Advocate Aurora Health (AAH) is among the 10 largest not-for-profit, integrated health systems in the United States and a leading employer in the Midwest with more than 70,000 team members, including more than 22,000 nurses and the region’s largest employed medical staff and home health organization. A national leader in clinical innovation, health outcomes, consumer experience and value-based care, the system serves nearly 3 million patients annually in Illinois and Wisconsin across more than 500 sites of care. As an AAH hospital, we recognize our role in addressing concerns about the accessibility and affordability of health care in Milwaukee 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 Milwaukee County 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>
</tr>
</thead>
<tbody>
<tr>
<td>Priority #1</td>
<td><strong>Access and Coverage</strong>&lt;br&gt; <em>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.</em></td>
</tr>
<tr>
<td>Priority #2</td>
<td><strong>Community Health Improvement Plan</strong>&lt;br&gt; <em>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 top finding in our needs assessment.</em></td>
</tr>
<tr>
<td>Priority #3</td>
<td><strong>Social Determinants of Health</strong>&lt;br&gt; <em>In alignment with the Advocate Aurora Health Community Strategy, this section describes our approach to addressing social determinants of health, the structural elements and conditions of our communities that influence the health of residents.</em></td>
</tr>
</tbody>
</table>

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.

For the purposes of data collection and Implementation Strategy planning, Milwaukee County was divided into five regions. The regions include the City of Milwaukee, Cudahy/Oak Creek/St. Francis/South Milwaukee (referred to as “South Shore”), Franklin/Greendale/Greenfield/Hales Corners (referred to as the “Southwest” region), Wauwatosa/West Allis/West Milwaukee (referred to as the “West” region), and Bayside/Brown Deer/Fox Point/Glendale/River Hills/Shorewood/Whitefish Bay (referred to as “North Shore”). Based on patient population and hospital location, the following report looks at the data and strategies relative to the City of Milwaukee and Southwest regions.

**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 our community benefits can be found by visiting http://www.aurora.org/commbenefits.

This Community Benefit Implementation Strategy was adopted by the Aurora Health Care Community Board on December 2, 2019.
Priority No. 1: Access, a signature community benefit focus for Aurora Health Care

Target population
Uninsured residents of Milwaukee County

Principal partner
• Aurora Health Care Medical Group (AHCMG)
• Aurora Family Service (AFS)
• Aurora Walker’s Point Community Clinic (AWPCC)

Community partner
• Milwaukee Health Care Partnership (MHCP)
• Sixteenth Street Community Health Center
• CORE/El Centro

Impact goal
• Increased number of non-emergent patients presenting in our emergency department (ED) are navigated to a medical home
• Chronic disease prevention, education, care, and support are available to under-insured individuals in our community

Current findings
In 2018, 8% of Milwaukee County respondents had an unmet medical need in the past 12 months, as did 9% of City of Milwaukee residents and 3% of Franklin/Greendale/Greenfield/Hales Corners residents. Access to health care was ranked as a top issue by community members and key stakeholders (Sources #1, #3).

