2022-2024 Community Health Improvement Plan (CHIP)

SSM Health Ripon Community Hospital

Serving our community for 85 years

845 Parkside Street
Ripon, WI 54971
ssmhealth.com

SSM Health
Ripon Community Hospital

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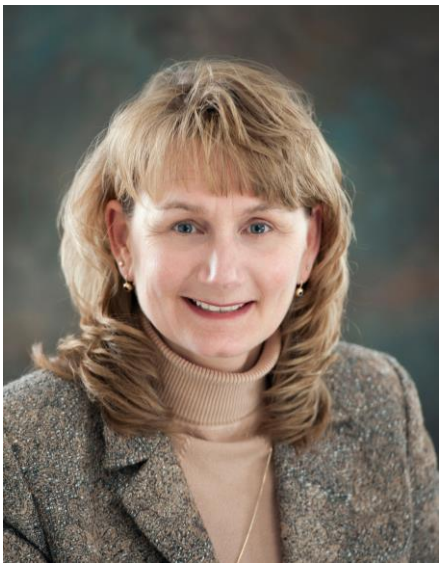
Message to our community



SSM Health Ripon Community Hospital has delivered exceptional, compassionate care for 86 years. Guided by our Mission - Through our exceptional health care services, we reveal the healing presence of God - we cherish the sacredness and dignity of each person as demonstrated through our Values of compassion, respect, excellence, stewardship, and community.

Our sustained community commitment can be seen through our collaborative partnerships with residents and organizations. We rely on these relationships to help us identify and develop plans to address high-priority community health needs.

Over the last 12 months, in collaboration with our community partners, we have conducted a community health needs assessment by gathering health-related information regarding Ripon and surrounding communities. We have also engaged with key health officials, conducted community discussion forums and/or focus groups) to identify concerns about the health of these communities and the number of area-based programs and organizations that exist to address their needs. These discussions identified needs that were prioritized based on the level of importance to community members and the hospital's ability to truly make an impact.

The priorities we will address over the next three years:

- Mental Health: provider availability, affordability, insurance, stigma, substance use, stress, suicide
- Chronic Disease: diabetes, cardiovascular disease, hypertension, obesity, food accessibility
- Substance Use: drugs (i.e. narcotics, marijuana), tobacco, and alcohol use

We will review these priorities using the following lenses:

- Health Equity: Each health area will apply a health equity lens to its initiatives, as well as incorporate initiatives that address social determinants of health, local community conditions, and a trauma informed approach.
- Social Determinants of Health (SDoH): SDoH are the conditions in which people are born, grow, live, work, and age. Access to care, social economic factors, cultural competency and other factors surfaced as common health concerns and were identified as a theme in barriers and challenges to good health.
- Trauma-informed care is grounded in an understanding of and responsiveness to the impact of trauma and creates opportunities to rebuild a sense of control and empowerment.

During this time, Ripon Community Hospital will further develop its community partnerships and deliver an exceptional experience through high-quality, accessible and affordable care to all residents. Please visit our website at ssmhealth.com to learn more about how we will continue to make a difference in our community.

I welcome your thoughts on how we can create a healthier Ripon community.

Sincerely,

DeAnn Thurmer
President
SSM Health Ripon Community Hospital

Who We Are – SSM Health

Ripon Community Hospital

Ripon Community Hospital has been providing quality health care with a personalized approach for 85 years. The facility features 16 private patient rooms, 13 medical/surgical and three intensive care rooms. Healing spaces, such as a meditation room and healing garden, have been incorporated into the hospital for patients and families to seek solitude and comfort. Care at Ripon Community Hospital is complemented by providers that specialize in taking care of patients while they are hospitalized. And emergency care and urgent care services are available 24 hours a day, seven days a week in the Emergency Department. Ripon Community Hospital is committed to providing medical care resources for the area's most vulnerable individuals through the Community Care program and by providing transportation for individuals to and from their providers' appointments. Ripon Community Hospital reaches out beyond its walls to benefit the community in several ways.

Our Services

- Ambulatory Infusion
- Anticoagulation Management
- Behavioral Health
- Cancer Care
- Cardiac Rehabilitation
- Cardiopulmonary Services
- Care Management
- Community Care Program
- Diabetes Services
- Domestic Violence Services
- 24/7 Emergency Department
- General Surgery
- Gynecology Services
- Hospitalists
- Imaging Services
    - Bone Density
    - Digital Mammography
- Intensive Care Unit
- Interpreter Services
- Laboratory Services
- Medical/Surgical Services
- Nephrology
- Orthopedics
- Pain Medicine
- Palliative Care
- Peripheral Artery Disease Rehabilitation
- Podiatry (Foot & Ankle)
- Pulmonary Rehabilitation
- Respiratory Care Services
- Ripon Wellness Center
- Special Diet Mobile Meal Program
- SSM Health at Work
    - Alcohol & Drug Testing (including DOT)
    - Corporate Consulting
    - Drug Screen Collection Site
    - Employee Assistance Program
    - Employee Physical Exams
    - Health Programs & Screenings
    - Health Risk Appraisal
    - Hearing Screenings
    - Occupational Medicine
    - Wellness Programs & Coaching
    - Work Injury Care Services
- Surgical Services & Ambulatory Care/Day Surgery
- Swing Beds
- Therapy Services
    - Athletic Training Services
    - Dry Needling
    - 24/7 Fitness Center
    - Outpatient Rehabilitation
- The Foundation for Ripon Medical Center
- Urgent Care
- Urology
- Volunteer Services

Executive summary

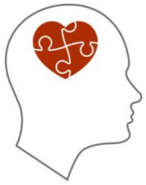
Background

SSM Health Ripon Community Hospital is pleased to present the 2022-2024 Community Health Improvement Plan (CHIP). The Affordable Care Act (ACA) requires 501©(3) tax-exempt hospitals to conduct a Community Health Needs Assessment (CHNA) every three tax years. Additionally, it is required to adopt a ic im lementation plan for addressing the identified needs as a result of the -2024 CHIP document will serve as the living document and strategic action plan to address the top three health priorities in our service area.

