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Chronic Disease

Chronic diseases are illnesses that last a long time, do not go away on their own, are rarely cured, and often result in disability later in life. Examples are stroke, cancer, diabetes, asthma, and arthritis, and heart disease.

Chronic diseases are among the most costly of all problems in the U.S. in terms of human suffering and compromised lifestyles, as well as by direct health care costs that impact the economy and, consequently, all residents.

Risk factors for chronic diseases include:

- **Lack of physical activity**
- **Unhealthy diet**
- **Tobacco use & secondhand smoke**
- **Excessive alcohol use**

How can you avoid chronic disease?

Physical activity: Adults should get 150 minutes of moderate-intensity physical activity per week. Children should get 60 minutes of moderate to vigorous intensity each day.

Diet & nutrition: Avoid sugar-sweetened beverages, eat more fruits and vegetables, limit portion sizes and promote breastfeeding infants.

Tobacco: There is no safe level of tobacco use for adults or children. Avoid all tobacco products and secondhand smoke.

Alcohol: Both the amount of alcohol (heavy drinking) and frequency (binge drinking) are risk factors.

What's Next?

Recommendations for making improvements in the five targeted areas will come in the 2013 Community Health Improvement Plan. This plan will incorporate evidence-based practices as well as recommendations from community partners and residents. The Green Lake Area Health & Wellness Coalition will lead this project. All area residents are welcome to participate. If you are interested, contact the Green Lake County Health Department at 294-4070.

Green Lake County
Department of Health & Human Services
571 County Road A PO Box 588
Green Lake, WI 54941-0588
920-294-4070
www.co.green-lake.wi.us

What factors influence health?

How healthy are area residents?

What are our most pressing health issues?

The answers to these questions can be found in the 2012 Community Health Needs Assessment compiled by the Green Lake County Health Department in collaboration with community partners. The report, available on the county website, provides an overall picture of the health of area residents, the factors that impact health, and priority areas of greatest concern.

The next step is the completion of a five-year Community Health Improvement Plan (CHIP) that will include specific recommendations for improving health habits of area residents. The long-term goal is to make Green Lake County one of the healthiest in Wisconsin!

HEALTHIEST WISCONSIN 2020

Everyone Living Better, Longer

Healthiest Wisconsin 2020 is a state plan with specific goals to promote the health of all residents. The plan stresses the elimination of health disparities and the promotion of health literacy to enable individuals to better communicate with health providers and thus make wise health decisions.

Of the 12 health focus areas included in *Healthiest Wisconsin,* five have been selected as highest priority for Green Lake County:

Physical Activity
Nutrition & Access to Healthy Foods
Alcohol & Drug Use
Mental Health
Healthy Growth & Development

Highlights from the 2012 Health Needs Assessment

Health varies greatly across communities, with some places being much healthier than others. Each year the Robert Wood Johnson Foundation and the UW Population Health Institute survey and report health outcomes and behaviors of Wisconsin's 72 counties. All counties are then ranked with those receiving higher numbers being considered "healthiest."

The category of Health Outcomes, based on an equal weighting of mortality and morbidity factors, represents the overall health of a county. According to the 2012 ranking, Green Lake County ranked 61st out of Wisconsin's 72 counties. Only 11 counties ranked lower than Green Lake County.

♦ An increasing proportion of the Green Lake area population is reporting poor or fair health—an increase from 13% in 2010 to 19% in 2012.

♦ Residents also reported an increased number of poor physical health days per month. **The 2012 rate is greater than 95% of other counties.**

♦ When asked the question "How often do you get the social and emotional support you need?" 20% of county residents who responded to this question reported "inadequate social support," above the state average of 17%.

Adult Obesity Rate

Year	Green Lake	WI
2010	27%	25%
2011	27%	28%
2012	30%	29%

Adult Physical Inactivity

Year	Green Lake	WI	Nation
2012	26%	23%	21%

Smoking During Pregnancy

Year	Green Lake	Nation
2011	19%	14%
2012	25%	14%

Morbidity	Green Lake	Wisconsin
Poor or fair health	19%	12%
Poor physical health days	4.7%	3.3%
Poor mental health days	4.8%	3.0%

Mortality

Year	Rank
2010	35
2011	35
2012	56

Morbidity

Year	Rank
2010	44
2011	55
2012	61

Morbidity represents quality of life.
Mortality represents the years of potential life lost before age 75.

Positive results from the 2012 Rankings:

- ✓ The county ranks #1 in the category of Environmental and Occupational Health.
- ✓ The number of low weight babies is well below the state average, putting the county in the top 90%.
- ✓ The county experiences a low crime rate.

