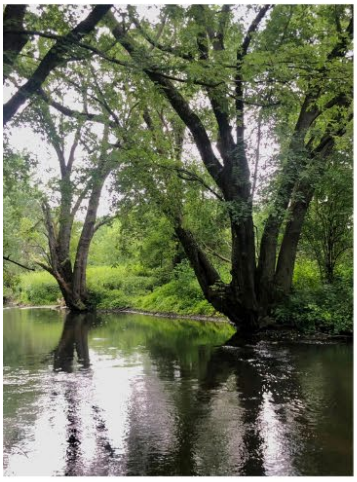


Photos Courtesy of River Falls Chamber

Healthier Together
Pierce County
St. Croix County

Community Health Needs Assessment and Implementation Plan

Contents

Executive Summary

The purpose of Healthier Together - Pierce & St. Croix County is to create and maintain healthy communities. Healthier Together accomplishes its mission by providing a strategic and collaborative framework for evidence-based and evidence-informed health improvement activities throughout the two-county region. The focus of the coalition's health improvement activities is determined by a community health needs assessment conducted every three years.

In 2021 and 2022, Hudson Hospital & Clinic, River Falls Area Hospital, Western Wisconsin Health, Westfields Hospital & Clinic, Pierce County Public Health, St. Croix County Public Health, and the United Way of St. Croix Valley led the planning and implementation of a two-county, community-based approach for creating and maintaining healthy communities. This is the third community health needs assessment and plan developed by these partners under the auspices of Healthier Together.

This effort included: (1) completion of a community health needs assessment to systematically identify and analyze health priorities in the community and (2) development of a community health improvement plan to address these priorities as a coalition and in partnership with others. The Healthier Together Leadership Team collaboratively developed an assessment and planning process grounded in three key principles: a broad definition of health, health equity, and cross-sector engagement. Through this process, Healthier Together engaged with community stakeholders to better understand the root causes of health issues in our communities, identified internal and external resources for health promotion, and created an implementation plan that leverages those resources to improve community health. Innovation was required to complete this process while the COVID-19 pandemic raged, and partners were often pulled in many different directions to respond to urgent community needs.

This two-year process identified the following priority areas: *Mental, Social, and Emotional Wellness* and *Thriving and Livable Communities for All.* This is Healthier Together's first community health improvement plan to include a priority area specifically to address the social determinants of health.

History of the Land

As we plan for our county's future, we must respect and acknowledge our communities' histories.

A Brief History of Pierce County[1]

Photo Courtesy of Pierce County Public Health

Native Americans were the first people to live in what is now Pierce County. Over time, Pierce County has been home to Ho-Chunk (Winnebago), Santee Dakota (Sioux), and Anishinaabeg (Ojibwe or Chippewa) peoples. Cultivation, building practices, and looting destroyed much of what existed before Euro-Americans arrived. The few artifacts that have been found indicate that the region has been inhabited for 10,000 to 12,000 years. The Diamond Bluff area has many extensive burial mounds that mark the Native American settlement.

European explorers began coming to the area in the mid-to-late 1600s. Government officials gave little consideration to the welfare of Native Americans already living in the Upper Mississippi region. Not only

[1] Information courtesy of University of Wisconsin-River Falls Archives and Area Research Center, accessed 5.23.2022 and Wisconsin Historical Society, accessed 5.23.2022

would the Dakota, Ho-Chunk, and Ojibwe face removal from traditional homelands, but their populations would be devastated by newly introduced diseases for which they had no immunity. They would lose thousands of members to undocumented epidemics before 1800, noted only by massive changes in numbers between one explorer or representative's visit and another.

In 1840, Saint Croix County was formed, covering a vast portion of northwest Wisconsin Territory. The state legislature split up Saint Croix County into Pierce, Polk, and Saint Croix counties in 1853. Pierce County was named after Franklin Pierce, the fourteenth president of the United States.

When Pierce County was developed, Prescott and River Falls were the largest communities in the county. Anthony Huddleston and his family had settled on the land near what would become Ellsworth in 1855.

In 1874, River Falls had the good fortune to have the state's fourth Normal School. Classes began in the fall of 1875 at the River Falls Normal School, today known as the University of Wisconsin-River Falls.

The eastern part of Pierce County was known initially for logging and mining. In the mid-1870s, high-quality iron ore was discovered, and by the early 1890s, Spring Valley had become a boom town. The city is also home to Crystal Cave, a popular tourist attraction.

A Brief History of St. Croix County[2]

St. Croix County once comprised most of northwestern Wisconsin and part of what is now northeastern Minnesota. Its Native American culture dates back thousands of years to the tribes of the Dakota and Ojibwa.

Photo Courtesy of St. Croix County

The peninsula formed by the St. Croix and the Mississippi Rivers was neutral territory between the Dakota and the Ojibwa, leaving it relatively open for settlement. European explorers began coming to the area in the mid to late 1600s. A trading post was established along the St Croix River in 1793. Trade with Native Americans continued for many years, dropping off in 1834 when farmers began moving into the area. White settlers' demand for land grew, and treaties pushed Native Americans from their land.

The lumber industry took hold in St. Croix County around 1840. In 1846, Stillwater and St. Paul were established as the election precincts for St. Croix County.

When Wisconsin was admitted to the Union as a full-fledged state in 1848, the western boundary of St. Croix County was set as the St. Croix River. The borders of St. Croix County, as we know them today, were established in 1853. The Hudson and River Falls Railway connected the county to the line of Chicago, Milwaukee, St. Paul, and Omaha Railway. By the end of the 1800s, wheat was the staple crop in St. Croix County, and there were seven cheese factories, 14 creameries, and one brewery.

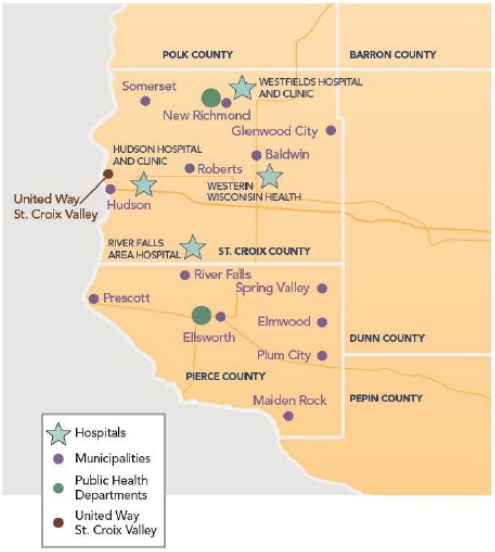
About Healthier Together

Previously two separate coalitions, Healthier Together- Pierce & St. Croix County was reformed in 2015 to encompass both counties under one umbrella. The mission of Healthier Together is to create and maintain healthy communities. Healthier Together accomplishes its mission by providing a strategic and

[2] Information courtesy of University of Wisconsin-River Falls Archives and Area Research Center, accessed 5.23.2022 and Wisconsin Historical Society, accessed 5.23.2022

collaborative framework for evidenced-based/evidence-informed health improvement activities throughout the two-county region. The focus of the coalition's health improvement activities is determined by a community health needs assessment conducted every three years.

Healthier Together Service Area



In 2022, Healthier Together formalized our commitment to health equity with a statement on the topic: The Healthier Together coalition prioritizes advancing health equity. Health equity means everyone has a fair and just opportunity to be as healthy as possible. We will do this by engaging impacted populations, building coalition competencies, and addressing the root causes of poor health (social determinants of health).

The coalition consists of an Executive Team, Leadership Team, Priority Area Action Teams, and At-Large members and is guided by a coalition charter. Executive and Leadership Team members include representatives from the following organizations:

Hudson Hospital & Clinic

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

Pierce County Public Health

Pierce County Public Health is a Level III Health Department founded in 1943 and accredited by the Public Health Accreditation Board (PHAB) in March 2015 and re-accredited in 2021. Its mission is to promote, protect and improve the lifelong health of individuals and communities in Pierce County through the effective use of data and evidence, community-driven prevention strategies, leadership, advocacy, partnerships, and the promotion of health equity. It fulfills this mission via involvement in numerous community collaborations and coalitions, along with organizational programming in maternal and child health, communicable diseases, environmental health, chronic disease and injury prevention, and access to care.

River Falls Area Hospital

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

St. Croix County Public Health

St. Croix County Public Health is a Level III Health Department founded in 1936 in response to a statewide tuberculosis crisis. The public health department became part of St. Croix County Health and

Human Services in 1994 and achieved national PHAB accreditation in September 2014. Its mission is to protect and promote health, prevent disease and injury and empower communities to live healthier lifestyles. To fulfill its mission, St. Croix County Public Health takes a lead role in community health assessment and improvement planning and is involved in numerous community programs and coalitions.

Western Wisconsin Health

Western Wisconsin Health, formerly Baldwin Area Medical Center, opened in Baldwin, Wisconsin in December 1936. The mission at Western Wisconsin Health is to "Build a Healthier Tomorrow… Together" by providing holistic and compassionate patient-centered care, developing innovative models of patient care, and creating a sustainable environment that produces lasting results for patients and the community. Western Wisconsin Health is a critical access hospital and rural health clinic providing acute care and chronic health condition services and is committed to promoting community health and wellness through numerous community-based programs and services. In 2010, Western Wisconsin Health opened a clinic in Roberts, Wisconsin. In 2016, Western Wisconsin Health opened a state-of-the-art facility in Baldwin that was designed using sustainable materials, strengthening the ability to offer competitive comprehensive health and wellness services. The two locations allow the organization to provide better care and more personalized support for patients in rural Wisconsin.

Westfields Hospital & Clinic

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

United Way St. Croix Valley

The mission of United Way St. Croix Valley is Uplifting people by building relationships, connecting resources and uniting the St. Croix Valley communities. They work to strengthen Wisconsin communities in Burnett, St. Croix, Polk, and Pierce Counties. United Way St. Croix Valley currently focuses on health, education, and financial stability. They also currently manage the region's 211 resource.

For more information about our coalition, please visit
https://www.healthiertogetherpiercestcroix.org/about

Demographics of Pierce and St. Croix Counties

The focus of inquiry for this CHNA was Pierce and St. Croix Counties—two rural communities in western Wisconsin. According to the U.S. Census Bureau, a total of 137,631 (42,587 Pierce and 95,044 St. Croix) residents live in the 1,295.73 square mile area occupied by the two counties.

Table: Demographic indicators for Pierce and St. Croix counties

Selected Indicator	Pierce County	St. Croix County
Population[2]		
Median household income	$73,873	$84,985
Median age[4]	37.3 years	39.2 years
Population estimates	42,587	95,044
Residents under age 18	20.6%	24.5%
Residents age 65 or older	15.3%	14.7%
Language other than English spoken at home	3.6%	3.4%
Foreign born residents	1.9%	2.6%
Race and Ethnicity[2]		
White alone	95.7%	95.9%
Black or African American alone	0.9%	0.9%
Asian alone	1.2%	1.1%
Hispanic or Latino	2.3%	2.6%
Social and Economic Factors		
Persons in poverty[2]	7.3%	4.9%
Children in poverty[1]	6%	5%
Percent of Population Asset Limited, Income Constrained, Employed (ALICE)[3]	24%	22%
Residents living in food insecurity[1]	8%	7%
Children eligible for free or reduced lunch[1]	15.3%	13.6%
Health Indicators[1]		
Ratio of primary care physicians to residents	2,380:1	2,020:1
Ratio of mental health providers to residents	1,940:1	610:1
Adults reporting binge or heavy drinking	26%	28%
Adults who are obese	33%	33%
Residents reporting poor or fair general health (age-adjusted)	13%	12%

Sources:
1 County Health Rankings, 2022
2 US Census Bureau, Quick Facts, Population Estimates July 1, 2021.
3 United for Alice 2018
4 United States Census Bureau. 2020 American Community Survey 5-Year Estimates.

Evaluation of 2020-2022 Plan

The COVID-19 pandemic required all of us to make changes to our lives and work. Many organizations leading Healthier Together were on the front lines of the COVID-19 response. In some cases, this prevented the completion of the plan we envisioned for our Healthier Together work. Despite the pandemic, Healthier Together members continued to work on improving our communities' mental health and preventing substance use disorders during each day of the pandemic in creative and impactful ways.

Healthier Together members gathered virtually in the Spring of 2022 to celebrate work accomplished despite the pandemic. Below is a summary of key accomplishments in the areas of Mental Health and Prevention of Substance Use Disorders.

