Aurora Memorial Hospital Burlington
Update for 2015
Posted: December 31, 2014
Aurora Memorial Hospital Burlington (AMHB) Implementation Strategy

Update for 2015

In 2013, AMHB 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 December 19, 2013 and posted to Aurora Health Care web site. That 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.

Our AMHB implementation strategy is organized into three main categories in alignment with three core principles of community benefit as shown below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Community Benefit Core Principle</th>
<th>Focus area</th>
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<tbody>
<tr>
<td><strong>Priority #1: Access</strong></td>
<td>Access for persons in our community with disproportionate unmet health needs</td>
<td>• Access (including mental health)</td>
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<td></td>
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<td>• Health care coverage</td>
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<tr>
<td><strong>Priority #2: Community Health Improvement</strong></td>
<td>Build links between our clinical services and local health department community health improvement plan</td>
<td>• Alcohol and drug use</td>
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<td>• High blood pressure and overweight/obesity</td>
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<td><strong>Priority #3: Community Benefit Hospital Focus</strong></td>
<td>Address the underlying causes of persistent health problems</td>
<td>• Senior care and chronic disease</td>
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<td>• Sexual assault</td>
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Note: In 2014 mental health was not a focus area within the implementation strategy. With the guidance from Aurora Behavioral Health Services and alignment of resources, mental health is now included in 2015.

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.

Significant health needs/issues not specifically addressed in our implementation strategy and the reason:

The implementation strategy does not include specific strategies for high cholesterol, tobacco use, nutrition, physical activity and injury prevention since these are part of the standard continuum of clinical care at Aurora Memorial Hospital of Burlington (AMHB) and Aurora Health Care Medical Group clinics except for what is covered in our focus on overweight/obesity (Priority #2). Although dental care is a significant health issue, our hospital does not have the resources to directly address this community health issue. Racine Community Health Center and Health Care Network provides dental services to children and adults without insurance or those who have limited access to dental care.

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.
**Implementation Strategy**

**Priority No. 1: Access**

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

Based on the 2012 western Racine County Community Health Survey, 11% of adult respondents reported unmet dental care, 8% reported someone in their household had not taken their prescribed medication due to cost, and 6% of adults reported unmet medical care in the last 12 months.

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

**Community partners**
- Health Care Network (HCN) - A non-profit agency providing free or low-cost medical care and pharmaceutical assistance to residents of Racine County who are medically uninsured and have a limited income. Services are provided at the HCN office, Waterford Clinic and throughout the County by health care professionals who volunteer their time, offices and skills.

**Target population**
- Low-income residents of Racine County who are uninsured

**Intended impact**
- An increase in medical home capacity and utilization by underserved populations, low-income individuals who are uninsured
- Low-income, uninsured individuals seeking primary and dental health care and all persons seeking mental health services in our ED will
  - Understand the benefits of obtaining primary care services in a medical home
  - Successfully transition to HCN and AHCMG physicians for primary care
  - Receive appropriate referrals for behavioral health services
  - Obtain affordable health insurance coverage
- Health Care Network branch at the Waterford Clinic is established

**Measures to evaluate impact**
- Number of patients referred from our hospital ED to primary care provider or HCN
  - Number of primary care appointments scheduled
- Number of non-emergent ED visits without a primary care physician (compare to 2014 baseline data)
- 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 (compare to 2014 baseline data)
- Number of HCN vouchers issued and utilized
- Number of uninsured patients screened and enrolled in financial assistance programs (e.g., Aurora’s Helping Hand Patient Financial Assistance program) or the Marketplace (the health insurance exchange)
- Number of ED behavioral health intake screenings

**Action plan** (see next page)
### Priority No. 1: Access

**Implementation Strategy**

<table>
<thead>
<tr>
<th>Action plan</th>
<th>Ongoing</th>
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<tbody>
<tr>
<td><strong>Ensure appropriate follow-up services for low-income, uninsured patients using our hospital Emergency Department (ED) to receive primary care and behavioral health:</strong></td>
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<tr>
<td>• Strengthen our linkage and referral system between our hospital ED and the Health Care Network (HCN)</td>
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<tr>
<td>• Ensure access (navigation and care coordination) to HCN and AHCMG and understanding of benefits of primary and preventive care by establishing a medical home with HCN or an AHCMG physician</td>
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<td>• Ensure literature about HCN is available in our ED, walk-in clinics and distributed to local churches</td>
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<tr>
<td>• Accept HCN vouchers for eligible diagnostic lab and radiology services for HCN-referred patients</td>
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<td>• Refer HCN patients needing specialty care to AHCMG physicians</td>
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<tr>
<td>• Establish a branch site for HCN at our Waterford Clinic</td>
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<tr>
<td>• Initiate behavioral health intake screenings in our ED</td>
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<td>• Expedite appropriate referrals, including Aurora Behavioral Health Services</td>
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<td><strong>Increase capacity of HCN to serve low-income, uninsured populations:</strong></td>
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<tr>
<td>• Support our physicians and caregivers who provide in-kind services to HCN patients</td>
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<tr>
<td>• Support development efforts that expand the capacity of HCN</td>
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<td><strong>Improve coverage for low-income, uninsured patients using our ED for primary care:</strong></td>
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<tr>
<td>• Actively screen 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</td>
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<tr>
<td>• Through our specially trained financial advocates, inform and educate all uninsured patients about the benefits of securing coverage through the Marketplace (the health insurance exchange) and assist those who need help</td>
<td>During open enrollment</td>
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</table>
Focus | Alcohol and drug use in our community

