

Oneida Community Health Improvement Plan (CHIP) 2014-2016



Oneida Community
Health Services Department
525 Airport Drive
Oneida, WI 54155

Origin: January 2014
Updated: May 2016



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Anna John Resident Centered Care Community

Employee Health Nursing



Oneidas bringing several hundred bags of corn to Washington's starving army at Valley Forge, after the colonists had consistently refused to aid them.

PO Box 365



Oneida, WI 54155



UGWA DEMOLUM YATEHE
Because of the help of this Oneida Chief in cementing a friendship between the six nations and the colony of Pennsylvania, a new nation, the United States was made possible.

Greetings,

I am excited and honored to present the Oneida Community Health Improvement Plan (CHIP) to the members of the Oneida Nation. This plan was developed from a lot of hard work by individuals dedicated to improving services that will promote a healthier Tribal Community.

This plan identifies health priorities, goals, and strategies that build the capacity and foundation for a healthier community. The plan will have little impact without the support and involvement from our community members. By working together and taking action, we can achieve a healthier future for the Oneida Community.

I look forward to working with the community, collaborating with tribal departments and developing partnerships with local agencies in implementing this plan.

A special thank you is extended to community partners and workgroup members for their time and dedication throughout this process.

We invite you to actively be a part of this plan.

Regards,

Eric Krawczyk, MPH, MCHES

Community/Public Health Officer

Community Health Services Public Health Accreditation Committee

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Plan Acknowledgments

Committee Acknowledgments

Thank you to the following individuals for taking the time out of their busy schedules to participate in the development of the Oneida Community Health Improvement Plan.

2012 Oneida Community Needs Assessment Committee

- Eric Krawczyk, Team Lead, Community Public Health Officer
- Melissa Nuthals, Statistician
- Tina Jorgensen, Health Promotion Disease Prevention Supervisor
- Char Kizior, Head Start Registered Nurse
- Beth Scheelk, Dietitian
- Dianne McLester-Heim, Ombudsperson
- Debbie Danforth, Comprehensive Health Division Director
- Dr. Ravi Vir, Medical Director

2014 Quality of Life Survey Assessment

- Melissa Nuthals, Statistician
- Input from Division Directors and staff
- Input from the Business Committee

Original Community Health Improvement Planning Committee – 2014

- Eric Krawczyk, Team Lead, Community Public Health Officer
- Melissa Nuthals, Statistician
- Tina Jorgensen, Health Promotion Disease Prevention Supervisor

Community Health Improvement Plan Review Team Members – 2016

- Eric Krawczyk, Team Lead, Community Public Health Officer
- Melissa Nuthals, Statistician
- Tina Jorgensen, Health Promotion Disease Prevention Supervisor
- Char Kizior, Head Start Registered Nurse
- Stefanie Reinke, Health Promotion Specialist
- Kimberly Cornelius, Community Health Nurse
- Michelle Myers, Community Health Nursing Supervisor

Special Acknowledgment

We wanted to thank our partners at Wood County Public Health Department and Forest County Potawatomi for their Community Health Improvement Plan. Their examples for a comprehensive Community Health Improvement Plan was instrumental in making updates to our Community Health Improvement Plan that originated in January 2014. Thank you!

Why Community Needs Assessments And Improvement Plans?

- Assessment is a core function of public health. By utilizing the expertise of our community. Partners and evaluating health data we are able to strategically plan goals and objectives for improving the health of our community.
- Fosters successful partnerships of many facets of our community in order to have a continuous planning process for identifying and addressing health needs in Oneida Community.

Healthiest Wisconsin 2020

Healthiest Wisconsin 2020 provides a guiding framework for communities to complete their own local health assessments and health improvement plans. It also serves as a call to action for everyone to act as partners dedicated to improving and protecting health throughout the state. It is outcomes driven and its proposed interventions are tested and based on best evidence.

1. Adequate, appropriate, and safe food and nutrition
2. Alcohol and other drug use
3. Chronic disease prevention and control
4. Communicable disease prevention and control
5. Environmental and occupational health
6. Healthy growth and development
7. Injury and violence
8. Mental health
9. Oral health
10. Physical activity
11. Reproductive and sexual health
12. Tobacco use and exposure

Focus areas from the Healthiest Wisconsin 2020 plan, were used to compare data collected directly from the community to baseline and health disparity summary reports. These focus areas have been identified as follow: **Decrease Obesity, Quality Diabetes Care, and Access to Care for Behavioral Health.**

Socio-ecological Model

The Oneida Community Health Improvement Plan is based on the Socio-Ecological model for Prevention. The model depicts the different levels that influence change and overall health. The model illustrates that when changes are made at an individual level they tend to only influence a small number of people. However changes made at the community or public policy levels influence a larger amount of people causing more to experience the change ¹⁴.

