



Community Health Needs Assessment (CHNA) Report

Froedtert Memorial Lutheran Hospital
Doing Business As:

Froedtert Hospital
Fiscal Year 2020
Effective July 1, 2019

Approved on 11/19/2020 by
Froedtert Hospital Board of Directors

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Executive Summary

Community Health Needs Assessment for Froedtert Hospital

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

Froedtert Health is a member of the Milwaukee Health Care Partnership (www.mkehcp.org), a public private consortium dedicated to improving care for underserved populations in Milwaukee County. Through the Partnership, Milwaukee's four health systems and the Milwaukee county Health Department aligned resources to participate in a shared data collection process. Supported by additional analysis from the Center for Urban Population Health, this robust community-wide CHNA includes findings from a community health survey, informant interviews, focus groups and a compiling of secondary source data. This shared CHNA serves as the foundation for Froedtert Hospital and is the basis for creation of an implementation strategy to improve health outcomes and reduce disparities in Milwaukee County and the hospital's primary service area.

Froedtert Hospital community engagement strategies are guided by the Community Health Improvement Advisory Committee (CHIAC) (**Appendix A**), with members representing a variety of stakeholder groups, including racial, ethnic, immigrant/refugee, disabled, elderly and faith-based organizations. The committee also includes key Froedtert & the Medical College of Wisconsin departments, and all members have a strong commitment to improving community health and reducing health disparities. With particular expertise in public health, population health, wellness and process improvement, the members of this committee provide guidance to Froedtert Hospital's CHNA. Under the direction of the Community Engagement Leadership Team and trained meeting facilitator; findings from the assessment were categorized and ranked to identify the top health needs in Milwaukee County.

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

Community Health Needs Assessment

In 2018, a CHNA was conducted to 1) determine current community health needs in Milwaukee County, 2) gather input from persons who represent the broad interest of the community and identify community assets, 3) identify and prioritize significant health needs, and 4) develop implementation strategies to address the prioritized health needs. Froedtert 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 was collected and taken into consideration for assessing and addressing community health needs:

Community Health Survey: Using the Center for Disease Control's Behavioral Risk Factor Surveillance System (BRFSS), a telephone-based survey of 1,312 residents was conducted by Froedtert Hospital in collaboration with the Milwaukee Health Care Partnership. The full report of this survey can be found at <https://www.froedtert.com/community-engagement>.

Key Informant Interviews: Froedtert Hospital Community Engagement team and leaders conducted 40 in-person interviews and four focus groups with community leaders of various school districts, non-profit organizations, health & human service department and business leaders. A list of organizations can be found on page 12 of this document. The full Key Informant CHNA can be found at <https://www.froedtert.com/community-engagement>.

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

CHNA Prioritization of Community Health Needs Process

Froedtert Hospital community engagement strategies are guided by the Community Health Improvement Advisory Committee (CHIAC), with members representing a variety of stakeholder groups, including racial, ethnic, immigrant/refugee, disabled, elderly and faith-based organizations. The committee also includes key Froedtert & the Medical College of Wisconsin departments, and all members have a strong commitment to community health improvement and reducing health disparities. With particular expertise in public health, population health, wellness and process improvement, the members of this committee provide guidance to Froedtert Hospital's community health improvement plan for the development and monitoring of the Implementation Strategy. Under the direction of the Community Engagement Leadership Team and a trained meeting facilitator, the planning process included five steps in developing the Implementation Strategy:

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

After several facilitated workout sessions in January 2019-March 2019, based on the information from all the CHNA sources, the most significant health issues were identified as:

- Mental Health,
- Chronic Disease,
- Access to Care,
- Violence Prevention,

- Substance Use,
- Infectious Diseases,
- Nutrition and Healthy Food

To identify the top priorities among the significant health needs identified, members of the Advisory Committee were asked to rate each priority based on the following criteria: feasibility of Froedtert Hospital to address the need (direct programs, clinical strengths and dedicated resources); alignment with Froedtert Health's strategic priorities; current or potential community partners/coalitions; and identification of achievable and measurable outcomes for each such significant health need. Of those significant health needs categories, three overarching themes were identified as priorities for Froedtert & the Medical College of Wisconsin Implementation Strategy for fiscal 2020-2022:

- Behavioral Health
- Chronic Disease
- Violence
- Access to Care

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

CHNA Report/Implementation Strategy Solicitation & Feedback

Froedtert Hospital is committed to addressing community health needs collaboratively with local partners. Hospital used the following methods to gain community input from April to June 2018 on the significant health needs of the Froedtert Hospital's community. These methods provided additional perspectives on how to select and address top health issues facing Froedtert Hospital's community.

Input from Community Members

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

- Identified up to three public health issues that are the most important for Milwaukee County, based on focus areas presented in *Healthiest Wisconsin 2020*, Wisconsin's State Health Plan. For each public health priority, informants were asked to identify:
 - Existing strategies to address the issue
 - Barriers/challenges to addressing the issue
 - Additional strategies needed to address the issue
 - Key groups in the community that hospitals should partner with to improve community health
 - Subgroups or populations recommended for specific outreach
- Selected the top three determinants of health (also called health factors) impacting our community, as described in the federal government's *Healthy People 2020*
- Rated the level of impact of two emerging areas identified in Wisconsin's *State Health Assessment and Health Improvement Plan*: Adverse Childhood Experiences (ACEs) and Alzheimer's Disease and Dementia

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

- Community Health Survey: When appropriate, data was stratified by gender, age, education household income level and marital status.

- **Key Informant Interviews:** The key informant interviews included input from members of organizations representing medically underserved, low-income and minority populations.

Summary of Community Member Input

The top five health issues ranked most consistently or most often cited for Milwaukee County were:

Key Informant Interviews:

- Mental Health
- Access to Health Care
- Violence
- Substance Use
- Nutrition and Healthy Food

Community Health Survey:

- Chronic Disease or Cancer
- Illegal Drug Use or Prescription/OTC Drug Abuse
- Access to Health Care
- Infectious Disease
- Violence or Crime

After adoption of the CHNA Report and Implementation Strategy, Froedtert Hospital publicly shares both documents with community partners, key informants, hospital board members, public schools, non-profits, hospital coalition members, Milwaukee County Health Departments, and the general public. Documents are made available via email, hard copies are made available at applicable meetings, and electronic copies are made available by PDF for download on <https://www.froedtert.com/community-engagement>.

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

Froedtert Hospital Community Service Area

Overview

Froedtert & the Medical College of Wisconsin is a 604-bed academic medical center and a leading destination for advanced medical care. The primary adult teaching affiliate of the Medical College of Wisconsin (MCW), Froedtert Hospital is a major training facility for more than 1,000 medical, nursing and health technical students annually. Froedtert Hospital also operates the region's only adult Level I Trauma Center. It is also a respected research center, participating in some 2,000 research studies, including clinical trials, every year. Froedtert Hospital is located on the Milwaukee Regional Medical Center campus. Froedtert Hospital is part of the Froedtert & MCW health care network, which also includes Froedtert Menomonee Falls Hospital, Menomonee Falls; Froedtert West Bend Hospital, West Bend; and more than 40 primary and specialty care health centers and clinics.

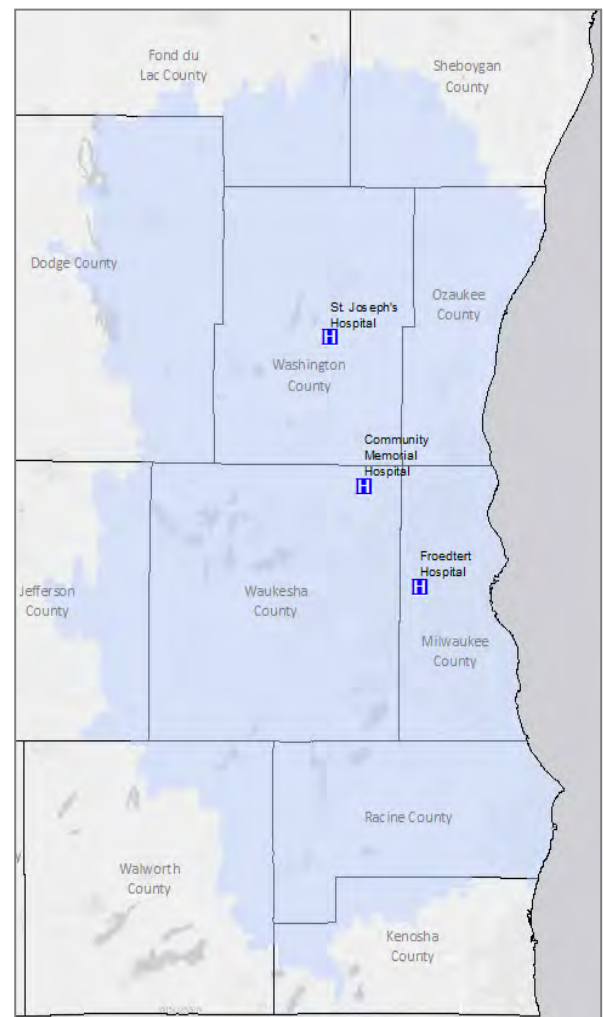
Mission Statement

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

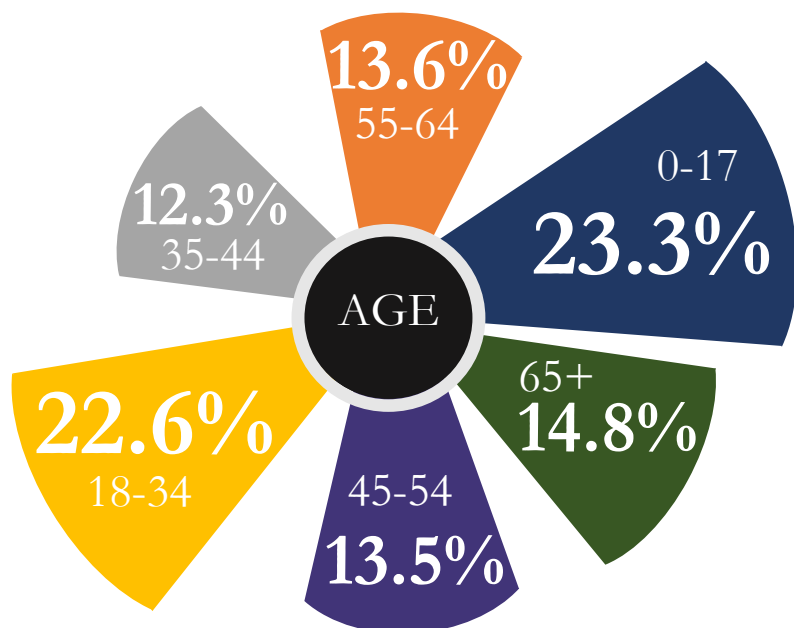
Froedtert Hospital Service Area and Demographics

