Healthiest Wisconsin 2010:
A Partnership Plan to Improve the Health of the Public -

A mid-term assessment of Transformation

Conducted by the Department of Health and Family Services, Division of Public Health in partnership with The University of Wisconsin Population Health Institute

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Alison Bergum, MPA; Amanda Jovaag, MS; and Andrea Hoekman, MPA conducted the online survey and prepared this report under the direction of D. Paul Moberg, PhD.

The project team thanks the following individuals for their many contributions to this project:

Project Advisory Committee

Patricia Frazak, RN – Dane County Department of Public Health
Carol Graham, RN – Public Health Advocate
Mark Huber, MS – Director, Community Health Planning, Aurora Health Care
Terri Timmers – DHFS Northern Regional Office
Susan Zahner, RN, DrPH – Assistant Professor, UW-Madison School of Nursing

Department of Health and Family Services, Division of Public Health

Patricia Guhleman
Stacia Jankowski
Margaret Schmelzer
Susan Wood

EXECUTIVE SUMMARY

'Transforming Wisconsin's public health system' is one of the overarching goals of *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public,* the State Health Plan for the decade 2001-2010. According to the authors of the plan, "This goal seeks to transform Wisconsin's public health system into a coordinated, effective, and sustainable system." Implementation of the plan is expected to yield benefits which include "protecting health, improving the quality of life, extending life expectancy, and containing the costs of health care."

In the spring of 2005, the Department of Health and Family Services, Division of Public Health partnered with the University of Wisconsin Population Health Institute to assess Wisconsin's progress towards this goal. This assessment is intended to:

- Provide a mid-course baseline for future evaluation;
- Better define and operationalize the concept of transformation;
- Serve as a needs assessment tool to identify potential gaps in current steps towards transformation; and
- Serve as a tool to inform policy development and educate the public.

The State Health Plan identifies 11 health priorities as the areas with "the greatest potential leverage for improving the health of the people of Wisconsin." The plan recognizes that progress towards its health priorities is integrally tied to progress towards the infrastructure priorities, the focus of the present mid-course baseline assessment.

Wisconsin's Public Health System

This project adopted the State Health Plan's definition of the public health system:

> *A social enterprise between government, the people, and the public, private, non-profit and voluntary sectors to promote the health of everyone.*[1]

However, the key informant interview component of this project demonstrated that, in practice, this definition is not universally accepted. Definitions of 'public health system' and, by extension, 'public health workforce' vary widely and often conflict. The absence of a universally accepted definition of which individuals, organizations, and services comprise Wisconsin's public health system led to a very broad and inclusive sampling frame for this project.

The current assessment assumes that Wisconsin's public health system will *continue* to change in response to the State Health Plan; it has already undergone changes since the 2002 publication of *HW2010*. This assumption underscores the fact that this report is intended as a mid-course baseline for future evaluations rather than an endpoint assessment. The report summarizes the perceptions and opinions of those who responded to the survey. Objective data on progress toward attainment of the plan's health priorities is also being tracked under other related efforts.

[1] (p. 10).

Methods

This project began with a thorough review of State Health Plan materials discussing transformation followed by intensive interviews with 21 key informants representing a broad cross-section of the state's public health system. These interviews garnered a sense of the "pulse" of the public health system, illustrated concrete transformational activities, and guided development of the survey instrument. (A separate report is under preparation summarizing findings from these interviews.)

An online survey was the final component of this project and the focus of the present report. The project team developed the survey instrument based on a model of transformation, the objectives of the five infrastructure priorities, and insights garnered from in-depth interviews. With assistance from numerous public health partners, the survey was distributed broadly (6,433 unique e-mail addresses) using the online service WebSurvey@UW) to individuals who might consider themselves to be part of Wisconsin's public health system. A total of 1,945 surveys (with at least one answer) were completed and submitted on-line.

Descriptive analyses summarizing responses and examining key items by region, occupational sector, years of public health service, and credential(s) was conducted for the current report. Results provide a baseline measure of the transformation of Wisconsin's public health system, as well as an indication of the breadth of influence the State Health Plan has had throughout the public health community.

Results

Impact of State Health Plan

Respondents to the survey, representing a broad range of individuals involved in many diverse roles in the public health system, are generally familiar with and making use of the plan. Fully 76 percent of all respondents indicated they are familiar with the plan. Throughout the survey, a scale of 1 (not at all) to 10 (very much so) was used to obtain respondent's perceptions of various aspects of the public health system. When asked "To what extent does the State Health Plan guide the activities of Wisconsin's public health system?," respondents provided a relatively high mean of 6.3 on the 10 point scale.

Table A summarizes the data on familiarity of respondents with the State Health Plan, and

Table A: Familiarity With and Use of the State Health Plan (n = 1945)

	%
Familiar with State Health Plan (n=1470)	76%
What components of the State Health Plan are you familiar with? (If familiar and responded, n=1128)	
Health priorities	86%
Overarching goals	64%
Infrastructure priorities	37%
Implementation plans	32%
How often do you reference the State Health Plan in your public health work? (n= 1284 responses)	
Daily	2%
Often	19%
Occasionally	52%
Never	26%

their use of the plan in their work. Respondents reported the most familiarity with the health priorities of the plan, followed by the goals of the plan. Respondents reported least familiarity with the implementation plans for the priorities of the plan. The majority of those who reported familiarity with the plan indicated referencing it in their public health work occasionally or often.

These results suggest a high degree of familiarity with the plan across many sectors of the public health system and extensive use of the plan to guide ongoing activities.

Ratings of Progress on Infrastructure Priorities

Table B provides the mean ratings attained for each infrastructure priority of the plan. This table has been arranged in descending order, with the highest rated priority listed first. The highest mean rating (6.7) was given to the competence of the public health workforce in Wisconsin. This was followed by high ratings for the trust, credibility, collaboration, and communication between partners. The partnerships DHFS has with local health departments were also rated relatively high.

Resource sharing, joint planning and joint decision-making, and community participation, all part of the recommended 'community health improvement planning' (CHIP) approach advocated in the state plan were rated at a more moderate level (5.6 to 5.9). This may indicate that these processes are less wide-spread and have not yet accomplished enough to attain high perceived success.

Workforce issues fell into a low-middle tier of perceived attainment. Adequate training and ethnic/racial composition were both rated at a mean of 5.4. Perceived diversity and sufficiency of the workforce both received mean ratings below 5.0.

The existence of an integrated electronic data system providing meaningful information on health priorities and public health system capacity was rated quite low (mean 4.2). Finally, the aspects of financing specified as infrastructure priorities in the plan were rated the lowest of all areas.

Conclusion

These data provide a mid-course snapshot of how the public health community in Wisconsin perceives its progress on the infrastructure priorities it has established. There is clearly room for movement in a positive direction on all issues—even the highest rated areas could be interpreted as receiving only from 61% and 67% of the possible rating. Further, the data suggest infrastructure areas in which increased attention is particularly needed—workforce development, financing, and integrated information systems. Improvements in the infrastructure priorities are expected to positively influence priority health outcomes.

Table B: Perceptions of Achievement of the State Health Plan's Infrastructure Priorities

	Mean*	SD
Extent Wisconsin's public health system has a competent workforce	6.7	1.9
The level of communication between your organization and its public health partners.	6.4	2.2
Extent of trust and credibility between public health system partners and the local health department in the community where you live or work. (CHIP)	6.3	2.2
Extent partners representing the public, private, non-profit, and voluntary sectors collaborate to create and promote healthy communities across Wisconsin?	6.1	2.0
The strength of the partnerships between Wisconsin's Department of Health and Family Services (DHFS) and local public health departments.	6.1	2.1
Level of resource sharing (data, technical assistance, etc.) among local public health system partners to achieve your community's public health priorities. (CHIP)	5.9	2.2
Level of joint planning and joint decision-making (turning planning into action) between your organization and its public health partners. (CHIP)	5.6	2.3
Extent of community participation in setting and supporting local public health priorities in the community where you live or work. (CHIP)	5.6	2.3
Extent that Wisconsin's educational institutions provide adequate training for the state's public health workforce (workforce)	5.4	2.1
How well does your organization's workforce represent the racial and ethnic composition of the population it serves?	5.4	2.6
Extent that Wisconsin's public health system has a diverse workforce	4.9	2
Extent Wisconsin's public health system has a sufficient workforce	4.7	1.9
Extent Wisconsin's public health system has an integrated electronic information system that measures public health system capacity	4.2	2.1
Extent Wisconsin has an integrated electronic information system that provides meaningful information about the health priorities outlined in Healthiest Wisconsin 2010	4.2	2.1
Extent Wisconsin's public health system has equitable financing	3.8	1.8
Extent Wisconsin's public health system has adequate financing	3.7	1.8
Extent Wisconsin's public health system has stable financing	3.6	1.8

*Mean rating on a scale of 1 (not at all) to 10 (very much so). Ns range from 858 to 1396 valid responses.

It is clear from these data that there is a great deal of awareness of the State Health Plan and that the plan is a significant guiding reference point in Wisconsin's public health system. Continued collection of objective indicator data tracking progress on the health priorities, and future surveys regarding perceptions of progress in implementing the infrastructure priorities, may help guide and evaluate the accomplishment of the priorities which have been set.

STATEMENT OF PURPOSE

'Transforming Wisconsin's public health system' is one of the overarching goals of *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public (HW2010)*, the State Health Plan for the decade 2001-2010. According to the authors of this plan, "This goal seeks to transform Wisconsin's public health system into a coordinated, effective, and sustainable system."[2] The plan's authors assert that achieving this goal will benefit Wisconsin's population:

> A strong public health system embodying sustainable collaborative partnerships can deliver untold benefits to the people of Wisconsin…including protecting health, improving the quality of life, extending life expectancy, and containing the costs of health care.[3]

In the spring of 2005, The Department of Health and Family Services Division of Public Health partnered with the University of Wisconsin Population Health Institute to assess Wisconsin's progress towards this goal. This assessment is intended to:

- Provide a mid-course baseline for future evaluations;
- Better define and operationalize the concept of transformation;
- Serve as a needs assessment tool to address any potential gaps in current steps towards transformation; and
- Serve as a tool to inform policy development and educate the public.

BACKGROUND: A MODEL FOR TRANSFORMATION

To better define and operationalize the concept of 'transformation,' the project team developed a model depicting Wisconsin's transformation process (page 9). This model is the product of: a critical review of key materials discussing transformation at a state and national level; input from the project's advisory committee; an examination of the objectives of the State Health Plan's infrastructure priorities; and the national Turning Point evaluation.

This model serves as the conceptual foundation of this project, informing the questions asked in key informant interviews and an online survey. When considering this model, it is important to recognize its underlying assumptions. These assumptions can be divided into three categories: (1) assumptions about transformation; (2) assumptions about Wisconsin's public health system; and (3) assumptions about change.

