Community Health Needs Assessment (CHNA) Report

Froedtert Bluemound Rehabilitation Hospital

Fiscal Year 2023
Effective July 1, 2022

Approved on 08/18/2022 by
Froedtert Hospital Board of Directors

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Executive Summary

Community Health Needs Assessment for Froedtert Bluemound Rehabilitation Hospital

A community health needs assessment (CHNA) is a tool to gather data and important health information on the communities Froedtert Bluemound Rehabilitation Hospital serves. This assessment guides our investments and helps us identify and measure community health needs and assets, which we are then able to better tailor our engagement with communities and allocate resources.

Froedtert Health is a member of the Milwaukee Health Care Partnership (www.mkehcp.org), a public private consortium dedicated to improving care for underserved populations in Milwaukee County. Through the Partnership, Milwaukee's four health systems and the Milwaukee County Health Department aligned resources to participate in a shared data collection process. Supported by additional analysis from Conduent Healthy Communities Institute and Center for Urban Population Health, this robust community-wide data collection process includes findings from a community health survey, informant interviews, focus groups, a compiling of secondary source data and internal hospital data. The data is taken into consideration in order to create an independent CHNA specific to Froedtert Bluemound Rehabilitation Hospital's service area and community health needs. The CHNA is the basis for creation of an implementation strategy to improve health outcomes and reduce disparities in Milwaukee County and the hospital's service area.

The CHNA was reviewed by the Froedtert Bluemound Rehabilitation Hospital CHNA/Implementation Strategy Advisory Committee (**Appendix A**) consisting of members of the Community Health Improvement Advisory Committee, Froedtert Hospital Board of Directors, community partners in Milwaukee County, and City of Milwaukee Public Health Department along with hospital and health system leadership/staff. Members of the committee were selected based on their specific knowledge of health needs and resources in Milwaukee County for a collective analysis of the findings from the Community Health Needs Assessment. Under the direction of the Community Engagement Leadership Team and trained meeting facilitator findings from the assessment were categorized and ranked to identify the top health needs in Milwaukee County.

Following the review of the CHNA, an implementation strategy was developed, targeting evidence-based programs and allocating resources appropriately. Froedtert Bluemound Rehabilitation Hospital Community Engagement leadership and staff will regularly monitor and report on progress towards the Implementation Strategy objectives and provide quarterly reports to the Community Health Improvement Advisory Committee, Froedtert Hospital Board Community Engagement Committee and 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 Bluemound Rehabilitation Hospital Community Service Area

Overview
Froedtert Bluemound Campus, part of the Froedtert & the Medical College of Wisconsin health network, include the Froedtert Bluemound Rehabilitation Hospital and Froedtert Bluemound Clinics.

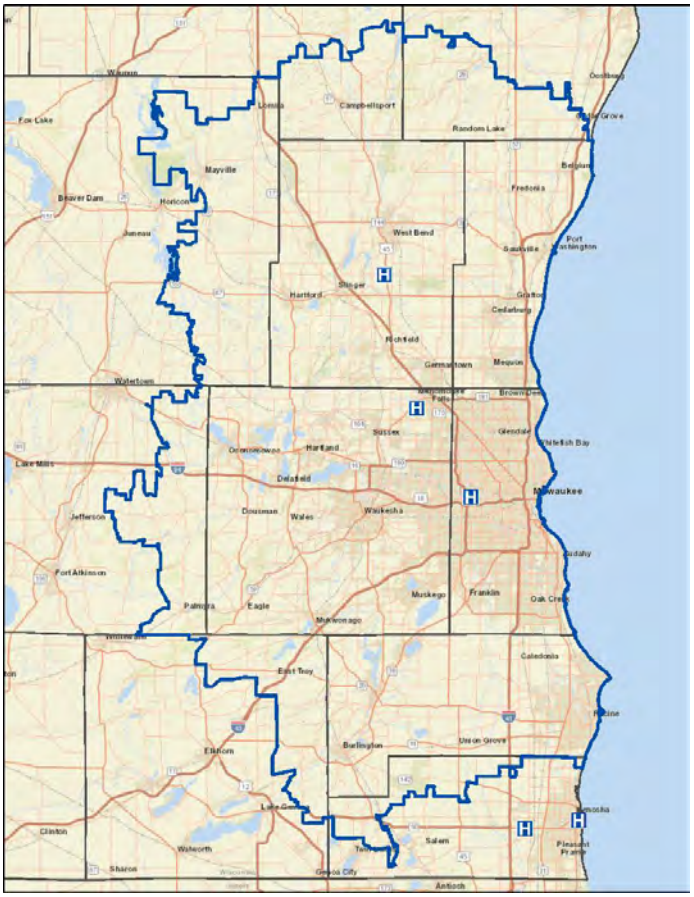
Froedtert Bluemound Rehabilitation Hospital is a 50-bed inpatient physical rehabilitation unit, along with clinical and support services that include radiology, pharmacy, lab and food service. This freestanding specialty hospital provides intensive inpatient rehabilitation services, such as physical, occupational and speech therapy. The on-site Froedtert Pharmacy location includes a drive-thru to serve patients and the community.

The Froedtert Bluemound Campus will function as a department of Froedtert Hospital.

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

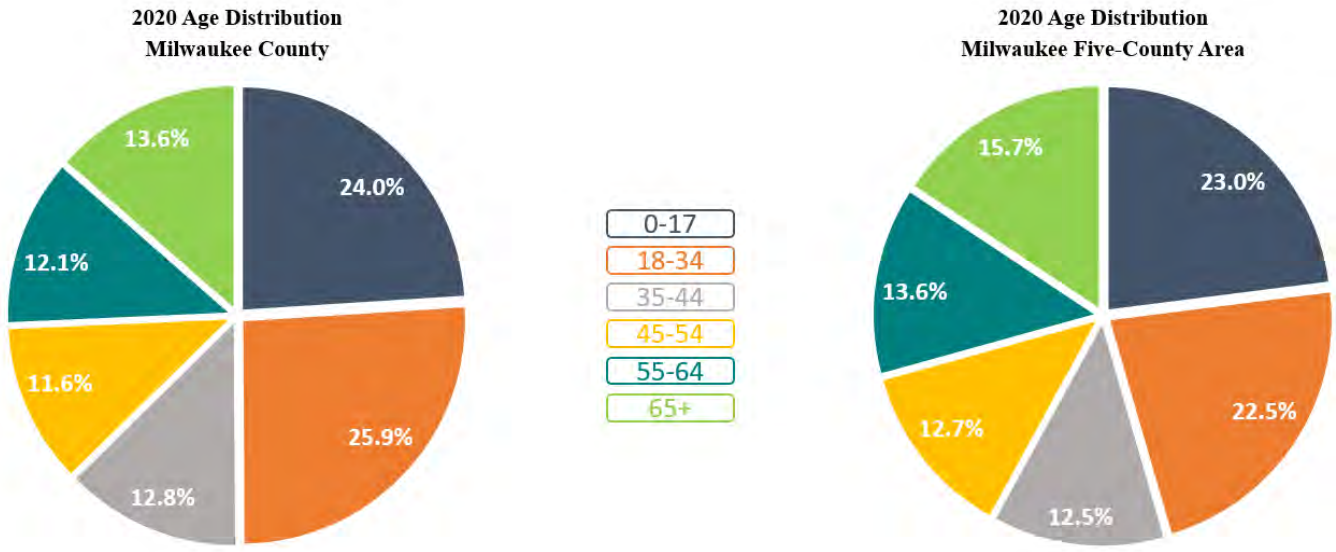
Froedtert Bluemound Rehabilitation Hospital Service Area and Demographics
For the purpose of the Community Health Needs Assessment, the community is defined as Milwaukee County, because 58.5% of discharges occur from this geography. All programs, activities, and partnerships under the CHNA will be delivered in Milwaukee County. Froedtert Bluemound Rehabilitation Hospital determines its service areas by completing an annual review and analysis of hospital discharges and market share according to various determinants.

The Froedtert Bluemound Rehabilitation Hospital total service area in Milwaukee County consists of 35 zip codes. – 53110 (Cudahy), 53129 (Greendale), 53130 (Hales Corners), 53132 (Franklin), 53154 (Oak Creek), 53172 (South Milwaukee), 53202 (Milwaukee), 53203 (Milwaukee), 53204 (Milwaukee), 53205 (Milwaukee), 53206 (Milwaukee), 53207 (Milwaukee), 53208 (Milwaukee), 53209 (Milwaukee), 53210 (Milwaukee), 53211 (Milwaukee), 53212 (Milwaukee), 53213 (Milwaukee), 53214 (Milwaukee), 53215 (Milwaukee), 53216 (Milwaukee), 53217 (Milwaukee), 53218 (Milwaukee), 53219 (Milwaukee), 53220 (Milwaukee), 53221 (Milwaukee), 53222 (Milwaukee), 53223 (Milwaukee), 53224 (Milwaukee), 53225 (Milwaukee), 53226 (Milwaukee), 53227 (Milwaukee), 53228 (Milwaukee), 53233 (Milwaukee), 53235 (Saint Francis).

