Winnebago County Public Health

Community Health Improvement Plan (CHIP) 2016-2020

PublicHealth
Prevent. Promote. Protect.
Winnebago County Health Department

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Winnebago County
The Wave of the Future

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Executive Summary

Dear Winnebago County Residents, May 2017

One of the essential services the Winnebago Public Health Department provides is the development of "policies and plans that support individual and community health efforts." One of the ways we achieve this goal is by developing a Community Health Improvement Plan (CHIP). The CHIP is the Health Department's opportunity to collaborate with the community to gather information and data, and to hear from community members and partners about health issues affecting our communities. This process allows for the identification of emerging and prevalent community health priorities, community assets, and resources to develop strategies to best address the public health needs of the communities we serve. What you are reading now is the culmination of that process, a plan that presents evidence, and outlines the voice of the community and how the community can work together to be a healthier place for all of our residents. We hope this document proves to be valuable to our community partners, funders, and each individual resident.

Developing a CHIP is a collaborative process. Although the Health Department is a key partner in ensuring the health of the community, it does not work in a vacuum. There is a complex network of organizations in existence that provide a myriad of healthcare and prevention services; businesses that provide insurance to their employees, local agencies who provide social services, businesses focused on making our community and residents healthier, and schools, families, and individuals who make up our community. No one person, organization or entity on its own, can make Winnebago County a healthier place to live, work and play. However, together WE can make a difference. The CHIP serves as a valuable tool for developing those partnerships and for understanding the various roles and responsibilities necessary to achieve this goal.

Improving community health also means focusing on specific populations that face health disparities. Strengthening the health of populations most in need is important. We know health is impacted by many factors, not just illness. Social disadvantages such as poverty, homelessness, and other societal issues impact health, both physical and mental health. In order to achieve health equity, we must make sure all of our residents have access to proper health services. Equalizing health opportunities will ultimately improve the community health for ALL residents.

Winnebago County Health Department is proud to share this planning process and the health priorities chosen by the residents of Winnebago County. We have many assets, the greatest being the people who call this area home.

The community health priorities for the next five years identified by our community are:

- Social and Place Connectedness
- Opportunities that Improve Health
- Healthy Foods and Beverages
- Mental Health
- Alcohol and Other Substance Use

For each of these health priorities, we have worked with community partners to identify strategies that will allow us to achieve our goals, have positive impacts, and improve health. The finalization of the CHIP is, however, the starting point for the work to make our communities healthier. There are many opportunities to get involved in this work; either personally, as a part of an organization, or as a part of a larger system. We invite you to join us in making Winnebago County a healthier place for you, your family, your neighbors, and all of our residents!

Sincerely,

Douglas D. Gleryn

Doug Gleryn, Health Officer

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Winnebago County Health Department

About Us and Our Community

Winnebago County

In Winnebago County, we take great pride in our communities, our people and our natural resources. Winnebago county is surrounded by beautiful lakes including Buttes des Morts, Little Lake Butte des Morts, Poygan, Rush, Winneconne and the largest fresh water lake in Wisconsin, Lake Winnebago.

We are the home to several significant industries, and a leader in paper production. Our community is home to many outstanding academic centers including the University of Wisconsin-Oshkosh, the UW-Fox Valley, and the Fox Valley Technical College. We are also home to three major health care systems that provide high quality care to our residents: Ascension Wisconsin, Aurora Health Care and ThedaCare.

Winnebago county is made up of urban, suburban, and rural areas. According to 2015 U.S. Census data, 169,546 residents reside in Winnebago County. Other county demographic data is shown on page 5. It important to note that while the demographics presented reflect information about the entire county, this CHIP report encompasses the work of the Winnebago County Health Department only; with the city of Menasha Health Department conducting their own CHIP.

Cities:
Menasha, Neenah, Omro, Oshkosh, parts of Appleton

Towns:
Algoma, Black Wolf, Clayton, Menasha, Neenah, Nekimi, Nepeuskun, Omro, Oshkosh, Poygan, Rushford, Utica, Vinland, Winchester, Winneconne, Wolf River

Villages:
Fox Crossing, Winneconne

Unincorporated communities:

Butte des Morts, Eureka, Larsen, Pickett, Metz (partial), Mikesville, Waukau, Winnebago

Winnebago County Health Department

The Health Department is comprised of six divisions:

Communicable Disease Prevention and Control; Community Health and Prevention; Environmental Health; Healthy Lifespan; Women Infants and Children (WIC), and Administration and Planning. The Winnebago Health Department took the lead in guiding the development of the Community Health Improvement Plan (CHIP), identifying priorities and preparing the CHIP document for the entire community to use as a planning resource.

Vision: The Winnebago County Health Department is a leader in creating a culture that optimizes health and wellness in our community.

Mission: Winnebago County Health Department leads change by providing services and building partnerships that strengthen the community.

Vales: Ethical practice of public health; Accountability; Collaboration and partnership; Building and sustaining a response public health workforce.

Strategic priorities: Continuous learning and growth; Fiscal and performance management; Communication and community awareness; Community leadership and health equity.

Demographic Profile of Winnebago County

Characteristics	Winnebago 2015	Winnebago 2010	% Change
Total Population *	169,546	166,994	1.5%
Median age (years) *	37.7	37.4	0.79%
Age *			
Persons under 5 years	5.6%	5.9%	-5.4%
Persons under 18 years	20.7%	21.6%	-4.34%
Persons 65 years and over	15.2%	13.4%	11.8%
Gender*			
Female	49.6%	49.7%	0.20%
Male	50.4%	50.3%	0.19%
Race and Ethnicity *			
White (non Hispanic)	92.7%	92.5%	0.21%
Black or African American	2.1%	1.8%	14.3%
American Indian, Alaskan Native	0.7%	0.6%	14.3%
Asian	2.8%	2.3%	17.8%
Two or more races	1.6%	1.5%	6.3%
Hispanic or Latino	4.1%	3.5%	14.6%
Speak language other than English at home +	5.3%	5.8%	-9.4%
Median household income *	52,018	50,974	2.00%
Percent below poverty in last 12 months +	12.0%	10.5%	12.5%
High School graduate or higher + (% of persons age 25 or older)	92.0%	86.7%	5.7%

* Source: U.S. Census Quickfacts. https://www.census.gov/quickfacts/table/PST045216/55139,00

+ https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml?src=bkmk

Overview of a Community Health Improvement Plan

A Guide for the Community, Developed by the Community

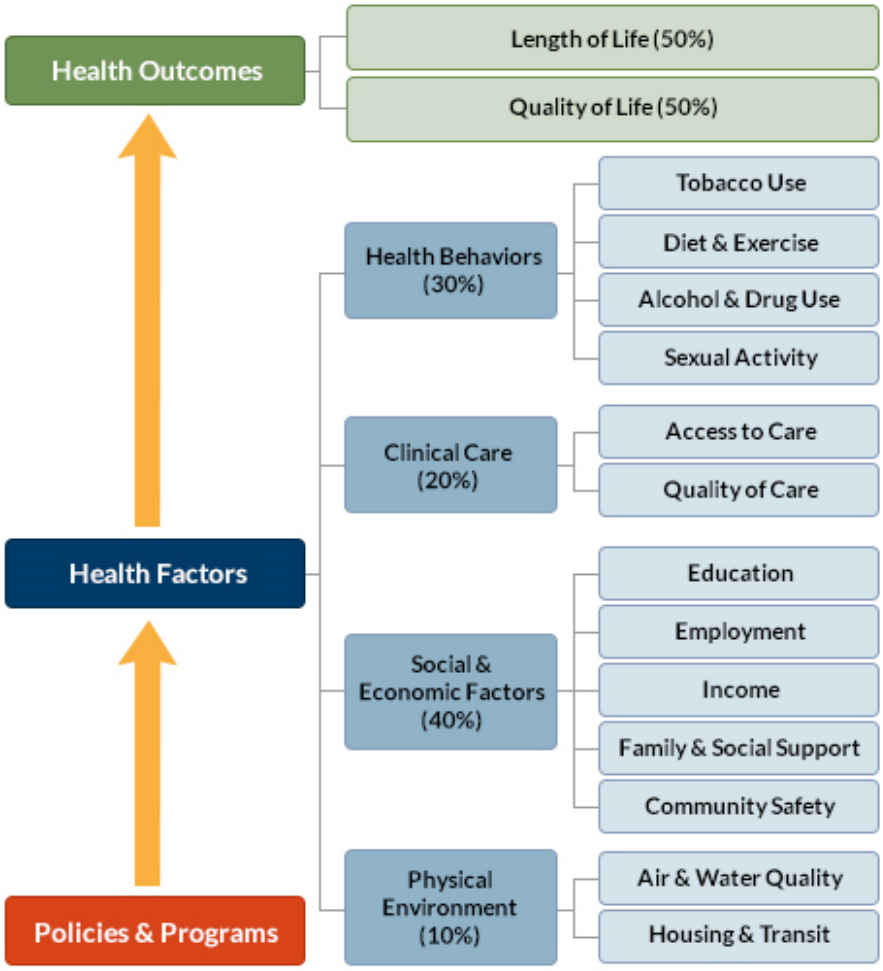
The community health improvement plan, or CHIP, is a 5 year community level plan that identifies priority areas for improving the community's health. It is developed through a process of gathering input from community partners and residents about issues impacting the community's health. While the health department guides the development of the document, the plan is intended to be used by stakeholders throughout the community to guide programs, policies, and initiatives that impact health.

