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/.

For questions or comments please contact:
Sarah Havens, Director
Office of Population Health
608-775-6580
sjhavens@gundersenhealth.org

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 *Data reported for 1/1/2023 – 9/30/2023 due to change in fiscal year	2024 FY
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.	58% of patients identifying and wanting assistance for food, housing or transportation referred to community resource 1,219 patients received information for community-based organizations for social needs. • A total of 9,626 programs were shared among the 782 patients.
Implement CRC workflow for referrals for patients experiencing	Quality Population Health 211 findhelp.org	Community Based Organizations (CBOs)	95% of patients with indicator(s) of stress/toxic stress wanting assistance,	55% of patients with indicator(s) of stress/toxic stress wanting assistance,	57% of patients with indicator(s) of stress/toxic stress wanting assistance, received a referral to	53% of patients with indicator(s) of stress/toxic stress wanting assistance, received a referral

stress/toxic stress (initiated with the SDOH survey)	Primary Care Social Services Nursing EPIC		receive a referral to a community resource	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	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	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 Referrals: • 113 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 Implemented work flow for Great Rivers 211 referral

						process to Stress Management Wellness Coaching
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	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	Hmong Health Event: 3rd annual event for the Hmong community about preventive care/healthcare • April 6, 2024 • Preventive care and mental health focus with presentations by Gundersen Hmong nurses • Offered an opportunity for guests to get a biometric (non-fasting) lipid test, blood pressures, and the opportunity to take the PHQ4 test. Entertainment was provided by Abigail Xiong, a local Hmong singer. • Attendees= 27 • About 30% of attendees participated in

				• 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	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	lipid/blood pressure and PHQ$ screenings Analysis were conducted on disparities seen in risk factors (smoking, obesity) clinical care (colorectal, breast cancer, cervical cancer screening, 15 month well-child, optimal diabetes testing, and influenza vaccine) and patient outcomes (hypertension and diabetes control, 30-day unplanned readmission, and low birthweight.) The impact of social drivers for these measures were studied. Some pilot work for breast cancer and 15 month well-child appointment was conducted.

					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:	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	SDOH Patient Phone Calls: respond to patients' social needs and provide information for community resources. • 2,855 referrals to CRCs 1,221 patients received information

				DEI: $9,411 SDOH: $173,957	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	and/or referrals to 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 • 1,865 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

					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	• Outcomes: 700 lbs. food collected and donated • Additionally, Gundersen Region nursing staff collected and donated personal care items and school for Hamilton and SOTA I elementary schools. • During the growing months, a weekly produce drive brought in home-grown fresh garden products which were donated to WAFER Food Pantry. Continue to support SMRT bus as a transportation solution Community Contributions: DEI: $93,172 SDOH: $495,469

					SDOH: $26,539.75	Community Service Value: SDOH/DEI: $64,567
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	90 patients referred to the HUB Over approximately 300 patients received contact with a CHW in the Gundersen ED

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 *Data reported for 1/1/2023 – 9/30/2023 due to change in fiscal year	2024 FY
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	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	As of 9/30/2024, 92.2% 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. **Worksite Screenings** 4,597 total worksite participants were screened for anxiety/depression at worksite events via a PHQ4 questionnaire. • 873 participants were screened at external worksite events; 2.6% scored high for depression risk and 5.7% scored high for anxiety risk.

				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.	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 *Notes: *For populations where activities continued from fiscal year 2023 to 2024 are being documented in 2024 progress updates. *Reduced screening numbers are due to change in Fiscal Year from calendar year to October-September. Data for this year are only reported from January 1st 2023-September 30th 2023.	• 3,712 participants were Gundersen employees participating in the MyHealth Reward program; 2.2% scored high for depression risk, and 5.8% 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. When applicable, employees were reminded about their company's EAP policy. *Notes: *For populations where activities continued from fiscal 2024 to 2025 are being documented in the 2025 progress updates.
Implement CRC workflow for referrals for	Quality Population Health	Community Based	95% of patients with indicators of stress/toxic stress	55% of patients with indicator(s) of stress/toxic	57% of patients with indicator(s) of stress/toxic stress	53% of patients with indicator(s) of stress/toxic stress

