Community Health Implementation Strategy: Dane County FY23 – FY25

UW Health Hospitals and Clinic Authority Board
Approved: October 27, 2022
Introduction

UW Health completed a joint 2022-2024 Community Health Needs Assessment (CHNA) with Healthy Dane Collaborative: UnityPoint Health-Meriter, SSM Health – St. Mary’s, Stoughton Hospital in collaboration with Group Health Cooperative and Public Health Madison Dane County.

We are proud to work collectively with many partners on our implementation strategy to improve health in our community.
## Community Health Improvement

<table>
<thead>
<tr>
<th>Community Health Needs Assessment</th>
<th>Community Health Implementation Strategy</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Tax-exempt hospitals</strong> complete a Community Health Needs Assessment (CHNA) every 3 years to identify priority health issues</td>
<td>• Following CHNA, required to complete Community Health Implementation Strategy (CHIS) that includes <strong>actions</strong>, resources, planned collaboration and anticipated impact.</td>
<td>• <strong>Implement</strong> community health implementation strategies and <strong>measure</strong> impact</td>
</tr>
</tbody>
</table>
Environmental and social factors greatly impact the health of a community.

We assessed input from the community and data related to each of the **Health Factors in the County Health Rankings Model** to better understand what is impacting the health of our community.

The Healthy Dane Collaborative conducted this Community Health Needs Assessment using a **health equity lens**.
We are using the framework of the *County Health Rankings & Roadmaps Take Action Cycle* to guide us in HOW to create a healthy community that results in community transformation.

Data Source:
## Collaborative Approach Among Health Systems

<table>
<thead>
<tr>
<th>Dane County Health Council</th>
<th>Community Engagement Partners</th>
<th>Community Collaborator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access Community Health Centers</td>
<td>Madison Metropolitan School District</td>
<td>Black Maternal and Child Health Alliance of Dane County</td>
</tr>
<tr>
<td>Group Health Cooperative of South Central Wisconsin</td>
<td>Public Health Madison &amp; Dane County</td>
<td></td>
</tr>
<tr>
<td>SSM Health</td>
<td>United Way of Dane County</td>
<td></td>
</tr>
<tr>
<td>UnityPoint Health Meriter</td>
<td>UW Health</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The logos and names represent the health systems and community collaborators involved in the collaborative approach.
Foundational Competency: Community Engagement

“The Black Maternal & Child Health Alliance is comprised of Black women serving in important roles in health care, our community, and as decision-makers and knowledge experts. Our highest priority is to ensure that the health and well-being of Black mothers remains front and center.”

CO-CHAIRS GREEN AND STEVENSON

This Photo by Unknown Author is licensed under CC BY-NC-ND.
Black Maternal and Child Health Alliance (bmcha.org)
<table>
<thead>
<tr>
<th>Reproductive Justice</th>
<th>Chronic Conditions</th>
<th>Behavioral Health</th>
<th>Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Outcomes</td>
<td>Heart Disease</td>
<td>Mental Health</td>
<td>Falls</td>
</tr>
<tr>
<td>Maternal Morbidity</td>
<td>Hypertension</td>
<td>Substance Use Disorder</td>
<td>Accidents</td>
</tr>
<tr>
<td>Infections</td>
<td>Diabetes</td>
<td></td>
<td>Violence</td>
</tr>
</tbody>
</table>
Strategy Selection

- **Responsible**
  Evidenced-based Strategies

- **Accountable**
  Recommendations from Community Members

- **Consulted**
  Review by UW Health cross functional team of experts of community recommendations and evidence-based practices, prioritized based on feasibility and impact
Cross-Functional Team Rounding

- Dane County Falls Prevention Taskforce
- Dane County Violence Prevention Collaborative
- Focused Interruption

- Focused Interruption Board
- Hospital Violence Intervention Stakeholders
- Healthy Kids Leadership Council
- PATCH

- Children’s Mental Coalition
- Geriatric Primary Care
- Maternal & Child Health Steering Group

- Pediatric Policy Council
- Performance & Care Model Committee
- Population Stakeholders Committee

- UW Health Adult Falls Injury Providers & Faculty
- UW Health & East Hospital Emergency Department Violence Intervention Stakeholders - Security, Social Work, & Emergency Department Leadership

GOAL

External Stakeholders
Internal Stakeholders
Reproductive Justice Priority

Vision: To improve birth outcomes for Black birthing patients and families in Dane County
UW Health is working in collaboration with many existing organizations and local champions in Dane County to address reproductive justice.