Health Equity and Upstream Strategies

The process and results are guided by principles of health equity: identifying underserved groups, engaging with people most affected by an issue, and developing priorities and strategies that are appropriate and effective for those most affected. Emphasis is placed on identifying priorities and strategies that will have the largest and longest-lasting impact.

While it is often health outcomes that capture our attention and motivate efforts for change, it is important to focus efforts on all factors that influence or drive those outcomes. That is where the greatest opportunity lies for real change

The figure to the right demonstrates how environmental, social, and economic factors have a significant impact on health and must be considered when developing effective, sustainable health improvement strategies.



(Image source: County Health Rankings 2016: Wisconsin—http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2016_WI.pdf)

Components of a CHIP

The community health improvement planning process includes the components below.

- Information from community health assessments
- Broad participation of community partners
- Issues and themes identified by stakeholders in the community
- Identification of community assets and resources
- A process to set the health priorities

We will describe each of these components as it relates to our process.

Our Process:
Community Health Assessment

Mortality	
Morbidity	
Chronic Disease Prevention and Management	
Oral Health	
Communicable Disease	
Mental Health	
Injury and Violence	
Alcohol and Other Substance Use	
Physical Activity & Nutrition	
Tobacco	
Sexual Health	
Access to Care	
Education	
Employment	
Adequate Income	
Community Safety	
Health Literacy	
Social Support	
Built Environment	
Natural Environment	

One major step in the community health improvement planning process is conducting a community health assessment (CHA). The CHA is a description of the health status of our community, made up of a compilation of many different data sets that cover a range of indicators from demographic information to education and income data to health conditions, health behaviors, injuries and hospitalizations. The table to the right represents a summary of key findings from the CHA, highlighting how Winnebago County is doing in comparison to the state of Wisconsin for key areas related to health.

Winnebago County's 2016 CHA can be found here: https://www.co.winnebago.wi.us/health/units/administration/community-health-data

Stoplight Color Code

A green circle indicates that data calculated for Winnebago County was >5% better than state data (as last reported).

A yellow triangle indicates that data calculated for Winnebago County was within 5% of the state data (as last reported).

A red square indicates that data calculated for Winnebago County was >5% worse than state data (as last reported).

Our Process:
Key Informant Interviews

To complement the data in the Community Health Assessment (CHA), we gathered qualitative data from community partners in two primary ways: key informant interviews and community conversations.

Key Informant Interview Planning

The Fox Valley Community Health Improvement Coalition (FVCHIC), worked collaboratively in planning the key informant interviews. The FVCHIC is comprised of a core group of representatives from four local health systems and five public health departments in the tri county region (Calumet, Outagamie and Winnebago). The FVCHIC, with the help of local partners identified key stakeholders in the region, developed interview questions and conducted key informant interviews. The data was collected in 2015.

Interview Process

Winnebago County Health Department staff along with other FVCHIC members identified and interviewed 134 individuals throughout the Fox Valley who have expert local knowledge about the population and/or are content experts on a particular health issue. These individuals or "key informants" represented various sectors of the community (education, health care, public health, faith based organizations, law enforcement, businesses, government and non-profit organizations). Key informants provided information on broad range of health issues and represent the broad interest of the community, including medically underserved, low income, and minority populations.

Each key informant was asked to select and rank up to five of the major health issues in the Fox Valley. The health issues presented to them were from the 13 Healthiest Wisconsin 2020 focus areas. These were: mental health; alcohol and other substance use; physical activity; nutrition; growth and development; chronic disease; access to health services; injury and violence; environmental and occupational health; oral health; tobacco; reproductive and sexual health; and communicable disease. Based on the rankings, they were asked to (a) identify existing strategies to address the issue; (b) list barriers/challenges to address the issue; (c) list additional strategies needed to address the issue; and (d) identify key groups or individuals in the community to partner with to improve community health.

Some key informants did not complete the ranking process so their information is not included in the findings below.

Key Findings

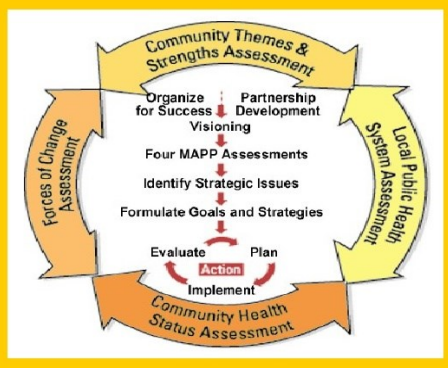
The table below provides a list of the top five health issues identified by the key informants; including information on how many times the issue was ranked in the top five and how many times it was ranked as the number one health issue in the region.

	Frequency	
	Top 5	**Number 1**
1. Mental Health	64	40
2. Alcohol and Other Substance Use	52	29
3. Physical Activity	32	21
4. Nutrition	34	15
5. Healthy Growth and Development	22	6

Our Process:
Community Conversations

In spring 2016, WCHD organized a series of community meetings, or community conversations, aimed at gathering information about community perceptions related to health. We were guided by the MAPP process (Mobilizing for Action through Planning and Partnership), focusing specifically on aspects of the Community Themes and Strengths Assessment, along with the Forces of Change Assessment.

The MAPP Model



Eleven conversations with approximately 90 community residents were held in the afternoons and evenings at various locations throughout the County. Some meetings were health topic-specific which were based on findings from the key informant interviews and state health priorities; other meetings brought together individuals from a particular sector of the population for discussions.

- **Topic specific** (each held twice): physical activity; healthy food systems; mental health; alcohol and other substance use
- **Population specific:** elected officials; older adults; residents with limited incomes

Process for Table Discussions

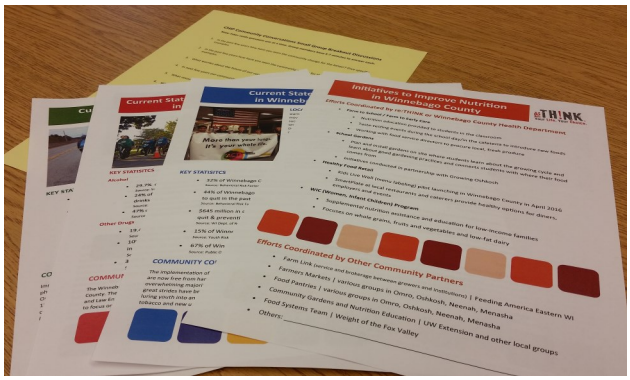
Depending on group size, people were divided into smaller groups and the facilitators asked the following questions:

- In the past few years how have you seen the community change for the better? Give specific examples.
- In the past few years how have you seen the community change for the worse? Give specific examples.
- What worries you about the future of our community?
- In next few years our community will be better when…
- What actions, policy, or funding priorities would you support to build a healthier community?
- What would excite you enough to become involved (or more involved) in improving our community?

Notes were taken either by health department staff, re:TH!NK coalition members, or University of Wisconsin Oshkosh students. Information was compiled and analyzed for common themes and to provide guidance for the next section of the CHIP process.

At the end of the table discussion, participants were given an evaluation form. This allowed participants to provide feedback on the conversation and contribute any additional insight about the health of the community they may have not felt comfortable sharing with the group.

For the community conversations tailored to low income residents, WCHD staff attended a pre-established community event and either interviewed neighborhood residents or asked the residents to fill out a short questionnaire.



Data sheets on each of the four topic areas with current community data from the CHA were provided to participants at the start of each meeting .
(see Appendix C for examples)

Our Process:
Community Conversations, continued

Process for Dots Exercise

After the conversations, we asked participants to assess five specific problem statements related to each of the four topic areas. Participants were given a different colored dot for each problem statement and asked to place these on a graph, with 'seriousness of the problem' on the X-axis and 'feasibility to make a change in Winnebago County' on the Y-axis.

For example, during the Substance Use community conversations, the problem statements included:

- Teen marijuana use is too high
- Opiate use (prescription drugs/heroin) is too high
- Underage drinking is too high
- Use of e-cigarettes among youth is increasing
- Excessive (binge) drinking is too common

See appendix D for all topics and problem statements used for the dots exercise.

Data was combined across the conversations and themes were identified to give a rich understanding of how our community members perceive health in our community related to each of the established topic areas and other topics that emerged during the discussion.

Following is a summary of key findings from the table discussions, the community event with residents with limited incomes and dots exercise. For more detailed results from the table discussions and community event, see appendix E.

