2025

Richland County Area Community Health Needs Assessment

Richland County, WI

On Behalf of

THE RICHLAND HOSPITAL
and Clinics

MESSAGE TO OUR COMMUNITY

Welcome to the 2025 Community Health Needs Assessment

At The Richland Hospital and Clinics, we believe that meaningful change begins with collaboration. The 2025 Community Health Needs Assessment (CHNA) reflects the collective efforts of local organizations, public health agencies, and community members who came together to share insights, experiences, and data. We are deeply grateful to everyone who participated in surveys, focus groups, and planning sessions. Your voices help shape the future of health in Richland County.

For over 100 years, The Richland Hospital has proudly served our community with a mission rooted in compassionate care and continuous improvement. Guided by our vision- **"Our patients above all else"**- we remain committed to providing high-quality healthcare that meets the evolving needs of our neighbors. The CHNA is not only a reflection of current health challenges but also a federally required process under the Affordable Care Act, designed to ensure hospitals remain responsive to community needs. It is accompanied by an implementation strategy that outlines how we plan to address identified priorities, and it serves as a roadmap for future improvement, accountability, and partnership.

The CHNA is closely linked to our Community Health Improvement Plan (CHIP) and is informed by the social determinants of health- factors such as housing, education, income, and access to care. These elements have a profound impact on health outcomes and equity. Through this assessment, we aim to better understand these challenges and identify opportunities to positively influence the health of our community. Our hope is that this work continues to guide collaborative efforts that foster a stronger, healthier Richland County.

As we look ahead to 2025, we reaffirm our commitment to three key health priorities: **Mental Health, Obesity,** and **Substance Use**. These areas remain central to our efforts, reflecting both ongoing community concerns and the progress we've made together. By continuing to focus on these priorities, we build on the momentum of previous years and strengthen our resolve to create lasting change. Together, we are shaping a future where every individual has the opportunity to thrive.

Sincerely,

Bruce Roesler
President and CEO
The Richland Hospital and Clinics

EXECUTIVE SUMMARY

The Richland Hospital and Clinics is proud to present the 2025 Community Health Needs Assessment (CHNA) for Richland County, Wisconsin. This important initiative builds upon the foundation laid in our previous assessment completed in 2022, continuing our commitment to understanding and addressing the health needs of our community. In accordance with the Patient Protection and Affordable Care Act (ACA), non-profit hospitals like ours conduct a CHNA every three years to identify key health priorities and develop strategies that promote wellness and equity. This fifth round of the CHNA was facilitated by VVV Consultants, LLC, under the leadership of Vince Vandehaar, MBA, beginning in November 2024.

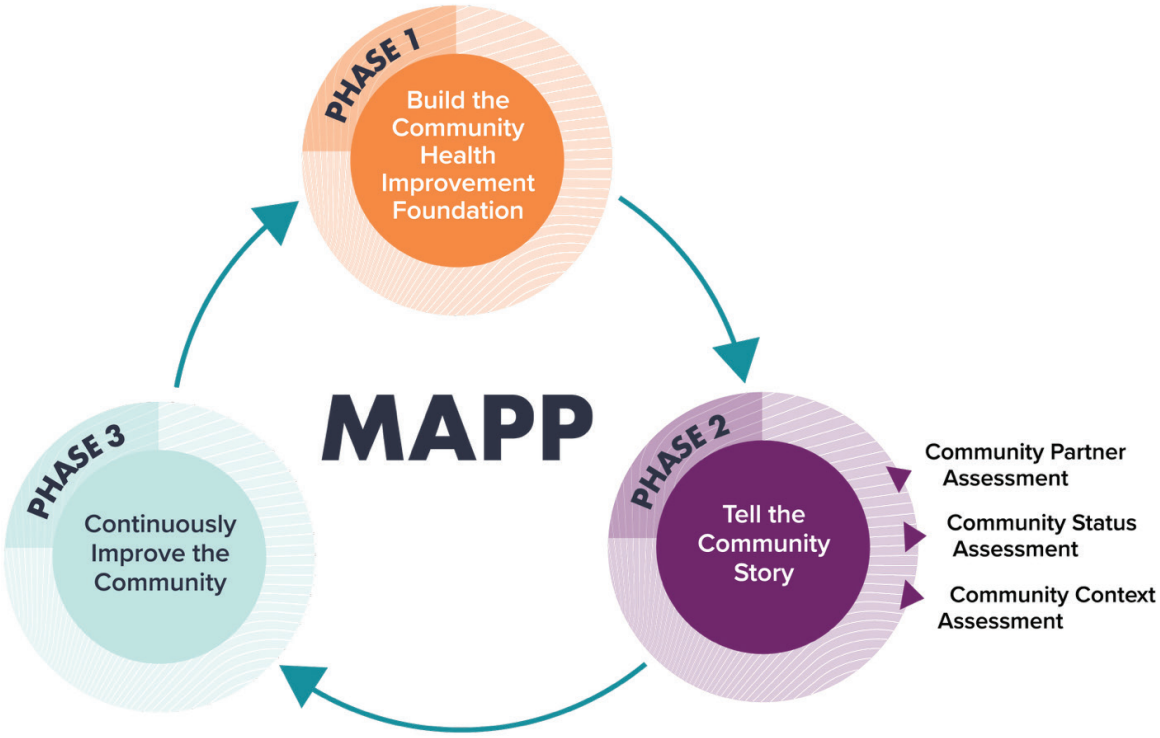
Creating a healthier community is a shared responsibility, and this assessment reflects the power of collaboration. Community leaders, healthcare providers, public health professionals, and residents came together to share insights, experiences, and data that help us better understand the challenges and opportunities we face. Through this collective effort, we reaffirm our focus on three critical areas: Mental Health, Substance Use, and Obesity. These priorities have guided our work over the past several years and continue to be central to our mission of improving lives through compassionate care and community engagement.

The CHNA is more than a report- it's a roadmap for action. It informs our Community Health Improvement Plan (CHIP) and helps us address the social determinants of health that shape the well-being of our residents. From housing and education to access to care and economic stability, these factors influence health outcomes in profound ways. By identifying needs and aligning resources, we aim to foster a more equitable and supportive environment for all who call Richland County home.

This year's assessment reaffirms our commitment to the ongoing priorities of Mental Health, Obesity, and Substance Use. These areas remain at the forefront of our efforts because they continue to impact our community deeply- and because we are seeing progress. Through partnerships, education, and expanded services, we are making strides together.