Based on the 2012 Western Racine County Community Health Survey, alcohol and drug use was one of the top three community health issues reported by adult respondents.

Based on the key informant interview findings, alcohol and drug use emerged as one of the top five health issues for Racine County (ranked #1).

Principal partners
- Aurora Behavioral Health Services
- Aurora Health Care Medical Group
- Aurora Pharmacy

Community partners
- Area schools
- Emergency Medical Services (EMS) providers
- Racine County Youth Coalition
- Law enforcement agencies

Target population
- Teens in western Racine County school systems
- Western Racine County residents

Intended impact
- Raised awareness of alcohol and drug use and abuse in western Racine County schools
- Improved knowledge among EMS providers about appropriate response for heroin use

Measures to evaluate impact
- Number of programs held in western Racine County on alcohol and drug awareness
- Number of EMS providers attending training session(s)
- Contracts with local Law Enforcement for Narcan administration oversight

Action plan

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<tr>
<th>Increase awareness and decrease injuries resulting from alcohol and drug use:</th>
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<tr>
<td>Partner with Racine County Youth Coalition to offer alcohol and drug awareness programming and assist with program development</td>
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<tr>
<td>Support the training of local EMS providers and first responders to current heroin use to facilitate appropriate early response, in partnership with our EMS coordinator</td>
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<tr>
<td>Provide medical oversight and training to law enforcement agencies for Narcan administration</td>
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Ongoing
Implementation Strategy

Priority No. 2: Community Health Improvement

Focus | High blood pressure and overweight/obesity

Based on the 2012 Western Racine County Community Health Survey, 27% of adult respondents reported high blood pressure in the past three years and 69% of adult respondents were classified as being overweight or obese.

As outlined by the Centers for Disease Control and Prevention, overweight and obesity can increase the risk for high blood pressure, high cholesterol levels, coronary heart disease, type 2 diabetes, stroke, some cancers and other health conditions. High blood pressure is a risk factor for heart disease and stroke.

Principal partners
- Aurora Health Care Medical Group clinics
- Aurora Wellness Center

Target population
- Western Racine County residents

Intended impact
- Increased community awareness about the importance of knowing blood pressure, cholesterol levels and BMI
- Linkage to information and referrals to lose or maintain weight, lower or maintain blood pressure and cholesterol levels

Measures to evaluate intended impact
- Number of individuals screened at community events
  - Percent with high blood pressure
  - Percent of individuals classified as overweight or obese
  - Percent of individuals first learning they have high blood pressure
- Number of free drop-in blood pressure screenings
  - Percent with high blood pressure
  - Number of referrals to provider for high blood pressure management
- Number of information packets distributed on healthy weight/weight loss, blood pressure and cholesterol

Action plan

<table>
<thead>
<tr>
<th>Raise awareness about high blood pressure, high blood cholesterol, and/or being overweight and the link to chronic diseases:</th>
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<tr>
<td>• Offer free screenings for blood pressure, and Body Mass Index (BMI) at community events</td>
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<tr>
<td>• Provide educational information on blood pressure, cholesterol and overweight/obesity at a variety of community events and locations</td>
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<tr>
<td>• Provide free drop-in blood pressure screenings at Aurora Health Care Medical Group clinics</td>
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<td>• Post free blood pressure screening dates and locations in clinics</td>
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Focus | Senior care and chronic disease

Based on the 2012 Western Racine County Community Health Survey, respondents 65 years and older were more likely to report high blood pressure, diabetes and heart disease or a heart condition. 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.

According to the Centers for Disease Control and Prevention, Advance Directives provide the opportunity to give family members peace of mind that they will know what to do on behalf of their loved one, should the need arise, and also helps the patient’s health care team make treatment decisions that reflect the patient’s preference and values.

Aurora’s Senior Resource Nurse (SRN) program 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. It was implemented in our service area in 2007.

Principal partners
- Aurora Health Care Medical Group (AHCMG) Senior Resource Nurse (SRN) program
- Aurora’s Acute Care for the Elderly ACE Tracker: A daily snapshot (accurate as of the midnight census from 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.

