



**Froedtert  
Menomonee Falls Hospital**

**Community Health Needs Assessment (CHNA)  
Report**

---

Froedtert Menomonee Falls Hospital  
(Community Memorial Hospital of Menomonee Falls, Inc.)

Fiscal Year 2019  
Effective July 1, 2018

Approved by Froedtert Menomonee Falls Hospital Board of Directors on 11/24/2020

## **Table of Contents**

<b>Executive Summary</b>	<b>2</b>
<b>Community Health Needs Assessment</b>	<b>3</b>
<b>CHNA Prioritization of Community Health Needs Process</b>	<b>4</b>
<b>CHNA Report/Implementation Strategy Solicitation &amp; Feedback</b>	<b>5</b>
<b>Froedtert Menomonee Falls Hospital Service Area</b>	<b>7</b>
<b>Froedtert Menomonee Falls Hospital Summary of Implementation Strategy</b>	<b>10</b>
<b>Froedtert Menomonee Falls Hospital Community Partnerships</b>	<b>13</b>
<b>Appendix A: Froedtert Menomonee Falls Hospital Community Outreach Steering Committee</b>	<b>14</b>
<b>Appendix B: Waukesha County Community Health Survey Report</b>	<b>15</b>
<b>Appendix C: 2017 Waukesha County Community Health Survey Report</b>	<b>16</b>
<b>Appendix D: 2017 Waukesha County Health Needs Assessment: A Summary of Key Informant Interviews</b>	<b>23</b>
<b>Appendix E: Key Informant Organizations Interviewed for purposing of conducting the Froedtert Menomonee Falls Hospital Community Health Needs Assessment</b>	<b>31</b>
<b>Appendix F: 2017 Waukesha County Health Needs Assessment: A Summary of Secondary Data Sources</b>	<b>33</b>
<b>Appendix G: Evaluation/Accomplishments 2016-2018 Froedtert Menomonee Falls Hospital CHNA Implementation Strategy</b>	<b>34</b>

## Executive Summary

Community Health Needs Assessment for Community Memorial Hospital of Menomonee Falls, Inc, (also known and doing business as Froedtert Menomonee Falls Hospital (“FMFH”).

A community health needs assessment (CHNA) is a tool to gather data and important health information on the communities Froedtert Menomonee Falls 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](http://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 Waukesha County Health Department aligned resources to participate in a shared data collection process. Supported by additional analysis from the Center for Urban Population Health, this robust community-wide CHNA includes findings from a community health survey, key informant interviews and a secondary source data analysis. This shared CHNA serves as the foundation for Froedtert Menomonee Falls Hospital and is the basis for creation of an implementation strategy to improve health outcomes and reduce disparities in the Hospital’s Primary Service Area in Northeast Waukesha County and Germantown in Washington County.

The CHNA was reviewed by the Froedtert Menomonee Falls Hospital Community Outreach Steering Committee (COSC) which is a subcommittee of the hospital’s Board of Directors. The COSC actualizes the mission of Froedtert Menomonee Falls Hospital through community engagement activities that improve the quality of life and enhance wellness resources which meet identified comprehensive health needs of the communities served. The Community Outreach Steering Committee is appointed annually by the hospital president and is advisory to the Froedtert Menomonee Falls Hospital Board and Administration. Membership appointments are made each June with members serving one year terms. The COSC meets quarterly and is composed of hospital and board representatives plus community members representing the various constituencies of the service area.

Following the review of the CHNA, an implementation strategy was developed, targeting evidence-based programs and allocating resources appropriately. Froedtert Menomonee Falls Hospital Community Engagement leadership and staff regularly monitor and report on progress towards the Implementation Strategy objectives and provide quarterly reports to the Hospital’s Board of Directors and health system’s Community Outreach 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.

## Community Health Needs Assessment

In 2017, a CHNA was conducted to 1) determine current community health needs in Waukesha 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 Menomonee Falls Hospital assesses 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 was collected and taken into consideration for assessing and addressing community health needs:

**Community Health Survey:** Using the Center for Disease Control’s Behavioral Risk Factor Surveillance System (BRFSS), a telephone-based survey of 400 residents was conducted by Froedtert Menomonee Falls Hospital in collaboration with the Milwaukee Health Care Partnership. The full report of this survey can be found at <https://www.froedtert.com/community-engagement>.

**Key Informant Interviews:** Froedtert Menomonee Falls Hospital Community Engagement team and leaders conducted 47 in-person interviews 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 E** of this document. The full Key Informant Results can be found at <https://www.froedtert.com/community-engagement>.

**Community Partner/Agency Reports:** To better understand the needs of our underserved populations; Froedtert Menomonee Falls Hospital obtained important data and trends from partner organizations such as Community Outreach Health Clinic, United Way of Greater Milwaukee & Waukesha County ALICE Report, and Impact 211 data specific to Froedtert Menomonee Falls Hospital’s primary service area to seek important trends, demographic data and services to provide an inclusive viewpoint of community needs for these unrepresented populations.

**Secondary Data Reports:** Utilizing multiple county and community-based publicly available reports, information was gathered regarding: Mortality/Morbidity data, Injury Hospitalizations, Emergency Department visits, Waukesha County Health Rankings, Public Safety/Crime Reports and Socio-economic data. A full summary of Secondary Data information can be found at <https://www.froedtert.com/community-engagement>.

**Washington County Service Area:** Froedtert Menomonee Falls Hospital’s primary service area also includes Germantown Wisconsin which is located on the southern border of Washington County. In deciding on CHNA priorities and strategies for this service area, the Community Outreach Steering Committee relied on CHNA data and reports from Washington County and obtained fiscal year to date publicly reported data from Robert Wood Johnson Foundation County Health Rankings, United Way of Washington County ALICE Report, and Impact 211 utilization reports respectively. All these data sources were compiled and reviewed by the COSC.

## CHNA Prioritization of Community Health Needs Process

Froedtert Menomonee Falls Hospital's Community Engagement strategies are guided by the Community Outreach Steering Committee (COSC) ([Appendix A](#)) which is a subcommittee of the hospital's Board of Directors. The COSC actualizes the mission of Froedtert Menomonee Falls Hospital through community engagement activities that improve the quality of life and enhance wellness resources which meet identified comprehensive health needs of the communities served. The Community Outreach Steering Committee is appointed annually by the hospital president and is advisory to the Froedtert Menomonee Falls Hospital Board and Administration. Membership appointments are made each June with members serving one year terms. The COSC meets quarterly and is composed of hospital and board representatives plus community members representing the various constituencies of the total service area. Functions include:

- Provide a leadership role in advocating community wide responses to health care needs in the community
- Facilitate and support community and health care partnerships
- Envision, assess and guide new community benefit opportunities
- Identify and describe unmet health needs
- Promote universal access to health care

Under the direction of the Community Engagement Leadership Team and trained meeting facilitator; the CHNA planning process included five steps in developing the Implementation Plan:

1. Reviewed the 2017 Community Health Needs Assessment results for identification and prioritization of community health needs (Waukesha and Germantown in Washington County)
2. Reviewed Impact 211 Data, Community Outreach Health Clinic Data, United Way ALICE report for Waukesha and Washington Counties
3. Reviewed previous CHNA/Implementation Plan priorities, programs and results
4. Reviewed current hospital and community health improvement initiatives and strategies
5. Ranked and selected priority areas
6. Select evidence-based strategies, partnerships and programs to address community health needs

After the facilitated workout session in March 2018, based on the information from all the CHNA data collection sources, the most significant health needs were identified as:

- Access to Care and Resource Navigation,
- Chronic Disease Management,
- Mental Health Services,
- Nutrition, Obesity and Physical Activity,
- Oral Health,
- Alcohol, Drug, Tobacco Abuse

To identify the top priorities among the significant health needs identified, members of the Community Outreach Steering Committee were asked to rate each priority based on the following criteria: feasibility of Froedtert Menomonee Falls Hospital to address the need (direct programs, clinical strengths and dedicated resources), alignment with Froedtert Health's strategic priorities, current or potential community partners/coalitions and each need has achievable and measurable outcomes. Of those significant health needs categories, four overarching themes were identified as the focus for Froedtert Menomonee Falls Hospital's Implementation Strategy for fiscal 2019 – 2021:

- Access to Health Care Services and Navigation of Community Resources
- Mental Health/Alcohol and Other Drug Abuse
- Chronic Disease Prevention and Management
  - Cancer
  - Nutrition and Physical Activity

An abridged version of the results and evaluation of the impact of actions taken to address the significant health needs identified in Froedtert Menomonee Falls Hospital's prior CHNA can be found in [Appendix](#)

C 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>.

## **CHNA Report/Implementation Strategy Solicitation & Feedback**

Froedtert Menomonee Falls Hospital is committed to addressing community health needs collaboratively with local partners. Froedtert Menomonee Falls Hospital used the following methods to gain community input from June-September 2017 on the significant health needs of the Froedtert Menomonee Falls Hospital’s community. These methods provided additional perspectives on how to select and address top health issues facing Froedtert Menomonee Falls 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 Menomonee Falls Hospital’s community, including Waukesha 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 E**. These local partnering organizations also invited the informants to participate in and conduct the interviews. 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 Waukesha County; and
- For those five public health issues:
  - Existing strategies to address the issue
  - Barriers/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

**Underserved Population Input:** Froedtert Menomonee Falls 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 Menomonee Falls 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 health issues ranked most consistently or most often cited for Waukesha County were:

#### **Key Informant Interviews:**

- Mental Health
- Alcohol and Drug Use
- Chronic Disease
- Access to Health Services
- Nutrition

#### **Community Health Survey:**

- Illegal Drug Use
- Access to Health Services
- Overweight/Obesity
- Chronic Diseases
- Prescription or Over the Counter Drug Abuse

After adoption of the CHNA Report and Implementation Strategy, Froedtert Menomonee Falls Hospital publicly shares both documents with community partners, key informants, hospital board members,

public schools, non-profits, hospital coalition members, the Waukesha County Public Health Division, 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 414-777-1926. Froedtert Menomonee Falls Hospital received no comments or issues with the previous Community Health Needs Assessment Report and/Implementation Strategy.

# Froedtert Menomonee Falls Hospital Community Service Area

## Overview

Froedtert & the Medical College of Wisconsin Community Memorial Hospital of Menomonee Falls (also known and doing business as “Froedtert Menomonee Falls Hospital”), founded in 1964 by the citizens of Menomonee Falls and surrounding communities, is a full-service hospital that specializes in cancer care, heart and vascular care, orthopaedics, women’s health and advanced surgical procedures. Froedtert Menomonee Falls Hospital is part of the Froedtert & MCW health care network, which includes Froedtert Hospital in Milwaukee, eastern Wisconsin's only academic medical center; hospitals in Kenosha, Pleasant Prairie and West Bend; and more than 40 primary and specialty care health centers and clinics.

