

2026-2027 Western Wisconsin Health Community Health Needs Assessment and Community Health Improvement Plan



Building a healthier tomorrow together



WESTERN WISCONSIN HEALTH

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I. Executive Summary

Western Wisconsin Health (WWH) operates a 22-bed critical access hospital, three rural health clinics (Baldwin, Roberts, Spring Valley), and a comprehensive array of health and wellness services. These include primary care, emergency and surgical services, behavioral health, women's health, multiple specialty services, rehabilitation, and lifestyle medicine.

In 2024, WWH provided care to over 15,900 clinic patients across 69,000+ visits, delivered 385 babies (up from 276 in 2023 due to regional birth center closures), and served 506 medical-surgical patients. With a dedicated workforce of 448 staff and 60+ volunteers, WWH is committed to growing alongside the rapidly expanding St. Croix County region.

As part of the Healthier Together Pierce-St. Croix County coalition, WWH co-led efforts in community health planning for St. Croix and Pierce Counties with county public health and local healthcare organization partners, including work within the 2023–2025 Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). The two key priority areas for this cycle were: 1. Mental, Social, and Emotional Wellbeing and 2. Thriving and Livable Communities (with focus on Social Determinants of Health).

In partnership with St. Croix and Pierce County Public Health Departments, WWH conducted a comprehensive Community Health Needs Assessment (CHNA) in 2024–2025. The process included review of 1. Primary Data: Community survey (in English & Spanish), 3 focus groups, and 24 key informant interviews and 2. Secondary Data: Census data, County Health Rankings, and public health datasets. Key community health insights noted that St. Croix and Pierce counties are among the fastest growing counties in Wisconsin with high rates of children, aging adults, and linguistically diverse households while nearly 1 in 3 households fall under the “ALICE” threshold (Asset Limited, Income Constrained, Employed). Childcare deserts, affordable housing shortages, and transportation barriers persist. Behavioral health, chronic disease, maternal health, and preventive care remain top priorities with high community concern for mental health across all demographics. Healthcare provider shortages exist for primary care providers, mental health providers, and dental care providers accepting Medicaid.

Using a stakeholder-informed, evidence-based prioritization process, the following were identified as top priorities for the 2026-2027 Community Health Improvement Plan (CHIP):

- 1. Mental Health and Wellbeing** with goals to expand behavioral health services, especially for youth and Spanish-speaking communities and improve access through telehealth, school partnerships, and care coordination.
- 2. Access to Care** with goals to recruit and retain providers across all disciplines and address financial and social barriers to primary and maternal care.

WWH will incorporate the CHIP into the WWH strategic plan and collaborate with community partners in this work. As St. Croix County and surrounding areas continue to grow, WWH remains a vital, adaptive, and community-centered healthcare provider committed to advancing the health and resilience of Western Wisconsin's rural communities.



II. About Western Wisconsin Health

The Baldwin Community Hospital opened its doors in December of 1936. It was built with funds donated by a local farmer and furnished through the support of the local communities. Almost 90 years later, numerous capital projects have resulted in Western Wisconsin Health's (WWH's) current 22-bed critical access hospital and rural health clinic, which opened in 2016.

Today, WWH is an independent, integrated clinic and hospital located in western Wisconsin serving St. Croix, Pierce, Polk, Barron, and Dunn Counties. WWH is building a healthier tomorrow through daily exercise of the core values of care, innovation, and sustainability. WWH offers comprehensive health and wellness services that include preventive care, behavioral health, primary care, lifestyle medicine, emergency care, advanced surgical procedures, integrative health, orthopedic services, rehabilitation services, women's health, and treatment for a broad range of medical conditions. WWH continues to grow and thrive through the support and dedication of its community and patients.

Consisting of three rural health clinics in Baldwin, Roberts and Spring Valley, along with the WWH Critical Access Hospital, WWH is thriving. In 2024, WWH served 15,909 clinic patients with a total of 69,402 visits. In addition, WWH delivered 385 babies in 2024 (up from 276 in 2023) and provided care for 506 medical-surgical patients. The very large increase of births is due to multiple birth center closures in the western Wisconsin region. As of 2025, 448 staff members are employed and approximately 60 volunteers consisting of hospital, auxiliary, and board members support the work of WWH. WWH is an ever-growing, ever-changing organization that continues to develop its staff and provide for its growing community. St. Croix County continues to grow at a rapid rate and WWH will continue to assess the need for expanded services across the organization.

WWH is fortunate to employ physicians and providers who have expertise and interests in both preventive and reactive scopes of care. From general practice and obstetrical services to specialties such as internal and functional medicine, WWH offers services across multiple disciplines. Occupational, Physical and Cardiac Rehabilitation are offered along with integrative services including massage, acupuncture, mind body medicine and more. These services offer patients ongoing and preventive care and encourage sustainable well-being. WWH also employs registered dietitians, a diabetic educator, health and wellness coaches, and a fully staffed behavioral health department to provide care for many diagnoses that require ongoing therapies. The fitness center includes a therapeutic heated pool, a variety of exercise equipment, personal training, and many group fitness volunteer led classes to keep the community active. Yoga, TRX, running/walking clubs, after work fitness, and spin are just a few examples of the fitness studio class offerings. WWH has a community trail on the 100 plus acres of property providing community members with opportunities to walk, run, snowshoe, cross country ski and even participate in 5ks to encourage a healthy lifestyle. These departments and disciplines all work together to achieve the WWH mission and treat the whole person.

Additional services include financial assistance through our Community Care program and Simple Health which allows patients to receive a team of care to address their holistic health of physical, mental, emotional and nutrition wellbeing. We also offer birth education and perinatal classes for new parents, community education on different health topics by our providers and transportation to and from appointments at little to no cost (donation if they are able to). We also have a food insecurity program called We Care in which any community member or patient identified by our staff with a one-time need or ongoing need can receive a recyclable bag full of groceries and resources for additional assistance outside of our walls. We serve about hundreds of community members each year for We Care.

This work supports WWH’s mission to Build a Healthier Tomorrow, Together.

Western Wisconsin Health Service Area:

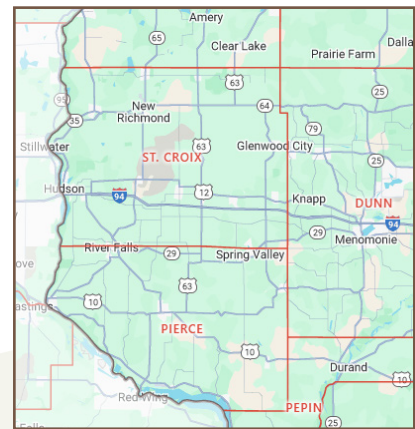
WWH’s current direct service area includes the towns of Baldwin, Woodville, Roberts, Hammond, Glenwood City, Spring Valley, Elmwood, Wilson, and Knapp in St. Croix, Pierce, and Dunn Counties along with secondary service area including other surrounding towns of Ellsworth, Amery, Boyceville, Deer Park, River Falls, New Richmond, and Somerset. St. Croix County is also reported as one of the fastest growing counties in Wisconsin. WWH has also seen an increase in service to patients from larger cities further away including Hudson, Menomonie, and Eau Claire, Wisconsin and even The Twin Cities.

Primary Market

- Baldwin: 54002
- Woodville: 54028
- Spring Valley: 54767
- Roberts: 54023
- Hammond: 54015
- Glenwood City: 54013
- Wilson: 54027
- Elmwood: 54740
- Knapp: 54749

Secondary Market

- Ellsworth: 54011 and 54010
- Amery: 54001
- Deer Park: 54007
- Boyceville: 54725
- Somerset: 54025
- River Falls: 54022
- New Richmond: 54017



Population Profile

The focus of inquiry for this CHNA was Pierce and St. Croix Counties—two primarily rural counties in western Wisconsin with proximity to the Minneapolis-St. Paul, Minnesota metro area. According to the U.S. Census Bureau, an estimated total of 141,334 residents lived in the 1,295.73 square mile area occupied by the two counties as of 2024.¹

St. Croix County is ranked as the third fastest growing county in the state of Wisconsin growing by 4.78% from 2020 to 2025.¹ Pierce County is ranked as the seventh fastest growing county with a growth rate of 4.13% since 2020.¹ Residents who are age 65+ in both counties represent a growing demographic, reflecting the counties aging trend.² Hispanic or Latino demographic has seen significant growth, increasing from 0.82% in 2000 to 3.1% and 3.3% respectively in 2024.²

¹ “Quick Facts.” United States Census Bureau, <https://www.census.gov/quickfacts/table/PST045215/55109>. Accessed 24 Sept. 2025.

² “Fastest Growing Counties in Wisconsin (2025).” World Population Review. *Fastest Growing Counties in Wisconsin (2025)*. Accessed 23 Sept. 2025.