MAPP PROCESS OVERVIEW

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven framework used to guide strategic planning for public health improvement. It brings together local organizations, leaders, and residents to assess health needs, set shared goals, and develop coordinated strategies. The process includes six phases: organizing partnerships, creating a shared vision, conducting assessments, identifying strategic issues, formulating goals and strategies, and implementing actions. MAPP is ongoing and continues throughout the life of the Community Health Improvement Plan (CHIP), helping ensure that efforts remain focused, collaborative, and responsive to the evolving needs of our community.



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ABOUT THE RICHLAND HOSPITAL AND CLINICS

Our Mission: Our patients, above all else.

Our Vision: As the community's trusted partner for health and well-being for over 100 years, our people will support your wellness potential for generations to come.

Our Values: Customer Service, Communication, Commitment, Compassion, Change, Civility, Community.

CEO: Bruce Roesler
333 E 2nd St, Richland Center, WI 53581 Phone: (608) 647-6321

The Richland Hospital and Clinics is one of the Top 100 Critical Access Hospitals in the U.S. Located 60 miles west of Madison, Wisconsin, and 65 miles east of La Crosse, Wisconsin, The Richland Hospital and Clinics is dedicated to providing compassionate, expert medical care to people in Southwest Wisconsin. Rural Health Clinics – Owned by the Richland Hospital, Inc.

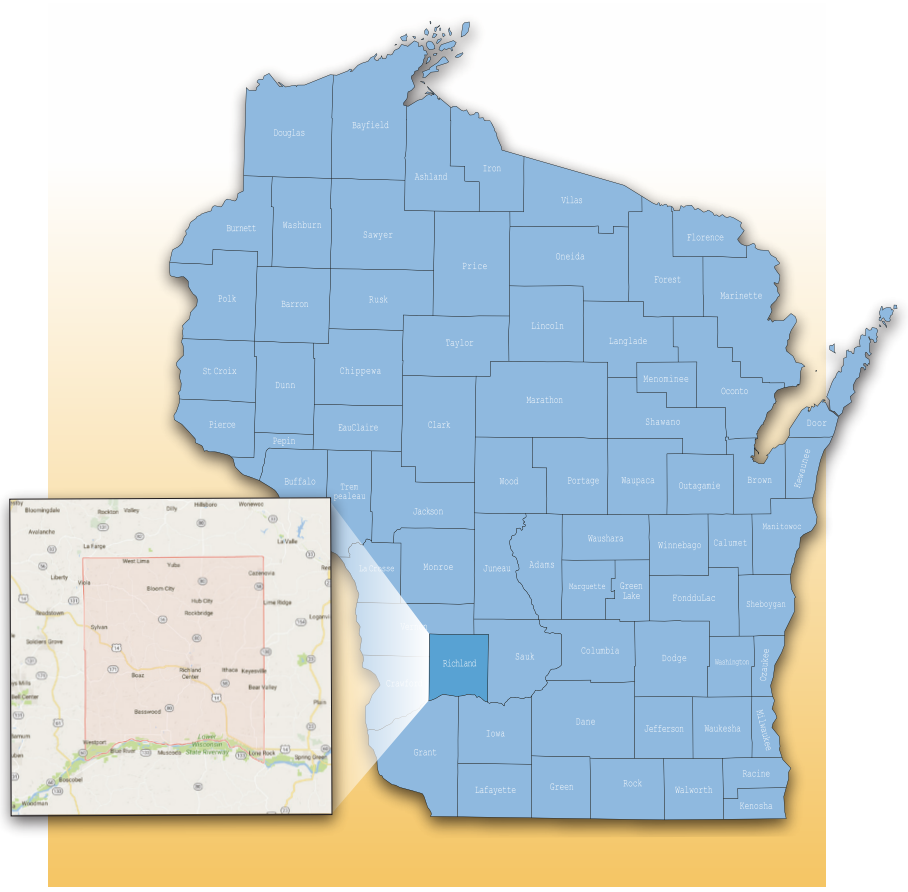
The Spring Green Medical Center is a provider-based Rural Health Clinic operated in Spring Green, Wisconsin, and owned by the Richland Hospital, Inc., as of 1995. The Clinic is located at 150 East Jefferson Street, Spring Green, WI 53581. The Muscoda Health Center is a provider-based Rural Health Clinic operated in Muscoda, Wisconsin, and owned by The Richland Hospital, Inc., as of 1995. The Clinic is located at 1075 North Wisconsin Avenue in Muscoda.

The Richland Hospital and Clinics offers a wide range of services designed to meet the diverse health needs of our community. Core offerings include Primary Care, Family Medicine, and Emergency & Urgent Care, supported by specialized services such as General Surgery, Orthopedics, Podiatry, and Pain Management. Our Birth Center, Midwifery, and Women's Health Services provide comprehensive care for women and families.

We also offer Diabetes Care, Medical Nutrition Therapy, and Infusion & Oncology Services, along with Sleep Testing, Sports Medicine, and Therapy & Rehabilitation. Additional support includes Senior Life Solutions, the Geriatric Assessment Clinic, and access to Visiting Specialists. Diagnostic and procedural services include Medical Imaging, Lab, Outpatient Procedures, and Anesthesia Services. Our Community Pharmacy and Support Services round out a robust system of care focused on improving health outcomes and enhancing quality of life.

DEFINITION OF COMMUNITY

The Richland Hospital and Clinics serves the residents of Richland County, a rural community in southwest Wisconsin with a population of approximately 17,300. The county seat, Richland Center, is the heart of the region and home to many of the hospital's patients and services. Established in 1842 and known for its fertile soil and scenic landscape, Richland County spans 589 square miles, with most of the area consisting of farmland, small towns, and natural spaces.



Richland County shares borders with Vernon, Sauk, Iowa, Grant, and Crawford counties, and many residents from these neighboring areas also rely on The Richland Hospital and Clinics for care. This geographic and demographic context helps shape the priorities of our Community Health Needs Assessment, ensuring that our strategies reflect the needs of the people who live, work, and seek care in this region.

DEMOGRAPHICS

Richland County, Wisconsin, is a rural community with a population of approximately 17,000 residents as of 2025, projected to decline slightly by 2028. The county includes key communities such as Richland Center, Lone Rock, Cazenovia, Viola, and Gotham. Richland Center is the largest city, home to over 9,500 residents. Household sizes average 2.4 people, and per capita income across the county is approximately $32,217. The population is predominantly White (93.8%), with small percentages identifying as Black (0.4%), Asian (0.5%), or Hispanic (2.1%). About 15.5% of housing units are rentals, and the socioeconomic index averages 54, indicating moderate economic stability. The county has a significant aging population, with over 3,500 residents aged 65 and older, and nearly 3,700 children under 18. Gender distribution is balanced, and younger adults (ages 20–35) make up a notable portion of the population. These demographic insights help shape the priorities and strategies outlined in the Community Health Needs Assessment, ensuring that services and resources are aligned with the needs of Richland County residents.