For the purpose of the Community Health Needs Assessment, the community is defined as Milwaukee County because we derive 58.1% of discharges occur from this geography. All programs, activities, and partnerships under the CHNA will be delivered in Milwaukee County. Froedtert 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 Hospital total service area in Milwaukee County consists of 35 zip codes. – 53110 (Cudahy), 53129 (Greendale), 53130 (Hales Corners), 53132 (Franklin), 53154 (Oak Creek), 53172 (South Milwaukee), 53202 (Milwaukee), 53203 (Milwaukee), 53204 (Milwaukee), 53205 (Milwaukee), 53206 (Milwaukee), 53207 (Milwaukee), 53208 (Milwaukee), 53209 (Milwaukee), 53210 (Milwaukee), 53211 (Milwaukee), 53212 (Milwaukee), 53213 (Milwaukee), 53214 (Milwaukee), 53215 (Milwaukee), 53216 (Milwaukee), 53217 (Milwaukee), 53218 (Milwaukee), 53219 (Milwaukee), 53220 (Milwaukee), 53221 (Milwaukee), 53222 (Milwaukee), 53223 (Milwaukee), 53224 (Milwaukee), 53225 (Milwaukee), 53226 (Milwaukee), 53227 (Milwaukee), 53228 (Milwaukee), 53233 (Milwaukee), 53235 (Saint Francis)

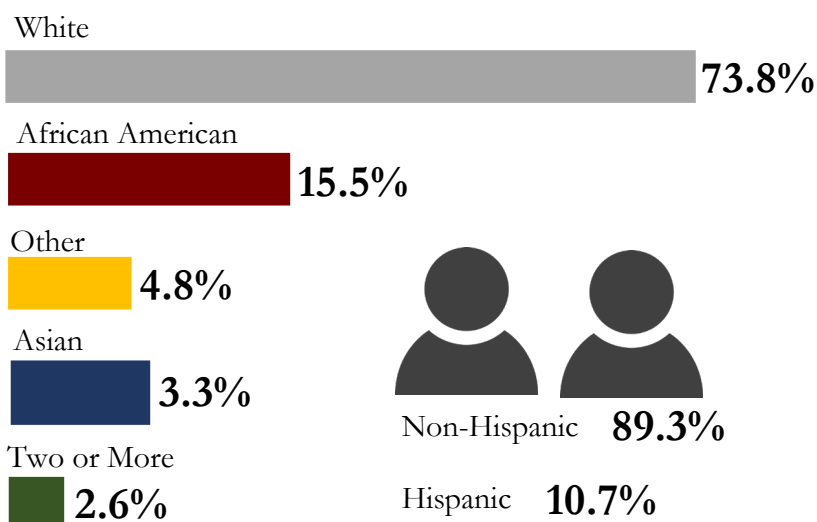


F&MCW Primary Service Area Demographics



Age – The two youngest cohorts comprise the largest percentage of the F&MCW primary service area: 45.9%. The 65+ age cohort is 14.8% of the population.

Race – In the F&MCW primary service area, the racial distribution is predominantly White (73.8%) and African American (15.5%). The census makes a distinction between race and ethnicity because individuals of Hispanic descent cross multiple races.



F&MCW Primary Service Area Demographics

Under \$25,000

20.8%

\$25,000-\$49,999

21.8%

\$50,000-\$99,999

32.4%

\$100,000 & Up

25.0%

Household Income – 42.6% of households in the F&MCW primary service area earn less than \$50,000 annually. The largest household income cohort is household earnings between \$50,000 and \$99,999, with 32.4%.

Payer Mix (Inpatient & Hospital-Based Outpatient) – Medicare, Medicaid, and Other Government payer sources make up 63.3% of the payer mix in Milwaukee County. Medicaid and Self Pay—the uninsured portion of the population—make up 19.1% of the payer mix.

45.7%

Medicare

2.3%

Other/Self
Pay

34.4%

Managed
Care

16.8%

Medicaid

0.8%

Other Gov't

Froedtert Hospital Summary of Implementation Strategy

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

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

Program: Behavioral Health Awareness, Education, Navigation and Community Partnerships **CHNA Significant Health Needs: Behavioral Health- Mental Health and Substance Use**

Goal: To improve behavioral health through mental wellness and substance use prevention for Milwaukee County residents.

Objectives:

1. Support and enhance collaborations with community organizations.
2. Increase outreach, education and awareness of behavioral health in hospital, clinical and community-based settings.

Froedtert Hospital Available Resources:

- Support Federally Qualified Health Centers' integrated primary care/behavioral health model.
- Support Milwaukee Health Care Partnership Psych Crisis Re-design for Milwaukee County.
- Support the McKinley Health Center and social worker (MSW).
- Engage people with lived experience to reduce stigma and increase awareness of behavioral health.
- Increase awareness of telehealth opportunities.
- Explore services provided by the criminal justice system.
- Support the Froedtert Health Behavioral Health Strategic Plan.
- Partner with Milwaukee County substance abuse and mental health task force(s).
- Collaborate with additional community organizations on awareness, education, prevention and navigation.

Froedtert Health Collaborative Partners:

- Mental Health America & National Association of Mental Illness
- Prevent Suicide Greater Milwaukee
- Community-based organizations with licensed clinics/providers
- Peer Support Groups
- Silver Cloud (web-based tool)
- Federally Qualified Health Center (FQHC) Partners
- Lutheran Social Services
- United Way of Greater Milwaukee & Waukesha County
- Milwaukee Area Schools
- Milwaukee Center for Independence
- Faith-based Organizations
- WISE Wisconsin
- IMPACT 2-1-1
- Serenity Inn
- Milwaukee County Health Departments
- Milwaukee County Substance Abuse Prevention Coalition
- Milwaukee Health Care Partnership (MHCP)

Program: Chronic Disease Management (Cancer, High Blood Pressure, Diabetes, Heart Disease)

CHNA Significant Health Needs: Chronic Disease and Nutrition and Healthy Food

Goal: To reduce the burden of chronic disease (cancer, high blood pressure, diabetes, heart disease) for Milwaukee County residents.

Objectives:

1. Build partner collaborations within select geography.
2. Improve chronic disease navigation and awareness of treatment and resources for targeted populations.
3. Increase opportunities for individuals to engage in physical activity and healthy eating.
4. Increase care for individuals suffering from chronic conditions.

Froedtert Hospital Available Resources:

- Participate in programs that address physical activity/nutrition, such as community run/walks, Harvest of the Month, Farmer's Markets and BUCKSFit.
- Implement the Community Care-A-Van in 53206 and 53208 zip codes.
- Promote and monitor the Girl Scouts Health in Action Patch Program (wellness education).
- Explore food pantry models that provide healthier options.
- Explore fruit and vegetable prescription programs.
- Connect to Cancer Outreach Coordinators and MCW Cancer Community Outreach Team.
- Support Cancer Outreach Coordinator located at Progressive Community Health Center.

Froedtert Health Collaborative Partners:

- American Cancer Society
- Susan G. Komen
- Milwaukee Health Care Partnership
- Milwaukee Area Health Education Center
- Fondy Farmers Market
- Victory Gardens
- Faith-based Organizations
- Beauty Salons/Barbershops
- Community Health Workers (CHWs)
- Milwaukee County Health Departments
- Milwaukee County Parks System
- Milwaukee Public Library System
- Neighborhood Associations
- Girl Scouts of Wisconsin Southeast
- MCW Cancer Community Outreach Team
- Milwaukee Bucks
- UMOs
- Shelters
- Milwaukee Area Schools & Higher Education Institutions

Program: Navigation and Support to Community-based Providers: Community Care-A-Van, Screening, Education

CHNA Significant Health Needs: Access to Care

Goal: To improve access to comprehensive, culturally competent, quality health & wellness services.

Objectives: 1. Increase reach to vulnerable populations to access healthcare services.

2. Support local efforts to increase community-based access to care.

Froedtert Hospital Available Resources:

- Implement the Community Care-A-Van with a focus in 53206 and 53208 zip codes.
- Increase access and navigation of resources through Community Health Worker (CHW), other healthcare navigators/coordinators, translation services & Froedtert Health Ambulatory Sites.
- Continue to expand opportunities through the school nurse at Westside Academy.
- Increase awareness of telehealth opportunities.