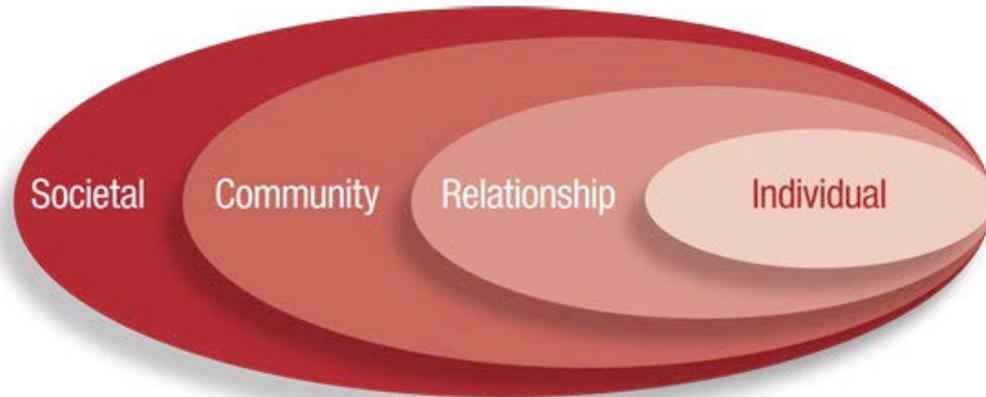
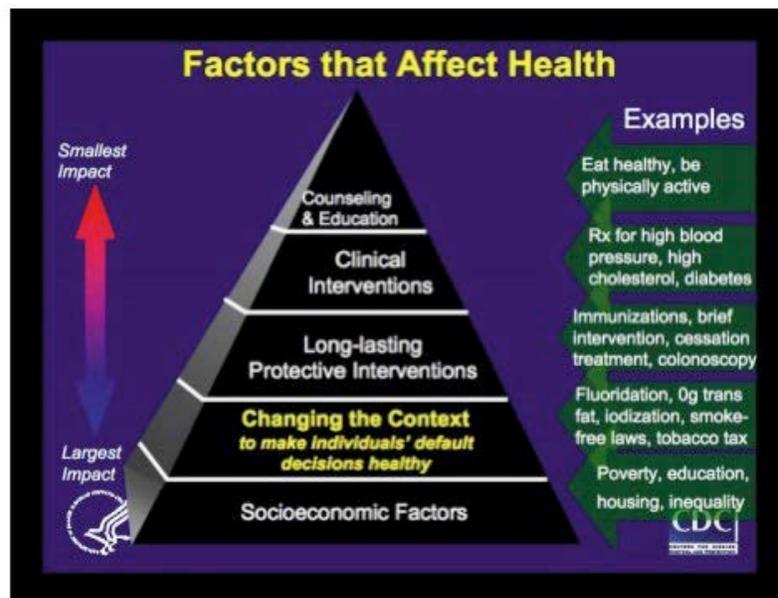


Figure 1.2. The Social-Ecological Model: A Framework for Prevention

Factor that Affect Health

There are many factors that influence health and how we address these factors can greatly affect the health of an individual and an entire community. For example, educating patients at a doctor’s visit will have very little impact on the overall health of an individual and a community. However, doctor’s visits combined with clinical interventions and policies that promote wellness will have a much greater influence on the overall health of an individual and community.



Oneida Community Overview

The Oneida Reservation straddles two counties in Wisconsin; Brown and Outagamie. It is approximately 10 miles by 10 miles for a total of 65,400 acres. The Tribe owns approximately 25,042 acres or 39% of the reservation (25,042 divided by 65,400)¹. About half of the land is residential /urban and half rural /agriculture. Parts of several neighboring communities reside within reservation boundaries. These include the town of Oneida, parts of the city of Green Bay and the villages of Ashwaubenon, Hobart and Pittsfield.

The Oneida Tribe has over 17,114 members around the world³. Approximately 24,086 Oneida and Non Oneida people live on the Oneida Reservation². Of this number, 4,496 people are Oneida Tribal members³. There are 7,599 Tribal Members in Brown and Outagamie counties³.

Our Process

The collaborative process used to assess the Oneida Community reflects a modified version of the model **Mobilize, Assess, Plan, Implement and Track** (MAP IT) as described in the “The Community Toolbox” found at <http://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/map-it/main>

M – mobilize

The key to improving the health of a community is to mobilize the right partners, assets and resources. It is critical that this collaborative approach be woven throughout the process. Throughout the steps of this model, different collaborative groups were gathered based on availability of partners and resources at the time. At minimum, these collaborative groups included representatives from a variety of health and wellness programming areas, front line program staff, Oneida Comprehensive Health Division leadership, Oneida Tribal Members, statistician or other assessment skill set resources. Oneida Comprehensive Health Division vision statement was adopted to align health and wellness related activities in the community.

A – assess

One way the Oneida Community has gathered unique data is through the collaborative process of a Community Needs Assessment. This specific data collection is driven by the Community Health Services Department of the Oneida Comprehensive Health Division.

In this process, community partners come together to look at and review available data, community assets and available resources. New data collection may also be part of this process. In partnerships with St Norbert College and our Enrollments Department, a modified version of the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System Questionnaire has been utilized. The survey is mailed out to Oneida Tribal Members, 18 years and older, living in Brown and Outagamie counties. This assessment occurs every five years. The last Community Needs Assessment was conducted February of 2012. 2,650 surveys were sent out through the mail.





Of this, 648 surveys were returned, making this a statistically relevant sample. Data collected in the survey is self-reported by the respondents. The type of information collected looks at the attitudes and beliefs about health and wellness, from a representative sample of the Oneida Community. The survey format automatically categorized qualitative data on attitudes and beliefs into measurable quantitative data. Because it's not realistic to improve all areas of health before the next Community Health Assessment, it's important to prioritize and select a few areas to focus improvement efforts. The Wisconsin state health plan, Healthiest Wisconsin 2020, has been a great tool to guide improvement action at the community level. Comparing health and infrastructure indicators from the state level to what is happening at the Oneida Community level allows us to demonstrate what's really going on locally. This assists the collaborative group set priorities that will drive the next step of developing a community health improvement plan.

