Wisconsin Public Health Council
2009 Report to Governor Jim Doyle

The Public Health Council, created in mid-2004 by the Legislature, advises the Governor, the Legislature, Wisconsin citizens and the Department of Health Services (DHS) on the state health plan, including implementing Healthiest Wisconsin 2010 and developing Healthiest Wisconsin 2020, and on the coordination of responses to public health emergencies. The Council strives to serve as a respected, objective, and balanced source of public health information for the Governor, the Legislature, and the DHS.

Council Organization
Public Health Council membership is through appointment by the Governor. The Council includes three committees: the Executive Committee, consisting of elected officers and committee chairs; the State Health Plan Committee; and the Emergency Preparedness Committee. In 2009, the Council met six times. Meeting agendas are posted in accordance with the state Open Meetings Law. They include an open forum at the beginning of each meeting for public input, and reports from each of the committees. The Council maintains a Web site where agendas and minutes are posted; Council meetings are recorded as webcasts, which can be accessed from the Web site at: http://publichealthcouncil.dhs.wi.gov/webcast/.

2009 Council Action

- **Participated in the All-Wisconsin Alcohol Risk Education (AWARE) Coalition**, originated by UW Health, to undertake legislative policy change on drunken driving issues in the state Legislature. In its letter of support to AWARE, the Council emphasized health promotion, prevention, screening and treatment in addition to the AWARE focus on drunken driving enforcement. As a supporting entity, the Council became one of approximately 50 organizations that joined the coalition, which successfully sought changes to the state's drunken driving laws. The Council's action supports the state health plan *Healthiest Wisconsin 2010* health priority "alcohol and other substance use and addiction."

- **Approved a resolution in 2009 to raise the state's beer tax,** which was presented to a legislative hearing on the issue in October. The state currently levies a tax of less than a penny per regular bottle of beer. A bill to raise the beer tax would have provided funding earmarked for law enforcement grants and alcohol and drug abuse and treatment and prevention programs. (See Attachment A)

- **Provided a letter of support for public health provisions in national health systems reform legislation to members of the Wisconsin delegation in Congress.** In particular, the letter advocated for: increasing funding for public health departments; strengthening workforce incentives; facilitating vaccination of children; and improving birth outcomes

through visiting nurse programs. Comprehensive bills have passed in both the House of Representatives and the Senate. (See Attachment B)

- **Elected Julie Willems Van Dijk as chair of Public Health Council for 2009.** Dr. Willems Van Dijk, a longtime Health Officer from Marathon County, has been a member of the Public Health Council since 2004. She previously chaired the Council's ad hoc Finance Committee, which produced the 2007 report, *Increased State Financing of Governmental Public Health: A Proposal to the Public Health Council from the Ad Hoc Finance Committee.* (http://publichealthcouncil.dhs.wi.gov/financeproposal.pdf) Dr. Ayaz Samadani, who served as Chair of the Council since its inception, continues as a member of the Council's Executive Committee.

- **Provided oversight to development of the next state health plan, *Healthiest Wisconsin 2020*.** State law requires that the Division of Public Health create a statewide public health agenda every 10 years. Three members of the Council participated as members of the *Healthiest Wisconsin 2020* Strategic Leadership Team: Dr. Gary Gilmore; Dr. Ayaz Samadani; and Dr. Willems Van Dijk. The Strategic Leadership Team met four times during 2009. Council members of the Strategic Leadership Team and Division staff provided the Council with updates throughout the year regarding progress.

  Several Council members participated as members of the *Healthiest Wisconsin 2020* Focus Area Strategic Teams (FAST) that met in two full-day meetings in the fall of 2009 in order to identify specific objectives and progress measures for the state health plan. FAST members from the Council were: John Bartkowski; Catherine Frey; Susan Garcia Franz; Dr. Gilmore; Terri Kramolis; Dr. John Meurer; Doug Nelson; Dr. A. Charles Post; Dr. Ayaz Samadani; Dr. Lynn Sheets; and Dr. Willems Van Dijk.

- **Discussed and approved changes to the Rules of Order regarding Council elections procedures.** In addition to those changes proposed in writing at the meeting in August, there will be an additional amendment allowing officer nominations from the floor. Among the major revisions were: changing the officer elections from an annual cycle to every two years; changing the Vice Chair position to Chair Elect; and expanding the information and discussion about the potential officers prior to elections at the Annual Meeting. Final Council approval occurred at the October 2009 meeting. The changes will be implemented for the 2010 Annual Meeting elections process.

- **Approved evaluative reports from its State Health Plan Committee on two health priorities from the 2010 *Healthiest Wisconsin* State Health Plan.** The reports dealt with 1) access to primary and preventive health services; (See Attachments C); and 2) mental health and mental disorders. (See Attachment D) The reports contained recommendations to advance population health in those two priorities.

The Council had two standing policy committees in 2009: the Emergency Preparedness Committee and the State Health Plan Committee. The Executive Committee of the Council is composed of elected officers and its Committee chairs. All formal committees are subject to the state public records and Open Meetings laws.

State Health Plan Committee
The Committee's mission is to propose public health policy recommendations and strategies to achieve the Council's responsibility to monitor progress of the legislatively mandated state health plan. The current 10-year state health plan, *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*, is mandated in Wisconsin Statutes, Chapter 250.07. The primary stewardship responsibilities of the State Health Plan Committee are: (1) monitor, evaluate and communicate progress toward achieving the state health plan; (2) champion achievement of the state health plan; and (3) promote broad-based ownership for achieving *Healthiest Wisconsin 2010*.

The Committee held four meetings in 2009 and formally reviewed progress on additional statewide public health priorities. The Committee has designed an effective evaluation model to measure progress and propose policy recommendations on *Healthiest Wisconsin 2010* to the Public Health Council. The Committee forwarded two health priority evaluation reports to the Council for approval. The reports focused on 1) access to primary and preventive health services, and 2) mental health/mental disorders.

Key access report findings were: a) Identify useful ways to capture and measure access to primary and preventive services through use of e-health data; 2) Initiate or expand oral health programs that increase capacity for dental services; and 3) Initiate programs that could be self-sustaining beyond public funding. A key mental health report finding was that there has been no measured change in key mental health indicators. Moreover, the Committee forwarded to the Council a "lessons learned" report highlighting findings from the Committee's monitoring and oversight role since the Council's inception. (Attachment E)

Emergency Preparedness Committee
The mission of the Committee on Emergency Preparedness, which was restructured in 2009, is to provide guidance and oversight to the planning and implementation of the public health, hospital and pre-hospital emergency preparedness programs. The restructured Committee will promote coordination and integration around preparedness issues. It will also communicate effectively around these issues. The new body will serve the Council as a preparedness resource. It will also develop recommendations as needed. The Committee will meet three times in 2010. This committee is also charged through agreement between the Division of Public Health and the federal Department of Health and Human Services to provide oversight to the state pandemic influenza planning.

Briefings and Deliberations:
Briefings and council deliberations in 2009 included the following topics. (Note: All Council meetings included updates on the Healthiest Wisconsin 2020 planning process, and on the H1N1 influenza conditions in the state.)

