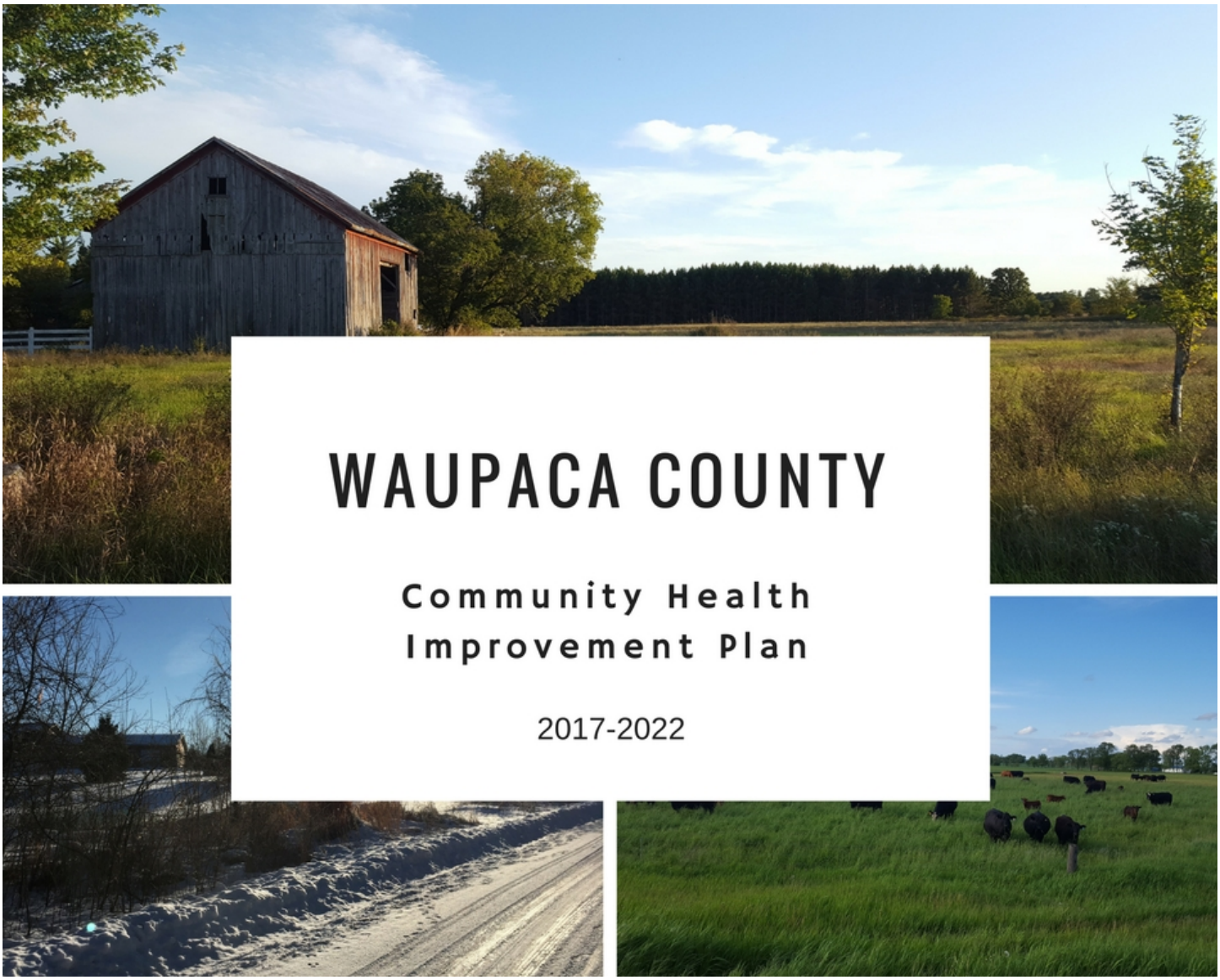


WAUPACA COUNTY

Community Health Improvement Plan

2017-2022

In collaboration with:

The CWHP Central Wisconsin Health Partnership
"Wellness with health in mind"

2017 Waupaca County

Community Health Improvement Plan

Table of Contents

Letter of Invitation

The places that we live, learn, work, and play contribute to our health and well-being. Our Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) look to identify issues, and offer strategies on ways to improve the health in Waupaca County. The health and vitality of a community are more greatly impacted when partners and stakeholders collaborate to identify and address the health needs of a community. Our goal is to create a path that engages all in the movement towards improved health.

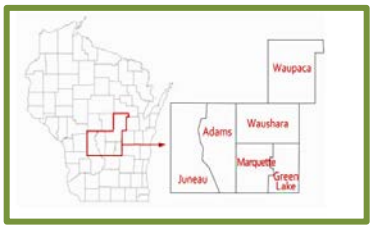
I hope you will take time to review the report and support a movement forward to become the healthiest county.

Yours in Good Health,

Acknowledgements

The Central Wisconsin Health Partnership

In order to better meet the needs of the community, the Waupaca County Community Health Improvement Plan was developed in collaboration with the Central Wisconsin Health Partnership. The Central Wisconsin Health Partnership (CWHP) is a consortium covering a six-county region including Adams, Green Lake, Juneau, Marquette, Waupaca, and Waushara Counties. The partnership includes county human services and public health departments, a Federally Qualified Health Center and other interested healthcare advocates and providers in the region.



