



**Froedtert
Menomonee Falls Hospital**

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

Community Memorial Hospital of Menomonee
Falls, Inc.
Doing Business As:

Froedtert Menomonee Falls Hospital

Fiscal Year 2022
Effective July 1, 2021

Approved by Froedtert Menomonee Falls Hospital Board of Directors on 08/26/2021

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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), a public private consortium dedicated to improving care for underserved populations in Milwaukee County. Through the Partnership, Milwaukee’s four health systems, ProHealth Care 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 data gathering includes findings from a community health survey, key informant interviews and a secondary source data analysis. This shared data gathering informs the subsequent CHNA for Froedtert Menomonee Falls Hospital. The CHNA 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.

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

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 Engagement Steering Committee. Additional progress on the Implementation Strategy will be reported annually through the hospital’s IRS Form 990 Schedule H filing and other reporting sources associated with strategic partners and community coalitions.

Community Health Needs Assessment

In 2020, 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 41 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>.

Social Determinants of Health Community Partner/Agency Reports: Social determinants of health have a major impact on people’s health, well-being, and quality of life and contribute to wide health disparities and inequities. To better understand these conditions; Froedtert Menomonee Falls Hospital obtained important social determinants of health data and trends, such as income, educational level, housing, and employment, from partner organizations. Data was utilized from agencies such as Community Outreach Health Clinic, United Way of Greater Milwaukee & Waukesha County ALICE Report, and Impact 211 which provided data specific to Froedtert Menomonee Falls Hospital’s primary service area and underserved communities.

Secondary Data Reports: Utilizing multiple county and community-based publicly available reports, information was gathered regarding: Mortality/Morbidity data, Injury Hospitalizations, Froedtert Menomonee Falls Hospital inpatient and outpatient data, 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>.

CHNA Prioritization of Community Health Needs Process

Froedtert Menomonee Falls Hospital created a CHNA/Implementation Strategy Advisory Committee (**Appendix A**) consisting of members of the Community Outreach Steering Committee, Froedtert Menomonee Falls Board of Directors, community partners in Waukesha County, and Waukesha County Public Health Department along with hospital and health system leadership/staff. Members of the committee were selected based on their specific knowledge of health needs and resources in Waukesha County for a collective analysis of the findings from the Community Health Needs Assessment. Under the direction of the Community Engagement Leadership Team and trained meeting facilitator; the CHNA planning process included six steps in developing the Implementation Plan:

1. Reviewed the 2020 Community Health Needs Assessment results for identification and prioritization of community health needs
2. Reviewed Impact 211 data, County Health Rankings, Community Outreach Health Clinic data, United Way of Greater Milwaukee & Waukesha County data and Waukesha County Health & Human Services data
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

Based on the information from all the CHNA data collection sources, the most significant health needs were identified as:

- Infectious Disease;
- Mental Health;
- Substance Use & Abuse (alcohol, tobacco and other drugs);
- Access to Health Care;
- Chronic Disease;
- Nutrition;
- Workforce Development (healthcare career exploration);
- Transportation
- Food Insecurity;
- Housing/Homelessness; and
- Safety/Violence

Before the facilitated workout session in February 2021, members of the CHNA/Implementation Strategy Advisory Committee were asked to rate each priority via Survey Monkey based on the following criteria to identify the top priorities among the significant health needs identified:

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

The top ranked significant health needs based on the Survey Monkey results included:

- Mental Health;
- Workforce Development (healthcare career exploration);
- Food Insecurity;
- Infectious Disease;
- Transportation; and
- Substance Use & Abuse (alcohol, tobacco and other drugs)

Of those significant health need categories, four overarching priorities were identified as the focus for Froedtert Menomonee Falls Hospital's Implementation Plan for fiscal 2022 – 2024:

- Mental Health;
- Workforce Development (healthcare career exploration);
- Infectious Disease; and
- Substance Use & Abuse (alcohol, tobacco and other drugs)

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 G**) 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 2020 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**). The interviewers used a standard interview script that included the following elements:

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

- How can health care organizations support the community during this pandemic?
- What methods of communication and outreach have been successful to reach partners and community members during the pandemic?
- How would you suggest health care organizations outreach to community partners and members to implement health initiatives?

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
- Substance Use and Abuse
- Access to Health Care
- Chronic Disease
- Nutrition

Community Health Survey:

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

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 Menomonee Falls Hospital, founded in 1964 by the citizens of Menomonee Falls and surrounding communities and originally named Community Memorial Hospital, 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, Manitowoc, New Berlin, Pewaukee, Pleasant Prairie and West Bend; and more than 40 primary and specialty care health centers and clinics.

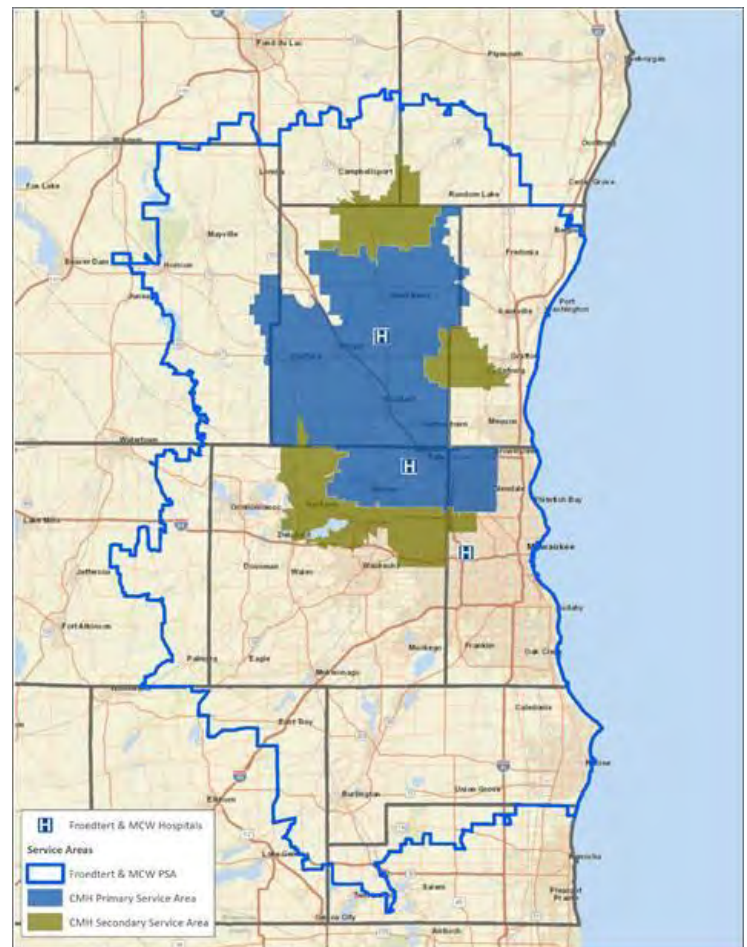
Mission Statement

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.

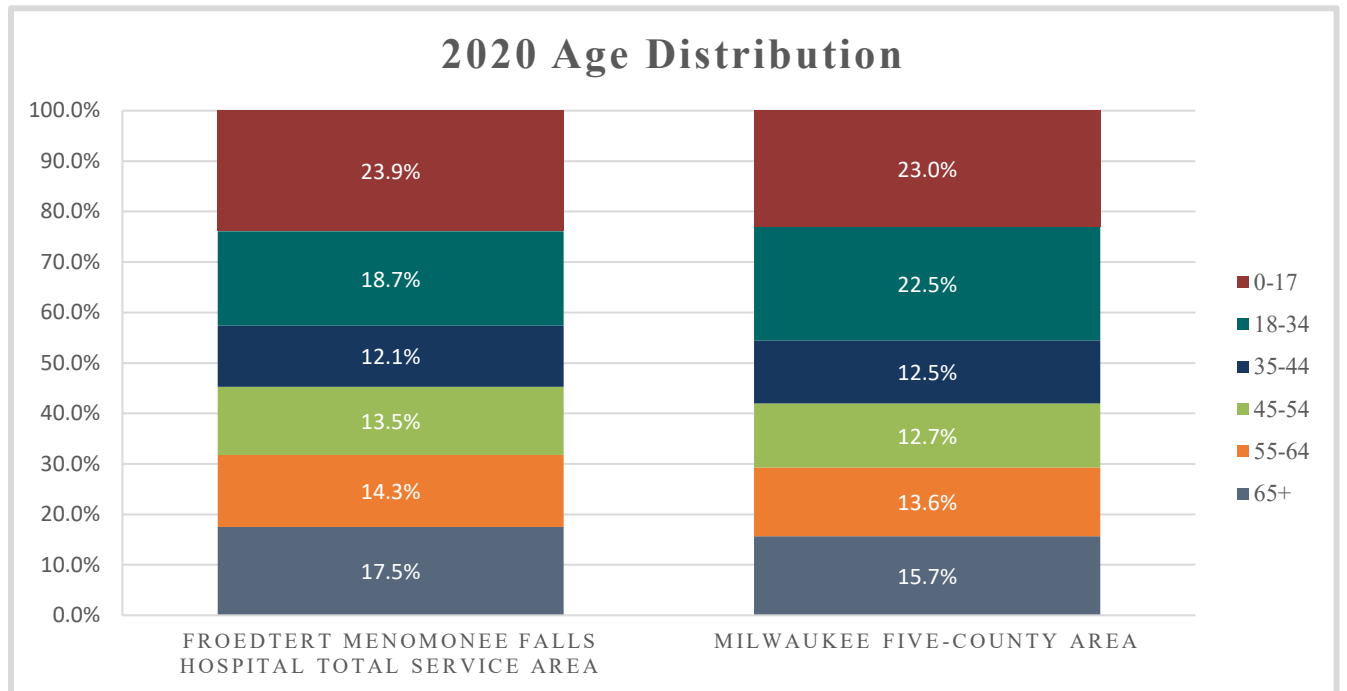
Service Area and Demographics

For the purpose of the Community Health Needs Assessment, the community is defined as Northeast Waukesha County and Germantown because the hospital derives 79.4% 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.

