SSMHealth

2025-2027

Community Health Needs Implementation Strategy

SSM Health Ripon Community Hospital

845 Parkside Street | Ripon, WI 54975

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Message to Our Community

SSM Health Ripon Community Hospital has delivered exceptional, compassionate care to Ripon community for more than 85 years. We are guided by our Mission – Through our exceptional health care services, we reveal the healing presence of God, and our values of compassion, respect, excellence, stewardship, and community.

Our sustained community commitment can be seen through our collaborative partnerships with residents and organizations. We rely on these relationships to help us identify and develop plans to address high-priority community health needs.

Over the last 12 months, in collaboration with our community partners, we have conducted a community health needs assessment by gathering health-related information. We have also conducted 10 interviews, 12 community conversations, two surveys with more than 1,000 respondents to identify concerns about the health of these communities and the number of area-based programs and organizations that exist to address their needs. These discussions identified needs that were prioritized based on the level of importance to community members and the hospital's ability to truly make an impact.

The priorities we will address over the next three years:

#1 – Mental Health: access to services, stigma, and social support

#2 – Substance Use: drinking culture, prevention, and access to services

#3 – Access to Health Care: transportation, affordability, and unmet care needs

During this time, SSM Health Ripon Community Hospital will further develop its community partnerships and deliver an exceptional experience through high-quality, accessible and affordable care to all residents. Please visit our website at Wisconsin: Community Health Needs Assessments | SSM Health to learn more about how we will continue to make a difference in our community.

I welcome your thoughts on how we can create a healthier Ripon.

Sincerely,

DeAnn Thurmer
President, SSM Health Ripon Community Hospital

Executive Summary

Background

SSM Health Ripon Community Hospital is pleased to present the 2025-2027 Community Health Improvement Plan (CHIP). The Affordable Care Act (ACA) requires 501C(3) tax-exempt hospitals to conduct Community Health Needs Assessments (CHNA) every three tax years. The link to the full 2024 CHNA can be found in Appendix B. Additionally, it is required to adopt strategic implementation plan for addressing the identified needs because of the CHNA. The 2025-2027 CHIP document will serve as the living document and strategic actional plan to address the top three health priorities in our service area. The 2025-2027 Community Health Improvement Plan for SSM Health Ripon Community Hospital was approved by the Wisconsin regional board on February 25th, 2025.

Priorities

The top three identified health priorities we will address over the next three years include:

Mental Health

access to services, stigma, and social support

Substance Use

drinking culture, prevention, and access to services

Health Care Access

transportation, affordability, unmet care needs

We will review these priorities using the following lenses:

- **Health Equity**: Each health area will apply a health equity lens to its initiatives, as well as incorporate initiatives that address social determinants of health, local community conditions, and a trauma informed approach.
- **Social Determinants of Health (SDoH):** SDoH are the conditions in which people are born, grow, live, work, and age. Access to care, social economic factors, cultural competency, and other factors surfaced as common health concerns, and were identified as a theme in barriers and challenges to good health.

Strategies

The hospital will collaborate with community partners to leverage available resources, expertise, and capacity to collectively address the health priorities identified. Strategies for priority needs may include but are not limited to the following:

- Mental Health: increase access to services, decrease mental health stigma in youth and adults, increase social supports
- Substance Use: decrease drinking culture, increase prevention resourcing and funding, increase access to services
- Health Care Access: increase transportation opportunities, identify affordable options, decrease unmet care needs

About SSM Health & Ripon Community Hospital

SSM Health
Nationally recognized for quality and innovation, SSM Health is a Catholic, not-for-profit, fully integrated health system working to advance health equity and empower all people to achieve their full potential.

With care delivery sites in Illinois, Missouri, Oklahoma, and Wisconsin, SSM Health provides convenient access to high-quality community-based services as well as world-class academic medicine, clinical trials, and research studies. The organization's footprint includes hospitals, physician offices, outpatient and virtual care services, senior care, comprehensive home care and hospice services, a fully transparent pharmacy benefit company, a health insurance company, and an accountable care organization. As one of the largest employers in every community it serves, the organization's 40,000 team members and 13,900+ providers are dedicated to fulfilling SSM Health's Mission.

Through our exceptional health care services, we reveal the healing presence of God.

Highlight of services
Located in Ripon, Wisconsin, SSM Health Ripon Community Hospital has been providing quality health care with a personalized approach for more than 85 years. The facility features 16 private patient rooms — 13 are medical/surgical rooms and three are part of the Intensive Care Unit (ICU). Surgical services are available on the hospital's first floor, immediately by the main entrance, and feature three surgical suites and one endoscopic procedure room. Care at SSM Health Ripon Community Hospital is complemented by hospitalists — physicians that specialize in taking care of patients while they are hospitalized. Emergency care and urgent care services are available 24 hours a day, seven days a week through highly-qualified physicians and nurses in the Emergency Department.

Community benefit
In 2023 SSM Health Ripon Community Hospital-Ripon provided more than $2,669,044 in community benefit, comprised of charity care, community services and unpaid costs of Medicaid and other public programs. Examples of out community benefit programs include:

- Community based health education
- Staff time on community coalitions and service to local nonprofits
- Financial sponsorship to local community partners

Hospital at a glance	
Admissions	436
ER visits	9,628
Beds	16
Employees	155
Medical staff	138
Volunteers	76

Introduction

Acknowledgements

Thank you to everyone who participated in the development of the Community Health Improvement Plan (CHIP). We would like to give a special thank you to the following groups and organizations who devoted time and efforts in developing the CHIP:

A full list of community partners, individuals and organizations that have assisted throughout the community health improvement process is in Appendix A.

