Community Health Needs Assessment (CHNA) Report

Froedtert Health Neighborhood Hospital, LLC
Doing Business As:

Froedtert Community Hospital – Pewaukee

Fiscal Year 2024
Effective July 1, 2023

Approved on 05/01/2023 by
Froedtert Health Neighborhood
Hospital, LLC Board of Managers

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Executive Summary

Community Health Needs Assessment for Froedtert Community Hospital – Pewaukee

A community health needs assessment (CHNA) is a tool to gather data and important health information about the communities Froedtert Community Hospital – Pewaukee serves. This assessment guides our investments and helps us identify and measure community health needs and assets, allowing us to better tailor our engagement with communities and allocate resources.

To produce this CHNA, Froedtert Community Hospital – Pewaukee utilized data from the 2020 Waukesha County Community Health Needs Assessment (CHNA) and focus groups specific to the Froedtert Community Hospital – Pewaukee service area.

Every three years, Froedtert Health, Advocate Aurora Health, Ascension Wisconsin, Children's Wisconsin, ProHealth Care and the Waukesha County Public Health Division align resources to participate in a robust, shared Waukesha County CHNA data collection process. Supported by additional analysis from the JKV Research, LLC and the Center for Urban Population Health, the CHNA includes findings from a community health survey, key informant interviews, focus groups, a compiling of secondary source data and internal hospital data.

Froedtert Health also conducted two focus groups specific to the Froedtert Community Hospital – Pewaukee service area. The data helps inform an independent CHNA specific to Froedtert Community Hospital – Pewaukee's service area and community health needs. The independent CHNA serves as the basis for the creation of an implementation strategy to improve health outcomes and reduce disparities in Froedtert Community Hospital – Pewaukee's service area.

The CHNA was reviewed by the Froedtert Community Hospital – Pewaukee CHNA/Implementation Strategy Advisory Committee (**Appendix A**), which consists of members of the Froedtert Community Hospital – Pewaukee Community Advisory Committee, local health department representatives, Waukesha County community partners, and hospital and health system leadership and staff. Committee members were selected based on their specific knowledge of health needs and resources in the Froedtert Community Hospital – Pewaukee service area for a collective analysis of the CHNA findings. Under the direction of the Department of Community Engagement's leadership team and a trained meeting facilitator, assessment findings were categorized and ranked to identify the top health need in the Froedtert Community Hospital – Pewaukee service area.

Following the review of the CHNA, an implementation strategy was developed, identifying evidence-based programs and allocating resources appropriately. Froedtert Community Hospital – Pewaukee Community Engagement leadership and staff will regularly monitor and report on progress toward achieving the implementation strategy's objectives. They also will provide quarterly reports to the Community Advisory Committee and the health system's Community Engagement Steering Committee. Additional progress on the Implementation Strategy will be reported annually through the hospital's IRS Form 990 Schedule H filing and other reporting sources associated with strategic partners and community coalitions.

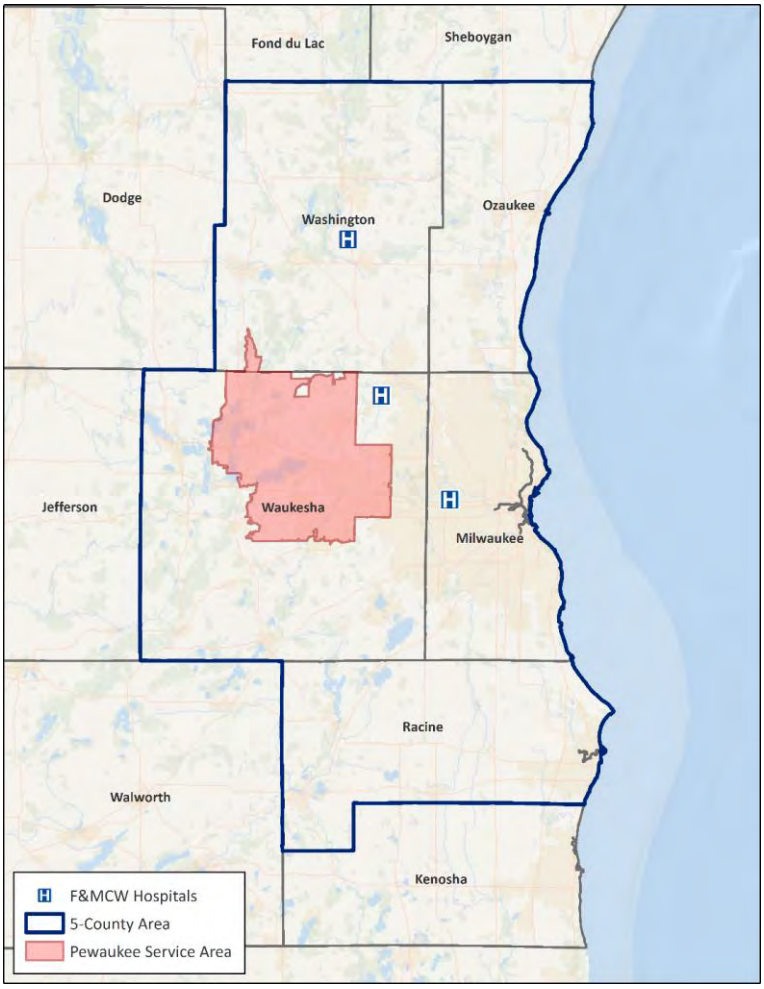
Froedtert Community Hospital – Pewaukee Community Service Area

Overview
Froedtert Community Hospital, part of the Froedtert & the Medical College of Wisconsin health network, includes locations in Mequon, Pewaukee, New Berlin and Oak Creek. Each licensed, accredited, acute-care facility provides high-quality care close to home in a small-scale hospital setting and features an emergency department, inpatient beds, laboratory, pharmacy and imaging services.

Mission Statement
The Froedtert & the Medical College of Wisconsin health network advances the health of the people of the diverse communities we serve through exceptional care enhanced by innovation and discovery.

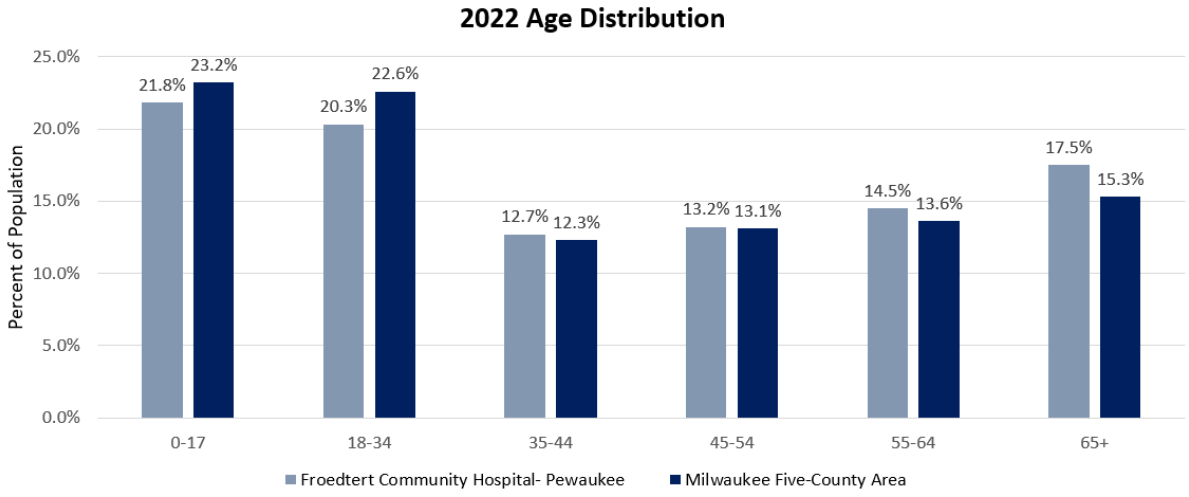
Froedtert Community Hospital – Pewaukee Service Area and Demographics
For the purpose of the Community Health Needs Assessment, the community is defined as ZIP codes within Milwaukee, Racine, and Waukesha County, because 31.2% of discharges occur from this geography. All programs, activities, and partnerships under the CHNA will be delivered in Waukesha County. Froedtert Community Hospital – Pewaukee determines its primary service area by completing an annual review and analysis of hospital discharges and market share according to various determinants.

The Froedtert Community Hospital – Pewaukee total service area consists of eight zip codes: 53029 (Hartland), 53045 (Brookfield), 53056 (Merton), 53058 (Nashotah), 53072 (Pewaukee), 53089 (Sussex), 53186 (Waukesha), and 53188 (Waukesha).

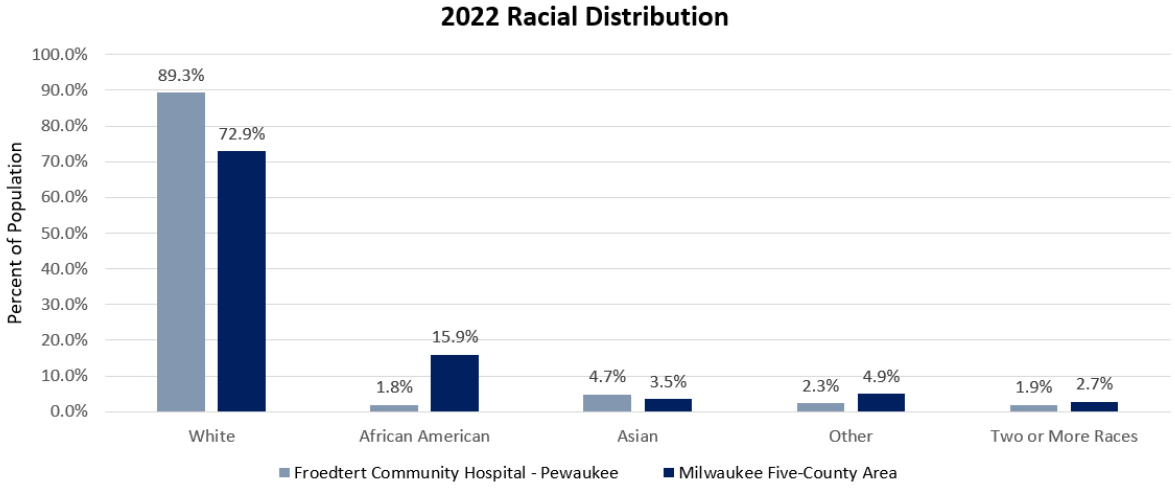


Froedtert Community Hospital – Pewaukee Primary Service Area Demographics

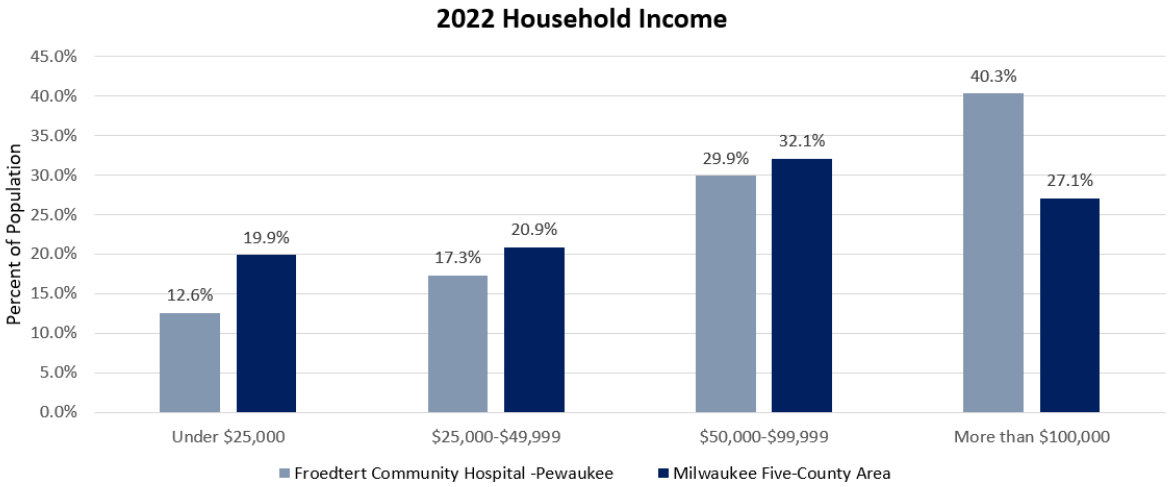
Age – The Froedtert Community Hospital – Pewaukee service area has a larger older population compared to the Milwaukee Five-County area. The 45 and older age groups are larger in the Froedtert Community Hospital – Pewaukee service area with 45.2% of population, while the Five-County area 45 and older age groups make up 42% of the population.



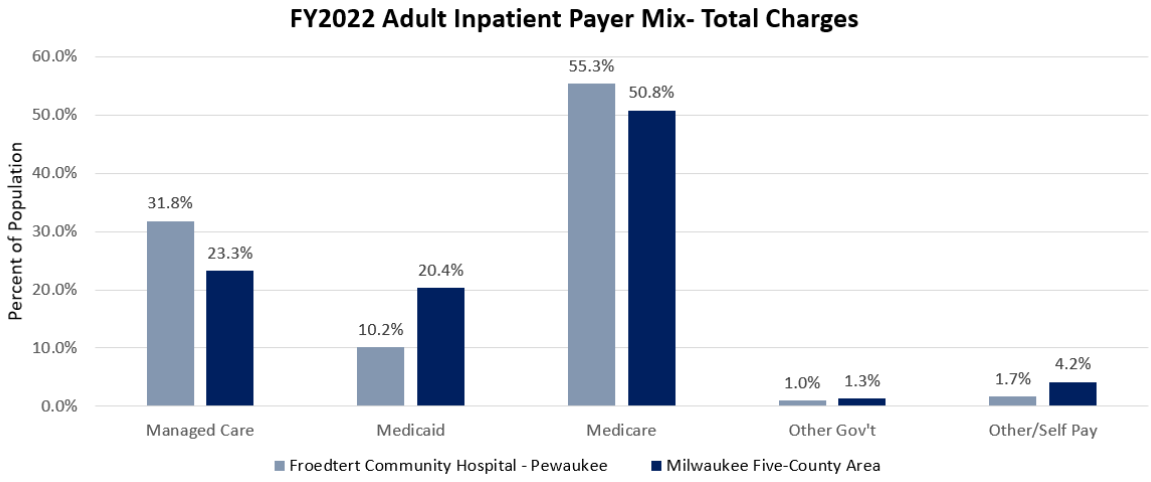
Race – The racial distribution in the Froedtert Community Hospital – Pewaukee service area is predominantly White (89.3%). The Milwaukee Five-County Area is 72.9% White and 15.9% African American.



