

# SWCAP Neighborhood Health Partners

Status Report: **November 2025**

Patient's Served:

Table 1.1 Month and Year-to-date visit data for Neighborhood Health Partners

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	2025 YTD Total	2024 YTD TOTAL	2023 YTD Total
Platteville visits	41	51	43	49	38	66	74	71	62	73	51	619	546	535
Monroe Visits	16	19	25	21	24	—	—	—	—	—	—	105	192	194
Total Visits	57	70	68	70	62	66	74	71	62	73	51	724	738	729
Show-rate	90.5 %	90.9 %	87.2 %	86.4 %	81.5 %	94.3 %	90.2 %	84.5 %	88.6 %	90.1 %	86.4 %	88.2 %	90.7 %	N/A
Telehealth Visits	0	1	0	1	0	1	3	3	1	1	1	12	4	5
IUD Insertions	2	4	3	1	1	1	4	2	2	1	3	24	25	14
Implant Insertions	4	6	4	2	5	2	2	5	3	2	3	38	27	22
IUD/ Implant Removals	3	8	7	6	5	4	9	4	2	2	0	50	42	31
Pap Tests	7	6	1	10	12	8	11	7	11	9	5	87	88	59
Primary Care Visits*  (began 3/17/2025)	N/A	N/A	2	7	3	6	7	8	10	8	15	66	N/A	N/A

\*Note: primary care visits are strictly primary care. If they are seen for reproductive health concern as well, these are entered under family planning visits.

2025 YTD Unduplicated patients & Income Level: 344 (all visit types, 19 are primary care patients only, 11 patients are primary and family planning)

Income Level (unduplicated patients):

100% & below FPL: 129 (37.8%)

101-150%: 54 (15.8%)

151-200%: 41 (12.1%)

201-250%: 24 (7%)

>250%: 93 (27.3%)

2025 YTD Payer Mix:

Insurance payer source by unduplicated patient:

Public Health Insurance/Medicaid: 188 (54.7%)

Private Insurance: 24 (7%)

Uninsured/Out-of-pocket: 132 (38.3%)

<p><b>November 2025 Visit Types/Services</b></p>	<ul style="list-style-type: none"> <li>● Primary Care Visits: 15</li> <li>● Annual Exams: 7</li> <li>● Contraceptive Visits: 11</li> <li>● STI/GYN concern: 11</li> <li>● Supply pick-up/mailing: 3</li> <li>● Cancer screenings (pap only visit): 0</li> <li>● Sports Physicals: 0</li> <li>● Pregnant Test Visit (only): 1</li> <li>● Other: 2 (lab only), 1 menopause management</li> <li>● STI screening Performed             <ul style="list-style-type: none"> <li>○ Chlamydia: 14</li> <li>○ Gonorrhea: 14</li> <li>○ HIV: 4</li> <li>○ Syphilis: 5</li> </ul> </li> </ul>
<p><b>November 2025 Expenses</b> (as of 12/3/2025)</p>	<ul style="list-style-type: none"> <li>● Total expenses for clinics last month: <b>\$17,008.68 (not all Nov expenses are in yet)</b></li> <li>● <b>Year-to-Date</b> Expenses through 12/3/25: <b>\$385,477.43 (direct costs – cannot get report with indirect to pull up).</b> <ul style="list-style-type: none"> <li>○ Amount billed to Medicaid/Commercial Insurance: <b>\$174,376.55 received to date</b></li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ Expenses paid by grant funds: <b>\$ 172,945.50 to date (\$46,000+ pending reimbursement yet from Title X as we are awaiting updated contract)</b></li> <li>○ Expenses paid by other means: <b>\$10,486.25</b> in grants from United Way and donations</li> </ul>
<p><b>New Developments</b></p>	<ul style="list-style-type: none"> <li>● Our pediatric primary care practice is growing, slowly but surely. We've got 8 new pediatric patients YTD that we've seen for well child visits and/or vaccines. A total of 18 vaccinations were given thus far! As Head Start classrooms return, we plan to partner with Head Start for the Darlington classroom to reach more children who are in need of services.</li> <li>● Marketing: working with Shyanne on improving marketing to reach more patients to continue to grow our primary care practice. Looking at implementing new marketing: Instagram posts, paid social media ads (more frequent renewals), targeted marketing for menopause management, primary care and well child visits. Additionally, we are planning outreach/marketing with the help of our CHWs to Amish and Latinx communities to improve their access to healthcare services in the near future.</li> </ul>

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**Program Director**

SWCAP Neighborhood Health Partners

# SWCAP Neighborhood Health Partners

Status Report: **December 2025**

Patient's Served:

Table 1.1 Month and Year-to-date visit data for Neighborhood Health Partners

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	2025 YTD Total	2024 YTD TOTAL AL	2023 YTD Total
Platteville visits	41	51	43	49	38	66	74	71	62	73	51	66	685	546	535
Monroe Visits	16	19	25	21	24	—	—	—	—	—	—	—	105	192	194
Total Visits	57	70	68	70	62	66	74	71	62	73	51	66	790	738	729
Show-rate	90.5 %	90.9 %	87.2 %	86.4 %	81.5 %	94.3 %	90.2 %	84.5 %	88.6 %	90.1 %	86.4 %	92.9 %	88.6 %	90.7 %	N/A
Telehealth Visits	0	1	0	1	0	1	3	3	1	1	1	0	12	4	5
IUD Insertions	2	4	3	1	1	1	4	2	2	1	3	4	28	25	14
Implant Insertions	4	6	4	2	5	2	2	5	3	2	3	5	43	27	22
IUD/ Implant Removals	3	8	7	6	5	4	9	4	2	2	0	6	56	42	31
Pap Tests	7	6	1	10	12	8	11	7	11	9	5	5	92	88	59
Primary Care Visits* (began 3/17/2025)	N/A	N/A	2	7	3	6	7	8	10	8	15	10	76	N/A	N/A

\*Note: primary care visits are strictly primary care. If they are seen for reproductive health concern as well, these are entered under family planning visits.

