# Community Health Needs Assessment

## 2025-2028

**ASPIRUS DIVINE SAVIOR HOSPITAL & CLINICS**

2817 New Pinery Road

Portage, WI 53901

## Acknowledgements

Aspirus Divine Savior is fortunate to work in partnership with many organizations committed to improving the health and well-being of our community. We extend our gratitude to the many community leaders who were willing to share their perspectives on the most important health issues facing the community, and who demonstrate a great interest in collaborating to improve the communities we serve.

Our appreciation also extends to the University of Wisconsin-Madison Division of Extension for their valuable support in analyzing the data, which has helped guide the selection of key health priorities. This report provides a foundation for developing a comprehensive community health improvement plan to address these important issues. We look forward to ongoing collaboration to build a healthier Columbia County.

Respectfully,

Chris Squire
President
Aspirus Divine Savior Hospital and Clinics

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## Executive Summary

Aspirus Divine Savior Hospital and Clinics and its community partners conducted a community health needs assessment from Fall 2024 through Spring 2025. The assessment included:

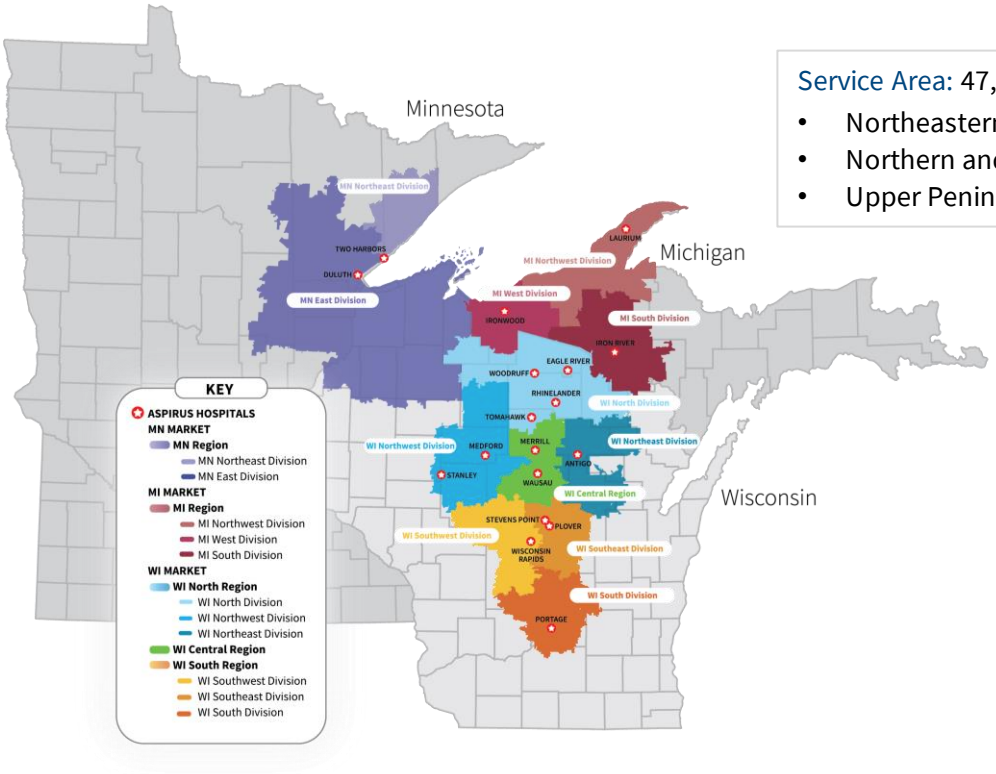
- The compilation of two kinds of data:
  - Community input. Community input was gathered through key informant interviews and community coalition meetings.
  - Health status data. Data on the health of the community was obtained primarily from the County Health Rankings and Roadmaps and the Wisconsin Department of Health Services.
- The review of data through the lens of multiple criteria (e.g., disparities, community momentum).
- A prioritization process that considered community input, health status data and criteria.
- The selection of a set of priorities the hospital is committed to formally pursuing over the next three years.

Aspirus Divine Savior Hospital and Clinics will be developing a plan to address mental health and substance use. As strategies are developed to address these issues, the hospital will be cognizant of the social drivers of health.

## Aspirus Health and Aspirus Divine Savior Hospital Profile

### Aspirus Health

Aspirus Health is a nonprofit, community-directed health system based in Wausau, Wisconsin, serving northeastern Minnesota, northern and central Wisconsin and the Upper Peninsula of Michigan. The health system operates 18 hospitals and 130 outpatient locations with nearly 14,000 team members, including 1,300 employed physicians and advanced practice clinicians. Learn more at aspirus.org.




Service Area: 47,517 square miles

- Northeastern Minnesota
- Northern and Central Wisconsin
- Upper Peninsula of Michigan

### Aspirus Divine Savior Hospital and Clinics

Aspirus Divine Savior Hospital and Clinics is committed to providing local access with high quality health care and has the opportunity to keep care local and strengthen access to primary and specialty care.

Among the services provided to residents of Columbia and Marquette Counties include inpatient hospital care, a 24/7 emergency department, urgent care, surgical services, imaging, and laboratory. The Aspirus La Vita Fitness Center is a medically based community fitness facility. Aspirus also offers various home care, hospice and senior living options in Portage.

## About the Community Health Needs Assessment

For Aspirus, the Community Health Needs Assessment (CHNA) is one way to live our mission – to heal people, promote health and strengthen communities – and reach our vision – being a catalyst for creating healthy, thriving communities. Conducting a CHNA is an opportunity to understand what health issues are important to community members. Community resources, partnerships and opportunities for improvement can also be identified, forming a foundation from which strategies can be implemented.

### Definition / Purpose of a CHNA

A CHNA is "a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize, plan and act upon unmet community needs."[1] The value of the CHNA lies not only in the findings but also in the process itself, which is a powerful avenue for collaboration and potential impact. The momentum from the assessment can support cross-sector collaboration that: 1) leverages existing assets in the community creating the opportunity for broader impact, 2) avoids unnecessary duplication of programs or services thereby maximizing the uses of resources, and 3) increases the capacity of community members to engage in civil dialogue and collaborative problem solving to position the community to build on and sustain health improvement activities.

### Compliance

The completion of a needs assessment is a requirement for both hospitals and health departments. For non-profit hospitals, the requirement originated with the Patient Protection and Affordable Care Act (ACA). The IRS Code, Section 501(r)(3) outlines the specific requirements, including having the final, approved report posted on a public website. Additionally, CHNA and Implementation Strategy activities are annually reported to the IRS.

In Wisconsin, local health departments are required by Wisconsin State Statute 251.05 to complete a community health assessment and create a plan every five years. The statute indicates specific criteria must be met as part of the process.

[1] Catholic Health Association of the United States, https://www.chausa.org

## Community Served and Demographics

### Our Community

The hospital's service area includes Columbia County as well as portions of surrounding counties. There are two hospitals in the county (including Aspirus Divine Savior Hospital). The city of Portage in Columbia County is a designated Health Professional Shortage Area (HPSA) for mental health (population-based HPSA). The nearby counties of Adams and Marquette are designated Medically Underserved Area (MUA).

For the purposes of our Community Health Needs Assessment, we have defined our "community" as Columbia County because (a) most population-level data are available at the county level and (b) most / many community partners focus on the residents of Columbia County.

### Demographics

Columbia County is a rural county in central Wisconsin. It covers 765.5 square miles, with 76.4 people per square mile and an overall population of 58,490 people. The table below outlines some of the basic demographics and related descriptors of Columbia County's population compared to Wisconsin.

| **Compared to Wisconsin, Columbia County has a higher percentage or proportion of individuals:** | **Compared to Wisconsin, Columbia County has a lower percentage or proportion of individuals:** |
|---|---|
| Who are White (alone) | Who are African American |
| Who are Veterans | Who are Asian |
| | Who are Hispanic |
| | With a bachelor's degree or higher |
| | With a disability |
| | In poverty |

Compared to Wisconsin, Columbia County also has a:

- Higher median age
- Higher median household income
- Lower proportion of households where a language other than English is the primary language
- Comparable percentage of high school graduates
- Comparable percentages of individuals under age 18 and over age 65
- Comparable percentage of individuals without healthcare coverage

Demographics of a community help with understanding changes in the population, economy, social and housing infrastructure.[2] Knowing who is part of the community and what their strengths and challenges are contributes to a stronger assessment and plan. See Appendix A for additional information.

## Process and Methods Used – Models and Frameworks

Aspirus' community health improvement approach is based on national research and models. This helps provide consistency and opportunities for alignment as we work across the health system and in our communities.

