Aurora St. Luke's Medical Center Community Health Implementation Strategy

January 1, 2023 – December 31, 2025

Community health improvement is an effective tool for creating a shared vision and supporting a planned and integrated approach to improving health outcomes. The basic premise of community health improvement is that entities identify community health issues, prioritize those that can be addressed, and then develop, implement, and evaluate strategies to address those issues. Tax-exempt hospitals are required to conduct a community health needs assessment (CHNA) and develop an implementation strategy to document how the hospital will address prioritized community health needs. The following outlines a summary of the CHNA process and provides details on Aurora St. Luke's Medical Center's plans to address their prioritized community health needs.

SUMMARY OF MILWAUKEE COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

Every three years, the health system members of the Milwaukee Health Care Partnership (Advocate Aurora Health, Ascension Wisconsin, Children's Wisconsin, and Froedtert Health) conduct a collaborative Community Health Need Assessment (CHNA) in Milwaukee County. The CHNA serves as the foundation from which hospitals and local health departments develop their respective community health improvement strategies.

These findings are also intended to inform a broader audience — community health centers, government health agencies, public health departments, philanthropy, community-based organizations, and civic leaders — about the top health issues facing our community.

The Milwaukee County CHNA relies on three sources of information:

- **Community Health Survey (primary data):** an on-line survey conducted August – October 2021, with more than 8,600 Milwaukee County residents completing 50 questions related to the top health needs in the community, individuals' perception of their overall health, access to health services, and social drivers of health, including racism and health equity
- **Stakeholder Interviews (primary data):** conducted by health system community benefit leaders with 103 individuals representing 93 organizations to identify the community's most pressing health issues and effective health improvement strategies. The focus groups were selected to assure input from organizations representing vulnerable populations and those with expertise in community health. The groups included leaders and representatives from Safety Net clinics, local public health departments, youth serving organizations, and organizations serving low-income populations
- **Health Compass Milwaukee (secondary data):** a dynamic website providing more than 300 of the most current health indicators for Milwaukee County at the county, municipal, zip code, and census tract levels (where available), as well as related demographic data such as race/ethnicity, education, income, and housing. healthcompassmilwaukee.org

This report along with additional Milwaukee County CHNA materials can be found on **Health Compass Milwaukee in the Local Reports section**.

Aurora Health Care®

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SIGNIFICANT HEALTH NEEDS IDENTIFIED AND SELECTED FOR IMPLEMENTATION STRATEGY AND WHY

Advocate Aurora Health has a strong history of community engagement and service. A targeted strategy was developed to build on this history—one that transforms and aligns our community-facing work through a health equity lens. Health equity means everyone has a fair and just opportunity to be as healthy as possible. The Advocate Aurora Health Community Strategy provides an overarching framework for the health system centered on six areas of focus which include: access to innovative care; access to behavioral health; workforce development; community safety; housing; and food security. The Aurora St. Luke's Community Health Implementation Strategy aligns with the Advocate Aurora Community Strategy, but this plan is unique to the health needs of the community served by Aurora St. Luke's. Aurora St. Luke's prioritized the following health issues to be addressed with their 2023-2025 Community Health Implementation Strategy:

- Access to Innovative Care and Services
- Behavioral Health: Mental Health and Substance Use
- Community Safety and Violence Prevention
- Workforce Development

Access to Innovative Care and Services

Access to health care was a top health issue identified in the Aurora St. Luke's Community Health Needs Assessment. Key stakeholder and survey respondent data call out that access to care is more comprehensive than just being seen by a health care provider. For this strategy, Access to Innovative Care and Services is about creating conditions in our hospital, across our health system and in our community to provide accessible, available, affordable, and targeted health care and health services to support everyone's ability to live well.

Data for Milwaukee County shows the county falls behind Wisconsin and other counties for adults without health insurance, no recent dental visits, and clinical care ranking (for access and quality as reported in the County Health Rankings). Additionally, many of these indicators are seeing significantly worsening trends. In Milwaukee, significant gaps exist in health care coverage between racial/ethnic groups.

Behavioral Health: Mental Health and Substance Use

Behavioral health, which includes treatment and services for mental health conditions and substance use disorder, is a growing public health concern and was identified as a top health issue in the Aurora St. Luke's Community Health Needs Assessment. In 2021, the mental health hospitalization rate in Milwaukee County was 852.1 admissions per 100,000 residents, higher than the Wisconsin average of 650.8 per 100,000 residents. The 2021 mental health emergency department visit rate was 1,353.4 visits per 100,000 residents, higher than the Wisconsin average of 919.8 per 100,000 residents. Non-Hispanic Black residents were disproportionately impacted, with a rate of 2,647.5 visits per 100,000 residents.

