Aurora Memorial Hospital of Burlington 2017 Implementation Strategy Update

In 2013, Aurora Memorial Hospital of Burlington (AMHB) completed its first Community Health Needs Assessment (CHNA) Report and 2014 Implementation Strategy, which was adopted by the Social Responsibility Committee of the Aurora Health Care (AHC) Board of Directors on November 22, 2013, and published to the AHC web site.

In 2015, AMHB completed and published a second CHNA Report with a three-year (2016-2018) Implementation Strategy, which was adopted by the Social Responsibility Committee of the AHC Board of Directors on November 17, 2015, and posted to AHC web site. Each CHNA Report provides a comprehensive overview of the community served and significant health needs identified and is available by visiting http://www.aurora.org/commbenefits.

Every year, experience in carrying out the implementation strategy informs the process of updating it for the succeeding year. As previously, our AMHB implementation strategy is organized into three main categories in alignment with three core principles of community benefit as shown below.

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<tr>
<th>Category</th>
<th>Community Benefit Core Principle</th>
<th>Focus area</th>
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<tr>
<td>Priority #1: Access</td>
<td>Access for persons in our community with disproportionate unmet health needs</td>
<td>• Access (including dental and mental health)</td>
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<td></td>
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<td>• Health care coverage</td>
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<tr>
<td>Priority #2: Community Health Improvement</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></td>
<td>• High blood pressure and the link to chronic disease; cancer</td>
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<tr>
<td>Priority #3: Community Benefit Hospital Focus</td>
<td>Address the underlying causes of persistent health problems</td>
<td>• Senior care: chronic disease and fall prevention</td>
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<td>• Sexual assault</td>
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<td></td>
<td></td>
<td>• Newborn health and safety</td>
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<tr>
<td></td>
<td></td>
<td>• Hepatitis C</td>
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</tbody>
</table>

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 programming in areas including women’s health and cancer care, greatly expanding the scope of options, opportunities and expertise we can offer to our patients in settings across Racine County. When this is the case, you will find the designation [IHCS] with measures reflecting regional and/or system-wide targets and tracking 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. 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.

Significant health needs/issues not specifically addressed in our implementation strategy and the reason:
Except for what is covered in our focus on overweight/obesity (Priority #2), the implementation strategy does not include specific strategies for high cholesterol, tobacco use, nutrition, physical activity and injury prevention, as these are part of the standard continuum of clinical care at Aurora Memorial Hospital of Burlington (AMHB) and Aurora Health Care Medical Group clinics.
Note: Our implementation strategies do not constitute the entirety of the community benefits our hospital provides each year. For an annual accounting of the community benefits we provide each year, please see our most recent report: http://www.aurora.org/commbenefits.
Focus | Access is an Aurora Health Care signature community benefit focus

In 2015, 13% of the respondents reported an unmet medical care need in the past 12 months, a significant increase from 6% in 2012. The percentage of adults who receive primary health services through a medical home have decreased from 84% in 2003 to 68% in 2015. Of the households with a child, 3% reported that a child did not receive needed medical care in the past 12 months. While the percentage of children who receive needed medical care meets the Healthy People 2020 goal of 4.2%, the number of individuals with an unmet medical need is increasing (Source #1).

The percentage of respondents with an unmet mental health care need in the past year statistically increased from less than <1% in 2012 to 4% in 2015 (Source #1). The Central Racine County Health Department¹, key informants and residents all identified mental health as one of the top four health issues challenging the community (Sources #1, #3).

In 2015, 17% percent of respondents reported that they did not get the dental care they needed sometime in the last 12 months, trending upward from 11% in 2012. In addition, 11% of the households reported that their child did not receive needed dental care in the past 12 months, an increase from 5% in 2012 (Source #1).

Principal partner
- Aurora Health Care Medical Group (AHCMG)
- Aurora Behavioral Health Services
- Aurora Consolidated Laboratories (ACL)

Community partners
- Health Care Network (HCN) - A non-profit agency providing free or low-cost medical care, dental 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 and skills to administer care in their offices.

