

HSHS
Sacred Heart
Hospital

Community Health IMPROVEMENT PLAN

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Introduction

HSHS Sacred Heart Hospital is an acute-care hospital located in Eau Claire, Wisconsin. For more than 130 years (nearly 80 at its current site), the hospital has served as a leader in health and wellness in the Chippewa Valley. HSHS Sacred Heart Hospital provides a wide range of specialties, including 24-hour Emergency Medicine, inpatient Behavioral Care, Cancer Care (in partnership with Prevea Health), Heart Care, Pediatrics and Women's Health.

HSHS Sacred Heart 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 Sacred Heart Hospital received 16,146 emergency department visits, totaled 6,808 admissions, registered 70,155 outpatient visits, and provided more than \$22.3 million in total community benefits (including subsidized care for the poor and broader community benefits).

In 2020-2021, HSHS Sacred Heart Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with sister hospital HSHS St. Joseph's, 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, Eau Claire County-specific CHNA Report may be found at <https://www.hshs.org/SacredHeart/About-Us/Community-Health-Needs-Assessment>.

This Implementation Plan builds off the CHNA Report by detailing the strategies HSHS Sacred Heart 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 Eau Claire 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 Sacred Heart Hospital, in collaboration with community partners, identified the following health priorities in Eau Claire and Chippewa 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 community members), local and national health data comparisons and input from local health coalitions (including Eau Claire Healthy Communities).

Community Health Needs That Will Not Be Addressed

HSHS Sacred Heart Hospital plans to address each of the top five health areas identified as significant needs in Eau Claire 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).

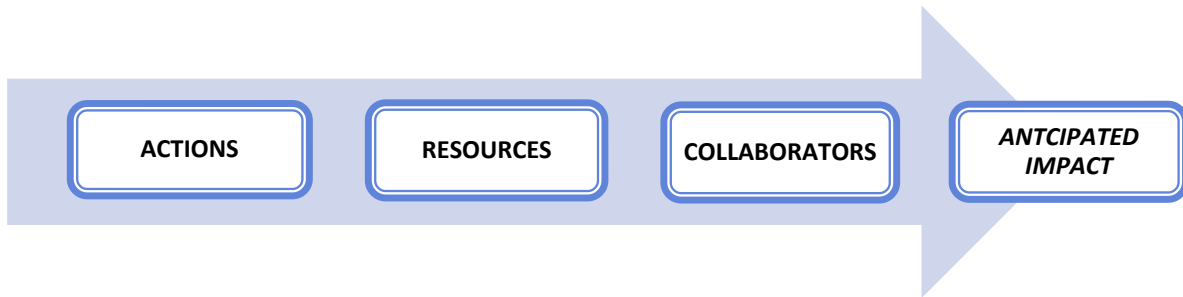
Primary Implementation Strategies

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

| Strategy | Description |
|--|--|
| <i>Increase Access to Prevention and Early Intervention Services</i> | This strategy involves taking actions that prevent disease or injury or limit their progression and impact. |
| <i>Improve Access to Care</i> | 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. |
| <i>Address Other Social Determinants of Health</i> | This strategy involves addressing other conditions and environmental factors that impact health, functioning and quality-of-life outcomes in the community. |
| <i>Engage in Unified Planning and Policy</i> | 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

- Eau Claire Healthy Communities
- Homeless Resources
- 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 Eau Claire County during CHNA discussions. Reasons commonly cited for the problem included lack of comfort with seeking help; 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 (19 per 100,000 in Eau Claire County versus 14 per 100,000 nationally in 2018-19)
- Self-inflicted injury hospitalizations per 100,000 people (68 in Eau Claire County versus 51 statewide during 2016-2018).

OUR STRATEGIES

For our Patients

- **Improve Access to Care**
 - Expand inpatient psychiatric bed capacity for adults.