The partnership worked together to complete the 2016 Community Health Assessment and as a result, identified key areas that needed improvement in all six counties. Addressing these health priority areas in a regional Community Health Improvement Plan allows for better sharing of ideas and resources to determine best practices for improving the health of the individual counties and the entire region.

Our Community Partners

Collaboration with community members, along with the Central Wisconsin Health Partnership, is vital for the development and implementation of the Community Health Improvement Plan. We would like to thank all our partners for attending meetings, providing data, completing surveys, and sharing their concerns and ideas on how we can improve the health of Waupaca County. This document would not be complete without the input we received. We thank you for the many different parts you have played in the process and look forward to future partnerships as we begin to implement this plan and work to make our communities a healthier place to live, work, and play.

Steering Committee

- Kathy Munsey, Green Lake County Health Officer
- Julia McCarroll, Green Lake County Health Educator
- Patti Wohlfeil, Waushara County Health Officer
- Brenna Root, Waushara County Health Educator
- Sarah Grossuesch, Adams County Health Officer
- Jamie Schenk, Marquette County Health Officer
- Lauren Calnin, Marquette County Health Educator
- Jed Wohlt, Waupaca County Health Officer
- Terry Harrington, Waupaca County Preparedness Program Specialist
- Barb Theis, Juneau County Health Officer
- Alyson Horkan, Juneau County Public Health Nurse

Other Community Partners

- ThedaCare
- Family Health La Clinica

Executive Summary

Where we live, learn, work, and play affects our health. Understanding the determinants of health, identifying best practices and creating partnerships to implement strategies to combat health related problems is a core function of public health. Every five years, local health departments are required to assess the health needs of the county they serve and develop a plan to address those needs. The 2017-2022 Community Health Improvement Plan provides the framework for improving the health of Waupaca County. It also helps to create a shared vision between the Health Department and community partners so that together we can create positive, measureable change in our communities.

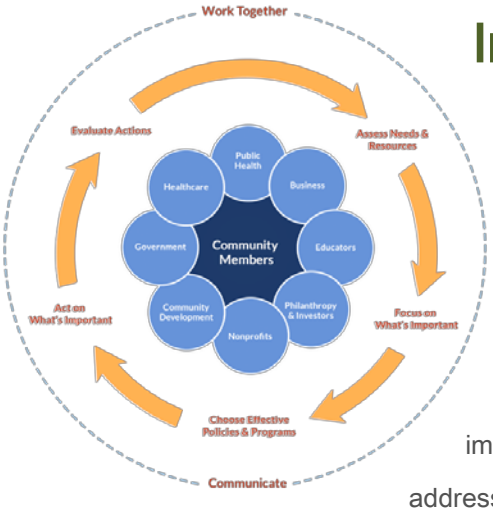
This plan addresses the three priority areas that were identified as a result of the 2017 Regional Community Health Assessment: Alcohol and Other Drug Abuse, Mental Health and Chronic Disease Prevention and Management. The key findings of the Community Health Assessment will be outlined in this document and the full assessment can be found at:

http://www.co.waupaca.wi.us/2017CHA%20Waupaca%20County.pdf

The 2017-2022 Community Health Improvement Plan is unique in the fact that it was written in collaboration with the Central Wisconsin Health Partnership (CWHP) to identify regional goals and objectives. Mental health and alcohol and other drug abuse (AODA) are top health concerns for many of the neighboring rural counties, which drives the need for change beyond the community and county levels. As a result, the goals and objectives under the Mental Health and AODA priority areas will be addressed regionally through the work of the CWHP as well as locally by community partners and coalitions. The county specific priority area, Chronic Disease Prevention and Management, will be addressed primarily at the county level through the Health Department and community partners and organizations.

The goals and objectives listed under each priority area were strategically chosen to align with the State of Wisconsin Health Improvement Plan. A wide range of strategies to improve health outcomes is included for each priority area to give community partners the opportunity to implement the strategies that will work best for their organization. Many of these strategies also align with those identified in the State Health Improvement Plan. By aligning with the state plan, we will not only help improve the health of our county, but we will also be able to help advance the efforts being made to make Wisconsin the healthiest state to live.

Community Health Improvement Process



Since 1993, Wisconsin State Statutes have required communities throughout Wisconsin to develop and implement local health plans to address health conditions affecting their residents. This process has been referred to as the "Community Health Improvement Process. The community health improvement process has two major phases: the community health assessment and the community health improvement plan. These two processes work together to assess the unique needs of the community and allows communities to work collaboratively to address the identified health needs.

CHA Timeline

August 2015- Central Wisconsin Health and Economic Summit

-March 2016 Health Surveys, key informant interviews, focus groups conducted

April 2016- Secondary data gathering, further community outreach

-May 2016 Primary and secondary data analysis, review additional data, consolidate data

June/July 2016- Town forums, listening sessions, begin draft of CHA

-August 2016 Finalizing the document

October 2016- Complete CHA, present to coalitions and Boards of Health

The Take Action Cycle

The six counties in the Central Wisconsin Health Partnership began the community health improvement process in 2015 when the Community Health Assessment was started. The overall health improvement planning process follows the *Wisconsin Guidebook on Improving Health of Local Communities*. This framework is built on the *Take Action Cycle Model* developed by County Health Rankings and Roadmaps. The following information outlines each step of the process.