Target population
- Uninsured and Medicaid-eligible persons seeking primary care in our hospital Emergency Department (ED)

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<th>Intended Outcomes</th>
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</thead>
<tbody>
<tr>
<td>• Provide appropriate follow-up with non-emergent patients using the ED for primary care</td>
<td>Ongoing</td>
<td>Number of non-emergent ED visits without a primary care physician</td>
<td>Annual volume</td>
<td>Decreased ED admissions for primary care needs</td>
</tr>
<tr>
<td>• Ensure coverage and care for uninsured and Medicaid-eligible patients using our ED for primary and dental care by actively screening patients for coverage through the Marketplace or financial assistance programs and assisting with application processes</td>
<td>Ongoing</td>
<td>Of those ED visits, number who saw an Aurora Health Care primary care provider within 28 days</td>
<td>Annual volume</td>
<td>Increased number of Medicaid-eligible and uninsured patients establish a health home for primary care</td>
</tr>
<tr>
<td>• Refer patients as appropriate to Health Care Network</td>
<td>Ongoing</td>
<td>Number of ED patients referred to HCN</td>
<td>Annual volume</td>
<td></td>
</tr>
<tr>
<td>• Accept vouchers from Health Care Network for eligible diagnostic lab and radiology services</td>
<td>Ongoing</td>
<td>Number of vouchers accepted, by type</td>
<td>Annual volume</td>
<td>Increased number of Medicaid-eligible and uninsured patients with access to diagnostic lab and radiology services</td>
</tr>
<tr>
<td>• Provide Behavioral Health coordinator in our ED to assess and appropriately expedite referrals for behavioral health services</td>
<td>Ongoing</td>
<td>Number of ED patients assessed for behavioral health services; number referred</td>
<td>Annual volume</td>
<td>Increased access to behavioral health services</td>
</tr>
<tr>
<td>• Through Aurora Health Care Better Together Fund grant:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• support new basic behavioral health services including licensed clinical supervisor and language service at Health Care Network</td>
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</tbody>
</table>
Focus | Alcohol and drug use in our community

In 2015, 37% of adults reported binge drinking in the past month, a sharply significant increase from 2003 (15%), and higher compared to the state (22.8%) and the United States (17%). Two percent indicated that they drove or rode in a vehicle when the driver had too much to drink (Source #1). Excessive drinking reflects the percent of adults who report either binge drinking or heavy drinking.

Prescription drug misuse is escalating statewide. In Racine County, the rate of opiate-related deaths was 8.7 per 100,000 in 2013, higher than the state average of 5.3 deaths per 100,000 population. When combined with all other sedative-related deaths, Racine County exceeded the Wisconsin rate (21.0 deaths per 100,000 population and 13.6 deaths per 100,000, respectively).

The Central Racine County Health Department, key informants and residents all identified alcohol and drug use/abuse as one of the top three health issues challenging the community (Sources #1 and #3).

Principal partners
- Aurora Health Care Medical Group (AHCMEG)
- Aurora Behavioral Health Services
- Aurora Psychiatric Hospital
- Aurora Pharmacies

Community partners
- Emergency Medical Services (EMS) providers
- Law enforcement agencies

Target population
- Racine County residents

Activities

<table>
<thead>
<tr>
<th>Time Frame</th>
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<th>Intended Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>Provide training to EMS agencies and quarterly continuing education</td>
<td>Number of trainings provided</td>
<td>Annual volume</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Number of individuals trained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Provide medical oversight and training to law enforcement for Narcan administration</td>
<td>Number of contracts established with local law enforcement for Narcan administration oversight</td>
<td>Annual volume</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Number of law enforcement trainings on Narcan administration and numbers trained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Screen for alcohol use as a cause for falls and injuries presented in our hospital ED when indicated</td>
<td>Number of individuals screened</td>
<td>Annual volume</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Refer ED patients to drug and alcohol programs when indicated</td>
<td>Number of referrals made</td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Support and actively engage in local drug Take-Back programs and activities</td>
<td>Number of community Take-Back initiatives</td>
<td>Annual volume</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Number of pounds of drugs collected</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Implementation Strategy**

**Priority No. 2: Community Health Improvement**

**Focus | High blood pressure and obesity and the link to chronic disease; cancer**

Based on the 2015 Central Racine County Community Health Survey, 31% of adults reported high blood pressure in the past 3 years, a statistically significant increase from 21% in 2003 (Source #1).

