



Froedtert  
West Bend Hospital

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

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Froedtert West Bend Hospital  
(St. Joseph's Community Hospital of West Bend, Inc.)

Fiscal Year 2018  
Effective July 1, 2017

Approved on 5/23/2017 by Froedtert West Bend Hospital Board of Directors

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## Executive Summary

Community Health Needs Assessment for St. Joseph’s Community Hospital of West Bend, Inc, (also known and doing business as Froedtert West Bend Hospital (“FWBH”).

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

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

The CHNA was reviewed by the Froedtert West Bend Hospital Implementation Plan Advisory Committee consisting of community partners in Washington County, Washington Ozaukee Public Health Department, Froedtert West Bend Hospital’s CHNA/Implementation Strategy Advisory Committee (**Appendix A**) 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 Washington County for a collective analysis of the findings from the Community Health Needs Assessment. Under the direction of the Community Engagement Leadership Team and trained meeting facilitator; findings from the assessment were categorized and ranked to identify the top health needs in Washington County.

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

## Community Health Needs Assessment

In 2016, a CHNA was conducted to 1) determine current community health needs in Washington 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 West Bend Hospital assessed the health needs of the communities it serves through a comprehensive data collection process from a number of key sources. Data and research included information from community members, public health officials, community leaders/experts, and non-profit organizations representing vulnerable populations in our service area. The following information/data sources was collected and taken into consideration for assessing and addressing community health needs:

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

**Key Informant Interviews:** Froedtert West Bend Hospital Community Engagement team and leaders conducted 20 in-person interviews with community leaders of various school districts, non-profit organizations, health & human service department and business leaders. A list of organizations can be found on **Appendix E** of this CHNA. The full Key Informant Results can be found at <https://www.froedtert.com/community-engagement>.

**Community Partner/Agency Reports:** To better understand the needs of our underserved populations; Froedtert West Bend Hospital obtained important data and trends from partner organizations such as Albrecht Free Clinic, United Way of Washington County ALICE Report, Casa Guadalupe Education Center and others to seek important trends, demographic data and services to provide an inclusive viewpoint of community needs for these unrepresented populations.

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

## CHNA Prioritization of Community Health Needs Process

Froedtert West Bend Hospital created a CHNA/Implementation Strategy Advisory Committee consisting of community partners in Washington County, Washington Ozaukee Public Health Department, Froedtert West Bend Hospital’s Community Health Initiatives Committee 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 Washington County for a collective analysis of the findings from the Community Health Needs Assessment. Under the direction of the Community Engagement Leadership Team and trained meeting facilitator, the planning process included five steps for selecting priorities for the CHNA and Implementation Strategy:

1. Reviewed the 2016 Community Health Needs Assessment results for identification and prioritization of community health needs;
2. Reviewed previous 2015 - 2017 Implementation Strategy programs and results;
3. Reviewed Washington Ozaukee Public Health Department 2016 – 2020 Community Health Improvement Plan;

4. Ranked and selected priority areas; and
5. Selected evidence-based strategies, partnerships and programs to address community health needs.

After the facilitated workout session in February 2017, based on the information from all the CHNA data collection sources, the most significant health needs were identified as:

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

To identify the top priorities among the significant health needs identified, members of the Advisory Committee were asked to rate each priority based on the following criteria: feasibility of Froedtert West Bend Hospital to address the need (direct programs, clinical strengths and dedicated resources); alignment with Froedtert Health's strategic priorities; current or potential community partners/coalitions; and identification of achievable and measurable outcomes for each such significant health need. Of those significant health needs categories, three overarching themes were identified as priorities for Froedtert West Bend Hospital's fiscal years 2018 – 2020:

- Access to Health Care Services and Navigation of Community Resources;
- Mental Health/Alcohol and Other Drug Abuse; and
- Chronic Disease Prevention and Management.

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

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

Froedtert West Bend Hospital is committed to addressing community health needs collaboratively with local partners. Froedtert West Bend Hospital used the following methods to gain community input from June-August 2016 on the significant health needs of the Froedtert West Bend Hospital's community. These methods provided additional perspectives on how to select and address top health issues facing Froedtert West Bend Hospital's community.

### **Input from Community Members**

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

- Ranking of up to five public health issues, based on the focus areas presented in Wisconsin's State Health Plan, that are the most important issues for Washington County; and
- For those five public health issues:
  - Existing strategies to address the issue;

- Barriers/challenges to addressing the issue;
- Additional strategies needed; and
- Key groups in the community that hospitals should partner with to improve community health.

**Underserved Population Input:** Froedtert West Bend 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 West Bend Hospital took the following steps to gain input:

- Community Health Survey: When appropriate, data was stratified by gender, age, education household income level and marital status.
- Key Informant Interviews: The key informant interviews included input from members of organizations representing medically underserved, low-income and minority populations.

**Summary of Community Member Input**

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

**Key Informant Interviews:**

- Alcohol and Other Drug Use
- Mental Health
- Chronic Disease Prevention and Management
- Nutrition
- Physical Activity

**Community Health Survey:**

- Illegal Drug Use
- Alcohol Use or Abuse
- Overweight or Obesity
- Access to Health Care
- Chronic Conditions

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

Feedback and public comments are always welcomed and encouraged, and can be provided through the contact form on the Froedtert & the Medical College of Wisconsin website at <https://www.froedtert.com/contact>, or contacting Froedtert Health, Inc.’s Community Engagement leadership/staff with questions and concerns by calling 414-777-1926. Froedtert West Bend Hospital received no comments or issues with the previous Community Health Needs Assessment Report and/Implementation Strategy.

# Froedtert West Bend Hospital Community Service Area

## Overview

Froedtert & the Medical College of Wisconsin St. Joseph’s Community Hospital of West Bend (also known and doing business as “Froedtert West Bend Hospital”), founded in 1930 by local doctors, community leaders and the Sisters of the Divine Savior, is a full-service hospital serving residents of West Bend, Washington County, and surrounding areas. Froedtert West Bend Hospital, specializing in birthing services, cancer care, emergency care, orthopaedics, surgical services and women’s health, is part of the Froedtert & Medical College of Wisconsin health network, which also includes Froedtert Hospital, Milwaukee; Froedtert Menomonee Falls Hospital, Menomonee Falls; and more than 40 primary and specialty care health centers and clinics.

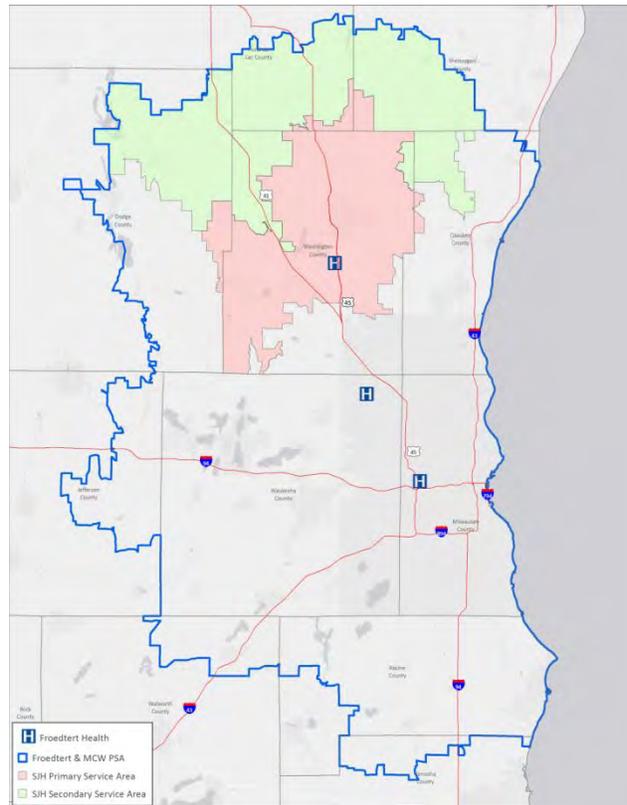
## Mission Statement

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

## Service Area and Demographics

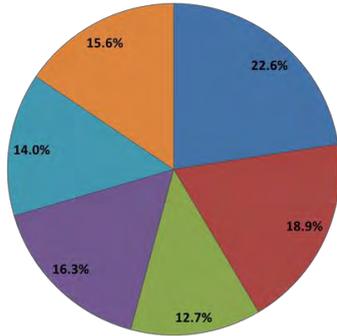
For the purpose of the Community Health Needs Assessment, the community is defined as Washington County because we derive 87.5% of discharges occur from this geography. All programs, activities, and partnerships under the CHNA will be delivered in Washington County. However, Froedtert West Bend Hospital’s total service area consists of Washington County as well as zip codes in eastern Dodge County. Froedtert West Bend Hospital determines its primary and secondary service areas by completing an annual review and analysis of hospital discharges and market share according to various determinants.

The map reflects the 15 zip codes – 53001 (Adell), 53002 (Allenton), 53010 (Campbellsport), 53011 (Cascade), 53021 (Fredonia), 53027 (Hartford), 53037 (Jackson), 53040 (Kewaskum), 53048 (Lomira), 53050 (Mayville), 53075 (Random Lake), 53086 (Slinger), 53090 (West Bend), 53091 (Theresa), and 53095 (West Bend).



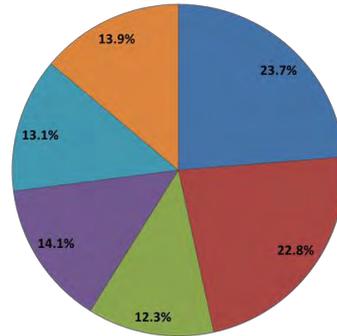
**Age** – The Froedtert West Bend Hospital total service area has a comparable age distribution as the Milwaukee Five-County area. The 18 – 34 age group is slightly smaller in the Froedtert West Bend Hospital total service area with 18.9% of population while the Five-County area 18 – 34 age group is 22.8% of the population.

