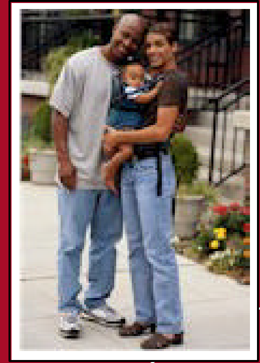
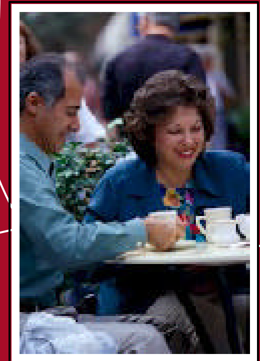
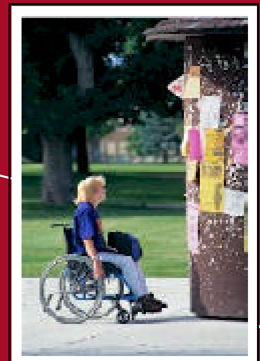
Healthiest Wisconsin 2010:

A Partnership Plan to Improve the Health of the Public







A Special Supplemental Report:

Engaging and Sustaining Selected Community Stakeholders in the Transformation of Wisconsin's Public Health System

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

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DEDICATION

The Wisconsin Turning Point Initiative presents this special report as a "toolbox of ideas and approaches" for use by the full spectrum of public health system partners in Wisconsin. It calls to the partners to rededicate themselves, their agencies, and their organizations to meaningfully include the diverse voices of community stakeholders as vital and active participants in the transformation of Wisconsin's public health system. Rededication will strengthen community capacity to achieve the three goals of the transformation--promote and protect health, eliminate health disparities, and transform Wisconsin's public health system for the 21st Century.

This special report contains the perspectives, insights, and recommendations to Wisconsin's public health system partners from five community Stakeholder Forums representing the interests of the following communities: African Americans; Hispanics/Latinos; Lesbian, Gay, Bisexual, and Transgendered Persons; Asians; and American Indians in Wisconsin. Their views concerning current and emerging needs and issues must be taken into account as the transformation of Wisconsin's public health system unfolds locally and statewide.

Collaborative partnerships between government and the people continue to be a foundational principle of the Wisconsin Turning Point Initiative and a core principle/value of the state health plan entitled *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public.* **Inclusion and sustained engagement of diverse communities will assure that their authentic voices are heard**. Incorporating these voices into the development of community health improvement plans will assure that community programs and services address the full range of actual and potential threats to health and the strengths within communities that protect health. The complexity of community life requires diverse involvement and collective energy to help achieve the shared vision of Wisconsin's public health system *"healthy people in healthy Wisconsin communities."* It will leave a lasting legacy that will benefit future generations.

ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation, based in Princeton, New Jersey, is the nation's largest philanthropy devoted exclusively to health and health care. It concentrates its grant making in three goal areas: to assure that all Americans have access to basic health care at reasonable cost; to improve care and support for people with chronic health conditions; and to reduce the personal, social, and economic harm caused by substance abuse—of tobacco, alcohol, and illicit drugs.

SPECIAL ACKNOWLEDGEMENTS

The Wisconsin Turning Point Initiative extends its gratitude for the technical assistance resources contributed by the Robert Wood Johnson Foundation. Other contributions were provided by the Great Lakes Inter-Tribal Council, the Division of Public Health, the Division of Public Health's HIV/AIDS Program, and the Office of Affirmative Action and Civil Rights Compliance, Wisconsin Department of Health and Family Services.

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Finally, the Executive Committee extends its special gratitude to the Division of Public Health's Office of Public Health Improvement for their leadership, creativity, and perseverance. They designed the Forums, created this report, and employed the transformational framework set forth in the State Health Plan entitled *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public* as the format to enable the Stakeholders to express their responses and reactions to Wisconsin's public health system transformation. These persons include: Margaret Schmelzer, State Health Plan and Public Health Policy Officer; Jennifer Argelander, Director; Office of Public Health Improvement; Denise Carty, Minority Health Officer; and Shirley Bostock, Program Assistant.

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INTRODUCTION

ABOUT THIS REPORT

This is a special supplemental report to the State Health Plan, *Healthiest Wisconsin 2010*: *A Partnership Plan to Improve the Health of the Public.* It describes the purpose, process, findings, and recommendations from five Wisconsin Turning Point Initiative's Community Stakeholder Forums. Each of the five community stakeholder groups formally met with the leadership of the Wisconsin Turning Point Initiative during August 2001 to April 2002. The five stakeholder groups and dates of meetings follow:

1. African American Community Stakeholders, August 21-22, 2001.
2. Hispanic/Latino Community Stakeholders, October 30-31, 2001.
3. Asian/Hmong Community Stakeholders, November 1-2, 2001.
4. Gay, Lesbian, Bisexual, and Transgendered Community Stakeholders, December 3-4, 2001.
5. American Indian Tribal Community Stakeholders, April 16-17, 2002.

The chief outcomes of the five forums were to:

1. gain insights into cultures and the forces influencing health disparities;
2. enhance knowledge and understanding of communities through direct experience; and
3. build relationships and provide opportunities for continuous learning.

This report is designed to:

1. Enhance the technical capacity and cultural competence among the public health system partners to locate and assure the sustained engagement of diverse community stakeholders in the transformation of Wisconsin's public health system.
2. Increase the public health system capacity to assure the inclusion of authentic and diverse voices of traditional and emerging community stakeholders on local, regional, and statewide partnership structures, coalitions, and workgroups.
3. Provide recommendations, insights, challenges, and assumptions to stakeholder groups and the public health system partners to increase knowledge and shape contemporary community public health processes and practices.

HOW TO USE THIS REPORT

This report is divided into four parts:

Part I provides a background of the forums and common public health language and definitions.

Part II provides provisional recommendations from the selected stakeholder communities and suggests broad recommendations to Wisconsin's public health system partners to assure diverse and sustained partnerships for the future.

Part III describes the processes used and successes and missteps experienced by the Wisconsin Turning Point Initiative in establishing the community stakeholder forums.

Part IV records, in the authentic voices of the participants at the stakeholder forums, their first-hand reactions, responses, and recommendations concerning self-selected elements of the Transformational Framework form of *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. It also records the special issues and concerns they face in their everyday lives, as both community leaders and members of their community.

Part IV reflects the participants' subjective views on how programs and services are carried out in their community and resultant barriers and problems from such programs, services, and mindsets. These perspectives, in some cases, may not necessarily match the original intent or criteria of such programs. Nonetheless, it is important for the reader to remember that "perception is reality." Part IV represents a starting point for mutual understanding and change. Part IV also includes the list of participants for each stakeholder forum.

HOW TO ACT UPON THIS REPORT

The public health system partners and community stakeholders are encouraged to review and discuss this report and disseminate it widely (both hard copy and electronically) within their organizations and among their community networks. As public health system advocates, the partners must improve practices to reach out to diverse community stakeholders and invite their sustained engagement in shaping of local, regional, and statewide public health systems.

The work of building partnerships has never been more important, given the disproportionate and devastating burden of health disparities these communities and others have endured and continue to face. Partnerships are a necessary ingredient in eliminating disparities because they add value and inform processes and outcomes. Eliminating health disparities requires that the partners reaffirm their commitment to inclusion. Inclusive partnerships provide great hope in reversing practice from "doing to the community" and moving toward "doing with the community."

Finally, this report can serve as a template to tailor approaches with new, nontraditional stakeholders at the neighborhood, town, city, county, and statewide levels. New nontraditional stakeholders include, but are not limited to, rural agencies/organizations such as 4-H; refugee-run, community-based organizations such as the 15 Mutual Assistance Associations in Wisconsin; faith communities; and the business and commerce sectors. Broad-based inclusion will assure engaged and sustained partnerships in service to the community and help community leaders and the public health system partners know their communities from the inside out.

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PART I

BACKGROUND AND DEFINITIONS

"None of us can expect to act on more than a tiny corner of the great complexity. But in our interrelated society, itself part of an uncompromising interdependent world, we have to *think* about the whole complexity in order to *act* relevantly on any part of it." (Harlan Cleveland)

Source: *The Knowledge Executive*

BACKGROUND

The idea of holding community stakeholders forums grew out of the recognition by the Wisconsin Turning Point Initiative that greater effort and knowledge were needed to assure collaborative partnerships between government and its partners in the public, private, nonprofit, and voluntary sectors. Collaborative partnerships were, after all, one of four foundational principles of the Wisconsin Turning Point Initiative since its inception in 1998. Furthermore, collaborative partnerships were identified as one of eleven core principles/values identified by the partners in *Healthiest Wisconsin 2010.*

Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public is the state health plan required of the Department every ten years by the Wisconsin State Legislature as set forth in s. 250.07, Wis. Stats. *Healthiest Wisconsin 2010* is based on a transformational framework that serves as the basic architecture for the state health plan and collaborative efforts to transform Wisconsin's public health system for the 21st Century (refer to the last page of this chapter to review the framework). This framework was used in each of the five Stakeholder Forums to create opportunities for dialogue, discussion, and sharing of views and provisional recommendations by the stakeholder participants.

The chief elements of the *Healthiest Wisconsin 2010* framework include:
- Vision statement
- Eleven core beliefs and principles
- Mission statement
- Three core public health functions and eleven essential public health services
- Five infrastructure (system) priorities
- Eleven health priorities
- Two major outcomes: (1) improve public health system capacity and (2) improved health of the public

The Wisconsin Turning Point Initiative continues to be committed to diversification by bringing new and fresh voices to the table. Many innovative methods were used to identify new partners, including direct outreach to key community-based agencies/organizations whose focus was to serve racial and ethnic population groups. While success was initially achieved in the early years of the Wisconsin Turning Point Initiative, unfortunately over time, several of these agencies/organizations were unable to sustain long-term participation of a public health system transformation of this magnitude. Reasons for this were in part attributed to:

- Demands for their services in their own communities (e.g., client/family advocacy, translation) that compelled them to prioritize direct services to their communities first.
- Lack of agency resources to support long-term involvement (e.g., dedicated staff time) even though meals and travel reimbursement were provided.
- Lack of immediate benefit to the community-based organization in terms of tangible programs and resources. One reason for this is that the concept of public health systems transformation is hard "to get one's arms around."

Despite these challenges, substantive and successful gains were made to diversify voices of the public health system partners during 1998-2001. New nontraditional partners (e.g., faith

communities, labor organizations) came into the public health system transformation along with new voices from traditional public health system partners (e.g., physicians, hospitals, nurses, faculty). Nonetheless, ethnic and racial diversity was largely absent.

Because of this continuing challenge it became necessary to rethink the outreach strategies and approaches used by the Wisconsin Turning Point Initiative and endeavor to improve practice and learn what was not working. This was critical given that racial and ethnic groups throughout Wisconsin suffer a disproportionate burden from health disparities. Moreover, "eliminating health disparities" and "promoting and protecting the health for all" were identified as two of three overarching goals of *Healthiest Wisconsin 2010.* Rethinking internal outreach strategies and approaches generated a number of questions that included:

- What was working well and what was not working in terms of communications, strategies, and approaches used by the Wisconsin Turning Point Initiative?
- How effective were communications in describing the pressing need for a public health system transformation to the community partners?
- Did the partners understand Wisconsin's new agreed-upon definition of "public health" (see "Definitions" below)? This is an ongoing challenge because people, in general, understand the medical care system better than they understand the public health system. Simply put, public health is not an easy concept to understand, even among health professionals.
- Why did the outreach strategies and approaches work well with traditional public health system partners, and even new nontraditional partners, yet these same strategies and approaches were ineffective with community-based organizations serving racial/ethnic communities?
- What needs to change? What is missing in our "toolbox" of public health strategies to assure that diverse voices are engaged and sustained? Tools include knowledge and application of data and information, population-based practice, dialogue, conflict resolution, diversified networks, and cultural competence, to name a few. How can the partners and communities contribute to the "toolbox" to assure that the tools are contemporary and adaptable? What tools and approaches are needed for the future?

If the Wisconsin Turning Point Initiative and its broad networks were challenged in bringing diverse voices to the table, it was assumed that local health departments, hospitals, educational institutions, and other organizational and institutional partners might be experiencing similar challenges. Knowledge and practice needed updating. **Direct communication and dialogue with community stakeholders was viewed as the most promising approach**.

Beginning in 2001, the Wisconsin Turning Point Initiative went directly to five community stakeholder groups to discover and uncover the current and emerging issues facing these communities and the actual and perceived barriers to building an effective public health system. Using a focus group approach, **the purposes of the Wisconsin Turning Point Initiative's community stakeholder forums were to**:

1. Learn what it takes to outreach, engage, and sustain community stakeholders in the transformation of Wisconsin's public health system.
2. Listen to the participants' views of the challenges and strengths in their community, and learn, first hand, about the issues these communities confront on a daily basis concerning

health, public health, social/economic conditions, and the environment (determinants of health).
3. Solicit reaction to the elements of the framework of the State Health Plan: *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*.
4. Communicate the knowledge and experience gained to Wisconsin's public health system partners to assist the partners in assuring the sustained engagement of community stakeholders in the local and statewide transformation of Wisconsin's public health system.

DEFINITIONS

Acceptance of common language leads to common understanding and knowledge. One of the main challenges of the community stakeholder forums was to communicate the interrelationship of the concept of public health and the concept of personal health. Most participants came to the community stakeholder forums with the understanding that "public health" was what a local or state health department did (e.g., provide communicable disease services, inspect restaurants, make home visits to families at risk).

It was heartening to witness the participants embrace the contemporary concept of public health and to see themselves and their community agencies as not only a part of Wisconsin's public health system, but also as direct beneficiaries of the public health system. This was transformational in itself. Sharing a common language is critical to common understanding. **Common understanding helps the partners develop shared goals and take collective action on an agreed-upon set of priorities**.

Health

As documented in *Healthiest Wisconsin 2010,* health is defined as "a state of well-being and the capability to function in the face of changing circumstances (Healthiest Wisconsin 2010, Institute of Medicine, 1997). Health, in this context, is both a concept and a self-perception. This definition views health as a positive concept, one that considers personal and social resources as well as physical, mental, and spiritual capacities. All of the partners contribute to the well being of individuals, families, and communities. As stated in the *Future of Public Health for the 21st Century* "…it is hardly necessary to argue that good health is fundamental to a good society. Without a certain level of health, people may not be able to fully participate in many of the goods of life, including family and community life, gainful employment, and participation in the political process." The definitions of health and public health are interwoven and interconnected (Institute of Medicine, 2002).

Public Health/Public Health System

Throughout our nation "public health" continues to be defined as "assuring conditions in which the population can be healthy" (Institute of Medicine, 1988; Institute of Medicine, 2002). As documented in *Healthiest Wisconsin 2010,* public health is defined as a system, a social

enterprise, whose focus is on the population as a whole. The public health system seeks to extend the benefits of current knowledge in ways that will have maximum impact on the health status of the entire population in several key areas:

- Prevent injury, illness, and the spread of disease.
- Create a healthful environment and protect against environmental hazards.
- Promote and engage healthy behaviors and promote mental health.
- Respond to disasters and assist communities in recovery.
- Promote accessible, high quality health services.

The public health system then is a broad collection of partners with a complex mission whose focus is on the entire population. Its mission is to "promote and protect the health of the people of Wisconsin." No one organization could fulfill the mission alone. While government has clear roles and responsibilities, some of which are defined in law, the public health system can only be viable if diverse organizations work together as mutual partners.

A viable public health system requires that the partners are collectively focused on achieving the shared vision of Wisconsin's public health system: *"healthy people in healthy Wisconsin communities."* Diverse partnerships and focusing on a common vision enable the system to achieve the overarching goals of (1) promoting and protecting health for all, (2) eliminating health disparities, and (3) transforming Wisconsin's public health system at the local community and statewide levels (*Healthiest Wisconsin 2010*).

Public Health System Partnerships

Partnerships are defined in the Implementation Plan for *Healthiest Wisconsin 2010* as "collaborative, synergistic alliances of diverse public health partners working towards community and population health improvement in areas too complex for one entity to accomplish. Public health system partnerships vary in their organizational structure, developmental stage, geographical focus, resource availability, and purpose. Operationally, these partnerships may share information, coordinate health-related services, identify health issues, set goals for action, plan and implement strategies and activities, and evaluate outcomes. Public health system partners include individual residents and diverse governmental, public, private, nonprofit, and voluntary organizations, agencies, and groups." (Lasker, Weiss, & Miller, 2001; *Healthiest Wisconsin 2010: An Implementation Plan to Improve the Health of the Public*, 2002).

FRAMEWORK FOR WISCONSIN'S PUBLIC HEALTH SYSTEM TRANSFORMATION

FRAMEWORK PLANNING IMPLEMENTATION

Shared Vision of Wisconsin's Public Health System Partners

Healthy people in healthy Wisconsin communities

A healthy Wisconsin is a place where…

- All residents reach their highest potential
- Communities support the physical, emotional, mental spiritual, and cultural needs of all people
- People work together to create healthy, sustainable physical and social environments for their own benefit and that of future generations

Guiding Principles / Core Values of the Public Health System Partners

Mission

To protect and promote the health of the people of Wisconsin

Core Public Health Functions

1. **Assessment**: Determine community strengths and current/emerging threats to the community's health through regular and systematic review of the community's health indicators with the public health system partners.
2. **Policy Development**: Establish a community health improvement plan and action steps with the public health system partners to promote and protect the health of the community through formal and informal policies, programs, guidelines, environmental changes, and programs and services.
3. **Assurance**: Address current/emerging community health needs/threats through governmental leadership and action with the public health system partners. Take necessary/reasonable action though direct services, regulations, and enforcement. Evaluate the improvement plan and actions, and provide feedback to the community.

Essential Public Health Services

1. Monitor health status to identify community health problems
2. Identify, investigate, control, and prevent health problems and environmental health hazards in the community
3. Educate the public about current and emerging health issues
4. Promote community partnerships to identify and solve health problems
5. Create policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and insure safety
7. Link people to needed health services
8. Assure a diverse, adequate, and competent workforce to support the public health system
9. Evaluate effectiveness, accessibility and quality of personal and population-based health services
10. Conduct research to seek new insights and innovative solutions to health problems
11. Assure access to primary health care for all
12. Foster the understanding and promotion of social and economic conditions that support good health

Overarching Goals

Eliminate Health Disparities

Promote and Protect Health for All

Transform the Public Health System

System (Infrastructure) Priorities

- Integrated electronic data and information systems
- Community health improvement processes and plans
- Coordination of state and local public health system partnerships
- Sufficient, competent workforce
- Equitable, adequate, and stable financing

Health Priorities

- Access to primary and preventive health services
- Adequate and appropriate nutrition
- Alcohol and other substance use and addiction
- Environmental and occupational health hazards
- Existing, emerging, and re-emerging communicable diseases
- High risk sexual behavior
- Intentional and unintentional injuries and violence
- Mental health and mental disorders
- Overweight, obesity, and lack of physical activity
- Social and economic factors that influence health
- Tobacco use and exposure

Policy Recommendations

Actions and Interventions by the Public Health System Partners

Outcomes: Improved Health of the Public and Improved Public Health System Capacity

PART II

RECOMMENDATIONS AND NEXT STEPS

"The strategies and approaches we take today--may not be the ultimate solutions to today's challenges, but must be an improved, evolving expression of an ideal."

Adapted "How Your Child is Smart"

PROVISIONAL RECOMMENDATIONS FROM THE SELECTED STAKEHOLDERS

This section provides provisional recommendations from the five stakeholder groups and does not include recommendations from the Wisconsin Turning Point Initiative. High energy coupled with enthusiastic participation and positive interaction characterized the work of the participants in each of the sessions. The opportunity to reflect, dialogue, and share information between diverse colleagues was so valuable that the stakeholders asserted many times that these kinds of public health system forums should continue on a recurring basis.

