Brown County
Community Health Needs Assessment
2021

bellin health

An assessment of Brown County, Wisconsin was conducted jointly by Bellin Memorial Hospital, Inc., in collaboration with Beyond Health, a steering committee comprised of leaders from both the public and private sectors. The committee included representation from healthcare partners, public health agencies and nonprofit partners that work collaboratively to identify actionable priorities, minimize disparities in health and adapt as needed to new and emerging health concerns. This partnership was established to optimize the coordination and use of resources while reducing duplicative efforts.

Provisions in the Affordable Care Act (ACA) require charitable hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt implementation strategies to meet the needs identified. The CHNA is a systematic process involving the community to identify and analyze community health needs, as well as community assets and resources, in order to plan and act upon priority community health needs. This process results in a CHNA report, which is used to develop implementation strategies based on the evidence and assets and resources identified in the CHNA process.

In FY2021 (July 1, 2020 through June 30, 2021), Bellin Memorial Hospital, Inc. conducted its CHNA in partnership with representatives from the community. Upon completion of the CHNA, the hospital developed a set of implementation strategies and adopted an implementation plan to address priority community health needs. The population assessed was Brown County, Wisconsin. Data collected throughout the assessment process were supplemented with qualitative data gathered through a CHNA steering committee with broad community representation, community conversations held with key informants, focus groups, secondary data and the opinions of community key stakeholders.

BROWN COUNTY COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN

2020-2021

EXECUTIVE SUMMARY

The Community Health Assessment is a tool for Brown County to develop a deeper understanding of the health of our community. By pulling together information and painting a picture of health and well-being in Brown County, we can begin to understand where and how we should focus our resources, in order to increase overall health at various levels: for individuals, within groups, and as a whole.

Leading these efforts is Beyond Health, a steering committee comprised of leaders from both the public and private sectors: healthcare partners, public health agencies, and non-profit partners who work collaboratively to identify actionable priorities, minimize disparities in health, and adapt as needed to new and emerging health concerns.

At the top of this list in 2020 is the COVID-19 pandemic. Throughout the past year, Beyond Health members have engaged in a robust public health response to the pandemic, continuing to monitor and assess health in Brown County and partner whenever possible to ensure that community members have the tools and resources needed to stay healthy in the midst of unprecedented barriers to health.

We know that gaps exist in health depending on affiliation with certain groups: whether that is race, ethnicity, age, socioeconomic status, or more. Brown County is actively committed to minimizing these inequities, acting upon knowledge gained as a part of this assessment process, and moving our interventions upstream to ensure the most impact possible. This means weaving an intentional focus on the determinants of health - and not just health outcomes - into both our analysis and chosen strategic priorities.

We understand health in our community through a mix of both listening to community members' perspectives, presenting measurable indicators of health, and looking introspectively at public health systems already in place. We would like to thank the taskforces who have dedicated time and resources to this work over the last three years, and are optimistic that collectively we can continue to build on progress made, moving into this next cycle of community health improvement planning together.

The Beyond Health Steering Committee

2020: THE PANDEMIC

COVID-19

The coronavirus pandemic has impacted health outcomes in many ways across the globe. Brown County has been affected by this largescale incident and our public health system has responded.

Throughout this report, we will include COVID-19 health impacts, data points, and community members' perspectives on the pandemic into our summaries whenever possible. While we are beginning to understand just how COVID-19 affects health, there are still many unknowns, including potential longer-term effects.

Our community's response has been to come together, partner, and work in a coordinated way to navigate the pandemic. However, the strains on public health, in terms of both resources and the workforce, has stretched already-limited resources even thinner.

Additionally, workers and families continue to carry the weight of job loss, childcare concerns, financial hardships, and more. And COVID-19 is shining a light on the fact that communities who have historically been impacted to a higher degree are disproportionately affected by the pandemic.

However, our public health system in Brown County is strong and we are looking forward into 2021 with expanded access to vaccines on the horizon, and with continued optimism. We are stronger together, and will continue to work together to ensure a healthy community for ALL of Brown County.

OVERALL HEALTH RANKING

21

of 72 Wisconsin counties

BROWN COUNTY COMMUNITY PROFILE

Brown County, WI is the home to a rich heritage of cultural and community traditions. Located in the Northeast region of Wisconsin, Brown County is home to more than a quarter of a million residents. The majority of jobs in the area are service-providing. Other jobs are goods-producing and include trade, transportation, and utilities, manufacturing and government. Brown County is made up of the following municipalities:

CITIES

Green Bay, De Pere

VILLAGES

Allouez, Ashwaubenon, Bellevue, Denmark, Hobart, Howard, Pulaski, Suamico, Wrightstown

TOWNS

Eaton, Glenmore, Green Bay, Holland, Humboldt, Lawrence, Ledgeview, Morrison, New Denmark, Pittsfield, Rockland, Scott, Wrightstown

TRIBAL NATIONS

Oneida

616 SQUARE MILES

COMMUNITY SNAPSHOT

264,542

Total Population

Male 50%

Female 50%

Urban 86%

Rural 14%

$62,100

Median Household Income

Median Age: 37

Average Life Expectancy: 80

Sources:
Industries: http://www.city-data.com/us-cities/The-Midwest/Green-Bay-Economy.html
County Health Rankings, population, sex distribution, median household income: U.S. Census Bureau, 2019. www.census.gov/quickfacts/fact/table/browncountywisconsin/PST04.and Average Life Expectancy: County Health Rankings 2020. www.countyhealthrankings.org/app/wisconsin/2020/overview.
Urban/Rural: http://www.city-data.com/county/Brown_County-WI.html

COMMUNITY PROFILE

Total Population 264,542

Race and ethnicity are two concepts related to ancestry. "Race" is usually associated with physical characteristics and "ethnicity" is typically linked with cultural expression and identification. It is possible to identify with one or more groups within established concepts of race and ethnicity, or to identify as outside of pre-established racial or ethnic groups.

RACE

88% White Alone

3% Black or African American Alone

3% American Indian and Alaska Native Alone

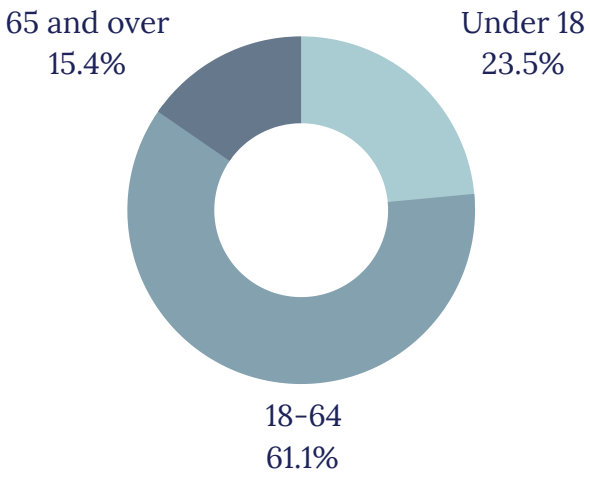
3% Asian Alone

3% Two or More Races

ETHNICITY

9% Hispanic Community

AGE



LGBTQ+

LGBTQ+ is an all-encompassing term meant to describe individuals who identify as lesbian, gay, bisexual, transgender and questioning or queer. This term refers to factors related to sexual identity and/or gender identity.

4% Adults (18+) in WI who identify as LGBTQ

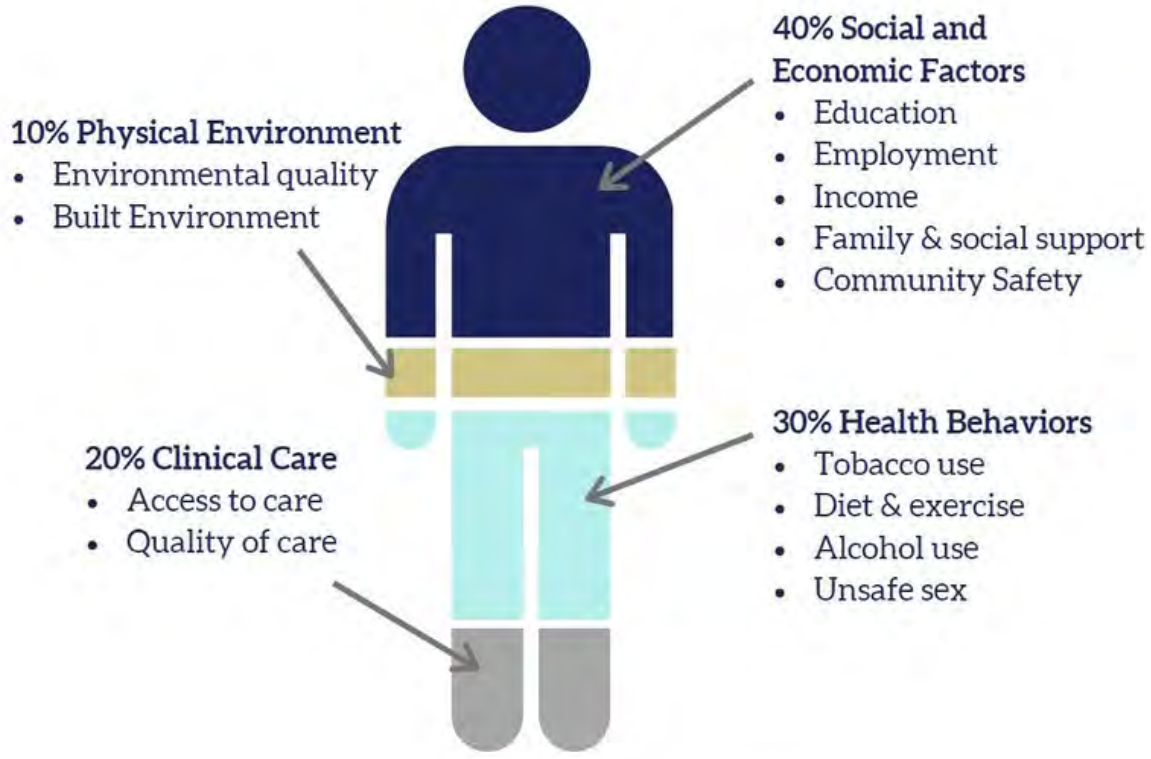
4% WI workforce members who identify as LGBTQ

29% LGBTQ adults in WI (25 +) who are raising children

Sources:
Intro: nationalgeographic.com/culture/topics/reference/race-ethnicity
Population, Race, Ethnicity, Age Data: U.S. Census Bureau, 2019. census.gov/quickfacts/fact/table/browncountywisconsin/PST0
LGBTQ+ Data: Wisconsin Interactive Statistics on Health, 2018. wish.wisconsin.gov/results/ LGBTQ+ Data: Census 2018; Gallup/Williams 2019, 2020. lgbtmap.org/equality-maps/profile_state/WI

WHAT DETERMINES OUR COMMUNITY'S HEALTH?

Health is more than the decisions that we make at an individual level. According to a model developed by the CDC, health behaviors make up only 30% of our overall health. 70% of our overall health is determined by factors that are bigger than the choices that we make on a daily basis. With this in mind, we can't focus solely on health outcomes - we must look at the bigger picture, focusing on what truly determines our health. This report will highlight examples from each of the categories listed here.



Source:
www.countyhealthrankings.org/sites/default/files/media/document/CHRRoverview2020v2.pdf

GROUNDING OUR WORK IN THE SOCIAL DETERMINANTS OF HEALTH

The 70% of our health which is made up of factors beyond our individual health behaviors and choices include the categories listed below. Recognizing this, public health agencies strive to address not only health behaviors, but to build partnerships, analyze policies, and engage in strategies which improve community conditions. By exploring the social determinants of health in this Community Health Assessment, we can capture a more comprehensive picture of the health of our community.

ADDRESSING HEALTH EQUITY AND RACISM:

RACISM IS A PUBLIC HEALTH CRISIS

Racism is one of the root causes of inequities that impact health. While this may be drawing renewed attention nationally, these conversations are not new. Health equity continues to be a priority for Public Health and Community Partners and is purposely highlighted in this Community Health Assessment and Improvement Plan. Public Health will continue to engage with community partners in order to better understand racism in our County and plan initiatives aimed at advancing equitable health and well-being.

A TIMELINE OF MOVING TOWARDS ACCEPTANCE OF RACISM AS A PUBLIC HEALTH CRISIS

1986

The World Health Organization (WHO) acknowledged that social justice & equity are fundamental for health and that health promotion actions should aim at reducing differences in current health status and ensuring equitable opportunities and resources so all people can achieve their fullest health

1999

US Dept. of Health and Human Services made elimination of health inequities a national public health goal

2018

The Wisconsin Public Health Association (WPHA) passed a resolution declaring racism a public health crisis in Wisconsin

2020

The Green Bay City Council, along with 18 other organizations representing healthcare, business, nonprofits, and education passed a resolution declaring racism a public health crisis locally showcasing the cross-sector commitment to ending racism in Brown County.

TODAY

February 2021, Brown County Board of Supervisors approved the resolution, "Resolution Advancing Racial Equity and Support Throughout Brown County." This is a step forward in formally recognizing the inequities that exist due to systemic racism that contribute to discrimination in housing, education, employment, and criminal justice which all affect health outcomes like morbidity, mortality, life expectancy, and health status. A subsequent resolution was passed to establish a subcommittee to focus on addressing racial equity and provide necessary support throughout Brown County.

RACISM AS A PUBLIC HEALTH CRISIS:

Some of the inequities in the social determinants of health that put racial and ethnic groups at increased risk for poor health in general and at risk of getting sick and also dying from COVID-19 include:

Discrimination: *Unfortunately, discrimination exists in systems meant to protect health, such as: health care, housing, education, criminal justice, and finance. Discrimination, which includes racism, can lead to chronic and toxic stress and shapes social and economic factors that put some people from racial and ethnic minority groups at increased risk health risks.*

Healthcare access and utilization: *People from some racial and ethnic minority groups are more likely to be uninsured than non-Hispanic whites. Healthcare access can also be limited for these groups by many other factors: lack of transportation, child care, ability to take time off of work, communication barriers, cultural differences between patients and providers, and historical and current discrimination in healthcare systems. Some people from racial and ethnic minority groups may hesitate to seek care because they distrust the government and healthcare systems responsible for inequities in treatment and historical events.*

Occupation: *People from some racial and ethnic minority groups are disproportionately represented in essential work settings such as healthcare facilities, farms, factories, grocery stores, and public transportation. Various factors impact the potential for health risks, such as close contact with the public or other workers, not being able to work from home, and not having paid sick days.*

Educational, income, and wealth gaps: *Inequities in access to high-quality education for some racial and ethnic minority groups can lead to lower high school completion rates and barriers to college entrance. This may limit future job options and lead to lower paying or less stable jobs. People in these situations often cannot afford to miss work, even if they're sick, because they do not have enough money saved up for essential items like food and other important living needs.*

Housing: *Some people from racial and ethnic minority groups live in crowded conditions that make it more challenging to follow prevention strategies. In some cultures, it is common for family members of many generations to live in one household.*

These factors and others are associated with more COVID-19 cases, hospitalizations, and deaths in areas where racial and ethnic minority groups live, learn, work, play, and worship. They have also contributed to higher rates of some medical conditions that increase one's risk of severe illness. In addition, community strategies to slow the spread of COVID-19 may cause unintentional harm, such as lost wages, reduced access to services, and increased stress, for some racial and ethnic minority groups.

Source: Centers for Disease Control: cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html

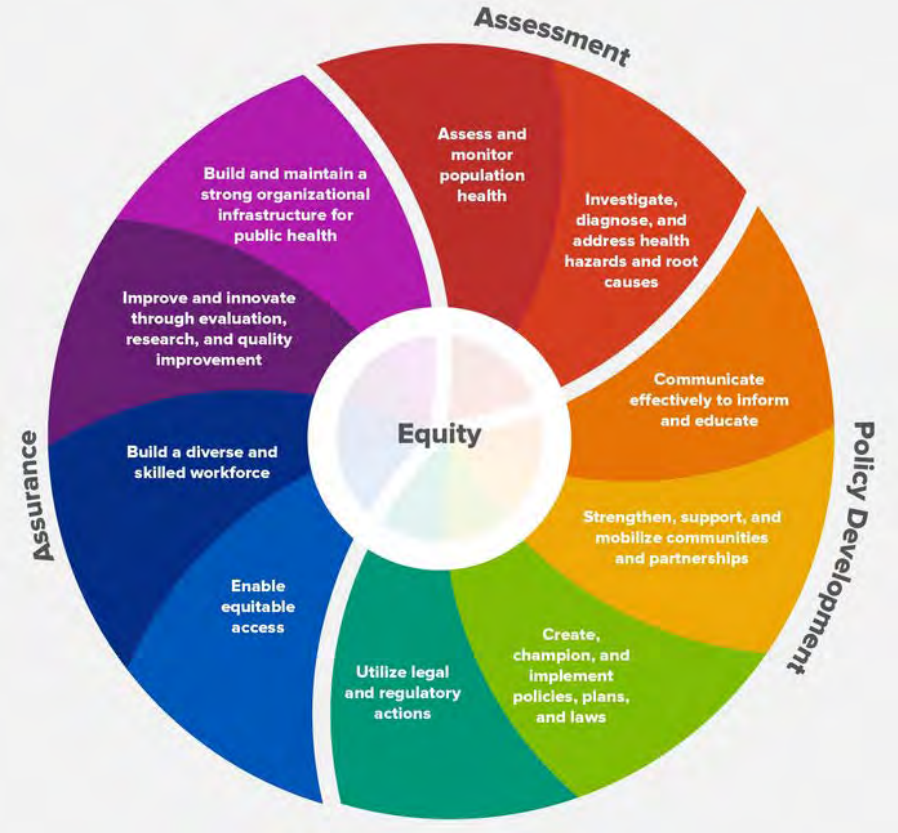
OUR APPROACH TO THE COMMUNITY HEALTH ASSESSMENT

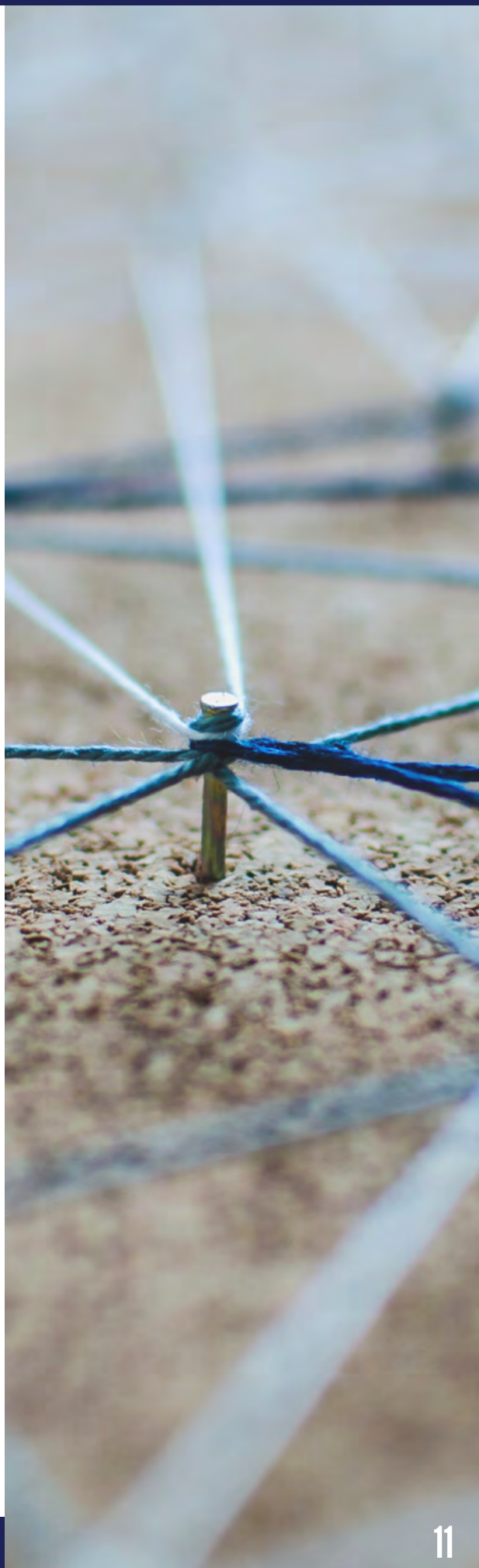
This report is is aligned with the Center for Disease Control and Prevention (CDC) social determinants of health model and will present a picture of health that is comprehensive and robust, utilizing the most recent data available.

