HSHS St. Joseph's Hospital

Community Health IMPROVEMENT PLAN

Table of Contents

Introduction 2

Community Health Needs Prioritization 3

Community Health Needs That Will Not Be Addressed 3

Primary Implementation Strategies 3

Community Health Improvement Plan Overview 4

Priority Snapshot: ***Mental Health*** 5

PLANNED ACTIONS – ***Mental Health*** 6

Priority Snapshot: ***Alcohol Misuse*** 8

PLANNED ACTIONS – ***Alcohol Misuse*** 9

Priority Snapshot: ***Chronic Disease Prevention and Management*** 11

PLANNED ACTIONS – ***Chronic Disease Prevention and Management*** 12

Priority Snapshot: ***Drug Use*** 13

PLANNED ACTIONS – ***Drug Use*** 14

Priority Snapshot: ***Obesity/Healthy Nutrition*** 16

PLANNED ACTIONS – ***Obesity/Healthy Nutrition*** 17

Next Steps 18

Approval 18

Introduction

HSHS St. Joseph's Hospital is an acute-care hospital located in Chippewa County, Wisconsin. For more than 136 years, the hospital has served as a leader in health and wellness in the Chippewa Valley. St. Joseph's Hospital provides a wide range of specialties, including 24-hour Emergency Medicine, Heart Care, Renal Dialysis, Home Health and Hospice, Palliative Care, Orthopedics, and Wound Care, as well as Residential Substance Use Disorder Treatment on our hospital campus at L.E. Phillips Libertas Treatment Center.

St. Joseph's Hospital partners with other area organizations to address the health needs of the community, living its mission *to reveal and embody Christ's healing love for all people through our high quality Franciscan health care ministry*, with a preference for the poor and vulnerable. The hospital is part of the Hospital Sisters Health System (HSHS), a highly integrated health care delivery system serving residents of rural and mid-sized communities in Wisconsin and Illinois. In 2020, St. Joseph's Hospital received 10,263 emergency department visits, totaled 2,646 admissions, registered 37,679 outpatient visits, and provided nearly $6.5 million in total community benefits (including subsidized care for the poor and broader community benefits).

In 2020-2021, St. Joseph's Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with sister hospital HSHS Sacred Heart, Chippewa County Department of Public Health, Eau Claire City-County Health Department, Mayo Clinic Health System, Marshfield Clinic Health System, United Way of the Greater Chippewa Valley, Chippewa Health Improvement Partnership, and Eau Claire Healthy Communities. This process involved gathering data from multiple sources to assess the needs of Chippewa and Eau Claire counties. This data then was presented to six focus groups (three in each county), to health coalitions in each county, the hospital board of directors, and other key stakeholders who together recommended the health priorities to be addressed in 2022—2024. Due to overlapping service areas and resources, this report reflects the combined priorities of both counties; however, the full, Chippewa County-specific CHNA Report may be found at https://www.hshs.org/StJosephsChippewaFalls/About-Us/Community-Health-Needs-Assessment.

This Implementation Plan builds off the CHNA Report by detailing the strategies HSHS St. Joseph's Hospital will employ to improve community health in the identified priority areas. This plan shall be reviewed annually and updated as needed to address ever-changing needs and factors within the community landscape. Nonetheless, HSHS strives to maintain the same overarching goals in each community it serves, namely to:

1. Fulfill the ministry's mission to provide high quality health care to all patients, regardless of ability to pay.

2. Improve outcomes by working to address social determinants of health, including access to medical care.

3. Maximize community impact through collaborative relationships with partner organizations.

4. Evaluate the local and systemic impact of the implementation strategies and actions described in this document to ensure meaningful benefits for the populations served.

For purposes of this CHNA Implementation Plan, the population served shall be defined as Chippewa County residents of all ages, although the hospital's reach and impact extend to other western Wisconsin counties as well.

Community Health Needs Prioritization

As detailed in the CHNA Report, HSHS St. Joseph's Hospital in collaboration with community partners identified the following health priorities in Chippewa and Eau Claire counties:

- Mental Health
- Alcohol Misuse
- Chronic Disease Prevention and Control
- Drug Use
- Obesity/Healthy Nutrition.

