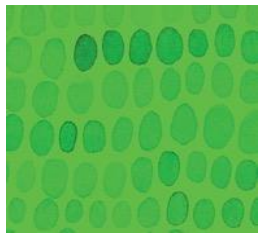


Approved April 2025

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP)

UnityPoint Health – Meriter July 2025- June 2028 Implementation Strategy in response to the 2024 Dane County Community Health Needs Assessment

UnityPoint Health

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Dane County Population Overview

PEOPLE

567,758 POPULATION

65.3% 18-64 YEARS OLD

7.7% HISPANIC/LATINO RESIDENTS

10.3% LANGUAGE OTHER THAN ENGLISH

Figure 3. PERCENT POPULATION BY RACE: COUNTY

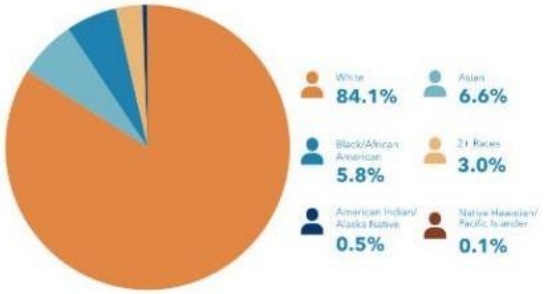
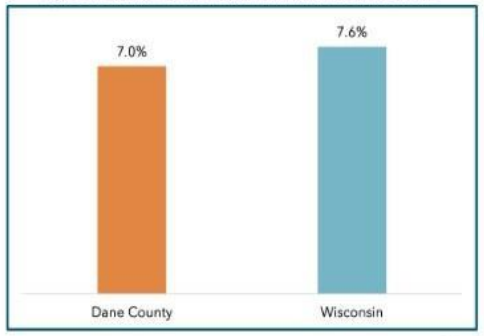


Figure 4. PERCENT POPULATION BY AGE: COUNTY, STATE

Figure 5. PERCENT POPULATION BY ETHNICITY: COUNTY, STATE



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Population

The total population of Dane County is 567,758 persons, with the population size of this region trending upward. Conduent's Health Equity Index (HEI) estimates areas of high socioeconomic need, which are correlated with poor health outcomes. ZIP codes are ranked based on their index value to identify relative levels of need. Amongst the population, here are the ZIP codes that show the highest need.

Health Equity Index

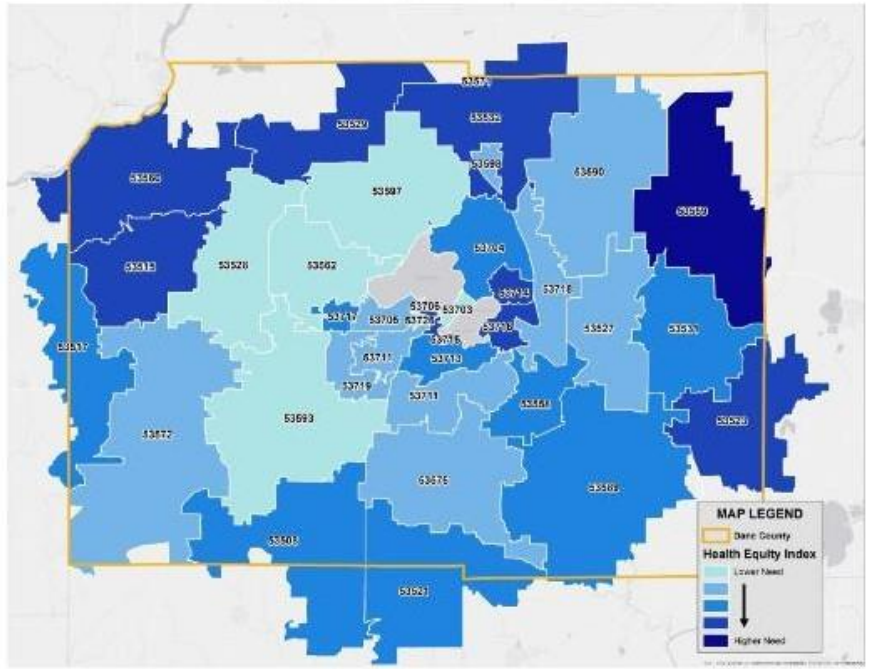
What high index values mean:
Communities with the highest values are estimated to have the highest socioeconomic needs correlated with:

