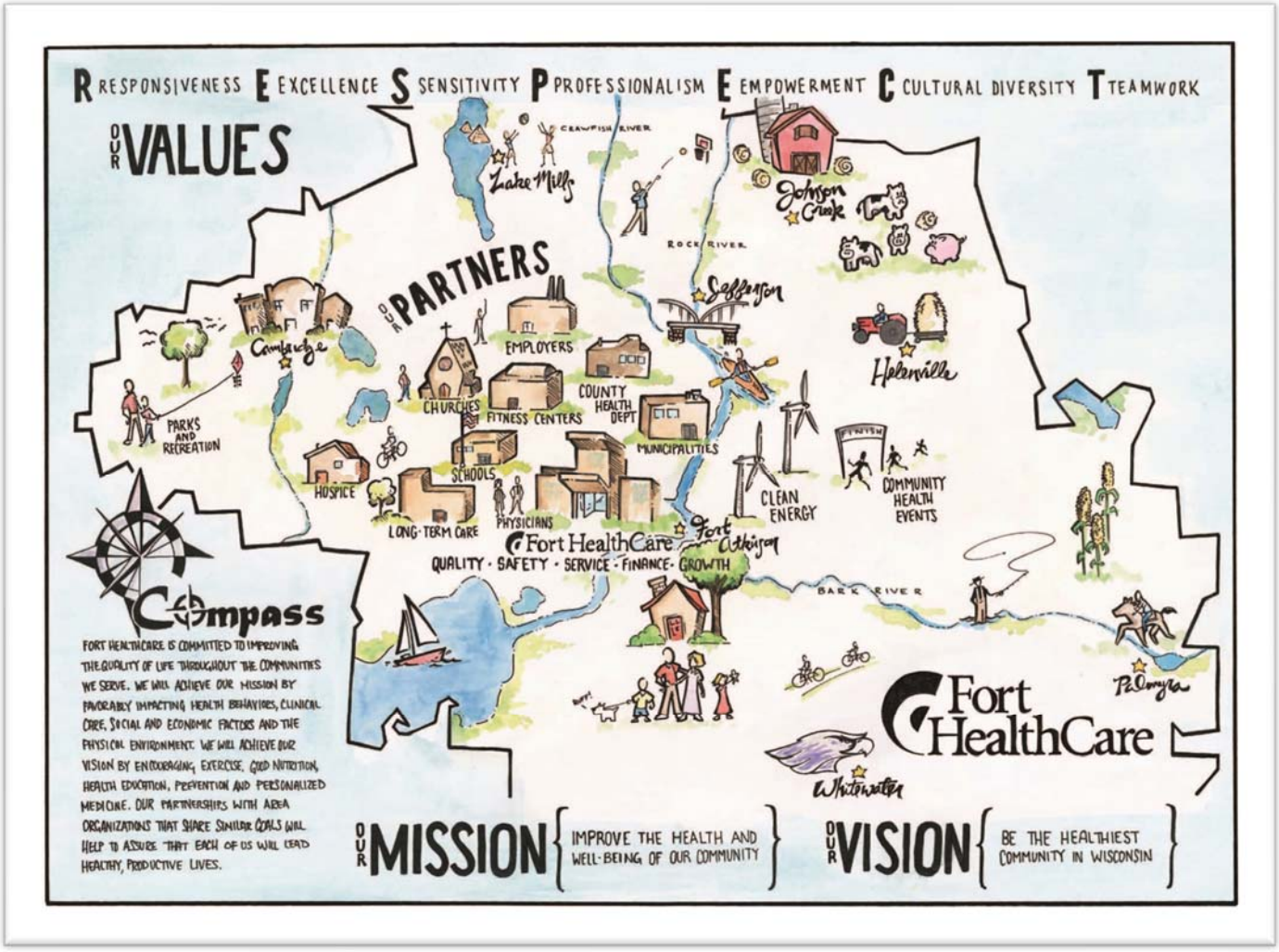
Community Health Implementation Plan (CHIP)

Fort HealthCare

2023-2025

Paper copies of this document may be obtained at Fort Healthcare, 611 Sherman Ave E, Fort Atkinson, WI 53538 or by phone 920-568-5475. This document is also available electronically via the hospital website https://www.forthealthcare.com/community-health-needs-assessment/.