Additional information is collected from the Oneida Community every two years through the Quality of Life Survey. This is another collaborative process facilitated by the Oneida Nation's statistician. A component of this assessment is survey collecting information from a representative sample of the Oneida Community. The type of information collected looks at attitudes and beliefs in relation to the programs and services available to Oneida Tribal Members. So it tends to be much broader than just health and wellness. The survey format automatically categorized qualitative data on attitudes and beliefs into measurable quantitative data. An additional piece of this assessment looks at data on social determinants; household income, number of people in the household, education levels, unemployment, etc. This social determinant data is often pulled from a variety of secondary data sources available to the public such as the United States Census, Internal Revenue Service, unemployment rates, etc. For ease of data analysis, the most current information is compiled and included in this assessment report.

Data analysis of the assessments included data tabulation and in both assessments was compared to data from the previous assessment. Each assessment summarized data analysis into separate Power Point presentations for convenience when sharing the information with leadership, stakeholders and the community. Broad reporting of the results did occur for both assessments. However not all activities were formally documented and therefore we provide the following summaries:

2012 Community Health Assessment PowerPoint presentation was shared with the Oneida Comprehensive Health Division Executive Management Team, the Wellness Council, informal updated to the Business Committee, student nurses, and a representative at WI Division of Public Health. Print copies and digital copies on CD of the report were made available and distributed at events that occurred late in 2012. The PowerPoint presentation is posted to the Community Health Services Department website for public view.

2014 Quality of Life Survey PowerPoint presentation was shared with the new Oneida Business Committee at a transition meeting August 18, 2014. Results were sent to tribal business units and division directors August 18th – 22nd 2014.

Additionally, the PowerPoint presentation and report information was made available on the internal INTRANET in a user-friendly format by August 14, 2014. Previous Quality of Life Survey data is also available here.

For the Oneida Nation, these two assessments will remain separate. However it is felt the information collected from both surveys demonstrate a comprehensive perspective. There is overlap in members participating in both collaborative group processes. Teams will therefore work together to prevent survey fatigue in the community by establishing different evaluation periods for each assessment. These assessments together meet the expectations listed in public health accreditation standards and measures.

P – plan

The next step was to create a plan with concrete steps and deadlines. We refer to this plan as our Community Health Improvement Plan. We incorporated the Oneida Comprehensive Health Division's vision statement and utilize the Healthiest Wisconsin 2020 plan, to guide this collaborative process in identifying goals and objectives for the plan. Oneida's current plan was created in 2014. The three focus areas identified using data from the Community Needs Assessment included; decrease obesity, quality diabetes services, and improved access to care for behavioral health services. During these discussions, the collaborative group noted additional data demonstrated greater than 50% of employees that worked for the tribal organization were Oneida Tribal Members. So the collaborative group at that time chose to add an employee wellness focus.

I – implement

The Community Health Improvement Plan was also communicated broadly in 2014 and 2015. The plan was shared with leadership, stakeholders and the community. It was posted to the Community Health Services Department website in 2015.

T – track

Tracking is a two-step process that includes data analysis and reporting on progress. Regular evaluation of the Community Health Improvement Plan has occurred. However, it historically has occurred in a somewhat decentralized method. For the Oneida Nation, nearly all health and wellness programs/ services fall under the Oneida Comprehensive Health Division. All activities and progress in health and wellness programming is filtered to the division's Executive Management Team on a quarterly and as needed basis. The Executive Management Team further filters this progress reporting to our Elected Officials- the Business Committee, and other stakeholders. In 2015, our public health accreditation teams began meeting to prepare for public health accreditation. We identified the need to incorporate more formal reporting of progress as it related to the focus areas identified in our Community Health Improvement Plan. In May 2016, a collaborative group was gathered with the purpose to update the plan to improve measurable reporting and better meet public health accreditation standards and measures. Using the evidence based tools and resources found in "The Community Toolbox", we were able to update our goals, objectives, and strategies to better show progress being made in the focus areas, as well as demonstrate activities and strategies in other health indicators connected to the state health plan.

At this time, the decision was made to place the employee wellness focus as a strategy in the decrease obesity focus area. We also added some comparative data from Healthiest Wisconsin 2020 as it related to our chosen focus areas. This updated plan will be distributed to leadership, stakeholders, and the community throughout the remainder of 2016. We also developed a summary flyer of the updated plan and will distribute at community events throughout the remainder of 2016. As a way to keep the community informed and engaged, we also added a notice that the next Community Needs Assessment is happening soon and that we look forward to their support and participation.

Resources and assets

Oneida Comprehensive Health Division

- Anna John Residential Coordinated Care Community (AJRCCC)
- Behavioral Health Services
- Employee Health Nursing
- Oneida Community Health Center

Oneida Governmental Services Division

- Elderly Services
- Social Services
- Oneida Family Fitness Center
- Head Start
- Child Care Services

Oneida Environmental Services Division

Farmers Markets

Oneida Nation School System

Oneida Police Department

Tribe's statistician

Partnerships with local health departments; Brown, Outagamie and City of DePere

Partnerships with State Health Department



Vision

A progressive sustainable health system that promotes
Tsi? niyukwaliho tál (our ways)