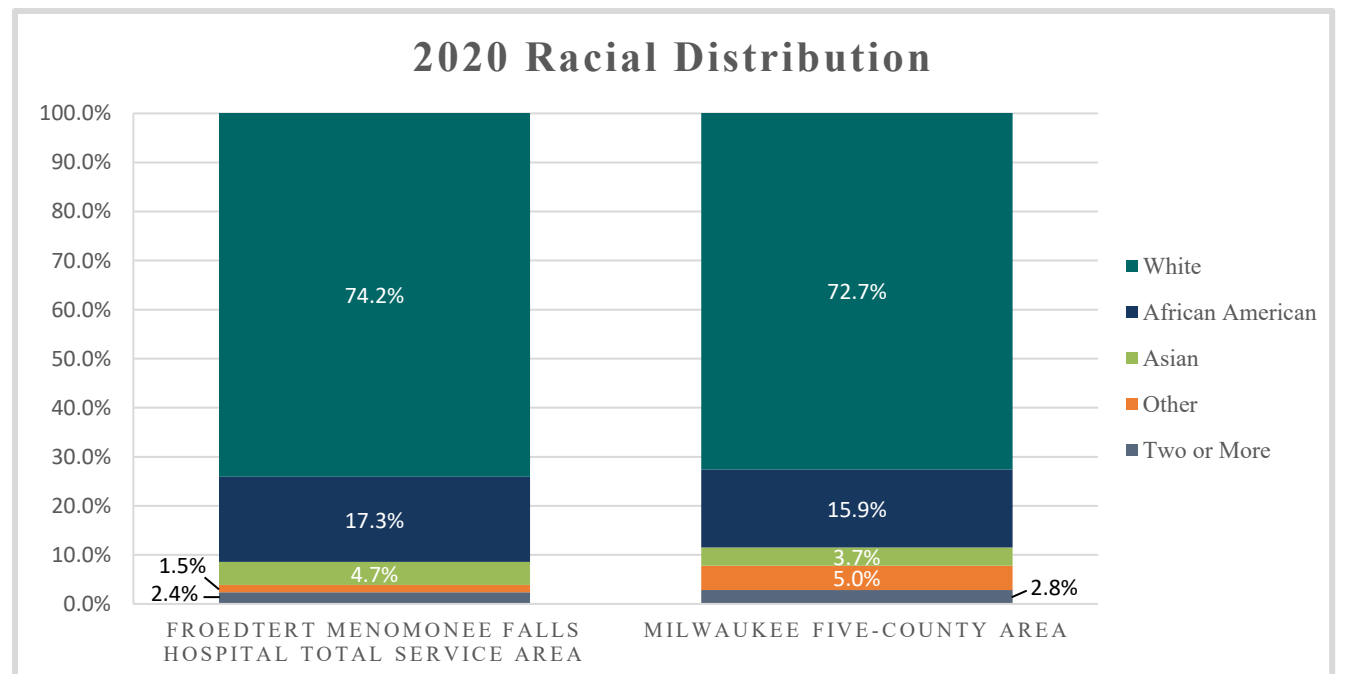
The map reflects the 25 zip codes – 53005 (Brookfield), 53007 (Butler), 53012 (Cedarburg), 53017 (Colgate), 53022 (Germantown), 53027 (Hartford), 53029 (Hartland), 53033 (Hubertus), 53037 (Jackson), 53040 (Kewaskum), 53045 (Brookfield), 53046 (Lannon), 53051 (Menomonee Falls), 53072 (Pewaukee), 53076 (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).



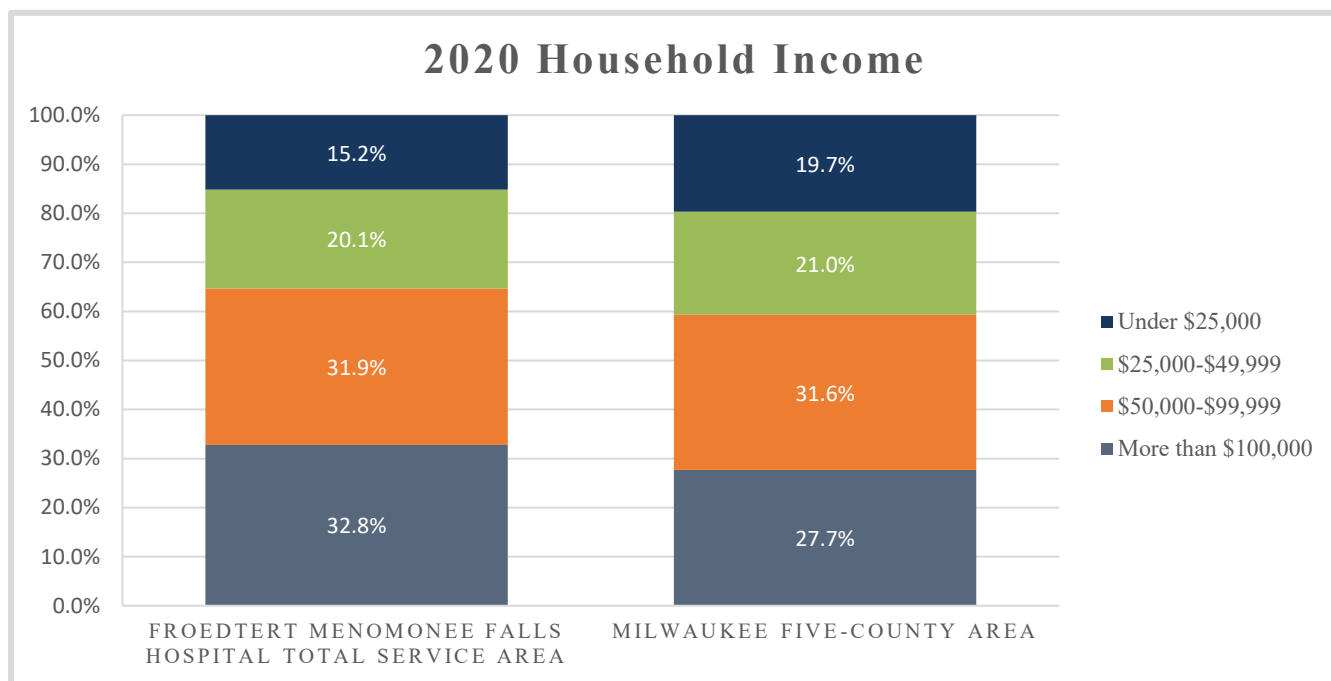
Age – The Froedtert Menomonee Falls Hospital total service area has a comparable age distribution as the Milwaukee five-county area. The percentage of 35-44, critical ages when people begin getting routine screenings is 12.1% in the Froedtert Menomonee Falls Hospital total service area and slightly higher at 12.5% in the five-county area.



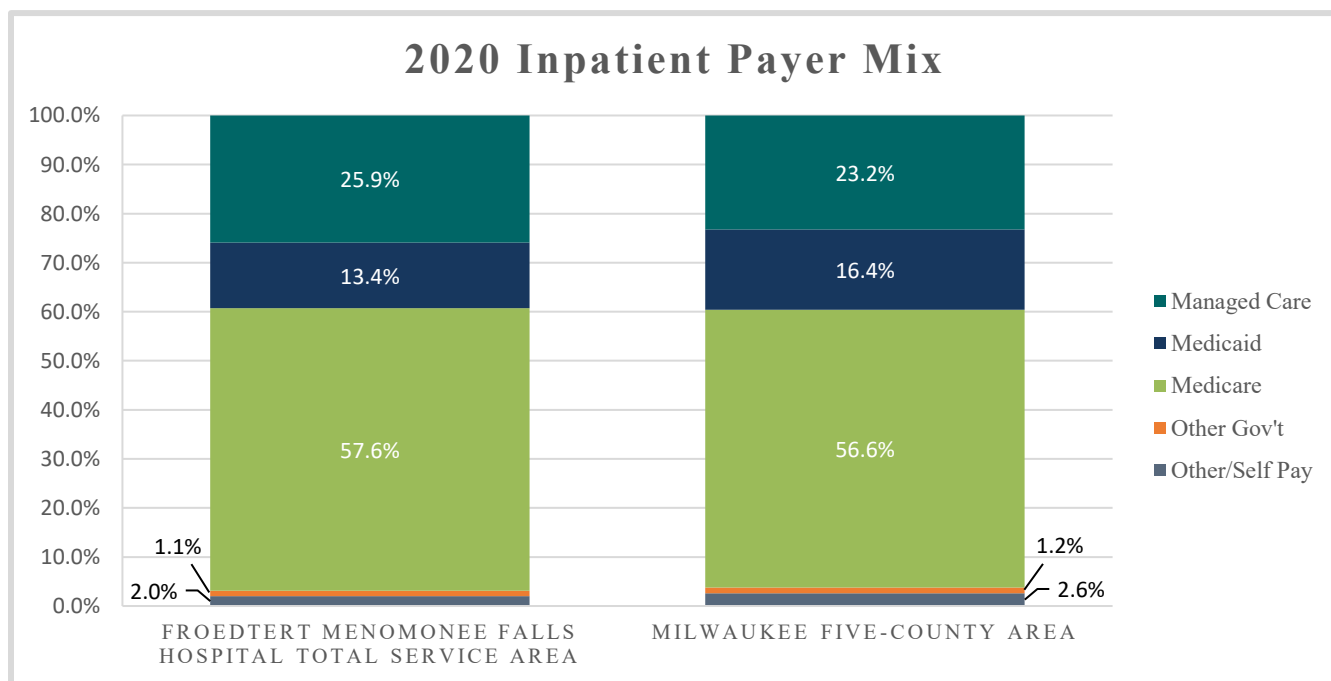
Race/Ethnicity – The racial distribution in the Froedtert Menomonee Falls Hospital total service area is predominantly White (74.2%) and African American (17.3%). This is similar to the Milwaukee Five-County Area which is also predominantly White (72.7%) and African American (15.9%).



Household Income – 35.3% of the Froedtert Menomonee Falls Hospital total service area earns less than \$50,000 annually whereas in the five-county area, 40.7% of the population earns \$50,000 or less.



Inpatient Payer Mix – 15.4% of the patients in the Froedtert Menomonee Falls Hospital total service area are Medicaid or Self Pay (uninsured) patients, compared to 19.0% in the 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>.

