CRCHD
Central Racine County Health Department

Community Health Improvement Plan

2018

The goal of this plan is to take information gathered in the Community Health Assessment 2017, together with input from our community members, the Board of Health, and governmental, business and community agency stakeholders, and translate it into a meaningful roadmap to improve our community's health together.

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INTRODUCTION

Mission and vision are integral to Central Racine County Health Department's work, and we have always focused our public health efforts on overarching, big-picture strategies as well as defined, programmatic details. With the national core public health functions of assessment, policy development and assurance as a framework, we utilize evidence-based strategies to conduct community health assessment and community health improvement planning. These two processes help us determine how to best meet our mission of ensuring a safe and healthy community through health promotion, disease prevention, and protection from health and environmental hazards. These processes also drive us toward achieving our vision of building a healthy future by protecting the public's health through focus on health improvement and health equity.

In 2017 Central Racine County Health Department undertook the process of developing our latest *Community Health Improvement Plan* (CHIP). This CHIP is an extension of our continuous efforts to monitor and report on the health status of the community as well as utilize quality improvement efforts to assess the effectiveness, accessibility and quality of programs and services. Required by state statute, every local health department develops a CHIP to help guide its work in addressing health conditions that impact residents. Wisconsin's health plan, *Healthiest Wisconsin 2020,* and the U.S. health plan, *HealthyPeople 2020,* provide foundational components for a CHIP by articulating health focus areas of overall significance; these focus areas are a starting point for assessing local health issues.

To begin the CHIP process, we first updated our *Community Health Assessment 2017* (CHA). We collaborated with a variety of community stakeholders, key-informants, and residents to gather qualitative and quantitative data and identify community opportunities and challenges. We then summarized the data using categories as outlined in National Association of County and City Health Official's (NACCHO) guidance. Our CHA relays local health data – jurisdictional or county, depending on what is available – and highlights local health issues of significance that inform the CHIP.

To develop the CHIP, Central Racine County Health Department convened community partners to prioritize health issues, develop goals and objectives, develop shared strategies for implementation, and articulate indicators by which to measure progress. This latest CHIP includes both existing and new health priorities and will be used to help guide our community's work in addressing health conditions that impact residents, including those conditions which may disproportionately affect some of our residents. The health priorities that currently resonate most strongly with community partners and residents include: mental health, substance abuse, chronic disease, and access to healthcare. These are the primary focus of our CHIP.

This plan is meant to be a community vision for priority health areas that our community would like to see improved. The CHIP is about the community, by the community, and for the health and well-being of the community.

ACKNOWLEDGEMENTS

It is with sincere gratitude that Central Racine County Health Department would like to thank the following people who helped bring the *Community Health Improvement Plan 2018* to fruition:

Central Racine County Health Department's Public Health Accreditation (PHAB) Team:

- Joella Eternicka, Associate Community Health Director and PHAB Coordinator
- Margaret Gesner, Health Officer
- Jeffrey Langlieb, Community Health Director
- Keith Hendricks, Environmental Health Director
- Silviano Garcia, Public Health Specialist
- Jennifer Loizzo, Environmental Health Sanitarian
- Michele Breheim, Environmental Health Sanitarian
- Pa Chang, Public Health Specialist

CHIP Planning Partners:

- Sue Stroupe, Citizen Representative, Central Racine County Board of Health
- Richard Goetsch, Member, Town of Dover Planning Commission
- Peter Smet, Superintendent, Burlington Area School District
- Kathleen Trentadue, Trustee, Village of Caledonia
- Marina Pappas, Executive Director, NAMI Racine County
- Dan Baran, Director, Professional Services Group
- Liz Powell, Executive Director, Racine Community Foundation
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- Alison Sergio, Executive Director, Health Care Network
- Jason Meekma, Executive Director, Focus on Community
- Jill Sheeley, District Nurse, Waterford Schools
- Jeff Collen, CEO, Racine Family YMCA
- Margaret Malnory, Regional Director, Ascension All Saints
- Kimberly Granger, Health Services Director, Racine Unified School District

CHIP Planning Partners (unable to attend CHIP Planning meeting):

- Margie Carrington, Executive Director, Health and Nutrition Services, Inc. (WIC)
- Bryan Joyce, Aurora Health Care
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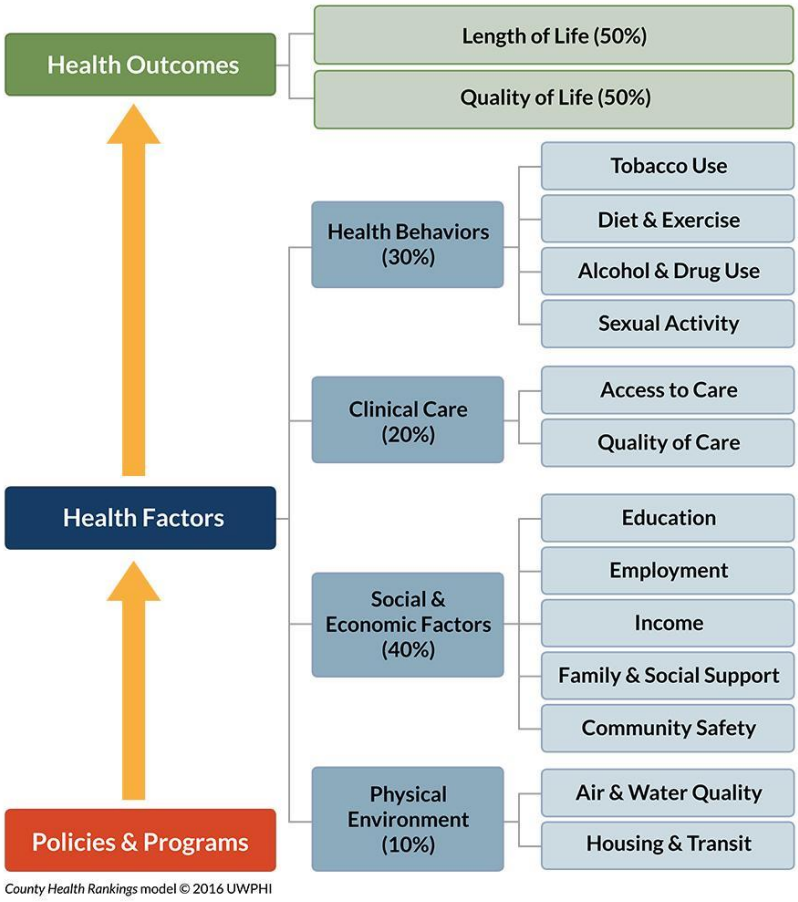
CHIP Planning Meeting Facilitators:

- Kimberly Payne and Arletta Frazier-Tucker, Payne and Frazier Consultants, LLC

SECTION 1: COMMUNITY OVERVIEW

Central Racine County Health Department (CRCHD) serves the 14 municipalities of Caledonia, Dover, Mount Pleasant, North Bay, Norway, Raymond, Rochester, Sturtevant, Union Grove, Yorkville, Town and Village of Waterford, and Town and City of Burlington (the "Jurisdiction"). CRCHD is one of two health departments in Racine County (the "County"). City of Racine Heath Department serves the City of Racine and two municipalities. Racine County is located in the southeast corner of Wisconsin along Lake Michigan. Racine County is home to the 5th largest city in the state, and includes suburban and rural communities. The population of Racine County increased 3.5% between the 2000 and 2010 Census to 195,865. During the same period, the Jurisdiction experienced a 9.2% population increase to 114,328 (*Source: 2010 U.S. Census Bureau).*



The County Health Rankings framework shows that the health of a community (length of life and quality of life) is a complex interplay of health factors (health behaviors, clinical care, physical environment, and social and economic factors).

Of 72 counties, Racine County ranks 63th overall for Health Outcomes and 64th for Health Factors. When broken down by individual Health Factors, Racine County ranked 62nd for Health Behaviors, 32nd for Clinical Care, 62nd for Social and Economic Factors, and 65th for Physical Environment *(Source: 2017 County Health Rankings & Roadmap).* As this framework demonstrates, the state of our community's health can be attributed to many factors. The *Community Health Assessment 2017* explored these factors at the County level and at the Jurisdiction level, whenever possible. The *Community Health Improvement Plan 2018* utilizes and builds on what we learned in the *Community Health Assessment 2017.*

SECTION 2: CHIP PROCESS

Using the MAPP Methodology

To develop our *Community Health Assessment 2017* (CHA) and *Community Health Improvement Plan 2018* (CHIP), Central Racine County Health Department used the Mobilizing for Action through Planning and Partnerships (MAPP) framework. The MAPP tool was developed by NACCHO in cooperation with the Public Health Practice Program Office, Centers for Disease Control and Prevention (CDC). The framework is a community-driven, strategic planning process for improving community health. It facilitates strategic thinking to prioritize public health issues and identify resources to address them. Using MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, considering their unique circumstances and needs, and forming effective partnerships for strategic action. In the MAPP model, the "phases" of the MAPP process are shown in the center of the model, while the four MAPP assessments—the key content areas that drive the process—are shown in four outer arrows.

Broad Participation of Community Partners

Central Racine County Health Department engaged a broad representation of community partners to develop the *Community Health Improvement Plan 2018*. Partners in this process are enumerated on the aforementioned ***Acknowledgements*** page. Represented sectors ranged from non-profits, public health, hospitals, and health care agencies to local school districts, government representatives, Board of Health representatives, business, and foundations and funders. Some of these partners were new while others were also part of the *CHA-CHIP Partner Group* and/or the *Racine County Community Health Data Committee*, both of which met numerous times in 2017.

The CHIP Planning meeting took place in January of 2018, where partners met to identify health priorities, formulate goals and strategies, and advance an action plan. Meeting partners also worked to elucidate community assets and resources, barriers and challenges, populations that may be disproportionately affected by health issues, and policies needed to promote health.

Issues and Themes

Prior to the CHIP Planning meeting, the *CHA-CHIP Partner Group* and the *Racine County Community Health Data Committee* conducted surveys of a wide range of community members and stakeholders, including residents, key-informants, and community partner agencies. All surveys asked respondents to rank priority health issues of greatest concern (see Table 1). Community partner survey respondents were also asked to define *health* and a *healthy community* (see Appendices A and B).

Table 1. Ranked Identified Health Issues by Survey Type

Ranked Identified Health Issues	Partner Survey	Resident Survey (Jurisdiction)	Resident Survey (County)	Key-Informant Survey
Other Drug Use / Illegal Drug Use	1	1	1	2
Rx / OTC Drug Use	2	8	9	2
Mental Health Issues	2	6	6	1
Alcohol Use / Abuse	3	5	7	3
Access to Healthcare/Affordable Healthcare	4	2	2	5
Nutrition	7	-	-	6
Physical Activity	5	-	-	7
Overweight / Obesity	-	3	4	-
Chronic Diseases	-	4 & 9	3 & 5	4
Educational Attainment	3	-	-	-
Tobacco Use	-	7	10	-
Injury/Violence/Crime	-	10	12	8
Adverse Childhood Experiences	8	-	-	-
Environment/Jobs/Income	6	-	-	9
Oral Health	-	-	-	10
Healthy Growth & Development	9	-	-	-
Other	10	-		

Information from Community Health Assessments

Preceding the CHIP Planning meeting, participants received an email with a link to the *Community Health Assessment 2017* as well as a *Community Health Assessment Summary Data 2017* document. Included in the latter document were key data and information, including top-ranked health issues that participants were asked to review prior to coming to the meeting. CHIP Planning meeting participants were also asked to come to the CHIP Planning meeting with their top three priority health concerns. In addition, they were asked to be prepared to talk about why they picked the three and what the consequences might be of not addressing each priority concern. At the CHIP Planning meeting, participants received hardcopies of the two aforementioned documents for use in their deliberations as well as the definitions of health and healthy community.