Contents



HOSPITAL OVERVIEW

Fort HealthCare (FHC) is a rural, independent, health system consisting of a 49-bed acute care hospital in Fort Atkinson, Wisconsin and 15 clinics in 6 communities across Jefferson County. FHC 's mission is to *improve the health and well-being of the community* and vision is to *be the healthiest community in Wisconsin*. FHC seeks to achieve their mission by favorably impacting health behaviors, clinical care, social and economic factors, and the physical environment. Partnerships with area organizations that share similar goals will help to assure that all residents will lead healthy, productive lives.

MISSION: Improve the health and well-being of the community.

VISION: Be the healthiest community in Wisconsin.

In 2022, FHC conducted a comprehensive Community Health Needs Assessment (CHNA 2022) in collaboration with the Dodge Jefferson Healthier Community Partnership (DJHCP). FHC collects and monitors multiple sources of qualitative and quantitative data to measure the impact of work implemented across the service area and ensure that FHC's strategic plan continues to be aligned with the organizational mission and vision (see APPENDIX A). Sources used in establishing this Community Health Improvement Strategy/Plan (CHIP), include the CHNA 2022, results from *Fort HealthCare 2022 Community Health Survey (FHC* patient population and employees), *County Health Rankings & Roadmaps – Jefferson, WI, and other resources* (see REFERENCES & RESOURCES). The CHNA/CHIP are established every three years, led by Population Heath and Community Health & Wellness with regular monitoring, evaluation, and updates provided annually to FHC leadership and board of directors.

OVERVIEW OF COMMUNITY HEALTH NEEDS ASSESSMENT & PRIORITIZATION PROCESS

FHC conducted a CHNA in collaboration with DJHCP from April - August 2022 and adopted by the FHC Board of Directors on November 1, 2022. To access the full report, visit https://www.forthealthcare.com/community-health-needs-assessment/.

DJHCP is a partnership of the following organizations:

- Dodge County Human Services & Health Department
- Fort HealthCare
- Greater Watertown Community Health Foundation
- Jefferson County Health Department
- Marshfield Medical Center-Beaver Dam
- Rock River Community Clinic
- Watertown Department of Public Health

The CHNA 2022 uses systematic, comprehensive data collection and analysis to define priorities for health improvement, creates a collaborative community environment to engage stakeholders, and an open and transparent process to listen and truly understand the health needs of Dodge and Jefferson Counties, Wisconsin. Additionally, DJHCP was more intentional with this CHNA to better focus on addressing health inequities. Social determinants of health such as **poverty, unequal access to health care, lack of education, stigma, and racism** are underlying, contributing factors of health inequities.

As part of the CHNA process, a summit including community stakeholders took place to review the quantitative and qualitative data collected. Participants then help to prioritize the significant health needs to be focused on over the next three years and brainstorm ways that might help improve the health issue(s) identified. Seventy-eight community stakeholders participated in person or virtually on August 11, 2022, at the Comfort Suites Conference Center in Johnson Creek, WI for the 2022 CHNA.

Based on the previous CHNA priorities, secondary data, focus group discussions, and survey results, summit participants selected the following significant health needs to be the focus of work for the community over the next three years. ***Equitable access to community-based resources and supports*** was the fourth rated health priority and voted to be "woven" into the top health priorities to ensure a healthy equity lens across all initiatives that may be established going forward.

Health Priorities CHNA 2022	
1. Access to Affordable Quality Mental Health Care	**Equitable Access to Community-Based Resources and Supports**
2. Access to Affordable Quality Housing and Affordable Reliable Transportation	
3. Access to Affordable Quality Childcare	

Previous priorities focused on mental health and substance misuse, obesity/nutrition and physical activity, and chronic disease. Socioeconomic-related issues have also been repeatedly listed as challenges/barriers for the community (I.e., transportation, affordable childcare, affordable housing). In 2022, socioeconomic-related issues shifted as top priorities to address in the community, as seen above. Work historically focused on through previous CHNA's and by FHC, however, are still shown to be a need according to the CHNA 2022 and other data sources monitored by FHC*. [Please note that the majority of FHC's patient population is in Jefferson County (Jefferson 70.9%, Dodge 1.3%, Other 27.8%). Therefore, Jefferson County data from the* CHNA 2022*,* County Health Rankings and Roadmaps, *and other sources are used in planning and monitoring by FHC].*