Our strategy
For our patients
• Through participation in the MHCP ED Care Coordination (MHCP EDCC) program, link Medicaid-eligible and uninsured patients using our hospital emergency department (ED) for primary care with medical homes
  - Past impact: 1,048 appointments were scheduled in our ED through the MHCP EDCC program in 2017 and 2018
• NEW: Refer uninsured patients to the Sixteenth Street Community Health Center and provide an automated care summary, improving patient care coordination with our partner provider
• Continue our Coverage to Care (C2C) program, launched in 2017, to provide intensive and systematic case-management for hospital ED high utilizers, incorporating health care literacy, health care advocacy, health care coordination and medical homes
  - Past impact: 472 individuals were served through C2C at ASLMC in 2017 and 2018 with a 43% reduction in their ED visits
• Through our Transitional Care Management program, provide discharged patients with primary care or specialist appointments within seven days of discharge for follow-up
  - Past impact: 74% of patients being discharged received a follow-up appointment within seven days in 2018
• Provide all patients discharged from ASLMC with a follow-up phone call in their preferred spoken language through our Discharge Phone Calls initiative. Discharge phone call staff are also trained on protocols for suicide assessment and linking patients with support for opioid and other drug issues
  - Past impact: 53,470 calls were provided in over 30 languages in 2017 and 2018; 8 discharge call staff were trained in suicide and opioid protocols, with the suicide protocol implemented twice
• Provide prescriptions upon discharge free of cost to uninsured patients who lack resources through the Aurora Essential Medication Fund
• NEW: Provide the Family Medicine Residency Clinic Follow-Up Appointment Program, which provides patients without an established Primary Care Provider (PCP) a follow-up structure within 24-72 hours of ED visit for acute medical conditions that require close outpatient monitoring to ensure appropriate improvement/resolution of their acute medical condition
Implementation Strategy 2020-2022

• Provide culturally appropriate care for Spanish-speaking patients through our Spanish Cancer Clinic
  – Past impact: 68 patients were served through 96 visits in 2017 and 2018

• Continue to advance our Cancer Nurse Navigator (CNN) program, offering referrals to both Aurora service
  providers and community partners
  – Past impact: 4,787 patients were served, with 1,202 referred to Aurora providers and 291 referred to
    community partners in 2017 and 2018

• Continue to partner with AFS to provide supportive cancer counseling services
  – Past impact: 3,447 individuals received cancer counseling services in 2017 and 2018

MEASURES, number of:
• Non-emergent ED visits without a primary care physician; number seen by an AHCMG primary care provider
  within 28 days
• Appointments scheduled; number of FQHC appointments and show rate
• Patients referred to Sixteenth Street Community Health Center
• Transitional Care Management appointments scheduled
• Follow-up phone calls provided; languages
• Number of prescriptions provided; dollar value
• Number of appointments made and kept through Family Medicine Residency Clinic Follow-up
  Appointment Program
• Patients served through the Spanish Cancer Clinic; visits provided
• Patients served through our CNNs
• Individuals provided with cancer counseling services

For our community
• Aurora Walker’s Point Community Clinic (AWPCC), funded by Aurora St. Luke’s Medical Center and operated
  by Aurora Health Care, is the largest free clinic in Wisconsin. Freestanding and community-based, it is open 48
  hours a week with evening and Saturday hours to serve a community with the highest percentage of uninsured
  persons in the state. Located in the Walker’s Point area of Milwaukee’s south side, the clinic is within and
  adjacent to predominantly Latino/Hispanic neighborhoods. AWPCC provides urgent care, family medicine, and
  specialist services, including behavioral health. Through AWPCC, provide:
  – Outpatient care to un- and under-insured patients
    ▪ Past impact: 13,819 patients were served in 2017 and 2018
  – Referrals to AHCMG physician specialists through Aurora’s Specialty Access for Uninsured Program (SAUP)
    ▪ Past impact: 1,023 patients were referred in 2017 and 2018
  – Well-Integrated Screening and Evaluation for Women (WISE Woman) program for cardiovascular screening
    including blood pressure, blood sugar, weight, and blood cholesterol levels and provide appropriate
    treatment
    ▪ Past impact: 612 individuals participated in 2017 and 2018
  – Breast and cervical cancer screenings through the Wisconsin Well Woman Program (WWWP)
    ▪ Past impact: 557 mammograms and 185 pap tests were provided in 2017 and 2018
  – Breast cancer education, screening reminders, and low or no-cost breast cancer screening resources to
    underserved women through the CHANGE grant
    ▪ Past impact: 1,464 women received breast cancer education, 619 received a screening reminder, and 666
      were provided with low or no-cost screening resources in 2017 and 2018
  – Referrals to CORE/El Centro to advance knowledge, skills, and social support to improve dietary behaviors
    and increase physical activity
    ▪ Past impact: 686 patients attended at least one visit in 2017 and 2018
- Bilingual social services to help underserved patients navigate the healthcare system and access safety-net resources, obtain legal documents, address domestic violence issues, and receive family counseling/family planning information
  - Past impact: 3,058 patients were provided with social services in 2017 and 2018
- Counseling with a team led by a bilingual PhD psychologist and four counseling students
  - Past impact: 780 patients were served through 3,005 counseling appointments in 2017 and 2018
- Health screenings to new refugees as part of the Refugee Health Coordination program
  - Past impact: 92 health screenings were provided in 2018