Oneida Community Focus areas

**Focus Area 1:
Decrease Obesity**

**Focus Area 2:
Quality Diabetes Care**

**Focus Area 3:
Access to Care**

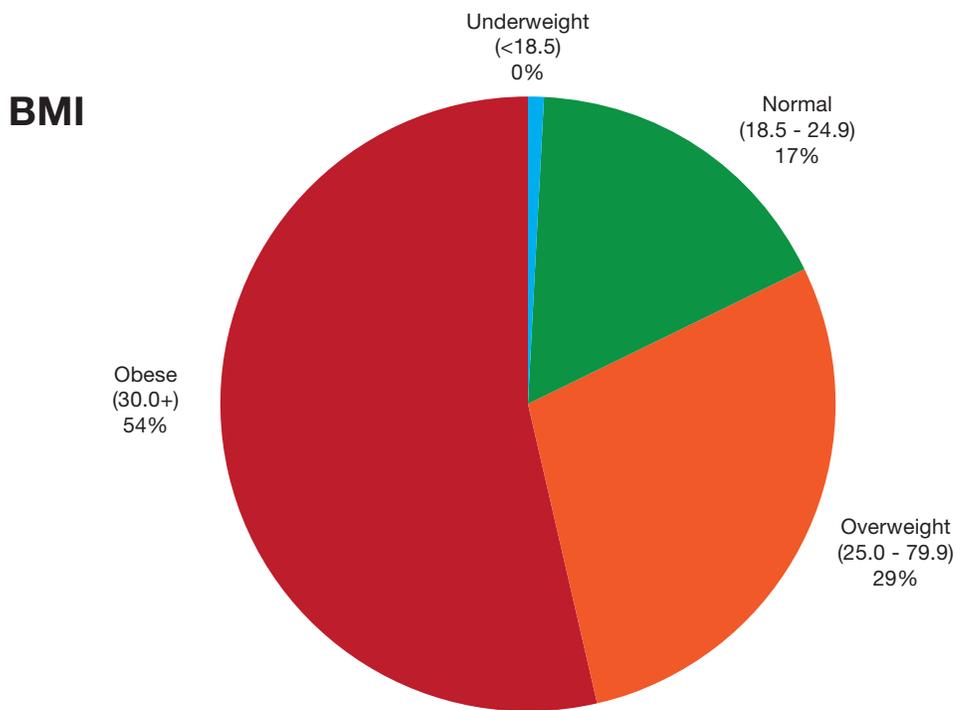
Focus Area 1: Decrease Obesity

According to the Centers of Disease Control and Prevention (CDC), there has been a dramatic increase in obesity in the United States over the last 20 years and rates continue to remain high. More than one-third of U.S. adults (35.7%) and approximately 17% (or 12.5 million) of children and adolescents aged 2-19 years are obese. Obesity is defined as having a BMI greater than 30. Body Mass Index (BMI is a screening tool used to estimate a person’s overall body fat⁶.

Overweight and obesity are major risk factors for chronic conditions including heart disease, stroke, type 2 diabetes and certain types of cancer, which happen to be the leading causes of preventable death in the U.S. Childhood obesity increases risk for early onset of these conditions. Children and adolescents who are obese are also at a greater risk for bone and joint problems as well as social and psychological problems.

The 2012 Community Needs Assessment survey demonstrated⁸:

- 83% of Oneida Community Tribal Members are overweight and obese with 54% considered obese.



2014 Data from Wisconsin Interactive Statistics on Health (WISH) demonstrates the follow rates for residents living in Brown and Outagamie Countries¹⁶.

Overweight – 39.3%
Obese – 24.3%

Conclusion:

Higher rates of overweight and obesity are noted in Oneida Tribal Members than other residents in Brown and Outagamie Countries.

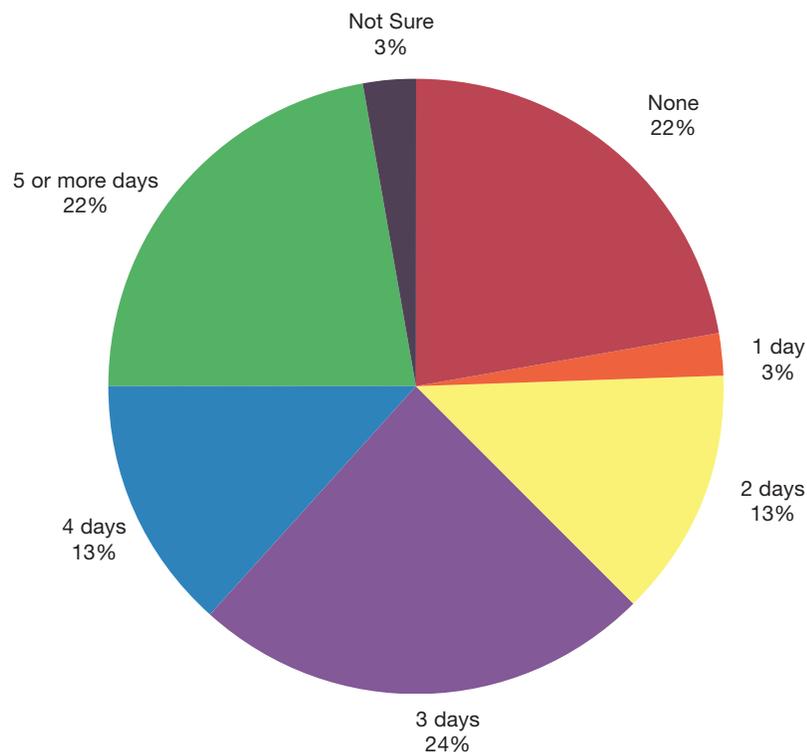
Unhealthy diet, lack of physical activity, tobacco use/ exposure and excessive alcohol use are the major risk factors for chronic disease. By eliminating these leading risk factors for chronic disease, it's estimated that at least 80% of all heart disease stroke and diabetes type 2 would be prevented, as well as over 40% of all cancers⁷.

Obesity rates could significantly be reduced in Oneida Community Tribal Members, if more individuals increased their physical activity levels and improved their diet.

The 2012 Community Needs Assessment survey demonstrated⁸:

- 62% of respondents exercised during the last month and 37% did not.
- 76% participated in moderate physical activities for at least 10 minutes outside of work.
- Of those who exercised, the median number of days with moderate exercise is 3 days per week.
- Of those who exercised, the median amount of time spent on moderate exercise is 13-30 minutes per day.