Many stakeholders said that these forums were the first time they were ever asked to reflect upon the public health system "as a whole." While discussing programs and services (e.g., infant mortality, asthma, HIV/AIDS) is important, whole systems thinking stimulated significant collective energy and a sense of hope. Many saw the forums not as an "event," but rather as the beginning of a "process." Participants saw the forums as unique, valuable, and critical to building trust. Once trust is achieved, functional and productive relationships become a real possibility where the stakeholders believe they are truly part of Wisconsin's public health system.

While all participants provided their views and reactions to the elements of *Healthiest Wisconsin 2010*, attendees went beyond these elements and raised key issues and "big picture" challenges to health and healthy communities that they routinely confront and experience. **The selected community stakeholder groups echoed that a significant transformation is required in a way that resources and services are provided to community stakeholder populations**. The outcome was a wealth of insights, fresh ideas, and advice from each community stakeholder forum.

Common themes resulted in recommendations that included (1) relationship building, (2) health communication and outreach, (3) access without barriers, (4) transformation of the public health systems, and (5) collection and monitoring of meaningful data on diverse communities. Similar themes and underlying recommendations have been offered by communities and in some cases are not new.

It is now time to seize the opportunity for the communities in partnership with the public health system to take collective action to effect broad systemic change. In a contemporary public health system that is goal-directed and committed to meaningful and effective change to improve the public's health, it is time to take a bold and proactive stance to progressively incorporate, when possible, the following recommendations with the mutually desired outcome of optimal health of racial/ethnic and sexually diverse populations over time.

Provisional Recommendations

1. Relationships

Ensure authentic dialogue with direct benefit to community participants.

- Overcome the current separations by relational bridge building.
- Enhance respect, understanding, and trust through inclusive partnerships, establishing "intervenor" positions, and cultural competence.
- Ensure meaningful inclusion, not tokenism.
- Promote open dialogue on issues and proposed solutions without fear of retaliation.
- Host public meetings in safe and familiar community spaces.
- Honor the perspectives of diverse communities.
- Provide tangible symbols of authentic outreach and connection such as Neighborhood Block Health Watch strategies and connecting to community faith-based organizations.

Guarantee a sustained commitment to working with communities.

- Act upon the advice and recommendations given, when possible, to acknowledge that they were not only heard, but that community involvement and comments are taken seriously.
- Continue public health forums by establishing periodic meetings as determined by the community.
- Formalize a systematic method to foster sustained community engagement to work on public health problems.
- Formalize a process for regular meetings with state and community representatives.

2. Health Communication and Outreach

Avoid oversimplification of widely diverse and rich cultures, and tailor communication, outreach, and program strategies to reflect this reality.

- Demonstrate understanding of targeted communities by including a written description of these communities with concurrence by the persons intended to benefit from the program and all public health program plans.
- Sponsor ethnographic studies of health beliefs and attitudes, concerns, and approaches in communities with a 4 percent or greater population of racial/ethnic minority residents. Similarly complete ethnographic health studies in Lesbian, Gay, Bisexual, and Transgendered communities.

Use culturally appropriate strategies to effectively reach populations and promote behavior change for improved health practices.

- Provide culturally sensitive and culturally competent prevention strategies in both oral and written communications.

- Match public health education programs with the cultural context of communities and use clear and consistent messages.
- Implement effective social marketing principles, including use of ethnically targeted local media and informal communication systems.
- Implement major long-term marketing campaigns to promote good health.

3. Access Without Barriers

Promote universal access for all populations without barriers.

- Assure access for all as a key strategy for eliminating disparities.
- Comprehensively address barriers to access, including discrimination, workforce issues, social/economic improvements, mental health, and alcohol and other substance use and addiction.
- Ensure insurance coverage for all.
- Make BadgerCare available to single people.

Increase community-based health systems that are culturally and linguistically appropriate.

- Adopt and enforce standards for delivery of culturally competent services.
- Implement cross-cultural education and cultural competence training.
- Promote community-based leadership to enhance access to care for populations not effectively reached.
- Provide more culturally appropriate mental health services.

Improve social and economic conditions.

- Reduce poverty.
- Address community racism.

Enforce measures to prevent discrimination in health care.

- Treat all consumers with respect and dignity.
- Promote social justice and elimination of social discrimination.
- Hold agencies and organizations accountable for their policies.

Increase the diversity of the health care workforce.

- Increase the number and availability of racial/ethnic health care providers and Lesbian, Gay, Bisexual, and Transgendered health care providers.

4. Transformation of the Public Health System

Statewide and local public health systems must focus with intensity on connecting with each of the stakeholders' communities.

- Assure effective consequences for noncompliance with public health regulations and laws. This means getting beyond words--to action.
- Focus more on prevention strategies, leadership development, and reduce dependency by empowering inclusive local and statewide partnerships that make decisions on program priorities and resource allocations (voice for all).
- Actively provide information in welcoming culturally accessible formats and language.

Change the composition of decision-making and policymaking bodies (legislature, health boards, and commissions) to reflect more racial/ethnic and Lesbian, Gay, Bisexual, and Transgendered representation.

- Set minimum composition requirements by the State, above what is currently identified in Chapter 251, Wis. Stats.
- Develop a statewide advisory council on minority and Lesbian, Gay, Bisexual, and Transgendered health.
- Establish a Lesbian, Gay, Bisexual, and Transgendered Health Officer in the Division of Public Health.

Develop the infrastructure and capacity of community-driven health programs.

- Facilitate/coordinate redistribution of power and health resources in local communities.
- Carry out public health programs and initiatives on a more level playing field.
- Direct more funding and resources to community-based organizations and local health departments for health promotion targeted to racial/ethnic communities.
- Primarily subcontract to organizations to provide health care that reflects the picture of the people they serve.
- Reduce categorization of public health programs and allow the flexibility to address community priorities and provide generalized services.
- Place more public health nurses and lay health extenders directly in communities, providing more direct neighborhood contact and in-home care.
- Balance the public system health professionals that primarily focus on administrative issues with public health practitioners providing direct services so as to better interpret key issues for communities and provide adequate help.
- Support more lay health workers and home visitation programs.

Fund and sustain nontraditional public health strategies and alternative approaches that are effective in diverse communities.

- Avoid the medical model and use more “holistic care” in planning and delivering health services to the community.

- Link traditional and nontraditional providers to consult and provide health care.
- Provide funding and third-party reimbursement for alternative and nontraditional strategies that work with racial and ethnic minorities and the Lesbian, Gay, Bisexual, and Transgendered communities.
- Incorporate spiritual approaches in health programs.
- Foster indigenous health practices in health services planning and delivery (e.g., healthy diets, physical activity, spiritual focus).
- Commit more resources for family-centered case management.

Encourage a greater emphasis on prevention and community self-reliance.

- Don't impose prevention programs, but instead discover with the community effective ways to encourage buy-in of the targeted community.
- Build on community assets and resiliency.
- Disseminate key information and build on natural strengths of the community.
- Reduce market forces that perpetuate risky behaviors in racial and ethnic minorities and in the Lesbian, Gay, Bisexual, and Transgendered communities.

Develop and support a systematic process for communities to set their own health priorities.

- Establish what is meant by basic health services for each community and provide those prioritized services.
- Provide a voice for all in the grassroots community.

Pilot and implement "Neighborhood Healthwatch Programs" mirrored on neighborhood safety watches structure and process.

- Build a formal network of Neighborhood Block Captains who will be community leaders responsible for relaying key health priorities and concerns for a circumscribed area.
- Work with Neighborhood Block Captains in consultation with a public health staff liaison (public health nurse) within the local health department.
- Assure strong coordinated leadership by the local health departments, Division of Public Health, and the Department of Health and Family Services.

5. Collection and Monitoring of Meaningful Health Data on Diverse Communities

Develop data systems that adequately capture the reality of various stakeholder groups, tracking outcomes, and driving resource decisions and program priorities.

- Increase the availability and reporting of reliable and meaningful health data.
- Survey specific identifiers such as race, ethnicity, primary language, country of origin, residence, age, income, and employment.
- Develop data systems that adequately capture the reality of various stakeholder groups, tracking outcomes, and driving resource decisions and program priorities.

- Commit more resources for adequate population survey samples of racial/ethnic and Lesbian, Gay, Bisexual, and Transgendered communities.
- Collect data on population subgroups.
- Carry out comprehensive community health assessment to identify unique needs and determine where the disparities exist.
- Use qualitative data to enhance knowledge of community health.
- Decrease reliance on phone surveys that do not adequately include important segments of the population.
- Avoid unnecessary duplication of data collection procedures.
- Utilize more bilingual and bicultural staff to collect and analyze data.

Use data to drive resource decisions and program priorities.

- Ensure that data and health improvement policies go hand-in-hand.
- Use data collected and reported to shape policy and drive actions.
- Commit the resources needed to act on the data to improve health for target populations.
- Analyze and share data.
- Remember that good policy requires data analysis and then sharing what the data means.
- Produce an annual report on group-specific health indicators based on community-based organizations and input from members of the affected communities.

RECOMMENDATIONS FROM THE WISCONSIN TURNING POINT INITIATIVE

The Wisconsin Turning Point Initiative makes the following process recommendations to the public health system partners. For details see Part III of this report. These process recommendations are based on lessons learned, successes, and missteps in establishing and managing the processes that supported the stakeholder forums. The recommendations are designed to enhance the capacity of the partners in replicating this process at the local and statewide levels. The importance of a well thought out process is critical to engaging and sustaining the active involvement of these and other community stakeholders in the transformation of Wisconsin's public health system.

1. Personal connection and the conscious building of respectful relationships are both critical factors for the success of these partnership efforts. Invitations should, therefore, be conducted person-to-person, or at the very least with a personal telephone call. If a letter or e-mail is sent as a first contact, it must be followed up closely by person-to-person contact. The whole point is to develop trust, integrity, and credibility if sustainable relationships are to develop. This type of work is about learning and changing practice and assumptions and, therefore, cannot be done at a distance or through mechanical means. It is time-consuming, hands-on work, but well worth the effort.

2. Each site selected should be accessible at a generally familiar location in the geographical concentration of each targeted population and at a site that is welcoming and comfortable to them. This ideally should include selecting food and beverages that the participants would enjoy eating. This personal touch cannot be overstated.

3. The community that will assist in identifying natural and appointed leaders must define its particular leadership structure. It is these "connectors" who are so important to getting the right mix of community stakeholders for broad perspective.

4. Formal/informal communication protocols and patterns of each community, if followed, will contribute significantly to the success of the efforts. These are best known through the "connectors." Connectors may also be stakeholders.

5. Time constraints and organizational limitations can affect the ability to do business as "unusual." Recognizing that the traditional approaches and systems have not allowed for significant input and necessary changes in providing effective services to these populations. Therefore, there must be major changes in how we do business. In this case, the roles were reversed, whereby the Wisconsin Turning Point Initiative became the learner, and the stakeholders were the teachers.

6. Low response rates to invitations to participate may be the result of historical or cultural factors affecting relationships with targeted communities. Personal communication in advance is an important strategy and builds a bridge to communication, participation, and relationship building.

7. Community expectations for timely information sharing, follow up, feedback, and sustained communications must be honored.

8. "Reality checks" as to the history of the relationship and quality of communication and services to each community, including funding patterns and partnerships, are critical.

9. The public health system partners and community stakeholders must endeavor to work together to identify shared beliefs/values; link organizational vision and mission statements; and agree upon a common set of priorities that will add value to community life, quality of life, and where the direct beneficiaries are the individuals, families, and population groups in all Wisconsin communities.

NEXT STEPS

As a first step, this Wisconsin Turning Point report will be released on the internet at www.dhfs.state.wi.us Second, the Wisconsin Turning Point Initiative will reconvene the five community stakeholder groups to reaffirm content, identify new challenges, and fill in any gaps brought forward in the content in Part IV of this Report.

Each selected community stakeholder group represented in this report will then need to achieve consensus on the provisional recommendations and take responsibility to develop local and statewide action plans to address these recommendations with the broader public health system partners.

Finally, the community stakeholder groups will need to provide direct input into updating and editing the current Implementation Plan for *Healthiest Wisconsin 2010* to assure that their issues, concerns, and recommendations are documented in the Implementation Plan.

This is the beginning of a process, not an event. The process must continue to be built upon by the public health system partners. Many vital, important, and pressing issues were raised. Compiling them into a report and disseminating the findings are simply not enough. What is needed is continued dialogue and action to address the issues and recommendations with these stakeholder groups and emerging community stakeholder groups. That is what the participants have asked for, and that is what the public health system partners must do.

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PART III

PROCESSES USED TO ESTABLISH THE SELECTED COMMUNITY STAKEHOLDER FORUMS

"True leaders must understand deeply the hurts and bruises, joys and struggles, aims and aspirations of their constituents. Through carefully listening and being sensitive to the needs of others, we can recognize their needs and offer ways to fill them. However, people will follow our advice and recommendations only when they trust our competence and believe that we have their best interests at heart."

Source: *Credibility: How Leaders Gain and Lose It–Why People Demand It*

THE PROCESS

Participants

The Wisconsin Turning Point Initiative's leadership sought to obtain the names of people who would contribute to the discussions and who represented both traditional and new nontraditional agencies and organizations to include the professional disciplines, community advocates, formal and informal leaders, and consumers. Several sources were synthesized to create the list of invitees and outreach strategies.

Personal invitations included explanations about the intent for meaningful and respectful dialogue with each individual. This pledge was reiterated and emphasized at each of the forums. A primary approach was to "tap" current networks and personal contacts. This approach built, from the bottom up, a cross-section of the stakeholder communities. This was a productive approach and brought to the table many new stakeholders who brought energized, fresh, frank, and hopeful perspectives to the table.

Invitations were extended to natural and appointed leaders in each stakeholder community both through personal telephone calls and written letters which were intended to ensure the full participation by the stakeholders. A hands-on personal touch was preferred over mass mailings. As a result, this personal touch was critical in establishing credibility and achieving a true cross-sectional response from each of the community stakeholder groups.

This approach was admittedly time-consuming, but paid off in the long run. It required obtaining an early "buy in" by introducing the purpose, intent, and rationale of the forums with each invitee before the formal letter of invitation was mailed. It was a respectful approach and validated the important contributions the stakeholders could make to the transformation of Wisconsin's public health system. The forums were effective in large part because they sought meaningful input, recommendations, and built trust-a foundation of effective partnerships.

Regrettably, the aforementioned approaches simply did not work with the Asian/Hmong community stakeholders. Although advanced consultation was sought with one expert from the Division of Public Health, and although a large number of stakeholders were contacted, only four stakeholders attended the Asian/ Hmong Community Stakeholder Forum. Refer to Part IV of this report for more information. Greater attention should have been paid "up-front" to the following factors:

- Build "up-front" substantial lead-time for personal contacts into the planning process.
- Exercise caution by making sure advisors and consultants know and understand the community and its cultural patterns.
- Keep in mind that no community is rigidly fixed or uniform in its views.
- Avoid "rushing the process" due to external pressures, such as a predetermined meeting date.
- Identify a broader array of key formal and informal leaders to provide encouragement, validate the purpose, and if possible, assist in making advanced personal contacts.
- Involve more Asian/Hmong stakeholders to help shape the process, context, and content.
- Follow up each letter of invitation with another personal phone call.

- Engage Asian/Hmong networks to make certain there were no conflicts with pre-existing conferences.

Structure and Content

Integrity of the planning process was critical. Planners were aware that the community stakeholders needed to know the Wisconsin Turning Point Initiative was genuinely seeking their authentic comments and planned to act upon them. To achieve this, the invited governmental leaders remained in a "listening role," as opposed to an "active talking role." Another step taken was a promise to publish this Report and include the authentic reactions, responses, and recommendations of the community stakeholders. (Refer to Part IV of this Report.)

A slightly different planning process was used to create the community stakeholder forums for the American Indian stakeholders and for the Lesbian, Gay, Bisexual, and Transgendered (LGBT) stakeholders. Here the formal and informal leaders from these two selected communities provided direct, hands-on leadership, by identifying the stakeholders to be invited, contacting them personally prior to the forums, and helping to assure that the setting and environs were conducive to comfort and hard work. Much of the success for these latter two selected community meetings is attributable to the Wisconsin HIV/AIDS Program, Division of Public Health; the Wisconsin Tribal Health Directors Association and the Great Lakes Inter-Tribal Council; and the Lesbian, Gay, Bisexual, and Transgendered Community Center in Milwaukee.

The formal mailing included key documents in advance of the forums that included:

- A letter of invitation describing the location, date, time, purpose, scope, and nature of the forums.
- A summary of the overall objectives, goals, and proposed agenda.
- Rules of engagement, follow-up guidelines, expected scope of the dialogue, and suggested themes for discussion that included the elements of the Wisconsin public health system transformational framework that included: core principles/values; essential public health services; overarching goals; health priorities; and infrastructure priorities.
- Expected outcomes and follow-up activities.
- Copy of the Executive Summary of *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public.*

Site Selection

Each forum was held within the geographical area where the stakeholder community was concentrated. Ideal site criteria included settings that were "neutral" and non-governmental, generally visible to the community, and known for cultural, racial, or ethnic affiliation. Vendors from the community were contracted to cater the reception and meals. This was done to further ensure the comfort level of community participants. Again, site selection for the Asian/Hmong stakeholder forum simply did not work well and was generally invisible and unknown to the community.

Stakeholder Forum	Location
African American Forum	Heart Love Place, Milwaukee
Hispanic/Latino Forum	United Migrant Opportunity Service, Milwaukee
Asian/Hmong Forum	Weston Community Center, Weston
Lesbian, Gay, Bisexual, Transgendered Forum (LGBT)	LGBT Community Center and the University of Wisconsin-Milwaukee Conference Center, Milwaukee
American Indian Forum	Menominee Casino Bingo Hotel, Keshena; and Lake of the Torches Casino, Lac du Flambeau

Three of the forums hosted started with an evening reception prior to the one-day structured forum. The reception provided an opportunity for individuals who were not able to participate in the full-day forum to have the opportunity to learn about *Healthiest Wisconsin 2010* and the public health system transformation process. The reception created an informal setting where all participants could:

- Network and become familiar with the purpose and intent of the forum.
- Meet and/or renew acquaintances with key leaders in the immediate community and other communities.
- Meet for the first time or renew acquaintances with governmental representatives and the Wisconsin Turning Point Initiative.
- Relax, enjoy, and prepare participants for the following day.

Forum Design and Process

A number of elements were considered in designing the structure of the full-day forum. These include:

- Flexibility to allow for consistent and meaningful participation of all participants.
- Complexity of nature of the subject matter.
- Timing constraints and organizational limitations.
- Maximum consistency across all forums, while acknowledging differences and strengths among each forum. This was primarily achieved by providing advanced orientation to the facilitators and recorders who would manage the small focus group breakout sessions.

The model chosen was an interactive, structured process that alternated between large forum sessions for the purposes of orientation, feedback, and evaluation and with small focus groups for the purposes of generating reactions, responses, and recommendations. Responses were recorded and summarized using flip charts. All notes were posted on the wall, and the information was reported back to the larger forum at the end of the meeting. A complete set of the responses, reactions, and recommendations for each of the forums is contained in Part IV of this Report.

The range of participants for each forum was 30 to 45. The forum design used small breakout groups comprised of 6 to 8 stakeholders. Each table was assigned an outside Facilitator and Recorder, briefed in advance. The "Nominal Group Technique" was the methodology used to prioritize responses. Structured questions were designed to draw out reactions to the elements of

Healthiest Wisconsin 2010 that included the core principles/values, essential public health services, overarching goals, health priorities, and infrastructure priorities. A document entitled "Rules of Engagement and Follow Up" was distributed to the stakeholders along with other relevant information to assure a smooth and efficient process.

Finally, observing simple amenities paid off that included: (1) the Chief of the Turning Point Initiative served as the "greeter" of all participants; (2) the provision of a registration table, nametags, and registration forms to update the database; (3) the availability of "sturdy" flip charts, extra copies of all mailed documents, audiovisual equipment (usually an overhead projector), large supplies of paper, markers, pencils, pens, tape, and evaluation/feedback forms; and (4) the food and refreshments being ready upon the arrival of the participants.