- Support Specialty Access for Uninsured Program (SAUP) & Emergency Department Medical Home (EDMH) programs and community clinics.
- Support the Milwaukee Health Care Partnership Housing Navigator Program for homeless population.
- Explore opportunities to increase health literacy by implementing universal screenings during intake process.

Froedtert Health Collaborative Partners:

- Faith-based organizations
- MKEN
- Impact 211
- Federally Qualified Health Centers
- Milwaukee Bucks
- Milwaukee Health Care Partnership
- Milwaukee County Health Departments
- Milwaukee Public Library System
- Neighborhood Associations
- Insurance Companies
- Neighborhood House/International Learning Center
- MKE Elevate
- SWIM Initiative
- Children's Hospital of Wisconsin
- Vivent Health
- Milwaukee County food pantries
- United Methodist Children's Services
- Silver Spring Neighborhood Center
- Greater Galilee Life Center
- Milwaukee Public Schools
- Covering Wisconsin
- Catholic Charities
- Muslim Community & Health Center
- Islamic Society of Milwaukee
- Milwaukee Muslim Women Coalition

Program: Violence Interrupter Program/Forensic Nurse Examiner

CHNA Significant Health Needs: Violence

Goals: To reduce violence and intentional injuries, and lessen their consequences for all people in Milwaukee County.

Objectives: 1. Expand community partnerships to support violence prevention programs.

2. Enhance innovative violence prevention programs at Froedtert Hospital.

Froedtert Hospital Available Resources:

- Support the Violence Interrupter Program through the efforts of the Comprehensive Injury Center.
- Increase awareness of sexual abuse resources offered by Froedtert Hospital.
- Explore resources with Milwaukee County crime prevention programs.
- Collaborate with community partners across sectors to inform programming in the Washington Park (53208) and Silver Spring (53218) neighborhoods to minimize incidences of violent crimes.
- Support 414 Life/Blueprint for Peace.
- Support MHCP Violence Prevention workgroup efforts.

Froedtert Health Collaborative Partners:

- Project Return
- Running Rebels
- Youth-based organizations
- NAACP Milwaukee

- Project Ujima
- Sojourner Family Peace Center
- West Allis Cardiff Model
- Safe and Sound
- Milwaukee Muslim Women's Center
- Milwaukee County / City of Milwaukee Office of Violence Prevention
- YWCA
- Black Panthers of Milwaukee
- Employ Milwaukee
- Community Advocates
- ResCare
- Medical College of Wisconsin
- Neighborhood Associations
- Milwaukee County Fire Departments
- Milwaukee County Police Departments
- Milwaukee County Health Departments
- Milwaukee Area Schools
- Project Safe Neighborhoods
- Black Health Coalition
- Faith-based Organizations
- Social Development Commission

Froedtert Hospital Community Partnerships

Partnerships	Priority Area Addressing
American Cancer Society	Chronic Disease
Beauty Salons/Barbershops	Chronic Disease
Black Health Coalition	Violence
Black Panthers of Milwaukee	Violence
Catholic Charities	Access to Care
Children's Hospital of Wisconsin	Access to Care, Chronic Disease, Behavioral Health, Violence
Community Advocates	Violence
Community Health Workers (CHWs)	Chronic Disease, Access to Care, Behavioral Health, Violence
Covering Wisconsin	Access to Care
Employ Milwaukee	Violence
Faith-based Organizations	Chronic Disease, Behavioral Health, Violence
Federally Qualified Health Centers (FQHCs)	Chronic Disease, Access to Care, Behavioral Health
Fondy Farmers Market	Chronic Disease
Girl Scouts of Wisconsin Southeast	Chronic Disease
Greater Galilee Life Center	Access to Care, Chronic Disease
IMPACT 2-1-1	Access to Care, Behavioral Health
Insurance Companies	Access to Care
Islamic Society of Milwaukee	Access to Care
Lutheran Social Services	Access to Care, Behavioral Health
MCW Cancer Community Outreach Team	Chronic Disease
Medical College of Wisconsin	Chronic Disease, Access to Care, Behavioral Health, Violence
Mental Health America & National Association of Mental Illness	Behavioral Health
Milwaukee Area Health Education Center	Chronic Disease
Milwaukee Area Schools	Chronic Disease
Milwaukee Bucks	Access to Care, Chronic Disease
Milwaukee Center for Independence	Behavioral Health
Milwaukee County Fire Departments	Violence
Milwaukee County Food Pantries	Access to Care
Milwaukee County Health Departments	Chronic Disease, Access to Care, Behavioral Health, Violence
Milwaukee County / City of Milwaukee Office of Violence Prevention	Violence
Milwaukee County Parks System	Chronic Disease
Milwaukee County Police Departments	Violence
Milwaukee Area Schools	Access to Care, Behavioral Health, Violence
Milwaukee County Substance Abuse Prevention Coalition	Behavioral Health
Milwaukee Health Care Partnership (MHCP)	Chronic Disease, Access to Care, Behavioral Health, Violence
Milwaukee Muslim Women's Center	Access to Care, Violence
Milwaukee Public Library System	Access to Care, Chronic Disease
MKE Elevate	Violence
MKEN	Access to Care

Muslim Community & Health Center	Access to Care, Chronic Disease, Behavioral Health, Violence
NAACP Milwaukee	Violence
Neighborhood Associations	Access to Care, Chronic Disease, Violence
Neighborhood House/International Learning Center	Access to Care
Peer Support Groups	Behavioral Health
Prevent Suicide Greater Milwaukee	Behavioral Health
Project Return	Violence
Project Safe Neighborhoods	Violence
Project Ujima	Violence
ResCare	Violence
Running Rebels	Violence
Safe and Sound	Violence
Serenity Inn	Behavioral Health
Shelters	Chronic Disease
Silver Cloud (web-based tool)	Behavioral Health
Silver Spring Neighborhood Center	Access to Care
Social Development Commission	Violence
Sojourner Family Peace Center	Violence, Behavioral Health
Susan G. Komen	Chronic Disease
SWIM Initiative	Access to Care
UMOS	Access to Care, Behavioral Health
United Methodist Children's Services	Chronic Disease, Access to Care
United Way of Greater Milwaukee & Waukesha County	Behavioral Health
Victory Gardens	Chronic Disease
Vivent Health	Behavioral Health, Access to Care
West Allis Cardiff Model	Violence
WISE Wisconsin	Behavioral Health
Youth-based Organizations	Violence
YWCA	Chronic Disease, Violence

Appendix A: Froedtert Hospital Community Health Improvement Advisory Steering Committee (CHIA)

Name	Title	Organization
Syed Ahmed, MD	Sr. Associate Dean of Community Engagement	Medical College of Wisconsin
Julie Bluma	Clinical Nurse Coordinator	Froedtert Health
Jennifer Casey	Executive Director	Fondy Food Center
Breen Causey	Community Care Coordinator	Froedtert Health
Tiffanie Cobb	Substance Abuse & Injury Prevention Manager	City of Milwaukee Health Department
Eric Conley	SVP/COO	Froedtert Health
Maritza Contreras	Community Engagement Program Coordinator	Froedtert Health
Ella Dunbar	Manager Community Relations	Social Development Commission
John Fangman, MD	Senior Medical Director, Ambulatory Services Froedtert & The Medical College of Wisconsin Associate Professor of Medicine Department of Medicine- Infectious Disease	Medical College of Wisconsin
Debra Fields	Community Education and Prevention	Sojourner Family Peace Center
Sarah Francois	Director of Fund Development & Marketing	Progressive Community Health Centers
Kerry Freiberg	VP Community Engagement	Froedtert Health
Monique Graham	Director Community Engagement	Froedtert Health
Katelyn Halverson	Community Engagement Program Coordinator	Froedtert Health
Sahar Katib Kayata, MD	Board Member	Milwaukee Muslim Women's Coalition
Sara Kohlbeck	Assistant Director, Comprehensive Injury Center	Medical College of Wisconsin
Jennifer Lefebvre	Evidenced-Based Prevention Program Coordinator	Milwaukee County Department on Aging
Carmen Pangilinan	Public Health Specialist	Wauwatosa Health Department
Connie Palmar	President/CEO	Outreach Community Health Center
Allyson Rennebohm	Community Nurse Coordinator	Froedtert Health
Kate Sweeney	Director, Cancer Center Patient Support Services	Froedtert Health
Phoua Vang	Director of Community Engagement	United Methodist Children's Services
Barb Wesson		Core- El Centro
Azure'De Williams	Executive Director	Milwaukee Area Health Education Center
Earnestine Willis, MD	Director, Center for the Advancement of Underserved Children	Medical College of Wisconsin
Amanda Wisth	Community Engagement Data Analyst	Froedtert Health

Appendix B: Milwaukee County Community Health Survey Report

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

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

1. Gather specific data on behavioral and lifestyle habits of the adult population. Select information will also be collected about the respondent's household.
2. Gather data on the prevalence of risk factors and disease conditions existing within the adult population.
3. Compare, where appropriate, health data of residents to previous health studies.
4. Compare, where appropriate and available, health data of residents to state and national measurements along with Healthy People 2020 goals.

Respondents were scientifically selected so the survey would be representative of all adults 18 years old and older in the county. The sampling strategy was two-fold. 1) A random-digit-dial landline sample of telephone numbers which included listed and unlisted numbers. The respondent within each household was randomly selected by computer and based on the number of adults in the household (n=647). 2) A cell phone-only sample where the person answering the phone was selected as the respondent (n=665). At least 8 attempts were made to contact a respondent in both samples. Screener questions verifying location were included. A total of 1,312 telephone interviews were completed between February 20 and May 12, 2018.

