Joint Community Health Needs Assessment
July 31, 2016

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Minneapolis, MN

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Introduction

Rogers Memorial Hospital, Inc. is Wisconsin's largest behavioral health care services provider and has been operating for over a century. Rogers Memorial Hospital, part of Rogers Behavioral Health, provides a significant segment of the inpatient mental health care in the state of Wisconsin. Rogers Memorial Hospital, Inc. currently operates three campuses with inpatient and specialized outpatient facilities in Oconomowoc, Milwaukee, and Brown Deer. Additional satellite locations are found in Kenosha, Madison and Appleton in Wisconsin as well as Tampa, Florida; Nashville, Tennessee; Skokie, Illinois; and Eden Prairie, Minnesota. These facilities are staffed by highly qualified mental health professionals including teams of physicians, therapists, counselors, dietitians, and other professional staff. To meet the individual needs of its patients, the hospitals offer the following hospital services:

- Inpatient Care: This intensive, short-term level of care provides stabilization for a variety of acute psychiatric symptoms and diagnoses. The primary focus is assessment, stabilization, and transition into partial hospitalization or outpatient therapy.
- Partial Hospitalization and Intensive Outpatient: These specialized outpatient programs provide transition from inpatient or residential care, an alternative to inpatient treatment, or a supplement to outpatient therapy. These half-day or part-time structured programs allow patients to continue involvement at home, work, or school.
- Residential Treatment: Residential treatment centers provide intensive extended care opportunities in a home-like setting for individuals seeking to overcome severe eating disorders, depression and other mood disorders, addiction including alcohol and substance use, and obsessive-compulsive disorder and relate anxiety disorders. Located at the Oconomowoc site on more than 50 acres of wooded lakefront property, each center provides a calming, confidential environment that allows patients to focus on their treatment.

Methods

Wipfli's Role

In December 2015, Wipfli LLP (Wipfli) was engaged by leadership at Rogers Memorial Hospital (RMH) to coordinate key aspects of the community health needs assessment (CHNA) process and write the joint CHNA report on behalf of the three hospital locations; Oconomowoc, Milwaukee and Brown Deer facilities. This joint CHNA report was completed in compliance with the IRS requirements described in section 501(r)(3) of the Internal Revenue Code.

CHNA Advisory Committee

The CHNA Advisory committee was formed by leadership at RMH. The team was tasked with completing the objectives outlined by the IRS CHNA requirements. The team consisted of the following members:

Matthias Schueth, VP of RMH Foundation
Stacy McGauvran-Hruby, Director of Marketing
Suzette Urbashich, Director of Rogers InHealth
Sue McKenzie, Director of Rogers InHealth
Emily Russart, Director of Finance

Community Served Determination

In keeping with the CHNA requirements, this report focuses on the community needs as they pertain to the hospital functions of RMH, not the ancillary programs RMH offers that are unrelated to its operations as a hospital organization. This CHNA was developed based on a collaborative effort between the three RMH hospital facilities:

1. Rogers Memorial Hospital - Oconomowoc Facility
2. Rogers Memorial Hospital - Milwaukee Facility
3. Rogers Memorial Hospital - Brown Deer Facility

These three facilities serve the same collective geographic service area. Over 55% of Wisconsin residents admitted were from Milwaukee and Waukesha counties. RMH's community outreach works with area residents, schools, clinics, and organizations from across the state to ensure everyone has access to services, information, and tools they can use to help them have a life worth living.
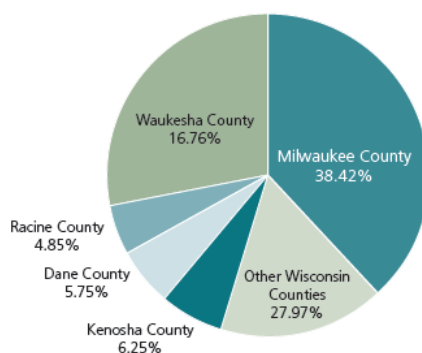
The definition of the community served by RMH was formed based on a historical analysis of admissions to the hospitals by County. While over half of patients admitted originate from Milwaukee and Waukesha Counties, Kenosha and Dane were also recognized by leadership as areas that are served collectively by RMH's hospital facilities.

CHNA Process

The CHNA was produced by the CHNA advisory committee at RMH, representing the three RMH hospital facilities in this collaborative process. Wipfli provided assistance in completing certain components of the report, including organizing and writing the joint CHNA.

The following outline explains the process RMH undertook to complete the CHNA. Each process and methodology is described in more detail throughout the report.

1. Formation of a CHNA advisory committee

2. Definition of the community served collectively by the RMH hospital facilities
    a. Demographics of the community
    b. Existing health care facilities and resources

3. Data collection and Analysis
    a. Primary data
    b. Secondary data
    c. County survey data

4. Identification and prioritization of community health needs and services to meet community health needs
    a. Results of primary, secondary and County survey data collection

5. Adoption of goals and implementation strategy to respond to prioritized needs in collaboration with community partners

6. Dissemination of priorities and implementation strategy to the public.

Secondary and County Survey Data Collection

There was an abundance of secondary data available with direct relevance to the CHNA process. The following is a list of data resources that were utilized to help capture the health needs of the community:

- ESRI – National Demographer service; Demographic information
- County Health Rankings – Health Rankings; County-specific indicators of health across a variety of measures
- Milwaukee County Youth Suicide Prevention Planning, 2014
- Kenosha County Community Health Survey Report, 2014
- Ozaukee County Community Health Survey Report, 2014
- Sheboygan County Community Health Survey Report, 2014
- Sheboygan County Secondary Data Report, 2014
- Sheboygan County Health Needs Assessment, 2014
- Waukesha County Community Health Assessment and Improvement Plan, 2014
- Kenosha County Community Health Improvement Plan 2011-2020, 2011
- Wisconsin Mental Health and Substance Abuse Needs Assessment, 2014

Primary Data Collection

RMH was able to rely heavily on data collected through various county surveys relevant to the health needs of the community served by the hospitals. These resources and the results are explained in more detail in the secondary and county survey data collection section of this report.

Once the county survey results were analyzed, RMH developed a survey instrument to drill into more detail regarding the health needs of the community. RMH's staff conducted surveys with individuals in the community. Survey respondents indicated they represent a mix of Wisconsin Initiative for Stigma Elimination (WISE) members, referring providers, municipal agencies as well as general community members. WISE is a statewide coalition of over 80 organizations and individuals promoting inclusion and support for all affected by mental illness by advancing evidence-based practices for stigma reduction efforts. The majority of WISE members are persons with lived experience and mental health advocates whose members participated in the survey, Individuals also included members of the Advocacy and Outreach Committee of Rogers (community members at large and RMH leadership). In December of 2015, interview participants were asked a series of questions designed by the Committee to drill down into the issues and needs surrounding mental health. Surveys asked participants to answer a series of questions regarding health needs and issues within the community. The results of these surveys helped to identify specific needs relating to mental health within the community that RMH serves.

Limitations/Information Gaps

While every effort was made to capture the true health needs of the community, the process of conducting a CHNA carries with it inherent limitations that need to be considered.

Surveys were conducted with a select group of people who represent the community that RMH serves. The views and opinions of those individuals are subject to bias, and therefore the needs developed through the interview process may not accurately reflect the true health needs of the population.

The health data that was analyzed as part of this study captures a wide array of health-related measures that help to better understand the needs of the population. However certain health needs might not be captured or reflected in the existing data sources, and therefore certain health needs may not have been given proper weight or importance.

Community/Demographic Profile - Secondary Data Results

Population

Waukesha County's population is expected to grow over the next five years, by 6,878 people. Milwaukee County is expected to grow by 4,415. Wisconsin is also expected to grow by 1.6%. Population is expected to rise nationally by 3.8%. All of the counties within RMH's service area are growing, with the exception of Racine County. This indicates that, all things equal, demand and utilization of services including mental health services will continue to rise.
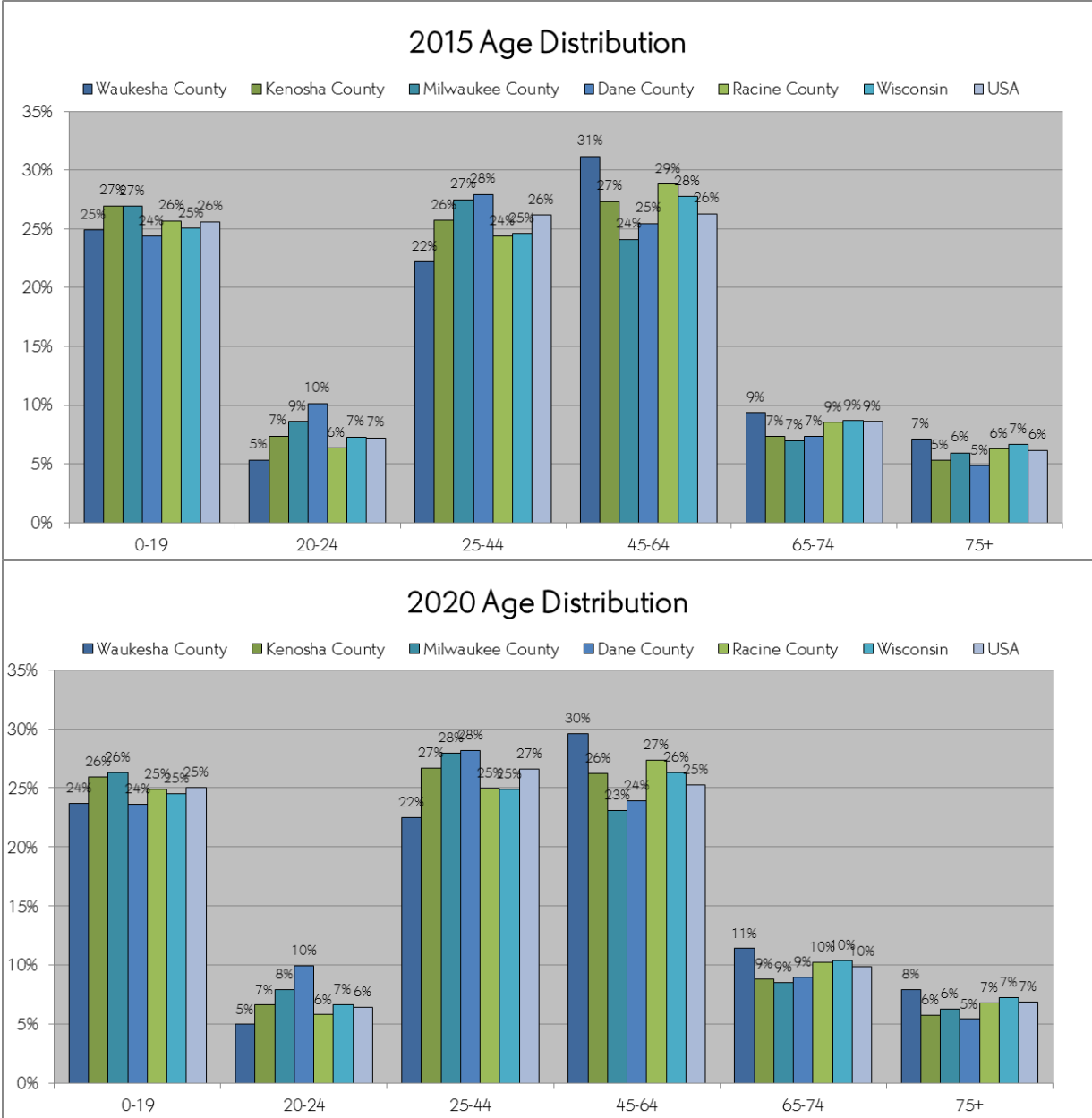
2015 and 2020 Population

	2015	2020	% Change (2015-2020)	Change (2015-2020)
Waukesha County	395,491	402,369	1.7%	6,878
Kenosha County	167,865	169,717	1.1%	1,852
Milwaukee County	939,707	944,122	0.5%	4,415
Dane County	507,522	535,063	5.4%	27,541
Racine County	193,921	193,760	-0.1%	-161
Wisconsin	5,742,139	5,834,632	1.6%	92,493
USA	318,536,439	330,622,575	3.8%	12,086,136

ESRI Business Information Solutions, 2015

Population by Age

Population was grouped into major age categories for comparison. Waukesha and Racine Counties tend to have an older population, while Kenosha and Milwaukee Counties have a relatively younger population, compared to Wisconsin and the US. These differences are expected to persist over the next five years, and reflect the need to target age-specific mental health services as necessary to meet the needs of the communities RMH serves.

2015 and 2020 Population Age Distribution

2015 Age Distribution

Legend: ■ Waukesha County ■ Kenosha County ■ Milwaukee County ■ Dane County ■ Racine County ■ Wisconsin ■ USA

2020 Age Distribution

Legend: ■ Waukesha County ■ Kenosha County ■ Milwaukee County ■ Dane County ■ Racine County ■ Wisconsin ■ USA

ESRI Business Information Solutions, 2015

Income

Income data was analyzed across the service area counties and compared to the state of Wisconsin and the Nation. All counties reported household income levels above Wisconsin's average except for Milwaukee, which fell significantly below in median, average, and per capita income. This is similar to income levels from the previous CHNA. Income levels are expected to rise across the service area over the next five years in line with inflation.

2015 and 2020 Income Levels

2015	Waukesha County	Kenosha County	Milwaukee County	Dane County	Racine County	Wisconsin	USA
Median Household Income	78,158	54,382	41,153	60,428	53,879	52,390	53,217
Average Household Income	100,465	68,818	57,226	79,451	69,023	68,135	74,699
Per Capita Income	39,805	26,273	23,506	33,670	27,248	27,779	28,597

2020	Waukesha County	Kenosha County	Milwaukee County	Dane County	Racine County	Wisconsin	USA
Median Household Income	88,988	64,966	47,831	74,374	62,764	60,187	60,683
Average Household Income	114,666	78,995	65,532	91,210	79,285	78,141	84,910
Per Capita Income	45,704	30,142	26,904	38,713	31,366	31,946	32,501

ESRI Business Information Solutions, 2015

Secondary Data Results

The County Health Rankings display health rankings of nearly every county in the nation and what influences the health of a county. They measure four types of health factors: health behaviors, clinical care, social and economic, and physical environment factors. In turn, each of these factors is based on several measures. A subset of the major health rankings are analyzed in this report. While these rankings do not directly pertain to the mental health status of the community, they do provide a valuable backdrop to the overall health of the community. This is important as health status may often influence or have association with mental health status within the community.

Out of 72 Wisconsin counties, Waukesha placed 14th overall for health outcomes based on the data collected by County Health Rankings. Milwaukee County ranked 71st.

