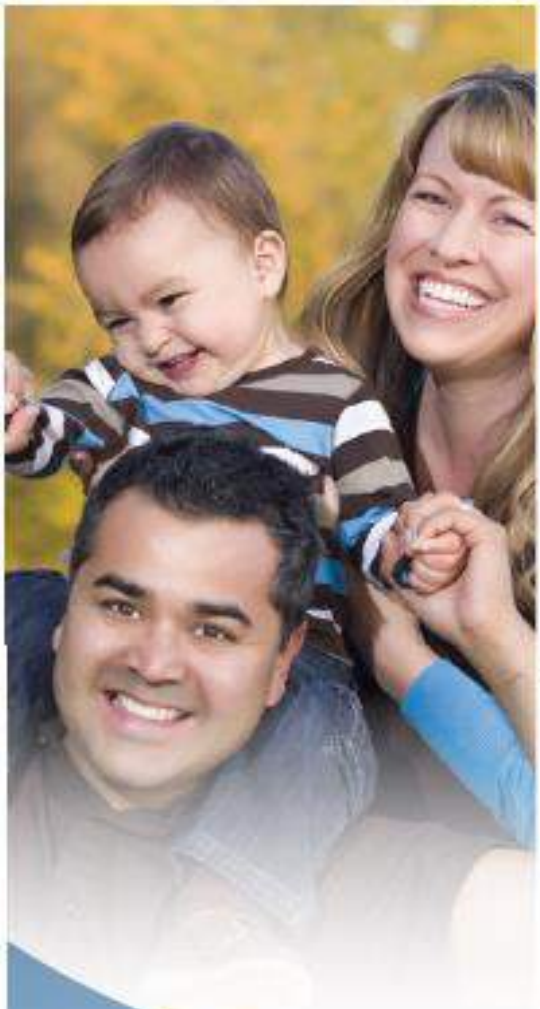

HSHS St. Vincent Hospital

Community Health IMPROVEMENT PLAN

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Introduction

HSHS St. Vincent Hospital is an acute-care hospital located in Brown County, Wisconsin. For more than 130 years (including 64 at its current location), the hospital has served as a leader in health and wellness in northeast Wisconsin. HSHS St. Vincent Hospital provides a wide range of specialties, including 24-hour Emergency Medicine, Cancer Care, Children's Health, Heart Care, Stroke Center and Women's Health.

HSHS St. Vincent 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, HSHS St. Vincent Hospital received 30,649 emergency department visits, totaled 10,811 admissions, registered 176,278 outpatient visits and provided more than $51 million in total community benefits (including subsidized care for the poor and broader community benefits).

In 2020-2021, HSHS St. Vincent Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with sister hospital HSHS St. Mary's and Beyond Health, a steering committee comprised of leaders from both the public and private sectors in Brown County. These leaders used the Social Determinants of Health (SDOH) model developed by the Centers for Disease Control and Prevention as the framework for conducting this task. This model considers the impact of the conditions in the environments where people are born, live, work, play, etc., on their health and well-being. The assessment process itself involved gathering both qualitative and quantitative data from a broad variety of sources, including community conversations with key informants, focus groups, and secondary data collection. The resulting report may be found online at https://www.hshs.org/StVincent/About-Us/Community-Health-Needs-Assessment.

This Implementation Plan builds off the CHNA Report by detailing the strategies HSHS St. Vincent 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 Brown County residents of all ages, although the hospital's reach and impact extend to other northeastern Wisconsin counties as well.

Community Health Needs Prioritization

As detailed in the CHNA Report, HSHS St. Vincent Hospital in collaboration with community partners identified the following health priorities in Brown County:

- Equitable Access (to resources in order to reduce health disparities)
- Social Cohesion (building connections between community members)
- Unified Planning and Policy

Under the broad umbrella of these priorities, based on health outcome data and observed community needs, HSHS St. Vincent Hospital has chosen to focus specifically on the following areas:

- Mental Health Care
- Healthy Nutrition and Physical Activity
- Treatment and Prevention of Alcohol and Drug Use/Abuse.

Community Health Needs That Will Not Be Addressed

HSHS St. Vincent Hospital plans to adopt the top three priorities identified as strategies to impact the focus areas identified above, with a special emphasis on equitable access to care.

