



Ascension Wisconsin  
Milwaukee County Hospital Campuses  
**Community Health Needs Assessment**

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2019-2022

This community health needs assessment report encompasses the results for the following Ascension Wisconsin hospital campuses:

- Ascension Columbia St. Mary's Hospital Milwaukee
- Ascension St. Francis Hospital
- Ascension SE Wisconsin Hospital - Franklin Campus
- Ascension SE Wisconsin Hospital - St. Joseph Campus
- Sacred Heart Rehabilitation Hospital

## Community Health Needs Assessment for Ascension SE Wisconsin Milwaukee County Hospitals

### An assessment of Milwaukee County

In 2016, Columbia St. Mary's and Wheaton Franciscan Healthcare were brought together as part of Ascension. For the purposes of this document, we will be using the current names of the hospitals and campuses, several of which now incorporate the Ascension brand.

In Milwaukee County, Wisconsin, Ascension Wisconsin operates, owns or has a joint venture relationship with seven hospitals. Ascension Wisconsin owns and operates Ascension Columbia St. Mary's Hospital Milwaukee, Ascension St. Francis Hospital, Ascension SE Wisconsin Hospital - Franklin Campus, Ascension SE Wisconsin Hospital - St. Joseph Campus, and Ascension Sacred Heart Rehabilitation Hospital. Additionally, the Orthopaedic Hospital of Wisconsin, LLC, is a joint venture between Columbia St Mary's, Inc. and Orthopaedic Group Joint Venture, LLC, and Midwest Orthopedic Specialty Hospital, LLC, is a joint venture between Wheaton Franciscan Healthcare - Southeast Wisconsin, Inc. and TS Ortho, LLC.<sup>1</sup> The community health needs assessment (CHNA) was conducted collaboratively on behalf of these seven hospitals in 2018 and focused on the needs of individuals in Milwaukee County.

This community health needs assessment report encompasses the results for:

- Ascension Columbia St. Mary's Hospital Milwaukee
- Ascension St. Francis Hospital
- Ascension SE Wisconsin Hospital - Franklin Campus
- Ascension SE Wisconsin Hospital - St. Joseph Campus
- Sacred Heart Rehabilitation Hospital

MOSH and OHOW each have their own, individual CHNA report. These may be found on their respective websites.

Based on this CHNA process, the hospitals will focus on the following priority health needs in 2019-2022:

- Access to Care (all campuses)
- Chronic Disease Prevention (all campuses)
- Infant Mortality (Ascension Columbia St. Mary's, Ascension St. Francis, and Ascension St. Joseph campuses)
- Mental Health (Ascension Columbia St. Mary's, Ascension Franklin, Ascension St. Francis, and Ascension St. Joseph campuses)

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<sup>1</sup>As noted in the approval language on page 20, this is a revised version of the Ascension SE Wisconsin Milwaukee County Hospitals CHNA. The second paragraph on this page was revised to reflect the correct legal names for each of the facilities included.

**Who We Are**

Ascension Wisconsin ([ascension.org/wisconsin](https://ascension.org/wisconsin)) operates 24 hospital campuses, more than 100 related healthcare facilities and employs more than 1,300 primary and specialty care clinicians from Racine to Eagle River. Serving Wisconsin since 1848, Ascension is a faith-based healthcare organization committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. As one of the leading non-profit and Catholic health systems in the U.S., Ascension operates 2,600 sites of care – including 151 hospitals and more than 50 senior living facilities – in 21 states and the District of Columbia.

Our Mission as a Catholic healthcare system: Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable.

Our Catholic health ministry is dedicated to spiritually-centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.

Ascension is continuing the long and valued tradition of addressing the health of the people in our community, following in the footsteps of legacy Wheaton Franciscan Healthcare and legacy Columbia St. Mary's. This flows directly from our Catholic Identity. In addition to the community health improvement efforts guided by our CHNA process, we contribute to other needs through our broader community benefit program.

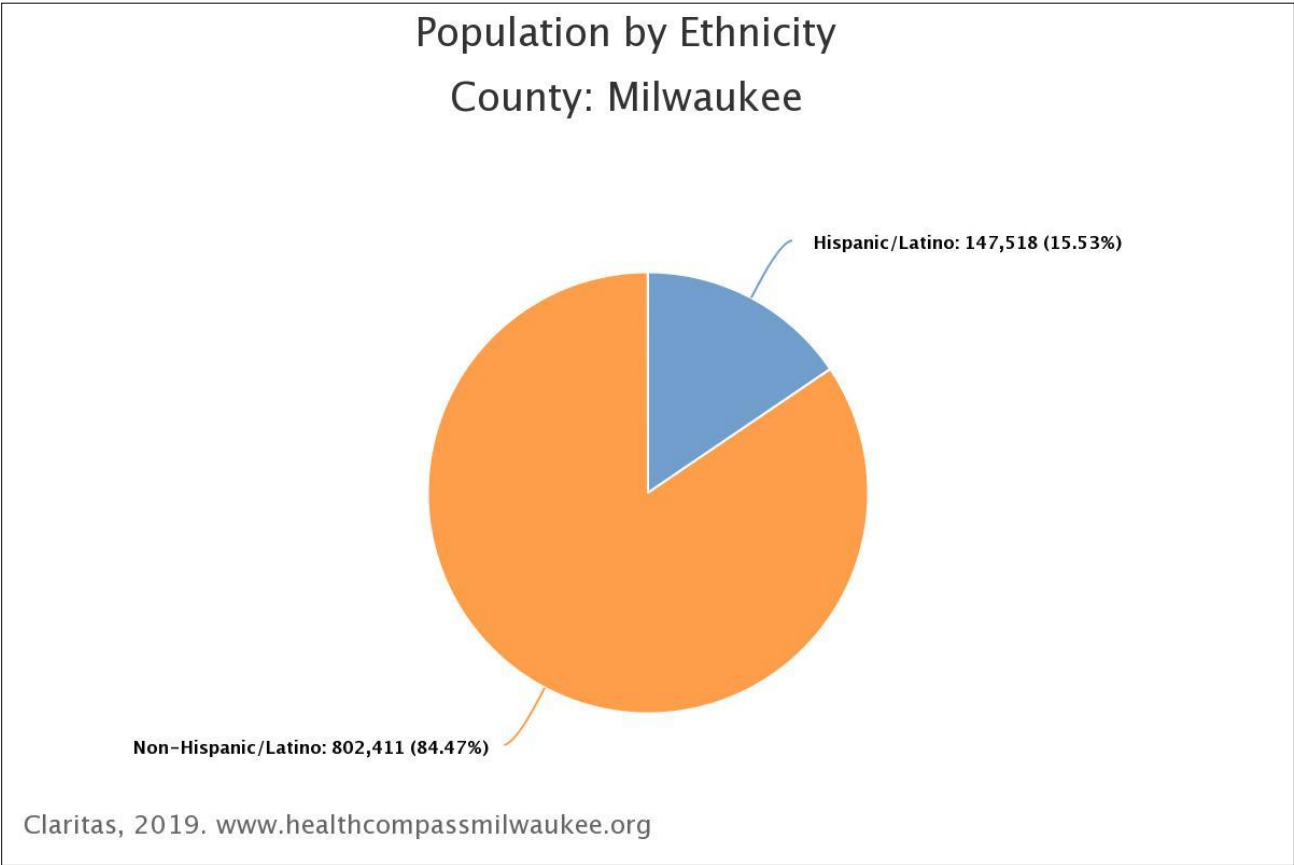
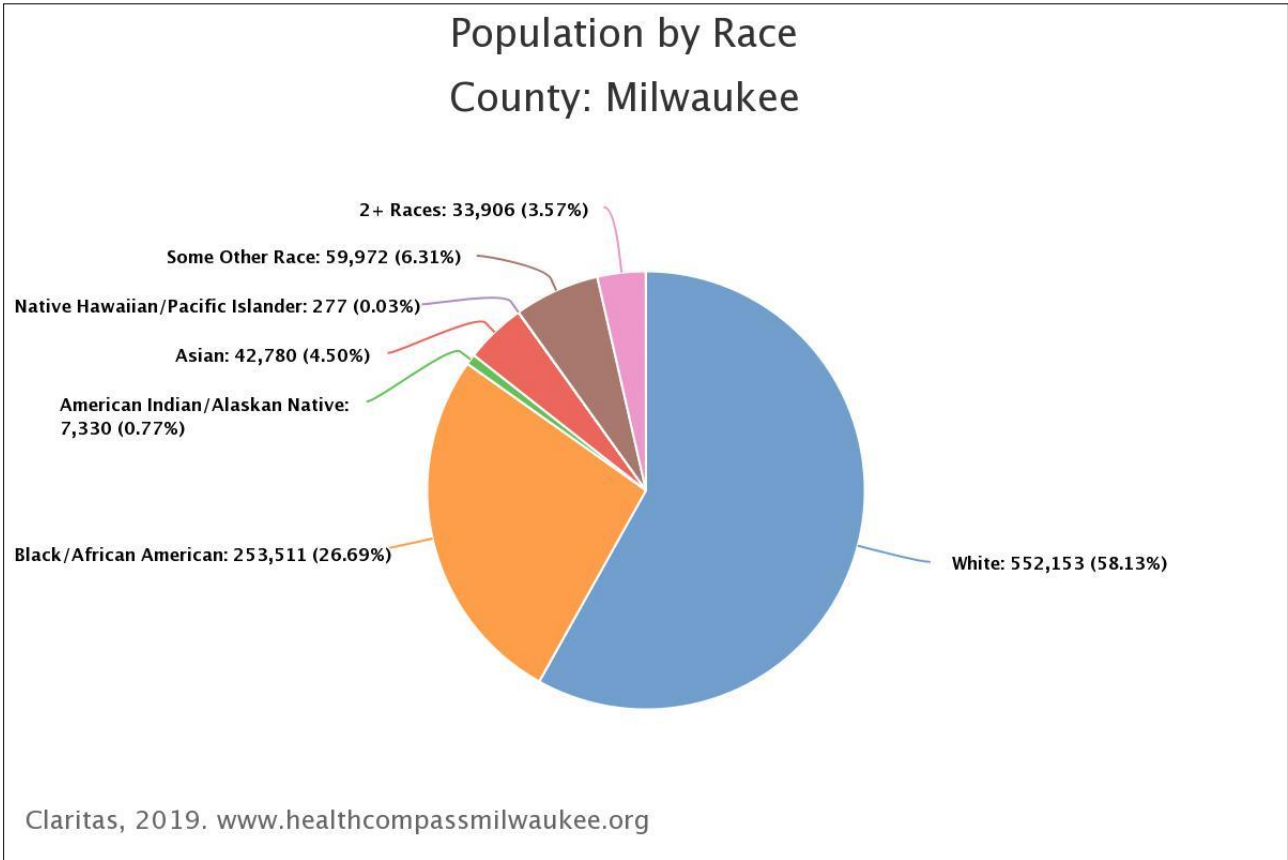
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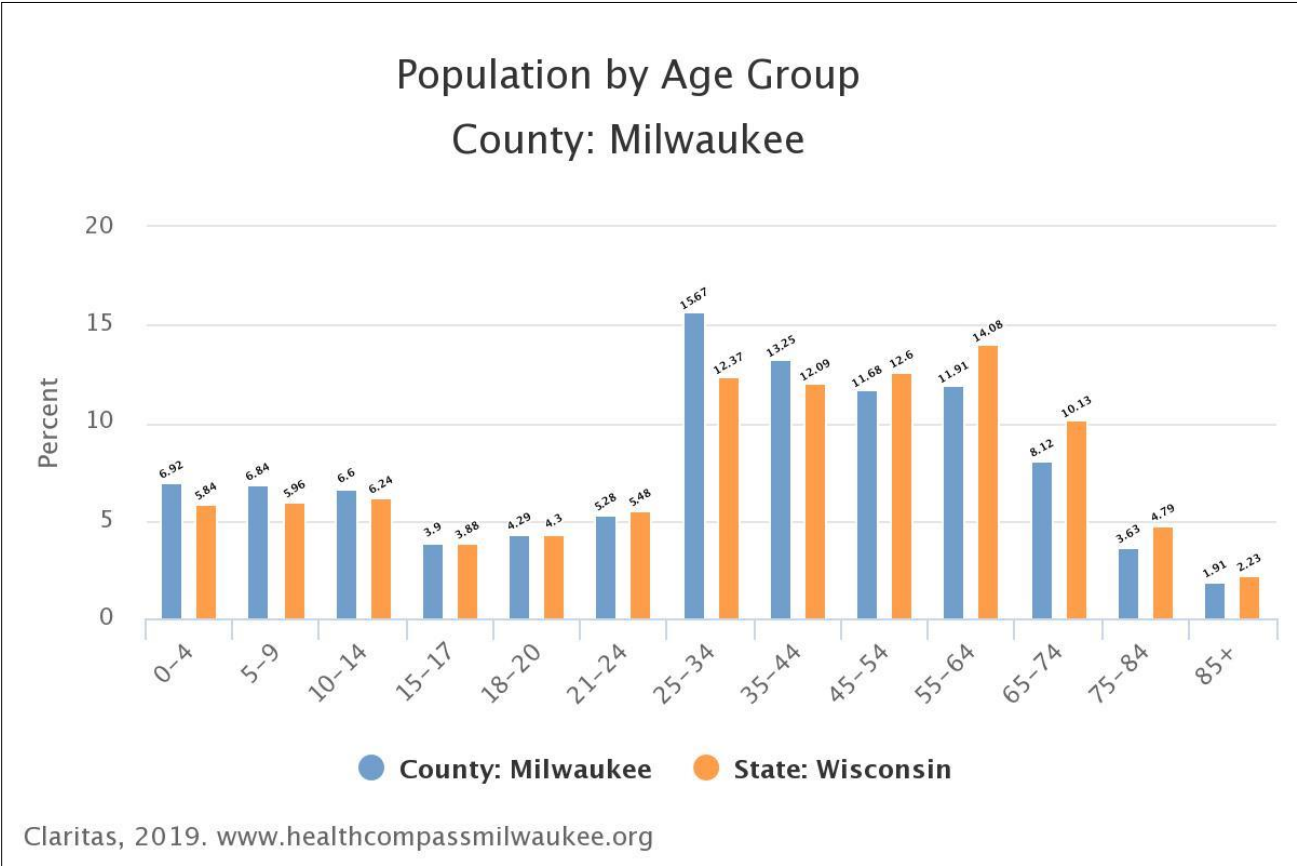
**Our Community**