Household Income – Households where income is less than $50,000 is 29.9% of the distribution in the Froedtert Community Hospital – Pewaukee service area. Within the Milwaukee Five-County area, the percent of households where income is less than $50,000 is 40.8%.



Payer Mix – For adult inpatients, 11.9% of Froedtert Community Hospital – Pewaukee service area patients are Medicaid and Self Pay payers. The Milwaukee Five-County area has 24.6% Medicaid and Self Pay patients in the payer mix.



*Milwaukee Five-County Area: Milwaukee, Ozaukee, Racine, Waukesha, Washington

Community Health Needs Assessment Process and Methods Used

In 2022, a CHNA was conducted to 1) determine current community health needs in the Froedtert Community Hospital – Pewaukee service area, 2) gather input from persons who represent the broad interest of the community and identify community assets, 3) identify and prioritize significant health needs, and 4) develop implementation strategies to address the prioritized health needs. Froedtert Community Hospital – Pewaukee assessed the health needs of the communities it serves through a comprehensive data collection process from a number of key sources. Data and research included information from community members, public health officials, community leaders/experts, and non-profit organizations representing vulnerable populations in our service area. The following information/data sources were collected and taken into consideration for assessing and addressing community health needs:

Community Health Survey: Froedtert Community Hospital – Pewaukee utilized data from the 2020 Waukesha County CHNA telephone survey of 400 residents that was conducted by Froedtert Menomonee Falls Hospital in collaboration with other local health care systems. The full report of this survey can be found at Froedtert Menomonee Falls Hospital Community Engagement.

Key Stakeholder Interviews: Froedtert Community Hospital – Pewaukee utilized data from the 2020 Waukesha County CHNA of 41 phone interviews with Waukesha County community leaders of various school districts, non-profit organizations, health and human service department and business leaders. A list of organizations can be found in **Appendix G**. The full Key Informant CHNA can be found at Froedtert Menomonee Falls Hospital Community Engagement. In addition, the Community Engagement team and leaders conducted two focus groups with five key stakeholders in the Froedtert Community Hospital – Pewaukee service area. A list of organizations can be found in **Appendix G**.

Secondary Data Report: Utilizing multiple county and community-based publicly available reports, information was gathered regarding: Mortality/Morbidity data, Injury Hospitalizations, Waukesha County Health Rankings, Public Safety/Crime Reports and Socio-economic data. A full summary of Secondary Data information can be found at Froedtert Menomonee Falls Hospital Community Engagement.

Internal Hospital Data: Internal data was gathered from Froedtert Community Hospital – Pewaukee's service area to gain a better understanding of specific health needs impacting the hospital's patient population.

Disparities and Health Equity

The Froedtert & the Medical College of Wisconsin health network's mission is to advance the health of the people of the diverse communities we serve through exceptional care enhanced by innovation and discovery. Froedtert Community Hospital – Pewaukee is committed to being an inclusive and culturally competent organization that provides exceptional care to everyone. Equity, diversity and inclusion are priorities for the hospital and the entire health network. Our health equity efforts focus on reducing health care gaps and increasing opportunities for good health by working to eliminate systemic, avoidable, unfair and unjust barriers. The community health needs assessment included a focus on equity, the identification of significant health needs and the prioritization of those needs. Equity will continue to be considered as Froedtert Community Hospital – Pewaukee identifies strategies to address those prioritized significant health needs.

Data Collection Collaborators

Froedtert Community Hospital – Pewaukee completed its 2022 data collection in collaboration with multiple community organizations serving Waukesha County. These organizations were heavily involved in identifying and collecting the data components of the 2020 shared CHNA:

- Ascension Wisconsin
- Aurora Health Care
- Children's Wisconsin
- Froedtert Health

- ProHealth Care
- Waukesha County Public Health Division

Data Collection Consultants
JKV Research, LLC and the Center of Urban Population Health (CUPH) were commissioned to support report preparation for the 2022 shared Waukesha County data collection process.

Community Health Needs Assessment Solicitation and Feedback

Froedtert Community Hospital – Pewaukee is committed to addressing community health needs collaboratively with local partners. Froedtert Community Hospital – Pewaukee used the following methods to gain community input from June to September 2020 and August and September 2022 on the significant health needs of the Froedtert Community Hospital – Pewaukee community. These methods provided additional perspectives on how to select and address top health issues facing Froedtert Community Hospital – Pewaukee's community.

Input from Community Members
Key Stakeholder Interviews: Key organizations with specific knowledge and information relevant to the scope of the identified significant health needs ("informants") in Froedtert Community Hospital – Pewaukee's community were identified by organizations and professionals that represent the broad needs of the community, and organizations that serve low-income and underserved populations. A list of key stakeholders can be found in **Appendix G**. These local partnering organizations also invited stakeholders to participate in and conducted the interviews. The 2020 Waukesha County CHNA interviewers used a standard interview script that included the following elements:

- Ranking of up to five public health issues, based on the focus areas presented in Wisconsin's State Health Plan, that are the most important issues for the County;
- For those five public health issues:
    - Existing strategies to address the issue
    - Barriers and challenges to addressing the issue
    - Additional strategies needed
    - Key groups in the community that hospitals should partner with to improve community health
    - Identification of subgroups or subpopulations where efforts could be targeted
    - Ways efforts can be targeted toward each subgroup or subpopulation; and
- To be responsive to the current conditions during the COVID-19 pandemic, the following additional questions were added to the interview guide:
    - What community needs or gaps have developed since the coronavirus pandemic began?
    - How can health care organizations support the community during this pandemic?
    - What methods of communication and outreach have been successful to reach partners and community members during the pandemic?
    - How would you suggest health care organizations outreach to community partners and members to implement health initiatives?

The 2022 Froedtert Community Hospital – Pewaukee CHNA interviewers used a standard interview script that included the following elements:

- Ranking of two social determinants of health that are the most important issues for the service area.
- For those two social determinants of health, identification of:
    - How COVID-19 has impacted this issue
    - One major effort the community could rally behind to improve the issue
    - The community stakeholders that are critical to addressing the issue
- Ranking of two health conditions and behaviors that are the most important issues for the service area.
- For those two health issues, identification of:
    - The populations most affected and how they are affected

- Existing strategies to address the issue
- Additional strategies needed and barriers to addressing the issue
- The community stakeholders that are critical to addressing the issue
- One major effort the community could rally behind to improve the issue
- One thing the organization needs to address this issue
- How COVID-19 has impacted this issue

Underserved Population Input: Froedtert Community Hospital – Pewaukee is dedicated to reducing health disparities. Gathering input from community members who are medically underserved, from low-income and minority populations, and/or from organizations that represent those populations is important in addressing community health needs. With that in mind, Froedtert Community Hospital – Pewaukee gained input from:

- 2020 Waukesha County Community Health Survey: When appropriate, data was stratified by gender, age, education household income level and marital status.
- 2020 and 2022 Key Stakeholder Interviews: The key stakeholder interviews included input from members of organizations representing medically underserved, low-income and minority populations.

Summary of Community Member Input

The top health issues/behaviors and social needs ranked most consistently or most often cited in the community health survey and by key stakeholders were:

Community Health Survey:

- Coronavirus/COVID- 19
- Illegal Drug Use
- Overweight or Obesity
- Chronic Diseases
- Mental Health or Depression
- Access to Health Care

Key Stakeholder Interviews:

- Mental Health
- Substance Use and Abuse
- Accessible and Affordable Healthcare
- Chronic Disease
- Nutrition
- Access to Social Services

Prioritization of Significant Health Needs

Froedtert Community Hospital – Pewaukee analyzed secondary data of several indicators, gathered community input from focus groups and utilized data from an online survey and key stakeholder interviews to identify the needs in the Froedtert Community Hospital – Pewaukee service area. Based on the information from all the CHNA data collection sources, the health needs were identified as:

- Mental Health
- Substance Use and Abuse (alcohol, tobacco and other drugs)
- Access to Health Care
- Chronic Diseases
- Access to Social Services

The CHNA was reviewed by the Froedtert Community Hospital – Pewaukee CHNA/Implementation Strategy Advisory Committee (**Appendix A**), which consists of members of the Froedtert Community Hospital – Pewaukee Community Advisory Committee, local health department representatives, Waukesha County community partners, and hospital and health system leadership and staff. Committee members were selected based on their specific knowledge of health needs and resources in the Froedtert Community Hospital – Pewaukee service area for a collective analysis of the CHNA findings. Under the direction of the Department of Community Engagement's leadership team and a trained meeting facilitator, the planning process included four steps in prioritizing Froedtert Community Hospital – Pewaukee's significant health needs:

1. Review current hospital and community health improvement initiatives and strategies.
2. Review the Community Health Needs Assessment results for identification and prioritization of community health needs.

3. Rank and selected priority areas.
4. Brainstorm evidence-based strategies, partnerships and programs to address community health needs.

During a facilitated workout session in January 2023, members of the CHNA/Implementation Strategy Advisory Committee were asked to rate each health need based on the following criteria, to identify the significant health needs:

- **Alignment:** the degree to which the health issue aligns with Froedtert Health's mission and strategic priorities.
- **Feasibility:** the degree to which Froedtert Community Hospital – Pewaukee can address the need through direct programs, clinical strengths and dedicated resources.
- **Partnerships:** the degree to which there are current or potential community partners/coalitions.
- **Health Equity:** the degree to which disparities exist and can be addressed.
- **Measurable:** the degree to which measurable impact can be made to address the issue.
- **Upstream:** the degree to which the health issue is upstream from and a root cause of other health issues.

Based on those results, **mental health** was identified as the top priority for Froedtert Community Hospital – Pewaukee's 2024-2026 Implementation Strategy.

Community Resources and Assets

Community Hospital – Pewaukee Community Engagement staff, leaders and external community partners work collaboratively to address the significant health needs of the community by leveraging existing resources including in-kind donations, financial contributions, dedicated staff, marketing/IT and clinical and medical expertise. Specific resources leveraged by the hospital are identified in the Implementation Strategy. In addition, community resources are noted by key stakeholders in **Appendix E**.

Approval of Community Health Needs Assessment

The completed Community Health Needs Assessment (CHNA) report was adopted by the Froedtert Health Neighborhood Hospital, LLC Board of Managers on 05/01/2023 and made publicly available on 05/02/2023.

Summary of Impact from the Previous Implementation Strategy

An important aspect of the three-year CHNA cycle is revisiting the progress made on priority needs set forth in the preceding CHNA. By reviewing the actions taken to address identified significant needs and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next CHNA cycle.

As Froedtert Community Hospital – Pewaukee is a newly established licensed hospital, this is the first CHNA that the hospital has been required to complete. Moving forward, the hospital will report on its actions.

Public Availability of CHNA and Implementation Strategy

After adoption of the CHNA Report and Implementation Strategy, Froedtert Community Hospital – Pewaukee publicly shares both documents with community partners, key stakeholder, hospital board members, public schools, non-profits, hospital coalition members, local public health departments and the general public. Documents are made available via email, hard copies are made available at applicable meetings, and electronic copies are made available by PDF for download on Froedtert Community Hospital Community Engagement | Froedtert & MCW.

Feedback and public comments are always welcomed and encouraged. Use the contact form on the Froedtert & the Medical College of Wisconsin health network website at https://www.froedtert.com/contact, or call Froedtert Health, Inc.'s Community Engagement leadership/staff at 414-777-3787.

Appendix A: Froedtert Community Hospital – Pewaukee CHNA/Implementation Strategy Advisory Committee

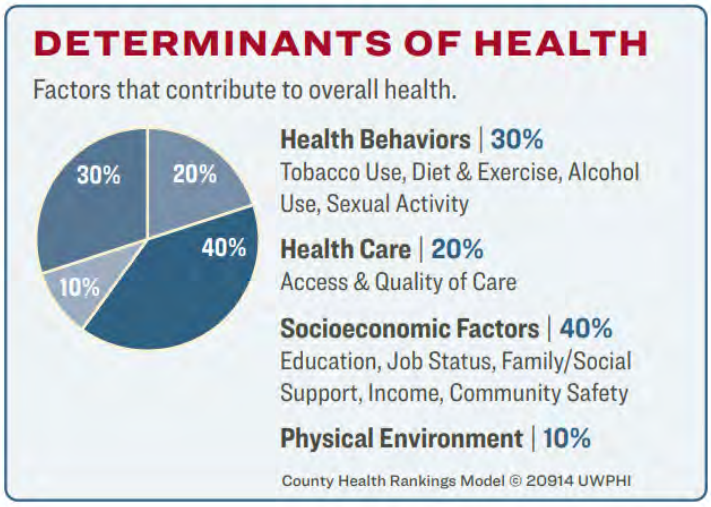
Name	Title	Organization	Hospital Affiliation
Chris Cook	Division Chief of EMS	Pewaukee Fire Department	CAC
Brian Foth	Sergeant	Police - Village of Pewaukee Police Department	
Tim Heier	Chief	Police - Village of Pewaukee Police Department	
Bala Narayanan	Manager- Strategic Programs	Froedtert Health	CAC
Nick Phalin	Director	Pewaukee Parks & Recreation	CAC
Adriana Plach	Continuous Improvement Coordinator	Pewaukee School District	CAC
John Roubik	Director of Human Resources	Hamilton School District	CAC
Liz Unruh	Special Events Director	Positively Pewaukee	CAC
RamaKrishna Vootkru	Vice President	Hindu Temple	
Jennifer Waltz	Executive Director	Sussex Area Outreach Services	CAC
Andy Dresang	Executive Director, Community Engagement	Froedtert Health	
Larry Dux	Director, Clinical Informatics	Froedtert Health	
Mandie Reedy	Community Engagement Coordinator	Froedtert Health	
Amanda Wisth	Manager of Community Benefit and Impact	Froedtert Health	
Patricia Nimmer	Director, Community Outreach/Partnerships	Froedtert Health	
Robert Ramerez	Director, Community Health	Froedtert Health	
Kiara Green	Executive Assistant Associate – Community Engagement	Froedtert Health	

Appendix B: Disparities and Health Equity

Health equity and health disparities are complex and closely connected, as are their root causes. This assessment derived language and context for these definitions from the Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute and the American Public Health Association.