Setting Health Priorities

The first order of business at the CHIP Planning meeting was to brainstorm potential strategic issues, develop understanding of why an issue is strategic, and identify consequences of not addressing an issue. Attendees participated in a round-robin discussion. Each person articulated their top three priority health concerns, why they chose them, and what the impact is on the community. They used the *Community Health Assessment 2017* and the *Community Health Assessment Summary Data 2017* document for reference as well as their own experiences in the field.

The next order of business for meeting participants was to choose priority health issues and consolidate overlapping or related issues. For this process, CHIP Planning meeting participants wrote down their final top three priority health issues for the community on sticky notes. They could pick one topic three times, one topic twice and the third once, and so forth. The responses were tallied and resulted out as follows:

1. Mental Health (n=18)
2. Substance Abuse (alcohol abuse, opioids, over-the-counter drugs, illegal drugs) (n=9)
3. Chronic Disease (n=8)
4. Access to Healthcare (n=8)

Other health issues receiving votes included educational attainment (n=3), healthy growth and development (n=3), adverse childhood experiences (n=3), tobacco (n=1), and healthy communication (n=1). Meeting participants decided to accept four Priority Health Areas given the tie, and they moved all the items in #2 under the category of Substance Abuse.

Formulating Goals & Strategies; Identifying Community Assets & Resources

The third order of business for the CHIP Planning meeting was for participants to formulate a goal for each of the Priority Health Areas determined by participants. The *Community Health Assessment 2017* as well as the *Community Health Assessment Summary Data 2017* assisted CHIP Planning meeting participants in the process of understanding the concerns of the community and – critically – the roles that community stakeholders play in addressing them. After establishing goals for each Priority Health Area, CHIP Planning meeting participants created an inventory of current assets, resources and strategies as well as gaps, challenges, and needed policies which could be used to identify strategy alternatives. Participants also identified the potential role for Central Racine County Health Department in addressing these priorities. Further, identified strategies were aligned with state and national priorities (see Appendices C-F for a complete compilation of results).

The Planning Process: Action Cycle

The last step in the planning process was to develop objectives and establish accountability. Objectives were developed for each of the four chosen Priority Health Areas, and then measurable indicators from the CHA were correlated with each objective. Subsequently, identified strategies (evidence-based, practice-based or promising practices) were aligned with chosen indicators. Identified strategies will drive indicator data which, in turn, will inform the objectives and overall goal for each Priority Health Area.

For each chosen strategy, we identified activities which will allow monitoring of community progress moving forward. In addition, we identified lead organizations for implementing strategies. The CHIP Planning meeting participants agreed to reconvene at six months and one year to evaluate our progress on our action plan and make adjustments as necessary. Central Racine County Health Department will be responsible for being the convener of this process and will also compile evaluation data.

The next sections detail Overarching Indicators of the health of the community as well as our four Priority Health Areas: Mental Health, Substance Abuse, Chronic Disease, and Access to Healthcare.

SECTION 3: COMMUNITY HEALTH PRIORITIES

Overarching Indicators of the Community's Health

Five overarching health indicators reflect the quality and length of life in our community (see Table 2). They are the tip of the iceberg, representing much larger and more complex community health issues. If our community addresses the four chosen Priority Health Areas – Mental Health, Substance Abuse, Chronic Disease, and Access to Healthcare – then these five Overarching Indicators will also be addressed by improving health status and reducing health disparities. These Overarching Indicators reflect where we are born, live, play, learn and work: social determinants of health.

Table 2. Overarching Health Indicators

Overarching Indicators*	Historical, Baseline, & Target for All Residents	Priority Population: Social Determinants, Poorer Health Outcomes and Health Inequities
QUALITY OF LIFE		
Self-Reported Health Status % of adults who report health status as excellent or very good	Jurisdiction / County Historical (2005): 59% / 56% Baseline (2017): 56% / 50% Target (HP2020): 80% / 80%	TBD
High School Graduation % of students who graduate from high school or get a GED	Baseline and Target defined by Higher Expectations and United Way of Racine County	Hispanic and non-Hispanic Blacks are disproportionately affected
Poverty % of individuals reporting below-poverty status in past 12 months	Jurisdiction / County Historical (2011-2015): 6% / 13% Target: 1% / 8%	Jurisdiction Black (any race/ethnicity, 2011-2015): 15% Hispanic (any race, 2011-2015): 13%
LENGTH OF LIFE		
Infant Mortality Rate of infant deaths per 1,000 live births in Racine County	County Historical (2007): 8 Baseline (2015): 10 Target (HP2020): 6	County Black Historical (2007): 25 Baseline (2015): 19
Years of Potential Life Lost Rate per 100,000 population of years of potential life lost (YPLL) before age 75 in Racine County (3 year rolling average)	County Historical (2000-2002): 7251 Baseline (2013-2015): 7293 Target (WI2020): 6333	County Black Historical (2000-2002): 10,680 Recent (2013-2015): 10,582 Male Historical (2000-2002): 9,395 Baseline (2013-2015): 9,213

*For these data, Jurisdiction represents residents of the Jurisdiction and County represents all residents of Racine County.

In the following sections, for each of the four Priority Health Areas we show the goal chosen by CHIP Planning meeting participants as well as the correlation to Healthiest Wisconsin 2020 and HealthyPeople 2020 focus areas. We also provide health issue definition, impact, data snapshot, social determinants of health, state and national prevention strategies, local strategies, and the role of Central Racine County Health Department. In addition, we relay the objectives for each goal, the indicators and measurements which link to each objective, and the strategies and activities which drive the indicators. We also indicate priority populations for which strategies may be targeted due to higher risks, poorer health outcomes, and health inequities. Targets are from Healthiest Wisconsin 2020, HealthyPeople 2020, or represent a difference of 5% from baseline where targets were not available. Of note, mental health and substance abuse may be interrelated and both may lead to chronic disease. Also of significance, the Access to Healthcare Priority Health Area #4 is cross-cutting and can be considered a social determinant of health for the other three Priority Health Areas for this CHIP.

Mental Health: Priority Health Area #1

GOAL
Increase opportunities for Racine County residents to experience their best mental health

Healthiest Wisconsin 2020: Mental Health
HealthyPeople 2020: Mental Health and Mental Disorders

Definition

Mental Health: "*Mental health* is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. *Mental disorders* are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. *Mental illness* is the term that refers collectively to all diagnosable mental disorders." *(Source: HealthyPeople 2020)*

Impact

"The burden of mental illness in the United States is among the highest of all diseases, and mental disorders are among the most common causes of disability. Recent figures suggest that approximately 1 in 4 adults in the United States had a mental health disorder in the past year—most commonly anxiety or depression—and 1 in 17 had a serious mental illness. Mental health disorders also affect children and adolescents at an increasingly alarming rate; in 2010, 1 in 5 children in the United States had a mental health disorder, most commonly attention deficit hyperactivity disorder (ADHD). It is not unusual for either adults or children to have more than one mental health disorder." *(Source: HealthyPeople 2020)*

"Mental health is essential to a person's well-being, healthy family and interpersonal relationships, and the ability to live a full and productive life. People, including children and adolescents, with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior, and suicide—the 11th leading cause of death in the United States for all age groups and the second leading cause of death among people age 25 to 34. Mental health disorders also have a serious impact on physical health and are associated with the prevalence, progression, and outcome of some of today's most pressing chronic diseases, including diabetes, heart disease, and cancer. Mental health disorders can have harmful and long-lasting effects—including high psychosocial and economic costs—not only for people living with the disorder, but also for their families, schools, workplaces, and communities." *(Source: HealthyPeople 2020)*

Social Determinants of Mental Health

"Several factors have been linked to mental health, including race and ethnicity, gender, age, income level, education level, sexual orientation, and geographic location. Other social conditions—such as interpersonal, family, and community dynamics, housing quality, social support, employment opportunities, and work and school conditions—can also influence mental

health risk and outcomes, both positively and negatively. For example, safe shared places for people to interact, such as parks and churches, can support positive mental health. A better understanding of these factors, how they interact, and their impact is key to improving and maintaining the mental health of all Americans." *(Source: Healthy People 2020)*

Data Snapshot: Central Racine County Health Department Jurisdiction & Racine County

1. In 2017, 6% of Jurisdiction adults and 5% of County adults reported seldom/never finding purpose in daily life, while 5% of Jurisdiction adults and 5% of County adults reported having considered suicide in the last year. Males, those of lower income, and 18-24 year olds were most impacted.
2. In 2016, 23% of County students reported as suffering from depression, while 1 in 5 reported having attempted suicide. Females were disproportionately impacted.
3. White residents in the County had the highest rate of suicide compared to other races.
4. Males in the County had a higher rate of suicides, but their female counterparts had a higher rate of emergency department (ED) visits from self-inflicted injuries.
5. From 2009 to 2017, the percent of adults reporting a mental health condition in the past 3 years increased from 12% to 17% for the Jurisdiction and 13% to 20% for the County.

(*Source: Central Racine County Health Department CHA 2017)*

National and State Prevention Strategies

"Mental and emotional well-being is essential to overall health. Positive mental health allows people to realize their full potential, cope with the stresses of life, work productively, and make meaningful contributions to their communities. Early childhood experiences have lasting, measurable consequences later in life; therefore, fostering emotional well-being from the earliest stages of life helps build a foundation for overall health and well-being." *(Source: National Prevention Strategy)*

"The prevention of mental, emotional and behavioral disorders (MEB) is inherently multidisciplinary. MEB disorders are common and start early in life and the greatest opportunity for prevention is among young people. School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes. Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk. Some preventive interventions have benefits which exceed costs, with the available evidence strongest for early childhood interventions. Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression among children and increasing effective parenting. New mental health issues have emerged among some special populations such as veterans, people in communities with large-scale trauma, and older adults." *(Source: HealthyPeople 2020)*

The *National Prevention Strategy* (below) outlines suggested interventions for *Mental and Emotional Well-Being* and the role that different community sectors play.

Overall Recommendations

- Promote positive early childhood development, including positive parenting violence-free homes.
- Facilitate social connectedness and community engagement across the lifespan.
- Provide individuals and families with the support necessary to maintain positive mental well-being.
- Promote early identification of mental health needs and access to quality services.

What Can Businesses and Employers Do?

- Implement organizational changes to reduce employee stress (e.g., develop clearly defined roles and responsibilities) and provide reasonable accommodations (e.g., flexible work schedules, assistive technology, adapted work stations).
- Ensure that mental health services are included as a benefit on health plans and encourage employees to use these services as needed.
- Provide education, outreach, and training to address mental health parity in employment-based health insurance coverage and group health plans.

What Can Early Learning Centers, Schools, Colleges, and Universities Do?

- Implement programs and policies to prevent abuse, bullying, violence, and social exclusion, build social connectedness, and promote positive mental and emotional health.
- Implement programs to identify risks and early indicators of mental, emotional, and behavioral problems among youth and ensure that youth with such problems are referred to appropriate services.
- Ensure students have access to comprehensive health services, including mental health and counseling services.