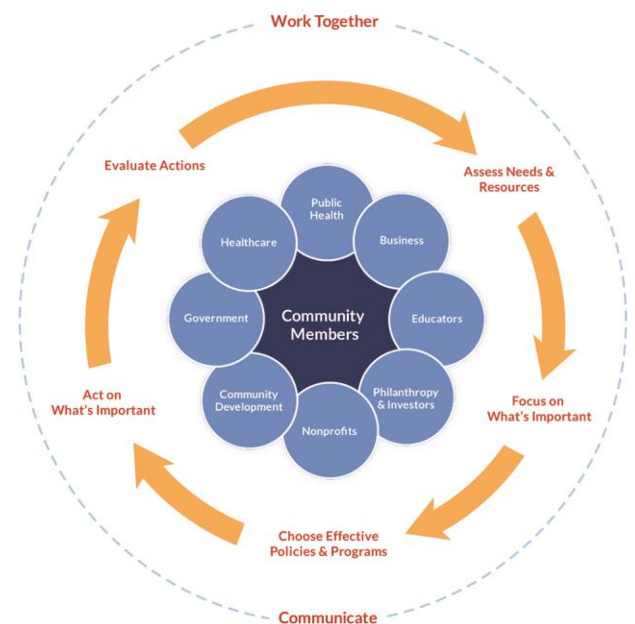
Considerations

Access to health care is a new priority area and team identified out of the 2024 CHNA. Future meetings have been set with community partners and individuals who indicated interest. Meetings have been scheduled, but no action team has been officially named at this time. This will be ongoing work that will be evolving through this CHIP process. Historically, chronic disease had been a longstanding action team that did not maintain its place as one of the top three health priorities. Chronic disease action team Living Well will continue their work and goals but will not be reported out in this CHIP. Additionally, the Ripon community is located entirely within Fond du Lac County and majority of its primary and secondary service areas include Fond du Lac County. Green Lake and Dodge counties are also within our service areas, and we continue to grow and expand efforts in those spaces.

Community Health Improvement Process Overview

Since 1933, Wisconsin State Statues have required communities throughout Wisconsin to develop and implement local health plans to address health conditions affecting their residents. This process is the "community health improvement process." This process has two major phases: the CHNA and CHIP. These two processes work together to assess the unique needs of communities, and allow public and private sectors to work collaboratively to address the identified health needs.

The development of our CHNA and CHIP, have followed guidelines and processes from our WI guidebook on Improving the Health and Local Communities, which is built on the Take Action Cycle by Community Health Rankings and Roadmaps. The CHNA aligns with the Assess Needs and Resources and identify our Focus on What's Important component of the cycle. The CHIP aligns with Choosing Effective Policies & Programs, Act on What's Important and Evaluating Actions.



Assess Needs and Resources
- Collect and analyze community health data
- Consider data to analyze health disparities
- Examine data on the underlying determinant of health
- Consider issues and themes identified by stakeholder and the community
- Identify community assets and resources

Focus on What's Important
- Identify set of priority community health issues to address
- Align the local health improvement plan with state and national priorities
- Summarize and disseminate the results of the assessment of the community

Choose Effective Policies and Programs
- Engage partners to plan and implement strategies
- Choose effective strategies
- Have a multilevel approaches to change, including policy approach

Act on What's Important
- Develop a detailed action plan
- Use a work plan to actively track progress
- Maintain momentum

Evaluate Actions
- Evaluate and monitor the process and the outcomes/indicators
- Revise the action plan based on evaluation results

Work Together and Community
- Collaborate with stakeholders and community members and communicate throughout
- Include broad participation from community

Community Health Improvement Process Overview

Greater Fond du Lac area stakeholders and community members came together through various coalitions, committees and workgroups to develop the 2025-2027 CHIP in response to the community health priorities identified through the 2024 CHNA. The Healthy Fond du Lac Steering Committee identified three health priorities based on a two-step prioritization process. A less of criteria was developed to aid in the selection of priority areas, which included:

- Alignment: the degree to which health issue aligns with our mission and strategic priorities.
- Feasibility: the degree to which the community can address the need through direct programs, clinical strengths, and dedicated resources.
- Partnerships: the degree to which there are current or potential community partners or coalitions.
- Health Equity: the degree to which disparities exist and can be addressed.
- Measurable: the degree to which measurable impact can be made to address the issue.
- Upstream: the degree to which the health issue is upstream from and a root cause of other health issues.

Based on the steering committee's final prioritization, the top-ranking priorities established the health areas of focus for the 2025-2027 CHIP.

The Top Three Priority Health Areas Identified for the 2025-2027 CHIP Include:

Mental Health

access to services, stigma, and social support

Substance Use

drinking culture, prevention, and access to services

Health Care Access

transportation, affordability, unmet care needs

The CHIP is a three-year work plan, intended to be a community effort and remain fluid to allow for the greatest community impact. The CHIP was developed in collaboration with the Fond du Lac County Health Department, Healthy Fond du Lac County Steering Committee, Drug Free Communities of Fond du Lac, Living Well Coalition, Fond du Lac County Mental Health Action Team, Access to Health Care Workgroup, and other community partners. The three-year CHIP should include evidence-informed strategies, multi-level approaches to change, emphasizing policy level change, and addressing existing health inequalities and disparities. Throughout the CHIP a health equity lens should be applied to ensure equal and equitable access to health and well-being for everyone. Additionally, the CHIP should include strategies utilizing social determinants of health and health equity which interplay between, individual, relationship, community and societal factors that impact health.. These models and frameworks can be found in Appendix C. The highlights and accomplishments of the past 2022-2024 CHIP can be found in Appendix D.

Community Health Improvement Process Overview

SSM Health Ripon Community Hospital and the Fond du Lac County Health Department hosted three community health improvement strategy sessions on: Mental Health, Substance Use and Access to Health Care. These sessions set the stage for the 2025-2027 community health improvement plan. Mental health, substance use and access to health care were identified as the top priority areas from the 2024 Community Health Needs Assessment. The strategy sessions were attended by community members (nonprofits, health care systems, government agencies and more, and showcases all the hard work our community does every day to tackle these issues.

Mental Health

- Monday, January 13, 2025
- Content Experts: Tiffany Parker and Michelle Dahlke, SSM Behavioral Health Leaders
- 48 attendees

Substance Use

- Tuesday, January 14, 2025
- Content Experts: Jeanette Morales, Drug Free Communities Coordinator, Rebecca Guynn, Department of Social Services Supervisor
- 34 attendees

Access to Health Care

- Thursday, January 16. 2025
- Content Experts: Shane Smith and Dr. Brent Meier, SSM Health-St. Agnes Hospital Leadership
- 43 attendees

Priority 1: Mental Health

Mental health was identified as the number one priority to address as a result of the 2024 CHNA. Mental health needs in Greater Fond du Lac area may include but is not limited to challenges, barriers or needs related to provider availability, affordability, transportation, insurance, stigma, substance use, culturally sensitivity and diverse providers and services, stress, and suicide.

Mental Health Overview in Fond du Lac County

15 deaths by suicide reported in 2024.

20% of adults reported to have a mental health condition in the past three years.

49% of youth reported significant problems with feelings (anxious, nervous, tense, etc.).

14% of households reported not receiving mental health care as needed.

67% of adults strongly agreed that mental health concern can be as serious as a physical concern.

