Community Health Needs Assessment (CHNA) Report

St. Joseph's Hospital of West Bend Inc.
Doing Business As:

Froedtert West Bend Hospital

Fiscal Year 2021
Effective August 26, 2020

Approved on 8/25/20 by Froedtert West Bend Hospital Board of Directors

Table of Contents

Executive Summary

Community Health Needs Assessment for Froedtert West Bend Hospital.

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), 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 2019, 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. St. Joseph's Hospital of West Bend Inc. doing business as 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 22 in-person interviews with 23 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 four steps for selecting priorities for the CHNA and Implementation Strategy:

1. Reviewed the 2019 Community Health Needs Assessment results for identification and prioritization of community health needs;
2. Reviewed previous 2018 - 2020 Implementation Strategy programs and results;
3. Brainstormed evidence-based strategies, partnerships and programs to address community health needs
4. Prioritized identified strategies

After the facilitated workout session in February 2020, based on the information from all the CHNA data collection sources, the most significant health needs were identified as:

- Access to Health Care and Navigation of Community Resources;
- Access to Oral Health;
- Chronic Conditions and Cancer;
- Mental Health;
- Nutrition, Obesity and Physical Activity;
- Alcohol, Drugs, Tobacco Abuse;
- Youth; and
- Social Determinants of Health

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, six overarching themes were identified as priorities for Froedtert West Bend Hospital's fiscal years 2021 – 2023:

- Access to Health Care Services and Navigation of Community Resources;
- Behavioral Health;
- Chronic Disease Prevention and Management;
- Youth Engagement;
- Social Determinants of Health; and
- Community Health Leadership

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 July-September 2019 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 the County; and
- For those five public health issues:
    - Existing strategies to address the issue
    - Barriers and challenges to addressing the issue

- Additional strategies needed
- Key groups in the community that hospitals should partner with to improve community health
- Identification of subgroups or subpopulations where efforts could be targeted
- Ways efforts can be targeted toward each subgroup or subpopulation

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:

- Mental Health
- Substance Use & Abuse
- Access to Health Care
- Alcohol Abuse
- Physical Activity

Community Health Survey:

- Illegal Drug Use
- Alcohol Use or Abuse
- Prescription or OTC Drug Abuse
- Mental Health or Depression
- Chronic Diseases

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

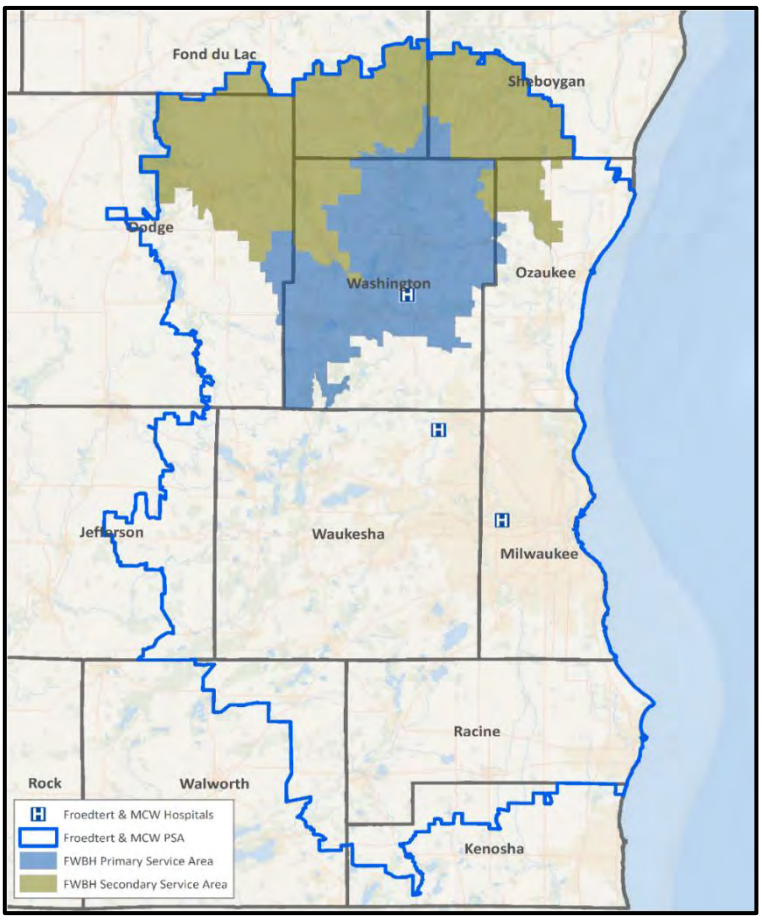
Froedtert & the Medical College of Wisconsin Froedtert West Bend Hospital, founded in 1930 by local doctors, community leaders and the Sisters of the Divine Savior, is a full-service hospital serving residents of West Bend, Washington County, and surrounding areas. Froedtert West Bend Hospital, specializing 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 people of the diverse communities we serve through exceptional care enhanced by innovation and discovery.

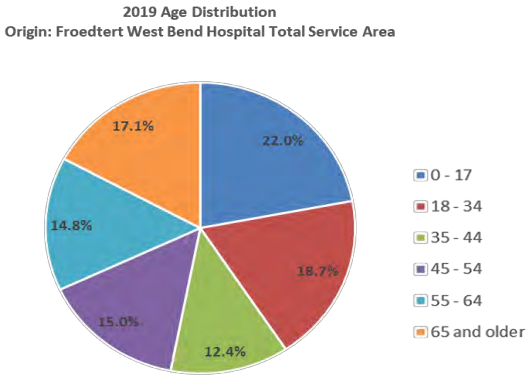
Service Area and Demographics

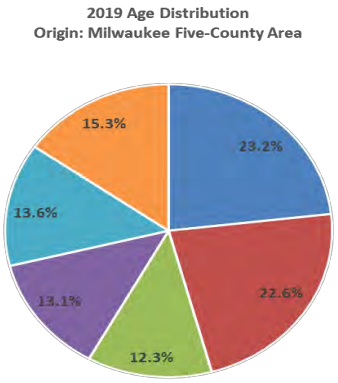
For the purpose of the Community Health Needs Assessment, the community is defined as Washington County because we derive 87.5% of discharges occur from this geography. All programs, activities, and partnerships under the CHNA will be delivered in Washington County. However, Froedtert West Bend Hospital's 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.

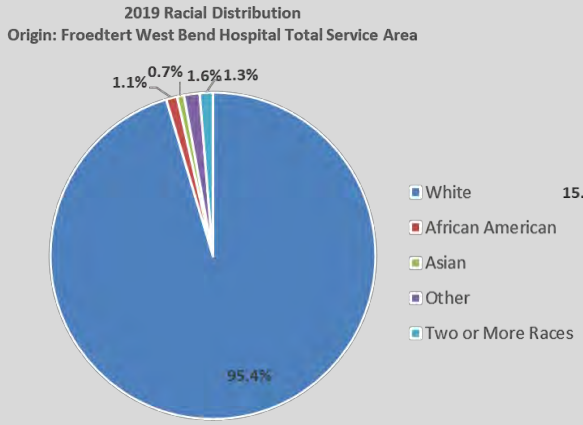


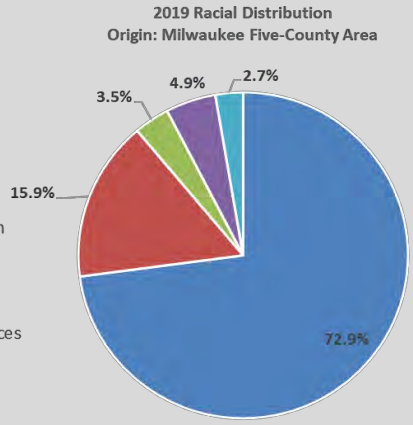
The map reflects the 15 zip codes – 53001 (Adell), 53002 (Allenton), 53010 (Campbellsport), 53011 (Cascade), 53021 (Fredonia), 53027 (Hartford), 53037 (Jackson), 53040 (Kewaskum), 53048 (Lomira), 53050 (Mayville), 53075 (Random Lake), 53086 (Slinger), 53090 (West Bend), 53091 (Theresa), and 53095 (West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

Age – The Freodtert 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 Freodtert West Bend Hospital Total Service area with 18.7% of population while the Five-County area 18 – 34 age group is 22.6% of the population.



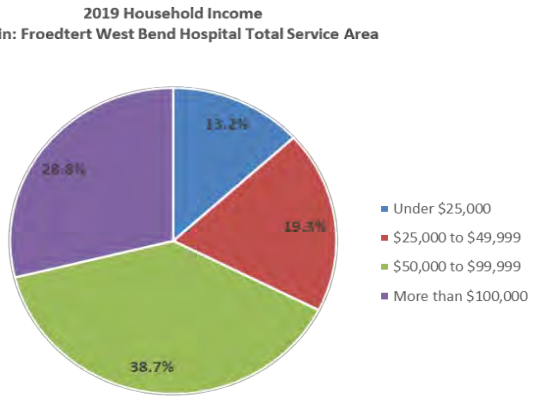


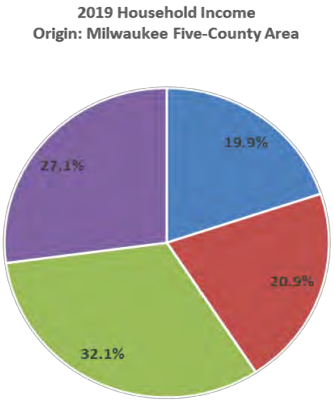


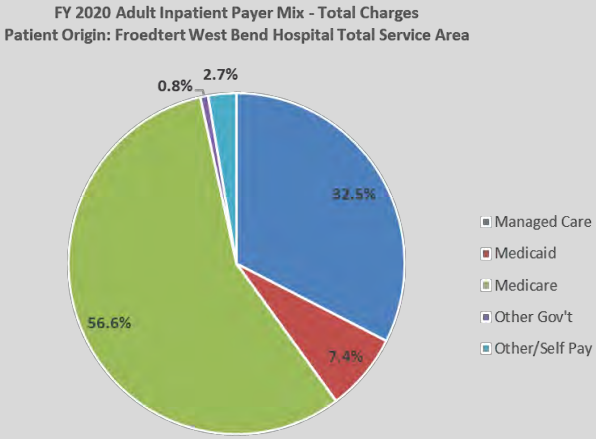


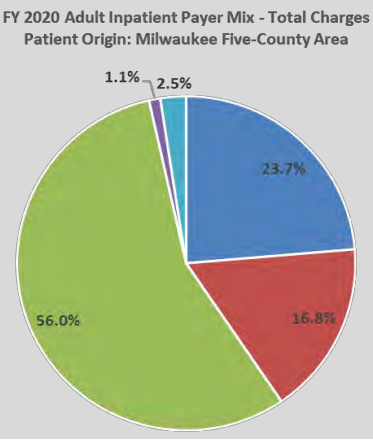
Race – The racial distribution in the Freodtert West Bend Hospital total Service area is predominantly Caucasian (95.4%). The Five-County area is more diverse; 15.9% of the population is African American and 11.1% are other races.