2025 Unduplicated patients & Income Level: 367 (335 in 2024)

Income Level (unduplicated patients):

- 100% & below FPL: 138 (38%) – was 33% in 2024
- 101-150%: 58 (16%)
- 151-200%: 44 (12.1%)
- 201-250%: 25 (6.9%)
- >250%: 98 (27%)

2025 Payer Mix:

Insurance payer source by unduplicated patient:

- Public Health Insurance/Medicaid: 202 (55%)
- Private Insurance: 26 (7.1%)
- Uninsured/Out-of-pocket: 139 (37.9%) – was 35% in 2024

<p><b>December 2025 Visit Types/Services</b></p>	<ul style="list-style-type: none"><li>● Primary Care Visits: 10</li><li>● Annual Exams: 5</li><li>● Contraceptive Visits: 23</li><li>● STI/GYN concern: 12</li><li>● Supply pick-up/mailing: 7</li><li>● Cancer screenings (pap only visit): 3</li><li>● Sports Physicals: 0</li><li>● Pregnant Test Visit (only): 4</li><li>● Other: 1 (breast concern); 1 lab visit</li><li>● STI screening Performed<ul style="list-style-type: none"><li>○ Chlamydia: 15</li><li>○ Gonorrhea: 15</li><li>○ HIV: 6</li><li>○ Syphilis: 7</li></ul></li></ul>
<p><b>December 2025 Expenses</b> (as of 1/8/2026)</p>	<ul style="list-style-type: none"><li>● Total expenses for clinics last month: <b>\$32,468.88 (not all Nov expenses are in yet)</b></li><li>● <b>Year-to-Date</b> Expenses through 12/31/25: <b>\$387,337 (direct costs only – cannot get report with indirect to pull up).</b><ul style="list-style-type: none"><li>○ Amount billed to Medicaid/Commercial Insurance: <b>\$210,626.36 received to date (some outstanding claims yet)</b></li><li>○ Expenses paid by grant funds: <b>\$ 172,107.08 to date (\$46,000+ pending reimbursement yet from Title X as we are awaiting updated contract)</b></li></ul></li></ul>

	<ul style="list-style-type: none"> <li>○ Expenses paid by other means: <b>\$12,011.25</b> in grants from United Way and donations</li> </ul>
<p><b>New Developments/ 2025 in Review</b></p>	<ul style="list-style-type: none"> <li>● In 2025 we saw growth in number of unduplicated patients and total visits despite closing a clinic location 5/30/2025. This was driven by our Monroe patients still seeing us in Platteville and 76 primary care visits!</li> <li>● In 2025 we launched primary care services for the whole family. This included: <ul style="list-style-type: none"> <li>○ 76 primary care visits</li> <li>○ 23 patients under 18 (age ranges from 1 to 17)</li> <li>○ gave 21 total vaccinations to children under 19 (this was in the last 3 months of the year)</li> <li>○ have several chronic disease patients we are now caring for all who've achieved good control of their conditions (A1C at goal of 7 or less, controlled blood pressure)!</li> </ul> </li> <li>● Trends: <ul style="list-style-type: none"> <li>○ The majority of pediatric patients we've seen are uninsured, which is a trend we will continue to watch in 2026. I'm concerned by this.</li> <li>○ Patients served at &lt;100% of federal poverty line and without insurance continues to grow year over year. We are at a 60%/40% split now for insured vs uninsured patients. This has great impact on our sustainability as a clinic especially in the wake of federal funding cuts and limited funding opportunities.</li> <li>○ We are seeing Influenza A cases in the area and have heard rumblings of COVID-19 as well. We've performed 4 rapid COVID-19/FLU A/B tests in clinic in the past couple of weeks. We're happy to be able to offer this service to improve access for sick care!</li> </ul> </li> <li>● Goals for 2026: <ul style="list-style-type: none"> <li>○ Continue to grow our pediatric practice. I'd like to see 50 well child visits this year (means we'd add 50 new pediatric patients). Our intent is to work closely with SWCAP Head Start and WIC programs to ensure we are providing access for our families.</li> <li>○ Focused outreach to our Amish and Latinx populations. These are prevalent populations in our community that are underserved. We want them to know we are here for them.</li> </ul> </li> </ul>

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- Offer niche services: menopause is something that isn't talked about enough and is a hot topic right now. We plan to do some educational content on social media to bring awareness to it and offer support and services for menopause symptom management for our community. Stay tuned!
  - Expand our practice: We spent time credentialing with Medicare as well as Iowa and Illinois Medicaid last year. We can offer both primary care and reproductive health services to these patient populations now which improves their access.
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SWCAP Neighborhood Health Partners

# SWCAP Neighborhood Health Partners

Status Report: **January 2026**

Patient's Served:

Table 1.1 Month and Year-to-date visit data for Neighborhood Health Partners

	<u>Jan 2026</u>	<u>2026 YTD Total</u>	<u>2025 YTD Total</u>	<u>2024 YTD TOTAL</u>	<u>2023 YTD Total</u>
Platteville visits	73	73	685	546	535
Total Visits	73	73	790	738	729
Show-rate	92.4%	92.4%	88.6%	90.7%	N/A
Telehealth Visits	0	0	12	4	5
IUD Insertions	0	0	28	25	14
Implant Insertions	1	1	43	27	22
IUD/ Implant Removals	4	4	56	42	31
Pap Tests	3	3	92	88	59
Primary Care Visits*	15	15	76	N/A	N/A

\*Note: primary care visits are strictly primary care. If they are seen for reproductive health concern as well, these are entered under family planning visits.

