Brown County Health Needs Assessment

A summary of key informant interviews

2018

Prepared by:

Center for Urban Population Health
1020 N. 12th Street, Suite 4180
Milwaukee, WI 53233
414.219.5100
www.cuph.org
www.healthofmilwaukee.org
This report was prepared by the Design, Analysis, and Evaluation team at the Center for Urban Population Health. Carrie Stehman, MA and David Frazer, MPH prepared this report. If there are any questions, please feel free to contact them at 414.219.5100.

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Introduction

This report presents a summary of public health priorities for Brown County, as identified in 2017 by a range of local experts and community members (“key informants”). This key informant report is conducted through Advocate Aurora Health. The Community Health Needs Assessment incorporates input from persons representing the broad interests of the community served, and from those who possess special knowledge of or expertise in public health.

Advocate Aurora Health identified key informants in Brown County, invited the informants to participate, and conducted the interviews in June and July 2017. The interviewers used a standard interview script that included the following elements:

- Ranking of up to five public health issues, based on the focus areas presented in Wisconsin’s State Health Plan, that are the most important issues for the County; and
- For those public health issues:
  - Existing strategies to address the issue
  - Barriers/challenges to addressing the issue
  - Additional strategies needed
  - Key groups in the community that hospitals should partner with to improve community health
  - Identification of subgroups or subpopulations where efforts could be targeted
  - Ways efforts can be targeted toward each subgroup or subpopulation

All informants were made aware that participation was voluntary and that responses would be shared with the Center for Urban Population Health for analysis and reporting. Based on the summaries provided to the Center for Urban Population Health, this report presents the results of the 2017 key informant interviews for Brown County.

The report first presents a summary of the health issue rankings, including a list of the five issues which were ranked most frequently by respondents. The next section describes the themes that presented themselves across the top ranked health topics. Finally, a summary of the strategies, barriers, partners, and potential strategies for targeted intervention described by participants is provided for each health issue.

Limitations: Only five key informants were interviewed in Brown County. The report relies on the opinions and experiences of a limited number of experts identified as having the community’s pulse. Responses may not be representative of the overall perception of community strengths and needs. It is possible that the results would have been substantially different if a different set of informants had
been interviewed. Results should be interpreted with caution and in conjunction with other Brown County data.

## A. Focus Area Ranking

In five interviews, key informants were asked to rank the top three to five major health-related issues in their county from a list of 13 focus areas identified in the State Health Plan. (See Appendix A for the full list of informants). The table below presents the results, including a summary of the number of times an issue was mentioned as a top five health issue, and the number of times an informant ranked the issue as the most important health issue. Importantly, most key informants only ranked three issue areas.

<table>
<thead>
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<th>Health Focus Area</th>
<th>Key Informant Rankings</th>
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<td>Mental Health</td>
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<td>Injury and Violence Prevention</td>
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B. Top Five Health Issues

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

1. Mental Health
2. Alcohol and Drug Use
3. Nutrition
4. Chronic Disease Prevention and Management
5. Physical Activity

Summaries of themes for each issue are presented below. As a guide, issues ranked as the top five priorities for the County are marked with this thermometer symbol:

C. General Themes

Overall, Brown County key informants focused on Behavioral Health issues—Alcohol and Drug Use and Mental Health equally—with a focus on increasing access to treatment and services and increasing coordination of resources and services in the county. Other priority areas included Nutrition, Physical Activity, and Chronic Disease Prevention and Management. Key informants talked about these three issues together due to the relationships between healthy eating, physical activity and prevention of chronic illness. Of note, only one key informant included Access to Health Services as a top-five health focus area in the county, but issues of access did arise related to all other top-rated health focus areas.

Responses to Nutrition, Chronic Disease, and Physical Activity particularly focused on accessing education about healthy eating, healthy cooking, physical activity, and diagnosis-related education for management of chronic disease. They also raised issues of having free and low cost options available for disease education and physical activity classes. Additionally, there needs to be transportation to program sites, food pantries, farmers markets, and grocery stores. Education and group classes also need to be culturally tailored and provide information in multiple languages.