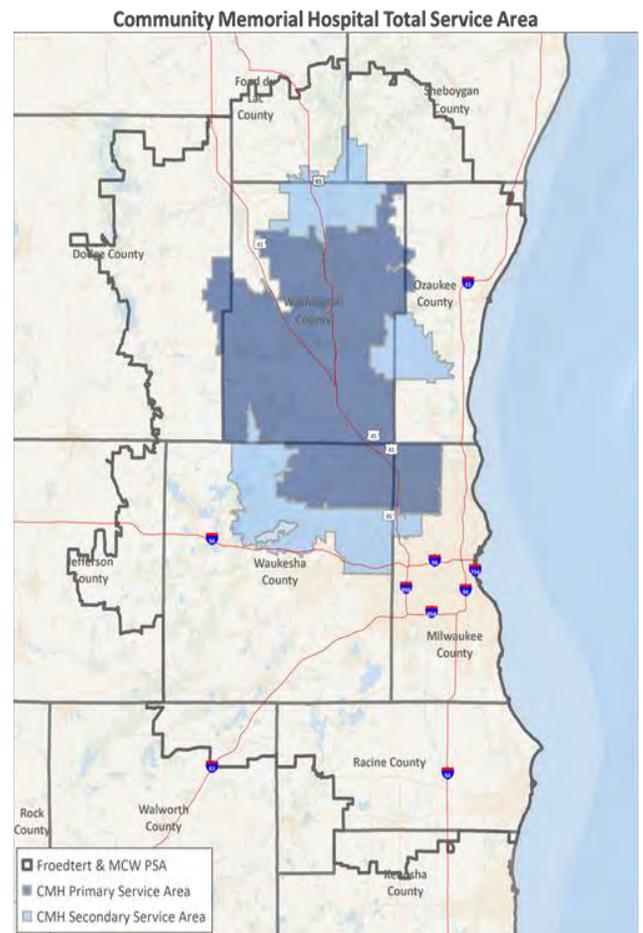
## Mission Statement

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.

## Service Area and Demographics

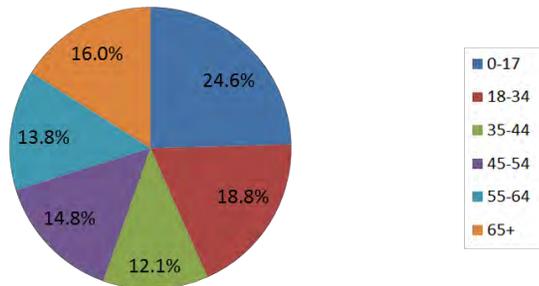
For the purpose of the Community Health Needs Assessment, the community is defined as Northeast Waukesha County and Germantown because we derive 73% of discharges occur from this geography. All programs, activities, and partnerships under the CHNA will be delivered in Waukesha County. However, Froedtert Menomonee Falls Hospital’s total service area consists of Waukesha County as well as zip codes in southern Washington County and western Milwaukee County. Froedtert Menomonee Falls Hospital determines its primary and secondary service areas by completing an annual review and analysis of hospital discharges and market share according to various determinants.

The map reflects the 25 zip codes – 53005 (Brookfield), 53007 (Butler), 53012 (Cedarburg), 53017 (Colgate), 53022 (Germantown), 53027 (Hartford), 53029 (Hartland), 53033 (Hubertus), 53037 (Jackson), 53040 (Kewaskum), 53045 (Brookfield), 53046 (Lannon), 53051 (Menomonee Falls), 53072 (Pewaukee), 53076 (Richfield), 53086 (Slinger), 53089 (Sussex), 53090 (West Bend), 53095 (West Bend), 53122 (Elm Grove), 53218 (Milwaukee), 53222 (Milwaukee), 53223 (Milwaukee), 53224 (Milwaukee), and 53225 (Milwaukee).

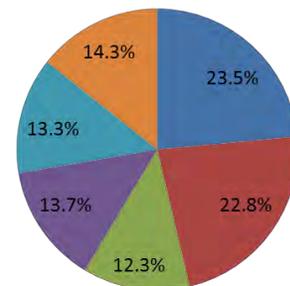


**Age** – The Froedtert Menomonee Falls Hospital Total Service Area has a comparable age distribution as the Milwaukee five-county area. The percentage of 35-44, critical ages when people begin getting routine screenings, is 12.1% in the Froedtert Menomonee Falls Hospital Total Service Area and slightly higher at 12.3% in the five-county area.

**2017 Age Distribution  
Froedtert Menomonee Falls Hospital  
Total Service Area**

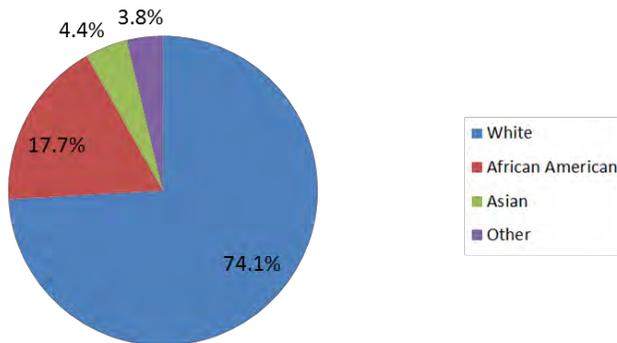


**2017 Age Distribution  
Milwaukee Five-County Area**

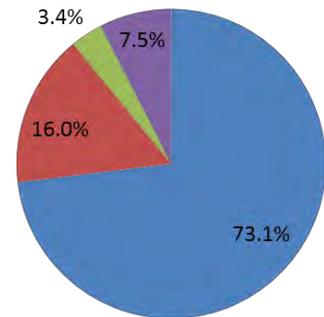


**Race/Ethnicity** – The racial distribution in the Froedtert Menomonee Falls Hospital Total Service Area is predominantly White (74.1%) and African American (17.7%). This is similar to the Milwaukee Five-County Area which is also predominantly White (73.1%) and African American (16.0%).

**2017 Racial Distribution  
Froedtert Menomonee Falls Hospital  
Total Service Area**

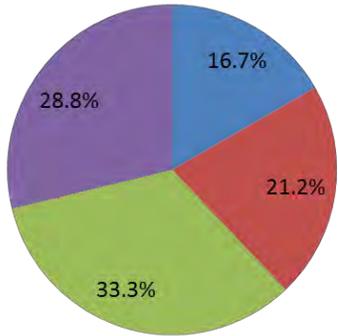


**2017 Racial Distribution  
Milwaukee Five-County Area**

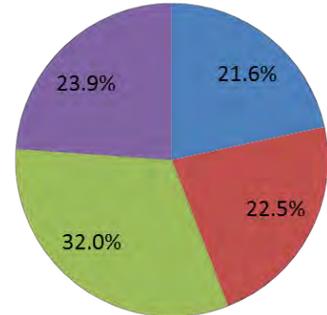


**Household Income** – 37.9% of the Froedtert Menomonee Falls Hospital Total Service Area earns less than \$50,000 annually whereas in the five-county area, 44.1% of the population earns \$50,000 or less.

**2017 Household Income  
Froedtert Menomonee Falls  
Hospital Total Service Area**

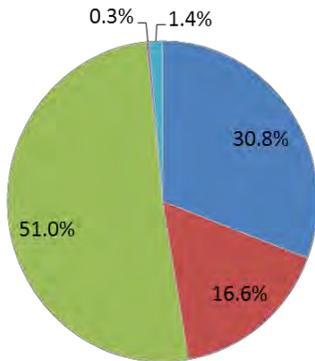


**2017 Household Income  
Milwaukee Five-County Area**

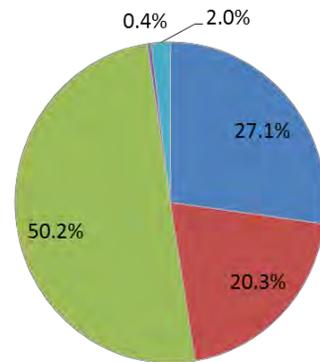


**Payer Mix** – 18.0% of the patients in the Froedtert Menomonee Falls Hospital Total Service Area are Medicaid or Self Pay (uninsured) patients, compared to 22.3% in the five-county area.

**FY 2017 Inpatient Payer Mix  
Froedtert Menomonee Falls  
Hospital Total Service Area**



**FY 2017 Inpatient Payer Mix  
Milwaukee Five-County Area**



## **Froedtert Menomonee Falls Hospital Summary of Implementation Strategy**

Froedtert Menomonee Falls Hospital has completed a separate Implementation Strategy that addresses the hospital's implementation strategy to meet the community health needs identified in this CHNA. The following is a summary of that separate, more comprehensive Implementation Strategy report.

The key programs, strategies and dedicated hospital resources intended to address identified significant community health needs are addressed below. Community Engagement and Froedtert Menomonee Falls Hospital have dedicated full time employees and budgeted funds toward serving the needs of the Froedtert Menomonee Falls Hospital communities. To access a copy of the full Implementation Strategy, please go to <https://www.froedtert.com/community-engagement>.

### **Community Outreach Health Clinic**

**CHNA Area of Focus:** Access to Health Services and Navigation of Community Resources, Chronic Disease Prevention and Management, and Mental Health /AODA

**Goal:** Expand assistance and support of the Community Outreach Health Clinic to improve access to healthcare for uninsured and underinsured populations.

**Objectives:** Continue the support of Community Outreach Health Clinic and community stakeholders to increase access to preventative and primary care, improve quality and reduce costs

#### **Froedtert Menomonee Falls Hospital Available Resources:**

- Continue referral process for uninsured/underinsured populations from FMF to Community Outreach Health Clinic
- Provide ancillary/specialty care services for COHC patients
- Screen uninsured patients for financial assistance programs (Marketplace, BadgerCare etc) including Froedtert Health's Financial Assistance Program
- Provide financial support for clinic operations and functions
- Screen patients for underlying AODA/Mental Health Conditions
- Provide behavioral health coaching and referral to community services

#### **Froedtert Menomonee Falls Hospital Collaborative Partners:**

- Addiction Resource Council
- Waukesha County Community Dental Clinic
- United Way of Greater Milwaukee & Waukesha County

### **CMH Family Medicine Residency Program**

**CHNA Area of Focus:** Access to Health Services and Navigation/Chronic Disease Prevention and Management

#### **Goal:**

- Improve primary care access to Waukesha and Washington County Residents
- Train physicians who will provide advocacy, representation and leadership for the specialty of Family Medicine

#### **Objectives:**

- Expand access to care and healthcare services to vulnerable populations in Waukesha and Washington County
- Develop skills in new physicians around, team development, continuity of care, collaboration, and leadership needed for effective team based care

#### **Froedtert Menomonee Falls Hospital Available Resources:**

- Provide access to care with family practice residents
- Provide paths to improve access to underserved populations in Waukesha and Washington County

#### **Froedtert Menomonee Falls Hospital Collaborative Partners:**

- Medical College of Wisconsin
- Waukesha County Community Dental Clinic
- Community Outreach Health Clinic

**Waukesha County Community Dental Clinic- Menomonee Falls**

**CHNA Area of Focus:** Access to Health Services and Navigations of Community Resources

**Goal:** Improve access to basic and preventative dental care for uninsured and underinsured children and adults residing in Community Memorial Hospital’s service area

**Objectives:** Support WCCDC’s Menomonee Falls Dental Clinic to increase access to preventative and general dentistry and reduce unnecessary emergency room utilization for oral health needs

**Froedtert Menomonee Falls Hospital Available Resources:**

- Education and awareness of dental clinic with community partners and agencies
- Develop referral process with Community Outreach Health Clinic, Emergency Department and Family Medicine Residency Program
- Promote Froedtert Health Classes and Screenings with WCCDC patients – especially those with chronic conditions

**Froedtert Menomonee Falls Hospital Collaborative Partners:**

- Waukesha County Community Dental Clinic
- Community Outreach Health Clinic
- Washington County Head Start Program
- Washington and Waukesha County School Districts
- Menomonee Falls, Sussex and Germantown Food Pantries
- Churches and Faith-based Organizations

**Cancer Care Navigation, Awareness, Prevention, and Screenings**

**CHNA Area of Focus:** Chronic Disease Prevention and Management- Cancer and Nutrition and Physical Activity

**Objective:** Implement programs to increase cancer awareness, screening and early detection at CMH and organizations across the hospital’s service area

**Froedtert Menomonee Falls Hospital Available Resources:**

- Dedicated navigator working with patients receiving care in the FMF Cancer Center and provide assessment and referrals for health system and community resources
- Screen all uninsured patients for financial assistance programs through the Marketplace or government sponsored programs
- Execute a minimum of two community cancer screening programs per year
- Execute quarterly cancer awareness and education events (classes, health fairs, events etc.)

