Bellin Health Community Health Implementation Plan 2021-2023

Introduction

For more than a century, Bellin Health has served the people of Northeast Wisconsin and Michigan's Upper Peninsula with caring, expertise and a second-to-none focus on quality that make it the region's premier health system. Known for its emphasis on preventive healthcare, Bellin is the area's leader in cardiac, orthopedics, sports medicine, digestive health, mental health and primary care medicine.

Bellin's flagship campus in Green Bay, Wis. is home to Bellin Hospital, a 244-bed general medical and surgical hospital that routinely has received state and national awards for safety and quality of care. Just down the road, the 80-bed Bellin Psychiatric Center provides top-quality inpatient, outpatient and addiction treatment services for individuals from across the region. And 30 minutes to the north, Bellin Health Oconto Hospital, a 10-bed critical care access facility, offers care close-to-home for patients outside the Green Bay metro area.

Bellin Health's vision is that the people in its region will be the healthiest in the nation, and the health system's 29 primary care physician clinics are at the heart of that effort. That aim is further bolstered by an ambulatory surgery center, urgent care services, 88 employer clinics, three Bellin Health FastCare retail health clinics, three Bellin Fitness Centers, and Bellin College, an accredited nursing and medical imaging institution. The Cancer TEAM at Bellin Health serves patients and families with a multidisciplinary approach to quality patient care, and Bellin is a founding partner of Unity Hospice, a nonprofit community provider of hospice care, palliative care and grief support serving Northeast Wisconsin.

In addition to serving its patients with award-winning care, Bellin Health is renowned for its community outreach efforts. Bellin is the official healthcare partner of the Green Bay Packers, a relationship that was bolstered with the 2017 opening of the Bellin Health Titletown Sports Medicine & Orthopedics clinic in the Titletown District just West of Lambeau Field. Bellin annually hosts one of the nation's largest 10K events, the Bellin Run, which brings walkers and runners of all ages and fitness levels to the streets of Green Bay in the spirit of health, wellness and community fun; as well as a participant-favorite women's half marathon and 5K event held each fall. With 5,000 employees, Bellin Health is the largest private employer in the Green Bay area, making the health system a major contributor to the economic vitality of the region in more ways than one.

Even beyond its service area, Bellin is a powerful player in creating positive large-scale change around healthcare. The health system is a founding member of the Institute for Healthcare Improvement (IHI), an international organization dedicated to improving health and healthcare worldwide, as well as the Wisconsin Collaborative for Healthcare Quality. Through its Bellin-ThedaCare Healthcare Partners collaboration, Bellin was a participant in the Centers for Medicare & Medicaid Services' (CMS) Pioneer Accountable Care program, generating $14 million in savings while producing the highest quality and lowest cost in the country among Medicare ACOs. Bellin also participated in the Next Generation ACO model, CMMI's subsequent Accountable Care Organization program, and is now part of the CMS Medicare Shared Savings Program (MSSP) — Enhanced Track.

Bellin Health is the only healthcare system in our market with a locally governed, community-focused Board of Directors. In addition to community health improvement services guided by our

triennial Community Health Needs Assessment (CHNA) process, the hospital contributes to other needs through our broader community benefit program including community health services, health professional education, subsidized health services, financial and in-kind contributions and community-building activities. In FY2020, the community benefit contributions totaled more than $57 million.

Bellin Health's Vision is All people in our region will be their healthiest during every stage of their lives and our communities will thrive. The organization has made a commitment to our communities and improving population health through our Community Ambassador Program. Across our regional footprint, the Bellin Ambassadors are engaged in community health improvement plans in the communities where they live, work and play. Their lived experiences and knowledge of their communities helps drive engagement, strengthens partnerships, and drives improvement. Our organization is committed to supporting our ambassadors to live out their passion for improving wellbeing in their communities and strengthening community partnerships.