Community partners
- Alzheimer Association
- Behavioral and crisis centers
- Racine County Aging and Disability Resource Center (ADRC)
- Intervention services
- Local charitable agencies
- Local law enforcement
- Local skilled nursing facilities
- Nutritional centers

Target population
- Frail older adults with multiple health conditions and challenges
- Individuals with chronic conditions
- Indigent, under-served, under-insured aging population
- Behavioral health patients in crisis or at risk

Intended impact
- A reduction in unnecessary and traumatic hospital re-admissions for at-risk frail older adults with chronic conditions, co-morbidities
- Frail older adult patients with chronic conditions at-risk for hospital admission/re-admission are connected to resources to achieve better outcomes and optimal lifestyle independence

Action plan (see next page)
Implementation Strategy

Priority No. 3: Community Benefit Hospital Focus

Measures to evaluate impact

To continually monitor the impact of the SRN program, the following data will be tracked on a monthly basis:

- Number of seniors served
- Number of successful responses to care management initiatives: pneumonia, heart failure, MI, stroke, COPD
- Number of interventions for dementia and delirium
- Collect discharge plan data for hip and knee replacement to promote shortened hospital stay and reduction of readmission
- Total referrals (by category; e.g. home assessments, resource option counseling; in-patient high risk transitional calls)
- Number of Advance Directives (Power of Attorney) on file
- Hospital re-admissions for frail elderly individuals 65 and older
- Number of Stepping On classes held and seniors attending
- Number of Living Well with Chronic Conditions classes held and seniors attending
- Number of Powerful Tools for Caregivers classes held and seniors attending
- Number of Strong Women classes held and individuals attending

Action plan

Ensure a continuum of patient-centered, community based care for our older adult population with multiple chronic conditions:

- Assure that frail elderly persons referred to our Senior Resource Nurse 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
  - Home safety and assessment for placement needs
  - Transportation needs for follow-up care

- Provide patient’s family with navigational strategies and education for:
  - Advance Directives (Power of Attorney)
  - Caregiver guidance and support resources
  - Medication management, safety
  - End-of-life treatment and care options
  - Transportation and supportive resources in the home

- Expand community awareness of special needs of frail elderly through outreach services including:
  - Community health screenings and education for early detection and intervention
  - Participate in local coalitions and agencies for at-risk elderly
  - Professional education to community based agencies and law enforcement

- Collaborate with community partners to offer the following programs to increase health, safety and independence for seniors in the community: Stepping On, Living Well with Chronic Conditions, Powerful Tools for the Caregiver, and Strong Women
Implementation Strategy

Priority No. 3: Community Benefit Hospital Focus

Focus I Sexual assault

Sexual assault can have harmful and lasting consequences for victims, families, and communities including, but not limited to, long term physical consequences, immediate and chronic psychological consequences, health behavior risks, and financial cost to victims, families and communities.

Aurora’s Sexual Assault Nurse Examiner (SANE) program offers trauma-informed and victim-sensitive services to people of all ages who have been affected. Our SANE nurses complete specialized training and receive certification to be a sexual assault nurse examiner and provide 24/7 coverage for three Aurora hospitals (ours and one each in neighboring counties).

Principal partner
- Aurora Health Care Medical Group (AHCMG) physicians, nurse practitioners and care providers

Community partners
- Child Advocacy Centers of Wisconsin
- Child Protective Services/Adult Protective Services
- County District Attorney’s office in Racine
- End Domestic Abuse Wisconsin (used to be Wisconsin Coalition Against Domestic Violence)
- Jockey International
- Local law enforcement
- Sexual Assault Services of Racine
- State and local agencies including the Association of Prevention of Family Violence, Women’s Resource Center and the Statewide Attorney General’s Sexual Assault Response Team (SART)
- WCASA (Wisconsin Coalition Against Sexual Assault)
- WI-IAFN Wisconsin Chapter International Association of Forensic Nurses

Target population
- Individuals who have been sexually assaulted

Intended impact
- Awareness of, and access to, services, resources and advocacy for those who have been sexually assaulted

Measures to evaluate impact
- Number of people provided with services and medical care related to sexual assault
- Number of community education/prevention/outreach trainings and attendance
- Number of scheduled on-call hours

Action plan

Support victims of sexual assault and violence:
- Provide 24/7, trauma-informed coverage to victims through our Sexual Assault Nurse Examiner program
- Provide sensitive, effective forensic evidence collection
- Refer victims of sexual assault to AHCMG providers for needed follow-up clinical and medical services

Advance knowledge and the capacity of the broader community to respond to issues related to sexual assault and personal violence:
- Partner with area high schools to provide resources for prevention of sexual assault
- Serve as faculty for the Wisconsin Department of Justice
- Provide specialized health education to AHCMG and hospital staff, high schools, law enforcement and community agencies, and education on sexual assault
- Serve on local, county and state coalitions and Sexual Assault Response Teams