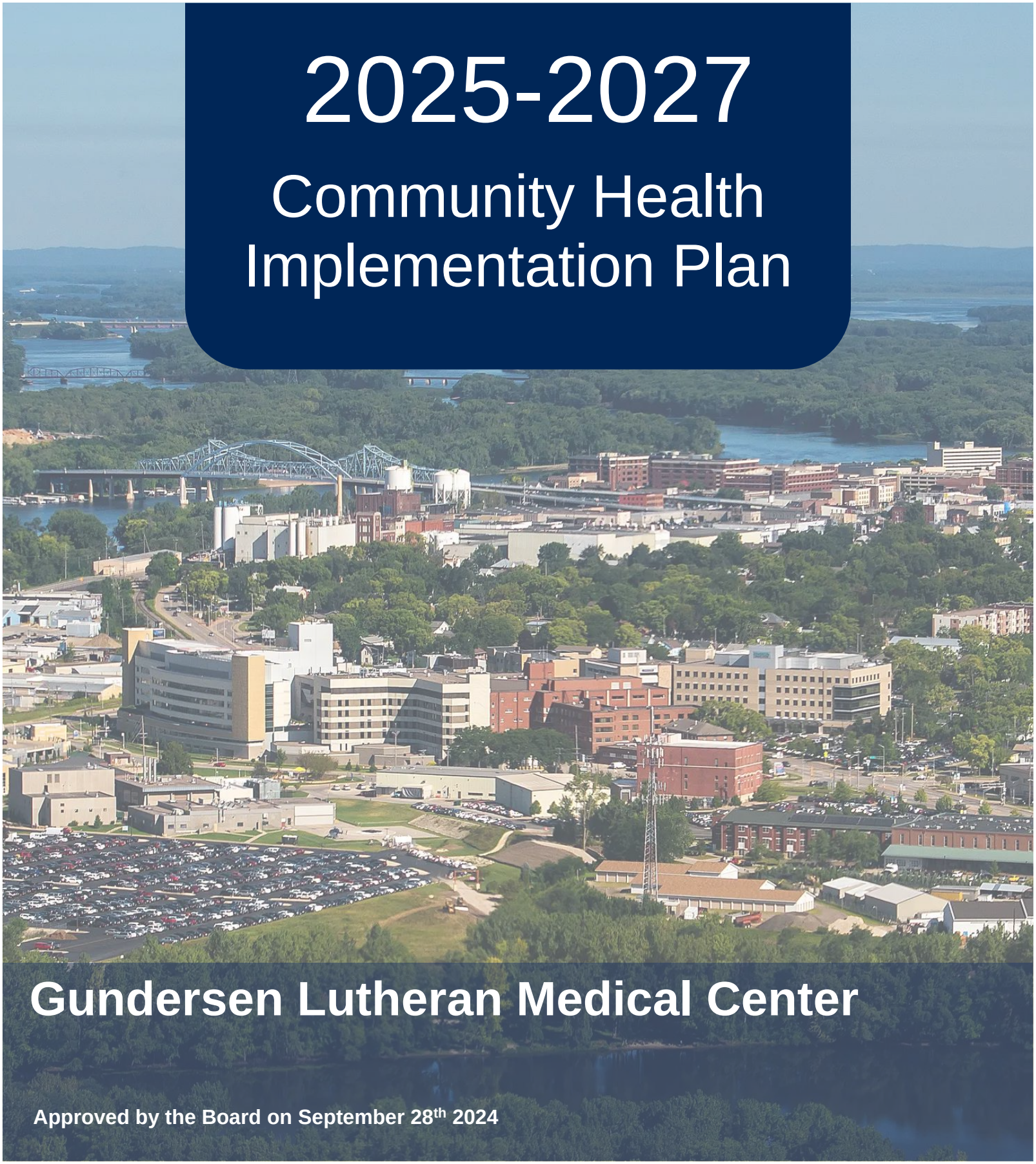
2025-2027

Community Health Implementation Plan



Gundersen Lutheran Medical Center

Approved by the Board on September 28th 2024

emplify HEALTH by Gundersen

bellinhealth + GUNDERSEN HEALTH SYSTEM
Together, we're becoming

emplify HEALTH

Vision of Bellin and Gundersen:

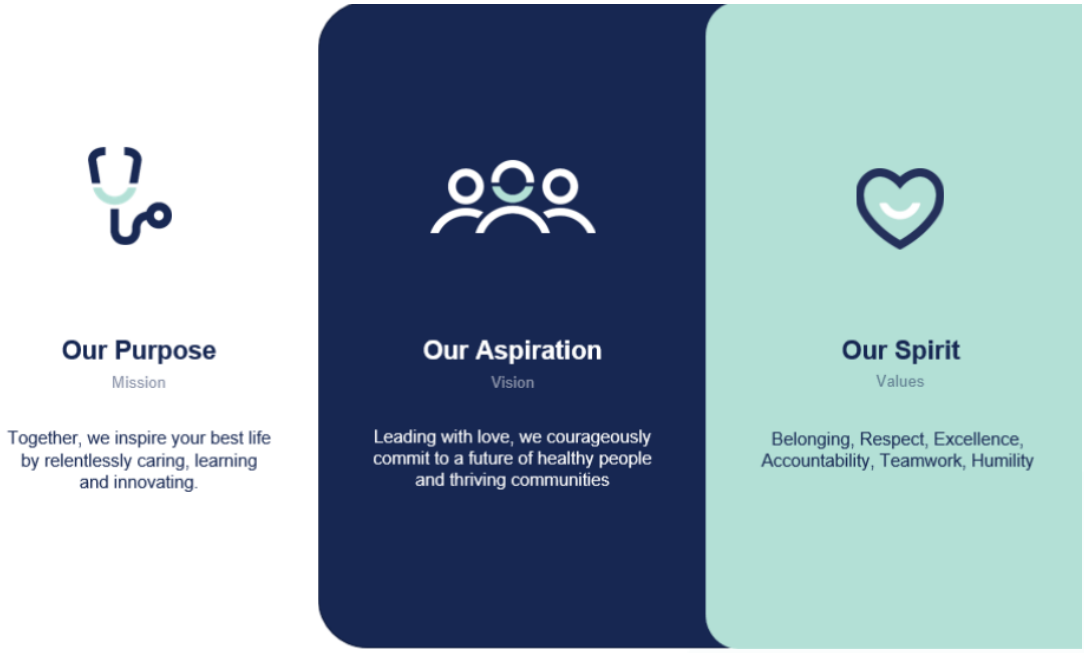
Bellin and Gundersen aim to create healthy people and thriving communities, starting with their youngest patients. Bellin opened Wisconsin's first Family Integrated Neonatal Infant Care Unit (NICU) in 2022, offering a unique "couplet care" model. Bellin's 29 primary care clinics and 88 on-site employer clinics support this vision. Gundersen's 9,000 employees, including 1,000 clinicians, serve 22 counties with seven hospitals and 65 clinics, seeing over one million patient visits annually.

Commitment to the Community:

Bellin and Gundersen provide trusted care in their communities. Bellin partners with the Green Bay Packers and hosts the Bellin Run, a large 10K event. Gundersen offers inpatient mental health care in La Crosse and collaborates with local schools and officials for community development. They also host the annual Steppin' Out in Pink breast cancer walk.

New Brand - Emplify Health:

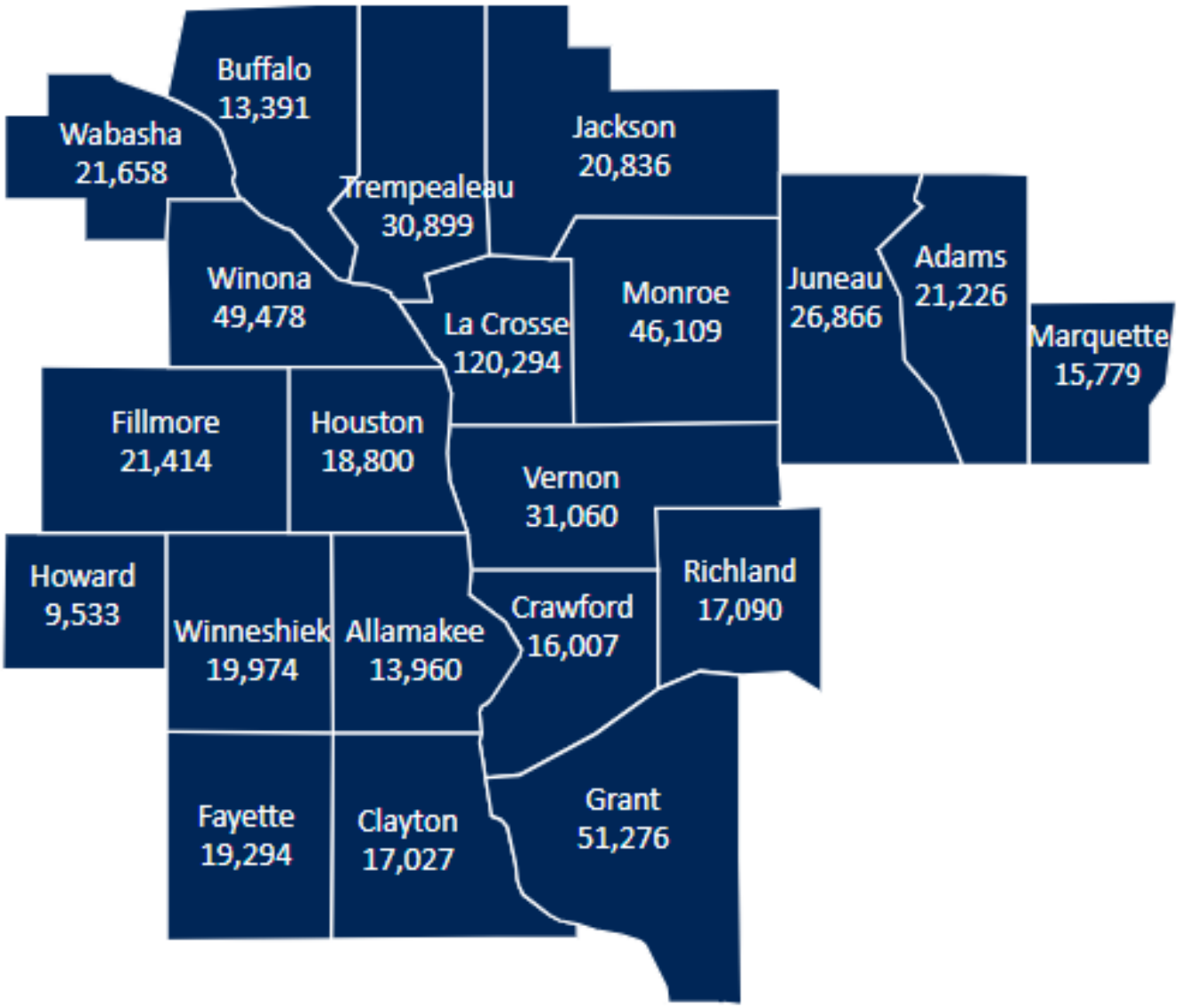
Bellin and Gundersen have united under the new brand Emplify Health, combining "empathy" and "amplify" to enhance access, empathy, and health outcomes. The transition to Emplify Health will take several years, honoring their legacy names and histories.



Gundersen Region Service Area

This Community Health Needs Assessment identifies the top health needs for the 21 counties in the Gundersen Lutheran Medical Center's service area.

The Population of the Gundersen Region's 21 County Service Area is 615,362



Introduction

Background

In 2010, the Patient Protection and Affordable Care Act (PPACA or the ACA) was passed with final regulations (Internal Revenue Service code 501(r)), posted in December 2014, titled "Additional Requirements for Charitable Hospitals; Community Health Needs Assessment for Charitable Hospitals; Requirements of Section 4959 Excise Tax Return and Time for Filing of the Return".

As part of this health care reform act, not-for-profit hospitals are required to complete a community health needs assessment.

Community health needs assessments seek to identify significant health needs for specific geographic areas and populations by focusing on the following questions:

- ***Who*** in the community is most vulnerable in terms of health status or access to care?
- ***What*** is the unique health status and/or access needs for these populations?
- ***Where*** do these people live in the community?
- ***Why*** are the problems present?

The question of ***how*** needs will be addressed is outlined in this document – the Community Health Implementation Plan.

Evidence of meeting these requirements is documented on a hospital's tax Form 990, Schedule H. There is no standard format to guide hospitals in how to satisfy these requirements.

Approval & Dissemination

The 2024 Gundersen Lutheran Medical Center Community Health Needs Assessment with the 21-County Health Indicator report and 2025-2027 Implementation Plan were presented to the Board and approved on September 28th, 2024. Progress is underway to implement the following plan.

Our implementation plan, including goals, tactics, resources, partners, and outcome measures, addresses the top health needs and concerns identified from the COMPASS NOW 6-county region, with consideration of the Gundersen Region 21-County Health Indicator report priorities. In addition, the implementation plan supports the Health System's Community Health Score priorities- which expand to include Better Beginnings and Optimal Weight focus areas- that serve to strengthen our efforts to improve the health and wellbeing of our communities. In addition, as we assess community health needs, we continue to investigate health disparities and strategies that aim to improve health equity across the system.

