As an affiliate of Advocate Aurora Health, the leading not-for-profit healthcare provider in eastern Wisconsin and Illinois, our purpose is to help people live well. We recognize our role in addressing concerns about the accessibility and affordability of health care in Walworth County. Further, we recognize that we are accountable to our patients and communities, and that our initiatives to support our communities must fit our role as a not-for-profit community hospital.

The implementation strategies presented here are the result of our process for assessing community health needs, obtaining input from community members and public health representatives, prioritizing needs, and consulting with our hospital staff and physician partners.

Our full Community Health Needs Assessment Report is available here: www.aurora.org/commbenefits.
Our implementation strategies are organized into three main categories aligned with three core principles of community benefit:

<table>
<thead>
<tr>
<th>Category</th>
<th>Community Benefit Core Principle</th>
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</table>
| Priority #1 | Access and Coverage  
*Increase access for persons in our community with disproportionate unmet health needs. In this section we outline our approach to link our community’s most vulnerable residents with medical care.* |
| Priority #2 | Community Health Improvement Plan  
*Build links between our clinical services and the local health department community health improvement plan (CHIP). In this priority we outline our approach to addressing behavioral health needs, a significant finding in our needs assessment.* |
| Priority #3 | Build a seamless continuum of care  
*Address the underlying causes of persistent health challenges in our community:  
- Chronic disease  
- Senior care  
- Infant mortality  
- Sexual assault* |

In addition to alignment with community benefit principles, our implementation strategies illustrate the coordination between population health activities within our hospital or clinic walls and outreach activities designed to target the broader community.

**Principal community health improvement tool: Community Partnerships**

For any community health concern, it is widely recognized that a diverse team of engaged community partners is essential for implementing strategic community health improvement initiatives that make a difference. Therefore, we recognize the need to be a good community partner. Our implementation strategies strongly reinforce our role as a partner for community capacity-building to address unmet community health needs.

These implementation strategies do not constitute the entirety of the community benefits our hospital provides each year. An annual account of the community benefits we provide can be found by visiting [http://www.aurora.org/commbenefits](http://www.aurora.org/commbenefits).

This Community Benefit Implementation Strategy was adopted by the Social Responsibility Committee of the Aurora Health Care Board of Directors on October 12, 2017.
Priority No. 1:
Access, a signature community benefit focus for Aurora Health Care

Current findings
Access to healthcare services ranked among the top five health issues for Walworth County. In 2016, 15% of the respondents delayed or did not seek medical care due to costs in the past 12 months; those who were male or in the bottom 60 percent household income bracket were more likely to report this. In addition, the number of individuals with an unmet medical need increased to 12% in 2016 compared to 7% in 2005 (Source #1). The Healthy People 2020 target is to reduce the proportion of persons who are unable to obtain, or delay in receiving necessary medical care, to 4.2%. Residents and key informants identified access to health care as a top five community health issue (Sources #1 and #3).

Our strategy
For our patients
• Provide appropriate follow-up with non-emergent patients using our emergency department (ED) for primary care
• Refer uninsured and self-pay patients using our ED for primary and dental care to OAFC
• Actively screen patients for coverage through the Marketplace or financial assistance programs and assist with application processes
• Provide follow-up calls to prioritized ED patients (pediatric, critical, elderly, etc.) to assure they understand their discharge instructions, address any questions related to the visit and identify any barriers or obstacles

MEASURES, number of:
• Non-emergent ED visits without a primary care physician; seen by an AHCMG primary care provider within 28 days
• Patients referred to OAFC
• Follow-up calls made to ED patients

For our community
• Provide free radiology and specialty services to patients referred by OAFC
• Conduct (with our AHCMG partner) a cardiology clinic one evening per month at OAFC

MEASURES, number of:
• Services provided for OAFC referrals (radiology and specialty)
• OAFC cardiology visits provided
Priority No. 2: Community Health Improvement Plan, focus on Behavioral Health

Current findings
Mental health and alcohol and other drug use (behavioral health) ranked among the top five health issues for Walworth County. In 2016, 22% of Walworth County adults reported a mental health condition (such as depression, anxiety disorder or post-traumatic stress disorder) in the past three years, a significant increase from 2007 (10%). Five percent of adults reported feeling so overwhelmed in the past year that they considered suicide (Source #1).