Increased Community Capacity Through Training and Awareness Activities

- Provided 11 Mental Health First Aid virtual trainings, resulting in 86 individuals becoming certified
- Provided Make it OK presentations to River Falls middle schoolers and First Congregational Church in River Falls
- Provided three Youth Mental Health First Aid training to staff in the Ellsworth school district
- Completed Narcan overdose training for 73 individuals in Pierce County and 38 in St. Croix, including law enforcement and human services partners
- Served as a panel member for the Anxiety in Children workshop at the Hudson Schools Mental Health Advisory Committee
- Hosted Make it OK table at Ellsworth High School
- Secured additional grant funding to provide training to St. Croix County behavioral health staff
- Coordinated School-Based Dialectical Behavior Therapy (DBT) Training for school mental health professionals to increase the capacity of group mental health and substance use services provided in schools

Promoted Self-Care and Resiliency Among Key Populations

- Completed two resiliency-building series (Taking Care of You and WeCOPE)
- Launched a free weekly self-care community of practice called Practicing the Pause
- Hosted self-care sessions for Hudson High School staff and parents
- Successfully applied for a school-based mental health grant from the Department of Public Instruction

Provided Services in Every-Changing Pandemic Environment

- Secured American Rescue Plan Act funding to expand early intervention and community-based interventions involving law enforcement and criminal-justice involved individuals
- Continued providing mental health and substance use services using virtual tools throughout the pandemic
- Expanded mental health resources within River Falls High School through a partnership with St. Croix Valley Restorative Services

Reinforced Community Collaborations

- Started the Healthier Together Health Equity workgroup
- Hosted mental health provider meetings focused on networking and system improvement
- Conducted meetings among school district mental health professionals to discuss collaboration opportunities for Youth Risk Behavior Survey data collection, mental health screening, and mental health curriculum options
- Strengthened communication between public health and city planning, with River Falls Planning Commission, to identify built environment effects on population health and wellbeing

Supported Mental Health by Connecting Families to Nature

- Secured funding for county park passes for the library park backpack program available at libraries in both counties to facilitate connecting children and families to nature in our local park system. Families in our counties checked out the park backpacks more than 130 times in 2021

A full report for work accomplished during 2020 and 2021 can be accessed here:
https://www.healthiertogetherpiercestcroix.org/priorities

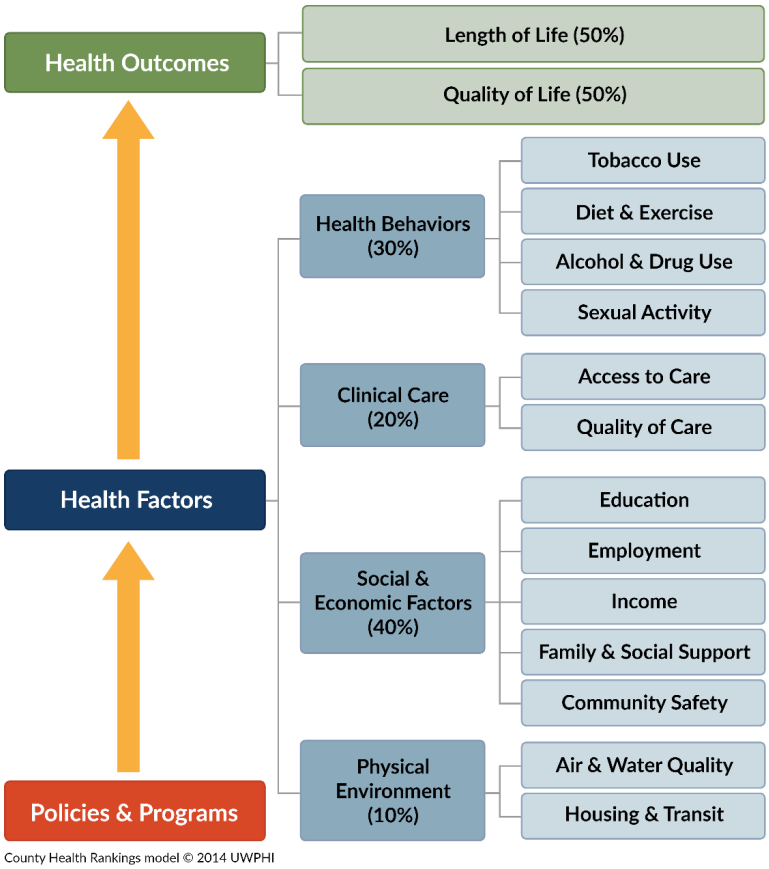
Overview

Community Health Assessment and Planning Principles and Process

Healthier Together designed an assessment and planning process that, like previous assessments and plans, engaged both community members and organizational stakeholders and took a wide variety of data sources into account. For this cycle, Healthier Together grounded our process with key principles of health equity, cross-sector engagement, and a more expansive view of health outcomes and factors that influence health.

Foundational Principle: Redefining Health

Many factors influence how well and how long we live, from our access to affordable housing or well-paying jobs to opportunities for a good education for our kids. Acknowledging health is influenced by factors broader than clinical care, Healthier Together redesigned our assessment process to reframe our definition of health. Healthier Together used the County Health Rankings model to organize our data and focus on the factors that influence health rather than solely focusing on health outcomes.



Foundational Principle: Health Equity

In 2020, Healthier Together formed a team focused specifically on health equity. Members of this subgroup engaged in training and professional development to learn more about health equity principles and tools and methods for integrating health equity into the assessment, planning, and implementation processes of public health interventions. As part of our stakeholder engagement process, the health equity working group developed and validated a statement on Healthier Together's shared commitment to health equity to be included in key plans and materials:

"The Healthier Together coalition prioritizes advancing health equity. Health equity means everyone has a fair and just opportunity to be as healthy as possible. We will do this by engaging impacted populations,

building coalition competencies, and addressing root causes of poor health (social determinants of health)."

Throughout the planning process, we demonstrated our shared commitment to health equity. During the primary data collection process, efforts were made to engage communities who suffer poorer health outcomes, including families on WIC, rural residents, and Spanish speakers. During secondary data collection, data available on the zip-code level with meaningful disparities were displayed on a map. When it came time to invite stakeholders to review available data and prioritize health issues, the Leadership Team invited new partners representing or serving the LGBTQIA+ community, children in out-of-home placements, Spanish speakers, racial and ethnic minority students, and people who've experienced lack of shelter to the table. During the objective development process, the health equity team assisted in revising the planning template (Appendix F) to ensure each objective was developed with a lens of health equity. Lastly, the health equity team worked closely with the Leadership Team to identify opportunities to further infuse health equity into the plan during the final objective review process. Healthier Together looks forward to continuing our journey to become advocates for equity and justice in our communities.

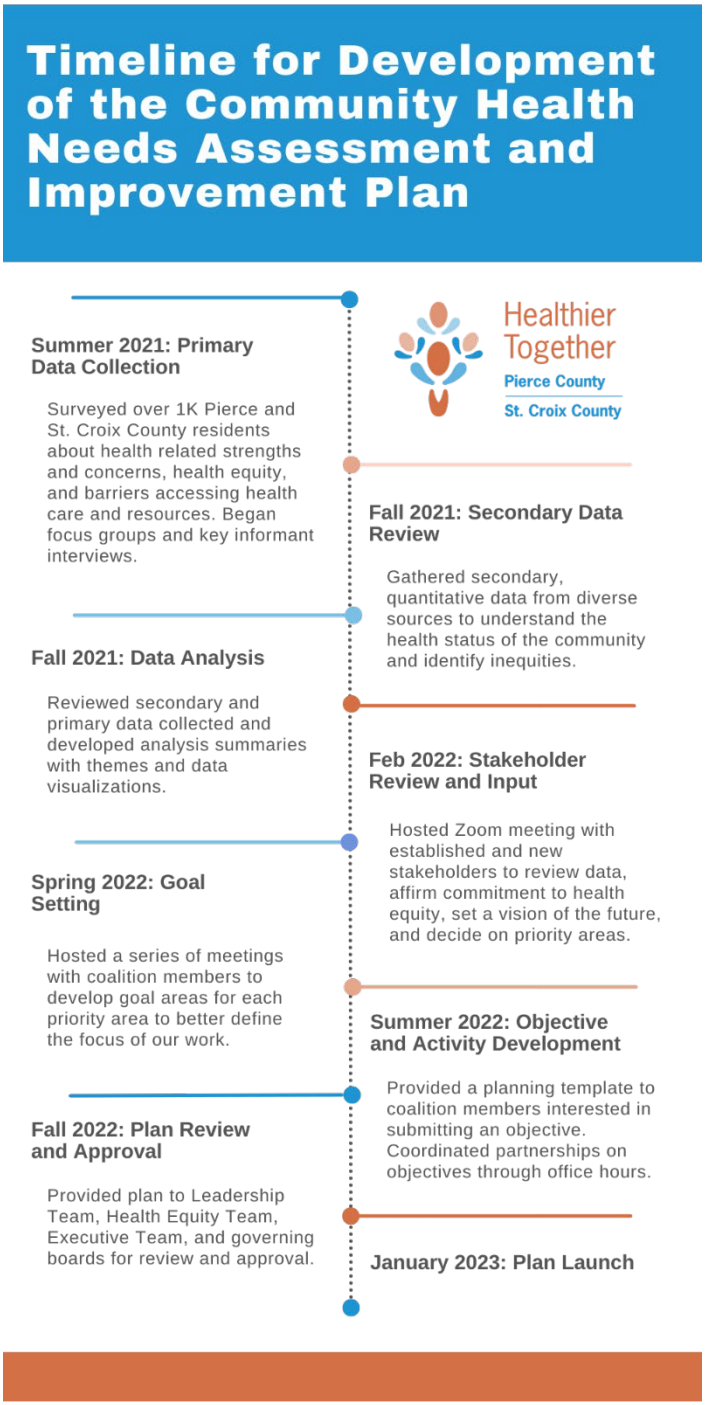
Foundational Principle: Cross-Sector Engagement

Healthier Together continues to strive to bring non-traditional partners to the table. Cross-sector partnerships are essential for addressing social, environmental, and economic factors that influence health. Healthier Together has successfully engaged partners from business, faith, education, human services, public safety, and other sectors in our assessment, planning, and implementation processes. During this cycle, we came to understand that access to healthy and affordable housing is a significant area of community need. In response, a focus group of professionals from the housing sector was conducted to understand better their perceptions of the connection between health and housing. Experts in housing were also engaged in the objective development process through a housing stakeholder

group. Members of this group include county and municipal planners, housing authorities, elected officials, and housing service providers.

Assessment and Planning Methods and Timeline

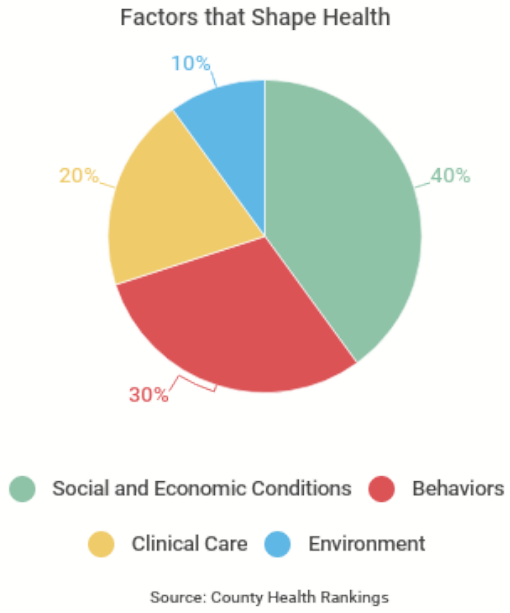
Rather than using any prescribed assessment or planning model, Healthier Together designed a process that fit our unique needs while still responding to and recovering from the COVID-19 pandemic. All meetings and activities were held using remote meeting software using digital tools to gather and share data, brainstorm, and gain consensus. Some of the activities were abbreviated or modified compared to past cycles to allow for the reduced capacity of local health departments and hospitals still addressing severe illness in our communities.



Key Insights: Secondary Community Data

Secondary data gathering and analysis took place in the summer and fall of 2021. Secondary data focused on gathering quantitative data from various sources across diverse sectors, selecting the best indicators available, and visualizing that data using maps, graphs, or infographics. Rather than focusing on health outcomes, our secondary data process focused on understanding the contexts in which residents are born, live, learn, work, play, and age to explain conditions that influence health outcomes. Healthier Together used the Community Health Rankings model as a framework for organizing our data elements by health behaviors, clinical care, social and economic factors, the physical environment, and health outcomes.

The summary below does not include all data categories or elements. The secondary data dashboard includes all indicators gathered and analyzed. The dashboard is located in Appendix B.



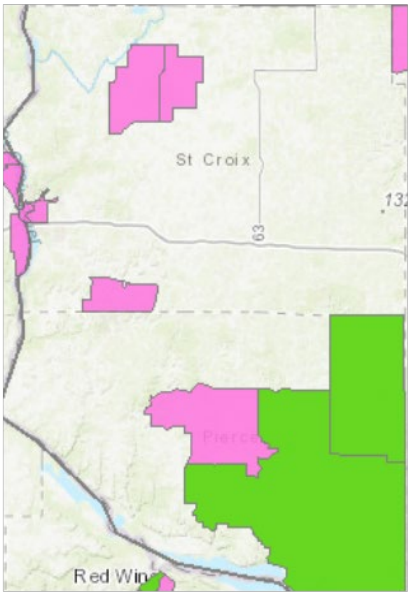
Health Behaviors

Health behaviors are actions individuals take that affect their health. They include actions that lead to improved health, such as eating well and being physically active, and actions that increase one's risk of disease, such as smoking, excessive alcohol intake, and risky sexual behavior.

Nutrition and Physical Activity

Good nutrition, physical activity, and healthy body weight are essential to a person's overall health and wellbeing. Together, these can help decrease a person's risk of developing serious health conditions, such as high blood pressure, high cholesterol, diabetes, heart disease, stroke, and cancer.

Food Access by Census Tract



Low Access: Tracts in which at least 500 people or 33% of the population lives farther than 1 mile (urban) or 10 miles (rural) from the nearest supermarket.

Low Access AND Low Income: Tracts that qualify as low access, but also have a high poverty rate (20% or greater or family income below the state median.

