



Wisconsin's State Health Plan: Lessons Learned from Monitoring the Year 2000 Plan

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Improving Health by Translating Research into Practice



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The willingness of numerous DHFS staff to provide information for this paper is a clear indication of the Department’s commitment to improving health in Wisconsin. The intent of this paper is not criticize the Department’s past work in monitoring the state health plan, but to draw lessons for policymakers from that work. This undertaking would not be possible without the participation of the Department and we gratefully acknowledge the Department’s readiness to review the history of monitoring and participate in learning lessons from that history.

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Executive Summary

The Wisconsin Department of Health and Family Services (DHFS), together with its public and private partners, is considering strategies for monitoring *Healthiest Wisconsin 2010*, the state health plan. Discussions are occurring in a number of venues. In order to provide policymakers with analysis to inform their deliberations, this paper reviews monitoring of the state's year 2000 health plan, *Healthier People in Wisconsin, A Public Health Agenda for the Year 2000*, and identifies lessons learned from that process.

Healthier People in Wisconsin was developed by a group of more than 150 people, in a process organized by the Department. The plan identified the state's public health needs and had 321 measurable objectives. The plan had few objectives related to overall health status and health disparities.

At the state level, the 2000 plan provided organizational direction, identified priorities for program development and resource allocation, and mapped what health related data would need to be collected. At the local level, health departments and private health care organizations used the plan to provide baseline data for measuring progress and to serve as a guide for local health planning.

Funding for implementation of the 2000 plan was limited. While the Department facilitated the development of the plan, no state funding was set aside for the implementation or monitoring of the plan. Because the Department saw its role as facilitating development of the plan, much of the responsibility for implementation and monitoring was assumed by local governments and private organizations.

Wisconsin's public health statutes were revised in 1993, requiring DHFS to update the state health plan every ten years and assigning the Department responsibility for coordinating state activities relating to the collection, analysis and reporting of health information. However, the law does not require monitoring of the state health plan or reporting on progress towards objectives in the plan.

In 1995, public health officials in the Department commissioned a midcourse review of Wisconsin's progress toward meeting the objectives of the 2000 plan. This was the first formal attempt by the Department to assess progress toward the plan's objectives. Ultimately, the Department issued a report titled *Mid-Course Review: A Progress Report on the Healthier People in Wisconsin Year 2000 Agenda*, summarizing progress toward achieving the plan objectives.

The published version of the mid-course review was a checklist that placed each of the 321 objectives into one of four categories: objective has been met; progress is being made toward meeting the objective; progress is not being made toward meeting the objective; and data are not currently collected in Wisconsin to measure this objective. The report stated that 10% of the objectives were met, progress was being made for another 45%, no progress was being made for 17%, and no data was available for 28%.

The published version of the midcourse review provided a relatively simple format through which readers could easily ascertain progress on 321 health objectives. It used the same reporting categories as the federal health plan, making an easy comparison with national data possible. However, the simplicity of the format had drawbacks. From an evaluation perspective, it provided limited information for each objective (unlike the draft report) and did not report on trends in summary measures of health, such as mortality or health disparities.

After the mid-course review, monitoring of the 2000 plan gradually became fragmented, with individual units in the Department tracking selected objectives based on internal needs. Results were not widely distributed. As of October 2003, there has been no statewide review of progress towards objectives in the 2000 plan and no final report.

The major lessons from the history of monitoring *Healthier People in Wisconsin* can be summarized as follows:

- Although a broad-based group of over 150 individuals were active in the development of the state health plan, they were not organizationally suited for the task of monitoring progress.
- Neither state law, nor the health plan itself, specified who was responsible for monitoring progress toward health plan objectives. Nor was there clarity regarding what health measures were to be monitored, how often monitoring and reporting was to occur, and how the monitoring results were to be distributed.
- A lack of funding dedicated to the specific purpose of monitoring and reporting made monitoring activities difficult.
- There were substantial differences between a comprehensive internal mid-course review and the summary version that was published. As a result, the usefulness of the published information may have been diminished.
- A lack of data on many objectives made monitoring of those objectives impossible.

By highlighting these lessons learned during Wisconsin's experience in monitoring the *Healthier People 2000* plan, we hope that public health policymakers and the larger public health community will be able to improve monitoring of *Healthiest Wisconsin 2010*.

Wisconsin's State Health Plan: Lessons Learned from Monitoring the Year 2000 Plan

Introduction

The Wisconsin Department of Health and Family Services, and its public and private partners in the larger public health community, are considering strategies for monitoring the 2010 state health plan. Discussions are occurring in a number of venues.

