Community Health Needs Assessment (CHNA) Report

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

Froedtert Menomonee Falls Hospital

Fiscal Year 2025
Effective July 1, 2024

Approved on 05/23/2024 by
Froedtert Menomonee Falls Hospital
Board of Directors
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Executive Summary

Community Health Needs Assessment for Froedtert Menomonee Falls Hospital

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

To produce this CHNA, Froedtert Menomonee Falls Hospital utilized data from the 2023 Waukesha County Community Health Needs Assessment (CHNA).

Every three years, Froedtert Health, Ascension Wisconsin, ProHealth Care, Aurora Health Care and the Waukesha County Public Health Department align resources to participate in a robust, shared Waukesha County CHNA data collection process. Supported by additional analysis from JKV Research, LLC, the CHNA includes findings from a community health survey, informant interviews, a compiling of secondary source data and internal hospital data. The data helps inform an independent CHNA specific to Froedtert Menomonee Falls Hospital’s service area and community health needs. The independent CHNA serves as the basis for the creation of an implementation strategy to improve health outcomes and reduce disparities in Froedtert Menomonee Falls Hospital service area.

The CHNA was reviewed by the Froedtert Menomonee Falls Hospital CHNA/Implementation Strategy Advisory Committee (Appendix A), which consists of members from the hospital Board of Directors, Community Outreach Steering Committee, Waukesha County community partners, the Waukesha County Public Health Department and hospital and health system leadership and staff. Committee members were selected based on their specific knowledge of health needs and resources in Waukesha County for a collective analysis of the CHNA findings. Under the direction of the Department of Community Engagement’s leadership team, assessment findings were categorized and ranked to identify the top health needs of the Froedtert Menomonee Falls Hospital service area.

Following the review of the CHNA, an implementation strategy was developed, identifying evidence-based programs and allocating resources appropriately. Froedtert Menomonee Falls Hospital Community Engagement leadership and staff will regularly monitor and report on progress toward achieving the implementation strategy’s objectives. They also will provide quarterly reports to the Community Outreach Steering Committee and the health system’s Community Engagement Steering Committee. Additional progress on the Implementation Strategy will be reported annually through the hospital’s IRS Form 990 Schedule H filing and other reporting sources associated with strategic partners and community coalitions.
Froedtert 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
The Froedtert & the Medical College of Wisconsin health network advances the health of the people of the diverse communities we serve through exceptional care enhanced by innovation and discovery.

Froedtert Menomonee Falls Hospital 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 71.6% 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 Froedtert Menomonee Falls Hospital total service area consists of 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).
Froedtert Menomonee Falls Hospital Primary Service Area Demographics

Age – The Froedtert Menomonee Falls Hospital total service area has a comparable age distribution to the Milwaukee Five-County area. The 20 – 34 age group is slightly smaller in the Froedtert Menomonee Falls Hospital total service area with 24.6% of population while the Five-County area 20 – 34 age group is 25.1% of the population.

![2023 Age Distribution](image)

Race – The racial distribution in the Froedtert Menomonee Falls Hospital total service area is predominantly Caucasian (69.5%). Froedtert Menomonee Falls Hospital total service area is similar to the Five-County area in diversity; 18.1% of the population is African American and 12.4% of the population identify as another race or two or more races.

![2023 Racial Distribution](image)
**Household Income** – Households with income less than $50,000 account for 29.7% of the distribution in the Froedtert Menomonee Falls Hospital total service area. Within the Milwaukee Five-County area, 35.0% of households have income less than $50,000.

![2023 Household Income](chart)

**Payer Mix** – For adult inpatients, the Froedtert Menomonee Falls Hospital total service area has 18.1% Medicaid and Self Pay payers. The Milwaukee Five-County area has 20.7% Medicaid and Self Pay in the payer mix.

![FY2023 Adult Inpatient Payer Mix- Total Charges](chart)

*Milwaukee Five-County Area: Milwaukee, Ozaukee, Racine, Waukesha, Waukesha*
Community Health Needs Assessment Process and Methods Used
In 2023, 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 assessed the health needs of the communities it serves through a comprehensive data collection process from a number of key sources. Data and research included information from community members, public health officials, community leaders/experts and non-profit organizations representing vulnerable populations in our service area. The following information/data sources were collected and taken into consideration for assessing and addressing community health needs:

Community Health Survey: Froedtert Menomonee Falls Hospital and community partners collaborated on a phone and online survey of 888 residents. The full survey report can be found at Froedtert Menomonee Falls Hospital Community Engagement.

Key Stakeholder Interviews: Froedtert Menomonee Falls Hospital Community Engagement team and leaders conducted 30 phone interviews with leaders of various school districts, non-profit organizations, health and human service departments and businesses. A list of organizations can be found in Appendix H. The full key stakeholder interview results can be found at Froedtert Menomonee Falls Hospital Community Engagement.

Secondary Data Report: Utilizing multiple county and community-based publicly available reports, information was gathered regarding: mortality/morbidity data, injury hospitalizations, Waukesha County Health Rankings, public safety/crime reports and socio-economic/social driver data.

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

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

Data Collection Collaborators
Froedtert Menomonee Falls Hospital completed its 2023 data collection in collaboration with multiple community organizations serving Waukesha County. These organizations were heavily involved in identifying and collecting the data components of the CHNA:

- Ascension Wisconsin
- Aurora Health Care
- ProHealth Care
- Froedtert Health
- Waukesha County Health Department
- JKV Research, LLC was commissioned to support report preparation for the 2023 shared Waukesha County data collection process.
Community Health Needs Assessment Solicitation and 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 August to November 2023 on the significant health needs of the Froedtert Menomonee Falls Hospital 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 Stakeholder 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 and organizations that serve low-income and underserved populations. A list of key stakeholders can be found in Appendix H. These local partnering organizations also invited the stakeholder to participate in and conducted the interviews. The interviewers used a standard interview script that included the following elements:

Social Determinants of Health:
- Top Rank, Second Rank
- What populations in our communities are most affected by this issue? How are they affected?
- What are the existing strategies and stakeholders to address the health issue? What is working well?
- If your organization works in this space, what is the best way that public health or health care organizations can support you?
- How has COVID-19 impacted this issue?

Health Conditions/Behaviors:
- Top Rank, Second Rank
- What populations in our communities are most affected by this issue? How are they affected?
- What are the existing strategies and stakeholders to address the health issue? What is working well?
- What additional strategies are needed to address this issue? What is keeping our community from doing what needs to be done to improve this issue?
- If your organization works in this space, what is the best way that public health or health care organizations can support you?
- How has COVID-19 impacted this issue?

Additional Questions/Comments:
- How would you suggest organizations reach out to community members to implement health initiatives?
- Do you have any additional comments you would like to share?

Underserved Population Input: Froedtert Menomonee Falls Hospital is dedicated to reducing health disparities. Gathering input from community members who are medically underserved, from low-income and minority populations, and/or from organizations that represent those populations, is important in addressing community health needs. With that in mind, Froedtert Menomonee Falls Hospital gained input from:
- Community Health Survey: When appropriate, data was stratified by gender, age, education household income level and marital status.
- Key Stakeholder Interviews: The key stakeholder interviews included input from members of organizations representing medically underserved, low-income and minority populations.

Summary of Community Member Input

The top five Waukesha County health issues/behaviors and social needs ranked most consistently or most often cited in the community health survey and by key stakeholders were:
Prioritization of Significant Health Needs

Froedtert Menomonee Falls Hospital, in collaboration with community partners and JKV Research, LLC, analyzed secondary data of several indicators and gathered community input through online and phone surveys and key stakeholder interviews to identify the needs in Waukesha County. Based on the information from all the CHNA data collection sources, the health needs were identified as:

- Mental Health and Access to Mental Health Services
- Alcohol Use and Substance Use
- Chronic Diseases
- Obesity
- Safe and Affordable Housing
- Economic Stability and Employment
- Accessible and Affordable Health Care

The CHNA was reviewed by the Froedtert Menomonee Falls Hospital CHNA/Implementation Strategy Advisory Committee (Appendix A), which consists of members from the hospital Board of Directors, Community Outreach Steering Committee, Waukesha County community partners, the Waukesha County Public Health Department and hospital and health system leadership and staff. Committee members were selected based on their specific knowledge of health needs and resources in Waukesha County for a collective analysis of the CHNA findings. Under the direction of the Department of Community Engagement leadership team the planning process included four steps in prioritizing Froedtert Menomonee Falls Hospital’s significant health needs:

1. Review the 2023 Community Health Needs Assessment results for identification and prioritization of community health needs.
3. Rank and selected priority areas.
4. Brainstorm contributing and restricting factors and root causes that impact community health needs.

During a facilitated workout session in February 2024, members of the CHNA/Implementation Strategy Advisory Committee were asked to rate each health need based on the following criteria, to identify the significant health needs:
• **Alignment**: the degree to which the health issue aligns with Froedtert Health’s mission and strategic priorities.
• **Feasibility**: the degree to which the hospital can address the need through direct programs, clinical strengths and dedicated resources.
• **Partnerships**: the degree to which there are current or potential community partners/coalitions.
• **Health Equity**: the degree to which disparities exist and can be addressed.
• **Measurable**: the degree to which measurable impact can be made to address the issue.
• **Upstream**: the degree to which the health issue is upstream from and a root cause of other health issues.

Based on those results, three overarching significant health needs were identified as priorities for Froedtert Menomonee Falls Hospital’s Implementation Strategy for fiscal 2025-2027:

- Mental Health
- Substance Use
- Chronic Disease

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

**Approval of Community Health Needs Assessment**
The completed Community Health Needs Assessment (CHNA) report was adopted by the Froedtert Menomonee Falls Hospital Board of Directors on 05/23/2024 and made publicly available on 05/24/2024.

**Summary of Impact from the Previous Implementation Strategy**
An abridged version of the results and evaluation of the impact of actions taken to address the significant health needs identified in Froedtert Menomonee Falls Hospital’s prior CHNA can be found in Appendix K of this CHNA. A copy of the complete prior CHNA can be found on Froedtert Menomonee Falls Hospital website at [Froedtert Menomonee Falls Hospital Community Engagement](https://www.froedtert.com/contact).

**Public Availability of Community Health Needs Assessment and Implementation Strategy**
After adoption of the CHNA Report and Implementation Strategy, Froedtert Menomonee Falls Hospital publicly shares both documents with community partners, key stakeholder, hospital board members, public schools, non-profits, hospital coalition members, the Waukesha County Public Health Department and the general public. Documents are made available via email, hard copies are made available at applicable meetings, and electronic copies are made available by PDF for download on [Froedtert Menomonee Falls Hospital Community Engagement](https://www.froedtert.com/contact).

Feedback and public comments are always welcomed and encouraged. Use the contact form on the Froedtert & the Medical College of Wisconsin health network website at [https://www.froedtert.com/contact](https://www.froedtert.com/contact), or call Froedtert Health, Inc.’s Community Engagement leadership/staff at 414-777-3787. Froedtert Menomonee Falls Hospital received no comments or issues with the previous Community Health Needs Assessment Report and Implementation Strategy.
# Appendix A: Froedtert Menomonee Falls Hospital CHNA/Implementation Strategy Advisory Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
<th>Hospital Affiliation</th>
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<tr>
<td>Desirae Bartos</td>
<td>Administrative Fellow</td>
<td>Froedtert Health</td>
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<tr>
<td>Carrie Booher</td>
<td>Business Development Executive</td>
<td>PS Companies</td>
<td>FMFH Board</td>
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<tr>
<td>Matt Carran</td>
<td>Director of Community Development</td>
<td>Village of Menomonee Falls</td>
<td>COHS Board</td>
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<tr>
<td>Brad Christianson</td>
<td>Business Development Executive</td>
<td>Ernst &amp; Young, LLP</td>
<td>FMFH Board</td>
</tr>
<tr>
<td>Michael DeGere, DPM</td>
<td>VP/CHD Medical Affairs &amp; Chief Medical Officer</td>
<td>Froedtert Health</td>
<td>COSC</td>
</tr>
<tr>
<td>Kwanza Devlin, MD</td>
<td>MD, FAAFP, Program Director, FMFH Family Medicine Residency Program</td>
<td>Froedtert Health</td>
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<tr>
<td>Andy Dresang</td>
<td>Executive Director, Community Engagement</td>
<td>Froedtert Health</td>
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<tr>
<td>Caitlin Dunn</td>
<td>Executive Director, Population Health and Care Coordination</td>
<td>Froedtert Health</td>
<td></td>
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<tr>
<td>Diane Ehn</td>
<td>VP/FH Post Acute Care</td>
<td>Froedtert Health</td>
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<tr>
<td>Allen Ericson</td>
<td>President, CHD/FWBH</td>
<td>Froedtert Health</td>
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<tr>
<td>Andres Gonzalez</td>
<td>Vice President, Community Engagement &amp; Chief Diversity Officer</td>
<td>Froedtert Health</td>
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<tr>
<td>Dessa Johnson</td>
<td>Director Emerging Markets &amp; Inclusion</td>
<td>Froedtert Health</td>
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<tr>
<td>Ben Jones</td>
<td>Health Officer/Public Health Manager</td>
<td>Waukesha County Department of Health and Human Services</td>
<td>COSC</td>
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<tr>
<td>Mark Lodes, MD</td>
<td>VP/FH Medical Education &amp; CMO Population Health</td>
<td>Froedtert Health</td>
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<tr>
<td>Bethany Lopresti</td>
<td>Executive Director Behavioral Health</td>
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<tr>
<td>Teri Lux</td>
<td>President, FMFH &amp; COO, CHD</td>
<td>Froedtert Health</td>
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<tr>
<td>Tami Martin</td>
<td>Director Workforce Development</td>
<td>Froedtert Health</td>
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<tr>
<td>Deb McCann</td>
<td>Executive Director Patient Care Services</td>
<td>Froedtert Health</td>
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<tr>
<td>Paul Mielke</td>
<td>Superintendent</td>
<td>Hamilton School District</td>
<td>COSC</td>
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<td>Lula Miller-Mays</td>
<td>Manager</td>
<td>Northwestern Mutual</td>
<td>COHS Board</td>
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<tr>
<td>Patricia Nimmer</td>
<td>Director, Community Outreach and Partnerships</td>
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<tr>
<td>Pam Parker</td>
<td>Community Representative</td>
<td>COHS Board</td>
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<tr>
<td>Robert Ramirez</td>
<td>Director, Community Health</td>
<td>Froedtert Health</td>
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<tr>
<td>Renee Ramirez</td>
<td>Chief Executive Officer</td>
<td>Community Smiles Dental</td>
<td>COSC</td>
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<tr>
<td>Mandie Reedy</td>
<td>Program Coordinator, Community Engagement</td>
<td>Froedtert Health</td>
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<td>Rick Rosser</td>
<td>Chief Executive Officer</td>
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<tr>
<td>Payal Shah</td>
<td>Optometrist</td>
<td>Lenscrafters</td>
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<tr>
<td>Cindy Simons</td>
<td>President &amp; CEO</td>
<td>Forward Careers, Inc.</td>
<td>FMFH Board</td>
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<tr>
<td>Laqunda Smith</td>
<td>Supervisor Clinical Support Services</td>
<td>Froedtert Health</td>
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<tr>
<td>Kelly Stueber</td>
<td>Director of Clinical Operations CP, VP Patient Care</td>
<td>Froedtert Health</td>
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<tr>
<td>Kara Waggoner</td>
<td>VP/CHD Business Operations</td>
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<tr>
<td>Amanda Wisth</td>
<td>Manager, Community Engagement</td>
<td>Froedtert Health</td>
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<tr>
<td>Brynn Wozniak</td>
<td>Outreach Clinic Volunteer</td>
<td>Froedtert Health</td>
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Appendix B: Disparities and Health Equity

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

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

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

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

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

**Health Disparities**
Identifying health disparities and barriers to good health are important components in assessing community health needs. Once identified, understanding upstream policies, systems, and social determinants that drive health disparities can help create practical, community-driven solutions that support individual and community health improvement. Analysis by race and place is utilized throughout the shared 2023 Waukesha County CHNA.

