2019-2021

Community Health Implementation Plan

Approved by the Board of Trustees/Board of Governors on November 26, 2018

GUNDERSEN HEALTH SYSTEM®

Gundersen Lutheran Medical Center

2019-2021 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 2019-2021.

The Gundersen Community Health Needs Assessment utilizes the COMPASS Now collaborative assessment that includes 6 counties in our service area, representing 74% of our hospital service patient population, and 43% of the overall population of our 21-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 21-county Health Indicator Report concurred with the COMPASS assessment priorities. However, reviewing the broader 21 county region assessment revealed a significant need not identified as a priority within the COMPASS process - obesity and diabetes. The table below outlines the priorities identified for the COMPASS Now region, individual county priorities from COMPASS Now report, and priorities identified through the 21-County Health Indicator Report.

21 County Region	**COMPASS Region**	**Buffalo County**	**La Crosse County**	**Monroe County**	**Trempealeau County**	**Vernon County**	**Houston County**
Livable wage jobs	Livable wage jobs	Access to public transportation	Livable wage jobs	Livable wage jobs	Livable wage jobs	Livable wage jobs	Livable wages
Improved mental health & access to services	Mental health and access to services	Access to mental health services	Access to mental health services	Access to mental health services	Access to mental health services	Access to mental health services	Access to mental health services
Reduced alcohol and drug misuse/abuse	Drug and alcohol misuse and abuse	Food security	Inclusion of socially diverse people	Food security	Inclusion of socially diverse people	Inclusion of socially diverse people	Access to public transportation
Wraparound support through lifespan-including Adverse Childhood Experiences	Wraparound support throughout the lifespan	Drug and alcohol misuse and abuse	Drug and alcohol misuse and abuse	Drug and alcohol misuse and abuse	Drug and alcohol misuse and abuse	Drug and alcohol misuse and abuse	Drug and alcohol misuse and abuse
Reduced obesity & rates of diabetes	Inclusion of socially diverse people	Number of volunteer EMS and first responders	Well-being of children and youth	Access to high quality childcare	High quality opportunities for teenagers and people in their 20's	Access to affordable healthcare services	Access to affordable, high quality housing
							School and community safety

Our implementation plan, including goals, and action steps, resources, partners and outcome measures, addresses the 5 priority needs identified for the COMPASS Now 6 county region and one additional priority identified by the 21-County Health Indicator Report. The priorities can be identified by the priority need 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:

Gundersen Health System
Population Health Initiatives

1. Adverse Childhood Experiences ACEs)/ Trauma Informed Care (TIC)
2. Homelessness
3. Substance Abuse/Mental Health
4. Chronic Illness

A link to the complete COMPASS Now 2018 assessment, 21 County Service Area Health Indicator Report and other related documents can be found at http://www.gundersenhealth.org/community-assessment/.

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Approval & Dissemination

The 2018 Gundersen Needs Assessment with the 21 County Service Area Health Indicator report and 2019-2021 Implementation Plan were both presented to the Board of Trustees/Board of Governors on November 26, 2018. Progress is underway to implement the plan. The assessment and implementation plan are posted on the website listed below, as well as be made available to the public through the Gundersen health libraries.

Identified Need/Issue: Wraparound support throughout the lifespan to improve quality of life

Goal: Augment and disseminate wrap around services for children and adults that will improve selected outcomes by 5% (determined by dashboard)

Action	Resource (program)	Partnerships	Measure of Impact
Develop dashboard that will identify and monitor impact of services	Population Health CPCS Program leaders 211	Better Together County Health Departments CESA 4 United Way	Dashboard with metrics developed by Q1 2019 Annual update and action based on identified areas of distress
Create a trauma-informed community	Population Health Pediatrics Behavioral Health	School Districts Better Together	ACE/TIC (plan to be developed)
Provide education and resources that enhance ability for older adults to stay active and independent for as long as possible (falls prevention, caregiver support, dementia care, healthy aging)	CPCS GMF Tri State Ambulance Nursing Trauma Services Neurology Primary Care Cass Street Pharmacy Winona Sports Medicine	Alzheimer's Assn ADRC Caregiver Coalition Falls Prevention Coalition La Crosse Park and Rec Dept Winona Friendship Center Arthritis Foundation Bethany St. Joseph Corp-Smart Seniors Monroe County Dementia Coalition	Metrics developed by Q1 2019 • Annual quality of life indicator • Reduced falls in designated geographic location
Continue rollout of coping/resilience program at schools (based on Heartmath methodology) and other locations	CPCS Population Health NCPTC	Schools Youth agencies (BGC; Y Teen Center)	# children Evaluation metric for specific age groups • Increased ability to cope with stressors • Ability to identify emotions
Offer programming to meet the needs of disadvantaged students	Global Health	Schools Employee and Community Volunteers	# volunteers # children mentored for the school year Evaluation metric for Global Partners Mentoring tbd
Support social diversity through education and involvement in community organizations/coalitions	HR Employee Relations MEO External Affairs	7 Rivers Alliance Workforce Connections PPH Neighborhood Assn Hmoob Cultural and Community Agency	# of orgs involved $ Community Contributions

