



# **Walworth County Community Health Improvement Plan**

**A Healthier County by 2015**

February 2012

Dear Members of the Walworth County Health Improvement Steering Committee,

On behalf of the Walworth County Public Health Division of the Department of Health and Human Services, we thank you for your wonderful collaborative spirit and for the work accomplished on the development of the Community Health Improvement Plan and Process (CHIPP).

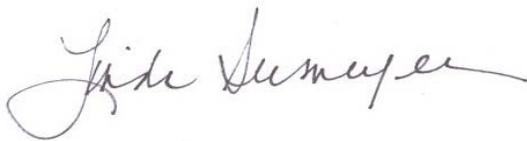
This plan is the culmination of efforts by Sue Schuler - MSN consultant, Erica Bergstrom - MPH student, community leaders, and staff and board members that will enrich the lives of Walworth County residents for many years to come. It encompasses the State of Wisconsin 2020 Plan, County Health Rankings, and the Aurora Health Care Survey. It reflects input from Mercy Health Care Systems and numerous agencies, ministries, schools, dental providers and many other health care partners.

The Core Functions and Essential Services of all the Public Health Departments in the State of Wisconsin are described within the plan to meet state statutes. Core Functions include: assessment, policy development, assurance and leadership.

As we move into the implementation phase of this process, we now have four priority areas to focus on for the next several years to continue the foundation that has been laid by your participation, support and expertise.

Your direction and continued partnership are highly valued. Working together, Walworth County can be the healthiest county in the State of Wisconsin.

Thank you very sincerely for your participation,



Linda Seemeyer  
Health and Human Services Director



Pat Grove  
Health Officer

## Acknowledgements

Walworth County would like to thank all who participated in the CHIPP process for dedicating their time and knowledge to helping improve the health of all of our citizens and visitors and for helping move Walworth County Public Health into the future.

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## Vision

Walworth County: an engaged, vibrant, and diverse community with a collaborative community health system that promotes healthy people, a safe environment and wellness education for all residents, employees, and visitors.

## Values

**Access:** We believe that all residents deserve access to quality health improvement programs and health care.

**Leadership:** We believe that all members of the community can be leaders in health promotion, be examples of healthy living, and residents should be empowered to make proactive health and lifestyle choices.

**Collaboration and Communication:** We believe that optimal health is only achieved through community members, healthcare providers and government agencies working together.

**Prevention and Education:** We are dedicated to improving the health of the community by addressing health problems through the provision of comprehensive prevention, education and early intervention programs.

**Awareness:** We are dedicated to providing community members with knowledge and information regarding health and the health services available to them, and that all healthcare providers are aware of the health concerns of their populations.

**Commitment and Accountability:** We believe that all who live and work in Walworth County share responsibility for achieving and maintaining health in the community.

**Efficiency:** We are dedicated to using the available resources wisely and to their fullest potential for quality, need identified and evidence based health programs.

# The Community Health Improvement Plan and Process (CHIPP) Model

## What Is CHIPP?

Since 1995, communities throughout Wisconsin have developed and implemented local health plans to address health conditions impacting their residents. This process has been referred to as “Community Health Improvement Plan and Process” named in part, due to the resulting health status changes in a community and the people that live there.

The Community Health Improvement Plan and Process begins with a:

- Locally based initiative
- Identifying local factors causing health concerns
- Recognizing community assets and resources
- Addressing local health priorities
- Linking to state and national priorities
- Mobilizing community resources to improve the health of residents

## Why Perform a CHIPP?

Local Health Departments are required to “Regularly and systematically collect, assemble, analyze and make available information on the health of the community,” (Wisconsin Statute Chapter 251.05). Once every 5 years Walworth County goes through this process to identify health concerns in the County and formulates strategies to address them in order to improve the total health status of the County.

The CHIPP Process is designed to:

- Form and strengthen partnerships
- Increase community awareness
- Tap a community’s innovative ideas
- Integrate isolated efforts
- Build on existing services
- Conserve resources and prevent duplication of efforts
- Develop comprehensive strategies that will work in our community

## Who Participates in a CHIPP?

County and Public Health staff are not involved in the CHIPP process alone. CHIPP is designed to move the County to action, and promote community work as a whole.

CHIPP members are:

- Representatives of the community
- Leaders with knowledge of the community
- Individuals interested and committed to creating a healthier community



Appendix A, Figure 1: Key Components of CHIPP

## How Do We Create a CHIPP Plan?

CHIPP is a process designed to utilize an array of different quantitative and qualitative data sources to create a comprehensive picture of health in Walworth County. After data collection, health priority areas based on those determined by the state are chosen and action plans to improve the health status of these priorities are designed.

The steps for a CHIPP plan are:

- Examine data: disease, death, disability, injury, community opinion
- Identify priority health problems: factors that can be impacted
- Identify community assets and resources to be supported or tapped
- Develop a health improvement plan to address priority concerns
- Present the health improvement plan to the community
- Implement the identified strategies and measure success

## What Are the Health Priority Categories and How Were They Decided On?

*Healthiest Wisconsin 2020*,<sup>41</sup> the state's health improvement plan, identifies 12 health focus priority areas and 9 health infrastructure priority areas that are the underlying and interrelated, causes of many diseases and health conditions in the state of Wisconsin. These areas were identified during a two year, interdisciplinary statewide study. Addressing these areas is

designed to improve the health in Wisconsin, and Wisconsin Counties by the greatest margin.