For the purposes of the CHNA, the Ascension Wisconsin hospitals listed above focused on the needs of Milwaukee County. Our “community served” was defined as such because (a) most community health data is available at the county level; (b) many of our assessment partners define their service area at the county level; (c) most of our service area is in Milwaukee County; (d) many of our service lines span multiple campuses within Milwaukee County.

**Demographic Profile of Milwaukee County**

The following data is from [Health Compass Milwaukee](#), which is sponsored by the health system members of the Milwaukee Health Care Partnership (MHCP), including Ascension Wisconsin, Advocate Aurora Health, Children's Hospital of Wisconsin and Froedtert and Medical College of Wisconsin.

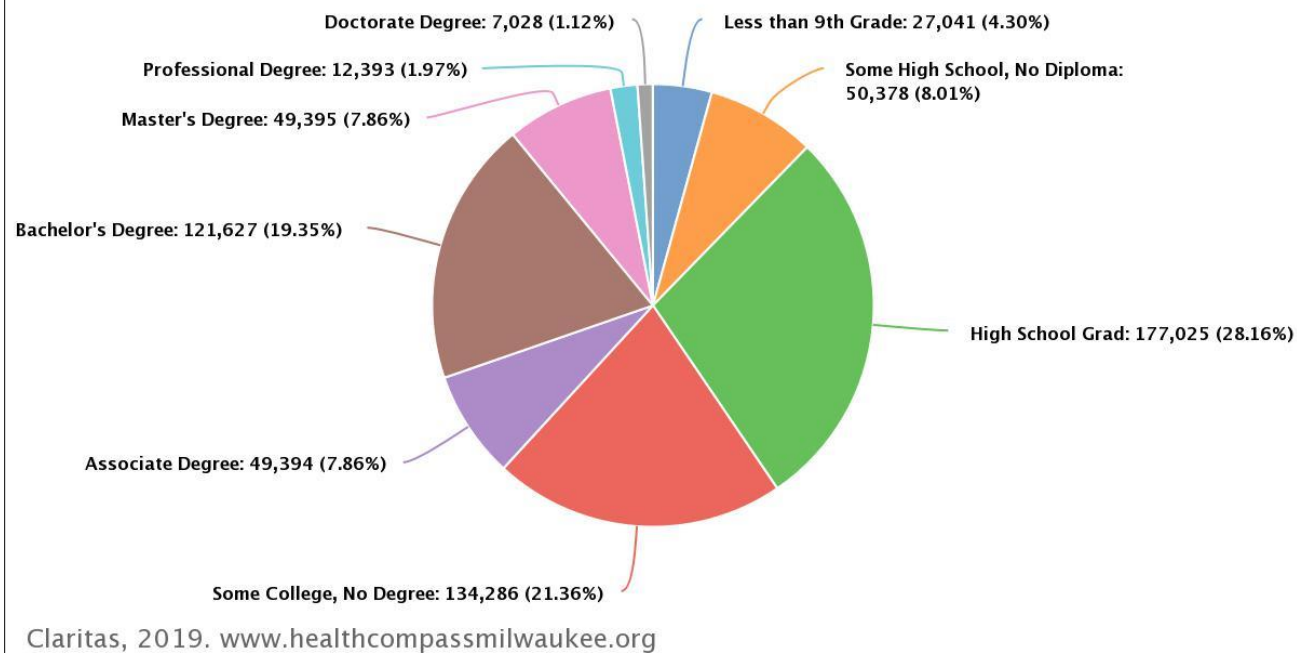




Population Age 5+ by Language Spoken at Home	County: Milwaukee		State: Wisconsin	
	Persons	% of Population Age 5+	Persons	% of Population Age 5+
Speak Only English	737,700	83.67%	4,983,305	91.33%
Speak Spanish	91,195	10.34%	253,061	4.64%
Speak Asian/Pac Islander Lang	22,417	2.54%	96,794	1.77%
Speak Indo-European Lang	22,414	2.54%	105,120	1.93%
Speak Other Lang	7,986	0.91%	18,321	0.34%

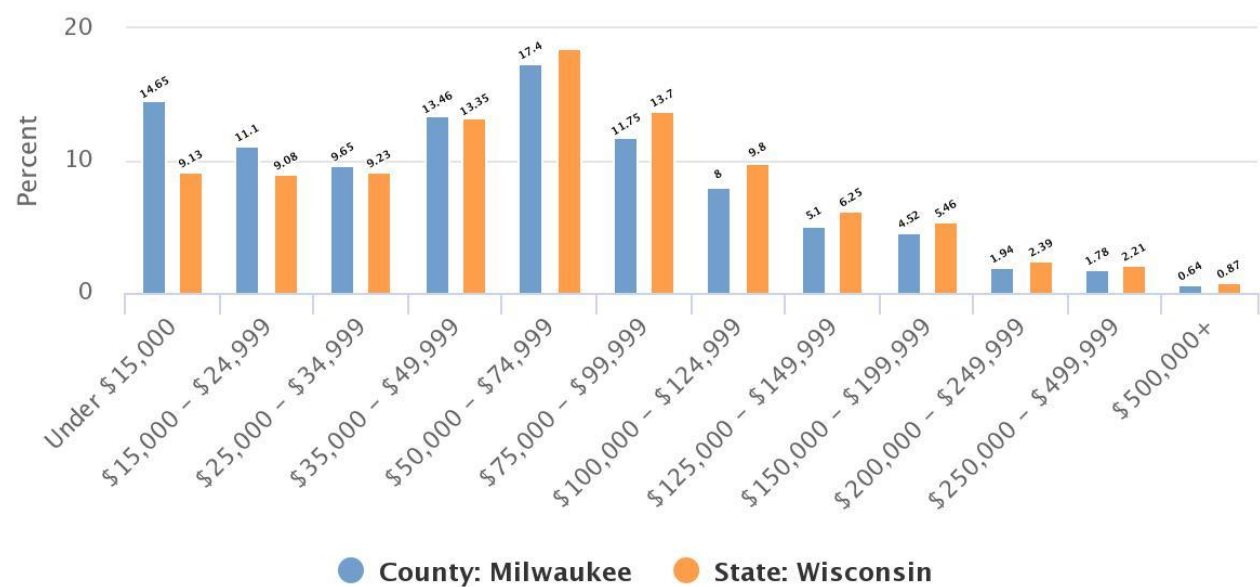
## Population 25+ by Educational Attainment

### County: Milwaukee



## Households by Income

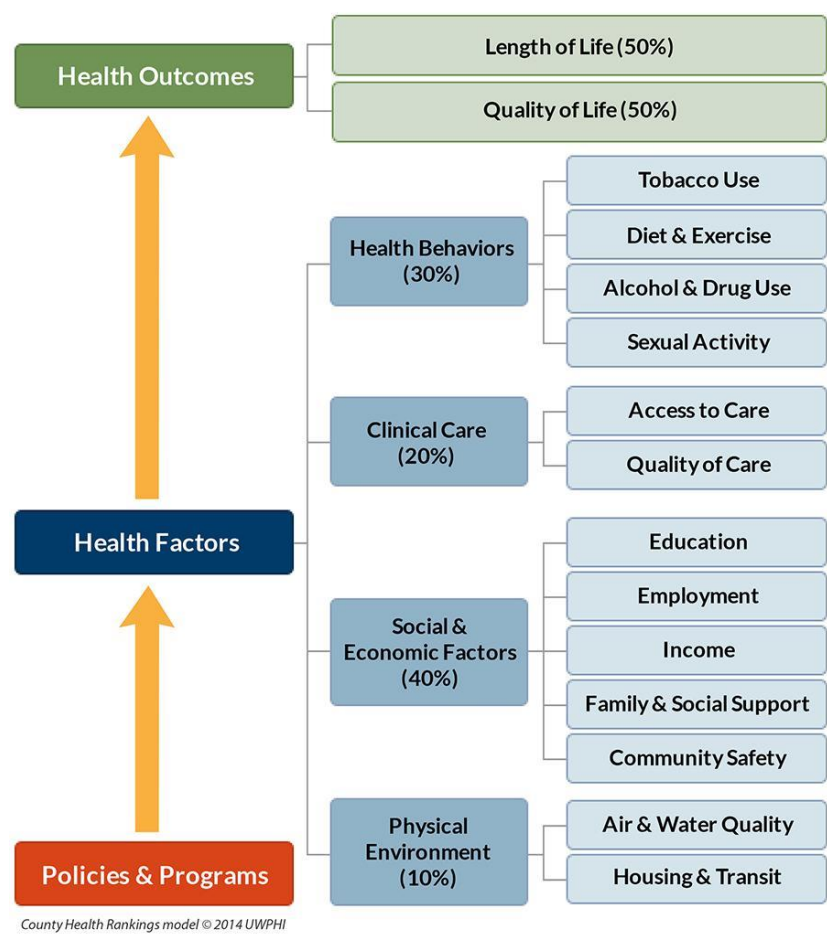
### County: Milwaukee



Claritas, 2019. [www.healthcompassmilwaukee.org](http://www.healthcompassmilwaukee.org)

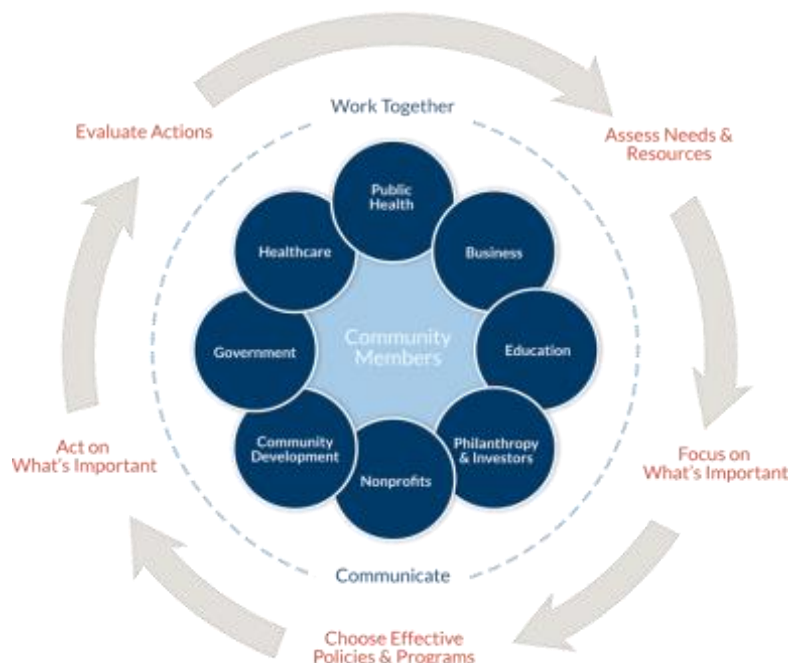
Our Community Health Improvement Approach

Ascension Wisconsin is committed to using national best practices in conducting the CHNA and implementing community health improvement strategies to assure that our work has a positive, measurable impact on the health of the people in the communities we serve. Our approach relies on the model developed by the County Health Rankings and Roadmaps and the Robert Wood Johnson Foundation, utilizing the determinants of health model as the model for community health improvement.