Household Income – Households where income is less than $50,000 is 32.5% of the distribution in the Freodtert West Bend Hospital total service area. Within the Milwaukee Five-County area, the percent of households that income is less than $50,000 is 40.8%.









Payer Mix – For adult inpatients, the Freodtert West Bend Hospital total service area has 10.1% of patients consist of Medicaid and Self Pay payers. The Milwaukee Five-County area has 19.3% of patients with Medicaid and Self Pay in the payer mix.

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.

Transportation, Health Care Access for Priority Populations, Health Literacy, Navigation of Community Resources

CHNA Significant Health Need: Access to Health Care and Navigation of Resources

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

Objective:

1. Provide and assist eligible patients with affordable transportation options.
2. Support community efforts to increase access to affordable transportation options within Washington County and surrounding areas.
3. Ensure a strong safety net of services that improve access to care among vulnerable populations.

Froedtert West Bend Hospital Available Resources:

- Provide subsidized medical transportation rides to underserved populations.
- Continue awareness of available transportation services for Froedtert staff that serve qualified individuals.
- Support the Washington County Coordinated Transportation Committee.
- Expand assistance and support of the Albrecht Free Clinic to improve access to healthcare, dental and behavioral care services for uninsured and underinsured population.
- Expand assistance and support of the Community Health Navigators to improve access to health care and navigation of resources.
- Explore virtual or digital community health opportunities and other innovative ways to deliver care.
- Improve health literacy by implementing digital programs such as Coverage to Care and/or Navigating MyChart Community Education Program.

Froedtert West Bend Hospital Collaborative Partners:

- Albrecht Free Clinic
- Washington County Coordinated Transportation Committee
- Casa Guadalupe Education Center

Prevention, Screening, Food Access, Support Services

CHNA Significant Health Need: Chronic Disease Prevention and Management

Goal: Reduce and prevent the occurrence and severity of chronic disease in Washington County through collaborative approaches.

Objective:

1. Increase number of community chronic disease and cancer screenings, access to support services and prevention opportunities.
2. Increase access to affordable and healthy foods.

Froedtert West Bend Hospital Available Resources:

- Increase number of screening opportunities in the community such as Albrecht Free Clinic, Casa Guadalupe Education Center and with other partners.

- Expand assistance and support of the Community Health Navigators and community partners to provide chronic disease prevention programs.
- Provide Community Education & Wellness classes through in-person or virtual experiences.
- Increase navigation to community and hospital services through care coordinators, social workers and partnered Community Health Navigators.
- Explore food prescription or Emergency Food Bag Programs to implement within hospital and clinics.
- Expand support and opportunities to utilize produce grown from hospital garden.
- Collaborate with community coalitions through the Washington Ozaukee Public Health Department focused on nutrition and physical activity.

Froedtert West Bend Hospital Collaborative Partners:

- Albrecht Free Clinic
- Casa Guadalupe Education Center
- Washington Ozaukee Public Health Department

Social Engagement, Prescription Drug Prevention, Screenings and Referrals

CHNA Significant Health Need: Behavioral Health

Goal:

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

Objective:

1.1 Increase opportunities for social engagement to reduce isolation, depression and addiction.
1.2 Increase opportunities for the safe removal of prescription drugs from households.
2.1 Enhance behavioral health training for the Community Health Navigators.
2.2 Increase number of behavioral health screenings and referrals.

Froedtert West Bend Hospital Available Resources:

- Support behavioral health support groups through community partnerships.
- Support and promote evidence-based initiatives through community behavioral health coalitions.
- Support Drug Take Back Day through community coalitions.
- Implement drug disposal program at Froedtert Health outpatient pharmacies.
- Support evidence-based behavioral health trainings for Community Health Navigators.
- Expand behavioral health screenings at Albrecht Free Clinic, Casa Guadalupe Education Center and other community partner sites.
- Expand and support the ED to Recovery Program.

Froedtert West Bend Hospital Collaborative Partners:

- Washington Ozaukee Public Health Department
- Elevate, Inc
- NAMI Washington County
- Albrecht Free Clinic
- Casa Guadalupe Education Center

Engagement and Workforce Development

CHNA Significant Health Need: Youth Engagement

Goal: Improve health outcomes among youth in Washington County.

Objective:

1. Increase engagement with schools and youth serving organizations to improve health outcomes for youth.
2. Provide youth workforce development opportunities to develop skills to secure meaningful health care careers.

Froedtert West Bend Hospital Available Resources:

- Understand current youth opportunities to promote health at local school districts.

- Support schools, youth serving organizations and community coalitions to implement evidence-based health initiatives around mental health and substance abuse/use.
- Support the implementation of the Youth Risk Behavior Survey throughout Washington County school districts.
- Provide in-person and virtual opportunities for youth to learn about health care careers and education such as programs, tours, speakers and internships.

Froedtert West Bend Hospital Collaborative Partners:

- Washington Ozaukee Public Health Department
- Washington County School Districts
- Washington County Non-profit Organizations
- Elevate, Inc

Social Determinants of Health

CHNA Significant Health Need: Food Insecurity, Economic Stability, Transportation and Charitable & In-Kind Support

Goal: Address social determinants of health to improve health outcomes in Washington County.

Objective:

1. Reduce food insecurity and barriers for patients through partnerships and referrals.
2. Support efforts to strengthen local workforce.
3. Provide and assist eligible patients with accessible and affordable transportation options.
4. Support non-profit and public/private organizations that will promote healthy communities through lifestyle behavior change, social determinants of health and navigation of resources for residents in Washington County.
5. Provide inclusive, culturally. and linguistically competent care to all patients, Information to community members and education to staff.

Froedtert West Bend Hospital Available Resources:

- Explore opportunities to increase access to healthy, nutrient rich and affordable food in partnership with food pantries, grocery stores, and other local organizations.
- Support economic vitality through involvement with local chamber of commerce, school districts and other organizations focused on economic development.
- Continue to support Project SEARCH to develop social and employment skills for adults with disabilities.
- Navigate appropriate medical transportation options to underserved populations.
- Align Healthy Community Fund grant dollars to support organizations that address identified community health needs.
- Continue to support the United Way Campaign to support local non-profits and organizations.
- Partner with Human Resources and Diversity & Inclusion to implement programs and policies that address bias and institutional racism.

Froedtert West Bend Hospital Collaborative Partners:

- Froedtert West Bend Hospital Board of Directors
- Interfaith Caregivers of Washington County
- Washington County non-profit organizations
- Washington County Chamber of Commerce Organizations
- Washington County Economic Development
- Washington Ozaukee Shared Ride Taxi
- United Way of Washington County

Community Health Leadership

CHNA Significant Health Need: Access to Health Care and Navigation to Resource, Chronic Disease Prevention and Management, Behavioral Health, and Youth

Goal: Increase efforts for Froedtert West Bend Hospital to be a leader in community health improvement.

Objective:

1. Support non-profit and public/private organizations that will promote healthy communities through lifestyle behavior change, social determinants of health and navigation of resources for residents in Washington County.
2. Expand health and wellness initiatives offered internally through Froedtert Health.
3. Actively support the development of community coalitions and partnerships to address community health needs.

Froedtert West Bend Hospital Available Resources:

- Facilitate and manage the Healthy Community Fund operations and committee functions
- Prioritize funding to partnerships and programs that identify community health needs
- Require collective impact strategies/programs for funding consideration
- Monitor outcomes and impact for organizations receiving Healthy Community Fund funding
- Promote impact of funding with Washington County residents and partners
- Continue to support building community capacity to address health priorities through staffing and financial support, county-level health coalitions and collaborative partnerships with diverse community stakeholders.
- Identify opportunities to partner with community stakeholders to impact social determinants of health.
- Partner with Workplace Wellness and community coalitions to implement opportunities to improve staff well-being.

Froedtert West Bend Hospital Collaborative Partners:

- Healthy Community Fund Committee Members
- Washington County non-profit organizations
- Washington Ozaukee Public Health Department

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 Health Care and Navigation to Resource, Chronic Disease Prevention and Management, Behavioral Health
- Casa Guadalupe Education Center- Access to Health Care and Navigation to Resource, Chronic Disease Prevention and Management, Behavioral Health
- Washington County Coordinated Transportation Committee- Access to Health Care and Navigation to Resource
- Washington Ozaukee Public Health Department- Access to Health Care and Navigation to Resource, Chronic Disease Prevention and Management, Behavioral Health, and Youth
- NAMI Washington County- Behavioral Health
- Elevate, Inc- Behavioral Health, and Youth
- Washington County School Districts- Youth
- Healthy Community Fund Committee Members- Access to Health Care and Navigation to Resource, Chronic Disease Prevention and Management, Behavioral Health, and Youth
- Washington County Non-profit Organizations- Access to Health Care and Navigation to Resource, Chronic Disease Prevention and Management, Behavioral Health, and Youth

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

Name	Title	Organization
Noelle Braun	Executive Director	Casa Guadalupe Education Center
Andy Dresang	Director, Community Engagement	Froedtert Health
Larry Dux	Director, Clinical Informatics	Froedtert Health
Mariah Bye	Community Education Coordinator	Froedtert Health
Allen Ericson	President, Froedtert West Bend Hospital & President Community Hospital Division	Froedtert Health
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
Ruth Henkle	Executive Director	Albrecht Free Clinic
Ann Johnson	Director, Froedtert West Bend Hospital Community Foundation	Froedtert West Bend Hospital
Kirsten Johnson	Health Officer	Washington Ozaukee Public Health Department
Melissa Kerhin	Community Engagement, Program Coordinator	Froedtert Health
Lori Landy	Behavioral Health Care Coordinator, Social Services FWBH	Froedtert West Bend Hospital
Teri Lux	President, Froedtert Menomonee Falls & COO, Community Hospital Division	Froedtert Health
Amy Maurer	Community Engagement, Program Coordinator	Froedtert West Bend Hospital
Deb McCann	CHD Executive Director, Patient Care Services	Froedtert Health
Heidi Moore	Director, Diversity & Inclusion	Froedtert Health
Brenda Raad	Dean of General Studies & Accreditation Liaison Officer	Moraine Park Technical College
Mandie Reedy	Community Engagement, Program Coordinator	Froedtert Menomonee Falls Hospital
Pete Rettler	Dean of the West Bend Campus	Moraine Park Technical College
Erika Smith	Director Enterprise Care Coordination & Redesign, Population Health	Froedtert Health
Christian Tscheschlok	Board President Committee Member	Froedtert West Bend Hospital Community Foundation Froedtert West Bend Hospital Healthy Community Fund
Shelly Waala	VP Patient Care Service/CNO	Froedtert Health
Tyler Weber	Health Educator	Washington Ozaukee Public Health Department
Matthew Weston, MD	Associate Professor	The Medical College of Wisconsin
Amanda Wisth	Community Engagement, Data Coordinator	Froedtert Health

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

Respondents were scientifically selected so the survey would be representative of all adults 18 years old and older in the county. The sampling strategy was two-fold. 1) A random-digit-dial landline sample of telephone numbers which included listed and unlisted numbers. The respondent within each household was randomly selected by computer and based on the number of adults in the household (n=220). 2) A cell phone-only sample where the person answering the phone was selected as the respondent (n=180). At least 8 attempts were made to contact a respondent in each sample. Screener questions verifying location were included. Data collection was conducted by Management Decisions Incorporated. A total of 400 telephone interviews were completed between July 15, 2019 and September 25, 2019.