The Priority Areas we focused on in our CHIPP are:

- Access to primary and preventive health services
- Oral health care
- Adequate and appropriate nutrition
- Alcohol and other substance use and addiction
- Environmental and occupational health hazards
- Existing, emerging, and re-emerging communicable diseases
- High risk sexual behavior
- Intentional and unintentional injuries and violence
- Mental health and mental disorders
- Overweight, obesity, and physical activity
- Social and economic factors
- Tobacco use and exposure

## What About the County Health Rankings?

The County Health Rankings, a survey applied nationwide to determine the health status of

counties in a variety of different areas, and to allow comparisons between the health status across states, was used

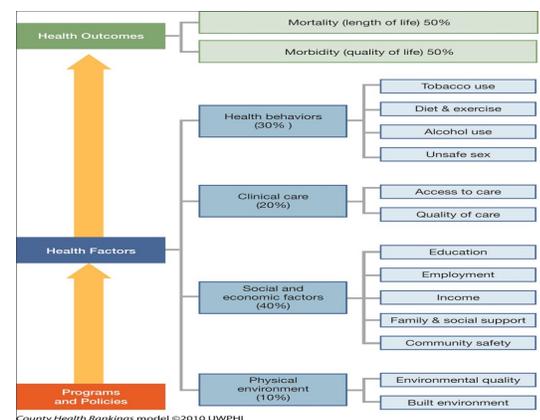


Figure N, Appendix A: County Health Ranking Areas

primarily in the identification of strategic issues and to help put into context the state of health in Walworth County. The County Health Rankings



report ranks Wisconsin counties according to their summary measures of health outcomes and health factors, as well as the components used to create each summary measure. Counties

receive a rank for each population health component; those having high ranks (e.g., 1 or 2) are estimated to be the “healthiest.”

The summary health outcomes rankings are based on an equal weighting of mortality and morbidity measures. The summary health factors rankings are based on the weighted scores of four types of

factors: behavioral, clinical, social and economic, and environmental. The weights for the factors are based upon a review of the literature and expert input, but represent just one way of combining these factors.

How Walworth County Ranks (Appendix A):

- Ranks 50 out of 72 Counties in Wisconsin
- 38<sup>th</sup> in Mortality
- 32<sup>nd</sup> in Health Factors
- 24<sup>th</sup> in Health Behaviors
- 64<sup>th</sup> in Clinical Care
- 33<sup>rd</sup> in Social Economic Factors
- 30<sup>th</sup> in Physical Environment

## Community Health Status Assessment

The Community Health Status Assessment is a data based inquiry designed to determine how healthy residents of Walworth County are and what the current status of health in our County looks like.

Data was collected through a number of different local, state, and national surveys, reports and databases and then categorized to mirror the health focus and Infrastructure focus areas designated in the *Healthiest Wisconsin 2020* report. These focus areas provide broad categories designed to encompass the total spectrum of health. In applying them to Walworth County each category was narrowed to reflect the health concerns of the residents of our County.

The following is a summary of the health status and infrastructure of Walworth County divided into the selected priority areas:

### Demographic Characteristics

- Population: 102,228 (2010).<sup>1</sup> Walworth is one of the fastest growing counties in the state, with an expected population increase of 28% by 2030.<sup>2</sup>
- Estimated race distributions: 89.1% of the population is White, 8.7% Hispanic, 1.1% African American, and 1.1% Other.<sup>3</sup>
- The older population in the County is growing at a faster rate than the younger.

### **Socioeconomic Characteristics**

- The average household income between 2005 and 2009 was \$53,910.<sup>4</sup>
- A higher percent of the population in 2009 received degrees higher than a high school diploma than did in 2000.<sup>4,5</sup>
- Roughly 10.3% of Walworth County's population lives below the federal poverty threshold, representing a significant increase since 2000, and 28% of those in poverty experienced a recent job loss.<sup>6</sup>

### **Access to Care and Public Health Spending**

- County Health Rankings rated Walworth County 64th of 72 for clinical care factors in 2011.<sup>7</sup>
- Since 2007 the percent of Walworth County residents without insurance has increased from 5% to 16%.<sup>8</sup>
- A slight increase since 2005 has been seen in the number of people seeking health care advice and services in urgent care and emergency departments.<sup>9</sup>
- The number of one-way trips provided by Walworth County Transportation services has decreased drastically since 1999.<sup>10</sup>
- Based on the County population Walworth County should have 20.3 FTE public health nurses (PHN)<sup>11</sup>, there are currently 6.4 FTE PHNs.<sup>11</sup>
- Wisconsin's public health funding per capita rank has dropped from number 1 in 2002 to number 48 in 2010.<sup>12</sup> Walworth County is among one of the lowest funded Counties in Wisconsin.<sup>13</sup>

### **Adequate, Appropriate, and Safe Food and Nutrition**

- Survey results show that approximately 58% of residents eat the recommended 3+ servings of fruits and 24% of residents eat the recommended

3+ servings of vegetables per day<sup>9</sup>

- Foodshare use has almost doubled since 2008<sup>14</sup>
- Food pantries and the reduced or free lunch program continue to see large numbers of users.<sup>15,16</sup>
- In 2010 WIC served 3,300 new participants and served these clients 14,400 times. 85% of the WIC new mothers initiated breastfeeding.<sup>17</sup>



### **Alcohol and Other Drugs**

- Alcohol use and abuse continues to be a problem in Walworth County with 24% of adults reporting engaging in binge drinking behaviors and 8% in heavy drinking.<sup>9</sup>
- In 2008 the County saw 1569 liquor law arrests and 892 operating while intoxicated (OWI) arrests.<sup>18</sup>

### **Chronic Disease Prevention and Management**

- Rates of high cholesterol and obesity have continued to rise since 2005 while high blood pressure, diabetes, heart disease and stroke remain constant.<sup>9</sup>
- Around 80% of adults in the County had a routine check-up in the past 2-years, representing 76% of males and 89% females.<sup>9</sup>
- Heart disease and cancer continue to be the leading causes of chronic disease mortality in Walworth County.<sup>9</sup>
- Incidence of different cancer types remains relatively stable with prostate, lung, and breast cancers leading in incidence.<sup>3</sup>
- Women's health is strong in the County, with 81% of women reporting having had a pap smear. Additionally 74% and 73% reporting having had

bone density scan at least once and a mammogram within the past 2 years.<sup>9</sup>

- Only 46% of men received a PSA Test in the past 2 years and only 36% had a digital rectal exam in the past year.<sup>9</sup>

