

**Healthiest Wisconsin 2010:  
A Partnership Plan to Improve the Health of the Public -  
Mid-term Key Informant Interviews**

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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## **EXECUTIVE SUMMARY**

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 'Transforming Wisconsin's public health system,' one of the three overarching goals cited in the State Health Plan for the decade 2000-2010, *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*.<sup>1</sup> This assessment included a focused effort to operationalize transformation, an online survey, and key informant interviews. This report focuses on the findings of the key informant interviews.

In-depth key informant interviews were intended to capture what transformation means to a broad range of interviewees, identifying both common conceptual themes and divergence in opinion. These interviews also garnered a sense of the "pulse" of the public health system in regards to transformation. The findings of these interviews informed development of an online survey used to assess transformation on a broader scale.

### **Methods**

The project team conducted five pilot interviews and sixteen final interviews with individuals representing a broad cross-section of Wisconsin's public health system. Attempts were made to achieve theoretical saturation in the sample of interviewees. Interviewees included individuals with a variety of racial and ethnic backgrounds, subject matter expertise, professional interests, and geographic locations.

Interviews took place in person and over the phone. Interviewers used a standard interview guide, customizing probes to fit each interviewee's experience and expertise. 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 of the plan's five infrastructure priorities as well as archetypal quotes from individual interviewees.

### **Results**

#### ***Transformation***

Interviewees articulated a number of different conceptual interpretations of transformation as it relates to Wisconsin's public health system. These responses reflected emphasis that falls into a continuum of opinion with the following anchors:

- (1) Transformation as a revitalization of the systems underlying Wisconsin's public health enterprise, which we call a systemic approach; and

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<sup>1</sup> (p. 24).

- (2) Transformation as a broadening of the public health discipline and delivery system, focusing across organizational boundaries to emphasize health outcome status, which we call a health outcomes approach.

Although there is some overlap in these groupings, there is considerable divergence in the suggested indicators of success. Interviewees who embraced the systemic approach emphasized measuring transformation in terms of infrastructure change whereas those who subscribed to the health outcomes approach focused on measuring success as increases in individuals served and/or better health outcomes. Despite differences in the articulated details of what transformation means and how it can be measured, interviewees agreed on two key points: (1) transformation involves fundamental change; and (2) this type of change is rarely easy. Whether transformation refers to systems change or changes in health outcomes, then, buy-in at the community and state level are crucial components of success.

### ***Partnerships***

Interviewees indicated that partnerships are vital to public health. They reported a broad array of agents that collaborate with public health entities, ranging from policy makers and legislators to hospitals and clinics to agencies that focus on specific issue areas. Interviewees cited a number of drivers for partnership formation, most commonly funder requirements, organizational resource shortages, and financial support. Interviewees generally agreed that commitment of resources; mutual respect, benefits, and buy-in; and explicit objectives, roles, and action plans are characteristics of successful partnerships. In addition, successful partnerships have regular communication and good business cases. There was less agreement, however, on the *outcomes* of successful partnership.

### ***Community Health Improvement Processes and Plans***

Community Health Improvement Processes and Plans (CHIPs) require communities to move beyond specific needs assessment and consider the entire spectrum of issues that affect the health of a population. Interviewees reported a wide variation of knowledge and familiarity with the CHIP process. Some individuals were deeply involved with CHIPs in their communities and able to provide a detailed description of the process. Others were unfamiliar with the term 'CHIP.' Individuals who reported familiarity with CHIPs cited a generally positive experience with a wide range of participating partners and fairly broad data use. They also outlined the differences between CHIPs and organizational strategic planning processes and provided suggestions for improving the CHIP process.

### ***Electronic Data and Information Systems***

A number of individuals emphasized the value of an integrated electronic data system; interviewees described such a system as secure, easily and readily accessible, easily understandable, concise, comprehensive, streamlined, and available for practical applications

such as grant writing. Interviewees reported that their organizations are currently collecting data from a variety of sources. Most respondents noted that although a great deal of data is available, it has numerous limitations. The most commonly cited limitations were inconsistency in collection parameters (especially in terms of race and ethnicity) and unavailability of local data. Some interviewees suggested that the state could improve consistency by setting mandatory standards for the collection of data tracking race and ethnicity in Wisconsin.

### ***Equitable, Adequate, and Stable Financing***

While interviewees had varied opinions on the equity of public health financing, most described the current funding system as unstable and inadequate. Respondents noted that these funding challenges impact their organizations in a number of ways—most commonly an inability to plan for the long term, increased caseloads, and reduced staffing levels. On the whole, interviewees noted an increased dependence on grants as federal, state, and local funding has decreased. A number of individuals went on to assert that grant application processes have become more competitive in recent years.

### ***Workforce***

Interviewees expressed a variety of opinions regarding the professions and individuals that comprise Wisconsin's public health workforce. There was general agreement, however, that there is room for improvement in the racial and ethnic diversity of this group in most of the state. A number of individuals reported that their organizations are already making efforts to recruit and retain a more diverse workforce, but saw a need to expand such targeted recruitment efforts in the future to secure a public health workforce that approaches the demographic profile of communities served. Citing Wisconsin's largely white population, others saw room for improvement in their organization's ability to work with clients of varying socioeconomic status instead.