Priorities

The top three identified health priorities we will address over the next three years include:

Mental Health



i.e. provider availability, affordability, insurance, stigma, substance use, stress, suicide

Chronic Disease

i.e. diabetes, cardiovascular disease, hypertension, obesity, food accessibility

Substance Use

i.e. drugs (i.e. narcotics, marijuana), tobacco, and alcohol use

We these priorities using the following lenses:

- **Health Equity:** Each health area will apply a health equity lens to its initiatives, as well as incorporate initiatives that address social determinants of health, local community conditions, and a trauma informed approach.
- **Social Determinants of Health (SDoH):** SDoH are the conditions in which people are born, grow, live, work, and age. Access to care, social economic factors, cultural competency and other factors surfaced as common health concerns and were identified as a theme in barriers and challenges to good health.
- **Trauma-informed care** is grounded in an understanding of and responsiveness to the impact of trauma and creates opportunities to rebuild a sense of control and empowerment.

Strategies

The hospital will collaborate with community partners to leverage available resources, expertise, and capacity to collectively address the health priorities identified. Strategies for priority needs may include but are not limited to the following:

- Mental Health: increase mental health resources, expand local mental health crisis services, mental health crisis response trainings, trauma-informed care, coping skills training, suicide prevention
- Chronic Disease: increase access to physical activity opportunities, chronic disease management classes, increase access to food
- Substance Use: drug drop boxes, alcohol compliance checks, naloxone education and distribution

Resources for Evidence-Based Strategies

- What Works for Health: https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health
- Robert Wood Johnson Foundation: https://www.rwjf.org/en/library/collections/health-policy-in-brief.html
- Healthy People 2030: https://www.healthypeople.gov/2020
- ASTHO: https://www.astho.org/Programs/Evidence-Based-Public-Health/
- The Community Guide: https://www.thecommunityguide.org/

Introduction

Acknowledgements

Thank you to everyone who participated in the development of the Community Health Improvement Plan (CHIP). We would like to give a special thank you to the following groups and organizations who d d tim d efforts in developing the CHIP:

- Healthy Fond du Lac County Steering Committee
- Drug Free Communities of Fond du Lac County (DFC)
- Comprehensive Services Integration of Fond du Lac County, Inc. (CSI)
- Living Well FDL Coalition

Full list of community partners, individuals, and organizations that have assisted throughout the community health improvement process is located in Appendix A.

Considerations

The COVID-19 pandemic impacted almost every aspect of our lives, affected jobs, transportation, social interactions, and perhaps most significantly, our health. The effects of COVID-19 can been seen in various health outcomes, described in the 2021 CHNA (Appendix B).

Due to the ongoing COVID-19 presence and impact, it should be considered that the goals and objectives may be adjusted due to COVID-19 restrictions, capacity of community stakeholders and organizations and the ability for community engagement. We may see challenges and opportunities to learn and adapt our strategies, policies, and outreach initiatives to better address the evolving health needs of the communities we serve. The impacts of the pandemic will not disappear when COVID-19 cases do; efforts must continue to push toward our goal of ensuring equitable health opportunities for all people.

Community Health Improvement Process Overview

Community Health Improvement Process

Since 1993, Wisconsin State Statutes have required communities throughout Wisconsin to develop and implement local health plans to nditions affecting their residents. This process is the "community health improvement process. This process has two major phases: the CHNA and CHIP. These two processes work together to assess the unique needs of communities and allow public and private sectors to work collaboratively to address the identified health needs.

The development of our CHNA and CHIP, have followed guidelines and processes from WI Guidebook on Improving the Health of Local Communities, which is built on the Take Action Cycle (Figure 1) by County Health Rankings and Roadmaps. The CHNA aligns with the Assess Needs and Resources and identifying our Focus on What's Important component of the cycle. The CHIP aligns with Choosing Effective Policies & Programs, Act on What's Important and Evaluating Actions.

Figure 1: Take Action Cycle

Assess Needs and Resources

alyze community health data

- Consider data to analyze health disparities
- Examine data on the underlying determinant of health
- Consider issues and themes identified by stakeholder and the community
- Identify community assets and resources.

Focus on What's Important

- Identify set of priority community health issues to address
- Align the local health improvement plan with state and national priorities
- Summarize and disseminate the results of the assessment to the community

Choose Effective Policies and Programs

- Engage partners to plan and implement strategies
- Choose effective strategies
- Have multilevel approaches to change, including policy approaches

mportant

a detailed Action Plan

- Use a work plan to actively track progress
- Maintain momentum

Evaluate Actions

- Evaluate and monitor the process and the outcomes/indicators
- Revise the action plan based on evaluation results

Work Together and Communicate: Collaborate with Stakeholders and Community Members Throughout

- Include broad participation from the community
- Actively involved stakeholders throughout the process

Community Health Improvement Process Overview

Community Health Improvement Plan (CHIP)

Fond du Lac County stakeholders and community members came together through various coalitions, committees, and work groups to develop the 2022-2024 Community Health Improvement Plan (CHIP) in response to the community health priorities identified through the 2021 CHNA. The Healthy Fond du Lac County Steering Committee identified three health priorities based on a two-step prioritization process. A list of criteria was developed to aid in the selection of priority areas, which included:

- Affects many people
- Has a serious impact on population health
- Actionable at the local level
- Attainable/realistic ability to be impacted in three to five years
- Viable strategies exist to impact the issue
- Ability to have measurable outcome to see impact
- Community capacity and willingness to address it
- Trending health concern; shows up as a theme in community conversations, interviews, public input survey, or other data presented

Based on the steering committees final prioritization, the top-ranking priorities established the health areas of focus for the 2022-2024 CHIP.

The Top Three Priority Health Areas Identified for the 2022-2024 CHIP Include:

Health

i.e. provider availability, affordability, insurance, stigma, substance use, stress, suicide

Chronic Disease

e. diabetes, cardiovascular disease, hypertension, obesity, food accessibility

Substance Use

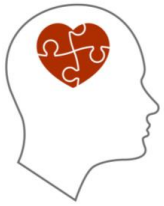
i.e. drugs (i.e. narcotics, marijuana), tobacco, and alcohol use

The Healthy Fond du Lac County Steering Committee also noted that social determinants of health, and access to care were themes identified as barriers and challenges to good health throughout the assessment process. A health equity lens will be applied throughout the development of the CHIP which will influence health outcomes among the three priority health areas.

