Aurora St. Luke’s Medical Center
Update for 2016
Posted: December 31, 2015
Executive Summary

Aurora St. Luke’s Medical Center (ASLMC) is Aurora’s flagship quaternary hospital and is internationally known for its expertise in heart care, the site of the majority of Aurora’s clinical research, home to the second-largest hyperbaric chamber in the world and a biorepository called ORBIT that is open to researchers around the world, streamlining medical research and discovery.

In 2013 ASLMC 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 November 22, 2013 and posted to Aurora Health Care web site. This 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 and 2015 Implementation Strategy informed the process for updating it for 2016.

It should be noted that addressing the social determinants of health to promote healthier communities requires more effort than can be carried out by one hospital alone. ASLMC is fortunate to be one of five Aurora hospitals located in Milwaukee County, working together and in concert with other providers and organizations within the county to address significant community health needs on a global level. The chart below represents the ongoing multi-stakeholder initiatives of which ASLMC is both directly and indirectly a part:

<table>
<thead>
<tr>
<th>Prioritized significant needs in Milwaukee County</th>
<th>Multi-Partner Initiatives</th>
<th>Milwaukee Health Care Partnership¹</th>
<th>Lifecourse Initiative²</th>
<th>United Way³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care access</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Health insurance coverage</td>
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<td>✓</td>
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<tr>
<td>Behavioral health</td>
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<td>✓</td>
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<tr>
<td>Obesity, nutrition and physical activity</td>
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<tr>
<td>Chronic disease</td>
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<td>✓</td>
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<tr>
<td>Infant mortality</td>
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<td>✓</td>
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<td>Sexual health</td>
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<tr>
<td>Health literacy</td>
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<td>✓</td>
<td>✓</td>
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<td>Poverty</td>
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<td>Racism</td>
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<td>Social determinants</td>
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<tr>
<td>Specialty access for uninsured persons</td>
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<td>✓</td>
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</table>

In addition to the resources dedicated each year to these ongoing initiatives, the ASLMC 2015 Implementation Strategy outlined specific priorities to work within its neighboring communities in Milwaukee County and with the hospital’s unique patient population. That work continues in 2016.

¹ The Milwaukee Health Care Partnership is a public/private consortium dedicated to improving health care coverage, access and care coordination for underserved populations in Milwaukee County. View http://mkehcp.org/
³ For United Way of Greater Milwaukee initiatives, view http://www.unitedwaymilwaukee.org/home
Implementation Strategy

ASLMC 2016 Implementation Strategy: Introduction
As in 2015, our 2016 ASLMC 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>
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<tbody>
<tr>
<td>Priority #1: Access and Coverage</td>
<td>• Access for persons in our community with disproportionate unmet health needs</td>
</tr>
<tr>
<td>Priority #2: Community Health Improvement</td>
<td>• Build links between our clinical services and local health department community health improvement plan</td>
</tr>
<tr>
<td>Priority #3: Community Benefit Hospital Focus</td>
<td>• Address the underlying causes of persistent health problems</td>
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It is widely recognized that a diverse team of engaged community partners is essential for implementing strategic community health improvement initiatives. Our implementation strategy reinforces the importance of our role as a partner for community capacity-building to address unmet community health needs.

The following table itemizes the significant health needs identified in our 2013 Community Health Needs Assessment and how our hospital and health system resources are allocated. The Key:

- I = addressed through our integrated healthcare system and strategic partnerships
- S = standard within the continuum of care
- H = specifically addressed within our hospital’s implementation strategy

<table>
<thead>
<tr>
<th>Significant community health needs/issues identified in the 2013 CHNA Report</th>
<th>Intent to address in the 2016 Implementation Strategy</th>
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<tbody>
<tr>
<td>Access</td>
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<tr>
<td>• medical</td>
<td>H and I</td>
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<tr>
<td>• prescription</td>
<td>H and I</td>
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<tr>
<td>• dental</td>
<td>I</td>
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<tr>
<td>Coverage</td>
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<tr>
<td>• enrollment, health care coverage or financial assistance</td>
<td>H and I</td>
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<tr>
<td>Chronic disease</td>
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<tr>
<td>• asthma</td>
<td>H</td>
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<tr>
<td>• cancer</td>
<td>H and I</td>
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<tr>
<td>• diabetes</td>
<td>H</td>
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<tr>
<td>• heart disease and stroke</td>
<td>H and I</td>
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<tr>
<td>Health risk behaviors</td>
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<tr>
<td>• alcohol use</td>
<td>I and S</td>
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<tr>
<td>• tobacco use</td>
<td>H and I</td>
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<tr>
<td>• nutrition and physical activity</td>
<td>H and I</td>
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<tr>
<td>Health risk factors</td>
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<tr>
<td>• high blood pressure, high cholesterol and overweight/obesity</td>
<td>H and I</td>
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<tr>
<td>Mental health</td>
<td></td>
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<tr>
<td>• Mental health conditions, inpatient and outpatient behavioral health services</td>
<td>H and I</td>
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</tbody>
</table>

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.
Priority No. 1: Access

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

Unmet medical care
- Based on the 2012 Community Health Surveys, adult respondents who reported unmet medical care: 13% of adults in the city of Milwaukee, 12% of adults in the city of Greenfield, 8% of adults in the village of Hales Corners, 4% of adults in the village of Greendale, and 3% of adults in the city of Franklin.