In Milwaukee County, the rate of drug overdose mortality was 41.7 per 100,000 population in 2016-2020, higher than Wisconsin rate of 21.7 per 100,000 population. From 2017-2021, the Milwaukee County substance use emergency department visit rate was 1,138.6 visits per 100,000 residents, higher than the Wisconsin average of 649.3 visits per 100,000 residents. Non-Hispanic Black residents were disproportionately impacted, with a rate of 1,715.9 visits per 100,000 residents.

Community Safety and Violence Prevention

Community safety and violence prevention was a top health issue identified from the community health survey, key stakeholder interviews, and focus group participants. Community input to the assessment elevated community safety themes such as reckless driving, civil unrest, and racial tension as well as violent crime and shootings. Survey data shows respondents' perception of violence-related issues and lack of economic opportunities as a root cause. While Milwaukee County residents overall reported their neighborhoods relatively safe to live in, those who lived in high-need zip codes and respondents of color were less likely to report that their neighborhood is safe. This reflects the geographically concentrated nature of the problem and segregation of communities in Milwaukee.

Workforce Development

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

The median household income in Milwaukee County is $55,078, which is lower than the state's median household income of $66,706. There is a large racial disparity in the median household income with the non-Hispanic White and Asian or Pacific Islander populations having the highest household incomes and the non-Hispanic Black, Native American and Hispanic or Latino populations having the lowest median household incomes.

HEALTH PRIORITY: Access to Innovative Care and Services

IMPACT:

Improve health among residents by creating conditions that provide accessible, available, affordable, and targeted health care and health services to support everyone's ability to live well

DESCRIPTION OF HEALTH NEED DATA:

- Nineteen percent of Milwaukee County residents reported an inability to access health services in the last 12 months
- Twenty-one percent of City of Milwaukee residents reported an inability to access health services in the last 12 months

Source: Milwaukee Community Health Survey, 2021

- The overall rate of insured residents in Milwaukee County 89.2 percent. The highest rate of insured residents is among the white non-Hispanic population (95.4 percent), and the lowest is among the Hispanic/Latino population (70.0 percent)

Source: American Community Survey, 2019

- The rate of preventable emergency department visits for the City of Milwaukee is 1,665.6 visits per 100,000 residents, but the rate is higher for the non-Hispanic Black population at 2,561.4 visits per 100,000 residents

Source: Wisconsin Health Association Information Center, 2017-2021

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: **ADVOCATE AURORA COMMUNITY STRATEGY**

- Access to Innovative Care

NATIONAL: **HEALTHY PEOPLE 2030**

- Settings and Systems: Health Care

HEALTH PRIORITY: Access to Innovative Care and Services cont.

STRATEGY #1: Increase access to primary care

SPECIFIC INTERVENTIONS AT AURORA ST. LUKE'S	COLLABORATIVE PARTNERS	OBJECTIVES
• Through participation in the Milwaukee Health Care Partnership Emergency Department Care Coordination (MHCP EDCC) program, link Medicaid-eligible and uninsured patients using our hospital emergency department for primary care with medical homes	• Milwaukee Health Care Partnership • Aurora Family Service	• Increase number of non-emergent patients presenting in our Emergency Department are navigated to a medical home
• Provide referrals to Aurora Medical Group physician specialists through the Specialty Access for Uninsured Program (SAUP)	• Milwaukee Health Care Partnership	• Increase access to specialty care for uninsured patients
• Refer uninsured patients to the Sixteenth Street Community Health Center and provide an automated care summary, improving patient care coordination with our partner provider	• Sixteenth Street Community Health Center	• Improve care coordination for uninsured patients
• Provide the Family Medicine Residency Clinic Follow-Up Appointment Program, which provides patients without an established Primary Care Provider a follow-up structure within 24-72 hours of Emergency Department visit for acute medical conditions that require close outpatient monitoring to ensure appropriate improvement/resolution of their acute medical condition	• Aurora Family Medicine Residency Clinic Follow-Up Appointment Program	• Increase number of non-emergent patients presenting in our Emergency Department are navigated to a medical home

MEASURING OUR IMPACT

- Appointments scheduled; Federally Qualified Health Center (FQHC) appointments and show rate
- Number of referrals to SAUP program
- Patients referred to Sixteenth Street Community Health Center
- Number of appointments made and kept through Family Medicine Residency Clinic Follow-up Appointment Program

HEALTH PRIORITY: Access to Innovative Care and Services cont.

