2022-2024 Community Health Implementation Plan Progress

The Community Health Implementation Plan was Approved by the Board of Trustees/Board of Governors on December 28, 2021

GUNDERSEN HEALTH SYSTEM

2022-2024 Community Health Implementation Plan

In 2010, the Patient Protection and Affordable Care Act (PPACA or the ACA) was passed. As part of this health care reform bill, not-for-profit hospitals are required to complete a Community Needs Assessment and a Community Health Implementation Plan that addresses the identified needs. Evidence of meeting these requirements is to be provided on a hospital's annual tax Form 990, Schedule H. The following document summarizes the regional Community Needs Assessment, and details Gundersen Lutheran's Community Health Implementation Plan for 2022-2024.

The Gundersen Community Health Needs Assessment utilizes the COMPASS Now collaborative assessment that includes 6 counties in our service area, representing 70% of our hospital service patient population, and 42% of the overall population of our 22-county service region. The COMPASS Now assessment has been an ongoing community needs assessment in collaboration with the United Way and other community partners since 1995, with updates every three years.

The 22-county Health Indicator Report concurred with the COMPASS assessment priorities. However, reviewing the broader 22 county region assessment revealed a significant need not identified as a priority within the COMPASS process - obesity and diabetes.

The table below lists the community health needs identified as priorities in the 2021 COMPASS Now report and Gundersen 22-County Health Indicator Report. The prioritized needs align with our Population Health strategic priorities.

COMPASS Now 2021 Priorities	22-County Health Indicator Priorities	Gundersen Population Health Priorities
Mental Heath	Suicide Poor Mental Health Status Provider Access	Mental Health
Substance Use	Excessive Alcohol Use Drug Overdose Death Opioid abuse and deaths	Substance Abuse (Opioids)
Safe, Affordable Housing Poverty/Financial Stability	Housing Insecurity Financial Insecurity – Poverty and Alice rates Food insecurity Transportation Adverse Childhood Experiences	Social Determinants of Health (including poverty/financial stability, housing, food, and transportation insecurity) & Adverse Childhood Experiences and Toxic Stress
	Diabetes Tobacco Obesity Physical Inactivity	Chronic Illness

Our implementation plan, including goals, and action steps, resources, partners and outcome measures, addresses the top priority needs identified for the COMPASS Now 6 county region and the 22-County Health Indicator Report. The priorities are stated directly or embedded as an action step. In addition, the implementation plan supports the Health System's four population health initiatives that serve to strengthen our efforts to improve the health of our communities:

A link to the complete COMPASS Now 2021 assessment, 22-County Service Area Health Indicator Report and other related documents can be found at https://www.gundersenhealth.org/community-assessment/.

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Approval & Dissemination

The 2021 Gundersen Needs Assessment with the 22 County Health Indicator report and 2022-2024 Implementation Plan were both presented to the Board of Trustees/Board of Governors on November 22, 2021 and approved on December 28, 2021. Progress is underway to implement the plan. The assessment and implementation plan are posted on the website and are available to the public through the Gundersen health libraries.

Identified Need/Issue: Social Determinants of Health

Goal: By 2024, Reduce number of patients reporting having food, housing, or transportation insecurity by 2% (baseline Q4 2022)

Action	Resource (program)	Partnerships	Measure of Impact	2022	2023	2024
Monitor and improve Social Determinants of Health screening and referral for Gundersen Health System patients and families	Quality Population Health 211 findhelp.org Primary Care Social Services Nursing EPIC	Community Based Organizations (CBOs)	95% of patients identifying and wanting assistance for food, housing or transportation will be referred to a community resource	57% of patients identifying and wanting assistance for food, housing or transportation referred to community resource 737 patients received information for community-based organizations for social needs. • A total of 3,887 programs were shared among the 737 patients.		
Implement CRC workflow for referrals for patients experiencing stress/toxic stress (initiated with the SDOH survey)	Quality Population Health 211 findhelp.org Primary Care Social Services Nursing EPIC	Community Based Organizations (CBOs)	95% of patients with indicator(s) of stress/toxic stress wanting assistance, receive a referral to a community resource	55% of patients with indicator(s) of stress/toxic stress wanting assistance, received a referral to a community resource. Stress Management Wellness Coaching: 140 Referrals • 134 Unique patients • 55% engaged in “at least some coaching” • Among patients with a first and last known stress level:		