Health care coverage
- Based on the 2012 Community Health Surveys, adult respondents who reported not being covered at least part of the time in the past 12 months: 22% of adults in the city of Milwaukee, 18% of adults in the city of Greenfield, 9% of adults in the village of Hales Corners, 6% of adults in the village of Greendale, and 3% of adults in the city of Franklin.

Principal partners
- Aurora Health Care Medical Group (AHCMG)
- Aurora Walker’s Point Community Clinic (AWPCC), funded by Aurora St. Luke’s Medical Center and operated by Aurora Health Care
- Aurora Behavioral Health Services (ABHS)
- Aurora Consolidated Labs
- Aurora Parish Nurses
- Bread of Healing Clinic

Community partners
- AIDS Resource Center of Wisconsin
- Catholic Charities
- City of Milwaukee Health Department
- CORE/El Centro
- Family Planning Health Services, Inc.
- Free and reduced rate dental clinics
- Milwaukee Health Care Partnership (MHCP) Emergency Department (ED) Care Coordination Initiative
- Milwaukee Public Schools
- Outreach Community Health Center (OCHC; formerly Health Care for the Homeless)
- Penfield Children’s Center
- Salvation Army Clinic
- Sixteenth Street Community Health Center and other Federally Qualified Health Centers
- University of Wisconsin – Milwaukee (UWM) College of Nursing Free Clinic
- Wisconsin Optometric Association

Target populations
- Medicaid-eligible and uninsured patients using our hospital emergency department (ED) for primary care and frequent users of the ED for non-emergent conditions
- Individuals and families who do not have insurance and cannot afford health care, including those experiencing barriers with language and immigration status
- Homeless persons
- Students attending South Division High School
Implementation Strategy

Priority No. 1: Access

Intended impact
- Uninsured and Medicaid-eligible patients are successfully navigated to a health home for primary care, chronic disease management, ophthalmic and dental care
- Uninsured and Medicaid-eligible patients obtain affordable health care coverage and gain increased access to health care providers
- Patients in ED needing behavioral health services receive expedited assessment and referrals
- Increased hospital follow-up visits as the result of primary care redesign
- Decreased hospital readmissions as a result of primary care redesign
- AWPCC serves as entry point to help those who are ineligible for coverage due to immigration status to become established in a “health home” at other community clinics
- A primary care “health home” for adolescents and students who are uninsured, homeless or who experience limitations or barriers to access because of immigration status is established

Measures to evaluate impact
  - Measures include total scheduled appointments, total kept appointments (FQHC only), show rate (FQHC only, percent), number of scheduled appointments by ASLMC with and without text reminders (per month), clinic appointment show rate for ASLMC with and without text reminders (per month), dental referrals
- Number of uninsured and Medicaid-eligible patients transitioned to a health home with AHCMG or one of four FQHCs in Milwaukee County
- 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
- Number of ED patients referred to appropriate levels of behavioral health services
- Patient experience service-impact scores (for primary care redesign)
- Number of patients referred through Aurora’s Specialty Access for Uninsured Program (SAUP)
- Annual AWPCC patient-visit numbers for medical, ophthalmic and behavioral-health services
- Number of students served at South Division High School; number of visits; return to class rates
- Number of uninsured and Medicaid-eligible patients successfully enrolled in the Marketplace