With a sample size of 1,312, we can be 95% sure that the sample percentage reported would not vary by more than ± 3 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 ± 3 percent, since fewer respondents are in that category (e.g., adults 65 years old or older who were asked if they ever received a pneumonia vaccination).

In 2015, the Census Bureau estimated 721,561 adult residents in Milwaukee County. Thus, in this report, one percentage point equals approximately 7,220 adults. So, when 24% of respondents reported they had high blood cholesterol, this roughly equals 173,280 residents $\pm 21,660$ individuals. Therefore, from 151,620 to 194,940 residents likely have high blood cholesterol. Because the margin of error is $\pm 3\%$, events or health risks that are small will include zero.

In 2015, the Census Bureau estimated 382,778 occupied housing units in Milwaukee County. In certain questions of the Community Health Survey, respondents were asked to report information about their household. Using the 2015 household estimate, each percentage point for household-level data represents approximately 3,830 households.

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

Appendix C: 2018 Milwaukee County Community Health Survey Report

Milwaukee County Community Health Survey Summary

This research provides valuable behavioral data, lifestyle habits, and the prevalence of risk factors and disease conditions of area residents. This summary was prepared by JKV Research for Ascension, Aurora Health Care, Children's Hospital of Wisconsin and Froedtert Health in partnership with the Center for Urban Population Health.

Health Care Coverage						Health Conditions in Past 3 Years					
Milwaukee County	2006	2009	2012	2015	2018	Milwaukee County	2006	2009	2012	2015	2018
Personally Not Currently Covered						High Blood Pressure	27%	29%	30%	29%	28%
18 and Older	11%	12%	14%	4%	9%	High Blood Cholesterol	22%	22%	21%	20%	24%
18 to 64 Years Old	13%	15%	16%	5%	11%	Mental Health Condition		13%	14%	18%	23%
At Least One Household Member Not Covered in Past Year	26%	25%	21%	14%	8%	Diabetes	8%	9%	10%	11%	10%
						Heart Disease/Condition	8%	9%	8%	9%	8%
Other Research: (2016)				WT	U.S.	Asthma (Current)	10%	12%	12%	14%	12%
Personally Not Covered (Currently)				9%	10%						
Unmet Care in Past Year						Physical Health and Nutrition					
Milwaukee County	2012	2015	2018			Milwaukee County	2006	2009	2012	2015	2018
Someone in Household in Past Year						Physical Activity/Week					
Prescription Drug Not Taken Due to Cost		11%	11%	12%		Moderate Activity (5 Times/30 Min)	33%	31%	35%	39%	36%
Unmet Medical Care Need		11%	12%	8%		Vigorous Activity (3 Times/20 Min)	22%	19%	24%	31%	35%
Unmet Dental Care Need		19%	18%	15%		Recommended Moderate or Vigorous	45%	41%	47%	49%	48%
Unmet Mental Health Care Need		4%	4%	3%		Overweight Status					
						Overweight (BMI 25.0+)	63%	66%	66%	69%	64%
Health Information and Services						Obese (BMI 30.0+)	28%	32%	33%	38%	38%
Milwaukee County	2006	2009	2012	2015	2018	Fruit Intake (2+ Servings/Day)	61%	58%	62%	62%	56%
Have a Primary Care Physician				86%	82%	Vegetable Intake (3+ Servings/Day)	24%	21%	26%	28%	30%
Primary Health Services						At Least 5 Fruit/Vegetables/Day	35%	31%	35%	38%	37%
Doctor/Nurse Practitioner's Office	77%	73%	70%	65%	62%	Other Research: (2016)				WT	U.S.
Urgent Care Center	3%	6%	7%	12%	18%	Overweight (BMI 25.0+)				67%	65%
Hospital Emergency Room	6%	7%	7%	11%	6%	Obese (BMI 30.0+)				31%	30%
Public Health Clinic/Com. Health Center	5%	7%	6%	4%	2%						
Hospital Outpatient	3%	2%	3%	2%	2%	Women's Health					
No Usual Place	5%	4%	6%	5%	8%	Milwaukee County	2006	2009	2012	2015	2018
Advance Care Plan	32%	31%	29%	31%	36%	Mammogram (50+, Within Past 2 Years)	78%	78%	77%	81%	77%
Dental Checkup (Past Year)	63%	60%	56%	62%	63%	Bone Density Scan (65 and Older)	67%	73%	71%	82%	83%
Flu Vaccination (Past Year)						Other Research: (2016)				WT	U.S.
18 and Older	36%	40%	38%	48%	47%	Mammogram (50 - 74; Within Past 2 Years)				80%	78%
65 and Older	71%	69%	63%	76%	75%						
Other Research: (2016)				WT	U.S.	Colorectal Cancer Screenings (50 and Older)					
Flu Vaccination (65 and Older, Past Year)				50%	59%	Milwaukee County	2006	2009	2012	2015	2018
Dental Checkup (Past Year)				73%	66%	Blood Stool Test (Within Past Year)	23%	--	14%	14%	13%
						Sigmoidoscopy (Within Past 5 Years)		10%	10%	11%	7%
Tobacco Use in Past Month						Colonoscopy (Within Past 10 Years)		58%	61%	67%	67%
Milwaukee County	2006	2009	2012	2015	2018	Screening in Recommended Time Frame		61%	67%	72%	72%
Cigarette Smokers	26%	25%	24%	19%	16%	Other Research: (2016)				WT	U.S.
Cigars, Cigarillos or Little Cigars				5%	6%	Screening in Recommended Time Frame				74%	68%
Electronic Cigarettes				6%	4%						
Other Research: (2016)				WT	U.S.	Mental Health Status					
Cigarette Smokers				17%	17%	Milwaukee County	2006	2009	2012	2015	2018
Electronic Cigarettes				5%	5%	Felt Sad, Blue or Depressed					
						Always/Nearly Always (Past Month)	8%	8%	7%	7%	8%
Smoking Policy at Home						Considered Suicide (Past Year)	6%	5%	5%	6%	6%
Milwaukee County	2009	2012	2015	2018		Alcohol Use in Past Month					
Not Allowed Anywhere	64%	74%	75%	78%		Milwaukee County	2006	2009	2012	2015	2018
Allowed in Some Places/at Some Times	14%	10%	10%	10%		Binge Drinker	19%	20%	31%	32%	32%
Allowed Anywhere	4%	4%	2%	2%		Other Research: (2016)				WT	U.S.
No Rules Inside Home	18%	12%	13%	10%		Binge Drinker				25%	17%

Household Problems in Past Year						Personal Safety in Past Year					
Milwaukee County	2006	2009	2012	2015	2018	Milwaukee County	2006	2009	2012	2015	2018
Alcohol	3%	3%	2%	2%	2%	Afraid for Their Safety	10%	9%	7%	6%	9%
Marijuana			2%	2%	1%	Pushed, Kicked, Slapped, or Hit	5%	6%	4%	3%	9%
Cocaine, Heroin or Other Street Drugs			<1%	<1%	2%	At Least One of the Safety Issues	13%	12%	9%	8%	14%
Misuse of Prescription or OTC Drugs			<1%	2%	1%						
Gambling			1%	1%	<1%	Children in Household					
						Milwaukee County			2012	2015	2018
Top Community Health Issues						Personal Health Doctor/Nurse Who					
Milwaukee County					2018	Knows Child Well and Familiar with History			89%	91%	95%
Chronic Disease or Cancer					34%	Visited Personal Doctor/Nurse for					
Illegal Drug Use or Prescription/OTC Drug Abuse					27%	Preventive Care (Past Year)			93%	92%	93%
Access to Health Care					20%	Did Not Receive Care Needed (Past Year)					
Infectious Diseases					17%	Medical Care			2%	2%	3%
Violence or Crime					16%	Dental Care			8%	9%	6%
Overweight or Obesity					15%	Specialist			2%	1%	5%
Mental Health or Depression					15%	Current Asthma			11%	11%	17%
Alcohol Use or Abuse					9%	Safe in Community/Neighborhood (Seldom/Never)			4%	5%	9%
Access to Affordable Healthy Food					6%	Screen Time (2 or Fewer Hours per Day)					38%
Tobacco Use					5%	Soda Consumption (0 in Past Week)					61%
Environmental Issues					5%	Children 2 or Younger					
Affordable Health Care					4%	As Infant, Slept in Bed with Respondent/Other Person			8%	7%	11%
Lack of Physical Activity					4%	Children 5 to 17 Years Old					
Lead Poisoning					3%	Physical Activity (60 Min./5 or More Days/Week)			66%	69%	58%
Driving Problems/Aggressive Driving/Drunk Driving					3%	Unhappy, Sad or Depressed in Past 6 Months					
						Always/Nearly Always			7%	3%	5%
						Experienced Some Form of Bullying (Past Year)			22%	18%	16%
						Verbally Bullied			18%	16%	13%
						Physically Bullied			10%	5%	6%
						Cyber Bullied			2%	2%	3%

Overall Health and Health Care Key Findings

In 2018, 9% of respondents reported they were not currently covered by health care insurance; respondents who were male, 18 to 24 years old, African American, Hispanic, with a high school education or less, in the bottom 40 percent household income bracket or unmarried were more likely to report this. Eight 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 40 percent household income bracket or unmarried were more likely to report this. *From 2006 to 2018, 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 while from 2015 to 2018, there was a noted increase. From 2006 to 2018, 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 2015 to 2018.*