• The Karen Yontz Women’s Cardiac Awareness Center at our hospital is a nationally recognized resource center dedicated to decreasing the incidence and impact of heart disease in women. Through the Karen Yontz Center:
  - Administer clinical heart risk appraisals
    - Past impact: 368 women received appraisals in 2017 and 2018
  - Provide educational events and resources
    - Past impact: 127 educational events were held in 2017 and 2018, with 5,313 women attending and 327 reporting an improvement in lifestyle practice and 169 adopting a stress-management practice
  - Conduct health risk lifestyle assessment quizzes related to heart disease and risk factors; offer behavioral contract
    - Past impact: 440 women received health risk assessments in 2017 and 2018, 498 women identified a personal risk factor change they were willing to make and 248 completed a 30-day check-in

MEASURES, number of:
• Unique patients served; visits provided
• Referrals to SAUP
• Women participating in WISE program
• Women receiving mammograms, pap tests
• Women provided with breast cancer education, screening reminders, low or no-cost resources
• Patients attending at least one CORE/El Centro visit
• Patients provided with social services
• Counseling appointments provided; patients served
• Cancer screening reminder calls/conversations; health coaching sessions provided by CHWs
• Refugee health screenings provided
• Individuals served through Transitional Clinic program
• Women who undergo clinical heart risk appraisals
• Educational events held; women attending, reporting improvement in lifestyle practice, adopting a stress-management practice
• Women receiving health risk lifestyle assessment, identifying change to make, completing check-in
Priority No. 2: Alignment with Community Health Improvement Plan
focus on behavioral health

Target population
Residents of Milwaukee County

Principal partners
• Aurora Health Care Medical Group (AHCMG)
• Aurora Behavioral Health Services (ABHS)

Community partners
Milwaukee Health Care Partnership (MHCP)

Impact goal
All patients who present in our ED needing behavioral health services are identified and referred to appropriate care

Current findings
Mental health and alcohol and other drug use (behavioral health) ranked among the top five health issues for Milwaukee County key stakeholders. In 2018, 28% of Milwaukee County adults reported a mental health condition (such as depression, anxiety disorder or post-traumatic stress disorder), as did 26% of City of Milwaukee residents and 17% of Franklin/Greendale/Greenfield/Hales Corners residents. Additionally, 32% of Milwaukee County residents reported binge drinking in the past month, along with 35% of City of Milwaukee residents and 37% of Franklin/Greendale/Greenfield/Hales Corners residents (Source #1). When compared to other Wisconsin counties, both the 2015-2017 age-adjusted ED rate due to substance use (42.6 per 100,000 population) and age-adjusted hospitalization rate due to substance use (21.3 per 100,000 population) in Milwaukee County is in the least-favorable quartile (Source #2).