The CHIP is a three-year plan, intended to be a community effort and remain fluid to allow for the greatest community impact. The CHIP was developed in collaboration with the Fond du Lac County Health Department, Healthy Fond du Lac County Steering Committee, CSI, DFC, Living Well FDL Coalition and other community partners. The three-year CHIP should include evidence-informed strategies, multi-level approaches to change, emphasizing policy level change and addressing equities and disparities. Throughout the CHIP a health equity lens should be applied to ensure equal and equitable access to health and wellbeing for everyone. Additionally the CHIP should include strategies utilizing the Socio-ecological model, which is a complex interplay between individual, relationship, community and societal factors that impact health, and consider strategies from a Primary Prevention, Secondary and Tertiary Prevention lens. These models and frameworks can be found in Appendix C. The highlights and accomplishments of the past 2018-2020 CHIP can be found in Appendix D.

Best practice for strategy development with our community partners typically requires an estimated six months to create SMART objectives and strategies to meet the needs around our community identified health priorities. Due to federal requirements and timelines for non-profit hospitals, this CHIP version (February 2022) serves as a foundational CHIP document. Proposed goals, strategies and inputs are based on initial conversations and brainstorming with community stakeholders and committees. We will continue to collaborate with our county coalitions and partners for further strategic development of goals, objectives, strategies, outcome measurements and evaluation metrics. The CHIP is a living document and updates on the CHIP can be shared with our hospital, stakeholders and community members annually or as requested.

CHIP – Strategic Planning



Priority 1: Mental Health

Priority Action Team:
Comprehensive Service Integration of Fond du Lac County, Inc. (CSI)
www.csifdl.org

According to the World Health Organization, the definition of health is a "State of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." (2014) Mental health is something we all have, and it varies in its degree from time to time. there is a significant impact on our thinking, feeling and/or behavior that treatment services or intervention may be required. In general, the sooner one gets treatment, the better the outcome. Having an untreated mental disorder can create serious problems such as increasing the chance of risky behaviors, drug or alcohol addiction, and in extreme cases, death. It also can ruin relationships, cause problems at work, and make it difficult to overcome serious illnesses.

Mental Health was identified as the number one priority to address as a result of the 2021 CHNA. Mental health needs in Fond du Lac County may include, but is not limited to challenges, barriers or needs related to provider availability, affordability, transportation, insurance, stigma, substance use, culturally sensitive and diverse providers and services, stress, and suicide.

Mental Health Data Overview

20 deaths by suicide reported in Fond du Lac County in 2020.
1 in 5 adults reported to have a mental health condition in the past three years.
1 in 5 youth reported they always or nearly always felt sad, blue or depressed in th
ed children with mental illness in Fond du Lac County
79% adults report to have their mental health condition under control (down from 96% in 2017)

Mental Health Goals

Goal 1: Decrease the number of deaths by suicide in Fond du Lac County

Performance Measures/Objectives:

- FDL County deaths by suicide
- Percentage of FDL County adults who report they "considered suicide"
- Percentage of FDL County youth who report they "seriously considered suicide"

Strategies:

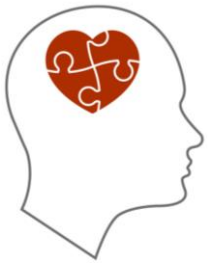
- Expand trainings for Question, Persuade, Refer (QPR), Mental Health First Aid for Adults (MHFA), Youth Mental Health First Aid (YMHFA). Explore additional trainings and programs for suicide prevention and mental health →
    - Potential new partners and collaborations: Businesses and employers

  Some evidence. Community Focus. Likely to decrease disparities
- Increase means for data collection, monitoring and evaluation of mental health needs, with community partners such as DCP, and public safety departments.
- Research universal and individual screening tools for behavioral and mental health needs across the lifespan and develop a plan to assess and expand SBIRT at the Ripon Community Hospital →

  Scientifically supported. Healthcare providers and community focus. Likely to decrease disparities

Why this matters: It is critical to ensure health care providers are equipped with best practices in identifying and responding to individuals who may be suicidal. Utilizing screening tools, providing professional trainings, and ensuring protocols for various settings in responding to individuals who are suicidal are important for systems to prevent suicide. It is also important to increase the public's knowledge of risk factors for suicide, ability to recognize warning signs of suicide and how to respond. Everyone can have a role in preventing suicide.

Continued, CHIP – Strategic Planning



Priority 1: Mental Health

Mental Health Goals

Goal 2: Increase access to behavioral health services

Performance Measures/Objectives:

lts who report that they or someone in their household "did not get the mental health care needed"

- Percent of adults who consider someone seeing a therapist or psychiatrist as a sign of strength
- Percent of adults who consider taking medication to treat a mental health issue as a sign of strength *(note: the 2017 question related to this was percentage of adults who agree that "people are caring and sympathetic towards persons with mental illness"*

Strategies:

- Increase Mental Health/Behavioral Health services and access to them. Potential steps could include:
    - Identify barriers and gaps in accessing services (i.e. transportation, financial, continuum of care) and current services
    - Telehealth
    - School-based programs/services
    - Crisis line
    - Mobile Crisis Unit
    - MH Co-Response models with law enforcement
    - NAMI
    - Infant/maternal health, SPROUT

      nce education and literacy. Shared resources with businesses for increasing equitable health, healthcare insurance coverage. Increase businesses providing health services, and trauma informed practices.
- Increase Mental Health resources and navigation tools (i.e. Pathways to Care Mental Health Navigation Tool, and Got Your Back App)
- Develop more universal approach to safety planning across the county (i.e. document with common language and format that can be used across populations and settings)
- Decrease stigma, campaigns, awareness, TIC, ACEs, build community

Health Equity Lens:

- Cultural competencies, language barriers to access services (resources-online & print, appointments, etc.), representation among providers that reflect the community, etc.
- Connect with populations impacted more by mental health

Assets and Resources

School-based programs (i.e. Fondy CARES)
Youth and adult screening programs in school and healthcare settings
Fond du Lac Family YMCA and Boys & Girls Club programs
National Alliance on Mental Illness (NAMI) Fond du Lac - Friendship corner center
Comprehensive Service Integration (CSI) of Fond du Lac County
Pathways to Care Mental Health Navigation Tool
Fond du Lac Area Mental Health Providers
United Way and 2-1-1 resources
Department of Community Programs (DCP)
First responders (e.g. EMS, law enforcement)
School districts & Universities
Senior centers
Churches, faith-based community
Lakeland Care
SSM Health
Aurora Health Care
Rawhide Youth Services (Equine Therapy)
SHARDS, Inc.
Delta Center
Solutions Center
Berry House
UW Extension – Youth Development

Continued, CHIP – Strategic Planning

Priority 2: Chronic Disease

Chronic diseases are illnesses that last a long time, do not go away on their own, are rarely cured, and often result in disability later in life. Multiple health conditions are classified as chronic diseases such as high blood pressure, high cholesterol, heart disease, obesity, diabetes, asthma and more. Nutrition and physical activity are important to maintain and improve overall health and both play a prominent role in obesity prevention and control. As established in the U.S. Dietary Guidelines (2005), good nutrition includes meeting nutrient recommendations yet keeping calories under control. Physical activity means any bodily activity that enhances or maintains physical fitness and overall health.