Identified Need/Issue: Mental health & substance abuse

Goal: Reduce number of deaths due to poor mental health and substance abuse and reduce the number of poor mental health days by 5%			
Action	**Resource (program)**	**Partnerships**	**Measure of Impact**
Develop dashboard that will identify and monitor impact of services	Population Health CPCS Program leaders		Dashboard with metrics developed by Q1 2019 Annual update and action based on identified activities
Alliance to HEAL (IHI initiative)	Population Health	Mayo Healthcare La Crosse Community Foundation Heroin & Drug Task Force La Crosse County Health Department	Plan developed by Q1 2019 Measures added based on plan $ community contribution
Continue participation in community collaboratives (i.e.: Change Direction, LCPN, Better Together)		Trane Co LHI County health/human services departments Worksites United Way LAHI 7C's Health Initiative Change Direction LCPN Better Together	# lives impacted $ contributed
Support community recovery coaches	Trauma Services Providers Social Workers Nurses	Coulee Recovery Center	# of referrals made by Gundersen Health System for recovery coaches
Reduce the number of patients exposed to opioids in the management of pain	Providers Pharmacy Pain Management		# opioid prescriptions per 1000 patients # opioid pills per prescription
Reduce harmful effects of drug addiction in pregnancy (Gunderkids)	Peds OB Family Medicine	HUB	# of youth still housed with parent(s)

Identified Need/Issue: Reduce obesity & rate of diabetes

Goal: Leverage community partnerships to address obesity and improve outcomes among patients with diabetes			
Action	**Resource (program)**	**Partnerships**	**Measure of Impact**
Develop dashboard that will identify and monitor impact of services	CPCS Program leaders		Dashboard with metrics developed by Q1 2019 Annual update and action based on identified activities
Continue to develop weight loss initiatives (Winning Weighs, LEAP)	Nutrition services Peds Family Medicine Behavioral Health Bariatrics	YMCA	Participants % meeting identified program goals
Deliver or partner with the HLC to implement disease management programs (HLWD, Dig Deep, Diabetes Support Group)	CPCS Physical Medicine Nutrition Services Behavioral Health Physical Therapy Endocrinology	YMCA	Participants HLWD – improved outlook on living with diabetes (post evaluation and overall health improvement) Dig Deep – % goal(s) met
Address policies related to offering free or reduced cost services (i.e. anti-kickback, Stark)	External affairs	Federal legislators	Communication with legislators Testimonies Position papers
Provide education and resources that engage the community (Minutes in Motion, 5210, other wellness challenges, Farm to School, Complete Streets)	CPCS Pediatrics Marketing GMF	Local media School District(s) County Health Departments Worksites Monroe Co Nutrition Workgroup Committee on Transit & Active Transportation (CTAT)	Participation for targeted audience/population % meeting goal of program

Identified Need/Issue: Livable wage

Goal: Reduce the impact of poverty on poor health by 5% by 2021, by partnering with communities to address SDOH.

Action	Resource (program)	Partnerships	Measure of Impact
Develop dashboard that will identify and monitor impact of services	CPCS Program leaders		Dashboard with metrics developed by Q1 2019 Annual update and action based on identified activities
Continue to support housing needs in La Crosse & Region	Population health Corporate Contributions CPCS 211	Collaborative to End Homelessness HUB	# people housed #HUB pathways completed

Continue to support affordable transportation options available throughout the region	External affairs
	Corporate Contributions
	HR
	Services Excellence
	Purchasing (Use of transportation & cost)
	CPCS
	Facilities
		SMRT bus
		Local agencies & services providers (i.e. taxis, Uber, Lyft)
		Committee on Transit & Active Transportation (CTAT)
		La Crosse Area Planning Committee (LAPC)
			• # of riders of SMRT bus
			• Dollars spent on transportation for patients to home or appts
			  ○ Payments to service providers
			  ○ Corporate Contributions
			• Alternative options:
			  ○ On campus #bike shelters/racks
			  ○ Other goals met

Support Neighborhood Plan (PPH) & JDC	External Affairs CPCS Facilities	City of La Crosse PPH Neighborhood Assn La Crosse Promise Habitat for Humanity Private developers	• Identified goals met in the PPH & JDC plans • Investments made in PPH • # housing units built • Progress of grocery store

Continue to support and develop the current HUB model	Population Health
	CPCS
	Trauma Services
	OB
	Medical Social Services
	211
		United Way
		St Clare Health Mission
		County health departments
		Mayo
		La Crosse Community Foundation
			• # patients referred
			• #pathways completed
			• Decrease in cost
			  ○ Decrease hospital & TEC visits
			  ○ Increase office visits

Support the implementation of Social Determinants of Health screening and referral for Gundersen Health System patients and families	Quality Population Health CPCS 211 Primary care depts Social Services Nursing	Service agencies	• % patients screened • % patients with a need referred to service
Address food insecurity in our service area by increasing screening of patients and partnering with related community organizations	Peds Population Health CPCS Nutrition Services	County Health departments Coalitions Food service agencies	Programs/screenings initiated