IMPROVING COMMUNITIES' HEALTH

Marshfield Clinic Health System

Dr. Susan Turney

The rural communities Marshfield Clinic Health System serves face unique challenges when it comes to accessing health care services. Many of our patients live long distances from the nearest health care facility. Public transportation and broadband internet access are much more limited in rural communities when compared to their urban counterparts.

Because of these unique challenges, it is critical for rural health care providers to be innovative in the way we care for our communities. One essential way we do this is by working outside our own clinical walls and forming partnerships with local organizations that share our passion for creating healthy communities.

We've put together this report to show how a thoughtful, strategic and comprehensive approach to community partnerships is making a difference for the people we serve every day. We are proud to share these stories about the work we are doing through our Center for Community Health Advancement, hand in hand with local partners across our service area. Together we are working to improve the health of our communities, where so many Wisconsin residents live, work and play.

This is an exciting time for us, and I am deeply proud of the people and programs you'll learn more about in these pages.

Sincerely,

Dr. Susan Turney
Chief Executive Officer | Marshfield Clinic Health System

Jay Shrader

People's contact with clinical health care is generally short.

After medical appointments they go home, back to their communities which most influence their health. That's where the Center for Community Health Advancement (CCHA) is, working to enrich lives beyond clinical walls.

As the Marshfield Clinic Health System's public health arm, CCHA has programs, services and staff that touch every county and tribe in our service area.

As a health system that prides itself on delivering rural health care, we have to innovate and think differently. That's what we are doing, working with other partners, too. This is not only important but necessary.

The No. 1 predictor of success is not funding but leadership support and our visionary leaders support this work. They place us as rural health leaders and believe providing clinical care inside our four walls isn't enough.

Communities have many needs. We have assessed them and chosen four initial priorities to tackle in the next three to five years through partnering with likeminded, visionary community-based organizations around our priorities - the ABCS.

This is where health and medicine meet social care and we lean on our partners to help us figure this out. And, nothing is more important than improving health and wellbeing where people live, work and play.

This edition of the report includes information about some of the new and innovative work we are doing in our communities. To learn more about these and other programs, please visit our website - ccha.marshfieldclinic.org.

Sincerely,

Jay Shrader
Vice President | Community Health and Wellness

Marshfield Clinic Health System

Marshfield Clinic Health System mission: We enrich lives.

Enriching lives happens in different ways, including improving the health of our communities beyond clinical walls. In 2018, as a result of conducting qualitative and quantitative assessments of community needs, the Health System identified four interconnected key community health priorities – the ABCS:

A

ALCOHOL AND SUBSTANCE ABUSE

- Reduce underage and excessive alcohol consumption
- Reduce opioid-related deaths

B

BEHAVIORAL HEALTH

- Decrease suicide rates
- Improve social and emotional development of children and adolescents

C

CHRONIC DISEASE

- Improve access to healthy foods and physical activity
- Improve self-management of chronic conditions
- Reduce tobacco use

S

SOCIAL DETERMINANTS OF HEALTH (SDOH)

- Increase knowledge and awareness of health equity
- Connect clinical practice to community efforts to address SDOH barriers

We use evidence-based strategies to address needs and seek innovative solutions to tie back or bridge to high-quality clinical care within communities.

Strategies

Organization

Discipline

Innovation

Coordination

Connection

Future

A

ALCOHOL AND SUBSTANCE ABUSE

Our goals

A.1. Prevent and reduce underage and excessive alcohol consumption

Measure(s):

- Adult binge drinking rate
- Underage drinking rate

Wisconsin continues to rank among the worst in the nation for both heavy drinking and binge drinking among adults. About one in four (24.3%) Wisconsin adults engaged in binge drinking in the previous month compared to the national median of 18.3%.

In 2017, 30.4% of students reported that they currently drink and 64.5% reported ever having had a drink. Also, 16.4% of students report binge drinking. More than one in three high school students in Wisconsin drank alcohol in the past 30 days.

