Beyond Health

Healthiest Brown County
"Connecting Beyond Health Care"

Community Health Improvement Plan 2015-2017

A message from the CHIP Steering Committee

This plan is the result of the work of many community members and partner agencies helping to move our community *Beyond Health to Healthiest Brown County.* This Community Health Improvement Plan is the result of that work and represents a long-term plan for improving the health of the county in four priority areas. The success of this plan depends on the Brown County community as a whole to move to a culture that embraces personal and community health. This plan is a call to action.

We would like thank all the members who give their time to the CHIP Steering Committee, the participants who were engaged at the community health needs assessment data summit, and those that dedicate their time and talents on the four focus area sub-committees. Members on these selected priority focus areas have met over the course of months to establish the goals, objectives, and strategies described within this plan. We would also like to extend appreciation to the Bellin Health System and Hospital Sisters Health System- St. Vincent/St. Mary's Hospitals for their leadership on the four priority focus area sub-committees. We thank the Wisconsin Division of Public Health, Aurora BayCare Medical Center and the Brown County United Way for their support on the Steering Committee.

This document will serve as the framework for many community health initiatives between now and 2018. We invite all Brown County residents to play a part in this plan to improve the health of the community as we strive for the *Healthiest Brown County.*

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CHIP Steering Committee Members:

Laura Hieb, Bellin Health
John Rocheleau, Bellin Health
Sharla Baenen, Bellin Health
Jody Wilmet, Bellin Health
Heidi Selberg, Hospital Sisters Health System
Jennifer Schnell, Aurora BayCare Medical Center
Elizabeth Scheelk, Wisconsin Division of Public Health
Howard Endow, Brown County United Way
Chua Xiong, Brown County Health Department
Chrystal Woller, City of De Pere Health Department

Summary of the Community Health Needs Assessment: November 2014

"Beyond Health" represents collaboration between Brown County Health Department, City of De Pere Health Department, Aurora BayCare Medical Center, Bellin Health System, 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. In November 2014, the **CHIP Steering Committee** brought together community stakeholders to review and discuss community health data collected based on the health focus areas cited in Healthiest Wisconsin 2020. The community stakeholders provided their knowledge and expertise in these areas and assessed the community's needs and opportunities for growth. After these stakeholders were presented with the community health assessment data, they were given the opportunity to select priority needs for Brown County.

Four health priorities for Brown County were selected from the Healthiest Wisconsin 2020 health focus areas at the Community Health Needs Assessment Summit. They are:

- Alcohol misuse
- Oral health
- Mental health
- Adequate, appropriate, and safe nutrition

Finally, **"Beyond Health"** is also a partnership among individuals, families, and organizations dedicated to improving the health of Brown County. Four planning groups of diverse community members meet regularly to develop and implement a **Community Health Improvement Plan** outlined with goals and objectives for each of the four priority health needs. The Steering Committee has been and will continue to meet regularly to evaluate the progress of the implementation teams.

Community Health Needs Assessment Participants

Achieve Brown County: Adam Hardy
Aging and Disability Resource Center: Meredith Hansen, Janelle Watson
Aurora Baycare Medical Center: Amy Jerdee
Bay Area Community Council: Bob Woessner
BC Planning and Land Svcs Department: Dan Teaters
Bellin College: Kathie De Muth
Bellin Health: John Rocheleau, Christopher Elfner, Jody Wilmet, Laura Hieb, Laura Cormier, Sharla Baenen
Brown County Executive Office: Troy Streckenbach
Brown County Community Treatment Center: Tina Cazzola
Brown County Health Department: Chua Xiong, Deborah Armbruster, Judy Friederichs, Patti Smeester, Rob Gollman, Stacy Ross
Brown County Human Services: Mary Miceli-Wink
Brown County Oral Health Partnership: Carrie Stempski
Brown County United Way: Ashley VandenBoomen, Greg Maass, Howard Endow, Jill Sobieck, Sarah Inman
Catholic Charities: Celia LaTour
Center for Childhood Safety: Kimberly Hess
City of De Pere Board of Health: Mike Donovan, Patricia Finder-Stone
De Pere Health Department: Chrystal Woller, Erin Bongers
ElizK Insurance: Elizabeth Kostichka
Greater Green Bay Chamber: Grant Dvorak
Greater Green Bay YMCA: Sandy Atkins
Hospital Sisters Health Ssytem: Heidi Selberg, Patti Glaser-Martin, Elaine Doxtator
Libertas: Barbara Coniff
Live54218: Jen Van Den Elzen, John Dye, Melinda Morella
N.E.W. Community Clinic: Bonnie Kuhr, Catherine Therrien, Seth Moore, Jamie Campbell
N.E.W. Curative Rehabilitation: Steve McCarthy
Northeast Wisconsin Technical College: Scott Anderson
Prevea Health: Angela Raleigh
Schneider National: Christine Schneider
St. Norbert College
St. Nicholas Hospital: Mary Paluchniak
St. Vincent Hospital: Kaitlin Swanson, Caroline Glander, Donna Boehm
State of Wisconsin- Division of Public Health: Elizabeth Scheelk
Unified School District of De Pere: Margie Hempel
UW-Green Bay: Leanne Zhu, Christine Vandenhouten, Thomas Erdman, Sarah Himmelheber
Brown County UW-Extension: Karen Early
West De Pere School District: Dawn Schaefer

The Purpose of a Community Health Improvement Plan

Wisconsin State Statute HS 140.04 requires local health departments to complete a community health assessment and use the gathered data to create and participate in a community health improvement plan every five years. The Affordable Care Act also requires non-profit health care systems to complete needs assessments every three years. All health systems can work collaboratively to meet the requirements of state and federal statutes. The Community Health Improvement Plan organizes the community health assessment data into a strategic plan to address the priority needs of the community by creating long-term goals and measurable outcomes (DHS, 2015). The local health department must also provide an annual report describing the progress and performance toward achieving the objectives that the local health department has identified as part of its community health assessment process [DHS 140.04(3)(c)].