In order to provide policymakers with analysis to inform their deliberations, this paper reviews monitoring of the state's year 2000 health plan, *Healthier People in Wisconsin, A Public Health Agenda for the Year 2000*, and identifies lessons learned from that process. It is not our intent to imply that the Department cannot (or should not) perform the monitoring of the state health plan or imply that others should take over this function.

The information and analysis for this report came from interviews with key individuals involved in the development, coordination, and tracking of *Healthier People in Wisconsin*. The interviews included staff from the Division of Public Health, the Office of Strategic Finance, and the Bureau of Health Information in the Department of Health and Family Services (DHFS).¹ Other interviews were with members of the original Public Health Agenda 2000 planning committee, technical advisors from the University of Wisconsin, and individuals from local health organizations. In addition to the interviews, background for this report included a limited analysis of Department documents and correspondence, which provided insight into the history and development of the 2000 plan. Finally, research included a comprehensive review of the Public Health Agenda 2000 mid-course evaluation and independent research conducted by graduate students at the University of Wisconsin, Department of Population Health.

The importance of monitoring the health status of Wisconsin residents and progress towards the health objectives in the 2010 plan cannot be overstated. Monitoring health outcomes can show progress in health status and risks, as well as improvement in health programs and systems. Conversely, monitoring can identify where effective approaches to health problems are known but not being implemented. Monitoring can also help illustrate what is not known, such as what data are missing, where there are no proven approaches for bringing about desired health outcomes, and where the distribution of significant public health problems has not been assessed. In short, monitoring allows us to know whether there is progress towards objectives, what we still do not know, and which populations, diseases or injuries, and health system areas need attention.

¹ The Department of Health and Human Services (DHSS) was renamed the Department of Health and Family Services (DHFS) in mid-1990s. In this paper we use both names interchangeably.

The health assessment process is one of establishing baseline information, monitoring changes, and evaluating the efficacy and efficiency of public health efforts intended to influence selected indicators or objectives. Part 1 of this paper recounts the state's monitoring efforts for the 2000 plan. Part 2 identifies lessons that could be learned from this history. Finally, Part 3 considers the lessons learned from monitoring the 2000 plan in light of some issues that could be considered when planning for monitoring of the 2010 plan.

Part 1:

History and Background

The Creation of *Healthier People in Wisconsin, a Public Health Agenda for the Year 2000*

The catalyst for the state's first health plan was an inquiry in 1987 from the State Assembly's Subcommittee on Maternal and Child Health (MCH) to the Department of Health and Social Services (DHSS) regarding the Department's long-range plan for MCH federal funds. From this simple beginning, health care leaders and government officials began a statewide initiative to develop a health plan for Wisconsin.

Wisconsin was not alone in developing a health plan. The concept of a coordinated agenda for health promotion and disease prevention was first established in 1979 in a report prepared by the Office of the Surgeon General. Since then, the federal government has regularly revised its agenda for national action. This work spurred similar efforts for the development of health plans at the state level and Wisconsin was one of 37 states that had health plans or specific objectives for the year 2000.²

Wisconsin's plan was created in 1989 and was titled *Healthier People in Wisconsin, A Public Health Agenda for the Year 2000*. More than 150 participants were involved in the development of the plan. Governor Thompson and DHSS Secretary Patricia Goodrich received the completed document on April 9, 1990.

Based in part on the federal *Healthy People 2000* plan, Wisconsin's 2000 plan had measurable goals and 321 specific objectives in seven sections that corresponded to the organizational structure of the Division of Health in DHSS: communicable diseases, chronic disease prevention, injury prevention, environmental health, reproductive/perinatal health, infant and child health, and adolescent health. Only limited objectives were included in areas outside the purview of the Division of Health, such as alcohol use and mental health.

Unlike the federal plan, however, Wisconsin's had few objectives related to health status, such as reducing health disparities and mortality among population segments. While the federal plan included objectives to reduce mortality among infants, children, young adults, and older adults, as well as to reduce health disparities, Wisconsin's 2000 plan included only one objective to reduce infant mortality and none for disparities.

² Public Health Foundation, *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey*. Washington, D.C., March 1998. 10 additional states had other documents with disease prevention and health promotion targets. Available on the Public Health Foundation's website: www.phf.org.

At the state level, *Healthier People in Wisconsin* also provided organizational direction, identified priorities for program development and resource allocation, and mapped what health related data would need to be collected. At the local level, health departments and private health care organizations used the plan to provide baseline data for measuring progress and to serve as a guide for local health planning.