These priorities emerged from several data sources, including a Community Health Survey, Community Conversations (online discussions with local residents), local and national health data comparisons, and input from local health coalitions (including the Chippewa Health Improvement Partnership).

Community Health Needs That Will Not Be Addressed

HSHS St. Joseph's Hospital plans to address each of the top five health areas identified as significant needs in Chippewa County in some capacity. In addition, the interconnectedness of various health issues, as recognized by participants in the CHNA process, is expected to produce additional benefits in other health areas examined (including but not limited to Physical Activity, Injury and Violence Prevention, and Healthy Growth and Development).

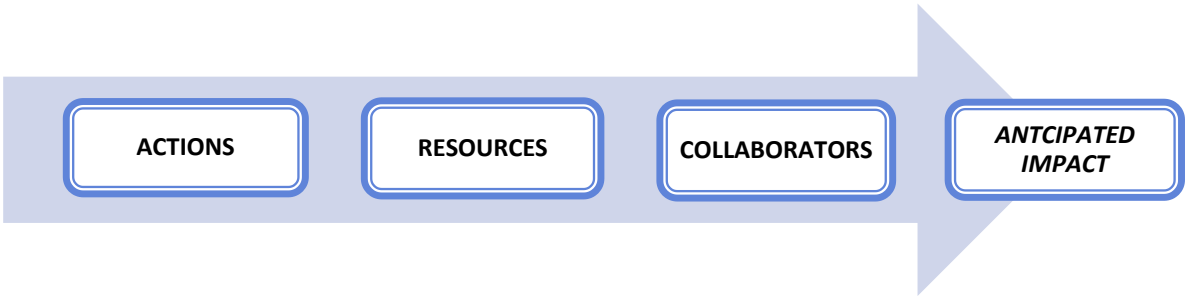
Primary Implementation Strategies

In each of the priority health areas identified, HSHS St. Joseph's Hospital shall employ strategies that fall into one or more of the categories described below.

Strategy	Description
Increase Access to Prevention and Early Intervention Services	This strategy involves taking actions that prevent disease or injury or limit their progression and impact.
Improve Access to Care	This strategy involves improving the ability of individuals in the hospital's service area to receive needed treatment and services on a timely basis in order to achieve optimal health outcomes.
Address Other Social Determinants of Health	This strategy involves addressing other conditions and environmental factors that impact health, functioning, and quality-of-life outcomes in the community.
Engage in Unified Planning and Policy	This strategy involves working with community partners to factor health considerations into decision-making that affects the general public or subsets of populations within the general public.

These strategies may be employed for the direct benefit of patients or for more indirect community benefit.

Examples of specific actions that fall under these broad strategies, as well as the anticipated impacts of those actions, are listed on the PLANNED ACTIONS pages for each of the health priorities. This format follows the basic premise that the stated actions, resources, and collaborative partnerships together will produce the intended impacts.



Community Health Improvement Plan Overview

These implementation strategies and actions are laid out by health priority, first with a "snapshot" of identified strategies, sample actions, and other relevant information, then with a more comprehensive and specific description of planned actions, resources, collaborative partners, and anticipated impacts.

As noted previously, these tables will be reviewed and revised as needed on at least an annual basis to reflect changing needs, resources, and opportunities within the community.

Priority No. 1: Mental Health

Target Populations

- Adolescents/Children
- Adults

Hospital Resources

- Colleague Time
- Community Benefits Funding
- Grant Funding
- Marketing Materials
- Virtual Platform

Community Partners

- Chippewa Health Improvement Partnership
- Hope Village
- Mental Health Matters
- Prevea Clinics
- Schools
- Trained Facilitators

Anticipated Impact

- Increase Resiliency
- Decrease Suicides and Self-Harm Injuries by Adolescents and Adults

Relevant Measures*

- Suicide Rate
- Emergency Department Visits for Nonfatal Intentional Self-Harm Injuries
- Suicide Attempts by Adolescents
- % Children/Adolescents Who Get Appropriate Treatment for Anxiety or Depression

*From the national health plan: *Healthy People 2030*

Current Situation

Mental Health consistently arose as the most prominent community health priority in Chippewa County during CHNA discussions. Reasons commonly cited for the problem included lack of affordability and/or awareness of services available; inability to easily access services (e.g., due to location/transportation, childcare needs, or other issues); and lack of understanding of mental health conditions and their importance to overall health. *Data supporting this concern include*:

- High suicide rates (20 per 100,000 in Chippewa County versus 14 per 100,000 nationally in 2018-19)
- High ratio of population to providers (1,110:1 locally versus 400:1 nationally in 2019).

