



Marshfield Clinic
Health System



Community Health Implementation Strategy

Marshfield Medical Center

2019-2022



Table of Contents

Page

Executive Summary.....	2
Overview of Community Health Needs Assessment.....	3
Implementation Strategy.....	5
Next Steps.....	15
Approval.....	16
Community Input.....	16
References.....	17

Executive Summary

Health System Overview

Marshfield Clinic was founded in 1916 by six physicians practicing in Marshfield, a rural, central Wisconsin city.

The Clinic became a 501(c)(3) nonprofit organization in 1992 and in 2014, Marshfield Clinic Health System, Inc., was formed. The Health System's mission is to enrich lives and create healthy communities through accessible, affordable, and compassionate health care.

The Health System includes Marshfield Clinics; Marshfield Medical Center hospitals in Marshfield including Marshfield Children's Hospital, Eau Claire, Rice Lake, Neillsville, Ladysmith, Minocqua, Beaver Dam, as well as a joint venture with Flambeau Hospital in Park Falls; Marshfield Clinic Research Institute; Security Health Plan of Wisconsin, Inc. (SHP); and Marshfield Clinic Health System Foundation.

Hospital Overview

Marshfield Medical Center (MMC) is a 315-bed, full-service hospital in Marshfield, Wisconsin. MMC offers primary, secondary, tertiary, and Level II Trauma Center hospital services provided by Marshfield Clinic specialists. MMC, previously Ministry Saint Joseph's Hospital, was acquired by Marshfield Clinic Health System in July 2017.

Implementation Strategy Overview

This Implementation Strategy is specific to MMC and addresses the community health priorities identified through a collaborative Community Health Needs Assessment (CHNA) process. This document outlines the plans for MMC to support specific community improvement efforts as part of a larger community-wide plan.

This plan was reviewed and approved by the authorized governing body, MCHS Hospitals Board, Inc. on September 4, 2019, which is on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed. Evaluation of the previous Implementation Strategy can be found in the 2019 CHNA for MMC, which was a collaborative, joint Community Health Assessment (CHA) report.

Overview of Community Health Needs Assessment

The MMC 2019 CHNA was a joint CHA report conducted in collaboration with the Wood County Health Department and Aspirus Riverview Hospital and Clinics, Inc.

The MMC CHNA written report included a description of the community health needs assessment process, established the community health priorities, and described the following:

- The community served by the hospital and how it was determined
- Community demographics
- The process and methods used to conduct the assessment including data and other information used, methods of collection and analyzing information, cited external source material
- How the hospital acquired input from persons that represent the broad interests of the community
- How data was collected and what types of data were used in the assessment process
- Health priorities and concerns of all population groups including the medically underserved, low-income, and minority groups
- The identified health priorities of both the community and hospital, including the process and criteria used to identify and prioritize identified needs
- Existing resources in the community available to respond to identified priorities

Accessing the Full CHNA Report

The written CHNA report was completed July 2019, presented to the MCHS Hospitals Board, Inc. for discussion and approved September 4, 2019. The full CHNA report, which details the entire assessment and prioritization process, can be found on the [Marshfield Medical Center website](#).

Prioritization Process

After completing an extensive analysis of the primary and secondary data, the National Association of County and City Health Officials (NACCHO) Prioritization Matrix was used to determine the health priorities, which included the following criteria:

- How is the county doing compared to the state and national goals?
- What health priorities have the largest community impact?
- What health priorities have the most serious impact?
- Is the community ready to change?

- Can these health priorities be changed over a reasonable period of time?
- Are there gaps in county efforts to address the health priority?
- Did the community and county data identify this as a health priority?

Health Priorities

The health priorities identified by the joint community health assessment (CHA) were:

- Substance Use
- Behavioral Health
- Active Communities and Community Food Systems

MMC plans to address most of the health priorities identified in the joint CHA. While labeling of the health priorities are different than what were included in the joint CHA report, MMC chose to label the health priorities to align with Marshfield Clinic Health System's Community Health Priorities.