Healthcare Access for Priority Populations & Navigation of Community Resources, Health Equity, Patient Access to Affordable Transportation and Chronic Disease Prevention and Management

CHNA Significant Health Needs: Access to Care (medical and dental), Transportation and Chronic Disease

Goal: Improve equitable access to primary, comprehensive, quality health and dental care services.

Objectives:

1. Ensure a strong safety net of services that improve access to care among priority populations.
2. Decrease the percent of residents who reported unmet medical and dental care (in household).
3. Provide inclusive, culturally and linguistically competent care to all patients, information to community members and education to staff.
4. Provide and assist eligible patients with affordable transportation options.
5. Increase number of community chronic disease and cancer screenings, access to support services and prevention opportunities.

Froedtert Menomonee Falls Hospital Available Resources:

- Expand assistance and support of the Community Outreach Health Clinic to improve access to healthcare and behavioral care services and navigation of resources for uninsured and underinsured population.
- Expand assistance and support of Community Dental Smiles to improve access to dental services and navigation of resources for uninsured and underinsured population.
- Support of the FMFH Family Medicine Residency Program.
- Partner with Human Resources and Diversity & Inclusion to implement programs and policies that address bias and institutional racism.
- Provide subsidized medical transportation rides to underserved populations.
- Develop a process to collect, manage and share transportation community resource.
- Increase access to preventative screenings around chronic disease, mammography, colonoscopies and other cancer- related conditions for priority populations.
- Support and promote initiatives through community coalitions and partner agencies through grants and in-kind contributions.

Froedtert Menomonee Falls Hospital Collaborative Partners:

- Community Outreach Health Clinic
- Community Smiles Dental
- Froedtert Menomonee Falls Hospital (FMFH) Family Medicine Residency Program
- Medical College of Wisconsin
- Waukesha County School Districts
- Menomonee Falls and Sussex Food Pantries
- Faith-based organizations
- United Way of Greater Milwaukee & Waukesha County
- Area Community Education and Recreation Departments

- American Cancer Society
- Bobbie Nick Voss Charitable Funds
- Eras Senior Programs Waukesha County

Social Engagement, Support Groups, Prescription Drug Prevention, Treatment, Screenings and Referrals Services

CHNA Significant Health Needs: Behavioral Health (mental health and substance use & abuse)

Goal:

1. Support behavioral health outreach, education, and prevention programs.
2. Improve access to behavioral health treatment, services and navigation of community resources.

Objectives:

1. Increase opportunities for social engagement to reduce isolation, depression and addiction.
2. Increase opportunities for the safe removal of prescription drugs from households.
3. Increase number of behavioral health treatment services, screenings and referrals targeted at underinsured populations through the Community Outreach Health Clinic.
4. Decrease the percent of residents who reported unmet mental health care (in household).

Froedtert Menomonee Falls Hospital Available Resources:

- Support behavioral health support groups and programs through community partnerships.
- Support and promote initiatives through community behavioral health coalitions and partner agencies through grants and in-kind contributions.
- Support Drug Take Back Day through Froedtert Menomonee Falls Hospital.
- Expand behavioral health screenings at Community Outreach Health Clinic and other community partner sites.
- Expand behavioral health services at Community Outreach Health Clinic through the Medically Assisted Treatment (MAT) program and access to psychotropic medication and counseling services.

Froedtert Menomonee Falls Hospital Collaborative Partners:

- Waukesha County Health & Human Services
- Elevate, Inc
- NAMI Southeast Wisconsin
- Community Outreach Health Clinic
- Menomonee Falls Police Department
- Aging & Disability Resource Center
- UW– Extension – Waukesha County
- Addiction Resource Council
- Eras Senior Programs Waukesha County

Program Development and Sponsorship

CHNA Significant Health Needs: Workforce Development (health care career exploration)

Goal: Increase student's exposure to health care careers.

Objectives: Increase opportunities for students to gain exposure to all health care careers.

Froedtert Menomonee Falls Hospital Available Resources:

- Evaluate current partnership and resources required to meet workforce development needs.
- Create effectiveness criteria of partnerships.
- Develop and implement a coordinated plan in partnership with Froedtert Health Workforce Development, Human Resources and Organizational Development.
- Provide scholarships to students interested in participating in health care career exploration programs through the FMFH Foundation.

- Develop a tracking tool to evaluate student involvement and long-term impact on health care careers.

Froedtert Menomonee Falls Hospital Collaborative Partners:

- Waukesha County School Districts
- Waukesha County Business Alliance
- Waukesha County Community Organizations

Health Disparities, Immunizations and Preparedness

CHNA Significant Health Needs: Infectious Disease

Goal: Support infectious disease outreach, education and prevention initiatives.

Objectives:

1. Increase outreach to priority populations to reduce health disparities related to access to care, language, historical trauma and other barriers.
2. Improve access to infectious disease immunizations.
3. Enhance collaborations with community partners on emergency preparedness efforts.
4. Achieve a low case activity level in Waukesha County by June, 2024.*

Froedtert Menomonee Falls Hospital Available Resources:

- Implement outreach and prevention initiatives through community partners as well as Froedtert Health's hotline, social media pages, website and other media modes.
- Implement immunization clinics in collaboration with community partners and local health department.
- Review and revise a coordinated emergency preparedness plan with the local health department.

Froedtert Menomonee Falls Hospital Collaborative Partners:

- Waukesha County Health Department
- Community Outreach Health Clinic
- United Way of Greater Milwaukee & Waukesha County
- Eras Senior Programs Waukesha County

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:

- Addiction Resource Council (Waukesha County)- Behavioral Health (mental health/ substance use & abuse)
- American Cancer Society – Chronic Disease
- Area Community Education and Recreation Departments – Chronic Disease
- Bobbie Nick Voss Charitable Funds – Access to Care, Chronic Disease
- Community Outreach Health Clinic – Access to Care, Chronic Disease, Behavioral Health (mental health/ substance use & abuse), Infectious Disease
- Community Smiles Dental – Access to Care
- Elevate Inc.- Behavioral Health (mental health/ substance use & abuse)
- Eras Senior Programs Waukesha County – Access to Care, Transportation, Behavioral Health (mental health/ substance use & abuse), Infectious Disease
- Faith-based Organizations – Access to Care, Chronic Disease
- Froedtert Menomonee Falls Hospital (FMFH) Family Medicine Residency Program- Access to Care
- Medical College of Wisconsin- Access to Care
- Menomonee Falls Police Department - Behavioral Health (mental health/ substance use & abuse)
- Menomonee Falls and Sussex Food Pantries – Access to Care, Chronic Disease
- NAMI Southeast Wisconsin- Behavioral Health (mental health/ substance use & abuse)
- United Way of Greater Milwaukee & Waukesha County – Access to Care, Infectious Disease
- UW– Extension – Waukesha County – Behavioral Health (mental health/ substance use & abuse)
- Waukesha County Aging and Disability Resource Center – Behavioral Health (mental health/ substance use & abuse)
- Waukesha County Business Alliance- Workforce Development
- Waukesha County Community Organizations- Workforce Development
- Waukesha County Health and Human Services - Chronic Disease, Behavioral Health (mental health/ substance use & abuse), Infectious Disease
- Waukesha County School Districts – Access to Care, Behavioral Health (mental health/ substance use & abuse), Workforce Development

Appendix A: Froedtert Menomonee Falls Hospital CHNA/Implementation Strategy Advisory Committee

Name	Title	Organization	FH Affiliation
Mike Bloedorn	Community Member/Community Coalition Volunteer	Menomonee Falls Resident	COSC
Carrie Booher	Business Development Executive	PS Companies	FMFH Board COSC
Andy Dresang	Director Community Engagement	Froedtert Health	
Diane Ehn	Vice President Post-Acute Care	Froedtert Health	COHS Board COSC
Kerry Freiberg	Vice President Community Engagement	Froedtert Health	
Kathy Klein	Wealth Advisor	Strategic Wealth Partners	FMFH Board COSC
Rebecca Luczaj	Waukesha County Justice Services Coordinator	Waukesha County Human Services	COSC
Teri Lux	President Froedtert Menomonee Falls Hospital	Froedtert Health	
Deb McCann	Executive Director of Patient Care Services - Froedtert Menomonee Falls Hospital	Froedtert Health	COSC
Meredith Musaus	Pastor	Holy Cross Lutheran Church	COSC
Chad Zambon	Dentist	Dental Professionals	COHS Board
Renee Ramirez	President/CEO	Community Smiles Dental	COSC
Heidi Moore	Diversity and Inclusion	Froedtert Health	
Cindy Simons	President & CEO	Forward Careers, Inc.	FMFH Board COSC
Ben Jones	Health Officer	Waukesha County Health Department	COSC
Allen Ericson	President Froedtert West Bend Hospital	Froedtert Health	
Rick Binzak	Vice President	BMO Harris Bank	FMFH Board
Corey Golla	School Administrator	School District of Menomonee Falls	FMFH Board
Travis Fisher MD	Associate Professor of Psychiatry	Medical College of Wisconsin	FMFH Board
Matt Carran	Director of Community Development	Village of Menomonee Falls	
Jessica Mulligan	Executive Director - Froedtert Menomonee Falls Hospital Foundation	Froedtert Health	COHS Board
Pamela Parker	Community Member	Menomonee Falls Resident	COHS Board
Linda Smith	Nurse Practitioner/Clinic Coordinator - Community Outreach Health Clinic	Froedtert Health	COHS Board
Kwanza Devlin	Associate Program Director - Family Medicine Residency Program	Froedtert Health	
Kate Sweeney	Director – Cancer Center Hematology & Transplant Services	Froedtert Health	
Brad Christianson	Business Development Executive	Ernst & Young, LLP (Y)	FMFH Board COSC
Edna Abernathy	President & CEO	E.R. Abernathy Industrial, Inc.	FMFH Board COSC
Dennis Shepherd	MCW Dept. of Emergency Medicine	Medical College of Wisconsin	FMFH Board
Amanda Wisth	Community Engagement Data Analyst	Froedtert Health	
Mandie Reedy	Community Engagement Coordinator	Froedtert Health	
Melissa Kerhin	Community Engagement Coordinator	Froedtert Health	
Allyson Rennebohm	Community Engagement Nurse Coordinator	Froedtert Health	
Larry Dux	Director Patient Care Informatics	Froedtert Health	

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 a random child (17 or younger) in the household through an adult who makes health care decisions for the child.
3. Gather data on the prevalence of risk factors and disease conditions existing within the adult population.
4. Compare, where appropriate, health data of residents to previous health studies.
5. Compare, where appropriate and available, health data of residents to state and national measurements along with Healthy People 2020 goals.