**2016 Age Distribution**  
Origin: F&MCW Froedtert West Bend Hospital  
Total Service Area



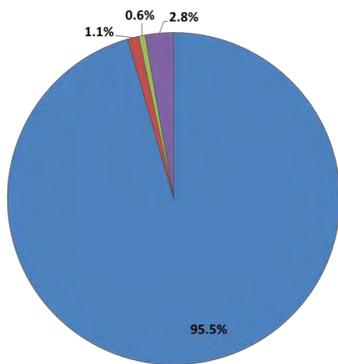
- 0 - 17
- 18 - 34
- 35 - 44
- 45 - 54
- 55 - 64
- 65 - UP

**2016 Age Distribution**  
Origin: Milwaukee Five-County Area



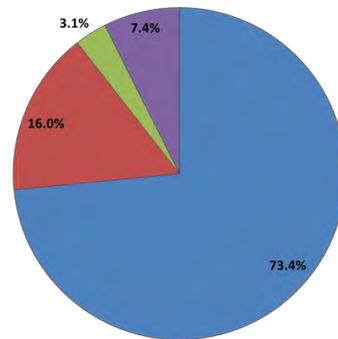
**Race** – The racial distribution in the Froedtert West Bend Hospital Total Service area is predominantly Caucasian (95.5%). The Five-County area is more diverse; 16.0% of the population is African American and 7.4% are other races.

**2016 Racial Distribution**  
Origin: F&MCW Froedtert West Bend Hospital  
Total Service Area



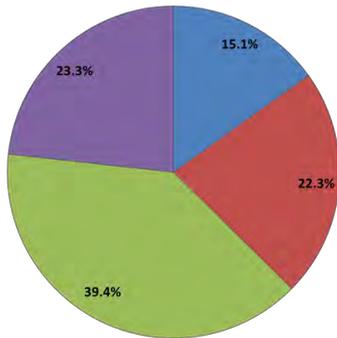
- White
- African American
- Asian
- Other

**2016 Racial Distribution**  
Origin: Milwaukee Five-County Area

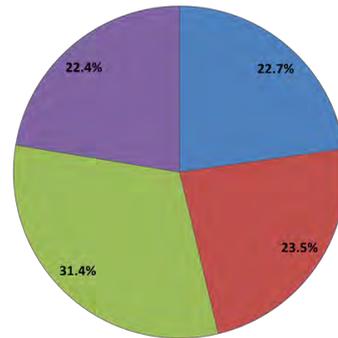


**Household Income** – Households where income is less than \$50,000 is 37.4% of the distribution in the Froedtert West Bend Hospital Total Service area. Within the Milwaukee Five-County area, the percent of households that income is less than \$50,000 is 46.2%.

**2016 Household Income**  
Origin: F&MCW Froedtert West Bend Hospital  
Total Service Area



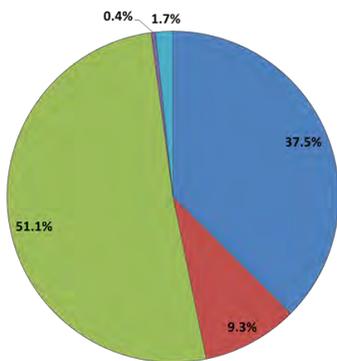
**2016 Household Income**  
Origin: Milwaukee Five-County Area



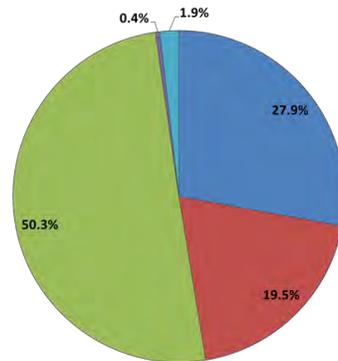
■ Under \$25,000  
■ \$25,000 to \$49,999  
■ \$50,000 to \$99,999  
■ \$100,000 and UP

**Payer Mix** – For adult inpatients, the Froedtert West Bend Hospital Total Service area has 11.0% of patients consist of Medicaid and Self Pay payers. The Milwaukee Five-County area has 21.4% of patients with Medicaid and Self Pay in the payer mix.

**FY2016 Adult Inpatient Payer Mix- Total Charges**  
Origin: F&MCW Froedtert West Bend Hospital  
Total Service Area



**FY2016 Adult Inpatient Payer Mix- Total Charges**  
Origin: Milwaukee Five-County Area



■ Managed Care  
■ Medicaid  
■ Medicare  
■ Other Gov't  
■ Other/Self Pay

## **Froedtert West Bend Hospital Summary of Implementation Strategy**

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

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

### **Albrecht Free Clinic**

**CHNA Significant Health Need:** Access to Care and Navigation

**Goal:** Expand assistance and support of the Albrecht Free Clinic to improve access to healthcare for uninsured and underinsured populations.

**Objective:** Strengthen our collaborative partnership with Albrecht Free Clinic and community stakeholders to increase access to preventative and primary health and dental care, improve quality and reduce costs.

#### **Froedtert West Bend Hospital Available Resources:**

- Continue referral process for uninsured/underinsured populations from Froedtert West Bend Hospital to Albrecht Free Clinic
- Serve on Board of Directors of Albrecht Free Clinic
- Provide vouchers for ancillary/specialty care services for Albrecht Free Clinic patients
- Screen uninsured patients for financial assistance programs (Marketplace, BadgerCare etc) including Froedtert Health's Financial Assistance Program

#### **Froedtert West Bend Hospital Collaborative Partners:**

- Albrecht Free Clinic
- Washington Ozaukee County Public Health
- Casa Guadalupe Education Center
- Aurora Healthcare

### **Community Health Navigators**

**CHNA Significant Health Need:** Access to Care; Navigation of Community Resources; and Chronic Disease Management

**Goal:** Expand assistance and support for the Community Health Worker network to improve access to healthcare services for vulnerable populations.

**Objective:** Increase the number of health education programs and activities conducted at various community-based settings and referrals to primary care and medical homes.

#### **Froedtert West Bend Hospital Available Resources:**

- Continue three year restricted grant to support two .5 FTE Community Health Navigators at Albrecht Free Clinic and Casa Guadalupe Education Center
- Utilize Community Health Worker to improve readmissions and /or navigation for high risk chronic conditions for patients in Washington County
- Provide paths to improve health insurance access to underserved populations in Washington County

#### **Froedtert West Bend Hospital Collaborative Partners:**

- Albrecht Free Clinic
- Casa Guadalupe Education Center

- Milwaukee Area Health Education Center

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

**CHNA Significant Health Need:** Chronic Disease (Prevention and Treatment) targeted at Skin, Prostate and Colorectal Cancers

**Goal:** Decrease the cancer mortality rate in Washington County

**Objective:** Implement programs to increase cancer awareness, screening and early detection

**Froedtert West Bend Hospital Available Resources:**

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

**Froedtert West Bend Hospital Collaborative Partners:**

- American Cancer Society
- Impact 211
- Commission on Cancer

**Evidence Based Community Education and Wellness Programs**

**CHNA Significant Health Need:** Chronic Disease Management (Prevention)

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

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

**Froedtert West Bend Hospital Available Resources:**

- Facilitate a minimum of three Living Well with Chronic Conditions/Diabetes programs each year
- Explore new community partners/agencies in Washington County to hold Living Well programs
- Identify bilingual resources for teaching Living Well series for Spanish speaking populations and connect to a medical home

**Froedtert West Bend Hospital Collaborative Partners:**

- Wisconsin Institute for Healthy Aging
- Washington County Aging and Disability Resource Center
- Casa Guadalupe Education Center

**Well Washington County “Think Well” Behavioral Health Coalition**

**CHNA Significant Health Need:** Mental Health/Alcohol and Other Drug Abuse

**Goal:** Improve the behavioral health of Washington County residents

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

**Froedtert West Bend Hospital Available Resources:**

- Actively participate in the coalition
- Provide clinical support/education through internal behavioral health resources
- Collaboration with Albrecht Free Clinic, Casa Guadalupe Education Center Community Health Navigators and AODA screening and referral networks.

**Froedtert West Bend Hospital Collaborative Partners:**

- Washington Ozaukee Public Health Department – Lead Agency
- Washington County Human Services
- NAMI
- Elevate Inc.

- Albrecht Free Clinic
- United Way of Washington County
- Aurora Healthcare
- Affiliated Clinical Services
- UW-Extension Washington County
- Washington County Sheriff's Department
- Washington County Department of Corrections
- Germantown Police Department
- West Bend School District

### **Healthy Community Fund Grant Program**

**CHNA Significant Health Need:** All Identified Significant Health Needs

**Goal:** Support non-profit organizations and resources that will promote healthy lifestyle choices as well as provide support for programs and services committed to the promotion of health and wellness in Washington County

#### **Objectives:**

- Increase self-management in high risk populations by addressing social determinants in health
- Expand health resources to assist, support, and navigate through community based clinical services and insurance coverage

#### **Froedtert West Bend Hospital Available Resources:**

- Facilitation and management of Healthy Community Fund operations and committee functions
- Restricted grant funding to non-profit organizations that address community health needs
- Monitoring outcomes and impact for organizations receiving Healthy Community Fund funding
- Promotion and awareness of impact of funding with respect to Washington County residents and partners

#### **Froedtert West Bend Hospital Collaborative Partners:**

- Albrecht Free Clinic
- Casa Guadalupe Education Center
- Easterseals Southeast Wisconsin
- Elevate Inc.
- Family Promise of Washington County
- Friends Inc.
- Heroin Task Force
- Interfaith Caregivers of Washington County
- Kettle Moraine YMCA
- NAMI Washington County
- Senior Citizens Activities Inc.
- Threshold Inc.
- United Way of Washington County
- Washington County Human Services
- Washington Ozaukee Public Health Department
- Well Washington County
- West Bend Chamber of Commerce
- West Bend School District
- Youth & Family Project