- Alcohol and Substance Abuse
- Behavioral Health
- Chronic Disease
- Social Determinants of Health

As these health priorities are addressed, health equity and social determinants of health needs will be incorporated throughout various initiatives.

Significant Health Needs Not Being Addressed By MMC

MMC will not be directly addressing "Active Communities" as part of the Chronic Disease health priority because Healthy People Wood County's Recreate Health Coalition is leading active communities efforts in Wood County in partnership with various other organizations. MMC will be an engaged partner supporting the efforts of Recreate Health.

Implementation Strategy

The Implementation Strategy is part of a community effort to address identified health priorities. Strategies will be implemented collaboratively with community and Marshfield Clinic Health System partners.

Health Priority 1: Alcohol and Substance Abuse

Goal 1.1: Reduce underage and excessive alcohol consumption

Goal 1.2: Reduce tobacco use

Long-term Indicator	County	State	Nation	Healthy People 2020 Target
Percent of adults aged 18 years who over reported excessive drinking	25% ¹	26% ¹	18% ²	25.4% ³
Percent of high school students who had at least 1 drink of alcohol in the past 30 days	30% ⁴	30% ⁴	30% ⁵	29% ¹³
Smoking during pregnancy	19% ¹	12% ¹	/	/

STRATEGY 1.1: SUPPORT IMPLEMENTATION OF AN ALCOHOL AND OTHER DRUG ABUSE (AODA) PREVENTION CURRICULUM

Objective 1.1.1: By September 2022, MMC will support the implementation of an AODA prevention curriculum to reduce underage alcohol consumption and/or prevent substance use and abuse.

Key Actions

- Help determine school partners to implement
- Help create and compile program materials
- Help develop schedule for implementation

Potential Collaborative Partners

- School Districts
- Local AODA prevention coalition

Resources

- Staff time
- Program materials and supplies

- Funding as appropriate to address community health priority

Target Population

- Youth

STRATEGY 1.2: IMPROVE REFERRALS/ACCESS TO SUPPORT TOBACCO CESSATION FOR PREGNANT WOMEN

Objective 1.2.1: By September 2022, MMC will participate in convening community partners to explore community processes for connecting pregnant women who use tobacco products (including electronic nicotine delivery systems) to tobacco cessation services and resources.

Key Actions

- Connect with community partners who serve pregnant women
- Convene community organization who serve pregnant women to discuss community processes
- Assess current community processes for referring pregnant women who smoke to tobacco cessation resources

Potential Collaborative Partners

- MMC OB Department
- SHP Wellness Team
- Institute for Quality, Innovation and Patient Safety (IQIPS)
- First Breath Program
- Quit Line
- University of Wisconsin – Center for Tobacco Research Institute
- Wood County Health Department
- Community organizations who serve pregnant women

Resources

- Staff time
- Supplies and materials
- Facility / space

Target Population

- Pregnant women who use tobacco

STRATEGY 1.3: ENGAGE IN AODA PREVENTION COMMUNITY GROUPS

Objective 1.3.1: By October 2019, MMC staff will actively engage in one community coalition that addresses AODA.

Key Actions

- Actively attend and engage in meetings
- Promote and participate in events and initiatives

Potential Collaborative Partners

- Healthy People Wood County
- AOD Prevention Partnership
- Wood County Drug Taskforce
- Wood County Health Department
- Marshfield Area Coalition for Youth

Resources

- Staff time
- Funding, supplies, and materials provided as appropriate to address community health priority

Target Population

- Broader community

Health Priority 2: Behavioral Health

Goal 2.1: Decrease suicide rates

Goal 2.2: Improve social and emotional development of children and adolescents

Long-term Indicator	County	State	Nation	Healthy People 2020 Target
Wood County suicide rate per 100,000	14.6 ⁶	15.4 ⁷	14 ⁷	10.2 ⁸
Percent of students who made a suicide attempt that resulted in injury, poisoning, or an overdose that had to be treated by a doctor or nurse during the past 12 months	3.1% ⁴	2.5% ⁴	2.4% ⁹	1.7% ⁹

STRATEGY 2.1: PROVIDE COMMUNITY TRAINING RELATED TO MENTAL HEALTH AND SUICIDE PREVENTION

Objective 2.1.1: By September 2022, MMC will partner with local community organizations to train 500 Wood County residents in QPR.