Action plan (see next page)
**Implementation Strategy**

**Priority No. 1: Access**

<table>
<thead>
<tr>
<th>Action Plan</th>
<th>Target Date</th>
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<tbody>
<tr>
<td><strong>Improve access for uninsured and Medicaid-eligible patients using ASLMC’s Emergency Department (ED) for primary and dental care, and those seeking or requiring behavioral health services:</strong></td>
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</tr>
</tbody>
</table>
| - Educate patients of the benefits of receiving routine primary care in a “health home” and refer to:  
  - One of Milwaukee’s four FQHCs  
  - An AHCMG family care practitioner  
  - The Family Practice Center at our hospital or multiple AHCMG community clinics at Aurora Sinai Medical Center                                                                                                                                                                                                                                           |             |
| - Carry out the MHCP Access and Care-coordination program and schedule same-day access:  
  - Provide on-site patient education about medical homes  
  - Schedule primary care and dental appointments to Aurora Walker’s Point Community Clinic (AWPCC), Salvation Army clinic, FQHCs and other community-based clinics using MyHealthDIRECT appointment-scheduling technology while the patient is in the hospital ED  
  - Provide text reminders of upcoming clinic appointments to patients’ personal cell phone                                                                                                                                                                                                                     | Ongoing     |
| - Include our AHCMG specialists in Aurora’s Specialty Access to Uninsured Program (SAUP) through our partnered safety-net medical home clinics for qualified patients (200% of FPL)  
  - AWPCC on Milwaukee’s near south side  
  - Bread of Healing Clinic on Milwaukee’s near north side                                                                                                                                                                                                                                                                                      |             |
| - Embed ABHS specialists in our ED  
  - Expedite screening and referral to appropriate resources including Aurora Psychiatric Hospital and Aurora Behavioral Health Services  
  - Further develop and implement multi-functional rapid response teams                                                                                                                                                                                                                                                                                 |             |
| - Implement primary care redesign to improve follow-up primary visits post-discharge and decrease hospital readmission rates                                                                                                                                                                                                                                                                                                         |             |
| - Provide referrals to free and reduced-rate dental clinics (Dental Associates, Lisbon Avenue Health Center, Marquette University Community Dental Clinics, Milwaukee Health Services MKL, Southside Guadalupe Dental Clinic, St. Elizabeth Ann Seton Dental Clinic)                                                                                                                                                                                                                             |             |
| **Through Aurora’s Better Together Fund:**                                                                                                                                                                                                                                                                                                                                                                                             |             |
| - Support expansion of primary health care services and enhances integrative clinic services at CORE/El Centro through grants totaling $100,000; monitor progress and impact                                                                                                                                                                                                                                      | Ongoing     |
| - Support expansion of primary and behavioral health care services at Sixteenth Street Community Health Centers through grants totaling $1,000,000; monitor progress and impact                                                                                                                                                                                                                                                     |             |
| - Support expansion of primary health care services at UWM College of Nursing Free Clinic through a grant of $85,453; monitor progress and impact                                                                                                                                                                                                                                                                                      |             |
| - Support expansion of behavioral health services at AIDS Resource Center of Wisconsin through a grant of $100,000; monitor progress and impact                                                                                                                                                                                                                                                                                       |             |
| - Support addition of a bilingual behavioral health therapist at Catholic Charities through a grant of $65,000; monitor progress and impact                                                                                                                                                                                                                                                                                      |             |
| - Support expansion of behavioral health services for toddlers and children at Penfield Children’s Center through a grant of $100,000; monitor progress and impact                                                                                                                                                                                                                                                                                         |             |
| **Improve access for persons who experience barriers due to immigration status, as well as homeless persons:**                                                                                                                                                                                                                                                                                                                       |             |
| - Screen and refer patients to our AWPCC for medical, ophthalmologic, behavioral health and social services and assist with navigation                                                                                                                                                                                                                                                                                                |             |
| - Provide an “Essential Medication Fund” for AWPCC patients who lack resources                                                                                                                                                                                                                                                                                                                                                              | Ongoing     |
| - Provide a team of AWPCC staff to assess and treat patients at the Salvation Army Clinic (for homeless persons)                                                                                                                                                                                                                                                                                                                        |             |
| - Accept vouchers for diagnostic lab and radiology services for patients referred from AWPCC                                                                                                                                                                                                                                                                                                                                         |             |
| - Support addition of a mental health counselor for individuals who are homeless at the Salvation Army of Wisconsin/Upper Michigan through a grant of $91,813; monitor progress and impact                                                                                                                                                                                                                                                |             |
**Priority No. 1: Access**

**Implementation Strategy**

<table>
<thead>
<tr>
<th>Action Plan</th>
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<tbody>
<tr>
<td><strong>Improve access for adolescents and students who are uninsured or who experience limitations due to immigration status:</strong></td>
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<tr>
<td>• Continue the success of our two-year pilot school-based clinic (begun in 2013) at South Division High School staffed with a nurse practitioner</td>
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<tr>
<td>– Deliver direct primary care to adolescents and students who are unable to access care elsewhere</td>
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<tr>
<td>– Establish a health home at South Division High School for students and, in particular, those students facing challenges with immigration status</td>
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<tr>
<td>– Provide care-coordination for students with identified health issues, concerns</td>
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<tr>
<td>• Pursue opportunities to adapt the model to leverage resources to meet more needs</td>
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<tr>
<td>• Support Aurora-employed specialists in neurology, ophthalmology, dermatology and urology, as well as an Aurora-employed physical therapist, to see and treat students referred through this school-based clinic</td>
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<tr>
<td><strong>Improve coverage for all uninsured persons:</strong></td>
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<tr>
<td>• Actively screen patients for Aurora’s Helping Hand Patient Financial Assistance program, as well as other safety-net programs, and assist with application processes</td>
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<tr>
<td>• Educate all about the benefits of securing coverage through the Marketplace and assist those who need help</td>
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<tr>
<td>• Support parish nurses who assist faith-community members in our geographic boundaries with accessing the Marketplace</td>
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<tr>
<td>• Dedicate one bilingual full-time staff position at AWPCC to help individuals identify coverage options and assist with applications in enrollment through the Marketplace</td>
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*Continued on the next page...*
Implementation Strategy

Priority No. 2: Community Health Improvement

Focus | Chronic disease prevention and management, health risk behaviors, health risk factors and mental health, particularly for persons with disproportionate unmet health needs

Aurora Walker’s Point Community Clinic (AWPCC) - Funded by Aurora St. Luke’s Medical Center and operated by Aurora Health Care, AWPCC is the largest free clinic in Wisconsin, freestanding and community-based, open 48 hours a week with evening and Saturday hours to serve a community with a high percentage of uninsured persons. 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. Our hospital provides the operating expenses and other financial support for AWPCC.