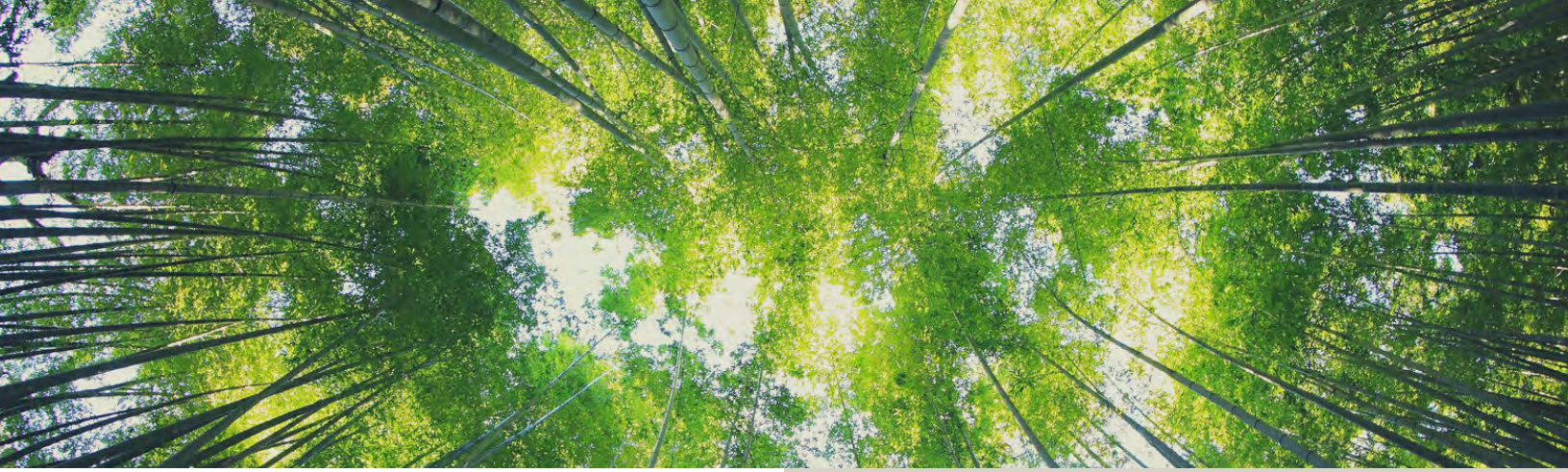
The following domains will be highlighted in this report:

- **Physical Environment**
- **Social and Economic Factors**
- **Health Behaviors**
- **Clinical Care**
- **Health Outcomes**

Additionally, the CDC has identified essential services that public health systems should provide in communities, and this framing is important to the overall assessment process:







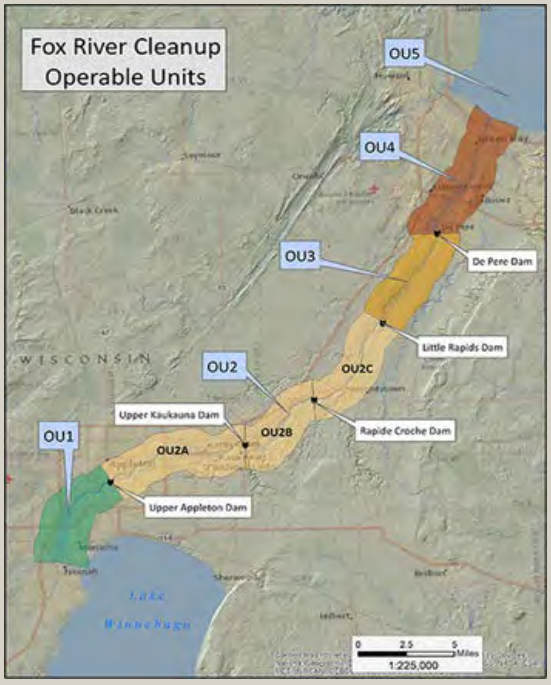
PHYSICAL ENVIRONMENT

The physical environment of a community can impact your health in many ways. From safe drinking water to clean air to being able to access healthy foods, each and every aspect of your environment plays a role in your health. When a community is able to provide a safe, equitable environment to its members, the community tends to be healthier.

The physical environment of a community includes both the natural and built environment.

Source:
Fox River Clean Up: dnr.wisconsin.gov/topic/FoxRiver/Background.html

FOX RIVER CLEANUP



The Fox River Cleanup Project, in partnership with the Wisconsin DNR, is a great success story of improving the water quality locally.

This 12 year project succeeded by accomplishing its goals of: achieving surface water quality criteria for PCBs, protecting humans who consume fish from exposure to contaminants that exceed protective levels, protecting ecological receptors from exposure to contaminants above protective levels, and reducing the transport of PCBs. To find out more information, check out this website:

foxrivercleanup.com/project-goals/

PHYSICAL ENVIRONMENT: WATER

Water is an essential component to living a healthy life. Water helps flush waste from your body, regulates body temperature, and helps your brain function. It is important to have clean and safe water in the community.

Brown County has experienced substantial flooding the last few years. This flooding has had an impact on many private wells, as well as in public waters. Approximately 5% of housing units in Brown County are within a 100 year flood zone. This is comparable to the rate of the state overall. Global warming leads to increased flooding, which can be costly to a community in terms of dollars and lives lost.

PERCENT OF POPULATION WITH WATER WITH OPTIMAL* FLUORIDE LEVELS

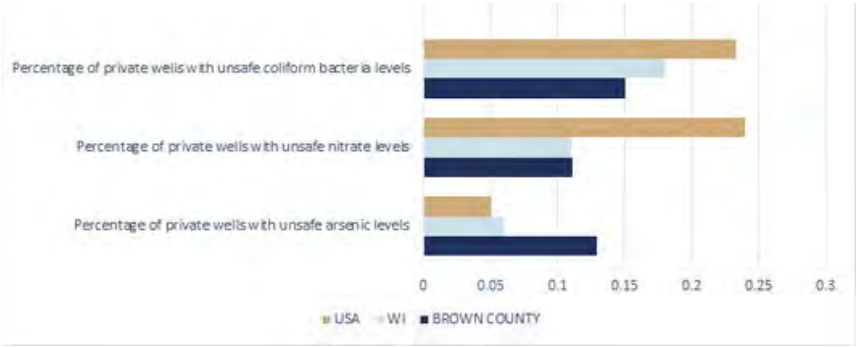
Brown County	Wisconsin
96%	88%

Fluoride can be found in most municipal water systems. It provides many health benefits to a community's members, such as preventing tooth decay and cavities.

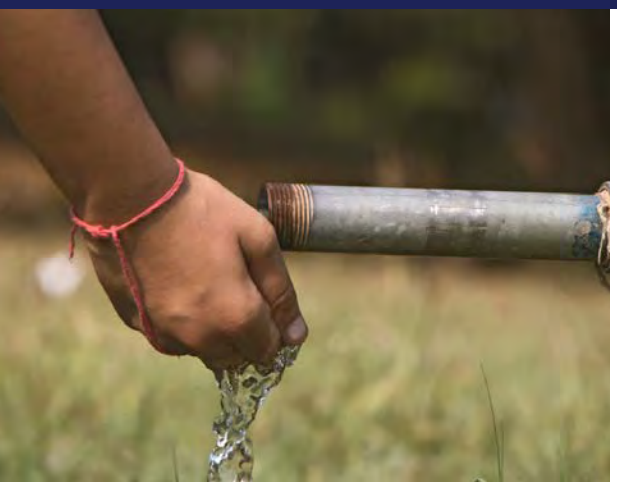
**Optimal has been defined as .8-1.3 mcg*

Ensuring a community's water is clean and safe is one way to make sure its members are healthy. Having high levels of coliform, nitrate, or arsenic in your well water can negatively impact health.

WELL WATER QUALITY



A LOCAL SUCCESS STORY: REMOVING LEAD WATER PIPES IN THE CITY OF GREEN BAY



In 2020, the City of Green Bay successfully completed a five year effort to remove all of the lead pipes in the City's limits. Lead exposure can lead to detrimental health impacts, especially in children,. Removing the lead pipes will have lasting benefits in the community. The City of Green Bay Water Utility replaced 1,781 utility owned and 247 privately owned lead service lines. The model used to accomplish this has been shared nationwide by the EPA. This currently leaves 15% of homes in Brown County with lead pipes, whereas the state of Wisconsin has 25% of homes that still have lead pipes.

Sources:
Flooding: browncounty.maps.arcgis.com/apps/webappviewer/index.html?id=1fba3fd419045e48aa6ba759838387c/; furmancenter.org/files/NYUFurmanCenter_HousingInTheFloodplain_May2017.pdf
Fluoride: dhs.wisconsin.gov/publications/p0/p00719-brown.pdf
Wells: dhs.wisconsin.gov/publications/p0/p00719brown.pdf mdpi.com/20799276/4/3/655/htm
Lead Pipes: wpr.org/green-bay-has-officially-replaced-all-citys-lead pipes

PHYSICAL ENVIRONMENT: TRANSPORTATION

Transportation plays a critical role in public health. Motorized vehicles can lead to increased air pollution, traffic crashes, and decreased physical activity. Looking at alternative methods of transportation can increase the health of a community.

PERCENT OF POPULATION WITH A DRIVER'S LICENSE

Brown County	Wisconsin
69%	**74%**

Drivers licenses have an impact on the economically disadvantaged in a community. Obtaining and maintaining a drivers license is expensive. If there are not adequate transportation options available to the community members, such as public transportation, many members of the community will struggle.

PERCENT OF POPULATION WITH ACCESS TO PUBLIC TRANSPORTATION

Brown County	Wisconsin
29%	**54%**

Public transportation is relied on by many to get to work or school, run errands, or visit the doctor's office . Investing in and promoting public transportation helps keeps the air cleaner by reducing the number of motorized vehicles on the road. When public transportation is lacking, many community members are unable to fulfill their basic needs.

DID YOU KNOW?

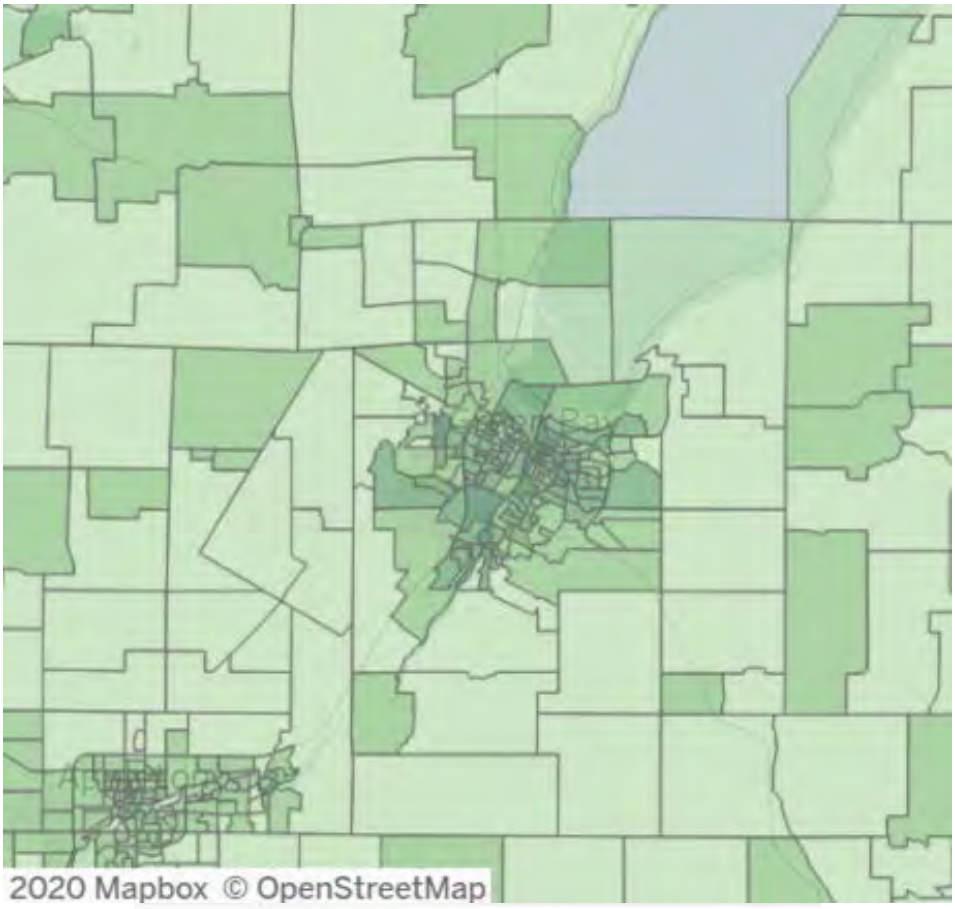
In 2017, the Brown County Bicycle and Pedestrian Plan Update was approved and goes in depth with the process taken to obtain public input, recommendations for improving amenities, and implementation. The Plan can be found here:

www.browncountywi.gov/departments/planning-and-land-services/planning/bicycle-and-pedestrian-planning/

Sources:
Licenses: datahub.transportation.gov/Roadways-and-Bridges/Licensed-Drivers-by-state-gender-and-age-group/xfkb-3bxx;
Public Transportation: wisconsindot.gov/Documents/about-wisdot/newsroom/statistics/factsfig/2018ff.pdf

PHYSICAL ENVIRONMENT: TRANSPORTATION

BROWN COUNTY WALKABILITY



Having a walkable community makes it easier to get from place to place, while encouraging community members to walk rather than use a motorized vehicle. Walkable neighborhoods tend to have more active members, as well as an overall healthier community.

Source:
Walkability: https://www.wihealthatlas.org/walkability

PHYSICAL ENVIRONMENT: OUTDOOR SPACES

URBAN TREE CANOPY COVERAGE

"Urban Tree Canopy Coverage" is a term to describe the layer of tree leaves, branches, and stems that provide coverage of the ground when viewed from above.

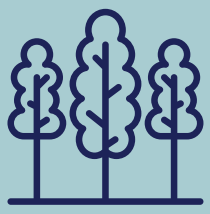
An Urban Tree Canopy Coverage Assessment aims to create a detailed land coverage map. This includes high-resolution landcover (<2'), high-resolution parcel data, individual parcels, and the entire watershed.

Improving a community's tree canopy coverage can lead to many benefits, such as reducing air pollution, providing comfort during peak summer temps, and giving wildlife a habitat.

In forested areas, a 40-60% tree canopy is the target, whereas the target for grassland cities is 20% and 15% for desert cities.

Brown County:

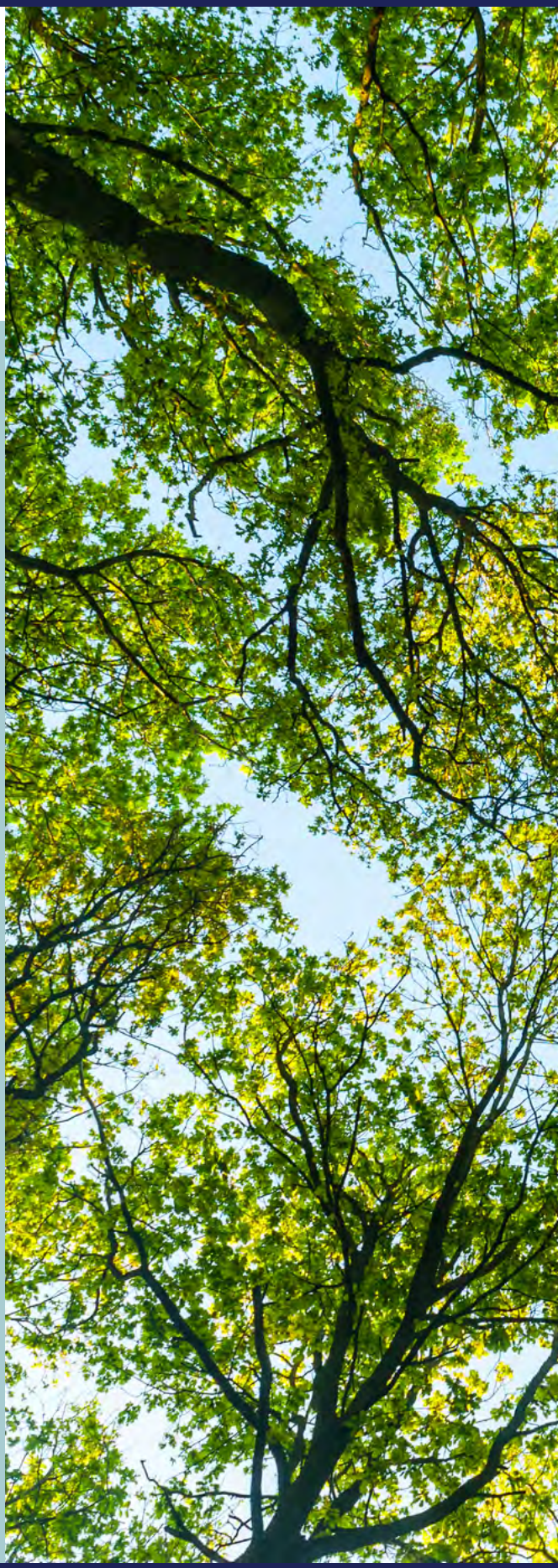
15%



Wisconsin:

29%

Source:
Urban Tree Canopy: www.cwp.org/making-urban-trees-count/

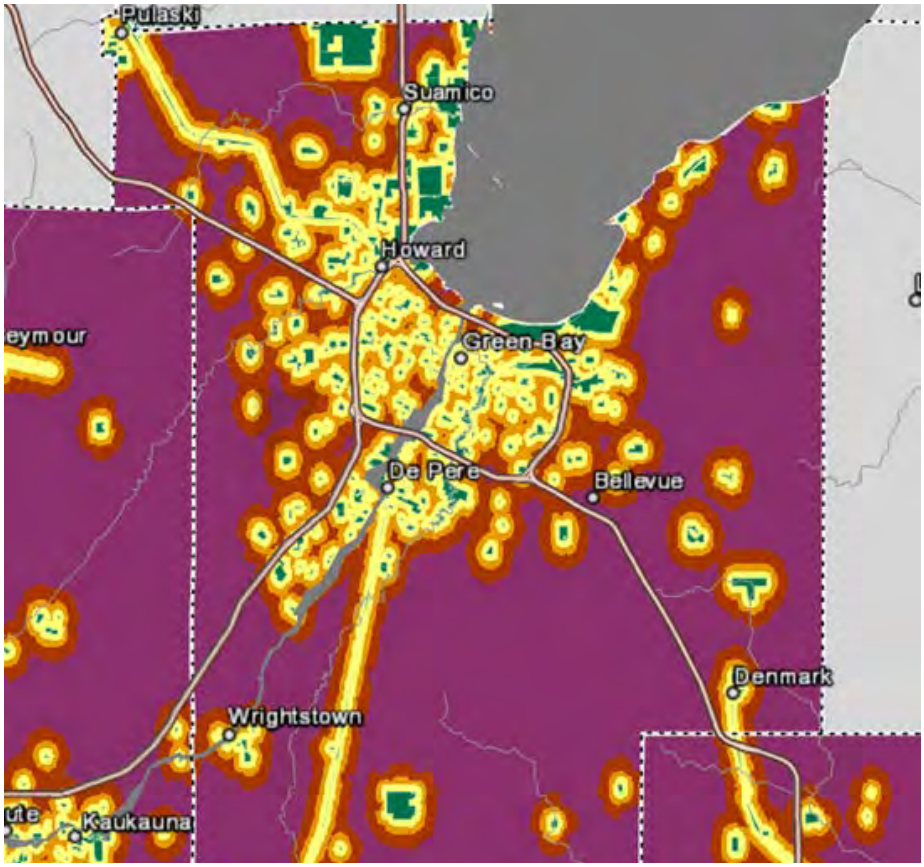


PHYSICAL ENVIRONMENT: OUTDOOR SPACES

When community members have access to parks and green spaces, they are more likely to live an active lifestyle. Parks help build healthy and stable communities, while also providing psychological and social health benefits to individuals.