National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes in communities of color, low-income populations and for LGBTQ+ individuals. Health disparities in these and other vulnerable populations described in the shared 2023 Waukesha County CHNA are informed by both community input (primary data) and health indicators (secondary data).
Appendix C: 2023 Waukesha County Community Health Needs Assessment: Community Health Phone Survey

The Waukesha County Community Health Needs Assessment survey results are available at [Froedtert Menomonee Falls Hospital 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 phone survey are provided in the Waukesha County Community Health Needs Assessment ([Appendix D](#)). The purpose of this project is to provide Waukesha County with information from an assessment of the health status of county 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 2030 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, including 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=180). 2) A cell phone-only sample where the person answering the phone was selected as the respondent (n=220). At least eight 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 Aug. 19 and Oct. 19, 2023.

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 random child in the household).

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

**Partners & Contracts:** This report was commissioned by Ascension Wisconsin, Aurora Health Care, ProHealth Care, Froedtert Health and the Waukesha Ozaukee Public Health Department in partnership with JKV Research, LLC.
Appendix D: 2023 Waukesha County Community Health Phone Survey Results

**Executive Summary**

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

<table>
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<th>Waukesha</th>
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<th>US</th>
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<tr>
<td>Excellent/Very Good</td>
<td>2012: 64%</td>
<td>2014: 57%</td>
<td>2015: 60%</td>
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<td>Good</td>
<td>2012: 25%</td>
<td>2014: 33%</td>
<td>2015: 25%</td>
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<td>Fair or Poor</td>
<td>2012: 10%</td>
<td>2014: 11%</td>
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<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmet Need/Care in Household</td>
<td>2012: 8%</td>
<td>2014: 8%</td>
<td>2015: 11%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Economic Hardships</th>
<th>Waukesha</th>
<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household Went Hungry (Past Year)</td>
<td>2012: --</td>
<td>2014: 4%</td>
<td>2015: 2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Information</th>
<th>Waukesha</th>
<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Source of Health Information</td>
<td>2012: 43%</td>
<td>2014: 50%</td>
<td>2015: 50%</td>
</tr>
<tr>
<td>Doctor or Other Health Professional</td>
<td>2012: 28%</td>
<td>2014: 30%</td>
<td>2015: 30%</td>
</tr>
<tr>
<td>Internet</td>
<td>2012: 9%</td>
<td>2014: 6%</td>
<td>2015: 13%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Services</th>
<th>Waukesha</th>
<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a Primary Care Physician (HP2030 Goal: 84%)</td>
<td>2012: --</td>
<td>2013: --</td>
<td>2014: 86%</td>
</tr>
</tbody>
</table>

---

Notes: NA-WI and/or US data not available. 2019 data. *Since 2020, the question was asked of any household member. In previous years, the question was asked of the respondent only. **In 2020, the question was asked of any household member. In all other study years, the question was asked of respondents only.
<table>
<thead>
<tr>
<th>Health Conditions in Past 3 Years</th>
<th>Waukesha</th>
<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26%</td>
<td>33%</td>
<td>31%</td>
</tr>
<tr>
<td></td>
<td>25%</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>11%</td>
<td>18%</td>
</tr>
<tr>
<td>Heart Disease/Condition</td>
<td>2012</td>
<td>2015</td>
<td>2017</td>
</tr>
<tr>
<td></td>
<td>9%</td>
<td>7%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>7%</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>Asthma (Current)</td>
<td>2012</td>
<td>2015</td>
<td>2017</td>
</tr>
<tr>
<td></td>
<td>8%</td>
<td>8%</td>
<td>11%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regularly Seeing Doctor/Nurse/Other Health Care Provider</th>
<th>Waukesha</th>
<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>High Blood Cholesterol</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mental Health Condition</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Heart Disease/Condition</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Diabetes</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Asthma (Current)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Weight</th>
<th>Waukesha</th>
<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65%</td>
<td>70%</td>
<td>69%</td>
</tr>
<tr>
<td>Overweight (BMI 25.0+)</td>
<td>2012</td>
<td>2015</td>
<td>2017</td>
</tr>
<tr>
<td></td>
<td>25%</td>
<td>34%</td>
<td>30%</td>
</tr>
<tr>
<td>Obese (BMI 30.0+) [HP2030 Goal: 36%]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tobacco Product Use in Past Month</th>
<th>Waukesha</th>
<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>Current Vapers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Of Current Smokers/Vapers in Past Year…</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quit Smoking/Vaping 1 Day or More Because Trying to Quit*</td>
<td>2012</td>
<td>2015</td>
<td>2017</td>
</tr>
<tr>
<td></td>
<td>45%</td>
<td>55%</td>
<td>67%</td>
</tr>
<tr>
<td>Saw a Health Care Professional Advised to Quit Smoking/Vaping*</td>
<td>2012</td>
<td>2015</td>
<td>2017</td>
</tr>
<tr>
<td></td>
<td>69%</td>
<td>67%</td>
<td>76%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exposure to Smoke or Electronic Vapor</th>
<th>Waukesha</th>
<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Allowed Anywhere [HP2030 Goal: 93%]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allowed in Some Places/At Some Times</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allowed Anywhere</td>
<td>2%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>No Rules Inside Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>8%</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Tobacco Products in Past Month</th>
<th>Waukesha</th>
<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigars, Cigarillos or Little Cigars Use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smokeless Tobacco Use</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delta-8 (Marijuana-lite, Diet Weed, Dabs) Use in Past Month</th>
<th>Waukesha</th>
<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delta-8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alcohol Use in Past Month</th>
<th>Waukesha</th>
<th>WI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>[HP2030 Goal 5+ Drinks: 25%]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driver/Passenger When Driver Perhaps Had Too Much to Drink</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

*Since 2020, tobacco questions included vaping. In previous years, questions were asked about smoking only.

**Binge drinking is defined as “4 or more drinks on an occasion” for females and “5 or more drinks on an occasion” for males.
<table>
<thead>
<tr>
<th>Mental Health Status</th>
<th>2012</th>
<th>2015</th>
<th>2017</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt Sad, Blue or Depressed Always/Nearly Always (Past Month)</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Felt Lonely or Isolated Always/Nearly Always</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>3%</td>
<td>N/A</td>
</tr>
<tr>
<td>Considered Suicide (Past Year)</td>
<td>2%</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Find Meaning &amp; Purpose in Daily Life Seldom/Never</td>
<td>4%</td>
<td>4%</td>
<td>6%</td>
<td>5%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Household Problems in Past Year Associated With…</th>
<th>2012</th>
<th>2015</th>
<th>2017</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>3%</td>
<td>6%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Marijuana or THC-Containing Products Including Delta-9</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>&lt;1%</td>
<td>2%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Cocaine, Heroin or Other Street Drugs</td>
<td>2%</td>
<td>&lt;1%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Misuse of Prescription Drugs or Over-the-Counter Drugs</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Afraid for Their Safety</td>
<td>4%</td>
<td>4%</td>
<td>6%</td>
<td>4%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pushed, Kicked, Slapped or Hit</td>
<td>1%</td>
<td>3%</td>
<td>5%</td>
<td>2%</td>
<td>2%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>At Least One of the Safety Issues</td>
<td>4%</td>
<td>5%</td>
<td>7%</td>
<td>7%</td>
<td>6%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care Provider-Knows Child &amp; Familiar with History</td>
<td>86%</td>
<td>89%</td>
<td>97%</td>
<td>95%</td>
<td>90%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Visited Primary Health Care Provider for Preventive Care (Past Year)</td>
<td>93%</td>
<td>95%</td>
<td>89%</td>
<td>97%</td>
<td>95%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Did Not Receive Care Needed (Past Year)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Care</td>
<td>3%</td>
<td>6%</td>
<td>2%</td>
<td>7%</td>
<td>3%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Care</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
<td>4%</td>
<td>2%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Asthma</td>
<td>3%</td>
<td>7%</td>
<td>3%</td>
<td>9%</td>
<td>15%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mental Health Condition</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>12%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Overweight or Obese</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>7%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Children 5 to 17 Years Old</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seldom/Never Safe in Community/Neighborhood</td>
<td>1%</td>
<td>0%</td>
<td>&lt;1%</td>
<td>0%</td>
<td>0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Felt Unhappy, Sad or Depressed Always/Nearly Always (Past 6 Months)</td>
<td>4%</td>
<td>0%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Experienced Some Form of Bullying (Past Year)*</td>
<td>18%</td>
<td>14%</td>
<td>14%</td>
<td>10%</td>
<td>14%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Verbally Bullied*</td>
<td>18%</td>
<td>14%</td>
<td>14%</td>
<td>5%</td>
<td>14%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Physically Bullied*</td>
<td>5%</td>
<td>2%</td>
<td>4%</td>
<td>&lt;1%</td>
<td>3%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Cyber Bullied*</td>
<td>3%</td>
<td>4%</td>
<td>1%</td>
<td>5%</td>
<td>4%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top County Social or Economic Issues</th>
<th>2012</th>
<th>2015</th>
<th>2017</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Stability and Employcathan</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>17%</td>
<td>N/A</td>
</tr>
<tr>
<td>Community Violence and Crime</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>15%</td>
<td>N/A</td>
</tr>
<tr>
<td>Safe and Affordable Housing</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>14%</td>
<td>N/A</td>
</tr>
<tr>
<td>Education Access and Quality</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>10%</td>
<td>N/A</td>
</tr>
<tr>
<td>Accessible and Affordable Health Care</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>9%</td>
<td>N/A</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>9%</td>
<td>N/A</td>
</tr>
<tr>
<td>Racism and Discrimination</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>8%</td>
<td>N/A</td>
</tr>
<tr>
<td>Social Connectedness and Belonging</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>6%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Top County Health or Behavioral Issues</th>
<th>2012</th>
<th>2015</th>
<th>2017</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Abuse and Drug/Substance Use</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>38%</td>
<td>N/A</td>
</tr>
<tr>
<td>Mental Health, Mental Conditions and Suicide</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>35%</td>
<td>N/A</td>
</tr>
<tr>
<td>Nutrition, Physical Activity and Obesity</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>17%</td>
<td>N/A</td>
</tr>
<tr>
<td>Access to Affordable Health Care</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>8%</td>
<td>N/A</td>
</tr>
<tr>
<td>Chronic Diseases</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>8%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Not asked. NA-WI and/or US data not available.
*Since 2020, the question was asked for children 5 to 17 years old. In previous years, the question was asked for children 8 to 17 years old.
General Health
In 2023, 53% of respondents reported their health as excellent or very good, 15% reported fair or poor. Respondents who were female, with a high school education or less, in the bottom 40 percent household income bracket, who were unmarried or smokers were more likely to report fair or poor health. From 2012 to 2023, there was a statistical increase in the overall percent of respondents who reported fair or poor health, as well as from 2020 to 2023.

Health Care Coverage
In 2023, 4% of respondents reported they were not currently covered by health care insurance; respondents 18 to 34 years old or in the bottom 40 percent household income bracket were more likely to report this. Four 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 or unmarried were more likely to report this. From 2012 to 2023, the overall percent statistically remained the same for respondents 18 and older or 18 to 64 years old who reported no current personal health care coverage, as well as from 2020 to 2023. From 2012 to 2023, the overall percent statistically decreased for respondents who reported someone in the household was not covered at least part of the time in the past year, as well as from 2020 to 2023.

In 2023, 6% 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 in the past year someone in their household did not receive the medical care needed; respondents in the bottom 40 percent household income bracket were more likely to report this. Ten percent of respondents reported 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. One percent of respondents reported in the past year someone in the household did not receive the alcohol/substance abuse treatment they needed or considered seeking. Five percent of respondents reported in the past year they did not receive the mental health care services they needed or considered seeking; respondents who were female or unmarried were more likely to report this. From 2012 to 2023, the overall percent statistically remained the same for respondents who reported someone in their household had not taken their prescribed medication due to prescription costs in the past year, as well as from 2020 to 2023. From 2012 to 2023, the overall percent statistically increased for respondents who reported unmet medical care in the past year while from 2020 to 2023, there was no statistical change. From 2012 to 2023, the overall percent statistically remained the same for respondents who reported unmet dental care in the past year while from 2020 to 2023, there was a statistical decrease. From 2012 to 2023, the overall percent statistically increased for respondents who reported unmet mental health care services in the past year while from 2020 to 2023, there was no statistical change. Please note: since 2020, unmet medical and dental care need was asked of the household. In previous years, it was asked of the respondent only. In 2020, unmet mental health care services was asked of the household. In all other study years, it was asked of the respondent only.