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

In 2018, the Census Bureau estimated 105,971 adult residents lived in Washington County. Thus, in this report, one percentage point equals approximately 1,060 adults. So, when 15% of respondents reported their health was fair or poor, this roughly equals 15,900 residents □5,300 individuals. Therefore, from 10,600 to 21,200 residents likely have fair or poor health. Because the margin of error is □5%, events or health risks that are small will include zero.

In 2017, the Census Bureau estimated 41,144 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 2017 household estimate, each percentage point for household-level data represents approximately 410 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: 2019 Washington County Community Health Survey Report

Executive Summary

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

	Washington					WI	US
Overall Health	2008	2011	2014	2016	2019	*2018*	*2018*
Excellent/Very Good	67%	51%	62%	58%	52%	*52%*	*51%*
Good	22%	29%	27%	27%	34%	*33%*	*32%*
Fair or Poor	12%	19%	12%	16%	15%	*15%*	*17%*
Health Care Coverage	Washington					WI	US
Not Covered	2008	2011	2014	2016	2019	*2018*	*2018*
Personally (Currently, 18 Years Old and Older) [HP2020 Goal: 0%]	2%	10%	5%	5%	6%	*10%*	*11%*
Personally (Currently, 18 to 64 Years Old) [HP2020 Goal: 0%]	3%	12%	6%	5%	7%	*11%*	*13%*
Personally (Past Year, 18 and Older)	6%	11%	10%	10%	10%	*NA*	*NA*
Household Member (Past Year)	8%	12%	10%	9%	11%	*NA*	*NA*
	Washington					WI	US
Did Not Receive Care Needed in Past Year	2008	2011	2014	2016	2019	*2018*	*2018*
Delayed/Did Not Seek Care Due to Cost	--	15%	16%	23%	15%	*10%*	*12%*
Unmet Need/Care in Household							
Prescription Medication Not Taken Due to Cost [HP2020 Goal: 3%]	--	14%	7%	17%	7%	*NA*	*NA*
Medical Care [HP2020 Goal: 4%]	--	12%	10%	15%	7%	*NA*	*NA*
Dental Care [HP2020 Goal: 5%]	--	19%	9%	15%	12%	*NA*	*NA*
Mental Health Care	--	1%	2%	3%	6%	*NA*	*NA*
Health Information	Washington					WI	US
Primary Source of Health Information	2008	2011	2014	2016	2019	*2018*	*2018*
Doctor	--	44%	44%	49%	47%	*NA*	*NA*
Internet	--	27%	32%	25%	32%	*NA*	*NA*
Myself/Family Member in Health Care Field	--	5%	5%	11%	11%	*NA*	*NA*
Family/Friends	--	4%	2%	<1%	4%	*NA*	*NA*
Other Health Professional	--	7%	6%	5%	3%	*NA*	*NA*
	Washington					WI	US
Health Services	2008	2011	2014	2016	2019	*2018*	*2018*
Have a Primary Care Physician [HP2020 Goal: 84%]	--	--	--	91%	87%	*81%*	*77%*
Primary Health Services							
Doctor/Nurse Practitioner's Office	87%	81%	84%	84%	74%	*NA*	*NA*
Urgent Care Center	1%	1%	4%	4%	9%	*NA*	*NA*
Hospital Emergency Room	2%	<1%	2%	2%	4%	*NA*	*NA*
Quickcare Clinic (Fastcare Clinic)	--	--	--	2%	3%	*NA*	*NA*
Public Health Clinic/Com. Health Center	6%	10%	4%	4%	2%	*NA*	*NA*
Worksite Clinic	--	--	--	3%	<1%	*NA*	*NA*
Hospital Outpatient	2%	1%	2%	0%	0%	*NA*	*NA*
No Usual Place	2%	6%	3%	<1%	7%	*NA*	*NA*
Advance Care Plan	43%	38%	43%	46%	42%	*NA*	*NA*
	Washington					WI	US
Vaccinations (65 and Older)	2008	2011	2014	2016	2019	*2018*	*2018*
Flu Vaccination (Past Year)	67%	66%	62%	72%	65%	*46%*	*55%*
Pneumonia (Ever) [HP2020 Goal: 90%]	68%	73%	79%	75%	79%	*75%*	*74%*

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

	Washington					WI	US
Routine Procedures	2008	2011	2014	2016	2019	*2018*	*2018*
Routine Checkup (2 Years Ago or Less)	86%	80%	91%	83%	83%	*87%*	*88%*
Cholesterol Test (4 Years Ago or Less) [HP2020 Goal: 82%]	81%	74%	84%	80%	75%	*83%*[1]	*86%*[1]
Dental Checkup (Past Year) [HP2020 Goal: 49%]	78%	71%	72%	72%	74%	*71%*	*68%*
Eye Exam (Past Year)	49%	42%	49%	42%	53%	*NA*	*NA*

	Washington					WI	US
Tested for a Sexually Transmitted Infection in Lifetime	2008	2011	2014	2016	2019	*2018*	*2018*
Tested for a Sexually Transmitted Infection, including HIV	--	--	--	--	37%	*NA*	*NA*

	Washington					WI	US
Health Conditions in Past 3 Years	2008	2011	2014	2016	2019	*2018*	*2018*
High Blood Pressure	21%	28%	27%	26%	24%	*NA*	*NA*
High Blood Cholesterol	19%	21%	23%	21%	21%	*NA*	*NA*
Mental Health Condition	11%	8%	18%	16%	21%	*NA*	*NA*
Heart Disease/Condition	10%	8%	6%	8%	11%	*NA*	*NA*
Diabetes	8%	9%	7%	13%	10%	*NA*	*NA*
Asthma (Current)	9%	8%	10%	9%	10%	*9%*	*10%*

	Washington					WI	US
Condition Controlled Through Meds, Therapy or Lifestyle Changes	2008	2011	2014	2016	2019	*2018*	*2018*
High Blood Pressure	--	97%	98%	94%	95%	*NA*	*NA*
High Blood Cholesterol	--	88%	91%	89%	90%	*NA*	*NA*
Mental Health Condition	--	100%	96%	89%	99%	*NA*	*NA*
Heart Disease/Condition	--	97%	75%	91%	93%	*NA*	*NA*
Diabetes	--	69%	96%	96%	90%	*NA*	*NA*
Asthma (Current)	--	88%	93%	91%	100%	*NA*	*NA*

	Washington					WI	US
Physical Activity							
Physical Activity/Week	2008	2011	2014	2016	2019	*2009*	*2009*
Moderate Activity (5 Times/30 Min)	42%	30%	35%	36%	41%	*NA*	*NA*
Vigorous Activity (3 Times/20 Min)	28%	26%	26%	28%	31%	*NA*	*NA*
Recommended Moderate or Vigorous	52%	40%	46%	45%	49%	*53%*	*51%*

	Washington					WI	US
Body Weight							
Overweight Status	2008	2011	2014	2016	2019	*2018*	*2018*
At Least Overweight (BMI 25.0+) [HP2020 Goal: 66%]	63%	70%	67%	69%	69%	*67%*	*66%*
Obese (BMI 30.0+) [HP2020 Goal: 31%]	26%	32%	31%	36%	36%	*32%*	*31%*

	Washington					WI	US
Nutrition and Food Security	2008	2011	2014	2016	2019	*2009*	*2009*
Fruit Intake (2+ Servings/Day)	64%	58%	66%	71%	61%	*NA*	*NA*
Vegetable Intake (3+ Servings/Day)	28%	22%	29%	34%	25%	*NA*	*NA*
At Least 5 Fruit/Vegetables/Day	37%	30%	40%	44%	33%	*23%*	*23%*
Often Read Food Label/Nutritional Information for First Time Purchase	--	--	--	55%	53%	*NA*	*NA*
Household Went Hungry (Past Year)	--	--	--	5%	4%	*NA*	*NA*

	Washington					WI	US
Colorectal Cancer Screenings (50 and Older)	2008	2011	2014	2016	2019	*2018*	*2018*
Blood Stool Test (Within Past Year)	--	15%	9%	10%	13%	*7%*	*9%*
Sigmoidoscopy (Within Past 5 Years)	15%	10%	9%	6%	7%	*3%*	*2%*
Colonoscopy (Within Past 10 Years)	64%	69%	72%	72%	67%	*71%*	*64%*
One of the Screenings in Recommended Time Frame [HP2020 Goal: 71%]	69%	74%	74%	75%	73%	*75%*	*70%*

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

[1]WI and US data for cholesterol test is from 2017.

	Washington					WI	US
Women's Health	2008	2011	2014	2016	2019	2018	2018
Mammogram (50+; Within Past 2 Years)	88%	77%	84%	82%	75%	78%	78%
Bone Density Scan (65 and Older)	78%	78%	88%	88%	85%	NA	NA
Cervical Cancer Screening							
Pap Smear (18 – 65; Within Past 3 Years) [HP2020 Goal: 93%]	90%	83%	92%	89%	77%	81%	80%
HPV Test (18 – 65; Within Past 5 Years)	--	--	57%	55%	56%	NA	NA
Screening in Recommended Time Frame (18-29: Pap Every 3 Years; 30 to 65: Pap and HPV Every 5 Years or Pap Only Every 3 Years)	--	--	95%	89%	86%	NA	NA

	Washington					WI	US
Tobacco Cigarette Smokers or Vapers	2008	2011	2014	2016	2019	2018	2018
Current Smokers [HP2020 Goal: 12%]	17%	17%	20%	18%	16%	17%	16%
Current Vapers (Past Month)	--	--	5%	8%	9%	5%[1]	4%
Of Current Smokers/Vapers…						2005	2005
Quit Smoking/Vaping 1 Day or More in Past Year Because Trying to Quit [HP2020 Goal Quit Smoking: 80%]	62%	62%	50%	46%	44%	49%	56%
Saw a Health Care Professional in Past Year and Advised to Quit Smoking/Vaping	67%	77%	78%	62%	65%	NA	NA

Exposure to Smoke/Vapor	Washington					WI[2]	US
Smoking Policy at Home	2008	2011	2014	2016	2019	'14-15	'14-15
Not Allowed Anywhere	81%	80%	83%	83%	90%	84%	87%
Allowed in Some Places/At Some Times	8%	7%	5%	9%	5%	NA	NA
Allowed Anywhere	2%	2%	2%	<1%	<1%	NA	NA
No Rules Inside Home	9%	12%	10%	7%	5%	NA	NA
Nonsmokers/Nonvapers Exposed to Second-Hand Smoke/Vapor in Past 7 Days [HP2020 Goal Nonsmokers: 34%]	28%	16%	9%	10%	14%	NA	NA

	Washington					WI	US
Other Tobacco Products in Past Month	2008	2011	2014	2016	2019	2018	2018
Smokeless Tobacco [HP2020 Goal: 0.2%]	--	--	8%	5%	7%	4%	4%
Cigars, Cigarillos or Little Cigars	--	--	4%	6%	4%	NA	NA

	Washington					WI	US
Alcohol Use in Past Month	2008	2011	2014	2016	2019	2018	2018
Binge Drinker* [HP2020 Goal 5+ Drinks: 24%]	29%	33%	39%	34%	39%	26%	16%
Driver/Passenger When Driver Perhaps Had Too Much to Drink	3%	3%	3%	2%	5%	NA	NA

	Washington					WI	US
Household Problems Associated With…	2008	2011	2014	2016	2019	2018	2018
Alcohol	3%	1%	1%	2%	4%	NA	NA
Marijuana	--	2%	2%	<1%	2%	NA	NA
Cocaine, Meth or Other Street Drugs	--	--	--	--	<1%	NA	NA
Heroin or Other Opioids	--	--	--	--	<1%	NA	NA

	Washington					WI	US
Personal Safety Issue in Past Year	2008	2011	2014	2016	2019	2018	2018
Afraid for Their Safety	4%	4%	7%	2%	8%	NA	NA
Pushed, Kicked, Slapped, or Hit	3%	3%	2%	3%	4%	NA	NA
At Least One of the Safety Issues	7%	6%	8%	4%	11%	NA	NA

--Not asked. NA-WI and/or US data not available. [1]Wisconsin current vapers is 2017 data. [2]Midwest data.
*In 2008, binge drinking was defined as 5 or more drinks regardless of gender. Since 2011, binge drinking has been defined as 4 or more drinks for females and 5 or more drinks for males to account for metabolism differences.

