

Public Health Council

Friday, August 7, 2015
Wisconsin Department of Health Services
1 West Wilson Street, Room B-370, Madison, WI 53703
Madison, WI 53703
9:00a.m. – 12:00p.m.

Council Members Present:

Mr. Terry Brandenburg; Ms. Mary Dorn; Dr. Gary Gilmore; Mr. Dale Hippensteel; Mr. William Keeton; Mr. Eric Krawczyk; Mr. Bob Leischow; Dr. Sandra Mahkorn; Dr. Alan Schwartzstein; Ms. Joan Theurer; Mr. Thai Vue; Dr. Darlene Weis

Council Members Excused:

Mr. Terry Brandenburg; Ms. Bridget Clementi; Dr. James Sanders; Ms. Stephanie Schultz; Mr. Jay Shrader; Mr. Michael Wallace

Council Members Absent:

Mr. Mark Villalpando

Division of Public Health (DPH) Staff:

María M. Flores	Program & Policy Analyst, Minority Health Program
Tasha Jenkins	Director, Office of Policy and Practice Alignment (OPPA)
Karen McKeown	Division Administrator and State Health Officer
Ashley Kraybill	UW Population Health Institute Fellow
Jennifer Russ	Population Health Specialist, OPPA
Jenny Ullsvik	Director, Office of Preparedness and Emergency Health Care

Guests:

Brad Christensen	Xerox Government Healthcare Solutions
Jing Wu	Former OPPA AHEC CHIP Intern

Acronym Guide and Links:

CDC	<u>Centers for Disease Control and Prevention</u>
CLAS	<u>Culturally & Linguistically Appropriate Services in Health & Health Care</u> (Minority Health Program)
DATCP	<u>Wisconsin Department of Agriculture, Trade and Consumer Protection</u>
DHS	<u>Wisconsin Department of Health Services</u>
DPH	<u>Wisconsin Division of Public Health</u>

FQHC	<u>Federally Qualified Health Center</u>
HW2020	<u>Healthiest Wisconsin 2020 / State Health Plan</u>
JFC	<u>Joint Committee on Finance</u>
LPHD	<u>Local Public Health Department</u>
MHLC	<u>Wisconsin Minority Health Leadership Council</u>
NACCHO	<u>National Association of County and City Health Officials</u>
PHAB	<u>Public Health Accreditation Board</u>
PHC	<u>Public Health Council</u>
SIM	<u>Wisconsin Site</u> <u>State Innovation Models Initiative</u> – federal site
SLOH	<u>State Lab of Hygiene</u>
WALHDAB	<u>Wisconsin Association of Local Health Departments and Boards</u>
WPHA	<u>Wisconsin Public Health Association</u> <i>A comprehensive guide can be found under "Public Health Acronyms & Abbreviations" at: https://share.health.wisconsin.gov/ph/OPPA/Policy/Council/SitePages/Home.aspx</i>

OPEN FORUM

Brad Christensen, Xerox Government Healthcare Solutions

- He came to learn about the Council. They do business with state governments across the country. They have a wide swath of business: anything from the end member, to commercial payers to provider communities. In state governments, they work with systems and services, such as: large-scale state MMIS systems; backroom call centers; assistance with long-term care; core services like outsourcing call centers, not necessarily technical components, but perhaps areas where a government does not have the staff or expertise.

COUNCIL BUSINESS

Review and Approve June 5, 2015 minutes

- Dr. Gary Gilmore moved to approve the minutes
- Dr. Sandra Mahkorn seconded

Discussion:

- Dr. Gilmore will meet with María M. Flores to correct very minor errors.
- *The following discussion regarding "Health in all Policies" (page 5 regarding three priority areas) will be inserted into the June 5, 2015 minutes as added clarification on the term "Health in all Policies".* Dr. Gilmore felt this term was too broad; does this mean public health policy? If so, this would make sense. Dr. Mahkorn agreed that clarification is needed
 - Joan Theurer stated that the phrase "health in all policies" is meaningful, it is branding that is used at all levels of public health – local, state, federal. It is not a campaign; it is an orientation that as we move forward, public policy, related to and in support of public health, should be examined for health implications. For

example, the Marathon County Health and Human Services Committee adopted "health in policies": any resolution or policy statement coming out of the committee has a public health implications statement. It reinforces the determinants of health – you cannot have a healthy community unless the social and economic issues are addressed, as well. It helps tie the concepts together so that people look at the implications of health around policies.