## **Froedtert West Bend Hospital Community Partnerships**

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

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

- Albrecht Free Clinic – Access to Care, Dental and Social Determinants of Health
- Casa Guadalupe Education Center – Access to Care, Healthy Living Programming, Chronic Disease Prevention and Management
- Elevate Inc. – Mental Health/ Alcohol and Other Drug Abuse
- Family Promise of Washington County- Access to Care, Mental Health/Alcohol and Other Drug Abuse, Social Determinants of Health
- Friends Inc.- Social Determinants of Health, Mental Health/Alcohol and Other Drug Abuse
- Heroin Task Force- Mental Health/Alcohol and Other Drug Abuse
- Interfaith Caregivers of Washington County- Access to Care, Chronic Disease Prevention and Management
- Kettle Moraine YMCA- Chronic Disease Prevention and Management
- NAMI Washington County- Mental Health/Alcohol and Other Drug Abuse
- Senior Citizens Activities Inc.- Chronic Disease Prevention and Management
- Threshold Inc.- Mental Health/Alcohol and Other Drug Abuse, Access to Care
- United Way of Washington County- Social Determinants of Health, Mental Health/Alcohol and Other Drug Abuse, Access to Care
- Washington County Human Services- Access to Care, Mental Health/Alcohol and Other Drug Abuse
- Washington Ozaukee Public Health Department- Access to Care, Mental Health/Alcohol and Other Drug Abuse, Social Determinants of Health, Chronic Disease Prevention and Management
- Well Washington County- Mental Health/Alcohol and Other Drug Abuse, Chronic Disease Prevention and Management
- West Bend Chamber of Commerce- Social Determinants of Health
- West Bend School District- Access to Care, Mental Health/Alcohol and Other Drug Abuse
- Youth & Family Project- Access to Care, Mental Health/Alcohol and Other Drug Abuse, Social Determinants of Health
- American Cancer Society- Chronic Disease Prevention and Management
- Impact 211- Social Determinants of Health, Mental Health/Alcohol and Other Drug Abuse, Access to Care
- Affiliated Clinical Services- Mental Health/Alcohol and Other Drug Abuse
- Germantown Police Department- Mental Health/Alcohol and Other Drug Abuse
- Wisconsin Institute for Healthy Aging- Chronic Disease Prevention and Management
- Washington County Aging and Disability Resource Center- Chronic Disease Prevention and Management, Mental Health/Alcohol and Other Drug Abuse, Access to Care

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

<b>Name</b>	<b>Title</b>	<b>Organization</b>
Brian Birchbauer	Board Member Committee Member	Froedtert West Bend Hospital Community Foundation Froedtert West Bend Hospital Healthy Community Fund
Mike Bloedorn	Committee Member	Froedtert West Bend Hospital Healthy Community Fund
Kristin Brandner	Executive Director	Washington County United Way
Noelle Braun	Executive Director	Casa Guadalupe Education Center
Linda Buntrock	Committee Member	Froedtert West Bend Hospital Healthy Community Fund
Andy Dresang	Director, Community Engagement	Froedtert Health
Larry Dux	Director, Clinical Informatics	Froedtert Health
Phyllis Eichenseer	Committee Member	Froedtert West Bend Hospital Healthy Community Fund
Allen Ericson	President, Froedtert West Bend Hospital & President Community Hospital Division	Froedtert Health
Chad Feltz	Committee Member	Froedtert West Bend Hospital Healthy Community Fund
Kerry Freiberg	VP Community Engagement	Froedtert Health
Jacci Gambucci	Board Member Committee Member	Froedtert West Bend Hospital Community Foundation Froedtert West Bend Hospital Healthy Community Fund
Andres Gonzalez	VP & Chief Diversity Officer, Diversity & Inclusion	Froedtert Health
Ann Johnson	Director, Froedtert West Bend Hospital Community Foundation	Froedtert West Bend Hospital
Melissa Kerhin	Community Engagement, Program Coordinator	Froedtert Health
Lori Landy	Behavioral Health Care Coordinator, Social Services FWB	Froedtert West Bend Hospital
Teri Lux	President, Froedtert Menomonee Falls & COO, Community Hospital Division	Froedtert Health
Amy Maurer	Community Engagement, Coordinator	Froedtert West Bend Hospital
Deb McCann	CHD Executive Director, Patient Care Services	Froedtert Health
Jim Strachota	Executive Director	Albrecht Free Clinic
Julie Upstill	Public Health Educator	Washington Ozaukee Public Health Department
Amanda Wisth	Public Health Educator	Washington Ozaukee Public Health Department

## Appendix B: Washington County Community Health Survey Report

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

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

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

Respondents were scientifically selected so the survey would be representative of all adults 18 years old and older in the county. The sampling strategy was two-fold. 1) A random-digit-dial landline sample of telephone numbers which included listed and unlisted numbers. The respondent within each household was randomly selected by computer and based on the number of adults in the household (n=300). 2) A cell phone-only sample where the person answering the phone was selected as the respondent (n=100). At least 8 attempts were made to contact a respondent in both samples. Screener questions verifying location were included. A total of 400 telephone interviews were completed between June 28 and August 1, 2016.

With a sample size of 400, we can be 95% sure that the sample percentage reported would not vary by more than  $\pm 5$  percent from what would have been obtained by interviewing all persons 18 years old and older with telephones in the county. When applicable, the data was compared with measures from the *Behavioral Risk Factor Surveillance System (BRFSS)* and indicators established by *Healthy People 2020*.

This margin of error provides us with confidence in the data; 95 times out of 100, the true value will likely be somewhere between the lower and upper bound. The margin of error for smaller subgroups will be larger than  $\pm 5$  percent, since fewer respondents are in that category (e.g., adults 65 years old or older who were asked if they ever received a pneumonia vaccination).

In 2015, the Census Bureau estimated 103,349 adult residents in the county. Thus, in this report, one percentage point equals approximately 1,030 adults. So, when 16% of respondents reported their health was fair or poor, this roughly equals 16,480 residents  $\pm 5,150$  individuals. Therefore, from 11,330 to 21,630 residents likely have fair or poor health. Because the margin of error is  $\pm 5\%$ , events or health risks that are small will include zero. In 2014, the Census Bureau estimated 52,554 occupied housing units in Washington County. In certain questions of the Community Health Survey, respondents were asked to report information about their household. Using the 2014 household estimate, each percentage point for household-level data represents approximately 530 households.

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

# Appendix C: 2016 Washington County Community Health Survey Report

## Summary

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

Overall Health						Health Conditions in Past 3 Years					
Washington County	2005	2008	2011	2014	2016	Washington County	2005	2008	2011	2014	2016
Excellent	20%	23%	15%	19%	15%	High Blood Pressure	25%	21%	28%	27%	26%
Very Good	43%	44%	36%	43%	43%	High Blood Cholesterol	21%	19%	21%	23%	21%
Fair or Poor	12%	12%	19%	12%	16%	Mental Health Condition		11%	8%	18%	16%
<i>Other Research: (2014)</i>						<i>Diabetes</i>					
<i>Fair or Poor</i>						<i>6% 8% 9% 7% 13%</i>					
						<i>Asthma (Current)</i>					
						<i>6% 9% 8% 10% 9%</i>					
						<i>Heart Disease/Condition</i>					
						<i>7% 10% 8% 6% 8%</i>					
Health Care Coverage						Condition Controlled Through Meds, Therapy or Lifestyle Changes					
Washington County	2005	2008	2011	2014	2016	High Blood Pressure		97%	98%	94%	
Not Covered						High Blood Cholesterol		88%	91%	89%	
Personally (currently)	3%	2%	10%	5%	5%	Mental Health Condition		100%	96%	89%	
Personally (past 12 months)		6%	11%	10%	10%	Diabetes		69%	96%	96%	
Household Member (past 12 months)	12%	8%	12%	10%	9%	Asthma (Current)		88%	93%	91%	
<i>Other Research: (2014)</i>						<i>Heart Disease/Condition</i>					
<i>Personally Not Covered (currently)</i>						<i>97% 75% 91%</i>					
						<i>9% 13%</i>					
Did Not Receive Care Needed in Past 12 Months						Routine Procedures					
Washington County			2011	2014	2016	Washington County	2005	2008	2011	2014	2016
Delayed/Did Not Seek Care Due to Cost			15%	16%	23%	Routine Checkup (2 yrs. ago or less)	84%	86%	80%	91%	83%
Prescript. Meds Not Taken Due to Cost (Household)			14%	7%	17%	Cholesterol Test (4 years ago or less)	77%	81%	74%	84%	81%
Unmet Care in Past 12 Months						Dental Checkup (past year)	76%	78%	71%	72%	72%
Medical Care			12%	10%	15%	Eye Exam (past year)	41%	49%	42%	49%	42%
Dental Care			19%	9%	15%	<i>Other Research:</i>					
Mental Health Care			1%	2%	3%	<i>Routine Checkup (≤2 years; 2014)</i>					
						<i>82% 81%</i>					
						<i>Cholesterol Test (≤5 years; 2014)</i>					
						<i>77% 76%</i>					
						<i>Dental Checkup (past year; 2012)</i>					
						<i>72% 67%</i>					
Health Information and Services						Physical Health and Nutrition					
Washington County	2005	2008	2011	2014	2016	Washington County	2005	2008	2011	2014	2016
Primary Source of Health Information						Physical Activity/Week					
Doctor			44%	44%	49%	Moderate Activity (5 times/30 min)	36%	42%	30%	35%	36%
Internet			27%	32%	25%	Vigorous Activity (3 times/20 min)	28%	26%	26%	28%	
Myself/Family Member in Health Field			5%	5%	11%	Recommended Moderate or Vigorous	52%	40%	46%	45%	
Other Health Professional			7%	6%	5%	Overweight Status					
Have a Primary Care Physician					91%	Overweight (BMI 25.0+)	59%	63%	70%	67%	69%
Primary Health Services						Obese (BMI 30.0+)	23%	26%	32%	31%	36%
Doctor/nurse practitioner's office	90%	87%	81%	84%	84%	Fruit Intake (2+ servings/day)	61%	64%	58%	66%	71%
Urgent care center	<1%	1%	1%	4%	4%	Vegetable Intake (3+ servings/day)	23%	28%	22%	29%	34%
Public health clinic/com. health center	5%	6%	10%	4%	4%	At Least 5 Fruit/Vegetables/Day	36%	37%	30%	40%	44%
Hospital emergency room	<1%	2%	<1%	2%	2%	Often Read Label of New Food Product					55%
Quickcare clinic/Fastcare clinic	--	--	--	--	2%	Household Went Hungry in Past Year					5%
Worksite clinic	--	--	--	--	3%	<i>Other Research (2014):</i>					
No usual place	1%	2%	6%	3%	<1%	<i>Overweight (BMI 25.0+)</i>					
Advance Care Plan	43%	43%	38%	43%	46%	<i>67% 63%</i>					
						<i>Obese (BMI 30.0+)</i>					
						<i>31% 30%</i>					
Vaccinations (65 and Older)						Colorectal Cancer Screenings (50 and Older)					
Washington County	2005	2008	2011	2014	2016	Washington County	2005	2008	2011	2014	2016
Flu Vaccination (past year)	40%	67%	66%	62%	72%	Blood Stool Test (within past year)	26%	--	15%	9%	10%
Pneumonia (ever)	61%	68%	73%	79%	75%	Sigmoidoscopy (within past 5 years)		15%	10%	9%	6%
<i>Other Research: (2014)</i>						<i>Colonoscopy (within past 10 years)</i>					
<i>Flu Vaccination (past year)</i>						<i>64% 69% 72% 72%</i>					
<i>Pneumonia (ever)</i>						<i>Screening in Recommended Time Frame</i>					
						<i>69% 74% 74% 75%</i>					
						<i>72% 70%</i>					