The De Pere and Brown County Health Departments have created partnerships with individuals and organizations throughout the county. All of these stakeholders play a part in identifying Brown County's health needs. They prioritize the health conditions impacting local residents and any modifiable risk factors contributing to those conditions, identify community resources to address those risk factors, and develop and implement objectives to address the top health priorities.

The health focus areas of the Brown County CHIP are chosen from the 12 Healthiest Wisconsin 2020 health objectives. These four focus areas have been chosen based on data collected in the community health needs assessment. A committee for each focus area has chosen the priority goal for that area and established specific objectives with measurable outcomes that will be used to meet that goal over the next three years.

Healthiest Wisconsin 2020 Overview

What is Healthiest Wisconsin 2020?

Wisconsin State Statutes require the Department of Health Services to create a public health agenda for the entire state every ten years. This requirement is fulfilled by Healthiest Wisconsin 2020 and represents a form of statewide community health improvement planning. The motto of Healthiest Wisconsin 2020 is "Everyone living better, longer," a reflection of the broad goals of improving health at all stages of life and eliminating health disparities between populations. All objectives of HW2020 are tied in some way to these two goals.

Healthiest Wisconsin 2020 provides a guiding framework for communities to complete their own local health assessments and health improvement plans. It also serves as a call to action for everyone to act as partners dedicated to improving and protecting health throughout the state. It is outcomes driven and its proposed interventions are tested and based on best evidence.

Brown County has identified four Healthiest Wisconsin 2020 health focus areas as priority health improvement needs for the community. They are: alcohol misuse, mental health, oral health, and nutrition.

Healthiest Wisconsin 2020 Health Focus Areas:

- Alcohol and drug use
- Chronic disease prevention and management
- Communicable diseases
- Environmental and occupational health
- Healthy growth and development
- Injury and violence prevention
- Mental health
- Nutrition and healthy foods
- Oral health
- Physical activity
- Reproductive and sexual health
- Tobacco use and exposure

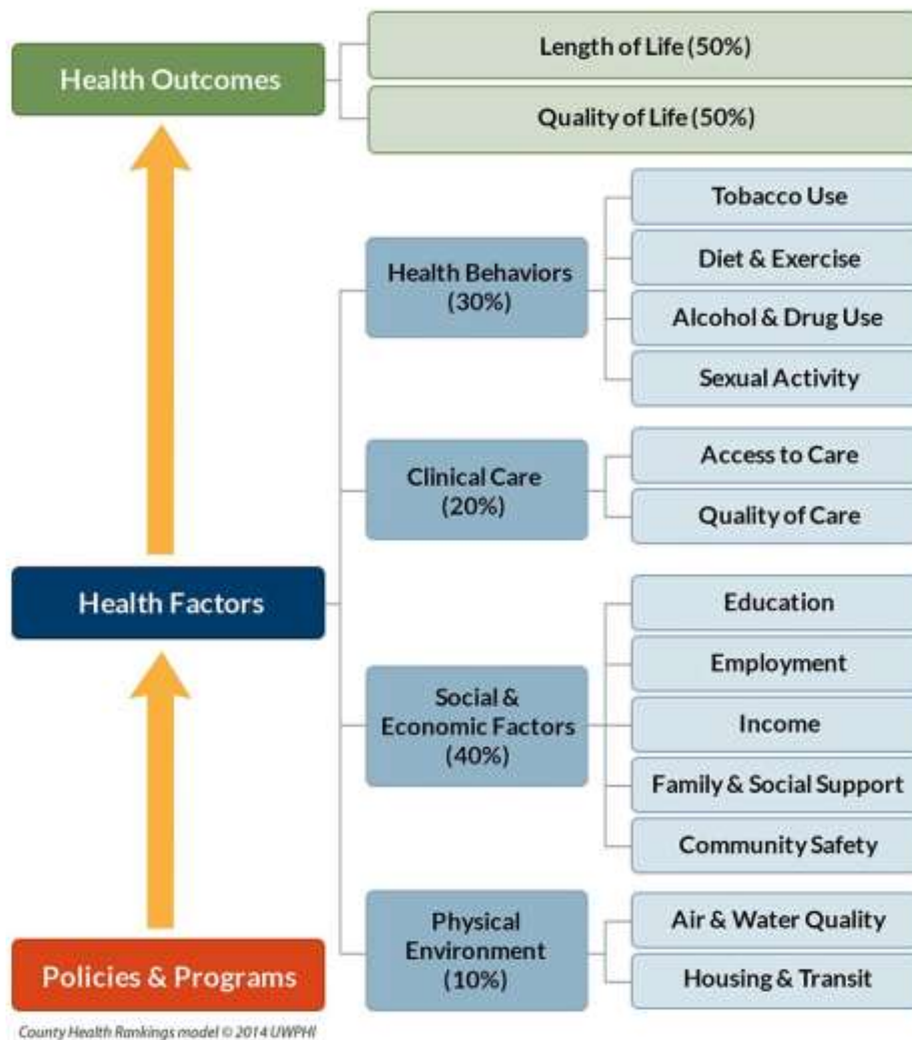
HW2020 Expected Health Outcomes:

- Reduced adverse health outcomes related to risky behaviors
- Reduced preventable illness and disability
- Reduced preventable death
- Policies and systems aligned for improved health
- Health disparities eliminated
- Health equity achieved
- Strengthened public health system