Assess Needs and Resources

The Community Health Assessment is a collaborative process of systematically collecting and analyzing health data to examine the health status of the community as well as identify priority health concerns for the population. The 2016

Community Health Assessment was completed in collaboration with the Central Wisconsin Health Partnership as a regional assessment with county specific data. The data for the health assessment was drawn from multiple primary data sources such as communicable disease reports, death records, local provider numbers, hospital admissions, and youth risk behavior studies. Secondary data from sources such as County Health Rankings, Wisconsin Department of Health and Human Services, and the U.S. Census Bureau were analyzed as well. This data, along with community input gathered from focus groups, surveys, and key informant interviews, was used to determine the health needs of the county.

Focus on What's Important

After gathering the community health data, the Community Health Assessment steering committee identified three health priorities that would be the focus of the Community Health Improvement Plan. Community and stakeholder feedback that was collected during key informant interviews and focus groups was the driving component used to determine which health concerns were a priority. The priorities were then narrowed down further by using four different criteria to assess community capacity and readiness to impact the identified priority. Those criteria included:

1. The magnitude of the problem
2. The severity of the problem
3. If there was a high need among a vulnerable population (health equity)
4. The Community's capacity and/or willingness to act on the problem

The steering committee ultimately decided on three health priorities: mental health, alcohol and other drug abuse, and chronic disease prevention. More about these focus areas can be found on page 12.

Choose Effective Policies and Programs

Effective, evidence-based or best practice strategies are instrumental in meeting the identified goals and objectives for each priority area. The steering committee worked to identify a variety of potential strategies to align with each goal and objective for the three priority areas. The steering committee used a variety of different databases such as "What Works for Health" and "The Community Guide" to search for evidence based and best practice strategies for the different priority areas. The final selection of the potential strategies included in this document was based on numerous factors such as evidence, community resources, health equity and community input and readiness. More information about the chosen strategies can be found under the Goal Page for each priority area.

Act on What's Important

Each of the six CWHP counties will be responsible for determining what program and policy implementation looks like in their own county. Although there are regional goals and objectives that the group will work on collaboratively, each county has unique strengths and challenges that must be considered when implementing health improvement strategies. Each county, along with their coalitions and community members, will define what they want to achieve under each priority area and how they will achieve it. A work plan template will be used for each county to track program implementation and progress towards goals and objectives. The sample work plan template can be found in Appendix A.

Evaluate Action

For each different priority health area, the CHIP Steering Committee has identified both long and short-term outcome indicators, which will serve as the primary measures on which to base program evaluation. These short and long-term indictors are directly related to the selected strategies listed under each priority area. Due to the differences in program implementation in each county, evaluation will also look slightly different. Evaluation tools will be developed for regional efforts and stakeholders will be updated regularly on progress.

Work Together

Everyone has a key role to play when it comes to improving the health of a community. As part of the community health improvement process, a variety of community members and key stakeholder agencies were engaged throughout the community health assessment and improvement planning process.

Community member input was gathered in the form of community surveys and key informant interviews during the "Assessing Needs and Resources Phase" of the Take Action Cycle and again in the "Choose Effective Policies and Programs" phase. Community input was the primary driver for determining the health priorities and strategies detailed in this document. Key policy makers, including members of the Waupaca County Board of Health, Representative Joan Ballweg, and Senator Luther Olsen were also engaged and updated throughout the health assessment and improvement planning process. Community Health Assessment findings were shared with these key policy makers and they were asked to support health improvement efforts at the local and state levels. Finally, it is the hope of the Central Wisconsin Health Partnership group that by working together on developing a regional health improvement plan, coordinated efforts can be established to improve health across county lines in Central Wisconsin.

Communicate

Communication is an ongoing part of the take action cycle and is vital to ensuring that key stakeholders and policy makers are kept up to date on important updates related to the community health improvement process and progress toward goals and objectives. Communication to partners and stakeholders occurs through a variety of different outlets:

- Partners are updated at bi-monthly Coalition meetings. Partners who are unable to attend meetings in person receive meeting minutes via email. Additionally, work plans will be updated and shared with coalition members to track progress towards goals and objectives.
- The final CHIP and work plans will be shared with community members via the County and Coalition websites, through social media, and at community events.

2017 Community Health Assessment Key Findings

The following sections provide a review of the key findings from the 2017 Community Health Assessment. The full Waupaca County report can be found on the Waupaca County Public Health website.

Demographics and Determinants of Health

Waupaca County is located in Central Wisconsin and serves as a home to 51,533 residents, according to the 2016 Census Bureau Estimates. The County spans 748 square miles, 65% of which is considered rural. The varying demographic and socioeconomic status of Waupaca County residents contributes to health vulnerabilities and disparities in certain populations, including the following:

Age Composition

The population in Waupaca and the other CWHP counties is aging. Currently, 20% of Waupaca County residents are over age 65. That number is expected to increase to 27% by the year 2030. With an aging population comes a unique set of challenges, such as social isolation and shifting health needs of the community.

Average Annual Wage

$10,205

The average wage for those in CWHP counties in $35,000 annually. This is over $10,000 dollars less than the Wisconsin average. Having a lower income is linked to poorer health outcomes.

Educational Attainment

CWHP counties have a lower number of adults with any form of formal education past high school. This measure is important to consider as the relationship between higher education and improved health outcomes is well known.

Access to Care

Access to healthcare services is critical to good health outcomes. Access to care includes measures such as uninsured rates and local care options. The majority of CWHP counties all have fewer health, dental, and mental health care providers per 1,000 people when compared to the state average.

2017 Community Health Assessment Key Findings

The following sections provides a review of the key findings from the 2017 Community Health Assessment. The full Waupaca County report can be found on the Waupaca County Public Health website.

