to participate on one of the groups or coalitions that are identifying actions and activities for all residents of Forest, Oneida and Vilas Counties.

As an **organization** it means you are willing to support the three health focus areas by putting the link on your website and informing your workforce of the three health focus areas. It could also mean that you are willing to support and act by putting forward resources within your organization for improvement of your workforce and/or put forward resources and time from your organization to engage in the groups or coalitions working on actions and activities for all residents of Forest, Oneida and Vilas Counties.

Instructions: To endorse the plan, you have two options: 1) Save this form as a word document, fill it out and email it as an attachment to coestreich@co.oneida.wi.us

Or 2) Print out this form, fill it out and fax it to 715-369-6112

Note: Your endorsement may be publicly acknowledged with health plan documents.

I am endorsing the health plan as an:

□ Individual
□ Organization

2. Your full name or name of organization / group:

3. What type of sector(s) best describes your organization?
□ Advocacy organization
□ Agriculture and food
□ American Indian Tribe
□ Business, labor, finance, commerce
□ Built environments
□ Civic organization, civic society
□ Community-based organization
□ Education
□ Elected official (state or local)

□ Energy and climate
□ Faith community
□ Health care organizations and hospitals
□ Health department (state or local)
□ Housing / building safety
□ Human services
□ Justice and law enforcement
□ Laboratory
□ Natural resources
□ Professional society and organization
□ Transportation
□ Urban / rural planning, land use
□ Veterinary
□ Waste management
□ Other Specify:

4. I will provide a link on my organization's website to the health plan
□ Yes
□ No

5. Contact Information (Please Print)
Contact Name: _____
Credentials (if applicable): _____
Organization (if applicable):

Position/Title (if applicable):

Mailing Address:

Telephone No. _____ Fax No. _____
E-mail:

Website:

6. Which focus areas will you and your organization work on to help accomplish the goals of *the* health plan?

□ Alcohol & Other Drug Abuse
□ Mental Health
□ Chronic Disease