Demographics of Pierce and St. Croix Counties:

Selected Indicator	Pierce County	St. Croix County
Population ¹		
Median Household Income	\$88,802 (2023)	\$97,229 (2024)
Median Age	38.4 years (2023)	39.8 (2023)
Population Estimates	43,380 (2024 estimate)	97,954 (2024 estimate)
Residents under age 18	19.8% (2024)	22.7% (2024)
Residents age 65 or older	17.8% (2024)	17.6% (2024)
Language other than English spoke at home	3.5% (2023)	9.3% (2023)
Foreign born Residents	2.3% (2023)	5.5% (2023)
Race and Ethnicity¹		
White or Caucasian	92.2% (2024)	90.9% (2024)
Black or African American alone	1.0% (2024)	0.7% (2024)
Asian alone	1.4% (2024)	0.97% (2024)
Hispanic or Latino	3.1% (2024)	3.3% (2024)
Two or more races	2.0% (2024)	4% (2024)
American Indian or Alaska Native	0.6% (2024)	0.1% (2024)
Social and Economic Factors		
Persons in Poverty ¹	8.3% (2023)	7% (2024)
Children in Poverty ¹	6.7% (2023)	9.9% (2023)
Percent of Population Asset Limited, Income Constrained, Employed (ALICE) ²	31% (2023)	18% (2023)
Residents living in food insecurity ³	10.1% (2023)	9.6% (2023)
Health Insurance status ¹	96.8% (2023)	95.4% (2023)
Unemployment rate ⁴	3.5% (2025)	3.3% (2025)
Health Indicators⁵		
Ratio of primary care physicians to residents	2,660:1 (2021)	1,900:1 (2021)
Ratio of mental health providers to residents	1,420:1 (2024)	530:1 (2024)
Adults reporting binge or heavy drinking	24.6% (2023)	21.3% (2023)
Adult obesity rate	34.6% (2024)	34.4% (2022)

Sources:

1 "Quick Facts." United States Census Bureau, <https://www.census.gov/quickfacts/table/PST045215/55109>. Accessed 24 Sept. 2025.

2 "The State of Alice in Wisconsin." UnitedForALICE, www.unitedforalice.org/county-reports/wisconsin#10/44.6999/-92.4719. Accessed 24 Sept. 2025.

3 "Food Insecurity among the Overall Population in the United States." Feeding America, <https://map.feedingamerica.org/>. Accessed 24 Sept. 2025.

4 "Wisconsin County Unemployment Rates." Wisconsin. https://jobcenterofwisconsin.com/wisconsin/wits_info/images/LAUS/uRatesCo.pdf. Accessed 24 Sept. 2025.

5 "Wisconsin." County Health Rankings & Roadmaps, www.countyhealthrankings.org/health-data/wisconsin/pierce?year=2024. Accessed 24 Sept. 2025.

Western Wisconsin Health Partnerships

WWH is a lead member in the Healthier Together Pierce – St. Croix County coalition alongside Pierce County Public Health Department, St. Croix County Public Health Department, Hudson Hospital and Clinic—Health Partners, River Falls Area Hospital—Allina Health, Westfield’s Hospital and Clinic—Health Partners, and the United Way of St. Croix & Red Cedar Valley. Previous Community Health Needs Assessment and Community Health Improvement cycles have been completed as the Healthier Together coalition with added specific goals and action plans for WWH.

While the coalition’s and each lead organization’s capacity and goals have changed over time, Western Wisconsin Health remains committed to working with community partners to collaborate in meeting community health needs. Western Wisconsin Health worked closely with St. Croix County Public Health and Pierce County Public Health to collect primary and secondary data and share community input. All organizations within the Healthier Together coalition plan to collaborate in aligned goals within each organization’s Community Health Improvement Plan to maximize resources for community health impact.

III. Evaluation of 2023-2025 Plan

Below is a summary of the key accomplishments in the 2023-2025 Priority areas of “Mental, Social, and Emotional Wellbeing” and “Thriving and Livable Communities.”

Improving Mental, Social, and Emotional Wellness

- Provided multiple programs to promote employee mental wellbeing including implementation of system wide mental wellness hour program and benefit starting in 2023.
- Provided school based behavioral health care to 3 school districts (1 in St. Croix County and 2 in Pierce County) and supported Resilience training program within the Baldwin-Woodville school district.
- Facilitated youth mental health collaboration between schools, healthcare, and counties meeting quarterly each year.
- Increased access to Behavioral Health telemedicine including establishing a satellite site at the Ellsworth library.
- Began outpatient Medication Assisted Treatment program in 2023, and piloted outpatient substance use disorder program in 2025.

Thriving, Livable Communities

- Implemented system-wide approach to address Social Determinants of Health (SDOH) through screenings and referrals. 49% of patients seen in the rural health clinic between January 2023-September 2025 have been screened for SDOH.
- Implemented wheelchair accessible van for patient transportation. 1996 van rides were completed for patients in 2024.
- Conducted diversity, equity, and inclusion survey among all staff and provided Diversity, Equity, and Inclusion (DEI) in healthcare training.
- Increased written communications in Spanish and expanded access to interpretation services with dedicated staff interpreter hours weekly and virtual interpretation services 24/7.
- Increased access to care for marginalized patient populations by providing mobile vaccine clinics and increasing access to maternal care for Spanish speaking patients and outlying rural communities without labor and delivery services reaching 385 births in 2024 and on track to exceed that record in 2025.

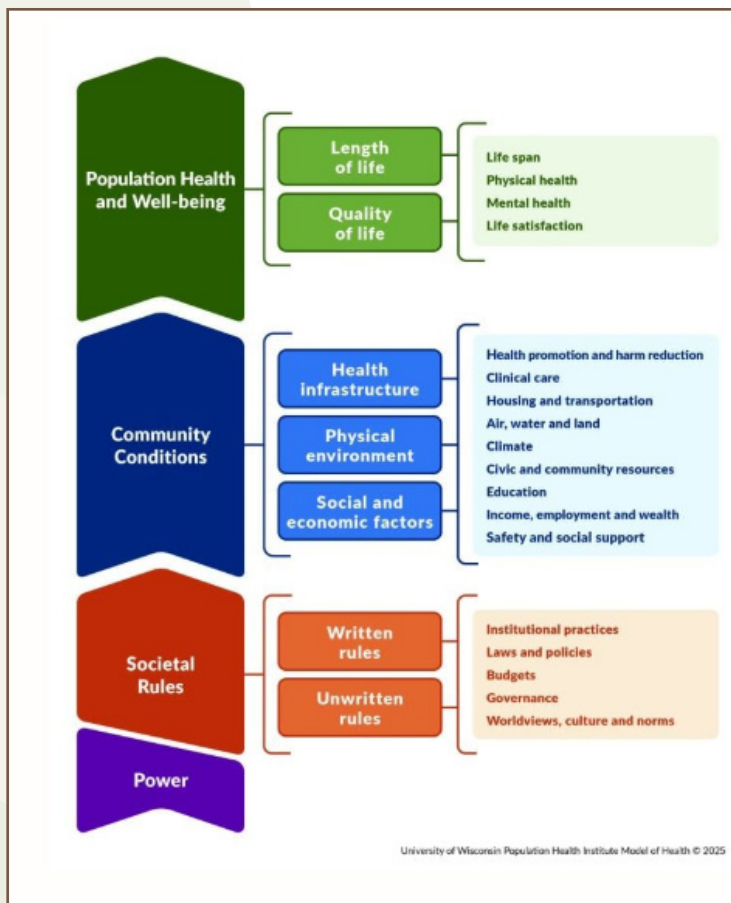
- Advocating for Wisconsin Medicaid expansion of dental care reimbursement in Rural Health Clinics (RHC) to provide financially sustainable dental services to patients with Medicaid.

Western Wisconsin Health partnered with Healthier Together - Pierce & St. Croix Counties Coalition to support additional objectives in the coalition's Community Health Improvement Plan.

IV. Overview of Community Health Assessment and Planning Principles and Process

A CHNA is completed every three years by nonprofit hospitals to define the community served and assess the health needs of the community. This process requires soliciting and incorporating input from all sectors of the community including public health experts. Once the CHNA is complete, the hospital creates a CHIP with goals and targets to improve the community health priorities identified.

Western Wisconsin Health partnered closely with St. Croix County Public Health and Pierce County Public Health departments to design an assessment and planning process like previous assessment and plan cycles that engaged both organizational stakeholders and community members while taking multiple data sources into account. Western Wisconsin Health applied the most recent County Health Rankings Model developed in 2025 to provide grounding principles for community health assessment and activities.



County Health Rankings Model: What Drives Our Health?

Health is influenced by much more than medical care. Factors such as access to affordable housing, well-paying jobs, reliable transportation, and educational opportunities all play a critical role in how long and how well people live. Recognizing this, Western Wisconsin Health uses the County Health Rankings model to organize data and better understand the drivers of health beyond clinical outcomes.¹

This framework emphasizes that improving health outcomes requires addressing the broader community conditions and societal influences that shape people's daily lives. This framework provided foundational principles for the WWH Community Health Needs Assessment and Improvement Plan.

¹ "University of Wisconsin Population Health Institute Model of Health." *County Health Rankings & Roadmaps, Explore health topics | County Health Rankings & Roadmaps*. Accessed 18 Sept. 2025.

Throughout the assessment and planning process, WWH engaged community stakeholders from multiple sectors within the community with a focus on health equity and factors that influence health in the community. Efforts were made in the community survey process and key informant interviews to engage communities facing significant health disparities such as Spanish speaking community members, rural residents, elderly residents, and families on the Women’s Infants and Children (WIC) program.