### **Communicable Disease and Immunization**

- From 2009 to 2010 reportable communicable disease rates remained relatively stable, with Chlamydia occurring much more frequently than other communicable diseases.<sup>19</sup>
- During the 2009-2010 H1N1 outbreak Walworth County had a peak case rate of 279.8 per 100,000 population and over 4,000 H1N1 vaccines were administered.<sup>20</sup>
- In 2010, 77% of County children under age 3 had completed the primary immunization series, and only about 5% of children had immunization waivers in all County school districts.<sup>21</sup>
- About 70% of adults over 65 years of age self report receiving seasonal vaccines in the last year.<sup>9</sup>

### **Environmental and Occupational Health**

- The DNR Groundwater Retrieval Network estimates that there are over 8,000 active wells in Walworth County.<sup>22</sup> In 2010 Walworth County Environmental Health Staff sampled 192 wells for coliform bacteria and nitrate levels. Three tested positive for bacteria and 7 for nitrate.<sup>23</sup>
- Of 1,196 children screened for lead in the County in 2010, 4 tested high enough to be considered lead poisoned and required investigation. One lead poisoned child results in an estimated societal financial loss of \$45,608 over the course of a lifetime.<sup>24</sup>
- Foodborne illness continues to be a concern in the County with 55 reported cases in 2010<sup>19</sup>

representing an estimated 1-5% of total cases.<sup>25</sup>

- There are 964 licensed establishments in the County that are inspected annually by 2.4 FTE sanitarians.<sup>26</sup>

### **Healthy Growth and Development**

- Walworth County had 1,191 live births in 2008 and an infant mortality rate of 3.6 per 1,000 live births.<sup>27</sup> Of these births only 4% were a low birth weight, and 1% a very low birth weight.<sup>3</sup>
- In 2008 78% of mothers received first-trimester prenatal care, which is lower than surrounding and comparable counties.<sup>28</sup>
- In 2008 PNCC enrolled 28 mothers, 85.7% of whom started care in their first trimester.<sup>29</sup>
- Walworth County child protective services performance indicators remained constant between 2009 and 2010 with the only large increase seen in the number of days of residential care center placements.<sup>30</sup>

### **Injury and Violence**

- In Walworth County 85% of adults report using their seatbelt always or nearly always and 26% report using a helmet while riding a bicycle or inline skating.<sup>9</sup>
- Falls continue to be the leading causes of ER visits and hospitalizations at rates per 100,000 population of 2,326<sup>31</sup> and 412<sup>32</sup> respectively.
- Motor vehicle crashes are the leading cause of injury and violence mortality in the County at a rate of 16 per 100,000, followed by falls at 12.<sup>33</sup>
- Suicide behavior in Walworth County occurred at rates of 12 deaths per 100,000, 59.9 per 100,000 inpatient hospitalizations, and 75.3 per 100,000 population for emergency department visits between 2001-2006.<sup>34</sup>

### **Mental Health**

- In 2009 7% of County adults reported feeling sad, blue, or depressed always or nearly always, and 3% reported considering suicide.<sup>9</sup>
- In 2010 Walworth County saw 375 psychiatric hospitalizations and 12 suicides.<sup>35</sup>

### **Oral Health**

- From 2003 to 2009 the number of adults reporting having had a routine dental checkup had dropped from 74% to 65%.<sup>9</sup>
- Less than 30% of all BadgerCare recipients in Wisconsin received any dental care in 2009.<sup>36</sup>
- In Wisconsin in 2008 60% of 8 year olds had experienced dental decay.<sup>37</sup> In the 2010 –2011 school year in Walworth County 590 children were served by Seal-A-Smile.<sup>38</sup>

### **Physical Activity**

- About 30% of adults report engaging in moderate physical activity 5 times a week for at least 30 minutes, while 45% report meeting the recommended exercise criteria for vigorous or moderate activity.<sup>9</sup>
- Overweight adults in Walworth County had increased sharply since 2003 from 53% to 61%.<sup>9</sup>

### **Reproductive and Sexual Health**

- Chlamydia remains the top reported sexually transmitted infection in the County with 203 cases reported in 2010, which is up from 125 case in 2006.<sup>19</sup>
- In 2008 just over 7% off all births in Walworth County occurred to teens aged less than 20 years.<sup>39</sup>

### **Tobacco Use and Exposure**

- Approximately 23% of Walworth County adults are current smokers, 49% are trying to quit, and 66% have been advised to quit.<sup>9</sup>
- In 2009 16% of all births were to mothers who smoked.<sup>40</sup>



## Focus Group Responses and Key Informant Interviews

### Focus Group Responses

Focus groups were conducted during the course of the Community Health Improvement Process to gain a better understanding of what health issues affect Walworth County residents and how health is perceived in the county. Responses were collected from the School Nurses of Walworth County, school systems, the Public Health staff, WIC staff, DHHS management team, and Early Head Start staff. Results from this section reflect opinion and perception and may not actually be indicative of the actual health status, but help allow us to understand community perceptions of health.

#### ***What are the most important health issues of Walworth County residents—biggest health concerns for households, families, and children with whom you work?***

- Access to health care including—laboratory services, vision care, primary care physicians, school based services, pharmaceutical access and availability, mental health care, oral health services
- Access to care for undocumented citizens and their families including barriers due to language
- Access to contraceptives and birth control education
- Transportation availability
- Increase in uninsured and underinsured residents in the County
- Oral Health—there are no available services for low income families or patients with Medicaid or no insurance

- Mental Health—child and adolescent care
- Lack of environmental health services
- Adequate and appropriate nutrition including—school lunch programs, parent and child knowledge and education, availability and affordability of foods of high nutritional value
- Obesity in children and adults
- Alcohol abuse and addiction—underage consumption, binge drinking
- Lack of a focus on preventative care

#### ***What is happening in Walworth County that has a positive impact on the health of individuals and families? How has this changed in the last 5 years?***

- Seal-A-Smile program
- Expansion of mental health programs for children and adults
- Whitewater Wellness (WW3) initiative
- Better access to nutrition through WIC
- Expansion of UW-Extension programs for children and families
- Adult Disability Resource Center (ADRC)
- School nurses in every district
- OWI prevention program
- Car seat and crib program
- Smoke free public establishments