2026 Unduplicated patients & Income Level: 53 (367 in 2025, 335 in 2024)

Income Level (unduplicated patients):

100% & below FPL: 24 (46.1%)

101-150%: 9 (17.3%)

151-200%: 4 (7.7%)

201-250%: 3 (5.8%)

>250%: 12 (23.1%)

2026 Payer Mix:

Insurance payer source by unduplicated patient:

Public Health Insurance/Medicaid: 21 (39.7%)

Private Insurance: 5 (9.4%)

Uninsured/Out-of-pocket: 27 (50.9%)

<p><b>January 2026 Visit Types/Services</b></p>	<ul style="list-style-type: none"> <li>● Primary Care Visits: 15</li> <li>● Annual Exams: 6</li> <li>● Contraceptive Visits: 19</li> <li>● STI/GYN concern: 15</li> <li>● Supply pick-up/mailing: 11</li> <li>● Cancer screenings (pap only visit): 0</li> <li>● Pregnant Test Visit (only): 0</li> <li>● Other: lab draw (7)</li> <li>● STI screening Performed <ul style="list-style-type: none"> <li>○ Chlamydia: 19</li> <li>○ Gonorrhea: 19</li> <li>○ HIV: 6</li> <li>○ Syphilis: 6</li> </ul> </li> </ul>
<p><b>January 2026 Expenses</b> (as of 2/6/2026)</p>	<ul style="list-style-type: none"> <li>● Total expenses for clinics last month: <b>\$16,836.94 (not all expenses in yet)</b></li> <li>● <b>Year-to-Date</b> Expenses through 12/31/26: <b>\$16,836.94</b> <ul style="list-style-type: none"> <li>○ Amount billed to Medicaid/Commercial Insurance: <b>\$24,370.35</b></li> <li>○ Expenses paid by grant funds: <b>\$ 0</b></li> <li>○ Expenses paid by other means: <b>\$0</b> in grants from United Way and donations</li> </ul> </li> </ul>
<p><b>New Developments</b></p>	<ul style="list-style-type: none"> <li>● February is Heart Health month – we will be doing FREE blood pressure screenings all month, walk-ins are welcome.</li> <li>● DHS performed their annual site visit for our Title X funding requirement, while we haven't received our official documentation, they verbally reported no findings. During their visit, we expressed our funding and sustainability concerns for family planning services– growing uninsured population, rising costs of providing care and continued funding costs despite these changes. We're hopeful that they will take our needs into consideration as year 5/5 of this funding cycle comes out for 4/1/2026.</li> <li>● We problem solved with DHS to bring fee-exempt testing for both Hepatitis C and Trichomonas – the only two STI tests that were not offered at no cost - to our uninsured patients through Wisconsin State Lab of Hygiene. We hope to be able to offer this to patients in the very near future!</li> </ul>

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- We are working on local outreach to small employers (who may not offer health insurance to their employees) to help them understand the services we offer to individuals and families at lower cost than many other clinics.
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SWCAP Neighborhood Health Partners

# Care Coordination Network Status Report

December 2025 – November 2025 activities

## SWCAP partners

Community Health Workers are consistently working with LIFT, Head Start, Supportive Housing, NHP clinic in Platteville, and Weatherization to wholistically serve all clients.

## Community agency and/or organizational partners

We have formed collaborative partnerships with each organization to refer patients to the SWCAP Care Coordination Network so that Community Health Workers can work individually with patients to address social determinant of health barriers identified by screening tools both organizations are utilizing. This is to improve health outcomes and equity.

We have Memorandum of Understandings (MOUs) with the following medical facilities

- Southwest Health,
- Grant Regional,
- Gunderson Boscobel,
- Upland Hills,
- Richland Hospital, and
- Lafayette Memorial Hospital

## Care Coordination Network News

CCN Project Manager activities for November 2025

- Attended WFA core team meeting
- Attended 3 sessions of the Family Centered Coaching training
- Presented on CCN leadership and allyship with CHWs
- Attended SWWI Homeless Coalition meeting
- Attended Iowa County Homeless Coalition meeting
- Met with Social Workers and others from Emplify Health to discuss referral process to CCN

Meetings facilitated

- 1:1 meetings with each Community Health Worker
- CCN staff meeting

## Case Numbers for Previous Month – November

## **Referral Sources**

SWCAP – 2

Community Partners – 2

Richland Hospital – 2

Self-Referrals - 8

Southwest Health – 5

Upland Hills Health - 1

**The number of referrals year to date is 394**

We continue to receive most of our referrals from Southwest Health and self referrals. Project Manager continues to work closely with the partners to ensure closed loop referrals to keep all parties engaged and informed.