MAP OF BROWN COUNTY PARKS

DISTANCE FROM OUTDOOR RECREATION AREAS



Legend

Parks, Schools, & Open Space

Outdoor Recreation Access

Distance

- Over 1 Mile
- 1 Mile
- 1/2 Mile
- 1/4 Mile

Sources:
Intro: www.tpl.org/health-benefits-parks
Parks Map: browncounty.maps.arcgis.com/apps/OnePane/basicviewer/index.tml?appid=e77ecd45a31d48738ba60371d67d8bb0
Outdoor Recreation: www.arcgis.com/apps/webappviewer/index html id=117ebb348c64415ebf10e0ae9f0ccff1

PHYSICAL ENVIRONMENT: HIGHLIGHTED RISKS

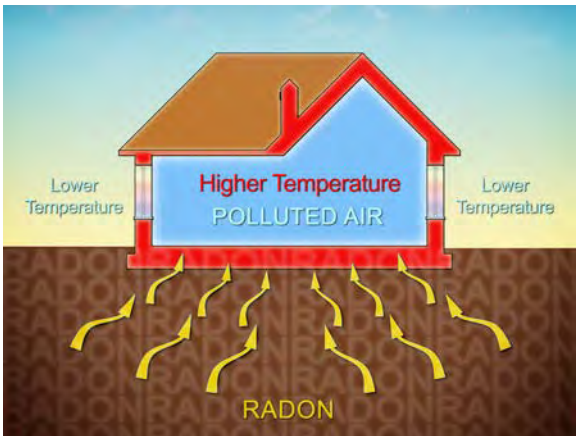
*Brown County's **liquor license** rate per 1,000 people is 1.2, while the State's is 1.5. While Brown County might be slightly lower than Wisconsin's as a whole, research conducted over decades has shown us that an over-concentration of alcohol outlets will result in higher rates of alcohol-related disorder even when all the licensees obey the law. When a cluster or over-concentration of alcohol outlets develops, local law enforcement costs usually increase as well.*

*Brown County currently has 6% of **tobacco** retailers within 500 feet of school, whereas the State is at 5%. When there are retailers near schools, there is an increase in misuse, as well as higher smoking rates among youth.*

ASTHMA

Asthma is a chronic disease that affects breathing and limits the ability to get oxygen into the lungs. Asthma symptoms often happen when a person is in contact with a trigger, such as outdoor air pollution or airborne pollens.

Disparities exist in Wisconsin when it comes to asthma and past data have shown that black individuals experience higher prevalence of asthma compared to other racial/ethnic groups. The hospitalization rate for black Wisconsin residents was 5.8 times as high as the rate for white residents.



***Radon** is an odorless, tasteless, colorless natural gas. It is the second leading cause of cancer in the United States and is the number one cause of lung cancer amongst non smokers. Radon can exist in your home, so testing your home regularly can decrease your risk of radon exposure.*

PERCENT OF RADON TESTS WITH RESULTS AT OR ABOVE EPA STANDARD*

Brown County	Wisconsin
53%	50%

*EPA Standard defined as 4 pCi/L

COAL

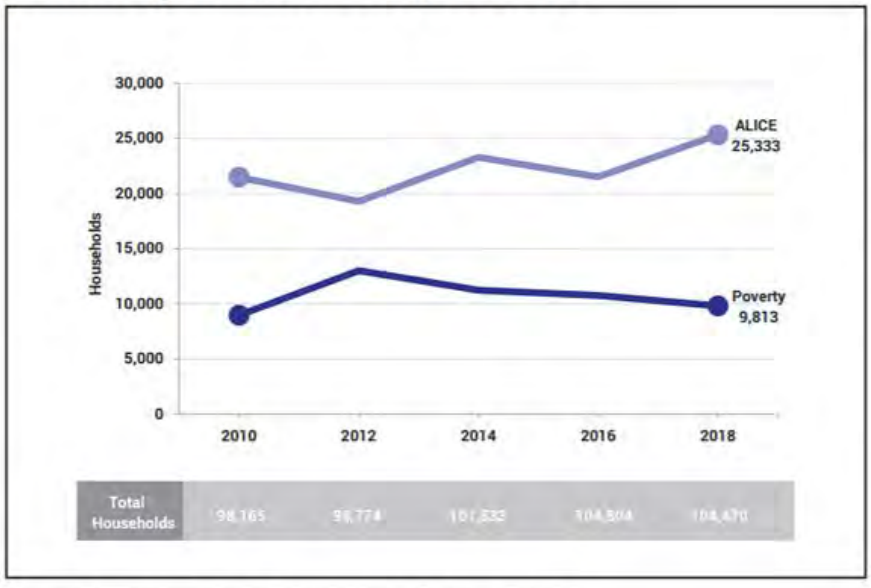
The coal piles in Green Bay are widely recognizable, but that is coming to an end. Georgia-Pacific plans to end their coal use and use natural gas boilers, which will help reduce air emissions. In addition, removing the coal and expanding economic activity at the Port is being supported through a WI Economic Development Corporation grant awarded to Brown County.

Sources:
Tobacco: https://truthinitiative.org/research-resources/targeted-communities/tobacco-social-justice-issue-low-income-communities;
Alcohol: https://www.cdc.gov/alcohol/pdfs/CDC-Guide-for-Measuring-Alcohol-Outlet-Density.pdf;
https://law.wisc.edu/wapp/communityproblems.html
Asthma: Brown County 2019 County Environmental health profile, https://www.dhs.wisconsin.gov/publications/p0/p00719-brown.pdf and the Wisconsin Department of Health Services (DHS). Wisconsin Environmental Public Health Tracking (EPHT) Program. Asthma Data 2014 Available at https://www.dhs.wisconsin.gov/epht/asthma.htm.
Radon: www.dhs.wisconsin.gov/publications/p0/p00719-brown.pdf
Coal: fox11online.com/news/local/georgia-pacific-to-end-coal-use-at-broadway-mill;
https://www.wbay.com/2021/01/04/state-grants-500000-for-port-of-green-bay-expansion/

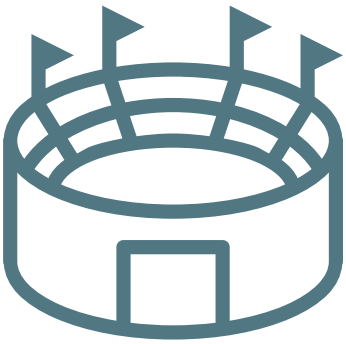
SOCIAL AND ECONOMIC FACTORS

Social and economic factors, such as income, education, employment, community safety, and social supports can significantly affect how well and how long we live. These factors also affect our ability to make healthy choices, afford medical care and housing, manage stress, and more.

Households by Income, Brown County, 2010 to 2018



Sources: ALICE Threshold, 2010-2018; American Community Survey, 2010-2018
(ALICE = Asset Limited, Income Constrained, Employed)



Brown County is 5th of 72 counties in WI ranked by visitor spending

Sources:
Intro: www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-outcomes
Tourism: industry.travelwisconsin.com/research/economic-impact
Visitor Spending: 2.2019. http://industry.travelwisconsin.com/research/economic-impact

SOCIAL AND ECONOMIC FACTORS

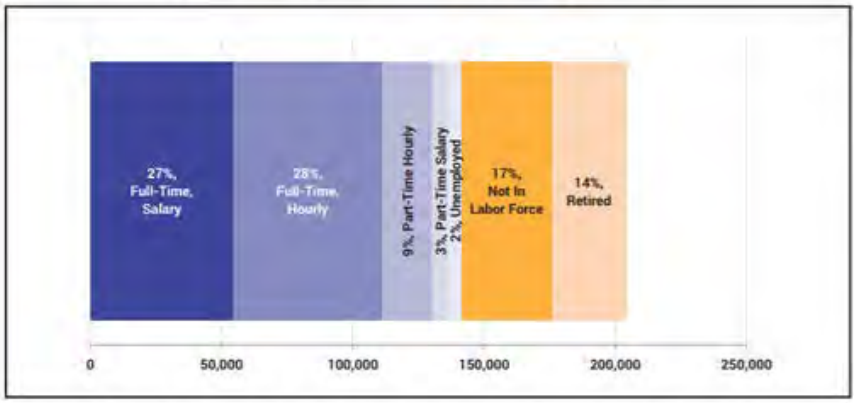
IN BROWN COUNTY:

15,122 *households are single parent households*

21,944 *people are living in poverty*

11% *of children under age 18 live in poverty*

Labor Status, Population 16 and Over, Brown County, 2018



Note: Data for full- and part-time jobs is only available at the national level; these national rates (51% of full-time workers and 75% of part-time workers paid hourly) have been applied to the total county workforce to calculate the breakdown shown in this figure. Full-time represents a minimum of 35 hours per week at one or more jobs for 48 weeks per year.

Sources: American Community Survey, 2018; Federal Reserve Bank of St. Louis, 2018

MEDIAN HOUSEHOLD INCOME

Overall	$62,100
Native American	$36,700
Hispanic	$46,500
Black	$23,200
Asian	$76,500
White	$62,900

THE CHANGING LANDSCAPE IN WI

- Over half of jobs were hourly paid in 2018
- Only 26% of working-age adults had the security of a full-time job with a salary
- 34% were out of the labor force

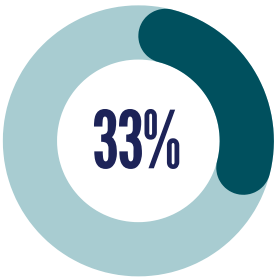
Sources:
number of households w/ single parent: WI Environmental Public Health Data Tracker, 2018. *dhsgis.wi.gov/DHS/EPHTracker /#/map/Populations%20and%20Vulnerabilities/popAndVulIndex/NOTRACT/52/593*
Median Income and Child Poverty: County Health Rankings, 2018. countyhealthrankings.org/app/wisconsin/2020/overview.
Overall Poverty: WI EPH Data Tracker, 2018. dhs.wisconsin.gov/epht/data.htm
Changing Landscape: American Community Survey, 2018

SOCIAL AND ECONOMIC FACTORS

MENTAL HEALTH AND EMPLOYMENT:

The World Health Organization has identified depression as the leading cause of disability worldwide. People with depression report **5x** *as many days per month when poor mental or physical health kept them from doing their usual activities, compared to those without depression. Depressed workers report an average of* **5.6** *hours a week of health-related lost productive time (1 hour absent and 4.6 hours of lost productivity on average). Additionally, more incidences of short-term disability are caused by mental health disorders (13%) than back problems, heart disease, arthritis, metabolic disorders and hyptertension.*

POOR MENTAL HEALTH DAYS



of employed adults in Brown County report 1 or more poor mental health days per month

POTENTIAL MENTAL HEALTH IMPACTS IN THE WORKPLACE:

- *Productivity*
- *Taking appropriate safety precautions*
- *Concentration*
- *Decision-making*
- *Judgement*
- *Relationship skills*
- *Meeting deadlines*
- *Worker retention*

FINANCIAL IMPACT ON THE WORKPLACE

Poor mental health days cost Brown County employers

$400,000,000

per year

DID YOU KNOW?

There are an average of

7,500,000

poor mental health days for all Brown County adults ***per year***

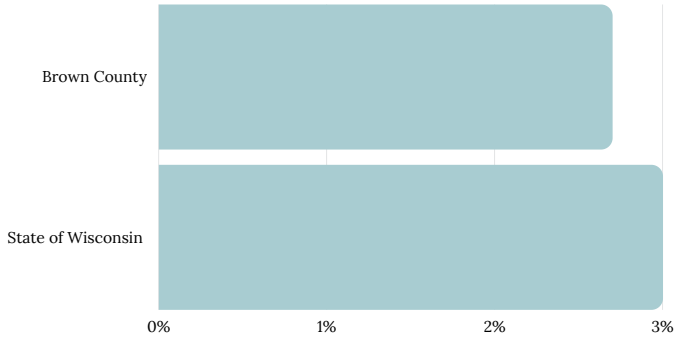
Behavioral Risk Factor Survey reports an average of 3.4 PMHDs/month among Brown County adults, which then works out to over 7 million PMHD/year.

Sources:
Behavioral Risk Factor Survey Data
Journal of Occupational and Environmental Medicine, July 2018

SOCIAL AND ECONOMIC FACTORS

EMPLOYMENT

Overall unemployment rates in Brown County and Wisconsin in 2020



HOUSING COSTS

Brown County

Montly Rent for 2 bedroom apartment: $860

Average Median Home Price: $180,400

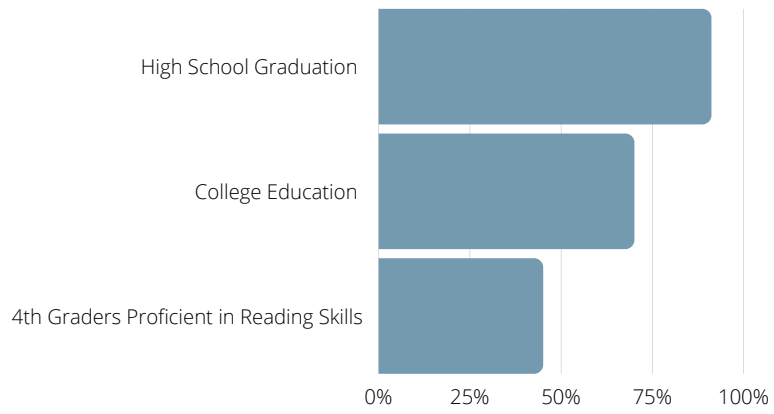
State of Wisconsin

Montly Rent for 2 bedroom apartment: $774

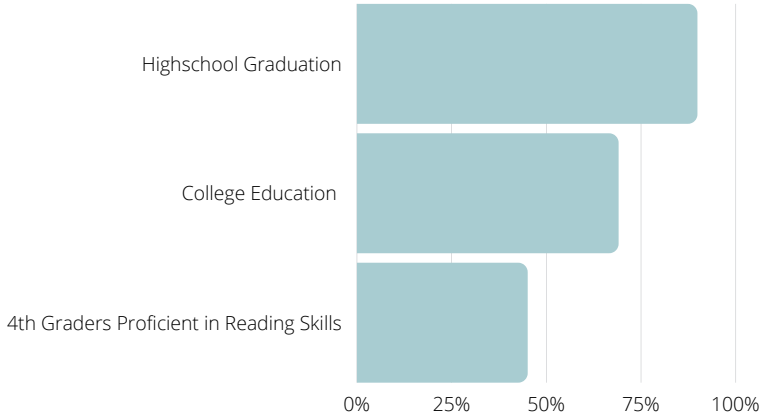
Average Median Home Price: $223,000

EDUCATION

Brown County



State of Wisconsin

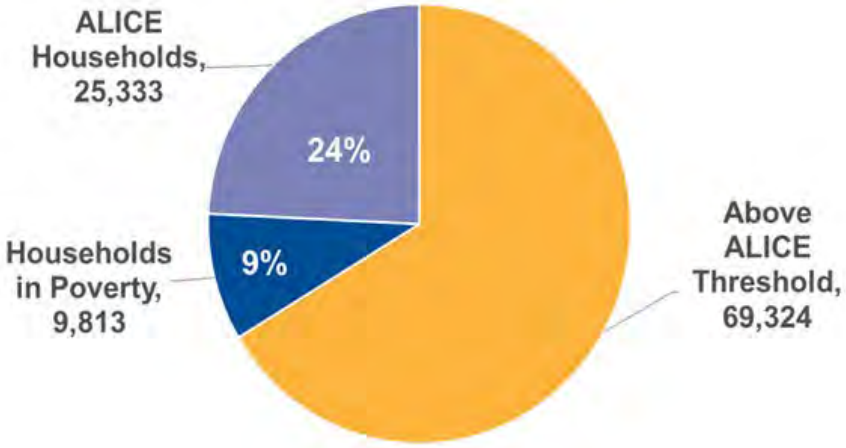


Sources:
Employment Data: countyhealthrankings.org/app/wisconsin/2020/rankings/brown/county/outcomes/overall/snapshot
Housing Costs Data: rentdata.org/states/wisconsin/2019; wra.org/HousingStatistics/
Education Data: cdn.ymaws.com/unitedwaywi.org/resource/collection/572412D0-E79C-45FA-9049-FBF519C516DC/Brown_County__ALICE2020_.pdf 4th Grade Literacy Data: countyhealthrankings.org/app/wisconsin/2020/measure/factors/116/data

WHO IS ALICE?