**Coalitions**
- Black Maternal and Child Health Alliance of Dane County
- African American Health Network

**Community-Based Organizations**
- Foundation for Black Women’s Wellness
- EQT By Design
- March of Dimes
- United Way
- Meadowood Health Partnership / Neighborhood Connectors
- Faith Based Organizations
- DAIS
- Rape Crisis Center
- UNIDOS
- The Rainbow Project

**Government Agencies**
- Public Health Madison Dane County
- Dane County Human Services/Joining Forces for Families
### Low Birthweight

#### Meriter births % of race with LBW

<table>
<thead>
<tr>
<th></th>
<th>Q1 2021</th>
<th></th>
<th>Q2 2021</th>
<th></th>
<th>Q3 2021</th>
<th></th>
<th>Q4 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td># LBW</td>
<td>% LBW</td>
<td>#</td>
<td># LBW</td>
<td>% LBW</td>
<td>#</td>
</tr>
<tr>
<td>Total</td>
<td>1088</td>
<td>111</td>
<td>10.20%</td>
<td>1295</td>
<td>112</td>
<td>8.65%</td>
<td>2597</td>
</tr>
<tr>
<td>White</td>
<td>783</td>
<td>78</td>
<td>9.96%</td>
<td>942</td>
<td>74</td>
<td>7.86%</td>
<td>1809</td>
</tr>
<tr>
<td>Black</td>
<td>88</td>
<td>17</td>
<td>19.82%</td>
<td>101</td>
<td>17</td>
<td>16.83%</td>
<td>207</td>
</tr>
<tr>
<td>Hispanic</td>
<td>97</td>
<td>6</td>
<td>6.19%</td>
<td>122</td>
<td>10</td>
<td>8.20%</td>
<td>295</td>
</tr>
<tr>
<td>Asian</td>
<td>82</td>
<td>6</td>
<td>7.32%</td>
<td>89</td>
<td>3</td>
<td>3.37%</td>
<td>190</td>
</tr>
<tr>
<td>other/none given</td>
<td>38</td>
<td>4</td>
<td>10.53%</td>
<td>41</td>
<td>8</td>
<td>19.51%</td>
<td>96</td>
</tr>
</tbody>
</table>
## Postpartum Visit Rate for UW Health by Race/Ethnicity

<table>
<thead>
<tr>
<th>Patient Race/Ethnicity</th>
<th>Count of Pregnancy Episodes</th>
<th>Count of Pregnancy Episodes with at least one Postpartum Visit</th>
<th>Percent of Pregnancy Episodes with at least one Postpartum visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, non-Hispanic</td>
<td>6,790</td>
<td>3,243</td>
<td>47.8%</td>
</tr>
<tr>
<td>Black or African American, non-Hispanic</td>
<td>1,067</td>
<td>375</td>
<td>35.1%</td>
</tr>
<tr>
<td>Asian, non-Hispanic</td>
<td>793</td>
<td>403</td>
<td>50.8%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>690</td>
<td>312</td>
<td>45.2%</td>
</tr>
<tr>
<td>Multiracial, non-Hispanic</td>
<td>220</td>
<td>89</td>
<td>40.5%</td>
</tr>
<tr>
<td>Unknown/Missing</td>
<td>94</td>
<td>33</td>
<td>35.1%</td>
</tr>
<tr>
<td>American Indian or Alaska Native, non-Hispanic</td>
<td>37</td>
<td>17</td>
<td>45.9%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander, non-Hispanic</td>
<td>8</td>
<td>3</td>
<td>37.5%</td>
</tr>
<tr>
<td>Total</td>
<td>9,699</td>
<td>4,475</td>
<td>46.1%</td>
</tr>
<tr>
<td>Initiatives</td>
<td>Internal &amp; External Partners</td>
<td>Anticipated Impact</td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Health Promoters                | • EOTO, LLC  
• Meadowood Health Partnerships  
• Dane County Health Council  
• Foundation for Black Women’s Wellness  
• Black Maternal and Child Health Alliance of Dane County | Access to health education for identified high need zip codes in Dane County facing the highest disparities.                                                                                           |
| Trauma Informed Care            | • Family Medicine-OB Staff Providers  
• Community Partners                                                                 | Trauma informed care provided to patients and families  
Vicarious trauma prevention for providers/clinic staff exposed to patient trauma.                                                                 |
| Human Milk Lactation Support    | • UPH-Meriter  
• Lactation Support  
• Clinical Nutrition                                                                 | Increased use of human milk feeding for all Black birthing patients.                                                                                   |
| Postpartum Care                 | • Ob-Gyn  
• Family Medicine  
• Virtual Care Roadmap                                                                 | Increased access to postpartum visits including chronic disease management, mental health support and education (in-person and virtual care)    |
## Reproductive Justice Strategies

