Aurora Medical Center Manitowoc County 2019 Implementation Strategy Update

In 2013, Aurora Medical Center Manitowoc County (AMCMC) conducted a Community Health Needs Assessment (CHNA) and completed a CHNA Report and Implementation Strategy that was reviewed and adopted by the Social Responsibility Committee of the Aurora Health Care (AHC) Board of Directors on November 22, 2013, and posted to the AHC web site.

In 2016, AMCMC completed and published its CHNA Report and 2017-2019 Implementation Strategy, which was adopted by the Social Responsibility Committee of the AHC Board of Directors on November 17, 2016, and posted to AHC web site. Each document provides a comprehensive overview of the community served and significant health needs identified and is available by visiting http://www.aurora.org/commbenefits.

Experience in carrying out the Implementation Strategy in 2018 informed the process for updating it for 2019. As previously, our AMCMC 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	Focus area
Priority #1: Access	Access for persons in our community with disproportionate unmet health needs	• Access • Health care coverage
Priority #2: Community Health Improvement	Build links between our clinical services and local health department community health improvement plan	• Behavioral health and brain care • Nutrition, physical activity, overweight/obesity and diabetes
Priority #3: Community Benefit Hospital Focus	Address the underlying causes of persistent health problems	• Sexual assault nurse examiner program • Hepatitis C

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.

We help people live well. Our hospital offers all the benefits of a true community hospital. Yet, as part of Aurora's integrated health care system (IHCS), our hospital benefits from Aurora's system-wide expertise and programing in areas including mental health and cancer care, greatly expanding the scope of options, opportunities and expertise we can offer to our patients in settings across Aurora's footprint and in our service area. When this is the case, you will find the designation IHCS with measures reflecting regional and/or system-wide targets, tracking and reports.

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.

Special focus: Health Disparities
Providing culturally competent and appropriate care has always been a priority for us in helping people live well. Going forward, in addition to the demographic data already collected by our providers, we will be making an extra effort to collect demographic information on individuals touched by the programs in our Implementation Strategies. This will support our efforts to identify disparities and work to address them.

It is not surprising that we are asked to support a wide array of community activities and events in Manitowoc County. However, today's community health needs require us to reserve limited charitable resources for programs and initiatives that improve access for underserved persons and specifically support community health improvement initiatives, as outlined in this Implementation Strategy.

Implementation **Strategy** | **Priority No. 1: Access**

Focus | Access is an Aurora Health Care signature community benefit focus

In 2016, the percentage of adults who receive primary health services through a medical home have decreased significantly from 72% in 2007 to 63% (Source #1). Having a consistent primary care provider and medical home allows for diseases to be detected and treated at an earlier stage, improves overall health, prevents disease and disability and reduces preventable deaths.[1]

Principal partner

- Aurora Health Care Medical Group (AHCMG)

Community partner

- Lakeshore Community Health Center (LCHC)

Target population

- Uninsured and Medicaid-eligible patients using our hospital emergency department (ED) for primary care and frequent ED users using the ED for non-emergent conditions

Activities

Time Frame	Measures to Evaluate	Targets/ Tracking	Intended Outcomes
• **Link Medicaid-eligible and uninsured patients using our hospital ED for primary care with a primary care provider, including the LCHC** • **Link Medicaid-eligible and uninsured patients using our hospital ED for dental care with the LCHC**			
Ongoing	Number of non-emergent ED visits without a primary care physician	Annual volume	• Increased number of Medicaid-eligible and uninsured patients establish a relationship with a primary care provider • Decreased ED admissions for primary care
	Of those ED visits classified as non-emergent and had no primary care provider, percent who saw an Aurora Health Care primary care provider within 28 days of the ED visit		
	Of those ED visits classified as non-emergent and had no primary care provider, number who were referred to LCHC		
	Number of Medicaid-eligible and uninsured patients referred to LCHC for dental care		Increased number of Medicaid-eligible and uninsured patients with access to dental care
• **Provide diagnostic imaging services for patients referred from the LCHC**			
Ongoing	Number of patients provided with diagnostic imaging services at no cost	Annual volume	Improved care for LCHC patients
• **Provide complimentary transportation for those needing access to our healthcare facilities**			
Ongoing	Number of complimentary rides provided	Annual volume	Increased access to care for individuals with transportation limitations

[1] Healthy People 2020 – Access to Health Services. U.S. Department of Health and Human Service. Available at http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services Accessed September 1, 2015.

Focus | Behavioral health and memory care

According to the *County Health Rankings*, Manitowoc County adults reported an average of 3.2 mentally unhealthy days in the past 30 days, less than the state average of 3.7 days (Source #2). In 2016, 15% of Manitowoc County adults reported a mental health condition (such as depression, anxiety disorder or post-traumatic stress disorder) in the past three years, comparable to 2013 (16%) but a significant increase from 2007 (9%) (Source #1).