Mental Health Goals

Goal 1: Increase access to behavioral health services

Performance Measures/Objectives:

- Percent of adults who report that they or someone in their household “did not get the mental health care needed”
- Precent of adults who consider someone seeing a therapist or psychiatrist as a sign of strength
- Percent of adults who consider taking medication to treat mental health issue as a sign of strength (note: the 2017 question related to this was percentage of adults who agree that “people are caring and sympathetic toward persons with mental illness”

Strategies:

Individual Level	Community Level	Organizational Level	Policy Level
Promote Virtual Behavioral Health Integration (VBHI) in primary care and telehealth options.	Support, build and maintain community support groups and tools (pathways to care document, NAMI peer to peer groups, local support groups).	Provide Schwartz Rounds quarterly in all hospital settings. Provide peer grief support groups (i.e. Care for the Caregivers) and Zero Suicide.	Encourage local employers to adopt a sick leave policy to include mental health (Workplace Mental Health Toolkit).

Priority 1: Mental Health

Goal 2: Decrease number of deaths by suicide

Performance Measures/Objectives:

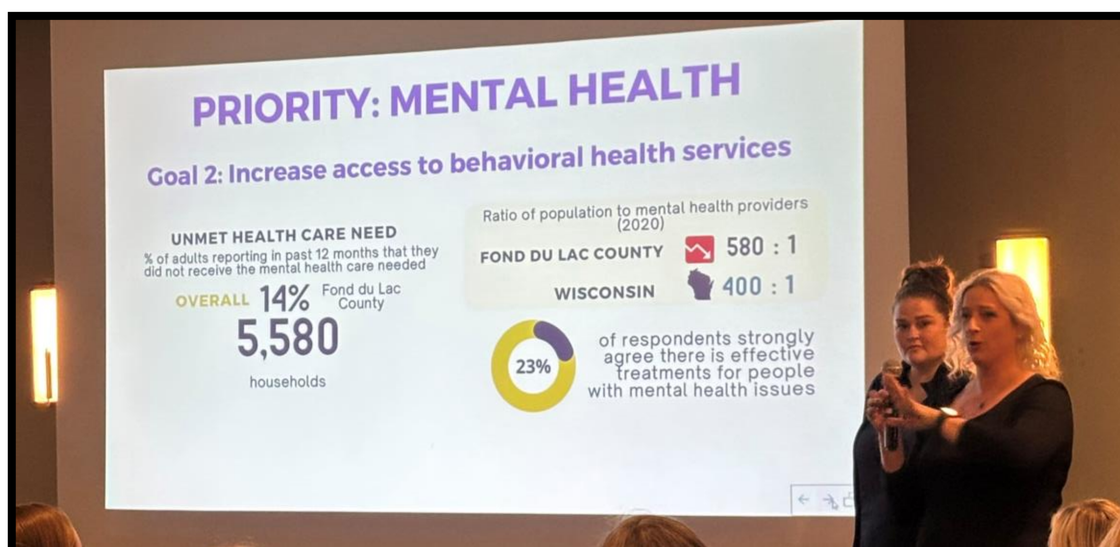
- Fond du Lac County deaths by suicide
- Percentage of Fond du Lac County adults who report they “considered suicide”
- Percentage of Fond du Lac County youth who report they “seriously considered suicide”
- PHQ9 screening rate in Fond du Lac County

Strategies:

Individual Level	Community Level	Organizational Level	Policy Level
Have SSM staff attend SODRT (Suicide Overdose Death Review Team) at every meeting.	Host at least 4 QPR trainings per year.	Promote Zero Suicide work and expand HeartMath education and training.	Encourage local employers to adopt a sick leave policy to include mental health (Workplace Mental Health Toolkit).

Mental Health Workgroup: Fond du Lac County Mental Health Action Team

- Has been in existence for more than 15 years.
- Has membership of over 20 agencies and organizations.
- For more information and to join the workgroup click here.



DRUG FREE COMMUNITIES of Fond du Lac

Priority 2: Substance Use

Substance use was identified as the number two priority to address in the 2025-2027 CHIP. Substance use needs in Greater Fond du Lac area may include but are not limited to barriers, challenges and needs related to tobacco, vaping, drugs (narcotics, marijuana, etc.) prescription medications, and alcohol use, mental health and access to care. Throughout the CHNA, substance use was consistently a top-ranking priority.

Alcohol and Other Drug Use Overview in Fond du Lac County

18 opioid related deaths in 2022, compared to 24 in 2020.

16% of youth reported drinking alcohol in the past month.

7% of youth reported binge drinking in the past month.

6% of youth who bought or drank alcohol at a community event.

44% of youth who this the community is “actively discouraging” or ”think it isn’t ok” underage drinking.

33% of youth who report they talked with their parents about alcohol in the past month.

27% of adults reported *binge drinking alcohol in the past month.

71% of adults reported drinking alcohol in the past month.

4% of youth who report using prescription medication for non-medical use.

23% of youth who report relative ease in obtaining prescription medication for non-medical use.

*Binge drinking is defined as 4+ drinks per occasion for women and 5+ drinks per occasion for men.

Substance Use Goals

Goal 1: Decrease underage drinking and binge drinking

Performance Measures/Objectives:

- Percent of youth reported binge drinking alcohol in the past month
- Percent of youth drinking alcohol in the past month
- Percent of youth who bought or drank alcohol at a community event
- Percent of youth who think the community is “actively discouraging” or “think it isn’t OK” underage drinking
- Percent of youth who report they talked with their parents about alcohol in the past month

Strategies:

Individual Level	Community Level	Organizational Level	Policy Level
Promote alcohol youth prevention programs (i.e. FACT and STAAND).	Host a Small Talks Campaign, annually. Build a Community Events Best Practice Toolkit	Fund and promote alcohol youth prevention work	Request sponsorship events to adhere to community events best practice toolkit

DRUG FREE COMMUNITIES

of Fond du Lac

Priority 2: Substance Use

Goal 2: Decrease misuse of opioids and prescription medications

Performance Measures/Objectives:

- Percent of youth who report using prescription medication for non-medical use
- Percent of youth who report relative ease in obtaining prescription medication for non-medical use
- Deaths by drug overdose

Strategies:.

Community Level	Organizational Level
Promote drug take back campaigns, annually and report poundage disposed. Promote FDL for Recovery's message.	Monitor quarterly PDMP and follow up with providers to ensure best practices are being followed. Report quarterly on poundage disposed from internal drug disposal bins.

Substance Use Workgroup: Drug Free Communities of Fond du Lac

- Has been in existence for more than 15 years.
- Has membership of over 20 agencies and organizations.
- For more information and to join the workgroup click here.