Though Access did emerge as a challenge across issues, key informants emphasized assets that exist in the county, including many existing programs, service providers, health care options, and community resources. Another community asset is the willingness of partners to work together, often noting the presence of collaboration as a strategy to improve health.
Issue Summaries

Alcohol and Other Drug Use

Five key informants’ interview rankings included Alcohol and Other Drug Use as a top-five health issue. Their responses highlight the intersections of this issue with other key health issues, such as Mental Health and Access to Health Services.

Existing Strategies: Key Informants noted a number of outpatient Alcohol and Other Drug Abuse (AODA) clinics and services in the county, a strong Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) presence, related services, and sober housing in the county to address this issue. Within health systems that use Epic, substance abuse screenings have been initiated. An Operating While Intoxicated (OWI) Taskforce was created in 2011, and the number of alcohol related traffic deaths has continued to drop since then. Collaboration between community agencies to raise awareness and educate the community on the effects of binge drinking is in place. Brown County also has funding for detox services.

Barriers and Challenges: Though providers and services do exist, there are insufficient treatment resources, often with waiting lists, and the out of pocket costs for AODA assessment, inpatient treatment, and insufficient transportation services are barriers to accessing services that do exist. There are not sufficient resources or treatment options culturally tailored to the Latino community. The stigma around substance abuse and mental illness creates a barrier for some people who may need to access services.

Needed Strategies: Key informants suggested expanding Medicaid coverage of treatment services and policy changes to allow easier access to treatment, more sober housing options in the county, education for health care providers, efforts to reduce cultural acceptance of alcohol abuse and provide alternatives at celebrations, and community education about the effects of drug and alcohol abuse as strategies that could further improve health related to substance abuse. Additionally, one key informant suggested bridging gaps to provide a seamless continuum of prevention, assessment, treatment, and aftercare services so no one falls through the cracks. Promoting implementation of effective policies, practices, and programs within the county, with ongoing quality assurance and improvement processes in place to sustain these policies, practices, and programs was also suggested. It was also suggested consumer feedback could be solicited to identify and address ways in which the current treatment and recovery systems and programs are or are not meeting the needs of county residents. Finally, it was suggested that a system-wide protocol be established, drawing on best practices that is monitored for effectiveness and efficiency, that is responsive to emerging needs and technologies, and that focuses on the development of process and outcome measures.
**Key Community Partners to Improve Health:** The following partners were named as being important to work together to improve health related to AODA in the county: Legislators, families (including children and teenagers), the Pharmacy Board, current stakeholder and partners in the OWI Taskforce, the AODA Taskforce, the AA and NA community, Brown County Community Treatment Center, the criminal justice system, faith based organizations, schools, and adult organizations.

**Subgroups/populations where efforts could be targeted and how efforts can be targeted:** No themes emerged about which subgroups or populations may be in need of targeted efforts, though three key informants indicated there were no one group or population that would need to be targeted more or less than others. One key informant did not identify a group to be targeted, but reinforced their earlier ideas about needing to increase access to care in the community, needing more providers who speak multiple languages, and needing more positive role models in the community. Another key informant believe that the homeless population, patients with a dual diagnosis, and patients with an attention deficit/hyperactivity disorder (ADHD) diagnosis could benefit from additional attention and outreach activities. It was suggested the homeless population might benefit from additional intensive case management, particularly those who frequently use the emergency department for problems related to alcohol abuse and other health concerns. One key informant recommended targeted messaging be delivered in the schools to educate students about the effects of alcohol and alternative methods of stress reduction.

**Chronic Disease Prevention and Management**

Three informants included Chronic Disease among their top-five health issues for the county. One key informant focused specifically on Dementia as the area of concern. One focused specifically on diabetes. The third addressed Chronic Disease, Nutrition, and Physical Activity together, as overlapping health focus areas, with strategies to improve Nutrition and Physical Activity ultimately working as Chronic Disease Prevention and Management strategies as well. Please refer to these sections for emergent themes on these topics.