Interviewees had a fairly positive view of Wisconsin's educational institutions as they relate to public health. There were, however, some appeals for improved coordination, more convenient class times and/or distance education, and increased access to continuing education opportunities. In addition, a number of interviewees asserted that public health curriculum and principles should expand into other fields of study.

### **Conclusion**

Three common themes emerged from key informant interviews:

- Lack of a uniformly accepted concept of transformation—some individuals emphasized systemic changes while others emphasized health outcomes;

- Differing perceptions of the organizations and individuals that comprise Wisconsin's public health workforce; and
- Disparities in data collection, public health financing, and health outcomes.

Although interviewees emphasized different aspects of change and varying conceptions of Wisconsin's public health work force, they do not necessarily disagree on salient issues of transformation. Instead, this variation in emphasis reflects the State Health Plan's integration of health and infrastructure priorities working in tandem to achieve the plan's overarching goals.

## INTRODUCTION

‘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.<sup>2</sup> In the spring of 2005, The Department of Health and Family Services (DHFS) Division of Public Health partnered with the University of Wisconsin’s Population Health Institute to assess Wisconsin’s progress towards this goal. This assessment included three stages:

- (1) Defining and operationalizing the concept of ‘transformation’ through development of a schematic depicting Wisconsin’s transformation process. This model is the product of: a review of key materials discussing transformation at a state and national level; input from the project’s advisory committee; an examination of the State Health Plan’s infrastructure priorities; and the national Turning Point evaluation. This model serves as the conceptual foundation of this project.<sup>3</sup>
- (2) Intensive interviews with 21 key stakeholders in Wisconsin’s public health system. These interviews garnered a sense of the “pulse” of the public health system as it relates to the infrastructure priorities of the State Health Plan and illustrated concrete transformational activities. Moreover, they guided development of the questions and closed-ended responses used in the survey instrument discussed below.
- (3) An online survey gathering perceptions of Wisconsin’s progress towards achieving the characteristics outlined in this project’s model of transformation. With assistance from a number of public health partners, this survey was distributed broadly across Wisconsin’s public health system (n=6,433 unique emails). Survey responses provided a baseline measure of transformation (n=1945 respondents).

The present report focuses on the key themes enumerated in the intensive interview component of this assessment project. An analysis of the online survey results are available from DHFS in a separate report entitled *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public - A Mid-term Assessment of Transformation*.

## METHODOLOGY

The project team conducted five pilot interviews and sixteen final interviews with individuals representing a broad cross-section of Wisconsin’s public health system. Attempts were made to achieve theoretical saturation in the sample of interviewees. This sample included individuals with a variety of subject matter expertise, professional interests, and personal characteristics (race, ethnicity, and sexual orientation).<sup>4</sup> In addition, these individuals

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<sup>2</sup> Wisconsin Department of Health and Family Services. *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. p. 24.

<sup>3</sup> To view the model, see Appendix A.

<sup>4</sup> For more information on the characteristics of key interviewees, see Appendix B.

represent a variety of work settings—state, regional, local, public, and private—and levels of responsibility within the organizations they serve.

The interview questionnaire was used as a guide rather than gospel; each interview question was intentionally broad, allowing interviewees to respond without bias.<sup>5</sup> Each interview took approximately one hour. Interviews were conducted over the phone and in-person, according to the interviewee's preference and geographic location.

Interviewers customized probes to fit each interviewee's experience and expertise. An interviewee with extensive experience forming and maintaining partnerships, for example, would have been asked numerous follow-up questions in this area but fewer follow up questions in an area where they have less expertise. While such individualized interviewing would not be appropriate in all circumstances, this approach enabled interviewers to best understand each interviewee's perspectives, illustrate their experiences in Wisconsin's public health system, and capture their expertise.

## **ANALYSIS**

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 as well as archetypal quotes from individual interviewees. Most interviews were attended or reviewed by two project team members. Interview notes were discussed and consensus reached on all emerging themes.

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<sup>5</sup> To read the full interview questionnaire, see Appendix C.

## RESULTS

### Transformation

Interviewees articulated a number of different conceptual interpretations of transformation as it relates to Wisconsin's public health system. These responses reflected emphasis that falls into a continuum of opinion with the following anchors:

- (1) Transformation as a revitalization of the systems underlying Wisconsin's public health enterprise, which we call a systemic approach; and
- (2) Transformation as a broadening of the public health discipline and delivery system, focusing across organizational boundaries to emphasize health outcome status, which we call a health outcomes approach.

Although there is some overlap in these groupings, there is considerable divergence in the suggested indicators of success. Interviewees who embraced the systemic approach emphasized measuring transformation in terms of infrastructure change whereas those who subscribed to the health outcomes approach focused on measuring success as increases in individuals served and/or better health outcomes.

### *Systemic Approach*

Interviewees who subscribed to the 'systemic approach' of transformation drew heavily on the infrastructure priorities of the State Health Plan when defining transformation. One individual described a transformed system as follows:

We would have a system that does the things that the State Health Plan says we should do...we would have achieved a system that provides [a] sufficient, competent public health workforce, collects and provides data that is needed for planning and decision making; it would include all of the infrastructure priorities.

Many individuals noted the importance of equitable, adequate, and sufficient resource allocation paralleling the *equitable, adequate, and stable financing* priority listed in the State Health Plan. One person, for example, reflected on financing by describing transformation as: "Striving for efficiency, the maximum use of limited dollars to achieve the best health outcomes in Wisconsin."