The Health of Brown County: County Health Rankings

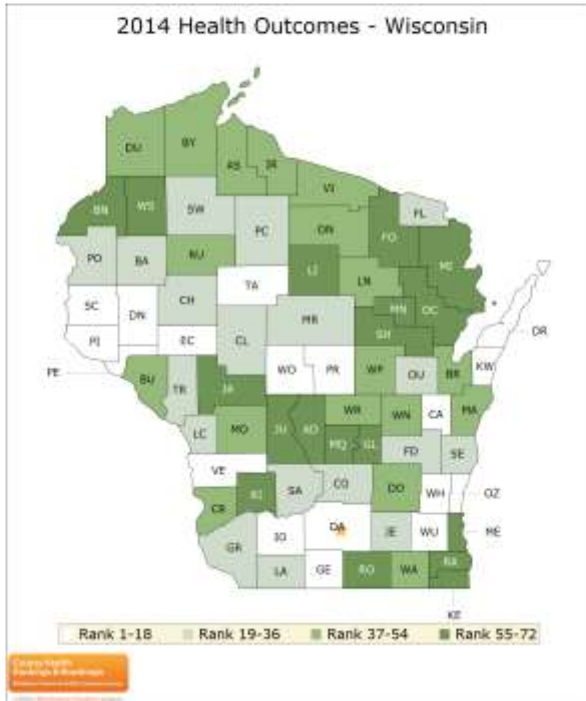
In 2010, the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute established the *County Health Rankings & Roadmaps* program, a collaborative effort to rank the health of counties in all 50 based on health outcomes (the county's present health) and health factors (the county's health in the future). The *County Health Rankings* are created based on a population health model that examines all the factors that contribute to the health of a community. This model demonstrates that many of these factors are found outside the doctor's office.

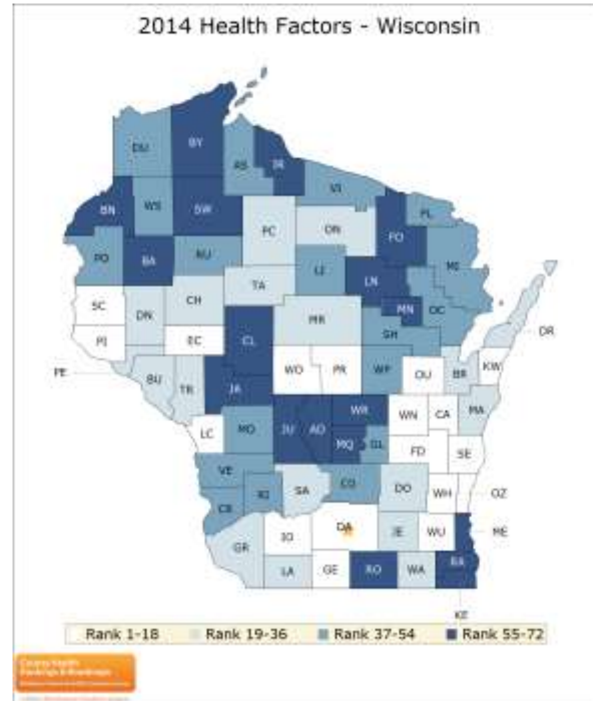
County Rankings Health Model:



In 2014, Brown County ranked #37 out of 72 in health outcomes. Brown County ranked #26 of out 72 in health factors.

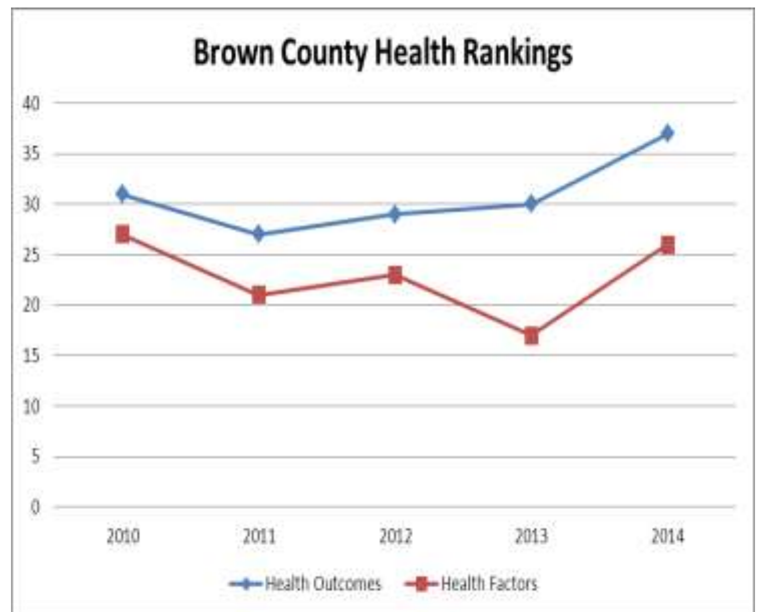
The 2014 health rankings show that Brown County needs improvement in the areas of adult obesity, alcohol-impaired driving deaths, self-reported physical health, and access to health care, especially primary care providers.





Brown County Health Rankings (Out of 72 counties in Wisconsin):

Year	2010	2011	2012	2013	2014
Health Outcomes	**31**	**27**	**29**	**30**	**37**
Mortality (Length of life)	17	15	14	12	12
Morbidity (Quality of life)	48	56	55	54	58
Health Factors	**27**	**21**	**23**	**17**	**26**
Health Behaviors	33	34	38	31	41
Clinical Care	13	19	22	13	18
Socio-economic factors	34	18	22	21	24
Physical Environment	64	60	66	21	21



*Lower numbers are more desirable for both health outcomes and health facto

2014 COUNTY HEALTH RANKINGS	Brown County	Error Margin	Top U.S. Performers*	Wisconsin	Rank (of 72)
Health Outcomes					**37**
Length of Life					12
Premature death	4,922	4,618-5,226	5,317	5,878	
Quality of Life					58
Poor or fair health	14%	12-17%	10%	12%	
Poor physical health days	3.9	3.1-4.7	2.5	3.2	
Poor mental health days	3.2	2.4-3.9	2.4	3.0	
Low birth weight	6.5%	6.2-6.9%	6.0%	7.0%	
Health Factors					**26**
Health Behaviors					41
Adult smoking	19%	15-23%	14%	18%	
Adult obesity	29%	25-34%	25%	29%	
Food environment index	8.3		8.7	8.3	
Physical inactivity	21%	17-24%	21%	22%	
Access to exercise opportunities	78%		85%	78%	
Excessive drinking	25%	21-30%	10%	24%	
Alcohol-impaired driving deaths	56%		14%	39%	
Sexually transmitted infections	456		123	431	
Teen births	31	30-33	20	29	
Clinical Care					18
Uninsured	11%	10-12%	11%	10%	
Primary care physicians	1,470:1		1,051:1	1,233:1	
Dentists	1,572:1		1,392:1	1,660:1	
Mental health providers	996:1		521:1	1,024:1	
Preventable hospital stays	40	37-43	46	55	
Diabetic screening	88%	83-92%	90%	90%	
Mammography screening	71%	66-76%	71%	70%	