Funding for implementation of the 2000 plan was limited. While DHSS facilitated the development of the plan, no state funding was set aside for the implementation or monitoring of the plan.

Because DHSS saw its role as facilitating development of the plan, much of the responsibility for implementation was transferred to local governments and private organizations. DHSS expected that governmental agencies and private health care organizations would work to meet the plan's objectives and that this devolution would make state funding unnecessary. To this end, DHSS held a statewide implementation conference in Wausau in June of 1990. At this conference, invited participants discussed implementation strategies and pledged the commitment of their respective organizations to select goals of the plan.

1993 Revision of the Public Health Statutes

In 1993, the Legislative Council's Special Committee on Public Health Statutes Revisions proposed a number of changes to the state's public health laws. One proposal, enacted into law later that year, requires the Department to lead the development of a state health plan at least once every 10 years and assume ongoing responsibility for it.

The revisions of the public health laws, as they relate to the state health plan, were incorporated into Chapter 250 of the Wisconsin Statutes. Section 250.07 says the Department shall:

- (1) At least once every 10 years, develop a successor document to healthier people in Wisconsin, a public health agenda for the year 2000, published by the department in February 1990.
- (2) Initiate, conduct and periodically evaluate a process for planning to use the resources of the state to meet the health needs of residents and, in conjunction with other state agencies, to implement the objectives that relate to state government in statutes or in public health rules promulgated by the department. The process shall involve representatives from public health organizations, governmental agencies and the general public.
- (3) Provide technical assistance to local units of government for the development of local public health plans.
- (4) Serve as the state lead agency in coordinating the activities within state government involving the collection, retrieval, analysis, reporting and publication of statistical information and other information related to health and health care.

Although the broad language of paragraph (4) makes the Department responsible for coordinating state activities that would be necessary for a status report on the state health plan, the statutes do not require such a report and are silent on state and local monitoring efforts.

State law requires DHFS to create a state health plan every ten years, but is silent on the issue of monitoring.

The Mid-Course Review of *Healthier People in Wisconsin, A Public Health Agenda for the Year 2000*

In 1995, public health officials in DHSS commissioned a midcourse review of Wisconsin's progress in meeting the objectives of the 2000 plan.³ This was the first formal attempt by the Department to assess progress towards the plan's objectives.

The Department drafted an extensive midcourse review. The Bureau of Public Health and the Office of Health Care Information collected and analyzed data available up to April 1995. This work allowed the Department to critically evaluate the extent to which the state had met each of the plan's objectives and to comment on whether success in meeting each objective was likely.

The Department developed a comprehensive report that provided detailed progress on each of the plan's 321 objectives. For each objective, the Department determined if there was progress or not, and if the objective had been or was likely to be reached. Departmental staff wrote detailed explanations of how they arrived at each assessment. These assessments were determined in part by small group meetings in which staff discussed why there was or was not progress, including the successes for each objective and barriers to further progress.

The comprehensive draft of the midcourse review was neither published nor made available in any other format. Instead, a summary report titled *Mid-Course Review: A Progress Report on the Healthier People in Wisconsin Year 2000 Agenda* was published.

The published version of the mid-course review was a comparatively simple checklist that placed each of the 321 objectives into one of four categories which mirrored those used to measure progress in the federal health plan. The four categories were:

- *Objective has been met.* (Data indicated that the objective had been met or exceeded.)
- *Progress is being made toward meeting the objective.* (Data suggested that there was discernable progress towards the objective or that it was likely to be met by the year 2000.)
- *Progress is not being made toward meeting the objective.* (Data indicated neither discernable progress toward reaching the objective nor a trend in the opposite direction.)
- *Data are not currently collected in Wisconsin to measure this objective.* (There was no data available to measure progress toward the objective.)

In 1995, DHSS developed a comprehensive report that provided detailed progress on each of the plan's 321 objectives. It was not published. Instead, a summary report was published.

³ Patrick Remington, currently Director of the Wisconsin Public Health and Health Policy Institute, was the DHSS Chief Medical Officer for Chronic Diseases at the time of the 1995 midcourse review. Remington was one of the lead staff involved in drafting the midcourse review.

Results of the Mid-Course Summary Review

As on the federal level and in other states, progress toward achieving the objectives of the 2000 plan was mixed. The summary review stated that 10% of the objectives were met, progress was being made for another 45%, no progress was being made for 17%, and no data was available for 28%.

Table 1 summarizes the results of the summary mid-course review for each of the seven major sections in the 2000 plan.