RICHLAND COUNTY HEALTH SNAPSHOT

(2023 COUNTY HEALTH RANKINGS)

OVERALL RANKINGS (out of 72 Wisconsin counties)

41st in Health Outcomes
52nd in Health Factors
40th in Physical Environment Quality

DEMOGRAPHICS

Population: ~17,197

- Age Distribution: **5.1%** under 5 years; **25.2%** aged 65+
- Children in single-parent households: **20.6%** (slightly above rural norm)
- Community stability: **92%** of residents lived in the same home over the past year

ECONOMIC & HOUSING INDICATORS

Per capita income: $34,011
Poverty rate: **13%**
Severe housing problems: **14.4%**
Food insecurity: **8.7%**
Limited access to healthy food: **19%**
Long commutes (driving alone): **32.5**

EDUCATION

High school graduates (age 25+): **92.1%**
Bachelor's degree or higher: **20.7%**

MATERNAL & CHILD HEALTH

Prenatal care in first trimester: **65.5%** (below rural avg. 73.5%)
Low birth weight: **6%**
Teen birth rate: **11.8 per 1,000 females** (ages 15–19)

HEALTHCARE ACCESS & QUALITY

Primary care physician ratio: **1 per 1,324 residents**
Preventable hospital stays: **2,711**
Patient ratings: **79%** rated hospital highly; **74%** would recommend
ER discharge time: ~80 minutes

MENTAL & PHYSICAL HEALTH

Adults diagnosed with depression: **23.4%**
Suicide rate: **15.8 per 100,000**
Average mentally unhealthy days/week: **4.8**
Obesity: **39.6%**
Physical inactivity: **23.1%**
Smoking: **17.9%**; Excessive drinking: **21.4%**
Chronic conditions: Diabetes **8.3%**, COPD **6.3%**, Cancer **6.5%**
Uninsured rate: **8%**
Life expectancy: **~79 years**

ADDITIONAL HEALTH INDICATORS

Alcohol-impaired driving deaths: **30% of traffic fatalities**
Cancer & heart disease mortality: **~160 per 100,000**
Access to exercise opportunities: **47.3%**
Mammography screenings: **33%** (below rural avg.)
High blood pressure: **29%**
Routine check-up rate: **70.8%**

DEMOGRAPHICS

Race & Ethnicity

Understanding the population and household makeup of Richland County is essential to evaluating community health needs. The county is predominantly White (95.9%), with smaller percentages identifying as Black (0.9%), Hispanic or Latino (3.3%), and Asian (0.5%). About 49% of residents are female, and 7% speak a language other than English at home. These demographic indicators provide important context for identifying health priorities and shaping strategies that reflect the needs of Richland County's diverse population.

Age

As of 2023, the county's population is estimated at 17,197, with 5.1% under the age of five and 25.2% aged 65 and older- highlighting a significant aging population.

Poverty

Economic conditions play a critical role in shaping access to healthcare and the ability of individuals to care for themselves. In Richland County, the per capita income is $34,011- below both the state average and the norm for similar counties. Approximately 13% of residents live in poverty, and 14.4% face severe housing challenges. Food insecurity affects 8.7% of the population, and nearly one in five residents (19%) have limited access to healthy food options. These economic indicators highlight the importance of addressing social determinants of health in our community planning.

Education

Education plays a vital role in shaping health outcomes, and local schools are actively contributing to student well-being by offering on-site health screenings and basic care. In Richland County, 52.8% of children are eligible for free or reduced-price lunch, reflecting economic challenges that can impact access to health services. Educational attainment is strong, with 92.1% of adults holding a high school diploma or higher, and 20.7% having earned a bachelor's degree or more.

Health Insurance

Based on state estimates, Richland County, Wisconsin had an uninsured rate of 8.0% in 2020, which is higher than both the Wisconsin state average of 6.5% and the average across 18 comparable counties at 7.1%, according to County Health Ranking.

SOCIAL DETERMINANTS DRIVING COMMUNITY HEALTH

Understanding the health of a community means looking beyond medical care alone. Social Determinants of Health (SDOH) are the conditions in which people are born, grow, live, work, and age- and they play a powerful role in shaping overall health outcomes. These factors include access to education, employment, housing, transportation, nutritious food, and social support. They influence everything from chronic disease risk to mental health and life expectancy. In Richland County, recognizing and addressing these determinants is essential to building a healthier, more equitable community. By identifying where gaps exist and where strengths can be leveraged, we can work together to create environments that support wellness for all residents.

The CHNA places a strong emphasis on Social Determinants of Health (SDOH) and health equity-recognizing that factors like income, education, housing, and access to care deeply influence individual and community health outcomes. In alignment with national efforts, the Centers for Medicare & Medicaid Services (CMS) outlines five key domains for advancing health equity in hospitals:

- **Equity as a Strategic Priority:** Hospitals are expected to identify populations experiencing disparities, set equity goals, allocate resources, and engage community partners.
- **Data Collection:** Gathering demographic and SDOH data from patients, training staff in culturally sensitive practices, and using certified electronic health record systems.
- **Data Analysis:** Stratifying performance metrics by demographic and social factors to identify gaps and inform decision-making.
- **Quality Improvement:** Participating in initiatives aimed at reducing disparities at the local, regional, or national level.
- **Leadership Engagement:** Hospital leadership and boards are encouraged to review equity strategies and performance indicators annually.

By integrating these practices, The Richland Hospital and Clinics strengthens its commitment to equitable care and ensures that all residents have the opportunity to achieve their best possible health.

Healthy People 2030 recognizes SDOH as key drivers of health outcomes and includes them among its leading health indicators. One of its core goals is to create social, physical, and economic environments that allow everyone to reach their full health potential. By integrating SDOH into public health planning and aligning with the 10 Essential Public Health Services, communities can strengthen their capacity to advance health equity.

Health equity means ensuring that every person has a fair and just opportunity to be as healthy as possible. Achieving this requires removing obstacles such as poverty, discrimination, and limited access to quality education, housing, and healthcare. Addressing SDOH is essential to building a healthier, more inclusive Richland County.