CHALLENGES AND SUCCESSES

One challenge was to move the discussion to a level of meaningful dialogue. To set the stage, each forum required extensive planning, research, and preparation. Principles that guided the development of the forums included:

1. Approaching each group respectfully and in a manner that encouraged an in-depth expression of facts, ideas, and perceptions.
2. Ensuring meaningful engagement of each participant, while acknowledging and respecting different perspectives.
3. Maintaining comfort with uncertainty.
4. Trusting the process and the "good will" of the participants and the forum planners.
5. Documenting and recording the perspective of the participants in "their words."

LESSONS LEARNED

From time to time, evaluation and modification of community outreach processes, methods, and approaches are vital. Although it can be difficult, recognition of process failures is an essential first step to learning. Review of processes resulted in new learning, fostered cultural competence, and built trust and mutual respect among the planners and participants.

PART IV

VOICES OF THE COMMUNITY STAKEHOLDERS

"Interface means where the surface of one thing meets the surface of another. It is less like a dividing line and more like a permeable membrane, and the action at the interface is the interplay, the communication, the mutual influence that goes on between societies…that are side by side. The interface is where vital relationships are established that are necessary for survival in a world of increasing interdependency."

Source: *The Four Fold Way*

AFRICAN AMERICAN COMMUNITY STAKEHOLDERS FORUM
AUGUST 21-22, 2001

Perspectives, Reflections, and Recommendations on Elements of the State Health Plan, ***Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public***

CORE PRINCIPLES AND VALUES

The following text reflects the participants' responses and reactions to selected core principles and values in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public.* It includes their views on what core principles/values would look like if they were "done right" in a transformed public health system.

Prevention is the most effective public health strategy:

- Prevention can significantly reduce the need for other services.
- Prevention includes, but is not limited to, issues of personal responsibility, accountability, and ownership.
- Individuals must be aware of their choices (which must be genuine), and additional individual capacity must be built.
- Marketing messages must be clear and consistent.
- The power of vested interests must be redistributed to more significantly empower citizens.

Good health results from the positive interaction of many forces:

- This core principle/value was also selected as a priority, yet the participants lacked the time to address it.

Collaboration is the key to success:

- The emphasis here must be on real partnerships.
- There must be a direct benefit (for the desired collaboration) that we can articulate to the public health partners (e.g., business, hospitals, clinics).
- There must be clarity of purpose before successful collaboration can take place.
- Partners must identify and take ownership of the public health process.
- We must have buy-in of critical partners (e.g., business), and partnerships must be sustained.
- Ensure buy-in of multiple partners regarding health priorities that were articulated by communities.
- There must be assurance among all collaborators that there will be sustained commitment to the process. Inconsistent commitment makes the process much less successful.
- Holistic interaction should be the foundation of all we do. There must be forums that clearly interconnect the issues and programs.
- All services must be linked to prevention programs.

- Collaboration: infrastructure must be in place to support this. True collaboration is power-sharing. It also means a paradigm shift to prevention.

The public health system must provide a voice for all:

- The emphasis here must be on honoring the perspectives of diverse cultures.
- When engaging African American communities, there must be assurance of inclusiveness of all persons who lend their voices to the process; the focus must be on the content of the message, not the messenger.
- Create a safe space for voices to be heard. Both the general public and professionals within public health systems must feel free to give their voices to the process without fear of retaliation.
- Communities must be empowered to share their voices (e.g., issues, concerns) to stimulate change.
- There must be an infrastructure and/or mechanisms established to assure that community voices are consistently obtained. This process can be used as an example or guide to instruct others in how to engage African American communities in Wisconsin.
- A memorandum of understanding should be established among partners, especially government-community partners, that identifies community priorities and approaches to solving problems and designates persons or organizations (chosen by communities) that can speak for, or be representative of, communities.
- There must be a paradigm shift in how community voices are utilized. Traditionally, the city/state convenes community representatives to lend their voice to established plans; the community becomes the consultant. A new proposed vision is for communities to request government representatives and other partners as "consultants" for community-generated improvement processes.
- There must be a strong linkage between soliciting community voices and seeing feedback and tangible results that demonstrate genuine accountability to the issues that were raised by those voices.
- Authentic listening must also include decision-making and data gathering. There should be a systematic way to hear the voices from the grassroots and for them to affect infrastructure, policymaking, and budget decisions. In order for this to happen there must be a perception change from above and below, which is accomplished through authentic interconnection (structures to assure that this happens).

All Wisconsin residents deserve a basic level of health services:

- The emphasis here must be on access and affordability.
- Reduce the use of emergency room care for non-emergency health care. To accomplish this, the public health system needs to increase the infrastructure and reimbursement to providers to operate more urgent care centers located close to the population served. Additional recognition is needed for those who practice alternative health care.
- Basic services should include prevention.

The more decisions are based on reliable data, then better public health decisions will be made:

- Develop and disseminate data on localized community health priorities (what communities state they need).
- Collect information on population subgroups.
- Increase the use of anecdotal data in "communities of color." This would involve an official comparison of "reliable data" versus the "anecdotal data" from "communities of color." The data will be reviewed and integrated into public health policies.

Note: A major challenge transcending all of the core principles/values set forth in *Healthiest Wisconsin 2010* concerns the mass exodus of African American families and general practitioners from the central city of Milwaukee, Wisconsin. Additional facility and delivery infrastructure problems indicate a clear need for a mobilized reinvestment in the central city of Milwaukee. This is an economic issue that is larger, but systemically related to, what public health should be about.

ESSENTIAL PUBLIC HEALTH SERVICES

The following text reflects the participants' responses and reactions to essential public health services referenced in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public.* It includes their views on what these essential public health services would look like if they were "done right" in a transformed public health system.

Educate the public about current and emerging health issues:

- The participants believed that this essential service was not clearly defined in *Healthiest Wisconsin 2010.* Text should have been added that addressed the importance of making information available, including information about current and emerging health issues, using writing formats and styles that are modified to fit the cultural context of community residents, public health system providers, and health and human service providers.

Promote community partnerships to identify and solve health problems:

- Emphasis must be on including nontraditional groups and building and maintaining infrastructure.
- The State should sustain the Turning Point Stakeholder Forums every couple of months. It is important that these continue.
- The Turning Point Stakeholder Forums should include briefings on cultural competence issues by initiating systematic training.
- Community partners must include: business community (Wisconsin Manufacturers and Commerce; churches; communities of faith; employment services; and black practitioners in the primary health care workforce).
- Universities must include faculty and researchers and must listen to the community and not force separately determined agendas.
- Benchmarks to measure success of partnerships must include:

- Development and implementation of a *Neighborhood Block Health Watch* Program (discussed later).
- Bottom-up decision-making.
- Local elected official buy-in.
- Development of a community-based system.
- State/community implementation.

- The private sector often does profiling to deny or limit services. Assumptions are too often made based on racial or cultural characteristics that undercut public health services (e.g., health problems of persons of color are a result of alcoholism or illegal drug use).
- There needs to be "public health intervenors." These would be troubleshooters who would intervene, train/educate, and resolve conflicts. They would be key contacts for situations of misunderstanding and discrimination. They would serve as ombudsmen and translators of issues to the larger system.

Assure a diverse, adequate, and competent workforce to support the public health system:

- Emphasis here is on what this group of participants called a major public health crisis.
- Increase academic support and encouragement of not only health-profession students, but those who might be interested in entering the health profession.
- Promote and implement recruitment, retention, and mentoring programs.
- Develop the workforce through long-term means by promoting early intervention with young students (work from the ground up).
- Provide education to providers on cross-cultural health beliefs and practices.
- Increase resources to support uniformly high standards of care for persons and organizations that serve high-risk populations.
- Ensure that there are more qualified, competent, and trusted health care professionals to disseminate accurate health information.
- Overcome the stereotyping and bias against African American health care providers as "less-qualified" than white professionals. This misinformed view circulates both within and outside African American communities.
- There needs to be all-out bulletins and urgent responses to provide incentives for medical practitioners (e.g., physicians, nurses, physician assistants) to be relocated, live, and practice in the central city of Milwaukee.
- Social work professors usually have little exposure to or knowledge of inner city dynamics. They need more training, direct interaction with these situations, and more substantive internships.
- Some persons of a particular race or color may still not be culturally competent with their own race/culture.
- There should be standards for the delivery of culturally competent services.
- Workforce benchmarks should include:
    - Educational institutions: mandatory recurring continuing education units for licensure that focus on understanding the cultural and environmental dynamics of communities.
    - Following American Psychological Guidelines for Cultural Competence.
    - Experiential preparation is a necessary part of all curricula.
    - Reciprocal experiential arrangements with educational institutions such as the University of Wisconsin-Eau Claire and the University of Minnesota.

- "Credentialing" of Health Maintenance Organizations: currently they will not hire African American employees because they have no licenses. This must change. Criteria for licensure should include familiarity with and ability to function with inner city dynamics.
- Increase the number of minority health care providers. Support retention of health care professionals by: (1) providing a health care subsidy fund for those willing to serve and live in the central city and (2) providing economic incentives and compensation to community providers who treat community residents at a level commensurate with hospital reimbursements.

Assure access and primary health care for all:

- Address comprehensive barriers to access (e.g., discrimination, workforce, transportation, social, economic, psychological).
- Identify and address/reduce localized barriers to access (e.g., the way public and private health programs and systems are run).
- Address environmental justice issues.
- Ensure local health care systems engage and include nontraditional providers and partners.
- Assure a diverse and competent health care workforce/staffing.
- Promote and assure cultural competence and culturally appropriate services (e.g., race/ethnic, gender-appropriate).
- Increase education and training as to what cultural competence really is and what aspects are important to all sectors within African American communities, including gender-appropriate services, etc.
- Increase resources to support uniformly high standards of care for persons and organizations that serve high-risk populations.
- Encourage empowerment of individuals to demand effective and comprehensive quality services and health care.
- Assure that clients are treated with respect and dignity (e.g., decrease bias and discrimination based on race, economic position, insurance coverage).
- Overcome stigma and prejudice in the health care system related to a person's disease or condition (e.g., HIV/AIDS, overweight/obesity, behavioral practices).
- Emphasize access to dental care. Research notes a strong correlation between good dental care and overall health among African Americans. Additionally, this requires a strategic response to the economic challenges noted under the core principles/values and that this is a recruitment, maintenance, and infrastructure issue. Good preventive care will not be realized if there are no practitioners of color to provide culturally sensitive and competent services.
- Develop "one stop shop" health care clinics from child-care, pediatric services, dentistry, and primary care, to elder care using case managed coordinated care models known to be effective with communities of color and that is easily accessible to local residents.

Foster the understanding and promotion of social and economic factors:

- Address and reduce the stigma of poverty.

Conduct research to seek new insights and innovative solutions to health problems:

- The key emphasis here is looking for effective nontraditional strategies that work with "communities of color," and then give increased points as part of the review process to future "requests for proposals" for agencies and organizations who use these nontraditional strategies.

HEALTH PRIORITIES

The following text reflects the participants' responses and reactions to selected health priorities in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. It includes their views on what these health priorities would look like if they were "done right" in a transformed public health system.

One focus group identified selected health priorities they wished to address, and then used the three overarching goals to identify the characteristics and/or benchmarks to describe how these priorities would look like if they were "done right".

The following reflects their thinking.

Health Priority (below)	Goal 1: Protect and Promote Health for All	Goal 2: Eliminate Health Disparities	Goal 3: Transform Wisconsin's Public Health System
Access to Primary and Preventive Health Services	Increase preventive health services in communities by 100 percent over baseline. Enhance preventive health education. Improve transportation and location to increase access.	Health care services should be more affordable.	Provide insurance coverage to all. Promote acceptance of health systems within the community.
Adequate and Appropriate Nutrition	Ensure a safe and adequate food supply.	Eliminate hunger and malnutrition. Increase education regarding benefits of optimum nutrition to overall health.	Increase African American nutrition professionals. Ensure that nutrition education and medical nutrition therapy become an intricate component of primary health services.

Health Priority (below)	Goal 1: Protect and Promote Health for All	Goal 2: Eliminate Health Disparities	Goal 3: Transform Wisconsin's Public Health System
Alcohol and Other Substance Use and Addiction	Increase education about the effect and impact of drugs and alcohol on African American communities. Eliminate stigma among providers and in the community regarding persons who use drugs.	Decrease the availability of drugs and alcohol in African American communities.	Promote a family-centered approach to alcohol and drug abuse treatment. Increase cultural competent services in the area of alcohol and drug abuse treatment.
Environmental and Occupational Health Hazards	Improve the environmental quality in African American communities by reducing risks for lead poisoning, violence, and poverty.	Reduce exposure to tobacco, alcohol, violence, and illicit substances in African American communities.	Promote educating children about the ozone levels, tobacco exposure, etc. Develop programs in African American communities that are empowered to make environmental changes.
Communicable Diseases	Increase the proportion of African Americans counseled about health behaviors in general.	Increase the proportion of African Americans counseled about health behaviors in general.	Reduce the service delivery gap to those that are at high risk for communicable disease. Increase primary care services to the African American population.
High Risk Sexual Behavior	Promote abstinence as a method of controlling high-risk sexual behavior. Confront fears regarding sexual behaviors and consequences.	Decrease stigma and directly confront issues and consequences of sexual behavior.	Implement consistent and universal assessment about sexual behaviors in health education.

Health Priority (below)	Goal 1: Protect and Promote Health for All	Goal 2: Eliminate Health Disparities	Goal 3: Transform Wisconsin's Public Health System
Intentional and Unintentional Injuries and Violence	Decrease image-makers' (media) tendency to sensationalize violence in African American communities.	Increase alternative options to handling stress in African American communities (e.g., increase resources, reduce barriers). Increase gun control and stop glorifying violence (image-makers).	Decrease marketing forces that perpetuate violence and risky behaviors in the African American community.
Mental Health and Mental Disorders	Provide culturally sensitive mental health treatment.	Provide health insurance for all.	Decrease barriers in accessing appropriate mental health treatment.
Overweight, Obesity, and Lack of Physical Activity	Decrease the marketing that promotes unhealthy eating in African American communities.	Focus on assessment of fitness and promoting teaching fitness skills.	Transform school, living, and work environments in African American communities to promote increased fitness and healthy eating.
Social and Economic Factors that Influence Health	Increase academic support, such as mentoring programs.	Increase the percentage of African American health professionals hired.	Reduce poverty among the African American population.
Tobacco Use and Exposure	Decrease the pervasiveness of tobacco promotion through image-makers, media, and advertisements. Increase the factual information regarding the dangers of smoking and disseminate in African American communities.	Raise awareness of the dangers of tobacco exposure by starting education at the elementary level.	Promote the direct link with cancer, heart disease, and lung problems (asthma) with the use of tobacco among the African American population.

A Special Idea Advanced by One Focus Group

"The Neighborhood Block Health Watch Program"

Note: One group of participants focused on elaborating the idea of a Neighborhood Block Health Watch strategy. It was an idea that the entire breakout group enthusiastically embraced as embodying the core principles/values, the essential services, and the transformation that is at the heart of the Wisconsin Turning Point Initiative and *Healthiest Wisconsin 2010*. Participants felt that this idea was singularly the most important element to initiate as part of the State Health Plan because it would have the most significantly positive effect. In the ensuing comments, this idea will be referred to as the Block Health Watch.

Description

The Block Health Watch is modeled after the law enforcement strategy of Neighborhood Safety Watches and the ideas put forth by the participants follow.

The Block Health Watch Program could be started as a pilot program in a number of different neighborhoods. There would be a "captain" who would have overall coordination responsibility along with a number of assistants who would cover the territory. The local health department would supply a liaison, such as a public health nurse, who would meet with the group and would: (1) help to get it organized; (2) ground it in the key elements of the existing system and current issues; (3) support and sustain its efforts; and (4) report issues back to the local health department and the community. Once the program was developed and implemented, there would be a number of Block Health Watch Captains reporting to a public health staff liaison and meeting routinely (every 2-3 months) to compare notes.

The Block Health Watch activists could provide a direct way to get out understandable information on current and emerging health issues. They could provide information on a variety of ongoing issues (e.g., asthma, diabetes, prenatal, postpartum care).

A strategy such as this would give a real voice for all, would be a true collaboration, and would get local community information and issues to the local health department directly. It would embody the essence of prevention (e.g., early detection, community-building, empowerment). It would provide a voice for all, in that the grassroots community would know more about its choices and be able to express what issues and data it found to be most important. The participants were clear that this information should have a profound effect on decisions as to what data to collect and what issues to prioritize.

Structure of Neighborhood Block Health Watch: A Model of Reciprocal Investment

- The Division of Public Health prioritizes concept, takes the lead in structuring, reallocates certain funds to focus on development and pilots, collects data, and sets policies. Legal issues of role development and liability must be defined and clarified.
- State Regional Offices support and work to develop/institutionalize knowledge gained.
- Local health departments provide staff to help develop, sustain, provide technical assistance, and develop liaisons with the Block Health Watch Program. Convene Block Captains to review broad issues, share new information, developments, successes, determine patterns, and develop indicators and data.
- Block Captain provides coordination. Four to five "block watchers" would assist the captain in a variety of tasks, including disseminating key information and building on natural strengths.
- Partnerships need to be developed to support and enhance the Block Health Watch Program and need to include: law enforcement; churches; housing providers; providers of transportation; employment; human services; schools; businesses; hospitals; and legislators.

Goals of the Neighborhood Block Health Watch

- Bring the community/grassroots into the equation in their proper, contributing role and reverse fragmentation and separation.
- Benchmarks can be meaningfully developed.
- Viable partnerships can be created-leadership must come from other levels in addition to government.
- This is a paradigm for prevention with authentic ties to "communities of color."
- Pilots should be initiated between the years 2004 and 2006 (one pilot per local health department).
- Implementation pilots would focus on infrastructure development and support strategies at all levels.
- There are issues of trust to be confronted: key staff must buy in and support authentically.
- The "Block Liaison" in the local health department could be a public health nurse having this work as a prioritized duty.
- This would mean re-writing objectives in consolidated grants and redefining local public health nursing duties (including training and recognition).

Benefits of the Neighborhood Block Health Watch

- Voices currently unheard are heard.
- Genuine dialogue is created and systematized in a way that health and human services providers can hear.
- Broad healing is facilitated.
- Develop critical policies that are tangible and concrete.
- Provide better identification of strengths, barriers, and needs.
- Proactively unleashes strengths.
- Cultural strengths (collective self).

- Vehicle for safe and appropriate community involvement.
- Provides authentic data from the community on meaningful issues.
- Allows for reporting by blocks, smaller increments, more pinpointing of issues.
- By creating hope and respect, it encourages engagement (including voting).
- This is a definite community stabilizer.

Essential Public Health Services Achieved through the Block Health Watch Program

Essential Service	Characteristics, Actions, Potential Benefit
Monitor health status to identify community health problems.	Utilize churches. Utilize Block Health Watch. Support this new infrastructure as an investment in and for the community (ownership and assets). Examples: Block Health Watch could connect persons showing early mental health issues with National Alliance for the Mentally Ill; persons with diabetes could be identified early; the community could be taught how to deal with seizures; or neighbors could help keep kids from foster care by providing supervision when a single mother is temporarily hospitalized.
Create policies and plans that support individual and community health efforts.	Support community processes to assure support of the Block Health Watch. The community must have a voice in policy decisions and be able to affect outcomes. Outcomes include: • Policies would be stronger, have more support, and be more functional. • Fear and mistrust, which often impede good decisions and their dissemination, would be undone. • Private and public workforce would be enhanced. • There would be more functional and effective advocacy. • Solutions and strategies would be more effective when the voice of the community is truly heard. • Cultural specificity and understanding are facilitated.
Evaluate effectiveness, accessibility, and quality of personal and population-based services.	Social disparities must be captured in an authentic way. Data gathered should reflect the vision of the neighborhood; neighborhoods should help to determine health indicators. Block Health Watch approach provides a way for this to happen.
Assure access to primary health care for all.	This relates to geography and to money. Universal health care is needed as the current system excludes many. Block Health Watch strategy would help with information on true access and the effects of lack of access.