OUR STRATEGIES

For our Patients

- ***Improve Access to Care***
  - Open inpatient psychiatric beds for adolescents at St. Joseph's Hospital.

INDICATORS:

- Progress toward opening of new adolescent psychiatric beds.
- Number of adolescents served annually through inpatient behavioral health.

For our Community

- ***Increase Access to Prevention and Early Intervention Services***
  - Train and partner with facilitators to provide suicide prevention, behavioral health "first aid," and trauma/resiliency training to school staff, students, and the general public.
- ***Improve Access to Care***
  - Work with rural school districts to ensure access to school-based mental health services.
- ***Address Other Social Determinants of Health***
  - Provide funding and other support to homeless resources (e.g., Hope Village) to help promote housing and economic stability, as well as facilitate access to health care services.

INDICATORS:

- Number of instructors trained, trainings provided, individuals trained.
- Number of school district partnerships, number of students counseled.
- Number of individuals served through Hope Village and other homeless resources, number of those individuals securing income and housing stability, as well as access to health care.

PLANNED ACTIONS – *Mental Health*

***Strategy*:** Work with community partners to increase access to prevention and early intervention services.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Work with schools and other community partners to provide *Question, Persuade, Refer* (*QPR*) suicide prevention training to student and adult populations.	- Colleague Time - Technology (virtual platform) - Marketing Materials - Grant Funding	- Chippewa County Schools - Chippewa Health Improvement Partnership - Community Members - Trained Facilitators	Reduce the Chippewa County suicide rate by training "Gatekeepers" to recognize and respond appropriately to signs of emotional crisis.
Work with schools and other community partners to provide *Mental Health First Aid* training for youth and adult populations.	- Colleague Time - Technology (virtual platform) - Marketing Materials - Community Benefits Funding	- Chippewa County Schools - Chippewa Health Improvement Partnership - Community Members - Trained Facilitators	Increase recognition and improve response to mental illness in student and adult populations. Reduce suicide and nonfatal intentional self-harm injury rates.
Work with the Mental Health Matters grant project to provide training on Adverse Childhood Experiences and Resiliency (ACE/R) to school staff and other organizations.	- Colleague Time	- Chippewa County Schools - Mental Health Matters - Other Community Partners	Increase resiliency in student populations. Reduce suicide attempts and nonfatal intentional self-harm by students.
Work with community partners to ensure early identification of pregnant and postpartum moms with behavioral health needs.	- Colleague Time - Maternity onto Motherhood (MOM) Program	- Prevea Health - Sacred Heart Hospital - Substance-free Pregnancy and Recovery Coalition	Promote recovery, strengthen families, prevent childhood trauma and intergenerational behavioral health concerns.

Strategy: Work with internal and external partners to improve access to care and services.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Open inpatient psychiatric beds for adolescents.	- Colleague Time - New Staff - Bed Space/Facility Renovations - Grant Funding - Operational Funding	- Law Enforcement - Referral Sources (counties, Northwest Connections, etc.)	Promote youth resilience and recovery, thereby reducing incidents of harm to self and others. Maintain natural support systems by keeping adolescents close to home, thereby reducing trauma from placements. Reduce amount of transport time by law enforcement, increasing time available to engage in other public safety responsibilities.
Continue partnership with Prevea to provide/expand	- Colleague Time - Foundation Funding	- Chippewa County Schools - Prevea Health	Promote youth resilience and recovery, thereby reducing

school-based mental health services.	- Marketing Materials		incidents of harm to self and others and increasing academic success.
Provide grief support to Chippewa Valley residents through the Healing Place.	- Colleague Time - Marketing Materials - Website	- Sacred Heart Hospital - Volunteer Facilitators	Promote connectedness and coping skills as protective factors against prolonged distress and potential self-harm.
Streamline behavioral health service access for pregnant and postpartum moms.	- Colleague Time - Maternity onto Motherhood (MOM) Program	- Prevea Health - Sacred Heart Hospital - Substance-free Pregnancy and Recovery Coalition	Ensure prompt access to care to promote mom's recovery and prevent trauma/mental health impacts on baby (and any other children).