Women's Health						Alcohol Use in Past Month					
Washington County	2005	2008	2011	2014	2016	Washington County	2005	2008	2011	2014	2016
Mammogram (50+; within past 2 years)	76%	88%	77%	84%	82%	Binge Drinker	21%	29%	33%	39%	34%
Bone Density Scan (65 and older)	59%	78%	78%	88%	88%	Driver/Passenger When Driver					
Cervical Cancer Screening						Perhaps Had Too Much to Drink	5%	3%	3%	3%	2%
Pap Smear (18 – 65; within past 3 years)	92%	90%	83%	92%	89%	Other Research: (2014)				WI	U.S.
HPV Test (18 – 65; within past 5 years)				57%	55%	Binge Drinker				22%	16%
Screening in Recommended Time Frame (18-29: Pap every 3 years; 30 to 65: Pap and HPV every 5 years or Pap only every 3 years)			95%	89%		Household Problems Associated With...					
Other Research (2014)			WI	U.S.	Washington County	2005	2008	2011	2014	2016	
Mammogram (50+; within past 2 years)			77%	76%	Alcohol	8%	3%	1%	1%	2%	
Pap Smear (18+; within past 3 years)			77%	73%	Marijuana			2%	2%	<1%	
Tobacco Cigarette Use					Gambling			1%	0%	<1%	
Washington County	2005	2008	2011	2014	2016	Misuse of Prescription or OTC Drugs			0%	3%	<1%
Current Smokers (past 30 days)	20%	17%	17%	20%	18%	Cocaine, Heroin or Other Street Drugs			<1%	<1%	0%
Of Current Smokers...						Times of Distress in Past Three Years					
Quit Smoking 1 Day or More in Past Year Because Trying to Quit	51%	62%	62%	50%	46%	Washington County					2016
Saw a Health Care Professional in Past Year and Advised to Quit Smoking	81%	67%	77%	78%	62%	Time of Distress and Someone in HH Looked for Community Support					19%
Other Research:			WI	U.S.	Of Respondents Who Looked for Support						41%
Current Smokers (2014)			17%	18%		Felt Somewhat/Slightly or Not At All Supported					
Tried to Quit (2005)			49%	56%		Mental Health Status					
Exposure to Smoke						Washington County	2005	2008	2011	2014	2016
Washington County	2008	2011	2014	2016		Felt Sad, Blue or Depressed					
Smoking Policy at Home						Always/Nearly Always (past 30 days)	4%	4%	3%	6%	5%
Not allowed anywhere	81%	80%	83%	83%		Find Meaning & Purpose in Daily Life					
Allowed in some places/at some times	8%	7%	5%	9%		Seldom/Never	3%	5%	3%	2%	7%
Allowed anywhere	2%	2%	2%	<1%		Considered Suicide (past year)	3%	3%	2%	4%	3%
No rules inside home	9%	12%	10%	7%		Children in Household					
Nonsmokers Exposed to Second-Hand Smoke in Past Seven Days	28%	16%	9%	10%		Washington County					2011
Other Research: (WI: 2005; US: 2006-08)			WI	U.S.		Personal Health Doctor/Nurse Who Knows Child Well and Familiar with History					84%
Smoking Prohibited at Home			75%	79%		Visited Personal Doctor/Nurse for Preventive Care (past 12 months)					99%
Other Tobacco Products in Past Month						Did Not Receive Care Needed (past 12 months)					82%
Washington County			2014	2016		Medical Care					<1%
Electronic Cigarettes			5%	8%		Dental Care					7%
Cigars, Cigarillos or Little Cigars			4%	6%		Specialist					9%
Smokeless Tobacco			8%	5%		Current Asthma					0%
Top County Health Issues						Safe in Community/Neighborhood (seldom/never)					6%
Washington County				2016		Children 5 to 17 Years Old					4%
Illegal Drug Use				51%		Fruit Intake (2+ servings/day)					71%
Alcohol Use or Abuse				22%		Vegetable Intake (3+ servings/day)					21%
Overweight or Obesity				18%		5+ Fruit/Vegetables per Day					26%
Access to Health Care				18%		Physical Activity (60 min./5 or more days/week)					63%
Chronic Diseases				14%		Children 8 to 17 Years Old					80%
Cancer				12%		Unhappy, Sad or Depressed in Past 6 Months					3%
Prescription or OTC Drug Abuse				9%		Always/Nearly Always					2%
Mental Health or Depression				8%		Experienced Some Form of Bullying (past 12 months)					19%
Environmental Issues				7%		Verbally Bullied					18%
Affordable Health Care				7%		Physically Bullied					9%
Driving Problems				5%		Cyber Bullied					6%
Lack of Physical Activity				5%		Personal Safety in Past Year					
Access to Affordable Healthy Food				5%		Washington County	2005	2008	2011	2014	2016
				5%		Afraid for Their Safety	8%	4%	4%	7%	2%
				5%		Pushed, Kicked, Slapped, or Hit	2%	3%	3%	2%	3%
				5%		At Least One of the Safety Issues	8%	7%	6%	8%	4%

### Overall Health and Health Care Key Findings

In 2016, 58% of respondents reported their health as excellent or very good; 16% reported fair or poor. Respondents with some post high school education or less, in the bottom 40 percent household income bracket or who were inactive were more likely to report fair or poor health. *From 2005 to 2016, there was no statistical change in the overall percent of respondents who reported their health as fair or poor, as well as from 2014 to 2016.*

In 2016, 5% of respondents reported they were not currently covered by health care insurance; respondents who were male, 18 to 34 years old, with a high school education or less or unmarried were more likely to report this. Ten percent of respondents reported they personally did not have health care coverage at least part of the time in the past 12 months; respondents who were male, 18 to 54 years old, with a high school education or less or unmarried were more likely to report this. Nine percent of respondents reported someone in their household was not covered at least part of the time in the past 12 months; unmarried respondents were more likely to report this. *From 2005 to 2016, the overall percent statistically remained the same for respondents 18 and older or 18 to 64 years old who reported no current personal health care coverage, as well as from 2014 to 2016. From 2008 to 2016, the overall percent statistically increased for respondents who reported no personal health care coverage at least part of the time in the past 12 months while from 2014 to 2016, the overall percent statistically remained the same. From 2005 to 2016, the overall percent statistically remained the same for respondents who reported someone in the household was not covered at least part of the time in the past 12 months, as well as from 2014 to 2016.*

In 2016, 23% of respondents reported they delayed or did not seek medical care because of a high deductible, high co-pay or because they did not have coverage for the care in the past 12 months; respondents 45 to 54 years old, with a high school education or less or with a college education were more likely to report this. Seventeen percent of respondents reported that someone in their household had not taken their prescribed medication due to prescription costs in the past 12 months. Fifteen percent of respondents reported there was a time in the past 12 months they did not receive the medical care needed; respondents 35 to 54 years old or in the bottom 40 percent household income bracket were more likely to report this. Fifteen percent of respondents reported there was a time in the past 12 months they did not receive the dental care needed. Respondents with some post high school education or less or in the bottom 40 percent household income bracket were more likely to report they did not receive the dental care needed. Three percent of respondents reported there was a time in the past 12 months they did not receive the mental health care needed. *From 2011 to 2016, the overall percent statistically increased for respondents who reported they delayed or did not seek medical care because of a high deductible/high co-pay/did not have coverage, as well as from 2014 to 2016. From 2011 to 2016, the overall percent statistically remained the same for respondents who reported someone in their household had not taken their prescribed medication due to prescription costs while from 2014 to 2016, there was a statistical increase. From 2011 to 2016, the overall percent statistically remained the same for respondents who reported unmet medical care or unmet dental care while from 2014 to 2016, there was a statistical increase. From 2011 to 2016, the overall percent statistically remained the same for respondents who reported unmet mental health care, as well as from 2014 to 2016.*

In 2016, 49% of respondents reported they contact a doctor when they need health information or clarification while 25% reported they go to the Internet. Eleven percent reported themselves or a family member is in the health care field and their source of information while 5% reported another health professional. Respondents 65 and older or in the bottom 40 percent household income bracket were more likely to report they contact a doctor. Respondents 18 to 34 years old were more likely to report the Internet as their source for health information. Respondents who were female, 35 to 44 years old, with a college education, in the top 40 percent household income bracket or married were more likely to report themselves or a family member in the health care field and their source for health information. Unmarried respondents were more likely to report another health professional as their source for health information. Ninety-one percent of respondents reported they have a primary care physician they regularly see for check-ups and when they are sick; respondents who were female, 65 and older, in the bottom 40 percent household income bracket or in the top 40 percent household income bracket were more likely to report a primary care physician. Eighty-four percent of respondents reported their primary place for health services when they are sick was from a doctor's or nurse practitioner's office; respondents who were female, 45 to 54 years old or 65 and older were more likely to report this. Forty-six percent of respondents had an advance care plan; respondents 65 and older were more likely to report an advance care plan. *From 2011 to 2016, there was no statistical change in the overall percent of respondents reporting a doctor or another health professional as their source for health information, as well as from 2014 to 2016. From 2011 to 2016, there was no statistical change in the overall percent of respondents reporting the Internet*

as their source for health information while from 2014 to 2016, there was a statistical decrease. From 2011 to 2016, there was a statistical increase in the overall percent of respondents reporting they were, or a family member was, in the health care field and their source for health information, as well as from 2014 to 2016. From 2005 to 2016, there was a statistical decrease in the overall percent of respondents reporting their primary place for health services when they are sick was a doctor's or nurse practitioner's office while from 2014 to 2016, there was no statistical change. From 2005 to 2016, there was no statistical change in the overall percent of respondents having an advance care plan, as well as from 2014 to 2016.