ALICE refers to Asset-Limited, Income Constrained, Employed individuals in our community who live above the federal poverty level, but below a household survival budget. ALICE households typically struggle with paying monthly bills, saving money for emergencies, and saving for investing in the future. ALICE households typically hold low-wage jobs and are more vulnerable to hardships, including health-related concerns.

ALICE IN BROWN COUNTY, 2018



TRENDS IN WISCONSIN

- *Overall Cost of Living*
- *Worker Vulnerability*
- *Flat Wages*
- *Total Number of ALICE households*

In Brown County, the average ALICE Household Survival Budget was $23,280 for a single adult, $25,416 for a single senior, and $72,864 for a family of four with young children in 2018.

DISPARITIES BY AGE

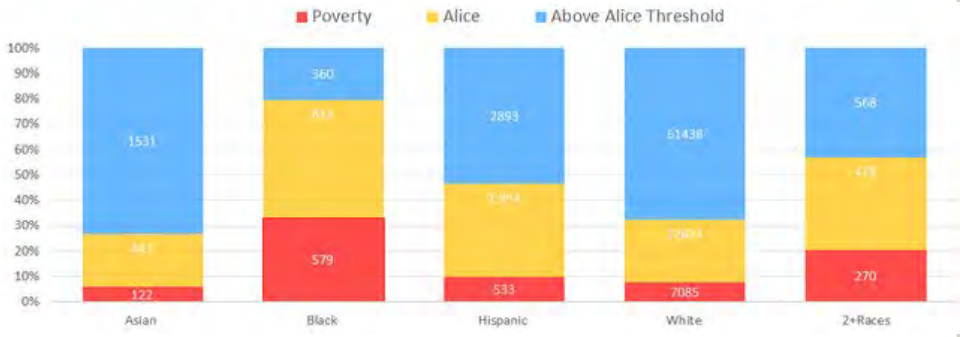
***53%** of households headed by individuals age 65 and older, and **48%** of households headed by individuals under age 25 lived below the ALICE threshold in 2018.*

For more information visit: UnitedforALICE.org/Wisconsin

Sources: ALICE Threshold, 2018; American Community Survey, 2018

SOCIAL AND ECONOMIC FACTORS

DISPARITIES BY RACE/ETHNICITY, 2018



IN BROWN COUNTY IN 2018, 1 IN 3 HOUSEHOLDS WERE BELOW THE ALICE THRESHOLD (MORE THAN 35,600)

79% *of Black households in Brown County lived below the ALICE threshold*

47% *of Hispanic households in Brown County lived below the ALICE threshold*

33% *of Caucasian households in Brown County lived below the ALICE threshold*

CHILD CARE QUICK FACTS

54% *of households in Wisconsin were located in a childcare desert*

72% *of parents/primary caregivers who live in Brown County households and have children under the age of 6 were working*

Sources:
Race/Childcare: ALICE Threshold, 2018; American Community Survey, 2018
Welcome Baby: 2019/2020 Program Data, Family Services of NE Wisconsin

WELCOME BABY PROGRAM

All Brown County parents with newborns receive a Welcome Baby Visit while pregnant or at the hospital, through a Family Services of Northeast Wisconsin Program. These visits are done by trained Community Resource Specialists and screen families for risk factors. During these visits information on community resources is shared and the families can be connected with early childhood programs. Between December 2019 and December 2020, 1608 total screenings were completed, and of those, 28% were positive for risk factors (457). Below are details from those positive screenings:

% POSITIVE SCREENINGS BY RACE

Native American	9%
Asian	4%
Black	10%
Hispanic	19%
Multiple Races	4%
African (Somali)	2%
White	38%
Unknown	14%

56% *of those who screened positive were referred to appropriate community resources (434 total)*

COMMON REFERRAL TYPES

Basic Needs: 37%	Counseling: 4%
BadgerCare: 2%	Public Health: 5%
Personal Safety: 1%	Housing: 11%
Financial Assistance: 15%	GED/Education: 4%
	Food Pantry: 41%

SOCIAL AND ECONOMIC FACTORS:
CONNECTEDNESS

Social networks are associated with geographic closeness, historical ties, political boundaries, etc. and can shape social and economic activities like: migration, trade, job-seeking, consumption, public health, social mobility and more.

SOCIAL SUPPORT

Number of membership associations per 10,000

Brown County	Wisconsin
9	12

INTERNET ACCESS

41% of households with incomes less than $20,000 without an internet subscription

14% of households have no internet access

8% of households have no computer

25% of households have no smartphone

Sources:
Intro: Baily M., Coa R., Kuchler T., Stroebel J., Wondg A. "Social Connectedness: Measurements, Determinants, and Effets", Journal of Economic Perspectives, Volume 32, Number 3—Summer 2018, Pages 259–280.
Social Supports: County Health Rankings; 2017. https://www.countyhealthrankings.org/app/wisconsin/2020/overview.
Internet Access: WI EPH Data Tracker for 2014-2018. https://www.dhs.wisconsin.gov/epht/data.htm.

With the COVID-19 pandemic, parents, students, teachers, small business owners, and community leaders have faced challenges when trying to connect with each other.

Brown County launched a website to test the internet speed in our community:

www.browncountywi.gov/broadband

The data collected from this will be used to support a request for federal funding and investment to improve our broadband internet infrastructure and web capabilities in areas like education, business, health care and overall quality of life.

Now is the time to come together as we aim to improve our internet access and connectivity.

HOMELESSNESS AND COVID-19

Brown County Health & Human Services and the area's housing and homeless service providers have been working together during the pandemic to support those in the community experiencing housing insecurity. The numbers of individuals and families at risk of housing insecurity grew during the pandemic. Brown County Public Health held a small focus group discussion with housing service providers to determine how the pandemic was effecting this population.

A LACK OF:
RESOURCES
POWER
SOCIAL CONNECTEDNESS

are ongoing hurdles that the homeless population and the service agencies experience and all of these disparities were made worse by the covid-19 pandemic in our community.

SOCIAL AND ECONOMIC FACTORS: HOMELESSNESS

During 2020, approximately **283** individuals (216 adults, 67 children) have been housed in Brown County homeless/housing shelters and facilities.

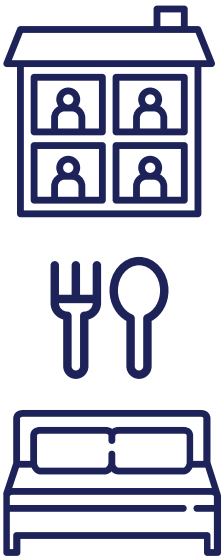
An additional **271** households are on a waiting list.

BROWN COUNTY HOMELESS & HOUSING COALITION

bchhcwi.org
bchomelesscoalition@gmail.com

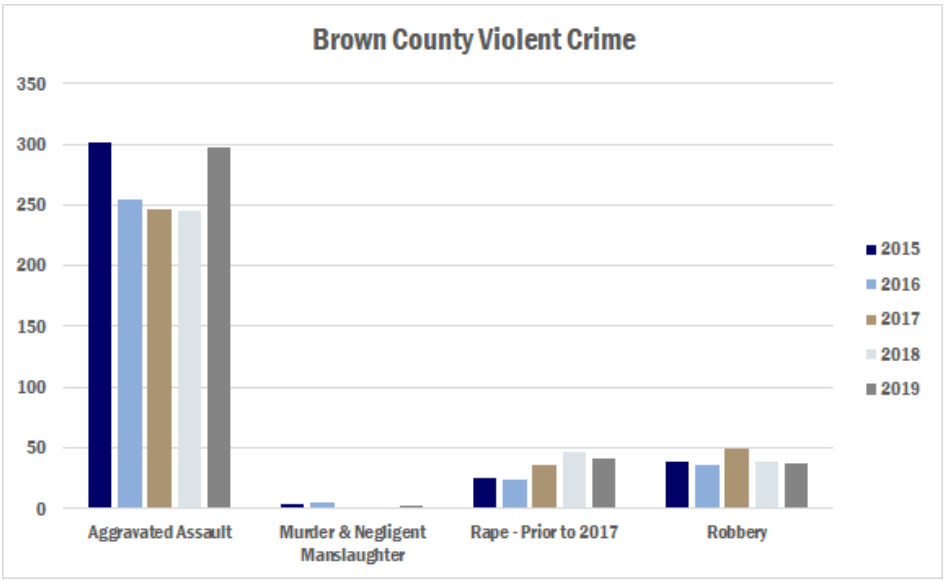
CRISIS CENTER: 24 HOURS
Phone: 436-8888
Walk-in: 300 Crooks St.

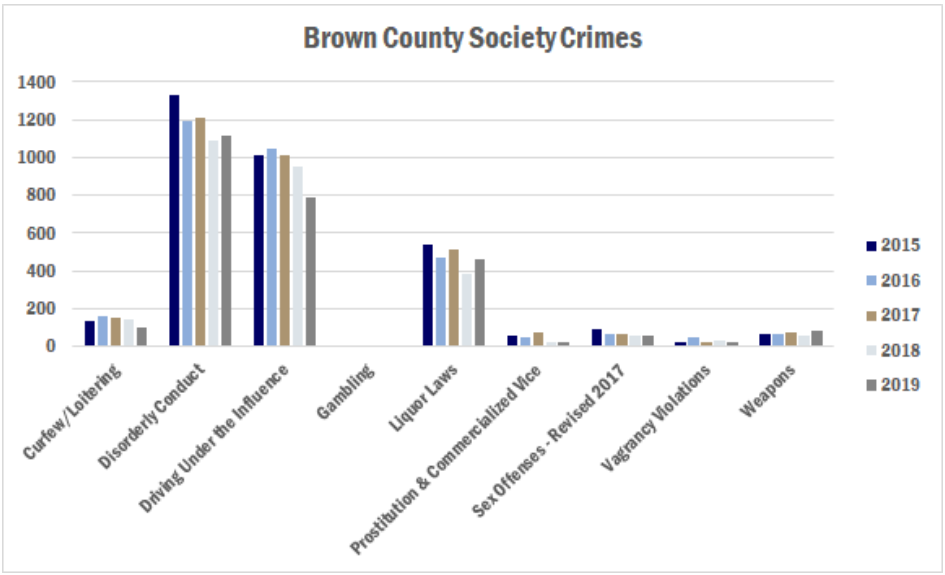
Non-Emergency Information:
Phone: 2-1-1
Text: Txt211 (898211)



Source: Local Brown County Data from 1/1/20-11/16/20 from Housing and Homeless Coalition.

SOCIAL AND ECONOMIC FACTORS: CRIME

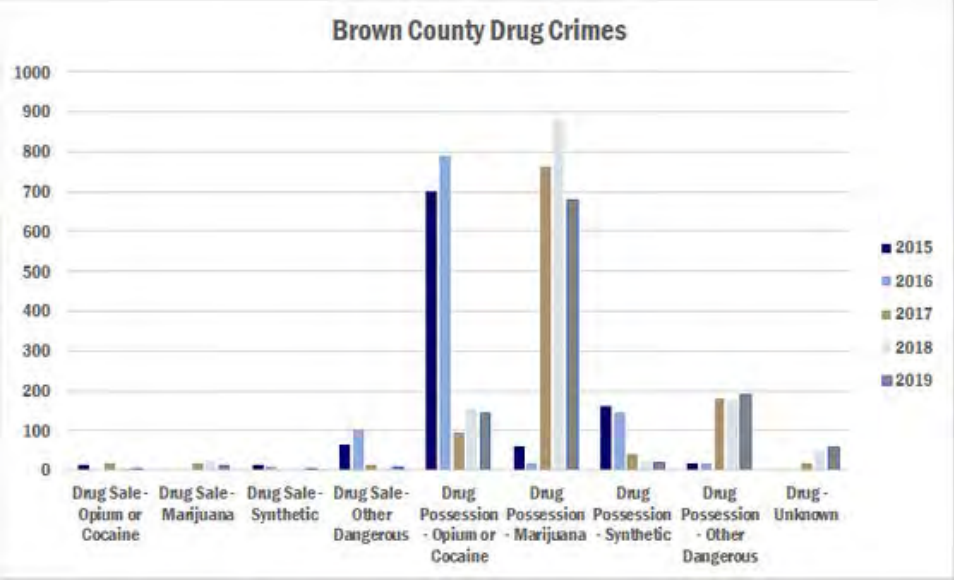


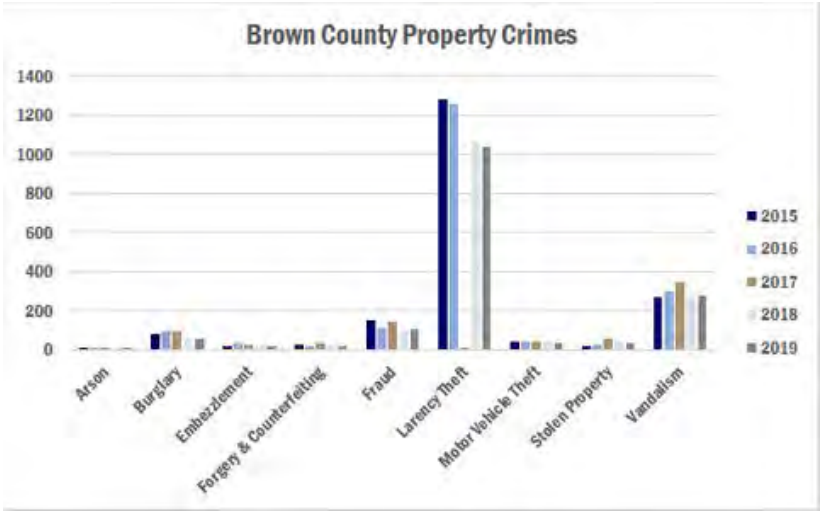


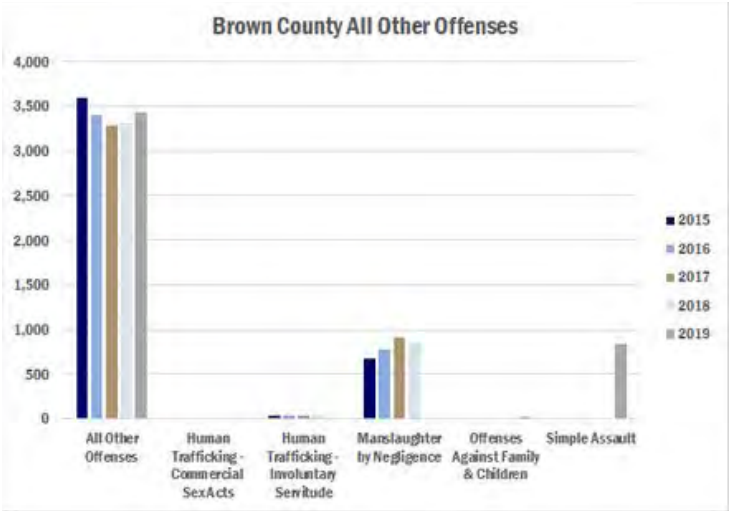
It has been shown that the stress of violence and untreated mental illness can lead to poor physical health, exacerbate chronic illness, and contribute to an increase in unhealthy choices and behaviors among adolescents and adults.

Sources:
The Power of Prevention: Chronic Disease, the Public Health Challenge of the 21st Century, CDC (2009), cdc.gov/chronicdisease/pdf/2009-power-of-prevention.pdf.
Green Bay Crime Reports 2018-2019. greenbaycrimereports.com/2020/06/brown-county-crime-statistics-2018-2019.html
*Rape and Sex Offense language was revised in 2017.
Source: *ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/topic-pages/rape*

SOCIAL AND ECONOMIC FACTORS: CRIME





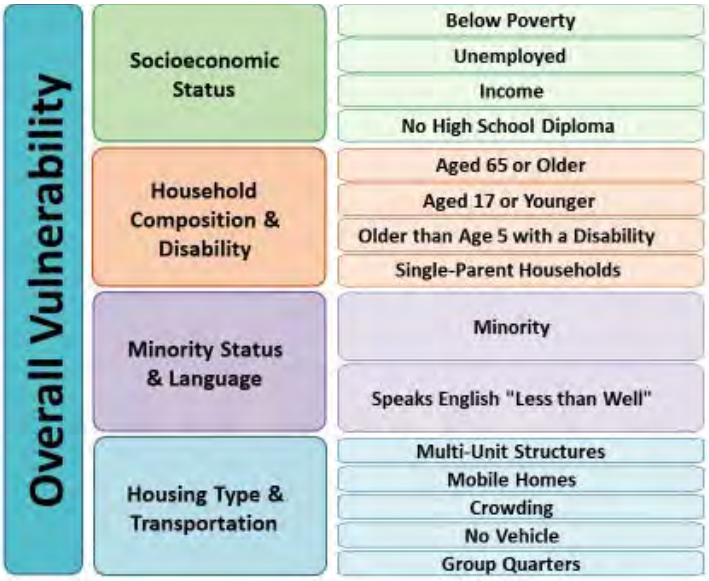


Source: https://www.greenbaycrimereports.com/2020/06/brown-county-crime-statistics-2018-2019.html

SOCIAL AND ECONOMIC FACTORS: VULNERABILITY

Every community must prepare for and respond to hazardous events, whether a natural disaster like a tornado or a disease outbreak, or an anthropogenic event such as a harmful chemical spill. The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability.

Social vulnerability index (SVI) based on variables including:



0.37

Brown County's 2016 Social Vulnerability Index score

Possible scores range from 0 to 1
(0 lowest to 1 highest vulnerability)

94 Cases of Human Trafficking reported in Wisconsin in 2019

Human trafficking is a form of modern slavery that occurs in every state, including Wisconsin. The statistics below are number off cases based on the contacts through phone calls, texts, online chats, emails, and webforms received by the National Hotline The National Human Trafficking Hotline for Wisconsin.

TYPE OF TRAFFICKING:
Sex Trafficking (71)
Labor Trafficking (10)
Trafficking Type Not Specified (8)
Sex and Labor (5)

GENDER:
Female (74), Male (13), Gender Minorities (< 3)

AGE: Adult (56), Minor (28)

Sources:
Social Vulnerability: Census Tract, www.atsdr.cdc.gov/placeandhealth/svi/documentation/SVI_documentation_2018.hBrown County, www.atsdr.cdc.gov/placeandhealth/svi/documentation/SVI_documentation_2018.html.
Human Trafficking:National Human Traffficking Hotline,, 2019. www.humantraffickinghotline.org/state/wisconsin.

AGING AND VULNERABLE POPULATIONS

Adult Protective Services investigates forms of abuse; this includes physical abuse, financial abuse, neglect by caregivers, emotional abuse and sexual abuse. The team provides linkage to community services, in addition to working with hospitals to assist when someone is in need of a guardian/decision maker. This includes providing training for guardians. These services are especially important as the population of Brown County ages.