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

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

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

In 2019, the Census Bureau estimated 318,146 adult residents lived in Waukesha County. Thus, in this report, one percentage point equals approximately 3,180 adults. So, when 9% of respondents reported their health was fair or poor, this roughly equals 28,620 residents $\pm 15,900$ individuals. Therefore, from 12,720 to 44,520 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 2019, the Census Bureau estimated 160,635 occupied housing units in Waukesha County. In certain questions of the Community Health Survey, respondents were asked to report information about their household. Using the 2019 household estimate, each percentage point for household-level data represents approximately 1,610 households.

Partners & Contracts: This report was commissioned by Ascension Wisconsin, Advocate Aurora Health, Children's Wisconsin, Froedtert & the Medical College of Wisconsin and ProHealth Care in partnership with Waukesha County Public Health Division 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.

Appendix C: 2020 Waukesha County Community Health Survey Report

Executive Summary

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

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

--Not asked. NA-WI and/or US data not available.

*In 2020, the question was asked about any household member. In previous years, the question was asked of respondents only.

	Waukesha					WI	US
Routine Procedures	<u>2009</u>	<u>2012</u>	<u>2015</u>	<u>2017</u>	<u>2020</u>	<u>2019</u>	<u>2019</u>
Routine Checkup (2 Years Ago or Less)	84%	85%	85%	86%	90%	87%	88%
Cholesterol Test (4 Years Ago or Less) [HP2020 Goal: 82%]	82%	79%	84%	84%	81%	84%	87%
Dental Checkup (Past Year) [HP2020 Goal: 49%]	74%	75%	76%	82%	76%	71% ¹	68% ¹
Eye Exam (Past Year)	41%	49%	55%	53%	39%	NA	NA
	Waukesha					WI	US
Health Conditions in Past 3 Years	<u>2009</u>	<u>2012</u>	<u>2015</u>	<u>2017</u>	<u>2020</u>	<u>2019</u>	<u>2019</u>
High Blood Pressure	22%	26%	33%	31%	29%	NA	NA
High Blood Cholesterol	24%	25%	26%	26%	22%	NA	NA
Mental Health Condition	13%	12%	11%	18%	19%	NA	NA
Diabetes	6%	7%	9%	12%	10%	NA	NA
Heart Disease/Condition	6%	9%	7%	12%	8%	NA	NA
Asthma (Current)	9%	8%	8%	11%	9%	10%	10%
	Waukesha					WI	US
Condition Controlled Through Meds, Therapy or Lifestyle Changes	<u>2009</u>	<u>2012</u>	<u>2015</u>	<u>2017</u>	<u>2020</u>	<u>2019</u>	<u>2019</u>
High Blood Pressure	--	96%	98%	98%	97%	NA	NA
High Blood Cholesterol	--	93%	81%	77%	92%	NA	NA
Mental Health Condition	--	94%	98%	97%	99%	NA	NA
Diabetes	--	97%	94%	96%	89%	NA	NA
Heart Disease/Condition	--	94%	87%	91%	93%	NA	NA
Asthma (Current)	--	88%	87%	98%	97%	NA	NA
	Waukesha					WI	US
Physical Activity/Usual Week	<u>2009</u>	<u>2012</u>	<u>2015</u>	<u>2017</u>	<u>2020</u>	<u>2009</u>	<u>2009</u>
Moderate Activity (5 Times/30 Min)	41%	33%	31%	44%	43%	NA	NA
Vigorous Activity (3 Times/20 Min)	33%	28%	31%	37%	40%	NA	NA
Recommended Moderate or Vigorous Activity	53%	47%	46%	56%	57%	53%	51%
	Waukesha					WI	US
Body Weight	<u>2009</u>	<u>2012</u>	<u>2015</u>	<u>2017</u>	<u>2020</u>	<u>2019</u>	<u>2019</u>
Overweight Status	63%	65%	70%	69%	70%	70%	67%
At Least Overweight (BMI 25.0+) [HP2020 Goal: 66%]	63%	65%	70%	69%	70%	70%	67%
Obese (BMI 30.0+) [HP2020 Goal: 31%]	21%	25%	34%	30%	34%	34%	32%
	Waukesha					WI	US
Nutrition and Food Security	<u>2009</u>	<u>2012</u>	<u>2015</u>	<u>2017</u>	<u>2020</u>	<u>2009</u>	<u>2009</u>
Fruit Intake (2+ Servings/Average Day)	68%	65%	65%	67%	61%	NA	NA
Vegetable Intake (3+ Servings/Average Day)	30%	29%	25%	39%	31%	NA	NA
At Least 5 Fruit/Vegetables/Average Day	42%	37%	33%	45%	35%	23%	23%
Household Went Hungry-Couldn't Afford Enough Food (Past Year)	--	--	--	4%	2%	NA	NA
	Waukesha					WI	US
Colorectal Cancer Screenings (50 and Older)	<u>2009</u>	<u>2012</u>	<u>2015</u>	<u>2017</u>	<u>2020</u>	<u>2018</u>	<u>2018</u>
Blood Stool Test (Within Past Year)	--	14%	12%	9%	10%	7%	9%
Sigmoidoscopy (Within Past 5 Years)	10%	4%	6%	7%	5%	3%	2%
Colonoscopy (Within Past 10 Years)	62%	59%	62%	80%	72%	71%	64%
One of the Screenings in Recommended Time Frame [HP2020 Goal: 71%]	66%	60%	65%	83%	75%	75%	70%

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

	Waukesha					WI	US
Women's Health Screenings	2009	2012	2015	2017	2020	2018	2018
Mammogram (50+; Within Past 2 Years)	76%	77%	78%	73%	84%	78%	78%
Bone Density Scan (65 and Older; Ever)	76%	86%	86%	86%	84%	NA	NA
Cervical Cancer Screening							
Pap Smear (18 – 65; Within Past 3 Years) [HP2020 Goal: 93%]	89%	83%	82%	80%	81%	81%	80%
HPV Test (18 – 65; Within Past 5 Years)	--	--	55%	47%	51%	NA	NA
Screening in Recommended Time Frame (18-29: Pap Every 3 Years; 30 to 65: Pap and HPV Every 5 Years or Pap Only Every 3 Years)	--	--	88%	84%	88%	NA	NA
	Waukesha					WI	US
Cigarette Smokers or Vapers	2009	2012	2015	2017	2020	2019	2019
Current Smokers [HP2020 Goal: 12%]	17%	17%	13%	14%	11%	15%	16%
Current Electronic Vapers (Past Month)	--	--	4%	4%	4%	4% ¹	5% ¹
Of Current Smokers/Vapers...						2005	2005
Quit Smoking/Vaping 1 Day or More in Past Year Because Trying to Quit [HP2020 Goal Quit Smoking: 80%]*	58%	45%	55%	67%	55%	49%	56%
Saw a Health Care Professional in Past Year and Advised to Quit Smoking/Vaping*	72%	69%	67%	76%	69%	NA	NA
Exposure to Smoke or Electronic Vapor	Waukesha					WI	US
Smoking Policy at Home	2009	2012	2015	2017	2020	'14-15	'14-15
Not Allowed Anywhere	85%	82%	86%	88%	88%	84%	87%
Allowed in Some Places/At Some Times	7%	8%	6%	3%	3%	NA	NA
Allowed Anywhere	2%	2%	<1%	<1%	2%	NA	NA
No Rules Inside Home	6%	7%	8%	9%	7%	NA	NA
Nonsmokers/Nonvapers Exposed to Second-Hand Smoke/Vapor in Past 7 Days* [HP2020 Goal Nonsmokers: 34%]	26%	10%	8%	7%	8%	NA	NA
	Waukesha					WI	US
Other Tobacco Products in Past Month	2009	2012	2015	2017	2020	2019	2019
Smokeless Tobacco [HP2020 Goal: 0.2%]	--	--	2%	4%	7%	3%	4%
Cigars, Cigarillos or Little Cigars	--	--	3%	4%	3%	NA	NA
	Waukesha					WI	US
Alcohol Use in Past Month	2009	2012	2015	2017	2020	2019	2019
Binge Drinker** [HP2020 Goal 5+ Drinks: 24%]	27%	22%	29%	26%	32%	22%	17%
Driver/Passenger When Driver Perhaps Had Too Much to Drink	2%	3%	<1%	2%	2%	NA	NA
	Waukesha					WI	US
Other Drug Use in Past Year	2009	2012	2015	2017	2020	2019	2019
Cocaine or Other Street Drugs	--	--	--	<1%	2%	NA	NA
Misuse of Prescription Pain Relievers	--	--	--	<1%	<1%	NA	NA
Heroin	--	--	--	0%	0%	NA	NA
	Waukesha					WI	US
Household Problems in Past Year Associated With...	2009	2012	2015	2017	2020	2019	2019
Alcohol	3%	3%	6%	1%	2%	NA	NA
Cocaine, Heroin or Other Street Drugs	--	2%	<1%	2%	1%	NA	NA
Marijuana or THC-Containing Products	--	1%	2%	1%	<1%	NA	NA
Misuse of Prescription Drugs or Over-the-Counter Drugs	--	1%	1%	1%	<1%	NA	NA

--Not asked. NA-WI and/or US data not available. ¹Wisconsin and US current vapers is 2017 data. ²Midwest data.

*In 2020, tobacco cessation, health professional advised quitting and exposure included current smokers and current vapers. In previous years, both questions were asked of current smokers only. **In 2009, binge drinking was defined as 5 or more drinks regardless of gender. Since 2012, binge drinking has been defined as 4 or more drinks for females and 5 or more drinks for males to account for metabolism differences.

