Oneida

Community Health Improvement Plan 2023 - 2028

Mid Cycle Review

Last updated July 2025

ONEIDA

Accredited Health Department
PHAB
Advancing Public Health Performance
Public Health Accreditation Board

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Partners

Yaw^ko (thank you) to all the partners who collaborated on the Oneida Community Health Improvement Plan. Your time, insight, and continued involvement is incredibly valued.

Big Bear Media
- Tourism
- Printing

Division of Public Works Community Development
- Planning
- Engineering
- Community Development/GIS

Oneida Community Members

Oneida Comprehensive Health Division (OCHD)
- Community Health Services
- Oneida Behavioral Health
- Medical
- Dental
- Optical

Oneida Human Services Division
- Recreation
- Transit
- Cultural Heritage
- Food Distribution Center

Oneida Nation Commission on Aging (ONCOA)

Oneida Nation Environmental, Land & Agriculture Division
- Sanitarian
- Natural Resources

Oneida Nation School System

Oneida Self-Governance

Tribal Action Plan

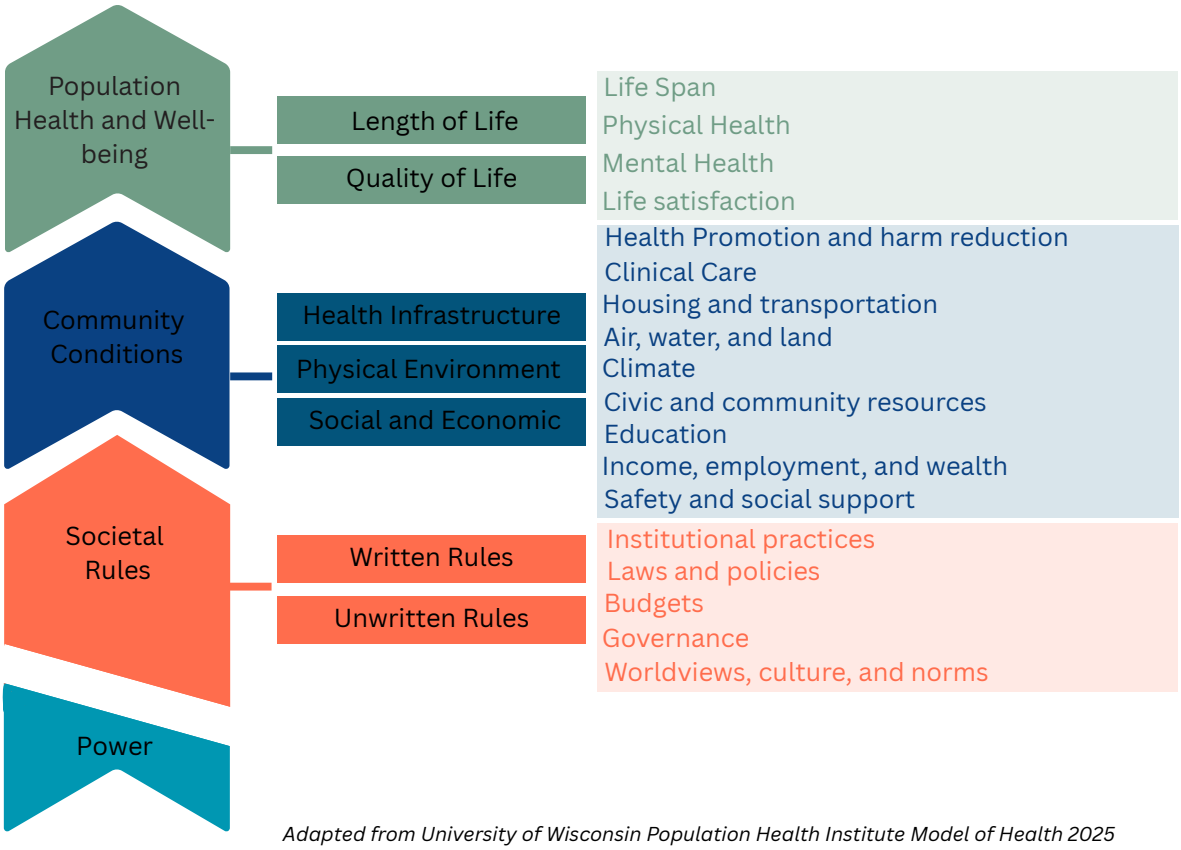
Introduction

What is a Community Health Improvement Plan?