Strategy: Work with community partners to address other social determinants of health, including economic stability.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Provide funding and other support to homeless resources (e.g., HOPE Village) to help promote housing and economic stability, as well as facilitate access to health care services.	- Colleague Time - Community Benefits Funding	- Hope Village - Other Community Partners	Increase protective factors, including health care access, for individuals affected by poverty and homelessness.

Priority No. 2: Alcohol Misuse

Target Populations

- Adolescents/Children
- Adults
- Pregnant/Postpartum Women

Hospital Resources

- Colleague Time
- Community Benefits Funding
- Foundation Funding
- Marketing Materials
- Virtual Platform

Community Partners

- Chippewa Health Improvement Partnership
- Local Policymakers
- Prevea Clinics
- Schools
- Trained Facilitators

Anticipated Impact

- Improve Resiliency
- Reduce Alcohol Misuse and Resulting Health Risks

Relevant Measures*

- Proportion of People Age 21 and Older Who Engage in Binge Drinking
- Proportion of Motor Vehicle Crash Deaths that Involve a Drunk Driver
- Proportion of People Who Have an Alcohol Disorder
- Cirrhosis Deaths
- Percentage of People with a Substance Use Disorder Who Get Treatment

*From the national health plan: *Healthy People 2030*

Current Situation

Alcohol Misuse likewise emerged as a significant and consistent concern in the Community Health Survey, community and health coalition discussions, and data comparisons. Reasons commonly cited for the problem included familial and community acceptance, ease of availability, lack of understanding regarding the impact of alcohol misuse on overall health, and lack of alcohol-free social activities. *Data supporting this concern include*:

- High percentage of adults who engage in binge or heavy drinking (26% in Chippewa County versus 19% nationally in 2017).
- High percentage of motor vehicle deaths involving alcohol (36% in Chippewa County versus 28% nationally from 2014-2018).

OUR STRATEGIES

For our Patients

- ***Improve Access to Care***
  - Ensure consistent use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) by providers.
  - Facilitate prompt referrals to substance use disorder (SUD) treatment for pregnant and postpartum mothers.

INDICATORS:

- Percentage of providers utilizing SBIRT.
- Percentage of patients screened by providers.
- Percentage of patients screening positive who are referred to substance use disorder (SUD) treatment providers.

For our Community

- ***Increase Access to Prevention and Early Intervention Services***
  - Work with community partners to promote resilience in youth through trainings with youth workers (e.g., school staff) and implementation of programming in schools (e.g., mindfulness).
- ***Improve Access to Care***
  - Work with rural school districts to ensure access to school-based mental health services.
- ***Address Other Social Determinants of Health***
  - Work with community partners to promote alcohol-free events, activities, and opportunities throughout each county.

INDICATORS:

- Number of youth workers trained, children receiving program opportunities.
- Number of school district partnerships, number of students counseled.
- Number of alcohol-free events/activities provided.