STRATEGY #2: Increase access to innovative services

SPECIFIC INTERVENTIONS	COLLABORATIVE PARTNERS	OBJECTIVES
• Provide prescriptions upon discharge free of cost to under-insured patients who lack resources through the Aurora Essential Medication Fund	• Aurora Pharmacy	• Increase patients who are able to access needed medications
• Provide Coverage to Care (C2C) program to deliver intensive and systematic case-management for hospital ED high utilizers, incorporating health care literacy, health care advocacy, health care coordination and medical homes	• Aurora Family Service	• Reduce preventable emergency department visits
• Provide the Cancer Nurse Navigator program, offering referrals to both Aurora service providers (examples include Social Worker, Chaplain, Integrative Medicine) and community partners and support groups	• After Breast Cancer Diagnosis • Leukemia and Lymphoma Society • American Cancer Society	• Help patients and their families through the diagnosis, treatment, and survivorship stages of cancer
• Provide supportive counseling to patients and families during the treatment phase of their cancer illness through the Oncology Supportive Counseling program	• Aurora Family Service	• Increase access to counseling services during cancer treatment
• Provide the Oncology Financial Navigation program through Aurora Family Service Center for Financial Wellness. This program provides financial counseling and navigation services to patients at-risk for financial distress due to the impact of cancer illness. The program is supported via United Way and other program grants	• Aurora Family Service	• Reduce financial distress among individuals impacted by cancer illness

HEALTH PRIORITY: Access to Innovative Care and Services cont.

STRATEGY #2: Increase access to innovative services cont.

SPECIFIC INTERVENTIONS	COLLABORATIVE PARTNERS	OBJECTIVES
Aurora Walker's Point Community Clinic, operated by Advocate Aurora Health, is the largest free clinic in Wisconsin and has been caring for people who are low income, immigrants, refugees and underserved in the Milwaukee community for more than 25 years. Services include urgent, primary, preventive, specialty and mental health care. Through Aurora Walker's Point Community Clinic, provide: • Outpatient care to un- and under-insured patients • Well-Integrated Screening and Evaluation for Women (WISE Woman) program for cardiovascular screening including blood pressure, blood sugar, weight, and blood cholesterol levels and provide appropriate treatment • Breast and cervical cancer screenings through the Wisconsin Well Woman Program (WWWP) • Breast cancer education, screening reminders, and low or no-cost breast cancer screening resources to underserved women through the CHANGE grant • Referrals to CORE/El Centro to advance knowledge, skills, and social support to improve dietary behaviors and increase physical activity • Health screenings to new refugees as part of the Refugee Health Coordination program • Bilingual social services to help underserved patients navigate the healthcare system and access safety-net resources, obtain legal documents, address domestic violence issues, and receive family counseling/family planning information	• Aurora Walker's Point Community Clinic	• Increase access to care

MEASURING OUR IMPACT

- Number of prescriptions provided; dollar value
- Number of individuals served by Coverage to Care
- Patients served through our Cancer Nurse Navigators
- Individuals provided with cancer counseling services
- Individuals served through Oncology Financial Navigation program
- Individuals served through Aurora Walker's Point Community Clinic services

HEALTH PRIORITY: Behavioral Health: Mental Health and Substance Use

IMPACT:

Improve mental health and reduce misuse of drugs and alcohol among Milwaukee County residents through preventative strategies and increased access to behavioral health services

DESCRIPTION OF HEALTH NEED DATA:

- Ten percent of Milwaukee County residents reported an inability to access mental health services in the last 12 months
- Eleven percent of City of Milwaukee residents reported an inability to access mental health services in the last 12 months

Source: Milwaukee Community Health Survey, 2021

- In Milwaukee County, the rate of drug overdose mortality was 41.7 per 100,000 population, higher than the Wisconsin rate of 21.7 per 100,000 population

National Vital Statistics System-Mortality, 2016-2020

- The rate of mental health emergency department visits for City of Milwaukee is 1,778.0 visits per 100,000 residents, and is nearly double for non-Hispanic Black residents, at 3,311.9 visits per 100,000 residents

Source: Wisconsin Health Association Information Center, 2017-2021

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: **ADVOCATE AURORA COMMUNITY STRATEGY**

- Access to Behavioral Health Services

STATE: **WISCONSIN STATE HEALTH PLAN PRIORITY AREAS**

- Alcohol
- Opioids
- Suicide

NATIONAL: **HEALTHY PEOPLE 2030**

- Health Conditions: Mental Health and Mental Disorders
- Health Behaviors: Drug and Alcohol Use

HEALTH PRIORITY: Behavioral Health: Mental Health and Substance Use cont.