#### ***What can be done within the County to improve the above issues?***

- Develop a free or low cost health care clinic or Federally Qualified Health Center (FQHC)

- Increase communication about and knowledge of available services
- Decrease stigmatization about poverty and the use of social services
- Increase pregnancy prevention and prenatal care programs for teens
- Increase availability and knowledge of available transportation services
- Create a stronger parenting education network
- Expand Seal-A-Smile and fluoride programs
- Establish a free or low cost dental clinic
- Increase availability of mental health services for children and adolescents
- Initiate a County Agent program to increase food safety
- Use better communication techniques to increase education about nutrition, physical activity, preventive care
- Promote healthy lifestyles for all ages by increasing communication through different media including websites, newspaper, radio, and public relations campaigns
- Create stronger collaborations between the community health system and businesses to promote a healthier population

### **Key Informant Interviews**

Key Informant Interviews were performed in order to gain a better understanding of what health in Walworth County really looks like. Key Informants are individuals who have a unique insight into the health status of the County. Most key informants have a particular niche of health knowledge and so results of this section are not necessarily reflective of the actual status

of County Health but instead provide insight from specialists into the health concerns seen in the county. Key informants included: health care providers, public health staff, aging and disability resources staff, humane society staff, Walworth County Department of Health Services administrators, and staff from other community support organizations.

### ***Think about the people/residents that you know and/or work with. What specific or related health issues or concerns do you see that need to be addressed to improve the health of these residents?***

- Access and Availability of care including lack of insurance and cost, preventive health services and care providers, transportation, and language and cultural barriers
- Lack of available care for individuals on Medicaid, and the uninsured
- Better identification of children with special needs and availability of resources for families
- Chronic disease prevention and education
- Availability and accessibility of care for the elderly
- Need access to child and adolescent psychologists
- Improved environmental health services including water testing, prevention and control of rabies, lead poisoning, and food safety
- Increasing obesity, poor nutrition, and a decrease in physical activity

### ***What are the immediate health priorities that need to be addressed for the citizens of Walworth County?***

- Education on a variety of health topics and disciplines
- Culturally appropriate services

## Identifying Strategic Issues

- Better enforcement of regulations
- Increased physical activity
- Dental health
- Nutrition
- Insurance
- Preventive care and services availability
- Availability of health care providers and specialized services
- Environmental health

### ***What are the top health priorities that need to be addressed over the next 5 years to improve the health of Walworth County residents?***

- Community outreach and support for preventive care programs
- Environmental health issues including an agent program
- Obesity/Nutrition
- Cultural barriers
- Dental health services
- County wide connectivity and cooperation
- Physical activity
- Care for the elderly
- Better quality care and access
- Chronic disease

### **How Strategic Issues Were Identified**

After assessment of the health of the Community was completed and presented the strategic planning committee met to identify the strategic issues affecting the health of Walworth County that need to be addressed. Issues were identified by considering a number of questions:

- Is there one health priority area that ranks much lower than others on the County Health Rankings (Appendix A)?
- How many people are affected by the issue?
- How severe is the effect?
- How important is the issue perceived to be?
- What are the consequences of not intervening?
- Are there strategies to address the issue that have been shown to work?
- How likely is it that we can improve the problem?
- Would there be community support for the issue?
- What other activities or programs are already running to address the problem?
- Will the County be willing to increase resources and support the issue, and will the Community support this increase?

The strategic planning committee then developed plans for improving the status of each strategic issue over the next 5 years.



## **10 strategic issues were selected by the Steering Committee for the county.**

Strategic issues are those fundamental policy choices or critical challenges that must be addressed for a community to achieve its vision.

- Access to Free Medical Clinic or other model (FQHC), to serve the uninsured, including transportation
- Access to free, low cost or Medicaid reimbursable dental services
- Environmental health, including an Agent program (food safety, lodging, recreational facilities)
- Comprehensive information and referral (resource directory, WEB, promotion of 211) with Public / Private Collaboration
- Prevention of chronic diseases including adequate funding, education/wellness programs (Life Course Model) by working with schools and employers
- Coordination of prevention goals, with a focus on the life course model (set goals for the entire county every year and focus on one outcome such as increased physical activity, increased fruit and vegetables, etc.)
- Early intervention for high risk families, including single moms who represent 51% of county births, teens, and disadvantaged families of Walworth County
- Mental health services for children and parents, with focus on emotional health/wellness vs. mental health
- Provision of mental health assessment in primary care
- Expansion of Alcohol and Drug Abuse prevention programs.

### **Survey of Steering Committee to Select Priorities**

The next step was to survey the Steering Committee and expert presenters to identify the top four priorities for the Walworth County Community Health Improvement Plan that will be implemented over the next five years. They are;

**Access to a free medical clinic**

**Access to free, low cost dental services**

**Prevention with a focus on the life course model**

**Early intervention with high risk families; including single-parent families, teens and disadvantaged families**

### **Creation of Workgroups**

The workgroups were established for each priority. They developed the overall goal and objectives, reviewed evidence-based practices to be used as strategies, and outlined measures of success, indicators and time-lines for each priority in our five year CHIPP.

# Strategic Issue 1: Access to a Free Medical Clinic or Other Models

*Access to high-quality health services* means universal access to affordable high-quality health services for all people in Wisconsin to promote optimal physical and mental health and to prevent illness, disease, injury, disability, and premature death.

High-quality health services include the full range of health care services, including medical, dental, mental health and long term care. *Access to high-quality health services* means they are available to the people of Wisconsin when, where, and how services are needed. This includes equitable access to health promotion and disease prevention services across the life span that are coordinated, culturally competent, and linguistically appropriate.

Health services promote a patient-centered medical home where there is a regular source of primary care and care is coordinated across health, public health, and other care systems, including long-term care that integrates health and social care and fosters independence and resilience. To be effective in producing good health outcomes, health services must be integrated, equitable, patient-centered, safe,

timely, and efficient to effectively meet the needs of diverse populations.