Birth Statistics

Rates of low birthweight in a community are often associated with poor health of the mothers. Low birthweight can lead to higher incidences of fetal mortality, inhibited growth, and cognitive developments and chronic disease in later life, and is generally a predictor of newborn health and survival. Low birthweight percentages in Waukesha County are lower than Dane, Kenosha, Racine, and Milwaukee Counties except for in 2015 when the rate trended upward and surpassed Dane by 0.2%. Rates in the service area are all above the national benchmark of 6.0%.
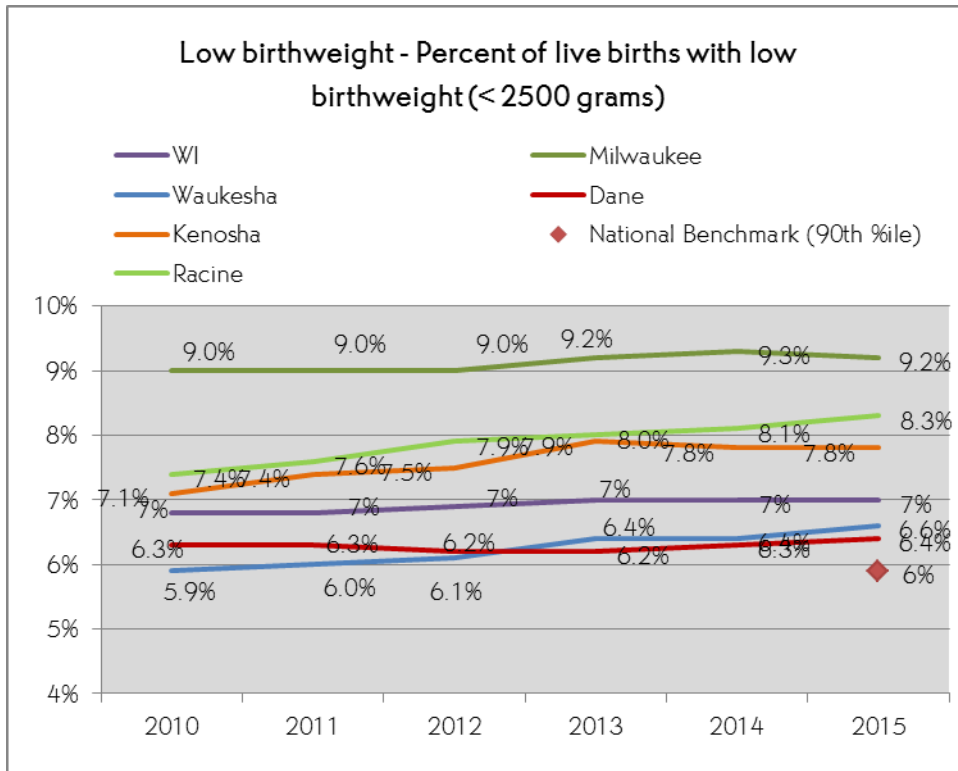
County Health Rankings, 2015

Insurance

Individuals without health insurance often forego care due to high cost, which can lead to a higher prevalence of chronic conditions. Lack of insurance also leads to a lack of access to mental and behavioral health services. The uninsured rate in Dane and Waukesha counties are all below Wisconsin and the national benchmark. Kenosha County's uninsured rate is above the national benchmark, and Milwaukee County uninsured rate has climbed significantly since 2010, although the rate has dropped by 1% in 2015.
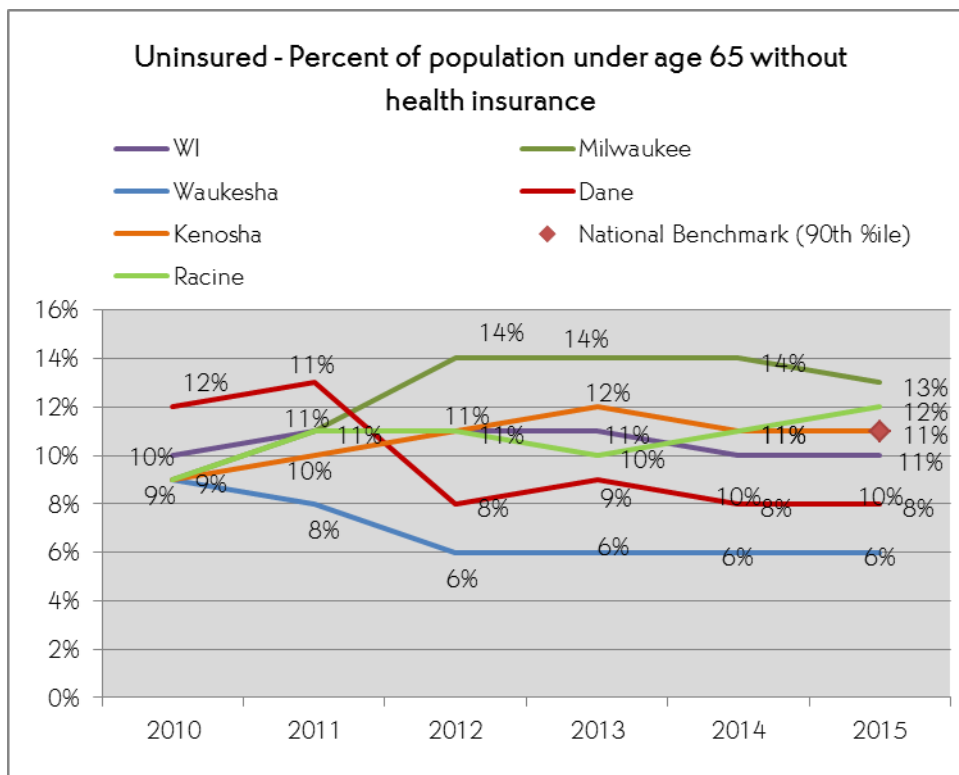
County Health Rankings, 2015

General Population Health

Reported general well-being is one measure of health included in the County Health Rankings Nationwide study. Reported general health of "poor or fair health" in the service area communities are all above national benchmarks and the state of Wisconsin, with the exception of Waukesha and Dane Counties, which fall at or below national benchmarks. A similar self-reported measure is "poor physical health days," which refer to days in which an individual does not feel well enough to perform daily physical tasks. Rates in the service area are all significantly higher than the national benchmark. Milwaukee in particular has a rate that is 1.6 times higher than the national benchmark.
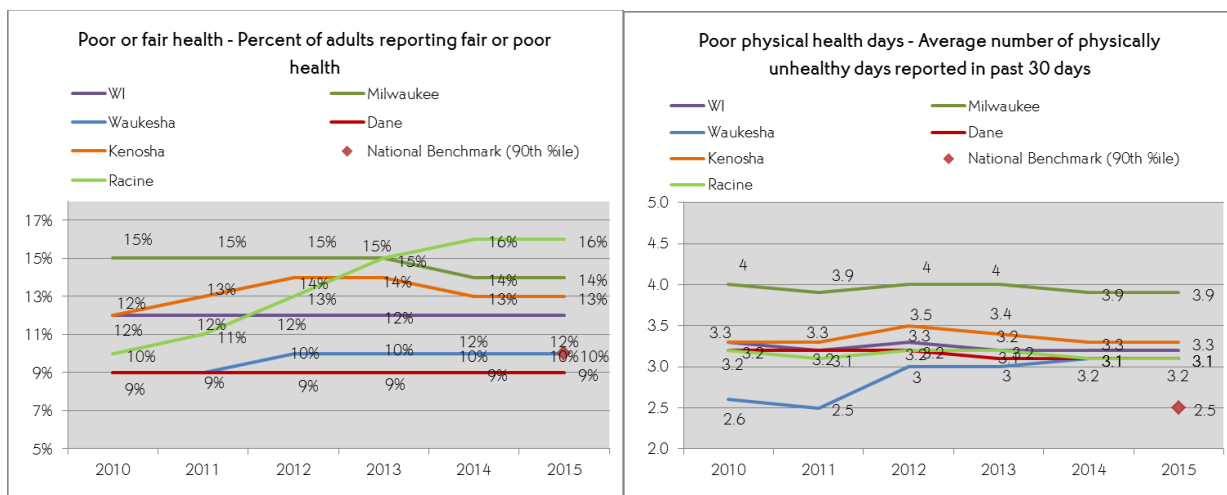
County Health Rankings, 2015

A third measure of general health is the percentage of adult obesity. Nationally, the rate has been around 25% of the population. In Wisconsin, the percentage of adults who are obese has risen to 29% in 2015, up from 25% in 2010. With the exception of Dane County, all of the counties within the service area have rates above the national benchmark. Racine, Milwaukee and Kenosha rates are above the Wisconsin average, and have been rising since 2010.
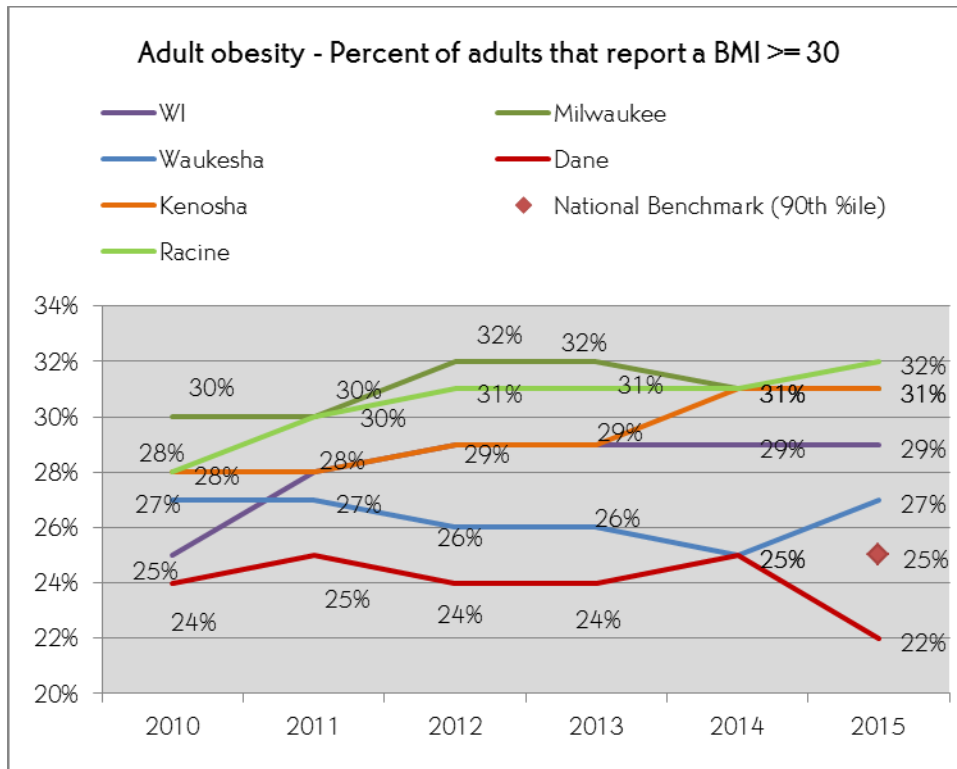
County Health Rankings, 2015

Another indicator, "Poor mental health days," refers to the number of days in the previous 30 days that a person indicates their activities were limited due to mental health difficulties. All of the counties within the service area appear above the national benchmark, indicating that mental health is a more significant issue. Rates in Kenosha, Milwaukee, and Racine counties are above the Wisconsin average. Rates were relatively flat from 2014 to 2015 across all Counties.
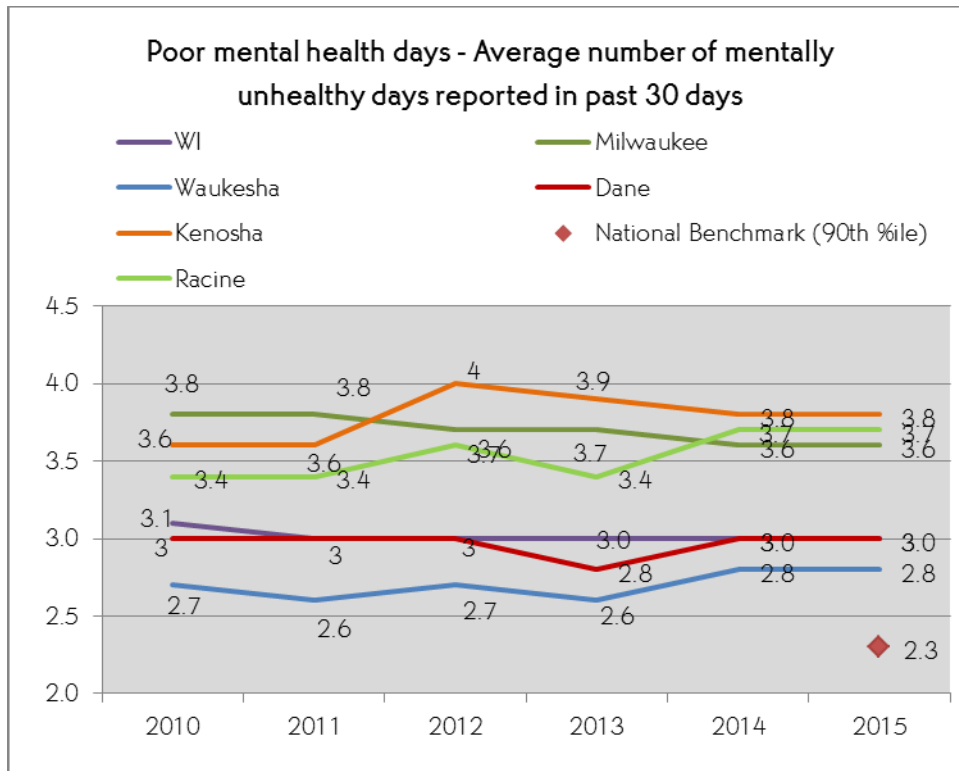
County Health Rankings, 2015

Adult Smoking

Cigarette smoking is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as low birthweight and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs. Rates in Dane and Waukesha counties are slightly above the national benchmark but well below the Wisconsin average, while rates in Milwaukee, Kenosha, and Racine counties are all above the Wisconsin average. Rates in all of the counties have been trending down since 2013.
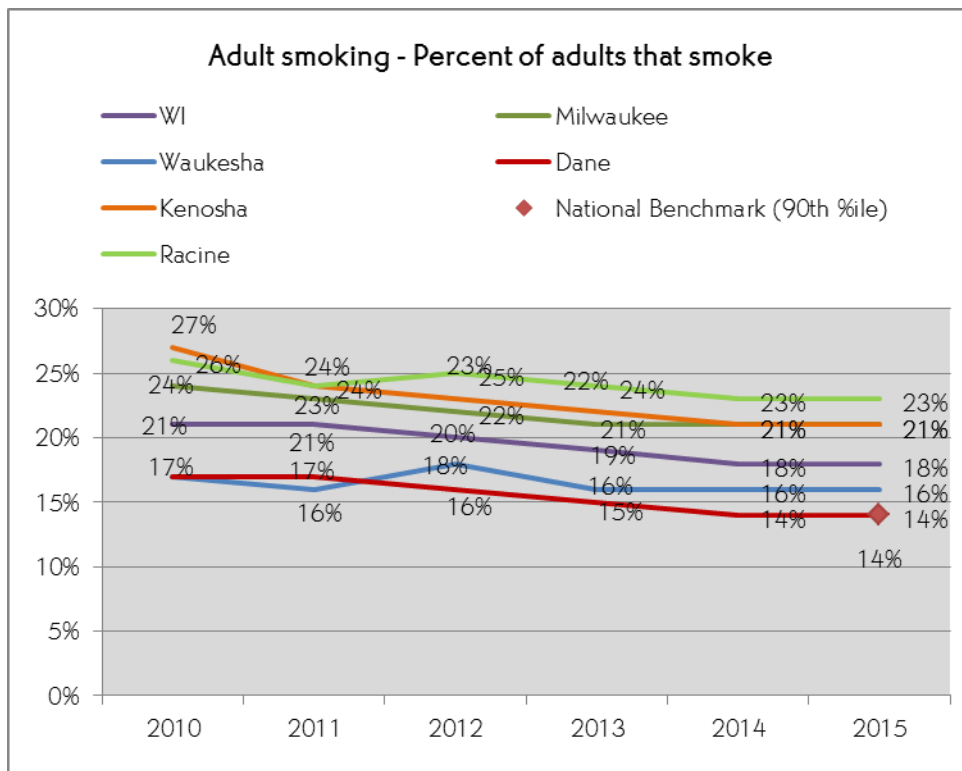
County Health Rankings, 2015