Racism affects opportunity and assigns value based on how a person looks. It unfairly advantages some individuals and communities and unfairly disadvantages others. Racism hurts the health of our nation by preventing some people from attaining their highest level of health. Racism can be intentional or not, and it impacts health in many ways; driving unfair treatment through policies, practices and resource allocation. It is a fundamental cause of health disparities across numerous health issues.

Determinants of health reflect the many factors that contribute to an individual's overall health. In addition to health care and health behaviors, it is estimated that socioeconomic conditions and the physical environment represent 50% of an individual's opportunity for good health. The determinants of health reflect a growing area of focus, research, and investment in areas like housing, education, community safety and employment to help build healthier communities.



Health disparities are preventable differences in ***health outcomes*** (e.g. infant mortality), as well as the ***determinants of health*** (e.g. access to affordable housing) across populations.

Health equity is the principle that opportunities for good health in vulnerable populations are achievable by eliminating systemic, avoidable, unfair and unjust barriers. Progress towards achieving health equity can be measured by reducing gaps in health disparities.

Health Disparities

Identifying health disparities and barriers to good health are important components in assessing community health needs. Once identified, understanding upstream policies, systems and social determinants that drive health disparities can help create practical, community-driven solutions that support individual and community health improvement. Analysis by race and place is utilized throughout the shared Waukesha County CHNA.

National trends have shown that systemic racism, poverty and gender discrimination have led to poorer health outcomes in communities of color, low-income populations, and for LGBTQ+ individuals. Health disparities in these and other vulnerable populations described in the shared Waukesha County CHNA are informed by both community input (primary data) and health indicators (secondary data).

Appendix C: 2022 Froedtert Community Hospital – Pewaukee Community Health Needs Assessment: 2020 Waukesha County Community Health Phone Survey

The Waukesha County Community Health Survey Report is available at https://www.froedtert.com/community-engagement.

The Community Health Survey is conducted approximately every three years and is used to identify community trends and changes over time. The health topics covered by the survey are provided in the Waukesha County Community Health Survey Report (**Appendix D**). The purpose of this project is to provide Waukesha County with information for an assessment of the health status of residents. Primary objectives are to:

1. Gather specific data on behavioral and lifestyle habits of the adult population. Select information will also be collected about the respondent's household.
2. Gather data on a random child (17 or younger) in the household through an adult who makes health care decisions for the child.
3. Gather data on the prevalence of risk factors and disease conditions existing within the adult population.
4. Compare, where appropriate, health data of residents to previous health studies.
5. Compare, where appropriate and available, health data of residents to state and national measurements along with Healthy People 2020 goals.

Respondents were scientifically selected so the survey would be representative of all adults 18 years old and older in the county. The sampling strategy was two-fold. 1) A random-digit-dial landline sample of telephone numbers which included listed and unlisted numbers. The respondent within each household was randomly selected by computer and based on the number of adults in the household (n=220). 2) A cell phone-only sample where the person answering the phone was selected as the respondent (n=180). At least 8 attempts were made to contact a respondent in each sample. Screener questions verifying location were included. Data collection was conducted by Management Decisions Incorporated. A total of 400 telephone interviews were completed between July 24, 2020 and September 4, 2020.

It is important to keep this data in context of COVID-19. On March 25, 2020, a public health emergency, Safer at Home, was declared in Wisconsin where all non-essential businesses were closed for approximately ten weeks. Waukesha County developed Stay Safe to Stay Open, following the federal Guidelines for Opening Up America Again and the Wisconsin Badger Bounce Back plan to safely open up businesses and activities in the county. During the community health survey data collection, non-essential business capacity was at 50%, adult remote options were encouraged and indoor gatherings were limited to 100 people or less with social distancing. As a result, behaviors may be different than in previous years.

With a sample size of 400, we can be 95% sure that the sample percentage reported would not vary by more than ±5 percent from what would have been obtained by interviewing all persons 18 years old and older with telephones in the county. This margin of error provides us with confidence in the data; 95 times out of 100, the true value will likely be somewhere between the lower and upper bound. The margin of error for smaller subgroups will be larger than ±5 percent, since fewer respondents are in that category (e.g., adults who were asked about a child in the household).

In 2019, the Census Bureau estimated 318,146 adult residents lived in Waukesha County. Thus, in this report, one percentage point equals approximately 3,180 adults. So, when 9% of respondents reported their health was fair or poor, this roughly equals 28,620 residents ±15,900 individuals. Therefore, from 12,720 to 44,520 residents likely have fair or poor health. Because the margin of error is ±5%, events or health risks that are small will include zero.

In 2019, the Census Bureau estimated 160,635 occupied housing units in Waukesha County. In certain questions of the Community Health Survey, respondents were asked to report information about their household. Using the 2019 household estimate, each percentage point for household-level data represents approximately 1,610 households.

Limitations: The breadth of findings is dependent upon who self-selected to participate in the online survey. Additionally, the community survey was a convenience sample, which means results may be vulnerable to selection bias and make the findings less generalizable. However, findings did show that the community survey participant sample was representative of the overall demographics of Waukesha County. A limitation to the survey is that it was conducted in English and Spanish only.

Partners & Contracts: This report was commissioned by Ascension Wisconsin, Advocate Aurora Health, Children's Wisconsin, Froedtert Health and ProHealth Care in partnership with the Waukesha County Public Health Division and the Center for Urban Population Health. The data was analyzed and prepared by JKV Research, LLC. Data collection was conducted by Management Decisions Incorporated.

Appendix D: 2022 Froedtert Community Hospital – Pewaukee Community Health Needs Assessment: 2020 Waukesha County Community Health Phone Survey Results

Executive Summary

This research provides valuable behavioral data, lifestyle habits, and the prevalence of risk factors and disease conditions of Waukesha County residents. The following data are highlights of the comprehensive study.

	Waukesha					WI	US
Rating Their Own Health	2009	2012	2015	2017	2020	*2019*	*2019*
Excellent/Very Good	68%	64%	57%	60%	63%	*50%*	*50%*
Good	23%	26%	33%	25%	28%	*34%*	*32%*
Fair or Poor	9%	10%	11%	15%	9%	*16%*	*18%*
Health Care Coverage			Waukesha			WI	US
Not Covered	2009	2012	2015	2017	2020	*2019*	*2019*
Personally (Currently, 18 Years Old and Older) [HP2020 Goal: 0%]	8%	6%	2%	2%	4%	*9%*	*11%*
Personally (Currently, 18 to 64 Years Old) [HP2020 Goal: 0%]	10%	7%	2%	2%	5%	*11%*	*14%*
Personally (Past Year, 18 and Older)	11%	7%	6%	3%	7%	*NA*	*NA*
Household Member (Past Year)	12%	10%	9%	7%	9%	*NA*	*NA*
			Waukesha			WI	US
Unmet Health Care Needed in Past Year	2009	2012	2015	2017	2020	*2019*	*2019*
Delayed/Did Not Seek Care Due to Cost	--	--	17%	17%	13%	*11%*	*12%*
Unmet Need/Care in Household							
Prescription Medication Not Taken Due to Cost [HP2020 Goal: 3%]	--	8%	8%	11%	5%	*NA*	*NA*
Medical Care [HP2020 Goal: 4%]*	--	4%	9%	12%	9%	*NA*	*NA*
Dental Care [HP2020 Goal: 5%]*	--	9%	12%	7%	16%	*NA*	*NA*
Mental Health Care*	--	<1%	3%	3%	4%	*NA*	*NA*
Health Information			Waukesha			WI	US
Primary Source of Health Information	2009	2012	2015	2017	2020	*2019*	*2019*
Doctor	--	40%	47%	49%	51%	*NA*	*NA*
Internet	--	28%	30%	30%	32%	*NA*	*NA*
Myself/Family Member in Health Care Field	--	9%	6%	13%	9%	*NA*	*NA*
			Waukesha			WI	US
Health Care Services	2009	2012	2015	2017	2020	*2019*	*2019*
Have a Primary Care Physician [HP2020 Goal: 84%]	--	--	--	86%	89%	*82%*	*76%*
Primary Health Care Services							
Doctor/Nurse Practitioner's Office	86%	86%	78%	68%	64%	*NA*	*NA*
Urgent Care Center	4%	5%	8%	21%	21%	*NA*	*NA*
Quickcare Clinic (Fastcare Clinic)	--	--	--	3%	2%	*NA*	*NA*
Hospital Emergency Room	2%	<1%	3%	<1%	3%	*NA*	*NA*
Public Health Clinic/Community Health Center	3%	5%	4%	<1%	2%	*NA*	*NA*
Virtual Health/Tele-Medicine/Electronic Visits	--	--	--	<1%	<1%	*NA*	*NA*
Worksite Clinic	--	--	--	4%	<1%	*NA*	*NA*
Hospital Outpatient Department	1%	<1%	<1%	0%	0%	*NA*	*NA*
No Usual Place	4%	2%	6%	3%	7%	*NA*	*NA*
Advance Care Plan	40%	39%	40%	46%	46%	*NA*	*NA*
			Waukesha			WI	US
Vaccinations (65 and Older)	2009	2012	2015	2017	2020	*2019*	*2019*
Flu Vaccination (Past Year)	75%	64%	73%	74%	82%	*64%*	*64%*
Pneumonia Vaccination (Ever) [HP2020 Goal: 90%]	74%	75%	73%	79%	84%	*77%*	*73%*

--Not asked. NA-WI and/or US data not available.
*In 2020, the question was asked about any household member. In previous years, the question was asked of respondents only.

	Waukesha					WI	US
Routine Procedures	2009	2012	2015	2017	2020	2019	2019
Routine Checkup (2 Years Ago or Less)	84%	85%	85%	86%	90%	87%	88%
Cholesterol Test (4 Years Ago or Less) [HP2020 Goal: 82%]	82%	79%	84%	84%	81%	84%	87%
Dental Checkup (Past Year) [HP2020 Goal: 49%]	74%	75%	76%	82%	76%	71%[1]	68%[1]
Eye Exam (Past Year)	41%	49%	55%	53%	39%	NA	NA

	Waukesha					WI	US
Health Conditions in Past 3 Years	2009	2012	2015	2017	2020	2019	2019
High Blood Pressure	22%	26%	33%	31%	29%	NA	NA
High Blood Cholesterol	24%	25%	26%	26%	22%	NA	NA
Mental Health Condition	13%	12%	11%	18%	19%	NA	NA
Diabetes	6%	7%	9%	12%	10%	NA	NA
Heart Disease/Condition	6%	9%	7%	12%	8%	NA	NA
Asthma (Current)	9%	8%	8%	11%	9%	10%	10%

	Waukesha					WI	US
Condition Controlled Through Meds, Therapy or Lifestyle Changes	2009	2012	2015	2017	2020	2019	2019
High Blood Pressure	--	96%	98%	98%	97%	NA	NA
High Blood Cholesterol	--	93%	81%	77%	92%	NA	NA
Mental Health Condition	--	94%	98%	97%	99%	NA	NA
Diabetes	--	97%	94%	96%	89%	NA	NA
Heart Disease/Condition	--	94%	87%	91%	93%	NA	NA
Asthma (Current)	--	88%	87%	98%	97%	NA	NA

	Waukesha					WI	US
Physical Activity/Usual Week	2009	2012	2015	2017	2020	2009	2009
Moderate Activity (5 Times/30 Min)	41%	33%	31%	44%	43%	NA	NA
Vigorous Activity (3 Times/20 Min)	33%	28%	31%	37%	40%	NA	NA
Recommended Moderate or Vigorous Activity	53%	47%	46%	56%	57%	53%	51%

Body Weight	Waukesha					WI	US
Overweight Status	2009	2012	2015	2017	2020	2019	2019
At Least Overweight (BMI 25.0+) [HP2020 Goal: 66%]	63%	65%	70%	69%	70%	70%	67%
Obese (BMI 30.0+) [HP2020 Goal: 31%]	21%	25%	34%	30%	34%	34%	32%

	Waukesha					WI	US
Nutrition and Food Security	2009	2012	2015	2017	2020	2009	2009
Fruit Intake (2+ Servings/Average Day)	68%	65%	65%	67%	61%	NA	NA
Vegetable Intake (3+ Servings/Average Day)	30%	29%	25%	39%	31%	NA	NA
At Least 5 Fruit/Vegetables/Average Day	42%	37%	33%	45%	35%	23%	23%
Household Went Hungry-Couldn't Afford Enough Food (Past Year)	--	--	--	4%	2%	NA	NA

	Waukesha					WI	US
Colorectal Cancer Screenings (50 and Older)	2009	2012	2015	2017	2020	2018	2018
Blood Stool Test (Within Past Year)	--	14%	12%	9%	10%	7%	9%
Sigmoidoscopy (Within Past 5 Years)	10%	4%	6%	7%	5%	3%	2%
Colonoscopy (Within Past 10 Years)	62%	59%	62%	80%	72%	71%	64%
One of the Screenings in Recommended Time Frame [HP2020 Goal: 71%]	66%	60%	65%	83%	75%	75%	70%

--Not asked. NA-WI and/or US data not available. [1]WI and US data for dental visit is from 2018.