2014 COUNTY HEALTH RANKINGS	Brown County	Error Margin	Top U.S. Performers*	Wisconsin	Rank (of 72)
Social & Economic Factors					24
High school graduation	86%			87%	
Some college	66%	64-68%	70%	65%	
Unemployment	6.3%		4.4%	6.9%	
Children in poverty	16%	13-18%	13%	18%	
Inadequate social support	14%	12-17%	14%	17%	
Children in single-parent households	30%	27-32%	20%	30%	
Violent crime	202		64	248	
Injury deaths	50	46-54	49	62	
Physical Environment					21
Air pollution - particulate matter	11.3		9.5	11.5	
Drinking water violations	0%		0%	6%	
Severe housing problems	14%	13-15%	9%	15%	
Driving alone to work	83%	82-83%	71%	80%	
Long commute - driving alone	15%	14-15%	15%	26%	

Health Outcomes	*Brown*	*WI*
Diabetes	9%	9%
HIV prevalence rate	78	107
Premature age-adjusted mortality	260	302
Infant mortality	6	7
Child mortality	46	54
* Cancer incidence	487	471
* Communicable disease	787	890
* Intentional injury hospitalizations	80	95
* Injury hospitalizations	744	832
* Fall fatalities 65+	86	111
* Alcohol-related hospitalizations	3	2

Health Behaviors	*Brown*	*WI*
Food insecurity	11%	13%
Limited access to healthy foods	6%	5%
Motor vehicle crash deaths	10	12
Drug poisoning deaths	8	10
* Smoking during pregnancy	12%	14%
* Motor vehicle crash occupancy rate	32	39
* On-road motor vehicle crash-related ER visits	597	585
Health Behaviors		
* Off-road motor vehicle crash-related ER visits	66	70
* Drug arrests	1,001	25,490
* Breastfeeding	20%	21%
Health Care		
Uninsured adults	14%	13%
Uninsured children	5%	4%
Health care costs (Medicare spending per enrollee)	$8,560	$8,329
Could not see doctor due to cost	8%	10%
Other primary care providers	1,234:1	1,417:1
* No recent dental visit	24%	24%
* Did not get needed health care	3%	2%
* Influenza immunizations 65+	24%	
* Childhood immunizations	74%	69%
* Dental utilization	20%	23%
* Local health department staffing	2	3
* Cervical cancer screening	82%	
* Colon cancer screening	70%	
* Cholesterol screening	83%	
* Coronary heart disease hospitalizations	3	3
* Cerebrovascular disease hospitalizations	2	2

**http://www.countyhealthrankings.org/app/wisconsin/2014/rankings/brown/county/brown/overall/snapshot*

Health Focus Areas: Alcohol Misuse

PRIORITY AREA: Alcohol Misuse
GOAL: Brown County will create a community-wide partnership among individuals, families, and organizations dedicated to impacting and reducing alcohol-related injury and disease and changing the culture around alcohol use in the De Pere and Brown County Communities.

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Short Term Indicators	**Source**	**Frequency**
By December 31, 2015, the rate of binge drinking in Brown County will decrease from 25% to 24%.	CHR	Annual
By December 31, 2015, the number of annual alcohol-related traffic fatalities in Brown County will decrease from 3 to 2.	CHR	Annual
Long Term Indicators	**Source**	**Frequency**
By December 31, 2017, the incidence of binge drinking in Brown County in accordance with county health ranking will decrease from 25% to 20%.	CHR	Annual
By December 31, 2017, there will be zero alcohol-related traffic fatalities in Brown County.	CHR	Annual
By December 31, 2017, 75% of pediatric and primary care providers in Brown County will screen youth and adults for alcohol and drug abuse.	Healthcare systems	

OBJECTIVE #1: By December 31, 2017, local health systems will standardize the screening for alcohol, depression, and substance abuse from youth to adulthood as evidenced by the adoption of a universal minimum standard set of questions.					
BACKGROUND ON STRATEGY **Source:** SBIRT- Screening, Brief Intervention, and Referral to Treatment http://www.integration.samhsa.gov/clinical-practice/sbirt **Evidence Base:** "Alcohol misuse: Screening and behavioral counseling interventions in primary care," recommendations from U.S. Preventive Services Task Force, Behavioral screening and intervention (BSI) at partner clinics lead to 20% decline in binge drinking (http://www.wiphl.org/index.jsp) **Policy Change (Y/N):** Yes					
ACTION PLAN					
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Review evidence-based practice research on pediatric AODA screening tool	10/31/15	Staff time Health system participation	*BCATF Goal Team #1*	Bring tool use recommendations forward to pilot	
Pilot youth screening with selected pediatric AODA tool	12/31/15	Health system participation Staff time Screening tool	*BCATF Goal Team #1*	Youth added to universal AODA screening process	
Engage youth and family practices to use piloted screening tool for adolescent AODA screening	12/31/15	Staff time Health system participation	*BCATF Goal Team #1*	Minimum standard set for youth AODA screening	
Create minimum standard set or select universal screening	12/31/15	Research time Staff time	*BCATF Goal Team #1*	Minimum standard set for	

tool for adult AODA screening				universal adult AODA screening	
Aggregate further youth data for Brown County focusing on school surveys and age of onset	3/30/16	Staff time School participation Access to data	BCATF Goal Team #1	Increased knowledge Completed assessment of youth risk	

OBJECTIVE #2: By December 31, 2017, a community-wide access platform will be created for all screened AODA patients with an established goal that improves access as measured by days from diagnosis to treatment.