In addition, we utilize the *Wisconsin Guidebook on Improving the Health of Local Communities*, developed with funding from the University of Wisconsin School of Medicine and Public Health from the Wisconsin Partnership Program. This guidebook builds on the County Health Rankings and Roadmaps' Action Center.



Based on these resources, our community health improvement strategy rests on the following principles to make our communities a healthy place to live, learn, work and play:

- Work collaboratively to effectively address health issues
- Pay attention to the forces that shape health outcomes, including social and economic determinants
- Focus efforts on populations with a disparate health burden to increase health equity
- Emphasize the powerful impact of policy and system-based approaches on change
- Use strategies with the best evidence of effectiveness
- Identify and track specific, measurable performance indicators

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## Framework and Data Sources

Our community health needs assessment is conducted in collaboration with other health systems using a coordinated approach and standard model led by the Milwaukee Health Care Partnership. Partners in Milwaukee County included Ascension Wisconsin, Advocate Aurora Health, Children's Hospital of Wisconsin and Froedtert and Medical College of Wisconsin.

To assess the health needs of Milwaukee County, the MHCP took the following steps:

- **Community Health Survey:** A telephone survey of 1,312 residents was conducted by JKV Research, LLC, between February 20 and May 12, 2018. The survey included questions about personal/family health and the respondent's perception of top health needs in the community.
- **Secondary Data:** Community health data was compiled from a variety of public sources that are maintained by Conduent Healthy Communities Institute or the Center for Urban Population Health (CUPH) and can be found at [Milwaukee Health Compass](#).
- **Key Informant Interviews:** Interviews were conducted by members of the MHCP in Milwaukee County with key stakeholders in Milwaukee County. (Note: Those interviewed included the local health department and representatives of organizations that serve medically underserved, low-income and minority populations.) See Appendices for more information.

Full reports including purpose, methodology, data sources and contact information for consultants and partners can be found here:

[Key Informant Report](#)

[Milwaukee Health Compass](#)

[Community Health Survey Report](#)

Additional Community Input:

- **Community Conversations:** Ascension Wisconsin also conducted several community conversations to solicit additional input on community health from area residents. (See description below.)

## Voice of the Community

Ascension Wisconsin is committed to addressing community health needs collaboratively with local partners. Ascension Wisconsin used the following methods to listen to community members' thoughts on the strengths and challenges of being a healthy community. These methods provided us with additional perspectives on how to select and address top health issues facing our communities.

### Input from Community Members

Key informants:

The list of key informants in Milwaukee County was developed by the assessment partners. These partners also invited the key informants to participate and conducted the interviews in April and June 2018. The interview script 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
- 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
  - How efforts can be targeted toward each subgroup or subpopulation

Community Conversations:

Ascension Wisconsin hosted five community conversations in January 2019 to listen to the community's answers to the following question: *"What do we need to work on together to improve the health of our community?"* Interactive, small group discussions were facilitated around these follow-up questions:

1. What does a healthy community look like?
2. To create a healthy community, what needs to change?
3. What would you expect to see in the next year to show we are heading in the right direction?

After each question, the table host for each group reported a summary of their group's conversation. Detailed notes were taken during the report-out and any notes taken by the table host or written by community members were gathered and compiled into a summary document. In addition, a graphic artist captured the conversation visually, creating a mural that tells a story representing the ideas shared in the report-out. Community members were given the opportunity to identify their top three priorities by voting on the mural with stickers. The entirety of the input, as well as the results of the voting, were taken into consideration in the prioritization process.

See full report in the Appendices.

### Input from Members of Medically Underserved, Low-income and Minority Populations and/or Organizations that Represent those Populations

Ascension Wisconsin is fueled by a commitment to human dignity, the common good, justice and solidarity. We believe the CHNA process must be informed by direct input from persons who experience health disparities based on income and/or race and ethnicity. With that in mind, Ascension Wisconsin took the following steps:

- **Community Survey:** Whenever the number of survey respondents was sufficient to allow for it, the data was reported by specific population groups including gender, age, household income level, education and marital status.
- **Key Informant Interviews:** The interviews of key informants included input from members of organizations representing medically underserved, low-income and minority populations.

As part of the process to select the health priorities, strong consideration was given to how individuals who are more vulnerable are impacted by the health issues. (See prioritization criteria below.)

### Summary of the Voice of the Community

Key Informant Interviews (Top five public health issues (from list in State Health Plan))	Community Phone Survey (Top three community health issues)	Ascension Wisconsin Community Conversations (Top three priorities to create a healthy community)
Mental health (79%) Access to healthcare (62%) Violence (46%) Substance use (31%) Nutrition and healthy food (26%) Chronic disease (18%)	Chronic disease (34%) Substance use (27%) Access to healthcare (20%) Infectious disease (17%) Violence (16%) Mental health (15%) Overweight/obesity (15%) Nutrition and healthy food (6%)	Mental health (25) Ascension St. Joseph is an anchor in the community (15) Ascension St. Joseph invests in the community (14) Ascension St. Joseph provides comprehensive services (11) Youth services (8) Culturally congruent care (7) Follow-up phone calls from providers (7) Communication between partners (6) Diversity outreach (5) Ascension St. Francis is information center (5) Healthcare navigators (5) Coordinated resources (4) Opportunities for employment (4) Share positive stories (4) Action plan developed by Ascension Wisconsin and community (4) Community safety (3)

### Input on the Previous CHNA

No written comments were received regarding the previous CHNA.

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## Priorities for Action

### Prioritization Process and Criteria

The Milwaukee Market Community Health Improvement Process (CHIP) team reviewed all the data described above and a summary of the top needs identified within each assessment source. In a meeting on January 29, 2019, the team participated in a facilitated decision-making process and based on a set of criteria listed below, made a recommendation for the health priorities. That recommendation was presented to the hospital leadership teams at its February 18, 2019, meeting for final approval.

#### Prioritization Criteria:

1. Scope of problem (burden, scope, severity, urgency)
2. Needs of residents who experience health disparities based on income and/or race and ethnicity
3. Feasibility (expertise, resources, available interventions)
4. Momentum/commitment
5. Alignment with current internal and external priorities

### Priorities Selected

The following health issues were selected as the priorities:

- Access to Care (all campuses)
- Chronic Disease Prevention (all campuses)
- Infant Mortality (Ascension Columbia St. Mary's, Ascension St. Francis, and Ascension St. Joseph campuses)
- Mental Health (Ascension Columbia St. Mary's, Ascension Franklin, Ascension St. Francis, and Ascension St. Joseph campuses)

### Health Needs Not Selected for this Plan

Ascension Wisconsin understands the importance of all the health needs of the community and is committed to playing an active role in improving the health of the people in the communities we serve. For the purposes of this CHNA, we have chosen to focus our efforts on the priorities listed above.

The following health needs were not selected to be included in this plan for the reasons described below.

- Alcohol and Substance Use: This health issue will be incorporated into the mental health priority, with at least one alcohol and drug use strategy to be implemented. We will also continue to provide screening, counseling and follow-up care to address alcohol and drug use. We are committed to maintaining these services while remaining open to any emerging needs or opportunities in these areas.
- Violence: Although this health priority is not included in the plan, Ascension Wisconsin will continue to work with MHCP to implement the Health Care Sector Priorities as part of the City of Milwaukee Violence Prevention Plan.
- Sexually Transmitted Infections: There are strong community organizations that are working to address this health concern. Although not a part of our plan, Ascension Wisconsin will continue to provide screening, counseling and follow-up care, as needed.

The following health needs were not selected by Sacred Heart Rehabilitation Hospital for the reasons described below.

- Infant Mortality: Sacred Heart Rehabilitation Hospital does not provide Obstetric or Gynecological services.
- Mental Health: Although Sacred Heart Rehabilitation provides mental health services for the patients that they service, they do not have the capacity to address mental health concerns at the community level.

The following health needs were not selected by Ascension Franklin for the reasons described below.

- Infant Mortality: Although infant mortality is a significant health concern in Milwaukee County, the infant mortality rate in Franklin, WI from 2014-2016 was 4.2 which is lower than City of Milwaukee rate of 9.1 during the same time period. The rate of infant mortality in Franklin, WI is well below the national Healthy People 2020 goal of 6.0. Additionally, Ascension Franklin does not provide Obstetric or Gynecological services.

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## Overview of Priorities

A description of each priority area, data highlights and relevant assets/resources are on the following pages.

## Access to Care

### Why it is Important

There are many aspects to having access to care. Coverage (having health insurance) is essential but does not ensure access to care. It is also necessary to have:

- Comprehensive coverage, including preventive services
- Providers who accept the individual's insurance
- Relatively close geographic location of providers to patients
- Services from a familiar and ongoing source

Having a familiar and ongoing source of primary care is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that the patient will receive appropriate care

And can lead to:

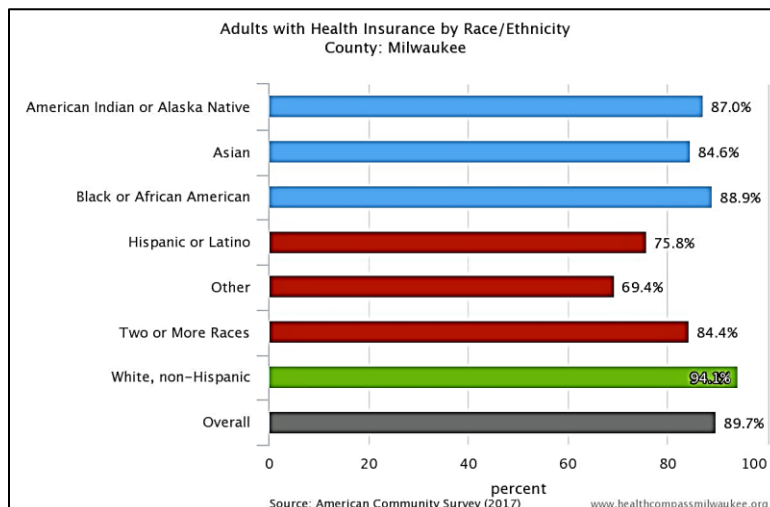
- Better health outcomes
- Fewer health disparities
- Lower healthcare costs

Additional barriers to care that may need to be addressed include:

- Transportation to the provider's office
- Long waits to get an appointment
- Lack of knowledge about the importance of preventive care
- Low health literacy

Access to healthcare impacts:

- Overall physical, social and mental health status
- Prevention of disease and disability
- Detection and early treatment of health conditions
- Quality of life
- Preventable death
- Life expectancy



### Data Highlights

From Milwaukee County Community Health Survey:

- Fifteen percent of respondents reported they had unmet dental healthcare needs in the past year
- Twelve percent of respondents reported a prescription drug was not taken due to cost
- Eighteen percent of respondents reported they receive their primary health services in urgent care

### Local Assets and Resources:

Key informants listed many organizations and services, such as school nurses and free and community clinics. Additional resources include:

- Milwaukee Health Care Partnership's focus on access to care and specialty care
- Efforts with Federally Qualified Health Centers and the City of Milwaukee Health Department to address barriers with navigating various systems
- Efforts to decrease use of emergency departments for primary care
- Milwaukee Enrollment Network's work to increase enrollment rates with the uninsured
- 2-1-1 Wisconsin for real-time services
- Mental Health Taskforce's dedication to increasing access to mental health services

## Chronic Disease Prevention

### Why it is Important

Chronic diseases include heart disease, stroke, cancer, diabetes and asthma. They are very costly, but effective management can prevent more serious complications. More importantly, they can often be prevented through healthy diet, physical activity and eliminating tobacco use and substance abuse.

