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Details: INFORMATIONAL HEARING FOR PROPOSED PUBLIC HEALTH INSTITUTE

(FORM UPDATED: 07/12/2010)

WISCONSIN STATE LEGISLATURE ... PUBLIC HEARING - COMMITTEE RECORDS

2005-06

(session year)

Assembly

(Assembly, Senate or Joint)

Committee on ... Public Health (AC-PH)

COMMITTEE NOTICES ...

- *Committee Reports ... CR*
- *Executive Sessions ... ES*
- *Public Hearings ... PH*
- *Record of Comm. Proceedings ... RCP*

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- *Appointments ... Appt*
- *Clearinghouse Rules ... CRule*
- *Hearing Records ... bills and resolutions*
(ab = Assembly Bill) (ar = Assembly Resolution) (ajr = Assembly Joint Resolution)
(sb = Senate Bill) (sr = Senate Resolution) (sfr = Senate Joint Resolution)
- *Miscellaneous ... Misc*

NO HARD COPIES WILL BE SENT.

Assembly

INFORMATIONAL HEARING

Committee on Public Health

The committee will hold a public hearing on the following items at the time specified below:

Wednesday, February 9, 2005

1:00 PM

415 Northwest
State Capitol

Proposed Public Health Institute

Last November, a Department of Health and Family Services Committee presented a report on options for a Public Health Institute in Wisconsin. This informational hearing will give various players in public health an opportunity to discuss the options available to Wisconsin.

The Committee will hear invited testimony from the following individuals:

Susan Wood, Department of Health and Family Services

Sue Garman, The Wisconsin Institute for Public Health/The Public Health Service Corporation of WI

Sarah Beversdorf, Wisconsin Public Health Association

Kathy Munsey, WI Assn. Of Local Health Departments and Boards

Mary Jo Baisch, UWM School of Nursing

Kathy Kuhn, Medical College of WI

Ellen L. Rautenberg, Medical and Health Research Association of New York City, Inc.

Michael Nazarko, the Executive Director for Health Research, Inc.

Representative J.A. Hines
Chair

Committee Meeting Attendance Sheet

Committee on Public Health

Date: 2/9/05

Meeting Type: Informational Hearing

Location: 415 NW

<u>Committee Member</u>	<u>Present</u>	<u>Absent</u>	<u>Excused</u>
Representative J.A. Hines, Chair	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative Gregg Underheim	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Representative John Townsend	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative Stephen Freese	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative Terri McCormick	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative Sheldon Wasserman	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative Tamara Grigsby	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Representative Charles Benedict	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Totals: 7 0 1

Carolyn Hughes
Carolyn Hughes
Committee Clerk

5089
239





DIVISION OF PUBLIC HEALTH

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Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

November 8, 2004

To: Helene Nelson
Secretary

From: Susan Wood
Director, Bureau of Health Information and Policy

Re: Report on Options for a Public Health Institute in Wisconsin

This report presents options for a Wisconsin Public Health Institute for your consideration. The purpose is to identify ways to strengthen the current public health system so that we are better prepared to achieve the goals set in the state health plan and to grow public health capacity outside of the government sector. This is viewed as one way to transform the public health system, one of the three overarching goals in the state health plan.

It is a companion to the report issued May 14, 2004 that addressed a number of organizational issues and the pros and cons of two structural options for an institute. The options in this report are presented in a matrix comparing mission, financing, rationale, pros and cons. There is also a two-page proposal from WPHA dated October 16, 2004 that is attached, and described as option #2 in the matrix. This report does not estimate costs for an institute, either for start-up or to sustain the organization. It also does not identify the potential that each of these options has to impact the number of state employees. The committee did not address either issue in any detail.

These options have been reviewed with members of the public health institute committee. This is the group that prepared the May report, with five new members added to represent the view points of the Medical College of Wisconsin, the State Medical Society, the University of Wisconsin Medical School, the Wisconsin Public Health Association and the Wisconsin Association of Local Health Departments and Boards. All of the committee members support the proposal from WPHA but have varied opinions about the other options. I am providing all of the options that were considered so that you have the full benefit of our review. These options are not mutually exclusive and we could pursue multiple options, or combine several of the options to develop an organization with broader scope.

In addition to the thoughtful work of the committee members, we have also benefited from the advice received from our staff and from people around the state including at four public forums that were held in September in Appleton, Milwaukee, Onalaska and Rice Lake. Two of these sessions were broadcast live on the Internet and then available on demand for later viewing. A summary of the comments received at the forums, and afterwards, was shared with the committee.

On behalf of the committee, thank you for the opportunity to work on this issue.

Committee Members:

Henry Anderson, DPH Chief Medical Officer
Mary Jo Baisch of the UWM School of Nursing
Terry Brandenburg, West Allis Health Officer
Fred Bove, Interim Director, DHFS Office of Strategic Finance
Cathy Frey of the UW Medical School
Millie Jones, DPH, Director of the Bureau of Community Health Promotion
Murray Katcher, DPH Chief Medical Officer
Kathy Kuhn of the Medical College of Wisconsin
Ron Laessig, State Lab of Hygiene
Doug Mormann, representing WALHDAB
Julie Patefield Halvorsen, representing WPHA
Pat Remington, UW Medical School
Margaret Taylor, DPH, Director of the Bureau of Local Health Support and Emergency Medical Services
Susan Turney of the State Medical Society

cc: Committee members
Mark Moody
Herb Bostrom

Public Health Institute Options
Final Report November 8, 2004

OPTIONS	MISSION	STRUCTURE	POSSIBLE FUNDING	RATIONALE	PROS	CONS	OTHER ISSUES
<p>1. Do not create a new organization at this time and/or use existing organizations to fill gaps in the current system.</p>		<p>DHFS contracts with community-based organizations and universities.</p>	<p>Existing grants and new grants used to fund contracts.</p>	<p>Many of the speakers at the forums were concerned about the timing of planning for an institute at the same time that there is a commitment to reduce the size of state government. There is also concern that it will weaken rather than strengthen the public health system in Wisconsin at a time when there are very serious health problems to address.</p>	<p>It should reassure concerned parties that the idea of an institute is not just a way to cut the size of state government. There is a risk that embarking on a major structural change in the state's delivery system for public health could interfere with progress in achieving the goals set in the state health plan. As a number of entities are now doing some aspects of what an institute could do, there is a danger of more fragmentation in the system. A new institute would not be competing with existing entities that could also do some or all of the work envisioned for an institute. Provides more time to do a thorough feasibility study of the unmet needs/gaps. Would not need to fund a new administrative structure.</p>	<p>We lose the opportunity to expand the resources to apply to the public health system and to the urgent health problems in our state. A stand-alone institute could give us a competitive edge despite all the groups that are now part of the delivery system. We lose the nimbleness that other states now have to attract federal and foundation grants to solve the state's public health problems. Wisconsin is unlikely to increase its share of federal funds. We now are about average in terms of the federal funds received from the Department of Health and Human Services.</p>	

Public Health Institute Options
Final Report November 8, 2004

OPTIONS	MISSION	STRUCTURE	POSSIBLE FUNDING	RATIONALE	PROS	CONS	OTHER ISSUES
<p>2. Incubator -- WPHA model "Wisconsin Idea Public Health Incubator" (WIPHI).</p>	<p>Purpose is to grow new ideas that can lead to large awards and other opportunities for Wisconsin's public health system by convening DPH, existing institutes and academic partners.</p>	<p>A new not-for-profit organization or a new arm of an existing not-for-profit organization. WPHA has offered to lead this development effort over the next two years.</p>	<p>Foundations Blue Cross dollars could be explored as a primary base-funding source. A broader funding portfolio would be developed in the first three years of operation.</p>	<p>The whole public health system and the population would benefit from a WIPHI, including the Department of Health and Family Services, which would be a major "customer" to which such an entity would respond. The WIPHI could encourage development of new ideas related to functions like those recommended by the first PHI committee -- such as research, evaluation, partnership promotion, education regarding emerging health issues, promotion of social and economic conditions that support good health, analysis of health status data and development of a public health workforce that is diverse and excellent.</p>	<p>This has the support of all members of the committee, the WPHA, WEHA and WALHDAB, the directors of both of the existing University-based Institutes and several other health officers. An incremental approach is easier to manage. WPHA's offer of leadership means that there would be less emphasis on DHFS doing this just to downsize state government.</p>	<p>It is a modest proposal in the short term, so that the impact would not be felt for two to four years -- although the planning process could be accelerated if adequate funding is provided.</p>	<p>WPHA is extremely interested in leading this development effort and believes that a model could be developed within a two-year period. A board made up of some of the best public health minds in Wisconsin would advise the WIPHI. One key reference for determining priorities would be Healthiest Wisconsin 2010 and subsequent comprehensive health planning documents. This model is a good fit with some of the other options, especially # 4, 5 and 6.</p>

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OPTIONS	MISSION	STRUCTURE	POSSIBLE FUNDING	RATIONALE	PROS	CONS	OTHER ISSUES
<p>3. Public/Private Health Information Network.</p>	<p>Purpose is to create a health information collaborative with four domains: -Health care provider - Personal health - Population health (preventive medicine) -Research and clinical trials</p> <p>Provide accurate, complete and publicly available health information to assess progress and outcomes in relation to the goals in the state health plan and to improve health care quality and safety statewide, improve efficiency and effectiveness of the health care system, and lower costs for health care.</p> <p>Expand opportunities for universities and the private sector for research and clinical trials.</p>	<p>A new not-for-profit organization; a newly created public health authority; or as an arm of an existing organization such as the Collaborative for HealthCare Quality.</p> <p>Data collection and reporting cannot be the sole responsibility of either purchasers or providers but it can be done by a trusted neutral entity that can apply and enforce consistent standards.</p>	<p>Assess a fee to health care professionals.</p> <p>Assess a fee to participating health care providers.</p> <p>Health care payers.</p> <p>Pharmaceutical companies.</p> <p>Foundations.</p> <p>Eventually -- health care savings in the Medicaid program.</p> <p>May be able to compete for Blue Cross funds in the future.</p>	<p>The state health plan, Healthiest Wisconsin 2010, identifies integrated electronic data and information systems as one of the five system priorities needed to build capacity in the public health service delivery system so that health status goals can be achieved.</p> <p>There is a very serious national problem with the safety and quality of health care that, unless addressed, is an enormous barrier to achieving the goals in our state health plan for safe and healthy people. In a significant number of cases, clinical care is duplicative, fails to improve health and even makes it worse.</p> <p>Health information technology is widely viewed as the most promising option to address this problem.</p> <p>(Continued on page 4)</p>	<p>All sectors will benefit from a system that has the appropriate information, supported by health information systems that are designed to produce care that is safe, effective, patient-centered, timely, efficient and equitable and thereby improve population health.</p> <p>Without accessible and centralized data there is no way to understand how medical services are priced and no way of comparing process or outcome performance.</p> <p>We have a fragmented and incomplete set of health information in Wisconsin including local data to track progress on the state health plan. This is a way to remedy this situation.</p> <p>Health care service data needs to be linked to population health data in the public health system to provide good decision support for clinicians and for policy makers.</p> <p>(Continued on page 4)</p>	<p>There are now several private efforts underway to publish information about cost and quality of health care services - this could be seen as competition with these initiatives.</p>	<p>This institute could also be charged with responsibility to evaluate the effectiveness, accessibility and quality of health services including developing new data sources to meet evaluation needs.</p> <p>There is considerable interest in this area based on the forums.</p> <p>Local data is especially important for measuring progress on health goals at the community level and there is clearly a gap in this area.</p>

Public Health Institute Options
 Final Report November 8, 2004

OPTIONS	MISSION	STRUCTURE	POSSIBLE FUNDING	RATIONALE	PROS	CONS	OTHER ISSUES
<p>3. (Continued) Public/Private Health Information Network.</p>				<p>In 2001 the Institute of Medicine (IOM) identified health information technology as a critical environmental force that can significantly improve health care quality. In 2003 the IOM, in <i>The Future of Public Health in the 21st Century</i>, found that "existing information networks make it difficult and sometimes impossible for governmental public health agencies to exchange information and communicate effectively with the health care delivery system for the purpose of surveillance, reporting and appropriately responding to threats to the public's health."</p> <p>The IOM, the National Committee on Vital & Health Statistics and the President's Information Technology Advisory Committee are promoting adoption of electronic health records and the creation of regional health information organizations (RHIOs) as an effective strategy to improve population health.</p>	<p>Timing is good because there is so much interest in this area and federal support to conduct regional demonstrations.</p> <p>Strongest method to secure financial resources and technology necessary to create integrated public health information systems.</p> <p>There are now several private efforts underway to publish information about cost and quality of health care services – one of these entities could become the basis for this institute.</p> <p>Institute could be more nimble than government and therefore able to respond quickly as technology changes.</p> <p>Provides an excellent opportunity to link business groups and purchasers with the public health system.</p>		

Public Health Institute Options
 Final Report November 8, 2004

OPTIONS	MISSION	STRUCTURE	POSSIBLE FUNDING	RATIONALE	PROS	CONS	OTHER ISSUES
4. Fundraising/ grant writing collaborative.	Purpose is to coordinate efforts of the various schools and foundations in terms of grant seeking and grant writing with DPH to assure that Wisconsin gets the maximum amount of federal grant funds for population health.	Jointly managed by some combination of the Medical College of Wisconsin, the Marquette Dental School, the Marshfield Research Foundation, the UW Foundation, the UW Medical, Veterinary and Pharmacy Schools, major Wisconsin nursing schools, the VA and DHFS.	Jointly funded by the institutions that participate. May be able to compete for Blue Cross funds in the future.	Wisconsin is about average in terms of the federal funds received from the Department of Health and Human Services. Grant writing capacity in the public sector has diminished as government is downsized. A coordinated focus on grant writing by experts will result in an increase in federal funds for population health and help to coordinate the efforts of the various schools and foundations.	Increase federal revenue to Wisconsin. Improve coordination across the public health related institutions, so that research is focused squarely on the population health goals in the state health plan.	The implementation activities for the grants would have to be contracted out, which could cause some fragmentation.	This is the model recommended by Representatives Freese, Hines and Wasserman. This function could be combined easily with other models.