A link to the complete COMPASS NOW 2024 Assessment, Gundersen Region 21-County Health Indicator Report and other related documents can be found at https://www.gundersenhealth.org/community-assessment.

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Approval & Dissemination

The 2024 Community Health Needs Assessment with the Gundersen Region 21-County Health Indicator Report and 2025-2027 Community Health Implementation Plan were presented to the Board and approved on September 28th, 2024. Progress is underway to implement the plan. The assessment and implementation plans are posted on the website and are available to the public through the Gundersen Lutheran Medical Center libraries.

2025-2027 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 (CHIP) 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 Health Needs Assessment (CHNA), and details Gundersen Lutheran Medical Center's Community Health Implementation Plan for 2025-2027.

The Gundersen Lutheran Medical Center Community Health Needs Assessment utilizes the COMPASS Now collaborative assessment that includes 6 counties in our service area, representing 72% of our hospital service patient population, and 43% of the overall population of our 21-county service area. 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 following table lists the health needs identified as priorities in the 2024 COMPASS Now Report, Gundersen Region 21-County Health Indicator Report, and our Emplify Health Population Health Strategic Priorities.

COMPASS Now 2024 Priorities	21-County Health Indicator Priorities	Population Health Priorities
Mental Health including Healthcare Access	Poor Mental Health Status Mental Health Provider Access Suicide	Good Mental Health
Substance Use	Tobacco Excessive Alcohol Use Drug Overdose Death Opioid Deaths Illicit Substance Use and Abuse	Substance Free
Social & Economic Issues (esp. Healthy Food)	Food Security Uninsured Housing Security Financial Security – Poverty and Alice Rates Transportation Security Adverse Childhood Experiences and Toxic Stress	Access to Healthy Food
	Preventive Care including Wellness Visits Dental Health Provider Access	Bright Beginnings
	Diabetes Obesity Physical Inactivity	Optimal Weight

Identified Need/Issue: Mental Health including Access to Healthcare

Goal: Slow the rate of decline in healthy mental health in the population to 74.6% reported in 2027 (Internal and external tactics facilitated by the Emplify Health Design and Implementation Teams)

Tactics	Resource (program)	Partnerships	Measure of Impact
Screen patients or worksite screening participants annually for depression/risk for depression	Population Health Primary Care Quality Business Health Services Nursing	Worksites	92% patients screened at least annually for clinical depression by 2027 # worksite participants screened for depression/anxiety per year
Monitor and improve Community Resource Connector referrals for patients experiencing stress/toxic stress (initiated with the Social Determinants of Health survey)	Population Health Quality 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	Population Health Behavioral Health 211	Schools County health/human services departments Worksites United Way NAMI Better Together HEAL Change Direction	At least 1 new intervention developed by 2027
Support community initiatives that improve mental health or access to mental health resources for all populations	Population Health Behavioral Health External Affairs	Federal, State, County, city health/human services departments Legislators Worksites United Way Better Together NAMI Change Direction	$ Community Contributions Community Service report Policy Testimonials
Additional tactics determined by Emplify Health Design and Implementation Team			Plan developed by 2025 Measures added based on plan

Identified Need/Issue: Substance Use

Goal: Increase the percent of the population that is smoke-free to 85.6% reported in 2027 (Internal and external tactics facilitated by the Emplify Health Design and Implementation Teams)

Tactics	Resource (program)	Partnerships	Measure of Impact
Offer tobacco cessation intervention to patients	Population Health Clinicians Nurses Medical Assistance Pharmacy Quality Behavioral Health Respiratory Therapy	WI, MN, IA Quit Lines First Breath	Increase the number of tobacco cessation intervention referrals to 30% by 2027
Provide or support education and resources that engage the community (including tobacco, vaping, and other drug and substance use)	Population Health Marketing GMF	Better Together Local media School District(s) County Health Departments Worksites Community Based Organizations (CBOs)	#lives touched $ Community Contributions Community Service reporting
Investigate drug related emergency room visits due to opioid use and develop strategies to address findings	Population Health ER Quality Behavioral Health Community Health Workers	Alliance to HEAL La Crosse County Health Department La Crosse Fire Department La Crosse Police Department Community Based Organizations (CBOs)	At least 1 new intervention developed by 2027
Monitor the number of patients exposed to opioids in the management of pain *(action/measure may change based on organizational strategy)*	Providers Pharmacy Pain Management		# of opioid pills per prescription (target 26 opioid pills per prescription) # of opioid prescriptions per 1000 patients (target 21.2 opioid prescriptions per 1000 patients)
Additional tactics determined by Emplify Health Design and Implementation Team	Population Health		Plan developed by 2025 Measures added based on plan