[2] (p. 24).
[3] (p. 24).

Transformation

This project considers the five infrastructure priorities listed in the State Health Plan to be the engines for transforming Wisconsin's public health system. According to the plan's authors, these priorities represent "the framework necessary to achieve agreed upon outcomes of improved health of the public and improved public health system capacity."[4] In other words, progress towards these priorities is a critical step towards realizing the coordinated, effective, and sustainable public health system championed by the plan.

The State Health Plan identifies 11 health priorities as the areas with "the greatest potential leverage for improving the health of the people of Wisconsin."[5] However, the plan recognizes that progress towards its health priorities does not happen in a vacuum; such progress is integrally tied to progress towards the infrastructure priorities that drive this project. This connection underlies a second assumption of this model—progress towards the infrastructure priorities will help Wisconsin's public health system build its capacity to achieve *HW2010*'s overarching goals.

Wisconsin's Public Health System

This project adopted the State Health Plan's definition of the public health system:

> *A social enterprise between government, the people, and the public, private, non-profit and voluntary sectors to promote the health of everyone.*[6]

However, the key informant interview component of this project demonstrated that, in practice, this definition is not universally accepted. Definitions of 'public health system' and, by extension, 'public health workforce' vary widely and, indeed, often conflict. The absence of a universally accepted definition of who comprises Wisconsin's public health system has impacted this project in a number of ways, most notably in the designation of the online survey's sampling frame.

For analysis and further discussion of this topic, see the Limitations section of this report.

Change

This model assumes that Wisconsin's public health system will *continue* to change in response to the State Health Plan; it has already undergone changes since the 2002 publication of *HW2010*. This assumption underscores the fact that this report is intended as a mid-course baseline for future evaluations rather than an endpoint assessment.

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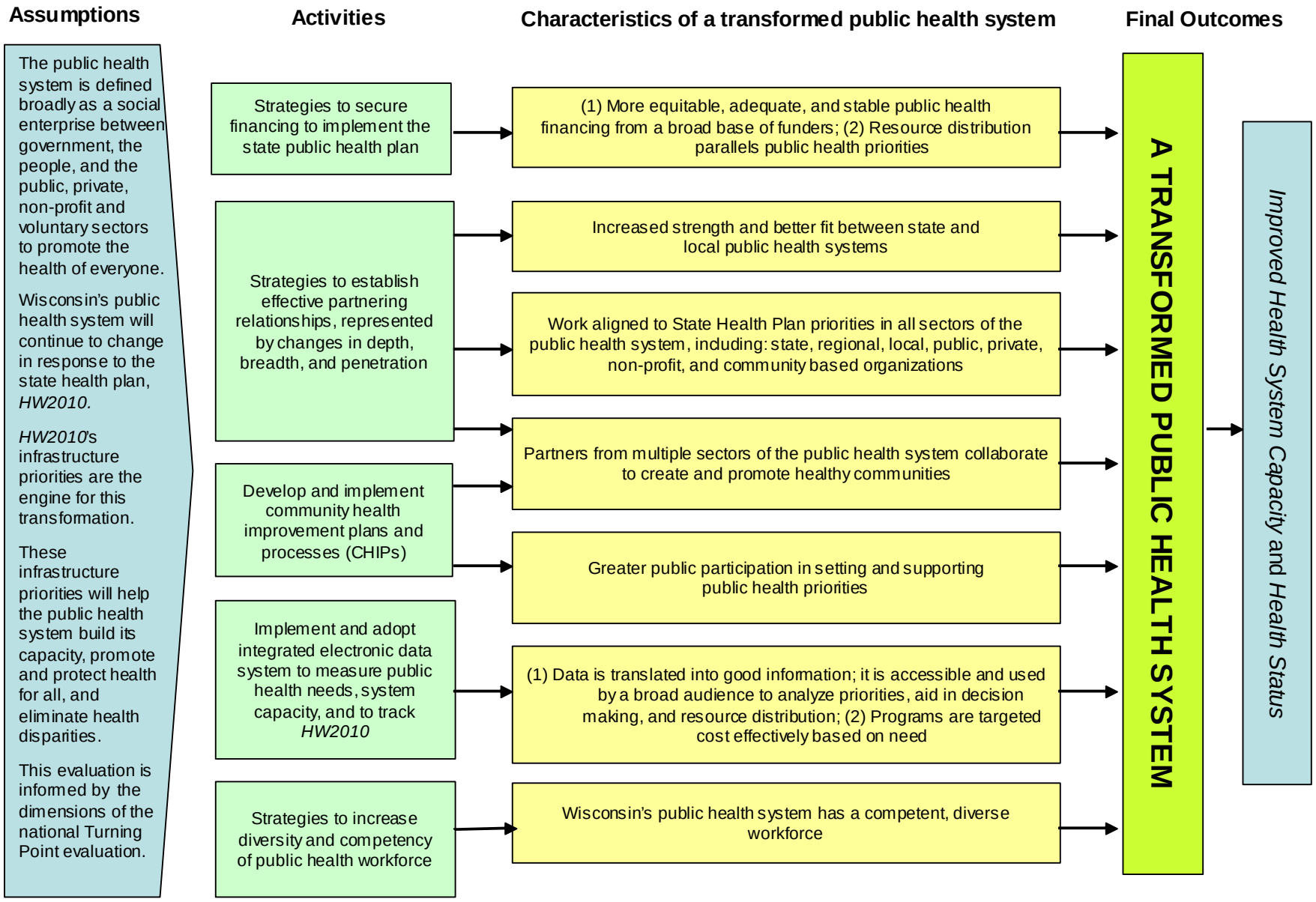
[4] (p. 27).
[5] (p. 40).
[6] (p. 10).

TRANSFORMATION PROCESS

FINAL DRAFT (Post Interviews)



METHODOLOGY

This project began with a thorough review of State Health Plan materials discussing transformation. Key documents reviewed include: planning documents from The Lewin Group, Inc.'s evaluation of the national Turning Point initiative; minutes from key formal structures and reports of the Wisconsin Turning Point initiative; and implementation plans for each of the State Health Plan's five infrastructure priorities.

The second component of this project included intensive interviews with 21 key informants. These informants represent a broad cross-section of the state's public health system, including individuals with a variety of racial and ethnic backgrounds, subject matter expertise, professional interests, and geographic locations. These interviews garnered a sense of the "pulse" of the public health system, illustrated concrete transformational activities, and guided development of the survey instrument.[7]

An online survey sent through WebSurvey@UW marked the final component of this project. Survey questions gathered perceptions of Wisconsin's progress towards achieving the characteristics outlined in this project's model of transformation (page 9). For example, a number of questions asked respondents to rate Wisconsin's performance in a specific infrastructure priority area on a scale of one to ten.[8]

With assistance from a number of public health partners, this survey was distributed broadly to individual members of Wisconsin's public health system.[9] Survey respondents include representatives of the public, private, and non-profit sectors as well as individuals with varied subject matter expertise, professional interests, geographic locations, and personal characteristics (race, ethnicity, and sexual orientation). An automated tracking system was used to generate reminder e-mails for non-respondents. Survey responses provided the information necessary to form a baseline measure of the transformation of Wisconsin's public health system.

[7] For a more thorough discussion of these interviews, see the report discussing key informant interviews (forthcoming).
[8] For a more detailed discussion of survey methodology, see Appendix A.
[9] For a list of entities that helped to distribute the survey, see Appendix B.

ANALYSIS

Key Informant Interviews

With permission from each interviewee, interviews were audio-taped. These tapes, as well as hand-written notes, were analyzed to find emerging themes regarding each infrastructure priority. Most interviews were attended or reviewed by two project team members. Interview notes were discussed and consensus reached on all emerging themes. This analysis was used to inform the formation of the survey; its results can be found in a separate report.

Survey

Quantitative data was extracted from the survey software on December 5, 2005. Analysis was conducted using SAS software 9.1. PROC SURVEYFREQ was used to calculate frequencies; PROC MEANS was used to calculate means, medians, and standard deviations of the survey rating scales. Data was analyzed by region, occupational sector, years of public health service, and respondent's credentials.

All valid survey responses were included in the entire analysis with the following exceptions:

(1) Respondents who reported that they are *definitely not* part of the public health system, their organization is *definitely not* part of the public health system, and they have not heard of the State Health Plan are excluded from all analyses except demographics (N=25);

(2) Respondents who reported that they have never heard of the State Health Plan are excluded from the analysis of questions regarding one's knowledge of the plan and its relevance to their public health work (N = 425);

(3) Respondents who reported that their place of employment is *definitely not* or *probably not* part of the public health system and those who are not currently employed are excluded from analyses of questions about one's organization (N = 314); and

(4) Respondents were requested to complete questions about Community Health Improvement Processes and Plans (CHIPs) *only if* they have participated in a health planning and priority setting process in the community where they live or work; it appears that 300 – 400 individuals opted out of this portion of the survey.

There are two other reasons for changing sample sizes throughout this report. First, due to the nature of the online survey instrument used for this project, respondents were rarely offered an 'I don't know' response option. Thus, the only means respondents had to indicate that they did not know the answer to a particular question was skipping that question. Second, a number of questions allowed respondents to select more than one answer. For these questions, the sample size was calculated as the number of people who chose *at least one* answer; this number will vary from question to question. In this case, missing respondents include both those who intended to skip a question and those for whom none of the available choices were applicable.

Qualitative data (survey comments) was extracted from the survey software on December 5, 2005. Responses to each open-ended question were copied into separate excel workbooks and comments were categorized by survey question and theme. Overarching themes and archetypal comments were identified for each area of the survey.

RESULTS

Respondent Characteristics

Survey invitations were sent to 6,244 unique e-mail addresses. Almost one-third of the individuals who received invitations responded to the survey (1,954); less than one percent (50) declined. In addition, 95 individuals who were notified of the survey through public health partners responded. In total, 1,945 individuals answered at least one question on the survey, although, as mentioned earlier, a fair number of respondents failed to complete the entire survey.[10]

Survey respondents represent a broad spectrum of Wisconsin's public health system. They come from a variety of occupational sectors, with varying levels of public health experience. Respondents come from different racial and ethnic backgrounds and from all regions of the state.

Relationship to the public health system

Table 1. Respondent relationship to the public health system

	n	%
Do you consider yourself to be part of Wisconsin's public health system?		
Definitely	1258	65%
Probably	442	23%
Probably not	154	8%
Definitely not	83	4%
Do you consider your place of employment to be part of Wisconsin's public health system?		
Definitely	1271	66%
Probably	347	18%
Probably not	161	8%
Definitely not	121	6%
Not currently employed	32	2%

Most respondents definitely consider themselves to be part of Wisconsin's public health system. Only 12 percent of respondents probably or definitely do not consider themselves to be part of the system. Most survey respondents are currently employed and about one-third of all respondents definitely consider their place of employment to be part of Wisconsin's public health system. For the purposes of this report, individuals who reported that their place of employment is 'probably not' or 'definitely not' part of Wisconsin's public health system and those who reported that they are 'not currently employed' are excluded from analyses of questions about one's organization.