Essential Service	Characteristics, Actions, Potential Benefit
Enforce laws and regulations that protect health and insure safety.	HIV affects persons of color in higher numbers. Lead paint and children is still an issue. Enforcement should be for all citizens; it is selective now and "communities of color" suffer. Need community representatives in the enforcement process. (Block Health Watch could be a big part of this.) Landfills, hazardous waste discharges, all must be more rigorously and equally enforced.

- This approach would be a model of "reciprocal investment." It acknowledges that the existing paradigm does not work for these communities.
- Pilot test in a variety of neighborhoods and geographies. May only work in areas where there are actual city blocks.
- Should look at the law enforcement program and see what we can learn from their Block Health Watch.
- Criteria for awarding pilots should relate to where we can get the most leverage (identified leaders, some embryonic organization, interest).
- This idea would be very fertile for combining and creating synergy among funding streams.
- By rebuilding strong community connections, there is less need for staff time on problems that will prevent using this approach.
- The idea represents a reclamation of community and cultural principles.
- The existing infrastructure can be used to get the message out to new partners--such as the business community and churches.
- Varying models may develop from the pilots.
- The Block Health Watch Captain should be trained in cardiopulmonary resuscitation (as well as other interested participants).
- This structure should be supported as a priority in budget decisions.
- The message should be about system problems as well as individual problems.
- This structure will feed into a strengthening of cultural understanding and respect.
- This is a way for citizens to work with providers to develop effective prevention and intervention strategies.
- The parish nurse connection would be of great value by helping to connect individuals and families with health care coverage and the medical assistance process.
- The Block Captain would know the culture and history of the area. This would be a major facet in removing fear and anxiety about the system, increasing access, and supporting prevention efforts.
- This approach is an excellent way to stimulate dialogue at the local level and to keep it going.
- Outcomes of this process must be disseminated in order to continue to build and adapt it as an ongoing process.
- This approach would create and sustain environments conducive to getting authentic input.

Dialogue, Reflections, and Questions

- The power to change may not lie within the immediate community assembled at this forum.
- If health is to be provided, it must be in the community such as the 16th Street Community Health Center and the Coggs Community Health Center.
- No one has ever convened us to think and reflect on the entire public health system. We are usually asked to react to programs and services, not the entire system. This work is important and today's discussions need to continue. The Wisconsin Turning Point Initiative needs to come back and meet with us on a regular basis.
- Care must be provided by people who look like the people they are serving.
- Health care is subcontracted to organizations whose providers do not reflect the picture of the people they serve. Right now it's majority people serving minority people.
- What will the Wisconsin Turning Point Initiative do to impact on the access/financing of health care?
  - Raise consciousness.
  - Create the forums for those issues to be heard and acted upon.
  - Need realistic and bona fide methods.
  - Stop the dance we've been in for such a long time.
- The Wisconsin Turning Point Initiative needs to help us secure authentic communication.
- "We" is the big pronoun reference.
- Holistic care makes sense for African American communities--but what doesn't make sense is the application of the concept of holistic care by the medical community.
- The Wisconsin Turning Point Initiative can be a neutral zone for our "communities of color," especially African Americans. We need to think what it would look like if we did a good job–then benchmark based on what it's supposed to look like.
- The Wisconsin Turning Point Initiative can be the place to share our story and our voice. But what we've experienced is *"once you put your pain out you can't win."*
- The Secretary and State Health Officer of the Department of Health and Family Services need to create a safe and comfortable place for some of the participants who have gathered at this forum to speak the truth. This will help the Department of Health and Family Services.
- We need organizational earthquakes.
- This event is part of the transforming process and we have the Wisconsin Turning Point Initiative to thank for it. A clear voice is needed.
- Where are all the public health nurses? We never see them anymore. We don't have nurses in our schools, and when the children go home sick they go home to empty houses.
- Wisconsin's public health system should support securing the authentic voice–this builds trust.
- On paper, it (the State Health Plan) seems so traditional, yet today's discussion is helping us think nontraditionally. People doing the outreach need to be here.
- This is a think tank and it's always worked–we need to do this more often and create our own power.

- I am a walk-in to this forum and it has revitalized my awareness to make health care services barrier-free.
- It would be a grand day when community-based organizations, health care, and insurance come together.
- Public policy doesn't take the time to do what we are doing today.
- Alternative funding is part of the transformation.
- This is not an event, but a process. Include this forum as an ongoing process. The Wisconsin Turning Point Initiative must continue this dialogue. Volunteer to commit.
- Formalize the relationship. No one has ever come to us to ask us to talk about the whole public health system.
- If the health care system and corporate America doesn't buy into this State Health Plan, there will be problems getting the work done.
- Sustainability comes from commitment. Without commitment, many people will just not commit their resources. Need to identify a direct benefit of this transformation to the partners.

African American Forum Participants
Invited and Attending
August 21-22, 2001

Community Participants:

Hafeezah Ahmad, Department of Workforce Development
Karen Barnes, New Concepts
Gwen Barnett, Ritual Well Being
Charlene Benford, Madison
William Clay, Opportunities Industrialization Center of Racine
JoAnn Craft, Penfield Children's Center
Darryl Davidson, City of Milwaukee Health Department
Mae Demps, Safe Group Services, Inc.
Andrea L Dudley, Prosperous Living Wellness Center
Yvonne D Greer, City of Milwaukee Health Department
Les Higgenbottom, Independent Care, Inc.
Michael Jackson, Dane County Veterans' Office
Carol Lobes, Edgewood College
W. Curtis Marshall, Wisconsin Association of Black Public Sector Employees
Juliette Martin-Thomas, Milwaukee
Dennis McClain, Dane County Juvenile Court Programs
Joe McClain, Tellurian, Inc.
Sandra Y. McClaron, Opportunities Industrialization Center of Racine County, Inc.
Patricia McManus, Black Health Coalition of Wisconsin
Wayman Parker, Milwaukee
Richard A. Perry, Beloit Area Community Health Center
Morris Reece, Marshfield Clinic
Elisa Romero, Milwaukee County Human Services Department
Angela Russell, Center for Cultural Diversity in Healthcare
Bruce E. Smith, Milwaukee
Antoinette Souffrant, Milwaukee Women's Center, Inc.
Jennifer Stenger, Beloit Area Community Health Center
Dale B Taylor, Department of Allied Health Professions
John White, Heart Love Place

State of Wisconsin Participants:

Jennifer Argelander, Division of Public Health, Department of Health and Family Services
Kenneth Baldwin, Division of Public Health, Department of Health and Family Services
Denise Carty, Division of Public Health, Department of Health and Family Services
Claude Gilmore, Division of Children and Family Services, Department of Health and Family Services
Robert Harris, Division of Public Health, Department of Health and Family Services
Gale Johnson, Division of Public Health, Department of Health and Family Services
Karen Johnson, Division of Public Health, Department of Health and Family Services
Kelli J. Jones, Division of Public Health, Department of Health and Family Services
Millie Jones, Division of Public Health, Department of Health and Family Services
Dian Palmer, Division of Public Health, Department of Health and Family Services
Margaret Schmelzer, Division of Public Health, Department of Health and Family Services
Meg Taylor, Division of Public Health, Department of Health and Family Services
Anthony Wade, Division of Public Health, Department of Health and Family Services

Invited, but did not attend:

Muhammad Abdullah, Milwaukee Islamic Dawah Center, Inc.
Bevan Baker, Milwaukee Health Department
Geraldine Bernard, Genesis Development Corporation
Anita Braden, Episcopal Diocese of Milwaukee
Stephen Braunginn, Urban League of Greater Madison
Georgia Cameron, Opportunities Industrial Center of Greater Milwaukee
Rosie Carradine Lewis, Milwaukee Healthy Women and Infants Project
The Honorable G. Spencer Coggs, Wisconsin State Assembly
Don Coleman, Madison

Rick Daniels, Milwaukee
Ray Anthony Fikes, Holy Cathedral Church
Robert Fyrst, Madison
Debora Garrett-Thomas, Madison
Harold Gates, Dane County Mental Health
The Honorable Gary George, Wisconsin State Senate
Jerry Hamilton, NAACP
Emma Harrell, Beloit Intercity Council, Inc.
Roy Hill, Milwaukee
George Hinton, Aurora Sinai Medical Center
Kimm Hurley-Smith, Community Partnerships
Archie Ivy, Milwaukee Inner City Congregations Allied for Hope
Joan Jacobson-Wolf, Messiah Lutheran Church
Julian Jasper, Milwaukee African-American Pastors Association
Jarrod G. Johnson, St. Luke's Medical Center
Mary Kirkendahl, Allied Dunn's Marsh Community Center
Isadore Knox, Jr., Affirmative Action Office
Joann Kraft, Pennfield Children's Center
Emmett Lee, Wayman African American Methodist Episcopal Church
Kenneth Little, Milwaukee Urban League
Eileen McRae, Division of Health Care Financing, Department of Health and Family Services
Charles McClelland, Holy Cathedral Church
Jestene McCord, Do Nothing, Inc.
The Honorable Gwendolynne Moore, Wisconsin State Senate
John Odom, Madison
Ifeueko Okundaye, Neenah
June Perry, New Concepts
Darryl Seay, Division of Children and Family Services, Department of Health and Family Services
Shirley Senaya, Milwaukee Adolescent Pregnancy Prevention Consortium
Myra Shelton, Department of Regulations and Licensing
Hazel Symonette, Office of Multicultural Affairs, University of Wisconsin
Cecelia Timmons, Center of Excellence in Women's Health
Earnestine Willis, Medical College of Wisconsin

AMERICAN INDIAN COMMUNITY STAKEHOLDERS FORUM
APRIL 16-17, 2002

Perspectives, Reflections, and Recommendations on Elementsof the State Health Plan,
Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public

CORE PRINCIPLES AND VALUES

The following text reflects the participants' responses and reactions to selected core principles and values in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. It includes their views on what these core principles/values would look like if they were "done right" in a transformed public health system.

Prevention is the most effective public health strategy:

- This concept has widespread implications. Through prevention lives are saved, lives are protected. Prevention is lifelong.
- For prevention to work, it must be valued in the community. It is not okay to hurt people or to smoke. Prevention must be embraced by the community and take the form of tribal resolutions, policies for smoking, and so forth. Resolutions and policies set up an environment for people to be healthy.
- Prevention needs to start at a young age and needs to come from within the family.
- We need to make people aware of the value of prevention in the first place. For example, alcohol and other substance use prevention awareness needs to become the norm--instead of a "taboo" subject.
- Need to keep prevention visible, and keep repeating the message of prevention.
- Make prevention culturally sensitive. Keep it simple. Not have it imposed. People must buy in.
- Keep at it, but also come at it in a number of different ways.
- Provide the opportunity for people to express themselves–helps to build ownership.

Good health results from the positive interaction of the physical, mental, emotional, spiritual, cultural, and environmental forces:

- It is a cultural concept for American Indians, even though not all members of the community practice it. Some people embrace Christian values. Sometimes people focus more in one aspect rather than in the holistic approach because of multiple roles in life.
- Approaches to good health include:
  - Promoting American Indian values.
  - Teaching health curricula in schools, including tribal history and language.
  - Incorporating traditional health practices in healthy eating and diabetic meals.
  - Translating and distributing information from professional documents, conducting research, and making certain the research is relevant to those the information is offered. Be practical and give tips.

- Identifying strengths in families and utilizing those strengths. "Positive talks" enable communities to improve health. Focus on assets, the positives, and reinforce the good that is being done. These types of actions give encouragement to others.
- Developing a team of comprehensive persons to work with individuals and families in each of the areas of health to include spiritual, physical, mental, and education.
  - Help to identify problems and solutions.
  - For kids it could be the school, family, or someone they look up to for cultural teaching.
  - Families need to identify the team they feel would provide needed information and support. It will be different for each person.

- Cultural activities are needed to increase healthy socialization.
- Incorporate spirituality in health care and public health practice. Spirituality is not the same as religion.
- Big impacts occur that go beyond tribal boundaries. When businesses drop insurance to save costs, the lack of insurance impacts the tribal workforce negatively. When they are insured less, they are likely to enroll in BadgerCare.
- As communities positively embrace their own cultures and their heritage, including the spiritual and the physical, they draw upon the strengths of themselves and their community.
- "When you're comfortable embracing your cultural norms and patterns, then people change their ways–they are calmer and more happy. They are more comfortable with the ceremonies, more comfortable transmitting traditions to youth, and they speak what is on their minds and in their hearts. People must understand the ways of the American Indian–the need to do it our way. And for each tribe, it manifests differently."
- "I think of good nutrition when I think of good health. We as adults need to teach children to eat well, as it impacts on all the elements of this Turning Point belief statement."
- "People need to want to have good health and accept the consequences of poor choices. Society teaches that it's someone else's problem and causes them to feel helpless, a victim mentality. It takes energy to get out of the 'victim hole' and sometimes people need assistance from programs to see the light, to see a way out."
- Balancing the physical and spiritual/emotional health is important. Balance cannot be achieved by just being physically healthy.
- "We have to remember the values that our elders taught us, and did in the past through ceremonies. This reinforces our health by providing safety and security."
- "Culture provides points of orientation to tell us who we are and where we are going. Without which we are lost, wander. We've got to be serious about the environment and balance of nature, and the creatures around us."
- Need to respect each other and the elements of what health is.
- "We say we respect, but we don't always."
- "I hope to be responsible to myself to balance my spirituality. When I do, I feel balanced with the environment and the world around us."
- "Be able to change and adopt new values. Some tribal members say 'I don't like doctors so why should I go?' 'My elders, parents, all drink, so why shouldn't I? It's all genetic anyway.'"
- Prevention means changing one's way of thinking–self-care, dental care. There's not a pill for everything. Health is also transmitting good health practices to subsequent generations in the family and community.

Collaboration is the key to success:

- If the core principle/value of collaboration were "done right," state government would require that department heads, administrators, and legislators would consult with tribes on the proposed program or legislation. This should come from the Governor on down.
- The above statement should also apply to local government. Need to define how to work together on consultation, education, and collaboration.
- Local service providers should meet on a regular basis to increase familiarity with each other's programs that work with families or impact families.
- Model Birth to Three Program for children with special needs programs.
- More collaboration is needed to break down barriers and mistrust. This must be with outside providers and move beyond your own agency.
- Regular tribal meetings are needed that include state and county representatives and providers on issues related to family services.
- Some agencies are territorial--which creates "denial of access to people."
- Interdisciplinary clinical teams for collaboration are preferred instead of individual focus. This is especially true in the areas of medical care, mental health, and alcohol and other drug abuse. Confidentiality and consent to release information are important.
- Interdisciplinary teams are needed to respond to general community issues that include housing and environmental health.
- Recognize that each American Indian community has different resources and is structured differently.
- Different American Indian communities face unique and different accessibility issues. For example, some communities have the services on site, whereas others have to travel long distances.
    - Different entities may manage the programs (e.g., tribal, county, hospital).
    - When collaborating, the unique needs of individuals and their circumstances must be considered.
- More money and resources are needed for family-centered case management in order to help families access a variety of needed services. More case management resources will decrease fragmentation.
- Training for the medical community is needed with respect to the importance of mental health services. Mental and behavioral models are different.
- Decrease stigma regarding mental health, and show that seeking mental health services is healthy.
- Vilas County has created a special committee to address American Indian issues in a formalized way. "This is a good thing! This shows good collaboration between county and tribal governments."
- Dollars and turf can hinder collaboration. "To send patients to tribal health, social services, and/or alcohol and other drug abuse services represents a loss of money for the Howard Young Clinic, and therefore, they don't refer except for uninsured."
- Community racism interferes with collaboration among local providers and institutions and local people, and until this is solved you won't have a level playing field.

Government has a responsibility to establish leadership and facilitate the achievement of the public health mission and vision in Wisconsin:

- State government needs to be an advocate for the American Indian.
- State government must foster maximum flexibility when things are carried out locally. Let people set their own priorities. This takes trust. This is built on respect and understanding of the unique systems on both sides. There needs to be a good understanding of what the expectations are and what the roles are. It takes feedback and action, but the way it usually goes is "we meet, we give input, and we never hear the results."
- Institutional racism and "territorialism" creates barriers to collaboration and undermines trust. This gets in the way of reliable and usable data. Racism and "territorialism" undermine the value of the data.
- If state and federal agencies would give us the resources, it would go a long way to lower the "second rate" view people have of tribal health services.
- We need, through state policy (statute and rule), enabling language to cause local health departments and the tribes to work together collaboratively. (The Department of Natural Resources may have already made such changes to their statutes.)
- We are not on a level playing field with local health departments, clinics, and the Department of Health and Family Services. We need a level playing field with all other providers.
- "Territorialism" is created by the "state and federal divide." Why aren't the tribes viewed in the same status as a local health department, and have Great Lakes Inter-Tribal Council (GLITC) viewed as the regional office?
- The federal government says that they will provide health and social security as long as the grass grows and water flows. But they don't have enough money and resources to meet the needs. The outside view, however, is a misperception and misunderstanding that the tribes are self-sufficient.
- The truth is, there are simply not enough resources to do the job, especially in rural areas, and there shouldn't be duplication, and this leads to more efficient collaboration, can lower costs, raise efficiency, and lower duplication.
- If the Wisconsin Turning Point Initiative is a departmental initiative, this same process needs to go to higher levels. It's a few progressive people who care, but it is not systemic.

Note: We have to be clear on how to use and implement this Report from these meetings, such as ongoing mechanisms for communication, planning, and learning about one another.

The public health system must be a voice for all. It is important to actively include and listen to the voices of all people and honor the perspectives of diverse cultures.

- The term "wrap around" service seems trite. The concept may be good, but it is not inclusive. Services must be all-inclusive. The phrase "can't be everything to all" and "can't be all inclusive" are just cop-outs. Need to change both concept and belief among people who work where they believe their organization "can't be everything to all."
- The local health departments don't get involved because they see tribal health services as independent and self-sufficient.
- The following statement was offered for all to consider. This statement is posted in visible locations at the Menominee Tribal Clinic for all to see, read, and consider:

Menominee Tribal Clinic Wellness Department Guidelines

Do With, Don't Do For
Walk Beside, Not In Front Of
Assist, Don't Control
Facilitate, Don't Determine
Provide Additional Resources, Not Regulation
Respect, Don't Put Down
Empathy, Not Sympathy

All Wisconsin residents deserve a basic level of health services.

- What does basic mean? Prescription drugs? Further discussion is needed on exactly what it means to provide basic health services.
- The Indian Health Services established a group to determine level of health care expenditures per capita that states: American Indian–$1,500/person/yr.; and European American–$3,000/person/yr.
- Due to inaccessibility of health care we are getting only 40 percent of what is needed and on top of that are asked to ration care.
- Access to basic health services and supports must include transportation, housing, waste disposal, water quality, recreation, and employment.

OVERARCHING GOALS

The following text reflects the participants' responses and reactions to the overarching goals in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public.* It includes their views on what the overarching goals would look like if they were "done right" in a transformed public health system.

- Focus on the unique needs and circumstances in different age groups.
- Promote more tribal leadership and accountability for the good health of the community despite individual behaviors and preferences.
- Educate incoming term representatives about key programs and health issues to sustain support for community health improvement efforts.
- Continue to meet with tribal communities over the next 10 years to monitor progress.
- Meeting sites should be accessible to more people.
- Establish a relationship with key contact persons.
- Take advantage of collaborative strengths among the tribes; they have a history of coming together and working well on issues of mutual concern.
- Avoid the false perception that sovereignty of the tribes is a "barrier" to collaboration with non-tribal entities.