In 2015, 9% of adults reported diabetes in the past three years, up slightly from 6% in 2003 (Source #1). Diabetes can cause serious health complications including heart disease, blindness, kidney failure and lower-extremity amputations.\(^2\)

Key informants and residents identified chronic diseases as one of the top four health issues challenging the community (Sources #1, #3).

**Principal partner**
- Aurora Health Care Medical Group (AHCMG)
- Aurora Wellness

**Target population**
- Central Racine County residents

**Activities**

<table>
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<tr>
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<th>Targets/Tracking</th>
<th>Intended Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>Number of community-based screenings</td>
<td>Annual volume</td>
<td>Increased knowledge of blood pressure and Body Mass Index (BMI) in the broader population</td>
</tr>
<tr>
<td></td>
<td>Number of individuals screened, number with high blood pressure or classified as overweight/obese</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of individuals screened who are currently being treated for high blood pressure, number with first-time high reading</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of individuals screened who report a behavior change as a result of screening, by change</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of information packets distributed on blood pressure and healthy weight/weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of free drop-in blood pressure screenings provided</td>
<td>Annual volume</td>
<td>Improved access to screening and referrals to lower or maintain blood pressure</td>
</tr>
<tr>
<td></td>
<td>Number of participants</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of referrals to provider for high blood pressure management</td>
<td></td>
<td></td>
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</tbody>
</table>

Focus | Senior care: chronic disease and fall prevention

According to the Central Racine County Health Survey, respondents who were 65 and older were more likely to report high blood pressure and high blood cholesterol. In addition, respondents who were aged 65 years and older were more likely to report heart disease/condition (Source #1). The key informants and residents identified chronic diseases as one of the top four health issues challenging the community (Sources #1, #3).

In 2013, the total number of injury emergency room visits among Racine County adults aged 65 years and older was 1,870, which is a rate of 6,723.0 per 100,000, higher than the state rate of 6,376.2 per 100,000. Also in 2013, the total number of injury emergency room visits due to falls among Racine County adults aged 75-79 years was 207 – a rate of 4,323.3 per 100,000. For Racine County adults aged 85+ years, the total number of injury emergency room visits due to falls was 403 – a rate of 10,140.9 per 100,000. (Source #2)

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 partner
- Aurora Health Care Medical Group (AHCMG)

Community partners
- Alzheimer’s Association
- Behavioral health and crisis centers
- Racine County Aging and Disability Resource Center (ADRC)
- Local charitable agencies
- Local law enforcement
- Local skilled nursing facilities
- Area meal sites and food pantries

Target population
- Individuals aged 65 years and older, or with multiple health conditions

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<tbody>
<tr>
<td>Ongoing</td>
<td>Number of seniors served</td>
<td>Annual volume</td>
<td>A reduction in traumatic hospital re-admissions for at-risk older adults with chronic conditions, co-morbidities</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Number of referrals and services provided, by type</td>
<td>Annual volume</td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Number of patient education services or consults provided, by type</td>
<td>Annual volume</td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Number of patients completing Advance Directives</td>
<td>Annual volume</td>
<td></td>
</tr>
<tr>
<td><strong>Provide community education programs, Stepping On and Healthy Living with Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Number of Stepping On sessions provided annually</td>
<td>2</td>
<td>Patients with chronic conditions are connected to resources to achieve better outcomes and optimal lifestyle independence</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Number of attendees</td>
<td>Annual results</td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Number of Healthy Living with Diabetes sessions provided annually</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Number of attendees</td>
<td>Annual results</td>
<td></td>
</tr>
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</table>
Focus | Sexual assault

The rate of rape for Racine County was 20.0 reports per 100,000 persons, slightly lower than Wisconsin’s overall rate of 21.0 per 100,000 in 2012.\(^3\) 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. The Central Racine County Health Department\(^4\), key informants and residents all identified violence/abuse/neglect as one of the top three health issues challenging the community (Sources #1, #3).