Demographics

Providing demographic data was an optional section of the online survey. Approximately two-thirds of survey respondents completed this section.

Survey respondents' credentials, years of education, and other demographic characteristics vary. Overall, more than twice as many women (70%) than men (30%) responded to the survey. More than 50 percent of respondents are 50 years of age or older.

[10] For more information on survey response rates, see Appendix C.

Although the vast majority of the respondents are white, 8 percent of respondents specified a race other than white. Additionally, 2 percent of the sample indicated Hispanic or Latino heritage. Further, 54 survey respondents indicated that they are members of Wisconsin's lesbian, gay, bisexual, and transgender (LGBT) community.

Table 2. Respondent credentials (N = 1037)

	N	%
MA	82	8%
MS	317	31%
MPH	79	8%
PhD	90	9%
RN	289	28%
MD	70	7%
Other	354	34%

Note: Respondents could select multiple credentials

Overall, survey respondents are extensively educated. Over one-half of respondents have more than a college education and more than 90 percent have at least a college or university degree. Some type of credential was indicated by 1,037 respondents, with MS (31%) and RN (28%) credentials being the most widely indicated. In addition, one-third of respondents reported credentials that were not specified in the survey options. To examine the additional demographic information collected, please see Appendix D.

Public Health Employment

The public health work of the respondents shows a wide breadth of experience. Most respondents have a long history of work in the public health system: 62 percent have ten or more years of service.

Individuals representing a number of occupational sectors responded to this survey. Individuals working in educational institutions, including colleges, universities, and K-12 institutions, make up the sector with the largest representation: one-fourth of all respondents reported working here. Governmental public health is also well-represented: 374 respondents work in county or local health departments, and an additional 351 work for either DHFS or another state agency. Hospitals, managed care, and community health centers make up the health care sector of this survey, and almost 10 percent of the sample reported working at one of these institutions. The private sector, including for-profit businesses, non-profit, and faith-based organizations, is another important partner in the public health system; the sample contains 255 individuals working in this sector. For the purposes of analysis, these organizations are grouped into six sectors: local public health departments,

Table 3. Employment characteristics

	n	%
Years worked or volunteered in the public health system		
Less than 5 years	345	20%
5 to 9 years	307	18%
10 to 20 years	518	31%
More than 20 years	524	31%
Place of employment		
County or local health department	374	22%
DHFS (Central Office)	194	11%
DHFS (Regional Office)	59	3%
State agency (not DHFS)	98	6%
Community health center	40	2%
Hospital	88	5%
Managed care organization/Insurer	27	2%
Educational institution (University, school, etc.)	421	25%
Faith based organization	11	1%
Non-profit organization	218	13%
Business	26	2%
Other	156	9%
Primary geographic boundaries of public health work		
Northeastern	219	13%
Northern	133	8%
Southeastern	270	16%
Southern	302	18%
Western	184	11%
Milwaukee	84	5%
Statewide	482	29%

state agencies, health care, educational institutions, private, and other.

Respondents are also well-dispersed throughout the state. The largest single group of respondents is individuals whose work extends through the entire state (29%). Respondents from the southeastern region of the state had to decide whether their work's primary geographic boundary is the entire southeastern region or specifically the city of Milwaukee; 270 reported that they work within the entire region and 84 reported that their work centers in Milwaukee. For the purposes of this report, these two groups are combined in all analyses.

Respondents were also asked to identify which of the 12 essential public health services outlined in *HW2010* constitute an important part of their public health work. As indicated in Table 4, the most commonly chosen responses were: (1) *Educate the public about current and emerging health issues*; (2) *Promote community partnerships to identify and solve health problems*; and (3) *Link people to needed health services*. Of respondents who selected at least one essential public health service, over 85 percent selected one or more of these three activities. The essential service *conduct research to seek new insights and innovative solutions to health problems* was selected by fewest respondents; however, a full third of respondents selected this activity.[11]

Table 4. Essential public health services performed by respondents (N = 1710)

	n	%
Educate the public about current and emerging health issues.	1309	77%
Link people to needed health services.	1227	72%
Promote community partnerships to identify and solve health problems.	1216	71%
Foster the understanding and promotion of social and economic conditions that support good health.	972	57%
Monitor health status to identify community health problems.	948	55%
Create policies and plans that support individual and community health efforts.	880	51%
Identify, investigate, control, and prevent health problems and environmental health hazards in the community.	876	51%
Evaluate effectiveness, accessibility, and quality of personal and population-based health services.	723	42%
Assure access to primary health care for all.	706	41%
Assure a diverse, adequate, and competent workforce to support the public health system.	685	40%
Enforce laws and regulations that protect health and ensure safety.	608	36%
Conduct research to seek new insights and innovative solutions to health problems.	559	33%

Note: Respondents were allowed to select multiple activities.

[11] For more information on the demographics of survey respondents, see Appendix D.

Respondent Familiarity with The State Health Plan

Table 5. State Health Plan components (n=1128)

	n	%
What components of the State Health Plan are you familiar with?		
Health priorities	967	86%
Overarching goals	718	64%
Infrastructure priorities	414	37%
Implementation plans	360	32%

Note: Respondents could select more than one component

Three-quarters of survey respondents reported awareness of *Healthiest Wisconsin 2010 (HW2010)*. As indicated in Table 5, however, the level of familiarity with the components of *HW2010* varies considerably among respondents; most respondents are familiar with the plan's health priorities (86%) while fewest are familiar with its detailed implementation plans (32%).

Survey results indicate that public health professionals generally consider the State Health Plan to be a useful document; it does not just 'sit on a shelf.' As demonstrated in Table 6, over half of respondents familiar with the plan reported referencing it occasionally and another 19 percent reported using it often. Only 26 percent of respondents reported never using the plan.

Table 6. Use of the State Health Plan (frequency)

	n	%
How often do you reference the State Health Plan in your public health work?		
Daily	28	2%
Often	248	19%
Occasionally	674	52%
Never	334	26%

As indicated in Table 7, survey results indicate that *HW2010* influences the activities of Wisconsin's public health system. This is especially true for local health departments: employees of local health departments gave a mean rating of 6.9 as compared to the mean rating of 6.3 given by all survey respondents.

Table 7. Rating the State Health Plan on a scale of 1 to 10: Guiding Wisconsin

	n	Mean	SD
To what extent does the State Health Plan guide the activities of Wisconsin's public health system?	1168	6.3	2.0

Open-ended survey comments suggest that the State Health Plan's ability to guide the activities of Wisconsin's public health system is hindered by funding concerns, the changing needs of local populations, and the importance of continuing core programs outside the scope of the plan. Sample comments include:

> Because the majority (63%) of our funding comes from federal grants, many or most of our activities are grant driven - rather than *HW2010* driven.

> The State Health Plan provides guidelines for public health focuses, but local concerns tend to dominate.

On the whole, however, *HW2010* appears to be used as the guide its authors intended it to be.

Equitable, Adequate, and Stable Financing

'Equitable, adequate, and stable financing' is one of the infrastructure priorities outlined in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public.* According to the authors of this plan "the transformation of Wisconsin's public health system cannot happen without equitable, adequate, and stable financing" (p. 36).

The perceptions in this section should not be mistaken for a comprehensive examination of funding streams for Wisconsin's public health system. This project does not systematically assess current programming or make judgments regarding how effectively or efficiently available funds are spent. Instead, it provides a picture of how public health professionals *perceive* the financial support available to the public health system and their own organizations.

As demonstrated by Table 8, survey results indicate dissatisfaction with the financing for Wisconsin's public health system; on a scale of one to ten, *adequacy*, *equity*, and *stability* all received mean ratings under four. Survey comments suggest that these low ratings stem largely from the total dollar amount allocated for public health, the limited funding sources available to organizations in the public health system, and the amount of tax dollars (GPR) the state commits to support public health activities.

Table 8. Rating Wisconsin's public health system on a scale of 1 to 10—Financing

	n	Mean	SD
Extent Wisconsin's public health system has adequate financing	1396	3.7	1.8
Extent Wisconsin's public health system has equitable financing	1311	3.8	1.8
Extent Wisconsin's public health system has stable financing	1344	3.6	1.8

Note: On this scale, 1 indicates "not at all" and 10 indicates "very much so."

Mean ratings for *adequacy*, *equity*, and *stability* varied across sectors of the public health system. As demonstrated in Table 9, employees of local health departments typically gave the lowest mean rating, followed closely by individuals who work for state agencies. Individuals from health care organizations awarded the highest mean rating.

Table 9. Financing Wisconsin's public health system on a scale of 1 to 10—mean rating by sector

	n	Adequacy	Equity	Stability
Local health department	374	3.4	3.4	3.2
State agency	351	3.7	3.8	3.5
Health care organization	155	4.1	4.0	4.0
Educational organization	421	3.9	4.0	3.8
Private/non-profit organization	255	3.8	3.7	3.9
Other	156	4.0	3.9	3.8

Although mean ratings were similar across Wisconsin's geographic regions, mean ratings decreased with increasing years of service in the public health system. That is, on average, the longer an individual has worked in the public health system, the lower they rated the adequacy, equity, and stability of financing for public health in Wisconsin.

Open-ended survey responses suggest that the absence of adequate, stable funding for Wisconsin's public health system threatens the state's public health infrastructure and organizations' ability to provide high quality services. As demonstrated in Table 10, almost 40 percent of respondents believe that their organization's funding is *inadequate to maintain current efforts* and only 8 percent feel that their organization's funding is stable enough to *consider expanding.* Open-ended survey responses suggest that financial challenges are widespread; respondents cited funding shortfalls for organizations addressing chronic disease, children's health, developmental disabilities, education, HIV/AIDs, mental health, nutrition, oral health, prevention, and refugee and immigrant health.

Table 10. Adequacy of organization's funding level (n=1296)

	%
Adequate to run current programs and consider expanding	8%
Adequate to run current programs	40%
Inadequate to maintain current efforts	38%
Not sure/Not applicable	14%

Survey comments suggest that the perceived lack of adequate, stable funding damages the morale of Wisconsin's public health workforce. A number of individuals asserted that limited state support represents a poor commitment to—and understanding of—public health on the part of the legislature and the Governor. Others expressed frustration at being expected to "do more with less."

Open-ended responses suggest that these concerns are particularly acute for small and rural health departments; according to one respondent, lack of funding forced their local health department to "prioritize activities and drop programs." Another respondent asserted that grants are not the answer to funding challenges for small organizations: "a small rural community has little chance of competing with larger urban communities for grant funding."