Priority Action Team:
Living Well Coalition
Fond du Lac County Health Department
P: 920-929-3085

Obesity is one of the most critical health issues of our time and is a complex health issue resulting from many interacting causes and factors in our society, behavior, and genetics. Obesity is also associated with poorer mental health outcomes and reduces quality of life. The burden of obesity and other diet-related chronic diseases are vast, and rates continue to rise. Changes at the community level, such as policies, systems, and environment, are more likely to be effective, although they may be more difficult to achieve.

According to Fond du Lac community members responses throughout the assessment, common barriers and challenges to chronic diseases and related health behaviors included, but not limited to, access and affordability to healthy foods, awareness of nutritious food and cooking healthy meals, access to indoor and outdoor recreation, access and affordability of healthcare services. insurance, stigma, transportation, and cultural competencies.

Chronic Diseases Data Overview

#1 – Heart diseases is the number one cause of death among adults
75% (3 in 4) adults were classified as at least overweight
About 1 in 3 youth were classified as at least overweight
52% of adults reported meeting aerobic physical activity guidelines
23% of adults reported eating the recommended servings of fruit per day
17% of youth reported eating the recommended servings of fruit per day
4,920 (6%) households reported they went hungry because they couldn't afford enough food

Chronic Disease Goals

Goal 1: Increase the number of Fond du Lac County residents living at a health weight for their height through healthier eating and more physical activity.

Performance Measures/Objectives:
- Percent of obese FDL County adults
- Percent of overweight/obese FDL County youth

Strategies:
- Research and identify chronic disease prevention and self-management classes.

Why Physical Activity Matters: Regular physical activity helps improve overall health and fitness, and reduces the risk for many chronic conditions, like heart disease, type 2 diabetes, obesity, and some cancers.

Goal 2: Increase Physical Activity

Performance Measures/Objectives:
- Percent of adults engaging in recommended amount of PA
- Percent of youth meeting recommended amount of PA

Strategies:
- Increase trail usage, enhance bike and pedestrian master plans → Some evidence. Community Focus. No impact on disparities likely
- Implement a physical activity campaign → Some evidence. Community focus. No impact on disparities likely
- Increase schools participating in safe routes to school
- Identify existing efforts and assess impact → Scientifically supported. School based focus. No impact on disparities likely

Continued, CHIP – Strategic Planning

Priority 2: Chronic Disease

Chronic Disease Goals

Goal 3: Increase Fruit and Vegetable Consumption

Performance Measures/Objectives:

- Percent of adults eating the recommended fruits/vegetables daily
- Percent of youth eating the recommended fruits/vegetables daily

Strategies:

- Increase SNAP usage (i.e. at Farmers Market)
- Increase access to and affordability of fruits and vegetables (i.e. incentive programs, EBT at farmers markets)
    - (i.e. increase pounds of produce donated at farmers markets)
- Assess current food forests or community/shared gardens and increase value/impact
- Increase health promotion programs offered to low-income housing residents.

Scientifically supported and expert opinion. Community focus. Likely to decrease disparities.

Expert opinion. Community focus. Likely to decrease disparities.

Expert opinion/some evidence. Community focus. Urban agriculture likely to decrease disparities.

Scientifically supported. Community and low-income housing focus. Urban No impact on disparities likely

Why Fruit and Vegetable Consumption Matter: *Eating an adequate amount of fruits and vegetables as part of an overall healthy diet can help protect against many chronic diseases, including obesity, heart diseases, type 2 diabetes, and some cancers. Communities can help individuals consume more fruits and vegetables by making them convenient and affordable in the places where people live, learn, work and play. This is particularly important for individuals and families that face food insecurity or lack access to stores selling quality produce at reasonable prices. Increase access to fruits and vegetables through the food forest initiative (urban agriculture and community gardens). Community gardens improve access to and consumption of fruits and vegetables. They are suggested to improve food security and increase fruit and vegetable availability in food deserts. Food forests are edible landscapes in community settings. They are intended to increase access to fruits and vegetables and the increase availability of healthy food in food deserts and suggested to reduce hunger and obesity.*

Goal 4: Increase Breastfeeding

Scientifically supported and expert opinion. Community focus. Likely to decrease disparities.

Performance Measures/Objectives:

- Percent of WIC infants ever breastfed

Strategies:

- Increase number of childcare centers and business centers who have adopted the Ten Steps to Breastfeeding-Friendly Toolkit *(Promote support for breastfeeding mothers in the workplace, early childhood education settings, and throughout the community. Expected outcomes include increased breastfeeding rates and improved health outcomes.)*

Health Equity:

- Mothers of color have higher rates of teen births, low-birth rates, and infant mortality.