CWHP Health Snapshot

ADULT SMOKING RATE

27%

Tobacco use is linked to a variety of chronic diseases.The smoking rate among CWHP adults is higher than the Wisconsin state average.

HEART DISEASE

#1

Heart disease is the leading cause of death in all CWHP counties.

EXCESSIVE DRINKING

23%

Similar to the state average, CWHP counties have an adult excessive drinking rate that nearly doubles that of top U.S. performers.

OBESITY RATES

31%

The average adult obesity rate for the six CWHP counties, which is higher than the state average at 29%.

Waupaca County Key Informant Interview Results

Community Strengths

- Tight-knit communities
- Local support groups
- Strong law enforcement presence
- Mobile crisis units
- Jail wellness and recidivism reduction programs
- Strong ADRC and Health and Human Services programs
- Safe Routes to School programs
- Local food pantries available
- Financial assistance program with Thedacare.

Community Challenges

- Limited mental health providers
- Limited options for AODA treatment
- Limited services at rural health clinics
- Marketplace offers only Dean Care insurance
- Increasing issues with elementary school kids acting out
- Tobacco use
- Lacking partnerships between law enforcement, schools, and the hospital system
- Lack of basic life skills
- Limited public transportation
- High free and reduced lunch usage
- Significant increase in FoodShare use
- Financial struggles for many residents

2013 – 2016 CHIP Priority Areas and Accomplishments

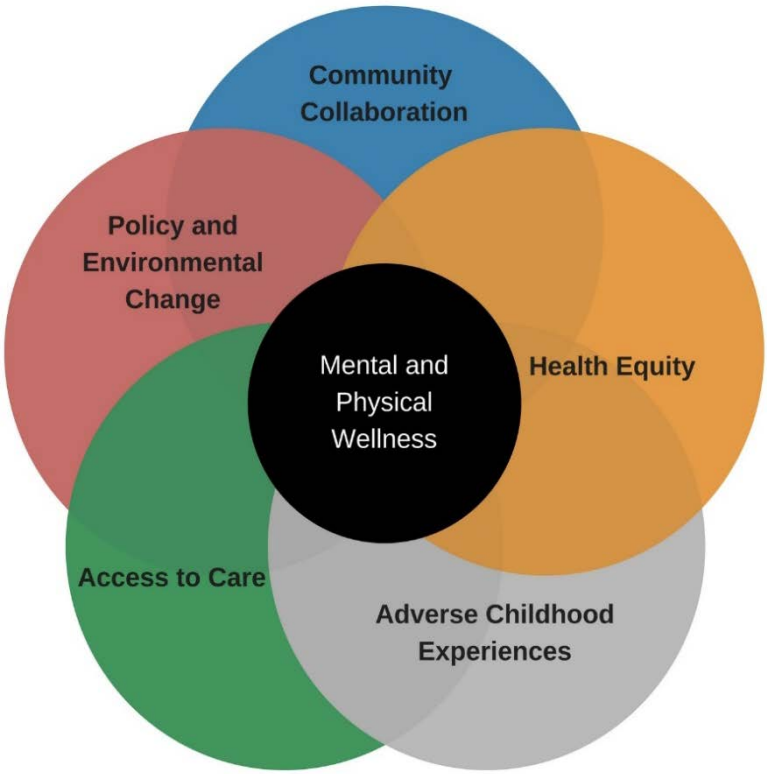
The community health improvement planning process is always changing based on the health needs of the community. The previous Community Health Assessment that was completed in 2013 identified five different health priority areas that have been the focus of health improvement planning efforts for the last four years. Those priority areas were; mental health, alcohol/drugs, overweight/obesity, finances/food security, and access to care. Although health priorities change over the years, the health department and local community partners strive to sustain all health improvement efforts year after year.

The following page highlights just some of the accomplishments that have been made because of the 2013 – 2016 Waupaca County Community Health Improvement Plan.

Mental Health	Alcohol/Drugs	Overweight/Obesity	Finances/Food Security	Access to Care
* Adverse Childhood Experiences (ACES) training at schools * Child psychologist collaboration and intervention including home services * DHHS programs provided ACES, depression, and resiliency screenings with families * Community-based presentation of Paper Tigers * Suicide Prevention Coalition guest speaker presentations at Waupaca High School for law enforcement and community members * Community Health Action Team (CHAT) formed to address ACES and develop TIC (Trauma Informed Care) communities	* Community created heroin and other drug task force * Initiate development of drug court * Community Health Action Team (CHAT) formed to address AODA issues * Volunteer recovery coaches available to communities * Medication disposal sites available in most municipalities * School hosted community training on recognizing teen addiction using model bedroom * Needle disposal sites available in some communities	* UW-Extension presentations at Healthy Beginnings (Public Health home visitation program) group events * "Yuck to Yummy" classes * Growth of community gardens * Farmer's Market expansions * Nutrition and Activity Coalition developed "Living the Waupaca Way" * Community "Farm to Table" dinner event *Collaboration and planning of county bike routes and walking trails	* Expansion of local food pantries * DHHS Caring Closet which offers free donated clothing and household goods * Private donations of diapers * Mission of Hope community events offering health and food services * Growth of community gardens * "Farm to School" program expansions	* School-based influenza immunization clinics * Family-based group educational events through Healthy Beginnings (Public Health home visitation program) *Public Health and Veterans Services hosted free Hepatitis C screening clinics * Community outreach and education of CDC recommended adult immunizations * Expanded Seal-a-Smile to include all Waupaca County school districts

2017-2022 Overarching Priority Areas

During the process of selecting health priority areas for the 2017-2022 CHIP, a few cross-cutting themes were identified that have an impact on all aspects of health. These themes expanded beyond the scope of just one health priority area. It was determined that these overarching priority areas were too important not to note due to the significant role they play in achieving both mental and physical wellness. For this reason, CWHP counties decided to select five overarching priority areas to focus on while choosing goals, objectives, and strategies to guide our work. These overarching priority areas include: Access to Care, Adverse Childhood Experiences (ACEs), Health Equity, Community Collaboration, and Policy, Systems and Environmental Change. These themes have been chosen as overarching priorities to work on in conjunction with the three identified health priorities in each CWHP county.