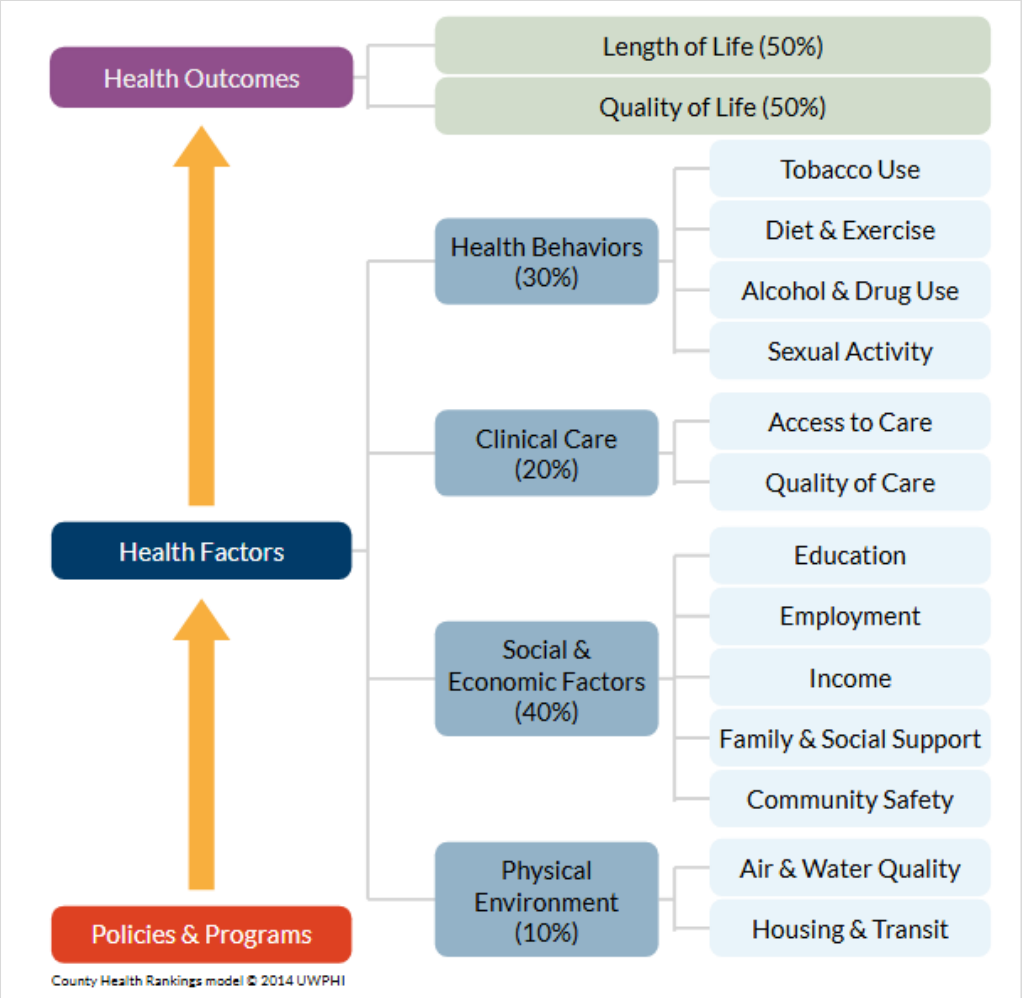
- For organizing data, Aspirus uses the County Health Rankings and Roadmaps Model. The model accounts for clinical, social, economic, behavioral and environmental factors that impact health.
- Aspirus recognizes that the factors affecting health are complex. The Bay Area Regional Health Inequities Initiative (BARHII) model helps represent those forces, as well as opportunities to intervene.
- A third model helps describe the difference between health equality and health equity.
- Lastly, Aspirus uses the Action Cycle from the County Health Rankings and Roadmaps . The Action Cycle describes how to conduct a community health needs assessment as well as community health improvement initiatives.

There are many other comparable models, which can be found in Appendix B.

[2] Dan Veroff, University of Wisconsin-Madison, Division of Extension, Organizational and Leadership Development. What you can learn about your community from demographics.

### Understanding Data: County Health Rankings Model

The County Health Rankings and Roadmaps Determinants of Health model was developed by the University of Wisconsin Population Health Institute (UWPHI). The Determinants of Health model (below) has three components – health outcomes, health factors and policies and programs. The County Health Rankings and Roadmaps (with funding from the Robert Wood Johnson Foundation) provides publicly available data within this framework for every county and state in the United States. For Aspirus Divine Savior, the health status data and much of the community input are organized in this framework.

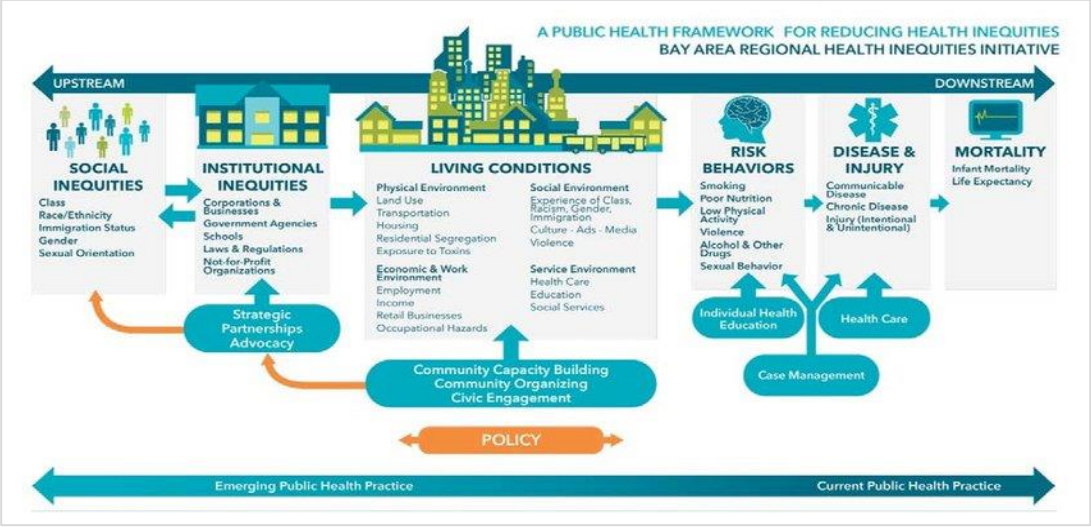


### Understanding Equity, Inequities and Complex Factors

As shown in the County Health Rankings Model above, there are many factors that affect health. Those factors are, in turn, affected by policies, systems and environmental factors. For example:

- Pricing and taxation on cigarettes impacts smoking levels.
- Zoning regulations impact how close or far a community is from a toxic waste dump.
- Stop signs, stop lights, school zones and roundabouts guide traffic patterns (and consequently the likelihood of accidents and injuries).

A model developed by the Bay Area Regional Health Inequities Initiative (BARHII) shows how those factors intersect.



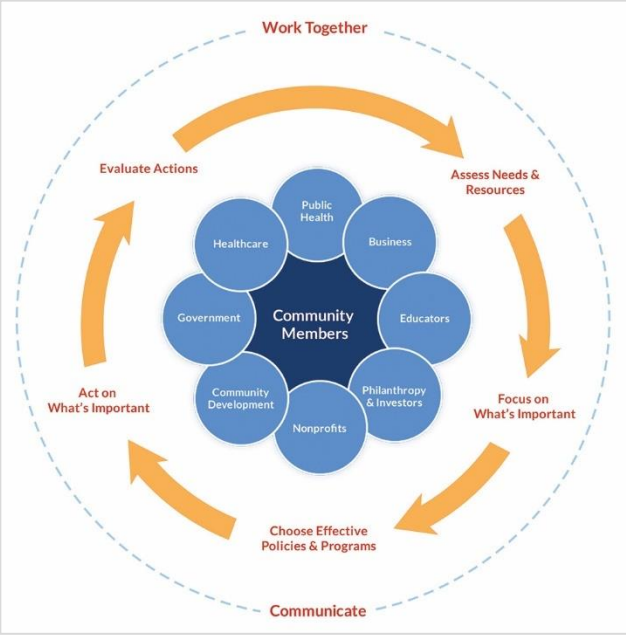

Another model helps explain the importance of recognizing that sometimes a one-size-fits-all solution does not work. The Robert Wood Johnson Foundation provided this health equity 'bicycle' model. If a person wants to go on a bicycle ride with their friends and family, each person needs a different bicycle solution to enjoy the ride. This parallels the work in health equity. Knowing what solutions work best for which people helps focus the provision of the appropriate resources.


Because of complex factors and forces, and the importance of individuals and communities getting what they need to be healthy, Aspirus is focused on strategies that impact everyone positively as well as strategies that disproportionately affect those who are most vulnerable to disease or illness.

## Understanding the Process: Action Cycle

The Action Cycle (from the County Health Rankings and Roadmaps) outlines, at a very high level, the overall community health assessment and improvement process:

- Assessing needs and resources
- Focusing on what's important (i.e., prioritizing)
- Choosing effective policies and programs (i.e., planning)
- Acting on what's important (i.e., implementing)
- Evaluating actions
- Effectively communicating and collaborating with partners




https://www.countyhealthrankings.org/resources/take-action-cycle

## Process and Methods Used – Applied

Aspirus Divine Savior gathered community input, compiled data and conducted a prioritization process to learn more about what is important to the community. The process included:

- Fall 2024: Aspirus staff conducted key informant interviews and collected secondary health status data.
- January 2025: The University of Wisconsin-Madison Division of Extension Regional Community Health Team reviewed, coded and analyzed the key informant interview information.
- February 2025: Aspirus staff brought a recommendation document with data and criteria to key stakeholders. Community stakeholders provided feedback and affirmed the prioritization of mental health and substance use.
- Spring 2025: The prioritized issues were shared with hospital leadership and the board of directors.

### Collaborators and / or Consultants

Aspirus Divine Savior conducted the needs assessment. The University of Wisconsin-Extension analyzed the key informant interview data. No paid consultants or vendors were utilized.

### Community Input

Columbia County community members provided their voice to the community health needs through key informant interviews (data gathering) and local community coalition meetings (prioritization). A concerted effort was made to ensure that the individuals and organizations represented the needs and perspectives of 1) public health practice; 2) individuals who are medically underserved, have low income, or are considered among the minority populations served by the hospital; and 3) the broader community at large and those who represent the broad interests and needs of the community served.

*Key Informant Interviews*

To gather community input, key informant interviews were completed. Key informant interviews provide qualitative data that reflects community members' first-hand knowledge, insights and expertise. Aspirus conducted 21 key informant interviews with different stakeholders in the community. A list of key informants as well as the set of questions can be found in Appendix C. A description of the process can be found in Appendix D.