A.2. Prevent and reduce opioid-related deaths and harm

Measure(s):

- Adolescents who have used an opioid prescription drug for non-medical purposes
- Number of opioid-related overdose deaths

In 2017, there were 926 overdose deaths involving opioids in Wisconsin, a rate of 16.9 deaths per 100,000 persons, higher than the national rate of 14.6 deaths per 100,000 persons. The greatest increase in opioid deaths was seen in cases involving synthetic opioids, mainly fentanyl, a rise from 56 deaths in 2012 to 466 deaths in 2017, according to the National Institute on Drug Abuse.

The opioid epidemic has been declared a national public health emergency. The rate of opioid overdose deaths in Wisconsin nearly doubled, from 5.9 deaths per 100,000 residents in 2006, to 10.7 deaths per 100,000 residents in 2015. Similarly, emergency room visits for suspected opioid overdoses increased 109 percent in Wisconsin from July 2016 to September 2017.

Highlighted efforts

AmeriCorps Recovery Corps

Northwoods Coalition

Our stories

Addressing recovery through coaches who have lived it

Marshfield Clinic Health System AmeriCorps Recovery Corps is the first AmeriCorps program in the nation to address substance abuse by engaging people with recovery experience themselves as members.

In 2019, it was named the Governor's Service Awards Program of the Year for Wisconsin.

Recovery Corps started in the Northwoods and has since expanded to Marathon, Lincoln and Langlade counties, serving schools and jails for example, with plans for expansion.

Program Manager Becky Boquist said, "the way we structure and support our members is unique and alleviates problems other recovery coaching programs have."

The program has exponentially increased its service goals, which was initially 100 people in the first year. The program surpassed that initial goal by serving 487 people in their communities thanks to dedicated, motivated coaches who go beyond expectations to meet communities' needs.

Boquist is mentoring similar programs nationwide to extend the reach of this innovative recovery program beyond Wisconsin. Coming into its third year, the federal AmeriCorps program in Washington, D.C., is researching Recovery Corps with hopes to feature the program in its study report.

Marshfield Clinic Health System AmeriCorps Recovery Corps 2018-19 Recovery Coaches are pictured at midterm training with Program Manager Becky Boquist (front row, second from right).

Coming together for stronger coalitions and healthier communities

Marshfield Clinic Health System is a key member of the Northwoods Coalition, the largest and oldest coalition dedicated to substance use prevention in Wisconsin.

The group brings community coalitions together to promote effective substance abuse prevention through networking, advocacy, mentoring and leadership.

Regional coalition representatives come from across the System's service area and include all 11 federally-recognized tribal nations. These representatives serve on an advisory board that helps shape policies, practices and programs addressing public health issues arising from alcohol and other drugs use.

Since the Coalition's founding in 1995, the Center for Community Health Advancement (CCHA) has provided support through education, training, technical assistance and more. Part of that support includes holding grants, distributing funds and implementing projects for Northwoods Coalition. Resulting from this collaboration, a wide range of initiatives have been developed to address prevention, each one specific to the community needs of our partner coalitions.

Northwoods Coalition Advisory Board members for 2019-20 attend a quarterly meeting.

B
BEHAVIORAL HEALTH

Our goals

B.1. Decrease suicide rates

Measure(s):

- Suicide rate
- Hospitalizations due to self-inflicted injury

Wisconsin consistently has higher youth suicide rates than the national average. Suicide is the 10th leading cause of death in Wisconsin and nationally, but the second leading cause of death among people ages 15-24. Between 2007 to 2015, the national youth suicide rate for ages 15-19 increased by 30% for males and doubled for teen females. In Wisconsin, youth suicide rates have doubled from 2007 to 2015. For every death by suicide, there are 10 times as many emergency visits and hospitalizations for self-inflicted injuries.

B.2. Improve social and emotional development of children and adolescents

Measure:

- Poor mental health days

Evidence shows experiences in early and middle childhood are extremely important for a child's healthy development and lifelong learning. Research on a number of adult health and medical conditions points to pre-disease pathways that have their beginnings in early and middle childhood.