Preventable Hospital Stays

Hospitalization rates for diagnoses treatable in outpatient settings suggest that the quality of care provided in the outpatient setting was less than ideal. The measure may also represent a tendency to overuse hospitals as a main source of care. Rates in the service area are all above the national benchmark and with the exception of Dane County. Kenosha in particular has a rate that is significantly above the national benchmark, though this rate has been falling consistently since 2010.
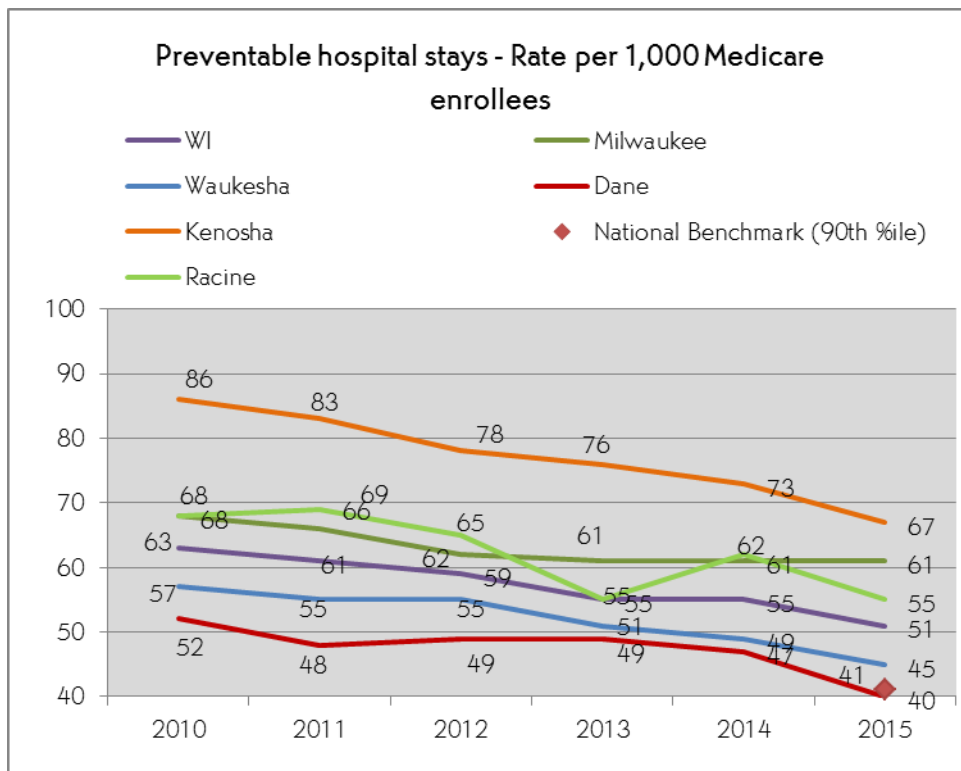
County Health Rankings, 2015

Diabetic Screening

Screening for potential health issues is a major indicator of future health issues within a community. Diabetes, which is one of the major health issues impacting our society today, was analyzed.

Diabetes screening rates were all at or below the national benchmark of 90% in 2015, with the exception of Dane County, which had screening rates of 94%.
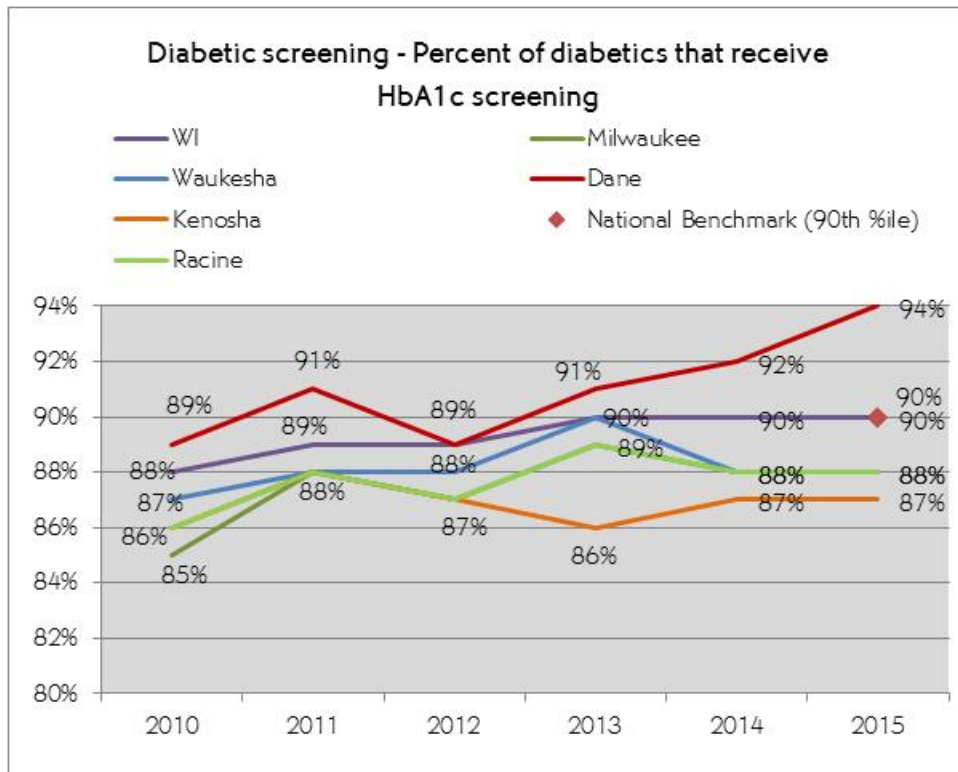
County Health Rankings, 2015

Mammography Screening

Mammography screening percentages in the service area are mixed. Rates in Racine and Milwaukee counties are at or below the Wisconsin average and national benchmark, while the rest of the counties remain at or above the national benchmark.
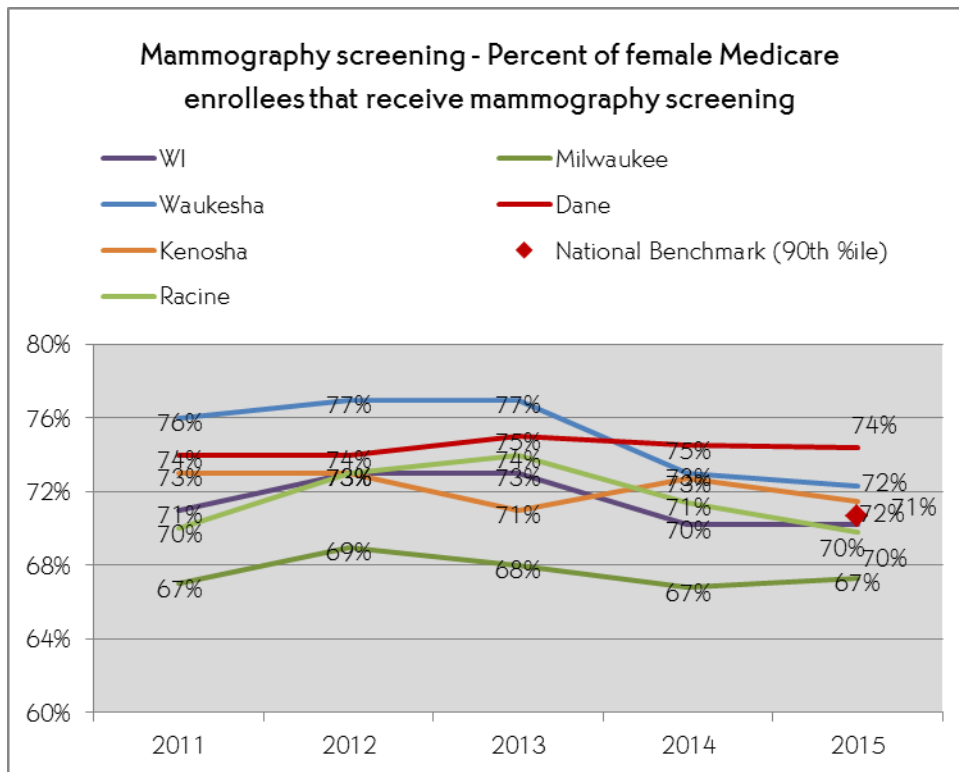
County Health Rankings, 2015

County Survey Results

Milwaukee County - Key Findings, 2014

Data gathered for youth suicide prevention planning reflects the highest suicide rates are for individuals between the ages of 30-49. With 23 for 30-39 age group and 21 for 40-49 age group.

Kenosha County Community Health Survey - Key Findings, 2014

2014 Findings: Respondents were given a list of eight health issues that communities face and were asked to select the three largest in Kenosha County. Respondents were more likely to select alcohol or drug use (70%), chronic diseases like diabetes, cancer or obesity (69%), or mental health/depression (38%).

Figure 27. County Health Issues for 2014

Health Issue	Percentage
Alcohol or Drug Use	70%
Chronic Diseases	69%
Mental Health or Depression	38%
Violence	29%
Teen Pregnancy	23%
Infectious Diseases	15%
Infant Mortality	2%
Lead Poisoning	2%

Alcohol Use: In 2014, 32% of respondents were binge drinkers in the past month. Respondents who were male, 18 to 34 years old or in the top 40 percent household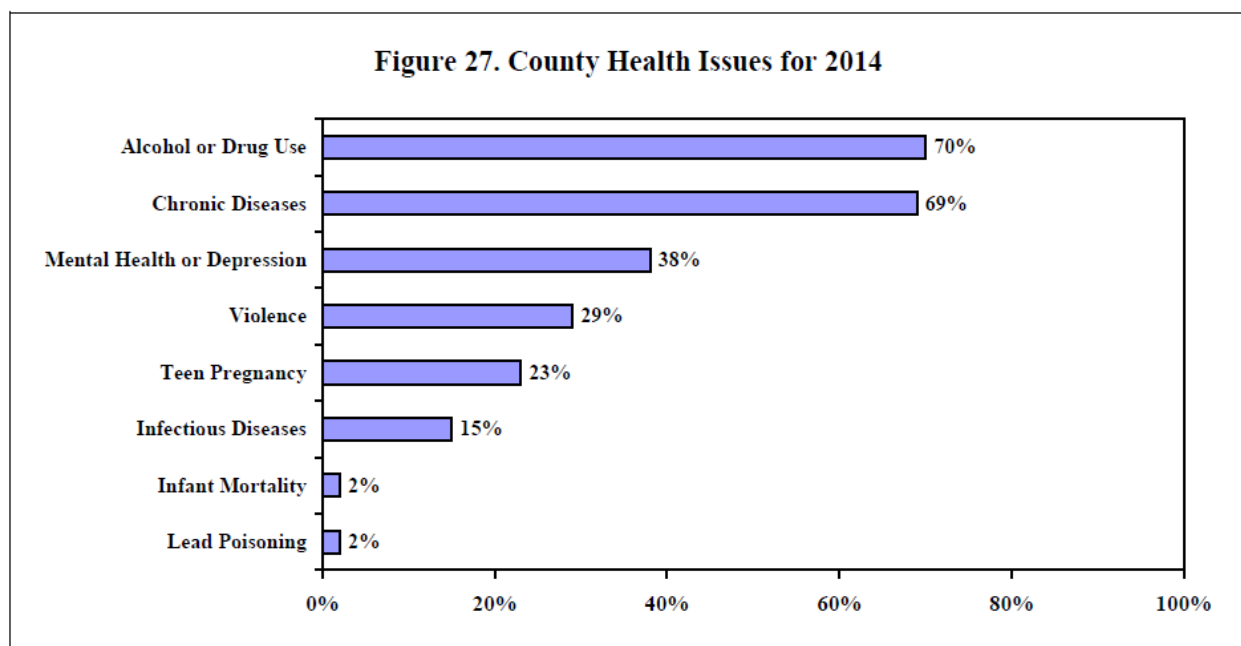 income bracket were more likely to have binged at least once in the past month. Six percent reported they had been a driver or a passenger when the driver perhaps had too much to drink; respondents 18 to 34 years old were more likely to report this.

Household Problems: In 2014, 2% of respondents reported someone in their household experienced a problem, such as legal, social, personal, or physical in connection with drinking alcohol in the past year. Two percent each reported a household problem with marijuana, the misuse of prescription drugs/over-the-counter drugs or gambling. One percent of respondents reported someone in their household experienced a problem with cocaine, heroin, or other street drugs.

Mental Health Status: In 2014, 7% of respondents reported they always or nearly always felt sad, blue or depressed in the past 30 days; respondents who were female, in the bottom 40 percent household income bracket or unmarried were more likely to report this. Eight percent of respondents felt so overwhelmed they considered suicide in the past

year; respondents who were female, with some post high school education or unmarried were more likely to report this. Seven percent of respondents reported they seldom or never find meaning and purpose in daily life; respondents who were 45 to 54 years old, in the bottom 40 percent household income bracket or unmarried were more likely to report this.

Personal Safety Issues: In 2014, 4% of respondents reported someone made them afraid for their personal safety in the past year; respondents who were in the middle 20 percent household income bracket or unmarried were more likely to report this. Five percent of respondents reported they had been pushed, kicked, slapped or hit in the past year; respondents who were female or with some post high school education were more likely to report this. A total of 8% reported at least one of these two situations; respondents with some post high school education or who were unmarried were more likely to report this.

Ozaukee County Community Health Survey - Key Findings, 2014

2014 Findings: In 2014, respondents were asked to pick the top three health issues in the county out of eight listed. The most often cited were alcohol or drug use (75%), chronic diseases (68%) and mental health/depression (48%). Respondents with a college education, in the top 40 percent household income bracket or married respondents were more likely to report alcohol/drug use as a top health issue. Respondents 18 to 34 years old or with at least some post high school education were more likely to report mental health/depression. Ten percent of respondents reported teen pregnancy as a top issue; respondents who were 35 to 54 years old or married were more likely to report this. Eighteen percent reported infectious diseases; respondents who were female, 18 to 34 years old, in the bottom 40 percent household income bracket or unmarried were more likely to report infectious diseases. Eleven percent reported violence; respondents who were 45 to 54 years old, 65 and older, with a high school education or less, in the middle 20 percent household income bracket or unmarried were more likely to report violence as a top issue. One percent reported infant mortality and less than one percent reported lead poisoning.