Others championed a unified system of statistics and data—*integrated electronic data and information systems*—and deep and frequent partnerships—*coordination of state and local public health system partnerships*. One interviewee noted the importance of data by citing the ability to identify core public health needs; describing a transformed system as: [An]

“ability to measure key health outcomes and indicators such as infant mortality, quality of life, and disability.” They went on to note:

The State Health Plan is the only thing that we have that provides the views of the constituents [or] community on what their public health needs are. It gives us something to measure in terms of ...what these community health providers feel is important.

Others focused on the coordination of state and local public health systems; for example, one individual listed “partnerships formed to eliminate or minimize certain diseases” as a possible indicator. Another interviewee listed elements of effective partnerships as indicators of change, citing “better channels of communication between the state and local health departments.”

Finally, a number of interviewees referenced the importance of professional expertise in local health departments—*sufficient, competent workforce* in the State Health Plan. For example, one interviewee described a transformed system as, “assuring a competent workforce to accomplish the goals set by the community.”

### ***Health Outcomes Approach***

Most interviewees approached the health outcomes anchor of our continuum. They generally saw transformation as movement towards a common vision, better coordination between local and state entities, and as embracing a broader concept of public health. For example, one interviewee noted that transformation involves “looking at public health in a manner that encompasses all aspects of the health of the members of our community...social, economic, and medical.”

Another individual described a changed system as, “A system that provides more access and an easily navigable system for all people, whether disabled, English as a second language, uninsured or otherwise.” Many interviewees expressed that a broader, more community-focused public health system would have a variety of benefits: it would meet the needs of a changing demographic, allow for greater access, and assist in moving toward a more encompassing concept of public health that addresses the things that drive demand for health care services (e.g., the determinants of health).

According to the interviewees who emphasized the health outcomes approach, ‘movement toward a common vision’ often entails more synergy between public health and health care delivery, a competent workforce, elimination of silos and an efficient use of limited dollars to achieve the best health outcomes for all of Wisconsin. One interviewee described this process as:

Moving away from a more traditional notion of public health such as surveillance and protection...to broader concepts such as population health which embrace those traditional notions and also look to things that drive

ultimately the demand for health services be it nutrition to smoking to seat belt use.

Interviewees who suggested that improved health outcomes are the best indicators of a successful transformation cited a number of health outcome indicators such as decreased alcohol consumption, increased exercise, and smoking cessation. Others called for data driven results in decreasing disparities and improving health outcome measures in infant mortality, injuries, morbidity, and mortality at local and aggregate levels.

Interviewees frequently underscored the importance of small community-based measures to consider changes in access and populations served. According to one interviewee, for example:

Smaller community based measures are better indicators of transformation... being able to capture smaller pockets of data...will be a good way of seeing some changes.

Others suggested that indicators for change could be found in the outcomes for goals and measures outlined in Community Health Improvement Processes and Plans (CHIPs).

### ***Commonalities***

Despite differences in the articulated details of what transformation means and how it can be measured, interviewees agreed on two key points. First, transformation involves fundamental change. According to one individual, “transformation implies that kind of significant evolution or change or development, not merely tinkering with the edges or components.” Another interviewee described transformation as follows: “the word transformation connotes change, but, it presents change from the place in time, not from the beginning; an evolution.”

Second, this type of change is rarely easy. According to another interviewee, “change has an intimidation factor to it; practitioners, clients—for better or worse—there is a reluctance towards it.” Whether transformation refers to systems change or changes in health outcomes, then, buy-in at the community and state level are crucial components of success.

### **Partnerships**

The authors of the State Health Plan assert that partnerships are essential to accomplishing the goals outlined in the plan:

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.<sup>6</sup>

Indeed, according to one interviewee, in recent years there has been a growing recognition among professionals in the public health field that “one organization cannot do it alone.” In general, interviewees reported a growing array of partners since the 2001 adoption of the State Health Plan—in part due to internal funding constraints—as well as increases in external expectations to form partnerships.

Interviewees cited a broad array of organizational partners. Most individuals listed agencies that focus on specific issue areas; others cited individual organizations such as local health departments, Department of Health and Family Services (DHFS) divisions, community members, hospitals, and policy makers (i.e., legislators). On the whole, interviewees reported that their organizations focus most heavily on building partnerships with organizations that have similar missions or complementary resources and skills.

Interviewees also indicated growth in the *types* of organizations their organizations have partnered with in recent years. By and large, interviewees expressed that as their own organization’s staff gets smaller, they depend more heavily on their partners. According to one individual, for example, “Local health departments are looking at partnering with different community agencies and groups in order to accomplish the broader aspects of public health.” Such dependence has its benefits, however. According to one individual, “By bringing all those partners in, you’re increasing the awareness of whatever issue you are dealing with.” Another interviewee echoed this sentiment:

As partners come together for specific events, they get to know each other and each other’s missions. They realize that they can work together on a broader set of issues because their missions really overlap.

Interviewees reported increased external expectations to partner in the past few years, most notably from funding organizations. For example, a number of interviewees cited The University of Wisconsin Medical School’s Partnership Fund for a Healthy Future and The Medical College of Wisconsin’s Healthier Wisconsin Partnership Program (Blue Cross/Blue Shield grants) academic partner requirements as an impetus for collaborating with universities. One individual referenced the funding climate more broadly:

In order to apply for grants these days, the more that you can demonstrate a partnership or collaboration with other agencies, the more likely you are to get [funded]...I have found that to be the driving force in collaborating.