Priority 3: Health Care Access

Lastly, health care access is the newest health priority for the 2025-2027 CHIP. During the goal setting session hosted by the Fond du Lac County Health Department and facilitated by the Office of Policy and Practice Alignment (OPPA) on December 5, 2024, financial barriers and lack of insurance and transportation were the most significant barriers to accessing care identified during the CHNA.

Health care access is not limited to the above-mentioned barriers to care. However, during the goal setting session health navigation and transportation were the most mentioned themes from the group. Since health care access is a new priority area majority of the work will be initial and data collection to better understand the need. Also, a new community workgroup will be formed and start the work outlined in this CHIP.

Health Care Access Overview in Fond du Lac County

23% of adults reported delaying or not seeking medical care because of cost

32% of adults reported someone in their household did not receive the health care needed in 2023

62% (about 4,200) of acute care patients at Ripon Hospital screened positive for transportation access in 2024

5.6% or 106 calls to 2-1-1 for transportation assistance (low-cost public or long-distance travel) were placed in 2023

Health Care Access Goals

Goal 1: Increase utilization of health navigators in the community

Performance Measures/Objectives:

- Percent of adults who reported delaying or not seeing medical care because of cost
- Percent of adults who reported someone in their household did not receive health care needed
- # of in-person appts compared to virtual appts (SSM Health)
- Percent of acute care patients screened for social determinants of health – transportation access
- Percent of calls to 2-1-1 for transportation assistance

Strategies:

Individual Level	Community Level	Organizational Level	Policy Level
Participate in new access to health care workgroup, at least six times annually.	Conduct an environmental scan of transportation resources.	Build pathways document for patients to access transportation services.	Reevaluate current patient transportation policy to be useful and concise.

Access to Health Care Workgroup will meet for the first time in March 2025.

Health Equity Lens

Health Equity: Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being. - World Health Organization

Health Disparity: Health disparities include differences in health outcomes, such as life expectancy, mortality, health status, and prevalence of health conditions. Health care disparities include differences between groups in measures such as health insurance coverage, affordability, access to and use of care, and quality of care. Disparities occur across multiple factors including race and ethnicity, socioeconomic status, age, geography, language, gender, disability status, citizenship status, and sexual identity and orientation. Reflecting the intersectional nature of people's identities, some individuals experience disparities across multiple dimensions.

Performance Measures/Objectives:
- Percent of acute care patients screened for social determinants of health
- Percent of patients using SSM Health Samaritan Clinic

Strategies:

Mental Health	Substance Use	Access to Health Care
Decrease barriers for unhoused individuals/families to receive mental health services, specifically medication assessments.	Decrease barriers for unhoused individuals/families to receive addiction services, specifically medication assessments.	Decrease barriers for unhoused individuals/families to enroll in Samaritan Clinic.

SSMHealth

2025-2027

Appendices

SSM Health Ripon Community Hospital

845 Parkside Street | Ripon, WI 54975

Appendix A: CHIP Collaborators

Mental Health Collaborators:

First Name	Last Name	Organization
Brooke	Mathes	Fond du Lac Police Department
Cathy	Loomans	The Center - City of FdL's Hub for Active Older Adults
Dan	Hebel	Boys and Girls Club
Jeanette	Morales	DFC/United Way
Julie	Feilbach	Blandine House
Kate	Nickel	Froedtert
Kim	Mueller	Fond du Lac County Health Department
Laura	Nakielski	SSM Health
Nicole	Johnson	Fond du Lac County Health Department
Paula	Morgen	Thedacare
Raine	Bleecker	Fond du Lac County Health Department
Rob	Toepel	Ripon School District
Robyn	Wise	Fond du Lac County Health Department
Sarah	Gradinjan	Fond du Lac County Health Department
Sue	Mitchell Metz	NAMI Fond du Lac
Zoe	Burckle	ADVOCAP
Tiffany	Parker	SSM Health
Deb	Shepro	ADVOCAP
Missy	Tate	SSM Health
Wendy	Compton	The Beacon House
Johanna	Brotz	Fond du Lac County Health Department
Heather	Larson	United Way
Jillian	Vande Zande	SSM Health OPBH
Isabel	Williston	ASTOP, Inc Sexual Abuse Center
Emily	Clark	Network Health
Heather	Schmidt	SSM Health
Megan	Ketter	Community Member
Jolene	Schatzinger	Womens Fund
Chris	Burnett	Yscreen
Katie	Pickhardt	Lakeland Care Plus
Mary	Noel Brown	SSM Health
Kristen	Theisen	Moraine Park Technical College
Valerie	Vande Zande	St Agnes Hospital, BH Outpatient
Chelsea	Puetz	St Mary Springs
Elizabeth	Wilson	UW-Green Bay/FCHD Intern
Sarah	Davis	Fond du Lac Public Library
Shari	Nett	ADVOCAP
Holly	Mulder	ARYA
Jason	Berdyck	Lakeland Care
Tom	Brockway	Exchange Club of Fond du Lac
Marcia	Fischer	Exchange Club of Fond du Lac
Pam	Sippel	Boys and Girls Club
Jen	Davies	Community Member
Eddie	Vossekuil	Victory Hills Wellness & Lifecoaching
Michelle	Dahlke	SSM Health

Substance Use Collaborators:

First Name	Last Name	Organization
Cathy	Loomans	The Center - The Hub for Active Older Adults
Jeanette	Morales	DFC/United Way
Julie	Fleibach	Blandine House
Katherine	Griffith	County Board Supervisor & Human Services Board Member
Kathryn	Reinke	SSM Health
Kim	Mueller	Fond du Lac County Health Department
Laura	Nakielski	SSM Health
Nicole	Johnson	Fond du Lac County Health Department
Raine	Bleecker	Fond du Lac County Health Department
Robyn	Wise	Fond du Lac County Health Department
Sarah	Gradinjan	Fond du Lac County Health Department
Sue	Mitchell Metz	NAMI Fond du Lac
Zoe	Burckle	ADVOCAP
Ellen	Buretta	Gratitude Club, Inc.
Deb	Shepro	ADVOCAP
Katie	Wirkus	Fond du Lac County Health Department
Missy	Tate	SSM Health
Johanna	Brotz	Fond du Lac County Health Department
Amber	Kilawee	United Way
Rebecca	Guynn	FDL DHS
Laura	Becker	Network Health
Todd	Vander Galien	Unity Recovery Services
Joyce	Gau	Community Member
Holly	Hynek	ACC Community Connections
Elizabeth	Wilson	UW-Green Bay/FCHD Intern
Sarah	Davis	Fond du Lac Public Library
Holly	Mulder	ARYA
Brooke	Mathes	Fond du Lac Police Department
James	Borgen	Fond du Lac Sheriff/Jail
Kelly	Northlee	Fondy Famous