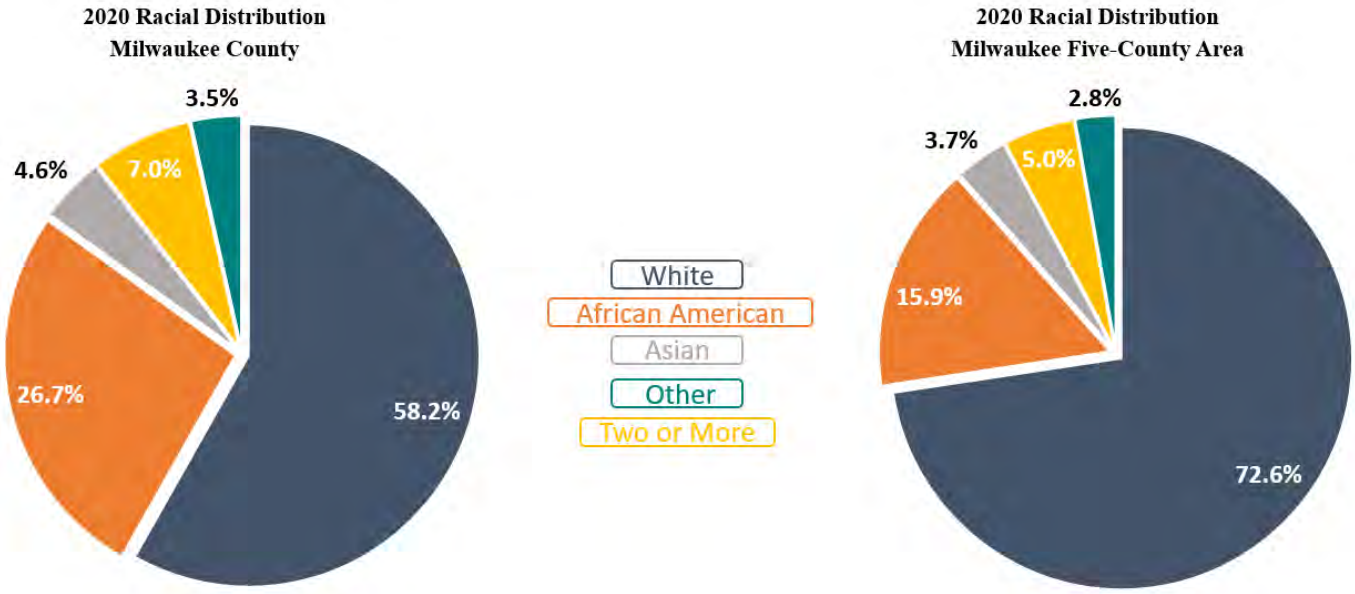


Froedtert Bluemound Rehabilitation Hospital Primary Service Area Demographics

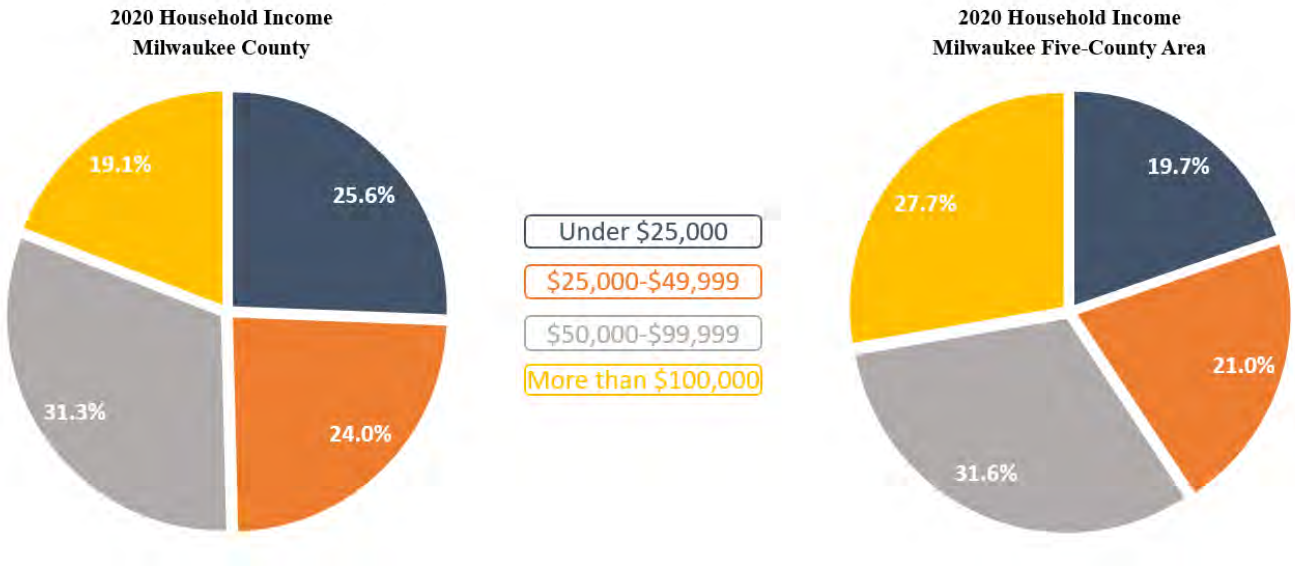
Age – Milwaukee County has a comparable age distribution as the Milwaukee Five-County Area.* The 18 – 34 age group is larger in Milwaukee County with 25.9% of population while the Five-County area 18 – 34 age group is 22.5% of the population.



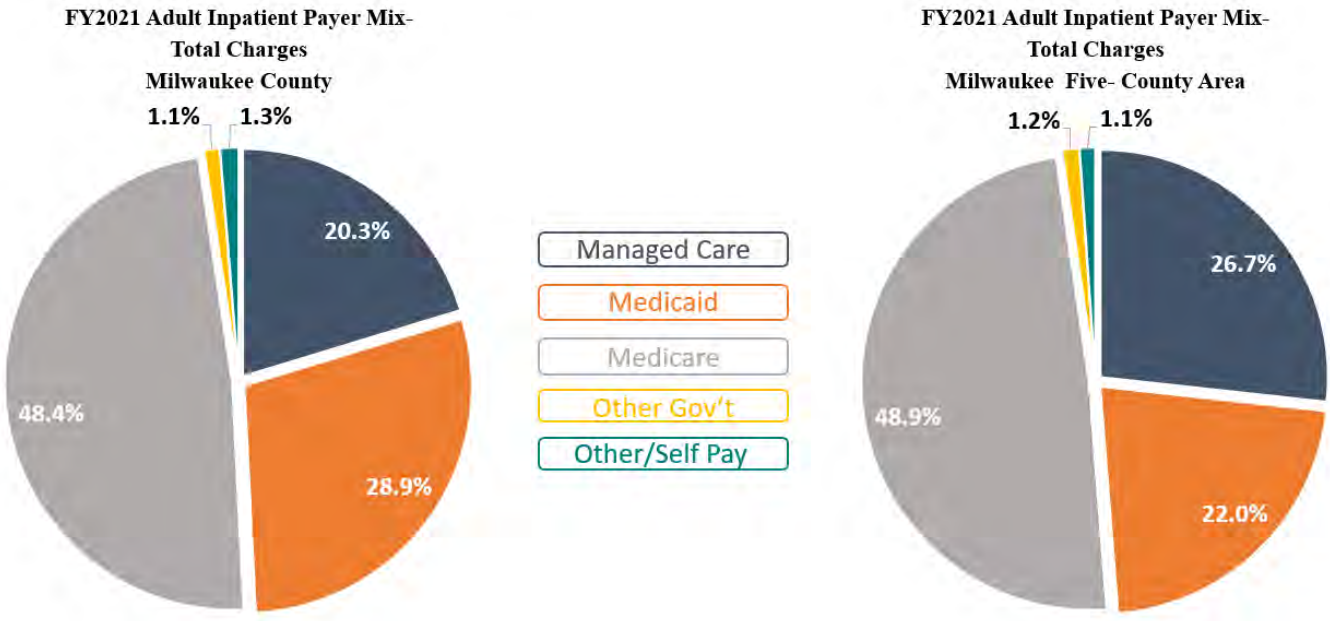
Race – The racial distribution in Milwaukee County is predominantly Caucasian (58.2%). Milwaukee County is more diverse with 26.7% as African American and 15.1% as other races. The Milwaukee Five-County Area is 72.7% White and 15.9% African American.



Household Income – Households where income is less than $50,000 is 49.6% of the distribution in Milwaukee County. Within the Milwaukee Five-County Area, the percent of households that income is less than $50,000 is 40.7%.



Payer Mix – For adult inpatients, Milwaukee County has 30.2% of patients consist of Medicaid and Self Pay payers. The Milwaukee Five-County Area has 23.1% of patients with Medicaid and Self Pay in the payer mix.



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

Community Health Needs Assessment Process and Methods Used

In 2021, a CHNA was conducted to 1) determine current community health needs in Milwaukee County, 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 Bluemound Rehabilitation Hospital 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: An online survey of 8,616 residents was conducted by Froedtert Bluemound Rehabilitation Hospital in collaboration with the Milwaukee Health Care Partnership. The full report of this survey can be found at www.healthcompassmilwaukee.org.

Key Informant Interviews: Froedtert Bluemound Rehabilitation Hospital Community Engagement team and leaders conducted 48 phone interviews and four focus groups with community leaders of various school districts, non-profit organizations, health & human service department and business leaders. A list of organizations can be found on **Appendix F**. The full Key Informant CHNA can be found at www.healthcompassmilwaukee.org.

Secondary Data Sources: Health Compass Milwaukee: Health Compass Milwaukee serves as a comprehensive source of health-related data about Milwaukee County residents and communities. This public database was used to compile numerous publicly reported health data and other sources specific to Froedtert Bluemound Rehabilitation Hospital's primary service area. For more information on health indicators specific to Milwaukee County go to www.healthcompassmilwaukee.org.

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

Disparities and Health Equity

Froedtert & the Medical College of Wisconsin'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 Bluemound Rehabilitation Hospital has a commitment to being an inclusive and culturally competent organization that provides exceptional care to everyone; therefore, equity, diversity and inclusion are priorities for not only the hospital but the entire health network. Health equity focuses on minimizing these differences and drives us to increase opportunities for good health by eliminating systemic, avoidable, unfair and unjust barriers. Equity was a focus of consideration during the entire community health needs assessment, the identification of significant health needs and the prioritization of those needs. Furthermore, equity will be considered as Froedtert Bluemound Rehabilitation Hospital identifies strategies to address those prioritized significant health needs.

Data Collection Collaborators

Froedtert Bluemound Rehabilitation Hospital completed its 2021 data collection in collaboration with the Milwaukee Health Care Partnership and its member organizations. The member organizations were heavily involved in identifying and collecting the data components of the CHNA. The Milwaukee County CHNA committee is a collection of individuals representing Milwaukee Health Care Partnership and its collective members which include the major health systems in Milwaukee:

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

Milwaukee Health Care Partnership
The Milwaukee Health Care Partnership is a public/private consortium dedicated to improving healthcare for persons of low income and who are, underserved in Milwaukee County, with the aim of improving health outcomes, promoting health equity and lowering the total cost of care. The member organizations and their connections in the community were many of the participating community voices during the CHNA data collection process.

Data Collection Consultants
Milwaukee Health Care Partnership commissioned Conduent Healthy Communities Institute (HCI) to support report preparation for its 2021 shared Milwaukee County data collection process. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems and implementing performance evaluation processes. The Center for Urban and Population Health (CUPH) provided further survey data analysis to facilitate the identification of population differences in survey answers.

Community Health Needs Assessment Solicitation and Feedback

Froedtert Bluemound Rehabilitation Hospital is committed to addressing community health needs collaboratively with local partners. Froedtert Bluemound Rehabilitation Hospital used the following methods to gain community input from August to October 2021 on the significant health needs of the Froedtert Bluemound Rehabilitation Hospital's community. These methods provided additional perspectives on how to select and address top health issues facing Froedtert Bluemound Rehabilitation Hospital's community.