A Community Health Improvement Plan (CHIP) is a five-year plan that serves as a guiding framework for health improvement initiatives within a community. The CHIP is a collaborative effort developed from community feedback and input. Its goal is to positively change the community's health.

What Makes a Community Healthy?

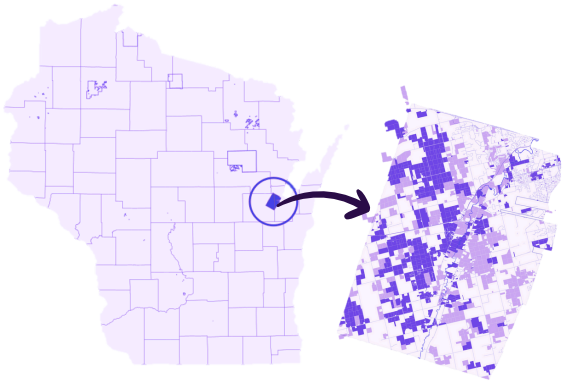
The World Health Organization describes health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Rather than treating an illness once someone is sick, disease prevention uses upstream efforts to reduce someone's chances of getting sick. Holistic health addresses all areas of wellness and is important to build a healthy community. Health is impacted by more than daily behaviors and choices. The health of the community is impacted by where people work, live, and play. Indigenous social determinants of health incorporate specific and unique aspects of American Indian and Alaska Native social, cultural, knowledge and beliefs, and political ways of life that create conditions that influence the health, healing and wellbeing of the peoples, which goes beyond the mainstream determinants of health.



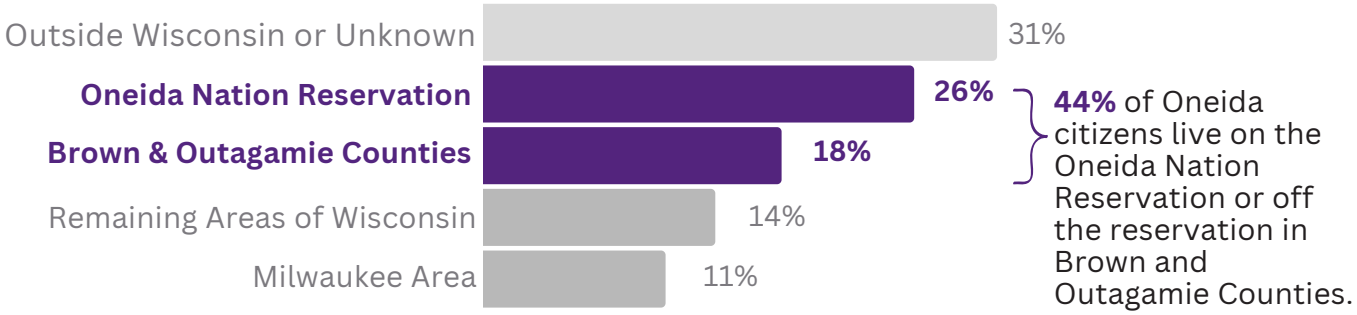
Adapted from University of Wisconsin Population Health Institute Model of Health 2025

Oneida Nation Community Profile

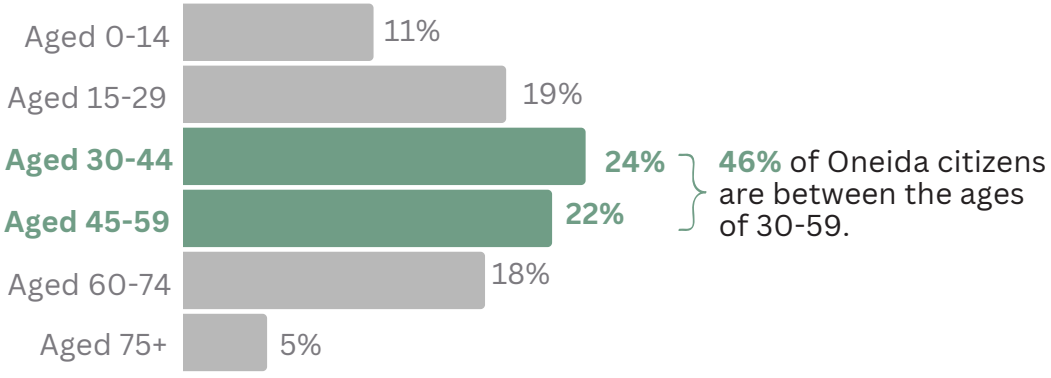
The Oneida Nation Reservation is located within the boundaries of Brown and Outagamie Counties in Northeast Wisconsin. It covers 65,400 acres, with approximately 28,888 being tribally owned. The Oneida Nation has approximately 17,243 citizens, with about 7,629 citizens living within Brown & Outagamie Counties.