Regular physical activity in adults can lower the risk of:

- Early death
- Coronary heart disease
- Stroke
- High blood pressure
- Type 2 diabetes
- Breast and colon cancer
- Falls
- Depression

Physical activity in children and adolescents can:

- Improve bone health
- Improve cardio-respiratory and muscular fitness
- Decrease levels of body fat
- Reduce symptoms of depression

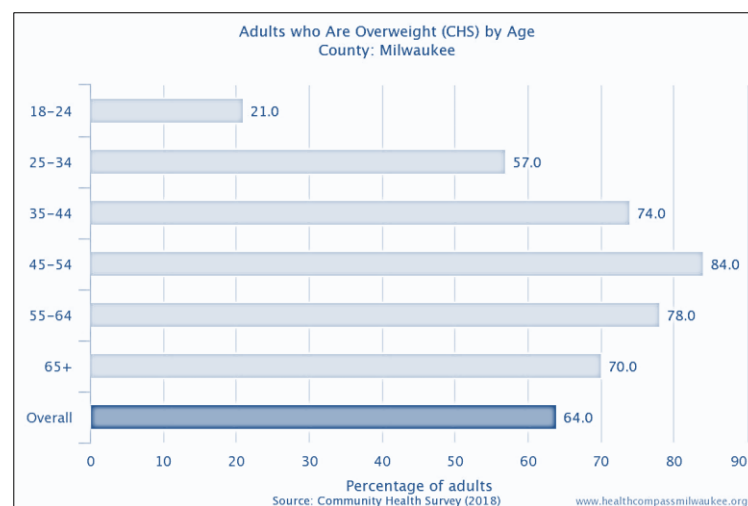
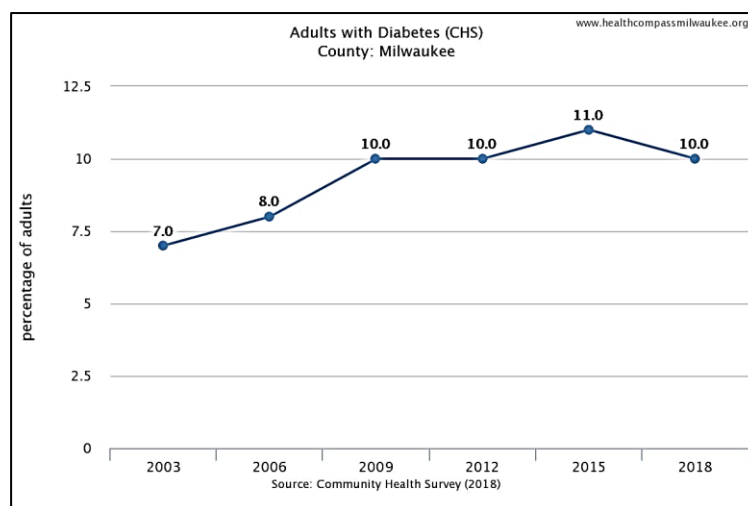
A healthy diet reduces risk of chronic diseases, some cancers, oral disease, malnutrition, anemia and others risk factors, diseases and illnesses.

At a healthy weight, one is less likely to develop chronic diseases or die at an earlier age.

Good nutrition in children is important to maintaining appropriate weight and healthy growth and development.

Source:

1. Healthy People 2020



### Data Highlights

While only 10 percent of Milwaukee County Community Health Survey respondents report having diabetes, 64 percent of respondents report being overweight, which increases their risk for developing type 2 diabetes.

### Local Assets and Resources:

Key informants identified numerous community initiatives to address chronic disease, including:

- Community outreach programs
- Awareness campaigns
- Chronic disease support groups
- Community health clinics
- Case management
- Nursing services
- Community health fairs
- Food share program at farmer's markets
- Community nutrition education



## Infant Mortality

### Why it is Important

Infant mortality represents the health of the most vulnerable age group: children younger than one year old. Infant mortality is seen as a strong indicator of the overall health of a community. Infant mortality rates and disparities highlight the impact of access to quality healthcare and of poverty and socioeconomic factors in a community.

### Leading Causes of Infant Mortality

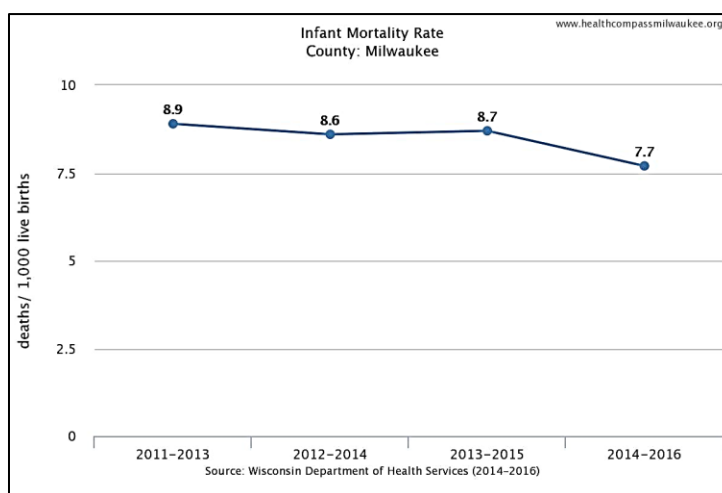
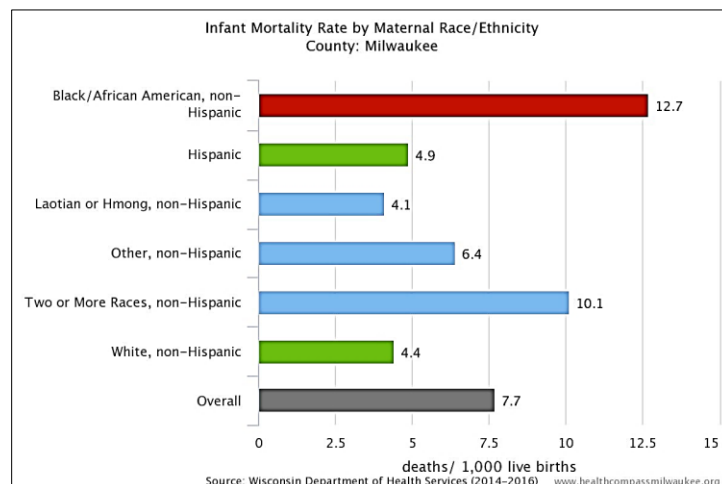
- Birth defects
- Preterm birth and low birth weight
- Sudden infant death syndrome
- Maternal pregnancy complications
- Injuries (e.g., suffocation)<sup>1</sup>

### Disparities in Infant Mortality

In Milwaukee County, the mortality rate among non-Hispanic black babies is more than double the rate of non-Hispanic white babies. Research has demonstrated that individual factors alone do not explain the disparity.<sup>2</sup> Non-Hispanic black babies have disproportionately higher rates of preterm birth and low birth weight.<sup>2</sup> Research suggests that structural racism and personal experiences of racism contribute to negative birth outcomes,<sup>3</sup> including preterm birth<sup>4</sup> and infant mortality.<sup>5</sup>

#### Sources:

1. CDC, Association of Maternal Child Health Programs.
2. Matoba N. & Collins JW. Racial disparity in infant mortality. *Seminars in Perinatology*, 2017; 41, 354-359.
3. Alhusen JL, Bower KM., Epsten E. & Sharps P. Racial discrimination and adverse birth outcomes: An integrative review. *Journal of Midwifery & Women's Health*, 2016; 61(6), 707-20.
4. Bower KM., Geller R.J., Perrin NA., Alhusen J. Experiences of racism and preterm birth: Findings from a pregnancy risk assessment monitoring system, 2004 through 2012. *Women's Health Issues*, 2018; 28(6), 495-501.
5. Wallace M., Crear-Perry J., Richardson L., Tarver M., & Theal, K. Separate and unequal: Structural racism and infant mortality in the US. *Health Place*, 2017; 45, 140-44.



### Data Highlights

According to Health Compass, the infant mortality rate in Milwaukee County for 2014-16 was at 7.7 as compared to a Healthy People 2020 goal of 6.0.

Milwaukee County experiences significant racial disparities in infant mortality rates. In 2014-16:

- Infant mortality rate for non-Hispanic white women was 4.4
- Infant mortality rate for non-Hispanic black women was 12.7

### Local Assets and Resources:

Key informants and the Milwaukee Market CHIP team identified several resources currently dedicated to decreasing the infant mortality rates and closing the racial disparity gap. One initiative is the Milwaukee Lifecourse Initiative for Healthy Families (LIHF) Collaborative. In addition, the Centering Pregnancy Program at Ascension SE Wisconsin Hospital - St. Joseph Campus is an asset to be leveraged in addressing infant mortality.

## Mental Health

Mental health can be defined as a state of successful mental function, resulting in productive activities, fulfilling relationships, ability to adapt and cope with challenges. Mental health is essential to personal well-being, relationships and the ability to contribute to society.

Approximately 20 percent of the population experiences a mental health problem during any given year.<sup>1</sup>

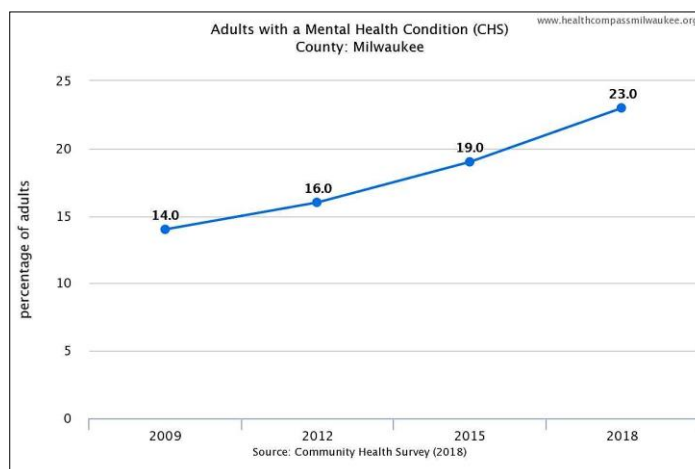
Mental health issues are associated with increased rates of risk factors, such as smoking, physical inactivity, obesity and substance abuse. As a result, these physical health problems can lead to chronic disease, injury and disability.<sup>2</sup>

### Challenges in Milwaukee County

- A lack of resources, especially for those who cannot afford out-of-pocket costs and lack commercial insurance
- Not enough providers, especially prescribers
- Long waiting lists to access care
- Primary care providers lack resources or expertise to manage complex mental illness needs of patients
- Stigma surrounding mental health
- Not enough supportive housing for those living with mental illness

#### Sources:

1. National Institute for Mental Health
2. Healthiest Wisconsin 2020; Healthy People 2020



### Data Highlights

From Milwaukee County Community Health Survey:

- Twenty three percent of respondents reported a mental health condition, such as an anxiety disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder or depression in the past three years.
- Respondents who were more likely to report a mental health condition include individuals who were female, 18 to 24 years old, African American, Hispanic, with a high school education or less, in the bottom 40 percent household income bracket, who were unmarried, not overweight, inactive, met the recommended amount of physical activity or were smokers.

From Key Informant Interviews:

- Mental health emerged as the most commonly discussed issue by Milwaukee County key informants, with 31 rankings indicating it is a top-three health priority issue.
- Many of the barriers related to mental health are related to access.

### Local Assets and Resources:

- Behavioral health services offered by Federally Qualified Health Centers
- Growing awareness of mental health needs among the public
- Crisis teams deployed by the Behavioral Health Division and Milwaukee Police Department
- Homeless mental health outreach through Outreach Community Health Centers
- Adverse Childhood Experiences (ACEs) education
- Creation of different access points by the “hub and spoke” model for Milwaukee’s Behavioral Health Division
- Trauma Informed Care Training
- Behavioral Health Coalition

\*Health priority for Ascension Columbia St. Mary’s, Ascension Franklin, Ascension St. Francis and Ascension St. Joseph

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## Results of the Previous CHNA Process

Our previous CHNA process was completed in June 2016. The priority health issues selected and addressed were:

Ascension Columbia St. Mary's Hospital Milwaukee:

- Cancer
- Health Literacy
- Infant Mortality
- Mental Health
- Nutrition and/or Physical Activity
- Oral Health
- Substance Abuse

Ascension SE Wisconsin Hospital - Franklin Campus:

- Nutrition and/or Physical Activity
- Reduce Alcohol Use and Violence

Sacred Heart Rehabilitation Hospital:

- Injury
- Chronic Disease

Ascension St. Francis Hospital:

- Infant Mortality
- Healthy Lifestyle with a Focus on Obesity and Diabetes
- Alcohol Use

Ascension SE Wisconsin Hospital - St. Joseph Campus:

- Healthy Lifestyle with a Focus on Obesity and Diabetes
- Infant Mortality
- Access to Care

An evaluation of the impact of our efforts to date to address these issues can be found in the Appendices.