Figure 27. County Health Issues for 2014
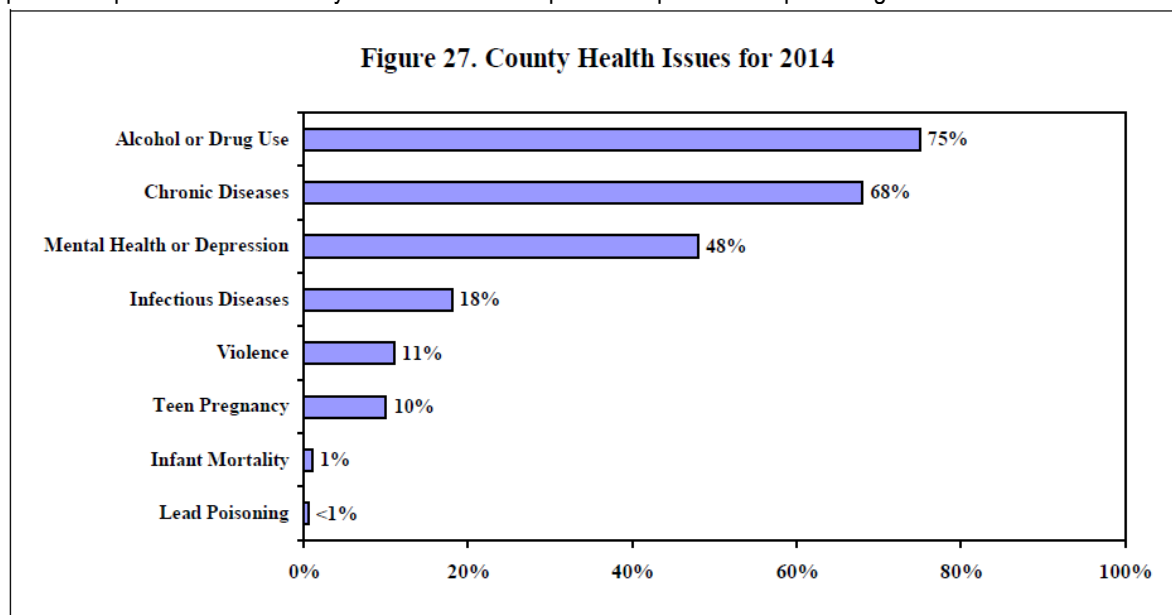
Household Problems: In 2014, 6% of respondents reported someone in their household experienced a problem, such as legal, social, personal, or physical in connection with drinking alcohol in the past year. Five percent of respondents reported someone in their household experienced a problem with marijuana. Five percent of respondents reported someone in their household experienced a problem with the misuse of prescription drugs/over-the-counter drugs. Three percent of respondents reported a household problem in connection with cocaine, heroin,

or other street drugs. One percent of respondents reported someone in their household experienced a problem in connection with gambling. Respondents in households with children were more likely to report a household problem with alcohol, marijuana or the misuse of prescription or OTC medications.

Mental Health Status: In 2014, 4% of respondents reported they always or nearly always felt sad, blue or depressed in the past 30 days; respondents who were 35 to 44 years old, with some post high school education or less or in the bottom 40 percent household income bracket were more likely to report this. Three percent of respondents felt so overwhelmed they considered suicide in the past year. Seven percent of respondents reported they seldom or never find meaning and purpose in daily life; respondents with a high school education or less or in the bottom 40 percent household income bracket were more likely to report this.

Personal Safety Issues: In 2014, 7% of respondents reported someone made them afraid for their personal safety in the past year; respondents who were 18 to 34 years old or in the bottom 40 percent household income bracket were more likely to report this. Five percent of respondents reported they had been pushed, kicked, slapped or hit in the past year; respondents who were female, 18 to 34 years old, with some post high school education, in the bottom 40 percent household income bracket or unmarried were more likely to report this. A total of 10% reported at least one of these two situations; respondents who were female, 18 to 34 years old, with some post high school education, in the bottom 40 percent household income bracket or unmarried were more likely to report this.

Sheboygan County Community Health Survey - Key Findings, 2014

The five health issues ranked most consistently as a top five health issue for the County were:

1. Mental Health
2. Alcohol and Drug
3. Access
4. Oral Health
5. Tie – Physical Activity and Tobacco

Alcohol Use: In 2014, 70% of respondents had an alcoholic drink in the past 30 days. In the past month, 7% were heavy drinkers while 25% were binge drinkers. Respondents 45 to 54 years old or with a high school education or less were more likely to have been a heavy drinker in the past month. Respondents 18 to 34 years old were more likely to have binged. Three percent of respondents reported in the past month they had been a driver or a passenger when the driver perhaps had too much to drink. Two percent of respondents reported in the past year there was a household problem associated with drinking alcohol.

Mental Health Status: In 2014, 9% of respondents reported they always or nearly always felt sad, blue or depressed in the past 30 days; respondents who were 45 to 54 years old, with some post high school education or less or in the bottom 40 percent household income bracket were more likely to report this. Ten percent of respondents felt so overwhelmed they considered suicide in the past year; respondents who were 18 to 34 years old, 45 to 54 years old, with some post high school education or less, in the bottom 40 percent household income bracket or unmarried were more likely to report this. Seven percent of respondents reported they seldom or never find meaning and purpose in daily life; respondents 18 to 34 years old, 45 to 54 years old or with some post high school education or less were more likely to report this.

Sheboygan County Secondary Data Report – 2014

Alcohol-related Hospitalizations, 2008 – 2009, and 2009 – 2010

Total Number and Rate per 100,000 Population			
	Number in 2010	2008-2009	2009-2010
Sheboygan County	972	814	822
Wisconsin	48,718	870	856

Drug-related Hospitalizations, 2008 – 2009, and 2009 – 2010

Total Number and Rate per 100,000 population			
	Number in 2010	2008 – 2009	2009- 2010
Sheboygan County	300	245	253
Wisconsin	15,135	259	262

Source: Wisconsin Department of Health Services, Division of Public Health and Division of Mental Health and Substance Abuse Services. Wisconsin Epidemiological Profile on Alcohol and Other Drug Use, 2012 (P-45718-12). Prepared by the Office of Health Informatics, Division of Public Health, in consultation with the Division of Mental Health and Substance Abuse Services and the University of Wisconsin Population Health Institute. September 2012. http://www.dhs.wisconsin.gov/publications/p4/p45718-12.pdf

Note: Hospitalization numbers and rates are based on patient's county of residence.

Alcohol and Drug Abuse as Underlying or Contributing Cause of Death, 2011 Profile

	Sheboygan County		Wisconsin	
Type	Deaths	Rate per 100,000	Deaths	Rate per 100,000
Alcohol	22	19	933	16
Tobacco Use	170	147	8,290	145
Other Drugs	18	---	636	11

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics, Health Analytics Section. Public Health Profiles, Wisconsin 2011 (P-45358-11) - June 2014. http://www.dhs.wisconsin.gov/localdata/publhlthprofiles.htm

--- Rates were not calculated when based on fewer than 20 events

Note: Alcohol and drug abuse as underlying or contributing cause of death provides a count of deaths with any mention of alcohol, tobacco use or other drugs on the death certificate. A death with more than one of these causes mentioned is counted for each one. For instance, a death that mentions both alcohol and tobacco will be counted in both categories.

Percent of Adults Reporting They Are Heavy Drinkers (2009 – 2010)

Sheboygan County	Wisconsin
8.7%	7.1%

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhs.wisconsin.gov, BRFSS Module, accessed July 2, 2014

Sheboygan County Health Needs Assessment – A Summary of Key Informant Interviews – 2014

Alcohol and Drug: Sixteen key informants included Alcohol and Drug abuse as a top five health issue.

Existing Strategies: Programs such as AA, Genesis, DARE, and the Sheboygan County Heroin Initiative have been working to address this issue. The Healthy Sheboygan County 2020 Alcohol and Other Drug Abuse (AODA) Committee, along with various health care providers and law enforcement efforts were commonly noted strategies used to address alcohol and drug abuse.

Barriers and Challenges: Interviewees reported the cultural acceptance of drinking and its status as a social norm in the state of Wisconsin as a main challenge. Also, a lack of knowledge, resources, treatment options, and capacity were cited as barriers.

Needed Strategies: Key informants suggested an increase in education on alcohol and drug usage, specifically focusing on youth, as well as educating school staff, parents, community members, and health care providers. Generally speaking, participants discussed the need for more information to be available to the community, and for there to be an increased awareness about which specific drugs are issues in Sheboygan County. Respondents believed that coordinating efforts within the community and across different agencies would be a useful strategy to pursue.

Key Community Partners to Improve Health: Hospitals should be working with Mental Health America, other local hospitals, additional mental health and general health care providers, law enforcement agencies, schools, civic organizations, churches, and public health agencies to address this issue. One respondent also identified tavern and restaurant associations as a group to include when working to combat alcohol and drug issues in the community.

Mental Health: Nineteen respondents ranked Mental Health as a top health issue for the County.

Existing Strategies: There are a plethora of existing programs and organizations working to address mental health issues in the County, including Mental Health America, the Lakeshore Community Health Center, Community Conversation, the Healthy Sheboygan County 2020 Committee on mental health, the AODA, the Mobile Crisis Response Team, and Bridgepoint Health. Mental health care providers, guidance counselors, public services, the church community, and public education and awareness events such as Mental Health Screening Day were also noted as existing strategies.

Barriers and Challenges: Although there are many existing strategies in place, the barriers that exist within the County reduce their effectiveness. The denial and stigma associated with mental health, the lack of understanding of mental health issues, and the lack of personal and financial resources to obtain services is prevalent in the community. Transportation to and from services, along with problems with continuity of care for individuals who have persistent mental health issues are current challenges.

Insurance barriers are also an immense challenge for individuals with and without insurance. For those with insurance, often times insurance companies have limited coverage for mental health care; and for those without insurance, finding a professional to provide services can prove difficult. The supply of mental health care providers does not meet the demand, partially due to the difficulty in recruiting and retaining professionals into a field that is not highly desirable.

Furthermore, for mental health providers in the area, another barrier is their lack of knowledge of existing community resources. Finally, respondents emphasized the overall lack of mental health providers for children and adolescents as a pressing challenge.

Needed Strategies: Additional strategies necessary to address the issue include running an anti-stigma campaign, increasing educational programs for the general public revolving around mental health issues, increasing the number of providers (especially for youth populations), increasing funding to address mental health, and creating more transitional programs like halfway houses. Participants also emphasized the importance of coordination and cooperation across different levels of care and within the community; further integration within the community is needed.

Key Community Partners to Improve Health: Hospitals should be partnering with health care providers (medical and mental health), other area hospitals, public health personnel, law enforcement agencies, schools, employers, faith-based organizations, and family members. Respondents also suggested working with community organizations and initiatives such as Mental Health America, Lakeshore Community Health Center, the Department of Health Services, and the Mobile Crisis Response Team. One participant also felt that partnering with the patients themselves would be beneficial in order to gain insight from their personal experience with mental health issues.

Waukesha County Community Health Assessment & Improvement Plan - Health Priorities

The Steering Committee used the following criteria to select priorities:
- The issue has a significant impact
- The community has interest and/or capacity
- The issue is actionable (can do something about it) and sustainable
- The issue is inter-related with other issues
- What happens if we do nothing?

The Steering Committee identified priorities based off the community health assessment utilizing the above criteria, but recognized that community feedback was a critical component to determining the most appropriate community health priorities. A community input meeting was held and community surveys were implemented to solicit feedback directly from the community. The surveys allowed for ranking of all the identified health priority areas, with a summary of results provided below.

After an in-depth and thorough review process, and incorporating extensive community feedback, the following health priority areas were confirmed:
- Access to Care
- Alcohol and Other Drug Abuse
- Mental Health

Access to Care:
A variety of assessments were completed. The following information highlights some of the most salient ACCESS TO CARE data and information from those assessments.
- Waukesha County Economic support cases have doubled in the last 10 years.
- Waukesha County medically uninsured was at 8% of adult population in 2009 versus 3% in 2006.
- Adult unemployment increase in 2009 to 7.5% versus 4% in 2008.
- There is a decrease in number of families who can afford health insurance and/or participate in low-income clinics.
- Health care reform will cause significant changes in the delivery of health care services.
- A new federally qualified community health center (FQHC) opened in 2012. In order to develop a community health center, communities must identify specific gaps in services and needs in populations that meet federal criteria.
- The frustrations experienced by individuals attempting to receive services may result in the decreased ability and "moxie" of those individuals to navigate the system as well as increased stress, which can contribute to chronic disease.
- When reviewing the essential services of public health, the following access-related services were rated by community members at the significant (second highest) level:
  - Linking people to needed personal health services and assuring the provision of health care when otherwise unavailable;
  - Evaluating effectiveness, accessibility, and quality of personal and population-based health services.
- Immediate health issues were identified as a priority issue in a comprehensive United Way assessment in 2011.
- Information and referral was identified as a strength (211 service exists) and a gap (not everyone knows about 211; services are not necessarily coordinated).
- Relevant system strengths include:
  - Partnerships, collaboration

- o Significant knowledge of populations in the community
- o Significant ability to link individuals with needed services
- Relevant system challenges include:
  - o Questions exist around "surge capacity"
  - o Translation services are needed, cultural competence
  - o May not be enough information regarding vulnerable populations
  - o Readability of material
- The results of community surveys showed the following results related to Access to Care:
  - o Overall, the highest-ranked priority with 64% of respondents choosing that priority.
  - o Access to health care was the top priority across all age groups, and for both men and women.

Alcohol and Other Drug Abuse:
A variety of assessments were completed. The following information highlights some of the most salient ALCOHOL AND OTHER DRUG ABUSE data and information from those assessments.
- Binge drinking went from 16% in 2006 to 27% in 2009.
- Funding for services is decreasing and changing.
- Unemployment is high, resulting in substance abuse issues and increased demand for services.
- Health care reform may affect billing and services.
- Changes in the evidence base may affect care.
- The frustrations experienced by individuals attempting to receive services may result in the decreased ability and "moxie" of those individuals to navigate the system as well as increased stress, which can lead to substance abuse issues.
- Substance abuse was identified as a priority issue through a comprehensive United Way assessment in 2011.
- Relevant system strengths include:
  - o Partnerships, collaboration
  - o Significant knowledge of populations in the community
  - o Significant ability to link individuals with needed services
- Relevant system challenges include:
  - o A need for more coordination of health promotion and related efforts
  - o Access to information
  - o System-level evaluations
  - o May not be enough information regarding vulnerable populations
- The results of community surveys showed the following results related to Alcohol and Substance Abuse:
  - o Overall, was tied as the second-highest ranked priority, with 38% of respondents choosing that priority.
  - o Substance abuse was the second-highest priority for respondents age 18-29, 40-49, and 50-59.
  - o Substance abuse was the third-highest priority for respondents age 30-39, men, and women.

Mental Health:
A variety of assessments were completed. The following information highlights some of the most salient MENTAL HEALTH data and information from those assessments.
- Funding for services is decreasing and changing.
- Unemployment is high, resulting in mental health issues and increased demand for services.
- Health care reform may affect billing and services.
- Increase in aging population and therefore an increase in the mental health services required for that population.
- Changes in the evidence base may affect care.
- The Diagnostic and Statistical Manual is being updated to Version V. This will have implications for billing and services.