What Can Community, Non-Profit, and Faith-Based Organizations Do?

- Provide space and organized activities (e.g., opportunities for volunteering) that encourage social participation and inclusion for all people, including older people and persons with disabilities.
- Support child and youth development programs (e.g., peer mentoring programs, volunteering programs) and promote inclusion of youth with mental, emotional, and behavioral problems.
- Train key community members (e.g., adults who work with the elderly, youth, and armed services personnel) to identify the signs of depression and suicide and refer people to resources.
- Expand access to mental health services (e.g., patient navigation and support groups) and enhance linkages between mental health, substance abuse, disability, and other social services.

What Can Individuals and Families Do?

- Build strong, positive relationships with family and friends.
- Become more involved in their community (e.g., mentor or tutor youth, join a faith or spiritual community).
- Encourage children and adolescents to participate in extracurricular and out-of-school activities.
- Work to make sure children feel comfortable talking about problems such as bullying and seek appropriate assistance as needed.

What Can Health Care Systems, Insurers, and Clinicians Do?

- See Healthcare Access Priority Health Area

Local Strategies

CHIP Meeting participants and key-informants identified strategies to meet the prevention goal of increasing opportunities to improve the mental health status of residents. Many suggested strategies and interventions aligned with the *National Prevention Strategy* and *What Works for Health: Policies and Programs to Improve Wisconsin's Health* and included: increasing public awareness, using social media campaigns, increasing screening, increasing education, implementing training (employer, provider, community), multi-agency collaboration, more group homes, more resource guides, focusing on schools (teach about mental health, bullying, suicide prevention; include parents), medication assistance, payment parity, early childhood work, and outreach teams. Both groups also identified gaps and contributing factors, including: stigma, lack of community/family support, psychiatric prescribing for youth, transportation, too few providers, lack of referral resources, beds, lack of awareness, overuse of law enforcement, lack of training, lack of education, lack of funds, pay for workers, lack of individual effort, and lack of adequate reimbursement. Last, both groups identified assets and resources as well as suggested policies (see Appendices C-F for a complete compilation of results).

Identified strategies were winnowed down to those strategies focused on the community, those with possible programmatic and policy actions, and those tied to social determinants of health. *Of note, Mental Health healthcare access concerns are enumerated in the Access to Healthcare Priority Health Area #4. Healthcare access can be considered a social determinant of health for Mental Health, Substance Abuse, and Chronic Disease Priority Health Areas.*

Role of Central Racine County Health Department

CHIP Meeting participants identified the potential role of CRCHD to address this priority as providing: 1) data; 2) navigation; 3) expertise and leadership; 4) investigation of policies; 5) advocacy; 6) lifespan initiatives; and 7) preventive strategy expertise.

Mental Health Objectives, Indicators and Time-Framed Targets

The objectives to meet the goal for all Racine County residents to experience their best mental health by December 31, 2022 are as follows:

1. Reduce the prevalence of depression in youth.
2. Increase the percentage of adult residents who report good or excellent mental health.
3. Reduce suicide rates.
4. Provide data to measure process and outcome measures.

The following indicators relate directly to the Mental Health objectives (see Table 3). Each defined indicator includes baseline and target measurements for all residents as well as measurements for priority populations experiencing poorer health outcomes and health inequities for whom the strategies may be targeted.

Table 3: Indicators, Measurable and Time-framed Targets for Mental Health

Indicator*	Historical, Baseline, & Target for All Residents	Priority Population: Social Determinants, Poorer Health Outcomes and Health Inequities
Objective: Decrease Prevalence of Depression in Youth by December 31, 2022		
Depression (students)** % middle and high school students reporting depression	**County**** Historical (2006): 18% Baseline (2016): 23% Target: 18%	**County**** Female Historical (2006): 22% Baseline (2017): 30%
Average Number of Student Developmental Assets (middle and high school students)**	**County**** Historical (2006): 17 Baseline (2016): 19 Target (Search Institute): ≥ 31	**County** LGBT (2016, RUSD only) Historical/Baseline: 11.5
Objective: Increase Percentage of Adult Residents who report Good or Excellent Mental Health by December 31, 2022		
Mental Health Condition (adults) % of adults reporting a mental health condition in past three years	**Jurisdiction** / **County** Historical (2009): 12% / 13% Baseline (2017): 17% / 20% Target: 12% / 15%	**Jurisdiction** Female Historical (2009): 15% Baseline (2017): 23% 18-34 Age Group Historical (2009): 12% Baseline (2017): 28% Household Income *Bottom 40%* Historical: (2009): 18% Baseline (2017): 41%
Mental Health Status (adults) % of adults reporting seldom/never finding purpose in daily life	**Jurisdiction** / **County** Historical (2005): 3% / 4% Baseline (2017): 6% / 5% Target: 1% / 0%	**Jurisdiction** Male Historical (2009): 5% Baseline (2017): 9% 18-34 Age Group Historical (2009): 1% Baseline (2017): 8% Household Income *Bottom 40%* Historical: (2009): 7% Baseline (2017): 3%
Social-Emotional Support (adult) % adults reporting no social-emotional support	**County** Historical (2005-2008): 18% Baseline (2005-2010): 17% Target: 12%	TBD
Objective: Reduce Suicide Rates by December 31, 2022		
Considered Suicide (adults) % adults who report they considered suicide in past year	**Jurisdiction** / **County** Historical (2005): 3% / 4% Baseline (2017): 5% / 5% Target: 0% / 0%	**Jurisdiction** Male Historical (2015): 6% Baseline (2017): 7% 18-34 Age Group Historical (2009): 3% Baseline (2017): 13% Household Income *Bottom 40%* Historical (2009): 6% Baseline (2017): 12%
Attempted Suicide (students)** % middle and high school students reporting attempted suicide	**County** Historical (2006): 16% Baseline (2016): 20% Target: 0%	**County** Female Historical (2006): 21% Baseline (2016): 25%

Indicator*	Historical, Baseline, & Target for All Residents	Priority Population: Social Determinants, Poorer Health Outcomes and Health Inequities
Suicide Attempt ED Visits Rate of ED visits for Suicide/Self-Inflicted Injuries	**County** Historical (2002): 45 Baseline (2014): 117 Target (WI2020): 116	**County** Female Historical (2002): 60 Baseline (2014): 153
Suicide Rate of suicides per 100,000 in Racine County	**County** Historical (2007): 9 Baseline (2015): 19 Target (HP2020): 10	**County** White Historical (2007): 9 Baseline (2015): 21 Male Historical (2007): 15 Baseline (2015): 24
Objective: Provide Data to Measure Process and Outcome Measures by December 31, 2022		
Healthy Childhoods e.g. toxic stress	TBD	TBD
Mental Health summary data TBD	TBD	TBD

*For these data, Jurisdiction represents residents of the Jurisdiction and County represents all residents of Racine County.
**Survey sample does not include students from all Racine County Schools.

Strategies and activities for Mental Health that drive the aforementioned indicator data are found in Table 4 (below). These are derived from CHIP Planning meeting participants and align with the *National Prevention Strategy (NPS)* and/or *What Works for Health: Policies and Programs to Improve Wisconsin's Health (WWfH).* These will be reviewed and referenced in the Annual CHIP Progress Report.

Table 4: Strategies and activities to increase opportunities for Racine County residents to experience their best mental health by December 31, 2022

Improvement Strategies	Activities (Annual Review)	Lead / Partners	Policies to Explore
Raise public awareness of mental health stigma	Initiate annual public awareness campaign (Ending the Silence); use social media for awareness Ensure united and cohesive messaging through collaboration Update resource guides	**NAMI / FSR / PSG** Community agencies and partners identified in Appendix C including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	Payment parity; promote access through adequate MA reimbursement for psychiatrists Advocacy
Increase local agency awareness of impact of childhood trauma on health outcomes	Implement trauma-sensitive and trauma-informed training Increase knowledge and tools for community agencies to assist residents	**Racine County Human Services Department** Community agencies and partners identified in Appendix C including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	Inclusion of trauma training for licensed practitioners
Promote healthy families and healthy relationships	Implement and expand programs that focus on early childhood Implement programs that facilitate social connectedness	**Racine County Home Visiting Network** Birth-3, Acelero Learning, Catholic Charities, LIHF, healthcare, public health, and human services as well as community agencies and partners identified in Appendix C including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	Reimbursement for bundled healthcare and home visiting services and care coordination
Promote and enhance interventions aimed at improving coping skills and social-emotional resiliency	Conduct school needs assessment Initiate school-based interventions based on needs assessment and best practice e.g. mental health, bullying, suicide prevention; inclusion of parents Implement Mental Health First Aid training Engage youth organizations	**West-end Schools / CRCHD** School administrators, counselors, social workers, nurses, teachers **RUSD / C2MH** Grant partners, mental health first aid training partners, school-based mental health clinics **YMCA / Other Agencies** Other agencies	Requirements for school staff to know depression and suicide warning signs
Improve availability of mental health data	Engage partners in dynamic process to identify data sources and gaps in descriptive mental health data	**CRCHD** All partner agencies	TBD e.g. data sharing agreements

Substance Abuse: Priority Health Area #2

GOAL
Prevent and effectively treat
substance abuse across the lifespan

Healthiest Wisconsin 2020 Health Focus Area: Alcohol and Other Drug Use
HealthyPeople 2020: Substance Abuse

Definitions

Substance Abuse: "Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values…" *(Source: HealthyPeople 2020)*

Substance Use Disorders: "The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to *substance use disorders*, which are defined as mild, moderate, or severe to indicate the level of severity. *Substance use disorders* occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home." *(Source: Substance Abuse and Mental Health Services Administration – SAMHSA)*

Binge Drinking: "Binge drinking is defined as a pattern of alcohol consumption that brings the blood alcohol concentration (BAC) level to 0.08% or more. This pattern of drinking usually corresponds to 5 or more drinks on a single occasion for men or 4 or more drinks on a single occasion for women, generally within about 2 hours." (*Source: National Institute on Alcohol Abuse and Alcoholism)*

Impact

"Substance abuse—involving drugs, alcohol, or both—is associated with a range of destructive social conditions, including family disruptions, financial problems, lost productivity, failure in school, domestic violence, child abuse, and crime. Estimates of the total overall costs of substance abuse in the United States, including lost productivity and health- and crime-related costs, exceed $600 billion annually. Substance abuse contributes to a number of negative health outcomes and public health problems, including: cardiovascular conditions; pregnancy complications; teenage pregnancy; HIV/AIDS; STDs; domestic violence; child abuse; motor vehicle crashes; homicide; and suicide." *(Source: HealthyPeople 2020)*

Social Determinants of Substance Abuse

"Several biological, social, environmental, psychological, and genetic factors are associated with substance abuse. These factors can include gender, race and ethnicity, age, income level, educational attainment, and sexual orientation. Substance abuse is also strongly influenced by

interpersonal, household, and community dynamics. Family, social networks, and peer pressure are key influencers of substance abuse among adolescents. For example, research suggests that marijuana exposure through friends and siblings was a primary determinant of adolescents' current marijuana use. Understanding these factors is key to reducing the number of people who abuse drugs and alcohol and improving the health and safety of all Americans." *(Source: Healthy People 2020)*

Data Snapshot: Central Racine County Health Department and Racine County

1. From 2005 to 2017, the percentage of surveyed adults who reported binge drinking increased by 43% in the Jurisdiction and 62% in the County. A higher percentage of males reported binge drinking compared to females as did 18-34 year olds.
2. The rate of overdose deaths (any drug) have nearly tripled between 2000 and 2016 in Racine County. Ages 25-34 and females are disproportionately impacted.
3. The rate of emergency department (ED) discharges related to opioids increased over 400% between 2005 and 2016 while hospital discharges climbed over 200% between 2005 and 2016.