According to the CHNA 2022, the leading causes of death in Jefferson County are heart disease, cancer, COVID-19, accidents, followed by respiratory diseases, Alzheimer's, and strokes. Furthermore, obesity levels remain high (34% of Jefferson County adults report a BMI of 30 or more) which is known to put people at increased risk of chronic diseases including diabetes, kidney disease, joint problems, hypertension, and heart disease. Furthermore, according to FHC's annual community health survey with patients and employees (n=634), high blood pressure (42.1%) is the most commonly diagnosed chronic condition/disease within households. Asthma (20.8%), diabetes (17.0%), and cancer (14.4%) also impact over 10% of households in Fort HealthCare's service area. The percentage of households reporting at least one person diagnosed with high blood pressure significantly increased compared to 2020 (35.1% to 42.1%). A majority (60.1%) have reported at least one diagnosed chronic condition/disease in their household including 31.4% with only one condition/disease, 15.6% with two, 9.6% with three, and 2.7% with four or more.

After review of the CHNA 2022 and multiple other sources, such as previous CHNA's, annual FHC community health surveys, and *County Health Rankings & Roadmaps,* FHC has expanded the list of priorities that will be the focus of this CHIP. Prior goals and work aimed around affordability and access to care, health equity, obesity, and chronic disease interventions/management continue to be priorities

in the community. Additionally, impacts from the COVID-19 pandemic, such as care foregone by many patients (i.e. limited access of health care providers, patient's perception of safety, patients losing healthcare insurance coverage) made it challenging to achieve prior goals. Priorities and goals in this CHIP are aligned with Fort HealthCare's core competencies, *Strategic Plan 2022-2024*, *Performance Improvement Plan*, and *Healthy People 2030*.

<table>
<tr><th colspan="2">Health Priorities CHNA 2022</th><th>Fort HealthCare 2023-2025 Health Priorities</th><th></th></tr>
<tr><td rowspan="3">Equitable access to community-based resources and supports.</td><td>Access to affordable quality mental healthcare.</td><td>Access to affordable quality mental healthcare.</td><td rowspan="5">Equitable access to community-based resources and supports.</td></tr>
<tr><td>Access to affordable quality housing and affordable reliable transportation.</td><td>FHC will support community partners focused on these efforts.</td></tr>
<tr><td>Access to affordable quality childcare.</td><td>FHC will support community partners focused on these efforts.</td></tr>
<tr><td colspan="2"></td><td>Obesity (Preventive/Nutrition/Physical Activity)</td></tr>
<tr><td colspan="2"></td><td>Chronic Disease (Cancer/Hypertension/Diabetes)</td></tr>
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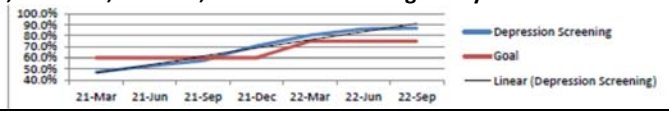
As noted above, Fort HealthCare will not be including housing, transportation, and childcare as a priority focus in this CHIP. FHC will, however, continue to be committed to providing resources, such as staff time and financial investments, to our community partners who are working on these important issues.

IMPLEMENTATION STRATEGY

The following is Fort HealthCare's implementation strategy, or Community Health Improvement Strategy/Plan (CHIP), that summarizes how the hospital plans to address the significant health needs of the community. FHC's Board of Directors adopted this implementation strategy on January 3, 2023 and was made widely available to the community via Fort Healthcare's website https://www.forthealthcare.com/community-health-needs-assessment/. Paper copies of this document may be obtained at Fort Healthcare, 611 Sherman Ave E, Fort Atkinson, WI 53538 or by phone 920-568-5475. Community input is always welcome. For questions, to provide comments, or to inquire about connecting with community groups helping to work on this plan, email wellness.advisor@forthc.com or call 920-568-5475.

