# Community Health Needs Assessment (CHNA) Report

Froedtert Memorial Lutheran Hospital
Doing Business As:

Froedtert Hospital

Fiscal Year 2026
Effective July 1, 2025

Approved on 05/22/2025 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 ThedaCare Health, Inc. 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, Milwaukee County Department of Health & Human Services, and City of Milwaukee Health Department aligned resources to participate in a shared data collection process. Supported by additional analysis from the Center for Urban Population Health and engagement from INPOWER, this robust community-wide data collection process includes findings from a community health survey, stakeholder interviews, focus groups, a compiling of secondary source data and internal hospital data. The data is taken into consideration in order to create an independent CHNA specific to Froedtert Hospital's service area and community health needs. The CHNA is the basis for creation of an implementation strategy to improve health outcomes and reduce disparities in Milwaukee County and the hospital's service area.

The CHNA was reviewed by the Froedtert Hospital CHNA/Implementation Strategy Advisory Committee (**Appendix A**) consisting of members of the Community Health Improvement Advisory Committee, Froedtert Hospital Board of Directors, community partners in Milwaukee County, and City of Milwaukee Public Health Department along with hospital and health system leadership/staff. Members of the committee were selected based on their specific knowledge of health needs and resources in Milwaukee County for a collective analysis of the findings from the Community Health Needs Assessment. Under the direction of the Community Engagement Leadership Team 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. Community Engagement leadership and staff will regularly monitor and report on progress towards the Implementation Strategy objectives and provide quarterly reports to the Community Engagement Committee of FMLH Board and Froedtert Hospital Board of Directors. Additional progress on the Implementation Strategy will be reported annually through the hospital's IRS Form 990 Schedule H filing and other reporting sources associated with strategic partners and community coalitions.

# Froedtert Hospital Community Service Area

**Overview**
Froedtert Hospital, the academic medical center of the Froedtert & the Medical College of Wisconsin health network, has 766 beds and is a leading referral resource for advanced medical care. Froedtert Hospital also operates the region's only adult Level I Trauma Center. The primary adult teaching affiliate of MCW, Froedtert Hospital is a major training facility for medical, nursing and health technical students. 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. For more information, visit *froedtert.com.*

In 2024, Froedtert Health and ThedaCare became one organization, making it possible for the health network to enhance access to care for more people in Wisconsin. Froedtert ThedaCare Health includes 22,000+ employees and 3,400+ providers offering services in 18 hospitals and more than 360 outpatient locations including primary care, health centers and clinics. The combined organization is a partner to the Medical College of Wisconsin, working in concert to expand its mission of patient care, innovation, medical research and education.

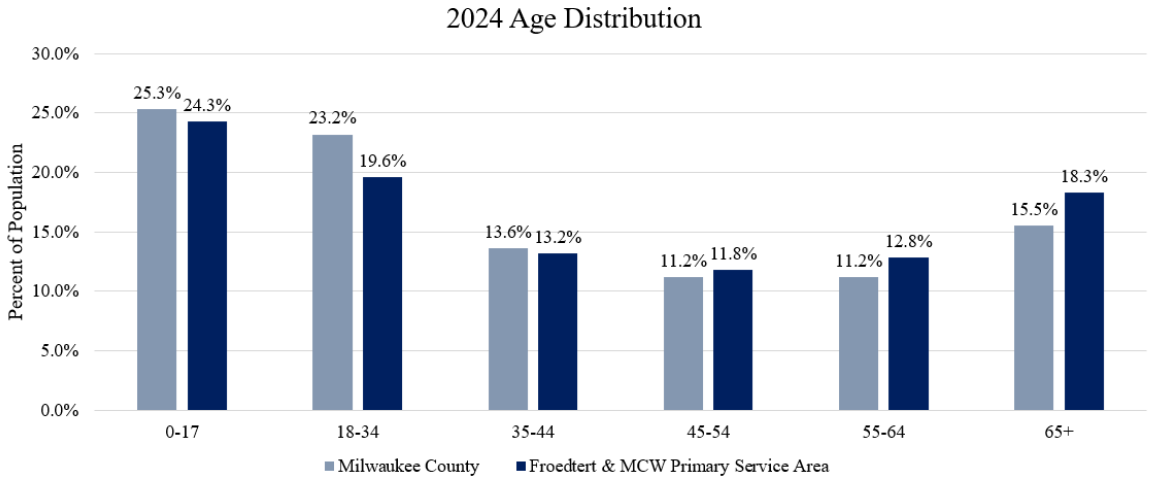
**Mission Statement**
The Froedtert & the Medical College of Wisconsin health network advances the health of the communities we serve through exceptional care enhanced by innovation and discovery.

**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 57.3% 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.

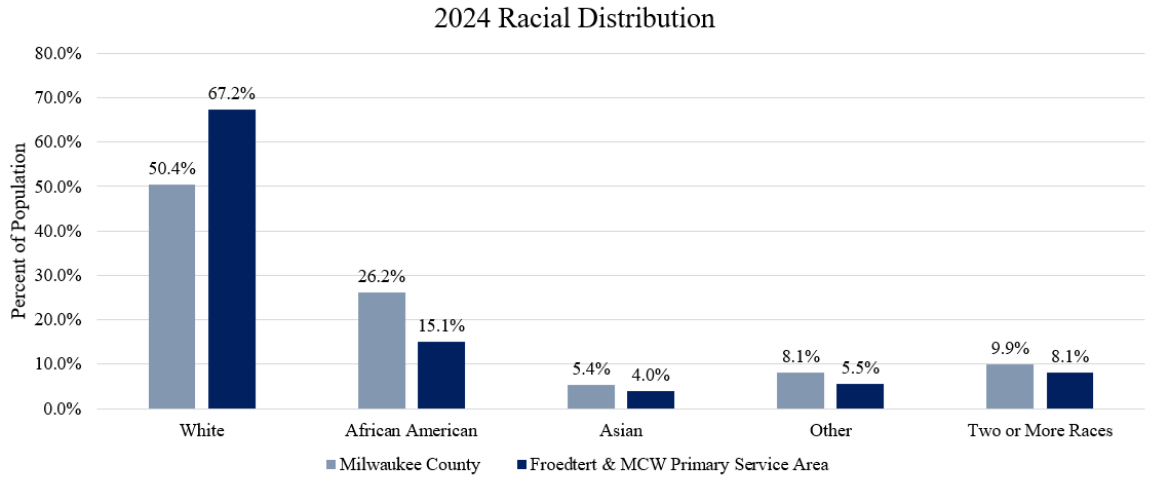
The Froedtert Hospital total service area in Milwaukee County consists of 35 zip codes. – 53110 (Cudahy), 53129 (Greendale), 53130 (Hales Corners), 53132 (Franklin), 53154 (Oak Creek), 53172 (South Milwaukee), 53202 (Milwaukee), 53203 (Milwaukee), 53204 (Milwaukee), 53205 (Milwaukee), 53206 (Milwaukee), 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).

# Froedtert Hospital Primary Service Area Demographics

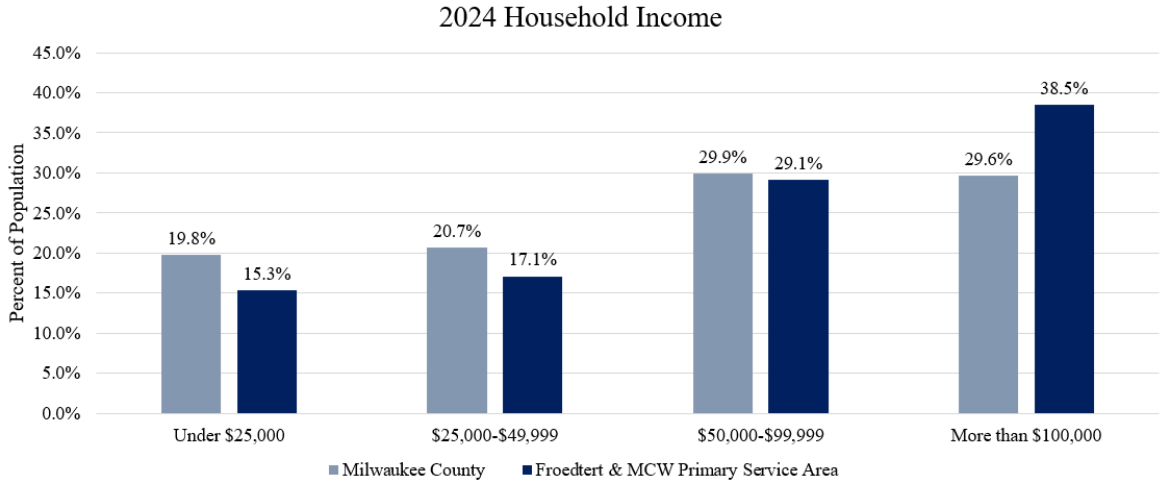
**Age** – Milwaukee County has a comparable age distribution as the Froedtert & MCW Primary Service Area. The 18 – 34 age group is larger in Milwaukee County with 23.2% of population while the Froedtert & MCW Primary Service Area 18 – 34 age group is 19.6% of the population.



