

Bellin Health

Community Health Needs Assessment Report & Implementation Plan



Beyond Health

Healthiest Brown County
"Connecting Beyond Health Care"

Beyond Health-A Collaborative Approach to Impacting
Population Health in Brown County, Wisconsin

August 2015

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Executive Summary

Background

Provisions in the Affordable Care Act (ACA) require charitable hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt implementation strategies to meet the needs identified through the CHNA. The CHNA is a systematic process involving the community to identify and analyze community health needs as well as community assets and resources in order to plan and act upon priority community health needs. This assessment process results in a CHNA Report which is used to plan, implement, and evaluate Community Benefit activities. Once the CHNA Report is completed, a set of implementation strategies is developed based on the evidence and assets and resources identified in the CHNA process.

Every three years, Bellin Health is required to conduct a CHNA and to adopt an Implementation Plan by an authorized body of the hospital in the same taxable year, and make the report widely available to the public. The hospital's previous CHNA Report and Implementation Plan was conducted and adopted in FY2012. In addition, the hospital completes an IRS Schedule H (Form 990) annually to provide information on the activities and policies of, and Community Benefit provided by the hospital.

To comply with these requirements, Bellin Health was a key part of a collaborative approach in conducting its CHNA and adopting an Implementation Plan in FY2015 (July 1, 2014 through June 30, 2015) in partnership with representatives from the community. Upon completion of the CHNA, the hospital developed a set of implementation strategies and adopted an Implementation Plan to address priority community health needs. The population assessed was Brown County, Wisconsin. Data collected throughout the assessment process was supplemented with the results of a behavioral risk factor community survey and the opinions of community leaders obtained via a community health needs assessment "summit" held in November 2014.

Identification and Prioritization of Needs: The following health needs were identified based on the perceived magnitude and seriousness of the problem and the feasibility of addressing it, as determined at a health needs summit attended by a group broadly representative of the community: Alcohol and Other Drug Abuse, Mental Health, Physical Activity and Nutrition, and Oral Health.

These needs were identified by using the Wisconsin Department of Public Health's CHIP Infrastructure Improvement Project's recommended list of health focus areas, identifying existing data that outlines the magnitude and seriousness of the health focus areas, and then convening a health summit with attendance broadly representative of the community to select the health focus area for intensive focus over the next three years.

Implementation Plan Development: As part of the engagement process with key stakeholders, attention has been given to natural partnerships and collaborations that will be used to operationalize the Implementation Plan. The Implementation Plan is considered a “living document” – a set of strategies that can be adapted to the lessons learned while implementing Community Benefit programs and services relevant to the priority needs. The broader set of community health needs will continue to be monitored for consideration as future focus areas.

I. Introduction

Background

Bellin Health is a not for profit health system in northeast Wisconsin, with Brown County as the primary service area. It is an integrated health care delivery system based in Green Bay. It has served people in Northeast Wisconsin and Michigan’s Upper Peninsula since 1908. It is comprised of Bellin Hospital, Bellin Psychiatric Center, 31 Bellin Health Medical Group primary care physician clinics, and 4 retail health clinics known as Bellin Health FastCare. Bellin also operates Bellin Health Partners, a physician-hospital organization with more than 200 specialty physician members, the Bellin Health Oconto Hospital, a critical care access hospital in Oconto, Bellin Fitness Center with four locations, and Bellin College. With its 3,650 employees, Bellin Health is known for its emphasis on preventive health care and is the region’s leader in cardiac, orthopedics, sports medicine, digestive health, mental health, cancer care and primary care medicine.

Bellin Health’s Mission and Vision

MISSION

Bellin Health is a community-owned, not-for-profit organization responsible for the physical and mental health of people living in Northeast Wisconsin and the Upper Peninsula of Michigan.

We exist to serve others through patient care excellence and community health improvement designed to positively impact the well-being of people living in our region. We are steadfast in our commitment to providing compassionate, safe, coordinated care, while striving to make that care more accessible and affordable for everyone.

Our innovations and never-ending pursuit of improvement drives the evolution of health care in the nation.

VISION

The people in our region will be the healthiest in the nation, resulting in improved economic vitality in the communities we serve.

Community Health Needs Assessment Population

For the purpose of this CHNA, Bellin Health defined its primary service area and populations as Brown County, Wisconsin. The hospital’s patient population includes all who receive care without regard to insurance coverage or eligibility for assistance.

Demographics

Bellin Health service area is comprised of approximately 530 square miles with a population of approximately 255,000 and a population density of 468 per square mile. The service area consists of the following suburban and rural communities:

Cities	Townships	Villages
<ul style="list-style-type: none"> • De Pere • Green Bay 	<ul style="list-style-type: none"> • Eaton • Glenmore • Green Bay • Holland • Humboldt • Lawrence • Ledgeview • Morrison • New Denmark • Pittsfield • Rockland • Scott • Wrightstown 	<ul style="list-style-type: none"> • Allouez • Ashwaubenon • Bellevue • Denmark • Hobart • Howard • Pulaski • Suamico • Wrightstown

Total Population Change, 2000 to 2014

According to the U.S. Census data, the population in the region rose from approximately 227,000 to approximately 255,000 between the year 2000 and 2010, a 12% increase.

Report Area	Total Population 2000 Census	Total Est. Population 2014	Total Population Change 2000-2014	Percentage Population Change, 2000-2014
Brown County	226,778	263,143	36,365	+16%
State of Wisconsin	5,363,673	5,743,349	379,676	+7.1%

Data Source: US Census Bureau Decennial Census; Claritas accessed via Databay Navigate software.