(Source: Central Racine County Health Department CHA 2017)

National and State Prevention Strategies

"Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. "*(Source: HealthyPeople 2020)*

The *National Prevention Strategy* (below) outlines suggested interventions for *Preventing Drug Abuse and Excessive Alcohol Use* and the role that different community sectors play.

Recommendations:

- Support state, tribal, local, and territorial implementation and enforcement of alcohol control policies.
- Create environments that empower young people not to drink or use other drugs.
- Identify alcohol and other drug abuse disorders early and provide brief intervention, referral and treatment.
- Reduce inappropriate access to and use of prescription drugs.

What Can State, Tribal, Local and Territorial Governments Do?

- Maintain and enforce the age 21 minimum legal drinking age (e.g., increasing the frequency of retailer compliance checks), limit alcohol outlet density, and prohibit the sale of alcohol to intoxicated persons.
- Require installation of ignition interlocks in the vehicles of those convicted of alcohol impaired driving.
- Implement or strengthen prescription drug monitoring programs.
- Facilitate controlled drug disposal programs, including policies allowing pharmacies to accept unwanted drugs.
- Implement strategies to prevent transmission of HIV, hepatitis and other infectious diseases associated with drug use.

What Can Businesses and Employers Do?

- Implement policies that facilitate the provision of SBIRT or offer alcohol and substance abuse counseling through EAPs.
- Include substance use disorder benefits in health coverage and encourage employees to use these services as needed.
- Implement training programs for owners, managers, and staff that build knowledge and skills related to responsible beverage service.

What Can Early Learning Centers, Schools, Colleges, and Universities Do?

- Adopt policies and programs to decrease the use of alcohol or other drugs on campuses.
- Implement programs for reducing drug abuse and excessive alcohol use (e.g., student assistance programs, parent networking, or peer-to-peer support groups).

What Can Community, Non-Profit, and Faith-Based Organizations Do?

- Support implementation and enforcement of alcohol and drug control policies.
- Educate youth and adults about the risks of drug abuse (including prescription misuse) and excessive drinking.
- Work with media outlets and retailers to reduce alcohol marketing to youth.
- Increase awareness on the proper storage and disposal of prescription medications.

What Can Individuals and Families Do?

- Avoid binge drinking, use of illicit drugs, or the misuse of prescription medications and, as needed, seek help from their clinician for substance abuse disorders.
- Safely store and properly dispose of prescription medications and not share prescription drugs with others.
- Avoid driving if drinking alcohol or after taking any drug (illicit, prescription, or over-the-counter) that can alter their ability to operate a motor vehicle.
- Refrain from supplying underage youth with alcohol and ensure that youth cannot access alcohol in their home.

What Can Health Care Systems, Insurers, and Clinicians Do?

- See Healthcare Access Priority Health Area

Local Strategies

CHIP Meeting participants and key-informants identified strategies to meet the prevention goal of increasing opportunities to reduce substance abuse. Many suggested strategies and interventions aligned with the *National Prevention Strategy* and *What Works for Health: Policies and Programs to Improve Wisconsin's Health* and included: skill development, more policy level support, increasing sustainability of treatment effects, and creating opportunities to convene funders with implementers. Both groups also identified gaps and contributing factors, including: funding, denial, knowledge of appropriate level of treatment, perception-media, diversion programs, physician knowledge, lack of services/resources (e.g. western Racine County), and overprescribing opioids by dentists. Last, both groups identified assets and resources as well as suggested policies (see Appendices C-F for a complete compilation of results).

Identified strategies were winnowed down to those strategies focused on the community, those with possible programmatic and policy actions, and those tied to social determinants of health. *Of note, Substance Abuse health access concerns are enumerated in the Access to Healthcare Priority Health Area #4. Healthcare access can be considered a social determinant of health for Mental Health, Substance Abuse, and Chronic Disease Priority Health Areas.*

Role of Central Racine County Health Department: CHIP Meeting participants identified the potential role of CRCHD to address this priority as providing: 1) advocacy; 2) data; 3) education; 4) resources; and 5) mediation/convening expertise.

Substance Abuse Objectives, Indicators and Time-Framed Targets:

The objectives to meet the goal of preventing and effectively treating substance abuse across the lifespan by December 31, 2022 are as follows:

1. Reduce overdose ED visits, hospitalizations and deaths.
2. Reduce rate of alcohol and drug abuse (adults and youth).
3. Reduce access to and inappropriate use of prescription drugs.
4. Provide data to measure process and outcome measures.

The following indicators relate directly to the Substance Abuse objectives (see Table 5). Each defined indicator includes baseline and target measurements for all residents as well as measurements for priority populations experiencing poorer health outcomes and health inequities for whom the strategies may be targeted.

Table 5: Indicators, Measurable and Time-framed Targets for Substance Abuse

Indicator*	Historical, Baseline, & Target for All Residents			Priority Population: Social Determinants, Poorer Health Outcomes and Health Inequities
Reduce overdose ED visits, hospitalizations and deaths by December 31, 2022				
Overdose Deaths Rate of overdose deaths involving any drug		**County**	**State**	**County** Ages 25-34 Male Historical (2000): 8 Historical (2000): 9 Baseline (2016): 37 Baseline (2016): 17
	Historical (2000):	5	5	
	Most recent (2016):	14	18	
	Target (WI2020):	13	13	
Overdose Hospital Admission Discharges Rate per 100,000 of opioid-related hospital admissions		**County**	**State**	**County** **(Overdose Hospital/ED Discharges Combined)** Ages 25-34 Non-Hispanic Historical (2005): 321 Historical (2005): 149 Baseline (2016): 1201 Baseline (2016): 490
	Historical (2005):	117	125	
	Most recent (2016):	266	264	
	Target (WI2020):	253	251	
Overdose ED Visit Discharges Rate per 100,000 opioid-related ED visit discharges		**County**	**State**	
	Historical (2005):	48	53	
	Most recent (2016):	194	206	
	Target (WI2020):	184	196	
Naloxone TBD e.g. number of doses given	TBD			TBD

Indicator*	Historical, Baseline, & Target for All Residents	Priority Population: Social Determinants, Poorer Health Outcomes and Health Inequities
Reduce rate of alcohol and drug abuse (adults and students) by December 31, 2022		
Binge Drinking (students)** % of middle and high school students who report binge drinking in their lifetime	<u>County</u> Historical (2006): 23% Baseline (2016): 16% Target (WI2020): 14%	TBD
Binge Drinking (adults) % of adults who report binge drinking in past 30 days	<u>Jurisdiction</u> <u>County</u> Historical (2005): 21% 21% Baseline (2017): 30% 34% Target (HP2020): 24% 24%	<u>Jurisdiction</u> <u>Male</u> <u>18-34 Age Group</u> Historical (2005): 32% Historical (2005): 36% Baseline (2017): 36% Baseline (2017): 45%
Operating While Intoxicated TBD e.g. number of arrests	TBD	TBD
Reduce access to and inappropriate use of prescription drugs by December 31, 2022		
RX Drug Monitoring Program	TBD	TBD
Med Collection Boxes/ Events	TBD	TBD
Objective: Provide Data to Measure Process and Outcome Measures by December 31, 2022		
Substance Abuse summary data TBD e.g. OFRT data	TBD	TBD

*For these data, Jurisdiction represents residents of the Jurisdiction and County represents all residents of Racine County.
**Survey sample does not include students from all Racine County Schools.

Strategies and activities for Substance Abuse that drive the aforementioned indicator data are found in Table 6 (below). These are derived from CHIP Planning meeting participants and align with the *National Prevention Strategy* (NPS) and/or *What Works for Health: Policies and Programs to Improve Wisconsin's Health* (WWfH). These will be reviewed and referenced in the Annual CHIP Progress Report.

Table 6: Strategies and activities to prevent and effectively treat substance abuse across the lifespan by December 31, 2022

Improvement Strategies	Activities (Annual Review)	Lead / Partners	Current Policies / Policies to Explore
Initiate Overdose Fatality Review Team (OFRT)	Provide data to identify contributing factors and inform prevention activities	**CRCHD** Law enforcement, drug courts, human services, healthcare, EMS, district attorney, other	TBD
Raise public awareness of the risks and consequences of alcohol abuse and opioids	Conduct annual public awareness campaign	**HSD / OFRT / Focus on Community / FSR / PSG** Community agencies and partners identified in Appendix D including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	TBD
Reduce opioid overdose fatalities through expanded naloxone access	Initiate Naloxone Use Surveillance	**Healthcare / CRCHD** **Law enforcement / EMS** Pharmacies, other	Naloxone availability through pharmacies
Reduce inappropriate access to and use of prescription drugs	Examine Prescription Drug Monitoring Program trends	**Healthcare / CRCHD / State Health Department**	Opioid lawsuit (Racine County)
Educate youth and adults about the risks of drug abuse (including prescription misuse) and excessive drinking.	Dispense household lock boxes Implement education measures	**Focus on Community / Partners2** Community agencies and partners identified in Appendix D including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	Enhance enforcement of laws prohibiting alcohol purchase by minors Alcohol taxes
Expand, facilitate and promote medication collection program to reduce drug access	Collect data on medication drug box utilization	**CRCHD / Law Enforcement / Focus** Healthcare, pharmacies, schools, agencies and partners identified in Appendix D including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	Facilitate policies allowing pharmacies to accept unwanted drugs
Improve availability of substance abuse data	Engage partners in dynamic process to identify data sources and gaps in descriptive substance abuse health data	**CRCHD** All partner agencies	TBD e.g. data sharing agreements

Chronic Disease: Priority Health Area #3

GOAL
Prevent and effectively treat chronic disease

Healthiest Wisconsin 2020: Chronic Disease Prevention and Management
HealthyPeople 2020: Nutrition, Physical Activity, and Obesity

Definition

"A chronic disease, as defined by the U.S. National Center for Health Statistics, is a disease lasting three months or longer. Generally incurable and ongoing, chronic diseases affect approximately 133 million Americans, representing more than 40% of the total population of this country. More and more people are living with not just one chronic illness, such as diabetes, heart disease or depression, but with two or more conditions. Almost a third of the population is now living with multiple chronic conditions." *(Source: National Health Council)*

Impact

"Chronic diseases and conditions—such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems. Two of these chronic diseases—heart disease and cancer—together accounted for nearly 46% of all deaths. Obesity is a serious health concern. During 2011–2014, more than one-third of adults (36%), or about 84 million people, were obese (defined as body mass index [BMI] ≥30 kg/m^2). About one in six youths (17%) aged 2 to 19 years was obese (BMI ≥95th percentile). Arthritis is the most common cause of disability. Of the 54 million adults with doctor-diagnosed arthritis, more than 23 million say they have trouble with their usual activities because of arthritis. Diabetes is the leading cause of kidney failure, lower-limb amputations other than those caused by injury, and new cases of blindness among adults." *(Source: CDC)*