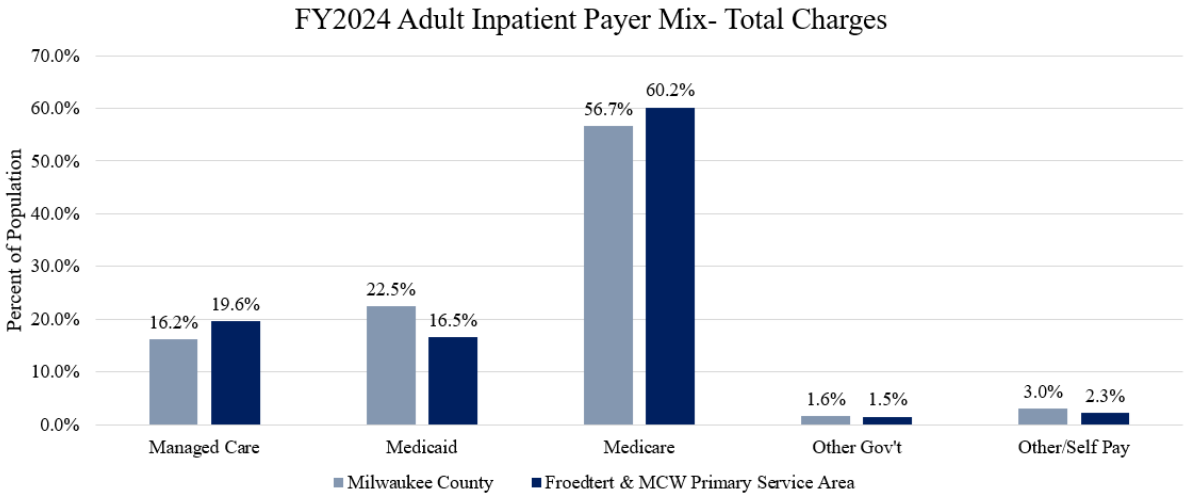

**Race** – The racial distribution in Milwaukee County is predominantly Caucasian (50.4%). Milwaukee County is more diverse with 26.2% African American and 23.4% other races. The Froedtert & MCW Primary Service Area is 67.2% White and 15.1% African American.



**Household Income** – Households where income is less than $50,000 is 40.5% of the distribution in Milwaukee County. Within the Froedtert & MCW Primary Service Area, the percent of households where income is less than $50,000 is 32.4%.




**Payer Mix** – For adult inpatients, Milwaukee County has 25.5% of patients consist of Medicaid and Self Pay payers. The Froedtert & MCW Primary Service Area has 18.8% of patients with Medicaid and Self Pay in the payer mix.




*Froedtert & MCW Primary Service Area: Milwaukee, Ozaukee, Racine, Waukesha, Washington

## Community Health Needs Assessment Process and Methods Used

In 2024, 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 were collected and taken into consideration for assessing and addressing community health needs:

***Community Health Survey:*** An online survey of 6,265 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://healthcompassmilwaukee.org.

***Key Stakeholder Interviews:*** Froedtert Hospital Community Engagement team and leaders conducted phone interviews with 46 stakeholders and 10 focus groups with community leaders of various school districts, non-profit organizations, health and human service department and business leaders. A list of organizations can be found in **Appendix G**. The full key stakeholder report can be found at https://healthcompassmilwaukee.org.

***Secondary Data Sources:*** Utilizing multiple county and community-based publicly available reports and Metopio, information was gathered regarding mortality/morbidity data, health care utilizations, health behaviors, chronic diseases, public safety/crime reports and socio-economic/social driver data.

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

### Health Impact

Froedtert Hospital has a commitment to being a culturally competent organization that provides exceptional care to everyone; therefore, health impact is a priority for not only the hospital but also the entire health network. Health Impact focuses on minimizing these differences and drives us to increase opportunities for good health by eliminating systemic, avoidable, unfair and unjust barriers. Health impact was a focus of consideration during the entire community health needs assessment, the identification of significant health needs and the prioritization of those needs. Furthermore, health impact will be considered as Froedtert Hospital identifies strategies to address those prioritized significant health needs.

### Data Collection Collaborators

Froedtert Hospital completed its 2024 data collection in collaboration with the Milwaukee Health Care Partnership and its member organizations. The member organizations were heavily involved in identifying and collecting the data components of the CHNA. The Milwaukee County CHNA committee is a collection of individuals representing Milwaukee Health Care Partnership and its collective members which include the major health systems in Milwaukee:

- Ascension Wisconsin
- Aurora Health Care
- Children's Wisconsin
- Froedtert ThedaCare Health, Inc.
- City of Milwaukee Health Department
- Milwaukee County Department of Health & Human Services

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

**Data Collection Consultants**
Milwaukee Health Care Partnership commissioned the Center for Urban and Population Health (CUPH) to support report preparation for its 2024 shared Milwaukee County data collection process and provided analysis of the community health survey and key stakeholder interviews. INPOWER supported the CHNA through developing and disseminating marketing materials to increase survey engagement.

## Community Health Needs Assessment Solicitation and Feedback

Froedtert Hospital is committed to addressing community health needs collaboratively with local partners. Froedtert Hospital used the following methods to gain community input from August to December 2024 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 Stakeholder 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 in **Appendix G**. These local partnering organizations also invited the informants to participate in and conducted the interviews. The interviewers used a standard interview script that included the following elements:

- Existing strategies to address the issue
- Barriers/challenges to addressing the issue
- Additional strategies needed to address the issue
- Key organizations or groups in the community that we should partner with to improve community health
- Geographic and other subgroups or populations in the community that experience the health issues
- Strengths/assets in the community
- Organizations that are working to address the issue
- What else should be considered when assessing the health of the community

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

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

| | Community Health Survey | Key Stakeholder Interviews |
|---|---|---|
| **Community Health Issues** | • Gun / community violence<br>• Mental health and mental conditions<br>• Drug use and abuse<br>• Alcohol use<br>• Chronic diseases | • Housing<br>• Mental Health<br>• Access to Care<br>• Violence<br>• Food Insecurity |
| **Community Social Needs** | • Access to affordable health care<br>• Access to affordable housing<br>• Access to mental health services<br>• Address gun / community violence<br>• Access to affordable healthy foods | |

## Prioritization of Significant Health Needs

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

- Violence
- Mental health
- Substance use
- Chronic disease
- Maternal and child health

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

1. Review the 2024 Community Health Needs Assessment results for identification and prioritization of community health needs.
2. Review previous 2023-2025 Implementation Strategy programs and results.
3. Rank and select priority areas.
4. Brainstorm contributing and restricting factors and root causes that impact community health needs.

During a facilitated workout session in March 2025, members of the CHNA/Implementation Strategy Advisory Committee were asked to rate each health need based on the following criteria to identify the significant health needs:

- **Alignment:** the degree to which the health issue aligns with the hospital's mission and strategic priorities.

- **Feasibility:** the degree to which the hospital can address the need through direct programs, clinical strengths and dedicated resources.
- **Partnerships:** the degree to which there are current or potential community partners/coalitions.
- **Health Impact:** the degree to which disparities exist and can be addressed.
- **Measurable:** the degree to which measurable impact can be made to address the issue.
- **Upstream:** the degree to which the health issue is upstream from and a root cause of other health issues.

Based on those results, three overarching themes were identified as priorities for Froedtert Hospital's Implementation Strategy for fiscal 2026-2028:

- Behavioral Health
- Access to Health Services
- Education

## Community Resources and Assets

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

## Approval of Community Health Needs Assessment

The completed Community Health Needs Assessment (CHNA) report was adopted by the Froedtert Hospital Board of Directors on 05/22/2025 and made publicly available on 05/30/2025.

## Summary of Impact from the Previous Implementation Strategy

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

## Public Availability of CHNA and Implementation Strategy

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

Feedback and public comments are always welcomed and encouraged. They can be provided through the contact form on the Froedtert & MCW website at www.froedtert.com/contact or through contacting Community Engagement leadership/staff by calling 414-777-3787. Froedtert Hospital received no comments or issues with the previous Community Health Needs Assessment Report and Implementation Strategy.

# Appendix A: Froedtert Hospital CHNA/Implementation Strategy Advisory Committee

| | | | |
|---|---|---|---|
| Al Castro | Program Director | United Community Center | |
| Amanda Wisth | Director, Community Benefit | Froedtert ThedaCare Health, Inc. | FMLH CE Committee |
| Amy Maurer | Community Engagement Coordinator | Froedtert ThedaCare Health, Inc. | |
| Andres Gonzalez | Vice President, Chief Belonging and Community Engagement Officer | Froedtert ThedaCare Health, Inc. | |
| Andy Dresang | Executive Director | Froedtert ThedaCare Health, Inc. | FMLH CE Committee |
| Ann Bria | THRIVE Workforce Manager | iThrive Consulting, LLC | |
| Ann Christiansen | Executive Director | Milwaukee Health Care Partnership | |
| Arvind Gopalratnam | Senior Vice President of Corporate Social Responsibility / Executive Director | Milwaukee Bucks Foundation | COHS Board Member |
| Austin Reeder | President, Froedtert Hospital | Froedtert ThedaCare Health, Inc. | FMLH CE Committee/ Board Member |
| Becca Laszkiewicz | Trauma Nurse Navigator | Froedtert ThedaCare Health, Inc. | |
| Beth McNally | Director, Heart, and Vascular Strategic Programs | Froedtert ThedaCare Health, Inc. | |
| Britney Roberson | Community Engagement Coordinator | Froedtert ThedaCare Health, Inc. | |
| Dr. Bryce Gartland | President, Froedtert ThedaCare Health, South Region | Froedtert ThedaCare Health, Inc. | |
| Candice Cole-Smith | CEO | Progressive Community Health Centers | |
| Chandra Rodgers | SVP, Community Affairs / Community Reinvestment Act Officer | Associated Bank | FMLH CE Committee |
| Charles Socci | VP Heart and Vascular | Froedtert ThedaCare Health, Inc. | |
| Dessa Johnson | Director, Belonging and Emerging Markets | Froedtert ThedaCare Health, Inc. | |
| Devin Hudson | Executive Director | Silver Spring Neighborhood Center | |
| Drew Tilkens | Director Network Operations | Froedtert ThedaCare Health, Inc. | |
| Edith Novoa | Health Navigator Manager | Core El Centro | |
| Eugene Manzanet, PhD | Senior Director, Diverse Business Development | Wisconsin Economic Development Corporation | FMLH CE Committee |
| Holly Greiten | Holistic Therapies Manager | Core El Centro | |
| Jake Richardson | Resident Physician | Medical College of Wisconsin | |
| Jasmine Johnikin | Community Outreach Nurse | Froedtert ThedaCare Health, Inc. | |
| John Ernst | Interim Chief Operating Officer | Froedtert ThedaCare Health, Inc. | |
| John Hyatt | President and CEO | IMPACT Inc. | |
| Julie Harris Robinson | President and CEO | Outreach Community Health Centers | |
| Justin Rivas | Director of Community Health Initiatives | Milwaukee Health Care Partnership | |
| Kathy Glaze | Belonging and Health Impact Program Manager | Froedtert ThedaCare Health, Inc. | |
| Kiara Green | Executive Assistant, Community Engagement | Froedtert ThedaCare Health, Inc. | |
| Kim Lombard | Injury Prevention and Outreach Coordinator | Froedtert ThedaCare Health, Inc. | |
| Kyle Anthony, MD | Resident Physician | Medical College of Wisconsin | |
| Laura Keller | Director of Clinical Support | Froedtert ThedaCare Health, Inc. | |
| Liz Juern | Director, Volunteer Services | Froedtert ThedaCare Health, Inc. | |
| Mandie Reedy | Community Engagement Coordinator | Froedtert ThedaCare Health, Inc. | |
| Mayowa Olalekan, MD | Resident Physician | Medical College of Wisconsin | |
| Megan Seidl, DO | Assistant Professor, Clinical, Family Medicine | Medical College of Wisconsin | |
| Morgan Miller | Community Outreach Nurse | Froedtert ThedaCare Health, Inc. | |