Access to Care

Having adequate access to health care services is an important part of promoting and maintaining health, prevention of disease, and reducing unnecessary disability and death. Access to health care has a direct impact on an individual's overall physical, social, and mental health status and quality of life.

Access to health services includes entry into the health care system (usually through insurance coverage), accessing a specific location where health care services are provided (geographic location), and finding a health care provider the patient can trust and communicate with. When considering access to health care, it is important to also include oral health care and obtaining necessary prescription drugs (Healthy People 2020).

Adverse Childhood Experiences

Our health is not determined by our genetics alone. The choices we make, environment in which we live, and our experiences all play a part in our health. The positive and negative experiences we have during childhood have a lasting effect on our health and well-being even into adulthood. Adverse childhood experiences (ACEs) are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. (Child Trends, 2014) The negative health effects of ACEs can be lessened when people have a strong support system and the skills to successfully cope with life's many challenges. This is what we call resilience, and it's something children learn best when they've been given the following positive supports:

- Caring relationships with parents, teachers, counselors or other adults actively involved in child's life
- Good peer relationships
- Positive disposition
- Positive coping style
- Good social skills

Building resilience is a lifelong process. Even in adulthood, learning how to adapt to change and recover from setbacks can mean thoughtfully considering behavior and attitudes, learning from the past and finding healthy ways to cope with daily stress. (ACEs, Wisconsin Department of Health Services)

Healthy Equity

Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people." It means that efforts are put in place to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives, despite race, ethnicity, gender or socioeconomic status. Everyone deserves a fair chance to lead a healthy life. No one should be denied this chance because of who they are or their socio-economic opportunities. Approximately 40% of factors that influence health, according to the University of Wisconsin Population Health Institute, are social and economic in nature. Focusing on health equity in our work will allow people in CWHP counties to have a better quality of life no matter where they live, work, learn, and play.

Community Collaboration

Collaboration is the focus of our work in public health. The community issues that we work to solve and emerging problems that our communities face can't easily be solved by one group alone. We rely on working together with community members, agencies, organizations, and individuals to solve community issues together. As we work together, we increase

the capacity of our communities to make changes that improve outcomes while learning to communicate effectively as a team. We are all in this together.

Policy, Systems and Environmental Change

Policy, systems and environmental (PSE) change is a new way of thinking about how to improve health in our communities. For a long time, many health programs have focused on individual behaviors with the assumption that if you teach people what will make them healthy, they will find a way to make those changes. Now we understand that health is not just about individual choices. It's not enough just to know how to be healthy – we need to have practical, readily available options around us. This is where PSE change comes into play. PSE change is a way to modify the environments around us to make healthy choices easier, more practical, and available to all members of our communities. By changing laws and shaping physical landscapes, a big impact can be made in a short amount of time with fewer resources used. When we change policies, systems and/or environments, communities are better able to work together to tackle issues such as addiction and chronic disease.

2017-2022 Health Priority Areas

Three health priority areas have been identified for the 2017-2022 Community Health Improvement Plan: mental health, alcohol and other drug abuse, and chronic disease prevention and management. The Community Health Assessment steering committee identified health priorities by first analyzing secondary data and by gathering community and stakeholder input via survey and key informant interviews. The priorities were then narrowed down to the top three by using four different criteria to assess community capacity and readiness to impact the identified priority. In addition to the three health priority areas, several different intersecting themes were identified as having an impact across nearly all health related issues. Access to care, adverse childhood experiences, health equity, and community collaboration, and policy and environmental change have been chosen as overarching priorities to work on in conjunction with the three identified health priorities.

Defining Goals, Objectives, and Strategies

In order to help create a shared vision among stakeholders, community members, and partners, each priority area has identified goals, objectives, and strategies listed to help guide the work being done.

GOALS

The priority area goals, developed by the steering committee, are broad statements that provide the long-term vision to guide program objectives and strategies. The goals for the mental health and AODA priority areas have been adopted by all six CWHP counties in an effort to help create regional change in Central Wisconsin. Goals will be monitored using the long-term indicators that are listed under each priority area.

OBJECTIVES

Along with a goal, each health priority area will also have objectives listed. The objectives are similar to goals in that they will help guide the progress being made towards improved health outcomes in each priority area. The main difference is that the objectives are more specific, measurable, and specify a timeline for completion. The objectives are set with the intention that they will help reach the goals. Objectives will be monitored using the short-term indicators listed.

STRATEGIES

For each objective listed under the three priority areas, there is a list of potential evidence-based strategies that can be implemented to help meet those objectives. A variety of strategies is listed for each objective to allow community coalitions and stakeholders the flexibility to adopt and implement the strategies that will work best for them. The strategies that also address an overarching priority area have been identified with the corresponding symbol found below.