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## Next Steps

Having identified the priority health needs to be addressed, next steps include:

- Collaborating with community partners through the Milwaukee Health Care Partnership
- Developing a three-year implementation strategy
- Creating a more specific annual action plan during each year of the implementation strategy
- Integrating the health priorities and implementation strategy into organizational strategic planning and resource investments and allocations

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## Approval

This community health needs assessment (CHNA) report was adopted by the Boards of Directors of Ascension SE Wisconsin Hospital, Inc., Columbia St. Mary's Hospital Milwaukee, Inc., Sacred Heart Rehabilitation Institute, Inc. and Ascension St. Francis Hospital, Inc. on April 24, 2019. Subsequently the legal names of the included entities on page 3 were revised for clarity. These revisions were approved by the Ascension Wisconsin Board on August 22, 2019 and the Boards of Directors of Ascension SE Wisconsin Hospital, Inc., Columbia St. Mary's Hospital Milwaukee, Inc., Sacred Heart Rehabilitation Institute, Inc. and Ascension St. Francis Hospital, Inc. on November 13, 2019.

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## Public Comments/Feedback

We welcome feedback from community members on this plan. Please see our public website for the email address for submitting comments.

# Appendices

## Appendix 1: Progress Report on Results of Previous CHNA Process<sup>2</sup>

Ascension Wisconsin is committed to making a positive, measurable impact on the health of the people in the communities we serve. To that end, we evaluate the strategies we implement to address the health needs of the community.

We use a logic model, an approach that is nationally recognized for program evaluation. Logic models provide methods for documenting the following:

- **Inputs:** Resources needed to implement the strategies
- **Outputs:** Actions taken, the number of programs/tactics implemented and the number of people reached
- **Outcomes:** Measures of the impact of the programs/strategies (such as changes in learning, actions or conditions)

To be specific about the outcomes for which we will be accountable, we set SMART metrics – metrics that are Specific, Measurable, Achievable, Realistic and Time-related.

### Evaluation Schedule/Process

At the beginning of the three-year cycle:

- Establish SMART metrics for medium-term (three-year) outcome indicators for each strategy
- Establish SMART metrics for long-term (beyond three years) outcome indicators for each priority area

At the beginning of each fiscal year in the three-year CHNA cycle:

- Establish SMART metrics for short-term (fiscal year) outcome indicators for each strategy
- Establish action steps and output indicators for each strategy

At the end of each fiscal year:

- Report on results for short-term outcome and output indicators
- Describe accomplishments and analyze results

At the end of the three-year cycle:

- Report on results for medium-term outcome indicators for each strategy
- Describe and analyze results
- Incorporate results into next Community Health Needs Assessment

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<sup>2</sup> The original CHNA report was posted in June 2019 with results for Year One and Year Two. This appendix was updated in fall 2019 to also include results for Year Three.

Health priorities identified in the preceding CHNA were:

## **Ascension Columbia St. Mary's Hospital Milwaukee**

### **Cancer Disparity**

#### *Expanded Mammography in the Community*

- Results for Year One:
  - Partnered with multiple community agencies, including 16<sup>th</sup> Street Community Clinic. Provided 653 mammograms in 2017.
- Results for Year Two:
  - The mobile coach was requested and available for 16 church and community partners; three of the seven new partnerships had successful screening events and 582 mammograms were provided to Milwaukee County residents. There was a decrease in the number of mammograms provided from 653 in FY17 to 582 in FY18 due to decrease in grant funding.
- Results of Year Three:
  - By continuing to use the mobile mammogram unit in the community, we are screening a diverse population of Milwaukee County women, covering eleven different zip codes. Five new community partners were added this year, which increases the opportunity to meet women that have never had a mammogram or are very delayed in their recommended screening.

### **Health Literacy**

#### *Ebenezer Health Resource Center*

- Results for Year One:
  - Two hundred people were referred to the health resource center and 50 people were registered for the food pantry and provided with health education resources.
- Results for Year Two:
  - The Ascension Ebenezer Health Resource Center continued to support referrals for diabetes management and access to the diabetic-friendly food pantry. Fifty percent (200 people) were referred to the health resource center, registered for the food pantry and were provided with health education resources. This exceeded the target of 100 people. The resource center also assisted clients who reported they do not have insurance, by offering enrollment support in BadgerCare.
- Results of Year Three:
  - Provided educational sessions at the Ascension Ebenezer Health Resource Center on blood pressure screenings, food insecurities, healthy food preparation, medication management and overall healthcare needs.

## **Infant Mortality**

### *Primary Care for Women at Risk for Poor Birth Outcomes*

- Results for Year One:
  - No action in year one.
- Results for Year Two:
  - Ascension Prospect Medical Commons hired additional case management staff to assist pregnant women who needed additional assistance with locating resources. By January 2018, there were two nurses providing case management services at the clinic. All pregnant women at the clinic were screened for eligibility for care management assistance. A community outreach nurse also assisted in providing prenatal education to new patients at the clinic. Thirty pregnant women participated in the education.
- Results for Year Three:
  - Ascension Prospect Medical Commons continued to support pregnant women who were at increased risk for adverse birth outcomes with establishing care with primary care providers. A registered nurse screened women upon intake to the obstetric clinic and made referrals to internal medicine providers for ongoing care for chronic health conditions.

### *Prenatal Oral Health Care*

- Results for Year One:
  - Provided prenatal oral health care to 377 women. Expanded referral sites by five.
- Results for Year Two:
  - Ascension Seton Dental Clinic is supporting medical and dental integration by expanding its services with dental hygienists in clinical settings. A dental hygienist provided services at two primary care clinics and offered prenatal oral health to more than 430 unique patients.
- Results for Year Three:
  - Continued to provide dental hygiene services at the Columbia St. Mary's Family Health Center, All Saints Family Care Center and the Women's Outpatient Center (WOC) at Ascension St. Joseph. Provided services to four patients per day.

### *Strong Baby Sanctuaries*

- Results for Year One:
  - Partnered with twenty-four churches to establish Strong Baby Sanctuaries, providing support for and education about healthy pregnancies and healthy families.
- Results for Year Two:
  - The Strong Baby Sanctuary program had fourteen new churches register to participate in the program. Three training events were held for sanctuaries.



- Results for Year Three:
  - Program expanded to 38 sites. Initiated a new Refer a Friend program which encourages individuals to refer a friend or family member to the program for prenatal care. Continued to provide education on infant mortality to participating sites. Over 70% of the Sanctuaries received ongoing training to address infant mortality.

### **Mental Health/Substance Abuse**

#### *Support Integrated Primary Care and Mental Health*

- Strategy was discontinued at Ascension Columbia St. Mary's Milwaukee campus.

#### *Partnership with Meta-House*

- Results for Year One:
  - Developed health education curriculum. One hundred percent of participants/residents were screened for a primary care provider and were referred to a provider if they said they did not have a primary medical home.
- Results for Year Two:
  - An Ascension Wisconsin nurse offers health education and screening for residents of Meta-House, spending more than 15 hours each week working with residents. One hundred percent of participants/residents were screened for a primary care provider and, if they said they did not have a primary medical home, were referred to a provider based on their insurance and choice. The nurse also offers health education to residents. Topics include women's health, nutrition, breast health, mental health and sexually transmitted infections, and osteoporosis, cancers and additional topics based on the resident's request.
- Results for Year Three:
  - Weekly health education sessions provided on topics such as dental, nutrition and exercise, HIV, Hepatitis, sexual transmitted infections, breast health, and bone health. On average 15 people attended each week. Residents were screened for primary care access. 100% of the residents seen are referred to a primary care provider if one is not established.

### **Nutrition and/or Physical Activity**

#### *Vegetable Prescription*

- Results for Year One:
  - Through a partnership with Ascension Columbia St. Mary's Milwaukee and Fondy Farmers Market, a Fruit and Vegetable Prescription Program was offered to 98 people.
- Results for Year Two:
  - The partnership between Ascension Columbia St. Mary's Milwaukee and Fondy Farmers Market continued to offer a Fruit and Vegetable Prescription Program to 125 people, which exceeded the target goal of 75 people. Participants could redeem their prescription for healthy food at a local farmers market. Nutrition education was offered to 100 percent of the participants. The overall goals for the Fruit and

Vegetable Prescription Program were to increase consumption of fruits and vegetables to prevent and treat chronic disease, support health and decrease food insecurity.

- Results for Year Three:
  - The partnership between Ascension Columbia St. Mary's Milwaukee and Fondy Farmers Market continued to offer a Fruit and Vegetable Prescription Program to 176 people. Nutrition education was offered to 100 percent of the participants.

### **Oral Health**

*Family Health Center: Develop an integrated approach to diabetes and oral healthcare at Ascension Columbia St. Mary's Milwaukee Family Health Center*

- Results for Year One:
  - Identified a curriculum for oral health education for providers.
- Results for Year Two:
  - Provided preventative oral screening and oral health education to patients at the Ascension Columbia St. Mary's Milwaukee Family Health Center. One hundred percent of the patients who needed additional oral health services were referred to a dental clinic. Twenty-nine patients with diabetes were screened and educated about the oral health implications of diabetes. Oral health education for providers not implemented due to staffing and funding challenges.
- Results for Year Three:
  - Dental hygienist provided preventative oral screening and oral health education to patients at the Ascension Columbia St. Mary's Milwaukee Family Health Center one day per week.

### *Smart Smiles*

- Results for Year One:
  - The Smart Smiles program partnered with 65 schools. A total of 651 children received restorative care and 10,500 kids were served in the program.
- Results for Year Two:
  - The Smart Smiles Program was successful in reaching 11,459 students in Milwaukee County, a nine percent increase, which exceeded the goal of four percent. It also increased the number of schools involved in the program to 77 from 55. A mobile dental coach was used at seven schools (target was eight).
- Results for Year Three:
  - The Smart Smiles Program was able to meet the goals and expectations of over 12,000 students completing a valid consent and 11,785 receiving preventative care. Seventy-seven schools participated in the program.

## Ascension SE Wisconsin Hospital - Franklin Campus

### Healthy Lifestyle with a Focus on Obesity, High Blood Pressure and Diabetes

#### *Couch to 5K*

- Results for Year One:
  - Associates are engaged with this event and use it as an opportunity to increase their activity with team support. We did not meet our goal for community participation, due to the proximity of the Franklin Community 5K being held the week before.
- Results for Year Two:
  - Hosted a community Couch to 5K program. Did not achieve goal to increase participation from prior year; attendance decreased. Twenty-five percent of respondents reported they increased their activity related to preparing for the event (goal was 25 percent); and 50 percent of participants verbally reported they would increase or maintain physical activity after visiting health education booths at the event (goal was 50 percent).
- Results for Year Three:
  - Event was cancelled due to poor weather and track conditions.

#### *Operation Fit Franklin*

- Results for Year One:
  - Ascension Franklin associate represents the Ascension Franklin campus on this community wellness team and is an active participant in event planning and providing resources to improve health.
- Results from Year Two:
  - Strategy was discontinued at Ascension Franklin campus.

#### *Pre-Diabetes Education*

- Strategy was discontinued at Ascension Franklin campus. It continues to be implemented at other Ascension Wisconsin campuses.

#### *Family Health Night*

- Results for Year One:
  - The Franklin Family Health Night had multiple booths offering health and wellness information and simulating operating room experiences to decrease anxiety. Partnered with multiple fire departments to promote fire safety in the home. Attendees were given a "ticket" to share a behavior change/new fact they learned. An estimated 250 people attended and received 110 tickets.

- Results for Year Two:
  - At Franklin Family Health Night, providers and community members interacted and learned about the best ways to practice healthy habits. Two hundred and eighty-three community members received education on many health topics including blood pressure screening, nutrition, mental health, stress reduction and risk factors for heart disease and stroke (goal was 200). Fifty percent of Family Health Night attendees reported they would change a behavior because of the event. One hundred percent of Family Health Night attendees without a primary care physician, who screened with high blood pressure, were connected to a provider for follow-up care.
- Results for Year Three:
  - An estimated 200 people attended the Franklin Family Health Night. Information on chronic health conditions, safety, nutrition, drugs and alcohol along with information on how to access a primary care provider was offered to attendees.

#### *Community Safety - Franklin Family Health Night*

- Results for Year One:
  - Provided information and resources at Franklin Family Health Night. Promoted the use of 2-1-1 services as a resource for crisis management. Two hundred and fifty people attended Franklin Family Health Night.
- Results for Year Two:
  - Ascension St. Francis Mental Health Department associates attended the event and distributed information to participants. Two hundred and eighty-three community members attended the event and received health education. Fifty percent of Franklin Family Health Night attendees reported they would change a behavior because of the event. One hundred percent of Franklin Family Health Night attendees requesting support at the event were connected to a resource.
- Results for Year Three:
  - Ascension Franklin partnered with Oak Creek health department on initiative related to substance abuse risk factors in adolescents. The health department featured the “Wake Up Call Room” at the Family Health Night event.