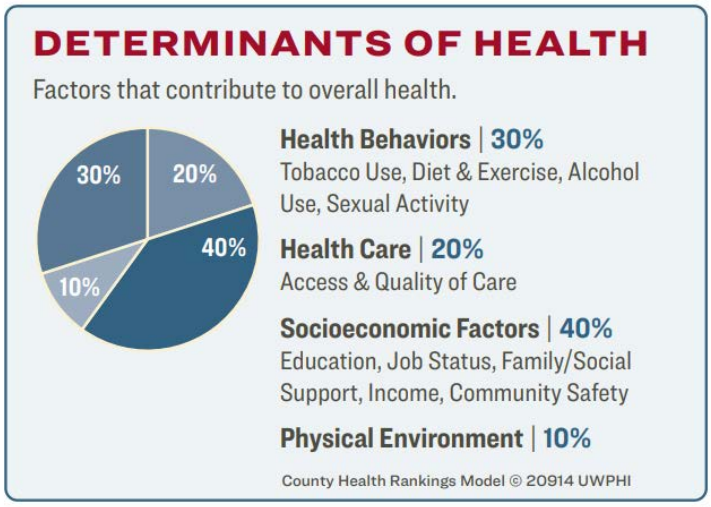
| | | | |
|---|---|---|---|
| Ogbeiye Ebuehi, DO | Resident Physician | Medical College of Wisconsin | |
| Patricia Nimmer | Director, Community Outreach and Partnerships | Froedtert ThedaCare Health, Inc. | FMLH CE Committee |
| Rachel Mosey | Communications Specialist Sr. | Froedtert ThedaCare Health, Inc. | |
| Rebeca Heaton Juarez | Interim Co-Executive Director | Core El Centro | |
| Robert Ramerez | Director, Community Health | Froedtert ThedaCare Health, Inc. | FMLH CE Committee |
| Rocio Tronco | Programming Manager | Core El Centro | |
| Rosamaria Martinez | Maternal and Child Health Director | City of Milwaukee Health Department | |
| Sean Crary | Resident Physician | Medical College of Wisconsin | |
| Staci Young, PhD | Sr Associate Dean, Associate Director, Professor Research, Family Medicine, Medical Effectiveness Research Center | Medical College of Wisconsin | |
| Stephanie Graham | Content Producer, Communications | Froedtert ThedaCare Health, Inc. | |
| Tami Martin | Director Workforce Development | Froedtert ThedaCare Health, Inc. | |
| Tierra Hoard | Community Outreach Nurse | Froedtert ThedaCare Health, Inc. | |
| Tim Baack | President and CEO | Pathfinders | FMLH CE Committee |
| Tyler Odeneal | Impact Manager | Safe and Sound | |
| Wendell Willis | Managing Director, DEER Accelerator | Froedtert ThedaCare Health, Inc. | |
| William Schmitt | Executive Director | Rooted & Rising | FMLH CE Committee |
| Zach Timm | Executive Director Heart and Vascular Service Line | Froedtert ThedaCare Health, Inc. | |

# Appendix B: Health Impact

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

People who are marginalized by society or who come from disadvantaged communities tend to have more chronic diseases and poorer health outcomes. Individuals' health outcomes are deeply influenced by factors such as race, ethnicity, socioeconomic status, geographic location, gender and other social determinants.

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




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

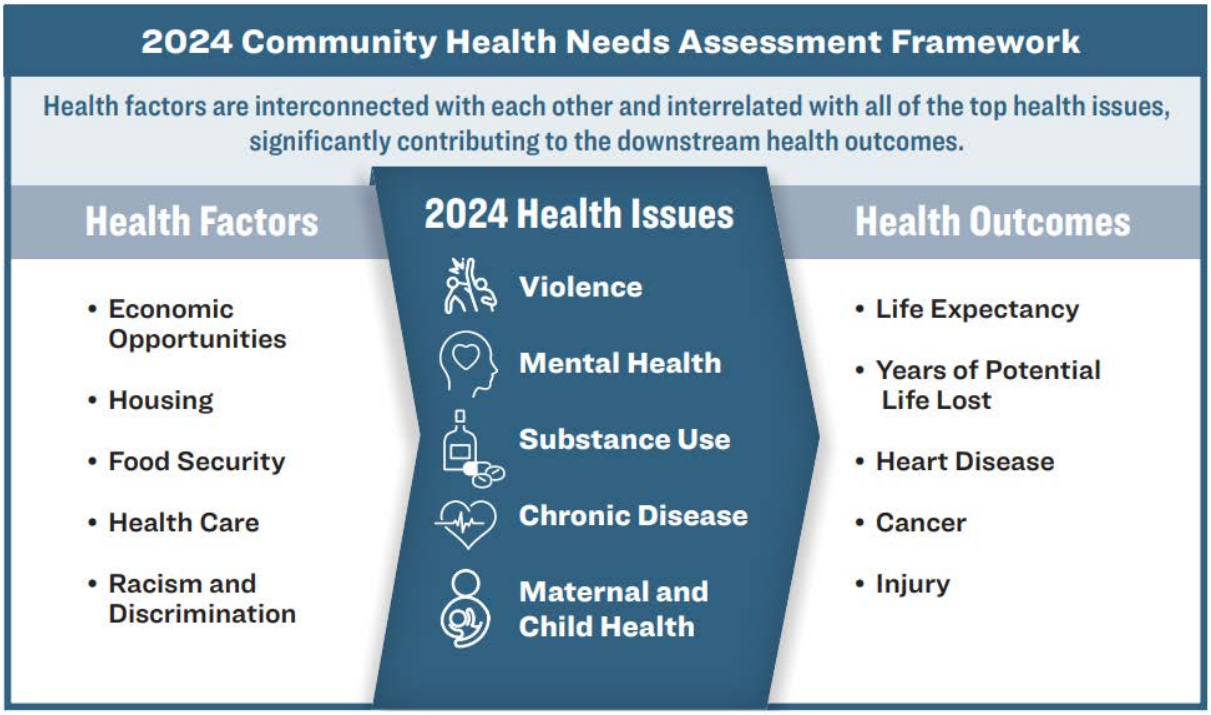
**Health Disparities**
Identifying health disparities and barriers to good health are important components in assessing community health needs. Once identified, understanding upstream policies, systems and social determinants that drive health disparities can help create practical, community-driven solutions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

Overall, the health disparities faced by marginalized communities are the result of complex interactions between socioeconomic, environmental and systemic factors. Addressing these disparities requires not only improving access to health care but also addressing the broader social and economic inequalities that disproportionately affect these communities.

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

## Appendix C: 2024 Milwaukee County Community Health Needs Assessment Framework

A healthy Milwaukee is a place where everyone has a fair and just opportunity to reach their best health and well-being. It is a complex path forward to achieve that goal. The framework below aims to communicate and contextualize the 2024 Milwaukee County Community Health Needs Assessment (CHNA) findings, recognizing the complexity of health and the interrelated nature of the key health factors, issues, and outcomes.



# Appendix D: 2024 Milwaukee County Community Health Needs Assessment: Community Health Survey

The Milwaukee County Community Health Needs Assessment survey results are available at https://healthcompassmilwaukee.org.

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

1. Gather specific data on behavioral and lifestyle habits of the adult population. Select information will also be collected about the respondent's household.
2. Gather data on the prevalence of risk factors and disease conditions existing within the adult population.
3. Compare, where appropriate, health data of residents to previous health studies.
4. Compare, where appropriate and available, health data of residents to state and national measurements along with Healthy People 2030 goals.

Community input was collected primarily via a non-random online community survey conducted by and *a small proportion (<200) done via a paper survey and then entered online* from May 2024 through October 2024. Available in English and Spanish, the survey consisted of 54 questions related to top health needs in the community, individuals' perception of their overall health, individuals' access to health care services, as well as social and economic determinants of health.

The survey was advertised with a variety of methods and incentives included random drawings that survey respondents would be entered in to win prizes (tickets, coupons, gift certificates). With a non-random convenience sample, it should be noted that the respondents are not a representative sample of the county but those that chose to respond to the survey questionnaire (non-random). This sampling procedure did recruit a high proportion of some demographic subgroups (Non-Hispanic Black and Hispanic/Latino) but may not reflect the true population estimate from the county for those subgroups.

Each question of the survey is evaluated using the number of respondents who answered the question, some respondents did not answer every question. The results of the survey are reported as percentages of individuals who responded to each question for each answer and each table is sorted by the highest percent response to the lowest. Participants include Milwaukee County residents aged 18 and older. There were 6,265 total submissions with 5,030 fully-completed surveys, which is approximately 73% of surveys completed.

**Limitations:** The breadth of findings depends on who self-selected to participate in the online survey. Additionally, the community survey was a convenience sample, which means results may be vulnerable to selection bias and make the findings less generalizable. A limitation to the survey is that it was conducted in English and Spanish only.

**Partners & Contracts:** This report was commissioned by Ascension Wisconsin, Advocate Aurora Health, Children's Wisconsin, Froedtert ThedaCare Health, Inc., Milwaukee Health Care Partnership, City of Milwaukee Health Department and Milwaukee County Health and Human Services in partnership with the Center for Urban Population Health and INPOWER.