	Washington					WI	US
Times of Distress in Past Three Years	2008	2011	2014	2016	2019	2018	2018
Times of Distress and Someone in HH Looked for Community Support	--	--	--	19%	19%	NA	NA
Of Respondents Who Looked for Support							
Felt Somewhat/Slightly or Not at All Supported	--	--	--	40%	52%	NA	NA

	Washington					WI	US
Mental Health Status	2008	2011	2014	2016	2019	2018	2018
Felt Sad, Blue or Depressed Always/Nearly Always (Past Month)	4%	3%	6%	5%	4%	NA	NA
Considered Suicide (Past Year)	3%	2%	4%	3%	8%	NA	NA
Find Meaning & Purpose in Daily Life Seldom/Never	5%	3%	2%	7%	6%	NA	NA

	Washington					WI	US
Children in Household	2008	2011	2014	2016	2019	2018	2018
Primary Health Care Doctor/Nurse Who Knows Child Well and Familiar with History	--	84%	99%	99%	90%	NA	NA
Visited Primary Doctor/Nurse for Preventive Care (Past Year)	--	82%	91%	91%	84%	NA	NA
Did Not Receive Care Needed (Past Year)							
Medical Care	--	<1%	<1%	2%	1%	NA	NA
Dental Care	--	7%	9%	5%	0%	NA	NA
Specialist	--	0%	2%	2%	1%	NA	NA
Current Asthma	--	6%	4%	10%	4%	NA	NA
Safe in Community/Neighborhood Seldom/Never	--	0%	0%	1%	2%	NA	NA
Children 5 to 17 Years Old*							
Fruit Intake (2+ Servings/Day)	--	71%	73%	82%	64%	NA	NA
Vegetable Intake (3+ Servings/Day)	--	21%	30%	39%	27%	NA	NA
5+ Fruit/Vegetables per Day	--	26%	38%	50%	28%	NA	NA
Physical Activity (60 Min./5 or More Days/Week)	--	63%	80%	61%	63%	NA	NA
Unhappy, Sad or Depressed Always/Nearly Always (Past 6 Months)	--	3%	2%	4%	6%	NA	NA
Experienced Some Form of Bullying (Past Year)	--	19%	32%	33%	19%	NA	NA
Verbally Bullied	--	18%	30%	30%	19%	NA	NA
Physically Bullied	--	9%	13%	3%	4%	NA	NA
Cyber Bullied	--	6%	0%	5%	9%	NA	NA

	Washington					WI	US
Top County Health Issues	2008	2011	2014	2016	2019	2018	2018
Illegal Drug Use	--	--	--	51%	51%	NA	NA
Alcohol Use or Abuse	--	--	--	22%	26%	NA	NA
Prescription or OTC Drug Abuse	--	--	--	9%	24%	NA	NA
Mental Health or Depression	--	--	--	8%	16%	NA	NA
Chronic Diseases	--	--	--	14%	15%	NA	NA
Overweight or Obesity	--	--	--	18%	15%	NA	NA
Access to Health Care	--	--	--	18%	15%	NA	NA
Tobacco Use	--	--	--	4%	11%	NA	NA
Violence or Crime	--	--	--	4%	6%	NA	NA
Cancer	--	--	--	12%	6%	NA	NA
Access to Affordable Healthy Food	--	--	--	5%	5%	NA	NA
Driving Problems/Aggressive Driving/Drunk Driving	--	--	--	5%	4%	NA	NA
Infectious Diseases	--	--	--	1%	4%	NA	NA

--Not asked. NA-WI and/or US data not available.
*In 2011, 2014 and 2016, the question was asked for children 8 to 17 years old.

General Health
In 2019, 52% of respondents reported their health as excellent or very good; 15% reported fair or poor. Respondents 65 and older, with a high school education or less, in the bottom 40 percent household income bracket, who were unmarried or inactive were more likely to report fair or poor health. *From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported their health as fair or poor, as well as from 2016 to 2019.*

Health Care Coverage
In 2019, 6% of respondents reported they were not currently covered by health care insurance; respondents who were 45 to 54 years old, in the middle 20 percent household income bracket or unmarried were more likely to report this. Ten percent of respondents reported they personally did not have health care insurance at least part of the time in the past year; respondents 35 to 54 years old or in the middle 20 percent household income bracket were more likely to report this. Eleven percent of respondents reported someone in their household was not covered at least part of the time in the past year; respondents in the middle 20 percent household income bracket were more likely to report this. *From 2008 to 2019, the overall percent statistically increased for respondents 18 and older or 18 to 64 years old who reported no current personal health care coverage while from 2016 to 2019, there was no statistical change. From 2008 to 2019, the overall percent statistically remained the same for respondents who reported no personal health care insurance at least part of the time in the past year, as well as from 2016 to 2019. From 2008 to 2019, the overall percent statistically remained the same for respondents who reported someone in the household was not covered at least part of the time in the past year, as well as from 2016 to 2019.*

In 2019, 15% of respondents reported they delayed or did not seek medical care because of a high deductible, high co-pay or because they did not have coverage for the care in the past year; respondents 18 to 34 years old or with a college education were more likely to report this. Seven percent of respondents reported that someone in their household had not taken their prescribed medication due to prescription costs in the past year; respondents who were in the bottom 40 percent household income bracket or married were more likely to report this. Seven percent of respondents reported there was a time in the past year someone in the household did not receive the medical care needed; respondents in the bottom 40 percent household income bracket were more likely to report this. Twelve percent of respondents reported there was a time in the past year someone in the household did not receive the dental care needed; respondents in the bottom 40 percent household income bracket were more likely to report this. Six percent of respondents reported there was a time in the past year someone did not receive the mental health care needed; respondents in the bottom 40 percent household income bracket were more likely to report this. *From 2011 to 2019, the overall percent statistically remained the same for respondents who reported in the past year they delayed or did not seek medical care because of a high deductible, high co-pay or because they did not have coverage for the medical care while from 2016 to 2019, there was a statistical decrease. From 2011 to 2019, the overall percent statistically decreased for respondents who reported someone in their household had not taken their prescribed medication due to prescription costs in the past year, as well as from 2016 to 2019. From 2011 to 2019, the overall percent statistically decreased for respondents who reported unmet medical care in the past year, as well as from 2016 to 2019. From 2011 to 2019, the overall percent statistically decreased for respondents who reported unmet dental care in the past year while from 2016 to 2019, there was no statistical change. From 2011 to 2019, the overall percent statistically increased for respondents who reported unmet mental health care in the past year while from 2016 to 2019, there was no statistical change.*

Health Care Information
In 2019, 47% of respondents reported they contact a doctor when looking for health information or clarification while 32% reported they look on the Internet. Eleven percent reported they were, or a family member was, in the health care field. Four percent reported family/friends while 3% reported other health professional. Respondents 65 and older were more likely to report they contact a doctor. Respondents who were male or 35 to 44 years old were more likely to report the Internet as their source for health information. Respondents 45 to 54 years old, with a college education or in the top 40 percent household income bracket were more likely to report themselves or a family member in the health care field. Respondents who were female, 18 to 34 years old or with a high school education or less were more likely to report family/friends. *From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported doctor as their source of health information/clarification, as well as from 2016 to 2019. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported the Internet or family/friends as their source of health information/clarification while from 2016 to 2019, there was a statistical increase. From 2011*

to 2019, there was a statistical increase in the overall percent of respondents who reported they were, or family member was in the health care field and their source of health information/clarification while from 2016 to 2019, there was no statistical change. From 2011 to 2019, there was a statistical decrease in the overall percent of respondents who reported other health professional as their source of health information/clarification while from 2016 to 2019, there was no statistical change.

Health Care Services

In 2019, 87% 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. Seventy-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 while 9% reported an urgent care center followed by 4% who reported hospital emergency room. Two percent reported public health clinic/community health center for health services. Respondents who were 65 and older or unmarried were more likely to report a doctor's or nurse practitioner's office as their primary health care when they are sick. Respondents 35 to 44 years old or with at least some post high school education were more likely to report an urgent care center as their primary health care. Forty-two percent of respondents had an advance care plan; respondents 65 and older were more likely to report an advance care plan. *From 2016 to 2019, there was no statistical change in the overall percent of respondents who reported they have a primary care physician. From 2008 to 2019, there was a statistical decrease in the overall percent of respondents who reported their primary place for health services when they are sick was a doctor's/nurse practitioner's office, as well as from 2016 to 2019. From 2008 to 2019, there was a statistical increase in the overall percent of respondents who reported their primary place for health services when they are sick was an urgent care center, as well as from 2016 to 2019. From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported their primary place for health services when they are sick was a hospital emergency room, as well as from 2016 to 2019. From 2008 to 2019, there was a statistical decrease in the overall percent of respondents who reported their primary place for health services when they are sick was a public health clinic/community health center while from 2016 to 2019, there was no statistical change. From 2008 to 2019, there was no statistical change in the overall percent of respondents with an advance care plan, as well as from 2016 to 2019.*

Routine Procedures

In 2019, 83% of respondents reported a routine medical checkup two years ago or less while 75% reported a cholesterol test four years ago or less. Seventy-four percent of respondents reported a visit to the dentist in the past year while 53% 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 unmarried respondents were more likely to report a routine checkup two years ago or less. Respondents 55 and older, with a college education, in the top 40 percent household income bracket or married respondents were more likely to report a cholesterol test four years ago or less. Respondents 45 to 54 years old, with a college education or in the top 40 percent household income bracket were more likely to report a dental checkup in the past year. Respondents who were female or 65 and older were more likely to report an eye exam in the past year. *From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported a routine checkup two years ago or less or a dental checkup in the past year, as well as from 2016 to 2019. From 2008 to 2019, there was a statistical decrease in the overall percent of respondents who reported a cholesterol test four years ago or less while from 2016 to 2019, there was no statistical change. From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported an eye exam in the past year while from 2016 to 2019, there was a statistical increase.*

Vaccinations

In 2019, 38% of respondents had a flu vaccination in the past year. Respondents 55 and older, with a college education, in the bottom 40 percent household income or in the top 40 percent household income bracket were more likely to report a flu vaccination. Seventy-nine percent of respondents 65 and older had a pneumonia vaccination in their lifetime. *From 2008 to 2019, there was no statistical change in the overall percent of respondents 18 and older who reported a flu vaccination in the past year while from 2016 to 2019, there was a statistical decrease. From 2008 to 2019, there was no statistical change in the overall percent of respondents 65 and older who reported a flu vaccination in the past year, as well as from 2016 to 2019. From 2008 to 2019, there was no statistical change in the overall percent of respondents 65 and older who had a pneumonia vaccination, as well as from 2016 to 2019.*

Tested for a Sexually Transmitted Infection
In 2019, 37% of respondents reported in their lifetime they had been tested for a sexually transmitted infection, including HIV, the virus that causes AIDS; respondents 35 to 44 years old were more likely to report this.