PERCENT OF OLDER ADULTS WHO LIVE ALONE

30%

Brown County

29%

Wisconsin

AVERAGE NUMBER OF CALLS PER YEAR: 1200

SERVICES PROVIDED TO 650 FAMILIES IN BROWN COUNTY IN 2020

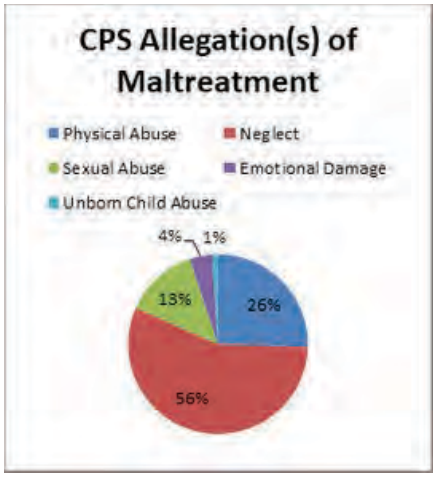
146 NUMBER OF FATAL FALLS 65+ YEARS OLD, FROM 2015-2017

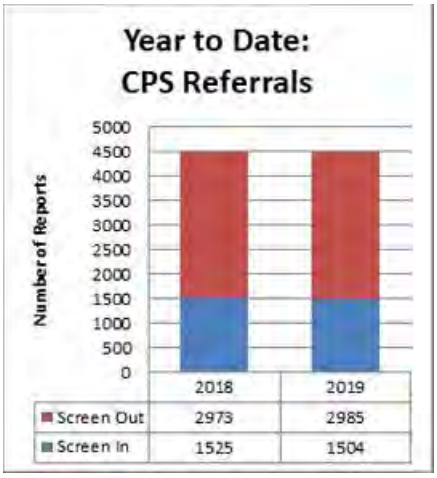
11% PERCENT OF COMMUNITY MEMBERS WITH A DISABILITY

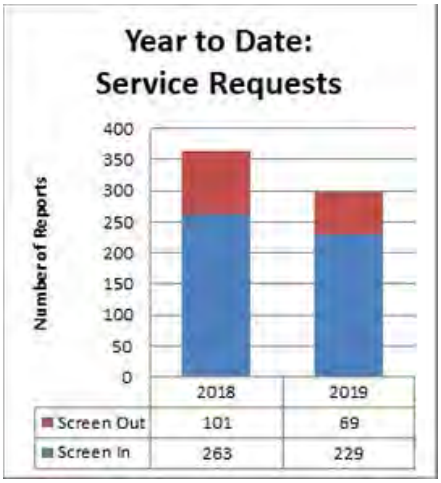
Sources:
Older Adults/Falls: countyhealthrankings.org/app/wisconsin/2020/measure/factors/120/data?sort=desc-4, 2014-2018.
Disability: data.census.gov/cedsci/table?q=S1810&g=0500000US55009&tid=ACSST5Y2019.S1810&hidePreview=true
achievebrowncounty.org/evidence-based-decision-making/community-data/brown-county-and-wisconsin-comparisons/
countyhealthrankings.org/app/wisconsin/2020/rankings/brown/county/outcomes/overall/snapshot; nces.ed.gov/

CHILD PROTECTIVE SERVICES: 2019

Throughout all of 2019, there were 4489 child neglect and abuse referrals made to the Brown County Child Protection Unit. An overwhelming majority of the concerns reported were in regard to neglect referrals, specifically parental substance use concerns. Physical abuse concerns represented 26% of the allegations of maltreatment and sexual abuse concerns represented 13% of the allegations of maltreatment.

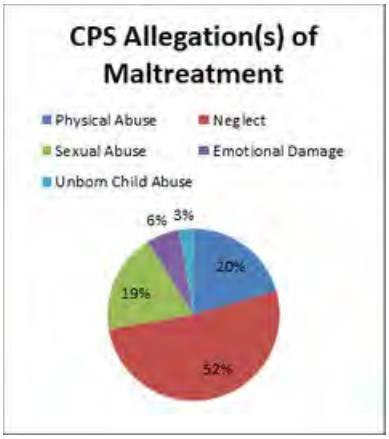


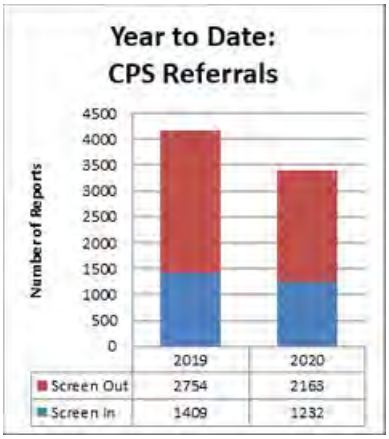


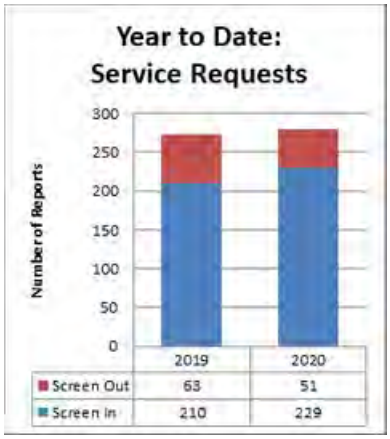


CHILD PROTECTIVE SERVICES: 2020

Brown County has recognized a concern over time with parental substance abuse and in the month of November over 1/3 of cases assigned were emergency/same day response cases with a significant number of individuals involved in drug use and sales. In April of this year, Family Recovery Court began in Judge Walsh's court room. There are currently 4 active participants in Family Recovery Court. These individuals receive extra support and intensive case management to assist with accountability. The Family Recovery Court Team, comprised of community partners, meets on a weekly basis.







Source: Brown County Health & Human Services, Child Protective Services Program Data, 2019-2020.

HEALTH BEHAVIORS

Health behaviors are actions individuals take that affect their health. They include actions that lead to improved health, such as eating well and being physically active, and actions that increase one's risk of disease, such as smoking, excessive alcohol intake, and risky sexual behavior.

Brown County has engaged in a coordinated community response to address a number of these factors, in the form of Community Health Improvement Plan Taskforces. The three taskforces currently focus on the following health behaviors:

NUTRITION AND PHYSICAL ACTIVITY

MENTAL HEALTH

ALCOHOL AND DRUG USE/ABUSE

Source: www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-outcomes

ALCOHOL CONSUMPTION

The reported incidence of binge drinking is significantly higher in Brown County than the United States overall.

The CDC reports that binge drinking is associated with many negative health outcomes including unintentional injuries, violence, sexually transmitted diseases, unintended pregnancy and fetal alochol disorders, and others.

The percent of adults who drink more than 4 or 5 alcoholic drinks in one day at least once per month; or the percent of adults who drink more than one or two drinks per day on average is:

27% in Brown County
24% in Wisconsin
17% in USA

*In a 2018-2019 survey of Wisconsin high school students, **24%** percent of 10th graders in Brown County had used alcohol in the past 30 days.*

*Additionally, **8%** of Brown County 10th graders had engaged in binge drinking.*

HEALTH BEHAVIORS:

SMOKING, VAPING, AND DRUG USE

ADULTS

15%

of Brown County adults are current smokers, as compared to 16% in WI and nationwide.

9%

of Brown County mothers report smoking during pregnancy, as compared to 7% nationally and 11% in WI

YOUTH RISK BEHAVIORS

4%

of Brown County 10th graders reported using painkillers to get high.

11%

of Brown County 10th graders reported using marijuana in the previous 30 days.

21%

of Brown County 10th graders reported ever using mariuana.

6%

of Brown County 10th graders reported smoking cigarettes in the previous 30 days.

14%

of Brown County 10th graders reported vaping in the previous 30 days.

4%

of all Brown County 10th graders reported using an illegal drug besides marijuana in the previous 12 months.

Sources:
Youth Data: YRBS Data 2018-2019,
County Data: County Health Rankings,
Adult Data: BRFSS Data, 2019
Maternal Health Data: PRAMS Survey
Binge Drinking: CDC

HEALTH BEHAVIORS:

NUTRITION AND PHYSICAL ACTIVITY

Nutrition

Adults

Local data does not exist for adult nutrition. This has been identified as an area for future research.

61%

of Wisconsin adults who report eating fruits at least 1 time per day
60% USA

77%

of Wisconsin adults who report eating vegetables at least 1 time per day
79.6% USA

Children

44%

of Brown County 10th graders reported eating fruit every day compared to the State average of 42.8%

41%

of Brown County 10th graders reported eating vegetables every day over the past 7 days compared to the WI State average of 37.8%

Physical Activity

20%

of adults age 20 and over reported no leisure-time physical activity, compared to 21% in the State of Wisconsin

56%

of 10th graders who exercise most days (4-7 in the past week) 58% in the State of Wisconsin

Sources:
Youth data: RBS Data 2018-2019,
Adult data: BRFSS Data 2019

HEALTH BEHAVIORS:

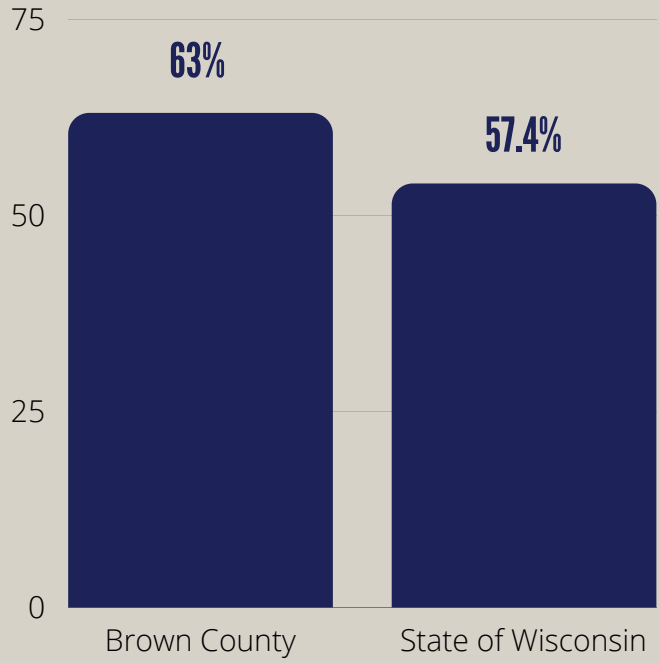
OTHER RISK BEHAVIORS

Birth rate per 1,000 female population ages 15-19:

19 Brown County
17 Wisconsin

SEXUAL ACTIVITY

Among sexually active students, the percent who used a condom during last sexual intercourse.



DRIVING AND VEHICLE SAFETY

Percent of students who texted or emailed while driving in the past 30 days:

45% Brown County
48% Wisconsin

Percent of 10th graders who report most of the time or always wearing a seat-belt:

89% Brown County
84% Wisconsin

Sources:
Youth Data: YRBS Data 2018-2019,
County Data: County Health Rankings, 2019
State Data: BRFSS Data 2019

HEALTH BEHAVIORS:

BREASTFEEDING AND INFANT HEALTH

The WIC (Women, Infants and Children) Program serves the Brown County community through nutrition assistance and education. Proper nutrition and assistance with breastfeeding are associated with positive outcomes in childhood.

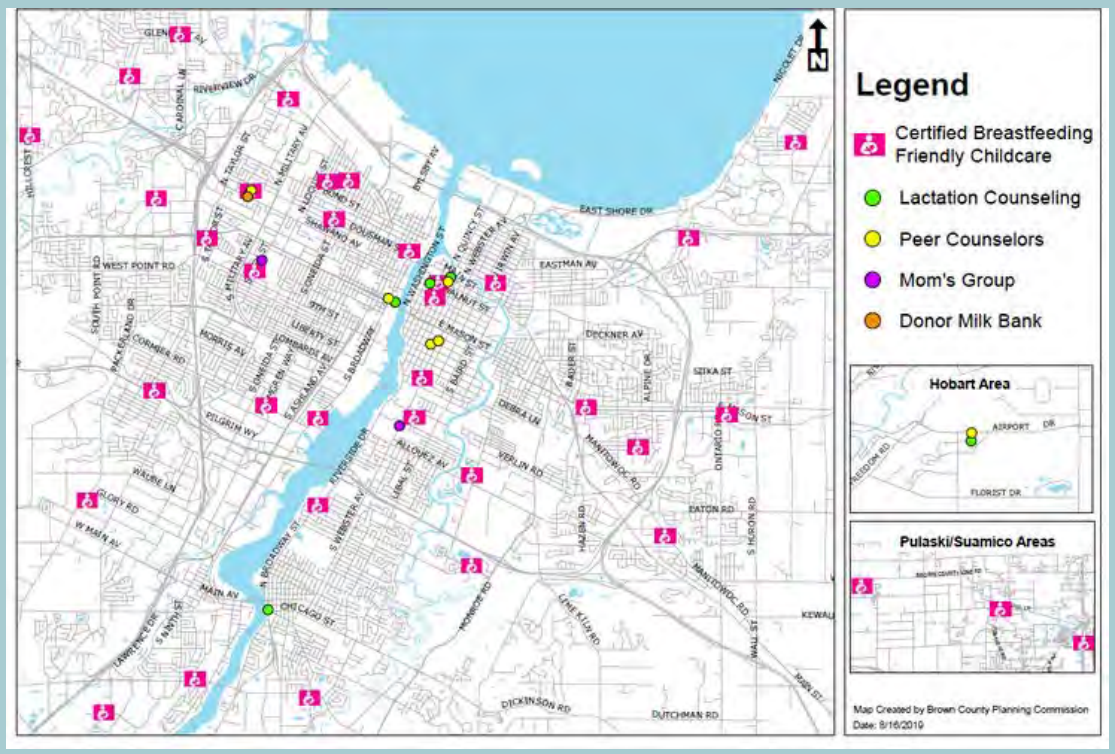
As of a September 2020 report from the Brown County WIC Program:

74% *of Brown County babies were breastfed at birth*

31% *of Brown County babies continued to be breastfed at 6 months*

71% *of Wisconsin babies were breastfed at birth*

34% *of Wisconsin babies continued to be breastfed at 6 months*



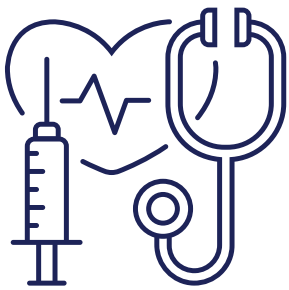
*In Brown County, **30%** of childcare centers have worksite lactation support programs. Having lactation support programs in the workplace leads to an increase in breastfeeding rates and employee retention and a reduction in healthcare costs and turnover rates.*

Sources:
WIC Data: September 2020 Agency Report
Breastfeeding Friendly Map: Brown County GIS. https://www.asphn.org/resource_files/657/657_resource_file2.pdf

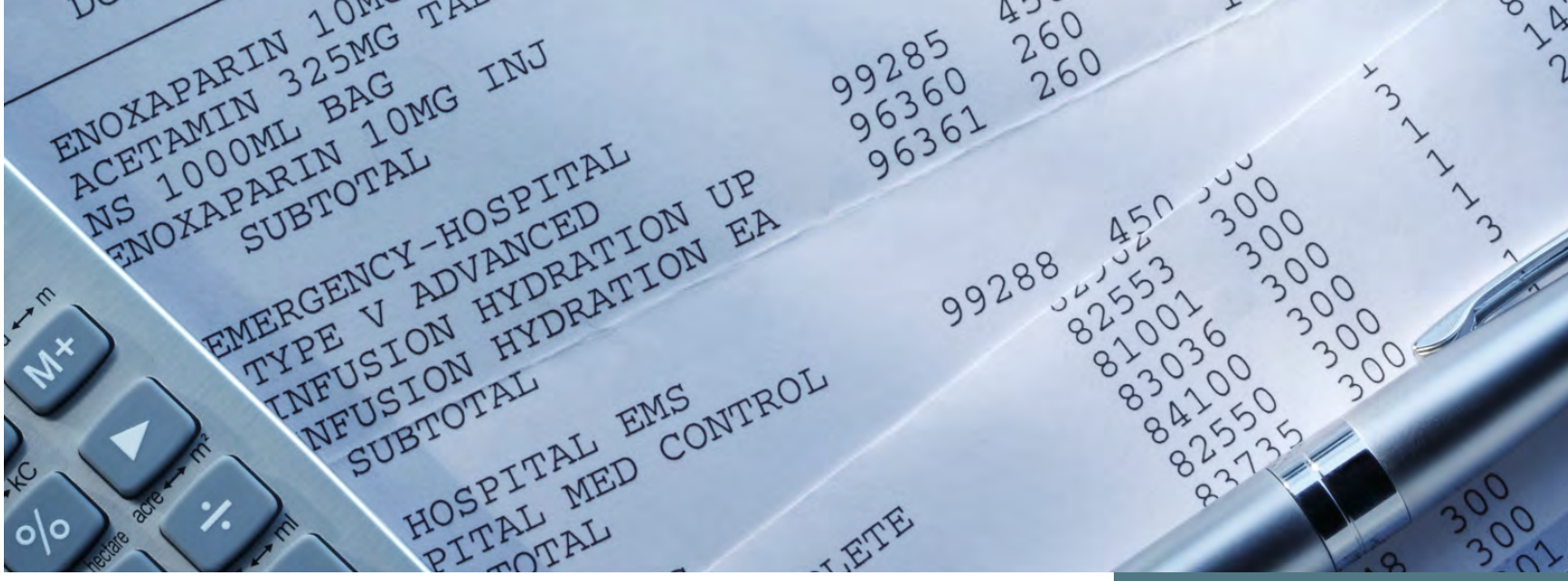
CLINICAL CARE

Access to affordable, quality, and timely health care can help prevent diseases and detect issues sooner, enabling people to live longer, healthier lives. While part of a larger context, looking at clinical care helps us understand why some communities can be healthier than others.

RATIO OF PEOPLE TO PROVIDERS	BROWN COUNTY	WISCONSIN
Primary Care Providers	1,400 to 1	1,270 to 1
Dental Care Providers	1,310 to 1	1,460 to 1
Mental Health Providers	510 to 1	490 to 1



Sources:
Intro: www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-outcomes
Provider Ratios: County Health Rankings, 2017-2019.
https://www.countyhealthrankings.org/app/wisconsin/2020/overview
Cost Barrier: Behavioral Risk Factor Surveillance Survey, 2016-2018. .https://www.dhs.wisconsin.gov/wish/brfs/index.htm



CLINICAL CARE:

HEALTH INSURANCE

5%
of children under 19 are uninsured

8%
of adults under 65 are uninsured

8% of Brown County's population under the age of 65 reported having no insurance

However, in a survey of 142 Spanish speaking community members, **45%** reported having no insurance

Type of public health insurance coverage	Percent of population covered
Public insurance alone	18%
Medicare coverage alone	7%
Medicaid or Means tested alone	11%
VA health care coverage alone	0.3%

Sources:
Percent on public health insurance: U.S. Census Bureau, 2019. data.census.gov/cedsci/table?q=Brown%20County,%20Wisconsin%20Health&tid=ACSST1Y2019.S2704&hidePreview=false.
Cost Barrier: Behavioral Risk Factor Surveillance Survey, 2016-2018. .https://www.dhs.wisconsin.gov/wish/brfs/index.htm
Adults and Children uninsured: County Health Rankings, 2020. www.countyhealthrankings.org
Spanish Speaking Uninsured: Health Navigator Community Survey. Planning Grant Needs Assessment for Spanish Health Navigator at Casa ALBA Melanie, 2020.