<table>
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<tr>
<th>Initiatives</th>
<th>Internal &amp; External Partners</th>
<th>Anticipated Impact</th>
</tr>
</thead>
</table>
| Medicaid Coverage for CHWs                       | • State Policy  
• Government Relations                                                                 | Improve outcomes for Medicaid beneficiaries by addressing health and social needs.                           |
| Guaranteed Income                                | • State Policy  
• Government Relations                                                                 | Provide and increase social safety net as well as racial and gender equity.                                  |
| Diversify Perinatal Care Team                    | • Dane County Health Council  
• Ob-Gyn, Family Medicine  
• Population Health  
• Social Work                                                                 | Prenatal care team reflects patient population being served.                                                |
| Social Determinants of Health Screening and Referrals  | • ConnectRx  
• Bright Futures 2.0                                                                 | Immediate connection to community resources.                                                                |
Reproductive Justice Implementation Timeline

FY23
- Health Promoters
- Guaranteed Income
- Social Determinants of Health Screening and Referral

FY24
- Human Milk Lactation Support
- Postpartum Care
- Medicaid Coverage for CHWs

FY25
- Trauma-Informed Care
- Diversify Perinatal Care Team
Chronic Conditions Priority

Vision: To improve chronic conditions care for BIPOC communities across the lifecourse
UW Health is working in collaboration with many existing organizations and local champions in Dane County to address chronic conditions.

**Coalitions**
- Healthy Kids Collaborative
- Latino Health Council
- African American Health Network
- Vision Zero Coalition
- People for Streets Coalition

**Community-Based Organizations**
- Meadowood Health Partnership
- Allied Wellness
- Latino Academy
- Bayview Community Center
- Mount Zion Baptist Church

**Government Agencies**
- Public Health Madison Dane
- City of Madison Traffic Engineering
- Local public school districts
Chronic Conditions Strategies

- **Individual Counseling/Education**
  - Health Promoters

- **Clinical Care**
  - Mammography/Breast Cancer Screening
  - Healthy Habits (5-2-1-0 Refresh and Active Transportation)

- **Prevention**
  - Cardiovascular Care (Diabetes and Hypertension) and Community Partnerships
  - Pediatric Fitness Clinic + Community Partnerships

- **Policy Initiatives**
  - Community Giving
  - Social Determinants of Health Screening & Referrals

- **Social Determinants of Health**
  - Support access to increased physical activity and healthy food for kids