	Waukesha					WI	US
	2009	2012	2015	2017	2020	2019	2019
Community and Personal Support							
Times of Distress and Looked for Community Resource Support (Past 3 Years)	--	--	--	18%	13%	NA	NA
Respondents Who Looked for Community Support							
Felt Somewhat/Slightly/Not at All Supported	--	--	--	43%	48%	NA	NA
	Waukesha					WI	US
	2009	2012	2015	2017	2020	2019	2019
Mental Health Status							
Felt Sad, Blue or Depressed Always/Nearly Always (Past Month)	5%	5%	4%	3%	4%	NA	NA
Considered Suicide (Past Year)	4%	2%	4%	4%	3%	NA	NA
Find Meaning & Purpose in Daily Life Seldom/Never	3%	4%	4%	4%	6%	NA	NA
	Waukesha					WI	US
	2009	2012	2015	2017	2020	2019	2019
Personal Safety Issues in Past Year							
Afraid for Their Safety	5%	4%	4%	4%	6%	NA	NA
Pushed, Kicked, Slapped or Hit	4%	1%	3%	5%	2%	NA	NA
At Least One of the Safety Issues	8%	4%	5%	7%	7%	NA	NA
	Waukesha					WI	US
	2009	2012	2015	2017	2020	2019	2019
Children in Household							
Primary Doctor/Nurse Who Knows Child Well and Familiar with History	--	86%	89%	97%	99%	NA	NA
Visited Primary Doctor/Nurse for Preventive Care (Past Year)	--	93%	95%	89%	97%	NA	NA
Did Not Receive Care Needed (Past Year)							
Medical Care	--	3%	4%	2%	4%	NA	NA
Dental Care	--	3%	6%	2%	7%	NA	NA
Specialist	--	3%	1%	<1%	6%	NA	NA
Current Asthma	--	3%	7%	3%	9%	NA	NA
Children 5 to 17 Years Old							
Fruit Intake (2+ Servings/Average Day)	--	75%	86%	67%	79%	NA	NA
Vegetable Intake (3+ Servings/Average Day)	--	30%	26%	27%	26%	NA	NA
5+ Fruit/Vegetables per Average Day	--	36%	48%	47%	47%	NA	NA
Physical Activity (60 Min./5 or More Days/Week)	--	70%	57%	60%	56%	NA	NA
Experienced Some Form of Bullying (Past Year)*	--	18%	14%	14%	10%	NA	NA
Verbally Bullied*	--	18%	14%	14%	9%	NA	NA
Physically Bullied*	--	5%	2%	4%	<1%	NA	NA
Cyber Bullied*	--	3%	4%	1%	3%	NA	NA
	Waukesha					WI	US
	2009	2012	2015	2017	2020	2019	2019
Top County Health Issues							
Coronavirus/COVID-19	--	--	--	--	48%	NA	NA
Illegal Drug Use	--	--	--	41%	31%	NA	NA
Overweight or Obesity	--	--	--	18%	22%	NA	NA
Chronic Diseases	--	--	--	17%	20%	NA	NA
Mental Health or Depression	--	--	--	10%	18%	NA	NA
Access to Health Care	--	--	--	21%	18%	NA	NA
Alcohol Use or Abuse	--	--	--	15%	11%	NA	NA
Cancer	--	--	--	11%	10%	NA	NA
Prescription or OTC Drug Abuse	--	--	--	17%	9%	NA	NA
Violence or Crime	--	--	--	5%	8%	NA	NA
Tobacco Use	--	--	--	5%	7%	NA	NA
Infectious Diseases	--	--	--	3%	5%	NA	NA
Access to Affordable Healthy Food	--	--	--	4%	5%	NA	NA

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

Rating Their Own Health

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

Health Care Coverage

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

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

Health Care Information

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

Health Care Services

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

Routine Procedures

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

Vaccinations

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

Prevalence of Health Conditions

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

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

Physical Health

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

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

Nutrition and Food Insecurity

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

Women's Health

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

Colorectal Cancer Screening

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

Alcohol Use

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

Tobacco Use

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

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

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

Other Drug Use

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

Household Problems

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

Community and Personal Support

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

Mental Health Status

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

Personal Safety Issues

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

Children in Household

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

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

Top County Health Issues

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

Appendix D: 2020 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 2020 by a range of providers, policy-makers, and other local experts and community members (“key informants”). These findings are a critical supplement to the Waukesha County community health needs assessment (CHNA) survey conducted through a partnership between the Ascension Wisconsin, Advocate Aurora Health, Children’s Hospital of Wisconsin, ProHealth Care, and Froedtert & 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 Wisconsin, Advocate Aurora Health, Children’s 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;
- For those five public health issues:
 - Existing strategies to address the issue
 - Barriers and challenges to addressing the issue
 - Additional strategies needed
 - Key groups in the community that hospitals should partner with to improve community health
 - Identification of subgroups or subpopulations where efforts could be targeted
 - Ways efforts can be targeted toward each subgroup or subpopulation; and
- To be responsive to the current conditions during the COVID-19 pandemic, the following additional questions were added to the interview guide:
 - What community needs or gaps have developed since the coronavirus pandemic began?
 - How can health care organizations support the community during this pandemic?
 - What methods of communication and outreach have been successful to reach partners and community members during the pandemic?
 - How would you suggest health care organizations outreach to community partners and members to implement health initiatives?

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

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

Limitations: Forty-one key informant interviews were conducted with 47 respondents in Waukesha County. Some interviews incorporated the views of more than one person from an organization. This report relies on the opinions and experiences of a limited number of experts identified as having the community’s pulse. However, responses may not be representative of the overall perception of

community strengths and needs. It is possible that the results would have been substantially different if a different set of informants had been interviewed. Results should be interpreted with caution and in conjunction with other Waukesha County data (e.g., community health survey and secondary data).

In 41 interviews, a total of 47 key informants were asked to rank the 5 major health-related issues in their county from a list of 15 focus areas identified in the State Health Plan. The five health issues ranked most consistently as a top five health issue for the County were:

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

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

Mental Health

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

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

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

Needed Strategies: More providers, more psychiatry extenders, shorter waiting periods, better access with and without insurance, small group support and counseling, peer support, telehealth appointments, virtual

appointments, “drop in” phone calls and doing more to reach people, health care systems need to be the hubs of services, expand social and emotional wellness supports, more community partnership and collaboration, continued public messaging to decrease stigma around mental illness and better understanding of the issues with less judgement, work with NAMI to identify additional strategies, inpatient facilities in Waukesha County for protective custody, more beds for uninsured mental health patients, more work against bullying in schools, especially related to social media, strategies to address substance use and mental health together, increasing access for businesses to get help from health care organizations on trainings and education, partner with business chambers to get the message out, people need more information and proactive messaging about mental health, more supports for homelessness and joblessness, more community resources for housing, more case management or social services, stronger suicide prevention efforts, better recruitment and retention into behavioral health careers, supports for practitioners to prevent burn out, and being proactive about what we can do to address gaps and be better prepared for a situation like the pandemic in the future are suggestions for strategies that could potentially improve mental health in Waukesha County.

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

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

- Seniors and people with disabilities, especially those who have lost their jobs and cannot afford COBRA, can be reached through social media, mailings, and at places where they already go like senior centers, recreation centers, food pantries, meal programs, medical appointments, and their care givers. There could also be partnerships with assisted living facilities to do education on site.
- Medically underserved populations can be reached through free clinics and Federally Qualified Health Centers and there should be a focus on changing policies so more people can be covered by insurance.
- People experiencing homelessness may need extra support and can be reached where they are at, by outreach programs that already exist or in shelters.
- Youth can be reached through schools, afterschool programs, sports, and other places they spend their time. There is a need to focus on stressors and how they deal with stress to cope and prevent mental health issues. A curriculum taught by mental health professionals would be helpful.
- Men who are experiencing chronic homelessness and mental illness can be reached by working with the Salvation Army and Hebron House as these organizations have the closest contact. There are also street outreach resources. It would be good to have a physical space or walk-in clinic where they could go for help.
- Some key informants suggested it is important to be there for Black people and other people of color to support mental health and address trauma. It is also important to hire staff and mental health professionals who reflect the community served.
- For the Hispanic community it is important to address the stigma around counseling and treatment and address the cultural challenges around mental health. It is also important for organizations to hire more bilingual staff.

- Some key informants mentioned that it affects everyone and there should be community-wide strategies like media messaging to reach everyone with information.

Substance Use and Abuse

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

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

Barriers and Challenges: Key informants named a number of challenges to addressing this issue, including a lack of crisis services or any services outside of 9am-5pm business hours, inpatient care is limited, services and treatment are expensive, it can be hard for people with Medicaid or without health insurance to find treatment options, COVID-19 has made it difficult for people to access services in person and loss of jobs has meant loss of insurance so people may no longer have access to services they need, lack of transportation, lack of follow up after leaving a rehab setting, peer pressure, cultural norms, ease of access to substances, and the social acceptability of alcohol abuse, vaping, and use of other drugs, and on the other hand, the stigma of addiction and use of certain drugs and some perceptions that it is a moral failing, the use of alcohol and drugs to relieve or cope with stress, co-occurring unmanaged mental health issues are masked with substance use, when people are isolated the issue can be hidden, some parents are unaware of the issue and challenges in the county, competing services in the community rather than collaboration or a cohesive approach, and there are siloed approaches in different sectors without anyone “owning” the problem, though the county is a leader there is not enough funding.

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

Key Community Partners to Improve Health: Case workers, hospitals and health systems, non-profit organizations, county resources, public health, health care providers, law enforcement, emergency services, the justice system, legislators, school districts, churches, shelters, mental health care providers, liquor stores, bars, libraries, parks and recreation departments, Sixteenth Street Community Health

Centers, Rogers, Waukesha Memorial, Narcotics Anonymous, NAMI Waukesha, The Women's Center, American Lung Association, Your Choice to Live, Waukesha County Heroin Task Force, Substance Use Advisory Committee, Intoxicated Driver Committee, WisHope Recovery, Waukesha Comprehensive Treatment Center, Addiction Resource Council, Hope Center, Elevate, and Lutheran Social Services were named as the key partners in the community to work on this issue.