Many interviewees reported greater levels of competition in forming partnerships, especially as they relate to securing grants and RFPs. However, some interviewees reported improvements in the operation of existing partnerships. Improvements mentioned included: more regular communication, more coordinated and collaborative activities, and better understanding of their partners’ capacity.

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<sup>6</sup> (p. 31).

A number of interviewees reported a lack of resources on the part of governmental public health partners to participate in meaningful relationships with other organizations. One interviewee described the resulting attitude from governmental partners as, “What can you do for us because we can’t do everything anymore.” Another noted, “Often times the responsibility is passed on to the private partnerships because government doesn’t have money.”

A number of individuals noted that the State Health Plan has a role in their organization’s partnerships. Some stated that the plan provides a global vision and outlines methods for aligning their work with the work of other organizations. Others reported that the *process* of creating *Healthiest Wisconsin 2010* helped to grow their networks. Yet others stated that the plan’s 11 health priorities drive partnership formation, sometimes at the expense of subject areas not included in the plan. According to one interviewee, for example, “some areas...were not included specifically in the plan. And around those [areas], it has been more difficult to get partners involved.” On the whole, however, most interviewees asserted that the State Health Plan plays a secondary role in their organization’s partnership formation—internal goals and objectives and funder expectations are typically the key drivers.

### ***Characteristics of Successful Partnerships***

Interviewees were asked to list characteristics of successful partnerships and to comment on successful outcomes of partnerships. There was notable agreement on the characteristics of successful partnerships. On the whole, interviewees agreed that successful partnerships have:

- A commitment of resources (time and money) from all involved parties
- Mutual respect and buy-in from all parties
- Explicit objectives, roles, and action plans
- Regular communication
- Good business cases

In addition, the partnership’s programs/interventions should be considered useful by its targeted community and the partnership should provide mutual benefit(s) to all parties involved in its activities.

Interviewees’ comments about the outcomes of successful partnerships, however, were more varied. One interviewee noted, “Almost all victories in public health are small ones” such as changes in rules or statutes. Another considered partnerships in the context of broader change—transformation—and stated: “Partnerships are the only way to see systemic changes...they are able to take many groups together and see the big picture rather than small issues.” Yet other interviewees cited *process* outcomes such as securing needed resources, conducting outreach, and increasing the breadth or number of participants in a given partnership.

Interviewees representing the business sector noted slightly different characteristics of successful partnerships. For example, some stated that partnerships are successful when they are relevant to employers, and when public health can provide connections to the workplace such as links between manageable chronic disease and work absenteeism. Some of those interviewed saw this as an emerging area for growth. According to one individual: “Business partnerships [are] an area that is ripe for expansion.” Regular communication, coordination and collaboration and a commitment to work together were cited as hallmarks of success for potential public health and business partnerships.

### **Community Health Improvement Processes and Plans**

*Healthiest Wisconsin 2010* states, “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.”<sup>7</sup> Community Health Improvement Processes and Plans (CHIPs) require communities to move beyond needs assessments for specific target populations and consider the broader (local) landscape of public health. Moreover, CHIPs require focused assessments that are connected and integrated within the broader community-wide health improvement plan. One interviewee described this process in detail:

The assessment phase includes focus groups where a community looks at all aspects of the health of a person...including the environmental, the mental, the medical, the community, the support, the religion, everything that makes a person healthy. Then [the community] bring[s] those different focus groups together and discuss[es] gaps in services, support[s] that with data...[Then, they] identify needs, prioritize them...grouped them...and came up with strategies.

However, a number of interviewees reported little familiarity with the CHIP process. Such variation suggests a broad range of levels of community involvement and understanding of CHIPs.

Interviewees who are familiar with the CHIP process reported regular use of data in priority setting and a broad group of participant organizations and sectors in local CHIPs. Participants mentioned include: universities, local health care providers, the Department of Natural Resources (DNR), UW Extension, mental health providers, community groups, non-profit organizations, and the Department of Health and Family Service (DHFS). These participants play a variety of roles, including: strategic planning, surveying, demographics, priority setting, outcomes management, research, and outreach.

Interviewees stressed that CHIPs, while important in developing concrete plans for action at the community level, do not replace the need for strategic planning at the organization level. According to one individual, CHIPs are a tool to define new need while strategic planning is a continuation of working toward already identified needs:

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<sup>7</sup> (p. 30).

The important difference is that strategic planning covers established programs and service gap areas versus only high need areas, for example, strategic planning includes “maintenance” of current services too.

This individual went on to note that, at times, needs overlap and strategies for action can be taken from strategic plans to address CHIP goals (or vice versa).

A few interviewees commented generally on the CHIP process, providing suggestions for improvement, technical assistance, and—perhaps—funding. One individual stated that the “challenge is to provide a compendium of everything going on at the state and local level, both in public health and outside.” The same interviewee suggested that the state should have a stronger role in gathering information, providing expertise in measurement, and partnership formation. Yet another saw CHIPs as “unfunded mandates.”