BACKGROUND ON STRATEGY
Source: Strengthening Treatment Access and Retention Quality Improvement (STAR-QI) http://www.fammed.wisc.edu/research/external-funded/star-si, NIAT-x Process Improvement www.niatx.net
Evidence Base: AHRQ Clinical Guidelines for screening, diagnosis, and referral for substance abuse disorders recommend initiating treatment within 14 days of diagnosis (http://www.guideline.gov/content). NIAT-x helped 12 state-provider partnerships implement EBP to increase access to substance abuse treatment, per Robert Wood Johnson Foundation (http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2013/rwjf405144)
Policy Change (Y/N): Yes

ACTION PLAN

Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Assess levels of care using Brown County AODA manual and identify gaps	10/31/15	Staff time	BCATF Goal Team #2	Written needs assessment Increased knowledge	
Define current state of access and barriers to treatment	12/31/15	Research time Staff time Access to data	BCATF Goal Team #2	Increased knowledge Baseline assessment report	
Establish current baseline for “days to treatment” from diagnosis	3/30/16	Staff time Community participation	BCATF Goal Team #2	Universal baseline for ‘days to treatment’	
Collaborate with mental health task force to begin planning “no wrong door” platform for co-occurring disorders	12/31/16	Staff time Coordination with mental health task force	BCATF Goal Team #2	Increased access to care Written plan of action for implementation	

OBJECTIVE #3: By December 31, 2015, the task force will begin to advocate for best practice policy regarding alcohol misuse in order to create a multi-faceted community approach to reducing binge drinking and driving while impaired.					
BACKGROUND ON STRATEGY **Source:** Community Trials Intervention to Reduce High Risk Drinking, http://www.pire.org/communitytrials/index.htm, **Evidence Base:** Leads to reduction in heavy/binge drinking, alcohol-related assaults, drunk driving (National Registry of Evidence-based Programs and Practices) **Policy Change (Y/N):** Yes					
ACTION PLAN					
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Create a defined collaborative effort with Drug Alliance and Heroin Task Force to establish aligned vision	6/30/15	Staff time Coordination with Drug Alliance, Heroin Task Force	BCATF Goal Team #5	Common vision	
Review literature on best practice strategies to reduce binge drinking and driving while impaired	6/30/15	Staff/student time	BCATF Goal Team #3	Increased knowledge of best practices	
Define current post-arrest treatment requirements for OWI violations	10/31/15	Staff time	BCATF Goal Team #4	Increased knowledge	
Develop evidence based practice education to teach the community on achieving zero drinking and driving deaths	12/31/15	Staff time Community participation	BCATF Goal Team #4		
Assess ordinances and municipal judge penalties for alcohol-related violations for at least two jurisdictions	12/31/15	Staff/student time Some travel	BCATF Goal Team #3	Increased knowledge Written assessment of baseline	
Partner with legislators and the Tavern League to develop tactics for reducing drinking and driving	3/30/16	Staff time Local government involvement	BCATF Goal Team #4	Implementation of new strategy or policy that leads to reduced drunk driving	
Compare ordinances and penalties in assessed jurisdictions to neighboring jurisdictions	6/30/16	Staff time Some travel	BCATF Goal Team #3	Increased knowledge Written assessment	
Implement at least one evidence based strategy selected from feedback at community focus groups to reduce alcohol-related violations in at least one jurisdiction	12/31/16	Staff time Community participation Local government involvement	BCATF Goal Team #3	Implementation of new strategy or policy that leads to reduced binge drinking	
Advocate on implementing at least one evidence based strategy that decreases alcohol related traffic deaths at the county or state level	12/31/16	Staff time Community Participation	BCATF Goal Team #3	Implementation of new strategy that reduces alcohol impaired driving	

ALIGNMENT WITH STATE/NATIONAL PRIORITIES			
Obj #	**Healthiest Wisconsin 2020**	**Healthy People 2020**	**National Prevention Strategy**
1	Improve access to services for vulnerable people	Increase the number of primary care settings that implement evidence-based alcohol Screening and Brief Intervention (SBI) (SA-10)	Identify alcohol and other drug abuse disorders early and provide brief intervention, referral, and treatment
2	Improve access to services for vulnerable people	Increase the proportion of persons who need alcohol abuse or dependence treatment and receive specialty treatment for abuse or dependence in the past year (SA-8.3)	Reduce barriers to accessing clinical and community preventive services, especially among populations at greatest risk
3	Change underlying attitudes, knowledge, and policies	Decrease the rate of alcohol-impaired driving fatalities (SA-17)	Support state, tribal, local, and territorial implementation and enforcement of alcohol control policies

BCATF = Brown County Alcohol Task Force

Health Focus Areas: Mental Health

PRIORITY AREA: Mental Health
GOAL: Brown County will increase access to mental health services for all populations in the county by identifying gaps and disparities and creating a common platform that mental health providers, partner agencies, and stakeholders can access.

PERFORMANCE MEASURES How We Will Know We are Making a Difference		
Short Term Indicators	**Source**	**Frequency**
By December 31, 2015, the number of annual suicides in Brown County will decrease from 35 to 33.	DHS WISH	Annual
By December 31, 2015, the average number of poor mental health days per 30 days as reported by county residents will decrease from 3.2 to 3.0.	CHR	Annual
Long Term Indicators	**Source**	**Frequency**
By December 31, 2017, the number of annual suicides in Brown County will decrease from 35 to 30.	DHS WISH	Annual
By December 31, 2017, the average number of poor mental health days per 30 days as reported by county residents will decrease from 3.2 to 2.8.	CHR	Annual
By December 31, 2017, the rate of intentional injury hospitalizations will decrease from 80/100,000 to 70/100,000.	CHR	Annual

OBJECTIVE #1: By December 31, 2017, the task force will create a document accessible to all stakeholders that identifies the current state of mental health care in Brown County, including all available resources and services provided, gaps and disparities in care, needed programs, and ratio of specific mental health providers to population.
BACKGROUND ON STRATEGY **Source:** Behavioral Health Treatment Needs Assessment Toolkit for States (SAMHSA) **Evidence Base:** Increasing coordination of care by sharing information via electronic health information exchange and incorporating behavioral health into primary care is rated as scientifically supported by “What Works for Health: Policies and Programs to Improve Wisconsin’s Health” **Policy Change (Y/N):** No