According to Walworth County's Health Rankings, 16% of the documented population in Walworth County does not have health insurance at some point in a 12 month period. In addition there are a number of undocumented individuals that do not have health insurance. Therefore, it is critical to develop another option for persons in the county to receive medical care. To that end, a first step in addressing access to health care is to develop a free clinic or a federally qualified health care center.

Public Health offers Immunization programs, Women, Infants and Children (WIC), Wisconsin Well Women Program (WWWP) and Maternal Child Health programs. One of the care functions of Public Health is to assure access to primary care and link people to services.

Free Clinics are volunteer-based, safety-net health care organizations that provide a range of medical, dental, pharmacy, and/or behavioral health services to economically disadvantaged

individuals who are predominately uninsured. Free Clinics are 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization. Entities that otherwise meet the above definition, but charge a nominal fee to patients, may still be considered Free Clinics provided essential services are delivered regardless of the patient's ability to pay.



## Strategic Issue 2:

# Access to free, low cost dental services



More than 830,000 visits to emergency rooms nationwide in 2009 were for preventable dental problems. Dental disease is the No. 1 chronic childhood

disease, sending more children in search of medical treatment than asthma. In a nation obsessed with high-tech medicine, people are not getting preventive care for something as simple as tooth decay. Close to 50 million Americans live in rural or poor areas where dentists do not practice. Most dentists do not accept Medicaid patients.

From 2003 to 2009 the number of adults reporting having had a routine dental checkup had dropped from 74% to 65%. Under 30% of all Badger Care recipients in Wisconsin received any dental care in 2009.<sup>36</sup>

*Oral health* is basic to general overall health throughout the life span. It means being free of mouth pain, tooth decay, tooth loss, oral and throat cancer, oral sores, birth defects, gum (periodontal) disease, and other diseases that affect the mouth and surrounding structures.

- Achieving good oral health requires access to a dental home, which is not a building, but rather a team approach to providing comprehensive oral health care services in a high quality and cost-effective manner.
- Early intervention with primary preventive measures (tooth brushing, flossing, good nutritional and infant feeding practices) begins during the preconception and prenatal periods. It includes care provided from both primary health care providers and oral health providers and continues through the life span.
- Older adults with poor oral health are at risk for malnutrition
- Early intervention with preventive measures, such as fluoride varnish and dental sealants, includes children and adults with developmental disabilities who experience significant problems of access to dental services.

In Wisconsin in 2008, 60% of 8 year olds had experienced dental decay<sup>37</sup>. School-based dental sealant programs are an evidence-based practice that provides dental sealants to students in vulnerable populations who are less likely than other students to receive oral health care from dentists in private practice. Programs are conducted in school settings with oral health

professionals (dentists, dental hygienists, and dental assistants). According to Oral Health America, approximately 75 percent of teeth sealed remain cavity free, compared to less than a third of teeth without sealants.

# Strategic Issue 3: Promote health, wellness and prevent chronic diseases across the life span

*Healthiest Wisconsin 2020* focuses on maintaining and improving the quality of life at every stage of life. Living better, longer does not mean simply increasing the number of years that people live. As the average age of Wisconsin residents increases over the decade (most likely with an increase in the prevalence of chronic disease), it becomes important to prevent additional injury, disability, and other poor health outcomes regardless of age or disability. Thus *Healthiest Wisconsin 2020* has increased the emphasis on preventing and managing disability, distress and chronic conditions, including oral health disorders that may not commonly be viewed as “life threatening.”



Living better, longer also means increasing access to healthy foods and to opportunities for physical activity—fundamental components of vibrant communities. This is the core strategy for reversing unprecedented increases in Type II

diabetes and preventing a constellation of health problems, including heart disease, high blood pressure, stroke, and cancer. This means, addressing health issues at young ages to improve health of older adults and even the health of the next generation (a “life-course” perspective on health). This shift in focus to include the quality of life influenced the



selection of this focus area and their related objectives. This subtle change in vision recognizes that there are opportunities to prevent additional problems and improve the quality of life even if a person already suffers from disease or disability; it also puts a premium on the prevention of chronic disease and disability that could affect people’s quality of life for decades. This part of the vision embodies the other major plan goal, to improve health across the life span.

According to the 2011 Aurora Health Care Survey Report on Walworth County, there are areas that

would improve the health of our residents. *From 2003 to 2011, there was:*

- *A statistical increase in the overall percent of respondents who reported their health as fair or poor.*
- *A statistical decrease in the overall percent of respondents who reported a dental checkup in the past year.*
- *A statistical increase in the overall percent of respondents who reported they always or nearly always felt sad, blue or depressed or they considered suicide and reported they seldom/never find meaning and purpose in daily life.*
- *A statistical increase in the overall percent of respondents being overweight.*
- *A statistical decrease in the overall percent of respondents who reported at least two servings of fruit or at least three servings of vegetables on an average day.*

According to the Prevention Institute, quality prevention activities:

- Advance solutions that combine knowledge, assets, and skills of community members which is the foundation for a stronger, healthier community environment and successful, sustainable prevention efforts.
- Pursue comprehensive actions to solve complex problems and achieve far-reaching gains in health and safety. Apply a layered framework of mutually supportive community prevention strategies to improve social and physical environments.
- Trace a pathway from medical concerns to the community conditions, norms and root factors leading to poor health and inequality. Research community solutions supporting prevention and wellness for everyone.
- Promote norms that support equity, health and safety. Norms are “behavior shapers”; levers for effective prevention. Altering policy is a vital factor for changing norms, leading to supportive behavior and improved health and safety.
- Encourage interdisciplinary partnerships to help break down silos; synthesize and integrate knowledge, perspectives, and tools across disciplines, and construct shared comprehensive solutions.
- Catalyze innovative strategies and analysis that change community-wide systems and foster a new way of thinking where prevention is primary.

# Strategic Issue 4: Early Intervention for High Risk Families



*Healthy growth and development* requires family-centered, community-based,

culturally competent, coordinated care and support throughout the life course during preconception and prenatal periods, infancy, childhood, adolescence, and adulthood.