Input from Community Members

Key Informant Interviews: Key organizations with specific knowledge and information relevant to the scope of the identified significant health needs ("informants") in Froedtert Bluemound Rehabilitation Hospital's community, including Milwaukee County, were identified by organizations and professionals that represent the broad needs of the community as well as organizations that serve low-income and underserved populations. A list of key informants can be found on **Appendix F**. These local partnering organizations also invited the informants to participate in and conducted the interviews. The interviewers used a standard interview script that included the following elements:

- Impact of the COVID-19 pandemic
- Identifying the top health issues affecting Milwaukee County residents
- Identifying the top leading factors that contribute to the issues
- Existing strategies to address the issue
- Groups or populations that seem to struggle the most with the issues
- Barriers/challenges to accessing services
- Additional strategies needed to address the issue
- Key groups in the community that hospitals should partner with to improve community health

Underserved Population Input: Froedtert Bluemound Rehabilitation Hospital is dedicated to reducing health disparities and input from community members who are medically underserved, low-income and minority populations and/or organizations that represent those populations are important in addressing community health needs. With that in mind, Froedtert Bluemound Rehabilitation Hospital took the following steps to gain input:

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

Summary of Community Member Input

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

Community Health Survey (Health Issues/Behaviors):

- Mental Health
- Infectious Disease
- Chronic Disease
- Drug Use & Abuse
- Alcohol Use & Abuse

Community Health Survey (Social Needs):

- Access to Affordable Health Care
- Access to Mental Health Services
- Access to Affordable Housing
- Gun Violence
- Community Safety

Key Informant Interview (Health Issues/Behaviors & Social Needs):

- Access to Health Care
- Mental Health
- Infectious Disease
- Alcohol & Drugs
- Community Safety

Prioritization of Significant Health Needs

Froedtert Bluemound Rehabilitation Hospital in collaboration with the Milwaukee Health Care Partnership, their member organizations, HCI and the Center of Urban Population Health (CUPH), analyzed secondary data of several indicators and gathered community input with contracted assistance from HCI through online surveys, focus groups and key stakeholder interviews to identify the needs in Milwaukee County. Based on the information from all the CHNA data collection sources, the health needs were identified as:

- Mental Health & Access to Mental Health Services;
- Equitable Access to Health Services;
- Drug Use/Overdose Deaths;
- Alcohol Use;
- Public Safety & Crime (Violence);
- Infectious Disease (COVID 19);
- Housing as Health;
- Youth & Adolescent Health;
- Maternal, Fetal & Infant Health; and
- Chronic Diseases

The CHNA was reviewed by the Froedtert Bluemound Rehabilitation Hospital CHNA/Implementation Strategy Advisory Committee (**Appendix A**) consisting of members of the Community Health Improvement Advisory Committee, Froedtert Hospital Board of Directors, community partners in Milwaukee County, and City of Milwaukee Public Health Department along with hospital and health system leadership/staff. Members of the committee were selected based on their specific knowledge of health needs and resources in Milwaukee County for a collective analysis of the findings from the Community Health Needs Assessment. Under the direction of the Community Engagement Leadership Team and a trained meeting facilitator the planning process included five steps in prioritizing Froedtert Bluemound Rehabilitation Hospital's significant health needs:

1. Reviewed the Community Health Needs Assessment results for identification and prioritization of community health needs
2. Reviewed previous implementation plan programs and results
3. Reviewed current hospital and community health improvement initiatives and strategies
4. Ranked and selected priority areas
5. Selected evidence-based strategies, partnerships and programs to address community health needs

Before the facilitated workout session in February 2022, 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:

- **Impact:** The degree to which the issue affects or exacerbates other quality of life and health- related issues.
- **Feasibility:** Can Froedtert Bluemound Rehabilitation Hospital address the need through direct programs, clinical strengths and dedicated resources?
- **Partnerships:** Are there current or potential community partners/coalitions?
- **Health Equity:** What disparities exist and how can we ensure that the disparities will be addressed?
- **Measurable:** What is the likelihood of being able to make a measurable impact on the problem?

Based on those results, the top ranked significant health needs included:

- Mental Health & Access to Mental Health Services;
- Equitable Access to Health Services;
- Substance Use (Alcohol & Other Drugs);
- Public Safety & Crime (Violence);
- Housing as Health;
- Maternal, Fetal & Infant Health; and
- Chronic Diseases

During the February 2022 workout session, members of the Advisory Committee were asked to further prioritize the top significant health needs by again rating each of the seven priority based on the above criteria. Of those significant health needs categories, four overarching themes were identified as priorities for Froedtert Bluemound Rehabilitation Hospital's Implementation Strategy for fiscal 2023-2025:

- **Behavioral Health (Mental Health & Substance Use);**
- **Equitable Access to Health Services;**
- **Chronic Disease; and**
- **Violence**

Community Resources and Assets

Froedtert Bluemound Rehabilitation Hospital 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 and assets are noted by key informants in **Appendix E**.

Approval of Community Health Needs Assessment

The completed Community Health Needs Assessment (CHNA) report was adopted by the Froedtert Hospital Board of Directors on August 18, 2022 and made publicly available on August 19, 2022.

Summary of Impact from the Previous Implementation Strategy

An abridged version of the results and evaluation of the impact of actions taken to address the significant health needs identified in Froedtert Bluemound Rehabilitation Hospital's prior CHNA can be found in **Appendix I** of this CHNA. A copy of the complete prior CHNA can be found on Froedtert Health's website at https://www.froedtert.com/community-engagement.

Public Availability of CHNA and Implementation Strategy

After adoption of the CHNA Report and Implementation Strategy, Froedtert Bluemound Rehabilitation Hospital publicly shares both documents with community partners, key informants, hospital board members, public schools, non-profits, hospital coalition members, Milwaukee County 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 https://www.froedtert.com/community-engagement.

Feedback and public comments are always welcomed and encouraged, and can be provided through the contact form on the Froedtert & the Medical College of Wisconsin website at https://www.froedtert.com/contact, or contacting Froedtert Health, Inc.'s Community Engagement leadership/staff with questions and concerns by calling 414-777-3787. Froedtert Bluemound Rehabilitation Hospital received no comments or issues with the previous Community Health Needs Assessment Report and Implementation Strategy.

Appendix A: Froedtert Bluemound Rehabilitation Hospital CHNA/Implementation Strategy Advisory Committee

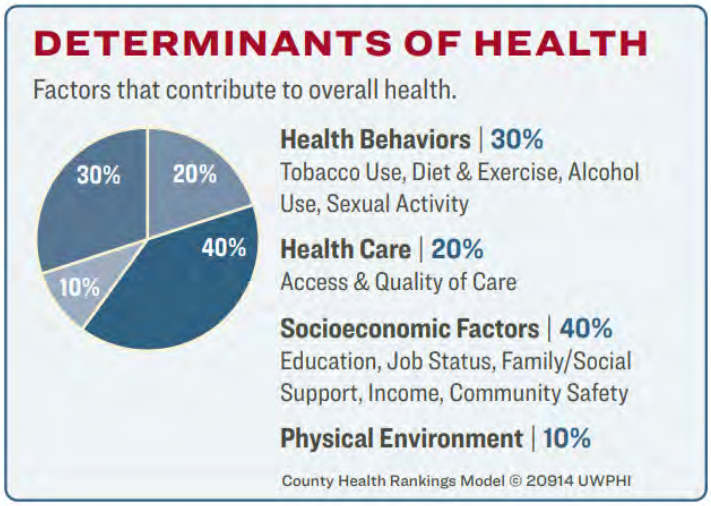
Name	Title	Organization	Froedtert Bluemound Rehabilitation Hospital Affiliation
Rafael Acevedo	Grant Compliance Manager	City of Milwaukee	Board Member
Louis Butler Jr.	Retired Partner	Retired Partner, DeWitt LLP	Board Member
Breen Causey	Community Care Coordinator	Froedtert Health	
Ricardo Colella, DO	Professor and Chief, Division of EMS Medicine Departments of Emergency Medicine, Pediatrics & the Institute for Health and Equity	Medical College of Wisconsin	CHIAC
Eric Conley	SVP/COO	Froedtert Health	Board Member
Frank Cumberbatch	Vice President - Engagement	Bader Philanthropies, Inc.	
Allison DeVan	Scientific Administrator, Cardiovascular Center	Medical College of Wisconsin	CHIAC
Ella Dunbar	Manager Community Relations	Social Development Commission	CHIAC
Jasmine Ervin	Data Specialist	CORE-El Centro, Inc.	CHIAC
Sarah Francois	Director of Fund Development & Marketing	Progressive Community Health Centers	CHIAC
Kerry Freiberg	VP Community Engagement	Froedtert Health	CHIAC
Lori Gendelman	Attorney	Otjen Law Firm, SC	Board Member
Monique Graham	Director Community Engagement	Froedtert Health	CHIAC
Katelyn Halverson	Community Engagement Program Coordinator	Froedtert Health	
Trenace Harris	Center Administrator, Cardiovascular Center	Medical College of Wisconsin	CHIAC
Rebecca Heaton Juarez	Program Director	CORE-El Centro, Inc.	CHIAC
Tierra Hoard	Community Outreach Nurse	Froedtert Health	
Dessa Johnson	Director of Emerging Markets	Froedtert Health	
Nina V. A. Johnson	SVP, SE WI Consumer and Business Banking	U.S. Bank	Board Member
Sahar Katib Kayata, MD	Board Member	Milwaukee Muslim Women's Coalition	CHIAC
Jennifer Langoehr	Community School Coordinator	Froedtert Health	
Leah Laven-Wilson	Director of Housing and Social Services	United Methodist Children's Services of WI, Inc.	CHIAC
Rachel Lecher	Public Health Strategist	City of Milwaukee Health Department	CHIAC
Mark Lodes, MD	Chief Medical Officer, Population Health	Froedtert Health	
Carmen Pangilinan	Public Health Specialist	Wauwatosa Health Department	CHIAC
Harvey Padek	Director of CHW Community-Clinical Linkages	Milwaukee Area Health Education Center	CHIAC
Allyson Rennebohm	Community Nurse Coordinator	Froedtert Health	
Justin Rivas	Director of Community Health Initiatives	Milwaukee Health Care Partnership	
Britney Roberson	Community Engagement Program Coordinator	Froedtert Health	
Shelly Sabourin	Executive Director	Froedtert Health	Bluemound Rehabilitation Hospital
Jenni Sevenich	CEO	Progressive Community Health Centers	Board Member
Penelope Stewart	Director of Marketing	Outreach Community Health Center	CHIAC
Kate Sweeney	Director, Cancer Center Patient Support Services	Froedtert Health	CHIAC
Barbara Wesson	Professor of Natural Health	UW Milwaukee	CHIAC
Amanda Wisth	Community Engagement Data Analyst	Froedtert Health	
Staci Young, PhD	Director of Center for Healthy Communities and Research	Medical College of Wisconsin	CHIAC
Laura Zindars	Director of Patient Care & Operations	Froedtert Health	Bluemound Rehabilitation Hospital
Anne Zizzo	President & CEO	Zizzo Group	Board Member

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.