Health Priority: Access to Affordable Quality Mental Health Care				
Community Health Goal 1: Increase linkages to appropriate care for behavioral health				
Strategy	Key Actions	Anticipated Outcomes	Resources	Partnerships
Telemental Health Services	Provide mental health care services (I.e., psychotherapy and counseling) via telephone or videoconference.	Increased access to behavioral health services. Improved mental health. Reduced suicide. Reduced emissions/# of miles traveled.	FHC behavioral health; FHC primary care	JCHH Area Behavioral Health Providers RRCC (FQHC-LAL) Schools
	Set up telemental health service "HUBS" in nontraditional settings with key partners serving vulnerable populations.	Increased access to behavioral health services. Improved mental health. Reduced suicide. Reduced emissions/# of miles traveled. Increase patient engagement.	FHC behavioral health; financial support as needed; WI DCTS/DHS telehealth grant.	JCHH Area Behavioral Health Providers RRCC (FQHC-LAL) Schools Paquette Center (Psychological Services/Family Counseling)
School Based Behavioral Health Program	Contract with schools to provide counseling services to youth in the schools.	Increase access to behavioral health services for youth.	FHC behavioral health; financial support as needed.	Schools JCHH GWCHF Other Community foundations (financial support)
Safer Suicide Care (Zero Suicide framework)	Identify (screen & assess) all patients 12+ for depression in the primary care setting at each visit and provide appropriate follow up.	Improved mental health Increased adherence to treatment Improved quality of life Increased patient engagement Increased patient satisfaction	FHC behavioral health; FHC primary care; FHC education dept., FHC population health	JCHH Area Behavioral Health Providers RRCC (FQHC-LAL)
	Improve provider/staff competency in Suicide Risk Assessment and suicide intervention.		FHC behavioral health; FHC primary care; FHC Zero Suicide Committee	JCHH RRCC (FQHC-LAL)

Community Health Goal 2: Improve behavioral health through mental wellness and substance use prevention.				
Strategy	Key Actions	Anticipated Outcomes	Resources	Partnerships
Support community wide environmental strategies, prevention and/or policy focused on improving mental health.	Actively participate in groups focused on improving mental health and suicide prevention.	Improve mental health. Reduce suicide rates.	FHC staff time; funding as appropriate.	DJHCP HealthWorks (healthcare network) JC Zero Suicide Committee JCPH JCHH
Support community wide environmental strategies, prevention and/or policy to address alcohol and substance misuse.	Actively participate in groups focused on improving alcohol and substance use prevention.	Reduce community impact related to substance use and misuse.	FHC staff time; funding as appropriate.	DJHCP JC Drug Free Coalition JCPH JCHH
FHC (Fort HealthCare); JCHH (Jefferson County Human Services); RRCC (Rock River Community Clinic); GWCHF (Greater Watertown Community Health Foundation); JCPH (Jefferson County Public Health); DJHCP (Dodge Jefferson Healthier Community Partnership); JC (Jefferson County); CCM (Comprehensive Care Management); CPJC (Community Partners of Jefferson); WCHQ (Wisconsin Collaborative for Healthcare Quality)				
Alignment FHC Strategic Plan	**Growth: To partner with our community to develop appropriate access to health & wellness services & grown community engagement and accountability for improved preventative care, nutrition, exercise, and health-affirming lifestyles.** Depression Screening 6 			
Alignment FHC Performance Improvement Plan 2023	**Priority Area: Behavioral Health** (Project Goals: Improve depression screening rate; improve follow up to depression when indicated; improve provider competency in Suicide Risk Assessment; improve provider competency in suicide intervention; create workflows to support effective and efficient suicide and depression intervention when indicated).			
Alignment Healthy People 2030 Objectives:	Increase the proportion of children and adolescents who get preventive mental health care in school — EMC-D06 Increase the proportion of primary care visits where adolescents and adults are screened for depression — MHMD-08 Increase the proportion of adults with depression who get treatment — MHMD-05 Increase the use of telehealth to improve access to health services — AHS-R02			

Health Priority: Obesity (Preventive/Nutrition/Physical Activity)				
Community Health Goal 1: Engage in community efforts related to obesity prevention.				
Strategy	Key Actions	Anticipated Outcomes	Resources	Partnerships
Support community wide environmental strategies, prevention and/or policy focused on nutrition and physical activity.	Actively support and participate in groups focused on improving nutrition and physical activity (i.e., school gardens, meals on wheels, food pantries, worksite wellness programs).	Increase access to healthy food options. Promote healthy eating. Create opportunities for active living.	FHC Community Health & Wellness; FHC Marketing; financial support as needed	DJHCP Schools Worksites Businesses Healthy Community Coalitions City Park & Rec departments Churches Master Gardeners Local Government Community members/groups JCPH programs (WIC, SNAP-ED, etc.) JC Breast Feeding Coalition UW-Extension FoodWise
Multi-component obesity prevention interventions.	Provide free or low-cost community-based wellness opportunities and challenges (i.e. indoor walking path, fitness classes, Rock the Walk, Slimdown Challenge, virtual 5K's).	Increased physical activity. Improved weight status.	FHC Community Health & Wellness; FHC Marketing; financial support as needed	DJHCP Schools Worksites Businesses Healthy Community Coalitions City Park & Rec departments Churches Master Gardeners Local Government Community members/groups
	Engage internal and external stakeholders to identify and build evidence-based strategies and community resources focused on weight management.	Improved weight status. Improved patient engagement. Improved patient satisfaction	FHC Community Health & Wellness; FHC Marketing; FHC Population Health; FHC primary care; financial support as needed.	DJHCP Schools Worksites Businesses Healthy Community Coalitions City Park & Rec departments Churches Master Gardeners Local Government Community members/groups JCPH programs (WIC, SNAP-ED, etc.)