	**Access to Care**
	**Policy, Systems, and Environmental Change**
	**Community Collaboration**
	**Health Equity**
	**Adverse Childhood Experiences** ** The "Shift Your Perspective" logo is used with the permission of the Wisconsin Department of Health Services." For more information on TIC visit: https://www.dhs.wisconsin.gov/tic/index.htm

The list of potential strategies included with each goal and objective is not an exhaustive list. More information on evidence-based strategies that improve health can be found using the resources listed below:

☐ Guide to Community Preventive Services

http://www.thecommunityguide.org/

☐ Healthy People 2020 Evidence-Based Resource Tool

http://healthypeople.gov/2020/implement/EBR.aspx

☐ Winnable Battles

http://www.cdc.gov/winnablebattles/

☐ Health.gov

http://www.health.gov/

☐ **What Works for Health (County Health Rankings)**
http://www.countyhealthrankings.org/roadmaps/what-works-for-health

☐ **National Registry of Evidence-based Programs and Practices (SAMHSA)**
http://nrepp.samhsa.gov/

Note: Individuals and organizations that are looking for ways to incorporate small changes that can have a big impact on health, please refer to documents in Appendix B.

Priority Area: Alcohol and Other Drug Abuse

Abuse of alcohol and other drugs is defined as using these substances, legal or illicit, in a way that results in recurrent failure to fulfill important obligations, recurrent use of substances in a way that is physically harmful, recurrent legal problems, or continued use of alcohol or other drugs despite having social or personal problems as a direct result of using that substance. Alcohol and other drug abuse can create a significant burden on both the state and local counties. In 2013, the economic burden of excessive alcohol use in all six counties totaled $180.9 million. This large financial burden is largely due to a host of negative outcomes associated with substance abuse such as lost productivity, failure at school, domestic violence, child abuse, and crime. Substance abuse can also lead to a variety of different health problems such as sexually transmitting infections, Hepatitis C, HIV/AIDS, pregnancy complications, and cardiovascular conditions.

SNAPSHOT OF WAUPACA COUNTY

In 2014, nearly **1 out of 4** (23%) Waupaca County residents reported binge drinking.

Source: Wisconsin Epidemiological Profile on Alcohol and Other Drugs, 2016

2x

In 2014, the OWI arrest rate in Waupaca County was **nearly twice as much as** the national average at 644 per 100,000 people.

Source: Wisconsin Epidemiological Profile on Alcohol and other Drugs, 2016

In 2014, 170 of the 704 deaths that occurred in Waupaca County had alcohol, tobacco, or other drugs listed as an underlying cause of death.

Source: Wisconsin Public Health Profiles, 2016

Goal 1: Decrease alcohol and drug misuse and abuse in CWHP Counties

Preventing and treating drug and alcohol misuse and abuse requires many different partners and strategies across all sectors. This goal is aimed at promoting both new and existing strategies to ultimately reduce deaths associated with substance use disorders.

CWHP Objective:

By 2022, at least one new or existing strategy will be implemented, strengthened, or expanded to help increase use of outreach, intervention, treatment, and support services for alcohol and drug misuse.

SHORT-TERM INDICATORS

- decrease in drug and alcohol related hospitalizations
- increase in number of drug court participants
- decrease in opioid prescribing rates

LONG-TERM INDICATORS

- decrease in drug and alcohol related deaths
- decrease in binge drinking rates among adults
- decrease in past 30 day use among youth who participate in the YRBS

Possible Strategies

Drug Court

Prescription Drug Monitoring Program

Naloxone Education and Distribution

Drug Drop Boxes

SBIRT (Screening, Brief Intervention, and Referral to treatment)

Responsible Beverage Server Training

Alcohol Access Restrictions in Public Places

Priority Area: Mental Health

Mental health can be defined as a state of well-being in which an individual realizes their full potential and is able to contribute to his or her community by working productively, and cope with the stresses of everyday life. Mental health is influenced by many different determinants such as poverty, stressful work conditions, discrimination, poor physical health, and an unhealthy lifestyle (WHO-4). Children are an especially vulnerable population that is at risk for potentially being negatively impacted by parents or family members suffering from mental illness. When children experience adverse events in childhood (ACEs), they are more likely to have poor mental health later in life and often suffer from illnesses such as depression and anxiety. The treatment of mental illness can be quite challenging, especially in rural areas, due to limited access of mental health services, social isolation, and fear of stigmatization. Enhancing protective factors can help create more resilient communities and create a foundation of emotional well-being from the earliest stages of life.

Snapshot of Waupaca County

0.63

per 1,000 people

Waupaca County only has about **0.63 mental health providers for every 1,000 residents**

Source: 2016 County Health Rankings

Nearly **1 in 10 Waupaca County** residents has experienced 4 or more Adverse Childhood Experiences

Source: Wisconsin ACE Brief 2011-12, Wisconsin ACE Map

Waupaca County has a slightly lower than average suicide rate at **13.3 per 100,00 people** compared to the state rate of 13.5

Source: Prevent Suicide Wisconsin 2015

Goal 1:

Improve mental health and decrease suicide rates in CWHP counties

In alignment with the State of Wisconsin's vision of preventing suicide, this goal is aimed at improving individual, family, and community characteristics that can help reduce the likelihood of having negative mental health outcomes such as suicide.

CWHP Objective:

By 2022, at least one new or existing strategy will be implemented, strengthened, or expanded upon to help increase and enhance mental health protective factors.