	Waukesha					WI	US
Women's Health Screenings	2009	2012	2015	2017	2020	2018	2018
Mammogram (50+; Within Past 2 Years)	76%	77%	78%	73%	84%	78%	78%
Bone Density Scan (65 and Older; Ever)	76%	86%	86%	86%	84%	NA	NA
Cervical Cancer Screening							
Pap Smear (18 – 65; Within Past 3 Years) [HP2020 Goal: 93%]	89%	83%	82%	80%	81%	81%	80%
HPV Test (18 – 65; Within Past 5 Years)	--	--	55%	47%	51%	NA	NA
Screening in Recommended Time Frame (18-29: Pap Every 3 Years; 30 to 65: Pap and HPV Every 5 Years or Pap Only Every 3 Years)	--	--	88%	84%	88%	NA	NA

	Waukesha					WI	US
Cigarette Smokers or Vapers	2009	2012	2015	2017	2020	2019	2019
Current Smokers [HP2020 Goal: 12%]	17%	17%	13%	14%	11%	15%	16%
Current Electronic Vapers (Past Month)	--	--	4%	4%	4%	4%[1]	5%[1]
Of Current Smokers/Vapers…						2005	2005
Quit Smoking/Vaping 1 Day or More in Past Year Because Trying to Quit [HP2020 Goal Quit Smoking: 80%]*	58%	45%	55%	67%	55%	49%	56%
Saw a Health Care Professional in Past Year and Advised to Quit Smoking/Vaping*	72%	69%	67%	76%	69%	NA	NA

	Waukesha					WI[2]	US
Exposure to Smoke or Electronic Vapor							
Smoking Policy at Home	2009	2012	2015	2017	2020	'14-15	'14-15
Not Allowed Anywhere	85%	82%	86%	88%	88%	84%	87%
Allowed in Some Places/At Some Times	7%	8%	6%	3%	3%	NA	NA
Allowed Anywhere	2%	2%	<1%	<1%	2%	NA	NA
No Rules Inside Home	6%	7%	8%	9%	7%	NA	NA
Nonsmokers/Nonvapers Exposed to Second-Hand Smoke/Vapor in Past 7 Days* [HP2020 Goal Nonsmokers: 34%]	26%	10%	8%	7%	8%	NA	NA

	Waukesha					WI	US
Other Tobacco Products in Past Month	2009	2012	2015	2017	2020	2019	2019
Smokeless Tobacco [HP2020 Goal: 0.2%]	--	--	2%	4%	7%	3%	4%
Cigars, Cigarillos or Little Cigars	--	--	3%	4%	3%	NA	NA

	Waukesha					WI	US
Alcohol Use in Past Month	2009	2012	2015	2017	2020	2019	2019
Binge Drinker** [HP2020 Goal 5+ Drinks: 24%]	27%	22%	29%	26%	32%	22%	17%
Driver/Passenger When Driver Perhaps Had Too Much to Drink	2%	3%	<1%	2%	2%	NA	NA

	Waukesha					WI	US
Other Drug Use in Past Year	2009	2012	2015	2017	2020	2019	2019
Cocaine or Other Street Drugs	--	--	--	<1%	2%	NA	NA
Misuse of Prescription Pain Relievers	--	--	--	<1%	<1%	NA	NA
Heroin	--	--	--	0%	0%	NA	NA

	Waukesha					WI	US
Household Problems in Past Year Associated With…	2009	2012	2015	2017	2020	2019	2019
Alcohol	3%	3%	6%	1%	2%	NA	NA
Cocaine, Heroin or Other Street Drugs	--	2%	<1%	2%	1%	NA	NA
Marijuana or THC-Containing Products	--	1%	2%	1%	<1%	NA	NA
Misuse of Prescription Drugs or Over-the-Counter Drugs	--	1%	1%	1%	<1%	NA	NA

--Not asked. NA-WI and/or US data not available. [1]Wisconsin and US current vapers is 2017 data. [2]Midwest data.
*In 2020, tobacco cessation, health professional advised quitting and exposure included current smokers and current vapers. In previous years, both questions were asked of current smokers only. **In 2009, binge drinking was defined as 5 or more drinks regardless of gender. Since 2012, binge drinking has been defined as 4 or more drinks for females and 5 or more drinks for males to account for metabolism differences.

	Waukesha					WI	US
Community and Personal Support	2009	2012	2015	2017	2020	*2019*	*2019*
Times of Distress and Looked for Community Resource Support (Past 3 Years)	--	--	--	18%	13%	*NA*	*NA*
Respondents Who Looked for Community Support Felt Somewhat/Slightly/Not at All Supported	--	--	--	43%	48%	*NA*	*NA*

	Waukesha					WI	US
Mental Health Status	2009	2012	2015	2017	2020	*2019*	*2019*
Felt Sad, Blue or Depressed Always/Nearly Always (Past Month)	5%	5%	4%	3%	4%	*NA*	*NA*
Considered Suicide (Past Year)	4%	2%	4%	4%	3%	*NA*	*NA*
Find Meaning & Purpose in Daily Life Seldom/Never	3%	4%	4%	4%	6%	*NA*	*NA*

	Waukesha					WI	US
Personal Safety Issues in Past Year	2009	2012	2015	2017	2020	*2019*	*2019*
Afraid for Their Safety	5%	4%	4%	4%	6%	*NA*	*NA*
Pushed, Kicked, Slapped or Hit	4%	1%	3%	5%	2%	*NA*	*NA*
At Least One of the Safety Issues	8%	4%	5%	7%	7%	*NA*	*NA*

	Waukesha					WI	US
Children in Household	2009	2012	2015	2017	2020	*2019*	*2019*
Primary Doctor/Nurse Who Knows Child Well and Familiar with History	--	86%	89%	97%	99%	*NA*	*NA*
Visited Primary Doctor/Nurse for Preventive Care (Past Year)	--	93%	95%	89%	97%	*NA*	*NA*
Did Not Receive Care Needed (Past Year)							
Medical Care	--	3%	4%	2%	4%	*NA*	*NA*
Dental Care	--	3%	6%	2%	7%	*NA*	*NA*
Specialist	--	3%	1%	<1%	6%	*NA*	*NA*
Current Asthma	--	3%	7%	3%	9%	*NA*	*NA*
Children 5 to 17 Years Old							
Fruit Intake (2+ Servings/Average Day)	--	75%	86%	67%	79%	*NA*	*NA*
Vegetable Intake (3+ Servings/Average Day)	--	30%	26%	27%	26%	*NA*	*NA*
5+ Fruit/Vegetables per Average Day	--	36%	48%	47%	47%	*NA*	*NA*
Physical Activity (60 Min./5 or More Days/Week)	--	70%	57%	60%	56%	*NA*	*NA*
Experienced Some Form of Bullying (Past Year)*	--	18%	14%	14%	10%	*NA*	*NA*
Verbally Bullied*	--	18%	14%	14%	9%	*NA*	*NA*
Physically Bullied*	--	5%	2%	4%	<1%	*NA*	*NA*
Cyber Bullied*	--	3%	4%	1%	3%	*NA*	*NA*

	Waukesha					WI	US
Top County Health Issues	2009	2012	2015	2017	2020	*2019*	*2019*
Coronavirus/COVID-19	--	--	--	--	48%	*NA*	*NA*
Illegal Drug Use	--	--	--	41%	31%	*NA*	*NA*
Overweight or Obesity	--	--	--	18%	22%	*NA*	*NA*
Chronic Diseases	--	--	--	17%	20%	*NA*	*NA*
Mental Health or Depression	--	--	--	10%	18%	*NA*	*NA*
Access to Health Care	--	--	--	21%	18%	*NA*	*NA*
Alcohol Use or Abuse	--	--	--	15%	11%	*NA*	*NA*
Cancer	--	--	--	11%	10%	*NA*	*NA*
Prescription or OTC Drug Abuse	--	--	--	17%	9%	*NA*	*NA*
Violence or Crime	--	--	--	5%	8%	*NA*	*NA*
Tobacco Use	--	--	--	5%	7%	*NA*	*NA*
Infectious Diseases	--	--	--	3%	5%	*NA*	*NA*
Access to Affordable Healthy Food	--	--	--	4%	5%	*NA*	*NA*

--Not asked. NA-WI and/or US data not available. *In 2020, the question was asked for children 5 to 17 years old. In previous years it was asked for children 8 to 17 years old.

Rating Their Own Health
In 2020, 63% of respondents reported their health as excellent or very good; 9% reported fair or poor. Respondents who were 65 and older, unmarried, inactive or smokers were more likely to report fair or poor health. *From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported their health as fair or poor while from 2017 to 2020, there was a statistical decrease.*

Health Care Coverage
In 2020, 4% of respondents reported they were not currently covered by health care insurance; respondents 18 to 34 years old, 45 to 54 years old, with a high school education or less or in the middle 20 percent household income bracket were more likely to report this. Seven percent of respondents reported they personally did not have health care insurance at least part of the time in the past year; respondents 18 to 34 years old, with a high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. Nine percent of respondents reported someone in their household was not covered at least part of the time in the past year; respondents who were in the bottom 60 percent household income bracket, unmarried or with children in the household were more likely to report this. *From 2009 to 2020, the overall percent statistically decreased for respondents 18 and older or 18 to 64 years old who reported no current personal health care coverage while from 2017 to 2020, there was no statistical change. From 2009 to 2020, the overall percent statistically remained the same for respondents who reported no personal health care insurance at least part of the time in the past year while from 2017 to 2020, there was a statistical increase. From 2009 to 2020, the overall percent statistically remained the same for respondents who reported someone in the household was not covered at least part of the time in the past year, as well as from 2017 to 2020.*

In 2020, 13% of respondents reported they delayed or did not seek medical care because of a high deductible, high co-pay or because they did not have coverage for the care in the past year; respondents 35 to 44 years old or with some post high school education were more likely to report this. Five percent of respondents reported that someone in their household had not taken their prescribed medication due to prescription costs in the past year; respondents who were in the bottom 40 percent household income bracket or unmarried were more likely to report this. Nine percent of respondents reported there was a time in the past year someone in their household did not receive the medical care needed; respondents who were in the bottom 40 percent household income bracket or unmarried were more likely to report this. Sixteen percent of respondents reported there was a time in the past year someone in the household did not receive the dental care needed; respondents who were in the bottom 40 percent household income bracket or unmarried were more likely to report this. Four percent of respondents reported there was a time in the past year someone did not receive the mental health care needed; respondents who were in the bottom 60 percent household income bracket or unmarried were more likely to report this. *From 2015 to 2020, the overall percent statistically remained the same for respondents who reported in the past year they delayed or did not seek medical care because of a high deductible, high co-pay or because they did not have coverage for the medical care, as well as from 2017 to 2020. From 2012 to 2020, the overall percent statistically decreased for respondents who reported someone in their household had not taken their prescribed medication due to prescription costs in the past year, as well as from 2017 to 2020. From 2012 to 2020, the overall percent statistically increased for respondents who reported unmet medical care or unmet mental health care in the past year while from 2017 to 2020, there was no statistical change. From 2012 to 2020, the overall percent statistically increased for respondents who reported unmet dental care in the past year, as well as from 2017 to 2020. Please note: in 2020, unmet medical, dental and mental health care need was asked of the household. In prior years, it was asked of the respondent only.*

Health Care Information
In 2020, 51% of respondents reported they contact a doctor when looking for health information while 32% reported they look on the Internet. Nine percent reported they were, or a family member was, in the health care field and their source for health information. Respondents 65 and older, with some post high school education or less or in the middle 20 percent household income bracket were more likely to report they contact a doctor. Respondents 18 to 44 years old or with a college education were more likely to report the Internet. Respondents with a college education, in the top 40 percent household income bracket or married respondents were more likely to report themselves or a family member in the health care field and their source for health information. *From 2012 to 2020, there was a statistical increase in the overall percent of respondents who reported doctor as their source of health information while from 2017 to 2020, there was no statistical change. From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported the Internet as their source of health information, as well as from 2017 to 2020. From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported they were/family member was in the health care field and their source of health information while from 2017 to 2020, there was a statistical decrease.*

Health Care Services

In 2020, 89% of respondents reported they have a primary care physician they regularly see for check-ups and when they are sick; respondents who were female, 45 to 54 years old, 65 and older or with some post high school education were more likely to report a primary care physician. Sixty-four percent of respondents reported their primary place for health care services when they are sick was from a doctor's or nurse practitioner's office while 21% reported an urgent care center. Respondents 65 and older or with some post high school education were more likely to report a doctor's or nurse practitioner's office as their primary health care when they are sick. Respondents 18 to 34 years old, with a high school education or less, with a college education or in the top 40 percent household income bracket were more likely to report an urgent care center as their primary health care. Forty-six percent of respondents had an advance care plan; respondents who were female, 65 and older, with a college education or married respondents were more likely to report an advance care plan. *From 2017 to 2020, there was no statistical change in the overall percent of respondents who reported they have a primary care physician. From 2009 to 2020, there was a statistical decrease in the overall percent of respondents who reported their primary place for health care services when they are sick was a doctor's/nurse practitioner's office while from 2017 to 2020, there was no statistical change. From 2009 to 2020, there was a statistical increase in the overall percent of respondents who reported their primary place for health care services when they are sick was an urgent care center while from 2017 to 2020, there was no statistical change. From 2009 to 2020, there was no statistical change in the overall percent of respondents with an advance care plan, as well as from 2017 to 2020.*