Population by Age Groups

Population estimates by gender was evenly divided by gender (49.6% male, 50.4% female). The county had the following population numbers by age groups in 2014:

Report Area	Total Population	Age 0 to 17	Age 18 to 24	Age 25 to 34	Age 35 to 44	Age 45 to 54	Age 55 to 64	Age 65+
Brown County	263,143	65,120	25,124	36,381	33,502	39,495	31,749	31,772
Brown County %	100%	24.8%	9.5%	13.8%	12.8%	15.0%	12%	12%
Wisconsin	5,743,349	1,331,934	552,900	736,199	712,609	869,414	739,853	800,440
Wisconsin %	100%	23.2%	9.6%	12.8%	12.4%	15.1%	12.9%	13.9%

Source: Claritas accessed via Databay Navigate

Population without a High School Diploma (age 25 and older)

Within the report area there are roughly 16,000 persons aged 25 and older without a high school diploma (or equivalent) or higher. This represents just over 9% of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes.

Report Area	Population Age 25+	Population Age 25+ with no HS Diploma	% Population Age 25+ with no High School Diploma
Brown County	172,899	16,029	9.3%
Wisconsin	3,858,515	378,380	9.8%

Note: This indicator is compared with the state average. Data Source: Claritas accessed via Databay Navigate

Population in Poverty

Poverty is considered a key driver of health status. Within the report area roughly of the population is living in households with income below the Federal Poverty Level (FPL). This is lower than the statewide poverty levels. This indicator is relevant because poverty creates barriers to access including health services, nutritional food and other necessities that contribute to poor health status.

Report Area	All ages	Ages 0-17
Brown County	12.1%	15.7%
Wisconsin	13.2%	18.3%

Source: Wisconsin Department of Health Services, County Health Rankings 2014 (2012 data)

Poor General Health

Within the report area 14% of adults 18 and older report having poor or fair health in response to the question “Would you say that in general your health is excellent, very good, good, fair or poor?” The state rate is 15%. This indicator is relevant because it is a measure of general poor health status.

Report Area	Total Population Age 18+	Percent Population with Poor or Fair Health	Estimated Population with Poor or Fair Health
Brown County	198,023	14%	29,703
Wisconsin	4,411,415	15%	66,171

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance (BRFS) Systems 2013. Brown County BRFS 2014.

II. Establishing the CHNA Infrastructure and Partnerships

Bellin Health led the planning, implementation and completion of the Community Health Needs Assessment in partnership with Brown County Health Department, City of De Pere Health Department, Aurora BayCare Medical Center, St. Mary’s and St. Vincent Hospitals (HSHS), WI Division of Public Health NE Regional Office and the Brown County United Way. This partnership was formed to improve the health of Brown County residents through conducting periodic community health needs assessments and leading community-wide action planning teams. The work of these teams has been branded as “Beyond Health”

Internal and External Steps

Bellin Health undertook a six month planning and implementation effort to develop the CHNA, identify and prioritize community health needs for its service area and formulate an implementation plan to guide ongoing population health initiatives with like-missioned partners and collaborators. These planning and development activities included the following internal and external steps:

- Identifying the methodology to be used for this update
- Confirming the involvement of Aurora Health in this process
- Identifying the framework for study, which was the Wisconsin Department of Public Health CHIP Improvement Project
- Collaborating with the local group “Live 54218” on the implementation of a local Behavioral Risk factor Survey
- Producing fact sheets on several of the identified health focus areas (the remainder were completed by other members of the CHIP steering committee)
- Working with Brown County and De Pere public health on the development of meeting materials, a detailed agenda, and an invitation list for a local health planning summit
- Preparing and presenting a detailed overview of the current health focus area assigned to us, including the reasons for selection last time, accomplishments, and work remaining
- Working with the Brown County Community Health Improvement steering committee to analyze the results of the summit
- Sharing results of the summit with our internal community benefit committee in order to develop the implementation plan
- Sharing the results of the needs assessment and the proposed implementation plan with our community advisory committee before bringing it to the Board of Directors for approval

III. Defining the Purpose and Scope

The purpose of the CHNA was to 1) evaluate current health needs of the hospital’s service area, 2) identify resources and assets available to support initiatives to address the health priorities identified, 3) develop an Implementation Plan to organize and help coordinate collaborative efforts impacting the identified health priorities, and 4) establish a system to track, report and evaluate efforts that will impact identified population health issues on an ongoing basis.

IV. Data Collection and Analysis

Description of Data Sources

Quantitative

Source	Description
Behavioral Risk Factor Surveillance System, Behavioral Risk Factor Survey, Youth Behavioral Risk Factor Survey	The largest, continuously conducted telephone health survey in the world. It enables the Center for Disease Control and Prevention (CDC), state health departments and other health agencies to monitor modifiable risk factors for chronic diseases and other leading causes of death. Local survey conducted in

Source	Description
	2014. Youth survey was conducted statewide by the WI department of Public Instruction in 2013.
US Census	National census data is collected by the US Census Bureau every 10 years.
Centers for Disease Control	States collect and disseminate vital statistics as part of the US's oldest and most successful intergovernmental public health data sharing system.
County Health Rankings	Each year the overall health of each county in all 50 states is assessed and ranked using the latest publically available data
Green Bay Area Chamber of Commerce Fact Book	Economic and population profile compiled annually
Wisconsin Department of Health Services- Wisconsin Interactive Statistics on Health	Resource developed by the Division of Public Health; includes data on births, fertility, mortality, cancer, injuries, and so on.
Healthy People 2020	Sponsored by the US Office of Disease Prevention and Health Promotion; compiles national data related to Healthy People 2020 objectives
Forward Wisconsin	Wisconsin's economic development agency; has workforce and economic development data
Wisconsin Epidemiological Profile on Alcohol and Other Drug Use 2014	Prepared by the Division of Mental Health and Substance Abuse Services, the University of Wisconsin Population Health Institute and the Office of Health Informatics, Division of Public Health
Wisconsin WINS	science-based, state-level initiative designed to decrease youth access to tobacco products
Wisconsin Child Abuse and Neglect Report	Wisconsin Department of Children and Families Annual report on child abuse and neglect with information on reports of abuse, neglect, victims, and maltreaters. Additional child welfare safety reports are also available
Uniform Crime Reporting Program	The Uniform Crime Reporting (UCR) Program has been the starting place for law enforcement executives, students of criminal justice, researchers, members of the media, and the public at large seeking information on crime in the nation. The program was conceived in 1929 by the International Association of Chiefs of Police to meet the need for reliable uniform crime statistics for the nation. In 1930, the FBI was tasked with collecting, publishing, and