In November, CCN served 150 clients – all of those clients were either transferred to a CHW or were discharged. 43 clients were discharged for the following reasons;

Declined further services - 5

Deemed inappropriate - 1

Moved, transferred or out of service area - 2

Not impactable - 7 (clients who do not participate in working with a CHW)

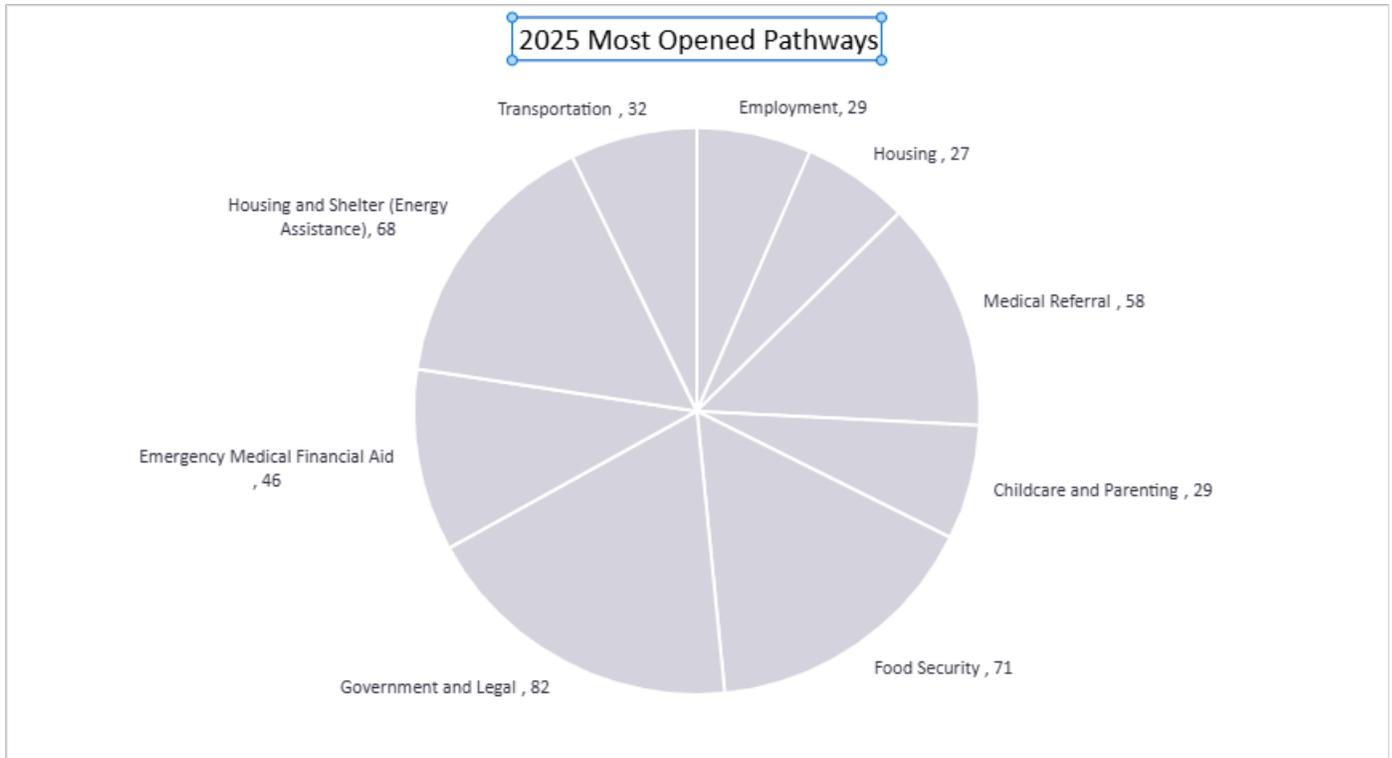
Pathways complete - 6

Patient Request - 2

Refer to another agency or level of care to not duplicate services - 8

Unable to locate after three separate attempts - 12

**Pathways Opened in November 2025 have been added to create the chart below**



We are beginning to see more calls for Medicaid/Medicare assistance, housing, and food security. With programs losing funding and closing, there are going to continue to be fewer resources in our area. We will work to build new relationships with any new or updated resources.

**Additional information about the clients we see in the Care Coordination Network**

Federal Poverty Levels of active clients

125% and below – 52

126% and above – 33

Unknown – 20

**CHW Activity Summary – November Events**

CHWs spend time meeting with outside agencies to educate and inform on the Care Coordination Network, CHW roles and provide feedback as to what they are seeing in the field. CHWs are collaborating with others to plan and facilitate events with other agencies.

You will find information on what CHWs have been working on below. Please reach out with any questions. If you would like to visit our Platteville office, or meet some of the Community Health Workers, call Christie at 608-553-4642.

### **Impact Stories -**

- Provided diabetes follow up and education to an individual who was sent home from the emergency room without instructions on how to administer his medication, after being seen for extremely high glucose levels. The individual was unaware he was diabetic and was grateful to have a community health worker help him navigate this new diagnosis.
- Participated in the Rural Health Cooperative's focus group on the experience of the Darlington Latinx community with access to health care. Approximately 40 community members relayed their experiences with area hospitals and clinics and voiced their desire for in-person Q & A sessions with medical professionals on subjects related to preventative measures for diabetes and other common medical conditions. There was also discussion on how to access medical financial aid.
- Connected individual to community work with a local humane society. He was able to complete mandatory community service hours while helping out with the humane society garage sale and with the construction of their new building.