Principal partners
- Aurora Health Care Medical Group (AHCMG) faculty and residents
- Volunteer specialist physicians from AHCMG
  - Referrals as appropriate through the Specialty Access for Uninsured Program (SAUP)
- The Healing Center, an off-site community benefit program of Aurora Sinai Medical Center, co-located with AWPCC, and the only resource in Milwaukee exclusively committed to serving victims of sexual violence at any point in their recovery and healing process

Community partners
- AIDS Resource Center of Wisconsin (Milwaukee Office)
- Bread of Healing Clinic
- City of Milwaukee Health Department
- Columbia St. Mary’s
- CORE / el Centro
- Family Planning Health Services, Inc.
- Friends of Hank Aaron State Trail
- Marquette University
- Meta House
- Milwaukee Health Care Partnership
- Milwaukee LGBT Community Center
- Milwaukee Public Schools
- Mount Mary College
- Multiple volunteers including retired nurses and physicians
- Outreach Community Health Center (formerly Health Care for the Homeless)
- Pathfinder’s
- Salvation Army
- State of Wisconsin Well Woman/WISEWOMAN program
-UMOS
- University of Wisconsin-Milwaukee
- Wisconsin Optometric Association

Target population
- Individuals and families who do not have health insurance and cannot afford health care, including those who experience barriers with language and immigration status

Intended impact
- Improved access to health services that address unmet health needs of target population
- Improved awareness and knowledge of health risk factors among patients served
- Improved access to chronic disease management care and services among patients served
Implementation Strategy  

Priority No. 2: Community Health Improvement

Measures to evaluate impact

- Number of patients served, including demographic information
- Number of referrals to the Specialty Access for Uninsured Program (SAUP)
- Number of individuals participating in
  - Well Woman Program for breast and cervical cancer screening
  - Well-Integrated Screening and Evaluation for WOMen (WISE Woman) for cardiovascular screening and treatment including blood pressure, blood sugar, weight and blood cholesterol levels
  - Wise Man for cardiovascular, cancer and mental health screening and treatment
- Number of referrals to CORE /EI Centro for fitness and nutrition programming
- Number of counseling appointments; patients served
- Number of mammograms and pap tests completed
- Number of women who received breast cancer education and screening reminder; number of low or no-cost breast cancer screening resources via the CHANGE grant
- Measures for care management reported to, and published by, the Wisconsin Collaborative for Healthcare Quality

Action Plan | Target Date
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Address unmet health needs of the community and patients in our target population:

Support efforts to address chronic disease at AWPC

- Facilitate a chronic disease management course during which patients come together to learn about their illnesses and the best way to self-manage, and share their successes and challenges
- Connect social services with nurse practitioner to better monitor and manage patients with chronic disease
- Refer patients to CORE/El Centro for fitness and nutrition programming
- Conduct annual retina screenings to prevent blindness among diabetics, monitor glucose levels and connect with care management (when appropriate)
- Refer as appropriate to AHCMG physician specialists through SAUP (Note: Some patients are referred for specialty access to the Bread of Healing Clinic for podiatry and sometimes neurology)

For healthy lifestyles and heart disease risk factors at AWPC

- Administer a Health Risk Assessment including blood pressure, glucose, cholesterol and an assessment of medical and family history, tobacco use, diet and physical activity
- Provide participants with knowledge, skills and social support to improve dietary behaviors and increase physical activity
- Provide referrals to CORE/El Centro and other providers to further support patients
- Provide walk-in blood pressure screenings and blood sugar checks

For breast and cervical cancer screening at AWPC

- Provide preventive health screenings including mammograms and pap test
- Through the CHANGE\textsuperscript{4} grant, AWPC intends to:
  - Reach over 650 women with breast cancer education
  - Reach over 500 women with screening reminders to increase awareness of the importance of having annual mammograms beginning at 40 years of age
  - Provide approximately 600 low or no cost breast cancer screening resources to underserved women who are age and risk eligible
- Refer as appropriate to AHCMG physician specialists and services
  - Note: The exception will be the Mobile Mammogram service operated by Columbia St. Mary’s (CSM). CSM has agreed to come to AWPC once per month to provide mammograms just outside the clinic.