In 2018, 12% of respondents reported that someone in their household had not taken their prescribed medication due to prescription costs in the past year; respondents in the middle 20 percent household income bracket or in households with children were more likely to report this. Eight percent of respondents reported in the past year someone in the household did not receive the medical care needed; respondents in the bottom 40 percent household income bracket or in households with children were more likely to report this. Fifteen percent of respondents reported in the past year someone in the household did not receive the dental care needed; respondents in the bottom 60 percent household income bracket or in households without children were more likely to report this. Three percent of respondents reported in the past year someone in the household did not receive the mental health care needed. *From 2012 to 2018, 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 or a household member did not receive the mental health care needed, as well as from 2015 to 2018. From 2012 to 2018, the overall percent statistically decreased for respondents who reported someone in their household did not receive the medical care needed or a household member did not receive the dental care needed, as well as from 2015 to 2018.*

In 2018, 82% of respondents reported they have a primary care physician they regularly see for check-ups and when they are sick; respondents who were female, 65 and older, non-white and non-African American, non-Hispanic, with at least some post high school education, in the top 40 percent household income bracket or married respondents were more likely to report a primary care physician. Sixty-two 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 urgent care center. Respondents who were female, 65 and older, white, non-Hispanic, with a college education, in the top 40 percent household income bracket or married respondents were more likely

to report a doctor's or nurse practitioner's office as their primary health care when they are sick. Respondents who were female, 25 to 44 years old, African American or non-Hispanic were more likely to report urgent care as their primary health care. Six percent of respondents reported hospital emergency room as their primary health care; respondents who were 35 to 44 years old, non-white and non-African American, with some post high school education or less or in the bottom 40 percent household income bracket were more likely to report this. Two percent of respondents each reported their primary place for health services when they are sick was a public health clinic/community health center or a hospital outpatient department. Thirty-six percent of respondents had an advance care plan; respondents who were female, 65 and older, white or non-Hispanic were more likely to report an advance care plan. *From 2015 to 2018, there was a statistical decrease in the overall percent of respondents reporting they have a primary care doctor, nurse practitioner, physician assistant or primary care clinic they regularly go to for checkups and when they are sick. From 2006 to 2018, there was a statistical decrease in the overall percent of respondents reporting their primary place for health services when they are sick was a doctor's or nurse practitioner's office while from 2015 to 2018, there was no statistical change. From 2006 to 2018, there was a statistical increase in the overall percent of respondents reporting their primary place was an urgent care center, as well as from 2015 to 2018. From 2006 to 2018, there was no statistical change in the overall percent of respondents reporting their primary place was a hospital emergency room while from 2015 to 2018, there was a statistical decrease. From 2006 to 2018, there was a statistical decrease in the overall percent of respondents reporting their primary place was a public health clinic or community health center, as well as from 2015 to 2018. From 2006 to 2018, there was no statistical change in the overall percent of respondents reporting their primary place was a hospital outpatient department, as well as from 2015 to 2018. From 2006 to 2018, there was a statistical increase in the overall percent of respondents who reported having an advance care plan, as well as from 2015 to 2018.*

In 2018, 63% of respondents reported a visit to the dentist in the past year. Respondents who were 35 to 44 years old, white, non-Hispanic, with a college education, in the top 40 percent household income bracket or married respondents were more likely to report a dental checkup in the past year. *From 2006 to 2018, there was no statistical change in the overall percent of respondents reporting a dental checkup in the past year, as well as from 2015 to 2018.*

In 2018, 47% of respondents had a flu vaccination in the past year. Respondents who were female, 65 and older, white, non-Hispanic, with a college education or married respondents were more likely to report a flu vaccination. *From 2006 to 2018, there was a statistical increase in the overall percent of respondents 18 and older who reported a flu vaccination in the past year while from 2015 to 2018, there was no statistical change. From 2006 to 2018, there was no statistical change in the overall percent of respondents 65 and older who reported a flu vaccination in the past year, as well as from 2015 to 2018.*

Health Risk Factors Key Findings

In 2018, out of six health conditions listed, the most often mentioned in the past three years was high blood pressure (28%), high blood cholesterol (24%) or a mental health condition (23%). Respondents who were 65 and older, white, non-Hispanic, with some post high school education, in the bottom 40 percent household income bracket, who were overweight or inactive were more likely to report high blood pressure. Respondents who were female, 65 and older, African American, non-Hispanic, with a high school education or less, in the bottom 40 percent household income bracket, who were overweight or inactive were more likely to report high blood cholesterol. Respondents who were female, 18 to 24 years old, African American, Hispanic, with a high school education or less, in the bottom 40 percent household income bracket, who were unmarried, not overweight, inactive, met the recommended amount of physical activity or smokers were more likely to report a mental health condition. Ten percent of respondents reported diabetes; respondents who were 65 and older, in the bottom 40 percent household income bracket, overweight, inactive or nonsmokers were more likely to report this. Eight percent reported they were treated for, or told they had heart disease/condition in the past three years; respondents who were 65 and older, white, non-Hispanic, with some post high school education, in the bottom 60 percent household income bracket, who were overweight or inactive were more likely to report this. Twelve percent reported current asthma; respondents who were female, 25 to 64 years old, non-Hispanic, in the bottom 40 percent household income bracket or unmarried were more likely to report this. *From 2006 to 2018, there was no statistical change in the overall percent of respondents who reported high blood pressure, diabetes, heart disease/condition or current asthma, as well as from 2015 to 2018. From 2006 to 2018, there was no statistical change in the overall percent of respondents who reported high blood cholesterol while from 2015 to 2018, there was a noted increase. From 2009 to 2018, there was a statistical increase in the overall percent of respondents who reported a mental health condition, as well as from 2015 to 2018.*

In 2018, 8% of respondents reported they always or nearly always felt sad, blue or depressed in the past month; respondents who were 25 to 64 years old, non-white and non-African American, with a high school education or less, in the bottom 40 percent household income bracket or in households without children were more likely to report this. Six percent of respondents felt so overwhelmed they considered suicide in the past year; respondents who were 18 to 44 years old, African American, non-Hispanic, with a high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. *From 2006 to 2018, there was no statistical change in the overall percent of respondents who*

reported they always or nearly always felt sad/blue/depressed in the past month or they considered suicide in the past year, as well as from 2015 to 2018.

Behavioral Risk Factors Key Findings

In 2018, 36% of respondents did moderate physical activity five times a week for 30 minutes. Thirty-five percent of respondents did vigorous activity three times a week for 20 minutes. Combined, 48% met the recommended amount of physical activity; respondents who were male, 18 to 24 years old, African American, Hispanic, with a high school education or less or who were not overweight were more likely to report this. *From 2006 to 2018, there was no statistical change in the overall percent of respondents who reported moderate physical activity five times a week for at least 30 minutes, as well as from 2015 to 2018. From 2006 to 2018, there was a statistical increase in the overall percent of respondents who reported vigorous physical activity three times a week for at least 20 minutes, as well as from 2015 to 2018. From 2006 to 2018, there was no statistical change in the overall percent of respondents who met the recommended amount of physical activity, as well as from 2015 to 2018.*

In 2018, 64% of respondents were classified as at least overweight while 38% were obese. Respondents who were 45 to 54 years old, non-white and non-African American, non-Hispanic, with some post high school education, in the top 40 percent household income bracket, who were married or inactive were more likely to be classified as at least overweight. Respondents who were female, 45 to 54 years old, non-white and non-African American, non-Hispanic, with some post high school education or inactive respondents were more likely to be obese. *From 2006 to 2018, there was no statistical change in the overall percent of respondents being at least overweight while from 2015 to 2018, there was a statistical decrease. From 2006 to 2018, there was a statistical increase in the overall percent of respondents being obese while from 2015 to 2018, there was no statistical change.*

In 2018, 56% of respondents reported two or more servings of fruit while 30% reported three or more servings of vegetables on an average day. Respondents who were female, 18 to 24 years old, white, Hispanic, not overweight or who met the recommended amount of physical activity were more likely to report at least two servings of fruit. Respondents who were female, 18 to 24 years old, Hispanic, with a college education, not overweight or who met the recommended amount of physical activity were more likely to report at least three servings of vegetables on an average day. Thirty-seven percent of respondents reported five or more servings of fruit/vegetables on an average day; respondents who were female, 18 to 24 years old, African American, Hispanic, with a college education, not overweight or who met the recommended amount of physical activity were more likely to report this. *From 2006 to 2018, there was a statistical decrease in the overall percent of respondents who reported at least two servings of fruit, as well as from 2015 to 2018. From 2006 to 2018, there was a statistical increase in the overall percent of respondents who reported at least three servings of vegetables while from 2015 to 2018, there was no statistical change. From 2006 to 2018, there was no statistical change in the overall percent of respondents who reported at least five servings of fruit/vegetables, as well as from 2015 to 2018.*

In 2018, 77% of female respondents 50 and older reported a mammogram within the past two years; married respondents were more likely to report this. Eighty-three percent of female respondents 65 and older had a bone density scan. *From 2006 to 2018, there was no statistical change in the overall percent of respondents 50 and older who reported having a mammogram within the past two years, as well as from 2015 to 2018. From 2006 to 2018, there was a statistical increase in the overall percent of respondents 65 and older who reported a bone density scan while from 2015 to 2018, there was no statistical change.*

In 2018, 13% of respondents 50 and older reported a blood stool test within the past year. Seven percent of respondents 50 and older reported a sigmoidoscopy within the past five years while 67% reported a colonoscopy within the past ten years. This results in 72% of respondents meeting the current colorectal cancer screening recommendations. Respondents in the top 60 percent household income bracket or married respondents were more likely to meet the recommendation. *From 2006 to 2018, there was a statistical decrease in the overall percent of respondents who reported a blood stool test within the past year while from 2015 to 2018, there was no statistical change. From 2009 to 2018, there was no statistical change in the overall percent of respondents who reported a sigmoidoscopy in the past five years while from 2015 to 2018, there was a statistical decrease. From 2009 to 2018, there was a statistical increase in the overall percent of respondents who reported a colonoscopy within the past ten years while from 2015 to 2018, there was no statistical change. From 2009 to 2018, there was a statistical increase in the overall percent of respondents who reported they had at least one of these tests in the recommended time frame while from 2015 to 2018, there was no statistical change.*

In 2018, 16% of respondents were current tobacco cigarette smokers; respondents who were 35 to 44 years old, non-Hispanic, with a high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to be a smoker. *From 2006 to 2018, there was a statistical decrease in the overall percent of respondents who were current tobacco cigarette smokers, as well as from 2015 to 2018.*

In 2018, 78% of respondents reported smoking is not allowed anywhere inside the home. Respondents who were in the top 40 percent household income bracket, married, nonsmokers or in households with children were more likely to report smoking is

not allowed anywhere inside the home. From 2009 to 2018, there was a statistical increase in the overall percent of respondents who reported smoking is not allowed anywhere inside the home, as well as from 2015 to 2018.

