Crossing Rivers Health

Your bridge to wellness

Community Health Needs Assessment

2017-2019 Implementation Plan

About Crossing Rivers Health

Prairie du Chien Memorial Hospital Association, Inc., doing business as Crossing Rivers Health (CRH), is an independent non-profit, 25-bed Critical Access Hospital established in 1957. Crossing Rivers Health serves the health and wellness needs of the region, through the more than 100 services provided to people throughout southwest Wisconsin and northeast Iowa. We could not accomplish our mission, without the expertise of more than 350 dedicated healthcare professionals.

Mission

Crossing Rivers Health will deliver high quality, personalized healthcare and education, in a friendly safe environment, to people in every stage of life collaboratively with other regional health care providers.

Vision

Crossing Rivers Health achieves the best outcome for every patient every time. It is where:

- Patient expectations are exceeded
- Physicians want to practice
- Caring people want to work
- The community sees a source of pride
- The region associates our name with high quality

Values

- Excellence
- Integrity
- Compassion
- Unity
- Joy

Overview

Crossing Rivers Health joined collaborative partners, including Crawford County Public Health, UW Extension and other regional healthcare and resource agencies to conduct a Community Health Needs Assessment (CHNA) beginning in 2015 and concluding in 2016. The CHNA is designed to reach broadly into the community to identify needs, gaps and barriers to health and health services. Through a process of primary research, data analysis, validation and prioritization, the assessment process identified three key themes of need.

Prioritized Health Needs

The collaborative partners involved in this Community Health Needs Assessment process share a common vision of improving health in their communities, and beyond. Each participating organization has unique resources, works with a varying set of community attributes, and each may ultimately address community health needs in somewhat different ways, sharing resources or joining forces whenever possible. Nevertheless, the partners agree on the following, identified health needs:

Empowering People

- Reducing/eliminating barriers to access
- Creating opportunities for screenings/early intervention
    - Alzheimer's/ Dementia
    - Cardiovascular disease/ Stroke

Empowering People (Cont.)

  - Diabetes
  - Mental Health
  - Cancer
- Improving health literacy
- Providing health and wellness education
- Creating awareness of mental health conditions and resources available

Connecting People to Services and Resources

- Improving patient advocacy
- Raising awareness of existing clinical services
  - Mental health
  - Preventive services
  - Family medical care
  - First-trimester care
  - Alzheimer's care
  - Diabetes care
- Offering important community services
  - Smoking cessation
  - Pregnancy, labor and delivery classes
  - Free or low-cost health and wellness classes
  - Senior specific programs
- Increasing cancer screening and prevention awareness
- Improve access to mental health services
- Recruiting and retaining dental providers/improving access to dentistry

Creating a Healthy Environment and a Culture of Wellness

- Promoting healthy eating and active living and support healthy choices
- Promoting access to healthy foods and activities
- Engaging in injury awareness activities
- Supporting prevention of drug and excessive alcohol use
- Focusing education and change on underlying causes of chronic illnesses

Implementation Plan

To address the health needs identified, the attached CHNA Implementation Plan has been developed by CRH leadership and approved by the Board of Directors of the Prairie du Chien Memorial Hospital Association, Inc., DBA Crossing Rivers Health on October 17, 2016.

Crossing Rivers Health 2017-2019 Implementation Plan

Priority: Empowering People			
Goal: Provide educational seminars and support groups for people identified with special needs			
Key Actions / Tactics	**Implementation Timeframe**	**Responsible Dept/Workgroup/Individual**	**Measure/Evaluation Expected Outcomes**
Diabetes			
Early Intervention: Monthly Diabetes Support Group at Hospital. Identify needs for stages and types. Establish a Facebook closed group.	2017-2018	Community Collaborative	# of Participants
Diabetes Fair Sugars tested, speaker- endocrinologist.	Annually	Community Collaborative	# Participants
Cancer			
Establish local Cancer support Group and/or Cancer Clear and Simple collaboration, 2 week program. Minimum of twice per year	2017	Patient Family Services (PFS) Education	# Participants
Mental Health			
Develop community task force to collaborate on strategies to provide community education on mental health resources. Discussions about opioid/drug addiction, identifying and managing Dementia/Alzheimer's, depression, anxiety.	2017-2019	Patient Family Services, Center for Behavioral Health and PdC Police Department	Programs implemented # Participants
Wellness			
Wellness Program and/or weight management. Referral BMI >30	2017-2019	Sleep, Lab, PT, Exercise, Behavioral Health, Cardiac Rehab	Referrals and participant program completion
Community medication review	2017-2018	Pharmacy	# Participants, savings to patients, errors caught
Offer healthy cooking and nutrition management classes to community.	2017	Nutrition Services	Improved nutrition/weight among participants

Priority: Connecting People to Services and Resources			
Goal: Improve access to healthcare within the primary and secondary service areas			
Key Actions / Tactics	**Implementation Timeframe**	**Responsible Dept/Workgroup/Individual**	**Measure/Evaluation Expected Outcomes**
Expand Telehealth services, including urgent, primary and specialty care. Educate rural population on use and benefits of telehealth	2017-2018	CMO, Clinics, Center for Specialty Care	Reach, utilization
Orthopedics		Center for Specialty Care	Utilization
Urology		Center for Specialty Care	Utilization
Smoking Cessation- Expanded programming for outpatients	2014-2016	Respiratory Therapy, Cardiac Rehab	# Participants
Raising awareness of existing services	2014-2016	Marketing/Communications, Education	Increased utilization Increased market share
Priority: Creating a Healthy Environment and Culture of Wellness			
Goal: Increase opportunities to be involved in healthy, active lifestyles.			
Key Actions / Tactics	**Implementation Timeframe**	**Responsible Dept/Workgroup/Individual**	**Measure/Evaluation Expected Outcomes**
CRH hosted run/walk + Health fair	2017-2019	Education, Rehabilitation	# Participants
Alcohol, tobacco and drug abuse prevention efforts- Adolescent and adult	2017-2019	PALS 4 Good, School, Education, teen court, PdC PD & K9	Underage drinking rate reduction, DUI rate reduction
Collaboration with Crawford County on the Move, Farm to School initiatives	2017-2019	UW Extension, Healthy Roots Coalition, Dietician, Education	# Participants
Lead by example organization- Develop walking path, active spaces, adopt ½ hour lunch & 15 minute exercise break, utilize local food producers for patient, visitor and employee meals- (25% of items served) share nutrition content in dining, restrict sodium, calories, fat in menu.	2017-2019	Nutrition Services, Dietician, Facilities, Administration	Development and adoption of efforts

Needs Crossing Rivers Health does not intend to meet (2017-2019)	Reason	Agency presently addressing	
Senior specific programs	Currently addressed	Aging, Disability and Resource Center	
Dialysis	Currently addressed	Gundersen Lutheran PdC Clinic	
Cancer care- Radiation Oncology	Outside of CRH scope	Major health systems	

This document has been prepared in compliance with Internal Revenue Code (IRC) Section 501 (r) which was added by the Patient Protection and Affordable Care Act (ACA) of 2010, Public Law 148 and required of all 501 (c)(3) non-profit hospitals.