HEALTH AND INFRASTRUCTURE PRIORITIES

The following text reflects the participants' responses and reactions to selected health and infrastructure priorities in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. It includes their views on what these health and infrastructure priorities would look like if they were "done right" in a transformed public health system.

Alcohol and other substance use and addiction:

- In a transformed public health system, alcoholism would be treated as the primary disease that it is, and not as a behavior. There must be more research to support treating alcoholism as a disease.
- Alcohol and other substance use is the underlying cause of many personal and community problems and issues that include: violence; child abuse and neglect; bankruptcy; physical illness (heart and liver disease); loss of friends; Fetal Alcohol Syndrome; marital difficulties; and family disruption, to name a few.
- The peer pressure to keep drinking is powerful. Sometimes isolation and loss of social support occurs when one stops drinking.
- In our instantaneous, self-gratifying oriented society, a powerful message is sent to the public that it is socially acceptable to drink.
- Need for long-term commitment, as there are no quick fixes for behavioral change.
- Need prevention funding.
- More and more children are reporting being sexually abused by someone who is drunk.
- "We don't integrate alcohol and other drug abuse referrals into the rest of the health care system. Because of this, a person who is being treated for alcoholism could easily be given a prescription containing alcohol by a health care provider to treat another condition (e.g., cough syrup)."
- The medical community does not like alcohol and other drug abuse providers telling them how to treat their patients.
- It is important not to generalize these behaviors to the whole American Indian population because most health and human service providers only see a small portion of the American Indian population. Generalization of this is dangerous and destructive.
- People must understand the history of alcoholism in the native community as not just behavioral, but as a history of a defeatist perspective.
- There must be balance, and parents must teach this and empower their children to make decisions. Historical trauma and "generational depression" are important for people to understand.
- These problems exist in the general population, only "it's not singled out as a problem." It's acceptable to point this out to American Indians. It's a double standard. The American Indian population is smaller, and it's convenient to apply racial and ethnic stereotypes and fuel institutional racism.
- Prevention is about teaching how to drink responsibly, or not to drink. Society should reach a point where it is acceptable not to drink. This is a very complex issue that is currently viewed much too simply.

- Reducing the use and dependence on alcohol and other drugs is important.
- There is a great need for better treatment to fund inpatient and outpatient care. Tribal communities can write for Substance Abuse Mental Health Service Administration (SAMHSA) grants.
- Promote abstinence and/or responsibility.
  - Educate about the impact on the family in parenting classes.
  - Provide multiple ways to disseminate information.
  - Provide patient and family education committees to understand the course of treatment.
- Encourage an older drinking age through education, modeling, positive recreation, and other diversionary activities.
- Ensure alternate ways of socializing for teenagers.
- Lack of sobriety affects jobs or could prevent employment.
- Gradually change the social norms regarding the use of alcohol.
- Stricter truancy enforcement is needed.
- Penalize household family members who practice and/or model negative behavior through heavy drinking and illicit drug use around young children.

Intentional and unintentional injuries and violence:

- Educate the local community about how violence is costing the tribe in terms of financial resources and human impact, such as incarceration.
- Develop more local accident and injury data (including serious and fatal results) so the tribes can analyze it, share it, and make it available to the community.
- Obtain data to help promote preventive behavior such as increasing the use of seatbelts and infant/child car seats.
- Develop an integrated system for more accurate and comprehensive collection and reporting of data regarding injuries and violence. Data should represent local communities.
- Use "talking circles" as intervention with alcohol and other drug abuse and violence issues.
- Develop men's re-education groups to address violence.
- Address underlying causes of violence and alcohol and other drug abuse in the community in areas that include:
  - Modeling.
  - Historical factors (introduction of alcohol into the American Indian community).
  - Economic challenges.
  - Clarification of values and priorities.
  - Permissive households that support underage drinking, wild parties, and fighting.

Social and economic factors that influence health:

- Education provides the means to acquire information to develop healthy lifestyles and have the financial resources to obtain good jobs to have a higher quality of life.
  - Develop partnerships with the Department of Public Instruction to assure good schools and teachers.
  - Provide funds to educate youth.

  - Make sure that all children can attend good schools. This applies, not just to kids, but a statewide education system for all.
  - Better educate people so they can obtain better jobs to improve their quality of life.
  - Ensure that children have the support of parents and their family in order to learn.
  - Need better collaboration between employers, institutions of higher education, elementary and secondary schools, and the technical colleges.
- Jobs, training, and money are necessary supports.
- This health priority involves the whole community.
- Economic prosperity comes before health issues in this country. It goes hand-in-hand that people cannot get well or stay well unless they have money. For example, people need money to buy food and basic needs.
- Every tribe uses the casino resources differently.
- Every tribe reinvests back to the tribal community differently. For example, the Oneida Tribe passed a resolution to provide up to $20,000 to high school graduates to support college and technical college opportunities. They are accountable for several guidelines that include maintaining a certain grade point average and must meet a certain number of credits and classroom hours per semester.
- One of the values of the Oneida Nation is to provide jobs for their people. This is consistent with 1 of the 12 national focus areas of the Oneida Nation.
- Each tribe is unique, and some tribes have access to greater resources than others do.
- Tribes share "people" resources with one another. (See Attachment A.)
- Tribes vary in their capacity to provide basic services.
- The Indian Health Services (IHS) has a regulation that requires tribal health clinics to provide services to all who request care, regardless of their tribal affiliation, and despite the fact that the clinic may not receive reimbursement for services provided.
- Tribal health systems desire to be more informed and have increased opportunity for input into the involvement in state health program planning, development, and operations as these involve the local health departments. They believe this is in their best interests as sovereign tribes. Mutual benefit can be expected when we first start with simple steps to strengthen the foundation for greater subsequent involvement of the tribes like local health departments enjoy through trust, community collaboration, and agreement:
  - Improve mechanisms of communication to ensure that consultation occurs early, that tribes are kept informed on an ongoing basis similar to local health departments, and that innovative approaches to accomplishing this (e.g., the special committee established in Vilas County) are initiated.
  - Educate/train State employees to clear up misconceptions about American Indian health systems and to prevent institutional racism.
  - Identify the simplest areas for increased collaboration (e.g., simple initial memorandums of understanding might be developed).
  - Avoid functions of local health departments that might involve questions of sovereignty until there are improved relationships, sufficient time, and mechanisms available for collaboration based on thorough consideration by the tribes concerning their interests.
  - Assure strong involvement of tribal representatives in the Implementation Plan for *Healthiest Wisconsin 2010*, as well as upholding each tribe's sovereign right to participate as they see fit.

- More advanced changes in involvement of tribal health systems might then, at each tribe's choice and following more extensive *Healthiest Wisconsin 2010* implementation planning, involve the following types of activities:
  - Apply aggregate data and research to community health planning.
  - Develop collaborative approaches to health career education and continuing training for American Indian people in public health.
  - Develop and plan new mechanisms for providing community health services (e.g., interdisciplinary, concentration on accidents and injuries, alcohol and other substance use, family-centered case management, retaining generalist public health nurses, releasing public health nurses from program administration and getting them back to the communities who need them).
  - Become more systemic (using the Wisconsin Turning Point Initiative process) throughout the state by involving other departments that are involved with education, transportation, housing, waste disposal, water quality, and employment/economic development.
  - Take statutory action to provide opportunities for tribal participation like local health departments and for additional funding streams.
  - Develop more advanced collaborative memorandums of understanding and/or agreements with tribal involvement and approval to build upon improved relationships and opportunities.
  - Develop improved policy impact estimation capability in Wisconsin so that the impact on the American Indian of various policy options might be more accurately predicted before new programs are implemented.
- How much of an advantage really is the Child Health Improvement Program in light of the co-pay? The State cannot just implement this program without considering the local economic and health systems structure.
- The Wisconsin Well Woman Program is a last resort of payment, and so is Contract Health. (Refer to Attachment A.) Tribal health clinics would pick the Wisconsin Well Woman Program first in order to contract money. However, the Department is putting up barriers to this option by implementing tighter policies and procedures.
- There is a need for good, high quality, and affordable childcare. This would include qualified childcare providers. There is a need to provide childcare 24 hours a day, 7 days a week. Unplanned pregnancies exacerbate this need.
- There is a great need for affordable housing. Low-cost housing doesn't always mean affordable.
- The use of new revenues in the tribes is still in the infancy stage. We need to have a long-term view with respect to investing this revenue. This ties into the policy research.
- "Now we are reaching a generation of elders who are in need of long-term care and support. However, there is a change in culture where many do not like to be called grandma and grandpa. Many are still working. 'I've raised my kids, now I don't want to be saddled by grandkids.' This is a new language and in the past elders would not talk this way."
- "There is a different cultural view of relationships with money. Some of this has to do with historical poverty and dependence."
- Don't just give information, but interpret it so that the client understands.
- Providers can't use the excuse of "too big a caseload" anymore. It's a responsibility of the providers--which includes the nurses, physicians, social workers, and health educators. We need to collaborate.

Sufficient and competent workforce:

- We need to support the important work and long-standing contributions that public health nurses and social workers give to our communities. They provide important education and parenting support to help families. A collaborative and integrative effort is needed between both of these important professional disciplines.
- There is a significant decrease in community infrastructure and capacity because public health nurses, health educators, social workers, and nutritionists are dealing with administrative issues. These issues drive them away from working directly with the people and the community. It drives them away from helping and interpreting issues for communities.
- Social workers need to do social work.
- Alcohol and other drug abuse counselors, as well as other providers, need to do more social work. This fosters trust. It is seen as a "good thing" on the reservation.
- Education–especially in the sciences–needs to be emphasized.
- Funds are changing and public health nurse generalists of the past are now being redirected to categorical programs and services such as maternal/infant programs. Yet, these categorical programs are run differently than generalized services to the community. It takes a lot of time and capacity to get new programs accepted and established in tribal communities. You spend a lot of time and effort to justify and help the programs.

APPENDIX A

American Indian Community Stakeholders Forum

Tribal Health Systems

Treaties between tribes and the U.S. Government, subsequent legislation, and court decisions hold that the U.S. Government has a "trust responsibility" for health care service provision to all federally recognized tribes. The federal Indian Health Services (IHS) in some cases directly operates hospitals and clinics on or near reservations. In Wisconsin and several other states, tribal governments operate their own health facilities in accordance with self-governance and the federal Indian Self-Determination Education Assistance Act Public Law 93-638.

Reservation-based programs consist of both direct and contract health services:

- Direct Health Services (DHS) are provided on-site and free of charge to eligible American Indians/Alaska Natives at either IHS or tribally-operated health clinics and hospitals. Health services include a range of primary care and preventive care and may include some specialty care (e.g., dental, pharmacy, vision, hearing services). Tribes may operate their own public health programs; Women, Infants, and Children (WIC); environmental health services; mental health; and Alcohol and Other Drug Addiction (AODA) programs.

- Contract Health Services (CHS) are provided by non-IHS, non-tribal health care providers. Tribally based CHS program offices authorize payment to off-reservation, non-tribal providers for health services rendered to eligible American Indians/Alaska Natives. CHS-funded services include emergency specialties and acute health care services. Tribes not affiliated with an IHS hospital or those with limited direct health service capacity depend heavily on contracted health providers.

Tribal clinics provide care for all eligible American Indians within their service area, including uninsured and underinsured tribal members. The IHS partially funds both Direct Health Services and Contract Health Services programs through annual allocations to the tribes. Funding is not an entitlement, but rather depends on annual congressional appropriations. American Indians and Alaska Natives, as United States citizens, may also be otherwise eligible for Medicaid, Medicare, and Veterans Administration health benefits. Many also hold private employer-sponsored insurance coverage.

Source:

Robideaux, Y. *Current Issues in Indian Health Policy*. Udall Center for Studies in Public Policy at the University of Arizona. October 1998.

American Indian Forum Participants
Invited and Attending
April 16-17. 2002

Community Participants:

Patricia Boyles, Ho-Chunk Central Health
Cheryl Caldwell, Menominee Tribal Clinic
Robin Carufel, Peter Christianson Health Center
Mark Caskey, Menominee Tribal Clinic
Georgette Coon, Menominee Aging
Linda Daniel, Family Resource Center
Stephen Everett, Great Lakes Inter-Tribal Council
Betty Gray, NACGP
Diana Gray, Peter Christenson Health Center
Jean Hilt, Peter Christenson Health Center
Scott Krueger, Menominee Tribal Clinic
Dawn McCusker, Great Lakes Inter-Tribal Council
Nancy Miller-Korth, Great Lakes Inter-Tribal Council
Sandra Ninham, Oneida Tribe
Brenda Owen, Ho-Chunk Nation
Cheryl Plautz, Forest County Potawatomi Health and Wellness Center
Glen Safford, Great Lakes Inter-Tribal Council
Bernie Stevens, Great Lakes Inter-Tribal Council
Marilyn Walker, Family Resource Center
Jerry Waukau, Menominee Tribal Clinic
Jennifer Weitzel, House of Wellness
Denise Wildcat, Family Resource Center

State of Wisconsin Participants:

Jennifer Argelander, Division of Public Health, Department of Health and Family Services
Denise Carty, Division of Public Health, Department of Health and Family Services
Evelyn Cruz, Division of Management Technology, Department of Health and Family Services
Diane Miller, Wisconsin State Employees Union/AFSCME Council 24
Margaret Schmelzer, Division of Public Health, Department of Health and Family Services

Invited but did not attend:

Deanna Bauman, Oneida Community Health Center
Breand Doren, Lac du Flambeau
Bert Dowd, Great Lakes Inter-Tribal Council, Inc.
Linda Hawpetoss, Oneida Nation Social Services
Karen Martin, Ho-Chunk Nation
Aletra Parsons, Lincoln Neighborhood Community Center, Inc.
Sandra M. Schuyler, Milwaukee Indian Health Center
Adrienne Thunder, Cross College Advising Service
Lynette Wychesit, Menominee Tribal Clinic

ASIAN COMMUNITY STAKEHOLDERS FORUM
NOVEMBER 1-2, 2001

Perspectives, Reflections, and Recommendations on Elements of the State Health Plan, ***Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public***

LESSONS LEARNED

The following text reflects the participants' responses and reactions to *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. Although the participants in this Turning Point Initiative Forum were small in number, they nonetheless provide great insight for Wisconsin's public health system partners to assure the sustained engagement of the Asian communities in the transformation of Wisconsin's public health system.

- Placing all Asians into one category is an over-simplification of widely diverse and richly different groups of people and cultures. They are different, and sometimes unique, in ways that include, but are not limited to:
  - Religion and ways of worship
  - Cultural values and language
  - Food, dress, kinship structure, gender, intergenerational relationships
  - Levels of acculturation and cohesion within their communities
  - Number of generations living in the U.S.
  - Citizenship and refugee status
  - Size of the Asian ethnic group in Wisconsin
- The Wisconsin Turning Point Initiative Forum organizers learned that each Asian group has individual and unique characteristics that affected the way in which they should have been invited to participate in the Wisconsin Turning Point Initiative Asian Community Stakeholders Forum. Among the more traditional groups, like the peninsular Southeast Asians (Hmong, Lao, Khmer, and Vietnamese), invitations should have been sent to the tribal leaders and local organization representatives, who then would designate the most appropriate person to represent the group. The Wisconsin Turning Point Initiative did not adequately identify who the tribal leaders and local organization representatives were in the Southeast Asian group. On the other hand, the insular Southeast Asians/Pacific Islanders (Filipino and Chamorro) only needed a direct call to someone who had personal ties with a Wisconsin Turning Point Initiative organizer. All contacts needed more than one phone call to establish a personal tie within a professional context.
- Minority representation must be included in the planning process. One reason for the small attendance is that nobody knew what the Wisconsin Turning Point Initiative was all about. We need to know the culture of the organization and its basic structure. The public health system lacks people who are trained to set up inter-agency and inter-organizational linkages, and otherwise build bridges. It is important that the organizations serving the Asian communities understand what public health is and its meaning to them before they will attend meetings.

- We learned that we should not send invitations only to the Asian representative or translator in an organization. Rather, send it to the head of the organization and ask them to invite the Asian representative or translator. This will build buy-in by the organization.
- We must allow for more time. Invitations should be sent no less than 4 weeks in advance of a meeting or forum.
- An assumption was made that everyone knows about the Wisconsin Turning Point Initiative, yet the community really knew nothing of it. How do we get information to the people? You cannot stop with just one meeting. You need to take this forum and create a series so you can get to the "deeper" levels of the community (i.e., the lowest level of interaction between members of the community). In addition, if you are dealing with the Hmong community, you need to examine their capacity in receiving and spreading this information. For example, the Hmong community wants to talk about what's affecting them, not just hear about the program.
- Identify who the key leaders are who serve the community. These leaders must be engaged first. Once this is done, establish a relationship with the leaders and then go to the people through the leaders. It is best to go through Wisconsin's 15 Mutual Assistance Associations rather than going directly to Hmong service delivery providers. Some Mutual Assistance Associations, who are better organized with commonly recognized leaders, tend to function better than others.
  - Public health leaders must inform the Mutual Assistance Association Agency Director.
  - Service providers do not develop policy, they implement policy of the Association.
  - Don't just ask for a list of people who you would like to invite. Rather ask how they should participate. The public health system partners need to improve their ability to ask the right questions.
  - Establish a continuous voice from start to finish.
  - Ask what the health issues are. If you ask for a Hmong representative, he or she should bring the local health department and hospital contacts to the table as well.
  - Allow the Hmong representatives empowerment to make decisions or recommendations. One gets a different result when you ask the local health department or the hospital to represent the Hmong and get the wrong solution to the problem.
- Be aware that the natural leaders have the pulse of the community and must be involved from the beginning in all program development and policy shaping issues affecting their community.
- Relationships between communities and the "establishment" command trust and respect.
- Be respectful of people's time, especially for those efforts that require a lot of work.
- One needs to go to the communities in their own locales, listen, transcribe, and bring back the information and insights to help shape planning and/or policy processes.
- It is important for the public health partners to understand and work within established cultural systems in the Asian community (e.g., leadership systems, familial hierarchy, decision-making processes).
- Culturally relevant and specifically tailored strategies are required for health promotion in community. Work outside the box.
- Effective partnerships and strategies with Asian and other diverse communities truly requires transformation of the "established systems" that include public health, health care, government, social services, and economic development.

- Public health must have an understanding and acknowledgement of diversity beyond the standard identified groups (e.g., African American, Asian, Hispanic/Latino).
- There is significant interracial, intra-group, inter-ethnic, intergenerational diversity among groups.
- When engaging with communities, it is important to not only convene natural leaders, but also demonstrate the commitment of key community decision-makers simultaneously with facilitators and primary program staff.
- Workplace diversity, that reflects communities, enhances the building of community relationships.
- Engagement is not only required for obtaining information from the community, but the methods that work for successful engagement are required in providing information to the community irrespective of the input requested.
- Community health concerns must not be dealt with categorically and in isolation. Holistic comprehensive forums are a must!
- We must protect and support our community leaders. Often our practitioners and community leaders are overworked and have not had the resources to build effective organizational and community capacity. Community liaisons must be supported.
- Public health must take advantage of nontraditional partners and resources with effective health promotion programs (e.g., churches, natural healers, private sector partners, schools).
- The Wisconsin Turning Point Initiative Forum was scheduled concurrently with a statewide public health conference that caused scheduling conflicts with other invited participants.
- Most of the public health issues deal with the Hmong, by far the largest Asian population in Wisconsin. However, health issues of other Asian populations are of equal concern. For example, tobacco is not a Hmong problem, but it requires extensive intervention in almost all other Asian groups. The emerging Asian populations are also experiencing more problems with high blood pressure and cardiac conditions, mainly because of a change in diet. The Wisconsin Turning Point Initiative attempted to be more inclusive in inviting different groups, yet the response was poor. We need to make sure the right people are around the table from the beginning. This should include representatives from alternative medicine.
- Sincere efforts must be made by the public health system partners to understand the belief systems of the Asian cultures. This will greatly help the public health community become "in tune" with the community. In tune with the community means: "Who are those who make up the diverse communities? What are the numbers? How do they function? We need to see them as a group, not people with disease. We should ask what their health changes are and how does the community respond to it?"
- Title VI does not go far enough. We need to move beyond linguistic requirements like translation and interpretation. We must become both linguistically and culturally competent to look at the whole person in the context of the social and environmental dynamic.
- Linear, single response, and time limited are characteristics of the current system. "Credibility is a problem because plans come and go--then you come back to us and say we need you to help us."
- The Asian communities do not understand the mission and scope of governmental public health agencies, both at the state and local levels. They do not understand how important public health issues are to their communities. Other resources in the communities do not maintain shared information about health and wellness. Also, participants were not fully

briefed on the reasons for the Wisconsin Turning Point Initiative Forum, or else they did not read the invitation carefully.