Highlighted efforts

Youth Net

Behavioral, Emotional, Screening Traits (b.e.s.t.)

Suicide prevention initiatives

Social Emotional Learning

Our stories

Behavioral health approach teaches students to identify and manage emotions

Children who identify and handle their emotions find they can better face life's challenges, but what about children who can't?

An innovative answer on the part of a clinical psychologist and an afterschool program, responding to a school district's observation, has become an impactful solution in Wisconsin.

Several years ago, Marshfield School District staff noticed students struggling with managing feelings. At the same time, staff with the Center for Community Health Advancement's (CCHA) afterschool program, Youth Net, wanted to provide more behavioral health resources for children.

Youth Net focuses on academic performance, social emotional learning (SEL) and healthy active living; and is a safe environment for children while supporting working families. Youth Net is located in the Marshfield Clinic Health System YMCA.

Marshfield Clinic Clinical Psychologist Michael Schulein, Ph.D., developed an innovative program, serving about 20 students each year out of about 100 children ages 8-18 enrolled in Youth Net. Youth Net staff, educators and caregivers saw early success which led to creating the Life Tools Curriculum Guide in 2019. The curriculum is being piloted in Marshfield, Phillips and Park Falls school districts. Life Tools is being expanded to other rural Wisconsin areas. The behavioral health curriculum is already being implemented in some school districts, with growing interest across the state.

School-based interventions to address behavioral health in the classroom

In 2013, Marshfield Clinic Health System's health plan, Security Health Plan, partnered with former School Psychologist Eric Hartwig, Ph.D., to develop the Behavioral, Emotional and Social Traits (b.e.s.t.) screening and interventions program.

b.e.s.t. brings behavioral health care directly into schools, providing a vital resource to help schools and teachers screen children who need intensive, focused attention. It leads to more productive, functional classrooms and equips students to better handle challenges. Teachers screen students at the beginning and end of a school year to help them determine areas to address and track progress.

Prior to the 2019-20 academic year, b.e.s.t. was an elementary school resource for grades pre K-6. This resource now includes a pilot for middle and high school students.

During the
2018-19
school year,
24,137
children screened;
1,212
teachers
trained

Supporting Zero Suicide efforts

Suicide is the 10th leading cause of death in the U.S. and can have a devastating impact on a community.

Realizing that suicidal individuals may fall through the cracks in a health care system, the Center for Community Health Advancement (CCHA) supports the Marshfield Clinic Health System's Zero Suicide initiative that focuses on Question, Persuade, Refer (QPR) training offered several times yearly.

These three basic steps teach how to help someone in crisis. CCHA also has hosted screenings of the suicide prevention documentary, "The Ripple Effect," which tells the true story of a man who survived a suicide attempt.

Volunteers gather at the Everett Roehl Public Library in Marshfield to hang green ribbons around town for a Zero Suicide mental health awareness campaign.

C

CHRONIC DISEASE

Our goals

C.1. Improve access to healthy foods and physical activity

Measure(s):

- Adult/youth obesity rate
- Physical activity rate

A chronic condition is a health condition or disease that's persistent, long-lasting or develops with time. Common chronic diseases include arthritis, asthma, cancer, chronic obstructive pulmonary disease, diabetes and hepatitis C.

Almost one in five children and more than one in three adults in the U.S. struggles with obesity, causing $147 billion in obesity-related health care costs each year. The national obesity rate is at 39.4% while Wisconsin's obesity rate is 4.5% higher. People who eat a healthy diet and get enough physical activity live longer and have fewer chronic diseases.

C.2. Improve self-management of chronic conditions

Measure(s):

- Diabetes adherence
- Falls rate

Evidence-based preventive interventions recommended for the general population are relevant to living well with chronic illness. In some cases, such interventions can affect the disease process, progression or complications of chronic disease.