Respondents reported that their organizations are responding to financial challenges by augmenting core funding and diversifying resources; on average, survey respondents reported that their organizations use three different mechanisms to diversify their resource base. As indicated in Table 11, partnering and grant-seeking are the most popular means of diversification. One-third of individuals surveyed reported that their organization has applied for a grant through The University of Wisconsin Medical School's Partnership Fund for a Healthy Future or The Medical College of Wisconsin's Healthier Wisconsin Partnership Program.

Table 11. Financing—Organizational efforts to diversify resource base in recent years (n=1141)

	%
Expansion of partnerships	66%
Grant applications to private foundations	52%
Grant applications to state and local governments	57%
Grant applications to federal government agencies	60%
Increased level of revenue-generating activities	42%
Solicitation of individual donations	24%
Solicitation of corporate sponsorships	18%
Other, please specify	7%

Note: This table summarizes answers to the question "What efforts has your organization made to diversify its resource base in recent years?" (individuals could select more than one response)

Despite the reported focus on partnership expansion, a number of respondents expressed concern that growing competition for funding challenges their organization's efforts to form new partnerships and maintain existing partnerships. According to one individual, "We need to focus on improving health status and outcomes—and less on who gets the money, if we are going to be true partners."

Sufficiency and Competency of the Public Health Workforce

'Sufficient, competent workforce' is a second infrastructure priority of the State Health Plan. The authors of the plan assert that "there must be a sufficient number of competent workers in Wisconsin's communities to carry out the core public health functions and essential public health services."[12] Moreover, this workforce "must be culturally and linguistically competent to understand the needs and deliver services to diverse populations in all Wisconsin communities."[13]

As demonstrated in Table 12, survey results suggest confidence in the competence of Wisconsin's public health workforce; on a scale of one to ten, survey respondents gave *competence* a mean rating of 6.7. There appears to be less confidence in the sufficiency of the workforce to meet public health needs, however; *sufficiency* received a mean rating of only 4.7.

Table 12. Rating Wisconsin's public health system on a scale of 1 to 10: Workforce

	n	Mean	SD
Extent Wisconsin's public health system has a competent workforce	1368	6.7	1.9
Extent Wisconsin's public health system has a sufficient workforce	1361	4.7	1.9

Note: On this scale, 1 indicates "not at all" and 10 indicates "very much so."

The mean ratings for *competence* and *sufficiency* did not vary significantly across employees of distinct sectors of the public health system or geographic areas of the state. Mean ratings were also similar across individuals with varying years of experience in public health.

Open-ended survey responses suggest a perception that Wisconsin's public health workforce is, on the whole, competent—it is simply not sufficient to meet the state's public health needs. According to one respondent, "Those on staff are highly competent, but overworked." Comments also suggest that staffing challenges are widespread; shortages were cited in the number of nurses, nutritionists, oral heath professionals, and local health department personnel. A number of individuals voiced concerns that these shortages will become more acute as the average age of the public health workforce increases.

Open-ended survey responses suggest that limited financial support for the public health system contributes to the "sufficiency problem." Respondents cited hiring freezes, non-competitive salaries, and a lack of rewards for high performance as challenges to recruiting and retaining high quality public health personnel. According to one individual:

> We are unable to recruit and retain staff for many of our high level positions because our salaries are so low relative to those paid by the private sector and federal agencies, and because there is no longer a sense of job security.

Although the public health workforce is generally perceived as competent, survey comments suggest that there is room for improvement in a number of areas. According to one respondent:

[12] (p. 34).
[13] (p. 34).

> The typical public health [worker] has been trained in clinical aspects (i.e., nursing, nutrition, code enforcement, etc.) but has not been trained in public health theories, grant writing, marketing, administration, and the other crucial skills needed to propel the field of public health into the future.

Open-ended responses suggest that additional training would also be valuable in the following areas: evaluation; diversity and cultural competence; use of evidence-based practices; professional/management skills; scientific skills; preventive health; women's health; and mental health.

Educational and Training Opportunities

Such knowledge and skills can be obtained through Wisconsin's formal educational institutions or through less formal continuing education and training opportunities. As indicated in Table 13, the training Wisconsin's educational institutions provide to the state's public health workforce is considered to be fairly adequate.

Table 13. Rating Wisconsin's public health system on a scale of 1 to 10 - Educational Institutions

	N	Mean	SD
Extent that Wisconsin's educational institutions provide adequate training for the state's public health workforce	1295	5.4	2.1

Note: On this scale, 1 indicates "not at all" and 10 indicates "very much so."

Mean ratings regarding the adequacy of Wisconsin's educational institutions varied somewhat by credential and geographic region. Ratings were notably lower from individuals with MPH degrees than respondents overall (4.3 vs. 5.4). In addition, ratings from individuals in the Southeastern portion of the state were lower than ratings overall (4.9 vs. 5.4).

Open-ended responses suggest a sense of excitement about Wisconsin's new MPH program and the transition from the UW Medical School to the UW School of Medicine and Public Health. According to one individual, "the new MPH program and School of Public Health in Wisconsin should significantly help increase the workforce here trained in public health." This excitement, however, is balanced by concerns about the Madison location of these programs and a fear that existing course offerings in other parts of the state will be "diminished or eliminated in favor of the program in Madison."

As indicated in Table 14, many public health professionals pursue continuing education and training opportunities outside of formal degree programs. Attending conferences and taking courses through technical school programs are the most commonly reported forms of continuing education and training, with online courses taking a close third.

Table 14. Percent of individuals that indicated someone from their organization has…

	n	Yes	No	Unsure
Attended a conference	1188	55%	17%	28%
Taken courses through a university or college sponsored program	1146	20%	32%	48%
Taken courses through a technical school program	1180	48%	39%	33%
Taken courses through an online program	1171	40%	17%	43%

Note: Survey respondents were allowed to indicate all appropriate educational activities.

Over half of all survey respondents reported that their organizations offer incentives (tuition reimbursement, pay increases, etc.) for employees to pursue continuing education and training opportunities. However, a number of individuals indicated that these incentives are limited in scope and dollar amount. Open-ended responses suggest that the number of individuals pursuing continuing education and training opportunities would increase with added organizational support. Sample comments include:

> If there were more scholarship money available I would love to attend more conferences regarding public health. Our budget is very tight.

> Individuals here must do most [continuing education] on their own vacation or leave time. Permission then is limited by capacity of agency to provide coverage for the person on leave.

However, there is also recognition that tight budget times necessitate a tradeoff between dollars spent on training and dollars spent on programs:

> Cumulative budget cuts over the last decade have substantially eroded the availability of such opportunities. Tuition reimbursements and discretionary compensation awards come out of the agency general operating budget instead of an earmarked budget item. Any money that goes to education gets cut from a program budget.

The sufficiency of Wisconsin's public health workforce to meet public health needs remains a concern for many respondents.

Diversity of the Public Health Workforce

As indicated in Table 15, Wisconsin's public health workforce is perceived to have some diversity (mean rating of 4.9). Wisconsin's public health workforce is also perceived to be fairly representative of the population it serves (mean rating of 5.4).

Table 15. Rating Wisconsin's public health system on a scale of 1 to 10: Workforce Diversity

	n	Mean	SD
Extent that Wisconsin's public health system has a diverse workforce	1259	4.9	2.0
How well does your organization's workforce represent the racial and ethnic composition of the population it serves?	1319	5.4	2.6

Note: On this scale, 1 indicates "not at all" and 10 indicates "very much so."

Mean ratings for diversity of Wisconsin's public health workforce did not vary significantly by sector of the public health system or geographic area. Mean ratings were also unaffected by varying years of experience in public health.

As indicated in Table 16, survey responses suggest that a fair number of organizations in Wisconsin's public health system recruit employees that represent the state's racial and ethnic communities. Advertising available positions in racially and ethnically diverse markets is the most commonly reported mechanism of such targeted recruitment. However, almost half of all survey respondents selected *not sure/not applicable* when asked to comment on their organization's recruitment practices.

Table 16. Organization efforts to recruit employees representing Wisconsin's racial and ethnic communities (n=1121)

	%
Forming mentoring relationships with local colleges and universities	22%
Participating in local career fairs	15%
Hosting interns with racially and ethnically diverse backgrounds	26%
Promoting careers in the health field at local K-12 schools	16%
Advertising available positions in racially and ethnically diverse markets	34%
Not sure/Not applicable	49%
Other	6%

Note: Individuals could select more than one response.

Perhaps as a result of these efforts, survey results indicate that individuals with racially and ethnically diverse backgrounds are better represented in public health's volunteer leadership positions than individuals representing the lesbian, gay, bisexual, transgender (LGBT) community. Almost one-half of those surveyed reported that individuals with racially and ethnically diverse backgrounds serve on their organization's advisory committee or executive or governing board, while only 17 percent reported LGBT participation. However, open-ended comments suggest that sexual orientation is not something that organizations typically ask their volunteers about.

Survey respondents indicate that their organizations are taking steps to prepare employees to meet the needs of the state's diverse populations. As indicated in Table 17, cultural sensitivity/competency training is the most commonly reported form of preparation, followed closely by the provision of interpretation services for individuals with limited English proficiency.

Table 17. Preparing to serve diverse populations

	n	Yes	No	Unsure
Provide access to cultural sensitivity/competency training	1189	79%	7%	14%
Provide training about the needs of low-income populations	1183	58%	18%	23%
Offer interpretation services for individuals with limited English proficiency	1180	71%	11%	17%

Note: Survey respondents were allowed to indicate all appropriate educational activities.

In each of these areas, there was notable variation in activity among sectors of the public health workforce. In general, employees of local health departments reported the most activity and employees of the Department of Health and Family services reported the least activity.

Data And Information Systems

'Integrated electronic data and information systems' is a third infrastructure priority outlined in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public.* According to the plan's authors:

> Lack of useful, reliable data makes it difficult to assure accountable planning, performance measurement, and measure outcomes in health and system capacity. Wisconsin's communities must have information about local needs and outcomes in order to make effective decisions that support health and foster healthy communities.[14]

As demonstrated in Table 18, survey results indicate that Wisconsin's integrated electronic data and information systems have room for improvement in their ability to measure health system capacity and provide meaningful information about *HW2010's* health priorities; each received a mean rating of 4.2 on a scale of one to ten.

Table 18. Rating Wisconsin's public health system on a scale of 1 to 10: Data Systems

	n	Mean	SD
Extent Wisconsin's public health system has an integrated electronic information system that measures public health system capacity	1092	4.2	2.1
Extent Wisconsin has an integrated electronic information system that provides meaningful information about the health priorities outlined in Healthiest Wisconsin 2010	1072	4.2	2.1

Note: 1 indicates "not at all," 10 indicates "very much so."

Mean ratings in these areas did not vary significantly by sector of the public health system or geographic region. There was some variation, however, in mean ratings from individuals with different levels of experience in the public health system. On average, ratings decreased as years of service in the public health system increased.