- preventable hospitalizations
- premature death
- self-reported poor health and well-being

Table 1. HEALTH EQUITY INDEX BY ZIP CODE

Highest Need ZIP Codes	Index Score (0 (lowest need) -100 (highest need))
53559: Marshall	56.4
53523: Cambridge	32.5
53714: East Madison	24.8
53560: Mazomanie	23.3
53706: Madison	22.9
53716: Monona	20.9

Figure 2. DANE COUNTY HEALTH EQUITY INDEX



Community Health Improvement Plan (CHIP) Background

The Patient Protection and Affordable Care Act, signed into law in March 2010, requires that nonprofit hospitals conduct a Community Health Needs Assessment at least once every three years beginning in March 2012. Departments of Public Health require local public health agencies to conduct a CHNA at least every five years.

These requirements present the opportunity for local community health leaders to join forces and identify priorities that can serve as a guide for programs, policies, and investments. Working together often creates efficiencies, new partnerships, and increased collaboration. Ultimately, community members benefit when data, resources and expertise are shared to attain the common goal of a healthier community. This CHNA was conducted in full partnership with the local health departments, hospitals, and many other community health organizations.

Conducting this comprehensive CHNA involved surveying community members and leaders as well as gathering relevant health data. The choice of our priorities reflects the idea that a high quality medical/clinic system is essential to treat people who are sick, and critical to help restore people's health; but it is not where health is created. Health is created in people's homes, workplaces, neighborhoods, and communities where people make healthy or unhealthy choices and establish healthy or unhealthy habits. The framework for those choices is the social, economic, and built environments we create. These are the Social Drivers of Health (SDoH).

The ACA also requires nonprofit hospitals to complete an **implementation strategy** in response to each CHNA. A hospital's implementation strategy must be a written plan that, for each significant health need identified, describes how the hospital facility plans to address the health need. In describing how a hospital plans to address a significant health need identified through the CHNA, the implementation strategy must:

- Describe the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions.
- Identify the resources the hospital plans to commit to address the health need.
- Describe any planned collaboration between the hospital and other facilities or organizations in addressing the health need.
- Be adopted by an authorized body of the hospital facility.

CHIP Overview Focus Areas

Initiatives:

2025-2028 Initiatives to Address Community Health Needs

	INITIATIVE	PRIORITY SUPPORTED			
		Reproductive Justice	Chronic Disease	Mental Health & Substance Use	Injury & Safety
1	Screen all pregnant patients that identify as Black for Social Determinants of Health (SDOH); Refer to ConnectRX	x	x	x	
2	Educate postpartum nursing staff and patients on Postpartum Mood and Anxiety Disorders (PMAD)	x		x	x
3	Develop lists of BIPOC patients who have a care gap and no future appointment; outreach to those patients.	x	x	x	
4	Improve rate of Physicals/Well Child Visits (Ages 18+)/Medicare Annual Wellness Visits		x	x	
5	Increase access to mental health services	x		x	x
6	Increase medical care services offered at NewStart (increase screening for hepatitis, HIV, treatments and immunizations for hepatitis in particular)		x	x	
7	Create purposeful tools to identify and mitigate risk for suicidal ideation			x	x
8	Ensure UPH-Meriter clinic patients 65+ are receiving an annual fall risk screening. If screen is positive, provide written education at discharge.		x		x
9	Partner with established community programs to provide clinical subject matter experts to support current initiatives.				x
10	Partner with established case management services to distribute CDC materials for STEADI (Older Adult Fall Prevention).		x		x

Reproductive Justice Strategies

UnityPoint Health

Objectives: Improve maternal and newborn morbidity and mortality in the birthing population served at UPH-Meriter.