- Local health departments and their partners need to overcome cultural factors affecting prevention and treatment. Such factors include:
  - Language barriers and the need for competent interpreters.
  - Lack of cultural competency in the workforce.
  - Understanding of the distrust of western medicine and dependence on indigenous medical treatment by tribal/community healers.

  To overcome these obstacles, local health departments and their partners may be able to change their attitude and mentality in order to lead and transform public health in the community. This is not an easy task to do.
- The way governmental and health care institutions collect data and "count the numbers" is important. If the data is not "right," we will make little to no progress. The partners must have cultural competence in order to collect appropriate data. The Division of Public Health's Minority Health Officer has a significant role in data collection and review and can make recommendations to change the direction of programs.
- How can advocacy groups use the data to make change? Community-based organizations often collapse because they often lack a strong organizational infrastructure.
- More disaggregated data on minority communities and sub-populations are needed. Cooperation and commitment from local jurisdictions to assess and identify minority health practices is a must.
- Statewide and local public health system partners need to be aware of state and local community organizations for partnership and communication channels. For example, the Mutual Assistance Associations would like to formalize a partnership with the State and local health departments. They would like to include this partnership as part of their performance objectives and evaluation process.
- Any project of the Division of Public Health should be introduced to an Asian community during community activities, formal and informal meetings, feasts, and rituals. They should seek natural forums where project issues can be discussed by a majority of the community. (Be aware of the possible need for interpretation.) Another way of connecting with a community is through faith-based organizations.
- More dialogue with the community will make the state and local health departments aware of the realities within each community and receive practical feedback for the implementation process. Local health departments should have the flexibility to tailor programs as their community needs arise.
- State and local health departments should collect nontraditional best practices that can be shared with all communities and their public health system partners.
- Issues for local implementation include:
  - Choosing local partners.
  - Understanding the political processes of all stakeholders.
  - Identifying decision-making practices used.
  - Knowing who is "at the table" from beginning to end.
  - Ensuring there is appropriate local representation from all stakeholders.
- The Department of Health and Family Services' policies, procedures, guidelines, and framework for the local public health system to follow must reflect the funding patterns, effective and targeted services, and delivery to all eligible populations.

REFLECTIONS AND RECOMMENDED STRATEGIES FOR HEALTHIEST WISCONSIN 2010: A PARTNERSHIP PLAN TO IMPROVE THE HEALTH OF THE PUBLIC

The following text reflects the participants' responses and reactions to *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. It includes their views on what the plan would look like if they were "done right" in a transformed public health system.

- Expansive role of partners is acknowledged, but be careful with the descriptions. For example, community-based organizations are identified, but not mutual assistance organizations. Mutual assistance organizations are not really community-based organizations.
- *Healthiest Wisconsin 2010* must be made relevant to local communities and minority groups within those larger communities.
- Local health assessments often are not relevant to the health concerns of minority groups.
- The structure of local health departments and boards of health (key decision-makers) do not reflect minority communities–there is no minority representation on the boards. This seriously thwarts authentic voices within communities who can identify the real priorities, which even when acknowledged, does nothing to improve health for all.
- How will the public health system partners be made accountable to address health promotion and the three goals of *Healthiest Wisconsin 2010* to actually improve the health of the communities?
- Local health prevention programs (e.g., overweight, obesity, lack of physical activity) should clearly be outcome-focused and linked to the overarching goals of *Healthiest Wisconsin 2010.*
- We need to counter the elitist, isolationist type of attitude with local health leadership that persists from openness to change and partnerships.
- How is "partnership" defined? It should not be shaped by casual inclusion and traditional prescriptive approaches that don't result in meaningful engagement.
- Partnership should not be "mandated" just to satisfy minimum or "forced" program requirements. This type of partnership is not sincere, meaningful, or respectful. Moreover, it defies the trustworthy and sustained relationship building that is required for transformational change and effective engagement of minority communities toward effective outcomes.
- Local health departments should represent the people, but this is too often not the case! Without this, plans and programs will never adequately address health.
- How does the plan best include minority communities?
- How do we make local health departments accountable to the needs of local minority populations?
- Public health officials must be trained to gain greater awareness about our cultures and practices (e.g., Hmong, Lao, Vietnamese) so they can effectively penetrate to the core of our society in order to become aware of aspects that hinder their ability to deliver public health needs. Training can be tailored to meet the demand. That means if the Hmong are the larger of the ethnic groups, such culture training can be a priority and so forth. Public health leaders

(e.g., administrator, staff) should be required to attend at least 1 to 3 days of cultural training. The La Crosse Mutual Assistance Association has such training in place.

- There is a need for ethnic language competency training for bilingual staff. For sure, the Hmong, Lao, and Cambodian are critical in this health care arena. Special training should be provided for bilingual staff in their specific language. This cannot be a 1 or 2 day training; it will be just like any course that is taught at the higher education level: at least a quarterly session.
- Cultural training, such as recommended for public health officials, should be geared toward bilingual staff/interpreters. Many bilingual staff/interpreters are not competent in their own culture.
- Public health needs to include bilingual and bicultural professionals at their administrative level. These are the people that will have both the cultural and technical expertise to penetrate their community and the larger community.

Strategies:

- Ensure that contract consolidation parameters require inclusion of minimum diversity standards.
- Enforce policies that recommend diverse representation of boards of health.
- Strengthen the statutory language regarding the membership of local boards of health to reflect the diversity of the communities in their jurisdiction.
- Incorporate, as part of the evaluation process for community health improvement processes and plans, the level of inclusion of minority populations in the development of such plans.
- Forge sustained state and local partnerships to enhance accountability and data-driven commitment to develop effective services for improved minority health.
- Establish, through the Department of Health and Family Services, benchmarks for all local health departments to include:
  - Minority representation in community planning, assessment, setting priorities, and assisting in the removal of barriers to accessing services. This includes the use of oral interpreters and written translation where needed.
  - Dissemination of funds and resources.
  - Provision of services.
  - Cultural and linguistic competence.
- Encourage increased commitment and active engagement of minority communities in democratic processes (e.g., advocate to legislators to provide resources to address their concerns).
- Ensure that the question, “How are our priorities related to those of minority communities?” is answered when evaluating and monitoring *Healthiest Wisconsin 2010* at both the statewide and local levels.
- Evaluate and monitor *Healthiest Wisconsin 2010* at both the statewide and local levels in terms of answering this question: “How are our priorities related to those of minority communities?”

Asian/Hmong and Pacific Islander Forum Participants Invited and Attending November 1-2, 2001

Community Participants:

Elizabeth Reyes, Madison
Thai Vue, La Crosse Area Hmong Mutual Assistance Association
Miva Yang, Sheboygan City Public Health

State of Wisconsin Participants:

Denise Carty, Division of Public Health, Department of Health and Family Services
Regina Cowell, Division of Management Technology, Department of Health and Family Services
Rick Delgado, Bureau of Communicable Disease, Department of Health and Family Services
Pepe Indalecio, Department of Employment Relations
Tam Phan, Division of Public Health, Department of Health and Family Services
Margaret Schmelzer, Division of Public Health, Department of Health and Family Services
Dhana Shrestha, Division of Public Health, Department of Health and Family Services

Invited but did not attend:

Vinod Daniel, Division of Public Health, Department of Health and Family Services
Chang Her, Department of Family Medicine, University of Wisconsin Medical School
Laty Keodouangsy, University of Wisconsin-Marquette
Xou Khang, Hmong Association of Wood County
LoNeng Kiagoukaysy, Hmong American Friendship
Yer Kue, Manitowoc County Health Department
Alice Kuramoto, Milwaukee School of Nursing, University of Wisconsin
Chia Lee, Hmong Association of Green Bay
Lo Lee, Hmong/American Partnership Fox Valley
Seng Lee, Hmong-Lao American Association
Wang Lee, Lakeshore Indochinese Mutual Assistance Association
Susan G. Levy, Office of Refugee Services
Bee Lo, Lorenz Clinic
Fai Dang Lor, Wausau Area Hmong Mutual Assistance Association
Phan Luong, Division of Public Health, Department of Health and Family Services
Jan Miyasaki, RESPECT
Choua Der Moua, Hmong American Association of Portage County
Her Moua, City of Milwaukee Health Department
Mayhoua Moua, Hmong American Women Association
Bounkham Nathavong, Catholic Social Service
Ruby K Paredes, Office of the Chancellor, University of Wisconsin
ThanhSon Pham, Milwaukee Health Department
Sharyl Sato, Rainbow Project
Prem Sharma, Glendale
Chia Thao, Lao Family Community
Chou Thao, Madison Department of Public Health
Tieu Minh Thu, Cudahy
Charles Valmadrid, Portage
Houamany Vang, Lakeshore Indochinese Mutual Assistance Association
Jai Vang, Hmong Association of Green Bay
Jer Vang, Lao Family Community
Ka Yi Vang, Wausau Area Hmong Mutual Assistance Association
May Vang, La Crosse County Health Department
See Vang, Eau Claire Area Hmong Mutual Assistance Association
Nhaxiu Paul Voung, Division of Public Health, Department of Health and Family Services
Mai Zong Vue, Division of Workforce Solutions, Department of Workforce Development
Jay Xiong, Sinai Samaritan Medical Center
Mary Xiong, Green Bay Hmong Women Association
Tong Xiong, Hmong American Community Association
Tou Xiong, City of Milwaukee Health Department
ChaSong Yang, Hmong Mutual Assistance Association of Sheboygan, Inc.
Phoua Yang, Milwaukee
Nao Yia, La Crosse County Health Department
Kuo Yang, Mid-State Technical College

HISPANIC/LATINO COMMUNITY STAKEHOLDERS FORUM
OCTOBER 30-31, 2001

Perspectives, Reflections, and Recommendations on Elements of the State Health Plan, ***Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public***

OVERARCHING GOALS

The following text reflects the participants' responses and reactions to the three goals identified in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. It includes their views on what these goals would look like if they were "done right" in a transformed public health system.

Promote and protect health for all:

- Will undocumented people benefit from this in a state that does not have universal health for all? Is it health for all or health for some?
- The state and federal entities should remove program requirements that are barriers for undocumented persons.
- The goal for health must be the norm--a guarantee and not a privilege.
- The profit motive contributes to health for some.
- Today we must listen to learn, and not listen to respond.
- People would not be afraid of seeking care and not wait until things get to a crisis state.
- Access to "health for all" would not face a major barrier--the barrier of finances and the ability of people to pay their bills. Our lower economic position is a major reason for the health disparities within the Hispanic/Latino population.
- Change the perspective from a medical model. Many things determine health-not just economics. People would be aware of the broad determinants of health. Holistic approaches would be valued.
- We would be focusing on the roots of the problem and stop treating only the symptoms at the community level–this is not to say we don't want disease/symptoms treated–but look at the root cause.
- Need balance between prevention and the treatment of health problems.
- Develop more prevention-focused education and health promotion directed to the Hispanic/Latino community.
- Targeted funding and resources for the programs are needed to support this goal.
- Set aside funds specifically for the Hispanic/Latino community.
- Increase mental health resources for Hispanics/Latinos.
- Build family resource centers in communities:
  - They establish a trusted presence and are well utilized by residents.
  - Must have many bilingual and bicultural staff, and offer a variety of comprehensive programs not only in health but also related to family and economic development.
  - Mental health services and social services are needed.

- Foster community self-reliance with community-sponsored fundraising activities.
- Sponsor more Hispanic/Latino community health fairs with a comprehensive, holistic, and family-centered focus.
- Develop more health education classes and materials in Spanish that are taught by bilingual and bicultural professionals.
- Provide transportation to families for health care.
- Messages and actually health education classes offered regularly on the television could be a very effective approach to provide education. The television is convenient and is often watched in households. It also could assure privacy and get across "stigmatized" messages such as HIV and AIDS.
- Propagate social marketing principles and activities that include:
  - Lay health workers or "*health promatoras*" who are trusted to go door-to-door to share information, link to resources, and provide family-focused health education.
  - Community outreach workers and home visitation programs.
  - A major, long-term marketing campaign to promote good health.
  - Television and local Spanish radio stations.

Eliminate health disparities:

- Color, class, or race would not matter.
- Total access without barriers.
- Recognition that certain groups are at-risk and need tailored approaches. We would move away from a "one-size fits all" approach.
- A sense of empowerment would exist and a recognition that people can take charge of their own health. If you give them information, they could do their own self-care.
- "Paternalism" and "maternalism" are rooted in "goodness." However, these approaches can cause over-protection and dependency. It doesn't empower people. We need to "teach communities how to fish."
- Directly observed therapy for tuberculosis.
- Need to start the elimination of health disparities at an early age. This includes prevention in the schools and engaging community leadership, such as what the United Migrant Opportunity Services is doing in our community.
- Need to provide the tools for the communities.
- Provide training so people can do their jobs well.
- Training and educating members of the community to serve their community (e.g., translation).
- Eliminate disparities by stopping outside people from doing for us, and let the community build support and develop itself. External organizations should be our consultants.
- Challenge the community to create solution-makers for a new generation.
- Get and stay involved.
- Set strong dreams.
- Link youth and community members to mentors and race models.

- We, as adults, need to take personal responsibility to bring children and youth to our jobs. One participant shared his views on how he regularly does this at the Milwaukee Fire Department. "The kids walk away with a new view--that the fire department is a warm place with warm people."
- People in positions of power are seen as a threat, which distances leaders from the people.
- Greater diversity is our strength.
- Equality: This is no "us" versus "them" issue. It's an issue for all of us.
- Ten years from now we wouldn't have to gather the Hispanic/Latino community together to hear their views because they would already be there--leading and involved.
- Ensure universal health insurance coverage and access to health care services.
- Educate the community on responsible use of health services to conserve available resources (e.g., avoid excessive use of the emergency room for non-serious conditions).
- Eradicate language barriers by promoting "English as a Second Language" programs in creative ways to reach a broad section of the community. Explain to limited English speaking immigrants resistant to learning English that there are tremendous advantages to learning English in this society--that it improves chances of success. In other words, make the process of learning easy and more convenient.
- Allocate more funding and resources to community-based organizations and local health departments for health promotions targeted to Hispanic/Latino communities.
- Prioritize mental health services for Hispanics/Latinos:
  - Many Hispanics/Latinos fall through the cracks and suffer from mental health problems due to adjustment and socioeconomic challenges in the United States.
  - Mothers neglect their own needs for the sake of their children--their children come first.
  - Need to give parents permission to address their own needs as well as their larger family.
- Educate consumers on the importance of prevention and self-care.
- Improve social and economic conditions.
- The local health department should lead a community-based collaborative approach with many diverse partners at the table, including the target community representatives.

Transform Wisconsin's public health system:

- If the determinants of health were achieved in a community, would we need health departments in the future?
- Many things contribute to health outside of state and local health departments.
- Shouldn't there be one agency to "oversee" or coordinate all of the agencies in a community that has a health mission? Shouldn't that be a local health department?
- A local health department in 2010 would be a clearinghouse for information directing people to the right resources and monitoring the health of the community.
- Local health departments would not be doing direct services and filling gaps, as the system would be working.
- It would be very scary to even consider a community without a local health department before the system is working and before the gaps are filled.
- If we reach the point of having a transformed system, public health could be released from fostering and carrying out co-dependency.

- Local health departments took on a larger role because the partners have not been accountable for their roles and have washed their hands and let the local health departments do it all. We need to reverse this and hold our community organizations accountable.
- Encourage widespread partnerships of many resource people that can impact health.
- Establish mobile health services in rural and urban Hispanic/Latino communities.
- Commit to sustained funding for long-term programs that can result in long-term solutions because:
  - Too often, funding is restricted and too short-lived.
  - It is difficult to attain positive outcomes with traditional funding streams.
  - Pilot programs that work are not continued or replicated in other areas due to lack of funding.
- Promote the development of bilingual/bicultural health professionals from the community.
- Improve health care infrastructure in communities where Hispanics/Latinos are more underserved with limited access to resources.

CORE PRINCIPLES AND VALUES

The following text reflects the participants' responses and reactions to the core principles and values in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. It includes their views on what core principles/values would look like if they were "done right" in a transformed public health system.

The more decisions are based on reliable data, better public health decisions will be made:

- The public health system should work to provide reliable, meaningful data.
- Data collection is not sufficient. We need information to effectively plan and identify priorities at the local, regional, and statewide levels.
- Privacy and confidentiality must be ensured.
- Seems to be the "American Way." We constantly give and get data, and nothing is done with that data. No actions are taken. We push data gathering too much.
- We need access to sufficient data and have proper allocations of resources to act on the data and the information it provides to communities and organizations.
- The Latino community does not respond well to surveys. If data is needed, we must employ more "user friendly" approaches to get this information.
- Phone surveys don't work well. It is seen as "intrusive." Simply counting people doesn't give you data. Phone surveys can be frightening. You must first build trust. Ways to build trust include attending community meetings, calling us rather than us calling you to discuss the data needs, and engaging people in partnerships.
- Data is a "Catch 22." Disadvantage is built in because "well-resourced" agencies keep getting the grants that provide the money to collect data. However, these agencies may not always do the best job when it comes to serving and helping our community.
- There are problems with the type of data needed and the way information is collected.

- We want to know what is happening in our community with the data that is collected and how we are doing in terms of increasing or decreasing health disparities.
- Language and linguistic differences influence the quality of data provided.
- Cultural issues may include discomfort in speaking up. Some women may defer to their husbands for financial decisions and providing information.
- Policies and data must go "hand-in-hand." Data must be incorporated in policies or we will not create actions and results that are accountable.
- We must hold agencies and organizations accountable for their policies.
- Need coordinated data collection and reporting with uniform standards for data collection and sharing of data across state and local agencies. Health care providers must also be part of this process. Leadership needs to be undertaken by state and local counties and agencies.
- Need more data on Hispanic/Latino health that is specific to counties and special groups, such as the undocumented and other "marginalized" groups that do not routinely interact with the system.
- More accurate identification of subpopulations within Hispanic/Latino communities is needed. "Hispanics" are described too broadly.
- Survey specific identifiers such as race, ethnicity, primary language, country of origin, residence, age, income, employment, and so forth.
- Comprehensive assessment is needed to identify unique needs and determine where the disparities exist.
- Recommend major resource centers in communities that provide services for Hispanics/Latinos to collect and report uniform data.
- Identify and encourage more bilingual and bicultural staff to assist in relating to communities and individuals for the collection of data. Provide more funding and resources for this.
- Ensure convenience, safety, and privacy for persons from whom information will be collected (e.g., work with schools, community centers, established places where people go, such as churches).
- Avoid unnecessary duplication of data collection procedures. We need more streamlined and integrated data systems across social service organizations.

Good health results from the positive interaction of physical, mental, emotional:

- Consider the spiritual, cultural, and environmental forces that influence health.
- A holistic and comprehensive framework is a must.
- Good health includes physical, mental, spiritual, emotional, and cultural sensitivity.

Prevention is the most effective public health strategy:

- Sure it is, but if we don't communicate it well or if we don't use a variety of mechanisms to get the message out, we end up changing nothing.
- Many Hispanics/Latinos are very focused on preventive care. There is a need for culturally appropriate strategies to effectively reach populations and promote behavior change for improved health practices.

