

B. State Priorities

The Division of Public Health, Bureau of Community Health Promotion, Family Health Section staff identified possible strategies or activities that will help Wisconsin move toward addressing the needs because it is not enough to agree that something is a problem. We must have a reasonable strategy for addressing the problem, in order for it to rise to the level of a priority need or a Wisconsin State Performance Measure. The public health assurance function is carried out in many ways or approaches from: providing services directly, contracting services, developing legislation, educating professionals and consumers, building systems, and/or improving data capacity. During the needs assessment process, staff considered effectiveness, efficiency, and acceptability based on their experience and insight regarding what can work -- within the sphere of control in state government.

1. Effectiveness:

- How effective is this to leading to a solution?
- Is it reachable by known interventions?
- Can it be tracked and measured?
- What are the health consequences of not implementing such a strategy/activity?

2. Efficient:

- How efficient is this to leading to a solution?
- Does the solution produce a result with a minimum of effort, expense, or waste?
- Is this appropriate use of Title V, Block Grant dollars?

3. Acceptable:

- How acceptable is this strategy/activity to clients, providers, and within state government?
- What is the degree of demographic, racial, and ethnic disparity?
- Does this solution help achieve a Healthiest Wisconsin 2010 Health Priority?
- Does this solution help promote the Governor's KidsFirst Initiative?

Wisconsin's 10 Priority Needs

1. Disparities in Birth Outcomes

Disparities in birth outcomes are related to NPM #15, #17, and #18 by addressing very low birthweight and early prenatal care. Wisconsin's continuing SPM #9 addresses the ratio of the Black infant mortality rate to White infant mortality rate.

In 2004, 420 Wisconsin infants died during the first year of life. Of these, 245 were white, and 125 were African American. The white infant mortality rate of 4.5 deaths per 1,000 live births in Wisconsin met the national Healthy People 2010 objective for the first time in 2004. In contrast, infant mortality rates for Wisconsin racial/ethnic minority populations have not met this objective; the African American infant mortality rate was 19.2. The disparity ratio of African American to white infant mortality rates was 4.3, meaning an infant born to an African American woman was 4.3 times more likely to die before reaching its first birthday than an infant born to a white woman. If African American infant mortality were reduced to the white infant mortality level, 96 of the 125 deaths would have been prevented.

For each racial/ethnic minority group in Wisconsin, the 2002-2004 infant death rate exceeded that of whites. The infant mortality rate of American Indians was 1.8 times greater than the white rate; the rate for Laotian/Hmong was 1.6 times the white rate. In comparison to all groups, the risk of death during the first year of life was greatest for African Americans.

Relative to other reporting states and the District of Columbia, Wisconsin's infant mortality ranking has fallen since 1979-1981. In 1979-1981, relative to other ranked states, Wisconsin had the third lowest African American infant mortality rate. For the 2001-2003 period, Wisconsin ranked 39th out of reporting states and the District of Columbia, indicating it had the highest African American infant mortality rate. Since 1979-1981, Wisconsin's rank based on white infant mortality rates has

also declined relative to other states, moving from a rank of 5 in 1979-1981 to 21 in 2000-2002. Thus, while Wisconsin's white infant mortality rate declined during the past two decades, improvement did not keep pace with many other states.

The infant mortality disparity of Blacks as compared to Whites ranked Milwaukee as the 4th worst among 16 U.S. cities (Big Cities Health Inventory, 2003).

2. Contraceptive Services

This priority takes into account the concerns voiced by many during the needs assessment process regarding unintended pregnancy, teen births, and abstinence from sexual activity. Our priority aligns with NPM #8 which examines rate of teen births. Wisconsin's new SPM #1 attempts to examine the access and utilization of contraceptive services by monitoring the percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.

Women are defined as "in need of contraceptive services and supplies" during a given year if they are ages 13-44 and meet three criteria: 1) they are sexually active, that is, they have ever had intercourse; 2) they are fecund, meaning that neither they nor their partner have been contraceptively sterilized, and they do not believe that they are infecund for any other reason; and 3) during at least part of the year, they are neither intentionally pregnant nor trying to become pregnant.