Key Findings from the Table Discussions

The positive changes in the community, participants discussed included: school gardens; more farmers markets; more demand for healthy food options; community support for recreational activities; promotion of physical activity in the schools, work places and throughout the community; multi-use trails; increased awareness and less stigma for those with mental health issues and addiction problems; and formation of community partnerships to address various community issues.

The conversation suggested there is room for continued improvement. One frequently discussed issue was poverty and its impact on health, as well as access to opportunities to improve health. Mental health and social isolation were highlighted as an increasing concern for both adults and youth, with discussion of schools seeing a rise in youth mental health problems.

Another issue brought up on many occasions was the increase in heroin and opiate use. The alcohol culture in Winnebago County and throughout the state of WI was often cited as a problem. People expressed concern about drunk drivers, and believe more readily available and affordable treatment should exist. They also indicated more sober living houses are needed in the county.

Approximately 85 community members and partners participated in the table discussions during April – June 2016.

Our Process:
Community Conversations, continued

Key Findings from the Community Event

The community conversation held at the pre-established community event provided unique and valuable insight into the perceptions and needs of residents with limited incomes.

From the 1:1 interviews, the biggest areas of concern that emerged were: nutrition – specifically the accessibility of healthy food; working together and communication; access to health services; and issues affecting youth—specifically youth programming and healthy opportunities for youth.

From the written survey responses, substance use, including addiction and overdose was by far the most frequently indicated concern, followed by access to health services, alcohol misuse, and oral health.

"Word Cloud"
Produced from all conversation notes recorded at the community event.

Key Findings from the Dots Exercise

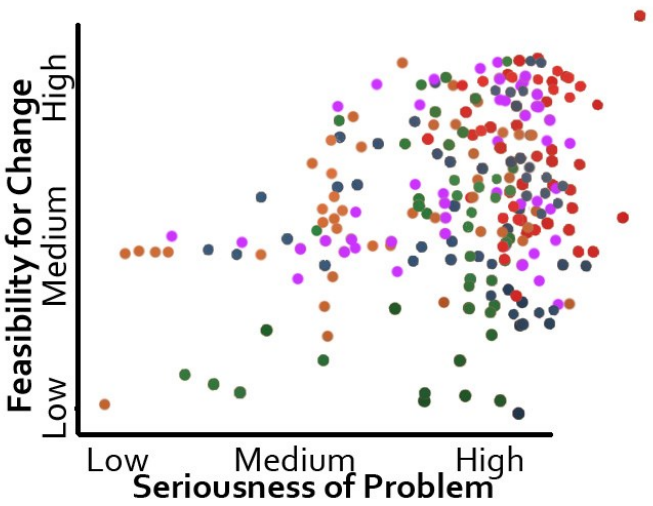
An example of results from the dots exercise and their interpretation is provided in the figure on the right. Combining results across conversations, the following five problems were identified as the **most serious** problems for residents:

- Opiate use is too high.
- Childhood trauma is too high.
- There are too many teen suicides.
- Underage drinking is too high.
- Excessive binge drinking is too common.

The following five problems were identified as the **most** feasible to change:

- Children are not getting enough physical activity in/at school.
- Many people believe that mental health is not as important as physical health.
- Opiate use is too high.
- Access to fresh, affordable fruits and vegetables is limited.
- Childhood trauma is too high.

Alcohol and Other Substance Use



How to interpret the graph above:

In this example, opiate use (red dot) is the most serious problem and has a high feasibility for making a change.

Underage drinking (green dot) is a serious problem but has a lower feasibility for changing the problem, according to community participants.

Our Process:
Determining Priorities

Data Analysis, Themes, and Prioritization

A team of Health Department staff compiled data collected from the Community Health Assessment (CHA), key informant interviews, community conversations, and dots exercise. Existing implementation efforts (local and regional) involving re:TH!NK and other community coalitions was also examined. Staff involved included: Emily Dieringer, Health Educator/Coalition Coordinator; Cindy Draws, Public Health Supervisor; Douglas Gieryn, Health Officer; Stephanie Gyldenvand, Health Educator/Coalition Coordinator; Heidi Keating, Public Health Planner; and Carolyn McCarty, Public Health Supervisor.

Additional staff were called upon to provide insight on certain health topics. Additional data analysis related to the community conversations were conducted by Taylor Neis, an Area Health Education Center (AHEC) intern with the Community Health Internship Program.

A series of six meetings were held to identify commonalities between the data sets and establish CHIP priorities. During the first two meetings, staff reviewed collected data and high level themes that emerged from each of the data sets. Themes were categorized and variations and/or notes, were captured on poster-sized paper. Team members used these high-level themes to create "bundles" of emerging priorities that included data from all sources, weighing slightly more heavily on the community conversations and dots exercises. Initial "bundles" included:

- Poverty and issues with lack of money
- Individual behaviors and choices
- Behavior and choices influenced by policies, systems, and the environment (PSE)
- Behavior and/or choices influenced by social conditions
- Access to resources that improve health outcomes
- Attitudes and beliefs
- Multi-faceted connections and components that affect one's or the community's health (e.g. mental health and substance use)

Several of the "first round" bundles were related to: the social determinants of health, causes of higher health risks and poorer health outcomes of specific populations, and health inequities. These bundle topics were taken into great consideration when the team looked at the specific factors from the data for each health issues. An example relates to the issue of nutrition; there is a difference between focusing on "healthy foods and beverages" versus the broader topic of "nutrition."

Additional team meetings were held to further examine which specific factors for each "bundle" were most applicable to what our community partners and residents identified as causes of poor health outcomes. The health department's current and future scope of work were also factors in determining the final focus areas, as well as emphasizing upstream preventive approaches and the needs of underserved and vulnerable populations. Specific strategies aligned with what our residents and the data intended, key community implementation partners, and measures of change were also identified.

Priority 1:
Social and Place Connectedness

Goal: Residents are connected and engaged in the places and spaces that matter to them.

Why is this an important issue for our community?

There is a body of literature including studies reviewed in a National Research Council and Institute of Medicine report that suggests that over 50% of premature deaths are attributable to non-medical factors such as where one lives and the opportunities available for health and economic mobility; including education, jobs, income, access to housing and transportation, community safety, and other well-established social determinants of health. The way our neighborhoods, streets, and homes are designed affects whether children can play outside and walk to school for example, or whether families can access basic goods and services, and even whether neighbors can socialize and look out for one another. Strengthening the connections between people and the places they share, referred to as "placemaking" is a collaborative process by which we can shape our public realm in order to maximize shared value. Placemaking gives people ownership of their place and the changes occurring within it. A strong sense of belonging and social connections are associated with physical and mental well-being while social exclusion denies opportunities for full economic and social participation in society.

What can you do to help?

Community members:

- Join or start a neighborhood association, volunteer group, or community coalition
- Know your neighbors well enough to understand if they have any unique needs
- Learn about and engage in the democratic decision-making process at the local/municipal level
- Conduct a walk audit in your neighborhood and share the results with your municipal leaders
    - Walk audit tool: https://www.dhs.wisconsin.gov/publications/p0/p00399.pdf

Organizations in the community:

- Follow the Seven Asset-Based Community Development Principles building on assets already found in the community (http://www.abcdinstitute.org/toolkit/index.html)
- Adopt or advocate for adoption of a "health in all polices" resolution within your organization or at the municipal level (download *Health in All Policies: A Guide for State and Local Governments* at http://www.phi.org/resources/?resource=hiapguide)
- Create partnerships to support and enhance existing efforts that are improving social connections in a community where spaces and events are available for people to gather, create new friendships, and contribute to the community through volunteering
- Make it a priority to build relationships with customers/clients, people you serve, partners, and others in the community

Priority 1:
Social and Place Connectedness, cont.

Strategy 1.1

Integrate public health into local municipal planning processes and decision-making systems so health outcomes are considered in decision-making processes ("health in planning").

Key partners: planners (public and private sector); public works departments; zoning departments; parks departments; elected officials; community development organizations; workforce development organizations

Measure of change (examples): number of comprehensive plans and/or zoning ordinances that include "health in planning" references; number of "health in all policies" resolutions passed

Strategy 1.2

Support community development initiatives designed to engage, improve, and strengthen community connectedness, and improve physical, social and service environments in local neighborhoods.

Key partners: community development organizations; social and civil service organizations; local municipalities; parks departments; school districts; senior centers; organizations working on racial literacy; chambers of commerce; minority chambers of commerce

Measure of change (examples): percent of people who report they volunteer; percent of people who report their neighborhood helps fulfill needs; walkscore and livability index scores

Strategy 1.3

Enable community and civic connections at a neighborhood level to improve neighborhoods and relationships with all people in those neighborhoods (specifically older adults, people with disabilities, people with lower incomes, new parents, and youth).