- Bob Leischow stated that the terminology is supported and promoted through NACCHO. There is very clear reference to this. It is not an initiative, but a strong focus on this as general terminology. It goes beyond public health. The idea is that between public health and traditional health systems, we can all come together and talk about policy from a synergistic perspective. Suggests keeping the terminology.
- Mary Dorn agreed. This is now the consistent language used in public health, and is well known. Health departments see this in local planning efforts and others working in non-traditional, non-governmental public health as being a method of working with legislators and the of community when policy is created to look at the health effects of that policy.

All were in favor of the motion to approve the minutes with Dr. Gilmore's edits and the "health in all policies" discussion inserted.

Report from Chair:

Bylaws and Rules of Order

Bill Keeton reported that there was a thorough vetting of the Bylaws and Rules of Order in Executive Committee meetings. They came up with a strong set of recommendations on how to move forward. There are a few outstanding issues that Tasha Jenkins sent to DHS Legal Counsel for a response.

Discussion:

- Dr. Gary Gilmore clarified the comment on page 4 about the Council's Secretary keeping a duplicate set of minutes. This issue was also sent to Legal Counsel, and a point was made if electronic copies count as a set. This is part of ongoing deliberations.
- Bill Keeton stated that the "Officer Elections Procedure" document was pulled from §1.07 because it is procedural, and should be left to the Nominating Committee.

Questions or concerns:

- Dr. Gilmore stated that there should be further refinement in the "Officer Elections Procedure" document, under (2), where it speaks to the Chair-Elect succeeding the Chair of the Council. To further clarify, and to assist those who are considering becoming Chair-Elect, it should show that being Chair is actually a 6-year commitment: 2 years as Chair-Elect, 2 years as Chair, and 2 years as immediate Past Chair. He suggests a final sentence line for (2) - "The former chair will serve as the immediate past chair on the Executive Committee."
- Dr. Alan Schwartzstein stated that §1.08(4), *Location*, seems vague and needs wordsmithing or clarification. Dr. Gary Gilmore stated that the original intent of the

Council was to allow for meeting at other locations; to demonstrate that the Council is truly a state-wide Council.

- Dr. Schwartzstein asked if Robert's Rules of Order Newly Revised is the official procedure that the government uses (§1.08(7)). Bill Keeton stated that unless another procedure is stated in a body's governing document, then, yes, Robert's Rules is the official procedure.
- Bill Keeton stated that the Bylaws are still a work in progress and these is a little more that needs to happen, but from time-to-time it will continue to be revised as the Council moves forward. He thanked everybody for the significant amount of time involved in revising the Bylaws.
- Once Tasha Jenkins hears back from Legal Counsel, she will send the information to the full Council and the Executive Committee to act on it. *Sent 08-17-2015.*

Chair Letter to the Governor.

Bill Keeton stated that he would like the letter to be forwarded to the Governor with today's date.

- Dr. Gilmore asked that the double set of quotes be removed from the second paragraph, last sentence.

Dr. Alan Schwartzstein made a motion to approve the Chair Letter to the Governor.

Dr. Gary Gilmore seconded

- There were three abstentions
- The motion passed

Bill Keeton announced that Alex Ignatowski took a new position outside of DHS, with another state agency.

COUNCIL UPDATES

Division of Public Health

Karen McKeown, Administrator and State Health Officer

Dr. Alan Schwartzstein asked about the action regarding of funding or defunding of Planned Parenthood.

Bill Keeton stated that three (3) bills were introduced: one regarding the sale of fetal tissue as it relates to research; a second bill that would change way state Medicaid interfaces with pharmacies and covered entities on the federal 340B drug discount pricing program; and a third bill regarding the Wisconsin Well Woman Program and dispersal of funding. He will send Council members information on the legislation.