Public Health Institute Options
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5. Public Health Workforce Development	Evaluate and address the barriers to an adequate workforce.	Not-for-profit or an arm of an existing organization.	May be able to compete for Blue Cross funds in the future.	<p>This is one of the five infrastructure priorities in the state health plan. It was cited frequently by people who participated in the forums as an appropriate function for an institute if one is developed.</p> <p>The Institute of Medicine - in the 2003 book <i>The Future of Public Health in the 21st Century</i> - notes that "the public health workforce must have appropriate education and training to perform its role. Today, a majority of governmental public health workers have little or no training in public health."</p>	<p>An institute could maintain an ongoing assessment of the current workforce in terms of the supply and demand.</p> <p>It could assess training needs and help to identify resources to meet these needs.</p> <p>Could support ongoing national efforts to credential the public health workforce and for strengthening the core competencies of current staff.</p> <p>Core competencies are needed for public health preparedness.</p>	<p>This is a more specialized mission than the other options and less likely to evolve over time.</p> <p>There is concern that this would duplicate existing efforts. We have the AHEC system in Wisconsin with a similar mission and new programs starting at UW to support workforce development and leadership development so this may not be necessary.</p> <p>The two medical schools have agreed to develop a Public Health Leadership Institute for Wisconsin that may fill some or all of these functions.</p>	<p>The committee felt that this was not as high a priority as other ideas at this time.</p> <p>To build upon existing resources, a consortium of public health researchers from participating academic institutions could be formed. There are models that already exist in community-based education research.</p>

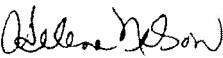
Public Health Institute Options
Final Report November 8, 2004

OPTIONS	MISSION	STRUCTURE	POSSIBLE FUNDING	RATIONALE	PROS	CONS	OTHER ISSUES
6. Prevention research and coordination organization.	<p>Expand the use of evidence-based, population-based approaches to community health improvement.</p> <p>Promote collaboration between employers and business groups on issues of population health.</p> <p>Expand opportunities for universities and the private sector for research and clinical trials.</p> <p>Develop and coordinate statewide public and private intervention strategies to assure maximum population impact.</p> <p>Serve as a convener and facilitator to bring stakeholders together.</p>	<p>University based; a not-for-profit corporation, or a public health authority.</p>	<p>Pharmaceutical companies.</p> <p>Foundations.</p> <p>Assess a fee to health care professionals.</p> <p>Private donations.</p> <p>Assess a fee to participating health care providers.</p> <p>Eventually – health care savings in the Medicaid program.</p> <p>May be able to tap into MA administrative funds for part of the work.</p> <p>May be able to compete for Blue Cross funds in the future.</p>	<p>There is a pressing need for research to establish evidence-based practices that improve population health and to disseminate what is known about evidence-based practices in an organized and effective way.</p> <p>Disease management strategies that are evidence-based can be targeted to priorities in the state health plan, and implemented on a statewide basis.</p> <p>For example, the organization could sponsor statewide research and interventions on access-to-care issues.</p> <p>For example, limited health literacy is associated with more severe disease and more costly care. The estimated range from \$29B to \$73B annually in the US.</p> <p>Wisconsin is 1.8% of the US population so the impact on Wisconsin is \$52M to \$131M annually.</p>	<p>This would fill a huge gap in the current public health delivery system.</p> <p>Provides an excellent opportunity to link up business groups and purchasers with the public health system.</p> <p>Could tap into Medicaid federal match to help promote and coordinate the use of disease management strategies.</p> <p>The state government cannot do this alone.</p> <p>Supports efforts to take a life-span approach to prevention.</p> <p>Long-term care is one area that would benefit. Properly implemented, population-based prevention strategies can reduce demand and improve quality of life. This has the potential to generate significant cost avoidance for both government and private payers as the older population increases over the next 20 – 30 years.</p>	<p>To the extent there is already organized activity to address this problem there may be some redundancy by creating a new entity for this purpose.</p> <p>In the health literacy area, UWM has a focus on this area, and the report from the 2003 Wisconsin Economic Summit called on the UW System to spearhead a statewide health literacy campaign, using the resources of University Extension.</p>	



State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

DATE: November 15, 2004
TO: Public Health Institute Committee
FROM: Helene Nelson

SUBJECT: Response to Your Report

I want to thank all of you for your thoughtful and diligent work on reviewing options for a Public Health Institute in Wisconsin, producing the report transmitted to me on November 8th by Susan Wood. Also, I appreciate the time that you took to receive comments, questions and advice from interested parties as part of the process.

Because of the strong interest in this topic, I would like to share my initial response to your report promptly. As the steward of state government's Public Health Division, I am very interested in how an institute can "add value" to our current public health system, complementing the appropriate strong roles of state and local government, our fine academic institutions, and other public health system partners. Of course, I recognize that there are many key players in the public health partnership, who will continue to express their views and influence the outcome of this dialogue. Also, the Governor and Legislature will provide the policy and fiscal direction for state government's role. In that context, I offer these comments.

First, the Committee supports the idea of a Public Health Incubator, a proposal submitted by the Wisconsin Public Health Association (WPHA) to create a lean, independent not-for-profit organization that would "grow" new ideas and link existing public health partners in pursuing those opportunities. I am happy to work with WPHA to develop this idea further. I would also like to explore the extent to which the Incubator could also be a vehicle to attract non-state funds including federal funds, foundation funds and other outside resources to help create a stronger public health system in our state. Members of the Assembly Public Health Committee have also expressed an interest in advancing this latter mission for an institute.

Second, I was impressed by the long list of "pros" and the short list of "cons" to additionally create a new public-private health information network or partnership. I am conferring actively with many interested parties about this idea now.

Finally, I am very eager to see our Department and other partners find a way to shift more resources and attention to "prevention" as a highly beneficial and cost-justified health investment. I do not anticipate that this requires any separate structure, but diligent work by many of us to advance this priority in times when governmental resources are particularly strapped.

Thank you again for your good work and sincere interest in public health.

Wisconsin.gov

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PROPOSAL

Wisconsin should pursue development of a *Wisconsin Idea Public Health Incubator* (WIPHI)*. Its purpose would be to “grow” new ideas and its model would be distributive. That is, it would be a lean, independent not-for-profit** that would seek to pull together the Division of Public Health, existing institutes and academic partners, including the two medical schools, to grow new opportunities that will help Wisconsin reach the goal of being the nation’s healthiest state.

Other public health institute models are interesting and important to study, but who says that Wisconsin has to pick a model from among those that already exist? We should be asking, “What would strengthen Wisconsin’s public health system in ways that can lead us to becoming the nation’s healthiest state?”

The whole public health system and the population would benefit from a WIPHI, including the Department of Health and Family Services, which would be a major “customer” to which such an entity would respond. The WIPHI could encourage development of new ideas related to functions like those recommended by the first PHI committee:

- * Research
- * Evaluation
- * Partnership promotion
- * Education regarding emerging health issues
- * Promotion of social and economic conditions that support good health
- * Analysis of health status data
- * Development of a public health workforce that is diverse and excellent

The concept would need to be further developed by calling on academic, public and private partners who have a *significant* history in public health research, education, and policy development. WPHA is extremely interested in leading this *development* effort and believes that a model could be developed within a two-year period. A board made up of some of the best public health minds in Wisconsin would advise the WIPHI. One key reference for determining priorities would be Healthiest Wisconsin 2010 and subsequent comprehensive health planning documents. Blue Cross dollars could be explored as a primary base-funding source. A broader funding portfolio would be developed in the first three years of operation.

The WIPHI would not have an economic development orientation although economic development might well result. Its purpose would not be to be to house displaced DPH workers, but it would work closely with DPH to plan strategies to improve public health in Wisconsin. One of the goals of a WIPHI could be finding ways to enhance large grant awards that come to Wisconsin, especially those that benefit governmental public health. The WIPHI would not be a health *systems* or health *care* research institute – this is better done by universities, federal agencies and provider groups and organizations.

**Draft title at this time – the important thing here is the concepts, not the title.*

***Preference at this time is a 501C3 or a new arm of a current 501C3, but other models might be considered.*

BACKGROUND

Concepts Supported

- If a PHI has enough merit, it does not require government action at this time. It can and should grow voluntarily out of the public health community (public and private)! The support and engagement of the Secretary in this process will be welcomed and extremely helpful however.
- Any effort to modify governmental public health in Wisconsin should be consistent with the Institute of Medicine's *The Future of the Public's Health in the 21st Century* (2003). This report was created by leading public health and governmental experts and should be the gold standard.¹
- If a PHI is developed in Wisconsin, functions should be selected from a "menu" of those recommended by the first PHI study committee.²

Concepts Opposed

- Creating a PHI for the purpose of decreasing the number of positions in the DPH.
- Inclusion as part of 2005-07 budget bill (or subsequent budget bills).
- Creating a PHI that would decrease the functional capacity of the DPH.
- A report to Secretary Nelson that does not have significant support of the committee members.
- A report to Secretary Nelson that does not directly address the impact that creation of a PHI would have on effectiveness of state and local governmental public health.
- Utilizing funding currently received by state and local public health agencies and non-profits in the form of block grants / consolidated contracts to fund start up of a PHI, which would weaken the public health system.

Why?

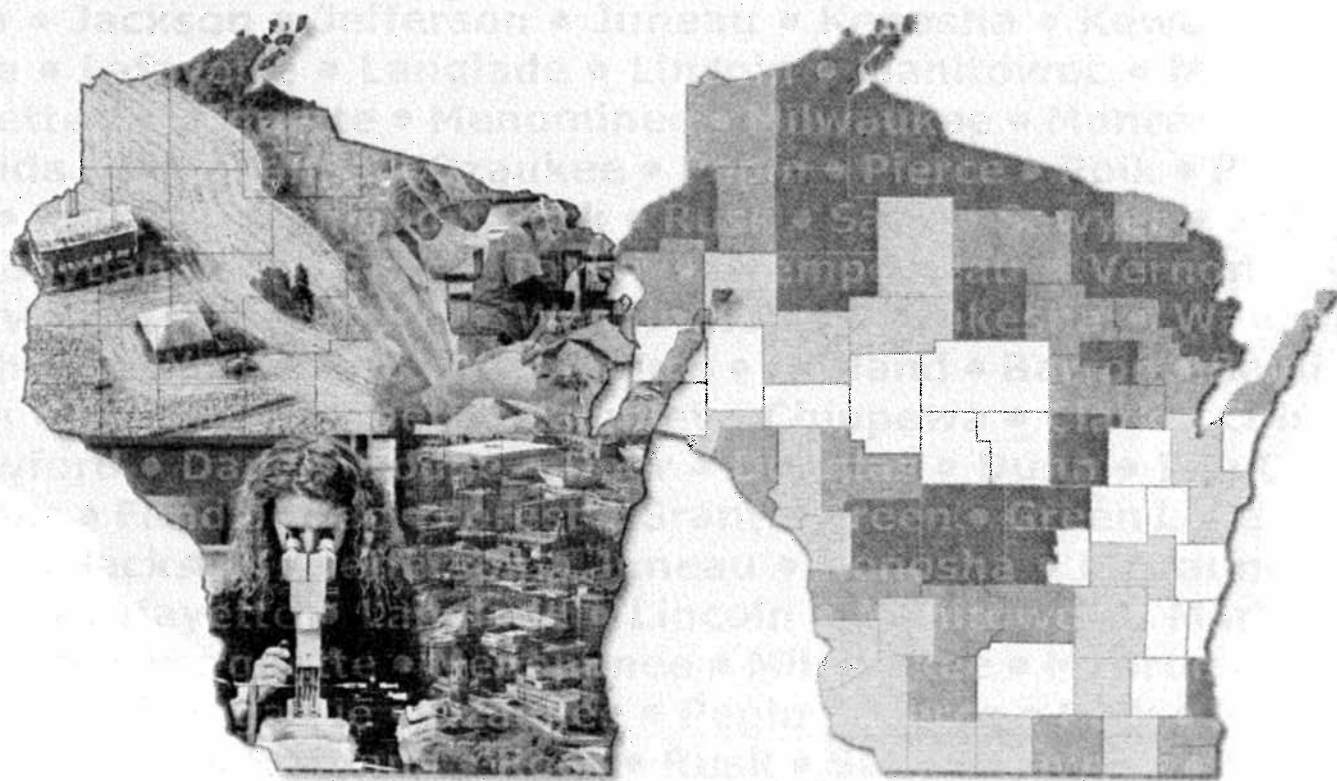
Diversion of dollars from an already inadequate, weak and under-funded governmental public health system will endanger the public's health. At this time, it is essential that DHFS and its public health system partners look for ways to strengthen our state's governmental public health system, by promoting implementation and evaluation of HW2010; appointing a permanent, strong leader as state health officer; and re-energizing a valuable staff that is fatigued by trying to do too much with too little in the context of threats of further downsizing. Beginning a **good idea** like a PHI with a **bad idea** like a budget driven FTE transfer will not promote a strong PHI model. The model should be developed with planning that asks, "What would strengthen Wisconsin's public health system in ways that can lead us to becoming the nation's healthiest state?"

