2013 *Community Health Needs Assessment* **Report**

2014 *Implementation* **Strategy**

Aurora West Allis Medical Center®

Aurora West Allis Medical Center
8901 W. Lincoln Avenue
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Aurora West Allis Medical Center
Update for 2015

Posted: December 31, 2014

Executive Summary

Aurora West Allis Medical Center (AWAMC) offers the community convenient access to high-quality care, a complete range of primary and acute care programs, and a tertiary care center for women's health services. Specialty services include cardiology, digestive diseases, cancer, orthopedics, and wound care and hyperbaric medicine. Aurora West Allis is home to the Aurora Women's Pavilion, where women at all stages of life will experience comprehensive care in a relaxed, healing environment. The facility offers women specialized programs and services for every stage of her life.

In 2013 AWAMC completed and published its Community Health Needs Assessment (CHNA) Report and 2014 Implementation Strategy, which was adopted by the Social Responsibility Committee of the Aurora Health Care Board of Directors on November 22, 2013 and posted to Aurora Health Care web site. This document, which provides a comprehensive overview of the community served and significant health needs identified, is available by visiting http://www.aurora.org/commbenefits. Experience in carrying out the 2014 Implementation Strategy informed the process for updating it for 2015.

It should be noted that addressing the social determinants of health to promote healthier communities requires more effort than can be carried out by one hospital alone. AWAMC is fortunate to be one of five Aurora hospitals located in Milwaukee County, working together and in concert with other providers and organizations within the county to address significant community health needs on a global level. The chart below represents the ongoing multi-stakeholder initiatives of which AWAMC is both directly and indirectly a part:

Prioritized significant needs in Milwaukee County	Multi-Partner Initiatives		
	Milwaukee Health Care Partnership[1]	Lifecourse Initiative[2]	United Way[3]
Health care access	✓	✓	✓
Health insurance coverage	✓		
Behavioral health	✓	✓	✓
Obesity, nutrition and physical activity		✓	✓
Chronic disease	✓		✓
Infant mortality	✓	✓	✓
Sexual health			✓
Health literacy	✓	✓	✓
Poverty		✓	✓
Racism		✓	✓
Social determinants		✓	✓
Specialty access for uninsured persons	✓	✓	✓

In addition to the resources dedicated each year to these ongoing initiatives, the AWAMC 2014 Implementation Strategy outlined specific priorities to work within its neighboring communities in Milwaukee County and with the hospital's unique patient population. That work continues in 2015.

[1] The Milwaukee Health Care Partnership is a public/private consortium dedicated to improving health care coverage, access and care coordination for underserved populations in Milwaukee County. View http://mkehcp.org/

[2] The goals of the Lifecourse Initiative are: 1) Strengthen father involvement in African-American families; 2) Reduce poverty among African-American families; 3) Expand access to health care. View http://www.planningcouncil.org/PDF/LIHF_Milw_CAP_final_w_cover.pdf

[3] For *United Way of Greater Milwaukee* initiatives, view http://www.unitedwaymilwaukee.org/home

AWAMC 2015 Implementation Strategy: Introduction

As in 2014, our 2015 AWAMC implementation strategy is organized into three main categories in alignment with three core principles of community benefit as shown below.

Category	Community Benefit Core Principle
Priority #1: Access and Coverage	• Access for persons in our community with disproportionate unmet health needs
Priority #2: Community Health Improvement	• Build links between our clinical services and local health department community health improvement plan
Priority #3: Community Benefit Hospital Focus	• Address the underlying causes of persistent health problems

It is widely recognized that a diverse team of engaged community partners is essential for implementing strategic community health improvement initiatives. Our implementation strategy reinforces the importance of our role as a partner for community capacity-building to address unmet community health needs.

The following table itemizes the significant health needs identified in our 2013 Community Health Needs Assessment and how our hospital and health system resources are allocated. The Key:

H = specifically addressed within our hospital's implementation strategy
I = addressed through our integrated healthcare system and strategic partnerships
S = standard within the continuum of care

Significant community health needs/issues identified in the 2013 CHNA Report	Intent to address in the 2015 Implementation Strategy
Access	
• medical	H and I
• prescription and dental	I
Coverage	
• enrollment, health care coverage or financial assistance	H and I
Chronic disease	
• asthma	H
• cancer	H and I
• diabetes	H
• heart disease	H and I
Health risk behaviors	
• alcohol and tobacco use	I and S
• nutrition	H and I
• physical activity	H and I
Health risk factors	
• high blood pressure, high cholesterol, overweight/obesity	H and I
Mental health	
• mental health conditions	I and S
Teen pregnancy	
• teen pregnancy in West Allis-West Milwaukee	H
Senior health	
• senior health issues, caregivers	H and I

Note: Our implementation strategies do not constitute the entirety of the community benefits our hospital provides each year. For a full accounting of the community benefits we provide each year, please see our most recent report: http://www.aurora.org/commbenefits.