- Mental Health/Mental Disorders Health Priority Report (February, 2009)
- All-Wisconsin Alcohol Risk Education (AWARE) coalition (February, 2009)
- Emergency Preparedness Committee Restructuring (February/April, 2009)
- Access to Primary and Preventive Health Services Report (April, 2009)
- Canadian Public Health Study Tour Presentation (April, 2009)
- Federal Economic Stimulus Update (April/June, 2009)

- Pandemic Public Health Funding Discussion (June, 2009)
- Statewide Workplace Smoking Ban Presentation (June, 2009)
- Revisions to Rules of Order for Elections Procedures (August/October, 2009)
- Public Health Financing Resolution Discussion (August, 2009)
- Nominating Committee Discussion (October, 2009)
- Wisconsin Partnership for a Healthy Future Program Update (October, 2009)
- Council Resolution on State Beer Tax (October, 2009)
- National Health Systems Reform Discussion and Action (December, 2009)
- Follow-up Presentation on State Beer Tax (December, 2009)

2008 Council Action:

Here are highlights of Public Health Council actions for the previous calendar year. The Council:

- Helped advise the *Healthiest Wisconsin 2020* (State Health Plan) planning process. State law requires that the Division of Public Health compile a statewide agenda every 10 years. The Division undertook a planning process for the 2020 plan, which covers the period from 2010 to 2020.
- Presented the Ad Hoc Public Health Finance Committee's report on public health financing to DHS Secretary Kevin Hayden.
- Continued to address the financing issue later in 2008, in a discussion with DHS Deputy Secretary Mark Thomas.
- Supported a motion regarding increased financing for high-risk sexual behavior interventions in Wisconsin.
- Joined the All-Wisconsin Alcohol Risk Education (AWARE) coalition, a group seeking policy change in the Legislature to combat drunken driving and other alcohol-related problems.
- Developed and presented to the Council on "Exactly What Is Public Health?" in August 2008, with varied perspectives from smaller and urban health departments, as well as the state health department. The PowerPoint presentation is at: http://publichealthcouncil.dhs.wi.gov/schedule/whatispublichealth200808.ppt

2009 Membership of the Public Health Council

Mary Jo Baisch
Bevan Baker
John Bartkowski
Amy Bremel
Bridget Clementi
Catherine Frey
Susan Garcia Franz
Gary Gilmore
Terri Kramolis
Corazon Loteyro
John Meurer
Deborah Miller
Douglas Nelson
A. Charles Post
Ayaz Samadani
James Sanders
Lynn Sheets
Mark Villalpando
Thai Vue
Julie Willems Van Dijk

Recorded by Kevin Wymore
Office of Policy and Practice Alignment

Mary Jo Baisch 2-26-2010

Mary Jo Baisch, Secretary Date

Attachment A

WISCONSIN PUBLIC HEALTH COUNCIL

Assure safe and healthy people by monitoring progress on the state health plan, Healthiest Wisconsin 2010, and on the readiness for public health emergencies.

PUBLIC HEALTH COUNCIL

RESOLUTION

October 9, 2009

In the interests of meeting the goals of *Healthiest Wisconsin 2010*, the state health plan, for addressing alcohol and other substance abuse and addiction, the Wisconsin Public Health Council submits the following resolution to the Governor of Wisconsin and the Wisconsin Legislature:

Whereas, Wisconsin has a longstanding history of high national rankings in such indicators as alcohol consumption, binge drinking and heavy drinking among U.S. states (all first in the nation in 2006); and

Whereas, about 42,800 Operating While Intoxicated (OWI) arrests, and 8,300 crashes resulting in 5,700 injuries and 300 deaths, occur in Wisconsin annually that are linked to alcohol; and

Whereas, the citizens of Wisconsin incurred $935 million in costs related to alcohol-related accidents and medical conditions in 2007; and

Whereas, about 457,000 adults and adolescents, or about 10 percent of the population, need services for alcohol or substance abuse each year; and

Whereas, alcohol abuse is a major contributor to criminal activity and to county jail and state prison incarcerations and court costs in the state; and

Whereas, the state's beer tax of $2 per barrel -- less than a penny per regular bottle of beer -- is the third lowest state beer tax in the nation, and has not risen since 1969; and

Whereas, numerous Wisconsin news media have embarked on campaigns strongly calling for increased efforts to address these problems, through increased prevention, law enforcement, and treatment options; and

Whereas, the Public Health Council recognized the need to act on alcohol risk education issues in 2008, and joined the statewide All-Wisconsin Alcohol Risk Education (AWARE) coalition to address this major population health risk by changing legislative policy; and

Whereas, the Public Health Council recognizes the importance of a tax on beer as a step in reducing alcohol related injuries and disease in Wisconsin. The Council supported this important public health strategy in its report: Increased State Financing of Governmental Public Health (December 7, 2007) (http://publichealthcouncil.dhs.wi.gov/financeproposal.pdf); and

Whereas, a legislative hearing on 2009 Assembly Bill 287, a proposal to raise the state beer tax, will be held in Madison October 13.

Now, be it resolved that Wisconsin should raise its beer tax as proposed in 2009 Assembly Bill 287; with the tax proceeds being earmarked for law enforcement grants and alcohol and drug abuse and treatment and prevention programs.

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Attachment B

WISCONSIN PUBLIC HEALTH COUNCIL

Assure safe and healthy people by monitoring progress on the state health plan, Healthiest Wisconsin 2010, and on the readiness for public health emergencies.

December 14, 2009

Herbert H. Kohl
U.S. Senator
14 West Mifflin Street, Suite 207
Madison WI 53703

Dear Senator Kohl:

As national health reform efforts move forward, the Wisconsin Public Health Council believes it is critical that prevention and robust public health funding remain part of the overall package. The Council, appointed by Governor Jim Doyle, is composed of public health professionals and stakeholders. It advises the Governor, the Legislature and the public on key public health matters.

Indeed, key health-related conditions -- lead poisoning, tobacco-related morbidity and mortality, tooth decay, obesity and many others -- originate in homes and communities. Society must address them "upstream" through public health interventions and through other non-medical means for supporting healthful lifestyle choices by the public. Proven public health interventions can prevent many cases of disease and disability that cause great suffering, require expensive treatment, and reduce worker productivity. However, inadequate funding has weakened our public health system's role in health promotion and prevention.

To help remedy this central problem, we ask you to preserve language in health reform bills to:

1. Increase funding for public health departments, which shield the nation from epidemics and preventable disease and injury and which provide key preventive services for both individuals and communities.
   - Create the public health investment fund and wellness trust to guarantee provision of cost-effective prevention programs for all Wisconsinites. This wellness trust, detailed initially in the House bill with $2.4 billion per year nationally, would provide our state with important "infrastructure" dollars. This is particularly crucial in Wisconsin, which ranks worse than any other state in state/local public health per capita funding.
   - Supplement, not replace, discretionary and mandatory funding for public health purposes.
   - As in the House bill, reserve explicit funding for state and local health departments (requiring maintenance of effort) to help them achieve accreditation and assure quality services nationwide.
   - Increase funding for research about community public health interventions and for the implementation of programs shown to be effective.

2. Stem the loss of critical public health professionals by strengthening training, recruitment and retention.
   - By early 2009, state and local health departments nationwide had lost 11,000 workers in the last year due to layoffs, attrition, and hiring freezes. Job losses are continuing, nationally, and in Wisconsin. A state workforce study has

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projected in 2006 that during the ensuing decade about 46 percent of the public health workforce would be lost due to retirements and reductions in workforce positions. It is important that adequate funding is available for educational programs for these very needed public health professionals. This is particularly important for the State of Wisconsin as we initiate new public health educational programs at UW-Milwaukee and UW-Madison and expand efforts at UW-LaCrosse.

- Both House and Senate bills address these shortages by providing new funding for loan repayments, scholarships, and training in return for service commitments in government health departments.

3. Facilitate vaccination of children -- the single most effective protection against communicable disease and epidemics -- by adopting House language to allow Vaccines for Children funds to be used at public health clinics.

4. Improve birth outcomes, child health and safety, and school readiness by funding high quality home visiting programs such as the Nurse Family Partnership and other similar programs.

5. Support public health initiatives that are moving even farther "upstream" to address the social and economic determinants of health that so strongly determine a person's chances to be healthy in the first place, and that underlie our state's – and our nation's – dismal health disparities.

We understand trade-offs exist for each dollar spent in a health reform proposal. However, the most inexpensive and cost-beneficial approach would be to direct substantial funds toward prevention, to bring about the greatest return on investment. Please maintain the commitment to prevention and public health capacity in both the House and the Senate proposals.

Sincerely,

Julie A. Willems Van Dijk, RN PhD
Chairperson
Wisconsin Public Health Council

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Attachment C

Wisconsin Public Health Council
State Health Plan Committee

Progress Report: *Healthiest Wisconsin 2010*
Health Priority: Access to Primary and Preventive Health Services
April, 2009

Report written by:
Mary Jo Baisch, Ph.D., R.N.
Shannon Chavez-Korrell, Ph.D.
Susan Garcia Franz, B.A.
Christopher Okunseri, B.D.S., M.Sc.