In 2018, 6% of respondents used cigars, cigarillos or little cigars in the past month; respondents who were male, 25 to 54 years old, African American, with some post high school education or less or unmarried respondents were more likely to report this. Four percent of respondents used electronic cigarettes in the past month; respondents who were male, 25 to 34 years old, Hispanic, with some post high school education or unmarried respondents were more likely to report this. From 2015 to 2018, there was no statistical change in the overall percent of respondents who reported in the past month they used cigars/cigarillos/little cigars. From 2015 to 2018, there was a statistical decrease in the overall percent of respondents who reported in the past month they used electronic cigarettes.

In 2018, 32% of respondents were binge drinkers in the past month. Respondents 25 to 34 years old, with some post high school education, in the top 40 percent household income bracket or unmarried respondents were more likely to have binged at least once in the past month. From 2006 to 2018, there was a statistical increase in the overall percent of respondents who reported binge drinking in the past month while from 2015 to 2018, there was no statistical change. Please note: binge drinking definition was 5+ drinks in 2006 and 2009 while it was 4+ drinks for females and 5+ drinks for males since 2012.

In 2018, 2% of respondents reported someone in their household experienced a problem, such as legal, social, personal or physical in connection with drinking alcohol in the past year. Two percent of respondents reported someone in their household experienced a problem in connection with cocaine/heroin/other street drugs. One percent of respondents each reported someone in their household experienced a problem in connection with marijuana or with the misuse of prescription drugs/over-the-counter drugs. Less than one percent of respondents reported someone in their household experienced a problem in connection with gambling. From 2006 to 2018, there was no statistical change in the overall percent of respondents reporting a household problem in connection with drinking alcohol, as well as from 2015 to 2018. From 2012 to 2018, there was a statistical increase in the overall percent of respondents reporting a household problem with cocaine/heroin/other street drugs, as well as from 2015 to 2018. From 2012 to 2018, there was no statistical change in the overall percent of respondents reporting a household problem with marijuana, the misuse of prescription drugs/over-the-counter drugs or gambling, as well as from 2015 to 2018.

In 2018, 9% of respondents reported someone made them afraid for their personal safety in the past year; respondents who were male, 18 to 24 years old, African American, Hispanic, with a high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. Nine percent of respondents reported they had been pushed, kicked, slapped or hit in the past year; respondents who were male, 18 to 24 years old, non-white and non-African American, Hispanic, with a high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. A total of 14% reported at least one of these two situations; respondents who were male, 18 to 24 years old, non-white and non-African American, Hispanic, with some post high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. From 2006 to 2018, there was no statistical change in the overall percent of respondents reporting they were afraid for their personal safety while from 2015 to 2018, there was a statistical increase. From 2006 to 2018, there was a statistical increase in the overall percent of respondents reporting they were pushed, kicked, slapped or hit, as well as from 2015 to 2018. From 2006 to 2018, there was no statistical change in the overall percent of respondents reporting at least one of the two personal safety issues while from 2015 to 2018, there was a statistical increase.

Children in Household Key Findings

In 2018, a random child was selected for the respondent to talk about the child's health and behavior. Ninety-five percent of respondents reported they have one or more persons they think of as their child's personal doctor or nurse, with 93% reporting their child visited their personal doctor or nurse for preventive care during the past year. Six percent reported there was a time in the past year their child did not receive the dental care needed while 5% percent reported their child was not able to visit a specialist they needed to see. Three percent reported their child did not receive the medical care needed. Seventeen percent of respondents reported their child currently had asthma. Nine percent of respondents reported their child was seldom or never safe in their community. Eleven percent of respondents with a child who was 2 years old or younger reported when their child was an infant, he/she slept in bed with them or another person. Thirty-eight percent of respondents reported their child has two or fewer hours of screen time on an average school/week day. Sixty-one percent of respondents reported their child did not drink soda or pop in the past week, excluding diet soda. Fifty-eight percent of respondents reported their 5 to 17 year old child was physically active five times a week for 60 minutes. Five percent of respondents reported their 5 to 17 year old child always or nearly always felt unhappy, sad or depressed in the past six months. Sixteen percent reported their 5 to 17 year old child experienced some form of bullying in the past year; 13% reported verbal bullying, 6% reported physical bullying and 3% reported cyber bullying. From 2012 to 2018, there was a statistical increase in the overall percent of respondents reporting their child has a personal doctor or nurse, as well as from 2015 to 2018. From 2012 to 2018, there was no statistical change in the overall percent of

respondents reporting their child visited their personal doctor/nurse for preventive care, as well as from 2015 to 2018. From 2012 to 2018, there was no statistical change in the overall percent of respondents reporting their child had an unmet medical need or unmet dental need, as well as from 2015 to 2018. From 2012 to 2018, there was a statistical increase in the overall percent of respondents reporting their child was unable to see a specialist when needed, as well as from 2015 to 2018. From 2012 to 2018, there was a statistical increase in the overall percent of respondents who reported their child had asthma or their child was seldom/never safe in their community, as well as from 2015 to 2018. From 2012 to 2018, there was no statistical change in the overall percent of respondents who reported when their child was an infant, he/she slept in bed with them or another person, as well as from 2015 to 2018. From 2012 to 2018, there was a statistical decrease in the overall percent of respondents who reported their 5 to 17 year old child was physically active five times a week for at least 60 minutes, as well as from 2015 to 2018. From 2012 to 2018, there was no statistical change in the overall percent of respondents who reported their 5 to 17 year old child always or nearly always felt unhappy/sad/depressed, as well as from 2015 to 2018. From 2012 to 2018, there was no statistical change in the overall percent of respondents who reported their child was bullied or in the type of bullying, as well as from 2015 to 2018.

Top Community Health Issues Key Findings

In 2018, respondents were asked to list the top three community health issues. The most often cited was chronic diseases or cancer (34%) followed by illegal drug use or prescription/over-the-counter drug abuse (27%). Respondents who were 18 to 24 years old, African American, Hispanic, with a high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to report chronic diseases or cancer as a top community health issue. Respondents who were 55 to 64 years old, non-African American, non-Hispanic, with at least some post high school education or in the top 40 percent household income bracket were more likely to report illegal drug use or prescription/over-the-counter drug abuse. Twenty percent of respondents reported access to health care as a top community health issue; respondents who were female, non-African American, with at least some post high school education or in the top 40 percent household income bracket were more likely to report this. Seventeen percent of respondents reported infectious diseases. Respondents who were male, 18 to 24 years old, African American, Hispanic, with a high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to report infectious diseases. Sixteen percent reported violence or crime as a top community health issue. Respondents who were 18 to 24 years old, African American, Hispanic or with a high school education or less were more likely to report violence or crime. Fifteen percent reported overweight or obesity as a top community health issue. Respondents who were female, 18 to 24 years old, non-Hispanic or with a college education were more likely to report overweight or obesity. Fifteen percent of respondents reported mental health or depression; respondents who were 25 to 34 years old, 45 to 64 years old, white, with a college education or in the middle 20 percent household income bracket were more likely to report this. Nine percent of respondents reported alcohol use or abuse as a top community health issue; respondents who were male, 25 to 34 years old, non-African American, non-Hispanic or with a college education were more likely to report this. Six percent of respondents reported access to affordable healthy food as a top community health issue. Respondents who were non-Hispanic, with a college education or married respondents were more likely to report access to affordable healthy food. Five percent of respondents reported tobacco use as a top community health issue. Respondents who were male, 25 to 34 years old, non-white and non-African American, Hispanic or in the top 40 percent household income bracket were more likely to report tobacco use. Five percent of respondents reported environmental issues; respondents 55 to 64 years old or in the middle 20 percent household income bracket were more likely to report this. Four percent of respondents reported affordable health care; respondents who were 35 to 44 years old, white, Hispanic, with a college education, in the top 40 percent household income bracket or married respondents were more likely to report this. Four percent of respondents reported lack of physical activity as a top community health issue. Respondents who were non-white and non-African American, non-Hispanic or with a college education were more likely to report lack of physical activity. Three percent of respondents reported lead poisoning; respondents who were 35 to 44 years old, white, Hispanic, with a college education or married were more likely to report this. Three percent of respondents reported driving problems/aggressive driving/drunk driving; respondents with a college education, in the middle 20 percent household income bracket or married respondents were more likely to report this.