Components include:

- Addressing factors that affect biologic, psychological, social and emotional growth and development.
- Conducting prevention, screening, assessment, and intervention to promote healthy growth and development across the life span.
- Promoting healthy social, emotional, behavioral, cognitive, linguistic, sensory, and motor development.

Healthy growth and development in early life have a profound effect on health across the life span. Research studies over the past decade

demonstrated the link between early life events and adult chronic diseases. They found that babies born at lower birth weights have an increased risk of developing heart disease, diabetes, and high blood pressure in later life. Infants with poor birth outcomes begin life with multiple risk factors that may prevent them from reaching their full health and development potential.

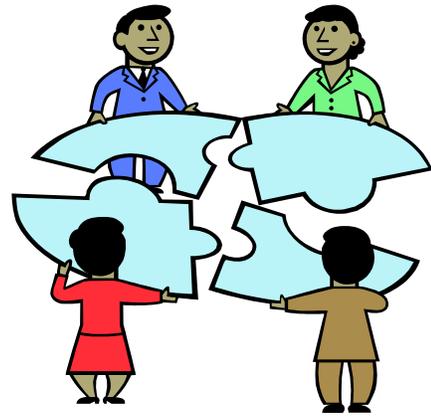
High risk is defined as a family unit that is particularly subject or exposed to a danger, internal or external, with one of more of the following risk factors:

- Shelter, safety and transportation insecurities
- Nutrition, food and health insecurities
- Economic stress issues (i.e., loss of job, unable to pay bills, loss of primary income source, homeless)
- Substance abuse, child abuse and neglect issues, or domestic violence in the home
- Recent divorce or loss of family members due to death or estrangement, including lack of paternal involvement
- Child development issues (i.e., low score on the developmental screen or issues noted

from recruitment notes, health history, or general observation)

- Changes in otherwise typical behavior
- Families involved with community agencies where a current family plan exists
- Children with disabilities
- Multi-generational families and teen parents
- Family literacy issues, including parent is failing or dropping out of an educational program

Research has shown that adolescents who perceive that they have good communication and are bonded with an adult are less likely to engage in risky behaviors. Parents who provide supervision and are involved with their adolescents' activities are promoting a safe environment in which to explore opportunities. The children of families living in poverty are more likely to have health conditions and poorer health status, as well as less access to and utilization of health care.



Children from families with risk factors have poor outcomes when compared to children in families without risk factors. Therefore, it is critical that we work to implement evidenced-based practices in Walworth County that will:

- Help health care providers shift their thinking to a prevention-based, family-focused, and developmentally-oriented direction
- Foster partnerships between families, providers, and communities
- Empower families with the skills and knowledge to be active participants in their children, as well as their own, health and development.

# Work Plan 1: Access to a Free Medical Clinic or Other Models

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
1. Create vision/mission statement			Accomplished	Community advocates, health systems and med. Community, county government, faith communities
2. Establish a 501(c)(3) for Free Medical Clinic or other model (FQHC)		Board of Directors Incorporation Professional Advisory Comm. Business Plan Budget and Fundraising Organizational Chart	Submitted application, approval in 3-6 months  Accomplished  Establishment of Profession. Advisory Committee business plan, budget, organization chart, budget and fundraising plan. Evaluation of sustainability	Board of directors, community advocates, steering committee

# Work Plan 1: Access to a Free Medical Clinic or Other Models

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
3. Determine eligibility, services and ancillary services		Establish cooperative service agreements with health systems and other providers as needed.	Establishment of cooperative service agreements	Health systems
4. Develop policies and procedures for clinical procedures	Review best practices	Establish medical staff, nursing staff, and volunteer policies quality improvements	Development of policies	County government/ policies available
5. Determine location and space to provide services		Choose Elkhorn location accessible to Walworth County residents with an environment which promotes quality services with respect, dignity and cultural competence	Rental, improvement of selected spaced and furnished clinic Creation of signage	Community volunteers/building trades Habitat for Humanity Health systems
6. Staffing for medical, nursing/ ancillary volunteers	Screening, licensing, credentialing, background checks, HIPAA, photo ID	Recruit volunteers Establish credentialing and HR policies Develop orientation and continuing education plan	Development of plan and policies	County government / electronic procedure available

# Work Plan 1: Access to a Free Medical Clinic or Other Models

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
7. Public relations/ patient outreach/ marketing plan	Review literature for best methods to market to Spanish population	Develop multifaceted marketing plan to reach target population	Creation of logo and bilingual public relations literature Media outreach, utilizing technology, bilingual text Community websites	Community newspapers, radio, TV, outdoor ads
8. Provide quality multifaceted service to target population		Open clinic Plan and evaluate how to increase the number of people served	Successful staffing of the clinic delivering quality care to the target population/with a monthly increase in the number of people served.	Collaboration and partnering with all in community

# Work Plan 2:

## Access to free, low cost dental services

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
1. Increase affordable and accessible dental health for uninsured and MA residents.	Educate, promote and provide services and resources for basic dental care.	Increase the number of MA/uninsured that have a dental home by 10%.	2012 – 2014 County residents with a dental home.	Burlington Dental Society Schools Public Health/WIC Headstart Human Services Children's Health Alliance
2. Increase the percentage of youth in Walworth County with fluoride and dental sealants.	Promote the Seal-A-Smile program at schools. Promote the education of fluoride treatments of WIC program.	Increase by 25% children receiving services in both programs.	2012 – 2014 Sustainable SAS program.	Same as above
3. Establish a Walworth County Dental Coalition.	Research the goals and objectives of the Wisconsin Dental Association.	Increase the number of MA dental service providers to serve the county.	2012 – 2014	Dental Society Community Agencies School Nurses Dental Professionals
4. Initiate dental clinical services at the Inspiration Ministry site for children and adults.	Provide preventive service and restorative care.	Establish office hours for dental services for MA and uninsured residents.	2012 – 2014	Dental Coalition Members Foundations Grant Funds
5. Partner with WDA for the Mission of Mercy Project.	Statewide dental service project to provide preventive service and restorative care.	Provide needed dental services to 100-200 underserved residents.	2012 - 2013	Mission of Mercy Volunteers Dental Coalition Members Burlington Dental Society