Days per Week spent doing Moderate Exercise



2014 Data from Wisconsin Interactive Statistics on Health (WISH) demonstrates the follow rates for residents living in Brown and Outagamie Countries¹⁶.

Any Exercise – 79.9%

Conclusion:

Lower exercise rates noted in Oneida Tribal Members than other residents in Brown and Outagamie Countries.

Obesity Prevention Improvement Plan 2014-2016

Goal 1: Reduce Oneida Tribal Members obesity rate.

Objectives	Strategies
<p>Objective 1: By 2017, Oneida Tribal Members age 18 years and older will reduce the obesity rate by 2%. (Baseline: 54% in 2012)</p>	<ul style="list-style-type: none"> • Offer Nutrition counseling through provider referral (Nutrition Dept, Medical Clinic). • Support Farmers Market events (OCIF). • Provide Wellness Coaching for overall Improvement of health status (HPDP). • Providing healthy recipes to the community (Nutrition Dept, HPDP, Head Start and Early Head Start). • Establish multidisciplinary team to develop strategies to impact the target population (Wellness Council).
<p>Socio-ecological Model Targets – Individual, Relationship, Community, Societal</p>	



How will we know if we are making progress?

Short term (2014-2015)

- Registered Dietitians will report an increase in referrals from primary care providers.
- Increase attendance at Farmer Market events.

Long term (2015-2016)

- Increased distribution of healthy recipes to Oneida Tribal Members.
- Oneida Tribal Members with a BMI of > 30 will decrease.
- Oneida Tribal Members report increased consumption of fruits and vegetables (JMIO registration repeats).
- Increased usage at Oneida Family Fitness Center.

Obesity Prevention Improvement Plan 2014-2016

Goal 2: Oneida Tribal Members will increase their physical activity levels.

Objectives	Strategies
<p>Objective 1: By 2017, Oneida Tribal Members age 18 years and older who regularly exercise will increase by 2%. (Baseline: 62% in 2012)</p>	<ul style="list-style-type: none"> • Provide community-wide physical activity opportunities (HPDP). • Support programming at Oneida Family Fitness Center (Tribe). • Develop employee wellness program (Wellness Council, HPDP).
<p>Socio-ecological Model Targets – Individual, Relationship, Community, Societal</p>	



How will we know if we are making progress?

Short term (2014-2015)

- Participation at community-wide physical activity opportunity events will increase.

Long term (2015-2016)

- Implemented policy for employees to have paid time off to exercise.
- Increase in Oneida Tribal Members that routinely achieve the recommended physical activity guidelines per week.
- Oneida Tribal Members with a BMI of > 30 will decrease.



Focus Area 2: Quality Diabetes Care

Diabetes is a major cause of heart disease and stroke among adults in the United States and is the leading cause of non-traumatic lower-extremity amputations, new cases of blindness, and kidney failure (1–3). In 2010, the Centers for Disease Control and Prevention reported that 25.6 million, or 11.3%, of US adults aged 20 or older had diagnosed or undiagnosed diabetes⁹.

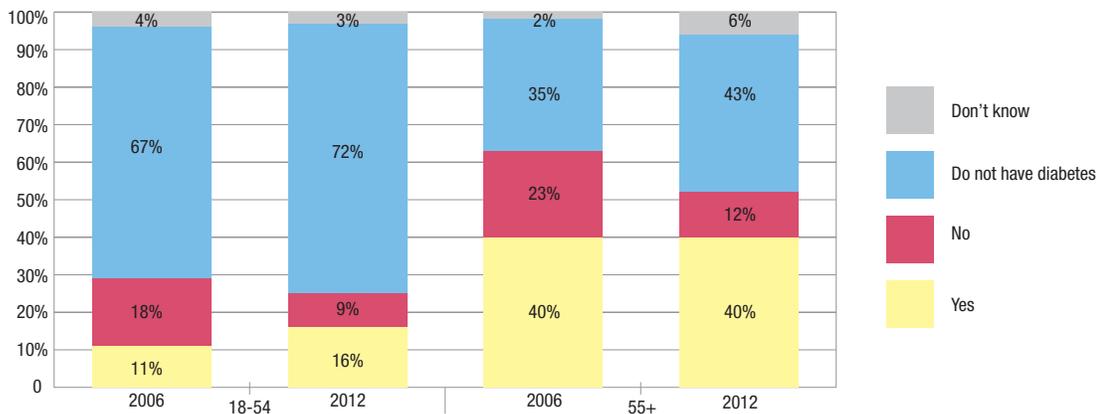
The Oneida Comprehensive Health Division currently receives Special Diabetes Program for Indians (SDPI) grant funding. Utilizing the evidenced based approach in the 2011 Indian Health Diabetes Best Practices model, the Oneida Community will mobilize resources to provide a comprehensive approach to the prevention and care of diabetes¹⁰.

<p>2014 Data from Wisconsin Interactive Statistics on Health (WISH) demonstrates a 9.0% rate of diabetes in Wisconsin residents¹⁶.</p>	<p>2014 Data from Wisconsin Interactive Statistics on Health (WISH) demonstrates a 7.3% rate of Diabetes in Brown and Outagamie Counties¹⁶.</p>	<p>Conclusion: Residents living in Brown and Outagamie Counties have a lower rate of diabetes than that of Wisconsin residents.</p>
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The 2012 Community Health Assessment survey demonstrated⁸:

- Of those that had been told they have diabetes by a healthcare provider, 57% check their glucose daily.
- 81% of members aged 55+ get checked for diabetes every year, down from 87% in 2006.
- 84% of respondents believe diabetes information is readily available from the Oneida Community Health Center.
- 46% receive education about diabetes from the Oneida Community Health Center, up from 37% in 2006.