V. Key Insights: Secondary Community Data

Secondary data gathering and analysis took place in the winter and spring of 2024-2025 through our partners at Pierce County Public Health and St. Croix County Public Health. Secondary data focused on gathering quantitative data from various sources across various sectors, selecting the best indicators available, and visualizing that data using maps, graphs, or infographics. Rather than focusing on health outcomes, our secondary data process focused on understanding the circumstances in which residents live and work to explain conditions that influence health outcomes. WWH used the Community Health Rankings model as a framework for organizing data elements by health behaviors, clinical care, social and economic factors, and health outcomes.

The summary below does not include all data categories or elements. The secondary data dashboard includes all indicators gathered and analyzed. The dashboard is located in Appendix A.

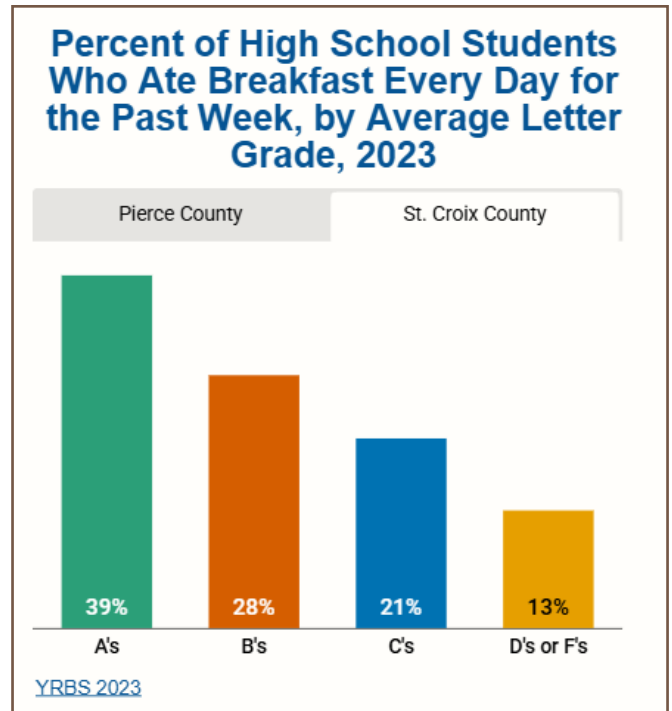
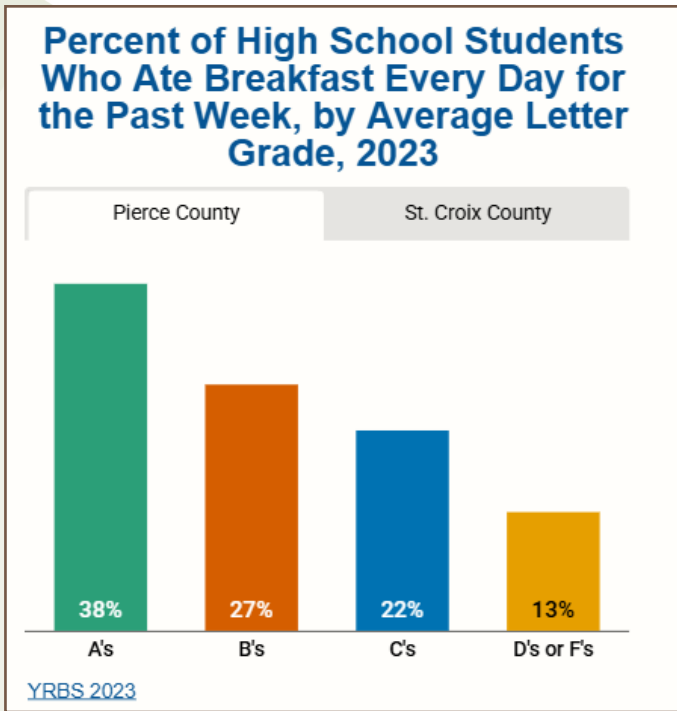
Health Behaviors

Health behaviors encompass a wide range of actions that can either be beneficial or harmful and have a significant impact on one’s health status. These include positive practices like eating well and exercising, as well as high-risk actions like smoking, heavy drinking, and unsafe sexual behavior.

Nutrition and Physical Activity

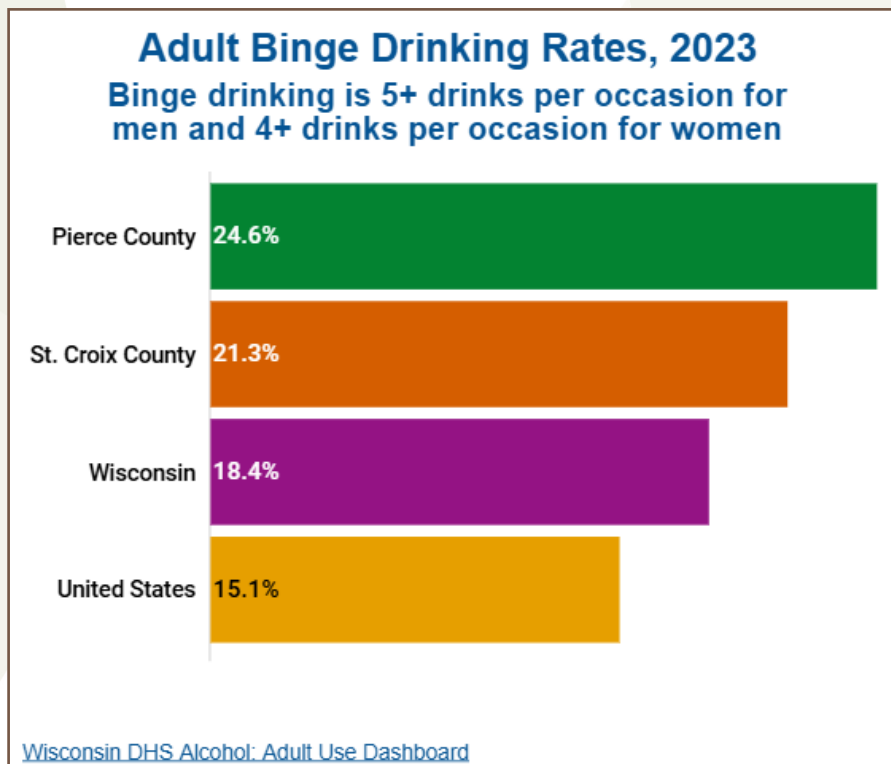
Good nutrition, regular exercise, and healthy body weight are crucial for overall health. Combined, they significantly reduce the risk of developing major diseases like high blood pressure, heart disease, diabetes, stroke, and cancer. The environment in which people are born, live, learn, work, and play greatly impacts nutrition and physical activity behaviors.

Eating breakfast daily is correlated with better grades in school. Data for both counties show a stark drop in letter grades for high school students who reported not regularly eating breakfast compared to those who do with similar percentages by grade level in each county.



Alcohol Use

Overconsumption of alcohol has significant negative impacts both on the health of individuals and on the costs to society. Excessive alcohol use leads to chronic health conditions such as cancer, liver, failure, and mental health conditions. It also leads to social problems such as car accidents, child neglect, and increased violence. Adult binge drinking rates among Pierce and St. Croix County residents are higher than the state and national averages.



Clinical Care

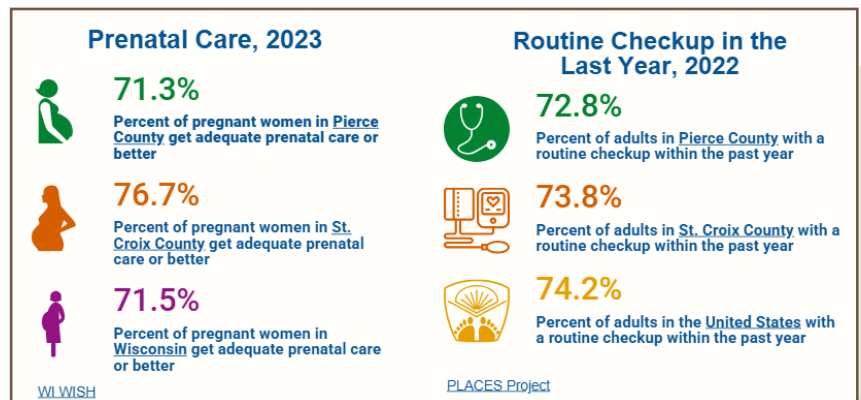
Access to Care

Affordable, high-quality, and timely healthcare promotes longevity by enabling earlier disease prevention and detection. When analyzing clinical care, we can better understand health disparities between communities. In Pierce and St. Croix counties, residents have far less access to in-county primary, dental, and mental healthcare than the average Wisconsin resident. This poor access to care contributes to significant barriers in accessing timely and appropriate care and increases the risk of delayed treatment, unmanaged chronic conditions, and unmet behavioral health needs. Limited local access also means many residents must travel outside the county—often across the state border into Minnesota—for essential services, which can create additional financial and transportation challenges.