# Appendix E: 2024 Milwaukee County Community Health Survey Results



## 2024 Milwaukee County Community Health Survey Summary

The data for this summary was obtained through an online survey conducted by Conduent Healthy Communities Institute from June through September 2024. Participants include Milwaukee County residents aged 18 and older. There were 6,265 total submissions with 5,030 fully completed surveys. The summary was prepared for Ascension Wisconsin, Aurora Health Care, Children's Wisconsin, Froedtert Health, Milwaukee County Department of Health and Human Services, and the City of Milwaukee Health Department in partnership with the Milwaukee Health Care Partnership.

Individual Health Conditions and Behaviors

### HEALTH CONDITIONS

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

| ***Response: "YES"*** | **County overall** | **Black/African American** | **Hispanic/Latino** | **High-need zip codes (11*)** | **Household with children** | **Older adult (>65 yrs)** |
|---|---|---|---|---|---|---|
| Diabetes | **12.7%** | 18.9% | 15.6% | 16.0% | 9.8% | 17.7% |
| High Blood Pressure | **31.7%** | 43.4% | 20.6% | 33.7% | 21.8% | 48.9% |
| High Cholesterol | **29.0%** | 23.5% | 21.8% | 25.5% | 19.6% | 44.9% |
| Heart disease or condition | **10.0%** | 8.9% | 6.4% | 8.2% | 5.4% | 21.7% |
| Mental health condition | **30.6%** | 27.8% | 31.1% | 29.9% | 36.0% | 15.8% |

### HEALTH BEHAVIORS

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

| ***Response: "YES"*** | **County overall** | **Black/African American** | **Hispanic/Latino** | **High-need zip codes** | **Household with children** | **Older adult (>65 yrs)** |
|---|---|---|---|---|---|---|
| Alcoholic Consumption (binge drinking) | **21.2%** | 22.0% | 20.9% | 21.5% | 20.7% | 15.9% |
| Smoking cigarettes | **8.7%** | 14.4% | 9.4% | 13.0% | 10.9% | 4.9% |
| Electronic cigarettes | **4.6%** | 5.6% | 6.2% | 6.5% | 5.9% | 0.5% |
| Personal Health | | | | | | |
| Very healthy | **9.3%** | 5.3% | 7.1% | 7.8% | 7.5% | 12.8% |
| Healthy | **42.6%** | 34.9% | 34.0% | 37.6% | 40.4% | 49.7% |
| Somewhat healthy | **38.1%** | 47.6% | 42.2% | 42.0% | 40.6% | 31.0% |
| Unhealthy | **8.3%** | 9.7% | 14.0% | 10.3% | 9.3% | 4.9% |
| Very unhealthy | **1.6%** | 2.5% | 2.7% | 2.4% | 2.2% | 1.5% |

### HEALTH CARE ACCESS

**Question:** *[INSERT COPY]*

| ***Response: "YES"*** | **County overall** | **Black/ African American** | **Hispanic/ Latino** | **High-need zip codes** | **Household with children** | **Older adult (>65 yrs)** |
|---|---|---|---|---|---|---|
| Health insurance | **94.6%** | 93.0% | 77.3% | 88.6% | 96.9% | 99.2% |
| Did not access health or dental in last 12 months | **22.3%** | 27.1% | 32.5% | 27.8% | 27.4% | 10.8% |
| Cost as reason | **54.0%** | 44.5% | 56.8% | 49.7% | 52.1% | 42.7% |
| Did not access mental health/substance use in last 12 months | **13.2%** | 14.9% | 17.0% | 14.0% | 16.4% | 4.9% |
| Cost as reason | **38.6%** | 28.8% | 43.4% | 37.3% | 34.8% | 19.7% |
| ED use in past 12 months | **39.4%** | 45.1% | 34.7% | 41.2% | 46.0% | 36.9% |

Community Health

### HEALTH ISSUES

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

| ***Response: "YES as one of the top three issues"*** | **County overall** | **Black/African American** | **Hispanic/Latino** | **High-need zip codes** | **Household with children** | **Older adult (>65 yrs)** |
|---|---|---|---|---|---|---|
| Gun violence/community violence | **53.0%** | 63.1% | 45.9% | 61.4% | 45.5% | 58.4% |
| Mental health and mental conditions | **44.7%** | 41.6% | 34.9% | 38.6% | 44.3% | 32.6% |
| Drug use and abuse | **27.9%** | 29.7% | 30.8% | 32.9% | 24.8% | 27.5% |
| Alcohol use and abuse | **24.7%** | 30.5% | 34.4% | 29.0% | 24.5% | 23.0% |
| Chronic diseases | **23.6%** | 26.0% | 19.3% | 21.1% | 14.8% | 31.7% |

### HEALTH NEEDS

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

| ***Response: "YES as one of the top three issues"*** | **County overall** | **Black/African American** | **Hispanic/Latino** | **High-need zip codes** | **Household with children** | **Older adult (>65 yrs)** |
|---|---|---|---|---|---|---|
| Access to affordable health care | **47.5%** | 41.1% | 50.5% | 44.0% | 39.6% | 49.1% |
| Access to affordable housing | **44.2%** | 55.6% | 40.7% | 46.4% | 40.0% | 39.6% |
| Access to mental health services | **32.9%** | 36.1% | 29.5% | 30.9% | 32.3% | 27.5% |
| Addressing community safety/gun violence | **28.3%** | 27.5% | 30.3% | 30.8% | 22.8% | 35.9% |
| Access to affordable, healthy foods | **27.0%** | 37.1% | 29.7% | 31.1% | 30.4% | 17.5% |

Community Health

**COMMUNITY HEALTH SERVICES**

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

| ***Response: "YES" to "I AM/I CAN"*** | **County overall** | **Black/African American** | **Hispanic/Latino** | **High-need zip codes** | **Household with children** | **Older adult (>65 yrs)** |
|---|---|---|---|---|---|---|
| Yes, I am connected to primary care that I am happy with | **87.1%** | 85.8% | 79.4% | 82.8% | 84.6% | 96.1% |
| Yes, I can get appointment when needed | **75.8%** | 78.3% | 68.5% | 73.3% | 73.7% | 84.3% |
| Yes, I can easily get to my health care provider | **91.0%** | 89.3% | 83.6% | 87.4% | 88.3% | 95.9% |

**COMMUNITY SOCIAL AND ECONOMIC CONDITIONS**

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

| ***Response: "YES"*** | **County overall** | **Black/African American** | **Hispanic/Latino** | **High-need zip codes** | **Household with children** | **Older adult (>65 yrs)** |
|---|---|---|---|---|---|---|
| Quality health care | **88.9%** | 74.7% | 81.4% | 80.0% | 85.2% | 95.8% |
| Affordable health care | **64.9%** | 61.3% | 65.1% | 64.3% | 64.5% | 77.9% |
| Affordable childcare | **23.2%** | 32.9% | 32.9% | 29.6% | 25.5% | 19.2% |
| Well-paying jobs 18+ | **39.5%** | 32.1% | 36.2% | 33.2% | 38.9% | 47.1% |
| Available jobs <18 | **49.0%** | 34.6% | 38.8% | 39.5% | 44.7% | 54.4% |
| Quality K-12 schools | **43.2%** | 27.6% | 40.1% | 30.5% | 43.5% | 53.8% |
| Affordable college | **58.2%** | 52.3% | 51.6% | 55.4% | 54.0% | 72.0% |
| Crime is not major issue | **54.9%** | 42.3% | 49.1% | 38.7% | 56.1% | 59.7% |
| Trust in law enforcement | **60.5%** | 38.5% | 51.5% | 41.6% | 57.1% | 79.3% |
| Affordable healthy foods | **62.9%** | 38.3% | 56.8% | 48.2% | 56.8% | 76.2% |
| Good sidewalks/trails | **79.5%** | 61.7% | 68.9% | 65.7% | 71.8% | 87.7% |
| Clean streets | **61.3%** | 32.7% | 42.9% | 32.8% | 55.1% | 76.2% |
| Safe air and water quality | **74.1%** | 55.5% | 65.0% | 54.1% | 67.5% | 83.4% |

Racism, Discrimination and Health Equity

**INDIVIDUAL: LIFE CHALLENGES WITH SOCIAL AND ECONOMIC CONDITIONS**

**Question:** *Thinking about your own life, do you feel that any of the following have been a challenge in your own life or not?*

| ***Response: "YES"*** | **County overall** | **Black/African American** | **Hispanic/Latino** | **High-need zip codes** | **Household with children** | **Older adult (>65 yrs)** |
|---|---|---|---|---|---|---|
| Unconscious bias | **49.9%** | 65.3% | 57.3% | 57.2% | 50.9% | 35.4% |
| Individual acts of racism/discrimination | **31.8%** | 60.0% | 47.6% | 43.5% | 35.5% | 21.2% |
| Structural or systemic racism | **24.6%** | 62.2% | 40.1% | 38.4% | 30.7% | 12.9% |
| Limited access to wealth | **24.6%** | 51.0% | 44.5% | 41.0% | 37.5% | 15.1% |
| Limited access to quality education | **14.5%** | 71.4% | 29.0% | 22.2% | 22.3% | 4.0% |
| Limited access to career opportunities | **29.0%** | 53.7% | 40.7% | 37.1% | 36.2% | 10.5% |
| Limited access to quality housing | **19.8%** | 39.1% | 33.7% | 31.2% | 26.7% | 7.4% |

**INDIVIDUAL: RACISM AND DISCRIMINATION IN HELATH CARE ACCESS**

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

| ***Response: "YES"*** | **County overall** | **Black/African American** | **Hispanic/Latino** | **High-need zip codes** | **Household with children** | **Older adult (>65 yrs)** |
|---|---|---|---|---|---|---|
| I feel heard and seen and listened to when receiving health care | **86.4%** | 80.6% | 81.7% | 83.1% | 84.0% | 95.2% |
| I feel I am treated differently because of my race or ethnicity when receiving health care | **10.9%** | 28.6% | 18.5% | 17.2% | 15.0% | 4.6% |
| I feel I am treated differently because of my gender when receiving health care | **16.3%** | 13.5% | 17.5% | 16.3% | 16.9% | 6.9% |
| I feel I am treated differently because of my sexual orientation when receiving health care | **4.9%** | 6.1% | 6.4% | 6.1% | 4.7% | 1.2% |
| I feel my family or support people are seen and listened to when receiving health care | **84.0%** | 75.0% | 77.4% | 78.0% | 80.5% | 94.0% |
| I feel seen and listened to when my child/children are receiving health care | **87.7%** | 81.6% | 87.6% | 84.6% | 88.5% | 93.8% |