Know Diabetes Score Card



Quality Diabetes Care Improvement Plan 2014-2016

Goal 1: Diabetes Education is available to Oneida Tribal Members with diabetes.

Objectives	Strategies
<p>Objective 1: By 2017, the percent of Oneida Tribal Members reporting diabetes education is readily available from the Oneida Community Health Center will increase by 4%. (Baseline: 84% in 2012.)</p>	<ul style="list-style-type: none"> • Provide community-wide education opportunities (Diabetes Team). • Provide small group education opportunities (Behavioral Health, Diabetes Team). • Provide one on one education opportunities (OCHD Providers, Oneida Family Fitness).
<p>Socio-ecological Model Targets – Individual, Relationship, Community, Societal</p>	



How will we know if we are making progress?

Short term (2014-2015)

- At minimum, consistent participation at community-wide diabetes education events.
- Increasing participation in small group diabetes education classes.
- Increasing participation in one on one diabetes education opportunities.

Long term (2015-2016)

- Decreased HgbA1C levels Oneida Tribal Members participating in education opportunities.



Quality Diabetes Care Improvement Plan 2014-2016

Goal 2: Provide an integrated, multidisciplinary approach to diabetes treatment for Oneida Tribal Members.

Objectives	Strategies
Objective 1: Oneida Comprehensive Health Division providers will continue to incorporate the 18 Best Practice Standards of Special Diabetes Program for Indians (SDPI).	<ul style="list-style-type: none"> • Standardized depression screening tool (OCHD Providers). • Referral system when depression is diagnosed (OCHD Providers). • Facilitate on-going multidisciplinary team meetings with the specific focus of working with patients with diabetes (Medical Clinic- DON). • Ensure Standards of Care – routine dental and eye exams, blood sugar control, foot care, etc. are being met (Diabetes Team).
Objective 2: By 2017, Oneida Comprehensive Health Division Providers will routinely screen patients diagnosed with diabetes for depression.	
Socio-ecological Model Targets – Individual, Relationship, Community, Societal	



How will we know if we are making progress?

Short term (2014-2015)

- Increased routine depression screening
- Implemented stream lined referral process.

Long term (2015-2016)

- Decrease number of patients experiencing complications related to diabetes such as ulcers, neuropathy, blindness, amputations, and kidney failure.



Focus Area 3: Access to Care – Behavioral Health

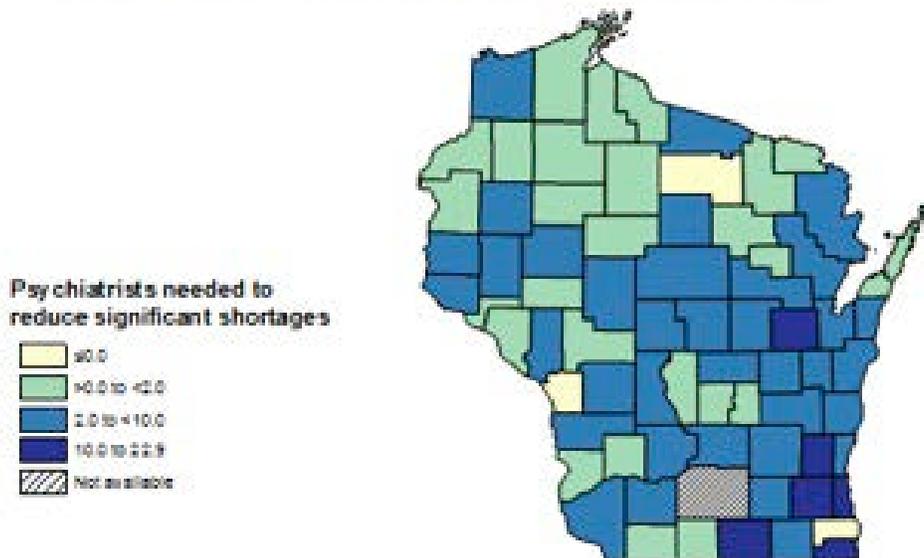
The burden of mental illness in the United States is among the highest of all diseases and is one of the most common causes of disability. It is estimated that 1 in 4 or 25% of adults in the U.S. have a type of mental illness. Rates of mental disorders are growing at an alarming rate in children and adolescents. In 2010, it was estimated that 1 in 5 children in the U.S. had a mental illness. Many mental disorders go unnoticed and as a result are left untreated. When mental illness is left untreated it can lead to unhealthy and unsafe behaviors including substance abuse, violent and self-destructive behavior and suicide¹¹.

Mental health and substance abuse are often times interlinked. According to the National Alliance of Mental Illness, recent studies indicate that the nearly one-third of people with all mental illnesses and approximately one-half of people with severe mental illnesses also experience substance abuse. On the other hand, more than one-third of all alcohol abusers and more than one-half of all drug abusers are also battling mental illness. Often time individuals with mental illness use drugs and alcohol to self-medicate. Drugs and alcohol may cause feelings of euphoria in the moment; however they ultimately worsen the underlying conditions¹².

Healthiest Wisconsin 2020 baseline and health disparity report; summary for Mental Health¹⁵.