Prenatal and Preventive Care

Limited access to local healthcare along with other factors such as healthcare insurance coverage and transportation access can impact a patient's ability to obtain preventative care. Nearly 30% of Pierce County residents did not receive adequate prenatal care in 2023 though this does align with the Wisconsin data. Both Pierce County and St. Croix County residents are slightly below the number of adults in the United States who received a routine preventive checkup in the past year in 2022.



Social and Economic Factors

Social Drivers of Health are conditions in the environment where people are born, live, work, and play such as economic stability, educational opportunities, social and community context, and neighborhood safety which profoundly influence a person's well-being and lifespan.¹ These conditions affect a person's capacity to access quality healthcare, manage stress, and live a healthy life.

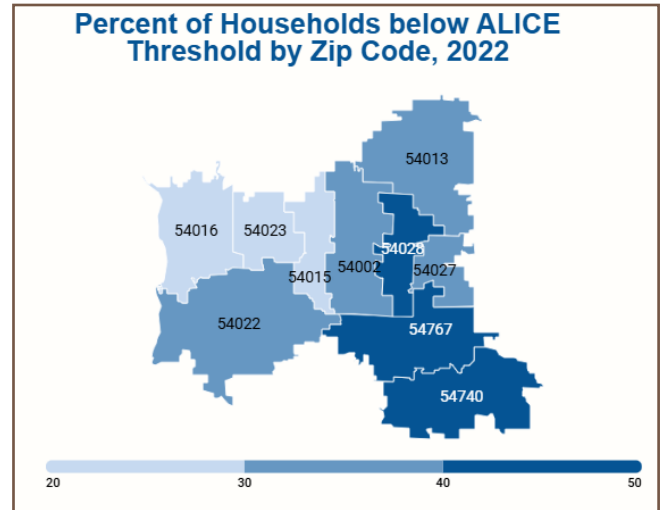


¹ "Social Drivers of Health and Health-Related Social Needs." CMS.gov, Social Drivers of Health and Health-Related Social Needs | CMS. Accessed 23 Sept. 2025.

Income/ALICE

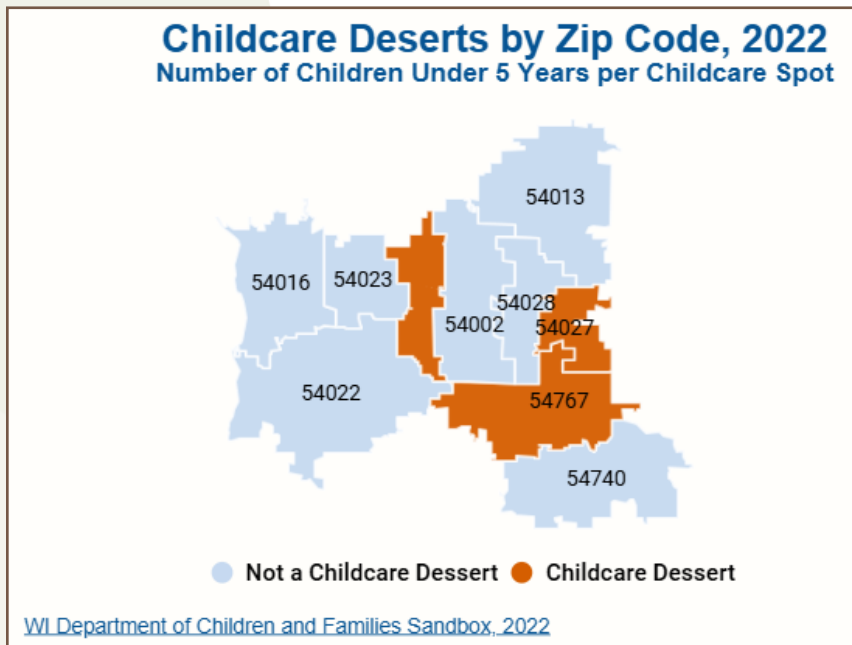
Equal access to economic opportunities is crucial for achieving equitable health outcomes. The United Way's ALICE metric, which stands for Asset Limited, Income Constrained, Employed, measures households that earn above the Federal Poverty Level but below the county's basic cost of living.

While some households are financially stable, many in Western Wisconsin Health's service area continue to struggle, primarily due to stagnant wages failing to keep up with the rising costs of necessities like housing, food, and childcare. In Pierce and St. Croix Counties, nearly one-third of households fall below the ALICE threshold, with a higher concentration found in rural areas in Western Wisconsin Health's service area compared to the more urban communities of River Falls and Hudson.¹



Childcare Access

Economic development, healthy child development, and family well-being depend on the availability of high-quality, affordable childcare. Both St. Croix and Pierce Counties are designated as childcare deserts in multiple census tracts, reflecting systemic gaps in early childhood infrastructure.²



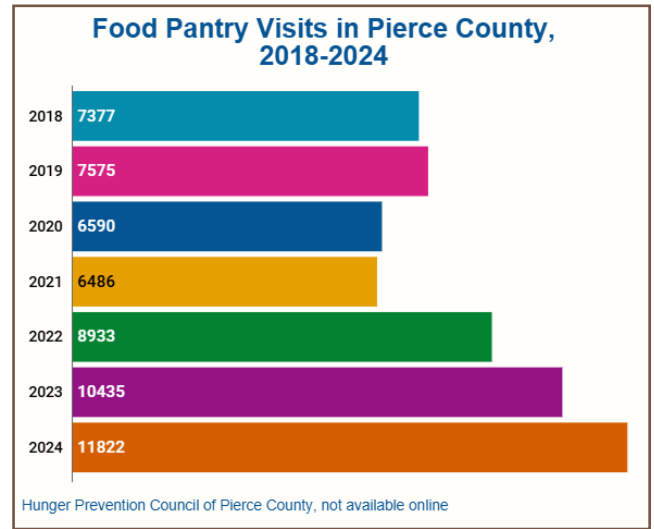
A "childcare desert" is defined as a census tract with more than three children under age five for every licensed childcare slot, or where no licensed childcare providers exist.² This issue is a critical factor in family well-being, workforce participation, child development outcomes, and long-term community well-being. From an equity perspective, the shortage has a disproportionate impact on lower-income families, single parents, and households in rural areas, where licensed providers are scarce. Strengthening childcare availability is increasingly viewed not only as a family support issue but also as a critical component of economic development and population health.

¹ "The State of Alice in Wisconsin." UnitedForALICE, www.unitedforalice.org/county-reports/wisconsin#10/44.6999/-92.4719. Accessed 24 Sept. 2025.

² "Access, Affordability, Quality and Workforce in Early Care and Education in Wisconsin." WI Dept of Children and Families. "<https://dcf.wisconsin.gov/childcare/pdg/sandbox/data2>" Sandbox Data 2 - PDG | Wisconsin Department of Children and Families. Accessed 23 Sept. 2025.

Food Insecurity

Food insecurity is when a person does not have enough food to eat and does not know where their next meal will come from.¹ Food insecurity impacts an average of 10% of residents in both counties as of 2023.² Data from the Hunger Prevention Council of Pierce County shows that food pantry visits have increased annually since 2022 for a total increase of 32.4% from 2022 to 2024.

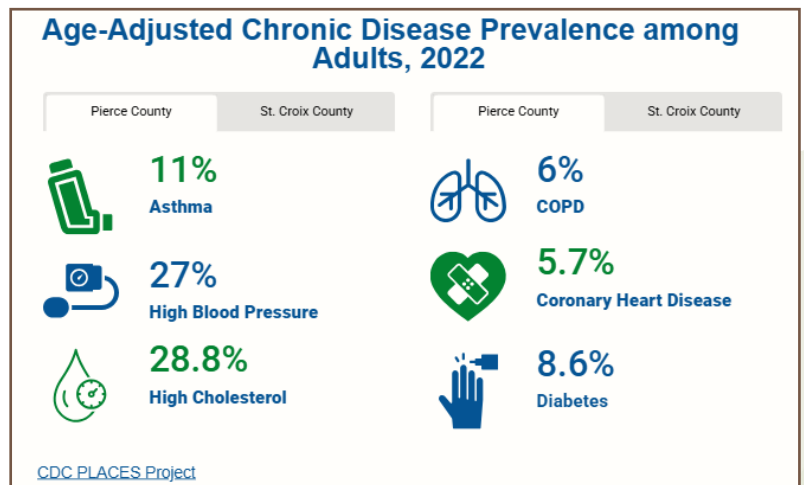
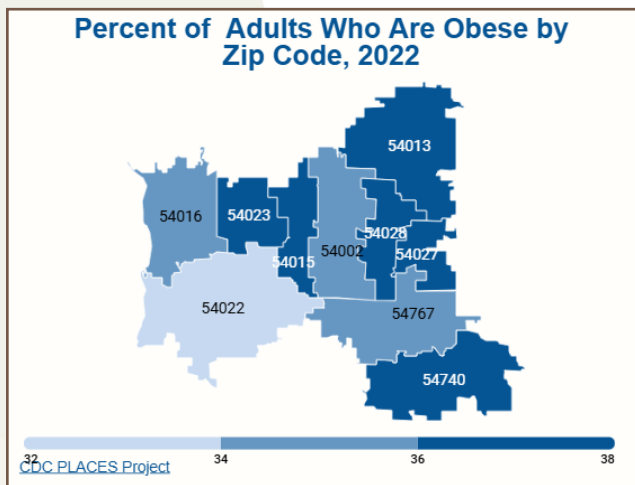


Health Outcomes

Chronic Diseases

Lifestyle factors like tobacco use, poor nutrition, and inactivity are major contributors to chronic diseases.