Why Breastfeeding Matters*: Breastfeeding is the recommended nutrition for infants due to short- and long-term benefits for both babies and mothers. Some of the benefits of breastfeeding for infants include a reduced risk for obesity and diabetes. Some of the benefits of breastfeeding for mothers include a reduced risk of type 2 diabetes, breast cancer, and ovarian cancer.*

Assets and Resources

Senior Centers
YMCA
School Districts
Boys and Girls Club
Big Brothers Big Sisters
EAP services & businesses
FABOH
Farmers markets
Community gardens
Foodshare/EBT
Women, Infants and Children (WIC) program
Senior dining program and Meals on Wheels
Nutrition education programs (UW-Madison Extension)
Living Well FDL Coalition
CSI – Physical Health Element
UW Extension - Agriculture
SSM Health
Universities

Continued, CHIP – Strategic Planning

Priority 3: Substance Use

DRUG FREE COMMUNITIES
Fond du Lac County

Priority Action Team:
Drug Free Communities
of Fond du Lac County (DFC)
P: 920-906-6700 Ext 4704

Alcohol and other drug use means any use of a substance that result in negative consequences. This includes a broad array of mood-altering substances such as, alcohol, tobacco, prescription substances, and illegal substances like methamphetamine and heroin. Negative consequences or unhealthy uses include, but are not limited to, operating a motor vehicle while intoxicated, drinking while pregnant, alcohol dependence, fetal alcohol spectrum disorder, alcohol-related hospitalizations, and more. (Healthiest Wisconsin 2020 profile, 2010)

Substance use was identified as the number three priority to address in the 2022-2024 CHIP. Substance use needs in Fond du Lac County may include, but is not limited to barriers, challenges and needs related tobacco, vaping, drugs (narcotics, marijuana, etc.), prescription medications, and alcohol use, mental health and access to care. Throughout the Community Health Needs Assessment, substance use was consistently ranked as a top priority.

Alcohol and Other Drug Use Data Overview

25 opioid related deaths in Fond du Lac County in 2020. Over double the deaths from 2019
74% of adults reported drinking alcohol in the past month
22% of youth reported drinking alcohol in the past month
37% of adults reported *binge drinking alcohol in the past month
**Binge drinking is defined as 4+ drinks per occasion for women and 5+ drinks per occasion for men.*
37% of adults reported binge drinking alcohol in the past month

Substance Use Goals

Goal 1: Decrease underage drinking and binge drinking

Performance Measures/Objectives:

- Percent of youth who drank alcohol in past 30 days
- Percent of youth who report binge drinking in past 30 days
- Percent of youth who bought or drank alcohol at a community event
- Percent of youth who report the community is actively discouraging alcohol use by youth in a way products are advertised, promoted or sold
- Percent of adults who report binge drinking in past 30 days
- Percent of youth who report they talked with their parents about alcohol in past 30 days

Strategies:

- Increase festivals evaluated annually using the Community Events Best Practices Toolkit → Evidence-based. Community focus. No impact on disparities likely
- Increase number of law enforcement agencies completing annual compliance checks
- Alcohol Outlet density (DFC) → Scientifically supported. Alcohol retailers. No impact on disparities
- Awareness and education campaign (small talks) (DFC)

Continued, CHIP – Strategic Planning

Priority 3: Substance Use

Goal 2: Decrease misuse of opioids/prescription medications

Performance Measures/Objectives:

- Percent of youth who report using prescription medication for non-medical use
- Percent of youth who report relative ease in obtaining prescription medication for non-medical use
- Number of opioid-related overdose deaths in FDL County

Strategies:

- Increase number of Narcan trainings and kits distributed (FDL Co HD) → Some evidence. Community Focus. Likely to impact disparities
- Syringe services program (FDL Co HD)
- Prescription medication prescribing practices and pain management (SSM)
- Prescription medication disposal (DFC, SSM)

Assets and Resources

Drug Free Communities Fond du Lac County Coalition
- Underage drinking prevention; i.e. wrist banding at fairs, community events best practices

Engagement within schools
- Programs like Anti-Crime Education (ACE)
- YScreen, school resource officers
- Connections to AODA Counselors

Media coverage on resources and concerns

Telehealth appointments
- Convenient and increase accessibility

Community Medical Services (CMS)

Drug Court (diversion program and provides connections to treatment services)

Department of Community Programs of Fond du Lac County

Release Advance Planning (RAP) program
- Connects inmates with services
- Vivitrol program to prevent relapse

Local treatment providers

Strong recovery community in FDL and local support groups
- Gratitude Club
- Family resource center