1. The IOM addresses the problem of fragmentation of the governmental public health infrastructure in chapter 3. <http://books.nap.edu/books/030908704X/html/96.html#pagetop>
2. The seven items can be found on page 6 of the initial PHI committee report and in the third paragraph of the attached proposal.



Wisconsin County Health Rankings 2004

socioeconomic • environment • health care
mortality • health status • behaviors



Wisconsin Public Health & Health Policy Institute
Department of Population Health Sciences
University of Wisconsin Medical School



We acknowledge those who assisted in the development of this report, including the Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services; Bureau of Air Management, Division of Air and Waste, Wisconsin Department of Natural Resources; and Aurora Health Care.

We would also like to acknowledge Robert Stone-Newsom, Senior Scientist, Wisconsin Public Health and Health Policy Institute; management and staff of the Bureau of Health Information and Policy; Bart Sponseller, Bureau of Air Management; Jane McElroy, University of Wisconsin Comprehensive Cancer Center; Matt Landis, Wisconsin Public Health and Health Policy Institute; and Amanda Jovaag. Report graphic design by Irene Golembiewski of Media Solutions, University of Wisconsin Medical School. Photography by University Communications, University of Wisconsin-Madison.

Funding for this report and other Institute work is provided by the University of Wisconsin Medical School.

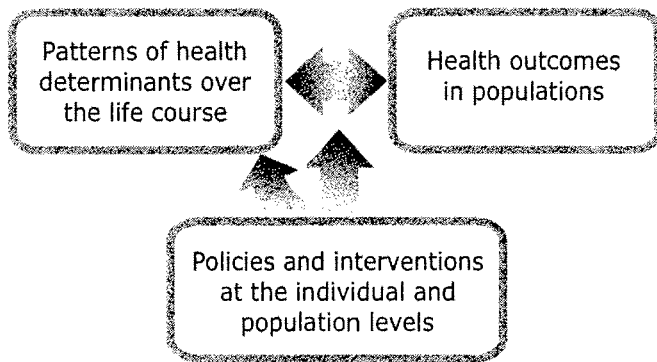
Suggested citation: Peppard PE, Kempf A, Dranger E, Kindig D, Remington PL. Wisconsin County Health Rankings, 2004. Wisconsin Public Health and Health Policy Institute, 2004.

Paul Peppard is a senior epidemiologist; Angela Kempf is a graduate student; Elizabeth Dranger is a masters graduate; David Kindig is senior advisor; and Patrick Remington is director; Wisconsin Public Health and Health Policy Institute.

Introduction

The Wisconsin Public Health and Health Policy Institute is pleased to present our *Wisconsin County Health Rankings—2004*. This annual report supports our mission by reporting on the health of Wisconsin communities and the factors that go into improving health. We hope that our efforts to summarize and communicate such information to broad audiences will add value to Wisconsin public health and health policy discussions.

The conceptual framework underpinning this effort is based on the model of population health improvement depicted below. This illustrates that health outcomes and their distribution across the population are produced by a set of health determinants, which in turn are influenced by policies and interventions which enhance or limit the determinants.



Health outcomes are often reported in terms of mortality, since years of life are very important and mortality data are available and reliable. However, most of us believe that health is measured not only in years of life but also in the quality of those years. Thus, we have created a health outcome ranking that incorporates how people in Wisconsin communities rate the state of their health while alive.

There are many health determinants with varying degrees of importance in influencing health outcomes. Data on many of them are not available at the county level. We have based our choice of health determinants data used in this report on the health priorities of the Wisconsin state health plan and produced a determinants ranking for each county based on what we know from the literature on how they should be combined.

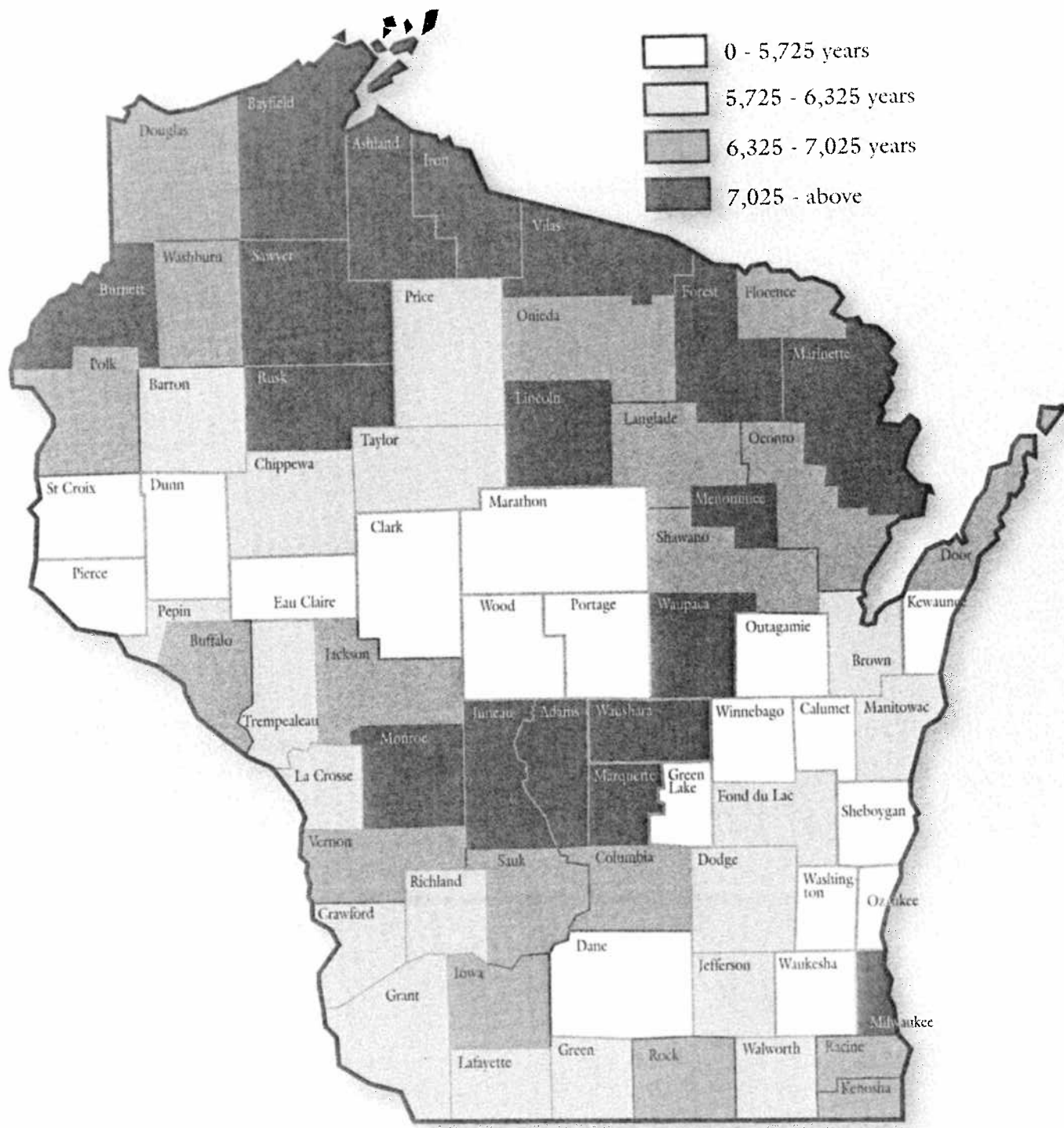
We acknowledge that the ranking of counties may be controversial. We present this report in the spirit of encouraging improvement and discussion, not judgment. Every community has strengths and weaknesses; we hope that the higher ranked counties provide insights for improvement and that the lower ones might draw additional resources for improvement.

In addition to the tables of county rankings, this year's report highlights two special topics: health change and health disparities. A discussion of how mortality outcomes have changed in counties over the past decade emphasizes the value of recognizing improvement or decline in community health over time. In light of the state health plan goal of eliminating health disparities, we also believe that it is important to examine not only differences between counties but disparities within counties as well.

While it is not possible to include all of the data used for each county and component in this report, it may be of value for readers to have access to this detailed local data. For that purpose, data tables of each health outcome and health determinant component can be accessed online at the Wisconsin Public Health and Health Policy Institute web site (www.pophealth.wisc.edu/wphi/), along with this rankings document and a more detailed description of the data and methods used.

We are pleased to present our second edition of this annual reporting process. This edition improves upon the 2003 county rankings. Improvements are based upon formally-solicited feedback and informal comments regarding the usefulness, limitations and strengths of the first edition. Through our continued research and the invaluable feedback provided regarding last year's report, you will notice some changes have been made. A summary of these changes is included in the *Overview of Methods*. We continue to welcome feedback and advice regarding how we might improve this effort so that it is truly useful in making Wisconsin communities as healthy as they can be.

Distribution of Mortality Among Wisconsin Counties: Annual years of potential life lost per 100,000 population



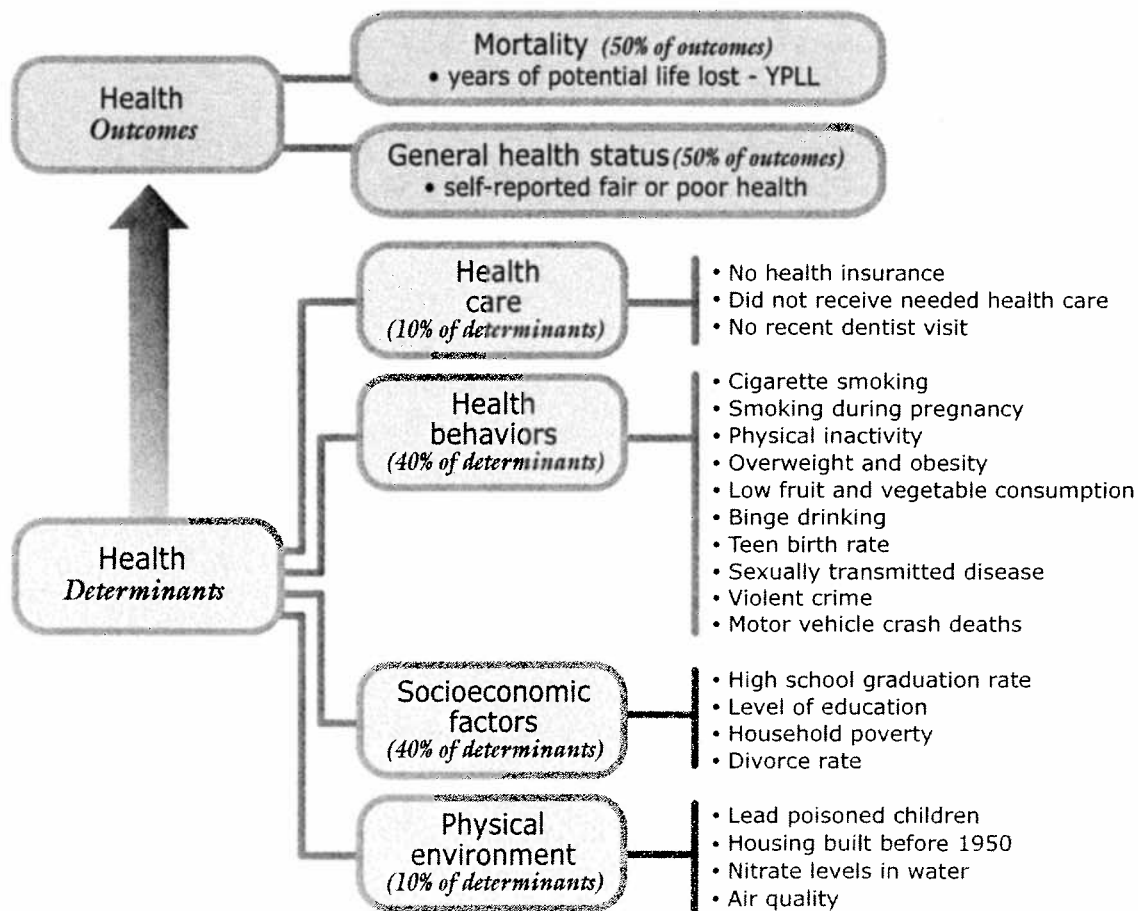
- Darker shade indicates higher (worse) mortality.
- Corresponding county ranks and the definition of years of potential life lost prior to age 75 (YPLL-75) are presented on page 6.
- YPLL-75 is calculated using data from U.S. Centers for Disease Control and Prevention WONDER database for years 1999-2001.

The Rankings

This report ranks Wisconsin counties according to their summary measures of health **outcomes** and health **determinants** as well as components of outcomes and determinants. The figure below depicts the structure of the rankings. Counties receive a ranking for each population health component shown in a box. Counties having high rankings (e.g., 1 or 2) are estimated to be the “healthiest.”

Estimates for health measures were calculated from the most recently available data. For many measures, an average of several years of recent data was used to obtain more stable estimates. However, estimates of county health are not measured perfectly and minor differences in the rankings among counties should be interpreted cautiously. For example, the data used for these rankings are not precise enough to indicate that a county ranked 40th is meaningfully more healthy than a county ranked 45th.