In 2016, 83% of respondents reported a routine medical checkup two years ago or less while 80% reported a cholesterol test four years ago or less. Seventy-two percent of respondents reported a visit to the dentist in the past year while 42% reported an eye exam in the past year. Respondents who were female, 65 and older, in the bottom 40 percent household income bracket, in the top 40 percent household income bracket or married respondents were more likely to report a routine checkup two years ago or less. Respondents who were 45 to 54 years old, with a college education, in the top 40 percent household income bracket or married were more likely to report a cholesterol test four years ago or less. Respondents who were female, with a college education, in the top 40 percent household income bracket or married respondents were more likely to report a dental checkup in the past year. Respondents 65 and older were more likely to report an eye exam in the past year. From 2005 to 2016, there was no statistical change in the overall percent of respondents reporting a routine checkup or an eye exam while from 2014 to 2016, there was a statistical decrease. From 2005 to 2016, there was no statistical change in the overall percent of respondents reporting a cholesterol test or a dental checkup, as well as from 2014 to 2016.

In 2016, 45% of respondents had a flu vaccination in the past year. Respondents who were female, 65 and older, in the top 40 percent household income bracket or married were more likely to report a flu vaccination. Seventy-five percent of respondents 65 and older had a pneumonia vaccination in their lifetime. Please note: In the 2004/2005 flu season, for a time there was a limited supply of flu vaccinations. During that period, it was only offered to persons in high-risk categories. From 2005 to 2016, there was a statistical increase in the overall percent of respondents 18 and older or 65 and older who reported a flu vaccination in the past 12 months while from 2014 to 2016, there was no statistical change. From 2005 to 2016, there was no statistical change in the overall percent of respondents 65 and older who had a pneumonia vaccination, as well as from 2014 to 2016.

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

In 2016, out of six health conditions listed, the most often mentioned in the past three years was high blood pressure (26%). Respondents who were 65 and older, in the bottom 40 percent household income bracket, overweight, inactive or nonsmokers were more likely to report high blood pressure. Twenty-one percent of respondents reported high blood cholesterol; respondents who were 65 and older, married or overweight were more likely to report this. Sixteen percent reported a mental health condition; unmarried respondents were more likely to report this. Thirteen percent of respondents reported diabetes. Respondents who were male, 55 and older, in the bottom 40 percent household income bracket, overweight or inactive respondents were more likely to report diabetes. Eight percent reported they were treated for, or told they had heart disease in the past three years. Respondents 65 and older, with some post high school education or less, in the bottom 40 percent household income bracket, who were overweight or inactive were more likely to report heart disease/condition. Nine percent reported current asthma; respondents who were female, 18 to 34 years old or in the bottom 40 percent household income bracket were more likely to report this. From 2005 to 2016, there was a statistical increase in the overall percent of respondents who reported diabetes, as well as from 2014 to 2016. From 2005 to 2016, there was no statistical change in the overall percent of respondents who reported high blood pressure, high blood cholesterol, heart disease/condition or current asthma, as well as from 2014 to 2016. From 2008 to 2016, there was a statistical increase in the overall percent of respondents who reported a mental health condition while from 2014 to 2016, there was no statistical change.

In 2016, 5% of respondents reported they always or nearly always felt sad, blue or depressed in the past 30 days; respondents in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. Three percent of respondents felt so overwhelmed they considered suicide in the past year. Seven percent of respondents reported they seldom or never find meaning and purpose in daily life; respondents with a high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. From 2005 to 2016, there was no statistical change in the overall percent of respondents who reported they always or nearly always felt sad/blue/depressed or they considered suicide, as well as from 2014 to 2016. From

2005 to 2016, there was a statistical increase in the overall percent of respondents who reported they seldom/never find meaning and purpose in daily life, as well as from 2014 to 2016.

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

In 2016, 36% of respondents did moderate physical activity five times a week for 30 minutes. Twenty-eight percent of respondents did vigorous activity three times a week for 20 minutes. Combined, 45% met the recommended amount of physical activity; male respondents were more likely to report this. *From 2005 to 2016, there was no statistical change in the overall percent of respondents who reported moderate physical activity five times a week for at least 30 minutes, as well as from 2014 to 2016. From 2008 to 2016, there was no statistical change in the overall percent of respondents who reported vigorous physical activity three times a week for at least 20 minutes, as well as from 2014 to 2016. From 2008 to 2016, there was a statistical decrease in the overall percent of respondents who met the recommended amount of physical activity while from 2014 to 2016, there was no statistical change.*

In 2016, 69% of respondents were classified as at least overweight while 36% were obese. Respondents who were male or 45 to 54 years old were more likely to be classified as at least overweight or obese. *From 2005 to 2016, there was a statistical increase in the overall percent of respondents being at least overweight or obese while from 2014 to 2016, there was no statistical change.*

In 2016, 71% of respondents reported two or more servings of fruit while 34% reported three or more servings of vegetables on an average day. Respondents with a college education, in the top 40 percent household income bracket, who were not overweight or who met the recommended amount of physical activity were more likely to report at least two servings of fruit. Respondents who were female, 45 to 54 years old, with a college education, in the middle 20 percent household income bracket, who were married, not overweight or who met the recommended amount of physical activity were more likely to report at least three servings of vegetables on an average day. Forty-four percent of respondents reported five or more servings of fruit/vegetables on an average day; respondents who were female, 35 to 54 years old, with a college education, in the top 40 percent household income bracket, who were married, not overweight or who met the recommended amount of physical activity were more likely to report this. Fifty-five percent of respondents reported they often read the labels of new food products they purchase; respondents who were female, 45 to 54 years old, 65 and older or who were not overweight were more likely to report this. Five percent of respondents reported their household went hungry because they couldn't afford enough food in the past 12 months; respondents in the bottom 40 percent household income bracket or who were unmarried were more likely to report this. *From 2005 to 2016, there was a statistical increase in the overall percent of respondents who reported at least two servings of fruit or at least three servings of vegetables on an average day while from 2014 to 2016, there was no statistical change. From 2005 to 2016, there was a statistical increase in the overall percent of respondents who reported at least five servings of fruit/vegetables on an average day while from 2014 to 2016, there was no statistical change.*

In 2016, 82% of female respondents 50 and older reported a mammogram within the past two years. Eighty-eight percent of female respondents 65 and older had a bone density scan. Eighty-nine percent of female respondents 18 to 65 years old reported a pap smear within the past three years. Fifty-five percent of respondents 18 to 65 years old reported an HPV test within the past five years. Eighty-nine percent of respondents reported they received a cervical cancer test in the time frame recommended (18 to 29 years old: pap smear within past three years; 30 to 65 years old: pap smear and HPV test within past five years or pap smear only within past three years). Respondents with a college education or married respondents were more likely to meet the cervical cancer recommendation. *From 2005 to 2016, there was no statistical change in the overall percent of respondents 50 and older who reported having a mammogram within the past two years, as well as from 2014 to 2016. From 2005 to 2016, there was a statistical increase in the overall percent of respondents 65 and older who reported a bone density scan while from 2014 to 2016, there was no statistical change. From 2005 to 2016, there was no statistical change in the overall percent of respondents 18 to 65 years old who reported having a pap smear within the past three years, as well as from 2014 to 2016. From 2014 to 2016, there was no statistical change in the overall percent of respondents 18 to 65 years old who reported having an HPV test within the past five years. From 2014 to 2016, there was no statistical change in the overall percent of respondents 18 to 65 years old who reported having a cervical cancer screening in the recommended time frame.*

In 2016, 10% of respondents 50 and older reported a blood stool test within the past year. Six percent of respondents 50 and older reported a sigmoidoscopy within the past five years while 72% reported a colonoscopy within the past

ten years. This results in 75% of respondents meeting the current colorectal cancer screening recommendations. From 2005 to 2016, there was a statistical *decrease* in the overall percent of respondents who reported a blood stool test within the past year while from 2014 to 2016, there was no statistical change. From 2008 to 2016, there was a statistical *decrease* in the overall percent of respondents who reported a sigmoidoscopy within the past five years while from 2014 to 2016, there was no statistical change. From 2008 to 2016, there was no statistical change in the overall percent of respondents who reported a colonoscopy within the past ten years, as well as from 2014 to 2016. From 2008 to 2016, there was no statistical change in the overall percent of respondents who reported at least one of these tests in the recommended time frame, as well as from 2014 to 2016.

In 2016, 18% of respondents were current tobacco cigarette smokers; respondents who were male, 18 to 34 years old, with some post high school education or less or in the bottom 60 percent household income bracket were more likely to be a smoker. In the past 12 months, 46% of current smokers quit smoking for one day or longer because they were trying to quit. Sixty-two percent of current smokers who saw a health professional in the past year reported the professional advised them to quit smoking. From 2005 to 2016, there was no statistical change in the overall percent of respondents who were current tobacco cigarette smokers, as well as from 2014 to 2016. From 2005 to 2016, there was no statistical change in the overall percent of current tobacco cigarette smokers who quit smoking for at least one day because they were trying to quit, as well as from 2014 to 2016. From 2005 to 2016, there was a statistical *decrease* in the overall percent of current smokers who reported their health professional advised them to quit smoking while from 2014 to 2016, there was no statistical change.

In 2016, 83% of respondents reported smoking is not allowed anywhere inside the home. Respondents who were in the top 60 percent household income bracket, married, nonsmokers or in households with children were more likely to report smoking is not allowed anywhere inside the home. Ten percent of nonsmoking respondents reported they were exposed to second-hand smoke in the past seven days; respondents 18 to 34 years old, with a high school education or less, in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. From 2008 to 2016, there was no statistical change in the overall percent of respondents who reported smoking is not allowed anywhere inside the home, as well as from 2014 to 2016. From 2008 to 2016, there was a statistical *decrease* in the overall percent of nonsmoking respondents who reported they were exposed to second-hand smoke in the past seven days while from 2014 to 2016, there was no statistical change.

In 2016, 8% of respondents used electronic cigarettes in the past 30 days; respondents 18 to 34 years old, with some post high school education or less or in the bottom 40 percent household income bracket were more likely to use e-cigarettes. Six percent of respondents used cigars, cigarillos or little cigars in the past 30 days; respondents who were male, 18 to 34 years old, with a high school education or less or in the middle 20 percent household income bracket were more likely to report this. Five percent of respondents used smokeless tobacco in the past month; respondents who were male, 18 to 34 years old, with a high school education or less or married were more likely to use smokeless tobacco. From 2014 to 2016, there was no statistical change in the overall percent of respondents who reported past month use of electronic cigarettes, cigars/cigarillos/little cigars or smokeless tobacco.