#### *Oak Creek Health Department Relationship*

- Results for Year One:
  - Established a relationship with Oak Creek Health Department. Exploring shared collaborative strategy.
- Results for Year Two:
  - Established a collaborative relationship with the Oak Creek Health Department. A shared collaborative strategy was developed to be implemented in FY19.
- Results for Year Three:
  - Ascension Franklin partnered with health department on initiative related to substance abuse risk factors in adolescents. The health department featured the “Wake Up Call Room” at the Family Health Night event. Ascension Franklin participated on Oak Creek Health Department’s Alcohol and other Drug Abuse (AODA) committee.

**Reduce Alcohol Use and Violence***AODA Coalition*

- Results for Year One:
  - Franklin Area Parents and Students United (FAPSU) is a community organization that focuses on ways to reduce addiction. An Ascension Franklin associate completed orientation and attended coalition meetings.
- Results for Year Two:
  - Developed a partnership with Volition Franklin; the organization offered education on safe medication disposal at Ascension Franklin campus for community members (283 participants).
- Results for Year Three:
  - Ascension Franklin associate engages with Volition Franklin as the Healthcare Sector Partner. Volition Franklin participated in Ascension Franklin's Family Health Night and provided information and resources on alcohol and drug use.

*Bullying Awareness*

- Results for Year One:
  - Literature was provided at Family Health Night event; discussion with Franklin school leaders regarding resources on bullying. Understood that each school has resources used to educate parents and students on bullying. Will offer resources but plans to choose a different goal for FY18.
- Results for Year Two:
  - Planned partnership and event were not completed.
- Results for Year Three:
  - No activities were taken.

## Sacred Heart Rehabilitation Hospital

### Chronic Disease

#### *Diabetic-Friendly Food Pantry*

- Results for Year One:
  - Established a diabetic-friendly food pantry. Offered Lunch and Learn program that provided participants with information on how to identify three strategies for healthier eating. Program was hosted on a weekly basis prior to the food pantry opening. Attendees participated in the free program and received a healthy meal.
- Results for Year Two:
  - Through Ebenezer Health Resource Center staff and a partnership with UW-Extension, pantry clients are offered health education, nutrition education, cooking demos and a Lunch and Learn program. The Ebenezer Health Resource Center-Diabetes Friendly Food Pantry increased the average number of people served per month from 1,100 in FY17 to 1,200 in FY18. In FY18, healthy food offered at the pantry increased from 50 percent to 70 percent. Thirty educational offerings were provided with UW-Extension.
- Results for Year Three:
  - Staff at Ascension Sacred Heart have identified a unique way to support the Ebenezer Health Resource Center and assist patients in healing. Each month, therapists from Ascension Sacred Heart take two to three patients to the food pantry. Patients participate in activities to support their healing such as categorizing food, lifting and carrying items and organizing food in the pantry.

### Injury and Falls

#### *Home Assessment*

- Strategy was discontinued at Sacred Heart Rehabilitation Hospital.

#### *Fall Prevention Education*

- Results for Year One:
  - Provided two fall prevention education sessions at Ebenezer Health Resource Center. One hundred percent of attendees were able to identify one fall prevention strategy.
- Results for Year Two:
  - The fall prevention education took place at Ebenezer Health Resource Center and at Clinton Rose senior living center. Fifteen senior women met for fall education prevention on a monthly basis. A community nurse also offered five fall prevention classes. One hundred percent of attendees were able to verbally identify fall prevention strategies for their home. Fall risk prevention education was also offered through the Urban Church Wellness program. Fall risk assessments were conducted for 100 people at Ebenezer.

- Results for Year Three:
  - Ascension Sacred Heart provided injury prevention education to elementary school students. The staff provide a hands-on experience for the kids with up to six stations that expose the students to daily situations that individuals who experience a brain injury may experience. Ascension Sacred Heart staff also provided education brain injury prevention and safety and provide the students with free bike helmets.

## **Ascension St. Francis Hospital**

### **Infant Mortality**

#### *Safe Sleep Education*

- Results for Year One:
  - Safe sleep education provided to all families. Working to develop a post-education parent survey.
- Results for Year Two:
  - The Ascension St. Francis program assisted new families, who indicated they needed a safe place for their baby to sleep, by offering a pack-n-play. One hundred percent of families being discharged received safe sleep education. One hundred percent of new moms verbally indicated understanding of safe sleep principles. One hundred percent of families who needed additional assistance were counseled onsite and referred to the Southside Health Center for a safe sleep clinic program.
- Results for Year Three:
  - One hundred percent of families being discharged received safe sleep education. One hundred percent of new moms verbally indicated understanding of safe sleep principles. One hundred percent of families who needed additional assistance were counseled onsite and referred to the Southside Health Center for a safe sleep clinic program. Safe sleep education was also provided at the Blanket of Love Program at Unity Church.

#### *Partner with Community Resources*

- Results for Year One:
  - Met with Southside Health Department to explore collaborative strategies to address infant mortality.
- Results for Year Two:
  - Strengthened collaboration with local church regarding health education, including: coordination with Community Services on infant mortality prevention program; identified additional areas of desired health education at the church.
- Results for Year Three:
  - Initiated Blanket of Love Program at Unity Church. Provided education on parenting and safe sleep practices.

*Prenatal Oral Healthcare*

- Results for Year One:
  - Developed a process to connect pregnant women who are at risk for poor birth outcomes to Seton Dental Clinic. Twenty-seven women were referred to the dental clinic and 12 women received an exam, which is below the 50 percent target.
- Results for Year Two:
  - Ascension St. Francis Hospital referred patients to Ascension Seton Dental Clinic's prenatal oral health program. The program referred 12 women to Ascension Seton Dental, which is below the target of 27 per year.
- Results for Year Three:
  - Ascension St. Francis Hospital referred 24 patients to Ascension Seton Dental Clinic.

*Baby Friendly Hospital Initiative*

- Results for Year One:
  - Breastfeeding education provided to nurses and post-education assessment completed by nurses. Breastfeeding information was added to New Mom Folders.
- Results for Year Two:
  - Ascension St. Francis Hospital continues to operate as a Baby Friendly Hospital. Breastfeeding information was provided in new-mom packets. One hundred percent of new mothers received breastfeeding education.
- Results for Year Three:
  - Ascension St. Francis Hospital continues to operate as a Baby Friendly Hospital. Initiating steps for re-designation as Baby Friendly Hospital. Breastfeeding information provided to all moms in new-mom packets. One hundred percent of new mothers received breastfeeding education.

*Babies Screened/Assessed for Alcohol and Other Drug Abuse (AODA)*

- Results for Year One:
  - Newborns were screened for AODA issues. Four percent of the newborns were diagnosed with ADOA issues. One hundred percent of the mothers whose infants were diagnosed with AODA issues were offered resources and received social services.
- Results for Year Two:
  - Staff developed a standardized reporting process for babies identified with AODA issues. One hundred percent of babies were screened/assessed for AODA issues. One hundred percent identified as positive were referred for services. One hundred percent of women were educated about the importance of suspending drug/alcohol use while breastfeeding.
- Results for Year Three:
  - Newborns were screened for AODA issues. One hundred percent of the mothers whose infants were diagnosed with AODA issues were offered resources and received social services.



*Early Engagement Program*

- Strategy was discontinued at Ascension St. Francis.

**Healthy Lifestyle with a Focus on Obesity and Diabetes***National Nutrition Month*

- Results for Year One:
  - Provided educational materials regarding healthy nutrition to individuals visiting Ascension St. Francis cafeteria. Eight hundred seventy-five community participants attended and were engaged in national nutrition month activities.
- Results for Year Two:
  - Ascension St. Francis offered healthy lifestyle and nutrition education to community members who eat at the hospital cafeteria. The cafeteria is utilized by local community members for healthy and affordable food options. The education consisted of monthly health topics, recipes, educational materials and flyers. The hospital also offered a farmer's market booklet, which highlighted locations and food offerings for each market in Milwaukee County. A super-food was highlighted each month and also was included in the various menu offerings at the cafeteria. Five hundred twenty-one community members had access to the education and healthy food.
- Results for Year Three:
  - Cafeteria highlighted a super-food each month. The super food was also included in the various menu offerings at the cafeteria.

*Explore Farmer's Market Produce Availability in Cafeteria*

- Strategy was discontinued at Ascension St. Francis.

*Community and School Education: Diabetes and Obesity*

- Strategy was discontinued at Ascension St. Francis.

*Community Diabetes Screenings*

- Strategy was discontinued at Ascension St. Francis.

*National Diabetes Prevention Program*

- Strategy was discontinued at Ascension St. Francis. This program continues to be implemented at other Ascension Wisconsin campuses.

**Alcohol Use***MKE Elevate*

- Results for Year One:
  - Ascension St. Francis associate attended MKE Elevate meetings to explore collaborative goals. MKE Elevate is a Community Health Improvement Planning Process led by the city.

- Results for Year Two:
  - Ascension St. Francis established a collaboration with MKE Elevate on mutual goals for community health improvement, particularly on accessing mental health and substance use disorder treatment services. The manager of behavioral health is actively representing the hospital through various communications. The hospital has also assisted in reducing barriers to access mental health by participating in community events in Milwaukee County. Staff from the behavioral health department offered mental health/substance abuse education at the Franklin Family Health Night.
- Results for Year Three:
  - No activity taken.

#### *Expand Services for AODA Assessment*

- Results for Year One:
  - Expanded the role of the Behavioral Health Liaisons to provide emergency department (ED) coverage.
- Results for Year Two:
  - There was a consistent behavioral health liaison (BHL) presence in the emergency department and other units throughout the hospital to assist patients with AODA concerns. Patients referred to the BHL had post-ED admission follow-up with suggestions/treatment referrals and providing information on community resources. BHL referred an average of 138 cases per month. In FY18, 40 percent of appropriate emergency department patients were referred to the BHL. One hundred percent of patients being referred to the BHL did receive information on community resources and treatment referrals.
- Results for Year Three:
  - Increased access to mental health substance abuse services by increasing outpatient appointment availability. Added emergency intake referral time blocks to provider schedules to expedite patient follow up with provider. Partnered with Emergency Department (ED) to increase use of inpatient mental health services and have process for providing resources when inappropriate for inpatient services via: Behavioral Health Liaison access, ED to recovery program/AODA coaches and Telebehavioral health consultations.

#### *Access to Recovery Services*

- Strategy was discontinued at Ascension St. Francis campus.

## Ascension SE Wisconsin Hospital - St. Joseph Campus

### Healthy Lifestyle with a Focus on Obesity and Diabetes

#### *National Diabetes Prevention Program*

- Results for Year One:
  - Offered one Diabetes Prevention Program.
- Results for Year Two:
  - National Diabetes Prevention Program (DPP) held at hospital for community members. One hundred percent of sessions attended have documented weight. Eighty three percent of attended sessions have documented physical activity minutes. Sixty-seven percent participant retention rate to date. Exceeded goal of 7.8 percent average weight loss (aggregate-target was 2 percent) over six months for participants having attended four or more sessions in the 16-week core portion of Diabetes Prevention Program.
- Results for Year Three:
  - Program was discontinued at St. Joseph Campus due to low enrollment.

#### *Nutrition Education to Children and Young Adults*

- Strategy was discontinued at Ascension St. Joseph Campus.

#### *Community Health Eating Education*

- Results for Year One:
  - Thirty-four participants enrolled in diabetes management group classes. Forty-three percent of participants attended three educational group sessions to increase knowledge related to diabetes, hypertension and weight management.
- Results for Year Two:
  - Ascension St. Joseph educated the community on healthy eating habits through support groups and outreach activities with diabetes management. Fourteen diabetes management group sessions were offered throughout the year. Completion rate of 68.4 percent, exceeding target of 50 percent. By June 30, 2018, 90 percent of attendees will be able to verbally identify healthier nutrition options in their daily life (target was 50 percent).
- Results for Year Three:
  - Ascension St. Joseph offered 10 diabetes management support groups. Participants were encouraged to attend three classes. Completion rate was 31%. Of those who completed the program, 100% were able to verbally healthier nutrition options.