Focus | Aurora Health Care signature community benefit focus is access

In 2012, 17% of adult respondents in West Allis-West Milwaukee reported unmet medical care, 11% reported someone in their household had not taken their prescribed medication due to cost, 11% reported unmet dental care and 4% reported unmet mental health care in last 12 months (Community Health Survey). Based on the key informant findings, access to health care services and health insurance coverage emerged as one of the top five health issues for Milwaukee County.

Principal partners

- Aurora Health Care Medical Group (AHCMG) physician partners
- Aurora Parish Nurse

Community partners

- **Greater Milwaukee Free Clinic (GMFC) -** The clinic, located two blocks from our hospital, provides free medical care to low income, working people in the Milwaukee area without medical insurance or the ability to pay for medical care. The clinic is staffed by volunteer professionals.
- **Milwaukee Health Care Partnership (MHCP) Emergency Department)ED) Care Coordination Initiative -** This community-wide emergency department initiative, *ED to Medical Home Care Coordination Process,* includes the following strategies:
  - Milwaukee County hospital EDs identify target populations, provide patient education and schedule appointments with medical homes
  - Using MyHealthDIRECT appointment scheduling technology, community health centers post open appointments. EDs schedule appointments electronically while the patient is at the hospital; and
  - Intake coordinators at community health centers reach out to patients prior to first appointment and attempt to reschedule if appointment is not kept
- West Allis-West Milwaukee Health Department

Target population

- Medicaid-eligible and uninsured patients using our hospital ED for primary care

Intended impact

- Uninsured and Medicaid-eligible patients currently relying on our ED for primary care services, chronic disease management and dental care are transitioned to a medical home
- Uninsured patients are transitioned into health insurance plans within the Marketplace that meet their needs

Measures to evaluate impact

- Number of non-emergent ED visits without a primary care physician (compare to 2014 baseline data)
- Number of uninsured patients screened for financial assistance and number enrolled in programs (e.g. *Aurora's Helping Hand Patient Financial Assistance* program) and the Marketplace (the health insurance exchange)
- The Milwaukee Health Care Partnership, in collaboration with MyHealthDIRECT, monitors and tracks the Milwaukee Health Care Partnership Emergency Care Coordination Initiative, http://mkehcp.org/care-coordination-2/emergency-department-care-coordination/
  - Measures include total scheduled appointments, total kept appointments (FQHC only), show rate (FQHC only, percent), number of scheduled appointments by AWAMC (per month), clinic appointment show rate for AWAMC (per month)

Action plan	Target date
Improve access for uninsured and Medicaid-eligible patients using our ED for primary and dental care:	
• Navigate uninsured patients to medical homes in the Milwaukee area including Aurora Health Care Medical Group clinics and Federally Qualified Health Centers	Ongoing
• Provide in-kind imaging and lab services for patients referred from GMFC	
• Collaborate with the West Allis-West Milwaukee Health Department's "Access to Care" committee to: – Distribute and print materials promoting the use of "211" for a listing of available resources – Promote the benefits of becoming established with a medical home for primary and preventive care offered at AHCMG and Federally Qualified Health Centers – Provide printing for the above-referenced information kit	
• Promote financial support for GMFC through Aurora's annual employee giving campaign	4th Quarter 2015
Improve coverage for uninsured and Medicaid-eligible patients using our ED for primary and dental care:	
• Screen all uninsured patients for financial assistance programs, including Aurora's *Helping Hand Patient Financial Assistance* program, and other safety net programs for which they qualify, and assist with application processes	Ongoing
• Inform and educate all uninsured patients at our hospital about the benefits of securing coverage through the Marketplace and provide assistance as needed	During open enrollment
• Our parish nurse will assist community members with accessing the Marketplace (the health insurance exchange)	

Focus | Access to care

In order to access cost effective, quality health care in a timely manner from the appropriate medical provider, it is extremely important for health care consumers to learn to advocate for their own health care needs.[4] Part of being a responsible consumer includes having an Advance Directive.