Initiatives and Tactics	Partners / Collaborations	Anticipated Impact	Initiative Goal and Measurement	Timeline
Utilize Connect RX: Screen all pregnant patients that identify as black for Social Determinants of Health (SDOH)	Dane County Health Council and Saving Our Babies	Improved outcomes for Black families at risk by providing community-based support, i.e.; housing security, food security, etc.	Progression to 100% of patients who identify as Black* in the Center for Perinatal Care will receive SDOH screening on their first prenatal visit to ensure referral to Connect RX if needed. Quarterly report will include: 1) Percent of patients screened 2) Number of referrals made to Connect RX 3) Number of individuals who are actively engaged in the Connect RX program.	Continue quarterly tracking.
Mental Health Education Intervention: Educate postpartum nursing staff and patients on Postpartum Mood and Anxiety Disorders (PMAD).	Nationally Recognized Speaker from Postpartum Support International Postpartum nursing units at Meriter Hospital; UPH-Meriter Nursing Informatics	Improve staff awareness in identifying mental health conditions in the postpartum period. Increase patient awareness of mental health conditions, symptoms, and how to get help to optimize safety.	100% of postpartum nursing staff will receive Postpartum Mood and Anxiety Disorders education. Prior to discharge, progression to 100% of postpartum patients will receive education on Postpartum Mood and Anxiety Disorders by year 3.	Staff education complete in Q4 FY2025. Patient education and tracking will begin in Q1, FY26.

* All patients, regardless of race or ethnicity, receive a SDOH screening and referral to appropriate resource on their first visit to the perinatal clinic.

Chronic Health Strategies

Objectives: Reduce chronic condition health inequities for BIPOC individuals in Dane County and improve access to primary care and screenings in UPH Meriter Clinic Patients.

Initiatives and Tactics	Partners / Collaborations	Anticipated Impact	Initiative Goal and Measurement	Timeline
Clinical Outreach: Develop lists of BIPOC patients who have a care gap and no future appointment and outreach to those patients	Primary Care	Improve outcomes for BIPOC patients by proactively reaching out to those without future appointments and assessing and addressing health maintenance gaps.*	Align BIPOC and white patients' diabetes and hypertension control by demonstrating quarter over quarter improvement in gap closure	Fall 2025-27
Patient Interventions: Improve rate of Physicals/Well Child Visits (Ages 18+)/Medicare Annual Wellness Visits	Artera (automated patient outreach software)	Increase opportunity for preventative care & Social Determinants of Health screening for UPH Meriter Clinic patients annually	Annual Wellness Visits and Physicals Completed in each calendar year.	Fall 2025-27

*All patients, regardless of race or ethnicity, are contacted at least once to close care gaps.

2024 American Heart Association **Go Red For Women Luncheon**

OP Behavioral Health Strategies – Adult/Pediatric

Objectives: Increase access to behavioral health in Dane County and implement strategies to mitigate safety risks for patients and caregivers across multiple settings.

UnityPoint Health

Initiatives and Tactics	Partners / Collaborations	Anticipated Impact	Initiative Goal and Measurement	Timeline
Increase access to mental health services Increase medical care services offered at New Start	New Start, Child and Adolescent Psychiatry and UnityPoint Health Primary Care Clinics	Newstart: Add a second walk in clinic day (currently one day per week) through repurposing current clinic appointment slots. Also, will expand medical care offered within the clinic (increase screening for hepatitis, HIV, treatments and immunizations for hepatitis in particular)	Measure volumes of New Start appointments monthly. Quarter over quarter increase in volumes expected with 3% increase as goal. Expand medical services offerings by Q2, 2026	Increase to two walk in New Start Clinics per week by Q2, 2026
		CAP: Intensive Outpatient Program moved to location off-site of the main campus by mid- 2025 with availability of 12 participants, addition of a second off-site location by end of 2026, preferably on the East side of Madison	2025: Increase minimum ADC to 9+ 2026: Maintain occupancy in first location and add 50% of occupancy (TBD) in second location by end of year.	End of 2026
Create purposeful tools to identify and mitigate risk for suicidal ideation	All Meriter Hospital Outpatient Departments, inclusive of PCP clinics and OB Triage	Develop and implement policy with stratification of level of suicide risk in outpatient settings and with action steps that appropriately correspond to the identified level of risk.	Collaborate with OB Triage leadership to complete suicide risk management guideline (2Q, 2025). Staff education and implementation of Meriter Hospital OB Triage guideline. (End of 3Q 2025) Collaborate with UPH BH Service Line to create suicide risk management policy for HODs (4Q 2025). Staff education and implementation of Meriter Hospital HOD policy (2Q 2026)	See goal/measurement

Injury & Safety Strategies

UnityPoint Health

Objective: Increase awareness of fall prevention risk and mitigation strategies in older adults and those who care for them.