Many chronic diseases, including heart disease, stroke, and type 2 diabetes, are preventable or manageable through proper medical care, a healthy diet, and physical activity. For instance, quitting smoking, exercising, and eating well can prevent heart disease and stroke deaths. Type 2 diabetes risk is linked to obesity, inactivity, family history, race, age, and blood pressure, and it can lead to serious health issues like cardiovascular and kidney damage. Prevention often involves healthy eating, exercise, and weight control. Rural parts of Pierce and St. Croix counties see higher rates of obesity than the more urban areas around River Falls and Hudson.



Mental Health

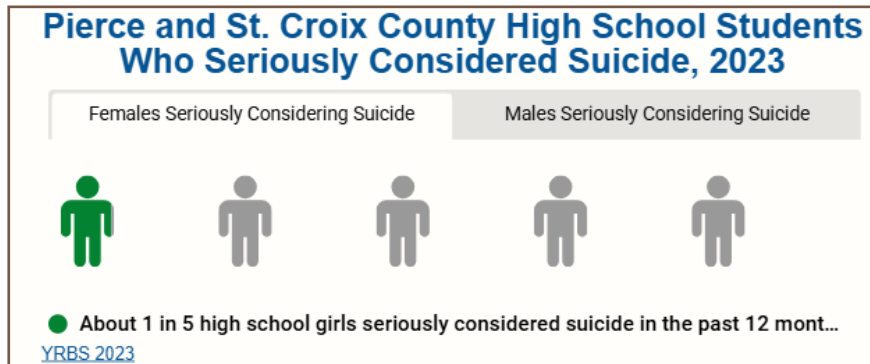
The mental health of residents in St. Croix and Pierce counties continues to worsen, with increasing indicators of depression and a growing number of people suffering from mental illness. The crisis affects both adults and youth, with roughly 15,500 people in St. Croix County and 7,400 people in Pierce County impacted.

This public health problem has severe consequences, including higher unemployment, poverty, and mortality rates. For adolescents, poor mental health is especially damaging and can result in risky sexual behavior, substance abuse, and academic failure.

¹ "Food Security in the U.S. - Definitions of Food Security." USDA, Economic Research Service, Food Security in the U.S. - Definitions of Food Security | Economic Research Service. Accessed 19 Sept. 2025.

² "Food Insecurity among the Overall Population in the United States." Feeding America, <https://map.feedingamerica.org/>. Accessed 24 Sept. 2025.

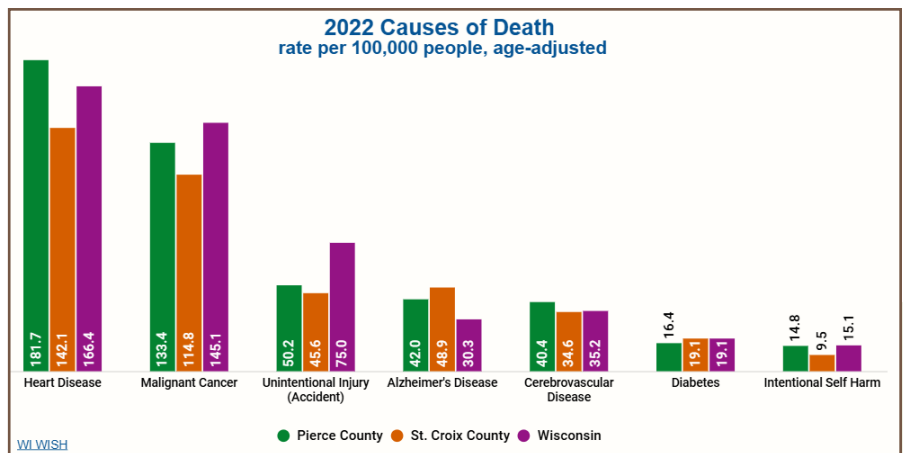
Access to treatment is a major barrier, as a large portion of those with mental illness are not receiving care—56% of adults in Pierce County, 52% in St. Croix, 37% of youth in Pierce, and 43% of youth in St. Croix.¹ Youth mental health is especially concerning where 1 in 5 high school girls seriously considered suicide in the past 12 months according to the 2023 Youth Risk Behavior Study.



Life Expectancy

Life expectancy serves as a reliable indicator of population health and mortality in the United States, though significant variation exists across different communities.

The COVID-19 pandemic caused a notable decline in U.S. life expectancy, which dropped by 1.5 years in 2020 to 77.0 years, its lowest point since 2003. Notably, estimates show that life expectancy varies among residents in communities like Pierce and St. Croix counties and in comparison to the Wisconsin state data.



Key Insights: Primary Data

In fall of 2024, Primary Data Collection was performed through a Community survey available in both English and Spanish which was distributed to the Healthier Together coalition’s email list, Western Wisconsin Health’s and public health departments’ social media, Western Wisconsin Health’s digital newsletter email list, and in paper copies to select locations including county WIC clinics (see Community Survey Tool in Appendix B).

Questions centered around health behaviors and health outcomes, social and economic factors, physical factors, clinical care, emergency preparedness, access to care, and health equity. A total of 686 St. Croix County community members and 431 Pierce County responded to this survey laying the groundwork for further community engagement and outreach.

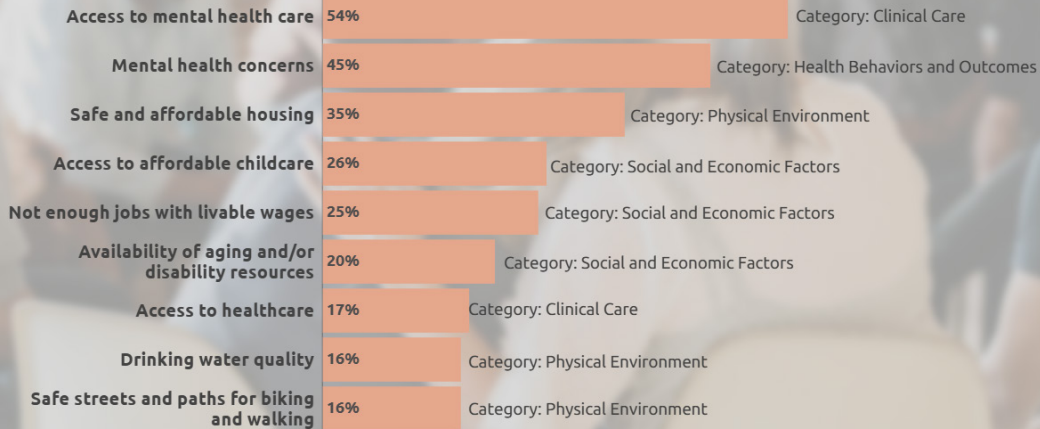
Community Survey Key Insights

St. Croix County community members responded that their highest community health concerns centered around access to mental health care and mental health concerns across all concern categories. Safe and affordable housing, access to affordable childcare, and access to jobs with livable wages rounded out the top 5 total concerns. (see Summary of Community Survey Results in Appendix C).

¹ “Wisconsin Mental Health and Substance Use Needs Assessment 2019.” WI DHS, Wisconsin Mental Health and Substance Abuse Needs Assessment Report 2019. Accessed 24 Sept. 2025.

Summary of St. Croix County Concerns

Top Concerns Across All Categories



In spring and summer of 2025, Western Wisconsin Health partnered with St. Croix County Public Health to understand more about the community’s health concerns and potential solutions.

Input was received from 3 focus groups (school and other community providers supporting youth mental health needs and medical providers) as well as 24 key informant interviews representing the following community sectors: schools, nonprofit organizations (such as food pantries, human service and support organizations, aging and disability resource organizations, free clinic, and healthcare), justice, Spanish speaking community members, and local government (see summary of findings in Appendix D). Input on local community strengths and assets was collected in Pierce and St. Croix County conversations (see Appendix E).

Combined themes from focus groups and key informant interviews regarding community health concerns and potential solutions include the following:

1. Mental & Behavioral Health

- Access & Affordability: Expand affordable care, virtual services, sliding fee scales, walk-in access.
- Workforce Shortage: Increase providers through training, incentives, and immigrant workforce.
- Coordination & Navigation: Use case managers, navigators, and improved care integration.
- Outreach & Education: Reduce stigma, promote services via media and community efforts.
- Tailored Support: Address needs of children, elderly, and Spanish-speaking populations.

2. Community Outreach & Engagement

- Targeted Outreach: Seniors, Latinx, isolated individuals via churches, newsletters, and events.
- Social Connection: Community events, volunteer programs, support groups to reduce loneliness.
- Cultural Inclusion: Programs in Spanish, culturally aware supports, faith leader involvement.

3. Housing & Homelessness

- Affordable Housing: Build low-income and smaller units; reform zoning to allow ADUs.
- Supportive Housing: Expand sober living, shelters, and multigenerational housing models.
- Policy Advocacy: Push for national/state housing policy reform and funding.