Short-Term Indicators

- increase in number of community organizations providing trauma informed services
- decrease in high school youth who report attempting suicide within the last 30 days

Long -Term Indicators

- decrease Suicide Rates
- decreased hospitalizations related to suicide attempts

Possible Strategies

Community Mentorship Programs

Mental Health First Aid

Coping Skills Training

Telemental Health Services

Trauma Informed Communities

Bullying Prevention Programs

Means Restriction Education

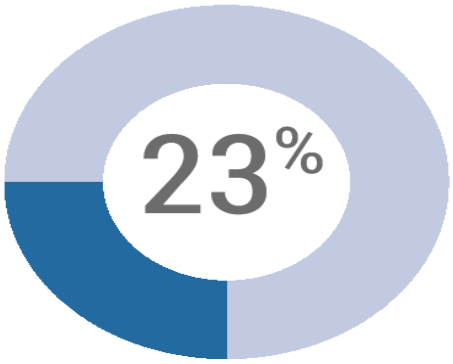
Priority Area: Chronic Disease

Chronic diseases are conditions that last a long time, do not go away on their own, and are rarely cured. These diseases often have permanent effects and can result in disability later on in life. Some examples of the most common chronic diseases include heart disease, cancer, diabetes, stroke, and asthma. These and other chronic diseases have a significant impact on both length and quality of life. Compared to urban communities, rural counties, like Waupaca County, disproportionately share the burden of chronic disease. The good news about chronic diseases is that many cases are preventable through lifestyle modification. Lack of physical activity, unhealthy diet, tobacco use or exposure to secondhand smoke, and excessive alcohol use are the four modifiable risk factors that primarily contribute to chronic disease in the United States.

Snapshot of Waupaca County

More than **1 in 4** Waupaca County women reported smoking during pregnancy

Source: Public Health Profiles, Wisconsin 2016



Nearly **one quarter** of Waupaca County residents do not participate in leisure time physical activity

Source: 2016 County Health Rankings

#1

Heart disease has been the leading cause of death in Waupaca county for over **ten years**

Source: Public Health Profiles, Wisconsin 2016

Nearly **one-third (31%)** of Waupaca County residents are obese

Source: 2016 County Health Rankings

Goal 1:

Promote chronic disease prevention and management

In alignment with the State of Wisconsin's vision of having communities that eat healthier and move more, this goal is aimed at implementing evidence based strategies that help prevent chronic diseases. Strategies will focus on modifiable risk factors such as physical activity, nutrition, breastfeeding, and eliminating tobacco use.

Objective:

By 2022, one new or existing strategy will be implemented, strengthened, or expanded upon to help promote chronic disease prevention and management.

Short-Term Indicators

- Increase in Trauma Informed Care communities
- Increase in breastfeeding rates
- Increased use of the tobacco Quitline
- Increased number of participants in chronic disease prevention and management programs

Long-Term Indicators

- Decreased rates of obesity
- Decreased rates of diabetes
- Decreased rates of heart disease

Possible Strategies

Trauma Informed Care communities

Breastfeeding Promotion Programs

Community walking or running groups

Tobacco Cessation Programs

Point of Decisions Prompts

Expansion of AODA Services

References

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Appendix A: Action Plan

Date Created: **Date Reviewed/Updated:**

PRIORITY AREA: Alcohol and Other Drug Abuse
GOAL:

PERFORMANCE MEASURES How We Will Know We are Making a Difference		
Short Term Indicators	Source	Frequency
Long Term Indicators	Source	Frequency

OBJECTIVE #1: Specific, measurable, attainable, relevant, time bound objective- there will be additional charts for each different objective
BACKGROUND ON STRATEGY- Source: Evidence Base: Policy Change (Y/N):
ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes

OBJECTIVE #2:					
BACKGROUND ON STRATEGY- Source: Evidence Base: Policy Change (Y/N):					
ACTION PLAN					
Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes

ALIGNMENT WITH STATE/NATIONAL PRIORITIES			
Obj #	State	Healthy People 2020	National Prevention Strategy
1			
2			

Date Created: **Date Reviewed/Updated:**

PRIORITY AREA: Mental Health
GOAL:

PERFORMANCE MEASURES How We Will Know We are Making a Difference		
Short Term Indicators	Source	Frequency
Long Term Indicators	Source	Frequency

OBJECTIVE #1: Specific, measurable, attainable, relevant, time bound objective- there will be additional charts for each different objective
BACKGROUND ON STRATEGY- Source: Evidence Base: Policy Change (Y/N):
ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes

OBJECTIVE #2:					
BACKGROUND ON STRATEGY- Source: Evidence Base: Policy Change (Y/N):					
ACTION PLAN					
Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes

ALIGNMENT WITH STATE/NATIONAL PRIORITIES			
Obj #	State	Healthy People 2020	National Prevention Strategy
1			
2			

Date Created: **Date Reviewed/Updated:**

PRIORITY AREA: Chronic Disease
GOAL:

PERFORMANCE MEASURES How We Will Know We are Making a Difference		
Short Term Indicators	Source	Frequency
Long Term Indicators	Source	Frequency

OBJECTIVE #1: Specific, measurable, attainable, relevant, time bound objective- there will be additional charts for each different objective
BACKGROUND ON STRATEGY- Source: Evidence Base: Policy Change (Y/N):
ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes

OBJECTIVE #2:					
BACKGROUND ON STRATEGY- Source: Evidence Base: Policy Change (Y/N):					
ACTION PLAN					
Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes

ALIGNMENT WITH STATE/NATIONAL PRIORITIES			
Obj #	State	Healthy People 2020	National Prevention Strategy
1			
2			

Appendix B: Organizational and Individuals Practices to Improve Health

What can state and local governments do to improve AODA?