The University of Wisconsin-Madison Division of Extension Regional Community Health Team coded and analyzed the interviews. The themes included:

- Major health issues: Alcohol and Other Drug Abuse (AODA), Mental Health, Food Security, Nutrition and Physical Inactivity, and Social Connection. Other issues mentioned include increased diversity in the community, human trafficking, oral health, hygiene, and fall injuries.
- Most vulnerable groups: The most mentioned groups include cultural and linguistic minorities, including Spanish-speaking and Amish populations (due to financial constraints and lack of culturally appropriate services). Another most-mentioned group is those who are aging and with disabilities (due to financial constraints, social isolation and lack of access to caregivers). Other vulnerable groups include families affected by financial constraints, incarceration, mental health and substance use, as well as teenagers and children, including LGBTQIA + youth.
- Major health drivers:
    - Access issues are underlined by multiple factors from the service providers' end, including the lack of providers and culturally-appropriate services, resources and navigation skills, partnership and trust, consistent and qualified employees (due to turnover, burn-out), as well as from the service users'/clients end, such as access to housing, transportation, childcare, financial ability, and work restrictions.
    - Community norms and conditions such as stigma, easy retail access of substances, and discrimination (based on race and sexuality) are also contributing to health access and health outcomes.

More complete results from the key informant interviews can be found in Appendix E.

### Input Received on the Last CHNA

No known input on the previous CHNA was received.

### Health Status Data / Outside Data

In addition to gathering input directly from community members, Aspirus Divine Savior compiled outside data reflective of the overall population's health status. These 'health status data' are gathered by credible local, state and national governmental and non-governmental entities and published/shared.

Reflective of the University of Wisconsin Population Health Institute (UWPHI) model, the data were grouped in the following categories:

- Health outcomes
- Health behaviors
- Clinical care
- Social and economic factors
- Physical environment

A summary of the health status data and corresponding sources can be found in Appendix F.

## Community Needs and Prioritization Process

To prioritize the issues, Aspirus staff met with community stakeholders during some standing/existing meetings. There were three prioritization opportunities:

- The Prevent Suicide Columbia County Coalition. The Prevent Suicide Columbia County Coalition is comprised of community partners aiming to address mental health needs through coordinated and collaborative initiatives. The Coalition includes approximately 20 organizations, including representatives from governmental public health, healthcare, non-profits, business and other sectors.
- The Prevention and Response Columbia County Coalition. The Prevention and Response Columbia County Coalition is comprised of community partners aiming to address substance use through coordinated and collaborative initiatives. The Coalition includes approximately 20 organizations, including representatives from governmental public health, elected officials, civic organizations, law enforcement, healthcare, non-profits, and other sectors.
- Coalition members who were not able to attend the formal meetings were able to complete a short input survey to provide input through.

The hospital brought a recommendation of the top priorities to the meeting. The recommendation was to continue with the current priorities:

- Substance use
- Mental health

The rationale for having a recommendation was:

- While some progress has been made in addressing the issues, the issues remain pressing.
- The health department led a robust process two years ago and will conduct another process in two years. The hospital wanted to respect community capacity and time by having a more abbreviated prioritization process at this time.
- The hospital's process can be an opportunity to identify emerging issues to plan for the health department's process in two years.

A recommendation document was prepared for the meetings and the online survey. The document compiled health status data and key informant interview results with criteria around: disparities; community momentum, readiness and alignment; internal infrastructure and capacity. Attendees were asked:

- What surprised you? What didn't surprise you? What else did you notice?
- Is anything going really well or not well in terms of strategies?
- What are any deep concerns with continuing to address these issues?
- Are there any emerging trends or other important information that is missing?

The coalition members' feedback was to continue addressing the top priorities as recommended: substance use; mental health.

Emerging issues were also identified:

- Falls
- Social connection
- Food security
- Nutrition and physical inactivity

These emerging issues will continue to be tracked along with addressing the top health priorities.

## Final Prioritized Needs

Over the next three years, Aspirus Divine Savior will formally address the following issues through its community health needs assessment and corresponding implementation strategy:

- Mental health
- Substance use

### Needs Not Selected

With the recommendation to continue the top health priorities listed above, other emerging needs were identified:

- Falls: Aspirus is implementing the CMS-required Age-Friendly measures to support healthy aging. As that internal work develops, Aspirus anticipates developing strategies and partnerships to strengthen the community supports for healthy aging and falls prevention. Aspirus Divine Savior actively partners with the Aging and Disability Resource Center, including for Stepping On Fall Prevention Programs on site.
- Social Connection: Although Aspirus will not be leading in this area due to limited capacity, Aspirus is committed to being a community partner at the table to contribute to solutions.

One way Aspirus will contribute is by screening for health-related social needs and helping facilitate referrals to community agencies as appropriate.

- Food security: Although Aspirus will not be leading in this area due to limited capacity, Aspirus is committed to being a community partner at the table to contribute to solutions. One way Aspirus will contribute to food security is by screening for health-related social needs and helping facilitate referrals to community agencies as appropriate.
- Nutrition and physical inactivity: Although Aspirus will not be leading in this area due to limited capacity, Aspirus Divine Savior will continue to implement nutrition-related Aspirus system strategies – fruit and vegetable prescription program (FVRx) and the NourishedRx program. Aspirus Divine Savior also periodically sponsors community runs/walks and other fitness-related efforts.

A brief overview of mental health and substance use is on the next pages.

### Healthcare Facilities and Community Resources

A brief description of health care and other organizations available to address community needs is in Appendix G.

# Mental Health

## Why is it Important?

More than 1 in 5 adults in the United States (59.3 million people in 2022) has a mental illness.[1] Mental health and physical health are closely related, with a correlation between some physical chronic illnesses and poor mental health.[2] Some risk factors include lack of access to education, income, employment and housing; adverse childhood experiences (ACEs); social isolation; drug or alcohol use.[2] Untreated mental health issues can contribute to issues such as family conflicts, problems with drugs or alcohol, weakened immune system, some chronic diseases and more.[3]

Sources: (1) National Institute of Mental Health, https://www.nimh.nih.gov/health/statistics/mental-illness. Accessed on 2/20/2025. (2) Centers for Disease Control and Prevention, https://www.cdc.gov/mental-health/about/index.html. Accessed on 2/20/2025. (3) Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968. Accessed on 2/20/2025.

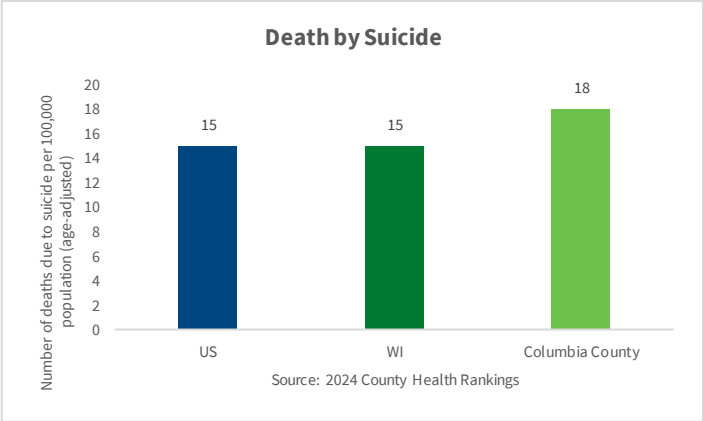
## Disparities and Inequities

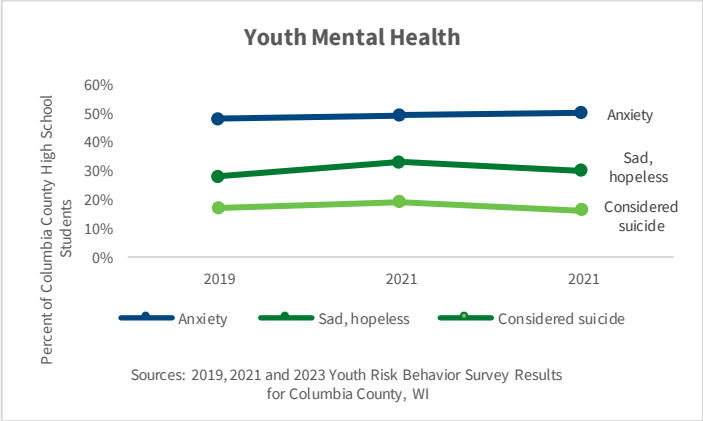
Disparities and inequities can show where interventions would be most beneficial.

- In the U.S., young adults (ages 18-25) have higher levels of any mental illness compared to adults 26-49 and over 50 years old.[1]
- Individuals in marginalized groups are more likely to have poor mental health.[2]
- The likelihood of depression decreases as education levels increase.[4]
- Depression is higher for women compared to men.[3]
- The suicide rate for men is four times the rate for women.[4]
- Over 50 percent of the students who identified in each of the following groups reported having anxiety: LGB; with disabilities; with food insecurity; with low grades; who are Hispanic; who have a multi-racial background.[5]

Sources: (1) National Institute of Mental Health, https://www.nimh.nih.gov/health/statistics/mental-illness. Accessed on 2/20/2025. (2) Macintyre, A., Ferris, D., Gonçalves, B.et al. What has economics got to do with it? The impact of socioeconomic factors on mental health and the case for collective action. Palgrave Commun4, 10(2018). https://doi.org/10.1057/s41599-018-0063-2. (3) Centers for Disease Control and Prevention, https://www.cdc.gov/mmwr/volumes/72/wr/mm7224a1.htm. Accessed on 2/21/2025. (4) National Institute of Mental Health, https://www.nimh.nih.gov/health/statistics/suicide#part_2557. Accessed on 2/21/2025. (5) Wisconsin Youth Risk Behavior Survey Summary Report (2021), Summary Report: 2021 Wisconsin Youth Risk Behavior Survey. Accessed on 2/21/2025.

