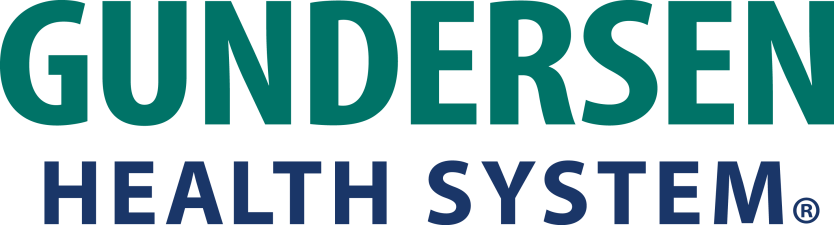
2022-2024

Community Health Implementation Plan Progress

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



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.

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| **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

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| **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\*Data reported for 1/1/2023 – 9/30/2023 due to change in fiscal year** | **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. | 61% of patients identifying and wanting assistance for food, housing or transportation referred to community resource  583 patients received information for community-based organizations for social needs.   * A total of 3,967 programs were shared among the 583 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: a free telephonic service for patients scoring high risk for stress on the SDoH questionnaire and indicating they would like to speak with a Community Resource Connector (CRC)  140 Referrals from the CRCs   * 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 | 57% of patients with indicator(s) of stress/toxic stress wanting assistance, received a referral to a community resource.  Stress Management Wellness Coaching: a free telephonic service for patients scoring high risk for stress on the SDoH questionnaire and indicating they would like to speak with a Community Resource Connector  109 Referrals from the CRCs   * 108 Unique patients * 58% 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   * 21% of patients self-reported an increase in coping skills |  |
| 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 | Breast Cancer Screening: Hmong Women 50+ Health Event   * April 28, 2023 * Attendees = 26 * Mammograms = 2 * Health education presentation by Hmong nurses * Educational displays= population health, quality, telephone nurse advisor, and Great Rivers 211 * Onsite participating departments= Population Health, Cancer Center, Admission and Registration, Financia Service, Interpreters, DEI, Breast Cancer, Family Medicine, Telephone Nurse Advisor, Quality   Analyzed diabetes care and outcomes by race/ethnicity, payer and living location among GHS patients. Outcomes:   * A1c control (less than 8%) is high at 76.5% * A1c control is lower among:   -Males  -Non-white patients (especially Black, Asian, and Hispanic  -Patients with Medicaid type insurance (68%)  -Patients who smoke or use smokeless products (71% of these patients have controlled A1c)   * 54.4% of all patients meet the all-or-none outcomes (A1c <8%, Blood Pressure <140/90, non-tobacco user, Daily aspirin/other antiplatelet use if IVD). GHS Corporate target is 60%. Meeting the all-or-none is lower for:   -Males  -Non-white patients (especially Black, Native American, and Hispanic patients)  -Patients with Medicaid type insurance (39%)  -Patients living in Rural Underserved or Rural zip codes)  Continue to discuss and explore how to care for patients with diabetes or whether care should be different based on findings.  Patients with a financial SDOH risk (specifically food or transportation insecurity) have poorer outcomes. Continue to explore how Gundersen can better assist patients to get to appointments or have access to culturally-specific and healthy food.   * Patients with any financial risk were less likely to have optimal testing, less likely to be tobacco-free and have blood pressure control, had poorer A1c control and less likely to meet the all-or-none outcome.   Street Medicine Team: Provides health care services for population living with homelessness in La Crosse.  300 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 referrals   Community Contribution:  DEI: $47,844  SDOH: $414,150  Community Service Value:  DEI: $9,411  SDOH: $173,957 | SDOH Patient Phone Calls: respond to patients' social needs and provide information for community resources.   * 1114 referrals   583 patients received referrals  and/or information for resources  GHS Summer Meal Program   * Provide free bagged breakfast and lunch meals to children and adolescents 18 years and younger in the La Crosse area * 1534 meals served   GHS Food Drive and Donation   * Collect and donate food and other supplies for Hamilton Elementary School in La Crosse & Irving Pertzsch Elementary School in Onalaska * Regional clinics were encouraged to hold food/items drives for their local pantries * Outcomes:   1720.4 lbs. food collected and donated  121 personal care items collected and donated  428 school supplies collected and donated  GHS Produce Drive and Donation   * Donate extra garden produce to WAFER which is distributed to those in need within the community * 126 lbs. of produce were collected and donated July to October 2023   Continue to support SMRT bus as a transportation solution  Continue internal workgroup to discuss and plan strategies to address transportation solutions  Community Contributions:  DEI: $77,650  SDOH: $312,550  Community Service Value:  DEI: $2,862  SDOH: $26,539.75 |  |
| 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 | 27 patients referred to the HUB 1/1/2023-9/30/2023  Approximately 388 patients received contact with a CHW in the Gundersen ED |  |