### **Advocacy -**

- Assisted with Community Health Needs Assessment in Lafayette County; talked to community members about healthcare in their area and what they like/dislike, resources they would like to see, challenges they are facing and suggestions about what they would like to have in terms of healthcare and health education.
- Attended Multilanguage Learners Family Night in Monroe at Monroe High School. Hosted mental health break out session in collaboration with SARP (Sexual assault Recovery Program) advocate. Talked to parents and other attendees about what a community health worker does.
- Continued sessions of Bienvenido program for area high school students in Monroe. Host mental health sessions in collaboration with Green Haven Domestic Violence advocate and SARP advocate.
- Began Family Centered Coaching Training. Learn about mindset and understanding our clients. Weekly 4-hour sessions centered around how we can celebrate our clients while helping them succeed by listening to understand.
- Helped several individuals with financial aid applications, with savings in the tens of thousands of dollars.

### **Needs**

Affordable

- Housing
- Transportation
- Unrestricted funding to help with utility bills/rent/car repairs

Readily accessible food pantries, currently people are limited by the times and locations in rural areas (see lack of transportation)

# Care Coordination Network Status Report

## December 2025 activities

### SWCAP partners

Community Health Workers are consistently working with LIFT, Head Start, Supportive Housing, NHP clinic in Platteville, and Weatherization to wholistically serve all clients.

### Community agency and/or organizational partners

We have formed collaborative partnerships with each organization to refer patients to the SWCAP Care Coordination Network so that Community Health Workers can work individually with patients to address social determinant of health barriers identified by screening tools both organizations are utilizing. This is to improve health outcomes and equity.

We have Memorandum of Understandings (MOUs) with the following medical facilities

- Southwest Health,
- Grant Regional,
- Gunderson Boscobel,
- Upland Hills,
- Richland Hospital, and
- Lafayette Memorial Hospital

### Care Coordination Network News

CCN Project Manager activities for December 2025

- Attended WFA core team meeting
- Attended 3 sessions of the Family Centered Coaching training
- Met with Rebecca Steffes at Community Connections Free Clinic to discuss continuation of partnership with a Community Health Worker
- With Kaitlyn Klug, social worker at SW Health, met with Grant County ADRC to discuss services, referrals and when to call ADRC vs. Send referral to SWCAP CCN
- Attended a statewide meeting for CIP Coordinators'
- Attended a Boot camp translation meeting – getting everyone updated and next steps
- Met with HS staff in Boscobel to work on the diaper grant; will spend time in January updating documents and process'
- Attended Health and Wellness Department meeting

Meetings facilitated

- 1:1 meetings with each Community Health Worker

## **Case Numbers for Previous Month – December**

### **Referral Sources**

Emplify Health – Boscobel – 4

Grant Co. Social Services – 1

Richland Hospital – 1

Southwest Health – 3

Upland Hills Health – 5

### **The number of referrals year to date is 414**

We continue to receive most of our referrals from Southwest Health, Upland Hills Health and self-referrals. Project Manager continues to work closely with the partners to ensure closed loop referrals to keep all parties engaged and informed.

In December, CCN served 128 clients – all of those clients were either transferred to a CHW or were discharged. 21 clients were discharged for the following reasons;

Not impactable - 3 (clients who do not participate in working with a CHW)