Overall summary **health outcomes** rankings are based on weighted scores (the weights are shown in parentheses in the figure) of two measures: mortality and general health status. **Health determinants** are based on weighted scores of four major components: health care, health behaviors, socioeconomic factors and the physical environment. Each of these four health determinant components is based, in turn, on multiple population health measures listed to the right of the determinant components.



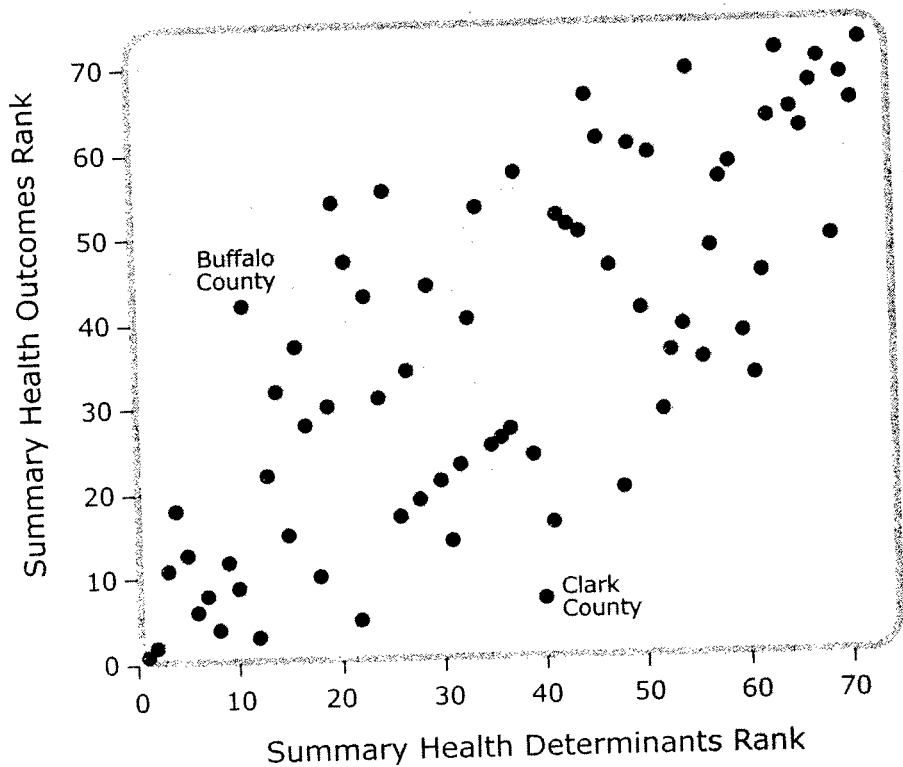
Summary Health Outcomes and Determinants Rankings

The table on the facing page presents the overall summary population health ranking for **health outcomes** and **health determinants**. Each of these rankings represents a summary of a number of individual health measures.

Not surprisingly, rankings of current health determinants and current health outcomes are related. This is seen in the figure below where the rank (1 being the "healthiest") of summary health outcomes is plotted against the rank of summary health determinants for each of the counties. While outcomes and determinants are not perfectly related, there is a strong correlation (correlation coefficient = 0.75).

However, some counties who rank high in determinants or outcomes rank low in the other. For example, Buffalo County (labeled below) ranks high in health determinants (#11) but among the bottom half of counties in health outcomes (#42). The relationship for Clark County is just the opposite, demonstrating a rank of 40th for health determinants and 7th for health outcomes. It is reasonable to speculate that counties with determinants ranks much lower than their outcomes rank may expect lower outcomes in the future; similarly those with much higher determinants ranks than outcome ranks may be on the way to improvement.

.....
 County rank of overall
 summary health
 outcomes index
 versus rank of overall
 summary health
 determinants index.
 Each point represents
 one Wisconsin county.



Summary 2004 Population Health Rankings for the 72 Wisconsin Counties: Ranks for Health Outcomes and Determinants

RANK	HEALTH OUTCOMES	HEALTH DETERMINANTS
1	Ozaukee	Ozaukee
2	Waukesha	Waukesha
3	Eau Claire	Washington
4	St Croix	Calumet
5	Portage	Pierce
6	Outagamie	Outagamie
7	Clark	Kewaunee
8	Kewaunee	St Croix
9	Dane	Iowa
10	Marathon	Dane
11	Washington	Buffalo
12	Iowa	Eau Claire
13	Pierce	Door
14	Winnebago	Sheboygan
15	Wood	Wood
16	Jefferson	Dodge
17	La Crosse	Fond du Lac
18	Calumet	Marathon
19	Florence	Walworth
20	Bayfield	Columbia
21	Lafayette	Polk
22	Door	Portage
23	Green Lake	Green
24	Richland	Brown
25	Sauk	Price
26	Dunn	La Crosse
27	Vernon	Grant
28	Fond du Lac	Florence
29	Langlade	Iron
30	Walworth	Lafayette
31	Brown	Winnebago
32	Sheboygan	Green Lake
33	Crawford	Manitowoc
34	Grant	Chippewa
35	Jackson	Sauk
36	Oconto	Dunn
37	Dodge	Vernon
38	Taylor	Lincoln
39	Pepin	Richland
40	Manitowoc	Clark
41	Rusk	Jefferson
42	Buffalo	Shawano
43	Green	Trempealeau
44	Iron	Oneida
45	Monroe	Vilas
46	Barron	Marinette
47	Polk	Barron
48	Rock	Bayfield
49	Douglas	Waupaca
50	Oneida	Rusk
51	Trempealeau	Washburn
52	Shawano	Langlade
53	Chippewa	Oconto
54	Columbia	Pepin
55	Price	Burnett
56	Racine	Jackson
57	Lincoln	Rock
58	Kenosha	Racine
59	Washburn	Kenosha
60	Waupaca	Taylor
61	Marinette	Crawford
62	Marquette	Monroe
63	Ashland	Ashland
64	Waushara	Forest
65	Milwaukee	Waushara
66	Vilas	Marquette
67	Sawyer	Sawyer
68	Adams	Juneau
69	Burnett	Douglas
70	Juneau	Adams
71	Forest	Milwaukee
72	Menominee	Menominee

Outcomes Components Ranking

The summary outcomes rankings are based on two components: mortality and general health status. The county rank and actual values for each county for those components are displayed here.

Mortality is measured as years of potential life lost prior to age 75 years (YPLL-75). This is an indicator of county mortality that accounts for the age at which a person dies—persons who die at a younger age are considered to have lost more “potential” years of life. For example, persons who die at age 65 are considered to have lost 10 “potential” years of life. YPLL is age-adjusted and estimated on a “per 100,000 persons” basis. The entire state average years of potential life lost was 6,334 years per 100,000 persons.

General Health Status is measured as the percent of the population that reports fair or poor health. The data are based on answers to the telephone survey question, “In general, would you say that your health is excellent, very good, good, fair, or poor?” The age-adjusted percentage of persons reporting less-than-good health (i.e., fair or poor) is detailed here. These data are gathered by the Wisconsin Department of Health and Family Services and the U.S. Centers for Disease Control and Prevention. The entire state average percent reporting fair or poor health is 12.0%.

RANK	MORTALITY: YEARS OF POTENTIAL LIFE LOST		GENERAL HEALTH STATUS: % WITH FAIR/POOR HEALTH	
	County	Value	County	Value
1	Waukesha	4,255 years	Ozaukee	7.6 %
2	Calumet	4,326 years	Eau Claire	8.0 %
3	Ozaukee	4,422 years	Waukesha	8.2 %
4	Eau Claire	4,671 years	Iowa	8.5 %
5	St Croix	4,861 years	Portage	8.5 %
6	Washington	5,045 years	Bayfield	8.6 %
7	Pierce	5,085 years	Outagamie	8.8 %
8	Kewaunee	5,159 years	Florence	9.0 %
9	Wood	5,162 years	St Croix	9.0 %
10	Portage	5,182 years	Clark	9.1 %
11	Green Lake	5,208 years	Rusk	9.4 %
12	Outagamie	5,344 years	Dane	9.8 %
13	Marathon	5,362 years	Kewaunee	9.9 %
14	Dane	5,368 years	Marathon	9.9 %
15	Winnebago	5,375 years	Jefferson	10.1 %
16	Dunn	5,424 years	Sauk	10.3 %
17	Sheboygan	5,632 years	Door	10.4 %
18	Clark	5,642 years	La Crosse	10.5 %
19	Brown	5,804 years	Jackson	10.5 %
20	Fond du Lac	5,860 years	Lafayette	10.5 %
21	Walworth	5,871 years	Vernon	10.7 %
22	La Crosse	5,911 years	Langlade	10.7 %
23	Pepin	5,944 years	Washington	10.7 %
24	Taylor	5,972 years	Iron	10.8 %
25	Richland	5,994 years	Richland	11.1 %
26	Jefferson	6,054 years	Winnebago	11.2 %
27	Crawford	6,064 years	Pierce	11.4 %
28	Trempealeau	6,105 years	Buffalo	11.5 %
29	Chippewa	6,154 years	Monroe	11.5 %
30	Dodge	6,172 years	Grant	11.6 %
31	Green	6,174 years	Wood	11.6 %
32	Lafayette	6,180 years	Oconto	11.6 %
33	Price	6,184 years	Fond du Lac	11.8 %
34	Barron	6,200 years	Walworth	11.8 %
35	Manitowoc	6,291 years	Crawford	11.9 %
36	Grant	6,303 years	Brown	12.0 %
37	Door	6,343 years	Dodge	12.1 %
38	Oconto	6,416 years	Green Lake	12.3 %
39	Iowa	6,433 years	Dunn	12.4 %
40	Washburn	6,444 years	Manitowoc	12.6 %
41	Vernon	6,494 years	Taylor	12.6 %
42	Langlade	6,517 years	Sheboygan	12.7 %
43	Oneida	6,552 years	Polk	12.9 %
44	Sauk	6,570 years	Rock	13.0 %
45	Shawano	6,710 years	Douglas	13.0 %
46	Polk	6,837 years	Pepin	13.1 %
47	Columbia	6,902 years	Calumet	13.3 %
48	Florence	6,907 years	Green	13.4 %
49	Rock	6,927 years	Columbia	13.6 %
50	Douglas	6,946 years	Oneida	13.7 %
51	Jackson	6,968 years	Shawano	13.8 %
52	Kenosha	6,969 years	Barron	13.9 %
53	Buffalo	6,973 years	Racine	14.1 %
54	Racine	7,025 years	Lincoln	14.3 %
55	Lincoln	7,030 years	Sawyer	14.4 %
56	Bayfield	7,204 years	Waupaca	14.6 %
57	Ashland	7,276 years	Waushara	14.6 %
58	Marinette	7,281 years	Trempealeau	14.7 %
59	Marquette	7,421 years	Milwaukee	14.8 %
60	Monroe	7,475 years	Chippewa	14.8 %
61	Vilas	7,571 years	Kenosha	14.8 %
62	Waupaca	7,618 years	Price	15.3 %
63	Iron	7,793 years	Marquette	15.8 %
64	Adams	7,939 years	Marinette	15.8 %
65	Rusk	8,178 years	Ashland	16.1 %
66	Waushara	8,418 years	Washburn	16.2 %
67	Milwaukee	8,629 years	Burnett	17.1 %
68	Juneau	8,705 years	Vilas	17.6 %
69	Burnett	8,790 years	Juneau	17.6 %
70	Sawyer	9,474 years	Forest	17.7 %
71	Forest	9,984 years	Adams	18.5 %
72	Menominee	15,913 years	Menominee	20.2 %