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

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

Access to Health Care

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

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

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

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

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

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

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

- People experiencing homelessness could be helped with outreach nurses to provide one-on-one help and with organizations who are already serving this population, like shelters.
- Seniors and people who may be isolated should be reached through partnerships with organizations who are already serving seniors like recreation departments and senior centers to help identify what needs they are seeing. It may also be helpful to do targeted outreach at churches and in medical settings, and conduct focus groups to better understand their needs.
- Low-income people need to be linked to appropriate information and resources and may be reached through apartment managers and schools.
- The Latinx community can be served through Sixteenth Street Community Health Centers and other organizations that support this community and are trusted partners. It is important to deliver linguistically and culturally appropriate messages.
- People who recently lost their jobs and insurance during the pandemic and do not know how to access care could be helped by working with the community organizations who already offer services to help identify what their needs are and what kinds of assistance they might qualify for.

Chronic Disease

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

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

Barriers and Challenges: People need more time and education, there is a need for medication, supplies, and medical care, there are a lack of providers at free clinics, volunteer providers are unable to help during COVID-19, lack of transportation to get to appointments, patients need more support and guidance after diagnosis, health care settings can be stressful and patients are often given a lot of information in a short period of time, there is some uncertainty about root causes of disease and why certain groups are able to manage their health better than others (e.g. gender differences), medical care and prescriptions are very expensive, there is a lack of general awareness and education about chronic disease, culturally there is a lot of confusing information about fad diets, outdated nutrition guidelines, body image issues, and a cultural acceptance of alcohol and unhealthy food consumption, lack of investment of time in preventive measures for wellness, incompatible medical records between health systems, lack of case management and patient outreach, lack of a strong referral network for Medicaid and uninsured patients, and not connecting patients with resources in the community are examples of barriers and challenges to improving health.

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

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

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

- Working parents could be reached at doctors' appointments is providers start conversations at primary care appointments. They can also be reached through social media.
- The age group of 45-65 years with chronic disease need more support than a free clinic can offer, so there should be better connections to case workers.
- Related to congestive heart failure patients, physicians and the medical community need to deliver a comprehensive message from the physician to the scheduler and deliver the message at multiple touchpoints within the care of the patient.
- Diabetic patients, especially men who seem less likely to receive help.
- People who chronically experience homelessness may benefit from bringing medical care to the shelters where they are already. Comorbidities should be addressed together.
- Low income families or those with Medicaid may need support accessing health services and county-level help.
- Seniors who may have trouble leaving home, or in assisted or skilled nursing living situations may need more support and can be reached by working with organizations that support seniors or places seniors are going, such as food pantries.
- Adolescents should receive this health care and education to address it early. They can be reached at schools.
- Cancer support groups.
- Undocumented Hispanic immigrants can use services at Sixteenth Street Community Health Centers as well as screenings in partnership with health systems.
- Adults and the community in general need more education and can be reached with mainstream messaging about healthy lifestyle, a county-wide campaign, outreach nurses, print and video educational materials, parish nurses, and community organizations.

Nutrition

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

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

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

Needed Strategies: Key informants' suggestions are to focus on food insecurity and reaching the most vulnerable, expand mobile food pantries, expand public education on nutrition and cooking and how to do it efficiently/quickly, partner with local restaurants on nutrition education, provide vouchers for farmers markets, provide social opportunities to get people eating together, especially for elderly, deliver nutrition

education to the families of young children to create good habits and engage families, have retired nurses as volunteers at the food pantry help with nutrition education, do more outreach with evidenced-based and research-based programs, and develop more community garden concepts or school gardens.

Key Community Partners to Improve Health: Feeding America, Hunger Task Force, food pantries, senior centers, Meals on Wheels, farmers markets, grocery stores, churches and faith groups, school districts, ADRC, UW-Extension, Waukesha County Nutrition Coalition, Waukesha County Public Health, health care systems, non-profits and community groups focused on this area, and the business community were the key partners identified by respondents.

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

COVID-19

Community needs or gaps that have developed since the coronavirus pandemic: The key themes that emerged from the responses have to do with gaps in information about what to do, lack of access to needed care and services during the pandemic, problems with technology and telehealth services, isolation, loneliness, and related coping methods, gaps in testing, lack of PPE and other supplies, families not having their basic needs met, issues related to employment and job loss, and lack of space.

Information about what to do: Key informants indicated they need information about COVID-19, information about job support, guidance for what precautions to take, information about testing, factual information from trusted sources, and guidance about what the most important messages are to get out to the community, as well as the problems generated by the spread of misinformation and lack of consensus on messages coming from government agencies. This resulted in a loss of trust in public health and government communications that has become a large challenge.

Lack of access to care and services: When everything had first shut down, there was a gap in services before organizations could figure out a process for getting back to providing support and services, some organizations have had to limit the number of patients seen, haven't been able to have volunteers working, have started telehealth appointments, and moved to curbside operations. Several key informants mentioned gaps and losses in mental health supports/ support groups, counseling, and access to care that is necessary at this time. People with chronic conditions have not been tracked and monitored as closely as they normally would have because that wasn't a priority. People have been waiting until things become a crisis to seek care. There are inconsistencies with appointments and rescheduling. Seniors in particular may be experiencing a lack of access to care due to trouble with virtual appointments and fear or anxiety

about in-person appointments. The pandemic has exacerbated issues that already existed accessing care for people who are un- or under-insured or have low income.

Technology and telehealth: Though it has been important to try to return to care virtually for safety reasons, it isn't accessible to everyone. Patients don't have the training or necessary technology to participate in these appointments and some have lost access to care or are waiting for face-to-face services to resume. Lack of access to broadband or the devices needed made it difficult for some students to connect to school and for schools to support students with other health and mental health needs to the level they would have at school in person. For people who are unhoused and do not have steady access to electricity or a variety of devices, it is not accessible.

Isolation and loneliness: In addition to the isolation and loneliness people may be feeling from staying home and having fewer daily interactions, key informants noted this is leading to depression, anxiety, other mental health concerns, substance use, and in some cases, more stress on family relationships that can lead to violence and abuse. Key informants suggested caregivers are feeling unsupported at this time and it is hard for families who have a loved one in assisted living or skilled nursing facilities that they are not able to visit.

Gaps in testing: It was very difficult to get tested for COVID at first, there is a lack of information about testing, there are still some issues with availability, it can take some time to get results back, which can make operations difficult in certain contexts, such as homeless shelters where it can be difficult to figure out who to isolate/quarantine. One key informant mentioned that Froedtert had done a good job of ensuring first responders had access to testing.

Lack of PPE: A couple key informants indicated they did not have enough PPE at some point since the pandemic began.

Families not having basic needs met: Several key informants mentioned there is an increase in people and families experiencing food insecurity, transportation difficulties, lack of money for gas, and needing more economic supports in general. There have been a reduction in food pantry donations, volunteers can't work with the public when they are concerned about the pandemic, and it is harder to meet needs for specific food items (e.g. for people with allergies or on specific diets related to chronic disease). FoodShare can help families get food, but not other necessities like paper products, shampoo, etc.

Issues related to employment: A lot of people have lost jobs, had hours reduced, had furloughs, or had to take other jobs that pay less or do not provide the level of protection from the pandemic that some jobs have. For caregivers who also continue to be employed, there is a gap in childcare while children cannot go to schools or childcare providers. For families who have newly had job loss or reductions of income, there is a gap in knowledge about how to access support services and resources available to them. People have lost their health insurance coverage that is tied to employment, and don't know where to turn for care. Businesses are also experiencing some gaps in information about what protocols they should be putting in place for safety.

Lack of space: Three key informants named lack of space as an issue during the pandemic, particularly for sheltering people experiencing homelessness, but also for social services programming to continue when operations have to be in person, but there isn't enough room to safely physically distance.

Other: Some of the gaps key informants mentioned did not fit in with these themes, such as the politics at the state and national levels have made conditions more difficult, people are on edge dealing with social issues, the pandemic has created conditions where they are seeing elder financial abuse, long-term care is

lacking supervision on a state level and visitation, and care coordination for vulnerable populations is an emerging need that is putting more pressure on free clinics.

Ways health care organizations can support the community during this pandemic: Key informants' responses discussed how health care organizations can be a hub for resources, trusted information, and messaging about the pandemic, they can share equipment and supplies, continue offering telehealth services, increase access to care and take on new patients, collaborate with other sectors, and work on testing. One suggestion that is cross-cutting across all these ideas is focusing on racial equity.

Sharing trusted information and messaging: Key informants suggested health care organizations are trusted in the community and people look to them for information. As such, it could be helpful for them to serve as a hub for resources and access, have one number to call to get answers, share knowledge about what is available, sharing messaging and education about the pandemic as well as wellness checks and immunizations in general, help people understand testing and where they can go to get it, provide vetted information and facts from reliable sources like the Centers for Disease Control and Prevention (CDC), work with schools on guidelines to follow and mitigation strategies when students don't follow through with guidelines, promote resources available at free clinics, bring more solutions to the public, and communicate about what exists. There were a few key informants who emphasized the need for health care organizations to mitigate the misinformation that is being spread about COVID and be the experts giving instructions, providing expertise, collaborating with public health to be on the same page in terms of messages and data and not work in silos, encouraging best practices in the community, and advising businesses and employers on what to do to keep their employees and customers safe. Consistent messaging is important, so when there are new recommendations based on emerging data, communicate about it transparently to patients and the public.

Share equipment and supplies: Key informants suggested they might need help getting PPE and cleaning supplies for their organizations and if larger health care organizations can help financially, or with donations or assistance obtaining supplies, or sharing spaces that aren't being used with community organizations, that can be very helpful in keeping smaller organizations operational.

Telehealth services: Health care organizations can help by using telehealth visits and assisting with access to these services.

Increasing access to health services: It would be helpful for health care organizations to increase access to care, especially for families who have lost services since the pandemic began, continue to provide access to preventive care, offer services at community-based facilities, and provide nurses to help in the community. The most frequently requested service is helping people access mental health and substance abuse services during this time when needs are high, and people already had trouble accessing this kind of care prior to the pandemic. There might be a particular need for behavioral health access among children.

Collaboration: Some key informants shared that it is important for health care organizations to collaborate with other organizations in the community, specifically on sharing data about the pandemic with public health, finding ways to increase services to vulnerable populations, meeting with other organizations to improve community partnerships and connections, working on community issues, and being a consistent presence to follow through on plans, and partnering with school districts' leadership to benefit the health of the community.