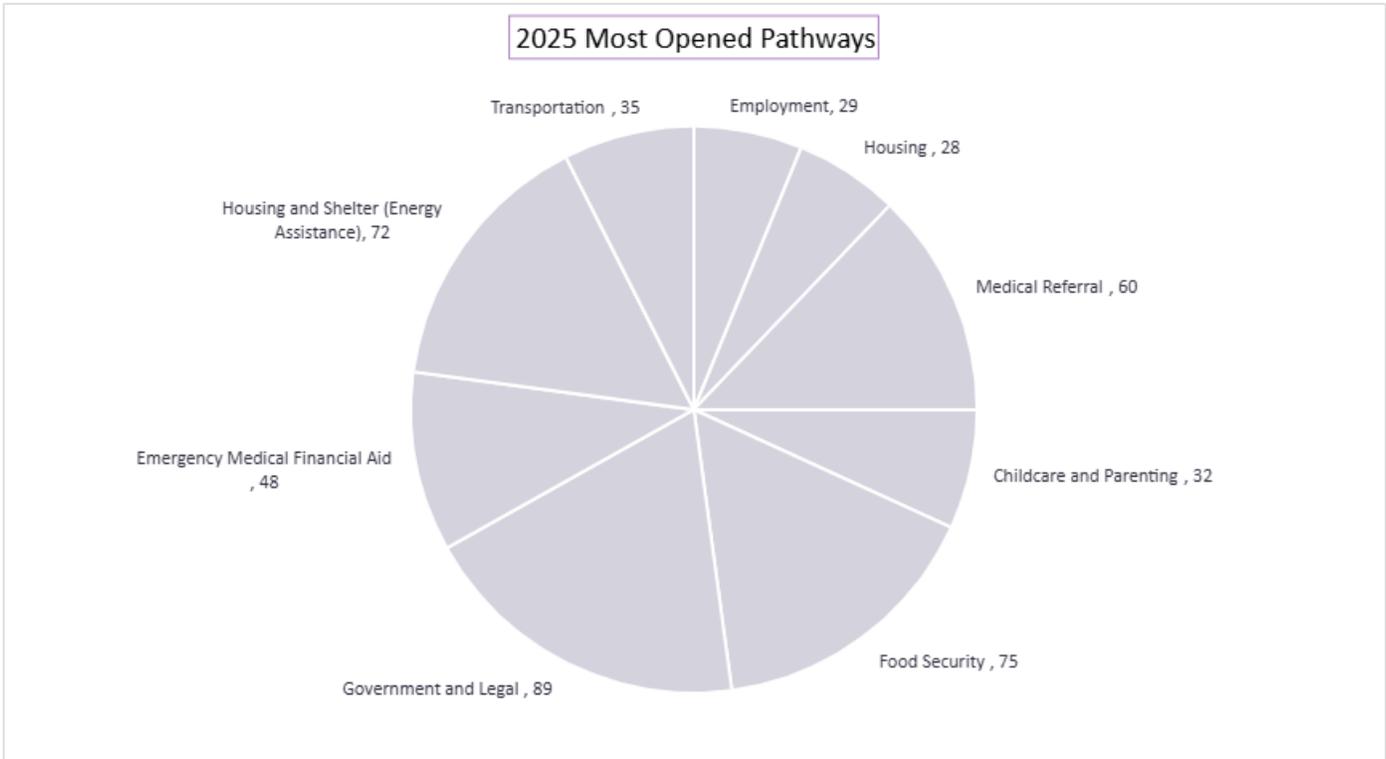
Pathways complete - 3

Patient Request - 1

Refer to another agency or level of care to not duplicate services - 3

Unable to locate after three separate attempts - 11

**Pathways Opened in December 2025 have been added to create the chart below**



We are beginning to see more calls for Medicaid/Medicare assistance, housing, and food security. With programs losing funding and closing, there are going to continue to be fewer resources in our area. We will work to build new relationships with any new or updated resources.

**Additional information about the clients we see in the Care Coordination Network**

Federal Poverty Levels of active clients

125% and below – 62

126% and above – 34

Unknown – 32

Unknowns include people we never got in touch with; we have no way of knowing what their income or household size is. This month, we had 11 clients who were not responding to our attempts to connect.

**CHW Activity Summary – December 2025 Events**

CHWs spend time meeting with outside agencies to educate and inform on the Care Coordination Network, CHW roles and provide feedback as to what they are seeing in the field. CHWs are collaborating with others to plan and facilitate events with other agencies.

You will find information on what CHWs have been working on below. Please reach out with any questions. **If you would like to visit our Platteville office, or meet some of the Community Health Workers, call Christie at 608-553-4642.**

**Impact Stories -**

Shadowed diabetes dietician at the Richland Free Clinic. Helped to interpret during session providing instruction on how to use blood sugar testing kit and information on healthy eating. These shadowing sessions will be followed by Diabetes Deep Dive training in February, offered by the Rural Wisconsin Health Cooperative.

### **Advocacy –**

Jen was elected President of the Wisconsin Association for Community Health Workers we meet bimonthly to discuss sustainability of the CHW workforce along with Training and Credentialing in the future.

Monica Sella, Monse Salcido Paz, and Susana Ortega, organized and helped interpret for the December 2025 Immigration Legal Clinic with attorneys from the Catholic Multicultural Center. The attorneys were able to provide 14 private consultations.

All CCN staff took time off to spend with family and friends over the holiday season. We will come back together in January to plan future events, updated documents, etc.

### **Needs**

Affordable

- Housing
- Transportation
- Unrestricted funding to help with utility bills/rent/car repairs

Readily accessible food pantries, currently people are limited by the times and locations in rural areas (see lack of transportation)

# Care Coordination Network Status Report

## January 2026 activities

### SWCAP partners

Community Health Workers are consistently working with LIFT, Head Start, Supportive Housing, NHP clinic in Platteville, and Weatherization to wholistically serve all clients.

### Community agency and/or organizational partners

We have formed collaborative partnerships with each organization to refer patients to the SWCAP Care Coordination Network so that Community Health Workers can work individually with patients to address social determinant of health barriers identified by screening tools both organizations are utilizing. This is to improve health outcomes and equity.

We have Memorandum of Understandings (MOUs) with the following medical facilities

- Southwest Health,
- Grant Regional,
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- Upland Hills,
- Richland Hospital, and
- Lafayette Memorial Hospital

### Care Coordination Network News

CCN Project Manager activities for January 2025

- Prepared Quarterly reports for all partners with MOUs
- Attended a training – Workplace Wellness with Sources of Strength
- Attended the Health and Wellness department meeting
- Met with Jodi S to discuss the Rubber Ducky diaper grant
- Met with Tawny Hardyman to discuss collaboration with Head Start
- Began attending the Family Centered Coaching Supervisor training
- Attended a 3-day conference in Orlando, FL –
  - Collaborated with FCC cohort
  - Rural Transportation – great ideas about billing Medicaid for LIFT services
  - Head Start Caucus – discussions revolved around issues that HS is having keeping staff, transportation, etc.
  - Data – using the Asana program to track goals, outcomes and next steps for the agency

Meetings facilitated

- 1:1 meetings with each Community Health Worker, twice a month

## **Case Numbers for Previous Month – January**

### **Referral Sources**

ADRC Grant Co. - 2

Boscobel Housing Authority – 1

Emergency Warming Center – 1

Medical facilities – 11

Self/Family/Friend referral – 6

Community Partners (Library, Jail, and School district)– 4

SWCAP program – NHP – 2

### **The number of referrals year to date is 30**

We continue to receive most of our referrals from Southwest Health, Upland Hills Health and self-referrals. Project Manager continues to work closely with the partners to ensure closed loop referrals to keep all parties engaged and informed.