### **Electronic Data And Information Systems**

The State Health Plan champions an integrated electronic data and information system. According to its authors, “public health improvement has required that we identify and measure the targeted changes in community conditions. Measurement of community health priorities requires focused information.”<sup>8</sup> The plan goes on to say: “Sound decisions about public health policies, strategies, and interventions can be made only if useful, appropriate, and timely information is available to the public health system partners, decision makers, and policy leaders.”<sup>9</sup>

Interviewees described this type of integrated electronic system as: secure, easily and readily accessible, easily understandable, concise, comprehensive, streamlined, and available for practical application (e.g., grant writing). Moreover, such a system must be interoperable and high tech in nature. One individual described this system as an “umbrella that [encompasses] all of the data systems we use.” They went on to describe its benefits: “It would make electronic reporting user friendly so we can have better information, more accurate information.”

On the whole, interviewees reported that their organizations use data fairly regularly to support grant/proposal writing and program advocacy efforts. Interviewees also reported that their organizations use data for priority setting, decision-making, planning, budgeting, grant writing, research, internal reports, needs identification, and tracking progress towards goals. According to one individual, “Data is a building block for comparative reporting, to collect and analyze internally.” Most interviewees agreed that formal tools like evidence-based practices and cost effectiveness analysis are too time consuming for regular use in their organizations.

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<sup>8</sup> (p. 44).

<sup>9</sup> (p. 44).

Interviewees reported collecting data from a variety of sources, including: the census, local health departments, the Department of Health and Family Services (DHFS), the DHFS minority health report, the Centers for Disease Control, and the Substance Abuse and Mental Health Services Administration (SAMHSA). While much of this data is accessible and ready to use, a number of interviewees reported room for improvement in the amount and user-friendliness of local data available. Interviewees also reported obstacles retrieving data on race and ethnicity appropriate for measuring and addressing disparities. For example, according to one individual:

Everyone captures race and ethnicity in a different way, some do both, some one, some do not know the difference...A pendulum swings, at some points in history race and ethnicity [were] captured, then not, and now it is popular again...If race and ethnicity are not captured in a consistent format, there is a lot of other data that is not being captured in a consistent format.

Another interviewee noted the challenges these shortcomings in data availability and consistency pose to needs assessment and grant writing efforts, stating: “When you are looking for gaps in needs...you need that data locally.” Other interviewees asserted that this lack of consistent data hampers efforts to make comparisons across different geographic areas and provide aggregate figures at the state level. Some individuals suggested that the state could play a role in improving consistency by mandating how data tracking language, race, and ethnicity is captured by organizations across the state.

## **Financing**

The State Health Plan advocates equitable, adequate, and stable financing of Wisconsin’s public health system as one of its infrastructure priorities: “the transformation of Wisconsin’s public health system cannot happen without equitable, adequate, and stable financing.”<sup>10</sup> Many interviewees expressed a great deal of concern that Wisconsin’s financing for public health is moving in the wrong direction. While there was mixed sentiment regarding the equity of available funding, most interviewees believe that funding for public health in Wisconsin has become unstable and inadequate in recent years.

Although some interviewees expressed that funding has become more equitable in recent years, citing diversity task forces and the DHFS Office of Minority Health, others indicated that Wisconsin’s system for financing public health is not equitable. According to one individual:

If we look at most of our health indicators, the disparities in Wisconsin regarding race, ethnicity, and probably poverty as well are greater than the equivalent disparities in the U.S. and are increasing in many areas...equitability in terms of health outcomes measurement has not taken place.

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<sup>10</sup> (p. 36).

Many interviewees consider current funding levels to be inadequate. Most attributed this situation to repeated budget cuts at the state level. According to one individual, for example, “health care and social services are first to be cut in tight budget years, despite the fact that a larger investment in maintaining health care would reduce financial burdens overall.” Another interviewee expressed frustration with what they perceive as public apathy, stating: “The public expresses minimal concern at reductions in funding for health care.” This sentiment was echoed by another interviewee:

Voters need to take a greater interest in their health and they need to complain...a[n example of a] success [is] senior care—fixed income folks who worked their tails off to make change.

Inadequate and tenuous funding has negative effects on the organizations that comprise Wisconsin’s public health sector. Interviewees reported the following impacts on their organizations: an inability to plan for the long term (i.e., 5-10 years out), increased competition, fewer staff, less attention to program needs, increased diversity in funding streams, and more time spent securing funds. Some interviewees also reported dramatic increases in case loads in the past few years (despite the loss of existing positions), continued denial of new positions, and reduced reach in programming.

Interviewees agreed that reductions in public funding have made organizations increasingly dependent on grant funding, citing grant applications to national, local, and private foundations, local and state governments, communities, and individuals. A number of individuals expressed concern that continued competition for a limited number of grants threatens the viability of small organizations and their programming. Comments in this vein included:

Small agencies are fighting for money...there are not enough dollars to have the organizations be sufficiently trained and able to implement their programs in a stable way.

[Limited staff] forces organizations to work in a superficial way on programs. There are not sufficient numbers for attention, oversight, and evaluation that the programs need to assure achievement of outcomes.

Sustainability and mission fit have also become salient issues for many organizations in recent years. According to one interviewee, “it is easy to find start up funds but to maintain programs is more difficult.” Another interviewee referenced the challenges of “chasing money and doing what funders ask for.”

Although most interviewees asserted that funding for public health is unstable, others expressed a belief that, in the wake of 9-11, some funding has become more stable. According to one individual, for example, “preparedness dollars have helped to build public health infrastructure, especially in the area of epidemiology.” A few respondents echoed this comment, referencing new dollars earmarked toward bioterrorism and tobacco prevention efforts.