\textsuperscript{4} The National Football League’s A Crucial Catch initiative has provided another year of funding to support increased access to breast cancer education and screening resources in underserved communities through the American Cancer Society’s Community Health Advocates implementing National Grants for Empowerment (CHANGE) program. The American Cancer Society has awarded a $50,000 CHANGE grant to Aurora Walker’s Point Community Clinic to strengthen efforts to increase breast cancer screening rates in Milwaukee.
### Action Plan

**For eye care at AWPCC**
- In collaboration with the Wisconsin Optometric Association, provide a volunteer optometry clinic
- Provide onsite diabetes retinal screenings for 500 people annually through the use of an onsite camera and involving eight Aurora employed volunteer ophthalmologists and optometrists

**For social and mental health at AWPCC**
- Provide social services to help underserved patients
  - Navigate the health care system and access safety-net resources
  - Obtain legal documents
  - Address domestic violence issues
  - Receive family counseling/family planning information
- Provide counseling with a team led by a bilingual PhD Psychologist and four counseling students

**Through Aurora’s Better Together Fund:**
- Support expansion of Seeking Safety’s services and trauma services and advocacy at Meta House through a grant of $31,716; monitor progress and impact
- Support expansion of sexual assault and domestic violence advocacy services to LGBT-identified individuals at Milwaukee LGBT Community Center through a grant of $20,455; monitor progress and impact
- Support expansion of sexual assault advocacy service delivery and capacity at Pathfinders through a grant of $30,000; monitor progress and impact
- Support expansion of sexual assault prevention and education at the University of Wisconsin – Milwaukee through a grant of $255,000; monitor progress and impact

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Focus | Chronic disease, diabetes and Hepatitis C

Based on the 2012 Community Health Surveys, chronic disease was one of the top three community health issues reported by adult respondents in the city of Milwaukee, Greenfield and Franklin, and villages of Greendale and Hales Corners.

Diabetes
Based on the Community Health Surveys, in 2012, adult respondents who reported diabetes within the past three years: 10% of adults in the city of Milwaukee, Greenfield and Greendale, 7% of adults in Franklin, and 6% of adults in Hales Corners.

Hepatitis C
Based on the 2013 Wisconsin Hepatitis C Virus (HCV) Surveillance Summary, Milwaukee County accounted for 22% of the Hepatitis C Virus (HCV) reports in 2013 (586 cases reported). Hepatitis C is a liver disease caused by HCV.

Principal partners
- Aurora Parish Nurses
- Aurora Health Care Medical Group (AHCMG)
- Aurora Abdominal Transplant Program
- Karen Yontz Women’s Cardiac Awareness Center

Target Population
- AHCMG and hospital-patient population
- Adults of any age with one or more chronic disease(s)

Intended impact
- Improved health status and positive self-care behaviors for individuals with chronic disease (e.g. heart disease, asthma, diabetes) who enroll in program

Measures to evaluate impact
- Number of participants enrolled in Living Well with Chronic Disease
  - Number of participants who complete all six sessions; type of chronic condition(s) addressed
  - Percent improvement (baseline to post six-months) on health status, self-efficacy, self-management behaviors and health care utilization
- Number of participants enrolled in Living Well with Diabetes
- A balanced scorecard for measuring program impact for patients with Hepatitis C

<table>
<thead>
<tr>
<th>Action Plan</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Improve self-efficacy of persons in our community living with chronic disease(s):</td>
<td></td>
</tr>
<tr>
<td>Promote and present Living Well with Chronic Disease, Wisconsin’s implementation of the evidence-based Stanford Chronic Disease Self-Management Program; two workshops per year co-facilitated by Aurora parish nurses</td>
<td>Bi-annually</td>
</tr>
<tr>
<td>Promote and refer patients to Living Well with Diabetes, a program for people newly diagnosed with type 2 diabetes facilitated by Aurora parish nurses</td>
<td>Annually</td>
</tr>
<tr>
<td>Promote and refer patients to Healthy Living with Diabetes, a program for people diagnosed with type 2 diabetes, at the Karen Yontz Women’s Cardiac Awareness Center</td>
<td>Annually</td>
</tr>
<tr>
<td>Launch a Hepatitis C program within Aurora Health Care to screen patients in primary care and specialty clinics, and to diagnose, manage, treat and track all patients diagnosed with Hepatitis C; expand program through building community partnerships</td>
<td>March 2015, ongoing</td>
</tr>
</tbody>
</table>
Focus | Stroke and chest pain: prevention, early detection and professional education

The phrase “time is brain” emphasizes that human nervous tissue is rapidly and irretrievably lost as stroke progresses and that therapeutic interventions should be emergently pursued.\(^5\) Eighty-five percent of heart damage occurs within the first two hours of a heart attack. Every 25 seconds, an American will have a coronary event.\(^6\) Heart disease is a leading cause of death in Milwaukee County. The American Heart Association and American Stroke Association recognized Aurora St. Luke’s for performance in treating cardiac and stroke patients, one of only 26 hospitals to receive “Triple Recognition.”

Principal partners
- Aurora Health Care Medical Group (AHCMG)
- Aurora Chest Pain Center, our accredited chest pain center
- Aurora Neuroscience Services, our Joint Commission Accredited Comprehensive Stroke Center
- Aurora Women’s Pavilion (at Aurora West Allis Medical Center) and other metro-Milwaukee Aurora hospitals

Community partners
- American Heart Association
- American Stroke Association
- Karen Yontz Women’s Cardiac Awareness Center

Target population
- Our patient population
- Broader community
- Emergency Medical Service (EMS) providers

Intended impact
- Public knowledge about the warning signs of stroke, heart attack and knowing what to do is expanded
- Health professions education among EMS providers is advanced and transport protocols for stroke and chest pain result in timely response and improved outcomes for patients