Key Actions

- Identify organizations and communities that need QPR training
- Conduct and/or help coordinate QPR trainings

Potential Collaborative Partners

- Wood County Health Department
- Marshfield Area Coalition for Youth – Mental Health Coalition
- Healthy People Wood County – Mental Health Matters
- QPR trainers

Resources

- Staff time
- QPR Program materials
- Funding as appropriate to address community health priority

Target Population

- Broader community

STRATEGY 2.2: IMPLEMENT ZERO SUICIDE SYSTEM-WIDE

Objective 2.2.1: By September 2020, MMC will conduct a workforce assessment to understand capacity and needs for addressing suicide prevention.

Objective 2.2.2: By September 2022, MMC will acquire a project manager to lead the implementation of Zero Suicide, which is a continuous quality improvement framework for transforming suicide prevention in health and behavioral health care systems.

Objective 2.2.3: By September 2022, MMC will adopt Zero Suicide.

Key Actions

- Convene planning meetings
- Establish a Zero Suicide Implementation Team
- Implementation Team attend training

- Collaborate with Zero Suicide experts for consultation
- Acquire project manager for Zero Suicide
- Engage and train MMC staff
- Integrate assessment into electronic medical records

Potential Collaborative Partners

- MCHS departments and entities (Center for Community Health Advancement (CCHA); IQIPS; Emergency Department; Behavioral Health; Division of Education (DOE))
- Law enforcement
- Wood County - Crisis
- Community members with lived experiences

Resources

- Staff time
- Materials and supplies
- Funding as appropriate to address health priority

Target Population

- MMC Staff
- Patients and community members who are at risk for suicide

STRATEGY 2.3: DEVELOP AODA AND MENTAL HEALTH RESOURCE APP

Objective 2.3.1: By September 2022, MMC will develop an app focused on providing community members access to information about existing AODA and mental health services and resources.

Key Actions

- Compile evidence-based substance use and mental health resources
- Engage students in assisting with development of app
- Contract with an app developer (Biomedical Informatics Research Center – BIRC)
- Identify local schools interested in piloting App
- Conduct youth focus groups to evaluate effectiveness and accessibility of App

Collaborative Partners

- National Institute of Mental Health (NIMH)

- Substance Abuse and Mental Health Services Administration (SAMSHA)
- National Institute of Drug Abuse (NIDA)
- Centers for Disease Control and Prevention (CDC)
- Local School Districts
- BIRC

Resources

- Staff time
- Print and advertising materials
- Translation services during content development
- Funding as appropriate to address health priority

Target Population

- Youth

STRATEGY 2.4: PROVIDE BEHAVIORAL HEALTH SUPPORT IN SCHOOLS

Objective 2.4.1: By September 2022, MMC will support two behavioral, social, emotional learning trainings for elementary school staff.

Key Actions

- Actively attend and participate in meetings
- Promote and participate in events and initiatives

Potential Collaborative Partners

- SHP
- Dr. Eric Hartwig

Resources

- Staff time
- Printing, materials, marketing
- Funding as appropriate to address community health priority

Target Population

- Elementary school staff

STRATEGY 2.5: ENGAGE IN MENTAL HEALTH COMMUNITY GROUPS

Objective 2.5.1: By October 2019, MMC staff will actively engage in one community coalition that addresses mental health.