PLANNED ACTIONS – *Alcohol Misuse*

***Strategy*:** Work with community partners to increase access to prevention and early intervention services.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Work with schools and other community partners to provide *Mental Health First Aid* training for youth and adult populations.	- Colleague Time - Marketing Materials - Technology (virtual platform)	- Chippewa County Schools - Other Community Partners	Improve the ability of school staff and others to detect alcohol misuse and intervene/direct individuals to treatment and other resources.
Work with the Mental Health Matters grant project to provide training on Adverse Childhood Experiences and Resiliency (ACE/R) to school staff and other organizations.	- Colleague Time	- Chippewa County Schools - Other Community Partners	Increase understanding by school staff, employers, and other community partners of trauma and resiliency. Improve the ability of schools and other organizations to develop protective factors for students and the general public and reduce the risk of alcohol misuse.
Work with the Chippewa Health Improvement Partnership (CHIP) Voices in Prevention Action Team to provide community education.	- Colleague Time - Marketing Materials	- Chippewa County Schools - CHIP Voices in Prevention Action Team - Other Community Partners	Reduce the risk and impacts of alcohol misuse.
Work with community partners to ensure early identification of pregnant and postpartum moms with behavioral health needs.	- Colleague Time - Maternity onto Motherhood (MOM) Program	- Prevea Health - Sacred Heart Hospital - Substance-free Pregnancy and Recovery Coalition	Reduce the risks and impacts of alcohol misuse on moms and babies. Reduce the likelihood of intergenerational misuse.

***Strategy*:** Work with internal and external partners to improve access to care and services.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Ensure consistent use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) by providers.	- Colleague Time - EMR - Medical Staff	- Prevea Health - Training Resources	Reduce the risks and impacts of alcohol misuse through prompt identification and referral to treatment and services.
Streamline behavioral health service access for pregnant and postpartum moms.	- Colleague Time - Maternity onto Motherhood (MOM) Program	- Prevea Health - Sacred Heart Hospital - Substance-free Pregnancy and Recovery Coalition	Reduce the risks and impacts of alcohol misuse on moms and babies through prompt access to treatment and services.
Continue partnership with Prevea to provide/expand school-based mental health services.	- Colleague Time - Foundation Funding - Marketing Materials	- Chippewa County Schools - Prevea Health	Reduce the risks and impacts of alcohol misuse by promoting youth mental health/building protective factors.

***Strategy*:** Work with community partners to address other social determinants of health, including economic stability.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Provide funding and other support to homeless resources (e.g., HOPE Village) to help promote housing and economic stability, as well as facilitate access to health care services.	- Colleague Time - Community Benefits Funding	- Hope Village - Other Community Partners	Increase protective factors, including health care access, for individuals affected by poverty and homelessness.
Work with the Chippewa Health Improvement Partnership (CHIP) Voices in Prevention Action Team to provide alcohol-free events, activities, and opportunities throughout the county.	- Colleague Time - Marketing Materials - Community Benefits Funding	- Chippewa County Schools - CHIP Voices in Prevention Action Team - Other Community Partners	Reduce the risk and impacts of alcohol misuse through the normalization of abstinence.

Priority No. 3: Chronic Disease Prevention and Management

Target Populations

- Food-Share Recipients
- General Public
- Uninsured/Underinsured Individuals

Hospital Resources

- Colleague Time
- Community Benefits Funding
- Marketing Materials

Community Partners

- Chippewa Health Improvement Partnership
- Local Policymakers
- Open Door Clinic
- Prevea Clinics

Anticipated Impact

- Fewer new chronic disease diagnoses
- Fewer deaths from chronic conditions

Relevant Measures*

- Proportion of Adults with Diabetes Who Receive Who Get Formal Diabetes Education
- Rate of Hospital Admissions for Diabetes Among Older Adults
- Heart Failure Hospitalizations in Adults
- Coronary Health Disease Deaths
- Stroke Deaths

*From the national health plan: *Healthy People 2030*

Current Situation

Chronic Disease Prevention and Management often arose during discussions in relation to Obesity, Healthy Nutrition, Physical Activity, and Mental Health. Reasons commonly cited for the problem included difficulty in making healthy lifestyle choices, lack of ability to pay for managing chronic conditions, and lack of understanding regarding the importance of preventing and managing chronic disease. *Data supporting this concern include*:

- Rate of new cancer diagnoses per 100,000 people (478 in Chippewa County versus 449 nationally between 2014-2018).
- Rate of coronary heart disease hospitalizations per 1,000 Medicare beneficiaries (13.3 in Chippewa County versus 10.5 statewide and 12.0 nationally during 2015-2017).