Measures to evaluate impact
- Number of risk assessments conducted each year
- Number of people with findings referred and navigated to a health care provider

Action plan (see next page)

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\(^6\) Chest pain information adapted from Society of Chest Pain Centers – EHAC brochure, 2011.
## Priority No. 2: Community Health Improvement

### Advance knowledge and awareness of risk factors, prevention and early detection and treatment of neurological and coronary events in the broader public:

<table>
<thead>
<tr>
<th>Action Plan</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Foster an environment in which hospital resources of our Chest Pain and Neurological Services Centers are combined to maximize community outreach and impact</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Perform personalized risk-assessments for, and refer as appropriate</td>
<td></td>
</tr>
<tr>
<td>- Patients in our emergency department and hospital patients presenting with “fuzzy” symptoms secondary to their admitting diagnoses</td>
<td></td>
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<tr>
<td>- People who attend major community or employee health fairs in which we participate</td>
<td></td>
</tr>
<tr>
<td>Promote the importance of time with recurring themes throughout the year: “Time is brain!” and “Time is muscle!”</td>
<td></td>
</tr>
<tr>
<td>Promote the benefits of receiving early treatment for heart attack or stroke and activating emergency medical services</td>
<td></td>
</tr>
<tr>
<td>Widely distribute a packet of comprehensive, consumer-centric educational materials entitled “For Your Well Being,” covering health risk behaviors, health risk factors, a series of prevention and wellness guidelines</td>
<td></td>
</tr>
<tr>
<td>Partner with the Karen Yontz Women’s Cardiac Awareness Center to reach its predominantly female membership and audiences to advance general knowledge, conduct risk-assessments and teach women how to recognize and respond to early warning signs of stroke or heart attack</td>
<td></td>
</tr>
<tr>
<td>Provide blood pressure screenings and educational materials for the Senior Group in Franklin</td>
<td>Bi-monthly</td>
</tr>
<tr>
<td>Participate in “Strike Out Stroke” community program, providing community education on stroke prevention and signs and symptoms of stroke</td>
<td>Annually</td>
</tr>
<tr>
<td>Participate in Stroke Month Awareness activities including blood pressure screenings, stroke risk assessments and stroke awareness display cases</td>
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</tr>
<tr>
<td>Sponsor at least two public educational activities focusing on stroke prevention and care annually</td>
<td></td>
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</tbody>
</table>

### Advance health professions education within the EMS community:

<table>
<thead>
<tr>
<th>Action Plan</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Our EMS/Trauma Coordinator continues to serve as a liaison to the community, providing education on Comprehensive Stroke Care</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Conduct specialized advanced health professional education for EMS providers in our broader service areas annually</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Participate in the Quarterly ED/EMS meeting to discuss acute stroke processes, stroke data and advances in acute stroke treatment.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Review and discuss stroke data and stroke processes at monthly site stroke steering committee</td>
<td></td>
</tr>
</tbody>
</table>
Focus | Cancer

The 2003-2007 total number of cancer cases for Milwaukee County was 9,283 (all sites). There were 2,505 cases of lung and bronchus cancer, 807 cases of colon and rectum cancer, 635 cases of female breast cancer and 464 cases of prostate cancer (2011 Wisconsin Cancer Facts and Figures).

Getting screening tests regularly may find breast, cervical, and colorectal (colon) cancers early, when treatment is likely to work best.

Principal partners
• Aurora Cancer Care
• Vince Lombardi Cancer Clinic of Aurora St. Luke’s Medical Center – specialized cancer care in a tertiary care setting involving national cooperative research studies and clinical trials affiliated with such leading research organizations as the National Cancer Institute, the Memorial-Sloan-Kettering Cancer Center and others
• Aurora Behavioral Health Services (ABHS)
• Aurora Medical Centers
  – St. Luke’s South Shore, Aurora Sinai Medical Center and Aurora West Allis Medical Center
• Aurora Health Care Medical Group (AHCMG)
• Aurora Integrative Medicine Services

Community partners
• After Breast Cancer Diagnosis (ABCD)
• American Cancer Society
• Leukemia Lymphoma Society
• Milwaukee Regional Cancer Care Network (MRCCN)
  – Pink Possible Cancer Outreach
• Susan G. Komen
• Wisconsin Well Woman Program
• Wisconsin Comprehensive Cancer Control Program (WCCCP)
• Wisconsin Ovarian Cancer Alliance

Target population
• The broader community
• Our patient population

Intended impact
• Increased cancer screening rates for breast, colon and lung conducted at our facilities
• Number of persons at-risk for lung cancer referred to our program for screening, long-term follow-up and smoking cessation
• Reduction of distress in our patient population

Measures to evaluate impact
• Number of cancer prevention and outreach activities held
• Number of cancer screenings by type
• Number of participants in:
  – Distress screenings
  – Support groups
• Number of completed survivorship care plans

Action plan (see next page)
### Implementation Strategy: Priority No. 3: Community Benefit Hospital Focus