C.3. Prevent and reduce tobacco use and exposure

Measure(s):

- Adult/youth tobacco use rate

Tobacco use is the largest preventable cause of death and disease in the U.S. Smoking-related illness costs more than $300 billion annually - nearly $170 billion for direct adult medical care and more than $156 billion in lost productivity - and 14% of all state deaths are attributable to smoking. E-cigarette use surpasses cigarette use from 7.9% in 2014 to 13.3% in 2016 among high school youth.

Highlighted efforts

Hydroponic Gardens

Youth E-Cigarette Use Prevention

Our stories

E-cigarettes and vaping: A new and growing public health concern

The Center for Community Health Advancement (CCHA) is addressing the growing e-cigarettes and vaping epidemic, since there is much momentum around the topic.

Misinformation is everywhere and schools, parents, coalitions, agencies and communities need correct information to reduce use.

CCHA hosted a conference in 2019 in Eau Claire and Wausau. Since then, stipends have been awarded for 38 community-based projects across the service area. CCHA communicates with partners, Department of Health Services, American Lung Association and others to determine next-steps and consider innovative ways to support communities, regions and partner-initiatives around these issues.

Center for Community Health Advancement staff host an E-cigarette and Vaping Forum in Eau Claire.

Hydroponic gardens are growing access to healthy, fresh produce year-round

The Center for Community Health Advancement (CCHA) is placing hydroponic garden units in locations across the Marshfield Clinic Health System service area to address the issue of food insecurity.

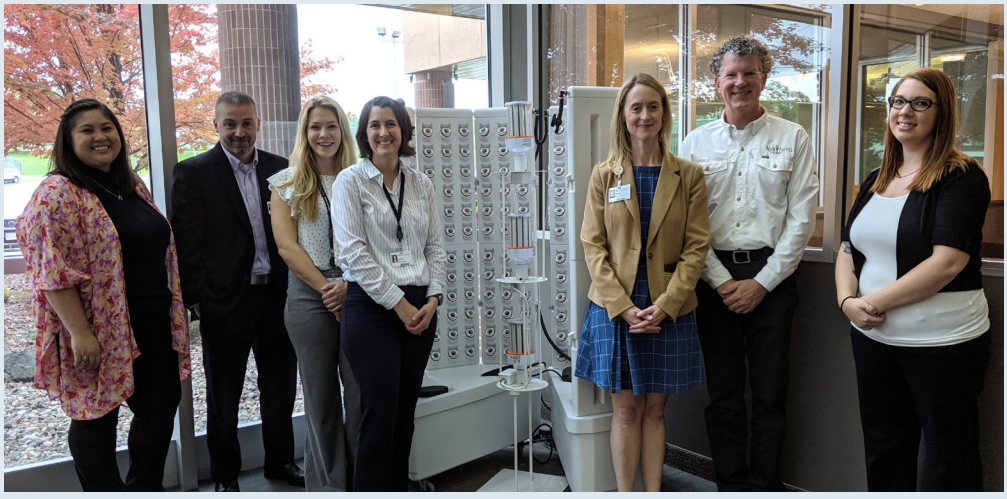
These indoor gardens, constructed by Wisconsin-based Fork Farms, LLC, grow plants in nutrient-rich water instead of soil.

They are strategically placed to help individuals and communities struggling with food insecurity access to fresh produce year-round and support awareness that healthy food is necessary for good health.

In 2018, the Health System awarded a healthy communities grant to the Lincoln County Health Department for the units. Their success inspired CCHA to look at community health data, place units where there is the greatest need and see what type of impact can be made on food insecurity, health and accessibility to fresh produce.

One identified area of great need is Rusk County. Units have been placed with community partners in Ladysmith, Flambeau and Bruce.

CCHA will continue to plant the seed in other communities, all to improve the health of their residents through access to affordable nutrition.



A hydroponic garden unit installation at the Fig Building included staff members from the Center for Community Health Advancement and Security Health Plan along with Steve Tyink (second from right), partnership development at Fork Farms, LLC.