**Froedtert Menomonee Falls Hospital Collaborative Partners:**

- American Cancer Society
- Bobbie Nick Voss Charitable Funds
- Waukesha County Public Health
- Washington County Public Health
- YMCA of Greater Waukesha
- Wisconsin Athletic Club

**Community Health Education and Outreach Programs (Living Well Series, Service Line Outreach and Support Groups)**

**CNHA Area of Focus:** Chronic Disease Prevention and Management and Nutrition and Physical Activity

**Goal:** Reduce morbidity and mortality from chronic conditions

**Objectives:** Increase self-management for individuals living with chronic conditions and reinforce healthy lifestyles to encourage behavior change

**Froedtert Menomonee Falls Hospital Available Resources:**

- Facilitate a minimum of three Living Well with Chronic Conditions/Diabetes programs each year
- Deliver evidence-based health screenings and education programs at FMF and in the community at community partner locations and strategic access points
- Explore opportunities for enhancing and expanding clinical support groups and community health education programs in community based settings

**Froedtert Menomonee Falls Hospital Collaborative Partners:**

- Wisconsin Institute for Healthy Aging
- Waukesha County Aging and Disability Resource Center
- Eras Senior Programs Waukesha County
- Menomonee Falls, Sussex and Germantown Food Pantries
- Area Community Education and Recreation Departments
- Silver Spring Neighborhood Center

**Mental Health/AODA**

**CNHA Area of Focus: Mental Health/Alcohol and Other Drug Abuse**

**Goal:** To provide knowledge our community needs and the access necessary for early intervention and continued treatment of mental illness and/or substance abuse

**Objectives:** Increase community awareness of mental health and alcohol and other drug abuse problems and collaborate for better case management and navigation of treatment

**Froedtert Menomonee Falls Hospital Available Resources:**

- Actively participate in Waukesha and Washington County steering committees and project teams
- In-kind support of Froedtert Health leaders, staff and physicians with knowledge and expertise in behavioral health
- Provide support groups and programs for individuals/family members impacted by mental illness and AODA issues
- Provide behavioral health and AODA screenings in the Community Outreach Health Clinic and connect patients and family members with community resources

**Froedtert Menomonee Falls Hospital Collaborative Partners:**

- Waukesha County Health and Human Services and Public Health Departments – Lead Agencies
- NAMI (Washington and Waukesha Counties)
- Addiction Resource Council (Waukesha County)
- Germantown School District
- Menomonee Falls Police Department
- School District of Menomonee Falls

## **Froedtert Menomonee Falls Hospital Community Partnerships**

The health needs in the Froedtert Menomonee Falls Hospital community cannot be addressed by one organization alone. In addition to its own actions to address the significant health needs of the community, Froedtert Menomonee Falls Hospital is committed to partnering with organizations and agencies to effectively leverage limited resources, address unmet community health needs and improve the overall health of the community.

Community partners dedicated to achieving the desired outcomes addressed in this CHNA are:

- Waukesha County Health and Human Services and Public Health Departments – Access to Care & Resource Navigation, Chronic Disease Management, Mental Health Services / Alcohol & Other Drug Abuse
- NAMI (Washington and Waukesha Counties) – Mental Health Services / Alcohol & Other Drug Abuse
- Addiction Resource Council (Waukesha County) Mental Health Services / Alcohol & Other Drug Abuse
- Germantown School District – Alcohol and Other Drug Abuse
- Germantown Youth Futures – Alcohol and Other Drug Abuse
- Elevate Inc.- Mental Health Services / Alcohol & Other Drug Abuse
- Menomonee Falls Police Department – Mental Health Services / Alcohol & Other Drug Abuse
- School District of Menomonee Falls – Mental Health Services / Alcohol and Other Drug Abuse,
- Wisconsin Institute for Healthy Aging – Chronic Disease Management
- Waukesha County Aging and Disability Resource Center – Chronic Disease Management, Mental Health Services / Alcohol & Other Drug Abuse, Access to Care & Resource Navigation
- Eras Senior Programs Waukesha County – Access to Care & Resource Navigation
- Menomonee Falls, Sussex and Germantown Food Pantries – Access to Care & Resource Navigation, Chronic Disease Management, Mental Health Services / Alcohol and Other Drug Abuse
- Area Community Education and Recreation Departments – Chronic Disease Management
- American Cancer Society – Chronic Disease Management
- Bobbie Nick Voss Charitable Funds – Access to Care & Resource Navigation, Chronic Disease Management
- Waukesha County Public Health - Access to Care & Resource Navigation, Chronic Disease Management, Mental Health Services / Alcohol & Other Drug Abuse
- Washington County Public Health - Access to Care & Resource Navigation, Chronic Disease Management, Mental Health Services / Alcohol & Other Drug Abuse
- YMCA of Greater Waukesha – Chronic Disease Management
- Wisconsin Athletic Club – Chronic Disease Management
- Waukesha County Community Dental Clinic – Access to Care & Resource Navigation
- Community Outreach Health Clinic – Access to Care & Resource Navigation, Chronic Disease Management, Mental Health Services / Alcohol & Other Drug Abuse
- Washington County Head Start Program – Access to Care & Resource Navigation
- Washington and Waukesha County School Districts – Alcohol & Other Drug Abuse
- Churches and Faith-based Organizations – Chronic Disease Management
- United Way of Greater Milwaukee & Waukesha County – Access to Care & Resource Navigation, Chronic Disease Management, Mental Health Services / Alcohol & Other Drug Abuse

## Appendix A: Froedtert Menomonee Falls Hospital Community Outreach Steering Committee

<b>Name</b>	<b>Title</b>	<b>Organization</b>
Ron Bertieri	Community Member	Menomonee Falls Resident
Mike Bloedorn	Community Member/Community Coalition Volunteer	Menomonee Falls Resident
Carrie Booher	FMF Board Member	Menomonee Falls Resident
Andy Dresang	Director Community Engagement	Froedtert Health
Diane Ehn	Vice President Post-Acute Care	Froedtert Health
Kerry Freiberg	VP Community Engagement	Froedtert Health
David Goldberg MD.	Vice President/Chief Medical Officer	Froedtert Menomonee Falls Hospital
Kathy Klein	FMF Board Member	Washington County Resident
Rebecca Luczaj	Waukesha County Justice Services Coordinator	Waukesha County Human Services
Teri Lux	President Froedtert Menomonee Falls Hospital	Froedtert Menomonee Falls Hospital
Deb McCann	Executive Director of Patient Care Services	Froedtert Menomonee Falls Hospital
Meredith Musaus	Pastor	Holy Cross Lutheran Church
Eric Nelson	Board Chairman, Ex Officio	Fiserv, Inc Menomonee Falls Resident
Randy Newman	Vice President Finance	Froedtert Community Physicians
Renee Ramirez	President/CEO	Waukesha County Community Dental Clinic
Anna Ruzinski	Menomonee Falls Police Chief/COSC Chair/Board Member	Village of Menomonee Falls
Kathleen Sitzberger	Community Member	Germantown Business Owner
Mike Snow	Germantown Police Chief	Germantown Police Department
Laura Westcott	Associate Principal	Hamilton School District
Kathy Young	Director Pupil Services	School District Menomonee Falls

## Appendix B: Waukesha County Community Health Survey Report

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 C**). 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 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 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=300). 2) A cell phone-only sample where the person answering the phone was selected as the respondent (n=100). At least 8 attempts were made to contact a respondent in both samples. Screener questions verifying location were included. A total of 400 telephone interviews were completed between June 5 and July 9, 2017.

With a sample size of 400, we can be 95% sure that the sample percentage reported would not vary by more than  $\pm 5$  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  $\pm 5$  percent, since fewer respondents are in that category (e.g., adults 65 years old or older who were asked if they ever received a pneumonia vaccination).

In 2015, the Census Bureau estimated 308,778 adult residents in the county. Thus, in this report, one percentage point equals approximately 3,090 adults. So, when 15% of respondents reported their health was fair or poor, this roughly equals 46,350 residents  $\pm 15,450$  individuals. Therefore, from 30,900 to 61,800 residents likely have fair or poor health. Because the margin of error is  $\pm 5\%$ , events or health risks that are small will include zero.

In 2015, the Census Bureau estimated 157,143 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 2015 household estimate, each percentage point for household-level data represents approximately 1,570 households.