DID YOU KNOW?

10% of adults experienced a time in the last year where they needed to see a doctor, but couldn't because of the cost.

CLINICAL CARE:

PREVENTIVE SNAPSHOT

PREVENTIVE SERVICES

include vaccinations, screenings, check-ups, and patient counseling aimed to prevent illnesses, disease, or other health problems.

In addition to visiting a physician when an illness or injury occurs, regular check-ups allow your Provider to monitor your health. Routine tests and exams check for chronic diseases and infections such as cancer, diabetes, and heart disease and are particularly important for middle-aged and elderly patients. In addition,

Routine vaccinations are recommended. Vaccines stimulate the immune system to produce immune responses that protect against infection. Vaccines provide a safe, cost-effective and efficient means of preventing illness, disability and death from infectious diseases.

There is even evidence that screening for social risks, such as interpersonal violence, alcohol use, tobacco use, obesity, adherence to healthy behaviors, and depression are beneficial when providing interventions.

80% *of children in Brown County (compared to 72% in WI) received the recommended routine childhood immunizations (DTaP, polio, MMR, Hib, hepatitis B, varicella, & Pneumococcal) by 24 months of age in 2019 (81% in 2018) and* **47%** *of youth ages 13-18 completed the HPV series in 2019 (43% in 2018).*

84 % *of pregnant mothers in Green Bay received adequate prenatal care, compared to 78% nationally.*

54% *of Medicare enrollees received an annual flu vaccination.*

60 % *of adults aged 50-75, reported having had colonoscopy within 10 years as their most recent colorectal cancer screening test.*

51 % *of female Medicare enrollees ages 65-74 received an annual mammogram.*

67 % *of Green Bay's adults reported receiving dental care in the past 12 months.*

Sources:
Prevention Overview: National Institute of Health niaid.nih.gov/research/vaccines and
Karina W. Davidson, Alex R. Kemper." Developing Primary Care–Based Recommendations for Social Determinants of Health: Methods of the U.S. Preventive Services Task", Sept. 2020. Information doi.org/10.7326/M20-0730
Childhood Vaccines and HPV: WI EPH Data Tracker 2018-2019. dhs.wisconsin.gov/epht/data.htm.EH tracker.
Prenatal and Dental Care: City Dashboard, 2017. cityhealthdashboard.com
Mammogram/Colonoscopy/Flu Vaccine: County Health Rankings, 2017. county healthrankings.org/app/wisconsin/2020/overview

MEDICAL HOME:
A MODEL FOR QUALITY CARE

The Agency for Healthcare Research and Quality (AHRQ) describes the Medical Home Model as a way to organize the delivery of primary care and highlights 5 critical functions and attributes of the Medical Home Model:

1. Comprehensive Care:
The care delivered aims to meet the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. This involves the patient and a team of care providers.

2. Patient-Centered:
The health care provided is relationship-based with an orientation toward the whole person ("holistic care").

3. Coordinated Care:
Care is coordinated across all parts of the health care system, including specialty care, hospitals, home health care, and community services and supports.

4. Accessible Services:
Services are delivered with attention to easy access and responsive to patients' preferences.

5. Quality and Safety:
Ongoing commitment to quality and quality improvement.

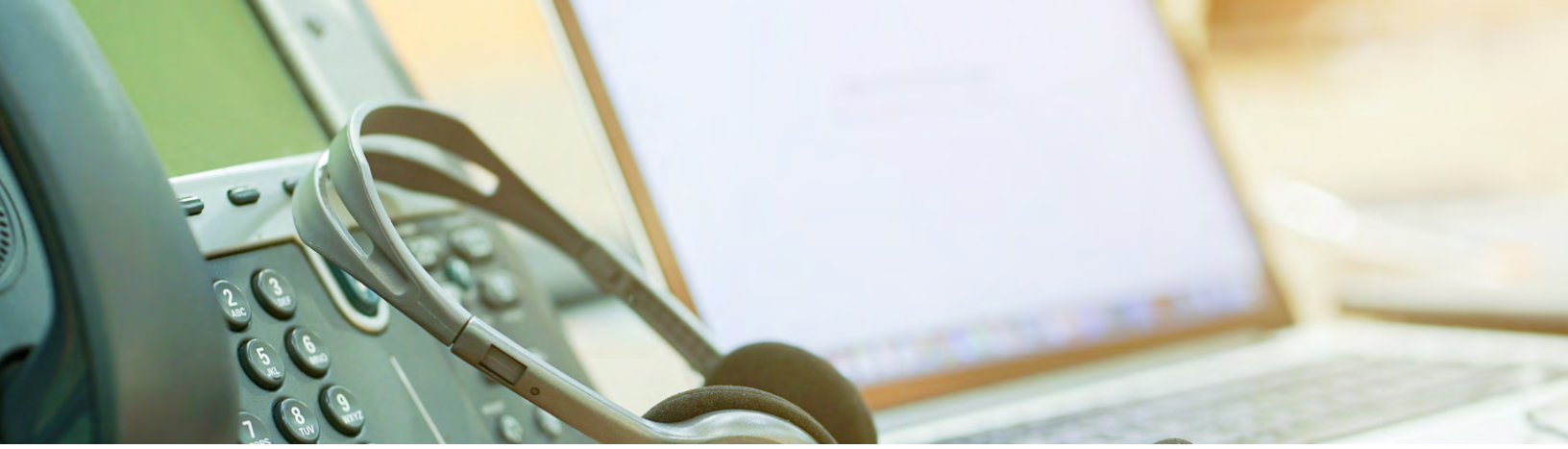
A "medical home" is a trusting partnership between you, your family, and your health care team. You and your health care team work together to access and coordinate specialty care, other health care and educational services, in and out of home care, family support, and other public or private community services that are important to the overall well-being of you and your family.

BROWN COUNTY PUBLIC HEALTH INVESTIGATES

Brown County Public Health (BCPH) surveyed 131 parents whose children received a flu shot through a BCPH community flu shot clinic. We found the ***majority of these parents thought having a medical home was "very important" but did not have a primary care doctor or any form of insurance. The parents identified financial and insurance difficulties as the top 2 obstacles to getting the medical care they and their families need.***

Public Health
Prevent. Promote. Protect.
Brown County
Health & Human Services

Sources:
Medical Home Model: dhs.wisconsin.gov/publications/p01747.pdf.
Functions/Attributes: Adapted from: https://pcmh.ahrq.gov/page/defining-pcmh.



PARTNER PROFILE:

A RESOURCE FOR NAVIGATING HEALTH CARE AND MORE

Information, community resources, and referrals on a variety of health and human service issues are available with one easy call to one of 2-1-1's trusted and caring call specialists.

Specialists are available to answer the helpline 24 hours a day, 7 days a week.

A database of local resources is maintained through a longstanding partnership between Brown County United Way, the Aging and Disability Resource Center of Brown County (ADRC), and the Crisis Center of Family Services.

2-1-1 is a statewide resource, available to everyone. There are eight 2-1-1 contact centers in Wisconsin, divided regionally.

Services are available 24 hours, every day, and all year round. Statistics on the reasons people contact 2-1-1 can be found online at 211counts.org

Brown County United Way

CALL
Dial 2-1-1 or 1-800-924-5514
TTY dial 7-1-1 Available 24/7

TEXT
Text your ZIP Code to 898211
Monday-Friday
8:00am to 5:00pm

CHAT
Chat online with 2-1-1
Monday-Friday
8:00am to 5:00pm

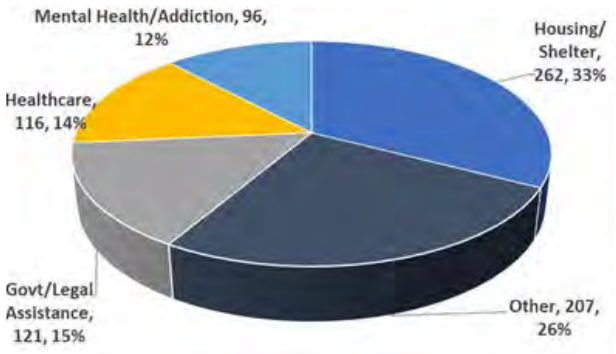
SEARCH
Search our online directory:get211.org

Available 24/7

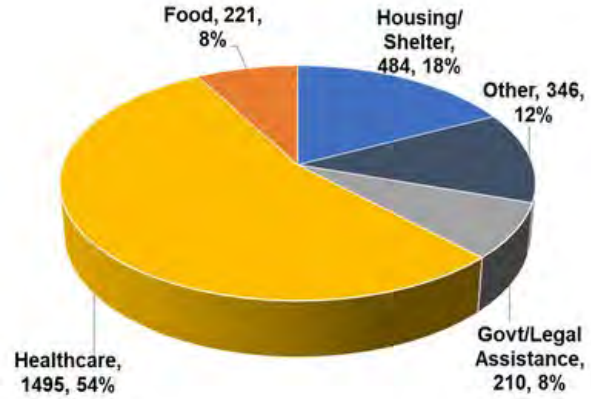
TOP COMMUNITY NEEDS AS IDENTIFIED BY 2·1·1

Get Connected. Get Help.™

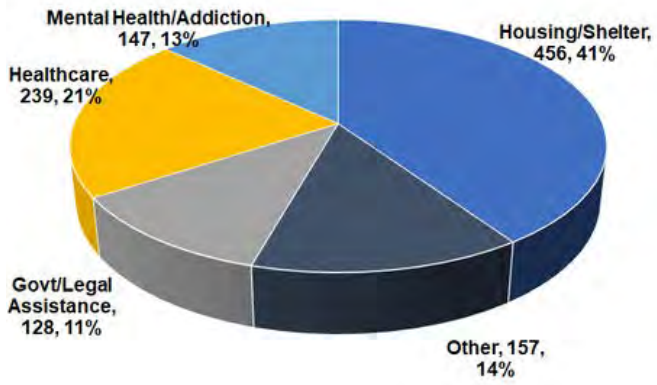
PRE-COVID (JAN-MAR 2020)



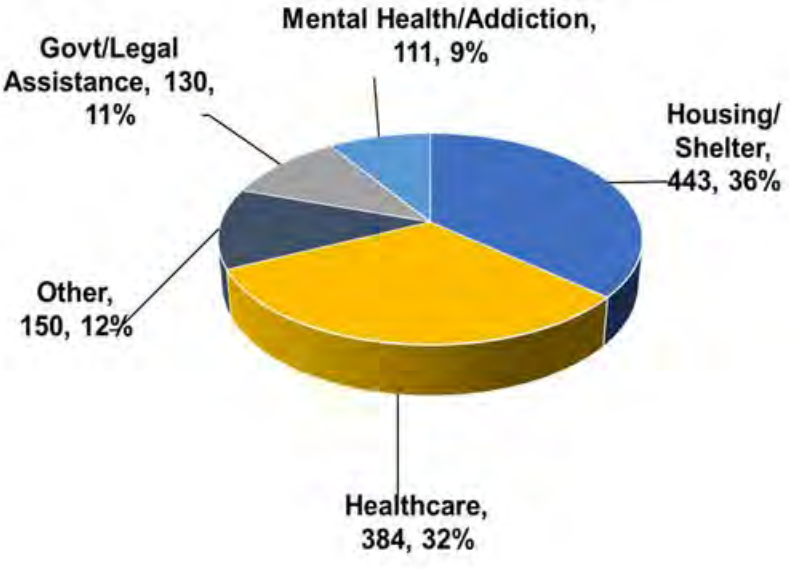
COVID 1ST WAVE (MAR-JUN 2020)



DURING COVID (JUN-AUG 2020)



DURING COVID (AUG-OCT 2020)



TOP COMMUNITY NEEDS AS IDENTIFIED BY 2-1-1

Get Connected. Get Help.™

2020 THEMES:

•1,840 Rental assistance-845 requests for Rental Assistance
and 497 for Shelters and 315 for Low-Income Housing Assistance
•2,090 COVID-19 specific testing/information requests (2,592 Healthcare total)
•1,365 total requests for Basic Needs (includes requests for Food, Utilities, Clothing/Basic Needs)
•573 Mental Health-specific

8,732 requests as of early December 2020

2019 THEMES:

•1,636 requests for Rental Assistance (646 Rental Assistance, 463 for Shelters, and 341 for Low-Income Housing Assistance)
•460 total requests for Healthcare (pre-COVID 19)
•749 requests for Utilities Assistance
•106 Disaster Requests
•403 requests for Food Assistance

6,270 requests during 2019

HEALTH OUTCOMES

Health outcomes represent how healthy a community is right now. They reflect the physical and mental well-being of residents within a community through measures representing not only the length of life but quality of life as well.

The average life expectancy at birth in Brown County is 79 years

12% of adults reported fair or poor health

There were 3,159 births in Brown County in 2019

There were 2,059 deaths in Brown County in 2019
This is a rate of 791 deaths per 100,000 individuals

Sources:
Intro: www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-outcomes
Life Expectancy: City Dashboard, 2015. www.cityhealthdashboard.com
Poor Health: County Health Rankings, 2017. https:// www.county healthrankings.org/app/wisconsin/2020/overview
Births/Deaths: Wisconsin Interactive Statistics on Health, 2018. https://wish.wisconsin.gov/results

HEALTH OUTCOMES:

CHRONIC DISEASE

68% of adults are overweight or obese

10% of adults have diabetes

36% of adults have high cholesterol

31% of adults have high blood pressure

COMMUNICABLE DISEASE NEW CASES

NAME	2017	2018	2019
Syphillis	13	34	19
Gonorrhea	195	181	245
Chlamydia	1109	1135	1110
Tuberculosis	3	0	1
Pertussis	6	14	4
HIV	3	7	10
Lyme Disease	10	41	82
Flu Hospitalizations	178	195	-
Salmonellosis	15	14	-

CANCER NEW CASES/DEATHS

TYPE	2017 CASES	2017 RATES
Trachea/Lung/Bronchus	157/119	61/46
Colorectal	91/31	36/12
Female Breast	164/27*	127/21*
Prostate	119/-	94/-
Melanoma	92/-	36/-
TOTAL	1230/455	479/177

*(*based on female deaths from breast cancer and female population)*

COVID-19 (CORONAVIRUS)*

Total Cases 25,357

Deaths 136

**as of 12/31/20*

Sources:
Chronic Disease: Behavioral Risk Factor Surveillance Survey, 2015-2019. www.dhs.wisconsin.gov/wish/brfs/index.htm
Communicable Disease: Wisconsin Public Health Profile, 2017. www.dhs.wisconsin.gov/publications/p4/p45358-2017-brown.pdf, www.dhs.wisconsin.gov/library/p-00415b-brown.htm, www.dhs.wisconsin.gov/tb/data.htm, www.dhs.wisconsin.gov/hiv/data.htm, www.dhs.wisconsin.gov/immunization/vpd.htm
dhsgis.wi.gov/DHS/EPHTracker,
Chlamydia: PHAVR Report for Brown County, 2019.
Cancers: www.dhs.wisconsin.gov/publications/p4/p45358-2017-brown.pdf
COVID: WEDSS Reports, Brown County 2021

HEALTH OUTCOMES:
INJURIES

NUMBER OF INJURY-RELATED HOSPITALIZATIONS BY AGE IN 2019

0-17	63
18-44	205
45-64	259
65+	512
TOTAL	1039

NUMBER OF INJURY-RELATED DEATHS BY AGE IN 2019

0-17	10
18-44	54
45-64	46
65+	96
TOTAL	206

2019: NUMBER OF INJURY-RELATED FATALITIES

- **6** Assault-Related/Homicide
- **5** Drowning-Related
- **23** Firearm-Related
  (Self-Inflicted firearm: 18/23)
- **20** Suffocation
- **42** *Poisoning
  (2018: 27)
  (Drug-related poisoning: 40/42 and 2018: 25/27)
- **40** *Suicide
  (2018: 28)
- **14** *Unintentional Motor Vehicle Injury
  (2018: 21)
  **Note the change from 2018 to 2019*

Source:
Wisconsin Interactive Statistics on Health, 2019. https://wish.wisconsin.gov/results/.

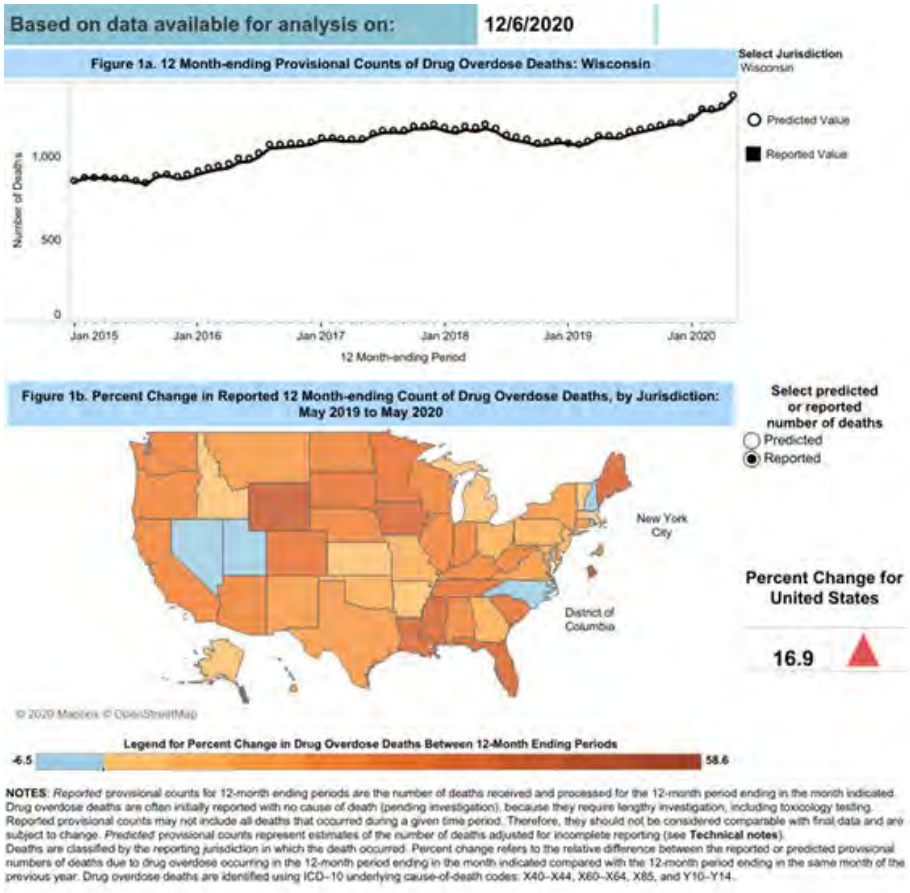
HEALTH OUTCOMES:

DRUG OVERDOSE DEATHS

The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) report that approximately 81,230 drug overdose deaths occurred in the United States in the 12 months prior to May 2020.