				JC Breast Feeding Coalition UW-Extension FoodWise

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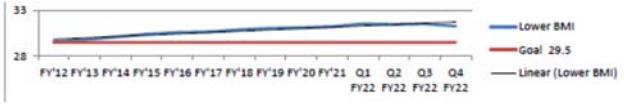
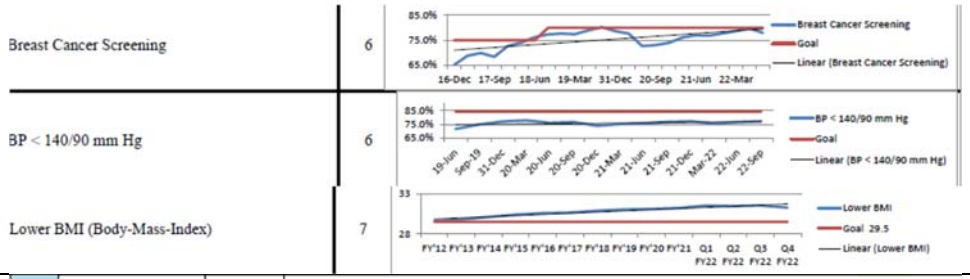
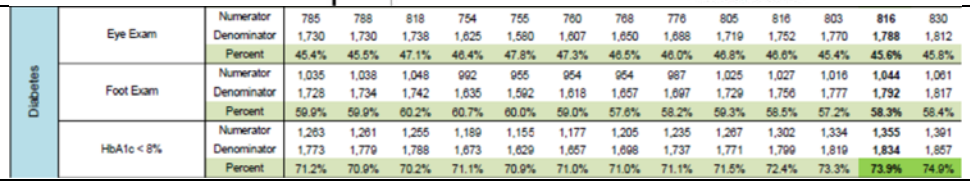
Alignment FHC Strategic Plan	Growth: To partner with our community to develop appropriate access to health & wellness services & grow community engagement and accountability for improved preventative care, nutrition, exercise, and health-affirming lifestyles. Lower BMI (Body-Mass-Index) 7 
Alignment FHC Performance Improvement Plan 2023	**Priority Area: Obesity** (Project Goals: Create a strategy around meeting the strategic goals of lowering BMI for service area, create/review standard work in how BMI is obtained in different departments (what is done for follow up?) research tools and resources that are meaningful for providers to be utilized for patients).
Alignment Healthy People 2030 Objectives:	Reduce the proportion of adults with obesity — NWS-03 Reduce the proportion of children and adolescents with obesity — NWS-04 Increase the proportion of health care visits by adults with obesity that include counseling on weight loss, nutrition, or physical activity — NWS-05