Increasing Population Impact

Increasing Individual Effort Needed
<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Internal &amp; External Partners</th>
<th>Anticipated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Promoters</td>
<td>• EOTO, LLC • Meadowood Health Partnership • Dane County Health Council • Foundation for Black Women’s Wellness • Black Maternal and Child Health Alliance of Dane County</td>
<td>Provide health education outreach in Dane County’s high need zip codes facing the highest disparities</td>
</tr>
<tr>
<td>Cardiovascular Care (Diabetes and Hypertension, Remote Patient Monitoring) + Community Partnerships</td>
<td>• Primary Care/Ambulatory Operations • Pharmacists in Primary Care • Population Health • Diabetes Educators • Telehealth • RN Care Coordination • Community Partnerships</td>
<td>Improve patient self-efficacy in managing hypertension and diabetes.</td>
</tr>
<tr>
<td>Mammography/Breast Cancer Screening</td>
<td>• Primary Care/Ambulatory Operations • Wisconsin Well Woman Program • Community Partnerships</td>
<td>Increased rates of early detection for Black &amp; Latinx patients</td>
</tr>
<tr>
<td>Pediatric Fitness Clinic + Community Partnerships</td>
<td>• Primary Care • Healthy Kids Collaborative • Community-based Organizations</td>
<td>Patients receive culturally responsive care and access to services.</td>
</tr>
</tbody>
</table>
## Chronic Conditions Strategies

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</table>
| Healthy Habits (5-2-1-0 Refresh and Active Transportation) | • Healthy Kids Collaborative  
• Local public-school districts  
• Dane County community centers and community-based organizations  
• Children's Health Alliance of Wisconsin  
• Department of Pediatrics and Family Medicine | Improvement of one school district wellness policy around 5-2-1-0-aligned best practices (ex. nutrition services, physical activity) |
| Support access to increased physical activity and healthy food for kids | • Healthy Kids Collaborative  
• Dane County municipalities  
• People for Streets Coalition | Improved walking and biking access with community partner organizations for zip codes in Dane County facing the highest disparities in active living |
| Social Determinants of Health Screening & Referrals | • Department of Pediatrics, Family Medicine  
• Ambulatory Social Work  
• Office of Population Health  
• Community-Based Organizations | Expansion of social determinants of health screening in well-child checks/Bright Futures 2.0 and broader SDOH screening and referral based on Social Determinants of Health Business Plan |
Chronic Conditions Implementation Timeline

FY23
Health Promoters
Mammography/Breast Cancer Screening
Social Determinants of Health Screening & Referrals

FY24
Cardiovascular Care
(Diabetes and Hypertension, Remote Patient Monitoring) + Community Partnerships
Healthy Habits: 5-2-1-0 Refresh + Active Transportation

FY25
Pediatric Fitness Clinic + Community Partnerships
Support access to increased physical activity and healthy food for kids (policy)
Vision: To improve access to mental health services and substance use disorder treatment
UW Health is working in collaboration with many existing organizations and local champions in Dane County to address behavioral health.

**Coalitions**
- African American Opioid Coalition
- Zero Suicide Collaborative
- Children's Mental Health Collaborative
- Recovery Coalition of Dane County
- Wisconsin Voices for Recovery

**Community-based Organizations**
- Safe Communities
- Anesis Therapy
- Foster
- EOTO, LLC
- Wisconsin Society of Addiction Medicine
- Community behavioral health providers (e.g., outpatient addiction treatment providers; BH provider agencies)

**Government Agencies**
- Wisconsin Department of Health Services
- Public Health Madison Dane County Overdose Fatality Review
- Dane County Human Services
- Dane County School Districts
- Dane County Human Services – Behavioral Health Resource Center
- Dane County Executive's Ending Deaths from Despair Task Force
- Veterans Administration Hospital
## Adult Behavioral Health Strategies

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Internal &amp; External Partners</th>
<th>Anticipated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Strategic Plan</td>
<td>Behavioral Health UPH-Meriter</td>
<td>Strategies will be for system of care with UWH and UPH-Meriter</td>
</tr>
<tr>
<td>Hub and Spoke / Improve Access to Addiction Medicine</td>
<td>• Behavioral Health • Family Medicine • General Internal Medicine</td>
<td>Reduce turnaround time for accessing appointments for Medication Assisted Treatment to 72 hours</td>
</tr>
<tr>
<td>Expand Access to Behavioral Health</td>
<td>• Behavioral Health • Ambulatory Operations</td>
<td>• Adult Collaborative Care • Adult Partial Hospitalization and Intensive Outpatient (IOP) • Expanding Behavioral Health Emergency Response • Coordinated Specialty Care • Interventional Psychiatry</td>
</tr>
<tr>
<td>Expand Zero Suicide</td>
<td>• Behavioral Health UPH-Meriter • Zero Suicide Collaborative • Safe Communities • Veterans Hospital</td>
<td>Mitigate suicide risk and implement policy in hospital-based outpatient locations.</td>
</tr>
<tr>
<td>Culturally Responsive Care</td>
<td>Behavioral Health Marketing &amp; Communications</td>
<td>Diversity of patients reflected in patient facing materials</td>
</tr>
</tbody>
</table>
Adult Behavioral Health Implementation Timeline