OUR STRATEGIES

For our Patients

- ***Increase Access to Prevention and Early Intervention Services***
  - Work with providers to ensure regular screenings and patient education.
- ***Improve Access to Care and Services***
  - Evaluate services available internally and work to address service gaps.

INDICATORS:

- Number of patient screenings conducted, number of counseling sessions.
- Service inventory taken and needs identified.

For our Community

- ***Increase Access to Prevention and Early Intervention Services***
  - Work with community partners to provide community education, health screenings, and referrals to care.
  - Work with local Farmers Markets to supplement the buying power of FoodShare recipients to purchase fresh produce.
- ***Improve Access to Care***
  - Continue financial support to the Open Door Clinic to facilitate the management of chronic diseases for uninsured and underinsured individuals.
- ***Engage in Unified Planning and Policy***
  - Work with state and local leaders to factor health implications into policy and budget decisions.

INDICATORS:

- Number of community-based screenings, education sessions, and referrals.
- Number of families receiving supplemental funds to buy fresh produce.
- Number of individuals receiving chronic disease screening and management services through the Open Door Clinic.
- Number of meetings with local leaders, policy impacts.

PLANNED ACTIONS – *Chronic Disease Prevention and Management*

***Strategy*:** Work with community partners to increase access to prevention and early intervention services.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Provide health education, screenings, and referrals to care.	- Colleague Time - Marketing Materials	- Chippewa Health Improvement Partnership - Other Community Partners	Reduce the prevalence and impacts of chronic diseases.
Work with providers to ensure regular screenings and patient education.	- Colleague Time - Marketing Materials	- Prevea Health	Reduce the prevalence and impacts of chronic diseases.
Work with local Farmers Markets to supplement the purchase power of FoodShare recipients to buy fresh produce.	- Colleague Time - Community Benefits Funding	- Farmers Markets	Reduce the prevalence and impacts of chronic disease by improving access to nutritious foods.

***Strategy*:** Work with internal and external stakeholders to improve access to care.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Evaluate services available internally and within the community and work to address service gaps.	- Colleague Time	- Chippewa Health Improvement Partnership - Other Community Partners	Reduce the prevalence and impacts of chronic diseases such as diabetes, heart disease, cancer, and dementia.
Support the provision of needed care for chronic conditions to low-income residents through funding and other support for the Open Door Clinic in Chippewa Falls.	- Colleague Time - Community Benefits Funding	- Open Door Clinic - Pharmacies	Improve the management of chronic disease/reduce impact severity.

***Strategy*:** Work with internal and external stakeholders to engage in unified planning and policy.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Work with state and local leaders to factor health implications into policy and budget decisions.	- Colleague Time	- Chippewa Health Improvement Partnership - Local, State Leaders - Other Community Partners	Reduce the risks and impacts of chronic disease.

Priority No. 4: Drug Use

Target Populations

- Adolescents/Children
- Adults
- Pregnant/Postpartum Women

Hospital Resources

- Colleague Time
- Grant Funding
- Marketing Materials
- Virtual Platform

Community Partners

- Chippewa Health Improvement Partnership
- Prevea Clinics
- Schools
- Trained Facilitators

Anticipated Impact

- Improve Resiliency
- Reduce Drug Use

Relevant Measures*

- Proportion of Adolescents Who Used Drugs in the Past Month
- Proportion of Pregnant Women Who Use Illicit Opioids During Pregnancy
- Proportion of People Who Get a Referral for Substance Use Treatment after an Emergency Department Visit
- Percentage of People with a Substance Use Disorder Who Get Treatment
- Drug Overdose Deaths Per 100,000 Population

*From the national health plan: *Healthy People 2030*

Current Situation

Drug Use frequently emerged as a major concern on the Community Health Surveys and in stakeholder discussions. This issue often was linked closely to mental health. Reasons commonly cited for the problem included ease of availability, lack of access to treatment, cost of treatment, and lack of understanding of the impact of drug use on overall health. *Data supporting this concern include*:

- Rate of methamphetamine-related overdose fatalities per 100,000 people (1.8 in Chippewa County versus 1.6 statewide from 2014-2019).
- Percent of high school students who have tried meth (3% in Chippewa County versus 2% statewide and nationally in 2019).