Routine Procedures

In 2020, 90% of respondents reported a routine medical checkup two years ago or less while 81% reported a cholesterol test four years ago or less. Seventy-six percent of respondents reported a visit to the dentist in the past year while 39% reported an eye exam in the past year. Respondents who were female, 65 and older or in the bottom 40 percent household income bracket were more likely to report a routine checkup two years ago or less. Respondents who were female, 45 to 54 years old, 65 and older, with some post high school education or married respondents were more likely to report a cholesterol test four years ago or less. Respondents 45 to 64 years old, with a college education, in the top 40 percent household income bracket or married respondents were more likely to report a dental checkup in the past year. Respondents 65 and older, with a college education, in the top 60 percent household income bracket or married respondents were more likely to report an eye exam in the past year. *From 2009 to 2020, there was a statistical increase in the overall percent of respondents who reported a routine checkup two years ago or less while from 2017 to 2020, there was no statistical change. From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported a cholesterol test four years ago or less, as well as from 2017 to 2020. From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported a dental checkup in the past year or an eye exam in the past year while from 2017 to 2020, there was a statistical decrease.*

Vaccinations

In 2020, 56% of respondents had a flu vaccination in the past year. Respondents who were female, 65 and older or married were more likely to report a flu vaccination. Eighty-four percent of respondents 65 and older had a pneumonia vaccination in their lifetime. *From 2009 to 2020, there was a statistical increase in the overall percent of respondents 18 and older who reported a flu vaccination in the past year while from 2017 to 2020, there was no statistical change. From 2009 to 2020, there was no statistical change in the overall percent of respondents 65 and older who reported a flu vaccination in the past year, as well as from 2017 to 2020. From 2009 to 2020, there was no statistical change in the overall percent of respondents 65 and older who had a pneumonia vaccination in their lifetime, as well as from 2017 to 2020.*

Prevalence of Health Conditions

In 2020, out of six health conditions listed, the most often mentioned in the past three years was high blood pressure (29%), high blood cholesterol (22%) or a mental health condition (19%). Respondents 65 and older, with some post high school education, who were overweight or inactive were more likely to report high blood pressure. Respondents 55 and older, with some post high school education, who were overweight or inactive were more likely to report high blood cholesterol. Respondents 35 to 44 years old, with some post high school education or in the bottom 40 percent household income bracket were more likely to report a mental health condition. Ten percent of respondents reported diabetes in the past three years; respondents who were 65 and older or overweight were more likely to report this. Eight percent reported they were treated for, or told they had heart disease/condition in the past three years. Respondents 65 and older, with some post high school education or less, in the bottom 60 percent household income bracket or inactive respondents were more likely to report heart disease/condition. Nine percent reported current asthma; respondents who were female or with a college education were more likely to report this. Of respondents who reported these health conditions, at least 89% reported the condition was controlled through medication, therapy or lifestyle changes. *From 2009 to 2020, there was a statistical increase in the overall percent of respondents who reported high blood pressure or a mental health condition while from 2017 to 2020,*

there was no statistical change. From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported high blood cholesterol, diabetes or current asthma, as well as from 2017 to 2020. From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported heart disease/condition while from 2017 to 2020, there was a statistical decrease.

Physical Health

In 2020, 43% of respondents did moderate physical activity five times in a usual week for 30 minutes. Forty percent of respondents did vigorous activity three times a week for 20 minutes. Combined, 57% met the recommended amount of physical activity; respondents who were 18 to 34 years old or not overweight were more likely to report this. *From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported moderate physical activity five times a week for at least 30 minutes, as well as from 2017 to 2020. From 2009 to 2020, there was a statistical increase in the overall percent of respondents who reported vigorous physical activity three times a week for at least 20 minutes while from 2017 to 2020, there was no statistical change. From 2009 to 2020, there was no statistical change in the overall percent of respondents who met the recommended amount of physical activity in a usual week, as well as from 2017 to 2020.*

In 2020, 70% of respondents were classified as at least overweight while 34% were obese. Respondents who were male, 35 to 44 years old, with some post high school education, in the middle 20 percent household income bracket or who did not meet the recommended amount of physical activity were more likely to be at least overweight. Respondents 35 to 44 years old, 55 to 64 years old, with some post high school education or inactive respondents were more likely to be obese. *From 2009 to 2020, there was a statistical increase in the overall percent of respondents who were at least overweight or obese while from 2017 to 2020, there was no statistical change.*

Nutrition and Food Insecurity

In 2020, 61% of respondents reported two or more servings of fruit while 31% reported three or more servings of vegetables on an average day. Respondents who were 35 to 44 years old, overweight, inactive or who met the recommended amount of physical activity were more likely to report at least two servings of fruit. Respondents who were female, 18 to 34 years old, 55 to 64 years old or with a college education were more likely to report at least three servings of vegetables on an average day. Thirty-five percent of respondents reported five or more servings of fruit/vegetables on an average day; respondents who were female, with a college education, in the middle 20 percent household income bracket or who met the recommended amount of physical activity were more likely to report this. Two percent of respondents reported their household went hungry because they couldn't afford enough food in the past year. *From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported at least two servings of fruit on an average day, as well as from 2017 to 2020. From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported at least three servings of vegetables on an average day while from 2017 to 2020, there was a statistical decrease. From 2009 to 2020, there was a statistical decrease in the overall percent of respondents who reported at least five servings of fruit/vegetables on an average day, as well as from 2017 to 2020. From 2017 to 2020, there was a statistical decrease in the overall percent of respondents who reported their household went hungry because they couldn't afford enough food in the past year.*

Women's Health

In 2020, 84% of female respondents 50 and older reported a mammogram within the past two years. Eighty-four percent of female respondents 65 and older had a bone density scan. Eighty-one percent of female respondents 18 to 65 years old reported a pap smear within the past three years. Fifty-one percent of respondents 18 to 65 years old reported an HPV test within the past five years. Eighty-eight percent of respondents reported they received a cervical cancer test in the time frame recommended (18 to 29 years old: pap smear within past three years; 30 to 65 years old: pap smear and HPV test within past five years or pap smear only within past three years). Respondents with a college education, in the top 40 percent household income bracket or married respondents were more likely to report a cervical cancer screen within the recommended time frame. *From 2009 to 2020, there was no statistical change in the overall percent of respondents 50 and older who reported a mammogram within the past two years, as well as from 2017 to 2020. From 2009 to 2020, there was no statistical change in the overall percent of respondents 65 and older who reported a bone density scan, as well as from 2017 to 2020. From 2009 to 2020, there was no statistical change in the overall percent of respondents 18 to 65 years old who reported a pap smear within the past three years, as well as from 2017 to 2020. From 2015 to 2020, there was no statistical change in the overall percent of respondents 18 to 65 years old who reported an HPV test within the past five years, as well as from 2017 to 2020. From 2015 to 2020, there was no statistical change in the overall percent of respondents 18 to 65 years old who reported a cervical cancer screen within the recommended time frame, as well as from 2017 to 2020.*

Colorectal Cancer Screening

In 2020, 10% of respondents 50 and older reported a blood stool test within the past year. Five percent of respondents 50 and older reported a sigmoidoscopy within the past five years while 72% reported a colonoscopy within the past ten years. This results in 75% of respondents meeting the current colorectal cancer screening recommendations. *From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported a blood stool test within the past year, as well as from 2017 to 2020. From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported a sigmoidoscopy within the past five years, as well as from 2017 to 2020. From 2009 to 2020, there was a statistical increase in the overall percent of respondents who reported a colonoscopy within the past ten years while from 2017 to 2020, there was no statistical change. From 2009 to 2020, there was a statistical increase in the overall percent of respondents who reported at least one of these tests in the recommended time frame while from 2017 to 2020, there was no statistical change.*

Alcohol Use

In 2020, 32% of respondents were binge drinkers in the past month (females 4+ drinks and males 5+ drinks). Respondents 35 to 44 years old or in the top 40 percent household income bracket were more likely to have binged at least once in the past month. Two percent of respondents reported they had been a driver or passenger when the driver perhaps had too much to drink in the past month. *From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported binge drinking in the past month, as well as from 2017 to 2020. From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported in the past month they were a driver or passenger in a vehicle when the driver perhaps had too much to drink, as well as from 2017 to 2020.*

Tobacco Use

In 2020, 11% of respondents were current tobacco cigarette smokers; respondents with a high school education or less were more likely to be a smoker. Four percent of respondents used electronic vapor products in the past month; respondents who were female, 18 to 34 years old or unmarried were more likely to report this. Fifty-five percent of current smokers or vapers quit for one day or longer because they were trying to quit in the past year. Sixty-nine percent of current smokers/vapers who saw a health professional in the past year reported the professional advised them to quit smoking or vaping. *From 2009 to 2020, there was a statistical decrease in the overall percent of respondents who were current tobacco cigarette smokers while from 2017 to 2020, there was no statistical change. From 2015 to 2020, there was no statistical change in the overall percent of respondents who reported electronic vapor product use in the past month, as well as from 2017 to 2020. From 2009 to 2020, there was no statistical change in the overall percent of current tobacco cigarette smokers or electronic vapor product users who quit smoking/vaping for at least one day in the past year because they were trying to quit, as well as from 2017 to 2020. From 2009 to 2020, there was no statistical change in the overall percent of current smokers/vapers who reported in the past year their health professional advised them to quit smoking or vaping, as well as from 2017 to 2020. Please note: in 2020, the tobacco cessation and health professional advised quitting questions included current smokers and current vapers. In previous years, both questions were asked of current smokers only.*

In 2020, 88% of respondents reported smoking is not allowed anywhere inside the home. Respondents with children in the household were more likely to report smoking is not allowed anywhere inside the home. Eight percent of nonsmoking or nonvaping respondents reported they were exposed to second-hand smoke or vapor in the past seven days; respondents 18 to 44 years old, with a high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. *From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported smoking is not allowed anywhere inside the home, as well as from 2017 to 2020. From 2009 to 2020, there was a statistical decrease in the overall percent of nonsmoking or nonvaping respondents who reported they were exposed to second-hand smoke or vapor in the past seven days while from 2017 to 2020, there was no statistical change. Please note: in 2020, the second-hand smoke exposure question included nonvapers while in previous years the question included nonsmokers only.*

In 2020, 7% of respondents used smokeless tobacco in the past month while 3% of respondents used cigars, cigarillos or little cigars. Respondents who were male, 18 to 54 years old, with some post high school education or less or in the top 40 percent household income bracket were more likely to report smokeless tobacco use. *From 2015 to 2020, there was a statistical increase in the overall percent of respondents who used smokeless tobacco in the past month, as well as from 2017 to 2020. From 2015 to 2020, there was no statistical change in the overall percent of respondents who used cigars/cigarillos/little cigars in the past month, as well as from 2017 to 2020.*

Other Drug Use
In 2020, less than one percent of respondents reported within the past year they used prescription pain relievers for nonmedical reasons while 6% reported more than one year ago. Zero percent of respondents reported within the past year they used heroin while 3% reported more than one year ago. Two percent reported they used cocaine or other street drugs within the past year while 8% reported more than one year ago. *From 2017 to 2020, there was no statistical change in the overall percent of respondents who reported it has been within the past year since they last used cocaine/other street drugs, used prescription pain relievers for nonmedical reasons or used heroin.*

Household Problems
In 2020, 2% of respondents reported someone in their household experienced a problem, such as legal, social, personal, physical or medical in connection with drinking alcohol in the past year. One percent of respondents reported someone in their household experienced some kind of problem with cocaine, heroin or other street drugs in the past year. Less than one percent of respondents each reported a household problem in connection with marijuana/THC-containing products or the misuse of prescription drugs/over-the-counter drugs. *From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported a household problem in connection with drinking alcohol in the past year, as well as from 2017 to 2020. From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported a household problem with marijuana/THC-containing products, cocaine/heroin/other street drugs or misuse of prescription drugs/over-the-counter drugs, as well as from 2017 to 2020.*

Community and Personal Support
In 2020, 13% of respondents reported someone in their household experienced times of distress in the past three years and looked for community support; respondents who were in the bottom 40 percent household income bracket or unmarried were more likely to report this. Forty-eight percent of respondents who looked for community resource support reported they felt somewhat, slightly or not at all supported. *From 2017 to 2020, there was no statistical change in the overall percent of respondents who reported in the past three years someone in their household experienced times of distress where they looked for community resource support. From 2017 to 2020, there was no statistical change in the overall percent of respondents who looked for community resource support and reported they felt somewhat, slightly or not at all supported by the resource.*

Mental Health Status
In 2020, 4% of respondents reported they always or nearly always felt sad, blue or depressed in the past month; respondents who were 35 to 44 years old, in the bottom 40 percent household income bracket or unmarried were more likely to report this. Three percent of respondents felt so overwhelmed they considered suicide in the past year. Six percent of respondents reported they seldom or never find meaning and purpose in daily life; respondents who were 35 to 44 years old, in the bottom 40 percent household income bracket or unmarried were more likely to report this. *From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported they always or nearly always felt sad, blue or depressed in the past month or they considered suicide in the past year, as well as from 2017 to 2020. From 2009 to 2020, there was a statistical increase in the overall percent of respondents who reported they seldom or never find meaning and purpose in daily life while from 2017 to 2020, there was no statistical change.*

Personal Safety Issues
In 2020, 6% of respondents reported someone made them afraid for their personal safety in the past year; respondents 18 to 44 years old or in the middle 20 percent household income bracket were more likely to report this. Two percent of respondents reported they had been pushed, kicked, slapped or hit in the past year. A total of 7% reported at least one of these two situations; respondents 18 to 34 years old, with some post high school education, in the middle 20 percent household income bracket or unmarried respondents were more likely to report this. *From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported they were afraid for their personal safety or they were pushed/kicked/slapped/hit in the past year, as well as from 2017 to 2020. From 2009 to 2020, there was no statistical change in the overall percent of respondents who reported at least one of the two personal safety issues in the past year, as well as from 2017 to 2020.*

Children in Household
In 2020, the respondent was asked if they make health care decisions for children living in the household. If yes, they were asked a series of questions about the health and behavior of a randomly selected child. Ninety-nine percent of respondents reported they have one or more persons they think of as the child's primary doctor or nurse, with 97% reporting the child visited their primary doctor or nurse for preventive care during the past year. Seven percent of respondents reported in the past year the child did not receive the dental care needed while 6% reported the child did not visit a specialist they needed.