Submitted to the Wisconsin Public Health Council
April 17, 2009

Progress Report: *Healthiest Wisconsin 2010*
Health Priority: Access to Primary and Preventive Health Services

Part I: Introduction

According to Healthiest Wisconsin 2010, Wisconsin's state health plan:

> "Access means that primary and preventive health care services are available and organized in a way that makes sense to individuals and families. Access means that people have the resources, financial and non-financial, needed to obtain and use available services. Accessible health care includes an infrastructure supporting a range of health services with the capacity to reach diverse people and adapt to the specific access issues that differ in communities."

(See http://dhs.wisconsin.gov/statehealthplan/implementation/pdf-files/summary.pdf, p. 27.)

In this document, "Access to Primary and Preventive Health Services" was included as one of the eleven health priorities. In the Implementation Plan for this health priority, four objectives were identified to monitor the priority:

- Increasing the percentage of the population with health insurance
- Increasing the public health infrastructure capacity for prevention
- Reducing barriers to access
- Increasing access to oral health.

The analysis of progress in this report included available data that do not reflect recent changes in the economy. The impact of these changes will be documented in surveys and reports that include the latter part of 2008.

Increasing the percentage of the population with health insurance

There are clear links between access to care and health insurance coverage. Lack of insurance over an extended period of time increases the potential for early death, and death rates among hospitalized patients without health insurance are significantly higher than among patients with insurance (USDHHS, 2000). The reasons for lacking insurance are complex and are not adequately represented in the "uninsured rate." People may choose not to be insured because they do not have access to employer sponsored insurance, the high costs associated with employer sponsored insurance or the high costs of COBRA (employer-based continuation insurance) after losing a job. People may only be insured for a part of the year. At a much lower cost, others may choose an insurance policy that provides coverage for only "catastrophic" or very serious/emergent health conditions. These types of policies leave individuals and families underinsured, lacking coverage for preventive medical care, dental, vision or other health services.

- The uninsured in Wisconsin include 66% of those who are employed in a company with less than 50 employees, and 8% of children who live with an employed adult (not covered in the year or covered only part of the year).

- Racial and ethnic minorities are more likely to be uninsured than are Whites. Among Hispanics, 30% percent were uninsured all year and another 8% were insured only part of the year. 20% of African Americans were uninsured all year and another 11% were insured only part of the year.
- 17% or about 350,000 younger adults (ages 18-44) were uninsured throughout the year and another 7% were insured only part of the year. (Family Health Survey, 2007)
- Public insurance covers a large number of Wisconsin residents either completely or in combination with private insurance carriers:
- Although 91% of adults 65 years and older are covered with Medicare, 12% have no supplementary coverage.
- 9% of residents have Medicaid coverage including BadgerCare, Healthy Start and other forms of Wisconsin Medicaid.
- 17% of Wisconsin children have Medicaid coverage. (Family Health Survey, 2007)

Increasing the public health infrastructure capacity for prevention

As a percentage of its Federal/State share, Wisconsin contributes less to its Medicaid program (42%) than the rest of the country (43%; Kaiser Family Foundation, 2008). The majority of this funding supports health care for the elderly (34%) and the disabled (43%). Only 11% of Wisconsin's Medicaid funding supports health care for Wisconsin children and about 12% of eligible adults. Although increasing, Wisconsin's uninsured rate is lower than most states, including 8.8% of adults (vs. 15.8% of adults in the U.S.) and 4.9% of children (vs. 11.7% of children in the U.S.; Trust for America's Health, 2009). The funding for public health in Wisconsin continues to decrease. For Fiscal Year 2007, Wisconsin ranked last of all fifty states in state funding for public health services at a per capita rate of $9.16 (vs. $33.26 per capita in the U.S.; Trust for America's Health, 2009) and ranking far below surrounding states in the Midwest.

One of the most significant changes in improving access to healthcare in Wisconsin has been the expansion of the BadgerCare program to include a wider group of eligible participants. This expansion provides increased access to low income individuals across the state and offers opportunities for including population groups who have previously not been eligible for Medicaid in this state. Funding for coverage for single adults without children has not yet been implemented, but plans are in place to begin the program in spring 2009.

While this expansion is a great improvement for low income residents of Wisconsin, it does not address the underinsured or the population above 200% of the Federal Poverty level, the rising cost of premiums for the insured population, including those adults over 64 years of age seeking physician coverage in coordination with their Medicare coverage. These issues will require monitoring and advocacy from the public health community in the state.

"Increasing the infrastructure capacity for prevention" can be measured in many ways. Over the past ten years, the indicators for tracking progress toward this objective related to tracking rates of unnecessary hospitalizations and rates of screening for cholesterol and breast, prostate, and colorectal cancers; and reducing the proportion of the population that reported difficulty accessing care. There was one objective for which there was no designated measure over the past

ten years: "Increasing provider exposure to U.S. Preventive Services Guidelines" and thus, a measure of the extent of providers using research-based preventive healthcare services was not tracked.

Reducing barriers to access

Insurance coverage is only one component of access to care. The availability of appropriate primary care practitioners and access to preventive health services also has an impact on improving health. Thus workforce issues, cultural competence, resources allocated to prevention rather than care, outreach, and other issues have an impact on access to health services. Wisconsin ranks 6th worst in the country for the availability of mental health services and is 23rd and 26th in availability of primary care and dental care services respectively. In many cases, the impact of racial/ethnic background on healthcare services was not adequately captured, and the necessary data to track progress toward this objective not available. This is particularly important when attempting to reduce the wide disparities in health outcomes noted in the state. Thus it is difficult to adequately assess whether progress toward removal of barriers to healthcare access is actually occurring.

Increasing access to oral health

As described, Wisconsin ranks 26th in the United States in the number of Health Professional Shortage Areas for dental providers. There is a wide disparity between those with commercial insurance coverage and those without. Even those with Medicaid find it very difficult to access dental health services. Further, there are disparities in available services depending on whether you live in an HMO saturated area of the state. The Legislative Audit Bureau reported in 2008 that statewide enrollment for Medicaid has increased by 15% over the previous five years, with almost 25% living in the four southeastern counties of the state.

The purpose of this report is to analyze progress toward the specific long-term objectives of the Access to Primary and Preventive Health Services health priority of the state health plan, Healthiest Wisconsin 2010, described in the following sections. In reviewing the specific objectives developed for Healthiest Wisconsin 2010, there has been little change overall in the progress toward the health priority of access to primary and preventive health services.

Part II: Progress in Achieving the Healthiest Wisconsin 2010 10-year Long-term Outcome Objectives

Health Insurance

Objective 1: By 2010, increase to 92 percent the proportion of the population with health insurance for all of the year.

Performance as of 2007: 91% (N = 6,523) of Wisconsin household residents had health insurance coverage during the past 12 months.

Baseline: In 2000, 88% of residents reported having health insurance during the past 12 months.

Performance Status: Improving.

Objective 2: System Infrastructure Capacity for Prevention
The second set of objectives was understood to be "developmental." The data used as baselines for this objective related to preventable hospitalizations and rates of screening for cholesterol, breast, prostate and colorectal cancers.

Objective 2a: Increase provider screening for chronic diseases and other health risks including alcohol and drug abuse.

Cervical cancer screenings for women aged 18+ years

Performance: Data in 2006 shows that 86% of Wisconsin women 18+ were receiving Pap tests. (Wisconsin Behavioral Risk Factor Survey, Bureau of Health Information and Policy, Division of Public Health, Department of Health Services.)

Baseline: In 2000, 87% of Wisconsin women reported having had a Pap smear in the past three years.

Performance Status: No Change

Mammograms for women 40+ years

Performance: Data shows that 78% of women in 2006 received mammograms. In 2002, 80% had mammograms and 2004 showed 75% of women receiving mammograms. (Wisconsin Behavioral Risk Factor Survey, Bureau of Health Information and Policy, Division of Public Health, Department of Health Services.)

Baseline: In 2000, 75% of Wisconsin women reported having had a mammogram in the past three years.

Performance Status: Slight improvement

Cholesterol screenings for adults 18+ years

Performance: Overall, screenings stayed the same or increased slightly with 77% of adults in 2007 reporting having been screened for cholesterol in the past five years. (Wisconsin Behavioral Risk Factor Survey, Bureau of Health Information and Policy, Division of Public Health, Department of Health Services.)