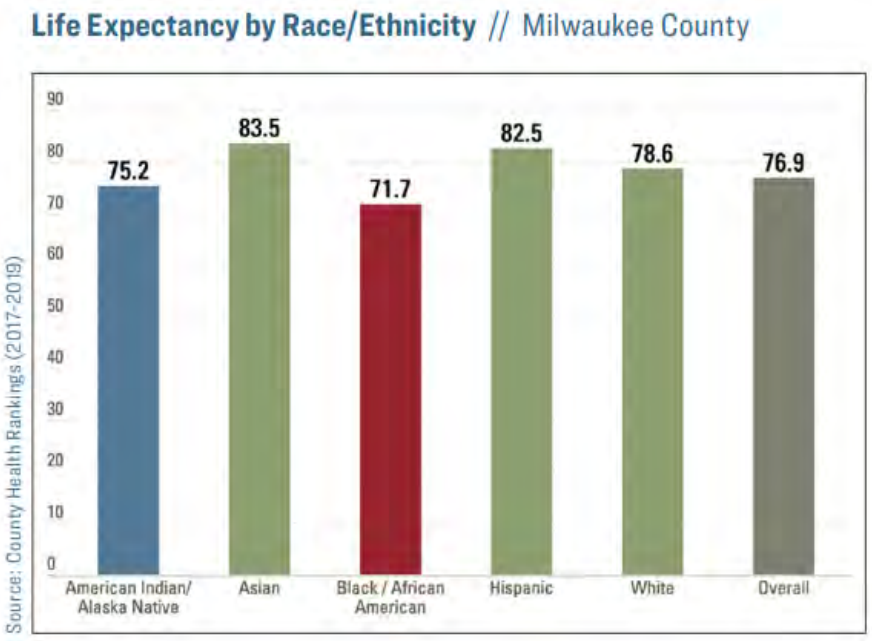
Health Disparities

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 Milwaukee 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 Milwaukee County CHNA are informed by both community input (primary data) and health indicators (secondary data).

Life expectancy and premature death are two examples of disparate health indicators in the secondary data. Life expectancy is a projection of expected years of life to be lived, and premature death is measured by years of potential life lost (YPLL).

Overall life expectancy is 76.9 years for the general population, but when broken down by racial and ethnic groups, Blacks (71.7 years) and American Indian/Alaskan Native (75.2 years) live shorter lives than Whites (78.6 years). Premature death by YPLL shows a rate of life lost that is twice as severe for Blacks when compared to Whites.

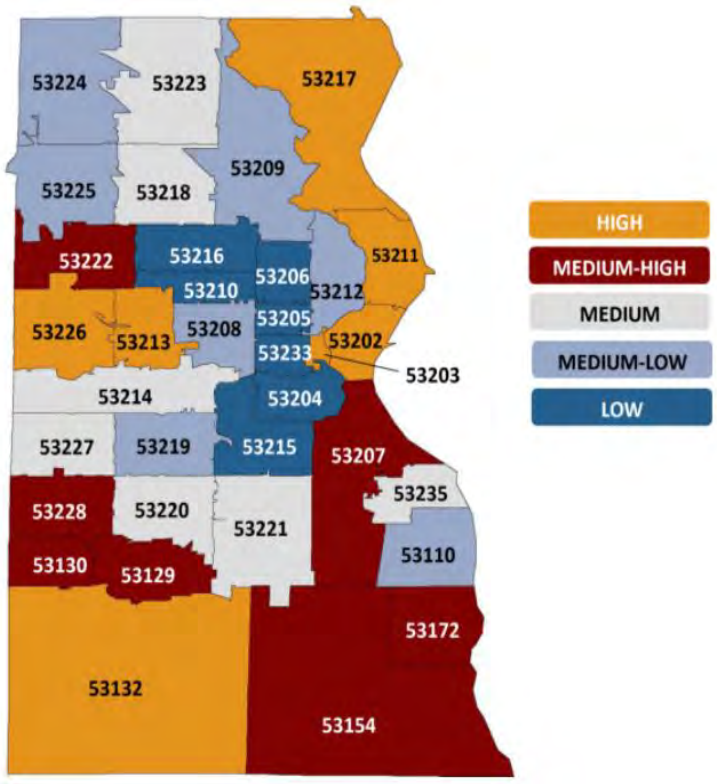


Community stakeholders (key informants and focus group participants) often noted that people of color (POC) are more negatively impacted by socioeconomic determinants that contribute to worse health outcomes. Additionally, older adults and children were the age groups that stakeholders identified as having more barriers to accessing health care and services. This input helped frame the priority populations identified in the shared Milwaukee County CHNA.

Disparities by Place

Zip code-level analysis in the assessment shows significant gaps in health outcomes by geography. This pattern is pronounced in the city of Milwaukee, where place overlaps with race because of residential hyper-segregation. With a history of policies and practices of discrimination and disinvestment, the data from these neighborhoods demonstrate the connection between decreased social and economic opportunities and poor health.

Health Equity Index Map by Zip Code



Developed by Conduent Healthy Communities Institute, the Health Equity Index® (HEI), found on Health Compass Milwaukee, groups together indicators related to income, poverty, unemployment, occupation, education, and language. The HEI helps identify areas of high socioeconomic need that are correlated with poor health outcomes. In the map, zip codes are ranked based on their HEI value, resulting in eleven zip codes[1] identified in the shared Milwaukee County CHNA as having the highest health needs.

[1] Highest need zip codes (dark blue) utilized for cross tabulation of community health survey responses: 53206, 53205, 53204, 53225, 53208, 53210, 53233, 53218, 53209, 53212, and 53215.

Other Issues of Concern

In addition to the top five health issues in 2021, other important areas of concern were identified in the assessment. Like the top five health issues, these are persistent and chronic issues facing the community that show significant health disparities by race and ethnicity.

MATERNAL, FETAL AND INFANT HEALTH

Maternal, fetal and infant health is a complex issue with sharp disparities facing the Black/African American community in particular. There are numerous secondary health indicators that speak to the severity of the issue, including:

- Babies with low birthweight
- Babies with very low birth weight
- Preterm births
- Preterm labor and delivery hospitalizations
- Infant mortality rate
- Mothers who received early prenatal care

Community input elevated the same concern related to infant mortality and the disparities that exist in African American communities. Stakeholders often linked the issue to access and utilization of prenatal care, infant care practices, and lack of trust in the health care system.

INFECTIOUS DISEASE

Infectious disease was further spotlighted in 2021 due to the inclusion of COVID-19 as an immediate health issue. When asked about top health issues in their community, 38% of community health survey respondents named infectious disease as an issue, with a rate of 43% in the older adult population subgroup. Infectious disease encompasses immunizations and communicable diseases such as HIV, other sexually transmitted infections (STIs), and COVID.

While COVID may be a snapshot in time issue, STIs and immunization access and uptake are ongoing issues of concern. Secondary data health indicators for infectious disease include:

- COVID incidence rate
- Chlamydia incidence rate
- Gonorrhea incidence rate
- Syphilis incidence rate
- Age-adjusted ER rate due to immunization – preventable pneumonia and influenza
- Age-adjusted hospitalization rate due to immunization – preventable pneumonia and influenza

The 2021 community health survey briefly addressed COVID by asking about vaccination status; however, the data gathered is a snapshot in time of late summer 2021 and faces limitations due to the convenience sampling of the survey that overly represents groups with low vaccine hesitancy.

Priority Populations

The distinction of priority populations in the shared Milwaukee County CHNA was intended to identify groups with the greatest health disparities and/or risk for poor health. This framework also serves to support population-specific health improvement planning, investments, and program development. This table shows each priority population and just one health indicator that reflects its unique health challenge.

Priority Population	Indicator
Black / African American	Blacks face twice the 'number of years of life lost,' compared to Whites.
Hispanic / Latino	70% of Latinos have health insurance, compared to a 95% coverage rate for Whites.
Children & Youth (< 18 years old)	Nearly 1 in 4 children live in poverty, a rate 3x more likely for Latinos and 4x more likely for Blacks, compared to Whites.
Older Adult / Elderly (> 65 years old)	Older adults face increased social isolation, more than 1 in 3 live alone.

Technical notes on racial/ethnic groups. *The capability to analyze and present data based on these priority populations relies on the data inputs available. We recognize that "race" and "ethnicity" are social categories, not biological ones. The majority of the shared Milwaukee County CHNA's secondary data relies on U.S. Census racial and ethnic categories that are not as detailed as current population dynamics in Milwaukee; and may sometimes be, but are not always, exclusive. The community health survey asked respondents to self-identify more detailed Hispanic ethnicities, but we also adhered to Census categories to align findings across sources. A final comment regards the use of the term "people of color" (POC). The term has grown in usage as a way to distinguish racial and ethnic groups who do not identify as "white." The term POC is also used in place of "racial minorities" because in certain locations, POC are no longer racial minorities, statistically speaking. This is true in hyper-segregated urban areas like Milwaukee.*

Appendix C: 2021 Milwaukee County Community Health Needs Assessment: Community Health Survey

The Milwaukee County Community Health Needs Assessment survey results are available at www.healthcompassmilwaukee.org

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 Milwaukee County Community Health Needs Assessment (**Appendix D**). The purpose of this project is to provide Milwaukee 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 the prevalence of risk factors and disease conditions existing within the adult population.
3. Compare, where appropriate, health data of residents to previous health studies.
4. Compare, where appropriate and available, health data of residents to state and national measurements along with Healthy People 2030 goals.

Community input was collected via an online community survey conducted by Conduent Healthy Communities Institute from August 17th, 2021, through October 4th, 2021. Available in English and Spanish, the survey consisted of 50 questions related to top health needs in the community, individuals' perception of their overall health, individuals' access to health care services, as well as social and economic determinants of health.

The survey was promoted by the Milwaukee Health Care Partnership's members and community partners via their individual channels and patient communications. Those efforts included a joint press release, health systems' websites and healthyMKE.com, social media, emails, newsletters, local events, and other promotional activities that took place during and prior to the seven-week response period.

A total of 9,006 surveys were submitted. Within the community online survey, 185 (2%) were nonresidents of Milwaukee County and 8,812 (98%) were residents. After eliminating non-Milwaukee County residents or incomplete submissions, the **final overall sample was 8,616**. The completion rate for the survey over the seven-week period was 71.4%. Intended to be a convenience sample, every effort was made to recruit participants from diverse racial, ethnic, and socio-economic populations in the county.

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 Milwaukee County. A limitation to the survey is that it was conducted in English and Spanish only.