- The frustrations experienced by individuals attempting to receive services may result in the decreased ability and "moxie" of those individuals to navigate the system as well as increased stress, which can lead to mental health issues.
- Mental health was identified as a priority issue in a comprehensive United Way assessment in 2011.
- Information and referral was identified as a strength (211 service exists) and a gap (not everyone knows about 211; services are not necessarily coordinated).
- Relevant system strengths include:
    - Partnerships, collaboration
    - Significant knowledge of populations in the community
    - Significant ability to link individuals with needed services
- Relevant system challenges include:
    - Some data limitations, including integration challenges
    - A need for more coordination of health promotion and related efforts
    - Access to information, and lacking information regarding vulnerable populations
    - System-level evaluations
    - High use of information technology and electronic records
- The results of community surveys showed the following results related to Mental Health:
    - Overall, was tied as the second-highest ranked priority, with 39% of respondents choosing that priority.
    - Mental health was the second-highest priority for women and respondents age 30-39.
    - Mental health was the third-highest priority for respondents age 40-49, 50-59, and 60-69.

Kenosha County Community Health Improvement Plan 2011-2020

Mental Health:

2020 GOALS	2020 OBJECTIVES	BASELINE	DATA SOURCE
Individuals served by Kenosha County's mental health and substance abuse programs will reflect the diversity of the community.	By 2020, the percent of Hispanic individuals represented in Kenosha County's community-based mental health and substance abuse services will increase to 10%.	7% (2010)	Kenosha Human Development Services client tracking system
Quality of life will be improved for persons with mental illness.	By 2020, psychiatric hospitalization rates will be reduced to 6.3/1,000 population. *Note: Assumes a corresponding increase in preventive services.*	7.6/1,000 (2008)	WI Dept. of Health Services Health Profiles
	By 2020, reduce the percent of Kenosha County residents who report feeling sad, blue or depressed to 6% of the population.	7% (2008)	Kenosha County Community Health Survey
Reduce the incidence of binge drinking in Kenosha County.	By 2020, reduce the percent of adults who report being binge drinkers to 18%.	23% (2008)	Kenosha County Community Health Survey
Kenosha County residents will have a greater understanding of mental illness and where they can go for assistance.	By 2020, at least 40% of households will be aware of mental health resources.	27.1% (2008)	Kenosha County Household Survey

Wisconsin Mental Health and Substance Abuse Needs Assessment - 2014

This needs assessment report presents a multitude of data-driven problems, issues, needs, and gaps. The needs assessment is intended to inform the Wisconsin Community Mental Health Services and Substance Prevention and Treatment plan.

The below priority areas were selected via a review process with stakeholders. To be equitable to both the mental health and substance abuse fields and to both the prevention and treatment approaches, it was decided to group the needs or issues into three categories, namely (1) prevention and treatment needs common to mental health and substance abuse, (2) mental health prevention and treatment needs, and (3) substance abuse prevention and treatment needs. The table below presents the rated and ranked priorities which informed the Community Mental Health Services and Substance Prevention and Treatment plan objectives, strategies and performance indicators

Score	Item	Item Description
81.2	SA-2	Reduce Substance use disorders for pregnant women and mothers with infants and young children.
79.9	MHSA-3	Increase children and youth who receive effective treatment and wrap-around services for mental health or substance use disorders. Youth have high rates of mental health and substance abuse needs.
79.6	MH-1	Increase psychiatrist availability, including, but not limited to, child psychiatrists in northern Wisconsin.
77.7	MHSA-4	Increase persons coming in contact with the criminal justice system that receive effective services for mental health or substance use disorders. These persons have high prevalence rates.
77.4	MH-2	Reduce Wisconsin's suicide rate below the national average, including, but not limited to, persons age 50-59, veterans, and active service members.
77.0	SA-8	Reduce alcohol and other substance-impaired motor vehicle crashes, injuries and fatalities among persons age 16-34.
75.8	MHSA-11	Improve mental health and substance abuse service outcomes and quality of care by addressing the use of evidence-based practices and treatments, practice-based evidence, consumer satisfaction and involvement, professional training, data collection, outcomes measurement, quality improvement approach, etc.
75.0	SA-1	Increase the substance abuse treatment professional workforce statewide.
74.4	MH-4	Early identification of those who have experienced adverse childhood experiences such as abuse, divorced parents, or living with persons who have a mental health or substance use disorder coupled with proven interventions to build resilience.
74.3	MHSA-6	Address barriers to accessing mental health or substance abuse treatment, including cost, motivation, transportation/distance, living in rural areas, and stigma in order to increase the number of persons receiving treatment.
73.9	SA-7	Reduce binge or heavy-occasion use of alcohol among persons age 18-34.
73.9	SA-6	Reduce use of alcohol among persons age 12-20.
73.3	SA-3	Reduce persons with addictions to prescription painkillers and heroin as well as overdoses and deaths among persons age 12 and older.
72.1	MHSA-1	Increase persons with any co-occurring mental health or substance use disorder who receive effective integrated treatment.
72.0	MHSA-8	Increase overall mental health and substance abuse workforce capacity and reduce waiting lists.
71.2	MHSA-9	Achieve mental health and substance abuse service appropriateness and equity by ensuring the appropriate mix of inpatient, detox, residential, intensive outpatient, outpatient, psychosocial rehabilitation services, crisis intervention, recovery support services, peer

Score	Item	Item Description
		specialists, recovery coaches, consumer-run centers, narcotic treatment, etc.
70.6	MHSA-12	Reduce the disparities in access to effective, culturally and linguistically competent mental health and substance abuse services among populations of differing races, ethnicities, sexual orientations and Deaf persons.
69.9	SA-5	Increase capacity to provide evidence-based, universal indirect environmental prevention strategies in areas of the state where data indicates there is need, including, but not limited to, rural villages, and towns.
69.8	MHSA-5	Increase young adults (age 18-25) and elders (age 60 and over) who receive effective treatment for mental health or substance use disorders. Young adult prevalence rates are higher than average and both groups' rates of receiving treatment are lower than average.
69.1	MH-3	Reduce mental health inpatient readmission rates by increasing the availability of community-based alternatives.
68.8	MHSA-2	Increase veterans, active service members, and military families who receive effective treatment for mental health or substance use disorders.
67.1	SA-4	Reduce high usage of detoxification services in areas where usage exceeds the state or national average.
66.6	MHSA-10	Collaboration or integration of substance abuse and mental health services with primary health care to improve overall health outcomes, including, but not limited to, smoking cessation.
63.0	MH-5	Provide parents and helping professionals working with infants and young children (e.g., childcare workers, home visitors, and pediatricians) the knowledge, skills, and practices that support healthy social and emotional child development.
55.3	SA-9	Reduce the use of synthetic drugs that have a similar effect as marijuana (spice) or stimulants (bath salts).
51.9	MHSA-7	Address access barriers to pathological gambling disorder treatment in order to increase the number of persons receiving treatment.

Fiscal Analysis of Mental Health Redesign in Milwaukee County

The mental health care system in Milwaukee County has undergone dramatic change in recent years, as County and community leaders have sought to ease reliance on emergency and inpatient care while enhancing the range and scope of community-based mental health services. Between 2010 and 2013, adult inpatient capacity at the County's Mental Health Complex decreased by 31%, while admissions at its emergency room facility (referred to as the Psychiatric Crisis Service, or PCS) dropped by 15%. In addition, the County recently closed one of its 72-bed long-term care facilities and plans to complete the closure of its second facility by the end of 2015.

Adult inpatient capacity reduction (measured by patient bed days)
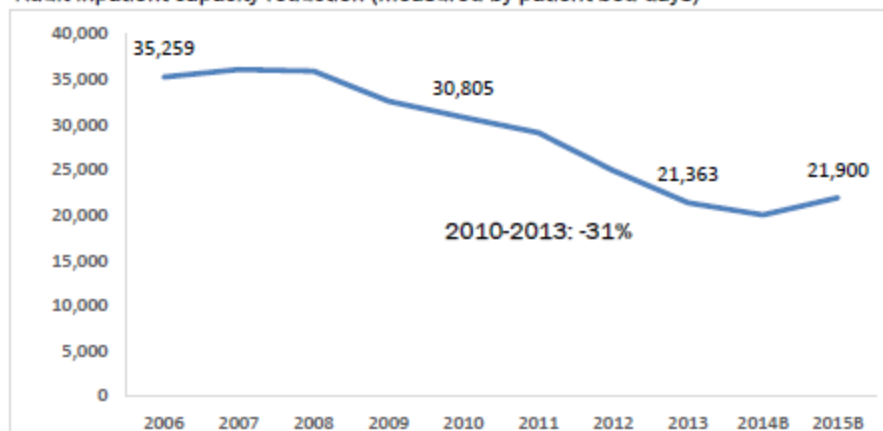
On the community side, an array of new treatment and recovery-oriented services has been added, including Comprehensive Community Services (CCS), a new Medicaid benefit that seeks to reduce inpatient admissions by strengthening early intervention and treatment programs; Community Recovery Services (CRS), which offers psychosocial services such as employment, housing, and peer support to eligible Medicaid clients; and a range of new community-based crisis services.

Seeking Strategies to Address Wisconsin's Nursing Shortage

In Wisconsin and across the country, one of the greatest workforce challenges facing the health care industry and employers as a whole is a shortage of registered nurses. Recent projections from the Bureau of Labor Statistics (BLS) indicate that 525,000 registered nurses (RNs) will leave the profession between 2012 and 2022 and that the national RN workforce will need to expand from 2.71 million to 3.24 million (a gain of 19%, or 526,800 workers) during the same period. Together, the need for replacements of retiring workers and new openings mean that approximately one million nurses will be needed to meet the nation's demand for nurses by 2022.1 Similar data indicate, meanwhile, that the State of Wisconsin will need to grow its RN workforce by 24% between 2010 and 2020 (**Chart 1**).

Chart 1: Projected need for Registered Nurses in WI in 2020
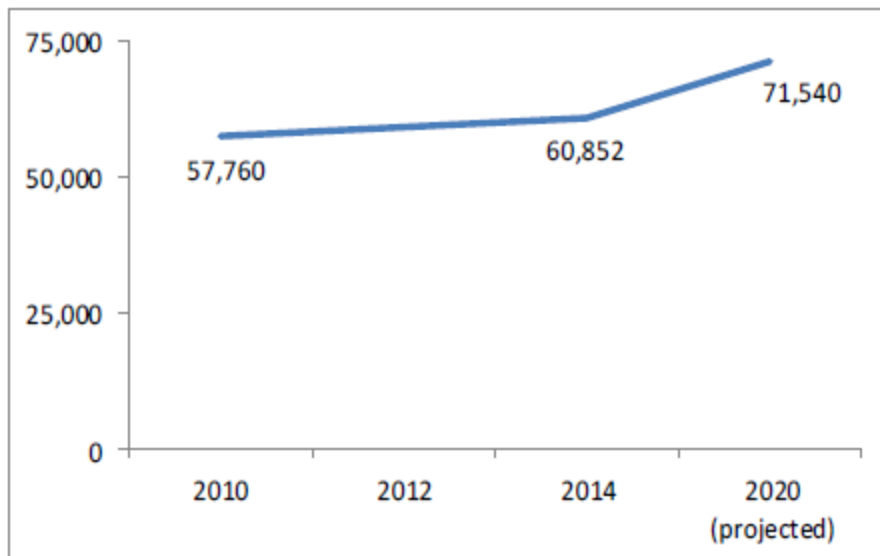
Source: Wisconsin Department of Workforce Development

The need for new registered nurses is triggered by several factors. First, a rash of retirements in the registered nursing profession over the next 10 years is expected—the current average age of a registered nurse (RN) is 47 and roughly one-third of registered nurses are age 50 or older.2

Second, overall demand for healthcare is expected to continue to increase, as provisions in the Affordable Care Act (ACA) are enabling more people to access healthcare at the same time that the aging of the "baby boomer" generation is creating a large elderly cohort with attendant healthcare needs. People are living longer, and as the population ages the number of older adults is expected to increase exponentially over the coming decades. This population places demands on nursing for the kinds of services older adults demand: living independently, self-management of chronic illnesses, and treatment of aging-based diseases

Mental Health Nurses and their Employers See Enhanced Role for Nursing in Milwaukee County's Mental Health System

Taken together, results from both surveys have significant implications for local health care employers and county administrators planning the redesign of Milwaukee's mental health system.

- There is a need for nurses with an interest in mental health now and in the future.
  - o Implication: Incentives for increasing the mental health workforce might be necessary. In addition, the mental health system redesign process should anticipate the need for more nurses.

- In general, employers are satisfied with the mental health nurse applicant pool, including recent graduates. However, very few nurses are nationally certified or advanced practice nurses.
  - o Implication: Schools of nursing are providing nurses with a basic foundation in mental health issues. Deeper knowledge among nurses is lacking; explanations for this gap should be explored.

- There is a role envisioned for more nurses in mental health outpatient/community settings, although it is unclear exactly what their roles should be. Currently, most nurses work with adults in inpatient settings.
  - o Implication: As the mental health system is redesigned, planners should explicitly consider the optimal roles of nurses in community health settings.

- Mental health nurses' job satisfaction comes from work with patients; dissatisfaction comes from pay.
  - o Implication: If nurses' responsibilities under a redesigned system are more administrative or policy-oriented, the reduction in patient contact may not be desirable, particularly if wages do not change.

- Employers and nurses have more disagreement than agreement about the most important skills and competencies for patients' recovery.
  - o Implication: This suggests either a lack of clear communication between employers and nurses or differing expectations as to the job objectives. More clarity is needed if the role of nurses is to change under a redesigned system.

- Employers and nurses have more agreement about the specific skills that need strengthening.
  - o Implication: These areas should garner the most attention and resources for professional development.
- Understanding dual/co-occurring disorder treatment and the needs of patients with dual disorders were seen both as important and in need of strengthening.
  - o Implication: As the county shifts its focus to dual/co-occurring disorder treatment, the need for improved training for nurses will be imperative.

IMPACT - Leading Indicators, Leading Change: First Ten Years and Future Prospects

Many of the people who access 2-1-1 are very close to, if not actually in, a serious crisis and 2-1-1 plays a vital role in their ability to come through the crisis. Because a caller sometimes had more than one request, IMPACT 2-1-1 recorded 1,441,894 separate requests in the period from 2003-2012. Three out of every four calls were made by women, and nearly nine out of every ten callers were from Milwaukee County.