Health Conditions
In 2019, out of six health conditions listed, the most often mentioned in the past three years was high blood pressure (24%) or high blood cholesterol or a mental health condition (21% each). Respondents 65 and older, with a high school education or less, in the bottom 40 percent household income bracket or who were overweight were more likely to report high blood pressure. Respondents who were 55 to 64 years old, overweight or nonsmokers were more likely to report high blood cholesterol. Respondents who were female, with some post high school education or in the bottom 40 percent household income bracket were more likely to report a mental health condition. Eleven percent reported they were treated for, or told they had heart disease/condition in the past three years. Respondents who were male, 65 and older, with a high school education or less, in the bottom 40 percent household income bracket, who were overweight, inactive or nonsmokers were more likely to report heart disease/condition. Ten percent of respondents reported diabetes; respondents 55 to 64 years old were more likely to report this. Ten percent reported current asthma; respondents 18 to 34 years old, with a high school education or less or in the bottom 40 percent household income bracket were more likely to report current asthma. Of respondents who reported these health conditions, at least 90% reported the condition was controlled through medication, therapy or lifestyle changes. *From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported high blood pressure, high blood cholesterol, heart disease/condition, diabetes or current asthma, as well as from 2016 to 2019. From 2008 to 2019, there was a statistical increase in the overall percent of respondents who reported a mental health condition while from 2016 to 2019, there was no statistical change.*

Times of Distress
In 2019, 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 were more likely to report this. Fifty-two percent of respondents who looked for community resource support reported they felt somewhat, slightly or not at all supported. *From 2016 to 2019, there was no statistical change in the overall percent of respondents who reported someone in their household experienced times of distress in the past three years or they felt somewhat, slightly or not at all supported by the community resources.*

Mental Health Status
In 2019, 4% of respondents reported they always or nearly always felt sad, blue or depressed in the past month; respondents who were 18 to 34 years old, in the bottom 40 percent household income bracket or unmarried were more likely to report this. Eight percent of respondents felt so overwhelmed they considered suicide in the past year; respondents 18 to 34 years old or in the bottom 60 percent household income bracket were more likely to report this. Six percent of respondents reported they seldom or never find meaning and purpose in daily life; respondents 45 to 54 years old, with a high school education or less or in the middle 20 percent household income bracket were more likely to report this. *From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported they always or nearly always felt sad, blue or depressed in the past month or they seldom or never find meaning and purpose in daily life, as well as from 2016 to 2019. From 2008 to 2019, there was a statistical increase in the overall percent of respondents who reported they considered suicide in the past year, as well as from 2016 to 2019.*

Physical Health
In 2019, 41% of respondents did moderate physical activity five times a week for 30 minutes. Thirty-one percent of respondents did vigorous activity three times a week for 20 minutes. Combined, 49% met the recommended amount of physical activity; respondents who were not overweight were more likely to report this. *From 2008 to 2019, 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 2016 to 2019. From 2008 to 2019, 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 2016 to 2019. From 2008 to 2019, there was no statistical change in the overall percent of respondents who met the recommended amount of physical activity, as well as from 2016 to 2019.*

In 2019, 69% of respondents were classified as at least overweight while 36% were obese. Respondents who were male, 55 to 64 years old, with some post high school education, in the top 60 percent household income bracket or who did not meet the recommended amount of physical activity were more likely to be classified as at least overweight. Respondents who were male, 55 to 64 years old or did an insufficient amount of physical activity were more likely to be obese. *From 2008 to 2019, there was no statistical change in the overall percent of respondents who were at least overweight, as well as from 2016 to 2019. From 2008 to 2019, there was a statistical increase in the overall percent of respondents who were obese while from 2016 to 2019, there was no statistical change.*

Nutrition and Food Insecurity

In 2019, 61% of respondents reported two or more servings of fruit while 25% reported three or more servings of vegetables on an average day. Respondents who were female, with a college education or married respondents were more likely to report at least two servings of fruit. Respondents who were female, 35 to 44 years old, with a college education, who were married, not overweight or met the recommended amount of physical activity were more likely to report at least three servings of vegetables on an average day. Thirty-three percent of respondents reported five or more servings of fruit/vegetables on an average day; respondents who were female, 35 to 44 years old, with a college education, who were not overweight or met the recommended amount of physical activity were more likely to report this. Fifty-three percent of respondents reported when they buy a food product for the first time, they often read the food label or nutrition information; respondents 18 to 44 years old, with a college education, who were married or met the recommended amount of physical activity were more likely to report this. Four percent of respondents reported their household went hungry because they couldn't afford enough food in the past year; respondents in the bottom 40 percent household income bracket were more likely to report this. *From 2008 to 2019, there was no statistical change 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 2016 to 2019, there was a statistical decrease. From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported at least five servings of fruit/vegetables while from 2016 to 2019, there was a statistical decrease. From 2016 to 2019, there was no statistical change in the overall percent of respondents who reported when they buy a food product for the first time, they often read the food label or nutrition information. From 2016 to 2019, there was no statistical change in the overall percent of respondents who reported their household went hungry because they couldn't afford enough food in the past year.*

Women's Health

In 2019, 75% of female respondents 50 and older reported a mammogram within the past two years. Eighty-five percent of female respondents 65 and older had a bone density scan. Seventy-seven percent of female respondents 18 to 65 years old reported a pap smear within the past three years. Fifty-six percent of respondents 18 to 65 years old reported an HPV test within the past five years. Eighty-six 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 report a cervical cancer screen within the recommended time frame. *From 2008 to 2019, there was a statistical decrease in the overall percent of respondents 50 and older who reported a mammogram within the past two years while from 2016 to 2019, there was no statistical change. From 2008 to 2019, there was no statistical change in the overall percent of respondents 65 and older who reported a bone density scan, as well as from 2016 to 2019. From 2008 to 2019, there was a statistical decrease in the overall percent of respondents 18 to 65 years old who reported a pap smear within the past three years, as well as from 2016 to 2019. From 2014 to 2019, there was no statistical change in the overall percent of respondents 18 to 65 years old who reported an HPV test within the past five years, as well as from 2016 to 2019. From 2014 to 2019, there was a statistical decrease in the overall percent of respondents 18 to 65 years old who reported a cervical cancer screen within the recommended time frame while from 2016 to 2019, there was no statistical change.*

Colorectal Cancer Screening

In 2019, 13% of respondents 50 and older reported a blood stool test within the past year. Seven percent of respondents 50 and older reported a sigmoidoscopy within the past five years while 67% reported a colonoscopy within the past ten years. This results in 73% of respondents meeting the current colorectal cancer screening recommendations. *From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported a blood stool test within the past year, as well as from 2016 to 2019. From 2008 to 2019, there was a*

statistical decrease in the overall percent of respondents who reported a sigmoidoscopy within the past five years while from 2016 to 2019, there was no statistical change. From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported a colonoscopy within the past ten years, as well as from 2016 to 2019. From 2008 to 2019, 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 2016 to 2019.

Alcohol Use

In 2019, 39% of respondents were binge drinkers in the past month (females 4+ drinks and males 5+ drinks). Respondents who were male or 18 to 34 years old were more likely to have binged at least once in the past month. Five 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; respondents with at least some post high school education were more likely to report this. *From 2008 to 2019, there was a statistical increase in the overall percent of respondents who reported binge drinking in the past month while from 2016 to 2019, there was no statistical change. From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported in the past month they were a driver or passenger in a vehicle when the driver perhaps had too much to drink while from 2016 to 2019, there was a statistical increase.*

Tobacco Use

In 2019, 16% of respondents were current tobacco cigarette smokers; respondents 18 to 34 years old or 45 to 54 years old were more likely to be a smoker. Nine percent of respondents used electronic cigarettes in the past month. Respondents who were male, 18 to 34 years old, with some post high school education, in the bottom 40 percent household income bracket or unmarried respondents were more likely to use electronic cigarettes. Forty-four percent of current smokers or vapers quit for one day or longer because they were trying to quit in the past year. Sixty-five percent of current smokers/vapers who saw a health professional in the past year reported the professional advised them to quit smoking or vaping. *From 2008 to 2019, there was no statistical change in the overall percent of respondents who were current tobacco cigarette smokers, as well as from 2016 to 2019. From 2014 to 2019, there was a statistical increase in the overall percent of respondents who reported electronic vapor product use in the past month while from 2016 to 2019, there was no statistical change. From 2008 to 2019, there was a statistical decrease in the overall percent of current tobacco cigarette smokers or electronic vapor product users who quit smoking or vaping for at least one day in the past year because they were trying to quit while from 2016 to 2019, there was no statistical change. From 2008 to 2019, there was no statistical change in the overall percent of current smokers or vapers who reported in the past year their health professional advised them to quit smoking or vaping, as well as from 2016 to 2019. Please note: in 2019, the tobacco cessation and health professional advised quitting questions included current vapers. In previous years, both questions were asked of current smokers only.*

In 2019, 90% of respondents reported smoking is not allowed anywhere inside the home. Respondents who were in the middle 20 percent household income bracket or in households with children were more likely to report smoking is not allowed anywhere inside the home. Fourteen percent of nonsmoking or nonvaping respondents reported they were exposed to second-hand smoke or vapor in the past seven days; respondents who were male, 18 to 34 years old or with some post high school education or less were more likely to report this. *From 2008 to 2019, there was a statistical increase in the overall percent of respondents who reported smoking is not allowed anywhere inside the home, as well as from 2016 to 2019. From 2008 to 2019, there was a statistical decrease in the overall percent of nonsmoking or nonvaping respondents who reported they were exposed to second-hand smoke or vapor in the past seven days while from 2016 to 2019, there was no statistical change. Please note: in 2019, the second-hand smoke exposure question included vaping exposure.*