- Karen McKeown stated that no Well Woman Program funds go to Planned Parenthood.
- Dr. Alan Schwartzstein stated that many women circumvent their family physician to obtain contraceptives, and instead utilize Planned Parenthood for this purpose.
- Dr. Gary Gilmore stated that these bills go to the heart of women's health and population health. It is part of the national dialogue on health. We need to be kept apprised of this legislation.

- Dale Hippensteel stated that there will be a lot of interest in the 340B drug discount pricing bill among the community health centers.
- Bill Keeton gave a broad overview of this program. This gave organizations that serve low-income or otherwise disadvantaged populations the ability to purchase certain medications at a discounted rate from the manufacturer. The organizations can then use some of the proceeds from the sale of these drugs to ensure that they keep offering services and access to care for those individuals. Many organizations use the funds to keep their infrastructure going in order to serve these populations. In other parts of country there may have been some instances where systems like large hospitals are not using this funding in the way intended.
 - Joan Theurer stated there is a lot of concern among organizations to remain viable if changes are made.

Karen McKeown:

- [Senate Bill 218](#) - bill prohibiting any employer from discriminating against employees refusing an influenza shot.
- There are several bills on Emergency Medical Services. There was outreach by an out of state provider that was responding to mutual aid calls and wanted to know if they need a Wisconsin license. A memo was issued state-wide, and caused issues because there were a lot of out-of-state providers being called in or doing transports in Wisconsin. Some communities relied almost exclusively on these out of state providers. The Division was quick to respond and work with Iowa, Minnesota and Michigan, which have similar requirements to easily obtain a Wisconsin license. The out of state fee would be waived for providers in those states with a letter of support. Illinois does not use the national examination, so a bill was introduced that stated that an out-of-state provider can do up to ten mutual aid calls per year without a Wisconsin license. This bill does not address the communities where the out-of-state provider is the primary provider.
- [Assembly Bill 213](#) which legislation regarding two EMS providers who at the same level in an ambulance providing service.
- Up for discussion in the fall, there will be conversations regarding community paramedics and possibly EMTs functioning in something similar to a home-health role.

Dr. Alan Schwartzstein stated that SB 218 seems to be a step backward in terms of public health. It brings to mind the measles outbreak in Disneyland, and the efforts to limit vaccines to religious exemptions. He recommended the Council step in and speak to this – if this is passed, there will be more influenza, pneumonia and death cases in Wisconsin.

- Karen McKeown stated that the bill is specific to flu, and it covers all employers, public and private.
- Dr. Gary Gilmore stated that the Council may want to weigh in from a more generic perspective.
- The Executive Committee will look into this for a possible resolution.

Dr. Alan Schwartzstein stated that another bill of interest circulating now is the Interstate Medical Licensure regarding interstate compacts for physicians. Several states are working on this issue, especially with regard to the advances in telemedicine. This would be a step toward reducing barriers to providing healthcare to shortage areas. The Sr. Vice President of Government and Legal Affairs for the Wisconsin Medical Society, Mark Grapentine, may be able

to provide more details. If requested, Dr. Schwartzstein would be able to provide this information for Council members.