Tobacco Free Living Coalition

Naloxone (Narcan) Distribution and Education

Mahala's Hope

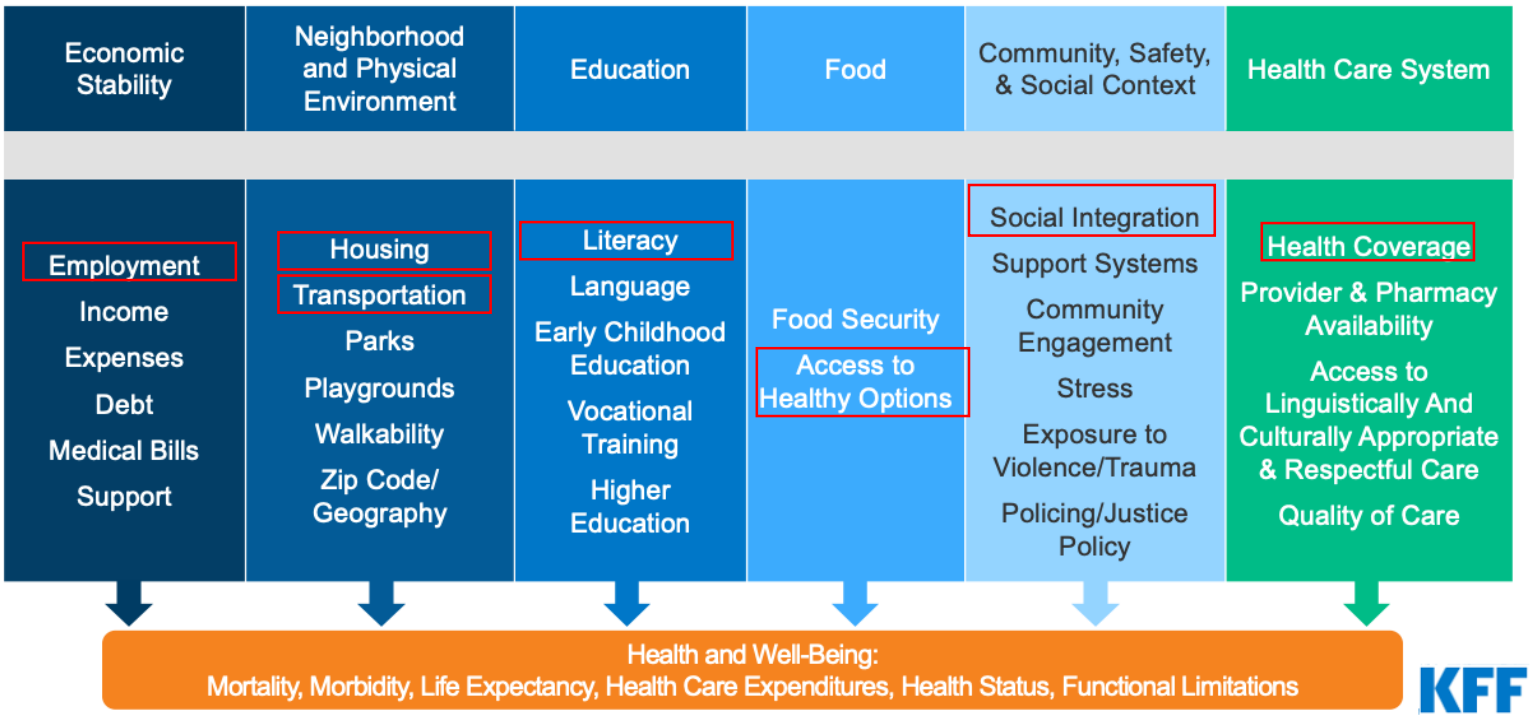
Beacon House

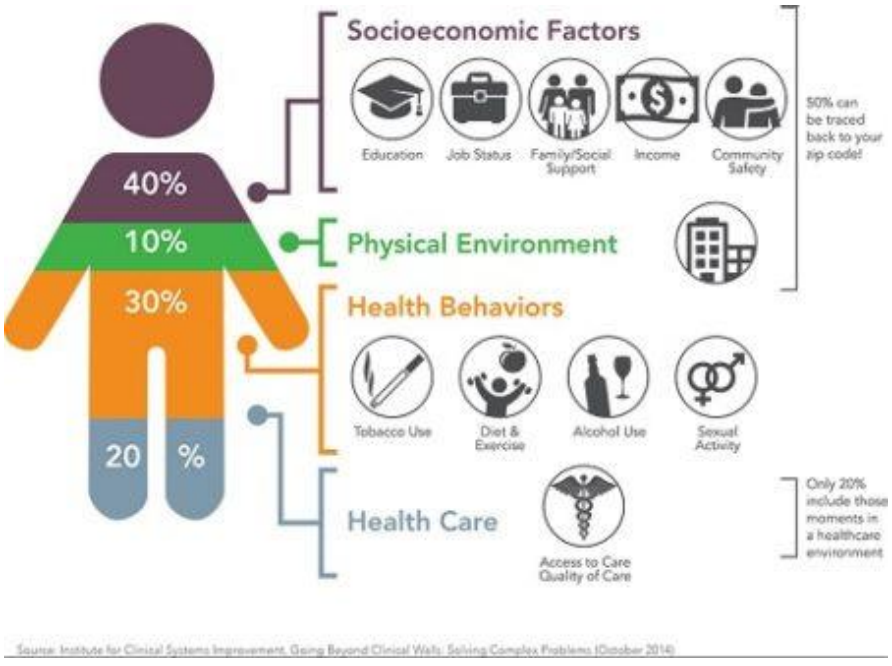
Blandine House

SSM Health

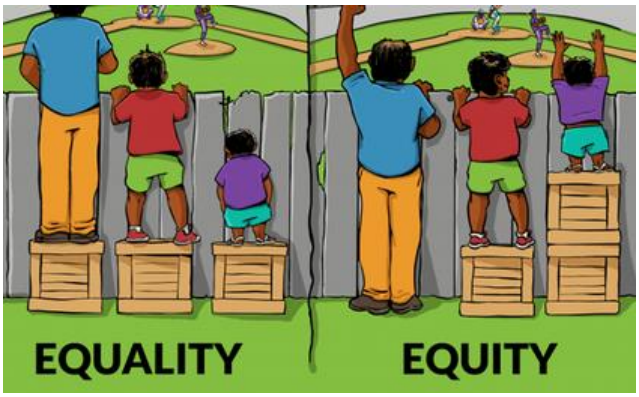
Social Determinants and Social Needs Lens

The social determinants of health (SDoH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Examples of these factors include safe and affordable housing, access to quality education, public safety, availability of healthy foods, accessible health care services, and positive social support systems. Research shows that the social determinants can be more important than health care or lifestyle choices in influencing health. For example, numerous studies suggest that social determinants account for between 30-55 percent of health outcomes. By applying what we know about SDOH, we can not only improve individual and community health but also advance health equity. Below show models of SDoH and in the red box indicates common SDoH challenges and barriers to health throughout the CHNA.





Health Equity Lens



Equality vs Equity – by the interaction for Social Change l Artist: Angus Maquire. Image Found: interactioninstitute.org

Equity is defined as "the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically" (WHO, 2016). Health is a fundamental human right. Therefore, to address health inequities, interventions need to be effective and sustainable, and focused on empowering those experiencing inequities. A characteristic common to groups that experience health inequities—such as poor or marginalized persons, racial and ethnic minorities, and women—is lack of political, social or economic power. Research indicates a strong relationship between self-reported racism and discrimination with negative mental health outcomes and negative health-related behaviors. Research also indicates that chronic stress from experiencing discrimination, such as racism, throughout the lifespan can lead to negative health outcomes. These outcomes are seen even after controlling for differences such as socio-economic status and access to adequate health care. The effect can include the following: Higher blood pressure, lower immune function, higher rates of nicotine and alcohol use and poor nutritional intake, lower rates of exercise and social support, higher rates of infant mortality.

Health inequities stem from differences in an individual's social determinants of health, such as housing and employment conditions, and economic or social disadvantages. Minorities and people of color have long experienced racism, discrimination, and exclusion from society, creating inadequate access to key opportunities that persists today.

Equity and Empowerment Lens:
In a person-driven system, all partners at all levels align around transformative values, relationships and goals moving towards racial equity, integrative an emphasis on doing less harm and supporting actions that heal and transform.

2022-2024

Appendices

SSM Health Ripon Community Hospital

845 Parkside Street, Ripon WI 54971

Appendix A: Acknowledgements and Community Partners

Full list of community partners, individuals, and organizations that have assisted throughout the community health improvement process.

