2025-2027 Community Health Implementation Plan

Gundersen Boscobel Area Hospital and Clinics

emplify HEALTH by Gundersen

bellinhealth + GUNDERSEN HEALTH SYSTEM
Together, we're becoming

emplify HEALTH

Community Health Needs Assessment 2025-2027 Implementation Plan

About Gundersen Boscobel

Memorial Hospital of Boscobel, Inc., doing business as Gundersen Boscobel Area Hospital and Clinics (GBAHC), was established in 1952 through a grassroots effort led by local citizens dedicated to establishing healthcare services locally. Today GBAHC is one of six affiliates of the La Crosse-based Gundersen Health System which united with Bellin Health in December 2022. Today, we remain a nonprofit, 25-bed Critical Access Hospital with primary care clinics in Boscobel, Fennimore and Muscoda, and a specialty clinic in Boscobel.

Our Mission: Together, we inspire your best life by relentlessly caring, learning and innovating.

Our Vision: Leading with love, we courageously commit to a future of healthy people and thriving communities.

Bellin and Gundersen Unite:

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.

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.

Overview

Gundersen Boscobel Area Hospital and Clinics joined several collaborative partners, including Grant and Crawford County Health Departments and regional healthcare organizations to conduct a Community Health Needs Assessment (CHNA) in 2024. By design, the CHNA provides crucial information about the health and wellness needs of the communities we proudly serve, and identifies the gaps and barriers to health and health services that exist.

Accessing the Full Report

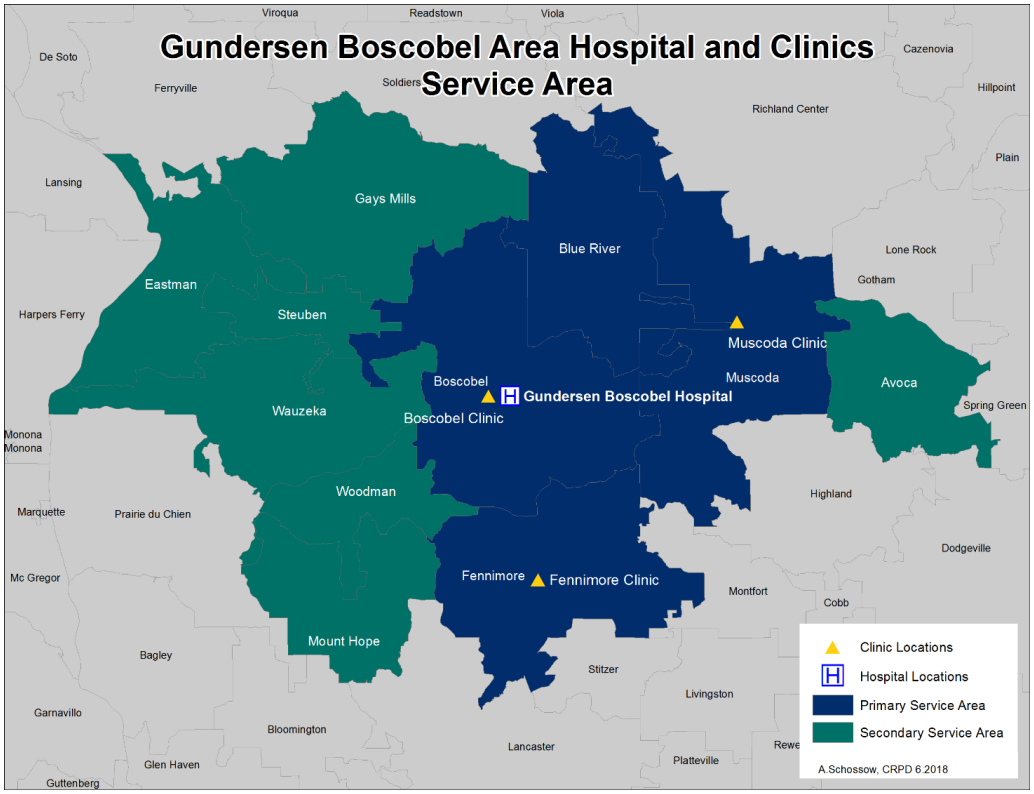
The written report was completed in September, presented to the GBAHC Hospital Board of Directors, and approved on September 24, 2024. The report, which details the full assessment, secondary data, and prioritization process, can be found on the Gundersen Boscobel Area Hospital and Clinics website at gundersenhealth.org/boscobel. This Implementation Plan (to be carried out in years 2025, 2026, 2027) was adopted by the GBAHC Hospital Board of Directors on February 14, 2025.