## Data Highlights




## Community Perceptions and Challenges

- Mental health was one of the top issues identified in the key informant interviews.
- Many interviewees recognized the intersection of mental health with a range of other issues such as AODA, elderly suicide, youth violence, and social media.
- One key informant interviewee said: “Mental Health continues to be a post pandemic problem which can lead youth to use substances”

# Substance Use

## Why is it Important?

Alcohol and drug use are leading causes of preventable deaths.[1] Smoking is the leading cause of preventable death, with more than 480,000 deaths annually and a reduced life expectancy of 10 years.[2] It is estimated that 41,000 deaths due to secondhand smoke exposure occur annually.[3]

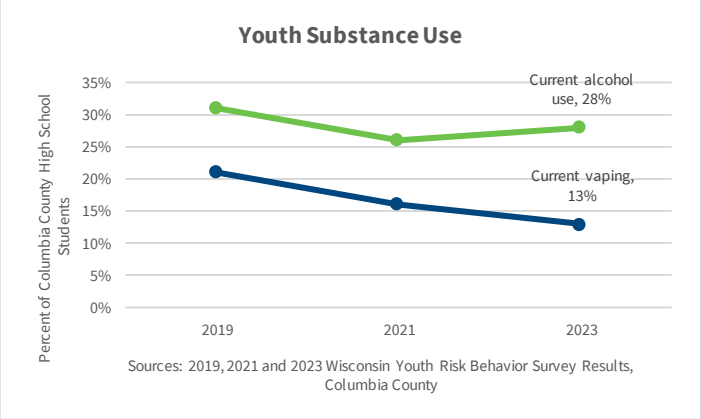
Alcohol is the most frequently used substance in the United States (ages 12+).[1] The number of alcohol-attributed deaths due to excessive alcohol use in the United States increased by 29% in the span of 5 years, from 138K in 2016-2017 to 178K in 2020-2021.[1] Short term risks and long-term impacts of excessive alcohol use include: violence (e.g., child maltreatment); unintentional injuries (e.g., falls); cancer; high blood pressure; long term memory problems and more.[4]

After a decade of increases in deaths due to drug overdoses (2011 to 2022), recent and preliminary data (for 2023 and 2024) show a leveling or decrease in overdose deaths in the United States. Drug dependence can result in a number of complications, including job loss, injuries, sexually transmitted infections, suicide, as well as family and social relationships.[5]

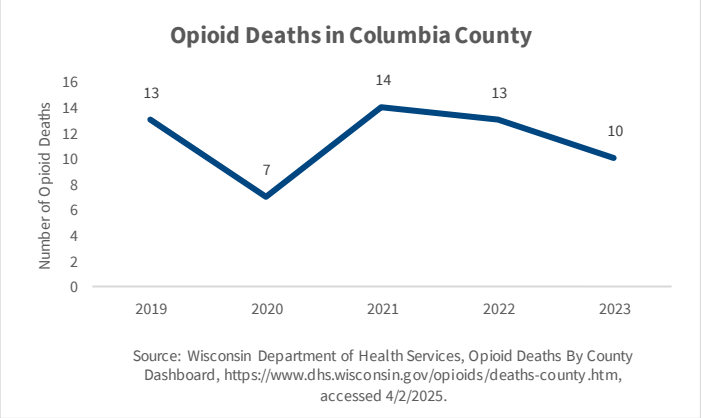
Substance misuse costs everyone. The estimated annual economic impact of alcohol misuse is $249B and for illicit drug use, the cost is $193B.[6] The estimated impact of smoking (healthcare spending and productivity) is $600B (2018).[7]

Sources: (1) Centers for Disease Control and Prevention, https://www.cdc.gov/alcohol/facts-stats/index.html. Accessed on 2/23/2025 and then revisited on 3/23/2025; page not available on 3/23/2025. (2) Association of American Medical Colleges, https://www.aamc.org/news/smoking-still-leading-cause-preventable-death-us-doctors-may-soon-have-new-tools-help-people-quit. Accessed on 3/23/2025. (3) Centers for Disease Control and Prevention, https://archive.cdc.gov/www_cdc_gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/index.htm. Accessed in February 2025 and then revisited on 3/23/2025. (4) Medical College of Wisconsin, Wisconsin Alcohol Policy Project, https://www.mcw.edu/departments/comprehensive-injury-center/wi-alcohol-policy-project/understanding-the-problem. Accessed on 3/23/2025. (5) Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/drug-addiction/symptoms-causes/syc-20365112. Accessed on 3/23/2025. (6) U.S. Department of Health and Human Services, https://www.hhs.gov/surgeongeneral/reports-and-publications/addiction-and-substance-misuse/index.html. Accessed on 3/23/2025. (7) Centers for Disease Control and Prevention, https://www.cdc.gov/tobacco/campaign/tips/resources/data/cigarette-smoking-in-united-states.html. Accessed on 3/23/2025.

## Data Highlights




Sources: 2019, 2021 and 2023 Wisconsin Youth Risk Behavior Survey Results, Columbia County




Source: Wisconsin Department of Health Services, Opioid Deaths By County Dashboard, https://www.dhs.wisconsin.gov/opioids/deaths-county.htm, accessed 4/2/2025.

## Community Perceptions and Challenges

- Substance use was one of the top issues identified in the key informant interviews.
- The data provides additional insights on emerging trends within these major health issues such as the misuse of Delta-8, THC and e-cigarettes among youth.

## Disparities and Inequities

Disparities and inequities can show where interventions would be most beneficial. Smoking is higher within a number of communities compared to their counterpart: rural; veterans; individuals with less than a high school diploma; individuals with blue collar or construction jobs; LGBT (compared to straight); communities.[1]

Sources: (1) American Lung Association, https://www.lung.org/research/sotc/by-the-numbers/top-10-populations-affected. Accessed on 3/23/2025.

## Social Drivers and Equity

Research shows that social and economic factors (social drivers) are significant 'upstream' contributors to individuals' and communities' health outcomes. In clinical settings, Aspirus hospitals are gathering social drivers of health (SDOH) data as a way to understand how to tailor care to better meet the unique needs of each patient, leading to improved health equity and better health outcomes. Using aggregated patient-level social drivers data can assist in understanding the root causes of complex health issues to improve access to preventative and chronic care services. Linking patient level SDOH data and community level data can provide stronger clinical-community linkages to help connect healthcare providers, community organizations and public health agencies.

Aspirus Divine Savior is committed to recognizing and addressing health-related social needs as part of its overall community health improvement efforts. A number of related strategies/approaches are being implemented within the hospital and clinics as well as with other community partners (e.g., Columbia County Health Department).

- Connecting patients with food and other basic needs resources (through FindHelp.org)
- Food security

As appropriate, Aspirus Divine Savior staff will be participating in coalitions and community-level efforts to address other health-related social needs (e.g., transportation, housing). Aspirus Divine Savior also provides public presentations (e.g., on back pain), support groups and other community-facing personal health programs.

## Evaluation of Impact from the Previous CHNA Implementation Strategy

Aspirus Divine Savior's priority health issues from the previous CHNA included:

- Substance use
- Mental health

A summary of the impact of efforts to address those needs is included in Appendix H.

## Approval by the Hospital Board

The CHNA report was reviewed and approved by the Aspirus Divine Savior Board of Directors on May 22, 2025.

## Conclusion

Thank you to all the community members who provided thoughts, input and constructive feedback throughout the process. Aspirus Divine Savior Hospital will continue to work with its partners to address the health issues important to the community.

# Appendices

## Appendix A: Demographics and Related Descriptors

The table below outlines some of the demographic characteristics of Columbia County, Wisconsin.

| | Columbia County | Wisconsin |
|---|---|---|
| **Population** | 58,490 | 5,893,718 |
| **Age <18** | 20.8% | 21.0% |
| **Age 65+** | 19.1% | 19.2% |
| **Median age** | 43.3 | 40.5 |
| **White alone** | 91.9% | 80.4% |
| **Black or African American alone** | 1.50% | 6.4% |
| **American Indian and Alaska Native alone** | <1% | 1.0% |
| **Asian alone** | <1% | 3.0% |
| **Two or more races** | 4.1% | 6.1% |
| **Hispanic or Latino** | 3.7% | 7.6% |
| **Language other than English spoken at home** | 4.2% | 9.3% |
| **High school graduate or higher** | 93.8% | 93.7% |
| **Bachelor's Degree or Higher** | 25.7% | 33.8% |
| **Individuals who are veterans** | 7.8% | 5.9% |
| **Individuals with disabilities** | 11.8% | 12.7% |
| **Persons in poverty** | 7.8% | 10.7% |
| **Median household income** | $82,792 | $74,631 |
| **Percent without healthcare coverage** | 4.6% | 4.9% |
| **Percent using public insurance (Medicaid, Medicare, veterans' benefits, etc.)** | 33.0% | 36.0% |

Sources:

WI: American Community Survey table S2704, accessed on January 5, 2025.

WI: Wisconsin - Census Bureau Profile and corresponding tables accessed on January 5, 2025.