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Green Lake County
COMPREHENSIVE COMMUNITY SERVICES (CCS) CONSUMER SATISFACTION SURVEY

We ask your help in improving the quality of our services. You do not need to provide your name if you do not wish. If you want to include your name, or if you want us to contact you about this survey or your ideas, please note this at the end. Thank you so much for taking the time to complete this survey!

Please read each statement and circle the number (1 to 5) that best describes your thoughts or feelings about each statement.

	Very Satisfied	Somewhat Satisfied	Just Okay	A Little Unsatisfied	Very Unsatisfied
1. CCS helps me achieve my goal.	5	4	3	2	1
2. The workers are caring and concerned.	5	4	3	2	1
3. The cost is reasonable.	5	4	3	2	1
4. I have been treated with respect.	5	4	3	2	1
5. My Recovery Team has been a good experience.	5	4	3	2	1
6. My ideas count in the development of my treatment plan.	5	4	3	2	1
7. I get the assistance I need.	5	4	3	2	1
8. CCS helps me to improve my skills.	5	4	3	2	1
9. CCS provides good information to me about programs in the community that could help me.	5	4	3	2	1
10. I know who to go to if I am not getting the service I need.	5	4	3	2	1
11. Overall, I am satisfied with CCS.	5	4	3	2	1

What was, or is, best about Green Lake County Comprehensive Community Services (CCS)?______________

____

Improvements I would suggest for Green Lake County Comprehensive Community Services (CCS):____

____

My Name: (optional)________________________________

I want to be contacted about this survey: Yes No

Green Lake County Health ar luman Services Department

CCS Recc.ery Plan

Today's Date:

Consumer Name: Case #_____ Initial Plan Date:

Date of program enrollment: Date of last Functional Screen:

Service Facilitator: New Recovery Plan ☐ Recovery Plan Update ☐

(at least every six months or as consumer's situation changes)

Required Signatures

Consumer	**Signature**	**Date**	**Print or Type Name**
Service Facilitator	**Signature**	**Date**	**Print or Type Name**
Licensed Mental Health or AODA Professional	**Signature**	**Date**	**Print or Type Name**
Psychiatrist	**Signature**	**Date**	**Print or Type Name**

*Signature indicates that the MHP or AODA professional has assessed the individual's needs and authorizes the psychosocial rehabilitation services contained in the plan.

Life Domain Areas to be addressed in Recovery Plan:

(a) Life Satisfaction	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(b) Basic Needs	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(c) Social Network / Family Involvement	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(d) Community Living Skills	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(e) Housing Issues	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(f) Employment	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(g) Education	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(h) Finances and Benefits	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(i) Mental Health	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months

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(j) Physical Health	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(k) Substance Use	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(l) Trauma and Significant Life Stressors	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(m) Medications	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months
(n) Crisis Prevention and Management	☐ See Goal Below	☐ No Identified Needs At This Time	☒ Reassess in 6 Months
(o) Legal Status	☐ See Goal Below	☐ No Identified Needs At This Time	☒ Reassess in 6 Months
(p) Other Identified Domains:	☐ See Goal Below	☐ No Identified Needs At This Time	☐ Reassess in 6 Months

DSM Diagnoses:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Consumer's individual and Family Strengths (Identify the individual's and family's past accomplishments, current aspirations, motivations, personal attitudes, attributes, etc. which can be used to help accomplish goals and objectives.):

Barriers (Describe the challenges as a result of the mental illness or addictive disorder that stand in the way of the individual meeting their goals and/or achieving the discharge criteria. Identifying these barriers is the key to specifying the objectives as well as services and interventions in the following sections of the plan.):

GOAL #1 (Goal should be stated in the individual's own words, and include statement of dreams, hopes, role functions and visions of life.)

	DOMAIN LETTER

OBJECTIVE (Using action words, describe the specific changes expected in measurable and behavioral terms. Include the target date for completion. Ex. Consumer will.........., as evidenced by ....)

INTERVENTIONS (Describe the specific activity, service, or treatment, the provider or other responsible person (including the individual or a family member), and the intended purpose or impact as it relates to this objective. The intensity, frequency, and duration should also be specified.)

GOAL #2 (Goal should be stated in the individual's own words, and include statement of dreams, hopes, role functions and visions of life.)

	DOMAIN LETTER

OBJECTIVE (Using action words, describe the specific changes expected in measurable and behavioral terms. Include the target date for completion. Ex. Consumer will………, as evidenced by …………)

INTERVENTIONS (Describe the specific activity, service, or treatment, the provider or other responsible person (including the individual or a family member), and the intended purpose or impact as it relates to this objective. The intensity, frequency, and duration should also be specified.)

GOAL #3 (Goal should be stated in the individual's own words, and include statement of dreams, hopes, role functions and visions of life.)

	DOMAIN LETTER

OBJECTIVE (Using action words, describe the specific changes expected in measurable and behavioral terms. Include the target date for completion. Ex. Consumer will………, as evidenced by ………..)

