

A close-up photograph of two hands shaking in a firm grip. The hand on the left is fair-skinned and wearing a dark blue sweater with a white and blue striped cuff. The hand on the right is dark-skinned. In the background, a woman with dark hair and a grey scarf is smiling, and the scene is set outdoors with a bright blue sky and blurred greenery.

# COMMUNITY HEALTH IMPROVEMENT STRATEGY

Orthopaedic Hospital of Wisconsin

**COLUMBIA ST. MARY'S  
COMMUNITY HEALTH IMPROVEMENT STRATEGY  
ORTHOPAEDIC HOSPITAL OF WISCONSIN**

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## Supporting Columbia St. Mary's Mission

Orthopaedic Hospital of Wisconsin is a member of Columbia St. Mary's and is driven by the Columbia St. Mary's mission.

Columbia St. Mary's, a healthcare provider founded in response to identified community needs, is sponsored by Ascension Health, a Catholic national health system, and Columbia Health System, a non-sectarian community health system.

Columbia St. Mary's exists to make a positive difference in the health status and lives of individuals and our community, with special concern for those who are vulnerable. We are committed to providing high quality, accessible, values-driven programs and services with equal attention to the physical, spiritual, and emotional dimensions of health.

The Columbia St. Mary's Community Health Improvement process ensures the mission is accomplished through a structured and sustainable method informed by the community, monitored by a Community Health Improvement Committee at each hospital and approved by the Columbia St. Mary's Board of Directors. Leadership for the Community Health Improvement process is provided by the Office of Mission Integration and the Community Services Department.

# COMMUNITY HEALTH IMPROVEMENT PHILOSOPHY

## Our community has many needs. It also has many strengths.

In order to make the best use of our resources, Columbia St. Mary's (CSM) and Orthopaedic Hospital of Wisconsin (OHOW) must address important needs in the community in partnership with people and organizations with similar missions. Programs and services to support community health are best when they are collaborative, strategic and sustainable.

Because of the size and nature of many community health issues, CSM and OHOW do not have enough resources to solve the problems. The best hope for success is seen in being **collaborative** to bring together the resources of many organizations. The organizations will seek to find partners that are mission-driven, devoted to excellence and capable of creative partnerships to solve community problems.

A program or service is **strategic** when it serves vulnerable people through the use of special talents and skills of people and programs within the organizations. Strategic programs are seen where great community need is addressed by unique talents and skills.

A program or service is **sustainable** when it is supported by a variety of sources including reimbursement, grants, donations, volunteer and student support and contributions from other organizations. It is important to have a variety of resources available to serve vulnerable people.

## PROCESS

The Columbia St. Mary's (CSM) Community Health Improvement Committee is authorized by the OHOW Board of Directors to develop the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) for Orthopaedic Hospital of Wisconsin to respond to the needs of the community. Milwaukee County is identified as the OHOW service area for this CHNA and CHIP process. This service area is consistent with the hospital's patient volume analysis.

The Committee meets regularly to oversee the development of the Community Health Needs Assessment and the development and implementation of a Community Health Improvement Plan.

The Committee authorized and encouraged Community Health Improvement staff to use the Milwaukee Health Care Partnership (MHCP) model of assessment in collaboration with hospital members of the partnership.

The CHNA was conducted to include three levels of information: a community telephone survey of residents to gather their input on community health needs; a secondary data report commissioned from a consultant proficient in gathering and interpreting of data from public health departments, state organizations and non-profit organizations working in the field of health; and interviews with key stakeholders in the field of health.

The Community Health Improvement Committee reviewed the Milwaukee Health Care Partnership CHNA and agreed that it was generally reflective of community health and needs in Milwaukee. The Committee did note that issues of disparity did not seem to be well-reflected in the CHNA, especially regarding cancer incidence and outcome and infant mortality. The Committee amended the MHCP CHNA findings to include cancer disparity and infant mortality.

The Community Health Improvement Committee evaluated the needs identified and discussed CSM and OHOW responses to those needs to be included in each Community Health Improvement Plan (CHIP). The Committee developed the CHIP based on Community Benefit Philosophy values of identifying strategic responses which apply organizational strengths to significant community needs; identifying responses that can be sustainable over time by using a variety of resources; and identifying responses that have or can develop strong partnerships to support the goals. The discussion of these values and CHNA needs resulted in consensus by the Committee on prioritizing these specific CHIP elements to be served.

Resources necessary to achieve plan goals are budgeted within OHOW administrative and departmental budgets.

The CHNA and CHIP are submitted to the OHOW Board for review and approval.

# 2016 COMMUNITY HEALTH NEEDS ASSESSMENT FINDINGS

## **INFANT MORTALITY**

Milwaukee infant mortality rates far exceed state and national rates. The death of babies before their first birthdays is the most tragic health disparity affecting African-Americans. The disparity is evident in infant mortality rates which show 15.6 deaths per 1,000 births for African Americans, with rates of 6.0 deaths per thousand for Hispanic infants and 5.3 deaths per thousand for non-Hispanic whites. Key stakeholders call for improvement in infant mortality overall but with a special focus on African-Americans.

## **ORAL HEALTH ACCESS**

According to secondary data and interviews with key respondents, the inability of children and adults to find a dentist who accepts BadgerCare or charity care is of concern. Dental disease is a primary cause for school absenteeism. Poor oral health is linked to poor overall health -- raising risks of chronic disease, systemic complications, and, for expectant mothers, prematurity and low-birth-weight babies.