patients experiencing stress/toxic stress (initiated with the SDOH survey)	211 findhelp.org Primary Care Social Services Nursing EPIC	Organizations (CBOs)	wanting assistance, receive a referral to a community resource	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	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	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 Referrals: • 113 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 • Implemented work flow for Great Rivers 211 referral process
Investigate opportunities to increase	Behavioral Health	Schools County health/human	1 new program developed by 2024	Stress Management Wellness	Planning started in 2023 to receive referrals for Gundersen	Stress Management Wellness Coaching: a free telephonic

community-based mental health resources	Population Health 211	services departments Worksites United Way NAMI Better Together HEAL Change Direction		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	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	service for patients scoring high risk for stress on the SDoH questionnaire and indicating they would like to speak with a Community Resource Connector Referrals: • 113 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 • Implemented work flow for Great Rivers 211 referral process Implemented referral process for Gundersen patients calling Great Rivers 211 seeking stress management resources and are an appropriate candidate for stress management wellness coaching.

				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	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	Participated and/or supported community events: • Heart Math/Coping Training - focus on Mental Health Stigma – with Bangor High School students. ○ Date: 2/1/2024 ○ # students served: 20 • Heart Math Training – focus on healthy stress management for older adults – at Elroy Clinic community room. ○ Date: 4/20/2024 ○ # people served: 11 • Heart Math/Coping Training for CESA4 school counselors on building youth resiliency ○ Date: 4/15/2024 ○ # people served: 18 • Coping skills presentation at Viterbo University

					• 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	○ Goal: to educate healthy coping skills ○ Date: 2/15/2024 ○ # students served: 16 • 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 and mental health and wellness information and resources ○ 400 attendees
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	Community Contributions: $110,350 Community Service Value: Mental Health: $8,410

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 *Data reported for 1/1/2023 – 9/30/2023 due to change in fiscal year	2024 FY
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:	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	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-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

				• 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	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	recovery continuum Workgroups and Objectives • **Prevention and Education:** ○ Education through various forms - social media, presentations, fact sheets, billboards, mailers, ads ○ Parent advisory group ○ Presentations and participation in parent meetings and community events ○ Family skills trainings ○ THC is Changing Campaign ○ Compliance checks ○ Increase visible enforcement of current social host law providing alcohol to underage persons in social situations ○ Create policy to require licensing of Novel THC retailers and set

				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	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	minimum purchase age to 21 ○ Change school policy from suspension to alternative to suspension ○ Peer to peer advocacy group ○ Teen intervene • **Harm Reduction** ○ Peer to peer advocacy group ○ Teen intervene • **Treatment and Recovery** ○ Peer to peer advocacy group ○ Teen intervene Community Contributions: see Mental Health Community Service Value: $42,543

					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	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 9/30/2023) Continue offering medication drop boxes at all Gundersen Pharmacy locations	26.54 opioid pills per prescription (as of 9/30/2024) Target is 26 pills per RX 22.57 opioid prescriptions per 1000 patients (as of 9/30/2024) Target is 21 opioid RX/ 1000 patients Continue offering medication drop boxes at all Gundersen Pharmacy locations

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 *Data reported for 1/1/2023 – 9/30/2023 due to change in fiscal year	2024 FY*Data reported for 10/1/2023 – 9/30/2024 NEW fiscal year
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	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	Discontinued pilot program. Continue offering free wellness coaching to all patients that use tobacco and/or nicotine. Continued training and communication across clinical and hospital departments to increase knowledge and encourage referral. Continue providing resources (tobacco quit line services, Frist Breath, Smokefree.gov, etc..) for community members searching for tobacco cessation information.

				• 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)	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-	28.3% of patients with a primary care visit in FY 2024 received a cessation intervention (and who were still alive on September 30). • 4415 unique patients among 15,603 adult patients seen in a primary care department

					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	during the same time.) Continue to educate internal departments about the tobacco cessation clinician smartset- a "one-stop- shop" for tobacco cessation resources and referral Planning to improve Epic platform and workflows for tobacco cessation wellness coaching: implementation of Epic Compass Rose for enhanced patient/coaching management • Planning began in fall 2024 for summer 2025 implementation
Explore the current state of BMI management for patients	Nutrition services Peds Family Medicine Behavioral Health Bariatrics	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	Participation in the Wisconsin Collaborative for Health Care Quality initiative for Obesity: • Assisted in the development of	The Wisconsin Collaborative for Healthcare Quality has summarized this measure for health systems in Wisconsin. In this measure, in Q2 of