Oneida Citizens by Location of Residence



Oneida Citizens by Age

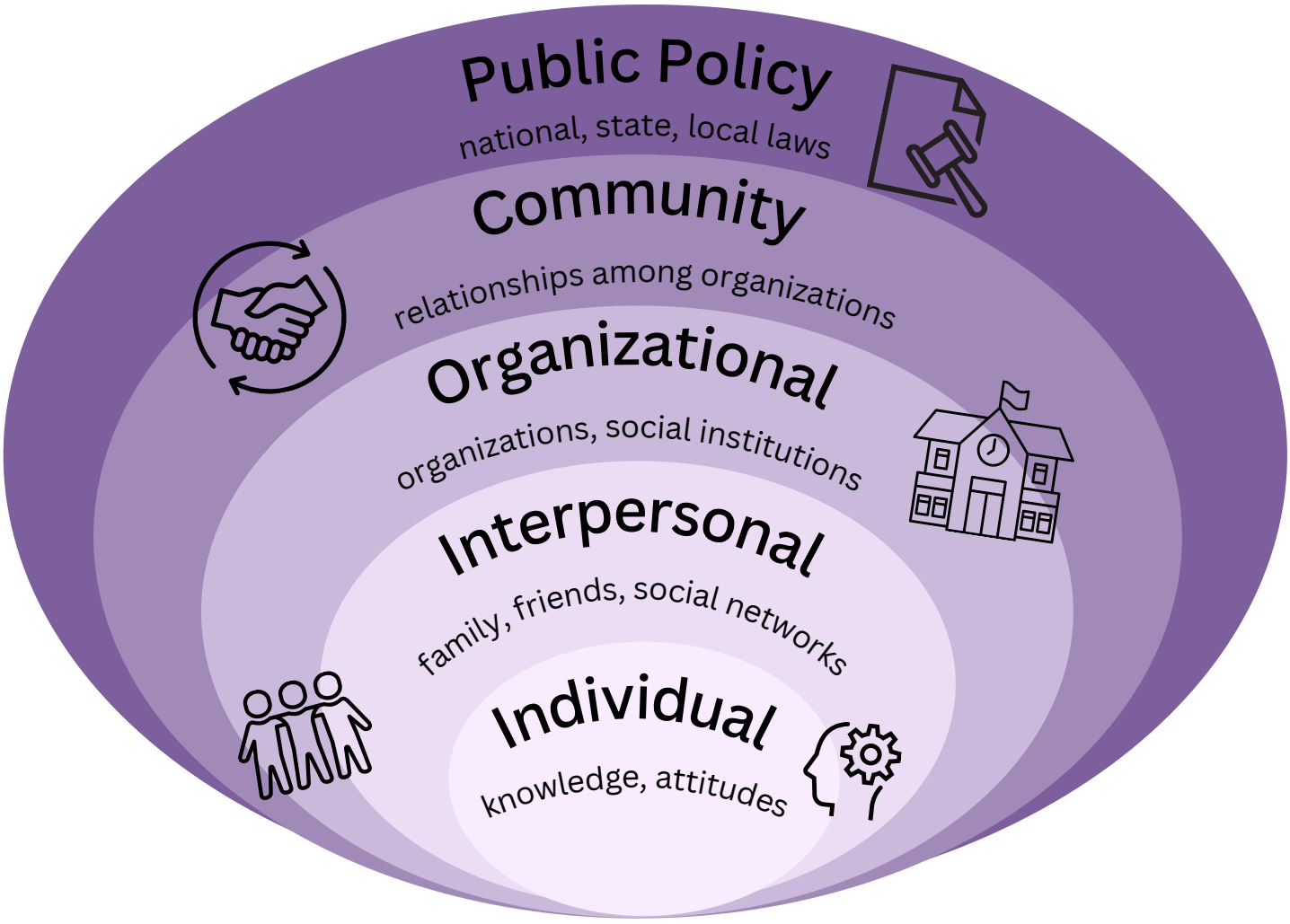


Data from Oneida Nation Enrollments (6/2025)

Health Improvement Model

Socio-Ecological Model

The socio-ecological model is used as a framework for the Oneida Community CHIP's strategies and initiatives. The socio-ecological model recognizes that there are multiple levels of influence on health behaviors and highlights the importance of working across levels to address the factors that influence both individuals and populations. The Oneida CHIP aims to target each level to improve health at individual, interpersonal, organizational, community, and public policy levels.