Determinants Components Ranking

RANK	HEALTH CARE	HEALTH BEHAVIORS	SOCIO-ECONOMICS	PHYSICAL ENVIRONMENT
1	Ozaukee	Ozaukee	Ozaukee	Vilas
2	Door	Iron	Waukesha	Burnett
3	Waukesha	Waukesha	Calumet	Florence
4	Jefferson	Washington	Washington	Menominee
5	Outagamie	Dane	Pierce	Washburn
6	Sheboygan	Florence	St Croix	Oneida
7	Brown	Iowa	Kewaunee	Price
8	Forest	Bayfield	Outagamie	Oconto
9	Fond du Lac	Vernon	Dodge	Forest
10	Washington	Walworth	Portage	Bayfield
11	Iowa	Pierce	Fond du Lac	Lincoln
12	Florence	Calumet	Sheboygan	Iron
13	Wood	Buffalo	Columbia	Sawyer
14	Trempealeau	Rusk	Marathon	Rusk
15	Buffalo	Oneida	Grant	Polk
16	Winnebago	Sawyer	Lafayette	Marinette
17	Dodge	Eau Claire	Iowa	Ashland
18	Polk	Richland	Door	Taylor
19	Calumet	Price	Manitowoc	Juneau
20	Columbia	Green	Buffalo	Shawano
21	Sauk	Chippewa	Eau Claire	Jackson
22	La Crosse	Polk	Pepin	Eau Claire
23	Walworth	Columbia	Wood	Dunn
24	Oconto	Sheboygan	Green Lake	Outagamie
25	Manitowoc	Wood	Dane	Door
26	Portage	Marathon	Jefferson	Brown
27	Marathon	Kewaunee	La Crosse	Ozaukee
28	Eau Claire	St Croix	Dunn	Kewaunee
29	Langlade	Sauk	Green	St Croix
30	Kewaunee	Rock	Brown	Washington
31	Dane	Door	Walworth	Wood
32	Racine	Outagamie	Shawano	Douglas
33	Marquette	Clark	Winnebago	Waushara
34	Green Lake	Barron	Taylor	Langlade
35	Washburn	La Crosse	Polk	Trempealeau
36	Oneida	Langlade	Chippewa	Buffalo
37	Barron	Brown	Lincoln	Adams
38	Price	Vilas	Waupaca	Clark
39	Clark	Burnett	Price	Barron
40	Vilas	Washburn	Sauk	Marquette
41	Green	Lafayette	Oconto	Vernon
42	Grant	Fond du Lac	Clark	Crawford
43	Richland	Milwaukee	Trempealeau	Waukesha
44	Lincoln	Marinette	Marinette	Winnebago
45	Marquette	Dodge	Richland	Chippewa
46	Waupaca	Winnebago	Barron	Fond du Lac
47	Douglas	Jackson	Vernon	Marathon
48	Rock	Shawano	Crawford	Pierce
49	Lafayette	Portage	Ashland	Grant
50	Adams	Lincoln	Kenosha	Iowa
51	Dunn	Kenosha	Vilas	Dodge
52	Milwaukee	Grant	Monroe	Green Lake
53	Rusk	Racine	Jackson	Walworth
54	St Croix	Trempealeau	Langlade	Dane
55	Menominee	Green Lake	Rock	Sauk
56	Vernon	Waupaca	Iron	Richland
57	Bayfield	Juneau	Washburn	Manitowoc
58	Kenosha	Dunn	Racine	Waupaca
59	Monroe	Waushara	Florence	Pepin
60	Jackson	Manitowoc	Waushara	Portage
61	Juneau	Douglas	Oneida	Jefferson
62	Chippewa	Monroe	Marquette	Monroe
63	Burnett	Ashland	Burnett	Racine
64	Pierce	Crawford	Rusk	La Crosse
65	Crawford	Marquette	Forest	Green
66	Shawano	Jefferson	Bayfield	Calumet
67	Waushara	Pepin	Sawyer	Sheboygan
68	Iron	Adams	Juneau	Kenosha
69	Taylor	Forest	Adams	Lafayette
70	Ashland	Oconto	Douglas	Columbia
71	Pepin	Taylor	Milwaukee	Milwaukee
72	Sawyer	Menominee	Menominee	Rock

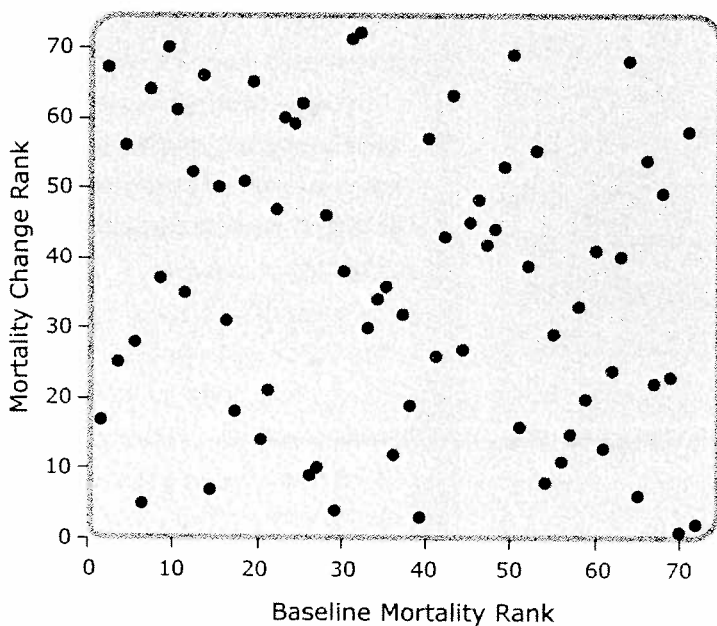
Here, counties are ranked according to measures representing four major categories of health determinants.

Each of these categories reflects a composite of one or more individual health measures that are summarized to create the component-level rankings (see the figure on page 3 for a list of the health measures corresponding to the major components ranked here). For example, the health behaviors ranking is calculated from data on smoking, physical activity, overweight and obesity, diet, binge drinking, teen pregnancy, sexually transmitted diseases, violent crime, and deaths from motor vehicle crashes (intended to act as a proxy of behaviors at high risk for causing injury or death).

Examining Change in Health Outcomes

The table to the right ranks counties based on the extent to which their mortality (YPLL-75) has improved over 10 years. Baseline is defined as 1989-1991 and current as 1999-2001. **A negative percent change indicates improvement (decline in years lost), while a positive percent change indicates worse mortality (increase in years lost).** The final column lists the county ranks for mortality at baseline (based on 1989-1991 data).

Examining the table, one can see that baseline levels of health are not necessarily indicative of the direction, relative to other counties, that health measures are changing. The figure below shows that there is virtually no correlation between baseline mortality rank and mortality change rank. The top ten counties for health improvement include some of the healthiest counties, some of the least healthy counties, and even some counties that fell in the middle of the baseline mortality rankings. Thus, current levels of mortality may not predict future mortality improvements, indicating that counties have the potential for improvement regardless of their current rank.



County baseline mortality rank versus mortality change rank. Each point represents one Wisconsin county.

MORTALITY CHANGE RANK	COUNTY	CHANGE	BASELINE MORTALITY RANK
1	Washburn	-33 %	70
2	Menominee	-28 %	72
3	Green Lake	-28 %	39
4	St Croix	-28 %	29
5	Calumet	-28 %	6
6	Langlade	-27 %	65
7	Eau Claire	-25 %	14
8	Price	-24 %	54
9	Pierce	-23 %	26
10	Kewaunee	-23 %	27
11	Oneida	-20 %	56
12	Clark	-20 %	36
13	Jackson	-19 %	61
14	Wood	-19 %	20
15	Shawano	-19 %	57
16	Iowa	-18 %	51
17	Waukesha	-18 %	1
18	Portage	-18 %	17
19	Walworth	-18 %	38
20	Columbia	-17 %	59
21	Marathon	-17 %	21
22	Vilas	-17 %	67
23	Adams	-17 %	69
24	Bayfield	-17 %	62
25	Ozaukee	-16 %	3
26	Trempealeau	-16 %	41
27	Barron	-16 %	44
28	Washington	-15 %	5
29	Douglas	-15 %	55
30	Crawford	-14 %	33
31	Winnebago	-14 %	16
32	Lafayette	-13 %	37
33	Ashland	-13 %	58
34	Chippewa	-13 %	34
35	Dane	-13 %	11
36	Dodge	-13 %	35
37	Outagamie	-12 %	8
38	Taylor	-12 %	30
39	Racine	-11 %	52
40	Iron	-11 %	63
41	Monroe	-11 %	60
42	Polk	-10 %	47
43	Sauk	-10 %	42
44	Lincoln	-9 %	48
45	Rock	-8 %	45
46	Green	-8 %	28
47	Richland	-8 %	22
48	Buffalo	-8 %	46
49	Juneau	-6 %	68
50	Fond du Lac	-6 %	15
51	Pepin	-6 %	18
52	Brown	-6 %	12
53	Marquette	-5 %	49
54	Milwaukee	-5 %	66
55	Waupaca	-5 %	53
56	Sheboygan	-4 %	4
57	Kenosha	-4 %	40
58	Forest	-4 %	71
59	Manitowoc	-4 %	24
60	Grant	-3 %	23
61	La Crosse	-3 %	10
62	Oconto	-3 %	25
63	Marinette	-1 %	43
64	Jefferson	0 %	7
65	Vernon	2 %	19
66	Door	2 %	13
67	Dunn	4 %	2
68	Sawyer	8 %	64
69	Burnett	12 %	50
70	Florence	13 %	9
71	Rusk	20 %	31
72	Waushara	21 %	32

Examining Health Disparities

COUNTY	MORTALITY RATE / 100,000 POP.		RATE RATIO
	High School Education or Less	More Than a High School Education	
Adams	471	123	3.8
Ashland	405	226	1.8
Barron	369	172	2.1
Bayfield	365	162	2.2
Brown	369	161	2.3
Buffalo	299	144	2.1
Burnett	393	181	2.2
Calumet	279	110	2.5
Chippewa	398	129	3.1
Clark	353	146	2.4
Columbia	382	173	2.2
Crawford	329	168	2.0
Dane	438	146	3.0
Dodge	392	143	2.7
Door	419	182	2.3
Douglas	305	122	2.5
Dunn	354	123	2.9
Eau Claire	360	131	2.7
Florence	261	80	3.3
Fond du Lac	399	136	2.9
Forest	516	217	2.4
Grant	294	164	1.8
Green	338	124	2.7
Green Lake	382	239	1.6
Iowa	361	152	2.4
Iron	319	143	2.2
Jackson	422	164	2.6
Jefferson	423	147	2.9
Juneau	543	257	2.1
Kenosha	452	164	2.8
Kewaunee	275	187	1.5
La Crosse	422	165	2.6
Lafayette	376	160	2.4
Langlade	337	192	1.8
Lincoln	426	159	2.7
Manitowoc	398	146	2.7
Marathon	331	132	2.5
Marinette	420	154	2.7
Marquette	488	154	3.2
Menominee	1015	228	4.5
Milwaukee	633	226	2.8
Monroe	427	201	2.1
Oconto	405	147	2.7
Oneida	460	183	2.5
Outagamie	323	131	2.5
Ozaukee	392	140	2.8
Pepin	343	169	2.0
Pierce	188	83	2.3
Polk	287	137	2.1
Portage	324	158	2.1
Price	420	200	2.1
Racine	487	178	2.7
Richland	341	219	1.6
Rock	463	161	2.9
Rusk	326	195	1.7
Sauk	378	168	2.2
Sawyer	390	218	1.8
Shawano	411	174	2.4
Sheboygan	356	145	2.5
St Croix	224	105	2.1
Taylor	322	121	2.7
Trempealeau	333	128	2.6
Vernon	404	171	2.4
Vilas	451	220	2.1
Walworth	417	158	2.6
Washburn	396	185	2.1
Washington	318	128	2.5
Waukesha	325	134	2.4
Waupaca	406	164	2.5
Waushara	445	175	2.5
Winnebago	376	151	2.5
Wood	343	149	2.3

One of the overarching goals of the *Healthiest Wisconsin 2010* state health plan is to eliminate health disparities, an aim shared by the national *Healthy People 2010* initiative. While disparities are often discussed in terms of differences in health status between ethnic or racial groups, such gaps can also be examined in terms of socioeconomic status, level of education, or gender. Summary health measures reported only at the county level may mask disparities that exist within the county. It can, therefore, be very informative to examine disparities within counties since recognizing disparities can play an important role in decisions regarding what steps to take to improve the health of a county.

In the table on the right, we present **mortality rates of persons aged less than 65 years by level of educational attainment**. These rates are adjusted for age and sex (important correlates of educational attainment and mortality). Mortality rates are given for those with a high school education or less, and for those with at least some college education. As a measure of mortality disparity related to educational attainment, the ratio of rates for less educated vs. more educated is given in the final column. Every county demonstrated a ratio of 1.5 or higher, indicating *at least* a 50% greater mortality rate among those with less education.

The individual numbers used to create the rate ratio are also important. In the table to the left, Milwaukee and Dunn counties have very similar ratios, indicating that the relative disparities by education in the two counties are similar. But Milwaukee County has much higher levels of mortality in both of the education groups (633 and 226) than Dunn County (354 and 123).

Ranks Sorted by County – Outcomes

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This table re-lists the county health outcomes ranks presented on the previous pages. They are intended to make it easier to read the ranks for specific counties.