**FY23**
- Behavioral Health Strategic Plan
- Expand Access to Behavioral Health
- Expand Zero Suicide

**FY24**
- Hub & Spoke + Improve Addiction Medicine Access
- Expand Access to Behavioral Health

**FY25**
- Culturally Responsive Care
Pediatric Behavioral Health

Vision: To expand behavioral and mental health support for children and adolescents.
Behavioral Health Strategic Plan - TBD
School Community Partnerships

Individual Counseling/Education

Clinical Care

Expansion of Pediatric/Adolescent Services Across Care Continuum

Prevention

Investments in School Mental Health Workforce

Policy Initiatives

State School-Based Mental Health Services Grant Expansion

Social Determinants of Health

Increasing Population Impact

Youth Community-Based Mental Health Support Expand Zero Suicide

Community Giving Culturally Responsive Care

Increasing Individual Effort Needed
### Pediatric Behavioral Health Strategies

<table>
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<th>Internal &amp; External Partners</th>
<th>Anticipated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Strategic Plan</td>
<td>Behavioral Health UPH-Meriter</td>
<td>Integrate long-term strategic planning with UnityPoint Health - Meriter</td>
</tr>
<tr>
<td>School Community Partnerships</td>
<td>Behavioral Health Healthy Kids Collaborative Madison Metropolitan School District Verona Area School District</td>
<td>Expanding partnerships to deliver behavioral health in school settings</td>
</tr>
</tbody>
</table>
| Expansion of Pediatric/Adolescent Services Across Care Continuum | • Behavioral Health  
• UPH-Meriter  
• Family Medicine  
• General Pediatrics and Adolescent Medicine | Expanded outpatient treatment options for children and adolescents with behavioral health needs. |
| Youth Community-Based Mental Health Support Pilots       | • Healthy Kids Collaborative  
• Dane County public school districts  
• Children’s Mental Health Coalition  
• Madison community centers  
• Child Health Advocacy | Increased mental health support for children and adolescents in community settings.     |
## Pediatric Behavioral Health Strategies

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Internal &amp; External Partners</th>
<th>Anticipated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Zero Suicide</td>
<td>• Behavioral Health • UPH-Meriter • Zero Suicide Collaboration • Safe Communities</td>
<td>Increased awareness and education on suicide prevention for parents</td>
</tr>
<tr>
<td>Investments in School Mental Health Workforce</td>
<td>State Policy Government Relations UPH-Meriter Children’s Mental Health Collaborative Wisconsin Coalition for Expanding Mental Health in Schools</td>
<td>Improve access to mental health services in schools</td>
</tr>
<tr>
<td>State School-Based Mental Health Services Grant Expansion</td>
<td>State Policy Government Relations UPH-Meriter Children’s Mental Health Collaborative Wisconsin Coalition for Expanding Mental Health in Schools</td>
<td>Continue to increase state grant funding for school-based mental health services</td>
</tr>
<tr>
<td>Culturally Responsive Care</td>
<td>Behavioral Health Marketing and Communications</td>
<td>• Patient population and staff are reflective of population served</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure that behavioral health treatment options for the BIPOC child/adolescent population are available.</td>
</tr>
</tbody>
</table>
Pediatric Behavioral Health Implementation Timeline

**FY23**
- Behavioral Health Strategic Plan
- School Community Partnerships
- Expansion of Pediatric/Adolescent Services Across Care Continuum
- Expand Zero Suicide

**FY24**
- Youth Community-Based Mental Health Support Pilots
- Investments in School Mental Health Workforce

**FY 2025**
- State Schools Based Mental Health Grant Expansion
- Culturally Responsive Care
Injury Prevention Priority

Vision: To reduce unintended and intended injury across the life-course
UW Health is working in collaboration with many existing organizations and local champions in Dane County to address injury prevention.