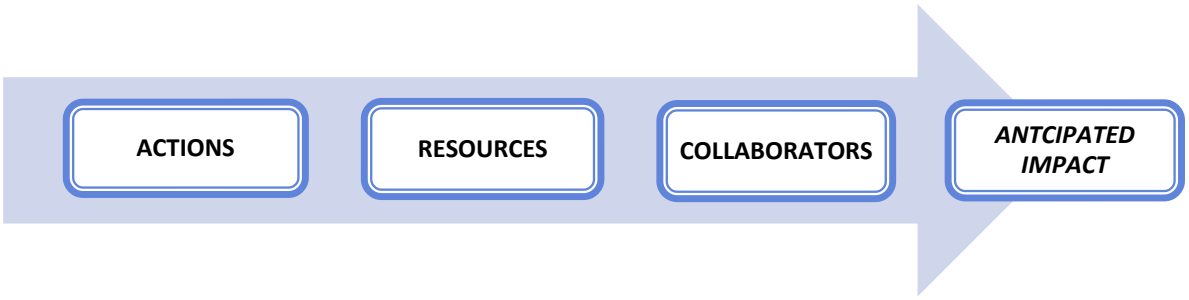
Primary Implementation Strategies

In each of the areas of health focus identified, HSHS St. Vincent 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.
Improve Opportunities for Social Cohesion or Connectedness	This strategy involves strengthening relationships and building solidarity among community members.
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 in tandem with community partners to factor health considerations into decision-making in order to improve community health.

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 Care

Target Populations

- Residents of Brown County
  - Adolescents
  - Adults

Hospital Resources

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

Community Partners

- Beyond Health
- Brown County Public Health
- De Pere Public Health
- Prevea Health
- Bellin Health
- Connections for Mental Wellness
- Oral Health Partnership
- Schools

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 and well-being consistently arose as the most prominent community health priority in Brown County during CHNA discussions. *Data supporting this concern include*:

- **11%** of adults in Brown County reported 14 or more days of poor mental health each month.
- **1,365** hospitalizations related to mental illness in Brown County.
- **40** deaths by suicide in Brown County.

OUR STRATEGIES

For our Patients

- ***Improve Access to Care***
  - Identify community assets and services.
  - Evaluate the current state of Mental Health services provided by HSHS and Prevea Health that can be accessible to all people.

INDICATORS:

- Progress toward creating more access to services.
- Progress toward recruiting enough providers to meet the need for service.
- Reduce the average number of poor mental health days reported by Brown County residents.

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 school districts to ensure access to school-based mental health services.
- ***Improve Opportunities for Social Cohesion or Connectedness***
  - Work with school districts to ensure access to school-based mental health services, acknowledging the isolation created by online learning in 2020-2021.
- ***Engage in Unified Planning and Policy***
  - Work with state and local leaders to improve access to mental health services by addressing regulatory and financial barriers, the need for services, and workforce challenges.
- ***Address Other Social Determinants of Health***
  - Provide funding and support to organizations such as Oral Helath Partnership and the pediatric dental surgical program that provides needed services to underserved children.

INDICATORS:

- Number of instructors trained, trainings provided, individuals trained.
- Number of school district partnerships, number of students counseled or programs created.
- Number of children served through OHP.

PLANNED ACTIONS – *Mental Health*

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

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
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.	- Colleague Time - Technology (virtual platform) - Marketing Materials	- Brown County Schools - Trained Facilitators	Increase recognition and improve response to mental illness in student and adult populations. Increase resiliency. Reduce suicide and nonfatal intentional self-harm injury rates.
Implement "No Wrong Door" policies between health systems.	- Colleague Time - Marketing or Communication Materials - Technology - Financial Support	- Beyond Health - Other health systems - Public Health - Public Schools - Post-secondary Schools systems: UWGB, NWTC, St. Norbert.	Increase access to prevention and early intervention mental health services for underserved populations due to language, economic or cultural barriers.