Economic Hardships
In 2023, 2% of respondents reported their household went hungry because they didn’t have enough food in the past year. Four percent of respondents disagreed or strongly disagreed “During the past month, my household has been able to meet its needs with the money and resources we have.” Respondents in the bottom 40 percent household income bracket were more likely to strongly disagree/disagree. Fourteen percent of respondents reported someone in their household in the past three years looked for community support; respondents who were in the bottom 40 percent household income bracket or unmarried were more likely to report this. Fifty-four percent of respondents who looked for community resource support reported they felt somewhat, slightly, or not at all supported. Two percent of respondents reported they had an issue with their current housing situation. From 2017 to 2023, there was no statistical change in the overall percent of respondents who reported their household went hungry because they didn’t have enough food in the past year, as well as from 2020 to 2023. From 2017 to 2023, there was no statistical change in the overall percent of respondents who reported in the past three years someone in their household looked for community resource support, as well as from 2020 to 2023. From 2017 to 2023, 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, as well as from 2020 to 2023.
Health Information
In 2023, 55% of respondents reported they trust a doctor or other health professional the most for health information while 24% reported the Internet. Fourteen percent reported they were/family member was in the health care field and their most trusted source for health information. Respondents 65 and older, with a high school education or less or in the bottom 40 percent household income bracket were more likely to report doctor or other health professional. Respondents who were male, 18 to 34 years old, respondents of color or with some post high school education were more likely to report the Internet. Respondents who were white, with at least some post high school 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 most trusted source for health information. From 2012 to 2023, there was a statistical increase in the overall percent of respondents who reported they trust their doctor or other health professional the most as their source of health information while from 2020 to 2023, there was no statistical change. From 2012 to 2023, there was no statistical change in the overall percent of respondents who reported they trust the Internet the most as their source of health information while from 2020 to 2023, there was a statistical decrease. From 2012 to 2023, there was a statistical increase in the overall percent of respondents who reported they were/family member was in the health care field and their source of health information, as well as from 2020 to 2023.

Health Services
In 2023, 89% of respondents reported they have a primary care physician they regularly see for check-ups and when they are sick; respondents 65 and older were more likely to report a primary care physician. Sixty-five percent of respondents reported their primary place for health services when they are sick was from a doctor’s or nurse practitioner’s office while 18% reported an urgent care center. Respondents who were female, 65 and older or with a high school education or less were more likely to report a doctor’s or nurse practitioner’s office as their primary health care when they are sick. Respondents 35 to 44 years old or respondents of color were more likely to report an urgent care center as their primary health care. Nine percent reported no usual place for their primary place for health services; respondents who were male or white were more likely to report this. From 2017 to 2023, there was no statistical change in the overall percent of respondents who reported they have a primary care physician, as well as from 2020 to 2023. From 2012 to 2023, there was a statistical decrease in the overall percent of respondents who reported their primary place for health services when they are sick was a doctor’s/nurse practitioner’s office while from 2020 to 2023, there was no statistical change. From 2012 to 2023, there was a statistical increase in the overall percent of respondents who reported their primary place for health services when they are sick was an urgent care center or no usual place while from 2020 to 2023, there was no statistical change.

Health Conditions
In 2023, out of six health conditions listed, the most often mentioned in the past three years was high blood pressure (29%), high blood cholesterol (24%) or a mental health condition (19%). Respondents who were male, 65 and older, white, with a high school education or less, in the bottom 40 percent household income bracket or who were overweight were more likely to report high blood pressure. Respondents who were 55 and older, white or overweight were more likely to report high blood cholesterol. Respondents who were female, 35 to 44 years old, in the bottom 40 percent household income bracket or unmarried were more likely to report a mental health condition. Twelve percent reported they were treated for, or told they had heart disease/condition in the past three years. Respondents 65 and older, with a high school education or less or in the bottom 40 percent household income bracket were more likely to report heart disease/condition. Eleven percent of respondents reported diabetes; respondents who were male, 65 and older or overweight were more likely to report this. Nine percent reported current asthma; unmarried respondents were more likely to report this. Of respondents who reported these health conditions, at least 72% reported they were regularly seeing a doctor, nurse or other health care provider for their health condition. From 2012 to 2023, there was no statistical change in the overall percent of respondents who reported high blood pressure, high blood cholesterol, diabetes or current asthma, as well as from 2020 to 2023. From 2012 to 2023, there was no statistical change in the overall percent of respondents who reported heart disease/condition while from 2020 to 2023, there was a statistical increase. From 2012 to 2023, there was a statistical increase in the overall percent of respondents who reported a mental health condition while from 2020 to 2023, there was no statistical change.
Body Weight
In 2023, 67% of respondents were classified as at least overweight while 27% were obese. Male respondents were more likely to be at least overweight. Respondents 45 to 54 years old were more likely to be obese. From 2012 to 2023, there was no statistical change in the overall percent of respondents who were at least overweight, as well as from 2020 to 2023. From 2012 to 2023, there was no statistical change in the overall percent of respondents who were obese while from 2020 to 2023, there was a statistical decrease.

Tobacco Product Use
In 2023, 9% of respondents were current tobacco cigarette smokers; respondents with a high school education or less or in the bottom 40 percent household income bracket were more likely to be a smoker. Four percent of respondents used electronic vapor products in the past month. Thirty-two percent of current smokers/current vapers tried to quit smoking/vaping at least one day in the past year because they were trying to quit. Fifty-nine percent of current smokers/vapers who saw a health professional in the past year were advised to quit smoking/vaping. From 2012 to 2023, there was a statistical decrease in the overall percent of respondents who were current tobacco cigarette smokers while from 2020 to 2023, there was no statistical change. From 2012 to 2023, 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 while from 2020 to 2023, there was a statistical decrease. From 2012 to 2023, 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 2020 to 2023. Please note: since 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 2023, 90% of respondents reported smoking is not allowed anywhere inside the home. Respondents in the top 40 percent household income bracket or with children in the household were more likely to report smoking is not allowed anywhere inside the home. Six percent of nonsmoking or nonvaping respondents reported they were exposed to second-hand smoke or vapor in the past seven days. From 2012 to 2023, there was a statistical increase in the overall percent of respondents who reported smoking is not allowed anywhere inside the home while from 2020 to 2023, there was no statistical change. From 2012 to 2023, 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 2020 to 2023, there was no statistical change. Please note: since 2020, the second-hand smoke exposure question included nonvapers while in previous years the question included nonsmokers only.

In 2023, 5% of respondents used cigars, cigarillos or little cigars while 4% of respondents used smokeless tobacco in the past month. Respondents who were male or married were more likely to report they used cigars, cigarillos or little cigars. Respondents who were male, 18 to 44 years old or with some post high school education were more likely to report smokeless tobacco use. From 2015 to 2023, 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 2020 to 2023. From 2015 to 2023, there was no statistical change in the overall percent of respondents who used smokeless tobacco in the past month while from 2020 to 2023, there was a statistical decrease.

Delta-8 Use
In 2023, 4% of respondents used Delta-8, also known as marijuana-lite, diet weed or dabs, in the past month. Respondents 18 to 34 years old were more likely to report they used Delta-8 in the past month.

Alcohol Use
In 2023, 31% of respondents were binge drinkers in the past month (females 4+ drinks in a row and males 5+ drinks). Respondents who were male or 18 to 34 years old were more likely to have binged 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 2012 to 2023, there was a statistical increase in the overall percent of respondents who reported binge drinking in the past month while from 2020 to 2023, there was no statistical change. From 2012 to 2023, 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 2020 to 2023.
Mental Health Status
In 2023, 4% of respondents reported they always or nearly always felt sad, blue or depressed in the past month; respondents in the bottom 60 percent household income bracket were more likely to report this. Three percent of respondents reported they always or nearly always felt lonely or isolated from those around them. Three percent of respondents felt so overwhelmed they considered suicide in the past year. Five percent of respondents reported they seldom or never find meaning and purpose in daily life; respondents 45 to 54 years old, respondents of color or in the bottom 60 percent household income bracket were more likely to report this. From 2012 to 2023, 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, they considered suicide in the past year or they seldom/never find meaning and purpose in daily life, as well as from 2020 to 2023.

Household Problems
In 2023, 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. Two percent of respondents reported someone in their household experienced some kind of problem in connection with marijuana/THC-containing products includingDelta-9 in the past year. One percent of respondents reported a household problem with cocaine, heroin or other street drugs while less than one percent reported the misuse of prescription drugs/over-the-counter drugs. From 2012 to 2023, 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 2020 to 2023. From 2012 to 2023, there was no statistical change in the overall percent of respondents who reported a household problem with marijuana/THC-containing products includingDelta-9, cocaine/heroin/other street drugs or misuse of prescription drugs/over-the-counter drugs, as well as from 2020 to 2023.

Personal Safety Issues
In 2023, 4% of respondents reported someone made them afraid for their personal safety in the past year; respondents 45 to 54 years old 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 6% reported at least one of these two situations; respondents 45 to 54 years old were more likely to report this. From 2012 to 2023, 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 2020 to 2023. From 2012 to 2023, 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 2020 to 2023.

Children in Household
In 2023, 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 percent of respondents reported they have one or more persons they think of as the child’s primary health care provider, with 95% reporting the child visited their primary health care provider for preventive care during the past year. Three percent of respondents reported in the past year the child did not receive the dental care needed while 2% reported the child did not receive the medical care needed. Fifteen percent of respondents reported the child currently had asthma. Twelve percent of respondents reported the child had a diagnosed mental health condition. Seven percent of respondents reported the child was overweight or obese. Zero percent of respondents reported the 5 to 17 year old child was seldom/never safe in their community. 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. Fourteen percent reported the 5 to 17 year old child experienced some form of bullying in the past year; 14% reported verbal bullying, 4% reported cyber bullying and 3% reported physical bullying. From 2012 to 2023, there was no statistical change in the overall percent of respondents who reported the child had a primary health care provider while from 2020 to 2023, there was a statistical decrease. From 2012 to 2023, there was no statistical change in the overall percent of respondents who reported the child visited their primary health care provider in the past year for preventive care, as well as from 2020 to 2023. From 2012 to 2023, 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 unmet medical care need, as well as from 2020 to 2023. From 2012 to 2023, there was a statistical increase in the overall percent of respondents who reported the child currently had asthma while from 2020 to 2023, there was no statistical change. From 2012 to 2023, there was no statistical change in the overall percent of respondents who reported the 5 to 17 year old child was seldom/never
safe in their community or was always or nearly always unhappy/sad/depressed in the past six months, as well as from 2020 to 2023. From 2012 to 2023, there was no statistical change in the overall percent of respondents who reported in the past year the 5 to 17 year old child was bullied overall as well as verbally bullied, physically bullied or cyber bullied, as well as from 2020 to 2023.

Top County Social or Economic Issues
In 2023, respondents were asked to list the top two social or economic issues in the county. The most often cited were economic stability and employment (17%) or community violence and crime (15%). White respondents were more likely to report economic stability and employment as a top social or economic issue. Respondents who were male or with a high school education or less were more likely to report community violence and crime. Fourteen percent of respondents reported safe and affordable housing; female respondents were more likely to report this. Ten percent of respondents reported education access and quality as a top issue. Nine percent of respondents reported accessible and affordable health care as a top issue; white respondents were more likely to report this. Nine percent of respondents were more likely to report food insecurity; respondents 35 to 44 years old were more likely to report this. Eight percent of respondents reported racism and discrimination as a top issue; respondents who were male or with a college education were more likely to report this. Six percent of respondents reported social connectedness and belonging; respondents with a high school education or less were more likely to report this. Four percent of respondents reported politics/government as a top issue; male respondents were more likely to report this.

Top County Health Conditions or Behaviors
In 2023, respondents were asked to list the top two health or behavioral issues in the county that must be addressed in order to improve the health of county residents. The most often cited were alcohol abuse and drug/substance use (38%) or mental health, mental conditions and suicide (35%). White respondents were more likely to report alcohol abuse and drug/substance use. Respondents 35 to 44 years old or with some post high school education were more likely to report mental health, mental conditions and suicide as a top health or behavioral issue. Seventeen percent of respondents reported nutrition, physical activity and obesity; respondents 35 to 44 years old, with a college education, in the top 60 percent household income bracket or married respondents were more likely to report this. Eight percent of respondents reported access to affordable health care as a top issue; respondents who were 65 and older or white were more likely to report this. Eight percent of respondents reported chronic diseases. Four percent of respondents reported tobacco and vaping products; male respondents were more likely to report this.
Appendix E: 2023 Waukesha County Community Health Needs Assessment: Community Health Online Survey

To supplement the Community Health Survey phone survey, an online survey was created by partners Ascension Wisconsin, Aurora Health Care, ProHealth Care, Froedtert Health and the Waukesha County Public Health Department.

The questionnaire was entered into Survey Monkey with links and QR codes for easy access. Partners marketed the survey throughout the county. A total of 488 online surveys was completed between Sept.15, 2023 and Nov. 25, 2023. This is a convenience sample and is useful to obtain information from harder-to-reach people who are often underrepresented in general population surveys. As a result, this is a good supplemental piece to the general population survey. Post-stratification was conducted at the estimated 5-year-age-group level by sex of the 2021 county characteristics of the American Community Survey. The margin of error is ±4 percent. The margin of error for smaller subgroups will be larger than ±4 percent, since fewer respondents are in that category.

The survey was conducted by JKV Research, LLC.
Appendix F: 2023 Waukesha County Community Health Online Survey Results

1. Do you live in Waukesha County, Wisconsin?
   Yes ................................................................. 94%
   No ................................................................. 6

2. Do you work in Waukesha County, Wisconsin?
   Yes ................................................................. 57%
   No ................................................................. 43
   → AND Q1=No.
   I’m sorry, you are not eligible for this survey. We are looking to collect data from those who live or work in Waukesha County. Thank you for your time.

3. Generally speaking, would you say that your own health is…?
   Poor ................................................................. 1%
   Fair ................................................................. 10
   Good ............................................................... 37
   Very good ........................................................... 43
   Excellent ........................................................... 10
   Not sure ............................................................. 0

4. Was there a time during the last 12 months that YOU OR SOMEONE IN YOUR HOUSEHOLD did not get the medical care needed?
   Yes ................................................................. 23% → CONTINUE WITH Q5
   No ................................................................. 76 → GO TO Q6
   Not sure .............................................................. 2 → GO TO Q6
5. What were the reasons you or someone in your household did not receive the medical care needed?  
[110 Respondents: MULTIPLE RESPONSES ACCEPTED]

Cannot afford to pay .................................................. 50%
Inconvenient hours .................................................... 34
Don’t know where to go ............................................... 31
Insurance did not cover it .............................................. 22
Unable to get appointment ........................................... 22
Co-payments too high ................................................ 14
Specialty physician not in area ...................................... 8
Poor medical care ...................................................... 7
Not enough time ....................................................... 6
Uninsured ................................................................. 5
Technology issues/no internet or computer .................... 2
Physical barriers ....................................................... <1
Lack of transportation ................................................ <1
Lack of child day care ................................................ <1
Language barriers ..................................................... 0
Not sure ........................................................................ 2
Other, (please specify) ............................................... 3  
  • Doctor didn’t think it was necessary.
  • I need a therapist, but I am older and most are too young and don’t have the experience or gravitas to make me feel safe to talk about severe trauma.
  • Lack of airborne infection control measures.
  • Lack of county DHS not providing notice of the ability to request reasonable accommodations.
  • My husband like many of the residents that move into the assisted living where I work are given just days to get out of rehab by insurance when they are not ready to go home.
  • Work occurrence policy.