**Coalitions**
- Dane County Violence Prevention Collaborative
- Dane County Falls Prevention Task Force
- Wisconsin’s Institute for Healthy Aging, Falls Free Wisconsin Initiative

**Community-Based Organizations**
- DAIS
- Rape Crisis Center
- Focused Interruption
- The Rainbow Project
- UNIDOS
- Safe Communities, Madison/Dane County

**Government Agencies**
- Dane County Traffic Safety Commission
- Vision Zero
- Dane County Aging and Disability Resource Center
- Dane County Area Agency on Aging
- Victims Services Program of Dane County District Attorney’s Office
Injury Health Strategy Pyramid

- Individual Counseling/Education
- Clinical Care
- Prevention
- Policy Initiatives
- Social Determinants of Health

- Increasing Population Impact
- Increasing Individual Effort Needed

- Trauma Informed Culture Learning Collaborative
- Child Passenger Safety Community Program
- Gun Violence Prevention Community Collaboration (HVIP)
- Age Friendly Primary Care Strategic Planning
- Community Giving Social Determinants of Health Screening & Referral

- Comprehensive Firearm Background Checks
- Screening and Referrals to UW Health Kids Safety Center
- Screening and Referrals for Falls
- Adult and Peds Firearm Prevention & Prior Injury Screening
### Initiatives

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Internal &amp; External Partners</th>
<th>Anticipated Impact</th>
</tr>
</thead>
</table>
| **Trauma Informed Culture Learning Collaborative (TICLC)** | • UW Madison School of Medicine and Public Health  
• UW Health TICLC Steering Committee  
• SMPH Standardized Patient curriculum team  
• Behavioral Health  
• State Medical Society Foundation  
• Resilient Wisconsin | • Reductions in reports of UW Health employee injury and burnout  
• UW Health patients receive care that is informed by awareness of the impact that recent and prior trauma has on their healing |
| **Screening and Referrals to UW Health Kids Safety Center** | • General Pediatrics and Adolescent Medicine  
• Family Medicine  
• UW Health Kids Safety Center | • Improve referral pathway to UW Health Kids Safety Center for children and youth with special healthcare needs  
• Increase awareness and access to UW Health Safety Kids Center products to improve home safety |
| **Screening and Referral for Falls** | • SMPH/UW Health Geriatricians and Fam Med Primary Care providers  
• Belleville and East Clinic  
• Safe Communities  
• Enterprise Analytics | • Reduce barriers to patient participation in recommended UW Health and community falls prevention programs and treatments  
• Patients 65 and older will be knowledgeable about the impact of falls and how to reduce the risk of falls injuries  
• Increase number of adults 65 and older who participate in upstream effective falls prevention activities |
<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Internal &amp; External Partners</th>
<th>Anticipated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult and Peds Firearm Prevention &amp; Prior Injury Screening</td>
<td>SMPH and UW Health Primary Care/Ambulatory Operations Emergency Department Safe Communities Focused Interruption</td>
<td>Patients with prior gunshot assault injury are aware of risk of future firearm injury and community and UW Health resources for support and services. Reduction in unintentional gunshot injuries</td>
</tr>
<tr>
<td>Child Passenger Safety Community Program</td>
<td>Primary Care/Ambulatory Operations</td>
<td>Reduction in child passenger safety related injuries</td>
</tr>
</tbody>
</table>
| Hospital-linked Gun Violence Prevention Community Collaboration (HVIP) | • UWH & East Emergency Department (Providers, nurses, social work, chaplaincy)  
• UWH & East Security  
• Adult & Peds Trauma  
• Focused Interruption  
• DA’s Office Victim Services Unit | • Support expansion of Focused Interruption’s capacity to provide aftercare program, and broaden prevention outreach  
• Support Hospital-linked Gun Violence Intervention |
<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Internal &amp; External Partners</th>
<th>Anticipated Impact</th>
</tr>
</thead>
</table>
| Age Friendly Primary Care Strategic Planning for Falls Prevention and Community Collaboration | • SMPH/UW Health Geriatricians and Fam Med Primary Care providers  
• Pharmacy  
• Cardiology  
• Test of Change Clinics (proposed: Belleville and East Clinic)  
• Safe Communities  
• WIHA  
• Population Health  
• Home-based Primary Care | • Increase opportunity for Primary Care Providers to identify falls risk  
• Reduction in unintentional injury adults 65 and older |
| Comprehensive Firearm Background Checks                                   | • State Policy  
• Government Relations                                                                 | Increased firearm safety |
| Social Determinants of Health Screening and Referral                       | • Department of Pediatrics, Family Medicine  
• Ambulatory Social Work  
• Office of Population Health  
• Community-Based Organizations                                             | Expansion of social determinants of health screening in well child checks/Bright Futures 2.0 and broader SDOH screening and referral based on Social Determinants of Health Business Plan |
Injury Prevention Health Implementation Timeline