This represents a worsening of the drug overdose epidemic in the U.S. and is the largest number of drug overdoses for a 12-month period ever recorded. The increase in drug overdose deaths appear to have accelerated during the COVID-19 pandemic.

12 Month-ending Provisional Number of Drug Overdose Deaths



NOTES: *Reported* provisional counts for 12-month ending periods are the number of deaths received and processed for the 12-month period ending in the month indicated. Drug overdose deaths are often initially reported with no cause of death (pending investigation), because they require lengthy investigation, including toxicology testing. Reported provisional counts may not include all deaths that occurred during a given time period. Therefore, they should not be considered comparable with final data and are subject to change. *Predicted* provisional counts represent estimates of the number of deaths adjusted for incomplete reporting (see **Technical notes**). Deaths are classified by the reporting jurisdiction in which the death occurred. Percent change refers to the relative difference between the reported or predicted provisional numbers of deaths due to drug overdose occurring in the 12-month period ending in the month indicated compared with the 12-month period ending in the same month of the previous year. Drug overdose deaths are identified using ICD-10 underlying cause-of-death codes: X40–X44, X60–X64, X85, and Y10–Y14.

18 Opioid Overdose Deaths in Brown County in 2018

Synthetic opioids *are the primary driver of the increases in overdose deaths. The 12-month count of synthetic opioid deaths increased 38% from the 12-months ending in June 2019 compared with the 12-months ending in May 2020. These newly released preliminary fatal overdose data, coupled with the known disruption to public health, healthcare, and social services as a result of the COVID-19 pandemic and related mitigation measures, highlight the need for essential services to remain accessible for those most at risk of overdose and the need to expand prevention and response activities.*

Sources:
Number of Drug Overdose Deaths Chart: cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
Overdose Deaths: emergency.cdc.gov/han/2020/han00438.asp
2018 Opioid Overdose Deaths in Brown County: Wisconsin Interactive Statistics on Health, 2018. wish.wisconsin.gov/results
Synthetic Opioids Data: emergency.cdc.gov/han/2020/han00438.asp

HEALTH OUTCOMES:

MENTAL HEALTH AND WELL-BEING

11% of adults in Brown County reported 14 or more days of poor mental health each month

1365 hospitalizations related to mental illness in Brown County

40 deaths by suicide in Brown County

According to WI Department of Health Services:

PEOPLE WHO ARE DEPRESSED ARE:

2X *more likely to smoke and be physically inactive than those without depression*

3X *less likely to comply with their medical treatment plan*

4X *more likely to have cardiovascular disease*

Sources:
Adult Data: County Health Rankings, 2017 and 2018. county healthrankings.org/app/wisconsin/2020/overview
Hospitalization Data: WI Public Health Profiles 2017, dhs. wisconsin.gov/publications/p4/p45358-2017-brown.pdf
Death Data: Wisconsin Interactive Statistics on Health, 2019. wish.wisconsin.gov/results

HEALTH OUTCOMES:
SCHOOL-BASED MENTAL HEALTH

The School Based Mental Health (SBMH) Collaborative, an initiative of Connections for Mental Wellness formed in 2016, aligns & coordinates school districts and mental health providers systems of care in order to provide Brown County youth, that face barriers to traditional mental health care, the clinical care access to mental health services in their schools.

The SBMH collaborative consists of partners from 8 Brown County public school districts:

Ashwaubenon
Green Bay
Howard-Suamico
Denmark
West DePere
Unified District of DePere
Wrightstown
Pulaski

Six mental health agencies together have served 436 youth since the 2016 inception. Even amid the pandemic within the 2019/2020 school year, the collaborative partners served 177 youth who identified as 'new to SBMH care' within 21 school based mental health sites in Brown County via telehealth or in-person therapy. The providers who are engaged in this important community collaboration include:

Bellin Health
Family Services of NEW
Catholic Charities
Prevea Health
Foundations Health & Wholeness
Innovative Counseling

Connections for mental wellness

Wisconsin 10th graders answered a survey reporting on a year in their lives:

15% reported seriously considering suicide

14% reported making a suicide attempt

9% reported attempting suicide

31% reported feeling so sad or hopeless that they stopped their usual activities

52% reported problems with anxiety

Source:
Youth Data: Youth Behavioral risk survey, 2019. dpi.wi.gov/sites/default/files/imce/sspw/pdf/WI_2019_YRBS_ Comparison_ Tables.pdf

HEALTH OUTCOMES:
MENTAL HEALTH AND SUICIDE

In 2019 The Family Services Crisis Center served 5,464 callers and 3,856 people in person who reported thoughts about/suicide attempts, 1993 callers with suicide attempts in progress, and 558 who expressed threats of suicide with plans.

That's over 4 people per day just in Brown County

According to The Family Services Crisis Center in Green Bay, approximately:

455 *Brown County residents who were experiencing suicidal thoughts or considering specific suicide plans called the Crisis Center each month.*

↑ **26% increase over the last 4 years**

321 *Brown County residents who were experiencing suicidal thoughts or considering suicide plans meet with a crisis counselor in person for a suicide assessment and plan for their safety each month.*

↑ **22% increase over the last 4 years**

MOST FREQUENT TOPICS/ISSUES IN 2019

Suicide	*Depression*
Mental Illness	*Relationship Issues*
Anxiety	*Behavioral Issues*
Homelessness	*Drug Abuse*
Alcohol Abuse	*Medical/Physical Health*

2020: THE PANDEMIC

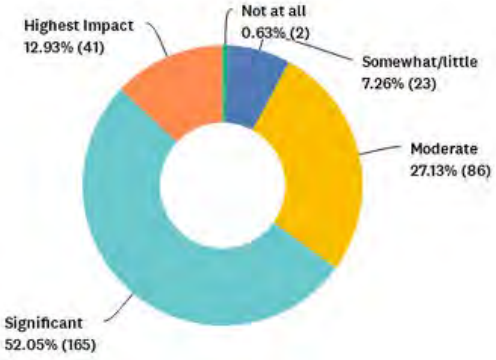
COVID-19

Brown County United Way conducted community surveys in 2020 to assess the impact of COVID-19 in Brown County. With a total of 347 responses in the first round, and 317 in the second, this information serves as a snapshot into survey respondents' perceptions from the 2nd round of surveys. And while it may not be generalizable to the full community, it serves as a beginning to understanding the extreme impacts that the pandemic has had on our lives.

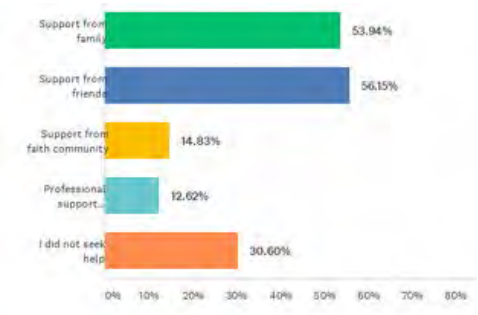
EMERGING THEMES:

- *Whole world impacted - truly an unprecedented event*
- *"Non-essential" workers and job insecurity concerns*
- *Families with school-aged children impacted greatly*
- *Seniors impacted: increased isolation, more likely to be ALICE households*
- *Groups disproportionately below the ALICE threshold are more vulnerable to COVID impacts - by race/ethnicity, age, household type, and more*

HOW SIGNIFICANTLY HAS THE PANDEMIC IMPACTED YOUR LIFE?



SYSTEMS OF SUPPORT/RESOURCES ACCESSED FOR EMOTIONAL WELL-BEING SINCE PANDEMIC STARTED*



Select all that may apply, 317 respondents

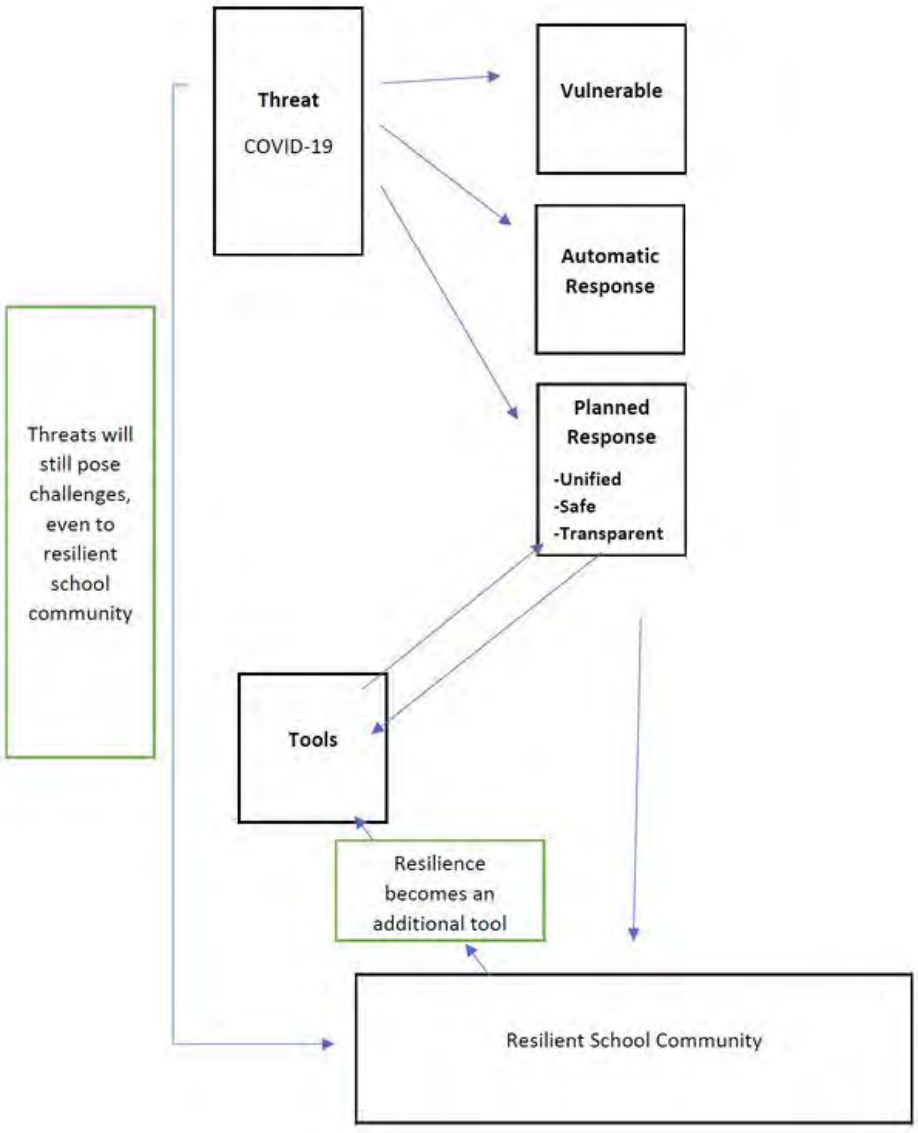
PANDEMIC IMPACTS ON FAMILY WELL-BEING

ANSWER CHOICES	RESPONSES	
Could not find childcare	9.46%	30
Felt like I couldn't leave the house/apartment	65.93%	209
Felt hopeless	31.55%	100
There was not enough food	4.10%	13
Had to provide care to an elder	11.36%	36
Other (please specify)	35.33%	112
Total Respondents: 317		

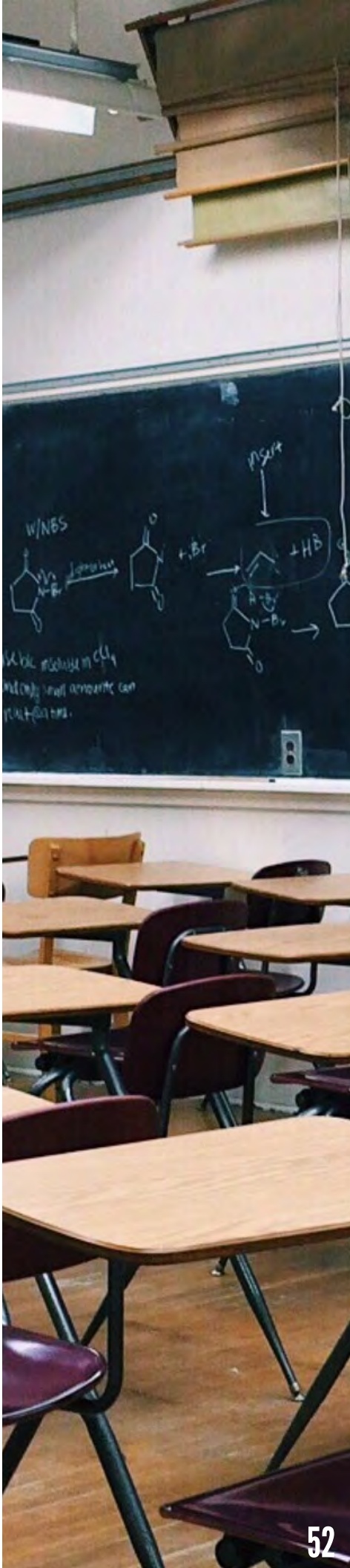
COVID-19 AND OUR SCHOOLS:

The COVID-19 epidemic has been a threat to our entire community and also our schools. It has exaggerated vulnerabilities, especially within certain populations.

A school-based focus group discussion was organized by the Howard Suamico School District and it was ***found that parents wanted a consistent plan among all the schools and communication about the plans to be frequent and clear****.*

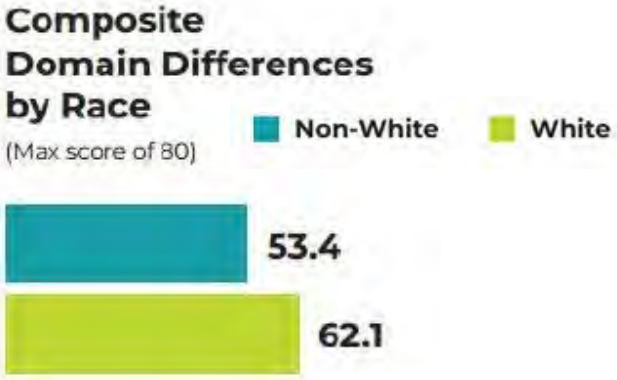


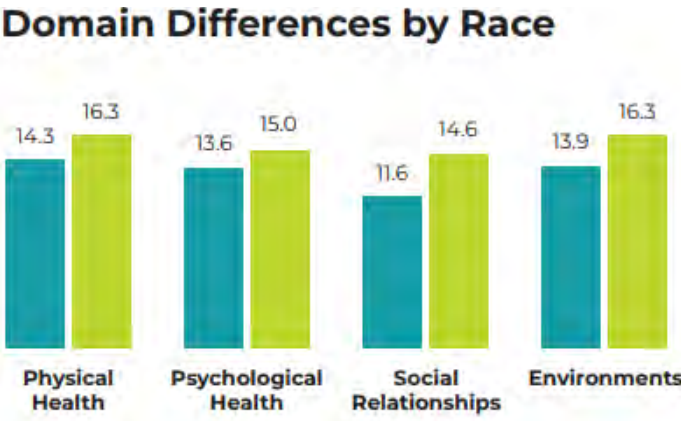
In order to reopen and carry out the school year the goal should be to create and carry out a thoughtful plan using existing and newly crafted tools that results in a resilient school and community.



WELL-BEING PROFILE:

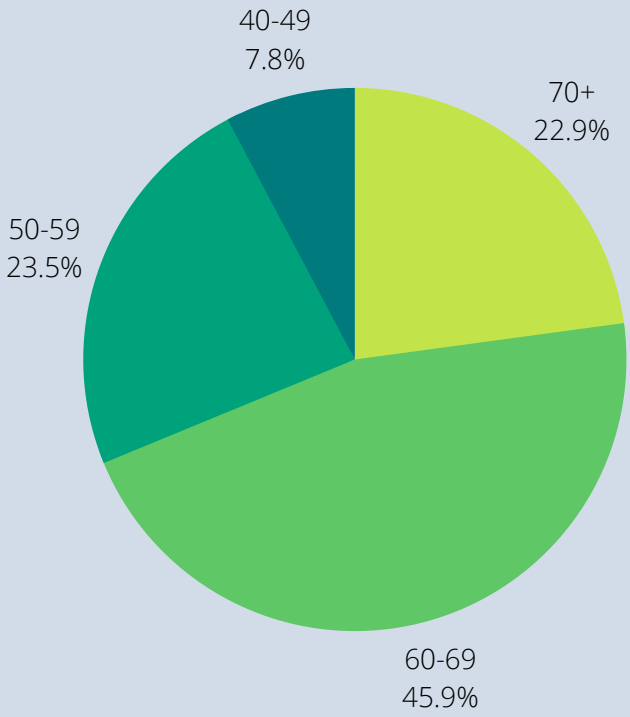
wello



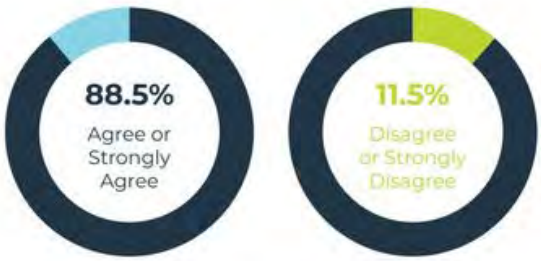


Results showed length of residence is not as important as feeling connected. Developing a sense of belonging and an inclusive community are especially important to one's well-being.

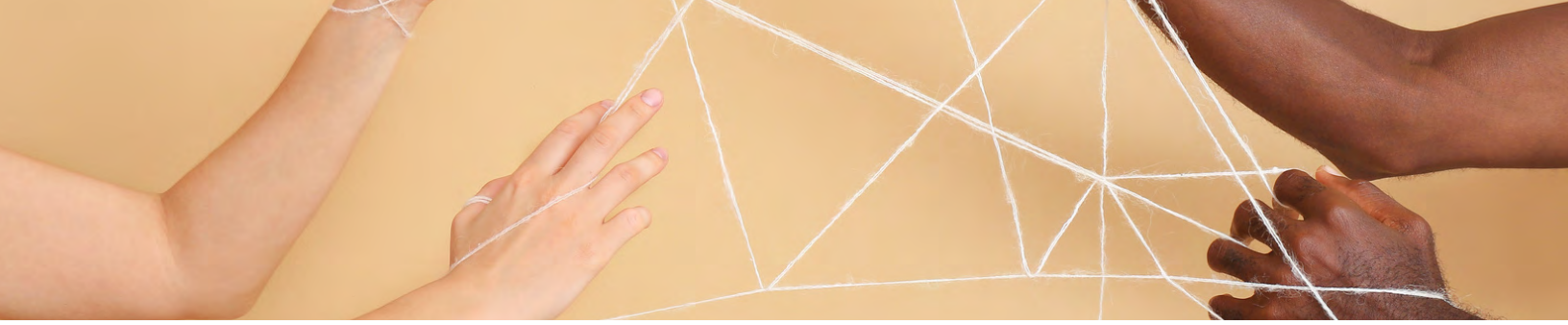
A well-being score of 70 + equals "good" well-being



Do you see yourself as a member of the Greater Green Bay community?