In January, CCN served 131 clients – all of those clients were either transferred to a CHW or were discharged. 31 clients were discharged for the following reasons;

Declined Further Services – 2

Deemed inappropriate – 2

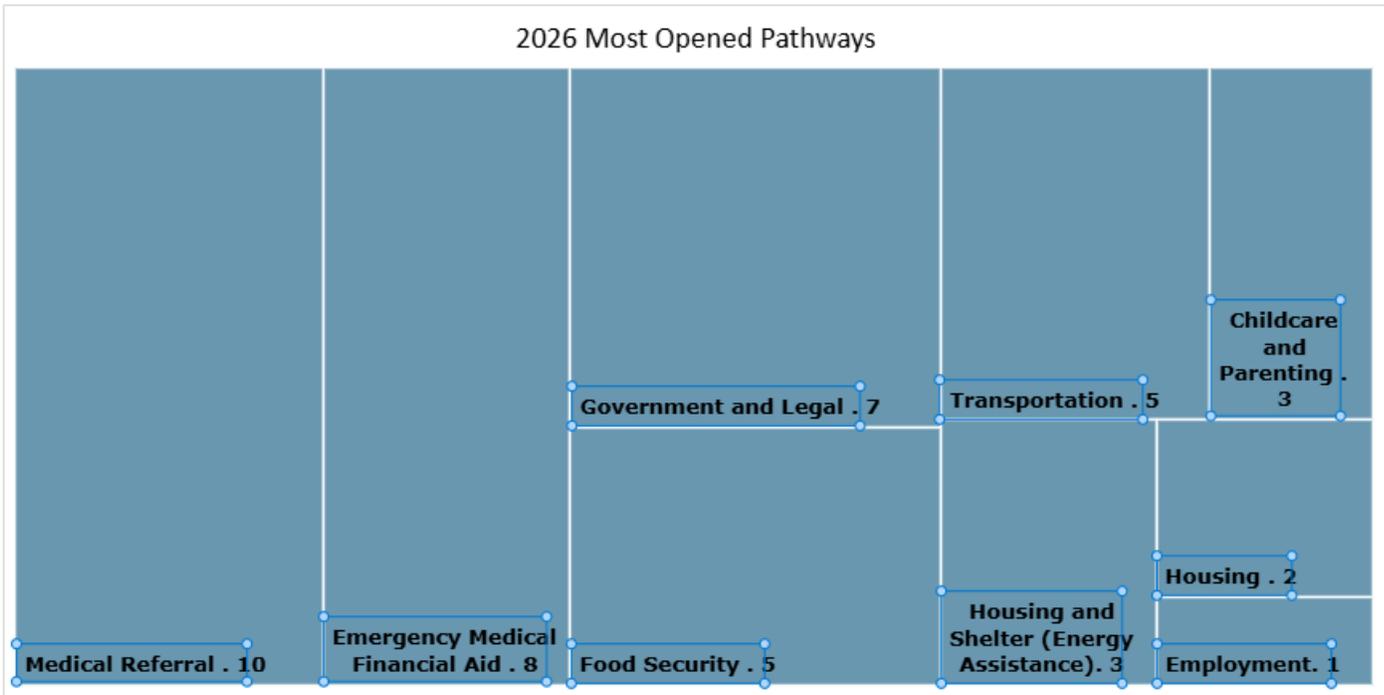
Not Impactable – 2

Pathways Complete – 8

Referred to another agency for a different level of care – 6

Unable to locate after several attempts - 11

**Pathways Opened in January 2026 have been added to create the chart below**



We are beginning to see more calls for Medicaid/Medicare assistance, housing, and food security. With programs losing funding and closing, there are going to continue to be fewer resources in our area. We will work to build new relationships with any new or updated resources.

**Additional information about the clients we see in the Care Coordination Network**

Federal Poverty Levels of active clients

125% and below – 80

126% and above – 29

Unknown – 22

Unknowns include people we never got in touch with; we have no way of knowing what their income or household size is. This month, we had 11 clients who were not responding to our attempts to connect.

**CHW Activity Summary – January 2026 Events**

CHWs spend time meeting with outside agencies to educate and inform on the Care Coordination Network, CHW roles and provide feedback as to what they are seeing in the field. CHWs are collaborating with others to plan and facilitate events with other agencies.

You will find information on what CHWs have been working on below. Please reach out with any questions. **If you would like to visit our Platteville office, or meet some of the Community Health Workers, call Christie at 608-553-4642.**

### **Impact Stories -**

A patient with chronic diabetes who is being monitored closely by his primary care provider and CHW was able to significantly improve glucose levels following implementation of dietary change recommendations.

A brief overview of hospital financial assistance applications submitted and approved in 2025 and 2026 showed patient savings of approximately \$156,000. These savings are in addition to the savings incurred by patients who qualified and were approved for Emergency Medicaid.