## **Infant Mortality**

### *Early Prenatal Care*

- Results for Year One:
  - Assisted women in obtaining appointment with OB provider within two weeks, if not sooner. Provided patient education on safe sleep, car seat and shaken baby prevention. Partnered on Lifecourse Initiatives for Healthy Families project. The Women's Outpatient Clinic established a high-risk center that was reinstated in November 2017. Women are screened for signs and symptoms of preterm labor. Women with a history of prior preterm birth (fitting appropriate clinical parameters) were offered 17OHP injections weekly between 16-18 weeks until 37 weeks.
- Results for Year Two:
  - The early prenatal care program promoted early, high-quality prenatal care for all residents in Milwaukee, with a specific focus on the zip codes near Ascension St. Joseph that have a high infant mortality rate. Due to staffing and capacity issues, the Centering Pregnancy program was not offered in FY 2018. One hundred percent of women who contacted the Women's Outpatient Center were offered new OB visits within four weeks of their initial phone call. By June 30, 2018, 100 percent of women who could not be seen due to scheduling challenges were referred to other Ascension Wisconsin providers.
- Results for Year Three:
  - Women who contacted the Women's Outpatient Center (WOC) were offered an appointment at the WOC or with another Ascension provider within three weeks of calling. Due to staffing changes, had a decrease in the number of Centering Pregnancy groups that were offered. Offered four Centering Pregnancy groups with a total of 15 participants.

### *Safe Sleep Program*

- Results for Year One:
  - Ascension St. Joseph offered culturally sensitive comprehensive safe sleep programs that are shared with women and families. The program offered safe sleep and car seat classes to 100 percent of the Women's Outpatient Center patients. Three hundred sixty-eight women participated in the safe sleep class and 406 participated in the car seat safety class.
- Results for Year Two:
  - Ascension St. Joseph continued to offer culturally sensitive comprehensive safe sleep programs to women and families. The program offered safe sleep and car seat classes to 100 percent of the Women's Outpatient Center patients. Four hundred eleven patients participated in safe sleep classes (Baseline FY17 was 368; target was 368). Four hundred fifty-one patients participated in car seat safety classes, exceeding the goal. (Baseline FY17 was 406; target was 406.)
- Results for Year Three:
  - Safe sleep and car seat safety classes offered to all patients who are seen at Women's Outpatient Center. Four hundred and eighteen women attended the safe sleep classes and 460 women attended the car seat classes.

## **Access to Care**

### *ED Follow-Up*

- Results for Year One:
  - The Transition of Care Management (TCM) program at Ascension St. Joseph provided education, outreach and follow-up care to patients entering the emergency department. The goal was to set up a medical home and help patients understand the necessity of a primary care provider and when to appropriately use the emergency department. TCM provided case management for patients with higher risk of poor health outcomes, especially those diagnosed with heart and/or renal failure.
- Results for Year Two:
  - The Transition of Care Management (TCM) program at Ascension St. Joseph had 82 referrals for uninsured/underinsured patients to a Federally Qualified Health Center or safety net clinic that participates in an emergency department care coordination program. TCM ensured appropriate follow-up care for underserved patients using emergency department for primary care. Sixty seven percent of patients engaged were scheduled with a primary care provider (target was 60 percent). The show rate for scheduled patients increased to 65 (target was 50 percent or above).
- Results for Year Three:
  - The Transition of Care Management (TCM) program at Ascension St. Joseph engaged with 1,218 individuals seen in the Emergency Department. They assisted 987 individuals in scheduling an appointment with a Primary Care Provider (PCP). Overall there was a 56% show rate for the PCP appointment.

### *Access to Primary Care*

- Results for Year One:
  - Seventy percent of the women who received a non-stress test in the Prenatal Assessment Center were asked about whether they have a primary provider. One hundred percent of all women who did not have a primary care provider were given resources to locate primary care providers.
- Results for Year Two:
  - Assisted women of childbearing age in obtaining primary healthcare prior to, during and after pregnancy. The overall goal was to reduce the risks of maternal medical condition affecting perinatal outcome in the community. The program supported father involvement with children and families, while also addressing stress reduction. Ninety four percent of women receiving a non-stress test in the Prenatal Assessment Center were asked about whether they had a primary provider (target was 75 percent). One hundred percent of all women who did not have a primary care provider were given resources to locate primary care providers as targeted.
- Results for Year Three:
  - Clinic social workers established a process to schedule a primary care visit for patients. One hundred percent of all women who did not have a primary care provider were given resources to locate primary care providers as targeted.

*Provide Financial Assistance*

- Results for Year One:
  - Financial counselors screened 6,396 patients for Medicaid, Community Care and/or other programs. Ascension Wisconsin's partners were successful in getting 3,613 patients approved for Medicaid.
- Results for Year Two:
  - Actively screened patients who were uninsured for the financial assistance program. The total number of people screened for financial assistance was 2,900 (target was FY17 baseline of 6,300). One hundred percent of Medicaid-eligible individuals were provided instructions and support to be enrolled into coverage.
- Results for Year Three:
  - Increased financial screening resources at Ascension St. Joseph campus and implemented necessary certifications so financial counselor could assist individuals in enrolling in the Marketplace Open Enrollment. Exceeded goal of screening ninety percent of self-pay patients for Medicaid and financial assistance program eligibility. Financial counselors screened 99% of individuals who are uninsured.

*Primary Care Physicians and Community Health Workers*

- Results for Year One:
  - Transitional Case Management referred patients seen in the emergency department to a primary care provider. An average of 60 patients per month were referred to primary care, with a 52 percent attendance rate.
- Results for Year Two:
  - Strategy was discontinued at Ascension St. Joseph.

*Specialty Access for Uninsured Program*

- Results for Year One:
  - The Milwaukee Health Care Partnership Specialty Access for Uninsured Partnership (SAUP) Program provides individuals, who are uninsured, access to physician, outpatient and inpatient specialty care. SAUP referred 11 patients to Ascension St. Joseph. Fifteen initial appointments were scheduled from January-June and all 15 appointments were kept.
- Results for Year Two:
  - TCM staff participated in the Milwaukee Health Care Partnership (MHCP) and received communications on the ED care coordination and Specialty Access for the Uninsured communications. Meetings with the community specialty program were attended regularly. The care manager associates responsible for managing the referrals participated to learn best practices.
- Results for Year Three:
  - Ascension St. Joseph continued to participate in the Specialty Access for Uninsured Partnership (SAUP) Program in partnership with the Milwaukee Health Care Partnership. 783 patients were referred to specialty providers within the legacy Wheaton Franciscan system.

## Appendix 2: Community Leaders/Stakeholders

In 2018, input about our community's most pressing health needs was provided by 80 individuals participating in key informant interviews and focus groups. Many organizations listed here serve low-income, minority and medically underserved populations. The informants represent an array of perspectives from communities that include, but are not limited to: African American, Native American, Hispanic, Hmong, senior citizens, youth, veterans, LGBTQ, individuals with disabilities, and persons living with mental illness and substance abuse.

Name	Title	Organization
Nicole Angresano	Vice President of Community Impact	United Way of Greater Milwaukee and Waukesha County
Ken Barbeau	Director of Community Programs and Services	Housing Authority of the City of Milwaukee
Michele Bria	Chief Executive Officer	Journey House
Michael J. Brunson, Sr.	Assistant Chief of the Patrol Bureau	Milwaukee Police Department
John Chianelli	Executive Director, Vice President	Whole Health Clinical Group
M. Riccardo Colella	Medical Director of the Emergency Medical Services Division	Milwaukee County Office of Emergency Management
Héctor Colón	President and Chief Executive Officer	Lutheran Social Services of Wisconsin and Upper Michigan
Matt Crespín	Associate Director	Children's Health Alliance of Wisconsin; Milwaukee County Oral Health Task Force
Danae Davis	Executive Director	Milwaukee Succeeds
Ricardo Diaz	Executive Director	United Community Center
Darrienne Driver	Former Superintendent	Milwaukee Public Schools
Andi Elliott	Chief Executive Officer	Community Advocates
Madeline Gianforte	Executive Director	CORE/ El Centro
Michael Gifford	President and Chief Executive Officer	AIDS Resource Center of Wisconsin
Martina Gollin-Graves	President and Chief Executive Officer	Mental Health America of Wisconsin
Shelley Gregory	Transgender Resource Coordinator	Milwaukee LGBT Community Center
Eve M. Hall	President and Chief Executive Officer	Milwaukee Urban League
Janel Hines	Director of Grant Programs and Strategic Initiatives	Greater Milwaukee Foundation
George Hinton	President and Chief Executive Officer	Social Development Commission
John Hyatt	President and Chief Executive Officer	IMPACT Inc.
Lyle Ignace	Chief Executive Officer	Gerald L. Ignace Indian Health Center

<b>Name</b>	<b>Title</b>	<b>Organization</b>
Laurene Gramling Lambach	President and Chief Executive Officer	Interfaith Older Adult Services
Mike Lappen	Administrator	Milwaukee County Behavioral Health Division
Amy Lindner	President	United Way of Greater Milwaukee and Waukesha County
Susan Lloyd	Executive Director	Zilber Family Foundation
Kent Lovern	Chief Deputy District Attorney	Milwaukee County District Attorney's Office
Mary Jo Meyers	Director	Milwaukee County Department of Health and Human Services
Reggie Moore	Director	City of Milwaukee Office of Violence Prevention
Mayhoua Moua	Executive Director	Southeast Asian Educational Development (SEAD) of Wisconsin, Inc.
David Muhammad	Program Manager	City of Milwaukee Office of Violence Prevention
Steve Ohly	Clinic Manager	Aurora Walker's Point Community Clinic
Heather Paradis	Medical Director of Community Services	Children's Hospital of Wisconsin
Paula Pennebaker	President and Chief Executive Officer	YWCA Southeast Wisconsin
Carmen Pitre	President and Chief Executive Officer	Sojourner Family Peace Center
Tammy Rivera	Executive Director	Southside Organizing Center
Maria Rodriguez	Resident Services Manager	Housing Authority of the City of Milwaukee
Kathryn Sprague	Aging Resource Center Manager	Milwaukee County Department on Aging
Kenneth J. Sternig	Emergency Medical Services Division Director	Milwaukee County Office of Emergency Management
Melinda Wyant Jansen	Vice President of Programs and Chief Academic Officer	Boys & Girls Clubs of Greater Milwaukee
Natalie Zaroni	Director of Client and Program Services	Milwaukee LGBT Community Center

**Focus Groups:**

Federally Qualified Health Center (FQHC) Coalition

Local Health Departments in Milwaukee County

Free and Community Clinic Collaborative (FC3)



## Appendix 3: Crosswalk Between This CHNA Report and 501(r) Requirements

Required Content from Section 501(r) Rules	Found in this Section
Definition of the community served and how it was determined	Our Community
Description of the process and methods used to conduct the assessment: <ul style="list-style-type: none"> <li>- Data and other information used in the assessment</li> <li>- Methods of collecting and analyzing the data/information</li> <li>- Any parties collaborated with or contracted with</li> </ul>	Framework and Data Sources
Description of how the hospital solicited and accounted for input from persons who represent the broad interests of the community <ul style="list-style-type: none"> <li>- Summary of the input</li> <li>- How it was provided</li> <li>- Over what period of time</li> <li>- Names of organizations providing input</li> <li>- Include at least one governmental public health department</li> <li>- Summary of nature and extent of their input</li> <li>- Description of populations being represented (medically underserved, low-income, minority)</li> <li>- Note any written input received on the prior CHNA</li> </ul>	Voice of the Community
Prioritized description of the significant health needs identified Description of the process and criteria used in prioritizing	Priorities for Action
Description of potential resources identified to address the needs	Overview of Priorities
Evaluation of the impact of the actions taken since completing the last CHNA to address the significant health needs in that CHNA	Appendix 1: Progress Report on Results of Previous CHNA Process

## Appendix 4: Wisconsin Community Conversations Summary of Themes



### Ascension Wisconsin Community Conversations Summary of Themes

Ascension Wisconsin hosted several community conversations in January 2019 to discuss with the community the following question: *“What do we need to work on together to improve the health of our community?”* The World Café method was used to guide the conversations and involved community members discussing three related questions:

1. What does a healthy community look like?
2. In order to create a healthy community, what needs to change?
3. What would you expect to see in the next year to show we are heading in the right direction?

After each question, the table host for each group reported a summary of their conversation to the larger group. Detailed notes were taken during the report-out and any notes taken by the table host or written on the tablecloths by community members were gathered and compiled into a summary document. Consultants with Ujima United, LLC organized, analyzed and coded the summary document to identify themes that emerged across the listening sessions. Themes were organized using the County Health Rankings Model. The following is a summary of the results.

#### 1. What does a healthy community look like?

The answers for the vision of what a healthy community looks like fall across all four main categories of determinants of health (health behaviors, clinical care, social and economic factors and physical environment) and beyond. The themes that are beyond the County Health Ranking model include infrastructure or system issues that either fall within the healthcare organization, i.e. cultural competency, or that fall outside clinical care, i.e. police involvement, ending homelessness. The answers for the vision for health also include partnerships across all these systems.