Requests were classified into five broad categories of need: basic, food, family/legal, health/mental health and income. More than half of requests were for basic needs and food needs. Beyond requests for food pantries and community shelters, which consistently made up about one-third of requests, other frequent needs were utility service payments, rent payment, household goods, furniture, and community clinics.
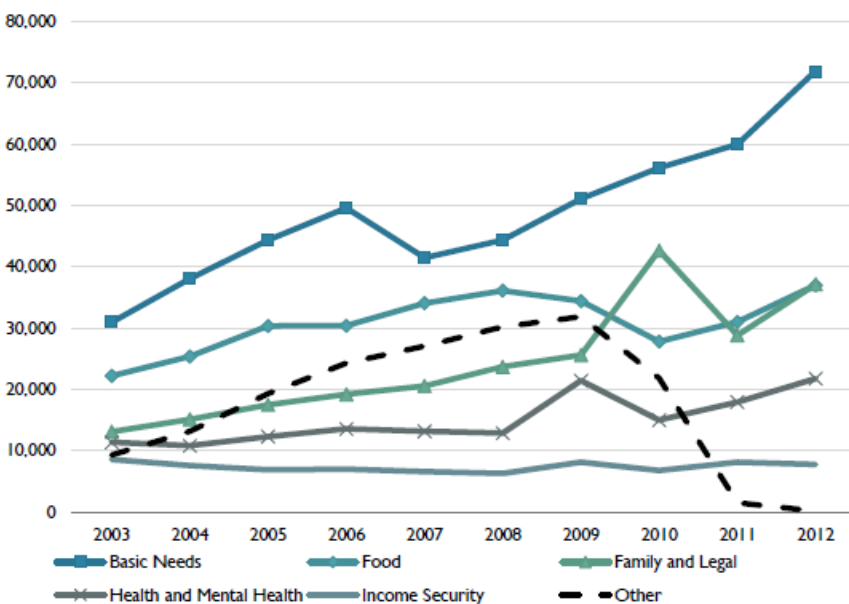
The number of callers whose needs cannot be met at the time of the call is a primary indicator used by 2-1-1s to gauge gaps in the local safety net. Data from 2-1-1s across the country show that unmet needs are similar everywhere, with calls for housing, utilities, and furniture/appliances topping the lists of unmet caller needs. The data from IMPACT 2-1-1 indicate consistently that the top ten unmet needs were for community shelters, appliances and transportation. In 2012, four out of five requests to IMPACT 2-1-1 for community shelter were met, but because shelter requests made up a large number of requests each year that left nearly 4,000 requests for shelter that could not be accommodated. IMPACT 2-1-1 is set to become the coordinated point of entry to the Milwaukee County shelter system, which could increase efficiencies in shelter placement and reduce this unmet need in the future.

On a percentage basis—if not in sheer number of requests—unmet needs for appliances and furniture are a bigger problem than the need for shelter. In fact, the two needs are interconnected. People transitioning out of homelessness need a cost-free option to furnish their new apartments. Without furnishings, homeless families may not be able to move into their own housing, or may be forced to move frequently and share overcrowded quarters with others. According to a 2012 Children's Health Watch policy action brief, the consequences of being near homeless can be substantial, particularly for children. Young children in families experiencing housing insecurity are at risk of developmental delays, increased hospitalizations and food insecurity.

In 2012, nearly three-quarters of requests to IMPACT 2-1-1 for general appliances were unmet, totaling more than 700 unmet requests. Between twenty and twenty-five percent of specific requests for refrigerators, stoves and beds

were unmet, totaling nearly 300 more requests. Elsewhere in the U.S., furniture banks (similar to food banks) collect donations of gently used furniture and provide the furniture free of charge to families in need. Southeastern Wisconsin, however, has no furniture banks to alleviate this documented, unmet need.

Mental Health Redesign SMART Goals: 2013 – 2014

The Mental Health Redesign addresses the improvement of mental health services for Milwaukee County residents served by public and private systems and organizations. Initial SMART Goals focus heavily on changes in the public sector system operated by the Milwaukee County Department of Health and Human Services while implementation planning continues on broader communitywide improvements involving major hospital systems, provider organizations, advocates, and persons with lived experience. Monthly progress reports on the SMART Goals and Improvement Areas will continue to be made to the County Board and the community.

1. **Improve satisfaction and recovery outcomes by:**
   - Using person-centered experiences to inform system improvement.
   - Providing services that are welcoming, person-centered, recovery-oriented, trauma-informed, culturally intelligent, and co-occurring capable;
   - Improving system-wide implementation of such services;
   - Increasing the use of self-directed recovery action plans;
   - Completing the functional integration of substance use disorder and mental health service components of the Milwaukee County Community Services Branch

2. **Promote stigma reduction in Milwaukee County through:**
   - Evidence-based MH/AODA stigma reduction public education presentations that include presentations by persons with lived experience to over 1000 residents in Milwaukee County supervisor districts.
   - Partnering with community efforts already underway led by NAMI, Rogers InHealth, and the Center for Urban Population Health Project Launch.

3. **Improve the quality of the mental health workforce through:**
   - Implementation of workforce competencies aligned with person-centered care;
   - Improved mental health nursing recruitment and retention;
   - Improved recruitment and retention of psychiatrists; and
   - Improved workforce diversity and cultural competency.

4. **Expand the network of Certified Peer Specialists who are well trained, appropriately compensated, and effectively engaged with peers and whose services are eligible for Medicaid reimbursement by:**
   - Increasing the number Certified Peer Specialists;
   - Recruiting and training Certified Peer Specialists with bilingual (Spanish) capability;
   - Increasing the number of programs that employ Certified Peer Specialists;
   - Establishing a Peer-operated program; and
   - Advocating for quality in the delivery of Certified Peer Specialist services.

5. **Improve the coordination and flexibility of public and private funding committed to mental health services.**

6. **Establish a mechanism to publicly chart system quality indicators that reflect progress on Redesign SMART Goals.**
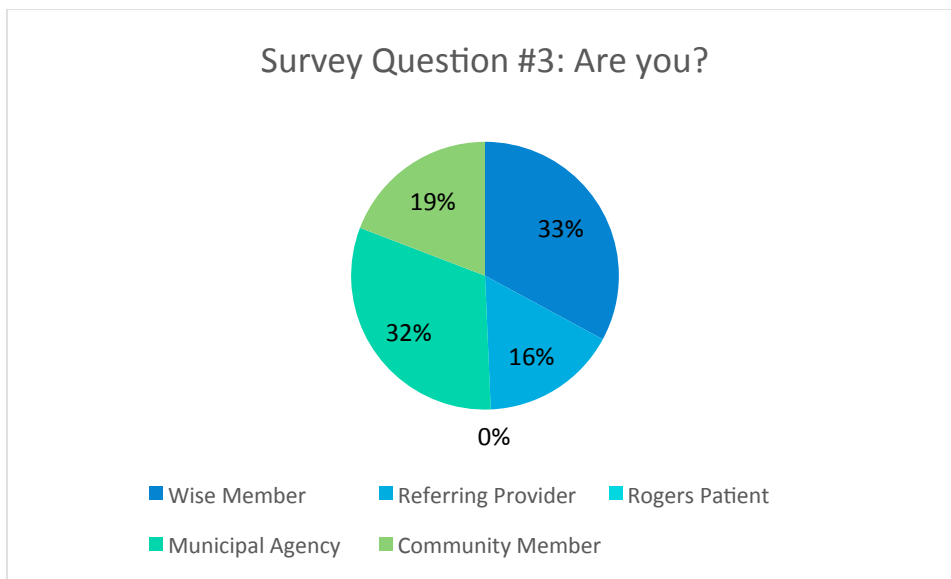
7. **Develop a structure for ongoing system improvement and oversight of the Mental Health Redesign process.**

8. **Improve crisis access and response to reduce Emergency Detentions.**

9. **Improve the flexible availability and continuity of community-based recovery supports.**

10. **Improve the success of community transitions after psychiatric hospital admission.**

11. **Improve the economic security of persons with mental illness by increasing utilization of disability-related benefits including SSI/SSDI and Medicaid.**

12. **Increase the number of individuals with mental illness who are engaged in employment, education, or other vocational-related activities.**

13. **Improve access to, and retention in, recovery-oriented supportive housing for persons with mental illness who are homeless or inadequately/unsafely housed.**

14. **Improve criminal justice and mental health system collaboration to reduce inappropriate incarceration of people with mental illness by:**
    - Establishing a data link between the Milwaukee County criminal justice system and Behavioral Health Division that respects privacy and confidentiality requirements and helps prevent inappropriate incarceration of persons with mental illness;
    - Supporting a continuum of criminal justice diversion services for persons with behavioral health needs; and
    - Participating in the Community Justice Council as the primary vehicle for communication and planning.

15. **Reduce the number of people who experience acute hospital admissions through improved access to, and utilization of, non-hospital crisis intervention and diversion services for people in mental health crisis.**

16. **Improve the level of cultural intelligence (CQ) operating in all components of the behavioral health system by:**
    - Developing a CQ knowledge base for the system;
    - Incorporating CQ standards into program standards and clinical policies and procedures;
    - Instituting workforce development strategies that promote CQ;
    - Developing an adequately resources and CQ translator and interpreter network;
    - Integrating CQ into each SMART Goal in the MH Redesign; and
    - Establishing a CQ system improvement plan based on the components listed above.

Primary Data Survey Results

With the results of the county surveys as a foundation, RMH developed and executed a survey to gather more detailed input on the most significant health needs in the community.

Survey Respondent Representation

Survey respondents were asked to indicate who they represent. In general, there was a fairly even representation of respondents; however, no RMH patients were represented in the study.

Survey Question #3: Are you?

- Wise Member
- Referring Provider
- Rogers Patient
- Municipal Agency
- Community Member

Experience with Behavioral Healthcare

Survey respondents were asked to indicate their experience with behavioral healthcare. Nearly half of the respondents indicated they support people accessing mental health or addiction services as part of their profession. 49% have accessed services themselves or have supported a family member/friend in accessing mental health or addiction services.

Survey Question #4: What has been your experience with behavioral healthcare?

2%

18%

31%

48%

- ■ I have accessed mental health or addiction services myself.
- ■ I have supported a family member/friend in accessing mental health or addiction services.
- ■ As part of my profession, I support people to access mental health or addiction services.
- ■ None of the above.
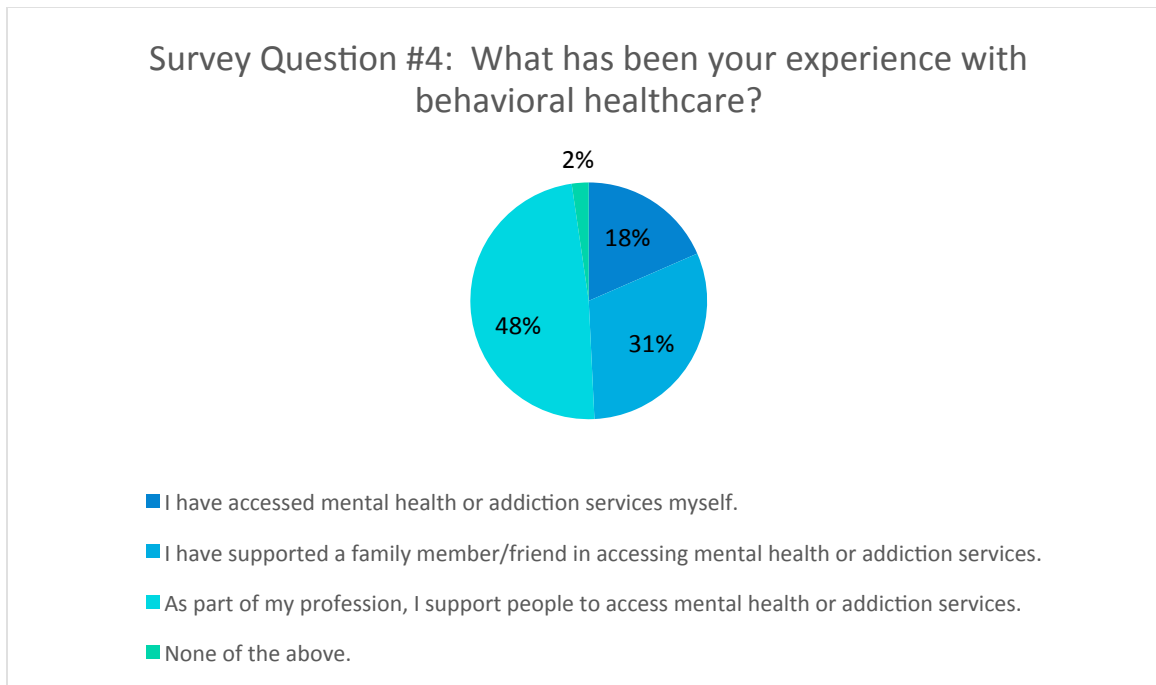
Awareness or Knowledge of Mental Illness

Survey respondents were asked to rate their community's awareness or knowledge of mental illness. Only 5% of respondents rated community awareness as excellent, and 27% as good. 53% rated awareness as fair and 16% as poor. This data shows in general the majority of respondents do not rate community awareness of mental illness positively.

Survey Question #5: How would you rate your community's awareness or knowledge of mental illness?

Excellent	5%
Good	27%
Fair	53%
Poor	16%

0%   10%   20%   30%   40%   50%   60%
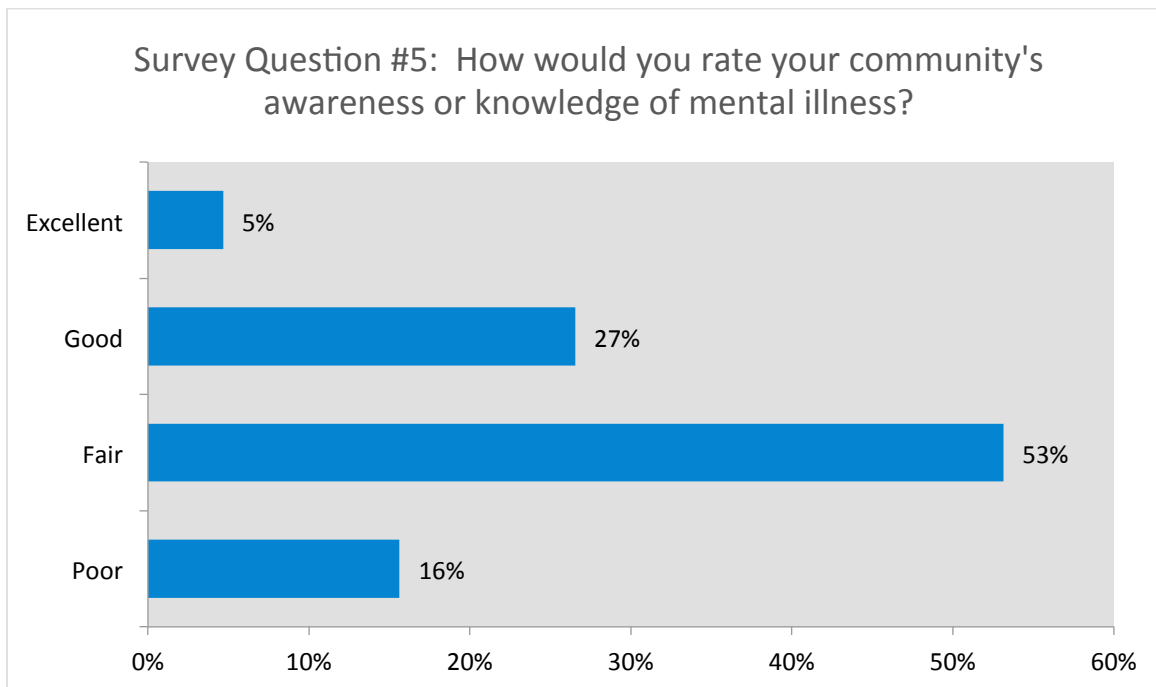
Awareness or Knowledge of Recovery and Maintaining Recovery

Survey respondents were asked to rate their community's awareness or knowledge of what it takes for recovery and how to maintain recovery. Only 7% of respondents rated community awareness as excellent or good. 46% of respondents rated awareness as fair and 48% rated awareness as poor. Clearly the vast majority of respondents did not rate the community's awareness or knowledge of recovery and maintaining recovery positively.