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COUNTY	SUMMARY		MORTALITY YPLL-75)		HEALTH STATUS (% FAIR/POOR)		MORTALITY CHANGE	
	Rank	Rank	Value	Rank	Value	Rank	Value	
Adams	68	64	7,939 years	71	18.5 %	23	-17 %	
Ashland	63	57	7,276 years	65	16.1 %	33	-13 %	
Barron	46	34	6,200 years	52	13.9 %	27	-16 %	
Bayfield	20	56	7,204 years	6	8.6 %	24	-17 %	
Brown	31	19	5,804 years	36	12.0 %	52	-6 %	
Buffalo	42	53	6,973 years	28	11.5 %	48	-8 %	
Burnett	69	69	8,790 years	67	17.1 %	69	12 %	
Calumet	18	2	4,326 years	47	13.3 %	5	-28 %	
Chippewa	53	29	6,154 years	60	14.8 %	34	-13 %	
Clark	7	18	5,642 years	10	9.1 %	12	-20 %	
Columbia	54	47	6,902 years	49	13.6 %	20	-17 %	
Crawford	33	27	6,064 years	35	11.9 %	30	-14 %	
Dane	9	14	5,368 years	12	9.8 %	35	-13 %	
Dodge	37	30	6,172 years	37	12.1 %	36	-13 %	
Door	22	37	6,343 years	17	10.4 %	66	2 %	
Douglas	49	50	6,946 years	45	13.0 %	29	-15 %	
Dunn	26	16	5,424 years	39	12.4 %	67	4 %	
Eau Claire	3	4	4,671 years	2	8.0 %	7	-25 %	
Florence	19	48	6,907 years	8	9.0 %	70	13 %	
Fond du Lac	28	20	5,860 years	33	11.8 %	50	-6 %	
Forest	71	71	9,984 years	70	17.7 %	58	-4 %	
Grant	34	36	6,303 years	30	11.6 %	60	-3 %	
Green	43	31	6,174 years	48	13.4 %	46	-8 %	
Green Lake	23	11	5,208 years	38	12.3 %	3	-28 %	
Iowa	12	39	6,433 years	4	8.5 %	16	-18 %	
Iron	44	63	7,793 years	24	10.8 %	40	-11 %	
Jackson	35	51	6,968 years	19	10.5 %	13	-19 %	
Jefferson	16	26	6,054 years	15	10.1 %	64	0 %	
Juneau	70	68	8,705 years	69	17.6 %	49	-6 %	
Kenosha	58	52	6,969 years	61	14.8 %	57	-4 %	
Kewaunee	8	8	5,159 years	13	9.9 %	10	-23 %	
La Crosse	17	22	5,911 years	18	10.5 %	61	-3 %	
Lafayette	21	32	6,180 years	20	10.5 %	32	-13 %	
Langlade	29	42	6,517 years	22	10.7 %	6	-27 %	
Lincoln	57	55	7,030 years	54	14.3 %	44	-9 %	
Manitowoc	40	35	6,291 years	40	12.6 %	59	-4 %	
Marathon	10	13	5,362 years	14	9.9 %	21	-17 %	
Marinette	61	58	7,281 years	64	15.8 %	63	-1 %	
Marquette	62	59	7,421 years	63	15.8 %	53	-5 %	
Menominee	72	72	15,913 years	72	20.2 %	2	-28 %	
Milwaukee	65	67	8,629 years	59	14.8 %	54	-5 %	
Monroe	45	60	7,475 years	29	11.5 %	41	-11 %	
Oconto	36	38	6,416 years	32	11.6 %	62	-3 %	
Oneida	50	43	6,552 years	50	13.7 %	11	-20 %	
Outagamie	6	12	5,344 years	7	8.8 %	37	-12 %	
Ozaukee	1	3	4,422 years	1	7.6 %	25	-16 %	
Pepin	39	23	5,944 years	46	13.1 %	51	-6 %	
Pierce	13	7	5,085 years	27	11.4 %	9	-23 %	
Poik	47	46	6,837 years	43	12.9 %	42	-10 %	
Portage	5	10	5,182 years	5	8.5 %	18	-18 %	
Price	55	33	6,184 years	62	15.3 %	8	-24 %	
Racine	56	54	7,025 years	53	14.1 %	39	-11 %	
Richland	24	25	5,994 years	25	11.1 %	47	-8 %	
Rock	48	49	6,927 years	44	13.0 %	45	-8 %	
Rusk	41	65	8,178 years	11	9.4 %	71	20 %	
Sauk	25	44	6,570 years	16	10.3 %	43	-10 %	
Sawyer	67	70	9,474 years	55	14.4 %	68	8 %	
Shawano	52	45	6,710 years	51	13.8 %	15	-19 %	
Sheboygan	32	17	5,632 years	42	12.7 %	56	-4 %	
St Croix	4	5	4,861 years	9	9.0 %	4	-28 %	
Taylor	38	24	5,972 years	41	12.6 %	38	-12 %	
Trempealeau	51	28	6,105 years	58	14.7 %	26	-16 %	
Vernon	27	41	6,494 years	21	10.7 %	65	2 %	
Vilas	66	61	7,571 years	68	17.6 %	22	-17 %	
Walworth	30	21	5,871 years	34	11.8 %	19	-18 %	
Washburn	59	40	6,444 years	66	16.2 %	1	-33 %	
Washington	11	6	5,045 years	23	10.7 %	28	-15 %	
Waukesha	2	1	4,255 years	3	8.2 %	17	-18 %	
Waupaca	60	62	7,618 years	56	14.6 %	55	-5 %	
Waushara	64	66	8,418 years	57	14.6 %	72	21 %	
Winnebago	14	15	5,375 years	26	11.2 %	31	-14 %	
Wood	15	9	5,162 years	31	11.6 %	14	-19 %	

Ranks Sorted by County – Determinants

COUNTY	SUMMARY	HEALTH CARE	HEALTH BEHAVIORS	SOCIO-ECONOMICS	PHYSICAL ENVIRONMENT
Adams	70	50	68	69	37
Ashland	63	70	63	49	17
Barron	47	37	34	46	39
Bayfield	48	57	8	66	10
Brown	24	7	37	30	26
Buffalo	11	15	13	20	36
Burnett	55	63	39	63	2
Calumet	4	19	12	3	66
Chippewa	34	62	21	36	45
Clark	40	39	33	42	38
Columbia	20	20	23	13	70
Crawford	61	65	64	48	42
Dane	10	31	5	25	54
Dodge	16	17	45	9	51
Door	13	2	31	18	25
Douglas	69	47	61	70	32
Dunn	36	51	58	28	23
Eau Claire	12	28	17	21	22
Florence	28	12	6	59	3
Fond du Lac	17	9	42	11	46
Forest	64	8	69	65	9
Grant	27	42	52	15	49
Green	23	41	20	29	65
Green Lake	32	34	55	24	52
Iowa	9	11	7	17	50
Iron	29	68	2	56	12
Jackson	56	60	47	53	21
Jefferson	41	4	66	26	61
Juneau	68	61	57	68	19
Kenosha	59	58	51	50	68
Kewaunee	7	30	27	7	28
La Crosse	26	22	35	27	64
Lafayette	30	49	41	16	69
Langlade	52	29	36	54	34
Lincoln	38	44	50	37	11
Manitowoc	33	25	60	19	57
Marathon	18	27	26	14	47
Marquette	46	45	44	44	16
Marquette	66	33	65	62	40
Menominee	72	55	72	72	4
Milwaukee	71	52	43	71	71
Monroe	62	59	62	52	62
Oconto	53	24	70	41	8
Oneida	44	36	15	61	6
Outagamie	6	5	32	8	24
Ozaukee	1	1	1	1	27
Pepin	54	71	67	22	59
Pierce	5	64	11	5	48
Polk	21	18	22	35	15
Portage	22	26	49	10	60
Price	25	38	19	39	7
Racine	58	32	53	58	63
Richland	39	43	18	45	56
Rock	57	48	30	55	72
Rusk	50	53	14	64	14
Sauk	35	21	29	40	55
Sawyer	67	72	16	67	13
Shawano	42	66	48	32	20
Sheboygan	14	6	24	12	67
St Croix	8	54	28	6	29
Taylor	60	69	71	34	18
Trempealeau	43	14	54	43	35
Vernon	37	56	9	47	41
Vilas	45	40	38	51	1
Walworth	19	23	10	31	53
Washburn	51	35	40	57	5
Washington	3	10	4	4	30
Waukesha	2	3	3	2	43
Waupaca	49	46	56	38	58
Waushara	65	67	59	60	33
Winnebago	31	16	46	33	44
Wood	15	13	25	23	31

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This table re-lists the county health determinants ranks presented on the previous pages. They are intended to make it easier to read the ranks for specific counties.

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Overview of Methods

I. Selection of population health measures

We focus on two categories of health measures—health outcomes and health determinants. Outcomes are intended to measure the current state of health in a county, while determinants are viewed as predictors of future health outcomes. Twenty-three measures of health outcomes and determinants were selected using the following criteria:

- the measure is a direct or proxy measure of an important aspect of population health;
- the data are reasonably valid;
- the data are publicly available;
- the data are available at the county-level;
- the data are current and updated periodically.

Health Outcomes: two components were used to represent health outcomes: death and health status while alive. Death and health status are each assessed with a single measure (years of potential life lost and self-reported health status). While much more specific health outcomes could be included here, these two address both length and quality of life.

Health Determinants: the selection of determinant measures was largely guided by the Wisconsin state health plan priorities. However, we do not include measures that represent specific diseases. We divided the 21 health determinant measures into four major components: health care, health behaviors, socioeconomic factors related to health, and the physical environment. Each of these four major components is comprised of multiple health measures.

II. Data sources

The figure on page 3 lists the outcomes and determinants components and their associated health measures. The data used for this report came from a variety of sources:

- **Complete population** (non-sample), annually available data. These data include vital statistics (mortality/YPLL, teen births, smoking during pregnancy) and were obtained from the Bureau of Health Information and Policy, Division Public Health, Wisconsin Department of Health and Family Services and the U.S. Centers for Disease Control and Prevention (CDC) WONDER database.
- **Census data:** based on near-complete population or large-sample decennial data (education level, income, divorce rate, and year housing structure built). These were obtained online from the U.S. Census Bureau.
- **Sample survey data:** based on moderate-sized annual samples primarily from the U.S. Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (cigarette smoking, physical inactivity, overweight and obesity, low fruit and vegetable consumption, and binge drinking) or the Wisconsin Department of Health and Family Service's Family Health Surveys (no health insurance, did not receive needed health care, and no recent dentist visit). These data are often quite sparse for some counties and were obtained from the Bureau of Health Information and Policy.
- **Other data** were obtained from the Wisconsin Department of Health and Family Services, Wisconsin Department of Natural Resources, Wisconsin Department of Public Instruction, Wisconsin Office of Justice Assistance, the U.S. Environmental Protection Agency, and Aurora Health Care's *Community Health Assessments*.

The specific time periods and sources corresponding to each health measure are further detailed on the Wisconsin Public Health and Health Policy Website (see the end of this section).

Overview of Methods continued

III. Rankings

Each of the 2 health outcomes measures and 21 health determinants measures were estimated for each county (often averaging over years). The mean and standard deviation of each of the health measures were calculated across the 72 counties. Counties were then given a “score” for each measure. This score was the number of standard deviation units that the county was from the mean of all the counties. To avoid a county’s rank being strongly influenced by one extreme component score, we truncated the score at (-3.0) or (3.0) if the actual score fell outside of this range. Weighted averages of the (truncated) scores were used to calculate the overall summary outcomes and determinants rankings and the rankings for the four major categories of determinants. The weights used for the components to calculate summary outcome and determinant rankings are given in the figure on page 3.

IV. Changes from the *Wisconsin County Health Rankings—2003*

The annual production of the *Wisconsin County Health Rankings* provides us the opportunity to incorporate improvements from the previous year’s document. Based on feedback received after the 2003 edition, discussion and advice from groups in many fields, and continued investigation into available data sources, a number of changes have been made for this year’s edition.

- **County-level estimates:** In cases of low-population, counties were previously grouped together and a county-specific estimate was calculated by combining both county-level and county-group-level data. This approach effectively reduced random error in the county-specific estimates, but at the expense of using data from outside the county to estimate within-county measures. For the current edition we have eliminated this procedure and instead combined additional years of data, when possible, to increase sample sizes. In this way, we prevent neighboring counties with very different levels of health from influencing county-level estimates.

• Data elements

- **Mortality:** Years of potential life lost (YPLL) is measured prior to 75 instead of 85 years of age as in the previous edition.
- **Health care (previously “access to health care”):** “No recent blood pressure check” has been removed from the rankings because it has not been included as a question in recent Behavioral Risk Factor Surveillance System surveys.
- **Health behaviors:** Violent crime has replaced firearm deaths.
- **Socioeconomic factors:** In addition to Census 2000 data on the level of educational achievement of the general population, we have added the current high school graduation rates.
- **Physical environment:** Percent of children tested who were positive for lead poisoning has been joined by an additional measure to strengthen the estimate of lead danger (pre-1950s housing), as well as estimates of water (nitrate levels) and air (pollution data) quality.

A more detailed methods description, as well as county-level component values, can be found on the Wisconsin Public Health and Health Policy Institute website: www.pophealth.wisc.edu/wphi/.



WISCONSIN
Public Health
&
Health Policy
INSTITUTE

Mission

In the spirit of the Wisconsin Idea,
to stimulate, create and communicate useful
public health and health policy research and analysis.

Contact Information

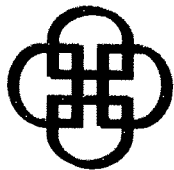
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MICHIGAN PUBLIC
HEALTH INSTITUTE

January 27, 2005

Representative J. A. Hines
Room 10 West
State Capitol
P.O. Box 8952
Madison, WI 53708

CENTRAL OFFICE

2436 WOODLAKE CIRCLE

SUITE 300

OKEMOS, MI 48864

PH: 517/324-8300

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WWW.MPHI.ORG

Dear Representative Hines,

I am writing to you at the request of Susan Garman of the Wisconsin Institute of Public Health. She states that information is needed by your office for a hearing on public health.

The Michigan Public Health Institute (MPHI) was founded in 1990 pursuant to the state statute which authorized the creation of a nonprofit organization, together with the public universities, to support the mission of public health. In that role we have:

- Secured \$50 million in non-state funding for public health from federal, foundation, and private sources.
- Acted as the "agent for the state" in applying for federal funding.
- Employed and placed over 60 highly qualified health professionals at the state health agency.
- Built video conferencing and satellite downlink conferencing facilities for use by the state.
- Assisted in technology transfer and commercialization of intellectual property.

The enclosed information is material on MPHI and the National Network of Public Health Institutes (NNPHI) which may be of use to you and your committee.

Please let me know if I can be of further assistance to you.

FOUNDERS

MICHIGAN DEPARTMENT
OF COMMUNITY HEALTH

MICHIGAN STATE UNIVERSITY

UNIVERSITY OF MICHIGAN

WAYNE STATE UNIVERSITY

Sincerely,

Jeffrey R. Taylor, Ph.D.
Executive Director

cc: Susan Garman



PUBLIC HEALTH CODE (EXCERPT)

Act 368 of 1978

333.2611 Coordination of activities; establishment of policy; interests to be considered; establishment, purpose, and powers of nonprofit corporation.