“When people struggle with basic needs, they struggle with mental health.”

- Community Member

4. Childcare & Family Support

- Access & Capacity: Build more centers, offer subsidies, school-based childcare.
- System Change: National policy reform and incentives for employer partnerships.



5. Aging & Disability Services

- Expanded Services: Dementia care, senior centers, daily living support, peer groups.
- Information Access: Better outreach via Aging and Disability Resource Center (ADRC), churches, and printed resources.

6. Transportation & Accessibility

- Improve transportation to health and social services, especially for rural and underserved groups.

7. Social & Economic Determinants

- Jobs & Income: Workforce training, job support, livable wage advocacy.
- Nutrition & Environment: Support for farmers markets, community gardens, and cleaner environments.
- Healthy Living: Promote physical activity, reduce screen time, support obesity prevention.

8. Youth & Education

- Mental health and substance use education in schools, youth programs, and reduced screen time.
- Promote apprenticeships and career paths in health and social services.

9. Systems & Policy Reform

- Integrated Services: Co-located services, co-responders, and cross-sector collaboration.
- Policy & Evaluation: Advocate for funding, evaluate programs, coordinate public systems.
- Holistic Care Models: Family-centered approaches, social determinant focus, peer involvement.

“Resources like crisis services, peer specialists, and case managers exist but are inefficient. There is a need for expanded high-acuity facilities and increase in our workforce capacity.”

- Community member

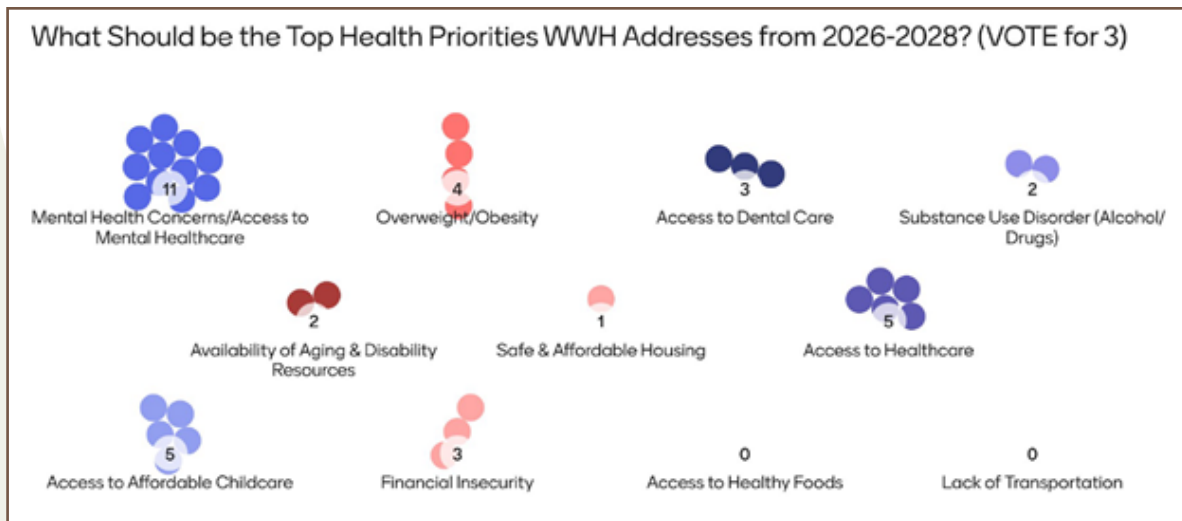
VI. Prioritized Health Needs

Summary of Prioritization Process for Community Health Issues

Community members representing multiple community sectors were invited to a Community Stakeholder meeting to discuss and prioritize top community health priorities for WWH in June 2025 (see Appendix F for list of stakeholder invitees and attendees). Participants reviewed primary and secondary data, participated in guided discussion questions regarding the health data considering disparities, how to consider feasibility and impact, and then completed a digital multi-voting/dot-voting activity.

The top 11 health priorities from the community survey were listed for the first round of voting. Each participant received 3 votes (dots) to allocate among the priorities they feel are most important. The second round of voting included the top 6 priorities from the first round. Participants then could select their top 2 priorities.

The final health priorities chosen were: 1. Mental Health and Wellbeing 2. Access to Healthcare



VII. Community Health Improvement Plan (CHIP) Outline

Input for potential strategies was provided from the focus groups, key informant interviews, and stakeholder meeting. Feedback was condensed into themes for WWH senior leaders, medical providers, and managers to provide input to shape the strategies. St. Croix and Pierce County Public Health departments provided review and feedback of goals and strategies from population health and health equity lens as well as opportunities for collaboration. Public health departments and the local hospitals all continue to have mental health and wellbeing as priorities while access to care is a shared goal with one other facility.

III. Priority Areas, Goals, and Strategies

Priority 1: Mental Health and Wellbeing

Mental Health Goal 1: Increase Access to Mental Health Services by end of 2027.

Strategy 1: By December 2027, increase visibility and availability of mental health providers.

- Action Plan:

1. Develop marketing campaign to promote available mental health services and mental health provider availability.
2. Ensure adequate mental health therapist staffing to maintain an average wait time of six weeks or less for new patient therapy appointments following referral by end of 2027.

Strategy 2: Improve access and affordability to mental health services.

- Action Plan:

1. Develop care pathway from mental health crisis in ED back to outpatient mental health services.
2. Assess opportunities to connect patients to financial counselors for assistance and resources to support accessing mental health care services.

Strategy 3: Provide mental health services that promote care across the lifespan.

- Action Plan:

1. Assess opportunities to enhance care for at risk patient populations (youth, seniors, and pregnant patients)
2. Ensure continuation of school based behavioral health services for youth in 3 local school districts.
3. Ensure continuation of psychiatric nursing home services to treat patients with cognitive and memory decline.

Mental Health Goal 2: Increase Community Engagement in Mental Health and Wellbeing by Implementing at Least 2 Prevention, Education, or Stigma-Reduction Initiatives Through Community Partnerships by end of 2027.

Strategy 1: Provide mental health programs for the community that support mental health and wellbeing and improve stigma with education and prevention strategies especially in youth and seniors.

- Action Plan:

1. Evaluate and implement minimum of 1 ongoing mental health stigma and prevention education series or program by end of 2027.
2. Implement minimum of 2 community and patient education sessions focused on early assessment, prevention, and management of early cognitive and memory decline for patients and caregivers.



Strategy 2: Provide programs that support Mental Health in the workplace.

- Action Plan:

1. Continue or enhance offering of WWH employee wellness hour.

Strategy 3: Increase community-based programs and strengthen partnerships between healthcare providers and community services.

- Action Plan:

1. Evaluate and implement minimum of 1 mental health stigma and prevention education series or program by end of 2027 in collaboration with a community partner.

Mental Health Goal 3: Increase the Number of Individuals with Substance Use Disorders who Access Evidence-Based Treatment Services in the Community by end of 2027.

Strategy 1: Increase the number of individuals receiving outpatient substance use disorder treatment services at WWH by 50% by end of 2026.

- Action Plan:

1. Implement continuous enrollment outpatient substance use disorder program with minimum of 3 groups offered weekly.

Strategy 2: Increase the number of adults with substance use disorders treated with medication-assisted treatment.

- Action Plan:

1. Expand number of primary care or psychiatric providers offering medication-assisted treatment.

Priority 2: Access to Care

Access to Care Goal 1: Improve Access to Timely Care by end of 2027.

Strategy 1: Decrease wait time to see PCP by Dec. 2027.

- Action Plan:

1. Maintain third next available to industry standard for rural primary care providers by optimizing panel size considering patient complexity and FTE.
2. Provide community education about standard/average wait times to guide patient expectation.
3. Assess same day appointment accessibility and increase same day visit standards based on need.
4. Leverage technology to streamline visit flow and increase clinic capacity.
5. Expand team-based care for preventive and chronic case management to clinical team members (nurses, MTM pharmacist, etc).



Strategy 2: Increase access to timely, culturally competent prenatal and maternal healthcare services to reduce disparities in birth outcomes, especially for underserved populations by Dec. 2027.

- Action Plan:

1. Develop tailored outreach to inform community of available prenatal and maternal resources.

Access to Care Goal 2: Address Social Drivers of Health (SDOH) to remove barriers to care for patients by end of 2027.

Strategy 1: Assess and address SDOH for greater than 50% of patients in annual well visits by Dec. 2027.

- Action Plan:

1. Ensuring community resources are known.
2. Collaborate with community partners to address gaps in community resources.

Strategy 2: Partner with community agencies to have community health workers conduct home visits by Dec. 2027.

- Action Plan:

1. Expand utilization of Baldwin EMS community paramedic home visit program.
2. Collaborate with Adoray to implement community health worker outreach program.



Access to Care Goal 3: Enhance Health Literacy by Increasing the Number of Patients who can Independently Navigate Healthcare and Utilize their Health Insurance Benefits by end of 2027.

Strategy 1: Implement program to assist patients with navigation of health insurance coverage and financial resources by Dec. 2027.