Regional Snapshot

Rural areas face common challenges. The below image provides a regional snapshot of the overlapping services areas for this Joint CHNA. Residents within Grant, Crawford, Iowa, and Lafayette Counties often seek services and resources beyond their local or even state boundaries, highlighting the importance of unified efforts to address their needs effectively.

Our Service Area

Gundersen Boscobel Area Hospital and Clinics' Primary Service Area (PSA) is shown below in blue. Our Secondary Service Area (SSA) is shown in green. The Implementation Plan is intended to address the top health needs for Grant and Crawford counties.

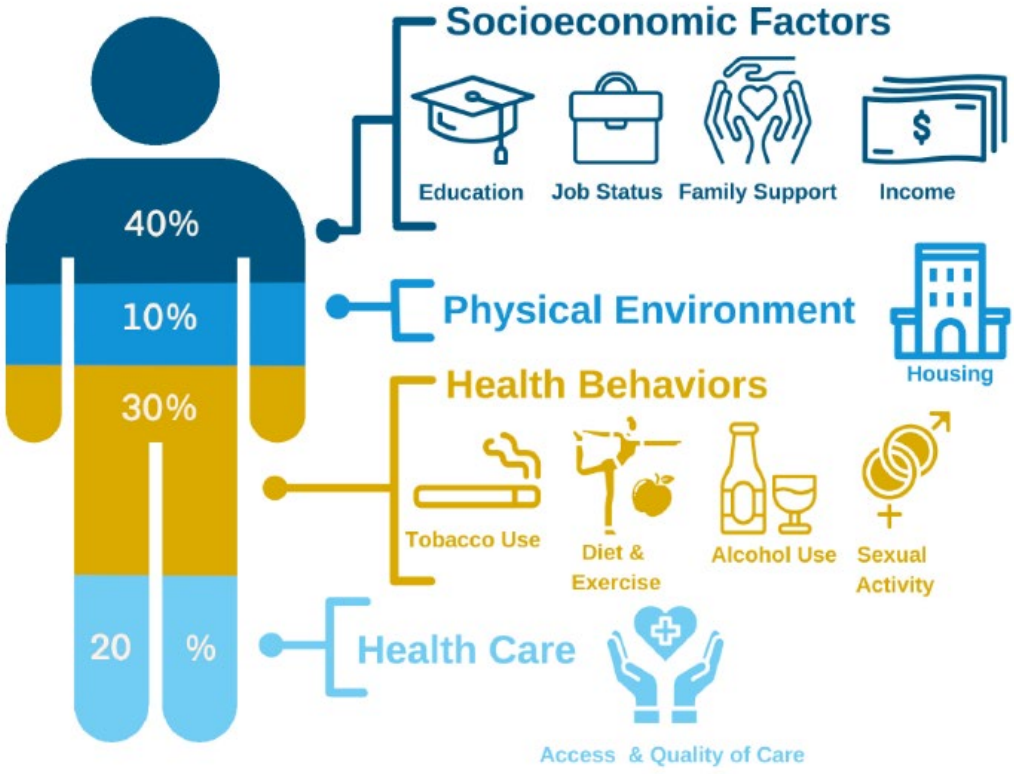


Social Determinants of Health

County Health Rankings

County Health Rankings are based on a model of community health that emphasizes the many factors that influence how long and how well we live. The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors).

This implementation plan will attempt to address the factors that have the greatest impact on one's overall health and well-being through collaborations, care delivery and advocacy efforts.



Source: UCLA Health – Social Determinants of Health Model

Implementation Plan

Our implementation plan, including goals, tactics, resources, partners, and outcome measures, and aims to address the top health needs and concerns identified from our 2024 Community Health Needs Assessment, with consideration of the Gundersen Region 21-County Health Indicator report priorities.