"Lack of exercise or physical activity, poor nutrition, tobacco use, and drinking too much alcohol—cause much of the illness, suffering, and early death related to chronic diseases and conditions. In the United States, chronic diseases and conditions and the health risk behaviors that cause them account for most health care costs. Eighty-six percent of the nation's $2.7 trillion annual health care expenditures are for people with chronic and mental health conditions." *(Source: CDC)*

"Good nutrition, physical activity, and a healthy body weight are essential parts of a person's overall health and well-being. Together, these can help decrease a person's risk of developing serious health conditions, such as high blood pressure, high cholesterol, diabetes, heart disease, stroke, and cancer. A healthful diet, regular physical activity, and achieving and maintaining a healthy weight also are paramount to managing health conditions so they do not worsen over time." (Source: HealthyPeople 2020)

Social Determinants of Chronic Disease

"A number of factors affect a person's ability to eat a healthful diet, stay physically active, and achieve or maintain a healthy weight. The built environment has a critical impact on behaviors

that influence health. For example, in many communities, there is nowhere to buy fresh fruit and vegetables, and no safe or appealing place to play or be active. These environmental factors are compounded by social and individual factors—gender, age, race and ethnicity, education level, socioeconomic status, and disability status—that influence nutrition, physical activity, and obesity. Addressing these factors is critically important to improving the nutrition and activity levels of all Americans; only then will progress be made against the Nation's obesity epidemic and its cascading impact on health." *(Source: HealthyPeople 2020)*

Data Snapshot: Central Racine County Health Department and Racine County

1. The percentage of current smokers in the Jurisdiction decreased from 2005 to 2017.
2. Adults reported an increase in moderate or vigorous physical activity (5x/week). The reported values for the Jurisdiction (57%) and the County (54%) were both above the Healthy People 2020 target goal of 48%.
3. From 2012 to 2017, there was a 14 % decrease in Jurisdiction children (ages 5 to 17) who were meeting the US Department of Health and Human Services recommendation of 60 minutes of physical activity per day. For County children, there was a 10% decrease.
4. Adults reporting 5+ fruits/vegetables per day stayed flat while there was an increase in children's fruit and vegetable intake.
5. From 2005 to 2017, the Jurisdiction saw a 10% increase in the percentage of adults who reported as overweight or obese (BMI≥25). This increase reached a percentage (73%) level above the Healthy People 2020 target of 66%. When this measurement was stratified by gender, males were consistently higher compared to their female counterparts. In addition, 18-34 year olds, 55-64 year olds, those with lower educational attainment status, and those of lower economic status were disproportionately impacted.
6. In 2015, heart disease was the leading cause of death for Hispanic and White County residents, while cancer was the leading cause of death for Black residents in the County.
7. In 2015, the County's three leading causes of cancer mortality were lung, breast, and prostate cancer.

National and State Prevention Strategies

"Engaging in regular physical activity is one of the most important things that people of all ages can do to improve their health. Physical activity strengthens bones and muscles, reduces stress and depression, and makes it easier to maintain a healthy body weight or to reduce weight if overweight or obese. Even people who do not lose weight get substantial benefits from regular physical activity, including lower rates of high blood pressure, diabetes, and cancer." *(Source: National Prevention Strategy)*

The *National Prevention Strategy* (below) outlines suggested interventions for *Physical Activity and Healthy Eating* and the role that different community sectors play.

Recommendations (Physical Activity and Healthy Eating):

- Encourage community design and development that supports physical activity.
- Promote and strengthen school and early learning policies and programs that increase physical activity.
- Facilitate access to safe, accessible, and affordable places for physical activity.
- Support workplace policies and programs that increase physical activity.
- Assess physical activity levels and provide education, counseling, and referrals.
- Increase access to healthy and affordable foods in communities.
- Implement organizational and programmatic nutrition standards and policies.
- Improve nutritional quality of the food supply.
- Help people recognize and make healthy food and beverage choices.
- Support policies and programs that promote breastfeeding.
- Enhance food safety.

What Can State, Tribal, Local and Territorial Governments Do?

- Design safe neighborhoods that encourage physical activity (e.g., sidewalks, bike lanes, lighting, multi-use trails, walkways, parks).
- Convene partners to consider health impacts when making transportation or land use decisions.
- Support schools and early learning centers in meeting physical activity guidelines.
- Ensure nutrition standards for foods served or sold in government facilities and government-funded programs and institutions.
- Strengthen licensing standards for early learning centers to include nutritional requirements for foods and beverages served.
- Work with hospitals, early learning centers, health care providers, and community organizations to implement breastfeeding policies.
- Ensure laboratories, businesses, health care, and community partners are prepared to respond to outbreaks of foodborne disease.
- Use grants, zoning regulations, and other incentives to attract full-service grocery stores, supermarkets, and farmers markets to underserved neighborhoods

What Can Businesses and Employers Do (Physical Activity and Healthy Eating)?

- Adopt policies and programs that promote walking, bicycling, and use of public transportation
- Design or redesign communities to promote opportunities for physical activity.
- Sponsor a new or existing park, playground, or trail, recreation or scholastic program, or beautification or maintenance project.
- Increase the availability of healthy food; limit marketing of unhealthy food to children and youth.
- Adopt lactation policies that provide space, break time for breastfeeding employees; offer lactation management services and support.
- Reduce sodium, saturated fats, and added sugars and eliminate artificial trans fats from products.
- Implement proper handling, preparation, and storage practices to increase food safety.

What Can Early Learning Centers, Schools, Colleges, and Universities Do?

- Provide daily physical education and recess that focuses on maximizing time physically active.
- Participate in fitness testing and support individualized self-improvement plans.
- Support walk and bike to schools programs; select school sites that can promote physical activity.
- Limit passive screen time; make physical activity facilities available to the local community.
- Implement and enforce policies that increase the availability of healthy foods.
- Eliminate high-calorie, low-nutrition drinks from vending machines, cafeterias, and school stores and provide greater access to water.
- Implement policies restricting the marketing of unhealthy foods.
- Provide nutrition education.

What Can Community, Non-Profit, and Faith-Based Organizations Do?

- Offer low or no-cost physical activity programs (e.g., intramural sports, physical activity clubs).
- Develop and institute policies and joint use agreements that address liability concerns and encourage shared use of physical activity facilities (e.g., school gymnasiums, community recreation centers).
- Offer opportunities for physical activity across the lifespan (e.g., aerobic and muscle strengthening exercise classes for seniors).
- Lead or convene city, county, and regional food policy councils to assess local community needs and expand programs (e.g., community gardens, farmers markets) that bring healthy foods, especially locally grown fruits and vegetables, to schools, businesses, and communities.
- Implement culturally, linguistically appropriate social supports for breastfeeding e.g. marketing campaigns, breastfeeding peer support.

What Can Individuals and Families Do?

- Engage in at least 150 minutes of moderate-intensity activity each week (adults) or at least one hour of activity each day (children).
- Supplement aerobic activities with muscle strengthening activities on two or more days a week that involve all major muscle groups.
- Consider following the American Academy of Pediatrics (AAP) recommendations for limiting TV time among children.
- Eat less by avoiding oversized portions, make half of the plate fruits and vegetables, make at least half of the grains whole grains, switch to fat-free or low-fat (1%) milk, choose foods with less sodium, and drink water instead of sugary drinks.
- Balance intake and expenditure of calories to manage body weight.
- Breastfeed their babies exclusively for the first 6 months after birth when able.
- Prevent foodborne illness by following key safety practices— clean (wash hands and surfaces often), separate (do not cross-contaminate), cook (cook food to proper temperatures), and chill (refrigerate promptly).

What Can Health Care Systems, Insurers, and Clinicians Do?

- See Healthcare Access Priority Health Area

Local Strategies

CHIP Meeting participants and key-informants identified strategies to meet the prevention goal of increasing opportunities to prevent and manage chronic disease of residents. Many suggested strategies and interventions aligned with the *National Prevention Strategy* and *What Works for*

Health: Policies and Programs to Improve Wisconsin's Health and included: increasing awareness of chronic disease, increasing treatment options and activities that prevent disease e.g. tobacco, substance abuse, activity, nutrition. Both groups also identified gaps and contributing factors, including: data for western Racine County, access to primary care/specialty care, lack of prevention funding, lack of a belief that prevention is a priority, cost of care and medicine, trust, misinformation, lack of motivation/follow through even though people have knowledge, and lack of accessible grocery stores. Last, both groups identified assets and resources as well as suggested policies (see Appendices C-F for a complete compilation of results).

Identified strategies were winnowed down to those strategies focused on the community, those with possible programmatic and policy actions, and those tied to social determinants of health. *Of note, Chronic Disease health access concerns are enumerated in the Access to Healthcare Priority Health Area #4. Healthcare access can be considered a social determinant of health for the Mental Health, Substance Abuse, and Chronic Disease Priority Health Areas.*

Role of Central Racine County Health Department: CHIP Meeting participants identified the potential role of CRCHD to address this priority as providing: 1) increased awareness; 2) community outreach; 3) mediation/convening; 4) resource navigation; 5) evidence-based programs/best practices; 6) credible information.

Chronic Disease Objectives, Indicators and Time-Framed Targets:

The objectives to meet the goal of preventing and effectively treating chronic disease by December 31, 2022 are as follows:

1. Increase % of children and adults meeting physical activity targets.
2. Increase % of children and adults meeting daily intake of fruits and vegetables.
3. Reduce obesity rate among children and adults.
4. Reduce mortality related to heart disease and cancer.
5. Provide data to measure process and outcome measures.

The following indicators relate directly to the Chronic Disease objectives (see Table 7). Each defined indicator includes baseline and target measurements for all residents as well as measurements for priority populations experiencing poorer health outcomes and health inequities for whom the strategies may be targeted.

Table 7: Indicators, Measurable and Time-framed Targets for Chronic Disease

Indicator*	Historical, Baseline, & Target for All Residents			Priority Population: Social Determinants, Poorer Health Outcomes and Health Inequities
Objective: Increase % of children and adults meeting physical activity targets by December 31, 2022				
Physical Activity (adults) % adults who report meeting moderate or vigorous physical activity requirements		**Jurisdiction**	**County**	**Jurisdiction** Household Income *Middle 20% Bracket* Historical (2009): 45% Baseline (2017): 44%
	Historical (2009):	40%	43%	
	Baseline (2017):	57%	54%	
	Target (HP2020):	48%	48%	
Physical Activity (children) % children with physical activity regiment of 60 minutes for 5 or more days (parent report)		**Jurisdiction**	**County**	TBD
	Historical (2012):	71%	69%	
	Baseline (2017):	61%	62%	
	Target(WI2020):	66%	66%	