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



Women's Health						Alcohol Use in Past Month						
Waukesha County	2006	2009	2012	2015	2017	Waukesha County	2006	2009	2012	2015	2017	
Mammogram (50+: within past 2 years)	89%	76%	77%	78%	73%	Binge Drinker	16%	27%	22%	29%	26%	
Bone Density Scan (65 and older)	68%	76%	86%	86%	86%	Driver/Passenger When Driver						
Cervical Cancer Screening						Perhaps Had Too Much to Drink	2%	2%	3%	<1%	2%	
Pap Smear (18 – 65; within past 3 years)	94%	89%	83%	82%	80%							
HPV Test (18 – 65; within past 5 years)				55%	47%	Other Research: (2016)				WI	U.S.	
Screening in Recommended Time Frame						Binge Drinker				25%	17%	
(18-29: Pap every 3 years; 30 to 65: Pap and HPV every 5 years or Pap only every 3 years)				88%	84%	Other Drug Use Within Past 12 Months						
Other Research: (2016)				WI	U.S.	Waukesha County					2017	
Mammogram (50 - 74; within past 2 years)				80%	78%	Misuse of Prescription Pain Relievers					<1%	
Pap Smear (21- 65; within past 3 years)				84%	80%	Heroin					0%	
						Cocaine or Other Street Drugs					<1%	
Tobacco Cigarette Use						Household Problems Associated With...						
Waukesha County	2006	2009	2012	2015	2017	Waukesha County	2006	2009	2012	2015	2017	
Current Smokers (past 30 days)	16%	17%	17%	13%	14%	Alcohol	2%	3%	3%	6%	1%	
Of Current Smokers...						Misuse of Prescription or OTC Drugs			1%	1%	1%	
Quit Smoking 1 Day or More in Past Year Because Trying to Quit	32%	58%	45%	55%	67%	Cocaine, Heroin or Other Street Drugs			2%	<1%	2%	
Saw a Health Care Professional in Past Year and Advised to Quit Smoking	64%	72%	69%	67%	76%	Marijuana			1%	2%	1%	
Other Research: (2016)				WI	U.S.	Times of Distress in Past Three Years					2017	
Current Smokers				17%	17%	Waukesha County						
						Time of Distress and Someone in HH Looked for Community Support					18%	
						Of Respondents Who Looked for Support						
						Felt Somewhat/Slightly or Not At All Supported					43%	
Exposure to Smoke						Mental Health Status						
Waukesha County	2009	2012	2015	2017		Waukesha County	2006	2009	2012	2015	2017	
Smoking Policy at Home						Felt Sad, Blue or Depressed						
Not allowed anywhere	85%	82%	86%	88%		Always/Nearly Always (past 30 days)	3%	5%	5%	4%	3%	
Allowed in some places/at some times	7%	8%	6%	3%		Find Meaning & Purpose in Daily Life						
Allowed anywhere	2%	2%	<1%	<1%		Seldom/Never	5%	3%	4%	4%	4%	
No rules inside home	6%	7%	8%	9%		Considered Suicide (past year)	3%	4%	2%	4%	4%	
Nonsmokers Exposed to Second-Hand Smoke in Past Seven Days	26%	10%	8%	7%								
Other Tobacco Products in Past Month						Children in Household						
Waukesha County			2015	2017		Waukesha County			2012	2015	2017	
Smokeless Tobacco			2%	4%		Personal Health Doctor/Nurse Who Knows Child Well and Familiar with History			86%	89%	97%	
Cigars, Cigarillos or Little Cigars			3%	4%		Visited Personal Doctor/Nurse for Preventive Care (past 12 months)			93%	95%	89%	
Electronic Cigarettes			4%	4%		Did Not Receive Care Needed (past 12 months)						
Other Research: (2016)			WI	U.S.		Medical Care			3%	4%	2%	
Electronic Cigarettes			5%	5%		Dental Care			3%	6%	2%	
Smokeless Tobacco			4%	4%		Specialist			3%	1%	<1%	
Top County Health Issues						Current Asthma						
Waukesha County				2017		Waukesha County				3%	7%	3%
Illegal Drug Use				41%		Safe in Community/Neighborhood (seldom/never)			1%	0%	<1%	
Access to Health Care				21%		Children 5 to 17 Years Old						
Overweight or Obesity				18%		Fruit Intake (2+ servings/day)			75%	86%	67%	
Chronic Diseases				17%		Vegetable Intake (3+ servings/day)			30%	26%	27%	
Prescription or OTC Drug Abuse				17%		5+ Fruit/Vegetables per Day			36%	48%	47%	
Alcohol Use or Abuse				15%		Physical Activity (60 min./5 or more days/week)			70%	57%	60%	
Cancer				11%		Children 8 to 17 Years Old						
Mental Health or Depression				10%		Unhappy, Sad or Depressed in Past 6 Months						
						Always/Nearly Always			4%	0%	1%	
						Experienced Some Form of Bullying (past 12 months)			18%	14%	14%	
						Verbally Bullied			18%	14%	14%	
Personal Safety in Past Year						Physically Bullied						
Waukesha County	2006	2009	2012	2015	2017	Waukesha County				5%	2%	4%
Afraid for Their Safety	5%	5%	4%	4%	4%	Cyber Bullied			3%	4%		
Pushed, Kicked, Slapped, or Hit	2%	4%	1%	3%	5%						1%	
At Least One of the Safety Issues	6%	8%	4%	5%	7%							

### Overall Health and Health Care Key Findings

In 2017, 60% of respondents reported their health as excellent or very good; 15% reported fair or poor. Respondents who were male, 55 to 64 years old, with a high school education or less or inactive respondents were more likely to report fair or poor health. *From 2006 to 2017, there was a statistical increase in the overall percent of respondents who reported their health as fair or poor, as well as from 2015 to 2017.*

In 2017, 2% of respondents reported they were not currently covered by health care insurance. Three percent of respondents reported they personally did not have health care coverage at least part of the time in the past 12 months. Seven percent of respondents reported someone in their household was not covered at least part of the time in the past 12 months; respondents who were in the bottom 40 percent household income bracket or unmarried were more likely to report this. *From 2006 to 2017, the overall percent statistically remained the same for respondents 18 and older or 18 to 64 years old who reported no current personal health care coverage, as well as from 2015 to 2017. From 2009 to 2017, the overall percent statistically decreased for respondents who reported no personal health insurance at least part of the time in the past 12 months, as well as from 2015 to 2017. From 2006 to 2017, the overall percent statistically decreased for respondents who reported someone in the household was not covered at least part of the time in the past 12 months while from 2015 to 2017, there was no statistical change.*

In 2017, 17% 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 12 months; respondents 35 to 44 years old, with a college education or married respondents were more likely to report this. Eleven percent of respondents reported that someone in their household had not taken their prescribed medication due to prescription costs in the past 12 months. Twelve percent of respondents reported there was a time in the past 12 months they did not receive the medical care needed; respondents 35 to 44 years old or 55 to 64 years old were more likely to report this. Seven percent of respondents reported there was a time in the past 12 months they did not receive the dental care needed; respondents 55 to 64 years old or in the bottom 40 percent household income bracket were more likely to report this. Three percent of respondents reported there was a time in the past 12 months they did not receive the mental health care needed. *From 2015 to 2017, the overall percent statistically remained the same for respondents who reported they delayed or did not seek medical care due to cost. From 2012 to 2017, the overall percent statistically remained the same for respondents who reported someone in their household had not taken their prescribed medication due to prescription costs, as well as from 2015 to 2017. From 2012 to 2017, the overall percent statistically increased for respondents who reported they did not receive the medical care needed or they did not receive the mental health care needed while from 2015 to 2017, the overall percent statistically remained the same. From 2012 to 2017, the overall percent statistically remained the same for respondents who reported unmet dental care while from 2015 to 2017, the overall percent statistically decreased.*

In 2017, 49% of respondents reported they contact a doctor when they need health information or clarification while 30% reported they go to the Internet. Thirteen percent reported themselves or a family member is in the health care field and their source of information. Respondents with a high school education or less or in the bottom 40 percent household income bracket were more likely to report they contact a doctor. Respondents who were 45 to 54 years old, in the top 40 percent household income bracket or married were more likely to report the Internet as their source for health information/clarification. Respondents who were female, 35 to 44 years old, with a college education or in the middle 20 percent household income bracket were more likely to report themselves or a family member in the health care field and their source for health information. Eighty-six percent of respondents reported they have a primary care physician they regularly see for check-ups and when they are sick; respondents who were female, 35 to 44 years old, 65 and older, with a high school education or less, in the bottom 40 percent household income bracket or in the top 40 percent household income bracket were more likely to report a primary care physician. Sixty-eight percent of respondents reported their primary place for health services when they are sick was from a doctor's or nurse practitioner's office while 21% reported urgent care center. Respondents who were female, 65 and older or with a high school education or less 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 or with some post high school education were more likely to report urgent care as their primary health care. Forty-six percent of respondents had an advance care plan; respondents 65 and older, with a college education or married respondents were more likely to report an advance care plan. *From 2012 to 2017, there was a statistical increase in the overall percent of respondents reporting a doctor as their source of health information while from 2015 to 2017, there was no statistical change. From 2012 to 2017, there was no statistical change in the overall percent of respondents reporting the Internet as their source of health information, as well as from 2015 to 2017. From 2012 to 2017, there was no statistical change in the overall percent of respondents reporting they were, or a family member was in the health care field and their source of health information while from 2015 to 2017, there was a statistical increase. From 2006 to 2017, there was a statistical decrease in the overall percent of respondents reporting their primary place for health services when they are sick was a doctor's or nurse practitioner's office, as well as from 2015 to 2017. From 2006 to 2017, there was a statistical increase in the overall percent of respondents reporting their primary place for health services when they are sick was an urgent care center, as well as from 2015 to 2017. From 2006 to 2017, there was no statistical change in the overall percent of respondents having an advance care plan, as well as from 2015 to 2017.*

In 2017, 86% of respondents reported a routine medical checkup two years ago or less while 84% reported a cholesterol test four years ago or less. Eighty-two percent of respondents reported a visit to the dentist in the past year while 53% reported an eye exam in the past year. Respondents 35 and older, with a high school education or less, with a college education, in the bottom 40 percent household income bracket or married respondents were more likely to report a routine checkup two years ago or less. Respondents 45 to 64 years old, with a college education or married respondents were more likely to report a cholesterol test four years ago or less. Respondents with a college education or in the middle 20 percent household income bracket were more likely to report a dental checkup in the past year. Respondents who were female, 65 and older, in the bottom 40 percent household income bracket or unmarried were more likely to report an eye exam in the past year. *From 2006 to 2017, there was no statistical change in the overall percent of respondents reporting a routine checkup, a cholesterol test or an eye exam, as well as from 2015 to 2017. From 2006 to 2017, there was no statistical change in the overall percent of respondents reporting a dental checkup while from 2015 to 2017, there was a statistical increase.*

In 2017, 60% of respondents had a flu vaccination in the past year. Respondents 65 and older, with a high school education or less or with a college education were more likely to report a flu vaccination. Seventy-nine percent of respondents 65 and older had a pneumonia vaccination in their lifetime. *From 2006 to 2017, there was a statistical increase in the overall percent of respondents 18 and older who reported a flu vaccination in the past 12 months, as well as from 2015 to 2017. From 2006 to 2017, there was no statistical change in the overall percent of respondents 65 and older who reported a flu vaccination or pneumonia vaccination, as well as from 2015 to 2017.*

#### **Health Risk Factors Key Findings**

In 2017, out of six health conditions listed, the most often mentioned in the past three years was high blood pressure (31%) or high blood cholesterol (26%). Respondents 55 and older, with a high school education or less, in the bottom 40 percent household income bracket, who were overweight or smokers were more likely to report high blood pressure. Respondents who were 65 and older, in the bottom 40 percent household income bracket, overweight or inactive were more likely to report high blood cholesterol. Eighteen percent reported a mental health condition; respondents with a high school education or less or unmarried respondents were more likely to report this. Twelve percent reported they were treated for, or told they had heart disease/condition in the past three years; respondents who were 65 and older or inactive were more likely to report this. Twelve percent of respondents reported diabetes. Respondents with a high school education or less, in the bottom 40 percent household income bracket, who were unmarried, overweight or smokers were more likely to report diabetes. Eleven percent reported current asthma; female respondents were more likely to report this. *From 2006 to 2017, there was no statistical change in the overall percent of respondents who reported high blood pressure, high blood cholesterol or current asthma, as well as from 2015 to 2017. From 2006 to 2017, there was a statistical increase in the overall percent of respondents who reported heart disease/condition, as well as from 2015 to 2017. From 2006 to 2017, there was a noted increase in the overall percent of respondents who reported diabetes while from 2015 to 2017, there was no statistical change. From 2009 to 2017, there was no statistical change in the overall percent of respondents who reported a mental health condition while from 2015 to 2017, there was a statistical increase.*

In 2017, 3% of respondents reported they always or nearly always felt sad, blue or depressed in the past 30 days. Four percent of respondents felt so overwhelmed they considered suicide in the past year; respondents who were female, 18 to 34 years old, with some post high school education or unmarried respondents were more likely to report this. Four percent of respondents reported they seldom or never find meaning and purpose in daily life; respondents who were male or unmarried were more likely to report this. *From 2006 to 2017, there was no statistical change in the overall percent of respondents who reported they always or nearly always felt sad/blue/ depressed, they considered suicide or they seldom or never find meaning and purpose in daily life, as well as from 2015 to 2017.*

#### **Behavioral Risk Factors Key Findings**

In 2017, 44% of respondents did moderate physical activity five times a week for 30 minutes. Thirty-seven percent of respondents did vigorous activity three times a week for 20 minutes. Combined, 56% met the recommended amount of physical activity; respondents 18 to 34 years old, with a high school education or less or unmarried respondents were more likely to report this. *From 2006 to 2017, there was a statistical increase in the overall percent of respondents who reported moderate physical activity five times a week for at least 30 minutes or who met the recommended amount of physical activity, as well as from 2015 to 2017. From 2006 to 2017, 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 2015 to 2017, there was no statistical change.*

In 2017, 69% of respondents were classified as at least overweight while 30% were obese. Respondents who were male, with a college education, in the bottom 40 percent household income bracket or married were more likely to be classified as at least overweight. Respondents with a high school education or less, in the bottom 40 percent household income bracket or married

respondents were more likely to be obese. From 2006 to 2017, there was a statistical increase in the overall percent of respondents being at least overweight or being obese while from 2015 to 2017, there was no statistical change.