6. In the past 12 months, was there a time that YOU OR SOMEONE IN YOUR HOUSEHOLD needed or considered seeking alcohol or drug abuse treatment but did not get it?

Yes .................................................................................. 3%  → CONTINUE WITH Q7
No, I got the services that I needed .............................. 1  → GO TO Q8
Does not apply, I did not need services in past year .... 95 → GO TO Q8
Not sure ........................................................................ <1  → GO TO Q8
7. What were the reasons you or someone in your household did not receive the alcohol or drug abuse treatment needed? [15 Respondents: MULTIPLE RESPONSES ACCEPTED]

- Stigma ................................................................. 10 Respondents
- Not enough time ............................................... 7 Respondents
- Cannot afford to pay ........................................... 6 Respondents
- Co-payments too high ......................................... 5 Respondents
- Don’t know where to go ....................................... 4 Respondents
- Insurance did not cover it .................................... 3 Respondents
- Inconvenient hours ............................................. 3 Respondents
- Poor AODA treatment care .................................. 2 Respondents
- Unable to get appointment ................................... 2 Respondents
- Lack of child day care ......................................... 1 Respondent
- Uninsured .............................................................. 0 Respondents
- Lack of transportation .......................................... 0 Respondents
- Specialty physician not in area .............................. 0 Respondents
- Physical barriers .................................................. 0 Respondents
- Language barriers ............................................... 0 Respondents
- Technology issues/no internet or computer ............ 0 Respondents
- Not sure ............................................................... 0 Respondents
- Other, (please specify) .......................................... 7 Respondents
  - Declined treatment offered.
  - Legal impacts.
  - My husband did not want to at first.
  - Put with someone exactly what you’re going through. It comes to a cultural barrier and a color barrier when it comes to privilege. Individuals get treatment and then they’re not harassted or traumatized on their jobs. When it tells the people of color that follows you throughout your treatment plan as well as your community and it’s not giving the same help.
  - There is no place in Waukesha County to take a drug addict except Rogers and it is $5,000 when you walk in. How many drug addicts have $5,000?

8. In the past 12 months, was there a time that YOU needed or considered seeking mental health care services but did not get it?

- Yes ................................................................. 25% → CONTINUE WITH Q9
- No, I got the services that I needed ...................... 16 → GO TO Q10
- Does not apply, I did not need services in past year .... 57 → GO TO Q10
- Not sure ............................................................ 2 → GO TO Q10
9. What were the reasons you did not receive the mental health care needed? [122 Respondents: MULTIPLE RESPONSES ACCEPTED]

Unable to get appointment ........................................48%
Don’t know where to go..............................................39
Cannot afford to pay .................................................37
Insurance did not cover it ..........................................19
Not enough time .......................................................14
Stigma ........................................................................14
Co-payments too high ...............................................13
Inconvenient hours ...................................................12
Poor mental health care ............................................ 5
Specialty physician not in area ................................. 5
Lack of child day care ............................................... 2
Uninsured ..................................................................<1
Lack of transportation .............................................. 0
Physical barriers ....................................................... 0
Language barriers .................................................... 0
Technology issues/no internet or computer ............. 0
Not sure ......................................................................<1
Other, (please specify) ..............................................27

- Again the culturally significant contact if you have an understand the stress or trauma and the constant layers of PTSD as well as emotional and physical trauma how can you diagnose me or help me properly if you can’t even conceive the pain in which a person is going through and it is not always textbook and most therapist follow textbook guidelines not understanding the trauma in which a person has experienced throughout their life history and there was one person who could and was helping in the Milwaukee area but their insurance job
- At ER help not allowed because suicide threatened (idealized) only but not physically attempted
- Couldn’t locate one who was old enough to treat a severely traumatized senior. The young therapists always seem intimidated by older patients. It makes me feel unsafe to talk about things.
- Debating on if I need it and not sure where to go that my insurance covers.
- Don’t want to waste my time with a doctor who doesn’t have the same religious beliefs as myself.
- Had to pay for other health care.
- Negative experience with only available provider.
- Not sure whether it would be helpful.
- Other communication barriers. DHS not calling legal guardian if adult prior to beginning outpatient services. Very poor quality. Counselor in training broke several conduct codes and did not provide civil rights access.
10. When you are sick, to which one of the following places do you usually go?

- Doctor’s or nurse practitioner’s office: 55%
- Urgent care center: 20%
- Quickcare clinic/Fastcare clinic: 4%
- Worksite clinic: 3%
- Virtual health/tele-medicine or electronic visit: 3%
- Public health clinic or community health center: 1%
- Hospital emergency room: <1%
- Hospital outpatient department: <1%
- Alternative medicine location, such as acupuncture, homeopathy, chiropractor, etc.: <1%
- Some other kind of place, please specify: 6%
- No usual place: 5%
- Not sure: <1%

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. You have diabetes, not associated with a pregnancy</td>
<td>9%</td>
<td>90%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>12. You have high blood pressure</td>
<td>39%</td>
<td>61%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>13. Your blood cholesterol is high</td>
<td>30%</td>
<td>68%</td>
<td>2%</td>
</tr>
<tr>
<td>14. You have heart disease or a heart condition</td>
<td>12%</td>
<td>87%</td>
<td>1%</td>
</tr>
<tr>
<td>15. You have a mental health condition, such as an anxiety disorder, obsessive-compulsive disorder, panic disorder, post-trauma</td>
<td>35%</td>
<td>64%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>16. You have asthma</td>
<td>16%</td>
<td>83%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

17. During the past 30 days, about how often would you say you felt sad, blue, or depressed?

- Never: 19%
- Seldom: 37%
- Sometimes: 32%
- Nearly always: 5%
- Always: 2%
- Not sure: 6%

18. How often do you feel lonely or isolated from those around you?

- Never: 33%
- Seldom: 28%
- Sometimes: 31%
- Nearly always: 4%
- Always: 3%
- Not sure: <1%
19. In the past year have you considered suicide?

Yes............................................................... 9%
No............................................................. 89%
Not sure................................................... 2

211 connects you with thousands of nonprofit and government services in your area. If you want personal assistance, call the three-digit number 211, 877-947-2211 or dial 988 for a crisis hotline.

20. To which gender identity do you most identify with? The purpose of this question is to identify the proper follow-up questions in this survey.

Male ............................................................. 48%
Female .......................................................... 50%
Transgender male/transgender female/nonbinary/prefer not to answer/not sure/other gender identity .................... 3

21. Considering all types of alcoholic beverages, how many times during the past 30 days did you have (5 or more drinks male) or (4 or more drinks female) on an occasion? Note: an alcoholic drink is one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail or one shot of liquor. [Due to an initial program error, only 375 respondents completed the corrected question.]

0 Times........................................................... 70%
Once............................................................. 12%
Twice.......................................................... 6%
Three times................................................ 2%
Four or more times..................................... 9%
Not sure...................................................... <1%

During the past year, has ANYONE IN YOUR HOUSEHOLD, INCLUDING YOURSELF, experienced any kind of problem such as legal, social, personal, physical or medical in connection with...? (Select an option for your response in each row below.)

<table>
<thead>
<tr>
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<th>Drinking alcohol ..................................................</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>6%</td>
<td>94%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>23.</th>
<th>Marijuana or THC-containing products including Delta-9 ..</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3%</td>
<td>96%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>24.</th>
<th>Cocaine, heroin, or other street drugs ........................</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1%</td>
<td>98%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>25.</th>
<th>Misuse of prescription drugs or over-the-counter-drugs ......</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2%</td>
<td>98%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

In the past 30 days, did you use... (Select an option for your response in each row below.)

<table>
<thead>
<tr>
<th>26.</th>
<th>Smokeless tobacco including chewing tobacco, snuff, plug, or spit ...</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2%</td>
<td>98%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>27.</th>
<th>Cigars, cigarillos or little cigars ........................................</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3%</td>
<td>97%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>28.</th>
<th>Electronic cigarettes, also known as e-cigarettes or vaping ..........</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2%</td>
<td>98%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>29.</th>
<th>Delta-8, also called marijuana-lite, diet weed or dabs ...............</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>4%</td>
<td>96%</td>
<td>0%</td>
</tr>
</tbody>
</table>

30. During the past year has anyone made you afraid for your personal safety?

Yes ............................................................. 7%
No ............................................................. 93%
Not sure ................................................... <1%
The next two questions are about issues that our community faces that need to be addressed in order to improve the quality of life of county residents.

31. What are the two largest social or economic issues in your community that must be addressed? (Select two.)

- Accessible and affordable health care ........................................... 40%
- Safe and affordable housing ...................................................... 26
- Community violence and crime .................................................. 19
- Affordable childcare .................................................................. 19
- Racism and discrimination .......................................................... 11
- Economic stability and employment .......................................... 10
- Environmental health (clean air, safe water, etc.) ...................... 9
- Social connectedness and belonging .......................................... 9
- Access to social services ............................................................. 8
- Education access and quality .................................................... 6
- Quality of health care ............................................................... 6
- Food insecurity .......................................................................... 6
- Accessible and affordable transportation .................................. 5
- Family support ............................................................................ 2
- Not sure ..................................................................................... 4
- Do not want to answer .............................................................. 1
- Other, (please specify) .............................................................. 10

- A place to take a drug addict for help.
- Access to affordable mental health services.
- Access to mental health care in a timely manner.
- Access to timely, professional Fire and EMS services.
- Addiction recovery.
- ADRC disability rep for over 50.
- Affordable drugs.
- All of the above.
- Availability of mental health care.
- Drug abuse and mental health crisis.
- Education is focused on college prep only. Need to bring back education in the trades and just daily living (personal finance/maintenance).
- Good prices affecting food I buy for a large family.
- Living on the same block as Salvation Army you are living on Skid Row of Waukesha you are dealing with theft, drunks, overdosing, loitering in the parking lot, living in the wooded area, and people ringing your doorbell at 4 am it's hell. Also, no help with water bill from a leak, no option for help when the city mows your lawn because you are too sick from mental health but they'll slap a lean on this POS, worst mistake of my life buying a house out here had less BS in Milwaukee.
- Many of these are connected.
- Mental Health.
- Mental health resources with getting fast appointments.
- Mental health services for our youth.
- More access to in-person mental health services.
- More trails/sidewalks to make walking on streets safer. I'd also like to see red light cameras installed. I am an avid runner and 2-3 times a week I almost get hit by a car not stopping to turn right on red or I witness someone doing it.

- Parenting skills and developing family values/beliefs.
- Property taxes are too high.
- Resources in the schools for bullying and to have consequences for those that do! Schools don't address nor do the police!
- Respect and acceptance of others - not imposing your beliefs on others.
- Safe drivers, not speeders or tailgaters. Tickets!!!
- Supportive ER staff who compare notes for mental health crisis. My son told Terri providers in the ER his true voices/thoughts but didn't feel comfortable sharing with intimidating behavioral health-they should share what they are being told. Thank God he lived through that psychosis after being turned away at ER because he has "no physical" injuries. Waukesha Memorial hospital is not a good psych intake center/ER.
- Taxes are too high, government is too big.
- The attack on trans students by Waukesha County school districts.
- Understanding how medical insurance trumps what a doctor indicates because they have "statistics" and the algorithm decides what will be paid for.
- Waukesha's drug problem.
32. What are the two largest health conditions or behaviors that must be addressed in order to improve the health of county residents? (Select two.)

Mental health, mental conditions and suicide ...........................................58%
Alcohol abuse and drug/substance use .....................................................40
Chronic diseases (heart disease, diabetes, cancer, autoimmune conditions, arthritis, etc.) .................................................................26
Nutrition, physical activity and obesity ......................................................21
Reproductive and sexual health (STD’s, abortion, etc.) ..............................6
Maternal, infant, and child health ..............................................................5
Tobacco and vaping products ...................................................................5
Intimate partner and domestic violence ....................................................4
Communicable diseases or COVID-19 (flu, cold, etc.) ..............................4
Unintentional injury, including falls and motor vehicle accidents .......... 3
Oral health ..............................................................................................<1
Not sure .................................................................................................5
Do not want to answer ............................................................................2

Other, (please specify) .............................................................................13
- Access to timely EMS Services with access to Paramedics service.
- Accessible health care that supports and affirms trans youth.
- All Health Care for All Conditions for Good Health No Matter What the Affliction.
- Breaking down the stereotype and stigmatism that comes along with asking for help, receiving help and not feeling this though you are this Giant Center that no one wants to help and all sin is sin.
- Care for elderly.
- COVID-19 and its associated after-effects including long COVID, heart attacks, strokes, diabetes, autoimmune conditions, lymphocytopenia, etc.
- Gun violence.
- Homelessness.
- Lack of desire to punish criminals.
- Let doctors assist with health care decisions for individuals. Government/county health needs to stop dictating health care decisions.
- Parenting skills to better support childhood health and education.
- Proper coordination and communication of lab results.
Finally, a few questions about you to make sure we have a good representation of the people in Waukesha County.

33. What is your age?

18-34 years old ........................................... 23%
35-44 years old ........................................... 16
45-54 years old ........................................... 16
55-64 years old ........................................... 19
65 and older ............................................. 23
No answer .................................................. 3

34. Are you Hispanic or Latino?

Yes .............................................................. 4%
No .............................................................. 92
Not sure ...................................................... <1
No answer .................................................. 3

35. Which of the following would you say is your race?

American Indian or Alaska Native ..................<1%
Asian .......................................................... <1
Black, African American ............................. 1
Native Hawaiian or Other Pacific Islander .... 0
White .......................................................... 85
Another race (please specify) ....................... <1
Multiple races ............................................ 9
Not sure ...................................................... <1
No answer .................................................. 3

36. What is the highest grade level of education you have completed?

8th grade or less ........................................... 0%
Some high school ....................................... 0
High school graduate or GED ....................... 10
Some college ............................................. 14
Technical school graduate ......................... 8
College graduate ....................................... 32
Master’s degree or higher ......................... 33
Not sure ...................................................... <1
No answer .................................................. 3
37. What is the zip code of your primary residence?