INDICATORS:

- Progress toward expansion of adult psychiatric beds.
- Number of adults 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 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 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 <i>Question, Persuade, Refer (QPR)</i> suicide prevention training to student and adult populations. | <ul style="list-style-type: none"> - Colleague Time - Technology (virtual platform) - Marketing Materials - Grant Funding | <ul style="list-style-type: none"> - Eau Claire County Schools - Eau Claire Healthy Communities - Community Members | Reduce the Eau Claire 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 <i>Mental Health First Aid</i> training for youth and adult populations. | <ul style="list-style-type: none"> - Colleague Time - Technology (virtual platform) - Marketing Materials - Community Benefits Funding | <ul style="list-style-type: none"> - Eau Claire County Schools - Eau Claire Healthy Communities - Community Members | 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. | <ul style="list-style-type: none"> - Colleague Time | <ul style="list-style-type: none"> - Eau Claire County Schools - Mental Health Matters - Other Interested Community Organizations | 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. | <ul style="list-style-type: none"> - Colleague Time - Maternity onto Motherhood (MOM) Program | <ul style="list-style-type: none"> - Prevea Health - St. Joseph’s 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 |
|--|--|---|---|
| Expand inpatient psychiatric beds for adults. | <ul style="list-style-type: none"> - Colleague Time - Bed Space/Facility Renovations - Grant Funding - Operational Funding | <ul style="list-style-type: none"> - Law Enforcement - Referral Sources (counties, Northwest Connections, etc.) | Promote resilience and recovery, thereby reducing incidents of harm to self and others. Maintain natural support systems by keeping adults in crisis 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 | <ul style="list-style-type: none"> - Colleague Time - Foundation Funding | <ul style="list-style-type: none"> - Eau Claire 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 - Office Space - Marketing Materials - Website - Foundation Funding | - Referral Sources (county agencies, other medical facilities, etc.) - 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 Clinics - Referral Sources - St. Joseph's 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 to help promote housing and economic stability, as well as facilitate access to health care services. | - Colleague Time - Community Benefits Funding | - Homeless Resources - 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
- Adults
- Pregnant/Postpartum Women

Hospital Resources

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

Community Partners

- Eau Claire Healthy Communities
- 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 (27% in Eau Claire County versus 19% nationally in 2017).
- High percentage of motor vehicle deaths involving alcohol (41% 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 <i>Mental Health First Aid</i> training for youth and adult populations. | <ul style="list-style-type: none"> - Colleague Time - Marketing Materials - Technology (virtual platform) | <ul style="list-style-type: none"> - Eau Claire 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. | <ul style="list-style-type: none"> - Colleague Time | <ul style="list-style-type: none"> - Eau Claire 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 Eau Claire Healthy Communities (EHC) High-Risk Drinking Prevention Action Team and Alliance on Substance Abuse Prevention (ASAP) to provide community education and engage in other prevention activities. | <ul style="list-style-type: none"> - Colleague Time - Marketing Materials | <ul style="list-style-type: none"> - ASAP - ECHC High-Risk Drinking 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. | <ul style="list-style-type: none"> - Colleague Time - Maternity onto Motherhood (MOM) Program | <ul style="list-style-type: none"> - Prevea Health - St. Joseph’s 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. | <ul style="list-style-type: none"> - Colleague Time - EMR - Medical Staff | <ul style="list-style-type: none"> - 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. | <ul style="list-style-type: none"> - Colleague Time - Maternity onto Motherhood (MOM) Program | <ul style="list-style-type: none"> - Prevea Health - St. Joseph’s Hospital/L.E. Phillips Libertas Center - 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. | <ul style="list-style-type: none"> - Colleague Time - Foundation Funding - Marketing Materials | <ul style="list-style-type: none"> - Eau Claire County Schools - Prevea Health | Reduce the risks and impacts of alcohol misuse by supporting 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 to help promote housing and economic stability, as well as facilitate access to health care services. | <ul style="list-style-type: none"> - Colleague Time - Community Benefits Funding | <ul style="list-style-type: none"> - Homeless Resources - Other Community Partners | Increase protective factors, including health care access, for individuals affected by poverty and homelessness. |
| Work with the Eau Claire Healthy Communities (EHC) High-Risk Drinking Prevention Action Team and Alliance for Substance Abuse Prevention (ASAP) to provide alcohol-free events, activities, and opportunities throughout the county. | <ul style="list-style-type: none"> - Colleague Time - Marketing Materials - Community Benefits Funding | <ul style="list-style-type: none"> - ASAP - EHC High-Risk Drinking Prevention Action Team - Local Policymakers - 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 Valley Free Clinic
- Eau Claire Healthy Communities (EHC) Chronic Disease Prevention Action Team
- Local, State Policymakers
- 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 (447 in Eau Claire County versus 438 nationally in 2017).
- Percent of high school students ever diagnosed with asthma (17% in Eau Claire County in 2019).