**COMMUNITY: PERCEPTION OF REASONS FOR HEALTH DISPARITIES**

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

| ***Response: "MAJOR REASON"*** | **County overall** | **Black/African American** | **Hispanic/Latino** | **High-need zip codes** | **Household with children** | **Older adult (>65 yrs)** |
|---|---|---|---|---|---|---|
| Historic gaps in wealth | **70.4%** | 79.0% | 64.3% | 72.0% | 68.9% | 71.7% |
| Structural/systemic racism | **66.1%** | 79.9% | 63.1% | 68.9% | 66.7% | 60.5% |
| POC have less access to quality education | **51.9%** | 66.4% | 54.3% | 56.4% | 56.1% | 42.8% |
| POC have less career opportunities | **50.8%** | 73.0% | 54.0% | 58.3% | 55.0% | 41.8% |
| POC have less access to quality housing | **61.8%** | 76.2% | 55.6% | 66.3% | 61.5% | 58.0% |
| POC are more likely to be exposed to bad environmental conditions | **61.6%** | 74.0% | 56.1% | 67.5% | 59.5% | 61.3% |
| Doctors are less likely to provide the same care to POC | **43.7%** | 61.7% | 46.7% | 50.9% | 47.9% | 28.5% |
| POC are less likely to have health care and/or insurance | **59.0%** | 68.6% | 51.0% | 60.1% | 56.9% | 57.0% |
| POC have less opportunities for healthy activities and/or eating | **41.2%** | 57.1% | 47.5% | 47.4% | 44.7% | 34.4% |

## Survey Respondent Demographics

Total sample size: n=6265

| RACE | n | % |
|---|---|---|
| White or Caucasian | 4217 | 67.3% |
| Black or African American | 1105 | 17.6% |
| Asian or Asian American | 103 | 1.6% |
| American Indian or Alaskan Native | 77 | 1.2% |
| Two or more races | 192 | 3.1% |
| Some other race | 175 | 2.8% |
| Prefer not to answer | 388 | 6.2% |

| ETHNICITY | n | % |
|---|---|---|
| Hispanic/Latino/Latinx | 781 | 12.5% |
| Mexican | 514 | 65.8% |
| Puerto Rican | 136 | 17.4% |
| South American | 34 | 4.3% |
| Central American | 41 | 5.3% |
| Cuban | 9 | 1.2% |
| Other | 43 | 5.5% |
| Non-Hispanic/Latino/Latinx | 5168 | 82.5% |
| Prefer not to answer | 316 | 5.0% |

| AGE | n | % |
|---|---|---|
| 18-20 | 38 | 0.6% |
| 21-24 | 161 | 2.6% |
| 25-34 | 1009 | 16.1% |
| 35-44 | 1320 | 21.1% |
| 45-54 | 1004 | 16.0% |
| 55-64 | 1320 | 21.1% |
| 65-74 | 1166 | 18.6% |
| 75-84 | 456 | 7.3% |
| 85 or older | 50 | 0.8% |

| GENDER | n | % |
|---|---|---|
| Woman | 4679 | 74.9% |
| Man | 1404 | 22.5% |
| Transgender Man | 23 | 0.4% |
| Transgender Woman | 4 | 0.1% |
| Non-binary | 65 | 1.0% |
| Prefer not to answer | 75 | 1.2% |

| SEXUAL ORIENTATION | n | % |
|---|---|---|
| Straight | 5412 | 86.7% |
| Gay | 127 | 2.0% |
| Lesbian | 82 | 1.3% |
| Bisexual | 227 | 3.6% |
| Pansexual | 65 | 1.0% |
| Queer | 97 | 1.6% |
| Other | 33 | 0.5% |
| Prefer not to answer | 202 | 3.2% |

| EDUCATION | n | % |
|---|---|---|
| Less than 9th grade | 42 | 0.7% |
| Some high school | 124 | 2.0% |
| High school graduate (GED) | 1490 | 23.8% |
| Associate degree | 883 | 14.2% |
| Bachelor's degree | 1971 | 31.5% |
| Master's/professional degree | 1755 | 28.0% |
| **INCOME** | | |
| Less than $25,000 | 624 | 9.9% |
| $25,000-$49,999 | 1025 | 16.4% |
| $50,000-$74,999 | 1076 | 17.2% |
| $75,000-$99,999 | 842 | 13.4% |
| $100,000-$124,999 | 740 | 11.8% |
| $125,000+ | 1146 | 18.3% |
| Prefer not to answer | 812 | 13.0% |
| **EMPLOYMENT** | | |
| Employed part-time | 651 | 10.4% |
| Employed full-time | 3454 | 55.1% |
| Out of work, looking | 191 | 3.0% |
| Not working by choice | 107 | 1.7% |
| Unable to work | 173 | 2.8% |
| Retired | 1538 | 24.5% |
| Student | 92 | 1.5% |
| Out of work, not looking | 59 | 0.9% |
| **HOUSEHOLD SIZE** | | |
| 1 | 1430 | 23.2% |
| 2 | 2397 | 38.9% |
| 3 | 904 | 14.7% |
| 4 | 825 | 13.4% |
| 5 | 380 | 6.2% |
| 6 or more | 233 | 3.8% |
| **LANGUAGE** | | |
| English | 5782 | 93.3% |
| Spanish | 340 | 5.5% |
| Other | 47 | 0.8% |
| Arabic | 13 | 0.2% |
| Russian | 2 | 0.03% |
| Hmong | 13 | 0.2% |

**Technical Notes:**

- Sample sizes: County overall (n=6265), Black/AA (n=1105), Hispanic/Latino (n=781), high-need zip codes (1870), Children in household (n=1654), older adult (n=1672)
- Sample size denominators vary across survey questions based on survey completion by respondent
- High need zip codes refer to 11 highest need zip codes based on an index of social and economic indicators, including: 53206, 53205, 53204, 53225, 53208, 53210, 53233, 53218, 53209, 53212, 53215
- Children in household refers to crosstabulation of survey results based on respondents that responded to having 1 or more children in their household

## Appendix F: 2024 Milwaukee County Community Health Needs Assessment: A Summary of Key Stakeholder Interviews

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

Milwaukee County conducted key stakeholder interviews and focus groups to gain deeper insights about perceptions, attitudes, experiences, or beliefs held by community members about their health. It is important to note that the information collected in an individual focus group or interview is not necessarily representative of other groups. A total of 46 key informants and 10 focus groups from non-profit organizations and government agencies representing communities that include, but were not limited to, African American, Native American, Hispanic, Hmong, the elderly, youth, LGBTQ+, individuals with disabilities, and those living with mental illness and substance use disorders were conducted between August and December 2024. Key partners, organizations, and topic groups were invited by the Milwaukee Health Care Partnership and its partner organizations to participate in these virtual interviews lasting 60 minutes and held in English.

Key informant interviews and focus groups were conducted by Milwaukee Health Care Partnership staff, representative health system members of the Partnership, and staff from the Center for Urban Population Health (CUPH).

Interviewers and focus group facilitators used a standard discussion guide from which informants identified the top two public health issues that are most important for Milwaukee County. 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 organizations or groups in the community that hospitals should partner with to improve community health
- Geographic and other subgroups or populations in the community which experience the health issues
- Strengths/assets in the community
- Organizations that are working to address the issue
- What else should be considered when assessing the health of the community

Interviews and focus groups were recorded via Zoom and transcribed by Reader AI for analysis. During interviews, notes were taken by at least one person to supplement transcripts. All data was uploaded into NVIVO software for thematic content analysis by CUPH staff. Primary coding used interview and focus group guides for major codes. The transcripts were coded initially for the following major categories:

- Major health issues in Milwaukee
- Barriers and challenges
- Strategies needed to address health issues

In addition, special analysis focused on issues faced by special populations including Children/Youth/Families and Refugee/Immigrant Communities. A full report of the qualitative data is available at Health Compass Milwaukee.

This report summarizes the top health issues, barriers and challenges, and strategies needed as identified in the analysis of the key informant interview and focus group data. A brief overview of select special populations' health needs is also provided. Representative de-identified quotes from interview and focus group transcripts for each main health issue and special population are available by request. The full 2024 Milwaukee County CHNA report is available at Health Compass Milwaukee. The Milwaukee County CHNA reports are developed in collaboration with the Center for Urban Population Health, cuph.org.

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

**Limitations:** This report is based on the experiences, viewpoints and opinions of a limited number of community members who were identified as having expertise in understanding the health and other needs of Milwaukee communities. A small number of invited key informants were not able to participate in an interview. It is possible the results would have been different if an alternative set of informants had been interviewed. In addition, the interviews were conducted by several different individuals, which may have resulted in some inconsistencies in data collection.

Although CUPH staff used a consistent data collection and analysis process to review and analyze the interview data, it is possible that certain responses could have been misinterpreted. Additionally, some informants or focus group participants 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 two identified health issues. Therefore, 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 46 key informants and 10 focus groups were asked to identify major health-related issues in Milwaukee County. The five health issues identified most consistently were:

1. Access to Housing
2. Mental Health
3. Access to Health Care
4. Violence
5. Food Insecurity

Many of these priorities were discussed in conjunction with one another as well as other related health, social, economic and political issues in the community. A detailed examination of each health topic is provided in the following sections along with barriers, challenges and needed strategies to address each issue. Given their interconnectedness, challenges and/or solutions may be noted in various issue areas.

## Top Health Issue: Access to Housing

Access to safe, affordable housing was the most commonly-mentioned health issue facing Milwaukee County community members. Informants discussed this topic in terms of various levels of access to housing, from homelessness, access to enough affordable housing, eviction challenges, and safety of housing, both in terms of violence and environmental hazards. Housing was also mentioned in connection to food insecurity, unemployment, lack of insurance, transportation, segregation and other social determinants of health (SDoH).