Table 1

Progress Toward the Objectives of *Healthier People in Wisconsin, A Public Health Agenda for the Year 2000*

Health Plan Section	Objective has been met	Progress is being made	Progress is not being made	Data not currently available	Total
Communicable Diseases	10 (20%)	17 (34%)	8 (16%)	15 (30%)	50 (100%)
Chronic Disease Prevention	3 (4%)	26 (34%)	23 (30%)	24 (32%)	76 (100%)
Injury Prevention	8 (14%)	20 (36%)	6 (11%)	22 (39%)	56 (100%)
Environmental Health	5 (15%)	24 (71%)	3 (9%)	2 (5%)	34 (100%)
Reproductive/Perinatal Health	4 (11%)	22 (61%)	5 (14%)	5 (14%)	36 (100%)
Infant and Child Health	2 (5%)	20 (50%)	0 (0%)	18 (45%)	40 (100%)
Adolescent Health	1 (4%)	14 (48%)	9 (31%)	5 (17%)	29 (100%)
TOTAL	33 (10%)	143 (45%)	54 (17%)	91 (28%)	321 (100%)

A Comparison of the Published and Unpublished Versions of the Midcourse Review

The published version of the midcourse review provided a relatively simple format through which readers could easily ascertain progress on over 300 health objectives. Moreover, by using the same reporting categories as the federal health plan, comparison with national data was possible.

However, the simplicity of the format had drawbacks. From a planning or decision-making point of view, it provided limited information. In addition, it did not highlight major issues concerning the health of the population, such as reducing mortality across the lifespan, improving quality of life, or reducing health disparities. The following comparisons between the summary review (published) and detailed review (unpublished) may give policymakers insight into the importance of detailed analysis and reporting of tracking data.⁴

Example 1:

Section 3 (Chronic Disease Prevention and Control), Chapter 2 (Cardiovascular Disease), Objective 2: Stroke mortality rate will be reduced to 32/100,000 population.

Published Report: Progress is being made toward this objective.

Unpublished Report: Since 1984-86, the age adjusted mortality rate for stroke declined from 48 per 100,000 to 43 per 100,000 in 1991-93. Without intervention, the rate is predicted to remain at 44 per 100,000 by 2000. More intensive efforts to detect and treat hypertension and reduce obesity are required to make progress towards reaching the objective.

Example 2:

Section 6 (Reproductive/Perinatal Health), Chapter 2 (Infant Mortality and Low Birth Weight), Objective 1: Infant mortality will be reduced to no more than 9 deaths per 1,000 live births, within any county, racial/ethnic or age group.

Published Report: Progress is being made toward this objective.

Unpublished Report: The infant mortality rate has declined from 8.6 in 1987 to 7.9 in 1994. Significant and unacceptable disparities between racial groups persist. For example, the black rate averaged about 2.3 times higher than the rate for whites during this period. It is likely that this objective will only be met for the white, non-Hispanic population.

A comparison between the summary review (published) and detailed review (unpublished) may give policymakers insight into the importance of detailed analysis and reporting of tracking data.

⁴ The text of the unpublished draft report was taken from the personal files of Patrick Remington, Director of the Wisconsin Public Health and Health Policy Institute.

Example 3:

Section 6 (Reproductive/Perinatal Health), Chapter 2 (Infant Mortality and Low Birth Weight), Objective 4: Women who obtain prenatal care during the first trimester of pregnancy will increase to 90%, within any county, racial/ethnic or age group.

Published Report: Progress is being made toward this objective.

Unpublished Report: The percentage of women who obtain prenatal care in the first trimester has remained steady during 1987–1994. Significant differences between racial groups have persisted, with rates for white women averaging about 25 percentage points above rates for black women and about 50 points above Indochinese women. Adolescents are less likely to get early prenatal care. During 1987–1994, the percentage of adolescents who obtained prenatal care in the first trimester averaged 60% compared to about 82% for all pregnant women. Although program activities have made progress in improving care delivery systems, it is likely that this objective will only be met for the non-Hispanic, non-adolescent white population.

Part 2:

Lessons Learned from Monitoring *Healthier People in Wisconsin, a Public Health Agenda for the Year 2000*

Healthier People in Wisconsin was an ambitious effort by the Department to improve the health of Wisconsin residents and many positive results came from the plan. The planning process strengthened links between the Department and its public and private partners and provided a process for identifying important public health issues in the state. The plan served as a guide for program development and resource allocation.