SOCIAL DETERMINANTS DRIVING COMMUNITY HEALTH *(cont.)*

Through Town Hall discussions and community engagement, it became clear that several key social determinants of health are significantly influencing the well-being of Richland County residents. **Economic stability** emerged as the most pressing factor, impacting access to basic needs such as housing, food, and healthcare. Closely following were challenges within the **healthcare system**, including provider availability, affordability, and access to preventive services. The importance of **community and social context**- including social support networks, civic engagement, and public safety- was also highlighted, as these elements shape how individuals experience health in their daily lives. Finally, the **neighborhood and physical environment**, including transportation, housing quality, and access to recreational spaces, plays a vital role in shaping health outcomes. These interconnected factors form the foundation of our understanding of community health and are explored in greater detail in Section V of this report. By addressing these determinants, we can work toward a more equitable and healthier future for all.

COMMUNITY PARTNERS

Working together to improve community health takes collaboration. Our 2025 Community Health Needs Assessment survey was made possible with the partnerships of many organizations and individuals on the steering team including Richland County Health & Human Services, Partners 4 Prevention, Richland School District, and VVV Consultants LLC.

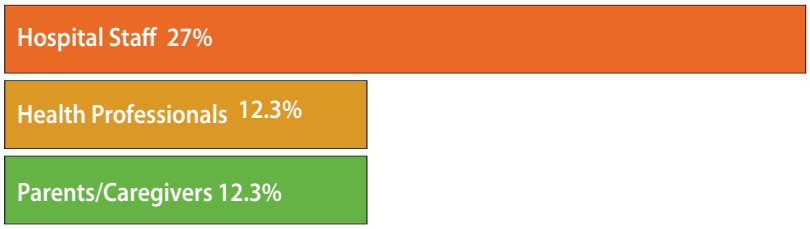
We would also like to thank all community members who completed the survey and participated in focus groups. We are sincerely grateful for your time and input.

PRIMARY DATA–COMMUNITY SURVEY RESULTS

WHO WAS SURVEYED?

To ensure broad and representative input for the CHNA Town Hall, a three-year patient origin summary was compiled using internal hospital records. This analysis confirmed that over 80% of patients served by The Richland Hospital and Clinics come from Richland Center, Lone Rock, Cazenovia, Viola, Gotham, Muscoda, Blue River, and Spring Green. These ZIP codes reflect the hospital's primary service area and help guide outreach and planning efforts that are truly community-centered.

HIGHEST PARTICIPATION OF RESPONDERS



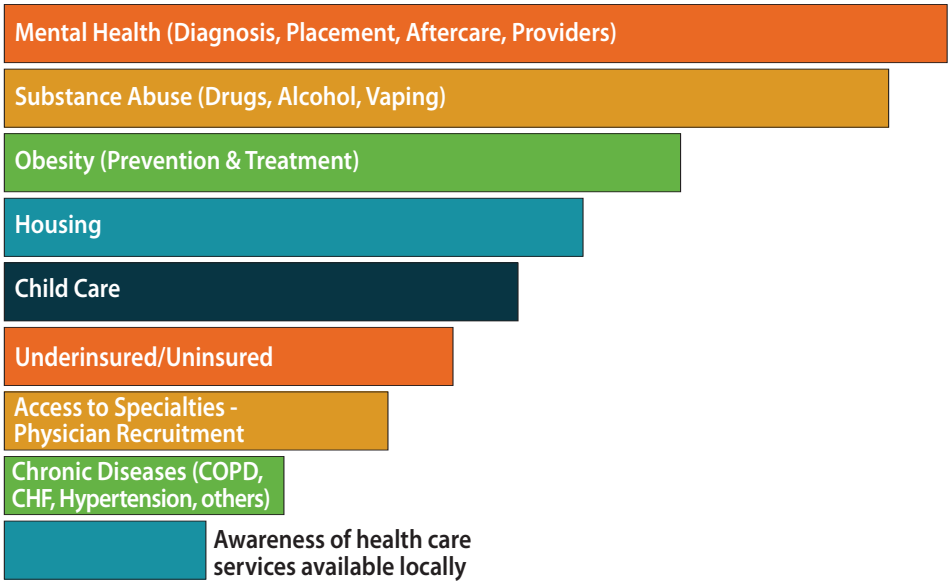
Respondents represented a range of sectors, with the highest participation from hospital staff (27.2%), followed by other health professionals (12.3%) and parents/caregivers (12.3%). Compared to broader regional norms, Richland had slightly lower representation from business leaders, educators, and elected officials.

RATE THE OVERALL QUALITY OF HEALTHCARE DELIVERY

When asked to rate the overall quality of healthcare delivery, 65.9% of respondents selected the top two ratings ("Very Good" or "Good"), though this was slightly below the regional norm of 70.7%. Only 6.7% rated care as "Poor" or "Very Poor."

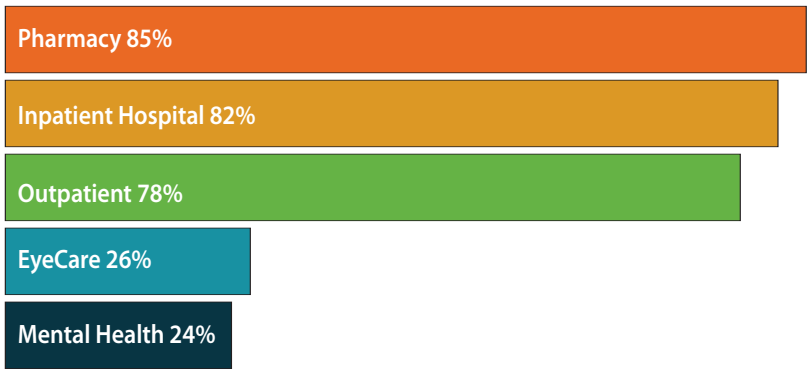
PRIMARY DATA-COMMUNITY SURVEY RESULTS

PAST CHNA UNMET NEEDS IDENTIFIED



Respondents also revisited previously identified unmet needs, with mental health services (including diagnosis, placement, and provider availability) ranked as the most pressing issue (19.2%), followed closely by substance abuse (18.0%) and obesity (13.8%). Housing, child care, and access to specialty care also emerged as ongoing concerns. When asked about the root causes of poor health in the community, the most frequently cited issues included limited access to mental health services (15.4%), lack of exercise (15.2%), poor nutrition (14.9%), and insufficient health and wellness education (12.9%).