GEOGRAPHY Access to health care

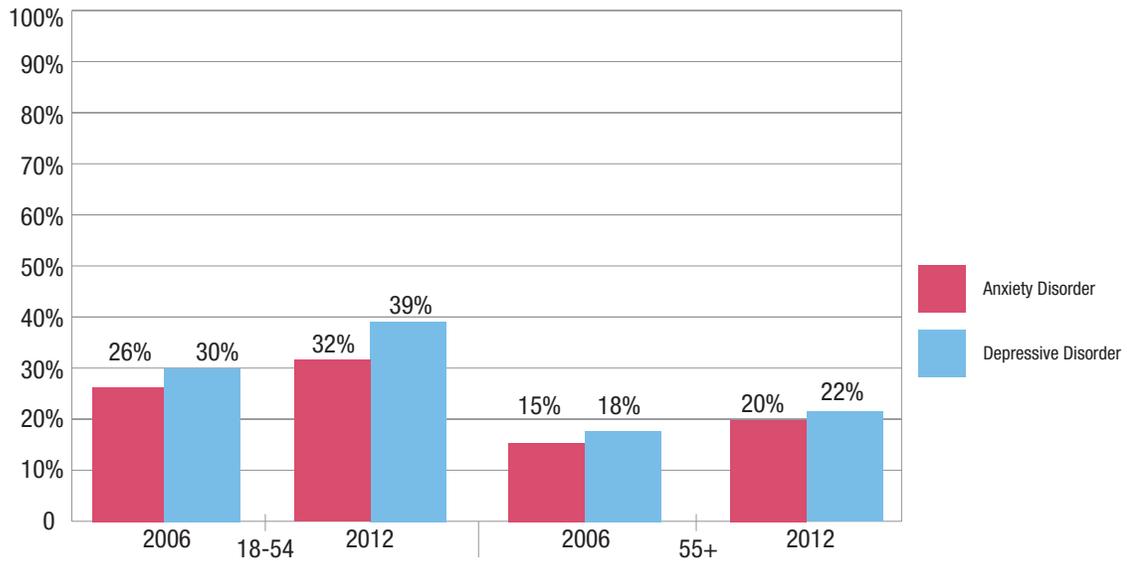
Number of full-time equivalent psychiatrists needed to remove significant shortages for the resident population, by county, 2011



Source: Wisconsin Department of Health Services, Primary Care Office, Shortage Designation Program.

The 2012 Community Needs Assessment survey demonstrated:

- 26% of respondents had been told by a healthcare provider that they have an anxiety disorder.
- 30% of respondents had been told by a healthcare provider that they have a depressive disorder.
- 21% of those aged 18-54 and 12% of those aged 55+ have used Oneida Behavioral Health Services in the past year.
- 14% of respondents indicated they needed to see a doctor at Oneida Behavioral Health Services in the past year, but could not due to lack of appointments.



2010 Data from Wisconsin Interactive Statistics on Health (WISH) demonstrates the following rates for WI residents¹⁶.

Depression – 16%
Anxiety – 12%

Conclusion:
 Higher rates of depression and anxiety are noted in Oneida Tribal Members than other residents in Brown and Outagamie Counties.



Access to Care Improvement Plan 2014-2016

Goal 1: Improve access to Behavioral Health Services for Oneida Tribal Members.

Objectives	Strategies
<p>Objective 1: By 2017, the percent of Oneida Tribal Members reporting they needed to see a provider at Oneida Behavioral Health Services but could not due to lack of appointments will decrease by 2%. (Baseline: 14% in 2012.)</p>	<ul style="list-style-type: none"> • Recruit and retain a qualified workforce (Behavioral Health). • Provide general education on how no shows impact access to care (OCHD Administration). • Implement a No Show Policy encouraging patients to keep scheduled appointments (OCHD Administration). • Improve communication within the health system providers in connecting individuals who need mental health or substance abuse services (OCHD Providers). • Promote utilization of Employee Resource Center- ERC and Employee Assistance Program- EAP resources (OCHD Providers).
<p>Socio-ecological Model Targets – Individual, Relationship, Community, Societal</p>	



How will we know if we are making progress?

Short term (2014-2015)

- Reduction in the No Show rate for Behavioral Health appointments.
- Increase utilization of ERC and EAP resources.

Long term (2015-2016)

- Behavioral Health routine exams are booking out less than 8 weeks.
- Behavioral Health will be fully staffed.



Additional Health Priorities

The following health priorities were not chosen as the focus areas for the Oneida Community Health Improvement Plan; however these topics greatly influence the overall health of the community. By continuing to address these health issues through community programs and partnerships we will work toward minimizing disease and maximizing health in the Oneida Community.

Chronic Disease Prevention and Management

Wisconsin's 2020 Goals:

- Increase sustainable funding and capacity for chronic disease prevention and management programs that reduce morbidity and mortality.
- Increase access to high-quality, culturally competent, individualized chronic disease management among disparately affected population of differing races ethnicities, sexual identities and orientation, gender identities, and educational or economic status.
- Reduce the disparities in chronic disease experienced among populations of differing races, ethnicities, sexual identities and orientations, gender identities and education or economic status.

Oneida's Actions:

- Follow best practice guidelines for chronic disease management and prevention.
- Provide education about lifestyle choices and the importance of preventive screening and well visits.
- Promote and encourage self-management support.

Communicable Disease

Wisconsin's 2020 Goals:

- Protect Wisconsin residents across the lifespan from vaccine –preventable disease through vaccinations recommended by the U.S. Advisory Committee on Immunization Practices.
- Implement strategies focused to prevent and control reportable communicable disease and reduce disparities among populations with higher rates.

Oneida's Actions:

- Provide education about communicable diseases and universal precautions.
- Offer education about the importance of immunizations as a method for prevention of communicable disease.
- Continue emergency preparedness planning, electronic disease reporting, and partner communication.

Reproductive and Sexual Health

Wisconsin's 2020 Goals:

- Establish a norm of sexual health and reproductive justice across the lifespan as fundamental to the health of the public.
- Establish social, economic and health policies that improve equity in sexual health and reproductive justice.
- Reduce the disparities in reproductive and sexual health experienced among populations of differing races, ethnicities and sexual identities and orientations, gender identities and educational or economic status.