#### Expand scope of early detection and cancer prevention outreach:
- Partner with the American Cancer Society to provide financial, staffing and/or in-kind support for a wide range of educational and outreach events reaching defined populations as well as the broader community, including:
  - *Sankofa Health and Wellness Forum* (for the African American community)
  - *Dia de la Mujer Latina* (at South Division High School), a one-day community event to celebrate the Latina woman and her family’s health, to provide clinical breast exams and cancer education in this culturally appropriate setting for early detection, along with diabetes risk assessments, blood pressure and body mass index measures and HIV testing also are provided
- Partner with Leukemia and Lymphoma Society to provide education on cancers of blood
- Conduct screening program for persons at high-risk for lung cancer identified in the EMR (55 years or older with significant smoking pack history) to follow-up with lung cancer nurse navigator for:
  - low-dose CT chest screening
  - long-term follow-up
  - smoking cessation
- Refer patients to the educational component of the *Living Well* program for breast cancer survivors at the *Aurora Women’s Pavilion* at Aurora West Allis Medical Center
- Provide our cancer experts to staff multiple cancer support groups across metro Milwaukee
- Secure presentation opportunities for our *Cancer Care Speakers Bureau*

#### Improve survival and quality-of-life for those who are diagnosed with cancer:
- Administer our distress tool and, as appropriate, refer patients to our principal and community partners for needed support services
- Provide unbilled massage, acupuncture and other complementary medicine services for our inpatients through Aurora Integrative Services
- Continue to provide or refer patients to support groups
- Sponsor and promote another survivorship celebration
- Produce two quarterly newsletters for cancer patients and survivors addressing cancer care information
- Provide weekly cancer clinic for native Spanish-speaking patients

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Logic Models (see next page)
## Priority No. 3: Community Benefit Hospital Focus

### Lung Cancer Logic Model

<table>
<thead>
<tr>
<th>Program</th>
<th>Activities</th>
<th>Impact</th>
<th>Short-term Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long-term Outcomes</th>
</tr>
</thead>
</table>
| Lung Cancer | • Primary Care tobacco cessation/counseling  
• Lung CT Screening Program (AAMC, AMMG, AMCC, AMMQ, ASLM, ASLMC, AMQK)  
• Volunteer Patient Advocate (VPA) program (internal outreach at ASLMC) | • Smoking cessation programs  
• Lung cancer risk and education outreach, e.g., Web, radio, PR materials, PCC offices, lobby boards, civic groups  
• Connect cancer patients to vital cancer information by increasing support and referrals to local partners for cancer programs and services  
• Speaking and outreach opportunities for Aurora HealthCare lung cancer experts within the community | • Number of patients in smoking cessation program  
• Number of patients participating in Lung CT Screening Program  
• Number of patients who interacted with VPA persons  
• Increased community visibility of Aurora Cancer Care’s resources and education related to risk screening | • % of patients compliant with smoking cessation (any program for any cohort)  
• % of patients diagnosed with lung cancer  
• High number of volunteers available for lung cancer screening, 75% with goal of a 100% fulfillment rate  
• Education of resources and screening readily provided to a diverse target population | • 5-year survival  
• Patients express they received supplemental support from volunteers during their treatments (qualitative feedback data)  
• Completed supportive referrals and documentation to provide appropriate and continuous follow-up and continuity of care  
• Overall increased knowledge of cancer screening benefits and cancer risks within diverse populations |

### Breast Cancer Logic Model

<table>
<thead>
<tr>
<th>Program</th>
<th>Activities</th>
<th>Impact</th>
<th>Short-term Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long-term Outcomes</th>
</tr>
</thead>
</table>
| Breast Cancer | • Primary Care  
• Care Management  
• WI Well Woman Cancer Program  
• Rapid Results Program (at AAMC & AWIP only)  
• Risk evaluation program: Breast  
• Volunteer Patient Advocate (VPA) program (internal outreach at ASLMC)  
• Aurora Cancer Care Speaker’s bureau  
• Team Phoenix | • Annual maintenance reminders by PCC, My Aurora and mail reminders  
• PCC referred to Rapid diagnosis for women with palpable lump  
• PCC documentation of risk, patient referral, targeted activities/education of risk factors, web, PR materials, PCC offices, civic groups  
• Connect cancer patients to vital cancer information by increasing support and referrals to local partners for cancer programs and services  
• Screening and outreach opportunities for Aurora HealthCare breast cancer experts within the community  
• Survivors who have chosen to redefine themselves as athletes join Team Phoenix | • Number who got mammogram/tot number of eligible women  
• Number of women who undergone genetic testing and counseling  
• Number of women who undergo risk evaluation that is documented in EMR  
• Number of patients who interacted with VPA persons  
• Increased visibility within the community of Aurora Cancer Care’s resources and education related to breast cancer screening  
• Survivors commit to a 16-week training program for a Sprint Distance Triathlon | • % of women compliant-target will improve cancer screening so that appropriate screening is performed for breast cancer (92% of eligible women)  
• % of women diagnosed with early and later stage cancer  
• High number of available volunteer spots filled, 75% with goal of a 100% fulfillment rate  
• Education of resources and screening readily provided to a diverse target population  
• Survivors learn: Nutrition, hydration, triathlon, strength, flexibility, safety, etc. | • Compliance to/fu with recommendations  
• One year survival  
• Support and referrals to local cancer programs and services have been utilized  
• Increased number of Aurora HealthCare resources utilized for screening, treatment and continuing care  
• Medically-directed, goal-oriented multisport training provided, which concludes with a triathlon completed | • 5 year survival rates  
• Patients express they received supplemental support from volunteers during their treatments (qualitative feedback data)  
• Completed supportive referrals and documentation to provide appropriate and continuous follow-up and continuity of care  
• Overall increased knowledge of cancer screening benefits and cancer risks within diverse populations  
• Patients become proactive in their own healthcare and survival by reducing their risk of recurrence with regular exercise and achieving an optimal body weight.
## Colorectal Cancer Logic Model