	Quality			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	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	2023, 40% of Gundersen patients had a BMI > 30. Only 52% of these patients had a obesity "diagnosis" on the problem list. Recent patient data through December of 2023 has 45.8% of adult patients at Gundersen with a BMI over 30. 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) Continue offering free Wellness Coaching supplementing current Gundersen clinical weight management programs for Meal Replacement and Medication • Data:

					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	# New referrals: 162 # Active participants: 245 Met Primary Outcome Goal-decreased weight: 76.7% • Successfully implemented expansion to offer wellness coaching to bariatric surgery patients
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	*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	Analysis were conducted on disparities seen in risk factors (smoking, obesity) clinical care (colorectal, breast cancer, cervical cancer screening, 15 month well-child, optimal diabetes testing, and influenza vaccine) and patient outcomes (hypertension and diabetes control, 30-day unplanned readmission, and low birthweight.) The impact of social drivers for

				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,	• 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	these measures were studied. Some pilot work for breast cancer and 15 month well-child appointment was conducted. Hmong Health Event: 3rd annual event for the Hmong community about preventive care/healthcare • April 6, 2024 • Preventive care and mental health focus with presentations by Gundersen Hmong nurses • Offered an opportunity for guests to get a biometric (non-fasting) lipid test, blood pressures, and the opportunity to take the PHQ4 test. Entertainment was provided by Abigail Xiong, a local Hmong singer. • Attendees= 27

				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	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	• About 30% of attendees participated in lipid/blood pressure and PHQ4 screenings

				○ 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	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/uninsur	

				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.	ed 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.	

				• 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) 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:	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	Offer community health and wellness education sessions at WAFER food pantry • Program focuses have included fall fruits and vegetables, stress around the holidays, goal setting, blood pressure screenings, open wellness forums, and connecting patrons to the services provided by the La Crosse County Economic Support. • Classes were offered twice each month –

				• 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	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	one in the daytime hours that the pantry is open and one in the evening hours when the pantry is open late. • Overall, participants were satisfied with the education sessions topics ***Physical Activity*** 2024 Minutes in Motion 6-week Community Physical Activity Challenge: • 1116 participants • 76% of post-survey respondents reported the challenge helped incorporate more physical activity into daily living. • % at risk for lack of physical activity decreased

				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	• 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	• 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: November: 8 February: 7 May: 8 August: 9 Offer 6-week Healthy Living with Chronic Pain Class • To increase confidence in managing chronic pain • Program held 9/3/2024-10/8/2024 • 6 participants

				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	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:	***Healthy Aging*** Healthy Aging Conference-Aging Strong: To educate conference attendees and raise awareness on actions we can take to help others preserve healthy bodies and minds. This conference will explore what it takes to motivate others to strive to age with good health, including both physical and mental well-being. • 29 attendees, 23 post surveys completed • 48% of those who complete the post survey indicated they are a professional caregiver • 91% agreed with the statement: "the conference was appropriate for my education

				• 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	• 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	and/or experience." • 91% indicated they were very satisfied/satisfied with the conference Stepping On Falls Prevention Program: Participants will gain strength and balance and will take actions to prevent falls • Winona 10/1/2023-10/24/2023 12 participants • Eagle Crest North: 1/22/24-3/4/24 11 participants • Stepping On Falls Prevention 3/25/2024-05/06/2024 9 participants Bingocize: Reduce falls and increase physical activity and socialization

					• 90% were satisfied with the program Community Contributions: $24,360 Community Service Value: $43,403	among older adults in assisted living Outcome goal: Assisted living participants will improve balance and strength and know how to prevent falls • 10/2/2023-12/6/2023 • 15 participants ***ACEs/TIC*** Offered 4 "Safe Sitter" and 1 "Safe at Home" classes for local youth age 11+ • safety and injury prevention for youth to care for themselves and younger children while home alone • Outcome goal: youth feel safe staying home alone and caring for younger children • # youth served: 83

						• 100% found information useful. • 90% were satisfied with the program. Continue participation and leadership with Safe Kids Coulee Region Coalition: Collaborate to reduce unintentional injuries for children in the Coulee Region • # people served: 104 Community Contributions: $86,866 Community Service Value: $47,599

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