Sec. 2611. (1) The department shall coordinate the health services research, evaluation, and demonstration and health statistical activities undertaken or supported by the department.

(2) The department shall establish policy consistent with this part to administer health services research, evaluation, and demonstration and health statistical activities undertaken or supported by the department. In establishing the policy the department shall consider the following interests:

(a) The individual's right and reasonable expectation of privacy concerning its use, including the protection of privileged communications and the expectations of the individual when giving the information.

(b) The freedom of persons to do business.

(c) The public's interest in the protection of private rights.

(d) The public's interest in the free access to governmental information.

(e) The protections necessary to encourage persons to provide information.

(f) The individual's interest in being informed of dangers of which he or she would not otherwise be aware.

(g) The public's interest in the effective use of available data to protect and promote the health of individuals and the public as a whole.

(h) The public's interest in the effective and efficient management of governmental activities.

(i) The individual's interest in data about himself or herself.

(j) The interests of other governmental entities in preparing reports.

(3) The department may establish a nonprofit corporation pursuant to the nonprofit corporation act, Act No. 162 of the Public Acts of 1982, being sections 450.2101 to 450.3192 of the Michigan Compiled Laws. The purpose of the corporation shall be to plan, promote, and coordinate health services research with a public university or a consortium of public universities within the state. The corporation may research, evaluate, and demonstrate all of the following:

(a) The cause, effects, extent, and nature of illness and disability among all or a particular group of the people of this state.

(b) The impact of personal illness and disability on the economy of this state and the well-being of all or a particular group of the people of this state.

(c) Environmental, laboratory, social, and other health related issues.

(d) The health knowledge and practices of the people of this state.

(e) The quality and availability of health resources in this state including, but not limited to, health care institutions and health professions.

(f) The determinants of health and nutritional practices and status including, but not limited to, behaviors that are related to health.

(g) Access to and use of health care services by all or a particular group of the people of this state including, but not limited to, the use of ambulatory health care services. The access and use may be categorized by specialty and type of practice of the health professional or health facility providing the service.

(h) Health care costs and financing including, but not limited to, trends in health care costs, sources of payments, and federal, state, and local expenditures for health care services.

(i) Public health policies and programs.

(j) Other issues considered appropriate by the board of directors of the corporation.

History: 1978, Act 368, Eff. Sept. 30, 1978;—Am. 1989, Act 264, Imd. Eff. Dec. 26, 1989.

Compiler's note: For transfer of certain powers and duties of the Michigan public health institute from the department of public health to the director of the department of community health, see E.R.O. No. 1996-1, compiled at § 330.3101 of the Michigan Compiled Laws.

Popular name: Act 368

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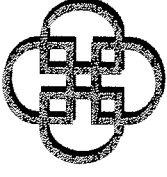
Michigan Public Health Institute

VISION

MPHI will be a unique public trust which will enable communities to apply state-of-the-art community health practices.

Strategic directions to pursue this vision:

1. Further develop effective partnerships with community-based and private organizations, educational institutions, and government.
2. Strengthen our position and reputation as a neutral and ethical organization.
3. Develop MPHII's role and potential as a grantmaker and funder.
4. Explore internal models of organizational structure and operation in order to increase or maintain our effectiveness.
5. Increase MPHII's visibility as a prototype or model for community/government/academic partnerships.
6. Develop recognition as an expert in community health.



MICHIGAN PUBLIC
HEALTH INSTITUTE

MISSION

The mission of MPHII is to maximize positive health conditions in populations and communities through collaboration, scientific inquiry, and applied expertise which:

- *carry the voice of communities to health policy makers, scientists, purchasers, and funders;*
- *advance the application of scientific health practices in communities; and*
- *advance community capacity to improve health and reduce disparities among population groups and geographic areas.*

Strategic directions to pursue this mission:

1. Place priority on science that has potential to bend community health trends into positive directions.
2. Place priority on projects that advance community capacity to improve health status and to reduce disparities in health status among population sub-groups.
3. Develop MPHII's role in advocating for community health improvement, especially as conduit for effective communication between communities and government, funders or academia.

VALUES

MPHI's board of directors, management, and staff are committed to uphold these values in our work, relationships, and governance:

- *collaboration and inclusiveness among MPHII, government, communities, and institutions in approaching matters of the public's health.*
- *state-of-the-art research, education, and demonstration as vehicles for advancing health practice.*
- *leadership and service for the benefit of community, rather than to advance institutions, partners, or staff.*
- *prevention of disease and promotion of health.*
- *ethical behavior in all scientific, professional, and interpersonal matters.*
- *quality, professionalism, and integrity in the work we do, the people we hire, and the workplace we create.*
- *innovation and continuous improvements in the workplace, as our assurance of maintaining our responsiveness and utility to our clients.*

The Michigan Public Health Institute was created by Public Act 264 of 1989, and charged with contributing "...to the improvement of public health in Michigan through increased collaboration among the Michigan Department of Public Health, the University of Michigan, Michigan State University, Wayne State University, and other interested organizations to promote health, prevent disease, and enhance the quality of life through an organized program of policy, development, planning, scientific research, service demonstration, education, and training."

In April 1996, in a reorganization of state government, the Department of Public Health was merged with other agencies into the Michigan Department of Community Health. Concurrently, MPHII's affiliation expanded to include all the functions of community health. Today, the Department of Community Health encompasses the operations of yesterday's governmental units of public health, mental health, Medicaid, services to the aging, and drug control policy.

THE MICHIGAN PUBLIC HEALTH INSTITUTE: A MODEL FOR UNIVERSITY, GOVERNMENT AND COMMUNITY RESEARCH AND PRACTICE PARTNERSHIPS

Jeffrey R. Taylor, PhD
G. Elaine Beane, PhD
Carol L. Genee

ABSTRACT

During the last decade, the U.S. health care industry has grown in scope and variety of services available, and in cost and delivery alternatives. At the same time, our increasing mobility as a global economy and society, the aging of our population, the growing impact of drugs on our culture, and a host of other factors have combined to present a myriad of fresh challenges for our health care community as well as for public health policy makers and planners.

The result has been a growing demand for state-of-the-art health care research, demonstration, evaluation, and training that will be used to address the needs of all segments of our population and focus on promoting health and enhancing the quality of life. Nonprofit health institutes, such as the one established in Michigan in the early 1990s, have been used by a handful of states and other entities to meet these challenges.

INTRODUCTION

Nonprofit institutes are widely regarded as being perhaps the best location for an experimental social innovation unit. As described by Fairweather and Tornatzky (1977), the ideal location for an experimental social policy research unit is one that "lies between

and overlaps various aspects of government and the university. The best organizational form seems to be one that involves funding and legitimacy by the executive, legislative, and operational units of government and of the university" (p. 389).

Such an organization offers a number of advantages, including the ability to bring researchers, policymakers,

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and community members together to work on neutral ground with a focus on cooperation and problem solving. Research is divided into contracted research, performed at the request of participating governmental agencies, and innovative research. (Fairweather & Tomatzky, 1977).

By the late 1980s, several state health departments across the coun-

The cooperative university/public health/nonprofit venture gives MPHl a competitive advantage in winning major research contracts and grant awards.

try—among them New York, California and Massachusetts—had “in-between” organizational arrangements that enabled them to conduct selected research, education, and service activities through closely aligned nonprofit entities. These “first wave institutes” encompassed a variety of functions as nonprofit research, development and educational institutes or foundations, and they gave their host states a number of inherent

advantages. As news of their success spread, other states and entities—including Michigan, Louisiana and the U.S. Centers for Disease Control and Prevention—established similar nonprofit institutes.

Although perhaps different in organizational details and range of projects, these institutes share inherent advantages. Unlike their government colleagues, they can:

- Compete for applied health science and community research awards from the National Institutes of Health and private foundations that virtually never award such funds to political entities, such as governmental agencies.
- Patent, license and market advances in vaccines, molecular biology, blood products, and other biologicals.
- Generate fee-for-service income by providing specialized health service capabilities to non-governmental client groups (e.g., the sale of health data, the provision of health training, or the sale of surplus biological products).
- Accept and undertake new projects in a timely manner, including recruiting professional, scientific and support staff and securing the necessary equipment and supplies.
- Terminate projects in an equally timely manner.
- Take advantage of unique cost savings measures, such as hiring personnel for the duration of the project, purchasing equipment through the use of preferential

procurement contracts held by collaborating institutions, and controlling indirect cost rates.

These advantages have not gone unnoticed. Today, an entirely new wave of players is contemplating the establishment of such institutes.

In a guest commentary published earlier this year (McDade & Hausler, 1998), Joseph McDade of the National Center for Infectious Diseases, Centers for Disease Control and Prevention, and William Hausler Jr. of the University of Iowa Hygienic Laboratory stated that the changing roles and responsibilities of the public and private health sectors have necessitated new arrangements able to "identify the specific functions of public- and private-sector laboratories, facilitate collaboration in areas of shared responsibility, and prevent unnecessary duplication of services." They recommended that "local public health institutes be formed, with public health laboratories as founding members, to improve strategic planning for public health," and cited the Michigan Public Health Institute (MPHI) as an example of an institute that can provide such a forum. Many groups, like the public health officials of Victoria, Australia (VicHealth, 1997), are considering the establishment of institutes quite similar to the one put into practice in Michigan.

This paper discusses the nonprofit Michigan Public Health Institute, one of only a handful of collaborative institutes across the nation specializing in public health research, development and education. Because of its status as a neutral, nonprofit institute with access to the best and the brightest in health care researchers and policymakers, MPHI stands as a model for

the establishment of other, similar organizations to meet the challenges of our ever-changing public health environment.

THE MICHIGAN PUBLIC HEALTH INSTITUTE EVOLVES

Throughout the latter half of the 1980s, key members of the Michigan Dept. of Public Health (MDPH) staff, representatives of state universities, legislators, and other interested parties joined forces to establish a closely aligned nonprofit public health entity in Michigan.

By the fall of 1990, organizers had passed enabling legislation and filed articles of incorporation that established the new Michigan Public Health Institute as a nonprofit 501(c)(3) corporation, adopted bylaws, and held their first meeting of the new board of directors (now comprised of representatives from the three partner universities, state government, foundations, and community agencies).

In the beginning, MPHI's directors envisioned the new institute as a major force in achieving the goals expressed in *The Future of Public Health* (U.S. Institute of Medicine, 1988) and *Healthy People 2000* (U.S. Dept. of Health and Human Services, 1991). They reasoned that the new institute had close ties with the academic, government, and health care provider communities within the state and therefore would be able to take full advantage of the entire depth and diversity of Michigan's health research community. Today, just as its founders envisioned, the institute offers its partners a number of advantages, similar to the perceived benefits enjoyed by the Research Triangle

Institute and its partners (Larrabee, 1991).

The three partner universities (Michigan State University, the University of Michigan, and Wayne State University) gain: (a) internship and training opportunities; (b) graduate employment opportunities; (c) access to specialized facilities; and (d) access to a broader talent pool for adjunct research and teaching appointments. In addition, they are able to take advantage of cooperative research, demonstration and training opportunities with other partner universities and state and local government, foundation, federal, and corporate sponsors. They have access to a reservoir of supplementary scientific resources that can be used to recruit graduate students and distinguished faculty. When they develop fundamental health policy innovations, MPHI provides them with an avenue for disseminating those innovations and putting them into action as public policy.

MPHI has subcontracted nearly \$3 million in projects to its partner universities. Inter-Institutional Personnel Agreements (IPAs) have been signed by MPHI and its university partners to permit the movement of personnel and other programmatic resources between and among the partners and the sharing of administrative costs on project grants. MPHI has sought and received a federally approved indirect cost rate of 12.4 percent on all direct costs, excluding equipment. MPHI and its university partners have worked together to establish the following three-part policy on indirect cost rates for university subcontracts with MPHI:

- For projects funded by the state of

Michigan, the universities cap their indirect cost rate at 20 percent of the total direct costs.

- For projects funded by federal government entities or foundations, the universities reflect their current applicable university indirect rate for on-campus or off-campus projects, subject to the rules of the funder.
- For projects in which universities become funding partners, the involved parties may negotiate a mutually acceptable rate on indirect costs on a case-by-case basis in recognition of the fact that they are investing for a mutually beneficial outcome.

The state health department also benefits by being an MPHI partner. As a result of its partnership, it: (a) receives access to diverse sources of funding; (b) gains the ability to tap into the scientific and technical resources of the state universities and MPHI; (c) broadens its research, development, demonstration, and training capabilities; and (d) is able to rapidly start and terminate projects.

MPHI gains access to expert faculty and government consultants, as well as to shared equipment and facilities. The cooperative university/public health/nonprofit venture gives MPHI a competitive advantage in winning major research contracts and grant awards. This spirit of cooperation also enables MPHI to divide the work from contracts and grant awards among university, MPHI, and government experts. Joint or adjunct appointments in research or teaching give MPHI scientists the opportunity to teach, supervise graduate study, and

co-author books and papers with their university and government colleagues.

MPHI COMES INTO ITS OWN

In 1994, MPHI was awarded a two-year master contract for research from the Health Care Financing Administration (HCFA). It was one of only 10 consortia in the United States selected for the award. The following year, HCFA awarded MPHI a prestigious five-year Master Contract for Research Centers to conduct long-term care research and policy development, making it one of a select few research consortia pre-qualified to bid on high-priority projects related to improving elder health care in the United States.

As the prime contractor under this Master Contract for Research Centers, MPHI works in conjunction with its three member universities and other Michigan- and U.S.-based health research collaborators to pursue research and demonstration projects. These projects are concerned with health system financing, access and quality of care, service delivery systems, managed care, provider payment, sub-acute care and long-term care.

