Wisconsin Healthiest Women Initiative
Small Group Break-out Sessions – All Qualitative Data Compiled
June 8, 2011

VISION

Health Care Practice Vision:

- Integrated care, team approach, medical homes
- Full spectrum care, broader options
- Inclusive system
- Linguistic and cultural proficiency
- Standards of care
- Timely care
- Choice of providers
- Systematic and comprehensive screening (mental health, violence, etc)
- Appropriate provider incentives (pay-for performance?)
- Trust between providers and clients

System Vision:

- Integrate public health and medicine
- Prevention & wellness model
- Efforts are community led (with local leadership and high-profile champions)
- Uniting CBOs
- Variety of accountability (provider, payment, insurer, consumer, government)
- Commitment to long term goal/plan
- Determining accountability structure and placing *value* on accountability
    - values of accountability should be established by big picture community (larger ownership – business, institutions, politics, etc) and the health impact analysis
- System designed around client, consumer-perspective driven system

Social Determinants Vision:

- Elimination of disparities
- Economic security
- Supportive environment

Data Vision:

- Problems identified by data *and* communities
    - Impacted population is engaged and offers input to interpret data
- Increased data sharing
- Transparency in data and decision-making

CHALLENGES

Community/Patient Challenges:

- Health literacy
- How to make "health" a priority when basic needs are not met
- Lack of capacity – agency & community
- Patient apathy
- Tools for empowerment are lacking, need to try and strengthen community
- Consumer driven services
- Including business planners, community developers and youth in conversation about improving access to and affordability of services
- Need to define "community", (e.g. racial/ethnic group; entire city; neighborhoods; etc.)

Health Care Practice Challenges:

- Cultural & linguistic competence
- Provider diversity
- Trust/confidence issues
- Stereotyping
- Limited scope of services
- Changing to a prevention framework rather than a treatment framework
- Development of relationship with providers is not promoted – much information received via internet
- Messaging is important – messaging can conflict with guidelines
- Need financial support for data analysis and dissemination
- Need incentives – pay for performance – providers motivated to improve patient outcomes
- Health information needs to be available at appropriate literacy level
- How to make "health" a priority when basic needs are not met

System Challenges:

- Funding and competition among agencies for scarce resources
- Political will & current/future policies (decisions driven by science not politics)
- Professional/provider will
- Racism
- Job development and security
- Religious barriers
- Workforce strategies
- Stigmas
- Sexism
- Competing interests
- Environments – safety and geography
- Poverty
- Segregation
- Classism

- Location of services is a problem in communities--hospitals moved out of the cities--providers no longer down the street
    - Resources aren't located in the right locations—barriers (transportation, etc.) Get close to the client!
- "Silos" – lack of collaboration
- Those that have resources aren't willing to invest in grassroots model
- Systems are hard to navigate for everyone.
- Duplicative services – the answer isn't always more programs but better coordination and collaboration.
- CBOs working in silos
- Responsibility of people with "power" ($, resources, position)
- Businesses need to be responsible for environmental factors
- Urban planning and the impact on health and safety (road construction, plants, stadium)
- System should take on roll of education and promoting consumer accountability

Data Challenges:

- "Data fatigue"
- Confidentiality is challenge
- Local data needed
- Hospital system should disseminate data effectively
- Capacity of support for data interpretation and presentation
- How do we track issues such as violence more effectively using providers (lifecourse perspective looks at accumulated trauma)
- Selecting what data we want to monitor
- PRAMS only provides a piece of what we need
- Using clear and consistent speech
- Knowing what to focus on--are there certain topic areas we want to focus on? (case management, reproductive health, healthy weight, depression)--or do we zero in on just a few things we can change?
- State needs to share data to improve accountability
- Need to track maternal health data on community level, legislative district level, zip code level, local government level
- Hard to collect data on undocumented population
- Need to collect data on social determinants of health – gender preference, economics, race

STRATEGIES

Community/Patient-Level Strategies:

- Patient education & self advocacy
- Health literacy support
- Let community leaders, with community input, decide where resources are placed
- Public awareness
    - Start young (health care, activity, obesity, nutrition)
- Engage public will to change policy
- Encourage/organize civic community "group" projects examples:
    - Kiwanis
    - Presentations
    - Local farmer's markets
    - Exercise facilities
    - Community "walks"
- Tap into existing community events such as faith-based & school-based events
- Ask the community what issues are going on/what problems there are on a day to day basis/and to identify community solutions
- Improving community capacity for data collection and data utilization
- Could we incentivize organizations to have community advisory committees to build community capacity?
- Word of mouth promotes clinics
- Well-established clinics in community are successful

Health Care Practice Strategies:

- Provider training
    - Cultural proficiency
    - How to talk to patients
    - How to screen for a variety of mental and behavioral health problems, etc
        - Brief intervention within context of primary care visit – effective
- Standards of Care
- Compare home visiting versus office visit no show rates
- Use home visiting to increase immunizations (compare to clinic no-show rates)
- Promote postpartum visits
- Provide care for moms with infants in NICU
- Providers need strong partnerships in rural areas
- Hold providers accountable for addressing present and past patient history (i.e. violence)
- Integrate life course model in care
- Integrating mental health into primary care
- Use community health workers more & incorporate into models of care because they do good work and are effective
- More school-based health centers needed [take services to where people are]
- Provide family planning and well-woman care to uninsured and under-insured
- Reinforce positive health messages with women at every opportunity (every woman, every time)

- Use more advance practice nurses

System Change Strategies:

- Remove barriers to clinical care (transportation support, offer incentives like gas cards, extend hours and use open access scheduling)
- Collaboration/coordination (improve programs and services rather than duplicating)
- Require as part of licensing for large health systems to have a community health advisory.
- Capitalize on competition between health systems
- Connect needs assessment info with large health systems.
- Use community health workers more effectively
    - Currently, they are often volunteers and have no resources – change this
- Bring back "old time" medicine – would change how practice is viewed
- Use leadership to unite CBOs and/or hold a summit to bring everybody to the table to determine priorities, what resources do they have and need, etc.
- Connect many stakeholders including FQHCs, WPHCA, community boards and educate about zip codes and relationship to health
- Expose people to availability of resources
- Reinstate our stations with staff - counter for movement to be automatic
- Provider accountability by increasing mechanism for advocating for clients (ombudsman)
- State accountability needs to know relationships and have clearly defined roles
- HMOs and Medicaid – hold accountable for quality of care and outcome measures
- Provide continuity and comprehensiveness of services
- Support early childhood services

Data Strategies:

- Identify key data components
- Immunization and lead are two examples of accountable data – how do we translate to other areas?
- Existing mechanisms for establishing accountability (i.e. pay for performance & medical homes)
- Data sharing back to community for positive change
- Local entity as source of data (energize communities)
- Human resources for measurement and collection
    - sharing services and communication
- Identify relevant info such as adolescent STI rate & disparities with African American birth outcomes and adolescent girls
- PM/QI models and tools
- Use data sets that are already available
- Focus on relevant data, e.g., teen pregnancy, gonorrhea rates in teens
- Add questions to BRFSS that will help collect data we need
- YRBS is a good source