However, the plan was a mammoth undertaking, seeking nothing less than to improve the health of millions of people. Moreover, the plan was the first of its kind in Wisconsin and comparative models in other states and at the federal level were also new. It required a considerable commitment of time and resources from stakeholders at all levels and a high level of statistical and managerial expertise. The implementation and monitoring costs were significant and a commitment to the plan was difficult because of competing demands for limited resources within DHSS.

After the mid-course review, monitoring of the 2000 plan gradually became fragmented, with individual units in DHSS tracking selected objectives based on internal needs. Results were not widely distributed. As of October 2003, there has been no statewide review of progress towards objectives in the 2000 plan and no final report.

Several reasons can be identified for the diminished attention to the 2000 plan. *Healthier People in Wisconsin*, and the subsequent revisions of the public health statutes, did not assign responsibility for implementation and monitoring of the plan. In the end, DHSS played a "coaching" role and passed much of the leadership for implementation to the local public health community, largely without state funding. Eventually, the plan became a set of guidelines for local efforts rather than a coordinated statewide effort to improve the health of the public.

Much of the Department's commitment to, and leadership for, the 2000 plan, was compromised by reorganization and downsizing in the early 1990s, which left few champions for oversight of the plan and some uncertainty about the future of the Department's role in it. Effective monitoring would have required DHSS to systematically absorb oversight activities into the existing work of employees — a large and costly effort that was not supported by the Department's leaders.

In addition, funding for monitoring was limited since the Department's budget did not set aside funds for this specific purpose.

The midcourse review was a massive undertaking by Department staff, who believed that a centralized unit for oversight was needed. However, after reorganization, any ability to centralize data collection was lost. Reorganization also created communication and system barriers that made oversight, data collection, tracking, and reporting difficult.

Some data did not exist. The midcourse review revealed that Wisconsin lacked data to measure progress for 91 (28%) of the plan's objectives — a disappointing finding, but one that could be found in other states too. Since then, DHFS has improved its data collection systems, but some Department staff contend that funding for these systems, and their capability to measure progress toward health plan objectives, has actually decreased.

The mid-course review of the 2000 plan revealed other disappointing outcomes, which may be one reason DHSS published a simplified, summary progress report rather than a finalized version of the comprehensive draft report. As the 1990s progressed, it became an increasingly difficult to keep *Healthier People in Wisconsin* on the political radar screen. Other people say that with 321 objectives to track, the 2000 plan was unmanageable and that DHSS simply did not have the resources to follow through.

The major lessons from the history of monitoring *Healthier People in Wisconsin* can be summarized as follows:

- Although a broad-based group of over 150 individuals were active in the development of the state health plan, they were not organizationally suited for the task of monitoring progress.
- Neither state law, nor the health plan itself, specified who was responsible for monitoring progress toward health plan objectives. Nor was there clarity regarding what health measures were to be monitored, how often monitoring and reporting was to occur, and how the monitoring results were to be distributed.
- A lack of funding dedicated to the specific purpose of monitoring and reporting made monitoring activities difficult.
- There were substantial differences between a comprehensive internal mid-course review and the summary version that was published. As a result, the usefulness of the published information may have been diminished.
- A lack of data on many objectives made monitoring of progress impossible.

Part 3:

Monitoring of *Healthiest Wisconsin 2010*

In addition to the lessons outlined above, policymakers may learn other lessons about monitoring the state health plan through an understanding of how other states used and monitored their health plans. This section of the paper provides information on year 2000 health plans in other states and how Wisconsin compared to those states. It also includes a brief discussion of national recommendations for monitoring and highlights specific monitoring issues facing Wisconsin.

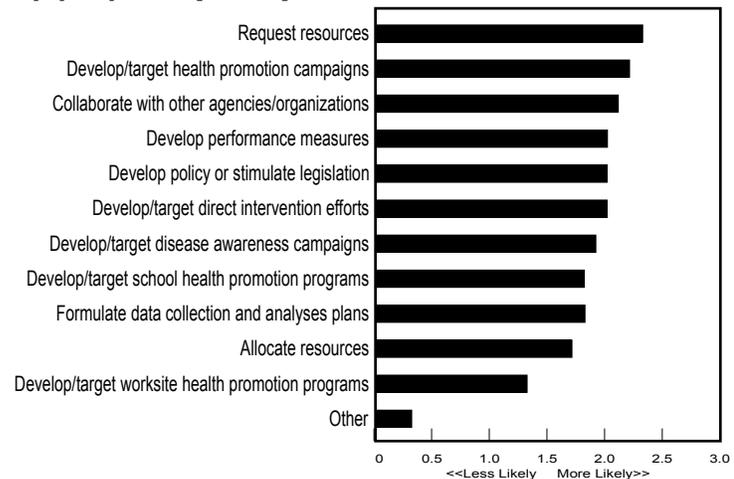
Setting and Using Health Plan Objectives