## Work Plan 3: Promote health, wellness and prevent chronic diseases across the life span

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
1. Inventory the prevention/wellness programs/models in the county and list potential collaborations	<p>Highlight evidenced-based practices</p> <p>La Crosse Healthy Consortium</p>	<p>Prevention programs are listed and publicized</p> <p>Determine gaps in services (type, geographic access, age groups, etc.)</p>	<p>Contact key stakeholders: government (Parks and Recreation), Chamber of Commerce, Family Resource Coalition, health fairs, Head Start, businesses (Health Insurance Providers), schools, hospitals, other non-profits (United Way, YMCA, Aquatic Center, libraries, senior networks)</p> <p>Introduce purpose of the inventory to potential responders, f/u with email of survey and have results by 8/1/12</p>	<p>See indicators/timeline, process conducted by: WPH, HHS, UW Extension</p>
2. Communication system (Prevention Education/ Screenings and Immunizations)	<p>Look at “successful” web pages on other public health sites</p>	<p>Communication system is established (websites, social media, non-computer, etc. - “How to Stay Healthy in Walworth County” page)</p>	<p>Determine essential elements of website components, links, conduct focus groups for communication strategies, how people hear about services: ongoing</p>	<p>Customer/ consumers, IT/ Communications Specialists, Rep from WC administration</p>

## Work Plan 3:

# Promote health, wellness and prevent chronic diseases across the life span

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
3. Increase the use of age-appropriate preventative services	Promote preventative practices, childhood immunizations	Utilize Aurora health survey data; county health rankings data; health plan data for things like numbers of cholesterol tests, blood glucose tests; immunization rates	Aurora health survey data; county health rankings data; health plan data for things like numbers of cholesterol tests; use data from free clinic when available	Local health systems, free clinic, health plans, health department
4. Employer Initiatives  Help employers recognize the benefits of worksite wellness program	Introduce employers to resources and best practices from the Wellness Council of Wisconsin (WCW) and public health organizations	First priority is to arrange worksite wellness presentations at partner sites. Increase the number of presentations ending in increase number of employers with work site wellness program	Arrange presenters at Partnership sites ASAP. Connect with participating employers to see what they need to implement their worksite wellness program	WCEDA, WCW, Working for Whitewater's Wellness (W3) and area chambers of commerce

# Work Plan 3:

## Promote health, wellness and prevent chronic diseases across the life span

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
<p><b>Physical Activity</b></p> <p>1. Increase physical activity of all residents</p>	<p>Consider adaptation of “Organizations Best Practices on PX Activity, tactic.” “Strong Woman” programs heart, bones. Provide a multicomponent intervention strategy, increased access to programs/facilities that Promote PX</p>	<p>Reduce obesity by 5%</p> <p>Lower obesity rates; maintain or increase number of minutes/day physical activity in schools’ number of programs offering free/low cost physical activity options to residents</p>	<p>Aurora Health Survey and County Health Rankings data; number of minutes of physical activity/day in schools;</p>	<p>Schools, PEP grant participants, parks and rec departments</p>
<p><b>Nutrition</b></p> <p>1. Increase residents’ ability to make healthy food choices</p>	<p>Promote Farmers’ Markets, Farm to school program implementation, school gardens, increase fresh fruit/vegetable, low fat and other healthy options in all schools; community gardens</p>	<p>Increase in number of people at farmers market, increase in number of food pantry, farmers market voucher’s used, increase in SNAP money spent on f/v, amount of WIC f/v money spent; increase in number of people using community gardens</p>	<p>Number of people at Farmer’s Markets, number of food pantry/WIC vouchers used for f/v; number of schools with successful Farm-to-School and/or garden programs; number of people using community gardens</p>	<p>Farmer’s Markets, WIC and Food Pantries, 4H, scouts, schools, PTA/O groups Farmers</p>

## Work Plan 3:

# Promote health, wellness and prevent chronic diseases across the life span

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
2. Grocery Initiative	Best practices Menus Recipes, "Shopping Matters" grocery tours	Number of fruits and vegetables bought Number of recipes taken		4H, scouts, schools, PTA/O groups
3. Employer Initiative (See nutrition and physical activity for more information)	Adapt some of the initiatives from the Waupaca County prevention project with employers/employees	Add incentives to health plans to increase physical activities	Incentive programs are implemented in with five new employers	Employer/employees, insurance providers
4. Vending machine selection	Follow Vending Machine guidelines that were written for the County buildings	Number of healthier vending machines in the County	Ask about vending machines when contracting businesses (survey)	Vending machine companies Businesses Schools Hospitals/physicians offices Gas stations
5. Breastfeeding Increase breastfeeding duration rates at 1 month, 3 months, 6 months and 12 months	Follow 10 steps to a BF friendly Health Department.  Include a question about whether businesses are BF friendly in the County inventory/survey	Rates on the BF report card, AHC stats and on WIC stats increase	Contact businesses to see how BF friendly they are, provide guidance if needed.	Employers Hospitals Schools Health care providers Public Health WIC

Promote physical, mental, spiritual and social wellness within the context of connecting with one's community by individual and community attention to eating wisely, activity, purpose and social connection.