Appendix D: 2018 Milwaukee County Health Needs Assessment: A Summary of Key Informant Interviews

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

The Public health priorities for Milwaukee County, were identified in 2018 by a range of providers, policy-makers, and other local experts and community members (“key informants”). These findings are a critical supplement to the Milwaukee County community health needs assessment (CHNA) survey conducted through a partnership between the Milwaukee County Health Departments, Advocate Aurora Health, Ascension, Children’s Hospital of Wisconsin, and Froedtert & the Medical College of Wisconsin. The CHNA incorporates input from persons representing the broad community served by the hospitals, focusing on a range of public health issues relevant to the community at large.

Key informants in Milwaukee County were identified by the Milwaukee Healthcare Partnership healthy systems’ community benefit leaders. Key informant interviews and focus groups were conducted by those leaders between April and June 2018. Interviewers and focus group facilitators used a standard discussion guide from which informants:

- Identified up to three public health issues that are the most important for Milwaukee County, based on focus areas presented in *Healthiest Wisconsin 2020*, Wisconsin’s State Health Plan. For each public health priority, informants were asked to identify:
 - Existing strategies to address the issue
 - Barriers/challenges to addressing the issue
 - Additional strategies needed to address the issue
 - Key groups in the community that hospitals should partner with to improve community health
 - Subgroups or populations recommended for specific outreach
- Selected the top three determinants of health (also called health factors) impacting our community, as described in the federal government’s *Healthy People 2020*
- Rated the level of impact of two emerging areas identified in *Wisconsin’s State Health Assessment and Health Improvement Plan*: Adverse Childhood Experiences (ACEs) and Alzheimer’s Disease and Dementia

All informants were made aware that participation was voluntary and that responses would be shared with the Center for Urban Population Health for analysis and reporting. This report presents the results of the 2018 CHNA key informant interviews for Milwaukee County, based on the summaries provided to the Center for Urban Population Health.

Limitations: This report relies on the opinions of a limited number of experts identified as having the community’s pulse. It is possible that the results would have been different if an alternative set of informants had been interviewed. Several invited informants were not able to participate. The variety of interviewers could have resulted in some inconsistencies in data collection. Although CUPH used a consistent analysis process to review the interview data, it is possible that certain responses could have been misinterpreted. Additionally, some informants did not answer all questions from the discussion guide, and some answered the questions generally across issues, rather than relating the questions back to their top three identified health issues. Results should be interpreted in conjunction with other Milwaukee County data available in the Milwaukee County Community Health Survey and Health Compass Milwaukee.

A total of 80 individuals representing 40 key informants and four focus groups were asked to rank the 5 major health-related issues in their county from a list of focus areas identified in the State Health Plan. The table below presents the results, including a summary of the number of times an issue was mentioned as a top five health issue, and the number of times an informant ranked the issue as the most important health issue.

The five health issues ranked most consistently as a top five health issue for the County were:

1. Mental Health
2. Access to Health Care
3. Violence
4. Substance Use
5. Nutrition and Healthy Food

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

Mental Health

Mental health emerged as the most commonly discussed issue by informants, who often referenced the connection between Mental Health and Access to Care, which was cited as a barrier. Informants also acknowledged links between substance and alcohol use to mental health.

Barriers and Challenges:

- Lack of resources for those who cannot afford out-of-pocket costs and lack commercial insurance
- Not enough providers, especially prescribers
- Not enough supportive housing for those living with mental illness
- Long waiting lists to access care
- Patients aren't accessing primary care, which can be the gateway to behavioral health resources
- Behavioral health screening does not equal access to health care
- Lack of access to medication when patients can't afford it
- Insufficient knowledge about mental health and mental illness within families
- Primary care providers lack resources or expertise to manage complex mental illness needs of patients
- Lack of training – agency staff not trained on how to identify symptoms of mental health problems; lack of training for intervention across all sectors
- Stigma of mental illness
- Managing crises rather than investing in prevention
- Low Medicaid reimbursement for mental health services

Needed Strategies:

- Focus on healing trauma, and availability of trauma-informed training in all sectors,* not just health care providers
- Focus on healthy mental and emotional development of youth
- More community-based internship and practicum sites to train students who do field work related to mental health, with a focus on recruiting and retaining more providers in behavioral health
- Community education on Adverse Childhood Experiences (ACEs) and trauma
- Expanding telehealth to cover mental health services
- Behavioral health services for those released from criminal justice system
- More affordable behavioral health services

Access to Health Care

Access to Health Care was rated as a top three health issue. Responses overlapped with mental health, substance and alcohol use, as well as determinants of health; education, poverty, and employment.

Barriers and Challenges:

- A constantly changing health insurance landscape
- A lack of providers that accept Medicaid, and low reimbursement rates that limit acceptance of patients with financial or behavioral health challenges
- High cost of behavioral health services and lack of adequate income to cover the cost of services
- Lack of child care services for parents during appointments
- Lack of transportation to services and appointments
- Behavioral health services are complex and hard to navigate, especially for those who are poor and vulnerable
- Those who are undocumented have difficulty getting assistance and accessing health care

- Long waiting times for appointments
- Patients do not prioritize preventive care and end up in crises
- Lack of appointments outside of traditional business hours
- Lack of access to prescribed medications
- Insufficient health literacy
- Lack of knowledge about health systems

Needed Strategies:

- School-based programs
 - School-based clinics that would open access to care for children and their families
 - Opportunities to enroll in BadgerCare and other benefits at schools
- Behavioral health hubs around the communities most in need of services
 - Utilizing existing space in the community for behavioral health services
- Transportation
 - More bus lines to make it easier to get to appointments
 - Partnerships for charity care transportation
- Nursing staff in an emergency call center to help with navigation of care
- Advocacy around costs of care, insurance, and policies
- Forums around system-level changes
- Communication and sharing of information between systems and patients (i.e. school, health care, social services)
- Awareness of chronic health conditions via health screenings in the community
- Services to help people move beyond poverty

Violence

Violence was also ranked as a top three health focus area. Informants addressed a breadth of topics, including domestic / intimate partner violence and gun violence. Informants noted the relationship between violence and substance use, mental health, and other underlying, unaddressed issues.

Barriers and Challenges:

- Lack of trust in law enforcement by people of color
- The public perception that violence is not a community-wide issue
- Lack of programs to address violence
 - Several large community institutions in Milwaukee are losing leadership that can impact its work
 - Unfilled positions at agencies that address violence in our community
- Increased crime in neighborhoods
- The political climate
- Fear
- All lives are not valued equally
- Unaddressed mental health issues
- Access to guns and lack of education on gun safety
- Provider fatigue among first responders
- Violence as a symptom of many untreated/unaddressed issues
- Lack of resources and despair
- Many initiatives that are not connected
- Social determinants of health
 - Lack of housing
 - Lack of job skills
 - Denial of racism
 - Concentrated poverty

Needed Strategies:

- Adoption of trauma-informed care and practices to care for people across sectors
- Collaboration
 - Dialogue between community and law enforcement
 - Collaboration with health care and other modalities for healing

- The City of Milwaukee should facilitate collaboration
- Community-based organizations partnering with academic institutions
- Early violence interventions
- Support for people leaving incarceration and support through the transition
- Elected leadership that understands and challenges structural racism at every level
- Restorative justice work
- Resources and support for asset mapping
- Providing conflict resolution and de-escalation skills training
- Common sense gun laws
- Individual and joint accountability
- Evaluation efforts to guide best practices, ensure accountability, monitor progress and outcomes
- Shared metrics to assess hope, ACEs, wellbeing, etc.

Substance Use

Informants made a connection between substance use and other issues, such as violence, which one participant defined as a symptom of a larger problem. A wide variety of topics were addressed including specific types of substance use disorders (such as opioids), barriers to care, and the need for cross-sector collaboration.

Barriers and Challenges:

- Stigma
- Social determinants of health
 - Poverty
 - Racial issues
 - Lack of available housing
 - Individuals are unable to maintain employment
- Treatment is complex and/or inaccessible
 - Treatment is not accessible or there are not enough rehabilitation services
 - A lack of insurance coverage or care is unaffordable
 - Not enough service providers or inpatient beds
 - The perception that treatment is ineffective or unavailable
 - Too few Federally Qualified Health Centers (FQHCs)
- A lack of coordination among community organizations
- The overall Wisconsin drinking culture
- Substances are too accessible
- A lack of resources in general, including funding for new initiatives
- Opioids are overprescribed and over-marketed by pharmaceutical companies
- Not enough individuals trained on the use of naloxone
- Drinking alcohol is legal
- Denial of a problem
- Lack of focus on the problem
- Trauma-informed care is not widely practiced across agencies
- Good Samaritan laws are unclear
- Fatigue experienced by providers
- Lack of education regarding pharmaceuticals

Needed Strategies:

- Having multiple services accessible at one location
- Collaboration across various agencies and sectors
- Housing
- Patient care transfers from hospitals to rehabilitation
- Reduce barriers to resources
- Cultural changes around substance use
- Identify successful strategies in other communities
- Increase insurance access
- Drug free communities

- Take adverse childhood experiences (ACEs) into account — get “upstream”
- Integrate the community health needs assessment (CHNA) findings into local community organization strategies
- Examine access to alcohol
- Pharmaceutical education
- Focus on all drug use
- Law enforcement should target those who sell substances in communities

Nutrition and Healthy Food

Informants indicated a connection between nutrition and other health issues including healthy growth and development and chronic disease management / prevention.