Identified Need/Issue: Social and Economic Issues: Access to Healthy Food

Goal: Increase the percent of the population that is food secure to 92.2% reported in 2027 (Internal and external tactics facilitated by the Emplify Health Design and Implementation Teams)

Tactics	Resource (program)	Partnerships	Measure of Impact
Monitor and improve Social Determinants of Health screening and referral for patients and families	Population Health 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 will be referred to a community resource
Provide free breakfast and lunch meals to children 18 years and younger during the summer months (June through August)	Foodservices	USDA	# of meals provided
Support community partners' efforts to impact diversity and social determinants of health especially related to food access, security, and healthy options	Population Health HR Employee Relations MEO External Affairs	Community Based Organizations (CBOs) Schools	$ Community Contributions Community service reporting
Provide education, support, and resources that engage the community regarding access to food and nutrition	Population Health Foodservices	WAFER UW Extension La Crosse County Health Department Salvation Army	At least 1 new intervention developed by 2027 Lbs. of food donated to local schools Lbs. of produced donated to local food pantry Lbs. of food donated to the Salvation Army
Additional tactics determined by Emplify Health Design and Implementation Team	Population Health		Plan developed by 2025 Measures added based on plan

Monitoring Long Term Outcomes

An implementation plan developed in response to the community health needs assessment and identified top priorities outlines specific goals and tactics to be taken in the next three years, 2025-2027. Any additional priorities identified in the assessment are being addressed by other community partners and Gundersen Lutheran Hospital area will support their efforts to the best of our abilities This improvement plan aligns with the Emplify Health Community Health Score. The Community Health Score was created to identify key metrics and monitor progress of our organization's population health strategies which are the foundation of a primary Vision, *"Leading with love, we courageously commit to a future of healthy people and thriving communities"*. Common threads connect the community health needs assessment to the Community Health Score. Embedded within each metric are detailed goals, with many mirroring those of the improvement plan.

Community Health Score

Our Vision Statement: *"Leading with love, we courageously commit to a future of healthy people and thriving communities,"* is core to Emplify Health's Community Health Score and reflects Thriving Communities. It is a population-level measure of health-related quality of life, that is self-reported by adults living in the communities within our service area, gathered and reported by the Center for Disease Control. This measure is reflective of our vision statement. We have defined a thriving community as *one where all people of all generations can achieve optimal physical, mental, and social well-being and can grow, belong, and flourish throughout their lives.*

The Thriving question is: *"Would you say that in general your health is: excellent, very good, good, fair or poor?"* Emplify Health established a 5-year goal to improve the overall percent of adults living in our communities, patients, and our employees that have "good or better" overall health.

Emplify Health will achieve this goal by working to achieve optimal physical, mental, and social well-being. Within these there are five identified bodies of work: better beginnings (healthy pregnancy & healthy children), substance free, optimal weight, good mental health, and access to healthy food. The metrics indicated in the chart are system goals. The metrics noted in the CHIP are specific to the Gundersen Region for current and 2027.

Community Health Score:	**Thriving - % of population with good or better health** Current: 84.5%, 2025 Goal: 85.7%, 2028 Goal: 85.5%				
3 Drivers of Thriving:	**Optimal Physical Well-Being**			**Optimal Mental Well-Being**	**Optimal Social Well-Being**
Population Health Priorities:	Bright Beginnings	Substance Free	Healthy Weight	Good Mental Health	Food Secure
5 Overall Measures:	% at healthy birthweight	% smoke free	% at healthy weight	% with healthy mental health	% food secure
	Current: 93.3% 2025 Goal: 93.3% 2028 Goal: 93.5%	Current: 83.1% 2025 Goal: 84.3% 2028 Goal: 86.5%	Current: 61.8% 2025 Goal: 62.4% 2028 Goal: 61.0%	Current: 75.3% 2025 Goal: 75.0% 2028 Goal: 74.5%	Current: 92.5% 2025 Goal: 91.8% 2028 Goal: 92.4%