**Existing Strategies:** With regard to Dementia, the Brown County Dementia Friendly Coalition is actively making progress on developing and providing Memory Cafes, training businesses to be dementia friendly so people with dementia can continue to be part of the community, and providing awareness, education, and support surrounding Down Syndrome and Alzheimer's Disease. Brown County recently received a grant relating to crisis support for people with Dementia, so this issue will also be developed in the near future. The Aging and Disability Resource Center (ADRC) and the Alzheimer's Association Greater Wisconsin Chapter have collaborated to offer multiple Memory Matters events to provide information on warning signs of dementia, and offer free, onsite memory screens in an effort to provide early detection. There is also one dementia diagnostic clinic in Brown County at Prevea.
Regarding diabetes diagnosis, there have been efforts to provide group education, fitness, and nutrition education classes through different organizations.

**Barriers and Challenges:** Related to dementia, the number of residents impacted, delayed and incomplete diagnoses, and the burden of care and safety for those affected are challenges. Almost 15,000 people had clinically diagnosable dementia in Brown County (2013). Family members and caregivers are also affected by a loved one's diagnosis. Many cases are diagnosed too late because people do not recognize early signs and symptoms, nor do they have a preventative memory screen annually. Care is costly and oftentimes falls on loved ones or caregivers until the condition is serious enough for placement in a memory care facility. Most importantly, 90% of those living with dementia live in their own homes or homes of a loved one in the community, not in nursing home settings. Another huge barrier is the lack of actual diagnoses or just giving the broad diagnosis of "dementia," rather than the cause of the diagnosis.

With regard to diabetes, expense related to treatment, blood glucose testing supplies, medication, and dialysis are barriers to management. High healthcare costs also limit access to care.

**Needed Strategies:** For dementia, raising awareness about the symptoms, understanding the impact of the cost of care, and promoting a dementia friendly community that is supportive of all adults with disabilities were recommended. It was also suggested the county look into bringing more diagnostic clinics to the healthcare community, with physicians who are well-trained in diagnosing and managing dementia-related conditions. In addition, mental health practitioners need to understand co-occurring conditions.

For diabetes management, it was suggested residents have a place to get education once they have a diagnosis, as well as a place to exercise, receive cooking and nutrition education, and a place to get their toe nails trimmed for free or at a low cost.

**Key Community Partners to Improve Health:** Key stakeholders to engage related to dementia include: Brown County Dementia Coalition, Alzheimer's Association, Memory Assessment clinics, health systems, public health, ADRC, memory care facilities, and the Wisconsin Alzheimer's Institute at the University of Wisconsin. For diabetes, it was suggested that those who can provide education about diabetes, exercise, and nutrition be engaged as primary partners to improve health.

**Subgroups/populations where efforts could be targeted and how efforts can be targeted:** For dementia, targeting the population under 65 years old would be useful because early onset dementia (prior to age 65) is also affecting roughly 4% of the county population. “Getting an early diagnosis is invaluable to anyone, but especially this sub-group, as treatment works most effectively when started early in the onset of dementia. Another sub-group to target would be the loved ones/caregivers of those with dementia. Different cultures have different beliefs around dementia (i.e. Hmong, Hispanic) and need to understand what are the dementia signs and symptoms.” It promoting the importance of annual memory screens, providing caregivers and families education.
about providing in-home, care, providing community education, and being aware of different cultural beliefs and attitudes about dementia were suggested.

Regarding diabetes, it was suggested that social groups and families receive prevention education together, including information about preparing healthy foods, the early signs of illness, and it should be available for free or at a low cost.

**Communicable Disease Prevention and Control**

Communicable Disease Prevention and Control was not ranked as a top health issue in Brown County. Existing strategies, barriers and challenges, strategies needed, key partners, targeted populations, and targeted potential efforts were not provided for this issue.