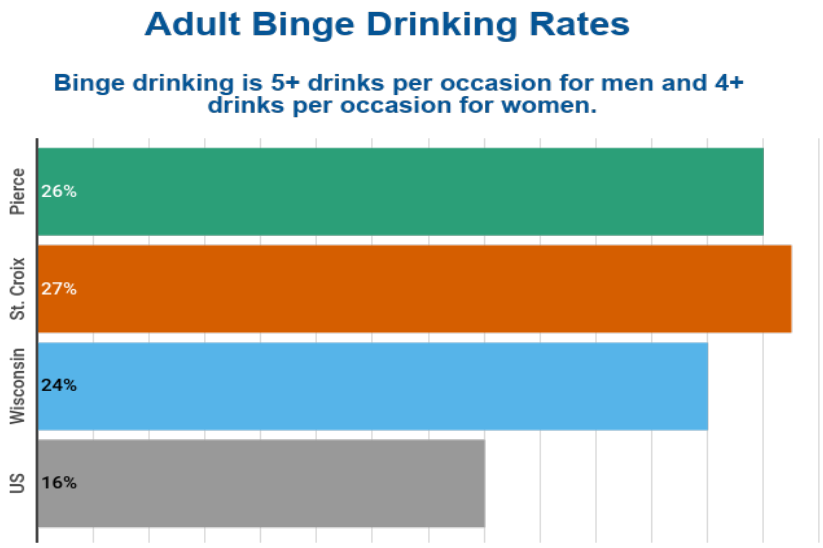
USDA Food Access Atlas

The environment in which we are born, live, learn, work, play, and age greatly influences our nutrition and physical activity behaviors. Only one city in the bi-county area has a complete streets policy to promote bimodal transportation (New Richmond). Both counties have experienced an increase in the prevalence of fast-food restaurants from 2011-2016, with an 18% increase in Pierce County and a 21% increase in St. Croix County.[3] In addition, several areas of southeast Pierce County have been identified as having low access to supermarkets while also being areas with high poverty rates. Lack of access to affordable, fresh foods limits the healthy choices available to residents of these food deserts.

[3] USDA Food Environment Map; https://www.ers.usda.gov/data-products/food-access-research-atlas/

Alcohol Use

Over-consumption of alcohol has significant negative impacts both on the health of individuals and on the costs to society. It is estimated that the annual economic cost of excessive alcohol use costs Pierce and St. Croix counties $30.9M and $65.5M, respectively.[4] Excessive alcohol use leads to chronic conditions such as liver failure, cancer, and mental health conditions. Excessive alcohol use can lead to social problems like increased violence, car accidents, and child neglect. Adult binge drinking rates among Pierce and St. Croix County residents are higher than state and national averages.

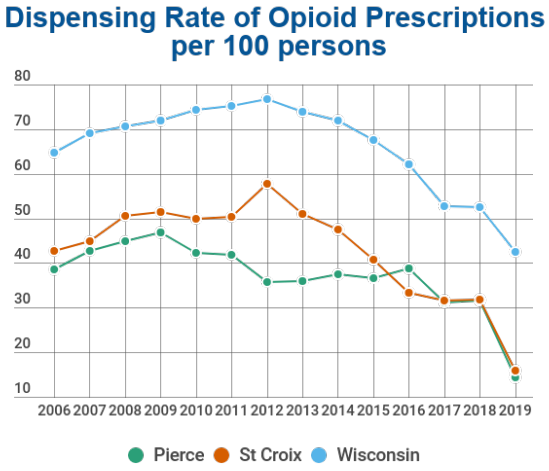


University of Wisconsin Population Health Institute's 2019 The Burden of Binge Drinking in Wisconsin

Tobacco Use

Tobacco use is the leading cause of preventable death in the United States. Smoking tobacco harms nearly every organ of the body. It affects not only those who choose to use tobacco but also people who live and work around tobacco use. Vaping has become prevalent among teens in both counties. 64% of St. Croix County high school seniors and 53% of Pierce County seniors report having tried vaping.[5]

Illicit Drug Use



CDC US Opioid Dispensing Rate Maps

The vast impact of addiction to methamphetamine, opioids, and other drugs harms families, businesses, and individuals. Fortunately, retail opioid prescription levels have been significantly lower in both counties compared to Wisconsin and the nation. Conversely, methamphetamine production and abuse have expanded from Minnesota and Iowa into primarily rural counties in western Wisconsin. According to the 2016 Wisconsin Methamphetamine Study, analysis of meth-related arrests, cases, charges, and seizure statistics provided by local law enforcement, state government agencies, and open source reporting indicates meth availability in Wisconsin likely jumped between 250 and 300 percent since 2011.

Clinical Care

Access to affordable, quality, and timely health care can help prevent diseases and detect issues sooner, enabling individuals to live longer healthier lives. While part of a larger context, looking at clinical care helps us understand why some communities can be healthier than others. Pierce and St. Croix Counties have far less access to in-county primary care, dental care, and mental health care compared to the

[4] University of Wisconsin Population Health Institute's 2019 The Burden of Binge Drinking in Wisconsin
[5] YRBS 2019

average Wisconsin resident. Pierce County has the poorest ratio of providers to residents in all three categories. This is not surprising, as Pierce County has no hospitals within county borders.

Access to Care

County Health Rankings 2021

Social and Economic Factors

Social and economic factors, such as income, education, employment, community safety, and social supports can significantly affect how well and how long we live. These factors affect our ability to make healthy choices, afford medical care and housing, manage stress, and more.

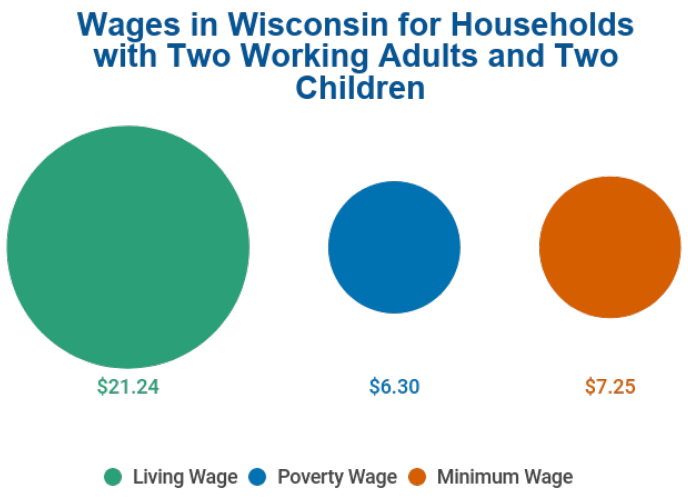
Education

Pierce and St. Croix Counties have strong higher education institutions within their borders, including the University of Wisconsin- River Falls, CVTC- River Falls, and Northwoods Technical College. Both counties are served by CESA 11 for Head Start and Early Head Start. Early Head Start is home-based, and Head Start is classroom-based out of New Richmond. Each year, the WI Department of Public Instruction (DPI) assesses K-12 public school districts on a scale of "fails to meet expectations" to "significantly exceeds expectations." All 12 of the two counties' districts were assessed as meeting expectations or better.

Employment and Workforce

Employment provides income and, often, benefits that can support healthy lifestyle choices. Unemployment and under-employment limit these choices and negatively affect the quality of life and overall health.

The economic condition of a community and an individual's level of educational attainment both play important roles in shaping employment opportunities. Education and health care are the largest employment sectors in both Pierce and St. Croix Counties, but wages in these sectors in Pierce and St. Croix are lower than the state average. Pierce's second-largest employment sector is Trade, Transportation, and Utilities. St. Croix's second-largest sector is Manufacturing. Both Pierce and St. Croix's eastern regions are designated Health Professional Shortage Areas for primary care providers by the Health



MIT Living Wage Calculator, 2019

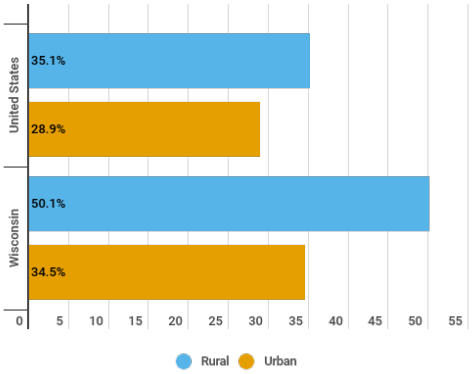
Resources and Services Administration (HRSA). Unemployment rates in both counties were 3.4% in 2019, which is considered population full employment by the federal reserve. Despite these positive employment numbers, many working families struggle to pay for basic living expenses. There is a significant gap between minimum wage and a living wage in our state.

Childcare

Economic development, healthy child development, and family wellbeing often depend on the availability of high-quality, affordable childcare.

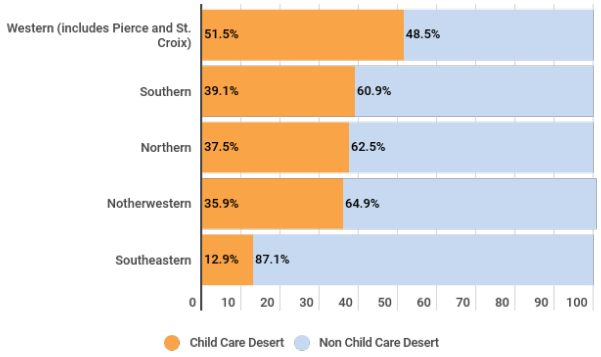
The most recent Census Bureau data shows 82,350 Wisconsinites currently are not working due to the need for care for children not in school or childcare.[6] Child care is a two-generational strategy, as it works as a support for parents and an early learning investment in children. Child care can be costly. The average annual cost of infant care in the state is $11,579. Childcare is usually considered affordable if it consumes 10% or less of a family's income, meaning a family would need an income of $115,790 to afford child care in Wisconsin. The median household income for Pierce County is $72,323, and the median for St. Croix is $84,756.[7] Pay for childcare providers is also low. In Wisconsin, the poverty rate for childcare workers is nearly 20%.[8] Additionally, unmet needs for childcare are unevenly distributed between rural and urban areas. The Western region of Wisconsin has the highest percentage of zip codes classified as child care deserts by the WI Department of Children and Families at over 50% (the state average is 38%).

Percent Gap in Childcare Supply, Urban vs Rural



Bipartisan Policy Center, The Supply of, Potential Need for, And Gaps in Child Care in Wisconsin in 2019

Percent of Zip Codes with Childcare Deserts by WI Region

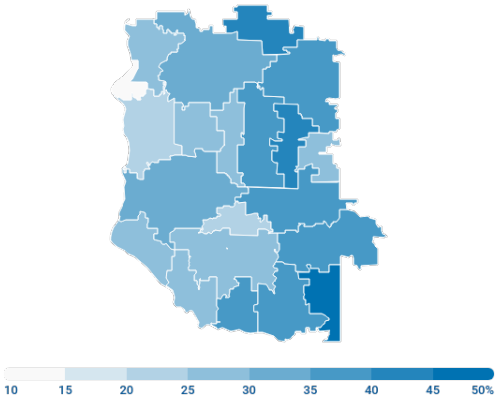


DCF Access to Childcare in Wisconsin Presentation to Early Childhood Advisory Counsel, 2018

Income/ALICE

Equitable economic opportunity is essential in ensuring equitable health outcomes in a society. The United Way developed a valuable tool for examining economic opportunity at the county level. ALICE is an acronym for Asset Limited, Income Constrained, Employed — households that earn more than the Federal Poverty Level but less than the essential cost of living for the county. While conditions have improved for some households, many continue to struggle, especially as wages fail to keep pace with the cost of household essentials (housing, child care, food, transportation, health care, and a basic smartphone plan). There have been significant shifts in household composition in the past few decades. The share of

% of households below ALICE threshold by Zip Code



[6] US Census Bureau, Household Pulse Survey, Week 32
[7] US Census Quick Facts 2019
[8] Center for Study of Childcare Employment

American adults who have never been married is at a historical high, as is the number of senior households. A growing number of people live alone or with roommates, and an increasing share of grown children live with their parents. ALICE and poverty-level households exist across all of these living arrangements. 24% of households in Pierce County and 22% of households in St. Croix County live under the ALICE threshold.[9]

Family and Social Support

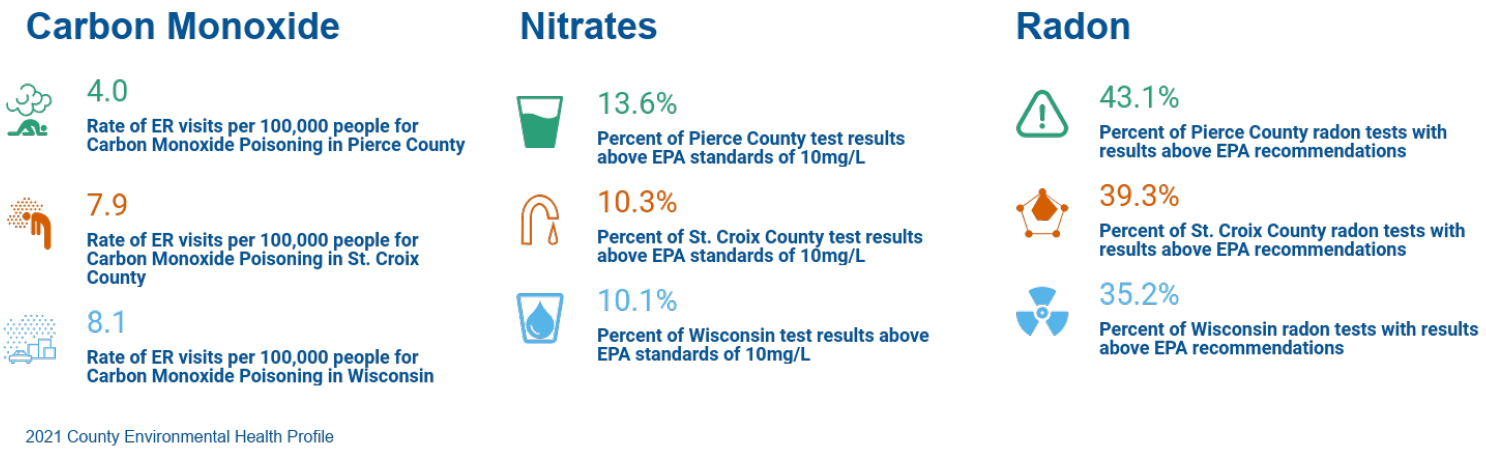
People with greater social support, less isolation, and greater interpersonal trust live longer and healthier lives than socially isolated people. While 28.8% of Wisconsin adults aged 65 and older live alone, only 23.7% and 25.2% of adults of that age group in Pierce and St. Croix County live alone, respectively. Students who feel connected, included, and engaged at school generally do better academically and socially. Strong school connectedness can also buffer young people against anxiety, depression, and peer pressure. One thing that can make a significant positive difference in students' school experience is whether or not they have at least one trusted adult at school. Approximately 65% of Pierce and St. Croix County high school students feel like they belong at school, and about 75% have at least one teacher or another adult to talk to.[10]

Physical Environment

The physical environment is where individuals live, learn, work, play, and age. People interact with their physical environment through the air they breathe, the water they drink, the houses they live in, and the transportation they access to travel to work and school. A poor physical environment can affect our ability and that of our families and neighbors to live long and healthy lives. The environments in which we are born, live, learn, work, play, and age have a significant impact on our health.