Appendix A: CHIP Collaborators

Access to Health Care Collaborators:

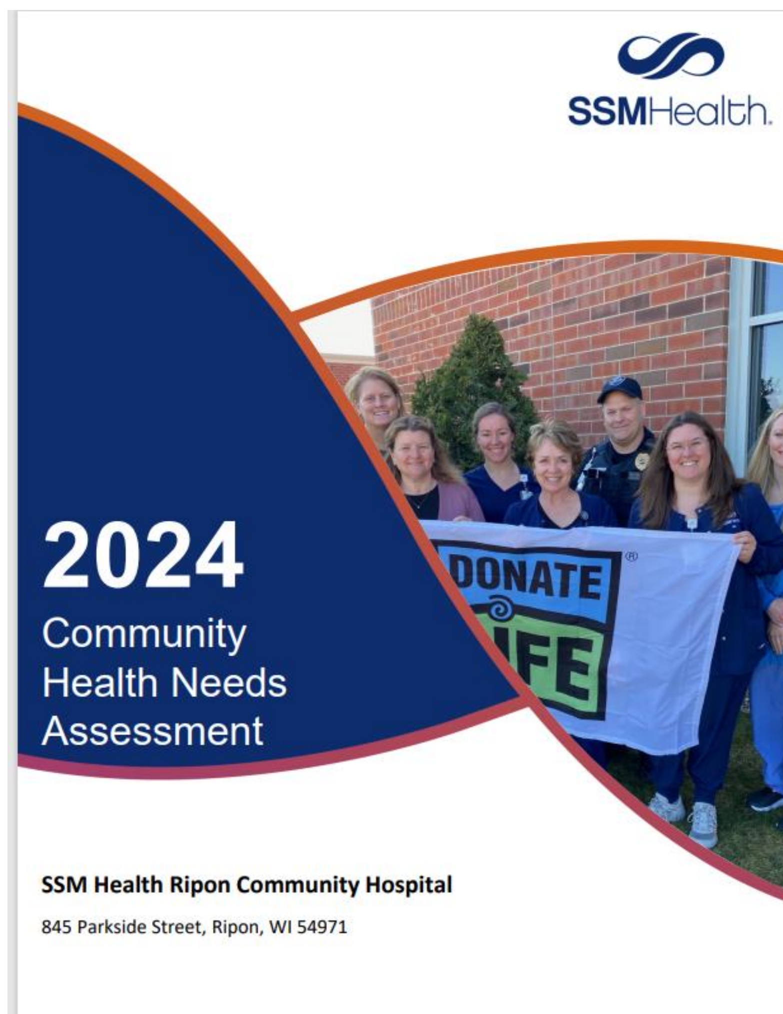
First Name	Last Name	Organization
Amanda	Wisth	Froedtert
Cathy	Loomans	The Center - The Hub for Active Older Adults
Debbie	Kapp	Aurora Health Care
Jeanette	Morales	DFC/United Way
Julie	Fleibach	Blandine House
Kim	Mueller	Fond du Lac County Health Department
Laura	Nakielski	SSM Health
Linda	Spitzer	ADRC of Fond du Lac County
Nicole	Johnson	Fond du Lac County Health Department
Raine	Bleecker	Fond du Lac County Health Department
Robyn	Wise	Fond du Lac County Health Department
Sarah	Gradinjan	Fond du Lac County Health Department
Sue	Mitchell Metz	NAMI Fond du Lac
Zoe	Burckle	ADVOCAP
Ellen	Buretta	Gratitude Club, Inc.
Deb	Shepro	ADVOCAP
Missy	Tate	SSM Health
Shane	Smith	SSM Health
Stephanie	Hopf	Fond du Lac County Health Department
Kathy	Steers	Froedtert
Maria	Feucht	SSM Health
Nicole	Gill	SSM Health
Jeff	Butz	FABOH
Julie	Schumann	Aurora Healthcare
Will	Huhndorf	Froedert & the Medical College
Johanna	Brotz	Fond du Lac County Health Department
Amber	Kilawee	United Way
Isabel	Williston	ASTOP, Inc Sexual Abuse Center
Megan	Ketter	Community Member
Jolene	Schatzinger	Womens Fund
Cristina	Raish	Thedacare/Froedtert
Jackie	Morgan	MPTC
Mary	Noel Brown	SSM Health
Elizabeth	Wilson	UW-Green Bay/FCHD Intern
Hayley	Peebles	Network Health
Katie	Hellmer	Lakeland Care
Rebecca	Schmitz	SSM Health Inpatient Physical Therapy/Cancer Center
Brent	Meier	SSM Health
Caroline	Janke	County Board Supervisor/Board of Health
Kay	Kruncos	Fond du Lac County Health Department
Sarah	Davis	Fond du Lac Public Library
Kristen	Theisen	MPTC

Appendix B: Community Health Needs Assessment Reports

The SSM Health Ripon Community Hospital is pleased to share the 2024 Community Health Needs Assessment (CHNA). The SSM Health Ripon Community Hospital partnered with the Fond du Lac County Health Department and Healthy Fond du Lac County Steering Committee and other community organizations and stakeholders to develop the 2024 CHNA.

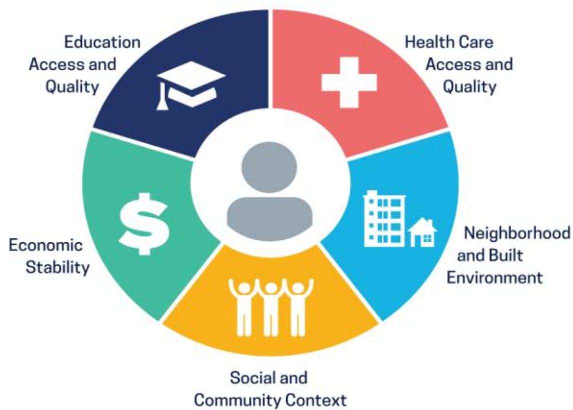
The purpose of a CHNA is to identify and address health needs in order to improve the health outcomes in our communities. The CHNA included a comprehensive collection and analysis of data and community perspectives to identify health issues of primary concern and is key to developing strategies to address the community's health needs, monitor health trends, and build strong communities. Data was collected through multiple methods including two surveys with nearly 1,000 responses total, 10 one-on-one interviews, 12 community conversations with several populations and organizations, as well as other secondary sources.