Adaptation of McLeroy, Bibeau, Steckler & Glanz (1988).

Process & Timeline

Community Health Services (CHS) utilized the Mobilizing for Action through Planning and Partnerships (MAPP) process to guide the CHIP work. The MAPP process is a framework for communities to prioritize health issues, identify resources to address them, and take action. There are a total of six phases in MAPP. The CHIP is in Phase 6 (Action Cycle) where continuous planning, implementation, and evaluation is occurring.

Phase 1
Organizing

In January 2022, a community health survey was put together by representatives from CHS, OCHD, Environmental Health, and Self Governance. The survey was sent out to all enrolled Oneida citizens 18+ years living in Brown & Outagamie Counties.

In March 2023, CHS put together a comprehensive Community Health Assessment (CHA) that incorporated data findings from the community health survey, community led focus groups, and additional data sources.

Phase 2
Visioning

Phase 3
Four MAPP Assessments

In April 2023, CHS completed the Forces of Change Assessment and the Local Public Health System Assessment to determine how current/future events may impact the health of the community and the capacity of CHS to deliver the essential public health services.

In May 2023, CHS requested community members, partners, and stakeholders to review the CHA and vote on which health areas to be prioritized over the next 5 years.

Phase 4
Identify Strategic Issues

Phase 5
Formulate Goals and Strategies

In August 2023, CHS invited partners and stakeholders and community members to discuss the priority areas. Three Priority-Area Teams were formed. Each team determined goals and strategies to be completed over the next 5 years.

Beginning in August 2023, CHIP Priority-Area Teams are actively working towards meeting identified objectives.

Phase 6
Action Cycle

Key Terms

To foster effective communication and collaboration among Oneida Community Members, CHIP Teams, Partners, and Collaborators, it is important to establish a shared understanding of key terms utilized within this document. By clearly defining these terms, we aim to eliminate ambiguity and ensure that everyone involved has the same understanding. This approach not only facilitates smoother interactions but also enhances the overall efficiency of our collective efforts.

Priority Area
Priority areas are broad, health-related areas identified through the prioritization process that was informed by CHA data.

Goal
Goals are general statements about what change we want to see. Goals are paired with indicators, which measure progress.

Indicator
Indicators are how we measure progress made towards a goal. These indicators are population level, meaning that they are not just based on one organization. They often are complex and can take multiple years to see measurable progress on.

Objective
An objective is a specific action that is done to achieve a goal. Objectives are SMART.

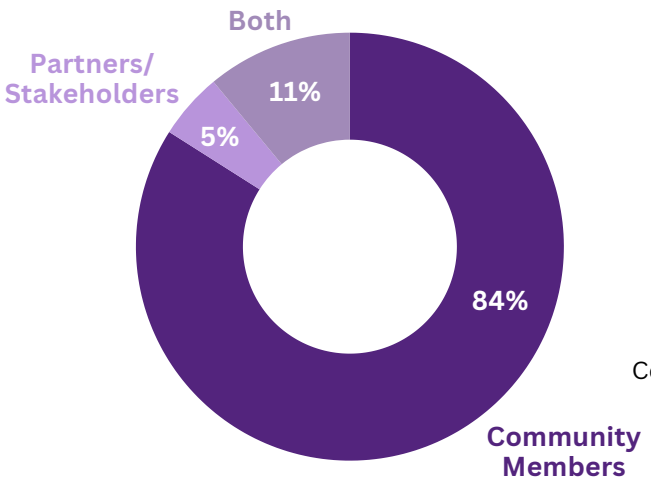
Specific: Specify what should happen.
Measurable: Make sure that there is data that can be used to measure progress.
Achievable: Objectives are feasible.
Relevant: Objectives are aligned with the mission and vision of the agency.
Time Bound: Specify a timeframe for achieving the objective.

Strategy
Strategies are a general approach or coherent collection of actions which has a reasoned chance of achieving desired objectives.