STRATEGY #1: Increase access to Behavioral Health Services

SPECIFIC INTERVENTIONS	COLLABORATIVE PARTNERS	OBJECTIVES
• Provide Aurora Behavioral Health resources in our Emergency Department to expedite appropriate referrals and assist with navigation, facilitate interactions with staff, and provide inpatient transfers, appointment scheduling and motivational interviewing	• Aurora Behavioral Health Services	• Identify and refer patients to appropriate Behavioral Health services
• Provide all patients discharged from the hospital with a follow-up phone call in their preferred spoken language. Discharge phone call staff are also trained on protocols for suicide assessment and linking patients with support for opioid and other drug issues	• Aurora Discharge Phone Calls initiative	• Support discharge instructions for patients
Through a partnership between local school districts and the Advocate Aurora Health Student and Family Assistance Program (SFAP) provide: • Virtual or in-person confidential counseling • Behavioral education on topics such as anger management and marijuana use • Life-balance services, such as financial counseling, legal consultation or assistance finding childcare	• Aurora Employee Assistant Program	• Increase access to Behavioral Health resources for students and their families

MEASURING OUR IMPACT

- Number of Emergency Department patients assessed for Behavioral Health services and disposition of patients needing behavioral health services
- Number of discharge phone calls made; number of discharge phone call staff trained in suicide and opioid/drug response; number of times suicide protocol was implemented; number of times opioid/drug protocol was implemented
- Number of school district partnerships; number of families served

HEALTH PRIORITY: Behavioral Health: Mental Health and Substance Use cont.

STRATEGY #2: Improve mental health through community collaborations and services

SPECIFIC INTERVENTIONS	COLLABORATIVE PARTNERS	OBJECTIVES
• Through the MHCP and in response to the lack of a psychiatric Emergency Department within Milwaukee County, provide leadership on the Behavioral Health Provider group dedicated to increasing inpatient and outpatient behavioral health care capacity and psychiatric crisis center planning	• Milwaukee Health Care Partnership	• Increase access to Behavioral Health inpatient and outpatient care
• Provide medical stabilization and referrals to the Mental Health Emergency Center (MHEC)	• Milwaukee County Mental Health Emergency Center	• Increase access to Behavioral Health care
• Participate in the Zero Suicide initiative in both our Emergency Department and primary care settings, predicated upon a commitment by healthcare leaders to: – Make suicide a "never" event so that not one person dies alone and in despair – Promote a just culture where caring, competent, and confident staff are supported to continuously improve and learn together – Keep patients actively engaged and supported to talk about suicide and despair, rediscover hope, and find ways to thrive		• Number of patients screened in the emergency department • Number of patients screened in primary care • Number of patients who screen positive on the Zero Suicide screen who are referred to behavioral health services
• Provide a drug take-back box, enabling community members to safely and securely discard unwanted opioid and other prescriptions	• Aurora Pharmacy	• Reduced availability of opioids and other unwanted prescriptions in the community
• Provide referrals to ED2Recovery program to support peer support services for individuals who have experienced a drug overdose	• Wisconsin Community Services (WCS)	• Increase referrals to ED2Recovery program to link people who have experienced an overdose with peer support specialists

MEASURING OUR IMPACT

- Process milestones of the Milwaukee Health Care Partnership Behavioral Health Provider Group
- Number of patients screened in the emergency department; number of patients screened in primary care; number of patients who screen positive on the Zero Suicide screen who are referred to behavioral health services
- Pounds of medications collected
- Number of ED2Recovery participants

HEALTH PRIORITY: Community Safety and Violence Prevention

IMPACT:

Increased safety and enhanced violence prevention and response

DESCRIPTION OF HEALTH NEED DATA:

- Violence prevention and community safety was a top health issue identified from the community health survey, key stakeholder interviews, and focus group participants
- While Milwaukee County residents overall reported their neighborhoods relatively safe to live in, those who lived in high-need zip codes and respondents of color were less likely to report that their neighborhood is safe