Four percent of respondents reported there was a time in the past year the child did not receive the medical care needed. Nine percent of respondents reported the child currently had asthma. Zero percent of respondents reported the child was seldom/never safe in their community. Seventy-nine percent of respondents reported the 5 to 17 year old child ate at least two servings of fruit on an average day while 26% reported three or more servings of vegetables. Forty-seven percent of respondents reported the child ate five or more servings of fruit/vegetables on an average day. Fifty-six percent of respondents reported the 5 to 17 year old child was physically active for 60 minutes five times a week. Two percent of respondents reported the 5 to 17 year old child always or nearly always felt unhappy, sad or depressed in the past six months. Ten percent reported the 5 to 17 year old child experienced some form of bullying in the past year; 9% reported verbal bullying, 3% cyber bullying and less than one percent reported physical bullying. *From 2012 to 2020, there was a statistical increase in the overall percent of respondents who reported the child had a primary doctor or nurse while from 2017 to 2020, there was no statistical change. From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported the child visited their primary doctor/nurse in the past year for preventive care while from 2017 to 2020, there was a statistical increase. From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported in the past year the child had an unmet medical care need, as well as from 2017 to 2020. From 2012 to 2020, there no statistical change in the overall percent of respondents who reported in the past year the child had an unmet dental care need or was unable to see a specialist when needed while from 2017 to 2020, there was a statistical increase. From 2012 to 2020, there was a statistical increase in the overall percent of respondents who reported the child currently had asthma, as well as from 2017 to 2020. From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported the child was seldom/never safe in their community, as well as from 2017 to 2020. From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported the 5 to 17 year old child ate at least two servings of fruit while from 2017 to 2020, there was a statistical increase. From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported the 5 to 17 year old child ate at least three servings of vegetables on an average day, as well as from 2017 to 2020. From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported the 5 to 17 year old child met the recommendation of at least five servings of fruit/vegetables on an average day, as well as from 2017 to 2020. From 2012 to 2020, there was a statistical decrease in the overall percent of respondents who reported the 5 to 17 year old child was physically active for at least 60 minutes five times a week while from 2017 to 2020, there was no statistical change. From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported the 5 to 17 year old child always or nearly always felt unhappy/sad/depressed in the past six months, as well as from 2017 to 2020. From 2012 to 2020, there was no statistical change in the overall percent of respondents who reported in the past year the child was bullied overall, physically bullied or cyber bullied, as well as from 2017 to 2020. From 2012 to 2020, there was a statistical decrease in the overall percent of respondents who reported in the past year the child was verbally bullied while from 2017 to 2020, there was no statistical change.*

Top County Health Issues

In 2020, respondents were asked to list the top three health issues in the county. The most often cited were coronavirus/COVID-19 (48%), illegal drug use (31%) or overweight/obesity (22%). Married respondents were more likely to report coronavirus/COVID-19 as a top health issue. Respondents who were male or in the top 40 percent household income bracket were more likely to report illegal drug use. Twenty percent of respondents reported chronic diseases as a top issue; respondents with a college education or in the top 40 percent household income bracket were more likely to report this. Eighteen percent of respondents reported mental health/depression; respondents 35 to 44 years old were more likely to report this. Eighteen percent of respondents reported access to health care; respondents 45 to 54 years old, with a college education, in the top 40 percent household income bracket or married respondents were more likely to report this. Eleven percent of respondents reported alcohol use or abuse; unmarried respondents were more likely to report this. Ten percent of respondents reported cancer as a top issue. Nine percent of respondents reported prescription or over-the-counter drug abuse. Eight percent of respondents reported violence or crime; respondents who were male or with a high school education or less were more likely to report this. Seven percent of respondents reported tobacco use. Five percent of respondents reported infectious diseases; respondents with a high school education or less were more likely to report this. Five percent of respondents reported access to affordable healthy food; respondents 45 to 54 years old or with a college education were more likely to report this. *From 2017 to 2020, there was a statistical decrease in the overall percent of respondents who reported illegal drug use or prescription/over-the-counter drug abuse as one of the top health issues in the county. From 2017 to 2020, there was no statistical change in the overall percent of respondents who reported overweight/obesity, chronic diseases, access to health care, alcohol use/abuse, cancer, violence/crime, tobacco use, infectious diseases or access to affordable healthy food as one of the top health issues in the county. From 2017 to 2020, there was a statistical increase in the overall percent of respondents who reported mental health/depression as one of the top health issues in the county.*

Appendix E: 2022 Froedtert Community Hospital – Pewaukee Community Health Needs Assessment: A Summary of 2020 Waukesha County Key Stakeholder Interviews

The Waukesha County Health Needs Assessment: A Summary of Key Informant Interviews Report can be found here: https://www.froedtert.com/community-engagement

The public health priorities for Waukesha County, were identified in 2020 by a range of providers, policy-makers, and other local experts and community members ("key informants"). These findings are a critical supplement to the Waukesha County community health needs assessment (CHNA) survey conducted through a partnership between the Ascension Wisconsin, Advocate Aurora Health, Children's Hospital of Wisconsin, ProHealth Care, and Froedtert Health. The CHNA incorporates input from persons representing the broad community served, and from those who possess special knowledge of or expertise in public health.

Key informants in Waukesha County were identified by Ascension Wisconsin, Aurora Health Care, Children's Wisconsin, Froedtert Health, and ProHealth Care in partnership with the Waukesha County Public Health Division. These organizations also invited the informants to participate and conducted the interviews from June to September 2020. The interviewers used a standard interview script that included the following elements:

- Ranking of up to five public health issues, based on the focus areas presented in Wisconsin's State Health Plan, that are the most important issues for the County;
- For those five public health issues:
    - Existing strategies to address the issue
    - Barriers and challenges to addressing the issue
    - Additional strategies needed
    - Key groups in the community that hospitals should partner with to improve community health
    - Identification of subgroups or subpopulations where efforts could be targeted
    - Ways efforts can be targeted toward each subgroup or subpopulation; and
- To be responsive to the current conditions during the COVID-19 pandemic, the following additional questions were added to the interview guide:
    - What community needs or gaps have developed since the coronavirus pandemic began?
    - How can health care organizations support the community during this pandemic?
    - What methods of communication and outreach have been successful to reach partners and community members during the pandemic?
    - How would you suggest health care organizations outreach to community partners and members to implement health initiatives?

All informants were made aware that participation was voluntary and that responses would be shared with the Center for Urban Population Health for analysis and reporting. This report presents the results of the 2020 CHNA key informant interviews for Waukesha County, based on the summaries provided to the Center for Urban Population Health.

Below presents a summary of the health issue rankings, including a list of the five issues which were ranked most frequently by respondents. The next section provides a summary of the strategies, barriers, partners, and potential targeted subpopulations described by participants are provided as well.

Limitations: Forty-one key informant interviews were conducted with 47 respondents in Waukesha County. Some interviews incorporated the views of more than one person from an organization. This report relies on the opinions and experiences of a limited number of experts identified as having the community's pulse. However, responses may not be representative of the overall perception of community strengths and needs. It is possible that the results would have been substantially different if a

different set of informants had been interviewed. Results should be interpreted with caution and in conjunction with other Waukesha County data (e.g., community health survey and secondary data).

In 41 interviews, a total of 47 key informants were asked to rank the five major health-related issues in their county from a list of 15 focus areas identified in the State Health Plan. The five health issues ranked most consistently as a top five health issue for the County were:

1. Mental Health
2. Substance Use and Abuse
3. Access to Health Care
4. Chronic Disease
5. Nutrition

Summaries of barriers/challenges, needed strategies and priority populations for each health issue are presented below in the order listed above. In addition, community identified resources, partners and assets are listed below.

Mental Health

Thirty-seven key informants' interview rankings included Mental Health as a top five health issue, and eighteen ranked it number one.

Existing Strategies: Agencies that deal with mental health and substance abuse have been collaborating, Impact 211 access, access to mental health medications through Direct Relief, substance abuse waiver to prescribe, meeting with clients in environments where they feel comfortable, National Alliance on Mental Illness (NAMI) Waukesha works on client referrals, follow through, and trainings for family members, free counseling at James Place, peer support programming, Friendship House, telehealth appointments expand access and can help people open up by doing the appointment where they are comfortable, app-based exercises to reinforce elements of support outside of clinical time, school-based services are helpful to meet the most vulnerable kids, resources in the schools and support for social and emotional wellness, schools proactively addressing trauma with students, social workers in medical settings, increased awareness of this issue, mental health navigators through a grant from the state, internal processes that include depression screening, Menomonee Falls Collective Impact Mental Health Workgroup, Criminal Justice Collaboration Committee, Crisis Intervention Training for law enforcement officers, local approaches to issues such as police department at the farmers market to talk about suicide prevention, trauma-informed care, Sixteenth Street Community Health Centers provides bilingual services for mental health, efforts to support caregivers, the Aging and Disability Resource Center works to provide resources and referrals, coalitions focused on suicide awareness, and QPR suicide prevention trainings in the community are examples of strategies in place to address mental health in the county.

Barriers and Challenges: The pandemic has increased isolation, stress, depression, and suicide and losing jobs and family members has been a challenge for everyone, there are not enough providers and waiting lists for appointments, especially for psychiatry and inpatient beds for children, lack of insurance coverage or services for people who lack insurance, the high cost of medications and medication management, telehealth can expand access, but there are barriers to using it if people do not have the technology and internet access they need to engage in it, there still needs to be a face to face component, though it is improving, there is still stigma associated with mental illness and seeking help, social media worsens mental health conditions and concerns, there are still silos across systems, people have some trouble accessing appointments due to challenges with transportation and child care, patients with unmet basic needs like food and shelter can struggle with treatment adherence, people

are unsure of where to start or how to access care, and co-occurring problems with chronic disease or substance use are barriers and challenges to improving mental health.

Needed Strategies: More providers, more psychiatry extenders, shorter waiting periods, better access with and without insurance, small group support and counseling, peer support, telehealth appointments, virtual appointments, "drop in" phone calls and doing more to reach people, health care systems need to be the hubs of services, expand social and emotional wellness supports, more community partnership and collaboration, continued public messaging to decrease stigma around mental illness and better understanding of the issues with less judgement, work with NAMI to identify additional strategies, inpatient facilities in Waukesha County for protective custody, more beds for uninsured mental health patients, more work against bullying in schools, especially related to social media, strategies to address substance use and mental health together, increasing access for businesses to get help from health care organizations on trainings and education, partner with business chambers to get the message out, people need more information and proactive messaging about mental health, more supports for homelessness and joblessness, more community resources for housing, more case management or social services, stronger suicide prevention efforts, better recruitment and retention into behavioral health careers, supports for practitioners to prevent burn out, and being proactive about what we can do to address gaps and be better prepared for a situation like the pandemic in the future are suggestions for strategies that could potentially improve mental health in Waukesha County.

Key Community Partners to Improve Health: Health systems, health care providers, non-profit organizations, county programs, NAMI Waukesha, Waukesha County, Aging and Disability Resource Center, public health, school districts, funders, churches and faith-based organizations, YMCA's afterschool programs, law enforcement, Homeless Engagement and Resource Team, homeless shelters and outreach programs, school groups, social service agencies, senior centers, chambers of commerce, criminal justice, public safety, law enforcement, municipalities, food pantries, local colleges and universities who have psychology and mental health or behavioral health-oriented programs, Suicide Awareness Task Force, Children and Family Services Advisory Committee, Hispanic Community Center, The Women's Center, James Place, Salvation Army, Community Action Coalition, La Casa de Esperanza, LSS Clubhouse, Hebron House, and community members with lived experience should work on improving mental health.

Subgroups/populations where efforts could be targeted and how efforts can be targeted:

- Seniors and people with disabilities, especially those who have lost their jobs and cannot afford COBRA, can be reached through social media, mailings, and at places where they already go like senior centers, recreation centers, food pantries, meal programs, medical appointments, and their care givers. There could also be partnerships with assisted living facilities to do education on site.
- Medically underserved populations can be reached through free clinics and Federally Qualified Health Centers and there should be a focus on changing policies so more people can be covered by insurance.

- People experiencing homelessness may need extra support and can be reached where they are at, by outreach programs that already exist or in shelters.
- Youth can be reached through schools, afterschool programs, sports, and other places they spend their time. There is a need to focus on stressors and how they deal with stress to cope and prevent mental health issues. A curriculum taught by mental health professionals would be helpful.
- Men who are experiencing chronic homelessness and mental illness can be reached by working with the Salvation Army and Hebron House as these organizations have the closest contact. There are also street outreach resources. It would be good to have a physical space or walk-in clinic where they could go for help.
- Some key informants suggested it is important to be there for Black people and other people of color to support mental health and address trauma. It is also important to hire staff and mental health professionals who reflect the community served.
- For the Hispanic community it is important to address the stigma around counseling and treatment and address the cultural challenges around mental health. It is also important for organizations to hire more bilingual staff.
- Some key informants mentioned that it affects everyone and there should be community-wide strategies like media messaging to reach everyone with information.

Substance Use and Abuse

Twenty-four key informants ranked Substance Use and Abuse as a top-five health priority for the county, with two of them ranking it as their first health priority area.

Existing Strategies: Naloxone training offered by the county, prevention education, Your Choice presentations, good collaborations like the Waukesha County Heroin Task Force, medication assisted treatment (MAT), support groups and other supportive transitions out of rehab, drug testing of athletes in schools, FACT- tobacco and vaping outreach to students, partnerships between schools and law enforcement, drug collection programs, responsive services after students have gotten in trouble, individual, family, and group therapy for substance use disorders (SUD), outreach through the Aging and Disability Resource Center, drug treatment courts and referrals to treatment services rather than jails, the county and law enforcement work well together, support for mothers with SUD, attention is being given to the opioid crisis, and intensive outpatient treatments are the strategies in place to address substance use and abuse in the county.