Principal partners

- Aurora Health Care Medical Group

Community partner

- West Allis-West Milwaukee Health Department (WAWM HD)

Target population

- West Allis-West Milwaukee residents

Intended impact

- West Allis-West Milwaukee residents will:
  - Gain competencies in accessing effective, quality health care in a timely manner from the appropriate medical provider
  - Learn to advocate for their own health needs

Measures to evaluate impact

- Number of newly completed Advance Directives as a result of our efforts
- Number of teaching tools developed and distributed (2015 measure)
- Number of venues utilized to distribute the responsible health care consumer materials
- Number of individuals who attended Advance Directives workshops and received documents

Action plan	**Ongoing**
Fulfill our role in supporting the WAWM HD Access to Care committee goal to launch a community campaign to educate residents on being responsible health consumers:	
• Distribute "Road to Better Health" materials and info-graphics through channels including church bulletins, offices of primary care providers,, school district, water bills, etc., to promote the three levels of care	
• Develop distribution channels for "Road to Better Health" videos	
Reinforce public awareness about Advance Planning within the context of being a responsible health care consumer:	
• Coordinate community presentations to increase the number of signed Advance Directives within our own patient population	

[4] Healthy People 2020 – Access to Health Services. U.S. Department of Health and Human Services. Available at http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1

Focus | Healthy Lifestyle Committee – Workplace wellness

Employers are becoming more aware that overweight and obesity, lack of physical activity and tobacco use are adversely affecting the health and productivity of their employees and ultimately, the bottom line of each business. Work-site health promotion and disease-prevention programs have been shown to improve employee health, increase productivity, and yield a significant return on investment for the employers.[5]

Community partners

- West Allis Chamber of Commerce
- West Allis-West Milwaukee Health Department (WAWM HD)

Target population

- West Allis-West Milwaukee businesses/employers

Intended impact

- New or expanded employee wellness programs among employers in West Allis-West Milwaukee
- Increased employer-employee knowledge about body weight, blood pressure, blood glucose and lipid levels

Measures to evaluate impact

- Education materials and resources developed for the employee wellness programs
- "Know Your Numbers" campaign is developed and implemented
- Number of employers engaged in this initiative
- Number of businesses that added or expanded employee wellness program
- Number of people reached by the "Know Your Numbers" Campaign

Action plan **Ongoing**

Fulfill our role in supporting the WAWM HD Healthy Lifestyles Committee – Workplace Wellness:
• Actively serve on the West Allis Chamber of Commerce Wellness Committee
• Provide outreach and resources to businesses in West Allis-West Milwaukee on ways to expand an employee wellness program
• Provide clinical content experts to Chamber of Commerce Wellness Committee and other community organizations to develop presentations (such as a dietician to develop a healthy eating presentation)
• Collaborate with the CHIP Obesity Committee to implement a communitywide preventive "Know Your Numbers" health education and screening campaign, including measures of weight, blood pressure, fasting blood glucose and lipids
• Provide annual education for area businesses to help start or expand employee wellness program

[5] Assistant Secretary for Planning and Evaluation. Prevention Makes Common "Cents". U.S. Department of Health and Human Services. Available at http://aspe.hhs.gov/health/prevention/

Focus | Healthy Lifestyles Committee – Teen pregnancy

Based on the West Allis–West Milwaukee Community Health Improvement Plan, in 2009, 19 of 886 West Allis-West Milwaukee births (2.1%) were to younger teens (<18 years).

Community partners

- *Shared Journeys* charter high school – Started in September 2012, this charter high school educates pregnant and parenting teens both in parenting and academics with coursework including: Child Development I and II, Career and Social Aspects of Society I and II, Prenatal Coursework, Independent Study, Cooperative Education Employment as well as Compass Learning for online general studies.
- West Allis-West Milwaukee School District

Target population

- Pregnant teens in the West Allis-West Milwaukee school system

Intended impact

- Improved birth outcomes for babies born to pregnant teens enrolled at *Shared Journeys* charter school
- 100% graduation rates of pregnant teens enrolled at *Shared Journeys* charter school
- Graduates of *Shared Journeys* charter school are able to secure and maintain employment to support their infants or enroll in post-secondary education

Measures to evaluate impact

- Percent of full-term deliveries to students enrolled in *Shared Journeys* charter school
- Percent of teens at *Shared Journeys* charter school who initiate breastfeeding
- Percent of teen mothers enrolled in *Shared Journeys* charter school who graduate
- Percent of teen mothers enrolled in *Shared Journeys* charter school who enroll in post-secondary education or job training
- Development and implementation of curriculum and evaluation tool for measuring the impact of the sexual wellness class