Health Priority: Primary and Secondary Chronic Disease Interventions (Cancer/Hypertension/Diabetes)				
Community Health Goal 1: Identify and reduce health disparities between FHC & RRCC patient populations.				
Strategy	Key Actions	Anticipated Outcomes	Resources	Partnerships
Comparative analysis of select health outcome measures between FHC & RRCC.	Monthly publication and transparency of data at FHC & RRCC.	Identify health disparities. Improved quality of care.	FHC population health; RRCC leadership; FHC primary care	RRCC (FQHC-LAL) HealthWorks WCHQ
	Deploy PRAPARE SDoH (social determinants of health) screening tool with most vulnerable populations.	Identify & overcome SDoH for equitable care. Reduce health disparities.	FHC population health; FHC primary care; FHC CCM program; RRCC leadership	RRCC (FQHC-LAL) HealthWorks Rainbow Hospice Care WCHQ
Community Health Goal 2: Increase the number of health screenings for vulnerable populations.				
Strategy	Key Actions	Anticipated Outcomes	Resources	Partnerships
Patient financial incentives for preventive care.	Collaborate with community partners to provide preventative mammogram screenings, including voucher program for low-income high-risk populations.	Increased preventive care.	FHC population health; FHC radiology; FHC community health & wellness; RRCC leadership	DJHCP RRCC (FQHC-LAL) Tomorrow's Hope Jefferson Co. Cancer Coalition JCPH
	Collaborate with internal and external stakeholders to provide free health screenings (i.e. blood pressure, prediabetes).	Increased preventive care. Increased adherence to treatment.	FHC population health; FHC pharmacy; FHC community health & wellness; FHC marketing	DJHCP RRCC (FQHC-LAL) JCPH Worksites Schools Churches Businesses
Community Health Goal 3: Improve health literacy among vulnerable populations.				
Strategy	Key Actions	Anticipated Outcomes	Resources	Partnerships
Collaborate on health literacy interventions	Work with community partners to ensure education and resource materials reflect cultural and linguistical competence.	Improved health-related knowledge. Increased patient engagement. Improved adherence to treatment.	FHC community health & wellness; FHC Quality-translation services as needed; financial support as needed for community partners.	DJHCP HealthWorks RRCC (FQHC-LAL) JC Literacy Council CPJC Conexiones Latinas The Unity Project
	Develop and deploy cultural competence training for healthcare staff.	Improved patient-provider communication. Increased patient engagement. Increased patient satisfaction.	Fort HealthCare's Diversity/Equity/Inclusion (DEI) & Health Equity Task Force; financial support as	DJHCP HealthWorks RRCC (FQHC-LAL) JC Literacy Council CPJC

			needed for community partners.	Conexiones Latinas The Unity Project
Community Health Goal 4: Increase the number of adults with controlled blood pressure.				
Strategy	Key Actions	Anticipated Outcomes	Resources	Partnerships
Enhance programming to impact chronic disease self-management and prevention with focus on hypertension.	Explore opportunities to collaborate with internal and external stakeholders to create an evidenced-based Self-Monitoring Blood Pressure (SMBP) program for FHC patients.	Reduce rates of preventable chronic conditions with focus on hypertension. Improved health outcomes. Improved quality of life. Increase patient engagement. Increased patient satisfaction.	FHC population health; FHC pharmacy, FHC community health & wellness; FHC primary care; FHC CCM program	RRCC (FQHC-LAL) JCPH Schools Churches Worksites Community businesses & organizations Pharmacy Collaborative of Jefferson County
	Expand Primary Care Pharmacy Services with FHC patients and key partner(s) serving vulnerable populations (RRCC), including comprehensive medication reviews (CMR), targeted medication reviews (TMR), proactive medication therapy management (MTM), and medication cost evaluation consults.	Reduce rates of preventable chronic conditions with focus on hypertension. Improved health outcomes. Improved quality of life. Increase patient engagement. Increased patient satisfaction.	FHC pharmacy; FHC population health; FHC primary care; RRCC leadership	FHC providers RRCC providers
Community Health Goal 5: Reduce rates of preventable chronic conditions with focus on diabetes.				
Strategy	Key Actions	Anticipated Outcomes	Resources	Partnerships
Enhance programming to impact chronic disease self-management and prevention with focus on prediabetes and diabetes.	Promote diabetes related self-management classes (i.e. free diabetes support group), events, and/or programs.	Reduce rates of preventable chronic conditions with focus on diabetes.	FHC diabetes education dept., FHC community health & wellness, FHC marketing; financial support as needed.	DJHCP RRCC (FQHC-LAL) Community Lions Clubs JCPH Schools Churches Worksites Community businesses & organizations
	Increase referrals and patient engagement in FHC's Diabetes Self-Management & Education Support (DSMES) program with patients, including key partners serving vulnerable populations (RRCC).	Reduce rates of preventable chronic conditions with focus on diabetes.	FHC diabetes education dept.; financial support as needed; RRCC leadership.	RRCC (FQHC-LAL) Area Primary Care Providers

	Expand Primary Care Pharmacy Services with FHC patients and key partner(s) serving vulnerable populations (RRCC), including comprehensive medication reviews (CMR), targeted medication reviews (TMR), proactive medication therapy management (MTM), and medication cost evaluation consults.	Reduce rates of preventable chronic conditions with focus on hypertension. Improved health outcomes. Improved quality of life. Increase patient engagement. Increased patient satisfaction.	FHC pharmacy; FHC population health; FHC primary care; RRCC leadership	FHC providers RRCC providers