Emergency Preparedness

Jenny Ullsvik, Director of the Office of Preparedness and Emergency Health Care

- Funding: the fiscal year started July 1, 2015. It is the 4th year of a 5-year cooperative agreement with about \$11.5M/year towards preparedness; additionally, they receive \$3.6M for hospital preparedness.
- Hospital preparedness has been transitioning into health care preparedness and bringing in partners that impact the health care system. As of July 1, there are [seven regional coalitions](#); this is part of the hospital or health care preparedness grant.
- The DHHS Assistant Secretary for Preparedness and Response will conduct a site visit in two weeks; they fund the health care preparedness program. The CDC funds the Public Health Emergency Preparedness Program; their visit will be in September.
- In June 2016 there will be a full-scale exercise in Milwaukee for all partners. This has never been done before in Wisconsin. It will test the capability to prophylax against anthrax. It will be flying in equipment and supplies and testing them to see how everybody works together.
- Hospital preparedness received three different Ebola grants. One was a short-term grant that already ended, the second (\$2M) is coming to an end, and the third is a 5-year health care / hospital preparedness grant.
 - The grants are to help with monitoring of patients. They have a short time frame to cover work they are already doing. For the 5-year grant, there is some infrastructure funds going to Category 1 facilities; some of this is retroactive funding, but they will need to maintain the objectives for 5 years.
 - Karen McKeown stated that these are opportunities to learn lessons, so moving forward, not much will need to be relearned. The lessons learned are also easily transferrable to other outbreaks, such as the bird flu. She recently attended an Ebola "in-progress" review. She learned other states are doing interesting things, such as Georgia, which built an application for smartphones, computers and tablets to mesh with their Ebola monitoring system, and it allows the self-reporting through the app. Currently this app is only available in Georgia for their monitoring system, but they would like to share it widely.
 - Dale Hippensteel asked if there were any difficulties with translating the app.
 - Karen McKeown stated that she did not hear about this as a challenge, she knows the locals did a great job. The app has many languages and international symbols.
 - She also stated that a strong recommendation that came out of the national meeting was that a database of those Ebola patients being monitored be created so that healthcare providers could access it in a HIPAA-sensitive way.
- Dr. Gary Gilmore asked where this all fits into strategic planning in terms of prioritization, how are other systems being engaged, such as transportation.
 - Karen McKeown stated that ongoing challenge the Division would like to solve in Wisconsin is how EMS responds. It is such a large system, with many volunteers. It would be good to build a formal system.

Thai Vue attended the June 11, 2015 Wisconsin Minority Health Leadership Council meeting.

- He would like the PHC to understand the Minority Health Leadership Council's role and how it was created. He shared information that is located on the [website](#). It was established in Spring 2007 by the Department of Health Services, made up of 15 members from diverse populations. Their mission is to advocate for the elimination of health disparities; to advise the Minority Health Program, and give input regarding development of strategies.
- The MHLC conducted their annual voting at the last meeting and filled all 15 vacancies.
- Evelyn Cruz reported on the Health Disparities Focus Groups that will inform the Mind-Course Review
- A few Council members formed a Community Team with the [Healthy Wisconsin Leadership Institute](#) that focused on mental health issues in minority populations and the intense stigma and barriers to care. Their final project, a video on Muslim Mental Health, was shown.
- The federal grant that funds the Minority Health Program's staff (Ruth DeWeese at 100% and María M. Flores at 50%) end August 31. Staff is uncertain where they will go, and what will happen to the office. The Council voted to send a letter to DP H Administration (Karen McKeown) for assurance that the Council assurance that the MHLC and disparities work will continue.
- The Council would like more detail on Public Health Council meetings and upcoming legislative issues. Many of the PHC committee activities could be coordinated with the MHLC to eliminate duplication.

Dr. Gary Gilmore stated that is another reason to coordinate "Council of Councils" meetings. The MHLC is definitely one of the Councils to have representatives attend a larger meeting.

Bill Keeton stated that there has been some conversations about this. There was a lot of momentum, but we need to come back to this idea at a later date. Once Kim Whitmore's position is filled, then there may be some movement. We need to make sure we have the resources and abilities to deal with this.

Karen McKeown stated that when there are more resources to conduct this type of partnering, it may be one meeting, and not an ongoing meeting.

HW2020 MID-COURSE REVIEW

Karen McKeown, Administrator and State Health Officer

Tasha Jenkins, Director, Office of Policy and Practice Alignment

Prior to the meeting, Karen McKeown sent the following items for the Council to consider:

These are the questions we are wrestling with internally, and on which we would value your input (including, where applicable, pros and cons for each):

- *How many priorities should we identify? Should it be a short list (3-5?) or a longer list (10)? (Please give pros and cons for both approaches.)*
- *If foundational work (e.g. communicable disease or preparedness) were not selected as a priority, how would its foundational nature continue to be captured? Or should it be a priority? (This may go back to the criteria.)*
- *Should priorities be narrow or broad? (e.g., if we selected chronic disease, would it be chronic disease in general? Or a specific chronic disease? Or obesity? Or physical activity or nutrition?) (Again, please provide pros and cons)*
- *Is our current messaging around the midcourse review clear?*
- *Looking at our process, are we missing input from critical partners or groups?*
- *How do we talk about the other important work that must continue, but that for whatever reason (hopefully clear from the criteria) is not selected as a priority?*