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

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Identify community mental health assets and services.	- Colleague Time	- St. Mary's Hospital - Mental Health Task Force - Other Community Stakeholders	Increased awareness should lead to increase utilization of services.
Work with the HSHS/Prevea Behavioral Health Executive Director to evaluate the current state of mental health service access through HSHS and Prevea Health.	- Colleague Time	- Prevea Health - HSHS St. Mary's Hospital Medical Center	Increase awareness and then access to mental health services for underserved populations due to language, economic or cultural barriers.
Develop diverse health navigator programs for mental health services.	- Colleague Time - Marketing or Communication Materials - Technology - Financial Support	- Beyond Health - Other Health Systems - Public Health - Public Schools - Post-secondary School Systems: UWGB, NWTC, St. Norbert.	Increase access to mental health services for underserved populations due to language, economic or cultural barriers.

Strategy: Work with community partners to improve opportunities for social cohesion or connectedness.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Work with school districts to ensure access to school-based mental health services to address effects of isolation caused by online learning.	- Colleague Time	- Brown County Schools - Prevea Health - Other Community Partners	Increase opportunities for social cohesion in healthy ways that provides social support and connectedness.

Strategy: Engage in unified planning and policy around mental health.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Work with state and local leaders to improve access to mental health services by addressing regulatory and financial barriers, the need for services, and workforce challenges.	- Colleague Time	- Brown County Schools - Prevea Health - Other Community Partners	By removing regulatory burdens or increasing reimbursement for mental health services, more people will have access to services.

Strategy: Work with community partners to address other Social Determinants of Health

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Provide funding and support to organizations such as Oral Health Partnership and the pediatric dental surgical program and provides needed services to underserved children.	- Colleague Time - Community Benefits Funding	- Oral Health Partnership - NEW Community Clinic - Other Health Systems - Prevea Health - Other Community Partners	Increase in dental care can lead to better overall health and a reduction of patients seeking emergent dental care services in Hospital Emergency Departments.

Priority No. 2: Healthy Nutrition and Physical Activity

Target Populations

- Residents of Brown County
  - Adolescents
  - Adults

Hospital Resources

- Colleague Time
- Engaged Leaders
- Grant Funding
- Marketing Materials

Community Partners

- Beyond Health
- Brown County Public Health
- De Pere Public Health
- Prevea Health
- Bellin Health
- Schools

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

Nutrition and Physical Activity consistently arose as a significant opportunity to improve health behavior and therefore a health priority in Brown County during CHNA discussions. Healthy nutrition and physical activity frequently accompanied discussions around Chronic Disease Prevention and Management, as well as Mental Health. *Data supporting this concern include*:

- **34%** of Brown County adults are considered obese versus 32% statewide and 30% nationally.
- **8%** of Brown County residents lack adequate access to food.

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.
  - Promote an internal work environment that encourages healthy food choices and opportunities for physical activity.

INDICATORS:

- Number of patient screenings conducted, community referrals made.
- Colleague participation and engagement in the Livewell program.

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.
  - Partner with Wello to support the Farm to School program.
- ***Improve Opportunities for Social Cohesion or Connectedness***
  - Identify Physical Activity venues in Brown County where social connectedness is part of the physical activity being offered or promoted.
- ***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 utilizing community-provided physical activity venues (e.g., walking trails).
- Number of meetings with local leaders, policy impacts.

PLANNED ACTIONS – Healthy Nutrition and Physical Activity

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

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Work with providers to ensure regular screenings, patient education, and referral to community resources.	- Colleague Time	- Prevea Health	Increase awareness, improve nutrition, increase physical activity and reduce obesity.
Work with community partners to provide community education, health and benefit screenings, and service referrals.	- Colleague Time	- Community Partners	Increase awareness, improve nutrition, increase physical activity and reduce obesity.
Promote an internal work environment that encourages healthy food choices and opportunities for physical activity.	- Colleague Time - Livewell Program	- Prevea Health	Improve healthy eating, increase physical activity, and promote healthier weight.
Work with local Farmers Markets to supplement the buying power of FoodShare recipients to purchase fresh produce.	- Colleague Time - Community Benefits Funding	- Farmers Markets - Other Community Partners	Improve nutrition and food security. Create healthy eating habits and reduce obesity.
Partner with Wello to support the Farm to School program.	- Colleague Time - Community Benefits Funding	- Wello - Schools	Increase access to healthy food options to students.

***Strategy*:** Improve opportunities for social cohesion and connectedness.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Identify Physical Activity venues in Brown County where social connectedness is part of the physical activity being offered or promoted.	- Colleague Time	- Beyond Health - Brown County Park Department	Increase opportunities for social cohesion in healthy ways that provides social support and connectedness.