<table>
<thead>
<tr>
<th>Programs</th>
<th>Activities</th>
<th>Impact</th>
<th>Short-term Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long-term Outcomes</th>
</tr>
</thead>
</table>
| Colorectal Cancer | • Annual maintenance reminders by PCP, My Aurora and mail reminders  
| | | | | | • Synergy survival rates  
| | | | | | • Patients express they received supplemental support from volunteers during their treatments (qualitative feedback data)  
| | | | | | • Overall increased knowledge of cancer screening benefits and cancer risks within diverse populations |
| | • Outreach to specifically African American and Latino communities  
| | | | | | • # of patients compliant  
| | | | | | • One-year survival  
| | | | | | • Increased number of Aurora HealthCare resources utilized for screening, treatment and continuing care |
| | • Connect cancer patients to vital cancer information by increasing support and referrals to local cancer programs and services  
| | | | | | • # patients diagnosed early stage colorectal cancer |
| | • Speaking and outreach opportunities for Aurora HealthCare cancer experts within the community | | | • Increased number of African American and Latino patients who undergo CRC screening compared to baseline |
| | | | | | • Number of patients who interacted with VPA persons |
| | | | | | • Increased community visibility of Aurora Cancer Care's resources and education re: high-risk screening |

### Implement Strategy

**Priority No. 3: Community Benefit Hospital Focus**
Focus | Heart health awareness

Heart disease is a leading cause of death in Milwaukee County. According to the American Heart Association and Go Red For Women, heart disease is the number one killer of women and more deadly than all forms of cancer. Fortunately there are ways to reduce a person’s risk for heart disease or treat current heart disease.


Principal partners
- Aurora Health Care Medical Group (AHCMG)
- Aurora Consolidated Labs

Community partners
- Karen Yontz Women’s Cardiac Awareness Center at Aurora St. Luke’s Medical Center – a nationally recognized resource center dedicated to decreasing the incidence and impact of heart disease in women providing heart disease risk assessments, educational programs and advocating for early diagnosis, intervention and best practices for treating heart disease in women see: http://www.karenyontzcenter.org
- American Heart Association

Target population
- The general public with a special focus on women
- Aurora caregivers, patients and visitors

Intended impact
Women who interface with the Karen Yontz Women’s Cardiac Awareness Center on at least one or more occasions will:
- Know their personal risk factors
- Understand the relationship between diet, fitness and heart-risk factors
- Understand the relationship between stress and heart-risk factors
- Adopt at least one healthier lifestyle practices (self-reported)

During National Go Red for Women events
- Women will learn the risk factors for heart disease and ways to minimize these risks
- 70% of individuals who completed the contract will successfully “check-in” 30 days later

Measures to evaluate impact
- Number of women who undergo heart risk appraisals at Karen Yontz Women’s Cardiac Awareness Center
- Number of women who attend Karen Yontz Women’s Cardiac Awareness Center educational events
- Number of attendees who self-report improvement in their lifestyle practices
- Number of attendees who report adopting a stress-management practice
- Number who received the health risk assessment quiz and education reinforcement
- Number who identified a personal risk factor and the behavior change they are willing to make
- Percent who completed 30-day “check-ins”

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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Help women understand and identify their risk factors for heart disease and preventive strategies to offset those factors:</td>
<td>Ongoing</td>
</tr>
<tr>
<td>• Provide highly visible permanent space in our atrium and in-kind operating expenses and services for the Karen Yontz Women’s Cardiac Awareness Center</td>
<td></td>
</tr>
<tr>
<td>• Encourage financial support to expand programming of the Karen Yontz Women’s Cardiac Awareness Center through the Aurora Foundation and Aurora’s annual employee-giving campaign</td>
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</tr>
<tr>
<td>• Support the American Heart Association’s National Go Red For Women:</td>
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</tr>
<tr>
<td>– Partner with Aurora dieticians and diabetes educators to provide information on reducing risks related to heart disease</td>
<td></td>
</tr>
<tr>
<td>– Provide a health risk assessment quiz related to heart disease and risk factors for individuals to complete – a question and answer sheet will be given back to the individual for education reinforcement</td>
<td></td>
</tr>
<tr>
<td>– Offer a behavioral contract (individuals will identify a risk and a plan to reduce it)</td>
<td></td>
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</tbody>
</table>