Oneida's Actions:

- Collaborate with partners to provide education about sexually transmitted infections (STIs), screening guidelines, testing options, prevention and treatment.
- Continue to distribute condoms and STI education through the Oneida Brown Bag Program.
- Providing “Choosing the Best” and Human Growth and Development curriculums in the Oneida Nation School System.

Healthy Growth and Development

Wisconsin's 2020 Goals:

- Increase the proportion of children who receive periodic developmental screening and individualized intervention.
- Provide pre-conception and inter-conception care to Wisconsin women in population groups disproportionately affected by poor birth outcomes.
- Reduce the racial and ethnic disparities in poor birth outcomes, including infant mortality.

Oneida's Actions:

- Promote and educate about the importance of breastfeeding, newborn screenings, well child visits, immunizations, maternal and infant nutrition and physical activity.
- Provide education about tobacco and substance abuse and its effects on healthy growth and development.
- Educate about the importance of safe sleep practices as a method of preventing SIDS.





Oral Health

Wisconsin's 2020 Goals:

- Assure access to ongoing oral health education and comprehensive preventions screening and early intervention, and treatment of dental disease in order to promote healthy behaviors and improve and maintain oral health.
- Assure appropriate access to effective and adequate oral health delivery systems, utilizing a diverse and adequate workforce, for populations of differing races, ethnicities, sexual identities and orientation, gender identities and educational or economic status and those with disabilities.

Oneida's Actions:

- Provide education about the importance of oral health and regular dental visits throughout the lifespan.
- Educate about the importance of oral health during preconception, prenatal and postnatal periods and how it affects the mother and baby's health.
- Promote childhood oral preventive measures, such as fluoride supplements, varnish and dental sealants.
- Provide on-site dental services at Head Start and Oneida Nation School System.
- Dental outreach clinic for patients diagnosed with diabetes.

Tobacco Use and Exposure

Wisconsin's 2020 Goals:

- Reduce tobacco use and exposure among youth and young adults by 50 percent.
- Reduce tobacco use and exposure among the adult population by 25 percent.
- Decrease the disparity ratio by 50 percent in tobacco use and exposure among populations of differing races, ethnicities, sexual identities and orientations, gender identities, educational or economic status, and high-risk population.

Oneida's Actions:

- Continue to educate the community about the health risks associated with tobacco use and exposure.
- Continue to offer the Tobacco Cessation Program through Oneida Behavioral Health Services.
- Implement a smoke free campus policy for the Oneida Comprehensive Health Division facilities.



Actions for a Healthier Oneida Community

Spread the Word

Educate your friends, family, coworkers and community about the identified health issues and the initiatives outlined in this plan. Lead by example, role model healthy behaviors to your family and loved ones.

Engage the Community

Talk to community members to identify ways to improve the health of the Oneida Nation. Specifically related to obesity, quality diabetes care, and improved access to Behavioral Health services. Even the smallest actions can make the difference.

Establish Partnerships

Agencies and organizations can review the Oneida Community Health Improvement Plan and identify opportunities for alignment between their work and the health priorities outlined in this plan. Successful change requires involvement from the entire community. Seek opportunities for collaboration and partnerships with internal and external agencies within the Oneida Community or throughout Brown and Outagamie Counties.



References:

1. Oneida Land Management website 06/2013
2. U.S. Census Bureau 2014 ACS 3-year estimates
3. Oneida Enrollments records 03/2015.
4. (2010, July 21). In CDC Healthy Places. Retrieved April 27, 2016, from <http://www.cdc.gov/healthyplaces/about.htm>
5. (n.d.). In NACCHO Community Health Assessment and Improvement Planning. Retrieved April 27, 2016, from <http://www.naccho.org/topics/infrastructure/CHAIP/>
6. (2012, April 27). In CDC Overweight and Obesity Facts. Retrieved April 27, 2016, from <http://www.cdc.gov/obesity/data/facts.html>
7. Wisconsin Department of Health Services. (2011, January). In The Epidemic of Chronic Disease in Wisconsin: Why it Matters to the Economy and What You Can Do to Help. Retrieved April 27, 2016, from <http://www.dhs.wisconsin.gov/publications/P0/P00238.pdf>
8. Oneida Community Needs Assessment (2012, February) and Quality Of Life Survey (2014)
9. Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf. Accessed April 27, 2016.
10. Special Diabetes Program for Indians (SDPI) Best Practices for FY2016. Retrieved April 27, 2016, from https://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsBP_New#BPTOPICS
11. (2013, June 6). In Healthypeople.gov Mental Health. Retrieved April 27, 2016, from <https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health>
12. (2013, January). In NAMI Dual Diagnosis: Substance Abuse and Mental Illness. Retrieved April 27, 2016 from, http://www.nami.org/Template.cfm?Section=By_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=23049
13. (2013, March 8). In HealthyPeople.gov 2020 Topics & Objectives. Retrieved April 27, 2016, from <http://www.healthypeople.gov/2020/topicsobjectives2020/default>
14. The Social Ecological Model of Health. Retrieved April 27, 2016, from http://www.atsdr.cdc.gov/communityengagement/pce_models.html
15. Healthiest Wisconsin 2020 summary presentations found at <https://www.dhs.wisconsin.gov/hw2020/baseline.htm>.
16. Wisconsin Interactive Statistics on Health (WISH) found at <https://www.dhs.wisconsin.gov/wish/index.htm>.
17. The Community Toolbox. Retrieved May 20, 2016, from <http://ctb.ku.edu/en>