- Action Plan:

1. Expand Patient Financial Services Department patient outreach to assist patients in navigating insurance coverage and increase number of patients in applying for WI Medicaid over baseline.

Strategy 2: Provide community education and engagement to help patients know when and how to access timely and cost-effective healthcare by Dec. 2027.

- Action Plan:

1. Develop and share community education regarding how to utilize insurance plans accessing the right care at the right time and other financial resources effectively.

Access to Care Goal 4: Ensure Adequate Healthcare Workforce to Sustain Access to Care by end of 2027.

Strategy 1: Assess anticipated healthcare practitioner workforce shortages and create ongoing programs to sustain workforce by Dec. 2027.

- Action Plan:

1. Model provider attrition rates and develop training pipeline programs to support workforce needs.

Strategy 2: Collaborate with minimum of three regional academic institutions to recruit, train, and retain professionals through targeted incentives and pipeline programs by Dec. 2027.

- Action Plan:

1. Evaluate current academic partnerships and expand partnerships and programs based on need.

VIII. Implementation & Monitoring

An internal WWH CHIP workgroup consisting of leaders from stakeholder departments will lead associated objectives in line with the WWH strategic plan and provide quarterly updates to this workgroup. External community partners will collaborate with leaders on their shared goals and objectives. St. Croix County Public Health and Human Services, Pierce County Public Health, Baldwin EMS, Adoray Home Health and Hospice, and Family Resource Center St. Croix Valley are current community collaborating partners in the planned initiatives. Public health departments and the local hospitals all continue to have mental health and wellbeing as priorities while access to care is a shared goal with one other facility.

IX. Evaluation & Reporting

Internal action teams and community collaborative partners will meet quarterly to assess progress in action plans. CHIP will be integrated into organizational strategic plan, and progress will be reviewed in quarterly organizational strategic plan meetings and reported quarterly to the WWH Compliance Committee. The overall goals and objectives will be revisited annually, and action plans with specific activities and progress measures will be developed as needed to address emerging trends within the goal areas. Action plans, metrics, and progress will be stored in the CHIP 2026-2027 project tracking document with all workgroup members having access. The CHNA/CHIP reports up through the WWH Compliance Committee for quarterly evaluation. Evidence-based models for public health and community health improvement guide this work (see Appendix G).

X. Sustainability & Continuous Improvement

Long-term strategies to maintain progress

- Establish ongoing community partnerships (e.g., county health departments, schools, EMS, Adoray, Family Resource Center) to ensure continuity of programs beyond initial implementation.
- Build staff capacity through training, pipeline development, and integration of evidence-based models (e.g., collaborative care, MAT, community paramedicine).
- Incorporate evaluation metrics into regular reporting cycles to monitor trends and reinforce accountability.

Integration into hospital strategic plan and budgeting

- CHIP goals and strategies will be directly aligned with Western Wisconsin Health's strategic plan, ensuring that leadership oversight, staffing, and resources are built into annual planning and budget processes.
- Budget allocations will support high-priority initiatives such as expanding behavioral health access, workforce development, and community-based care models.
- Financial sustainability will be reinforced by leveraging reimbursement opportunities (e.g., behavioral health billing, MAT services, team-based care codes) and state/federal grant programs.

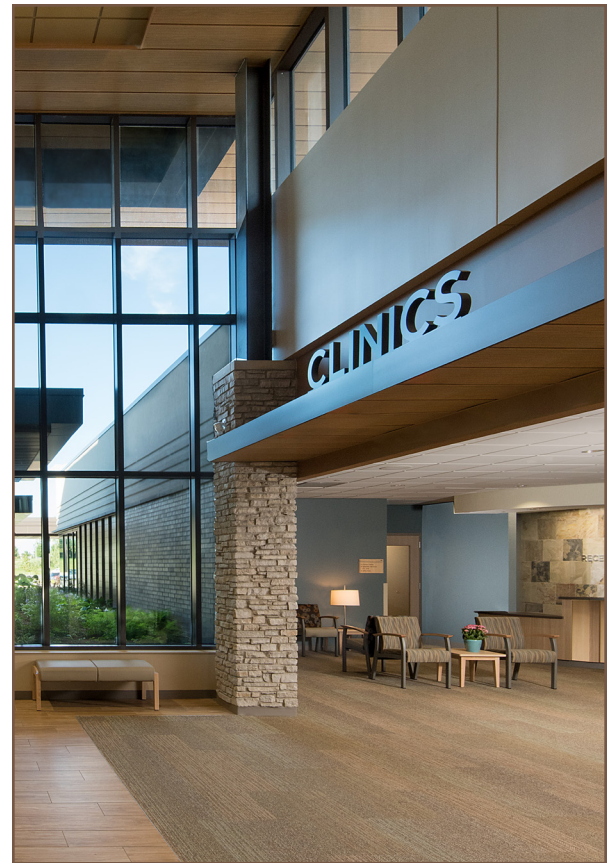
Opportunities to adapt based on new data or community needs

- Quarterly review by the WWH CHIP workgroup will include data-driven updates from EHR metrics, community surveys, County Health Rankings, and Wisconsin DHS reports.
- Feedback loops with community partners will be used to refine strategies, scale successful programs, and sunset those with limited impact.
- Flexibility will be built into each goal area, allowing rapid response to emerging health issues, workforce shifts, or changing demographic needs in the service region.

XI. Acknowledgments

WWH would like to thank many community partners who made this assessment and plan possible:

- St. Croix County Public Health and Pierce County Public Health who provided community survey distribution, collection, and analysis, data sets, collaboration in focus group and key informant interview facilitation, and expertise throughout the assessment process.
- Individual community members who offered their time and valuable insights.
- Partner organizations that met to review and prioritize data and develop implementation plans and the individuals who contributed their expertise and experience to ensure a thorough and effective outcome.
- Healthier Together Leadership Team, representing the four area hospitals, two public health departments in the two-county region and the United Way of St. Croix and Red Cedar Valley for their collegial partnership in sharing data and strategies and collaboration in aligned priorities.




Appendix A. Secondary Data Dashboard

Western Wisconsin Health's 2024 data dashboard with Pierce County and St. Croix County data can be found here:

<https://infogram.com/1pzmy2xnnxm2r0t2djzwqr06d3f12j5nngm?live>

Appendix B. Community Health Survey 2024



Community Health Survey 2024

Thank you for taking the time to fill out this survey. This survey was created as a way to get the community's opinion about factors that impact community health in Pierce or St. Croix County. **This survey is for people who live in Pierce or St. Croix County** and takes about 5-10 minutes to complete. All answers are anonymous.

1. Are you 18 or older? Yes No

2. What county do you live in? Pierce St. Croix

3. Zip Code of residence _____

4. What are the best parts about the county you live in? **Please choose up to three.**

<input type="radio"/> Good place to raise children	<input type="radio"/> Access to dental care
<input type="radio"/> Good Schools	<input type="radio"/> Safe neighborhoods/low crime
<input type="radio"/> Access to affordable health care	<input type="radio"/> Access to healthy foods
<input type="radio"/> Clean environment (water, air, etc.)	<input type="radio"/> Places to be active outdoors (parks, paths, trails, and green space)
<input type="radio"/> Good jobs/job opportunities	<input type="radio"/> Affordable housing
<input type="radio"/> Sense of community	<input type="radio"/> Low cost of living
<input type="radio"/> Acceptance of diversity/welcoming community	<input type="radio"/> Access to transportation

What is the main concern in each of the following categories you would like to see public health and their partners work on?

5. Health Behaviors and Outcomes **Please choose one**

<input type="radio"/> Excessive alcohol use	<input type="radio"/> Overweight and obesity
<input type="radio"/> Drug use	<input type="radio"/> Mental health concerns
<input type="radio"/> Tobacco/vaping use	<input type="radio"/> Chronic diseases (cancer, heart disease, diabetes)
<input type="radio"/> Physical inactivity	<input type="radio"/> Communicable diseases (measles, COVID, Lyme disease, sexually transmitted infections, etc.)
<input type="radio"/> Injuries and accidents	
<input type="radio"/> Oral or dental health	
<input type="radio"/> Access to healthy foods	

6. Social and Economic Factors **Please choose one**

<input type="radio"/> Education opportunities	<input type="radio"/> Unemployment
<input type="radio"/> Not enough social and/or community support	<input type="radio"/> Access to affordable childcare
<input type="radio"/> Violence in the home or the community	<input type="radio"/> Availability of aging and/or disability resources
<input type="radio"/> Not enough jobs with livable wages	<input type="radio"/> Discrimination or unfair treatment

7. Physical Environment **Please choose one**

<input type="radio"/> Air pollution	<input type="radio"/> Access to transportation
<input type="radio"/> Drinking water quality	<input type="radio"/> Safe streets and paths for biking and walking
<input type="radio"/> Climate change	<input type="radio"/> Access to safe places to be active outdoors
<input type="radio"/> Safe and affordable housing	<input type="radio"/> Access to high-speed internet

8. Clinical Care **Please choose one**

<input type="radio"/> Access to healthcare	<input type="radio"/> Low rates of routine vaccinations (childhood, flu, etc.)
<input type="radio"/> Access to dental care	<input type="radio"/> Limited use of preventative care services (annual exam, mammogram, colonoscopy, etc.)
<input type="radio"/> Access to reproductive and sexual health care	
<input type="radio"/> Access to mental health care	

9. Comments or other health problems in your community that you would like your local public health department and their partners to address:

PLEASE COMPLETE THE SECOND PAGE OF THE SURVEY

On the second page, we are going to ask you some questions about your household.