Action plan	**Target date**
Fulfill our role in supporting the Healthy Lifestyles Committee – teen pregnancy:	
• Serve on the *Shared Journeys* Charter School governance board	Ongoing
• For pregnant teens enrolled primarily at *Shared Journeys* charter school: – Provide childbirth education, breastfeeding and infant care classes located at our hospital – Provide education, work-development and job-skills mentoring at our hospital	
• Implement the sexual wellness class for Shared Journeys Charter School students, based on an evidence-based sexual education program	3rd quarter 2015

Focus | Senior care

In 2012, respondents 65 years and older in West Allis -West Milwaukee were more likely to report high blood pressure, high cholesterol, diabetes and heart disease or heart condition (Community Health Survey). As outlined by the Centers for Disease Control and Prevention, older adults who practice healthy behaviors, take advantage of clinical preventive services, and continue to engage with family and friends are more likely to remain healthy, live independently, and incur fewer health-related costs.

Our *Transitions of Care* program (formerly Senior Resource Nurse) is a NICHE-designated (http://www.nicheprogram.org), non-billable, geriatric nurse-driven program to help our hospital improve the care of older adults treated within our system and also frail elderly persons referred from within our community.

Principal partners

- Aurora Health Care Medical Group physicians in Milwaukee County
- BOOST program and tool (Better Outcomes by Optimizing Safe Transitions)
- Aurora's *Acute Care for the Elderly* program and ACE Tracker- A daily snapshot (accurate as of the midnight census for the previous day) of current Aurora inpatients and observation patients aged 65 and older occupying beds at Aurora hospitals. This snapshot is compiled from data available within Smart Chart (our EMR) and used by our patient care managers, case managers, Senior Resource Nurse and interdisciplinary teams to identify those geriatric patients who are at highest risk for functional decline during hospitalization
- *Aurora at Home*

Community partners

Multiple collaborating agencies including, but not limited to:

- Interfaith Older Adult Programs
- Milwaukee County Department of Aging
- Local Senior Centers and Senior Housing
- Community Care
- West Allis-West Milwaukee Health Department

Target population

- Frail older adults with multiple health conditions, challenges
- High-risk or complex patients (including those lacking in resources)

Intended impact

- A reduction in the average number of re-hospitalizations within 30 days per patient
- Reduction in the average number of days hospitalized during the 30-days post-discharge time period
- Improvement in patient satisfaction with discharge process

Measures to evaluate impact

- Total number of patients served
- Number of re-admissions for pneumonia, heart failure and COPD
- Number of Emergency Department visits within 30 days after discharge

Action plan (see next page)

Action plan	**Target date**
Prevent readmissions and improve overall outcomes for older adults with multiple chronic conditions:	
• Implement the *Transitions of Care* Program house-wide to follow high-risk patients from the hospital setting into their home environment for at least 30 days post discharge	1st quarter 2015
• Identify high-risk or complex patients at AWAMC early in their hospitalization	Ongoing
• Perform comprehensive screenings/assessments of patient's and family's needs post discharge, and utilize a standardized Algorithm of Services	
• Conduct a Care Conference prior to discharge, partnering with the patient and family/support network to discuss the patient's unique needs, available community resources, and in-home plan of care	
• Provide seamless care coordination and communication hand-offs between services, providers and settings	

Focus | Support unpaid caregivers who support our senior population

A caregiver is an unpaid individual (a spouse, partner, family member, friend, or neighbor) involved in assisting others with activities of daily living and/or medical tasks. The close relationship between the caregiver and care recipient, and the challenges of providing direct care, can lead to psychological and physical stressors. This is why it is important for caregivers to develop self-care strategies and for us to provide the tools they need.