Many interviewees reported that their organizations' allocation of resources—both time and money—have changed in the past few years along with changes in funding streams. Most interviewees expressed that their organizations are “doing more with less.” A number of individuals explained that their organizations use program income as efficiently as possible to continue providing existing services but resource limitations keep them from expanding services or caseloads significantly. However, the effects of inadequacy and instability in funding are neither uniform across organizations nor equal in their impacts across sectors: a few interviewees, particularly those who work in health care delivery and cooperative sectors, expressed that their organization's funding has remained unchanged in the past few years.

### **Sufficient, Competent Workforce**

‘Sufficient, competent workforce’ is another 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.”<sup>11</sup> Interviewees expressed a variety of opinions regarding the professions and individuals that comprise Wisconsin’s public health workforce, but general consensus that there is room for improvement in the racial and ethnic diversity of this group.

The question “When you think of Wisconsin’s public health workforce, who does that include?” yielded 12 unique answers from 20 interviewees.<sup>12</sup> These answers varied most significantly in their breadth. Some individuals described a public health workforce that includes a wide range of occupational sectors and professions (e.g., nurses, doctors, public health aids and administrators, relevant college and university employees, community groups, churches and non-profits that focus on health, hospitals, nursing homes, pharmacists, dentists, oral hygienists, school nurses, nutritionists, animal control, and businesses). According to one individual, for example, the public health workforce includes “anyone that has the ability to assist [local health departments].” Another interviewee echoed this opinion, stating: “There are a wide range of players who are committed to coming together for the good of public health.” In contrast, some individuals described a workforce comprised almost entirely of public sector employees.

A number of interviewees reported changes in the composition of Wisconsin’s public health workforce in recent years. Changes cited include: increases in the number of bio-terrorism specialists, epidemiologists, environmental health specialists, health educators, and sanitarians. Others simply cited decreases in public health personnel and program reach.

Some individuals anticipated additional changes in the composition of the public health workforce as the current workforce, comprised primarily of white women, approaches retirement. A number of interviewees expressed optimism that such changes will result in a

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<sup>11</sup> (p. 34).

<sup>12</sup> This question was not asked of one interviewee.

more diverse workforce in the future. According to some individuals, many organizations are already making efforts to recruit and retain a more diverse workforce. These efforts include:

- Outreach and education to minority and rural junior high and high school students;
- Strategic plans for diversity;
- Advertising employment opportunities in diverse markets;
- Support for technical colleges;
- Minority representation on advisory boards and other committees; and
- Partnerships with other organizations (such as the Urban League) in outreach and advertising for open positions.

Despite such efforts, a number of interviewees reported that their organization's endeavors to improve workforce diversity have not been very successful to date. According to one individual:

Diversity has been a massive failure in Wisconsin...our population here is primarily white and, with disparities, African Americans in Wisconsin have not really had a chance to get in the workforce.

Another individual described some of the challenges of successfully recruiting and retaining a racially diverse workforce:

Our recruiting of African American[s] to Madison has not been very successful, nor has retention once they are here because, people haven't attended to their needs as well as they need be.

Many individuals expressed a need to expand such targeted recruitment efforts in the future. Interviewees suggested a number of methods of expansion, including: developing scholarships and stipends to support underrepresented groups pursuing careers in public health; utilizing organizations such as Area Health Education Centers (AHEC) to encourage students to consider jobs in the public health field and help establish a pipeline of students and future workers; and increasing the number of mentoring programs and career fairs for young children. Others suggested a need for a more systemic approach to preparing individuals for careers in the public health field—improving education. According to one interviewee, for example, it is difficult to attain a diverse workforce “because young minorities are not getting the science background that they need.”

### ***Cultural Competency***

The State Health Plan asserts that Wisconsin's public health workforce “must be culturally and linguistically competent to understand the needs and deliver services to diverse populations in all Wisconsin communities.”<sup>13</sup> One interviewee described cultural

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<sup>13</sup> (p. 34).

competency as “beliefs, behaviors, and patterns; the ability to distinguish between ethnicity and culture, [to] honor and respect beliefs, interpersonal thoughts, behaviors, and attitudes.” This individual also stressed the importance of *acting* on competency skills once they are attained. Another individual described cultural competency as a series of steps:

First, there need to [be] people who look like the target population. Second, is input of populations included in the design of the programs and interventions...it cannot be from the top down...Next, the willingness and ability to be flexible to change the interventions serving the population.

This interviewee went on to describe the actions they believe are prerequisites for attaining cultural competence in an organization:

Certainly language accessibility is key to cultural competence, willingness to step outside the stereotypes of numbers and look at the structure of the local community, ask leaders what works in their community and what does not.

A number of interviewees suggested Wisconsin’s public health system could be more culturally competent. Some individuals made specific suggestions to improve cultural competency, including:

- Actively placing individuals representing ethnic and racial minorities on advisory boards and/or committees;
- Involving these individuals in conference planning; and
- Pursuing feedback from diverse communities on how public health organizations can and do serve the needs of ethnic and racial minorities, especially in terms of quality.

One interviewee noted, “Until we get cultural representation in the designs of the programs, we are not really going to have programs that benefit equally people of diverse populations.” This sentiment was echoed by another interviewee:

We think we have all the answers because we have education, degrees, and all of this...but what about the people that are out there that we think we are meeting their needs and we are far from doing so...we must bring them in to help us measure what we are doing.