Air and Water Quality

Harmful (and helpful) substances are in our air, water, soil, and food. Carbon monoxide (CO) poisoning prevents oxygen from getting to the body, which can damage tissue and even cause death. CO is a toxic gas that cannot be seen or smelled. CO is created whenever fuel or other materials are burned. Both Pierce and St. Croix County have lower rates of emergency room visits for CO poisoning compared to the state at large. About 4 in 10 Wisconsin homes get their water from private wells. In Wisconsin, nitrate is one of the most common groundwater contaminants. High nitrate levels are linked with certain birth defects. Infants who consume drinking water with high nitrate levels are at risk of blue baby syndrome, a condition that limits the blood's ability to carry oxygen. While St. Croix County's percentage of private well water test results above the EPA standards for nitrates are only slightly above the state average,



[9] 2018 United for Alice
[10] YRBS 2019

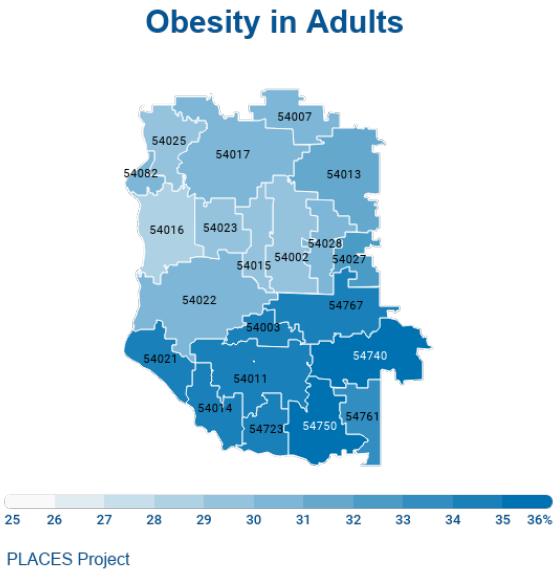
Pierce County's rates are more than 3% above the state average. Radon is a naturally occurring radioactive gas that can cause lung cancer. Radon can leak into homes and other buildings through cracks in the foundation. Both Pierce and St. Croix County have higher rates of radon tests above EPA recommendations compared to Wisconsin.

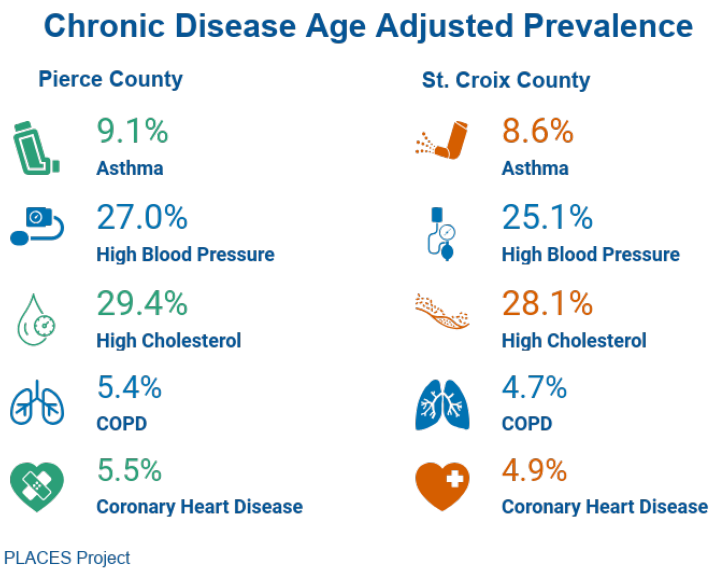
Health Outcomes

Chronic diseases are often partially caused by behaviors such as tobacco use, lack of physical activity, or poor eating habits. Environment, poverty, and genetics also significantly impact the development and management of chronic diseases. Many chronic diseases can be prevented or managed through proper medical care and resources to support healthy choices.

Chronic Disease

Type 2 diabetes risk factors include obesity, inactivity, family history, race, age, and blood pressure. Diabetes can have a variety of serious health consequences, including cardiovascular disease, nerve damage, and kidney damage. Type 2 diabetes can often be prevented with healthy eating, physical activity, and weight control. Obesity rates are higher in rural areas of Pierce and St. Croix Counties.





Heart disease and stroke deaths are often preventable through smoking cessation, physical activity, and good nutrition. Pierce County residents suffer higher rates of asthma, high blood pressure, high cholesterol, COPD, and coronary heart disease than St. Croix County residents.

Communicable Disease

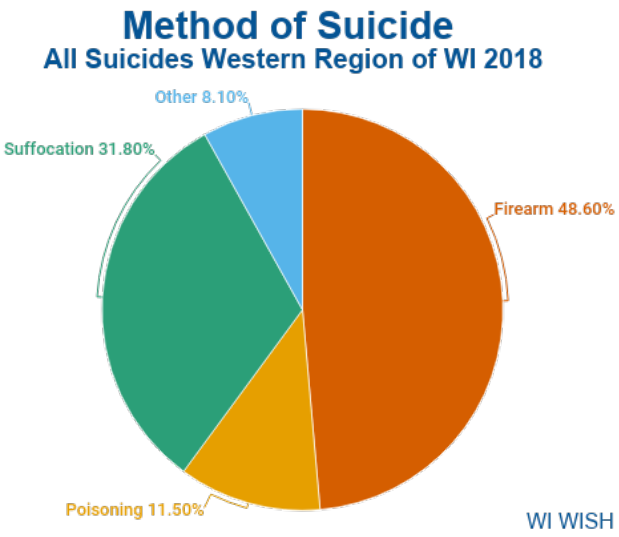
Communicable diseases, also known as infectious or transmissible diseases, result from the infection, presence, and growth of pathogenic (capable of causing disease) biologic agents in human or other animal hosts. The COVID-19 pandemic is the most significant public health emergency to face the US in living memory. The pandemic has impacted every sector of our community, demonstrating the potential impact of novel and re-emerging infections on the public and the healthcare system. As of June 2022, COVID-19 claimed the lives of 150 St. Croix County residents and 73 Pierce County residents.

Mental Health

Overall health depends on both physical and mental wellbeing. About 6,000 adults and nearly 1,400 youth in Pierce County and almost 12,000 adults and about 3,500 youth in St. Croix County have a mental illness. It is estimated that 56% of Pierce County and 52% of St. Croix County adults with mental illness

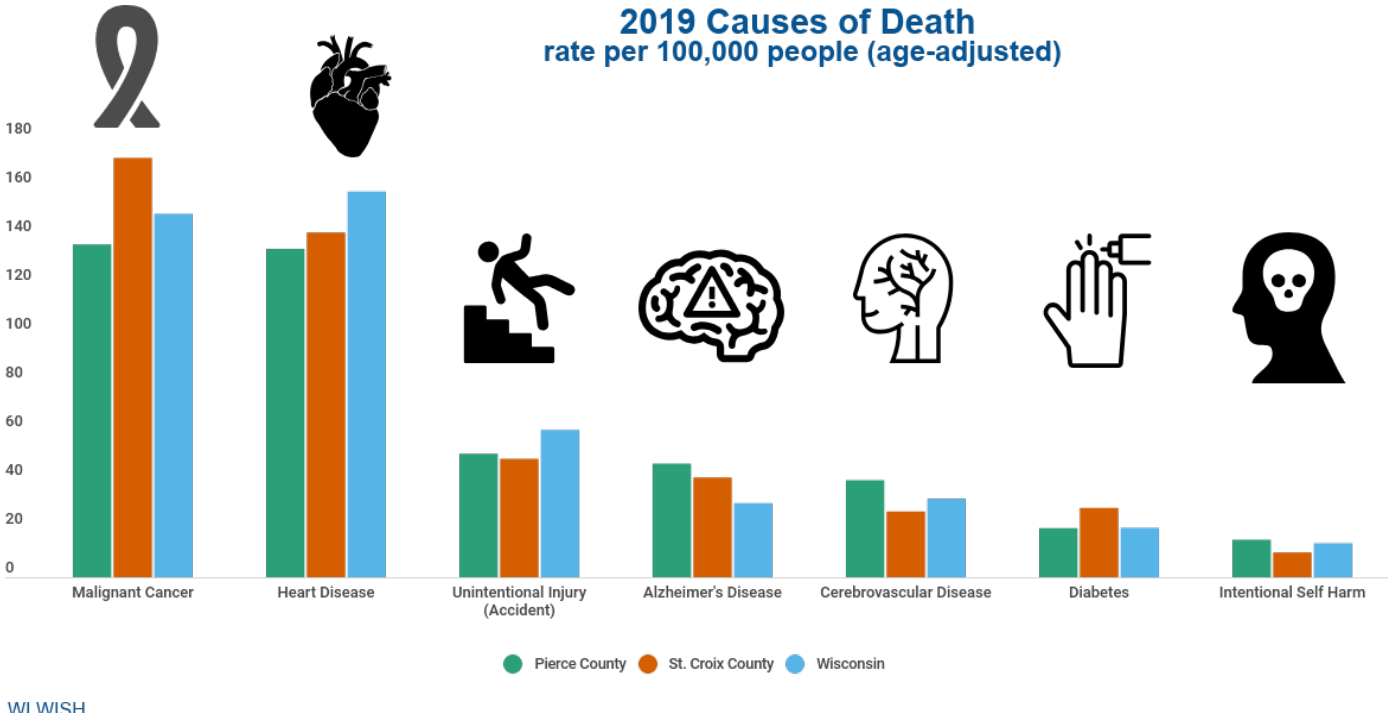
do not receive public or private services, while 37% of youth in Pierce and 43% in St. Croix can say the same.[11]

Poor mental health days can lead to higher unemployment, poverty, and mortality rate. Poor mental health can also result in serious adverse outcomes for the health and development of adolescents. It can lead to risky sexual behavior, illicit substance use, adolescent pregnancy, school absences/dropout, and other delinquent behaviors. About 1 in 5 Pierce and St. Croix County high school girls and about 1 in 10 high school boys have seriously considered suicide.[12] Firearms are, by far, the most commonly used method of suicide in this region of Wisconsin.



Causes of Death

Life expectancy estimates provide a reliable snapshot of population health and mortality in the United States. Life expectancy in the United States fell by a year and a half in 2020 to 77.3 years, the lowest level since 2003, primarily due to the deaths caused by the COVID-19 pandemic. Life expectancy from 2017-2019 was slightly higher in Pierce County (81.4 years) and St. Croix County (81 years) compared to Wisconsin (79.5 years). The top three causes of death in Pierce County, St. Croix County, and Wisconsin were all the same: malignant cancer, heart disease, and unintentional injury (accident). Rates of malignant cancer deaths are higher in St. Croix County than in Wisconsin or Pierce County.



[11] Wisconsin Mental Health and Substance Use Needs Assessment 2019
[12] YRBS 2019

Key Insights: Primary Community Data

Both qualitative and quantitative primary data were collected as part of the assessment process. Quantitative data was collected through a community health survey conducted in the summer of 2021. Focus groups and key informant interviews were conducted to gather qualitative data about community health strengths and concerns.

Community Health Needs Assessment Survey

The survey was collected virtually (using Survey Monkey) and via paper. Versions in Spanish were also available. Over 1,000 responses were collected, with 38.7% of respondents being Pierce County residents and 61.3% being St. Croix County residents. Respondents were overwhelmingly female (75.8%) and white (95.8%). We got responses from residents in every zip code in Pierce and St. Croix Counties.