Focus areas/Example activities: conduct an assessment related to social networks/connectedness

Key partners: neighborhood associations; law enforcement agencies; parks departments; faith-based communities; senior centers; community development organizations; volunteer organizations; civil service organizations

Measure of change (examples): social support network size; voter turnout; percent of people who report receiving the social or emotional support they need all or most of the time ; percent of people who feel a strong sense of belonging to their local community

Priority 2:
Access to Opportunities that Improve Health

Goal: Improve and expand access to and availability of already existing services or opportunities.

Why is this an important issue for our community?

There is clearer understanding that the social and physical environments in which people live, work, and play have a significant impact on their health. Healthy People 2020, the federal government's roadmap for improving health by 2020, highlights this understanding by including the creation of "social and physical environments that promote good health for all" as one of four over-arching goals. This publication identifies some of the social determinants of health, such as the availability of resources to meet daily needs (e.g., housing and food), access to economic opportunities, access to health care services, opportunities for recreational activity, transportation options, and socioeconomic activities. These social determinants demonstrate it is not only the availability of resources, but also one's ability to access those resources that impacts health.

What can you do to help?

Community members:

- Connect with and participate in community efforts working to address these issues like hub, LEAVEN, ADVOCAP, re:TH!NK, etc.
- Volunteer to help people seeking services and resources navigate the system
- Use public transportation or explore other alternative modes of transportation (e.g., walking, biking)
- Learn about ways health is impacted by the social and physical environment in the community
    - Unnatural causes: http://www.pbs.org/unnaturalcauses/
- Become familiar with the services and opportunities available for vulnerable populations within your community and share what you know with others

Organizations in the community

- Identify potential gaps related to who is being reached by the services and opportunities you provide
- Work with other community partners, agencies, and service providers to identify creative solutions
- Work to fill identified gaps by tailoring your efforts to meet the needs of vulnerable populations (elderly, youth, limited income families, etc.)
- Refer to and advocate for community efforts which support people working toward self-sufficiency
- Support employees volunteering in community efforts which connect people to services and opportunities
- Support employee wellbeing by providing adequate wages
- Consider the needs of vulnerable populations (e.g., access to transportation, cost, hours of operation) when developing and delivering your services and programs
- Involve people impacted by lack of opportunities in planning and decision-making processes

Priority 2:
...Opportunities that Improve Health, cont.

Strategy 2.1

Support activities which connect agencies serving similar populations in order to increase access to multiple services.

Focus areas/Example activities: increase use of and access to entities such as The Hub or Leaven; educate community partners about the concept of no 'wrong door/warm hand-off'

Key partners: organizations working to address poverty; social service providers; community clinics; schools; organizations supporting individuals achieving self-sufficiency or connecting individuals to resources; faith-based organizations; healthcare providers; libraries; transportation service providers; seniors' centers

Measure of change (examples): Number of participants accessing The Hub or Leaven services; Proportion of residents who are knowledgeable about community resources and support services

Strategy 2.2

Identify barriers to accessing social service programs and gaps within those programs.

Focus areas/Example activities: conduct an assessment to understand who is eligible for services but not using/accessing them and why; and to understand who is not eligible but in need of services

Key partners: social service providers; economic support organizations; workforce development organizations; food pantries; public housing agencies; organizations supporting individuals in achieving self-sufficiency; community members experiencing barriers to social service programs

Measure of change (examples): completion of an assessment that identifies barriers; development of an action plan that seeks to address the identified barriers

Strategy 2.3

Improve access to transportation.

Focus areas/Example activities: increase use of safe, active transportation; improve public and para-transit systems; support policy that allows individuals to maintain a driver's license with non-vehicular violations

Key partners: transportation planners; bicycling and walking clubs; transportation service providers (public and private); transportation advocates; funding agencies; municipalities; transit riders; legislators

Measure of change (examples): percent of people using active transportation to travel to work; number of people accessing public transportation

Strategy 2.4

Support efforts to ensure a range of affordable housing is available for all.

Focus areas/Example activities: home improvement loans and grants; transitional housing; mixed use, mixed income, and affordable rentals

Key partners: organizations working to provide safe, affordable housing; zoning departments; Landlords

Measure of change (examples): proportion of population experiencing homelessness; number of and per cent occupancy in transitional housing units; number of individuals participating in the Housing Choice

Priority 3:
Healthy Foods and Beverages

Goal: Increase access to and consumption of fruits, vegetables, and healthy beverages while decreasing consumption of sugar-sweetened beverages in children and adults.

Why is this an important issue for our community?

Diet is a major modifiable determinant of chronic disease and obesity, yet the majority of Winnebago County residents do not have healthy eating habits. According to the 2015-16 Youth Risk Behavior Survey (YRBS), 63.3% of high school students in Winnebago County ate vegetables (not counting potatoes) less than once a day. Diets among low-income households are particularly concerning. According to the 2015 Winnebago County Community Health Survey (WCBRFS) data, 24% of adults with household income less than $10,000 ate no vegetables on an average day, compared to an overall county average of 7%. This same population reported drinking the most sugar-sweetened fruit drinks, sweet tea, or sports/energy drinks per day (27% reported that on days when they consumed these beverages, they consumed 5 or more).

What can you do to help?

Community members:

- Participate in healthy living coalitions that address healthy eating
- Support initiatives that address issues related to increasing consumption of fruit and vegetables and decreasing consumption of sugar-sweetened beverages
- Develop and promote personal and family nutrition goals by decreasing consumption of sweetened beverages, choosing water as a beverage and increasing consumption of fruit and vegetables

Organizations in the community:

- Participate in healthy living coalitions that address healthy eating
- Develop and implement healthy eating guidelines in your workplace
- Increase access to healthy food in your workplace environment through healthy vending machine policies or workplace Community Supported Agriculture (CSA) programs
- Encourage schools and licensed day cares to adopt policies that meet or exceed state and national standards related to nutrition

Priority 3:
Healthy Foods and Beverages, cont.

Strategy 3.1

Improve food environment in food retail and social settings focusing on most vulnerable populations.

Focus areas/Example activities: improve nutritional content of foods available for people with food insecurity

Key partners: food banks, pantries, and other hunger-relief programs; food retail establishments; state coalitions and government entities working on food insecurity

Measure of change (example): number/percent of food retail establishments offering healthy options; percentage of residents who live within 1/4 mile (urban) of a retail food establishment offering healthy options

Strategy 3.2

Improve food environment in institutions that serve children.

Focus areas/Example activities: increase servings of vegetables provided in daycares/schools

Key partners: school food authorities; organizations engaged in Farm to School and Farm to Early Care and Education; afterschool programs

Measure of change (examples): percent of youth who consume adequate amounts of fruits and vegetables (YRBS); percent of institutions that regularly offer health menu options

Strategy 3.3

Improve food environment in institutions that serve adults

Focus areas/Example activities: increase servings of vegetables provided in assisted living centers, faith based organizations, colleges and universities, recreational centers, etc.

Key partners: institutional food service departments such as universities, healthcare, long-term care and assisted living facilities; government buildings; workplaces , recreational centers, etc.

Measure of change (examples): percent of adults who consume adequate amounts of fruits and vegetables (Winnebago County Community Health Survey); percent of institutions that regularly offer healthy menu options

Strategy 3.4

Improve residents' ability to recognize and use healthy foods.

Focus areas/Example activities: increase nutrition literacy

Key partners: government, healthcare, and private institutions that provide nutrition education; convenience stores; grocery stores; restaurants; food pantries

Measure of change (examples): percent of people served who are comfortable recognizing and using healthy foods; percent of people served who are choosing or preparing healthy foods

Priority 4:
Mental Health

Goal: Improve mental health systems of care and mental health among residents.

Why is this an important issue for our community?

Mental health conditions are conditions that affect brain chemistry or brain function. According to the National Alliance on Mental Illness (NAMI), one in five adults experiences a mental health condition in a given year. Prominent issues in Winnebago County related to mental health include: high rates of suicide, lack of access to specialized and timely mental health treatments, and high incidence of adverse childhood experiences (ACEs). According to the 2016 Youth Risk Behavior Survey (YRBS), 19.4% of Winnebago County high school students reported seriously considering attempting suicide (WI average: 13.2%); 13.6% of Winnebago County high school students reported attempting suicide one or more times (WI average: 6%). In addition, more than 20% of adult Winnebago County residents have four or more ACEs, compared to 14% statewide (O'Connor, Finkbiner & Watson, 2012). Improving mental health will help us achieve lower rates of substance abuse, less violence, a more productive workforce, and lower rates of disability due to mental illness.

What can you do to help?

Community members:

- Participate in local coalitions engaged in mental health such as the North East Wisconsin Mental Health Connection (NEWMHC) or the National Alliance on Mental Illness (NAMI), etc.
- Learn about signs and symptoms of mental illness and suicide (e.g., Youth Mental Health First Aid, QPR training), and what to do if you see it
- Promote and model healthy coping strategies and resiliency with family members
    - http://therealhappyhour.org/
- Learn about mental health stigma and assist in reducing negative effects on those with mental illness,
    - http://www.nami.org/
    - http://www.newmentalhealthconnection.org/

Organizations in the community:

- Promote and support employees' mental wellness (e.g., EAP, healthy lifestyles)
- Provide information and education on mental health and suicide prevention to reduce stigma
- Adopt policies and procedures that support employees' mental wellness (e.g., support during a mental health crisis or suicide)
- Support community events that promote community awareness and cohesion; use local, national and international events as opportunities to talk about mental health needs and issues

Priority 4:
Mental Health, cont.