Aaron Goldstein, Fond du Lac Police Department
Alexandria Berg, SSM Health Greater Fond du Lac Region
Alicia Hans, Comprehensive Service Integration of Fond du Lac County Mental Health Access Committee
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Catherine Wirkus, Fond du Lac County Health Department - RAP Program
Cathy Loomans, Fond du Lac Senior Center
Chelsea Monroe, Fond du Lac Department of Community Programs
Community Table, Waupun
Dan Hebel, Boys and Girls Club of Fond du Lac
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Eric Toney, Fond du Lac County
Erin Brendelson, Fond du Lac School District
Erin Gerred, Fond du Lac County
Fond du Lac Boys & Girls Club
Fond du Lac Public Library
Fond du Lac Pride Alliance
Gratitude Club, Fond du Lac
Heather Schmidt, DO, SSM Health Greater Fond du Lac Region
Hiram Rabadan-Tores, Latinos Unidos
Jaclyn Jaeckels, Fond du Lac ADRC
Jeff Butz, Fond du Lac Area Businesses on Health (FABOH)
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Jennifer Walters, Aurora Health Care
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Lori Schrage, Moraine Park Technical College
Louise Gudex, Fond du Lac Housing Authority
Maria Turner, Fond du Lac Areas Women's Fund
Marian Sheridan, Fond du Lac County Board of Health
Marty Ryan, Fond du Lac County Board, Board of Health & Rotary
Megan Hyland, Lakeland Care
Molly Jaster, Fond du Lac Area Foundation
NAMI FDL
Renee Weier, SSM Health St. Agnes Hospital
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Sacred Heart School, Fond du Lac
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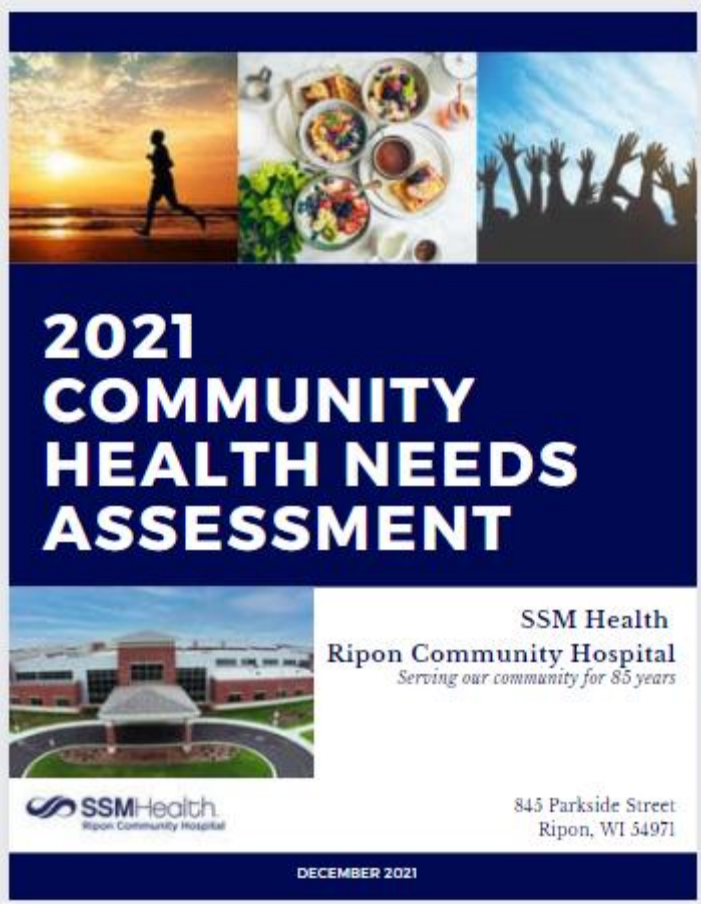
Sarah Van Buren, Waupun Aging Coalition
Shoua Vang, Hmong Association
Solutions Center, Fond du Lac
SSM Health St. Agnes Hospital, Fond du Lac
Vicente Lezama Morales, Latinos Unidos
Village Grounds, Rosendale

Appendix B: Community Health Needs Assessment Reports

The SSM Health Ripon Community Hospital is pleased to share the 2021 Community Health Needs Assessment (CHNA). The SSM Health Ripon Community Hospital partnered with the Fond du Lac County Health Department and Healthy Fond du Lac County Steering Committee and other community organizations and stakeholders to develop the 2021 CHNA.

The purpose of a CHNA is to identify and address health needs in order to improve the health outcomes in our communities. The CHNA included a comprehensive collection and analysis of data and community perspectives to identify health issues of primary concern, and is key to developing strategies to address the community's health needs, monitor health trends, and build strong communities. Data was collected through multiple methods including two surveys with nearly 1,000 responses total, 37 one-on-one interviews, 16 community conversations with several populations and organizations, as well as other secondary sources.

As a result of this Community Health Assessment Process, three health priorities were identified. For the full CHNA Report for Ripon Community Hospital, please visit SSM Health's website or https://www.ssmhealth.com/resources/about/community-health/community-health-needs-assessments



Appendix C: Additional Models and Lenses Used to Develop the 2022-2024 CHIP

Levels of Prevention – Moving Upstream

Upstream – Determinants Of Health

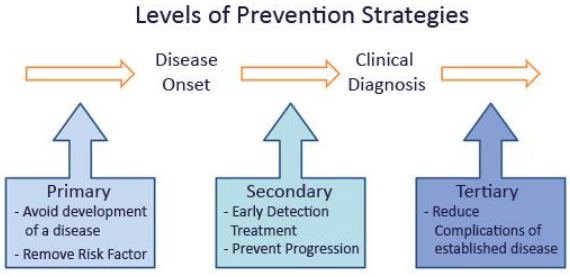
Downstream – Disease & Disability

What is Prevention? Prevention activities are typically categorized by the following three definitions.

- Primary Prevention—intervening before health effects occur, through measures such as vaccinations, altering risky behaviors (poor eating habits, tobacco use), and banning substances known to be associated with a disease or health condition.
- Secondary Prevention—screening to identify diseases in the earliest stages, before the onset of signs and symptoms, through measures such as mammography and regular blood pressure testing.
- Tertiary Prevention—managing disease post diagnosis to slow or stop disease progression through measures such as chemotherapy, rehabilitation, and screening for complications.

This model will be considered and utilized throughout the 2022-2024 CHIP.