However, cultural competency (in terms of racial and ethnic diversity) is not a salient issue for every interviewee. Some interviewees referred instead to the importance of appropriately serving different socio-economic groups. According to one individual, for example:

Rural health departments in Wisconsin are still largely white; the local health departments have mostly white staff—this represents the racial and ethnic composition of their constituents...socio-economic disparities are more of an issue up north as is providing training about special needs of this population.

## *Workforce Education*

Few interviewees shared comments regarding the adequacy of public health educational programs in the state of Wisconsin. However, a number of individuals who shared insights in this area expressed concern about the location and cost of currently available educational opportunities. Others saw a need for increased coordination among campuses, between educational institutions and the state, and among disciplines.

A number of interviewees expressed excitement about the recent introduction of the Master's in Public Health (MPH) program at the University of Wisconsin School of Medicine and Public Health. However, many there also expressed concern that current educational opportunities for individuals outside Madison and Milwaukee are insufficient. One individual expressed particular displeasure that the MPH program is not currently offered online or through distance learning. Interviewees also expressed concern about the expense of educational programs (formal degree programs and continuing education). According to one individual, "Wisconsin does have quality programs for a good foundation [in public health] but the price is expensive which limits some minority students."

Interviewees noted similar barriers to continuing education opportunities in public health. According to one individual, for example, there has been, "less encouragement to attend continuing education and conferences" in the past few years. Others felt that continuing education courses are not convenient. Some classes, for example, are only offered during the day and others are not available online.

Finally, many saw a need for public health educational programs to branch out and collaborate with non-traditional public health partners. According to one individual, for example, there is a:

Need to infuse more public health principles and practices into a wide variety of professional programs, not only medicine in the formal health care fields, but also education and the like.

This sentiment was echoed by a call for improved coordination among educational institutions and state government. One individual, for example, suggested that improved coordination among Wisconsin's campuses is critical to building the public health workforce. Other individuals felt that the state could do a better job of informing their partners, technical schools, and colleges about the role of public health and in encouraging students to consider careers in the public health field.

## **DISCUSSION**

This report discusses 21 key informants' perceptions of Wisconsin's public health system in five distinct areas outlined by *Healthiest Wisconsin 2010*: 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. Specific insight into the perceived strengths and weaknesses of Wisconsin's public health system can serve as a guide for future activities in each of these areas. In addition, three underlying themes provide insight into deeper challenges facing Wisconsin's public health system: variations in interpretations of 'transformation;' divergence in understanding of the composition of Wisconsin's public health system; and disparities in data collection, financing, and health outcomes.

### **Transformation**

Interviewees articulated a number of different conceptual interpretations of transformation as it relates to Wisconsin's public health system. These interpretations can be placed into a continuum of opinion that ranges from a sweeping change of the systems underlying Wisconsin's public health system to an emphasis on the improvements in health care delivery and health outcomes resulting from such changes. Interviewees who subscribed to the 'systemic approach' to transformation emphasized the infrastructure priorities of the State Health Plan when describing transformation. Alternatively, those who viewed transformation in terms of health outcomes described it as movement towards a common vision, better coordination between local and state entities, and as embracing a broader concept of public health. Despite these differences in emphasis, most respondents agreed that transformation involves fundamental change and hard work.

This variance in the conceptualization of transformation and its indicators underscores the importance of crafting and using language that clearly links the infrastructure priorities to health outcomes when disseminating the State Health Plan. Clear, linking language is more than rhetoric; it can serve as a foundation for building support for implementation of activities to achieve the State Health Plan's infrastructure priorities. Moreover, it can help ensure that these priorities are broadly relevant to Wisconsin's public health community.

### **Public Health System**

Interviewees' definitions of 'public health system' and, by extension, 'public health workforce' also varied. 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.*<sup>14</sup>

However, interviews demonstrated that this definition is not universally accepted. For example, 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 significantly in their breadth. Some individuals focused on traditional public health roles such as epidemiology and surveillance, and spoke about a workforce comprised primarily of public sector employees; others described a public health workforce that includes a wide range of occupational sectors and professions.

This variation in opinion was particularly notable in its discussion of the relationship between health care and public health entities. While some individuals drew a sharp boundary between health care activities and public health, others saw a blending of activities into a shared field. This discrepancy was also referenced in the context of partnerships and workforce. For example, some interviewees focused on partnerships *with* health care providers such as hospitals and clinics while others viewed these entities as components of the same system. Moreover, some individuals who worked in clinical settings saw themselves as part of the public health system while others saw themselves as working closely *with* the public health system.

## **Disparities**

Interviewees noted disparities in Wisconsin’s data collection efforts and public health financing in addition to its health outcomes. Accessing information that captures race and ethnicity in a consistent format was one of the most common obstacles cited in data retrieval efforts. According to one interviewee, for example, “Everyone captures race and ethnicity in [a] different way, some do both, some one, some do not know the difference.” Many key informants asserted that capturing local information in a consistent format is critical to comparisons among different geographic areas and aggregate measures of disparities across the state.

Certainly, a lack of equitable and adequate financing perpetuates disparities in health outcomes. According to one interviewee, for example:

If we look at most of our health indicators, the disparities in Wisconsin regarding race, ethnicity, and probably poverty as well are greater than the equivalent disparities in the U.S. and are increasing in many areas...equitability in terms of health outcomes measurement has not taken place.