Within Aurora’s system-wide Sexual Assault Nurse Examiner (SANE) program and Abuse Response Services, Aurora’s (SANE) program at AMHB offers trauma-informed and victim-sensitive services to people of all ages who have been affected. Our SANE nurses complete specialized training and certification to be designated a sexual assault nurse examiner and provide 24/7 coverage at two Aurora hospitals, in both Racine and Walworth Counties, where service numbers doubled in 2015.

Principal partner
• Aurora Health Care Medical Group (AHCMG)

Community partners
• Area high schools
• 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)
• 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)
• Wisconsin Coalition Against Sexual Assault (WCASA)
• Wisconsin Chapter International Association of Forensic Nurses (WI-IAFN)
• Racine County Child Death Review (CDR) Team

Target population
• Individuals who have been sexually assaulted

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</table>
| Ongoing    | - Provide trauma-informed and victim-sensitive services to people of all ages who have been affected, including forensic evidence collection, through 24/7 coverage  
- Provide SDFI®-TeleMedicine forensic photodocumentation based on and designed around the Federal Rules of Evidence  
- Refer as appropriate to medical, clinical, counseling and advocacy services | Number of individuals provided with services for sexual assault  
Number of post-assault care management services provided, by level  
Number of referrals provided, by type  
Number of personal advocacy and liaison services provided, by type  
Number of scheduled on-call hours  
Number of community education/prevention/outreach trainings, number of attendees | Annual volume | - Increased access to trauma-informed care and forensic nursing  
- Increase in reported and/or prosecuted cases  
Increased community knowledge of available resources |
Focus | Newborn health and safety

First Trimester Care
In 2014, 56.6% of Hispanic mothers and 52.5% of African American mothers in Racine County accessed first trimester prenatal care, lower than White mothers at 76.7% and lower than the Healthy People 2020 goal of 77.9%. Early prenatal care can provide essential information to the mother and direct changes for nutrition-related and behavioral risk factors affecting the mother and baby. Women who delay or do not receive prenatal care are at risk of having undetected complications, sometimes resulting in death.

Babysitting
Parents often allow adolescent babysitters to care for their children. Research has shown that approximately 60% of 14- and 15-year-olds have worked as babysitters during the previous year, while approximately 56% of 13-year-olds have worked as babysitters. Since infants and children who are under the care of adolescent babysitters may become ill or be unintentionally injured, it is important to train babysitters to be prepared for such situations.

Principal partner
- Aurora Health Care Medical Group (AHCMG)

Community partners
- Hispanic Access Foundation

Target population
- Families of infants born in our communities

Activities

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<tbody>
<tr>
<td>By 12-31-17</td>
<td>Milestones related to strategy development</td>
<td>Deadlines</td>
<td>Strategy in place for 2018-2020 execution</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Number of babysitting classes offered, number of participants</td>
<td>Annual volume</td>
<td>Increased ability among babysitters to provide safe, appropriate care</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Results of pre- and post-tests measuring knowledge gained</td>
<td>Annual results</td>
<td></td>
</tr>
</tbody>
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Implementation Strategy

Priority No. 3: Community Benefit Hospital Focus

Focus | Hepatitis C Program

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, so there likely were even more hepatitis C-related deaths than reported.

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.9

In 2014, according to the Wisconsin Division of Public Health:10
- 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 partners
- Aurora Health Care Medical Group (AHCMG)

Community partner
- AIDS Resource Center of Wisconsin

Target population
- Adults born from 1945 to 1965 residing in the Burlington & Walworth service area
- Patients who self-identify for other factors*

System Activities – Hepatitis C

<table>
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<tr>
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<th>Measures to Evaluate</th>
<th>Activities</th>
<th>Long-term Outcomes</th>
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</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td>Data collected regionally as part of Aurora Health Care Burlington &amp; Walworth service area</td>
<td>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</td>
<td>Decreased burden of hepatitis C in our communities Decrease in rates of cirrhosis and liver cancer in our patient population over time</td>
</tr>
</tbody>
</table>

* 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