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>53188</td>
<td>12%</td>
</tr>
<tr>
<td>53186</td>
<td>9%</td>
</tr>
<tr>
<td>53189</td>
<td>9%</td>
</tr>
<tr>
<td>53045</td>
<td>8%</td>
</tr>
<tr>
<td>53051</td>
<td>6%</td>
</tr>
<tr>
<td>53066</td>
<td>6%</td>
</tr>
<tr>
<td>53089</td>
<td>6%</td>
</tr>
<tr>
<td>53072</td>
<td>6%</td>
</tr>
<tr>
<td>53005</td>
<td>5%</td>
</tr>
<tr>
<td>53151</td>
<td>4%</td>
</tr>
<tr>
<td>53149</td>
<td>3%</td>
</tr>
<tr>
<td>Other (2% or less)</td>
<td>14%</td>
</tr>
<tr>
<td>No answer</td>
<td>11%</td>
</tr>
</tbody>
</table>

38. What is your current employment status?

- Employed, working full-time: 51%
- Working part-time: 15%
- Not working by choice: <1%
- Out of work, but looking for work: <1%
- Out of work, but NOT currently looking for work: <1%
- Retired: 24%
- Unable to work: 8%
- Not sure: <1%

39. What is your annual household income before taxes?

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $10,000</td>
<td>7%</td>
</tr>
<tr>
<td>$10,000 to $20,000</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>$20,001 to $30,000</td>
<td>8%</td>
</tr>
<tr>
<td>$30,001 to $40,000</td>
<td>2%</td>
</tr>
<tr>
<td>$40,001 to $50,000</td>
<td>4%</td>
</tr>
<tr>
<td>$50,001 to $60,000</td>
<td>5%</td>
</tr>
<tr>
<td>$60,001 to $75,000</td>
<td>9%</td>
</tr>
<tr>
<td>$75,001 to $90,000</td>
<td>7%</td>
</tr>
<tr>
<td>$90,001 to $105,000</td>
<td>7%</td>
</tr>
<tr>
<td>$105,001 to $120,000</td>
<td>8%</td>
</tr>
<tr>
<td>$120,001 to $135,000</td>
<td>5%</td>
</tr>
<tr>
<td>Over $135,000</td>
<td>25%</td>
</tr>
<tr>
<td>Not sure</td>
<td>7%</td>
</tr>
<tr>
<td>No answer</td>
<td>6%</td>
</tr>
</tbody>
</table>

40. Was there a time during the last 12 months that your household was hungry, but didn’t eat because you didn’t have enough food?

- Yes: 9%
- No: 90%
- Not sure: <1%
41. How strongly do you agree or disagree with the following statement: “During the past month, my household has been able to meet its needs with the money and resources we have.”

| Strongly Agree | 40% |
| Agree | 42 |
| Disagree | 14 |
| Strongly Disagree | 4 |
| Not sure | 0 |

42. How many children under the age of 18 are living in the household?

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 children</td>
<td>70%</td>
</tr>
<tr>
<td>1 child</td>
<td>11</td>
</tr>
<tr>
<td>2 children</td>
<td>11</td>
</tr>
<tr>
<td>3 children</td>
<td>6</td>
</tr>
<tr>
<td>4 children</td>
<td>1</td>
</tr>
<tr>
<td>5 children</td>
<td>&lt;1</td>
</tr>
<tr>
<td>6 or more children</td>
<td>0</td>
</tr>
<tr>
<td>Not sure</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

For the next questions, we would like to talk about the oldest child.

43. What is the age of this child? [134 Respondents]

<table>
<thead>
<tr>
<th>Age</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 years old or younger</td>
<td>21%</td>
</tr>
<tr>
<td>5 to 9 years old</td>
<td>10</td>
</tr>
<tr>
<td>10 to 17 years old</td>
<td>69</td>
</tr>
<tr>
<td>Not sure</td>
<td>0</td>
</tr>
</tbody>
</table>

44. Does the child have a diagnosed mental health condition, such as an anxiety disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder or depression? [106 Respondents]

<table>
<thead>
<tr>
<th>Response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>21%</td>
</tr>
<tr>
<td>No</td>
<td>78</td>
</tr>
<tr>
<td>Not sure</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

45. During the past 6 months, how often was the child unhappy, sad or depressed? [105 Respondents]

<table>
<thead>
<tr>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>0%</td>
</tr>
<tr>
<td>Nearly always</td>
<td>6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>19</td>
</tr>
<tr>
<td>Seldom</td>
<td>58</td>
</tr>
<tr>
<td>Never</td>
<td>15</td>
</tr>
<tr>
<td>Not sure</td>
<td>2</td>
</tr>
</tbody>
</table>
46. Please list any additional thoughts or comments you have about helping us improve the health of county residents.

- A balanced diet, physical exercise, mental and social activity.
- Abortion is not health care and has no place in a survey related to community health.
- Access to a county or community pool for physical activity.
- Access to affordable health care/insurance has a significant impact on entrepreneurship and economic vitality. As a disabled veteran, I receive health care at no cost through the VA, which enabled me to start the business that has supported me for 18 years, instead of struggling to try to hold down a traditional job which would create conflicts with my health conditions.

- Access to developmental evaluations—like ASQ.
- Access to quality mental health care, seems what is in my network, is not very good.
- Advance initiatives which are inclusive and support all of our county residents.
- Affordable housing and enough food to maintain healthy outcome.
- Affordable housing, not just for seniors for everyone, when you spend all your income on housing, there becomes a huge need for other social services. Housing is a HUGE issue that the county needs to enforce with each municipality, because it drains the county services because the villages and towns don’t offer affordable housing. Mukwonago hasn’t added affordable housing in YEARS!!! A studio apartment is $1,200.00 per month.

- Affordable transportation evenings and weekends for those of us that no longer drive. Currently I feel very isolated and am never able to attend city social events. No fireworks, no parades, etc. I never thought my life would become like this.

- Allow the doctors to assist individuals with their personal health care decisions. The county and government need to stop dictating the health care of the population as they are not the professionals.

- Anxiety about rising costs is difficult to manage sometimes. Having a local food pick up has been a savior for my family.

- As one of the wealthiest counties in the state, those that are struggling to make ends meet, are struggling with the stigma of asking for/accepting help/assistance & don’t know where to look for support services without embarrassment.

- As painful as the water/ sewer bills are...thank you for completion of the needed project on time, on budget and with minimal issues, exceptionally transparent all the way!

- Ascension is not helpful to the community.

- Basic needs of the residents need to be met...housing, food, etc. Especially children.

- Better nutrition for school aged children, free breakfast and lunches for all.

- Better resource for teens for mental health.

- Bias against others and in school districts.

- Caregiver support.

- Change youth's attitude towards alcohol is what cool kids do. Many 30s, and older adults I know, think something is wrong with you, if you don’t want marijuana smoking in your neighborhood. You are shunned for that. Teenagers lack a teen center to hang out at, there used to be one in Waukesha. Need a rehabilitation center for chemically dependent people. Single homeless people especially young men need a safe place to stay.

- CLTS is too limited in providing needed services. They’d rather just pay for “stuff” than services.

- Combating drugs and alcohol problems will decrease the crime and violence in our community. This must be a priority for Waukesha county!!

- Communication between patient and doctors who really listen to each other.


- Don’t sell vaping stuff and cigarettes in so many stores like gas stations and drugstores. Have end stage lung cancer patients tell their stories to be used in classrooms possibly starting in 6th grade thru 12th. Show also on TV, movie theaters.

- Easy access to therapy.

- Education on healthy food and motivation for restaurants to make healthy options on their menus.

- Education on personal responsibility is needed rather than be dependent on the community for things you can control yourself. I believe in providing help, but personal responsibility needs to be included in the discussion.

- Ensure residents know where they can seek help/t financial or health care needs.

- Faster transportation time from getting from one county to the next better lighting and stop racially profiling individuals when they’re trying to drive through the community to get to other jobs or trying to look for jobs.

- For the first, having been in excellent health my entire life, I am now in debt with medical bills because my teacher’s salary and health insurance is so poor.
• Heading into retirement would like social security meetings NOT associated with investment firms. I don’t
know where to find such a meeting based solely on social security process.
• Health care costs and premiums are way too high. Government subsidies are not the answer, it all comes from
the taxes we pay. We must find ways to lower the costs of medical care.
• I believe it is important that elected officials state clearly the things the county is doing and things individuals
can do to protect health, community, government. They must state openly and clearly that protecting the
health of others by masking, distancing, staying home, providing healthcare for all is the right thing to do.
They must state clearly that violence toward others is not appropriate in families, community, and
government.
• I had to respond negatively to the questions regarding access to mental health services because it did not
involve family members in Waukesha County. However, I have had horrible experiences recently with a
family member who was suicidal and in a mental breakdown. It was a nightmare to try to get her the help that
she needed. When I now see commercials on tv advertising helplines I do not take them seriously.
• I love living in Waukesha, WI. I do worry about the rise of ultra conservatism in the area, embracing all sorts
of conspiracy theories and legitimizing fascist behaviors.
• I think it is important to increase penalties for drunk driving and to have some common sense gun laws such
as background checks, waiting periods, and gun registration.
• I think we really need to put resources directly to families to help parents learn how to develop important
parenting skills. Skills focused in building strong values and beliefs so they can provide for their children to
have better mental and physical health, as well as better education. It is very sad to see the issues my family
members that are teachers are having to deal with in the early elementary years, which only gets worse as the
children get older.
• I wish there were more sidewalks so that people could walk, run, and bike safely. This would encourage
people to walk more, improving health.
• It’s two children under 18 in the household there should be an option for taking care of somebody else in the
household who is over 18 like a disabled person or parent.
• I’m one of the lucky ones where I live in a safe, affordable place with access to insurance and health care but
Waukesha is quickly becoming a place where families will be unable to afford living here. Housing is crazy
expensive and the job market isn’t keeping up with the standard of living. This causes stress, anxiety etc.
• Increase and improve healthy diet (veggie and vegan) info and availability, leading to healthy weight and
disease prevention.
• Increase of rats in city of Waukesha. I’ve lived here for 39 years and never saw them till early October.
Nothing is in my yard to attract them. Besides being disgusting. I’m concerned about the diseases they may
carry. The city just tells us to “clean up.” I have nothing to clean.
• Intercounty transportation options are non-existent and should be a higher priority. Individual suffering from
mental health crises should not be jailed but treated humanely and with compassion. Our mental health system
is broken. Child care options for single mothers are cost prohibited and holding women back from advancing
in our society and community. Time to have the government get involved. Employers aren’t stepping up!
• Invest in more alternative transportation - better sidewalks, better/safer bike lanes, safe public transportation.
• It is imperative that Waukesha County school districts affirm and support transgender students. It is also
necessary to train physicians and support staff to care for transgender youth, and at the very least to have the
infrastructure to call their patients by their correct name and pronouns in Waukesha County. This will keep
the youth here healthy, and it does not endanger others to keep youth healthy in this manner.
• It would be nice to have a cost friendly and less competitive option for middle school kids to participate in
sports. Mukwonago YMCA is the only option for volleyball team sport. More than skill development. It does
not have to be sports, but something that has kids moving and not on a screen with other kids of like age.
• Keep growing the police community connection & presence in every neighborhood. Special concern near rail
road tracks in downtown Waukesha, too many deaths there. Also bars in downtown Waukesha need a police
presence on duty, especially on weekends, on foot in uniform like downtown Milwaukee does, too much
unnecessary violence.
• Knowledge of resources.
• Legalize marijuana. Need dispensaries in our state to keep revenue here instead of it going to neighboring
states.
- Make public health accountable or they will shut down schools again next time there is an opportunity.
- Make sure disabled people know about and have help accessing supports and services available to them through county and help work through state disability bureau and US gov.
- Mental health amongst our children is an urgent concern. We have experienced this personally. Your survey only asked about our oldest child, but we have other kids including one who has had these struggles. The access to mental health and crisis services is URGENT. When kids/families are in crisis and are waiting 12+ months to see a professional it is too long. Every parent should have access to help for a young person who is struggling in our community. Additionally, we have noticed a number of professionals like dentists, vets and pediatricians leaving their practices in our community, and their employers being unable to replace them. We need to make our community attractive to young professionals in these fields to continue to meet the needs within our growing community.
- Mental health services must expand. Prevention/basic health services needs to be where people are located (schools, grocery stores etc.). Schools need to not only prepare for college but also for the trades and just general adult living (personal management/finance/maintenance).
- Mental health services, homelessness, drug use needs better access and services. For my personal situation, being under employed and having limited choices to make a change due to ageism in hiring, major rent increase over the past few years, and inflation is making it hard to meet current financial obligations let alone trying to add to savings or even make any kind of contribution to retirement funds. I also had to not have a diagnostic mammogram done within six months of my annual one, as advised, due to cost even with insurance and even though I am just four years removed from breast cancer lumpectomy and radiation. I'm waiting for the next annual mammogram. Next year I will have to cancel the stress test that gets ordered every other year for the first time because my insurance isn’t changing and I won't be able to afford it. I am paying off the echo cardiogram that out of pocket cost to me was $1,800 this year. I basically have a running $200/month payment for my medical provider since cancer treatment in 2018. I won't even discuss dental health at the expense.
- More grants to help keep up with home improvements like roof, and windows, forgiven for lack of being able to upkeep lawn if rare and really could use a helping hand not to lose 350 dollars and the ability to feed myself to pay the city and making my depression and suicidal thoughts worse due to stress because you are working with me. 850-dollar water bill city waits two weeks to tell me again can't feed myself, can't afford proper heat out of fear of bill to make up a year plus of water in a month no help offered...again the worst mistake of my life buying this house with the Salvation Army the city should buy the block and build these people housing vs. letting people relocate only to find the block in Waukesha.
- More mental health services. Problem is people are not going into this field so you can’t hire more! Need to find ways to encourage people to enter this field of work….
- More mental health treatment and support for unhoused people.
- More needs to be done to find affordable housing for the homeless population in the city of Waukesha, Hop Center helps where they can, but more needs to be done on the city and county level.
- More oral health resources are needed in our community.
- More resources for seniors.
- More resources to help those who don't have insurance get it as well as get health care when they don’t.
- More Vaccination Programs for Children and Adults.
- My only thought as I'm completing this is that residents in Waukesha county who are having health issues (for a variety of other reasons) may not be able to complete this survey online. I became aware via an email newsletter but how will marginalized members of Waukesha county even have an opportunity to complete this survey?
- Need behavioral health ED to offload demand on hospitals for those in need of ambulatory detox.
- Need more doctors in Waukesha to participate in affordable market place health insurance plans.
- Need more Doctors- Family Practice and not have to use Urgent Care just to be seen. Need more Peds Drs.
- Need more walk-in clinics for all not just families in poverty.
- Need to have improved resources for young adults with cognitive disabilities. Need more job coaches available.
- No transportation for those who use wheelchairs in ages below 65, but if over 65 there is no issue getting a ride program. This is unbelievable.
• Offer Brand Name and Generic prescription drugs to those with an RX, especially for brand name, that insurance won't cover. Also, get rid of the Waukesha County Mental Health Center or Get Contracts with hospitals nearby that will ACCEPT Medicaid (not just Medicare). This federal policy not allowing an IMD to bill MEDICAID causes residents emotional and financial suffering beyond words. When a person has MEDICAID, they should be able to use it. If the FEDS won't change the laws, then our county should be empathetic and proactive enough to change the current practices. Send patients with MEDICAID to a hospital who accepts their insurance(s). Please recertify this facility and follow what Granite Hills has done for Milwaukee residents - they accept and can bill Medicaid!
• Older residents have resources, it is the younger 18-40 year olds with debt despite a "decent" wage who are struggling financially and do not take time to see a doctor for a physical or maintenance care.
• Our politicians have to stop representing themselves and start doing the work that supports the community.
• Our residents need to have access to more free activities that are for families and people of all ages on a regular basis, not just for a few sparse days out of an entire year. The core benefits outweigh the costs.
• Pay attention to the big causes of death/disease: CV, cancer, Covid...too much communication and attention to drug abuse, especially Fentanyl. I don't know anyone in our family or friends circle that has drug abuse issues.
• People need more affordable access to healthier foods versus processed foods, which is the only choice they currently have.
• Post Covid, we have seen lots of my child’s friends in need of mental health services. Perhaps it’s the age now in high school but would like to see a continued effort and funding to help teens.
• Reasonable Cash for HC Services! Could even be based on a scale scale based on home income. Aurora HC had a Urgent Care at Walmart in Pewaukee - $29 manned by a PA or NP. Offer minimal POC onsite testing. Didn't accept Ins. IT was Great! Then it went up to $39, $49 - Offered Coupons for $10 & 20 off from time to time. Then it went up to $79 and started billing insurance and NOW you have your Co-Pay issue...Now you might have well go to your FM/IM Provider...Can't Waukesha Community offer 1 location with the same $29 offer? Work with Local Residency programs for MD's, etc...
• Reasonably priced health care available to home/bound patients. I'm often denied care because I'm chronically ill and can't leave my bed. During the last year I needed an ambulance to receive emergency treatment and was admitted each time. Despite having BCBS through my spouses employer, we still owed over $700 for each ride even after all deductibles were met. No one should be forced to ambulance shop in an emergency!
• Remove covid restrictions so health care workers can get back to work. We need them!
• Safety re: guns, in schools, home and elsewhere should also be considered a health issue.
• Senior care and Day Care programs for Seniors.
• Seniors need a source to find safe housing that they can afford on fixed income. Wait lists for subsidized housing are way too many years long. This uncertainty causes anxiety and depression.
• Social media.
• Social services are an important support system for people in our community to have access to. Shelter and food security are the baseline that people need to be successful in other aspects of their lives.
• Society needs a universal health care system that gives comprehensive full care to all regardless of financial status. The total wealth of a very small percentage of the population is more than enough, when taxed fairly, to cover full universal health care.
• Spread out the locations of your Agencies, most resources are located in Waukesha.
• Thank you for doing this.
• Thank you for reaching out to the community.
• Thank you for taking this survey - I would like to have crime and prevention and community involvement increase as we gain a larger population - also taking care of infants and young children to take some burden off young families will pay off for the county in the long run - overall this is a great place to live!
• The ADRC in Waukesha is an excellent resource.
• The fact seems to be doing well. Keep it up.
• The fact that you offer this survey for residents to complete will help!
The vaping that exists with young adults who do not believe that addiction will occur with use.