Screenings for women increased in 2007 with 79% versus 75% of women in 2001. Overall, there was a slight change in cholesterol screening for men. Men reported decreased screenings (68% of men in 2005) and increased their screenings in 2007 (74%).

Baseline: In 2001, 72% of adults over 18 years of age reported having been screened for cholesterol.

Performance Status: No change – slight increase

Colorectal screenings for adults 50+ years

Performance: 44% of adults in 2006 had blood stool tests versus 47% of adults in 2004. Women were tested more often (47%) than men (40%). (No data were available regarding the rate of individuals receiving colonoscopies.)

Performance Status: Worsening or no change

Baseline: In 2001, 50% of adults over 50 years of age reported having had a blood stool test for colorectal cancer (Behavioral Risk Factor Survey).

Objective 2b. Increase provider exposure to U.S. Preventive Services Guidelines (evidence-based practice guidelines for preventive care).

No data were available concerning this objective.

Difficulty Accessing Care

Objective 3: By 2010, reduce by 10 percent the proportion of the population that reports difficulties, delays, or the inability to receive ongoing primary and preventative health care (e.g., check-ups and management of acute and/or chronic care).

Performance as of 2007: 2% of Wisconsin household residents reported needing medical care during the past 12 months but did not receive it.

Performance Status: Slight improvement

Baseline: In 2001, 3% of Wisconsin household residents reported needing "medical care during the past 12 months but did not receive it" (Behavioral Risk Factor Survey).

Oral Health Services

Objective 4a: By 2010, 33% or more of Wisconsin's Medicaid and BadgerCare Plus members will have received oral health services (preventive and/or restorative) from a dental provider in the past year.

Performance as of 2007: 23.5%. Overall, there was no improvement from 2000 to 2007. (Wisconsin Family Health Survey, Bureau of Health Information and Policy, Division of Public Health, Department of Health Services.)

Baseline: In 2000, 22.7% of Wisconsin residents reported receiving any dental care during the year.

Performance status: No improvement.

Objective 4b. By 2010, 46% or more of Wisconsin's residents who were uninsured throughout the previous year will have received oral health services from a dental provider in the past year.

Performance as of 2007: 41%. Although the target was not met for this objective, there was slight improvement (including the reported error rate) in reporting of dental visits among those who were uninsured between 2000 and 2007 (Wisconsin Family Health Survey, Bureau of Health Information and Policy, Division of Public Health, Department of Health Services).

Baseline: In 2000, 36% of Wisconsin residents who were uninsured all of the previous year reported receiving any dental care.

Performance status: Slight improvement

Objective 4c. By 2010, 70% or more of Wisconsin's residents who were uninsured for part of the previous year will have received oral health services from a dental provider in the past year.

Performance as of 2007: The target for this objective was not met. For the years 2004-2007, only 50% of Wisconsin residents who were uninsured for part of the year reported receiving any dental care during the year. In the years between 2000 and 2007, the rate of those uninsured for part of the year who received dental care continued to decline (Wisconsin Family Health Survey, Bureau of Health Information and Policy, Division of Public Health, Department of Health Services).

Baseline: In 2000, 57% of Wisconsin residents who were uninsured for part of the year reported receiving any dental care during the year.

Performance status: Not improved

Part III: Recommendations

Data

- Identify useful ways to capture and measure access to primary and preventive services through use of e-health data.
- Use the Medicaid data set as well as survey data to expand available indicators regarding access to care.
- Include HEDIS indicators in measuring objectives and tracking progress toward access to care (e.g., childhood immunization status).
- Develop survey questions that address more qualitative issues of access such as satisfaction with, availability, and accessibility of health care services.
- Collect and analyze data regarding services for underrepresented groups common in Wisconsin: immigrants, non-English speakers, LGBT community, underrepresented religious groups (Amish, Jehovah's Witness), and farmers.
- Utilize available Medicaid data and other State databases (e.g., Behavioral Risk Factor Surveillance Survey, BFRSS; Wisconsin Youth Oral Health Data) to develop evidence-based oral health policies that are measurable and have significant impact on primary care and oral health.
- Continue to monitor water fluoridation quality for 251 or more systems available and advocate for the maintenance and expansion of community water fluoridation programs.

Health Insurance

- Enact BadgerCare Plus in the next biennial budget cycle including support for infrastructure for full implementation of the program.
- Advocate for elements in Medicaid pay-for-performance measures that address access to primary and preventive health services.

Workforce

- Implement the workforce report: Wisconsin Health Care Workforce: Grow Wisconsin Initiative (2007) to increase the number of health professionals and particularly to include more racial and ethnic minority providers.
- Increase primary care and dental workforce in urban and rural areas.
- Expand scholarships, loan forgiveness, and other funding support for students interested in providing care in inner cities and rural areas.
- Develop tax credits and grants for those practitioners practicing in inner cities and rural areas.
- Expand training in multi-cultural competence among primary care office staff and providers.
- Track retention of primary care providers in inner city and rural areas.
- Support language training for primary care providers.

- Review scope of practice for professions complementary to dentistry (e.g., hygienists, dental assistants) and utilize non-dental providers to provide non-technical preventive procedures to children and serve as referral source for children to dental providers.

Reduce Barriers to Access

- Increase outreach and advocates for Wisconsin residents seeking health care services.
- Ensure transportation services are accessible, timely, and affordable for those seeking health care services.
- Ensure all written health education materials and directions meet CLAS (Office of Minority Health Culturally and Linguistically Appropriate Services) standards and are culturally, physically, and cognitively accessible for all populations.
- Expand culturally competent and community-based services to improve screening rates for chronic disease and cancer.
- Initiate or expand oral health programs that increase capacity for dental services in federally qualified health centers and school-based clinics to be able to serve high-risk and/or underserved populations.

Preventive Services

- Using the U.S. Preventive Services Guidelines as a minimum, ensure that evidence-based screening practices are included in insurance coverage plans.
- Educate the public regarding the evidence for water fluoridation programs.

Finances

- Initiate programs that could be self-sustaining beyond public funding to provide health promotion information and prevention strategies/procedures for populations at risk.
- Increase funding for community-based organizations and programs that provide health promotion and screening services for underserved and/or at risk populations.

Appendix 1. Increasing Health Insurance Coverage

Objective 1: By 2010, increase to 92 percent the proportion of the population with health insurance for all of the year.

Indicator: Health insurance during past 12 months

Health insurance during past 12 months

Health Priority A: Access to Primary and Preventive Health Services

Objective A1: By 2010, increase to 92 percent the proportion of the population with health insurance for all of the year.

2010 Target: 92%

Federal 2010 Target: 100%

Performance Status: No change.

Performance as of 2006: 89% (N = 6,523) of Wisconsin household residents had health insurance coverage during the past 12 months.

Percent of Wisconsin Household Residents with Health Insurance Coverage during the Past 12 Months

Year (N)	Total		Males		Females	
	Percent	+/-	Percent	+/-	Percent	+/-
2000	88%	1%	87%	1%	88%	1%
(N)	(6,894)		(3,305)		(3,589)	
2001	88%	1%	87%	1%	88%	1%
(N)	(9,549)		(4,641)		(4,908)	
2002	89%	1%	89%	1%	89%	1%
(N)	(7,995)		(3,871)		(4,124)	
2003	90%	1%	89%	1%	92%	1%
(N)	(6,398)		(3,082)		(3,316)	
2004	89%	1%	88%	1%	91%	1%
(N)	(6,330)		(3,094)		(3,236)	
2005	89%	1%	87%	1%	91%	1%
(N)	(6,272)		(3,007)		(3,265)	
2006	89%	1%	88%	1%	90%	1%
(N)	(6,523)		(3,095)		(3,428)	
2007	91%	1%	90%	1%	91%	1%
(N)	(6,857)		(3,306)		(3,551)	

Appendix 2. Increasing the Public Health Infrastructure Capacity for Prevention

Objective 2: Increase provider screening for chronic diseases and other health risks.

Objective A2b: Increase provider screening for chronic diseases and other health risks.

2010 Target: No target established

Indicator: Cervical cancer screening, women 18+

Federal 2010 Target: Mostly developmental with Behavioral Risk Factor Survey data for cholesterol screenings. Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project data available for hospitalizations for uncontrolled diabetes, pediatric asthma, and immunization preventable pneumonia/influenza for adults over 64 years of age.