S

SOCIAL DETERMINANTS OF HEALTH (SDOH)

Our goals

S.1. Increase knowledge and awareness of health equity

Measure(s):

- Knowledge change survey results (pre/post)
- Number of new or improved policies that address

As the field of SDOH grows and evolves, there is increasing emphasis on better understanding and addressing fundamental causes, or upstream factors, of poor health and inequities. Social, economic and educational factors influence Wisconsin's grade for overall health and eliminating health disparities has remained the same since 2007. According to the University of Wisconsin Population Health Institute's 2016 Wisconsin Report Card, the state of Wisconsin has an overall health disparities grade of "D." The Report Card also notes that while Wisconsin's grade for overall health has remained the same since 2007, the health disparities grade has gotten worse since 2010, moving from a C- to a D in 2013 and 2016. This change indicates Wisconsin needs to do more to reduce health disparities associated with gender, socioeconomic status, race/ethnicity and geography.

S.2. Improve health outcomes by connecting clinical practice to community efforts to address SDOH barriers

Social determinants of health are the economic and social conditions that influence individual and group differences in health status.

Measure(s):

– Clinical measures (e.g., BMI, diabetes, blood lipids, etc.)

– Health care use (e.g., ER/urgent care visits, no shows)

Up to 40% of individual health outcomes, particularly among low-income populations, are attributed to social and economic factors like food insecurity, transportation and housing. Health literature and research consistently finds people living in lower socioeconomic neighborhoods and communities have poorer health outcomes.

Highlighted efforts

Community Connections Team

Food Pharmacy

Our stories

Continuing the quality health care experience beyond clinic walls

Community Connections Team (CCT) is an innovative program that connects people in need with helpful resources in their communities.

This is a holistic, humanistic approach to health care. CCT Program Manager Trevor Begin said, "historically in health care, a patient sees a provider, symptoms are treated. The patient follows a regimen and has a regimen and have follow-up appointments without factors outside clinical walls being considered. We now know health is impacted more by factors outside the health care setting than inside them.

The process of meeting needs begins during the medical visit when patients are screened for caregiver support, job search, child care, health insurance, housing and more. CCT volunteers give their time within the health care setting to assess patients' social needs and connect them with community resources to address underlying social needs that can negatively impact their health.

Anywhere from 70-100 patients receive followup daily, either face to face or by phone. A diverse constituent group oversees the program with representatives from clinics, campuses, community, volunteers, local organizations and, most important, those directly affected by the program.

In 2018, a Wisconsin Partnership Program $1 million grant catapulted the program. Now it impacts people in Stevens Point and Marshfield and expanded into Marathon, Lincoln and Langlade counties through a partnership with Northcentral Health Care in Wausau.

78% of patients would not have looked for resources without CCT

95% agreed CCT connected them with resources met their needs

97% would recommend to others

Food Pharmacy prescriptions help patients manage diabetes differently

Health care doesn't necessarily address what influences health in patients' homes but that's changing.

CCHA, with Security Health Plan, is addressing diabetes management through innovation, relationships and partnerships for a groundbreaking solution. Instead of managing only diabetes symptoms, plans are for a food pharmacy approach including a health care team. Patients will collaborate with a certified diabetes educator, Security Health Plan health coach, pharmacy residents and registered dietitians.

Patients will be recruited from a 30-mile radius of Marshfield Clinic Lake Hallie Center for the pilot program and screened for risk or diagnosis of diabetes and food insecurity. The first year's goal is to have 100 patients participate. Patients will get individualized care and food, along with resources to address social determinants of health, with referral to CCHA's Community Connections Team for other social determinants of health.

Center for Community Health Advancement staff members JoAnna Bernklau and Emily Brunstad meet with Feed My People Food Bank staff to discuss a partnership with the food pharmacy program.

Marshfield Clinic
Health System

To learn more about CCHA and its innovative programs,
please visit our website - ccha.marshfieldclinic.org.

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