Columbia County: Accessed on January 6, 2025. Census Tables:

S1501 Educational Attainment

P8 Race and P9 Ethnicity

Census Bureau Profiles Results – with links to Wisconsin and Columbia County

Some groups of individuals in the communities served are more likely to experience health disparities based on a number of demographic variables. One of those groups in Columbia County is individuals who are Hispanic or Latinx. The term Hispanic or Latinx refers to people of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.[1] Latinx Americans have lived in Wisconsin since before statehood, but the largest wave of migration came during and after World War II when the U.S. government established the Emergency Farm Labor Program to recruit Mexicans to work in agricultural fields during the labor shortage.[2] From 1951 to 1964, Wisconsin farmers participated in the program, and between 1942 and 1964, millions of Mexican farm laborers came to Wisconsin.[3] Since then, many other Hispanic/Latinx groups have also made Wisconsin their home. In Columbia County, the number of individuals who are Hispanic or Latino increased from 1444 in 2010 to 2139 in 2020.[4]

**References**


1. Wisconsin Department of Health Services. Hispanic/Latinos in Wisconsin: Overview. https://www.dhs.wisconsin.gov/minority-health/population/hispanlatino-pop.htm
2. Wisconsin Historical Society. Hispanic History. https://www.wisconsinhistory.org/HispanicHistory
3. Wisconsin Historical Society. Mexicans in Wisconsin. https://www.wisconsinhistory.org/Records/Article/CS1791
4. U.S. Census https://data.census.gov/table?q=P9&g=050XX00US55019,55021,55067,55119 accessed on 4/27/2025 and https://data.census.gov/table/DECENNIALSF12010.P9?q=P9&g=050XX00US55019,55021,55067,55119 accessed on 4/27/2025

## Appendix B: Frameworks and Models of Factors that Impact Health and Health Equity

Aspirus strives to include research, evidence and best practices into its community health improvement work. This appendix includes some frameworks and models that show the intersection between health and a variety of factors.

### Model Type: Contributors to Health and Illness

| Title / Name | Source |
|---|---|
| Social Ecological Model of Health | Wisconsin Department of Health Services<br>https://www.dhs.wisconsin.gov/publications/p03361.pdf |
| Mental Health and Well-Being:<br>A Socio-Ecological Model | University of Minnesota<br>https://mch.umn.edu/sem/ and<br>https://drive.google.com/file/d/14p1GfTVwbDU96TmkPr0zmP2iJENEIXsk/view |
| Social Drivers of Health | Midwest Kidney Network<br>https://www.midwestkidneynetwork.org/equity-in-healthcare/social-drivers-of-health-sdoh |
| Social Determinants of Health | Healthy People 2030<br>U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.<br>https://health.gov/healthypeople/objectives-and-data/social-determinants-health |
| Social Determinants of Health | Beckers Hospital Review |
| Vital Conditions for Health and Well-Being | National Association of Community Health Centers and the Rippel Foundation<br>https://www.nachc.org/resource/vital-conditions-for-health-and-well-being/ and<br>https://rippel.org/vital-conditions/ |
| Societal Factors that Influence Health: A Framework for Hospitals | American Hospital Association (2024)<br>https://www.aha.org/societalfactors and<br>SocietalFactorsFramework_Fall2024.pdf |
| Impact of Social Determinants of Health | American Hospital Association (2018)<br>https://www.aha.org/landing-page/addressing-social-determinants-health-presentation |
| Social Determinants and Social Needs:<br>Moving Beyond Midstream | Brian Castrucci and John Auerbach in<br>https://www.healthaffairs.org/content/forefront/meeting-individual-social-needs-falls-short-addressing-social-determinants-health |
| Social Determinants and Social Needs | National Academies<br>https://nap.nationalacademies.org/read/25982/chapter/4#36 |

### Model Type: Health Equity

| Title / Name | Source |
|---|---|
| Equality and Equity (bicycles) | Robert Wood Johnson Foundation<br>https://www.rwjf.org/en/insights/our-research/infographics/visualizing-health-equity.html |
| Framework for Reducing Health Inequities | Bay Area Regional Health Inequities Initiative (BARHII)<br>https://barhii.org/framework |

**Model Type: Assessment, Planning and Implementation Process**

| Title / Name | Source |
|---|---|
| Action Cycle | County Health Rankings and Roadmaps<br>https://www.countyhealthrankings.org/resources/take-action-cycle |
| Mobilizing for Action through Planning and Partnerships (MAPP) | National Association of County and City Health Officials (NACCHO)<br>https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp |
| Community Health Assessment Toolkit | AHA Community Health Improvement<br>[American Hospital Association (AHA) Community Health Improvement]<br>https://www.healthycommunities.org/resources/community-health-assessment-toolkit |

**Model Type: Other**

| Title / Name | Source |
|---|---|
| Why Collect Standardized Data on Social Drivers of Health | National Association of Community Health Centers<br>https://www.nachc.org/about-nachc/our-work/social-drivers-of-health/ |

## Appendix C: Community Input – Key Informant Interviewees and Questions

As part of the Aspirus Divine Savior Hospital community health needs assessment process, 21 key informant interviews were conducted in Fall 2024. Key informants represented a cross-section of community sectors.

| Agency | Population Focus |
|---|---|
| Boys and Girls Club | Youth |
| Pardeeville School District | Youth |
| Aspirus Divine Savior Child Care | Youth |
| Portage School District (3)* | Youth; youth who are minorities |
| Portage Park and Recreation Department | Youth |
| Portage Elected Official | All community |
| Columbia County Public Health (3) | All community; women and children; Amish |
| Portage Public Library | All community; individuals who are homeless and/or have low income |
| Riverhaven Homeless Shelter* | Individuals who are homeless |
| St. Mary Catholic Church | Individuals with low income |
| Aspirus Divine Savior Hospital | Healthcare |
| Prevention and Response Columbia County | Individuals with substance use |
| Aging and Disability Resource Center* | Individuals who are older and/or disabled |
| Noble Community Clinics* | Individuals who are minorities |
| Harbor Recovery Center | Individuals with substance use |
| UW Madison Extension | Individuals with low income |

* Agencies that represent individuals who are medically underserved, have low income, or are considered among the minority populations served by the hospital.

The interviews were conducted by the Community Health Improvement Specialist at Divine Savior. The notes from the interviews were reviewed and summarized by a quantitative analysis expert at the University of Wisconsin-Extension.

**Interview Questions**

1. What do you believe are the 2-3 most important issues that must be addressed to improve health and quality of life in our community? Why? [See attached list for ideas.]
2. Are there any emerging issues or new trends that are affecting the community (positive or negative or neutral)?
3. Who are most vulnerable or underserved groups in the community?
4. What barriers or challenges do you think communities that are underserved face?
5. In which areas do you believe our community is ready for change?
6. What are some ideas you have to help our community improve its health and wellness?
    a. Prompt: Are there changes you'd like to see?
    b. Prompt: Are there current services/programs that are working well or do not work well?
    c. Prompt: What are things you've seen in other communities that might work here?
7. Is there anything else that you'd like to share today as it relates to the needs of our community?

| | |
|---|---|
| **Health Behaviors**<br>☐ Alcohol use/misuse<br>☐ Drug abuse (prescribed and illegal)<br>☐ Tobacco, vaping, Delta-8, CBD and other related products<br>☐ Injuries due to accidents (e.g., motor vehicle, farm, bicycle)<br>☐ Injuries due to falls<br>☐ Poor oral or dental health<br>☐ Physical inactivity<br>☐ Poor nutrition<br>☐ Lack of sleep<br>☐ Excessive use of social media<br>☐ Unsafe sexual activity that could result in unintended pregnancies or diseases | **Social and Economic Factors**<br>☐ Aging-related health concerns<br>☐ Harassment or discrimination of groups of people (e.g., LGBTQ, racial or ethnic minorities)<br>☐ Families not functioning well (ex: abuse, inattentive parenting, trauma)<br>☐ Limited educational opportunities<br>☐ Families not having enough money for basic needs (like safe housing, household expenses and food)<br>☐ Reliable transportation / Ability to get to appointments & run errands with ease<br>☐ Limited social connectedness and belonging<br>☐ Limited religious or spiritual opportunities<br>☐ Violence in the home or community<br>☐ Access to affordable, quality childcare |
| **Clinical Care**<br>☐ Availability and affordability of health insurance<br>☐ Availability and affordability of dental care<br>☐ Lack of doctors and other healthcare providers<br>☐ Lack of mental health care providers<br>☐ Fewer people using preventive services (ex: annual exam, mammogram, colonoscopy)<br>☐ Fewer people getting routine & recommended vaccinations (ex: flu, infant vaccines) | **Outcomes & System**<br>☐ Poor mental health<br>☐ Increased rate of self-harm or suicide<br>☐ Chronic diseases (e.g., diabetes, heart disease, etc.)<br>☐ Infant and child deaths<br>☐ Overweight or obesity levels |
| **Physical Environment**<br>☐ Air pollution<br>☐ Drinking water quality<br>☐ Lack of safe and affordable housing options<br>☐ Limited access to public or purchased transportation<br>☐ Limited access to public parks and recreation | *Note*: "Community" refers to where you live, learn, work, and play. This is often the neighborhood, city/town, or county that you live in. |

## Appendix D: Community Input – Key Informant Interview Process

To gather community input, key informant interviews were completed. Key informant interviews provide qualitative data that reflects community members' first-hand knowledge, insights and expertise. Key informant interviews allow for a deeper exploration of community issues and they:

**Promote diverse perspectives** – By interviewing a variety of key informants, including representatives from schools, faith community, local government, healthcare professionals, the recovery community and others, the CHNA can capture a broader range of perspectives and experiences.

**Build relationships** – Interviews can help build relationships with community members and create a foundation for future partnerships.

**Facilitate action** – The insights gained from key informant interviews can help identify gaps in services, unmet needs, and areas where interventions can be targeted for maximum impact.

**Inform the Implementation Strategy** – The information gathered from key informant interviews is used to inform the development of the hospital's Implementation Strategy, which outlines specific actions for improving community health.

The hospital conducted 21 key informant interviews with different stakeholders in the community. The notes from the interviews were documented.

A specialist from the University of Wisconsin-Madison Division of Extension Regional Community Health Team coded and analyzed the interview content. The complete results were compiled and provided in a report. Having a 'neutral' analysis helped ensure the integrity of the process. The expertise of the specialist helped ensure a robust and reliable qualitative analysis process. The results are being used to inform both the Community Health Needs Assessment as well as the creation of the corresponding Implementation Strategy.