In 2019, 7% of respondents used smokeless tobacco in the past month while 4% of respondents used cigars, cigarillos or little cigars. Respondents who were male, 18 to 44 years old, with some post high school education or in the middle 20 percent household income bracket were more likely to report smokeless tobacco use. Married respondents were more likely to report they used cigars, cigarillos or little cigars. *From 2014 to 2019, there was no statistical change in the overall percent of respondents who used smokeless tobacco or used cigars/cigarillos/little cigars in the past month, as well as from 2016 to 2019.*

Household Problems

In 2019, 4% 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; married respondents were more likely to report this. Two percent of respondents reported someone in their household experienced some kind of problem with marijuana. Less than one percent of respondents each reported a household problem in connection with cocaine/meth/other street drugs or heroin/other opioids. *From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported a household problem in connection with drinking alcohol in the past year, as well as from 2016 to 2019. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported a household problem with marijuana in the past year, as well as from 2016 to 2019.*

Personal Safety

In 2019, 8% of respondents reported someone made them afraid for their personal safety in the past year; respondents 18 to 34 years old or in the middle 20 percent household income bracket were more likely to report this. Four percent of respondents reported they had been pushed, kicked, slapped or hit in the past year; respondents 35 to 44 years old, with some post high school education or in the middle 20 percent household income bracket were more likely to report this. A total of 11% reported at least one of these two situations; respondents 35 to 44 years old, with some post high school education or in the middle 20 percent household income bracket were more likely to report this. *From 2008 to 2019, there was a statistical increase in the overall percent of respondents who reported they were afraid for their personal safety in the past year, as well as from 2016 to 2019. From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported they were pushed/kicked/slapped/hit in the past year, as well as from 2016 to 2019. From 2008 to 2019, there was no statistical change in the overall percent of respondents who reported at least one of the two personal safety issues in the past year while from 2016 to 2019, there was a statistical increase.*

Children in Household

In 2019, the respondent was asked if they make health care decisions for children living in the household. If yes, they were asked a series of questions about the health and behavior of a randomly selected child. Ninety percent of respondents reported they have one or more persons they think of as their child's primary doctor or nurse, with 84% reporting their child visited their primary doctor or nurse for preventive care during the past year. One percent of respondents each reported in the past year their child did not receive the medical care needed or their child did not visit a specialist they needed while 0% reported their child did not receive the dental care needed. Four percent of respondents reported their child currently had asthma. Two percent of respondents reported their child was seldom/never safe in their community. Sixty-four percent of respondents reported their 5 to 17 year old child ate at least two servings of fruit on an average day while 27% reported three or more servings of vegetables. Twenty-eight percent of respondents reported their child ate five or more servings of fruit/vegetables on an average day. Sixty-three percent of respondents reported their 5 to 17 year old child was physically active for 60 minutes five times a week. Six percent of respondents reported their 5 to 17 year old child always or nearly always felt unhappy, sad or depressed in the past six months. Nineteen percent reported their 5 to 17 year old child experienced some form of bullying in the past year; 19% reported verbal bullying, 9% cyber bullying and 4% reported physical bullying. *From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported their child had a primary doctor or nurse, while from 2016 to 2019, there was a statistical decrease. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported their child visited their primary doctor/nurse in the past year for preventive care, as well as from 2016 to 2019. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported in the past year their child had an unmet medical care need or was unable to see a specialist when needed, as well as from 2016 to 2019. From 2011 to 2019, there was a statistical decrease in the overall percent of respondents who reported in the past year their child had an unmet dental care need, as well as from 2016 to 2019. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported their child currently had asthma, as well as from 2016 to 2019. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported their child was seldom/never safe in their community, as well as from 2016 to 2019. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported on an average day their 5 to 17 year old child ate at least two servings of fruit, ate at least three servings of vegetables or met the recommendation of at least five servings of fruit/vegetables while from 2016 to 2019, there was a statistical decrease. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported their 5 to 17 year old child was physically active for at least 60 minutes*

five times a week, as well as from 2016 to 2019. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported in the past six months their 5 to 17 year old child always or nearly always felt unhappy/sad/depressed, as well as from 2016 to 2019. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported in the past year their child was bullied overall while from 2016 to 2019, there was a statistical decrease. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported in the past year their child was verbally bullied while from 2016 to 2019, there was a statistical decrease. From 2011 to 2019, there was no statistical change in the overall percent of respondents who reported in the past year their child was cyber bullied or physically bullied, as well as from 2016 to 2019.

Top County Health Issues

In 2019, respondents were asked to list the top three health issues in the county. The most often cited were illegal drug use (51%), alcohol use/abuse (26%) or prescription/over-the-counter drug abuse (24%). Respondents who were male, 45 to 54 years old, with some post high school education, in the top 60 percent household income bracket or married respondents were more likely to report illegal drug use as a top health issue. Respondents 45 to 54 years old or with a college education were more likely to report alcohol use or abuse. Respondents with a college education or in the top 40 percent household income bracket were more likely to report prescription or over-the-counter drug abuse. Sixteen percent of respondents reported mental health/depression; respondents 45 to 54 years old were more likely to report this. Fifteen percent of respondents reported chronic diseases as a top issue; respondents with a high school education or less were more likely to report this. Fifteen percent of respondents reported overweight or obesity; respondents who were male or in the top 40 percent household income bracket were more likely to report this. Fifteen percent of respondents were more likely to report access to health care; respondents who were female or married were more likely to report this. Eleven percent reported tobacco use as a top issue; respondents 35 to 44 years old or with a high school education or less were more likely to report this. Six percent of respondents reported violence or crime; respondents 18 to 34 years old or in the middle 20 percent household income bracket were more likely to report this. Six percent of respondents reported cancer as a top issue; respondents 65 and older were more likely to report this. Five percent of respondents reported access to affordable healthy food; respondents in the bottom 40 percent household income bracket were more likely to report this. Four percent of respondents reported driving problems/aggressive driving/drunk driving; respondents 18 to 34 years old, with some post high school education or in the middle 20 percent household income bracket were more likely to report this. Four percent of respondents reported infectious diseases as a top issue. *From 2016 to 2019, there was no statistical change in the overall percent of respondents who reported illegal drug use, alcohol use/abuse, chronic diseases, overweight/obesity, access to health care, violence/crime, access to affordable healthy food or driving problems/aggressive driving/driving drunk as one of the top health issues in the county. From 2016 to 2019, there was a statistical increase in the overall percent of respondents who reported prescription/over-the-counter drug abuse, mental health/depression, tobacco use or infectious diseases as one of the top health issues in the county. From 2016 to 2019, there was a statistical decrease in the overall percent of respondents who reported cancer as one of the top health issues in the county.*

Appendix D: 2019 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 prioirties for Washington County, were identified in 2019 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 Survey conducted through a partnership between the Washington Ozaukee Public Health Department, Aurora Health Care, Children's Hospital of Wisconsin, and Froedtert & the Medical College of Wisconsin. The Community Health Needs Assessment incorporates input from persons representing the broad interests of the community served, and from those who possess special knowledge of or expertise in public health.

Key informants in Washington County were identified by the Washington Ozaukee Public Health Department, Aurora Health Care, Children's Hospital of Wisconsin, and Froedtert & the Medical College of Wisconsin. These organizations also invited the informants to participate and conducted the interviews from June to September 2019. 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 and challenges to addressing the issue
    - Additional strategies needed
    - Key groups in the community that hospitals should partner with to improve community health
    - Identification of subgroups or subpopulations where efforts could be targeted
    - Ways efforts can be targeted toward each subgroup or subpopulation

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. Based on the summaries provided to the Center for Urban Population Health, this report presents the results of the 2019 key informant interviews for Washington County.

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 describes the themes that presented themselves across the top ranked health topics. Finally, summaries of the strategies, barriers, partners, and potential targeted subpopulations described by participants are provided as well.

Limitations: Twenty-two key informant interviews were conducted with 23 respondents in Washington County. One interview incorporated the views of two people from the organization. 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., community health survey and secondary data reports).

In 22 interviews, a total of 23 key informants were asked to rank up to 5 of the major health-related issues in their county from a list of 15 focus areas identified in the State Health Plan. Key informants were also able to write in other health issue areas if they believed it was a top health issue for the county. (See

Appendix A for the full list of informants). 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. Importantly, not every informant ranked five issues and not every informant provided rankings within their top selections. In interviews with more than one participant, only one set of rankings was provided. The five health issues ranked most consistently as top five health issues for the County were:

1. Mental Health
2. Substance Use & Abuse
3. Access to Health Care
4. Alcohol Abuse
5. Physical Activity

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

Mental Health

Twenty-one out of 22 key informants' interview rankings included Mental Health as a top five health issue, with 13 key informants ranking Mental Health as the number one health issue overall. Many key informants noted that services are available for those who have insurance and resources but are lacking for others. Key informants also emphasized that mental health is a widespread issue that affects all populations within the community.

Existing Strategies: The strategies identified varied by type of organization. Key informants affiliated with the education system or with youth generally mentioned onsite counselors, federal grants, Kettle Moraine Counseling, faculty being trained in mental health and trauma-informed care, a behavioral health intervention team on campus, increased awareness about mental health, safety/security measures, programs within schools instead of external programs, Community Support Coalition, and a program called "Think Well." Law enforcement mentioned a partnership with Acute Care Services, Crisis Intervention Team (CIT) training, and on-going training and learning regarding mental health. Service providers mentioned the existence of a senior center to bring potentially lonely people together, increased awareness, Kettle Moraine Counseling services, county programs, the Cultivate Movement which aims to increase access to and knowledge of services, more community conversations about mental health, the National Alliance on Mental Illness (NAMI), more newly funded mental health programs than in the previous five years, services for the chronically mentally ill, general community commitment and desire to improve mental health, programs within schools, decreasing stigma, treatment being available to people with insurance and motivation, primary care screening for mental illness, schools identifying needs earlier, some bilingual mental health resources, Washington County Walk-In Services (mental health screening and assessment), Albrecht Free Clinic vouchers, and Affiliated Clinical Services. Key informants from the business community mentioned non-profit partnerships, Albrecht Free Clinic, Froedtert and Medical College of Wisconsin St. Joseph's Hospital Health Community Fund which invests in non-profit mental health programs, employers being aware of the issue and looking to hire mental health professionals, and MRA (an employer association focused on human resources) working on opiate and trauma-informed care for human resources leaders in Southeastern Wisconsin. Others in the business community suggested that not much is being done, or that many are interested in helping, but efforts are uncoordinated.