The Public Health Foundation, a non-partisan organization based in Washington, D.C., has published a national study titled *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey*. According to this study, Wisconsin was one of 37 states that had state health plans or objectives for the year 2000. All of these states used the federal health plan (*Healthy People 2000*) to help set their objectives to some extent. Thirty-three states reporting using the federal plan substantially and 22 of these indicated that most or all of their published health objectives used the same measure as the federal plan. The number of objectives among state plans ranged from 20 to over 300. Illinois had 790 objectives and Wisconsin, with 321 objectives, was in the upper range.

The Public Health Foundation study also shows for what purposes states used their health plan objectives (Figure 1). These uses obviously impact what kind of monitoring is desirable.

Figure 1

Likelihood of using objectives in state health plans, by purpose (N=45)



Source: Public Health Foundation, 1998.

State agencies were overwhelmingly responsible for collecting or managing the collection of the tracking data for year 2000 health plan objectives.

Measuring Objectives: Who Collects, Analyzes, and Publishes Data?

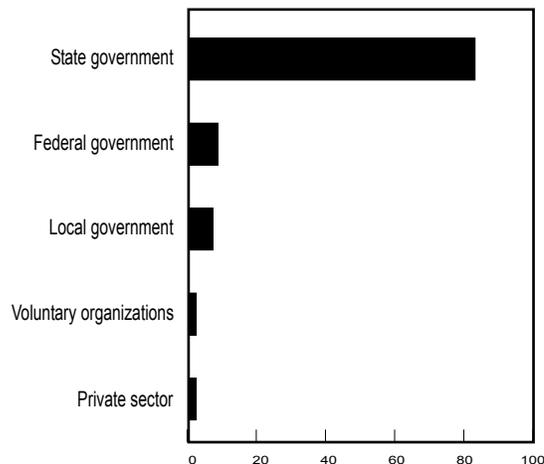
According to the Public Health Foundation study, state agencies were overwhelmingly (82%) responsible for collecting or managing the collection of the tracking data for year 2000 health plan objectives (Figure 2). The remaining 18% used federal, local, voluntary and private organizations for that role.

In Wisconsin, the state collects and manages most of the data necessary for evaluating progress toward state health plan objectives. As noted above, state law requires DHFS to serve as the lead state agency in the collection, retrieval, analysis, reporting and dissemination of data related to the state health plan. Moreover, the Department has the capacity to centralize those activities, which would help track behavioral objectives that cross program categories. For example, tobacco and alcohol use and obesity are major risk factors that affect multiple health outcomes and monitoring of plan objectives related to these factors should not be limited by program categories.

However, state law does not require the Department to monitor the state health plan and is silent on the role of the larger public health community (acting through groups like the Public Health Advisory Council). Therefore, while the Department may seem like the natural body to monitor *Healthiest Wisconsin 2010*, state law does not provide the clarity regarding responsibility for monitoring that was lacking in the 2000 plan.

Figure 2

Who collected data for year 2000 state health plans



Source: Public Health Foundation, 1998.

2003 Senate Bill 120 would formalize in state law the role of the Public Health Advisory Council. This bill is a product of the Joint Legislative Council's 2002 Special Committee on the Public Health System's Response to Terrorism and Public Health Emergencies. The bill would require the Public Health Advisory Council to advise the governor, legislature, DHFS, and the public on progress in implementing the state health plan.

However, the bill does not resolve all of the problems identified in monitoring of the 2000 plan. It does not specify what measures of health should be monitored, at what intervals monitoring and reporting should occur, nor does it allocate funding for the purpose of monitoring. Most importantly, it is not clear whether this bill will even be enacted into law.

Measuring Objectives: What to Monitor?

State health plans are an objective statewide evaluation of health from three important perspectives: the health status of the people in the state, the major health risks they face, and the systems that exist to protect and improve their health. They provide an overview of what is known and how to approach public health problems, using data and information for informed decision-making. Some, but not all, state plans contain policy guidelines or priority lists of recommended actions.

Most states, like the federal government, include demographic information on the population, their overall morbidity and mortality experience, and other general measures. States can use this information to develop disease prevention and health promotion efforts that are likely to affect multiple health-related outcomes.