## Appendix E: Community Input – Key Informant Interview Results

A summary of the key informant interview results is below.

***What are the major health issues and emerging trends in the community?***

This section presents health behaviors and problems which are deemed important in the communities by the interviewees. Major issues identified include **Alcohol and Other Drug Abuse (AODA), Mental Health, Food Security, Nutrition and Physical Inactivity, and Social Connection**. Other issues mentioned include increased diversity in the community, human trafficking, oral health, hygiene, and fall injuries.

This result is consistent with past findings – AODA and Mental Health were among the top three priority areas identified in the 2022 Community Health Needs Assessment.

The data provides additional insights on emerging trends within these major health issues such as the **misuse of Delta-8, THC and e-cigarettes among youth**. Many interviewees recognize the **intersection of mental health with a range of other issues such as AODA, elderly suicide, youth violence, and social media**.

***Who are the most vulnerable groups in our community?***

This section presents the most vulnerable groups of community members in terms of health and well-being. The most mentioned groups include **cultural and linguistic minorities**, including Spanish-speaking and Amish populations (due to financial constraints and lack of culturally appropriate services). Interviewees noted changing demographics in the community, such as an increase of non-English speaking families, and **Spanish-speaking older students aged 18-20**, who are not taken care of by adults, and not interacting outside of their own community. Another most mentioned group is those who are **aging and with disabilities** (due to financial constraints, social isolation and lack of access to caregivers). Other vulnerable groups include **families affected by financial constraints, incarceration, mental health and substance use**, as well as teenagers and children, including **LGBTQIA+ youth.**

This result aligns with key informant interviews conducted for the 2022 Community Health Needs Assessment, which identified low income families, children, elderly and newcomers as vulnerable groups.

***What are the major health drivers and barriers in the community?***

In public health, there is an understanding that health outcomes can be influenced by non-medical factors. These include the social, environmental, and economic aspects of individuals and communities. They are also commonly known as the social determinants of health. This section presents key interviewees' understandings of such determinants in the Columbia community.

This data provides key insights that there needs to be efforts targeting service providers, service users, and community members at large. Acce**s**s issues are underlined by multiple factors from the service providers' end, including the **lack of providers and culturally-appropriate services, resources and navigation skills, partnership and trust, consistent and qualified employees** (due to turnover, burn-out), as well as from the service users'/clients end, such as access to **housing, transportation, childcare, financial ability, and work restrictions**. Community norms and conditions such as **stigma, easy retail access of substances,** and **discrimination** (based on race and sexuality) are also contributing to health access and health outcomes.

Some of these identified barriers align with results from the voted top five issues presented in the 2022 Community Health Need Assessment, i.e. lack of communication between partners (aligning with 'social capital'), lack of healthcare providers (aligning with 'access to health care' and 'service providers' capacity'), and transportation.

***What are the major assets or areas ready for change in the community?***

The aim of asset-based approach to public health is to promote and strengthen the factors that support good health and wellbeing, protect against poor health and foster communities and networks that sustain health. This section presents assets and readiness identified by the key interviewees, which can be leveraged in addressing health challenges faced by the Columbia community.

The most highlighted asset in the community is services for AODA supported by **The Harbor Recovery Center and new sober living houses** in the community. Along with this, interviewees think that people are **ready to address AODA issues**. Interviewees also identified **community engagement, recognition of resource gaps** (for underserved population), **peer support/mentoring model and patient centered care** as emerging trends and assets in the community. They also noticed that **people are getting connected to resources** and the city is trying to **address housing**.

***What are the proposed solutions to address health issues in the community?***

This section presents key interviewees' thoughts and suggestions about potential solutions to address health issues in the community. They serve as a bank of ideas, some of which are already being implemented in the community. Like any strategy, they should be considered and prioritized through the lens of feasibility and impact as well.

Many interviewees have urged to further **develop and strengthen partnerships** for resource-sharing and warm referrals. **Family support, improved access to resources, culturally appropriate services, youth empowerment** are suggested solutions that can improve multiple health outcomes. There are also specific suggestions for **improving food nutrition, physical activity, and AODA**. Solutions should be "**meeting people where they are**".

## Appendix F: Health Status Data and Sources (Outside Data)

The tables below provide an overview of how Columbia County compares to Wisconsin on measures of health. Citations for the data are included. The complete set of data is available upon request. Please note: Columbia County rates that are better than Wisconsin rates may still be at an unacceptable level.

| HEALTH OUTCOMES | | | | | | |
|---|---|---|---|---|---|---|
| **Measure** | **Description** | **Year(s)** | **Top Performers** | **US Overall** | **WI** | **Columbia** |
| Premature Death* | Years of potential life lost before age 75 per 100,000 population (age-adjusted). | 2019-2021 | 6,000 | 8,000 | 7,100 | 6300 |
| Poor or Fair Health | Percentage of adults reporting fair or poor health (age-adjusted). | 2021 | 13% | 14% | 13% | 12% |
| Poor Physical Health Days | Average number of physically unhealthy days reported in past 30 days (age-adjusted). | 2021 | 3.1 | 3.3 | 3.1 | 3.2 |
| Poor Mental Health Days | Average number of mentally unhealthy days reported in past 30 days (age-adjusted). | 2021 | 4.4 | 4.8 | 4.8 | 4.4 |
| Low Birthweight* | Percentage of live births with low birthweight (< 2,500 grams). | 2016-2022 | 6% | 8% | 8% | 6% |
| Life Expectancy* | Average number of years people are expected to live. | 2019-2021 | NA | 77.6 | 78.2 | 78.4 |
| Premature Age-Adjusted Mortality* | Number of deaths among residents under age 75 per 100,000 population (age-adjusted). | 2019-2021 | NA | 390 | 340 | 320 |
| Child Mortality* | Number of deaths among residents under age 20 per 100,000 population. | 2018-2021 | NA | 50 | 50 | 40 |
| Infant Mortality* | Number of infant deaths (within 1 year) per 1,000 live births. | 2015-2021 | NA | 6 | 6 | NA |
| Frequent Physical Distress | Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted). | 2021 | NA | 10% | 9% | 10% |
| Frequent Mental Distress | Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted). | 2021 | NA | 15% | 14% | 15% |
| Diabetes Prevalence | Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted). | 2021 | NA | 10% | 8% | 7% |
| HIV Prevalence+ | Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population. | 2021 | NA | 382 | 137 | 94 |

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

Source: 2024 County Health Rankings and Roadmaps website.

| HEALTH FACTORS | | | | | | |
|---|---|---|---|---|---|---|
| **HEALTH BEHAVIORS** | | | | | | |
| **Measure** | **Description** | **Year(s)** | **Top Performers** | **US Overall** | **WI** | **Columbia** |
| Adult Smoking | Percentage of adults who are current smokers (age-adjusted). | 2021 | 14% | 15% | 14% | 16% |
| Adult Obesity | Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted). | 2021 | 32% | 34% | 34% | 35% |
| Food Environment Index | Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best). | 2019 & 2021 | 8.9 | 7.7 | 9.1 | 9.2 |
| Physical Inactivity | Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted). | 2021 | 20% | 23% | 19% | 19% |
| Access to Exercise Opportunities | Percentage of population with adequate access to locations for physical activity. | 2023, 2022 & 2020 | 90% | 84% | 84% | 75% |
| Excessive Drinking | Percentage of adults reporting binge or heavy drinking (age-adjusted). | 2021 | 13% | 18% | 25% | 25% |
| Alcohol-Impaired Driving Deaths | Percentage of driving deaths with alcohol involvement. | 2017-2021 | 10% | 26% | 35% | 29% |
| Sexually Transmitted Infections+ | Number of newly diagnosed chlamydia cases per 100,000 population. | 2021 | 151.7 | 495.5 | 472.3 | 246.2 |
| Teen Births* | Number of births per 1,000 female population ages 15-19. | 2016-2022 | 9 | 17 | 12 | 8 |
| Food Insecurity | Percentage of population who lack adequate access to food. | 2021 | NA | 10% | 7% | 6% |
| Limited Access to Healthy Foods | Percentage of population who are low-income and do not live close to a grocery store. | 2019 | NA | 6% | 5% | 5% |
| Drug Overdose Deaths* | Number of drug poisoning deaths per 100,000 population. | 2019-2021 | NA | 27 | 26 | 26 |
| Insufficient Sleep | Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted). | 2020 | NA | 33% | 31% | 31% |

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

Source: 2024 County Health Rankings and Roadmaps website.

| HEALTH BEHAVIORS | | | | | | |
|---|---|---|---|---|---|---|
| **Measure** | **Description** | **Year(s)** | **Top Performers** | **US Overall** | **WI** | **Columbia** |
| Chronic alcohol-related hospitalizations – emergency room | Visits per 100,000 population | 2021<br>2022<br>2023 | NA | NA | 632.0 | 540.1 |
| Chronic alcohol-related hospitalizations – inpatient | Visits per 100,000 population | 2021<br>2022<br>2023 | NA | NA | 572.8 | 416.5 |
| Alcohol-attributed deaths -- chronic | Rate per 100,000 residents | 2021<br>2022<br>2023 | NA | NA | 25 | 30 |
| Alcohol-attributed deaths -- Acute | Rate per 100,000 residents | 2021<br>2022<br>2023 | NA | NA | 30 | 35 |
| Opioid-related deaths | Rate per 100,000 residents | 2023 | NA | NA | 24 | 17.2 |
| Opioid-related hospitalizations – emergency room | Rate per 100,000 residents | 2023 | NA | NA | 43.7 | 29.2 |
| Opioid-related hospitalizations – inpatient | Rate per 100,000 residents | 2023 | NA | NA | 16.6 | 13.7 |

Sources:

- Wisconsin Department of Health Services. DHS Interactive Dashboards, Alcohol Hospitalizations Module [web query]. Data last updated 3/4/2024. (Inpatient and Emergency Department)
- Wisconsin Department of Health Services. DHS Interactive Dashboards: Alcohol Death Module. Last Updated 11/21/2024 1:59:22 PM. (Chronic and Acute)
- Wisconsin Department of Health Services. Data Direct, Opioid Summary Module [web query]. Data last updated 11/20/2024. Hospitalization. (Inpatient and Emergency Department)
- Wisconsin Department of Health Services. https://www.dhs.wisconsin.gov/opioids/deaths-county.htm Opioid-related deaths

| CLINICAL CARE | | | | | | |
|---|---|---|---|---|---|---|
| **Measure** | **Description** | **Year(s)** | **Top Performers** | **US Overall** | **WI** | **Columbia** |
| Uninsured | Percentage of population under age 65 without health insurance. | 2021 | 6% | 10% | 6% | 6% |
| Primary Care Physicians | Ratio of population to primary care physicians. | 2021 | 1,030:1 | 1,330:1 | 1250:1 | 2540:1 |
| Dentists | Ratio of population to dentists. | 2022 | 1,180:1 | 1,360:1 | 1360:1 | 2770:1 |
| Mental Health Providers | Ratio of population to mental health providers. | 2023 | 230:1 | 320:1 | 400:1 | 780:1 |
| Preventable Hospital Stays* | Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. | 2021 | 1,558 | 2,681 | 2,451 | 2457 |
| Mammography Screening* | Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening. | 2021 | 52% | 43% | 50% | 41% |
| Flu Vaccinations* | Percentage of fee-for-service (FFS) Medicare enrollees who had an annual flu vaccination. | 2021 | 53% | 46% | 52% | 52% |
| Uninsured Adults | Percentage of adults under age 65 without health insurance. | 2021 | NA | 12% | 7% | 7% |
| Uninsured Children | Percentage of children under age 19 without health insurance. | 2021 | NA | 5% | 4% | 5% |
| Other Primary Care Providers | Ratio of population to primary care providers other than physicians. | 2023 | NA | 760:1 | 670:1 | 1160:1 |

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

Source: 2024 County Health Rankings and Roadmaps website.

| SOCIAL & ECONOMIC FACTORS | | | | | | |
|---|---|---|---|---|---|---|
| **Measure** | **Description** | **Year(s)** | **Top Performers** | **US Overall** | **WI** | **Columbia** |
| High School Completion | Percentage of adults ages 25 and over with a high school diploma or equivalent. | 2018-2022 | 94% | 89% | 93% | 94% |
| Some College | Percentage of adults ages 25-44 with some post-secondary education. | 2018-2022 | 74% | 68% | 70% | 64% |
| Unemployment | Percentage of population ages 16 and older unemployed but seeking work. | 2022 | 2.3% | 3.7% | 2.9% | 2.6% |
| Children in Poverty* | Percentage of people under age 18 in poverty. | 2022 & 2018-2022 | 10% | 16% | 13% | 9% |
| Income Inequality | Ratio of household income at the 80th percentile to income at the 20th percentile. | 2018-2022 | 3.7 | 4.9 | 4.2 | 3.7 |
| Children in Single-Parent Households | Percentage of children that live in a household headed by a single parent. | 2018-2022 | 13% | 25% | 22% | 20% |
| Social Associations | Number of membership associations per 10,000 population. | 2021 | 18.0 | 9.1 | 11.0 | 12.3 |
| Injury Deaths* | Number of deaths due to injury per 100,000 population. | 2017-2021 | 64 | 80 | 93 | 102 |
| High School Graduation+ | Percentage of ninth-grade cohort that graduates in four years. | 2020-2021 | NA | 86% | 90% | 90% |
| Disconnected Youth | Percentage of teens and young adults ages 16-19 who are neither working nor in school. | 2018-2022 | NA | 7% | 5% | 6% |
| Reading Scores*+ | Average grade level performance for 3rd graders on English Language Arts standardized tests. | 2018 | NA | 3.1 | 3.0 | 2.9 |
| Math Scores*+ | Average grade level performance for 3rd graders on math standardized tests. | 2018 | NA | 3.0 | 3.0 | 2.9 |
| School Segregation | The extent to which students within different race and ethnicity groups are unevenly distributed across schools when compared with the racial and ethnic composition of the local population. The index ranges from 0 to 1 with lower values representing a school composition that approximates race and ethnicity distributions in the student populations within the county, and higher values representing more segregation. | 2022-2023 | NA | 0.24 | 0.27 | 0.07 |
| School Funding Adequacy+ | The average gap in dollars between actual and required spending per pupil among public school districts. Required spending is an estimate of dollars needed to achieve U.S. average test scores in each district. | 2021 | NA | $634 | $355 | $2,830 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Gender Pay Gap | Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as | 2018-2022 | NA | 0.81 | 0.81 | 0.81 |
| Median Household Income* | The income where half of households in a county earn more and half of households earn less. | 2022 & 2018-2022 | NA | $74,800 | $71,100 | $78,800 |
| Living Wage | The hourly wage needed to cover basic household expenses plus all relevant taxes for a household of one adult and two children. | 2023 | NA | NA | $49.27 | $44.69 |
| Children Eligible for Free or Reduced Price Lunch+ | Percentage of children enrolled in public schools that are eligible for free or reduced price lunch. | 2021-2022 | NA | 51% | 39% | 30% |
| Residential Segregation - Black/White | Index of dissimilarity where higher values indicate greater residential segregation between Black and white county residents. | 2018-2022 | NA | 63 | 77 | 52 |
| Child Care Cost Burden | Child care costs for a household with two children as a percent of median household income. | 2023 & 2022 | NA | 27% | 31% | 24% |
| Child Care Centers | Number of child care centers per 1,000 population under 5 years old. | 2010-2022 | NA | 7 | 6 | 10 |
| Homicides* | Number of deaths due to homicide per 100,000 population. | 2015-2021 | NA | 6 | 4 | NA |
| Suicides* | Number of deaths due to suicide per 100,000 population (age-adjusted). | 2017-2021 | NA | 14 | 15 | 18 |
| Firearm Fatalities* | Number of deaths due to firearms per 100,000 population. | 2017-2021 | NA | 13 | 11 | 9 |
| Motor Vehicle Crash Deaths* | Number of motor vehicle crash deaths per 100,000 population. | 2015-2021 | NA | 12 | 10 | 14 |
| Juvenile Arrests+ | Rate of delinquency cases per 1,000 juveniles. | 2021 | NA | NA | NA | 10 |
| Voter Turnout+ | Percentage of citizen population aged 18 or older who voted in the 2020 U.S. Presidential election. | 2020 & 2016-2020 | NA | 67.9% | 75.1% | 76.4% |
| Census Participation | Percentage of all households that self-responded to the 2020 census (by internet, paper questionnaire or telephone). | 2020 | NA | 65.2% | NA | 74.2% |

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

Source: 2024 County Health Rankings and Roadmaps website.

| SOCIAL & ECONOMIC FACTORS | | | | | | |
|---|---|---|---|---|---|---|
| **Measure** | **Description** | **Year(s)** | **Top Performers** | **US Overall** | **WI** | **Columbia** |
| Falls-related Emergency Department Visits | Unintentional fall-related emergency department visits for individuals 65+ per 100,000 population | 2020<br>2021<br>2022 | -- | -- | 4999.9 | 6639.6 |
| Falls Deaths | Unintentional falls-related deaths in ages 65+ per 100,000 population | 2020<br>2021<br>2022 | -- | -- | 177.8 | 238.5 |

Sources:

- Wisconsin Dept. of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, https://www.dhs.wisconsin.gov/wish/index.htm, Injury-Related Emergency Department Visits Module, most recently accessed 5/4/2025.
- Wisconsin Dept. of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, https://www.dhs.wisconsin.gov/wish/index.htm, Injury-Related Mortality Module, most recently accessed 5/4/2025.

| PHYSICAL ENVIRONMENT | | | | | | |
|---|---|---|---|---|---|---|
| **Measure** | **Description** | **Year(s)** | **Top Performers** | **US Overall** | **WI** | **Columbia** |
| Air Pollution - Particulate Matter | Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). | 2019 | 5.0 | 7.4 | 7.8 | 8.5 |
| Drinking Water Violations+ | Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation. | 2022 | NA | NA | NA | Yes |
| Severe Housing Problems | Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. | 2016-2020 | 8% | 17% | 13% | 12% |
| Driving Alone to Work* | Percentage of the workforce that drives alone to work. | 2018-2022 | 70% | 72% | 77% | 79% |
| Long Commute - Driving Alone | Among workers who commute in their car alone, the percentage that commute more than 30 minutes. | 2018-2022 | 17% | 36% | 28% | 42% |
| Traffic Volume | Average traffic volume per meter of major roadways in the county. | 2023 | NA | 108 | 281 | 40 |
| Homeownership | Percentage of owner-occupied housing units. | 2018-2022 | NA | 65% | 68% | 76% |
| Severe Housing Cost Burden | Percentage of households that spend 50% or more of their household income on housing. | 2018-2022 | NA | 14% | 11% | 9% |
| Broadband Access | Percentage of households with broadband internet connection. | 2018-2022 | NA | 88% | 88% | 86% |

*Indicates subgroup data by race and ethnicity is available; + Not available in all states.

Source: 2024 County Health Rankings and Roadmaps website.

## Youth Risk Behavior Survey Results

The Youth Risk Behavior Survey (YRBS) results were also used in this report. The YRBS is a national survey conducted in most schools in Wisconsin. The results can help communities understand the behaviors and situations that are contributing to youth mortality and morbidity.