FHC (Fort HealthCare); JCHH (Jefferson County Human Services); RRCC (Rock River Community Clinic); GWCHF (Greater Watertown Community Health Foundation); JCPH (Jefferson County Public Health); DJHCP (Dodge Jefferson Healthier Community Partnership); JC (Jefferson County); CCM (Comprehensive Care Management); CPJC (Community Partners of Jefferson); WCHQ (Wisconsin Collaborative for Healthcare Quality)

Alignment FHC Strategic Plan	**Growth:** To partner with our community to develop appropriate access to health & wellness services & grown community engagement and accountability for improved preventative care, nutrition, exercise, and health-affirming lifestyles. 
Fort HealthCare HealtheRegistries	
Alignment FHC Performance Improvement Plan 2023	**Priority Area: Obesity** (Project Goals: Create a strategy around meeting the strategic goals of lowering BMI for service area, create/review standard work in how BMI is obtained in different departments (what is done for follow up?) research tools and resources that are meaningful for providers to be utilized for patients). **Priority Area: Healthy Equity, Diversity/Equity/Inclusion (DEI), Civil Rights Compliance** (Project goals: build foundation and competence for internal, FHC stratification of quality measures and more broadly deploy PRAPARE SDoH screening tool; cultural competency training; ensure FHC is compliant with key elements of civil rights compliance).
Alignment Healthy People 2030 Objectives:	Increase the proportion of females who get screened for breast cancer — C05 Increase control of high blood pressure in adults — HDS05 Decrease the proportion of adults who report poor communication with their health care provider — HC/HIT02 Increase the proportion of adults whose health care providers involved them in decisions as much as they wanted — HC/HIT03 Increase the proportion of adults whose health care provider checked their understanding — HC/HIT01 Reduce the proportion of adults who don't know they have prediabetes — D-02 Increase the proportion of eligible people completing CDC-recognized type 2 diabetes prevention programs — D-D01

NEXT STEPS

This implementation strategy outlines a three-year community health improvement plan. Fort HealthCare's Community Health and Wellness department, with oversight from the Executive Director of Population Health, will coordinate tracking progress with internal and external stakeholders involved, report progress annually to the FHC leadership and board of directors, and share actions taken to address the needs with the community at large.

REFERENCES & RESOURCES

References and resources used for planning and monitoring progress related to this Community Health Improvement Plan (CHIP).

Dodge Jefferson Healthier Community Partnership. (2022, October). *Community Health Needs Assessment – Dodge & Jefferson County, WI.* Retrieved from https://fort.wpenginepowered.com/wp-content/uploads/2022/11/CHNA_DodgeJefferson_Counties-_Community-report_2022v2_FHC.pdf**.**

Dodge Jefferson Healthier Community Partnership. (2019, May). *Community Health Needs Assessment – Dodge & Jefferson County, WI.* Retrieved from https://fort.wpenginepowered.com/wp-content/uploads/2019/10/CHA_Dodge-and-Jefferson-Community-report_2019v5.pdf.

Peltier, Dr. James and Dahl, Dr. Andy. (June 2022). *Fort HealthCare 2022 Community Health Survey.* Applied PhD Research, University of Wisconsin – Whitewater.

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Wisconsin Collaborative for Healthcare Quality (member): https://www.wchq.org/

University of Wisconsin Population Health Institute resources:

- What Works for Health (database of evidence-informed policies, programs, and system changes): http://improvingwihealth.org/wwfh/index.php
- County Health Rankings & Roadmaps: https://www.countyhealthrankings.org/explore-health-rankings/wisconsin/jefferson?year=2022

Healthy People 2030 resources: https://health.gov/healthypeople

Wisconsin Health Atlas: https://www.wihealthatlas.org/

Wisconsin State Health Plan: https://www.dhs.wisconsin.gov/statehealthplan/index.htm

Wisconsin United for ALICE (Asset Limited, Income Constrained, Employed) research center: https://www.unitedforalice.org/state-overview-mobile/Wisconsin

Neighborhood Health Partnerships Program (UW-Madison Institute for Clinical and Transitional Research): https://nhp.wisc.edu/

APPENDIX A (FHC Strategic Plan 2022-2024)