Source: Milwaukee Health Care Partnership Community Health Needs Assessment

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: **ADVOCATE AURORA COMMUNITY STRATEGY**
- Community Safety

STATE: **WISCONSIN STATE HEALTH PLAN – KEY CONDITIONS**
- Improved Social and Community Conditions
- Healthy Environments and Supportive Systems

NATIONAL: **HEALTHY PEOPLE 2030**
- Health Behaviors: Violence Prevention

STRATEGY #1: Increase safety and enhanced violence prevention and response

SPECIFIC INTERVENTIONS	COLLABORATIVE PARTNERS	OBJECTIVES
• Support the Violence-Free West Allis Collaborative and Medical College of Wisconsin on an initiative to translate the Cardiff Violence Prevention Model. The model aims to develop a clearer picture about where violence is occurring in neighborhoods common to each of our hospitals. This will include providing data to be combined and mapped along with other hospital and police data on violence	• Violence-Free West Allis Collaborate • Medical College of Wisconsin	• Data report sent to Violence-Free West Allis Collaborative

MEASURING OUR IMPACT

- Process milestones

HEALTH PRIORITY: Workforce Development

IMPACT:

Increased opportunities for stable employment

DESCRIPTION OF HEALTH NEED DATA:

- The median household income in Milwaukee County is $55,078, which is lower than the state's median household income of $66,706
- There is a large racial disparity in the median household income with the non-Hispanic White and Asian or Pacific Islander populations having the highest household incomes and the non-Hispanic Black, Native American and Hispanic or Latino populations having the lowest median household incomes

Source: American Community Survey, 2016-2020

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL: **ADVOCATE AURORA COMMUNITY STRATEGY**
- Workforce Development

STATE: **WISCONSIN STATE HEALTH PLAN – KEY CONDITIONS**
- Improved Social and Community Conditions
- Healthy Environments and Supportive Systems

NATIONAL: **HEALTHY PEOPLE 2030**
- Social Determinants of Health: Economic Stability

STRATEGY #1: Increase opportunities for stable employment

SPECIFIC INTERVENTIONS	COLLABORATIVE PARTNERS	OBJECTIVES
• Provide training programs for nursing assistant, medical assistant, sterile processing/surgical tech, cardiovascular tech and phlebotomist positions	• Herzing University • ACL Laboratories • Center for Healthcare Careers of Southeast Wisconsin	• Hire trained individuals into permanent employment and upskill frontline team members
• Provide Temporary Work Experience internships at our hospital. The 90-day internship is intended to give job seekers with cognitive and physical barriers first-hand, paid experience on job duties, role expectations, and workplace culture	• Wisconsin Division of Vocational Rehabilitation (DVR)	• Offer permanent employment opportunities at Advocate Aurora Health when positions become available
• Offer paid Culinary Registered Apprenticeship and Facilities Maintenance Technician Registered Apprenticeship positions. These full-time paid, benefit eligible positions equip participants with both on-the-job training and instruction through MATC, resulting in a technical diploma	• Wisconsin Department of Workforce Development (DWD) • Milwaukee Area Technical College (MATC)	• Hire trained individuals into permanent employment

HEALTH PRIORITY: Workforce Development cont.

STRATEGY #1: Increase opportunities for stable employment cont.

SPECIFIC INTERVENTIONS	COLLABORATIVE PARTNERS	OBJECTIVES
• Through the NAVIGATE program, provide current team members in entry-level or middle-skilled positions (CNAs, food services, transporters, environmental services, etc.) with soft-skills workshops, mentorship, and career coaching and development designed to help them advance into higher-level positions		• Provide advancement opportunities for current team members
• Provide work-study positions to local high school students	• Local high schools	• Provide first-hand, paid experience to local high school students
• Provide the Bridge to Practice program. In this program, current experienced nurses at Aurora St. Luke's Medical Center mentor second year UW-Milwaukee nursing students to explore the reality of the nursing work environment, specialty practice settings, and issues related to practice	• UW-Milwaukee	• Recruitment and retention of nurses

MEASURING OUR IMPACT

- Number of individuals, by program type trained and hired, by position
- Number of individuals completing interns; number of interns hired
- Number of current culinary and facilities apprentices; number of individuals completing an apprenticeship
- Number of team members participating in NAVIGATE; advancement outcomes
- Number of schools participating in work-study partnerships
- Number of nursing students participating; post evaluation data

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