**FY23**
- Trauma Informed Culture Learning Collaborative
- Screening and Referrals to UW Health Kids Safety Center
- Child Passenger Safety Community Program

**FY24**
- Screening and Referral for Falls – (Primary Care Clinic Test of Change)
- Gun Violence Prevention Community Collaboration (HVIP) Aftercare Program
- Adult and Peds Firearm Prevention & Prior Injury Screening

**FY25**
- Age-Friendly Primary Care
- Comprehensive Firearm Background Checks
## Reproductive Justice

- \# and % of Black babies born with low birthweight compared to white babies born with low birthweight
- \# and % of Black birthing patients screened for intimate partner violence during prenatal and postpartum visits compared to white birthing patients
- \# and % of Black birthing patients screened for intimate partner violence prior to labor and delivery discharge at UPH-Meriter compared to white birthing patients
- \# and % of Black birthing patients exclusively using human milk feeding at discharge for families who deliver at 37 weeks or greater by maternal race
- \# and % of Black birthing patients completing postpartum visits at 3 weeks postpartum broken down by insurance payor
- \# and % of eligible Black birthing patients active in ConnectRx.

## Chronic Conditions

- Hypertension: Black and Latinx adult UW Health Primary Care patients identified with uncontrolled hypertension based on WCHQ measures
- Diabetes Control: number of Black & Latinx adult UW Health Primary Care patients identified with uncontrolled diabetes based on WCHQ measures
- \# and % of children and adolescents with controlled diabetes
- \# and % of Black and Latinx patients screened for breast cancer in UW Health Primary Care & mammography compared to white patients based on WCHQ measures

## Behavioral Health

- \# and % of patients able to access appointments within a 72-hour window in Hub & Spoke (opioid tx)
- \# and % of patients receiving Behavioral Health appointments within 2 weeks
- \# and % of Black birthing patients completing postpartum visits at 3 weeks postpartum broken down by insurance payor

## Injury Prevention

- \# and % patients 65 and older who were screened, referred and completing falls prevention programs
- \# and % of patients 65 and older receiving falls prevention referrals
- \# and % of patients 65 and older receiving falls prevention follow up as recommended

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**Note:**
- Hypertension: Black and Latinx adult UW Health Primary Care patients identified with uncontrolled hypertension based on WCHQ measures.
- Diabetes Control: number of Black & Latinx adult UW Health Primary Care patients identified with uncontrolled diabetes based on WCHQ measures.
- \# and % of children and adolescents with controlled diabetes.
- \# and % of Black and Latinx patients screened for breast cancer in UW Health Primary Care & mammography compared to white patients based on WCHQ measures.
- \# and % patients 65 and older who were screened, referred and completing falls prevention programs.
Our Commitment to the Community

UW Health remains committed to improving health outcomes in Dane County. We will:

- Continue community engagement as we develop and implement community health improvement initiatives
- Implement activities in alignment with the needs that were voiced by the community in the Community Health Needs Assessment
- Communicate our progress
- Address social determinants of health in conjunction with clinical care
- Measure community health improvement
- Embrace and acknowledge diversity, equity and inclusion principles
“Nothing about us, without us.”