An example of Levels of Prevention



Continued, Appendix C: Additional Models and Lenses Used to Develop the 2022-2024 CHIP

Socio-Ecological Model

The Healthy People 2020 and many community, state, national and international organizations utilize and have adapted this models for their programs and interventions. According to Healthy People 2020 Framework, health and health behaviors are determined by influences at multiple levels, including personal (i.e., biological, psychological), organizational/institutional, environmental (i.e., both social and physical), and policy levels. Because significant and dynamic inter-relationships exist among these different levels of health determinants, interventions are most likely to be effective when they address determinants at all levels. Historically, many health fields have focused on individual-level health determinants and interventions. Healthy People 2020 should therefore expand its focus to emphasize health-enhancing social and physical environments. Integrating prevention into the continuum of education—from the earliest ages on—is an integral part of this ecological and determinants approach. This model will be considered and utilized throughout the 2022-2024 CHIP.

A Social-Ecological Model for Physical Activity - Adapted from Heise, L., Ellsberg, M., & Gottemoeller, M. (1999)

Appendix D: 2018-2020 CHIP Review

The 2018-2020 Community Health Improvement Plan included three priority health areas with two additional overarching goals. Below displays the priority health area goals, performance measures and highlights over the past three years. New overarching Goals in 2018 included Trauma-Informed Care (TIC) and Social Determinants of Health (SDOH). Goals involved were to increase awareness of TIC and SDOH in shaping health outcomes.

Priority 1: Nutrition & Physical Activity

Goal Statement: Increase the number of Fond du Lac County residents living at a healthy weight for their height through eating healthier and being more active.

Performance measures	2021 Goal	2017 Baseline	2018	2019	2020
Percentage of Fond du Lac County adults engaging in the recommended amount of physical activity	29%	24%	n/a	n/a	21%
Percentage of Fond du Lac County youth meeting the physical activity recommendation of 60 minutes every day	26%	21%	23%	21%	23%
Percentage of FDL School District students (K-12) in the healthy fitness zone	34%	29%	37.5%	46%	n/a
Percentage of Fond du Lac County adults eating the recommended 5 servings of fruits and vegetables daily	37%	32%	n/a	n/a	26%
Percentage of Fond du Lac County youth eating the recommended 5 servings of fruits and vegetables daily	22%	17%	18%	18%	14%

Accomplishments & Highlights

- Breastfeeding friendly efforts (workplaces, child care centers, peer support)
- Produce donation program at Fond du Lac Farmers Market (donates produce to local food pantries), increase in local community gardens (access to fresh produce)
- Promote Active Living – use of trails for walking and biking
- FDL School District PEP grant – revised physical education program and increased students physical activity levels and opportunities to be active throughout the day

Continued, Appendix D: 2018-2020 CHIP Review

Priority 2: Mental Health

Goal Statement: Reduce stigma around mental health and suicide. Increase access to behavioral health services across the lifespan and for those in high-risk groups. Decrease the number of deaths by suicide.

Performance measures	2021 Goal	2017 Baseline	2018	2019	2020
The average number of suicides per 3 year period	9 (2019-21)	19 (2015-17) 2017: 21	17 (2016-18) 2018: 11	18 (2017-19) 2019: 21	17 (2018-20) 2020: 20
Percentage of Fond du Lac County youth who report they "seriously considered suicide"	12%	13%	13%	15%	14%
Percentage of Fond du Lac County adults who report they "considered suicide"	4%	5%	n/a	n/a	7%
Percentage of adults who agree that, "people are caring and sympathetic towards persons with mental illness"	65%	59%	n/a	n/a	n/a
Percentage of adults who agree that they or someone in their household, "did not get the mental health care needed"	8%	9%	n/a	n/a	7%

Accomplishments & Highlights

- QPR suicide prevention training (question, persuade, refer) - increase number of gatekeepers that can connect individuals to resources and reduce stigma toward mental health and suicide (462 trained in 2020; 1620 to date)
- Destination Zero Grant – supported implementation of screening for suicide during patient visits (Columbia Suicide Screening - implementation continues among SSM Health providers at FDL, Ripon, Waupun, locations)
  - Survivors of suicide loss support group started
  - County Self-Harm Death Review Team (multi-sector)
- Awareness efforts to reduce stigma and share resources on how to navigate mental health resources/services (radio spots, newsletters, CSI website, sticker & window clings with website & crisis numbers)
- Mental Health Pathways to Care Navigation Tool for adults (web-based version, hard copies were distributed throughout community)
- New performance measures identified in 2020, and questions added to the 2020 Community Health Survey: Percentage of adults who agree that they, "consider someone seeing a therapist or psychiatrist as a sign of strength" and "consider someone taking medication to treat a mental health condition as a sign of strength"

Continued, Appendix D: 2018-2020 CHIP Review

Priority 3: Alcohol & Other Drugs

DRUG FREE COMMUNITIES
Fond du Lac County

Goal Statement: Decrease underage drinking, adult binge drinking, and the misuse and abuse of drugs, particularly opioids

Performance measures	2021 Goal	2017 Baseline	2018	2019	2020
Percentage of Fond du Lac County youth who report the community is actively discouraging alcohol use by youth in a way products are advertised, promoted or sold in the past 30 days	49%	47%	45%	47%	47%
Percentage of Fond du Lac County youth who drank alcohol in the past 30 days	17%	21%	19%	21%	22%
Percentage of Fond du Lac County youth who report they bought or drank alcohol at a Fond du Lac County Community Event	4%	6%	5%	6%	6%
Percentage of Fond du Lac County youth who reported binge drinking in the past 30 days	8%	11%	9%	10%	9%
Percentage of adults who reported binge drinking in the past 30 days	35%	38%	n/a	n/a	37%
Percentage of Fond du Lac County youth who report relative ease in obtaining prescription medication for non-medical use	28%	33%	30%	28%	28%
Number of opioid-related overdose deaths in Fond du Lac County	5	7	6	7	25

Accomplishments & Highlights

- Follow best practices for community events (ID checks for alcohol purchases, signage)
- Law enforcement agencies conduct annual compliance checks (reduce sales to minors for underage drinking)
- Overdose education and prevention, Narcan training, and distribution
- Increase number of providers using the evidence-informed practice Screening, Brief Intervention, and Referral to Treatment (SBIRT)

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