In 2016, 34% of respondents were binge drinkers in the past month. Respondents who were male, 18 to 34 years old, with a college education or in the middle 20 percent household income bracket were more likely to have binged at least once in the past month. Two percent of respondents reported they had been a driver or a passenger when the driver perhaps had too much to drink in the past month. From 2005 to 2016, there was a statistical *increase* in the overall percent of respondents who reported binge drinking in the past month while from 2014 to 2016, there was no statistical change. From 2005 to 2016, there was a statistical *decrease* in the overall percent of respondents who reported they were a driver or passenger in a vehicle when the driver perhaps had too much to drink in the past month while from 2014 to 2016, there was no statistical change.

In 2016, 2% of respondents reported someone in their household experienced a problem, such as legal, social, personal or physical in connection with drinking alcohol in the past year. Less than one percent of respondents each reported someone in their household experienced some kind of problem with marijuana, gambling or with the misuse of prescription drugs/over-the-counter drugs. Zero percent of respondents reported a household problem in connection with cocaine, heroin or other street drugs. From 2005 to 2016, there was a statistical *decrease* in the overall percent of respondents reporting a household problem in connection with drinking alcohol in the past year while from 2014 to 2016, there was no statistical change. From 2011 to 2016, there was a statistical *decrease* in the

*overall percent of respondents reporting a household problem with marijuana while from 2014 to 2016, there was no statistical change. From 2011 to 2016, there was no statistical change in the overall percent of respondents reporting a household problem with the misuse of prescription drugs/over-the-counter drugs while from 2014 to 2016, there was a statistical decrease. From 2011 to 2016, there was no statistical change in the overall percent of respondents reporting a household problem with cocaine/heroin/other street drugs or gambling, as well as from 2014 to 2016.*

In 2016, 19% of respondents reported someone in their household experienced times of distress in the past three years and looked for community support; respondents in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. Forty-one percent of respondents who looked for community resource support reported they felt somewhat, slightly or not at all supported.

In 2016, 2% of respondents reported someone made them afraid for their personal safety in the past year. Three percent of respondents reported they had been pushed, kicked, slapped or hit in the past year. A total of 4% reported at least one of these two situations; respondents in the bottom 40 percent household income bracket or unmarried respondents were more likely to report this. *From 2005 to 2016, there was a statistical decrease in the overall percent of respondents reporting they were afraid for their personal safety, as well as from 2014 to 2016. From 2005 to 2016, there was no statistical change in the overall percent of respondents reporting they were pushed, kicked, slapped or hit, as well as from 2014 to 2016. From 2005 to 2016, there was a statistical decrease in the overall percent of respondents reporting at least one of the two personal safety issues, as well as from 2014 to 2016.*

#### **Children in Household Key Findings**

In 2016, a random child was selected for the respondent to talk about the child's health and behavior. Ninety-nine percent of respondents reported they had one or more persons they think of as their child's personal doctor or nurse, with 91% reporting their child visited their personal doctor or nurse for preventive care during the past 12 months. Five percent of respondents reported there was a time in the past 12 months their child did not receive the dental care needed while 2% reported their child did not receive the medical care needed. Two percent reported their child was not able to visit a specialist they needed to see. Ten percent of respondents reported their child currently had asthma. One percent of respondents reported their child was seldom or never safe in their community. Eighty-two percent of respondents reported their 5 to 17 year old child ate at least two servings of fruit on an average day while 39% reported three or more servings of vegetables. This results in 50% of respondents reporting their 5 to 17 year old child ate at least five or more servings of fruits or vegetables. Sixty-one percent of respondents reported their 5 to 17 year old child was physically active five times a week for 60 minutes. Four percent of respondents reported their 8 to 17 year old child always or nearly always felt unhappy, sad or depressed in the past six months. Thirty-three percent reported their 8 to 17 year old child experienced some form of bullying in the past year; 30% reported verbal bullying, 5% cyber bullying and 3% reported physical bullying. *From 2011 to 2016, there was a statistical increase in the overall percent of respondents reporting their child had a personal doctor/nurse or their child visited their personal doctor for preventive care in the past year while from 2014 to 2016, there was no statistical change. From 2011 to 2016, there was no statistical change in the overall percent of respondents reporting in the past 12 months their child had an unmet medical need, unmet dental need or their child needed to see a specialist but could not, as well as from 2014 to 2016. From 2011 to 2016, there was no statistical change in the overall percent of respondents who reported their child had asthma while from 2014 to 2016, there was a statistical increase. From 2011 to 2016, there was no statistical change in the overall percent of respondents reporting their child was seldom/never safe in their community, as well as from 2014 to 2016. From 2011 to 2016, there was no statistical change in the overall percent of respondents who reported their 5 to 17 year old child ate at least two servings of fruit a day, as well as from 2014 to 2016. From 2011 to 2016, there was a statistical increase in the overall percent of respondents who reported their child ate at least three servings of vegetables a day or ate at least five servings of fruits/vegetables while from 2014 to 2016, there was no statistical change. From 2011 to 2016, there was no statistical change in the overall percent of respondents who reported their child was physically active five times a week for at least 60 minutes while from 2014 to 2016, there was a statistical decrease. From 2011 to 2016, there was no statistical change in the overall percent of respondents who reported their 8 to 17 year old child always or nearly always felt unhappy, sad or depressed, as well as from 2014 to 2016. From 2011 to 2016, there was a statistical increase in the overall percent of respondents who reported their 8 to 17 year old child was bullied overall or verbally bullied while from 2014 to 2016, there was no statistical change. From 2011 to 2016, there was no statistical change in the overall percent of respondents who reported their 8 to 17 year old child was physically bullied while from 2014 to*

2016, there was a statistical decrease. From 2011 to 2016, there was no statistical change in the overall percent of respondents who reported their 8 to 17 year old child was cyber bullied, as well as from 2014 to 2016.

#### **County Health Issues Key Findings**

In 2016, respondents were asked to report the top three health issues in the county. The most often cited was illegal drug use (51%) followed by alcohol use/abuse (22%). Respondents 18 to 54 years old, with a college education or in the middle 20 percent household income bracket were more likely to report illegal drug use as a top health issue. Respondents 35 to 44 years old, with a college education or in the top 60 percent household income bracket were more likely to report alcohol use/abuse as a top health issue. Eighteen percent reported overweight or obesity as a top county health problem. Respondents with a college education or in the top 60 percent household income bracket were more likely to report overweight or obesity. Eighteen percent of respondents reported access to health care as a top county health issue; respondents who were female, 45 to 54 years old, with a college education or married were more likely to report this. Fourteen percent of respondents reported chronic diseases as a top issue. Twelve percent of respondents reported cancer as a top issue; respondents in the top 40 percent household income bracket were more likely to report this. Nine percent reported prescription or over-the-counter drug abuse; respondents with a college education or in the top 40 percent household income bracket were more likely to report this. Eight percent of respondents reported mental health/depression as a top county health issue; female respondents were more likely to report this. Seven percent of respondents reported environmental issues, such as air, water, wind turbines or animal waste. Respondents 18 to 44 years old, with a high school education or less or unmarried respondents were more likely to report environmental issues. Seven percent of respondents reported affordable health care; respondents 45 to 64 years old or with a college education were more likely to report this. Five percent of respondents reported driving problems/aggressive driving or drunk driving as a top county health issue; respondents in the middle 20 percent household income bracket or married respondents were more likely to report this. Five percent of respondents reported lack of physical activity as a top issue. Respondents who were male, 18 to 34 years old or with some post high school education were more likely to report lack of physical activity. Five percent reported access to affordable healthy food; respondents 18 to 34 years old, with some post high school education or less or in the middle 20 percent household income bracket were more likely to report this. Four percent reported tobacco use. Respondents 18 to 34 years old, in the middle 20 percent household income bracket or unmarried respondents were more likely to report tobacco use as a top county health issue. Four percent reported violence or crime as a top county health issue; respondents 18 to 34 years old or with some post high school education were more likely to report this.

## Appendix D: 2016 Washington County Health Needs Assessment: A Summary of Key Informant Interviews

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

The public health priorities for Washington County, were identified in 2016 by a range of providers, policy-makers, and other local experts and community members (“key informants”). These findings are a critical supplement to the Washington County community health needs assessment (CHNA) survey conducted through a partnership between the Washington Ozaukee Public Health Department, Advocate Aurora Health, Children’s Hospital of Wisconsin, and Froedtert & the Medical College of Wisconsin. The CHNA incorporates input from persons representing the broad community served by the hospitals, focusing on a range of public health issues relevant to the community at large.

Key informants in Washington County were identified by the Washington Ozaukee County Public Health Department, Aurora Health Care, Children’s Hospital of Wisconsin, and Froedtert & the Medical College of Wisconsin. Staff from the Washington Ozaukee County Health Department, Aurora Health Care, and Froedtert & the Medical College of Wisconsin also invited the informants to participate and conducted the interviews. The interviewers used a standard interview script that included the following elements:

- Ranking of up to five public health issues, based on the focus areas presented in Wisconsin’s State Health Plan, that are the most important issues for the County; and
- For those five public health issues:
  - Existing strategies to address the issue
  - Barriers/challenges to addressing the issue
  - Additional strategies needed
  - Key groups in the community that hospitals should partner with to improve community health

All informants were made aware that participation was voluntary and that responses would be shared with the Center for Urban Population Health for analysis and reporting. This report presents the results of the 2016 CHNA key informant interviews for Washington County, based on the summaries provided to the Center for Urban Population Health.

Below presents a summary of the health issue rankings, including a list of the five issues which were ranked most frequently by respondents. The next section provides a summary of the strategies, barriers, and partners described by participants. Themes that crossed health topics are also presented.

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

A total of 20 key informants were asked to rank the 5 major health-related issues in their county from a list of 13 focus areas identified in the State Health Plan. The table below presents the results, including a summary of the number of times an issue was mentioned as a top five health issue, and the number of times an informant ranked the issue as the most important health issue. The five health issues ranked most consistently as a top five health issue for the County were:

1. Alcohol and Other Drug Use
2. Mental Health
3. Chronic Disease Prevention and Management

4. Nutrition
5. Physical Activity

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

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

Nineteen key informants ranked Alcohol and Other Drug Use as a top five health issue for the county. General themes related to this issue are the strength and importance of cross-sector partnerships to address substance abuse, and the necessity of acknowledging this issue across the life course, and engaging families and communities to identify, prevent, and treat substance abuse.