There is too many competing health care providers that are saturating the market with little concern about the economically disadvantaged in our community.

Too many anti everything people in Waukesha county. Lots of me, my self, I kinds of individuals in the rural areas.

Vote republicans out of office.

Waukesha Memorial Hospital needs better mental health professional educated staff or call in NAMI resource during crises. It gets assumed all mental health is substance abuse and that is very damaging. Goal should be to help that population before they turn to drugs/alcohol. If Waukesha County programs decide to share resources with Milwaukee county there needs to be things available outside of Milwaukee. Crime fear and lack of transportation prevents using inner city group/peer resources.

We appreciate the efforts you are making to improve the health of county residents. Please use the information people are giving you to follow up with constructive, realistic efforts.

We are blessed.

We desperately need to address indoor air quality in our schools, businesses, medical facilities, etc. We particularly need our hospitals, clinics, pharmacies, and other medical facilities to address infection control and prevention of airborne transmission of pathogens including, but not limited to SARS-CoV-2. Immunocompromised people should not have to risk their lives to seek health care. Cancer patients should not risk acquiring COVID when they get chemo. Hospital-acquired COVID infections have over a 10% fatality rate. We need mask mandates in health care facilities and on public transit, as well as HEPA filtration, CO2 monitoring and ventilation in all public spaces. Not only will this reduce the transmission of COVID, but it will also reduce flu, RSV, strep, tuberculosis, and many, many other pathogens, and it will protect members of our community who are unable to mask such as newborn babies and disabled people. We also need a public health information campaign so that the public understands airborne transmission (i.e. that pathogens spread through the air like smoke) and so that the public understands that COVID is not "just a cold" or "just the flu" but rather that it is a serious vascular condition and that a "mild" initial infection does not mean that no damage was done. We also need to invest more in wastewater monitoring, both for SARS-CoV-2 and for other pathogens, because this is our best early-warning system. It is unfortunate that Waukesha stopped sampling our wastewater, and it would be extremely beneficial if we could restart now that the Lake Michigan water project is complete. And finally, we need to be investing heavily in accessibility and infrastructure to support the people being disabled by COVID. Our community is unprepared for the dramatic increase in neurological and physical problems that COVID is causing.

We must educate people and promote acceptance of all races and genders. The hate that exists because of the political climate is dangerous.

We need affordable health care and we need to be able to see a doctor when needed not 5 months down the road. I use Froedttert physicians and you can't get in to see them when you need to.

We need more Froedtert clinics in Waukesha city.

We need to address mental health and substance abuse because it not only afflicts the individual but also their family and parents and/or children. There are inadequate resources and treatment options for children with fetal alcohol spectrum disorders (FASD) and the best thing is to prevent FASD from occurring.

We need to strengthen our elder care services and the number of quality skilled nursing facilities in the area.

Working with legislation to lower the cost of health insurance and medical costs.

You are not dementia friendly.

There should have been a question about how long it takes to get services at the county or at an agency...wait-list.
Appendix G: 2023 Waukesha County Community Health Needs Assessment: A Summary of Key Stakeholder Interviews

The Waukesha County Community Health Needs Assessment key stakeholder interview results can be found at Froedtert Menomonee Falls Hospital Community Engagement.

This report presents a summary of public health priorities for Waukesha County, as identified and reported in 2023 by a range of providers, policymakers, and other local experts and community members (“key stakeholders”). These findings are a critical supplement to the Waukesha County Community Health Survey conducted through a partnership between Ascension Wisconsin, Aurora Health Care, ProHealth Care, Froedtert Health and the Waukesha County Public Health Department. The Community Health Needs Assessment incorporates input from persons representing the broad interests of the community served, and from those who possess special knowledge of or expertise in public health.

Ascension Wisconsin, Aurora Health Care, ProHealth Care, Froedtert Health and the Waukesha County Public Health Department identified 30 key stakeholders in Waukesha County. These organizations also invited the stakeholders to participate and conducted the interviews from August to October 2023. The interviewers used a standard interview script that included the following elements:

Social Determinants of Health:

- Top Rank, Second Rank
- What populations in our communities are most affected by this issue? How are they affected?
- What are the existing strategies and stakeholders to address the health issue? What is working well?
- If your organization works in this space, what is the best way that public health or health care organizations can support you?
- How has COVID-19 impacted this issue?

Health Conditions/Behaviors:

- Top Rank, Second Rank
- What populations in our communities are most affected by this issue? How are they affected?
- What are the existing strategies and stakeholders to address the health issue? What is working well?
- What additional strategies are needed to address this issue? What is keeping our community from doing what needs to be done to improve this issue?
- If your organization works in this space, what is the best way that public health or health care organizations can support you?
- How has COVID-19 impacted this issue?

Additional Questions/Comments:

- How would you suggest organizations reach out to community members to implement health initiatives?
- Do you have any additional comments you would like to share?

All informants were made aware that participation was voluntary and that responses would be shared with JKV Research for analysis and reporting. Members from the team interviewed the key informants and entered responses into Survey Monkey for analysis.

Key Findings

1. The top social determinants of health were safe and affordable housing; accessible, affordable and quality health care; food insecurity; social connectedness and belonging; economic stability and employment and accessible and affordable transportation. The complexities of the interconnected determinants were highlighted often. Populations affected varied somewhat, although people with low income, unemployed/underemployed, older, or people of color crossed several social determinants of health. Starting or expanding collaborations, more funding or marketing/communication of services to increase awareness were needed strategies to address
most issues. Best way to be supported were more funding, support of existing services or increase access/resources. Key stakeholders varied somewhat on the determinant, but typically included government agencies, health care systems, advocates, employers and community leaders.

2. By far, the top health condition/behavior in their community was mental health, mental conditions and suicide followed by alcohol and substance use. Chronic diseases and nutrition/physical activity and obesity were next. “Everyone,” people who were older or with low income were the most often listed affected populations. Similar to social determinants of health, the health conditions/behaviors were not necessarily singular. Collaboration, additional providers/services as well as increasing awareness, education or access were the most often listed strategies needed. Best way to be supported included more funding, support of existing services or increase access/resources. Key stakeholders varied somewhat on the condition/behavior, but typically included schools, government agencies and health care systems, including mental health.

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

The six health issues identified most consistently were:
- Mental Health, Mental Conditions and Suicide
- Alcohol and Substance Use
- Chronic Diseases
- Nutrition, Physical Activity and Obesity
- Safe and Affordable Housing
- Accessible, Affordable and Quality Health Care
- Food Insecurity
- Social Connectedness and Belonging
- Economic Stability and Employment

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

Social Determinants of Health Rankings
Key informants were asked to select the top two social determinants of health in the community they serve. Table 2 indicates the selected determinants and the number of key informants who ranked it as the top social determinant of health. The top six social determinants of health are listed in detail. The remaining determinants are limited in the amount of information available.

General Themes
Several key informants indicated it was difficult to identify two social determinants of health because they were so inter-related. For example, safe and affordable housing, the top

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<td>Safe and Affordable Housing</td>
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social determinant of health, is invariably linked to food insecurity, accessible and affordable transportation and economic stability and employment. Populations affected varied somewhat, although people with low income, unemployed/underemployed, older, or people of color crossed several social determinants of health. Starting or expanding collaborations, more funding or marketing/communication of services to increase awareness were needed strategies to address most issues. Best way to be supported were more funding, support of existing services or increase access/resources. Stakeholders included government agencies, advocates, employers, community leaders and health care systems. COVID-19 exacerbated most issues.

Top Social Determinants of Health Summaries
Safe and Affordable Housing
Fourteen key informants’ interview rankings included safe and affordable housing as a top social determinant of health, and nine ranked it number one.

Populations Affected and How: The most often cited population affected was the low to mid income households. People who were older, with special needs/disabilities or with mental health issues were also listed a handful of times. The jobless/under-employed/underinsured, people of color, youth, single parents or families were also mentioned. Instability was the description of how populations are affected. The lack of affordable housing or landlord refusal of vouchers can create issues with finances, employment and lead to homelessness or overall instability.

Existing Strategies: Collaborations/coalitions, housing resources, government services, social support agencies, nonprofits or funding to help make housing more affordable were the most often cited strategies. Crisis management or vouchers were also mentioned.

Critical Community Stakeholders: Top critical stakeholders included government leaders and government agencies. Collaborations/partnerships were listed next. Nonprofits, city planners, landlords/property managers and employers were also listed by a few key stakeholders.

Best Way to be Supported: Over three-quarters of key informants indicated that raising awareness about the housing situation was the best way organizations could be supported. In addition, there should be health system participation, collaboration or more funding. Communities need to build more affordable rentals and permanent supportive housing since there are not enough to meet the need. Increase landlord accountability/responsibility, a centralized services system/navigators, just-in-time help as well as legislative policy changes were also ways to support organizations who worked in this space. In addition, efforts to be inclusive should be practiced.

COVID-19 Impact: Nearly half of key informants stated COVID-19’s impact was an increased demand for affordable housing. COVID exacerbated unemployment/business closures/stable income and increased rent/housing costs. The ending of the rent moratorium and federal assistance also had an impact.

Accessible, Affordable and Quality Health Care
Seven informants’ interview rankings included accessible and affordable health care as a top social determinant of health, and three ranked it number one.

Populations Affected and How: The most often cited populations affected were households with low to mid income or near/below poverty level. People of color were also identified. Poor access to health care due to a high-cost burden can affect their economic stability, delay services and have less overall health/wellbeing.

Existing Strategies: Health care providers were the most often cited existing strategy followed by nonprofits or mental health services. More funding was also listed.
Community Stakeholders: Critical stakeholders included health care providers/systems, government agencies and collaborations/partnerships.

Best Way to be Supported: Collaboration, awareness of resources or health system participation were the most often mentioned ways organizations could be best supported. Increase funds, accessibility, affordability or mental health providers were also mentioned. Navigators to help identify resources available or provide support through a continuum of care were ways to support organizations.

COVID-19 Impact: Half of key informants stated COVID-19 had an impact on people delaying health care services due to cuts in services. Money came from the federal level to support health care industry but it has now been cut. Lack of awareness on how to access health care was also listed.