Source	Description
	archiving those statistics. Has national, state and local data,
Crime in Wisconsin 2012	Statistical Analysis Center, Wi Department of Justice. provides an overview of offenses reported to law enforcement using Uniform Crime Reporting program
Wisconsin Traffic Safety Summary	Wisconsin Department of Transportation
Wisconsin County Oral Health Surveillance System	Compiles all available oral health data into one page reports for all 72 counties, the City of Milwaukee and the state. Reports include data on demographics, Medicaid/BadgerCare+ enrollment and dental utilization rates, prevention programs, dental workforce, dental safety net, and oral disease burden
Wisconsin Department of Health Services, Wisconsin Immunization Program	internet database that records and tracks immunization dates of Wisconsin children and adults, used to track vaccination rates
Dartmouth Atlas	Uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians to help policymakers, the media, health care analysts and others improve their understanding of our health care system; forms the foundation for many of the ongoing efforts to improve health and health systems across America.
Wisconsin Public Health Information Network	A secure, online network from the Department of Health Services for integrating the information resources of the public health system and all public health partners. Using the Wisconsin PHIN, public health practitioners can securely contribute, retrieve, analyze, and eventually visualize public health data
Economic Benefit of Preventing Disease/National Prevention Strategy	The National Prevention Strategy is a comprehensive plan that will help increase the number of Americans who are healthy at every stage of life. The National Prevention Strategy was released on June 16, 2011 by the National Prevention, Health Promotion, and Public Health Council. You can download the strategy in full or read the strategy broken out by section
The Burden of Diabetes Wisconsin	Report published by the Wisconsin Department of Health Services
National Cancer Institute	

Source	Description
Burden of Asthma Wisconsin	Report published by the Wisconsin Department of Health Services
Burden of Heart Disease and Stroke Wisconsin	Report published by the Wisconsin Department of Health Services
US Department of Housing and Urban Development	Housing statistics
US Department of Agriculture	Data on access to food
EPA Safe Drinking Water Information System	Water quality data
CDC WONDER Outdoor Air Quality 2011	Acronym for Wide-ranging Online Data for Epidemiologic Research, contains data on a number of elements beyond outdoor air quality

Qualitative

The quantitative data was reviewed to help validate the selection of health priorities. In alignment with IRS Treasury Notice 2011-52,2 data reviewed represented 1) the broad interests of the community, and 2) the voice of community members who were medically underserved, minorities, low-income, and/or those persons with chronic illnesses. These people attended the community health improvement project summit in November 2014.

Participant	Organization	Role
Scott Anderson	Northeast Wisconsin Technical College	Associate Dean, Allied Health Sciences
Deborah Armbruster	Brown County Health Department	MCH Nurse Manager
Sandy Atkins	Greater Green Bay YMCA	Director of Center Operations
Sharla Baenen	Bellin Psychiatric Center	President
Donna Boehm	St. Vincent Hospital	Director, Regional Cancer Services
Erin Bongers	De Pere Health Department	Public Health Nurse
Jamie Campbell	N.E.W. Community Clinic - WIC	Project Nutritionist, RD
Tina Cazzola	Brown County Community Treatment Center	Substance Abuse Counselor In Training
Barbara Coniff	Libertas	Director
Laura Cormier	Bellin Health Oconto Hospital	Vice President Operations
Kathie DeMuth	Bellin College	Assistant Professor
Mike Donovan	City of De Pere Board of Health Chair/Council President	

Participant		Organization	Role
Elaine	Doxtator	HSHS St. Mary's Hospital Medical Center	Director Emergency Dept/Nursing Resource
Grant	Dvorak	Greater Green Bay Chamber	Health Educator
John	Dye	Live54218	Chairman, Executive Committee
Christopher	Elfner	Bellin Health	Team Leader
Howard	Endow	Brown County United Way	Community Impact Manager
Thomas	Erdman	University of Wisconsin Green Bay	Academic Curator Richter Museum of natural History
Patricia	Finder-Stone	De Pere Board of Health/LWVGGB/BACC	Volunteer/BOD
Judy	Friederichs	Brown County Health Department	Director
Caroline	Glander	St. Vincent Hospital	RN-Patient Navigator (Cancer Center)
Patti	Glaser-Martin	Hospital Sisters Health System/Prevea Health	Sr. Manager, Internal Communication and Community
Rob	Gollman	Brown County Health Department	Environmental and Laboratory Division Manager
Meredith	Hansen	Aging & Disability Resource Center	Resource Specialist
Adam	Hardy	Achieve Brown County	Executive Director
Margie	Hempel	Unified School District of De Pere	Health Services Coordinator
Kimberly	Hess	Center for Childhood Safety	Executive Director
Laura	Hieb	Bellin Health	
Sarah	Himmelheber	University of Wisconsin- Green Bay	
Sarah	Inman	Brown County United Way	VP of Community Investment & Strategic Impact
Amy	Jerdee	Aurora Baycare Medical Center	Vice President of Clinical Operations
Elizabeth	Kostichka	ElizK Insurance	Independent Insurance Agent
Bonnie	Kuhr	N.E.W. Community Clinic	CEO