Women are defined as "in need of publicly-funded contraceptive services and supplies" if they meet the above criteria and have a family income under 250% of the federal poverty level (estimated to be less than \$42,625 for a family of four). All women younger than 20 who need contraceptive services and supplies are assumed to need publicly supported care, either because their personal incomes are below 250% of poverty or because of their heightened need--to preserve confidentiality--for obtaining care that not depend on their family's resources or private insurance.

640,420 women ages 13-44 are estimated to be in need of contraceptive services and supplies in Wisconsin. Ninety-three percent of females aged 15-44 years at risk of unintended pregnancy used contraception in 1995. Approximately 27% of the estimated need for public support family planning services has been met through the Medicaid Family Planning Waiver through March 2006.

3. Mental Health for All Population Groups

Mental health as a priority need links with the NPM #16 that focuses on deaths from suicide. Wisconsin's SPM #3 monitors the percent of children, ages 6 months -- 5 years, who have age appropriate social and emotional developmental levels. (It is important to note that we recognize the importance of women's mental health, postpartum depression, the stigma associated with a mental illness diagnosis and adolescent indicators of need, however our SPM focus is on young children.)

According to the 2003 National Survey of Children's Health, 33 % of parents of young children, aged 0-5 years of age, have at least one concern about their child's learning, development or behavior and over 10% of children aged 3-17 are reported to have moderate or severe difficulties in the areas of emotions, concentration, behavior, or getting along with others. In addition, the 2005 National Health Interview Survey found 20% of boys and 12% of girls aged 4-17 years of age had parents who had talked to a health care provider or school personnel about their child's emotional or behavioral difficulties during the previous 12 months. Mental Health hospitalizations of children have increased from 4.7 per 1,000 children in 1997 to 5.5 per 1,000 children in 2003 according to the 2005 WisKids Count Data Book compiled by the Wisconsin Council on Children and Families, Inc.

4. Medical Home for All Population Groups

This priority need is an outgrowth of the NPM #3 which focuses on children with special health care needs; it also supports Wisconsin's new SPM #5 which maintains the focus on children with special health care needs and includes the priority of a dental home. The American Academy of Pediatrics believes that all children should have a medical home and as part of their focused priorities, the Wisconsin MCH Advisory Committee identified medical and dental home for all children. In addition, Wisconsin has been identified by MCHB as a Medical Home Leadership state.

A child with a medical home does not use a hospital emergency room as their primary place of care. According to the Wisconsin Family Health Survey in 2004, 1% of all children (under age 18) used the hospital emergency room as their primary place of care; among both Hispanic and white children, less than 1% used the emergency room as their usual place for care, while 5% of African American children did so. National SLAITS data indicate that: children without a medical home are twice as likely to experience delayed or forgone care; non-White children are significantly less likely to have a medical home; and poor children and children whose special health care needs have a significant adverse impact on their activity levels are more than twice as likely not to have a medical home and have unmet health care needs.

5. Dental Health (including CSHCN, racial/ethnic, linguistic, geography, income)

The dental health priority has shifted focus to access and accessibility. The NPM #9 concentrates on delivery of protective sealants whereas Wisconsin's new SPM #2 will observe the percent of Wisconsin Medicaid and BadgerCare recipients, ages 3-20, who received any dental services during the year.

Both Governor Jim Doyle, in his KidsFirst Initiative, and the state health plan, Healthiest Wisconsin 2010, identify oral health as a critical need. The National Survey of CSHCN reported that 83.1% of Wisconsin CSHCN required dental services and 92.6% received all needed dental services. 7.4% did not receive all needed dental services, which translates to 13,000 children with unmet oral health needs each year. The Wisconsin Family Health Survey revealed that 4.3% of CSHCN, or 12,800 children, did not receive needed dental care. The two primary reasons given were they couldn't afford dental care or had inadequate insurance.

In Wisconsin, 30.8% of children have at least one primary or permanent tooth with an untreated cavity. Compared to White children, a significantly higher proportion of minority children had caries experience and untreated decay. Twenty-five percent of the White children screened had untreated decay compared to 50% of African American children, and 45% of Asian children, and 64% of American Indian children. In addition, children who attend lower income schools have significantly more untreated decay (44.5%) compared to children in both middle (31.7%) and higher income schools (16.6%).