Cervical cancer screening, women 18+

Percent of Wisconsin Women Aged 18+ Who Had a Pap Smear in the Past Three Years

Year (N)	Total	
	Percent	+/-
2000	87%	2%
(N)	1,195	
2001	90%	1%
(N)	1,574	
2002	88%	1%
(N)	1,991	
2004	86%	2%
(N)	2,098	
2006	86%	2%
(N)	2,088	

Appendix 2. Increasing the Public Health Infrastructure Capacity for Prevention (continued)

Indicator 2c. Cholesterol screening, adults 18+

Cholesterol screening, adults 18+

Health Priority A: Access to Primary and Preventive Health Services

Objective A2b: Increase provider screening for chronic diseases and other health risks.

2010 Target: No target established

Indicator: Cholesterol screening, adults 18+

Percent of Wisconsin Adults Aged 18+ Screened for High Cholesterol in the Past Five Years

Year (N)	Total		Males		Females	
	Percent	+/-	Percent	+/-	Percent	+/-
2001	72%	1%	68%	2%	75%	2%
(N)	3,520		1,578		1,942	
2003	75%	1%	71%	2%	78%	2%
(N)	3,976		1,612		2,364	
2005	73%	1%	68%	3%	77%	2%
(N)	4,789		1,955		2,834	
2007	77%	1%	74%	2%	79%	2%
(N)	7,328		2,943		4,385	

Appendix 2. Increasing the Public Health Infrastructure Capacity for Prevention (continued)

Indicator 2. D. Colorectal cancer screening, adults 50+

Colorectal cancer screening, adults 50+

Health Priority A: Access to Primary and Preventive Health Services
Objective A2b: Increase provider screening for chronic diseases and other health risks.
2010 Target: No target established
Indicator: Colorectal cancer screening, adults 50+

Percent of Wisconsin Adults Aged 50+ Who Have Ever Had a Blood Stool Test

Year (N)	Total		Males		Females	
	Percent	+/-	Percent	+/-	Percent	+/-
2001	50%	3%	47%	4%	52%	4%
(N)	1,306		525		781	
2002	49%	2%	47%	4%	51%	3%
(N)	1,834		703		1,131	
2004	47%	3%	44%	4%	50%	4%
(N)	2,009		786		1,223	
2006	44%	2%	40%	4%	47%	3%
(N)	2,428		982		1,446	

Percent of Wisconsin Adults Aged 50+ Who Have Ever Had a Blood Stool Test, by Race/Ethnicity

Years (N)	Total		African American*		White*	
	Percent	+/-	Percent	+/-	Percent	+/-
2001-2002	50%	2%	40%	7%	50%	2%
(N)	3,140		170		2,777	
2002, 2004	48%	2%	36%	8%	48%	2%
(N)	3,844		251		3,456	
2004, 2006	45%	2%	31%	7%	46%	2%
(N)	4,467		297		3,988	

Percent of Wisconsin Adults Aged 50+ Who Have Ever Had a Sigmoidoscopy or Colonoscopy

Year (N)	Total		Males		Females	
	Percent	+/-	Percent	+/-	Percent	+/-
2001	57%	3%	57%	4%	58%	3%
(N)	1,302		521		781	
2002	56%	2%	58%	4%	55%	3%
(N)	1,826		698		1,128	
2004	59%	3%	58%	4%	61%	3%
(N)	2,002		486		1,216	
2006	64%	2%	64%	4%	64%	3%
(N)	2,428		979		1,449	

Appendix 2. Increasing the Public Health Infrastructure Capacity for Prevention (continued)

Percent of Wisconsin Adults Aged 50+ Who Have Ever Had a Sigmoidoscopy or Colonoscopy, by Race/Ethnicity

Years (N)	Total		African American*		White*	
	Percent	+/-	Percent	+/-	Percent	+/-
2001-2002	57%	2%	49%	8%	57%	2%
(N)	3,128		165		2,771	
2002, 2004	58%		56%	10%	58%	2%
(N)	3,829		239		3,421	
2004, 2006	62%	2%	54%	8%	62%	2%
(N)	4,459		294		3,986	

Appendix 3. Reducing Barriers to Health Care Access

Objective 3. Reduce the proportion of the population that reports difficulties, delays, or the inability to receive ongoing primary and preventive health care (e.g., check-ups and management of acute and/or chronic illnesses).

Indicator 2. D. Needed to see doctor but could not

Federal 2010 Target: Developmental.

Health Priority A: Access to Primary and Preventive Health Services

2010 Target: No target established

Percent of Wisconsin Household Residents Who Needed Medical Care during the Past 12 Months but Did not Receive It

Year (N)	Total		Males		Females	
	Percent	+/-	Percent	+/-	Percent	+/-
2000	3%	<1%	2%	<1%	3%	1%
(N)	(6,894)		(3,305)		(3,589)	
2001	3%	<1%	2%	<1%	4%	1%
(N)	(9,549)		(4,641)		(4,908)	
2002	2%	<1%	2%	<1%	2%	<1%
(N)	(7,995)		(3,871)		(4,124)	
2003	1%	<1%	1%	<1%	2%	<1%
(N)	(6,398)		(3,082)		(3,316)	
2004	2%	<1%	2%	<1%	2%	<1%
(N)	(6,330)		(3,094)		(3,236)	
2005	2%	<1%	2%	<1%	2%	<1%
(N)	(6,272)		(3,007)		(3,265)	
2006	2%	<1%	2%	<1%	3%	1%
(N)	(6,523)		(3,095)		(3,428)	
2007	2%	<1%	1%	<1%	2%	<1%
(N)	(6,857)		(3,306)		(3,551)	

Appendix 3. Reducing Barriers to Health Care Access (continued)

Percent of Wisconsin Household Residents Who Needed Medical Care during the Past 12 Months but Did Not Receive It, By Age

Year	Total		Ages 0-17		Ages 18-44		Ages 45-64		Ages 65+	
(N)	Percent	+/-	Percent	+/-	Percent	+/-	Percent	+/-	Percent	+/-
2000	3%	<1%	2%	1%	3%	1%	3%	1%	1%	1%
(N)	(6,894)		(1,902)		(2,648)		(1,567)		(777)	
2001	3%	<1%	2%	1%	4%	1%	3%	1%	1%	1%
(N)	(9,549)		(2,665)		(3,537)		(2,267)		(1,080)	
2002	2%	<1%	1%	<1%	3%	1%	3%	1%	1%	1%
(N)	(7,995)		(2,124)		(2,890)		(1,960)		(1,021)	
2003	1%	<1%	<1%	<1%	2%	1%	2%	1%	1%	1%
(N)	(6,398)		(1,750)		(2,256)		(1,656)		(736)	
2004	2%	<1%	1%	<1%	3%	1%	2%	1%	<1%	<1%
(N)	(6,330)		(1,606)		(2,075)		(1,782)		(867)	
2005	2%	<1%	1%	<1%	4%	1%	2%	1%	1%	1%
(N)	(6,272)		(1,636)		(2,035)		(1,695)		(904)	
2006	2%	<1%	1%	<1%	3%	1%	3%	1%	1%	1%
(N)	(6,523)		(1,823)		(1,978)		(1,860)		(862)	
2007	2%	<1%	1%	<1%	3%	1%	2%	1%	2%	1%
(N)	(6,857)		(1,691)		(1,972)		(2,165)		(1,029)	

Appendix 3. Reducing Barriers to Health Care Access (continued)

Percent of Wisconsin Household Residents Who Needed Medical Care during the Past 12 Months but Did Not Receive It, by Race/Ethnicity

Year (N)	Total		African American*		American Indian*		Asian*	
	Percent	+/-	Percent	+/-	Percent	+/-	Percent	+/-
2000	3%	<1%	4%	1%	1%	2%	--	--
(N)	(6,894)		(695)		(100)		(81)	
2001	3%	<1%	3%	1%	1%	2%	4%	3%
(N)	(9,549)		(867)		(121)		(144)	
2002	2%	<1%	4%	2%	--	--	--	--
(N)	(7,995)		(550)		(89)		(84)	
2003	1%	<1%	2%	1%	--	--	--	--
(N)	(6,398)		(438)		(82)		(89)	
2004	2%	<1%	5%	2%	--	--	--	--
(N)	(6,330)		(557)		(97)		(53)	
2005	2%	<1%	5%	2%	5%	4%	--	--
(N)	(6,272)		(526)		(123)		(66)	
2006	2%	<1%	4%	2%	2%	2%	--	--
(N)	(6,523)		(571)		(187)		(68)	
2007	2%	<1%	4%	2%	2%	2%	--	--
(N)	(6,857)		(502)		(172)		(57)	