Karen McKeown discussed the Management Retreat and Division's strategic plan in terms of looking how to best move forward the work of *HW2020* – a new set of goals around health outcomes should not be recreated when there is already such a list. The Division has several priorities, lasting from 3-5 years. The CLAS Standards (Culturally and Linguistically Appropriate Services in Health and Health Care) are envisioned more as a 5-year project. The DPH managers were asked what they believed the most important priority – something that resources could be diverted to – was the Mid-Course Review. It is hard to ask partners what to align around given that there are 23 focus areas in *HW2020*.

Tasha Jenkins stated that by 2016, the Mid-Course Review will be finished, and work will have begun on a new 5-year state health plan.

- Accreditation standards mandate that state health plans be no more than 5 years old, so moving the Division to a 5-year plan creates a more focused set of priorities that will be build on the current set of priorities. Partnership engagement is an important piece of that, such as: hospital community health needs assessments (CHNA); LPHD community health assessments (CHA) and community health improvement plans (CHIP); the Health Equity Check-Ins; and input from partners such as the Public Health Council, DPH staff, LPHD staff and other partners.

Dr. Sandra Mahkorn stated that in the State Health Plan Committee meeting, they discussed requirements of the Mid-Course Review and the accreditation process. They identified criteria, and there was much overlap. They came up with 13 areas of criteria; 5 of which were sent prior to today's meeting:

- 1) feasibility (financial political will, sustainability);
- 2) impact (incidence, prevalence, cost, existing trends);
- 3) health equity/inequality/disparities/diversity(not just where populations are doing poorly, but where they are exceeding, such as Asian infant mortality);
- 4) measurability (where good metrics or data exist); and
- 5) evidence-based (do they exist for a certain priority?).

The Committee's next step would be meeting and creating a table with the 23 objectives and see how they measure up.

- Bill Keeton stated that the questions Karen McKeown sent fit well with the Committee output.

Karen McKeown asked how the Council can be most helpful. Would it make sense to add an additional question - does making this a priority of the state health plan make a difference? There is some work that might meet all the criteria, but the work is already happening, and it may not make sense to bring in new, additional partners. However, she envisions the priorities as ones that they can get additional alignment around the state, and bring in new partners and do new activities it would make more of a difference. For example, newborn screening is very important, but would it need to be a statewide priority because the people who need to be engaged on newborn screening already are, and the work is going on anyway.

Dr. Sandra Mahkorn stated that one of the purposes of conducting a mid-course review is to examine what we are doing well (that could be possibly dropped as a priority), what not so well, and also ensuring continuous quality improvement.

Karen McKeown asked if the current messaging around the Mid-Course Review was clear.

- Dr. Gary Gilmore stated that there are different segments/targets for messaging and marketing. Those segments need to be looked at first. Definitely include public, continuing and new partners. The Committee could probably help in the effort.
- Dr. Sandra Mahkorn asked how much of a marketing strategy would be used? Part of it is educating on why priorities were picked. The Division would need to really explain and get buy-in so people can understand what the core indicators are. Listening to partners is also critical.

Karen McKeown asked if it would make sense if the LPHD community health assessments and community health improvement plans were used as a strong component for analysis, and then not engage the public until the priorities are chosen.

- The health departments are community driven; it could be explained to the public that the priorities are the community's priorities based on the LHD public meetings.
- What if public engagement is not brought in until there is a final or proposed list of priorities, and then it is described how those priorities were chosen and how the community was involved. The state has not typically reached out to individuals, and it is important that work not be duplicated.

Dr. Alan Schwartzstein stated that as the Division moves forward with communications, it is important that the words "important" and "priorities" are separated. Within the larger audience, every objective will have an advocate that thinks it is a priority. He likes the idea of doing this work with a limited group initially, but the more priorities we have the harder it is to move forward. The current messaging is not quite clear. What is the message?