Strategy 4.1

Expand mental health services and focus on integration of these into primary care.

Focus areas/Example activities: build/enhance public/private partnerships for case management and provide mental health services (e.g., no wrong door to the right mental health services)

Key partners: mental health community coalitions; health care systems; mental health providers; human services departments; community foundations/funders; professional schools and education organizations

Measure of change (example): number of primary care physicians trained in providing mental health services; number of health care systems using a team-based care approach that includes mental health

Strategy 4.2

Prevent suicide-related behaviors.

Focus areas/Example activities: expand/sustain evidence-based strategies related to suicide prevention

Key partners: community coalitions engaged in mental health; health care systems; school districts; mental health providers; law enforcement; human service organizations; coroners; suicide attempt and loss survivors; businesses/workplaces

Measure of change (examples): number of mental health service providers with suicide prevention policies and practices; number of students thinking about suicide, making a plan, and attempting suicide (YRBS); number of suicide deaths; number of suicide attempts reported at emergency departments

Strategy 4.3

Promote protective factors, healthy relationships.

Focus Area/Example activities: increase awareness among residents about social and place connectedness

Key partners: school districts; youth-serving organizations; organizations working in the area of domestic abuse; primary care providers; media; health care systems

Measure of change (examples): number of people with a high ACEs score; number of students with a sup portive adult in their life (YRBS); number of teens experiencing teen dating violence (YRBS)

Strategy 4.4

Improve coping skills and build resilience in individuals that have experienced or are vulnerable to trauma.

Focus areas/Example activities: reduce use of tobacco and other substances among people with poor mental health; reduce self-harm; increase participation in group activities and neighborhood associations

Key partners: school districts; mental health/substance use providers; human services departments; local and statewide coalitions; law enforcement; helplines; landlords; housing agencies

Measure of change (examples): number of people with high ACEs score; percent of individuals who have experienced trauma and are misusing substances; rates of depression

Priority 5:
Alcohol and Other Substance Use

Goal: Reduce substance use and addiction .

Why is this an important issue for our community?

Wisconsin ranks number one in the U.S. in rates of adult binge drinking, and also ranks number one in intensity of drinking; with adults reporting an average of nine drinks per occasion. Our state also ranks number one in driving a motor vehicle under the influence of alcohol. Excessive alcohol consumption in Winnebago County in 2014 contributed to at least 43 alcohol-related deaths (2016 Winnebago County Public Health Profile) and 1,251 alcohol-related hospitalizations (Wisconsin Epidemiological Profile on Alcohol and Other Drugs, 2016). The estimated annual cost of excessive alcohol use in Winnebago County, including health care, lost productivity, and other costs, is $214.8 million (Burden of Excessive Alcohol Report, 2013).

Opioid use, including heroin, in Winnebago County has increased since 2010. Each year, from 2002 to 2010, the county averaged 15 drug-related deaths per year. In 2015 there were 24 drug-overdose deaths. Alcohol and Other Substance Use was identified as one of the top five health issue by local leaders during the key informant interviews. Some key informants specifically noted concerns related to opiate addiction, the pervasive drinking culture that exists in our area, and drinking and driving.

What can you do to help?

Community members:

- Safely dispose of prescription medications using local Drug Drop Boxes
- Securely store prescription medications to limit unintended access
- Do not share your prescription medications and do not use medications prescribed to someone else
- Talk and act responsibly about the alcohol and other substance use, especially in the presence of children
- Support community policies that limit the use and sale of alcohol in public spaces (parks, events, etc.)
- Know current substance use issues and resources available in the community to help friends/family that may be using and abusing alcohol and other substances

Organizations in the community:

- Limit access to alcohol at organization-led events
- Provide safe, responsible options for events that do include alcohol (e.g., safe rides, single serving sized beverages, restricting where alcohol is served and consumed), promote the use of public transit and alternative transportation
- Incorporate substance use support into employee services
- Support community efforts to prevent substance use
- Enhance community efforts to increase social and place connectedness

Priority 5:
Alcohol and Other Substance Use, cont.

Strategy 5.1: Reduce access and exposure to alcohol in social settings.

Focus areas/Example activities: decrease focus on alcohol at social events; improve alcohol guidelines at festivals; generate support for policies/ordinances limiting minors in bars and alcohol marketing; reduce the "alcohol specials" that promote heavy drinking; reduce reliance on alcohol for fundraising

Key partners: restaurants and bars; festival organizers; law enforcement; local elected officials; business partners; parents and youth; local coalitions and organizations working on substance use prevention

Measure of change (examples): number of alcohol outlets in Winnebago County; changes in festival/event guidelines around alcohol sales; number of alcohol sales to minors

Strategy 5.2: Reduce access to and misuse of prescription and illicit drugs.

Focus areas/Example activities: promote Prescription Drug Monitoring Program; decrease access to medications in the home; promote proper disposal of prescription drugs

Key partners: primary care providers; hospital systems; prescribers; pharmacists; parents and youth; law enforcement; individuals in recovery; employers; senior-serving organizations; youth-serving organizations

Measure of change (examples): number of opiate prescriptions; number of overdoses and overdose deaths; pounds of prescription drugs collected at drug drop box sites

Strategy 5.3: Improve access to treatment and recovery options.

Focus areas/Example activities: build/enhance public/private partnerships for coordinated care and providing recovery/treatment services; payment for appropriate treatment (in-patient, outpatient, medication-assisted treatment)

Key partners: insurance providers; health care systems; treatment providers; recovery support providers; primary care providers; employers; law enforcement; judicial system

Measure of change (examples): percent of people with a positive assessment who receive treatment; decrease length of wait times to access treatment; increase referrals to treatment instead of incarceration

Strategy 5.4: Improve data collection related to alcohol/drug use

Focus areas/Example activities: implement system to measure place of last drink; collect qualitative data from high school youth related to underage drinking

Key partners: schools; law enforcement; data collection/analysis experts; health care systems; treatment providers; primary care providers; local and state agencies

Measure of change (examples): number of organizations with adequate access to data needed to understand community needs and resources related to use and misuse of alcohol and other substances

Summary of Goals and Indicators of Success

1. Social and Place Connectedness

Residents are connected and engaged in the places and spaces that matter to them.

Indicator 1a: Increase the percent of adults who report usually or always receiving the social and emotional support they need from 76% in 2015 to 78% in 2020. *(Data source: Winnebago County Community Health Survey)*

Indicator 1b: Increase opportunities for social connectedness, as measured by the number of memberships in neighborhood related associations per 10,000 population, from 11.1 in 2014 to 15 in 2020. *(Data source: see County Health Rankings [County Business Patterns])*

2. Access to Opportunities that Improve Health

Improve and expand access to and availability of existing services or opportunities.

Indicator 2a: Increase the percentage of the population with adequate access to locations for physical activity from 84% in 2014 to 88% in 2020. *(Data source: see County Health Rankings [calculated composite measure])*

Indicator 2c: Decrease the percentage of adults without health insurance from 17% in 2014 to 16% in 2020. *(Data source: see LIFE study [U.S. Census Bureau])*

3. Healthy Food and Beverages

Increase access to and consumption of fruits, vegetables and healthy beverages while decreasing consumption of sugar-sweetened beverages in children and adults.

Indicator 3a: Increase the percentage of high school youth who consume vegetables at least once daily from 39% in 2015 to 41% in 2020. Increase the percentage of adults who consume more than 1 serving of vegetables per day from 58% in 2015 to 61% in 2020. *(Data source: YRBS, Winnebago County Community Health Survey)*

Indicator 3b: Increase the percentage of high school youth who consume soda ≤3 times during the past 7 days from 73% in 2015 to 77% in 2020. Increase the percentage of adults who did not drink any regular soda or pop containing sugar from 51% in 2015 to 54% in 2020. *(Data source: YRBS, Winnebago County Community Health Survey)*

Indicator 3c: Increase the county's Food Environment Index score (a measure of access to healthy foods and food insecurity) from 7.6 in 2015 to 8.0. in 2020. *(Data source: see County Health Rankings [USDA Food Environment Atlas, Map the Meal Gap from Feeding America])*

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CHIP Goals and Indicators of Success, cont.

4. Mental Health

Improve mental health among residents and mental health systems of care.

Indicator 4a: Reduce the ratio of population to mental health providers from 540:1 in 2016 to 500:1 in 2020 *(Data source: see County Health Rankings [National Plan and Provider Enumeration System])*

Indicator 4b: Decrease the percentage of high school youth who, in the past 12 months, have felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities from 27% in 2015 to 25% in 2020. *(Data source: Winnebago County YRBS)*

Indicator 4c: Decrease the percent of adults who report experiencing 3 or more days or poor mental health days from 30% in 2015 to 25%in 2020. *(Data source: Winnebago County Community Health Survey)*

5. Alcohol and Other Drugs

Reduce misuse of and addiction to drugs and alcohol.