Principal partner

- Aurora Rehabilitation Services

Community partners

- First United Methodist Church of West Allis
- Mitchell Manor West Allis Senior Living Community
- Synergy HomeCare
- VMP Manor Park

Target population

- Unpaid caregivers of aging persons with chronic disease(s) in our service area

Intended impact

- Increased recognition, validation and support for the in-home care provided
- Increased caregiver self-efficacy (reported increase in confidence to perform caregiving duties and commitment to self-care behaviors)

Measures to evaluate impact

- Number of participants
- Number of health screenings completed
- Percent reporting confidence to perform caregiving duties and commitment to self-care behaviors
- Responses to a participant evaluation
- Feedback received via email

Action plan	**Target date**
Support caregivers and address their emotional, psychological and physical challenges:	
• Provide our fifth annual *Recognition, Renewal and Care for Caregiver*s event, a low-cost, annual, interactive, day-long seminar for those caring for aging adults with long-term health conditions, such as stroke, Alzheimer's/Parkinson disease, dementia, etc., with complimentary respite care available for the care-receivers	October 2015
– Finalize expert presentations and free health screenings	April 2015
– Finalize hands-on exhibits to help caregivers learn how to safely assist their loved ones	May 2015
– Provide on-site respite care	October 2015
• Conduct an education program for family caregivers in association with the Alzheimer's Association, *Understanding Dementia,* twice per year	March and September 2015

Focus | Chronic disease

In 2012, 11% of adults in West Allis-West Milwaukee reported current asthma, 10% of adults reported diabetes and heart disease or heart conditions, and 4% of adults reported cancer. Chronic disease was one of the top three community health issues reported by adults (Community Health Survey).

Principal partner

- Aurora Parish Nurses

Community partner

- Wisconsin Department of Health and Human Services

Target population

- Adults of any age with one or more chronic disease(s)

Intended impact

- Improved health status and positive self-care behaviors for individuals with chronic disease (e.g. heart disease, asthma, diabetes) who enroll in program

Measures to evaluate impact

- Number of participants enrolled
- Number of participants who complete all six sessions; type of chronic condition(s) addressed
- Percent improvement (baseline to post six-months) on health status, self-efficacy, self-management behaviors and health care utilization
- Previous evaluations on the *Living Well with Chronic Disease* program

Action plan	**Target date**
Improve self-efficacy of persons in our community living with chronic disease(s):	
Promote and present *Living Well with Chronic Disease* and/or *Living Healthy With Diabetes*, Wisconsin's implementation of the evidence-based Stanford Chronic Disease Self-Management Program	Annual
• Provide two workshops each year co-facilitated by two Aurora parish nurses specially trained through the state to implement the program at the local level. Each 2.5-hour session in the six-week program will cover: – Techniques to deal with frustration, fatigue, pain and isolation – Appropriate exercise for maintaining and improving strength, flexibility and endurance – Appropriate use of medications – Communicating effectively with family, friends and health professionals – Nutrition – Understanding and evaluating new treatments	January/February and September/October 2015

Focus | Cancer survivorship and healthy lifestyle

Many cancer survivors are faced with health challenges for months and sometimes years after the completion of cancer treatment. Research conducted by the Virginia Commonwealth University suggests that cancer survivors need to take a more comprehensive approach to their health, rather than focusing just on their cancer.[6]

Principal partners

- Aurora Health Care Medical Group

Community partner

- Wisconsin Athletic Club

Target population

- Survivors of all cancers who have completed active treatment

Intended impact

- Participants will make lifestyle changes to achieve and maintain optimal health and reduce risk factors for cancer recurrence specifically
- Participants will achieve 7% weight loss and engage in a minimum of 150 minutes of physical activity per week

Measures to evaluate impact

- Number who complete program; both phases or phase 1 only
- Average increase in weekly physical activity
- Percent improvement in blood glucose and cholesterol profile
- Average reduction in body weight for participants with a Body Index Measure (BMI) greater than 25

Action plan	**Ongoing**
Provide the six-month Living Well Beyond Cancer year-long program, a Lifestyle Management Program that incorporates nutrition education, a health club membership with exercise instruction, stress management, peer support and lifestyle coaching in two phases:	
1. Phase one is conducted over a three month period and includes – Twelve weekly educational classes held at Wisconsin Athletic Club – Three-month membership to Wisconsin Athletic Club (all six locations included) – Individual exercise prescription from exercise specialist (BMI taken and monitored); weekly monitored food and activity journals and progress; emphasis on healthy lifestyle skills and extensive support from program coordinators, facility management staff, dietitians, exercise specialists and group members	
2. Phase two is a three-month maintenance program specific to cancer survivorship taking place at our hospital – Educational classes and continued support from program coordinators and group members at our hospital – Weekly, evidence-based weight-maintenance strategies	

[6] Ning, Y. (2012, April). Nearly Half of Cancer Survivors Died From Conditions Other Than Cancer. Paper presented at the American Association for Cancer Research Conference, Chicago, IL.