In addition, Gundersen Boscobel's implementation plan supports the Health System's Community Health Score priorities that serve to strengthen our efforts to improve the health and wellbeing of our communities. Understanding that community change is a long-term process that requires commitment and strong partnerships, no one organization can accomplish lasting change or succeed without united community action.

For questions or comments please contact:
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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 Boscobel Area Hospital and Clinics' Community Health Implementation Plan for 2025-2027.

The Gundersen Boscobel Area Hospital and Clinics Community Health Implementation Plan utilizes the collaborative CHNA that includes three counties in our service area. We also drew upon the COMPASS Now assessment which has been an ongoing community needs assessment in collaboration with the United Way and other community partners, including Gundersen Health System, since 1995, with updates every three years.

The following table lists the health needs identified as priorities in the 2024 CHNA, Gundersen Region 21-County Health Indicator Report, and our Emplify Health Population Health Strategic Priorities.

Our CHNA 2024 Priorities	21-County Health Indicator Priorities	GHS Population Health Priorities
Mental Health	Poor Mental Health Status Mental Health Provider Access Suicide	Good Mental Health
Substance Misuse	Tobacco Excessive Alcohol Use Drug Overdose Death Opioid Deaths Illicit Substance Use and Abuse	Substance Free
Chronic Conditions	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

Goals:

1. Slow the rate of decline in *healthy mental health* in Grant and Crawford Counties to 75% (Grant) and 73.9% (Crawford) reported in 2027 (internal and external tactics).
2. Reduce the % of survey respondents who were unaware of mental health resources within our community reported in 2027 (internal and external tactics).
3. Decrease the percentage of students who report rarely or never getting the help (emotional support) they need in 2027 (internal and external tactics).

Tactics	Resource (program)	Partnerships	Measure of Impact
Screen patients annually for depression/risk for depression	Primary Care Quality Nursing		92% patients screened at least annually for clinical depression by 2027
Investigate opportunities to increase Community Resource Connector referrals for patients experiencing stress/toxic stress (initiated with the Social Determinants of Health survey)	Quality 211 988 findhelp.org Primary Care Nursing EPIC SWCAP	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 awareness of community-based mental health resources	Population Health Behavioral Health 211 988 SWCAP	Schools County Health/Human Services departments Worksites NAMI	At least 1 new intervention developed by 2027
Investigate opportunities to increase hospital/clinic-based mental health resources across the lifespan	Behavioral Health Senior Life Solutions		At least 1 new service/program developed by 2027
Support community initiatives that improve mental health or access to mental health resources for all populations	Behavioral Health Marketing	Worksites Make It Ok Collab. NAMI Schools	$ Community Contributions Community Service report Policy Testimonials
Support employee health and wellness through annual MyHealth Rewards program participation	Human Resources Employee Health Population Health	Gundersen Health System	Increase % of employees who complete annual screenings 2027

Identified Need/Issue: Substance Misuse

Goals:

1. Increase the percent of population (Grant and Crawford Counties) that is smoke-free (nicotine and tobacco products) to 82% reported in 2027 (internal and external tactics).
2. Reduce the percentage of students who report currently vaping by 2027.
3. Reduce the number of opioid-related hospitalizations by 2027.

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 Quit Lines First Breath Gundersen Health System	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 BAHC Foundation	Local media School District(s) County Health Depts. 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	Grant County Health Dept. Crawford County Health Dept. Local Fire Depts Local Police Depts 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)

Identified Need/Issue: Chronic Conditions

Goals:

1. Slow the rate of increase of adults in Grant and Crawford Counties who report fair/poor health by 2027.

Tactics	Resource (program)	Partnerships	Measure of Impact
Explore gaps in care specific to cancer screening	Quality Primary Care Surgery Specialty Clinic EPIC Repository		Implement at least one new strategy to address barriers to screening
Controlling high blood pressure	Quality Primary Care EPIC Repository Specialty Departments		Implement at least one new strategy to address barriers to patients achieving controlled BP
Monitor patients who fall on the Diabetic Registry and explore gaps for those whose diabetes is not considered optimally controlled.	Quality Primary Care EPIC Repository Specialty Departments Diabetic Educator	Gundersen Health System	Implement at least one new strategy to address barriers to patients achieving Diabetes Optimal Control

Monitoring Long Term Outcomes

This implementation 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. 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%