Percent of Wisconsin Household Residents Who Needed Medical Care during the Past 12 Months but Did Not Receive It, by Race/Ethnicity (continued)

Year	Hispanic		White*		Multiple Races*	
	Percent	+/-	Percent	+/-	Percent	+/-
2000	10%	5%	2%	<1%	--	--
(N)	(158)		(5,668)		(79)	
2001	11%	4%	3%	<1%	3%	3%
(N)	(227)		(7,884)		(149)	
2002	2%	2%	2%	<1%	--	--
(N)	(262)		(6,768)		(95)	
2003	3%	2%	1%	<1%	--	--
(N)	(197)		(5,383)		(99)	
2004	2%	2%	2%	<1%	--	--
(N)	(186)		(5,279)		(88)	
2005	1%	1%	2%	<1%	--	--
(N)	(193)		(5,196)		(99)	
2006	1%	1%	2%	<1%	--	--
(N)	(267)		(5,250)		(94)	
2007	2%	2%	2%	<1%	6%	5%
(N)	(221)		(5,699)		(107)	

Appendix 4. Increasing Access to Oral Health

Objective 4a. By 2010, 33% or more of Wisconsin's Medicaid and BadgerCare recipients will have received oral health services (preventive and/or restorative) from a dental provider in the past year.

2010 Target: Developmental. 20% of children and adolescents under age 19 within 200% of the Federal Poverty level received any preventive dental service in 1996.

Indicator 4. Dental visit in past year, Medicaid / BadgerCare recipients

Table 1: Wisconsin Medicaid and BadgerCare Fee-for-Service Recipients and HMO Enrollees Who Received Any Dental Service During the Year

Fiscal Year	Percent Who Received Any Dental Service	Number Who Received Any Dental Service	Unduplicated Number of Recipients
2000	22.7	109,647	483,350
2001	22.5	115,595	513,603
2002	Data not available		
2003	22.6	130,142	576,495
2004	24.1	195,724	810,980
2005	23.9	201,156	839,329
2006	22.6	194,524	859,274
2007	23.5	204,411	870,990

Source: Wisconsin Medicaid Dental Facts, Division of Health Care Financing, Department of Health Services.

Appendix 4. Increasing Access to Oral Health (continued)

Objective 4b. By 2010, 46% or more of Wisconsin's residents who were uninsured throughout the previous year will have received oral health services from a dental provider in the past year.

Indicator 4b. Dental visit in past year, people uninsured all year

2010 Target: Greater than or equal to 46%

Indicator: Dental visit in past year, people uninsured all year

Percent of Wisconsin Household Residents Age 1 and Older, Uninsured All of the Past Year, Who Had a Dental Care Visit during the Year

Year (N)	Total (Age 1+)		Males		Females	
	Percent	+/-	Percent	+/-	Percent	+/-
2000	36%	5%	34%	7%	39%	8%
(N)	(315)		(168)		(147)	
2001	44%	5%	40%	6%	49%	7%
(N)	(427)		(247)		(180)	
2002	44%	6%	37%	7%	53%	9%
(N)	(300)		(170)		(130)	
2003	42%	6%	44%	8%	38%	9%
(N)	(250)		(142)		(108)	
2004	36%	5%	32%	7%	42%	8%
(N)	(319)		(168)		(151)	
2005	34%	5%	32%	7%	37%	8%
(N)	(302)		(176)		(126)	
2006	35%	5%	33%	7%	37%	7%
(N)	(339)		(175)		(164)	
2007	41%	5%	36%	7%	47%	8%
(N)	(315)		(174)		(141)	

Appendix 4. Increasing Access to Oral Health (continued)

Percent of Wisconsin Household Residents Age 1 and Older, Uninsured All of the Past Year, Who Had a Dental Care Visit during the Year, By Age

Years (N)	Total (Age 1+)		Ages 1-17		Ages 18-44		Ages 45-64		Ages 65+	
	Percent	+/-	Percent	+/-	Percent	+/-	Percent	+/-	Percent	+/-
2000-2002	41%	3%	50%	8%	42%	4%	34%	6%	--	--
(N)	(1,042)		(170)		(575)		(274)		(23)	
2001-2003	43%	3%	56%	8%	41%	4%	40%	6%	--	--
(N)	(977)		(147)		(563)		(249)		(18)	
2002-2004	40%	3%	47%	9%	40%	4%	38%	6%	--	--
(N)	(869)		(117)		(516)		(225)		(11)	
2003-2005	37%	3%	40%	9%	35%	4%	42%	6%	--	--
(N)	(871)		(120)		(518)		(224)		(9)	
2004-2006	35%	3%	36%	8%	33%	4%	41%	6%	--	--
(N)	(960)		(157)		(514)		(274)		(15)	
2005-2007	37%	3%	45%	8%	34%	4%	41%	6%	--	--
(N)	(956)		(156)		(483)		(306)		(11)	

Appendix 4. Increasing Access to Oral Health (continued)

Objective 4c. By 2010, 70% or more of Wisconsin's residents who were uninsured for part of the previous year will have received oral health services from a dental provider in the past year.

Percent of Wisconsin Household Residents Age 1 and Older, Uninsured Part of the Past Year, Who Had a Dental Care Visit during the Year, by Race/Ethnicity

Years (N)	Total (Age 1+)		African American*		Hispanic		White*	
	Percent	+/-	Percent	+/-	Percent	+/-	Percent	+/-
2000-2003	57%	2%	47%	6%	55%	9%	58%	2%
(N)	(2,021)		(262)		(112)		(1,522)	
2001-2004	55%	2%	39%	6%	--	--	57%	3%
(N)	(1,837)		(227)		(95)		(1,390)	
2002-2005	52%	3%	39%	7%	--	--	54%	3%
(N)	(1,483)		(200)		(69)		(1,110)	
2003-2006	51%	3%	48%	7%	--	--	51%	3%
(N)	(1,272)		(210)		(59)		(902)	
2004-2007	50%	3%	48%	6%	--	--	50%	3%
(N)	(1,222)		(230)		(66)		(832)	

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Wisconsin Public Health Council
State Health Plan Committee

Final Report (January 2009)
Progress Report: Healthiest Wisconsin 2010
Health Priority: Mental Health and Mental Disorders

Part I: Introduction

Addressing the mental health needs of Wisconsin consumers remains a priority. Approximately one in seven Americans will suffer from major depressive disorder. According to the National Committee for Quality Assurance and National Institutes of Health 2007 State of Health Care Quality Report, major depressive disorder is the leading disability in the United States.

In the Wisconsin public mental health system, the number of encounters statewide was approximately 196,634 in 2005; note that clients served in the private sector are not included in this number. Public service recipients are reported to the State through the Human Services Reporting System and Medicaid data systems, which include some duplication of clients. To date, no coordinated agreements have been made by these systems to retrieve, share, and compile unified data.

According to the National Surveys on Drug Use and Health (2004-2005), Wisconsin adults experienced serious psychological distress (SPD) "in the past year" at a rate of 11.8%, which resulted in Wisconsin ranking 25th highest in the nation for reported SPD. Additionally, 8.4% of Wisconsin adults experienced a major depressive episode (MDE) in that same period, compared to the national average of 7.6%; this resulted in Wisconsin ranking 15th highest in the nation overall, for major depressive episodes. These numbers indicate that Wisconsin is at the national average for SPD and has a higher rate of major depressive episodes than the national average.

However, through a partnership between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC), the Wisconsin Behavioral Risk Factor Survey (BRFS) included questions on depression and serious psychological distress in 2006 and 2007, respectively. The BRFS assesses more recent experiences with SPD and depression (past 30 days). The 2006 data indicate that the overall Wisconsin prevalence rate for depression was 7% and the estimated prevalence rate for SPD in 2007 was 3%. This suggests that there may be a difference for responders when asked about past year experiences compared to experiences specific to the last 30 days. In the future, consistent use of one measure with national comparisons is recommended for ease of evaluating Wisconsin's performance.