MPHI has experienced exponential growth. At the end of 1992, the institute had three funding sources, no employees, four new projects, and an annual income of \$371,056. By the end of fiscal 1997, MPHI had 120 full-time employees and an income of \$16.1 million for the year.

A sizable portion of the institute's growth in the last two years has been due to a re-focusing of its mission, vision, values and strategic objectives. These changes were made necessary in part by a 1996 executive reorganiza-

tion of state government in which the Michigan Dept. of Public Health became the Community Public Health Agency within the Michigan Dept. of Community Health. (Today's Michigan Dept. of Community Health encompasses the operations of the former state governmental units of public health, mental health, Medicaid, services to the aging, and drug control policy.

MPHI and its partners are focusing on building community capacity through leadership development, technical assistance, program evaluation and training.

As part of that executive reorganization, a number of the functions of the previous state health department are being "devolved" to communities. In response to this change, MPHI and its partners are focusing on building community capacity through leadership development, technical assistance, program evaluation and training. The institute's current projects involve community-based

human services collaboration, child and family health, health care systems and financing, risk factor reduction/ chronic disease prevention, violence and injury prevention, and laboratory and infectious diseases.

MPHI encourages the formation of multi-institutional collaborative grant-writing and research teams. These project groups may be located at any of the partner institutions or at MPHI. Personnel, purchasing and business systems are under the leadership of researchers. Teams are established as "semi-autonomous" research groups, with their own offices or suites. Program directors, pulled from the ranks of researchers, are encouraged to provide leadership and service to the research groups in their area, but all share in the decision-making.

This leadership style has been described as *primus inter pares* or "first among equals" (Greenleaf, 1977). Although one person is chosen to be the group leader, that person is not the "chief." Instead, governance and guidance are spread among the group of peers, all of whom are able and willing to share in the running of the organization. This servant leadership style is compelling. It empowers the individual, and it can be seen throughout all levels of activity at MPHI.

As research is completed, MPHI disseminates the findings to as wide an audience as possible, often publishing the research in peer-reviewed journals, health care trade publications, and university or foundation publications. For instance, at the completion of the institute's community health profiles project — designed to improve the health assessment, planning and evaluation capacities of local public health departments and their hospital partners in Michigan — pro-

ject leaders published a discussion of their findings in a statewide journal for hospital and health care administrators (Monaghan, Schillo, & Beane, 1995). Similarly, research regarding activities being undertaken throughout Michigan to revitalize the process of community health assessments was published last year in a peer-reviewed journal for public health managers (Paul-Shaheen, Schillo, Beane, & Kleinau, 1997). Furthermore, research regarding a pilot program to educate the public about the safe use of firearms was published this year by a peer-reviewed journal for social marketers (Roberto, Johnson, Meyer, Robbins, & Smith, 1998).

BUILDING FOR THE FUTURE

As the decade comes to a close, MPHI is placing a greater priority on science that has the potential to focus community health trends in positive directions, as well as projects that advance community capacity to improve health status and to reduce disparities in health status among population subgroups. It also is developing its role as an advocate for community health improvement, especially as a conduit for effective communication between communities and government, funders and academia. MPHI's new direction can be found in a recent MPHI report on the efforts of 26 communities (Patterson, 1996) and a subsequent statewide conference involving state, community and foundation players.

The institute currently invests about 55 percent of its gross income in communities in the form of grants and support to universities, community-based organizations, and others working to promote health and pre-

vent disease. It is working toward the day when it invests as much as 60 percent of its financial resources in endeavors that increase local leadership capacity in communities, promote research and education in advancing public health practices, and builds on effective public health collaborations with universities, communities and institutions.

One of the most promising long-range projects undertaken by MPHI during the last few years is the Michigan Community Health Leadership Institute (MCHLI). Established by MPHI in 1995, the MCHLI offers public and private health care professionals, community leaders, and members of the academic community the opportunity to acquire the skills necessary to lead Michigan's efforts in solving state and local health problems. Programs are one year long and include on-site and distance learning opportunities. Modules are interactive and consist of team projects, presentations, discussions, and case studies. Faculty members are drawn from Michigan's colleges and universities, as well as from the national public and private sectors.

MPHI's recently completed conference center and interactive learning center will offer an endless array of learning opportunities for MCHLI scholars and other key constituents. Its offerings will enable MPHI, its partners, and its clients to remain in the vanguard of health research, development and training. The facility includes a three-room, 145-participant videoconferencing facility that offers satellite downlink capability and the opportunity to host fully interactive video conferences on a simultaneous basis with participants

in as many as 45 sites around the world. The adjoining community health sciences virtual library, currently under construction, will provide workstation-based electronic library service, on-site reference and literature search services, access to information regarding funding resources and opportunities, multimedia resources, inter-library document delivery, and a "best practices" information exchange between health groups.

CONCLUSIONS

The executive reorganization of Michigan state government that was begun in January 1996 continues today. Many see it as a defining movement in "devolving" some state government responsibilities to communities. In response to these changes, local communities are striving to reform their systems to integrate services and support the choices of families and individuals. As local governments and non-profits struggle to develop additional expertise in their communities, they are expressing an increased need for training and support services. Likewise, as the size of their own staff significantly decreases, state agencies are expressing an eagerness to contract these services to qualified experts.

MPHI is well-positioned to accept many of these additional responsibilities, and it is doing so. The institute is playing a key role in supporting communities working to respond to devolution, something that many states may soon be experiencing.

In today's changing health care environment, MPHI serves as an effective, collaborative voice of communities. It also stands as a model for the

establishment of other nonprofit health institutes that can take advantage of their organizational neutrality and university-government-commu-

nity connections to meet the nation's changing public health needs through public health research, development and education.

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SPOTLIGHT

Michigan Public Health Institute

Building Research Partnerships

- reducing cardiovascular disease in Michigan
- providing information on Alzheimer's disease to anyone, anywhere in the state who needs it
- targeting preventive health programs to the places where they are needed

These are just a few of Michigan's health care goals. Delivering ambitious efforts like these, however, is beyond the capacity of any one group or organization.

"I really think that the name of the game today is partnership" says Jeff Taylor, who heads an organization that is trying to improve health in Michigan through research, conferences of experts, statewide information networks, and new education programs. Taylor is the executive director of the Michigan Public Health Institute (MPHI), a consortium of researchers from Michigan universities, government agencies, and other organizations that address health issues. Taylor explains that partnerships are attractive to potential funders of such programs because the combined groups can bring together more experts than any one partner can offer, making a "more complete" research team.

MPHI oversees about \$6 million in grants annually, and carries out nearly 70 projects each year from offices in Detroit and Ann Arbor as well as its Okemos headquarters

At the University of Michigan, an MPHI partner, many health researchers have been involved in MPHI projects, says Taylor. This includes faculty members, graduate students, and research scientists from the School of Public Health, School of Social Work, Medical School, and Institute for Social Research.

Other research partners include Michigan State University (MSU), Wayne State University (WSU), and the Michigan Department of Community Health (formerly the Michigan Public Health Department). Many private and non-profit health organizations, such as the American Cancer Society and Vector Research, Inc. of Ann Arbor also collaborate on MPHI projects.

The "clout" of MPHI's assemblage of researchers is shown by its "Master Contract for Research Centers." This contract qualifies MPHI to bid on high-priority health care studies, a status awarded to only a few research consortiums nationwide.



Charles Kuntzleman measuring body fat on a youngster.

Photos courtesy of MPHI



Jeff Taylor

To earn the Master Contract, MPHI recruited hundreds of researchers covering vast areas of expertise like health economics, health policy and financing, managed care, and biostatistics. William Weissert, UM professor of health management and policy and the Master Contract project director for MPHI, says he had unsuccessfully tried to secure this status for the UM several years ago. But through MPHI, Weissert organized researchers from Michigan universities and five private research organizations. With the Master Contract in hand, MPHI won its first federal contract, the Medicaid State Profile Project, and a second contract, Longterm Care, beating out nationally known competitors like the Rand Corporation and the Urban Institute.

Their work resulted in a computerized system that keeps track of how each state spends its Medicaid dollars. Currently, each state can choose what percent of the poor they cover with Medicaid, what services to cover, and how much to pay for these services. The ability to easily compare different Medicaid programs will help federal policy makers see how each state will be affected by policy changes.

Besides mustering the partners needed for these projects, MPHI overcomes some less obvious and much trickier obstacles to collaborative research. The Institute reduces the time and headaches involved in negotiating a complex relationship between collaborators. Collaboration procedures,

from proposal writing to budgets to communication, have already been established by MPHI, so teams can prepare proposals quickly, and researchers can get on with their research.

In addition, MPHI creates a neutral zone for collaboration where all participants are equal partners. "This can enhance the chances for true mutual collaboration, and can minimize frustrations, jealousies, and unproductive competitiveness," says Toby Citrin, UM professor of public health and founding member of MPHI's initial Board.

MPHI collaboration allows many university researchers the satisfaction of putting their theories into practice. "It's difficult for faculty members to be part of this kind of applied research — the kind of work that may not result in publications for peer-review," says Susan Morrel-Samuels, of the department of Health Policy and Management in the UM School of Public Health. "Through MPHI collaborations, faculty can get involved without jeopardizing their own research agendas."

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Fit Kids/ Fit Parents?

Perhaps the way to better adult cardiovascular health in Michigan is through children. Charles Kuntzleman, a researcher in the UM division of kinesiology, is heading MPHI's Cardiovascular Disease Pediatric Antecedents Project.

Kuntzleman had already been studying the health of Michigan children. Through MPHI Kuntzleman linked up with the Michigan Community Health Department to expand his research. The Pediatric Antecedents Project aims to reduce cardiovascular disease in families by identifying children at risk of developing cardiovascular disease or by helping families maintain low risk behavior.

For the study, cardiovascular health data, including height, weight, and physical activity levels, were collected from parents of children already involved in Kuntzleman's research. One goal is to determine if there is a relationship between child and parent risk. For example, does high blood pressure in a child indicate a parent with heart disease? If so, community health organizations will be able to identify families who are at risk for heart disease.

A second group of children will participate in an educational component. Students will take home "Skill-A-Week" activities that include health strategies to discuss and implement with their parents.

Kuntzleman wants to determine if the health behavior of a parent can be improved by first educating the child, who then takes the knowledge home. "Adults didn't have good physical education programs because

of poor physical education and health requirements in school," says Kuntzleman.

After the 9-12 week period, the parents' cardiovascular fitness will be measured again. If take-home lessons successfully improve adult cardiovascular health, then the state health department could use this strategy throughout Michigan.

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Community Health Profiles

How do you anticipate local or regional health problems? How do you direct health programs where they are needed? It requires a wealth of data on the health of individuals, on environmental factors, and on health systems already in place. Every county in Michigan now has that information thanks to the Community Health Profiles Project (CHPP), which tapped collaborators throughout the state to develop health status profiles for every county in the state.

Included in these published profiles are demographic, social, and economic indicators; and health status indicators, such as maternal and infant health, mortality and risk behaviors. Also provided is information about health systems — their capacity, supply, access and use. The profiles enable communities to conduct assessments of their local health conditions.

"The subject areas of these profiles are so broad, so all-encompassing, it requires a response from a wide variety of individuals and a wide variety of data," says Susan Morrel-Samuels, a UM School of Public Health researcher, and a collaborator on CHPP. "It definitely was a project of a scale that required collaboration."

UM professor of environmental and industrial health Bruce Chin is the primary author of the project's environmental health component. This section includes measures of the quality of a community's air, water, shelter, workplace, food, and waste. County-specific environmental data can be used to determine how environmental factors affect a community's health.



Bruce Chin and Susan Morrel-Samuels

Currently CHPP results are being used by community health departments, hospitals, and other health organizations for assessing their community's needs, setting priorities, and for developing and evaluating programs.

According to Toby Citrin, UM professor of public health and former MPHI board member, this information is in high demand as the country's health care system places an increasing emphasis on prevention. "This project has significantly strengthened the entire public health infrastructure of the state," says Citrin.

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Dementia Information

As our population ages, more and more families confront the difficulties of caring for a parent or spouse with a dementing illness. Often the dementia results from Alzheimer's disease. Huntington's disease, Parkinson's disease, and multiple strokes also cause dementias. People with severe cognitive decline need medical assistance for diagnosis and treatment, respite care, and management of day-to-day living. Family members want to know what to expect and how to care for their loved ones and whether caregiving assistance is available. Also they wish to know whether they or their children will be afflicted with the disease.

The Michigan Dementia Program was established in 1986 to aid the state in responding to the needs of individuals and families affected by dementia. The program's partners are the University of Michigan, Michigan State University, Wayne State University, the Michigan chapters of the Alzheimer's Association, Michigan Parkinson's Foundation, the Michigan chapters of the Huntington's Disease Society, and the Michigan Department of Community Health.

The Program's referral information centers throughout the state provide resource libraries, contacts for appropriate professionals, and access to community and public health services.

The Michigan Dementia Program also works closely with pathology departments at the University of Michigan and Michigan State University, and has a statewide network of pathologists who have established uniform procedures for postmortem examination of brain tissue of people thought to have Alzheimer's disease.

UM neurology professor Sid Gilman, who directs an Alzheimer's disease program at the funded by the National Institutes of Health, was key in organizing the MPHI project and getting it funded. Gilman points out that statewide support is what makes the program successful.

—Jamie Saville