Indicator 5a: Decrease the percentage of adults who drink two or more drinks on one occasion, during the last 30 days from 67% in 2015 to 65% *(Data source: Winnebago County Community Health Survey)*

Indicator 5b: Decrease the percentage of adults who drank 5 or more drinks on one occasion from 14% in 2015 to 10% in 2020. *(Data Source: Winnebago County Community Health Survey)*

Indicator 5d: Decrease the number of drug overdose deaths in Winnebago County from 28 in 2016 to 20 in 2020 *(Data Source: Winnebago County Coroner)*

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Related State/National Priorities

Social/Place Connectedness

Healthiest Wisconsin 2020, Pillar Objective 3:

Policies to reduce discrimination and increase social cohesion

Healthiest Wisconsin 2020, Pillar Objective 8:

Environments that foster health and social networks

Healthy People 2020 goal:

Create social and physical environments that promote good health for all

Opportunities that Improve Health

Healthiest Wisconsin 2020 focus area:

Access to high quality health services

Healthy People 2020 goal:

Create social and physical environments that promote good health for all

Healthy People 2020 goal:

Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life

Healthy Foods and Beverages

Healthiest Wisconsin 2020 focus area:

Adequate, appropriate, and safe food and nutrition

Healthy People 2020 goal:

Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights

Mental Health

Healthiest Wisconsin 2020 focus area:

Mental Health

Healthy People 2020 goal:

Improve mental health through prevention and by ensuring access to appropriate, quality mental health services

Alcohol and Other Drugs

Healthiest Wisconsin 2020 focus area:

Alcohol and other drug use

Healthy People 2020 goal:

Reduce substance abuse to protect the health, safety, and quality of life for all, especially children

Priority-related Best Practices and Resources

The resources below can help you identify additional opportunities for activities and interventions that address each of the identified priority areas.

Social and Place Connectedness

- **Healthy People 2020, Social Determinants of Health, Interventions and Resources:** https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources
- **What Works for Health, Family and Social Support:** http://whatworksforhealth.wisc.edu/factor.php?id=6
- **Build Healthy Places Network:** http://buildhealthyplaces.org/network_resources/
- **Robert Wood Johnson Foundation:** http://www.rwjf.org/en/our-focus-areas/topics/built-environment-and-health.html
- **Plan4Health:** https://www.planning.org/nationalcenters/health/psecoalitions/resources.htm
- **AARP Foundation:** http://connect2affect.org/resources/
- **ChangeLab Solutions, Healthy Planning Guide:** http://www.changelabsolutions.org/sites/default/files/BARHII_Healthy_Planning_Guide_FINAL_web_090821-rebrand.pdf
- **American Planning Association, Healthy Plan Making:** https://planning-org-uploaded-media.s3.amazonaws.com/legacy_resources/research/publichealth/pdf/healthyplanningreport.pdf

Opportunities that Improve Health

- **Healthy People 2020, Access to Health Services, Interventions and Resources:** https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/ebrs
- **Healthy People 2020, Social Determinants of Health, Interventions and Resources:** https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources
- **What Works for Health, Access to Care:** http://whatworksforhealth.wisc.edu/factor.php?id=16
- **American Public Health Association, Improving Health by Increasing Minimum Wage:** https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2017/01/18/improving-health-by-increasing-minimum-wage



Best Practices and Resources, cont.

Healthy Foods and Beverages

- **Healthy People 2020, Nutrition and Weight Status, Interventions and Resources:** www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status/ebrs
- **What Works for Health, Diet and Exercise:** http://whatworksforhealth.wisc.edu/factor.php?id=12
- **The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables:** www.cdc.gov/obesity/downloads/fandv_2011_web_tag508.pdf
- **CDC Healthier Food Retail: An Action Guide for Public Health Practitioners:** www.cdc.gov/nccdphp/dnpao/state-local-programs/pdf/healthier-food-retail-guide-full.pdf

Mental Health

- **Healthy People 2020, Mental Health and Mental Disorders, Interventions and Resources:** www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/ebrs
- **What Works for Health, Access to Care:** http://whatworksforhealth.wisc.edu/factor.php?id=16
- **SAMHSA, National Registry of Evidence-based Programs and Practices:** https://www.samhsa.gov/nrepp
- **The Community Guide, Mental Health:** https://www.thecommunityguide.org/topic/mental-health

Alcohol and Other Drugs

- **Healthy People 2020, Substance Abuse, Interventions and Resources:** https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse/ebrs
- **What Works for Health, Alcohol and Drug Use:** http://whatworksforhealth.wisc.edu/factor.php?id=13
- **SAMHSA, National Registry of Evidence-based Programs and Practices:** https://www.samhsa.gov/nrepp
- **The Community Guide, Excessive Alcohol Consumption:** https://www.thecommunityguide.org/topic/excessive-alcohol-consumption



Next Steps

Our immediate next steps include sharing the findings of our CHIP with the community. The Winnebago County Health Department's community coalition, re:TH!NK, will host community events to encourage community members and partners to join action teams working on many of the priorities identified in the CHIP. We will also continue to identify ways to integrate these priorities into all of the work of the health department.

However, the power of the CHIP is so much greater when people, organizations, and systems throughout the community use it as a resource in their efforts. There are endless ways to get involved in the work!

- Use the ideas in the "**What can you do to help**" section and strategies of each of the priorities to make a change within your life, family, organization, and community.
- Join our community coalition, re:TH!NK (website: rethinkwinnebago.org).
- Contact us!

  Email: health@co.winnebago.wi.us
  Phone: 920-232-3000

The CHIP is a living document. As our community learns, grows, and changes, this document will also grow and change to adapt to that learning. Through it all, we will remain committed to using evidence to inform our practice, communicating our work and our findings with our community, and integrating a health equity focus into the work. To help community partners in maintaining these same commitments, we've provided a few resources below.

- **Evidence-based interventions and best practices**
  - **The Community Guide to Preventive Health Services:** https://www.thecommunityguide.org/
  - **What Works for Health:** http://whatworksforhealth.wisc.edu/
  - **Healthy People 2020:** https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources

- **Health communication**
  - **The Community Guide, Health Communications:** https://www.thecommunityguide.org/topic/health-communication

- **Health equity**
  - **The Community Guide, Health Equity:** https://www.thecommunityguide.org/topic/health-equity



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Appendix A:
Partner List

Many partners contributed to the development of the CHIP in many different capacities. The list below is not exhaustive of all partners involved throughout the process, but is representative of the variety of partners who supported and contributed to this effort specifically through the Community Conversations.

Affinity Health System
Aurora Health Care
City of Neenah
City of Oshkosh Senior Services
East Central Wisconsin Regional Planning Commission
Home Care Assistance
Local business owners
Lutheran Homes of Oshkosh, Inc
Lutheran Social Services
Menasha School District
NAMI Fox Valley
Neenah City Council
Neenah Police Department
Neenah School Board
NEW Mental Health Connection
Nova Counseling
Options Treatment Programs
Oshkosh Area Community Foundation
Oshkosh Area United Way
Oshkosh City Council
Oshkosh Police Department
Oshkosh School Board
Parkview Health Center
Reach Counseling
Relocate Fox Cities
re:TH!NK
Samaritan Counseling Center
Schenck
Solutions Recovery Club
Town of Menasha
UNA
United Way Fox Cities
University of Wisconsin Oshkosh
University of Wisconsin-Extension, Winnebago County
Village of Fox Crossing Police Department
Winnebago County Aging and Disability Resource Center
Winnebago County Board
Winnebago County Board of Health
Winnebago County Heroin Task Force
Winnebago County Human Services
Winnebago County Human Services Board
Winnebago County Parks Department
Wisconsin State Assembly Representatives
YMCA

And community members throughout Winnebago County.

Thank you!

Appendix B:
Data Summary

Primary and Secondary Data

The CHIP begins with partners and data. Much of the data for the assessment is from secondary data sources. Secondary data refers to data collected by another organization for another purpose. Local public health departments use many secondary data sets on a regular basis to compare rates or trends of health outcomes.

Primary data is purposely collected by the health department in order to better understand specific situations, issues and potential solutions. Primary data identifies community perceptions and priorities and community resources. Primary data can be both quantitative and qualitative, collected by various means including surveys, listening sessions, interviews and observations. Primary data is collected to better understand contributing factors or elements of secondary data sets.

Primary Data

The primary data collected for the community health improvement plan includes:

- Key Informant Interviews, 2015
- Winnebago County Community Health Survey
- Winnebago County Youth Risk Behavior Survey (WCYRBS)*
- Community Conversations, 2016
    - Legislative Breakfast
    - 8 Topic Focused Community Conversations (nutrition, physical activity, alcohol and other drugs, mental health)
    - 8 Topic Focused "Dots" Seriousness and Changeability
    - Boys and Girls Club Food Pantry interviews
    - Oshkosh Senior Center

Secondary Data

Secondary data sets are increasing from many health related topic areas. Here is a list of most used data sets.