Participant		Organization	Role
Celia	LaTour	Catholic Charities	
Greg	Maass	Brown County United Way	Pres/CEO
Steve	McCarthy	N.E.W. Curative Rehabilitation	President and CEO
Mary	Miceli-Wink	Brown County Human Services	AODA Counselor
Seth	Moore	N.E.W. Community Clinic - Outreach Healthcare	Nurse Practitioner / Program Coordinator
Melinda	Morella	Live54218	Assistant Director
Mary	Paluchniak	St. Nicholas Hospital	Facilitator - Outreach
Angela	Raleigh	Prevea Health	Marketing Associate
John	Rocheleau	Bellin Health System	V.P. Business Support and I.T.
Stacy	Ross	Brown County Health Department	
Dawn	Schaefer	West De Pere School District	School Nurse
Elizabeth	Scheelk	State of Wisconsin - Division of Public Health	Public Health Educator
Christine	Schneider	Schneider National	Health and Wellness Manager
Heidi	Selberg	Hospital Sisters Health System	VP
Patti	Smeester	Brown County Health Department	
Rose	Smits	Community Volunteer	Community Volunteer
Jill	Sobieck	Brown County United Way	Community Partnership for Children Coordinator
Carrie	Stempski	Brown County Oral Health Partnership	Executive Director
Troy	Streckenbach	Brown County	Brown County Executive
Kaitlin	Swanson	St. Vincent and St. Mary's Hospitals	Director of Planning & Strategic Support
Dan	Teaters	BC Planning & Land Services Dept./Green Bay MPO	Transportation Planner/GIS
Catherine	Therrien	N.E.W. Community Clinic	N.E.W. Dental Clinic Coordinator
Ashley	VandenBoomen	Brown County United Way	Research and Initiatives Manager
Jen	Van Den Elzen	Live54218	Director

Participant	Organization	Role
Christine Vandenhouten	University of Wisconsin Green Bay	Associate Professor
Janelle Walton	Aging & Disability Resource Center of Brown County	Disability Benefit Specialist
Jody Wilmet	Bellin Health	VP
Bob Woessner	Bob, Inc.	CEO
Chrystal Woller	De Pere Health Department	Director
Chua Xiong	Brown County Health Department	Nurse Manager
Leanne Zhu	University of Wisconsin - Green Bay	Assistant Professor in Nutritional Sciences

By holding the summit and by sharing the priorities and implementation plans with the hospital community advisory committee, the hospital took into account input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of, or expertise in public health (local, regional, state and/or tribal). Members of medically underserved, low-income and minority populations served by the hospital or individuals or organizations representing the interests of such populations also provided input. The medically underserved are members of a population who experience health disparities, are at risk of not receiving adequate medical care as a result of being uninsured or underinsured, and/or experiencing barriers to health care due to geographic, language, financial or other barriers.

A community wide CHNA steering committee was developed to guide the structure of the process to ensure that the requirements of all parties were met. Members of the CHNA Steering Committee represented organizations that have a legal or regulatory requirement to conduct a CHNA. The CHNA Steering Committee members included.

CHNA Steering Committee Member	Organization
Judy Friedrichs,	Brown County Public Health
Chrystal Woller,	City of De Pere Public Health
Heidi Selberg,	Hospital Sisters Health System
John Rocheleau	Bellin Health
Jodi Wilmet	Bellin Health
Laura Heib	Bellin Health
Mark Huber	Aurora Health
Howard Endow	United Way
Christopher Colletta	WI Department of Health Northeast Region

V. Identification and Prioritization of Needs

As part of the identification and prioritization of health needs, the CHNA Steering Committee considered the estimated feasibility and effectiveness of possible interventions by to impact these health priorities; the burden, scope, severity, or urgency of the health need; the health disparities associated with the health needs; the importance the community places on addressing the health need; and other community assets and resources that could be leveraged through strategic collaboration in the hospital's service area to address the health need.

Based on the CHNA planning and development process described, the following community health needs were identified:

1. Alcohol and other Drug Abuse
2. Mental Health
3. Physical Activity and Nutrition
4. Oral Health

VI. Description of Community Health Needs

1. Alcohol and Other Drug Abuse

This team is led by Laura Hieb, Chief Nursing Officer. The data sheet for Alcohol and Other Drug Abuse presented at the Community Health Improvement summit is below:

An estimated 22 million people nationally have drug and alcohol problems. 95% of them are unaware of their problem.

Approximately 80,000 deaths annually in the United States are attributed to excessive drinking. It is the third leading lifestyle-related cause of death.

Drug and alcohol problems can lead to:

- ▶ Alcohol and drug dependencies
- ▶ Alcohol poisoning
- ▶ Fetal alcohol spectrum disorder
- ▶ Hypertension
- ▶ Heart attack
- ▶ Liver, brain, and heart disease

Substance abuse has a major impact on

Binge/Heavy Drinking Statistics:

- Brown County: 25%
- Wisconsin Overall: 24%

Binge drinking is defined as 5+ drinks/occasion for men and 4+ drinks for women.

Heavy drinking is defined as 2+ drinks/day for men, 1+ for women

Binge drinking is responsible for 76% of the economic cost of excessive alcohol consumption.

Economic Burden of Excessive Alcohol Use:

- Brown County: \$318 million
- Wisconsin: \$6.8 billion

Percentage of Wisconsin **high school students** that ever drank alcohol:

individuals, families and communities.

Drug and alcohol use can also lead to costly physical, mental and public health problems including:

- ▶ Teenage pregnancy
- ▶ HIV/AIDS and other STDs
- ▶ Domestic violence
- ▶ Child abuse
- ▶ Motor vehicle crashes
- ▶ Physical fights
- ▶ Crime
- ▶ Homicide
- ▶ Suicide

Wisconsin's rates for various measures of alcohol use and abuse are among the highest if not the highest in the nation.

Sources: Healthiest Wisconsin 2020; Healthy People 2020

- 65.0% of females
- 66.6% of males

Percentage of Wisconsin **high school students** that ever drank alcohol before age 13:

- 14.1% female
- 15.1% male

Brown County **Alcohol-Related Motor Vehicle Deaths**

(Death Rate per 100,000 population from 2008-2012):

	2008	2009	2010	2011	2012
Brown County	4	5	4	4	4
Wisconsin	4	4	4	4	4

Source: Wisconsin Epidemiological Profile on Alcohol & Other Drug Use, 2014

Alcohol Related Hospitalizations (per 1,000 population):

- Brown County: 2.6
- Wisconsin: 2.0

Other Drug Consumption:

- Heroin and other opioid-related deaths are an increasing problem in Wisconsin, as they are nationally.
- Annual numbers of heroin and other opioid-related deaths in the state increased steadily from 2003-2012.
- The proportion of drug deaths with a mention of opioids, the largest category, increased by approximately 48% between 2004 and 2012.
- The proportion with a mention of benzodiazepines doubles between 2005 and 2012, while mentions of cocaine have decreased steadily since 2006.