ACTION PLAN					
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Investigate Greater Green Bay Community Foundation basic needs grant to fund ongoing Behavioral Health Council to coordinate resources	6/30/15	Staff time Grant funding Person to fill newly created coordinator position		Behavioral Health Council led by independent coordinator compiling resources	
Hold Community Mental Health mini-Summit to gather stakeholders' assessment of current state	6/30/16	Space to hold summit Coordination with partners Staff time		Coordination with partner agencies to create consensus on current state of mental health access as perceived by providers/information gathering	Target date could be as early as 12/31/2015 depending on grant funding and personnel
Use current data to identify disparities in care related to payer source (i.e., private insurance, medical assistance, self-pay)	12/31/15	Staff time Access to data Access to Medicaid claims		Identification of inadequate access to care related to payment status	
Use existing data to identify disparities in care related to gender, race, socio-economic status, age, and/or diagnosis	12/31/15	Access to data Existence of data Student assistance Research time		Data-supported identification of disparities in access in vulnerable populations	
Breakdown mental health provider: population ratio by specific specialties (psychiatrist, PMH-NP, counselor)	12/31/15	Access to NPI registry data Staff/student time		Clear understanding of current access state as defined by entity	
Create an on-line listing of mental health services/community events provided in Brown County (downloadable to PDF for a hard copy).	6/30/17	Staff/student time Input from partner agencies Inter-agency collaboration		Document accessible to partner agencies listing all current mental health treatment resources in Brown County	

OBJECTIVE #2: By December 31, 2017, the mental health task force will create a draft proposal for creating a community-wide "No Wrong Door" access platform for mental health treatment and connection between mental health providers. (The goal is to create the right access at the right time by having a comprehensive view and collaborative connections between all Brown County mental health service providers.)

BACKGROUND ON STRATEGY
Source: N.E.W. Mental Health Connection, "No Wrong Door"
Evidence Base: NACCHO/ASTHO, "No Wrong Door: Assuring Services and Seamless Care"
Policy Change (Y/N): Yes

ACTION PLAN					
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Work with N.E.W. Mental Health Connection as model to establish similar platform in Brown County	12/31/16	Staff time Collaboration with N.E.W. Mental Health Connection		Independent coordination platform for establishing "No Wrong Door"	

Work with primary care providers to identify education needs and strengthen primary care as entry point to "Right Care, Right Person, Right Time" mental health treatment	12/31/16	Staff time Collaboration with primary care providers		Increased understanding of mental health referrals at primary care level Primary care strengthened as access point for mental health services	
Use mental health treatment resource manual to begin creating electronic infrastructure for inter-agency contact	12/31/17	Staff time Funding Research time N.E.W. Mental Health Connection assistance Access to adequate software		Creation of common platform for inter-agency referral and collaboration	
Investigate and implement "No Wrong Door" gatekeeper training for mental health agency frontline staff in order to successfully implement shared referral database	12/31/17	Staff time Training time Collaboration with mental health agencies Collaboration of N.E.W. Mental Health Connection		Mental health agency staff are successfully trained in "No Wrong Door" policy so that electronic shared referral database is used appropriately and client is directed to appropriate agency	

OBJECTIVE #3: By December 31, 2017, the mental health task force will complete an inventory of all mental health screening tools currently utilized across community settings and develop a common screening platform that is appropriate for each community setting (Schools, Crisis Center, Psychiatric Hospitals, Emergency Departments, primary care, mental health clinics, and other healthcare settings).

BACKGROUND ON STRATEGY

Source: *Behavioral Health Treatment Needs Assessment Toolkit for States (SAMHSA), Zero Suicide in Health and Behavioral Health Care (SAMSHA, SPRC, National Action Alliance for Suicide Prevention) Perfect Depression Care(Henry Ford Health System)*

Evidence Base: Although suicide is a statistically very rare event, even within psychiatric populations, improvement efforts *focused on the processes of care* in which patients and clinicians live and work can drive successful clinical quality improvement work.

Policy Change (Y/N): No

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Complete an inventory of current depression screening tools used across settings.	12/31/15	Staff time to complete assessment		Comprehensive list of depression tools utilized across Brown County	
Complete an inventory of current suicide risk screening tools used across settings (consider	12/31/15	Staff time to complete assessment		Comprehensive list of suicide risk tools utilized across	

collaboration with the Brown County Coalition for Suicide Prevention on this activity).				Brown County	
Identify best practice depression screening tools and develop recommendations of tools for various community settings.	12/31/16	Staff time to complete assessment and develop recommendation		Best practice tools identified with recommendation for future implementation	
Identify best practice suicide risk screening tools and develop recommendations of tools for various community settings.	12/31/16	Staff time to complete assessment and develop recommendation		Best practice tools identified with recommendation for future implementation	

ALIGNMENT WITH STATE/NATIONAL PRIORITIES

Obj #	Healthiest Wisconsin 2020	Healthy People 2020	National Prevention Strategy
1	Develop comprehensive data to track disparities	Increase the proportion of persons who have a specific source of ongoing care (AHS-5)	Standardize and collect data to better identify and address disparities
2	Assure access to high-quality health services for all	Increase the proportion of adults with mental health disorders who receive treatment (MHMD-9)	Reduce barriers to accessing clinical and community preventive service, especially among populations at greatest risk

Health Focus Area: Nutrition

PRIORITY AREA: **Nutrition**

GOAL: Support programs that make healthy foods more accessible and affordable for low income residents of Brown County.