INTERVENTIONS (Describe the specific activity, service, or treatment, the provider or other responsible person (including the individual or a family member), and the intended purpose or impact as it relates to this objective. The intensity, frequency, and duration should also be specified.)

CCS Schedule of Services and Supports

Service Code	Array of Services	Assigned Staff or Provider	Start Date	Frequency of Service	Payment Source	End Date
001	Assessment					
002	Recovery Planning					
003	Service Facilitation					
004	Communication and Interpersonal Skills Training					
005	Community Skills Development and Enhancement					
006	Diagnostic Evaluations and Specialized Assessments					
007	Employment Related Skills Training					
008	Medication Management					
009	Physical Health Monitoring					
010	Psycho Education					

011	**Psyschotherapy**					
012	**Recovery Education and Wellness Management**					
013	**Substance Abuse Treatment**					
014	**Other:**					
	Other:					
	Other:					

Discharge Criteria:

Discharge from the Green Lake County CSP/CCS program will occur based on the individualized criteria below unless any one of the follow applies:

- The consumer no longer wants services.
- The whereabouts of the consumer are unknown for at least three months despite diligent efforts to locate the consumer.
- The consumer refuses services from the CSP/CCS program for at least three months despite diligent outreach efforts to engage the consumer.
- The consumer enters a long-term care facility for medical reasons and is unlikely to return to community living.
- The consumer is deceased.
- Psychosocial rehabilitation services are no longer needed.

In addition, the following individualized criteria would lead to discharge from the Green Lake County CSP/CCS program (Describe changes in the individual's current needs and circumstances that would need to occur in order for them to succeed in discharge or transition to a different level of services):

If this is a recovery plan update, include consumer's statement regarding satisfaction with services at this time:

Copies of the completed recovery plan were provided to:

Next Recovery Team Meeting Date: **Time:** **Location:**

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Green Lake County Department of Human Services
Comprehensive Community Services (CCS)

ASSESSMENT

Summary of Strengths & Needs

This section to be completed by CCS.
Initial Plan of Support Start Date: ____________ **Completion Date:** ____________

Instructions: Complete the Summary of Strengths & Needs within 30 days of application.

Consumer's Name: ______________________ **Consumer ID #:** ______________________

Date of Birth: ______________________

Date(s) of Assessment: ______________________

Treatment Provider/ Service Facilitator: ______________________

Please list family and natural supports:

Relationship To Consumer	Name	Age	Gender	Live in the consumer's home?

Emergency Response

- What options or choices have you developed in case of an emergency or crisis?
- What do you feel you need to prevent a crisis from getting worse?
- What are steps or actions that you would like assistance with during an emergency or crisis?
- Who would you like us to contact in an emergency or crisis?
- What are warning signs that alert you that you are not functioning well?
- What health or safety issues contribute to crises in your life?

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

ADDITIONAL CRISIS INFORMATION	Date Completed/Updated	Staff Member
Crisis Plan (6-month)		
Commitment/Settlement Agreement		

Living Situation

- Tell me about your current living situation.
  In what ways does your current living situation meet or fail to meet your needs (for space, privacy, and comfort)?
- Tell me about any safety concerns? (Examples: living on busy street, safe neighborhood, fire safety/disaster plan, unsanitary conditions, architectural modifications, etc.)
- How do you manage your bills and costs related to your living situation? (Examples: rent, heat, mortgage, utilities, etc.)

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

Dates		Consumer's Living Arrangements (past 3 years)
Start	End	

Family and Support Network

- Describe relationships among family members and extended family. (Examples: custody issues, are they a resource to the family, etc.)
- Who (other than family members) offers support to you and your family? (Examples: churches, paid services, mentoring, Personal Care Attendant, support groups, adult disability services, respite, etc.)
- Are there supports that you or your family members are not receiving that you would find helpful? (Examples: Parent education/training, child care, support groups, etc.)
- Is your work affected as a result of your family's needs? Please explain.

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

NAMES (of important support network)	Relationship	Address and Phone Number

Social & Recreational

- Describe your friendships or acquaintances, social connections, social ties outside the immediate family.
  Describe how you and your family relate, interrelate, associate, or connect well with others.
- Describe how you and your family participate in activities together. Are there other activities as a family or individually that interest you?
- Describe barriers that prohibit your participation towards desired activities.

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

Mental Health

- Please provide your individual/family mental health history.
  Describe your experiences seeking and accessing mental health providers, i.e., have you been able to get timely appointments, will your insurance pay for a local provider, etc.).
- Describe any alternative/non-traditional services you are receiving or are interested in receiving.

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

Cognitive and Emotional Functioning

- Is there any particular learning style that suits you best?
  Are there any specific strategies you utilize to reduce stress?
- What are some examples of previously stressful situations for you?
- Are there any struggles with transition for you?
- What are successful coping strategies and examples of less successful ones?