Source: Wisconsin Epidemiological Profile on Alcohol & Other Drug Use, 2014

2. Mental health

This team is led by Sharla Baenen, President of Bellin Psychiatric Center. The data sheet for Mental Health presented at the Community Health Improvement summit is below:

Mental health can be defined as a state of successful mental function, resulting in productive activities, fulfilling relationships, ability to adapt and cope with challenges.

Mental health is essential to:

- Personal well-being
- Relationships
- The ability to contribute to society

Mental disorders are one of the most common causes of disability:

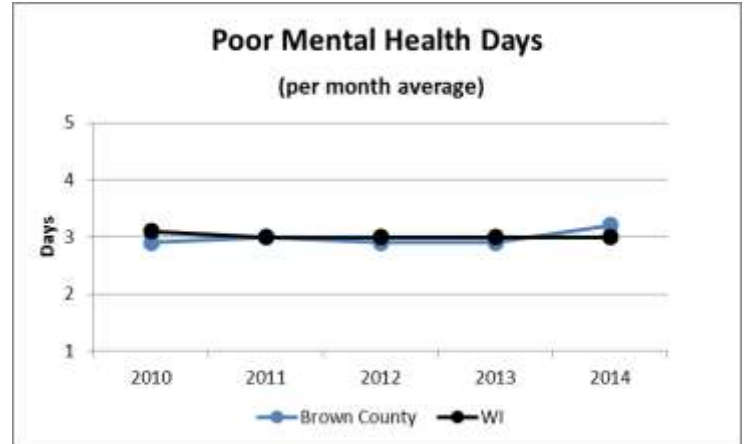
- 13 million adults have seriously debilitating mental illness each year in the US.
- Approximately 20% of the population experiences a mental health problem during any given year.

Suicide:

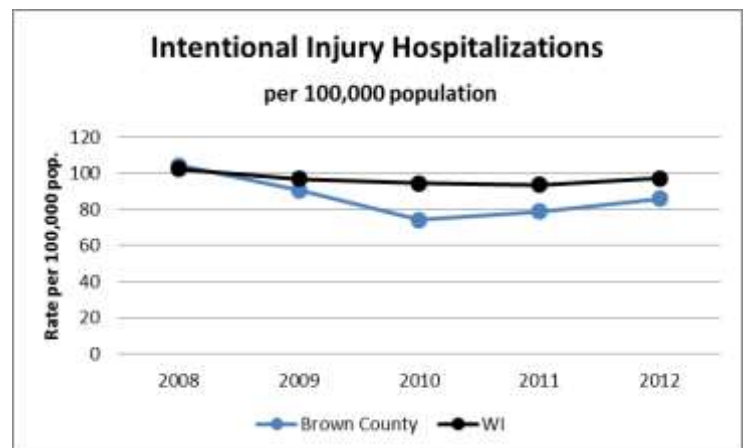
- Is a major preventable public health problem
- Is the 11th leading cause of death overall in the US with 30,000 deaths per year
- There are an estimated 8 -12 attempts for every suicide death.

Mental health issues are associated with physical health problems:

- Smoking
- Physical Inactivity
- Obesity
- Substance Abuse



Source: County Health Rankings/BRFSS



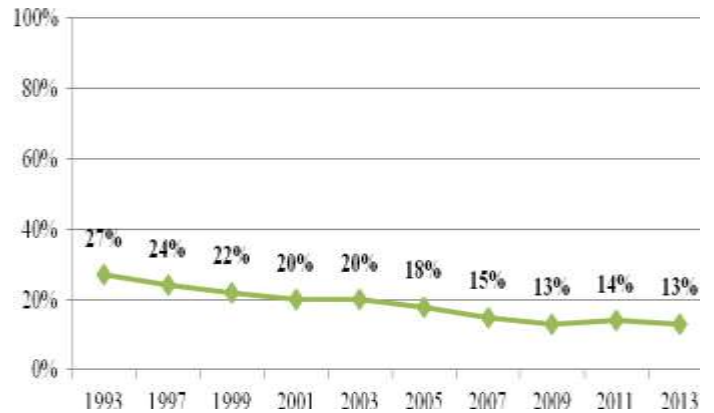
Source: DHS WISH System

These physical health problems can in turn lead to :

- Chronic Disease
- Injury
- Disability

Sources: County Health Rankings, Healthiest Wisconsin 2020, Healthy People 2020

Percentage of Wisconsin students who seriously considered attempting suicide during the past 12 months. (1993 - 2013)*



*Note: Decreased from 1993-2013. Data from 1995 unavailable.

Source: Youth Risk Behavior Survey

3. Physical Activity and Nutrition

This team is lead by John Rocheleau, Vice President of Business Support and Information Technology. The data sheet for Physical Activity and Nutrition presented at the Community Health Improvement summit is below:

Regular physical activity in adults can lower the risk of:

- ▶ Early death
- ▶ Coronary heart disease
- ▶ Stroke
- ▶ High blood pressure
- ▶ Type 2 diabetes
- ▶ Breast and colon cancer
- ▶ Falls
- ▶ Depression

Physical activity in children and adolescents can:

- ▶ Improve bone health
- ▶ Improve cardio-respiratory & muscular fitness
- ▶ Decrease levels of body fat
- ▶ Reduce symptoms of depression

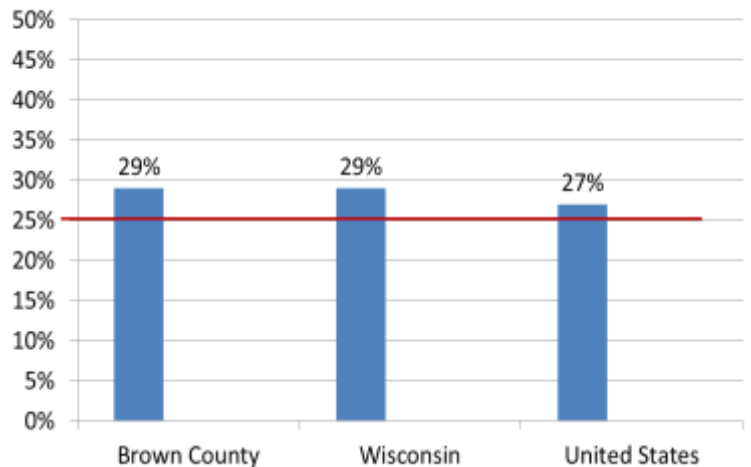
Healthy diet reduces risk of:

- ▶ Overweight/obesity

Adult Obesity

The Green Bay metropolitan area was recently named nationally in the top ten most obese cities in the US.