				In general, stress level decreased, and coping skills increased		
Investigate disparities for patient outcomes and develop strategies to address findings Possible disparities to consider: - Explore colorectal or breast cancer screening, or tobacco cessation - Street medicine	Quality Population Health Cancer Center Family Medicine Residency – Street Medicine program Primary Care	As defined by the intervention – CBO's, municipalities, funders, etc.	Implement at least 1 intervention identified to address findings by 2024	Breast Cancer Screening: Implemented Hmong Women 50+ Health Event • May 21, 2022 • Attendees = 15 Mammogram = 7 Covid vaccines = 5 Labs = 1 FIT = 2 Displays = 4 (stroke, cancer center, population health, 211) • On-site participating departments = population health, cancer center, admit and registration, financial service, lab, soc serv-interpreters, DEI, breast center, vaccine clinic, nurse advisor • 86% agree/strongly agree = purpose was clear to me • 91% agree/strongly agree = planning process was adequate • 80% agree/strongly agree = communication regarding the plan, needs, and the day was adequate • 100% agree/strongly agree = from your perspective, patients/ community members who attended were satisfied with the event		

				• 86% agree/strongly agree = we achieved our goal(s). Street Medicine Team: Provides health care services for population living with homelessness in La Crosse. • 884 people served		
Support community partners' efforts to impact diversity and social determinants of health especially food, housing, and transportation	HR Employee Relations MEO External Affairs Global Partners	Community Based Organizations (CBOs) 7 Rivers Alliance Workforce Connections PPH Neighborhood Assn Hmoob Cultural Center Schools	$ Community Contributions $ Community Investment Community service reporting	SDOH Patient Phone Calls: respond to patients' social needs and provide information for community resources. • 1446 people served Community Contribution: DEI: $47,844 SDOH: $414,150 Community Service Value: DEI: $9,411 SDOH: $173,957		
Refer patients who are high emergency room utilizers to appropriate CBO or internal program	TEC Quality Population Health Social Services Nursing EPIC	Community Based Organizations (CBOs) HUB CHW	# Identified patients seen frequently in the ER receiving referral to HUB or CHW	63 patients referred to the HUB 1/1/2022 and 9/24/2022 Approximately 50 patients received contact with a CHW		

Identified Need/Issue: Mental Health

Goal: Reduce number of deaths due to poor mental health and substance abuse and reduce the number of poor mental health days by 5% by 2024

Action	Resource (program)	Partnerships	Measure of Impact	2022	2023	2024
Screen patients or worksite screening participants annually for depression/risk for depression	Quality Population Health Primary Care Business Health Services Nursing	Worksites	95% patients screened at least annually for depression by 2024 # Worksite participants screened for depression/anxiety per year	As of 12/31/2022, 90.7% of patients seen in the last 12 months had been screened for depression with a PHQ4 or PHQ9. 4,194 people were screened for anxiety/depression at worksite events via a PHQ4 questionnaire. 2.2% of those scored high for depression and 5.1% scored high for anxiety risk. Of those screened: • 1,441 people were screened at external worksite events; 2.4% scored high for depression risk and 4.9% scored high for anxiety risk. • 2,753 people were Gundersen employees; 2.1% scored high for depression, and 5.2% sored high for anxiety risk.		

Implement CRC workflow for referrals for patients experiencing stress/toxic stress (initiated with the SDOH survey)	Quality Population Health 211 findhelp.org Primary Care Social Services Nursing EPIC	Community Based Organizations (CBOs)	95% of patients with indicators of stress/toxic stress wanting assistance, receive a referral to a community resource	55% of patients with indicator(s) of stress/toxic stress wanting assistance, received a referral to a community resource. 737 patients received information for community-based organizations for social needs; 3,887 programs shared		
Investigate opportunities to increase community-based mental health resources	Behavioral Health Population Health 211	Schools County health/human services departments Worksites United Way NAMI Better Together HEAL Change Direction	1 new program developed by 2024	Stress Management Wellness Coaching: 140 Referrals 134 Unique patients • 55% engaged in "at least some coaching" • Among patients with a first known and last known stress level: In general, stress level decreased, and coping skills increased HeartMath training with Trane Company employees and presentations on knowing the signs and symptoms of depression and what to do if you or someone you know needs help • Two trainings sessions (March 2022 and April 2022) totaling 3 hours • 40 participants Learning sessions about coping skills at Fort McCoy		

				• Four 45-minute sessions offered June 2022 through September 2022 • 40 participants HearthMath training at Viterbo University • One 2-hour training session; 16 participants		
Continue support of community initiatives and policies that improve mental health or access to mental health resources for all populations	Behavioral Health External Affairs Population Health	Federal, State, County, city health/human services departments Legislators Worksites United Way Better Together NAMI Change Direction	$ Community Contributions Community Service report Policy Testimonials	Community Contributions: $64,049 (includes MH and Substance abuse) Community Service Value: Mental Health: $7,573		