### BARRIERS/CHALLENGES:

Growing elderly homeless population

Homeless shelters often operate at or past capacity or are unable to provide enough services to match community need.

- Inadequate access to affordable housing units (apartments and homes)
- Old housing stock that presents residents with environmental health hazards
    - Lead-based paint and lead piping
    - Flooding issues
    - Mold, other environmental hazards
    - Pest control problems

- Many low-income housing units in unsafe neighborhoods
    - Gun violence, reckless driving create unsafe neighborhoods
- Ongoing negative impacts of historical redlining policies that cause persistent community segregation
- Eviction disparities and policies inequitably impacting certain communities
- Lack of employment opportunities in certain lower-income neighborhoods limits individuals' ability to earn a living wage to sustain access to safe housing
- Inadequate space and resources to provide safe sleeping spaces for babies, children
- Intergenerational trauma of homelessness/housing instability impacting health
- Siloed nature of the existing resources in Milwaukee

**NEEDED STRATEGIES:**

- Understand, examine and address all factors that lead to homelessness, which include SDoH such as education, income, food insecurity, transportation and access to health care
- Change landlord and tenant rights and policies in Wisconsin
    - Imbalance of rights favoring landlords who allows high rent charges despite poor quality housing
- Educate tenants on their housing rights
- Funding for shelters and advocacy organizations supporting tenants' rights
- Extended maternal and paternal leave for families to transition into parenting
    - Home visiting programs to help families make safe adjustments to their homes to provide the healthiest environment possible for babies and children
- Homeless Continuum of Care Program
    - Coordination among various organizations to communicate about the whole person's needs, from health to social to economic
- Community outreach assessment of homeless individuals' needs
    - Provide services directly to people right away, connecting them to necessary resources in the community
- Raise the federal poverty level
- Housing First Model application in Milwaukee
- More strategic collaboration of nonprofit, governmental and funding agencies
    - Education for community members about existing housing resources in Milwaukee

**<u>Top Health Issue: Mental Health</u>**

Mental health was talked about in terms of experiences of mental health challenges including anxiety, depression, substance use and abuse/addiction, as well as access to behavioral health care and culturally-competent treatment options. Key informants commented that COVID-19 had a significant impact on mental health in the community in both positive and negative ways. Positive consequences included a reduction in stigma around mental health, as more individuals and communities, particularly youth, openly talked about experiences of mental health challenges and seeking help and treatment options. Virtual appointments also made access to behavioral health therapy more available to certain populations. However, stigma around mental health still persists, particularly about behavioral health disorders and among the elderly and some communities of color. Another negative consequence was the unprecedented isolation that COVID-19 caused and its long-lasting impact on the mental health of the elderly and youth populations in the Milwaukee community.

**BARRIERS/CHALLENGES:**

- Lack of insurance to access behavioral health care
- Low trust among certain communities for existing governmental and health care services
- Stigma around talking about mental health challenges and seeking help
- Medication management difficulties, including consistent payment options
- Inadequate number of behavioral health providers to match community need

    - Cultural competency of providers to match/understand lived experiences of communities of color
    - Language barriers between providers/systems and patients
- Increased need for behavioral health services post-COVID, particularly for youth
- Long wait lists for treatment and medication management
- Transportation challenges to consistently get to appointments
- Limited education/marketing to the general public about existing resources in the community
- Siloed nature of existing resources in Milwaukee
- Lack of employment opportunities in certain lower-income neighborhoods limits individuals' ability to have access to insurance through an employer
- Difficulty navigating the complex health system
- Licensing requirements for providers can be lengthy, complicated

**NEEDED STRATEGIES:**

- Medical respite services
- Behavioral health services in schools for youth
- Behavioral health services co-located with other health services
- More free community clinics located in communities of need
- Better transportation options to get to appointments
- Build trust with community members
- Utilize retired physicians/nurses as volunteers in clinics to provide more services to communities in need
- Lower Medicaid eligibility requirements
- Health system navigation support
- Increased use of harm-reduction strategies
- Career pathways for more students, particularly students of color, to learn about and go into behavioral health care fields
- Tuition reimbursement/payment options for students in behavioral health care disciplines
- Translation services/more bilingual services for behavioral health care
- More peer specialists, community health workers and doulas who are trusted in the community and can connect individuals to trusted resources and providers/treatment
- More funding for non-traditional services to provide support to community members

**Top Health Issue: Access to Health Care**

Access to health care encompassed physical locations of health clinics, insurance status, provider availability based on payer source, difficulty navigating large health systems, continuity of care, and cultural patient-provider fit. In addition, language barriers and experiences of discrimination in the health care setting were also mentioned within this theme. Access to care was directly related to other SDoH, including transportation to appointments, health literacy, housing and food insecurity, and trust in the health care system more broadly.

**BARRIERS/CHALLENGES:**

- The physical location of clinics is not where the greatest needs are for certain communities
    - Lack of reliable, low-cost, or free transportation limits accessibility to clinics
    - Not being able to show up on time for appointments results in being denied services from providers in the future
- Difficulty navigating large health care systems and care across contexts and insurance providers
- Experiences of racism and/or discrimination in the health care setting impacts the quality of interactions and desire to return to care
- Poverty
- Low health literacy among the patient population, particularly those who are not native English speakers

    - Some community members may not understand their insurance benefits or where they can access care with their coverage
- Cultural competency of care providers
- Language barriers for patients
    - Translators are not always available for patients or families, particularly for behavioral health, vision and dental services
    - Cultural barriers still exist in communication even with translators available
- Lack of insurance that covers health care where and when needed
    - Underinsurance creates a barrier to seek care due to higher co-pays or deductibles
- Lack of established primary care provider (PCP) or being removed from a PCP or clinic if the patient does not cancel the appointment or show up to the appointment on time (often due to lack of transportation)
- Not enough behavioral health providers to meet community need
    - Particularly among communities of color
- Lack of adequate preventive care access in neighborhoods
- Need for education in the community about available resources and support

**NEEDED STRATEGIES:**

- Community health workers and navigators to assist individuals in understanding their insurance, navigating the health care system and coordinating care
- More free community clinics located in communities of need
- Better transportation options to get to appointments
- Build trust between patients, providers and health systems through community engagement and community voice empowerment
- Utilize retired physicians/nurses as volunteers in clinics to provide more services to communities in need
- Lower Medicaid eligibility requirements
- Health system navigation support
- Career pathways for more students, particularly students of color, to learn about and go into health care fields
- Translation services/more bilingual services, particularly for dental and vision services
- More peer specialists, community health workers, social workers and doulas who are trusted in the community and can connect individuals to trusted resources and providers/treatment
- Increased communication in the community about existing resources and health system navigation support
- Collaboration and streamlining of existing resources in the community
    - Less siloed, competitive programming, interventions and funding needed

**Top Health Issue: Violence**

The general theme of violence discussed includes domestic violence, gun violence and reckless driving or street violence. Violence was also discussed in relation to many SDoHs, most significantly socioeconomic status, employment opportunities, education, housing instability, food security, racism and community trauma.

**BARRIERS/CHALLENGES:**

- Poverty, lack of economic stability and employment
- Reckless driving and car theft culture
- Fear of law enforcement – historical traumas and discrimination fuel existing distrust in some communities
- Excessive speeding, racing culture
- Hit-and-runs create feelings of unsafe streets, environments
- Gun violence on the streets, particularly among youth, inhibits feeling safe to be out in the community to be physically/ socially active

- Domestic violence/abuse hidden in the community, stigma around getting help and support
- Trauma and retraumatization of community members through repeated violence exposure
- Youth experiencing gun violence or other forms of violence in their community as part of everyday life
- Culture of violence, lack of trust/security in the community

**NEEDED STRATEGIES:**

- Gun locks made widely available
- Legislation to support limiting access to purchasing firearms, red light policies
- Street design to reduce speeding
- More prevention and intervention strategies for adults in the community who are involved in violence or live in violence zones
- Gun safety education
- Build trust among community members and law enforcement through community engagement and community voice empowerment
- More employment opportunities in neighborhoods that have suffered from historical disinvestment, redlining policies
- Increased collaboration among existing resources, more streamlining
- Improved education for youth
    - Better driver education
- Alcohol ignition locks on cars
- Better data to understand the community of drivers who are unlicensed and uninsured and how to better respond to those drivers to prevent violence

**Top Health Issue: Food Insecurity**

Food insecurity was the final of the five top health issues discussed by key informants. This included lack of regular access to food for self or family, inability to access nutritious food, low supply of foods that fit cultural traditions and high cost of food. Food insecurity was often mentioned in conjunction with access to housing and health care, as well as employment, transportation, cultural barriers and poverty.

**BARRIERS/CHALLENGES:**

- Lack of regular source of any food, particularly healthy, nutritious food
- Lack of access to foods that fit cultural traditions
- Not enough supply in food pantries, particularly supply that matches cultural traditions
- Housing insecurity directly related to food insecurity
- Poverty, lack of economic stability, and unemployment
- Lack of knowledge about where to find food resources in the community
- Language barriers
- Increased cost of food in general

**NEEDED STRATEGIES:**

- More funding for food pantries to increase supply
- Education in the community about existing food resources
- Increased availability of culturally appropriate foods for those in need
- Policies that promote economic and job investment in underserved communities
- Collaboration among existing organizations, streamlining of resources

## Special Population Reports

Two communities within the larger Milwaukee County population were a focus for the 2024 Community Health Needs Assessment:

- Children/Youth

- Refugee/Immigrant

A summary of the major health needs of each population along with needed strategies is provided below.