As a result of this Community Health Assessment Process, three health priorities were identified. For the full CHNA Report for Ripon Community Hospital, please visit SSM Health's website or Wisconsin: Community Health Needs Assessments | SSM Health

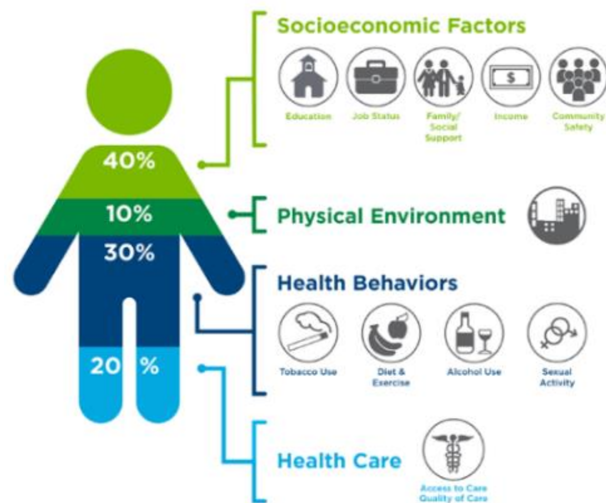


Appendix C: Additional Resources Used to Develop the 2025-2027 CHIP: Social Determinants of Health

The social determinants of health (SDoH) and the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, life and age and the wider set forces and systems shaping the conditions of daily life. Examples of these factors include safe and affordable housing, access to quality education, public safety, availability of healthy foods, accessible health care services, and positive social support systems. Research shows that the social determinants can be more important than the health care or lifestyle choices influencing health. For example, numerous studies suggest that social determinants account for between 30-55 percent of health outcomes. By applying what we know about SDoH, we can not only improve individual and community health but also advance health equity. Below shows models of SDoH and health outcomes.

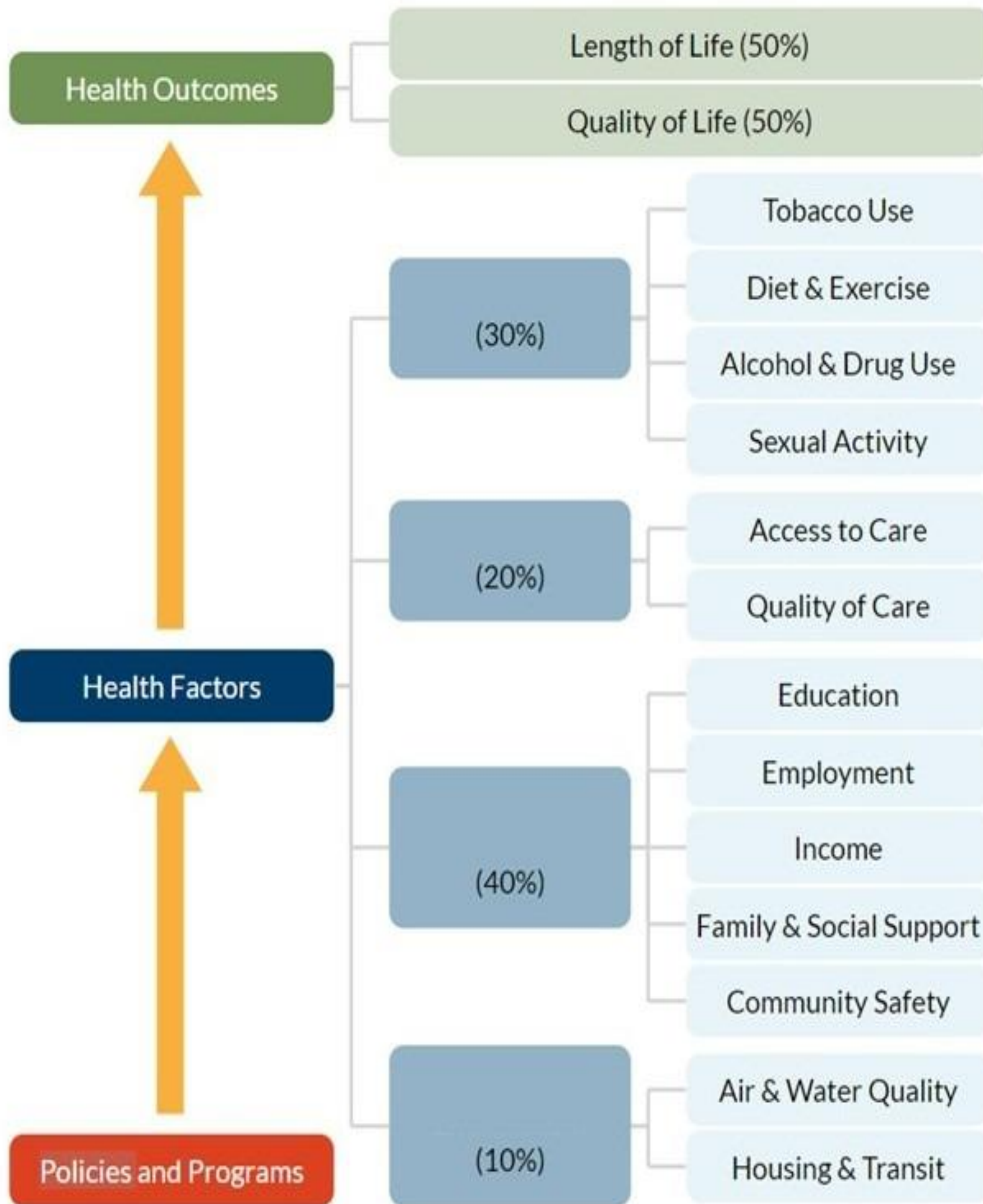


What Goes Into Your Health?