*Existing Strategies:* Law enforcement; the justice system; prescription drug drop boxes; the Heroin Task Force; community awareness; Screening, Brief Intervention, and Referral to Treatment (SBIRT) at Albrecht Free Clinic and Casa Guadalupe; Well Washington County; health care providers, services, and systems in the county; Elevate, Inc.; Washington County Human Services and the Washington Ozaukee County Public Health Department; Exodus House; Prevention Network of Washington County; before and after school care that offer drug free environments; Youth Futures' alternative activities; Alcoholics Anonymous meetings; food pantry requirements that clients come sober; providers that accept Medicaid; Unity Club; and bilingual therapists and counselors are strategies in place to address Alcohol and Other Drug Use in the county.

*Barriers and Challenges:* Key informants named a number of barriers and challenges to addressing Alcohol and Other Drug Use in the County, including: lack of funding for staff and programs; the small number of police department staff; stigma about drug abusers; a perception that Narcan is a waste of tax money; Wisconsin's cultural acceptance of drinking and some drug use; parental awareness is lacking; not enough entry points to get help; not enough information on what and where resources are; lack of reimbursement for alcohol and other drug abuse services; lack of transportation; no female inpatient housing and lack of housing generally; lack of treatment facilities, especially for low income and uninsured; not enough focus on Exodus House and other related resources; laws are lenient; denial that alcohol and drugs are a disease; lack of a combined effort among schools and other agencies; Genesis closed unexpectedly and immediately leaving a lot of patients in limbo; 38 youth were hospitalized for drug abuse/overdose over the span of a year and a half; and too many addicts are sitting in jail where they are not able to get the help they need and become repeat offenders, going back to their addictions when they are released.

*Needed Strategies:* Key informants identified strategies needed to address this issue in the county, including: additional programs and services funded strictly through donations; public awareness of the issue through social media; more treatment programs, especially those accessible to Medicaid or uninsured populations; talking about the dangers of drug abuse with families; increased understanding of the signs of heroin and other drug abuse; peer-to-peer support groups, especially for youth; breaking the cycle of alcoholism; offer more sober housing; better coordination/collaboration with private and non-profit organizations focused on treatment and services; the senior population needs to be located; the community needs to be more open and to listen more; discussion among health systems, business leaders, schools and family units; parks and recreation departments could provide venues to hold alternative activities and education sessions; policy changes; Child Death Review Committee; and a common goal for the community to work toward and a plan of how all the agencies fit together.

*Key Community Partners to Improve Health:* Police departments, local government, civic groups, treatment providers, the general community, municipalities, families, children, the Albrecht Free Clinic, Washington County Human Services, Elevate, Inc., United Way of Washington County, youth service organizations, medical/hospital systems, Alcoholics Anonymous, the District Attorney's office, the Washington Ozaukee County Public Health Department, and Youth Futures were named as the key partners to work together to improve health related to this issue.

### **Mental Health**

Fifteen respondents ranked Mental Health as a top five health issue for the county. Key themes related to Mental Health include the need for better Access to Mental Health Services, increased awareness of the

services and supports that do exist and how to access them, and the importance of multi-sectoral work to address this issue.

*Existing Strategies:* Crisis Intervention Team training with police officers; collaboration between organizations; Acute Care Services; police and paramedic; immediate services such as the inpatient mental health unit; Screening, Brief Intervention, and Referral to Treatment (SBIRT) at Albrecht Free Clinic and Casa Guadalupe; Impact 2-1-1; crisis hotlines; counseling services; Elevate, Inc.; Washington County Human Services; National Alliance on Mental Illness (NAMI) Washington County; Affiliated Clinical Services; the Aging and Disability Resource Center; Mental Health Friendly Community pilot program; and the court system's work with students that are truant to get to root cause were identified as providers, services, and strategies in place to address Mental Health in the county.

*Barriers and Challenges:* Commonly named barriers and challenges were related to accessing services and a shortage of resources. There are not enough providers to serve the community, or those who need services either cannot afford them or do not have transportation to get to them, and it can be difficult to afford medications. There is a lack of resources available to train police, school staff, and other key community staff about these issues. Other barriers and challenges include the stigma and embarrassment around mental illness, lack of awareness about mental health, the lack of housing for those with mental illness, and Impact 2-1-1 is not up to date and has long wait times.

*Needed Strategies:* Increased access to services, refresher and ongoing trainings for police officers, public awareness, early interventions, proper housing and employment for those living with mental illness, additional support networks, better connected systems to treat cases (schools, health systems, agencies, providers), coordination between community groups and health care to work together in strategies and tactics to address root causes of issues, increased funding and reimbursement for services, services for homeless, social skill building, first responders trained in mental health first aid, and removing the stigma of mental illness were provided as strategies needed to improve health.

*Key Community Partners to Improve Health:* Friends of Abused Families, the county, non-profit organizations, police departments, Washington County Human Services, United Way of Washington County, Well Washington County, St. Vincent de Paul, Habitat for Humanity, senior centers, local health care providers, the YMCA, Albrecht Free Clinic, NAMI Washington County, Affiliated Clinical Services, Better Together funds, and "anyone who will help" were named as the partners necessary to improve Mental Health.

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

Chronic Disease Prevention and Management was ranked as a top five health issue by nine key informants. Key informants' discussion of this issue identified overlap between Chronic Disease Prevention and Management and Nutrition, Access to Health Services, and Tobacco Use and Exposure.

*Existing Strategies:* Existing health care providers and health services in the county, the YMCA, programs and outreach through Casa Guadalupe Education Center for the Latino population, Albrecht Free Clinic's chronic disease case management focus, farmers markets, community wellness programs, walking and biking trails and parks in Washington County, Interfaith Caregivers of Washington County's transportation assistance, healthy vending machine policies, breastfeeding support, diabetes prevention programs, Moving for Better Balance, Live Strong, assistive devices available, health information materials from health systems, Well Washington County coalition facilitating and pulling community partners together, diabetes support groups, Stepping On, caregiver classes, farm-to-table initiatives, assisted living facilities, the Community Paramedic program, wellness and injury prevention education, smoking cessation programs, and group exercise classes were named as strategies in place to address Chronic Disease Prevention and Management.

*Barriers and Challenges:* Everyday life is very fast paced and people are busy, many residents commute long distances to work and work long hours, lack of physical education and health education, lack of focus on wellness and eating healthily, lack of motivation to be more active and healthier, lack of knowledge of how to navigate health care systems, lack of support or information regarding chronic disease, high rates of obesity, lack of sustainability of programs, lack of provider education, high costs of health care and medications, lack of transportation, not enough time spent during primary care visits,

Wisconsin's drinking and food culture doesn't promote wellness, financial challenges of low return for ambulance services, lack of emergency medical service resources for the number and time spent on emergency calls, language barriers, many smokers are not committed to quitting, patients with many chronic issues cycle through all our systems, and lack of coordination of care with primary care providers were identified as challenges and barriers to addressing Chronic Disease in the county.

*Needed Strategies:* More programs; better availability of healthy eating options; youth education to develop healthy habits from a young age; increased focus on prevention and pretreatment; increased services and communication; more help for patients to successfully navigate insurance and health care; increased Medicaid reimbursement and increased access to affordable services; promotion of outdoor activities in winter; Community Paramedic program; nurse triage for 9-1-1 calls; better communication about fall prevention; better consumer education on appropriate use of Emergency Care, Walk-in, Urgent, and Primary Care; better partnerships among health care systems, such as a partnership between Aurora Health Care and Froedtert Health on addressing root causes and prevention; and integrating mental health care with primary care are ideas of strategies that would be needed to improve health related to this issue.

*Key Community Partners to Improve Health:* The YMCA, United Way of Washington County, Washington Ozaukee County Public Health Department, Albrecht Free Clinic, NAMI Washington County, Elevate, Inc., senior centers, school districts, anyone doing evidence-based prevention programming, Interfaith Caregivers of Washington County, St. John's Lutheran Church Jackson Auto Ministry, Well Washington County coalition, assisted living facilities in the county, group homes, Fire and Rescue Departments, the American Heart Association, local pharmacists, the Aging and Disability Resource Center, and Washington County Human Services were named as key partners to improve health in the county.

### **Nutrition**

Nutrition was ranked as a top five health issue by seven key informants. Discussion of Nutrition included some overlap with Physical Activity. Most respondents addressed healthy cooking and eating across the lifespan, especially within the family context. Some responses directly addressed food access and hunger in the county as it relates to nutrition.

*Existing Strategies:* The YMCA's programming and dieticians; children's programs that teach healthy cooking, kitchen safety, and eating healthily; after school programs that offer children healthy snacks; UW-Extension nutrition education includes recipes and samples; Wellspring, Inc.'s farm to school program; community gardens; parks and recreation department nutrition classes and weight loss classes; farmers markets; food pantries; Women, Infants, and Children (WIC) Program services; dieticians at the Aging and Disability Resource Center; and summer lunch programs and snack programs for kids were named as existing strategies that address Nutrition.

*Barriers and Challenges:* Lack of nutrition education; nutritious choices are not always mainstream choices; families are busy and lack time and lack of parent involvement; cell phones, computer games and other technology that take time away from wellness; items at food pantries are often not the most nutritious; some people only have access to a microwave or toaster oven that do not provide the optimal environment for healthy eating; cultural norms related to food lead to unhealthy choices; many unhealthy beverages are widely available; unhealthy vending machine options; and too much sugar in our diets were named as barriers and challenges to this issue.

*Needed Strategies:* More community gardens, nutrition education opportunities, more cooking classes and demonstrations, kiosks at grocery stores that provide information for fast and easy meals that are healthy for busy families, incorporating nutrition into existing programs, better communication and collaboration with programs and agencies that are already doing the work, and health systems taking on more of a role in education and nutrition were strategies proposed by key informants to improve nutrition in the county.

*Key Community Partners to Improve Health:* The YMCA, Wellspring, Inc., school districts, UW-Extension, St. Vincent de Paul, health care systems in the county, grocery stores, local growers, parks and recreation departments, private gyms and fitness facilities, and Boys and Girls Clubs of Washington County were identified as the key partners needed to improve Nutrition.

## **Physical Activity**

Six key informants ranked Physical Activity among their top five health priorities for the county. Some respondents noted the relationship between Physical Activity and Nutrition as an important factor in wellness. Responses emphasized Physical Activity among youth and families.