10. In the last 12 months, what barriers have you experienced accessing health care or health resources for yourself or your household? **Check all that may apply.**

- | | |
|---|---|
| <input type="checkbox"/> Ability to take time off from work | <input type="checkbox"/> Language barriers |
| <input type="checkbox"/> Access to childcare | <input type="checkbox"/> Negative past experiences with medical care |
| <input type="checkbox"/> Inconvenient appointment times | <input type="checkbox"/> Proximity to medical specialists |
| <input type="checkbox"/> Wait times to get an appointment | <input type="checkbox"/> Race/ethnicity |
| <input type="checkbox"/> Finding a provider | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Internet/technology access | <input type="checkbox"/> Insurance coverage (lack of coverage, poor coverage, provider not covered) |
| <input type="checkbox"/> Internet/technology knowledge | <input type="checkbox"/> Other barriers not listed |
| <input type="checkbox"/> Gender identity/expression | <input type="checkbox"/> I have not experienced any barriers to accessing health care or health resources |
| <input type="checkbox"/> Cost of care (deductible, copay, out-of-pocket expenses) | |
| <input type="checkbox"/> Lack of trust in medical providers | |

11. If you have experienced any other barriers to accessing health care or health resources that are not listed or would like to tell us more, please comment here.

12. Do all individuals and groups in your county have the same opportunities to live a healthy life?

- Yes No

13. If you disagree with the previous statement and want to tell us more, please comment here.

Household Preparedness Questions

14. What is your **main** source of information for a disaster or emergency event?

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> TV | <input type="checkbox"/> Friends, family, word of mouth |
| <input type="checkbox"/> Internet/online news | <input type="checkbox"/> Radio | <input type="checkbox"/> Place of worship |
| <input type="checkbox"/> Text message/cell phone alert | <input type="checkbox"/> Social media | <input type="checkbox"/> Other _____ |

15. Has your household prepared an Emergency Supply Kit with supplies like drinking water, non-perishable food, first aid supplies, flashlights, and extra batteries that is kept in a designated place in your home?

- Yes No

16. What would be the **main** reason that may prevent your household from evacuating if asked to do so?

- | | |
|--|---|
| <input type="checkbox"/> Lack of transportation | <input type="checkbox"/> Concern about leaving property |
| <input type="checkbox"/> Concern about personal safety | <input type="checkbox"/> Nowhere to go |
| <input type="checkbox"/> Health concerns | <input type="checkbox"/> Cost concerns |
| <input type="checkbox"/> Lack of trust in public officials | <input type="checkbox"/> No reason, would evacuate |
| <input type="checkbox"/> Concern about leaving pets | <input type="checkbox"/> Other |

Demographics

Gender: Male Female Non-binary Other
 Prefer not to say

Age: 18-24 years 25-44 years 45-64 years
 65 years and over

Ethnic Origin: Asian/Pacific Islander White
 Hispanic or Latino Native American/Alaska Native
 Black or African American Other Two or more

Thank you for your time! The results of this survey will be used by public health to plan and implement community health activities over the next few years.

Appendix C. Community Survey Results

Pierce County's 2024 community health needs assessment survey results can be found here:

<https://infogram.com/1p9y9vl179krqeu7qjjezj7km9h36vqy59g?live>

CHNA 2024 Pierce County by AZ Snyder - Infogram

St. Croix County's 2024 community health needs assessment survey results can be found here:

<https://infogram.com/1p2mx0g1yvrzw9u0ex7j9xgzyrhr5z5rqzp?live>

2024 SCC CHA Survey Results - Infogram

Appendix D. Focus Group and Key Informant Summaries

2025 Findings from Key Informant Interviews and Focus Groups: <https://infogram.com/1p57jqge2djlnosp19gml15edds3zv0e9z5>

<https://infogram.com/1p57jqge2djlnosp19gml15edds3zv0e9z5>

Appendix E: Community Assets and Resources¹

During the key informant interviews hosted Pierce County Public Health, St. Croix County, and WWH respectively, participants were asked about community assets and resources related to the topics discussed. The list below highlights some of the assets and resources serving the two counties that can enhance community well-being, which were mentioned during these interviews. This is not an exhaustive list of relevant resources.

Community Health Need	Strengths/Community Assets
<p>Mental Health</p>	<ul style="list-style-type: none"> • Faith Communities and Organizations • Aging and Disability Resource Center • Local Library Programs • St. Croix Valley Restorative Services • Free Clinic (for referrals) • Committed Hospital and Private Providers • School-based Programs and Support • Mental Health Screenings during Primary Care • County Mental Health Providers • Community Clubs • Chambers of Commerce • Telehealth for Therapy • Law Enforcement • PFLAG • Out in the Valley • 211/911/988 • Farmer Angel Network
<p>Access to Healthcare</p>	<ul style="list-style-type: none"> • Free Clinic of Pierce and St. Croix Counties • Culturally relevant wellness strategies • Aging and Disability Resource Center • Employer premium incentive programs • New Western Wisconsin Health Clinic (SV) • Existing clinics (Allina, MHealth, Mayo) • Stronger provider-to-provider relationships • Telehealth services are increasing • Medicaid/Medicare transportation programs • UWRF Student Counseling Services • Medical assistance (Medicare/Medicaid) • Subsidized marketplace insurance (ACA) • School nurses • EMS agencies • Long-term care facilities • Home care agencies • Farm worker healthcare outreach (WWH, UWEC) • Regional non-profit dental providers

Community Health Need	Strengths/Community Assets
Substance Use	<ul style="list-style-type: none"> • Aging and Disability Resource Center • School staff and programs/policies • Renaissance Charter Academy in River Falls • Law enforcement, including DARE • Human Services substance use providers • 211 resource referrals • Faith-based recovery programs • Kinnic Falls Inc. • Tobacco compliance checks • New Hazelden Betty Ford location in Hudson • St. Croix Valley Restorative Services
Resources for Older Adults and People with Disabilities	<ul style="list-style-type: none"> • Aging and Disability Resource Center • Seniors Staying Put • Meals on Wheels • EMS Agencies • Touching Hearts at Home • Grocery Stores with delivery programs • Local Faith Communities • Local libraries

Appendix F. Organizations and Community Sectors in Attendance at June 2025 Stakeholder Prioritization Meeting

Local Businesses:	OEM Fab, Lupient Ford, Baldwin Lightstream, Lindus Construction, Ellsworth Cooperative Creamery, St. Croix Electric Cooperative, Alliance Partners, Alera Group
Local Nonprofits:	United Way St. Croix & Red Cedar Valleys, Family Resource Center St. Croix Valley (2 representatives), Adoray Home Health and Hospice, Family Friendly Workplace, St. Croix Valley SART
Local Government:	St. Croix Health and Human Services, St. Croix County Public Health (3 staff), Village of Baldwin
Local Law Enforcement:	Baldwin Police Department
Local Long Term Care Organizations:	Park View Community Campus, Christian Community Homes

Appendix G: Resources for Identifying Evidence-Based and Promising Public Health Practices

Evidence-based practices are activities or strategies that have been demonstrated through scientific research to be effective in preventing or delaying a specific health outcome. Promising practices are programs or strategies that appear to have been effective in one context but lack sufficient research to determine their effectiveness in other contexts. The following list includes well-known, user-friendly, and public health-focused databases.

Source	Summary
CDC Health Impact in 5 Years (HI-5)	This initiative highlights non-clinical, community-wide approaches that have evidence reporting 1) positive health impacts, 2) results within five years, and 3) cost-effectiveness.
The Community Guide	This guide is a compilation of evidence-based findings and interventions designed to enhance health and prevent disease.
What Works for Health Wisconsin	This database provides communities with information to help select and implement evidence-informed policies, programs, and system changes that will improve the variety of factors that affect health.
NACCHO's Model Practices Database	This database contains programs from Local Health Departments across the United States that are nationally recognized as model practices.
Healthy People 2030 Evidence-Based Resources	This database utilizes five key categories: health conditions, health behaviors, populations, settings and systems, and social determinants of health. Each category has numerous sub-categories of relevant resources.
County Health Rankings What Works for Health	The database helps identify policies and programs that include evidence-informed programs, policies, and systems changes that can support community change efforts around specific topics and themes.
SAMHSA Evidence-Based Practice Resource Center	This database provides communities, clinicians, policy-makers, and others with the information and tools to incorporate evidence-based practices into their communities or clinical settings.
CityHealth	This registry rates the nation's largest cities based on their progress in adopting evidence-based policy solutions that will help them provide access to a safe place to live, a healthy body and mind, and a thriving environment for everyone.
Blueprints for Healthy Youth Development	This registry offers a comprehensive listing of scientifically proven and scalable interventions that prevent or reduce the likelihood of antisocial behavior, promoting a healthy course of youth development and adult maturity.