Open-ended responses suggest concern that information silos are still being created and sustained at the state level. According to one individual:

> [The] state continues to develop systems in silos, SPHERE, WEDSS, WIR, TB, STD-MIS, Stellar...Need to integrate system[s] so data flows between them, if a single solution can not be found.

A number of respondents expressed disappointment with current systems. According to one individual, for example: "SPHERE seems to provide limited benefit and is very time consuming to enter data." Further, shortcomings in available systems have led some organizations to use alternate systems: "Many, many health departments are using other data systems such as CHAMPS because of the inability to use SPHERE because it is not fully functional."

[14] (p. 29).

Data Use

As illustrated in Table 19, survey respondents reported that their organizations use available data fairly regularly; mean ratings for data use ranged from 6.1 to 6.8 on a scale of one to ten. Mean ratings were lowest from individuals whose work focuses in the southern region of Wisconsin and from individuals who have worked in the public health system for more than 20 years.

Table 19. Data Use

	n	Mean	SD
To what extent does your organization use available data when conducting the activities below?			
Needs assessment	1091	6.8	2.6
Budgeting	1040	6.1	2.8
Setting priorities	1072	6.6	2.6
Targeting programs	1065	6.6	2.6
Measuring performance	1072	6.4	2.7

Open-ended responses suggest that there are limitations in available data. According to one individual:

> A better question is when do we have data to use in budgeting, priority setting, targeting, etc. The systems don't necessarily collect what we need and they don't talk to one another.

Other respondents suggested a need for increased data at the county, city, zip code and census tract level, as well as by race and ethnicity (including American Indians and Hmong).

Data Access

Open-ended responses indicate a belief that available data is more easily accessible now than it used to be, but also suggest room for improvement in this area (see Table 20). Comments suggest a role for targeted training in improving access: "Recent EPI training helped locate where to find this data," and "I have been able to access the data I need because I have training in researching."

Table 20. Data Access

	n	Mean	SD
How easy is it for you to access the following types of data??			
Local health outcomes	1120	4.8	2.6
Specific health conditions	1119	5.4	2.6
Specific racial or ethnic groups	1110	5.0	2.7
State Health Plan objectives	1113	6.0	2.8
Statewide, population-based data	1119	6.1	2.8

Open-ended survey responses suggest that the challenges accessing timely, applicable data can threaten organizations' effectiveness, especially in regards to securing needed funding. For example:

> Data sources from the state are getting better about access, but there is still a significant gap of statewide and local data that we can use to apply for grants, particularly for minority populations.

> Although the statewide data is available on the DHFS and 2010 website, local (county and city) information is very hard to find or does not exist…All health departments and boards of health want to know how their LHD [Local Health Department] and the population they serve compare to the state as a whole…to show that they are higher or lower.

Overall, survey responses suggest that public health professionals make good use of available data but would benefit from improvements in integration and accessibility.

Partnerships

'Coordination of state and local public health system partnerships' is a fourth infrastructure priority outlined in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. According to the plan's authors:

> The productive engagement of all the public health system partners and their networks is essential to achieving the shared vision [of *HW2010*]. To be effective, the work of Wisconsin's public health system must be coordinated through collaborative partnerships at both the state and local levels.[15]

As demonstrated by Table 21, survey results indicate satisfaction with the partnerships in Wisconsin's public health system. Survey results suggest a moderate level of communication among public health partners (mean rating 6.4) and a lower level of joint planning and joint decision-making (mean rating 5.6). Results also indicate confidence that partners representing various sectors of the public health system collaborate to create and promote healthy communities (mean rating 6.1). In addition, survey results suggest satisfaction with the strength of partnerships between the Department of Health and Family Services and local health departments (mean rating 6.1).

Table 21. Rating Wisconsin's public health system on a scale of 1 to 10: Partnerships

	n	Mean	SD
To what extent do partners representing the public, private, non-profit, and voluntary sectors collaborate to create and promote healthy communities across Wisconsin?	1206	6.1	2.0
Rate the strength of the partnerships between Wisconsin's Department of Health and Family Services (DHFS) and local public health departments.	1113	6.1	2.1
Rate the level of communication between your organization and its public health partners.	1225	6.4	2.2
Rate the level of joint planning and joint decision-making (turning planning into action) between your organization and its public health partners.	1177	5.6	2.3

Note: 1 indicates "not at all," 10 indicates "very much so."

Mean ratings for each of the aforementioned scales varied across sectors of the public health system. Mean ratings were highest from employees of local health departments in all areas except *strength of partnerships between DHFS and local public health departments*. In this area, the mean rating from state employees was slightly higher than the mean rating from local health department employees.

Mean ratings also varied by respondents' credential(s) and by geographic area of Wisconsin. Individuals with a 'RN' credential rated partnerships higher than respondents with other credentials. On average, ratings from individuals whose work focuses on the western region were higher than ratings from individuals who focus on other regions of the state. Mean ratings were unaffected by years of experience in the public health system.

[15] (p. 31).

Open-ended responses suggest additional variation. According to one individual:

> In urban locations, there appears to be a greater collaboration between health-minded organizations. However, in the rural parts of WI, the idea of health coalitions, community-level health goals and united educational efforts are scarce.

Partnership Formation

As indicated in Table 22, a number of factors drive partnership formation for organizations in Wisconsin's public health system. *Internal goals and objectives* and *resource limitations* are the two most commonly reported factors, with 68 percent and 67 percent of respondents reporting each; on average, respondents selected four out of a possible eight factors.

Table 22. Factors driving formation of partnerships (n=1095)

	%
Internal goals and objectives	68%
Resource limitations	66%
Prior experience with successful partnerships	59%
Requirements of granting organizations	58%
Gathering community input	57%
State Health Plan principles	36%
Inclusion of diverse racial or ethnic groups	34%
Desire to influence legislation	27%

Note: Respondents were allowed to select multiple answers.

A number of these factors appear more relevant to some sectors of the public health system than others. *Desire to influence legislation, internal goals and objectives,* and *inclusion of diverse racial and ethnic groups* were reported most frequently by individuals who work for private or non-profit organizations. The remaining factors were chosen most frequently by employees of local public health departments.

Open-ended responses suggest that partnerships are valuable tools for organizations in Wisconsin's public health system. For example:

> Partnerships are critical to the successful maintenance and delivery of the public health system in Wisconsin. Public health is much bigger than the governmental public health component.

> Partnerships have been one of the best successes of the State Health Plan.

Partnership Characteristics

According to The Lewin Group Inc., evaluators of the National Turning Point Initiative, 'depth,' 'breadth,' and 'penetration' are three characteristics of a successful partnership. Depth reflects the level of involvement of each partner organization (i.e., number of staff participating). Breadth reflects the number and diversity of organizations involved in a partnership. And, penetration reflects the extent to which the work of a partnership is incorporated into the work of each partner organization.

As demonstrated in Table 23, survey responses indicate a moderate increase in the depth of public health partnerships since 2001. Just over half of all survey respondents reported increases in the level of staff participation in their organization's partnerships and 42 percent reported more frequent communication among partners.

Table 23. Since 2001, have your organization's partnerships changed in terms of... (Depth)

	n	Increased	Decreased	No change	Not sure/ Not Applicable
Frequency of communication between partners	1041	51%	6%	20%	23%
Staff participation (number)	1043	42%	16%	19%	23%

As demonstrated in Table 24, survey responses indicate a similar increase in the breadth of public health partnerships since 2001. Just over half of all survey respondents reported increases in the array of partner organizations and 44 percent reported increased involvement of "non-traditional" partners.

Table 24. Since 2001, have your organization's partnerships changed in terms of...(Breadth)

	n	Increased	Decreased	No change	Not sure/ Not Applicable
Inclusion of a broader array of partner organizations?	1020	52%	4%	19%	25%
Involvement with "non-traditional" partners?	1022	44%	2%	23%	30%

As demonstrated in Table 25, survey responses indicate a less sizeable increase in the penetration characterizing public health partnerships since 2001. Although 41 percent of all survey respondents reported increases in the integration of their partnership's goals into their organization's internal activities, far fewer report increases in the financial support and stability of their partnerships (27 and 25 percent respectively). Open-ended responses suggest that low reports of increased financial support and stability cannot be attributed wholly to a lack of interest. According to one individual, for example, "Money, or lack thereof, drives partnerships, or limitations of partnerships."

Table 25. Since 2001, have your organization's partnerships changed in terms of...(Penetration)

	n	Increased	Decreased	No change	Not sure/ Not Applicable
Integration of partnership goals into internal activities?	1022	41%	5%	25%	29%
Financial support for partnership activities?	1010	27%	9%	30%	34%
Stability (or formality)?	1001	25%	8%	33%	34%

The proportion of respondents reporting *no change* remained fairly constant at 20 to 30 percent for all sectors of the public health system. Increases in the components of depth, breadth, and penetration were most commonly reported by employees of private or non-profit organizations. Employees of private or non-profit organizations also appear to be most aware of changes in the characteristics of their partner organizations; the percentage of private/non-profit employees that selected *not sure/not applicable* was consistently lower than employees in other sectors of the public health system who selected this option.

Decreases in the components of depth, breadth, and penetration were most commonly reported by employees of state agencies. In the case of *staff participation*, the proportion of state employees that reported a decrease was significantly higher than the proportion of employees of other sectors; 23 percent as compared to 12 to 17 percent.

Open-ended comments suggest that organizations face a number of barriers to partnership formation as well as attempts to increase the depth, breadth, and penetration characterizing existing partnerships. Resource limitations (time and dollars) appear most prominent among these barriers. According to one respondent:

> Financial concerns within my organization have forced me to be more considerate of my time and priorities and less focus on the community/public health partnerships that don't have a financial benefit for the organization.

Another respondent offers the following suggestion to strengthen partnerships in Wisconsin's public health system:

> It would be helpful for the state to continue to encourage (and mandate) partnerships between organizations. This would be especially helpful for county agencies when we approach private clinics and hospital systems for partnerships.

Overall, it appears that members of Wisconsin public health system are actively engaged in partnerships, and appreciate their importance to their work.

Community Health Improvement Processes and Plans

'Community health improvement processes and plans,' often called CHIPs, are the fifth infrastructure priority outlined in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public.* According to the plan's authors: "To improve the health of communities—to make them places where people are healthy, safe, and cared for—requires the ability to work and plan together for the future."[16]

Respondents were instructed to complete this section, *only if* they have participated in a health planning/priority setting process in the community where they live or work. Therefore, the sample sizes are smaller here than in other sections of this report.

As demonstrated in Table 26, survey results indicate satisfaction with the health planning and priority setting activities in Wisconsin's communities. Respondents expressed most satisfaction with the extent of trust and credibility between local health departments and their public health system partners (mean rating 6.3), followed closely by the level of resource sharing among local health system partners (mean rating 5.9).