In 2017, 67% of respondents reported two or more servings of fruit while 39% reported three or more servings of vegetables on an average day. Respondents who were female, 55 to 64 years old, with a college education, in the top 40 percent household income bracket or married respondents were more likely to report at least two servings of fruit. Respondents who were female, 35 to 44 years old, with a college education, in the top 40 percent household income bracket or who met the recommended amount of physical activity were more likely to report at least three servings of vegetables on an average day. Forty-five percent of respondents reported five or more servings of fruit/vegetables on an average day; respondents who were female, 35 to 44 years old, with a college education, in the top 40 percent household income bracket or who did the recommended amount of physical activity were more likely to report this. Four percent of respondents reported their household went hungry because they couldn't afford enough food in the past 12 months; respondents who were in the bottom 40 percent household income bracket, unmarried or in households with children were more likely to report this. From 2006 to 2017, there was no statistical change in the overall percent of respondents who reported at least two servings of fruit, as well as from 2015 to 2017. From 2006 to 2017, there was a statistical increase in the overall percent of respondents who reported at least three servings of vegetables, as well as from 2015 to 2017. From 2006 to 2017, there was no statistical change in the overall percent of respondents who reported at least five servings of fruit/vegetables while from 2015 to 2017, there was a statistical increase.

In 2017, 73% of female respondents 50 and older reported a mammogram within the past two years. Eighty-six percent of female respondents 65 and older had a bone density scan. Eighty percent of female respondents 18 to 65 years old reported a pap smear within the past three years. Forty-seven percent of respondents 18 to 65 years old reported an HPV test within the past five years. Eighty-four 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 or married respondents were more likely to meet the cervical cancer recommendation. From 2006 to 2017, there was a statistical decrease in the overall percent of respondents 50 and older who reported having a mammogram within the past two years or respondents 18 to 65 years old who reported having a pap smear within the past three years while from 2015 to 2017, there was no statistical change. From 2006 to 2017, there was a statistical increase in the overall percent of respondents 65 and older who reported a bone density scan while from 2015 to 2017, there was no statistical change. From 2015 to 2017, there was no statistical change in the overall percent of respondents 18 to 65 years old reporting an HPV test within the past five years or reporting they had a cervical cancer screen within the recommended time frame.

In 2017, 9% of respondents 50 and older reported a blood stool test within the past year. Seven percent of respondents 50 and older reported a sigmoidoscopy within the past five years while 80% reported a colonoscopy within the past ten years. This results in 83% of respondents meeting the current colorectal cancer screening recommendations; male respondents were more likely to meet the recommendation. From 2006 to 2017, there was a statistical decrease in the overall percent of respondents who reported a blood stool test within the past year while from 2015 to 2017, there was no statistical change. From 2009 to 2017, there was no statistical change in the overall percent of respondents who reported a sigmoidoscopy in the past five years, as well as from 2015 to 2017. From 2009 to 2017, there was a statistical increase in the overall percent of respondents who reported a colonoscopy within the past ten years, as well as from 2015 to 2017. From 2009 to 2017, there was a statistical increase in the overall percent of respondents who reported at least one of these tests in the recommended time frame, as well as from 2015 to 2017.

In 2017, 14% of respondents were current tobacco cigarette smokers; respondents who were female, 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 be a smoker. In the past 12 months, 67% of current smokers quit smoking for one day or longer because they were trying to quit. Seventy-six percent of current smokers who saw a health professional in the past year reported the professional advised them to quit smoking. From 2006 to 2017, there was no statistical change in the overall percent of respondents who were current tobacco cigarette smokers, as well as from 2015 to 2017. From 2006 to 2017, there was a statistical increase in the overall percent of current tobacco cigarette smokers who quit smoking for at least one day because they were trying to quit while from 2015 to 2017, there was no statistical change. From 2006 to 2017, there was no statistical change in the overall percent of current smokers who reported their health professional advised them to quit smoking, as well as from 2015 to 2017.

In 2017, 88% of respondents reported smoking is not allowed anywhere inside the home. Respondents who were in the top 40 percent household income bracket, married or nonsmokers were more likely to report smoking is not allowed anywhere inside the home. Seven percent of nonsmoking respondents reported they were exposed to second-hand smoke in the past seven days; respondents with a high school education or less or unmarried respondents were more likely to report this. From 2009 to 2017, 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 2015 to 2017. From 2009 to 2017, there was a statistical decrease in the overall percent of respondents

*who reported they were exposed to second-hand smoke in the past seven days while from 2015 to 2017, there was no statistical change.*

*In 2017, 4% of respondents used smokeless tobacco in the past month; respondents 18 to 34 years old or with some post high school education were more likely to use smokeless tobacco. Four percent of respondents used cigars, cigarillos or little cigars in the past 30 days. Four percent of respondents used electronic cigarettes in the past month; respondents with some post high school education or unmarried respondents were more likely to report this. From 2015 to 2017, there was no statistical change in the overall percent of respondents who reported in the past month they used smokeless tobacco, cigars/cigarillos/little cigars or electronic cigarettes.*

*In 2017, 26% of respondents were binge drinkers in the past month. Respondents who were male, 18 to 34 years old, with some post high school education or in the middle 20 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 a passenger when the driver perhaps had too much to drink in the past month. From 2006 to 2017, there was a statistical increase in the overall percent of respondents who reported binge drinking in the past month while from 2015 to 2017, there was no statistical change. From 2006 to 2017, there was no statistical change in the overall percent of respondents who reported they were a driver or passenger in a vehicle when the driver perhaps had too much to drink in the past month, as well as from 2015 to 2017.*

*In 2017, less than one percent of respondents reported within the past 12 months they used prescription pain relievers for nonmedical reasons while another less than one percent reported more than 12 months ago. Zero percent of respondents reported within the past 12 months they used heroin within the past 12 months while 2% reported more than 12 months ago. Less than one percent reported they used cocaine or other street drugs within the past 12 months while 6% reported more than 12 months ago.*

*In 2017, 1% of respondents reported someone in their household experienced a problem, such as legal, social, personal or physical in connection with drinking alcohol in the past year. Two percent of respondents reported someone in their household experienced a problem with cocaine, heroin or other street drugs. One percent of respondents each reported a household problem in connection with marijuana or with the misuse of prescription drugs/over-the-counter drugs. From 2006 to 2017, there was no statistical change in the overall percent of respondents reporting a household problem in connection with drinking alcohol while from 2015 to 2017, there was a statistical decrease. From 2012 to 2017, there was no statistical change in the overall percent of respondents reporting a household problem with cocaine/heroin/other street drugs while from 2015 to 2017, there was a statistical increase. From 2012 to 2017, there was no statistical change in the overall percent of respondents reporting a household problem with marijuana or with the misuse of prescription drugs/over-the-counter drugs, as well as from 2015 to 2017.*

*In 2017, 18% of respondents reported someone in their household experienced times of distress in the past three years and looked for community support. Of respondents who looked for community support, 39% reported mental health issues as their reason for household distress, 30% reported economic hardship and 26% reported personal medical issues. Respondents in the top 40 percent household income bracket were more likely to report mental health issues as their reason for distress. Respondents in the bottom 60 percent household income bracket were more likely to report economic hardship or personal medical issues. Forty-three percent of respondents who looked for community resource support reported they felt somewhat, slightly or not at all supported; married respondents were more likely to report this.*

*In 2017, 4% of respondents reported someone made them afraid for their personal safety in the past year; respondents with a college education were more likely to report this. Five percent of respondents reported they had been pushed, kicked, slapped or hit in the past year; respondents 45 to 54 years old or with a college education were more likely to report this. A total of 7% reported at least one of these two situations; respondents 35 to 54 years old or with a college education were more likely to report this. From 2006 to 2017, there was no statistical change in the overall percent of respondents reporting they were afraid for their personal safety, as well as from 2015 to 2017. From 2006 to 2017, there was a statistical increase in the overall percent of respondents reporting they were pushed, kicked, slapped or hit while from 2015 to 2017, there was no statistical change. From 2006 to 2017, there was no statistical change in the overall percent of respondents reporting at least one of the two personal safety issues, as well as from 2015 to 2017.*

### Children in Household Key Findings

In 2017, a random child was selected for the respondent to talk about the child's health and behavior. Ninety-seven percent of respondents reported they have one or more persons they think of as their child's personal doctor or nurse, with 89% reporting their child visited their personal doctor or nurse for preventive care during the past 12 months. Two percent of respondents each reported there was a time in the past 12 months their child did not receive the medical care needed or dental care needed while less than one percent reported their child was not able to visit a specialist they needed to see. Three percent of respondents reported their child currently had asthma. Less than one percent of respondents reported their child was seldom or never safe in their community. Sixty-seven percent of respondents reported their 5 to 17 year old child ate at least two servings of fruit on an average day while 27% reported three or more servings of vegetables. Forty-seven percent of respondents reported their child ate five or more servings of fruit/vegetables on an average day. Sixty percent of respondents reported their 5 to 17 year old child was physically active five times a week for 60 minutes. One percent of respondents reported their 8 to 17 year old child always or nearly always felt unhappy, sad or depressed in the past six months. Fourteen percent reported their 8 to 17 year old child experienced some form of bullying in the past year; 14% reported verbal bullying, 4% physical bullying and 1% reported cyber bullying. *From 2012 to 2017, there was a statistical increase in the overall percent of respondents reporting their child has a personal doctor or nurse, as well as from 2015 to 2017. From 2012 to 2017, there was no statistical change in the overall percent of respondents reporting their child visited their personal doctor/nurse for preventive care, as well as from 2015 to 2017. From 2012 to 2017, there was no statistical change in the overall percent of respondents reporting their child had an unmet medical need, an unmet dental need or was unable to see a specialist when needed, as well as from 2015 to 2017. From 2012 to 2017, there was no statistical change in the overall percent of respondents who reported their child had asthma or their child was seldom/never safe in their community, as well as from 2015 to 2017. From 2012 to 2017, there was no statistical change in the overall percent of respondents who reported their 5 to 17 year old child ate at least two servings of fruit while from 2015 to 2017, there was a statistical decrease. From 2012 to 2017, there was no statistical change in the overall percent of respondents who reported their child ate at least three servings of vegetables or ate at least five servings of fruits/vegetables, as well as from 2015 to 2017. From 2012 to 2017, there was no statistical change in the overall percent of respondents who reported their child was physically active five times a week for at least 60 minutes, as well as from 2015 to 2017. From 2012 to 2017, there was no statistical change in the overall percent of respondents who reported their 8 to 17 year old child always or nearly always felt unhappy/sad/depressed, as well as from 2015 to 2017. From 2012 to 2017, there was no statistical change in the overall percent of respondents who reported their 8 to 17 year old child was bullied or in the type of bullying, as well as from 2015 to 2017.*

### County Health Issues Key Findings

In 2017, respondents were asked to list the top three health issues in the county. The most often cited was illegal drug use (41%). Respondents in the top 40 percent household income bracket were more likely to report illegal drug use as a top health issue. Twenty-one percent reported access to health care; respondents who were female, 35 to 44 years old, 55 to 64 years old or with a college education were more likely to report this. Eighteen percent reported overweight or obesity as a top county health issue. Respondents who were female or 18 to 34 years old were more likely to report overweight or obesity. Seventeen percent reported chronic diseases; respondents who were male, in the bottom 40 percent household income bracket or unmarried were more likely to report this. Seventeen percent of respondents reported prescription or over-the-counter drug abuse; respondents who were female, 18 to 34 years old or with some post high school education were more likely to report this. Fifteen percent of respondents reported alcohol use or abuse as a top health issue; respondents 18 to 34 years old, with some post high school education or in the top 40 percent household income bracket were more likely to report this. Eleven percent of respondents reported cancer; respondents with a high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. Ten percent of respondents reported mental health or depression; respondents with a college education or in the middle 20 percent household income bracket were more likely to report this. Seven percent of respondents reported environmental issues as a top county health issue. Respondents who were in the top 40 percent household income bracket or married were more likely to report environmental issues. Seven percent of respondents reported affordable health care; respondents who were in the middle 20 percent household income bracket or unmarried were more likely to report this. Five percent of respondents reported tobacco use as a top health issue; respondents who were male, 18 to 34 years old, with a high school education or less or unmarried respondents were more likely to report this. Five percent of respondents reported violence or crime; respondents 65 and older were more likely to report this. Four percent of respondents reported access to affordable healthy food as a top county health issue.