**Children, Youth, and Families**

**HEALTH ISSUES AND BARRIERS**:

Key informants who spoke about the health needs of children, youth and families in Milwaukee County focused on several topics. These included increased mental health challenges and treatment needs, negative stigma around mental health and access to behavioral health providers. Many mentioned that the mental health needs of youth post-COVID have increased, social isolation continues to have a negative impact on many, and that provider options do not match the needs of youth in the County. In addition, key informants discussed how systemic housing and food insecurity also directly impact children, youth and families on an everyday basis, particularly as many children obtain most of their meals from school breakfast and lunch programs. Children may not have access to nutritious food at other times of the day, week or year when school is not offering this resource. Housing stock and environmental health greatly impact children because of lead and other household contaminant exposure that lead to increased rates of childhood asthma and lead poisoning. This directly impacts the physical and cognitive development of vulnerable children in Milwaukee. Access to health care, dental care in particular, was discussed among some informants as well, as the link between dental health and chronic illnesses and infection is recognized. There is also a contingent of youth who are over the age eligibility requirements for many health and social service benefits who may lose coverage or access to necessary care and support. Finally, key informants recognized that community trauma and ACEs (adverse childhood experiences) in the form of violence can have a significant impact on the development of Milwaukee children and youth. The main discussion was around street violence (reckless driving) and gun violence and the trauma and culture of insecurity that can result from those repeated exposures. Barriers include a lack of coordinated prevention and intervention programming, inadequate funding to existing youth resources in the community, persistent stigma around mental health, social isolation after COVID-19, policies that limit access to health insurance benefits, language barriers, distrust in some community services and systems, such as law enforcement, overmarketing/convenience of fast food/unhealthy food options versus nutritious choices, and lack of after-school opportunities to engage youth and help develop employability skills.

**NEEDED STRATEGIES:**

- More mental health providers in ZIP codes of need for youth
- School-based health and mental health services, including dental clinics
- More coordination and collaboration among youth-serving organizations
- Environmental health strategies to mitigate lead exposure in homes
- Improved health of existing/new affordable housing stock
- Trauma-informed care, trauma prevention and intervention programming
- Gun violence prevention programming
- Improved access to quality education
- Working with parent coordinators/utilizing that as a resource to connect with youth, families more

**Refugee/Immigrant Communities**

**HEALTH ISSUES AND BARRIERS:**

The top health issues discussed for the refugee/immigrant community included lack of stable housing, poor housing quality, food insecurity and inability to access foods that match cultural traditions, lack of access to health care and health insurance, mental health, particularly stigma, and challenges with chronic disease management. Key informants mentioned how language serves as a significant barrier for many of these health issues, such as health literacy, the ability to understand physician communication, navigating complex health systems, advocating for oneself and family, and managing physical and mental health challenges, are all directly impacted by the ability to understand and speak English. Cultural adaptation to

the United States health care, housing, transportation, employment, and educational systems was also mentioned as a barrier that many in this community face. Language can also limit refugee/immigrant community members from knowing or easily accessing existing resources in the community. This includes access to affordable, reliable transportation, given the literacy needed to navigate a complex public transit system in an urban setting. The cultural traditions and lifestyles of their native lands may be markedly different from what is experienced in the United States and it takes time to learn, adjust to, and navigate. Policies that regulate employability, eligibility for health insurance, and other assistance programs can also limit this community's access to systems that support health and prosperity. In addition, there continues to be a strong negative stigma surrounding mental health diagnoses among the refugee/ immigrant population, which deters seeking treatment or discussing any challenges more openly. A mismatch culturally and in terms of language between these community members and most health care providers creates another power differential and barrier to accessing necessary care. If appropriate language translation is not available, or even if it is, patients can misunderstand directions, not ask necessary questions, and/or feel that they do not have the skills to advocate for their own or their family members' health decisions. Western medicine traditions may also counter those of refugee/immigrant populations, creating another discrepancy between patient and provider that may result in lower adherence to medical advice or seeking treatment or care in the future.

**NEEDED STRATEGIES:**

- Increased language translation, support services for a variety of refugee/immigrant communities
- Better transportation options
    - Support resources to help this community navigate existing system
- Advocacy groups to support the rights of this community
- Policies that support housing and health care access
- Community health workers to support health care and other SDoH system navigation and advocacy
- Cultural competency training for health care providers
- More affordable, healthy housing availability
- Increased food supply that meets nutrition and cultural needs for refugee/immigrant populations
- Care coordination to assist with chronic disease management
- Targeted education on existing resources in the community
- Mental health stigma reduction interventions
- Collaboration among existing resources in the county, particularly partnering with faith-based communities that serve refugee/immigrant populations

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

# Appendix G: Key Stakeholder Organizations Interviewed for purposes of conducting the Froedtert Hospital CHNA

| Key Informant Organizations | Description of Organizations |
|---|---|
| ABC for Health | Advocacy & Benefits Counseling for Health, Inc. (ABC for Health), is a Wisconsin-based, nonprofit public interest law firm that promotes health impact and social justice. |
| Badger Philanthropies | Strives to be a philanthropic leader in improving the quality of life of the global communities in which it works. |
| Children's Health Alliance of Wisconsin, Milwaukee County Oral Health Task Force | Coalition to improve oral health and access to care. |
| City of Milwaukee Health Department | Government agency providing population health support. |
| City of Milwaukee, Office of the Mayor (Vision Zero) | Focused on reckless driving |
| City of Milwaukee Office of Community Wellness and Safety | Government department to reduce violence. |
| Community Advocates | Community advocacy agency. |
| Feeding America Eastern Wisconsin | Agency that operates food banks across eastern Wisconsin. |
| Gerald L. Ignace Indian Health Center | Federally qualified health center primarily serving the Native American population. |
| Greater Milwaukee Foundation | Community philanthropic foundation providing funds to strengthen community organizations and programs. |
| IMPACT, Inc. | Nonprofit social service agency providing access and navigation to community resources. |
| Medical College of Wisconsin Institute for Health & Humanity | Focused on researching the root causes of health disparities in our communities, and advancing the best practices to foster health impact throughout the world. |
| Journey House | Family empowerment agency. |
| Lutheran Social Services of Wisconsin and Upper Michigan | Nonprofit social service agency to improve the health and wellbeing of our community. |
| Marquette University | Higher education. |
| Medical College of Wisconsin | The Medical College of Wisconsin brings a synergy between the best medical education, research and patient care. |
| Mental Health America of Wisconsin | Mental health advocacy agency. |
| Milwaukee Consortium for Hmong Health | To engage Asian American community for positive change regarding chronic diseases and cancer health and wellness. |
| Milwaukee County Behavioral Health Division | Government department connecting residents with behavioral health services. |
| Milwaukee County Department of Aging and Disability Resource Center | 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 Housing Services | Supporting individuals with accessing and maintaining housing. |
| Milwaukee Fire Department | Emergency response. |
| Milwaukee Police Department | Emergency response. |
| Milwaukee Urban League | Nonprofit committed to addressing disparities, advancing economic stability and improving educational outcomes. |
| Muslim Community & Health Center | Strengthens the Milwaukee community and increases the well-being of its residents by providing free and charitable health care services, social services, counseling, emergency assistance, educational and job-training programs. |
| Overdose Public Health Safety Team (OD-PHAST) | Reviews individual fatal overdose cases occurring across the county and brings together key public health, public safety and other partners for regular review and analysis of aggregate data and key metrics. |
| Safe & Sound | Nonprofit uniting residents, youth, law enforcement, and community resources to build safe and empowered neighborhoods. |
| Sixteenth Street Community Health Centers | To improve the health and well-being of Milwaukee and surrounding communities by providing quality patient-centered family-based health care, health education, and social services that's free from linguistic, cultural, and economic barriers. |
| Sojourner Family Peace Center | Nonprofit providing safety, shelter, advocacy, and support for individuals affected by domestic or sexual violence. |
| United Community Center/Milwaukee Latino Health Coalition | Nonprofit agency providing education, cultural arts, recreation, community development, and health and human services programing to residents of all ages on Milwaukee's near south side. |
| United Way of Greater Milwaukee and Waukesha County | Engages, convenes, and mobilizes community resources to address root causes of local health and human services. |
| UniteWI | A coordinated care network of health and social care providers. |
| Vivent Health | Health care provider for sexually transmitted infections and harm reduction programming. |
| YWCA Southeast Wisconsin | Nonprofit working to eliminate racism and empower women. |

| Group Interviews/Focus Groups | Description of Groups |
|---|---|
| Safety Net Clinics | Including representatives from the Free and Community Clinic Collaborative (FC3), a coalition of safety net clinics that provide free and low-cost health care services to uninsured and underinsured patients. |
| Public Health Leaders | Including representatives from the local health departments serving Milwaukee County municipalities. |
| Youth Community Members | Including 2 focus groups comprised of Milwaukee County residents ages 14 – 18. |
| Youth Focus | Including representatives from community-based organizations serving children and adolescents. |
| Faith Focus | Including representatives from organizations based in or affiliated with religious groups serving Milwaukee County. |
| Justice System Focus | Including organizations and leaders with lived experience in the justice system in Milwaukee County. |
| Refugee Focus | Including organizations serving refugee populations in Milwaukee County. |
| Mental Health Focus | Including organizations working to address mental health needs in Milwaukee County. |
| Milwaukee Health Department, Family and Community Health | Including individuals working with families through programs under Milwaukee Health Department's Family and Community Health branch. |

## Appendix H: 2024 Secondary Source Data: Health Compass Milwaukee

Most of the secondary data used for this assessment were collected from Health Compass Milwaukee, a web-based community health platform developed by Conduent Community Health Solutions.

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 Ascension Wisconsin, Aurora Health Care, Children's Wisconsin, Froedtert ThedaCare Health, Inc., the Milwaukee Health Care Partnership, and the Center of Urban Population Health. For more information on health indicators specific to Milwaukee County go to https://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)

**Other publicly available data sources used in the secondary data collection.**

- County Health Rankings
- Area Deprivation Index
- United Way ALICE Report
- Milwaukee County Youth Risk Behavior Survey
- Wisconsin Interactive Statistics on Health (WISH)

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

# Appendix I: 2024 Internal Hospital Data

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

## Froedtert ThedaCare Health, Inc. data sources used

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

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

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

# Appendix J: Review of the Fiscal Year 2023-2025 Froedtert Hospital CHNA Implementation Strategy

Froedtert Hospital's previous CHNA implementation strategy addressed the following priority health needs: behavioral health, access to health services, chronic disease prevention and violence prevention.

The table below describes the actions taken during the 2023-2025 CHNA to address each priority need and indicators of improvement.