Partners & Contracts: This report was commissioned by Advocate Aurora Health, Ascension Wisconsin, Children's Wisconsin and Froedtert & Medical College of Wisconsin in partnership with the Center for Urban Population Health. The data was analyzed and prepared by Conduent Healthy Communities Institute and the Center for Urban Population Health.

Appendix D: 2021 Milwaukee County Community Health Survey Results

Summary: Milwaukee County Community Health Survey

This summary is a partial list of data from an online survey conducted by Conduent Healthy Communities Institute from August through October 2021 on behalf of Advocate Aurora Health, Ascension Wisconsin, Children's Wisconsin, Froedtert Health and the Milwaukee Health Care Partnership (MHCP). As part of an overall Community Health Needs Assessment to better understand community needs and community perception of health, the survey contained 50 questions and collected input from 8,616 Milwaukee County residents ages 18 years and older. The community health survey was promoted by MHCP member organizations and community partners across numerous traditional and digital communication channels, including a press release, member and partner websites, social media, emails, newsletters, events and on-the-ground outreach.

Sample sizes: *County overall (n=8616), Black/African American (n=642), Hispanic/Latino (n=463), High-need zip codes (1535), Household with children (n=1145), Older adult (n=3450)*

Individual Health Conditions and Behaviors

PERSONAL HEALTH

Question: *Self-rated personal health:*

	County overall *n=8616*	Black/African American *n=642*	Hispanic/Latino *n=463*	High-need zip codes *n=1535*	Household with children *n=1145*	Older adult (>65 yrs) *n=3450*
Very healthy	11.9%	2.1%	9.4%	9.8%	12.7%	13.5%
Healthy	46.0%	38.4%	36.8%	42.6%	42.7%	50.9%
Somewhat healthy	32.9%	44.2%	37.3%	36.8%	34.5%	29.4%
Unhealthy	7.3%	9.4%	13.0%	9.3%	8.3%	4.8%
Very unhealthy	1.9%	2.1%	3.5%	1.5%	1.8%	1.5%

HEALTH CONDITIONS

Question: *In the past three years, have you been treated for or been told by a doctor, nurse or health care provider that you have:*

Response: "YES"	County overall	Black/African American	Hispanic/Latino	High-need zip codes	Household with children	Older adult (>65 yrs)
Diabetes	**13.0%**	23.8%	15.8%	15.2%	6.3%	17.7%
High blood pressure	**36.8%**	52.1%	27.3%	38.8%	18.3%	53.3%
High cholesterol	**31.5%**	34.3%	24.9%	30.3%	18.2%	41.6%
Heart disease or heart condition	**12.1%**	9.6%	8.1%	10.6%	3.7%	20.7%
Mental health condition	**20.9%**	20.5%	30.0%	24.1%	27.7%	10.7%

HEALTH BEHAVIORS

Question: *In the past three years, have you participated in:*

Response: "YES"	County overall	Black/African American	Hispanic/Latino	High-need zip codes	Household with children	Older adult (>65 yrs)
Alcoholic consumption (binge drinking at least monthly)	**22.7%**	14.7%	18.6%	19.4%	21.2%	19.7%
Smoking cigarettes (some times or daily)	**7.9%**	10.2%	10.6%	11.0%	8.3%	5.8%
Electronic cigarettes (some times or daily)	**2.3%**	2.8%	4.3%	2.9%	2.8%	1.1%

HEALTH CARE ACCESS

Question: *Questions varied.*

Response: "YES"	County overall	Black/ African American	Hispanic/ Latino	High-need zip codes	Household with children	Older adult (>65 yrs)
I have health insurance	**97.4%**	95.0%	87.5%	94.8%	96.9%	99.1%
Did not access health care or dental health services in last 12 months	**18.7%**	24.6%	30.8%	23.0%	23.1%	12.0%
Cost as reason	**52.2%**	44.7%	56.6%	48.7%	51.7%	44.8%
Did not access mental health/substance use services in last 12 months	**9.8%**	12.7%	13.9%	11.5%	15.5%	3.6%
Cost as reason	**37.5%**	28.0%	38.2%	31.9%	32.2%	18.1%
I used the ER in the past 12 months	**19.0%**	26.5%	23.6%	22.5%	21.3%	19.3%

Community Health

HEALTH ISSUES

Question: *From the following list, what do you think are the three most important health issues/conditions in your community?*

Response: "YES as one of the top three issues"	County overall	Black/African American	Hispanic/Latino	High-need zip codes	Household with children	Older adult (>65 yrs)
Mental health	**50.4%**	51.1%	58.2%	49.5%	62.0%	37.4%
Infectious disease *(includes COVID-19 as an issue)*	**38.3%**	29.6%	31.0%	30.2%	34.9%	43.3%
Chronic disease	**35.3%**	40.7%	34.3%	34.9%	30.1%	38.7%
Drug use and abuse	**34.8%**	42.7%	37.7%	44.1%	36.3%	33.3%
Alcohol use and abuse	**30.7%**	32.7%	36.6%	33.3%	30.4%	30.4%

HEALTH NEEDS

Question: *From the following list, what do you think are the three most important community needs that have to be addressed to improve health for everyone in the community?*

Response: "YES as one of the top three issues"	County overall	Black/African American	Hispanic/Latino	High-need zip codes	Household with children	Older adult (>65 yrs)
Access to affordable health care	**44.4%**	36.4%	46.3%	39.9%	38.6%	45.0%
Access to mental health services	**29.7%**	28.2%	32.1%	27.0%	38.3%	21.9%
Access to affordable housing	**22.7%**	31.6%	29.5%	28.1%	22.7%	21.4%
Gun violence	**21.2%**	26.8%	11.6%	28.4%	n/a*	27.5%
Community safety	**19.7%**	22.1%	21.6%	22.0%	16.3%	22.4%

Community Health

HEALTH CARE SERVICES

Question: *Below are some statements about health care services in your community. Select an option for your response in each.*

Response: "YES"	County overall	Black/African American	Hispanic/Latino	High-need zip codes	Household with children	Older adult (>65 yrs)
Yes, I am connected to primary care that I am happy with	**90.8%**	88.6%	83.6%	89.0%	85.8%	96.2%
Yes, I can get an appointment when needed	**83.9%**	84.0%	80.2%	81.5%	77.5%	90.1%
Yes, I can easily get to my health care provider	**94.1%**	91.6%	89.9%	92.3%	92.3%	96.4%

COMMUNITY SOCIAL AND ECONOMIC CONDITIONS

Question: *Below are some statements about your community. Select an option for your response in each row below.*

Response: "YES"	County overall	Black/African American	Hispanic/Latino	High-need zip codes	Household with children	Older adult (>65 yrs)
There are affordable health care services	**51.4%**	45.4%	40.7%	46.5%	47.8%	58.5%
Childcare resources are affordable and available	**15.7%**	16.0%	16.1%	13.5%	19.4%	13.6%
There are plenty of well-paying jobs 18+	**37.5%**	22.7%	27.0%	28.3%	40.1%	35.9%
There are plenty of available jobs <18	**42.4%**	26.8%	31.7%	32.7%	46.9%	37.0%
K-12 schools are well-funded and provide quality education	**44.5%**	19.0%	30.5%	22.6%	52.5%	47.3%
Our local university/college is of quality and affordable	**45.1%**	27.2%	34.7%	39.5%	44.4%	49.8%
Crime is not a major issue in my neighborhood	**54.3%**	33.9%	40.8%	29.5%	56.6%	55.6%
There is a feeling of trust in law enforcement	**59.8%**	24.3%	43.8%	34.9%	57.3%	65.9%
Affordable healthy food options are accessible nearby	**77.7%**	45.2%	57.7%	56.0%	76.5%	82.6%
There are good sidewalks/trails for walking/biking safely	**83.2%**	53.0%	66.7%	67.0%	79.4%	86.8%
The streets are clean and buildings are well maintained	**75.7%**	36.0%	56.6%	44.2%	73.9%	82.0%
The air and water quality are safe	**70.2%**	46.4%	55.8%	51.5%	67.5%	75.3%

Racism, Discrimination and Health Equity

INDIVIDUAL: LIFE CHALLENGES WITH SOCIAL AND ECONOMIC CONDITIONS

Question: *Thinking about your own life, do you feel that any of the following have been a challenge?*

Response: "YES"	County overall	Black/African American	Hispanic/Latino	High-need zip codes	Household with children	Older adult (>65 yrs)
Unconscious bias	**34.1%**	58.5%	52.6%	43.1%	38.7%	26.3%
Individual acts of racism/discrimination	**20.2%**	56.0%	42.6%	32.2%	24.0%	15.3%
Structural or systemic racism	**19.9%**	63.8%	41.8%	33.4%	25.2%	15.4%
Limited access to wealth	**20.2%**	45.6%	35.0%	31.9%	23.7%	12.0%
Limited access to quality education	**11.1%**	31.1%	23.4%	19.6%	16.4%	6.4%
Limited access to career opportunities	**20.4%**	44.2%	37.6%	29.2%	26.8%	10.4%
Limited access to quality housing	**13.1%**	41.0%	26.1%	24.4%	15.4%	8.8%

INDIVIDUAL: RACISM AND DISCRIMINATION IN HEALTH CARE ACCESS

Question: *Below are some statements about health care services and providers (doctors, nurses, other hospital clinic staff) in your community.*

Response: "YES"	County overall	Black/African American	Hispanic/Latino	High-need zip codes	Household with children	Older adult (>65 yrs)
I feel heard and seen and listened to when receiving health care	88.9%	84.9%	82.8%	87.3%	84.7%	94.5%
I feel I am treated differently because of my race or ethnicity when receiving health care	5.4%	21.5%	13.1%	10.2%	8.3%	3.1%
I feel I am treated differently because of my gender when receiving health care	9.0%	10.1%	11.2%	11.0%	12.6%	4.3%
I feel I am treated differently because of my sexual orientation when receiving health care	2.3%	2.3%	3.4%	3.5%	2.9%	0.9%
I feel my family or support people are seen and listened to when receiving health care	70.6%	62.6%	67.3%	68.5%	73.4%	75.3%
I feel seen and listened to when my child/children are receiving health care	46.9%	55.4%	54.3%	46.8%	86.3%	41.1%

COMMUNITY: PERCEPTION OF REASONS FOR HEALTH DISPARITIES

Question: *On average, people of color (POC) in the U.S. have worse health outcomes compared to White people. Do you think any of the following are reasons for the difference?*