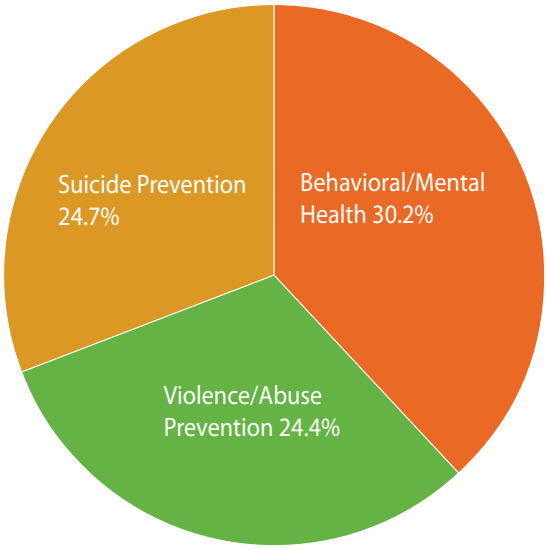
APPROVAL OF HEALTHCARE DELIVERY SERVICES



Perceptions of healthcare delivery services varied. Pharmacy services received the highest approval (85% top two box rating), followed by inpatient hospital services (82%) and outpatient services (78%). Conversely, mental health services (24%) and eye care (26%) received notably lower ratings.

PRIMARY DATA-COMMUNITY SURVEY RESULTS

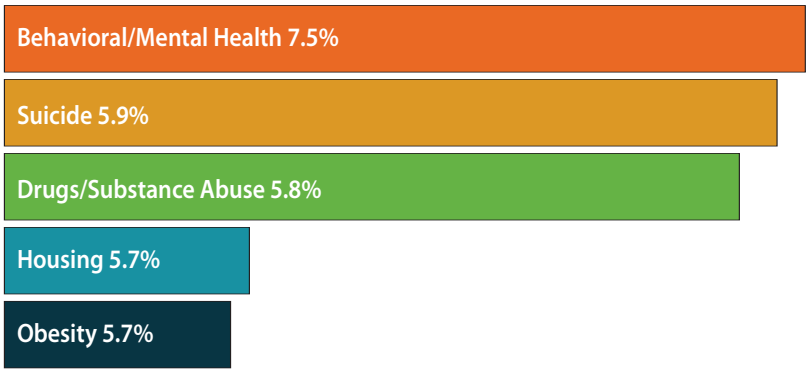
POOR/VERY POOR COMMUNITY HEALTH READINESS ASSESMENT



Community health readiness was also assessed, with behavioral/mental health (30.2%), suicide prevention (24.7%), and violence/abuse prevention (24.4%) receiving the highest "poor/very poor" ratings, indicating areas needing improvement. On the positive side, prenatal/child health programs and emergency preparedness were rated more favorably.

Access to providers remains a concern, with 46.2% of respondents indicating there are not enough providers or staff available at the right times.

HEALTHCARE TOPICS NEEDING FURTHER DISCUSSION



Finally, when asked which healthcare topics should be discussed further at upcoming town hall meetings, behavioral/mental health (7.5%), suicide (5.9%), drugs/substance abuse (5.8%), housing (5.7%), and obesity (5.7%) were among the top priorities, reflecting ongoing community concerns and the need for targeted interventions.

SECONDARY DATA

Quantify Community Need

As part of the CHNA process, secondary research was conducted to assess the historical and current health status of Richland County, the primary service area for The Richland Hospital and Clinics. Data sources such as the Kansas Hospital Association (KHA), Wisconsin Vital Statistics, and the Robert Wood Johnson County Health Rankings were used to evaluate key indicators of community health. This research provides a foundational understanding of local health trends, disparities, and areas of concern, helping to guide strategic planning and prioritize resources for the Community Health Improvement Plan (CHIP).

PRIORITIZATION OF HEALTH NEEDS

The Richland Hospital and Clinics partnered with VVV Consultants LLC, Richland County Health & Human Services, Partners 4 Prevention, and other community stakeholders to conduct the 2025 Community Health Needs Assessment (CHNA). This collaborative process included:

- Collection of primary and secondary data through surveys, focus groups, and public health reports.
- Community engagement sessions to review findings and gather feedback.
- Prioritization discussions guided by evidence-based criteria.

How Priorities Were Determined

Priorities were selected using the following criteria:

- Ranking of priority areas based on community survey results and validated secondary data sources.
- Impact on population health, including issues affecting large numbers of residents or creating disparities among vulnerable groups.
- Current efforts and gaps in Richland County, identifying opportunities for improvement at individual, organizational, and community levels.

Top Health Priorities for 2025–2027

1. Mental Health

- Access to diagnosis, treatment, and aftercare
- Provider availability and suicide prevention resources

2. Obesity

- Prevention and treatment through nutrition education and physical activity
- Community engagement in healthy lifestyle programs

3. Substance Use

- Prevention and treatment for drugs, alcohol, and vaping
- Expanded access to addiction medicine and harm reduction strategies

These priorities remain consistent with previous CHNA cycles (2016, 2019, 2022) and reflect ongoing community concerns. Additional emerging issues include housing affordability, transportation barriers, and access to specialty care.

PRIORITY PROFILE: MENTAL HEALTH

Mental health includes emotional, psychological, and social well-being. It affects how we think, feel, and act.

KEY STATISTICS:

- 19.2% of survey respondents ranked mental health as top need
- 23.4% of adults diagnosed with depression
- Suicide rate: 15.8 per 100,000
- Average 4.8 mentally unhealthy days/week
- Youth concerns: anxiety, depression, suicide risk
- 55% of Richland County high school students report one or more of those issues, with even higher rates among LGBTQ (81%) and Hispanic (66%) students. (2021 YRBS)
- 25% of 2nd to 6th graders at some or high behavioral risk. (2023 SAEBRS)
- 2025 Key Informant Interviews with counselors, HHS staff, and LE, "many students struggle with mental health issues."

COMMUNITY VOICE:

Access to mental health providers is limited. Social media use and bullying affect youth. We need the availability of more age-specific psychiatrist and counseling options.

SOCIAL DETERMINANTS IMPACT:

Transportation, broadband access, and affordability and overuse of social media are barriers to care.

PRIORITY PROFILE: OBESITY

Obesity is a chronic condition that increases the risk of heart disease, diabetes, and other health problems.