Key Actions

- Actively attend and engage in meetings
- Promote and participate in events and initiatives

Potential Collaborative Partners

- Healthy People Wood County
- Mental Health Matters
- Wood County Health Department
- Marshfield Area Coalition for Youth

Resources

- Staff time
- Funding, supplies, and materials provided as appropriate to address community health priority

Target Population

- Broader community

STRATEGY 2.6: CONDUCT A COMMUNITY MENTAL HEALTH AWARENESS CAMPAIGN

Objective 2.6.1: From September 2019 – September 2022, conduct a community mental health awareness campaign that includes collaborative community educational and engagement events and activities.

Key Actions

- Plan community events and activities
- Promote and participate in events and initiatives

Potential Collaborative Partners

- Healthy People Wood County
- Mental Health Matters
- Wood County Health Department
- Marshfield Area Coalition for Youth
- Local community organizations and groups

Resources

- Staff time
- Funding, supplies, and materials provided as appropriate to address community health priority

Target Population

- Broader community

Health Priority 3: Chronic Disease

Goal 3.1: Improve access to healthy foods and physical activity

Goal 3.2: Improve self-management of chronic conditions

Long-term Indicator	County	State	Nation	Healthy People 2020 Target
Percent of Obese Adults	29% ¹	31% ¹	29% ²	30.5% ¹⁰
Percent of children in WIC Obesity (ages 2-5, enrolled in WIC program)	/	15% ¹¹	14% ¹¹	9.4% ¹²

STRATEGY 3.1: IMPROVE ACCESS TO HEALTHY CHOICES

Objective 3.1.1: By September 2022, MMC will implement a hospital-wide educational campaign regarding sugar sweetened beverages.

Key Actions

- Identify or develop educational materials
- Identify locations/areas within MMC to display sugar shockers
- Collaborate with community partners to ensure campaign aligns with community messages

Potential Collaborative Partners

- MMC Cafeteria Staff
- Federal, state or local organizations that have educational materials on sugar sweetened beverages
- Healthy People Wood County

Resources

- Staff time
- Funding as appropriate to support health priority

Target Population

- MMC staff, patients, visitors

STRATEGY 3.2: IMPLEMENT A PRIMARY PREVENTION STRATEGY TO SUPPORT CARE DELIVERY EFFORTS RELATED TO CHRONIC DISEASE MANAGEMENT

Objective 3.2.1: By September 2022, MMC will complete one community health screening for community members.

Objective 3.2.2: By September 2022, MMC will refer 100% of community members who were screened and are at risk for diabetes to a diabetes prevention program.

Key Actions

- Work with internal partners to plan events
- Track and monitor progress of biometric screening events
- Evaluate community members for social determinants of health needs
- Refer community members to health coaches
- Refer uninsured community members to patient navigators
- Refer community members to diabetes prevention programs
- Assist with connecting community members to a primary care provider

Potential Collaborative Partners

- Internal MCHS teams
- Community volunteers
- YMCA of Marshfield

Resources

- Staff time
- Supplies and materials
- Facility / space

Target Population

- Broader community
- Community members who have chronic conditions or are at risk

STRATEGY 3.3: ENGAGE IN CHRONIC DISEASE COMMUNITY GROUPS

Objective 3.3.1: By October 2019, MMC staff will actively engage in one community coalition that addresses chronic diseases.

Key Actions

- Actively attend and engage in meetings
- Promote and participate in events and initiatives

Potential Collaborative Partners

- Healthy People Wood County
- Recreate Health Coalition
- Wood County Health Department
- Healthy Lifestyles Marshfield Area Coalition

Resources

- Staff time
- Funding as appropriate to address community health priority

Target Population

- Broader community

Health Priority 4: Social Determinants of Health

STRATEGY 4.1: SCREEN PATIENTS, MEMBERS, AND COMMUNITY FOR SOCIAL DETERMINANTS OF HEALTH NEEDS USING A STANDARDIZED ASSESSMENT TOOL

Objective 4.1.1: By September 2022, MMC will support the development or obtainment of a universal screening tool for assessing social determinants of health needs for MCHS patients, SHP members and community members.