Data collected for 2004-2005 via the Mental Health/Alcohol and Other Drug Abuse Functional Screen, a Wisconsin-based screen that measures levels of need within Wisconsin's major programs for mental health consumers with a serious mental illness (SMI), revealed that of those who had co-occurring mental health and substance abuse diagnoses, higher than average rates of inpatient stays, criminal justice system involvement, suicide attempts, and homelessness were

reported. Of adults with SMI, only 28% were employed (Human Services Reporting System, 2005). In addition, 7% of adults with SMI and 20% of youths who reported a serious emotional disturbance were arrested in the past year (Mental Health Statistics Improvement Program, 2006). Untreated mental illness in Wisconsin appears to be highly correlated with socio-economic difficulties across the lifespan, with physical health also suffering, including a life expectancy loss of 20% fewer years of life expected.

Youth in Wisconsin aged 12-17 years reported experiencing a Major Depressive Episode (MDE) in the past year at a somewhat higher rate than the national average (9.6% vs. 8.8%, respectively). Wisconsin's national rank for youth MDE prevalence is 11th highest. The youth depression rate in 2005 increased slightly from the 2003 rate. The 2005 rate of female youth depression was significantly higher than for males (33.3% vs. 22.2% respectively). The youth depression rate seems closely tied to the rate of completed youth suicide for Wisconsin, which is currently ranked the 8th highest in the nation. The 1999-2003 youth suicide rate for 15-19-year-olds in Wisconsin was higher than in surrounding states (10.9 per 100,000 population aged 15-19 in Wisconsin, compared to 10.6 in Iowa, 9.4 in Minnesota, 8.3 in Indiana, 7.8 in Michigan, and 6.1 in Illinois).

Social and economic factors are correlated with frequent mental distress (FMD) among Wisconsin adults, versus those without FMD. Approximately one-quarter of Wisconsin adults with FMD earned an annual income less than $20,000 in 2004. Approximately one-third of those with FMD had poor health or health-related problems such as obesity and/or smoking. FMD was reported by 15% of adults who had attained less than a high school level of education, compared with just 5% of adults with a college degree (Wisconsin Behavioral Risk Factor Survey, 2004; Bureau of Health Information and Policy, 2004; Division of Public Health, 2004; Department of Health and Family Services, 2004).

Nationally, exposure to a traumatic event (e.g., sexual abuse) has also been shown to be significantly correlated to mental health diagnoses, poorer health, and risk for substance abuse and addiction. Given the rates of serious mental illness for certain segments of Wisconsin's population (e.g., female youth depression, American Indian female depression), the likelihood of a correlation between lifetime trauma exposure and poorer mental health in Wisconsin is high. This co-occurrence of trauma and poorer mental health is also a risk factor for vulnerability to poverty, homelessness, and socio-economic marginalization.

A major contributor to Wisconsin's average or below average ranking on many mental health and mental disorder indicators and health disparities overall is likely due to barriers to access to adequate health care including mental health care. One of the major barriers to access is lack of equitable health insurance, especially regarding the unemployed and marginalized populations.

Efforts towards reducing the health disparities for mental health consumers in both primary and other mental health care facilities (e.g., private practice and community-based health clinics) should include enacting insurance parity for all, supported by private and public partnerships, in an effort to combat financial barriers to access in mental health care. In addition, addressing issues of reimbursement will allow more providers to serve those afflicted with depression. The present reimbursement model results in less than 50% of service costs being covered.

Limitations to the evaluation of progress on Healthier Wisconsin 2010 Mental Health and Mental Disorders objectives include a lack of consistent access to services by financial, geographical, and cultural demographics, limitations related to data sources, a lack of consistent and coordinated tracking of all marginalized populations (e.g., Lesbian, Gay, Bisexual, Transgender-LGBT), and the lack of integrated services, work force training/education, and consistent identification of mental health needs across all health fields.

A primary finding of this report is that there has been no measured change in key mental health indicators. This suggests a need for the use of available specific and objective measures. If these measures are not available they should be developed. These data need to be collected and stored in a manner that allows for access to enable them to be monitored and reported on annually.

Part II: Progress in Achieving the Healthiest Wisconsin 2010-Year Long-Term Outcome Objectives

Objective I—Stigma Reduction
By 2010, 80% of State-administered employee group health plans, Medicaid-funded programs, BadgerCare, and Supplemental Security Income (SSI) managed care will, by contract, incorporate questions for mental health problems into their screening and referral processes.

Performance as of 2005: *The Department's Division of Mental Health and Substance Abuse Services provided a limited data and program update to the State Health Plan Committee. Unfortunately, due to limited resources and capacity, a comprehensive data and program review was not possible.* As of November 2005, none of these health plans or programs required screening for mental health problems despite data being gathered and available from Department of Health and Family Services, Mental Health and Substance Abuse Services, and Department of Public Health.

Performance Status: No change

Objective II—Discrimination/Anti-Stigma
2a: *By 2010, an additional 15% of the general public will demonstrate an understanding that individuals with mental health disorders can recover through treatment to lead productive, healthy, and happy lives.*

2b: *By 2010, an additional 15% of the general public will demonstrate the belief that individuals with mental health disorders are capable of sustaining long-term productive employment.*

Performance as of 2005: *The Department's Division of Mental Health and Substance Abuse Services provided a limited data and program update to the State Health Plan Committee. Unfortunately, due to limited resources and capacity, a comprehensive data and program review was not possible.*

Performance Status: No change

Objective III: Cultural Competence
By 2010, 87% of the publicly funded mental health consumers will feel their service provider was sensitive to their culture during the treatment planning and delivery process.

Performance as of 2005: *The Department's Division of Mental Health and Substance Abuse Services provided a limited data and program update to the State Health Plan Committee. Unfortunately, due to limited resources and capacity, a comprehensive data and program review was not possible.*

Performance Status: No change

Objective IV: Access to Care

4a: *By 2010, Wisconsin's public mental health clients who have access to "Best Practice" mental health treatments will increase by 10%.*

4b: *By 2010, Wisconsin's public mental health clients who have access to "Evidence-based" mental health treatments will increase by 10%.*

> **Performance as of 2005:** *The Department's Division of Mental Health and Substance Abuse Services provided a limited data and program update to the State Health Plan Committee. Unfortunately, due to limited resources and capacity, a comprehensive data and program review was not possible.*

Performance Status: No change

Part III: Recommendations

1. **Create a uniform system for tracking mental health data.** This will require forming a data-sharing agreement between the Division of Public Health and the Division of Mental Health and Substance Abuse Services (DMHSAS). This will result in a uniformly available system for proper tracking and reporting of mental health data. The data-sharing agreement should include provisions to avoid present client duplication. This system should have the ability to retrieve and compile the data currently omitted for private sector clients and other marginalized groups to accurately reflect Healthiest Wisconsin 2010 objectives.

2. **Collect data and select indicators that address access and mental health outcome data.** These data should include youth depression and suicide, women and postpartum depression, marginalized populations, particularly Latino/Hispanic, American Indian/Alaska Native (distinguishing between urban, rural, and Tribal communities with consideration for the nation-wide trend of living off-reservation), gay, lesbian, bisexual, transgender persons, and the elderly, as well as intersections of the aforementioned populations. These data should include evidence based on recovery outcomes programs and potential for recovery. ***Additionally, clients served in the private sector need to be included.*** Such efforts would greatly benefit from the continuous inclusion of the Behavioral Risk Factor Survey (BRFS), Youth Risk Behavior Survey (YRBS), National Committee for Quality Assurance (NCQA) data, Health Effectiveness Data and Information Set (HEDIS) reporting, and the National Health Survey. Community-based methods for over-sampling marginalized populations, with a conscious sensitivity to utilize the most productive means of gathering personal data, and solid training for professionals for the implementation of same should be utilized. Finally, an overall focus is needed on gathering mental health data for alcohol and drug abuse, traumatic exposure, sexual abuse and depression (especially with American Indians) in a culturally competent manner.