Response: "MAJOR REASON"	County overall	Black/African American	Hispanic/Latino	High-need zip codes	Household with children	Older adult (>65 yrs)
Historic gaps in wealth	**63.5%**	83.9%	67.9%	72.5%	63.9%	63.0%
Structural/systemic racism	**57.1%**	85.6%	65.0%	69.0%	63.3%	52.8%
POC have less access to quality education	**45.0%**	65.1%	57.9%	53.3%	50.3%	40.3%
POC have less career opportunities	**42.1%**	72.5%	53.8%	54.5%	45.6%	38.6%
POC have less access to quality housing	**50.9%**	75.8%	58.7%	60.3%	63.9%	48.0%
POC are more likely to be exposed to bad environmental conditions	**50.1%**	76.0%	53.4%	58.7%	50.8%	49.9%
Doctors are less likely to provide the same care to POC	**26.0%**	56.8%	36.1%	37.5%	36.4%	15.5%
POC are less likely to have health care and/or insurance	**49.9%**	70.0%	54.2%	56.0%	51.8%	47.4%
POC have less opportunities for healthy activities and/or eating	**28.6%**	47.3%	34.6%	35.2%	33.3%	24.8%
POC are genetically less healthy than whites	**7.7%**	20.8%	15.2%	12.7%	9.4%	6.0%

CHILDREN'S QUALITY OF LIFE **Question:** *In general, would you say your child's quality of life is:*	
Excellent	50.9%
Very good	37.5%
Good	10%
Fair	1.6%
Poor	0.2%

HEALTH PLAN COVERAGE FOR CHILDREN **Question:** *Which type(s) of health plans(s) do children in your home have to cover the costs of health care services? Select all that apply.*	
Insurance through an employer	77.8%
Medicaid/Children's Health Insurance Program (CHIP)/BadgerCare	20.2%
Private insurance I pay for myself (HMO/PPO)	3.0%
I pay out of pocket/cash	2.3%
Insurance through the Health Insurance Marketplace/Obama Care/Affordable Care Act (ACA)	2.2%

CHILDREN'S HEALTH ISSUES **Question:** *Have the children (under 18) in your home experienced any of the following health issues? Select all that apply.*	
No, the child/children have not faced any health issues	49.0%
Mental or behavioral health (fearfulness, depression, self-regulation)	21.8%
Chronic diseases (allergies, asthma, diabetes)	13.7%
Oral health/dental health	8.4%
Overweight or underweight	8.2%
Hearing and/or vision	7.3%
Infant health (low birth weight, premature birth)	6.7%
Childhood disabilities or special needs	6.3%
Infectious diseases (measles, COVID-19)	5.4%

CHILDREN'S ACCESS TO HEALTH SERVICES **Question:** *In the past 12 months, was there a time when children in your home needed medical care or other health related services but did not get the services that they needed?*	
No, they got the services that they needed	81.3%
Yes	8.9%
Does not apply, the child/children did not need services	9.7%
Which of the following services were the children in your home not able to get in the past 12 months when they needed them?	
Mental health services	34.1%
Dental care (routine cleaning or urgent care)	24.7%
Well child visit/check-up	23.5%
Sick visit/urgent care visit	20.0%
Services for special needs	17.7%
Prescription medications	16.5%
Select the top reason(s) that children in your home did not get the medical/health care services that they needed in the past 12 months.	
Office/service/program has limited access or is closed due to COVID-19	41.3%
Wait is too long	28.8%
Cost - too expensive/can't pay	26.3%
Insurance not accepted	20.0%

CONCERNS FOR CHILDREN'S HEALTH **Question:** *Do you have concerns for any of the following activities for the children (under 18) in your home? Select all that apply.*	
I have no concerns	65.1%
Nutrition and eating habits	23.5%
Physical activity and exercise	20.6%
Drug use and abuse (prescription drug misuse and street drug use, including marijuana and weed)	5.1%
Vaping, juuling and e-cigarette use	3.6%
Other	3.5%
Alcohol use	3.4%
Cigarette smoking and other tobacco use	2.1%

Technical Notes:

- Sample sizes: County overall (n=8616), Black/AA (n=642), Hispanic/Latino (n=463), High-need zip codes (1535), Children in household (n=1145), Older adult (n=3450)
- Sample size denominators vary across survey questions based on survey completion by respondent
- Convenience sample survey method was utilized; results may not be generalizable
- Survey methods: 50 total questions, online, English/Spanish, no incentive, voluntary, anonymous
- High-need zip codes are based on a suite of social and economic indicators found on healthcompassmilwaukee.org. Those zip codes are: 53206, 53205, 53204, 53225, 53208, 53210, 53233, 53218, 53209, 53212, 53215
- The Community Health Survey is one of three data inputs for the Milwaukee Community Health Needs Assessment. View the full report at healthcompassmilwaukee.org

Survey Respondent Demographics

Total sample size: n=8616

RACE	n	%
White or Caucasian	6742	80.5%
Black or African American	642	7.7%
Asian or Asian American	108	1.3%
American Indian or Alaskan Native	53	0.6%
Two or more races	186	2.2%
Some other race	81	1.0%
Prefer not to answer	560	6.7%
ETHNICITY		
Hispanic/Latino/Latinx	463	5.4%
Mexican	156	36.5%
Mexican American	123	28.7%
Puerto Rican	121	28.2%
South American	27	6.3%
Central American	22	5.1%
Cuban	5	1.2%
Dominican	5	1.2%
Other	25	5.8%
Non-Hispanic/Latino/Latinx	7474	86.8%
Prefer not to answer	679	7.9%
AGE		
18-20	35	0.4%
21-24	128	1.5%
25-34	799	9.5%
35-44	1102	13.1%
45-54	1039	12.4%
55-64	1656	19.7%
65-74	2651	31.6%
75-84	751	9.0%
85 or older	48	0.6%
GENDER		
Female	5938	70.8%
Male	2221	26.5%
Transgender Male	10	0.1%
Transgender Female	9	0.1%
Non-binary	34	0.4%
Other	22	0.3%
Prefer not to answer	159	1.9%
SEXUAL ORIENTATION		
Straight	7334	87.5%
Gay	156	1.9%
Lesbian	86	1.0%
Bisexual	175	2.1%
Pansexual	48	0.6%
Queer	52	0.6%
Other	44	0.5%
Prefer not to answer	463	5.5%

EDUCATION	n	%
Less than 9th grade	37	0.4%
Some high school	110	1.3%
High school graduate (GED)	2034	24.3%
Associate degree	1218	14.5%
Bachelor's degree	2614	31.2%
Master's/Professional degree	2372	28.3%
INCOME		
Less than $25,000	738	8.8%
$25,000-$50,000	1332	10.6%
$50,000-$75,000	1392	16.6%
$75,000-$100,000	1132	13.5%
$100,000-$125,000	897	10.7%
$125,000+	1186	14.2%
Prefer not to answer	1704	20.3%
EMPLOYMENT		
Employed part-time	754	9.0%
Employed full-time	3354	39.9%
Out of work, looking	110	1.3%
Not working by choice	186	2.2%
Unable to work	273	3.2%
Retired	3431	40.8%
Student	84	1.0%
Out of work, not looking	45	0.5%
HOUSEHOLD SIZE		
1	2141	25.8%
2	3853	46.4%
3	1142	13.7%
4	770	9.3%
5	278	3.3%
6 or more	129	1.6%
PRIMARY LANGUAGE		
English	8060	96.8%
Spanish	160	1.9%
Other	67	0.8%
Arabic	17	0.2%
Russian	12	0.1%
Hmong	10	0.1%

Appendix E: 2021 Milwaukee County Community Health Needs Assessment: A Summary of Key Informant Interviews

The Milwaukee County Community Health Needs Assessment key informant interview results can be found at www.healthcompassmilwaukee.org

Milwaukee County conducted key informant interviews and focus groups 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 or interview is not necessarily representative of other groups. A total of 48 key informant interviews representing communities that include, but were not limited to: African American, Native American, Hispanic, Hmong, the elderly, youth, LGBTQ+, individuals with disabilities, and those living with mental illness and substance use disorders were conducted during August 2021-September 2021. A total of 55 participants in four focus groups were conducted during October 2021 and November 2021. Key partners, organizations, and topic groups were invited by the Milwaukee Health Care Partnership and its partner organizations to participate in these virtual interviews lasting sixty minutes and held in English.

Key informants in Milwaukee County were identified by the Milwaukee Healthcare Partnership healthy systems' community benefit leaders. A large array of community organizations, faith and community leaders, government officials, and health system leadership gave feedback when facilitators asked specific questions about community health.

Interviewers and focus group facilitators used a standard discussion guide from which informants were asked to identify:

- Impacts of the COVID-19 pandemic
- The top health issues affecting Milwaukee County residents
- The top leading factors that contribute to the issues
- Existing strategies to address the issue
- Groups or populations that seem to struggle the most with the issues
- Barriers/challenges to accessing services
- Additional strategies needed to address the issue
- Key groups in the community that hospitals should partner with to improve community health

All informants were made aware that participation was voluntary and that responses would be shared with the Conduent Healthy Communities Institute for analysis and reporting. Notes from the key informant interviews and focus groups were managed by Conduent HCI through the web-based qualitative data analysis tool, *Dedoose*. Interview text was coded using a pre-designed codebook, organized by themes, and analyzed by Conduent for significant observations. There were 8,449 codes extracted from the key stakeholder and focus group interviews. The frequency with which a health topic was discussed was used to assess the relative importance of that health and/or social need to determine the most pressing health needs of the community.

These findings are a critical supplement to the Milwaukee County Community Health Needs Assessment (CHNA) survey conducted through a partnership between the Milwaukee County Health Departments, Advocate Aurora Health, Ascension Wisconsin, Children's Hospital of Wisconsin, and Froedtert & the Medical College of Wisconsin. The CHNA incorporates input from persons representing the broad community served by the hospitals, focusing on a range of public health issues relevant to the community at large.

Limitations: The breadth of findings is dependent upon the opinions of a limited number of experts identified as having the community's pulse. It is possible that the results would have been different if an alternative set of informants had been interviewed. Several invited informants were not able to participate. The variety of interviewers could have resulted in some inconsistencies in data collection. Although Conduent Healthy Communities Institute used a consistent analysis process to review the interview data, it is possible that certain responses could have been misinterpreted. Additionally, some informants did not

answer all questions from the discussion guide, and some answered the questions generally across issues, rather than relating the questions back to their top identified health issues. Results should be interpreted in conjunction with other Milwaukee County data available in the Milwaukee County Community Health Survey, Health Compass Milwaukee and internal hospital data.

A total of 48 key informant interviews and four focus groups were asked to identify major health-related issues in Milwaukee County. The five health issues identified most consistently were:

1. Access to Health Care;
2. Mental Health;
3. Infectious Disease;
4. Alcohol & Drugs; and
5. Community Safety

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.