### **Advocacy –**

#### **Needs**

Affordable

- Housing
- Transportation
- Unrestricted funding to help with utility bills/rent/car repairs

Readily accessible food pantries, currently people are limited by the times and locations in rural areas (see lack of transportation)

# **Community Wellness Group Monthly Board Report**

**December 2025**

Month: November 2025 Activities

**Monthly Report Opportunity House – Sheryl Brokopp**

**The Opportunity House served 6 individuals.**

## **Social Media**

- Post Views: **583**
- Post Engagements: **26**

## **Outreach & Networking**

- 11/5, 12, 26 Collaborative Meetings with the Fletcher Group
- 11/6, 20 Iowa County Treatment Court
- 11/10 Coaching Models Sub-Committee
- 11/5, 12, 19, 26 Meetings with Unified Community Services
- 11/13 Wisconsin Sober Home Operators COP
- 11/13, 26 Grant County Treatment Court
- 11/18 Meeting with Southwest Vo-Tech Professor
- 11/25 Health and Wellness Departmental Meeting
- 

## **Training & Learning Opportunities**

- 11/6 Financial Stability for Recovery Homes- The Fletcher Group
- 11/11 How Isolation Fuels Opioid Addiction- Raechel Wurzman
- 11/14 Rural Resiliency Circle – Sunriseag.net
- 11/24 Open Enrollment Meeting – Courtney Messer

## **Ongoing Work**

- Monitor and Manage Traffic by Motion Sensor Cameras
- Individual Meetings with Residents
- Ongoing Search for suitable affordable Housing
- SAGE Ledger/Accounts Payable and Receivables/Send Invoices
- Adoni Trainings
- Sending Online Invoices/Payments

## **Maintenance at 504 Bennett Rd.**

- Restart Womens Water Heater several times

# **Community Wellness Group Monthly Board Report**

**January 2026**

Month: December 2025 Activities

**Monthly Report Opportunity House – Sheryl Brokopp**

**The Opportunity House served 6 individuals.**

## **Social Media**

- Post Views: **401**
- Post Engagements: **12**

## **Outreach & Networking**

- 12/3/17 Collaborative Meetings with the Fletcher Group
- 12/4, 18 Iowa County Treatment Court
- 12/8 Coaching Models Sub-Committee
- 12/3, 17 Meetings with Unified Community Services
- 12/11 Wisconsin Sober Home Operators COP
- 12/11, 23 Grant County Treatment Court
- 12/23 Health and Wellness Departmental Meeting

## **Training & Learning Opportunities**

### **Ongoing Work**

- Monitor and Manage Traffic by Motion Sensor Cameras
- Individual Meetings with Residents
- Ongoing Search for suitable affordable Housing
- SAGE Ledger/Accounts Payable and Receivables/Send Invoices
- Adoni Trainings
- Sending Online Invoices/Payments

### **Maintenance at 504 Bennett Rd.**

- Clean Element on Water Heater Womens side

**SWCAP WIC Progress Report**  
January 2026  
Amy Graber, WIC Director/Nutritionist

Client Volume:

Most recent months available:

Oct 2025	823 Women, Infants, and Children received WIC food benefits.
Nov 2025	790 Women, Infants, and Children received WIC food benefits

News

- ♥ In November, Congress passed a bill to end the 43-day government shutdown. The bill fully funds WIC for fiscal year 2026. In 2026, Wisconsin WIC will transition from a calendar year (Jan-Dec) to the federal fiscal year, Oct-Sept. Our fiscal year 2026 grant will be a nine-month grant, Jan-Sept. Then fiscal year 2027 will begin in Oct 2026 through Sept 2027.
  
- ♥ Meetings and Trainings
  - Met with our new Regional Nutrition Consultant Kara Kerrigan. The consultant that we had for many years, Terrell Brock, has retired.
  - WIC Partnership with Clinical RDNs and Specialty Care Providers webinar
  - Statewide WIC webinars for WIC Directors
  - Statewide WIC webinar on upcoming changes to WIC foods
  
- ♥ SWCAP WIC has 11 “WIC vendors” – grocery stores and pharmacies that redeem WIC benefits in our four-county service area (Crawford, Richland, Iowa and Lafayette counties). In 2025, WIC benefits redeemed at these stores totaled \$652,394.06. Many thanks to these vendors and to the WIC staff who diligently issue benefits to WIC families every month.



Village of Muscoda	Service ended	0	0	0	0	0	0	0	0	0	0
Jenor Apartments	43	43	43	43	43	43	43	43	Service ended		
Muscoda Low-income Apartments	21	21	21	21	Service ended	0	0	0	0	0	\$0.00
Village of Viola/Senior Apartments	33	43	45	48	Service ended	0	0	0	0	0	0
Estimated affected people due to lack of food/funding	63	63	63	63	135	135	135	178	178	178	178

# 2026 Food Pantry Status Report

Location	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	TOTAL
<b>Arena People Served</b>	33												33
Backpacks	30												30
Number of Employees	1	1	1	1	1	1							
Number of Volunteers	2	2	2	2	2	2							
<b>Darlington People Served</b>	368												368
Backpacks													0
Number of Employees	1	1	1	1	2	2							
Number of Volunteers	18	18	18	18	18	18							
<b>Dodgeville People Served</b>	669												669
Backpacks	120												120
Number of Employees	2	2	2	2	2	2							
Number of Volunteers	9	10	15	15	10	9							
<b>Hazel Green People Served</b>	270												270
Backpacks													0
Number of Employees	1	1	1	1	1	1							
Number of Volunteers	7	7	7	10	7	7							
<b>Riverdale People Served</b>	119												119
Backpacks	95												95
Number of Employees	1	1	1	1	1	1							
Number of Volunteers	36	36	36	39	39	39							
<b>Pop-Up Stops/Senior Deliveries</b>	72												72
senior deliveries													
Number of Employees	2	2	2	2	2	2							
Number of Volunteers	2	2	2	2	2	2							

Estimated affected people due to lack of food/funding