Identified Need/Issue: Substance abuse

Goal: Reduce the rate of drug overdose deaths to less than 27.02/100,000 by 2024

Action	Resource (program)	Partnerships	Measure of Impact	2022	2023	2024
Continue to provide leadership for Alliance to HEAL	Population Health ER Behavioral Health	Alliance to HEAL Mayo Healthcare La Crosse Community Foundation La Crosse County Health Department	Plan developed by Q1 2022 Measures added based on plan $ community contribution Community Service reporting	Strategic Planning in 2023 Current Goals: • Limit the supply of opioids in our community • Raise awareness of the risk of opioid addiction • Reduce opioid-related addiction, deaths, and crime in our communities • Create a readily accessible, coordinated, systemic response that increases treatment capacity and enhances the prevention, treatment, and recovery continuum Alliance to HEAL includes 5 workgroups: • Driver Team: GHS provides leadership • Primary Prevention: Continuation of the Wake-Up Call program • Harm Reduction Workgroup: GHS representation – grant writing for Narcan- The committee worked on		

				distribution of Narcan and fentanyl test strips in the community Continuation of Sharps Disposal and Safe Medication Disposal programs • High Risk Population and Medicated Assisted Treatment – GHS representation Continuation of MAT program education and referral • Recovery Informed Employment: Working to develop a robust recovery program for employment in the recovery community • Peer Support and Sober Living: working to increase awareness and access to peer support and sober living in the greater La Crosse area Community Contributions: see Mental Health Community Service Value: $16,536		
Investigate drug related emergency room visits due to opioid use and develop	ER Population Health Quality Behavioral Health	Alliance to HEAL La Crosse County Health Department Community Based	1 new program developed by 2024	Implemented Medication Assisted Treatment in the Emergency Room • A chart review is being done on every patient		

strategies to address findings		Organizations (CBOs)		presenting in the Emergency Room Exploring process to implement Peer Recovery Coaches in the Emergency Room		
Reduce the number of patients exposed to opioids in the management of pain *(action/measure may change based on organizational strategy)*	Providers Pharmacy Pain Management		Reduce # of opioid pills per prescription to 26 by 2022 Reduce # of opioid prescriptions per 1000 patients to 21.2 by 2022	25.51 opioid pills per prescription (12/31/2022) 23.19 opioid prescriptions per 100 patients (12/31/2022)		

Identified Need/Issue: Chronic Disease

Goal: Slow the rate of increase of adults in service area will report fair/poor health by 2024

Action	Resource (program)	Partnerships	Measure of Impact	2022	2023	2024
Implement diabetes management plan to offer wellness coaching to patients who use tobacco	Population Health Clinicians Quality		Reduce smoking status to 10% among patients with diabetes by 2024 (21.5% reduction)	Piloted wellness coaching outreach to 1080 diabetic patients with an all-or-none risk score of 1 for tobacco use. • 21% had at least one coaching session • 16 % accepted wellness coaching • 2% active at the end of 2022 (19 patients) • 7% quit rate among coached patients • Pilot patients were more likely to have Medicare and Medicaid type insurance • Pilot patients more likely to be from a Rural zip code category • Pilot patients that received a letter in the mail were more likely to have at least one coaching session 19% of patients that received a MyChart letter engaged in “some coaching provided”		

				24% of patients that received a letter in the mail engaged in "some coaching provided"		
Refine and promote referral process for clinicians for cessation for patients who use tobacco	Population Health Clinicians Nurses Medical Assistants Pharmacy	WI, MN, IA Quit Lines	70% patients aged 18 + years of age identified as tobacco users who receive tobacco cessation intervention (referrals, meds, counseling) during the 12-month measurement period by 2024	35.3% patients 18+ identified as a tobacco user received a tobacco cessation intervention (referrals, meds, counseling)		
Explore the current state of BMI management for patients	Nutrition services Peds Family Medicine Behavioral Health Bariatrics Quality	YMCA Community Based Organizations	% Identified patients being referred to an intervention	Participation in the Wisconsin Collaborative for Health Care Quality initiative for Obesity: • 58% of Gundersen's patients have a BMI in the obesity category Multidisciplinary team began to meet in 2022 to centralize information about internal and external resources. Begin to build process for population management of obesity. • 2023- begin Wellness Coaching supplementing current Gundersen clinical weight management programs for Meal Replacement		