KEY STATISTICS:

- 39.6% of adults are obese
- 23.1% report physical inactivity
- Access to exercise opportunities: 47.3%
- High blood pressure affects 29% of adults
- Limited access to healthy food: 19%
- 44% of youth reporting ate vegetables every day for the past 7 days. (2021 YRBS)
- 65% of youth reporting exercised on 4-7 days. (2021 YRBS)

COMMUNITY VOICE:

Obesity is a chronic condition that increases the risk of heart disease, diabetes, and other health problems, and can have root causes early in life. Healthy food options and affordable exercise opportunities are needed.

SOCIAL DETERMINANTS IMPACT:

Economic stability, access to nutritious and affordable food, and encouraging use and creation of safe recreational spaces are major challenges.

PRIORITY PROFILE: SUBSTANCE ABUSE

Substance use includes misuse of alcohol, tobacco, and drugs, impacting health and safety.

KEY STATISTICS:

- 18% of survey respondents ranked substance abuse as a top need
- Alcohol-impaired driving deaths: 30%
- Adult tobacco use: 18.9%
- Adult binge-drinking: 21.4%
- Underage drinking: 25% report use during last 30 days. (2021 YRBS)
- Youth tobacco/vaping use: 40% high school students have tried. (2021 YRBS)
- Prescription drug misuse (youth): 6% report misuse. (2021 YRBS)
- Youth marijuana use: 22% high school youth have tried. (2021 YRBS)
- 9 in 10 adults who develop a substance use disorder started using a substance in their teens (NIH)
- Drugs mentioned: meth, opioids, fentanyl, heroin

COMMUNITY VOICE:

Substance abuse prevention and treatment programs are critical.

SOCIAL DETERMINANTS IMPACT:

Primary prevention strategies and access to treatment services are needed.

IMPACT OF PREVIOUS PRIORITIES: 2023–2025

The Richland Hospital and Clinics and community partners focused on three key priorities identified in the previous CHNA: Mental Health, Substance Use, and Obesity. Below is a summary of major initiatives and progress in each area.

MENTAL HEALTH

SUMMARY:

Expanded access to mental health services and increased community awareness through education and prevention programs.

KEY INITIATIVES:

- **Senior Life Solutions (SLS)**: Grew intensive outpatient counseling for seniors; increased average daily census from 8 to 10.
- **SafeTALK Suicide Prevention Trainings**: Sponsored multiple community and staff sessions annually.
- **School Crisis Case Worker**: Added to Richland School District to support students in crisis.
- **Community Awareness Campaigns**: Mental Health Awareness Month events, lobby displays, and Spring Sprout 5K.
- **Policy Updates**: Implemented Suicide Risk Protocol and screening tools (C-SSRS) with ongoing refinements.

IMPACT:

Improved access to mental health services, increased suicide prevention awareness, and strengthened community partnerships.

SUBSTANCE USE

SUMMARY:

Enhanced treatment options and prevention strategies through education, medication-assisted treatment, and community collaboration.

KEY INITIATIVES:

- **Medication-Assisted Treatment (MAT)**: Increased MAT-certified providers from 1 to 4 in primary care settings.
- **Drug Take Back Days**: Supported biannual events and installed permanent drug drop boxes.
- **NARCAN Training**: Expanded community access to overdose reversal resources.
- Youth Prevention Programs: Supported Youth4Change, post-prom parties, and school-based education.
- **Community Campaigns**: Collaborated on "Small Talks" and "Parents Who Host Lose the Most" initiatives.

IMPACT:

Improved prevention education, reduced stigma, and increased access to treatment resources.

IMPACT OF PREVIOUS PRIORITIES (2023–2025)

OBESITY

SUMMARY:

Promoted healthy lifestyles through education, fitness events, and medical management programs.

KEY INITIATIVES:

- **Spring Sprout 5K & Community Fitness Events**: Encouraged physical activity for staff and residents.
- **Nutrition Education**: Hosted "Let Food Be Your Medicine" events and National Nutrition Month campaigns.
- **School Wellness Support**: Assisted with summer strength training programs and policy development.
- **Get Fit Program**: Continued lifestyle counseling and medical management for weight loss.

IMPACT:

Increased community engagement in healthy eating and exercise, and improved access to obesity management resources.

PRIORITIZATION OF HEALTH NEEDS

VVV Consultants LLC was engaged to collaborate with The Richland Hospital and Clinics (TRHC) in planning and executing the 2025 Community Health Needs Assessment (CHNA). Their role included gathering relevant data, facilitating stakeholder and community engagement, and guiding conversations throughout the process. This report incorporates their analysis of multiple secondary data sources to identify broad health trends across the region. To ensure inclusive community input, an online survey was developed in both English and Spanish. The results were shared with community and stakeholder groups for review and prioritization.

The top three health priorities identified- mental health treatment, substance abuse prevention and treatment, and obesity prevention and treatment– remain consistent with those highlighted in the 2016, 2019, and 2022 CHNA cycles. While these continue to be the central focus for strategic planning, several emerging concerns were also noted. These concerns align with the six recognized social determinants of health and include: the need for economic development to raise wages and expand housing options; a shortage of affordable housing; limited access to groceries and healthy food; transportation challenges, particularly for older adults; affordability and local access to specialty healthcare; and a need for enhanced health education in schools around nutrition and physical activity.

TRHC will continue to prioritize the three main health issues while monitoring these additional concerns for potential synergy in community health improvement efforts. The conclusion of this assessment emphasizes the importance of TRHC's ongoing support for local coalitions and organizations, as well as its commitment to identifying and addressing opportunities within its own system to advance health outcomes in Richland County and the broader service area.

2025 Appendices

APPENDIX A:
PRIMARY DATA COMMUNITY HEALTH SURVEY QUESTIONS

The Richland Hospital and Clinics in Richland County, WI is working to update a comprehensive community-wide 2025 Community Health Needs Assessment (CHNA) to identify unmet health needs. To gather current area feedback, a short online survey has been created to evaluate current community health needs and delivery.

NOTE: Please consider your answers to the survey questions as it relates to ALL healthcare services in our community, including but not limited to The Richland Hospital and Clinics.

While your participation is voluntary and confidential, all community input is valued. Thank you for your immediate attention! CHNA 2025 online feedback deadline is February 7, 2025.