- State and National Youth Risk Behavior Survey (YRBS)
- State and National Behavior Risk Factor Surveillance Survey (BRFSS)
- County Health Rankings
- Winnebago County Core Data Set
- Fox Cities Life Study 2016
- Healthiest WI 2020 (WI State Health Plan)
- Disparity Report (WI State Health Plan)
- WI Interactive Statistics on Health (WISH)
- Public Health Profiles
- Healthy People 2020

* Winnebago County Health Department contracts with CESA 6 to provide a summary of YRBS for school districts who participate in administering the survey

** Winnebago County Health Department collaborates with the Fox Valley Community Health Improvement Coalition which coordinates the administration of the Winnebago County Community Health Survey.

Appendix C:
Example Handout, Community Conversations

Current State of Physical Activity in Winnebago County

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LOCAL DATA SUMMARY

The Centers for Disease Control and Prevention recommends adults get a minimum 150 minutes of moderate-intensity physical activity every week for important health benefits and prevention of diseases like heart disease and diabetes. Being overweight or obese increases one's risk for developing chronic diseases. Nearly two-thirds of adults and children are considered overweight or obese in Winnebago County. About half of adults and half of high school students in the County meet the recommendations for physical activity. Top barriers to getting enough exercise are "Don't have the time," "I'm not the sporty type," and "Don't have the energy."

Key informants interviewed understood the interconnectedness of physical activity and nutrition in overall obesity prevention and healthy lifestyle promotion. Nine of the 32 informants in Winnebago County listed "physical activity" as a "top five health-related" priority and four informants ranked it is as the Number 1 priority.

KEY STATISITCS

- 58.3% of Winnebago County 5th graders are overweight or obese*
  Source: UW Madison Active Schools Core 4+ Program Activity and Fitness Report for Fall Semester 2014
- 70.3% of Winnebago County adults are overweight/obese^
  Source: 2012 Transform WI Winnebago County Mini-SHOW (Survey of the Health of Wisconsin)
- 48% of Winnebago County high school students were physically active for at least 60 minutes on most (5+) days of the week (Wisconsin- 49.5%; National- 47.3%)
  Source: Youth Risk Behavior Survey 2013-14
- 49% of Winnebago County adults who participate in moderate physical activity report an average of 5+ days/week in which they exercise for at least 10 minutes at a time
  Source: Behavioral Risk Factor Surveillance System Survey 2015

COMMUNITY CONDITIONS

Improving community conditions to be more pedestrian/bicycling friendly is a public health best practice that increases access to physical activity opportunities (like walking and bicycling) for all people. Bicycle/pedestrian plans exist for the municipalities of Oshkosh and Town of Menasha and the urbanized areas are covered in the Appleton (Fox Cities) and Oshkosh regional plan. About 15% of all county roadways have bicycle improvements including some sort of paved shoulder and 42% of all roadways within the county have sidewalks. It is typically difficult for most residents to get around Winnebago County using active transportation (biking, walking, using transit). Only 4-5% of County residents use active transport to get to work. Common reasons residents do not bike, walk or use transit include long travel distance, too much vehicle traffic, lack of bike routes/lanes or sidewalks, transit routes don't go where they need to go, often or directly enough, and personal safety concerns.

*For children, a healthy BMI is one that falls between the 5th and 85th percentiles based on their age (in months) and gender. Overweight is 85th-95th percentile, and Obese is equal or greater than the 95th percentile.
^Actual heights and weights of participants were measured for the SHOW data collection giving a more accurate representation of BMI. Self-reporters typically under report weight and over report height.

Appendix D:
Dots Exercise Topics & Problem Statements

Alcohol and Other Drug Abuse

- Underage drinking is too high
- Excessive (binge) drinking is too common
- Teen marijuana use is too high
- Opiate use (Prescription Drugs/Heroin) is too high
- Use of e-cigarettes among youth is increasing

Nutrition and Healthy Food Systems

- Access to fresh, affordable fruits and vegetables is limited
- Availability of locally grown produce in schools is limited
- Healthy menu items in restaurants, convenience stores, etc. are difficult to identify
- Current food environment makes it difficult to eat healthy
- Children are not developing healthy eating habits

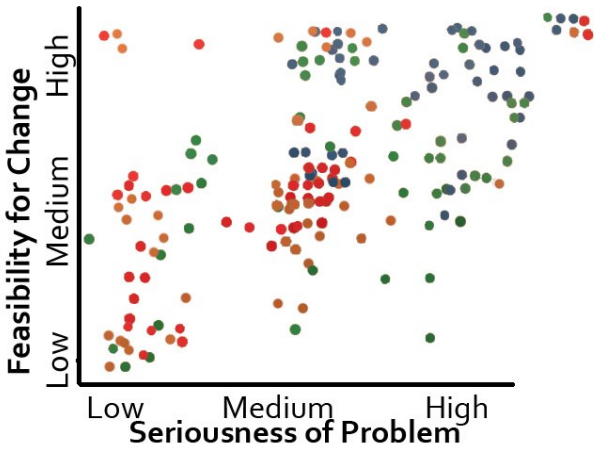
Physical Activity

- Access to active transportation opportunities (biking/walking, using transit) is limited
- Children are not getting enough physical activity in/at school
- There are not enough low-cost active recreation opportunities available for youth
- There are not enough low-cost physical activity opportunities available for adults

Mental Health

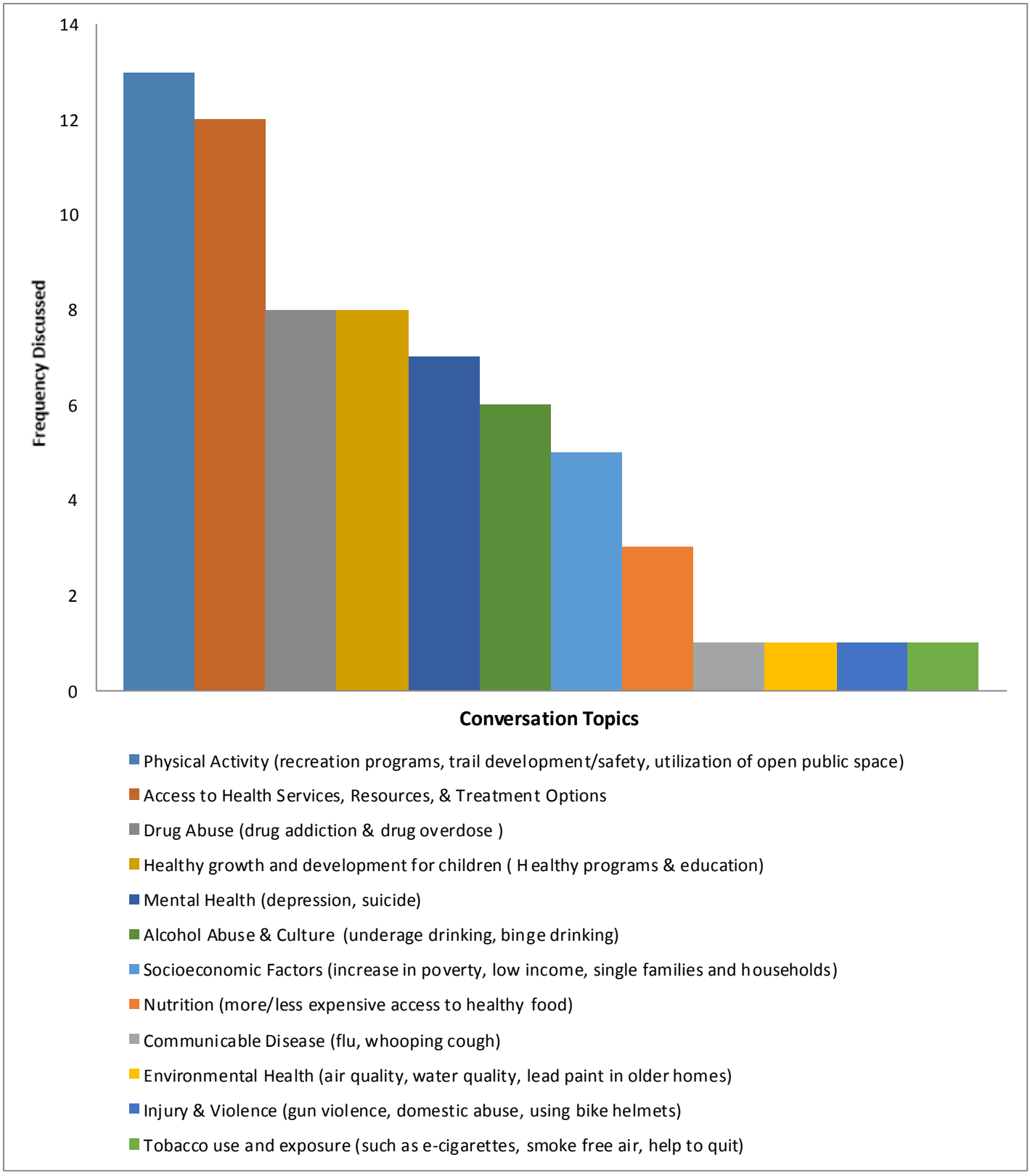
- There are long waiting lists to see mental health care providers
- It is difficult to know how or where to receive mental health care
- Many people believe that mental health is not as important as physical health
- There are too many teen suicides
- Childhood trauma (abuse, neglect, domestic violence) is too high

Example of combined dots from all conversations for the physical activity problem statements. Each color represents a different problem statement.