Barriers and Challenges: Key informants named a number of challenges to addressing this issue, including a lack of crisis services or any services outside of 9am-5pm business hours, inpatient care is limited, services and treatment are expensive, it can be hard for people with Medicaid or without health insurance to find treatment options, COVID-19 has made it difficult for people to access services in person and loss of jobs has meant loss of insurance so people may no longer have access to services they need, lack of transportation, lack of follow up after leaving a rehab setting, peer pressure, cultural

norms, ease of access to substances, and the social acceptability of alcohol abuse, vaping, and use of other drugs, and on the other hand, the stigma of addiction and use of certain drugs and some perceptions that it is a moral failing, the use of alcohol and drugs to relieve or cope with stress, co-occurring unmanaged mental health issues are masked with substance use, when people are isolated the issue can be hidden, some parents are unaware of the issue and challenges in the county, competing services in the community rather than collaboration or a cohesive approach, and there are siloed approaches in different sectors without anyone "owning" the problem, though the county is a leader there is not enough funding.

Needed Strategies: Some examples of strategies that could potentially address this issue are crisis services and treatment or support services available outside of 9am-5pm business hours, walk-in services with open door services beyond scheduled appointments, more collaboration among those doing prevention and treatment work, universal health care or treatment options for people who are uninsured and cannot pay out of pocket, broader offerings for MAT so it is accessible everyone who needs it, more counseling services, more funding for programs, continuous outreach to patients leaving rehab and support across various stages of recovery, better integration of the justice system with treatment, better strategies to address vaping through education, vape detectors, making products harder for young people to obtain, address vaping at pediatric and primary care appointments, better public messaging about the dangers of vaping any substances, education for parents to see signs their children are using substances and support for those parents and families, more resources for addressing root causes upstream, more peer support and case management models for SUD so people don't encounter gaps, outreach to the business community and to employees, messaging to address stigma of addiction and seeking help, and resources to support people seeking help.

Key Community Partners to Improve Health: Case workers, hospitals and health systems, non-profit organizations, county resources, public health, health care providers, law enforcement, emergency services, the justice system, legislators, school districts, churches, shelters, mental health care providers, liquor stores, bars, libraries, parks and recreation departments, Sixteenth Street Community Health Centers, Rogers, Waukesha Memorial, Narcotics Anonymous, NAMI Waukesha, The Women's Center, American Lung Association, Your Choice to Live, Waukesha County Heroin Task Force, Substance Use Advisory Committee, Intoxicated Driver Committee, WisHope Recovery, Waukesha Comprehensive Treatment Center, Addiction Resource Council, Hope Center, Elevate, and Lutheran Social Services were named as the key partners in the community to work on this issue.

Subgroups/populations where efforts could be targeted and how efforts can be targeted:

- Some key informants believed children and teens need education through schools, social media, sports, therapy, and collaboration with experts. Parents also need education and support about signs to look for and remaining engaged in their children's lives and understanding that families may need help if parents are using as well.

- People experiencing homelessness can be reached through HEART, the Homeless Engagement And Response Team subgroup of the collaborative with NAMI Waukesha, health care organizations, emergency services, and housing services.
- The elderly and people with disabilities can be reached through existing programs developed to work with these populations.
- One key informant named a few different key groups: integrated SUD treatment and MAT, SUD groups for women, SUD groups for clients who have behavioral health and co-occurring disorders, and SUD services for teens. These would require adequate staffing of providers and improved marketing of the programs.
- The Hispanic population may need specialized outreach because there can be fear about seeking treatment, especially if they are not legal residents. It was suggested they could be reached in health care settings. Materials should be available in multiple languages and be culturally appropriate. Another idea is targeted marketing in Spanish communicating the idea that it is okay to talk about this issue.
- Some key informants emphasized that this is a community wide issue and there needs to be a community effort to address it. There could be a better review of data to determine where there may be disparities and realign the taskforce to review the data and determine what the targets should be.

Access to Health Care

Eighteen informants included Access to Health Care in their top-five health issues for the county and eight ranked it as their number one issue.

Existing Strategies: Health systems are creating more satellite locations, there are options for care for people who have health insurance and money, organizations that have a "medical home" model, there are some safety net options for people who have Medicaid or are un- and under-insured, such as Sixteenth Street Community Health Centers, Lake Area Free Clinic, Community Outreach Health Clinic, telehealth/telemedicine appointments, transportation to appointments for the elderly and disabled, school nurses on staff in school districts, community resources are shared with families from the schools, after hours care is expanding for those who work during normative office hours, there are discharge planners at emergency departments and urgent care centers, some senior housing and assisted living offer skilled nursing and consulting doctors onsite, apps that help people save money on prescriptions, social workers that help connect families to appropriate resources, care coordination and focus on meeting wraparound needs beyond medical care, communication and collaboration between organizations that serve vulnerable patients, and strong partnerships between schools, public health, and health care are examples of strategies in place to increase access to health care.

Barriers and Challenges: One challenge often mentioned was lack of access to care for uninsured patients, lack of insurance coverage, especially as people have been losing employment in the

pandemic, and lack of coverage for mental health services. Other major barriers seem to be lack of transportation to appointments, lack of appointments outside of traditional business hours, lack of capacity to care for everyone, trouble navigating the insurance marketplace, Medicaid paperwork, Medicare enrollment without navigators to provide support, language barriers at appointments, especially for Spanish-speaking patients, and obstacles to using technology for appointments including the hardware needs, internet access, and literacy about how to use these systems. Other barriers and challenges named by key informants are staff turnover, medical racism and discrimination, people being unsure of where to go for help, lack of basic resources like food, housing, and other social determinants of health-related needs, lack of understanding of signs of trauma from some providers, and fear of seeking services during COVID-19.

Needed Strategies: Political and systemic changes that allow more people access to health care, financial assistance, partnerships to provide more care in schools, increasing access to transportation for appointments, navigators to help people with insurance, appointments, finding transportation, more bilingual staff in health care and community organizations, more opportunities for virtual visits, better communication between primary and specialty care, health care organizations need to be less siloed, community health nurses, better utilization of the Family Medicine Residency Program, care coordination, focus on connecting people to basic needs like food and housing, meeting patients where they are at, taking care of patients without exposing clinic providers and staff to COVID-19, and community-focused collaborative efforts/collective impact are potential strategies to improve access to health care.

Key Community Partners to Improve Health: Health systems, health care providers, Sixteenth Street Community Health Centers and other Federally Qualified Health Centers, free clinics, Wisconsin Association of Free and Charitable Clinics, National Association of Free Clinics, Family Medicine Residency Program, skilled nursing facilities, assisted living facilities, transportation agencies, Aging and Disability Resource Center, Eras, National Alliance on Mental Illness (NAMI) Waukesha, school districts, faith-based groups and churches, Sussex Area Outreach Services, community health workers, food pantries, law enforcement, Sussex Community Summit, non-profit organizations, Waukesha County Health and Human Services, public health, United Way of Greater Milwaukee and Waukesha County, business community, chambers of commerce, library systems, La Causa, 211, the Salvation Army, Hispanic Resource Center, Hope enter, James Place, The Women's Center, and La Casa de Esperanza were named as the important partners to include in efforts to improve access to health care.

Subgroups/populations where efforts could be targeted and how efforts can be targeted: Key informants named several subpopulations where efforts to improve access could be targeted.

- People experiencing homelessness could be helped with outreach nurses to provide one-on-one help and with organizations who are already serving this population, like shelters.
- Seniors and people who may be isolated should be reached through partnerships with organizations who are already serving seniors like recreation departments and senior centers to help identify what

needs they are seeing. It may also be helpful to do targeted outreach at churches and in medical settings, and conduct focus groups to better understand their needs.

- Low-income people need to be linked to appropriate information and resources and may be reached through apartment managers and schools.
- The Latinx community can be served through Sixteenth Street Community Health Centers and other organizations that support this community and are trusted partners. It is important to deliver linguistically and culturally appropriate messages.
- People who recently lost their jobs and insurance during the pandemic and do not know how to access care could be helped by working with the community organizations who already offer services to help identify what their needs are and what kinds of assistance they might qualify for.

Chronic Disease

Seventeen respondents' rankings included Chronic Disease as a top health issue for the county. One of these ranked it as their top health priority area for the county. One respondent focused on obesity, one on cancer, one on hypertension and diabetes, and one focused on the importance of addressing physical activity, nutrition, chronic disease prevention, and mental health at the same time. Other respondents provided general examples of strategies, barriers, partners, and potential interventions for subpopulations.

Existing Strategies: Medical treatment, telehealth appointments and nurse follow up, health care providers working with patients on healthy lifestyles, diet, and medication management, clinic programs for chronic disease patients, free clinics, Waukesha County Public Health, evidence-based programs, the prescription outreach program helps people get medications for free, direct relief program provides access to donated medications and supplies, school health rooms and staff, discharge planners from medical care, warm handoffs to follow up appointments after a patient is discharged, partnerships with community-based wellness programs, Fit in the Parks through Waukesha County, employer sponsored health assessment and wellness programs with rewards for healthy living, early education and outreach programs in the community, the Live Well group for obesity, the Women, Infants, and Children (WIC) program's Family Fit program, nutrition education through UW-Extension, Live Well Waukesha County, and a Hispanic Wellness Program were examples of health care, public health, and community health strategies to prevent and manage chronic disease in the county.

Barriers and Challenges: People need more time and education, there is a need for medication, supplies, and medical care, there are a lack of providers at free clinics, volunteer providers are unable to help during COVID-19, lack of transportation to get to appointments, patients need more support and guidance after diagnosis, health care settings can be stressful and patients are often given a lot of information in a short period of time, there is some uncertainty about root causes of disease and why certain groups are able to manage their health better than others (e.g. gender differences), medical care and prescriptions are very expensive, there is a lack of general awareness and education about chronic

disease, culturally there is a lot of confusing information about fad diets, outdated nutrition guidelines, body image issues, and a cultural acceptance of alcohol and unhealthy food consumption, lack of investment of time in preventive measures for wellness, incompatible medial records between health systems, lack of case management and patient outreach, lack of a strong referral network for Medicaid and uninsured patients, and not connecting patients with resources in the community are examples of barriers and challenges to improving health.

Needed Strategies: There is a need for cost-effective and easily accessible health services and supports such as medications, healthy meals, and physical activity opportunities, as well as education about why these are important. Community education and outreach programs, community screenings, upstream solutions, awareness of what works and how to access it, better connections to the services and programs that already exist, streamlined referral processes between systems, outreach staff or community health navigators, more telehealth services, and assistance with transportation to get to appointments are examples of strategies that could help prevent and manage chronic disease.

Key Community Partners to Improve Health: Health care providers, health care systems, hospital outreach programs, insurance companies, state and national free clinic associations, free clinics, Federally Qualified Health Centers, Waukesha County Public Health, Department of Health and Human Services, the Aging and Disability Resource Center, municipalities, libraries, school districts, faith organizations, UW-Extension, food pantries, senior centers and other groups for elders, the business community, Live Well, parks and recreation departments, Carroll University's student clinic for physical therapy, occupational therapy, and exercise physiology, fitness clubs, and non-profit organizations in the community were named as the key partners to work on this issue.

Subgroups/populations where efforts could be targeted and how efforts can be targeted: Key informants offered quite a few suggestions for tailoring outreach related to chronic disease.

- Working parents could be reached at doctors' appointments is providers start conversations at primary care appointments. They can also be reached through social media.
- The age group of 45-65 years with chronic disease need more support than a free clinic can offer, so there should be better connections to case workers.
- Related to congestive heart failure patients, physicians and the medical community need to deliver a comprehensive message from the physician to the scheduler and deliver the message at multiple touchpoints within the care of the patient.
- Diabetic patients, especially men who seem less likely to receive help.
- People who chronically experience homelessness may benefit from bringing medical care to the shelters where they are already. Comorbidities should be addressed together.
- Low income families or those with Medicaid may need support accessing health services and county-level help.
- Seniors who may have trouble leaving home, or in assisted or skilled nursing living situations may need more support and can be reached by working with organizations that support seniors or places seniors are going, such as food pantries.

- Adolescents should receive this health care and education to address it early. They can be reached at schools.
- Cancer support groups.
- Undocumented Hispanic immigrants can use services at Sixteenth Street Community Health Centers as well as screenings in partnership with health systems.
- Adults and the community in general need more education and can be reached with mainstream messaging about healthy lifestyle, a county-wide campaign, outreach nurses, print and video educational materials, parish nurses, and community organizations.

Nutrition

Nutrition was ranked as a top-five issue by eleven key informants and the number one issue by three of them.

Existing Strategies: Food pantries and food banks, Hunger Task Force, farmers markets and winter markets, incentivizing shopping for produce at markets through doubling FoodShare, local farms, community gardens, and gardeners, farm to table boxes, nutrition education from hospitals, information about how to prepare food, FoodWise Nutrition Education program, Teen Cuisine cooking and nutrition education, Waukesha County Nutrition Coalition, senior meal program and other community meal programs, public health and ADRC programs, and public education campaigns are strategies in place to address nutrition.

Barriers and Challenges: The financial and time costs of purchasing, growing, and preparing fresh produce and other healthy foods make them inaccessible to some people, lack of transportation and social isolation make it hard for some people to get to healthy food options, a lack of community level nutrition education and health promotion, COVID-19 related constraints and stress, food insecurity and food deserts in the county, challenges related to behavior change among adults, lack of funding for programs, and eligibility criteria for some programs are barriers and challenges to improving nutrition.