## Appendix D: 2017 Waukesha County Health Needs Assessment: A Summary of Key Informant 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 2017 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, Advocate Aurora Health, Children’s Hospital of Wisconsin, ProHealth Care, and Froedtert & the Medical College of Wisconsin. 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 the Waukesha County’s Public Health Division, Ascension, Advocate Aurora Health, Children’s Hospital of Wisconsin, ProHealth Care, and Froedtert & the Medical College of Wisconsin. These organizations also invited the informants to participate and conducted the interviews. 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; and
- For those five public health issues:
  - Existing strategies to address the issue
  - Barriers/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

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 2016 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-seven key informant interviews were conducted with 71 respondents in Waukesha County. Some interviews incorporated the views of more than one person from an agency or organization. The 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 surveys and secondary data reports).

In 47 interviews, a total of 71 key informants were asked to rank the 5 major health-related issues in their county from a list of 13 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. Alcohol and Other Drug Use
3. Chronic Disease Prevention and Management
4. Access to Health Services
5. Nutrition

Summaries of themes for each issue are presented below in the order listed above.

### **Mental Health**

Forty-three key informants' interview rankings included Mental Health as a top five health issue. Sixteen of these ranked it as their top health priority area for the county. Access to Mental Health Services was a key theme across responses.

*Existing Strategies:* Key informants named the following services, resources, and strategies currently in place to improve Mental Health in the county: Aurora's Better Together grant; expansion of Medicaid; peer support specialists and support groups; mental health first aid, the Affordable Care Act; National Alliance on Mental Illness (NAMI) of Waukesha County provides resources to individuals and local agencies regarding mental illness and increasing awareness; family support groups; crisis intervention programs; Waukesha County Mental Health has open access for appointments and provides psychiatric evaluation and treatment; James Place counseling services offers free counseling services regardless of insurance status; resources through 211; Screening, Brief Intervention, and Referral to Treatment (SBIRT) training; mobile crisis team; education; Crisis Intervention Training (CIT); family activities; services at Rogers Memorial Hospital and Community Memorial Hospital, ProHealth Care behavioral health services and emergency line coordinates referrals; Jeremy House offers minimal shelter for the mentally ill population; health systems promoting screenings and education; Substance Abuse and Mental Health Services Administration (SAMHSA)'s free educational materials; Sussex Outreach Services' case management program; counselors and mental health providers on-site at schools; and anti-bullying efforts in schools.

*Barriers and Challenges:* Key informants named the following as barriers or challenges to improving mental health in the county: a lack of services and providers. There is a two month wait time for Waukesha County Mental Health. For patients who have Medicaid, it can be a six to eight month wait to see a provider. Follow up care is challenging. There are a limited number of bilingual counselors. Cost of services, transportation, stigma of mental illness, people stop taking medication, lack of services for the uninsured, financial barriers to accessing services, telehealth rules and regulations, and a lack of psychiatric support. More broadly, lack of affordable housing, supportive housing, and transitional housing, and lack of employment are barriers. The systems that do this work are "siloed." There are major communication challenges between agencies, providers, and other resources. People don't know where to send individuals experiencing mental illness. 211 is often overlooked as a resource. Navigating the services is challenging. A limited number of psychiatrists accept Medicaid. At schools there isn't enough capacity to meet the need-- kids are having significant issues without enough support or connections, and there is not an appropriate handoff in place for them. There are communication barriers between schools and students' medical providers/health systems.

*Needed Strategies:* Key informants recommended the following strategies could help improve Mental Health: more providers and shorter waiting times to get in to appointments; long acting injectable medications covered by insurance companies; more supportive community resources; case management; alternatives to hospitalization; intensive outpatient treatment centers or programs; crisis stabilization; more peer specialists; mobile and telehealth options; more crisis intervention training (CIT) for law enforcement; education for emergency departments and providers; home health providers; a central source for mental health care; school-based mental health services; more suicide prevention work; people to come to the table as partners with more collaboration; more programming in areas outside of the cities;

more funding and training for peer support; open door policy for mental health services; fewer restrictions and concerns about liability; case management with personality disorders; grant dollars to support community wraparound and support services; health care to take the lead on resources for families; literature shared at back to school nights; proper follow up for those coming in with mental health concerns; a mental health record or log that people can fill out and first responders could access when they encounter the person to know what medications they're on, who their provider is, and what works to help them; and greater connections between providers of mental health services and providers of services to the homeless population.

*Key Community Partners to Improve Health:* Key informants suggested the following partners should be present to work on this issue: mental health care providers, health care systems, Sixteenth Street Community Health Centers, Catholic Charities, churches and faith communities, business leaders, Waukesha County Health and Human Services, law enforcement, elected officials, first responders, Waukesha Hispanic Collaborative Network, NAMI of Waukesha County, pharmacists, pharmaceutical companies, insurance companies, the state, the Aging and Disability Resource Center of Waukesha County, Zero Suicide Network, foundations, Family Care, hospital social workers, schools, Mental Health Advisory Committee, food pantries, housing coalition, Hebron House, Jeremy House, Salvation Army, Impact 211, the Women's Center, Family Promise, Waukesha County Mental Health, ERAs, the nonprofit community more broadly, Wisconsin Department of Health Services, SAMHSA, Waukesha County Public Health Division, workforce development agencies, Waukesha County Community Health Improvement Plan and Process, Wisconsin Department of Public Instruction, Wisconsin School Counselor Association, support groups, parent outreach groups, Waukesha County Business Alliance, and local chambers of commerce.

*Subgroups/populations where efforts could be targeted and how efforts can be targeted:* Though key informants recognized this is a community-wide issue and everyone is affected, some examples of vulnerable populations who may need additional outreach were identified as Latinos, immigrants, refugees, human trafficking survivors, the homeless, seniors (especially with dementia), parents and caregivers, low-income residents, children and families of those who have mental illness, veterans and their families, and middle school students. Key informants thought community members could be reached through peer support groups, employment groups, and project on college campuses. For the homeless, reach through NAMI and shelter outreach and workshops for the un- and under-employed. For seniors, work with caregiver support groups, involve physicians' offices, senior meal sites, and the Aging and Disability Resource Network. Reach the medically underserved at Community Outreach Health Clinic and food pantries. Middle schools' students are an area of great need-- work on getting stabilization and support services there. Create new model of how we provide mental health services in schools through county and care systems. Collaborate with schools in a more proactive approach. Focus more on peer programs. Use the VA for more opportunities to talk and engage with veterans. Find ways to support employers to support their staff at work. Finally, they recommended trauma informed approaches be used across all populations.

### **Alcohol and Other Drug Use**

Forty informants included Alcohol and Other Drug Use in their top health issues for the county, with 18 ranking it as their top health priority area.

*Existing Strategies:* The following organizations, resources, and strategies are in place to address substance use in the county: Addiction Resource Council, halfway houses, Rosecrance, Rogers Memorial Hospital, Aurora Psychiatric Hospital, health systems that offer behavioral health services, Screening, Brief Intervention, and Referral to Treatment (SBIRT), Heroin Task Force with pillar action teams, Drug Free Communities Waukesha County, school district activities, State's Attorney General "Dose of Reality" campaign, medication drug coalitions, Narcan training, working with local police departments, parent education, new state prescription monitoring system, early intervention efforts in schools, school districts use the Youth Risk Behavior Survey to build programs and strategies to prevent and address identified risk behaviors, DARE program in schools, AODA committees in school districts, "Parents Who Host Lose The Most" education on liability, legal and health consequences of underage drinking,

medication drop boxes and one day collections, undercover stings and providing positive reinforcement for good behavior, schools' Collective Impact group, physician outreach, updated resources in 211, a lot of nonprofit organizations are engaged in this work, employer programs, school resource officers, schools working with athletes and their parents, outreach from the Your Choice to Live, Inc. and Stairway to Heroin program in schools, drug testing in schools and support for those who are using, Gals Institute, Alcoholic and Narcotics Anonymous groups, and sober living options.

*Barriers and Challenges:* Key informants named some challenges and barriers to addressing Alcohol and Drug Use. Many of these barriers are issues of access, while some are larger systems issues, challenges related to awareness and understanding, and other issues: alcohol abuse is normalized as part of our culture; substances can be an escape from stressors of life; addiction is a disease people have forever; these issues are often intertwined with mental health issues but the treatment options are separate; narcotic and opiate drug addiction are difficult to treat; cuts to federal and state funding; competition rather than working together in services; lack of programs or services outside of the City of Waukesha; lack of transportation to access services; people don't know where to seek help; there is a stigma attached to addiction; drugs and alcohol are easily accessible; there are too many task forces and not really knowing what is working or what the impact is; chronic homelessness; lack of a Veterans Court in Waukesha County and lack of support for veterans who have substance abuse issues; and lack of enough medication assisted treatment providers.

*Needed Strategies:* Key informants suggestions for addressing this issue include: Better understanding of opiates, treatment options, and brain pathways; creating ways for people to make meaningful connections with other people; sensitive questions asked by trained social workers, not added to a checklist of questions; more flexible scheduling of appointments; professionals working together on dual diagnosis; access to mental health services for younger ages to prevent substance abuse later in life; a more coordinated approach with multiple sectors working together with shared resources and outcome measurements (Drug Free Communities is a good example); more treatment options are needed; use of higher education research, like with UW Extension; campaigns around normalization; expand drug and alcohol courts; tougher consequences for impaired driving; treatment for those who are incarcerated; more consistent messaging around alcohol issues; school presentations and parent outreach; encourage people in recovery to speak about their experiences; use of Narcan; trauma informed care; education about healthy families and healthy relationships.; supporting parents and families of people in treatment; build campaigns across organizations that have a mission to work on AODA issues, and find a lead agency to be a backbone for coalition work on this issue; more support groups and increased awareness of their presence; peer specialists through the State Curriculum for mental health and AODA; veterans peer support; churches and faith based organizations should discuss these topics and influence parishioners and community members; a comprehensive program with detox, treatment, and support systems in the community; and "single entry point" access to care.