Source: Institute for Clinical Systems Improvement, Going Beyond

Appendix C: Additional Resources Used to Develop the 2025-2027 CHIP: Upstream Thinking



Appendix C: Additional Resources Used to Develop the 2025-2027 CHIP: Logic Model and Action Plan

LOGIC MODEL Problem Statement:					
What problems or issues does the project attempt to solve or address? What is needed by the target population and what strategies will lead to positive change.					
Project Objective 1: [State the project objective here and divide the logic model by each objective. Objectives are concrete and viewed as targets under the general goal.]					
Needs	**Inputs**	**Activities**	**Outputs**	**Outcomes**	**Impact**
What are the needs of the community, based on the community health needs assessment? What do beneficiaries/ partners/ clients need to address or solve the issues mentioned in the problem statement?	What human and financial resources will be used for this project? What do you need to complete your project? [Staff, Time, Money, Materials, Equipment, Partners]	What will you do to cause the positive changes you have planned? What activities will be conducted to meet the needs or address the issues of the community?	What will be produced or delivered or who will participate in activities? [Products created or resources developed; Serviced delivered; # participants in workshop, # of workshops, policies revised/developed, facilitators trained, program developed, toolkit created, etc] Measured with performance indicators	What changes will happen after an activity has been implemented? [Increased awareness, knowledge, or attitudes; Improved skills; Change in behavior, practice, or decision making; Policy change] Measured with performance indicators Training: What will participants learn from your training? What actions will they take after training?	What long-term changes do you expect to occur in the social, cultural, political, environmental, health system or economic context (think 1/3/5 years)?
Assumptions:			External Factors		
What needs to happen, and who needs to be involved (outside of your organization), for your project to be successful?			*How will the things that are outside of your control interfere with your project?*		

Action Steps	Timeframe	Resources required	Lead / group	Short term Outcome (data)	Date completed / Notes

Appendix D: 2022-2024 CHIP Review

Mental Health

The 2022-2024 Community Health Improvement Plan included three priority health areas with two additional overarching goals. Below displays the priority health area goals, performance measures and highlights over the past three years. Overarching goals in 2022-2024 included Social Determinants of Health (SDOH). Goals involved were to increase awareness of SDOH in shaping health outcomes.

Performance Measures	2020 Baseline	2024 Goal	2024 Actual	Goal Status
Percent of FDL County Adults who report they "considered suicide"	7% (2020)	6%	4% (2024)	Met
Suicide deaths (rate per 100,000, age adjusted)	21.0 (2019)	20.0	19.7 (2022)	Met
Percent of FDL County youth who report they "seriously considered suicide"	14% (2020)	13%	16% (2024)	Not Met
Percent of adults who report that they or someone in their household did not get the mental health care needed	7% (2020)	6%	14% (2024)	Not Met
Improve the provider to population ratio	1:700	Favorable trend	1:580 (2023)	Met
Percent of adults who consider someone seeing a therapist or psychiatrist as a sign of strength*	91%	92%	N/A	N/A
Increase the percent of adults who consider taking medication to treat a mental health issue as a sign of strength*	91%	92%	N/A	N/A

Priority Action team: FDL County Mental Health Action Team

Evaluation, summary, reflections, and considerations

In reflecting on the performance measure, three of the seven objectives were met. Two of the objectives had an unfavorable trend and two objectives did not have a data point available as the questions were changed in the Community Health Survey so a comparison was not available.

In 2022, the coalition transitioned from CSI Mental Health Access coalition to a mental health action team facilitated by the health department. The coalition continues to seek a community partner co-lead who is a mental health subject matter expert to assist in action team facilitation. The coalition membership currently stands at 28 members, representing 14 organizations.

Overall, there have been strides in mental health in the areas of stigma reduction as during the pandemic and post the importance of maintaining mental health was stressed and more conversations openly took place. However, major challenges continue in the mental health field with workforce shortages and addressing long waitlists for services.

Appendix D: 2022-2024 CHIP Review- Substance Use

DRUG FREE COMMUNITIES of Fond du Lac

The 2022-2024 Community Health Improvement Plan included three priority health areas with two additional overarching goals. Below displays the priority health area goals, performance measures and highlights over the past three years. Overarching goals in 2022-2024 included Social Determinants of Health (SDOH). Goals involved were to increase awareness of SDOH in shaping health outcomes.

Performance Measures	2020 Baseline	2024 Goal	2024 Actual	Goal Status
Percent of youth who drank alcohol in the past 30 days	22% (2020)	21%	16%	Met
Percent of youth who report binge drinking in the past 30 days	9% (2020)	8%	7%	Met
Percent of youth who bought or drank alcohol at a community event	6% (2020)	5%	6%	Not Met
Percent of youth who think the community is “actively discouraging” or “think it isn’t ok” underage drinking	47% (2020)	48%	44%	Not Met
Percent of youth who report they talked with their parents about alcohol in the past 30 days	30% (2020)	31%	33%	Met
Percent of adults who report binge drinking in past 30 days	37% (2020)	36%	27%	Met
Percent of youth who report using prescription medication for non-medical use	4% (2020)	3%	4%	Not Met
Percent of youth who report relative ease in obtaining prescription medication for non-medical use	28% (2020)	27%	23%	Met
Opioids related death rate	24.0 per 100,000 (2020)	23.0 per 100,000	18.3 per 100,000 (2022)	Met

Priority Action team: Drug Free Communities of Fond du Lac

Evaluation, summary, reflections, and considerations

In reflecting on the performance measures, six of the nine objectives were met while progress continues toward the goals set for the coalition. Two of the objectives not met had no trend change at all. Overall, 2022-2024 was a transitional time frame for the Drug Free Communities of Fond du Lac Coalition as the coalition rebooted and received a federal grant award to support the coalition action plan. Prior to the reboot, a smaller actional team was working together to support a few key strategies in moving forward with reduced capacity. Now, coalition membership is currently at 50 members, representing more than 20 organizations.

Overall, coalition recruitment from multiple sectors, funding, and staff/ organizational capacity are all considerations to whether strategies are viable and can continue to be implemented. Strategy implementation relies on these individuals and organizational members to obtain the resources necessary for strategy implementation and active participation and engagement to remain effective.

Appendix D: 2022-2024 CHIP Review-Chronic Disease

The 2022-2024 Community Health Improvement Plan included three priority health areas with two additional overarching goals. Below displays the priority health area goals, performance measures and highlights over the past three years. Overarching goals in 2022-2024 included Social Determinants of Health (SDOH). Goals involved were to increase awareness of SDOH in shaping health outcomes.