- Going to the community is a must. Don't expect the community to go to classes in settings that are outside normal, comfortable, and trusted settings of work, play, and worship.
- Prevention strategies must be culturally sensitive and culturally competent in both oral and written communications.

The public health system must provide a voice for all:

- This is critical for historically "marginalized" groups.

Collaboration is the key to success:

- Collaboration with the Hispanic/Latino community must be done in a meaningful way with careful planning, commitment, and forethought.
- Communities don't have time to waste by becoming involved in unorganized and poorly thought out initiatives.

All Wisconsin residents deserve a basic level of health services:

- Universal access to care is a must.

ESSENTIAL PUBLIC HEALTH SERVICES

The following reflects the participants' responses and reactions to selected essential public health services in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. It includes their views on what these essential public health services would look like if they were "done right" in a transformed public health system.

Create policies and plans that support individual and community health efforts:

- Need more immigrant-inclusive policies at the state and local level.
- Educate, inform, and engage Hispanics/Latinos in the democratic process.
- "Grow your own leaders" --especially at the local level.
- Partner with organizations to advocate for Hispanic/Latino health issues and other priorities.
- Change the composition of decision-making and policymaking bodies (e.g., legislature, local health boards, commissions) to include Hispanics and Latinos and advocates who represents the community.
- Promote the education and development of leaders who are more informed and sensitive to Hispanic/Latino issues--change the attitudes of current leadership.
- Educate legislators and policymakers as to how Hispanic/Latino concerns are related to their priorities, and how Hispanic/Latino issues impact the broader communities.
- Public health departments do an adequate job, especially with children's programs. However, these programs and services can be significantly enhanced with bilingual and bicultural staff. Increased funding for programs must be specifically targeted to the Hispanic/Latino community.

- The composition of local boards of health must reflect and represent the community. The State needs to set minimum composition requirements over and above what is currently identified in Chapter 251, Wis. Stats.
- Leadership training is needed for minority community members who wish to serve at this level.
- Good policy requires data analysis and then sharing and explaining what the data means.
- We need to preview policy models in other states.

Promote access to primary and preventive health and dental services, and link people to needed health services:

- Universal access to care is a must!
- Increase eligibility requirements to cover the underserved. Coverage is needed for adults as well as children.
- Insurance companies need to cover more preventive services for clients.
- Address special access issues of low-wage working adults and the elderly (seniors).
- Need greater availability of bilingual and bicultural providers.
- Develop creative approaches for certifying foreign-educated medical doctors to provide health care services as fully licensed physicians, or for those in supportive roles, such as physician's assistants and medical assistants.
- Promote and develop safety-net providers. Emulate models that work, such as community health centers, hospital systems, and faith-based communities that serve the health needs of the underserved. Look to other models in other states.
- Reallocation of existing and new funding resources.
- The public, private, and parochial schools should be responsible for assuring school health services and school health education.
- Active participation in Medicare and Medicaid should be a requirement for licensure for the health professionals in Wisconsin.
- Institutionalize access to care through contracts, memorandums of understanding, and letters of agreement.
- Promote community-based leadership to improve access to health care:
  - "Promotoras de Salud" (Health Promoters)
  - Partnerships between faith communities, local health departments, and the public health system.
  - Continue and create "Latino Professional Network" with local health departments.
- Assure affordable access to health care that is culturally and linguistically appropriate regardless of "legal status."
- Ensure that the Hispanic/Latino perspective is addressed whenever health decisions, health programs, and/or medical research is being planned and/or implemented.
- Ensure that the medical and health professionals are receptive to BadgerCare, Medicaid, and other similar programs.
- Educate the decision-makers about access to care.

- Collaborate with the private sector concerning objectives of providing high quality and affordable health care.
- Educate the community about health issues, such as prevention and access to health care services.

Promote community partnerships to identify and solve health problems:

- Include traditional and nontraditional partners (e.g., employers, private industry).
- Include the voices of the people in all plans and partnerships.

Monitor health status to identify community health problems:

- Need coordination among agencies.
- Need comprehensive data that is both quantitative and qualitative.

Educate the public about current and emerging health issues:

- English-English translation is needed before Spanish translations can be made. Too many times bilingual workers are asked to translate complex forms and fact sheets into Spanish, when they are not even understandable in English. What is needed is to first translate the English document into an understandable document (bringing the technical language down), then translating it into Spanish.
  - Things need to first be developed in the language and not just translated. They have to be at a level of understanding. A literal translation doesn't work (e.g., migrant farm workers generally have a sixth-grade level of literacy).
  - Just because materials are translated, it doesn't mean they will be able to read and use them.
  - Need leaders in the organizations to make sure this happens.
- The community agencies serving the Hispanic/Latino community know what primary languages the people are speaking. There are hundreds of native languages in Latin American countries.
- If appropriate Spanish translations were taken care of, we would be happy--organizations are not doing a good job getting things translated even into Spanish.
- Effective communication is critical and is not a dialect issue--it's how we communicate complex issues, and then language.
- Know your target population. In Wisconsin the majority of the Hispanic/Latino population is Mexican.
- Pictures and flyers don't work well to communicate the prevention message. Need to get it deeper into the community.

Assure a diverse, adequate, and competent workforce:

- Asthma, hypertension, and diabetes are important health problems and health disparities in the Hispanic/Latino community. A diverse, well-educated, and culturally competent workforce is critical to reduce these disparities.

- Hispanics/Latinos do not want to talk about health problems such as cancer and diabetes. They feel uncomfortable. It's a cultural difference.
- The public health workforce needs to be a strong advocate and have an advocacy role.
- Educating early in order to develop a cadre of young people with basic skills and the interest to pursue careers in public health.
- Require cultural competency training in the curricula for health profession students.
- Continuing education in cultural competency for the health professions is needed. Require cultural competency training as part of the institution's licensure/accreditation process.

Promote community partnerships to identify and solve problems:

- Community Hispanic/Latino leaders and organizations would come together as partners to prevent duplication of some things, and coordinate and collaborate to provide effective services.
- The State must play an important role in connecting agencies to prevent reinvention of the wheel.
- Need a central clearinghouse for collaboration and assure equal access to resources.
- Private health sector must be involved in identifying how, where, and why service gaps exist, and help fill gaps in community services.
- Private business sector and employees are not involved in community development like they should be.
- Workforce employment issues need to be strengthened so people don't miss open enrollments for health coverage.
- Business sector needs to be approached in terms, and in language that they understand. They would get a substantial return on their investment by investing in the community.
- The human resources personnel in the private sector and private businesses are needed and would help bridge communications between the Hispanic/Latino community and the companies in the community.
- The private sector is concerned about the impact on the bottom line. The cost of health plans is increasing. One of their biggest challenges is wages and health benefits. Pretty soon health care insurance will be so costly they can't offer it.
- The State needs to get the private sector involved in state-level public health system partnerships. This will help them get involved in local public health partnerships at the community level.
- Consumers must be members of public health system partnerships, not just agencies and organizations. Consumers must play a major role.

Assure access to primary health care for all:

- Legal status, gender, and cultural sensitivity are important issues to consider under access to care.
- One thing we need to do is seek the best of what health care has to offer--but this costs money. On the one hand we want the best for our families, yet we seek services that are out of proportion to what is required (e.g., get a CT scan for a headache).
- We need to go outside of government to build partnerships with private providers.

- Dental health care access is horrendous in Wisconsin.
- There is a lot of finger pointing about the lack of access to dental services. This needs to stop. What we need are solutions.
- State government has not made a financial commitment to assuring dental health access for W2 and Medical Assistance recipients.
- State and private sectors need a seamless partnership to assure health and dental services.
- Enforcement is lacking. There are no real consequences for those who don't comply. The State must enforce the requirement to provide culturally and linguistically appropriate services with the private sector for BadgerCare and Medical Assistance.
- Employers need to exercise creativity and options in designing dental health insurance plans that are flexible and portable.
- If universal health and dental care were realized, it would be a dream come true.
- Need creative solutions for children and families currently uninsured due to births outside of the United States.
- Immigrants are not considered when it comes to access to primary and preventive health services.
- Preventive health services need to be covered for population groups who are experiencing high cost illnesses.
- There are not enough mental health sessions for people who need treatment, once it is approved.
- We need to decrease and eliminate mental health stigma.
- Mental health should have been included in the definition of Essential Public Health Service #7--Link People to Needed Health Services.

SYNTHESIS OF PUBLIC POLICY ISSUES

The following text reflects a synthesis (integrated response) by one group of forum participants concerning *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public.* It includes their views on what a transformed public health system would look like if it were "done right" in a transformed public health system.

PUBLIC POLICY

Identified outcomes

- Public health system that includes parity, equity, and inclusion of Hispanics/Latinos at all levels.
- Culturally competent health services are accessible and available statewide, including language services (e.g., interpreters).

Philosophy

- Persons need to assume responsibility for their own health, while at the same time society has a responsibility to each individual.

Laws, rules, regulations

- We need the development and enforcement of policies that are positive for public health (define public health in its broadest definition).
- We need to enforce and improve current laws and regulations.
- We need to review and revise current laws that do not produce positive public health outcomes.
- We need a living wage for all workers.
- We need to avoid developing "exploitative" policies that make it easy to " bring in" migrants without health and insurance benefits. Nobody cares about the sick worker because the employer can easily replace him or her. Need laws to prevent this exploitation and the lack of benefits.
- Make sure people have health insurance. Make BadgerCare work. Let people have insurance options. Implement national health insurance.
- Migrants often have inadequate housing. Who is responsible, and who should be responsible for these bad conditions?
- Public health needs to have a "stick" to enforce public health regulations.

Public health policy and operations

- Public health resources need to be accessible to the Hispanic/Latino community. Resources need to exist, language barriers overcome (e.g., translators), and effective targeting and marketing needs to be done so the community has information about caring for itself and understanding how the system works.
- Current health resources do not meet needs of migrants--resources are not available to help them.
- There is a growing immigrant population--migrants and immigrants have differing needs.
- Hispanics/Latinos need to trust the health care system. Public health is responsible for creating an environment that will allow for that trust.
- We need independent public health investigators with teeth, but there are costs to having this resource.
- Sustain the Wisconsin Turning Point Implementation Plan.
- Program eligibility--need to flex eligibility criteria to consider annual earning versus monthly earnings, as many migrant workers only work for part of a year.
- Need safe, comfortable health care for migrants and immigrants. Tuberculosis is an "all community" problem. Often Hispanic/Latino workers don't seek medical care out of fear of getting turned in if not documented. Many do not get preventive care. Calling and getting voice mail, and not a person, is intimidating, especially if a person's command of the English language is poor.
- Need more resources if we are to have health for <u>all.</u>

- There are disparities in resources due to different funding rules and regulations.
- We must recognize that we need to keep "resolving" issues as new waves of immigrants come here over time.
- Hispanic/Latino people need to know of the laws that exist to protect their health. We need to use Spanish radio stations and television.
- Inclusiveness.

One identified outcome

- The health workforce, at all levels, is representative of the population.

Policy influence

- We need the development and enforcement of policies that are positive for public health, including reviewing and improving current policies that define public health in the broadest possible definition. This includes leadership inclusiveness from the start, marked by partnerships and connections between Hispanic/Latino and traditional power structures.
- The Hispanic/Latino community needs to identify points where they can influence policy (e.g., State Migrant Council). We need shared information in the Hispanic/Latino community using Spanish radio stations and television.
- Leadership inclusiveness is the first step in developing partnerships and connections between Latino and traditional power structures.
- Must meet their needs so they can participate (e.g., provide transportation and childcare).
- Public health needs to continue to maintain connections with various communities--not once every ten years.

Workforce

- Need to mentor Hispanic/Latino youth into the health professions so they can become nurses and doctors, instead of being certified nursing assistants. Youth need college and technical school recruitment connections. It is important that we target Hispanics/Latinos in grade school and high school, and encourage them into these professions.

Public acceptance

- Some do not want to accept Hispanic/Latino community. There is a backlash of the dominant culture against the Hispanic/Latino population--use "our" money for "them"?
- The public health system and the general public need to recognize that Hispanics/Latinos want to retain their culture while acculturating to the United States.
- Relationships need to be built with the Hispanic/Latino community. Public health needs to reach out to this community via nontraditional partners and using safe environments and trusted entities (e.g., churches).

Desired outcome

- Have data that shows that Hispanic/Latino health data and information is not statistically worse than other groups, or the population as a whole.

Public knowledge

- The Hispanic/Latino community needs to be knowledgeable about health issues.
- Need buy-in from employers who need to learn that it is not cost effective to have sick workers.

Public health community knowledge

- The health community needs to know the differing needs of the migrant population and immigrants.
- To access different groups, the public health community needs to identify those places that feel "first impact," such as food pantries.
- Need demographics and data on health issues for medical awareness.
- Need to interview and correctly survey inside the community. The issue there is the need for money to do the research and gather and analyze the data (e.g., migrants have "Third World" diseases and suffer from pesticide inhalation).
- It is important to track outcomes over time.
- Public health needs to know and advance best practices:
  - Know what works for different groups.
  - Know what approaches are effective.

Dialogue, Reflections, and Questions

- I was privileged to have worked with such a dedicated group of participants. All were practitioners and were very committed to their communities. It appeared that the process was valuable for most, although I sensed slight uneasiness and impatience by one participant.
- There were positive comments that acknowledged that the State appeared genuine in its goal to ensure inclusiveness and listen to authentic voices. One participant stated: "Thank you for being here and listening to us." The context of the statement was in response to comments about not being able to guarantee all requests.
- A poignant comment was offered to the facilitator at the end: "Even if you can't achieve all that we desire, I am pleased that our concerns went through the prism of someone who is genuinely committed. "

Hispanic/Latino Community Stakeholders Forum
Invited and Attending
October 30-31, 2001

Community Participants:

Elkid Alvarez, Racine
Jesus Alvarez, United Migrant Opportunity Services, Inc. (UMOS, Inc.)
Gladis Benavides, Benavides Enterprises, Inc.
Mary Lynn Bennett, Bilingual Skill Services
Shiva Bidar-Sieleff, University of Wisconsin Hospitals and Clinics
Vincent Bobot, City of Milwaukee
Angelo Bonoccorso, UMOS, Inc.
Mary Ann Borman, UMOS, Inc.
Louis B. Butler, Jr., Milwaukee
Violetta Castro, Dane County Mental Health
Emilio Jimenez, American Family Life Assurance Company
Ted Kay, Family Health/La Clinica
Marilyn Lira, UMOS, Inc.
Victor Lozada, Milwaukee
Alfredo Luna, Milwaukee Area Technical College
Kevin Magee, Legal Action of Wisconsin
Barbara Medina, Bureau of Child Welfare
Donna Moldonado, Catholic Charities
Theresa Perales, Community Activist
Julia J. Ramirez, Aurora Health Care
Teal Rivera, UMOS, Inc.
Teofila Rivera, UMOS, Inc.
Cuauhtemoc Rodriguez, Milwaukee
Leonor Rosas, UMOS, Inc.
Alfred Sanchez, United States Department of Health and Human Services
Karen Sanchez, Green Bay
M. Nubia Serrano, Milwaukee County Department of Aging
Teresa Tellez-Giron, Dane County Department of Human Services
Beatriz Zahn-Cantelmo, Birth to Three of Greater Dane County

State of Wisconsin Participants:

Cristina Caputo, Division of Public Health, Department of Health and Family Services
Denise Carty, Division of Public Health, Department of Health and Family Services
Regina Cowell, Division of Management Technology, Department of Health and Family Services
David Duran, Division of Management Technology, Department of Health and Family Services
Margaret Schmelzer, Division of Public Health, Department of Health and Family Services

Invited but did not attend:

Jimmy Aeuilu, Union Peurtorriquena
Alberto Aguilar, Latinos Unidos
Bernadette Anderson, The Speech Excel Center
Mario Avila, Mario Avila and Associates
John Bartkowski, 16th Street Community Health Center
Ann Marie Bernard, YWCA
Mateo Cadena, Bureau of Migrant, Refugee, and Labor Services, Department of Workforce Development
Kathleen Cantu, University of Wisconsin-Madison School of Nursing
Ernesto Chacon, The Federation for Civic Action
The Honorable Pedro Colon, Wisconsin State Assembly
Daisy Cubias, Office of the Mayor for the City of Milwaukee
Rosa Dominguez, Opportunities Industrialization Center of Greater Milwaukee
David Espinoza, La Causa, Inc.
Themis Flores de Pierquet, Division of Public Health, Department of Health and Family Services
Kristine Freundlich, Office of Strategic Finance, Department of Health and Family Services
Lucio Fuentes, Partners for Community Development
Maria Gamez, Bilingual Communications and Consulting, Inc.
Daniel Ganchert, Holy Redeemer Catholic Church
Sylvia Garcia, Alliant Energy
Yolanda Garza, University of Wisconsin-Dean of Students Office
Patricia Gomez, Milwaukee Area Technical College
Belem Gonzales, Janesville
Luticia Gonzales, Equal Employment Opportunities Commission
Barbara Graham, Legal Services for Immigrants - Catholic Charities
Anita Herrera, Wisconsin Education Association Council
Oscar Herrera, Department of Regulation and Licensing
Rosa Herrera, Hispanic Community Resource Center

Norma Iribarren, Dane County Mental Health
Maria Jenkins, Sound Bytes
Dina Knibbs, University of Wisconsin-Extension
Maria Kohlman, Salvation Army
Elsa Lamelas, Milwaukee County Courts
Emilio Lopez, Aurora Weir Education Center
Juan Jose Lopez, Madison Metropolitan School District
Luis Lopez, Latino Peace Officers Association
Pedro Lopez, Primera Iglesia Luterana
Lupe Martinez, United Migrant Opportunity Center
Olga Martinez, Nutrition and Health Association
Rocio Martinez, Madison Area Technical College
Kevin McGee, Legal Action of Wisconsin
Zoilo Melendez, Latino Health Organization
Maria Monreal Cameron, Hispanic Chamber of Commerce of Wisconsin
Filberto Murguia, Council for the Spanish Speaking
Paul W. Nannis, Center for Urban Projects
Aracely Olguin, St. Croix County Job Center
Lori K Olivares, Wisconsin Electric
Abel Ortiz, Jobs for Progress, Service Employment Redevelopment
Rudy Pineda, Green Bay
Noemi Prieto, Milwaukee
Perfecto Rivera, Community Relations of Milwaukee
Maria Rodriguez, Milwaukee City Housing Authority
Rachel Rodriguez, University of Wisconsin-Madison School of Nursing
Elisa Romero, Milwaukee County Human Services Department
Juan Carlos Ruiz, Wisconsin's Citizens Action
Ana Rumm, Madison
Angel Sanchez, Milwaukee Common Council
Walter Sava, United Community Center
Romilia E. Schlueter, Centro Guadalupano
Rosa Serrato, Unidos Against Domestic Violence
Arnolda W. Sevilla, Neighborhood Improvement and Development Corporation
Cecilia Smith-Robertson, Neighborhood Improvement and Development Corporation
Daniel Soto, Council for the Spanish Speaking
Teri Terill, Cedarburg
Nitza Torres, Jefferson
Lavinia Valdiviero, Madison Area Technical College
Patricia Villareal, Milwaukee County Human Resources
Sanjuanita Villegas, Jefferson
Vassy Virella, Milwaukee
Ann Luisa Wolf, Diocese of Madison

LESBIAN, GAY, BISEXUAL, AND TRANSGENDERED (LGBT) COMMUNITY STAKEHOLDERS FORUM DECEMBER 3-4, 2001

Perspectives, Reflections, and Recommendations on Elements of the State Health Plan, ***Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public***

(Prepared by Patrick Flaherty, Milwaukee LGBT Community Center)

CORE PRINCIPLES AND VALUES

The following text reflects the participants' responses and reactions to selected core principles and values in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. Several of the core principles/values follow without commentary. This is because these core principles/values were seen as important, yet the participants lacked sufficient time to address related issues. The following text includes their views on what core principles/values would look like if they were "done right" in a transformed public health system.