OUR STRATEGIES

For our Patients

- ***Improve Access to Care***
  - Ensure consistent use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) by providers.
  - Facilitate prompt referrals to substance use disorder (SUD) treatment for pregnant and postpartum mothers.

INDICATORS:

- Percentage of providers utilizing SBIRT.
- Percentage of patients screened by providers.
- Percentage of patients screening positive who are referred to substance use disorder (SUD) treatment providers.

For our Community

- ***Increase Access to Prevention and Early Intervention Services***
  - Work with community partners to promote resilience in youth through trainings with youth workers (e.g., school staff) and implementation of programming in schools (e.g., mindfulness).
- ***Improve Access to Care***
  - Work with rural school districts to ensure access to school-based mental health services.
- ***Address Other Social Determinants of Health***
  - Work with community partners to promote housing and economic stability of youth and their families, as well as to facilitate access to health care services.

INDICATORS:

- Number of youth workers trained, children receiving program opportunities.
- Number of school district partnerships, number of students counseled.
- Number of families referred to community resources, number of homeless families who achieve housing and income stability.

PLANNED ACTIONS – *Drug Use*

***Strategy*:** Work with community partners to increase access to prevention and early intervention services.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Work with schools and other community partners to provide *Mental Health First Aid* training for youth and adult populations.	- Colleague Time - Marketing Materials - Technology (virtual platform)	- Chippewa County Schools - Other Community Partners	Improve the ability of school staff and others to detect drug use and intervene/direct individuals to treatment and other resources.
Work with the Mental Health Matters grant project to provide training on Adverse Childhood Experiences and Resiliency (ACE/R) to school staff and other organizations.	- Colleague Time	- Chippewa County Schools - Other Community Partners	Increase understanding of trauma and resiliency. Improve the ability of schools and other organizations to develop resiliency in students and the general public and reduce the risk of drug use.
Work with community partners to ensure early identification of pregnant and postpartum moms with behavioral health needs.	- Colleague Time - Maternity onto Motherhood (MOM) Program	- Prevea Health - Sacred Heart Hospital - Substance-free Pregnancy and Recovery Coalition	Reduce the risks and impacts of drug use on moms and babies. Reduce the likelihood of intergenerational drug use.

***Strategy*:** Work with internal and external stakeholders to improve access to care and services.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Ensure consistent use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) by providers.	- Colleague Time - EMR	- Prevea Health - Training Resources	Reduce the risks and impacts of alcohol misuse through prompt identification and referral to treatment and services.
Streamline behavioral health service access for pregnant and postpartum moms.	- Colleague Time - Maternity onto Motherhood (MOM) Program	- Prevea Health - Sacred Heart Hospital - Substance-free Pregnancy and Recovery Coalition	Reduce the risks and impacts of drug use on moms and babies through prompt access to treatment and services.
Continue partnership with Prevea to provide/expand school-based mental health services.	- Colleague Time - Foundation Funding - Marketing Materials	- Chippewa County Schools - Prevea Health	Reduce the risks and impacts of drug use by promoting youth resilience and supporting recovery.

***Strategy*:** Work with community partners to address other social determinants of health, including economic stability.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Provide funding and other support to homeless resources (e.g., HOPE Village) to help promote housing and economic stability, as well as facilitate access to health care services.	- Colleague Time - Community Benefits Funding	- Hope Village - Other Community Partners	Increase protective factors, including health care access, for individuals affected by poverty and homelessness.

Priority No. 5: Obesity/Healthy Nutrition

Target Populations

- Adults, Adolescents, and Children
- Food-Share Recipients
- Uninsured/Underinsured Individuals

Hospital Resources

- Colleague Time
- Community Benefits Funding
- Marketing Materials

Community Partners

- Chippewa Health Improvement Partnership
- Farmers Markets
- Hope Village
- Local Leaders
- Open Door Clinic
- Prevea Clinics

Anticipated Impact

- Greater Food Security
- Lower Rates of Obesity

Relevant Measures*

- Proportion of Children and Adolescents with Obesity
- Proportion of Adults with Obesity
- Proportion of Health Care Visits by Adults with Obesity that Include Counseling on Weight Loss, Nutrition, or Physical Activity
- Household Food Insecurity