1,097
People took the survey

425 (38.7%)
Were Pierce County residents

676 (61.3%)
Were St. Croix County residents

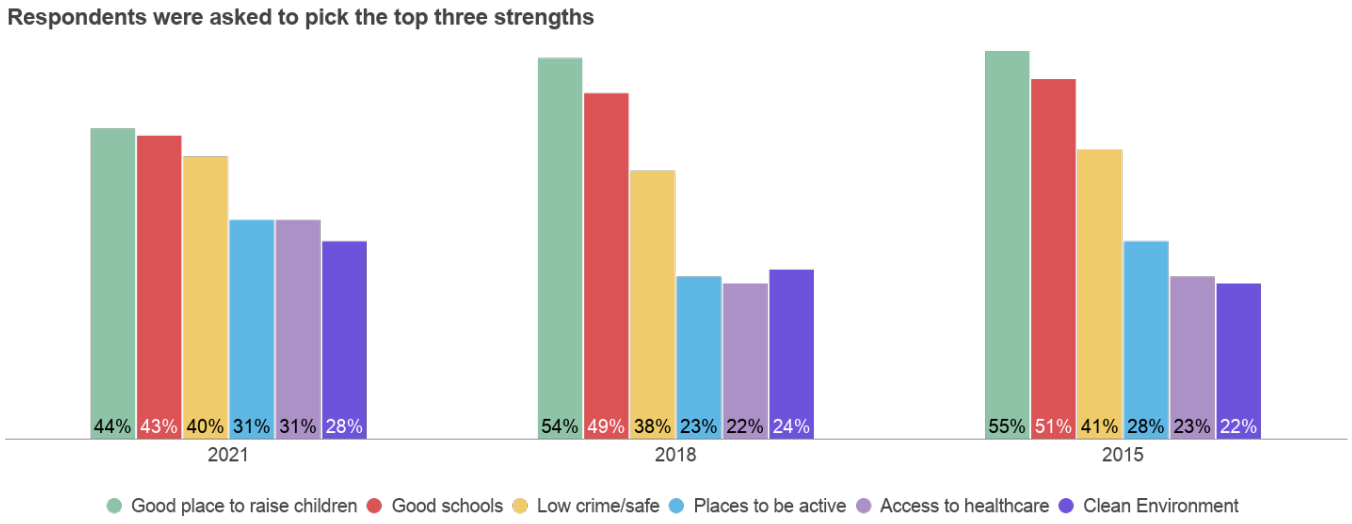
75.8%
Of respondents were female

95.8%
Of respondents were white

Community Strengths

Respondents were asked to select the top three strengths of our community. We compared historical data from previous surveys. Responses did not change much from previous years, with "good place to raise children," "good schools," and "low crime/safe" rising to the top for strengths. These top three remain consistent when data was disaggregated by county.

Top Community Strengths: 2021 vs 2018 vs 2015

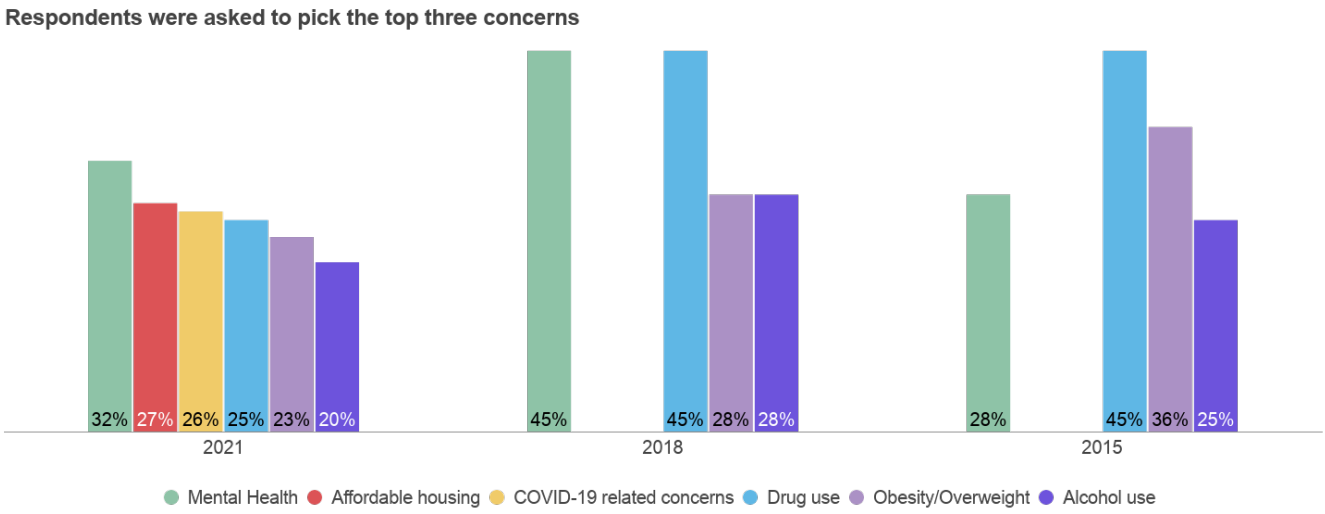


Note: In 2018 and 2015 access to healthcare was ability to get healthcare

Community Concerns

Respondents were asked to select the top three concerns they had about our community. Affordable housing and COVID-19 were offered as new options compared to previous surveys. The top three community issues in 2021 were "mental health," "affordable housing," and "COVID-19-related concerns." Drug use previously ranked second as a community concern, fell to fourth.

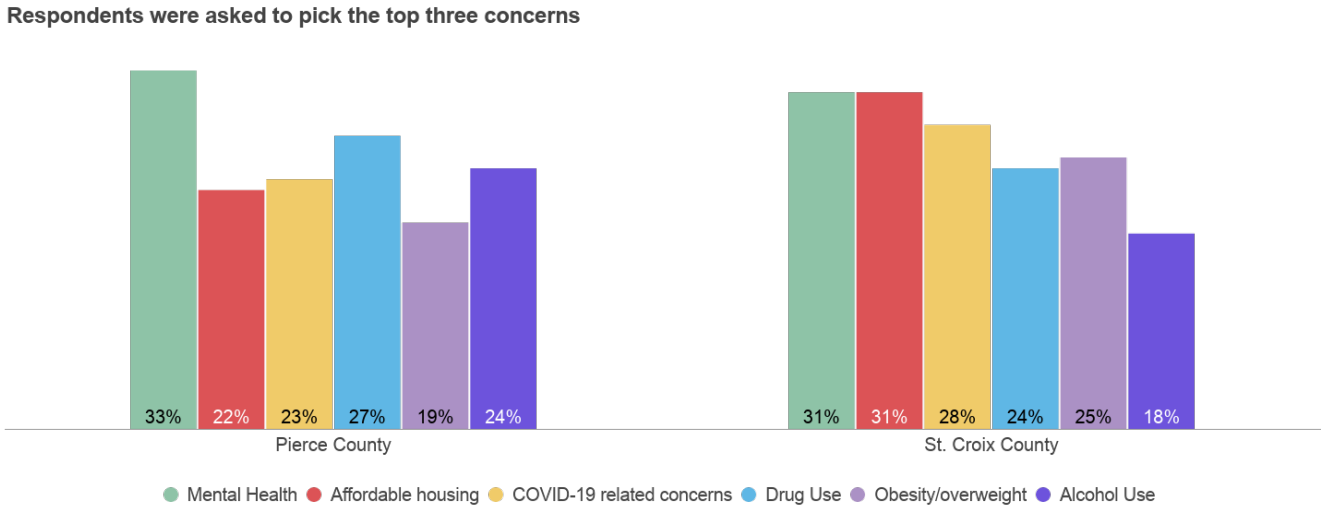
Top Community Concerns: 2021 vs 2018 vs 2015



Note: In 2018 and 2015 affordable housing and COVID-19 were not options for community concens.

Interestingly, when data was disaggregated by county, only 22% of Pierce County respondents ranked affordable housing as a top concern, and 31% of St. Croix County residents ranked housing as a top concern. Pierce County residents appeared more concerned with alcohol use, with 24% ranking it as a top concern, with only 18% of St. Croix residents ranking alcohol use as a top concern.

Top Community Concerns: Pierce County vs St. Croix County



Additional data

More data from the survey, including analysis of questions related to COVID-19 and barriers to access to care, are included in Appendix A.

Focus Groups/Key Informant Interviews

Focus groups were organized and led by Leadership Team members, and a thematic analysis was conducted based on the notes. Focus group or key informant interview participants included healthcare providers, public health officials, school district leaders, community members experiencing

homelessness, Hispanic community members, law enforcement officials, community non-profit service providers, youth, and experts in the field of housing.

Participants were asked to think about what has changed in the community over the past year or two. Themes in responses included: division in the community, increased mental health challenges, delayed medical care, more complex health and social situations, more food resources, and changes in how people access care/programs/work.

> "The pandemic became much more than a health issue. It is a political issue that has divided communities. We will need to find a way to rebuild trust." - School district leader

Participants noted that increased isolation and mental health issues were significantly made worse by the pandemic. Increased alcohol consumption, lack of civility, and workplace fatigue among healthcare and school staff were also noted as substantial needs emerging during the pandemic.

Discussion on inequities was an essential part of each focus group or interview. Many participants pointed out that people experiencing inequities often "fly under the radar" and that service and medical providers may have less awareness of hidden inequities. The Hispanic community focus group members indicated that they had experienced more racism in the past two years than ever before. Around the housing issue, housing experts and people experiencing homelessness described discrimination against Section 8 housing and resistance in communities to low-income housing projects.

> "I fear that the reliance on social media for information will make it even more difficult to share correct information. We are not listening to the experts anymore." -Healthcare provider

Participants were asked about their fears and hopes for the future of their communities. Participants reported worries about the continued political divide, lack of civil discourse, and concerns about social media platforms being used to propagate hate and misinformation. Lack of trust between residents and systems (i.e., public health, health systems, school districts, etc.) was also a significant concern. Participants also noted concerns related to increased medical and basic living costs.

Participants reported hoping for a renewed commitment to helping others through donations and neighbors helping neighbors. Providers also hoped for more funding for mental health services now that there is an increased understanding of how the pandemic impacted mental health.

More data from the focus groups and key informant interviews are included in Appendix D.

Connection with the State of Wisconsin Health Assessment

At the same time, Healthier Together was gathering community data, Wisconsin Department of Health Services was gathering data statewide for their own assessment process. The following needs were themes in their qualitative collection process:

- Increasing social and community connections
- Access to reliable transportation
- Access to affordable housing
- Access to jobs and other opportunities
- Decreasing institutional bias
- Access to quality and culturally informed healthcare
- Access to community-based resources

Similar themes emerged both locally and statewide related to access to basic living needs, as well as addressing bias.

Prioritizing Community Health Issues

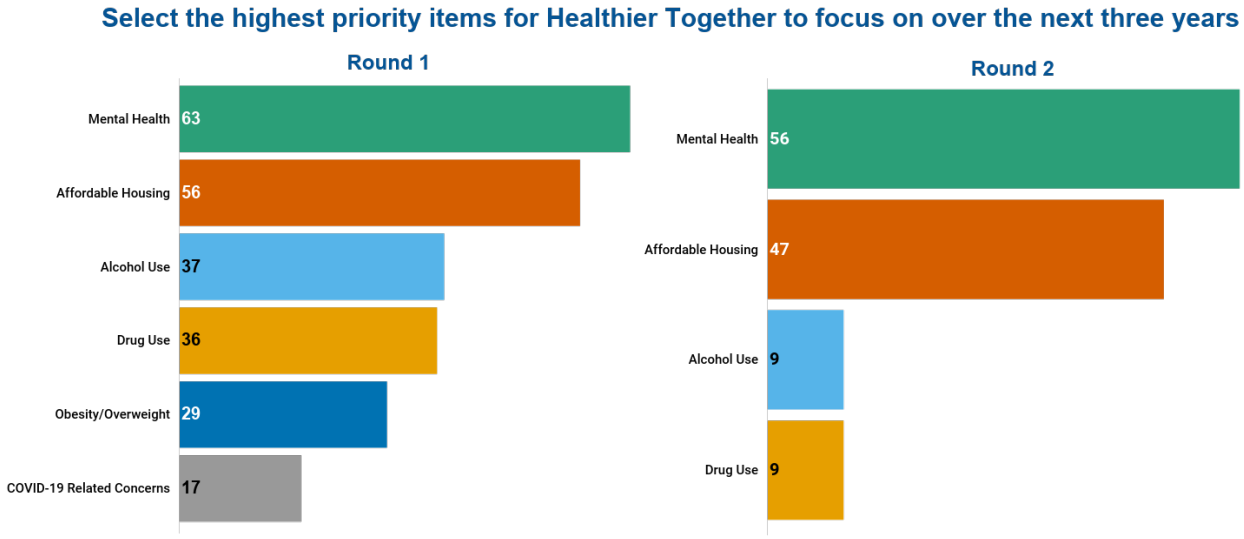
Healthier Together convened a group of diverse stakeholders in February 2022 to review secondary data related to various health topics, community survey results, key insights from focus groups and identified community assets.

Due to the ongoing COVID-19 pandemic, the stakeholder meeting was held virtually. Participants were provided with data ahead of time, including recorded data presentations. The stakeholder meeting was facilitated by staff from the Wisconsin Department of Health Services (DHS) Office of Policy and Practice Alignment. Stakeholders were identified by reviewing lists from the previous cycle's stakeholders. Key populations and emerging issues were also considered when determining new partners to invite to the meeting. The Leadership Team intentionally invited members of the LGBTQIA+ community, planning/zoning agencies, disability service providers, and housing organizations not previously engaged to the table in response to results from the focus groups and community survey.