Needed Strategies: Key informants' suggestions are to focus on food insecurity and reaching the most vulnerable, expand mobile food pantries, expand public education on nutrition and cooking and how to do it efficiently/quickly, partner with local restaurants on nutrition education, provide vouchers for farmers markets, provide social opportunities to get people eating together, especially for elderly, deliver nutrition education to the families of young children to create good habits and engage families, have retired nurses as volunteers at the food pantry help with nutrition education, do more outreach with evidenced-based and research-based programs, and develop more community garden concepts or school gardens.

Key Community Partners to Improve Health: Feeding America, Hunger Task Force, food pantries, senior centers, Meals on Wheels, farmers markets, grocery stores, churches and faith groups, school districts, ADRC, UW-Extension, Waukesha County Nutrition Coalition, Waukesha County Public Health, health

care systems, non-profits and community groups focused on this area, and the business community were the key partners identified by respondents.

Subgroups/populations where efforts could be targeted and how efforts can be targeted: The subpopulations most frequently named as being higher risk for poor nutrition are youth and families, women as influencers in the home, low income people and families, people experiencing homelessness, Latino families, and seniors and other adults who are isolated and have difficulty leaving home. Youth and families can be reached at schools, non-profits where they receive other services, and food pantries and may need help learning how to prepare foods and what kind of foods make healthy meals. Women should be reached at health care appointments and given information without judgement. People who have low income or are experiencing homelessness can be reached with social media messaging and meeting them with resources and education where they are at already. Latino families can be reached at St. Joseph's Church in Waukesha, which has a large Latino membership and works with Latino families and businesses. They have hired bilingual educators. Seniors and other isolated adults can be reached through senior housing, partnering with Eras Senior Network, partnering with the Aging and Disability Resource Center's Senior Wellness Programs, providing handouts with information and recipe ideas, provide education about what to do with ingredients that may be unfamiliar, and find out what the Nutrition Coalition has done and what type of programs need more funding or advocacy.

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Appendix F: 2022 Froedtert Community Hospital – Pewaukee Community Health Needs Assessment: A Summary of Key Stakeholder Focus Groups

The Froedtert Community Hospital – Pewaukee Community Health Needs Assessment key stakeholder focus group results can be found at Froedtert Community Hospital Community Engagement | Froedtert & MCW.

Froedtert Community Hospital – Pewaukee conducted a focus group to gain deeper insights about perceptions, attitudes, experiences or beliefs held by community members about their health. It is important to note that the information collected in an individual focus group is not necessarily representative of other groups. A total of two focus groups were conducted with five respondents representing communities that include, but were not limited to: the elderly, youth, individuals with disabilities, and those living with mental illness and substance use disorders were conducted in July 2022. Key partners, organizations and topic groups were invited by the Froedtert Health Community Engagement leadership team to participate in these virtual focus groups lasting 90 minutes and held in English.

Focus group facilitators used a standard discussion guide from which stakeholders were asked to identify:

- Ranking of two social determinants of health that are the most important issues for the service area.
- For those two social determinants of health, identification of:
    - How COVID-19 has impacted this issue
    - One major effort the community could rally behind to improve the issue
    - The community stakeholders that are critical to addressing the issue
- Ranking of two health conditions and behaviors that are the most important issues for the service area.
- For those two health issues, identification of:
    - The populations most affected and how they are affected
    - Existing strategies to address the issue
    - Additional strategies needed and barriers to addressing the issue
    - The community stakeholders that are critical to addressing the issue
    - One major effort the community could rally behind to improve the issue
    - One thing the organization needs to address this issue
    - How COVID-19 has impacted this issue

All stakeholders were made aware that participation was voluntary and that responses would be analyzed by Froedtert Health Community Engagement staff. Based on the summaries, this report presents the results of the 2022 key stakeholder focus groups for the Froedtert Community Hospital – Pewaukee service area.

Limitations: Two key stakeholder focus groups were conducted with five respondents in the Froedtert Community Hospital – Pewaukee service area. This report relies on the opinions and experiences of a limited number of experts identified as having the community's pulse. However, responses may not be representative of the overall perception of community strengths and needs. It is possible that the results would have been substantially different if a different set of stakeholders had been interviewed. Results should be interpreted with caution and in conjunction with other Waukesha County data (e.g., key informant interviews, community health survey and secondary data).

In two focus groups, a total of five key stakeholders were asked to rank two social determinants of health issues and two health conditions and behaviors. The areas ranked most consistently were:

1. Access to Social Services;
2. Accessibility, Quality and Affordability of Healthcare;

3. Mental Health, Mental Conditions, Suicide; and
4. Nutrition, Physical Activity and Obesity

Summaries of barriers/challenges, needed strategies and priority populations for each health issue are presented below in the order listed above. In addition, community identified resources, partners and assets are listed below.

Social Determinants of Health Issue Summaries

Access to Social Services
COVID-19 impact: Increase of students in need of behavioral health services, lack of individuals in the social service industry, telehealth services, economic impact, long waitlists for services, need for more awareness of community resources, COVID-19 increased isolation and lack of connectedness.

An effort that the community could rally behind to improve this issue: Continue to talk about the issue and find way to support students and their families. Increase access to providers and address stigma.

Community stakeholders critical to addressing this issue: Use schools as an opportunity to leverage access, primary care physicians, pediatricians, urgent care and ER, health care able to deal with mental health crisis onsite, youth sports, municipality, churches and "it takes a village for this one".

Accessibility, Quality and Affordability of Healthcare
COVID-19 impact: Had to pay for COVID-19 testing because of school exposure.

An effort that the community could rally behind to improve this issue: Making health care equitable for all families and insurance coverage.

Community stakeholders critical to addressing this issue: Legislators.

Health Condition and Behavior Issue Summaries

Mental Health, Mental Conditions, Suicide
Populations most affected and how they are affected: All population are impact but those that are not insured or underinsured, individuals who don't have access to technology, cannot pay for services, school aged kids or lack transportation are significantly impacted.

Existing strategies: Providers and programming in schools, suicide hotline, increased awareness, and more support programs from employers.

Needed strategies: Lack of providers, not enough providers accepting BadgerCare, no space/beds, wait times are long, stigma, insurance barriers, limit social media, and elderly population don't talk about mental health issues or know how to access care. Elderly are isolated.

Community stakeholders critical to addressing this issue: Schools, churches, employers, families and facilities that provide support for aging populations.

An effort that the community could rally behind to improve this issue: Increase mental health providers funding and increase awareness.

Organization needs: More education on how we can access services, front line workers need training and more resources/funding.

COVID-19 impact: Increased the need for services.

Nutrition, Physical Activity, and Obesity

Populations most affected and how they are affected: Children, elderly or those with mobility issues.

Existing strategies: Strong parks and recreation programs, fitness centers, federal funding for free school lunches, trails, grocery stories and health care systems.

Needed strategies: Educating families on physical activity and healthy habits, focus on behavior change, and provide affordable programs.

Community stakeholders critical to addressing this issue: This is a collective effort, coaches, parks and rec departments, and intermural teams.

An effort that the community could rally behind to improve this issue: Programming for students, behavior changes and awareness of poor behaviors.

Organization needs: Focus on teen activities, facility access to get more gym spaces and obesity education.

COVID-19 impact: Lack of engagement in activities and COVID-19 increased activities to be physically active outside.

Appendix G: Key Stakeholder Organizations Interviewed for purposes of conducting the 2022 Froedtert Community Hospital – Pewaukee CHNA

Waukesha County CHNA Key Informant Organizations	Description of Organizations
Addiction Resource Council, Inc.	Nonprofit providing addiction resources and education.
Aging and Disability Resource Center of Waukesha County	Provides information, assistance, counseling and supportive services for older adults, caregivers, people with disabilities and adults with mental health or substance use concerns.
Community Outreach Health Clinic	Free medical clinic for uninsured.
Easterseals Southeast Wisconsin	Nonprofit serving people with disabilities and at-risk families.
Elmbrook Church	Serving people who are homeless, disfranchised, mentally ill, and jobless.
Eras Senior Network, Inc.	Nonprofit serving seniors, adults with disabilities, and family caregivers.
Family Service of Waukesha	Nonprofit counseling center.
Hamilton School District	Provides education to youth.
Hebron House of Hospitality	Nonprofit dedicated to ending homelessness.
HOPE Network for Single Mothers	Nonprofit serving single mothers.
Kettle Moraine School District	Provides education to youth.
Lake Area Free Clinic	Free medical clinic for uninsured.
LindenGrove Communities	Provides assisted living, memory care, short-term rehabilitation & skilled nursing housing.
Menomonee Falls Area Food Pantry	Provides food for low-income individuals & families.
Menomonee Falls Police Department	Emergency response.
Menomonee Falls Schools	Provides education to youth.
Mukwonago Area School District	Provides education to youth.
Mukwonago Food Pantry	Provides food for low-income individuals and families.
National Alliance on Mental Illness (NAMI) Waukesha, Inc.	Nonprofit provides support for mental health.
Pewaukee Food Pantry	Provides food for low-income individuals & families.
Pewaukee Police Department	Emergency response.
Oconomowoc Area Chamber of Commerce	Nonprofit supporting local businesses.
Oconomowoc Area School District	Provides education to youth.
School District of Pewaukee	Provides education to youth.
School District of Waukesha	Provides education to youth.
Sixteenth Street Community Health Centers	Free medical clinic for uninsured.
Sussex Area Outreach Services	Provides food for low-income individuals and families.
The FOOD Pantry Serving Waukesha County	Provides food for low-income individuals and families.
The Women's Center	Nonprofit providing safety, shelter and support for individuals affected by domestic and sexual violence.
United Way of Greater Milwaukee & Waukesha County	Engages, convenes, and mobilizes community resources to address root causes of local health and human service needs.
University of Wisconsin-Extension Waukesha County	Shares, develops and delivers resources and programs to respond to community issues.
Waukesha County	Local government.
Waukesha County Business Alliance	Nonprofit supporting local businesses in Waukesha County.
Waukesha County Community Dental Clinic	Nonprofit proving oral health services.
Waukesha County Fire Chiefs' Association	Emergency response.
Waukesha County Health and Human Services	Government department that provides community programs to individuals & families challenged by disabilities, economic hardship and safety concerns.
Waukesha County Medical Examiner's Office	Government department that investigates deaths.
Waukesha County Department of Health and Human Services, Public Health Division	Government department that prevents disease and promotes health.

Waukesha Free Clinic	Free medical clinic for uninsured.
YMCA at Pabst Farms	Nonprofit providing services that help people improve their health and well-being.
Froedtert Community Hospital – Pewaukee Focus Group Organizations	**Description of Organizations**
Pewaukee School District	Provides public education for youth.
Positively Pewaukee	Nonprofit dedicated to making Pewaukee a premiere destination and a place people love to call home.
Sussex Area Outreach Services	Nonprofit serving individuals and families with food, emergency financial assistance, preventive health programming, resources and referrals.
Pewaukee Parks & Recreation	Providing programs, parks, sports clubs for Pewaukee residents.
Hamilton School District	Provides public education for youth.

Appendix H: 2022 Secondary Data Report

In 2022, Froedtert Health Community Engagement staff compiled secondary data from a variety of publicly available data sources. Data for each indicator were presented by race and ethnicity and gender when the data were available. Race data categorized as 'unknown' or 'missing' were rarely included. Therefore, not all races are represented in the data that follow. A secondary data analysis was completed between September and November 2022.

Publicly available data sources used for the Secondary Data Report

- U.S. Census Data (CENSUS)
- Wisconsin Department of Health Services (DHS)
- Wisconsin Family Health Survey (FHS)
- Behavioral Risk Factor Surveillance System (BRFS)
- Community Health Survey (CHS)
- Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics
- Wisconsin Interactive Statistics on Health (WISH)
- University of Wisconsin Population Health Institute. *County Health Rankings* 2022. Accessible at www.countyhealthrankings.org.

Limitations: Secondary data is limited to availability of data, with some health topic areas having a robust set of indicators while others are more limited. Some secondary data sources do not include subpopulation data and others only display values for a select number of race/ethnic groups.

Appendix I: 2022 Internal Hospital Data

Internal health care data can provide a unique window into the heath needs of community members who have received care. Custom Froedtert Community Hospital – Pewaukee datasets and other information resources were produced to help benchmark patient data against the community health needs assessment.

Froedtert Health data sources used

- **Health Equity Strategy Alignment Tool: Community Vulnerability Assessment**
  - Per Vizient, "the community assessment is determined by the Vizient Vulnerability Index, a measure used to summarize data on social determinants of health at the neighborhood level. A vulnerability index can provide context for the obstacles that patients face in accessing health care and can quantify the direct relationship between these obstacles and patient outcomes. National health equity indices were evaluated to determine alignment with key relevant metrics that are available on a national level, encompass a broad scope and have a known relationship to health equity risks. Metrics that met these criteria were identified to serve as the foundation for the Vizient Vulnerability Index."

- **EPIC: Social Determinants of Health (SDOH) Screening**
  - Patients are screened using the SDOH questionnaire released by Epic, which leverages evidence-based screening tools when available. SDOH data is used at the patient level to enable care teams to address specific social needs of their patients and incorporate into their care plan or refer the patient to community-based resources as appropriate. At the patient population level, SDOH data is analyzed to understand the prevalence of social needs of patients by race and ethnicity, geography, payer, clinical service area, etc. This information will then be used in planning new programs and services, advocacy efforts, and community engagement.

- **Impact 211**
  - IMPACT 211 provides a central access point for people to take the first step toward regaining stability. During times of personal crisis or community disaster, the free, confidential helpline and online resource directory make it easy for residents to get connected to information and assistance. Data reports are generated to summarize demographics, total calls and referrals, requested services and unmet services by county and zip code.

- **Wisconsin Hospital Association CHNA Dashboard**
  - The Wisconsin Hospital Association Information Center created a Community Health Needs Assessment (CHNA) Mapping Tool to allow hospitals and community partners the opportunity to identify areas of need in their community by analyzing clinical conditions and community characteristics. Using data from both the WHA Information Center and American Community Survey, the tool allows for specific analysis down to the census tract level of individual communities.