Percentage of Adults (age 20+) with BMI >30



*Source: County Health Rankings (CHR) – Health Factors, Adult Obesity (www.countyhealthrankings.org), BRFS Module, and Healthy People 2020, Nutrition & Weight Status Module (<http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx>). Accessed 08/15/2014.

- ▶ Malnutrition
- ▶ Anemia
- ▶ Heart disease
- ▶ High blood pressure
- ▶ Type 2 diabetes
- ▶ Osteoporosis
- ▶ Oral disease
- ▶ Diverticular disease
- ▶ Some cancers

At healthy weight one is less likely to:

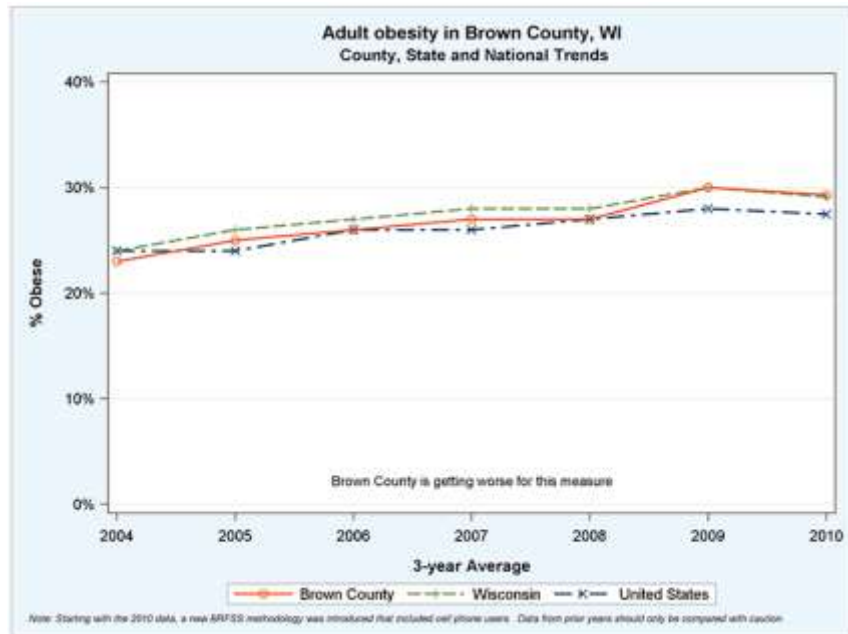
- ▶ Have complications during pregnancy
- ▶ Die at an earlier age

Good nutrition in children is important:

- ▶ To healthy growth & development
- ▶ To maintaining appropriate weight

Annual health care costs are \$1400 higher for people who are obese than for those are not.

Sources: Healthiest Wisconsin 2020; Healthy People 2020



*Source: County Health Rankings (CHR) – Health Factors, Adult Obesity - County, State and National Trends (www.countyhealthrankings.org), Accessed 08/15/2014.

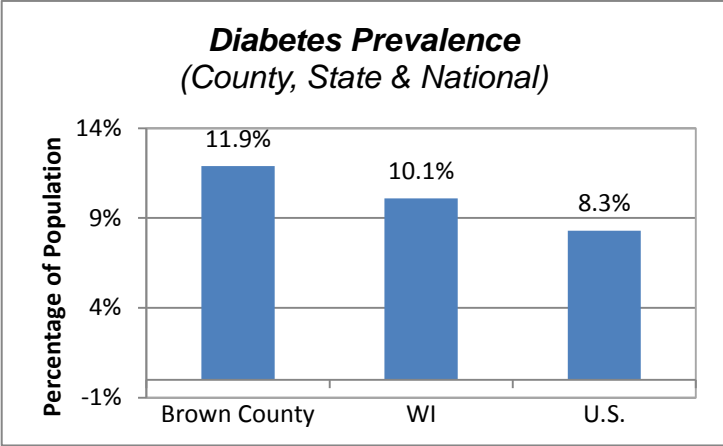
Childhood Obesity ¹

For third grade children in Wisconsin, **17% are obese and 33% are overweight or obese**. In high poverty schools, the rate of obesity increases to **28%**.

Among local low-income families, **18.4%** of two-year-olds and **19.4%** of four-year-olds are already at the **95th percentile or higher for BMI**, outpacing state and national trends.

Chronic Disease Prevalence

70% of all Wisconsin deaths are attributable to chronic disease and nearly half the population of does not meet the recommendations for physical activity. A powerful income disparity drops 61% of the general public who are physically active to only 43% of people with low incomes.