Barriers and Challenges: Again, responses varied by organization type. Key informants affiliated with schools and the education system identified barriers and challenges such as lack of directed services, the need for service dollars, access for youth, health insurance availability and cost, lack of social workers, a perceived decrease in services from the county, lack of mental health professionals, long wait times for appointments, teachers in need of more resources, technology and social media, mental health issues interfering with teaching and learning, stigma, and transportation. Law enforcement mentioned that jail is not always the most appropriate place for a person to be but that there aren't necessarily resources

available for people, that mental health issues can drive people to substance abuse or other risky behaviors, and that not a lot of people have access to medical resources without a court order. Service providers mentioned challenges identifying those in the community who are in need of help, transportation, stigma, funding, the need for agencies to communicate and partner with one another, insurance and financial barriers, lack of providers and waiting periods, the 72 hour hold is not long enough, it's hard for people to find the right treatment, varying prescribing patterns between providers, a disconnect between mental health and how law enforcement interacts with the community, accessibility, reimbursement for clinicians, lack of case management, the system being more reactive than proactive, personal attitudes and lack of motivation, lack of resources for older adults/geri-psych, culture and beliefs in some communities, work schedules do not allow for treatment, lack of bilingual counselors, and lack of knowledge about mental health resources. Key informants in the business community mentioned many similar barriers and challenges, including stigma, access issues due to a lack of providers and financial barriers, not enough programs, and not enough coordination among programs. They also mentioned some issues unique to the business community, including workplace disincentives, workplace stigma and concerns about opening up to employers, mental health and addiction often co-occurring, lack of resources in small- and medium-sized employers, and workplace culture.

Needed Strategies: Educators suggested strategies such as increased funding for dealing with mental health, more agency support, increased awareness, increased education on addiction, more locations that offer mental health programs, and more programs that accept low-income/ uninsured/underinsured families. Law enforcement suggested an expanded relationship with Affiliated Clinical Services, increased funding, more mental health professionals assisting and collaborating with law enforcement (including outside of normal business hours), more education on existing community resources, and better care coordination. Service providers suggested partnering with community churches and hospitals/clinics to identify people in need, working on prevention strategies, targeting youth, training for sports coaches, positive communication, continuation of education and awareness, increased mental health screenings, education on medication, proactive approaches, collaboration among agencies, more evidence-based programming, better coordination with Well Washington, increasing Crisis Intervention Training for law enforcement, more education for providers who do not specialize in mental health, shifting from reactive to proactive care, increasing access for patients without insurance, focusing efforts on underlying issues of mental health, more policy around the state, incentivizing providers to move to rural areas, more appropriate resources for the elderly at skilled nursing facilities and assisted living facilities, and more bilingual counselors. In the business community, suggestions included removing stigma, implementing prevention programs, improving reimbursement for services, outreach for human resources leaders and business owners, making stakeholders aware of referral networks, working with chambers of commerce, the media, and/or social media to disseminate information, looking at root causes such as adverse childhood experiences, increasing awareness, increasing autonomy for human resources, working with companies such as MRA, decreasing the cost of accessing mental health services, and integrating programs into the workforce.

Key Community Partners to Improve Health: Key groups in the community were identified, including: County health services, United Way, employers, the Society for Human Resource Management, employer associations, chambers of commerce, health systems, the health department, law enforcement, churches and faith-based organizations, NAMI, community groups and non-profits, social workers, schools, Elevate, Life of Hope, libraries, economic development councils, MRA, Washington County government, state government, mental health agencies, juvenile justice system, County Human Services, Boys and Girls Clubs, Girls Y Group, Affiliated Clinical Services, Aging and Disability Resource Center, Kettle Moraine Counseling, Rogers, Youth and Family Project programs, Journeys program, Think Well, Community Support Coalition, youth groups, free clinics, West Bend Counseling LLC, MOWA (art therapy), and psychology organizations and groups.

Subgroups/populations where efforts could be targeted and how efforts can be targeted: Populations who could be targeted include youth, including low-income youth and youth with a history of adverse childhood experiences, who could be reached through curricular interventions in schools, summer

programming, or libraries, peer support programs, education for parents on identifying mental health issues, and services to navigate health systems. One informant suggested that targeting youth could prevent more serious problems as children get older. Seniors, including low-income seniors, could be targeting through local community agencies and by reaching out to their adult children on how to care for their parents. Unemployed or laid-off individuals could be helped by the Workforce Development County Offices. Employers could be targeted to work with their employees through a human resources group made up of employers or by chambers of commerce "lunch n learn" groups. People of color would benefit from culturally competent providers, while the Hispanic/Latino community specifically could be reached by Casa Guadalupe and would benefit from more bilingual resources and more bilingual providers. One informant suggested that both youth and seniors would benefit from education on normal socialization and health. Another informant noted that youth, the aging population, and low-income and middle-income groups would all benefit from data-informed/evidence-based programming with more effort to get at root causes. Other populations identified as needing special attention include people in the county jail, uninsured/underinsured populations, and people with more mild-to-moderate mental health needs. Several informants noted that all groups and populations in the community would benefit from mental health resources.

Substance Use & Abuse

Fifteen informants included Substance Use and Abuse in their top health issues, with four ranking it as the number one health issue affecting the county. Key informants noted that this issue affects the entire community.

Existing Strategies: As with mental health, different strategies were identified by representatives of different types of organizations. Informants affiliated with the education system mentioned municipal and school policies, groups centered around non-use, strong health curriculum in schools, students engaged in the school lifestyle by participating in sports and clubs, DARE in the elementary schools, Too Good for Drugs curriculum, community non-profits offering free programs for individuals and families, community events, training programs for professionals, school board conversations, and non-profits working to reduce stigma. Law enforcement identified the new drug court in Washington County, various drug programming within the jails, strong enforcement, and the DARE program. Community organization service providers mentioned education in schools, referral programs to support groups, NAMI support groups, Elevate's programming, coalitions that have been formed, cross-sector involvement, community awareness and involvement, having the right people coming to the table, work with the criminal justice system (e.g. Treatment and Diversion (TAD) grant), the OWI diversion program, increased medication-assisted treatment in the jail, work on an official drug court for 2020, awareness and education initiatives, the Heroin Task Force, the PDMP database for prescribers, and available counseling services. Representatives from the business community identified services through Casa Guadalupe, the Albrecht Free Clinic, the Community Health Navigator program through Froedtert Health, and drug court and the TAD program.

Barriers and Challenges: Representatives from education noted that barriers and challenges include a general misunderstanding of the dangers involved in using substances, stigma, transportation, cost of services, increased prescription use, and challenging home lives of children. Law enforcement noted that there are not enough resources, there is stigma, crimes are caused because of addiction, people are released from jail without continual support or access, and there is a lack of data collection. Service providers discussed a lack of treatment programs, co-morbidities of addiction, wait times for treatment, the cost of treatment and other financial barriers, the high rate of addiction/use in the community, the proximity of Washington County to high drug-use areas such as Chicago and Milwaukee, growing acceptance of marijuana use, a need for more data, lack of coordination among systems of care, lack of funding, confusing regulations around medication-assisted treatment, high rates of relapse, lack of support and mentorship for those in recovery, the magnitude of the problem making it difficult to address, children being displaced by family substance abuse issues, some people don't want to help, challenges reaching patients before they end up in jail, and stigma. Representatives from the business community

identified access to mental health services, access for pain management, time and cost of services, insurance issues, access to prescription opioids, lack of training for employers on how to handle situations involving substance use, workplace stigma, lack of resources within the workplace, workplace culture, and challenges finding qualified workers who can pass drug tests.
Needed Strategies: Numerous strategies were suggested to address substance use and abuse. Informants from the education field mentioned additional parent education, having a strong health curriculum, having school policies around use, helping families build strong relationships where conversations can be open and supportive, more school involvement, helping families cope with stress, increasing teacher knowledge of available resources, normalizing conversations that are necessary for people to talk about how they feel, educating providers, and removing stigma. Law enforcement suggested increasing resources, more/easier access to inpatient services, continued education, and ongoing support for people who are incarcerated or who present to emergency departments for substance abuse. Service providers suggested drug courts, alcohol courts, viewing the problem through a trauma-informed lens, SCRAM bracelets which continuously monitor alcohol in the system, more data for evaluation, more funding, increased awareness, programming to delay first use, improved coordination and collaboration, prevention of vaping, consistency around policies for treatment of addiction, initiatives around safe driving for OWI, focusing not only on those who use but also on their families since they are also at risk, care coordinators in clinics, referral programs, school and community outreach programs, peer support, and education programs for parents and students. Business community representatives called for case management, increased reimbursement for providers, engaging workplaces as a source of prevention, increased funding and other resources, addressing stigma, focusing on prevention, more human resources training, companies being open to offering second chances for those with a failed drug test, employer education for substance abuse at work, policies at the state level including strict OWI responses, county-level response with education in schools, and the medical field being involved at the legislative level.
Key Community Partners to Improve Health: Key partners in the community were identified, including Washington County and municipalities, Elevate, private sector businesses, Hartford Area Development Corporation, health providers, insurers, Centers for Medicare and Medicaid Services, law enforcement, Acute Care Services, District Attorney's Office, Health Department, community support networks such as Alcoholics Anonymous, NAMI, Life of Hope, Human Services, UW-Extension, clergy, schools, Medical Examiner's Office, first responders, jails/prisons, employers, chambers of commerce, Heroin Task Force, school counselors, Kettle Moraine Counseling, child protective services, probation/parole, Head Start, Albrecht Free Clinic, senior centers, and shelters.
Subgroups/populations where efforts could be targeted and how efforts can be targeted: Several different subgroups were identified with different ideas about how to target them. Medium- or low-skilled workers could be targeted through manufacturers; Farm families could be targeted by working with agriculture professionals and UW-Extension educators; Adolescents could be targeted by working with schools and educating parents; People who are incarcerated could be reached by working with jail administrators and the Department of Corrections; Child care providers could be encouraged to train in Mental Health First Aid or other programs; 45-55 age group could be reached with evidence-based programming; Underinsured and uninsured individuals could be reached through a mixture of policy, insurance, and health systems.

Access to Health Care
Eight key informants ranked Access to Health Care as a top health priority for the county. Many focused on transportation and finances as key barriers to access in Washington County.
Existing Strategies: Existing strategies to address access to health care mentioned by respondents include: volunteers providing rides to appointments, free clinics and federally qualified health centers, collaborations among organizations, Interfaith Caregivers of Washington County, West Bend Taxi, Impact 211, Family Promise (coordinated entry for the homeless), health systems, and Albrecht Free Clinic.

Barriers and Challenges: Barriers and challenges to healthcare access include lack of transportation, long wait times for appointments, uninsured populations, lack of funding and resources, limited services, lack of driver's licenses, Internet access, duplication of services, access for the Medicaid population, lack of community health campaigns (e.g. well child, immunizations, etc.), and the mindset of the community and state.
Needed Strategies: Informants suggested several strategies to address issues with access, including a dedicated van for the senior center with funding for maintenance and insurance, funding for Interfaith Caregivers of Washington County so they can resume their ride services, parent education, lifestyle and culture change, patient education about the importance of primary care, increasing awareness of existing resources, funding or grants for lower cost services, destigmatizing mental health, vouchers for transportation, increasing utilization of 211, increasing referral efficiency, increase local campaigns around health, making coalitions more robust, and involving the government and medical community.
Key Community Partners to Improve Health: Key partners include Interfaith Caregivers of Washington County, schools, healthcare systems, the Public Health Department, client-based services, Head Start, Judicial Court System, probation, youth treatment centers, Washington County, libraries, organizations that refurbish old electronics to increase computer access, Impact 211, law enforcement, Aging and Disability Resource Center, senior living facilities, Albrecht Free Clinic, cities/municipalities, non-profit community, County Human Services, county nurses, experts on community campaigns, and partners in the medical profession.
Subgroups/populations where efforts could be targeted and how efforts can be targeted: Several subgroups were identified, including: low-income seniors who could be helped by funding for non-profit transportation services; the working poor who could be reached by non-profit organizations and Human Services; youth; people who do not drive; and the Hispanic population.