Identified Need/Issue: Mental Health

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| **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 \*Data reported for 1/1/2023 – 9/30/2023 due to change in fiscal year** | **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.  **Worksite Screenings**  4,194 total worksite participants were screened for anxiety/depression at worksite events via a PHQ4 questionnaire. 2.2% of those scored high for depression risk 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. | As of 9/30/2023, 91.8% of patients seen in the clinic at least twice in the last 24 months and at least once in the most recent 12 months screened for clinical depression with a PHQ4 or PHQ9.  **Worksite Screenings**  893 total worksite participants were screened for anxiety/depression at worksite events via a PHQ4 questionnaire.   * 228 participants were screened at external worksite events; 1.3% scored high for depression risk and 4.9% scored high for anxiety risk. * 665 participants were Gundersen employees participating in the MyHealth Reward program; 3.5% scored high for depression risk, and 6.4% scored high for anxiety risk. * All worksite participants were provided with information on free local mental health and wellbeing resources such as 211 and   Communitylink  \*Note: For populations where activities continued from fiscal year 2023 to 2024 are being documented in 2024 progress updates |  |
| 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 | 57% of patients with indicator(s) of stress/toxic stress wanting assistance, received a referral to a community resource.  Stress Management Wellness Coaching: a free telephonic service for patients scoring high risk for stress on the SDoH questionnaire and indicating they would like to speak with a Community Resource Connector (CRC)   * 109 Referrals from the CRCs * 108 Unique patients * 58% 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  21% of patients self-reported an increase in coping skills |  |
| 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: a free telephonic service for patients scoring high risk for stress on the SDoH questionnaire and indicating they would like to speak with a Community Resource Connector  109 Referrals from the CRCs  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 focused on 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 | Stress Management Wellness Coaching: a free telephonic service for patients scoring high risk for stress on the SDoH questionnaire and indicating they would like to speak with a Community Resource Connector  109 Referrals from the CRCs   * 108 Unique patients * 58% 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   * 21% of patients self-reported an increase in coping skills   Planning started in 2023 to receive referrals for Gundersen patients calling Great Rivers 211 seeking stress management resources and are an appropriate candidate for stress management wellness coaching  Participated and/or supported community events:  Presence at Dance for Hope Suicide Prevention Initiative event   * GHS Information and Referral staff Provided information on Great Rivers 211 Resources * Population Health provided general health and wellness information and resources * 400 attendees   Coping Skill Program at West Union High School, IA Students:   * 2/2/2023 * To help youth destigmatize mental health * Outcome goal: you will identify symptoms and seek assistance if needed * # Attendees: 300   Bangor Middle School Coping Skills Program (3/2/2023) and Bangor High School Coping Skills Program (3/29/23-3/30/2023)   * Teach youth about stress, mental health, and help with self-regulation techniques * Outcome goal: students will leave with practical techniques to use and understand why they are helpful * 23 attendees at Bangor Middle School * 32 attendees at Bangor High School   Coping Skills Presentation at Viterbo University   * 3/23/2023 and 9/28/2023 * Goal: To help college students learn how to better self-regulate during stressful times * Outcome goal: students will leave with practical techniques to use and understand why they are helpful * 14 attendees on 3/23 * 14 attendees on 9/28 |  |
| 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 | Community Contributions:  $55,387 (includes Mental Health and Substance abuse)  Community Service Value:  Mental Health: $20,365.25 |  |