**Environmental and Occupational Health**

Environmental and Occupational Health was not ranked as a top health issue in Brown County. Existing strategies, barriers and challenges, strategies needed, key partners, targeted populations, and targeted potential efforts were not provided for this issue.

**Healthy Growth and Development**

Healthy Growth and Development was not ranked as a top health issue in Brown County. Existing strategies, barriers and challenges, strategies needed, key partners, targeted populations, and targeted potential efforts were not provided for this issue.

**Mental Health**

All five respondents ranked Mental Health as a top health issue for the County. Key informants’ responses also intersected with issues of Alcohol and Drug Use and Access to Health Services, other health focus area included in this report.

*Existing Strategies:* Many examples of strategies in place to improve mental health in the county were provided. These include organizations that offer advocacy and support, health services that offer inpatient and outpatient treatment, case management services, infrastructure and institution becoming more responsive to the county’s mental health needs through additional staffing or specialized training, housing programs, resources to refer to, a grant for maternal mental health screening, support groups and programming, and community assessment.
Barriers and Challenges: Key informants named a number of barriers and challenges to addressing and preventing mental illness in the county, including negative cultural attitudes and stigma about mental illness, lack of service and health care providers and primary care providers who lack knowledge about mental health issues, high costs of treatment and care and barriers for the un- or under-insured, lack of transportation to services, lack of Spanish speaking providers, waiting lists for assessment and treatment, co-occurring issues of AODA, homelessness, and poverty along with mental illness, lack of a coordinated system to provide continuity of care, lack of consistency of services offered in schools, lack of a program to send patients to after they leave the emergency department, and people living in isolation who may have formerly had more social connections (e.g. immigrants, the aging and elderly, the unemployed).

Needed Strategies: Key informants offered examples of strategies that could address these issues. Many addressed issues of access, including recruiting more specialist providers and educating primary care providers, recruiting Spanish-speaking providers, addressing transportation barriers, reducing Medicaid barriers, having a referral system for under- and un-insured patients to receive care for free or low cost, and increasing case management services for those who do not require inpatient care. Other ideas are to increase community awareness of mental illness and change attitudes to reduce stigma attached to mental illness, and have more social groups (e.g. for Latinos) to decrease isolation. One person suggested organizations partner to develop shared measurable goals and improve accountability, establishment of a forum for communication that includes patients and community members to improve accessibility and choice, create an organized system for disseminating research-based data and success stories to the community, implementing trauma-focused screening and assessment tools for all systems and methods to integrate trauma indicators into existing professional screening instruments to better inform treatment intervention and referrals, and integration of social supports and community resources with mental health services.

Key Community Partners to Improve Health: The Brown County Community Treatment Center, Brown County Mental Health Task Force, ADRC, health care providers, police departments, Brown County Behavioral Health, employers, veterans, criminal justice system representatives, basic needs services providers (e.g. housing, child care, transportation), non-traditional providers who can facilitate referrals to mental health services in an effective and efficient manner, faith based organizations, school districts, families (including teenagers and children), residency and clinical internship programs for health care providers, and Spanish speaking counselors were named as partners to be engaged to improve mental health.

Subgroups/populations where efforts could be targeted and how efforts can be targeted: A few suggestions for targeted interventions with specific populations were suggested. First, people under 60 years old should be targeted because it is very difficult for someone under 55 to prove a mental illness disability for Social Security Administration (SSA) purposes, and having increased care may prevent the need for Social Security Disability Insurance (SSDI) or Social Security Income (SSI) at all, or at least provide more detail for a case file.
Second, mental health first aid training and integration of support for employers, veterans, faith based organizations, and other key community groups. This key informant suggested collaboration with local employers on educational campaigns to reduce stigma and increase community awareness of mental illness and available resources. Participate in efforts to promote continuity of care across systems, particularly for individuals transitioning from one system to another, such as young adults aging out of the children’s system, individuals returning to the community from a correctional setting, and veterans reentering civilian life, along with their families. Participate in efforts to promote integration of social supports and community resources with mental health services.

