2022-2024 Community Health Implementation Plan

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
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
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
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
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 and Community Agency Schools	$ Community Contributions $ Community Investment Community service reporting
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

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
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
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
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
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

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
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
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
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

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
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)
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 age 18 + years of age identified as tobacco users who receive tobacco cessation intervention (referrals, meds, counseling) during the 12-month measurement period by 2024
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
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
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

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