Access to Health Care

Barriers and Challenges	Needed Strategies
• Affordable healthcare • People do not know how to access health care services • Provider deserts • Lack of numeracy and lack of health literacy • Cost of care • Economic disparity and other forms of discrimination • Fragmentation of health and social service systems • Having to go to multiple places for care • Provider shortage • Lack of access to technology • Lack of adequate outpatient services (preventative) particularly for those who have Medicaid • Lack of in person assistance • Lack of specialized services • Limitations Title 19-Medicaid • Medical mistrust • Language • Poverty is connected with low access to healthcare • Fear of documentation • Transportation limitations	• Address safe housing and neighborhoods • Access to centers that are closer • Access to interpreters for effective communications • Access to mental health services • Added virtual services • Communication, access, and trust • FQHCs • Coordination and infrastructure with technology and data is needed • Health systems could work together to establish financial structures for medical home models, there needs to be an initial investment. • Extend hours • Put county services at FQHCs • Government and legislative support • Medicare Expansion • Promote wellness and healthy lifestyles • Address social determinants of health- housing, education, poverty

Priority Populations

- Hispanic
- Native Americans/Tribes
- African Americans

Mental Health

Barriers and Challenges	Needed Strategies
• Accessible mental health services • Alcohol and drug programs/mental health all spiked during the pandemic because people were staying home, not going to treatment, not going to AA groups. • Health care cost and insurance • Lack of providers • Bilingual providers and counselors • Stigma • Communication • Patients have delayed care due to pandemic such as cancer screenings • Racism/discrimination • Behavioral health is over diagnosed • Complexity of mental health • Many of the young people don't admit to having mental health issues • Misdiagnoses or not diagnosed • Isolation/disconnection • Inability to handle conflict or know of to de-escalate at situation- this often time leads to violence • Health inequities in health care system • Individuals don't know they are suffering from mental illness • Lack of trust with the health care system • Individuals are not able to meet just basic needs like having food or housing • Intergenerational families and dynamics • Interpersonal and community trauma • Safe and stable housing • Suicide rates among certain populations • Stress of pandemic and current economic environment • Dealing with dementia or schizophrenia	• CART Team deployment. • Access to fresh fruit • trauma-informed care • Engage youth and families to create a culture of kindness • Telemedicine services • Cultural relevance • Civic response team • Addressing delayed trauma for those most at risk due to the pandemic • New crisis center- services need to be reverted into the community rather than away • Addressing community safety and violence • Rethink of services are delivered- telehealth at all levels of care or hybrid approach that is dynamic. Use 24-hour facilities to help deliver care at all hours. • Establishment of early intervention programs through the collaboration of multiple offices to screen and identify people being arrested and providing off-ramps where they could be accountable, addressing mental health needs, drug abuse issues, and connecting them to services in the community. Housing • Social connectedness initiatives • Target African American males to reduce stigma of seeking mental health services • Wrap services around the most vulnerable. Utilizing a "no wrong door" policy, family and supportive systems-level approaches. • Mental health changes for youth development include breathing techniques, building trusted community network has seen higher participation rates with virtual assistance in keeping kids connected. • Need for more social support services • Mobile mental health professionals deployed into situations of violence/mental health crisis • Focus on social determinants of health • Provide more services to the aging population to reduce isolation • Establish safe spaces or environments • Teach coping techniques • Funding

Priority Populations	
• Aging population/elderly • Youth and young adults • Families • Immigrants/refugee families • LGBTQ	• Native populations • African American males • Veterans • Homeless population

Infectious Disease

Barriers and Challenges	Needed Strategies
• Vaccine hesitancy • Politics in the public health realm • COVID has highlighted many types of health disparities • Some of the early challenges of COVID-19 were lack of info, and access to screening and testing. • Health departments themselves are overtasked and under-resourced	• Vaccine mandates • Community based outreach personal and cultural communication efforts • Understanding COVID restrictions (ie. When to mask, when to social distance) • Legislative authority to control communicable diseases and ordinances

Priority Populations
• Younger Native Americans • African Americans

Alcohol & Drugs

Barriers and Challenges	Needed Strategies
• The drug trade itself with high rates of violence is a health issue • Exchanging of drugs within community, • Sex trafficking • Safe driving • People who were going through alcohol and drug treatment could not be admitted for a few months the services were impacted • Had to stop day treatment programs due to COVID • Many do not want to talk about substance abuse • Drug convictions • Not a lot of places for people to get help • Affordable housing, communities paying half of their income to live in unsafe/unhealthy housing areas • Racism and discrimination • Access to childcare and daycare	• With the Alcohol/drug programs, earlier transition to telehealth, participants more savvy with the cell/smart phone & tablets • Involvement with workgroup on opioids and post-fatality review board • Digital literacy • Address underage use, binge drinking, & drinking and driving • Detox center • Milwaukie County is rich in resources

Priority Populations

- 53214-zip code high for overdose

Community Safety

Barriers and Challenges	Needed Strategies
• Community members are scared to step outside of their house • If you aren't safe, you don't sleep well. You don't go out and walk around. You don't have access to healthy food. • Childcare is a huge issue • Access to affordable anything • Neglect • More pressures, more drugs, more alcohol • Concentrated poverty equals concentrated crime, including prostitution (i.e. STI increase) • Urban center density a factor in crime • Reckless driving and young kids stealing cars • People spending all their resources on housing to be safe • People don't feel like they have community – don't know their neighbors • Firearm possession • Internal capacity, underfunded and understaffed relative to similar size cities and levels of violence	• Promote wellness and healthy life • Address social determinants of health • Address all forms of safety- domestic violence, gun violence, elder or child abuse • Geo mapping shows how violence is in proximity to hospitals • Address trauma • Community prevention work is primarily done without law enforcement

Priority Populations

- Abuse with the Elderly
- Black trans women
- Child abuse and neglect
- Domestic violence seen in refugee families
- Victims of human trafficking
- LGBTQ
- Female population
- Veterans

Identified Community Resources	
All area hospitals	Mental Health taskforce
Aurora annual health conference	Milwaukee Behavioral Health
Beyond the Bell	Milwaukee Behavioral Health Crisis Assessment and Response Team (CART)
Boys & Girls Clubs of Greater Milwaukee	Milwaukee Coordinated Entry
Civic action team	Milwaukee County Behavioral Health provider (crisis center, CART Team deployment)
Community Resilience Team/Group	Milwaukee Fatherhood Initiative
Community Resource Network	Milwaukee Health Department
CORE El Centro	Milwaukee Public Libraries
County Housing Division/Housing Navigators	Milwaukee Public Schools (Cristo Ray, Augustin Prep, UCC, whole network of private/charter school network)
Criminal justice system	Milwaukee Urban League
Crisis Center	Partners of Change
Detox Center	Pretty girls are educated
Doula Program	Resource Business Development (Bids)
Dream team united	Rogers Behavioral Health
EMT	Running Rebels
Energy assistance	SaintA (Partnership with Boys & Girls Clubs of Greater Milwaukee, Medical College of Wisconsin, federal SAMHSA grant)
Eviction Prevention Coalition & Landlord Organizations	Sixteenth Street Community Health Center
Fatherhood Fire Program	Social Development Commission adopted food pantries in Glendale
Fathers Making Progress	Sojourner Family Peace Center
Food banks	Sojourner Family Peace Center and Children's Wisconsin
Food network "Feeding American"	Southside Organizing Center
Food stamp program, Free lunch programs	Strong Baby Sanctuaries
FQHCs	The Alma Center
Froedtert & the Medical College of Wisconsin regional health network (partnership between Froedtert Health and the Medical College of Wisconsin)	The Credible Messenger Program
Greater Milwaukee foundation	The Vaccine Integrated Communications, Outreach, and Mobilization (VICOM)
Health Department	True School
Healthcare Partnership	Unitika
Healthy Connection	United Way
Healthy Homes Initiatives	Urban underground
Hispanic Collaborative	Vaccination clinics with temples, Walgreens, South & North side pharmacies
Hunger Taskforce	Veterans Affairs
Impact Connect	Veterans Office
Indian Health Center	Vivent's HIV Medical Home
Islamic Society of Milwaukee (ISM)	VOLAG
Lutheran Social Services of Wisconsin and Upper Michigan,Inc.	We Care Crew/Coalition
Manyu Health System	We Got This
Medical College/APAMSA-Medical Student Group	Workgroup on opioids/post-fatality review board

Appendix F: Key Informant Organizations Interviewed for purposes of conducting the Froedtert Bluemound Rehabilitation Hospital CHNA

Key Informant Organizations	Description of Organizations
Ascension/United Way	United Way, Ascension and other organizations received a BUILD challenge grant for Sherman Park. It focuses on decreasing community violence and strengthening collaborative partnership in the Sherman Park Community.
Badger Philanthropies	Strives to be a philanthropic leader in improving the quality of life of the diverse global communities in which it works.
Black Health Coalition of Wisconsin	A group of local organizations and individuals whose collaborative goal is to address the health problems of African Americans.
Boys & Girls Clubs of Greater Milwaukee	Nonprofit youth serving agency providing academic and recreational programming.
Children's Health Alliance of Wisconsin, Milwaukee County Oral Health Task Force	Coalition to improve oral health and access to care.
City of Milwaukee Health Department	Government agency providing population health support.
City of Milwaukee, Office of the Mayor	Government agency
City of Milwaukee Office of Violence Prevention	Government department to reduce violence.
Community Advocates	Community advocacy agency.
CORE- El Centro	Social service agency providing holistic healing and wellness services.
Disability Rights Wisconsin	A private non-profit organization that protects the rights of people with disabilities statewide.
Diverse & Resilient	Provides services to achieve health equity and improve the safety and well-being of LGBTQ people and communities in Wisconsin.
Feeding America Eastern Wisconsin	Agency that operates food banks across eastern Wisconsin.
Gerald L. Ignace Indian Health Center	Federally qualified health center primarily serving the Native American population.
Greater Milwaukee Foundation	Community philanthropic foundation providing funds to strengthen community organizations and programs.
IMPACT, Inc.	Nonprofit social service agency providing access and navigation to community resources.
Institute for Health and Equity at the Medical College of Wisconsin	The Institute for Health & Equity is focused on researching the root causes of health disparities in our communities, and advancing the best practices to foster health equity throughout the world.
Interfaith	Provides information, assistance, and supportive services to increase the self-sufficiency and well-being of older adults in the community.
Journey House	Family empowerment agency serving diverse populations.
Lutheran Social Services of Wisconsin and Upper Michigan	Nonprofit social service agency to improve the health and wellbeing of our community.
Mental Health America of Wisconsin	Mental health advocacy agency.
Milwaukee Center for Independence (Whole Health Clinical Group)	Service provider and advocacy agency for adults with mental illness.
Milwaukee County Behavioral Health Division	Government department connecting residents with behavioral health services.
Milwaukee County Department of Aging	Provides information, assistance, counseling and supportive services to older adults and caregivers.
Milwaukee County Department of Health and Human Services	Government department that prevents disease and promotes health.
Milwaukee County District Attorney's Office	Governmental department promoting public safety and advocating for violence prevention.
Milwaukee County Office on African American Affairs	Government agency providing services to African American communities.
Milwaukee Fire Department	Emergency response.
Milwaukee Latino Health Coalition	A collaboration of individuals and organizations dedicated to promoting health and wellness, reducing health disparities, eliminating stigma, and striving for social justice through education advocacy, research, and sharing of resources.
Milwaukee Police Department	Emergency response.
Milwaukee Public Schools	Provides public education for Milwaukee youth.
Milwaukee Rescue Mission/Safe Harbor	Faith-based organization.
Milwaukee Urban League	Nonprofit committed to addressing disparities, advancing economic stability and improving educational outcomes.
Muslim Community & Health Center	Strengthens the Milwaukee community and increases the well-being of its residents