In 2020-2021, Bellin Health conducted a Community Health Needs Assessment (CHNA) in collaboration with Beyond Health, a steering committee comprised of leaders from both the public and private sectors in Brown County. These leaders used the Social Determinants of Health (SDOH) model developed by the Centers for Disease Control and Prevention as the framework for conducting this task. This model considers the impact of the conditions in the environments where people are born, live, work, play, etc., on their health and well-being. The assessment process itself involved gathering both qualitative and quantitative data from a broad variety of sources, including community conversations with key informants, focus groups, and secondary data collection. The resulting report may be found online at https://www.bellin.org/patients_visitors/company-information/community-health

Community Health Needs Prioritization

As detailed in the CHNA Report, Bellin Health, in collaboration with community partners, identified the following health priorities in Brown County:

- Equitable Access
- Social Cohesion
- Unified Planning and Policy.

BROWN COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN PRIORITIES: 2022-2024

Strategy Leads will be responsible for convening stakeholders, setting shared goals, and monitoring progress towards goals. Strategy leads will ensure communication with Beyond Health in a liaison capacity.

Community-level indicators will evolve over time and are dependent on data available as work on the health priorities progresses. Data will be stratified to highlight and target inequities whenever possible.

EQUITABLE ACCESS

Take steps to level the playing field

Strategy 1: Decrease income and asset gap in Brown County

Strategy Lead: Brown County United Way

Strategy 2: Improve environmental quality and physical environments for all

Strategy Lead: Brown County Public Health

Strategy 3: Advocate for equitable access to healthcare

Strategy Lead: Beyond Health Subcommittee, Health Systems Shared Facilitation

SOCIAL COHESION

Help people connect with each other and their community

Strategy 1: Build community and civic connections at neighborhood level

Strategy Lead: NeighborWorks Green Bay

Strategy 2: Increase availability and visibility of healthy food options

Strategy Lead: University of Wisconsin-Madison Division of Extension Brown County

Strategy 3: Improve walkability and recreational opportunities

Strategy Lead: Greater Green Bay Active Communities Alliance

UNIFIED PLANNING AND POLICY

Make sure policies help the entire community

Strategy 1: Integrate population health into community planning efforts

Strategy Lead: Beyond Health Subcommittee, HSHS Facilitation

Strategy 2: Safe, accessible housing and transportation options

Strategy Lead: Blueprint Project Manager for The Taskforce

Strategy 3: Support and create policies that decrease inequities in a coordinated and transparent way

Strategy Lead: Health Equity Coalition

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For purposes of the CHNA Implementation Plan, the populations served shall be defined as Brown County residents of all ages, although the hospital's reach and impact extend to other Northeastern Wisconsin counties as well.

Under the broad umbrellas of these priorities, based on the health outcome data and observed community needs, Bellin has chosen to focus specifically on the areas outlined in the action plan

Community Health Improvement Plan Overview

These implementation strategies and actions are laid out by health priority, first with a "snapshot" of identified strategies, sample actions and other relevant information; and then with a more comprehensive and specific description of planned actions, resources, collaborative partners and anticipated impacts.

***These tables will be reviewed and revised at least annually and as needed to reflect changing needs.*

PLANNED ACTIONS – *Equitable Access*

***Strategy*: **Partner with local health systems and the N.E.W. Community Clinic on efforts to increase access to preventative screenings and early intervention services for diverse populations. Priority focus will be around access to Diabetes Services and equitable access to Depression Screenings (PHQ9).

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Collaborate with the local health systems and N.E.W. Community Clinic to share base data on access to **diabetes care** across diverse populations	- Wisconsin Hospital Association (WHA) - Colleagues' time from local health systems - IT support - Decision Support - EPIC analysts	- Local health systems (Advocate Aurora, HSHS, N.E.W. Community Clinic) - WHA - Beyond Health - Local community leaders	Year one will be building the baseline data to identify the gap across the community population. Year two and three will set targets to close the gaps
Collaborate with the local Health systems and N.E.W. Community Clinic to share base data on access to **depression screenings (PHQ9)** across diverse populations	- WHA - Colleagues' time from local health systems - IT support	- Local health systems (Advocate Aurora, HSHS, NEW Clinic)	Year one will be building the baseline data to identify the gap across the community population. Increase access to depression screening for underserved populations due to language, economic or cultural barriers.

***Strategy*:** Increase access to screenings and early intervention services for individuals of color and the Somali and refugee community.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Increase mammography and colorectal screening for individuals of color	- Health Equity Team - Health Disparities Team - GI Team - Mammography Team	- Bellin Primary Care - Community nonprofit partners - Employer partners	Increase screening rates by 2% for patients of color and close health disparity gap.