*From the national health plan: *Healthy People 2030*

Current Situation

Obesity and **Healthy Nutrition** frequently accompanied discussions around Chronic Disease Prevention and Management, Physical Activity, and Mental Health. Reasons commonly cited for problems in these areas included lack of understanding regarding the health risks associated with obesity, difficulty adopting healthy weight management practices, cost of healthy weight support groups and treatment, inability to buy enough food, lack of time to make healthy food, and the cost of healthy foods. *Data supporting this concern include*:

- Percent of obese adults (31% in Chippewa County versus 30% nationally in 2017).
- Percent of population lacking adequate access to food (9% in 2018).
- Rate of coronary heart disease hospitalizations per 1,000 Medicare beneficiaries (13.3 in Chippewa County versus 10.5 statewide and 12.0 nationally during 2015-2017).

OUR STRATEGIES

For our Patients

- ***Increase Access to Prevention and Early Intervention Services***
  - Work with providers to ensure regular screenings, patient education, and referral to community resources.

INDICATORS:

- Number of patient screenings conducted and community referrals made.
- Service inventory taken and needs identified.

For our Community

- ***Increase Access to Prevention and Early Intervention Services***
  - Work with community partners to provide community education, health and benefit screenings, and service referrals.
  - Work with local Farmers Markets to supplement the buying power of FoodShare recipients to purchase fresh produce.
- ***Address Other Social Determinants of Health***
  - Provide funding and other support to homeless resources (e.g., Hope Village) to help promote housing and economic stability, as well as facilitate access to health care services.
- ***Engage in Unified Planning and Policy***
  - Work with state and local leaders to factor food security and healthy weight implications into policy and budget decisions.

INDICATORS:

- Number of community-based screenings, education sessions, and referrals.
- Number of families receiving supplemental funds to buy fresh produce.
- Number of individuals served through Hope Village and other homeless resources, number of those individuals securing income stability.
- Number of meetings with local leaders, policy impacts.

PLANNED ACTIONS – *Obesity/Healthy Nutrition*

***Strategy*:** Work with community partners to increase access to prevention and early intervention services.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Work with community partners to provide health education, screenings, and referrals to resources.	- Colleague Time - Marketing Materials	- Chippewa Health Improvement Partnership - Other Community Partners	Increase awareness, improve nutrition, and reduce obesity.
Work with providers to ensure regular screenings, patient education, and referrals.	- Colleague Time	- Prevea Health	Increase awareness, improve nutrition, and reduce obesity.
Work with local Farmers Markets to supplement the purchase power of FoodShare recipients to buy fresh produce.	- Colleague Time - Community Benefits Funding	- Farmers Markets	Improve nutrition and food security. Create healthy eating habits and reduce obesity.

***Strategy*:** Work with community partners to address other social determinants of health, including economic stability.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Provide funding and other support to homeless resources (e.g., HOPE Village) to help promote housing and economic stability, as well as facilitate access to health care services.	- Colleague Time - Community Benefits Funding	- Hope Village - Other Community Partners	Improve the ability of homeless individuals to access health care and other needed resources, including nutritious food.

***Strategy*:** Work with internal and external stakeholders to engage in unified planning and policy.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Work with state and local leaders to factor food security and healthy weight implications into policy and budget decisions.	- Colleague Time	- Chippewa Health Improvement Partnership - Local, State Leaders - Other Community Partners	Improve access to nutritious food and food security. Reduce the prevalence of obesity.

Next Steps

This Implementation Plan outlines intended actions over the next three years. Nonetheless, Community Benefits/Community Health staff annually shall do the following:

- Review progress on the stated strategies, planned actions, and anticipated impacts.
- Report this progress at minimum to hospital administration, the hospital Board of Directors, and community health coalitions.
- Work with these and other stakeholders to update the plan as needed to accommodate emerging needs, priorities, and resources.
- Notify community partners of changes to the Implementation Plan.

Approval

This Implementation Plan was adopted by the hospital's Board of Directors on September 9, 2021.