Alcohol Abuse
Seven informants' rankings included Alcohol Abuse as a top health issue for the county. Several were not aware of existing strategies and do not believe enough is currently being done to address this issue.
Existing Strategies: Current strategies to address alcohol abuse in the community were identified by key informants, including OWI enforcement, staffed drug recognition experts in the Sheriff's Department, underage drinking enforcement, the Every 15 Minutes program, the DARE program, school health curricula, involving peers in prevention, parent chats at schools, Taking Care of You program, drug court and the Treatment and Diversion (TAD) program, awareness in the community, and Elevate's focus on prevention.
Barriers and Challenges: Several barriers and challenges to addressing alcohol abuse were named. These include a drinking culture, issues with the justice system, overcrowded jails lacking resources, lack of access to treatment and services, lack of access to sober activities or programs, parents modeling drinking behaviors, the Tavern League lobby, loose DUI/OWI laws, easy access to alcohol, stigma, parents allowing youth to drink, lack of funding, culture and beliefs, education for the bilingual population, and challenges in the workforce, particularly in manufacturing and construction.
Key Community Partners to Improve Health: Informants identified key partners in the community, such as law enforcement, Acute Care Services, health systems, the Health Department, Alcoholics Anonymous, Elevate, Human Services, Rogers, Affiliated Clinical Services, Aging and Disability Resource Center, Washington County, Life of Hope, and NAMI.
Subgroups/populations where efforts could be targeted and how efforts can be targeted: Several respondents discussed a focus on youth, suggested they could be reached by early education including programs such as Every 15 Minutes and Strengthen Families, by education and supports for parents, and by limiting alcohol at functions intended for youth, such as parents drinking at softball games. Other subgroups mentioned include seniors, the Hispanic/Latino community who could be reached with education including education on binge drinking, the uninsured, and rural residents.

Physical Activity
Physical Activity was ranked as a top health issue by seven key informants. In their comments, many key informants also discussed nutrition, access to healthy foods and obesity more generally.
Existing Strategies: Some existing strategies identified by key informants include Washington County offering many free or low-cost opportunities to be physically active, including many youth opportunities, public trails and access to biking, a strong YMCA, the School Lunch Program, the Harvest of the Month program, and business incentives and workplace gyms. Informants also identified strategies employed by their specific organizations, such as a school district prioritizing physical education and recess and school employees focusing on wellness; a senior center offering low-cost fitness activities and no membership fee, a Strong People Initiative in partnership with the YMCA, and Reiki massage; a technical college promoting a Health & Wellness Campus Program, an Employee Health & Wellness Program, offerings from student government such as disc golf, and corporate challenges; and an education and social services organization tying physical activity into their programming, including Zumba, yoga, and dance classes, a Family Wellness Program, a Living Healthy with Diabetes Program, a Living Well with Chronic Conditions Program, and a Prevention of Chronic Conditions Program.
Barriers and Challenges: Informants named several barriers and challenges to engaging people in adequate physical activity, including the reliance of youth and adults on electronic devices, lack of family activity time, finding affordable instructors for fitness classes, funding, transportation, lack of time, schools phasing out physical activity, unorganized play no longer being a priority for youth, the cost of gyms, classes, or clubs, culture, work commutes being too long for walking or biking, social media, television, video games, lack of education about benefits of exercise, and language barriers.
Needed Strategies: Identified strategies to address these barriers and challenges include education in schools on the impact of sedentary lifestyles, expanding low-cost and no-cost physical activity programs and classes, transportation options, incorporating physical activity and play into everyday life, having workout facilities and classes available at workplaces, increasing outreach and education on chronic disease, promotion of trails and parks, and making activity fun, especially for youth.
Key Community Partners to Improve Health: Informants named key community partners, including the YMCA, health systems, fitness centers, Moraine Park/nursing programs, community hospital dieticians and nutritional services, the Parks and Recreation Department, Boys and Girls Clubs, schools, daycares, large employers, the Senior Center, and legislators, the County Board, and the Common Council.
Subgroups/populations where efforts could be targeted and how efforts can be targeted: The two subgroups mentioned most often were youth and seniors. Informants suggested that youth could be reached by partnering with youth-serving organizations, offering programming in schools, and providing education for parents. Seniors could be reached by increasing efforts to identify people who may benefit from outreach and educating hospital social workers on the services available. Other respondents suggested that all groups would benefit from increased physical activity and could be reached by emphasizing physical activity at doctors' appointments and by having human resources departments leading efforts in the workplace.

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

Aging and Disability Resource Center of Washington County- Provides information, assistance, and access to services and community resources for seniors and adults with disabilities
Albrecht Free Clinic- Free medical and dental clinic for uninsured
Casa Guadalupe Education Center, Inc- Nonprofit serving Latinx community
Cedar Community- A senior living facility
Ecomonic Development Washington County- Provides support for the creation of quality jobs and economic prosperity in Washington County
Elevate Inc. – Nonprofit providing prevention, intervention and recovery support around substance abuse and mental health
Extension Washington County- Designs educational programs focused on agriculture, community development, human development & relationships, nutrition education, 4-H youth development, and positive youth development
Family Center of Washington County- Nonprofit that provides programs for parents, youth and families
FRIENDS Inc. – Nonprofit providing services and resources for individuals affected by domestic and sexual violence
Germantown School District- Provides services for youth and participates in the Youth Risk Behavioral Survey
Hartford Area Chamber of Commerce- Supports local businesses
Hartford Area Development Corporation- Nonprofit dedicated to economic development and growth in the Hartford area
Kettle Moraine YMCA- Nonprofit providing services that help people improve their health and well-being
Moraine Park Technical College- Higher education institute
Senior Citizens Activities, Inc- Provides programs and activities for seniors to socialize
Slinger School District- Provides services for youth and participates in the Youth Risk Behavioral Survey
United Way of Washington County- Nonprofit that engages, convenes and mobilizes community resources to address community health needs
Washington County Human Services Department- Provides community programs to individuals and families challenged by disability, economic hardship and safety concerns
Washington County Medical Examiners Office- Responsible for investigating deaths in Washington County
Washington County Sheriff's Department- Law enforcement agency
Washington Ozaukee Workforce Development Board- Provides support for local business and economic growth
West Bend Area Chamber- Nonprofit supporting local businesses in Washington County

Appendix F: 2019 Washington County Health Needs Assessment: A Summary of Secondary Data Sources

In 2019, the Center for Urban Population Health was enlisted to create a report detailing the health of Washington County using secondary data. This health data report is one piece of a variety of data sources being used by local health systems to describe their communities and the health priorities of their service areas. Indicators for which primary data are being collected were excluded from this report. In addition, rather than repurposing data from the comprehensive county rankings report created by the University of Wisconsin Population Health Institute (2019), the county level data from the rankings report is included in its entirety at the end of this report.

All of the data used in this report come from publicly available data sources. Data for each indicator were presented by race and ethnicity and gender when the data were available. Race data categorized as 'unknown' or 'missing' were rarely included in this report. Therefore, not allraces are represented in the data that follow.

In some cases data were not presented by the system from which they were pulled due to their internal confidentiality policies which specify that data will not be released when the number is less than five. In other cases, data were available but the rates or percentages are not presented in this report. This is due to the indicator having small numbers in the numerator or denominator resulting in rates or percentages that were subject to large year to year fluctuations and, as such, would not have provided a meaningful representation of the data for the population subset.

When applicable, Healthy People 2020 objectives are provided for each indicator. These objectives were 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 2018-2020 Froedtert West Bend Hospital CHNA Implementation Strategy

Identified Need	Program	Actions	Outcomes
Access to Care and Navigation	Albrecht Free Clinic	• Continue referral process for uninsured/underinsured populations from Froedtert West Bend Hospital to Albrecht Free Clinic • Serve on Board of Directors • Provide vouchers for ancillary/specialty care services for AFC patients • Screen uninsured patients for financial assistance programs (Marketplace, BadgerCare etc) including Froedtert Health's Financial Assistance Program	• Over 4,000 medical patient visits • Over 200 patient referrals for specialty consultation • Over 3,000 dental visits • Over 400 lab tests performed at no cost to Albrecht Free Clinic patients • Over 300 radiology procedures performed at no cost to patients • Over 300 hours donated by Froedtert & the Medical College of Wisconsin Community Physicians to care for patients in the Albrecht Free Clinic
Chronic Disease Prevention & Management	Community Health Navigator Model in Partnership with Albrecht Free Clinic and Casa Guadalupe Education Center	• 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	• Over 2,000 individuals served through Community Health Navigators • Over 1,000 referrals • Over 2,000 individuals screened for chronic disease and behavioral health • Over 500 individuals participated in chronic disease programming • Over 500 individuals participated in general health education programs
Chronic Disease Prevention and Management – Cancer	Cancer Care Navigation, Awareness, Prevention and Screenings – Kraemer Cancer Center	• 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.)	• Over 100 participants in cancer related community education classes • Over 100 individuals impacted by the Oncology Social Woker/Navigation • Over 1,000 individuals participated in healing yoga, walking clubs and dance therapy • 50 individuals have been screened for caner related diseases with 11 referrals • 94 individuals participated in LIVESTRONG
Chronic Disease Prevention and Management	Evidence Based Community Education and Wellness Classes	• 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	• Over 20 community education classes offered • Over 200 community education class participants • Over 100 individuals participated in chronic disease prevention classes at Casa Guadalupe Education Center

		populations and connect to a medical home	• Over 600 support group participants • Over 40 Living Well with Chronic Disease participants
Mental Health/Alcohol and Other Drug Abuse	Partnership – Think Well Washington County, Behavioral Health/AODA Task Force in Washington County	• Communities build a foundation that supports a culture where individuals seek answers, get diagnosed and receive the support and services they need around mental health. • Expansion of peer support networks in Washington County for individuals and families living or impacted by mental illness or addiction. • Increase funding for mental health initiatives through local, county and state funding and private and non-private.	• Supported the implementation of Cultivate Wellness in Our Parks, Crisis Intervention Training, WISE Basic Training and Change Direction Campaign • Over 1,000 individuals impacted by Hidden in Plain Sight • Over 100 students trained for Peer 4 Peers • Over 200 participated in Narcan trainings • Over 2,000 students impacted by Impact 4 Life • 10 individuals participated in ED to Recovery
Identified Community Health Needs in Washington County	Froedtert West Bend Hospital Healthy Community Fund (Annual Grant Program)	• 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 HCF funding • Promotion and awareness of impact of funding with Washington County residents and partners	• $725,435 were awareded to Washington County non-profits • Over 5,000 individuals were impacted by funded non-profits