	- IT Support - Marketing - Improvement Advisor - Data Analytics and Outreach Specialist	- Green Bay Packers	
Community partnership with COMSA addressing **SDOH for Somali and refugee populations**	- Grant Funding - IT - Primary Care - Local nonprofit partners	- COMSA - Bellin - Community partners (i.e. N.E.W. Community Clinic, etc.)	Build trust with community and connection point for easy navigation to healthcare and SDOH resources

Strategy: Continue to support the Oral Health Partnership and provides access to oral care for the low-income children in our community.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Oral Health Partnership Provide a referral source for low-income children to access services offered by OHP.	- Colleague time from Bellin system and OHP system.	- OHP associates and board members - Bellin Health staff and providers	Goal for OHP is to treat 10,000 patients and have 22,000 appointments in 2022

PLANNED ACTIONS – *Unified Policy and Planning*

Strategy: Continue to support the Alcohol and Drug Coalition for Change with community partners to increase policy changes that create safer communities and support cultural change around alcohol and drug use.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Collaborate with the Alcohol and Drug Coalition on supporting at least two policy changes in our community that creates a safer environment surrounding alcohol and drug use.	- Wisconsin policy and local ordinance information - Local policy committees that impact the health and welfare of the community - Alcohol and Drug Coalition for Change sub-team - Alliance for WI Youth	- All local health systems and members of the Alcohol and Drug Coalition for Change - Brown County Tavern League - Beyond Health - The Drug Alliance for Youth - Green Bay Packers - Farmer's Market leadership - City/state Leaders - Wisconsin Alcohol Policy Project	To influence the development of local policies that positively support a culture of decreased alcohol and drug use and promote a safer community.

Strategy**:** Lead a unique collaboration with local nursing home, health system, college and the Wisconsin National Guard to produce more Certified Nursing Assistants (CNAs) and increase capacity at a local nursing home.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Collaborate with the Wisconsin National Guard, HSHS, Odd Fellow Nursing Home to create access to care for hospital patients who are transitioning to the nursing home	- Wisconsin National Guard - Wisconsin Department of Health Services (DHS) - Media - Training support from Bellin College and Bellin Health - Nursing staff from Bellin and HSHS	- Wisconsin National Guard - DHS - Odd Fellow Nursing Home - Bellin College - HSHS	Intent of the collaboration is to open up more nursing home beds within Odd Fellow Nursing Home by training National Guard Members to be CNAs

PLANNED ACTIONS – *Social Cohesion*

Strategy**:** Facilitation of the community-wide Alcohol and Drug Coalition for Change with a focus on interventions that lead to increased sober awareness and cultural change at local events and businesses.

ACTION	RESOURCES	COLLABORATION	ANTICIPATED IMPACT
Community-wide Alcohol and Drug Coalition for Change has key initiatives that will promote sober awareness and decreased drug use within the community	- Alcohol and Drug Coalition for Change - Wisconsin Policy on Alcohol and Drug legislation	- All local health systems and members of the Alcohol and Drug Coalition for Change - Brown County Tavern League - Beyond Health - The Drug Alliance for Youth - Green Bay Packers - Farmer's Market leadership - City/state Leaders - Wisconsin Alcohol Policy Project	The collaboration and efforts of this coalition will drive cultural change to the Brown County community, improving our outcome measures around unhealthy alcohol and drug use and improving our overall county health rankings

Health Needs That Will Not Be Addressed At This Time

In addition to the health needs Bellin selected as top priorities, the CHNA identified other significant health needs in Brown County. Strategy owners/organizations are assigned to lead work within this space and capitalize on community resources and partners collaborating to address the needs.

Next Steps

This Implementation Plan outlines intended actions over the next three years. As part of the plan, Community Benefits/Community Health staff annually shall do the following:

- Review progress on the stated strategies, planned actions and anticipated impacts.
- Report this progress at minimum to hospital administration, the Committee on Quality and Experience.
- Work with these and other stakeholders to update the plan as needed to accommodate emerging needs, priorities and resources.
- Notify community partners of changes to the Implementation Plan.

Approval

This implementation plan was adopted by the Board Committee on Quality & Experience - February 9, 2022.