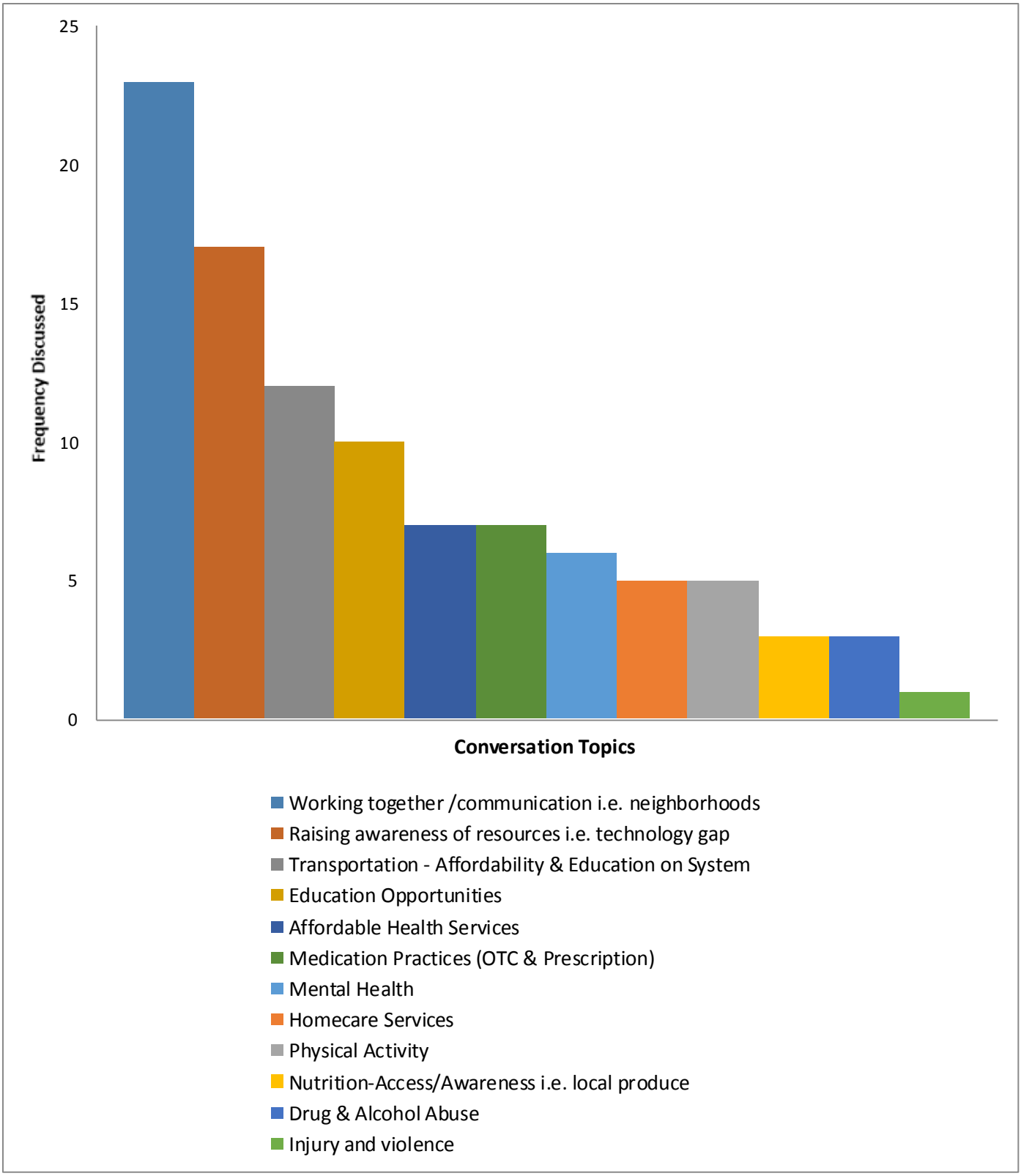
Appendix E:
Community Conversation Key Findings

Elected Officials, Legislative Breakfast



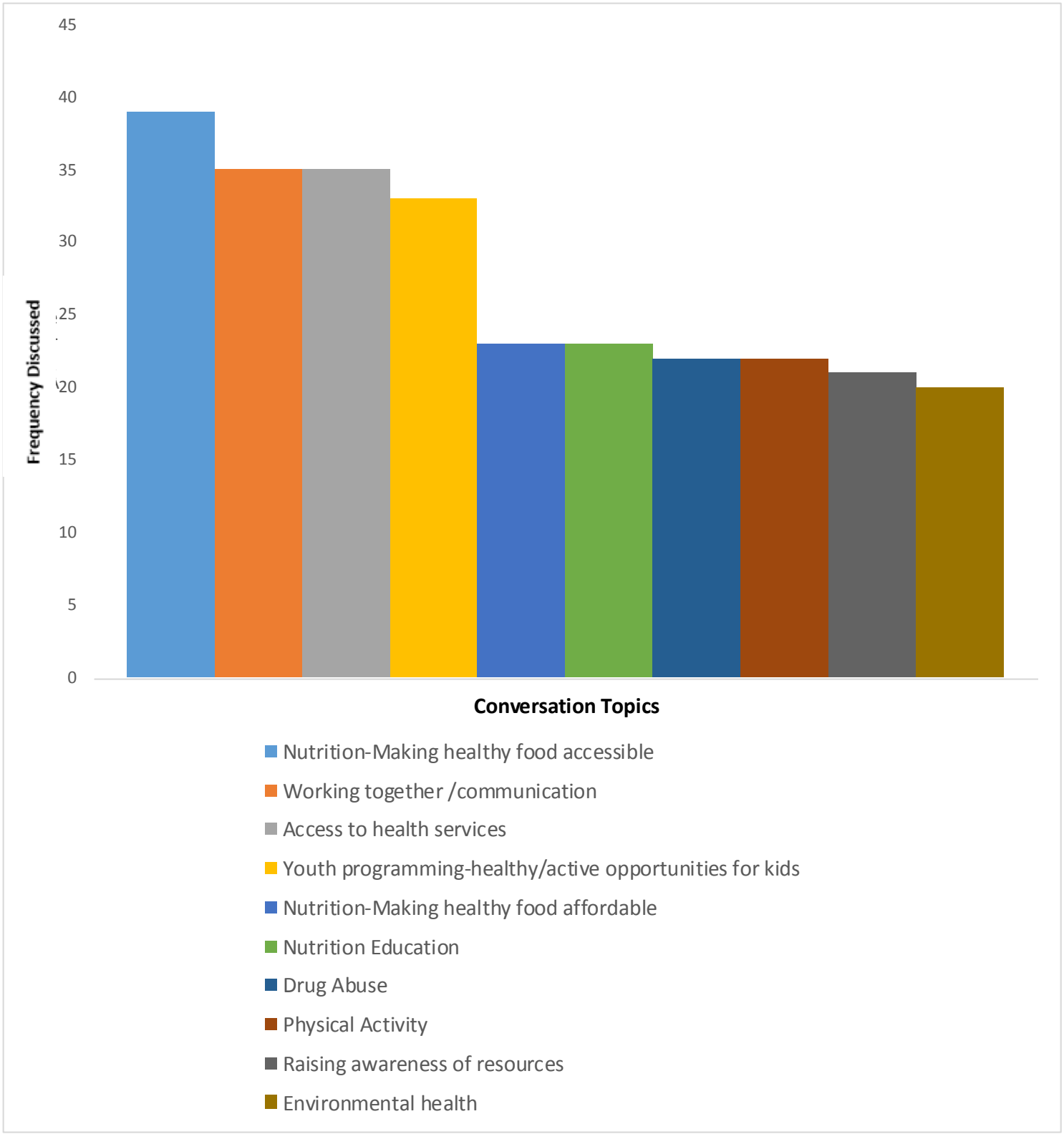
Appendix E:
Community Conversation Key Findings, cont.

Older Adults, Senior Center Conversation



Appendix E:
Community Conversation Key Findings, cont.

Residents with Lower Income, Top 10 Health Problems from Interviews



Appendix E:
Community Conversation Key Findings, cont.

Residents with Lower Income, Biggest Issues Identified on Written Questionnaires