*Key Community Partners to Improve Health:* Key informants named Waukesha County, Sixteenth Street Community Health Centers, Addiction Resource Council, law enforcement, Drug Free Communities, Your Choice, Heroin Task Force Pillars, Waukesha County Health and Human Services, schools, UW-Extension, Center for Urban Population Health, Sussex Outreach Services, nonprofit organizations whose missions are AODA related, local providers of treatment services, churches and faith communities, Your Choices, Inc., Tavern League, court system, parents, United Way, the business community, veterans groups, Waukesha County Community Health Improvement Plan and Process, Housing Action Coalition, veterans groups, civic groups, colleges and universities, Salvation Army, Hebron House, La Casa de Esperanza, Head Start program, YMCA, and Thriving Waukesha County as the key partners needed to improve health in the county.

*Subgroups/populations where efforts could be targeted and how efforts can be targeted:* Key informants suggested kids ages 9-12 could be reached with prevention messages or programming at school or in YMCAs, youth sports programs, or other activities. Young adults (middle school aged to about 35) could receive interventions at school and during primary care appointments. At the high school level, education should include relatable stories and personal testimonials combined with resources. The elderly,

unemployed residents, incarcerated people, the Asset Limited, Income Constrained, Employed (ALICE) population, low-income residents, and the uninsured were also identified as potentially more in need of attention around this issue.

### **Chronic Disease Prevention and Management**

Twenty-five key informants ranked Chronic Disease Prevention and Management as a top health priority for the county. Responses to this issue overlapped with Access to Health Services.

*Existing Strategies:* Key informants noted there are good health care providers and health systems in the Waukesha County. Beyond existing health services, the strategies in place to address this issue include: resources through partners about where to send patients with complex issues, community awareness, education emphasizing prevention, healthy lifestyles, and medication management, great partnerships in the community, Aurora's Better Together grant used for transportation pilot program, good Public Health Division in the county, good supportive services such as Aging and Disability Resource Center, natural resources (e.g. hiking trails, parks, and lakes) that can support preventive behaviors, consumer education, wellness programs and incentives, the 5210 campaign, Hispanic Resource Center provides diabetes education to older adults, food pantries' specialized diet program, fall prevention programming, the Alzheimer's Association support groups for caregivers, community outreach nurses, parish nurses, nurse navigators, use of electronic medical records and data mining on impacting care and treatment for those with chronic conditions, and technology makes it easier for younger people to get information.

*Barriers and Challenges:* Key informants named the following as barriers and challenges: Lack of insurance; personal denial of risk; high costs of health care, prescriptions, and insurance; patients' delayed access to primary care; transportation barriers; diagnostic tests and maintenance medications are expensive; lack of awareness of what is covered and not covered by insurance; fear of dependency on prescription drugs; homelessness, not having a place to go, or having more immediate concerns to manage; lack of understanding of how to enter health care leads to over use of emergency department; limited emergency department referrals and referrals after hospitalization; income inequality; unhealthy diets; lack of health literacy and financial literacy; fast growing aging population in the county, especially those with chronic conditions; a lot of dual diagnosis/multiple chronic conditions; population health focus is needed, rather than focus on caring for illness; evidence that programs aren't meeting people's needs; funding cuts to prevention programs; Wisconsin's climate makes it harder to be active in the cold months and the culture doesn't promote the healthiest lifestyle choices; self-management is hard, especially for older generations; and a workforce shortage in long-term care.

*Needed Strategies:* Key informants provided the following suggestions to address this issue: being more intentional about prevention; being more creative about how to engage the community; increasing workforce, perhaps by incentivizing those career paths or returning to work in the county after school; more telehealth services; more drop in hours at health care providers; more recovery options, discharge planning, and determine where people without stable housing will go after discharge; more work on health literacy and financial literacy; recruit providers who reflect the population they are serving; in-home services; cultural sensitivity- especially for Hispanic patients; health coaching and health educators integrated with care teams/physicians; school outreach; exercise and healthy eating information and classes; provider prescribed prevention becoming insurance billable; cash for service model to help those who do not have means or good insurance coverage; walkable communities, safe routes to school, and walking school busses as examples of ways to keep people active; taxes unhealthy food and transportation- force people to make different decisions; create a health plan in preparation for retirement- establish workers' relationship with a provider prior to retiring and get all their screenings and blood work done; work on wellness programs for seniors, living wills, and advanced care plans; think about health more holistically and outside of the doctor's office; balance screen time and play time; implement strategies at a younger age; better lobbying and policy changes; and creating a different model of paying for health care where everyone can be covered (e.g. expanding BadgerCare, single payer system, etc.).

*Key Community Partners to Improve Health:* Key informants named the following as important partners to work on this issue: the nonprofit sector, food pantries, the Women's Center, providers of alternative and integrative therapies, pharmacies, pharmacists, prescription drug companies, Office of the

Commissioner of Insurance, County Veterans Services Office, pain management clinics, Sixteenth Street Community Health Centers, Salvation Army, faith communities, Department of Health and Human Services, Public Health Division, business leadership, elected officials, legislators, Aging and Disability Resource Center, 4-H, schools, media outlets, Wisconsin Association of Free and Charitable Clinics, Inc., Sussex Outreach Services, Meals on Wheels, and Waukesha County Technical College.

*Subgroups/populations where efforts could be targeted and how efforts can be targeted:* Key informants identified the following populations as potentially the most vulnerable: low income residents, the un- or under-insured, Latinos, non-native English speakers, seniors, children, adolescents, expectant mothers, the homeless, families of people who have chronic conditions. Those wanting to reach these groups should take information and prevention education to where people already are, where they live their lives and spend time. Partner with AARP to reach seniors. Provide in-home services and education. Address adolescents with career fairs and job-shadowing opportunities in health care. Reach the homeless in shelters. Offer programs in libraries. Focus on nutrition and prevention education for people who already have, or are at risk for, a chronic disease. Find out which places are meaningful to target group and go to those places to reach them. Offer referrals to programs at the YMCA, personal training, activities, and partnerships with grocery stores and farmers markets to help everyone eat healthily. Employers should share information with employees through Employee Assistance Program and Human Resources departments.

### **Access to Health Services**

Twenty-two informants' rankings included Access to Health Services as a top health issue for the county. Four of these respondents ranked this at their top health priority area. Key informants' responses reflected overlap with Oral Health, Mental Health, and Alcohol and other Drug Use with regard to improving access to all of these services. Responses also incorporated elements of Nutrition and Chronic Disease Prevention, focusing on the importance of preventing illness when access to care is limited.

*Existing Strategies:* Key informants noted that there are excellent health systems and health care providers in the county. They also shared information about existing strategies, including community screenings, community education, prevention efforts, and organizations that provide free or reduced cost services and complementary services to fill gaps in care and improve access for the county's residents. Examples of these include: the HOPE Network distributes information about health services and resources available and has a fundraiser to support clients' access to services, The Women's Center, Family Services of Waukesha, Impact 211, Sixteenth Street Community Health Centers, UW-Extension, Waukesha County provides nutrition education, energy assistance programs, housing coalitions, Women Infants and Children (WIC) program, Aging and Disability Resource Center, Waukesha County Transportation Network, web-based Elder Tree linkage for elderly residents, wellness screenings, health risk assessments, employee assistance programs, Sussex Community Summit, Hamilton Connects, English Language Learners (ELL) teachers that connect families to the community, Interfaith programs, the Find-A-Ride Network, patient navigators, La Casa de Esperanza, Lake Area Free Clinic as a safety net, partnerships with health care systems and other community organizations, and Thriving Waukesha County's Homelessness and Transportation Coalitions.

*Barriers and Challenges:* The most commonly named barriers to accessing health service are lack of providers and services for the underinsured or uninsured, the high cost of health services, the high cost of insurance, as well as co-payments, medications, and medical supplies. Further barriers are lack of transportation, a lack of appointments offered during evening or weekend hours, language barriers, and difficulty knowing where to go for care or how to navigate complicated health care systems and insurance. Other barriers named are patient mistrust of providers or systems, lack of understanding of what "wellness" really means, and larger issues like joblessness, low wages for workers, homelessness and housing insecurity, and other issues, like mental illness or substance abuse, preventing people from seeking health care. For providers, patients' medical histories are unknown if medical records can't be obtained in a timely manner or if they have been seen in several health systems with different electronic health records systems.

*Needed Strategies:* Key informants shared ideas for strategies to improve access to health services. For providers, a better medical records system or electronic medical record that allows providers easier access to diagnoses, medication lists, appointment histories, and data when patients travel between systems, clinics, and emergency departments, and continued interviews and discussions with local community health care partners to evaluate how to promote HIPAA compliant access to health information. At the community level, awareness of the services, resources, and people who can make those connections, a continuum of resources, a community forum on resources and services to look at the big picture would be helpful in connecting people to services. Other suggestions include: culturally competent providers, care that is more accessible using technology, ability for smaller agencies to provide interpreters, transportation, more telehealth services, texting abilities for providers, and phone counseling that is covered by insurance, education for first responders, neighborhood networks, mobile services for insurance enrollment assistance, medical community going to where people are and seeing people where they feel comfortable, use of peers, such as seniors bringing their neighbors so they have trust and comfort, changing community norms so people know their neighbors and proactively offer to help and share resources, a single payer health care system, appointments offered outside of traditional business hours, community education really breaking things down for people to understand what their insurance plan involves before they have to go in for services, increased transparency of health care costs, a single entry point for referrals to care, financial support for community-based grassroots organizations and nonprofits providing services, and promoting career development in primary care and mental health professions.

*Key Community Partners to Improve Health:* Many partners are important to improving access to health services, including health care providers, major hospital and health systems, local clinics, EPIC and other electronic medical record vendors, schools, libraries, the business community, law enforcement, bus and cab companies, the Aging and Disability Resource Center, ERAs Senior Network, insurance companies, food pantries, recreation departments, faith communities, hospital discharge planners, the Public Health Division, clinical students, local non-profits, Easterseals' Safe Babies Healthy Families, organizations who serve pregnant moms, civic organizations, county government, social services in the community, United Way, and Thriving Waukesha County. One key informant shared how they think partners could work together on this issue: *"Continue to work together as systems. Better education on how to plan for costs and best use of insurance coverages. Question what is necessary for care. Help promote education on care needs and how best to obtain services."*

*Subgroups/populations where efforts could be targeted and how efforts can be targeted:* The groups who may be most vulnerable are the un- and under-insured, low income residents, middle income residents (who struggle to afford insurance or health care but do not qualify for Medicaid or free services), elderly living at home alone who are isolated, English language learner (ELL) students and their families, children, pregnant women, refugees, survivors of trafficking, and young families. It was suggested these groups could be reached at apartment complexes, food pantries, schools, and through work with insurance carriers and employers. It was noted these groups should be contacted in places they already go (e.g. at schools, community centers, senior centers, food pantries, home, etc.) to decrease the burden of having to make it to additional appointments.

## **Nutrition**

Nutrition was ranked as a top health issue by sixteen key informants. Key informants addressed hunger and food insecurity, as well as making healthier dietary choices.

*Existing Strategies:* Waukesha County key informants named many community resources and strategies in place to address hunger and nutrition: nutrition information in HOPE Network newsletter and new member packets, referrals to food pantries, UW-Extension programming focuses on youth of low to moderate income families and provides long term programming, Waukesha County Health and Human Services nutrition education with Aging and Disability Resource Center and meal program, FoodShare accepted at farmers markets, farmers markets and food pantries receiving more fresh produce, school lunch programs, wellness programs for employees, population health models being used, primary care physicians, after school and summer meal programs for kids, people carry water bottles and drink more

throughout the day, growing awareness around nutrition and healthy choices, teachers encouraging healthy snacks, Meals on Wheels and home delivery food programs, and restaurant donations of extra food to the Women’s Center and Hope Center.