PERFORMANCE MEASURES
How We Will Know We are Making a Difference

Short Term Indicators	Source	Frequency
By December 31, 2016, Brown County will increase the percent of healthy foods donated in food pantry food drives by 2% over 2014 performance.	Sample survey	Biennial
By December 31, 2016, a document summarizing food pantry models and best practices around the country will be accessible to committee members.	Sub-committee report	Annual
By June 1, 2015 a mechanism will be established and maintained to provide monthly opportunities to share updates and leverage resources.	Meeting minutes	Monthly
Long Term Indicators	**Source**	**Frequency**
By December 31, 2017, Brown County will increase the percent of healthy foods donated in food pantry food drives by 5% over 2014 performance.	Sample survey	Biennial
By October 31, 2017, a first draft county wide plan to align food pantry infrastructure to current and future needs will be created.	Sub-committee report	Annual
By December 31, 2017, at least two area food pantries will adopt best practices that prioritize healthy food selection in all food sourcing, including fresh and frozen.	Survey of food pantries	Annual

OBJECTIVE #1: **By December 31, 2017, Brown County will improve the food choices offered by food pantries by increasing the percentage of healthy food options and reducing the amount of low-nutrient foods, without reducing the total amount of food donated.**

BACKGROUND ON STRATEGY
Source: Beyond Bread: Healthy Food Sourcing in Emergency Food Programs, http://www.whyhunger.org/uploads/beyondbread, Healthy Shelves: Promoting and Enhancing Good Nutrition in Food Pantries, http://foodsecurity.missouri.edu/healthy-shelves, Canvas Network: Developing Food Bank Nutrition Policy to Procure Healthful Foods.
Evidence Base: Minneapolis Healthy Food Shelf Network, http://www.minneapolismn.gov/health/living/foodshelf, "A Qualitative Study of Nutrition-Based Initiatives at Selected Food Banks in the Feeding America Network," Rudd Center for Food Policy and Obesity at Yale University
Policy Change (Y/N): Yes

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Continue public messaging campaign for "Food Drive Five"	12/31/17	Staff time Continued financial support		Continuation of message	
Assess extant literature regarding healthy food policies at food banks and food pantries	12/31/15	Staff/student time		Written assessment of food pantry nutrition policies	
Continue communication with food sourcing partners regarding prioritization of healthy food selection	12/31/17	Staff/student time Food pantry participation		Increased links to healthy food sourcing for food pantries	
Reach out to at least two area food pantries to provide education on food pantry healthy food policies	6/30/16	Staff time Travel time? Food pantry participation		Increased knowledge	
Determine how and when healthy food donations at future food drives will be measured (continue to use same sample?)	12/31/15	Staff time Access to data from food pantries		Increased knowledge of food donation breakdowns	
Select and implement at least one healthy food sourcing strategy from (Beyond Bread, Healthy Shelves, other evidence) source material in two area food pantries	12/31/17	Staff time Research time Food pantry participation		Implementation of evidence based healthy food sourcing strategy	

OBJECTIVE #2:
By December 31, 2017, Brown County will initiate a planning process to align food pantry infrastructure in the community to meet current and projected growth needs.

BACKGROUND ON STRATEGY
Source: Community Food Security Assessment Toolkit, http://www.ers.usda.gov/publications/efan-electronic-publications-from-the-food-assistance-nutrition-research-program, How to Run a Food Pantry, http://www.endhungerinamerica.org/publications/how-to-run-a-food-pantry/
Evidence Base: Charity Food Programs that Can End Hunger in America, Second Harvest Gleaners Food Bank of West Michigan; Soup Kitchen and Food Pantry Best Practices Guide, New York City Coalition Against Hunger
Policy Change (Y/N): Yes

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Utilize census tracts to identify current needs in relation to existing food pantry locations	12/31/15	Staff time Student time		Increased knowledge Needs assessment	
Conduct a literature review of food pantry infrastructure and best practices around the country	6/30/17	Staff time Student time		Increased knowledge Inventory of best practices	
Create inventory of current food pantry infrastructure and resources in Brown County	6/30/17	Staff time Student time Food pantry participation		Written inventory of baseline infrastructure and status	
Create and disseminate survey of current needs and opportunities to area food pantries	6/30/17	Food pantry participation Staff time		Opportunity for food pantries to have a voice Written assessment of needs and opportunities	
Investigate collaboration and pooling of resources among local pantries	12/31/17	Food pantry participation Staff time		More efficient allocation of resources	

OBJECTIVE #3:
By June 1, 2015 Brown County will identify and monitor community needs as they relate to non-emergency food security.

BACKGROUND ON STRATEGY
Good nutrition is essential for health beginning in the prenatal period and extending throughout life. Both the quantity and quality of consumption can impact health. Insufficient nutrition can harm growth and development while excessive consumption can lead to overweight, obesity, and numerous health complications.
Source/Evidence Base: What Works For Health, http://whatworksforhealth.wisc.edu/factor.php
Policy Change (Y/N): Yes

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Maintain a standing agenda item for discussion/information regarding non-emergency food	Ongoing 12/31/17	Coalition Members		A cumulative assessment of non-emergency	

security.				food security priorities in Brown County.	
Scan the literature and current trends in non-emergency food security to stay current on best practices.	Ongoing 12/31/17	Coalition Members		A cumulative assessment of non-emergency food security priorities in Brown County.	
Monitor non-emergency food infrastructure development, stabilization and best practice evolution.	Ongoing 12/31/17	Coalition Members		A prioritized list of non-emergency food security issues in Brown County.	

ALIGNMENT WITH STATE/NATIONAL PRIORITIES			
Obj #	**Healthiest Wisconsin 2020**	**Healthy People 2020**	**National Prevention Strategy**
1	Make healthy foods available for all, Increase access to healthy foods and support breastfeeding	Reduce consumption of calories from solid fats and added sugars in the population aged 2 years and older (NWS-17)	Increase access to healthy and affordable foods in communities
2	Identify resources to support partnerships, Build effective partnerships resulting from respect and empowerment	Reduce household food insecurity and in doing so reduce hunger (NWS-13)	Engage and empower people and communities to plan and implement prevention policies and programs, support research to identify effective strategies to eliminate disparities

Health Focus Areas: Oral Health

PRIORITY AREA: Oral Health
GOAL: To promote and improve oral health and assure access to effective and adequate oral health services for the benefit of all Brown County Citizens.