In 2016, 40% of adults in Manitowoc County reported binge drinking in past month, a statistically significant increase from 2003 (19%), and higher compared to the state (23%) and the United States (16%). Also, prescription drug mis-use is escalating statewide. In Manitowoc County, the rate of emergency department visits due to opiate poisonings (also known as opiate overdoses) was 13.6 per 100,000 population in 2014, higher than its 2013 rate of 4.9 per 100,000 population, but lower than the state average of 14.6 opiate poisonings per 100,000 population.

Principal partner

- Aurora Health Care Medical Group (AHCMG)

Community partners

- Healthiest Manitowoc County Coalition

Target population

- Manitowoc County residents

Activities

Time Frame	Measures to Evaluate	Targets/ Tracking	Intended Outcomes
• **Implement behavioral health informational and educational programs for the general public**			
Ongoing	Number of programs provided, individuals attending	Annual volume	Increased community education and awareness of behavior health options
• **Plan, develop and implement Memory Clinic to provide patients with memory assessments**			
Ongoing	Number of patients who received memory assessment, by age	Annual volume	Increased access to care for memory related illnesses

Focus | Nutrition, physical activity, overweight/obesity and the link to diabetes

In 2016, 70% of the children in Manitowoc County did not eat the recommended five or more servings of fruits of vegetables per day and 31% did not get the recommended 60 minutes of physical activity five or more days a week. In addition, 42.8% of the students responded playing video or computer games or using a computer for non-school work three hours or more on an average school day, more than the Wisconsin or US rate (34.2% and 41.3% respectively) (Source #3).

Further, 38% of the adults in Manitowoc County did not eat the recommended five or more servings of fruits or vegetables per day and 49% did not get the recommended moderate or vigorous activity. The majority (71%) of adults in Manitowoc County were classified as being overweight and the percentage who were classified as being obese increased significantly from 26% in 2003 to 34% in 2013 to 42% in 2016 (Source #1).

Healthiest Manitowoc County and the *2020 Manitowoc County Community Health Improvement Plan (CHIP)* identified nutrition and physical activity as one of the key health priorities.

One of the conditions often linked with being obese is diabetes[2]. In 2016, 9% of adults in Manitowoc County reported diabetes in the past three years. Unmanaged diabetes may lead to serious health complications including heart disease, blindness, kidney failure and lower-extremity amputations.[3]

Principal partner

- Aurora Health Care Medical Group (AHCMG)

Community partners

- Healthiest Manitowoc County Coalition
- Manitowoc County Extension Office
- Manitowoc and Two Rivers Area Schools
- Public Health Department
- The Y
- Lakeshore Community Health Center (LCHC)
- "Mi Pueblo" Hispanic Community Center

Target population

- Manitowoc County residents, including youth and those diagnosed with diabetes

Activities – next page

[2] National Institute of Diabetes and Digestive and Kidney Diseases. Available at https://www.niddk.nih.gov/health-information/diabetes/causes. Accessed September 8, 2016.
[3] Centers for Disease Control and Prevention. - Diabetes Public Health Resources. Available at http://www.cdc.gov/basics/diabetes.html. Accessed September 1, 2015

Activities – align financial support and hospital initiatives for nutrition, physical activity and overweight/obesity and the link to diabetes

Time Frame	Measures to Evaluate	Targets/ Tracking	Intended Outcomes
Support Healthiest Manitowoc County Coalition goals for addressing nutrition, physical activity, overweight/obesity and the link to diabetes: • **In partnership with the Y, continue to provide *Kid Shape 2.0,* a six-week community-based program for students who are overweight or obese, and their families, which includes instruction and activities related to healthy eating, physical activity and behavior modification** • **Design, pilot and implement a recruitment strategy to increase outreach and target racially/ethnically diverse individuals**			
Ongoing	Number of 6-week *Kid Shape 2.0* sessions offered per year	3	Increased healthy lifestyle habits among program participants
	Number and demographics of children and families enrolled in *Kid Shape 2.0*, per session	Annual volume	
	Percent of children and families who complete the entire session		
	Number of participants decreasing BMI after 6-week session	Annual results	
	Number of participants reporting recommended amount of physical activity after 6-week session		
	Results of behavioral modification assessment before and after 6-week session		
By 12-31-18	Process milestones for design, pilot and implementation of recruitment strategy	Deadlines	Increased attendance, especially among racially/ethnically diverse individuals
• **Provide free community presentations and seminars on physical health and fitness and prevention of sports injuries, featuring cardiac and orthopedic physicians, as well as rehabilitation specialists, at Manitowoc Lincoln, Reedsville, Two Rivers and Mishicot high schools**			
Ongoing	Number of presentations/seminars provided	Annual volume	Increased community awareness on prevention of sports injuries
	Number of students and faculty reached, number of community members reached		
• **Supply cafeteria food to local food pantries, support and conduct food drives for the pantries** • **Provide financial support for local food pantries**			
Ongoing	Amount of cafeteria food provided to local food pantries	Annual volume	Local food pantries are able to provide additional meals for those in need
	Number of food drives held		
	Amount of food collected at food drives		
Ongoing	Financial support provided	Annual total	