Testing: Key informants believe there is a great need for community COVID testing, especially for low income residents, seniors, and in more rural areas. The county needs more consistency in how testing is done, drive through testing sites, testing at places like food pantries, and schools need faster access to COVID test results.

Methods of communication and outreach that have been successful to reach partners and community members during the pandemic: Key informants reported communicating electronically through email, social media, texting, and messaging apps, telehealth platforms, phone calls and voice messages, word of mouth and face-to-face interactions, more traditional communications like mailings, flyers, newsletters, and traditional mass media such as TV and newspapers. Most reported using a variety of these methods. Across all of these types of communication, they mentioned the importance of timely and accurate messages.

Electronic and web-based communications: Key informants reported communicating with their patients, clients, and community members through Facebook Messenger, their own Facebook page, other social media, emails, texting, online newsletters, virtual conferences, advertising on phones (ads in games on phones), posting resources on their websites, standing meetings on Zoom, web-based calling, Canvas for online learning, webinars, and Constant Contact newsletters. Some mentioned virtual meetings have made it easier to get together than before. Though several key informants mentioned using social media and finding it effective at reaching people, some cautioned against it because people who are not as connected to technology may miss out on the message.

Telehealth: Telehealth and telephonic appointments are available for medical and behavioral health visits, but it is important to remember that patients may not have access or may need support to access these appointments.

Phone calls: The phone is commonly used to stay connected. Phone outreach to clients, members, participants, and patients keep people connected and helps with feelings of isolation for some people, weekly calls, voice messages, following up over the phone, having a hotline, sending people messages and giving them a number to call back, voice mail reminders, and continuing to call and leave messages with persistence to connect people to the resources they need are examples of how organizations are using phone communication during the pandemic.

Mailings, flyers, newsletters: Printed materials are helpful to disseminate information to staff and then they can pass it along to patients, clients, and community members. Key informants mentioned using printed materials, monthly or quarterly newsletters that are sent out, printable guidance or flow charts from CDC and other trusted sources, pictures and visuals and humor are helpful for people, flyers advertising resources such as 211 or the food pantries' phone numbers and hours, materials to hand out to people during curbside pick up services, mailings with Medicaid HMOs, and printed resources that can be picked up in the community are examples of how this method is used.

Word of mouth and face-to-face: Key informants mentioned word of mouth being an effective communication tool, as well as board meetings, face-to-face meetings, personal contact from schools to students and families, committees working on outreach at the food pantry, updates that come from professionals set an example for the community, encouraging people to check in with their own employees, families, neighbors, and friends, Aurora Health Care's steering committee municipal updates, live Q & A sessions, and providing a case manager role to support families and be a presence in the community where ever people are (schools, community centers, etc.) in case they are not ready to reach out on their own are communication strategies that have been helpful.

TV, newspapers, mass media: Key informants reported using mass media strategies such as TV screens that have scrolling announcements and provide information about community resources, public service announcements, television statements, news broadcasts, newspapers, and radio to communicate messages.

Accurate and timely information: Across all of these strategies, key informants noted it is important for messages to come from a trusted source and to have standard messaging that reaches the entire community. It has to be timely, factual, and non-threatening.

Other: Other ways key informants mentioned they reach out to the community are through surveys of families and through their registration processes. Two people suggested that articles coming from health care organizations to the community could be helpful and referenced articles coming from the Medical College. State level daily briefings have been helpful for coordination between emergency medical systems and health care. One respondent suggested an impact team collaboration for health systems, the county, and other stakeholders to manage the pandemic moving forward.

Suggestions for how health care organizations can reach out to community partners and members to implement health initiatives: Some key informants provided specific methods that could be used, some focused on meeting with people to build partnership and the importance of collaborating, some focused on helping with access to care, sharing information and being a trusted source, and some suggestions were about testing.

Methods of outreach: Key informants suggested outreach through social media (Facebook), first responders, messages in bus shelters, electronic communication, TV messages, Menomonee Falls village newsletter, cable access, Zoom meetings, phone calls, Google Meet, short video messages, information that people can look up on their smart phone, letters, and home visits. Some emphasized the importance of tailoring the method to your audience because virtual and online communications are fast and accessible, but only for people who are online. It misses those without electricity, internet, access to technology, or barriers to using technology. One respondent suggested making online communications easier to understand for those who are newer to the internet.

Partnerships and collaboration: Health care organizations should meet face-to-face (or through virtual meetings) with community organizations, hear the voices of smaller providers, hear what is happening in the community, have small groups meetings to network and talk through issues, reach out to the appropriate staff or leaders in an agency that are empowered to make things happen, partner with school districts to bring services onsite, reach out to non-profit organizations, include more people to get more ideas, have public events when it is safe to do so again, work with the chambers of commerce to provide education to businesses, create partnerships with community-based organizations so they can spread your message to the people they work with in the community, personally meet with key stakeholders outside of large events, partner with community health centers to bring testing, technology, education, PPE, and bulk supply buying options or price sharing to meet the higher patient demands at this time, be consistent and show transparency and follow through in collaboration with partners, be explicit about roles and designate people to be a point of contact and make connections in partnerships, organize Zoom meetings to bring leaders together, continue to partner with public health, coordinate efforts, clarify expectations, and participate in collaborative groups that are already meeting like the Mental Health Advisory Committee, the local Continuum of Care, Crisis Intervention Training, Community Collaborative, and the Heroin Task Force. It was noted that ProHealth is involved, but others could also be to allow for more resource sharing and improved access.

Access to care: Key informants suggested health care organizations can help with access to care by having Zoom meetings with community partners to explain what services are available through the community that can meet the mental health needs of the community, offering mental health services to help the underserved, work on stigma reduction around mental health, expand urgent care hours, go to where people are, increase transportation options to services, address daycare options for patients, have broader hours and a “help line,” hire a liaison who is in the clinic area that is connected to resources,

community health navigators are needed, offer services like flu shot clinics to organizations, reduce duplication of services, and look into outreach strategies.

Sharing information: Keep information up to date, give organizations suggestions, information packets, advise organizations what they can do safely within the current restrictions, continue to provide information on safety precautions, and make assessments for what patients can do to address COVID concerns.

Testing: It was suggested health care organizations should continue to offer more COVID testing, support organizations doing testing, offer drive up testing, and be part of an impact team to manage testing and vaccines as we move forward.

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

- Waukesha County Department of Health and Human Services, Public Health Division – Government department that prevents disease and promotes health
- Waukesha Free Clinic– Free medical clinic for uninsured
- YMCA at Pabst Farms – Nonprofit providing services that help people improve their health and well-being

Appendix F: 2020 Waukesha County Health Needs Assessment: A Summary of Secondary Data Sources

The Waukesha County Health Needs Assessment: A Summary of Secondary Data Sources Report is available at <https://www.froedtert.com/community-engagement>

In 2020, 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 (2020), the county level data from the rankings report is included in its entirety at the end of this report.

All of the data used in this report come 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 in this report. 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
- US Census Bureau Census 2000
- Wisconsin Department of Children and Families

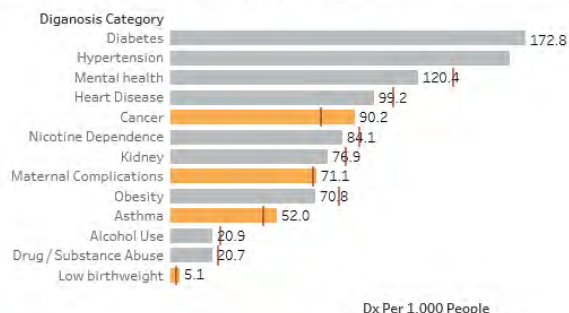
Partners & Contracts: This report was commissioned by Ascension Wisconsin, Advocate Aurora Health, Children’s Hospital of Wisconsin, ProHealth Care, and Froedtert & Medical College of Wisconsin in partnership with the Center for Urban Population Health and Waukesha County Public Health Division. The report was prepared by the Center for Urban Population Health, a partnership of Aurora Health Care/Aurora Research Institute, LLC, the University of Wisconsin-Milwaukee, and the University of Wisconsin School of Medicine and Public Health.

Community Health Needs Dashboard

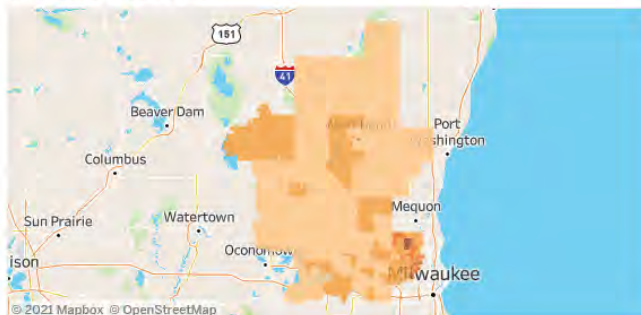
The Wisconsin Hospital Association (WHA) Information Center created a Community Health Needs Assessment (CHNA) Mapping Tool to allow hospitals, and community partners, the opportunity to identify areas of need in their community by analyzing clinical conditions and community characteristics. Using data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

Clinical Conditions

How much more than the statewide average have people in your service area been given diagnoses in these categories?

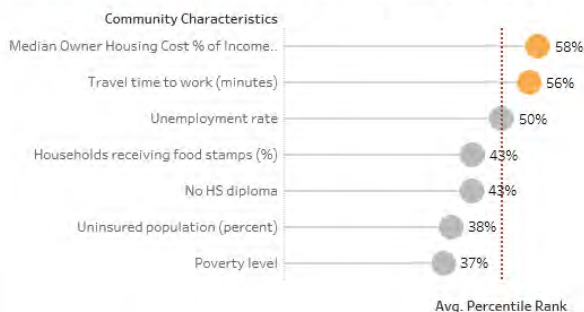


Where are the **most occurrences** of Diabetes diagnoses per 1,000 people?