Survey Question #6: How would you rate your community's knowledge of what it takes for recovery and how to maintain recovery?

Rating	Percent
Excellent	2%
Good	5%
Fair	46%
Poor	48%
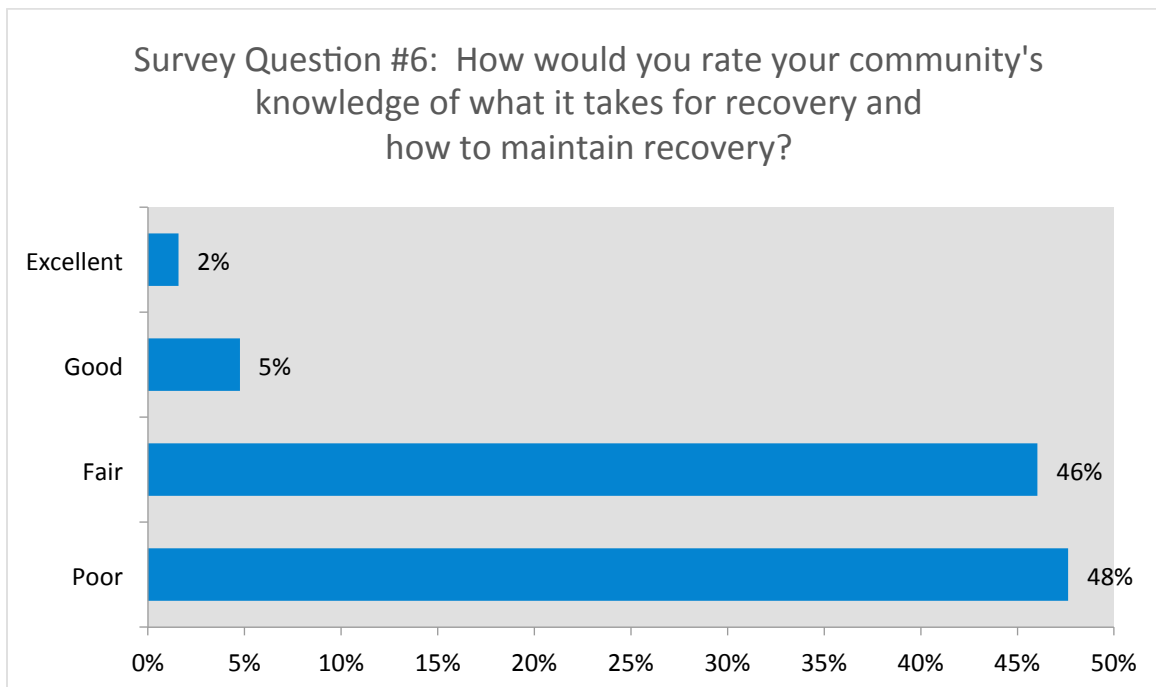
Use or Referrals for Health Resources other than Hospital or Clinic

Survey respondents were asked to indicate what health resources, other than a hospital or clinic, they have used or referred others to in the past three years. Results varied, with the top health resources including specialized resources, support groups, local organizations, parent peer/peer support specialists and website/internet resources.

Survey Question #7: What health resources, other than a hospital or clinic, have you used or referred someone to in the past three years?
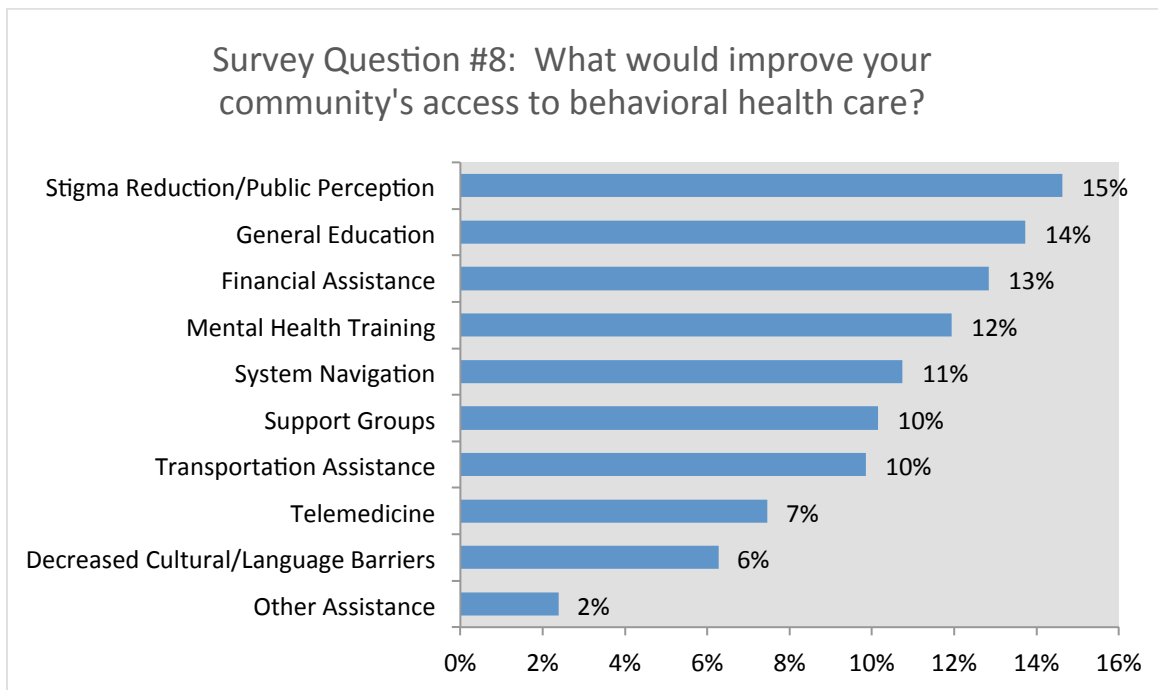
Resource	Percentage
Specialized Resources	14%
Support Group (AA, Al-Anon)	12%
Local Organization (NAMI, MHA)	11%
Parent Peer/Peer Support Specialist	11%
Website/Internet	11%
School Counselor/Nurse	10%
Church Group	8%
Law Enforcement	6%
Community Center	6%
Transitional Housing	6%
Recreation Program	5%

Improving Community Access to Behavioral Health Care

Survey respondents were asked to indicate what would improve your community's access to behavioral health care. The top response was "stigma reduction/public perception". This was followed by "general education", "financial assistance", and "mental health training" as the other top responses.

Survey Question #8: What would improve your community's access to behavioral health care?

Response	Percentage
Stigma Reduction/Public Perception	15%
General Education	14%
Financial Assistance	13%
Mental Health Training	12%
System Navigation	11%
Support Groups	10%
Transportation Assistance	10%
Telemedicine	7%
Decreased Cultural/Language Barriers	6%
Other Assistance	2%

Better Support for Those in Recovery

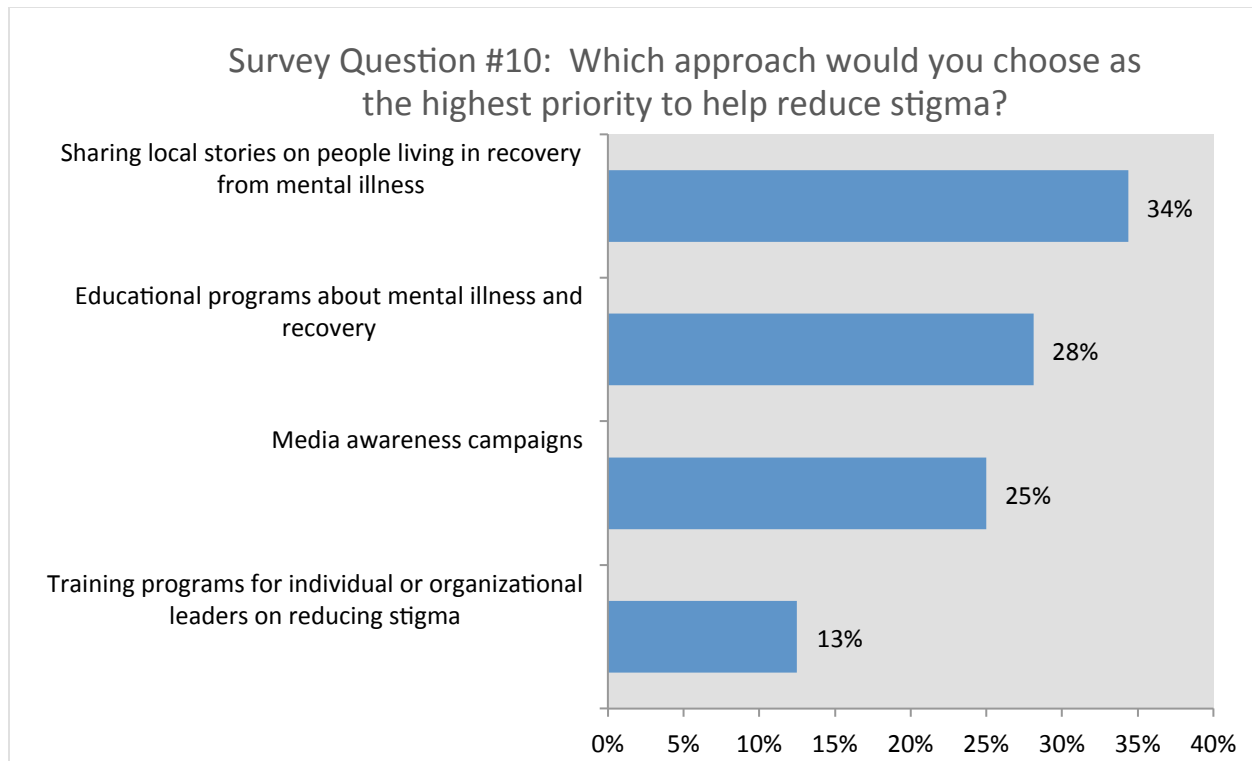Survey respondents were asked to list in order of importance the most important ways the community can better support those in recovery. "Peer support specialists" garnered the top score, followed by "support groups" and "advocate for support services for people with mental illness". "Crisis hotlines" and "school/teacher education" were considered the least important ways the community can better support those in recovery.

Survey Question #9: How can a community better support those in recovery? List in order of importance with 1=Most important and 8=least important.

Category	Score
Peer Support Specialists	5.84
Support Groups	4.67
Advocate for Support Services for People with Mental	4.59
Transitional House/Transition options after treatment	4.56
Crisis Respite Centers	4.41
Crisis Intervention Team Training	4.20
Crisis Hotlines	3.89
School/Teacher Education	3.83

Reducing Mental Health Stigma

Survey respondents were asked to choose the highest priority approach to helping reduce the stigma associated with mental illness. "Sharing local stories on people living in recovery from mental illness" was indicated as the highest priority approach, followed closely by "Educational programs about mental illness and recovery" and "media awareness campaigns"

Survey Question #10: Which approach would you choose as the highest priority to help reduce stigma?

Approach	Percentage
Sharing local stories on people living in recovery from mental illness	34%
Educational programs about mental illness and recovery	28%
Media awareness campaigns	25%
Training programs for individual or organizational leaders on reducing stigma	13%

Summary of Key Findings and Prioritized Needs

The RMH advisory committee met and reviewed the results of the secondary data, other data including community health needs assessments conducted for the service as well as surveys conducted by RMH. Based on their review of the findings and in light of the community served by RMH, the advisory committee determined that the most significant needs were:

1. Access to Services
2. Substance Abuse Disorders
3. Education, Awareness, Advocacy and Stigma Reduction
4. Mental Health Training
5. After Care Support
6. Peer Support Specialist

An implementation strategy was developed to respond to these priorities.

Existing Health Care and other Facilities and Resources

A complete list of health care and other facilities and resources available within the community to meet the health needs including location, contact information, and description of services can be found in Appendix 3:

Implementation Plan

Once the health needs were prioritized by the CHNA advisory committee, the final step in the CHNA process involved developing an implementation strategy. The purpose of the implementation strategy is to develop a clear set of goals to respond to the priorities identified through the CHNA. The implementation strategy is essentially a written plan that addresses each of the community health needs identified through the CHNA, describing how RMH plans to meet the health needs, and identifying health needs RMH does not intend to meet and why.

With the support of Wipfli, the CHNA Advisory Committee developed the implementation strategy. The committee addressed the following implementation strategy components within each priority identified:

1. Objectives/Strategy
2. Tactics (How)
3. Programs/Resources to Commit
4. Impact of Programs/Resources on Health Need
5. Accountable Parties
6. Partnerships/Collaboration

The detailed implementation strategy for each priority can be found in Appendix 4. In summary, the following priorities were addressed through the implementation strategy:

1. Access to Services
2. Substance Abuse Disorders
3. Education, Awareness, Advocacy and Stigma Reduction
4. Mental Health Training
5. After Care Support
6. Peer Support Specialist

References

Association for Community Health Improvement

Flex Monitoring Team

ESRI Business Information Solutions, 2012

County Health Rankings

Kenosha County Community Health Survey Summary, 2012

Waukesha County Community Health Survey Summary, 2012

Milwaukee County Health Needs Assessment – Findings and Future Strategies, 2012

Access to Care: Action Plan – Waukesha County Community Health Improvement Process; County-specific health goals, 2012

Meriter Health Services Community Health Needs Implementation Plan – Health strategies, 2013-2015

Waukesha County Alcohol and Other Drug Abuse Work Plan – Waukesha County Goals, 2012

Racine County Health Needs Assessment – Findings and Future Strategies, 2012

CHIPP Mental Health Planning Team – Waukesha County Goals, Objectives and Work Plan, 2012

Appendix 1

Existing Health Care and other Facilities and Resources

Wheaton Franciscan Healthcare - St. Francis
3237 S. 16th Street
Milwaukee, WI 53215

Aurora St. Luke's
2900 W. Oklahoma
Milwaukee, WI 53215

St. Mary's Hospital
700 S. Park Street
Madison, WI 53715

Redi Clinic
2300 N. Mayfair Road
Wauwatosa, WI 53226

West Grove Clinic
10012 W. Capitol Drive, Suite 101
Wauwatosa, WI 53222

Shorehaven
3900 W. Brown Deer Road
Brown Deer, WI 53209

American Behavioral Clinic
10424 W. Bluemound Road
Milwaukee, WI 53226

Connections Counseling
5005 University Avenue
Madison, WI 53705

Meriter (New Start)
202 S. Park Street
Madison, WI 53715

UW Health Behavioral Health and Recovery Clinic
25 Kessel Court #200
Madison, WI 53711