3. **Enact insurance parity for all.** This should be inclusive of private and public services, in an effort to combat financial barriers to access in mental health care, with diligent consideration of the unique needs of Tribally enrolled persons living in off-reservation settings, given that more American Indians live in urban settings than on reservations in Wisconsin and nationally, with American Indian women hospitalized for depression in

Wisconsin at a rate significantly higher than any other race/ethnicity. Special efforts towards reducing the health disparities for mental health consumers in both primary and other mental health care facilities (e.g., private practice and community-based health clinics) will facilitate this process. In addition, address issues of reimbursement (e.g., systems of reimbursement of uninsured/under-insured people, which results in less than 50% of service costs being covered).

4. **Develop private and public partnerships for creating a funded comprehensive "Combat Mental Health Stigma" marketing campaign.** This campaign should consider professional health education models suited for grassroots, private, and community-based public health outreach and outcome evaluation with considerations for marginalized populations.

5. **Convene a taskforce through the Division of Public Health and the Mental Health Division Bureau of Prevention, Treatment and Recovery**. This taskforce will make recommendations to the Department of Health Services that identify and support culturally competent, evidence-based, and best practice approaches to address mental health needs. Along with this, ongoing monitoring and fidelity of treatment should be evaluated. The work of this taskforce should include consideration of community-based initiatives and networking including community-supported programs and access for marginalized populations, such as those listed in recommendation #2, that go beyond managed care programs such as Medicaid and Medicare. Deliberations should further consider evidence for potential for recovery, behavioral outcomes, outreach to those in need, and diversion to alternative systems when treatment is not needed.

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Wisconsin Public Health Council
State Health Plan Committee

Report on Lessons Learned To Date: Recommendations for Healthy People 2020

The State Health Plan Committee is a committee of the Wisconsin Public Health Council. The work of the Committee is linked to the Public Health Council through the Council's charge to advise the Department of Health Services (DHS), the Governor, the legislature and the public *on progress in implementing DHS' 10-year public health plan.*

This report of "Lessons Learned" through the process of analyzing the infrastructure and health priorities of Healthiest Wisconsin 2010 is intended to better inform the development of Healthiest Wisconsin 2020, our next state health plan.

The State Health Plan Committee was formed in early 2005 to analyze progress toward the infrastructure and health priorities of Healthiest Wisconsin 2010. The first reports to the Public Health Council in 2006 included a report of issues in identifying progress toward and *recommendations for improving the infrastructure priorities*: Recommendations to Increase the Potential for Public Health System Transformation, 2006 (http://publichealthcouncil.dhs.wi.gov/shp/rectransformation.pdf). This Transformation Report highlighted a set of transcending issues that need to be addressed:

1. The **ability to fund public health priorities**
2. The **collection and production of health data**, including State Health Plan profiles by county and major cities, in a timely, locally-based, and standardized format
3. The **impact of health disparities** on specific populations and the need to aggressively address the disparity in order to maximize the most at need populations, and
4. **Assurance that prevention is the lead strategy** for all interventions

Based on the recommendations of this report, the Public Health Council selected a task force to address the issues of financing. Their report (Increased State Financing of Governmental Public Health: A Proposal to the Public Health Council from the Ad Hoc Finance Committee) completed in December 2007 detailed important issues about funding for public health in Wisconsin, and particularly health promotion and disease prevention compared with similar states. This groundbreaking report included a set of recommendations that were built, in part, on the State Health Plan progress report for Alcohol, Substance Use and Addiction (Progress Report 2007: Alcohol, Substance Use and Addiction PDF, 67 KB) and supports recommendations for evidence-based practices to reduce rates of alcohol abuse in Wisconsin.

To date, the State Health Plan Committee has completed analysis of seven of the health priorities and has submitted the following reports to the Public Health Council:

- Progress Report 2009: Access to Primary and Preventive Health Services
- Progress Report 2009: Mental Health and Mental Disorders
- Progress Report 2008: High-Risk Sexual Behavior
- Progress Report 2006: Obesity, Overweight, Lack of Physical Activity
- Progress Report 2006: Adequate and Appropriate Nutrition
- Progress Report 2006: Tobacco Use and Exposure

What Have We Learned from this Process?

Issues to Consider in Planning

- There remains a need to determine what optimal public health is. What does it mean? How is it linked to the Healthiest State Project and how will the results of that project be incorporated into Healthiest Wisconsin 2020?
- The State Health Plan needs to be the lead document for the DHS. Currently, the development of SHP for 2020 does not appear to be integrated into the daily interests and goals of ongoing DHS programs and projects. The lack of integration was also apparent in the 2010 plan.
- Reporting on attainment of the health plan goals cannot be done without significant investment in data collection and human resources. Adequate and accurate data are a necessary requirement for community/public health planning and staff must be available to assist in the analysis.
- The data to be collected on HP2010 were identified about eight years ago because our experience has brought us to a new level of sophistication; we need to reconsider what data elements should be collected and how.
- At all points in the process of 2020 planning consider that budgets of community-based organizations (CBOs), private organizations, and the state are limited. How will these resource issues be addressed so that all can collaborate for community health improvement? How can funding be distributed so that new as well as existing partners are included?
- How can the State Health Plan Committee and state staff efficiently support each other to collect the data required for accountable tracking of the State Health Plan progress?
- The reporting process of the State Health Plan Committee to Public Health Council must be improved so that the outcomes of these efforts are meaningful. The Council should identify what is useful information that they can actually process and use.
- It is unclear if the 2020 Focus Area Strategic Teams will be identifying measures for the objectives they devise. If they are, it will be important to determine immediately if these data are or can be available.

- Expand the use of strategies such as social marketing in the state health plan to show the public the value of the public health system and what it being done to promote health.
- Identify the economic implications of the lack of progress toward each priority.

Tracking Healthiest Wisconsin 2020 Health Priorities

- Address the individual infrastructure priorities for Healthiest Wisconsin 2020.
- Consider the sources for data gathering; there may be duplication of available data.
- Consider what data elements or datasets will be the most relevant or the best indicators for the health priority.
- In order to assure that particularly marginalized communities that experience health disparities are addressed in planning, monitoring, and evaluation, data collection should include information from community health partners as well as governmental sources of data.
- There is a need to determine common methods for reporting data in order to avoid duplication, overlap, and inconsistency.
- Define indicators of a public health system vis a vis value for the public's health.
- Address the disconnect between rural and urban components of the public health system and health outcomes.

Staffing Issues

- Work of Volunteers: State Health Plan Committee
    - Partnership of volunteers and state is still in early stages
    - Although these partners have built networks and generally cooperate, they do not always coordinate efforts, nor are they particularly collaborative. This situation reflects increased, but fragile trust in one another and in the partnerships. Theory would suggest that there needs to be a greater commitment of time and incentives to relinquish turf.
    - The work is time intensive – the State Health Plan committee needs more focus, while still preserving oversight.
    - Work of volunteers is important, but sometimes seems futile in light of budget and staff constraints. The work of volunteers extends the work of state staff and enhances perspective and expertise. They need to be honored and valued, and compensated.
- Work of State Staff
    - With categorical links to federal funding, program staff are often ensconced in their programs, not necessarily targeted toward State Health Plan health priorities and risk factors.
    - Track 2010 needs to be reviewed - should state staff devote this time to the effort and if so, what should be tracked in 2020?

Specific Data Recommendations

- Ensure implementation plans address populations that exhibit disparities in health outcomes.
- Capture qualitative data on satisfaction and access.
- Expand current state health plan data collection to include e-health and Medicaid/ BadgerCare data, as well as data from other areas/departments that impact health (i.e. DPI, DNR) for evaluating impact on state health plan priorities.
- Include outcomes of the insurance Pay-For-Performance measures in analyzing progress.

Final Recommendation Concerning Public Health System Transformation
The issues related to "transforming Wisconsin's public health system" continue to transcend each health priority that we have analyzed. We recommend that the report to Recommendations to Increase the Potential for Public Health System Transformation, 2006 (http://publichealthcouncil.dhs.wi.gov/shp/rectransformation.pdf) be reviewed by each member of the Strategic Leadership Team of Healthiest Wisconsin 2020 and others involved in the state health planning process. In this way, members of the state health planning teams across Wisconsin may be better informed advocates and include these key issues for a stronger state public health system.

Submitted respectfully by the State Health Plan Committee

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