**Health Behaviors:** The healthy behaviors’ recommendations revolve around access to and creating the conditions that support healthy behaviors.

- **Access:** to proper nutrition, healthy foods, gyms and exercise areas
- **Education:** on exercise, nutrition and healthy meal preparation
- **Infrastructure:** bilingual health education, culturally and linguistically appropriate training

The health behaviors determinant of health was more prominent in the Ascension St. Francis forums, as well as need for education and the connection to education and infrastructure. Healthy behaviors were less prominent at the Ascension St. Joseph forum, only mentioned 3 times, twice about physical fitness and once for health education.

### Clinical Care

- **Access:** easier access to care, quality and affordable care for all, across the lifespan
- **Infrastructure:** Holistic/integrated services, workforce diversity, partnerships with systems outside health care, multilingual services, cultural competency and sensitivity, health literacy, advocacy, support navigating systems and access resources, no duplication of services and belief that health care is a right

The clinical care determinant of health was more prominent in the Ascension St. Francis service area. However, when these topics came up in the Ascension St. Joseph area, it was reflected as infrastructure issues.

### Social and Economic Factors

- **Community connectedness:** Neighbors interacting with each other and positive relationships between them, getting along
- **Safety:** in schools, neighborhoods (free of criminal activity, gun violence and homelessness, no speeding traffic) and low incarceration
- Police involved and working well with residents
- Increased support groups
- Increased education
- Low unemployment, low poverty
- Increased communication and activities with and among children
- Engagement, community participation, understand community, proud, respect and conflict resolution

The social and economic factors determinant of health was more prominent in the Ascension St. Joseph area, and the themes reflected more emphasis on economic issues, civic engagement, access to resources. The ideas shared were more conceptual and intangible.

### Physical Environment

- Safe environment, playgrounds
- Fresh water, no lead in water or blood
- Clean streets, sidewalks
- Urban gardens, green space
- Grocery stores, healthy foods and no food desserts
- Access to affordable and reliable transportation
- Well-kept/aesthetically pleasing

Most comments during the conversations fell into the four health determinants categories listed above. The only health outcome that was called out during these sessions is mental health.

#### **Infrastructure:**

- **Organizational capacity:** health literacy, cultural competence, holistic/integrated services, approach to change, bilingual services and diverse workforce
- **Systems changes to support health:** police involvement, end homelessness
- **Partnerships with:** schools, churches, non-profits, government, etc.
- Systems alignment, interdependence, ownership, accountability, reflective leadership, address biases, vision for healthy community, deliver on promises, work together and intentional approaches to problems
- Different backgrounds, diversity

## **2. In order to create a healthy community, what needs to change?**

The answers for this question emphasized infrastructure changes.

#### **Health Behaviors**

- **Mental health:** Decrease trauma; decrease hopelessness and attitude
- Healthy food, education to increase healthy choices, food education for children
- Investment in preventative care; provide people with tools to be healthy
- Earlier involvement in care; education of children

#### **Access to Care**

- **Education:** how to navigate healthcare
- **Communication tools:** info for community members to increase awareness
- Youth and senior programs
- Personal attention and focus to patients' levels of understanding and issues/barriers (i.e. transportation)
- Proper follow up education and after seeing a patient
- Investment in preventative care

#### **Social and Economic**

- **Investment in economic development;** entrepreneurship; income
- **Safety:** healthy conflict resolution; block watch
- **Community conditions:** segregation; inclusion – everyone's voice heard
- Education
- Job creation and entrepreneurship, jobs, and eliminate poverty
- Meaningful opportunities for 13-22 year-olds; involve youth
- Role models
- Teach advocacy/empower community; invest in community and people
- Sense of community identity

### Physical Environment

- Too many corner stores with unhealthy options
- Transportation
- Green space

### Infrastructure

- **Leadership changes:** Leaders need to follow through; accountability
- **Partnerships:** Shared problem solving; get people involved/working together; collective ownership (i.e. build park as community); and systems need to incorporate the community
- **Workforce:** Providers need education; hire staff from community
- **Asset-driven model:** lead with what's positive; take pride in community; what's working?
- **Attitude:** take ownership (i.e. neighborhood association, church – knowing resources); open minded/listen
- **Community engagement:** invite community to events; listen to community and follow through; mindset – be open minded and listen to each other; passion is there to serve community; “We should go to them, be more involved; get community together; people involved in decisions should know community
- **Trust:** Ensure community knows follow up on issues/concerns to enhance reputation; more transparency in community investments
- **Health literacy:** using relevant communication tools to spread education
- Channel individual passion into the community; being invested in people
- Incorporate the community in hospital (community events, community uses Ascension facilities, associates educated on community, know patients)
- Purposeful living
- Increase values/morals
- Transparency, community involvement; be visible in changes being made; money going to community – make sure where it's going is understood; what is being done?

### 3. What changes would you expect to see in the next year to show we are heading in the right direction?

In question 1, Ascension St. Francis had a lot of emphasis on Health Behaviors. However, in reflecting on question 3, the emphasis was on infrastructure issues, as well as Ascension Wisconsin's organizational capacity. While Ascension St. Joseph also had feedback regarding infrastructure and organizational issues, they had more attention placed on mental health, health behaviors and health outcomes (chronic disease management, infant mortality) than did Ascension St. Francis focus groups. Ascension St. Joseph also had more emphasis on the determinants of health than did Ascension St. Francis.

### Health Outcomes

- Better quality of life
- Quality of care and improved quality of life

### Health Behaviors

Healthy behaviors didn't come up for Ascension St. Francis but did come up for Ascension St. Joseph. As in question 1, the feedback revolved around addressing conditions and infrastructure, rather than disease specific outcomes. The only exception was in the case of mental health and infant mortality, which were called out as specific health outcomes to be addressed.

- **Conditions that support healthy behaviors:** healthy food, fresh food – available closer; space for gym; restrict liquor and tobacco licenses
- **Mental Health:** decrease need for behavioral health; lots of folks walking around with mental illness not getting help
- Infant mortality
- Address lead issues

### Clinical Care

The major themes identified were around access and wrap-around services, with a focus on prevention and wellness. Also mentioned was lower ED and hospital stays. Quality of care did not come up as a strong theme.

### Access

- **Health Services:** more prevention education; preventative classes; support groups; mental health wrap-around services for pregnant women and fathers; increase urgent care, mental health and dental access; increase primary care; self-care for chronic disease
- **Alternative Delivery:** reduce lead levels in our children, reduce lead levels in MPS; mobile care delivery; increase doulas and pregnancy services, community health workers
- **Navigating:** more advocates to help patients navigate the system, how to access resources; all-inclusive one source to find out about Ascension resources; resource hub; follow-up phone calls; increase community health workers and advocates
- **Invest:** hospitals need to remain in the community; see real investment in community hospitals like Ascension St. Joseph and Ascension St. Francis; community education programs; providing space for exercise
- **Increase Access:** Increased access to affordable, accessible mental health care; communicate health education programs – accessible, easy like yoga; mental health wrap-around services that are accessible; accessibility in healthcare for elderly
- **Holistic:** services that compliment what is at the hospital

### Social and Economic

Ascension St. Francis emphasized resources for youth, schools and parents. For Ascension St. Joseph, the themes reflected more emphasis on safety, workforce, community investments, civic engagement, community support and access to resources.

- **Youth:** school changes – more government funding; more health education in schools; more money for local schools for training programs; place for kids to come and hang

- out; equal investment in schools; invest in children - encourage community service and engagement (i.e. candy stripers and scholarships)
- **Family & Social Support:** more advocates; people come together and look after each other; parent support groups; activate spaces in community; increase recreational activities; bring things back to the neighborhood; annual health fair; accountable for elderly; refugee programs
- **Investments:** financial commitment to community; equal investment in all schools; ratio of business (i.e, more open than closed); changes on Burleigh (i.e. businesses coming back); fewer vacant stores; increase viable businesses; increase home ownership and decrease absentee landlords; hub or incubator similar to Sherman Phoenix – bring in groups to train; want to know Ascension has a plan to invest in community
- **Employment:** better jobs; workforce development (more college/business incubators); \$15/hour contract workers; increase training for jobs and entrepreneurship; job growth to support families
- **Safety:** decrease crime; stats around decreased crime; decrease drugs, decrease violence; improved police relationships; increase safety; decrease gun violence; decrease incarceration and increase rehab investment
- **Civic Engagement:** need action; disempowerment; political action to support/enhance/incentivize services; increase voter turnout and vet right candidates
- **Address Community Conditions:** dismantling segregation – (most segregated city article), Ascension's role, partner with businesses, education, etc.; more home owners
- **Positive Attitude:** tell positive stories and celebrate the neighborhood; see positive changes

### Physical Environment

- **Beautify:** Foreclosure homes – paint murals; Improve cosmetics; clean up community, clean streets; Partner to ensure clean streets;
- **Safety:** better street lighting; walkable neighborhood
- Access to transportation
- Decrease lead levels
- Improve athletic field Washington/North

### Infrastructure

Both hospital campus service areas had strong feedback for infrastructure issues, especially around engagement and organizational changes. The majority of Ascension St. Francis feedback had an emphasis on organizational changes to address, including improved perception; accountability; leadership; cultural and linguistic competencies; and respect for the community served.

### Organizational changes

- **Improved Perception:** hospital is an intimidating setting – address by hosting a social mixer event with leaders, RNs and MDs, admission to event would be screening, healthy cooking/dancing; more welcoming staff and environment – patients have left feeling judged; friendly, respectful staff; improve trust; improve community opinion of hospital; friendly environment

- **Accountability:** want to know there's a plan – priorities identified/direction/engagement with other stakeholders and partners; identify partner with regular meetings; implement good ideas; make action plan public for accountability – be open to suggestions; see where things are in a year. Do-able actions to improve health; bed sores – accountability.
- **Transparency:** of community benefits money to ensure nonprofit status
- **Measure Outcomes:** think smaller to see outcomes within next year; start now and build from there
- **Leadership:** leadership from within the community; identify community ambassadors; Ascension be a leader in the community; Ascension can serve as a catalyst – look at existing partnerships; partner together; Ascension St. Joseph is anchor of community
- **Organizational:** cultural & linguistic competency: Spanish-speaking community feeling more welcome; culturally welcoming; cultural training from the top to receptionists; more welcoming staff and environment
- **Respect:** improving trust and opinion of the hospital; people are willing to drive to other parts of town or even out of town to access care that treats them with more respect
- **Build Trust:** Ascension needs to show people what they are going to do before folks buy in and believe

### Workforce

- **Pipeline:** money for training pipeline with MATC/UWM; offer trainings/certificates on campus then hire them; increase number of primary care providers
- **Diversity:** hire from neighborhood/community; community organizers in hospital; hire diverse employees at Ascension
- **Ratios:** hiring and staffing ratios that allow workers to also spend time in the community to provide context for the care they are giving
- **Training:** culturally-based and trauma-based training; standard of care – culture of hospital needs to be improve
- **As Employer:** want to come to Ascension St. Joseph (good reputation); Ascension is hub for thriving/sustainable jobs (allow unions)

### Community Engagement

- **Forums:** more access to these community forums for people who can't come in person; more community involvement in these types of sessions; follow-up from these meetings (i.e. what came from it?)
- **Diversity Committee** – used to have trainings for staff, did food drives, etc. – need to resurrect it
- **Neighborhood Association** – bigger meetings, more well-known with Ascension involvement; hospital should host neighborhood association meetings quarterly
- **Build Community:** family fun days; social mixer with nurses, doctors, leaders, as precursor to have stronger discussions with community about health (healthy foods, dancing, screenings with information); intergenerational events; community space at Ascension St. Joseph



- **Respect:** listen, awareness; real relationship with those being served
- **Partner with Community:** participants are brought in at the beginning of making change; be a part of decision making – not just asking people for opinions; empower collaborations; engage partners

### Communication

- **Open Channels:** information from Ascension on these conversations and how they pick priorities; community awareness of today's discussion; report and follow up from Ascension after all these discussions; ongoing dialogue; advertise Ascension St. Francis – behavioral health, senior meals; conversation with Ascension St. Joseph
- **Communication Tools and Tone:** Social media; billboards of success stories; sharing how a follow-up phone call changed their life; positive publication/press: marketing and messaging – knowing community, preventative ideas; better marketing of programs; more advocacy – no compassion for people without voice; create picture of who is doing what/murals to show change; website as communication site

To learn more about Ascension Wisconsin, visit [ascension.org/wisconsin](https://ascension.org/wisconsin)



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