Identified Need/Issue: Substance abuse

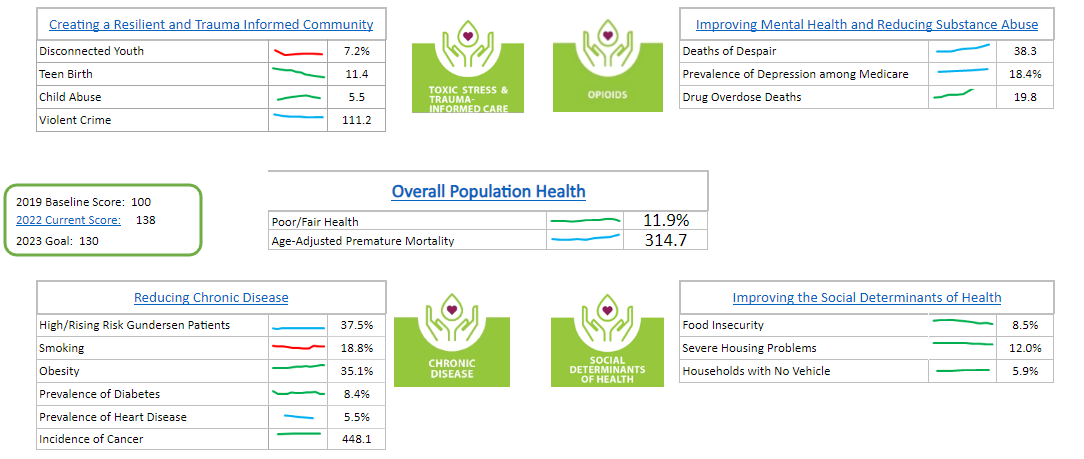
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| **Goal:** Reduce the rate of drug overdose deaths to less than 27.02/100,000 by 2024 | | | | | | |
| **Action** | **Resource (program)** | **Partnerships** | **Measure of Impact** | **2022** | **2023 \*Data reported for 1/1/2023 – 9/30/2023 due to change in fiscal year** | **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 | Continue active participation and leadership in Alliance to HEAL  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   Workgroups   * Primary Prevention:   To prevent and delay substance use initiation among pre-teens, and young adults;  Continuation of the Wake Up Call program   * Peer Support and Sober Living: To increase awareness and access to peer support and sober living in the greater La Crosse Area * Recovery Informed Employment: To develop a robust recovery program for employment in the recovery community * Harm Reduction: To lessen the negative impacts of opioid and other substance abuse in La Crosse County: needle/sharps disposal program, safe medication disposal program, Narcan training and distribution program. * High Risk Population and Medical Assisted Treatment program: To increase the number of individuals moving toward treatment for substance use disorder: continuation of MAT program education and referral   Community Contributions: see Mental Health  Community Service Value:  $6,360 |  |
| Investigate drug related emergency room visits due to opioid use and develop strategies to address findings | ER  Population Health  Quality  Behavioral Health | Alliance to HEAL  La Crosse County Health Department  Community Based Organizations (CBOs) | 1 new program developed by 2024 | Implemented Medication Assisted Treatment in the Emergency Room   * A chart review is being done on every patient presenting in the Emergency Room   Exploring process to implement Peer Recovery Coaches in the Emergency Room | Continue Medication Assisted Treatment in the Emergency Room  Continue 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 1000 patients (12/31/2022) | 24.11 opioid pills per prescription (as of 9/30/2023)  22.46 opioid prescriptions per 1000 patients (as of 9/30/1023)  Continue offering medication drop boxes at all Gundersen Pharmacy locations |  |