Food Insecurity
Seven informants’ interview rankings included food insecurity as a top social determinant of health, and three ranked it number one.

Populations Affected and How: The most often cited populations affected were people who were older or households with low income or near/below poverty. Lack of support/limited resources or travel distance for food has increased food insecurity. High-cost burden can lead to an unhealthy quality of life. Food pantries have seen an increase of patrons.

Existing Strategies: Nonprofits were the most often cited strategy. Collaborations/coalitions, community programs, free/reduced school lunch, government services or volunteers were also existing strategies.

Critical Community Stakeholders: Critical stakeholders included government agencies, collaborations/partnerships and the faith community.

Best Way to be Supported: Awareness of resources, navigators to help identify the resources available, collaborations or health system participation were the most often mentioned ways organizations could be best supported. Increase access, increase affordability as well as target at-risk populations were also listed.

COVID-19 Impact: Half of key informants stated COVID-19 decreased income through unemployment/closures, which then increased food insecurity. Funding at the federal level helped at first, but with that assistance ending, food insecurity increased.

Social Connectedness and Belonging
Seven informants’ interview rankings included social connectedness and belonging as a top social determinant of health, and three ranked it number one.

Populations Affected and How: “Everyone” was most often cited population affected. People who were older, youth, people of color or teens were specifically listed. With a lack of social connectedness, people feel isolated or do not feel like they belong, increasing mental health issues. Some noted that social media has been a mostly negative influence on connectedness.

Existing Strategies: Community programs or safe social groups were the most often cited strategies. Peer coach/recovery coach/support groups or accessibility to resources were listed by a few informants as well.

Critical Community Stakeholders: Critical stakeholders were schools, government agencies, public sector/community centers, health care providers/systems, collaborations/partnerships and nonprofits.
Best Way to be Supported: Increase awareness or more marketing of programs for social connectedness/belonging were the most often mentioned ways organizations could be supported. Collaborations, support of existing programs, more planning efforts or health system participation were also efforts to address social connectedness and belonging.

COVID-19 Impact: Half of key informants stated COVID-19’s impact was an increase in isolation and social disconnectedness. COVID-19 exacerbated the issue and delayed social skills for children due to virtual learning, which wasn’t as effective as in-school learning. One positive outcome was some families reconnected and started new hobbies due to safety procedures of staying home.

Economic Stability and Employment
Six informants’ interview rankings included economic stability and employment as a top social determinant of health, and five ranked it number one.

Populations Affected and How: The most often cited populations affected were the unemployed, underemployed or under/uninsured. People who were older were also listed. The lack of training/job preparation can affect one’s employment or finances.

Existing Strategies: Job training education was the most often cited strategy. Keeping workers employed or government services were also existing strategies.

Critical Community Stakeholders: Most often cited critical stakeholders were health care providers/systems, government agencies, employers, schools, nonprofits and collaborations/partnerships.

Best Way to be Supported: Several key informants indicated health system participation was the way organizations could be best supported. Awareness of resources, navigators to help identify the resources available, collaborations or increase funding were mentioned. Employer education of maintaining a healthy workforce, health education or prevention/early prevention would also help with economic stability.

COVID-19 Impact: Key informants stated COVID-19’s impact was an increase in unemployment/business closures/income instability as well as the impact of inflation on the economy.

Accessible and Affordable Transportation
Six informants’ interview rankings included accessible and affordable transportation as a top social determinant of health, and one ranked it number one.

Populations Affected and How: Half of key informants indicated rural residents or those who were homebound as the most affected populations. People who were older were also listed. Without affordable transportation access, community members’ have limited access to health care, employment as well as healthy food options.

Existing Strategies: Transportation accessibility or resources were the most often cited existing strategies.

Critical Community Stakeholders: Critical stakeholders included government agencies and nonprofits. Collaborations/partnerships were also listed.

Best Way to be Supported: Increase awareness through marketing/communication, easier access or more affordable were the most often mentioned ways organizations could be supported. Collaboration or training of staff were also mentioned.

COVID-19 Impact: A few key informants stated COVID-19’s impact was fewer transportation services offered, as well as fewer staff/volunteers who returned after the shut-down.
Remaining Social Determinants of Health
The remaining social determinants of health are listed below along with populations affected, strategies, critical stakeholders, best way to be supported and COVID-19 impact. Please be aware of the limited number of key informants who listed these as one of their top two rankings.

Affordable Childcare
Five informants’ interview rankings included affordable childcare as a top social determinant of health, and two ranked it number one.

Existing strategies to meet the issue included before/after care at schools, schools starting a 3-year-old program and expanding 4-year-old program or training childcare providers. Schools and government agencies were listed as critical community stakeholders. Employee-based/sponsored childcare, increase childcare staffing, school run daycares or affordability were the most often mentioned ways organizations could be supported. COVID-19 increased the awareness of the problem and increased cost. This caused a reduction in staff, increasing the need for affordable childcare.

Access to Social Services
Five informants’ interview rankings included access to social services as a top social determinant of health, and one ranked it number one.

Existing strategies included navigators to help connect people to the resources that they need. Critical stakeholders included government agencies, schools, nonprofits, volunteers and health care providers/systems. Increased awareness, communication, funding, support for current agencies, collaborations, a simpler process or navigators were the most often mentioned ways organizations could be best supported.

Family Support
Three informant’s interview rankings included family support as a top social determinant of health, and they ranked it number one.

Communication/awareness of available resources that focus on family support, social connectedness and physical activity for families were existing strategies. Nonprofits, schools, community centers, collaborations/partnerships and faith community were listed as critical stakeholders. Educational programs on how to be a supportive family member, increase awareness or communication of current resources were the most often mentioned ways organizations could be supported.

Health Conditions/Behaviors Rankings
Key informants were asked to select the top two health conditions/behaviors in their service area. Table 3 indicates the conditions/behaviors that were selected as well as the number of key informants who selected it as the top condition/behavior. The top four health conditions/behaviors are listed in detail. The remaining conditions/behaviors are limited in the amount of information available.
General Themes

“Everyone,” people who were older, or with low income were listed most often when asked about populations affected for most of the top four health conditions/behaviors. Mental health/conditions/suicide was overwhelmingly listed as the top priority. Similar to social determinants of health, the health conditions/behaviors were not necessarily singular. As a result, holistic approaches and collaboration were often listed as strategies to best meet the inter-connected conditions/behaviors. Awareness of services or education were often listed as well. The best way to support organizations who work in the space reported more funding, support of existing services or increase access/resources. Key stakeholders varied somewhat on the condition/behavior, but typically included schools, government agencies, and health care systems.

Top Health Conditions/Behaviors Summaries

Mental Health, Mental Conditions, and Suicide

Twenty-three key informants’ interview rankings included mental health, mental conditions and suicide as a top health condition/behavior and 14 (61%) ranked it number one. All informants were asked to select the most important health topic of the three (mental health, mental conditions and suicide) that must be addressed in Waukesha County to improve the health and quality of life in their community. Twelve key informants ranked overall mental health as the most important health topic. Five key informants ranked mental health conditions as the most important health topic followed by two key informants who ranked suicide. The remaining five did not select any of the three.

Populations Affected and How: Over half of key informants reported the most affected population was “everyone.” Youth, people with low income or who were older were listed next. People who were uninsured, who lacked knowledge of health care access, teens, people of color or homeless/transient people were also listed. Poor mental health can affect their social connectedness/sense of belonging, families, employment, relationships or school success. Affected populations may have poor access to health care, lack AODA or mental health knowledge, have an unhealthy quality of life, have housing issues or suicide ideation. Employers also lack resources.

Existing Strategies and Critical Community Stakeholders: Collaborations, government services, accessible resources or awareness were the most often cited strategies. Mental health screenings/services in schools, crisis management, nonprofits, student programs or education were also existing strategies. Training, health care providers, more funding, community campaigns and programs, mental health providers with officers, telehealth, social support, prevention, access for under-insured people or decreasing stigma were also listed. Government agencies, law enforcement, schools, communication, health care providers/systems, social support agencies and AODA providers were critical stakeholders.

Additional Strategies Needed: Additional strategies included more access/resources, collaboration, education, crisis management, more providers, nonprofits or reduce stigma. Increase funding or staff as well as expand behavioral or mental health services were also mentioned. Law enforcement de-escalation or training were listed by a few key informants. Navigators, school mental health screening, social support agencies or more corporate buy-in were also listed.

Best Way to be Supported: Collaboration, health system participation or marketing/communication to increase awareness were the most often mentioned ways organizations could be best supported. Mental health education, increased funding or support of existing services were also mentioned. More mental health providers, school-based programs, mental health services provided at school, staffing, professional development/training or referrals were listed by a few informants. Just-in-time help, planning, prevention, early intervention, trauma-informed care or EAP including mental health were also listed.
COVID-19 Impact: Isolation and social disconnectedness increased stress levels/anxiety/mental health which was exacerbated by the COVID pandemic, revealing the greater need for services and a longer waiting list. Dealing with the grief and stress of the COVID-19 pandemic was also listed. Access became more difficult until there were some telehealth services, which improved access for some. One positive outcome of the COVID pandemic was an overall increase of the importance of mental health.

Alcohol and Substance Use
Sixteen key informants’ interview rankings included alcohol and substance use as a top health condition/behavior and six ranked it number one.

Populations Affected and How: Nearly half of key informants reported the most affected population was “everyone.” People with mental health issues, teens, families or people with high ACE’s were also listed. Alcohol and substance use may affect employment, finances, housing, relationships, access to health care or impact overall health, including mental health.

Existing Strategies and Critical Community Stakeholders: Collaborations or government services were the most often cited strategies. Awareness, nonprofits or mental health services were also existing strategies. Behavioral health services, Narcan or reducing stigma were listed by a few informants as well. Education, community campaigns, peer coaching, medication, housing resources or more funding were also listed. Government agencies, granting agencies, health care providers/systems, AODA providers, mental health providers, treatment facilities, law enforcement, schools, college involvement/adult educators, nonprofits, caregivers and neighborhood/community were listed as stakeholders.

Additional Strategies Needed: Education, access to services/resources or increase awareness of the issue were the most often identified additional strategies needed. Criminal justice system, government services, behavioral health service or more funding and were also listed. More collaboration, student programs, peer coaching, determine root causes, reduce stigma, housing resources, health care providers or early intervention were also listed.

Best Way to be Supported: Collaboration was the most often mentioned way organizations could be best supported. Marketing/communication to increase awareness, health system participation or more AODA services were also mentioned. Long-term patient focus, more affordable, early intervention, holistic continuum, support of existing services, family involvement or target at-risk populations were also listed.

COVID-19 Impact: Isolation and social disconnectedness increased with the COVID-19 pandemic, as did alcohol and substance use.

Chronic Diseases
Nine key informants’ interview ranking included chronic diseases as a top health condition/behavior and seven ranked it number one.

Populations Affected and How: Older people were the most often listed affected population followed by low-income households, people of color or “everyone.” Affected populations may have a high-cost burden or lack of education about health care/nutrition/physical activity/mental health.

Existing Strategies and Critical Community Stakeholders: Education or collaboration were the most often cited strategies. Accessible resources, health care providers, prevention or early intervention were also existing strategies listed. Health care providers/systems were the most often listed critical stakeholders. Public sector/community centers, schools and insurance companies were also mentioned.

Additional Strategies Needed: Education, more access to resources or more funding were the top additional strategies needed. Health care providers, affordability of insurance, awareness, healthy eating/nutrition or physical activity options were listed as additional strategies needed.
**Best Way to be Supported:** Collaboration, marketing/communication to increase awareness, health education or nutrition support were the most often mentioned ways organizations could be best supported. Health system participation, increase access, more affordable, as well as a good referral system were also listed.

**COVID-19 Impact:** COVID-19’s safety procedures caused health care delays and caused a more sedentary life with less activity and poor nutrition.

**Nutrition, Physical Activity, and Obesity**
Nine key informants’ interview rankings included nutrition, physical activity and obesity as a top health condition/behavior and three ranked it number one. All informants were asked to select the most important health topic of the three (nutrition, physical activity and obesity) that must be addressed in Waukesha County to improve the health and quality of life in their community. Five key informants ranked nutrition as the most important health topic while two key informants ranked obesity. Zero key informants selected physical activity. Two did not select any of the three topics.

**Populations Affected and How:** “Everyone” was the most often listed affected population followed by low-income households or older people. Affected populations may have a lack of knowledge about nutrition/physical activity, unhealthy convenient foods, chronic diseases or have an unhealthy quality of life, which all can lead to physical health issues/chronic diseases.

**Existing Strategies and Critical Community Stakeholders:** Nonprofits were listed as the most critical existing strategy. Collaborations, education, cooking/nutrition classes, community programs, wellness incentives, fitness centers/programs, healthy eating/nutrition education, accessible resources or government services were also listed. Additional stakeholders included colleges/adult educators and farmers.

**Additional Strategies Needed:** Physical activity options through fitness centers or healthy eating/nutrition education were most often listed additional strategies needed. Increase access, affordability of resources or community programs were also mentioned.

**Best Way to be Supported:** Collaboration was the most often mentioned way organizations could be best supported. Health system participation, nutrition support, health education, marketing/communication to increase awareness or support of existing services were listed by a few informants.

**COVID-19 Impact:** COVID-19 caused a more sedentary life with less activity and poor nutrition. COVID exacerbated bad habits, isolation and social disconnectedness.

**Remaining Health Conditions/Behaviors**
The remaining health conditions/behaviors are listed below along with populations affected, strategies, critical stakeholders, best way to be supported and COVID-19 impact. Please be aware of the limited number of key informants who listed these as one of their top two rankings.

**Reproductive Health, Sexual Health, and STI’s**
One key informant interview ranking included reproductive health, sexual health and STI’s as a top health condition/behavior and zero ranked it number one. Awareness of the issue, accessibility of services or reproductive education were listed as additional strategies needed. Marketing/communication to increase awareness or health education for young women was mentioned as a way an organization could be supported.
**Tobacco and Vaping Products**
One key informant’s interview ranking included tobacco and vaping products as a top health condition/behavior and zero ranked it number one. Increase mental health providers, parental education or longer medical appointments were listed as additional strategies needed. Mental health education for parents was mentioned as a way an organization could be supported.

**Feminine and Hygiene Products**
One key informant’s interview ranking included feminine and hygiene products as a top health condition/behavior and zero ranked it number one. Increase donations or more funding to provide products to women and families were additional strategies needed.