Table 26. Rating Wisconsin's public health system on a scale of 1 to 10: CHIPs

	n	Mean	SD
Extent of community participation in setting and supporting local public health priorities in the community where you live or work.	907	5.6	2.3
Extent of trust and credibility between public health system partners and the local health department in the community where you live or work.	884	6.3	2.2
Level of resource sharing (data, technical assistance, etc.) among local public health system partners to achieve your community's public health priorities.	858	5.9	2.2

Note: 1 indicates "not at all," 10 indicates "very much so."

There was little variation in mean ratings for *community involvement*, *trust and credibility*, and *resource sharing* by differing years of public health experience. There was, however, notable variation between sectors of the public health system and geographic regions. Mean ratings were lowest from employees of private or non-profit organizations and from individuals whose work focuses on southeastern Wisconsin. Ratings were highest from employees of local health departments and from RNs.

As indicated in Table 27, survey results suggest a perception that individual expertise is valued when Wisconsin's communities identify their public health priorities. Ratings by sample sub-groups in this area mirror the distribution outlined above. Mean ratings were lowest from respondents whose work focuses in southeastern Wisconsin and employees of private or non-profit organizations. Conversely, mean ratings were highest from local health department employees and respondents with "RN" credentials.

[16] (p. 30).

Table 27. Expertise valued

	n	Mean	SD
To what extent do you feel that your expertise is valued in setting public health priorities for your community?	906	5.9	2.5

Note: 1 indicates "not at all," 10 indicates "very much so."

As illustrated in Table 28, survey responses indicate that Wisconsin communities employ a number of planning and decision-making tools when identifying public health priorities; the median number of tools respondents reported using is four. However, survey responses also suggest narrow recognition of the use of these tools. As indicated in Table29, local health department employees are much more likely to know which tools their community uses when identifying public health priorities than respondents who work for other sectors of the public health system. Similarly, individuals with a "RN" credential are much more likely to know which tools are used in the identification of public health priorities than their colleagues with other credentials.

Table 28: Tools used by communities to identify public health priorities (n=818)

	%
Local data	72%
State-level data	67%
Expertise of local health department staff	61%
Community input	61%
State Health Plan priorities	53%
Local media	23%
Not sure	20%
Other	3%

Note: Respondents allowed to select multiple answers

Table 29. Tools used by communities to identify public health priorities - Percentage by sector

	Local Data	State Data	LHD Expertise	SHP Health Priorities	Community Input	Not Sure
Local health department (LHD)	88%	76%	77%	66%	76%	8%
State agency	59%	68%	49%	46%	46%	28%
Health care organization	60%	61%	54%	51%	50%	30%
Educational organization	65%	61%	55%	42%	58%	25%
Private/non-profit organization	71%	64%	59%	56%	64%	23%
Other	67%	59%	48%	33%	52%	28%

Open-ended comments suggest that this discrepancy in knowledge can be explained in part by discrepancies in familiarity with the CHIP process, the priority setting process advocated by the Department of Health and Family Services and utilized by many local health departments. While almost half of all local health department employees reported participation in the CHIP process, only 25 percent of respondents who work for private or non-profit organizations reported participation. According to one employee of a non-profit organization, "[I] wouldn't have any idea how to get involved with the CHIP process." Employees of health care organizations and educational institutions also reported lower participation rates, 22 and 16 percent respectively.

Open-ended survey comments suggest that some individuals are not certain how to join the CHIP process. According to one individual, "I don't know how to participate in this planning process. I don't remember seeing any call for participation in this process in my area." A number of comments also suggest that some individuals simply aren't certain what the CHIP process is: "Have participated in various attempts at health planning and priority setting, but not aware if it

is part of a ‘CHIP’ process.” Yet others indicate a disconnect between ‘community planning’ and ‘public health planning:’

> Although the concept of ‘healthy communities’ is increasing, public health is really not in the fore front of community planning activities. Public health institutions do their strategic planning, communities do their planning. Sometimes they talk to each other. More often than not, they plan separately and only obtain limited input from each other.

Respondents who have participated in the CHIP process provide mixed reviews. While one individual called CHIPs a “great experience and worthwhile process,” other respondents commented that it is “very time consuming” and “needs improvement engaging minorities.”

LIMITATIONS

The primary goal of this report is to establish a baseline from which to evaluate Wisconsin's success transforming its public health system. Thus, the analysis presented here should be viewed as a first step in this process rather than the final product of an evaluation of transformation. This report, like all others, has a number of limitations. These limitations are primarily associated with the project's definition of transformation, the survey's sampling frame, and the survey instrument itself.

Defining Transformation

The model that serves as the framework for this assessment (page 9) considers 'transformation' to be comprised of changes in the infrastructure of Wisconsin's public health system. However, the key informant interview component of this project demonstrated that some individuals look instead to improvements in health outcomes when they consider transformation. While the overall goal of public health is to improve the health of populations, achieving the systemic changes outlined in this model can be considered necessary pre-requisites for this health improvement.

Sampling Frame

There is not an existing list that encompasses all members of Wisconsin's public health system. Moreover, as discussed earlier in this report, there is not a uniformly accepted definition of which professions and individuals comprise this system. Thus, this project adopted the following definition of 'public health system:'

> *A social enterprise between government, the people, and the public, private, non-profit and voluntary sectors to promote the health of everyone.*

While broadly encompassing, this definition provides little operational guidance in determining who should be included in the sampling frame for this project's survey.

In the absence of a comprehensive list of the members of Wisconsin's public health system, the project team chose not to artificially bound the public health system. Instead, the team opened the survey to as wide an audience as possible, consulting colleagues, advisory boards, and contacts within DHFS and the University of Wisconsin to obtain as many e-mail lists thought to contain public health professionals as possible.[17] The survey distribution list compiled by the project team included over 6,000 unique e-mail addresses. However, it is clearly not a census of Wisconsin's public health workforce: it may disproportionately represent some sectors and organizations relative to others and may exclude some important organizations and individuals.

Such broad distribution ostensibly reached some individuals who did not possess the working knowledge of the public health system presumed by the survey. While these individuals would have been unable to provide informed answers to a number of survey questions, the project team

[17] Appendix C contains the organizations that assisted in survey distribution by either sharing their e-mail list or forwarding the survey to their members.

feels that the length and complexity of the survey served as a deterrent to these individuals taking—and completing—the survey. In instances where uninformed individuals did complete the survey, their responses were considered in the overall analysis, contributing to this project's baseline of progress towards transformation.

Even with a solid working knowledge of the public health system, some individuals expressed difficulty interpreting the meaning of 'your organization' as it was used in the survey instrument. A number of individuals commented that they were unsure whether they were supposed to reply based on the large organization in which they are employed, or the smaller unit within which they primarily work. Thus, it is unclear which entity respondents had in mind while they were completing the survey.

In a perfect evaluation of the transformation of Wisconsin's public health system, one would find concrete evidence of changes in policy, administration, funding, and systems towards the objectives outlined in the State Health Plan. This project has attempted to gather perceptions of the public health system to understand where it is now and provide a baseline for comparison at a later date. While perceptions are just that, not hard facts, it is clear that people act on their perceptions of fact, rather than on facts alone. Would a system truly be transformed if those changes were not recognized and acted upon by members of that system?

DISCUSSION/CONCLUSION

Earlier sections of this report detail perceptions of Wisconsin's public health system in five distinct areas: equitable, adequate, and stable financing; sufficiency, competency and diversity of the public health workforce; data and information systems; partnerships; and community health improvement processes and plans. As a whole, these perceptions provide a picture of where we are now, serving as a baseline for future evaluation(s). Taken separately, however, these perceptions can serve as a needs assessment tool, highlighting strengths and weaknesses in Wisconsin's public health system today and identifying gaps in our progress towards transformation.

Survey respondents were only moderately satisfied with the performance of Wisconsin's public health system; on a scale of one to ten, mean ratings ranged from 3.6 to 6.7. Survey respondents reported most satisfaction in the areas of *partnerships* and *community health improvement processes and plans.* Satisfaction in the area of *sufficiency, competency, and diversity of the workforce* varied significantly, with *competency* receiving the highest overall rating and *sufficiency* and *diversity* receiving more middle-of-the-road ratings. Program and policy changes are, perhaps, most indicated in the areas of *data and information systems* and *equitable, adequate, and stable financing*: mean ratings were lowest in these areas.

As discussed in previous sections of this report, overall means present only a partial picture of where we are today; these figures mask variation among the occupational sectors of the public health system, geographic region, years of experience, and credential. This variation was most noticeable in the areas of *equitable, adequate and stable financing*, *partnerships,* and *community health improvement processes and plans.* In the area of *equitable, adequate and stable financing,* local health department employees gave the lowest mean ratings, followed closely by state agencies; health care organization employees gave the highest ratings. In addition, mean ratings decreased as years of experience increased. In terms of *partnerships,* the highest mean ratings came from local health departments, RNs, and the Western region of Wisconsin. Last, in terms of *community health improvement processes and plans,* employees of the non-profit/private sector gave the lowest ratings and local health department employees gave the highest ratings. In addition, individuals with a RN credential gave high mean ratings and individuals from Southeastern Wisconsin gave low mean ratings.

What is the public health system, and who is the public health workforce?

This project adopted the State Health Plan's definition of the public health system:

> *A social enterprise between government, the people, and the public, private, non-profit and voluntary sectors to promote the health of everyone.*[18]

However, in-depth interviews suggested that, in practice, there is not one uniformly accepted definition of the public health system or one single rationale used to determine who is included in this system. The question "When you think of Wisconsin's public health workforce, who does that include?" yielded 12 unique answers from 20 interviewees. These answers varied most

[18] (p. 10).

significantly in their breadth; some interviewees described a public health workforce that includes a wide range of occupational sectors and professions, while others described a workforce comprised primarily of public sector employees. According to one interviewee, the public health workforce includes "anyone that has the ability to assist [local health departments]."

Survey respondents expressed similar uncertainty in response to the question "Do you consider yourself to be part of Wisconsin's public health system?" As one survey respondent noted:

> It all depends on how one defines 'public health.' [One] does not need to work strictly in the public health sector to help address issues of consequence to the health care of Wisconsin residents. If 'public health' refers to improving the health of Wisconsin residents, then, yes, I am part of the system. If it doesn't, I'm not.

In their comments, respondents reported use of various rationales to determine whether one is part of the public health system. These rationales included:

- Employer (organizational mission)
- Educational training
- Perceptions of colleagues
- Perceptions of members of the 'traditional' public health system
- Job responsibilities
- Receipt of public services (safety net)
- Ability to impact the physical or mental health of others through prevention, advocacy, education, etc.
- Organizational partners

Perhaps as a result of such varied definitions and guidelines, survey results suggest that individuals of the same profession don't always agree on whether they are part of the public health system. School nurses are one notable example of such a 'conflicted' profession: while some school nurses reported that they are part of the public health system, others reported working closely *with* the public health system.