*Existing Strategies:* There are existing programs for youth in the county, such as Triple Play, Smart Moves, Spark, Play 60, Runner Club, and evidence-based programs that are run nationally through the Boys and Girls Clubs. Youth sports programs in schools, competitive youth sports, free and low-cost classes offered through community organizations, fitness and sports programs run through the parks and recreation departments, parks, playgrounds, and trails throughout the county, and Get Moving Washington County were named as strategies in place to increase Physical Activity in the county.

*Barriers and Challenges:* Technology makes kids more sedentary and less interested in physical activity, low income families may not be able to afford sports programs or gym memberships, families are too busy and many people in the county commute long distances to work, it is hard to do activities outside in cold weather, lack of motivation, lack of transportation, lack of knowledge about the benefits of physical activity, lack of health education and physical education in schools, and lack of focus on wellness and eating healthily were named as barriers and challenges to health in the county.

*Needed Strategies:* Limiting children's usage of phones and other devices, more collaboration among local partners in programming, providing ideas for what families can do at home indoors when the weather gets cold, employers and insurance companies promoting and incentivizing wellness, fun runs and fitness challenges, scavenger hunts, advertising and promotion of existing opportunities and resources, scholarships for low income families to enroll children in programs, and encouraging active lifestyle and healthy eating in children and the youngest ages so they will form healthy habits were identified as strategies needed to improve Physical Activity in the county.

*Key Community Partners to Improve Health:* The YMCA; school districts, particularly physical education and health education departments; UW-Extension; gyms and fitness centers; parks and recreation departments; the county; senior centers; the Boys and Girls Clubs of Washington County; health systems and hospitals; and Well Washington County were named as key partners to improve health in this area.

**Partners & Contracts:** This report was commissioned by Advocate Aurora Health, Children's Hospital of Wisconsin and Froedtert & the Medical College of Wisconsin in partnership with the Center for Urban Population Health and Washington Ozaukee Public Health Department. The report was prepared by the Center for Urban Population Health.

## **Appendix E: Key Informant Organizations Interviewed for purposes of conducting the Froedtert West Bend Hospital CHNA**

- Albrecht Free Clinic - Free medical and dental clinic for uninsured
- Aurora Health Care Washington County- Health system in Washington County
- Boys and Girls Clubs of Washington County – Nonprofit providing mentoring, after school program, meals and healthy activities for youth in Washington County
- Casa Guadalupe Education Center - Nonprofit serving Latinx community
- City of Hartford Parks & Recreation – Community programming focused on individual & family activities
- City of West Bend Fire & Rescue – Emergency response
- Elevate Inc.- Nonprofit providing prevention, intervention and recovery support around substance abuse and mental health
- Family Promise of Washington County- Nonprofit providing resources and services that prevent and end homelessness
- Friends of Abused Families- Nonprofit providing services and resources for individuals affected by domestic and sexual violence
- Germantown High School- Provides services for youth and participates in the Youth Risk Behavioral Survey
- Germantown Park & Recreation– Community programming focused on individual & family activities
- Germantown Police Department- Law enforcement and emergency response
- Interfaith Caregivers of Washington County- Nonprofit providing health, social and transportation services to seniors
- Kettle Moraine YMCA- Nonprofit providing services that help people improve their health and well-being
- St. Boniface/St. Gabriel Food Pantry- Provides food for low income individuals and families
- United Way of Washington County- Engages, convenes, and mobilizes community resources to address root causes of local health and human services needs
- Washington County Human Services Department- Provides community programs to individuals and families challenged by disability, economic hardship and safety concerns
- Washington Ozaukee Public Health Department- Government department to improve the quality of life by promoting, protecting, and enhancing the health and well-being of the public
- West Bend Area Chamber of Commerce- Nonprofit supporting local businesses in Washington County
- West Bend School District- Provides services for youth and participates in the Youth Risk Behavioral Survey

## **Appendix F: 2016 Washington County Health Needs Assessment: A Summary of Secondary Data Sources**

In the fall of 2016, the Center for Urban Population Health was enlisted to create reports detailing the health of various counties using secondary data. These health data reports are one piece of a variety of data sources being used by three local health systems to describe their communities and the health priorities of their service areas. These reports were specifically developed to complement a telephone survey being done in each county. Because of their complementary nature, these reports are not all-inclusive. Indicators for which primary data are being collected were excluded from this report. In addition, rather than repurposing data from the comprehensive county rankings report created by the University of Wisconsin Population Health Institute (2016), the county level data from the rankings report is included in its entirety at the end of this report.

All of the data comes from publicly available data sources. Data for each indicator were presented by race and ethnicity and gender when the data were available. Race data categorized as ‘unknown’ or ‘missing’ were rarely included. Therefore, not all races are represented in the data that follow. In some cases data were not presented by the system from which they were pulled due to their internal confidentiality policies which specify that data will not be released when the number is less than five. In other cases, the data were available but the rates or percentages are not presented in this report. This is due to the indicator having small numbers in the numerator or denominator resulting in rates or percentages that were subject to large year to year fluctuations and, as such, would not have provided a meaningful representation of the data for the population subset.

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

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

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

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

## Appendix G: Review of the Fiscal Year 2015-2017 Froedtert West Bend Hospital CHNA Implementation Strategy

Identified Need	Program	Actions	Outcomes
Access to Care and Navigation	Albrecht Free Clinic	<ul style="list-style-type: none"> <li>Continue referral process for uninsured/underinsured populations from St. Joseph's Hospital to Albrecht Free Clinic</li> <li>Serve on Board of Directors</li> <li>Provide vouchers for ancillary/specialty care services for AFC patients</li> <li>Screen uninsured patients for financial assistance programs (Marketplace, BadgerCare etc) including Froedtert Health's Financial Assistance Program</li> </ul>	<ul style="list-style-type: none"> <li>4,422 medical patient visits</li> <li>228 patient referrals for specialty consultation</li> <li>1,020 dental visits</li> <li>829 lab tests performed at no cost to Albrecht Free Clinic patients</li> <li>353 radiology procedures performed at no cost to patients</li> <li>Over 400 hours donated by Froedtert &amp; the Medical College of Wisconsin Community Physicians to care for patients in the Albrecht Free Clinic</li> </ul>
Access to Care/Navigation and Chronic Disease Management	Community Paramedicine Program	<ul style="list-style-type: none"> <li>Develop Community Paramedicine Pilot Program</li> <li>Seek funding from St. Joseph's Community Foundation for funding and support pilot program</li> <li>Identify patients at risk for readmission and develop referral and tracking process with West Bend Fire and Rescue</li> <li>Provide clinical oversight and education for patients and community partners involved</li> </ul>	<p>Completed the following:</p> <ul style="list-style-type: none"> <li>Program charter</li> <li>Business plan and</li> <li>Project team</li> <li>Contract between Froedtert West Bend Hospital and West Bend Fire &amp; Rescue</li> <li>Program policies and procedures</li> <li>Referral indicators</li> <li>Intake and discharge process</li> <li>Credentialing/Approval of Program Medical Director</li> <li>EPIC protocols, program materials, communication tools</li> </ul>
Access to Care/Navigation and Chronic Disease Management	Community Health Navigators	<ul style="list-style-type: none"> <li>Provide financial support through a community grant that covers the expenses for two Community Health Navigators at Albrecht and Casa Guadalupe</li> <li>Integrate Community Health Navigators with SJH/CP Clinical Leaders and Staff</li> <li>Conduct routine evidence based health prevention and management programs (Living Well with Chronic Conditions, Community Education Programs etc.)</li> </ul>	<ul style="list-style-type: none"> <li>464 individual assisted in risk reduction and self-management for healthy living</li> <li>66 individuals received direct case management at Albrecht Free Clinic</li> <li>783 individuals were screened various health needs</li> <li>99 individuals were referred to YMCA's Diabetes Prevention Program</li> <li>388 individuals impacted by health education events</li> <li>214 individuals were referred to community resources</li> </ul>
Access to Care and Navigation, AODA/Mental Health and Chronic Disease Management	Impact 211	<ul style="list-style-type: none"> <li>Assess the current state of Washington County organizations, programs and services available in in Impact 211 database</li> <li>Participate in Impact 211 database education and training session to further</li> </ul>	<ul style="list-style-type: none"> <li>Assembled an action team</li> <li>Created a GAP analysis to identify the need of implementing Impact 211 resources in Washington County</li> <li>Held an Impact 211 training with</li> </ul>

		<p>understand the functionality and capabilities of the system</p> <ul style="list-style-type: none"> <li>• Working with Impact 211 staff, facilitate multiple Impact 211 database training sessions for Washington County area businesses and non-profit organizations</li> </ul>	<p>13 organizations and 17 participants.</p>
<p>Chronic Disease (Prevention and Treatment) targeted at Skin, Prostate and Colorectal Cancers</p>	<p>Cancer Care Navigation, Awareness, Prevention and Screening</p>	<ul style="list-style-type: none"> <li>• Dedicated nurse navigators working with patients receiving care in the Kraemer Cancer Center and provide assessment and referrals for health system and community resources</li> <li>• Screen all uninsured patients for financial assistance programs through the Marketplace or government sponsored programs</li> <li>• Execute a minimum of two community cancer screening programs per year</li> <li>• Execute quarterly cancer awareness and education events (classes, health fairs, events etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• 220 individual screened for cancer</li> <li>• Over 100 individuals impacted through community outreach</li> <li>• Over 100 individuals served through the Oncology Social Worker/Navigator</li> </ul>
<p>Chronic Disease Management (Prevention)</p>	<p>Evidence Based Community Education and Wellness Programs</p>	<ul style="list-style-type: none"> <li>• Facilitate a minimum of three Living Well with Chronic Conditions/Diabetes programs each year</li> <li>• Explore new community partners/agencies in Washington County to hold Living Well programs</li> <li>• Identify bilingual resources for teaching Living Well series for Spanish speaking populations and connect to a medical home</li> </ul>	<ul style="list-style-type: none"> <li>• 275 individual impacted by community education and wellness programs</li> </ul>
<p>Mental Health/Alcohol and Other Drug Abuse</p>	<p>Well Washington County “Think Well” Behavioral Health Coalition</p>	<ul style="list-style-type: none"> <li>• Actively participate in the coalition</li> <li>• Identify service gaps within Froedtert Health</li> </ul>	<ul style="list-style-type: none"> <li>• Participated in a newly formed coalition called Well Washington County</li> <li>• Participated in a mental health gap analysis through Well Washington County</li> <li>• Participate in the Prevention Network and Heroin Task Force</li> </ul>