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

Significant Trauma History

At any time in your life, have you:

- Witnessed someone seriously injured or killed due to an unnatural event such as a shooting or auto accident?
- Experienced a natural disaster, severe accident, or threat to your life?
- Had a child/loved one experience a serious medical, mental health, or developmental setback?
- Witnessed a physical or sexual assault against a family member or significant person?
- Been forced to have sexual contact, to touch someone sexually, or be touched sexually when you did not want them to?
- Has anyone slapped, pushed, grabbed, shoved, choked, kicked, bit, or punched you?
- Been threatened with, or actually used a knife, gun, or other weapon to scare or harm you?
- Been afraid that a specific person (known to you well or not) would harm you physically?
- Any other events in your life that have been traumatic for you?

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

Substance Use

- Describe your level of involvement with use of substances (include alcohol and/or other drugs, prescription and/or OTC drugs) over the past 12 months.
- Please tell me about any concerns that you, or people who are important to you, may have about this level of involvement, including any unwanted results of your using.
- Have you accessed treatment and support for substance use issues in the past? If so, what has been particularly helpful for you?
- Do you have concerns about the level of substance use involvement of any one currently living with you?
- Do you and family/household members have access to needed substance use treatment and support?
- ASI completed? Yes ______ No ______

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

Health Status of the Consumer	
Diagnoses and dical conditions (including mental health):	
Relevant medical history (including mental health):	
Current Health Status and symptoms:	
Hospitalizations/ Surgeries (mental health/AODA/ medical):	
Other Health Information: Allergies, vision, dietary, aversions, etc.	

Current Prescribed Medications		
Name/Dose/Frequency	**Purpose/How Effective**	**Who Prescribes/First Prescribed**

Over-the-counter Medications and Supplements	
Name/Dose/Frequency	**Purpose/How Effective/How Long Taken/Used**

Service Providers (include alternative/complementary providers)		
Provider Type	Name/Clinic	How long have you received/how satisfied are you with these services?
ı rimary Physician:		
Psychiatrist:		
Psychotherapist:		
AODA Counselor:		
Other:		
Other:		
Other:		
Other:		

Therapy, Other Services, and Wellness Activities		
Community Based/Home Based	Frequency	Provider or On Your Own
Physical Therapy (PT)		
Occupational Therapy (OT)		
Speech Therapy		
ercise/Activities		
Mind/Body practices (yoga, martial arts, Thai Chi, etc.		
Acupuncture or Other Body Work		

Cultural & Spiritual

Please describe any cultural or spiritual beliefs, practice of family traditions that are important to you and your family such as your religious faith or ethnic identity.

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

Educational

ıild considerations may include:

- Describe your child's current educational setting (school or home school, grade level, attendance, teachers, etc.).
- Who are the important people in your child's education?
- What kind of supports is your child getting at school? Does your child have an Individualized Educational Program (IEP)?
- Describe how your child is doing in his/her schoolwork.
- How is your child doing behaviorally in school?
- How satisfied are you with the educational programming he/she is receiving?

Adult considerations may include:

- Are you participating in or would like to participate in college a course(s), vocational training, on the job training, or other educational opportunities?

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

Employment

- Please describe your work experiences for me.
  What do you see as assets that you bring to a potential employer?
- Describe your level of satisfaction with your current employment.
- Tell me about any employment goals you may have for the future.

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

Legal

- Please describe any current legal issues that may be affecting you. (Examples: divorce and/or child custody process, bankruptcy, mortgage foreclosure, pending criminal charges, restraining order).
- Please identify any history of criminal charges or convictions.
- Are you currently on a deferred prosecution agreement, on probation or JIPS status, or under a restraining order?

What do you see as your strengths in this area?

What do you see as barriers or challenges in this area?

Is this an area that you would like to work on as an area of intervention? If yes, what is your goal?

How will you know if you are making progress towards this goal? How will you know if this goal is achieved?

Case Formulation Page

Assessment Summary

Consumer Name ______________________ Dates of Assessment ______________________

	Individuals Participating in Assessment Process	Dates of Contact for Assessment	Relationship to Consumer	Possible CCS Team Member?
1.				
2.				
3.				
4.				
5.				
6.				

The information on which outcomes and service recommendations are based (Service Domains Assessment is based on):

____

Desired outcomes and measurable goals desired by the consumer.

____

Significant differences of opinion, if any, which are not resolved among members of the recovery team.

____

Signatures of persons present at meetings being summarized:

Consumer Signature ______________________ Date ____________

Parent/Legal Guardian ______________________ Date ____________

CCS Staff Completing Assessment Summary ______________________ Date ____________

Mental Health Professional ______________________ Date ____________