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

| Significant Health Need | Objective | Actions | Outcomes |
|---|---|---|---|
| **Behavioral Health** | Increase access to behavioral health services targeted at priority populations through hospital and community-based partnerships. | • Support access and navigation to acute and crisis mental and behavioral health services.<br>• Educate CHW about behavioral health resources to support patient navigation to behavioral health services.<br>• Continue to support community-wide safe medication disposal and pilot medication disposal kiosk in Froedtert ThedaCare Health, Inc. facilities.<br>• Introduce youth to behavioral health career opportunities through Froedtert ThedaCare Health, Inc. health care career programs (shadowing, mentoring, speakers).<br>• Partner with community organizations to offer screenings and resources to reduce older adult isolation and loneliness. | • Over 15,000 individuals received behavioral services at the Froedtert Hospital inpatient unit and the Mental Health Emergency Center.<br>• The community health worker (CHW) participated in Milwaukee County Behavioral Health – Housing & Homelessness Resources, Continuum of Care Housing programs and attended and participated in educational programs on well-being, poverty, ethics and boundaries. Training was provided through community partners and Milwaukee Adult Health Education Center (AHEC).<br>• 660.3 pounds of medication collected from 2023-2025 from the medication takeback receptacle at Bluemound Campus and the Oak Creek medication collection event.<br>• Introduced 605 youth to behavioral health careers by hosting presentations in West Allis and Oak Creek School Districts.<br>o Average of 36.87% increase in knowledge regarding behavioral health careers after presentation<br>o Average of 19.67% in crease in knowledge regarding mental/behavioral health in the first year.<br>o 23% increase in knowledge on how they could practice self-care in daily life.<br>• Seniors at Milwaukee Christian Center were provided education, screenings, and referrals.<br>o Education: 586 |

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| | | | o BP Screenings: 168<br>o BG Screenings: 136<br>o Referrals: 12 |
| | Support and enhance collaboration with community organizations to increase behavioral health outreach, education and awareness within hospital and community-based settings. | • Support Froedtert ThedaCare Health, Inc. Behavioral Health Services by helping to identify community-based partners to fill potential gaps in service delivery.<br>• Participate in Milwaukee County mental health and substance use coalitions to increase awareness, education, prevention and navigation. | • Behavioral Health began partnering with Wisconsin Community Services to offer peer support to individuals with substance use disorders.<br>• Behavioral Health Coalition Participation:<br>o Healthiest Oak Creek Coalition<br>o RISE Drug-Free Coalition<br>o Wauwatosa Substance Use CHIP Coalition<br>o Southwest Suburban Health Department CHIP |
| **Access to Health Services** | Ensure a strong safety net of services that improve access to care among priority populations. | • Increase health literacy, education and navigation through the Community Care-A-Van program.<br>• Increase access and navigation to resources through the CHW.<br>• Support the wellness hub model inside Gee's Clippers to bring health services to the community.<br>• Expand health education and access opportunities through the school nurse and community school coordinator at Westside Academy.<br>• Utilize a social determinants of health screening and referral platform to address patient social needs.<br>• Support Specialty Access for Uninsured Program (SAUP) and Emergency Department Medical Home (EDMH) programs and community clinics.<br>• Support the implementation of a Southside Family Medicine Residency program.<br>• Support Patient Financial Services and the Milwaukee Enrollment Network's efforts to enroll individuals in health insurance coverage. | • The Community Care-A-Van program provided 9,451 health educational encounters to community members. Education consisted of heart health, stroke, nutrition, chronic disease management, food demonstrations, cancer and social determinants of health resources.<br>• The Community Care-A-Van program also provided 1,938 blood pressure screenings, 1,214 blood glucose measurements, 306 influenza vaccines and 457 referrals for care.<br>• The community health worker (CHW) was trained in Milwaukee Health Care Partnership – Connect 2 Care real time referral training. The CHW also participated in several community outreach programs to provide access to health care services to undocumented and uninsured individuals.<br>• Gee's MKE Wellness Clinic provided 5,762 health educational encounters to community members and barber shop clients. Education consisted of chronic disease management, social determinants of health resources, CPR, men's health, colorectal cancer, Narcan, stop the bleed.<br>• Gee's MKE Wellness Clinic also provided 577 blood pressure screenings, 147 blood glucose measurements, 230 hair, nail and skin screenings.<br>• School nurse program came to an end and Froedtert ThedaCare Health, Inc. expanded the community outreach nursing team to include the school |

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| | | | nurse FTE.<br>• Nearly 300,000 patients have been screened utilizing the SDOH screening tool with over 5,000 of those patients referred for additional support.<br>• Over 700 referrals have been provided through SAUP.<br>• Over 60 appointments have been scheduled by just Froedtert Hospital for the EDMH program.<br>• The Southside and Northside Family Medicine Residency Programs have served over 11,000 patients.<br>• Over 500 patients were assisted with insurance enrollment through the Milwaukee Enrollment Network. |
| | Support non-profit organizations that strive to create healthy communities in Milwaukee County. | • Implement the Froedtert Hospital Community Investment Fund to support organizations that address significant health needs, social determinants of health and target priority populations in Milwaukee County. | • $850,000 was allocated through the Community Investment Fund.<br>• Total number of organizations for each health need.<br>▪ Behavioral Health: 7 organizations<br>▪ Chronic Disease: 14 organizations<br>▪ Access to Care: 15 organizations<br>▪ Violence Prevention: 8 organizations |
| | Support the Health Impact initiatives by providing resources to meet yearly goals and objectives. | • Support Health Impact by addressing gaps in medical care, screenings, education and navigation to resources related to breast and colon cancer, pneumococcal vaccines, diabetes, hypertension and readmissions. | • Health Impact initiatives were implemented such as flu vaccine clinics, colon cancer test kit distribution, blood pressure and blood glucose screenings to reach composite measure goals for both BIPOC-A and non-BIPOC-A patients and community members. |
| | Increase the number of staff and providers at all levels of the organization. | • Introduce youth to health care career opportunities through Froedtert ThedaCare Health, Inc. health care career programs (shadowing, mentoring, speakers). | • 530 students exposed to health care careers through F&MCW Ignite program.<br>• Over 1,500 students exposed to health care careers through career fairs.<br>▪ Oak Creek Career Fair<br>▪ Hands-on Healthcare Career Expo<br>▪ Carmen Schools Mock Interviews<br>▪ Hmong American Peace Academy Career Fair<br>▪ Milwaukee Academy of Science Career Fair<br>▪ Ronald McDonald House Youth Ambassador Program<br>▪ Milwaukee Public Schools Career Expo |
| **Chronic Disease** | Increase prevention efforts, navigation to | • Increase chronic disease screenings and education through the Community Care- | • Health Impact initiatives were implemented such as flu vaccine |

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| **Prevention** | resources and treatment of chronic diseases targeted at priority populations. | A-Van program.<br>• Increase access to preventative screenings for chronic diseases and other cancer-related conditions.<br>• Support Health Impact by addressing gaps in medical care, screenings, education and navigation to resources related to breast and colon cancer, pneumococcal vaccines, diabetes, hypertension and readmissions.<br>• Support the community health worker (CHW) by providing resources to increase prevention, education and navigation efforts. | clinics, colon cancer test kit distribution, blood pressure and blood glucose screenings to reach composite measure goals for both BIPOC-A and non-BIPOC-A patients and community members.<br>• Gee's MKE Wellness Clinic provided 577 blood pressure screenings, 147 blood glucose measurements.<br>• Gee's MKE Wellness Clinic provided 230 hair, nail and skin screenings.<br>• The Community Care-A-Van program also provided 1,938 blood pressure screenings, 1,214 blood glucose measurements, 306 influenza vaccines and 457 referrals for care.<br>• The community health worker (CHW) attended training on Diabetes and Hypertension through Milwaukee Adult Health Education Center (AHEC). The CHW also participated in self-monitoring blood pressure education through American Heart Association Libraries with Heart program. |
| | Support and enhance collaborations with community organizations. | • Partner with community organizations to implement physical activity, nutrition and wellness initiatives, such as BUCKSFit and the Girl Scouts Health in Action Patch Program.<br>• Support the Milwaukee Health Care Partnership Housing Navigator Program for homeless populations.<br>• Continue partnerships with Federally Qualified Health Centers (FQHCs) to provide chronic disease prevention and treatment opportunities. | • 158 Girl Scouts completed the Health in Action Patch Program<br>• Hosted 32 Bucks Markets using services lines and community partners to provide education and resources to attendees.<br>• Over 200 Froedtert Hospital patients were referred into the Housing Navigation Program, now known as Housing is Health.<br>• Provided financial support to Outreach Community Health Center community garden program.<br>• Provided financial support to Progressive Health Centers for a Certified Diabetes Care and Education Specialist.<br>• Attended three Outreach Community Health Centers health and resource fair.<br>• Planned three health and resources fairs with Progressive Community Outreach Center. Fairs included mammogram and prostate screenings. |
| **Violence Prevention** | Enhance innovative violence prevention programs at Froedtert Hospital. | • Increase awareness of sexual abuse resources offered by forensic nursing at Froedtert Hospital.<br>• Support provider and staff education around human trafficking.<br>• Increase awareness of the Froedtert & | • 144 people were offered sexual abuse resources offered by forensic nursing.<br>• 23 providers and staff educated around human trafficking.<br>• 183 people served at Grief Clinic. |

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| | | Medical College of Wisconsin Grief Clinic and trauma survivors support group. | |
| | Strengthen and expand community partnerships to support violence prevention programs. | • Support the Violence Interrupter Program through the efforts of the Comprehensive Injury Center and 414 Life / Blueprint for Peace.<br>• Participate in Milwaukee County violence prevention coalitions.<br>• Participate in the Milwaukee Community Schools Partnership to support positive youth development and community engagement. | • 108 Stop the Bleed trainings hosted.<br>• Violence Prevention Coalition Participation:<br>▪ MKE Elevate Safe & Supportive Communities Action Team<br>▪ RISE Drug-Free Coalition<br>▪ Reckless Driving Taskforce<br>▪ Wisconsin Anti-Violence Effort (WAVE)<br>▪ West Allis Safety & Violence Prevention Action Team<br>• Milwaukee Community Schools Partnership youth supported by Community School Coordinator and Nurse: 1,057<br>Partnership youth supported 1,057 through the Milwaukee Community School Coordinator Program: Partnership ended June 2024. |