Source: Wello. (2020). Community Health and Well-Being Survey: Brown County, Wisconsin, 2019 Survey Results. Retrieved from www.wello.org/measure.



RACISM AND ITS IMPACTS ON HEALTH: A COLLABORATIVE COMMUNITY STUDY

In June of 2020, Brown County Public Health and the YWCA of Greater Green Bay partnered to carry out a qualitative study aimed at exploring the impact of race on health and well-being in our community.

Twenty-two adults participated in five different focus group discussions that were held with community members of color from the Somali, Hmong, African-American, Native American, and Hispanic/Latinx Communities in Brown County.

For the participants, ongoing racism negatively impacts their experiences with health structures and systems and their access to them

The negative impacts of racism on **relationships, roles, spaces and resources** influence health and well-being, and create and perpetuate health inequities for people of color.

RELATIONSHIPS, ROLES, AND SPACES

"My son has long dreadlocks and they told him that he needed to take a drug test before they prescribed the medication he was on before."

"The gynecologist of color was much more familiar with my situation, referring to scientific reasons for my pain."

"It is just the looks we get from being brown skinned in Green Bay."

"Their faces change if you sounded white on the phone or if you brought in your insurance card, it's all those little microaggressions."

"Once you have a physician that you have a relationship with, it's good but to find a physician and get that is in my opinion over and above what a white person would have to do to get healthcare."

"Sometimes I'm the only person that is not white"

"I remember what our brothers and sisters have gone through. I am not anti-vaccine, but it's the racism that has been attached to that. Now, it feels like it is being forced on us because we're in a pandemic."

"I feel like I have to prioritize what I share with the doctors, just to prove that I'm being reasonable with my symptoms or concerns."

"When you're Hmong you only go to the doctor when you absolutely need to vs. annual well-care."

"Those who are oldest tend to be the second parent because we know English, have an education, and we know how to navigate the system, so our parents rely on us."

Bring in more multi-cultural doctors... this will build our trust. Any person of color would respond better to a person of their race."

RESOURCES

""My mom and I couldn't go to the doctor, it was a scary time before getting on insurance... I got to the point where I was rationing how often I used my inhaler. It affected both my physical and mental health."

"I had two jobs in order to get healthcare."

"We didn't tell our parents we were injured because we knew they couldn't afford care."

"Even when she (mom) spoke the language, they would discount her experience and I often have to fight doctors who wouldn't believe what she was saying."

"Insurance helps, but there are certain things that cost so much, and it just piles up."

"There's too much deficit orientation when talking about Latinos and we need to flip the script and be more positive and tell the stories about positive aspects."

"There is mistrust with the system because how we've been treated in the past."

"Knowing that it is an issue (diabetes) and knowing the treatment my people have historically faced and there's a correlation to why we have these health issues today."

"Anxiety comes from being a minority in a Westernized system or being in a place where you are the only minority. That is where a lot of that anxiety comes from that a lot of us walk around with on a daily basis."

"I think universal healthcare could stop so many obstacles."

"I am hopeful that everyone will get their fair chance to get the vaccine."

"We want the same medical care as the white people do."

Project funded by the Greater Green Bay Community Foundation Basic Needs Giving Partnership Fund

BROWN COUNTY:

FOCUSED ON HEALTH EQUITY FOR ALL IN OUR COMMUNITY

This summary document has highlighted a number of areas for further exploration, specifically raising the question: does belonging to a certain group lead to differences in health outcomes? In certain cases, that answer is yes. We know that conditions in which we live and work impact our health, but even more importantly, those conditions affect certain groups more than others.

Two terms are often used interchangeably: equality and equity. Equality provides support equally across populations. Equity recognizes that not everyone is starting from the same place, and encourages decision-making and resource allocation that keeps those differences in mind. A targeted approach to community-wide interventions is necessary when resources are limited, and the Community Health Improvement Planning Process integrates the findings from this document into prioritization of strategic issues moving forward.

EQUALITY SOUNDS FAIR. EQUITY IS FAIR.

FROM ASSESSMENT TO COMMUNITY IMPROVEMENT PLANNING

The CHA was carried out using a health equity lens and is aligned with the Center for Disease Control and Prevention (CDC) social determinants (SDOH) of health. The information and data relevant to the health in Brown County were presented under the following headings:

Physical Environment | **Social and Economic Factors** | **Health Behaviors** | **Clinical Care** | **Health Outcomes**

Social determinants of health are the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. They can be organized into five ***key areas*** *with* ***key issues*** *representing these social determinants:*

ECONOMIC STABILITY

Employment
Food Insecurity
Housing Instability
Poverty

SOCIAL AND COMMUNITY CONTEXT

Civic Participation
Discrimination
Incarceration
Social Cohesion

HEALTH AND HEALTHCARE

Access to Health Care
Access to Primary Care
Health Literacy

NEIGHBORHOOD AND BUILT ENVIRONMENT

Access to Foods that Support Healthy Eating Patterns
Crime and Violence
Environmental Conditions
Quality of Housing

EDUCATION

Early Childhood Education and Development
Enrollment in Higher Education
High School Graduation
Language and Literacy

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

FROM ASSESSMENT TO COMMUNITY IMPROVEMENT PLANNING

NEXT STEPS:

The findings, quantitative and qualitative combined, were reviewed by Beyond Health, and several meetings were held to discuss what additional information and data related to key issues should be added to the Community Health Assessment.

The Public Health Team continued to develop the assessment to address gaps identified by the Steering Committee and held an internal working meeting to assess and identify key issues in the different areas representing the various determinants of health in Brown County.

KEY QUALITATIVE/QUANTITATIVE FINDINGS IDENTIFIED*

- ✓ Increased unemployment during COVID-19 pandemic
- ✓ Homelessness
- ✓ Low number of people participating in organizations (civic engagement)
- ✓ Racism and its impact on health experiences
- ✓ Lack of resources, power, and social connectedness
- ✓ Lack of participation in public transportation
- ✓ Inadequate or missing internet access
- ✓ Alcohol consumption
- ✓ Barriers in access to health care
- ✓ Costly, confusing, and not always culturally appropriate health care
- ✓ Lack of walkable communities
- ✓ Rates of obesity

**this list is a sampling of findings, and is not meant to be fully comprehensive*

FROM ASSESSMENT TO COMMUNITY IMPROVEMENT PLANNING

IDENTIFYING ROOT CAUSES

In order to keep thinking about the problems from a health equity perspective and aim to address the social determinants of health, the internal team held a working meeting to engage in an exercise around identifying the underlying causes of problems. We conducted a "5 Whys" group exercise for several issues in order to better understand the root cause of issues affecting Brown County. The purpose of this was to prepare for planning interventions that will do more than focus on individual health outcomes, but instead will improve health disparities and overall population health.

AN EXAMPLE:

Why is there a difference between the percent of the population with access to public transportation in Brown County compared to Wisconsin?
(See page 12)

PERCENT OF POPULATION WITH ACCESS TO PUBLIC TRANSPORTATION

Brown County	Wisconsin
29%	54%

?

ASKING THE 5 WHYS:

An exercise to explore potential root causes for issues identified from the data collected and reported in the Community Health Assessment

Other key issues were also further examined during the strategic meeting in which the Public Health team worked towards exposing potential root causes of the issues. The team engaged in "5 whys" exercises and although there was overlap and more steps were necessary than 5, this illustration summarizes the process:

IDENTIFIED AREA OF CONCERN

Why do only 29% of the Brown County population have access to public transportation?

WHY?

Lack of Metro choices/ routes

WHY?

Lack of investment in infrastructure and promotion

WHY?

There is not a Regional Transportation Authority advocating for equity across the region

WHY?

The population that relies on public transportation do not have a strong voice in economic and political development

WHY?

Discriminate Access

CONTRIBUTING ROOT CAUSE

FROM ASSESSMENT TO COMMUNITY IMPROVEMENT PLANNING

NEXT STEPS IN THE PROCESS

Considering the root causes of the key issues and how they overlap and intersect, the Public Health then team drafted a sample of strategic issues (improving social connectedness, promoting community cohesion, and empowering community voices) and presented them to the Beyond Health Steering Committee for feedback and to begin brainstorming how the agencies and community organizations can organize and implement interventions on this level.

After initial buy-in from the Steering Committee, the Public Health strategists met again to discuss the feedback and how to consolidate overlapping or related strategic issues.

In order to evaluate priorities and establish goals with strategies for the CHIP, the strategic issues were then evaluated, compared and revised considering the urgency and the potential to address the issues through interventions utilizing the network that includes Public Health, healthcare partners from the Steering Committee, and community partners.

STRATEGIC ISSUES CONSIDERED FOR INCLUSION:

- **Improve social connectedness**
- **Promote community cohesion**
- **Empower community voices**
- **Promote political and policy equity and cohesion**
- **Unify educational institutions**
- **Improve opportunities for equitable resource attainment and retention**
- **Build up economic stability**
- **Eliminate discriminatory policies and structures**
- **Connect policies and practices across Brown Country**
- **Promote healthier attitudes, beliefs, and practices into culture norms**
- **Advocate for equitable and quality health care**
- **Improve natural and built environments to promote safety and good health**

LOOKING TO 2021 AND BEYOND:

Based on findings from the assessments summarized earlier in this report, Beyond Health, with support from the Public Health Team, engaged in an internal prioritization process, highlighting below the top three strategic issues for consideration in the upcoming Community Health Improvement Plan (CHIP). Next steps include identification of how we measure success, who is responsible for carrying this important work forward, and sharing results widely with the community.

PRIORITY 1: EQUITABLE ACCESS

Calling out racism as a public health crisis and amplifying the voices of marginalized groups in the community is a strategy aimed at promoting diversity, equity, and inclusivity in health. This includes people of color, women, the LGBTQ+ population, individuals with different abilities, those with financial, housing, and food insecurity and more. By intentionally taking steps to build trust in public health and mobilizing resources in targeted ways, we can reduce health inequities and improve agency and health outcomes for all.

PRIORITY 2: SOCIAL COHESION

Fostering high levels of social cohesion made up of social inclusion, social capital, and social diversity can positively influence individual and population health. The social, political, and structural institutions in our community have the ability to promote social cohesion and healthy norms by developing and aligning resources in a way that is responsive, supportive, and effective.

PRIORITY 3: UNIFIED PLANNING AND POLICY

Prioritizing health, diversity, equity, and inclusivity in policy planning and delivering policies in a coordinated and unified way can build and improve the well-being in the entire community. In addition, clear and unified communication about policy planning and delivery can build trust between the community and institutions/agencies/ schools, etc. and can positively influence individual and collective well-being in the community.

Source: Chuang et al. International Journal for Equity in Health 2013, 12:87 p://www.equityhealthj.com/content/12/1/87

PRIORITY SUGGESTION 1: EQUITABLE ACCESS

Goal: *Amplify marginalized community voices and improve access to resources in order to reduce health inequities. Focus on building trust in the health system. Allocate resources in a way that is responsive, supportive, and effective in order to minimize differences between individuals and groups in the community.*

POTENTIAL STRATEGIES

Decrease income and asset gap in Brown County

Example Actions:

- *Increase minimum wage in Brown County*
- *Increase access to affordable, high quality child care*
- *Expand affordable post-secondary education opportunities and employment opportunities*

Example Measures:

- *ALICE data*
- *Focus group discussions and community conversations data*
- *Stratified median household income*
- *Stratified data on income spent on childcare*
- *Stratified data on the Supplemental Nutrition Assistance Program (SNAP)*

Improve environmental quality and physical environments for all

Example Actions:

- *Expand lead prevention and mitigation programming*
- *Remove the coal piles along the Fox River*
- *Expand number of safe playgrounds and youth-friendly spaces (Improving built spaces)*

Example Measures:

- *Inclusion of community organizations and impacted individuals in policy and planning discussions*
- *Air and water quality metrics*
- *Unintentional injury and related fatality statistics*
- *Blood lead levels in children by demographic groups and census tract data*

Advocate for equitable access to healthcare

Example Actions:

- *Develop diverse health navigator programs*
- *Implement vision programs for children in the community*
- *Implement "No Wrong Door" policies between health systems*
- *Create transparency around billing and resources for accessing care*

Example Measures:

- *Stratified data for:*
  - *those with medical insurance (also consider prescription drugs, dental, vision)*
  - *those who report avoiding health care because of cost*
  - *those who complete routine well baby visits and immunization schedules*
  - *infant and maternal morbidity and mortality outcomes*

Additional strategies for consideration:

- *Improve access to to preventive services across the lifespan*
- *Expand equitable access to mental health services, increase integration into primary care, and reduce stigma. Integrate alcohol and drug abuse efforts into these initiatives.*
- *Fair policing and crime prevention efforts across the community*

PRIORITY SUGGESTION 2: SOCIAL COHESION

Goal: *Build connections between community members, both with each other and their environments. Improve on formal and informal social supports, and demonstrate improved cultural attitudes towards healthy habits which will reduce health inequities and improve identified health outcomes.*

POTENTIAL STRATEGIES

Build community and civic connections at a neighborhood level

Example Actions:

- *Community Schools Initiatives*
- *Continue Parent Cafe programming*
- *Increase full broadband access across rural and urban areas*
- *Develop and promote sober social connection opportunities*

Example Measures:

- *Number of formal/informal supports identified by community members*
- *Inclusion of community organizations and impacted individuals in policy and planning discussions*
- *Proportion of households with access to broadband internet*
- *Suicide rates*
- *YRBS mental health measures*
- *Sense of belonging measures*

Increase availability and visibility of healthy food options

Example Actions:

- *Conduct breastfeeding/first food deserts mapping project*
- *Farm to Table/School to Table initiatives*
- *Neighborhood Gardens in partnership with neighborhood associations*

Example Measures:

- *Breastfeeding rates*
- *SNAP usage data by demographic group*
- *School lunch data*
- *Proportion of youth and adults who meet recommended nutrition guidelines*
- *Overweight and obesity measures*

Improve walkability and recreational opportunities

Example Actions:

- *Provide financial support for development of walkable neighborhoods and/or green spaces (sidewalk advocacy)*
- *Map recreational opportunities to identify gaps*
- *Increase number of free/low-cost community events*

Example Measures:

- *Proportion of youth and adults who meet recommended physical activity levels*
- *Perception of quality of life measures*
- *Proportion of individuals who walk or bike to work*

Additional strategies for consideration:

- *Promotion of protective factors, healthy relationships, and community resiliency*
- *Improve supports for women and families*
- *Support diverse and inclusive community and civic engagement opportunities focused on social connectedness and individual well-being*
- *Promotion of tobacco and vaping-free spaces*

PRIORITY SUGGESTION 3: UNIFIED PLANNING AND POLICY

Goal: *Social, political, and structural institutions in our community develop and align practices and policies in a way that is equitable, effective, responsive, and transparent. Build well-being in our community by including health considerations in all policies in an intentional and coordinated way.*

POTENTIAL STRATEGIES

Integrate population health considerations into community planning efforts

Example Actions:

- *Support workplaces in becoming breastfeeding friendly*
- *Integrate health perspectives into Comprehensive Community Plan*
- *Integrate diverse health perspectives into City of Green Bay's affordable housing project*

Example Measures:

- *Proportion of comprehensive planning documents, community-wide initiatives with intentional focus on health*
- *Analysis of large-scale collaborative (collective impact) initiatives and driving indicators*
- *Inclusion of diverse community organizations and impacted individuals in policy and planning decision-making*

Safe, accessible housing and transportation options

Example Actions:

- *Analyze housing stock in Brown County by census tract and assess for lead/radon risk*
- *Support temporary payments to landlords to minimize eviction risks*
- *Advocate for accessible and cost-efficient public transit*

Example Measures:

- *Gap analysis data for housing and transportation in Brown County*
- *Housing data by demographic group*
- *Qualitative data around potential barriers to adequate housing and transportation*
- *Homeless population data stratified by demographics*
- *Usage data for public transit*

Support and create policies that decrease inequities in a coordinated and transparent way

Example Actions:

- *Develop and promote a set of policy recommendations ("health in all policies" guide)*
- *Ensure policies for COVID-19 vaccine distribution are equitable*
- *Enforce and increase penalties for impaired driving infractions*
- *Adopt trauma-informed policies*

Example Measures:

- *Employment statistics*
- *Findings from analysis of policy implementation by local municipalities, through a social justice lens*
- *Inclusion of diverse community organizations and impacted individuals in policy and planning decision-making*

Additional strategies for consideration:

- *Improve data collection around gun-related injuries and fatalities*
- *Support collaboration amongst schools to create unified and transparent practices which support health for all*
- *Enhance data, data sharing among partners, and resource allocation to inform public health interventions*

COMMON LANGUAGE IN THE CHIP: KEEPING US ON THE SAME PAGE

BIG PICTURE LANGUAGE:

Strategic Issues: Complex community issues which require coordinated effort to improve, and which lead to movement in the right direction for multiple health outcomes.
Health Priorities: Strategic issues which have been chosen as a focus area for our community as part of the CHIP.
Goals/Strategies: Focus areas (collections of actions) under each of the chosen health priorities. The best results come when they include actions from multiple agencies or groups.
Results: End conditions of well-being for entire populations - children, adults, families and communities, stated in plain language.

TASKFORCE LANGUAGE:

Objectives/Aim Statements: Time-driven statements which outline specific accomplishments to be undertaken in support of the health priorities. What is the shared purpose of the group's actions?
Tactics/Actions/Action Steps: Specific steps to be taken with clear start and end dates, to improve indicators or performance measures.

RESULTS LANGUAGE:

Indicators: Quantitative measurement of results at the community (population), not program level.
Performance Measures: Program-level outputs which contribute to moving community-level indicators in the desired direction. Qualitative and quantitative can be used for this level of reporting.
Turning the Curve: Making changes in the right direction. Is our level of change acceptable or do we need to revise our approach?

A SINCERE THANK YOU:

The Beyond Health Steering Committee is made up of the following individuals:

- Anna Destree, Brown County Public Health
- Andrea Kressin, Brown County Public Health
- Debbie Armbruster, De Pere Health Department
- Chris Culotta, WI Department of Health Services, Division of Public Health
- Sarah Inman, Brown County United Way
- Kim Franzen, NEW Community Clinic
- Jeff Stumbras, Prevea Health
- David Lally, HSHS
- Jennifer Schnell, Advocate Aurora
- Sharla Baenen, Bellin Health
- Laura Hieb, Bellin Health
- Jody Anderson, Bellin Health

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Public Health Strategist Team (Assessment Coordination):

- Kit Ledvina
- Autumn Linsmeier
- Katrina Nordyke
- Claire Paprocki

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- Kris Kovacic, BCPH
- Orpita Nilormee, BCPH
- Mollie Passon, Oneida Nation
- Emma Kane, CAHL
- Sara Lornson, DPHD

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“NOTHING IN LIFE IS TO BE FEARED; IT IS ONLY TO BE UNDERSTOOD. NOW IS THE TIME TO UNDERSTAND MORE, SO THAT WE MAY FEAR LESS.”

Marie Curie