Addressing these disparities is an important component of a successful transformation, and a critical step on the path towards achieving the other overarching goals of *Healthiest Wisconsin 2010*: ‘Promote and protect health for all’ and ‘Eliminate health disparities.’

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<sup>14</sup> (p. 10).

## **Concluding Thoughts**

Although systemic changes were the foundation of this project, interviewees indicated that such changes are not intuitively appealing to some members of the public health system. Instead, a number of interviewees cited improvements in *health outcome* measures such as infant mortality, and morbidity and mortality; changes in access and populations served; and decreases in disparities as indicators of transformation. (These are being monitored by the Department of Health and Family Services and the UW Population Health Institute). These articulations are not contradictory; they simply emphasize different components of the transformation process. While some individuals focused on the processes of systemic change (the means), others highlighted the ends of this process— improved health outcomes and reduced disparities. This variation in emphasis reflects the State Health Plan’s integration of health and infrastructure priorities working in tandem to achieve the plan’s overarching goals.

# TRANSFORMATION PROCESS

## Assumptions

The public health system is defined broadly as a social enterprise between government, the people, and the public, private, non-profit and voluntary sectors to promote the health of everyone.

Wisconsin's public health system will continue to change in response to the state health plan, *HW2010*.

*HW2010s* infrastructure priorities are the engine for this transformation.

These infrastructure priorities will help the public health system build its capacity, promote and protect health for all, and eliminate health disparities.

This evaluation is informed by the dimensions of the national Turning Point evaluation.

## Activities

Strategies to secure financing to implement the state public health plan

Strategies to establish effective partnering relationships, represented by changes in depth, breadth, and penetration

Develop and implement community health improvement plans and processes (CHIPs)

Implement and adopt integrated electronic data system to measure public health needs, system capacity, and to track *HW2010*

Strategies to increase diversity and competency of public health workforce

## Characteristics of a transformed public health system

(1) More equitable, adequate, and stable public health financing from a broad base of funders; (2) Resource distribution parallels public health priorities

Increased strength and better fit between state and local public health systems

Work aligned to State Health Plan priorities in all sectors of the public health system, including: state, regional, local, public, private, non-profit, and community based organizations

Partners from multiple sectors of the public health system collaborate to create and promote healthy communities

Greater public participation in setting and supporting public health priorities

(1) Data is translated into good information; it is accessible and used by a broad audience to analyze priorities, aid in decision making, and resource distribution; (2) Programs are targeted cost effectively based on need

Wisconsin's public health system has a competent, diverse workforce

## Final Outcomes

**A TRANSFORMED PUBLIC HEALTH SYSTEM**

Improved Health System Capacity and Health Status

**Appendix B: Key Informant Characteristics**

	Health Care Organizations		Health Departments		Government/Policy		Other Sectors		Education
	Hospitals/Clinics/ Managed Care	Health care provider	State DHFS	Local HD	Other state agencies	Policy Makers	Non-Profit	Business	Schools and Universities
Rural									
Urban									
Statewide									
African American									
Hispanic									
American Indian									
Asian									
LGBT									

## **Appendix C: Interview Questionnaire**

1. When you think of transformation of the public health system in Wisconsin, what does that mean to you?
2. How might you measure it?

### **Equitable, adequate, and stable financing**

3. The State Health Plan lists “equitable, adequate, and stable financing” as one of its infrastructure priorities. What evidence have you seen—if any—that public health financing has become more equitable, adequate and/or stable over the past few years?
4. How has your organization’s allocation of resources (both time and money) changed in the past few years? How have these changes reflected transformation?
5. I’d like to ask you to reflect on your organization’s funding sources a few years ago as compared to its funding sources today. What changes do you notice?

### **Coordination of state and local public health system partners**

6. What types of organizations are represented in your organization’s partners? (government, private, non-profit, voluntary)
7. How have your organization’s partnerships/coalitions changed since the 2001 adoption of the State Health Plan?
  - Depth? (involvement of more than one representative from a partner organization)
  - Breadth? (Breadth includes non ‘public health’ partners)
  - Penetration? (extent to which the partnership’s work becomes the work of partner orgs)
  - Link to State Health Plan
8. Could you give an example of a successful partnership? What do you think makes it successful?

### **Community health improvement processes and plan (CHIPs)**

9. Could you describe your organization’s experience with community health improvement planning processes? How is your community involved? Who is involved? How do you use data in this process?

10. How is your organization's strategic planning related to community health improvement processes and plans? Provide examples.

### **Integrated electronic data and information systems**

11. When you think of integrated electronic data and information systems, what does that mean to you? What are its characteristics?

12. Describe your organization's use of health data systems.

- Use of data in priority setting? Decision making? Budgeting?
- How does your organization access the data you need to make informed decisions?
- How has your organization's access to public health data changed over the past few years?

13. Which analytical tools, if any, does your organization use to target its programs, evaluate its programs, plan, etc.? (e.g., evidence based practices, cost effectiveness analysis)?

### **Sufficient, competent workforce**

14. When you think of the public health workforce, who does that include?

15. What changes in the composition of Wisconsin's public health workforce have you noticed over the past few years? Can you give examples?

16. Diversity and competency in the public health workforce are often cited as important goals. What is your organization doing to increase diversity in its workforce? To increase competency in its workforce?

17. How adequate are Wisconsin's educational programs for preparing the public health workforce to address current and future community health challenges? Continuing education programs?