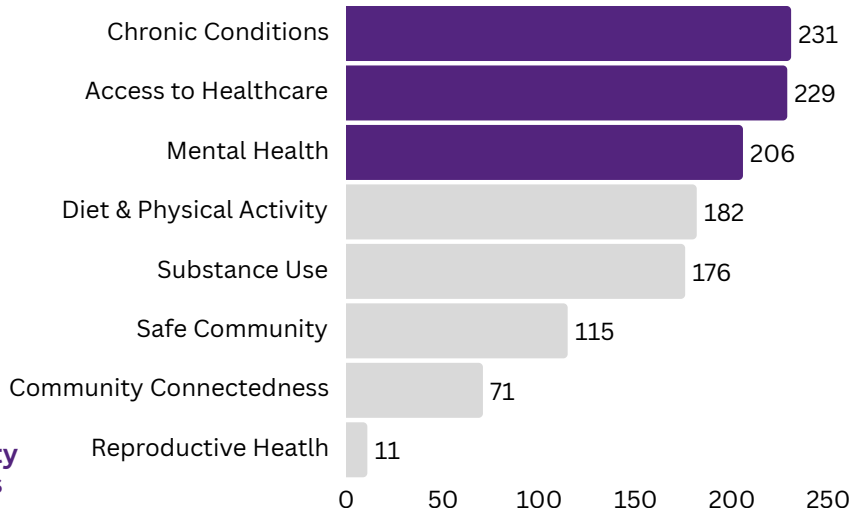
Determining the Priority Areas

To help determine which areas of health should be prioritized over the next five years, CHS sought out community and partner feedback through a brief survey. The CHA was posted online and shared through multiple communication channels to reach both Oneida Community Members and partners/stakeholders. At the end of the assessment, a link to a survey was provided for participants to vote on which health priorities they felt should be an area of focus for the next five-year CHIP. In addition, booklets of the 2022 CHA were mailed to all Oneida citizens 55+ years living in Brown & Outagamie Counties along with a paper version of the survey for them to mail back.

Survey Respondents



Health Priority Voting Results



After receiving just over 400 survey responses, it was determined that Access to Healthcare, Chronic Conditions, and Mental Health would be the 3 CHIP priorities over the next 5 years.

Access to Care

Chronic Conditions

Mental Health

Mission and Vision

Mission

We provide the highest quality, holistic health care to ensure the wellness for OUR Oneida Community.

Vision

Oneida Community Members will live healthy lifestyles through Improved Access to Care, Chronic Condition Management & Prevention, and Strong Mental Health.

Overview of Priority Areas

Priority Area #1: Improved Access to Care

Access to health care is defined as the “timely use of personal health services to achieve the best possible health outcome.” Having access to care allows individuals to seek out necessary care or treatment and have their health needs met. Access to affordable, quality health care is critical for overall health; however, many people face barriers that impact their ability to receive access to care and increase their risk of poor health outcomes.

Priority Area #2: Chronic Conditions Management and Prevention

Chronic conditions are health problems that are long-lasting and tend to get worse over time. These conditions require continuing medical care and can lead to death or disability. Eating healthy, exercising, sleeping well, not smoking, and avoiding alcohol are some ways chronic conditions can be prevented and managed. Preventing and managing these conditions can ensure we live long healthy lives.

Priority Area #3: Strong Mental Health

Mental health is our emotional and social well-being. It is important for all ages as it affects how we think, feel, and act. Poor mental health can increase the risk of other problems, including chronic conditions, like diabetes and heart disease. Mental illness is very common, especially in the Native American population, yet it often goes untreated. Strengthening the community's mental health can improve quality of life to ensure the community lives happy, healthy lives.

Priority Area #1:

Improved Access to Care

Background: The CHIP Team reviewed various access to care indicators from both the Community Health Survey and the Quality of Life Survey and identified transportation as a key area for improvement and opportunity. Challenges in accessing transportation can result in an individual needing to reschedule or cancel appointments, delay essential care, or misuse of medicine.

Goal 1: Increase access to comprehensive, high-quality care-coordination and health care services for all Oneida Community Members.

Indicator 1.1: Percent of adults that had to delay medical care in the past 12 months because they were unable to get transportation (Community Health Survey).

Objective 1: By December 31, 2028, decrease the percent of adults that had to delay medical care in the past 12 months because they were unable to get transportation by 5%.

Collaborators/Partners: OCHD, Human Services Division

Strategy 1.1: By September 30, 2025, broaden the partnership network to incorporate two additional transportation partners.