PERFORMANCE MEASURES How We Will Know We are Making a Difference		
Long Term (Public Health) Indicators	**Source**	**Frequency**
1. Reduce the number of emergency department visits for oral health concerns	WHA Hospital data	quarterly
2. Reduce percent of adults with self-reported oral health problems	BRFS	As available
3. Increase number of third graders with dental sealants	WI COWS	As available
4. Increase percent of Badger Care enrollees who receive dental services during the year	WI COWS	As available
5. Reduce number of third graders with untreated dental decay	WI COWS	As available
Short Term (Locally collected) Indicators	**Source**	**Frequency**
1. Decrease the percentage of adults and children seeking care for dental concerns at Brown County Emergency departments. (Same as above)	WHA Hospital Data	Quarterly

2. Monitor number of referrals to NEW Clinic dental program by each ED (explore use of Epic for this purpose)(intermediate measure for #1 above)	Hospital data	Monthly
3. Increase the number of patients seeking care at the NEWCC dental clinic who have completed treatment. (both uninsured and BadgerCare, proximate measure for #2 above)	NEWCC Dental Clinic	Annually
4. Increase the number of BadgerCare recipients who received dental services (proximate measure for #4 above)	NEWCC Dental Clinic OHP	Annually
5. Increase the number of individuals receiving treatment for dental pain (proximate measure for #1 above)	NEWCC Dental Clinic; OHP	Quarterly
6. Increase number of 3rd grade students children who have been given dental sealants (proximate measure for #3 above)	OHP	
7. Head start sealants		
8. Increase number of primary care clinics screening patients for oral health needs via Basic Screening(measure is # of practices using BSS)	Bellin Health, Prevea, & Aurora Health Systems	Quarterly

OBJECTIVE #1: Reduce the number of emergency department visits for oral health concerns that could be addressed in a dental office				
ACTION PLAN				
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Progress Notes**
a. Develop and implement a community-wide protocol (antibiotics and pain management)for use in the emergency department for patients with dental pain --share with BDK for possible additional implementation	Year 1-2			
b. Develop and implement orientation program re NEW Dental program for ED staff	Year 1-2			
c. Provide education to existing Medicaid patients on the proper use of the emergency department for dental conditions	Year 1-2			
d. Evaluate the use of the oral health resource sheet and oral hygiene kits offered to the EDs	Year 1-2			
e. Explore feasibility of increasing capacity at NEW Dental Clinic, current site or east side location	Year 1-2			
f. Explore feasibility of providing dental hygiene services to uninsured patients via the NWTC Dental Hygiene program	Year 1-2			
g. Study the use of urgent care for dental conditions; determine what share of ED visits are occurring outside of “office hours”	Year 1-2			

OBJECTIVE #2: Develop strategies for groups where evidence has shown improved health outcomes with proper oral health care				
BACKGROUND ON STRATEGY **Evidence Base: yes** **Policy Change (Y/N): no**				
ACTION PLAN				
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Progress Notes**
a. Review and Refresh strategies for women aged 18-44	Year 1-2			
b. Develop strategies for diabetic patients	Year 1-2			
c. Develop strategies for patients with cardiovascular disease	Year 1-2			

OBJECTIVE #3: Formalize collaboration among groups addressing oral health				
ACTION PLAN				
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Progress Notes**
a. Explore opportunities for collaboration with MCW, e.g., incorporation of oral health in curriculum, research projects on diabetes and cardiovascular disease relationship to dental health	Year 1-2			
b. Identify at least one opportunity for collaboration among OHP , NEW Clinic and Oral Health Community Action Team	Year 1-2			
c. Explore opportunities to collaborate with BDK (Brown/Door/Kewaunee Dental Society)	Year 1-2			

OBJECTIVE #4: Incorporate BSS screening questions within primary care practices				
BACKGROUND ON STRATEGY **Source: ACOG position paper** **Evidence Base: ACOG position paper** **Policy Change (Y/N): y**				
ACTION PLAN				
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Progress Notes**
a. Determine extent to which BSS screening is used in primary care and OB Care practices in Brown County	Year 1-2			
b. Advocate for broader use of BSS	Year 1-2			
c. Evaluate the usefulness of resource materials provided to practices	Year 1-2			

OBJECTIVE #5: Influence public policy to support oral health initiatives				
ACTION PLAN				
Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Progress Notes**
a. Advocate to have Medicaid cover 2 cleanings per year	Year 2-3			
b. Advocate to have Medicaid cover dental clinic dispensing fluoride	Year 2-3			
c. Advocate for SNAP benefits to allow purchase of oral hygiene supplies	Year 2-3			
d. Advocate for dental care to be an essential health benefit for adults as well as children	Year 2-3			
e. Advocate for oral health questions to be included in the nurse licensing exam (pursue year 1-2)	Year 2-3			
f. Advocate for oral health questions to be included in the licensing exam for other health professionals (e.g. MD, DO, NP, PA)	Year 2-3			
g. Support efforts by local dental health professionals to secure dental student rotations in Green Bay (pursue year 1-2 depending on need and requests)	Year 2-3			

Activity: Explore feasibility of community wide campaign to promote dental wellness	***Target Date***	***Resources Required***	***Lead Person/ Organization***	***Progress Notes***
a. Identify proper structure for such a community wide initiative	*Year 3+*			
b. Engage community partners and their current activities	*Year 3+*			
c. Develop plan and strategy	*Year 3+*			
d. Determine needed resources	*Year 3+*			

(As resource becomes available)

Activity: Develop and implement a comprehensive oral health education program for health care professionals	***Target Date***	***Resources Required***	***Lead Person/ Organization***	***Progress Notes***
a. Determine if there has been any increase in oral health content in health professionals curricula subsequent to prior survey				
b. Develop a series of brief oral health related education modules for non-dental providers (University of Manitoba)				
c. Determine venue and strategies for engaging various groups of non-dental health care providers (physicians, nurses, other) , including engaging BDK in process				
d. Explore process for securing continuing education credit for health professionals who complete the training				

How to Become Involved

You can make a difference in the Brown County Community by joining one of the four health priority committees.

To learn more, call the Brown County Health Department at (920) 448-6400 *or* call the City of De Pere Health Department at (920) 339-4054. Visit us online at www.co.brown.wi.us\health (Brown County Health Department) *or* www.de-pere.org (City of De Pere Health Department).

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http://legis.wisconsin.gov/rsb/code.htm