Different measures of health can be included in state health plans. Outcome measures, including total deaths, leading causes of death, life expectancy, self-reported health status and hospitalization rates are generally included. This information is readily available from vital statistics and hospital discharge data. Trends over time and breakdowns by age, gender, race and ethnicity are often also included. Major risk and protective factors, such substance abuse and health behaviors, are also tracked and readily available from the Behavioral Risk Factor Surveillance System. Finally, state objectives often cover a range of "sentinel" events such as infectious disease, non-infectious disease, violence and injury, family and individual health, environmental health, and health systems.

Policymakers in DHFS and in the larger public health community need to decide what measures of health should be monitored to measure progress toward the objectives in *Healthiest Wisconsin 2010*. Ideally, some combination of specific plan objectives, together with measurements of health status and disparities, would be monitored.

This would be a departure from monitoring of the 2000 plan, which focused only on plan objectives and provided no information on measures of health status and health outcomes. If such measures are not tracked, the health community may overlook important health issues and programs designed to address such issues.

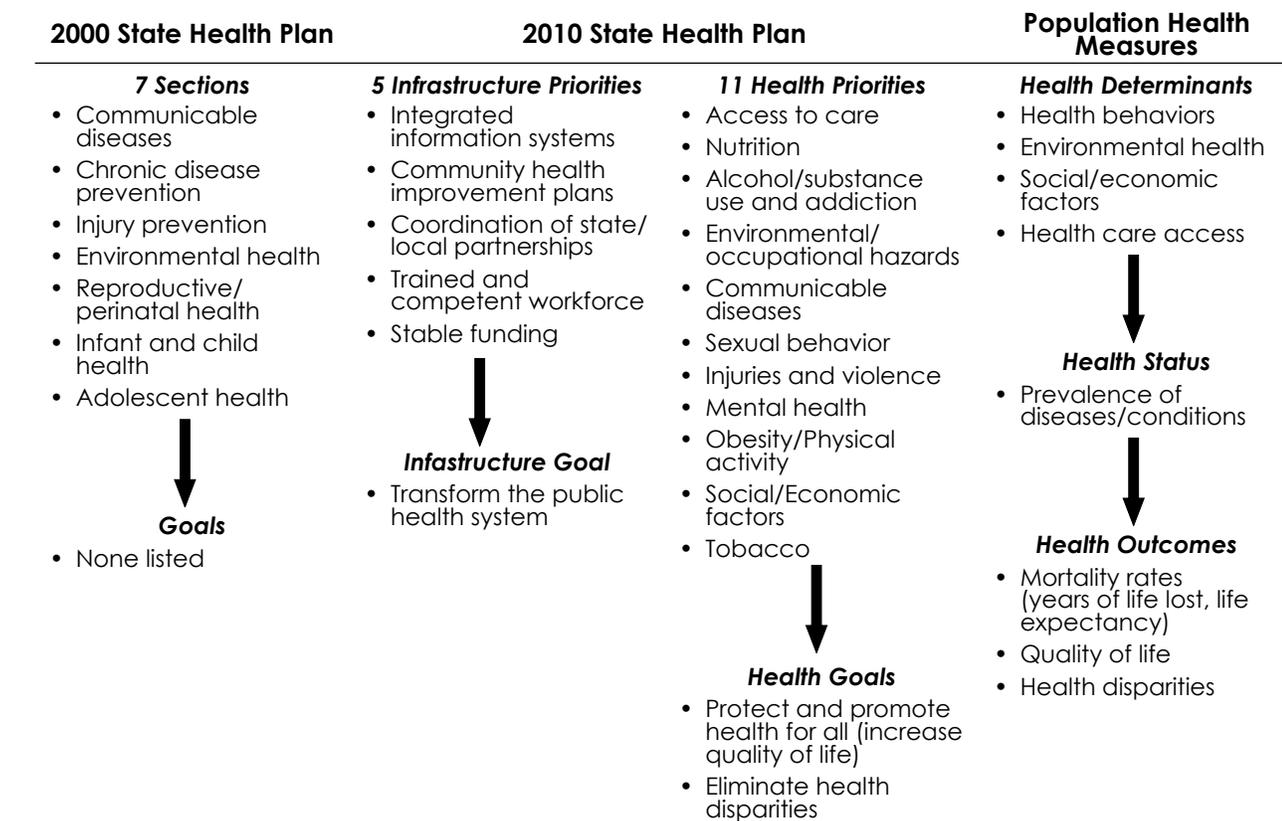
Ideally, some combination of specific plan objectives, together with measurements of health status and disparities, would be monitored.