In addition to Leadership Team organizations, the following organizations were invited to the stakeholder meeting (not all were able to attend):

- Allina Health EMS
- Assistance Resource Center - River Falls
- Baldwin-Woodville School District
- C3 Church (Hudson and Ellsworth)
- CASA of St. Croix County
- Pierce County Board of Health
- University of Wisconsin-River Falls
- Citizen Review Panel/Foster Parent Community
- City of New Richmond
- City of River Falls
- City of Prescott
- City of Hudson
- Community Member, business owner
- Ellsworth School District
- Elmwood School District
- Family Resource Center St. Croix Valley
- First Lutheran Church
- Free Clinic of Pierce & St. Croix Counties
- Gethsemane Lutheran Church (Baldwin)
- Glenwood City School District
- Hudson Backpack Program
- Hudson School District
- Pierce County Judge, CJCC chair
- Operation HELP
- Our Neighbor's Place
- Out in the Valley/Mental Health Provider
- Pierce County Econ Development
- Pierce County Hunger Prevention Council
- Pediatrician at MHealth Fairview
- Pierce ADRC
- Pierce County Human Services
- Pierce County Land Management
- Pierce County Sheriff
- Pierce County WIC/Hunger Prevention Council Board
- Plum City School District
- Prescott School District
- Restorative Services
- River Falls School District
- Salvation Army - Grace Place
- SCC CJCC
- SCC Community Development
- SCC Foster Care Coordinator
- School District of New Richmond
- School District of Somerset
- Spring Valley School District
- St. Croix Central School District
- St. Croix County ADRC
- St. Croix County Behavioral Health
- St. Croix County Medical Examiner
- St. Croix County Parks
- St. Croix County Sheriff's Office
- St. Croix County HHS Board
- St. Croix Therapy
- St. Croix Valley Food Bank
- St. Croix Valley Foundation
- St. Croix Valley SART
- Turningpoint
- University of Wisconsin – Madison Division of Extension
- UWSCV Success by 6 Director
- Veteran's Service- Pierce County
- WestCAP
- Youth Action Hudson

During the meeting, stakeholders used a multi-voting process to reach an agreement on top priority areas for focus during the next three years. The menu of priorities was based on the community health survey's top six needs.



This process identified mental health and Affordable housing as top priority issues.

The Healthier Together Executive Team met after the stakeholder meeting to review the results of the prioritization process. The executive team broadened the title of the mental health priority area to "Mental, Social, and Emotional Wellness" to encompass a more inclusive view of this work. The team reframed the housing priority area into a broader priority area focusing on the community contexts that impact health and renamed the priority area "Thriving and Livable Communities for All." While housing could be an important part of this priority area, the Executive Team wanted to give broader freedom to the coalition to work on other social determinants of health, including access to care and basic needs, a clean environment, healthy housing, and access to high quality and affordable child care.

The Healthier Together Leadership Team then wrote scope statements for each priority area.

Mental, Social, and Emotional Wellness

Mental wellness includes our emotional, psychological, and social health. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Healthier Together is focused on creating policy, systems, and environmental changes that support mental wellness for all residents of Pierce and St. Croix Counties and prevent mental illness from occurring.

Mental and physical health are equally important components of overall health and impact each other in complex ways. For example, depression increases the risk for many physical health problems, including diabetes, heart disease, and stroke. Similarly, chronic conditions can increase the risk of mental illness.

Healthier Together acknowledges that substance use disorders and mental health issues are often co-occurring and must often be addressed together as part of this priority area.

Thriving and Livable Communities for All

Healthier Together understands that the conditions in the environments where our residents are born, live, learn, work, play, and age affect a wide range of health outcomes. These conditions can include factors such as economic stability, access to quality education and childcare, access to health care,

access to affordable and healthy housing, access to transportation, safe air and water, access to nutritious foods, and safe and plentiful places for physical activity.

Disparities in these conditions contribute to vast health inequities in health outcomes. Simply promoting healthy choices won't eliminate these health disparities. Instead, organizations across sections need to act to improve conditions in people's living environments.

Healthier Together is committed to supporting social, physical, and economic environments that promote attaining the full potential of health and wellbeing for all.

Connection with the State of Wisconsin Health Improvement Plan

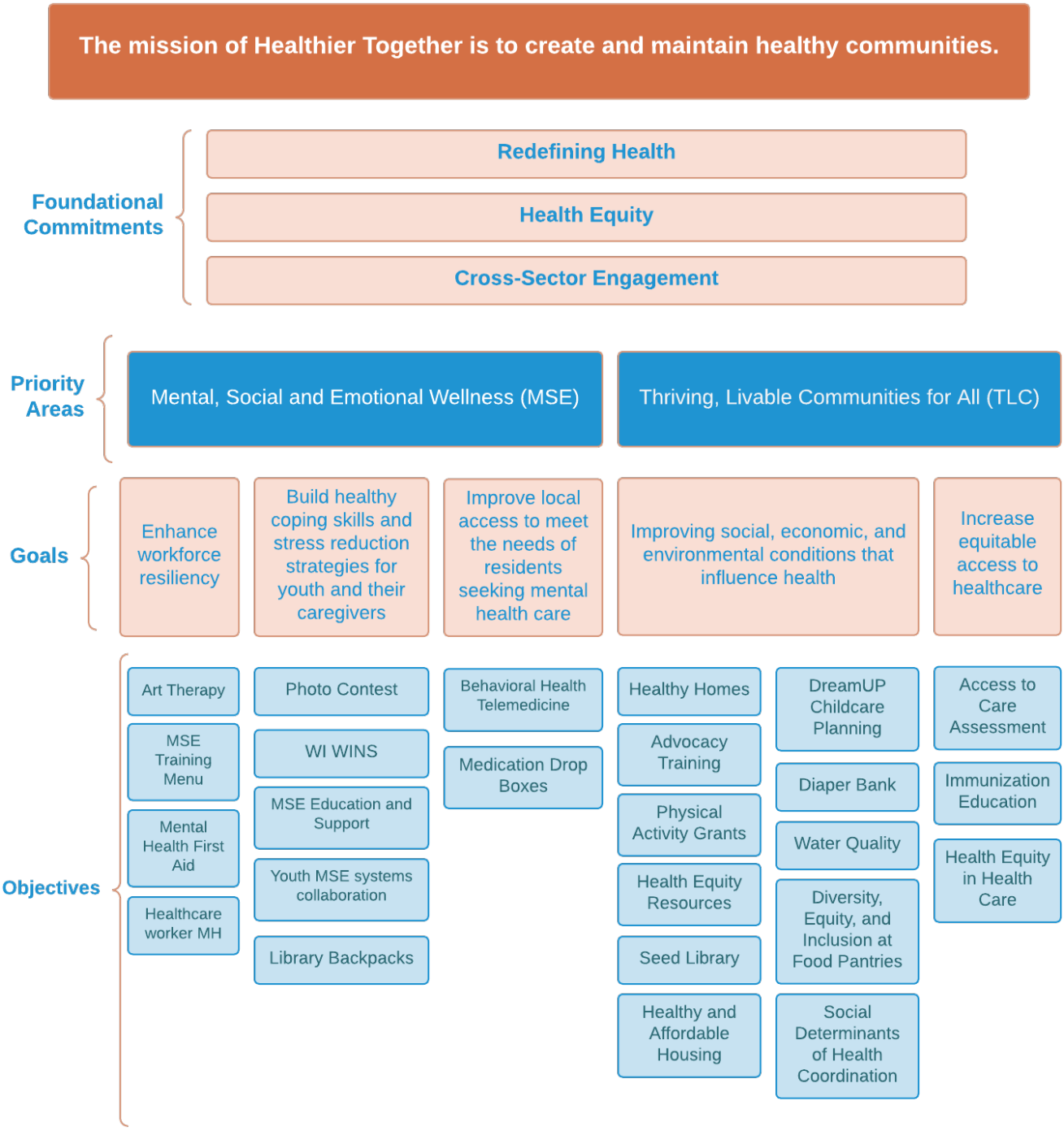
The Wisconsin Department of Health Services was simultaneously developing its Statewide Health Improvement Plan while Healthier Together developed our plan. The following priority areas were preliminarily identified through the statewide process:

- Social and community conditions (the social determinants of health)
- Physical, mental and systemic safety
- Person and community-centered health care
- Social connectedness and belonging
- Mental and emotional health and wellbeing

It is clear that the social determinants of health, access to care and mental, social and emotional wellbeing are shared priorities statewide and locally.

Goals and Objectives

The following goals and objectives were named through a coalition-wide, participatory planning process led by the Leadership Team. Objective templates were provided to all coalition members (Appendix F), and resources for locating evidence-based or evidence-informed practices were shared to assist coalition members with research (Appendix H). These goals and objectives will be revisited annually, and action plans with specific activities and progress measures will be developed. A complete listing of goals and objectives can be located in Appendix G.



Tracking Implementation

Throughout the implementation phase, the Leadership Team and individual objective owners will track population-level and progress measures to document progress toward meeting goals and objectives and adjust the implementation plan as needed. Each objective and associated performance measures will be evaluated annually during a data review and group discussion, resulting in appropriate changes to the CHIP as indicated. At the conclusion of the plan, population-level measures tied to goal areas will also be evaluated to understand the collective impact activities may have had on the health status of our communities.

Strengthening Leadership for Collective Impact

Healthier Together's Leadership team is the backbone of the coalition. In the Collective Impact model, backbone organizations help maintain the overall strategic coherence of a coalition and coordinate and manage day-to-day operations and implementation work, including stakeholder engagement, data collection and analysis, and communications.

In order to continuously grow and develop our skills in explorative and inclusive leadership, Healthier Together's Leadership Team plans on working with the University of Wisconsin – Madison Division of Extension Educators on a self-reflection and coaching process during the implementation of the CHIP. The first goal of the coaching session is to strengthen trust and alignment among Leadership Team members through strengths-based assessment and transparent communication. The coaching process will also be used to thoughtfully re-examine the coalition's shared mission, core agreements, roles, and organization.

The Five Conditions of Collective Impact
Courtesy of USC Student Affairs

Acknowledgments

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

- Individual community members who offered their time and valuable insights;
- Partner organizations that met to review and prioritize data and develop implementation plans and the individuals who contributed their expertise and experience to ensure a thorough and effective outcome;
- Member organization's staff who provided knowledge, skills, and leadership to bring the assessment and plan to fruition;
- Members of the CHNA steering team, representing the four hospitals, United Way of St. Croix Valley, and two public health departments in the two-county region;
- Wisconsin Department of Health Services Office of Policy and Practice Alignment for facilitating our issue prioritization process.

Appendices

Appendix A. Community Health Needs Assessment Survey

Healthier Together Pierce & St. Croix Counties
Community Health Survey 2021

Please take a few minutes to complete the survey below. The purpose of this survey is to determine community strengths and weaknesses. The results of this survey will be used to address community health needs.

1) Are you 18 or older? ___ Yes ___No

2) What county do you live in? ___Pierce ___St. Croix
Note: If you don't live in Pierce or St. Croix counties, please do not fill out this survey. Thank you for your time!

3) What are your county's top three community health related strengths? Please choose up to three.

___ Good place to raise children
___ Good schools
___ Access to healthcare
___ Clean environment (water, air, etc.)
___ Good jobs and healthy economy
___ Acceptance of racial diversity
___ Acceptance of religious diversity
___ Sense of community
___ Access to dental care
___ Low crime/safe neighborhoods
___Access to healthy foods
___ Places to be active (parks/paths/recreation)
___ Affordable housing
___Transportation
___Acceptance of diversity in political views
___Acceptance of diversity in gender identity/expression

4) What are the three most important health related concerns in your county? Please choose up to three.

___ Access to healthcare
___Access to dental care
___Reproductive and sexual health
___Communicable diseases (measles, influenza, etc.)
___COVID-19 related health concerns (long-term impacts, variants, etc.)
___ Chronic disease (cancer/heart disease/diabetes)
___ Obesity/Overweight
___ Physical inactivity
___ Access to healthy foods
___ Lack of affordable housing
___Lack of acceptance of racial diversity
___Lack of acceptance of religious diversity
___ Dementia care
___ Mental health conditions
___ Alcohol use
___ Drug use
___Tobacco, e-cigarette use
___Lack of Transportation
___ Domestic violence
___ Community safety and violence
___Motor vehicle safety
___ Unclean environment (water, air, etc.)
___Lack of acceptance of diversity in political views
___Lack of acceptance of diversity in gender identity/expression

5) Do you think health resources are equitable (fair and just) regardless of age, race, income, and/or gender in your community? Yes____ No____

6) Comments or other health problems in your community that should be addressed by Healthier Together:

_____

_____

_____

PLEASE COMPLETE THE SECOND PAGE OF THE SURVEY

On the second page, we are going to ask you some questions about your household.

7) What barriers have you experienced to accessing health care or health resources for yourself or your household? Check all that may apply.

___ Ability to take time off from work
___ Access to childcare
___ Age
___ Convenient appointment times
___ Cost of care (such as high deductibles, copays, out-of-pocket expenses)
___ Gender identity/expression
___ Income
___ Internet/technology access
___ Internet/technology knowledge
___ Insurance coverage (lack of coverage, poor coverage, provider not covered)
___ Lack of trust in medical providers
___ Language barriers
___ Negative past experience with medical care
___ Proximity to medical specialists
___ Race/Ethnicity
___ Transportation
___ Other barrier not listed:_____
___ I have not experienced any barriers to accessing health care or health resources

8) How was your household most impacted by the COVID-19 pandemic? Please choose up to three.