Karen McKeown stated that the message is just being developed because it just occurred to Tasha that this is not just a mid-course review, it is also the development of a new 5-year state health plan. There is a lot of investment of time, resources and emotion in *HW2020*, but they don't want to disregard that at all. It will be used as a foundation and be acknowledged, and also help people realize that it is not just a mid-course review, but also the creation of a new plan with a prioritized set of objectives.

Dale Hippensteel stated that in his experience developing his local health plan in Sheboygan County, they had partners, not hospitals, but they participated. The last time it was done the

hospitals were partners. The Division should look to the five DPH Regions, and see that many of the CHIP plans are done – the work is already done.

- Karen McKeown stated that the UW Population Health Institute already has this prioritized list of information on local health assessments and the hospital plans: [Assessing and Improving Community Health in Wisconsin](#). There are a few major groupings. She wondered if by looking at this, we may almost already be there, or do we need to do more of a process to be more credible.
- Dr. Alan Schwartzstein stated that he felt that there does not need to be more of a process to involve mere people and make it more complicated.
- Dr. Gary Gilmore stated that we would be remiss if recent, secondary data are not used as starting point. There may be a need to explore certain areas that are not fully described or defined. The only reason to do something anew would be if there is a distinct purpose that emerged from the review of the data. The UW Population Health Institute work is highly regarded nationally. He agrees there needs to be a distinction between the words "importance" and "priority" and there should be no impression given that one is more important than another. With regard to the timeline, the messaging needs to state that this is ongoing work, and should state that because something is not listed as a priority now, it does not mean that it could not or should not emerge in the near future.
- Karen McKeown stated that this was a good point. In the Division's 5-year plan, "ongoing work" is called "rolling". Having the state health plan be a 5-year plan, it is an opportunity for the priorities to be updated more quickly.
- Bill Keeton stated that in the messaging should also be tailored to organizations that use the state health plan to apply for funding.

Karen McKeown asked the group what they thought the name should be, given that it is not really the Mid-Course Review anymore, but a new plan. *Healthiest Wisconsin 2021 (2016-2021)? Or Healthiest Wisconsin: . . . (fill in the blank).*

Dr. Alan Schwartzstein suggested *Healthiest Wisconsin 2020: amended / revised / revisited* (one word that does not confuse people, but not "priorities") because all the focus areas are important, and the work on all of them are important. The concern is that someone will look at the document, and feel their work is ignored if a word like "priorities" is used.

Eric Krawczyk stated that since this is an ongoing process, the messaging needs to be simple and short.

Dr. Sandra Mahkorn stated that in the committee meeting, they learned more of the background and development of the plan. The 23 Focus Area Strategic Teams who worked on the process also felt that it should be narrowed down. Message should include this, and that there needs to be a rational way to establish priorities, and that criteria were applied to establishing priorities. People need to know that that this has to be a dynamic and continuous process.

Dr. Gary Gilmore stated that also with the ACA IRS requirements that healthcare organizations need to be part of the community outreach and activities. There are many examples of this in Wisconsin. In Western Wisconsin, the [Compass](#) approach which is nationally funded through the United Way involved varied partners from the beginning; they provide a good model on

how to engage many different partners. They do this on a 5-year basis, and health care entities are very interested because their IRS requirement is very three years. It should not be all on DPH shoulders. It should be part of strategic planning.

Tasha Jenkins stated that this is the direction many LHDs are headed in; and have agreed to partner with hospitals so that both can meet their requirements on a three year cycle.

Dr. Alan Schwartzstein stated that one of the first focus areas is access to health care. There are many organizations moving to improve access to primary, secondary & tertiary care, and doing ongoing work. This objective is important, but is there enough work being done in this area that this may not need to be a priority.

Dr. Gary Gilmore stated that this was a great example. No additional work should be created, but we need to tap into the capacity being generated.

Karen McKeown stated that what is in the plan is what the state is working on, but not necessarily the Department of Health Services. Should we keep what the DHS can work on, and take off the list of priorities what DHS cannot lead? She sees the set of priorities could be a rallying point for partners to align with the Department.

- Dr. Gilmore stated that the priorities probably should be what the Division and Department are leading; however it can be informed as this is a continuing assessment.