Indicator*	Historical, Baseline, & Target for All Residents			Priority Population: Social Determinants, Poorer Health Outcomes and Health Inequities			
Objectives: Increase % of children and adults meeting daily fruit and vegetable intake by December 31, 2022							
Fruit and Vegetable Intake (adults) % adults who report eating 5+ fruits/vegetables/day		**Jurisdiction**	**County**	**Jurisdiction**			
	Historical (2005):	38%	38%	Male		55-64 Age Group	
	Baseline (2017):	38%	35%	Historical (2005)	29%	Historical (2005):	36%
	Target:	43%	43%	Baseline (2017):	29%	Baseline (2017):	31%
				High School or Less		Household Income	
				Historical (2005):	30%	*Bottom 40%*	
				Baseline (2017):	24%	Historical (2009):	36%
						Baseline (2017):	30%
Fruit and Vegetable Intake (children) % children who eat 5+ fruits/vegetables/day (parent report)		**Jurisdiction**	**County**	**Jurisdiction**			
	Historical (2012):	34%	37%	Girl		13-17 Age Group	
	Baseline (2017):	46%	38%	Historical (2012):	36%	Historical (2012):	19%
	Target:	51%	51%	Baseline (2017):	42%	Baseline (2017):	40%
				Household Income			
				Bottom 60%			
				Historical (2012):	31%		
				Baseline (2017):	24%		
Objective: Reduce obesity rate among children and adults by December 31, 2022							
Obesity (adults) % of adults who report being overweight or obese		**Jurisdiction**	**County**	**Jurisdiction**			
	Historical (2005):	66%	68%	Male		High School or Less	
	Baseline (2017):	73%	75%	Historical (2005):	83%	Historical (2005):	66%
	Target (HP2020):	66%	66%	Baseline (2017):	81%	Baseline (2017):	84%
				18-34 Age Group		Household Income	
				Historical (2005):	63%	*Bottom 40%*	
				Baseline (2017):	75%	Historical (2009):	73%
				55-64 Age Group		Baseline (2017):	82%
				Historical (2005):	69%		
				Baseline (2017):	82%		
Obesity (children) % of children obese (parent report)			**State**	TBD			
	Historical (1999):		10%				
	Baseline (2013):		12%				
	Target (HP2020):		15%				
Objective: Reduce mortality related to heart disease and cancer by December 31, 2022							
Tobacco Use (adults) % adults who report being current smokers		**Jurisdiction**	**County**	**Jurisdiction**			
	Historical (2005):	20%	25%	35-44 Age Group		Household Income	
	Baseline (2017):	11%	19%	Historical (2005):	21%	*Top 40%*	
	Target (HP2020):	12%	12%	Baseline (2017):	17%	Historical (2012):	17%
						Baseline (2017):	15%
				High School or Less			
				Historical (2005):	30%		
				Baseline (2017):	15%		
Cancer Mortality rate per 100,000	**Overall Cancer**		**County**	**County**			
	Historical (2007):		178	Overall Cancer (Black)			
	Baseline (2016):		159	Historical (2007):	143		
	Target (HP2020):		161	Baseline (2016):	221		
	Breast Cancer (Female)						
	Target (HP2020):		21	Breast Cancer (Females)			
	Prostate Cancer (Male)			Historical (2007):	22		
	Target (HP2020):		22	Baseline (2016):	21		
				Prostate Cancer (Males)			
				Historical (2007):	32		
				Baseline (2016):	27		
Coronary Heart Disease*			**County**	**County**			
Rate per 100,00 who die from coronary heart disease	Historical (2007):		110	Male			
	Baseline (2016):		95	Historical (2007):	175		
	Target (HP 2020):		103	Baseline (2016):	133		
*As defined by ICD-10 codes I20-I22,I24-I25				Black			
				Historical (2007):	152		
				Baseline (2016):	133		
Objective: Provide Data to Measure Process and Outcome Measures by December 31, 2022							
Chronic Disease summary data TBD	TBD			TBD			

*For these data, Jurisdiction represents residents of the Jurisdiction and County represents all residents of Racine County.

Strategies and activities for Chronic Disease that drive the aforementioned indicator data are found in Table 8 (below). These are derived from CHIP Planning meeting participants and align with the *National Prevention Strategy* (NPS) and/or *What Works for Health: Policies and Programs to Improve Wisconsin's Health* (WWfH). These will be reviewed and referenced in the Annual CHIP Progress Report.

Table 8: Strategies and activities to prevent and effectively treat chronic diseases by December 31, 2022

Improvement Strategies	Activities (Annual Review)	Lead / Partners	Policies to Explore
Make facilities available for physical activity	Convene local partners	**YMCA / Other** Aurora Wellness Center, senior centers, community centers, schools	Grants to fund programming
Support tobacco control efforts	Participate in coalition meetings and/or initiatives	**Tri-County Tobacco Coalition** Community agencies and partners identified in Appendix E including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	TBD
Initiate Health in All Policies	Assess potential for HiAP plan	**CRCHD** Racine County, municipalities	Engage local and state policy-makers
Support community efforts to promote breastfeeding	Education Support peer breastfeeding	**WIC** Racine County Home Visiting Network members, LIHF, healthcare providers, UW-Extension, Head Start	Baby friendly hospital
Provide community and establishment education to prevent foodborne outbreaks	Continue Establishment inspection and licensing Implement food safety online class	**CRCHC / Other** Food establishments, schools	TBD
Identify additional strategies for health promotion and disease prevention	Provide HPV vaccinations Other TBD	**CRCHD** Community agencies and partners identified in Appendix E including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	TBD
Improve availability of chronic disease data	Engage partners in dynamic process to identify data sources and gaps in descriptive chronic disease health data	**CRCHD** All partner agencies	TBD e.g. data sharing agreements

Access to Healthcare: Priority Health Area #4

GOAL
Increase access to comprehensive, quality healthcare across the lifespan

Healthiest Wisconsin 2020: Alcohol and Other Drug; Chronic Disease Prevention and Management; Injury and Violence; Oral Health; Healthy Growth & Development
HealthyPeople 2020: Access to Health Services

Definition

"Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires 3 distinct steps: 1) gaining entry into the health care system (usually through insurance coverage); 2) accessing a location where needed health care services are provided (geographic availability); and 3) finding a health care provider whom the patient trusts and can communicate with (personal relationship). Access to health care impacts one's overall physical, social, and mental health status and quality of life." *(HealthyPeople 2020)*

Impact

"A person's ability to access health services has a profound effect on every aspect of his or her health, yet at the start of the decade, almost 1 in 4 Americans do not have a primary care provider (PCP) or health center where they can receive regular medical services. Approximately 1 in 5 Americans (children and adults under age 65) do not have medical insurance. People without medical insurance are more likely to lack a usual source of medical care, such as a PCP, and are more likely to skip routine medical care due to costs, increasing their risk for serious and disabling health conditions. When they do access health services, they are often burdened with large medical bills and out-of-pocket expenses. Increasing access to both routine medical care and medical insurance are vital steps in improving the health of all Americans." *(Source: HealthyPeople 2020)*

Healthcare Access as a Social Determinant of Health

"Access to health services affects a person's health and well-being. Regular and reliable access to health services can: 1) prevent disease and disability; 2) detect and treat illnesses or other health conditions; 3) increase quality of life; 4) reduce the likelihood of premature (early) death; and 5) increase life expectancy. Primary care providers (PCPs) play an important role in protecting the health and safety of the communities they serve. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with: 1) greater patient trust in the provider; 2) good patient-provider communication; and 3) increased likelihood that patients will receive appropriate care." *(Source: HealthyPeople 2020)*

"Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and

communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be." *(Source: Healthy People 2020)*

"Health-care services (primary, secondary, tertiary care) have not until recently been considered an SDH. Inequities in access to health care are changing this view. These inequities include barriers faced by certain population groups at point of care, such as the lack of cultural competence of health-care providers. The authors show how a social justice perspective can help nurses understand how to link inequities in access to poorer health outcomes, and they call on nurses to break the cycle of oppression that contributes to these inequities." *(Source: National Institutes of Health)*

Data Snapshot: Central Racine County Health Department and Racine County

1. From 2005 to 2017, CRCHD residents continue to report the doctor/nurse practitioner's office as their top primary source for health services. However, in the most recent years (2015-2017) respondents have reported a more than 8-fold increase in the use of urgent care centers as a primary source of care when compared to 2005.
2. From 2011 to 2016, Racine County had less health care providers (e.g. primary care provider, dentist, mental health provider) per capita compared to the State.
3. From 2015 to 2016, the lack of health insurance coverage in Racine County has been highest for adults.
4. Unmet health, dental and mental healthcare needs have increased.

National and State Prevention Strategies

"Millions of Americans still lack health insurance coverage. In addition, data from the *Healthy People Midcourse Review* demonstrate that there are significant disparities in access to care by sex, age, race, ethnicity, education, and family income. These disparities exist with all levels of access to care, including health and dental insurance, having an ongoing source of care, and access to primary care. Disparities also exist by geography, as millions of Americans living in rural areas lack access to primary care services due to workforce shortages. Specific issues that should be monitored over the next decade include:

- Increasing and measuring insurance coverage and access to the entire care continuum (from clinical preventive services to oral health care to long-term and palliative care).
- Addressing disparities that affect access to health care (e.g., race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location).
- Assessing the capacity of the health care system to provide services for newly insured individuals.
- Determining changes in health care workforce needs as new models for delivery of primary care become more prevalent, such as the patient-centered medical home and team-based care.
- Monitoring the increasing use of telehealth as an emerging method of delivering health care.

(Source: HealthyPeople 2020)

The *National Prevention Strategy* (below) outlines suggested interventions for *Healthcare Systems, Clinicians and Insurers* across the health focus areas of Mental Health, Substance Abuse and Chronic Disease.

Overall Recommendations

- Inform patients about the benefits of preventive services and offer recommended clinical preventive services as a routine part of care.
- Adopt medical home or team-based care models.
- Reduce or eliminate client out-of pocket costs for certain preventive services, and educate and encourage enrollees to access these services.
- Establish patient and clinical reminder systems for preventive services.
- Expand hours of operation, provide child care, offer services in convenient locations (e.g., near workplaces), or use community or retail sites to provide preventive services.
- Create linkages with and connect patients to community resources (e.g., tobacco quitlines), family support, and education programs.
- Facilitate coordination among diverse care providers (e.g., clinical care, behavioral health, community health workers, complementary and alternative medicine).
- Communicate with patients in an appropriate manner so that patients can understand and act on their advice and directions.
- Promote early identification of mental health needs and access to quality services.
- Identify alcohol and other drug abuse disorders early and provide brief intervention, referral and treatment.
- Reduce inappropriate access to and use of prescription drugs.
- Support policies and programs that promote breastfeeding.

Mental Health: What Can Health Care Systems, Insurers, and Clinicians Do?

- Educate parents on normal child development and conduct early childhood interventions to enhance mental and emotional well-being and provide support (e.g., home visits for pregnant women and new parents).
- Screen for mental health needs among children and adults, especially those with disabilities and chronic conditions, and refer people to treatment and community resources as needed.
- Develop integrated care programs to address mental health, substance abuse, and other needs within primary care settings.
- Enhance communication and data sharing (with patient consent) with social services networks to identify and treat those in need of mental health services.

Substance Abuse: What Can Health Care Systems, Insurers, and Clinicians Do?

- Identify and screen patients for excessive drinking using SBIRT, implement provider reminder systems for SBIRT (e.g., electronic medical record clinical reminders), evaluate the effectiveness of alternative methods for providing SBIRT (e.g. by phone, via internet).
- Identify, track, and prevent inappropriate patterns of prescribing and use of prescription drugs and integrate prescription drug monitoring into electronic health record systems.
- Develop and adopt evidence-based guidelines for prescribing opioids in emergency departments, including restrictions on the use of long-acting or extended-release opioids for acute pain.
- Train prescribers on safe opioid prescription practices and institute accountability mechanisms to ensure compliance. For example, the use of long-acting opioids for acute pain or in opioid-naïve patients could be minimized.

Chronic Disease: What Can Health Care Systems, Insurers, and Clinicians Do?