OUR STRATEGIES

For our Patients

- **Improve Access to Prevention and Early Intervention Services**
 - Work with providers to ensure regular screenings and patient education.
- **Improve Access to Care**
 - 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

- **Improve 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 Chippewa Valley Free 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 Chippewa Valley Free 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. | <ul style="list-style-type: none"> - Colleague Time - Marketing Materials | <ul style="list-style-type: none"> - ECHC Chronic Disease Prevention Action Team - Other Community Partners | Reduce the prevalence and impacts of chronic diseases. |
| Work with providers to ensure regular screenings and patient education. | <ul style="list-style-type: none"> - Colleague Time - Marketing Materials | <ul style="list-style-type: none"> - Prevea Health - St. Joseph's Hospital | 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. | <ul style="list-style-type: none"> - Colleague Time - Community Benefits Funding | <ul style="list-style-type: none"> - Farmers Markets - Other Community Partners | 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. | <ul style="list-style-type: none"> - Colleague Time | <ul style="list-style-type: none"> - ECHC Chronic Disease Prevention Action Team - 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 Chippewa Valley Free Clinic in Eau Claire. | <ul style="list-style-type: none"> - Colleague Time - Community Benefits Funding | <ul style="list-style-type: none"> - Chippewa Valley Free Clinic - Other Community Partners | 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. | <ul style="list-style-type: none"> - Colleague Time | <ul style="list-style-type: none"> - ECHC Chronic Disease Prevention Action Team - Local, State Policymakers - 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
- Foundation Funding
- Marketing Materials
- Virtual Platform

Community Partners

- Alliance for Substance Abuse Prevention (ASAP)
- Mental Health Matters
- 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 (2.6 in Eau Claire County versus 1.6 statewide from 2014-2019).
- Percent of high school students who have tried meth (2% in Eau Claire County, the same rate as state and national rates 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 <i>Mental Health First Aid</i> training for youth and adult populations. | <ul style="list-style-type: none"> - Colleague Time - Marketing Materials - Technology (virtual platform) | <ul style="list-style-type: none"> - Eau Claire 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. | <ul style="list-style-type: none"> - Colleague Time | <ul style="list-style-type: none"> - Eau Claire 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, thereby reducing the risk of drug use. |
| Work with community partners to ensure early identification of pregnant and postpartum moms with behavioral health needs. | <ul style="list-style-type: none"> - Colleague Time - Maternity onto Motherhood (MOM) Program | <ul style="list-style-type: none"> - Prevea Health - St. Joseph’s Hospital/L.E. Phillips Libertas Center - 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. | <ul style="list-style-type: none"> - Colleague Time - EMR | <ul style="list-style-type: none"> - 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. | <ul style="list-style-type: none"> - Colleague Time - Maternity onto Motherhood (MOM) Program | <ul style="list-style-type: none"> - Prevea Health - St. Joseph’s Hospital/L.E. Phillips Libertas Center - 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. | <ul style="list-style-type: none"> - Colleague Time - Foundation Funding - Marketing Materials | <ul style="list-style-type: none"> - Eau Claire 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 to help promote housing and economic stability, as well as facilitate access to health care services. | <ul style="list-style-type: none"> - Colleague Time - Community Benefits Funding | <ul style="list-style-type: none"> - Homeless Resources - 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

- Eau Claire Healthy Communities (ECHC) Chronic Disease Prevention Action Team
- Farmers Markets
- Homeless Resources
- Local Policymakers
- 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 (28% in Eau Claire County in 2017).
- Percent of population lacking adequate access to food (9% in 2018).

OUR STRATEGIES

For our Patients

- **Improve 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.

For our Community

- **Improve 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 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 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. | <ul style="list-style-type: none"> - Colleague Time - Marketing Materials | <ul style="list-style-type: none"> - ECHC Chronic Disease Prevention Action Team - Other Community Partners | Increase awareness, improve nutrition, and reduce obesity. |
| Work with providers to ensure regular screenings, patient education, and referrals. | <ul style="list-style-type: none"> - Colleague Time | <ul style="list-style-type: none"> - 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. | <ul style="list-style-type: none"> - Colleague Time - Community Benefits Funding | <ul style="list-style-type: none"> - 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 to help promote housing and economic stability, as well as facilitate access to health care services. | <ul style="list-style-type: none"> - Colleague Time - Community Benefits Funding | <ul style="list-style-type: none"> - Homeless Resources - 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. | <ul style="list-style-type: none"> - Colleague Time | <ul style="list-style-type: none"> - ECHC Chronic Disease Prevention Action Team - 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.