Diabetes Activities – continued next page

Activities – Diabetes

Time Frame	Measures to Evaluate	Targets/ Tracking	Intended Outcomes
• **Provide resources including staff, supplies, interpretation services and/or support groups for classes held at LCHC** • **Design, pilot and implement an outreach strategy to target Hispanic individuals in our community diagnosed with diabetes***			
By 6-30-19	Process milestones for launch of pilot programs	Deadlines	Classes implemented
Ongoing	Number of classes held	Annual volume	Improved diabetes management among program participants as measured by program evaluations
	Number of attendees, by demographics		
	Program evaluations measuring self-reported improvement in diabetes management	Results	
	Type and amount of resources provided	Annual volume	
By 12-31-19	Process milestones for design, pilot and implementation of recruitment strategy	Deadlines	Plan implemented

*Hispanic individuals make up the largest minority demographic group in Manitowoc County, representing 3.3% of the population (please see page 6 of the CHNA Report)

Focus | Sexual Assault Nurse Examiner (SANE) Program

The rate of rape for Manitowoc County was 10 reports per 100,000 persons, lower than Wisconsin's overall rate of 21.0 per 100,000 in 2012.[4] 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.

Sexual violence can have harmful and lasting consequences for victims, families and communities including, but not limited to, unintended pregnancy, sexually transmitted infections, long term physical consequences, immediate and chronic psychological consequences, health behavior risks and financial cost to victims, families and communities.[5]

Principal partner

- Aurora Health Care Medical Group (AHCMG)
- Aurora Healing and Advocacy Services (AHAS)

Community partner

- Manitowoc County Police and Sheriff Departments
- Manitowoc County Health Department
- Manitowoc County Domestic Violence Center
- United Way of Manitowoc County

Target population

- Victims of sexual assault and domestic violence

Activities

Time Frame	Measures to Evaluate	Targets/ Tracking	Intended Outcomes
• **Provide 24/7, trauma-informed coverage for victims of sexual assault and violence through our SANE program** • **Provide sensitive, effective forensic evidence collection** • **Advance knowledge within the broader community on how to respond to issues related to sexual assault and violence**			
Ongoing	Number of people provided with services and medical care related to sexual assault, domestic violence, human trafficking, victims of crime and pediatric victims	Annual volume	Increased access to care for victims of sexual assault and violence in our communities
	Number of referrals to counseling and social service agencies		
	Number of annual community education/prevention/outreach presentations	12	Improved community response to sexual assault and violence
	Number of people attending education/prevention/outreach presentations, types of groups	Annual volume	

[4] Wisconsin Department of Justice, Crime in Wisconsin 2012, September 2013. Available at https://wilenet.org/html/justice-programs/programs/justice-stats/library/crime-and-arrest/2012-crime-in-wi.pdf. Accessed February 22, 2016

[5] Centers for Disease Control and Prevention – Sexual Violence: Consequences. Available at http://www.cdc.gov/violenceprevention/sexualviolence/consequences.html. Accessed July 22, 2015.

Focus| Hepatitis C Program (health system population health strategy) IHCS

According to the CDC, hepatitis C-related mortality in 2013 surpassed the total combined number of deaths from 60 other infectious diseases. Death certificates often underreport hepatitis C.

The greatest hepatitis C burden falls on baby boomers, those born from 1945 to 1965. Many baby boomers were infected during medical procedures prior to 1985, when injection and blood transfusion technologies were not as safe as they are today. Without diagnosis and treatment, hepatitis C may lead to liver cancer and other life-threatening diseases and may be transmitted to others.[6]

In 2014, according to the Wisconsin Division of Public Health[7]:

- Wisconsin hepatitis C incidence rate per 100,000 population – 56.1
- Median age of death in Wisconsin due to hepatitis C – 57 years
- Hepatitis C is under-reported on death certificates and plays a larger role in premature death in Wisconsin than is recognized.

Principal partner

- Aurora Health Care Medical Group (AHCMG) Primary Care Providers

Community partner

- AIDS Resource Center of Wisconsin

Target population

- Patients born from 1945 to 1965 residing in the Green Bay, Manitowoc & Marinette service area
- Patients who self-identify for other factors*

System Activities – Hepatitis C

Time Frame	Measures to Evaluate	Activities	Long-term Outcomes
Ongoing	Data collected regionally as part of Aurora Health Care Green Bay, Manitowoc & Marinette service area	Patients in cohort are identified and screened Referrals, staging and standardized care-delivery process for our patient population are implemented for those who test positive	Decreased burden of hepatitis C in our communities Decrease in rates of cirrhosis and liver cancer in our patient population over time

* Other patients at risk for hepatitis C include persons:

- Who are HIV positive
- Who injected illegal drugs
- Who received clotting factor concentrates produced before 1987
- On chronic hemodialysis
- With persistently abnormal alanine aminotransferase (ALT) levels
- Who received transfusions or organ transplants prior to 1992
- With recognized occupational exposures
- Born to HCV-positive women

[6]CDC, http://www.cdc.gov/media/releases/2016/p0504-hepc-mortality.html, accessed May 6, 2016.
[7] WI DHS, "Wisconsin Hepatitis C Surveillance Study: 2014", https://www.dhs.wisconsin.gov/publications/p00440-2014.pdf, accessed May, 6, 2016.