- For more information on the YRBS in Wisconsin: https://dpi.wi.gov/sspw/yrbs
- For links and downloads to county-level (including Columbia County) data: https://dpi.wi.gov/sspw/yrbs/online

**Special Populations and Disparities**

Some groups of individuals are more likely to experience higher (or lower) levels of a particular disease, illness or injury. Understanding those disparities can help improve interventions. Individuals who are Hispanic, compared to non-Hispanic white individuals, are at higher risk for diabetes, asthma (Puerto Ricans), cervical cancer, liver disease and obesity.[1] Children who are Hispanic, compared to non-Hispanic white children, are more likely to suffer from infant mortality (Puerto Ricans), asthma (Puerto Ricans) and obesity. Children who are Hispanic are 34 percent more likely to attempt suicide as a high schooler.[2] Approximately 3.7 percent of the residents of Columbia County are Hispanic.[3]

**References**

1. https://www.familiesusa.org/resources/latino-health-inequities-compared-to-non-hispanic-whites/
2. https://www.familiesusa.org/resources/latino-health-inequities-compared-to-non-hispanic-whites/
3. U.S. Census. Census Bureau Profiles Results with links to WI and Columbia County. Census Table P9 Ethnicity. Accessed on January 6, 2025.

## Appendix G: Healthcare Facilities and Community Resources

A subset of the healthcare and other resources in the community that can help address community health needs are in the table below. A more comprehensive set of resources can be found at findhelp.org or https://aspiruscommunity-resources.findhelp.com/, and then searching by zip code and program need/area.

| Agency | Need/Resource |
|---|---|
| Portage United Way | Multiple services/funding |
| Sleep in Heavenly Peace | Beds for children |
| Head Start | Education |
| Family Resource Center/Renewal Unlimited | Education, Family Resources, Housing |
| St. Vincent DePaul Free Clinic of Portage | Health Care |
| Pregnancy Resource Center | Health |
| River Haven Homeless Shelter | Housing |
| Portage Farmers Markets | Food |
| Portage Food Pantry | Food |
| Alcoholics Anonymous | Substance Use Recovery |
| Columbia County Health Department; Women, Infant & Children Program | Food, Nutrition |
| Reach Out Lodi | Food pantry, personal items, community closet |
| Columbia County Health Department | Health |
| Hope House | Domestic Abuse Assistance |
| Aspirus Divine Savior Hospital and Clinics | Health Care |
| Aging and Disability Resource Center | Health Classes, Equipment Lending, Meals on Wheels, Benefits Support |
| Harbor Recovery Center | Substance Use Recovery |
| Portage Cab | Transportation |
| Aspirus Tivoli Community (assisted living facility) | Aging |
| SSM Health Portage (clinic) | Health Care |
| UW Health Portage (clinic) | Health Care |
| Multiple counselor/therapist services | Mental Health & Substance Use |

## Appendix H: Evaluation of Impact from the Previous CHNA Implementation Strategy

Aspirus Health is working to strategically build strong, effective community health efforts that meet local needs. We do this work in the context of the ever-changing healthcare landscape as well as other economic pressures.

The significant health priorities identified in Aspirus Divine Savior 2022-2025 (most recent) CHNA and Implementation Strategy were **mental health** and **substance use**. A summary of the impact of efforts to address those needs is below. The summary reflects FY23, FY24 and a portion of the current (FY25) fiscal year. FY25 was incomplete at the time of this report's approval.

**MENTAL HEALTH**

Over the past few years, Aspirus Divine Savior developed a partnership with the Boys & Girls Club. In FY22, the hospital provided financial support to open the new location in Portage. The Boys & Girls Club develops and implements programing to address youth academics, social development and physical health. In FY23, the hospital purchased a vertical garden for the Club. The vertical garden was used to teach gardening skills and nutrition. In FY24, the hospital provided funding and the Club served 110 children. Early in FY25, hospital staff brought nutrition and exercise programing to the Club. At the time of this report (Spring 2025), the hospital continued this programming.

Aspirus Divine Savior provided funding for a Mental Health First Aid course. In FY23, twelve people attended the training. In FY24, ten people attended the training. In FY25 eight people attended the training.

The hospital is part of the Prevent Suicide Coalition and the Prevention and Response Coalition. In FY23, FY24 and FY25 (unless otherwise indicated), Coalition efforts included the activities below.

- Providing funding to schools to implement Sources of Strength.
- Planning a mental health anti-stigma campaign.
- Creation and distribution of a mental health resources brochure. Five hundred were printed and have been distributed so far. Aspirus staff distributed brochures internally (e.g., to clinics, the emergency department and care coordination) and externally.
- Planning and implementing the Fall Walk for Hope. Aspirus staff assisted on the planning committee and the hospital contributed financially. In FY24, 150 people attended the event. In FY25, 205 attended.
- Distributing gun locks and medication lock boxes to reduce access to means of suicide (FY23 and FY24 only).

In FY24, Aspirus Divine Savior helped fund the Hope House of South Central Wisconsin to provide support to victims of domestic and sexual violence.

**SUBSTANCE USE**

In FY23 and FY24 Aspirus Divine Savior had a medication drop box in the front entrance. This assures unused prescription drugs are disposed of in the appropriate manner. Pharmacy staff spent about 1 hour per week disposing of the medications. They collected approximately 792 pounds per year. In FY25, Aspirus Divine Savior purchased a medication drop box for the Portage Police Department.

At the start of FY23, Aspirus Divine Savior contracted with Satori House to provide recovery coaching to patients in the emergency department. During FY23, Satori House disbanded. As a result, Aspirus started working with Three Bridges Recovery to bring the grant-funded program back. Aspirus Health Foundation and the hospital provided funding to include recovery coaching services that were not covered under the ED2 Recovery Grant. This partnership with Three Bridges Recovery continued in FY24 and FY25.

In FY23, FY24 and FY25, the hospital provided funding to support Harbor Recovery Center. Harbor Recovery Center provides services and support to individuals and their families who are struggling with substance use and/or mental health. They also provide educational opportunities and events to build a recovery culture. In 2022, Harbor Recovery Center served 114 people through primary services and 907 through secondary services. In 2023, Harbor Recovery Center served 220 people through primary services and 1400 through secondary services. In 2024, Harbor Recovery Center served 273 people through primary services and 3445 through secondary services. Secondary services includes anything that is not a one-on-one session. Examples of secondary services are family meals, events and support groups.

In FY23, FY24 and FY25 Aspirus Divine Savior staff served on the Prevention and Response Columbia County Coalition. This coalition collaborates with Columbia County communities to identify, guide, support, lead and advocate for prevention and recovery strategies to decrease the occurrence of substance abuse in Columbia County. A staff member also attended the Overdose Fatality Review meetings which is a process for understanding the risk factors and circumstances leading to fatal overdoses and identifying opportunities to prevent future overdoses.

In FY23, FY24 and FY25, Aspirus Divine Savior staff participated in the county's Overdose Fatality Review Committee.

**OTHER**

Aspirus offers a Fruit and Vegetable Prescription (FVRx) Program. A health care provider writes the Prescription for Health, which is a $20 voucher for patients to purchase fruits and vegetables from local farmers. The program also provides nutrition information and access to recipes. The combination of provider guidance, a voucher for produce and knowledge can have a powerful impact on fruit and vegetable consumption and ultimately health outcomes. Aspirus primarily supports the program financially, though some technical assistance and resource-linking is also provided. Aspirus Divine Savior participated in the Aspirus Fruit and Vegetable Prescription (FVRx) Program in FY23. In July 2022, several vouchers were given to patients. The program started fully in May of 2023. The season concluded in Fall 2023. In summer 2024, 110 vouchers were given to the Portage Boys & Girls Club participants, and dozens were given to Aspirus Divine Savior patients. During the 2024 season,19 vouchers were redeemed at the local farmers market. The program continues in Summer 2025.

In FY23 and FY24, Aspirus Divine Savior added resources to the FindHelp social needs platform. The platform is integrated into Aspirus' electronic health record and supports providers in identifying resources to meet patients' social needs (e.g., transportation, housing, food). Postcards with Findhelp information were also printed and distributed throughout the community.

In FY23, FY24 and FY25, the hospital continued to support the community with its medically-integrated wellness center, La Vita. Community members can access the facilities. LaVita Fitness Center also coordinates a food drive annually and collects over 500lbs of food each year.

In FY23, FY24 and FY25, Aspirus Divine Savior was represented on the Portage Area United Way board. The hospital also provided financial support. The Portage Area United Way is an organization that provides funding to Portage area agencies who provide much needed services to those in our community that need it most.

Aspirus Divine Savior provides multiple programs for the community throughout the year. In FY23 these included a brain health presentation at the Aging and Disability Resource Center as well as support groups for individuals with diabetes and individuals with a brain injury or stroke. In FY24 programs included a health presentation at a local daycare, a mini course day at Portage High School, participation in the Touched Twice health fair and National Night Out. Support groups for individuals with diabetes and individuals with a brain injury or stroke also continued. In FY25 programs included breast cancer awareness at the Portage High School, a safety booth at Woodridge Elementary School, senior exercise information at the Portage Library, and a variety of health topic presentations for the community held at Aspirus Divine Savior. Support groups for individuals with diabetes and individuals with a brain injury or stroke also continued in FY25.

In FY23, FY24 and FY25 Aspirus Divine Savior hosted blood drives every other month to keep the blood supply up for local patients.

The hospital provided funding for Kinship Mentoring in FY23 and FY25. Kinship Mentoring matches safe, nurturing adult mentors with area youth, so they reach their full potential and become positive contributors to society.

In FY23, the hospital provided funding for a community sharing supper. The committee prepared a free meal which is provided to all community members.

In FY25, the hospital provided funding for Health Occupations Students of America (HOSA) for their state leadership conference.

In FY25, the hospital provided funding for the Riverhaven Homeless Shelter.

aspirus.org

May 2025