Performance Measures	2020 Baseline	2024 Goal	2024 Actual	Goal Status
Percent of overweight and obese adults	75% Overweight 41% Obese	74%	78% 36%	Not Met
Percent of overweight youth	30%	29%	27%	Met
Heart disease death rate per 100,000 population	176.4 (2019)	170.0	187.3 (2022)	Not Met
Percent of adults engaging in recommended amount of physical activity	52%	53%	44%	Not Met
Percent of youth meeting recommended amount of physical activity	23%	24%	27%	Met
Percent of population with adequate access to locations for physical activity	85% (2019)	86%	78% (2020-23)	Not Met
Percent of households reporting food insecurity	6%	5%	8%	Not Met
Percent of fruit and vegetables serving consumed by adults (one or more servings per day)	6%	5%	8%	Not Met
Percent of fruit and vegetables serving consumed by youth	2+ serving fruit 35% 3+ serving veg. 17%	36% 18%	38% 17%	Not Met

Priority Action team: Living Well Coalition

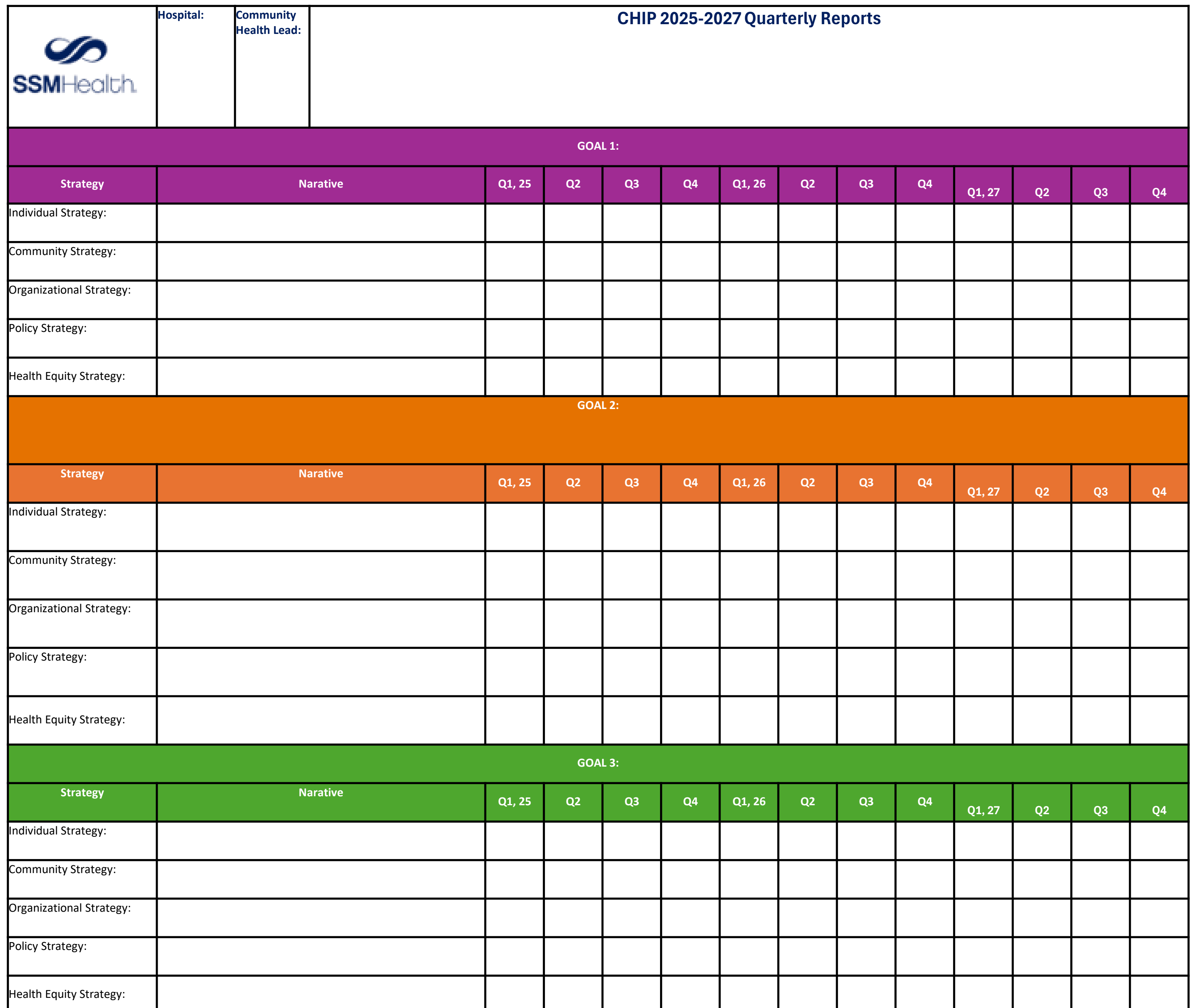
Evaluation, summary, reflections, and considerations

While many of the goals set were not achieved (seven of nine) based on performance measurement, it should be noted that there were still some positive program outcomes achieved which were impactful. Also important to note is the two-performance measures met were youth related indicating that strategies aimed towards this population are working. As school settings have made significant strides in physical activity and nutrition standards and programs, we hope to see positive trends continue as this population ages.

Its not surprising that there is a greater food security need due to growing need in many areas post pandemic and with a greater cost of living. Although we have worked on specific local projects, there are multiple, greater factors that impact food insecurity (i.e. FoodShare and other benefits were drastically reduced and even re-enrollment required). During the pandemic, not only did individual families and students (at schools) receive additional food benefits, but food banks were receiving more food through federal pandemic relief efforts. Individual/family benefits, along with food pantry support, has dropped since then, likely relying more on the local donations. In addition, families on FoodShare or other benefits had an increase in benefits during the pandemic, which would likely impact how/what they were reporting for rates of hunger during the last Community Health Assessment in 2020.

Appendix E: 2025-2027 Quarterly Report and Timeline

For the 2025-2027 CHIP, SSM Health in the Wisconsin region has identified the need to report out the work towards the CHIP for our staff within our hospitals and clinics as well as a community. The chart below is a reporting tool for that data and narrative for the next three years.



SSMHealth	Hospital:	Community Health Lead:	CHIP 2025-2027 Quarterly Reports

GOAL 1:													
Strategy	Narative	Q1, 25	Q2	Q3	Q4	Q1, 26	Q2	Q3	Q4	Q1, 27	Q2	Q3	Q4
Individual Strategy:													
Community Strategy:													
Organizational Strategy:													
Policy Strategy:													
Health Equity Strategy:													

GOAL 2:													
Strategy	Narative	Q1, 25	Q2	Q3	Q4	Q1, 26	Q2	Q3	Q4	Q1, 27	Q2	Q3	Q4
Individual Strategy:													
Community Strategy:													
Organizational Strategy:													
Policy Strategy:													
Health Equity Strategy:													

GOAL 3:													
Strategy	Narative	Q1, 25	Q2	Q3	Q4	Q1, 26	Q2	Q3	Q4	Q1, 27	Q2	Q3	Q4
Individual Strategy:													
Community Strategy:													
Organizational Strategy:													
Policy Strategy:													
Health Equity Strategy:													

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