Third, it was suggested that everyone, including people with cognitive delays, people with mental illness, and the homeless, should be reached. An example of how to reach people in need is for emergency departments could do more to give community contacts and treatment, flag frequent users, and devise a system for referral to intensive case management.

Finally, it was suggested all ages need to be targeted in social situations, especially within groups of the same cultures (e.g. Latino, Hmong) to provide them education about how and where they can get help.

Nutrition

Three respondents included Nutrition as a top health issue for the County, and two of them provided examples of existing strategies, barriers and challenges, needed strategies, and key partners to engage to promote health. Responses focused on food access, food security, and healthy eating, with some responses overlapping with issues of Physical Activity and Chronic Disease Prevention and Management.

Existing Strategies: Key informants provided the following examples of existing strategies to support healthy Nutrition in the county: The Food Drive 5 toolkit encourages healthy donations to food drives/food pantries, community food drive assessment have led to a rise in donation of healthy foods, partnerships with local food pantries, farmers market and yoga Saturdays and Thursdays, events that do not have alcohol, and the Women, Infants, and Children (WIC) program.

Barriers and Challenges: Some barriers and challenges named by key informants were the underutilization of Supplemental Nutrition Assistance Program (SNAP) or FoodShare benefit money that may not be enough to sustain food security, and eligibility guidelines for these programs may not actually reflect a household’s ability to purchase nutritious, healthy foods; FoodShare benefits need to include the ability to buy household items like diapers and soap; and the weather in Wisconsin makes it difficult to access fresh produce some months of the year.
**Needed Strategies:** Key informants suggested the development and adoption of nutritional policies and programs in workplaces and schools, going beyond working with food pantries and food drives to make population wide changes, use of an assessment tool to use to determine community interest, current community opportunities available, and potential improvements needed, and use the assessment results to prioritize changes, broadening of the scope of Food Drive 5 to include promotion of healthy concession foods in parks and recreation facilities, an increase in opportunities for the consumption of healthy foods for vulnerable populations (e.g. low income, aging and elderly, people with mental illness, and disabled populations, etc.), public education on how to cook healthy food, more community gardens, and education about how to grow vegetables in an apartment.

**Key Community Partners to Improve Health:** Employers, school districts, Brown County, fitness centers, non-profit community gardens, and chronic disease diagnosis groups are examples of community partners that should be engaged to improve Nutrition in the county.

**Subgroups/populations where efforts could be targeted and how efforts can be targeted:** Key informants provided the following feedback about targeted efforts. First, it was suggested that employers, school districts, and the County could increase access to information around healthy food access and preparation programs and activities that address health related topics such as nutrition and weight management in Brown County. This could include special recommendations for locations of grocery stores and healthy corner stores, pantries, and information on FoodShare and WIC acceptance.

Another suggestion is to focus on increasing participation in SNAP/FoodShare by families with children by working with the County and other partners to conduct outreach to families who qualify for free or reduced cost school meal programs and therefore may also be eligible for SNAP/FoodShare.

Another suggestion is a cross-sector health promotion campaign on healthy eating and active living that includes development and implementation of a multi-media social marketing campaign for families on preventive strategies in the home and community to prevent obesity and other chronic diseases.

Finally, one key informant suggested this issue crosses all classes and cultures and interventions should focus on chronic disease diagnoses. Such an intervention should be conducted in a safe environment and include affordable options for exercise, information about FoodShare, nutrition education, coupons or discounts for activities, motivational triggers, self-management goals, and wellness options.
Physical Activity

Three key informants included Physical Activity as a top-five priority and two of them provided information about existing strategies, barriers and challenges, and strategies and partners needed to improve Physical Activity. Key informants’ responses overlapped with issues of Nutrition and Chronic Disease Prevention and Management.