Our strategy
For our patients
• Provide counseling with a team led by a bilingual PhD psychologist and four counseling students at Aurora Walker’s Point Community Clinic, as described on page 4
• NEW: Participate in the Zero Suicide initiative in both our ED and primary care settings, predicated upon a commitment by healthcare leaders to:
  – Make suicide a “never” event so that not one person dies alone and in despair
  – Promote a just culture where caring, competent, and confident staff are supported to continuously improve and learn together
  – Keep patients actively engaged and supported to talk about suicide and despair, rediscover hope, and find ways to thrive

MEASURES, number of:
• Individuals screened through Zero Suicide initiative; caring contacts made

For our community
• NEW: Through the MHCP and in response to the lack of a psychiatric Emergency Department within Milwaukee County, provide leadership on the Behavioral Health Provider group dedicated to increasing inpatient and outpatient behavioral health care capacity and psychiatric crisis center planning
• NEW: Provide a drug take-back box in our front lobby, enabling community members to safely and securely discard unwanted opioid and other prescriptions, reducing their availability within the community

MEASURES:
• Process milestones in expanding service and participation in MHCP Behavioral Health Provider Group
• Pounds of medication collected
Priority No. 3:  
Alignment with Community Strategy focus on social determinants of health – community safety

**Current findings**  
The chronic stress associated with living in unsafe neighborhoods can accelerate aging and harm health. Unsafe neighborhoods can cause anxiety, depression, and stress, and are linked to higher rates of pre-term births and low birthweight babies, even when income is accounted for. Fear of violence can keep people indoors, away from neighbors, exercise, and healthy foods. Companies may be less willing to invest in unsafe neighborhoods, making jobs harder to find.¹ In 2018, 16% of City of Milwaukee residents reported having at least one safety issue in the past year (afraid for their personal safety, pushed, kicked, slapped or hit) (Source #1). The rate of rape for Milwaukee County was 34.55 per 100,000 in 2017, higher than the state rate of 25.36 per 100,000.²

**Our strategy**  
For our community

- NEW: Team up with the Violence-Free West Allis Collaborative, a translation of the Cardiff Violence Prevention Model, aimed at developing a clearer picture about where violence is occurring in neighborhoods common to each of our hospitals. This will include providing data to be combined and mapped along with other hospital and police data on violence

**MEASURES:**
- Process milestones

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Priority No. 3:
Alignment with Community Strategy focus on social determinants of health – workforce development

Current findings
A steady job in favorable working conditions means more than just a paycheck. Employment can also mean a link to health insurance benefits for a family, the ability to pay for childcare services or education, and the opportunity to purchase healthy, nutritious food. Unemployment, on the other hand, can lead to negative health outcomes such as a decline in one’s ability to access care for themselves or their family members, development of depression or other behavioral health issues, or an inability to pay for basic living expenses. Employment can also affect health if one’s working conditions are unsafe or if wages are not at a level that sustains one’s living expenses.  

In 2018, the average unemployment rate in Milwaukee County was 6.35%, with a rate as high as 19.71% in the City of Milwaukee.  

Our strategy
For our community

• NEW: Hold on-site job fairs and participate in off-site job fairs to recruit and hire community residents for entry-level positions
• NEW: Provide paid training programs for nursing assistant, medical assistant, and phlebotomist positions, with the goal of hiring trained individuals into permanent employment
• NEW: In partnership with the DWD and MATC, offer paid Culinary Registered Apprenticeship and Facilities Maintenance Technician Registered Apprenticeship positions. These full-time paid, benefit eligible positions equip participants with both on-the-job training and instruction through MATC, resulting in a technical diploma
• NEW: Through the NAVIGATE program, provide team members in entry-level or middle-skilled positions (CNAs, food services, transporters, environmental services, etc.) with soft-skills workshops, mentorship, and career coaching and development designed to help them advance into higher-level positions
• NEW: Place two individuals with cognitive and physical barriers in internships at our hospital through the Temporary Work Experience internship program, in partnership with AMCS and DVR. The 90-day internship is intended to give job seekers first-hand, paid experience on job duties, role expectations, and workplace culture. At the end of the internship, a review takes place with the goal of hiring the intern into a permanent position as an Advocate Aurora team member. Interns have the support of an assigned job coach from our hospital who stays with them throughout the duration of the internship and works with them to develop an individual plan and transitional steps to meet job role expectations
• NEW: Provide Nursing Assistant training positions to Carmen High School students
• NEW: Provide work-study positions for students from Cristo Rey Jesuit High School