Identified Need/Issue: Chronic Disease

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| **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 \*Data reported for 1/1/2023 – 9/30/2023 due to change in fiscal year** | **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 continued 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” | Continued follow up with 2022 pilot patients who accepted wellness coaching support and still active in 2023   * Patient outreach discontinued in 2023   A clinician Epic smartphrase was developed in 2023   * Includes a direct referral to wellness coaching for patients living with Diabetes and use tobacco |  |
| 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) | 30.1% patients 18+ identified as a tobacco user received a tobacco cessation intervention (referrals, meds, counseling)  Continue to educate internal departments about the tobacco cessation clinician smartset- a “one-stop- shop” for tobacco cessation resources and referral  In-patient order set was developed to provide smoking cessation education to hospitalized patients and referral to internal and external resources/programs |  |
| 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 | Participation in the Wisconsin Collaborative for Health Care Quality initiative for Obesity:   * Assisted in the development of the WCHQ obesity toolkit.   Continue to be actively involved in developing measures to monitor progress on treatment of obesity and monitor the health of patients with obesity (diabetes and hypertension control)  Participated in a public hearing held by the WI childhood obesity task force. Representatives from Gundersen presented on Gundersen’s Family LEAP (Learn, Eat and Active Play) program  Began free Wellness Coaching supplementing current Gundersen clinical weight management programs for Meal Replacement and Medication in January 2023   * Coaching expanded from one coach to two coaches’ due to the number of referrals and need * Data:   # Referrals: 179  % Met Primary Outcome Goal- decreased weight: 73.9%   * Future planning: wellness coaching expansion to include bariatric surgery patients in 2024 |  |
| 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, admission and registration, financial services, lab, social services, 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. | *Breast Cancer Screening and Disparities*  Metrics:   * Since March of 2021, the overall Breast Cancer screening rate has improved from 79.6% to 82.5%. Breast cancer screening improved by 3.8% in non-White patients and 3.1% in White patients. The overall gap increased from December of 2022 to June of 2023 * Identified barriers to cancer screening include language, cultural, stigma/fear of illness, decision making, competing illnesses     Based on metrics, developed an Epic Campaign targeted at Medicaid or uninsured women who are missing their mammogram.   * Communication assures patients that mammogram screenings are covered by insurance under preventive care. Information on state resources aid in covering the cost of mammogram screenings is included for uninsured patients   Offered a self-schedule option for mammogram screenings in MyChart  The Center for Breast Care offers 2 open appointment slots per day for walk-ins and patients who were unaware they needed a mammogram and agree to get one “today”  Offered Hmong Women aged 50+ Community Health Event   * 4/28/2023 * Attendees = 26 * Mammograms = 2 * Education presentation provided by Hmong nurses * Educational displays= population health, quality, telephone nurse advisor, and Great Rivers 211 * Onsite participating departments= Population Health, Cancer Center, Admission and Registration, Financial Services, Interpreters, DEI, Breast Cancer, Family Medicine, Telephone Nurse Advisor, Quality   *Colorectal Cancer Screening and Disparities*   * Since 2021, the overall Colorectal Cancer screening rate has improved from 76.5% to 78.6%. The gap between the White and non-White patients has remained the same (about 12% lower in non-White patients) after some improvement * Non-White patients were more likely to complete a colon cancer screening with a less invasive stool tests than White patients * Patients with Medicaid/uninsured are less likely to be screened than patients with private insurance but more likely to use a less invasive procedure * Patients living in rural communities are less likely to be screened but more likely to use a less invasive procedure * Identified barriers to cancer screening include language, cultural, stigma/fear of illness, decision making, competing illnesses * Continue “Epic campaigns” 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)  WAFER Food Pantry | #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 | Offer community health and wellness education sessions at WAFER food pantry   * Planning occurred in 2023 * One session offered in August 2023 with a focus on Smart Shopping Tips and Strategies * Occurs every-other-month * Evaluation will be implemented in the 2024 fiscal year   *Physical Activity*  2023 Minutes in Motion 6-week Community Physical Activity Challenge:   * 2008 participants * 82% of post-survey respondents reported the challenge helped incorporate more physical activity into daily living. * % at risk for lack of physical activity decreased * average # of days/week of physical activity increased   *Chronic Disease Education and Prevention*  Offer Quarterly Diabetes Support Group:   * support and education to those living with prediabetes, diabetes or caring for someone with diabetes * Attendance:   February,12  May, 8  August, 15  Offer 6-week Healthy Living with Diabetes Class:   * To increase confidence in managing diabetes * Program held 2/8/2023-3/15/2023 * 6 participants * Among post-survey respondents, 67% reported an increase in confidence managing their diabetes (\*please note low number of participants impacts outcome measure on post-survey)   Offer 6-week Healthy Living with Chronic Pain Class   * To increase confidence in managing chronic pain * Program held 2/6/2023 – 3/13/2023 * 10 participants * Satisfaction: 93% * 84 individuals enrolled in total since 2019   Monthly chronic pain support group:   * To help former Healthy Living with Chronic Pain participants support each other * 6 enrolled with most attending each monthly class   *Healthy Aging*  Healthy Aging Conference: 9/15/2023   * To educate attendees about Alzheimer’s and Dementia Care * 79 attendees * Among post-survey respondents, 92% agreed with the statement: “the conference was appropriate for my education and/or experience.” * 95% of post-survey respondents indicated they were very satisfied/satisfied with the conference   Aging Mastery Program Workshops:   * To educate older adults about falls prevention * 60 people served   Stepping On Falls Prevention Program:   * 4/3/23-5/15/23 * 16 participants   *ACEs/TIC*   * Offered “Safe Sitter” and “Safe at Home” classes for local youth age 11+ * Delivering education/awareness for youth in the community to best prepare them for their own safety regarding babysitting as well as providing them with the tools they need to be responsible for childcare * 5 classes held from 1/1/2023-9/30/2023 * 75 attendees * 100% found the information useful * 90% were satisfied with the program   Community Contributions:  $24,360  Community Service Value:  $43,403 |  |

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