- Maintain and enforce the legal drinking age, limit alcohol outlet density, and prohibit the sale of alcohol to intoxicated persons.
- Promote the use of drug drop boxes to remove expired or unwanted controlled medications from homes.
- Implement harm reduction strategies to prevent transmission of HIV, hepatitis, and other infectious diseases.
- Implement and sustain tobacco prevention and control programs.

What can employers and businesses do improve AODA?

- Provide evidence-based incentives to increase tobacco cessation.
- Make work sites tobacco free.
- Implement training programs for owners, managers, and staff that build knowledge on responsible beverage service.

What can healthcare providers and insurers do to improve AODA?

- Create linkages with and connect patients to community resources such as tobacco quit lines or support groups.
- Identify and screen patient for excessive drinking using Screening, Brief Intervention, and Referral to Treatment (SBIRT).
- Identify, track, and prevent inappropriate patterns of prescribing and misuse of prescription drugs.
- Train prescribers on safe opioid prescription practices and institute accountability mechanisms to ensure compliance.

What can early learning centers and schools do to improve AODA?

- Promote tobacco free environments.
- Encourage children to participate in extracurricular and out of school activities.
- Teach children about the health risks of tobacco and other drugs.

What can community organizations, non-profits, and churches do to improve AODA?

- Support community programs that promote healthy youth development.
- Consider hosting support groups such as Alcoholics or Narcotics Anonymous.
- Increase awareness of the proper storage and disposal of prescription medications.

What can individuals and families do to improve AODA?

- Actively participate in community and prevention efforts.
- Quit using tobacco products and ask a health care provider or call 1-800-QUIT-NOW for support.
- Make homes smoke free and protect children from secondhand smoke.
- Safely store and dispose of medications and never share prescriptions with others.
- Avoid binge drinking and using illicit drugs, seek help from your healthcare provider when needed.

What can state and local governments do to improve mental health?

- Conduct comprehensive community health assessments and develop community health improvement plans.
- Ensure that those in need, especially vulnerable populations, are identified and referred to mental health services.

What can employers and businesses do to improve mental health?

- Implement organizational changed to reduce employee stress such as developing clearly defined roles and responsibilities.
- Provide reasonable accomodations such as flexible work schedules and adaptive work stations.
- Ensure that mental health services are included as a benefit on health plan and encourage employees to use those services when needed.

What can healthcare providers and insurers do to improve mental health?

- Educate parents on normal child development and conduct early interventions to enhance mental and emotional well-being.
- Screen for mental health needs among children and adults.
- Develop integrated care programs to address mental health needs in the primary care setting.

What can early learning centers and schools do to improve mental health?

- Ensure students have access to comprehensive health services, including mental health or counseling services.
- Implement programs and policies to prevent abuse, bullying, and violence.
- Implement programs to identify risks and early indicators of mental, emotional, and behavioral problems among youth.

What can community organizations, non-profits, and churches do to improve mental health?

- Provide informational tools to both men and women to promote respectful, nonviolent relationships.
- Provide space and organized activities that encourage inclusion for all people.
- Support child and youth development programs.

What can individuals and families do to improve mental health?

- Build strong, positive relationships with family and friends.
- Become more involved in the community.
- Encourage children to participate in extracurricular activities.
- Work to make sure children are comfortable talking about problems such as bullying.

What can state and local governments do to improve chronic disease?

- Include health criteria as a compenent of decision making(e.g. health in all policies).
- Create healthy environments that support people's ability to make healthy choices.
- Work with hospitals, daycares, and worksites to implement breastfeeding policies and programs.
- Facilitate collaboration of community partners to create healthier communities.

What can employers and businesses do to improve chonric disease?

- Adopt lactation policies that provide space and break time for breastfeeding employees.
- Provide nutrition information to customers, make healthy options and appropriate portion sizes the default.
- Sponsor a new or existing park, playgroud, or trail.
- Implement worksite health initiatives.

What can healthcare providers and insurers do to improve chronic disaese?

- Screen for obesity by measuring body mass index and deliver appropriate care according to clinic guidelines for obesity.
- Assess dietary patterns and provide nutritional education and counseling.
- Conduct physical activity assessments, provide counseling, refer patient to fitness professional or consider exercise prescription.

What can early learning centers and schools do to improve chronic disease?

- Incorporate health education into coursework.
- Elimintate high-calorie, low-nutrition drinks from food vending machine, cafeterias, and school stores.
- Provide daily physical education and recesses that maximize time spend being physical active.
- Support walk- and bike-to-school programs.

What can community organizations, non-profits, and churches do to improve chronic disease?

- Develop and institute policies and joint use agreements that encourage shared used of facilities.
- Start a community garden.
- Create a healthy community cookbook.
- Offer healthy options such as fruit or salad at community pot luck dinners.

What can individuals and families do to improve chronic disease?

- Visit your healthcare provider to receive clinical preventive services.
- Breastfeed babies exclusively for the first 6 months after birth.
- Avoid oversized portions, fill half your place with fruits and vegetables, make at least half of your grains whole grains, and drink water instead of sugary drinks.
- Adults should engage in at least 150 minutes of moderate-intensity physical acticity each week or at least 60 minutes per day for children.