- Conduct physical activity assessments, provide counseling, and refer patients to allied health care or health and fitness professionals.
- Support clinicians in implementing physical activity assessments, counseling, and referrals (e.g., provide training to clinicians, implement clinical reminder systems).
- Use maternity care practices that empower new mothers to breastfeed, such as the Baby-Friendly Hospital standards.
- Screen for obesity by measuring body mass index and deliver appropriate care according to clinical practice guidelines for obesity.
- Assess dietary patterns (both quality and quantity of food consumed), provide nutrition education and counseling, and refer people to community resources (e.g., Women, Infants, and Children (WIC); Head Start; County Extension Services; and nutrition programs for older Americans).

Local Strategies

CHIP Meeting participants and key-informants identified strategies to meet the prevention goal of increasing opportunities to increase access to comprehensive, quality healthcare across the lifespan. Many suggested strategies and interventions aligned with the *National Prevention Strategy* and *What Works for Health: Policies and Programs to Improve Wisconsin's Health* and included: promoting place based services, increasing transportation to healthcare, improving enrollment into insurance, increasing awareness of available services, and increasing awareness of chronic disease treatment options. Both groups also identified gaps and contributing factors, including: lack of mobile clinic on west end, lack of comfortable places to access healthcare, institutionalization of healthcare, stigma of healthcare, lack of transportation, unemployment, lack of flexible appointment hours, lack of vaccines for adults, lack of trust, decrease access to dental care (Medicaid and Medicare), high deductibles (out of pocket costs), lack of alternative medications and holistic treatment, lack of dental insurance, decrease in primary care providers,

lack of psychiatric prescribing for youth, too few mental health providers, lack of referral resources, beds, lack of funds, pay for workers, lack of adequate reimbursement, access to primary care/specialty care, lack of prevention funding/lack of a belief that prevention is a priority, cost of care and medicine, physician knowledge, lack of services/resources for substance abuse (especially western Racine County), and overprescribing opioids by dentists. Last, both groups identified assets and resources as well as suggested policies (see Appendices C-F for a complete compilation of results).

Identified strategies were winnowed down to those strategies focused on the community, those with possible programmatic and policy actions, and those tied to strategies which are evidence-based, practice-based or promising practices.

Role of Central Racine County Health Department

CHIP Meeting participants identified the potential role of CRCHD to address this priority as providing: 1) advocacy; 2) data; 3) convening; and 4) vaccinations.

Access to Healthcare Objectives, Indicators and Time-Framed Targets

The objectives to meet the goal of increasing access to comprehensive, quality healthcare across the lifespan by December 31, 2022 are as follows:

1. Increase proportion of children and adults with a usual medical home.
2. Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, mental health care, and/or prescriptions.
3. Increase the availability and accessibility of primary care providers, mental health providers, and substance abuse providers.
4. Provide data to measure process and outcome measures.

The following indicators relate directly to the Access to Healthcare objectives (see Table 9). Each defined indicator includes baseline and target measurements for all residents as well as measurements for priority populations experiencing poorer health outcomes and health inequities for whom the strategies may be targeted.

Table 9: Indicators, Measurable and Time-framed Targets for Healthcare Access

Indicator*	Historical, Baseline & Target	Priority Population: Social Determinants, Poorer Health Outcomes and Health Inequities
Objective: Increase proportion of children and adults with a usual medical home by December 31, 2022		
Source of Care / Utilization % adults who report using urgent care as primary source of health services	Jurisdiction / County Historical (2005): 2% / 2% Most recent (2017): 17% / 21% Target: 12% / 16%	Jurisdiction 18-34 Age Group Historical (2009): 11% Baseline (2017): 0% Male Historical (2009): 7% Baseline (2017): 19% Household Income *Top 40%* Historical (2009): 8% Baseline (2017): 24%
Insurance Status % of adults who report no health insurance in past 12 months	Jurisdiction / County Historical (2009): 9% / 15% Most recent (2017): 4% / 5% Target (HP2020): 0% / 0%	Jurisdiction 35-44 Age Group Historical (2009): 8% Baseline (2017): 11% Some Post High School Historical (2009): 7% Baseline (2017): 8% Household Income *Middle 20%* Historical (2009): 5% Baseline (2017): 9%
Insurance Status % of children without health insurance (parent report)	County / State Historical (2010): 5% / 5% Most recent (2014): 5% / 5% Target (HP2020): 0% / 0%	TBD

Indicator*	Historical, Baseline & Target	Priority Population: Social Determinants, Poorer Health Outcomes and Health Inequities
Objective: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, mental health care, and/or prescriptions by December 31, 2022		
Healthcare Costs % adults who delayed/did not receive care in past 12 months due to cost (self-report)	**Jurisdiction** / **County** Historical (2015): 21% / 21% Most recent (2017): 17% / 17% Target: 12% / 12%	**Jurisdiction** 45-54 Age Group Historical (2015): 23% Baseline (2017): 24% 55-64 Age Group Historical (2015): 17% Baseline (2017): 23% High School or Less Historical (2015): 10% Baseline (2017): 16% Household Income *Top 40%* Historical (2015): 11% Baseline (2017): 17%
Prescription Costs % household prescription medications not taken due to cost (self-report)	**Jurisdiction** / **County** Historical (2009): 7% / 12% Most recent (2017): 8% / 10% Target: 3% / 5%	**Jurisdiction** Household Income *Top 40%* Historical (2009): 4% Baseline (2017): 10%
Unmet Dental Care % of adults who did not get needed dental care (self-report)	**Jurisdiction** / **County** Historical (2012): 11% / 15% Most recent (2017): 14% / 13% Target: 9% / 8%	**Jurisdiction** 55-64 Age Group Historical (2012): 12% Baseline (2017): 19% High School or Less Historical (2012): 15% Baseline (2017): 21% Household Income *Bottom 40%* Historical (2012): 21% Baseline (2017): 15%
Unmet Medical Care % of adults who did not get needed medical care (self-report)	**Jurisdiction** / **County** Historical (2012) 6% / 8% Most recent (2017): 9% / 11% Target: 4% / 6%	**Jurisdiction** 55-64 Age Group Historical (2012): 12% Baseline (2017): 16% High School or Less Historical (2012): 6% Baseline (2017): 13% Household Income *Bottom 40%* Historical (2012): 7% Baseline (2017): 11%
Unmet Mental Health Care % of adults who did not get needed mental health care (self-report)	**Jurisdiction** / **County** Historical (2012): <1% / 2% Most recent (2017): 3% / 3% Target: 0% / 0%	**Jurisdiction** 18-34 Age Group Historical (2015): 10% Baseline (2015): 10% College Graduate Historical (2015): 7% Baseline (2015): 7%
Objective: Increase the availability and accessibility of primary care providers, mental health providers, and substance abuse providers by December 31, 2022		
Mental Health Providers Ratio of resident to providers	**County** Historical (2014): 1000:1 Baseline (2016): 899:1 Target (WI2020): 597:1	NA
Primary Care Providers Ratio of resident to providers	**County** Historical (2011): 1861:1 Baseline (2014): 2076:1 Target (WI2020): 1240:1	NA
Dental Care Providers Ratio of resident to providers	**County** Historical (2012): 1891:1 Baseline (2015): 1726:1 Target (WI2020): 1563:1	NA
Objective: Provide Data to Measure Process and Outcome Measures by December 31, 2022		
Healthcare Access data TBD	TBD	TBD

*For these data, Jurisdiction represents residents of the Jurisdiction and County represents all residents of Racine County.

Strategies and activities for access to healthcare that drive the aforementioned indicator data are found in Table 10 (below). These are derived from CHIP Planning meeting participants and align with the *National Prevention Strategy* (NPS) and/or *What Works for Health: Policies and Programs to Improve Wisconsin's Health* (WWfH). These will be reviewed and referenced in the Annual CHIP Progress Report.

Table 10: Strategies and activities to increase access to comprehensive, quality healthcare across the lifespan by December 31, 2022

Improvement Strategies	Activities (Annual Review)	Lead / Partners	Policies to Explore
Explore a more integrated, effective health system through collaboration between clinical care and public health.	Convene meeting of partners Ensure community agencies understand current healthcare initiatives e.g. targeted outreach for chronic disease, 3.99 prescriptions program	**CRCHD / Primary Care Providers / PSG / FSR** Healthcare systems, human services, non-profits, insurers, Community Care Transitions Coalition, other	Bundled packages of home visits offered to insurers and clinicians in exchange for reimbursement
Promote use of primary care provider for all clients	Identify barriers to utilizing medical home Identify # of clients linked to primary care provider through urgent care and EDs Identify why people repeatedly return to urgent care and/or EDs Identify characteristics of east-end versus west-end users of free healthcare	**CRCHD / Primary Care Providers** Community agencies and partners identified in Appendix F including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	Provide advocacy at local and state level for access to care e.g. sliding scale for Medicaid/Badgercare recipients so they do not go on and off of healthcare
Obtain more detailed insurance coverage and access to the entire care continuum (from clinical preventive services to oral health care to long-term and palliative care).	Survey of providers Access detailed prevention and treatment coverage Explore perception of access versus reality i.e. relationship of insurance coverage to access and relationship of high deductibles to access Identify areas of need for health literacy (what plans cover)	**CRCHD / Providers** Community agencies and partners identified in Appendix F including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	TBD
Linking those in need with potential providers in a health assurance role (quality of care)	Continue navigator role (HSD) Utilize health care advocates and other programs which link people to insurance Implement care coordination Integrate resource guides and directories	**All agencies**	TBD
Promote early identification of mental health needs, substance abuse needs and/or and access to quality services	Participate in workgroups Participate in strategy teams Support school-based mental health clinics or other healthcare/school relationships	**C2MH and HWPP** Community agencies and partners identified in Appendix F including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	Provide advocacy to change Medicare policy which only pays for LCSW, not MSW or BSW Advocate for students to go into areas of needed practice/licensure
Explore public-private partnerships to implement community preventive services	Convene meetings with healthcare providers and community providers e.g. free care clinics, school-based health centers, other clinic models Continue to advocate for pediatric subscribers	**Schools / CRCHD / Healthcare** Community agencies and partners identified in Appendix F including providers, non-profits, healthcare, funders, schools, community centers, and coalitions	TBD
Improve availability of healthcare access data	Engage partners in dynamic process to identify data sources and gaps in descriptive healthcare access data Identify access at County and other facilities (crisis versus ongoing care)	**CRCHD** All partner agencies	TBD e.g. data sharing agreements

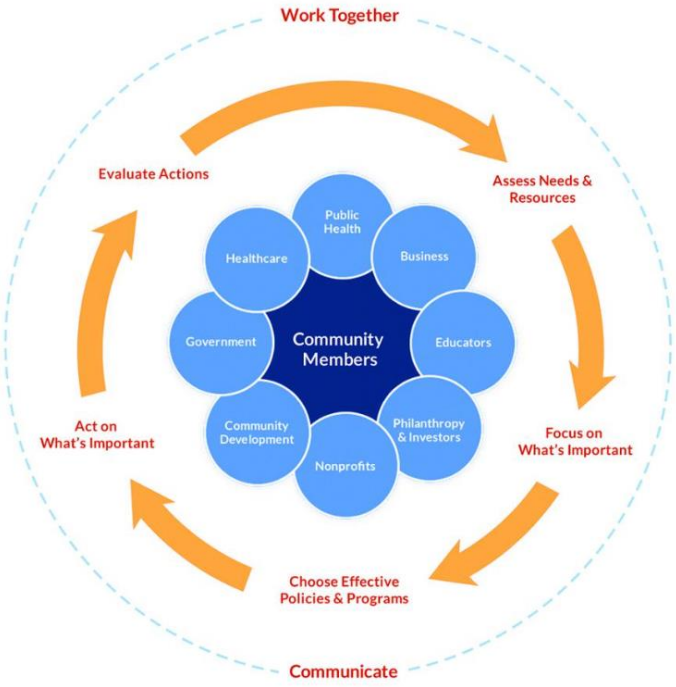
SECTION 4: CONCLUSIONS AND PROGRESS

This plan is both a product and an "ongoing process using science, quality improvement, partnerships, and large-scale community engagement" (Healthiest Wisconsin 2020). This plan is not meant to be a work plan for our health department, but rather a vision for the work that we want to accomplish together as a community. In addition, this plan does not include other ongoing strategies that the health department and community partners may be addressing such as injury prevention, toxic stress, infectious diseases, environmental hazards, and maternal/child health.