**Additional Questions/Comments**
Key informants were asked to include how they would suggest organizations reach out to community members to implement health initiatives and provide any additional comments.

**General Suggestions on Reaching Community**
Most suggestions involved communication/marketing/regular updates to their clients/list. Going to where the people are for community involvement or collaborations were also indicated numerous times. Maintaining affordability and accessibility, involving health care organizations, schools, business community, faith-based organizations and the health department were also listed. Being inclusive and cultural competent is important. Knowledge of social media’s influences was also mentioned.

**Additional Comments**
A few key stakeholders were positive on Waukesha County’s ability to provide services to residents. In addition, the inter-connectedness of social determinants of health or conditions/behaviors made it difficult for some key stakeholders to select only two. The importance of working towards a crisis stabilization center was mentioned by one stakeholder. Another comment included the need to understand the homeless population in the community better.
Appendix H: Key Stakeholder Organizations Interviewed for purposes of conducting the Froedtert Menomonee Falls Hospital CHNA

<table>
<thead>
<tr>
<th>Organization</th>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging &amp; Disability Resource Center</td>
<td>Manager</td>
<td>Mary Check Smith</td>
</tr>
<tr>
<td>Arrowhead Union High School District</td>
<td>Superintendent</td>
<td>Conrad Farner</td>
</tr>
<tr>
<td>Community Action Coalition for South Central Wisconsin</td>
<td>Development Director</td>
<td>Jeremy Otte</td>
</tr>
<tr>
<td>Community Outreach Health Clinic</td>
<td>Nurse Practitioner/Clinic Coordinator</td>
<td>Linda Smith</td>
</tr>
<tr>
<td>Community Smiles</td>
<td>President/CEO</td>
<td>Renee Ramirez</td>
</tr>
<tr>
<td>Elmbrook Schools</td>
<td>Superintendent</td>
<td>Dr. Mark Hansen</td>
</tr>
<tr>
<td>Eras Senior Network</td>
<td>Executive Director</td>
<td>Darryl Anderson</td>
</tr>
<tr>
<td>Falls Area Food Pantry</td>
<td>Executive Director &amp; Pantry Director</td>
<td>Widge Liccione &amp; Jeannine Matuszak</td>
</tr>
<tr>
<td>Family Service of Waukesha</td>
<td>Director Agency Development</td>
<td>Laura Cherone</td>
</tr>
<tr>
<td>Habitat for Humanity</td>
<td>Director of Operations</td>
<td>Sara Clark</td>
</tr>
<tr>
<td>Hebron Housing Services</td>
<td>Executive Director</td>
<td>Kathleen Fisher</td>
</tr>
<tr>
<td>Lake Area Free Clinic</td>
<td>Executive Director</td>
<td>Mary Reich</td>
</tr>
<tr>
<td>Mukwonago Food Pantry</td>
<td>Executive Director</td>
<td>Hannah Hazelberg</td>
</tr>
<tr>
<td>Mukwonago School District</td>
<td>Superintendent</td>
<td>Joe Koch</td>
</tr>
<tr>
<td>NAME SE WI</td>
<td>Executive Director</td>
<td>Mary Madden</td>
</tr>
<tr>
<td>School District of Menomonee Falls</td>
<td>Superintendent</td>
<td>David Munoz</td>
</tr>
<tr>
<td>Shorehaven</td>
<td>CEO</td>
<td>Dale Dahlke</td>
</tr>
<tr>
<td>Sixteenth Street Community Health Center</td>
<td>Clinic Manager</td>
<td>Liz Kirsch</td>
</tr>
<tr>
<td>United Way</td>
<td>Health Portfolio Manager/Lead for Empowering Minds</td>
<td>Amanda Weiler</td>
</tr>
<tr>
<td>UW-Madison Extension, Waukesha County</td>
<td>FoodWise Program Administrator</td>
<td>Jill Herz</td>
</tr>
<tr>
<td>Waukesha County Business Alliance</td>
<td>President &amp; CEO</td>
<td>Suzanne Kelly</td>
</tr>
<tr>
<td>Waukesha County Department of Health &amp; Human Services</td>
<td>Public Health Officer</td>
<td>Ben Jones</td>
</tr>
<tr>
<td>Waukesha County Fire Chiefs Association</td>
<td>Chief</td>
<td>Steve Howard</td>
</tr>
<tr>
<td>Waukesha County Gov.</td>
<td>Waukesha County Circuit Court Judge</td>
<td>Judge Jack Melvin</td>
</tr>
<tr>
<td>Waukesha County Government</td>
<td>Waukesha County Executive</td>
<td>Paul Farrow</td>
</tr>
<tr>
<td>Waukesha County Mental Health Services</td>
<td>Clinical Services Manager</td>
<td>Kirk Yauchler</td>
</tr>
<tr>
<td>Waukesha Food Pantry</td>
<td>Director of Program Services</td>
<td>Michael Egly</td>
</tr>
<tr>
<td>Waukesha Free Clinic</td>
<td>Executive Director</td>
<td>Amy Vega</td>
</tr>
<tr>
<td>YMCA at Pabst Farms</td>
<td>Branch Executive Director</td>
<td>Jessica Meiling</td>
</tr>
<tr>
<td>YMCA of Greater Waukesha County</td>
<td>Association Director of Healthy Living</td>
<td>Chelsea Kujawa</td>
</tr>
</tbody>
</table>
Appendix I: 2023 Secondary Data Report

In 2023, data was collected through a secondary data analysis using Metopio and other publically available sources. This health data 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. Data for each indicator were presented by race and ethnicity and gender when the data were available. A secondary data analysis was completed in November 2023. All of the data come from publicly available data sources.

Publicly available data sources used for the Secondary Data Analysis

- Behavioral Risk Factor Surveillance System (BRFS)
- Center for Disease Control. SVI Interactive Maps – Social Vulnerability, 2020
- Metopio
- United Way ALICE Report
- U.S. Census Data (CENSUS)
- Waukesha County Youth Risk Behavior Survey
- Wisconsin Department of Health Services (DHS)
- Wisconsin Department of Justice
- Wisconsin Family Health Survey (FHS)
- Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics
- Wisconsin Interactive Statistics on Health (WISH)

Limitations: Secondary data is limited to availability of data, with some health topic areas having a robust set of indicators while others are more limited. Some secondary data sources do not include subpopulation data and others only display values for a select number of race/ethnic groups.
Appendix J: 2023 Internal Hospital Data

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

Froedtert Health data sources used

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

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

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

- **Wisconsin Hospital Association CHNA Dashboard**
  - The Wisconsin Hospital Association Information Center created a Community Health Needs Assessment (CHNA) Mapping Tool to allow hospitals, and community partners the opportunity to identify areas of need in their community by analyzing clinical conditions and community characteristics. Using data from both the WHA Information Center and American Community Survey, the tool allows for specific analysis down to the census tract level of individual communities.
Appendix K: Review of the Fiscal Year 2022-2024 Froedtert Menomonee Falls Hospital CHNA Implementation Strategy

Froedtert Menomonee Falls Hospital’s previous CHNA implementation strategy addressed the following priority health needs: Population Health and Health Equity, Behavioral Health, Workforce Development and Infectious Disease.

The table below describes the actions taken during the 2022-2024 CHNA to address each priority need and indicators of improvement.

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

<table>
<thead>
<tr>
<th>Significant Health Need</th>
<th>Program</th>
<th>Actions</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Population Health and Health Equity      | Healthcare Access for Priority Populations and Navigation of Community Resources, Health Equity, Patient Access to Affordable Transportation, Chronic Disease Prevention and Management | • 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 the FMFH Family Medicine Residency Program.  
• Partner with Human Resources and Diversity and 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 resources.  
• 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. | • Almost 5,000 patients received care at the Community Outreach Health Clinic with over 200 specialty referrals, 5,604 ancillary services, and 11,365 medications dispensed.  
• Community Smiles Dental provided 22,323 dental appointments with over 85,000 dental procedures, 1,633 emergency exams and a value of care at $5,991,207.  
• FMFH Family Medicine Residency Program had over 31,000 patient visits.  
• Program implemented by Diversity and Inclusion include pronouns on staff ID badges, emerging markets initiative, diversity education such as micro aggression module and unconscious bias session, implementing signature community events and workforce development efforts.  
• Provided 7,796 subsidized medical transportation rides.  
• Covered over $21,000 in transportation costs.  
• Transitioned transportation to Care Coordination for better management of the program.  
• Over 1,750 individuals participated in the FIT in the Park program that we supported.  
• Provided education on nutrition topics, fall prevention, organ donation, virtual visit options, cancer, mental wellness, heart health, and sharps disposal after FIT in the Park exercise classes.  
• Provided monthly health |
education to bingo players at the Menomonee Falls Senior Center. Covered a variety of topics such as digital tools available to help manage one’s health, preventing falls, healthy movements, safe sleep for babies, heart health, and nutrition.

- Educated clients at Sussex Area Outreach Services on nutrition topics including a Walk Through the Pantry with a Dietitian.
- 69 educational opportunities that resulted in 1,497 educational interactions. Education was held in a variety of settings such as prior to bingo at a senior center, after FIT in the Park workouts, in a food pantry lobby and stand-alone classes at community sites.
- 272 blood pressure screenings were completed in the community.
- 60 balance screenings were completed at 2 Mug for a Rug, Zero Falls in the Falls events.
- Each year dozens of Community Outreach Health Clinic patients are educated and counseled about colorectal cancer screenings and encouraged to schedule a colonoscopy.
- 6 colonoscopies provided to uninsured patients in partnership with the Bobbie Nick Voss Charitable Funds.
- 9,428 Fecal Immunochromical Tests (FIT) Kits were mailed to F&MCW patients who were overdue on colonoscopy screenings. 1,655 kits were returned (17.6%) and 97 of those kits tested positive.
- The hospital’s Community Outreach Steering Committee provided $172,560 in grants to support needs such as maternal and child health, physical activity, housing, access to care and behavioral health. In addition, the health network sponsorship program dedicated over $36,000 to support partners in Waukesha County.

| Behavioral Health | Social Engagement Support Groups | Support behavioral health support groups and programs through community partnerships. | Support and promote initiatives | Froedtert Health Behavioral Health Department supports a mental health peer support group. | 9 educational opportunities |
### Prescription Drug Prevention, Treatment, Screenings and Referrals Services

- 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.

### Workforce Development

<table>
<thead>
<tr>
<th>Program Development Sponsorship</th>
<th>Mission Critical Careers</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Evaluate current partnership and resources required to meet workforce development needs.</td>
<td>- Develop and implement a coordinated plan in partnership with Froedtert Health Workforce Development, Human Resources and Organizational Development.</td>
</tr>
<tr>
<td>- Create effectiveness criteria of partnerships.</td>
<td>- Develop a tracking tool to evaluate student involvement and long-term impact on health care careers.</td>
</tr>
<tr>
<td>- 57 Froedtert in Action volunteers mentored 144 LAUNCH students tasked with solving real-world health care industry problems.</td>
<td>- 3 Pewaukee High School students received monthly one-on-one mentoring during the school year.</td>
</tr>
<tr>
<td>- 42 LAUNCH students participated in mock interviews with Froedtert in Action volunteers.</td>
<td>- $172,100 was awarded through the hospital’s scholarship program to support students pursuing health care careers.</td>
</tr>
</tbody>
</table>

Impacting 224 people. Provided education on topics such as medication safety and disposal, stress management, embracing youth’s interest with social media, and benefits of volunteering on your mental wellness.

- Provided spring and fall yard cleanup support to local senior citizens and people with disabilities. This initiative is more than yard work; it is connecting with community members who may be experiencing social isolation. 118 yards were cleaned by 399 Froedtert in Action volunteers.
- Froedtert Health staff served as active members on the Waukesha County Heroin Task Force. In addition, staff served as leads for the Waukesha County CHIP Steering Committee, data action team, and mental health action team. Staff are also active on both the substance use and healthy aging action teams.
- 1,176 pounds of unused medications collected from 680 households at Froedtert Menomonee Falls Hospital.
- 735 behavioral health screenings were conducted at the Community Outreach Health Clinic as well as 536 counseling and management sessions and 115 individuals received medication-assisted treatments.
- In partnership with Froedtert Health Behavioral Health and Waukesha County Human Services, at least two presentation to over 40 students were conducted to educate students on mental wellness and mental health care careers.
- Provide scholarships to students interested in participating in health care career exploration programs through the FMFH Foundation.
- Promote mission critical careers at Froedtert Health in areas such as nursing, behavioral health, technicians and medical assistants.
- 18 Froedtert in Action volunteers offered a multi-session virtual job shadow experience with 10 LAUNCH and 14 Menomonee Falls High School students.
- 8 Froedtert in Action volunteers served as an authentic audience to 130 LAUNCH students. Froedtert Health staff listened and provided feedback to students who researched and presented on a disease.
- 475 Wakesha County students attended the Discovering Health Care Expo where F&MCW staffed 9 career booths. This event showcases the variety of career options within health care.
- 37 health care career presentations were completed for 2,838 students. Presentations were done in collaboration with health care specific high school classrooms and Junior Achievement.
- Froedtert Health received recognition and awards for its work with the LAUNCH program: 2022 Wisconsin Association of School Board’s Business Honor Roll, Community Partners in Stroke Care Award, and Golden Apple Excellence in a Community Partnership award.

<table>
<thead>
<tr>
<th>Infectious Disease</th>
<th>Health Disparities</th>
<th>Immunizations</th>
<th>Preparedness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Implement outreach and prevention initiatives through community partners as well as Froedtert Health’s hotline, social media pages, website and other media modes.</td>
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<tr>
<td></td>
<td>Implement immunization clinics in collaboration with community partners and local health department.</td>
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<td></td>
<td>Review and revise a coordinated emergency preparedness plan with the local health department.</td>
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<td></td>
<td>217 people from 5 local food pantries received a free flu vaccine.</td>
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<tr>
<td></td>
<td>75 Community Outreach Health Clinic patients received a free flu vaccine.</td>
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<tr>
<td></td>
<td>A flu clinic was held at the Menomonee Falls Senior Enrichment Fair. 107 attendees received their flu shot at the event.</td>
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<tr>
<td></td>
<td>Froedtert Health hosted 9 drive thru flu clinics in Menomonee Falls. 1,726 flu vaccines were provided. 108 Froedtert in Action volunteers assisted at the event to help with traffic control.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>2 educational classes were offered at community events to 44 people. Classes were on COVID: Truth vs. Myth and Vaccines for the Elderly.</td>
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</tbody>
</table>