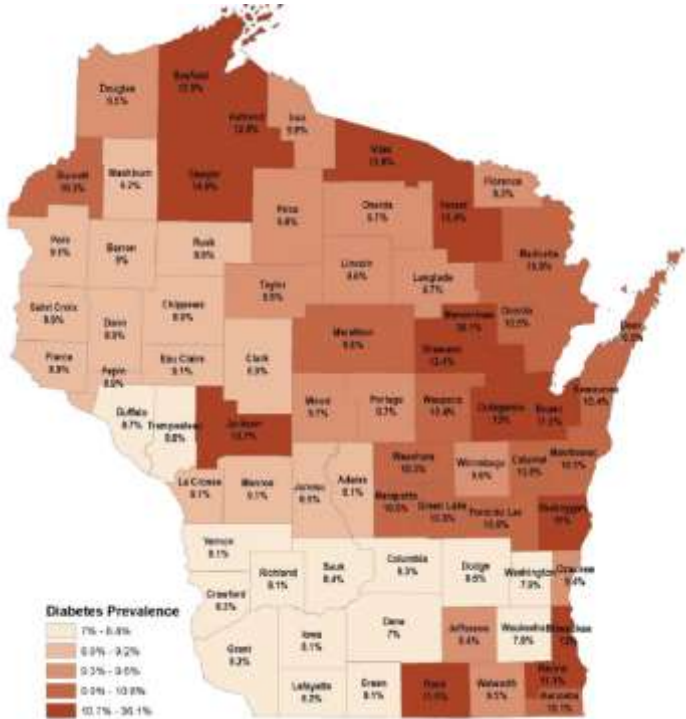


One in four adults has pre-diabetes, putting them at an increased risk of developing type 2 diabetes, heart disease, and stroke.

The cost of diabetes in Wisconsin is *\$6.10 billion* annually, totaling a staggering *\$290 million* in Brown County alone.

Source: Wisconsin Diabetes Prevention

Wisconsin, September 2011.



4. Oral Health

Jody Wilmet, Vice President of Oncology, Diagnostics and Hospital Physicians is the Bellin administrative sponsor for this team. The data sheet for Oral Health presented at the Community Health Improvement summit is below:

Good oral health improves the ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions

Good oral health can prevent:

- ▶ mouth pain
- ▶ tooth decay
- ▶ tooth loss
- ▶ oral and throat cancer
- ▶ birth defect
- ▶ other diseases of the mouth

Good oral health care can prevent other diseases through early detection of diseases that start with oral symptoms but that can affect health in other parts of the body.

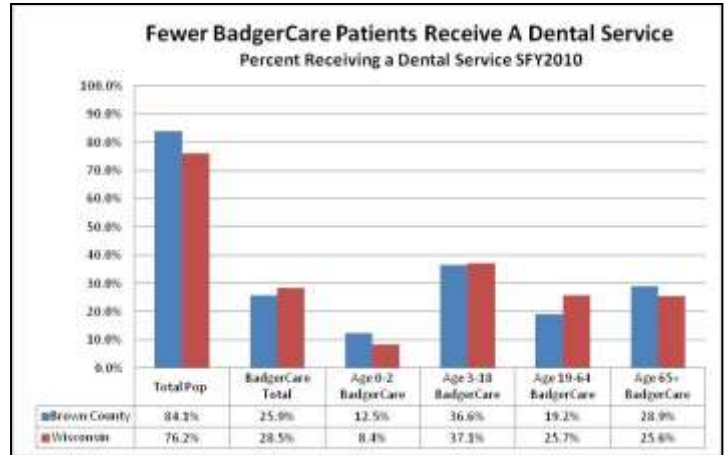
People more likely to have poor oral health:

- ▶ People with disabilities
- ▶ People with other health conditions
- ▶ People with lower levels of education and income

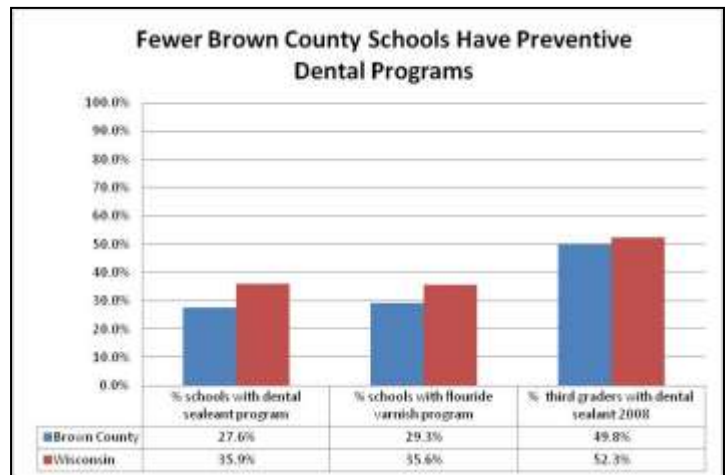
Lack of access to preventive dental care:

- ▶ Increases rates of oral diseases
- ▶ Is related to education level, income, race and ethnicity
- ▶ Is higher in Wisconsin for people on BadgerCare or lacking dental insurance coverage

Over the past 50 years there has been a significant improvement in oral health in the US. This is mostly due to effective



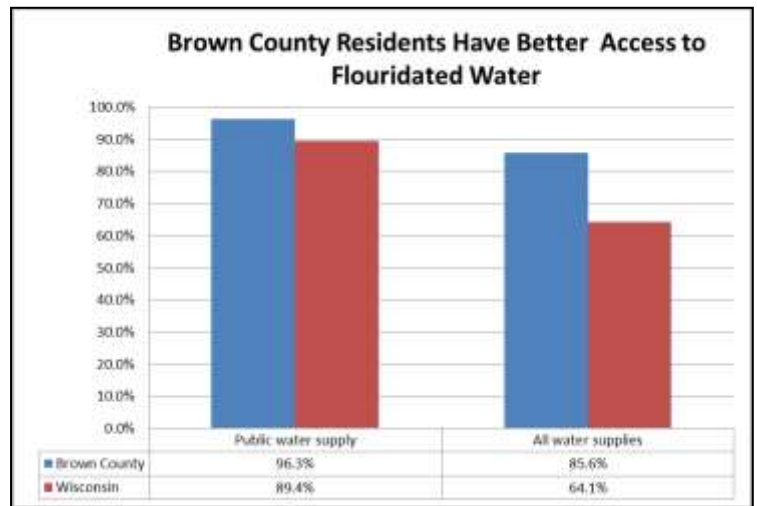
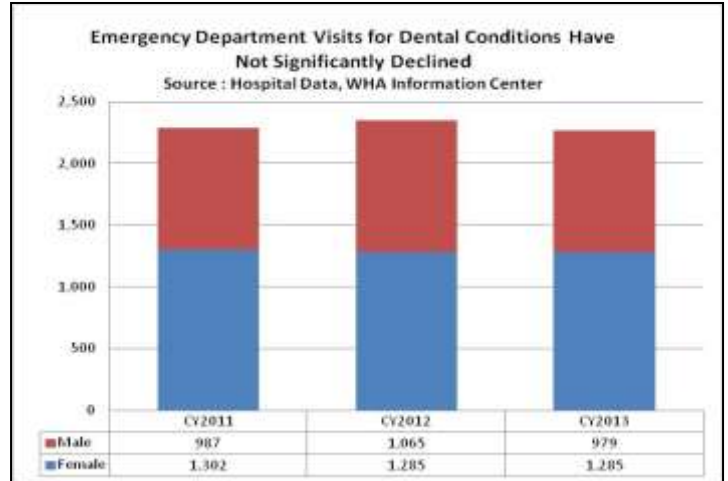
Behavioral Risk Factor Survey: 10% of respondents reported an untreated dental condition