For example, in 2003, students in the Department of Population Health at the University of Wisconsin analyzed trends in overall mortality, infant and neonatal mortality, and mortality among children and adults in Wisconsin. One of the major findings of these studies is that although mortality rates have declined in every age group over the decade, health disparities, as reflected in mortality data, have actually increased, especially among African Americans in Wisconsin.⁵

Figure 3 compares health measures in Wisconsin's 2000 and 2010 health plans with common public health measures that states often use to monitor the health of their populations.

Figure 3

Linking state health plan goals and objectives to measures of population health in Wisconsin



Source: Wisconsin Public Health and Health Policy Institute, 2003.

⁵ Results of the students' work are summarized in Dranger, E, P Remington, and P Peppard, *Progress in Reducing Mortality Among Wisconsin Residents, 1980-2000: Rates Decline, but Disparities Increase*. Madison: Wisconsin Public Health and Health Policy Institute. Working Paper, October 2003.

What to Monitor: Infrastructure Priorities

Unlike the year 2000 plan, *Healthiest Wisconsin 2010* also includes one goal (transform the public health system) and five priorities that are aimed at improving the public health infrastructure in the state. Infrastructure is important because it contributes to the resources and capacity necessary for addressing the health priorities and effecting change in population health status. Thus, policymakers may also want to consider how to monitor the extent to which the infrastructure priorities are addressed over the decade and the extent to which they contribute to realizing the health priority objectives.

Measuring Objectives: How Often and How are the Results Disseminated?

According to the Public Health Foundation study, two-thirds of the states updated their year 2000 tracking data annually and most revised and updated their state plans at least every two years. Wisconsin was among the 19% of states that tracked once or did not track at all.

The Public Health Foundation study suggests that, at minimum, states should track health problems and outcomes using a core set of health indicators to create a report card that can be monitored on a continual basis. One of the reasons for this recommendation is that a constant flow of information can inspire and challenge people to reach targeted goals. In addition, more frequent monitoring could help by providing information to aid with both state and local planning and resource allocation.

Policymakers may also want to consider how progress is reported. The experience of monitoring and reporting on the 2000 plan indicates that in the absence of a specific monitoring and reporting schedule, these activities will not occur. Instead, monitoring will be fragmented and no reporting will occur.

Moreover, policymakers may want to consider what kind of reporting occurs. The substantial differences between the draft and published mid-course reviews for the 2000 plan show that the kind of reporting affects the usefulness of the information that is conveyed. Ideally, monitoring *Healthiest Wisconsin 2010* would help with the allocation of resources, collaboration among different state agencies and with local governments, and the development of health campaigns and other policy initiatives. However, to serve this purpose, the monitoring information that is reported must be of sufficient detail to provide help with these goals.

Unlike the year 2000 plan, Healthiest Wisconsin 2010 also includes one goal and five priorities that are aimed at improving the public health infrastructure in the state.

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Measuring Objectives: Baseline Data

Baseline data is critical for measuring progress. Not surprisingly, the Public Health Foundation study reports that approximately three-quarters of the states with health plans indicated that the availability of baseline data influenced the selection of their health objectives.

While baseline data were available for most of states' objectives at the time, over half of the data were three or more years old and generally not available at the local level. Vital statistics was the most frequently used source for baseline data, followed by the Behavioral Risk Factor Surveillance System, Notifiable Disease Reports, or other public sources of data. Wisconsin was among four states where the private sector was a significant source of data, but also had little success in developing new baseline data sources.

According to the Public Health Foundation study, timeliness of states' tracking data improved over baseline data, with only 25% of tracking data being three or more years old or unusable. However, 50% of the tracking data for a small number of localities was four or more years old or unusable and among those was Milwaukee.

Moreover, Wisconsin's mid-course review acknowledged that no data was available for measuring progress towards 91 of the 2000 plan's 321 objectives (28%).

Given these limitations in currently available data, policymakers may want to consider what baseline data is needed to accurately measure progress towards the objectives in *Healthiest Wisconsin 2010* and how that data can be obtained.

Wisconsin's mid-course review acknowledged that no data was available for measuring progress towards 91 of the year 2000 plan's 321 objectives.

Conclusion

The intent of this paper is to review the history of monitoring for the 321 objectives in *Healthier People in Wisconsin, A Public Health Agenda for the Year 2000*. By writing this history, we hope to highlight lessons from that monitoring process that may shed light on current discussions regarding monitoring of the current state health plan, *Healthiest Wisconsin 2010*.

Monitoring is one of the core functions of public health and is administratively important from the view of accountability, resource allocation and program planning. For the health of our state and for the efficient use of limited resources, effective monitoring of the 2010 state health plan is essential.

Hopefully we can learn from past experiences to improve monitoring of the 2010 plan.