	by providing free and charitable health care services, social services, counseling, emergency assistance, educational and job-training programs.
P3 Development Group	Organization that collaborates with clients seeking solutions for DEI, Economic, Leadership and community development initiatives.
Safe & Sound	Nonprofit uniting residents, youth, law enforcement, and community resources to build safe and empowered neighborhoods.
Social Development Commission	Community action agency to address economic disparities.
Sojourner Family Peace Center	Nonprofit providing safety, shelter, advocacy, and support for individuals affected by domestic or sexual violence.
Southeast Asian Educational Development (SEAED) of Wisconsin, Inc.	Nonprofit to advocate for an engage the Asian American community for positive change regarding chronic diseases and cancer health and wellness.
United Community Center	Nonprofit agency providing education, cultural arts, recreation, community development, and health and human services programing to residents of all ages on Milwaukee's near south side.
United Way of Greater Milwaukee and Waukesha County (2 people interviewed)	Engages, convenes, and mobilizes community resources to address root causes of local health and human services.
UniteWI	A coordinated care network of health and social care providers.
Vivent Health	Health care provider for sexually transmitted infections and harm reduction programming.
YWCA Southeast Wisconsin	Nonprofit working to eliminate racism and empower women.
Zablocki VA Medical Center	Provides health care services to Veterans, their families, and caregivers.
Zilber Family Foundation	Philanthropic foundation dedicated to enhancing well-being in Milwaukee.
Zilber School of Public Health	Higher education institute.
Group Interviews/Focus Groups	**Description of Groups**
Safety Net Clinic Focus	Including representatives from Milwaukee's five Federally Qualified Health Centers (FQHCs) and the Free and Community Clinic Collaborative (FC3), a coalition of 25 safety net clinics that provide free and low-cost health care services to uninsured and underinsured patients
Socio-economic Focus	including representatives from community-based organizations serving low-income populations
Public Health Focus	Including representatives from the eleven local health departments serving Milwaukee County municipalities
Youth Focus	including representatives from community-based organizations serving children and adolescents

Appendix G: 2021 Secondary Source Data: Health Compass Milwaukee

Most of the secondary data used for this assessment were collected from Health Compass Milwaukee, a web-based community health platform developed by Conduent Community Health Solutions. Additional state and local data were identified by the CHNA workteam. Two tools were used to analyze the secondary data from the Health Compass Milwaukee data platform: HCI's Data Scoring Tool® and the Index of Disparity.

Health Compass Milwaukee serves as a comprehensive source of health-related data about Milwaukee County residents and communities. This public database was used to compile numerous publicly reported health data and other sources specific to Froedtert Bluemound Rehabilitation Hospital's primary service area. The database was created through collaboration with Advocate Aurora Health, Ascension Wisconsin, Children's Wisconsin, Froedtert & the Medical College of Wisconsin, the Milwaukee Health Care Partnership, and the Center of Urban Population Health. For more information on health indicators specific to Milwaukee County go to www.healthcompassmilwaukee.org.

Publicly available data sources used in Health Compass Milwaukee

- 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)

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

Partners & Contracts: This shared secondary data source is sponsored by the health system members of the Milwaukee Health Care Partnership: Advocate Aurora Health, Ascension Wisconsin, Children's Wisconsin and Froedtert & Medical College of Wisconsin in partnership with Conduent Healthy Communities Institute and the Center for Urban Population Health.

Appendix H: 2021 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 Bluemound Rehabilitation Hospital 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 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 our 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 of Southeastern Wisconsin 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.

Appendix I: Review of the Fiscal Year 2020-2022 Froedtert Hospital CHNA Implementation Strategy

Froedtert Bluemound Rehabilitation Hospital, part of the Froedtert & the Medical College of Wisconsin health network, opened in July 2022. The 2023-2025 Community Health Needs Assessment and Implementation Strategy are the first reports for the Froedtert Bluemound Rehabilitation Hospital. Since this hospital will function as a department of Froedtert Hospital, below is the summary of impact from the previous Froedtert Hospital CHNA Implementation Strategy.

Froedtert Hospital's previous CHNA implementation strategy addressed the following priority health needs: Behavioral Health (mental health & substance use), Chronic Disease and Nutrition & Healthy Food, Violence and Access to Care.

The table below describes the actions taken during the 2020-2022 CHNA to address each priority need and indicators of improvement.

Note: At the time of the report publication in August, the last fiscal year fourth quarter data was not entirely collected. The table reflects results submitted by that time.

Significant Health Need	Program	Actions	Outcomes
Behavioral Health (Mental Health & Substance Use)	Awareness, Education, Navigation and Community Partnerships	• Support FQHCs' integrated primary care/behavioral health model. • Support Milwaukee Health Care Partnership Psych Crisis Re-design for Milwaukee County. • Support the McKinley Health Center and McKinley social worker (MSW). • Engage people with lived experience to reduce stigma and increase awareness of behavioral health. • Increase awareness of telehealth opportunities. • Explore services provided by the criminal justice system. • Partner with Milwaukee County substance abuse and mental health task force(s). • Collaborate with additional community organizations on awareness, education, prevention and navigation.	• Froedtert & Medical College of Wisconsin invested $3.7 million in the National Avenue Clinic through Sixteenth Street Health Center. • Froedtert & Medical College of Wisconsin supported the creation of the Milwaukee Mental Health Emergency Center through MHCP and other community partnerships. • The McKinley Social Worker has served over 2,000 patients. • With work through community coalitions, individuals with lived experience were engaged to reduce stigma and increase awareness. • Made telehealth advancements through the Get Care Now App and Silver Cloud. • With work through community coalitions, services are provided for individuals in the criminal justice system. • Froedtert Health participated in over 100 meetings across the 12 different community behavioral health coalitions. • The health systems involvement with community coalitions, task forces and FQHCs has reached 2,757 individuals through awareness, education, prevention and navigation efforts

Chronic Disease and Nutrition & Healthy Food	Chronic Disease Management (cancer, high blood pressure, diabetes, heart disease)	• Participate in programs that address physical activity/nutrition, such as community run/walks, Harvest of the Month, Farmer's Markets and BUCKSFit. • Implement the Community Care-A-Van in 53206 and 53208. • Promote and monitor the Girl Scouts Health in Action Patch Program (wellness education). • Promote Living Well with Chronic Conditions programs. • Support Cancer Outreach Coordinator located at Progressive Community Health Center. • Explore fruit and vegetable prescription programs. • Explore food pantry models that provide healthier options.	• Over 98,000 individuals were impacted through 95 community events, health fairs and outreach activities. • Through the health systems partnership with the Milwaukee Bucks, over 600 individuals were directly impacted by programs. • Over 10,000 individuals were served by the Care-A-Van nurses who also conducted over 900 chronic disease screenings. • Since the patch programs inception, 672 girls have earned patches. • Living Well with Chronic Conditions was discontinued due to lack of participants and staffing. • 104 health screenings were provided from the Cancer Outreach Coordinator. • The cancer care and outreach team have impacted over 27,000 individuals through events and programs. • Provided 123 free mammography screenings and 139 free prostate cancer screenings. • A Food Rx model is in development to address food insecurity and access to healthier options.
Violence	Violence Interrupter Program/Forensic Nurse Examiner	• Support the Violence Interrupter Program through the efforts of the Comprehensive Injury Center. • Increase awareness of sexual abuse resources offered by Froedtert Hospital. • Collaborate with community partners across sectors to inform programming in the Washington Park (53208) and Silver Spring (53218) neighborhoods to minimize incidences of violent crimes. • Support 414 Life/Blueprint for Peace. • Support MHCP Violence Prevention workgroup efforts.	• Through the Violence Interrupter Program, over 700 individuals have been impacted. • Froedtert Health provided support to 157 individual who were sexually abused through the SANE program. • Froedtert Health participated on a variety of collaborative workgroups and provide outreach in the identified zip codes. Some events/partnerships include the Distracted Driving Awareness Block Party, Violence Free West Allis Coalition, and Health Care Collaborative Against Sex Trafficking. • Froedtert Health continually supports the 414 Life/Blueprint for Peace and the MHCP Violence Prevention workgroup through in-kind and financial supports.
Access to Care	Navigation and	• Implement the Community Care-A-	• Over 10,000 individuals were

	support to community-based providers: Community Care-A-Van, Screening, Education	Van with a focus in 53206 and 53208 zip codes. • Increase access and navigation of resources through Community Health Worker (CHW), other healthcare navigators/coordinators, translation services & Froedtert Health Ambulatory Sites. • Continue to expand opportunities through the school nurse at Westside Academy. • Increase awareness of telehealth opportunities. • Support Specialty Access for Uninsured Program (SAUP) & Emergency Department Medical Home (EDMH) programs and community clinics. • Support the Milwaukee Health Care Partnership Housing Navigator Program for homeless population. • Explore opportunities to increase health literacy by implementing universal screenings during intake process.	served by the Care-A-Van nurses who also conducted over 900 chronic disease screenings. • The United Methodist Children's Services CHW has supported over 800 individuals, provided over 100 referrals and impacted over 1,000 individuals through outreach. • 2,242 students have seen the Westside Academy school nurse for health visits. The nurse provided 232 dental services, administered 572 medications. • Made telehealth advancements through the Get Care Now App, Digital Diabetes Program, Babyscripts and Silver Cloud • 1,104 referrals have been made through the SAUP program and 1,025 appointments were scheduled by Froedtert health for the EDMH program. • 106 individuals have been served through the Housing Navigator Program with 73 placed in short-term housing and 29 in long term housing. • Froedtert Health rolled out a new navigation program called NOWPOW, which screens individuals for social determinants of health and provides a direct referral. Over 24,000 individuals have been screened since inception.