___ Inability to obtain healthy and affordable food
___ Increased alcohol/substance use
___ Child care issues
___ Death or illness of a household member
___ Social isolation/loneliness
___ Access to reliable internet for school, work or tele-health
___ Access to COVID-19 testing
___ Physical abuse
___ Inability to find or remain in affordable housing
___ Educational access/achievement issues
___ Delay in receiving medical care
___ Mental health concerns
___ Loss of employment
___ Access to COVID-19 vaccinations

___ Other: _____

9) During the COVID-19 pandemic, where did you obtain health advice or information you trusted the most? Please choose up to three.

___ Your primary care provider (doctor, nurse practitioner, physician's assistant)
___ Another healthcare provider (dentist, chiropractor, etc.)
___ Center for Disease Control and Prevention (CDC)
___ World Health Organization (WHO)
___ WI Department of Health Services
___ Your local health department
___ Print, TV or radio media
___ Friends and family
___ Your employer
___ Your church
___ Your school or your child's school
___ Social media

___ Other:_____

Gender: ___ Male ___ Female ___Non-binary ___Other ___Prefer not to answer

Age: ___ 18-24 years ___ 25-44 years ___ 45-64 years ___ 65 years and over

Household Income: ___ under $25,000 ___ $25,000-$49,999 ___ $50,000-$99,999 ___ $100,000-$149,999 ___ $150,000-$199,999 ___ $200,000 and over

Zip Code: _____

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino

Race: ___American Indian/Alaska Native ___Asian ___Black or African American ___Native Hawaiian/Pacific Islander ___White ___Other ___Two or more races

Thank you for your time! Results of this survey will be used by Healthier Together to plan and implement community health activities over the next few years.

Appendix B. Community Survey Results

Healthier Together's 2021 community health needs assessment survey results can be found here: https://infogram.com/1p1rnwkq5yw0z1cmv00mzk0pg0a61w60r6p?live

Appendix C. Secondary Data Dashboard

Healthier Together's 2022 data dashboard can be found here: https://infogram.com/1plrldl1m0qg5ehqrkzm576yg5czz1lz5ez?live

Note: This dashboard may be continuously updated as new data sources become available. Visit our website for the most updated community health data: https://www.healthiertogetherpiercestcroix.org/

Healthier Together Pierce – St. Croix Community Key Informant Interview Analysis

December 2021 – January 2022

Healthier Together
Pierce County
St. Croix County

Focus Groups/ Interview Participant Groups

- Healthcare Providers
- Public Health
- School Districts
- Community Members Experiencing Homelessness
- Hispanic Community Members
- Law Enforcement
- Community Nonprofit Service Providers
- Youth
- Housing Experts

Thinking back over the last year or two, how is your community/ the community you serve different than other years?

Themes

- Division of Community
- Increased Mental Health Challenges
- Delayed Medical Care
- More Complex Health & Social Situations
- More Food Resources
- Change in how People Access Care/ Programs/Work

Thinking back over the last year or two, how is your community/ the community you serve different than other years?

Quotes

"Previously I fell through the cracks, recently I have been able to get more help."

– Community Member

"The pandemic became much more than a health issue. It is a political issue that has divided communities. We will need to find a way to rebuild trust."

– School District

"There is a higher level of need and circumstances are more challenging."

– Community Service Provider

Thinking about the community today, if you had to choose, which 2 or 3 of these 5 priorities seem the most important?

1. **Mental Health (Nearly all participants)**	2. Drug use *+Alcohol*	3. Overweight/ Obesity
4. Affordable Housing (tie)	4. COVID Concerns (tie)	*Other: Physical Inactivity; Transportation; Access to/lack of resources; Language barriers/ Discrimination*

How has COVID impacted you/ your community's needs?

Themes

- Increased SOCIAL ISOLATION and mental health issues
- Increased alcohol consumption
- Lack of civility and stress is impacting mental wellness
- Healthcare/school staff fatigued and stressed
- Challenging to keep up with changing COVID guidelines/ restrictions and funding options related to COVID funding (i.e. housing)

How has COVID impacted you/ your community's needs?

Quotes

"COVID has exposed and exaggerated different types of needs than in the past."

– Community Service Provider

"During COVID, there is a lot of individual focus and sense of community has gone away. People are more isolated and alone."

– Community Member

When you think about your experiences with inequities or working with people experiencing inequities *(related to race, religion, economic opportunity, education access/quality, healthcare access/quality, environment, gender identity, social support, or disabilities)* **tell us about the ways you have seen these people being treated differently.**

Themes

- Many people experiencing inequities fly under the radar or people aren't aware. Need to build systems assuming barriers (i.e. language, transportation, etc.)
- Experience more discrimination/racism in the past 2 years.
- Some service providers feel they treat everyone the same regardless of inequities but recognize they may have less awareness about some hidden inequities.
- People are supportive of affordable housing, but they don't want it close to them.
- Challenges accessing some services and basic needs.
- Common materials need to be translated and distributed in the right locations.

When you think about your experiences with inequities or working with people experiencing inequities *(related to race, religion, economic opportunity, education access/quality, healthcare access/quality, environment, gender identity, social support, or disabilities)* tell us about the ways you have seen these people being treated differently.

Quotes

"People assume that more options equals increased accessibility. However, virtual options aren't s option for those without internet/bad connections. More in-person options doesn't help someone without transportation and having more [printed] materials doesn't help if they aren't in the person's first language." – Community Service Provider

"I have experienced more blatant discrimination and racism in the past 2 years." – Hispanic Community Member

"Racial topic…Some of those things go on unnoticed, unchecked, things we never hear about, but we're not so naïve to think it doesn't happen." – School District

"There is stigma around Section 8 housing and the type of renters they will be. Many rental owners do not want anything to do with Section 8. - Housing Expert

What do you FEAR the most for the future?

Themes

- Fear of continued political divide and inability to go back to civil discourse
- Concern about use of social media platforms to propagate hate and misinformation
- Lack of trust between residents and systems (i.e. public health, health systems, school district, etc.)
- Continued increased medical costs and lack of access
- Fear of overall price increases—housing, gas, cost of raising families

What do you FEAR the most for the future?

Quotes

"Fear the inability for communities to have disagreements and not hate each other in the process. I fear it will tear our community apart. It will drive up mental health issues, stress, etc."
– School district

"I fear that the reliance on social media for information will make it even more difficult to share correct information. We are not listening to the experts anymore." *- Health Provider*

What do you HOPE the most for the future?

Themes

- Renewed sense of helping others through donations, neighbors helping neighbors, etc.
- Overall better understanding of the mental health needs (youth and adult) of the community and hopefully that there will be more access and funding for needed services.

What do you HOPE the most for the future?

Quotes

"Mental health and addiction is at least being discussed. It is not being slipped under the rug. Stigma is going down some but still an issue."

– Community Member

"I hope that everyone will learn to be more welcoming to everyone (people of color, transgender people, etc.).

- Youth

"I am hopeful that the community will continue to donate to food shelves and rise up to help their neighbor's need."

– Medical Provider

Closing Thoughts

"Main goal of Healthier Together should be to bring people together– make a "bigger tent" – to make sure that all opinions are represented. Need preventative focus to prevent and manage chronic disease– these are results we will not see for 5-10 years. Focus on blue zone approach/built environment to get upstream of chronic disease."

– Medical provider

Appendix E. Assets and Resources

United Way St. Croix Valley developed this list of community assets in preparation for the Healthier Together stakeholder meeting in February 2022. This is not intended to be an exhaustive list of community resources and reflects feedback from HT's large group members and our local 211 resource database.

Community Health Need	Strengths/Community Assets	
MENTAL HEALTH & SUBSTANCE USE	• Arbor Place • Aurora Community Counseling • NAMI • Northwest Counseling & Guidance Clinic • Pierce County Department of Human Services • St. Croix County Department of Human Services • Western Wisconsin Health • The Butterfly Path • Adulteen Counseling • St. Croix County Veterans Services • Burkwood Treatment Center • Monarch House • ONYX • Mindful SOULution • WI Quit Line • MBC Collaborative	• Mental Health First Aid Trainings • Make It OK Ambassadors • 211 Wisconsin Addiction Recovery Helpline (WARH) • Change to Chill • SAMHSA • Programs for Change • Peace Tree Counseling • ADRC St. Croix County • Walk On Therapeutic Riding • Medication disposal programs • Hudson Alano Club • New Richmond Alano Club • St. Croix Valley Restorative Services • Pierce County Treatment Court • St. Croix County Treatment Court • River Falls Alano Club
HOUSING	• Assistance and Resource Center • Northwoods Homeless Shelter • Operation Help • Our Neighbors' Place • River Falls Housing Authority • Prescott Housing Authority • Rural Housing	• St. Croix Valley Habitat for Humanity • St. Croix Valley Job Center • Salvation Army – Grace Place • Salvation Army – Pierce County • Turning Point • THUG Life • WestCAP
COVID-19	• Pierce County Public Health • St. Croix County Public Health • Hudson Hospital & Clinic • Western Wisconsin Health	• Westfields Hospital • River Falls Hospital • Lakeview Hospital • Hudson Area COVID Taskforce
OBESITY, FOOD & PHYSICAL ACTIVITY	• Baldwin Community Food Pantry • Christian Food Cupboard of Hudson • Five Loaves Food Shelf & Clothing Center	• Roberts Congregational UCC Church Food Pantry • Hunger Prevention Council of Pierce County, Inc. • The Centre New Richmond • Abundant Yoga Community

	• Woodville Food Pantry • Pierce County Food Pantry • Hudson Backpack Program • Prescott Food Pantry • River Falls Community Food Pantry • Somerset Food Pantry • St. Croix Valley Food Bank • WIC • Ruby's Pantry – Faith Community Church • Servant of the Shepherd Church Food Pantry • Journey House Food Pantry • UW-Extension FoodWise • Local farmers & farmers' markets • Spring Valley Community Food Pantry • Plum City Food pantry • Elmwood Food Pantry • The Zone • Santosha Studio • River Valley Trails • The Press Room • YMCA in Hudson	• Kids in Nature Healthier Together Workgroup • HealthPartners Power-Up • Hudson Fresh Express Mobile Market • Mobile food pantries • YMCA in Hudson • The Centre • Western Wisconsin Health Fitness Center • Snap Fitness • Anytime Fitness • Inspiring Actions Yoga • Lighthouse Yoga & Fitness • HOTWORX • Riverfront Athletic Club • River City Ironworx Gym • Peek-A-Boo Boxing Gym • Curves • UWRF Falcon Center • Raider Fitness Center • Wild River Fitness Center • In Balance Yoga & Fitness LLC • Farrell's Extreme Bodyshaping
ADDITIONAL ASSETS	• ADRC • SART • United Way St. Croix Valley • Workforce Resource • Free Clinic St. Croix & Pierce Counties • School District Partners • Family Resource Centers	• Free Clinic of Pierce & St. Croix County • St. Croix County Economic Support Unit • Center for Independent Living - Western Wisconsin • Pierce County Economic Support • Library System • County & State Park Systems
COMMUNITY COALITIONS, TASKFORCES, AND FOUNDATIONS	• Hudson Inclusion Alliance • Youth Resource Committee • Raider Network • Hunger Prevention Council • Western Wisconsin Homeless Coalition • Success By 6 • HAMA • St. Croix Valley Foundation • River Falls Community Foundation • Hudson Community Foundation	• Somerset Community Foundation • New Richmond Area Community Foundation • CARES Coalition • UW - Extension St. Croix County • UW – Extension Pierce County • New Richmond Community Health Action Team (CHAT) • St. Croix County CJCC • Pierce County CJCC

Appendix F. Objective Template

Healthier Together Pierce and St. Croix Counties
2023-2025 Community Health Improvement Implementation Plan

2023-2025 Healthier Together Objective Template

Date Submitted: **Date Reviewed/Updated:**

TLC PRIORITY GOAL SELECTION *(select only one goal)*
__ **Goal 1: Improve social, environmental and economic conditions that influence health**
__ **Goal 2: Increase equitable access to health care**

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**			
Indicator	**Baseline (please include year)**	**Source**	**Frequency**

OBJECTIVE:
Objective Coordinator: **Objective Team Members:**
OBJECTIVE BACKGROUND: **Please answer the following questions as completely as possible. If you have questions, please attend Office Hours.** **1) Evidence-Based/Evidence-Informed:** Was evidence-based/evidence-informed resources used in the development of this objective? If so, please list resources used. **2) Health Equity:** Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Health equity is an important consideration for the role it plays in individual and community health but the opportunities to be healthy are not the same for all. There are differences in health based on race, ethnicity, neighborhood, sexual orientation, and other factors. What health inequities, gaps in health, or root causes are addressed by your objective? **3) Impacted and/or target population(s):** What population(s) will be impacted by this objective? How are you planning to engage and collaborate with the target population in this objective? Have you considered potential unintended consequences to your target population or another population?