Key Actions

- Explore existing universal screening tools
- Identify key partners across MCHS entities (clinics, SHP)

Potential Collaborative Partners

- Internal MCHS partners (clinic, SHP)
- Universal screening tool developer

Resources

- Staff time
- Marketing
- Funding as appropriate to address health priority

Target Population

- Marginalized and low income populations

- Populations with social determinant of health needs

STRATEGY 4.2: CAPACITY BUILDING AND LEADERSHIP DEVELOPMENT IN MARGINALIZED COMMUNITY

Objective 4.2.1: By September 2022, MMC will support the efforts of capacity building and leadership development in one marginalized community in Wood County.

Key Actions

- Assist in planning, development and implementation process as needed
- Attend and be engaged in meetings
- Identify marginalized community

Potential Collaborative Partners

- Healthy People Wood County
- Wood County Health Department
- Aspirus Riverview Hospital
- In courage Community Foundation
- Local community members

Resources

- Staff time
- Facility space for meetings
- Funding as appropriate to support health priority

Target Population

- Marginalized community

Next Steps

This implementation strategy outlines a three-year community health improvement process. Each year within this timeframe, MMC will:

- Create an annual work plan with specific action steps for that year
- Set and track annual performance indicators for each strategy, evaluate for effectiveness and areas of improvement.
- Track progress toward long-term performance indicators
- Report progress toward the performance indicators to the hospital board

- Share actions taken to address the needs with the community at large

Approval

This Implementation Strategy Report was adopted by the MCHS Hospitals Board, Inc. on September 4, 2019.

Community Input

If you would like to serve on a coalition that helps meet the aims of this report, or have a comment on this assessment, please contact the Marshfield Clinic Health System's Center for Community Health Advancement at communityhealth@marshfieldclinic.org or (715) 221-8400.

References

1. County Health Rankings. (2018). Wood County. Retrieved from <https://www.countyhealthrankings.org/app/wisconsin/2019/rankings/wood/county/factors/overall/snapshot>
2. County Health Rankings. (2019). National Data. Retrieved from <https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation>
3. Healthy People 2020. (n.d.). Reduce the proportion of adults who drank excessively. Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse/objectives>
4. Healthy People Wood County. (2017). Wood County Youth Behavioral Health Survey. Retrieved from <https://static1.squarespace.com/static/585a36e0cd0f681882faf326/t/5b5790b76d2a73c04df48043/1532465336745/YRBS+2017+Completed.pdf>
5. Center for Disease Prevention and Control. (2017). Youth Behavioral Health Survey. Retrieved from <https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2017/ss6708.pdf>
6. Wisconsin Division of Health. (2013). WISH Data Query System. Retrieved from <https://www.dhs.wisconsin.gov/wish/index.htm>
7. Healthy People 2020. (n.d.). Suicide (age adjusted, per 100,000 population). Retrieved from <https://www.healthypeople.gov/2020/data-search/Search-the-Data#objid=4804;>
8. Health People 2020. (n.d.). Reduce the suicide rate. Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives>
9. Healthy People 2020. (n.d.). Suicide attempts by adolescents that required medical attention. Retrieved from <https://www.healthypeople.gov/2020/data-search/Search-the-Data#objid=4810;>

-
10. Healthy People 2020. (n.d.). Reduce the proportion of adults who are obese. Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status/objectives#4968>
 11. The State of Obesity. (2014). Obesity Among WIC Participants Ages 2-4. Retrieved from <https://www.stateofobesity.org/wic/>
 12. Health People 2020. (n.d.). Reduce the proportion of children aged 2-5 years who are considered obese. Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status/objectives#4968>
 13. Healthy Wisconsin. (2018). Wisconsin State Health Improvement Plan 2018 Addendum. Retrieved from <https://www.dhs.wisconsin.gov/publications/p01791a.pdf>