MEASURES, number of:

• Job fairs held and attended; offers made and individuals hired
• Individuals trained and hired, by position
• Individuals completing an apprenticeship
• Team members participating in NAVIGATE; advancement outcomes
• Interns placed and hired
• Students trained as nursing assistants
• Cristo Rey students participating

Target population
Residents of Milwaukee County

Principal partners
• Aurora Health Care Medical Group (AHCMG)
• Aurora Medical Center Summit (AMCS)

Community partners
• Wisconsin Division of Vocational Rehabilitation (DVR)
• Wisconsin Department of Workforce Development (DWD)
• Milwaukee Area Technical College (MATC)
• Carmen High School
• Cristo Rey Jesuit High School

Impact goal
Increased opportunities for stable employment

4 Health Compass Milwaukee. Available at http://www.healthcompassmilwaukee.org/indicators/index/indicatorsearch?doSearch=1&grouping=1&subgrouping=2&ordering=1&resultsPerPage=150&i=3140_281327_281325_281335&showSubgroups=0&showOnlySelectedSubgroups=1&primaryTopicOnly=&sortcomp=0&sortcompIncludeMissing=0&showOnlySelectedComparisons=1&showComparisons=1&i=520&handpicked=1&requireSubgroups=0&handpickedItems%5B0%5D=520&card=0. Accessed May 13, 2019.
Priority No. 3: Alignment with Community Strategy focus on social determinants of health – Coronavirus/COVID-19 Pandemic Response

Target population
Milwaukee County Residents

Principal partners
• Aurora Health Care Medical Group (AHCMG)
• ACL Laboratories

Community partners
• Wisconsin Department of Health Services
• City of Milwaukee Health Department
• Local Federally Qualified Health Centers, Free Clinics and other local organizations addressing health inequities and social determinants of health exacerbated by the COVID-19 pandemic.

Impact goal
Increase the amount of outreach and education resources available to Milwaukee County residents during the COVID-19 pandemic.

Current findings
On April 4, 2020, Governor Tony Evers declared all counties in the State of Wisconsin as a disaster area in response to the outbreak of COVID-19. Since then, cases have been reported in every county in the Advocate Aurora Health (AAH) Wisconsin service area. AAH has implemented several initiatives aimed at increasing the amount of available outreach and education resources in Wisconsin during the Coronavirus/COVID-19 pandemic.

Our strategy
For our patients
• NEW: Test patients scheduled for elective procedures as supplies allow
• NEW: Provide increased number of virtual and telephone visits in order to provide necessary care for patients while minimizing the transmission risk of COVID-19
• NEW: Launch the Safe Care Promise, which includes extra steps we are taking to keep our patients, visitors and team members safe. This includes virtual check-ins, universal masking and screening for all who enter our locations, encouraging social distancing through rearranged furniture and staggering appointment times, and enhanced cleaning in all areas, including additional disinfectant for high-touch spaces.

MEASURES:
• Process milestones to establish testing for hospital patients
• Number of patients tested within our hospital
• Number of virtual and telephone visits provided

For our community
• NEW: Increase community member access to reliable COVID-19 information with our system-wide COVID-19 Resource Center
  – Online Symptom Checker
  – COVID-19 Symptom Checker Hotline (866) 443-2584
• NEW: Provide education to community members and local organizations to help them update operations in response to the COVID-19 pandemic so they may continue to provide services safely
• NEW: Collaborate with appropriate community partners to increase access to community testing

MEASURES:
• Number of community organizations our team members work with to update operations
• Process milestones related to establishing or increasing local community testing

Note: Plans to address selected priorities are dependent upon resources and may be adjusted on an annual basis to best address the health needs of our community during the COVID-19 pandemic.