# Work Plan 4: Early Intervention for High Risk Families

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
1. Define high risk families	Develop work group to identify and define high risk priorities	Publish definition agreed to by CHIPP	6/1/2012	HHS, PH, UWEx, Head Start, Schools, Medical Staff, ELN, Law Enforcement, Courts, FRC
2. Strengthen communication to consumers regarding service provisions	Improve communication among service providers: <ul style="list-style-type: none"> <li>Enhance knowledge among service providers of one another's services</li> <li>Conduct a comprehensive analysis of available services to identify overlaps and gaps in services</li> <li>Develop interagency referral procedures,</li> </ul>	<ul style="list-style-type: none"> <li>Collaborative meetings conducted</li> <li>Services inventoried and grid developed</li> <li>MOUs created between and among agencies</li> <li>Procedure in place for referrals, follow-up and tracking.</li> <li>Directory of services created with plan for dissemination; survey community residents and agencies to determine effectiveness</li> </ul>	1/31/2013 Meeting minutes  Services inventory grid distributed and in use  MOUs implemented  Periodic report on interagency referrals and tracking procedures  Survey indicates directory is effective for residents and agencies	HHS, PH, UWEx, Head Start, Schools, Medical Staff, ELN, Law Enforcement, Courts, FRC, consumers

## Work Plan 4: Early Intervention for High Risk Families

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
2. Strengthen communication to consumers regarding service provisions	<p>including follow-up to assure services were accessed</p> <p>Provide an updated directory of services to families and community providers and disseminate effectively, using electronic and print media.</p> <p>Link with identified partners through web sites and published literature</p> <p>Determine best form of communication with customers / consumers</p>	<p>Count-wide partners are linked on-line and through the published directory</p> <p>Consumers identify best contact information and update routinely</p>		

## Work Plan 4: Early Intervention for High Risk Families

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
3. Promote cultural competency in program services across the county	Assess strengths and limitations in service delivery system related to cultural competency	On-going agency competency assessment	Cultural competency assessments show continued progress among agencies	HHS, PH, UWEx, Head Start, Schools, Medical Staff, ELN, Law Enforcement, Courts, FRC, consumers
	Assist service organizations in evaluating and strengthening cultural competency through training and Diversity Circles	Develop plan for on-going cultural competency supports through county-wide training and Diversity Circle activities	Cultural competency assessments show continued progress among agencies  Surveys demonstrate continuous progress	
	Develop translating and interpreting resources for non-English speaking populations	Consumer satisfaction survey provides feedback on cultural competency of agencies and services	Surveys demonstrate continuous progress in availability of translating and interpreting resources	
	Promote dual language learning and communication	Identify and widely distribute resources for language learning	Surveys demonstrate increase in capacity to serve and utilize resources due to increase in dual language speakers	

## Work Plan 4: Early Intervention for High Risk Families

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
3. Promote cultural competency in program services across the county	Improve access to high quality Behavioral Health services for Spanish-speaking families	Recruit and train a Spanish-speaking in-home family therapist	3/1/2012	
4. Identify and inventory current and available services throughout the county that promotes healthy families	<p>Highlight evidenced-based programs</p> <p>Identify the target audience and partners</p> <p>Utilize opportunities for enhanced education:</p> <ul style="list-style-type: none"> <li>• Birth control—methods and availability</li> <li>• Sex education / curriculum</li> </ul>	<p>Prevention programs are listed and publicized</p> <p>Determine gaps in services (type, geographic access, age groups, etc.)</p>	10/31/12	HHS, PH, UWEx, Head Start, Schools, Medical Staff, ELN, FRC, Consumers, Churches, Park Districts



## Work Plan 4: Early Intervention for High Risk Families

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
5. Identify families and members of the families at risk, referring them to the appropriate services without duplicating services.	Create a program for teen dads that emphasizes the importance of their role with the baby and promotes bonding	Identified partners are utilizing the process to refer pregnant teens	1/1/2014 <i>Teen parenting group and teen MOPS</i>	HHS, PH, Schools, Medical Professionals, Family
	Encourage more involvement with the teen's parents (grandparents)			
	Create a program for parenting teens, that works to promote safe parenting, fiscal awareness and planning, future education and job training or placement			
	Develop effective screening for trauma in adults and children to include TSI and Trauma Symptom checklist for kids	Mental Health/AODA team to acquire screening tools and implement them into assessment process	3/1/2012	

## Work Plan 4: Early Intervention for High Risk Families

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
<p>6. Identify and close the gaps in services available to high risk families.</p>	<p>Service providers in Walworth County will work together to provide services to high risk families comprehensively without duplicating services.</p> <ul style="list-style-type: none"> <li>• Enhance knowledge among service providers and county residents regarding services that are available</li> <li>• Develop interagency referral process, including follow-up to assure services are accessed</li> </ul>	<p>Available services will be inventoried and a network developed</p> <p>Develop MOUs between and among agencies</p> <p>Develop procedures to coordinate services for families with a mechanism for evaluation</p>	<p>1/31/2013</p>	<p>Service providers in Walworth County</p>

## Work Plan 4: Early Intervention for High Risk Families

Objectives	Strategies/Evidence-Based Practices	Measures of Success	Indicators and Timeline	Partners
6. Identify and close the gaps in services available to high risk families.	Service providers will train other county providers to identify potential high risk clients and refer appropriately, i.e. have access to the trauma checklist to know what to look for when encountering clients.	County service providers are seamless in operations and referrals within other departments and agencies	1/1/2014	

## Moving Forward

The Community Health Improvement Plan and Process is an ongoing community based, quality improvement endeavor. Subcommittees were formed in November 2011, to address the four (4) Work Plans. The groups identified objectives, strategies with evidence based practices, measures of success, indicators, timelines and community partners. Community members are moving forward into the Implementation Phase.

Each subcommittee has reached out to include more members of the community. The level of expertise and enthusiasm has reflected a collaborative effort that taps into community assets, resources and innovative ideas building on existing services. Subcommittees meet monthly and the Work Plans are updated with new activities. Members of each workgroup have a committed investment to success. Each workgroup is embracing the challenges presented including; time management, barriers to funding and homework assignments.

Accomplishments are beginning to emerge in relationship to the plan and change is taking place.

The common thread that runs through the Work Plans is a focus on prevention across the life span. We set goals to be a Healthier County by 2015 that will be measured by the County Health Rankings Report and reductions in chronic health problems. Healthier lifestyles for all Walworth County residents can be achieved as we move forward.

Interested individuals or organizations are invited to join the effort. To become involved or for more information contact Public Health @ 262-741-3140 or e-mail: [walcoph@co.walworth.wi.us](mailto:walcoph@co.walworth.wi.us).

Walworth County Public Health/Health and Human Services



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