Thirty percent of adults in Walworth County reported binge drinking in the past month, a statistically significant increase from 2005 (23%) (Source #1). In addition, the rate of emergency department (ED) visits due to opiate poisonings (also known as opiate overdoses) was 8.4 per 100,000 population in 2014, higher than its 2013 rate of 5.0 per 100,000 population.1

Our strategy
For our patients
• Provide ABHS referrals through tele-intake services in our ED and through inpatient tele-psychiatry consultations
• Screen for behavioral health issues in the ED including mental health, depression, alcohol abuse and drug use, and provide follow-up care and referral as appropriate
• Partner with WCDHHS to provide referrals to women:
  – Women’s alcohol and other drug abuse (AODA) Wrap-Around program
  – My Baby & Me program to reduce alcohol use during pregnancy
  – First Breath program to reduce smoking during pregnancy

MEASURES, number of:
• Individuals screened and referred
• Women referred to WCDHHS; as reported by WCDHHS, number who:
  – Remain engaged in AODA Wrap-Around program
  – Successfully reduce alcohol use during pregnancy
  – Successfully refrain from smoking during pregnancy

For our community
• Provide training to EMS agencies and quarterly continuing education based upon needs identified by EMS agencies, run report trends and state requirements, including care for opioid overdoses
• Provide medical oversight and training to law enforcement in Narcan administration, including Walworth County Sheriff and Lake Geneva Police Department

MEASURES, number of:
• Trainings provided; individuals trained
• Agencies provided with medical oversight

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Priority No. 3: Community benefit hospital focus on chronic disease

Current findings
Chronic diseases ranked among the top five health issues for Walworth County. In 2016, 7% of adults reported heart disease or a heart condition in the past three years (Source #1). The term “heart disease” refers to several types of heart conditions, such as coronary artery disease, angina, heart failure and arrhythmias. High blood pressure, high cholesterol and smoking are key risk factors for heart disease.\(^2\)

Ten percent of adults reported diabetes in the past three years, a consistent trend since 2005 (Source #1).

Our strategy
For our patients
- Continue Care Management strategies to address high blood pressure (BP) within our clinic population by scheduling the patient’s 6-month hypertension follow-up visit before they leave the clinic; rechecking any BP 140/90 or higher; scheduling for a 1-2 week nurse visit if BP remains elevated; scheduling with provider if BP remains elevated at nurse visit
- Provide two evidence-based Healthy Living with Diabetes programs annually, open and promoted to the community covering understanding diabetes, getting the right health care, monitoring blood glucose, learning about food and diabetes, adding activity to your life, understanding medications and living with diabetes

MEASURES, number of:
- Improvements in Care Management score: 86% of patients between ages 18 and 85, with diagnosed hypertension, under good control (publicly accessible at www.wchq.org)
- Attendees for Healthy Living with Diabetes sessions

For our community
- Provide free outreach blood pressure screenings and education at various community locations/events
- Provide free drop-in blood pressure screenings at Lake Geneva Clinic
- Provide education on a variety of chronic disease-related topics including hypertension, stroke, heart disease, chest pain, sexual assault, injury prevention, and women’s health at the Walworth County Fair. A dry event with over 135,000 attendees in 2016, the Walworth County Fair provides an excellent opportunity to interface with community residents who might not otherwise be reached or attend our events.

MEASURES, number of:
- BP screenings; individuals screened and evaluation data
- Individuals referred for follow-up
- Individuals educated
- Individuals engaged

Target population
Residents of Walworth County

Principal partners
- Aurora Health Care Medical Group (AHCMG)
- Aurora Pharmacy

Community partners
- Walworth County Department of Health & Human Services (WCDHHS)
- Aging and Disability Resource Center (ADRC)

Impact goal
Increased awareness and control of chronic disease

Priority No. 3: Community benefit hospital focus on senior care

**Target population**
Residents aged 65 and older in Walworth County

**Principal partners**
- Aurora Health Care Medical Group (AHCMG)
- Aurora Senior Resource Nurses (SRN)
  Aurora’s SRN program is a non-billable NICHE-designated (http://www.nicheprogram.org) geriatric nurse-driven program to help our hospital improve the care of older adults treated within our facilities, as well as frail elderly persons referred from within our community. The program was implemented in our service area in 2007.

**Community partners**
- Skilled nursing facilities in Walworth County
- Aging and Disability Resource Center of Walworth County

**Impact goal**
Reduced readmissions and admissions for falls

**Current findings**
In 2014, the total number of injury emergency department (ED) visits among Walworth County adults aged 65 years and older was 1,136, which is a rate of 7,228.3 per 100,000, significantly higher than the state rate of 4,249.7. The rate of injury-related hospitalizations due to falls among Walworth County adults aged 80-84 years was 3,746.7 per 100,000 population, higher than the state rate of 3,023.2 per 100,000.