1. In your opinion, how would you rate the "Overall Quality" of healthcare delivery in our community?

◯ Very Good ◯ Good ◯ Average ◯ Poor ◯ Very Poor

2. How would our community area residents rate each of the following health services?

	Very Good	Good	Fair	Poor	Very Poor
Ambulance Services	◯	◯	◯	◯	◯
Child Care	◯	◯	◯	◯	◯
Chiropractors	◯	◯	◯	◯	◯
Dentists	◯	◯	◯	◯	◯
Emergency Room	◯	◯	◯	◯	◯
Eye Doctor/Optometrist	◯	◯	◯	◯	◯
ily Planning ices	◯	◯	◯	◯	◯
Home Health	◯	◯	◯	◯	◯
ice/Palliative	◯	◯	◯	◯	◯
Telehealth	◯	◯	◯	◯	◯

3. How would our community area residents rate each of the following health services? (Continued)

	Very Good	Good	Fair	Poor	Very Poor
Inpatient Hospital Services	○	○	○	○	○
Mental Health Services	○	○	○	○	○
Nursing Home/Senior Living	○	○	○	○	○
Outpatient Hospital Services	○	○	○	○	○
Pharmacy	○	○	○	○	○
Primary Care	○	○	○	○	○
Public Health	○	○	○	○	○
School Health	○	○	○	○	○
Visiting Specialists	○	○	○	○	○

4. In your own words, what is the general perception of healthcare delivery for our community (i.e. hospitals, doctors, public health, etc.)? Be Specific.

5. In your opinion, are there healthcare services in our community/your neighborhood that you feel need to be improved, worked on and/or changed? (Please be specific)

6. From our past CHNA and surrounding communities, a number of health needs were identified as priorities. Are any of these an ongoing problem for our community? Please select top three.

- [ ] Mental Health (Diagnosis, Placement, Aftercare, Providers)
- [ ] Substance Abuse (Drugs, Alcohol, Vaping)
- [ ] Child Care
- [ ] Underinsured/Uninsured
- [ ] Awareness of HC services
- [ ] Housing
- [ ] Obesity (Prevention & Treatment)
- [ ] Chronic Diseases (COPD, CHF, Hyper, others)
- [ ] Access to Specialties - Physician Recruitment

7. Which past CHNA needs are NOW the most pressing? Please select top three.

- [ ] Mental Health (Diagnosis, Placement, Aftercare, Providers)
- [ ] Substance Abuse (Drugs, Alcohol, Vaping)
- [ ] Child Care
- [ ] Underinsured/Uninsured
- [ ] Awareness of HC services
- [ ] Housing
- [ ] Obesity (Prevention & Treatment)
- [ ] Chronic Diseases (COPD, CHF, Hyper, others)
- [ ] Access to Specialties - Physician Recruitment

8. In your opinion, what are the root causes of "poor health" in our community? Please select top three.

- [ ] Chronic Disease Management
- [ ] Lack of Health & Wellness
- [ ] Lack of Nutrition / Access to Healthy Foods
- [ ] Lack of Exercise
- [ ] Limited Access to Primary Care
- [ ] Limited Access to Specialty Care
- [ ] Limited Access to Mental Health
- [ ] Family Assistance Programs
- [ ] Lack of Health Insurance
- [ ] Neglect
- [ ] Lack of Transportation

Other (Be Specific).

9. Community Health Readiness is vital. How would you rate each of the following?

	Very Good	Good	Fair	Poor	Very Poor
Behavioral/Mental Health	○	○	○	○	○
Emergency Preparedness	○	○	○	○	○
Food and Nutrition Services/Education	○	○	○	○	○
Health Wellness Screenings/Education	○	○	○	○	○
Prenatal/Child Health Programs	○	○	○	○	○
Substance Use/Prevention	○	○	○	○	○
Suicide Prevention	○	○	○	○	○
Violence/Abuse Prevention	○	○	○	○	○
Women's Wellness Programs	○	○	○	○	○
Exercise Facilities / Walking Trails etc.	○	○	○	○	○

10. Social Determinants are impacting healthcare delivery. These determinants include 1) Education Access and Quality, 2) Economic Stability, 3) Social / Community support, 4) Neighborhood / Environment, and 5) Access to Quality Health Services. Being this a strong topic of interest, do you have any thoughts, ideas, and/or specific suggestions (food, housing, transportation, support, etc.) to address these 5 social determinants to improve our community health? (Please Be Specific)

11. Over the past 2 years, did you or someone in your household receive healthcare services outside of your county?

○ Yes ○ No

If yes, please specify the services received

12. Access to care is vital. Are there enough providers/staff available at the right times to care for you and your community?

◯ Yes ◯ No

If NO, please specify what is needed where. Be specific.

13. What "new" community health programs should be created to meet current community health needs?

14. Are there any other health needs (listed below) that need to be discussed further at our upcoming CHNA Town Hall meeting? Please select all that apply.

- ☐ Abuse/Violence
- ☐ Access to Health Education
- ☐ Alcohol
- ☐ Alternative Medicine
- ☐ Behavioral/Mental Health
- ☐ Breastfeeding Friendly Workplace
- ☐ Cancer
- ☐ Care Coordination
- ☐ Diabetes
- ☐ Drugs/Substance Abuse
- ☐ Family Planning
- ☐ Health Literacy
- ☐ Heart Disease
- ☐ Housing
- ☐ Lack of Providers/Qualified Staff
- ☐ Lead Exposure
- ☐ Neglect
- ☐ Nutrition
- ☐ Obesity
- ☐ Occupational Medicine
- ☐ Ozone (Air)
- ☐ Physical Exercise
- ☐ Poverty
- ☐ Preventative Health/Wellness
- ☐ Sexually Transmitted Diseases
- ☐ Suicide
- ☐ Teen Pregnancy
- ☐ Telehealth
- ☐ Tobacco Use
- ☐ Transportation
- ☐ Vaccinations
- ☐ Water Quality

Other (Please specify).

15. For reporting purposes, are you involved in or are you a..... ? Please select all that apply.

- [ ] Business/Merchant
- [ ] Community Board Member
- [ ] Case Manager/Discharge Planner
- [ ] Clergy
- [ ] College/University
- [ ] Consumer Advocate
- [ ] Dentist/Eye Doctor/Chiropractor
- [ ] Elected Official - City/County
- [ ] EMS/Emergency
- [ ] Farmer/Rancher
- [ ] Hospital
- [ ] Health Department
- [ ] Housing/Builder
- [ ] Insurance
- [ ] Labor
- [ ] Law Enforcement
- [ ] Mental Health
- [ ] Other Health Professional
- [ ] Parent/Caregiver
- [ ] Pharmacy/Clinic
- [ ] Media (Paper/TV/Radio)
- [ ] Senior Care
- [ ] Teacher/School Admin
- [ ] Veteran

Other (Please specify).