Strategy 1.2: By February 28, 2026, perform an analysis of six months' worth of Social Determinants of Health (SDOH) data to pinpoint two subpopulations that need improved transportation assistance in order to increase the transportation services that the Oneida Nation provides to underserved populations.

Strategy 1.3: By February 28, 2026, conduct an analysis of six months' worth of Social Determinants of Health (SDOH) data to pinpoint two services that the community faces transportation barriers in accessing to reduce transportation barriers for these services.

Strategy 1.4: By June 30, 2026, engage in targeted outreach to identified groups and services that require transportation assistance within the community.

The formalization of this Priority Area is still underway at the time of this document. Please note that collaborators, partners, and strategies may be subject to change.

Priority Area #2:

Chronic Conditions Management and Prevention

Goal 1: Improve, manage, and prevent chronic conditions by promoting healthy lifestyles and increasing awareness of resources in the Oneida Community.

Indicator 1.1: Percent of adults (not pregnant) that have been told they have diabetes by a doctor, nurse, or other health care professional (Community Health Survey).

Indicator 1.2: Percent of adults that exercised in the past month (Community Health Survey).

Indicator 1.3: Percent of adults that rate their physical health as "Excellent" or "Very Good" (Community Health Survey).

Indicator 1.4: Percent of adults that are obese (BMI > 30 kg/m2) (Community Health Survey).

Indicator 1.5: Percent of adults that include exercise in their diabetes treatment plan (Community Health Survey).

Indicator 1.6: Percent of adults that currently use e-cigarettes or other electronic "vaping" products every day or some days (Community Health Survey).

Objective 1: By December 31, 2028, Oneida Community Members will be more aware of activities, on the Reservation, that promote a healthy lifestyle.

Collaborators/Partners: OCHD, Big Bear Media, Human Services Division, Environmental, Land & Agriculture Division, Division of Public Works Community Development

Strategy 1.1: By June 30, 2026, finalize Oneida Trail Guides Version 2 and distribute 1,000 to Oneida Community Members.

Objective 2: By December 31, 2028, OCHD Providers and Oneida Community Members will be aware of the most prevalent chronic conditions impacting the community through the promotion of prevention strategies and data.

Collaborators/Partners: OCHD, Oneida Digital Technology Services, Oneida Human Services Division

Strategy 2.1: Through December 31, 2028, monitor available data on chronic conditions that impact the Oneida Community Members.

Strategy 2.2: Through December 31, 2028, provide top three chronic condition resources and education to Oneida Community Members at 4 community events each year.

Strategy 2.3: By December 31, 2025, implement one Culture is Prevention Vaping Prevention Activity for 20 youth ages 13-17.

Collaborators/partners from Jan - Mar 2025 90-day Plan.

Priority Area #3:

Strong Mental Health

Goal 1: Strengthen and promote the mental wellness of the Oneida Community.

Indicator 1.1: Percent of adults that always or usually get the social and emotional support they need (Community Health Survey).

Indicator 1.2: Percent of adults that rate their mental health as “Excellent” or “Good” (Quality of Life Survey).

Indicator 1.3: Percent of adults that have considered suicide in the past 12 months (Community Health Survey).

Objective 1: By December 31, 2028, identify and raise awareness of at least one mental health gap within the Oneida Community.

Collaborators/partners: OCHD

Strategy 1.1: By August 31, 2025, conduct four focus groups utilizing the Deliberate Inquiry Method to identify gaps in mental health within the community.

Strategy 1.2: By December 31, 2025, the outcomes of the Focus Groups will guide the development of two community outreach activities.

Strategy 1.3: By January 31, 2026, the outcomes of the Focus Groups will be used to inform one program or service improvement.

Collaborators/partners from Jan - Mar 2025 90-day Plan.

Next Steps and Monitoring

The CHIP is designed to address key health priorities by setting high-level goals, identifying clear objectives, and implementing effective strategies. Recognizing the dynamic nature of policies and external factors, the CHIP is adaptable and could evolve annually to reflect changing needs and conditions. Each year, the CHIP partners will gather to celebrate past achievements and identify work for the upcoming year.

The groups within CHIP focus on establishing performance measures that will evaluate the quantity, quality, and overall impact of the strategies on the community. To facilitate ongoing evaluation and transparency, we are developing a better way to monitor our work, which will allow partners and CHIP Teams to track progress and outcomes over time, ensuring that the work remains responsive and effective in improving the health of the Oneida Community.

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Introduction (page 4)

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