If everyone in Wisconsin works together to guarantee access to health services, health information, and environmental protection, the public health system will be able to create and sustain healthy communities and individuals.

A strong public health system can help create an environment where individuals are more likely to reach their fullest potential.

Prevention is the most effective public health strategy:

- The public health system should take proactive roles in preventing and resolving problems such as same-sex domestic violence, suicide prevention, depression, etc.
- Low-cost access to prescription drugs and preventative health care will help avoid costly health emergencies.

Good health results from the positive interaction of physical, mental, emotional, spiritual, cultural, and environmental forces:

- Elimination of social discrimination and social justice should be part of the public health agenda.
- Public health should take a multidisciplinary approach to health, recognizing the various components of good health, including LGBT-sensitive spirituality and mental health services.
- In the same way that an LGBT individual's health is a complex balance of mind, body, and spirit, LGBT individuals are in turn part of a more complex social structure. For good

community and individual health, providers should support and respect a gay or lesbian person's relationship to their partners and chosen family. Providers should recognize the role the community plays in a person's health, be it membership in a racial minority group, the larger LGBT community, or an LGBT subculture.
- Health providers should take the time to get the "total picture" from patients.

Collaboration is the key to success:

- Real collaboration challenges the comfort level of collaborators as they learn to work with one another. It is not at all about tokenism.
- Collaboration includes resources. Greater collaboration on LGBT health should include increased competition from LGBT community-based organizations for Department of Health and Family Services and other funding sources.

Government has a responsibility to establish leadership and facilitate the achievement of the public health mission and vision in Wisconsin:

- Government must hear from the LGBT community and others that are not currently heard.
- Specifically, the Department of Health and Family Services should establish an LGBT Health Officer in the Office of Minority Health. (This was mentioned by a majority of the participants.)
  Note: The Wisconsin Department of Health and Family Services has a Minority Health Program—not an Office of Minority Health.
- Specifically, a staffed statewide advisory council on LGBT concerns could be re-established by the Governor.
- Resources, both public and private, should be available to decrease health disparities for LGBT people. Resources should be devoted to LGBT organizations serving health needs locally. An LGBT-specific state Request for Proposal could be administered by an LGBT Health Officer in the Office of Minority Health.
- Real dialogue requires ongoing communication, such as thorough explicit representation of LGBT health needs on boards and committees.
- Health assurance should include greater advocacy for better social health, such as vigilant enforcement of anti-discrimination laws in housing and employment, and the State's hate crime penalty enhancement. (The Milwaukee County District Attorney, it was mentioned, has never enforced the hate crime penalty enhancer in hate crimes.)
- Health assurance should be *reasonable* and shouldn't overreach: disproportionate enforcement of health codes at LGBT bars (e.g., such as Milwaukee's police raids to look for "fruit flies" in bottles), bath houses, and public sex environments further stigmatize a community and may drive risk behaviors underground. A harm reduction methodology is better.

The public health system must be a voice for all:

- Nontraditional partners in public health should be sought.
- The voices of different socioeconomic groups, races, genders, religions, sexual orientations, etc., should be brought to the table.

- Meaningful inclusion, not tokenism, is key.
- An LGBT Health Officer in the Office of Minority Health could ensure a voice and, perhaps, issue an annual report on LGBT health indicators based on LGBT community-based organizations and individual input.
- Public health agencies should strive to empower many voices rather than purport to speak for all.

All Wisconsin residents deserve a basic level of health services:

- Although the State Health Plan, *Healthiest Wisconsin 2010*, refers to sexual orientation, the Executive Summary omits any reference to discrimination on the basis of sexual orientation, even though the State of Wisconsin was the first to recognize this menace by prohibiting discrimination on the basis of sexual orientation. All residents deserve basic health services, regardless of sexual orientation and gender identity.
- All residents deserve good health care regardless of their wealth or access to health insurance. A government-ensured universal health care system is needed.
- BadgerCare should be made available to single people, especially because in today's legal environment, all LGBT people are classified as "single," whether partnered or not.
- LGBT families are denied health care because they are not recognized; domestic partner health insurance benefits equivalent to that available to spouses is good health policy.

The more decisions are based on reliable data, the better public health decisions will be made.

Privacy and confidentiality must be assured.

Sound decisions are data-driven and based on well-established principles and practices in the biomedical, social, and environmental sciences.

OVERARCHING GOALS

The following text reflects the participants' responses and reactions to the overarching goals in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. Only one of the three goals is without commentary. All three goals were identified as important, yet due to time constraints the participants lacked sufficient time to address them. The following text includes their views on what the overarching goals would look like if they were "done right" in a transformed public health system.

Eliminate health disparities:

Health disparities for LGBT people must be identified before they can be eliminated. This means researching and tracking LGBT-specific indicators. Possible disparate health outcomes for LGBT people include deserving scientific scrutiny:

- Breast cancer for lesbians.
- Alcohol and other drug abuse problems.

- HIV/AIDS and other sexually transmitted infections.
- Mental health problems, including increased suicide risk.
- Cervical cancer screening rates for lesbians.
- Unequal health resources for LGBT people include:
  - Lack of openly gay and other culturally competent providers.
  - Lack of LGBT consumer knowledge of gay and gay-sensitive providers.
  - Lack of research on LGBT people's health problems. Examples given include the Department of Public Instructions' youth sexual behavior survey (which makes same-sex behavior invisible, unlike the States of Minnesota or Massachusetts), and federal research that doesn't examine LGBT prevalence of things like anal warts or youth suicide.
    - ? Lack of public and private resources for LGBT health-promoting community-based organizations.
    - ? Lack of access to family-based health insurance through denial of domestic partner benefits and an entitlement system based on heterosexual parenting (e.g., BadgerCare).
  - Eliminating health disparities among LGBT people requires a multi-pronged strategy.
  - Include culturally competent research regarding health disparities, with explicit LGBT input on Independent Review Boards, program design, and evaluation.
  - While protecting confidentiality, include sexual orientation as often as appropriate in demographic studies of health indicators.
  - Eliminate barriers to equal resources by designating funding specifically for LGBT health concerns and depoliticizing allocation processes. The Wisconsin Tobacco Resource Center, for example, should follow the example of the national American Legacy Foundation and designate specific anti-tobacco funding for LGBT people, since prevalence is higher in the LGBT community.
  - Promote better service to the LGBT community from "mainstream" providers, including domestic violence, medical health care, mental health, 911 response, victims of crime, etc.
  - Eliminate barriers to family-based health insurance by encouraging domestic partner benefits (and eliminate the discriminatory treatment by the Wisconsin Department of Revenue of these benefits as taxable income). Open BadgerCare to eligible single individuals.
  - Recognize that the LGBT community is actually many communities with unique health needs that cross age, language, class, race, etc.
  - Promote social health by full enforcement of anti-discrimination laws, hate crime penalty enhancers, and working to end oppression.
    - ? Promote personal and community ownership and responsibility of their health.
    - ? Eliminate special funding categories and other preferences for abstinence-only sexual health education; such education, which implicitly denies and shames sexuality, should be replaced with harm reduction models of behavior change.

Promote and protect health for all.

Transform the public health system.

- Recognize that LGBT people have specific health needs that require cultural competency and resources. LGBT input should be constantly sought, including public hearings and community forums.
- Prevent the "ghetto-ization" of the public health system.
- Address LGBT issues on a statewide level, as well as at the local community level.
- Provide better, ongoing training to public health providers. Encourage "apprenticing" in all aspects of public health (e.g., funding, staffing, certification).

ESSENTIAL PUBLIC HEALTH SERVICES

The following text reflects the participants' responses and reactions to the 12 essential public health services in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. Several of the essential public health services follow without commentary. This is because these services were seen as important, yet the participants lacked sufficient time. The following text includes their views on what the essential public health services would like if they were "done right" in a transformed public health system.

Monitor health status to identify community health problems.

Identify, investigate, control, and prevent health problems:

- Consult the LGBT community on what health needs deserve greater attention. Similarly, involve the LGBT community in program and research design and implementation.

Educate the public about current and emerging health issues:

- Prioritize health needs.

Promote community partnerships to identify and solve health problems.

- Utilize existing LGBT community-based organizations, such as the Chippewa Valley LGBT Community Center in Eau Claire, Outreach in Madison, Milwaukee LGBT Community Center, and Galaxy in La Crosse.
- New LGBT Health Officer position in the Office of Minority Health should convene an LGBT health task force with power to: (1) conduct needs assessment; (2) contract with LGBT community-based organizations to meet health needs; and (3) advocate for public policy that promotes LGBT health.

Create policies and plans that support individual and community health efforts.

Enforce laws and regulations that protect health and insure safety.

Link people to needed health services.

Assure a diverse, adequate, and competent workforce to support the public health system:

- Recruit health providers who come from the communities they serve. Promote health professions as a career option for those early in life.

Evaluate effectiveness, accessibility, and quality of personal and population-based health services:

- The Division of Public Health should be flexible about developing new services based on research findings.

Conduct research to seek new insights and innovative solutions to health problems.

Assure access to primary health care for all:

- Ensure that health care is not denied to anyone because of sexual orientation and gender expression/identity.
- Work to overcome financial, language, cultural, etc., barriers to health care.
- Ensure that providers--in this case, LGBT-competent providers--are geographically available to consumers (e.g., a clinic in a shopping center on a bus line).
- Eliminate barriers to family health insurance by providing domestic partner benefits.
- Educate consumers about how to access health providers who are competent to serve them (one example given is the Milwaukee LGBT Community Center's Lesbian Community Health Program and the Center's Information and Resource Referral Line).

Foster the understanding and promotion of social and economic conditions that support good health:

- Promote LGBT recreational options outside of alcohol and tobacco-laden environments.
- Help all youth develop healthy attitudes towards homosexuality; and help parents (both heterosexual parents of LGBT children and LGBT parents).

HEALTH PRIORITIES

The following text reflects the participants' responses and reactions to the 11 health priorities in *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*. Several of the health priorities follow without commentary. This is because they were seen as important, yet the participants lacked sufficient time to address them. The following text includes their views on what the health priorities would like if they were "done right" in a transformed public health system.

Access to primary and preventative health services:

- Create a universal/national health care system.
- Bring services to the people (e.g., provide transportation).
- Assure culturally competent staff, with LGBT advocates, to help people negotiate the health care systems.

Adequate and appropriate nutrition:

- Educate young gay men and lesbians about body image and how it relates to nutrition.
- Emphasize fresh produce in diets.
- Make sure there is no discrimination against LGBT people in WIC and other nutrition-based programs.

Alcohol and other substance use and addiction:

- Distinguish between substance use and substance abuse, using harm reduction model. Seek other approaches beyond the criminal justice model.
- Include LGBT people in public health campaigns.
- Health departments should provide money to community centers for alcohol/drug free events. LGBT community-based organizations should provide recreation outside of the bar environment.
- Ensure LGBT-sensitive AODA services (provide funding to LGBT-targeted treatment programs, publicize and support existing LGBT 12 step groups, etc.).

Environmental and occupational health hazards:

- Public health systems should promote environments that support LGBT individual health by enforcing anti-discrimination laws dealing with housing, employment, and public accommodations. Enforce hate crimes laws and end barriers to family-based health insurance by offering domestic partner benefits.

Existing, emerging, and re-emerging communicable diseases:

- Work to "bring down" HIV; Hepatitis A, B, and C; Tuberculosis; and other infections.
- Behavior interventions should take holistic view that includes mental health, LGBT supportive environments, etc.

High risk sexual behavior:

- Work to shift behaviors away from high-risk activity.

Intentional and unintentional injuries and violence.

Mental health and mental disorders:

- Support parity between mental health and conventional medical health in benefits and treatment.
- Eliminate managed care obstacles to mental health services and prescription drugs.
- Don't pathologize homosexuality.
- Assure culturally competent mental health providers through LGBT specific training.
- Explore accredited certification for therapists, AODA counselors, and others who have completed training to serve LGBT clients.

Overweight, obesity, and lack of physical activity:

- Promote social policy that supports individual physical activity as opposed to spectator sports.
- Work to end the stigma of LGBT youth in primary and secondary physical education. Such treatment has the effect of turning some LGBT youth away from physical exercise.
- Promote physical activity in LGBT youth groups.
- Promote a healthy, more reality-based body image in the LGBT community. The current all-or-nothing paradigm implies that exercise isn't worth it unless you have two hours each day to devote to the perfect gym body.
- Promote the incorporation of exercise into busy lives, including those with young children.

Social and economic factors that influence health:

- Eliminate health disparities between demographic categories such as race, sex, sexual orientation, etc.

Tobacco use and exposure:

- Replace reliance on big tobacco sponsorships and other funding by promoting greater public investment in LGBT community-based organizations, greater individual and foundation philanthropy.
- Provide tobacco settlement dollars to LGBT programs seeking to end disproportionate smoking rates in LGBT community.
- Promote recreation outside of bar environments.

Additional Recommendations:

Before adjourning, structured dialogue participants came together as a whole to reflect on the day's discussions. Individuals suggested some additional specific recommendations to better the health of LGBT people:

- Come out. Whether as a patient or provider, disclosing that one is lesbian, gay, bisexual, or transgendered--when appropriate--can increase the level of trust and communication in a clinical setting.
- Reinstate the Governor's Advisory Council on LGBT affairs.
- Use the leverage of state funding to institutions that teach medical providers to require greater LGBT-specific training.
- Provide LGBT-specific funding opportunities for LGBT community-based organizationss and others that seek to improve health outcomes.
- Provide capacity-building opportunities.
- Assure accountability in every aspect of the public health system.

LGBT Friendly Resource/Provider List
(Provided by Structured Dialogue Participants)

Resources

LGBT Information and Resource Referral (IRR) Line – (414) 271-2656. Referrals to medical providers, therapists, attorneys, and more. Operated by the Milwaukee LGBT Community Center, 315 W. Court Street, Suite 101, Milwaukee, WI 53212.

Diverse and Resilient Youth (414) 219-7914 – a statewide capacity building program assisting in the healthy development of LGBT youth programs.

Gay Youth Wisconsin Hotline – 1-866-Gay-Youth (429-9688). (414) 272-8336. Milwaukee.

Healthy People 2010. Companion Document for LGBT Health. www.glma.org (the web site of the Gay and Lesbian Medical Association).

"LGBT Health: Findings & Concerns," *Journal of the Gay and Lesbian Medical Association.* Volume 4:3, 2000.

Rainbow Alliance for Youth – a statewide network of LGBTQ youth programs. (414) 219-7914. Milwaukee.

Dr. Pat Stevens, Ph.D., RN. – researcher in Milwaukee.

Providers
(Consult your LGBT Community Center for contact information.)

Medical:

Tara Rakowski, MD, OB, at St. Mary's Hospital
Margaret Knight, MD
Robert Gremminger, MD
Jeff Miller, RN.
Ken Loving, MD (family practice)
Sarah Rowe, NP
Richard Grunke, MD
David Wacker, MD (dermatologist)
Seth Dubry, MD (family practice)
Paul Maes, DO (family practice)
Mark Behar, PA-C (family practice)
Michael Goss, MD (family practice)
Jacquelyn Dinnuson, MD (family practice)
Lyn Telford, MD (family practice)
Jose Avilla, RNC (family & HIV)
Deb Reed, RN

Therapists:

Cathy Arney, MSW
Sue Bronson
Gary Hollander, Ph.D.
Eleanor Ward (Madison)
Milwaukee LGBT Community Center IRR Directory
The Counseling Center of Milwaukee

Lesbian, Gay, Bisexual, and Transgendered Forum and Participants Invited and Attending December 3-4, 2002

Community Participants:

Neil Albrecht, Milwaukee LGBT Community Center
Cathy Arney, Milwaukee
Mark P. Behar, Aurora Medical Center
Dave Bodoh, Milwaukee LGBT Community Center
Mary Kay Bultman, Planned Parenthood of Wisconsin
Brenda Coley, Center AIDS Intervention Research
Fran Culbert, Milwaukee
Charles Daniels, Charles D Productions, Inc.
Chris Doerfler, Milwaukee
Shannon DuPree, Charles D. Productions, Inc.
Kurt Dyer, Milwaukee
Kelly Esser, Milwaukee
Rachel Federlin, Milwaukee
Kira Hagquist, Milwaukee
Kathy Herbst, Milwaukee
Elna Hickson, PFLAG
Gary Hollander, Center for Urban Population Health
Stephanie Hume, ARCW
Alphonso Jackson, Milwaukee LGBT Community Center
Ricardo Jimenez, 16th Street Community Health Center
Amy Kistnek, Lesbian Community Health Project
John Klinger, Eau Claire
Marc Korobkin, Bayside
Deb Lang, Milwaukee LGBT Community Center
Michael Lisowski, Milwaukee
Ita Meno, Milwaukee
Kathy Proedel, Milwaukee
Jason Rasmussen, GLSEN
L G Shanklin-Flowers, InReach
Kari Sievert, Dane County Division of Public Health
James Stodola, AIDS Network
Virginia Thomas, Cedar Grove
Joe Witkowski, Milwaukee LGBT Community Center
D. Young, Milwaukee LGBT Community Center

State of Wisconsin Participants:

Barbara Bitters, Department of Public Instruction
Regina Cowell, Division of Management Technology, Department of Health and Family Services
Molly Herrmann, Bureau of Communicable Diseases, Department of Health and Family Services
Karen Johnson, Division of Public Health, Department of Health and Family Services
Michelle Llanas, Division of Public Health, Department of Health and Family Services
Barbara Nehls-Low, Division of Public Health, Department of Health and Family Services
Margaret Schmelzer, Division of Public Health, Department of Health and Family Services
James Vergeront, Division of Public Health, Department of Health and Family Services

Invited, but did not attend:

Chris Ahmuty, American Civil Liberties Union of Wisconsin
Peter Angilello, Youth Pride-Green Bay
Carmen Barnes, Milwaukee
Karen Baumann, GALAXY
Betsy Blair, SSMC
Terry Boughner, Milwaukee
Randall Brown, Milwaukee
Patricia Bujard, Associated Mental Health Consultants
The Honorable Timothy Carpenter, Wisconsin State Assembly
Tony Chakonas, Wisconsin AIDS Fund
Mark Charles, Milwaukee LGBT Community Center
Ralph E. Chrisman, Milwaukee
Gerry Coons, Milwaukee
Seth Dubry, Wiselives Center
Joshua Feyen, Madison
Gary Fitzgerald, African American HIV/AIDS Task Force
Luis Garcia, Washington, DC
Karen Gotzler, Urban Economic Development Association
Roger Gremminger, Menomonee Falls
Michael Gross, Aurora Center for Well Being
Laurie Guilbault, LAMM/EF
Beth Hancock, VNA
Bill Hanel, Counseling Center
Connie Highsmith, Isaac Coggs Clinic
Gerald Johnson, Green Bay
Jerry Johnson, Milwaukee
Brian Juchems, Madison
Shannon Kenevan, LGBT Partnership
Jeff Kloko, MPS and Project Q

Steven Korzinek, ARCW
Marilyn Levin, GALAXY
Kevin Little, Milwaukee
Paul Mandracchia, Milwaukee
Adam McKinney, Milwaukee
Carmen Murguia, Milwaukee
Mark O'Neil, GALAXY
Steven Peck, Shorewood
Matthew Pijan, Gay/Straight Alliance UWMC
Carmen Pitre, Milwaukee
Margaret Pofahl, Phoenix Clinic
Narra Smith-Cox, Department of Professional Development and Applied Studies, University of Wisconsin
Leonard Sobczak, Milwaukee
Patricia Stevens, University of Wisconsin-Milwaukee School of Nursing
Jacque Stock, Wauwatosa
Bob Tollefson, Eau Claire
Mary Triggiano, Milwauke
Thomas Zander, Fox Point

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