ACTION PLAN **Actions Taken to Complete Objective (add rows if needed)**				
Activity	**Timeline**	**Resources Required**	**Lead Person/ Organization**	**Activity Progress Metric**

Appendix G. Goals and Objectives List

Priority Area: Mental, Social and Emotional Health

- **Goal 1: Enhance workforce resiliency and wellbeing**
  - **Objective 1a:** By July 2023, engage at least 15 community members in arts-based focus groups to better understand their experience of the pandemic, while also supporting community recovery through artistic expression.
  - **Objective 1b**: By May of 2023, develop and promote a menu of mental health and emotional wellness training and assistance programs throughout St. Croix and Pierce counties.
  - **Objective 1c**: Expand Youth and Adult Mental Health First Aid training opportunities through strategic collaboration with YMCA in Hudson, United Way St. Croix Valley and other community partners in St. Croix and Pierce County, resulting in 250 new individuals trained as Mental Health First Aiders by December of 2023.
  - **Objective 1d:** By December 2023, address the short and long-term mental health impacts that COVID-19 had on healthcare workers (direct and non-direct patient care) by offering 4 resiliency training and employee engagement opportunities to promote wellbeing, teamwork, and employee retention.
- **Goal 2: Build healthy coping skills and stress reduction strategies for youth and their caregivers**
  - **Objective 2a**: By July 2023, engage at least 10 youth in the photo contest to express their experience during the pandemic and their hopes for the future.
  - **Objective 2b**: By June 2023, conduct checks of 34 facilities in Pierce County and 71 facilities in St. Croix County to see if they will sell tobacco or vaping products to minors. Take an education-based approach for retailers who do sell.
  - **Objective 2c**: By December 2025, increase awareness of mental health, mental illness, substance use disorders and their associated stigma through community awareness, education and support opportunities by establishing 4 new communities partners.
  - **Objective 2d**: By December 2023, increase youth mental health collaboration among school, county, medical, and non-profit partners to support mental health screening, support, and coordination of care for youth to bimonthly meetings with at least 92% of Pierce and St. Croix County school districts participating.
  - **Objective 2e:** By December 2023, increase access to the library parks backpack program with multilingual materials in every backpack.
  - **Objective 2f**: By Spring 2025, the Mental, Social and Emotional Wellness group will meet with St. Croix and Pierce County community foundations (St. Croix Valley Foundation, Hudson Community Foundation, New Richmond Community Foundation, Somerset Community Foundation, River Falls Community Foundation, Prescott Community Foundation) to inform grantmaking that supports programs that build healthy coping skills and stress reduction strategies for youth and their caregivers.
- **Goal 3: Improve local access to meet the needs of residents seeking mental health care**
  - **Objective 3a**: Maintain behavioral health crisis telemedicine in 4 hospital EDs and increase behavioral health telemedicine in 2 satellite sites by 2025.
  - **Objective 3b**: By 2025, increase amount of prescription medications and opioids collected in a secure manner at drop box locations at hospitals by 5%.
  - **Objective 3c**: By December 31, 2023, increase participation by 10% for two community symposium events that inform, and/or educate the public on issues related to mental health and/or substance use disorders.

Priority Area: Thriving and Livable Communities for All

- **Goal 1: Improve social, environmental, and economic conditions that influence health**
  - **Objective 1a:** By December 2023, present Having a Healthy Home at 5 community events or meetings.
  - **Objective 1b:** Through the state-funded Project Growth: DREAM UP! grant opportunity, the established grant Core Team Members will participate in a strategic Planning Process for the purpose of improving and expanding the childcare capacity within a specified region of St Croix and Pierce Counties. By 9/2023, core team members will have met 6 times to establish an agreed goal for improvement.
  - **Objective 1c:** By December 2023, provide grassroots advocacy training to at least 15 Healthier Together members.
  - **Objective 1d**: By January 2024, begin a monthly distribution of free diapers to Pierce County residents who need them.
  - **Objective 1e**: By December 2023, complete the final housing assessment process and report to include at least three potential next steps related to housing policy, systems, or environmental changes.
  - **Objective 1f**: By December 2024, six community-led projects to increase equitable opportunities for physical activity will be funded and completed.
  - **Objective 1g**: In 2023-2025, Pierce and St Croix Counties will join together to complete 6 screening events in order to increase the number of private well screened for Nitrate for all, increase access to lab certified Nitrate testing of drinking water for all, and evaluate results to identify townships with elevated nitrate levels to plan future activities.
  - **Objective 1h**: By 2023, establish a health equity page on Pierce/St. Croix Healthier Together's website. This page will provide vetted resources that have been previously explored or implemented by workgroup members. These resources can then support the work of Healthier Together as well as the public around the subject of health equity and the social determinants of health. Once established it will be improved and maintained throughout the 2023-2025 Community Health Improvement Plan.
  - **Objective 1i:** By December 2023, implement a system-wide approach to address Social Determinants of Health (SDoH) in 4 medical centers in Pierce and St. Croix counties through screening, systems, community partnerships, and referrals.
  - **Objective 1j**: By July 2023, 50% of food pantries in Pierce and St. Croix Counties will implement a new Diversity, Equity, and Inclusion practice in their pantry operations.
  - **Objective 1k**: By December 2023, at least 20 Pierce County community members will participate in a seed library to empower families to grow vegetables and fruits at home.
- **Goal 2: Increase equitable access to health care**
  - **Objective 2a**: By May 2023, complete an access to care assessment through qualitative research on 30 individuals or families experiencing homelessness or in transitional housing in St. Croix County.
  - **Objective 2b**: Increase communication and communication strategies with the public on immunizations to increase the rates of vaccination in children 0-18y by 10% as documented in WIR by the end of 2025.
  - **Objective 2c**: Identify and address barriers to care to ensure health equity for all we serve in the 4 medical centers in Pierce and St. Croix Counties by 2025.
  - **Objective 2d**: By December 2025, establish at least 2 new dental partnerships to increase access to dental care for Pierce and St. Croix County residents.

Appendix H. Resources for Identifying Evidence-Based and Promising Public Health Practices

Healthier Together
Pierce County
St. Croix County

Resources for Identifying Evidence-Based and Promising Public Health Practices

Healthier Together identified a need for resources action team members can use to identify evidence-based and/or promising practices to use in developing strategies for our Community Health Improvement Plan. Evidence-based practices are activities or strategies shown through scientific research to be effective at preventing or delaying a health outcome. Promising practices are programs or strategies that appear to have worked in one context but do not have enough research to determine if they will be effective elsewhere. The following list includes well-known, user-friendly, and public health-focused databases.

Source	Summary	Tips on Navigation
CDC's Health Impact in 5 Years (HI-5)	The Health Impact in 5 Years (HI-5) initiative highlights non-clinical, community-wide approaches that have evidence reporting 1) positive health impacts, 2) results within five years, and 3) cost-effectiveness. Topics include: school-based programs to increase physical activity, safe routes to school, tobacco control interventions, pricing strategies for alcohol products, and multi-component worksite obesity prevention, and early childhood education.	Choose a subject area using the menu on the left
Guide to Community Preventative Services	This guide is a collection of evidence-based findings interventions to improve health and prevent disease. It contains a wide variety of topics including: adolescent health, cancer, cardiovascular disease, diabetes, excessive alcohol consumption, health communication and health information technology, health equity, mental health, nutrition, obesity, oral health, physical activity, tobacco, and worksite health.	Start with the topic dropdown at the top of the page to direct to your area
What Works for Health Wisconsin	What Works for Health provides communities with information to help select and implement evidence-informed policies, programs, and system changes that will improve the variety of factors that affect health.	To search, click on a health factor (blue boxes in chart) or search by keyword at the top of the left column

Source	Summary	Tips on Navigation
NACCHO's Model Practices Database	This is a database of programs from Local Health Departments across the United States that are nationally recognized as model practices.	Create a free NACCHO account in order to access/download materials. Search the database by type of practice, state, year, submission type, and size of area served by the Local Health Department
Healthy People 2020 Evidence-Based Resource Tool	This database includes evidence-based practices on many topics in public health, and visually summarizes the strength of evidence for each practice. Common topics include: access to health services, adolescent health, educational and community-based programs, health-related quality of life & wellbeing, maternal and child health, mental health and mental disorders, nutrition and weight, older adult's health, physical activity, sleep health, social determinants of health, and substance abuse.	Use the search criteria on the left to filter results by topic area
CDC Community Health Improvement Navigator	This database provides a summary of best practices for seven targeted risk factors: tobacco use and exposure, unhealthy diet, high blood pressure, obesity, physical inactivity, high cholesterol and diabetes.	Search for practices by risk factors, target populations, outcomes, settings, intervention types, or assets
SAMHSA's Evidence-based Practices Resource Center	This database provides evidence-based Treatment Improvement Protocols, toolkits, resource guides, and clinical practice guidelines on four topics: substance use prevention, substance use treatment and recovery, opioid specific resources, and serious mental illness and other mental health.	Search resources using the drop-down boxes for topic area, population, and/or target audience
Public Health Agency of Canada's Canadian Best Practices Portal	This portal includes evidence-based resources on substance use, prevention of chronic diseases, health equity, mental health, injury prevention, and oral health.	Select search all interventions from Interventions on the menu at the top of the screen. Sort by evidence type, population, topic, risk factor, and community setting
City Health	City Health rates the nation's 40 largest cities based on their progress in adopting an evidence-based policy package. City Health focuses on nine policies that are largely under city jurisdiction, backed by evidence, and show a track record of bipartisan support.	Choose a policy to learn more.
Blueprints for Healthy Young Development	This registry contains evidence-based positive youth development programs that aim to promote health and wellbeing of children and teens. Programs are family, school, and community-based and target all levels of need.	Select method to search; either all the criteria step by step, all criteria all at once, or search keyword

2023-2025
Western Wisconsin Health Community Health Implementation Plan Addendum

Western Wisconsin Health will pursue the following community health objectives and action plans in 2023-2025
"Please Note: some objectives are independent of coalition partners."

WESTERN WISCONSIN HEALTH

Priority Area: Mental, Social, and Emotional Health

Goal 1: Enhance workforce resiliency and wellbeing

Objective 1a: By December 2023, address the short and long-term mental health impacts that COVID-19 had on healthcare workers (direct and non-direct patient care) by offering resiliency training and employee engagement opportunities to promote wellbeing, teamwork, and employee retention.

Western Wisconsin Health Action Plan:

1. Develop Health Program & Employee Engagement Specialist role to focus on employee support strategies and outcomes as they relate to employee engagement and employee wellbeing.
2. Develop and implement new employee support strategies.

Goal 2: Build healthy coping skills and stress reduction strategies for youth and their caregivers

Objective 2a: By December 2025, increase awareness of mental health, mental illness, substance use disorders and their associated stigma through community awareness, education and support opportunities.

Objective 2b: By December 2023, increase youth mental health collaboration among school, county, medical, and non-profit partners to support mental health screening, support, and coordination of care for youth to bimonthly meetings with 75% of Pierce and St. Croix County schools participating.

Western Wisconsin Health Action Plan:

1. Facilitate bimonthly meetings to collaborate in opportunities to provide mental health screenings and mental health care to schools.

Goal 3: Improve local access to meet the needs of residents seeking mental health care.

Objective 3a: Maintain behavioral health crisis telemedicine in 4 hospital Emergency departments and increase behavioral health telemedicine in 2 satellite sites by 2025.

Western Wisconsin Health Action Plan:

1. Provide Behavioral Health telehealth visits to patients in Ellsworth (library satellite site) and Plum City (school satellite site) by July 2023.

Objective 3b: By 2025, increase amount of prescription medications and opioids collected in a secure manner at drop box locations at hospitals by 5%.

Western Wisconsin Health Action Plan:

1. Explore options to provide secure collection and disposal of prescription medications and opioids at WWH.

Objective 3c: Increase access to local substance use disorder outpatient treatment through contractual partnership by 2023.

Western Wisconsin Health Action Plan:

1. Begin contract with substance use disorder provider by end of 2023.

Priority Area: Thriving and Livable Communities for All

Goal 1: Improve social, environmental, and economic conditions that influence health.

Objective 1i: By December 2023, implement a system-wide approach to address Social Determinants of Health (SDoH) through screening, systems, community partnerships, and referrals.

Western Wisconsin Health Action Plan:

1. Hire Community and clinical care coordinator to coordinate community resource referrals and needs with patients.
2. Assess patients for SDoH concerns in annual physicals, well child checks, and ED/hospital admissions.
3. Collect and evaluate SDoH data to further inform community health needs.

Goal 2: Increase equitable access to healthcare.

Objective 2a: By December 2024, Identify and address barriers to care to ensure health equity to all we serve.

Western Wisconsin Health Action Plan:

1. Conduct health equity, diversity, and inclusion survey among staff and community.
2. Develop patient advisory group with patients representing marginalized populations in our community.
3. Provide staff diversity, equity, and inclusion training.
4. Increase communications in Spanish.
5. Assess and strategize opportunities to better support maternal care for marginalized populations in our community.

Objective 2b: By 2023, increase access to wheelchair accessible transportation for patients.

Western Wisconsin Health Action Plan:

1. Fundraise through 2022 to purchase wheelchair accessible van to provide patients access to medical services by 2023.

Objective 3c: By June 2023, expand Dental-care options for Medicaid, under-insured, and uninsured patients.

Western Wisconsin Health Action Plan:

1. Partner with Children's Dental Services to provide mobile dental care on-site at WWH.

The Western Wisconsin Health Action Plan activities are a work-in-progress and subject to change throughout the 2023-2025 implementation time frame.

PIERCE COUNTY Public Health

ST. CROIX COUNTY Wisconsin
Innovation Through Cooperation
Public Health

WESTERN WISCONSIN HEALTH

Westfields Hospital & Clinic

Hudson Hospital & Clinic

Allina Health
RIVER FALLS AREA HOSPITAL

United Way
United Way St. Croix Valley

Healthier Together
Pierce County
St. Croix County

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