Initiatives and Tactics	Partners / Collaborations	Anticipated Impact	Initiative Goal and Measurement	Timeline
Ensure UPH-Meriter Clinic patients 65+ are receiving an annual fall risk screening. If screen is positive, provide written education at discharge.	UPH-Meriter Primary Care Clinics	Increase awareness of fall risk, educate on ways to mitigate or reduce falls	• Increase screening rate from 79% to 90% of patients 65 or older will receive an annual fall risk screen during their UPH Meriter Clinic visit.	Fall 2025-2027
Partner with established community programs (Stepping On-example) Only Leaves Should Fall to provide clinical subject matter experts to support current initiatives.	Safe Communities of Madison	Provide community support for fall prevention programs and increase awareness for high fall risk activities.	• Metric will include both number of individuals who attend classes as well as those who are non-English speaking. Targeting 25 patients per quarter, 100 per year with increasing rate of non-English speaking patient	Fall 2025-2027
Partner with established case management services to distribute CDC materials for STEADI (Older Adult Fall Prevention)	New Bridge Senior Coalition-Madison	Utilizing the existing relationships with community case managers, disseminating and educating patients and case managers should help raise awareness to fall risks and prevent future falls.	• Train 100% of New Bridge Case Managers on Fall Prevention in the Elderly utilizing CDC Fall Prevention Education. Upon completion of post-survey, staff will be able to list 5 ways to help patients and families create a safe home environment.	Summer 2025-provide education for New Bridge Staff Fall 2025-2027 provide patient-facing materials

About UnityPoint Health – Meriter

Who we are

UnityPoint Health – Meriter provides convenient, personal care to patients in hospital and clinic settings. As a partner of UW Health and affiliate of UnityPoint Health, we are devoted to showing our people and communities how much they matter.

We offer primary and specialty care, have the busiest birthing center in Wisconsin and are regularly recognized for outstanding quality and patient experience.

We are proud to be part of UnityPoint Health, providing care throughout Iowa and Wisconsin.

CHIP Project Team

- Community Health Impact Committee (Subcommittee of the UnityPoint Health – Meriter Board of Directors)
- Executive Sponsor: James Arnett, Meriter Market President
- CHNA Project Management Personnel
  - Corinda Rainey-Moore, EdD, Community Engagement Manager
  - Jennifer Vohs, RN, BSN, MHA, GERO-BC, Population Health Manager
  - Jessika Kasten, MBA, Regional Marketing Director

This plan was reviewed and approved by the UnityPoint Health - Meriter Board of Directors on April 16, 2025.

UnityPoint Health

Subject Matter Experts

Reproductive Justice	Mental Health and Substance Use
• ***Carla Griffin, Executive Director-JOA** • Robbie Sonnentag, Director of Perinatal Services • Lindsey Rosemeyer, Director of Inpatient Care Coordination/ConnectRX contact	• Brad McKinney, Sr. Director Behavioral Health Services (UWH/Meriter) • ***Monica Case, Director of Behavioral Health Services** • Michael Rivers, Director of Collaborative Care-BHC • ***Matt Johannsen, Director of Behavioral Services/New Start**
Chronic Conditions	**Injury & Safety**
• ***Dave Childers, VP of Clinic Operations** • ***Dr. Derek Clevidence, Medical Director Primary Care** • Michael Rivers, Director of Primary Care • Wyatt Richards, Clinical Quality • Ad Hoc: Elizabeth Albracht, Director of Clinical Services	• ***Betty Brien, ED Trauma Coordinator** • Andy Stephani, Emergency Department Director • Cassy Cooley, Outpatient Therapies Manager • Carrie Bennett, HELP Program (Hospital Elder Life Program) • Jennifer Vohs, Population Health Manager

***SME lead**