Thai Vue asked about health equity and health disparities. From his work on *HW2010* and *HW2020*, a fairly good job was done with bringing health disparities to the surface, and thanked the Division with making this happen, but Wisconsin in general has not done so well with reducing health disparities. The leaders around the state need to see the improvements that can be attributed to the Division; for example, the reduction in tobacco use within the Hmong population, from 20% to 6% use in the adult population in just 15 years. There are many changes occurring, and with regard to the Minority Health Program and the Wisconsin Minority Health Leadership Council, will those continue, or be phased out?

Karen McKeown will continue, and there will be an update on this at the next PHC meeting. They will talk to the WI Minority Health Leadership Council first. She stated that one suggestion was to pull out health disparities and make it a stand-alone priority issue. Everybody can incorporate health disparities in their work.

Dr. Alan Schwartzstein stated that when the Division talks to people, three points should be used so as to not lose people's interest. The plan is supposed to be for everybody, not just DHS.

Karen McKeown stated that perhaps the message would either be what the Division and Department are leading on, or the top priorities for the state, to include what issues partners are leading. The access priority is consistently selected by LPHDs. For example, access for Medicaid patients to receive oral health care. This work is not led by the Division or the Department, and there are other similar issues.

Dr. Gary Gilmore stated that there is another term that has not come up, and that is "latitude". We start with "these are the areas we have determined, but we are open to additional insights

to other partners around the state,” and show that it is continuing and ongoing. We can't be locked in that we are always the leader in all of the areas. We need to show we are welcome to additional input and capacity-building.

Dr. Gary Gilmore encourages a fulcrum of focus from the beginning. If we do not, we lose the ability to build capacity from the health care system and other aligned systems. He would like this to be the starting point, rather than something that is figured out 5 years down the road, along with leadership by the Division for priorities established in a collective manner.

Karen McKeown stated that connecting with the State Health Plan subcommittee would be a next step.

SIM GRANT

Jennifer Russ, MPA, Population Health Specialist, Office of Policy and Practice Alignment

Jennifer Russ went over the Transformation Model graphic with five components:

1. Define the Population
2. Fact Finding
3. Shared Transformation Goals Development
4. Performance Gap Identification and Analysis
5. Best and Better Practices Identification and Analysis
6. Better Practices Implementation Requirements and Considerations

She emphasized that the final product is a plan – not implementing changes to health and health care. The Triple Aim is the main aim of the plan (simultaneously improving population health, improving the patient experience of care, and reducing per capita cost). They are looking at a way to produce a framework of collaboration to improve health and health care and reduce costs that can be used with any population. Of the five components of the transformation model, they are in the process of shared transformation goals development; however, these are rapidly changing. They are looking at upstream drivers, disparities, optimizing care so that the framework would work with future populations.

Populations:

1. Adults 18-64 with diabetes + hypertension; and
2. Adults 18-64 with depression + diabetes.

The Preliminary Findings Report came out June 4, 2015, and is linked on the DHS SIM website; however it is on a Google Drive

(https://drive.google.com/file/d/0B4kKzOjii_8WQmcwYk1acTdrSG8/view?usp=sharing) and not currently accessible to the public. The workgroup is in the process of changing this. They are currently wrapping up the key facts report.

Much of the tasks going forward are focusing on the most impactful things that could be done going forward. They are also looking at a “state-of state” for all populations, and what would be the most important populations to run through the model.

There are also a lot of suggestions with their penultimate component of the Transformation Model: *Best and Better Practices Identification and Analysis*. Looking at what is really wrong before they can fix it. In terms of better practices, there are a lot of good practices going on in the state, and ways to standardize these better practices. There will also be more outreach to advisory panel members. For gap analysis, they will be asking for the expertise of PHC members to see why is Wisconsin is not at the "ideal state."

WRAP-UP

Next Steps:

- There may be a need for Committee meetings between now and the end of the year.
- Bill Keeton will send Council members an e-mail regarding legislation. *Sent immediately following the meeting.*
- Dr. Alan Schwartzstein announced he is nominated for a national leadership role.

Dr. Darlene Weis made a motion to adjourn.

Dr. Sandra Mahkorn seconded.