**Our strategy**

**For our patients**
- Assure that frail elderly patients and persons referred to our SRNs are assessed for:
  - Behavioral health needs
  - Cognitive impairment (using MoCA Montreal Cognitive Assessment)
  - Family and social support
  - Home visits when possible
  - Nutrition needs
  - Pharmaceutical assistance program
  - Safe-At-Home or appropriate supportive placements
  - Transportation needs for follow-up care
- Provide patient education and support for:
  - Advance Directives (Power of Attorney)
  - Family guidance and support services
  - Medication management/safety

**MEASURES, number of:**
- Patients served
- Fall-related admissions for residents 65 and older

**For our community**
- Provide two Stepping On sessions annually. Stepping On is a high-level, evidence-based program proven to reduce falls and build confidence in older people.
- Additionally, SRNs conduct outreach blood pressure screenings throughout the year.

**MEASURES, number of:**
- Stepping On classes; attendees
- Events and type of events conducted
- Attendees and evaluations

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Priority No. 3: Community benefit hospital focus on infant mortality

Current findings
From 2012 to 2014, the rate of infants dying before their first birthday in Walworth County stayed the same at 3.7 deaths per 1,000 live births, lower than the statewide rate of 5.7 deaths per 1,000 live births (Source #2).

Our strategy: sustain or reduce rates

For our patients
• Staff our Lactation Center with International Board-Certified Lactation Consultants accessible seven days a week to:
  – Provide telephone consults, advice, support and schedule outpatient consults
  – Inform mothers about – and promote – available resources, such as Lactation Consultants, Peer Counseling and Lactation Rooms, within their county of residence
• Provide education to new mothers prior to discharge on:
  – Car seat safety
  – Infant safe sleep
• Provide referrals for portable cribs and baby boxes distributed by WCDHHS as needed

MEASURES, number of:
• Outpatient and phone consults provided
• Mothers educated
• Portable cribs and baby boxes distributed by WCDHHS
• Percentage of mothers breastfeeding at discharge

For our community
• Provide educational classes to community residents:
  – Infant CPR classes
  – Two reduced-cost babysitting classes per year to area teens, with education including babysitting as a business, baby development, baby safety with CPR and choking, baby care, and include a video by the American Safety & Health Institute

MEASURES, number of:
• Infant CPR classes provided and attendees
• Babysitting classes provided and attendees
• Participants with knowledge gained (as measured in completed evaluations) for above classes
Priority No. 3: Community benefit hospital focus on sexual assault

Target population
Residents of Walworth County

Principal partner
• Aurora Health Care Medical Group
• Aurora Healing & Advocacy Services (AHAS)

Community partners
• Local law enforcement
• New Beginnings APFV
• Walworth County Alliance for Children

Impact goal
Increased access to care for sexual assault

Current findings
The rate of rape for Walworth County was 22.3 reports per 100,000 persons, lower than Wisconsin’s overall rate of 24.3 per 100,000 in 2016. However, sexual assault and rape are underreported and the definition of sexual assault varies across different agencies; therefore, the number and rate may vary depending on the source.

Our strategy
For our patients
Consistent within Aurora’s system-wide Sexual Assault Nurse Examiner (SANE) program and AHAS, provide:
• 24/7 trauma-informed and victim-sensitive services, including forensic evidence collection and SDFI®-TeleMedicine forensic photodocumentation system based on the Federal Rules of Evidence
• Referrals as appropriate to medical, clinical, counseling and advocacy services

MEASURES, number of:
• Individuals served and referrals provided

For our community
• Provide 12 community education/prevention/outreach trainings
• Provide the award-winning Healthy Kids Club program, an interactive health education program for kindergarten students that teaches kindergartners about healthy habits, personal safety around strangers, safe touches, and appreciating the differences in individuals
• Support expansion of sexual assault treatment capacity and advocacy services for teens and elders at New Beginnings APFV
• Participate in training to expand sexual assault treatment capacity and advocacy services, including a new child abuse and neglect therapy program, through the Walworth County Alliance for Children

MEASURES:
• Number of educational events provided; attendees
• Number of Healthy Kids Club programs provided; schools engaged and kindergarteners educated
• Process milestones

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