6. Health Insurance and Access to Health Care

There is a strong relationship between health insurance coverage and access to health care. During the needs assessment process, our stakeholders had difficulty looking at one need without the other; thus, we combined them into one priority. The NPM #13 requires data on percent of children without health insurance. The Wisconsin SPM #6 monitors the movement to address this need by measuring the percent of children less than 12 years of age who receive one physical exam a year.

Wisconsin ranks high in the proportion of people who have health insurance. However, state data indicate that the maternal and child health population are less likely to be insured for the entire year. This presents opportunities for public health system partners to intervene at the

individual, family and community-wide level and corresponds with the state health plan, Healthiest Wisconsin 2010. Within the state health plan, health insurance coverage is specifically delineated as key to whether or not health care services are likely to be sought and obtained.

7. Smoking and Tobacco Use

The Wisconsin continuing SPM #7 looks at percent of women who use tobacco during pregnancy. Smoking during pregnancy is a major risk factor for infant mortality, low birthweight, prematurity, stillbirth, and miscarriage. Overall in 2004, 14% of pregnant women in Wisconsin reported smoking during pregnancy; this rate is higher than the national rate of 10.2% (preliminary data 2004). In terms of racial differences, American Indian women continue to report the highest percentage of smoking during pregnancy, nearly 2.5 times as high as the overall state percentage.

8. Intentional Childhood Injuries

Discussions during the needs assessment process resulted in dividing injury into intentional and unintentional injuries. The NPM #16 relates to the priority as it addresses deaths from suicide among older teens. However, Wisconsin's new SPM #4 focuses on child abuse, neglect and maltreatment issues. We will monitor the number of substantiated reports of child maltreatment to Wisconsin children, ages 0-17, during the year.

In 2004, there were 42,451 total reports of child abuse and neglect with 8,600 substantiations in Wisconsin. This reflects a substantiation rate of 6.1 per 1000 of Wisconsin's children and youth between ages of ages newborn through 17 years. The largest number of substantiated reports (2,254) is for youth between the ages of 15 and 17 with 1,617 reported substantiations of sexual abuse.

9. Unintentional Childhood Injuries

The priority need for unintentional childhood injuries relates with the NPM #10 and the new SPM #10 both addressing death from motor vehicle crashes but for different age groups; 14 and under; and 15-19, respectively.

In Wisconsin, there are almost two times the number of unintentional injuries and deaths than intentional or violent injuries and deaths in the 0-19 age group. From 2000-2004, more than 1,600 children, teenagers, and young adults died from injuries (682 from motor vehicle-related injuries) and more than 31,000 were hospitalized; 51% of hospitalizations were caused by poisonings (19%), falls (16.8%), and motor vehicle-related injuries (16.4).

10. Overweight and At-Risk-for-Overweight

The concern about overweight and at risk for overweight was clear during the needs assessment process and surfaced as a priority need for Wisconsin. The priority need for overweight and at risk of overweight relates to the new NPM #14 and also NPM #11 (breastfeeding). Wisconsin's continuing SPM #8 also looks at the percent of children, 2-4 years who are obese or overweight.

The prevalence of overweight in Wisconsin children from age 2 to age 5 is 13.3%. Overweight and at-risk-for-overweight has increased among all racial and ethnic groups. The prevalence of at-risk-for-overweight for children aged 2 to 5 or older increased from 13.8% in 1994 to 16.3% in 2004. In 2004, the highest rates for overweight and at-risk-for-overweight were among American Indian (20.5% and 22.6%), Hispanic (18.1% and 18.3%) and Asian (15.8% and 17.1%). Rates for Whites were slightly lower at 11.9% and 16.0%, and Blacks were at 10.7% and 14.3%.

/2007/ There were no significant changes in Wisconsin's ten priority needs. Our full 172 page document, including the Data Detail Sheets can be found as an attachment to Section II - Needs Assessment. //2007//

/2008/ These ten priority areas remain priorities as well as our State and National Performance measures. //2008//

/2009/ No significant change. //2009//