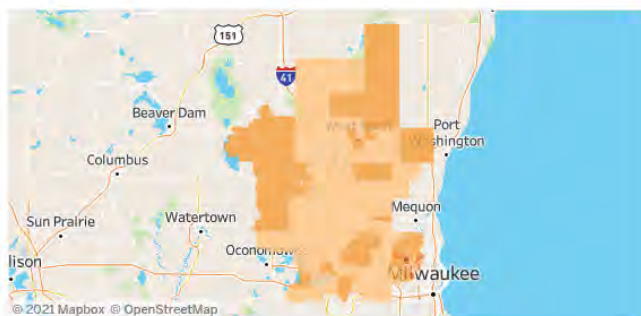


Community Characteristics

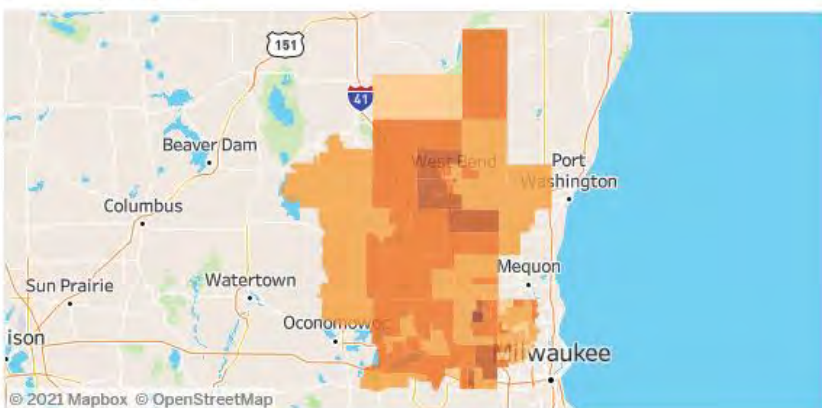
How far above 50% is the average percentile rank of your service area for these community characteristics?



Where are the **highest levels** of Median Owner Housing Cost % of Income Est?



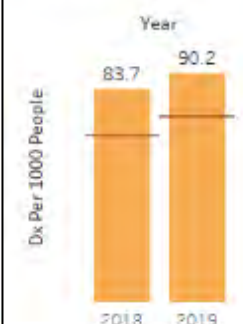
Where are the **most occurrences** of Cancer diagnoses per 1,000 people?

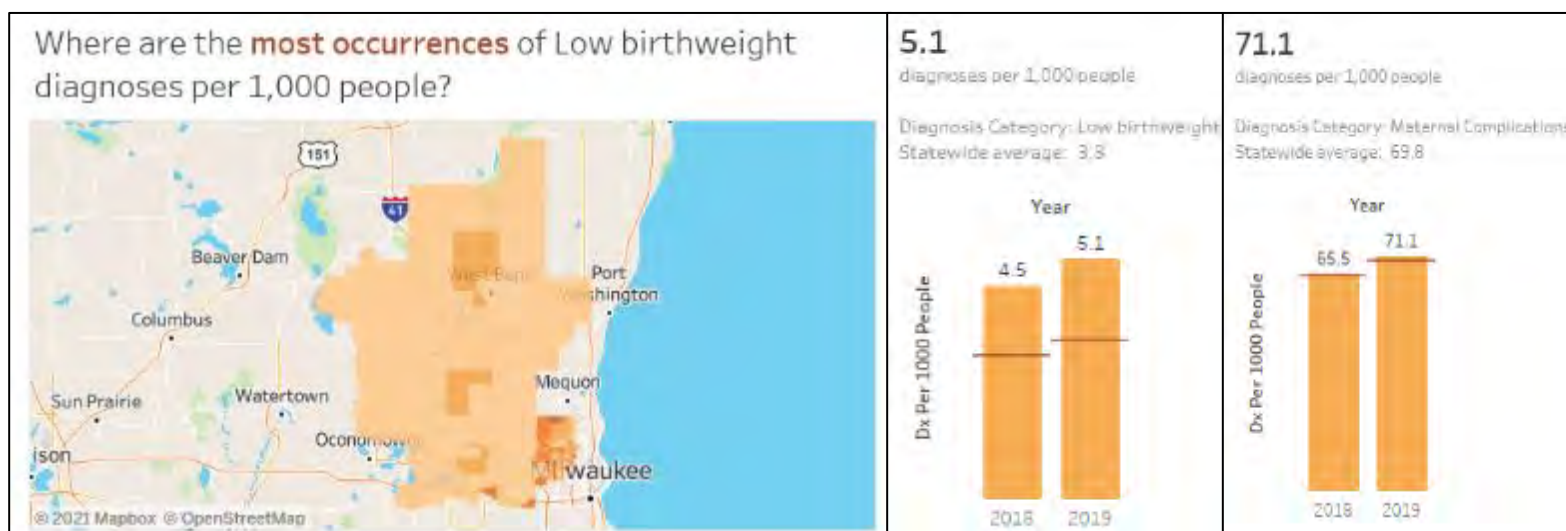
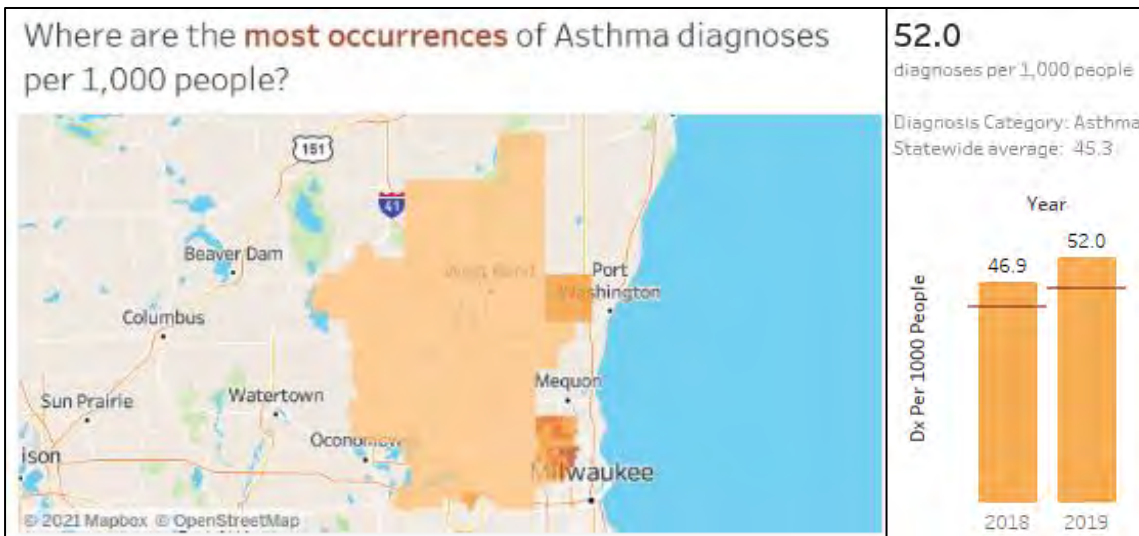


90.2

Diagnoses per 1,000 people

Diagnosis Category: Cancer
Statewide average: 73.2





Where are the **highest levels** of Median Owner Housing Cost % of Income Est?



Appendix G: Review of the Fiscal Year 2019-2021 Froedtert Menomonee Falls Hospital CHNA Implementation Strategy

Identified Need	Program	Actions	Outcomes
Access to Health Services and Navigation of Community Resources Chronic Disease Prevention and Management Mental Health/AODA	Community Outreach Health Clinic	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 2,419 medical patient visits 255 new patients 88 specialty referrals 2,593 ancillary services (laboratory tests, cardiology and radiology procedures) 4,232 medications dispensed 297 behavioral health screenings (psychiatrist visits and counseling/AODA visits) 278 counseling/case management
Access to Care and Navigation Chronic Disease Prevention and Management	Froedtert Menomonee Falls Hospital Family Medicine Residency Program	<ul style="list-style-type: none"> Provide access to care with family practice residents Provide paths to improve access to underserved populations in Waukesha and Washington County 	<ul style="list-style-type: none"> 23,271 patient visits Free skin cancer and depression screenings Mega Colon and colon cancer education and outreach at Wheeling for Healing Educated clients about important health numbers at the Sussex Area Outreach Services and Menomonee Falls Food Pantries Provided education on exercise and mental health during the Fit in the Parks program Promoted the career choice of being a Family Medicine Doctor at a Health Care Career Expo and participated in career exploration tours at Froedtert Menomonee Falls Hospital
Access to Health Services and Navigation of Community Resources	Waukesha County Community Dental Clinic – Menomonee Falls	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 5,724 dental appointments 10,185 preventative appointments 4,734 restorative appointments 20,681 dental procedures 1,976 unique patient visits 1,047 emergency exams \$1,449,847 value of care
Chronic Disease Prevention and Management – Cancer	Cancer Care Navigation, Awareness, Prevention	<ul style="list-style-type: none"> Dedicated navigator working with patients receiving care in the FMF Cancer Center and provide assessment and referrals for health system and community resources 	<ul style="list-style-type: none"> 23 colonoscopies provided to uninsured patients 58 individuals screened for skin cancer

Obesity, Nutrition and Physical Activity	and Screenings – Froedtert Menomonee Falls Hospital Cancer Center	<ul style="list-style-type: none"> • 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.) Execute quarterly cancer awareness and education events (classes, health fairs, events etc.) 	<ul style="list-style-type: none"> • 219 cancer-related community education class participants • 342 health topic presentation participants • 114 Be Strong Stay Strong participants • 66 underserved clients worked with the Oncology Social Worker and Cancer Navigator
Chronic Disease Prevention and Management Obesity, Nutrition and Physical Activity	Community Health Education and Outreach Programs (Living Well Series, Service Line Outreach and Support Groups)	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 76 community education classes with 1,317 participants • 137 participants screened for heart related conditions • 234 participants screened for blood pressure • Over 1,000 individuals served through the Fit in the Parks program • Participated in the development and distribution of the Harvest of the Month program
Mental Health/Alcohol and Other Drug Abuse	Partnership – Community Based Mental Health/AODA Coalitions	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 1,170 pounds of unused medications collected at Froedtert Menomonee Falls Hospital with a total of 4,036 for Waukesha County • Over 4,000 lives touched through Impact for Life and educational programs • 297 behavioral health screenings (psychiatrist visits and counseling/AODA visits) at Community Outreach Health Clinic • 278 counseling/case management at Community Outreach Health Clinic • Supported the Opiate Action Team through the Waukesha County CHIPP Coalition