16. For reporting analysis, please enter your HOME 5-digit ZIP code.

APPENDIX B:
PRIMARY DATA COMMUNITY CONVERSATIONS

COMMUNITY TOWN HALL CHNA 2025

Date: 3/20/2025 – 5:00-6:30 PM • The Ramada Attendance: N=42

INTRO: Following is a recap of the community conversation during CHNA 2025 Town Hall

- There are more seniors in the community, similar to what the data shows. The community acknowledges the different health challenges to an older population.
- Other than English, people in the community are speaking Spanish, Mandarin, Russian, and ASL.
- Some of the community drives to Madison for work (over an hour away).
- Broadband access and affordability is an issue in Richland County as data suggests.
- Mothers are going to TRHC, Sauk Prairie, and Madison to deliver their babies.
- Childcare is a significant need. The entire community said, "yes!" when asked.
- "We need psychiatrists and optometry" when asked about specialist.
- The DOH has increased vaccination rates for the underinsured and undocumented populations.
- Drugs in the community are Meth, Coke, Alcohol, Marijuana, Fentanyl, Opioids, Heroin, and Tobacco. The community agrees that substance abuse is separate.
- STDs are a concern in the community – from the DOH.
- All chronic diseases are an issue and worth working on.
- There is access to exercise "there are a lot of places to workout" but affordability and time to exercise are barriers.
- There are not enough mammography screenings opportunities in the county.
- There are Amish in the community speaking German and English.

Things going well for healthcare in the community:

- Access to exercise (some free) available
- Community filled with volunteers
- Emergency Department
- EMS
- Hospital
- OB services at the hospital

Areas to improve or change in the community:

- Broadband access (affordable and accessible)
- Childcare (safe, affordable, access)
- Family planning
- Health education
- Healthy food (access and affordable)
- Home health
- Housing (safe and affordable)
- Mental Health (diagnosis, treatment, aftercare, providers)
- Obesity (healthy foods and exercise)
- Ophthalmologist
- Parenting skills
- Opportunities and collaboration in the community (family-oriented)
- Providers
- PT at the Hospital
- Public Health / DOH
- School district
- School health
- Substance abuse (drugs and alcohol)
- Tobacco and vaping
- Transportation
- Uninsured and underinsured
- Visiting specialists (RHE, NEU, CARD, DERM)

APPENDIX C:
SECONDARY DATA COUNTY HEALTH RANKINGS

Richland County ranks mid-range among Wisconsin counties for health outcomes, similar to the state average but below national benchmarks. According to County Health Rankings, **Richland County ranked 41st out of 72 Wisconsin counties in Health Outcomes**.

Population: 17,090

	Richland County	Wisconsin	United States
Premature Death	6700	7100	9000
Poor/Fair Health	15%	13%	14%
Poor Physical Health Days	3.5	3.1	3.3
Poor Mental Health Days	4.8	4.8	4.8
Low Birthweight	6%	8%	8%
Diabetes Prevalence	8%	8%	10%
Adult Smoking	18%	14%	15%
Adult Obesity	40%	34%	34%
Physical Inactivity	23%	19%	23%
Excessive Drinking	21%	25%	18%
Alcohol Impaired Driving Deaths	30%	35%	26%
Sexually Transmitted Infections (STIs)	267.3	472.3	495.5
Teen Births	12	12	17
Preventable Hospital Stays	2711	2451	2681
Injury Deaths	85	93	80
Air Pollution	8.0	7.8	7.4

APPENDIX D: REFERENCES

Healthy People 2030
The Richland Hospital and Clinics Data
County Health Rankings and Roadmaps
American Community Survey (US Census Bureau)
Wisconsin Department of Health Services- Data and Statistics
Robert Woods Johnson County Health Rankings
New Social Determinant Data Resources
Sources of community-health level indicators:

County Health Rankings and Roadmaps
The annual Rankings measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income inequality, and teen births in nearly every county in America. They provide a snapshot of how health is influenced by where we live, learn, work and play.

Prevention Status Reports (PSRs)

The PSRs highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to prevent or reduce important public health problems.

Behavioral Risk Factor Surveillance System

The world's largest, ongoing telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Data is collected monthly in all 50 states, the District of Columbia, Puerto Rico, the US Virgin Islands, and Guam.

The **Selected Metropolitan/ Micropolitan Area Risk Trends** project was an outgrowth of BRFSS from the increasing number of respondents who made it possible to produce prevalence estimates for smaller statistical areas.

CDC Wonder Databases using a rich ad-hoc query system for the analysis of public health data. Reports and other query systems are also available.

Center for Applied Research and Engagement Systems
Create customized interactive maps from a wide range of economic, demographic, physical and cultural data. Access a suite of analysis tools and maps for specialized topics.

Community Commons
Interactive mapping, networking, and learning utility for the broad-based healthy, sustainable, and livable communities' movement.

Dartmouth Atlas of Health Care
Documented variations in how medical resources are distributed and used in the United States. Medicare data used to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians.

APPENDIX D: REFERENCES

Disability and Health Data System
Interactive system that quickly helps translate state-level, disability-specific data into valuable public health information.

Heart Disease and Stroke Prevention's Data Trends & Maps
View health indicators related to heart disease and stroke prevention by location or health indicator.

National Health Indicators Warehouse
Indicators categorized by topic, geography, and initiative.

US Census Burea
Key source for population, housing, economic, and geographic information.

US Food Environment Atlas
Assembled statistics on food environment indicators to stimulate research on the determinants of food choices and diet quality, and to provide a spatial overview of a community's ability to access healthy food and its success in doing so.

Centers for Medicare & Medicaid Services Research and Data Clearinghouse
Research, statistics, data, and systems.

Environmental Public Health Tracking Network
System of integrated health, exposure, and hazard information and data from a variety of national, state, and city sources.

Health Research and Services Administration Data Warehouse
Research, statistics, data, and systems.

Healthy People 2030 Leading Health Indicators
Twenty-six leading health indicators are organized under 12 topics.

Kids Count
Profiles the status of children on a national and state-by-state basis and ranks states on 10 measures of well-being; includes a mobile site external icon.

National Center for Health Statistics
Statistical information to guide actions and policies.

Pregnancy Risk Assessment and Monitoring System
State-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.

Web-based Injury Statistics Query and Reporting System (WISQARS)
Interactive database system with customized reports of injury-related data.

Youth Risk Behavior Surveillance System
Monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults.

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