***Strategy*:** Engage in unified planning and policy around healthy nutrition and physical activity.

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	- Beyond Health	Increase food security and lower rates of obesity.

Priority No. 3: Alcohol and Drug Use/Abuse

Target Populations

- Residents of Brown County
  - Adolescents
  - Adults

Hospital Resources

- Colleague Time
- Engaged Leaders
- Grant Funding
- Marketing Materials

Community Partners

- Beyond Health
- Brown County Public Health
- De Pere Public Health
- Prevea Health
- Bellin Health
- Connections for Mental Wellness
- Schools

Anticipated Impact

- Improve Resiliency
- Reduce Drug and Alcohol Use and Misuse

Relevant Measures*

- Proportion of Adolescents Who Used Drugs in the Past Month
- 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

Alcohol Consumption – The reported incidence of binge drinking is significantly higher in Brown County than the United States overall. The percent of adults who drink more than 4 or 5 alcoholic drinks in one sitting at least once per month and/or the percent of adults who drink more than 1-2 drinks per day on average is:

- 27% in Brown County
- 24% in Wisconsin
- 17% in the United States.

Drug Use/Abuse – Drug use and misuse continue to be a major health priority in Brown County and specifically among our youth. According to the Youth Risk Behavior Survey data for 2018-2019:

- 4% of Brown County 10th graders reported using pain killers to get high.
- 11% of Brown County 10th graders reported using marijuana in the previous 30 days.

OUR STRATEGIES

For our Patients

- ***Improve Access to Care***
  - Evaluate the current state of Behavioral Health services provided by HSHS and Prevea Health that can be accessible to all people.
  - Ensure consistent use of Screening, Brief Intervention and Referral to Treatment (SBIRT) by providers.

INDICATORS:

- Progress toward improving access to services.
- Percentage of providers utilizing SBIRT, percentage of patients screened.

For our Community

- ***Improve 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).
  - Coordinate regular Medication Take Back days to remove unused prescriptions from the community.
- ***Improve Opportunities for Social Cohesion or Connectedness***
  - Work with school districts to ensure access to education and awareness programs for Alcohol and Drug Use.

INDICATORS:

- Number of youth workers trained, children receiving program opportunities.
- Amount in weight of unused prescription medication collected and disposed.

PLANNED ACTIONS – *Treatment and Prevention of Alcohol and Drug Use/Misuse*

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

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
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).	- Colleague Time	- Beyond Health - Schools	Improve the ability of schools and other organizations to develop resiliency in students and reduce the use of alcohol and other drug use.
Coordinate regular Medication Take Back days to remove unused prescriptions from the community.	- Colleague Time - Collection Receptacles	- Beyond Health - Prevea Health - Other Community Partners	Reduce prescription drug misuse.

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

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Work with the HSHS/Prevea Executive Director of Behavioral Health to evaluate the current state of Behavioral Health service access through HSHS and Prevea Health.	- Colleague Time	- Prevea Health	Improve service access.
Ensure consistent use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) by providers.	- Colleague Time - EMR	- Prevea Health	Reduce the risks and impacts of alcohol and other drug use and misuse through prompt identification and referral to treatment and services.
Implement "No Wrong Door" policies between health systems.	- Colleague Time - Marketing or Communication Materials - Technology - Financial Support	- Beyond Health - Other Health Systems - Public Health - Public Schools - Post-secondary School Systems: UWGB, NWTC, St. Norbert	Increase access to drug and alcohol addiction services for all people including the underserved populations due to language, economic or cultural barriers.
Develop diverse health navigator programs for addiction prevention and treatment services.	- Colleague Time - Marketing or Communication Materials - Technology - Financial Support	- Beyond Health - Other Health Systems - Public Health - Public Schools - Post-secondary School Systems: UWGB, NWTC, St. Norbert	Increase access to addiction prevention and treatment services for all people including for underserved populations due to language, economic or cultural barriers.

***Strategy*:** Improve opportunities for social cohesion or connectedness.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Work with school districts to ensure access to education and awareness programs for Alcohol and Drug Use.	- Colleague Time	- Prevea Health	Reduce the risks and impacts of drug use by youth.

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 Sept. 15, 2021.