As with all public health issues, solutions to the identified priority health areas will not likely be singular or simple nor can they be addressed by public health agencies alone. We need our existing partners, partnerships and collaborations – as well as businesses, citizens and all manner of public and private agencies – to work together to "move the needle" on these challenging issues. As we move forward together, we will use various measures to understand and categorize change and successes in addressing these challenging issues.

Of course, data and statistics will be reviewed as they become available to evaluate for changes and improvements. Challenges that we anticipate will be the availability of relevant current data as many of the data sources can be 2-4 years delayed, and there are issues of access to Jurisdiction level data as well. Even with these challenges, data will be reviewed and analyzed during the implementation of this plan.

Additional facets of change will be reviewed to document progress. Improvements in the availability of, access to and progress of community services will be monitored and measured where possible. Importantly, developments and enhancements in community partnerships and community engagement will also be documented. We know that working together is the best way to improve our community for the future. Improvements in community partnerships and services are an important indicator of our ability to address the needs and challenges outlined in this plan, and thus attention will be given to progress in these areas.



We look forward to working together with you to make our community a healthier place for all!

APPENDICES

Appendix A: What is Health?

Appendix B: What is a Healthy Community?

Appendix C: Mental Health Information

Mental Health Strategies and Interventions, Barriers and Contributing Factors, and Assets and Resources

	Surveys and Key-Informants	CHIP Meeting Participants
Strategies and Intervention	More group homes More resource guides Employer, provider, community and mental health training Focus on schools: teach about mental health, bullying, suicide prevention; include parents Hire more providers, including for schools Increase public awareness Medication assistance Outreach teams Social media campaigns Multi-agency collaboration	Increase screening and education More work in schools Using social media Collaboration Training
Barriers and Contributing Factors	Lack of detoxification and rehabilitation facilities Lack of care following rehabilitation Lack of prescribing providers for treatment Multiples rehabilitation stints Co-morbidity: substance and mental health Increased access to drugs Over-prescribing of opioids Cost of treatment Lack of insurance Youth: lack of developmental assets	Too few school counselors – too narrow scope of practice Psychiatrist that can prescribe for <18-year olds Transportation Rural Areas
Assets and Resources	Large employers with resources Senior and Community Centers Recruitment of providers Increased awareness Non-profit services VA programs/services Hope Center (free counseling) Schools Healthcare systems Public Health Behavioral Health Services (BHS): SAIL National Alliance on Mental Illness (NAMI) Racine County Early childhood agencies	Racine Family YMCA (YMCA) School nurses, counselors and social workers School administration Behavioral Health Services (BHS) Family Service of Racine (FSR) United Way of Racine County (UWRC) Racine Community Foundations (RCF) Focus on Community (Focus) Racine County Aging and Disability Center (ARDC) Children's Collaborative for Mental Health (C2MH) HWPP grant for RUSD National Alliance on Mental Illness (NAMI) Racine County Health Care Network (HCN) Senior Centers Community Care Catholic Charities Lutheran Social Services (LSS) Professional Services Group (PSG) Churches Homeless Assistance Leadership Organization (HALO) Transitional Living Services, Inc. Racine County Home Visiting Network (RCHVN) Mental Health First Aid (RUSD) Love, Inc Partners2 Women's Resource Center Government boards and commissions
Suggested Policies		Fix Medicaid to annual versus monthly coverage to address gaps in coverage Recognize mental health as a diagnosis with coverage

Appendix D: Substance Abuse Information

Substance Abuse Strategies and Interventions, Barriers and Contributing Factors, and Assets and Resources

	Surveys and Key-Informants	CHIP Meeting Participants
Strategies and Intervention	More providers More treatment options More community supports Availability of treatment for those unable to pay Team approach/whole family Stiffer penalties for drug dealers More focus on prevention More family supports Increased understanding of science of addiction Community-based research Shared services/work together	Skill development (all age groups) More policy level support Increase sustainability of effects Convene funders with implementers – create this opportunity
Barriers and Contributing Factors	Lack of detoxification and rehabilitation facilities Lack of care following rehabilitation Lack of prescribing providers for treatment Multiples rehabilitation stints Co-morbidity: substance and mental health Increased access to drugs Over-prescribing of opioids Cost of treatment Lack of insurance Youth: lack of developmental assets	Funding Denial Knowledge of appropriate level of treatment Perception-media Diversion Programs Physician knowledge Lack of services/resources, especially west of Racine County Overprescribing opioids (dentists)
Assets and Resources	Racine County Home Visiting Network: Household Education and Referrals Focus on Community Racine County Youth Coalition: Opioid Prevention funding YMCA PREP and YLA Programs Some education at schools; law enforcement at some schools Medication Collection Dropbox program and DEA Medication Collection events Police/healthcare partnerships Prescription Drug Monitoring Program website for providers Counseling / treatment agencies Non-profits support groups / addiction support groups Behavioral and mental health providers / services Narcan use / Narcan providers Some business supports Health care/public health Legislators, churches, student groups, community centers, senior groups Drug/Substance Abuse Courts Employee Assistance Programs Law enforcement First responders	Focus on Community (Focus) Racine Family YMCA (YMCA) Behavioral Health Services (BHS) Family Service of Racine (FSR) United Way of Racine County (UWRC) Racine Community Foundations (RCF) Partners2 (P2) Health Care Network (HCN) Corrections, Ellsworth Correction Facility Healthcare Systems Rogers ANON, AA, support groups Recovery Community School nurses, counselors and social workers School administration Medication Assistance Treatment Employee Assistance Programs (EAP) Faith Community UW Extension Fire Departments/1st Responders Public Libraries 4H Racine County Youth Coalition (RCYC) Women of Worth -Ascension National Alliance on Mental Illness (NAMI) Lutheran Social Services (LSS) Health Care Network (HCN) Government boards and commissions

Appendix E: Chronic Disease Information

Chronic Disease Strategies and Interventions, Barriers and Contributing Factors, and Assets and Resources

	Surveys and Key-Informants	CHIP Meeting Participants
Strategies and Intervention	Health education Food pantries, farmer's markets Church programs Community education Medication delivery services Enroll more clients in MIH Expand affordable transport Increase access to affordable, healthy food Taylor messages and education by racial and cultural groups More nutrition education opportunities, including schools Neighborhood gardens Free cooking classes Increase awareness of obesity Social media: market programs Revitalize community centers Community activities /outreach	Strategies addressed for Mental Health and Substance Abuse Outreach Open schools to public for activity
Barriers and Contributing Factors	Unhealthy lifestyles Transportation issues Lack of knowledge of resources Expense of healthy eating and gym memberships Lack of motivation Under-funded programs Lack of stores with healthy options in high-poverty areas High stress Lack of time, including for healthy meal prep Lack of community center status Sedentary lives Technology use / time Cost of wellness programs or fitness memberships School funding cuts for physical activity Injuries Lack of nutrition education opportunities, including schools	Data west of Interstate 94 Access to primary care/specialty care Lack of prevention funding/lack of a belief that prevention is a priority Cost of care and medicine Trust Misinformation Lack of motivation/follow through even though they have knowledge Lack of accessible grocery stores
Assets and Resources	Food pantries, Meals on Wheels, grocery stores Supplemental Nutrition Assistance Program (SNAP) Home visiting education UW-Extension programs WIC Classes at health care agencies / wellness programs YMCA, other non-profits Healthcare and HMOs Local businesses, community centers, schools Fitness / recreation centers / bike trails / gyms / beaches Youth sports/activities Churches, home health agencies, businesses, government Support groups National Night Out programs Farmer's Markets and Neighborhood Gardens Head Start – Acelero Community Messaging	Healthcare systems and public health Health Care Network (HCN) YMCA and Recreation Departments School nurses, counselors and social workers School administration Data American Heart Association UW Extension Jane Kramer Foundation L.E. Tobacco Cessation Programs and other Programs American Cancer Society Relay 4 Life United Way of Racine County (UWRC) Racine Community Foundations (RCF) Focus on Community (Focus) Racine Family YMCA (YMCA) Behavioral Health Services (BHS) Family Service of Racine (FSR) Professional Services Group (PSG) Racine County Home Visiting Network (RCHVN) Government boards and commissions NAMI Businesses
Suggested Policies	Implement policies re: activity in school and childcare Utilize preventive strategies insurance will pay for Focus on childcare centers and food they serve Employers: workplace wellness to incentivize physical activity	

Appendix F: Access to Healthcare Information

Access to Healthcare Disease Strategies and Interventions, Barriers and Contributing Factors, and Assets and Resources

	Surveys and Key-Informants	CHIP Meeting Participants
Strategies and Intervention	Expand RX assistance programs Transportation access Assistance/education in healthcare enrollment Loan forgiveness (healthcare) Access to volunteer, free care Mobile medical units Appointments outside of normal business hours Program advertising Public/private partnerships Free health screenings Increased access to providers Increase in urgent care options (versus ED)	Place based services Transportation to healthcare Improve enrollment into insurance Increase awareness of available services
Barriers and Contributing Factors	Inability to afford medications Lack of investment in prevention Cost to access care: insurance, time off work, co-payments, medication costs, transportation Lack of providers / lack of specialty providers in some areas Lack of robust transportation system Low wages for healthcare workers Not accessible to all due to background checks	Mobile clinic (West) Comfortable places to access HC Institutionalization of HC Stigma of healthcare Transportation Unemployment Flexible appt hour Vaccines for adults Lack of trust Decrease in providers Long waiting list to see County providers – they are only seeing people in crisis
Assets and Resources	Community Messaging Preventive medical visits / healthcare Mobile Integrated Health (MIH). Two healthcare systems in county Free healthcare for uninsured / Health Care Network Aging and Disability Resources Center School nurse resources Mobile Integrated Health Two health departments Planned Parenthood Community collaborations	Health Care Network (HCN) Hospital Systems Mobile Clinic – east end Public Health Children's Hospital of Wisconsin School nurses, counselors and social workers School administration Seal-a-Smile Badgercare Nursing homes Aging and Disability Resource Center (ADRC) Community Care Immunizations Recovery community United Way of Racine County (UWRC) Racine Community Foundations (RCF) Focus on Community (Focus) Racine Family YMCA (YMCA) Behavioral Health Services (BHS) Family Service of Racine (FSR) Professional Services Group (PSG) Racine County Home Visiting Network (RCHVN) Government boards and commissions NAMI