Barriers and Challenges:

- Issues of access:
 - The cost of healthy foods compared to less expensive fast foods and convenience foods
 - Lack of produce and other healthy food options in convenience and corner stores
 - Transportation costs and time to get to better food retailers
 - Lack of time to cook or eat with family due to multiple jobs and activities leads to consumption of fast foods
- Lack of community education about nutrition and the importance of nutrition related to healthy growth and development, and chronic disease prevention
- The lack of younger generations’ connection to ancestors’ healthy food traditions
- The presence of excess sugar in the food environment
- The inherent difficulty of sustainable behavior change

Needed Strategies:

- Greater awareness of where resources are located
- Additional education efforts about nutrition and healthy food choices
- Incorporating lessons about nutrition and physical activity into existing youth and family programs
- Engaging multiple generations together in gardening activities
- Cooking and nutrition education
- Teaching new moms the importance of healthy foods for their children’s growth and development
- Expanding the amount and types of food retailers that accept FoodShare
- Encouraging schools, employers, and insurance companies to further incentivize or support healthier food choices
- Need to focus on this issue from a macro level through continuing efforts to help people secure employment that offers family-sustaining wages.

Appendix E: Key Informant Organizations Interviewed for purposes of conducting the Froedtert Hospital CHNA

Aurora Walker's Point Community Clinic – Safety net clinic with primary care for the uninsured.

Boys & Girls Clubs of Greater Milwaukee - Nonprofit youth serving agency providing academic and recreational programming.

Children's Health Alliance of Wisconsin, Milwaukee County Oral Health Task Force – coalition to improve oral health and access to care.

Children's Hospital of Wisconsin – Nonprofit healthcare provider for children.

City of Milwaukee Office of Violence Prevention – Government department to reduce violence.

Community Advocates - Community advocacy agency

CORE- El Centro - Social service agency providing holistic healing and wellness services.

Gerald L. Ignace Indian Health Center - Federally qualified health center primarily serving the Native American population.

Greater Milwaukee Foundation – Community philanthropic foundation providing funds to strengthen community organizations and programs.

Housing Authority of the City of Milwaukee – Government department providing high quality housing options to residents.

IMPACT, Inc. - Nonprofit social service agency providing access and navigation to community resources.

Interfaith Older Adult Services - Provides information, assistance, and supportive services to increase the self-sufficiency and well-being of older adults in the community.

Journey House – Family empowerment agency serving diverse populations.

Lutheran Social Services of Wisconsin and Upper Michigan –Nonprofit social service agency to improve the health and wellbeing of our community.

Mental Health America of Wisconsin – Mental health advocacy agency

Milwaukee County Behavioral Health Division – Government department connecting residents with behavioral health services.

Milwaukee County Department of Aging - Provides information, assistance, counseling and supportive services to older adults and caregivers.

Milwaukee County Department of Health and Human Services - Government department that prevents disease and promotes health

Milwaukee County District Attorney's Office – Governmental department promoting public safety and advocating for violence prevention.

Milwaukee County Office of Emergency Management – Government department for emergency preparedness and response.

Milwaukee LGBT Community Center – Nonprofit agency advocating for the LGTBQ community and inclusivity in Milwaukee.

Milwaukee Police Department - Emergency response

Milwaukee Public Schools - Provides public education for Milwaukee youth

Milwaukee Succeeds – Collaborative partnership to improve educational achievement in Milwaukee.

Milwaukee Urban League –Nonprofit committed to addressing disparities, advancing economic stability and improving educational outcomes.

Social Development Commission – Community action agency to address economic disparities.

Sojourner Family Peace Center - Nonprofit providing safety, shelter, advocacy, and support for individuals affected by domestic or sexual violence.

Southeast Asian Educational Development (SEAED) of Wisconsin, Inc. - Nonprofit to advocate for an engage the Asian American community for positive change regarding chronic diseases and cancer health and wellness.

Southside Organizing Center - neighborhood-based organization dedicated to the development and sustainability of Milwaukee's near south side neighborhoods

United Community Center - nonprofit agency providing education, cultural arts, recreation, community development, and health and human services programming to residents of all ages on Milwaukee's near south side.

United Way of Greater Milwaukee and Waukesha County - Engages, convenes, and mobilizes community resources to address root causes of local health and human services needs

Whole Health Clinical Group – Service provider and advocacy agency for adults with mental illness

YWCA Southeast Wisconsin - Nonprofit working to eliminate racism and empower women.

Zilber Family Foundation – philanthropic foundation dedicated to enhancing well-being in Milwaukee

Vivent Health- Health care provider for sexually transmitted infections and harm reduction programming.

Group Interviews/Focus Groups:

Federally Qualified Health Center (FQHC) Coalition - Coalition comprised of the leaders from the Milwaukee Healthcare Partnership and all 5 FQHCs in Milwaukee.

Local Health Departments in Milwaukee County: Government departments that prevent disease and promotes health.

Free and Community Clinic Collaborative (FC3) - Coalition comprised of the safety net clinics in Milwaukee County.

Appendix F: 2018 Secondary Source Data: Health Compass Milwaukee

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

Publicly available data sources used in Health Compass Milwaukee

- U.S. Census Data (CENSUS)
- Wisconsin Department of Health Services (DHS)
- Wisconsin Family Health Survey (FHS)
- Behavioral Risk Factor Surveillance System (BRFS)
- Community Health Survey (CHS)

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

Appendix G: Review of the Fiscal Year 2017-2019 Froedtert Hospital CHNA Implementation Strategy

Identified Need	Program	Actions	Outcomes
Chronic Disease	Community Outreach Program	<ul style="list-style-type: none"> • Offer a minimum of two Living Well Classes with Chronic Conditions/Diabetes each year • Explore new community partnerships/agencies in service area to hold Living Well with Chronic Conditions/Diabetes and service line programs • Explore partnership with food outlets to promote healthy food choices in Milwaukee County and those serving the Washington Park community (53208, 53206, 53204 zip codes) • Explore opportunities for expanding community health education /resources (Faith-Based communities, local FQHC's, Milwaukee Co. health departments) 	<ul style="list-style-type: none"> • 2,856 individuals were screened for chronic diseases • 28 individual participated in the Living Well Classes • 1,478 raised garden beds were created during the Victory Garden Blitz • Over 150,000 individuals were reached during community outreach events
Chronic Disease- Cancer	Cancer Care Navigation, Awareness and Screening	<ul style="list-style-type: none"> • Provide quarterly cancer awareness and community education events • Dedicated Community Outreach Coordinator to work with underserved populations in Milwaukee County by providing community resources, navigation and education • Execute a minimum of two community cancer screenings per year • Partnership with the MCW's cancer team • Introduce new service of mammography and ultrasound at Progressive Community Health Center 	<ul style="list-style-type: none"> • Over 16,000 individuals were reached during community events • 233 individuals were screened for cancer-related diseases • Over 600 community members attended the Women's Wellness Day through Progressive Community Health Center • Offered over 10 cancer screening events • Partnered with Clinical Cancer Center Community Outreach Coordinators and MCW Cancer Team on community events
Access to Care and Chronic Disease Management	Partnership-Community Based Clinical Service and Community Health Worker Model	<ul style="list-style-type: none"> • Recruit and train individuals on Community Health Worker Model • Utilize Community Health Worker to improve readmissions and /or navigation for high risk chronic conditions for patients in 53208 zip code • Actively participate in Milwaukee Health Care Partnership • Provide paths to improve health insurance access to underserved populations in Milwaukee County 	<ul style="list-style-type: none"> • 108 individuals referred through the Community Health Worker • Over 5,000 individuals reached through services • 5 individuals enrolled in assistance programs • Community Health Worker assisted individuals with access and navigation of health and dental services, food, financial, employment, transportation and safety needs
Access to Care	Partnership-Community Clinics	<ul style="list-style-type: none"> • Partnership with new Sixteenth Street Community Health Center for underserved populations in Milwaukee County zip code 53219 & 53215 • Expansion of new primary care clinic 	<ul style="list-style-type: none"> • Over 4,000 individuals served through the Emergency Department to Medical Home initiative • Over 1,000 referrals to Froedtert Health specialists through the

		<ul style="list-style-type: none"> in Oak Creek Explore food and nutrition outlet with new clinic expansions (i.e. Meijer 	<ul style="list-style-type: none"> Specialty access for the Uninsured Program Over 10,000 appointments scheduled through the Emergency Department Care Coordination Over 1,000 individuals enrolled in the marketplace
Access to Care	School Health Program	<ul style="list-style-type: none"> FTE 0.75 school nurse in inner-city school in Milwaukee County in the 53208 zip code 	<ul style="list-style-type: none"> 4,566 students seen by the RN through the school health program 765 students received sealants from Seal a Smile 11 health lessons were taught by the school RN
Injury & Violence	Injury and Violence Prevention Programs/Partnerships	<ul style="list-style-type: none"> Provide forever changed program minimum twice per year Provide falls prevention education minimum twice per year Provide injury prevention & vehicle safety program minimum twice per year Partner with Milwaukee County crime prevention programs (i.e. Milwaukee Homicide Review Board) Explore research based programs (i.e. Cardiff Model in the ED program to reduce street violence and accident and emergency (A & E) violence related attendances) Explore partnership with non- profit organizations to support reductions in violence 	<ul style="list-style-type: none"> Over 3,000 individuals reached through injury and violence prevention events Launched Violence Interrupter Program and served 26 individuals
Behavioral Health	Partnership with Community Organizations and Health Service Agencies	<ul style="list-style-type: none"> Partner with Milwaukee County opioid and heroin task force Explore partnerships with community organizations and health service agencies in Milwaukee County who currently serve this population Collaboration with Federally Qualified Health Centers (FQHC's) behavioral health strategies/offerings 	<ul style="list-style-type: none"> Attended monthly meetings with various Heroin Task Force Committees and substance abuse prevention coalitions Over 3,000 lives touched through behavioral health coalition efforts