## **SUBSTANCE ABUSE**

The rates of binge drinking have increased from 17% of community respondents reporting bingeing in the past year in 2002 and increasing to 32% in 2015. Secondary Data Reports also reflect increase in drug abuse. Key respondents also speak of limited access to substance abuse treatment, particularly for at-risk populations such as pregnant women.

## **CANCER DISPARITY**

The Community Health Improvement Committee agreed to include in the assessment issues of disparity that significantly affect the health of a vulnerable group. Therefore, the committee includes breast cancer mortality in African-American women, occurring at a rate of 32 per 100,000 as opposed to 21 per 100,000 for Caucasian women, as an issue of concern. Similar disparity exists with lung and prostate cancers.

## **MENTAL HEALTH**

An increase in concern regarding mental health in the community was seen with 32% of community survey respondents making it a top concern as opposed to 21% three years ago. Key community stakeholders reported concern for inability to improve access by hiring mental providers, particularly those with prescriptive authority. An increased focus will be on integrating behavioral health with primary care.

## **INJURY AND VIOLENCE**

Survey respondents (42%) and key stakeholders (49%) mention violence in the community as a concern, including domestic violence, falls, gun violence, youth violence, and crime. Information

from the North Shore Health Department shows that fall incidence in Milwaukee County far exceeds the state average.

## **CHRONIC DISEASE**

The incidence of hypertension, diabetes, and asthma has increased over the last nine years, surveys and secondary data show. Chronic disease, particularly diabetes and hypertension, are major health disparities among African-Americans. Key stakeholders say this is one of the larger health issues for African-Americans.

## **OVERWEIGHT/OBESITY**

These issues are grouped because of the consistent concern among key stakeholders. Levels of overweight and obesity are greater than in the state and nation, according to Secondary Data Reports. Incidence of overweight increased from 62% to 69% of population in the past 12 years, with vegetable intake decreasing during that time. Stakeholders mention difficulties in access to physical activity and healthy foods as key barriers to greater health.

## **HEALTH LITERACY**

Key stakeholders list poor health literacy as an important concern. This includes understanding of health systems and how to use them, as well as understanding of key issues of health and illness. Stakeholders underscore the importance of providing understandable and culturally appropriate education.

## **SEXUAL HEALTH**

Many key stakeholders list the issue as an area of concern, and Secondary Data Reports show a higher-than-state-average incidence of teen pregnancy and sexually transmitted infection. Existing community partnerships do focus on this issue and have experienced success in reducing incidence; but both continue to exceed state averages.

# FY 2017-2019 COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

## **INJURY AND VIOLENCE**

A program of Home Assessment will be designed to help patients and caregivers develop plans to avoid falls and decrease risks. Physical therapists and occupational therapists will conduct the assessments and advise patients and caregivers. This will be part of an Orthopaedic Hospital of Wisconsin approach.

### **Goal**

Develop and implement pilot program of Home Assessment in partnership with North Shore Health Department and North Shore Paramedics

**Action:** Work collaboratively to develop program design through research by student interns and collaboration with partners

**Partners:** Joseph J. Zilber School of Public Health at University of Wisconsin-Milwaukee, Orthopaedic Hospital of Wisconsin professionals, North Shore Health Department and Paramedics

**Outcomes/Impact:** Pilot service model will assess 20 people by Fiscal Year 2017, 30 by Fiscal Year 2018 and 40 by Fiscal Year 2019

## **CHRONIC DISEASE**

CSM, as a partner in community service with OHOW, has a history of work to manage diabetes through church partnership and food pantry partnership and therefore developed a diabetes-friendly food pantry model as well as the Ebenezer Health Resource Center, both at the same location. These will be supported through the Orthopaedic Hospital of Wisconsin Community Health Improvement Plan, given the history of support for health programs at Ebenezer.

### **Goal**

Create diabetes-friendly food pantry at Ebenezer food pantry

**Action:** Work with partners to develop healthy food pantry through contributions, purchases and related educational programs

**Partners:** Feeding America, Hunger Task Force, dietary instructors, CSM Foundation and other funders, and Ebenezer Health Resource Center staff

**Outcomes/Impacts:** Healthy foods, as defined by dietitians, increase from 15% of food types offered to 20% of food types in Fiscal Year 2017, 30% by Fiscal Year 2018 and 45% by Fiscal Year 2019

Appreciation of healthy foods and engagement with staff increase average monthly pantry use from 800 families per month in baseline Fiscal Year 2016 to 850 in Fiscal Year 2017, 900 in Fiscal Year 2018 and 950 in Fiscal Year 2019

## **NEEDS NOT ADDRESSED IN THE PLAN**

OHOW and CSM work together to address needs in the community. As an orthopaedic hospital serving a limited range of patient needs, many of the needs in the CHNA are more appropriately addressed within the CSM CHIP.

The following needs are addressed in the FY17-19 CSM Milwaukee Community Health Improvement Plan

*INFANT MORTALITY*

*ORAL HEALTH*

*SUBSTANCE ABUSE*

*CANCER DISPARITY*

*MENTAL HEALTH*

*OVERWEIGHT OBESITY*

*HEALTH LITERACY*

*SEXUAL HEALTH*