Suggestions for future analysis

Further analysis is suggested in the following areas: (1) Conducting separate analyses for respondents who work in Milwaukee; (2) Determining important predictors of satisfaction with the public health system using multivariate regression analysis; (3) Conducting analyses by selected essential service area; (4) Conducting additional sub-group analysis (e.g., job title, race and ethnicity, and area of public health expertise); and (5) Conducting hierarchical analysis which takes into account disproportionate responses from employees of various organizations.

Concluding thoughts

This project considers the infrastructure priorities listed in *HW2010* to be the engines for transforming Wisconsin's public health system. Thus, today's perceived status (mean ratings) in each priority area should be considered baseline measures for progress towards transformation as we approach the 2010 expiration of the State Health Plan. Repeating this survey closer to 2010

(possibly 2008 *and* 2010) will provide a basis for measuring change in each of the plan's five infrastructure priority areas.

Although infrastructure changes are championed by the State Health Plan, they are not intuitively appealing, or even meaningful, to some members of the public health system. In fact, in response to the question "When you think of the transformation of the public health system in Wisconsin, how might you measure it?" a number of interviewees cited improvements in health outcome measures such as infant mortality, and morbidity and mortality overall. (These are being monitored by the Department of Health and Family Services and the UW Population Health Institute). Others mentioned changes in access and populations served, as well as decreases in disparities. Realizing these improvements is unlikely, however, without adequately funded programs implemented and managed by a sufficient, competent workforce and supported by community partners.

Healthiest Wisconsin 2010 relies on an infrastructure of workforce, data systems, partnerships, financing, and community planning to achieve its overarching goals of 'Transforming the Public Health System,' 'Eliminating Disparities,' and 'Protecting Health for All.' This analysis suggests that there is room for movement in a positive direction in each of these areas: even the highest rated areas could be interpreted as receiving only 61% to 67% of the possible total rating. Workforce development, financing, and integrated information systems received the lowest ratings, suggesting the greatest need for increased attention in these areas. Continued changes in all five infrastructure priority areas will better prepare Wisconsin's public health system to address current and emerging public health challenges.

APPENDIX A: Survey Methodology

The project team developed an online survey instrument based on the transformation model, the objectives of the five infrastructure priorities, and insights garnered from the in-depth interviews. The survey queried respondents on their involvement with the public health system, knowledge of the State Health Plan, perceptions of Wisconsin's public health system, and demographic characteristics.

The sampling frame was designed to include anyone who would consider themselves to be part of Wisconsin's public health system. The project team collected e-mail distribution lists from organizations representing each sector cited in *Healthiest Wisconsin 2010's* definition of the public health system. In addition, specific attempts were made to include organizations with diverse constituents (race, ethnicity, and sexual orientation), varying geographic locations, and areas of expertise. E-mail addresses provided by willing organization were stored in a secure Access database and duplicates were removed. The database contained a total of 6,433 unique e-mail addresses. Each address was assigned an identification number.

In addition, a number of organizations that were not willing to share constituent e-mail addresses offered to distribute the survey via their own channels. These organizations were provided with a link and suggested survey text to distribute on November 29, 2005.

The project team used the online service WebSurvey@UW to distribute the survey and collect responses. A notification e-mail was sent to the sample on November 14, 2005 informing individuals they would soon be receiving an important survey. E-mail addresses that were returned as invalid were removed from the sample (n=189). The initial survey distribution occurred on November 16, 2005. Non-respondents were sent up to two reminder e-mails. Additional survey invitations were e-mailed at the request of survey takers and these individuals were added to the sample.

The survey closed on December 3, 2005 and results were downloaded from the Web site on December 5, 2005. All responses were identified only by sequential numbers, not by e-mail address, in analytic files.

APPENDIX B: Survey Distribution

The following entities contributed to the distribution of the online survey

2005 Ryan White Title II Grantee List
AIDS/HIV Providers
Area Health Education Centers (AHEC)
Benefits Specialists
CAP Network
Children's Health Alliance
County Human Service Departments
Dane County Latino Health Council
Department of Public Instruction
DHFS Bureau of Environmental and Occupational Health
DHFS Bureau of Mental Health and Substance Abuse Services
DHFS Bureau on Aging Directors
DHFS Division for Supportive Living
DHFS Division of Health Care Financing
DHFS Division of Public Health
DHFS Friends
DHFS Office of Strategic Financing
DHFS Regional Offices
Diverse and Resilient
Environmental Health Steering Committee
Federally Qualified Health Centers (FQHCs)
Friends of Public Health
Friends of the State Health Plan
Great Lakes Intertribal Council (GLITC)
Health Alert Network (HAN)
Health Coordinators - Educational Staff
Health Watch
Hispanic HIV Leadership Task Force
Local Health Departments
Maternal and Child Health Advisory Committee
Medical College of Wisconsin
Newborn Screening Database
Northeastern Wisconsin Research Alliance
Oral Health Consultants
Public Health Advisory Committee (PHAC)
Public Health Council (PHC)
Public Health Partners
Ryan White Physicians
South Central Public Health Preparedness Consortium
State Health Plan Committee of the PHC
Tribal Health Clinics

United Migrant Opportunities Services (UMOS)
UW Medical School
UW Population Health Institute
Washington County Health Department
Well Woman Program Coordinators
WI Network
WIC Advisory Committee
WIC Directors
Wisconsin Association Of Local Health Departments And Boards (WALHDAB)
Wisconsin Association on Alcohol and Other Drug Abuse (WAAODA)
Wisconsin Covering Kids and Families
Wisconsin Dietetic Association
Wisconsin Environmental Health Association (WEHA)
Wisconsin Environmental Health Steering Team
Wisconsin Migrant Council Board
Wisconsin Minority Health Partners
Wisconsin Partnership for Activity and Nutrition
Wisconsin Primary Health Care Association (WPHCA)
Wisconsin Public Health Association (WPHA)
Wisconsin State Lab of Hygiene

APPENDIX C: Response Rates

Response Rates

Total Sample of unique emails	6433	
Bouncebacks	189	
Sample of working unique emails	6244	
Declined	50	0.8%
Did not Respond	4234	67.8%
Responded	1954	31.3%
Unknown	6	0.1%
Additional anonymous respondents	95	
Total Respondents (N)	**2049**	
# Respondents who answered no questions	104	
Total Respondents who answered at least one question	**1945**	

APPENDIX D: Demographic Data

Note: Respondents were informed that providing demographic data was optional. Approximately two-thirds of 1,945 survey respondents completed this section.

Respondent demographics

	n	%
Gender		
Male	395	30%
Female	912	70%
Age		
29 or under	85	7%
30-39	190	15%
40-49	355	27%
50-59	535	41%
60+	138	11%
Race	1289	
American Indian	21	2%
Asian	17	1%
Black or African American	43	3%
Pacific Islander	2	0%
White	1192	92%
Other, please specify	24	2%
Hispanic or Latino		
Yes	28	2%
No	1244	98%
Lesbian, gay, bisexual, transgender (LGBT)		
Yes	54	4%
No	1214	96%
Highest level of education		
Some high school	0	0%
High school degree or GED	17	1%
Some technical school or vocational training	19	1%
Technical school graduate or Associate degree	38	3%
Some college	40	3%
College degree	480	37%
Post graduate or professional degree	693	54%

Organization size

	n	%
People employed by your organization		
Fewer than 5	97	6
5 – 14	222	13
15 – 49	310	19
50 – 99	189	11
100 – 999	530	32
1,000 or more	326	19

APPENDIX E: Survey Codebook

A. Introduction

'Transform Wisconsin's public health system' is one of the goals of Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public, the State Health Plan published in 2002. The Wisconsin Division of Public Health has contracted with the University of Wisconsin Population Health Institute to assess progress towards achieving this goal.

This survey is designed to capture perceptions of organizational and systems-level changes in Wisconsin's public health system and establish a baseline for future comparison. All individual responses and identities will remain confidential; only group characteristics will be used in any publications or reports that result from this survey. We will identify completed surveys by number, not by name or organization. However, a master list of e-mail addresses will be kept to facilitate a follow-up survey.

Completing this survey is voluntary, and you may skip any questions you do not want to answer or that are not applicable to you. The survey takes approximately 15 - 20 minutes, and it must be completed in one session, so please allow enough time before you begin.

A1. Do you consider yourself to be part of Wisconsin's public health system?

1 Definitely
2 Probably
3 Probably not
4 Definitely not

A2. Please add any comments about your answer to question #1 (optional).

A3. Do you consider your place of employment to be part of Wisconsin's public health system?

1 Definitely
2 Probably
3 Probably not
4 Definitely not
9 Not currently employed

A4. Have you heard of the State Health Plan, Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public?

1 Yes
0 No

B. Background: Public Health

B1. The State Health Plan outlines 12 essential public health system services. Please indicate the activities you consider to be significant components of your responsibilities as an employee or volunteer in the public health field.
(mark any that apply)

		Marked	Unmarked
B1a	Monitor health status to identify community health problems.	1	0
B1b	Identify, investigate, control, and prevent health problems and environmental health hazards in the community.	1	0
B1c	Educate the public about current and emerging health issues.	1	0
B1d	Promote community partnerships to identify and solve health problems.	1	0
B1e	Create policies and plans that support individual and community health efforts.	1	0
B1f	Enforce laws and regulations that protect health and ensure safety.	1	0
B1g	Link people to needed health services.	1	0
B1h	Assure a diverse, adequate, and competent workforce to support the public health system.	1	0
B1i	Evaluate effectiveness, accessibility, and quality of personal and population-based health services.	1	0
B1j	Conduct research to seek new insights and innovative solutions to health problems.	1	0
B1k	Assure access to primary health care for all.	1	0
B1l	Foster the understanding and promotion of social and economic conditions that support good health.	1	0

B2. How many years have you worked or volunteered in the public health system?

1 Less than 5 years
2 5 to 9 years
3 10 to 20 years
4 More than 20 years

B3. What specific areas of public health do you currently work or volunteer in (maternal and child health, primary care, cardiovascular disease, environmental health, policy, community development, etc.)?

B4. Please select your place of employment.

1 County or local health department
2 DHFS (Central Office)
3 DHFS (Regional Office)
4 State agency (not DHFS)
5 Community health center
6 Hospital
7 Managed care organization/Insurer
8 Educational institution (University, school, etc.)
9 Faith based organization
10 Non-profit organization
11 Business
12 Other

B5. What is your job title?

B6. How many people does your organization employ?

1 Fewer than 5
2 5 - 14
3 15 - 49
4 50 - 99
5 100 - 999
6 1,000 or more

B7. Please indicate the primary geographic boundaries of your work. (See map below)

1 Northeastern
2 Northern
3 Southeastern
4 Southern
5 Western
6 Milwaukee
7 Statewide

B1extra. Why don't you consider yourself to be part of Wisconsin's public health system? (mark any that apply)

1 I work in health care, not public health.
2 I work in neither health care nor public health.
3 I do not live or work in Wisconsin.
9 Other; please specify.