CSM Milwaukee
2301 N. Lake Drive
Milwaukee, WI 53211

Community Memorial Hospital
W180N8085 Town Hall Road
Menomonee Falls, WI 53051

Aurora Psychiatric Hospital
1220 Dewey Avenue
Wauwatosa, WI 53213

Tellurian
2914 Industrial Drive
Madison, WI 53716

Lakeshore Medical Clinic
5900 S. Lake Dr
Cudahy, WI 53110

Sixteenth Street Community Health Center
1032 S Cesar E Chavez Dr
Milwaukee, WI 53204

Cornerstone Counseling Services - Brookfield
16535 W. Bluemound Rd
Brookfield, WI 53005

Cornerstone Counseling Services - Greenfield
4811 S 76th St 208
Greenfield, WI 53220

Mercy Options
903 Mineral Point Ave
Janesville, WI 53548

Stress Management and Mental Health Clinics
10201 West Lincoln Ave 308
West Allis, WI 53227

Fort Healthcare
1520 Madison Ave
Fort Atkinson, WI 53538

Children's Hospital of Wisconsin
8915 W. Connell Ct
PO Box 1997
Milwaukee, WI 53226

Wheaton Franciscan Medical Group
4448 West Loomis Rd 101
Greenfield, WI 53220

Psychiatric Services - Wheaton Franciscan
1244 Wisconsin Ave, Ste 303
Racine, WI 53403

Psychology Associates
11803 W. North Ave
Milwaukee, WI 53226

Child Development Center
PO Box 1997 MS 744
Milwaukee, WI 53201-1997

Renew Counseling Center
1225 W. Mitchell St #223
Milwaukee, WI 53204

Credence Therapy Associates
1 1/2 W. Geneva St
Elkhorn, WI 53121

ACACIA Clinic
6040 W Lisbon Ave
Milwaukee, WI 53218

Pathways Counseling Center
13105 W. Bluemound Rd #100
Brookfield, WI 53005-8046

Froedtert Town Hall Health Center
West 180 North 7950 Town Hall Rd
Menomonee Falls, WI 53051

Affiliated Clinical Services
111 E. Washington St
West Bend, WI 53095

Columbia St. Mary's Hospital Ozaukee
13111 N Port Washington Rd
Mequon, WI 53097

Froedert St. Joseph's Hospital - West Bend
3200 Pleasant Valley Rd
West Bend, WI 53095

The Wisconsin Psychiatric Institute and Clinics
6001 Research Park Blvd
Madison, WI 53719

Saint A
8901 W Capitol Dr
Milwaukee, WI 53222

Aurora Sheboygan Memorial Hospital
2629 N. 7th St
Sheboygan, WI 53083

Comprehensive Counseling Services
1317 W. Grand Ave
Port Washington, WI 53074

Access Community Health Centers
Sun Prairie Clinic
1270 W. Main Street
Sun Prairie, WI 53590

Catholic Charities
30 South Franklin
Madison, WI 53703

Centro Hispano
810 W, Badger Rd
Madison, WI 53713

The Family Center
8025 Excelsior Dr
Madison, WI 53717

Family Services
128 E. Olin Ave.
Madison, WI 53713

Jewish Social Services of Madison
6434 Enterprise Lane
Madison, WI 53719

Meta House Inc
2625 N. Weil St
Milwaukee, WI 53212

Prevea Behavioral Care
3425 Superior Ave
Sheboygan, WI 53081

Appendix 2

Rogers Memorial Hospital

Community Health Needs Assessment
Implementation Plan

July 31, 2016

Table of Contents

Status Update on 2013 Survey Priorities

Update for Priority 1: Access to Health Care

Rogers has made tremendous progress in meeting our goals to increase access to behavioral healthcare in the communities we serve through new programming, additional bed capacity and recruitment of new physicians. Since the last community health needs assessment, Rogers has:

- Opened a 56-bed inpatient hospital in Brown Deer, WI, with dedicated units for adults and for adolescents and children (April 2015).
- Greatly increased access to specialized outpatient programs with the addition of 16 new partial hospital programs and ten intensive outpatient programs across our southeast and central Wisconsin locations, creating capacity for up to 270 new slots for admissions, including:
  - Three specialized outpatient centers with expanded and consolidated partial hospital and intensive outpatient programs
    - Brown Deer Outpatient Center, part of Rogers Memorial Hospital—Brown Deer (August 2014, December 2014).
    - Lincoln Center Outpatient Center, part of Rogers Memorial Hospital—West Allis (May 2014)
    - Silver Lake Outpatient Center, part of Rogers Memorial Hospital—Oconomowoc (September 2015).
  - Expanded services at satellite specialized outpatient locations:
    - Rogers Memorial Hospital—Madison
    - Rogers Memorial Hospital—Kenosha

  This included new programming for OCD and anxiety, depression and other mood disorders, dual diagnosis, addiction and the addition of posttraumatic stress disorder treatment to our array of services.
- Added 52 residential beds, including the opening of Rogers FOCUS mood disorders adult program; Rogers Nashotah program for teen girls with emotional dysregulation; Rogers FOCUS adolescent mood disorders program; and new beds approved for a new home for the OCD Center facility.

Update for Priority 1: Access to Health Care

- Recruited more than 23 new psychiatrists and physicians, in addition to psychologists and Rogers' first nurse practitioners and physician assistants, to increase access to providers.

Rogers also opened a sixth satellite outpatient location in Appleton, offering four partial hospital programs serving up to 40 patients. With this additional capacity, Rogers was able to serve more people in need than ever before, with nearly 11,500 admissions in fiscal year 2015 across our Wisconsin programs.

Update for Priority 2: Reduce Stigma

To reduce the stigma of mental illness and support education, advocacy and awareness around mental illness and recovery, the work of Rogers InHealth over the past three years has included:

- A research partnership with Dr. Patrick Corrigan, Illinois Institute of Technology, to investigate and evaluate best practices to reduce self-stigma and public stigma.
- Development of a national survey on impact and prevalence of youth disclosure of mental illness; presentation of preliminary findings to the 7th Annual International Stigma Conference-February, 2015;
- Development of a research based tool for youth disclosure and resources for adult response-Honest, Open, Proud (HOP). The youth version is currently in randomized control trials; presentation at the Annual Research & Policy Conference for Child, Adolescent, and Behavioral Health Conference, March, 2016.
- Development of a web based video library of over 70 video stories/interviews on stigma, recovery, and resilience for individuals, families, schools, and workplaces; partner projects with Mental Health America, International Obsessive Compulsive Disorder Foundation, Wisconsin United for Mental health, Wisconsin Workforce Development, and others. See www.rogersinhealth.org
- Development and evaluation of the TLC4 model of stigma reduction: targeted, local, credible, continuous, change-focused contact-current partner projects focus-school and healthcare.
- Development of tools for disclosure, response, and supports for students, schools, and families around resiliency and recovery; current partnership/consultation with the Wisconsin Department of Public Instruction on their Mental Health Framework for Schools.

Update for Priority 2: Reduce Stigma (Continued)

- Facilitate the formation and work of WISE-Wisconsin Initiative for Stigma Elimination-a statewide coalition of nearly 100 members dedicated to learn and utilize best practices for stigma reduction, and the related development and dissemination of tools and resources; see www.wisewisconsin.org Statewide members include: MHA, NAMI, WI Family Ties, Grassroots Empowerment, and the WI Department of Health Services.
- Development of resources for stigma reduction in workplace and primary health care organizations; training and support for 7 regional health care coordinators to train and consult with health care organizations around stigma reduction.
- Consultation to/coordination of in-school/integrated mental health therapy services; School Community Partnership for Mental Health with Milwaukee Public Schools.
- Collaboration building for communities, organizations, and providers around mental health and stigma reduction initiatives.
- Training of trainers and facilitators in stigma reduction basics and strategic disclosure (HOP) around the state.
- Development of compassion fatigue/resilience training.

Update for Priority 3: Integrate Behavioral Health into Primary Care

Rogers Memorial Hospital, through its key corporation, Rogers Partners in Behavioral Health, developed several proposals for consideration with local health systems to begin the process of integrating behavioral health into primary care. Within this timeframe, the local market was not yet fully invested in this particular strategy; as a result, Rogers chose to focus its full efforts on enhancing access across the care spectrum which Rogers provides in Wisconsin.

Priority 1: Access to Services

Objective/Strategy

- Increase access to effective mental health services

Tactics (How)

- Build charity fund to increase access for those with limited or exhausted resources
- Shift or expand specialized programming across levels of care to meet community need (intensive outpatient/partial hospital, inpatient, residential)
- Increase implementation of telepsychiatry services across system
- Expand call center capability to efficiently handle higher volume of calls
- Explore evening and weekend programming for partial hospital and intensive outpatient services

Programs/Resources to Commit

- Expanded Rogers Memorial Hospital Foundation endowment to support additional patient care grants
- Administration and all Rogers Behavioral Health System staff
- New staff for expanded programs

Impact of Programs/Resources on Health Need

- Create more access for mental health and addiction care
- Decrease barriers to care
- Improve patient flow into our various levels of care

Accountable Parties

- Rogers Behavioral Health administrative team
- Rogers Memorial Hospital Foundation

Partnerships/Collaboration
- Community

Priority 2: Substance Use Disorders

Objective/Strategy

- Expand substance use disorder services throughout the Rogers system in response to identified community need.
- Develop and employ an effective response within Rogers programming to the heroin epidemic

Tactics (How)

- Evaluate the need, using current trends and evidence-based practices, to create and strengthen services for special populations, e.g., dually diagnosed individuals, medication-assisted therapy for opiate addicted individuals, children and adolescents, emerging adults, etc.
- Revise and expand Family and Friends programming
- Further collaborate with the Herrington McBride Alumni Association to focus on and refine their role in providing adjunctive support
- Investigate appropriate delivery and location of supportive living facilities
- Provide education and advocacy on addiction treatment services to insurers and third-party payors.
- Identify, explore and evaluate potential community partnerships to supplement and enhance the services provided by Rogers.

Programs/Resources to Commit

- New Director of Addiction Services on board with expanded scope
- Continued outreach to community-based stakeholders including other providers, local business organizations, etc.
- Staff expertise

Impact of Programs/Resources on Health Need

- Targeted services designed to meet community-specific needs
- Ongoing innovation and assimilation of best practices across Rogers Memorial Hospital
- Demonstrated clinical outcomes that validate the cost/benefit of services provided

Priority 2: Substance Use Disorders (continued)

Accountable Parties

- Rogers Memorial Hospital Addiction Services team
- Herrington McBride Alumni Association
- Community partners as appropriate

Partnerships/Collaboration

- Area community leaders and industry stakeholders, including accountable care organizations, managed care organizations, community-based support organizations, local social service providers, and law enforcement
- Key donors/contributors

Priority 3: Education, Awareness, Advocacy and Stigma Reduction

Objective/Strategy

- Increase capacity of organizations to effectively reduce stigma surrounding mental illness in their sector
- Increase knowledge and advocacy around mental illness in multiple sectors and regions of our state

Tactics (How)

- Provide facilitative leadership to WISE - Wisconsin Initiative for Stigma Elimination
- Serve on WI DPI design and implementation team for WI's youth mental health framework
- Provide training to schools, workplaces, congregations, and community organizations
- Build capacity of staff in mental health organizations around the state (train trainers)
- Create multi-media and other resources to support objectives

Programs/Resources to Commit

- Rogers InHealth staff
- The more than 40 organizational members of WISE and other Rogers InHealth partners
- Expertise of Rogers staff
- Media equipment/resources

Impact of Programs/Resources on Health Need

- Reducing stigma will allow people to access care and support earlier in the process of the illness.
- Students, employees, members of faith communities, etc. will find early support and helpful referrals to services
- Policymakers will learn about how to improve the mental health care system
- Organizations dedicated to education and stigma reduction will implement evidence-based programming and approaches

Priority 3: Education, Awareness, Advocacy and Stigma Reduction (continued)

Accountable Parties

- Rogers InHealth Co-Directors
- Rogers Memorial Hospital Foundation
- Rogers Behavioral HealthAdministration
- WISE Executive Committee

Partnerships/Collaboration

- WISE membership, Patrick Corrigan, PhD, and other local, regional and national partners

Priority 4: Staff Mental Health Training

Objective/Strategy

- Improve quality of mental health service delivery system-wide
- Improve safety of patients, providers and the care environment
- Contribute to expanding access through educational initiatives

Tactics (How)

- Update and enhance training modules/topics including therapeutic boundaries, culture of care, suicide prevention and assessing patient safety, safety in a psychiatric setting, crisis intervention, psychiatric care 101, first aid and fire safety.
- Recruit and hire an Employee Safety Manager to partner with management and staff to deliver environmental safety, both at work as well as outside of work.
- Utilize data to implement training programs to minimize injuries associated with patient care and crisis de-escalation.
- Continue to develop partnerships with a variety of community groups including Easter Seals, Grand Avenue Club and others to explore vocational and occupational opportunities with their clients, who often suffer from physical or mental health issues, within our organization.
- Increase opportunities for students to learn about mental healthcare through internship, practicum or residency programs.
- Continue the Health Care Career Expo for Waukesha County High School students as an annual event.
- Double the number of CBT trained clinicians and improve therapeutic competencies of clinical specialists with advanced training of 'Cognitive Behavior Therapy' (CBT).
- Improve skill sets of clinicians on 'Dialectic Behavior Thinking' (DBT) and incorporate across all service lines. Dialectical Behavioral Thinking (DBT) is one style of Cognitive Behavioral Therapy.
- Train 1800 employees on 'Active Listening' techniques and incorporate into new-hire training.
- Establish virtual training delivery methods to all regional facilities

Programs/Resources to Commit

- Rogers Human Capital staff and our leadership team
- Academic and Community Engagement Specialist
- Employee Safety Manager

Impact of Programs/Resources on Health Need

- Greater competencies and skill sets
- Improved care delivery and patient safety

Accountable Parties

- Rogers Memorial Hospital leadership
- Human Capital Staff
- Rogers Memorial Hospital staff

Partnerships/Collaboration

- Waukesha County Business Alliance
- Southeastern WI hospitals and healthcare systems

Priority 5: After Care Support

Objective/Strategy

- Increase after care support with focus on support groups and transitional housing.

Tactics (How)

- Explore options for support group approaches- online, face-to-face, etc.
- Establish first transitional housing unit
- Hire a support group specialist

Programs/Resources to Commit

- RMH Foundation funds committed to transitional housing and support specialist

Impact of Programs/Resources on Health Need

- Decreased re-admissions
- Improved patient outcomes
- Expanded after-discharge support options

Accountable Parties

- Rogers Memorial Hospital administration
- Rogers Memorial Hospital Foundation

Partnerships/Collaboration

- DWD job centers, businesses, Private funders

Priority 6: Peer Support Specialist

Objective/Strategy

- Determine the effectiveness of a peer support staffing model as an addition to the RMH treatment team

Tactics (How)

- Explore role of peer support in both inpatient and intensive outpatient settings at RMH
- Explore role of peer support in both adolescent and adult populations
- Explore options of direct employment or a contracted service through a partner agency

Programs/Resources to Commit

- Human resources and treatment programs staff

Impact of Programs/Resources on Health Need

- Decreased re-admissions
- Improved patient outcomes.

Accountable Parties

- Rogers Memorial Hospital administration

Partnerships/Collaboration

- Hospitals and agencies that currently employ peer support specialist models