				and Medication Management		
Continue to explore gaps in care specific to cancer screening	Cancer Center Primary Care Quality Population Health Specialty Department(s)	Community Based Organizations	Implement at least one new strategy to address barriers to screening	Multidisciplinary team focused on improving gaps to breast cancer screening: • Analysis of screening gaps between White women and non-White women has found an improvement in the gap between them from 10.1% in March of 2021 to 8.6% in December of 2022 Screening Gap between White and Hmong women greatest in 2021 (17.2%) and led to the Hmong Screening Event • Implemented Hmong Screening Event May 21, 2022 Mammograms = 7 Covid vaccines = 5 Labs = 1 FIT Test = 2 Displays = 4 (stroke, cancer center, population health, 211) ○ Participating departments = population health, cancer center, admit and registration, financial service, lab, soc serv-		

				interpreters, DEI, breast center, vaccine clinic, nurse advisor ○ 86% agree/strongly agree = purpose was clear to me ○ 91% agree/strongly agree = planning process was adequate ○ 80% agree/strongly agree = communication regarding the plan, needs, and the day was adequate ○ 100% agree/strongly agree = from your perspective, patients/ community members who attended were satisfied with the event ○ 86% agree/strongly agree = we achieved our goal(s). • Universal language in all communication to patients about when screening should happen. • Promotion of Wisconsin Well Women Program in clinic exam rooms		

				• Re-implementing same day walk-in appointments in most locations for women who didn't have an appointment but have decided "Today is the Day." Multidisciplinary team focused on improving colorectal cancer screening. This has led to the following: • Analysis of screening gaps between White and non-White patients found an improvement in the gap between them from 12.5% in March of 2021 to 11.7% in December of 2022 Non-white patients more likely to complete a less-invasive (stool test) procedure over a colonoscopy. Team continues to send FIT to unscreened patients to improve the screening rate overall, and to decrease the gap, especially in rural locations. • Implementation of "Epic Campaigns" started late		

				in 2022 (and will be ongoing) to remind patients who received a FIT, to complete it.		
Provide or support education and resources that engage the community (Minutes in Motion, 5210, other wellness challenges, Complete Streets)	OPH Pediatrics Marketing GMF	Local media School District(s) County Health Departments Worksites Monroe Co Nutrition Workgroup Committee on Transit & Active Transportation (CTAT)	#Lives touched $ Community Contributions Community Service reporting	2022 Minutes in Motion 6-week Community Physical Activity Challenge: • 2554 participants • 80% of post-survey respondents reported the challenge helped incorporate more physical activity into daily living. Desk to 5K/Half Marathon/Marathon Program: • 2/23/22-5/7/22 • 224 participants Quarterly Diabetes Support Group in La Crosse: • support and education to those living with prediabetes, diabetes or caring for someone with diabetes • 30 individuals registered and attendance numbers were 7, 9, 10, 4 for the four support group meetings 6-week virtual Healthy Living with Diabetes Class:		

				• To increase confidence in managing their/a loved one's diabetes • 14 total registered • 44% of enrollees described their health as "Poor" or "Fair" in the pre-survey. Overall, 23% of enrollees described their health in this way which is higher than those living in the GHS's service area (13%). • Of those who completed post-survey, 100% answered "I am more confident in my ability to manage my diabetes • Virtual format allowed those across GHS's service area to participate in the classes. Offer 6-week virtual Healthy Living with Chronic Pain Class • To increase confidence in managing their own or a loved one's chronic pain • 47 individuals have completed the class since 2019 with 21 increasing their confidence in managing chronic conditions.		

				Monthly virtual chronic pain support group: • 6 enrolled, with most attending each monthly class. 2022 Healthy Aging Conference: 9/9/2022 • To educate attendees on social isolation and loneliness • 40 attendees • Among post- survey respondents, 94% agreed with the statement: “the conference was appropriate for my education and/or experience.” • 88% indicated they were very satisfied/satisfied with the conference Dementia Live Simulation Event:9/22/2022 • Spread awareness and offer support to those living with or caring for someone with dementia • 60 participants Community Contributions: $84,500 Community Service Value: $78,223		

Monitoring Long Term Outcomes

This implementation plan aligns with the Gundersen Health System Community Health Scorecard. The Community Health Scorecard was created to identify key metrics and monitor progress of our organization's population health strategies which are the foundation of a primary mission, to improve the health of our communities. Common threads connect the community health needs assessment to the scorecard. Embedded within each metric are detailed goals, with many mirroring those of the implementation plan.

Population Health Scorecard Main Cover