*Barriers and Challenges:* Key informants named barriers to improved nutrition in the county. Many of these were related to access and education. Issues of access include lack of money and people having to choose between food and rent or health care, lack of fresh produce during the winter months, lack of transportation to larger grocery stores, farmers markets, or meal programs, and embarrassment about needing to ask for assistance. Other barriers and challenges include programs that aren’t sustainable and don’t focus on system level change, a local culture that embraces unhealthy food traditions, lack of time to grocery shop and cook and the prevalence of convenience options, a culture where food is used as a reward, isolation issues with older adults, meal sites and programs stigmatized “only for low income,” and some people who need assistance don’t qualify for FoodShare benefits.

*Needed Strategies:* Key informants provided suggestions to improve nutrition in the county: visiting nurses that go to people’s homes with nutrition information and education, work with schools’ food service programs, school gardens supported by the business community, education for parents, home delivery services for new moms and single parents, increased workforce and staffing at pantries, making nutrition labels visible at restaurants, education in the workplace, spending time and efforts on youth to make healthy habits for life, cooking classes teaching how to cook for single people and families, teaching how to use food differently, teaching how to cook on a budget, intergenerational opportunities for education, expand summer lunch programs, more empty lot gardens, and wraparound and activities and programs to help kids get healthy meals and snacks outside of school.

*Key Community Partners to Improve Health:* Schools, food pantries, health care systems, libraries, community gardens, UW-Extension, current and retired farmers, 4H, Future Farmers of America, Waukesha County Health and Human Services, business community, foundations who can fund initiatives or programs, grocery stores, faith based groups, child care providers, cooking classes, nonprofits, Waukesha County Business Alliance, Public Health Division, Waukesha County Health Improvement Plan and Process, children and family service committee, and the Rotary and other civic groups were named as key partners to improve health in the county.

*Subgroups/populations where efforts could be targeted and how efforts can be targeted:* Key informants suggested reaching children and their families with nutrition education in schools and at pediatrician appointments. Other groups potentially in need of nutrition resources and education are the elderly, lower income residents, people with chronic conditions, the homeless, and residents with mental illness, who could be reached through targeted meal programs.

**Partners & Contracts:** This report was commissioned by Ascension, Advocate Aurora Health, Children’s Hospital of Wisconsin, ProHealth Care, and Froedtert & the Medical College of Wisconsin in partnership with the Center for Urban Population Health and Waukesha County Public Health Division. The report was prepared by the Center for Urban Population Health.

## **Appendix E: Key Informant Organizations Interviewed for purposing of conducting the Froedtert Menomonee Falls Hospital CHNA**

- 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
- Arrowhead Union High School District – Provides education for youth
- City of New Berlin Fire Department – Emergency response
- City of New Berlin Police Department – Emergency response
- Community Outreach Health Clinic – Free medical clinic for uninsured
- Dryhooch Waukesha County – Peer support for veterans
- Easterseals – Nonprofit serving people with disabilities and at-risk families
- Elmbrook Church James Place – Serving people who are homeless, disfranchised, mentally ill, and jobless
- ERAs Senior Network, Inc. – Nonprofit serving seniors, adults with disabilities, and family caregivers
- Falls Area Food Pantry – Provides food for low income individuals & families
- Family Service of Waukesha – Nonprofit counseling center
- Food Pantry of Waukesha County, Inc. – Provides food for low income individuals and families
- Hamilton School District – Provides education to youth
- Hebron House of Hospitality – Nonprofit dedicated to ending homelessness
- HOPE Network, Inc. – Nonprofit serving single mothers
- Kettle Moraine School District – Provides education to youth
- La Casa de Esperanza – Nonprofit serving Hispanic population
- Lake Area Free Clinic – Free medical clinic for uninsured
- LindenGrove Communities – Provides assisted living, memory care, short-term rehabilitation & skilled nursing housing.
- Mukwonago Food Pantry - Provides food for low income individuals and families
- Mukwonago Area School District - Provides education to youth
- National Alliance on Mental Illness (NAMI) Waukesha, Inc. – Nonprofit provides support for mental health
- New Berlin Food Pantry - Provides food for low income individuals & families
- Oconomowoc Area School District – Provides education to youth
- Oconomowoc Area Chamber of Commerce - Nonprofit supporting local businesses
- Saint Joseph’s Medical Clinic – Free medical clinic for uninsured
- School District of Menomonee Falls – Provides education to youth
- School District of New Berlin – Provides education to youth
- School District of Waukesha – Provides education to youth
- Sixteenth Street Community Health Centers – Free medical clinic for uninsured
- Sussex Outreach Services – 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 services needs
- University of Wisconsin-Extension – Shares, develops and delivers resources and programs to respond to community issues
- Village of Menomonee Falls – Local government
- Waukesha County – Local government
- Waukesha County Business Alliance – Nonprofit supporting local businesses in Waukesha County

- Waukesha County Community Dental Clinic – Nonprofit providing oral health services
- 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 – Government department that investigates deaths
- Waukesha County Mental Health Services – Government department that provides mental health services
- Waukesha County Public Health Division – Government department that prevents disease and promotes health
- YMCA at Pabst Farms – Nonprofit providing services that help people improve their health and well-being
- YMCA of Greater Waukesha County - Nonprofit providing services that help people improve their health and well-being

## **Appendix F: 2017 Waukesha County Health Needs Assessment: A Summary of Secondary Data Sources**

In 2017, the Center for Urban Population Health was enlisted to create a report detailing the health of Waukesha County using secondary data. This health data report is one piece of a variety of data sources being used by local health systems to describe their communities and the health priorities of their service areas. Indicators for which primary data are being collected were excluded from this report. In addition, rather than repurposing data from the comprehensive county rankings report created by the University of Wisconsin Population Health Institute (2017), the county level data from the rankings report is included in its entirety at the end of this report.

All of the data comes from 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. In some cases data were not presented by the system from which they were pulled due to their internal confidentiality policies which specify that data will not be released when the number is less than five. In other cases, data were available but the rates or percentages are not presented in this report. This is due to the indicator having small numbers in the numerator or denominator resulting in rates or percentages that were subject to large year to year fluctuations and, as such, would not have provided a meaningful representation of the data for the population subset.

When applicable, Healthy People 2020 objectives are provided for each indicator. These objectives were not included unless the indicator directly matched with a Healthy People 2020 objective.

### **Publicly available data sources used for the Secondary Data Report**

- American Community Survey
- University of Wisconsin Population Health Institute- County Health Rankings
- Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics
- Wisconsin Interactive Statistics on Health (WISH)
- Wisconsin Department of Justice
- US Census Bureau American Fact Finder
- Wisconsin Department of Children and Families

**Partners & Contracts:** This report was commissioned by Ascension, Advocate Aurora Health, Children’s Hospital of Wisconsin, ProHealth Care, and Froedtert & Medical College of Wisconsin in partnership with the Center for Urban Population Health and Waukesha County Public Health Division. The report was prepared by the Center for Urban Population Health.

## Appendix G: Review of the Fiscal Year 2016-2018 Froedtert Menomonee Falls Hospital CHNA Implementation Strategy

Identified Need	Program	Actions	Outcomes
Access to Care, Navigation and Mental Health/AODA	Community Outreach Health Clinic	<ul style="list-style-type: none"> <li>Continue referral process for uninsured/underinsured populations from CMH to Community Outreach Health Clinic</li> <li>Provide ancillary/specialty care services for COHC patients</li> <li>Screen uninsured patients for financial assistance programs (Marketplace, BadgerCare etc) including Froedtert Health's Financial Assistance Program</li> <li>Provide financial support for clinic operations and functions</li> <li>Screen patients for underlying AODA/Mental Health Conditions</li> <li>Provide behavioral health coaching and referral to community services</li> </ul>	<ul style="list-style-type: none"> <li>Free or reduced pharmaceuticals dispensed: 3,208</li> <li>Laboratory Tests (Donated by Hospital): 2,186</li> <li>Cardiology Procedures (Donated by Hospital): 15</li> <li>Radiology Procedures(Donated by Hospital): 104</li> <li>Referrals to Specialty Care (Donated by F&amp;MCW Community Physicians): 108</li> <li>Clinic served 2,300 individuals</li> </ul>
Access to Care/Navigation and Chronic Disease Management	Community Paramedicine Program	<ul style="list-style-type: none"> <li>Develop Community Paramedicine Pilot Program – December 2015</li> <li>Determine technological needs, templates, care plans, agreements, education and related resources for pilot program</li> <li>Identify patients at risk for readmission and develop referral and tracking process with Menomonee Falls and Lisbon Fire Departments</li> </ul>	<p>Completed the following:</p> <ul style="list-style-type: none"> <li>Developed contract between FMF and Town of Lisbon Fire &amp; Rescue</li> <li>Completed policies and procedures</li> <li>Identified indicators for referrals</li> <li>Intake and discharge process</li> <li>Credentialing/Approval of Program Medical director</li> <li>Developed program materials</li> </ul>
Chronic Disease – Cancer	Cancer Care Navigation, Awareness, Prevention and Screenings – Community Memorial Cancer Center	<ul style="list-style-type: none"> <li>Dedicated nurse navigators working with patients receiving care in the CMH Cancer Center and provide assessment and referrals for health system and community resources</li> <li>Screen all uninsured patients for financial assistance programs through the Marketplace or government sponsored programs</li> <li>Execute a minimum of two community cancer screening programs per year</li> <li>Execute quarterly cancer awareness and education events (classes, health fairs, events etc.)</li> </ul>	<ul style="list-style-type: none"> <li>8 colonoscopies provided to uninsured patients</li> <li>18 individuals screened</li> <li>12 presentations to the Tri-county YMCA Livestrong program</li> <li>8 community classes completed</li> <li>9 health topic classes completed and impacting 267 individuals</li> </ul>
Chronic Disease	Community Health Education and Outreach Programs	<ul style="list-style-type: none"> <li>Facilitate a minimum of three Living Well with Chronic Conditions/Diabetes programs each year</li> <li>Explore new community partners/agencies in service area to hold Living Well with Chronic Conditions/Diabetes and Service Line programs</li> </ul>	<ul style="list-style-type: none"> <li>59 people participated in the Living Well with Chronic Conditions workshop</li> <li>847 individuals received screenings at community events</li> <li>86 individuals participated in Be Strong Stay Strong program</li> </ul>

		<ul style="list-style-type: none"> <li>• Explore opportunities for enhancing and expanding clinical support groups and community health education programs in community based settings</li> </ul>	
Mental Health/Alcohol and Other Drug Abuse	Partnership – Waukesha County Health Improvement Plan Steering Committee	<ul style="list-style-type: none"> <li>• Actively participate in Waukesha and Washington County steering committees and project teams <ul style="list-style-type: none"> <li>○ Heroin Task Force</li> <li>○ Drug Free Communities Drug Collection and Awareness Events</li> <li>○ Washington County Community Health Coalition</li> </ul> </li> <li>• In-kind support of Froedtert Health leaders, staff and physicians with knowledge and expertise in behavioral health</li> <li>• Identify service gaps within Froedtert Health</li> </ul>	<ul style="list-style-type: none"> <li>• Over 4,000 pounds of prescription and over-the-counter medications were collected</li> </ul>