C. Background: Turning Point

C1. To what extent does the State Health Plan guide the activities of Wisconsin's public health system? (1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

C2. Please explain your rating in question #1 (optional).

C3. How often do you reference the State Health Plan in your public health work?

1 Daily
2 Often
3 Occasionally
4 Never

C4. What components of the State Health Plan are you familiar with?
(mark all that apply)

		Marked	Unmarked
C4a	Overarching goals	1	0
C4b	Health priorities	1	0
C4c	System (Infrastructure) priorities	1	0
C4d	Implementation plans	1	0

C5. Did you participate in Wisconsin's policy process to create and implement the State Health Plan? (This process spanned 1999 - 2003 and is often referred to as the Turning Point Initiative.)

1 Yes
0 No

C6. If so, how?

D. Financing

D1. To what extent does Wisconsin's public health system have adequate financing?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

D2. To what extent does Wisconsin's public health system have equitable financing?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

D3. To what extent does Wisconsin's public health system have stable financing?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

D4. To what extent is your organization's allocation of resources influenced by the 11 health priorities and 5 system (infrastructure) priorities outlined in Healthiest Wisconsin 2010?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

D5. How adequate is your organization's funding level?

1 Adequate to run current programs and consider expanding
2 Adequate to run current programs
3 Inadequate to maintain current efforts
9 Not sure/Not applicable

D6. What efforts has your organization made to diversify its resource base in recent years?
(mark any that apply)

		Marked	Unmarked
D6a	Expansion of partnerships	1	0
D6b	Grant applications to private foundations	1	0
D6c	Grant applications to state and local governments	1	0
D6d	Grant applications to federal government agencies	1	0
D6e	Increased level of revenue-generating activities	1	0
D6f	Solicitation of individual donations	1	0
D6g	Solicitation of corporate sponsorships	1	0
D6h	Other, please specify	1	0

D7. Has your organization applied for funding from The University of Wisconsin Medical School's Partnership Fund for a Healthy Future or The Medical College of Wisconsin's Healthier Wisconsin Partnership Program (Blue Cross/Blue Shield dollars)?

1 Yes
0 No
9 Not sure/Not applicable

D8. Indicate the level of competition for public health funding your organization faces today as compared to the level of competition it faced in 2001.

1 Less competition
2 More competition
0 About the same level of competition
9 Not sure/Not applicable

D9. Please add any additional comments about public health financing in Wisconsin.

E. Workforce: Sufficiency and Competency

E1. To what extent does Wisconsin's public health system have a competent workforce?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

E2. To what extent does Wisconsin's public health system have a sufficient workforce?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

E3. To what extent do Wisconsin's educational institutions provide adequate training for the state's public health workforce?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

E4. Does your organization...

	Yes	No	Not sure/Not applicable
Recruit through career fairs?	1	0	9
Promote health careers at K-12 schools?	1	0	9
Provide field placements or internships for public health students?	1	0	9

E5. How many of your organization's recent new hires have formal training in public or community health?

1 All
2 Most
3 Some
4 None
9 Not sure/Not applicable

E6. In the past year, has anyone from your organization received additional training in public health through...

	Yes	No	Not sure/Not applicable
Attending a public health leadership conference?	1	0	9
Coursework at a university or college sponsored program?	1	0	9
Coursework at a technical school program?	1	0	9
Coursework through an online program?	1	0	9

E7. Does your organization offer incentives (tuition reimbursement, pay increases, etc.) for employees to participate in continuing education courses or conferences?

1 Yes
0 No

9 Not sure/Not applicable

E8. Please add any additional comments about the sufficiency and competence of Wisconsin's public health workforce.

F. Workforce: Diversity

F1. To what extent does Wisconsin's public health system have a diverse workforce?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

F2. How well does your organization's workforce represent the racial and ethnic composition of the population it serves?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

F3. How does your organization recruit employees who represent Wisconsin's racial and ethnic communities?
(mark any that apply)

		Marked	Unmarked
F3a	By forming mentoring relationships with local colleges and universities	1	0
F3b	By participating in local career fairs	1	0
F3c	By hosting interns with racially and ethnically diverse backgrounds	1	0
F3d	By promoting careers in the health field at local K-12 schools	1	0
F3e	By advertising available positions in racially and ethnically diverse markets	1	0
F3f	Not sure/Not applicable	1	0
F3g	Other, please specify	1	0

F4. Does your organization...

		Yes	No	Not sure / Not applicable
F4a	Provide access to cultural sensitivity/competency training?	1	0	9
F4b	Provide training about the needs of low-income populations?	1	0	9
F4c	Offer interpretation services for individuals with limited English proficiency?	1	0	9
F4d	Have individuals with racially and ethnically diverse backgrounds on its advisory committee, executive or governing board?	1	0	9
F4e	Have individuals representing the lesbian, gay, bisexual, transgender (LGBT) community on its advisory committee, executive or governing board?	1	0	9

F5. Please add any additional comments about the diversity of Wisconsin's public health workforce.

G. Data and Information Systems

G1. To what extent does Wisconsin have an integrated electronic information system that measures public health system capacity?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

G2. To what extent does Wisconsin have an integrated electronic information system that provides meaningful information about the health priorities outlined in Healthiest Wisconsin 2010?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

G3. To what extent does your organization use available data when conducting the activities below?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

G3a	Needs assessment
G3b	Budgeting
G3c	Setting priorities
G3d	Targeting programs
G3e	Measuring performance

G4. How easy is it for you to access the following types of data?
(1 indicates very difficult, 10 indicates very easy)

1 2 3 4 5 6 7 8 9 10

G4a	Local health outcomes
G4b	Specific health conditions
G4c	Specific racial or ethnic groups
G4d	State Health Plan objectives
G4e	Statewide, population-based data

G5. Please add any additional comments about public health data and information systems in Wisconsin.

H. Partnerships

H1. To what extent do partners representing the public, private, non-profit, and voluntary sectors collaborate to create and promote healthy communities across Wisconsin?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

H2. Rate the strength of the partnerships between Wisconsin's Department of Health and Family Services (DHFS) and local public health departments.
(1 indicates weak partnerships, 10 indicates strong partnerships)

1 2 3 4 5 6 7 8 9 10

H3. Rate the level of communication between your organization and its public health partners.
(1 indicates interaction initiated fresh each time, 10 indicates smooth and immediate dialogues)

1 2 3 4 5 6 7 8 9 10

H4. Rate the level of joint planning and joint decision-making (turning planning into action) between your organization and its public health partners.
(1 indicates no joint planning, 10 indicates significant joint planning)

1 2 3 4 5 6 7 8 9 10

H5. What factors drive your organization's formation of partnerships?
(mark any that apply)

H5a	Requirements of granting organizations
H5b	Principles of the State Health Plan
H5c	Resource limitations
H5d	Desire to influence legislation
H5e	Internal goals and objectives
H5f	Inclusion of diverse racial or ethnic groups
H5g	Gathering community input
H5h	Prior experience with successful partnerships
H5i	Not sure/Not applicable
H5j	Other, please specify

H6. Since 2001, have your organization's partnerships changed in terms of...

		Yes, increased	Yes, decreased	No change	Not sure / Not applicable
H6a	Staff participation (number of staff)?	1	2	0	9
H6b	Frequency of communication between partners?	1	2	0	9
H6c	Integration of partnership goals into internal activities?	1	2	0	9
H6d	Inclusion of a broader array of partner organizations?	1	2	0	9
H6e	Involvement with "non-traditional" partners?	1	2	0	9
H6f	Financial support for partnership activities?	1	2	0	9

H6g	Community participation?	1	2	0	9
H6h	Stability (or formality)?	1	2	0	9

H7. Please add any additional comments about public health partnerships in Wisconsin.

I. Community Health Improvement Processes & Plans

'Community health improvement processes and plans' is the fifth infrastructure priority of the State Health Plan. Its implementation plan lists the following objective: "By 2010, 100 percent of local health departments will have implemented and evaluated a community health improvement plan that is linked to the State Health Plan."

Questions in this section aim to capture your perceptions of health planning and priority setting by local health departments and communities. If you have not participated in such a process in the community where you live or work, please scroll to the end of this page, click "next," and continue with the next section of this survey.

I1. Rate the extent of community participation in setting and supporting local public health priorities in the community where you live or work.
(1 indicates none at all, 10 indicates a great deal)

1 2 3 4 5 6 7 8 9 10

I2. Rate the extent of trust and credibility between public health system partners and the local health department in the community where you live or work.
(1 indicates distrust and lack of credibility, 10 indicates mutual trust and credibility)

1 2 3 4 5 6 7 8 9 10

I3. Rate the level of resource sharing (data, technical assistance, etc.) among local public health system partners to achieve your community's public health priorities.
(1 indicates limited sharing, 10 indicates extensive sharing)

1 2 3 4 5 6 7 8 9 10

I4. To what extent do you feel that your expertise is valued in setting public health priorities for your community?
(1 indicates not at all, 10 indicates very much so)

1 2 3 4 5 6 7 8 9 10

I4. What types of planning and decision-making tools does your community use to identify its public health priorities?
(mark any that apply)

I4a Local data
I4b State-level data
I4c Expertise of local health department staff
I4d State Health Plan priorities
I4e Community input
I4f Local media
I4g Not sure
I4h Other, please specify

I5. Have you ever participated in your community's 'Community Health Improvement Planning (CHIP) process'?

1 Yes
0 No
9 Not sure

I6. Please add any additional comments about health planning and priority setting by local health departments and communities.

J. Demographic Information (Optional)

J1. What is your e-mail address?
Note: E-mail addresses will be retained for a future survey to measure change over time. E-mail addresses will not be distributed.

J2. What is your gender?

0	Male
1	Female

J3. What is your age group?

1	29 or under
2	30-39
3	40-49
4	50-59
5	60+

J4. What is your race?
(mark all that apply)

J4a	American Indian
J4b	Asian
J4c	Black or African American
J4d	Pacific Islander
J4e	White
J4f	Other, please specify

J5. Are you Hispanic or Latino?

1	Yes
0	No

J6. Are you a member of the lesbian, gay, bisexual, transgender (LGBT) community?

1	Yes
0	No

J7. Please indicate your highest level of education.

1	Some high school
2	High school degree or GED
3	Some technical school or vocational training
4	Technical school graduate or Associate degree
5	Some college
6	College degree
7	Post graduate or professional degree

J8. What are your credentials?
(mark any that apply)

J8a	MA
J8b	MS
J8c	MPH
J8d	PhD
J8e	RN
J8f	MD
J8g	Other, please specify

J9. Please add any additional comments about this survey or the transformation of Wisconsin's public health system.