Existing Strategies: Key informants named the parks system, low cost fitness centers, Silver Sneakers, and efforts made in schools, such as required gym classes through high school as strategies in place to increase physical activity in the county.

Barriers and Challenges: Lack of education, lack of transportation, and the associated expenses of exercise and sports participation were named as barriers to being more physically active. One key informant also said the cultural conditions are such that obesity is socially acceptable at a younger age.

Needed Strategies: More fitness centers, more free and low-cost exercise options and increased awareness about free and low-cost resources that do exist, education about physical activity, and making exercise fun, comfortable, and appealing within different cultures and respects cultural differences were suggested as strategies to improve Physical Activity in the county.

Key Community Partners to Improve Health: Key informants suggested engaging cultural groups, seniors, fitness centers, and chronic disease diagnosis groups to partner around this issue.

Subgroups/populations where efforts could be targeted and how efforts can be targeted: One key informant suggested targeting seniors, especially women, at all income levels. Ideas for how efforts could be targeted were not included.

Oral Health

Oral Health was not ranked as a top health issue in Brown County. Existing strategies, barriers and challenges, strategies needed, key partners, targeted populations, and targeted potential efforts were not provided for this issue.

Reproductive and Sexual Health

Reproductive and Sexual Health was not ranked as a top health issue in Brown County. Existing strategies, barriers and challenges, strategies needed, key partners, targeted populations, and targeted potential efforts were not provided for this issue.
**Tobacco Use and Exposure**

Tobacco Use and Exposure was not ranked as a top health issue in Brown County. Existing strategies, barriers and challenges, strategies needed, key partners, targeted populations, and targeted potential efforts were not provided for this issue.

**Access to Health Services**

Access to Health Services was ranked as a top-five health focus area by one key informant, with a focus on access to AODA and Mental Health services. Lack of access emerged as a barrier or challenge across all issues ranked in the top five by all key informants.

*Existing Strategies:* This key informant identified existing health services expanding sites and locations and free health screenings as strategies in place to address lack of access.

*Barriers and Challenges:* Barriers and challenges include providers not accepting patients at certain sites, narrow networks, frequency and availability of free screenings and follow up post-screening, and language barriers.

*Needed Strategies:* Referral coordinators, who have more awareness of resources to help patients get the health care they need, more screenings and follow up post-screening, and multi-language signage are examples of strategies that could be implemented to improve access to care.

*Key Community Partners to Improve Health:* Community centers and the non-English speaking population were provided as examples of partners who could be engaged to improve health.

*Subgroups/populations where efforts could be targeted and how efforts can be targeted:* Patients who may be more vulnerable due to low income level, un-insured or under-insured status, and racial or cultural minorities were named as those who may need targeted outreach. No specific suggestions for engaging these groups were provided.

**Injury and Violence Prevention**

Injury and Violence was not ranked as a top health issue in Brown County. Existing strategies, barriers and challenges, strategies needed, key partners, targeted populations, and targeted potential efforts were not provided for this issue.
Appendix A

Brown County Key Informants

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<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Kay Baranczyk</td>
<td>Chief Executive Officer</td>
<td>YWCA Greater Green Bay</td>
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<tr>
<td>Shromona Bose-Bigelow</td>
<td>Health &amp; Self-Sufficiency Portfolio Manager</td>
<td>Brown County United Way</td>
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<tr>
<td>Meredith Hansen (and other staff)</td>
<td>Resource Specialist</td>
<td>Aging and Disability Resource Center of Brown County</td>
</tr>
<tr>
<td>Bonnie Kuhr</td>
<td>Chief Executive Officer</td>
<td>N.E.W. Community Clinic</td>
</tr>
<tr>
<td>Melanie Maczka</td>
<td>Executive Director</td>
<td>Casa ALBA Melanie</td>
</tr>
</tbody>
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† Denotes this individual’s position/organization represents low-income populations

†† Denotes this individual’s position/organization represents medically underserved populations

††† Denotes this individual’s position/organization represents minority populations