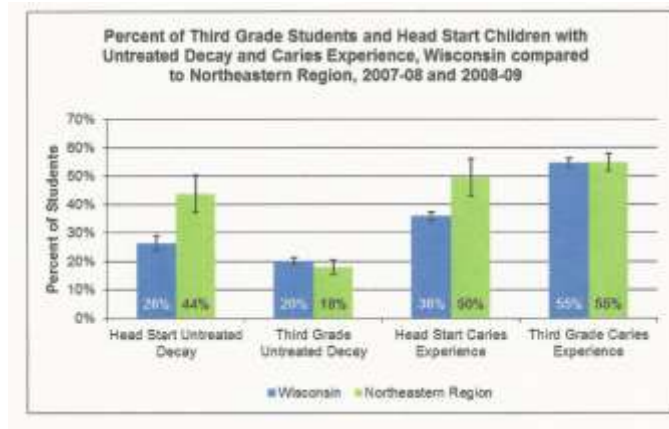
prevention and treatment efforts, especially community water fluoridation.

Sources: Healthiest Wisconsin 2020; Healthy People 2020

Data source: Wisconsin County Oral Health Surveillance system unless otherwise noted



Green Bay is a Dental Health Professional Shortage Area



VII. Description of Resources Available to Meet Priority Health Needs

Hospitals and Related Medical Groups

Brown County, Wisconsin has three fully integrated health care systems serving Brown County and many regional communities. These include Hospital Sisters Health System (St. Vincent and St. Mary's Hospitals) with its physician partner Prevea Health; Bellin Health and Bellin Medical Group, and Aurora Health, Aurora Medical Group, and BayCare Clinic.

Community Organizations and Government Agencies

Brown County is blessed to have many social agencies and civic groups who work to address community needs. These include but are not limited to Catholic Charities, United Way and the United Way agencies, veterans groups, two universities and a technical college with a commitment to community service, a private psychiatric hospital, many counseling agencies, food pantries, LIVE54218 (a group addressing physical activity and nutrition), Aging and Disability Resource Center, and many more. Many of these organizations and more actively participate in the community wide action planning teams formed to address the identified community needs. For example, the oral health community action planning team includes representatives from all three health systems and both public health departments, the University of Wisconsin Green Bay and Northeast Wisconsin Technical College, the Aging and Disability Resource Center, NEW Community Clinic, the Oral Health Partnership. The health systems have taken the lead in convening and staffing these community action planning teams, a role formerly played by Brown County Public Health.

VIII. Documenting and Communicating Results

This CHNA Report and Implementation Plan is available to the community on the hospital's public website: www.bellin.org. To obtain a hard copy, please contact Bellin Health at (920) 433-3500.

The hospital will also provide in its annual IRS Schedule H (Form 990) the URL of the web page on which it has made the CHNA Report and Implementation Plan widely available to the public as well as a description of the actions taken during the taxable year to address the significant health needs identified through its most recent CHNA as well as the health indicators that it did not address and why.

IX. Implementation Plan

Bellin Health will partner with the community wide action planning teams to develop, implement, monitor and evaluate both new and ongoing initiatives that address the identified priority community health needs. The implementation strategies and interventions will include, but are not limited to, the following initiatives categories.

1. Oral Health -Bellin Health is involved in the implementation and/or continuation of the following efforts to improve access to care.
 - a. Lead the activities of the community Oral Health Task Force, which has its own three year plan with goals and outcome measures (work plan will be attached to this report upon completion).
 - b. Support Public Health's efforts to retain fluoridation in public health water supplies via testimony when requested
2. Mental Health, AODA, Physical Activity and Nutrition –Bellin Health is engaged in the development, implementation and/or continuation of the following efforts to improve services.
 - a. Support the activities of the community action planning teams, which have their own three year plan with goals and outcome measures (work plans will be attached to this report upon completion).
 - b. Work with Public Health and our community partners to identify and implement at least one new evidence-based community program that addresses one of the identified health priorities.
3. Identify and implement programs to provide appropriate care to poor and needy.
 - a. Develop strategies to reduce ED visits for dental conditions
 - b. Develop strategies to reduce ED visits by Medicaid patients and provide them with care in settings appropriate to their needs.
 - c. Provide assistance to community members to enroll in insurance products through the market place or to enroll in BadgerCare, as appropriate for their situation

Next Steps

Bellin Health will leverage existing partnerships and community resources to coordinate strategic efforts to address identified community health needs that can be monitored, evaluated and improved upon over time with lessons learned from the field and evidence-based best practices. In the next months, we will review what current efforts by Bellin Health and community partners are having, or have the highest potential, to have the most impact on improving related health indicators. We will review how our Community Benefit programs and activities are being monitored, success indicators being tracked and what accountability measures are in place. This analysis will be done in a collaborative manner with respective partners with the intent to identify new and current resources that can be better integrated and deployed to maximize positive impact on population health and will be done in collaboration with the Brown County CHIP Steering Committee.

The significant awareness generated by completing the CHNA Report and Implementation Plan provides us with leads of key individuals and organizations who we can engage to refine and implement key activities related to each of the identified community health needs.

Support documentation on file and available upon request.